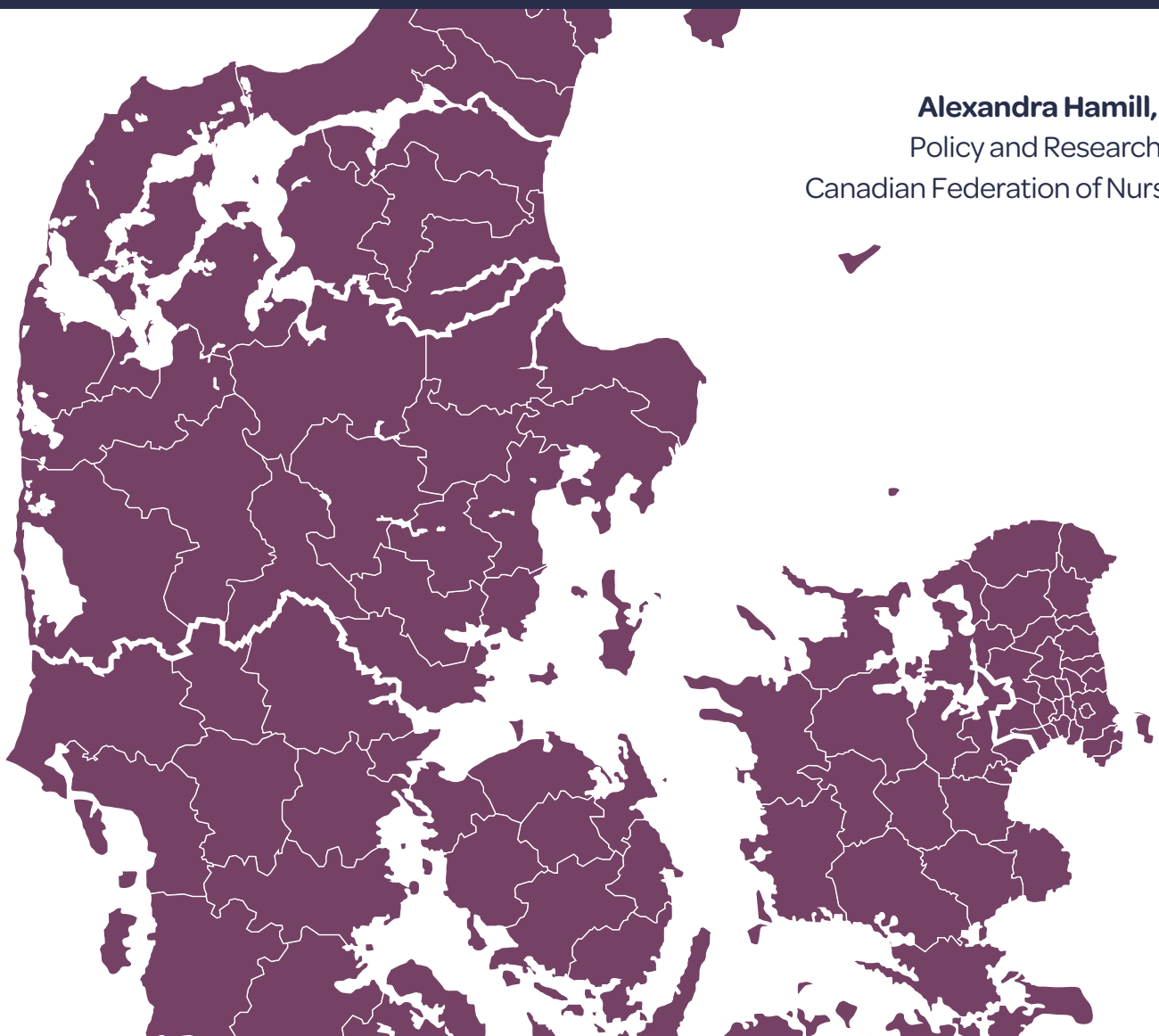
CANADIAN FEDERATION OF NURSES UNIONS

October 2026

Healthy aging, dignified care:

Lessons on seniors' care from Denmark



Alexandra Hamill, MPH, BSc
Policy and Research Specialist
Canadian Federation of Nurses Unions

Canadian Federation of Nurses Unions

The CFNU is Canada's largest nurses' organization representing frontline unionized nurses and nursing students in every sector of health care – from home care and LTC to community and acute care – and advocating on key priorities to strengthen public health care across the country. We are relentless advocates for the health and safety of our members and the patients that we care for from coast to coast to coast. Join us as we speak up for a stronger health care system and a better workplace for all nurses.

Land acknowledgement

From coast to coast to coast, we acknowledge the ancestral and unceded territory of all the Inuit, Métis and First Nations Peoples that call this land home. The Canadian Federation of Nurses Unions is located on the traditional unceded territory of the Algonquin Anishnaabeg People. As settlers and visitors, we feel it's important to acknowledge the importance of these lands, which we each call home. We do this to reaffirm our commitment and responsibility to improve relationships between nations, to work towards healing the wounds of colonialism and to improve our own understanding of local Indigenous Peoples and their cultures.

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Nova Scotia Nurses' Union

Prince Edward Island nurses' union

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UNA United Nurses of Alberta

SIINB NBNU

PSAC · North Public Service Alliance of Canada

BC NURSES' UNION

CNSA AEIC

ONTARIO NURSES' ASSOCIATION

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President's message

During the COVID-19 pandemic, we all said and heard that the way our seniors were treated in long-term care (LTC) was appalling. At the time, health care and political leaders echoed that there would be a reckoning for seniors' care and that action must be taken to reform the system. After six years, has enough been done to improve seniors' care? Canada's nurses say, not enough!

The idea to conduct this study tour started at the 2024 Prince Edward Island Nurses' Union annual general meeting. The late Honourable Mark McLane, PEI's Minister of Health and Wellness at the time, had just returned from a visit to Denmark. He exclaimed that we all need to do better for our seniors, and that we should see how they are doing it in Denmark. Paula Doucet, President of the New Brunswick Nurses Union, said: "Let's get it done – nurses working in long-term care have been asking for long enough!" And so, the planning began.

Two years later, on our first day in Denmark, we met with the Honourable Dr. Carolyn Bennett, Canadian Ambassador to the Kingdom of Denmark. She gave us a rapid orientation to Denmark from a Canadian perspective and shared with us a profound reminder of the important place of seniors in our society as keepers of wisdom and knowledge. This special role is irreplaceable, and they must be protected and cared for. She noted that Danish seniors are referred to as *citizens*, which is a dignified and respectful term acknowledging their important place in society.

We saw that home and community care is at the center of the Danish health care model, which aims to meet the specific needs and preferences of seniors. Leadership and investment in these areas result in innovations in quality and efficiency that allows more seniors to age close to home.

Seeing the approach to seniors' care in Denmark reignited in me the spark that so many of us had during the pandemic: to advocate for better LTC in Canada. We must keep seniors' care on the agenda and invest in the nurses and health care workers at the center of the system.

I would like to express gratitude to all of those who supported the study tour and made this excellent learning experience happen.

To those in Denmark, *tusund tak* to our tour hosts: the Honourable Dr. Carolyn Bennett, Canadian Ambassador to the Kingdom of Denmark, the Danish Nurses' Organization (DNO) Copenhagen and Central Jutland, the Danish Health Authority, Rigshospitalet, KL – Local Government Denmark, Rødovre Municipality, Bakkegården, OK-Fonden Dyruphus, Lysningen, Middelfart Municipality, House of Generations, Aarhus University Hospital, VIA University College and Systematic. Your willingness to share your time and expertise

made this report possible and will inform our ongoing advocacy for a better future for seniors' care in Canada.

Thank you to the CFNU National Executive Board, who are always supportive of innovative research projects, and CFNU staff team Alexandra Hamill, Julien Le Guerrier and Carrie Steeves for planning and organizing the tour. I would also like to acknowledge Katie Tucker and Isabella Boteju at the Royal Danish Consulate in Canada for connecting us with an excellent array of experts in Denmark.

We saw that home and community care is at the center of the Danish health care model, which aims to meet the specific needs and preferences of seniors. Leadership and investment in these areas result in innovations in quality and efficiency that allows more seniors to age close to home.

Merci to our member organization tour delegates: Darlene Jackson – President of the Manitoba Nurses Union (MNU), Paula Doucet – President of the New Brunswick Nurses Union (NBNU), Janet Hazelton – President of the Nova Scotia Nurses' Union (NSNU), Yvette Coffey – President of the Registered Nurses' Union Newfoundland and Labrador (RNUNL), Kelley Charters – Director of minimum Nurse Patient Ratios (mNPR) at the British Columbia Nurses' Union (BCNU), and JoAnn Carey – Chair of Nursing Home Provincial Negotiating Team at the Ontario Nurses' Association (ONA). Your curiosity and careful reflections led to the findings and recommendations that we will take forward from this report.

