Providing integrated health and social care for older persons in Denmark

Ellinor Colmorton
Thomas Clausen
Steen Bengtsson

The Danish National Institute of Social Research

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1 Introduction

In the course of the 20th century the public sector in Denmark has been developed continuously to secure the welfare of citizens. In the beginning of the 20th century the public services mainly concerned economic security in case of loss of income while in the second half of the century the provision of services has increased as public services were provided to improve the citizens’ living conditions. This development has also concerned the elderly.

In Denmark, health and social care is available on a universal basis dependent on need and not age or ability to pay. If an older person is in need of care, it is accepted and underwritten by legislation that the public assumes responsibility for the care services required (Blackman et al., 2001). Health service, hospitals and social care are provided at no cost to the elderly and financed through general taxation (Wagner, 1994).

Due to the fact that, in Denmark, the rate of women participating in the labour market is one of the highest in Europe, and that people retire earlier the nature and scope of informal family care has changed. Families have no legal obligations to care for elderly family members. Assistance given by family members or relatives is considered additional input to the assistance provided by the public services, rather than a substitution. Although there continues to be a culture of additional support provided by family members, in particular by children of older people, family care rarely substitutes for public care (Blackman et al., 2001).

The development of Danish policy on older persons has in the course of the 20th century been characterised by incremental changes and adaptations to different socio-economic challenges and public demands. These developmental trends in the Danish policy on elderly led to an increasing awareness that the various policies concerning older persons lacked internal coherence and in many cases policies in one area contradicted policies in another. On this background the Commission on Elderly was constituted in the late seventies. The objective of the commission was to formulate coherent visions and objectives for the Danish policy on elderly. One of the main recommendations of the Commission on Elderly was to aim at an increasing level of integration of the services provided to senior citizens. According to the commission “a higher level of coherence must be considered a central means to achieve tangible improvements in the living conditions for the individual older person, while ensuring that this is achieved without an extreme rise in expenditure” (Ministry of Social Affairs, vol. 3, 1982: 30; our translation). In the subsequent years the following developments have characterised the Danish policy on elderly.

During the 1980’s and to the end of 1990’s an increasing part of the elderly population has made use of the possibility of receiving services provided by the public (Ministry of Social Affairs, 2000). Most of the period the Danish economy has been characterised by stagnation. Consequently it has been difficult to meet growing needs of care for older people by a similar growth in the use of economic resources. Instead the growing need for elderly care has been met through restructuring and innovation for example in the form of a shift from institutional care to home care along the lines of the recommendations of the Commission on Elderly. At the same time the municipal organisation of services and the use of staff have changed (Ministry of Social Affairs, 1995). These developments have resulted in an increasing level of integration of the health and social care services provided by the local – municipal – level of government.
This process of integration, however, has until now to a large extent eluded the health services of hospital services that are provided by the regional level of government. As will be discussed over the following pages, the boundaries between local and regional government, thus, appear to constitute a significant barrier in terms of integrating the health services provided by the regionally administered hospitals with the health and care services provided by the municipalities.

In the second half of the 1990’s, however, changes in the public policy resulted in a reduction of public services, first of all in the area of care for the elderly. Economic considerations combined with an increasing request for home help had the consequence that the municipalities gave priority to personal care at the expense on the emphasis practical assistance. Altogether, this meant less time to practical assistance. At the same time there has been a change in measuring the services. Before the help was given and measured according the total need, while it is now measured according to a detailed description of the needs. For the citizens it appears that the help provided is less generous (Hansen, 2000).

However, in the following decades the Danish welfare state will increasingly be confronted with the challenges of coping with an ageing population. The challenges associated with an increasing proportion of potential recipients of elderly care, thus, put the tax-financed Danish model of universal provision of elderly care under pressure.

The presentation will focus on the following issues in the organisation of elderly care in Denmark. After a brief presentation of basic concepts in Danish elderly care the attention of the paper will be directed towards a description of the structure of health and social care services. This description will focus on who are providing and who are provided with health and social care. Furthermore, this description will discuss the conflicts between the actors involved in the provision of health and social care services. The subsequent section will discuss model projects that aim at solving various problems in the existing system through innovation of new ways of working. Finally, the presentation will focus on the lessons that can be learned from the model projects and from the aggregate experiences of providing health and social care services in Denmark.

2 Basic principles and concepts in Danish elderly care

The Commission on Elderly announced the principles in policy for older persons in the beginning of 1980’s. The general objective of Danish Ageing Policy is to improve the individual’s possibility of living at home or to ease his or hers everyday existence and improve his or her quality of life. Danish ageing policy is based on the general principles of (i) ensuring continuity in the individual’s life, (ii) making use of older people’s own resources, (iii) preserving older people’s self-determination, and (iv) sustaining older persons ability to influence their own circumstances.

The philosophy behind these principles is that (i) older persons do not make up a homogeneous group with uniform needs, (ii) the provision of services to older persons shall not be provided as package solutions in nursing homes, but be given in accordance with the individual need for aid,

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1 The Commission on Elderly – appointed by The Danish Government – worked from 1979 to 1982. The aim was to formulate a coherent Danish Ageing Policy.
and (iii) residents at nursing homes - as other older persons - should have influence on their own economy and daily lives (Ministry of Social Affairs, 1982).

The concept of Danish ageing policy presupposes that a broad and varied range of services and activities is available to the elderly. The services concerning integrated health and social care are home help, home nursing, rehabilitation and nursing homes2 (Ministry of Social Affairs, 1998).

The central government lays down the general legislative framework for the provision of services for older persons but the municipalities decide on and are responsible for the range and organisation of the services provided. It is furthermore the responsibility of the municipality to provide coherent services to the individual as well as monitoring that resources are used in an effective way. Even though the services will vary from one municipality to another the cooperation between home nurses, home-helpers and other social and health services is a central requirement.

2.1 Integrated care at the municipal level

The aim of Danish elderly policy is to enable older persons to live a life as close to the normal life as they want. The key phrase is “in your own home as long as possible.” It presupposes that a varied range of services is available to the elderly. Only in cases of actual illness treatment will be given in hospital. When an older person no longer needs treatment, the local authority assumes responsibility for care and services. Apart from nursing homes, Denmark has almost no institutions outside the hospital system taking care of the frailest elderly. Their needs are met through integrated health and social care within municipalities. Integration between home help and home nursing means that in practice the two professions, social and health are formally working together in integrated teams. The service includes also physiotherapist and occupational therapist.

With the social reform of 1976 social security and some health and social services were unitied in municipalities. The idea was that the citizens only had to contact one authority instead of several authorities, as was previously the case. But in the municipalities social services were spread on several departments. One for home nursing, one for home help, one for health, one for nursing homes and one for social work for elderly. Each department had their own budgets, management and employees. This diversion entailed that an elderly citizen might have several case managers and the cooperation between the departments was not always flexible.

During the period of economic stagnation in the 1980’s the social services were under pressure for more effectiveness. There was almost no discussion about competitiveness or of involving the market as in UK or later in Sweden. Instead focus was on gearing the municipal health and social care units for a more effective use of the resources. The result was among other things a reorganisation of health and social services for elderly.

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2 In 1988 new legislation was implemented on dwellings for dependent elderly and this legislation was directly inspired by the recommendations of The Commission on Elderly. According to this legislation municipalities could no longer build nursing homes according to former legislation. Adapted dwellings with 24-hour assistance service replace the nursing homes. 24-hour assistance services are provided to all elderly independent of where they live.
The aim was an integrated health and social care. The integrated health and social services implies that the services are provided to all elderly – independent of where they live – by integrated teams of home-helpers, home nurses etc. Each elderly 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 coordinate the efforts and cancel when the elderly is hospitalised, on vacation or visiting relatives. The decision of support is made on request from GP’s, hospitals, the elderly or relatives.

As services are provided without regard to type of housing, no distinction is made between nursing homes, adapted dwellings and independent housing for the elderly. The 24-hours assistance services are accessible for all elderly in need. By providing personal assistance at all hours of the day this service contributes to reducing the demand for nursing home places, handling early discharges from hospital, and preventing some incidents of socially induced hospitalisation.

According to the Act on Housing for Older people it must be possible to call in speedy assistance at any time of the day or night to all sheltered housing. In addition, ready assistance may be made available for other types of dwelling. If an ordinary telephone does not provide an adequate means of calling, an emergency call system may be installed (Ministry of Social Affairs, 1995).

