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Caring for an Ageing Denmark



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National Institute on Ageing

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About the National Institute on Ageing

The National Institute on Ageing (NIA) improves the lives of older adults and the systems that support them by convening stakeholders, conducting research, advancing policy solutions and practice innovations, sharing information and shifting attitudes. Our vision is a Canada where older adults feel valued, included, supported and better prepared to age with confidence.

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Foreword

As a former family doctor and former Cabinet Minister with experience across a range of health and social policy portfolios, and now as Canada's Ambassador to the Kingdom of Denmark, I have spent much of my career thinking about what it means to keep people well—not simply how we care for people when they become sick.

My experience in medicine taught me that health does not begin at the hospital entrance. It is shaped by the places where people live, the communities they belong to, the supports available to them, and their ability to remain active, independent, and connected to their communities.

This becomes particularly important as we think about how we support people as they age. Today, Canada and Denmark are both experiencing significant demographic changes. Our populations are ageing, and the number of older adults who will require health care, appropriate housing, long-term care, and community supports will continue to grow. This presents an important opportunity to ask a fundamental question: How can we design our systems not only to care for people when they need help, but to help them remain healthy and independent for as long as possible?

In my role as Canada's Ambassador to Denmark, I have had the opportunity to see firsthand the depth of the relationship between our two countries and the many areas where we can learn from one another. Canada and Denmark have different histories, governance structures, and approaches to delivering health and social services. Yet we share many of the same aspirations—and increasingly, many of the same challenges.

Denmark's experience offers valuable perspectives as Canada looks ahead to the needs of an ageing population. Over many decades, Denmark has evolved its approach to care with a strong emphasis on helping older adults remain active, independent, and connected to their communities, with the right support available to them where they live.

What I find especially important about the Danish experience is its emphasis on supporting people before they reach a point of crisis. Longstanding investments in home and community-based services can enable earlier and proactive supports, help people maintain their functional abilities and independence for as long as possible, and potentially reduce the need for hospital care or an admission to a long-term care home. This approach can also make more effective use of health care resources, while easing some of the pressures on families and unpaid caregivers while bringing important economic benefits.

This approach reflects something I have believed throughout my career: we need to look beyond the health care system itself. Housing, transportation, social connection, accessible communities, rehabilitation, and community-based supports are all part of the conditions that allow people to age well. A home is not simply a place to live; for an older person, it can be their foundation for living independently, with dignity, and connected to their communities.

Of course, Canada can't adopt a single model. Our health and social systems have developed differently, and our geography, federal structure, population diversity, and regional realities require Canadian solutions. But international experience can help us ask better questions and consider new ways to address challenges we increasingly share.

This is why I welcome this report and the opportunity it provides to look more closely at the experiences of Denmark and Canada. The comparison is not about identifying one system as a model for the other. It is about learning: what has worked, what challenges remain, and what principles might help us strengthen our own approaches to ageing.

As we prepare for a future in which more Canadians and Danes will live longer lives, our goal should be not simply to add years to life, but to add health, independence and dignity to those years. Denmark's experience contributes meaningfully to this conversation, and I hope this report will encourage continued dialogue and collaboration between our two countries as we work toward that shared goal.



The Honourable Dr. Carolyn Bennett, MD
Ambassador of Canada to the Kingdom of Denmark

Executive Summary

Canada faces growing challenges in improving care for its ageing population while containing rapidly expanding health care expenditures. Like many countries, more of its older population is living longer than ever before, often with more complex, interrelated health and social needs. While Canada has made many efforts to strengthen its health and long-term care systems, challenges like uneven access, system fragmentation, and workforce shortages remain. Denmark has faced similar demographic changes but has developed a more coordinated, prevention-focused approach to health and long-term care services that offers useful lessons for Canada.

This report is intended to inform policymakers, health system leaders, planners, researchers, and organizations involved in designing and delivering health, long-term care, and housing services for older adults in Canada. By examining Denmark's experience, the report identifies lessons and policy considerations to guide future planning and reform efforts in Canada's health and long-term care systems.

Denmark's current approach is the product of more than a century of policy developments and care reforms that have progressively shifted its focus away from the provision of institutional care towards prevention, rehabilitation, home and community-based care, and supporting older adults to remain healthy and independent in their own homes for as long as possible. Denmark's experience also shows the value of long-term policy planning and implementation, with many of its successes built through decades of continual reforms and refinements. As a result, Denmark is frequently recognized as an international leader in promoting healthy ageing and supporting older adults to age in the right place.

This report examines how Denmark organizes and delivers health, long-term care and housing services for its ageing population. Like Canada, its systems are built on the principle of universal access, meaning services are available based on need rather than income, and they have also fostered strong care coordination and integration across its three levels of government. In Denmark, its 98 municipalities have long played a key role as the main providers and coordinators of housing, preventative, rehabilitative and long-term care services, especially those delivered at home and in the community. While national legislative, policy and funding frameworks help ensure consistency across the country, local responsibility has enabled Danish municipalities to tailor services to best meet local needs. This demonstrates that strong national policy directions can equally co-exist with strong localized service delivery models.

A key strength of Denmark's approach has been its longstanding focus on helping people stay healthy, independent and living in their own homes and communities for as long as possible. Compared to Canada, Denmark has long invested more in its provision of home and community-based care services, which allows for earlier proactive support, a reduced need for hospital-based care, or care in long-term care homes and less strain on unpaid caregivers.

This commitment to "ageing in the right place" has guided many of Denmark's major reforms over the past five decades and has helped most older Danes continue to live in their own homes rather than in institutional care settings. A key feature of this approach is its strong focus on prevention and rehabilitation.

Rather than focusing solely on responding to illness and disability after they occur, Denmark has increasingly invested in initiatives that help older adults maintain or regain functional abilities, preserve independence, and delay or avoid the need for more intensive, institutional care. In

Denmark, prevention is built into its care systems and is reflected across its policies, services and care pathways.

Denmark's health and long-term care systems are also supported by strong digital frameworks and tools that help providers share information more easily, improve care coordination and outcomes, and reduce administrative burdens. A highly developed digital infrastructure supports these efforts. Shared electronic health records, e-prescribing systems, and national digital health platforms facilitate communication across sectors, while digital and assistive technologies increasingly support independent living, safety, and ageing at home. Built incrementally since the mid-1990s on common standards rather than a single system, Denmark's digital health infrastructure is now widely used: 97% of adults hold a national digital identity, the national health portal receives close to four million visits a month and more than 3.5 million Danes use the Min Læge ("My Doctor") app to communicate with their primary care provider. A shared medication record is also available across hospitals, municipal and primary care providers, and pharmacies.

Denmark has also introduced policies to better coordinate care across the continuum, especially when care recipients move between hospitals and community settings. Financial incentives, discharge planning, and follow-up support help ensure smoother transitions and prevent unnecessary hospital stays. These efforts highlight the importance of integrating the work of care providers and organizations across both the regional and municipal levels to provide more effective and coordinated care. Recent reforms, including the 2024 Elderly Act (*Ældreloven*), further aim to improve coordination, reduce paperwork, and create more integrated care pathways for older adults.

The 2024 Elderly Act and broader health reforms also reflect Denmark's ongoing efforts to strengthen person-centred care, simplify care pathways, increase local flexibility, and improve coordination between municipalities, hospitals, and primary care providers.

These efforts also shape Denmark's approach to dementia care. Through investments in specialist memory clinics, dementia-specific workforce training, municipal dementia coordinators, post-diagnostic support services, and dementia-friendly communities, Denmark has sought to improve access to services, strengthen care coordination, and enhance quality of life for people living with dementia, their families, and caregivers.

Despite these strengths, Denmark still faces challenges. Like Canada, it faces workforce shortages and rising demand for various forms of care and support as its population ages. Care needs are becoming more complex, especially as its older population is also living with higher rates of chronic illness and dementia. While Denmark's workforce strategy is more coordinated than Canada's, care provider shortages remain a major ongoing concern. Although Denmark relies less on unpaid caregivers than Canada, families still play a growing role in providing care. As Denmark continues to expand services that enable older adults to age in place and remain connected to their homes and communities, supporting unpaid caregivers is becoming increasingly necessary. Existing supports for caregivers—such as financial benefits and counselling—are available but can vary by municipality. This has highlighted the need for stronger and more consistent supports for Danish caregivers. At the same time, Denmark's experience shows that support for unpaid caregivers cannot replace the need for the adequate provision of formal care services and the workforce capacity to deliver them.

Comparing Denmark and Canada shows both similarities and important differences. Both countries have public health systems, but Denmark's health, long-term care and housing systems are more coordinated, with clearer roles and stronger national direction. Canada's systems are more decentralized, leading to differences in access and service quality across and even within

its provinces and territories. Canada also faces additional challenges due to its size, geography, and diversity, which can make delivering consistent care more difficult.

Importantly, Denmark demonstrates that sustained investment in long-term care, prevention, rehabilitation, and home- and community-based services and the digital infrastructure, systems and tools that enable them, can support positive health outcomes while helping to manage overall system pressures. While Denmark has allocated more than twice the share of its overall health expenditures to the provision of long-term care than Canada, its overall health care expenditures account for significantly less of its GDP compared to Canada, by building a system that places a strong emphasis on maintaining independence, preventing decline, and supporting care closer to home.

Overall, Denmark's experience shows the value of long-term policy planning and implementation, clear governance, strong investments in home and community-based care, and better coordination across services. It also demonstrates how strong national direction, local flexibility and preventative and integrated care can work together to support healthy ageing. At the same time, it shows that even well-developed systems must keep adapting to changing needs. The lessons from Denmark highlight the importance of improving integration, supporting its care provider workforce, developing and using digital tools effectively, and better recognizing the role of unpaid caregivers. These insights can help guide both Denmark and Canada as they work to build more sustainable, person-centred care systems that support healthy ageing and enable more older persons to age in the right place.

Introduction

Over the past few decades, Canada has paid increasing attention to how it can better care for its ageing population. During this time, Canada's health and long-term care systems have become the subject of several reports, enquiries and reviews. Strategies to address their longstanding and growing inadequacies have been the focus of successive political agendas of governments at all levels, and particularly in the wake of the COVID-19 pandemic ¹.

Denmark is also grappling with how to best care for its rapidly ageing population, which comprises an increasingly diverse cohort of older adults with more complex health and social care needs than at any other point in its history. Indeed, one of the greatest challenges both countries now face is providing culturally appropriate, cost-effective, and sustainable care and support across a variety of settings to meet the needs of their ageing populations.

This National Institute on Ageing (NIA) report was developed to inform policymakers, health system leaders, planners, researchers, and organizations involved in the planning and delivery of health, long-term care, and housing services for older adults in Canada by examining how Denmark has organized and adapted its systems to support an ageing population. Specifically, it details the history and structure, as well as the logistical and financial aspects, of Denmark's long-term care system and how it fits within the country's broader health care and social security support systems. In addition, this report highlights Denmark's focus on prevention, reablement/rehabilitation, and the implementation of innovative digital technologies to better promote both healthy ageing and ageing in the right place, while identifying lessons that may inform future policy and system planning in Canada.

Background

Denmark's population, which has grown by over a million individuals within the last 50 years, now numbers close to 6 million people and is both rapidly ageing and facing greater levels of frailty ². Although considerably smaller than Canada in both geographic size and population, and with a more homogeneous population in terms of primary language, immigration status, and race, Denmark shares several important characteristics with Canada. As a result, the Danish health and long-term care systems offer important insights from which Canada can learn ³.

Denmark is experiencing some of the highest estimated life expectancies in the country's history. A male born in Denmark in 2025 can expect to live to an average of 80.4 years, while a female born in Denmark in 2025 can expect to live to an average of 84.1 years ⁴, for an overall population life expectancy of 82.2 years. These estimates are similar to Canada's current expected overall life expectancy of 83 years and sex-based estimates of 80.7 for males and 85 for females ⁵.

According to 2025 population estimates based on the UN World Population Prospects, approximately 1.27 million Danes, or 21% of Denmark's population, were aged 65 years and older ⁶. This number has nearly doubled since 1970, when almost 600,000 or 12.2% of Danes were aged 65 years and older ⁷. Current population projections and demographic assumptions indicate that the share of Denmark's population aged 65 years and older will continue to rise, exceeding 24%

by the mid-2030s, remaining above this level through at least 2050, and potentially reaching as high as 29% by 2070 ^{8,9}. Furthermore, about 670,000 (11%) of today's older Danes are 75 years and older, with more than 190,000 (3%) being 85 years and older ². Additionally, based on the latest available data, 95% of Danes aged 65 and older and 83% of those aged 85 and older live at home ¹⁰. By comparison, 93.9% of adults aged 65 and older and 72% of those aged 85 and older in Canada live at home ^{11,12}.

Table 1 provides current and future comparisons of Canada's and Denmark's ageing populations.

Table 1: Comparing Canada and Denmark's Ageing Populations in 2025 or Latest Available Year

	Canada 11–14	Denmark 2,10,15,16
Total Population	41.6 million	6 million
Population aged 65+	8.1 million (19.5% total)	1.27 million (21% total)
Population aged 75+	3.56 million (8.5% total)	670,000 (11% total)
Population aged 85+	1.02 million (2.4% total)	190,000 (3% total)
Older Population 65+ living at home	93.9%	95%
Older Population 85+ living at home	72%	83%
Overall Life Expectancy*	83 years	82.2 years
Life Expectancy Males*	80.7 years	80.4 years
Life Expectancy Females*	85 years	84.1 years

*Estimated life expectancy at birth for the 2025 birth cohort

Denmark has developed a comprehensive system of social, financial, health, and long-term care supports for its older population ³. While still evolving and improving, this report primarily examines Denmark's current approach to caring for and supporting older Danes.

Key Definitions

Older Adults: In this report, the NIA defines older adults, older Canadians, and older Danes as people aged 65 years and older. In Canada, older adults may be referred to as 'patients' or 'clients' depending on the type of care and support services being accessed. In Denmark, older recipients of care and support are primarily referred to simply as 'citizens.'

Ageing in the Right Place (AIRP): The NIA defines AIRP as the process of enabling healthy ageing in the most appropriate setting based on an older person's personal preferences, circumstances, and care needs.

Long-Term Care (LTC): The NIA defines long-term care as a range of preventive and responsive care services and supports, primarily for older adults, that may include assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), provided by either not-for-profit or for-profit providers, or unpaid caregivers in settings that are not location-specific. LTC services can be provided in home and community-based settings or in designated buildings designed for that purpose. The latter includes *long-term care (LTC) homes*, more commonly called *care homes* in Denmark. Because long-term care is the most commonly used term in international literature, it will be used here in place of *elderly care*, which is the more widely accepted term used to describe the provision of long-term care in Denmark.

The Overall Structure of Denmark's Health and Long-Term Care Systems

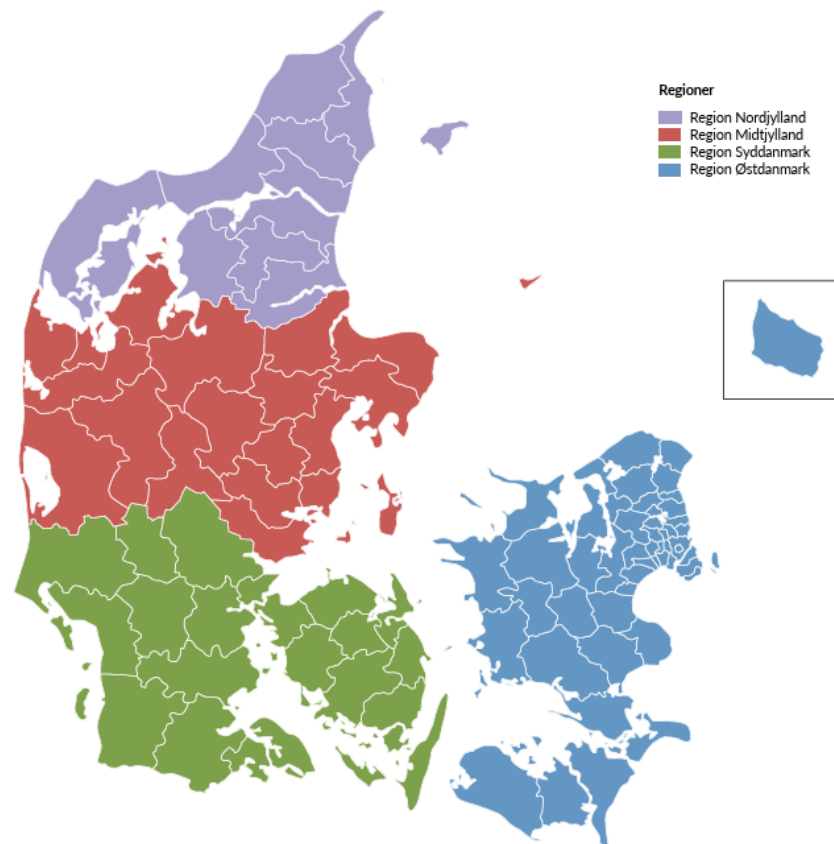
Denmark's health care system is organized across national, regional, and municipal levels and is founded on the principle of subsidiarity, whereby services are delivered as close to citizens as possible and at the lowest level of government capable of providing them effectively. Traditionally characterized by a high degree of decentralization, Denmark applies this principle pragmatically, periodically redistributing responsibilities when evidence suggests that greater regional or national coordination will improve the quality, continuity, or efficiency of care ¹⁷.

The national government establishes Denmark's overall health policy, legislation, and regulatory framework; determines how health care is financed, primarily through general taxation and block grants; and provides overall planning and oversight of the country's health care system.

The regional level (organized across five and soon to be four regions) manages different forms of care and a variety of health care providers, such as hospital and psychiatric care, as well as the planning and financing of primary and specialist care. While regions play a central role in service planning and delivery, they do not levy taxes themselves and are financed through national and municipal government contributions ^{18,19}.

Denmark's health and LTC systems are currently undergoing a significant structural transition as part of its recent health care reforms (Sundhedsreformen). Under the approved health reform (effective January 1, 2027), Denmark will move from five health regions to four by merging its two eastern regions: the Capital Region and the Zealand Region will combine into a single, larger region covering Zealand and its adjacent islands. The new Region of East Denmark will have approximately 2.7 million inhabitants, representing about half of Denmark's population ²⁰. Figure 1 shows Denmark's four future health regions.

Figure 1: Denmark's Four Health Regions (*regioner*)



Source: Ministry of Interior and Health (*Indenrigs- og Sundhedsministeriet*):
<https://www.ism.dk/Media/638628566572432382/Sundhed%20tæt%20på%20dig%20-%20del%202%20-%20tilg.pdf>

The local level, which is organized across 98 Danish municipalities, is responsible for the provision of health promotion and preventative care (e.g., physical exercise classes, etc.), rehabilitation services, long-term care, as well as alcohol and drug use treatment services.

Denmark's municipalities therefore play a central role in the organization and delivery of both home- and community-based as well as institutional forms of long-term care. They also provide free dental care for children and young people up to age ²² through municipal dental clinics (*kommunal tandpleje*), as well as preventive and therapeutic dental care (*omsorgstandpleje*) for adults who cannot access regular dental care due to disability, chronic illness, or reduced mobility – including many LTC home residents and recipients of extensive home care ²¹.

While municipalities retain considerable autonomy over the ways they provide care, their responsibilities are being increasingly shaped by national legislation, guidelines, and coordination requirements, meaning that while services may vary across municipalities, they are doing so within an increasingly standardized national delivery framework^{18,22}.

This multi-level and functionally differentiated governance structure creates strong interdependencies between regions and municipalities, particularly at critical transition points in the care continuum, such as when patients are discharged from hospital to municipal home care or long-term care services. To address these coordination challenges and better align incentives across sectors, Denmark has implemented a set of financial, organizational, and clinical responsibility mechanisms that directly link hospital discharge practices to municipal care provision and capacity.

In practice, coordination between regional hospitals and municipal care providers in Denmark is supported through a mix of financial incentives, organizational arrangements, and shared clinical responsibility. Since 2007, municipalities have been required to pay a daily fee to the regions for patients who are medically ready for discharge but remain in hospital because suitable municipal home care or LTC home services are not available. This payment system is intended to encourage municipalities and hospitals to coordinate care earlier and ensure patients can transition out of hospital safely and on time. If a discharge is delayed beyond a defined period (commonly 3 days), the daily fee increases, strengthening the incentive to avoid prolonged hospital stays. The fees collected are later redistributed across municipalities based on population size, which means that municipalities with fewer delayed discharges benefit overall^{23,24}.

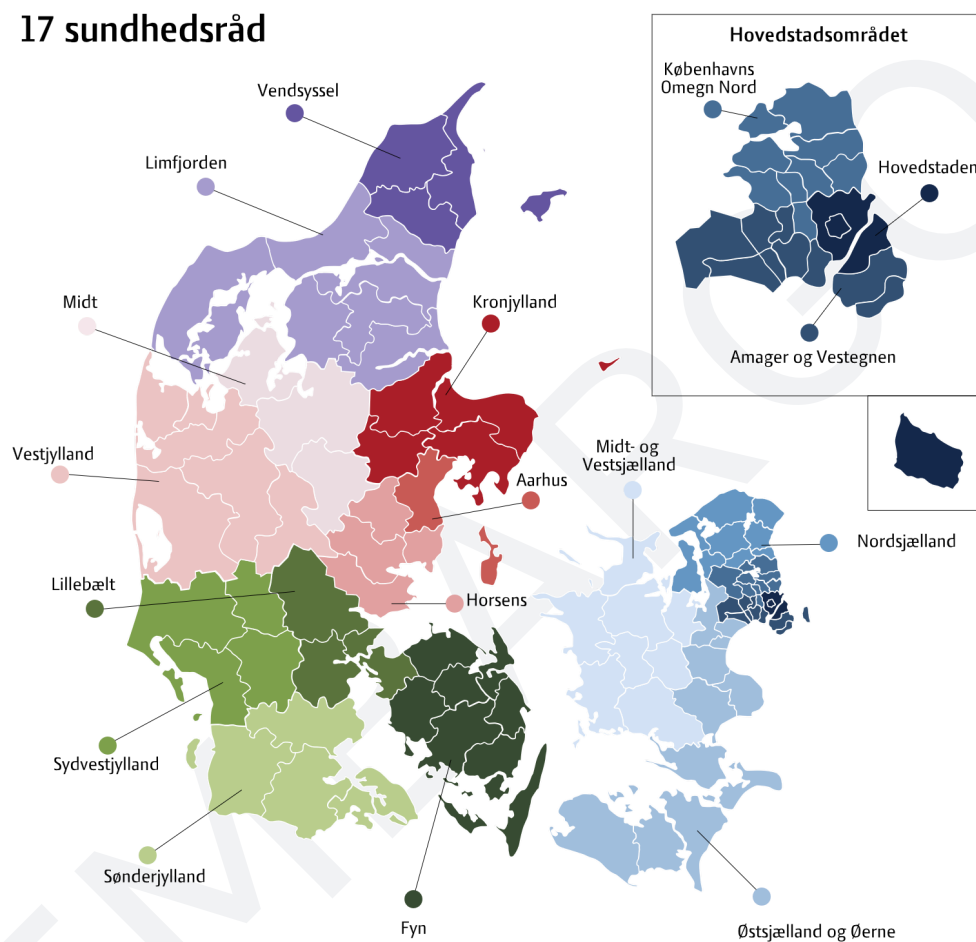
However, this system has also led to disagreements between regions and municipalities about when a patient is medically fit for discharge. These tensions have grown as hospitals increasingly treat patients with more complex, resource-intensive care needs. Municipalities have raised concerns that some patients are being discharged earlier than they ought to be despite needing substantial support, shifting additional responsibilities and pressures onto municipal services. To improve coordination and reduce these challenges, Danish municipalities have introduced pre-discharge coordination functions, such as discharge coordinators and transitional care roles. These arrangements focus on early planning, better communication across sectors, and more personalized support for older patients to ensure that safer and more coherent discharges occur²⁵.

In addition, Denmark introduced an extended post-hospital treatment responsibility scheme in 2022 to improve care continuity after discharge for patients receiving municipal services. The scheme was first implemented in the Capital Region of Denmark for patients hospitalized for at least 24 hours and discharged to municipal nursing care, allowing municipal home nursing services and primary care providers to receive direct advice and guidance from hospital staff during the post-discharge period. The effectiveness of this approach depends on a robust, well-resourced home care system. Under this scheme, the hospital physician responsible for the patient's care before discharge remains available to provide clinical guidance for a defined period after discharge. One year after its initial implementation in Denmark's Capital Region, the programme was evaluated and subsequently agreed upon by the Danish government, Danish Regions, and Local Government Denmark for nationwide rollout, reflecting broad cross-sector support. While the responsibility period was initially set at 72 hours, it was extended to 96 hours in 2025. Evaluations have shown high satisfaction among hospital, municipal, and primary care professionals, with improved access to hospital expertise, faster support in uncertain cases, and clearer communication—particularly on medication management and changes in a patient's condition. After this post-discharge period, full ongoing clinical responsibility for a recently hospitalized patient transfers to their primary care provider²⁶.

Importantly, Denmark's health and LTC systems are currently undergoing a significant structural transition as part of its recent health care reforms (Sundhedsreformen). These reforms place greater emphasis on the creation of integrated care pathways, particularly for older persons and individuals with complex or chronic health conditions, and aim to strengthen care coordination between hospitals, primary care providers, and municipal services^{20,27}. As part of this effort to improve coordination, Denmark also introduced local health clusters (sundhedsklynger) in 2022 to foster collaboration between hospitals, primary care providers, and municipalities. These clusters were organized around the country's acute hospitals, with approximately 21–22 health clusters established nationwide^{28,29}. However, its ongoing health care reforms build on and restructure this approach. Under its new system to be implemented in 2027, the current cluster-based model will be replaced by 17 local health councils (sundhedsråd), whose boundaries are shown in Figure 2, which will operate within the country's four future health regions and take on a broader role in the planning, coordination, and implementation of integrated care services at a sub-regional level^{20,30,31}. Unlike the health clusters, the new health councils will have broader responsibilities for governance, planning, and coordination across the delivery of regional and municipal care services, rather than serving primarily as collaborative forums³².

These developments are expected to influence how municipalities organize and deliver prevention, rehabilitation, and long-term care services, as well as how they collaborate with regional health care providers and local primary care providers,²⁷.

