THE ORGANISATION OF DANISH HEALTHCARE

MINISTRY OF FOREIGN AFFAIRS OF DENMARK

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For any questions about the report please contact paramb@um.dk.

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1. INTRODUCTION

The Danish healthcare system has universal coverage and is financed by general taxes. Thus, it provides free and equal access to healthcare for all of its 6.0 million citizens.[1]

As in many other countries, the demographic development in Denmark is putting increasing pressure on the healthcare system, calling for new ways of delivering healthcare services as well as new paradigms for collaboration between actors in the healthcare system.

During the past 15 years, the Danish healthcare system has undergone major changes in the effort to meet these challenges. Focus has been on providing the most value for money. Three enabling strategies have been key: 1) structural transformation, 2) cross-organisational collaboration, and 3) digital transformation. The changes made over the past 15 years have resulted in today's healthcare system, which is able to deliver more and better services at regional and municipal levels, and a system in which preventive healthcare and treatment are integrated better.

This paper presents key characteristics of the Danish healthcare, focusing on its institutional and organisational setup. The paper covers the question of how Denmark has succeeded in creating a collaborative healthcare system which is both decentralised and efficient. Thus, the paper describes:

KEY TO SUCCESS #1.
The organisation and governance of Danish healthcare.

KEY TO SUCCESS #2.
Increased collaboration between organisational levels.

KEY TO SUCCESS #3.
The role played by digitalisation.

Finally, the paper describes selected new initiatives in Danish healthcare, and the paper includes an appendix presenting key quantitative indicators provided for a comparison with France.

The purpose of the paper is to serve as a basis for dialogue and discussion among healthcare officials and decision-makers in European countries who are facing demographic and other challenges comparable to the ones in Denmark. The aim is to contribute to reflections on how to build a resilient and future-proof healthcare system.

2. THE ORGANISATION AND GOVERNANCE OF DANISH HEALTHCARE

A first reform in 2007 centralized planning and regulation, and in 2024 a new reform was introduced to create a more balanced and equitable healthcare system.

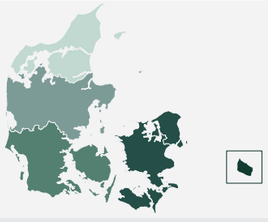
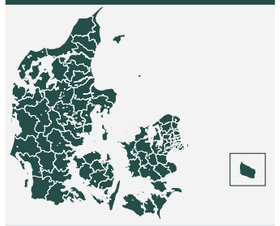
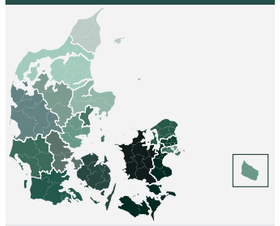
The organisation of the Danish healthcare system

The organisation of the Danish healthcare system has been based on a comprehensive structural reform implemented in 2007. This reform reorganized the Danish healthcare system by reducing the number of municipalities from 271 to 98, replacing 14 dissolved counties with 5 large regions, introducing a new division of responsibilities between the state, regions, and municipalities, and implementing a new financing system.[2]

However, in November 2024 a new health reform was presented by the Danish government. The aim of this reform is to create an even more balanced healthcare system, which is closer to the citizens and which reduces health inequalities.[3] Hence, the 2024-reform also brings changes to the organisation of the Danish healthcare system.

The Danish healthcare sector operates across three political and administrative levels: The state, the regions and the municipalities (national, regional and local levels).[4] Each administrative level has different responsibilities in healthcare, see Figure 1.[5]

Figure 1 Administrative levels and responsibilities from the 2024 reform[6,7]

STATE	4 REGIONS	98 MUNICIPALITIES	17 HEALTH COUNCILS
			
• Legislation • National healthcare policy • The overall framework of the healthcare economy • Specialty planning	• Hospital (somatic and psychiatric, in and outpatient) • Primary healthcare contracts (CP, special practitioners, adult dental services, physiotherapists, psychologists, chiropodist, chiropractor) • Reimbursement of medicine • Rehabilitation at specialized level and advanced retraining • Patient-targeted prevention • Acute specialized nursing care	• Homecare • Rehabilitation services outside the hospital, except services related to rehabilitation at a specialized level and parts of advanced retraining. • Treatment of substance and alcohol abuse • Prevention and health promotion (except patient-targeted prevention) • District nurses • Children's dental services	• Planning and coordination (develop local health plans, strengthen collaboration between regions and municipalities) • Implementation of the Health Reform • Transfer of health responsibilities (the health tasks transferring from municipalities to the regions • Citizen involvement and dialogue • Financing and investment • Organizational structure

NEW REGIONAL ORGANISATION

As part of the 2024 reform, a new organisational change has been introduced at the regional level. The existing five regions are restructured into four, with two out of five regions merging into a new region: 'Region Eastern Denmark'.

Five regions are reorganized into four to improve resource allocation, strengthen physician coverage, and ensure balanced, high-quality healthcare access nationwide.

The decision to merge the two regions on Zealand follows years of attempts to attract physicians to Region Zealand and to strengthen cooperation with the Capital Region—efforts that have not fully resolved the challenges. The creation of the new Region Eastern Denmark aims to make better use of medical capacity across the entire area by bringing all hospitals on Zealand under a single regional authority. Its implementation will make hospitals in the capital area assume greater responsibility for ensuring physician coverage throughout the region. A unified region—with joint employer and leadership responsibility —will improve the ability to allocate resources where they are most needed.

Altogether, the end goal of the new regional organisation is to establish four sustainable regions with a better balance between the population's demand for health services and the healthcare system's resources, thereby ensuring that all citizens have access to a high-quality healthcare system. The restructuring will be finalised and take effect in January 2027.[8]

TRANSFER OF RESPONSIBILITIES FROM LOCAL TO REGIONAL LEVEL

Another key element of the 2024 reform is the transfer of responsibilities from municipalities to regions, set to take effect on January 1, 2027. Regions and municipalities are responsible for delivering all primary and secondary care. Among other things, the municipalities are responsible for delivering healthcare prevention and rehabilitation. The government has by now only defined some areas, where the responsibilities will be transferred from the municipality to the regions. These include:

Several healthcare responsibilities are transfered from municipalities to regions to streamline service delivery and ensure a more coherent and efficient healthcare system.

- Acute specialized nursing
- Patient-targeted prevention
- Specialized rehabilitation and advanced recovery training
- Offer of temporary stays in health and care facilities for individuals requiring medical care

Other responsibilities which will be transferred are not fully defined yet, because the government in order to ensure a smooth transition will conduct a comprehensive review to define the precise scope of the transfer.[9]

The Danish Health Authority will be responsible for developing a proposal outlining additional changes in responsibilities beside the beforementioned. This proposal will be presented to and discussed with the political parties who agreed to the 2024 reform.

The transfer of already agreed-upon tasks from municipalities to regions will proceed as planned, ensuring a structured and efficient implementation of the reform.[10, 11]

The creation of 17 new Health Councils – politically elected bodies with funding and decision-making authority – is to strengthen local governance and coordination across sectors.

ESTABLISHMENT OF 17 HEALTH COUNCILS

Another organisational change introduced by the 2024 reform relates to the political governance structure in the new regions. As part of the reform, the existing 21 health clusters are being replaced by 17 new Health Councils. This shift reflects a recognition that the health clusters failed to deliver the expected results, particularly in driving cross-sectoral change. According to the Structural Commission [12], which provided recommendations for the reform, the clusters lacked authority, binding decision-making power, and dedicated funding. This made it difficult to launch joint initiatives or commit financially across municipalities and regions. In contrast, the new Health Councils will have access to funding and will develop binding local healthcare plans. [13]

The 17 new health councils will consist of elected politicians from both the municipalities and the regions within the geographical area of the health council.[14] They are established with the aim to strengthen local political decision-making, so that health care decisions will be made closer to the citizens and services will be better tailored to local needs. Furthermore, the wish is to strengthen care and monitoring, while also enabling healthcare services to be delivered closer to or within the citizens own homes, thereby improving accessibility and continuity of care.[15]

The Health Councils will oversee the direct management of healthcare responsibilities within their designated geographical areas. This includes the strategic planning and prioritization of healthcare services, the allocation of financial resources for local health initiatives, and the oversight of hospital operations and general medical services. Additionally, the Health Councils will assume responsibility for healthcare tasks transferred from municipalities to the regions, ensuring a seamless transition and integration of services[16]. Furthermore, the Health Councils will play a key role in the development and enhancement of general medical services, including the establishment of new home treatment teams.