Many local authorities cooperate on measures of prevention and rehabilitation for the elderly, with the aim of enabling older people to remain in their homes as long as possible. In addition, practical and personal assistance is supplied by local authorities, which employ physiotherapists or occupational therapists.

As regards discharge of older people from hospital, there are no regulations or standards to ensure coordination, although in some counties the hospitals and the municipalities have reached their own agreements on coordination. The problems with integration health and social service are often connected with discharge from hospital. The decrease in the average number of bed days at hospital results in an increasing demand for domiciliary care. The process of integration of health and social care, thus, appears to be most advanced at the municipal level. As will be discussed later, the bulk of the problems in terms of integration occur at the interface between the regionally administered hospital system and the municipally administered health and social care services.

### 2.2 The concept of self-care

The provision of integrated health and social care for older persons is based on the concept of self-care. The concept of self-care includes an accept of the human being as a free, independently thinking and acting individual with the ability to make decisions about his or her life. According to Orem’s concept of self-care, the role of health care personnel is consultative and their professional skills should be used to ensure that each member of the community receives the assistance he or she requires to continue being responsible for his or her life (Wagner, 1994).

To a wide extent, Danish policy on older persons is founded on making use of older people’s own resources, to preserve older people’s self-determination, influence on own conditions and to ensure continuity in older people’s lives. The services are governed by the principle of help to self-help and are therefore to be performed together with the older person insofar as this is possible, so that the skills of the recipient are maintained or retrained. The home help may support the older person in maintaining social contacts and areas of interest (Bierring et al., 1987).
The concept of self-care has among other things resulted in a change for elderly in nursing homes. Nursing home staff are not supposed to take over responsibility for the life of individual residents. Each resident is to decide what services he or she wants to make use of. Staff are responsible for treatment, care and supervision.

Since 1993 all residents at nursing homes have to manage their pensions and pay rent, pay for electricity, heath and for services as meals, hairdressing, shaving etc. When older persons have to pay directly for the services, their incentives to do things themselves increase as well as their self-determination (Ministry of Social Affairs, 1995).

3 Provision of health and social care in Denmark

3.1 Who is receiving health and social care services?

Health and social care services constitute the largest single area of the municipal services. In 2001 roughly 180.000 persons aged 67 or more received home help from the municipalities. Thus, in Denmark 24 per cent of older persons over 67 years of age receive public home help – the highest rate in Scandinavia (Social Appeal Board, 2001; Daatland, 1997; Rostgaard et al., 1998). In total more than 212.000 persons received home help in 2001. 112.000 of these received less than four hours of help a week. Furthermore, 28.000 persons lived in nursing homes in 2001, another 57.000 were attached to a day-care centre and 63.000 adapted dwellings had been established. Finally, the municipal expenditures on elderly care amounted to 3 billion euros in 2000. In 2000 the overall direct transfers in cash or kind to elderly citizens in Denmark amounted to 10,6 percent of the GDP.

According to figures on who are doing the work in the households of elderly, however, it does not seem that the responsibilities left with the municipalities just because one has reached a certain age. A study from the end of 1980’s shows that two thirds of all elderly aged 70 years or more and living at home do not receive home help (Platz, 1990). Another study from the middle of 1990’s shows that among persons between 80-100 years more than 40 per cent do not receive home help (Hansen & Platz, 1995).

Still, more than one third of all hospitalised persons are over 65 years and are using more than 50 per cent of the total amount of bed-days in all hospitals. Over the latter years hospitals have been run more effectively, which has resulted in a decrease in the average days patients stay at the hospital. This means that also older persons are discharged earlier, thus requesting more services from the municipality once back home which again put emphasis on the provision of integrated care (The National Association of Local Authorities in Denmark, 2000; Felbo & Søland, 1996).

3.2 Who provides health and social care services?

Health and social care is characterised by an extensive delegation of responsibilities to politically elected regional and local authorities. Regional (16 counties) and local (275 municipalities) authorities administer health and social policy respectively. The Ministries (Health and Social) are
responsible for overall control and for establishing the broad legislative and financial framework of health and social policy.

An important feature of Danish legislation on health and social welfare is that it provides only the general framework. The local authorities determine actual contents and organisation of the health and social care services provided. As a consequence of the decentralisation of responsibilities to counties and municipalities, there are variations in the services provided to older persons depending on where they live.

- *The Ministry of Interior and Health* is responsible for primary health services and hospitals.
- *The Ministry of Social Affairs* is responsible for pensions for and the care of the elderly.

As noted above the responsibilities of implementing health and social policy have been delegated to the counties and municipalities.

### 3.2.1 Counties

The 16 counties administer hospitals, including geriatric rehabilitation services, primary health care (except home nursing) and health promotion initiatives. Long-term care is not in general a county health authority responsibility, but older people with mental illnesses, such as dementia, may be referred for care at specialised units. Counties are therefore responsible for the running of hospitals and for the coverage of general practitioners (GPs) (Blackman et al., 2001). Hospitals and GPs are financed through general taxation, which means that the users do not pay directly for services provided by hospitals and GPs. The charges for medicine are subsidized to a high degree.

### 3.2.2 Municipalities

The 275 municipalities administer pensions, nursing homes and adapted dwellings for older persons, home nurses, psychotherapists, occupational therapists, and social care as home help. The referrals of all aids to older persons, who are not in hospitals, are coordinated in the municipality by the health visitor, who is also the case-manager.

The municipalities have a statutory duty to offer home help for both practical and personal assistance, home nursing and provide housing for disabled persons – including adapted dwellings, nursing homes and attached day care facilities. Care is free of charge to the recipient irrespective of the type of housing of the recipient. Other social services provided are: transport for people requiring treatment, day centres, which may offer recreational activities as well as rehabilitation, loan of equipment and aids and, finally, meals on wheels, for which there is a charge.

The municipalities are the main provider of services, but some of the nursing homes and attached day care facilities are run by voluntary organisations. These organisations have contractual agreements with the municipality. The municipalities, however, remain responsible for standards in the home, admission criteria, and the setting of rents and services charges. In all practical ways,

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3 The objective of occupational therapy is to restore or maintain the patients physical and mental abilities.
there is no distinction between nursing homes and day care facilities run by the municipality and those run by voluntary organisations (Blackman et al., 2001).

3.3 What kinds of health and social care services is provided?

This section will provide a brief outline of the components of the health and social care services that are provided in Denmark. With two exceptions the services that are described below are fully provided by the municipalities. The General Practitioners are organised at the county level and the rehabilitation services can be provided either by the county or the municipality, depending on whether the older person has received hospital treatment or not. As the content of the health services provided by the hospitals appear fairly self-evident, these will not be described below.

Over the past decades there has been a drive in Danish elderly policy to integrate the services provided at the municipal level. The individual kinds of services described below are thus provided in concert depending on the need of the individual user. The actualities of the services provided may differ from municipality to municipality, as the municipalities individually are entitled to organise the services provided on the basis of the perceived need profile of the community.

3.3.1 24-hour health and social care

The municipal health and social services are accessible 24-hours every day. Persons in acute need of help can, thus, call in assistance in case of need. In special cases and for shorter periods a carer might stay in the home of a very ill person day and night. This 24-hour home care system made it possible to care for very dependent people in an ordinary dwelling (Hansen, 2001). Many elderly remain in their own homes even in case of heavy care needs and the demand for 24-hour service has risen sharply (Social Appeal Board, 2001).

The most recent developmental trend is the introduction of ‘integrated schemes’ comprising both staff in nursing homes/adapted dwellings and social and health staff working in the community. There are integrated staff-units of this kind in 86 per cent of the 275 municipalities, while in the remaining municipalities staff may work in integrated teams but formally still belong to their individual professional group. The integrated teams consist of eight to ten persons, who are responsible for the care of older people in a local area, i.e. the two sets of professionals provide home care together (Blackman et al., 2001). The integrated teams primarily consist of home-helpers and home nurses. The services provided by these two professional groups will be presented below.

3.3.2 Home help

The aim of the municipally organised home help is to provide (i) personal care and assistance, (ii) assistance or support for necessary practical work in the home, and (iii) assistance in maintaining physical or mental skills. Home help services are provided by trained staff.