Figure 2: Distribution of Denmark's 17 Health Councils (*sundhedsråd*) Across Four Health Regions



Source: <https://www.regioner.dk/media/eowfrewv/sundhedsraad-kort-svg>

Digitalization and the Use of Technology in Denmark's Health and Long-Term Care Systems

Digitalization has become a defining characteristic of Denmark's health and long-term care systems and underpins the delivery, coordination, and continuous improvement of care across the country. Over several decades, Denmark has developed a nationally integrated digital health ecosystem that connects hospitals, primary and specialist care providers, long-term care providers, pharmacies, municipalities, and citizens through shared digital infrastructure, common interoperability standards, and coordinated governance^{33,34}. These investments have enabled health information to move securely across care settings, strengthened clinical decision-making, supported continuity of care, reduced administrative burden, and provided a robust foundation for quality improvement, research, and health system planning.

National Coordination and Governance of Digital Health

National coordination has been central to the development of Denmark's digital health infrastructure. The Ministry of Health, Danish regions and municipalities, Local Government Denmark (KL), the Danish Health Data Authority, and the Agency for Digital Government jointly oversee the strategic direction, governance, and evolution of Denmark's digital health infrastructure³³.

Denmark's digital health infrastructure has developed gradually over more than three decades through strong national coordination and a common, standards-based approach. Rather than creating a single national IT system, Denmark has connected existing systems through shared standards and infrastructure and introduced national digital services over time. This approach has enabled health and care providers across sectors to exchange information and support more coordinated services for citizens³⁵⁻³⁷.

Close collaboration among the national government, regions, and municipalities has supported this development. National priorities and funding are established through agreements between these three levels of government, while common standards and shared infrastructure help ensure that different IT systems can communicate with each other. These foundations have supported the development of a range of digital health services, which are discussed in more detail later in the report^{21,38,39}.

This long-term approach has created a relatively integrated digital environment across hospitals, municipal and primary care providers, pharmacies, and citizens. It has also provided an important foundation for the growing use of digital services, telemedicine, and technology-enabled care in the community and at home³⁵⁻³⁷.

From January 2027, Denmark's digital health governance will move towards greater national integration through the establishment of Digital Health Denmark (Digital Sundhed Danmark). This development builds on Denmark's long-standing approach of coordinating digital infrastructure across the national, regional, and municipal levels⁴⁰.

This collaborative but increasingly binding governance model has produced common technical standards, national information systems, and shared digital services that are implemented consistently across the health care system^{33,41}.

Public and Private Roles in the Provision of Digital Health Services

Denmark's digital health infrastructure combines public ownership and governance with private sector development and delivery. Public authorities generally own the national services and data, establish requirements and standards, and procure software and technical services from private companies through competitive tenders. Private vendors therefore play an important role in both developing and operating digital solutions, while the public sector retains responsibility for governance, data, and the overall direction of the system^{42,43}.

This model lets public authorities use private-sector expertise while maintaining control over key digital infrastructure and avoiding dependence on a single supplier. Common standards and interoperable systems also make it possible to change suppliers without necessarily replacing the underlying infrastructure or losing access to existing data. Examples across national and regional digital services demonstrate how infrastructure and applications can be procured separately, allowing different suppliers to contribute to the system over time⁴⁴⁻⁴⁷.

The model also extends to welfare technologies and local care services. Municipalities can work with private companies to develop and test digital and technology-enabled solutions before procurement. This public-private approach has supported the development of technologies used across the provision of health and, particularly, long-term care, where municipalities play a central role in delivering care in people's homes and LTC homes^{42,43,48}.

Overall, Denmark's approach combines public stewardship with a competitive private sector market. This separation of public ownership from private delivery has helped support the development of interoperable digital infrastructure while allowing the health and care system to adopt and replace technologies as needs change.

Digital Identification and Communication

Every Danish resident receives a unique Civil Personal Registration (CPR) number, introduced in 1968, which serves as the foundational identifier across the country's health and social care systems⁴⁹. Secure digital authentication is provided through MitID, Denmark's national digital identity system, enabling citizens to safely access public services and health information online⁵⁰. Together, these national digital identifiers support accurate patient identification, secure information sharing, and reliable linkage of health information across organizations throughout an individual's lifetime^{18,49}.

MitID is now widely used across Denmark. By 2025, 97.2% of the population aged 15 and over held an active MitID, providing a common means of accessing public and health services online^{51,52}. Since November 2014, residents aged 15 and over have generally been required to receive official correspondence from public authorities through Digital Post, Denmark's secure digital mailbox for communication with government and public authorities, unless they are granted an exemption. In the first quarter of 2026, 95.2% (4.86 million) were enrolled in Digital Post, while 4.7% (238,000) were exempted from the requirement, with exemptions concentrated among Denmark's oldest citizens^{53,54}. This illustrates the importance of maintaining non-digital communication options for older adults who may have difficulty accessing or using digital services.

National Digital Portals and Citizen Access

Citizens interact with the health care system through a suite of nationally coordinated digital platforms. Sundhed.dk serves as Denmark's national health portal and provides secure access to hospital records, laboratory and diagnostic results, referrals, vaccination records, medication information, advance directives, organ donor registration, and other personal health information. Citizens can also communicate electronically with their health care providers, renew prescriptions, review appointments, and access a growing range of digital self-service functions through the platform ⁵⁵.

Sundhed.dk has become a widely used national digital health service. Launched in December 2003 as a joint initiative of the national government, regions, and municipalities, the portal recorded about 3.8 million visits per month in 2023 (approximately 124,000 per day). At that time, 96% of Danes reported knowing about the portal, and one in five used it each month ^{56,57}. Use continued to grow in 2024. Citizens logged in 10.9 million times through the portal and a further 5.9 million times through the companion MinSundhed app, which was introduced in 2019 and has been downloaded more than six million times. The citizen-facing health record generated 30 million page views, including 7.7 million views of medication records, 3.5 million views of test results, and 3.4 million views of hospital records ⁵⁸.

This level of access reflects a longer-term shift towards giving citizens direct access to their health information. Since the national e-journal was launched in April 2010, citizens have been able to view their own hospital records online ⁵⁹.

Citizens also access a wide range of public services through Borger.dk, Denmark's national citizen portal. Using their secure MitID credentials, citizens can select or change their general practitioner, apply for health-related benefits, update personal information and complete other public sector transactions through a single digital interface ⁶⁰.

Digital Primary Care Services

Routine communication by patients with their primary care providers is further supported through MinLæge (My Doctor), a national mobile application launched in late 2018 and backed by the Organization of General Practitioners (PLO) and the Ministry of Health, with the software developed by the Danish company Trifork; all general practice IT systems in Denmark are connected to it. The application enables patients to securely communicate with their family physician, request appointments, renew prescriptions, participate in video consultations where available, access referrals, and review selected information from their medical record using a smartphone ⁶¹.

Uptake of the MinLæge app has been rapid, reaching two million unique users in February 2023, three million active users in May 2025, and more than 3.5 million active users by spring 2026, or roughly six in ten Danes. On average, more than 1,600 users were active per general practice, with an active user being defined as someone who has consented to use the app and has done so within the previous 12 months ^{62–64}. This rapid uptake builds on a longer shift towards greater digital contact with primary care providers. The share of primary care consultations conducted through e-consultations increased from 9% in 2012 to about 23% in 2022, with 8.8 million e-consultations recorded in 2021. In addition, two in three Danes aged 15–89 reported having digital contact with their primary care provider in the previous year ^{65,66}.

The strong presence of digital infrastructure in general practice has supported this transition. The app is owned by the organization representing general practitioners, while general practice IT systems have been certified against national standards since the 1990s. This established

infrastructure helped enable 97% of Danish primary care providers to exchange standardized electronic messages as early as 2005 and has supported near-universal adoption of new national digital services in primary care ^{36,67}.

Together, these platforms provide citizens with digital access to a broad range of health and administrative services, supporting greater access to health information and routine health care services.

Electronic Health Records and Information Sharing

Electronic health records and digital care documentation systems are used throughout Danish hospitals, primary and specialist care practices, pharmacies, municipalities and long-term care services ^{33,41}. Although health care organizations use different local clinical information systems, nationally established and harmonized interoperability standards have enabled specific types of health information to move securely between providers and across sectors ^{33,41,68}. Clinicians can therefore access certain patient information generated in other parts of the health care system, subject to appropriate privacy protections and role-based access controls.

Denmark's Health Act (Sundhedsloven) supports these arrangements with an explicit legal framework. Health professionals may access patient information when necessary for the patient's current treatment, while patients can control access to their information in several ways. They can request that information not be retrieved, restrict access to specific records, medication data, or laboratory results, and use the MinLæge app on sundhed.dk to see who has accessed their data and when. Access outside an established treatment relationship is subject to additional notification and monitoring ^{21,69,70}.

National digital services also have specific statutory foundations. The Shared Medication Record (Fælles Medicinkort) and vaccination register are established under the Health Act, while a 2019 amendment created a common digital infrastructure through which hospitals, municipal and primary care services can share selected health information. This extends Denmark's information sharing framework beyond health care providers to municipal care providers providing care in both LTC homes and in people's homes ⁷¹.

One of the most important components of this infrastructure is Denmark's Shared Medication Record (Fælles Medicinkort, FMK), which provides a common, up-to-date record of each patient's medications. Authorized health care professionals across hospitals, municipal and primary care services and pharmacies can access the same medication information, supporting medication reconciliation and safer transitions between care settings ⁷². This is particularly important for older adults, who may use multiple medications and receive care across several providers

FMK was introduced gradually across the health and long-term care systems and is now integrated into clinical systems used by hospitals, general practices, pharmacies, and all 98 municipalities. The record includes current medications and medication histories, while prescriptions are generally issued electronically through FMK ⁷³⁻⁷⁵.

Other national digital services, including electronic referrals, laboratory reporting, and diagnostic imaging systems, further support information sharing and continuity of care across the health and long-term care systems ^{68,72}.

Digital infrastructure plays an increasingly important role in supporting older adults with multiple chronic conditions and complex care needs. Through MedCom's Fast Healthcare Interoperability Resources (FHIR) standards, specific types of health information can be transferred automatically between different health care providers, including when a patient is admitted to or

discharged from a health care facility. Health care professionals must actively send other information, such as when municipalities send information to hospitals through a “correspondence” message that enables communication between different electronic health record (EHR) systems.⁷⁶ Together, these mechanisms support the exchange of shared health records, medication information, and other clinical information across hospital, primary and specialist care, rehabilitation, and long-term care settings.

The growing use of digital services has been accompanied by relatively high levels of public trust. In 2025, 84% of Danes aged 15–89 reported trusting public digital solutions, the highest level recorded, while trust among those aged 75–89 was 72%, up seven percentage points since 2021. In addition, 89% reported feeling secure using Digital Post, compared with 77% in 2017.⁷⁷ These findings indicate relatively high acceptance of digital public services among older adults, although differences in digital access and ability remain important considerations for the oldest age groups.

Effective January 1, 2027, Denmark will launch Digital Health Denmark, a new national organization that brings together MedCom, Sundhed.dk, the Danish Health Data Authority, and selected regional digital health solutions within a single governance structure. This initiative aims to improve coordination across the health system, accelerate the implementation of telemedicine, artificial intelligence (AI)-powered tools, and home-based care, and support a more integrated and future-oriented health care system.⁴⁰

Further, digital welfare technologies support Denmark’s emphasis on healthy ageing, rehabilitation, and ageing in the right place by enabling older adults to receive safe, coordinated, and person-centred care while maintaining their independence for as long as possible.^{33,78}

Beyond Health: Connecting Citizen Data Across Sectors

Denmark’s health data infrastructure forms part of a wider public sector system in which the CPR number provides a common identifier across different administrative systems. This allows information from national registers to be linked across sectors, supporting the reuse of information already held by public authorities rather than requiring citizens to provide the same information repeatedly. Denmark’s approach to “once only” data collection aims to reduce administrative burden while giving citizens greater access to information held about them by the public sector.^{79,80}

For older adults, this cross-sector approach is particularly relevant to their income security and access to benefits. Employers and public authorities report taxable income to the national income register (eIndkomst), which municipalities and Udbetaling Danmark use to determine a citizen’s eligibility for benefits without routinely requiring them to provide supporting documentation.^{81,82} Citizens can also access information about their benefits, payments, cases, appointments, and other public services through Mit Overblik on borger.dk.^{83–86}

The same approach is increasingly being applied to people with complex health and social care needs. Hospitals, primary and municipal care services can share selected information through common digital infrastructure, while standardized municipal documentation supports information exchange across long-term care and social services.^{71,87,88} This can support more coordinated services for older adults who receive care from multiple providers or across different sectors. Initiatives to develop more integrated assessments and service plans for people with complex needs further reflect this direction.^{89,90} Denmark’s broader digital-government infrastructure has also been recognized internationally, ranking first in the United Nations E-Government Development Index in every survey since 2018 and second in the OECD’s 2023 Digital Government Index.^{91,92}

Cross-sector data sharing is supported by safeguards and oversight. Denmark's Data Protection Agency (Datatilsynet) supervises public sector data processing, while the Data Ethics Council provides advice on the balance between the benefits of new technologies and citizens' rights and legal protections⁹³. At the same time, the use of linked data for purposes such as fraud detection has raised concerns about privacy and potential discrimination⁹⁴. Denmark's experience therefore illustrates both the potential of connected citizen data to support coordinated services and the importance of transparency, privacy protection, and ethical oversight.

Welfare Technologies

Denmark has also been an international leader in the development and implementation of welfare technologies (velfærdsteknologi), which refers to digital and non-digital solutions that support independence, safety, rehabilitation, and quality of life while improving the efficiency and sustainability of health and social care services⁹⁵. Welfare technologies form an integral component of municipal service delivery rather than a separate innovation program. Municipalities routinely evaluate and implement technologies that address identified clinical or functional needs to enable older adults to remain healthy and independent, participate in their daily activities, and live safely in their own homes for as long as possible^{18,78}.

Welfare technologies are deployed across the continuum of care. Common examples include medication dispensing devices, digital safety alarms, telehealth platforms, remote monitoring technologies, falls detection systems, sensor technologies, automated lighting, electronic door access systems, ceiling-mounted patient lifts, robotic cleaning devices, automated toilets, bathing and transfer equipment, pressure-relieving mattresses, mobility aids, and cognitive support technologies for individuals living with dementia⁹⁶. Municipalities also make extensive use of digital care planning systems, mobile documentation platforms, and assistive technologies that support frontline staff in delivering coordinated, efficient, and person-centred care⁹⁷. Technology selection is typically guided by individual functional assessments, anticipated clinical benefit, and the potential to improve independence, safety, and quality of life, while also reducing physical strain on caregivers and supporting the more efficient use of municipal resources.

A mature ecosystem of public authorities, municipalities, healthcare providers, academic institutions, and private companies supports the implementation of welfare technologies by collaborating to evaluate, refine, and scale innovative solutions. Because municipalities are responsible for both financing and delivering most long-term care services, they are well positioned to realize the benefits of investments in innovative technologies and new models of care. Improvements in efficiency, workforce capacity, and health outcomes translate directly into operational and financial gains for the organizations making those investments. Municipalities frequently undertake pilot projects and real-world evaluations before broader implementation, with evidence shared nationally through organizations such as Local Government Denmark (KL), the Danish Social and Housing Authority, and Healthcare Denmark^{98,99}. This approach has accelerated the adoption of effective technologies, promoted consistent implementation across municipalities, and contributed to Denmark's position as a global leader in technological innovations to support healthy ageing.

A Brief History of Denmark's Approach to Delivering Long-Term Care Services

Denmark's approach to caring for its older population has been gradually developed over more than a century, shaped by a series of legal and policy reforms. This longer history of sustained policy development, compared to most other countries, helps explain why Denmark is often regarded as an international leader in ageing and long-term care policy and offers valuable lessons for Canada ^{7,100}.

Prior to 1891, older adults in Denmark without the support of family caregivers were typically placed in 'poor houses', often at the cost of their civil rights, including the loss of voting rights, property rights, guardianship over their children and the right to marriage ^{101,102}. This changed with Denmark's 1891 Old Age Support Act (Lov om alderdomsunderstøttelse), which granted citizens over 60 who could not care for themselves the right to receive public support without forfeiting their civil rights. Danish municipalities, thereafter, were appointed as administrators of this service and thus became responsible for the placement and care of older persons in need of care and support, primarily in care homes for older people ¹⁰³.

Forty years later, Denmark's 1933 Social Reform Act (Socialreformen) unified previously fragmented social legislation and regulations that were being administered differently across municipalities into four laws, simplifying the nation's administration of public benefits. This Act became foundational in shaping the modern Danish welfare system and its administration and delivery of care and support services for older persons in Denmark ¹⁰⁴. Fundamentally, these reforms introduced a more coherent, rights-based system, guaranteeing specific benefits to those meeting defined criteria, which had a profound impact on the provision of care for older persons in Denmark ^{104,105}. Despite these reforms, however, most older persons continued to be cared for by their family members ¹⁰⁶.

Before the 1960s, other legislation related to care and support for older persons focused mainly on financial benefits such as old age annuities and pensions. However, from the 1960s onwards, demographic ageing significantly increased demand beyond just financial supports for care services, which prompted the establishment of municipal long-term care (LTC) homes ¹⁰⁶. The significant expansion of institutional care toward the end of the 1960s, however, created growing financial strain on municipal budgets as municipalities had to serve increasing numbers of LTC home residents. ¹⁰⁶ In response, many municipalities expanded and increasingly prioritized home care services as an alternative to providing institutional care. During the 1970s, Danish eldercare policy increasingly embraced the principle that older adults should remain in their own homes for as long as possible. ¹⁰⁷

This approach was not only driven by the goal of easing pressure on municipal finances but also by older adults' preference to remain in their own homes and 'age in place' rather than live in LTC homes ¹⁰⁸.

The deinstitutionalization movement around the care of older people in Denmark thus started in the 1970s ^{78,106,109}. Economic crises of the 1970s and 1980s further reinforced this trend, contributing to broader public sector reorganizations (Risager, 2023b) and the downsizing of institutional care, including geriatric psychiatry hospital beds, that often housed individuals living with severe forms of dementia ^{102,110}.

Older Danes aged 65 years and older made up 10.5% of the Danish population in 1960, 12.2% in 1970, and 14.3% in 1980^{111,112}. In other terms, from 1960 to 1980, the population of older Danes increased by more than 250,000 people, representing more than a 50% increase in the absolute numbers of older Danes¹¹³. During this time, the growth in the number of older Danes was accompanied by increasing health care expenditures. As a share of GDP, Denmark's health care spending also exceeded that of both Canada and the United States.

In 1980, while Denmark's health care expenditures accounted for 9.3% of its GDP, health care expenditures for the United States and Canada made up only 9.1% and 7.2% of their GDPs, respectively¹¹⁴. These evolving demographic and fiscal pressures were a critical driver of changes in how health and LTC services were being organized and delivered across Denmark.

While Denmark laid the foundations of its approach earlier, its most decisive shifts in caring for older people began in the late 1980s. Beginning in 1987, a series of new reforms accelerated the country's move towards supporting older people to remain living in their own homes for as long as possible and strengthened the integration of health and LTC services^{115,116}. During this period, Denmark's broader health policy vision also became increasingly oriented toward prevention, coherence, and sustainability, with a focus on maintaining the health and independence of its citizens outside institutional settings^{108,115}. These reforms collectively aimed to create a more coherent, cost-effective, high-quality and sustainable health and long-term care system.

In response to its rapidly ageing population and increasing concerns about the sustainability of its health care system, Denmark has continued to pursue a long-term reform strategy, evolving both its health and LTC services to better meet the changing needs of its ageing population⁴¹. Although some of its more recent reforms have attracted renewed attention to Denmark's approaches to caring for its older population, these changes built on much earlier policy shifts and reforms that began to increasingly prioritize the provision of preventative and home and community-based care for older adults. Its decisive shifts in the 1980s further contributed over time to a substantial reduction in the need for hospital-based care, leading to the closure of approximately 30% of the country's hospital beds, and alleviated the need to build additional LTC home beds over the following two decades^{32,41,117,118}.

A longstanding feature of this reform trajectory has been a strong emphasis on prevention. In 1996, Danish municipalities became required to offer preventive home visits to older adults considered at increased risk of functional decline, social isolation, or deteriorating health to discuss health, living conditions, and emerging support needs, to promote independence and delay the need for more intensive care¹¹⁹. While this policy was refined over time, by 2023, municipalities were required to offer preventive home visits to all adults in the year they turned 75 and 80 years of age, annually from 82 years of age onward, to individuals living alone in the year they turned 70 years of age, and, as needed, to adults 65–81 years of age deemed at particular risk of functional decline. Conducted by trained municipal professionals, these visits aimed to identify early social, physical and psychological concerns and proactively connect individuals with the appropriate preventive, rehabilitation, and support services before their needs escalated^{120,121}. These preventive home visits became one of the most visible and widely recognized measures supporting ageing in place within Denmark's long-term care system.

Legislative amendments to the Danish Service Act in 2003 further transformed the delivery—but not the financing—of publicly funded home care. Whereas municipalities had previously been the sole providers of home care services, they were thereafter required to offer citizens a choice between municipal and approved private providers. The introduction of the free-choice (*frit valg*) scheme was intended to strengthen citizens' self-determination (*selvbestemmelse*) while introducing managed competition to improve the quality, efficiency, and responsiveness of

publicly funded services. Municipalities continue to assess care needs, determine service entitlements, and finance home care regardless of the provider selected, ensuring that access remains universal^{122,123}.

In 2007, Local Government Structural Reforms (Kommunalreformen) transferred greater responsibility for managing prevention, rehabilitation, and LTC services to Danish municipalities, while strengthening local incentives to support more ageing at home and further reduce reliance on hospitals and other forms of institutional care¹²⁴.

To further guide its reform agenda, the Danish government established two commissions in 2012 and 2013 to develop new policy recommendations. Although these commissions predated the World Health Organization's work on the United Nations Decade of Healthy Ageing (2021–2030), their focus on improving ageing-related services fully aligned with the principles later articulated in the UN's Decade of Healthy Ageing^{125,126}. The resulting recommendations emphasized that older Danes should be treated as active participants in their care and thus be free to choose where and how they age, ensuring care for the frailest older adults, prioritizing the quality of services, health outcomes, and information, and working towards better integrating Danish health and LTC systems. As a result of a series of further reforms that followed, including the further development of LTC supports and the greater implementation of digital and assisted-living technologies, the number of older Danes living in their own homes increased by 5% for those 85–89 years of age and by 9% for those aged 90 years and older between 2010 and 2019^{41,127,128}. Now an estimated 95% 10,15,16 of Danes aged 65 and older, and 83% of Danes aged 85 and older, are currently ageing at home.

[Pop-Up Fact] Older adults in Denmark make substantial use of long-term care services provided outside of LTC homes. In 2025, approximately 11.5% of Danes aged 67¹ years and older received municipal home care services¹²⁹. Although this proportion includes all adults aged 67 and older, utilization increases substantially with age, reflecting the growing need for support among the oldest segments of the population.

Beginning in 2015, amendments to Paragraph 83a of the Danish Social Service Act (Serviceloven §83a) required municipalities to assess whether a short-term, time-limited rehabilitation program could improve a person's functional ability before granting them access to long-term home care services. If rehabilitation is likely to improve the person's functional ability and reduce their need for assistance, the municipality must offer a rehabilitation program before making a final decision on providing long-term home care services. This marked an important shift in the provision of Danish LTC services from a predominantly compensatory model ("we'll do things for you") to a restorative or reablement model ("let's help you regain the ability to do them yourself"). Furthermore, the legislation applies broadly to persons with reduced functional abilities (nedsat funktionsevne) who require assistance under the Service Act, rather than being restricted to older adults^{130,131}.

Importantly, these services are available to older adults across the continuum of care, including those with significant frailty and those residing in LTC homes.^{132,133}

¹ Denmark has gradually increased the statutory retirement (public pension) age, and for recent cohorts it is now 67 years, with further increases planned. Because many social and care policies are tied to the transition into retirement, Statistics Denmark uses 67+ as the standard threshold for older adults indicators in municipal social care statistics, including home care and nursing home use.

More recent reforms under the new 2024 Elderly Act (*Ældreloven*) that became effective on 1 July 2025 have further adjusted how preventive efforts are organized. It removed the statutory requirement for municipalities to offer preventive home visits at fixed age thresholds, reflecting a broader shift toward prevention that is person-centred, risk-based, and locally adaptable—a recognition that age alone can be a poor proxy for need. Danish municipalities now have greater flexibility to tailor initiatives to local population characteristics and individual risk factors, such as social isolation, functional decline, and loss of independence.^{134,135} These reforms reframe prevention as a multidisciplinary, community-based effort spanning rehabilitation, social participation, nutrition, housing, physical activity, and integrated care^{136,137}. Rather than mandating standardized preventive home visits universally, which remain a useful tool, municipalities can allocate resources toward the individuals and initiatives with the greatest potential benefit. Prevention thus remains central to Denmark’s health and LTC systems, closely aligned with the broader goal of supporting ageing at home while reducing the need for institutional care.

Denmark’s health and LTC systems continue to evolve, with a strong emphasis on digitalization and public–private cooperation as means of delivering care closer to people’s homes and at lower cost. Indeed, one of the Danish health care system’s key strengths lies in its early adoption of digital health solutions, which allowed it to reach near-universal use by 2014 of electronic health records, including a shared medication record, and e-prescribing^{53,138}. In addition, Denmark’s national e-health infrastructure—such as *sundhed.dk* and its use of interconnected electronic records—facilitates clinical data sharing and coordination between regional health care providers and municipalities providing long-term care services in both LTC homes and through the provision of home care services^{41,139}. This digital integration has been widely regarded as critical for ensuring greater care continuity across health and LTC systems, and better enabling the provision of care closer to home and ageing in the right place¹³⁹. However, the sharing of care records between hospitals and primary and community care providers is not fully seamless. Hospitals generally receive an admission note and limited read-only access to community care records upon admission, indicating that challenges to fully integrated information sharing remain.

Reflecting the cumulative effects of these long-term reforms, Denmark’s long-term care services now represent 16% of Danish health care expenditures, compared to 9% in the United States and 7% in Canada. However, Denmark’s overall health care expenditures accounted for only 9.4% of GDP in 2024¹⁴⁰, substantially lower than corresponding expenditures for the United States (17.2%) and Canada (11.3%) in 2024¹⁴⁰ (see Figure 3).