Public funding accounts for 85 percent of all health spending and is funded by general taxes.

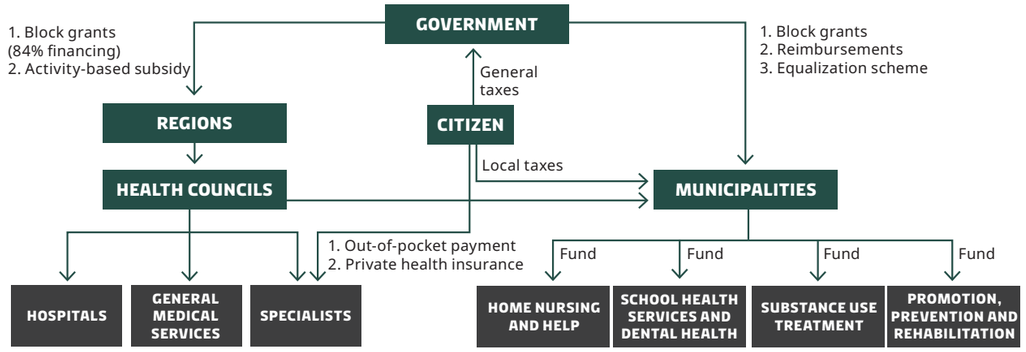
Financing of the Danish healthcare system

In general, healthcare and social services are primarily financed through general taxation at the national level. Hence, public funding accounts for about 85 per cent of all healthcare spending in Denmark (85 per cent in 2021).[17] The remaining share is mainly made up of out-of-pocket payment by households – for example, expenses related to pharmaceuticals, dental care and private insurance premiums fees for supplementary treatments that are not, or only partly, covered by public financing (e.g., physiotherapy and psychological services) or voluntary health insurances.[18]

Public healthcare funding is distributed from the state to the regions through a combination of an annual fixed allocation (block grants) and an activity-based component linked to performance. Municipalities receive funding both through state allocations, and from locally raised taxes, as well as reimbursements for services they provide on behalf of the regions and the state.[19]

The overall financial framework is established through an annual agreement between the government, regions, and municipalities. In this agreement, the

Figure 2 Financing of the Danish healthcare system



parties jointly set objectives for the level of healthcare activity and expenditure for the coming year.[20] This collaborative process creates a shared framework which supports both the commitment and the capacity of all parties to adhere to the agreed budget.[21]

Block grants finance about 84 per cent of the regions' total healthcare spending.[22] With the 2024 reform, it was decided that the municipal co-financing scheme will be abolished from 2027 onwards, when additional responsibilities are transferred from the municipalities to the regions. As a result, the financing of municipalities and regions will be adjusted through block grants and a new equalization model, to be developed in 2028–2029. The aim is to create a simpler and more coherent healthcare system, with a clearer distribution of responsibility for treatment and prevention. A portion of the block grants allocated to the regions will be redistributed to the Health Councils based on a state-determined distribution key that considers differences in demographics and socio-economy across the councils. Within each Health Council, a share of these funds will then be allocated to the municipal level to support the financing of local healthcare responsibilities. Further discussions on these financial changes are scheduled for fall 2025, with the goal of passing the necessary legislation in spring 2026.[23]

While the full details of the 2024 reform's revision to the regional financial models are still being finalized, the updated model builds upon the existing framework and has been adapted to reflect the structural changes introduced by the reform. As part of this revision, block grants to each region will be increased, with particular emphasis on providing additional support to smaller regions.[24]

The block grants consist of a smaller basic amount and two distribution keys:

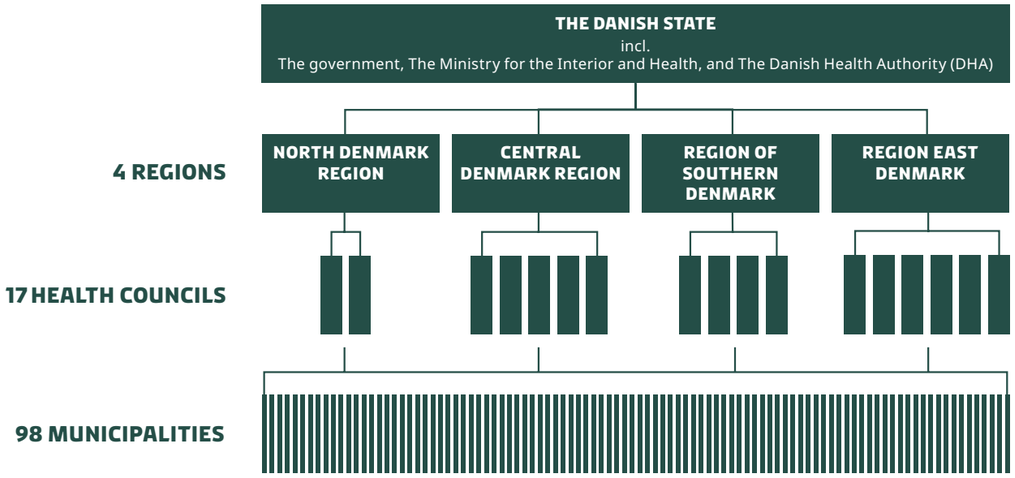
- The first distribution key is based on demographic factors, such as population size and age distribution.
- The second distribution key incorporates a combination of economic, social, geographical, and health-related variables—for example, the number of families receiving unemployment benefits or the number of patients diagnosed with psychiatric conditions.[25, 26]

The block grants consist of a smaller basic amount and two distribution keys: 1) demographic factors and 2) a combination of economic, social, geographical, and health-related variables

The governance of the Danish healthcare system

The political and administrative governance of the Danish healthcare system can overall be illustrated as in the figure below. After the figure, each of the bodies and their respective tasks and responsibilities will be described.

Figure 3 *Political and administrative governance of the Danish healthcare system from the 2024 reform*



The national government is responsible for the overall regulatory, planning and supervisory functions.

The national government, i.e. the Ministry for the Interior and Health, has the overall regulatory responsibility and supervision of healthcare in Denmark.[27]

The Ministry for the Interior and Health prepares the regulatory framework and plans all healthcare services. The national government/Ministry for the Interior and Health of Denmark is responsible for:

1. National planning of specialist services and medical specialists,
2. Approval of regional hospital planning and
3. Mandatory healthcare agreements between regions and municipalities, which coordinate service delivery.[28]

The centralization of these responsibilities aims to ensure high-quality, professional treatment and consistency in patient care pathways, while also ensuring efficient use of resources.[29]

The Danish Health Authority is responsible for initiating and implementing the reform

The Danish Health Authority (DHA), an agency under the Ministry for the Interior and Health, is responsible for advising and supporting the Ministry, as well as the regions and municipalities, on general health matters.

As part of the 2024 reform, the DHA has been assigned several new tasks and mandates thus making DHA is responsible for initiating key reform efforts:

- Preparing expert recommendations for a **new national health plan** - This plan will set the overall strategic direction for the Danish healthcare system over the next 8–10 years. The DHA is scheduled to complete the expert recommendations by the beginning of 2026, with the final national plan set for implementation by 2027 and subsequent updates every four years. The plan will provide a framework for implementing concrete governance tools within the healthcare sector, such as the national clinical guidelines.
- Establishing **national task descriptions for general medical services** – These descriptions will define future tasks and requirements for general practice, outlining the full scope of what general practice is expected to deliver. This includes functions, tasks, required competencies, collaboration with the broader healthcare system, as well as extended and more flexible opening hours and improved accessibility. The goal is to prioritize which services are best delivered in general practice and which should be handled elsewhere.
- Preparing national guidelines and approving the regions' **practice plans for private specialist practitioners**.
- Developing **quality standards for municipal health services**
- Preparing expert recommendations on which **tasks are to be transferred from the municipalities to the regions**
- Developing the clinical framework for the new **chronic disease care packages** (please read Chapter 3 for more information)[30]

As before the 2024 reform, the tasks of the DHA also include developing national clinical guidelines and guidelines for the training of specialist doctors and other healthcare professionals[31], as well as issuing preventive packages targeting the most common health risks and for developing national treatment plans. The national treatment plans and their associated guidelines are implemented by the regions, while the preventive packages serve as tools for municipalities to promote and improve the health of their citizens.[32, 33]

Other responsibilities of the DHA include the regulation of vaccinations and the monitoring of care quality in hospitals and pharmacies.[34, 35] The monitoring of hospital care quality is based on data on selected quality indicators linked to the eight national goals (see Box 1).[36]

Box 1 *The eight national goals for quality monitoring in the health sector* [37]

BOX 1: THE EIGHT NATIONAL GOALS FOR QUALITY MONITORING IN THE HEALTH SECTOR

The quality indicators are part of the Danish Healthcare Quality Program, which consists of eight national goals.

