

Healthcare Denmark

Chronic Diseases

– How Denmark Manages a Defining Health Challenge

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Foreword



Today, around one in five Danes lives with a chronic disease, and this number is expected to grow as people live longer and treatments continue to improve. This requires us to rethink how healthcare is organized and delivered.

Our ambition is twofold as we want to adapt our health system to an ageing population, increasing demand, and workforce shortages, while ensuring that chronic disease has as little impact as possible on people's everyday lives. Our goal is not only to help people live longer with chronic disease, but to enable people to live active, independent, and fulfilling lives.

To achieve this, we are undertaking the most comprehensive healthcare reform in almost two decades. The reform is designed to prepare our health system for the future by strengthening prevention, improving coordination across sectors, and bringing care closer to people's everyday lives.
For people living with chronic disease, the ambition is healthcare that is easier to navigate, more coherent, and better adapted to individual needs. Too many people still experience fragmented pathways, repeated assessments, and a lack of coordination across the health system.

A key element of the reform is therefore the introduction of so-called chronic care packages. Inspired by Denmark's successful cancer pathways, these packages establish clear rights, stronger follow-up, and more personalized care.

Every person living with a chronic disease will have the right to an individual plan, developed together with their general practitioner, who will play an even stronger role in coordinating care across the health system.

At the same time, Denmark is investing in life science to bring research, innovation, and healthcare closer together. Our ambition is to ensure that new treatments, digital health solutions, and health technologies reach patients faster and create value for both individuals and society.

I hope this publication offers valuable insights into Denmark's approach to managing chronic disease and inspires closer international collaboration. Together, we can accelerate better solutions and improve the lives of people living with chronic disease worldwide.

Ida Auken, Minister for Health and Minister for Ecclesiastical Affairs

Introduction: Chronic Diseases – A Defining Health Challenge

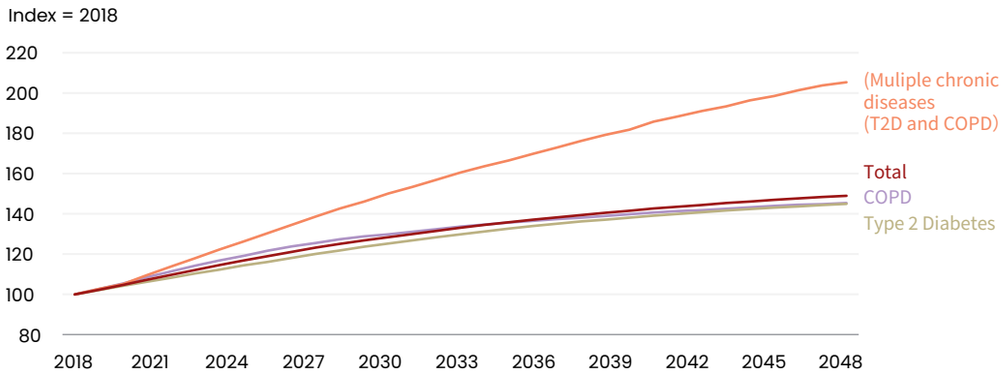
Chronic diseases are among the greatest healthcare challenges facing societies today [1].As people live longer and the population ages, more people will develop one or more chronic diseases. In Denmark, the number of people over 80 years old is expected to increase by almost 40% from 2025 to 2035[2], placing increasing demand on chronic disease management.

Today, at least one in five Danes lives with one or more chronic diseases[3]. The growing number of people who need lasting healthcare, including medical treatment, is increasingly impacting patients, their families, caregivers, the healthcare system, workforce participation, and hence the overall national economy and productivity.

The economic consequences are already substantial. **According to the Danish Chamber of Commerce, as many as 34% of working-age people with chronic diseases are either temporarily or permanently outside the labor market.** This illustrates how chronic diseases not only increase healthcare demand but also reduce workforce participation and economic productivity.[5]

Addressing these challenges requires care that helps people manage their condition, maintain their quality of life and, where possible, remain in the workforce. In Denmark, collaboration across general practice, hospitals and municipal services supports this approach, combining treatment with prevention and support for everyday life.

Projected number of people with selected chronic diseases in Denmark, 2018–2050[4]



> Noncommunicable diseases are one of the defining health challenges of our time, placing increasing pressure on people, communities and health systems. Obesity is a major driver of this growing burden and a leading cause of disability, increasing the risk of type 2 diabetes, cardiovascular disease and cancer.
>
> This is not inevitable. With strong political leadership, bold policy action to create enabling environments, investment in prevention and access to quality care, we can change this trajectory.



Dr. Hans Henri P. Kluge,
WHO Regional Director for Europe

The public sector has invested in specialized hospitals and treatment services, with the 2024 Healthcare Reform[12] prioritizing further investment in general practice and community-based healthcare. This has been complemented by private investment in research, innovation and the development of chronic care – for example, foundations have supported investments in public-private partnerships. The investments have therefore supported not only treatment itself, but also the broader capacity and development of chronic care.[6]

However, the growing number of people living with chronic diseases requires continued innovation, stronger collaboration, and new models of care.

Denmark does not have all the answers and still has unresolved challenges within chronic care.

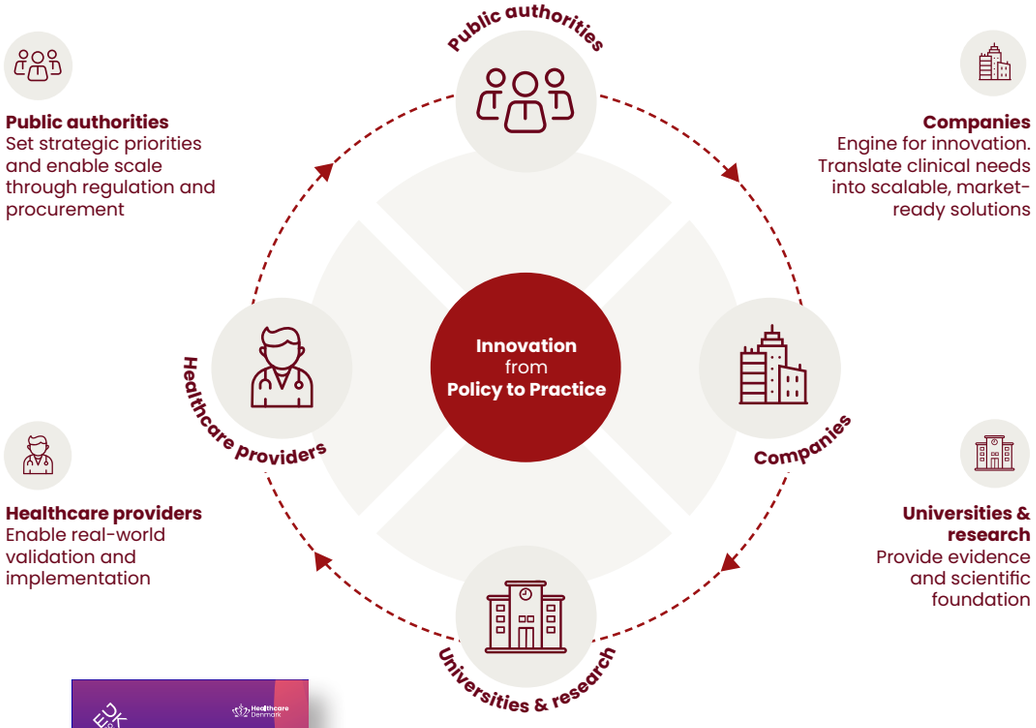
Chronic disease (Noncommunicable diseases)