I would like to thank Dr. Samir Sinha – Professor of Medicine, University of Toronto, and Director of Health Policy Research, National Institute on Ageing, for joining our delegation. Your expertise as one of Canada's leading experts in ageing and seniors' care was invaluable as you contextualized our observations within the current best evidence and the Canadian and Danish policy landscapes.

Finally, I would like to acknowledge and thank the nurses and health care workers in our LTC and home care sectors. We will continue to work with you to fight for a better future for you and the clients you care for.

In solidarity,



Linda Silas
CFNU President



Foreword by Dr. Carolyn Bennett

Canadian Ambassador to the Kingdom of Denmark

As a former family doctor, former Cabinet Minister responsible for varied aspects of Health Portfolios, and now Canadian Ambassador to the Kingdom of Denmark, it was an honour to welcome Linda Silas and the CFNU delegation with Dr. Sinha to Copenhagen this spring on their study tour to learn about the Danish approaches to addressing the needs of older persons.

During my time learning from Indigenous leaders, I have often asked why their older persons are called *elders*, and in non-Indigenous communities they are called *elderly*! The respect for the Indigenous knowledge keepers and language speakers is the foundation of the well-being of elders and their revered place in their communities. During the outbreak of COVID in Canada, it was truly impressive the way in which the Indigenous elders were protected by all generations in their communities, while the death toll in our nursing homes spoke to a literal fatal flaw in the way in which older persons have been treated in non-Indigenous society.

Only by embarking on the reforms necessary for cost-effective evidence-based appropriateness of care – the most appropriate care, by the most appropriate provider, at the most appropriate time and in the most appropriate place – can we ensure that increasing life expectancy is indeed more years of health, safety and dignity. The reforms require an ability to develop learning health systems that obtain real-time data, and then a commitment to improvement. Solutions are often found by learning from other jurisdictions confronting similar problems. In so many areas Canada and Denmark are working together to share ideas to respond to optimizing the well-being of their citizens.

Canada and Denmark share the common values of a strong democracy, universal health care, human rights and sustainable development. We even share a common border now at Hans Island!



As a Canadian, I have been impressed that the social safety net here in Denmark is strong – a virtual Kevlar hammock which rarely lets people fall through the cracks. The senior poverty figures from OECD data shows a senior poverty rate of **2.9% in Denmark** versus **14.8% in Canada**. There is no question that the tax burden for Danes is much higher than in Canada and the consumption tax (VAT) is 25%. In Denmark those higher taxes help fund: post-secondary education with little or no direct cost and a monthly grant to help cover the living expenses of the students, parental leave, strong unemployment benefits, larger public pension supports and – most relevant to this paper – more generous seniors' care.

I believe this report is a timely contribution to health policy in Canada and hope that the relationships built throughout the study tour will enhance the future collaboration between our two great countries.



The Honourable Dr. Carolyn Bennett
Canadian Ambassador to the Kingdom of Denmark









Danes are very socially conscious, and they truly care for citizens in their communities.

Social society and volunteers are actively integrated into the care framework, and I would like to see more acknowledgement of these contributions in Canada.

- Paula Doucet, President of the New Brunswick Nurses Union (NBNU)

Recommendations

The federal government, in partnership with nurse and health care worker organizations, provincial and municipal representatives, seniors' advocacy groups and Indigenous elders must develop a **national seniors' care strategy** for Canada.

This strategy must be supported by robust **legislation** that enforces national minimum **quality standards** for seniors' care, including long-term care services such as home and community care, and care in long-term care homes.

It must also be **funded** through dedicated **long-term financial agreements** with the provinces and territories.

A national seniors' care strategy should prioritize the following principles:

1. Care close to home and aging in the optimal place
2. Increased funding and cohesive frameworks to enable nurses and other health care workers to deliver higher-quality and more comprehensive home and community care
3. Person-centered care, autonomy, choice and continued participation in society
4. Standards for staffing long-term care homes, home care and other seniors-focused health services
5. Pay parity, and safe and healthy working conditions for nurses and health care workers in the seniors' care sector
6. Proactive disease prevention and rehabilitation programs
7. Supports for people living with dementia and for their families/other unpaid caregivers
8. Continuous quality improvement and innovation in the provision of excellent care

Background and purpose

Denmark is a world leader in providing health and social care to its older citizens close to their homes, and in ways that support autonomy, dignity and independence. Danish health care prioritizes upstream health promotion and disease prevention efficient acute care, and comprehensive integrated community care.

Canadian researchers, politicians, policymakers and health leaders have identified Denmark as a model for future-forward health policy for many years. Following this example, a delegation from the Canadian Federation of Nurses Unions (CFNU), along with Geriatrician and Clinician Scientist Dr. Samir Sinha from the National Institute on Ageing, headed to Denmark for a week in May 2026 to see the system in action. The group met with representatives of many different aspects of health and seniors' care, from policy to direct care delivery and older citizens themselves.

The group travelled from Copenhagen to Odense and finally to Aarhus, meeting with dozens of individuals that together wove the story of Danish seniors' care and in particular the role that nurses play in supporting this robust system.



In health care, we need a bigger perspective. We need to look ahead.

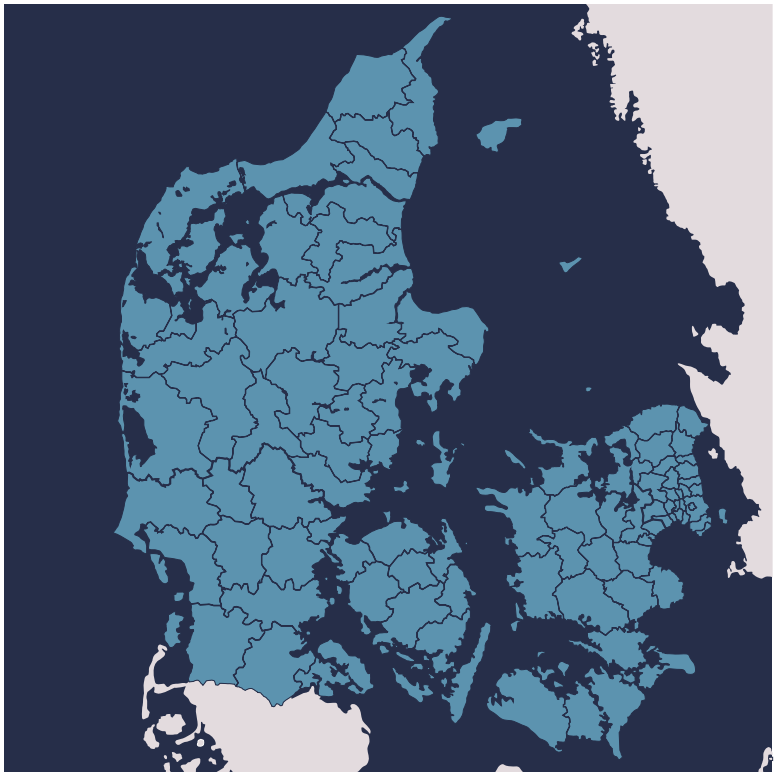
We need to think about reforms, recruitment and the future of elder care. But at the same time, nursing is never really about the view from above. It is about staying close to people. Close to everyday lives. Close to the patients, citizens and family.

That is where our profession lives... [the delegation from Canada is] here because elder care matters. Because recruitment matters. Because the future of health care matters. And because across borders we can learn from each other.

- Jacob Gøtzsche, Chairman, Danish Nurses' Organization, Central Jutland Region

About Denmark

Denmark is a small country with a population of just over 6 million people.[1] It is made of a peninsula jutting North from Germany and 444 islands.[2] The country is organized into five administrative regions and 98 municipalities.[3] The Kingdom of Denmark is a constitutional monarchy and parliamentary democracy. Twelve parties are represented in parliament and must work together to form a ruling coalition.[4]



Denmark is a high-income country with a per capita GDP of €47,800 (~$76,550 CAD).[5] It has a robust social welfare program, including a public health care system, subsidised childcare, pensions for seniors and free education through post-secondary.[6] There is a robust system for unemployment called Flexicurity, which provides unemployment assistance for up to two years following a job loss. Denmark has a high rate of unionization – approximately two thirds of workers are unionized.[7] This high rate of unionization keeps wages high for the whole country.[8]

Denmark has ranked in the top three countries for happiness each year that the World Happiness Report has published rankings. Danes attribute their happiness to the robust social safety net, high social cohesion, low crime and corruption, personal empowerment, and the spirit of *hygge* – a concept that loosely translates to enjoying the pleasant, relaxed things in life.[9]

Denmark has a robust social welfare program, including a **public health care system, subsidised childcare, pensions for seniors and free education through post-secondary.**

Nurses identify the challenges and solutions to delivering high-quality care long before most. If health care leaders and policymakers genuinely listen and act on their guidance, we will see a much stronger and more resilient health care system in the future.