An applicant for home help is entitled to an individual assessment of his or her need for personal care and practical assistance. A nurse, a home-helper or a home help manager normally visits the applicant in his or her home to assess the need for care. Provision of care does not take help that could be provided by adult children or other family members living outside the household into ac-
count. The range of services available to meet need, the entitlement or eligibility criteria applied, and the number and type of hours of help allocated are all dictated by the budget and political preferences of the local municipality (Blackman et al., 2001).

Since 1998, the majority of municipalities tended to be less generous when assessing for home help for domestic tasks. Instead, home help is more likely to be targeted on the most dependent elderly in need of personal care. Some municipalities may be evading the law by withholding home help for domestic care (Blackman et al., 2001).

3.3.3 Home nursing

Home nursing is provided free of charge either following referral from a GP or in cooperation with the home help services. The home nurse often plays a key role in terms of supporting the home help and assessing the individual senior citizen’s need for assistance. Home nursing is often carried out on short-term basis following discharge from a hospital to ensure that the treatment, the older person has received at hospital, is sustained. The home nursing services are organised and administered by the municipalities.

3.3.4 Preventive home visits

All municipalities are been obliged to conduct at least two preventive home visits a year from social- and health workers for older people aged 75 years or more. The aim of the preventive home visits is to reduce risk factors for elderly. This might be reducing falls, social isolation, suicide, traffic accidents and to improve physical activities. The visit is made on acceptance by the older person (Rostgaard & Fridberg, 1998) The municipality may also decide to make exceptional visits in relation to the death of a spouse, serious illness or discharge from hospital. The person (often a nurse) making the visit must have thorough knowledge of general social as well as health issues.

A recent investigation into the municipal activities with regard to the preventive home visits shows that the elderly in 85 percent of the municipalities are offered preventive home visits twice a year. For various reasons 15 percent of the municipalities do not meet their obligations in this regard (The Social Appeal Board, 2002).

3.3.5 Nursing homes and adapted dwellings

Denmark no longer builds conventional nursing homes. Separate dwellings individually adapted to the needs and capacities of the elderly are replacing institutions, which are thought to limit the independence of the elderly. Such dwellings may be integrated into existing housing or constructed separately (Ministry of Social Affairs, 1995).

During the last 20 years the availability of nursing home places has been reduced from approximately 40 places to approximately 20 places per 100 persons aged 80 or more. In their place independent adapted dwellings have been built, but they are not all staffed and are therefore not all as fully supportive care units as the conventional nursing homes.

The municipalities have the responsibility for assessing people’s needs for adapted housing. The municipality is obliged to ensure that those who cannot remain at home, even if they receive
home assistance or personal care, can be admitted to a nursing home or another care facility such as different forms of adapted dwellings, staffed around the clock (Blackman et al., 2001).

3.3.6 General practitioners

For many older persons the general practitioner often constitute the primary link between the elderly and the health and social care services provided by the municipalities as the GP refers persons who experience loss of functions or trouble in handling everyday domiciliary tasks to the municipal services. The GPs may also participate in preventive home visits and promote preventive measures in their consultation after agreement.

GPs are self-employed but their activities are highly regulated through agreements between their professional organisations and the counties’ Health Insurance Negotiating Committee. Using the GP in municipal work depends on the specific contracts between the municipality and GPs. Because of the stipulations of these contracts – and the many GPs involved – formalised cooperative relations between the GPs and the municipalities appear troublesome in many cases.

3.3.7 Rehabilitation

Rehabilitation is part of a continuous treatment at hospitals, while maintenance training typically is a municipal service. In a Danish context rehabilitation is defined as conscious and goal-oriented training, which aims at restoring the patient’s earlier function level, before the accident or illness took place, whereas maintenance training is defined as conscious training to prevent loss of function and to maintain or improve the functions of the individual.

As will be discussed in further detail below, however, the division of labour with regard to rehabilitation is the cause of significant conflict between the municipalities and the counties. As a result of a long running debate about lack of sufficient rehabilitation and an unclear division of labour in the field of rehabilitation the ministries of Health and Social Affairs have passed legislation in order to clarify the responsibilities of the counties and the municipalities. Thus, the municipalities are responsible, when elderly become ill without hospitalisation, but need rehabilitation. This effort is connected to the existing maintenance training. The counties, however, are responsible that discharged patients have a carefully arranged plan of rehabilitation. The act may ensure that all patients, who need it, have a continuing coherent rehabilitation plan, no matter who have the responsibility.

3.3.8 Other services

Other types of municipal services for older persons are, centres of social activities and maintenance training, day care in nursing homes, meals-on-wheels, gardening services, technical aids, alarm systems, adaptation of housing, short stay and/or night care in nursing centres.

3.4 Problems and solutions in the provision of health and social care

Even though health and social care appears to be fairly well integrated at the municipal level the problems persist in coordinating the activities of the municipalities and the counties.
The main problems concern (i) patients who cannot take care of themselves after hospitalisation and therefore may have to wait at the hospital for a place in an adapted dwelling or a nursing home, (ii) cooperation between the hospital and the municipality to ensure home nurses and home help in relation to discharge from hospital, and (iii) rehabilitation at hospitals and after discharge from hospital.

The collaboration and the division of labour between hospital and health and social care units vary from municipality to municipality and from one hospital department to another. This is due to the fact that decision-making in this field is decentralised and, thus, not based on governmental guidelines or centralised legislation.

A study in 4 municipalities from 1992, concerning elderly with massive health problems and/or social problems shows that policy on ageing mostly works. But there appears to be room for improvement, however. The health and social services are often provided too late, which means that the preventive potentials of the health and social care services are not fully utilised. Most of the elderly do not know the possibilities of services and the social workers and decision makers often do not know the elderly well enough to provide sufficient proactive services. In almost all studied cases there are unsolved problems, which maybe are due to the fact that the capacity is too scarce, for example too few adapted dwellings or that the health and social worker are too busy or not well enough qualified. In the following the main problems concerning integration between the hospitals and the municipalities will be mentioned.

### 3.4.1 Bottlenecks in the system

One problem concerns patients who are not able to take care of themselves upon discharge from hospital and therefore are waiting for a place in a nursing home or an adapted dwelling. These patients cannot be discharged due to the lack of nursing homes or other municipal efforts. The problem has existed for years (The Association of County Councils in Denmark & The National Association of Local Authorities in Denmark, 1991; Ministry of Health, 2001).

The counties administer and finance the hospitals, while the municipalities administer and finance the measures concerning elderly discharged from hospitals. The municipalities thus have an economic incentive to prolong the stay of elderly citizens at the hospitals (The Association of County Councils in Denmark & The National Association of Local Authorities in Denmark, 1991). One of the solutions has been to make the municipalities pay for patients at hospitals who have finished their treatment. From 1993 the counties are allowed to make the municipalities pay per day for patients waiting for a place on a nursing home. Since 1993 there has, thus, been a decrease in the amount of elderly somatic patients at hospitals waiting for a place in nursing homes (Ministry of Health, 2001).

Until now the experiences with payment shows that patients in counties with payment, are waiting on the hospital in shorter time than in counties without payment (Ministry of Health, 2001). Other solutions for municipalities have been to establish temporary places on nursing homes or other places for elderly who will recover after a shorter period and return to their homes.
3.4.2 Discharge from hospitals and coordinating efforts

The decrease in the average number of bed days for elderly patients in hospitals requires an extended cooperation and dialogue between the hospital, the general practitioners and the health and social care units in the municipalities to ensure that the patients are in ‘safe’ hands upon discharge. Discharge from a hospital can be described as an upheaval for the elderly. Returning to one’s own home can be experienced both as a relief and a load. In any case there will be a need for follow up in the home with the purpose to clarify and solve problems concerning e.g. home help, aids and medicine. Experiments show that the following up after discharge will reduce the amount of elderly, who later needs living in nursing homes (Hansen et al, 1994).

There are, however, different understandings at the hospitals and in the municipalities of central concepts when patients are discharged. They mainly disagree about when a patient has finished treatment. The hospital alone has the competence to make decisions about the discharge of patients. According to municipalities, however, elderly patients are often discharged with out having finished their treatment. The municipalities experience a development, where the municipalities have to take over more and more tasks from hospitals - without general planning or more resources (Feldbo & Søgaard, 1996).