The term chronic disease is defined as conditions of long duration, generally slow in progression and not passed from person to person.[1]

However, chronic diseases are often closely interconnected. For example, people living with diabetes have an increased risk of developing related conditions such as cardiovascular disease and chronic kidney disease. Early prevention, detection and treatment are therefore essential to managing disease progression, preventing complications and reducing the risk of multimorbidity.[7]

This publication presents Danish experiences and solutions that aim to improve prevention, detection, treatment, and quality of life for people living with chronic diseases. Some of the ideas and solutions presented here are well established, while others are still being tested or implemented. By sharing our experiences we hope this publication will inspire international dialogue, mutual learning, and better solutions for chronic care.

The cases presented in this publication are selected examples of Danish approaches and innovations. They are intended to illustrate different solutions and collaborations within different chronic care areas. Some of the cases are public initiatives, some are private and some are a collaboration between the public and private sector.





Learn more about Public-Private Partnerships in Denmark[8]

Facts About the Danish Healthcare System

1 **Universal, tax-funded healthcare**
Denmark provides universal access to healthcare through a tax-funded system, with care delivered across general practice, hospitals, and municipalities.

2 **Strong primary care**
General practitioners (GPs) are the first point of contact for most patients and play a central role in the prevention, diagnosis, treatment, and long-term management of chronic diseases. Around 90% of patient contacts are managed in general practice without referral to specialist or hospital services.[9]

3 **One of the world's most digitalized healthcare systems**
Denmark has a nationwide digital healthcare infrastructure that enables healthcare professionals across general practice, hospitals, pharmacies and municipalities to securely share relevant patient information, supporting coordinated and continuous care across public and private healthcare providers. For the patient, Denmark's digital healthcare infrastructure enables patients to move seamlessly from consultation to patient support and follow-up care - delivering timelier, more convenient, accessible, and scalable healthcare for all.

4 **Public-private collaboration in Danish healthcare**
Denmark has a long tradition of public-private collaboration in healthcare and life science. Combining public-sector knowledge of patient needs and clinical practice with private-sector expertise, technology, and funding helps develop and implement new solutions. Cases in this publication show how these collaborations can improve prevention, treatment, and long-term chronic care while making better use of healthcare resources. The cases in this publication illustrate different forms of public and private collaboration in practice.

Rethinking Chronic Disease

Structural changes in chronic disease management

One of Denmark's key strategies for responding to population aging and the growing impact of chronic disease is to future-proof the healthcare system through comprehensive reform. Therefore, in 2024, the Danish government launched the most extensive healthcare reform[10] in almost two decades. While Denmark already has a strong healthcare system, the reform is based on the recognition that an aging population and the increasing prevalence of chronic diseases among people in the workforce require a more preventive, coordinated, and long-term approach to healthcare.

By strengthening prevention, improving coordination across sectors, and bringing more care closer to people's everyday lives, the reform aims to create more coherent, personalized, and long-term care while ensuring the long-term sustainability of Denmark's healthcare system as well as economic resilience.

The 2024 healthcare reform reduces the number of regions from five to four, alongside 98 municipalities, and establishes 17 new health councils comprising elected politicians from both regions and municipalities to strengthen coordination across the healthcare system.[12]



How the Healthcare Reform Strengthens Chronic Care[11]

- **Bringing care closer to home:** People with chronic diseases will increasingly **receive care closer to home.** Prevention, rehabilitation, self-management support, telemedicine, and home-based treatment will enable more people to manage their condition while living active and independent lives. Hospitals will increasingly focus on patients with the most specialized and complex needs. From 2027, responsibility for patient-targeted prevention and certain specialized rehabilitation services will transfer to the regions but municipalities will continue to play a key role in health promotion, prevention, rehabilitation, and cross-sector collaboration.

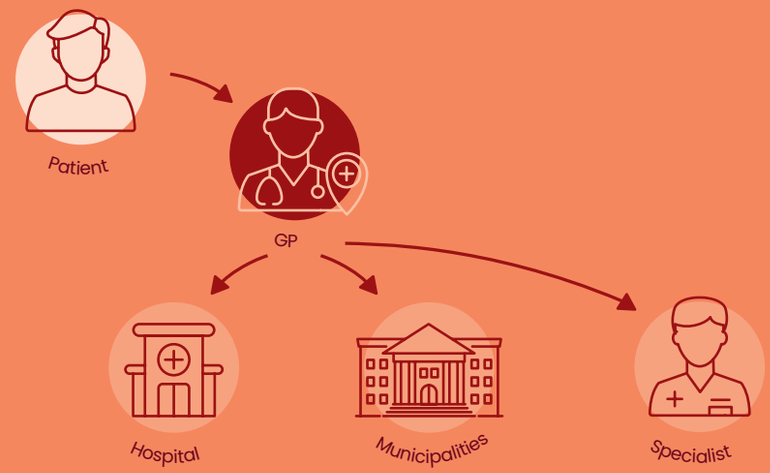
- **Strengthening general practice:** General practitioners will become the central **coordinating hub for chronic care,** working closely with hospitals and municipalities to deliver more personalized, coordinated care closer to patients' everyday lives.

- **Introducing national chronic care packages:** The reform introduces national chronic care packages to ensure more consistent and personalized care across Denmark. Inspired by Denmark's cancer care pathways, the **packages strengthen patient rights by introducing individual treatment plans,** faster access to prevention and rehabilitation services, and follow-up tailored to each patient's needs.