- Dr. Samir Sinha, Professor of Medicine, University of Toronto, and Director of Health Policy Research, National Institute on Ageing





Danish health system

All Danes have access to comprehensive public health care. The system is funded predominantly through taxes, and most services are provided free of charge at the point of use.[10] The Danish health care philosophy asks the health system to:

- Ensure dignity and autonomy of patients
- Support rehabilitation and self-help
- Offer freedom of choice
- Provide care as close to home as possible
- Optimize the use of scarce resources
- Promote innovation, continuous improvement and healthy economic competition
- Ensure access to high-quality care in all parts of the country[10,11,12]

Care close to home

The Danish health care system prioritizes home and community care over insitutional health care settings such as hospitals. Hospital stays are for acute, short-term or highly dependent complex cases. After hospital discharge, citizens can receive holistic care in their homes, which allows them to heal in a comfortable and familiar setting.[10]



Governance and responsibilities

Health care in Denmark is organized and administered across three different levels of government, each with distinct roles and responsibilities.[10]

The overview below reflects the Danish health system at the time of the study tour in May 2026. However, municipal and regional responsibilities are set to change on January 1, 2027, in accordance with the *2024 Agreement on Health Reform*.[10]

National level

Ministry level and national agencies



- Overall regulation, control, and supervision
- Developing guidlines
- No direct role in supplying health services

5 regions

From 600,000 - 1.9 million citizens



- Operation of hospitals
- Psychiatric care
- General practitioners
- Other practioning health personnel (e.g. physiotherapists, dentists)

98 Danish municipalities

From 1,793 - 659,350 citizens



- Elderly and senior care
- Home nursing
- Child nursing
- Rehabilitation
- Prevention

Adapted from the Danish Health Authority's presentation "The national framework for eldercare in Denmark" delivered on May 18, 2026, in Copenhagen by R. Søndergaard, H.S. Dalum and M.D. Tiemensma during CFNU Danish Seniors' Care Study Tour.

State: The state (Government of Denmark) governs national health policy and sets the framework for health spending. The Danish Health Authority (*Sundhedsstyrelsen*) advises and supports the Ministry of Health, regions and municipalities on matters of health. The national role in the organization of the Danish health system is to set the standards, guidelines and coordinated policy direction for the regions and municipalities. The Danish government funds regional and municipal health services but is not directly responsible for their delivery.[10,13,14]

Regions: At the time of the study tour there were five regional governments across Denmark, each representing between 600,000 and 1.9 million citizens. Regional governments are primarily responsible for hospital services and primary health care, including general practitioner funding, drug reimbursement, in-hospital rehabilitation and patient-targeted disease prevention. Each region has a central highly specialized tertiary care hospital and several smaller regional hospitals.[10,13]

Municipalities: Municipalities organize and deliver a significant proportion of health care, especially the types of services most often used by seniors. Each of the 98 municipalities is responsible for LTC, which includes home care, community care and LTC homes. They are also responsible for community-based rehabilitation, public health disease prevention, children's dental services and community acute care teams.[10,13]

Community acute care teams are interdisciplinary but are led by nurses who provide acute care in citizens' homes with advanced training, highly specialized equipment, and support from primary care and acute care medical teams.[15]



Short-term stay rehabilitation centers provide transitional and rehabilitative care filling the gap between acute and home care.[16] The Danish health care philosophy leans heavily on home and community care whenever possible and reablement of citizens so they can continue caring for themselves for as long as possible.[11]

Municipalities must provide public home care services to their residents. Home care continues to be available to older citizens if they transition to supportive seniors' housing without necessarily requiring institutional long-term care. When citizens' care needs exceed the capacity of home and community-based care, municipalities also deliver or fund care in LTC homes through several different funding and operational schemes.[10,12] Community nursing care clinics are used in concert with home care to deliver nursing services to citizens of all ages that can attend centralized clinics to improve efficiency of service delivery.

> ***It was incredible to see how much respect Danish people have for older adults. We need to have more of that in Canada and treat our seniors with dignity.***
>
> **- Janet Hazelton, President of the Nova Scotia Nurses' Union (NSNU)**

Municipalities are responsible for ensuring their citizens can be safely discharged from acute care to the community, including ensuring adequate home care supports and often equipment is in place. Municipalities may pay penalties for patients that could be discharged but for whom appropriate accommodations had not been arranged causing them to remain in hospital longer than necessary.[17]

A variety of social welfare programs, including housing, education and childcare, are also under the purview of municipal services.[10,11]

Nurses and other health care providers in Denmark

Health care providers by the numbers in Canada and Denmark

	Canada	Denmark	OECD average
Practising nurses per 1,000 population	**10.0***	**10.5****	**9.2**
Practising doctors per 1,000 population	**2.7**	**4.5**	**3.9**
LTC workers per 100 seniors aged 65+	**3.7**	**7.0**	**5.0**

From the OECD *Health at a Glance 2025* report [18,19]

*Includes registered nurses, licensed practical nurses (registered practical nurses in Ontario), registered psychiatric nurses, and nurse practitioners
**Includes registered nurses only

Canada and Denmark appear to have a similar number of practising nurses per 1,000 population; however, the variation in designations included in the comparison presents an inflated picture of nursing workforce capacity in Canada. Denmark has a greater number of practicing doctors per 1,000 population and long-term care workers per 100 seniors while Canada lags behind the OECD average on both measures.

Registered nurses (*sygeplejerske)* are the only authorized health care professionals who carry the professional title of *nurse* in Denmark. They have a similar role in the health system as registered nurses in Canada, though their scope of practice differs. Social and health assistants (SSA) are also an authorized health care profession that occupies the role of nurse assistants. Social and health helpers (SSH) complete a vocational education program but are not authorized health care professionals and provide a similar range of services as home support workers, personal support workers, health care aides, continuing care assistants, personal care attendants and similar unregulated health care providers.

Registered nurses (*sygeplejerske*)

Registered nurses (RNs) complete a 3.5-year professional bachelor of nursing program at an accredited university college. The title registered nurse (*sygeplejerske*) is a protected professional title in Denmark, and they are authorized by the Danish Patient Safety Authority.[20,21] Registered nurses work in all levels of the health system, often in leadership positions in municipal home care, nursing care clinics and long-term care. In 2026 there were approximately 36,126 full-time-equivalent RN positions employed by the regions – primarily in hospitals.[22] An additional 11,428 RNs are employed by municipalities in roles including home care, community acute care teams (*akutteam*), community clinic care, long-term care homes and short-term stay rehabilitation facilities.



Social and health assistants (*SOSU assistants or social- og sundhedsassistent*)

Social and health assistants complete a vocational education the duration of which may vary based on prior education. Some of these programs provide both general courses to complete upper year secondary school education as well as a vocational certificate and prepares students to continue to higher education if desired. Some SOSU assistants will choose to bridge to professional bachelor of nursing programs. They may receive credit for prior learning, which in some cases may reduce the length of the nursing program to 2.5 years.[23,24,25,26]

Social and health assistants (*social- og sundhedsassistent*) is a protected title authorized by the Danish Patient Safety Authority. The program broadly teaches about nursing care, medicine and rehabilitation. SOSU assistants work very closely with RNs in both regional and municipal settings in a nurse assistant role. In 2026 the full-time equivalent of 6,875 SOSU assistants were employed by regional institutions such as hospitals.[22]

Social and health helpers (*SOSU helpers or social- og sundhedshjælper*)

Social and health care helpers complete a vocational education program where students learn to help citizens with activities of daily life, personal care and practical tasks. The duration of the complete program is typically 1 year and 7 months but may vary based on previous education and qualifications.

SOSU helpers are not regulated professionals, but these positions do require the completion of a vocational education program. SOSU helpers are predominantly employed in municipal health care delivery settings such as home care and LTC homes.[27,28,29]

In January 2024,
65,409
SOSU helpers and SOSU assistants
were employed in Danish municipalities.[30]

Unskilled workers (*ufaglærte*)

Unskilled jobs are a defined category in Denmark, with several online portals that match job seekers who do not have formal education or qualifications to open jobs in their communities. Unskilled workers are often young people and students. They can gain exposure to an industry and job experience through these positions.[31]

Unskilled workers are hired in some health care settings to complete basic tasks that may or may not be patient-facing. The delegation heard that in many instances unskilled workers that are hired in health care workplaces are students with interest in the health care field. Often these jobs take the form of social companions, facilities services support, dietary support and other support tasks.[32]

Registered nursing education

The number of nursing seats that are funded is decided and funded by the government. The number of funded seats is based on projected workforce needs and funding availability. It must be noted that not all nursing school seats are filled due to difficulty attracting students to the profession. Although there was a 3% increase in the number of students admitted to nursing school between 2025 and 2026, 1,135 seats remained unfilled.[33] Most students from Denmark, the European Union and European Economic Area do not pay tuition, and eligible students may apply for the Danish State Educational Grant (SU), which is a small stipend for living expenses.[34] Funding a number of nursing education places based on workforce projections allows the government a degree of influence over future health workforce planning.