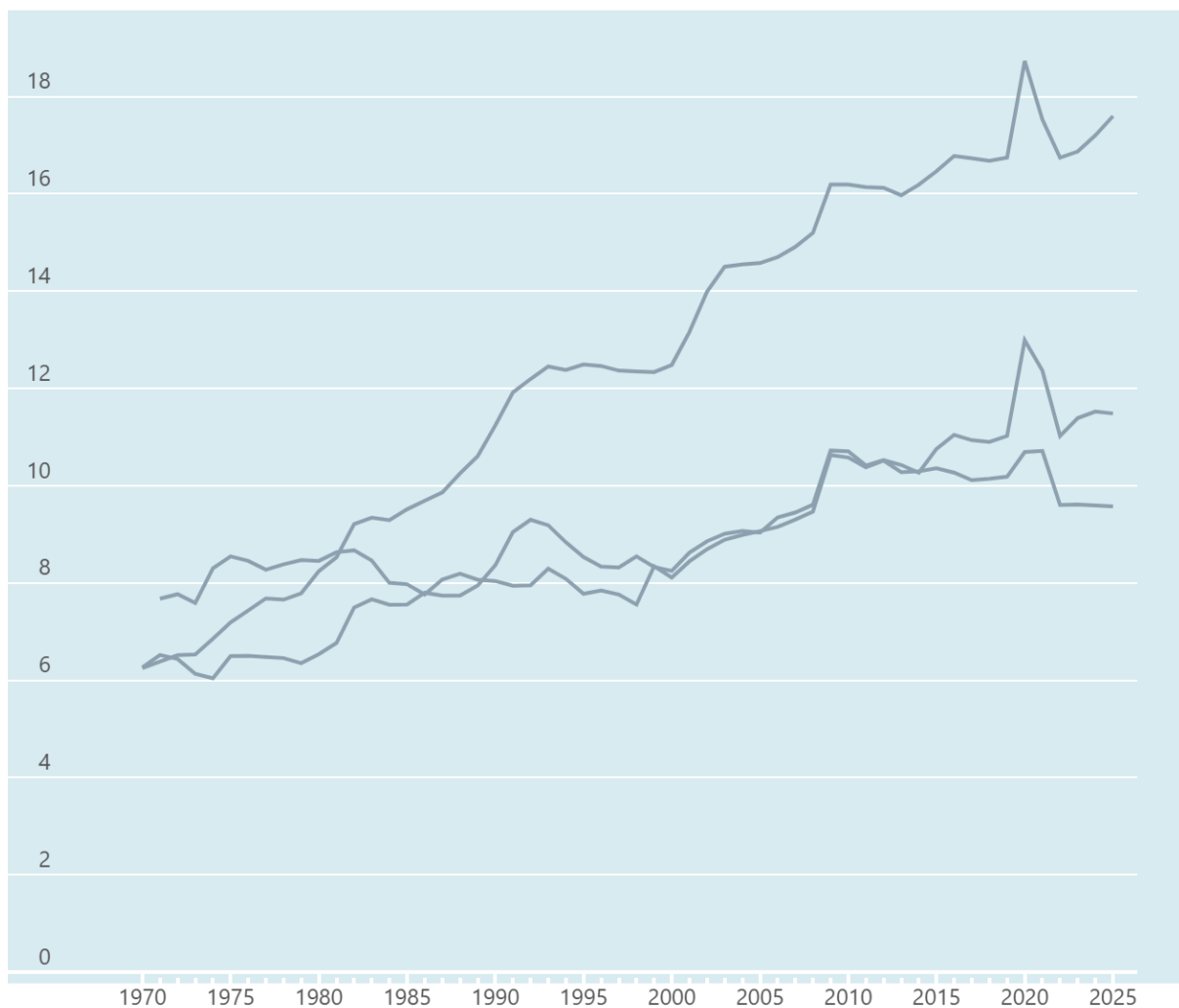
Figure 3: Comparing Health Expenditures as a % of GDP (1970 – 2025)

(DSD_SHA@DF_SHA) Health expenditure and financing ⓘ

(FREQ) Frequency of observation: (A) Annual •

(MEASURE) Measure: (EXP_HEALTH) Expenditure

(COMBINED_UNIT_MEASURE) Combined unit of measure: (PT_B1GQ, _Z) Percentage of GDP



© (DSD_SHA@DF_SHA) Health expenditure and financing OECD

Remarkably, while Denmark's overall health care expenditures remained comparatively low, its overall reported health outcomes have significantly improved. Indeed, since 1980, Denmark has not only seen an increase in its population's life expectancy, but also a reduction in avoidable deaths from treatable conditions, while its citizens have reported greater rates of satisfaction with their care ^{141,142}.

More broadly, Denmark's approach has decentralized health care delivery, increased trust in competent and qualified health care providers to deliver care, developed a prevention-driven strategy, maximized patient choice and flexibility in the delivery and uptake of services and carefully introduced market forces and incentives, including the private provision of services, into its publicly-funded health care sector ¹⁴³. However, this approach has also raised concerns that private providers may focus on less complex cases, while public providers continue to manage more complex and resource-intensive care

Overall, Denmark's approach to the provision of long-term care has changed since it first began offering publicly funded care for older adults in the 1930s ⁷⁸. Its more recent reforms have led to an important paradigm shift in the provision of LTC services from a burden-based to a strengths-based system and from a late intervention and care to a more comprehensive approach with an emphasis on prevention, rehabilitation and home and community-based care ¹⁴⁴. Ultimately, these changes have given rise to its current long-term care system that, with the increasing use of digital and assisted-living technologies, enables older Danes to age in the right place with a high quality of life and a high degree of independence ⁷⁸.

See Appendix for an overview of key legislative Acts and major reforms governing health and long-term care in Denmark.

Types of Housing and Long-Term Care (LTC) Services Provided in Denmark to Enable Ageing in the Right Place

Denmark's LTC system is designed to enable older adults to age in the right place by prioritizing independence, autonomy, continuity, and timely access to publicly funded supports.

Under the 2024 Elderly Act (*Ældreloven*), Danish municipalities serve as the primary entry point and coordinating authority for all LTC services, including preventative services, reablement and rehabilitation, home care and home-based nursing, and LTC home services for older adults. Municipalities are responsible for conducting needs assessments, planning and financing services, overseeing providers, and ensuring equitable access across Denmark's universal welfare system¹⁰⁸. Municipalities fund services primarily through their own revenues, supplemented by national government transfers.

Building on this governance structure, the 2024 Elderly Act has significantly reshaped the regulatory framework for both municipal and non-municipal private LTC providers. It introduces clearer and more uniform rules for service provision, including updated contractual and payment arrangements. While municipalities retain overall responsibility for needs assessment, financing, and oversight of approved services, the Act reflects a political aim to strengthen user choice and improve conditions for independent and private providers within Denmark's universal LTC system¹⁴⁵.

1. Proactive and Preventative Care Services

Preventive care services in Denmark aim to improve older adults' quality of life and support their ability to live independently for as long as possible. These services are primarily delivered at the municipal level and include a combination of community-based social activities, physical exercise and balance training programs and volunteer support. In particular, municipalities provide physical training facilities and rehabilitation and reablement programs, many of which incorporate strength and balance exercises designed to reduce the risk of falls among older adults^{108,146}.

Preventive efforts in Denmark have also embraced the greater use of welfare technologies to promote greater independence among older Danes. These technologies include wearable devices that often incorporate fall detection, global positioning system (GPS) tracking, and personal emergency response systems.⁷⁸ By enabling older Danes to take walks without a caregiver, these technologies may help prevent frailty and encourage greater mobility and independence. Additional rehabilitative services discussed later in this report also aim to promote greater levels of independence and prevent falls⁷⁸.

Historically, many of these preventive objectives were pursued through the statutory provision of preventative home visits, which for decades constituted a central element of Denmark's preventative approach to ageing. Following their nationwide introduction in 1996, Danish law

required municipalities to offer preventive home visits to older adults living in the community. Initially, these visits were mandated annually for older citizens living alone from the age of 70 and for all citizens aged 75 years and older¹⁴⁷. Subsequent legislative amendments modified the target population to all citizens aged 82 years and older¹⁰⁸. The legal framework was subsequently expanded to allow earlier and more flexible visits for adults aged 65–79 assessed as being at increased risk of social, mental, or physical decline, reflecting an increasing emphasis on the early identification of and response to vulnerability¹⁴⁸.

Denmark's preventative home-visit program was rooted in strong empirical foundations, notably the 1980–1983 Rødovre Project, a pioneering Danish intervention evaluating the impact of providing preventative home visits every three months for community-dwelling adults aged 80 years and older compared with a similar group of older adults who did not receive this service in the Danish municipality of Rødovre. In this project, specially trained nurses conducted holistic assessments focusing on health, functional ability, social networks, and living conditions, prioritizing prevention and early support rather than treatment. During the visits, the primary aim was to identify emerging needs early and engage older adults in a dialogue about their overall well-being, living conditions, and available support options. Preventative home visits were therefore intended not only to reduce avoidable health care utilization, but also to strengthen autonomy, delay functional decline, and ultimately better enable ageing in place^{107,149}. The project's evaluation demonstrated substantial benefits for its participants, including 50% fewer emergency doctor visits, 19% fewer hospital admissions, 31% fewer LTC home placements and 25% fewer deaths compared with controls. These findings provided a compelling rationale for scaling up the provision of preventative home visits nationwide and positioned the programme as an internationally recognized example of proactive, community-based prevention.

While many municipalities continue to employ proactive home-based or outreach interventions for vulnerable older adults following the 2024 Elderly Act that removed the requirement, these activities are now embedded within broader prevention, rehabilitation and reablement, and community support strategies rather than delivered as a uniform national programme^{134,135}.

2. Reablement and Rehabilitation Services

Since 2015, Danish law has required municipalities to offer short-term rehabilitation programs to citizens before conducting a formal assessment to determine the level and type of home care for which an individual qualifies¹³³. In this way, municipalities must first evaluate an individual's potential for 'reablement' before providing traditional home care services. These rehabilitation and reablement programs are designed to help older adults improve their functional capacity and become more self-reliant whenever possible. The programs are based on an individual assessment of the person's resources and needs and involve setting individual goals in collaboration with the individual^{132,150}. This idea of having agency over one's own life has become a core tenet of the provision of Danish LTC services and for this reason, rehabilitation and reablement programs are centred around and adapted to an individual's needs and goals¹³³.

Rehabilitation services can be provided at rehabilitation centres and at home after being hospitalized or losing some level of functionality in the community. More than 30% of Danish municipalities have adopted a digital platform for at-home rehabilitation called DigiRehab¹⁵¹. DigiRehab is a tablet-based, digitally supported rehabilitation tool that delivers individualized exercise programmes based on functional screening and physical-ability tests. The program typically consists of two weekly training sessions of 20 minutes each over a 12-week period, supported by video demonstrations and carried out with assistance from home care staff or family caregivers^{78,152}.

An evaluation of a 12-week DigiRehab programme conducted in the Vejle Municipality showed that a majority of participants were able to reduce or stabilize their use of home care services. Specifically, approximately 90% have maintained or improved their physical ability, while 66% have reduced or maintained their need for ongoing home care supports¹⁵². Reported outcomes indicate an average reduction of approximately 45 minutes of home care per week, which, if sustained over time, would correspond to an estimated reduction of roughly 39 care hours per year on average per person. In addition, municipal and programme-level analyses suggest that among participants whose functional ability improved and whose reduced care needs were maintained, annual reductions of up to approximately 80 hours of home care have been observed^{152,153}.

A nationwide satisfaction survey conducted by Statistics Denmark in June 2023, involving 53,688 citizens, reported that 79% of respondents were satisfied or very satisfied with their municipal rehabilitation services¹⁵⁴. Alongside these generally positive assessments, ongoing national reforms are reshaping the organization and delivery of rehabilitation services across the Danish health care system. Recent Danish health care reforms (Sundhedsreformen) have introduced important changes to the organization of rehabilitation services, particularly regarding the division of responsibilities between Denmark's municipalities and regions. From 2027 onwards, the responsibility for providing specialized and advanced rehabilitation services will be transferred from municipalities to the regions, which already organize hospital-based care, while municipalities will continue to provide basic rehabilitation and reablement services as part of their standard provision of community-based LTC services. This proposed shift aims to create more coherent and continuous care pathways, especially for citizens with complex or multi-faceted needs, and to reduce fragmentation between the hospital sector, municipal services, and home-based care providers. At the same time, the reform is likely to affect how municipalities organize their remaining rehabilitation services and how they collaborate with regional care providers within this new governance framework^{155,156}. The 17 new health councils (sundhedsråd) are poised to play a key role in coordinating this transition.

3. Home-Based Care Services

Home-based care services constitute a central pillar of Denmark's long-term care system, supporting older adults to live safely, independently, and with dignity in their own homes for as long as possible. These services include both non-clinical and clinical support tailored to varying levels of functional and health-related needs. Home-based care services for older adults in Denmark are broadly organized into:

- a. **Home Care (Hjemmepleje)**, which assists with activities of daily living and practical household tasks;
- b. **Home Nursing Services (Hjemmesygepleje)**, which deliver clinically oriented care in the home, including medical and nursing interventions.

Together, these services promote care continuity, user choice, and coordination across health and social care systems, enabling older adults to remain at home for as long as possible.

a. Home Care (Hjemmepleje)

Home care services are designed for Danish citizens who have difficulty managing day-to-day living activities because of illness or short- or long-term disability. Danish home care services, however, also embrace the principle of promoting self-reliance among older Danes who live at home but are no longer able to carry out activities of daily living without support¹⁰⁸. Home care services are divided into:

- Practical assistance (e.g., cleaning, laundry, meals)
- Personal care (e.g., bathing, dressing, toileting, mobility support)

The intensity and duration of home care services can vary substantially depending on individual need and may be provided on a permanent, temporary, or intermittent basis, including as short-term support following hospitalization or during periods of acute illness or increased vulnerability¹⁵⁷. Individuals can apply for home care services through their local municipality, which will ultimately decide the amount and type of support a citizen receives based on an individual needs assessment¹⁰⁸. In addition to assessing eligibility, municipalities establish quality standards and finance these services. The municipality can provide home care directly or through private providers it approves or contracts. Those who qualify to receive permanent home care supports receive these services free of charge, regardless of who provides them (municipal or private provider). However, services like meal delivery services (maximum daily charge 63 DKK (\$13.66 CAD/day), laundry services, and other optional additional services may incur user charges¹⁵⁸. On the other hand, citizens who qualify to receive respite care or caregiver relief supports may be required to make income-tested co-payments to receive them if their income exceeds 188,900 DKK (\$40,788 CAD) for single households and 284,000 DKK (\$61,323 CAD) for couples in 2026¹⁵⁹. Households with incomes below these thresholds pay no co-payment for eligible caregiver respite services. Above the threshold, a modest hourly co-payment applies, beginning at 3 DKK (\$0.65 CAD) per hour, increasing gradually with income, and capped at 168 DKK (\$36.28 CAD) per hour (2026 rates)¹⁵⁹.

Municipalities determine how they reimburse home care providers, either through an approval model (godkendelsesmodellen) or a competitive tendering model (udbudsmødellden). Under the approval model, municipalities calculate a reimbursement rate based on the expected cost of delivering standard quality services and approve any provider that meets these requirements, with all approved providers receiving the same reimbursement for the same service. Under the tendering model, municipalities award contracts through public procurement, with providers reimbursed according to the negotiated contract price. In both models, municipalities pay providers directly, ensuring that citizens receive publicly funded services at no additional cost¹⁶⁰. daily routines, where appropriate and in accordance with an older adult's individual needs, preferences, and self-determination. These technologies may provide reminders to eat, exercise, and take medications through additional remote monitoring and support. Private providers may therefore distinguish themselves through additional competencies (e.g. continuity of caregivers, scheduling flexibility, responsiveness, communication) or fee-based services (e.g. intensive cleaning, gardening, or companionship services). According to the Danish Ministry for Elder Affairs, the proportion of home care recipients choosing a private provider increased from 33.4% in 2011 to 42.9% in 2023, meaning that nearly half of all Danish home-care recipients now receive services from a private provider¹⁶¹. However, despite their growing market share, the available evidence does not consistently demonstrate superior outcomes associated with private providers.

Home care services in Denmark are available around the clock, seven days a week. The amount of home care that is actually provided is individually assessed and varies widely, with average weekly hours provided often increasing markedly with age and level of need¹⁶². In 2024, Statistics Denmark recorded that on a daily basis approximately 70% of Danish home care recipients were assigned less than 2 hours of home care, 10.77% were assigned between 2 and 4 hours of care, 10.36% were assigned between 4 and 8 hours of care, 4.85% were assigned 8 to 12 hours of care, and 3.85% were assigned 12 to 20 hours of home care services¹²⁹. These service patterns show how home care has traditionally been delivered through relatively short, task-based visits, which recent reforms have sought to address further.

The 2024 Elderly Act (*Ældreloven*) marked an important shift in the organization of home-based care through the introduction of the concept of holistic care (*helhedspleje*). Under this model, personal care, practical assistance, and elements of basic rehabilitation are to be delivered as part of a single, coordinated care pathway rather than as separate services. The Act promotes greater flexibility in how care is actually provided, moving away from rigid time allocations toward a needs- and goals-oriented approach that emphasizes continuity, personal relationships, and responsiveness to changing circumstances ¹⁶³. Under the new Act, older adults are invited to have direct input into the types of services provided and into the identification of their personal health and social care needs and goals.

A key organizational feature supporting this shift is the increased use of fixed care teams (*faste teams*). These teams are intended to improve care continuity, strengthen trust between caregivers and care recipients, and reduce the number of different staff members entering an individual's home by having permanent staff teams working in a defined geographic area. At the same time, both municipal and approved non-municipal providers have been granted greater discretion in how services are organized locally, within the overarching municipal responsibility for financing, quality assurance, and oversight ^{163,164}.

The 2024 Elderly Act has also reinforced and systematized the use of digital and welfare technologies (i.e., technologies that support health, care, and independent living) in the provision of long-term care services, with a stronger focus on self-determination, care continuity, and efficient coordination between services ¹⁶⁵. Older Danes living at home have access to a range of digital and welfare technologies designed to support their safety, independence, and everyday self-care needs. The municipality grants access to these technologies based on an assessment of the individual's functional abilities, health status, and daily living needs. These welfare technologies include personal emergency response systems that allow older adults to reach a monitoring station with the click of a wireless button if immediate attention is needed; in that case, a care provider is immediately alerted and provided with the information needed to assist the home care client. Beyond emergencies, digital monitoring solutions increasingly support services. Consistent with the principles of the 2024 Elderly Act, which emphasize self-determination and person-centred care, the use of these technologies is intended to support independence and self-management amongst older adults and is tailored to their wishes and assessed care needs ^{166,167}.

One example of this new integrated approach to using digital technologies in the provision of LTC services is the deployment of digital medication management solutions, such as an automated medicine dispenser in the homes of older Danes to support safe and timely medication intake. These devices are not provided universally to all home care recipients; rather, municipalities may offer them following an individual assessment of an older person's needs, functional abilities, and care requirements, where they are expected to support safe and timely medication intake while promoting independent living and self-management ^{96,168}. These dispensers include a list of the patient's current medications and dosage information to ensure users take the right pills at the right times. Additionally, these dispensers are operated in conjunction with an older user's primary care record, namely the user's Shared Medication Record, which lists all of a patient's medication plans, prescriptions, and purchases. Full integration with an older user's existing patient records makes it easy for home care professionals to access and update patient information, serving as a single point of contact. These dispensers are particularly useful because any changes a prescriber makes to a patient's prescriptions are immediately updated on the medication dispenser, with the new medications being delivered within 24 hours. If a patient forgets to take their medications, their home care provider is notified ^{169,170}. This digital solution has reduced reliance on home care providers for medication management support and allows individuals to be more involved in their own care, while keeping home care providers appropriately informed so they can intervene when and if necessary.

Denmark's approach to integrating the use of digital technologies into the provision of its LTC services are contributing to older people feeling safer in their own homes and support continued independent living at home for as long as possible ⁷⁸.

As part of the 2024 Elderly Reform (Ældreformen), Denmark introduced a new approach to measuring quality in the provision of long-term care by making the experiences of older adults a central indicator of system performance ¹⁷¹. The country's first nationwide home-care user satisfaction survey, conducted by Statistics Denmark between November 2024 and February 2025, received responses from approximately 123,000 home-care recipients aged 67 years and older, of whom 78% reported being satisfied with the services they received, 15% were neither satisfied nor dissatisfied, 6% were dissatisfied and 1% were very dissatisfied ¹⁷². Developed jointly by the Ministry of Children, Senior Citizens, and Housing (Ældreministeriet), KL (Local Government Denmark), Statistics Denmark, and VIVE (The Danish Centre for Social Science Research), the survey reports results for all 98 municipalities ¹⁷². Municipal-level reporting enables benchmarking against national averages, neighbouring municipalities, and demographically similar jurisdictions, fostering transparency, shared learning, and continuous quality improvement rather than punitive ranking. To monitor the impact of the Elderly Reform over time, the survey will be repeated every two years. Importantly, it moves beyond traditional measures such as staffing levels and service volumes to evaluate outcomes that matter most to older adults, including continuity of caregivers, involvement in care decisions, respectful communication, and overall satisfaction ¹⁷².

b. Home Nursing Services (Hjemmesygepleje)

Home nursing services (Hjemmesygepleje) provide clinically oriented care in the home for individuals requiring clinical care, such as wound care, medication management, palliative, and post-surgical care. These services are typically prescribed by a primary care provider based on an assessment of individual need and are provided free of charge through the local municipality ¹⁷³. This service is critical to enabling early hospital discharge and supporting higher-acuity patients at home.

In addition to providing ongoing home nursing, many Danish municipalities have established specialized acute nursing functions (kommunale akutfunktioner). These multidisciplinary municipal services assess and manage older adults and other medically complex patients experiencing acute—but not immediately life-threatening—changes in health status at home or in temporary municipal care settings. Staffed by specially trained nurses working in close collaboration with general practitioners, hospitals, and emergency medical services, the teams provide rapid clinical assessment, treatment, monitoring, and coordination to prevent avoidable hospital admissions while enabling people to remain safely at home ^{174,175}. These services also offer nurses opportunities to practice at an advanced level, including through emerging Advanced Practice Nursing (APN-sygeplejerske) roles in Denmark. APNs have expanded clinical competencies that enable them to practice with greater autonomy and responsibility. Within their defined scope of practice, they can assess and diagnose patients and initiate or adjust treatments for acute and chronic conditions, providing nursing care at an advanced level ^{176,177}.

To support rapid clinical decision-making during home visits, many acute nursing functions have incorporated point-of-care testing (POCT) into their assessments. Basic diagnostic blood tests are routinely used in some municipalities, while others have piloted more advanced diagnostics, including portable ultrasound, to support the assessment of acute illness in the home ¹⁷⁸. This approach remains in the testing phase and is not currently standardized across municipalities.

4. Independent Housing for Older Adults (Ældreboliger)

In addition to home-based services, Danish municipalities organize a form of intermediate housing for older adults known as homes for senior citizens (Ældreboliger). These dwellings are self-contained, non-institutional rental houses or apartments purpose-built for older adults and adults living with disabilities who can no longer live independently in ordinary housing but do not yet require a 24-hour institutional care environment and can be well supported as needed, with access to traditional home care services.

Ældreboliger are typically organized as part of Denmark's non-profit public housing sector (almene boliger) and are regulated under the Public Housing Act (Almenboligloven). This form of housing may exist as a collection of houses grouped as part of a larger neighbourhood, or as a group of apartments in a public housing building that may also include other forms of public housing on site, creating intergenerational living communities. Ældreboliger are designed to be fully accessible, with step-free access, wide doorways, and adapted bathrooms and, in some cases, kitchens, allowing residents to live independently while receiving regular home care and nursing services as needed through the local municipality. Importantly, Ældreboliger do not have permanently attached on-site staff, distinguishing them from plejeboliger (LTC homes), which provide round-the-clock access to care and support. However, because multiple residents with similar care needs are co-located within the same building or housing complex, municipal home care and nursing services can often be delivered more efficiently than to individuals dispersed throughout the community. This concentration reduces travel time for care providers, supports more coordinated scheduling, and results in staff being present in the building on a regular basis, allowing residents to benefit from frequent contact with familiar care providers within independent living environments.

Allocation to Ældreboliger is needs-based rather than age-based, with municipalities prioritizing applicants whose functional limitations or housing conditions make independent living in standard housing impractical. As such, Ældreboliger function as a key component of Denmark's "ageing in the right place" strategy, further helping to delay or avoid admissions to more expensive and resource-intensive LTC homes while further supporting autonomy and continuity of community-based care^{157,179}.

5. Long-Term Care (LTC) Homes (Plejeboliger)

Long-term care (LTC) homes (plejeboliger) constitute the most intensive form of publicly funded long-term care in Denmark and are intended for older adults whose care needs exceed what can be safely met through municipal home-based care services, independent housing for older adults, or community-based supports. LTC homes provide round-the-clock personal and nursing care in residential settings and are fully integrated into Denmark's universal, municipally organized LTC system. While care homes (plejeboliger) form the core of residential LTC provision, the Danish system encompasses several distinct LTC home models that reflect differences in governance arrangements, ownership structures, care specialization, and length of stay. Together, these models are designed to address diverse and evolving care needs, while maintaining public financing, municipal oversight, and equitable access across the country.

Within the broad category of LTC homes (plejeboliger), residential long-term care for older adults in Denmark includes:

- a. Care homes (Plejeboliger), the general residential LTC model providing permanent housing with 24-hour personal and nursing care and typically owned, operated, and regulated by municipalities within Denmark's publicly funded LTC system;

- b. Municipally owned, independently governed LTC homes (Lokalplejehjem), publicly owned homes operating with enhanced managerial autonomy;
- c. Privately owned and operated LTC homes (Friphejeboliger), privately run facilities functioning fully within the public LTC system;
- d. Dementia care housing (Demensboliger / Demensplejehjem), specialized LTC settings for residents living with moderate to severe dementia;
- e. Short-term residential care/respite care (Midlertidige pladser / Aflastning), temporary, goal-oriented residential care setting stays for rehabilitation, recovery, or caregiver respite.

Municipalities regulate, oversee, and finance all publicly accessible care homes, regardless of ownership structure. Care providers – whether public, private non-profit, or private for-profit – are paid directly by municipalities to deliver nursing care, personal care, and practical assistance according to each resident's assessed needs. Residents, in turn, pay housing-related costs, including rent, utilities, meals, and certain optional services. National regulations set maximum co-payments for meals (i.e., 4,453 DKK or \$962 CAD per month in 2026)¹⁵⁹, while housing costs vary based on market factors such as municipality, building age, apartment size and eligibility for housing subsidies¹⁸⁰.