- **Using digital solutions to connect care:** Denmark's nationwide digital health infrastructure makes it possible for hospitals, GPs, municipalities, and patients to work from the same information. A new shared **digital treatment overview** will be implemented to further strengthen coordination and continuity by giving everyone involved access to the patient's care plan.

Co-designing Municipal Rehabilitation

SOLUTION → P. 17



General practitioners as a cornerstone

General practitioners (GPs) are the cornerstone of chronic disease management in Denmark and serve as the patient's main point of contact throughout the care pathway. The 2024 Healthcare Reform will further strengthen this role. From 2027, GPs will take on greater responsibility for coordinating chronic care across hospitals, municipalities, and other healthcare providers, ensuring that care is tailored to each patient's individual needs. To support this transition, Denmark will expand the general practice workforce from approximately **3,500 to 5,000 GPs.**[12]

Specialist hospitals will increasingly support GPs in this task rather than delivering routine chronic care themselves. For example, GPs will have easier access to specialist expertise from hospitals such as the Steno Diabetes Centers when managing patients with complex diabetes in the community, enabling more people with chronic diseases to receive high-quality care closer to home.[10,11]

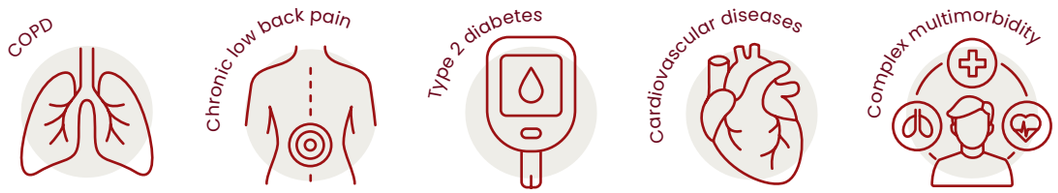
National chronic care packages – a new approach to chronic disease management

One of the central initiatives of Denmark's 2024 Healthcare Reform is the introduction of national chronic care packages. Inspired by Denmark's internationally recognized cancer care pathways, the packages aim to shift chronic disease management from reactive, standardized follow-up to proactive, personalized, and needs-based care.



Chronic Care Packages

The chronic care packages will be introduced gradually, beginning with COPD and chronic low back pain in 2027, followed by type 2 diabetes, cardiovascular disease, and complex multimorbidity in 2029.



Inspired by Denmark's cancer care pathways, the new chronic care packages aim to help people live longer and better lives with chronic disease while preventing deterioration, complications and avoidable hospitalizations.

The packages translate this ambition into coordinated pathways with clearly defined responsibilities across municipal, general practice, hospitals, and rehabilitation services.

They also introduce two new patient rights: access to an individualized treatment plan and timely access to patient-centered prevention services tailored to individual needs.

Patient Journey

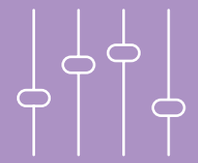


Assessment and personal plan
General practice assesses the patient's health, functional capacity, life situation, resources, and motivation.

Coordinated early support
Relevant treatment, prevention, and rehabilitation services are initiated according to need.

Ongoing needs-based care
The plan will be adjusted over time, supported by a shared digital overview intended to help patients and their GPs follow the care pathway.

Key elements of the **Chronic Care Packages** will include:

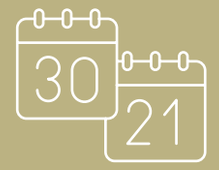


Personalized, needs-based care will be tailored to each patient's individual needs and will replace routine follow-up.



General practitioners as the coordinating hub – ensuring coherent care across hospitals, municipalities, and primary care throughout the patient's journey.





Stronger patient rights – including an individual treatment plan within **30 days** of diagnosis and access to prevention and rehabilitation services within **21 days** of referral.



A shared digital treatment overview – enabling patients and healthcare professionals across sectors to work from the same care plan and support coordinated follow-up.

RETHINKING CHRONIC DISEASE



Solution

Co-designing Municipal Rehabilitation

CURIA is a Danish research and development project that aims to strengthen the ability of people under 65 living with multiple chronic diseases to manage their health and wellbeing in everyday life.

Many people complete rehabilitation or health programs offered by their municipality, but afterwards they often lose support and struggle to maintain healthy habits.

CURIA addresses this challenge by creating stronger links between people living with chronic diseases and local communities. Through the project, citizens, relatives, healthcare professionals, and community organizations work together to develop solutions based on real-life needs and experiences.

In practice, this can help a citizen transition from a municipal rehabilitation program into local community activities. For example, someone who has completed a rehabilitation course may be connected to a local walking group, volunteer network, or social community that helps them stay physically active and socially engaged.

The project draws on knowledge from three Danish municipalities and has led to new ways of supporting health literacy, social participation, and long-term wellbeing for people living with chronic diseases. The co-designed solutions are currently being developed and tested in one municipality.[13]