VIA University College

The delegation had the opportunity to meet with registered nursing program faculty, students and administrators from VIA University College in Aarhus. Students receive a professional bachelor's degree that combines theory and practice and is focused on employment in the field. At the time of the tour, the program was 3.5 years in length, however, following the enaction of the Health Reform, the nursing program will be shortened by three months for students admitted from the summer of 2027 onwards.[35] Faculty and the Danish Nurses' Organization have expressed concerns about student readiness given the reduction in teaching time.[36]





VIA University College simulation lab

Union representation of nurses in Denmark

Danish Nurses' Organization (DNO) (Dansk Sygeplejeråd)

The DNO kindly hosted the delegation at two of their offices, in Copenhagen and Aarhus, to share ideas about nurses' roles in seniors' care and engage in international solidarity.



The DNO represents over 75,000 registered nurses across Denmark and is the only trade union that has the right to collectively bargain on behalf of nurses.[37,38] The DNO advocates for nurses and their interests, including providing a response to the Health Reform and Elder Care Reform from their members' perspectives. In their report Nurses for a Healthier Society (*Sygeplejersker for et sundere samfund*) the DNO proposes several recommendations that center nursing care in the new reforms and highlights opportunities for nurses to be leaders in this next phase of the Health Reform.[39] Among other recommendations, they advocate for more opportunities for independent practice and greater integration of advanced practice nurses, especially in community care settings. A January 1, 2024, amendment to the *Authorization Act* legally defined nurses' scope of practice, including the addition of several authorized actions such as independent urinary catheter insertion and removal, simple wound suturing and limited rights to prescribe medications.[40] The DNO advocates for the work of nurses to be recognized and for their roles to be respected within the new health care frameworks.

After total compensation negotiated by the Danish Nurses' Organization, nurses working in municipalities (non-hospital settings, including home care, clinics, long-term care and rehabilitation/short-term care) are paid slightly more than nurses working in hospitals.[37] Excluding pension contribution and supplements for evening, weekend and holiday pay, the average net base salary for nurses in community settings is approximately 1% higher than hospital nurses (community: DKK 38,316/month {$8,171 CAD} | hospital: DKK 37,905/month {$8,084 CAD}).[37] The delegation heard that like in Canada, hospitals are the more sought-after work environments in Denmark; however, the slight lift of pay for community nurses shows that their work is valued.

The meetings with the DNO underscored the critical role that nurses must play in advancing the Health and Elder Care reforms. Nurses are leaders in health care, and the DNO's advocacy for expanded scopes of practice and advanced practice will further allow Denmark's health care system to adapt to changing population needs.





Denmark and Canada share a belief that publicly delivered health care is a fundamental right. Denmark has shown the boldness to pursue the reforms needed to make its system stronger, and I see that same potential in Canada. Our health care system is failing Canadian patients. Turning that around will take courage, but we have the foundation, the expertise and the opportunity to make meaningful change a reality.

- Kelley Charters, Director of minimum Nurse Patient Ratios (mNPR) at the British Columbia Nurses' Union (BCNU)





Observations

Future-focused health policy

Denmark has a history of timely and forward-thinking social policy reforms. Leaders consider not only the immediate future but also long-term impacts of present legislation. Although the general direction of health policy is set at the national level by elected leaders, the laws and agreements must be interpreted for practical coordinated implementation.

Danish Health Authority (*Sundhedsstyrelsen*)

The Danish Health Authority provides professional advice to national, regional and municipal authorities and develops national professional guidance, standards and planning frameworks to support the implementation of health legislation and political agreements such as the 2024 *Agreement on Health Reform and The Elderly Act.*[13]

Health Reform

At the time of the study tour in May 2026, the Danish health system was on the precipice of substantive system transformation, preparing for the next major steps to enact the *2024 Agreement on Health Reform* (*Aftale om Sundheds-Reform 2024*).[11]

The *Agreement on Health Reform* legislation was passed in 2024 by the ruling government consisting of three political parties at the time, along with four additional political parties.[41]

Although Denmark had a high-quality health care system prior to the reform, it was deemed necessary due to emerging trends in the population need. The key trends include an aging population and growing geographical disparities between access to high-quality health care across the country. The reform calls on all levels of government to take renewed ownership over the provision of high-quality health care tailored to local needs. It aims to improve care close to citizens' homes, especially in areas of the country where citizens are sickest.

Reorganization: The Health Reform would merge Denmark's densely populated Capital Region with the less densely populated Zealand region, creating a new, larger region called Eastern Denmark. The intention of this change is to redistribute health services to reduce inequities between higher- and lower-resourced areas.[11]

Several health care services that had previously been the responsibility of municipalities will be transferred to the regions. Services that will change hands include: acute care nursing, patient-targeted disease prevention, the majority of rehabilitation services and most temporary health care beds (*sundheds-og omsorgspladser*). These shifts in responsibility will bring intermediate services that fill the gaps between acute and community care closer to centralized regional hospital resources. Conversely, these transitional care services may become more distant from municipal health and social services such as home care.[11]

To coordinate health services between the municipalities and regions, 17 health councils will be formed, each encompassing between two and nine municipalities. The representatives of these health councils will be elected representatives from both regional and municipal councils. Health councils will work together to implement the *Agreement on Health Reform*, engage citizens, and develop financing and organizational structures.[10,11]







Investment: The Health Reform calls for financial investment in primary care, regional and municipal services, and digital health infrastructure. The Danish government has committed to significant investments to support the implementation of the reform. Funding will increase each year, reaching an annual investment of DKK 6.4 billion in 2030 (approximately 1.4 billion CAD). A portion of the investment will go towards the goal of having 5,000 primary care physicians practicing across Denmark by the year 2035 (approximately one primary care physician per 1,200 patients). An additional DKK 27.5 billion (approximately 5.8 billion CAD) will be invested in technology and physical health infrastructure between 2025 and 2035.11 The framework will slow the growth of hospital services while focusing on rapidly increasing the growth rate of community care services.[10,11]

Health data and technology: The Health Reform sets out a plan for improvements to health data infrastructure, digitalization and interoperability. It establishes the new national organization, Digital Health Denmark, which will be jointly owned by the national, regional and municipal governments.[42] Digital Health Denmark will develop and deploy digital health solutions across the country that adhere to data and architecture standards to ensure interoperability, accessibility, quality and security.[11]

Prevention and rehabilitation: The overarching philosophy of health care in Denmark focuses on supporting the health and wellbeing of citizens so they can care for themselves as much as possible for as long as possible. Rehabilitation and conscious care planning with a focus on maintaining or restoring function allows citizens to remain in their homes later in life with reduced reliance on long-term care.

Implementation: Aspects of the Health Reform have been rolling out gradually since the agreement passed, but on January 1, 2027, the new regional and health council structure, and the redistribution of responsibilities outlined in the reform will take effect.[11,13]

Elder Care Reform

The Elder Care Reform was initiated in 2024 to re-align seniors-focused services, including long-term care services with the available resources and preferences of older Danish citizens. The Elderly Act (*ældreloven*) is the key legislation upholding the new Elder Care Reform that came into force on July 1, 2025.[43] The act is formed around three key values that guide the delivery of seniors' services.[12]

First, the **autonomy and self-determination** of seniors must be upheld and centered in all decisions surrounding long-term care. This is enacted through the provision of flexible services awarded based on individual needs for holistic care, including home nursing care. The type of services required are regularly discussed between the citizen and their dedicated care team and adjusted on an ongoing basis.[12]

Second, **confidence in professional staff** gives nurses, allied health care workers and other care providers the autonomy to organize and tailor citizens' care to their individual needs. The framework puts trust in competent, trained staff and management to organize their time and priorities in accordance with the needs of those for whom they have a duty to provide care. Nurses and other care team members are trusted to enact their professional judgement to adjust services in collaboration with citizens based on holistic care needs.[12]

Third, **relatives, civil society volunteers and communities are essential collaborative partners** in caring for senior citizens. The framework acknowledges the critical roles of these collaborators and is conscientious of avoiding increased obligations on unpaid caregivers.[12]

As part of the Elder Care Reform, the Minister for Senior Citizens will gather and share information on all long-term care residences and holistic care providers. This data collection will be used to identify performance indicators such as user satisfaction and staffing metrics. Additionally, each municipality is compelled to organize at least one senior citizens' council which is elected by their peers to advise on local matters related to seniors.[12]



I found this study tour very eye-opening. Seniors deserve to be valued and treated with compassion – if Denmark can do it, so can we here in Canada.