1. Better continuity of patient care in clinical pathways
2. Stronger measures for chronically ill and elderly patients
3. Higher survival rates and improved patient safety
4. High-quality treatment
5. Quick assessment and treatment
6. Greater patient involvement
7. More health equality and additional healthy life years
8. More efficient healthcare system

These goals are developed to ensure that every health professional or service worker in the health sector (in hospitals, municipalities and regions) work in the same direction to secure an effective health care system with high quality of care, and to make it less complicated to foresee areas in need of quality improvement. Thus, the goals are implemented on a local, regional and national level. The regions follow up on the goals every quarter.

Today, the Danish progress on the eight goals is measured through a total of 40 different quality indicators, which mainly focus on hospital care structure, process of care or treatment and the result of care. The latest status report shows that there has been a positive development on 57 per cent of the quality indicators from 2022 to 2023. Among other things, it is worth noticing that Denmark has seen a positive development on all the indicators regarding the goal of enhanced effort for the chronically ill and elderly and high-quality treatment. However, the development of indicators at hospital level may, in early 2022, be directly or indirectly affected by COVID-19 as well as a high level of sick leave among hospital staff.

Regional and municipal actors are systematically and substantially involved in planning and regulation processes before the issuance of new national plans and regulations.

INVOLVEMENT OF DIFFERENT LEVELS IN PLANNING AND REGULATION

While planning and regulation are centralised at the national level, regional and municipal actors are systematically and substantially involved in these processes. As a result, dialogue and coordination among relevant stakeholders take place before the issuance of new national plans and regulations —a practice set to be further strengthened through the introduction of the aforementioned Health Councils. This dialogue also includes relevant professional medical societies and patient organisations. Although this process may at times be time-consuming, it plays a crucial role in ensuring the actual implementation of plans and regulations by regions and municipalities.

To establish a shared political direction for collaboration between regions, municipalities, and the primary sector (GPs), it was decided in the 2007 reform that a health agreement should be developed between these parties every four years. As a result of the 2024 reform and the establishment of the new Health Councils, the current format of the health agreements will be discontinued and appears to be replaced by a new local healthcare plan, to be developed and adopted by each Health Council. Based on national and regional healthcare planning, this plan will outline the transition from hospital-based care towards a strengthened healthcare system close to the citizens, including the local implementation of general medical services.

The local healthcare plans are to be developed following the publication of the new National Health Plan and must align with the regional healthcare plan. Each plan will serve as the framework for the Health Council's work and must set concrete and binding goals aimed at ensuring more equitable, accessible, and cohesive patient care. Additionally, the plan must include a strategy to improve the geographical accessibility of healthcare services.[38] As with the previous health agreements, it is proposed that the local healthcare plans will be valid for four years[39], supporting long-term alignment and shared vision between regions, municipalities, and general practice.

The agreements have served as a political instrument to unite all three levels and provided a framework for collaboration within the healthcare system. Once completed, the political health agreements have been submitted to the Danish Health Authority (DHA).[40, 41, 42]

Through the local healthcare plan, the Health Councils can also establish a framework for closer cooperation between healthcare stakeholders and a flexible and efficient use of the overall capacity.

THE REGIONS AND THE DANISH HOSPITAL STRUCTURE

The regions own and operate both somatic and psychiatric public hospitals, as well as local community mental healthcare centres.[43, 44] The regions are responsible for both primary and secondary healthcare services, which include:

- Hospital care (including emergency care)
- Psychiatric care
- Healthcare services provided by general practitioners (GPs) - all of whom are private practitioners in Denmark
- Healthcare services provided by specialist practitioners (such as rheumatologists, ENT specialist, gynaecologist etc.), and other private practicing healthcare professionals, including physiotherapists and psychologists[45]
- Administration of the drug reimbursement plan, which is based on digital data collected from pharmacies when prescriptions are dispensed.[46]

The regional level is mainly responsible for hospital management and services as well as agreements with self-employed healthcare professionals, and received a few new responsibilities with the 2024 reform.

As part of the 2024 reform, the regions have taken on new responsibilities previously managed by the municipalities. These include:

- Acute specialized nursing care
- Patient-targeted prevention
- Specialized rehabilitation and advanced recovery training
- Temporary stays in health and care facilities for individuals in need of medical care

Regions collaborate by referring patients across regional borders in cases of resource constraints (e.g., lack of available hospital beds) or when specialized treatment is required.[47]

If a region cannot provide diagnostic treatment at a publicly owned hospital within 30 days of a patient's referral, the patient has the right to choose treatment at a private hospital. This right also applies if the region is unable to provide a diagnostic assessment within 30 days, or if treatment for a life-threatening condition is unavailable. The costs are fully covered by public health insurance and are therefore free of charge for the patient.

As part of the 2024 reform, the hospitals' existing 72-hour post-discharge responsibility for treatment care obligation will be extended to 96 hours. This initiative is part of a broader effort to strengthen regional healthcare services and promote more coherent patient care pathways. By increasing hospitals'

responsibility following discharge, the reform aims to improve continuity of care while also providing greater support to general practitioners and municipal healthcare staff.[48]

Initially, the extended 96-hour obligation will apply to selected patient groups—such as elderly patients in emergency departments and individuals receiving psychiatric treatment. The final definition of the included patient groups will be determined through further agreements between the government and relevant stakeholders.

Since 2002, private hospitals in Denmark have been delivering healthcare services financed by the regions. However, these hospitals are relatively small and primarily offer specialized care. As a result, private hospitals accounted for just 1.3 percent of all publicly funded hospital activity in 2022 — a small increase from 1.25 percent in 2017.[49, 50]

The 2007 reform, which merged 14 regions into five, paved the way for a new public hospital structure. This included reducing the number of acute hospitals from 40 to 21, with each hospital serving a population of 200,000 to 400,000 citizens.[51, 52] The goal was to improve both the quality of care through increased specialization and the efficiency of resource use through economies of scale.[53] This structure and the number of emergency hospitals will be retained under the new 2024 reform.[54]

A cornerstone in this strategy is the Super Hospital Program, representing an investment of EUR 6.6 billion (at 2019 prices) in 16 new hospital projects. Of these, six are entirely new modern, state-of-the-art hospitals, while the remainder are expansions of existing hospital facilities.[55] The Super Hospital Program differs from typical hospital construction in Denmark due to the government's central involvement —not only in financing 60 percent of the program, but also in its planning and management, and also because the program has been guided by an Expert Panel established in 2007.[56] The Ministry for the Interior and Health oversees the program primarily to ensure that regions stay within budget and achieve the anticipated efficiency gains.[57]

Currently, a total of 46 hospital construction projects—both large and small—are underway across the regions, including the 16 projects within the Super Hospital Program.[58]

PRIVATE PRACTISING GENERAL PRACTITIONERS AND SPECIALIST PRACTITIONERS

General practitioners act as 'gatekeepers' in the Danish healthcare system.

In addition to private hospitals, other private actors in the healthcare sector include general practitioners (GPs) and specialist practitioners.