Denmark employs a coordinated, risk-based inspection system to oversee all LTC homes, regardless of ownership. Since July 2025, oversight has been organized through the new Elder Care Inspection (Ældretilsyn), which coordinates inspections with the Danish Patient Safety Authority and the Danish Working Environment Authority to reduce duplication and provide a more holistic assessment of care quality¹⁸¹. Inspections evaluate not only clinical quality and patient safety—including medication management, documentation, infection prevention, and staff competencies—but also the dignity, autonomy, quality of daily life of residents, and compliance with the principles of the Elderly Act^{145,182}. Rather than conducting routine annual inspections of every LTC setting, authorities use a risk-based approach to identify homes requiring oversight, with additional inspections and enforcement actions undertaken when significant concerns are identified. Standardized national inspection criteria apply equally to municipal, private not-for-profit, and private for-profit providers, ensuring consistent quality expectations across the sector^{183,184}.

The physical design of Danish LTC homes reflects the country's broader philosophy that these settings should support dignity, autonomy, and quality of life while minimizing the institutional character traditionally associated with these care settings. Although there are no nationally prescribed architectural templates, municipalities and private providers have converged around a common set of principles. Perhaps the defining principle is that an LTC home is regarded first and foremost as the resident's home^{185,186}. Residents typically occupy single-occupancy suites, including a private accessible bathroom and, in most cases, a kitchenette or small kitchen. Often referred to as “apartments”, the units are intentionally designed to accommodate a resident's own furniture, artwork, photographs, and personal possessions, allowing familiar routines and personal identity to remain central even after admission to long-term care^{108,186}.

Danish LTC homes are also generally modest in size, reflecting the country's preference for smaller, more residential care environments. Only about 3% of nursing homes accommodate more than 100 residents, while the average LTC home houses just over 40 residents¹⁸⁷. Moreover, Danish LTC homes are commonly divided into smaller household-style living environments, typically accommodating between eight and twelve residents who share a domestic kitchen, dining room, and living area. This configuration creates opportunities for more meaningful social interaction, encourages residents to participate in everyday activities according to their interests and abilities, and allows care providers to develop stronger relationships with a consistent group of residents over time¹⁸⁸. Meals are frequently served within these smaller households,

contributing to a quieter, more familiar, and less institutional atmosphere than is typical of traditional LTC home layouts¹⁸⁸.

Universal accessibility is a fundamental characteristic of Danish LTC home design. Buildings are constructed to accommodate residents with varying levels of physical and cognitive ability, incorporating features such as step-free entrances, wide corridors and doorways, spacious accessible bathrooms, ceiling-mounted lifting systems where appropriate, wheelchair turning space, large elevators, and adaptable living environments that can accommodate changing care needs over time⁷⁸. Importantly, many design elements are integrated seamlessly into the residential environment, avoiding the appearance of a clinical or institutional setting while ensuring the building remains functional as residents' needs evolve^{78,189}.

Connection to nature and community is another defining characteristic of Danish LTC home design. Most care settings incorporate access to natural light, gardens, courtyards, walking paths, patios, and other accessible outdoor spaces that encourage residents to spend time outdoors, engage in recreational activities, and enjoy natural surroundings, contributing to physical, emotional, and social wellbeing^{190,191}. LTC homes are also intentionally integrated into their surrounding neighbourhoods rather than isolated from them. Many include cafés, community rooms, childcare programs, or shared amenities, while volunteers, schools, and local organizations regularly participate in activities within the home¹⁹².

a. Care Homes (Plejeboliger)

The Danish LTC home sector remains predominantly municipally owned and operated, accounting for over 90 per cent of these institutions nationwide¹⁸⁰. LTC or nursing homes (Plejeboliger) are available for older adults who require more complex care than can be provided by municipal home-based care services or independent housing for older adults. Currently, approximately 40,000 older Danes live in LTC homes across Denmark¹⁹³, distributed across approximately 923 LTC homes nationwide, housing approximately 40 residents overall per care home¹⁹⁴. The average age of a Dane moving into an LTC home is 84 years old, with an expected current average length of stay of two years and six months^{128,195}.

The vast majority of LTC home placements in Denmark are permanent, with fewer than 5% designated for short-term or temporary stays. Occupancy rates are consistently high, with LTC homes operating at approximately 96% of capacity. Residents typically have complex care needs. More than half are living with dementia, approximately one in five have experienced a stroke, and over 5% have Parkinson's disease. Around one in five residents have a diagnosed mental health condition¹⁸⁷.

Unlike many jurisdictions, Denmark does not prescribe a national minimum resident-to-staff ratio, minimum care hours or unified staffing formula for its LTC homes. Rather than regulating staffing inputs, national legislation places responsibility on municipalities to ensure that facilities are staffed with enough personnel possessing the competencies necessary to meet residents' assessed needs and to fulfil their statutory obligations under the Elderly Act¹⁴⁵. Municipalities establish local financial and organizational frameworks, while individual providers and LTC home managers allocate staff across shifts according to resident needs, available competencies, care setting characteristics, and operational judgment. Local Government Denmark (KL) supports municipalities through guidance on workforce planning, scheduling, recruitment, and care organization, but does not prescribe a common staffing norm^{196,197}. Thus, staffing levels in Danish LTC homes vary by time of day, day of the week, and municipality.

A 2025 study by the Danish Centre for Social Science Research, or VIVE, reported

an average ratio of 2.6 residents per staff member during weekday day shifts, increasing to 6.5 in the evening and approximately 21 at night. On weekends, staffing levels are lower, with an average of 4.5 residents per staff member during day shifts, 6.7 in the evening, and 21.5 at night. Staffing ratios also vary considerably across municipalities, ranging from 1.4 to 4.1 residents per staff member on weekday day shifts, and from 7 to 40 residents per staff member on weekend night shifts ^{194,198–200}.

Although data on staff-to-resident care hours are not available, the 2025 VIVE study included a breakdown of LTC home residents' care needs. The most prevalent forms of care provided involved help with activities of daily living (ADLs), with 77% of surveyed residents requiring help with bathing and using the toilet, 49% needing help moving and 32% needing help eating. Only 3% of residents were permanently bedridden, while 8% required palliative care ¹⁹⁹. The report also noted that the most significant change in care needs among LTC home residents observed between 2019 and 2025 was the much higher need for dementia care, with the proportion of residents living with dementia increasing from 51% in 2019 to 59% in 2025 ²⁰⁰.

To address residents' diverse care needs, Danish LTC homes are also staffed by a range of care professionals who focus not only on meeting an individual's physical care needs but also on supporting learning, participation, autonomy, and personal development in everyday life. However, the workforce is made up mainly of social and health care helpers and social and health care assistants, who together account for about 60% of staff on weekday day shifts. In comparison, nurses account for 9% of staff, while interns, temporary workers, and students make up 19%. Unskilled workers represent 8% of the workforce, whereas other health professionals, including physiotherapists, occupational therapists, and clinical dietitians, account for 3% of staff. Pedagogical staff represent approximately 2% of the workforce ²⁰⁰.

In terms of employment patterns, permanent part-time employees working 30–36 hours per week make up the largest share of the LTC home workforce (37%), while an additional 18% work fewer than 30 hours per week. Permanent full-time employees (37 hours per week) account for around 13% of staff, and approximately 21% are hourly paid substitutes or temporary workers, reflecting the flexible staffing arrangements required to cover different shifts and absences ²⁰⁰.

The implementation of digital health care solutions has been particularly important in the context of Danish LTC homes as well, with the aim of better streamlining tedious and/or physically demanding tasks, freeing up time for health care professionals and care providers to provide more direct care hours while helping prevent staff burnout in these settings ⁷⁸.

b. Municipally Owned and Independently Governed LTC Homes (Lokalplejehjem)

Lokalplejehjem represent a newly established category of LTC homes in Denmark, introduced under the 2024 Local Care Home Act (Lov om lokalplejehjem), which came into effect in January 2025. These homes are municipally owned but operate with greater freedom and flexibility, similar to independent or private LTC homes. Unlike traditional municipally operated care homes, which are managed within the municipality's standard administrative and budgeting structures, lokalplejehjem are granted greater authority over local management decisions, including staffing arrangements, budget priorities, purchasing decisions, service organization, and the development of local care initiatives. Importantly, they remain publicly financed, municipally owned, and subject to the same national legislation, quality requirements, resident rights, and municipal oversight as other LTC homes. This model is intended to reduce administrative micromanagement, strengthen local leadership, and allow greater flexibility in staffing, service organization, and daily routines, while maintaining public accountability and universal access. Lokalplejehjem thus constitute a hybrid model that combines the strengths of public ownership

with the responsiveness and innovation typically associated with private providers, all within Denmark's publicly funded LTC system^{201,202}.

c. Privately Owned and Operated LTC Homes (Friplejeboliger)

A small minority of care homes are operated by private not-for-profit and, to a lesser extent, private for-profit providers. Importantly, these care settings function fully within the municipal long-term care system and remain subject to municipal responsibility, supervision and financing. As such, private care provision in Denmark does not constitute a separate or parallel system but rather represents an alternative mode of service delivery within a predominantly public model^{143,203}.

Consequently, operators of private LTC homes (friplejeboliger) have relatively little scope to differentiate themselves through the clinical services they provide. Instead, competition has evolved around the resident experience. Providers distinguish themselves through their philosophy of care, organizational culture, physical environment, specialized programming, family engagement, and the overall quality of life they create for residents²⁰⁴. In addition to the standardized publicly funded care package, many providers also offer optional privately purchased services—such as hairdressing, podiatry, massage, enhanced housekeeping, transportation, wellness services, guest meals, and cultural excursions—that allow residents to personalize their living experience without altering their entitlement to publicly funded care²⁰⁵. Perhaps the most significant differentiator among private providers is that many present themselves not as health care settings but as places to live. Rather than organizing the day around institutional efficiency, providers frequently describe adapting services around the preferences of residents. This may include flexible wake-up and mealtimes, individualized activity schedules, opportunities to participate in cooking or gardening, and allowing residents to maintain personal routines. Similarly, providers often distinguish themselves through rich social programming that extends well beyond traditional recreational activities. Creative arts, music therapy, woodworking, gardening, cycling, partnerships with schools and community organizations, and animal-assisted activities emphasize meaningful occupation and continued community engagement rather than entertainment alone^{206,207}.

Private providers also place considerable emphasis on organizational culture and the continuity of relationships between residents and caregivers. Friplejeboliger may therefore organize around small, permanent care teams, consistent assignment of caregivers, and flatter management structures. Many organizations complement this approach with investments in staff mentorship, continuing education, interdisciplinary collaboration, leadership development, and employee wellbeing²⁰⁴.

Operators may also develop expertise in specific resident populations or clinical approaches. Dementia care is perhaps the most common example, with providers creating recognizable domestic environments, sensory gardens, neighbourhood-inspired layouts, circular walking paths, colour-coded wayfinding, and opportunities for safe outdoor activity. Others distinguish themselves through rehabilitation-oriented models that integrate physiotherapy, occupational therapy, mobility training, and reablement principles into everyday life with the goal of preserving independence for as long as possible. Additional specialization may include palliative and end-of-life care or care for neurological conditions such as Parkinson's disease and multiple sclerosis^{191,208}.

Finally, providers distinguish themselves through their organizational mission and identity. Not-for-profit organizations frequently emphasize community engagement, volunteerism, charitable traditions, and social purpose, while for-profit organizations are more likely to highlight innovation, customer service, operational responsiveness, and modern facilities. These

organizational identities allow residents and families to select environments that most align with their personal values and preferences.

Unlike in Canada, purely private, market-based retirement homes or assisted-living residences that provide an alternative pathway to care outside the public system are relatively rare in Denmark. Private providers therefore tend to complement the public system by offering choice and service diversity, rather than functioning as a parallel privately financed sector. The Danish experience demonstrates that competition can be structured around resident experience, organizational innovation, and quality of life while preserving universal access.

d. Dementia Care Housing (Demensboliger / Demensplejehjem)

Demensboliger and demensplejehjem are specialized LTC housing solutions designed for individuals with moderate to severe dementia who require extensive, continuous support. These LTC homes may exist as dedicated dementia care homes or as specialized units within larger LTC homes, but they are distinguished by their provision of purpose-built physical environments, adapted layouts, and care practices tailored to working with residents living with moderate to severe forms of dementia. Design features typically emphasize safety, familiarity, orientation, and reduced sensory overload, while staffing models include enhanced competencies in dementia care and pedagogical approaches that support autonomy, meaningful activity, and relational continuity.

As a general principle, residents of LTC homes may not be routinely confined or prevented from leaving solely because they have dementia, as such restrictions constitute an infringement on personal liberty and are subject to strict legal safeguards²⁰⁹. Instead, LTC homes mitigate wandering and elopement risk through environmental design, individualized care planning, close staff supervision, and, where appropriate, legally authorized assistive technologies such as door alarms or location systems. Restrictive measures may only be implemented under narrowly defined statutory conditions and require individualized assessment and authorization²¹⁰.

The growing importance of demensboliger within Denmark's LTC system reflects the rising prevalence and complexity of dementia presentations among LTC residents. As such, dementia care housing has become a central component of Denmark's strategy to deliver appropriate, high-quality care for individuals with advanced cognitive decline within LTC settings^{211,212}.

e. Short-Term Residential Care/Respite Care (Midlertidige pladser / Aflastning)

Midlertidige pladser, including aflastning (respite care), constitute a distinct form of short-term residential care within Denmark's LTC system, designed to provide temporary care-oriented accommodation and intensive support when permanent placement is neither required nor appropriate. These services are typically used to facilitate post-acute recovery following hospitalization, support the provision of reablement or rehabilitation services, stabilize a person's health or functioning, or provide temporary relief for family caregivers. Stays are typically time-limited (one to four weeks) and goal-oriented, with an emphasis on restoring or improving an individual's functional abilities and enabling their return home whenever possible. Temporary care places may be located within dedicated short-stay units, rehabilitation centres, or as designated beds within LTC homes, and are accessed through municipality-led needs assessments and care planning. By offering flexible, transitional support, midlertidige pladser play a critical role in smoothing care transitions, preventing unnecessary hospital stays or premature admissions to LTC homes while supporting Denmark's broader strategy to enable ageing in the right place²¹³.

Effective January 1, 2027, under Denmark's new Health Care Reforms (Sundhedsreform), the regions will assume responsibility for about 70% of the 3,800 existing municipal temporary and acute care places, which will be converted into regional health and care places (regionale sundheds- og omsorgspladser). These regional health and care places will be provided without user fees and will have regularly affiliated physicians, alongside health and care services designed to support patients who need temporary health-related care but do not require hospital admission^{214,215}.

See Table 2 for an overview of housing and LTC services provided in Denmark.

Table 2: An Overview of Housing and Long-Term Care (LTC) Services Provided in Denmark

Care Category	English Term	Danish Term	Service/housing model & care level	Typical users/purpose	Key Acts / legal framework
Proactive & Preventative Care Services	Preventative Care Services	Forebyggende indsatser / Forebyggende tilbud	Municipal preventive services; outreach, social participation, exercise, health promotion; may include proactive home visits	Older adults at risk of functional, social, or health decline	Social Services Act (Serviceloven); Elderly Act (Ældreloven, 2024)
	Preventative Home Visits	Forebyggende hjemmebesøg	Structured preventive visits to identify early needs (formerly statutory; now targeted/flexible)	Older adults at risk of vulnerability	Social Services Act; Elderly Act
Reablement & Rehabilitation Services	Reablement	Hverdagsrehabilitering	Time-limited, intensive support integrated with home care to regain independence in daily activities	Older adults newly assessed for home care	Social Services Act; Elderly Act

	Rehabilitation	Rehabilitering	Goal-oriented interventions to restore or improve function after illness, hospitalization, or decline	Older adults with temporary or reversible functional loss	Health Act: Rehabilitation after discharge from a hospital, based on a medically justified need and normally a rehabilitation plan; Social Services Act: Municipal rehabilitation for physical functional impairment caused by illness when the illness was not treated during a hospital admission.
Home-Based Care Services	Home Care	Hjemmepleje	Municipally funded, non-clinical care delivered at home, comprising: (i) personal care (assistance with ADLs such as bathing, dressing, toileting, transfers); and (ii) practical assistance (household support including cleaning, laundry, shopping, and meal services)	Older adults living at home or in ældreboliger	Social Services Act; Elderly Act

	Home Nursing Services	Hjemmesygepleje	Clinical nursing at home (wound care, injections, medication, palliative care)	Older adults with medical care needs	Health Act (Sundhedsloven)
Independent Housing for Older Adults	Senior Citizens Housing	Ældreboliger	Self-contained, accessible rental apartments; no 24-hour staff; home care and nursing provided as needed	Older adults unable to manage in ordinary housing but not needing continuous care	Public Housing Act (Almenboligloven); Social Services Act
LTC Homes	Care Homes	Plejeboliger	Independent apartments with integrated 24-hour personal and nursing care; permanent on-site staff	Older adults with extensive, permanent care needs	Public Housing Act; Social Services Act; Elderly Act
	Municipally Owned, Independently Governed LTC homes	Lokalplejehjem	Municipally operated care homes with enhanced operational autonomy; publicly funded and regulated	Older adults with extensive, permanent care needs	Local Care Home Act (Lov om lokalplejehjem); Elderly Act
	Privately Owned & Operated LTC homes	Friplejeboliger	Privately operated care homes within the public LTC system	Older adults with extensive, permanent care needs choosing private providers	Act on Private Care Homes (Lov om friplejeboliger); Social Services Act
	Dementia Care Housing	Demensboliger / Demensplejehjem	Dementia-specific LTC units with adapted design and staffing	Persons with moderate to severe dementia	Public Housing Act; Social Services Act;

				with extensive , permanen t care needs	
	Short-term Residential Care / Respite Care	Midlertidige pladser / Aflastning	Short-term stays for rehabilitation, to provide caregiver respite, or support post-acute recovery	Persons with temporar y extensive care needs	Social Services Act

Accessing Long-Term Care Services in Denmark

The 2024 Elderly Act (Ældreloven) reinforces Danish municipalities as the primary entry point to access LTC services, embedding access decisions within a person-centred framework that emphasizes self-determination, continuity, and the provision of holistic care. Danish municipalities hold the main responsibility for organizing and delivering local services ^{216,217} with access being determined through a local needs assessment.

Although each municipality decides its own service levels, all 98 municipalities document their needs assessments, the services granted and the care actually delivered using a common national data standard, Common Language III (Fælles Sprog III, FSIII), developed and owned by KL. FSIII builds on two earlier generations (Fælles Sprog I, 1998; Fælles Sprog II, 2003) and was written into the 2013 national strategies for digital welfare and digital health, which municipalities implemented through a national rollout by 2020 ^{88,218}. The assessment is multidimensional and uses a standardized classification system to evaluate a citizen's level of functioning across pre-defined domains, including physical functioning, self-care, mobility, mental and cognitive functioning, social participation, and their ability to manage their daily activities independently ^{88,219,220}. Because the same concepts are used everywhere, FSIII data can be mapped into the standardized MedCom messages exchanged with hospitals (admission reports and care pathway plans), flow into Statistics Denmark's home care statistics and, since 2023, are reported to a new national register of municipal care and nursing services (KPOS) at the Danish Health Data Authority ^{409–411}. A simplified version ("FSIII 2.0"), developed in partnership with all 98 municipalities to reduce documentation burden, cuts the number of described health conditions from 43 to 23 and is being implemented from late 2025 through 2026 ^{88,220}.

As access to LTC services is fundamentally needs-based, assessments are to be guided by the principle of free and equal access, irrespective of income, wealth, age, household composition, or labour market attachment ^{22,221}. Importantly, eligibility does not consider the availability of family caregivers, and no minimum threshold is required to access in-kind services or cash benefits. This approach helps ensure that care is allocated according to need rather than personal

financial resources or family circumstances, reducing inequities in access and limiting reliance on family caregivers to fill gaps in available service provision.

Home nursing is offered for free to all Danish citizens with either a prescription from a primary care provider or after a municipal needs assessment is initiated by the individual, relatives, or health care professionals. Municipalities are legally responsible for providing necessary assistive devices and funding home modifications for individuals with permanent functional impairments. This includes mobility aids, wheelchairs, hospital beds, and other assistive devices or welfare technologies, as well as structural adaptations such as ramps, accessible bathrooms, widened doorways, and ceiling-mounted lift systems when required to enable safe and independent living. These supports are provided based on assessed functional need rather than an individual's financial circumstances, ensuring that economic barriers do not prevent access to essential equipment or home adaptations that support ageing in the right place ^{108,130,222}.

In addition to home care and home nursing, municipalities provide rehabilitation services aimed at restoring functional abilities, maintaining independence, and supporting a citizen's capacity for self-care. These services are typically time-limited, tailored to individual needs, and may include patient education and training programmes. Rehabilitation services are available to all Danish citizens based on their assessed need. Furthermore, when a primary care provider prescribes treatment from a podiatrist, psychologist, chiropractor, or physiotherapist, municipalities are responsible for partial coverage of these services, reducing out-of-pocket costs and supporting equitable access ^{132,223,224}.

In Denmark, there is a cap on the waiting time to receive a place in a local LTC home. Once an older citizen has been referred for placement, the waiting time must not exceed two months ¹⁸⁰. This statutory guarantee is supported by municipal capacity planning efforts, which require municipalities to maintain sufficient LTC home capacity to meet the two-month deadline. As a result, Danish LTC homes do not operate under sustained system-wide over-occupancy levels, and waiting lists are generally limited to cases involving individual preferences rather than an overall shortage of beds.

Denmark enforces the two-month placement guarantee through a legal right to timely access to appropriate accommodation rather than financial penalties. If a municipality is unable to provide a suitable place within the prescribed timeframe, it remains legally responsible for securing appropriate accommodation through alternative arrangements and its decisions may be subject to administrative review or appeal. In most cases, municipalities seek to accommodate residents within their own jurisdiction to maintain proximity to family, established health care providers, and community networks. However, where appropriate capacity is unavailable locally, municipalities may fulfil their obligation by arranging placement in another municipality through inter-municipal agreements while retaining responsibility for coordinating the placement and financing the resident's care. This rights-based approach establishes clear accountability for timely access while allowing municipalities flexibility in how they fulfil their statutory obligations ²²⁵.

The only exception to the two-month placement rule in Denmark is if an older person wants to be placed in a specific LTC home; then there is no set maximum waiting time ^{180,217}. In such situations, longer waiting times reflect personal choices rather than a lack of timely access to care.

In contrast, waiting times for LTC home placements in Canada are substantially longer. In Ontario, the median waiting time for admission to an LTC home is typically reported in the range of approximately 150–200 days, depending on region and point of entry ²²⁶. In Quebec, access to public LTC homes (CHSLDs) often involves substantially longer delays, with commonly reported waiting times exceeding 12–24 months in many regions ^{227,228}.

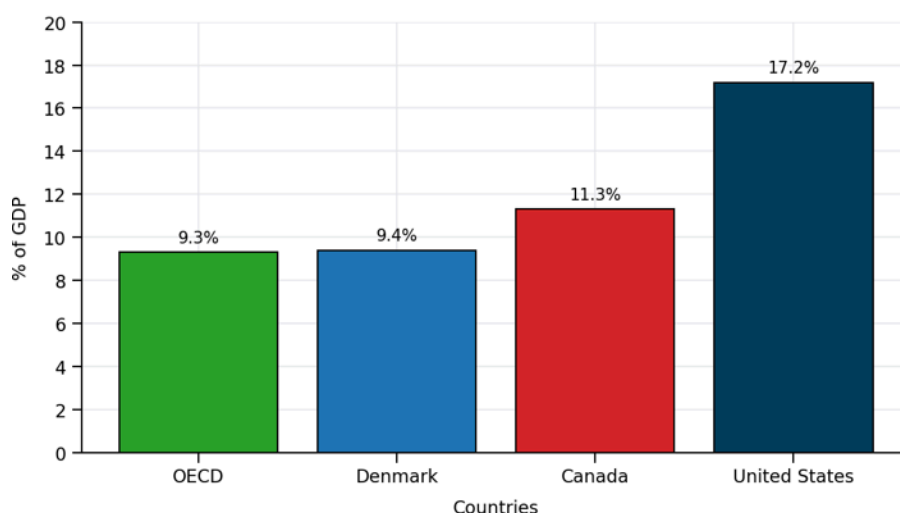
Government Funding of Long-Term Care Services

General Health Care Financing

Health and LTC services in Denmark are financed principally through the collection of general tax revenues and funded through a system of government block grants, reimbursements, and equalization schemes¹⁴³. In 2024, public funding accounted for 83.43% of total health care expenditures in Denmark. Health care spending represented 17.55% of total general government expenditures that year²²⁹. Patient out-of-pocket payments financed the bulk of the remaining health care expenditures, accounting for 13.87% of health expenditures, while private health insurance and non-profit organizations made up only 2.59% and 0.11%, respectively, of health care spending²²⁹.

As noted earlier in this report, the percentage of Denmark's GDP spent on health care has fluctuated over time relative to other OECD countries. In 1980, Denmark's public health care spending accounted for 9.3% of its GDP, comparable to 9.1% for the United States and significantly higher than 7.2% for Canada and that of other countries¹¹⁴. However, in response to its rapidly ageing population, Denmark made increasingly significant changes to its provision of LTC services by the late 1980s, which eventually allowed it to close nearly a third of its hospital beds and avoid adding additional LTC home beds by investing more in the provision of home and community care services²³⁰. In doing so, by 1999, Denmark's health care spending accounted for 8.4% of its GDP²³¹, less than 9.3% for Canada and significantly lower than 12.9% for the United States²³². Two decades later, Denmark's current health care expenditures continue to remain lower than those of both the United States and Canada. As of 2024, Denmark's health care spending accounted for 9.4% of its GDP, less than 11.3% for Canada and significantly lower than 17.2% for the United States¹⁴⁰. Meanwhile, the OECD average for health care expenditures across 38 member countries as a percentage of their GDP in 2024 was 9.3%¹⁴⁰. (See Figure 4)

Figure 4: National Health Care Expenditures as a % of GDP (2024)



The Danish health care system is financed based on an annual agreement between multiple parties—the Danish government, Denmark’s regions, and its municipalities—who determine the objectives to be achieved with the upcoming year’s health care budget. These agreements establish fixed expenditure levels and budgetary targets while allowing regions and municipalities autonomy in the day-to-day operation of health services. For example, the agreements have traditionally required regions to improve the efficiency of health service delivery and increase health care activity within established expenditure limits, including a target of approximately 2% annual improvement. A region’s budget for the following year also depends on whether or not this goal has been met ²¹⁷.