Information and communication is another area causing problems. The municipalities express problems with no or late warnings when a patient is discharged. Beside that, information from hospital to domiciliary care about results achieved at hospital or changes in use of medication is lacking for the elderly receiving home help. Furthermore, there are disagreements about the patients needs in their own homes when they are discharged from hospital. The experience of municipal home-helpers is that the patient upon discharge sometimes can manage less than reported by the hospital officials. This can be explained through different understandings of “autonomy”, as hospital staff often does not consider architectural barriers or other problems occurring in patients’ homes that are not equipped for long-term care. Also the GP often misses information about the results achieved by the hospital treatment, because he or she receives the discharge report long time after the patient was discharged (Feldbo & Søgaard, 1996).

3.4.3 ‘Getting the municipalities into the hospitals’

One way of solving discharge problems is to develop cooperation models between hospitals and municipalities where staff from the municipality participate in planning the discharge from the hospital. This can be done by (i) the home nurse who sometimes visits the elderly at the hospital and thus also gets information from the hospital staff or (ii) by inviting the home nurse to meetings concerning discharge of an older patient.

One solution on the problem might be to employ a visiting nurse, visiting all citizens above 65 years who is either admitted to hospital, losing a spouse or moving into the municipality. The purpose with visiting the elderly at hospital is to build bridges between the hospital and the home and to deal with questions and problems - before they arise. There have, however, been problems with the cooperation model caused by the rules of professional secrecy (Feldbo & Søgaard, 1996).

Another solution has been discharge-meetings with staff from hospital and municipality to strengthen the coherence in the effort. It is inconvenient when the hospital discuss social efforts with the patient without involving the municipality. The reason is that hospital staff not always
knows about the range of care services provided and the assignment criteria in the municipalities, which might result in expectations from the elderly that cannot be fulfilled (Hansen et al., 1991).

3.4.4 ‘Getting the hospital to work with the municipalities’

Another way of strengthening the cooperation between the sectors concerning discharge from hospital is to let the staff from the hospital having outgoing functions. Two typical solution models are home visits and geriatric teams.

*Home visits* after discharge from hospital take place in cooperation between hospital, municipality, the elderly and relatives if possible. The purpose of the visit is to arrange a rehabilitation plan close to the daily practice in the home and to estimate the need for aid, changes in the home and specific care efforts. Because of shortening of the average number of bed days at hospitals and the increasing number of patients coming through the hospitals, the pressure on occupational and physiotherapist, which often is the group with outgoing tasks, has increased. Often there will be waiting time for home visits, which either extends the time at hospital or the discharge will be without a home visit (The National Association of Local Authorities in Denmark, 2000).

To ensure a coherent treatment and follow-up after discharge from hospital, some hospitals have established *geriatric teams*. A geriatric teams can be made up of staff form hospital, for example a doctor, a nurse, secretary and occupational and physiotherapist, social workers or others. The aim of the team is to treat the elderly in his or her own surroundings and prevent (re-)admission to hospital. The team is supposed to ensure a coordination of the effort for the elderly between the two sectors. The target group for the geriatric teams is elderly with complex health problems and/or loss of function.

The efforts of the geriatric teams concerning discharge have resulted in a rapid growth in the access to municipal services, mostly home help, home nurse, day-centre, meals on wheels, changes in the home and aids. It is not possible to measure, how many of these services would have been offered without the geriatric effort. In one municipality that cooperates with geriatric teams it is estimated that the teams have contributed to uncover needs, which otherwise would not have been discovered (The National Association of Local Authorities in Denmark, 2000).

3.4.5 *Cooperation between hospital, general practitioner and the municipality*

The GP has also a role connected to the discharge from the hospital. The GP mostly becomes informed about the medical condition of the patient when the patient is discharged. The GP subsequently has to carry on treatment, monitor rehabilitation and carry out the necessary control (Hansen et al, 1994).

As discussed above formal barriers often hinder the cooperation between the GP and the municipality. The GPs, thus, rarely participate in formalised cooperation with either the hospital or the municipality in case one of their patients is discharged from hospital and requires further treatment in the subsequent period.

One development project which involved GPs and the home nurse in a systematic follow-up on elderly patients discharged from hospitals shows that it is possible to prevent institutionalisation of elderly persons through follow-up visits. In the project, a district nurse visited the elderly per-
sons in their homes the day after discharge from hospitals and two weeks later the general practitioner visited the discharged patients (Hansen et al, 1994).

Most hospitals have gradually established warning systems to inform the municipality. It might be warnings about patients, who are to be discharged to their own homes or patients who are discharged to a nursing home. At the hospital in Herning there is e.g. a cooperation contract which stipulates that the domiciliary care has to be notified at least 3 days before a discharge, if the discharge concerns a patient who needs municipal health or social care. The purpose is to avoid hasty discharge and the problems in the municipality following when a patient with needs for services is discharged without prior notification.

3.4.6 Rehabilitation

The county and municipal services concerning rehabilitation have been discussed for several years. The discussion concerns both the coherence in the service and the division of labour between the counties and municipalities (Ministry of Health, 2001). One of the impediments for sufficient rehabilitation is the division of responsibility between counties and municipalities, which have not been clearly clarified.

Until recently the boundary between health and social rehabilitation has not been laid down in the legislation neither in the Social Act nor in the Health Act (Ministry of Health, 1994).

It is difficult to make a clear delimitation between rehabilitation in the health system (counties) and maintenance training and prevention of loss of function in the social system (municipalities). A gradual shift from the specialised rehabilitation at hospitals to the rehabilitation that is normally carried out in the municipalities appears to be taking place. Between the two sectors there is a so-called grey area where patients can get jammed insofar as none of the rehabilitative bodies accept responsibility for the rehabilitation of a given patient. The problems of delimitation between the two sectors in connection with the obligation to continue or to start training are typically related to discharge from hospitals.

The municipalities have stated that discharged patients are frailer and less self-reliant than earlier due to the shortening of hospital stays. Therefore municipalities have to provide increasingly specialised efforts of rehabilitation, which is straining the economy of municipalities. The municipalities claim that the boundaries between the counties and the municipalities have shifted. The counties claim that the methods of treatments have become gentler and therefore it is not necessary to use as many resources at rehabilitation on each patient as earlier (Felbo & Søland, 1996). From the perspective of the municipalities the counties appear to shift the economic burden of rehabilitation to the municipalities, and a conflict of interest with regard to the financing of rehabilitation upon discharge, thus, becomes evident at the interface between the hospitals and the health and social care units.

A study in 2 hospitals and 4 municipalities concludes that there has been displacement of tasks from hospitals to municipalities. The hospitals hardly fulfil the needs for rehabilitation for patients living in municipalities without training therapists. There are patients who fall into a hole when they are discharged and rehabilitation at hospital ends, if the municipalities have no physiotherapist employed (Engberg & Tang, 2000).
Projects in several municipalities show that coherent rehabilitation efforts reduce the economic expenditures of health and social care. The reduction in expenditures is held to be caused by fewer re-admissions, decreasing need for home nurses, home help and aids. A project in the municipality of Vejle shows that a goal-directed and limited rehabilitation effort in the citizen’s own home gives both better quality of life for the elderly and reduce the use of home care. Especially when the rehabilitation effort has started as early as possible (The National Association of Local Authorities in Denmark, 2000).

It is necessary that the counties and municipalities cooperate on the issue of rehabilitation. An improved cooperation and coordination between the county and the municipality can among other things be improved by increasing communication, cooperation contracts and contracts specifying who is doing what. In these ways they obtain more coherence in the efforts towards the citizens and a better use of resources (Ministry of Social Affairs, 1998). The counties and municipalities are not able to reap the full rewards of well-planned rehabilitation due to the conflict of interest in terms of the financing and division of labour of rehabilitation.

4 Overcoming the barriers: model projects and experiments

The different kinds of services that are provided in Danish elderly policy have been developed over a long period. A large part of the developmental impetus stems from model projects and experiments in individual municipalities. These projects are often carried out in collaboration with the Ministry of Social Affairs. In this section the focus will be on five model projects that have contributed to the evolution and improvement of health and social care services in Denmark over the past 20 years.

The experiences gained from these and other model projects and experiments are pooled in e.g. the Ministry of Social Affairs, the Ministry of Health, the Institute for Service Development and the National Association of Local Authorities in Denmark, in order to provide all counties and municipalities with inspiration for the evolution of health and social care services provided at the regional or local level.