Patients generally require a referral from a GP in order to:

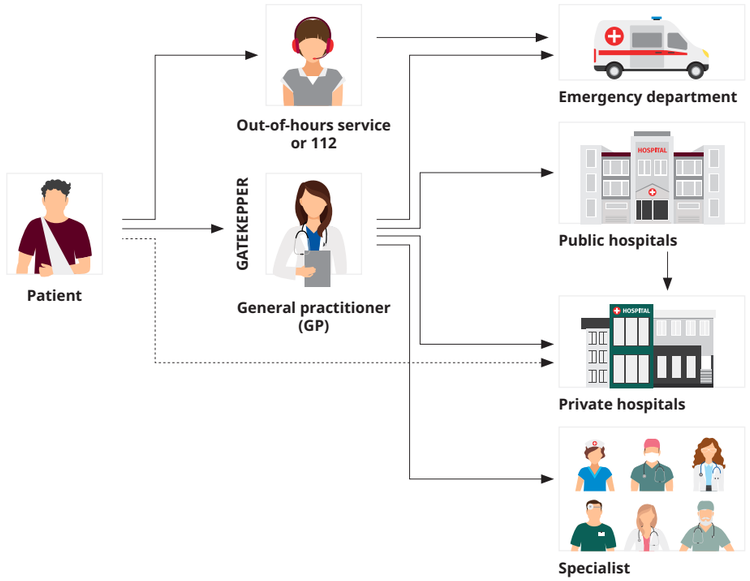
- see a special practitioner
- receive home nursing care
- be admitted to a hospice
- be admitted to a hospital and/or an emergency clinic. However, admission to an emergency clinic is also possible through the medical hotline or via the emergency medical service (112).[59]

Hence, GPs play a key role as 'gatekeepers' between the primary and the secondary levels of care. On average, each GP manages approximately 1,600 patients. Most treatments are handled directly by the GP, without the need for referral to specialized care at the secondary level. This approach helps reduce overall healthcare system costs, as treatment in primary care is generally less expensive than in secondary care.

GPs and special practitioners run their own private businesses. Their fees are invoiced to the regions based on agreed and detailed price schedules and the number of patients attended to.

As part of the 2024 reform, a commitment has been made to strengthening the general practice sector by expanding both its capacity and competence. Hence, the number of GPs will be increased from 3,500 to at least 5,000 by 2035. This expansion is designed to reflect the growing scope of responsibilities, as more healthcare tasks are being reorganized and shifted to general medical services.[60]

Figure 4 *The function of the GPs*



Another measure to reinforce general practice involves providing financial support to geographical areas with limited GP coverage—areas that often have a higher concentration of patients requiring more intensive medical care.[61]

Lastly, the 2024 reform introduces a new fee-for-service structure for GPs, designed to strengthen the general practice sector by aligning compensation with patients' treatment needs. Under this new structure, GPs treating more severely ill patients will receive higher fees per patient and manage fewer patients, compared to GPs treating patients with less serious conditions. This fee structure will allow GPs with a heavy patient load to reduce their number of patients without experiencing a loss of income.[62]

Scheduled for implementation in 2027, the simplified fee structure is also intended to ensure that productivity gains benefit the healthcare system as a whole, while promoting interdisciplinary collaboration and strengthening the cooperation between general practice and the broader healthcare system.[63]

An example of how the relationship between primary and secondary care has continually been monitored and strengthened is the special fee for managing patients with chronic diseases. To incentivize GPs to handle an increasing number of such patients, an agreement introduced in January 2018 allows GPs to charge an additional premium when treating individuals with chronic conditions. This initiative has contributed to keeping patients with chronic diseases out of hospitals—while also benefiting patients, as GPs are typically located closer to the patients than the nearest hospital.

Emergency health-care services play an important role as treatment starts from the moment of their arrival.

OUT-OF-HOURS PRIMARY CARE AND EMERGENCY MEDICAL SERVICES (112)

Out-of-hours primary care (the medical hotline) and the emergency medical service (112) are also administered by the regions.

The **out-of-hours primary care** is provided by specialised nurses and/or GPs, who can refer patients to an emergency room or an after-hours clinic, depending on the patient's situation.[64]

Emergency medical services play a central role in the modernization of the Danish hospital system. Emergency calls (112) are initially received by the police and then forwarded to a healthcare professional, who assesses the need for an ambulance or other pre-hospital services. Paramedics, medical doctors, or specialised nurses may be dispatched to the scene by car or helicopter, ensuring that emergency care begins immediately upon arrival. Treatment is delivered in the ambulance or specially equipped helicopter, meaning that patient care starts at the scene. Most regions collaborate with private contractors for ambulance services, making this a strong example of successful cooperation between private providers and the public healthcare system.[65]

The municipalities have responsibilities within prevention and health promotion.

THE MUNICIPALITIES

With the 2007 reform, the government sought to bring healthcare services closer to citizens by assigning Denmark's 98 municipalities responsibility for facilities and activities aimed at disease prevention and health promotion.[66]

Municipal responsibilities include:

- Pre- and postnatal home visits
- Dental services for children
- School health services
- Physical and mental rehabilitation
- Home nursing care and nursing homes
- Preventive measures targeting common health risks
- Treatments for alcohol or substance abuse, as well as housing support for people with mental disabilities or those experiencing homelessness.[67]

Municipalities that are not prepared to receive a patient upon hospital discharge and provide appropriate home care will incur financial penalties for each additional day the patient remains hospitalized. These penalties were significantly increased in January 2017—from EUR 265 to EUR 530 per day of delay—which has been linked to a reduction in delayed discharges and a decrease in bed-days.[68, 69]

A successful example of a prevention initiative is the case "A Good Start in Life." Despite the existence of a shared pregnancy journal, collaboration between hospitals, municipalities, and general practitioners has been characterised by insufficient information and knowledge sharing among the parties involved. To address this, the initiative—launched in the Southern Region of Denmark—brought together a municipality, a hospital, and general practitioners with the aim of improving joint care for pregnant women and newborns. The approach involved identifying best practices and ensuring their consistent implementation through dialogue and joint training sessions. Furthermore, shared data has been ensured to document the process, enabling effective quality assurance. As a result, the initiative has led to improved overview of available services, enhanced digital communication between general practitioners, midwives, and nurses, and stronger working relationships—allowing future challenges to be resolved more efficiently and collaboratively. The initiative has since been made permanent and is now implemented across all municipalities in the Southern Region of Denmark. Today, the physical maternity record has been replaced by a new national electronic maternity record.[70]

The "A Good Start in Life" initiative exemplifies a successful prevention effort.

3. INCREASED COLLABORATION BETWEEN ORGANISATIONAL LEVELS

The changes to the division of tasks and responsibilities have created new interfaces and increasing demand for sectoral collaboration.

The change to the distribution of tasks and responsibilities between state, regions and municipalities has created new interfaces and placed demands for further collaboration across authority and sector boundaries. The demand is reinforced by the fact that, in the future, the healthcare system will see an increasing pressure due to the ageing population, more patients with chronic illnesses and, not least, the political objective to ensure coherent patient pathways.

This is an area where Denmark has not quite reached its goal yet, but in which new solutions are constantly developing. Increasingly so, in the form of private-public partnerships with the involvement of patients and relatives.

For instance, focus has been on securing close sectoral collaboration in the areas of cancer and heart diseases, since cancer and heart diseases are the two leading causes of death in Denmark.

Denmark has introduced 30 cancer patient pathways to increase and ensure the quality and outcome of treatment.

The Ministry of Health has introduced Cancer Patient Pathways linking GPs, hospitals and specialist diagnostic centres to improve the diagnostic process. When a GP suspects cancer, they can refer patients through one of the clear referral pathways, based on the severity of symptoms.[71] 30 packages cover around 40 different cancer diseases. The packages are issued by authorities at the national level and used at both regional and municipal levels. The packages aim to increase and ensure quality of care and swift clarification of diagnosis and treatment. Each cancer package consists of a standardised description of a patient's treatment pathway from the moment the disease is first suspected to the time of rehabilitation or, in some cases, palliation.

Figure 5 The flow of the cancer packages

Denmark has introduced cardiac rehabilitation programmes to reduce the number of re-admissions.