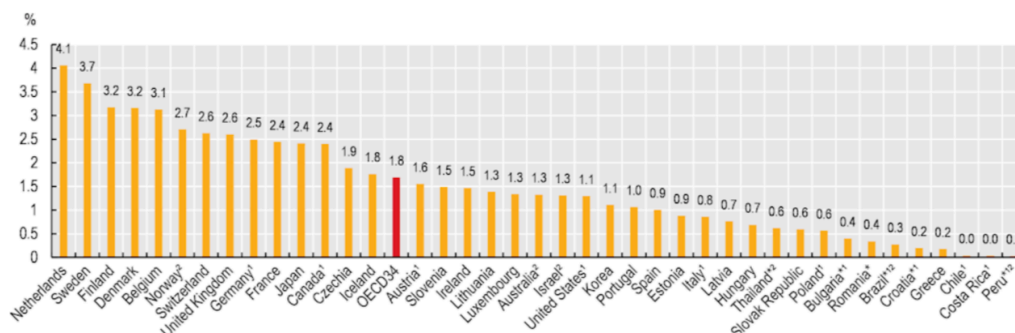
Long-Term Care Spending

In 2023, 3.2% of Denmark’s GDP was spent on the provision of long-term care² ²³³. Danish municipalities have jurisdiction over the organization and provision of long-term care services and co-finance regional health care spending with additional support from the collection of local taxes and funding from the national government, the latter of which entails both block grants and equalization mechanisms. Block grants from the government are distributed proportionally to municipalities according to their tax base, while equalization mechanisms are embedded within block grants to allocate resources more equitably across the municipalities ^{217,221}.

In 2023, 34 OECD countries spent an average of 1.8% of GDP on long-term care, including both health and social components. Denmark’s 3.2% LTC spending rate is almost double the OECD average. While Canada spent more than the OECD average with its 2.4% LTC spending rate, it was still one-third less than Denmark’s. ²³³. (See Figure 5)

² LTC spending comprises both health and social services provided to LTC-dependent people who need care on an ongoing basis. The health component of LTC spending relates to nursing care and personal care services (help with ADLs). It also covers palliative care and care provided in LTC institutions (including boarding costs) or at home. LTC social expenditures primarily covers the provision of help with IADLs.

Figure 5: Total Long-Term Care Spending as a Share of Gross Domestic Product (GDP) in 2023 (or nearest year)



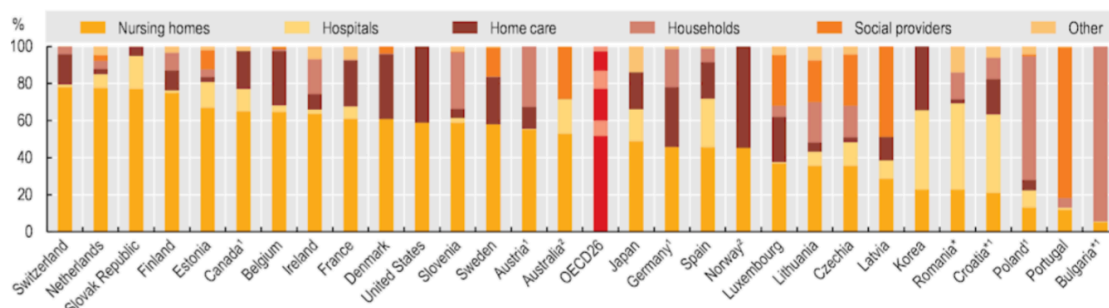
1. Countries not reporting spending for LTC (social). In many countries this component is therefore missing from total LTC, but in some countries it is partly included under LTC (health). 2. 2022 data. * Accession/partner country.

Source: OECD Health Statistics 2025.

In addition, different countries allocate their long-term care budgets differently across various types of care provision: hospitals, LTC homes, home care, social care, households and others. (see Figure 6). In 2023, Denmark spent 61% of its LTC expenditures on care in LTC homes, 35% on home care, 3% on social care, and 1% on hospital-based long-term care. At the same time, Canada spent far less on the provision of home care (19%), while spending more on its provision of care in LTC homes (66%) and hospital-based long-term care (13%) compared to Denmark ²³³. The latter hospital-based LTC expenditures in Canada largely represent the costs associated with people who are designated as alternate level of care (ALC) patients – mostly older persons who no longer need hospital care and who are awaiting to return home with the provision of home care services or for an LTC home bed to become available (see Figure 7).

On average in 2023, across 26 OECD countries, roughly half of all LTC expenditures went to care in LTC homes, which accounted for the largest share in most member states. On average, about one-sixth of total LTC expenditures went to home care services. The remaining expenditures were distributed among hospital-based LTC services, households that receive care allowances to support family caregiving, and providers focused primarily on social support. Each of these three categories accounts for roughly 10% of overall LTC expenditures across 26 OECD Countries included in this analysis ²³³.

Figure 6: Total types of long-term care spending in 2023 (or nearest year)

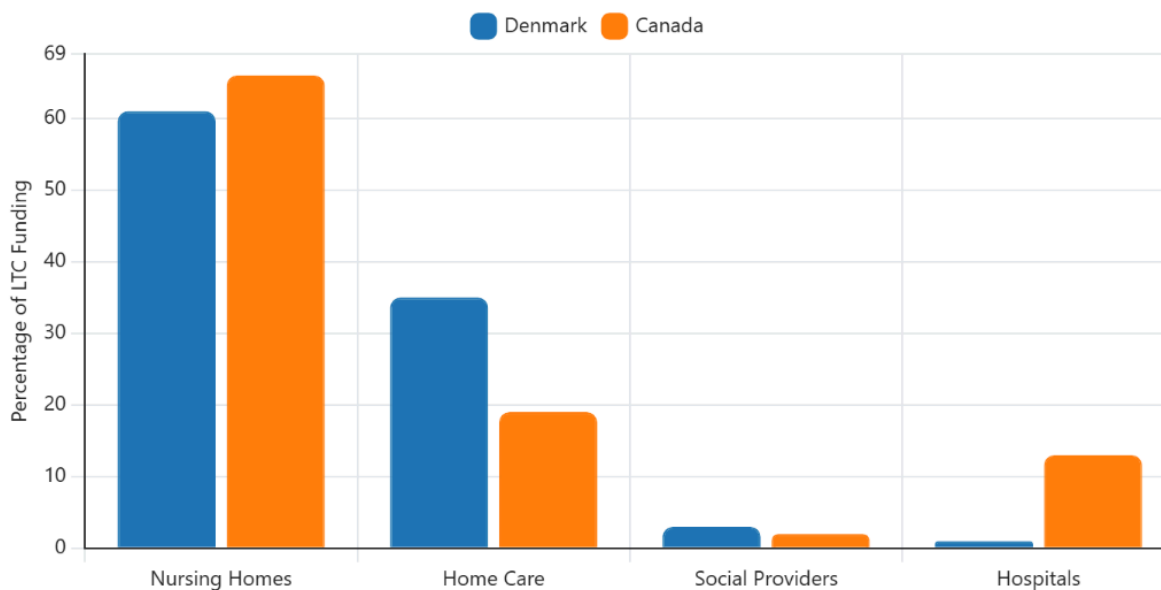


1. Countries not reporting social LTC. The category "Social providers" refers to providers where the primary focus is on help with IADL or other social care. 2. 2022 data. * Accession/partner country.

Source: OECD Health Statistics 2025.

Hospitals include long-term medical and nursing care provided within a hospital setting (e.g. palliative or long-stay beds). **LTC institutions/homes** refer to institutions that provide accommodation and LTC as a package. **Home care** applies to services provided to people with functional restrictions who reside in their own home. **Social care providers** include non-medical services that support Instrumental Activities of Daily Living (IADL), which help people with tasks necessary for independent living, such as shopping, cleaning, cooking, laundry and managing finances. **Households** refer to the direct, private, out-of-pocket payments made by individuals or their families for care services.

Figure 7: Comparing Denmark and Canada's 2023 LTC Funding Distribution by Provider



Personal Financial Contributions Related to the Provision of Long-Term Care Services in Denmark

Denmark's 1933 Public Housing Act states that older adults living in LTC homes and other forms of housing for older Danes must pay rent, utilities (including electricity, water, and heating), meals, and cleaning services. When moving in, residents are generally required to pay a deposit or down payment, a shift from previous legislation that did not require such payments. Paying a deposit depends on the year in which an LTC home was built. If the LTC home was built before 1988, residents are not required to pay a deposit, while if it was built after 1988, residents may need to pay a deposit of up to 3 months' rent¹⁸⁰. Deposit loans and housing benefits to support rent payments are available to older Danes as well if they choose to apply²³⁴. Base rent prices vary by the year an LTC home was built, its location, the size of the apartment (private or shared), and the level of access to assisted-living technologies it provides. However, an individual's final out-of-pocket rent payment is subject to means-testing based on their income and eligibility for housing benefits. As a result, final accommodation costs can vary significantly across LTC residents.

Older Danes with no other income besides their state pension pay an average of DKK 1,500 (\$325.55 CAD) per month to live in an LTC home in the City of Copenhagen²³⁵. In contrast, LTC homes in Sønderborg (a town located in Southern Denmark), typically cost DKK 4,113 (\$892.49 CAD) per month. Additional expenses include approximately DKK 75.76 (\$16.45 CAD) for laundry, DKK 179.26 (\$38.92 CAD) for cleaning, and DKK 110.97 (\$24.09 CAD) for personal spending²³⁶. While privately run LTC homes are not more expensive than municipality-owned and operated LTC homes, residents can often pay for additional services, such as extra cleaning, wellness, and other services in these settings¹⁰⁸.

While LTC home residents retain access to their pension and financial resources²³⁷, rent for LTC homes can be expensive. For some, subsidies are available, and rent payments, along with payments for medication, laundry, and other services, are capped at 10-20% of a person's income, depending on the municipality. In addition, help with personal care and support are free for LTC home residents.

Similarly, in Denmark, home care services include nursing, personal care and support services, which are provided free and have no associated co-payments. However, individuals receiving care through a private provider can purchase additional services beyond what the municipality provides free of charge²³⁷. See Table 3 for a funding and cost overview of long-term services in Denmark.

Table 3: A Funding and Cost Overview of LTC Services in Denmark

Service Type	Funding Status	Notes
Home Nursing	Free of Charge	Clinical care provided at home by nurses.
Home Care Services	Free of Charge	Personal care and support (e.g., hygiene, cleaning).
Rehabilitation Services	Free of Charge	Includes physical therapy and recovery support at home or in facilities. Training and care during a temporary residential stay (e.g., at a rehabilitation centre after hospitalization) are free, but municipalities may charge for meals, linen and laundry, typically about DKK 160–170 (\$34.44 – 36.0 CAD) per day in 2025–2026; no charge may be made for the accommodation itself 238–240
LTC Home Nursing and Care Services	Free of Charge	Clinical and non-clinical care provided within LTC homes.
Meal Delivery Services	Co-payment Required	Subsidized but not free; residents pay a portion of the cost based on their financial circumstances
Temporary Home Care Visits	Co-payments May Apply	Depends on duration and type of service.
LTC Home Rent & Utilities	Payments Apply but May be Subsidized	Residents pay rent and utility costs based on their financial circumstances; financial aid may be available.
Assistive Devices (e.g., walkers, lifts)	Payments Apply but May be Free or Subsidized	Some devices are covered; others require co-payment or full payment based on one's financial circumstances.

Denmark's Long-Term Care Workforce

As Denmark's population continues to age, its health care system is experiencing increasing strain due to a growing shortage of trained care professionals and other care providers. Although Denmark maintains above-average numbers of practicing physicians (4.4 per 1,000 population) and nurses (10.2 per 1,000 population) compared to OECD and Canadian averages of 3.7 and 2.8 for physicians and 9.2 and 11.04 for nurses (per 1,000 population), respectively²⁴¹⁻²⁴³, these levels are still not considered high enough to meet the growing need for health and LTC services.

At the same time, staffing levels in Danish LTC homes can vary considerably across municipalities, with a recent national study showing an average of 2.6 residents per staff member during the daytime; however, this average masks disparities ranging from 1.4 to 4.1 residents per staff member, depending on local conditions²⁰⁰. By comparison, available Canadian data indicate average staffing levels of approximately 3.5–3.7 hours of direct care per resident per day²⁴⁴, which corresponds to roughly 6.5–7.0 residents per staff member per shift, assuming an eight-hour shift and continuous coverage³.

Like other countries navigating the challenges of rapid population ageing, Denmark faces a persistent shortage of both health and LTC workers, which is placing increasing strain on the current care professionals and providers who remain in the sector while intensifying pressure on its health and LTC systems as a whole¹⁹⁹. These pressures are already evident at the local level, as municipalities report persistent shortages of social and health care assistants (social- og sundhedsassistenter, SOSU assistants) and social and health care helpers (social- og sundhedshjælpere, SOSU helpers) across a range of LTC services, including home care and LTC homes. Workforce shortages have also contributed to a growing reliance on unskilled workers (ufaglærte) or care staff who do not actually hold any formal social or health care qualifications. Recent national data indicate that nearly one-quarter (approximately 25%) of employees in Danish long-term care services are unskilled workers, a proportion that has increased substantially in recent years.^{245,246}

Understanding the implications of this trend requires considering the composition of Denmark's current LTC workforce, which includes several occupational groups with varying levels of education and responsibility. Registered nurses complete a 3.5-year professional bachelor's degree in nursing before obtaining authorization to practice. Social and health care assistants (SOSU assistants) complete an upper-secondary vocational education programme, followed by approximately 2 years and 4 months to 2 years and 10 months of post-secondary vocational training, and perform their duties. SOSU Assistants are authorized healthcare professionals under Denmark's Authorization Act, with a protected professional title and statutory responsibilities for providing delegated nursing care, administering medications, documenting care, and contributing to clinical assessment and rehabilitation^{247,248}. These regulated health care professionals are broadly comparable to licensed practical nurses (LPNs) in Canada (or registered practical nurses (RPNs) as called in Ontario). Additionally, other nursing professions in Canada provide support to older adults, including registered nurses (RNs), registered nurse prescribers, nurse practitioners (NPs), and registered psychiatric nurses with specialized mental health training²⁴⁹.

³ This estimate is based on hours of direct care per resident per day and does not account for staffing relief required for breaks, meal periods, leave, or other non-direct-care time. Actual staffing requirements may therefore be higher.

Social and health care helpers (SOSU helpers) complete a shorter vocational training programme of approximately 1 year and 2 months and primarily provide personal care, assistance with activities of daily living, and practical supports, similar to personal support workers (PSWs) or care aides (CAs) in Canada. SOSU Helpers are not an authorized health profession but work as an integral part of interdisciplinary care teams under the direction of authorized healthcare professionals and within defined municipal competencies²⁵⁰. By contrast, unskilled workers may be employed without a formal care qualification, although many receive workplace orientation and on-the-job training. The increasing dependence on this group of care providers reflects ongoing recruitment and retention challenges and has raised concerns about ensuring adequate competencies and maintaining quality of care as demand for long-term care services continues to grow^{251,252}.

Currently, long-term care occupations ranked among those with the highest shares of unsuccessfully filled vacancies within Denmark's public sector^{253,254}. Nevertheless, recently, in 2025, the Danish Ministry for Senior Citizens projected that, within the next ten years, Denmark could face a shortage of up to 15,000 health and social care workers, as its population continues to age²⁵⁵. Furthermore, given that the residents to staff ratios in Danish LTC homes is, on average, eight times higher during night shifts compared to day shifts, this projected shortage will likely place a particular burden on night shift workers²⁰⁰. As the demand for LTC services continues to rise, outpacing the workforce that provides these services, these shortages threaten to further widen existing care gaps.²⁵⁶ Similar pressures are evident in Canada, where pan-Canadian workforce projections anticipate persistent shortages over the next decade, particularly in occupations central to the delivery of care for older adults. The largest projected gaps are among registered nurses, licensed practical nurses, personal support workers or care aides, and family physicians and nurse practitioners—roles that form the backbone of long-term care, home care, and broader health services for ageing populations²⁵⁷.

In Denmark, the wages of health care professionals and care providers are typically negotiated and implemented through sector-specific collective agreements rather than set unilaterally by employers, with separate agreements covering regional hospitals, municipal services (including the provision of home care and care in LTC homes), and private providers. Pay structures are supplemented by additional remuneration for factors such as shift work, seniority, work functions, credentials, and local conditions. Despite these sectoral distinctions, wage determination remains highly coordinated across Denmark's public health and LTC systems, reflecting the country's commitment to the provision of equitable compensation through collective bargaining and regulatory frameworks. Central to this framework is the Danish 1976 Equal Pay Act, known as the Act on Equal Pay to Men and Women (Ligelønsloven), which mandates equal compensation for equal work or work of equal value and prohibits wage discrimination based on gender. Employers with at least 35 employees, including at least 10 men and 10 women performing the same job function, are required to prepare and share annual gender-segregated wage statistics or an equal pay report^{258–260}.

In many aspects, Denmark's 1976 Equal Pay Act is comparable to Ontario's 1987 Pay Equity Act, which seeks to address systemic gender-based wage discrimination by enforcing pay equity for female occupational classes. Both regulations emphasize the idea of equal compensation for work of equal value and aim to remedy historical undervaluation of female-dominated fields²⁶¹. Despite these shared objectives, progress toward wage parity varies across jurisdictions. In 2024, the median full-time working women earned approximately 10% less than their male counterpart across 38 OECD countries on average. By comparison, the gender pay gap was wider in Canada, at approximately 16%, while markedly smaller at approximately 4% in Denmark, suggesting that Denmark has come much closer to achieving wage parity than both Canada and the OECD overall²⁶². This distinction is particularly relevant to the health and LTC sectors, where women comprise a large proportion of the workforce²⁶³. By supporting more equitable compensation and helping to reduce the historical undervaluation of care-related occupations, Denmark's pay equity

framework may contribute to the attraction and retention of workers in these sectors. Although wage equity alone cannot address all workforce challenges, it reflects a broader commitment to valuing care work and supporting the sustainability of the health and long-term care workforce.

In addition to Denmark's sector-based wage-setting framework, another defining feature of its labour model is the high degree of coordination and consistency, particularly within its public health and LTC sectors, provided through collective agreements, which apply across regions and municipalities and help limit excessive wage fragmentation within its health and long-term care workforces. While pay and conditions are not identical for regional and municipal employees, collective agreements are negotiated in parallel bargaining rounds and follow shared economic frameworks, which helps limit excessive wage fragmentation. These agreements establish pay scales for nurses, health care assistants, helpers and other health and social care workers according to their occupation, qualifications, and negotiated supplements rather than relying on market-based competition between care settings. As a result, a nurse employed in a regional hospital and one employed in a municipal home care service will typically have similar—but not identical—wages, with differences primarily reflecting sector-specific agreements and supplements for working irregular hours, specific work functions, or seniority. As a result, the Danish collective bargaining mechanism has contributed to comparatively narrower wage differences between hospitals, municipal LTC home and home care services than those observed in more decentralized wage-setting systems such as Canada.^{264–267} In recent years, sector-wide collective agreements have also increased wages for health care and LTC providers, reflecting efforts to address workforce shortages and strengthen the LTC workforce^{267,268}.

In contrast, Ontario's health and long-term care systems are marked by significant wage disparities within and between sectors. Generally, health care professionals, provider and other staff working in publicly funded hospitals tend to earn higher wages than comparable workers in LTC homes, while workers providing publicly funded home and community care often receive the lowest compensation^{269–271}.

As a result of these disparities, many care professionals and providers leave home and community care settings and even LTC home settings in search of higher-paying positions within the health care system and even beyond it, exacerbating workforce retention challenges in a sector that is already understaffed and under significant strain²⁷². By comparison, Denmark's more unified system of wage-setting across public health and LTC employers helps promote greater workforce stability, an important factor in sustaining the country's longstanding emphasis on providing home and community-based care whenever possible.

Denmark has also made a unique commitment towards implementing digital tools and technologies in its provision of health and LTC services to improve efficiency and to lighten staff workloads. Assisted-living technologies are increasingly being used to support physically demanding care tasks by improving working postures and reducing exposure to heavy lifting and other physically strenuous activities, thereby alleviating physical strain and lowering the risk of work-related injuries among care providers. Implementing innovative solutions is intended to save care providers time that can be reallocated to providing more direct care, training, and resident assistance. By reducing manual handling and repetitive tasks, these solutions allow staff to conserve physical and mental resources rather than replace workers or de-professionalize care tasks. These technologies also have the potential to improve work environments and staff experiences by enhancing workplace safety and supporting more sustainable care practices. Evidence from a 2017 study in the Danish municipality of Copenhagen shows that assisted-living technologies improve working postures for health care professionals, relieving physical strain and reducing work-related pain and injuries. For example, patient-turning systems for transferring, moving, and handling patients have been implemented in LTC homes in the Danish municipality of Hillerød, where the technology has made transfers smoother and

gentler for residents and has led to a marked improvement in staff safety; notably, no transfer-related work injuries have been reported since the system was introduced ^{78,273,274}.

Additional assisted-living technologies used in care for older adults in Denmark include ceiling-mounted lifts integrated throughout LTC homes, multifunctional care beds that allow residents to reposition or exit the bed with minimal staff assistance, and sensor-based monitoring solutions that reduce the need for routine physical checks. Digital platforms that support medication management and communication with relatives further reduce routine tasks for staff, while digital rehabilitation and training technologies enable older adults to exercise more independently, lowering ongoing assistance needs and freeing staff time for more complex or personalized care ⁷⁸.

Denmark's Caregivers

Currently, 13% of Denmark's population, i.e., 750,000 people, are estimated to be serving as informal caregivers or Uformel omsorgsperson, the Danish term used to mean family members, friends and neighbours providing care ²⁷⁵. Although unpaid care provided by family members and friends is estimated to contribute economic value equivalent to nearly 3% of Denmark's GDP ¹⁰, the rights of these unpaid caregivers have not been defined in Danish legislation, as the primary objective of the current 1998 Social Services Act (Serviceloven) is to protect the rights of care recipients ²⁷⁵.

While the Danish National Health Authority has made recommendations on how to better support caregivers, the International Alliance of Carer Organizations (IACO) has stated that these recommendations are "rarely met." For example, professionals and other care providers are urged, but not obligated, to collaborate with caregivers ²⁷⁵. To promote change, in 2017, Carers Denmark and Dane Age proposed a national strategy to better protect caregivers. The five basic principles of this proposed national strategy were:

- Caregivers must be recognized, included, and informed.
- Legal rights for caregivers must be improved.
- Evidence on the needs of caregivers and relevant interventions must be improved.
- Health issues and social isolation among caregivers must be prevented.
- A better work-care-life balance must be provided for caregivers. ²⁷⁵

Over the past 15 years, budget cuts and difficulties recruiting both care professionals and providers have shifted some caregiving responsibility from paid providers to caregivers. According to a 2023 National Bureau of Economic Research analysis, Denmark's health and LTC systems are under pressure due to its ageing population and increased demand for care services, necessitating the greater involvement of family caregivers ¹⁰. Therefore, it has been seen as especially important that the Danish government takes action towards fulfilling the goals of the proposed national caregivers strategy ²⁷⁵. Despite these issues, the perceived burden of dependency on caregivers in Denmark compared to other countries is still considered to be light to moderate because LTC services and supports in Denmark are more readily accessible and better funded overall ^{22,276}. While the burden on caregivers in Denmark may be considered moderate, the intensity of caregiving can vary significantly at the individual level. Indeed, some Danish caregivers report experiencing significant physical, emotional, and financial strain, particularly when providing intensive care to individuals with severe disabilities or chronic

conditions ²⁷⁶. Therefore, while the overall burden may be perceived as mild to moderate, individual caregivers' experiences can differ substantially.

In terms of the financial supports available to Danish caregivers, one option is to receive a care allowance (plejevederlaget), a taxable cash benefit intended to compensate for lost income during a period of caregiving. This benefit is available to individuals caring for a terminally ill relative or close friend at home ²⁷⁷. It is also available to both employed and unemployed caregivers, with the amount varying based on employment status. Employed caregivers receive a weekly benefit equal to 1.5 times their sick pay, subject to an absolute and a relative ceiling. The absolute ceiling is 206.16 DKK/hour or around 7,627 DKK/week (\$1,644 CAD/week) for a full-time employee (2026 rate), subject to individual municipal assessment ²⁷⁸. The relative ceiling ensures the allowance does not exceed the caregiver's previous income. An unemployed caregiver will receive a fixed amount of 19,090 DKK/month (\$4,078.80 CAD/month) (2026 rate) ²⁷⁹.

A care allowance is typically provided for 2 to 6 months, with possible extension in special circumstances. The allowance is intended to support family caregivers who provide full-time care to a terminally ill or seriously ill relative at home and is not intended for part-time or intermittent caregiving. It expires two weeks after the care recipient's death ²⁷⁷. In addition, the local authority assesses each case and allocates compensation; as a result, local budget constraints can limit how many family caregivers can receive benefits through this mechanism. For this reason, the IACO has called for a national standard setting criteria for compensating family caregivers to ensure greater uniformity across Denmark ²⁷⁵.

It is also possible for working family caregivers who are living with a close relative they are caring for to sign an employment contract with the municipal council for up to six months, which can be extended in the case of extenuating circumstances ^{275,280}. This arrangement refers to the “self-appointed helper” (selvudpeget hjælper) or family employment contract under Danish eldercare legislation and allows municipalities to formally employ a co-residing family member to perform specified personal and practical care tasks—such as bathing or daily assistance—that would otherwise be delivered by municipal home care providers, with the municipality retaining responsibility for approval, supervision, and continuity of care ^{281,282}.

Recognizing the impact of providing care on family caregivers, another important support available for caregivers is the provision of mental health care supports. It is currently estimated that one in six Danish municipalities has made guidance counsellors available for caregivers to offer one-on-one support, share information about caregiver rights and available resources, facilitate peer groups, etc. Support groups for caregivers are also organized by a number of organizations, including Carers Denmark. A distinctive feature of caregiver peer support groups in Denmark is that they are organized across diagnoses rather than around specific conditions. This approach reflects caregivers' preference for support that focuses on the challenges and demands of the caregiving role itself, rather than on disease-specific care needs and management strategies. These groups are called Carer Self-Help Groups Across Diagnoses (Pårørendegrupper på tværs). The only commonality that participants share is their role as a family caregiver. In addition, caregivers can access psychotherapy through Denmark's publicly funded health-care system, with a 40% co-payment required for up to 12 sessions with a psychologist, while the remaining cost is covered through the national health insurance scheme. ^{275,283} Caregivers must seek support within 12 months of a traumatic occurrence, such as an accident, serious diagnosis, or emergency hospital treatment. However, the time limit is rarely enforced. Although eligibility for publicly subsidized psychotherapy is governed through Denmark's national health insurance regulations and referral criteria under the Danish health care system, municipalities are responsible for providing most mental health services in Denmark. The level and range of mental health support is not standardized across municipalities and can thus vary based on local needs and resources ²⁸⁴.