The first project cited has had a major impact on the provision of integrated health and social care in Denmark, as it was one of the first experiments with the provision of health and social care services around the clock in Denmark. The discussion above showed that the primary problem in terms of integrating health and social care in Denmark appear at the interface between regional and local authorities, and the four remaining concern initiatives to overcome the barriers and difficulties inherent to the coordination of the efforts of the hospitals and the municipalities.

4.1 Developing 24-hour integrated health and social care

The municipality of Skaevinge started a project in 1984 with the purpose to create a more dynamic and flexible provision of services for elderly persons. All categories of staff working with elderly persons were involved together with actual and potential elderly users.

The starting point was a traditional municipality organisation with (i) a nursing home, (ii) a department for home nursing, (iii) a department for home help, (iv) a department for health, and (v)
an office for social work for elderly. These different departments all had their own budgets, management and employees (Wagner, 1994).

The objectives of the Skaevinge project were:

- To separate housing from health and social care and introduce 24-hours integrated health and social care. All citizens are eligible and might have equal access to provided health and social care, irrespective of living at home or on institution.

- To evolve a common professional understanding between the health- and social care workers through working with the concept of self-care as basis for the health and social care.

- To provide early and individual care in order to obtain better health statuses and prevent admissions to hospitals in the target group.

- To organise service provision in autonomous teams with the responsibility and competence to plan actual health and social care services provided without a delaying hierarchical structure.

- To integrate the traditional health and social care sectors and bring them together in one common department in order to obtain a better utilization of the pooled resources (Wagner & Mogensen, 2001).

4.1.1 The results of the project

The project has produced a whole host of results of which the most significant will be mentioned below. The former nursing home was converted into individual apartments in order to provide residential units that resembled the type of housing that the residents were accustomed to before requiring sheltered housing. At the same time a health centre was established, putting together home nursing, public health nursing and day centre under one roof. Here, the various professional and technical groups worked closely together for the first time. The centre directs its attention towards all potential older users in the municipality regardless of their housing status.

Due to the availability of the 24-hour service throughout the municipality and improved information on self-care and possibilities for help in their homes, many older persons have chosen to keep on living in their own homes instead of opting for residence in nursing homes or adapted dwellings. The day centre in the former nursing home has also been extended and work has been further developed and systematised, particularly in identifying potential clients in the community in need of support (Wagner, 2000).

Furthermore, the project shows that it is important to be aware of professional and cultural differences in the health sector and in the social sector when collaboration is to be established. Staff in the health sector suffers from the ‘maid servant syndrome’, as they are been paid to be on duty eight hours daily and have acquired some deep-seated habits of ‘helping’ and ‘taking care of’ instead of encouraging the patients to do as much as possible themselves. And the patients expect these services since the nurses are being paid to perform them. On the other hand, staff in the social sector appears to be more accustomed to the principle of self-care where the citizen plays an important role in the provision of services. The social sector builds on the use of older persons own resources to preserve older persons self-determination and influence on own conditions in order to ensure continuity in older peoples lives (Wagner, 1994).
An evaluation of the Skaevinge project was conducted in 1997. The evaluation shows that:

- The older persons estimate that their health statuses had improved. They were asked in 1985 and again in 1997.
- Even though the number of persons with 75 years or more has increased by 30 per cent, the operational expenditures have decreased.
- There is the same amount of staff in 1996 as there was in 1986.
- The preventive efforts have entailed a surplus of capacity, which among other things have been used to establish acute beds and rehabilitation places in the community to prevent unnecessary admissions to hospitals.
- The use of bed days at hospitals have been reduced with 30-40 per cent for all citizens in the community.
- The municipality has not had waiting days at hospitals during 10 years for older peoples who have finished treatment at hospital.
- There is no waiting time to apartments in the health centre or on home help.
- The use of and expenditure to national health insurance is less than in the rest of the county.

The result of the project thus provide a compelling argument for the provision of integrated health and social care, as it not only appears to have improved the well-being of the users but also – in line with the reasoning of the Commission on Elderly – has produced these results in an economically efficient way. According Wagner (2000) to these results were obtained because the municipality has put weight on prevention, flexibility and individual health and social care.

As already mentioned, the most significant result from the project is that all 275 municipalities provide integrated health and social efforts and 24-hours health and social care services along the lines of the Skaevinge project.

4.2 Acute-rooms as a substitute for hospitalisation

Acute-rooms administered by the municipality are an alternative to hospitalisation for elderly who do not need specialised treatment at the hospital and where the GP can take responsibility for the treatment. Acute-rooms are established in municipality centres for elderly or at nursing homes. Referrals to acute-rooms will take place in consultation between the GP or the doctor from the emergency service and the health and social care unit, relatives or the elderly themselves. The acute-rooms have 24-hours nurses. The GP or the doctors from the emergency service provide medical service (Felbo & Søland, 1996).

In 1992 the municipality of Roedding made an agreement about cooperation with the county concerning establishment of acute rooms financed by the county and the municipality. The interest of the county was to avoid expensive and unnecessary admissions to hospitals among older persons. The municipality wanted to improve their elderly service and to avoid unnecessary spells of hospitalisation.
4.2.1 The results of the project

Along with a reorganisation of the service for elderly the municipality of Roedding reserved 10 of the earlier rooms at 3 nursing homes. Removal to an acute-room happens in situations with acute illness as e.g. pneumonia, fever or fall accidents. According to the municipality both professional staff and the elderly users find that the acute-rooms are a success. During the stay at the acute-rooms the elderly receive service from their own home-helpers, home nurse and GP. The elderly are pleased that they can receive service from staff they already know instead of being treated by a new team at the hospital. Another important factor is that the elderly remain in the local community with enhanced possibility for visits from relatives and friends (Feldbo & Søland, 1996).

The elderly from the municipality of Roedding are not hospitalised as much as elderly in the neighbour municipality and the differences have increased over the years. The elderly citizens who used the acute-rooms in the period from autumn 1995 to spring 1996 (6 persons) were satisfied with the assessment and the service they received during the stay. They were especially satisfied to be helped through an acute crisis and that it could take place in their homes or close to their homes (Hansen et al., 1997). The stay has first of all helped the elderly through a critical phase while medical treatment and rehabilitation has been individualised.

The question is whether the elderly has received an optimum treatment through the acute stay or that some elderly would have been better off if they were hospitalised. During the stay at the acute room the citizen is observed by the GP and it is also possible to use specialists from the hospital. It has happened in several cases among other things as ambulant treatments at hospital or as visits from hospital wards. This might ensure that the elderly receive the right medical treatment, but one cannot say whether the result might have been different through admission to the hospital (Hansen et al., 1997).

4.3 Evolving ‘good cooperation’ between hospital and municipality

Admission to hospital and discharge are critical phases in a treatment, because the responsibility is handed over from one sector to another. Different projects have aimed at improving the communication between the hospitals and the health and social care units, so that information on the patient in one sector is passed on to another sector with the consent from the citizen in order to ensure a coherent treatment. Cooperation and communication has been in focus in the latest years and different projects have been started in that respect.

Several municipalities have thus entered a contract with the counties concerning cooperation in case of admission to hospital and discharge from hospital. As an example of cooperation the following will describe the content of a contract at the hospital of Skive with several municipalities.

The background for the contract was that it was often difficult to coordinate and establish the necessary municipal measures prior to discharge of patients in need of support, which resulted in waiting time for patients prior to discharge. Waiting time prior to discharge unnecessarily extends hospital stays for patients who have finished treatment. Furthermore, re-admissions that could have been avoided occurred.

On the background of an analysis of the interaction between the sectors, a working group with nurses of hospital departments and district nurses from 5 municipalities prepared information ma-
bular material about ‘Good cooperation practice’ and a checklist that could be used as a tool to control that all guidelines were followed. The purpose of the contract was to ensure quality and continuity in treatment, care and rehabilitation of the patient in the event of admission to and discharge from hospital.

One of the cornerstones in the cooperation between hospital and municipality is ‘The citizen booklet’. It is an open communication system in writing for the citizens, staff in the municipality and staff at the hospital. The booklet belongs to the citizen and follows the citizen if the citizen accepts it. The booklet is established when a citizen receives home help or home nurse. The booklet is supposed to ensure that the citizen receives information and participates in decisions concerning treatment, training and care. The staff can use the booklet as a tool (information about the condition of the citizen and information from one colleague to another) and documentation for the provided services (Hansen et al., 1997).