The packages target specified actors in the healthcare system. They provide a clear distribution of responsibilities and tasks regarding a given patient. The role of each actor is specified as is the required collaboration between actors. Consequently, the packages have contributed to an increase in early detection of diseases, better collaboration between sectors as well as continuity and uniform treatments for cancer patients across the country.[72, 73]

In 2017, the National Board of Health prepared new programme packages outlining the patient pathway for patients with a heart disease. These packages cover the entire treatment flow from the time the patient experiences symptoms and sees their doctor, to assessment and treatment and subsequent follow-up, including cardiac rehabilitation and palliation.[74]

Cardiac rehabilitation is a term covering post-treatment of patients with heart disease and is recommended for patients with ischemic heart disease, heart failure, heart valve surgery and heart rhythm disorder.[75] Cardiac rehabilitation comes with a comprehensive package, which includes:

- Physical exercise
- Patient information and education
- Psychosocial interventions including work retention
- Dietary change support
- Support to quit smoking
- Optimisation of drug treatment
- Clinical follow-up and maintenance of goals.

Cardiac rehabilitation is offered in continuation of diagnostics and treatment and can be carried out exclusively in hospitals and/or in the primary sector or be a shared process between the two.[76]

Chronic disease care packages

As part of the 2024 reform Denmark is now also introducing chronic disease care packages inspired by the cancer packages.

The 2024 reform also introduces the implementation of **chronic disease care packages** - a systematic framework for treating chronic conditions across the healthcare system, similar to the Cancer Patient Pathways described in Chapter 3. These care packages will particularly focus on the initial period following a diagnosis, as this phase is considered crucial for lifelong treatment outcomes. Early intervention leads to better prognoses for future health conditions. Under the chronic care package, a patient is entitled to:

1. **A personalized treatment plan**, developed by the general practitioner in collaboration with the individual patient, within a specified timeframe following the diagnosis.
2. **Initiation of treatment**, which may include starting medication, referrals for further examinations related to comorbidities, and timely access to relevant patient-centered services—such as dietary counseling, physical training, disease management courses, smoking cessation support, and more.

With the new chronic care packages, people with chronic conditions are entitled to a comprehensive package of healthcare interventions tailored to the individual and their varying needs. The specific care pathways and interventions tailored to the individual will be categorized by need, using red, yellow, and green classification system.

This classification system allows care plans to be adjusted according to the patient's situation - for instance, whether the patient is vulnerable requiring intensive, coordinated support across multiple sectors of the healthcare system, or has a well-managed condition and is capable of daily self-care and may benefit from digital services. Based on the red, yellow, green categorization, patients will be offered different intervention packages that reflect both clinical assessments and their personal life context.

Follow-up will be carried out by the patient's general practitioner at intervals agreed upon individually. During the follow-ups, the GP will evaluate whether re-categorization is needed based on any changes in the patient's health status.

Initially, five disease-specific chronic care packages will be developed for the following patient groups:

- Patients with chronic obstructive pulmonary disease (COPD)
- Patients with lower back pain
- Patients with diabetes
- Patients with cardiovascular diseases
- Patients with complex multimorbidity

The implementation of these care packages will be phased in over several years, starting with COPD and lower back pain in 2027, followed by diabetes in 2028, cardiovascular diseases in 2029, and complex multimorbidity in 2031.

The clinical framework for the chronic disease care packages will be developed by the Danish Health Authority, with broad involvement from experts, patient organisations, and other relevant stakeholders. To ensure appropriate oversight - particularly to evaluate whether patients are receiving the right interventions as part of their care pathway - a monitoring system will be established. The monitoring system will encompass both general medical services and patient-targeted preventive initiatives.

Early detection and treatment of complications after hospitalisation for hip fracture through a collaboration between the municipal nurse and the hospital.

EARY DETECTION AND TREATMENT AFTER HIP FRACTURE HOSPITALISATION

A concrete example of how different health professionals cooperate within different organisational levels of the healthcare system in Denmark is the initiative of early detection and treatment of complications in the elderly after a hip fracture hospitalisation. A broken hip of an elderly debilitated citizen can be the start of a long and often fatal process. It is very important that the patient is trained and monitored – even after discharge. The elderly are known to often fall between two chairs, thus an initiative was started as a collaboration between a hospital and two municipalities in the Southern Region of Denmark. The purpose has been to detect and treat complications in the elderly after hospitalisation for a hip fracture. This has been done by having a municipal nurse visit the elderly three days after discharge. The nurse focuses on systematic observation and measurement of vital values. Through a systematic review, the nurse can react when the progress has not been satisfactory. The municipal nurse has been able to contact the hospital doctor responsible for treatment up to 14 days after discharge. The initiative has been carried out as a blind study. The effect was a fall in re-admissions of 50 per cent and a significant reduction in mortality. It has now been made permanent and expanded to several municipalities.

STENO DIABETES CENTRES

An additional example is the five Steno Diabetes Centres that have been established in a public-private partnership between the healthcare authorities and the Novo Nordisk Foundation.[77] The centres are owned and operated by the public health authorities (the regions). The Novo Nordisk Foundation supports the centres with a donation to modernise and systematise the current treatment options for people with diabetes. The donation covers treatment, research, education and cross-sectoral cooperation as well as new buildings. The vision of the centres is to establish the conditions for fewer new cases of diabetes, as well as higher quality of life and longer life for people with diabetes. With the centres, the Novo Nordisk Foundation wants to strengthen the quality of diabetes treatment and improve the prevention of complications, for the benefit of both the individual with diabetes and society.[78]

A public-private partnership between the Danish healthcare system and the Novo Nordisk Foundation has established five Danish Steno Diabetes Centers.

4. THE ROLE PLAYED BY DIGITALISATION

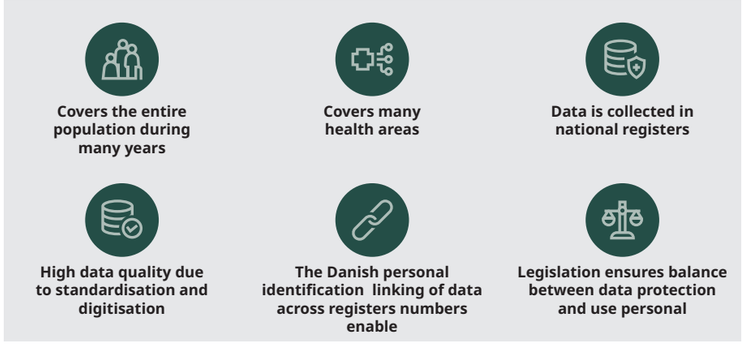
Denmark has been at the forefront for 20 years, and today, the Danish health service is among the most digitalised in the world.

Denmark has prioritised digitalisation for at least 20 years, and today, the Danish healthcare system is among the most digitalised in the world. The foundation was laid more than 50 years ago with the integration of a unique personalised ID number issued at birth to all inhabitants. Later, several other initiatives followed, including national IT strategies and national classifications and terminology.[79] A solid digital infrastructure in the healthcare system and high digital literacy among healthcare providers as well as a culture rooted in trust have also been important factors.[80]

At the same time and in connection with this, Denmark has a long-standing tradition of digital monitoring and registration of patients in contact with the healthcare system. Thus, the healthcare system is characterised by its digital communication between different levels as well as between health professionals, and by digitalised working procedures. Systematic and digital collection of data enables large-scale monitoring and analysis of health data as well as of patients in contact with the healthcare system. Even though health professionals can use different IT systems, they all use the same language and data format. In Denmark, standards for integration between IT systems in the healthcare sector are prepared and maintained by a joint public, nonprofit organisation (MedCom), which is owned jointly by the Ministry of Health, Danish Regions and the National Association of Municipalities. The standards make it possible to communicate between IT systems, including across sectors, and ensure data quality.

Figure 6 illustrates the interconnection of different types of health data as a common platform across healthcare actors at different levels:

Figure 6 Why is our health data unique?



Source: Danish Health Data Authority

IT solutions have not only had a significant positive impact on cross-sectoral collaboration in healthcare (e.g., between GPs and hospitals), but also in improved continuity of care.