The Quality and Accreditation of Long-Term Care Services

Danish LTC Service Standards

Legislation and policies related to long-term care in Denmark take a person-centred approach to promote the independence, dignity, and autonomy of older Danes, encouraging them to learn to care for themselves and remain in their own homes for as long as possible. Thus, the overarching goal of Denmark's LTC system is to enable both healthy ageing and ageing in the right place.

Launched in 2016 as a joint effort between the national government, the regions, and the municipalities, the Danish National Quality Programme for Healthcare (Det Nationale Kvalitetsprogram) sought to promote the continued improvement of the quality of care across Denmark²⁸⁵. The program included specific initiatives in addition to its national goals, such as needs assessments tailored to the individual, coordinated care management across all levels of the health care system, learning teams to share information on best practices, increased transparency of data, and incentives to promote high standards for treatment of care recipients^{217,286}. However, the program is now being reshaped as part of the 2024 Health Care Reform. From January 2027, a new National Health Plan (National Sundhedsplan) and 17 regional Health Councils (Sundhedsråd) will provide a new framework for health planning. Each Health Council will develop a local health plan (nærsundhedsplan) to guide the reorganization and expansion of local health care and strengthen coordination and care closer to citizens' homes^{287,288}.

Danish LTC Service Regulation

The 1998 Social Service Act (Serviceloven) established that Danish municipalities were fully responsible for providing LTC services and thus set their own quality standards (kvalitetsstandarder) for preventative initiatives, rehabilitation and home care services, and care in LTC homes. These standards define, for example, the expected involvement of relatives and the distribution of care responsibilities between public and private providers^{289,290}. Furthermore, these standards help determine a municipality's service level, and the municipal council must ensure it has adequate resources to deliver it. This organization of Denmark's LTC system allows for services to be provided in or as close to home as possible for older Danes^{108,291}. The Danish Health Authority (Sundhedsstyrelsen) provides national guidelines and best practices for care, including preventative, rehabilitation and long-term care services, while the Danish Patient Safety Authority (Styrelsen for Patientsikkerhed) ensures the delivery of high-quality care and makes requests to change practices when safety lapses are found^{292,293}. The Danish Patient Safety Authority accomplishes this task through risk-based supervision of health care settings and services for older people, as well as investigations of registered health professionals who have been flagged due to a patient safety concern²⁹³.

In 2022, the Danish government further established the Ministry of Senior Citizens (Ældreministeriet) to address the growing policy and system-level challenges associated with its rapidly ageing population. While a Minister for the Elderly had existed since November 2016 – initially under the Ministry of Health and later the Ministry of Social Affairs and Senior Citizens – the creation of a standalone ministry marked a consolidation and elevation of older persons and LTC policy within Denmark's governance structure^{148,294}.

The Ministry of Children, Senior Citizens and Housing (formerly known as the Ministry of Senior Citizens) is currently responsible for legislation, policy development, and quality oversight of LTC services. While these services were previously regulated under the 1998 Social Services Act (Serviceloven) as part of Denmark's broader social services framework, they are now governed by a dedicated legislative framework under the 2024 Elderly Act (Ældreloven) following recent long-term care reforms. Within this new framework, the Ministry has played a central role in advancing a shift toward holistic, citizen-centred care, including fixed care teams, trust-based governance, and greater continuity of services. These reforms have shifted long-term care provision away from task-based, time-measured regulation toward greater self-determination for senior citizens and improved integration across relevant health and social care services, most of which are delivered at the municipal or local level. To support this shift, the Ministry for Senior Citizens collaborates closely with the Ministry of Health to strengthen coordination among general practitioners, hospitals, and municipal care services, particularly for older adults with complex and chronic care needs^{295,296}.

Medical Care for Older Danes

Denmark provides health care through a national single-payer system funded through general taxation, offering universal care to all Danish citizens under the principles of free and equal access. Danes can choose to receive their care from any public hospital and some private hospitals as well³.

Health Insurance

For health insurance coverage, Danish residents are generally assigned to Health Insurance Group 1 by default. They can, however, actively choose to switch to Health Insurance Group 2, which provides greater flexibility in accessing health care providers.²¹⁷

Health Insurance Group 1

More than 99% of Danes choose to be a member of Health Insurance Group 1 and can receive free medical care from the primary care providers (PCPs) they are registered with through the Danish public health care system. With a referral from their PCP, Danes in this insurance group can also receive free care from private practice specialists. Some specialists, such as ophthalmologists, audiologists, and dentists, do not require a referral. Services provided by other health care professionals, such as dentists, physiotherapists, and psychologists, fall within Denmark's primary health care system and typically require a co-payment. In some cases, the particular circumstances of a patient will allow them to receive public subsidies^{143,217}.

Health Insurance Group 2

Fewer than 1% of Danes choose to be members of Health Insurance Group 2 and can seek care from any PCP and visit private practice specialists without a referral. However, they may encounter fees, i.e., co-payments associated with the services they receive.

Primary Care for Older Adults

PCPs, typically referred to as general practitioners (GPs) in Denmark, are the first point of contact for older Danes accessing the health care system in non-emergency situations. Approximately 3,500 PCPs currently work in the public health care system. Each PCP manages approximately 1,600 patients. The average Dane sees their PCP seven times a year, though 10% of Danes do not make any contact with their PCPs within a year^{297,298}. PCPs play an important role in the overall health care system because they are able to treat most patients without needing to refer them to more specialized care²¹⁷.

The Danish health care system is patient-oriented and based on the individual's right to autonomy, including a free choice of hospital and PCP¹⁴³. For children born in Denmark, registration in the Civil Personal Registry (CPR) begins automatically after the birth is digitally registered, and the child is then assigned a PCP. The PCP is listed on the child's health insurance card (sundhedskort). This contrasts sharply with Canada, where finding a family doctor is the patient's responsibility and often proves challenging. In addition, all Danish citizens can change their assigned PCP by logging onto a website, seeing which PCPs are accepting new patients, and requesting a change of provider²⁹⁹. PCPs typically provide care to patients who live close to them and although PCP shortages remain a concern in both Denmark and Canada, Denmark's patient registration system ensures that more than 98% of residents are attached to a PCP²⁹⁷, compared with approximately 83% of Canadian adults reporting access to a regular PCP^{300,301}.

At present, Denmark has an additional 1,200 doctors currently receiving specialist training to become PCPs; in 2024 alone, 265 doctors completed their PCP specialist training²⁹⁷. To further meet anticipated future demand for primary care, Denmark has set a target of adding approximately 1,500 more PCPs to its current complement of approximately 3,500 by 2035^{302,303}.

Many Danish PCPs work in group practices with other primary care physicians, while some run their own clinics. They are usually assisted by medical secretaries and nurses, and in some situations, midwives or other allied health professionals work with PCPs, notably to provide maternal and preventive care. While the exact team composition varies by clinic, collaboration and coordination across providers are central to primary care in Denmark. To best meet the needs of their patients, most PCPs have time blocked off every morning for walk-in patients with urgent health concerns³⁰².

PCPs in Denmark also provide after-hours care through a nationwide on-call system known as lægevagten. Danes who require medical care outside regular clinic hours can make a call to an after-hours line (e.g., 1813 in the Capital Region), where they will be triaged by a PCP or a trained nurse and, depending on their needs, be directed to receive medical advice over the phone, be referred to an urgent care clinic staffed by PCPs, or, in special cases such as frail or immobile patients, be visited at home by a team of nurses called the "AkutTeam."³⁰⁴ The last option is particularly helpful for older Danes who do not necessarily require emergency care but cannot leave their private dwelling or LTC home. The provision of after-hours care is critical to avoiding unnecessary visits to hospital emergency departments, which is more cost-efficient for the health care system and better for the patient^{305,306}.

PCPs also serve as gatekeepers to other health care services and help coordinate the best course of treatment for their patients. If a patient needs to see a specialist, receive hospital care or access other health care services offered by Danish municipalities, a PCP is responsible for writing the referral. Once the PCP creates a general referral for a given specialist, they submit it to a central database. Then, based on wait times, location, hours, and more, the patient chooses a specialist and calls the office directly to book an appointment, giving them choice and control

over their specialist care.^{302,307} PCPs do not, however, serve as gatekeepers to services rendered by dentists, ear-nose-throat specialists, and eye specialists³⁰⁸.

To improve continuity of care and reduce avoidable hospitalizations in LTC homes, Denmark has made stronger PCPs involvement in LTC settings a priority. National initiatives have encouraged more stable PCPs responsibility for care homes, supporting closer collaboration between primary care and municipal LTC services and improving medical oversight for residents with complex needs^{41,297}. Progress has been made, particularly in areas with sufficient PCP capacity, and these efforts reflect Denmark's broader commitment to strengthening community-based primary care. Although PCPs shortages and regional differences still affect consistent implementation, these challenges are widely recognized and are being actively addressed through ongoing primary care and long-term care reforms^{18 309}.

Geriatric Medicine

The majority of patients that are seen by geriatricians are over 70 years old, have multi-morbidity (i.e., two or more chronic health conditions), are affected by age-related changes, and experience reduced functionality³¹⁰. Geriatricians typically provide care for these older adults in conjunction with other health professionals such as specialized nurses, physiotherapists, occupational therapists, social workers, dietitians, speech pathologists, and chiropractors. These multidisciplinary geriatric teams can exist in a variety of different settings, including acute hospital units, orthogeriatric surgical wards, inpatient and outpatient rehabilitation services, hospital outreach initiatives, and, more rarely, within community or home-based programs³¹¹. One such example is in dementia memory clinics, where the multidisciplinary teams consist of geriatricians, neurologists, psychiatrists, neuropsychologists, and nurses³¹².

The Danish Health Authority estimates that in 2024, Denmark had about 181 geriatricians. This number is relatively low compared to the country's ageing population. In 2024, there were over 1.2 million individuals aged 65 and older in Denmark, resulting in a ratio of around 6,600 older adults per geriatrician³¹³. This data highlights the need for targeted efforts to address the geriatrician shortage. However, a recent Danish survey on factors influencing junior doctors' specialization in geriatric medicine indicates a growing interest among new doctors in pursuing this specialty. Of approximately 130 eligible respondents, 75 responded, with 13% expressing interest and 44% indicating potential interest in a career in geriatric medicine. Denmark expects to see a significant increase in its number of geriatricians, from 173 doctors specializing in geriatric medicine in 2021 to 497 by 2045^{313,314}. This suggests a positive trend toward addressing the anticipated shortage of geriatricians³¹³. By comparison, there were about 460 geriatricians in Canada in 2025³¹⁵, serving 8.1 million individuals aged 65 and older, an older population that is more than six times the size of Denmark's older population^{316,317}. This results in a ratio of approximately 17,600 older adults per geriatrician in Canada³¹⁸, showing that despite its current shortage, Denmark maintains a much more favourable ratio of older adults to geriatricians compared to Canada.

Dental Care for Older Adults

Dental care services are part of the primary health care system in Denmark and do not require a referral from a GP, but do usually require the patient to make a co-payment towards the dental care they receive¹⁴³. In contrast, publicly funded dental care for older adults in Canada remains limited and varies considerably across provinces and territories, with most routine dental services financed through private insurance or out-of-pocket payments. Recent federal initiatives, including the Canadian Dental Care Plan, have expanded coverage for eligible older

adults, but access remains more fragmented than in Denmark's nationally regulated reimbursement system.³¹⁹

Children and young people are normally treated by the municipal dental service up to age 22, although they may choose a private practitioner for care; all other non-dependent Danes living in the community must receive dental care from private practitioners. Fixed fees for services are established by the national health insurance program. The amount paid out of pocket versus reimbursed depends on several factors, including the type of service received, the patient's age, and whether the dentist is under contract with the regions. For example, reimbursements covering up to half of the fee are offered for the most common preventive or restorative dental treatments. Dental services for dentures, crowns, and bridges are either paid in full by the patient or are partially covered by a patient's private health insurance plan³²⁰⁻³²².

For the most part, only episodic care in emergency situations was available to LTC home residents and non-institutionalized older adults with severe disabilities before 1994, at which point municipalities were mandated to offer publicly funded oral health care services to frail and dependent older Danes who had difficulty using ordinary dental care services. This municipal outreach dental care scheme (Omsorgstandplejen) provides preventive and therapeutic dental care. Dependent older Danes can choose to receive dental care from private or public providers, unlike non-dependent older Danes; however, the majority use public dental services, which are better able to provide outreach services, such as dental care delivered in LTC homes for individuals who have difficulty travelling to conventional dental clinics³²³.

On-site dental health care services are also available to older Danes living in long-term psychiatric care settings³²⁴⁻³²⁶.

Vision Care for Older Adults

Visual impairments, which can significantly decrease one's quality of life and ability to care for oneself, affect more and more Danes as they age. Being able to swiftly access health care services is essential to managing visual impairment, as early detection and appropriate treatment play an important role in determining the severity and progression of age-related eye diseases³²⁷. As such, PCPs in Denmark are being encouraged to become more involved in the detection of visual impairments³²⁸. Denmark's national health insurance system covers eye care services when provided by ophthalmologists and when treatments are medically necessary. Some services are not fully covered (e.g., glasses, contact lenses, elective/cosmetic procedures, laser correction) and require out-of-pocket payment or payment via private insurance plans³²⁹. By comparison, coverage for routine eye care in Canada varies by province and territory. Although some jurisdictions provide publicly funded eye examinations for older adults, coverage is not universal, and many older Canadians must pay out of pocket or rely on private insurance to cover the costs of routine eye care, eyeglasses, and contact lenses.³³⁰

There are also organizations in Denmark that offer resources to Danes with low vision or vision impairment, such as the Danish Association of the Blind (Danske Blindesamfund)³³¹, and IBOS – The Danish Institute for Visual Impairment (Institutet for Blinde og Svagsynede)³³².

Hearing Care for Older Adults

Older adults in Denmark can access hearing care, including hearing tests and hearing aids, through the public system (via ENT specialists or public hearing clinics), with partial subsidies available. The 2005 Social Services Act mandates a subsidy (up to a cap) for hearing aids and related services once a specialist refers the patient. Subsidies may cover much of the cost

depending on the type of device. Older persons may also choose private providers but will often pay extra beyond the subsidy they are eligible for. Private clinics are used especially to access premium devices or faster service. For instance, public treatment through a hospital's clinic usually has a waiting period. This can range from 6 to 12 months for certain types of devices or non-urgent fittings^{333,334}. In Canada, funding for hearing aids is primarily administered through provincial and territorial assistive-device programs rather than a single national subsidy framework, resulting in variation in coverage and eligibility criteria across jurisdictions^{335,336}.

Older Adults and Immunizations⁴

Immunizations that are part of national immunization programmes or vaccinations for risk groups, i.e., older Danes, are free for the individual and paid for by the regions³³⁷. In addition to influenza vaccination, several other vaccines are recommended and publicly supported for older adults in Denmark. However, vaccinations that are obtained for personal reasons, such as for travel, are paid for out-of-pocket³³⁸.

Influenza Vaccination

Influenza vaccines are available for free to Danes who are 65 years of age and older or who have a chronic disease^{217,337}. In the 2023–2024 season, Denmark achieved a 78% influenza vaccination rate among adults aged 65 and over, surpassing the WHO target of 75%³³⁹. This level of coverage is comparable to rates reported in other high-performing countries such as Canada (73%)³⁴⁰ and EU Member States, including Ireland (76%) and Sweden (69%)³³⁹. Notably, Denmark also demonstrated exceptionally high uptake of the influenza vaccine among LTC home residents, with coverage levels reaching 86.4%³⁴¹. According to the ECDC, Denmark has consistently ranked among the top EU countries for influenza vaccination and saw substantial long-term improvement, with older adults receiving markedly more vaccinations over the past decade³³⁹.

COVID-19 Vaccination

COVID-19 vaccination is offered free of charge to all adults aged 65 and older, as well as to individuals with chronic conditions, with annual autumn vaccination campaigns targeting older populations and LTC residents. During the 2024–2025 season, approximately 75% of adults aged 65 years and older received the seasonal COVID-19 booster vaccine, reflecting the continued high acceptance of COVID-19 vaccination in Denmark amongst this age group^{342,343}, while the uptake level in Canada for the vaccine stood at approximately 54% of adults aged 65 years and older during the 2024–2025 season³⁴⁴.

Pneumococcal Vaccination

Pneumococcal vaccination has also been prioritized for older adults in Denmark. Unlike influenza and COVID-19 vaccines, which are offered at least annually, pneumococcal vaccination is intended to provide longer-lasting protection and is typically administered as a single dose, with revaccination considered after several years when clinically indicated³⁴⁵. During the COVID-19 pandemic, Denmark implemented a temporary national pneumococcal vaccination programme from April 2020 to January 2023, initially targeting adults aged 65 years and older with increased clinical risk before expanding to include all adults aged 65 and over. Uptake was rapid, with 61% of older adults vaccinated in the first year and continued digital reminders and outreach efforts

⁴ Where available, Canadian vaccination data are presented to provide context for vaccine uptake among older adults. Direct comparisons should be interpreted cautiously, as eligibility criteria, target populations, and reporting approaches differ between Denmark and Canada.

supported further increases in coverage over time ³⁴⁶. By the end of the programme period, cumulative pneumococcal vaccination coverage among adults aged 65 years and older had risen to approximately 75% ^{347,348}. In comparison, the latest reported uptake level in Canada of this vaccine stood at approximately 54.7% of adults aged 65 years and older as of 2023 ³⁴⁹. Following the end of the temporary national pneumococcal vaccination programme in January 2023, pneumococcal vaccination in Denmark has not continued as a universal or annual programme for all older adults, but instead remains a recommended vaccine primarily for specific risk groups, including older adults with certain chronic conditions, and is offered either with partial subsidy or through individual clinical assessment ³⁴⁵.

Respiratory Syncytial Virus (RSV) Vaccination

RSV vaccination has only recently become available for older adults, and comprehensive coverage data in Denmark remain limited. Unlike influenza and COVID-19 vaccination, RSV vaccination has not been implemented through a universal, publicly funded national programme and is offered primarily on a risk-based, clinician-initiated basis. As a result, uptake monitoring has been fragmented and is not yet routinely reported in national vaccination surveillance. Early real-world evidence suggests that coverage remains low: a nationwide Danish cohort study conducted during the 2024–2025 RSV season found that only 5.9% of adults aged 60 years and older with chronic obstructive pulmonary disease (COPD)—a group at particularly high risk of severe RSV disease—had received an RSV vaccine ³⁵⁰. In comparison, the latest reported uptake level in Canada of this vaccine stood at approximately 15.8% of adults aged 65 years and older as of April 2024 ³⁵¹. These findings indicate that, despite the availability of effective vaccines, RSV vaccination uptake among older adults in Denmark remains at an early stage.

Shingles Vaccination

Shingles (herpes zoster) vaccination among older adults in Denmark is also not supported by a universal, publicly funded national programme, and population-level coverage data remain limited. While vaccination is recommended for older adults and certain risk groups, it is primarily offered when individuals seek care or interact with health care providers, rather than through a systematic population-based vaccination program, and is generally on a self-paid basis, and uptake is not routinely captured through the country's national immunization surveillance systems. However, targeted public subsidies are available for selected high-risk groups, specifically adults aged 18 years and older with clinically significant immunosuppression, based on an individual medical assessment and in accordance with Danish Health Authority guidelines ³⁵². As a result, no official coverage estimates are available for adults aged 65 years and older. Indirect evidence from European comparisons and the launch of large-scale population-based studies in Denmark suggests that shingles vaccination uptake among older adults remains low, particularly when compared with routinely recommended and publicly funded vaccines such as influenza and COVID-19. In comparison, the latest reported uptake level in Canada stood at approximately 38.8% among adults aged 50 years and older as of 2023 ³⁴⁹.

Together, these efforts highlight Denmark's effective use of targeted vaccination programmes, coupled with strong digital infrastructure, to rapidly increase uptake of recommended vaccines among older adults. Furthermore, the Danish Vaccination Register (Det Danske Vaccinationsregister, DDV), operated by the Danish Health Data Authority with Statens Serum Institut as the data owner under §157a of the Health Act, went live in 2013 and incorporates all publicly reimbursed vaccinations administered since 1996. Furthermore, since November 2015, every vaccination administered in Denmark has been required to be reported to the register, whether or not it is part of a national immunization programme. Citizens can view their own vaccination records on sundhed.dk, while clinicians can access them through their own systems. This register also became the operational backbone of Denmark's COVID-19 vaccination

programme, through which 98% of older Danes received at least one dose, while 94% received three total doses (primary series plus a booster) during the peak vaccination campaigns ^{21,353–355}

Although Denmark currently maintains a comprehensive national vaccination register that records all administered vaccines, the availability of population-level uptake estimates depends on whether vaccination is delivered through an organized national programme with clearly defined target groups. For both RSV and shingles vaccines, vaccination is offered primarily on a risk-based, clinician-initiated, or self-paid basis rather than through a universal publicly funded programme. As a result, neither vaccine has a formally defined national target population, and uptake is not routinely aggregated, analyzed, or published by age group in national surveillance outputs. Consequently, while individual vaccinations are recorded in the vaccination register, reliable population-level coverage estimates for older adults cannot currently be derived or reported in the same way as for programme-based vaccines such as influenza, COVID-19, or pneumococcal vaccinations.

Chronic Disease Management

Chronic diseases and multimorbidity, i.e., the coexistence of two or more diseases/conditions, are major drivers of health care need and service utilization in Denmark and globally, creating significant challenges for health care systems and providers ³⁵⁶. The rapid ageing of populations has been accompanied by an increase in the number of older adults living with at least one chronic disease. As the number of older adults needing chronic disease management rises, the strain on the health and LTC systems will also increase. In fact, in Denmark, between 2015 and 2030, the number of Danes living with diabetes is expected to almost double ³¹⁰ whereas the number of Danes living with Chronic Obstructive Pulmonary Disease (COPD) is also expected to increase by 40% during this time ³¹⁰.

The Danish approach to chronic disease management has focused on implementing systematic prevention and early detection initiatives to protect older Danes from deteriorating chronic diseases and multimorbidity and adopting digital solutions to enable older Danes with chronic diseases to be more involved in their own care ³¹⁰. For example, Denmark has strengthened its focus on the prevention and management of chronic diseases through public health initiatives targeting key behavioural risk factors, particularly smoking and alcohol consumption ³⁵⁷. While smoking and alcohol use have historically been relatively high compared with many European countries, partly reflecting lower taxation levels than in some neighbouring countries, tobacco control measures, including cigarette price increases introduced between 2019 and 2022, have contributed to declining smoking rates ^{358,359}. Comprehensive screening, early detection, and disease management programs further support the prevention and treatment of chronic conditions, including cancer.

In Denmark, PCPs play a key role in early detection and prevention efforts. Danish municipalities are also tasked with health promotion and disease prevention activities, managing initiatives to reduce substance use and abuse and promoting exercise and healthy eating habits ³¹⁰.

Denmark has long used standardized care pathways (pakkeforløb), introduced in the late 2000s to coordinate care for people with specific health conditions, initially for cancer care and later for selected cardiac and other serious medical conditions. These pathways provide a structured framework for coordinating diagnosis, treatment, rehabilitation, and follow-up across health care providers, while allowing care to be adapted to individual needs. As part of Denmark's recent health reforms, this approach is being extended to people living with chronic conditions through the introduction of chronic care packages (kronikerpakker) ³⁶⁰. These packages seek to replace fragmented, provider-centred care with integrated care pathways that emphasize early

intervention, continuity, prevention, and self-management. Furthermore, rather than adopting a one-size-fits-all approach, each package will be tailored to the individual's clinical needs, functional status, and capacity to manage their condition, ensuring that care intensity is proportionate to the complexity of the patient's circumstances ^{361,362}.

A defining feature of this reform is the introduction of new patient rights. Individuals diagnosed with conditions covered by a chronic care package will be entitled to receive a personalized treatment plan developed by their general practitioner within 30 calendar days of diagnosis ³⁶². The plan will establish individualized treatment goals, identify the roles of relevant healthcare providers, coordinate care across sectors, and connect patients with appropriate prevention, rehabilitation, and self-management supports. Patients referred to municipal prevention or rehabilitation services will also have the right to begin those services within 21 calendar days of referral. These measures are intended to improve continuity of care, strengthen coordination between primary care, hospitals, and municipalities, and reduce avoidable deterioration and hospital admissions ³⁶².

Implementation will occur in phases beginning in 2027. The first chronic care packages will focus on chronic obstructive pulmonary disease (COPD) and chronic low back pain, followed by packages for type 2 diabetes, cardiovascular disease, and people living with complex multimorbidity. While disease-specific, all packages share a common framework centred on proactive care planning, multidisciplinary collaboration, patient education, and support for self-management, reflecting Denmark's broader objective of delivering health care closer to home and improving outcomes for people living with chronic illness ^{361,362}.

Many of Denmark's initiatives involve promoting greater coordination and less fragmentation of care. For example, by collaborating with hospitals, rehabilitation centres, social workers, and more, nurse case managers link municipalities and local hospitals to facilitate smoother access to care for patients with chronic diseases ³⁶³. In addition, Denmark's efforts to improve the quality of chronic disease management include improving the timeliness of care, which is crucial to preventing the worsening of chronic diseases. For example, outpatient clinics in Southern Denmark have started offering a "same-day complication screening package" for diabetes patients, as it is important for screening to be completed in a timely manner given that the risk of complications is high among diabetes patients and treatment must be initiated in the early stages to prevent disease progression. With this "same-day complication screening package," screening becomes more accessible for patients, with results available the same day ³⁶⁴. Similar same-day solutions are also being offered to patients with multimorbidity ³⁶⁵.

Finally, Denmark's approach to chronic disease management involves the implementation of a range of innovative digital solutions, which include online questionnaires using Kommunal PRO (Municipal Patient Reported Outcomes) ³⁶⁶, AI and remote monitoring algorithms predicting the risk of deterioration among COPD and heart failure patients to reduce hospitalizations ³⁶⁷, and regional pilots of digital outpatient clinics that provide patients with equipment for self-monitoring and self-reporting so that the clinic can follow a patient's health status and provide guidance on how to also avoid emergency situations ³⁶⁸. PRO have been organized nationally since 2016 through a PRO secretariat at the Danish Health Data Authority and a national steering group of authorities, regions, municipalities and patient organizations, with standardized national questionnaires now available in thirteen clinical areas, including COPD, heart failure, diabetes, stroke and palliative care ^{369,370}.