Issues in the contract are:

- The ideal communication between the sectors is a dialogue between staff at the hospital and in the municipality. The amount of care is estimated and provided by the municipality according to the resources and needs of the citizen.
- The therapist at the hospital contacts the health and social care department in the municipality if the patient is in need of a home visit, changes in the home, aids, follow-up or continuous rehabilitation administered by the municipality.
- If the function level of the citizen has changed dramatically compared to the status prior to admission to hospital, staff from the municipality visits the home to clarify needs for changes in the home and aids. The main rule is that the citizens cannot be discharged before necessary aids and changes in the home are prepared, guaranteed or installed and the necessary services have been arranged.

4.3.1 The results of the project

A precondition for ‘Good cooperation practice’ to work is that the contract is essential for admission to hospital, that the contract is followed in practice and that the booklet is used. According to an evaluation of the project, the case records shows that the documentation for the items in the cooperation contract has not been fulfilled sufficiently. In the evaluation only one patient has brought the booklet to the hospital, which means that is has not had any influence at the selected admissions to hospital. The municipalities are normally not informed about hospitalisation of citizens and it is not relevant if the citizens do not receive services from the municipality, but even if the citizen receives services, they are not systematically informed (Hansen et al., 1997).

The result of the contract of ‘Good cooperation practice’ has been that the staff at the hospital and the staff in the municipality normally are in contact in order to clarify the needs for services after discharge. Home transport, aids and changes in the home are normally arranged before discharge. A common understanding has been developed; when a patient is discharged, it is a common task for hospital and municipality to find a solution, if there are problems. This understanding form a basis for developing a better practice in the future and it is concluded that citizens are not discharged, without information is given to the municipality prior to discharge, if there is need for services (Hansen et al., 1997).
4.4 Coordinating the provision of rehabilitative measures

Insufficient rehabilitation measures provided by counties and municipalities have been discussed through many years. The largest impediment for sufficient rehabilitation has been a vague legislative definition of the responsibilities between the counties and municipalities. Hospitals are responsible for finishing the treatment of patients but it is not clear whether rehabilitation is a part of the treatment - and therefore a task for hospitals. The responsibilities of the municipalities have neither been clearly defined and therefore the rehabilitative measures differ quite a lot among municipalities. As discussed above the division of labour with regard to rehabilitation is the cause of tension between counties and municipalities – not least in terms of which of the branches are obliged to carry the financial burdens associated with rehabilitation.

New legislation about rehabilitation from 2001 gives the citizen the right to a rehabilitation plan upon discharge from hospital. The right to municipal rehabilitation comes into play when the illness is not treated at a hospital. The new legislation strengthens the demand for a formal cooperation concerning rehabilitation and for making arrangements with exact instructions for referrals.

A developmental project running for several years with the purpose of preparing a general model, with focus on the citizen’s needs of rehabilitation, has been started parallel with the new legislation. The objective is to develop a model, which the municipalities can use including the demands for a rehabilitation plan as the legislation demands from hospitals. According to the legislation all hospitalised patients with an identified need for rehabilitation are entitled to a plan outlining the goals for and contents of the rehabilitation efforts. The hospitals (counties) are responsible for preparation and implementation of the action plan. (Ministry of Social Affairs, 2002)

The model for municipalities includes the same demands for action plans, as the legislation demands from hospitals. As the model includes the possibility for expressing both actual and potential profiles of function ability for citizens, the model can be used in cooperation between the two sectors. The tools developed in the model can contribute to the description of the relations of cooperation between county and municipality and as a concrete tool in the daily distribution of work between the parties. The use of the tools also has an additional effect, in relation to defining the division of labour between the counties and municipalities.

A total of eight municipalities have participated in developing and testing the model. Four municipalities have been in charge of the developing work. Subsequently four other municipalities have contributed to quality control and testing the developed tools. The model aims at:

- Ensuring a simple and coherent rehabilitation process for the individual even though several services may be involved (e.g. training, domiciliary care, aids).
- Ensuring sufficient and equal services for all citizens where the citizens own requests and priorities of rehabilitation efforts are included in the basis for referral.
- Ensuring unambiguous definitions and delimitation of each services contents, to be used in practice of rehabilitation as well as in relation to other departments in the organisation (e.g. domiciliary care, hospitals, GP, physiotherapists).
- Creating basis for a goal-oriented effort and an aggregated evaluation. The citizens actual function ability is supposed to be documented as well as the potential function capacity might be estimated.
The project is under progress and the concrete experiences with the use of the model within the municipality are not expected until primo 2003. Therefore the project has not yet been evaluated.

4.5 Overcoming communication problems: MedCom

A great part of the problems of integrating the services provided by the hospitals and the health and social care units concern communication problems related to admission to and discharge from hospital. The problems concern both the communication between hospital and GP and between hospital and the municipal health and social care units (Wagner & Olsen, 1999).

MedCom is a project, involving cooperation between municipalities, hospitals, general practitioners and private companies linked to the health sector. The purpose of MedCom was to develop nationwide standards for the most common communication flows between medical practices, hospitals and pharmacies: referrals and discharge letters, laboratory requests, results and prescriptions. All counties, hospitals, pharmacies, two thirds of medical practices (GP), one thirds of specialists and 16 local authorities use the Danish Health Care Network - MedCom (MedCom - The Danish Healthcare Data Network, 2001). The next step in the project, which takes place in the period from 2000-2002, is concentrated on communication flows between hospitals and the social and health care sector within municipalities.

The first phase of the MedCom project makes it possible for the hospital to warn the municipality, when a citizen is hospitalised or discharged. The messages contain information about where and when a patient is hospitalised or discharged and the status of the patient. This information is useful for the municipality when planning the services that are to be provided to the individual upon discharge.

The second phase of MedCom is testing communication of care reports and warnings messages between hospital and municipality. The health and social care unit in the municipality gives information about practical assistance and need for personal care, aids and use of medicine. The care report can be sent from the municipality immediately after admission to hospital and provides information to the hospital about care and treatment of the patient as well as medication.

Before the patient is discharged the hospital sends a warning to the municipality, which use the information to prepare to assume responsibility of the patient. After discharge the hospital sends an updated care report to the health and social care unit to ensure that important information for the further treatment is not been lost (e.g. information about medicine) when the patient is removed from hospital to the municipality. One municipality has asked for hospital admissions and discharge warnings for all older persons of more than 75 years of age. All elderly who do not receive home help or home nursing, have been contacted after discharge in order to monitor the need for health and social care on a more systematic basis.

4.5.1 The results of the project

The second phase has not yet been evaluated, but the preliminary report from the participating municipalities shows that the citizens receive better services and that the hospitals and the health and social care units avoid wasted time. The earlier experiences were that the communication between the two sectors could fail. The home-helper visited the citizen and found out that he or her
had been admitted to hospital. Or a citizen who needed help was alone for several days, because the health and social care unit was unaware that the citizen had been discharged from hospital. The project ensures that the information is given immediately. The aim of the project is to make as many counties and municipalities as possible use MedCom.

5 Conclusions and perspectives

In Denmark the provision of health and social care is integrated in all municipalities. These processes of integration started in the beginning of 1980s on the basis of the recommendations expressed by the Commission on Elderly. At first, model projects were established in a few municipalities and the experiences from these were used to develop models for integrated care. However, integrated health and social care-schemes have not been implemented in all municipalities until the end of 1990s. Due to an extensive delegation of powers to the local authorities integrated health and social care has been managed in different ways in the municipalities.

The development of integrated care is connected to the liquidation of traditional nursing homes. The result of this process of de-institutionalisation has been that the services that were earlier provided in the nursing homes exclusively are now provided to all elderly regardless of housing status. Due to the fact that integrated care builds on the concept of self-care, de-institutionalisation has resulted in a strengthening on the emphasis on the older persons own resources in order to preserve their self-determination.

At the same time the developments at hospitals have been to intensify and to improve productivity with increasing weight on intensive, short and ambulant treatment. Elderly patients are thus discharged earlier from hospitals with increasing needs for sustained treatment and care in the local setting. The decrease in the average number of stay-days at the hospitals has thus resulted in an increasing demand for integrated health and social care in the municipalities.