- JoAnn Carey, Chair of Nursing Home Provincial Negotiating Team at the Ontario Nurses' Association (ONA)

KL (*Kommunernes Landsforening*) Local Government Denmark



KL is the organization in Denmark representing all 98 municipalities. KL's 400 employees advocate on behalf of the municipalities to influence national and EU policies. They also provide resources and consulting services to individual municipalities to help them interpret national and regional standards. Membership fees from municipalities are the primary funding source for KL, but they also draw funding from their delivery of courses and consultancy fees.[44]

Each of the 98 municipalities is responsible for organizing and delivering multiple complex health services. KL reduces duplication of effort between municipalities by providing centralized guidance on policy interpretation for all members. KL supports their municipal member organizations through sharing best practices: supporting new act implementation, legal support, organizing conferences, hosting networks, representing municipalities at the EU, developing supportive tools and frameworks, and sharing news and publications. KL also operates as the employers' association with authority to negotiate binding contracts with municipal staff, including nurses.[44]

KL negotiates the allocation of the national budget that municipalities receive. Municipalities typically receive nearly half of the national budget, and in 2025, 59% of municipal spending went to social welfare and employment, including seniors' services. A further 8% went directly to municipal health care services.

Mayors and other local government representatives have a strong influence over the delivery of health care services within their communities. KL plays a critical role in providing them the support they need to do that complex job effectively. With the introduction of the new Elder Care Reform, KL helped to spread and scale care delivery frameworks that align with the new policies.[45]

Innovative municipally driven seniors' care solutions

Motivated and dedicated municipalities have been incubators for innovative approaches to caring for their citizens. Several of these approaches were later expanded to benefit citizens across the country and even internationally.

Preventive home visits for seniors
Rødovre Municipality



Rødovre is a mid-sized municipality with a population of around 45,000 people in the greater Copenhagen area. Like the rest of Denmark, nearly one in five residents is over the age of 65.[46] The municipality of Rødovre has a long history of innovating care for its older citizens by implementing a preventive care program to identify health and social care needs upstream.[47]



In 1980, the Rødovre Project (*Rødovre Projektet*) was initiated to study a new proactive model of community care in the namesake municipality.[48] The randomized controlled trial took place over three years in partnership with the municipality and community nurses. The intervention was a series of regular visits from a community care nurse for older citizens in their homes. The community care nurse would use a semi-structured interview and professional judgement to identify health risks and connect older citizens with community resources and medical care as needed. The intervention group saw marked improvements over the control group. Over the follow-up period there were 25% fewer deaths, 19% fewer hospital admissions, 24% fewer days in hospital, 31% fewer admissions to long-term care and 50% fewer after-hours physician visits among the intervention group. The visits facilitated connection with community civil society (volunteer) organizations and other programs aimed at improving self-care, safety and community engagement.[47,48]



Following the success of the pilot project, the program was implemented in Rødovre permanently, and preventive care visits for all older citizens were enshrined in Danish law in 1996.[49,50] At the time of the study tour, the preventive home visits looked very similar to the original pilot project, with a few small changes made for scalability. Preventive home visits



from community nurses were initiated at 70 years of age for those who lived alone, otherwise citizens would receive visits at the ages of 75, 80, 82 and then yearly after that. Citizens who had lost a spouse could also receive a visit which often included grief counselling.[47]

The nurses that the delegation met who conducted home visits were pleased with the type and scope of their work. They each had a "panel" of 300-1,500 citizens depending on their level of need and visited approximately 3-4 patients per day. They felt that they were making a real difference in the lives of seniors in their community.

Although this program was required by law through the 1996 *Act on Preventive Home Visits*, the new Health Reform will override the requirement for municipalities to continue providing this service.[11] Some may choose to delay the visits, space them further apart or eliminate them altogether in favour of other programs. However, the nurses and municipal representatives in Rødovre were confident that their municipality and many others would continue providing the service given the strong evidence in favour of the benefits even if they may need to delay the age of first visit due to increasing average life expectancy. Furthermore, the delegation heard that Rødovre is considering other opportunities to maximize the program such as expanding the visits to vulnerable people under the age of 65. The representatives felt that citizens of Rødovre have come to expect preventive home visits, that these visits are part of the culture and deliver good value.

House of Generations (*Generationernes Hus*)
Aarhus Municipality

The House of Generations (HoG) is a municipally owned and operated housing and community services hub located in the municipality of Aarhus. The home was officially opened in September 2021 and aims to create a community that citizens can live in for their whole lives, especially as they age. The HoG is a complex comprised of four residential housing towers and several communal gathering spaces throughout.[51]

The building provides 304 cost-controlled public housing units designed for seniors (100 units), youth (40 units), families (40 units), supportive housing for people with disabilities (24 units) and long-term care (100 units). All unit types are scattered throughout the buildings to create an organic neighbourhood-like feel, apart from seven blocks of long-term care floors that are grouped for logistical purposes. The structure of the buildings, especially the hallways and common areas, compels residents to move through them to encourage social interaction.[52]











In addition to housing, there are several meeting/party rooms, communal kitchens, activity rooms, a large gymnasium/auditorium, training gym, wood shop, bicycle repair shop, café restaurant, day care with 150 spaces, health clinic and more. There are also 37 roof-top terraces to provide access to the outdoors in a high-density area. The majority of the ground floor, including the restaurant and health clinic, is open to all community members, not just residents of the towers.[51]

Residents are encouraged to organize community events and use the communal areas. The older generations tend to build more community connections with each other because they spend more time in and around the home. A coffee club has emerged, mostly consisting of older citizens, where they meet to celebrate birthdays and socialize. On the day that the delegation visited the home, a younger resident of the HoG was volunteering with a visit of the kindergarten to the long-term care floor. The delegation also met up with several residents who were taking part in a boxing club led by physiotherapists working with the long-term care home. The club was initiated in part by one of the residents that was a professional boxing coach in his career. The delegation also participated in a sing-along with live music largely attended by older citizens in one of the building's atriums. Other examples of groups that have emerged are a knitting group, reading group, generation choir, a reception group that staffs the welcome desk, and a music and movement group. The common spaces are considered part of the housing units and the "magic" of the project.

The HoG is still an experimental concept, and they are working on continuous enhancements to the home to improve community connectivity and implement resident-centered decision-making frameworks that best suit the concept and facilitate community building.

All residents benefit from being part of a community. In particular, seniors living in independent apartments and long-term care residents are integrated into a larger community. This brings spontaneity and community close to their homes rather than being segregated in seniors' living apartments or standalone long-term care residences. The proximity of several communal and municipal resources such as the health clinic may allow independent seniors to continue living in their homes independently for longer.[51]

Integrated primary and community care

Middelfart Municipality

Middelfart is another medium-sized municipality with approximately 40,000 residents. The municipality employs around 750 people in the health and seniors' care sector.[53]

In 2021, Middelfart was given the opportunity to be "set free" from status quo health delivery legislation and instead was simply given the mandate to provide care for their citizens. This freedom allowed them to completely re-think the way they provided the municipal scope of health and social care services to citizens. Along with two other municipalities that were "set free", the successful innovations explored during this period led to several aspects of the Elder Care Reform.[54]



The bottom-up rebuilding of Middelfart's primary care and community health services delivery model came largely from patient-facing care providers such as nurses and community members. The freedom within the blanket responsibility to care for the citizens brought the voices of those providing and receiving care to the forefront. The municipality made the bold decision to put their trust directly in the competent hands of nurses, health care workers and managers closest to the point of care. They flattened the care delivery hierarchy and made team culture and trust in capable team members a critical component of the new model.[55]

Fixed care teams

Care was reorganized around "fixed care teams" that ensure continuity of care for citizens by creating a dedicated team of permanent employees that work in a geographically bound area. These highly autonomous care teams may consist of registered nurses (approximately 45 are employed by the Municipality of Middelfart), social and health care assistants, social and health care helpers, and other allied health professionals. Because the care teams are consistent, they get to know the needs and preferences of the citizens for whom they provide care as well as each other. New employees have a structured onboarding and mentoring program until they become ingrained in the collaborative team-based care delivery model.[56]

Citizens are awarded "packages" of time with the fixed care team based on their level of need. They can then work with their team to build a care plan that matches their needs and wishes. This approach reduces task-based care allocation which allows for more holistic care of the person.[55]