The Danish Health Data Authority's comprehensive data programme and existing technology also became a cornerstone in the Danish healthcare response to COVID-19. [81] For example, a vaccination database used to record childhood vaccinations was further developed and used to register the results of SARS-COV-2 field tests. This meant that Denmark was able to get physical solutions on the market extremely fast. At the same time, Denmark was able to develop and evolve our existing infrastructure, booking systems and databases, and rely on existing data security measures. Consequently, Denmark could formulate solutions to any data collection issue without having to spend months developing new systems and could relatively quickly create a strong data infrastructure to accurately record a high influx of COVID-19 test results.[82]

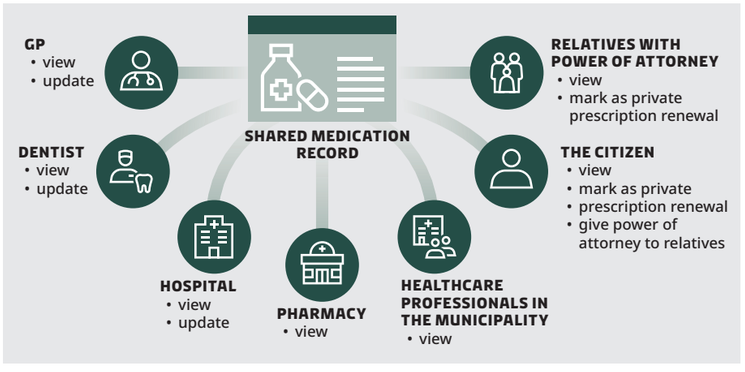
Well-functioning national IT infrastructure and databases made it possible to set up new IT solutions quickly.

IT solutions such as the **Shared Medication Record** and the **Danish e-Health Portal** (sundhed.dk) are highly acclaimed outside Denmark.

The Shared Medication Record gives healthcare professionals access to a complete, up-to-date prescription-medicine overview for the patient across the entire healthcare system. The shared medication record prevents incorrect medications and increases patient safety by ensuring that information about the citizen's current medication is always available to the health personnel treating the citizen – and to the citizen.

The Shared Medication Record contains up-todate information on every Danish citizen, which is shared across all local systems in the healthcare sector.

Figure 7 The Shared Medication Record



Source: Danish Health Data Authority

The Danish E-Health Portal (Sundhed.dk) is the official Danish health website providing access to information for citizens and healthcare professionals. The portal was launched in 2003 as a collaboration between the state, the regions and the municipalities. The purpose of the E-Health Portal is to: a) bring together relevant information from all parts of the health service, b) offer a shared platform of communication, c) empower citizens by offering maximum insight and transparency in the healthcare sector, and d) offer healthcare providers easy access to clinical information about their patients' medical history. Currently, citizens can go to the National Health Record via the Danish E-Health Portal to see their medical records from the hospital, e-journals, medication data, vaccinations, laboratory results, COVID-19 test results as well as a log of when this data has been accessed.[83] This makes sundhed.dk a globally unique e-health portal for citizens and health professionals, and it

is the largest electronic patient portal in Europe with nearly 1.8 million Danes visiting the portal every month.[84]

E-health solutions enable more individualised treatment by empowering patients and involving them in their treatment and are therefore seen as an important tool to be able to meet the challenges posed by the ageing population.

A regional telehealth initiative made large-scale and nationwide after the success.

Denmark has a tradition of testing new healthcare initiatives in a region or municipality before implementing them nationally. A successful example of this is the now national implementation of the telehealth project TeleCare North. The project was first implemented in the North Denmark Region, the smallest of the Danish regions. TeleCare North was an ambitious experiment offered to all patients with COPD. Like other chronically ill, COPD patients are in dialogue with several health professionals: hospital staff, GP, home nurses etc. However, not every health professional has the same information about the patient, the course of the illness or COPD. For this reason, some patients experienced the treatment as fragmented.

The purpose of the TeleCare North project was to establish routines to make collaboration between various health professionals more effective, to establish new communication channels, and to ensure that all health professionals could share information and more treatment in the patient's home without the need for physical meetings. This was done by telemedical home monitoring, where COPD patients were given tablets to register their health information and through which questions could be sent to a health database, which enabled all health staff to monitor patients and answer questions. The project set high demands for openness among health professionals, which were met by all the involved actors because of the benefits for the patients. The project included patients from all 11 municipalities in the North Denmark Region, from hospitals as well as GPs. Thus, the project managed to roll out telehealth support to all 1,256 COPD patients within the region who were able to use telehealth support. The evaluation of the project showed more effective collaboration between levels and health professionals. Because of the big success of the project, it has been decided to implement the initiative nationally. The implementation started in 2021 and is intended to also include other chronically ill patients.

5. NEW INITIATIVES

The Danish healthcare system has undergone major changes and improvements since the reform in 2007 and the implementation of the first national IT strategy, and is today far better positioned for dealing with the challenges related to the demographic development, compared to other European countries.

Still, the growing proportion of elderly as well as a higher life expectancy pose a challenge that needs attention over the following years.[85] The ageing population means an increase in the number of individuals with comorbidity and chronic diseases such as cancer, COPD, diabetes and coronary heart diseases. Additionally, Denmark faces challenges with several health risks such as obesity, tobacco use and alcohol consumption, which contribute to an increase in lifestyle-related diseases.[86] Furthermore, the number of individuals with mental health disorders has been increasing in the Danish population, especially among young individuals.[87] In combination with a rising shortage of healthcare workers, these factors are putting increasing pressure on the healthcare sector in Denmark, both financially and organisationally. Therefore, a focus on strengthening and accelerating the cohesive, collaborative and digital healthcare system will continue in the future years.

Two examples of planned initiatives to address the challenges are reviewed in the following.

Strategy for Life Science towards 2030

In recent years, life science has become an important part of the Danish economy, driving growth and innovation. Supported by strong research, tech expertise, investment, and skilled talent, the sector is shaping the future of prevention, diagnostics, and treatment, while easing pressure on healthcare staff.[89]

To support the growth of the industry the Danish Government launched a new life science strategy in November 2024, including an annual investment of EUR 13.4 million. The strategy introduces new initiatives across six focus areas, based on recommendations from the Danish Life Science Council:[90]

Figure 8 The six focus areas of Denmark's new Life Science strategy

Denmark's 2024 Life Science Strategy invests €13.4 million annually to boost research, innovation, and AI use in healthcare, strengthen public-private partnerships, and enhance the country's position as a global leader in life science growth and medical advancement.

Several of these initiatives are interesting to elaborate on:

Initiative 2 aims to attract more clinical trials to Denmark, improving treatment options for Danish patients. Key actions include:

- Establishing a fourth Medical Research Ethics Committee to ensure phase 1 trials are approved within 14 days.
- Further developing **Trial Nation**, a public-private partnership that serves as a one-stop shop for companies and researchers seeking trial sites and patients. Trial Nation includes the Ministry of Industry, Business, and Financial Affairs, the Ministry of the Interior and Health, the five regions, Danish Patients, Organisation of Danish Medical Societies and more than 20 Danish and foreign life science companies.
- Promoting the use of **AI in healthcare** to support medical decisions, predict complications, perform diagnostics, monitor side effects and automate clinical tasks and research. The area therefore has the potential
- Establishing **a digital task force to make the public sector a world leader in the use of artificial intelligence**. The task force will, among other things, address legal barriers to adopting new technologies. This is to ensure the harnessing of the potential of AI to bring major health benefits, free up labour and cut costs, and hence address the beforementioned challenges.

The robustness of the Danish healthcare system is partly due to strong, trusting and mutually dependent public-private partnership between the healthcare system, research environments and life science companies. To address the beforementioned challenges, **initiative 3** of the new Life science strategy however acknowledges the need for even more innovation in the healthcare sector and for ensuring the dissemination of new and existing healthcare solutions. The government will amongst others:

- Launch a **Health Innovation Index** to track adoption of new technologies and benchmark Denmark internationally.
- Explore the possibility of establishing a **national framework** for impact assessment of digital innovative health solutions.

Another action taken to support the implementation and scaling of innovative, efficient and labour-saving healthcare solutions, is the establishment of two new national bodies; Digital Health Denmark and National Center for Health Innovation. These will be described below.

Digital Health Denmark and the National Center of Health Innovation – an entry point for private actors in the Danish healthcare

As part of the 2024 reform, two new entities are being established within the Danish healthcare sector: (1) Digital Health Denmark and (2) the National Center for Health Innovation. These initiatives will play a central role in developing and disseminating new health solutions and infrastructure across the healthcare system.

DIGITAL HEALTH DENMARK

Digital Health Denmark will be established as a national operational and development organisation, playing a central role in advancing and distributing new healthcare solutions and infrastructure throughout the Danish healthcare system. In close collaboration with the National Center for Health Innovation, it will ensure that both citizens and healthcare professionals have easy and coherent access to essential patient care information. In addition, it will facilitate secure and efficient use of health data for research and innovation, backed by a strengthened shared data infrastructure.[91]

Digital Health Denmark will unify key health IT organisations to streamline health-care operations, improve access to patient information, support research and innovation, and foster a more diverse and competitive supplier market.