Even though integrated care exists in all municipalities, problems still remain in terms of integrating the efforts of the hospitals (counties) and health and social care units (municipalities) when older persons are discharged from hospitals. Some of the main problems concern (i) elderly who cannot take care of them selves after treatment at hospitals and therefore waiting for a place in an adapted dwelling or a nursing home, (ii) cooperation between hospital and municipality to ensure home nursing and home help when patients are discharged from hospital, and (iii) rehabilitation.

A variety of factors – professional, cultural, organisational and financial – constitute barriers to the process of genuine integration between the health and social care services provided by the counties and municipalities in concert. Many projects have been developed with the intent to solve the problems at the interface between the hospitals and the health and social care units. These problems partly stem from the fact, that the legislation comes from two different ministries and furthermore are administered and financed by different regional and local authorities, namely the counties and the municipalities. The scarcity of economic resources and the priorities within the counties and municipalities might have the result that disagreements about who is the responsible party, arise in some areas at the interface between the hospitals and the health and social care units. One result might be that the municipalities do not provide adapted dwellings to elderly at hospital whose discharge is dependent on adapted housing, because it – economically – can make
sense for the municipality to contribute to prolong the period of hospitalisation of elderly citizens. Another result might be that the hospitals discharge elderly patients before the treatment is actually finished and, thus, pass on the buck to the municipalities in terms of rehabilitation.

Another impediment in integrating health and social care services in the municipalities as well as at the interface between the hospitals and the municipalities might stem from cultural, professional and organisational differences between the sectors. The differences in culture between health and social care staff can result in different views on the citizen’s need for services when discharged from hospitals. The staff at hospital might overestimate the needs for services and the patient’s expectations will be influenced accordingly, while the municipality subsequently will tend to provide less service than expected. The result can be users who are discontented with the municipal services. When cooperation between hospitals and municipalities is established, it is important to be aware of the differences and to find common conceptions concerning the need of services. The modes of care also appears to differ between health care and social care staff.

Furthermore, one has to be aware that cooperation does not just arise without support or supervision. When cooperation is being established it is important that all persons involved know what the cooperation imply and who to cooperate with. It is important that all staff involved participate in courses or education with the aim of obtaining a common understanding of what kind of service the hospital can provide and what the municipality can provide; to know when and what to cooperate on and be motivated to cooperate. It is also important that the different professions are involved in the decisions about how the cooperation is organised and what it implies. Finally, it is important to note that cooperation is implemented by the managers and that the management, thus, reorganise the organisation according to the implemented patterns of cooperation.

Also the organisation of health and social care at the regional and local level influence the cooperation, i.e. both the organisation of hospitals and the organisation of municipalities. Some hospitals have established geriatric departments where the treatment of elderly is holistic whereas others have stuck to a more departmental structure. In the geriatric departments the elderly patients are treated for several diseases in the same department instead of being moved from one department to another. When patients are moved from one department to another, information is often lost and one has to start from the beginning to collect information about the patient.

To sum up, there appears to have been very favourable conditions for developing an integrated system of health and social care services to elderly people in Denmark. The institutional structure has eased this process of integration because the institutional elderly care in nursing homes and home help and home nursing in the elderly persons own home was managed by the same agency – the municipality – before the processes of integrating the services got under way. The integration of all types of permanent care has thus been possible within the municipal institutional framework. Unsurprisingly, the most significant stumbling block towards the provision of truly integrated health and social care services by counties and municipalities in concert, thus, appears to be bridging the organisational gaps between the local and regional levels of government.

One of the lessons to learn from the Danish experience is that collaboration between hospitals and municipalities can be organised in many ways, depending on motivation and existing cooperation. It is not possible to emphasise the best practice or the best model for cooperation or to expect that a general model can be implemented in all counties and municipalities. The parties involved can
learn from each other’s experiences, but not always directly copy a model developed by others because the organisation of and access to services are different.

A more radical solution might be to unite health and social care in one ministry or to let either the counties or the municipalities organise and administer both health and social care services. The problem of organising the levels of decentralised government has been discussed for years – including the organisation of the health service. The government has appointed a committee, which within 2 years puts forward a proposal to a new organisation of the decentralised levels of government and the health service. One proposal has been to abolishment of the counties and to centralise health services. However, if such a solution is implemented the problems of integrating the health and social care services provided by the hospitals and the municipalities will remain.

5.1 The political debate on elderly care in Denmark

In spite of what might be expected, the issue of elderly care has been strongly contested on the political scene in Denmark in the past decade. The issue of elderly care has in conjunction with the resource situation of the hospitals been crucial to the electoral vote cast in the last three general elections (cf. Borre et al, 1999: 122).

The history of the development of elderly care in Denmark, however, appears to be a textbook example on how to generate public discontent. From the 1950s the old peoples homes got more staff with care functions so that they gradually developed into nursing homes and a home help service was established for elderly persons in need of domestic services. From the 1960s and especially in the 1970s this development gathered momentum. In 1960 about 15.000 received home aid, ten years later this number was more than doubled, but during the 1970s the number of home aid receivers was more that four doubled into about 150.000. However, since then the number of home help receivers however has not grown as fast as the number of elderly.

The massive expansion of home help that took place in the last part of the 1970s can also be regarded as an employment project as most municipalities were in need of creating jobs – especially for women. The system, thus, developed faster than the need. In some cities every pensioner who wanted it could get a home help these years. As the problems of financing this system grew and persisted during the 1980s and 1990s, the criteria for getting home help were tightened in order to reduce public spending on elderly care. This caused a great deal of press debate, where many elderly stood forth and told they had received home help since ‘god knows when’ where they were quite able, but now where they really needed the assistance it was either reduced or taken away.

Since the beginning of the 1990s where they began to contract out parts of the elderly care in Sweden, a discussion has been ongoing as to whether this should be done in Denmark as well. The opinions have been strongly polarised with the bourgeois parties as proponents and the centre-left parties as opponents. In practice, however, the municipalities have opted for a more pragmatic stance. Only few bourgeois municipalities have actually opted to contract out the municipal health and social care services, and some Social Democratic municipalities have used this instrument to create more value for money in the elderly care. Until now contracting out has not proven a success, as most of the privateers that hitherto have entered the market have found themselves incapable of competing with the publicly provided services in terms of price and quality.
Recently the bourgeois government has passed legislation obliging the municipalities either to contract out or to give their users a choice between public and private providers of health and social care services. The majority of the municipalities are expected to choose the last mentioned model. In order to make contracting out easier the legislation also demands that the municipal administration of elderly care has to be divided into two parts, with one part of the administration acting as the customer, and another part of the administration acting as the supplier of services. With this transformation of the public administration some of the preparations that will be necessary if the municipalities want to contract out are already made in any case. The municipalities only have to replace ‘the providing’ office with the private company that wins the tender.

In the general perception of many Danes, elderly citizens are – often mistakenly – perceived as a ‘weak’ social group. A number of press reports that have pointed to cases of neglect in nursing homes and in the home help service, have sounded the political alarm bells of central government, which has led to a demand for the municipalities to upgrade the level of service provided to elderly citizens in need. Furthermore, the Danish elderly care has been criticised for organisational slack and an increasingly ‘Fordist’ work ethic. According to the critics home help-appointments are often cancelled without prior notice, and the intensification of the workload of the staff have accordingly reduced the services of the home-helpers to that of cleaning rather than caring (cf. Rold Andersen, 1999).

Such debates and calls for improvements in the services provided – in order to provide a more dignified service – have persisted, in spite of a vast majority of receivers of health and social care expressing high levels of satisfaction with the services provided. On the background of the apparent public discontent on the issue, the municipalities have thus been imposed by central government to increase the level of service – and, thus, spending – even though the budgets of the municipalities are highly constrained through the general spending agreements between local and central government. In order to accommodate the requirements of the central government the local authorities now have to cut the budgetary cake anew.

The current drive in Danish elderly policy, thus, appears to point to increased spending in the field, and the although the political debate pays tribute to the problems associated with an ageing population this seemingly does not have much effect on the political priorities in terms of the promises of increased spending.