Solution

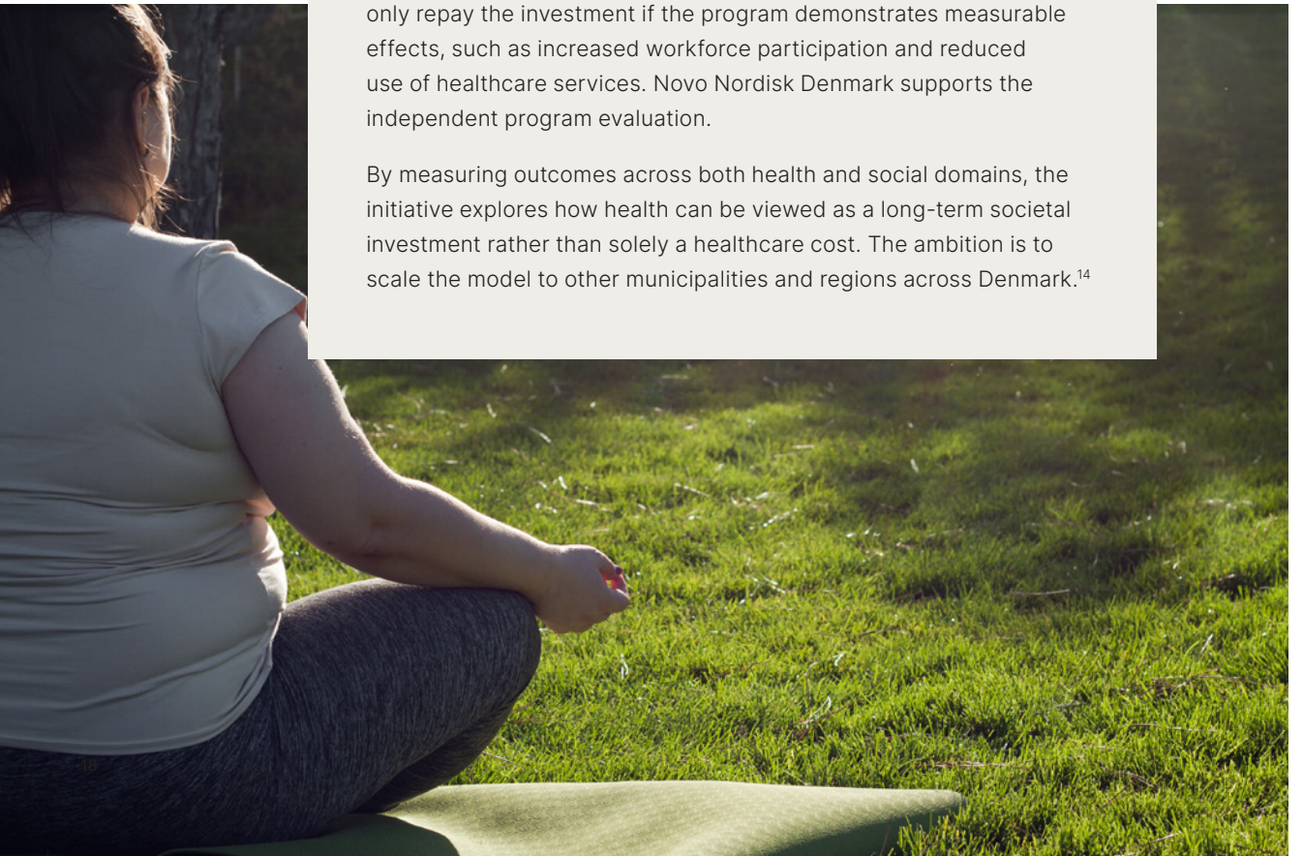
Creating Sustainable Health Solutions for People with Severe Obesity

"A Life in Balance" is a project which explores whether better support for people living with severe obesity can create value beyond health outcomes alone. Alongside improving health and wellbeing, the initiative seeks to strengthen workforce participation and reduce the use of healthcare services, helping more people live healthier, more independent lives.

The program combines clinical care provided by Zealand University Hospital with physical training, health education, and community-based support delivered by Lolland Municipality. Together, these elements create a coordinated pathway that supports citizens in managing their health closer to their everyday lives.

The initiative is financed through a social investment model, with Den Sociale Kapitalfond funding both the clinical and community-based parts of the intervention. Lolland Municipality and Region Zealand only repay the investment if the program demonstrates measurable effects, such as increased workforce participation and reduced use of healthcare services. Novo Nordisk Denmark supports the independent program evaluation.

By measuring outcomes across both health and social domains, the initiative explores how health can be viewed as a long-term societal investment rather than solely a healthcare cost. The ambition is to scale the model to other municipalities and regions across Denmark.[14]



Coordinating Care for People with Multimorbidity

People living with multimorbidity face particularly complex health and care needs, characterized by both high disease and treatment burden. This often requires coordinated care across multiple services.

Denmark is strengthening coordination to better align treatment with each person's needs, everyday life and priorities. From 2029, chronic care packages tailored to individual needs and priorities will be launched.

Solution

A Stepped-Care Approach to Multimorbidity and Polypharmacy

The Clinic for Multimorbidity is part of the Medical Diagnostic Center, University Clinic for Innovative Patient Pathways at the Regional Hospital Central Jutland and a regional, cross-hospital collaboration with the Department of Clinical Pharmacology at Aarhus University Hospital.

Its holistic, person-centered stepped-care model offers specialized, cross-disciplinary support or outpatient services for complex multimorbidity and polypharmacy, tailored to the patient and referring general practitioner (GP).

The stepped-care model includes a pathway for less complex patients with polypharmacy, providing a comprehensive medication review and adjustments conducted by a specialist in Clinical Pharmacology.

For the most complex patients, a multidisciplinary pathway combines specialist assessments, a comprehensive medication review by a pharmacist and clinical pharmacologist, and a functional assessment by occupational and physical therapists. The patient meets the responsible physician before and after a multidisciplinary team (MDT) conference. The MDT conference involves relevant specialists, therapists, pharmacist, clinical pharmacologist, and optionally the GP. A joint treatment plan agreed with the patient includes relevant supplementary diagnostic investigations when indicated, medication adjustments, support for rehabilitation or civil society involvement in the primary sector among other tailored interventions.

Ongoing research is investigating both the implementation and effectiveness of the clinic's services. Patients, whose skepticism reflects previous experiences navigating healthcare services, describe involvement, care coordination, and explanations of clinical reasoning as vital.[15]



Solution

A Regional Plan for people living with Chronic Neurological Conditions

People living with chronic neurological conditions often require long-term treatment and support from hospitals, specialist practitioners, general practitioners and municipal services. Coordinated planning across sectors, healthcare professionals and caregivers can help ensure earlier diagnosis, consistent treatment, care and rehabilitation and greater continuity for patients and their families.

In 2025, the Region of Southern Denmark adopted Denmark's first regional brain health plan. Developed with input from municipalities, patient organizations and healthcare professionals from many specialties, the plan includes more than 30 initiatives covering dementia, epilepsy, multiple sclerosis, headache, Parkinson's disease, and rehabilitation following concussion.

The initiatives aim to strengthen capacity, accelerate diagnosis and provide more coordinated treatment, care and rehabilitation closer to patients' everyday lives. They include stronger collaboration with general practitioners and municipalities, improved rehabilitation and home monitoring for people with epilepsy and Parkinson's disease. The region has allocated DKK 13.7 million in 2026–2027 and DKK 14.4 million from 2028 onwards, with approximately half dedicated to dementia care. A broadly composed steering committee is monitoring progress and incorporating new ideas from patients and the healthcare system.[16]

Supporting People Living with Neurological Conditions

In Denmark, care for people with chronic neurological conditions, including dementia, spans general practice, hospital specialists and municipal care services. This makes coordination essential as people's treatment and support needs change over time.

The 2024 Healthcare Reform aims to strengthen care closer to home and improve continuity across services.