Although not mandated by the *Elderly Act*, fixed care teams have been adopted by most municipalities in Denmark as a functional framework to support the broader mandates of the act. Older citizens are centered in this care delivery model by genuinely engaging them in care decisions. This operationalizes a core aspect of the Elder Care Reform.[12]

Community acute care teams (*akutteam*)



In addition to fixed care teams, Middelfart and other municipalities make use of community acute care teams. These teams can perform many assessments and treatments in citizen's homes that would otherwise be performed in hospitals. They are primarily composed of nurses who have access to advanced field-testing equipment such as point-of-care blood testing as well as the tools to perform advanced treatments such as starting intravenous fluids. Nurses on these teams always have access to citizens' primary care providers and/or on-call resource physicians who can interpret findings and provide a diagnosis and orders for treatments.[15]

These community acute care teams support the community fixed care teams when patients become less stable and require more acute interventions. Often, citizens can be diverted from inpatient hospital treatment through the assessment and interventions that these teams can provide in their homes such as point-of-care blood tests, and intravenous fluids and antibiotics. Approximately 30% of visits from an acute care nurse prevented an acute hospital admission.[15] Furthermore, it was found that citizens that are admitted to hospital require 20-30% more home and community nursing services following a hospital admission, compared to similar cases that are diverted. Additional cost savings were found in fewer general practitioner visits, fewer ambulance trips and lower hospital treatment costs.[15]



At the time of the tour, community acute care teams were under the jurisdiction of the municipalities, however, following the Health Reform, they will move under the jurisdiction of the regions.[11] This means that they will have more connectivity with the regional hospitals, but it does risk their connection to municipal community care services, including fixed care teams.

Model approaches to dementia care and care in LTC homes

Danish long-term care homes provide person-centered care through comfortable, adaptive and supportive environments for citizens. A culture of self-sufficiency and rehabilitation leads to a lower overall need for long-term care homes, therefore LTC residences are a last resort option for those whose needs truly exceed the capacity of a strong community care system.[12]

When citizens do require care in an LTC home, single-occupancy rooms, if not suites, are the norm, as are smaller buildings with fewer residents. A wide variety of operational partnerships allow for municipal funding and oversight of LTC homes while providing a wide variety of options to citizens.[12] Deliberate integration of nature, animals, children and the natural rhythms of life reduce the feelings of institutionalization and build purpose for residents. The relatively small residences and high level of staffing allow for work-life balance for health care providers, the capacity for professional curiosity, and the capability to adapt care to meet the physical psychosocial needs of citizens.

Bakkegården

Bakkegården is a specialized long-term dementia care home in Gladsaxe Municipality in the suburbs of Copenhagen. The home includes 107 units across seven community "houses", which is considered rather large by Danish standards. The residence specializes in the care of typically older citizens living with advanced dementia.[57]

Denmark has a National Dementia Action Plan (*national Demens-handlingsplan* 2025) that promotes the values of dignity, security, autonomy, respect for the individual and their lived experiences, holistic care and meaningful participation in life experiences.[58] This strategy gives citizens living with dementia, their relatives and caregivers the tools they need to remain in their homes and communities for as long as possible. However, given the disease progression of dementia, the care needs of these citizens often exceed the capacity that community supports can provide. Care homes such as Bakkegården provide care for these citizens that upholds the values of the National Dementia Action Plan. Given the acuity of residents at Bakkegården, the environment has been designed for this specialty care. The care provided aligns with the principles of the National Dementia Action Plan.[58]



Dignity

Each resident lives in a single-occupancy suite with their own washroom. They receive the care they need from trained staff, registered nurses, social and health care assistants and other care providers to support their physical needs.



Security

Bakkegården is designed as a community with seven houses on the property with outdoor spaces that are easy and safe for residents to access. All staff that work on the site receive a minimum three-day training course on dementia care, safety and de-escalation. Citizens that are a danger to themselves or others receive an advanced level of care at a facility that is designed to prioritize safety. The ratio of care workers to residents is approximately 1:3-4 although not strictly supported by regulation.

Autonomy

Citizens are supported to maintain choice in their day-to-day life through flexible and adaptable care scheduling. Citizens are afforded free movement throughout the buildings and across the grounds and are not on a locked unit. The home's staff strive for a very low rate of antipsychotic medication use. At the time of the visit only 6.5% (7 of 107) of residents with presumed or diagnosed dementia were being prescribed antipsychotic medications.

In 2024-2025, **24%** of LTC residents in Canada recieved an antipsychotic medication without a diagnosis of phsychosis.[59]

Respect for the individual and holistic care

Special care is taken to understand what the citizen's life was like before arriving at Bakkegården. Care planning is scaffolded around the Tom Kitwood philosophy of person-centered care, which informs every part of individualized care at Bakkegården.[60] Staff are heavily encouraged to be curious to learn about residents and find creative ways to bring "normal" activities into residents' lives.

Meaningful participation in life experiences

Bakkegården is designed to integrate spontaneity to reflect the natural rhythm of life. This includes the incorporation of children, animals and nature into the home. Residents are encouraged to interact with the sheep and birds that are kept on site. It is the combined responsibility of all staff to care for the animals, and residents are encouraged to help as well. Additionally, staff may bring their own pets in to the home, and children and families are welcomed to enjoy the grounds. Nurses and specialist *social pedagogues* (similar to recreation therapists in Canada) are tasked with developing tailored activities that reflect citizens' unique experiences to build a fulfilling life at Bakkegården. There was a workshop outbuilding with space for playing music and engaging in crafts such as woodworking and spinning and weaving yarn. Given proper safety precautions, residents also have access to nature in the form of large gardens and woods, and a stream where they can fish.



OK Fonden Dyruphus

OK Fonden Dyruphus is a small LTC home in the Municipality of Odense. Like Bakkegården, it specializes in dementia care, but unlike Bakkegården, the residence is very small and typical of Danish LTC homes. There are 27 residents in total among three houses with nine residents each.[61]

OK Fonden is an organization that operates private non-profit LTC homes across Denmark. Private long-term care is quite different in Denmark than it is in Canada. OK Fonden's LTC homes are funded by municipalities and are operated on a non-profit basis at the same basic cost to residents as municipally operated homes. They are regulated by the Danish Patient Safety Authority, the same regulatory body that oversees municipally owned and operated LTC homes. Citizens in Denmark that have been referred to a nursing home have free choice to select which LTC home they wish to live in. Because the cost to citizens is approximately equivalent between private, foundation and municipal LTC residences, the selection is genuinely a choice for citizens.[61,62]

Private, non-profit LTC homes such as OK Fonden operate with freedom of their approach to care within strict quality guidelines. At OK Fonden, they operate under the key philosophy that life should be lived all life long. This approach leads them to prioritize meeting the person where they are and adapting the staff's approach to the needs of the citizen. There is a relatively high ratio of staff to residents, which ensures that their intensive approach to care can be executed.[61]

In addition to the use of the Tom Kitwood person-centered care philosophy that is also employed by Bakkegården LTC home,[60] the staff and families of residents at OK Fonden homes in Odense employ the Marte Meo approach to promote wellbeing, positive communication and understanding of the person living with dementia.[63,64] This approach addresses the fact that people living with dementia have reduced capacity to change their behaviour. Employees of the home are taught to see the person beyond the disease and adapt their behaviour to meet the needs of residents. The Marte Meo Method involves recording interactions between the resident and staff or families. The staff or family then watch the footage back to reflect on











the interactions and discover opportunities to improve future interactions to support the care of the person living with dementia., The delegation heard that prior to the implementation of the Marte Meo Method, 40% of residents were being prescribed antipsychotic medications, but after the introduction of the method, on average only 4-5 out of 27 residents who are living with advanced dementia require these medications. The Marte Meo Method is a unique and innovative approach that is possible because it has been implemented in very small residences with ambitious nursing and care staff. Although it may not be widely replicable, the freedom of approach allows these small highly motivated organizations to innovate and meet the needs of citizens.

OK Fonden also hosts cognitive stimulation therapy (CST) groups, which is a therapy to intervene early to slow the progression of dementia. This is offered both to residents and to citizens in the community living with the early stages of dementia. This program supports the Danish value of allowing citizens to stay in their homes for as long as possible.

Like the municipally owned and operated Bakkegården, the OK Fonden home is built with the comfort and safety of residents in mind. Each citizen has a two-room suite with a terrace and access to a safe outdoor area with plenty of space to enjoy nature. All staff receive extensive training on dementia care. Delegates noted that the small and light-filled residence felt much more like a home than many large institutional LTC homes in Canada.