The current political debate and priorities on elderly care in Denmark thus appear to be more focussed on providing more quality in the services provided rather than bracing the welfare state for future pressures that are to be expected due to an increasing number of potential recipients of health and social care services over the coming decades.
6 References


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**Annex: Model ways of working**

**A1 The Skaevinge project**

<table>
<thead>
<tr>
<th>Name</th>
<th>The project of Skaevinge (24-hours care with integrated health and social care)</th>
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<tr>
<td>Provider</td>
<td>Ministry of Social Affairs and the municipality of Skaevinge</td>
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| Objectives | • To integrate the traditional health and social care departments in one department to obtain of better utilisation of the united resources,  
• To obtain a common understanding through working with the concept of Self-care,  
• To introduce 24-hours integrated health and social care,  
• To change the organisation of the services by introducing autonomous groups with more responsibility and competence to each employed and a better planned health and social care without delaying hierarchic structure. |
| Target group and number of clients | • Older users  
• Elderly citizens |
| Number of staff involved | All categories of staff working with the elderly (home help, public health nursing, home nursing and nursing homes) |
| Methods | • Action research theory  
• The staff’s and citizens active involvement  
• Self-care approach, building on the accept of the human being as a free, independently thinking and acting individual  
• 24 - hours service regardless of type of dwelling occupied |
| Strengths and weaknesses | Strengths:  
• The asses to 24-hours health and social care service irrespective of living at home or at institution has the result that many older persons have chosen to remain at home.  
• The former nursing home was converted into individual apartments and a health centre was established - putting together home nursing, public health nursing and day centre. The centre directs its attention toward all pensioners in the municipality.  
Weaknesses:  
• The consequences of intervention on the health status of the older people were not examined in these studies, and some clinical-empirical studies were needed to show if health status has improved among the elderly  
• It would have been obvious to discuss the cause and the effect of the intervention, but due to its multi-factorial nature it would be almost impossible to draw conclusions regarding single items as to many confounding factors would have to be considered |
Results of evaluation/key-words

- The evaluation of the project 10 years later (1997) shows among other things that:
  - The operation expenditures have decreased even though the number of persons on 75 years or more has increased with 30 per cent,
  - The use of bed days at hospital have been reduced with 30-40 per cent for all citizens in the municipality and
  - During 10 years there has been no waiting days for older persons who have finished treatment at hospitals.

A2 Acute-rooms in the municipality of Roedding

<table>
<thead>
<tr>
<th>Name</th>
<th>Acute-rooms in the municipality of Roedding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider</td>
<td>The municipality of Roedding and County of Soenderjylland</td>
</tr>
</tbody>
</table>
| Objectives                | - To reduce inappropriate admission to hospital
                                    - To intensify observation and care of elderly
                                    - To facilitate returning to own home |
| Target group and number of clients | - Elderly citizens who, in an acute situation, need more care and treatments than can be provided at home
                                    - Elderly citizens who might be discharged within 2 weeks.
                                    - 20-25 elderly use the service during a year |
| Number of staff involved  | GPs, doctors from emergency service, home nurses |
| Methods                   | Corporation between the GPs, emergency service and home nurses
                                    A nurse observes the elderly in the acute-room |
| Strengths and weaknesses  | Strengths:
                                    - The elderly were satisfied with the service. They were pleased to be helped in a acute situation and to stay closed to their homes.
                                    - During the stay the home nurse could observe the older persons need for help in the future and plan the future services.
                                    Weaknesses:
                                    - One can question whether the elderly had the optimal treatment or would be better of at the hospital? |
| Results of evaluation/key-words | The project has not been evaluated. But the results have been so positive that the project has been extended and prolonged.
                                    The elderly from Roedding are less hospitalised than the elderly from the neighbour municipality and the difference has increased during the last years. But it cannot be proved that the acute rooms cause the difference. |
A3  Good cooperation practice

<table>
<thead>
<tr>
<th>Name</th>
<th>Good cooperation practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider</td>
<td>The management of nurses at the hospital of Skive and 5 municipalities: Fjends, Sallingsund, Skive, Spoettrup and Sundsoere.</td>
</tr>
</tbody>
</table>
| Objectives            | • To ensure the patient quality and continuity in welfare, caring and rehabilitation courses when hospitalised and discharged for hospital  
                          • To reduce waiting time at hospitals for patients who have finished treatment  
                          • To reduce the number of re-admissions |
| Target group and number of clients | Elderly citizens (70+ years) at the hospital of Skive (between 1000 and 1200 a year). |
| Number of staff involved | GPs, doctors from hospital, nurses, home help, home nurses |
| Methods               | A working group with nurses from hospital departments and nurses from 5 municipalities prepared a contract  
                          A check-list according to discharge  
                          A booklet belonging to the patients used to give information between all involved staff |
| Strengths and weaknesses | Strengths:  
                          • There have been an increase in dialogs between hospital and the municipalities  
                          Weaknesses:  
                          • The booklet is not used in all cases or used as intended  
                          • The check-list is not always followed |
| Results of evaluation/key-words | The result of the contract of "Good cooperation practice" has been that staff at hospital and staff in municipalities normally are in contact by telephone or arrange meetings about the needs for help after discharge.  
                          The patients are not discharged if there is need for services without information is given to the municipality prior to discharge.  
                          There is a common understanding for a better practice in the future.  
                          At the time for evaluation the reduce in re-admissions was not observed, because lack of data |
## A4 Rehabilitation

<table>
<thead>
<tr>
<th>Name</th>
<th>Around municipal rehabilitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider</td>
<td>Ministry of Social Affairs and 8 municipalities: Hjoerring, Esbjerg, Broendby, Soelleroed, Skagen, Fjerritslev, Dronninglund and Hobro</td>
</tr>
</tbody>
</table>
| Objectives                  | • To develop a general model to ensure rehabilitation with focus on the citizen’s needs of rehabilitation  
• To ensure a simple and coherent process for the citizen also when several actors are involved  
• To ensure unambiguous definitions and delimitation of each service contents, to be used in practice of rehabilitation as well as in relation to other departments in or outside the organisation (e.g. domiciliary care, hospitals, GP, physiotherapists)  
• To ensure sufficient and equal service for all citizens, where the citizens own requests and if any priority of rehabilitation efforts are included in the basis for referral. |
| Target group and number of clients | All older persons in need of rehabilitation. |
| Number of staff involved    | Practical and administrative staff in 8 municipalities and the relevant counties. |
| Methods                     | • Four municipalities have been in charge of the developing work  
• Four other municipalities have contributed to quality control and testing the developed tools. |
| Strengths and weaknesses     | Strengths:  
• The citizen gives priority to different function abilities and this priority is part of the documentation together with the professional assessment of rehabilitation possibilities.  
• There is a quality control and testing of the developed tools  
Weaknesses:  
• A well-tested model is not enough to ensure older peoples rehabilitation. Use of the model presupposes that the municipalities allocate economic resources to rehabilitation as well as educate their staff in using the model |
| Results of evaluation/key-words | The developmental project is not finished and the concrete experiences with the use of the model within the municipality are not expected until the beginning of 2003. |
### MedCom

<table>
<thead>
<tr>
<th>Name</th>
<th>MedCom - The Danish Healthcare Data Network</th>
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</thead>
<tbody>
<tr>
<td>Provider</td>
<td>Ministry of Health, Ministry of Social Affairs, The National Board of Health, Association of County Councils in Denmark, The National Association of Local Authorities in Denmark, Copenhagen Hospital Corporation, Copenhagen and Frederiksberg Local Authorities, Danish Pharmaceutical Association, Danish Dental Association, Association of Danish doctors, Kommunedata, Tele Danmark, Dan Net</td>
</tr>
</tbody>
</table>
| Objectives | • Developing Communication standards for the most common communication flows between local authorities and hospitals  
• Expanding communication between medical practices, hospitals and pharmacies  
• Expanding basic communication between hospitals and local authorities |
| Target group and number of clients | All hospitals, pharmacies and laboratories, all medical practices, local authorities |
| Number of staff involved | Potentially all staff in all counties, hospitals, pharmacies, two thirds of the GP’s, one third of medical specialists and 16 municipalities. |
| Methods | • Establishing pilot projects  
• Developing and testing care reports and warning messages between hospital and municipality  
• Dissemination of experiences |
| Strengths and weaknesses | Strengths:  
• The project facilitate the communication between hospital, medical practices and local authorities  
• The information is given immediately  
• The citizens receives better service  
• The hospital and the domiciliary care can avoid wasted time  
Weaknesses:  
• Not all medical practices and local authorities use the system |
| Results of evaluation/key-words | The developmental project is not finished and the concrete experiences with the use of the model within the municipalities are not expected until the beginning of 2003.  
A preliminary report from the participating municipalities shows that the citizens receive better service and the hospitals as well as the domiciliary care avoid wasted time. |