Reflecting this direction, national recommendations published in 2025 envisage a greater role for general practice in dementia diagnosis and treatment, supported by hospital specialists. Regional planning and person-centered dementia care illustrate complementary approaches to supporting people's everyday functioning and quality of life.

Solution

Supporting People with Dementia from Diagnosis to Everyday Life

In Aarhus, hospital-based dementia assessment and treatment are complemented by municipal support for everyday life. Aarhus University Hospital provides specialist diagnosis, identifies treatment options and offers outpatient follow-up when medication is prescribed.

Following diagnosis, residents can be connected with a municipal dementia coordinator who guides individuals and their relatives through available services as care needs change

At Demenshjørnet, people with early-stage dementia can take part in physical and cognitive training. Anyone affected by dementia can also access advice through an open-door approach. Relatives can speak with a psychologist, join support groups and receive referrals for legal advice. Families can receive help with planning ahead so that the person's preferences guide their future care.

As the condition progresses, the municipality can also provide respite support at home and short-term respite stays, with activities tailored to the individual. The aim is to support quality of life for both the person with dementia and their relatives.[17]

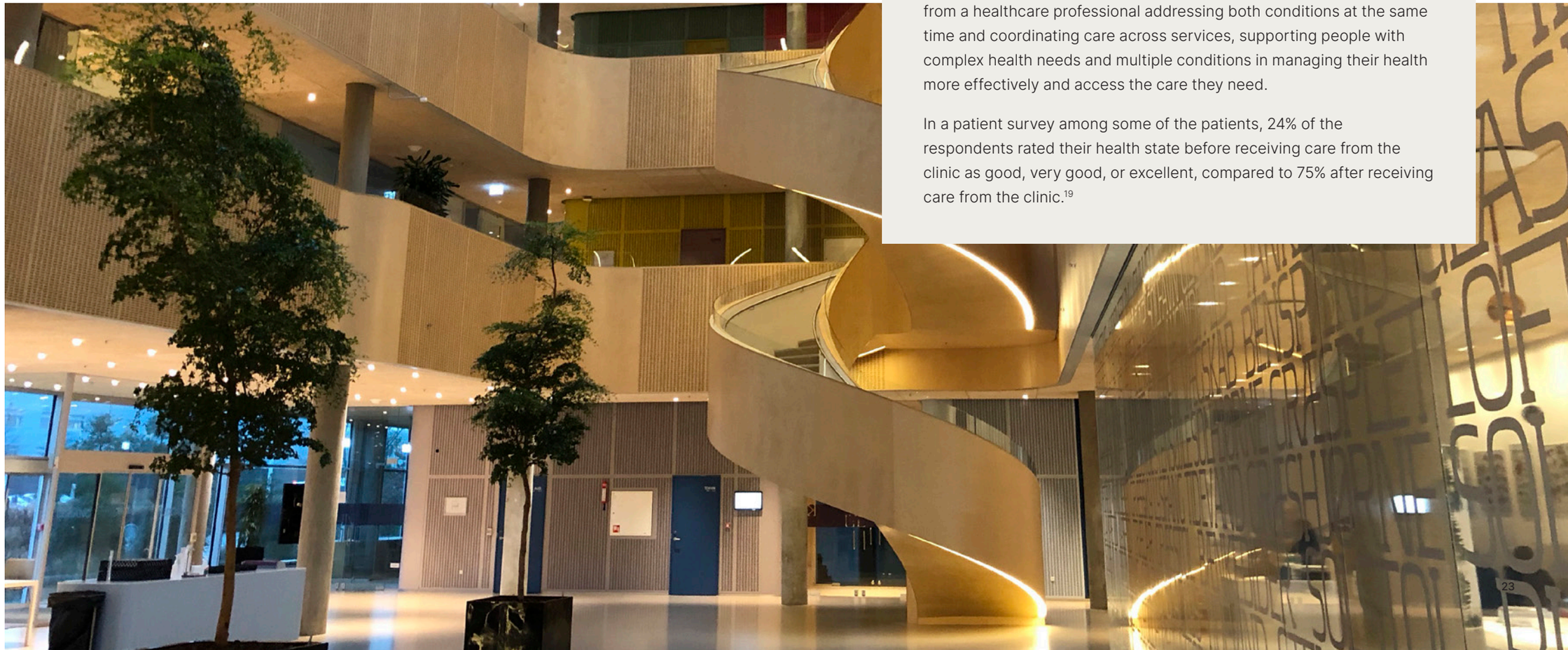


Integrating Physical and Mental Healthcare

Mental and physical illnesses often occur together, creating complex treatment needs. When care is organized separately, patients may face fragmented pathways and insufficient coordination between healthcare professionals.

As part of the 2024 Healthcare Reform, Denmark is integrating psychiatric and somatic services at regional and hospital levels. Organizational and management integration is being implemented across the regions, with a national deadline of January 2027.[18]

The aim is to support earlier detection of coexisting illnesses and more coordinated treatment that considers the patient's overall needs. The organizational changes are intended to strengthen collaboration across specialties.



Solution

Coordinated Care for Patients with Severe Mental Health Illness and Chronic Disease

People living with both severe mental illness and diabetes face a significantly higher risk of diabetes-related complications, poorer quality of life, and premature death than those with diabetes alone.

To better support people living with both severe mental illness and diabetes, the Fusion Clinic in Region Zealand brings care together in one coordinated service. The clinic provides personalised and flexible treatment, including health assessments, medication management, counseling, and support to help patients better understand and manage their conditions.

Care is delivered primarily in the patient's own home by a multidisciplinary team that includes nurses, psychiatrists, diabetes specialists, social workers, and dietitians. The patient receives a visit from a healthcare professional addressing both conditions at the same time and coordinating care across services, supporting people with complex health needs and multiple conditions in managing their health more effectively and access the care they need.

In a patient survey among some of the patients, 24% of the respondents rated their health state before receiving care from the clinic as good, very good, or excellent, compared to 75% after receiving care from the clinic.[19]

Bringing Chronic Care Closer to Home

Bringing Treatment Closer to Home

In Denmark, care for people living with chronic diseases extends beyond hospitals to general practice, community pharmacies and people's own homes.

Home-based treatment, accessible medication advice and follow-up tailored to individual needs can make care easier to fit into everyday life and reduce unnecessary hospital visits.

These approaches require clear guidance and coordination between healthcare professionals, with support adapted to each person's needs and ability to manage their treatment.