Lysningen

Lysningen is a municipal short-term stay rehabilitation and transitional care center in the Municipality of Odense. It has 63 rooms (all single-occupancy) among four departments organized by the type of care delivered. The rehabilitation center is owned and operated by the municipality and heavily integrated in the municipality's home care services. Eligible citizens can be referred by municipal assessment teams to receive a short-term stay at the facility based on their level of need and rehabilitation potential in each program. There are five main types of stays offered at the facility: 1) assessment, 2) palliative, 3) transitional, 4) rehabilitation, and 5) respite.[16,65]

Lysningen and similar facilities in each municipality across Denmark play an integral role in the rehabilitation of citizens and provide a crucial link between acute care in public hospitals and home and community care. Citizens may be referred to Lysningen from an acute care stay at a hospital or from community care, usually following an acute functional decline and/or while waiting on appropriate housing and community supports. Each stay is organized around defined goals and not intended for extended stays. Early discharge planning with a goal of improved or maintained independence is a core component of all rehabilitative stays. Although quick discharge is important for this facility, it is also important to note that the services provided are flexible enough to fill the gaps between acute care and home care and under certain circumstances may be used for longer stays.[65]

Citizens are assessed for their eligibility and motivation to participate in the rehabilitative programs. They receive 24-hour/day support from an interdisciplinary team of nurses, social and health care assistants, physiotherapists and occupational therapists. Citizens must have a clear potential for rehabilitation and actively participate in the rehabilitation process.[16] The nurses at Lysningen reported that a typical stay is approximately three weeks, including an assessment period.







At the time of the study tour, rehabilitation centers like Lysningen were owned and operated by municipalities, however, following the implementation of the Health Reform, the jurisdiction of these facilities will be moved to the regions. This will increase their alignment with the existing large regional hospitals, but there are concerns that there will be less integration with municipal home care and other community services. This change will, however, remove the daily copayment of $159 DKK (approximately $34 CAD) that covers meals, linens and other incidental costs, and is expected to increase collaboration with physicians.[11, 65]

During the visit, the delegation saw nurses and allied health care providers dedicated to enabling citizens to regain their independence and return to everyday life. The targeted and personalized programming is representative of Denmark's core health value of helping people to help themselves.



> ***The Danish rehabilitation perspective emphasizes supporting citizens in regaining independence and participating in everyday activities and routines.***
>
> **- Maja Gjerløv Nisgaard, Clinical Nurse Specialist, MSc, Lysningen**

Streamlined hospital-based seniors' care

There are five large tertiary university hospitals in Denmark – one in each region. These hospitals are central hubs for specialist care, including trauma and emergency. Regions will also have smaller regional hospitals within health councils closer to citizens' homes. These are typically lower-acuity and accommodate fewer medical specialties.[10] Inpatient hospital care is highly specialized and considered the last resort for the sickest patients. The average length of stay in both acute care hospitals that the delegation visited was less than four days.

The delegation heard that there is virtually no wait time in emergency rooms because a wide variety of acute assessment, monitoring and treatment can be delivered in the community. Furthermore, patients do not self-refer to emergency rooms – they either arrive via ambulance in the case of an emergency, or they can be admitted by their primary care physician or specialist.[10] The delegation heard that citizens experiencing an emergency outside of their general practitioner's regular hours can be triaged by a nurse or doctor over the phone. Triage is strict, and patients are only referred to the emergency room if absolutely necessary. If they are referred to the emergency room, they will be sent to the least crowded hospital and given a time of arrival, which significantly reduces wait times. This system is possible given the high rate of connectivity between citizens and primary care providers who can often divert non-emergency care. Nearly all Danes (upwards of 99.5%) are registered with a primary care provider who allocates patients to the appropriate level of care.[66]

Discharge planning is an integrated aspect of hospital care along with close coordination with municipal care services. Municipalities have a responsibility to provide the necessary supports for citizens to be discharged to community care virtually as soon as it is deemed possible and safe by the hospital care team.[10] This does not, however, absolve the hospital of all responsibility – at the time of the tour the discharging physician would remain responsible for patients 72 hours following discharge, but following the Health Reform, they will be responsible for 96 hours of care after discharge.[11]

If a citizen is discharged to their home, an LTC home or other municipal supportive housing, home care and community acute care teams continue to monitor their progress.[10]



Seniors in Denmark are treated with respect as full citizens of their communities. You can see this respect in the investment in high-quality health care services that are tailored to their needs and preferences.

- Yvette Coffey, President of the Registered Nurses' Union Newfoundland and Labrador (RNUNL)



Rigshospitalet (Copenhagen)

Rigshospitalet is a very large tertiary hospital is Copenhagen with 994 beds and 11,115 employees, including 3,759 registered nursesand 2,277 doctors.[67,68] In addition to serving the Capital Region of Denmark, it also operates as a resource hospital for the Danish territories of Greenland and the Faroe Islands. The hospital optimizes hospital resources to provide high-quality care while limiting lengths of stay and providing outpatient care whenever possible.



Walking through the hospital, it was noticeably quiet with very few alarm bells ringing. The delegation visited the intensive care unit with 20 beds in one of the newer wings of the hospital. All patients on that floor were in single-occupancy rooms, and although not yet the standard, this is increasingly the norm throughout the hospital. In the newer north wing of 209 patient rooms, 196 are single-occupancy with a private bathroom.[69] On this unit, the ratio of nurses to patients is 1:1, and if they are treating a child the ratio is 2:1 (i.e., two nurses for one patient).

Similarly, in the neurological ICU, where most patients are sedated, 14 nurses are on staff for up to 16 patients (one nurse for 1.25 patients), with a slight reduction of 12 nurses on nights (one nurse for 1.3 patients). The normal working week for nurses is 37 hours on average, and overtime is worked sparingly under sustainable conditions – not expected or mandated. Shifts are scheduled four weeks in advance, and nurses can adjust and trade shifts as desired. Many nurses on this unit had been working there for more than 10 years, and several had been there for more than thirty years. Notably, the nurses discussed a hospital policy aimed at retaining more experienced nurses, where after 55 years of age they are no longer required to work night shifts, which they felt would aid retention of experienced nurses. New nurses on the unit receive a dedicated six-week supervised orientation. Additionally, there is a dedicated simulation lab on the floor for all nurses to practice simulated scenarios every two weeks. It comes complete with a full suite of instruments and mannequins to maintain fidelity in practicing and updating skills.



Patient simulation lab

Overall, the nurses that the delegation met reported good working conditions, high job satisfaction, and confidence that they could remain working in that environment for the foreseeable future.

Aarhus University Hospital

AUH is another regionally operated large tertiary teaching hospital in Denmark's second-largest city, Aarhus. The hospital serves a population of 370,000 people and supports approximately 500 of 600 medical specialties available across Denmark. There are 837 beds in somatic care and an additional 274 in psychiatric care. The hospital employs approximately 12,000 people, including 3,931 nurses in somatic care and an additional 681 in psychiatric care. The average length of stay for somatic (not psychiatric) care was 3.0 days in 2025.[70]

The delegation had the opportunity to meet with two nurses practicing in the Department of Geriatrics to learn about the hospital-based resources available to older citizens in the hospital catchment area. The department consists of five different programs throughout the hospital to provide targeted care for older citizens: two geriatric inpatient units with 32 beds in total, a geriatric outpatient clinic, geriatric emergency department team, Hospital-at-Home program and a falls clinic. The Department of Geriatrics provides care to the sickest and most frail older citizens, with over 91% living with moderate or severe frailty. The citizens treated by this team have complex health needs and are often experiencing cognitive or functional decline.[71]



Inpatient geriatric acute unit

The inpatient unit admits approximately 1,600 patients each year, with an average length of stay of under one week (6.7 days) and a 13.6% 30-day acute readmission rate. The department provides interdisciplinary team-based care, including nurses, physicians, physiotherapists and occupational therapists. When a patient is admitted, the team receives an automatically generated electronic admission report from the citizen's community care patient record, and a similar report detailing hospital activities goes back to the community care record when the patient is discharged. Goal setting and discharge planning are integrated into care, with the first discharge planning meeting usually taking place the day after the citizen is admitted. The floor has a dedicated care coordinator who works with the care team, the citizen and their relatives to align goals of care and begin preparation for discharge as soon as possible.[71]







Mobile geriatric acute team

The geriatric acute team is a part of the Department of Geriatrics at Aarhus University Hospital. It is mobile and can assess citizens in their homes or upon admission to the emergency department. Based on patient needs the team can either admit the citizen or initiate Hospital-at-Home services avoiding admission to an inpatient unit. Hospital-at-Home services can include a range of advanced assessments and treatments usually provided in hospitals. Tests can include physical examinations, blood tests, ECG and bladder scans. Treatment at home can include blood transfusions, oxygen therapy, CPAP treatment and oral/IV antibiotics or other fluids. The geriatric acute team is led by a geriatrician, who can order treatments, observation and other care that will be carried out by community care teams. The geriatric acute team assumes responsibility for the patient for a fixed period if they are receiving home care. The provider-in-charge will follow up with municipal health care providers and visit the citizen if the patent's condition deteriorates. Since the inception of this program, AUH has seen a steep decline in the number of hospital admissions to medical wards for citizens 80 years of age and older, compared to the rest of Denmark. This specialized acute care provides a separate pathway, even for high-needs patients, to remain in their homes and avoid the additional costs and disruptions of hospital admissions.[71]