By consolidating the resources of the organisations sundhed.dk, MedCom, and the Danish Health Data Authority, it will create a unified entity under joint ownership by municipalities, regions, and the state. As a result, Digital Health Denmark will streamline operations across the healthcare system and strengthen its position in the supplier market, particularly with IT vendors. This structure is to help reduce unintended dependencies on dominant suppliers in the Danish healthcare system and create more opportunities for public tenders that are more accessible to smaller vendors, fostering a more diverse and innovative supplier base.[92]

Digital Health Denmark is expected to be fully operational by 2026. In preparation, the Ministry of the Interior and Health will begin developing a roadmap in 2025, in close cooperation with municipalities and regions, to assess the necessary conditions for expanding the organisation's task portfolio. The first transfer of responsibilities to Digital Health Denmark is anticipated to begin in 2027.[93]

NATIONAL CENTER FOR HEALTH INNOVATION

A core objective of the 2024 healthcare reform is to ensure that healthcare organisations and companies operate within clear, coherent frameworks that support innovation. The National Center for Health Innovation will play a key role in achieving this goal.[94]

The center will focus on identifying, evaluating, and scaling both mature and emerging solutions. It will also guide and support local innovation to ensure that new approaches are implemented nationwide. The center's specific objectives include[95]:

Figure 9 *The objectives of The National Center for Health Innovation*

The new National Center for Health Innovation will act as the one point of contact for private companies to engage with Denmark's public healthcare system, facilitating innovation and accelerating the adoption of effective healthcare solutions.

The center will be established as an independent entity and integrated into Digital Health Denmark by 2026. Its creation will be formalized through legislation and governed under the joint executive leadership of Digital Health Denmark, ensuring a cohesive approach to implementing innovative solutions and advancing digitalization.[96]

Discussions with regional and municipal stakeholders will address the center's portfolio and funding model, including the potential for joint public financing.[97]

As the one point of contact for private stakeholders, the National Center for Health Innovation will serve as a key entryway for private companies wishing to engage with the public healthcare system. While not a direct public-private partnership, the initiative responds to the private sector's call for streamlined access to the public healthcare sector. In this role, the center will facilitate dialogue and foster the promotion of effective, healthcare solutions with a strong business perspective.[98]

APPENDIX A: HEALTH INDICATORS

Demography

Like many other European countries, Denmark is experiencing a growing share of elderly citizens, reflected in the increasing proportion of the population aged 65 and over (cf. Figure 10). This trend is very similar to the demographic development in France.

Figure 10 Share of population over the age of 65[99]

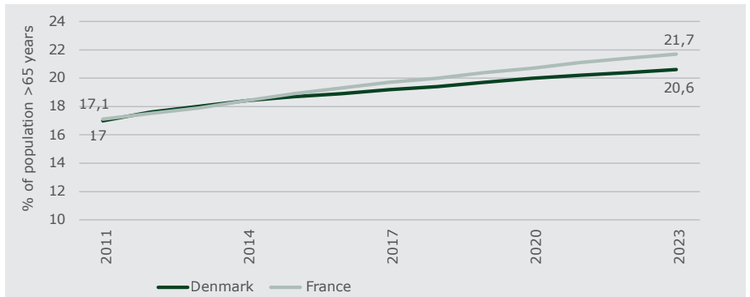
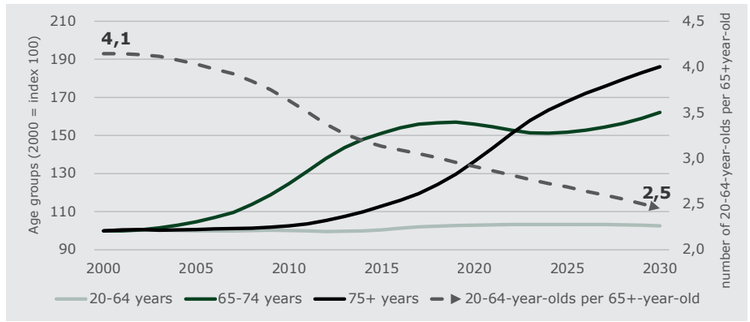


Figure 11 provides a more detailed view of Denmark's demographic trends. While the proportion of the population aged 65 and over is increasing, the share of citizens aged 20–64—who make up the Danish workforce—remains relatively stable. As a result, the ratio of working-age adults to those over 65 is steadily declining, indicating that fewer taxpayers and potential healthcare workers will be available to pay for, support and care for an ageing population.

Figure 11 Demographic development in Denmark – development in tax payers and potential health workers[100]



At the same time, life expectancy at birth in Denmark has risen by five years—from 77 years in 2000 to 82 years in 2023. [101] In comparison, France experienced a four-year increase during the same period, from 79 years to 83 years.[102]

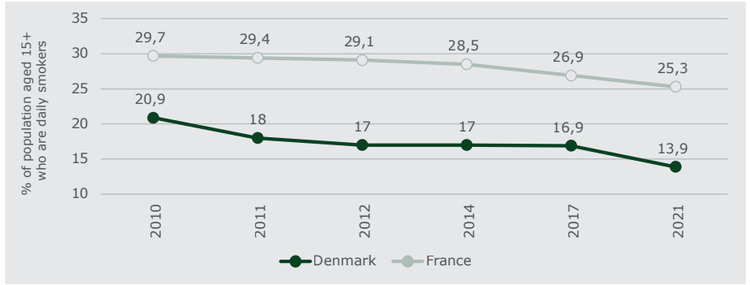
In both countries, women tend to live longer than men. In Denmark, life expectancy in 2023 was 84 years for women and 80 years for men. Similarly, in France, women had a life expectancy of 86 years, compared to 80 years for men. [103]

Health risk factors

Internationally, Denmark is regarded as having a relatively good overall health status. However, several risk factors continue to impact the health status in Denmark —most notably obesity, tobacco use, and alcohol consumption.

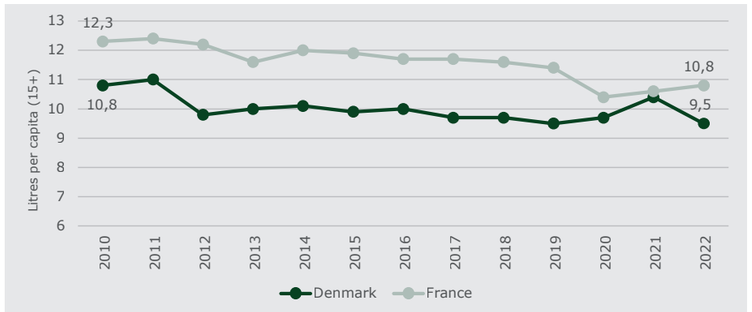
In 2021, approximately 14 percent of Danish adults were daily smokers, a decline from nearly 21 percent in 2010. By contrast, France, which had a similar smoking rate in 2010, has also seen a reduction, but still reported a significantly higher rate of daily smokers in 2021 at 25 percent (cf. Figure 12).

Figure 12 Development in prevalence of daily smokers [104]



In 2022, 16 percent of Danish adults reported regular heavy alcohol consumption, making alcohol use a significant public health concern in Denmark. [105] However, alcohol consumption has declined since 2010. By 2022, the average consumption amounted to 9.5 litres of alcohol per capita (aged 15 and older), which is lower than in France, where the figure was 10.8 litres per capita (cf. Figure 13).