Solution

Making Allergy Care More Accessible while Reducing Costs

Allergic conditions affect over a million people and can significantly impact quality of life, school attendance, and productivity. As respiratory allergies often require long-term management, improving access to treatment and supporting patient self-management are important priorities for both patients and healthcare systems.

ALK contributes to this approach by supporting home-based treatment options for eligible patients with respiratory allergies, reducing the need for repeated clinic visits. A Danish study estimated that this home-based treatment approach reduced total treatment costs by 37% over three years, while achieving comparable clinical outcomes[20].

At the same time, digital allergy management tools can further support patients by helping them monitor symptoms and prepare for consultations with healthcare professionals, contributing to more informed dialogue and earlier intervention when needed.

Together, home-based treatment and digital support illustrate how innovative approaches can improve access to care and support more patient-centered management of chronic allergic conditions. Patients benefit from fewer clinic visits and less disruption to daily life, while healthcare systems can reduce resource use and improve efficiency.





Solution

Pharmacies Providing Free Support to People with Chronic Disease

Around half of all medication users do not take their medication as intended[21]. In Denmark, pharmacies therefore offer free medication consultations to people living with chronic diseases. The service helps patients understand their medication, use it correctly and feel more confident managing their treatment in everyday life.

The consultation is available for people who:

- were diagnosed with a chronic disease within the past six months and have started medication; or
- have been receiving medication for a chronic disease for more than six months but experience difficulties following their treatment.

By providing accessible guidance close to where people live, pharmacies can help improve medication adherence and support safer and more effective long-term treatment.[22]

Bringing Care into the Home

For people living with chronic diseases, care at home can reduce the burden of hospital visits and make treatment easier to fit into everyday life. Home monitoring helps healthcare professionals identify changes and respond when support is needed.

For selected patients, hospital-level assessment and treatment can also be provided safely at home. Both approaches bring care closer while maintaining access to professional support.

Solution

Coordinated Home Monitoring for People with Heart Failure

In the North Denmark Region, TeleCare Nord brings heart failure care closer to patients through home monitoring and coordinated follow-up involving hospitals, municipalities, and general practitioners.

Patients receive equipment and guidance to measure their weight, blood pressure, and pulse at home and answer questions about their symptoms. Measurements are shared digitally with healthcare professionals in the municipality or hospital. If changes suggest that the patient's condition is worsening, staff contact the patient to assess whether treatment adjustments or additional support are needed.

The service combines monitoring with patient education, helping people understand their condition and take a more active role in everyday care. General practitioners or hospital doctors can refer eligible patients, while follow-up is organized according to their needs.

Now supported by the Telma platform, TeleCare Nord illustrates how shared digital infrastructure can be translated into practical, coordinated care for people living with heart failure.[23]

Solution

Hospital at Home - A New Model for Integrated Home-Based Care

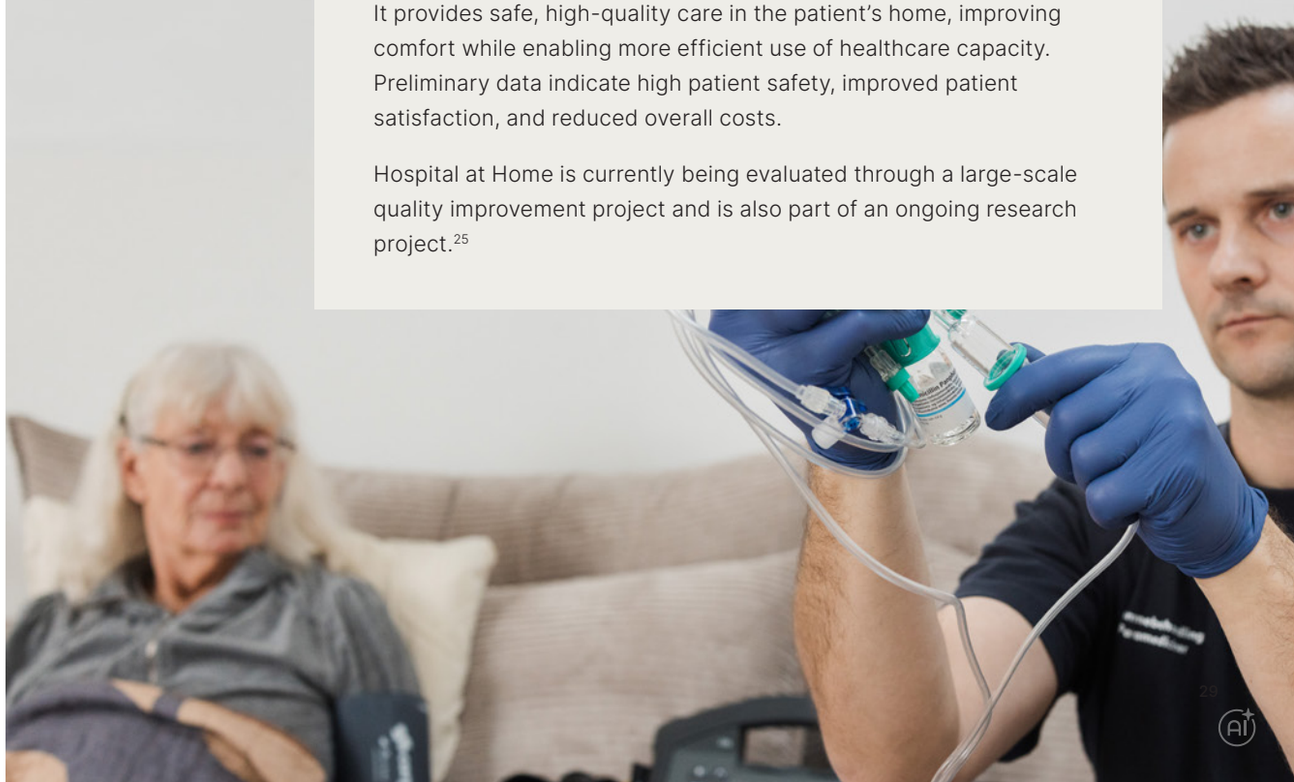
Hospital at Home brings hospital-level diagnosis and treatment directly into the patient's home. Many infections can be managed safely at home, and the model enables patients with suspected infections to receive clinical assessment, diagnostic testing, video consultations, and medication delivery without hospital admission.

This is particularly valuable for people living with chronic diseases and multimorbidity, who often receive care across multiple settings and are more vulnerable to complications associated with hospital admissions.[24] By shifting assessment, diagnostics and care to the home, the model reduces the challenge of frequent hospital visits and supports more continuous care. Nearly 50% of patients who would otherwise have been admitted are now treated safely at home.