Health care technology

Denmark is a world leader in health care technology innovation, and these technologies are a key element of the Danish health care system. In 1995, the first Danish health care digitalization strategy paved the way for electronic health records across the country.[72]

The Danish government strives to provide their citizens with high-quality care in their own homes and sees technology a key strategy to achieve this. Like Canada, Denmark has a rapidly ageing population and a senior care workforce that is not keeping pace with the demands and acuity of evolving patient demographics. Digitalization of health records and other technologies increase the capacity of health care providers to deliver high-quality services in citizens' homes.[72]

The Health Reform established the framework for the new national organization Digital Health Denmark.[11] The organization centralizes the responsibility of creating and implementing digital health infrastructure and other health technologies. This organization is poised to set standards for data collection and retention to ensure inter-operability between digital systems. The government also sets standards for privacy and security of digital records, data architecture, and information technology supply and contracting.[72]

Denmark is known globally as a key innovator in health and life sciences, including health care technologies. This is a critically important export category for Denmark – in 2020 the health and life sciences sector represented the highest proportion of Danish exports to the US at $7.54 billion USD.[73]



Systematic



The delegation visited with the health technology company Systematic, which is one of the two primary vendors for electronic community health and social care records in Denmark. While Systematic serves Western Denmark (about half of the population), Epic, the other primary vendor, serves the majority of Eastern Denmark. Systematic's representatives discussed that contracts for EMRs (electronic medical records) and all information technology services are awarded in a way that promotes continued competition and encourages innovation between companies, avoiding monopolies and stagnant innovation. This is one of the roles of the new Digital Health Denmark organization.[74]



The Danish health system aims to create a one-citizen-one-journey system for electronic health records. This would ensure that each citizen's health history can follow them to avoid duplication and loss of information. Although there are robust data standards across Denmark, hospitals and home care still use different electronic health record programs that do not transfer data directly. One of Systematic's products, Columna Axon, aims to bridge this gap – providing hospitals with limited access to community health and social care records and vice-versa. This reduces duplication in the system and smooths the journey for patients moving between municipal home care and regional hospital care.[75] In the context of increasingly centralized sub-acute care with the Health Reform, inter-operability of health records between hospitals and municipal care will be of paramount importance.

Other technologies

The delegation saw and heard about several other technologies throughout the tour. With so much technology being embedded in Danish health care and the promise to increase it, a concern was raised by the delegation over the possibility of replacement of trained health care professionals. This concern was always generally met by nurses and health policymakers with the assurance that the technologies are assistive devices to provide a higher quality of care to the increasingly complex population. It is understood that they provide nurses and caregivers more time to spend monitoring and evaluating their patients, planning care, engaging in professional curiosity and attending to patients' psychosocial needs. Innovative technologies are used primarily to improve patient care quality and improve nurse and other care staff workflow – not as a substitution for "warm hands".

With rapidly increasing demand on health care services, especially home care, the Danish government sees health care assistive technologies as opportunities to continue improving health care given the growing demands.[76]

Artificial intelligence (AI) patient surveillance

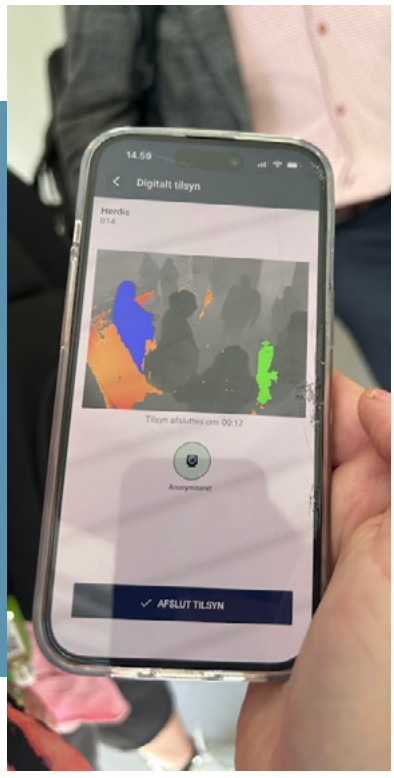
The delegation saw two instances of AI-powered patient surveillance systems.

The first was an in-room video monitoring and app system at Bakkegården nursing home, and the second was an acute care patient monitoring system at Rigshospitalet. For both systems, each patient room is equipped with a special camera that monitors movement and uses artificial intelligence to send alerts to nurses and care providers about changes in movement. The sensitivity of movement detection could be adjusted to avoid false alerts, and the AI interpretation can provide tailored alerts for certain types of movement that require care provider attention.[77,78]

The system for long-term care homes was used to monitor citizens with dementia in their personal rooms at Bakkegården. Staff were equipped with smart phones that had the accompanying app downloaded and connected to all room cameras in the residence. The camera produced a heat map showing the general outline of patients, and different figures appeared as different coloured shapes on the app. Nurses and other authorized staff had access to this information around the clock. Staff reported that they often use the system to check on patients without disturbing them in their rooms and to plan care based on residents' natural sleep/wake cycles. Additionally, it would alert staff of safety concerns such as falls, wandering or prolonged inactivity.[77]

The acute patient monitoring system is designed to monitor critically ill patients in the ICU. On the neurological ICU floor that the delegation visited, patients are sedated most of the time. The primary use for this monitoring system was to alert nurses to patients waking from sedation. Through the use of the AI monitoring system as well as other protocols, the nurses on this floor reported zero use of physical arm and leg restraints for this patient group.[78]





Portable documentation

Handheld computers were used by nurses at the Rigshospitalet hospital in Copenhagen. These are small handheld devices that allow nurses to access the electronic health record system and document their activities.[79] It also allowed them to send secure messages between the care team, receive alerts, scan barcodes to track medication dispensation, take photos to document wound healing, and more. Medications were kept in patient rooms in individually wrapped packages to reduce medication errors and essentially eliminating the need for large medication carts.[79]



In-home medication dispensers

In Middelfart Municipality the delegation heard about the ways in which medication dispensation robots are used to augment municipal home care. These robot dispensers read and distribute medications in individually wrapped cellophane packets to streamline at-home medication dispensation. They remind citizens to take the prescribed medications at the correct time with the goal of eliminating medication errors while reducing the burden of home care nurses. These machines are connected to care providers and can alert when medication has not been taken. The system also allows a citizen to contact support if they have questions.[15]



Virtual reality simulation lab

At the VIA University College registered nursing program, the faculty walked the delegation through one of their options for simulation, a virtual reality dementia simulation. To build empathy and help students to better care for future patients, this technology simulates the difficulties that people with dementia experience. Virtual reality has the capacity to expose students to more in-depth and high-fidelity simulation exercises before experiencing them in real life.[80]

Point-of-care blood testing

A portable rapid-result blood testing device is used by community acute nurses and the mobile geriatric acute team based in Aarhus University Hospital to assess patients' blood chemistry in their homes. This device can provide results for common blood tests such as blood glucose, hemoglobin, infection markers, electrolyte balance and kidney function in 3-5 minutes with a small amount of blood. This allows for a greater capacity for community assessment and treatment of patients. It may also lead to complete diversion from inpatient health care services if treatment can be provided in the community.[81]



As our population ages, people deserve to age where they feel most at home. For many seniors, that means staying in their own homes and communities. Our health care system has a responsibility to honour that choice by making the investments in home and community care needed to support them.

- Darlene Jackson, President of the Manitoba Nurses Union (MNU)







Conclusion

Several transferrable lessons can be learned from the Danish approach to seniors' care and applied to Canada's health systems. The highly integrated, organized and increasingly equitable systems work well together to create a network of services with clear patient pathways and transfer of responsibility.

Strong investment and ongoing funding agreements ensure that there are sufficient resources to provide adequate levels of care to maintain and improve health. This proactive and rehabilitative approach keeps older citizens in their homes for longer, which is both their preference and less costly to the health system. Continuous investment in technology and system innovation nurtures new ideas to address the evolving needs of the population. Bold and forward-thinking reforms for health and, in particular, seniors' care make the system resilient and adaptable to changing needs and capacity.

These same principles can be adapted to bring about long-overdue updates to improve care for older adults living in Canada by creating a reliable and sustainable system that will support seniors and their families well into the future.





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Healthy aging, dignified care:

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