Canada has similar priorities, where primary care providers, interdisciplinary teams, and community-based programs play important roles in chronic disease prevention and management. However, the organization and delivery of these services are primarily the responsibility of provinces and territories, resulting in variation in the implementation of team-based care models, service integration, and access to chronic disease management programs across jurisdictions. ³⁷¹

Mental Health Care for Older Danes

The Danish approach to mental health care is holistic, focusing on comprehensive health care services and social supports through local mental health initiatives, while also reducing stigma. Denmark has established numerous national anti-stigma campaigns to encourage inclusion and fight against mental health-related discrimination^{372,373}. The Danish Health Authority has also created a mental health promotion program to bolster local mental health initiatives, especially prevention efforts, which has been successfully implemented across the country.³⁷³ Denmark shares responsibility for mental health care across multiple levels of government. While municipalities play an important role in mental health promotion, prevention, and social support services, the Danish regions are primarily responsible for the provision of specialized mental health and psychiatric care³⁷⁴.

Denmark is using innovative technologies, such as apps and telepsychiatry, to continually improve the provision of mental health care and broaden the reach of mental health services, as well as improve the design of new psychiatric hospitals that reduce the potential for suicide attempts and incorporate healing architecture³⁷⁵.

In September 2022, the Danish government further committed to transforming the provision of Danish mental health care with a 10-year plan aiming to reform psychiatric care by focusing on prevention, early detection, and ensuring equal access to quality care, all of which will require multi-sector collaboration and public-private partnerships^{373,375}.

Canada has similar priorities, with national and provincial initiatives focused on reducing stigma, promoting mental health literacy, and expanding access to community-based and virtual mental health services. However, unlike Denmark's more centralized approach, the organization and delivery of mental health services in Canada vary across provinces and territories, resulting in differences in service availability and access.³⁷⁶

Dementia Care Supports and Services

Dementia is an increasingly important health concern for societies facing the paradigm of an ageing population³⁷⁷. According to the most recent data from the Danish Dementia Research Centre, there are approximately 100,000 Danes aged 65 years and older living with dementia. With the number of Danes living with dementia expected to increase significantly over the coming decades to over 145,000 people by 2040, Denmark has strived to become a leader in the provision of high-quality dementia treatment and care³⁷⁸.

Like Denmark, Canada is experiencing a growing prevalence of dementia as its population ages. Both countries have adopted national dementia strategies emphasizing early diagnosis, person-centred care, support for unpaid caregivers, and improved coordination across health and social care sectors. Canada's National Dementia Strategy, released in 2019, focuses on three broad objectives: preventing dementia, advancing therapies and finding a cure, and improving the quality of life of people living with dementia and their caregivers. The strategy promotes dementia-inclusive communities, earlier diagnosis, improved care coordination, workforce capacity building, and increased support for family caregivers³⁷⁹. Across Canada, specialized memory clinics, geriatric assessment services, community support programs, and caregiver resources are available to support people living with dementia; however, the implementation and delivery of dementia care services in Canada largely occur through provincial and territorial systems, resulting in greater variations in service models and access across jurisdictions.³⁷⁹⁻³⁸¹

Denmark strives to protect and ensure the dignity, safety, and quality of life of people with dementia and their families, as is demonstrated by its efforts to make Denmark an increasingly “dementia-friendly society”. Denmark has addressed this challenge through a coordinated, long-term policy approach that places person-centred care at the centre of dementia services. Under the National Action Plan on Dementia 2025, launched in 2017, Denmark adopted the principle that people living with dementia should be supported to maintain their independence, functional abilities, and quality of life for as long as possible, with services tailored to individual needs and preferences throughout the dementia journey. The strategy established three overarching national goals: to make all 98 municipalities dementia-friendly, ensure that 80% of people living with dementia receive a formal diagnosis, and reduce the use of antipsychotic medications among people living with dementia by 50% before 2025 ³⁸².

A central component of Denmark's dementia strategy was promoting early detection and timely diagnosis. To support this objective, Denmark strengthened and reorganized its network of specialist-led multidisciplinary memory clinics to provide more consistent and high-quality diagnostic assessments, promote faster diagnosis and treatment initiation, and improve access to specialist expertise across the country. The specialist memory-clinic network works closely with the Danish Dementia Research Centre, Denmark's national centre for dementia expertise, education, research, and quality development. Together, these specialized services have played a key role in strengthening diagnostic capacity, advancing best practices in dementia care, and supporting Denmark's progress toward its national goal that 80% of people living with dementia receive a formal diagnosis ^{382,383}.

Obtaining a formal diagnosis is particularly important in Denmark because it provides access to specialized dementia services, rehabilitation programmes, post-diagnostic support, and dementia-specific pharmacological treatments, including acetylcholinesterase inhibitors such as donepezil (Aricept). While the specialist memory-clinic model has contributed to high-quality and standardized diagnostic practices, it has also concentrated responsibility for dementia diagnosis and treatment initiation within specialist services. Evaluation of the National Dementia Action Plan suggests that specialist memory clinics have been particularly successful in achieving the national target that 80% of referred individuals receive a formal diagnosis, thereby improving access to evidence-based treatment and support services. However, because diagnostic confirmation and initiation of dementia-specific drug therapies have traditionally been centred within specialist settings, the model has also limited the ability of primary care practitioners to independently diagnose and initiate treatment for people living with dementia ^{382,384}.

Recognizing this challenge, Denmark is increasingly focused on strengthening the role of primary care within dementia care pathways. As primary care practitioners are often the first point of contact for individuals experiencing cognitive symptoms, expanding their role in dementia assessment, diagnosis, treatment, and ongoing management has the potential to improve diagnosis rates and reduce delays in access to care and support ³⁸⁵. These developments are expected to complement the existing specialist-clinic model while promoting earlier intervention and more accessible care closer to home.

Denmark's approach to dementia care extends beyond diagnosis and treatment and is characterized by strong coordination across health and long-term care sectors. Formal collaboration between hospitals, municipalities, and primary care providers is now better supported by integrated care pathways, digital health records, and the establishment of new municipal dementia coordinators who help organize post-diagnostic support, provide counselling and education, care coordination, facilitate access to community services, guidance and support of family caregivers, as well as training, education and capacity building for local care providers ³¹². Indeed, dementia coordinators are now established throughout Danish municipalities and have become a key component of local dementia care pathways. Although they play an important role in coordinating services, supporting families, advising care staff, and facilitating access to

community resources, there is currently no nationally standardized role description, competency framework, or formal training requirement governing the position. Recent national surveys have identified considerable variation in how dementia coordinator services are organized and delivered across municipalities, highlighting opportunities to further formalize the role and promote greater consistency in dementia care and support nationwide. In response, dementia coordinators have increasingly organized through national professional networks and associations that facilitate knowledge exchange, professional development, and the sharing of best practices across municipalities ^{386,387}.

The National Action Plan on Dementia also prioritized strengthening dementia knowledge, expertise, and skills among health care professionals to improve the quality and consistency of care. Initiatives such as free ABC Demens e-learning modules and practice-oriented training for staff providing home care and care in LTC homes were introduced to build workforce capacity ³⁸⁸. Denmark has further supported workforce development through the establishment of its National Knowledge Centre for Dementia (Nationalt Videnscenter for Demens), which provides nationwide continuing education, professional training programmes, implementation support, conferences, network meetings, and e-learning resources for dementia care professionals ^{389,390}.

Beyond improving diagnosis, care coordination, and workforce capacity, the National Dementia Action Plan also sought to strengthen collaboration across health and social care sectors, expand support for family caregivers, and promote the development of dementia-friendly hospitals, housing models, and communities. Together, these initiatives reflect Denmark's broader commitment to creating a dementia-friendly society that supports the dignity, independence, and wellbeing of people living with dementia throughout their dementia care journeys ³⁹¹.

[Pop-Up Fact] Denmark is often highlighted for its innovative initiatives referred to as “dementia villages”, a term that in practice covers different types of approaches to creating more dementia inclusive communities as well as specialized LTC care settings.

Some initiatives are community-based and aim to create local dementia-inclusive environments, focusing on awareness-raising, inclusion, and engagement within existing towns or villages. An example is the dementia-friendly community project in the Danish municipality of Varde, which seeks to support people living with dementia by strengthening local networks, improving public understanding around dementia, and enabling the participation of people living with dementia in everyday community life through collaborations between municipalities, civil society, and local residents ³⁹².

In contrast, other initiatives described as dementia villages refer to specialized LTC homes, designed specifically for people living with dementia. A prominent example is the Svendborg Dementia Village, a purpose-built LTC setting that combines private housing, integrated care services, and accessible public spaces such as shops and activity areas, all staffed by health care professionals and providers trained in dementia care. These residential dementia villages aim to provide a safe, dignified, and familiar everyday environment while reducing institutional features and maximizing independence within a controlled setting ^{393,394}.

[Pop-Up Fact] Svendborg Dementia Village is a unique example in Denmark, inspired by the Netherlands’ De Hogeweyk dementia village model. While its village-style features, such as shops and community spaces, are not typical of Danish care homes, the principles it reflects are

widely embedded in the provision of Danish long-term care settings: small-scale living environments, private apartments, access to nature, autonomy, relationship-centred care, rehabilitation, and strong connections to community life. Svendborg is therefore best understood as an exceptional application of broader Danish dementia care values, rather than a model commonly replicated nationwide.

The Retirement Income System for Older Danes

Denmark's national pension system allows older Danes to have multiple sources of retirement income. Eligibility to claim a state pension typically begins once an individual reaches the official pension age. The current state pension age in Denmark is 67, and it is scheduled to rise to 68 in 2030 and to 69 in 2035 ³⁹⁵.

A state pension in Denmark can be deferred for up to 10 years, divided into no more than two periods, to receive a higher monthly pension or a lump sum later. To delay one's pension, the individual must be actively employed or self-employed for at least 750 hours (roughly 14 hours per week on average) in a calendar year during the deferral period. ³⁹⁶

In addition, for an employee who earns a wage, their employer typically allocates a portion of their salary to a pension savings account. Individuals can also choose to establish their own personal pension scheme ³⁹⁷.

These three potential sources of retirement income represent the pillars of the Danish pension system, which complement each other:

1. Statutory pensions include state pensions (Folkepension), disability pensions, and ATP (Labour Market Supplementary Pension) that are funded by general taxation and primarily aim to protect older Danes who have reached retirement age from poverty. The amount an older Dane receives varies based on several factors, including age, marital status and employment history. A statutory pension consists of a basic amount, which in 2026 is DKK 7,544 per month before taxes (\$1,631 CAD), and a pension supplement, which depends on marital status. In 2026, single pensioners can receive DKK 8,729 per month (\$1,888 CAD), and married or cohabiting pensioners can receive DKK 4,467 each per month before taxes (\$966 CAD). A pensioner's economic situation also affects the amount received in the pension supplement ³⁹⁸.
2. Occupational or labour market pensions are primarily contribution-defined pension schemes, with contributions typically around 12% of gross wages. These pensions are embedded in employment contracts ³⁹⁷.
3. Individual or private pensions are voluntary pension schemes that provide individuals the opportunity to create additional savings vehicles and can be set up through a pension company or bank.

All three types of pensions contribute to securing an individual and their family's standard of living as best as possible upon their exit from the workforce ³⁹⁸. According to the OECD,

Denmark's pension system provides a relatively high level of income security in retirement, with a net pension replacement rate ⁵ of approximately 77.1% of pre-retirement earnings for average earners (100% of average wage) ³⁹⁹.

Canada's retirement income system is similarly described as having three pillars. The first pillar provides benefits based on age and years of residence in Canada and includes the Old Age Security (OAS) pension, the Guaranteed Income Supplement (GIS), the Allowance, and the Age Credit. The second pillar consists of mandatory earnings-related programs, namely the Canada Pension Plan (CPP) and Quebec Pension Plan (QPP). The third pillar includes workplace registered pension plans (RPPs) and private savings vehicles such as Registered Retirement Savings Plans (RRSPs) and Tax-Free Savings Accounts (TFSPs). Eligibility to claim a public pension typically begins once an individual reaches the eligible pension age. The current public pension age in Canada is 65 ⁴⁰⁰. You can also defer claiming your pension. Similar to the Canada and Quebec Pension Plans, the longer one waits to receive their pension, the larger the sum it will be ⁴⁰¹. Further, Canada's mandatory public pension system (CPP/QPP + OAS) provides a net pension replacement rate of 45.1% of pre-retirement net earnings for an average earner (100% of average wage) ³⁹⁹.

Comparing Danish and Canadian Approaches to Caring for their Ageing Populations

Supports available to older Danes can be broadly grouped into three pillars: health care, long-term care, and retirement income supports. Similar programs also exist to support older Canadians. However, these Canadian and Danish support mechanisms share similarities and differences, some of which are highlighted in Table 8.

Denmark has a similarly decentralized approach to the governance of its health care system compared to Canada, where each province and territory has its own distinct health and long-term care systems. However, Denmark's decentralized approach has been coupled with strong national steering mechanisms—including binding legislation, national quality standards, financial equalization schemes, and shared digital infrastructure—which help limit regional and municipal variation in access and service quality. The OECD's 2023 assessment of health data maturity ranked Denmark first among member countries, noting that it “scored highest in seven of the eight measures”, with data extracted from electronic records for all key national datasets, coded to clinical standards, covering more than 80% of the population and linkable through a unique patient identifier; Denmark is also one of only five OECD countries whose patient portal gives the entire population access to their comprehensive health data, whereas Canada was classed as only offering portal access to only some records ¹¹⁸.

Denmark and Canada also both have single-payer health care systems. Furthermore, the retirement income systems in both Denmark and Canada are designed to give older persons

⁵ According to OECD, the net pension replacement rate is defined as the individual net pension entitlement divided by net pre-retirement earnings, taking into account personal income taxes and social security contributions paid by workers and pensioners. It measures how effectively a pension system provides a retirement income to replace earnings, the main source of income before retirement.

multiple sources of retirement income. Although the structure of retirement income systems differs between the two countries, both systems provide older adults with broad access to multiple forms of public support. This shared emphasis on income security helps older adults maintain financial security and reduces barriers to accessing health and LTC services.

While Canada spends a larger share of its GDP on health care, it allocates a smaller share of its GDP to long-term care than Denmark. In addition, Canada places greater emphasis on institutional care in LTC homes and hospitals, whereas Denmark focuses more on home and community-based care services.³¹¹ Denmark's higher level of public LTC investments has further allowed for earlier proactive interventions, a greater emphasis on prevention and reablement, and reduced reliance on hospitals and unpaid family caregiving—features that shape overall care experiences, system-level efficiencies, sustainability and economic productivity.

Although Denmark's current model of care has room for improvement, it does have several strengths that Canada should take note of, specifically its focus on prevention, rehabilitation, and reablement programs for older citizens, its greater investments in home and community-based services, its formal recognition of municipalities as the primary coordinators of long-term care services, its systematic integration of digital health infrastructure across sectors, and its comparatively lower reliance on unpaid caregiving.

Together, these features support healthy ageing and ageing in the right place, reduce caregiver burden and fragmentation of care, and contribute to a higher quality of life for both care recipients and caregivers.

Table 8. Comparing Canada and Denmark's Support Systems for Older Adults

Category	Indicator	Country	
		Canada	Denmark
Long-Term Care	Governance and Funding	Provincial & Territorial Governments	Municipalities (with additional financial support from the national government)
	System Type	Universal public coverage; Some private services	Universal public coverage; Some private services
	Overall Spending on LTC (% GDP) (2023) ²³³	2.4	3.2
	- Spending on LTC Homes	66%	61%
	- Spending on Home Care Services	19%	35%

	- Spending on LTC in Hospital-Based Care (e.g., ALC)	13%	1%
	LTC Home Residents	5%	Nearly 3%
	Home Care Service Recipients*	10% ^{402,403}	11.5% ¹²⁹
	Older population 65+ living at home	93.9% ¹²	95% ¹⁰
	Older population 85+ living at home	72% ¹¹	83% ¹⁰
Health Care	Governance	Provincial & Territorial Governments	Regions and municipalities
	Overall Spending on Health Care Expenditures (% GDP) (2023) ¹⁴⁰	11.3%	9.4%
	System Type	Universal public coverage (Medicare)	Universal public coverage
	PCP Attachment	Nearly 83% ³⁰⁰	More than 98% ²⁹⁷
	Primary Care Registration Model	Individuals are generally responsible for finding a PCP	Residents are automatically assigned a PCP and may change providers through a national registration system.
	After-Hour Primary Care	Varies across provinces and territories.	Nationwide <i>lægevagten</i> system with nurse/physician triage and home visits.
Specialized Care	Nursing Workforce	Registered Nurses (RNs), Licensed/Registered Practical Nurses (LPNs/RPNs), Nurse Practitioners (NPs), and Personal Support Workers (PSWs).	Registered nurses supported by Social and Health Assistants (SOSU Assistants) and Social and Health Helpers (SOSU Helpers) within municipal care services.
	Number of Geriatricians	460 (in 2025) ³¹⁵	181 (in 2024) ³¹³
	Older Adults per Geriatrician	~17,600:1 ³¹⁸	~6,600:1 ³¹³

Healthy Ageing Supports & Services	Dental Care	Coverage varies across provinces and territories. Most routine services rely on private insurance, out-of-pocket payments, or federal programs for eligible older adults.	Nationally regulated reimbursement system with co-payments. Publicly funded outreach dental services available for frail and dependent older adults, including LTC residents.
	Vision Care	Routine eye care coverage varies by province and territory; many older adults rely on private insurance or out-of-pocket payments.	Medically necessary ophthalmology services publicly covered; glasses and contact lenses generally require co-payment or private insurance.
	Hearing Care	Provincial and territorial assistive-device programs provide hearing aid coverage, with varying eligibility criteria.	Public hearing assessments and subsidized hearing aids available through ENT specialists and public hearing clinics.
	Chronic Disease Management	Delivered through primary care providers, interdisciplinary teams, and community programs; approaches vary across provinces and territories.	Integrated chronic disease management emphasizing prevention, digital health solutions, multidisciplinary care, and coordinated chronic care packages.
Immunization Programs	Immunization Plan	National recommendations with publicly funded programs administered by provinces and territories. Coverage and eligibility vary by jurisdiction.	Nationally coordinated immunization programs with free vaccines for older adults and comprehensive digital vaccination tracking.
	Influenza Vaccination Rate (2023-2024)	73%	78%

	COVID-19 Booster Vaccination Rate (2024-2025)	54%	75%
	Pneumococcal Vaccination Rate	54.7% (2023)	75% (April 2020 until January 2023)
	RSV Vaccination Rate	15.8% (April 2024)	5.9% for adults 60+ (2024-2025)
	Shingles Vaccination Rate	38.8% for adults 50+ (2023)	No official coverage estimates are available
Dementia Care	Dementia Care Supports	National strategy implemented through provincial and territorial systems, resulting in variation in services and access.	National Action Plan on Dementia with nationally defined goals and coordinated implementation.
	Diagnostic and Care Supports	Specialized dementia services and memory clinics available, with access varying across jurisdictions.	National network of multidisciplinary memory clinics, dementia coordinators in all municipalities, and standardized post-diagnostic supports.
	Dementia-Friendly Communities	Initiatives vary across provinces, territories, and municipalities.	National objective to create a dementia-friendly society, including dementia-friendly municipalities and specialized dementia villages.
Retirement Income	Main Income Streams	1. Age- and residence-based benefits (OAS, GIS, Allowance, Age Credit) 2. Mandatory earnings-related pensions (CPP/QPP) 3. Workplace pension plans and private retirement savings (RPPs, RRSPs, TFSA's)	1. Statutory pensions 2. Labour market pensions 3. Individual pensions
	Government Pension Plans	CPP/QPP, OAS, GIS	State Pension (<i>Folkepension</i>)

	Pension Uptake	Nearly 99% of the population aged 65+ years received the CPP/QPP and OAS (in 2025) ⁴⁰⁴	Nearly 98% received the state pension (in 2025) ⁴⁰⁵
	Net Pension Replacement Rate (for average earners)	45.1% ³⁹⁹	77.1% ³⁹⁹

PCP: Primary Care Providers; CPP: Canada Pension Plan; QPP: Quebec Pension Plan; OAS: Old Age Security; GIS: Guaranteed Income Supplement; RPPs: Registered Pension Plans; RRSPs: Registered Retirement Savings Plans; TFSA: Tax-Free Savings Accounts; RSV: Respiratory Syncytial Virus

* Canada (65+), Denmark (67+)

Specific Challenges Unique to Canada in Caring for Its Ageing Population

Canada's much greater cultural and linguistic diversity than Denmark's makes it significantly more difficult to design and deliver equitable, culturally appropriate programs and services, especially with respect to its Indigenous populations. LTC homes, home care services, and other community supports must routinely accommodate individuals who speak different languages, hold distinct cultural norms, and have varied expectations of care, which creates barriers to communication, service navigation, and culturally safe and appropriate care provision—challenges documented in national reports showing that diversity within Canada's care system is rapidly increasing and creating pressure on providers to adapt to residents' cultural identities and practices. These barriers also extend to caregivers, particularly those from racialized and immigrant communities, who face language obstacles, medical mistrust, and limited awareness of available programs, all of which complicate access to support and contribute to inequities in the caregiving experience. By comparison, Denmark's smaller, more homogeneous population and nationally standardized care frameworks have reduced—though not eliminated—the complexity of delivering culturally appropriate care services.

^{406–411}

Canada's sheer geographic scale and dispersed population create further challenges in supporting older adults and their caregivers. Delivering consistent health and LTC services across vast rural, remote, and northern regions is inherently difficult. Long travel distances, workforce shortages, and limited service infrastructure impede equitable access, making it far harder for older adults to age in place ⁴¹². While the demand for care is growing at the same time the availability of care providers is shrinking, many older adults, especially those outside major urban centres, already struggle to find and sustain needed supports ⁴¹³. These geographic inequities also complicate the ability to coordinate care in the community and following a hospitalization—areas where Denmark's compact geography and dense service network provide structural advantages.

These access challenges are compounded by the absence of a comprehensive, coordinated national health workforce strategy in Canada. Health workforce planning in Canada remains

fragmented across federal, provincial, and territorial jurisdictions, limiting Canada's overall ability to systematically anticipate and respond to the growing care needs associated with population ageing. Current workforce planning is constrained by fragmented data systems, inconsistent standards, and limited coordination across jurisdictions ⁴¹⁴. As a result, Canada is experiencing widespread shortages of health and care workers, particularly in LTC home and home care settings, including physicians, nurses and personal support workers ^{415,416}.

Furthermore, Canada lacks a national licensure system for any type of health care professional, so doctors, nurses and other health and social care professionals cannot easily work beyond the province or territory where they are based, especially on short notice ^{417,418}. This lack of flexibility has made it harder to address care gaps nationwide. In contrast, Denmark's LTC system benefits from clearer municipal roles and responsibility for service provision, nationally supported training initiatives (e.g., dementia-specific education), the growing use of digital tools designed to reduce workload pressures, as well as wage increases as incentives ^{267,268}—although workforce shortages remain a challenge there as well.

Available national workforce data have highlighted how these capacity constraints are intensifying as the population ages. Although some segments of Canada's health care workforce have seen modest growth, the overall supply of health care professionals and providers has not kept pace with rising demand for their skills—especially among older adults with complex and chronic conditions. In 2024, 5.7 million Canadian adults lacked access to a regular health care provider, constraining access to the ongoing primary and preventative care essential for healthy ageing. Meeting current demands would require an estimated 49% increase in PCPs; however, the per capita supply has declined over the past five years, from 11.8 to 11.5 per 10,000 population, alongside reductions in their overall direct care capacity ⁴¹⁵. This contrasts with Denmark's near-universal PCP attachment rate, which supports earlier detection, chronic disease management, and continuity of care across settings.

Canada's digital health infrastructure remains fragmented in ways that Denmark resolved a decade or more ago. There is no national patient identifier and no national strategy binding provinces and territories to common health data standards ⁴¹⁹. Indeed, a 2026 environmental scan of all thirteen Canadian health care jurisdictions found that nearly all lacked interoperability between hospitals, primary and specialist care providers, with information exchange “heavily dependent on fax or mailed letters in every jurisdiction” ⁴²⁰. Only 13% of Canadian adults can electronically access all three core components of their record (test results, immunizations and medications), while 31% have no electronic access at all. Digital availability depends heavily on where you live. Saskatchewan leads the country with 38% of residents having complete access, whereas Quebec lags behind at roughly 8%; only 29% of Canadian primary care providers share patient information electronically outside their practice ^{421–423}.

In response to this current and unacceptable paradigm, the federal government first introduced its Connected Care for Canadians Act, in June 2024 (Bill C-72) to require vendor interoperability through the use of common standards so different digital health platforms can exchange information smoothly, prohibit data blocking by stopping companies from blocking, delaying, or charging high fees to prevent the sharing or moving of electronic health records, empower patients by allowing people to safely and easily see their own complete health information no matter where they live; and improve patient safety by reducing the need to repeat the provision of medical histories, delayed testing, and medical errors caused by fragmented and disconnected health care systems. Unfortunately, this Act died on the Order Paper when Parliament prorogued in March 2025. The Act, however, was reintroduced in the Senate as Bill S-5 in February 2026 and was passed by the Senate in May 2026 and is now awaiting second reading in the House of Commons at the time of writing ^{424,425}.

At the same time, several care professionals critical to caring for older Canadians—particularly nursing professionals—have faced persistent workforce challenges, including high workloads, workplace violence, job dissatisfaction, compensation concerns, and limited opportunities for retention and career advancement. These factors have contributed to difficulties in recruiting and retaining care providers, with many providers reducing their involvement in direct care or leaving frontline practice earlier in their careers ^{416,426,427}.

Together, these trends indicate that Canada's health care workforce is neither sufficiently growing nor remaining in direct care roles at the pace required to support an ageing population, contributing to persistent access challenges and increasing pressure on Canada's health and LTC systems as well as caregivers ⁴¹⁵.