Developed through a collaboration between Copenhagen University Hospital Herlev-Gentofte and Falck, Hospital at Home demonstrates how combining public clinical expertise with private operational strength can make care for people with chronic diseases more accessible, efficient, and patient-centered.

It provides safe, high-quality care in the patient's home, improving comfort while enabling more efficient use of healthcare capacity. Preliminary data indicate high patient safety, improved patient satisfaction, and reduced overall costs.

Hospital at Home is currently being evaluated through a large-scale quality improvement project and is also part of an ongoing research project.[25]



Digital Transformation of Chronic Care

Digital Transformation of Chronic Care

The 2024 Healthcare Reform builds on Denmark's nationwide digital health infrastructure to strengthen coordination and continuity of care. By enabling healthcare professionals across sectors to work from the same information, digital solutions support more coherent patient pathways and enable patients to have a better overview of their healthcare.

Data, trust and infrastructure

Denmark's digital healthcare system is built on strong public governance structure, shared digital infrastructure, and a high level of public trust. This enables healthcare professionals to securely access and share relevant patient information across different parts of the healthcare system while protecting privacy and patient safety.

As a result, information follows the patient across hospitals, general practitioners, and municipal health services. This helps healthcare professionals gain a more complete overview of a patient's health, avoid duplication, and coordinate care more effectively. This is particularly important for people living with chronic diseases, who often receive care from many different providers including both public and private healthcare providers.

Beyond sharing information, digital solutions can support home monitoring and follow-up tailored to individual needs. This helps healthcare professionals respond earlier to changes in a patient's condition and focus resources on those who need additional support.



Digital Pathways from Consultation to Treatment and Follow-up Care

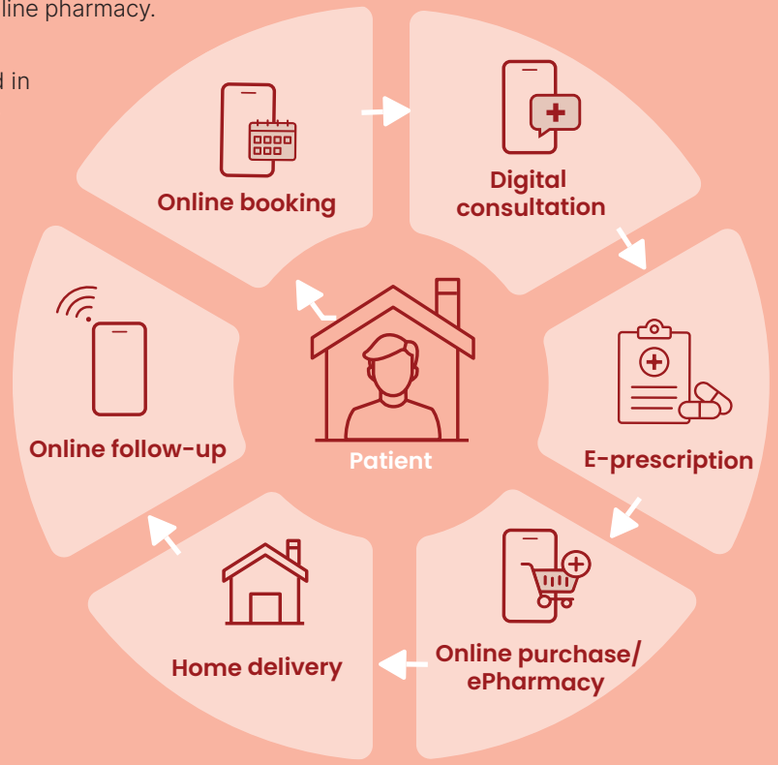
Denmark's digital healthcare infrastructure enables patients to move seamlessly from consultation to patient support and follow-up care - often without requiring a physical visit to the GP or hospital. This is particularly valuable for people living with chronic diseases, who often require ongoing treatment, medication, and regular follow-up.

Patients can book and attend mail or video consultations directly with their general practitioner (GP) through a secure system in the My Doctor (Min Læge) app. From the consultation, a prescription for medicine can be issued digitally and the patient can redeem it through a physical or online pharmacy.

All medication prescribed in Denmark is automatically registered in the national Shared Medication Record (Fælles Medicinkort, FMK).

The system is a nationwide digital infrastructure developed and operated by the Danish Health Data Authority and used across the healthcare sector to ensure that healthcare professionals have access to updated medication information across sectors. This allows pharmacies across Denmark to access and dispense medicines.

The Danish Medicines Agency authorizes pharmacies that sell medicines online and through apps, ensuring that online pharmacies comply with the same regulatory requirements as physical pharmacies.





As a result, both over-the-counter and prescription medicines in Denmark can be obtained either at physical pharmacies or through licensed digital pharmacies offering online or app-ordering and home delivery.

The combination of national digital infrastructure, strong regulatory oversight, and coordinated public governance enables safe and efficient digital pathways from consultation to treatment across the Danish healthcare system.

For people living with chronic diseases, digital and online care models can provide greater convenience, choice, and flexibility, while expanding access to care and enabling the healthcare system to support more patients without placing the same demands on physical healthcare capacity.



Want to learn more about how Denmark has created a secure digital healthcare and data-sharing platform for both patients and healthcare providers?

Read more here.[26]

> By combining digital innovation with robust regulation and oversight, Denmark has created a framework that enables secure digital access to healthcare services, medicines, and medical devices. Strong public governance and regulatory oversight ensure that CE marked digital solutions meet the same high standards of safety and quality as traditional healthcare services.