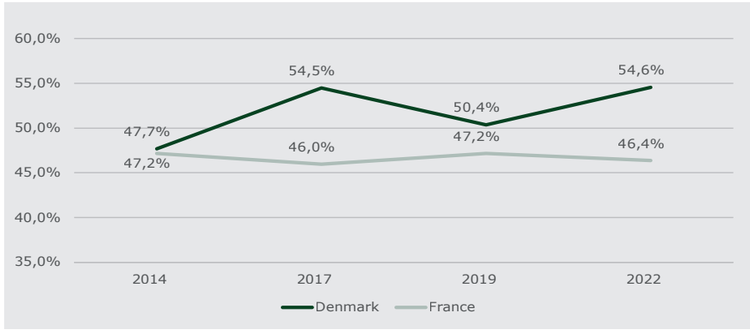
Figure 13 Development in prevalence of alcohol consumption [106]*



** Alcohol consumption is defined as annual sales of pure alcohol in litres per person aged 15 years and older [107]*

In 2022, the obesity rate in Denmark was 54.6 per cent. [108] As in many other countries, the prevalence is increasing—this trend has also been observed in France earlier, but the rate has levelled off in recent years.[109] Denmark's obesity rate remains higher than that of France (cf. Figure 14).

Figure 14 Development in prevalence of obesity (BMI equal or greater than 25)[110]

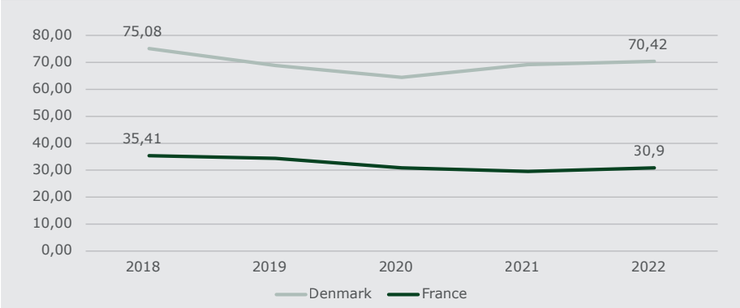


The leading causes of death in Denmark are cancer, as well as cardiovascular and respiratory diseases—all of which are closely linked to the behavioral health risk factors mentioned above. For example, lung cancer remains the most common cause of cancer-related deaths in the Danish population.

A closer look at Denmark's ageing population reveals that nearly half of those over the age of 65 live with at least one chronic disease. At age 65, women can expect to live an additional 21 years and men 18 years—of which approximately 8 and 9 years, respectively, are spent with disability. [111]

Mental health is another important health indicator. Since 2018, the number of deaths from mental and behavioral disorders has decreased in both Denmark and France (cf. Figure 15). The relatively high numbers observed in Denmark compared to France and other European countries may be attributed to differences in registration practices, particularly regarding the documentation of causes of death. Furthermore, in recent years, Denmark has placed increased focus on mental health and on reducing the stigma associated with mental health issues. This heightened awareness and improved openness may have led to more accurate reporting and classification, thereby influencing the national statistics. [112]

Figure 15 Development in standardized death rates per 100,000 due to mental health and behavioural disorders in Denmark and France[113]



Note: Compiled based on death certificates and ICD codes F00-F99

Healthcare expenditure

It appears that the ageing population, the behavioural health risks and the growing challenge of poor mental health post considerable challenges to the health authorities, also cost-driving challenges. The accomplishments in terms of effectiveness and cost-effectiveness of the healthcare system should be seen in relation to these considerable challenges – challenges that are very much like those of other European countries. In some areas (tobacco and alcohol consumption – and accompanying diseases), the Danish society faces bigger challenges than many other countries.

Compared to other European countries, Denmark has a notably low average number of hospital bed days—just five per 1,000 population.[114] This efficiency is largely due to a significant reduction in delayed discharges, meaning patients no longer stay in hospital once acute care is no longer needed. As a result, Denmark also has fewer hospital beds per capita than many other OECD countries, including France (cf. Figure 16).

Additionally, the average length of stay (ALOS) in Danish hospitals is relatively short (cf. Figure 17). Both indicators have declined over the past decade without any measurable drop in care quality [115], suggesting that Denmark's hospital system has become more efficient over time.

Figure 16 Development in number of hospital beds per 1,000 population [116]

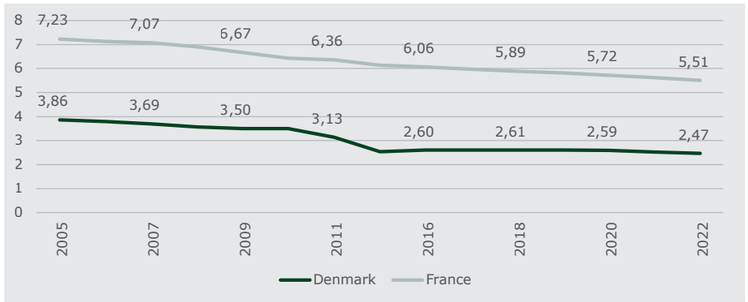
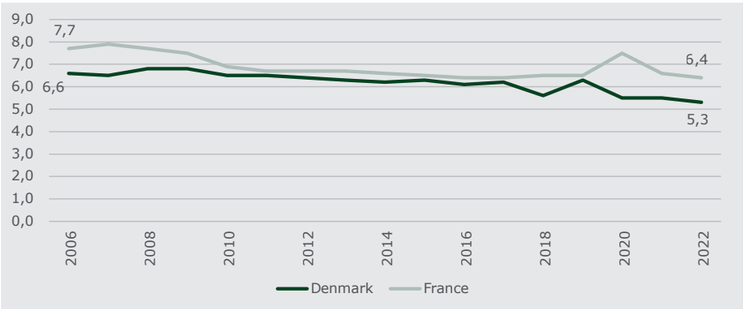
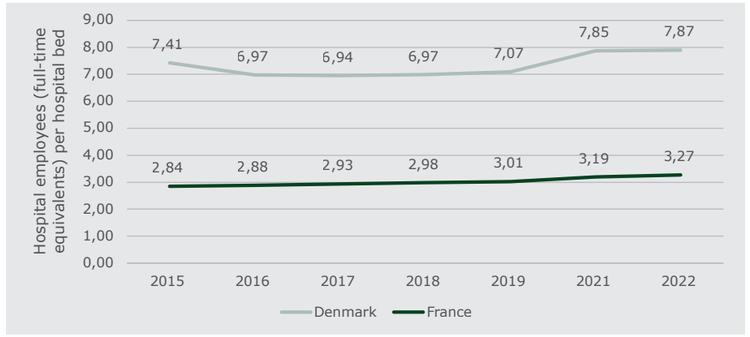


Figure 17 Development in average length of stay (ALOS) [117, 118]



The number of employees in hospitals per bed is on the other hand almost 2.5 times as high in Denmark as in France. In 2022, there were almost 7.9 employees per bed in Denmark against 3.3 in France (cf. Figure 18).

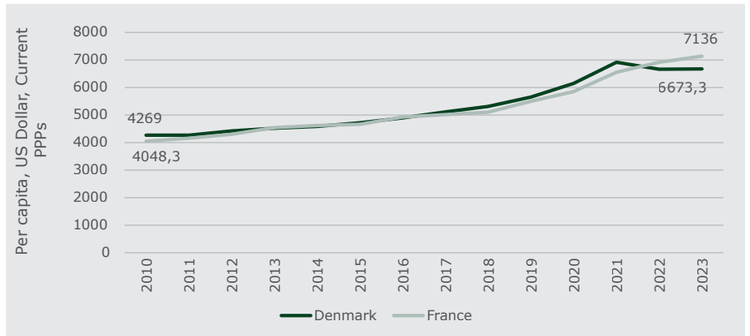
Figure 18 Hospital employees (full-time equivalents) per hospital bed (own calculations based on OECD data[119])



As Danish hospital activity increasingly shifts to outpatient care, traditional metrics such as the number of beds and average length of stay have become less relevant. Consequently, Denmark has updated its definition of a hospital stay. Previously, a bed day was defined by admission to a prescribed hospital bed. Today, the statistics distinguish between inpatient or outpatient hospital stays: an inpatient stay involves a duration of 12 hours or more, while an outpatient stay lasts less than 12 hours.[120] Between 2009 and 2018, the number of somatic outpatient stays in Danish hospitals rose by 40 per cent.[121]

In terms of expenditure, Denmark's per capita health spending reached USD 6,673.3 in 2023 (cf. Figure 19). Health spending accounted for 9.48 per cent of Denmark's GDP in 2022, compared to 11.88 per cent in France.[122, 123] Over the past decade, Denmark's healthcare expenditure has grown at a moderate pace, broadly in line with developments in France. Overall, health spending levels in the two countries remain relatively similar.

Figure 19 Development of cost per capita health spending [124]



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