Finally, Canada is also dealing with a rapidly expanding caregiver crisis. The National Seniors Council notes that demand for care is increasing, caregivers themselves are ageing, the pool of available caregivers is shrinking, and care needs are becoming more complex due to population ageing, disability, and mental health challenges. Furthermore, nearly one in five (20%) caregivers of older adults are themselves aged 65 or older ⁴¹³. Many older caregivers must provide care while managing their own chronic health conditions, financial strain, and social isolation. Research suggests that caregivers face significant barriers to providing care, including inadequate supports, financial pressures, and adverse impacts on their physical and mental wellbeing. These challenges may be particularly pronounced among equity-deserving groups, including racialized, Indigenous, and LGBTQ2S+ caregivers, who often experience greater caregiving-related hardships ^{413,428}. Denmark's more extensive publicly funded LTC system has reduced its reliance on unpaid caregiving and buffers families from assuming primary responsibility for complex care needs—representing a major structural difference between the two countries' approaches to the provision of long-term care services ²⁷⁶.

The Future of Caring for an Ageing Denmark

The range of supports that are available to older Danes today has evolved in a gradual but increasingly comprehensive fashion over the past century. In principle, the Danish model of care has been designed to facilitate equitable access to most services that are necessary for older adults to maintain a high quality of life as they age and to live as long as possible in their own homes. This long-term development has been supported by a clear governance approach: municipalities are responsible for delivering care, but they do so within national laws, rules, and shared digital systems that help guide and coordinate services across the country. In practice, while the Danish long-term care system lacks standardization across municipalities and more comprehensive supports for unpaid caregivers, its overall system of providing care for its older citizens still appears to be much more comprehensive and effective than Canada's less well-resourced, comprehensive, and preventative approach ^{127,429}.

Notwithstanding the successes of the Danish health and LTC systems, challenges remain, the most pressing of which are the increasing complexity of care needs of older adults, especially due to the higher incidence of chronic disease among members of this population, and the demand for qualified care providers during a time of care provider burnout and the associated retention problems that come with that ⁴³⁰. These challenges are most visible in LTC homes, where more residents now live with advanced dementia and require higher levels of medical and

personal support, placing greater demands on care provider skills, coordination, and continuity of care.

In response to the challenges that the Danish health care system is facing, Denmark's Resilience Commission recently developed 20 recommendations, targeting prioritization, workforce capacity, professional competencies, flexibility, and digitalization ⁴³¹. These recommendations were organized into three broad areas: (1) stronger prioritizing and wiser task solutions (Recommendations 1–8), (2) attractive workplaces and time for the core tasks (Recommendations 9–15), and (3) right competencies and professional flexibility (Recommendations 16–20) ⁴³¹. See Box # for more information.

Box #. Key Recommendations of Denmark's Resilience Commission (2023)

STRONGER PRIORITIZING AND WISER TASK SOLUTION

- Recommendation 1: National Priority Council should free up resources for the core task.
- Recommendation 2: Improper treatment to be reduced through stronger prioritizing rooted in professional expertise
- Recommendation 3: Prioritizing should be strengthened through common decision-making, differentiated offers and increased self-care
- Recommendation 4: Improper documentation must be reduced
- Recommendation 5: Competences should be used across geography and sectors.
- Recommendation 6: Introduce a common principle of "digital and technological first".
- Recommendation 7: Ensure a better framework for the rapid deployment of proven, labour-saving technologies
- Recommendation 8: Digital competences and technological understanding must be strengthened

ATTRACTIVE WORKPLACES AND TIME FOR THE CORE TASK

- Recommendation 9: Management must be prioritized, and management quality must be strengthened
- Recommendation 10: Get more to work more hours
- Recommendation 11: Out of hours work must be thinned out and distributed among more persons
- Recommendation 12: Jobs and career paths should be rooted in patient- and citizen-centred work
- Recommendation 13: Realize the potential arising from late retirement
- Recommendation 14: Competences from abroad must be utilized more efficiently through strengthened attachment
- Recommendation 15: More and better introductions for new graduates

RIGHT COMPETENCES AND PROFESSIONAL FLEXIBILITY

- Recommendation 16: Ensure increased coherence and more flexibility across healthcare training programmes
- Recommendation 17: Reform retraining and further training to target career paths towards practice
- Recommendation 18: Remove professional silos; more should contribute
- Recommendation 19: The connection between training and job must be strengthened to avoid a practice and responsibility shock

- Recommendation 20: Ensure more strategic and long-term management of the offer of healthcare training programmes

The Commission's focus on digital solutions reflects Denmark's wider efforts to improve care quality and accountability by helping health professionals share information more easily, reduce duplication, and clarify who is responsible for a citizen's care. Recommendations 6–8 emphasize long-term investment in digital tools that help reduce paperwork and free up staff time for direct care, while also ensuring that digital skills are taught in basic health and care training programmes.⁴³¹

Another commission, the Danish Health Care Structure Commission, highlighted the need for stronger collaboration across sectors and municipalities, clearer national quality standards, and more organized use of innovative technologies and digital solutions⁴³². These recommendations show a growing understanding that future improvements in care depend not only on adding services, but also on strengthening oversight, reducing differences between municipalities, and tracking overall system performance.

Denmark is also currently reorganizing the institutions behind its digital infrastructure. As noted earlier, the 2024 Health Care Reform agreement creates Digital Sundhed Danmark, which from 2027 merges the national health portal, the standards body MedCom and the Danish Health Data Authority into one organization owned by the state, regions and municipalities, with authority to set binding national architecture and DKK 2 billion (\$429,986,000 CAD) for 2026–2035^{433,434}. Even the country most often cited as a digital health leader has concluded that three separate national organizations were one too many—a pointed lesson for Canada, where responsibility for digital health is spread across Canada Health Infoway⁶, the Canadian Institute for Health Information⁷, Health Canada, and its thirteen provincial and territorial health care systems.

In summary, while Denmark has made significant progress, it continues to refine its legal framework governing care provision. Historically, the Social Services Act (Serviceloven), adopted in 1998, regulated social services—including LTC services—while the Health Act (Sundhedsloven), adopted in 2005, regulated health care services separately. This separation contributed to unclear responsibilities and duplicated documentation, particularly at transition points between hospital-based care, primary and specialist care, and municipal long-term care and rehabilitation services. To address these problems, Denmark introduced its 2024 Elderly Act (Ældreloven), which establishes long-term care for older adults as a distinct legal area¹³⁴. Indeed, rather than merging existing legislation, this reform establishes the provision of long-term care services as a distinct legal domain, replacing parts of the 1998 Social Services Act (Serviceloven) for older adults, while the 2005 Health Act (Sundhedsloven) continues to regulate the provision of health care services. The 2024 Elderly Act, which entered into force in 2025, promotes dignity, freedom of choice, and independence among older Danes by giving older adults greater influence over decisions regarding their care and support, while prioritizing care approaches that encourage autonomy and active participation in daily life. The Act also reduces administrative burdens on care providers, thereby allowing them to have more time to provide direct care^{296,435}.

Denmark's approach to ageing also includes a broader dementia strategy that extends beyond service delivery. Building on the National Action Plan on Dementia 2025, launched in 2017, priorities included earlier diagnosis through memory clinics, mandatory dementia-specific

⁶ Canada Health Infoway is an independent, federally funded, not-for-profit organization created in 2000 to accelerate the adoption of digital health solutions across Canada

⁷ The Canadian Institute for Health Information (CIHI) is an independent, non-profit organization that collects and analyzes data on Canada's health care systems and the health of Canadians

training for care providers, municipal dementia coordinators to support families, and the continued development of dementia-friendly communities and care environments. These efforts aim to protect autonomy, inclusion, and quality of life for people living with dementia.

Despite these reforms, challenges remain. Denmark's health and long-term care systems are highly decentralized, and municipalities retain considerable responsibility for determining how services are organized and delivered within the framework of national legislation. As a result, access to services, eligibility criteria, and levels of service provision may vary between municipalities, potentially leading to geographic differences in the experiences of care recipients⁴¹. In addition, like many European countries, Denmark faces ongoing pressures related to population ageing, workforce shortages, and increasing demand for health and long-term care services, which continue to pose challenges for ensuring equitable access to care across the country¹⁰.

Denmark's digital-first model also carries an ageing-related cost that Canadian planners should note. In 2025, about 270,000 citizens (5%)^{436,437} were exempted from being required to use Digital Post, while 3.4% of adults (about 170,000) had no active MitID^{438,439}, with the membership of both these groups being predominantly concentrated among people aged 69 years and over. Indeed, the DaneAge Association (Ældre Sagen) (See Box 1) counts some 209,000 people aged 65 years and over exempted from Digital Post and 116,000 people aged 65 years and over without a digital identity^{440,441}. Among internet users aged 85–89 years, 36% said they needed help with public digital self-service tasks, while approximately 40% of internet users aged 75–89 years reported being unable to install an app⁴⁴². In response, the government, KL and Danish regions adopted six joint principles for digital inclusion in 2024 (“design solutions for everyone”, “help those who help”, “provide usable alternatives”), expanded the digital power of attorney (digital fuldmagt) so that relatives can act on an older person's behalf (about 250,000 citizens have granted a helper read access to their Digital Post), and made digital inclusion the first focus area of the 2026–2029 national digitalization strategy^{442,443}. DaneAge's three demands remain the benchmark: there must always be a non-digital alternative, a person to talk to, and a right to exemption that applies across all public authorities⁴⁴¹.

Box 1: About the DaneAge Association (Ældre Sagen)⁴⁴⁴

DaneAge is a large, non-profit national organization headquartered in Copenhagen, Denmark that protects and advocates for the interests of older citizens. Founded in 1986, it has over 1.1 million adult members, including more than 21,000 volunteers and 215 local chapters across Denmark that provide local activities, information, counselling, friendly visiting services and other forms of support to older persons through community volunteers and local advocacy on behalf of older citizens.

As a non-partisan, neutral group independent of political parties, religion, or ethnic origins, it works with governments and the public across Denmark to promote a society without age barriers and ageism. Its current five main areas of advocacy are focused on enabling:

- A labour market appreciating and utilizing the skills and resources of mature persons
 - Flexible homes and multi-generational local communities
 - Adequate pension incomes for retired persons
 - A health care system without age discrimination
 - Sufficient and high-quality home care for citizens in need of this
-

Another major challenge to the sustainability of the long-term care system in Denmark and other countries is the difficulty in recruiting doctors and care workers to work in LTC homes and across LTC services, which is a particular problem in certain areas where shortages of physicians and care providers also threaten access to medical care and place additional pressure on hospitals⁴⁴⁵. Denmark is increasingly treating workforce planning as central to its overall system sustainability, combining expanded training (including geriatrics and dementia competencies), fixed care teams to improve continuity, and digital tools to reduce physical and administrative workload. Nonetheless, recruitment and retention issues still remain.

Furthermore, fewer Danes have received home care services in recent years, and unmet needs increasingly fall on unpaid caregivers, further increasing their burden²³⁷. Although Denmark relies less on unpaid care from family members and friends than in many other countries, caregiver burden has become a growing policy concern. This is why Carers Denmark has been advocating for increased access to 24-hour respite care to support unpaid caregivers. This increased support would not only be beneficial to caregivers, but it would also be beneficial to the Danish government as well, as supporting caregivers to provide care reduces the need for institutional care and its associated expenditures²⁷⁵.

Over the coming years, Canada will have the opportunity to observe how Denmark continues to respond to challenges both countries are facing—standardization and equity, quality assurance, dementia-responsive care, budget constraints, workforce sustainability and caregiver support. Both countries, and others around the world, are facing the need to bolster their care and support systems for their ageing populations, and Denmark's experience suggests that doing so requires adequate funding, appropriate prioritization of funds, clear governance structures, strong accountability mechanisms, effective use of digital systems, and a long-term vision for coordinating care across sectors.

A Proposed Strategic Roadmap for Strengthening Canada's Health, Long-Term Care and Housing Systems to Support its Ageing Population

Building on Denmark's strong foundation in universal access, municipal responsibility, home and community-based care as well as preventative and rehabilitative-focused care, and informed by the NIA's 2022 report [*Ageing in the Right Place: Supporting Older Canadians to Live Where They Want*](#) and 2023 report, [*Enabling a More Promising Future for Long-Term Care in Canada*](#), the following roadmap outlines strategies to strengthen the long-term sustainability, quality, and equity of Canada's health, long-term care and housing systems in the context of population ageing. It brings together key themes identified in both this and the previously mentioned NIA reports, including ageing in the right place, integrated care, workforce sustainability, caregiver support, housing, and system accountability. Together, these proposed strategies seek to support healthy ageing, strengthen the capacity and sustainability of health, long-term care and housing systems, and improve outcomes for older adults and their caregivers.

Changing the System: Strengthening Community-Based and Integrated Care

Make Home-Based and Community Care the First Option

Canada should continue shifting the provision of care, whenever appropriate, away from institutional settings and towards integrated home and community-based care models that support older adults to age in the right place. Therefore, Canada's health and long-term care systems should consider implementing the following elements of Denmark's approach by:

- Prioritizing policies and investments that enable older adults to remain safely and independently in their homes for as long as possible.
- Expanding access to home care, community supports, adult day programs, and supportive housing services.
- Improving coordination between hospitals, primary care providers, home care and long-term care services to ensure smoother transitions between care settings.
- Clearly defining responsibilities across the care system to reduce care gaps and confusion.

Expand Access to Affordable and Accessible Housing Options for Older Adults

Canada should strengthen the availability of affordable, accessible, and age-friendly housing options that enable older adults to age in the right place and remain active and connected members within their communities for as long as possible. Therefore, Canada's jurisdictions should consider implementing the following elements of Denmark's approach by:

- Increasing the supply of affordable and accessible housing designed to meet the changing needs of older adults.
- Supporting a wider range of housing choices, such as age-friendly housing, supportive housing, co-housing, home sharing and other community-based living options that help people stay healthy, independent and connected to others.
- Encouraging housing designs that are accessible, easy-to-use and can be adapted as people's mobility or functional and care needs change over time.
- Expanding programs that help older adults modify or upgrade their homes to support safe and independent living.
- Improving coordination between housing, health care, home care and community services providers so older adults can safely remain in their own homes and communities as long as possible.
- Treating affordable and accessible housing as a key public service and strengthening government involvement in planning, funding and developing age-friendly housing similar to its role in developing LTC housing options.

Prioritize Reablement and Everyday Independence

Canada should place greater emphasis on helping older adults maintain and regain their functional independence. Therefore, Canada's health and long-term care systems should consider implementing the following elements of Denmark's approach by:

- Focusing care and support services on helping older adults regain skills, maintain their independence, and delay the need for more institutional forms of long-term care.
- Focusing on prevention and early support to delay the need for more intensive care.
- Making reablement a key starting point for people receiving home care services.
- Expanding access to rehabilitation and support services that help people stay active and independent in their own homes and communities for as long as possible.
- Focusing on prevention and early support to delay the need for more intensive care.

Ensure Dementia-Responsive Care is Provided Across the Care Continuum

Canada should ensure the provision of dementia care becomes a core component of both its health and long-term care services and planning as the number of Canadians living with dementia is expected to double over the coming decades. Therefore, Canada's health and long-term care systems should consider implementing the following elements of Denmark's approach by:

- Improving access to early assessment and diagnosis.
- Expanding access to post-diagnosis supports and dementia services.
- Improving care coordination for people living with dementia and their families.
- Improving supports for family caregivers of people living with dementia.
- Providing dementia-specific training for staff across health and long-term care settings.
- Promoting the creation of dementia-friendly communities and care settings that support dignity and quality of life.

Supporting the Workforce: Caring for the Care Providers

Build a Strong and Skilled Care Workforce

Canada should build and maintain a workforce that is adequately trained, supported, and recognized in ways that enable its ability to meet the needs of its ageing population. Canada's health and long-term care systems should consider implementing the following elements of Denmark's approach by:

- Strengthening recruitment efforts to properly meet growing workforce needs.
- Improving training in areas such as geriatrics, dementia care, rehabilitation and team-based care.
- Reducing administrative burden, such as redundant paperwork, through simplified documentation and better use of shared digital tools, so staff can focus on providing direct care.
- Involving the professions and their technology vendors in co-designing and even owning the digital tools they are expected to use.

Improve Working Conditions and Care Provider Retention

Canada should invest in the health, safety, and wellbeing, and overall working conditions of its care providers to enable it to meet the care needs of its ageing population. Canada's health and long-term care systems should consider implementing the following elements of Denmark's approach by:

- Reducing workload pressures through better staffing, flexible scheduling, appropriate pay and supportive workplaces.
- Creating opportunities for career growth and professional development.
- Using digital tools to reduce physical strain and administrative tasks without compromising care quality or substituting for less care or less qualified care

- Monitoring staffing shortages and turnover, particularly in rural and long-term care settings.

Building a Strong Foundation: Governance, Accountability, and Sustainability

Ensure Role Clarity and Accountability

Canada should improve care system performance, strengthen accountability mechanisms, and clarify roles across all sectors involved in providing care and support for its ageing population. Canada's health and long-term care systems should consider implementing the following elements of Denmark's approach by:

- Clarifying roles and responsibilities across sectors to reduce fragmentation and duplication, particularly during care transitions.
- Strengthening inspections and follow-up so problems are identified and addressed quickly.

Ensure Equity and Consistency in Care Quality

Canada should provide equitable access to safe and high-quality care regardless of where anyone lives. Canada's health and long-term care systems should consider implementing the following elements of Denmark's approach by:

- Strengthening and upholding national standards for home and community care and long-term care homes.
- Improving transparency so people understand what services and standards of care and support they can expect.

Enhancing Excellence Through Data; Digitalization and System Learning

Canada should support the development of digital infrastructure that lets information follow the older person throughout the care system to better enable their care, not through the development of a single national system, but rather through a set of mutually reinforcing mechanisms that suit its federal systems of governance of care provision. Canada's jurisdictions and care systems should consider implementing the following elements of Denmark's approach by:

- Legislating a statutory basis for sharing information for treatment, for the development of national registers such as medication and vaccination records, and for mandating common care standards on public and private providers alike, as Denmark did through its Health Act and as the proposed Connected Care for Canadians Act begins to do.
- Putting care standards before care systems by establishing a permanent, jointly owned standards and certification body, like Denmark's MedCom organization, so that any information technology vendor's system can be certified to exchange information and no jurisdiction becomes dependent on a single supplier, and IT services can be re-tendered and moved between suppliers without disrupting care.

- Building incrementally in the development of shared national services starting, as Denmark did, with the highest-value use cases (a shared medication record, a vaccination register, standardized discharge and referral messages) and a single lifelong identifier and digital identity.
- Linking financing to deadlines by writing digital milestones and shared funding into federal/provincial/territorial agreements with dates, as Denmark does in its annual economic agreements.
- Extending the same care standards throughout the provision of long-term care services by adopting a common national documentation standard for both assessments and the delivery of services that feeds a national register, as Canada could do by completing and linking the implementation of interRAI assessment systems across all of Canada's provinces and territories ⁴³⁸.
- Designing health information systems to promote trust and inclusion by giving Canadians transparency over who has viewed their record, the right to block access, a non-digital alternative and a right to exemption, and a digital power of attorney for relatives, so that a digital-first system does not exclude the oldest adults it most needs to serve.
- Linking health with income, housing and social data where it serves the citizen the way Denmark uses one identifier, shared basic registers and a national income register to calculate pensions and housing benefits automatically and to show citizens all their cases and payments in one place, removing the administrative burden that older adults, their care providers and caregivers would otherwise carry.
- Expanding interoperability, shared information systems and digital records that allow care providers to access timely, accurate information and reduce administrative work to better support the provision of care.
- Including digital skills training in health and workforce entry to practice and continuing education programs.
- Ensuring digital solutions are accessible in rural, remote, and underserved communities by eliminating connectivity barriers, and ensuring training and support is available for older care recipients and their caregivers.

Use Data to Monitor Outcomes and Improve System Performance

Canada should support strengthening the overall quality and use of its health data to better monitor outcomes and improve care quality, accountability and overall system performance. Canada's jurisdictions and care systems should consider implementing the following elements of Denmark's approach by:

- Collecting and using data consistently across regions to track quality and outcomes.
- Using evidence to identify gaps, improve care and guide funding decisions.
- Developing and enforcing data standards across public and private as well as between provinces and health systems, particularly for staffing
- Standardizing how care assessments, services and user satisfaction are documented and feeding that data into secure national registers that create comparable data on who receives care services and how they experience them.

Supporting Caregivers and Families as Care Partners

Canada should support and recognize unpaid caregivers as essential care partners given the critical role they play in supporting the overall health and wellbeing of older persons. Canada's jurisdictions and care systems should consider implementing the following elements of Denmark's approach by:

- Acknowledging unpaid caregivers as essential members of care systems.
- Including the needs of caregivers in care planning decisions, especially for the provision of dementia care.
- Expanding access to training, practical supports and respite care to better enable caregivers and prevent caregiver burnout.
- Giving caregivers formal, secure digital access to act on behalf of the person they care for, so that caregiving does not require sharing passwords or excluding the older person from the provision of digital services.

Conclusion

Denmark's experience demonstrates that building a high-performing health and long-term care system for an ageing population depends on a clear vision supported by strong governance, consistent investment, and continuous system learning. Its emphasis on prevention, municipal leadership, integrated care pathways, and digital innovation provides a solid foundation for delivering more coordinated and person-centred care.

At the same time, Denmark's ongoing reforms make clear that even well-developed systems must continuously adapt to changing demographic pressures, workforce constraints, and increasing care complexity. Addressing these challenges will require further efforts to improve equity across municipalities, enhance workforce capacity, support unpaid caregivers, and establish consistent quality standards nationwide.

The lessons Canada can learn from Denmark are significant and target key areas for strategic improvement to better enable healthy ageing and ageing in the right place. Care can be increasingly community-based, with investments in people and skills, clear care responsibilities and accountabilities, and data and digital systems used strategically to improve outcomes for all older adults. On digitalization in particular, Denmark's lesson is less about technology and more about its methods: thirty years of developing common standards, shared national services built one use case at a time, decisions and funding committed jointly by all levels of government, and a legal framework that makes information flow to provide safe and high-quality care while giving its citizens transparency and control over their health data.

As Denmark and Canada face similar demographic and care system pressures, Denmark's approach offers practical lessons and strategic directions to inform more resilient, equitable, and sustainable care systems for current and future generations of older Canadians.

Appendix

Appendix A. An Overview of Key Legislative Acts and Major Reforms Governing Health and Elderly Care in Denmark

Act / Reform (English name)	Danish name	Policy area	Status	Key dates	Purpose / main relevance
Social Services Act	<i>ServiceLOVEN</i>	Social services, disability services, selected welfare support	In force (scope reduced for long-term care)	Adopted: 1998 Continuously amended	Core framework for Danish social policy; although this Act historically regulated elderly care and now primarily applies to disability and social services for non-elderly populations following the introduction of <i>ÆldreLOVEN</i> , it still applies to older people for services that fall outside the scope of <i>ÆldreLOVEN</i> .
Health Act (Health Care Act)	<i>SundhedsLOVEN</i>	Health care services (prevention, treatment,	In force	Adopted: 2005 Continuously amended	Main legal framework for the Danish health care system;

		rehabilitation)			regulates roles of regions, municipalities, and providers and remains separate from elderly care legislation.
Structural Reform	<i>Kommunalreformen</i>	Governance and public sector: - reduced the number of municipalities from 271 to 98; - replaced 13 counties with five regions; - reshaped the division of responsibilities across levels of government 446,447	In force	2007	The governance structure established under the 2007 Local Government Reform remains the foundation of Denmark's health, social care, and local government system.
Elderly Act	<i>Ældreloven</i>	Elderly care and long-term care	In force	Adopted: December 2024 Entered into force: 1 July 2025	New standalone framework for elderly care (or long-term care); replaces relevant parts of Serviceloven for older adults, emphasizes dignity, self-determination, holistic care, and reduced administrative burden.
Elderly Care	<i>Ældrereformen</i>	Governance and	Implemented via	Political agreement:	Reform package

Reform (package)		organization of elderly care	multiple laws	April 2024 Implementation: 2025–2027	underpinning Ældreloven and related legislation (e.g., elderly supervision, local care homes); aims to reduce fragmentation, improve coordination, and increase professional discretion.
Health Care Reform 2024	<i>Sundhedsreformen 2024</i>	Health system structure and governance	Implementation ongoing	Political agreement: November 2024 Phased implementation: 2025–2027	Major restructuring of the health care system (fewer regions, local health councils, stronger primary care); complements but does not replace Sundhedsloven or Ældreloven.
Act on Elder Care Supervision	<i>Lov om ældretilsyn (Ældretilsynsloven)</i>	Supervision of the quality of care in LTC homes and home care	In force	Adopted: 19 December 2024 (LOV nr 1653 af 30/12/2024) Operative: 1 July 2025	Replaces the 98 municipal inspection regimes with a cross-municipal Elder Care Inspection (Ældretilsynet) carried out by three designated municipalities (Gentofte, Silkeborg and Hjørring) and coordinated with the Danish Patient Safety Authority's health inspections

					and the Working Environment Authority (samtilsyn); the purpose is to support care units in ensuring the quality of holistic care under the Elderly Act.
Public Housing Act (also translated as the Social Housing Act)	<i>Lov om almene boliger m.v. (Almenboligloven)</i>	Non-profit housing, including senior housing (ældreboliger) and LTC homes (plejeboliger)	In force (LBK nr 207 af 25/01/2026)	Original act 1996 Continuously amended	Sets the rules under which municipalities provide and design senior housing and LTC homes; § 105 obliges municipal councils to ensure sufficient senior housing, and § 5 defines LTC homes (plejeboliger) as senior housing with attached service areas.
Act on Digital Health Denmark	<i>Lov om Digital Sundhed Danmark</i>	National digital health organization	Adopted December 2025 In force Fully operational: 1 on January 2027, following a preparatory transition year throughout 2026	Political agreement: November 2024 (Sundhedsreformen 2024)	Merges sundhed.dk, MedCom and the Danish Health Data Authority into one organization owned by the state, regions and municipalities, with a mandate to set binding national digital solutions and architecture.

Act on Public Digital Post	<i>Lov om Offentlig Digital Post</i>	Digital communication between public authorities and citizens	In force	Adopted: June 2012 Mandatory for citizens aged 15+: 1 November 2014	Makes digital communication with the public sector the legal default, with statutory grounds for exemption; it underpins the “digital by default” public sector on which digital health services rely.
Health Act – digital provisions	Sundhedsloven §§ 41–42a, 157, 157a, 193a–b	Health data sharing and national registers	In force	FMK (§ 157): 2010 Vaccination register (§ 157a): 2012–2013 §§ 42a and 193b amended: 2019	Authorises look-up of health information for treatment without separate consent, citizen opt-out, statutory national medication and vaccination registers, ministerial power to mandate standards and a common digital infrastructure across hospitals, primary care and municipalities.

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