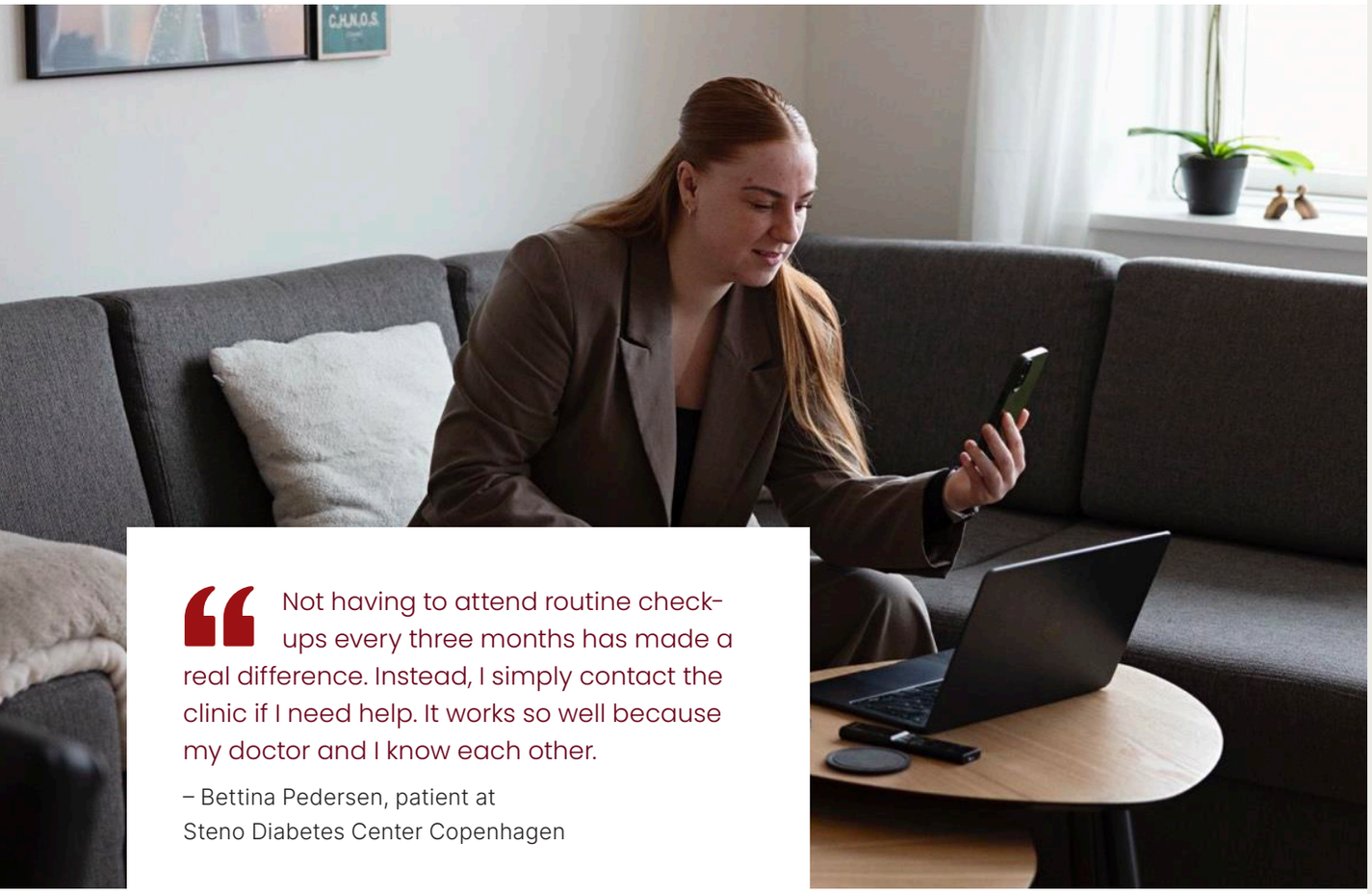


Nils Falk Bjerregaard,
Director General,
Danish Medicines Agency

For people living with chronic disease, this can make treatment more accessible and easier to integrate into everyday life, for example by enabling patients to order medicines online safely through licensed pharmacies, with home delivery available on a day-to-day basis and through better diagnostics applicable in the patient's own home. For some patients, digital access can also provide greater privacy and might help reduce barriers associated with stigma when seeking treatment.

From Routine Follow-up to Personalized Needs-based Care

Instead of asking all patients to attend routine check-ups, digital solutions make it possible to tailor follow-up to each person's needs. This helps healthcare professionals focus on the patients who need support the most, while reducing unnecessary hospital visits for others.



> "Not having to attend routine check-ups every three months has made a real difference. Instead, I simply contact the clinic if I need help. It works so well because my doctor and I know each other.
>
> – Bettina Pedersen, patient at Steno Diabetes Center Copenhagen

DIGITAL TRANSFORMATION OF CHRONIC CARE

Solution

Driving Innovation in Future Outpatient Care

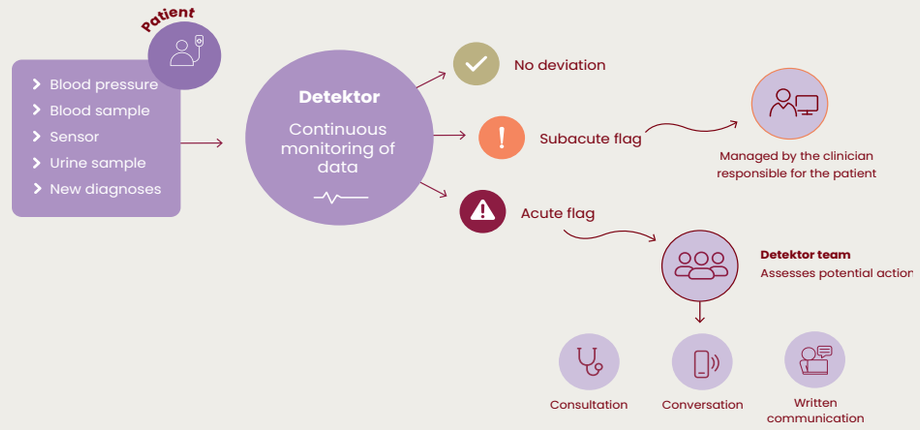
Steno Diabetes Center Copenhagen acts as a development and innovation hospital, translating clinical insight, data and digital solutions into new models of care with relevance far beyond diabetes. At the core is a shift from routine-based follow-ups to individualized, needs-driven patient pathways. Supported by Detektor – a digital remote patient monitoring with key clinical parameters – clinicians gain real time insight into the entire patient population and can intervene proactively when risk arises.

For patients, needs-based follow-up means fewer routine hospital visits and greater flexibility.

Patients are stratified according to their individual needs, while the digital tool Detektor provides clinicians with an overview of each patient's health data. This enables healthcare professionals to proactively offer additional consultations at Steno to patients whose data indicate a need for closer follow-up.

Since 2022, Steno has reduced physical consultations by around 30% while maintaining high patient satisfaction and improving clinical outcomes. Capacity is reallocated to patients with the greatest need, increasing both efficiency and quality of care. Integrated into the regional health IT platform, Detektor is designed to be specialty-agnostic. This positions Steno as an innovation partner contributing scalable solutions for future outpatient care.[27]

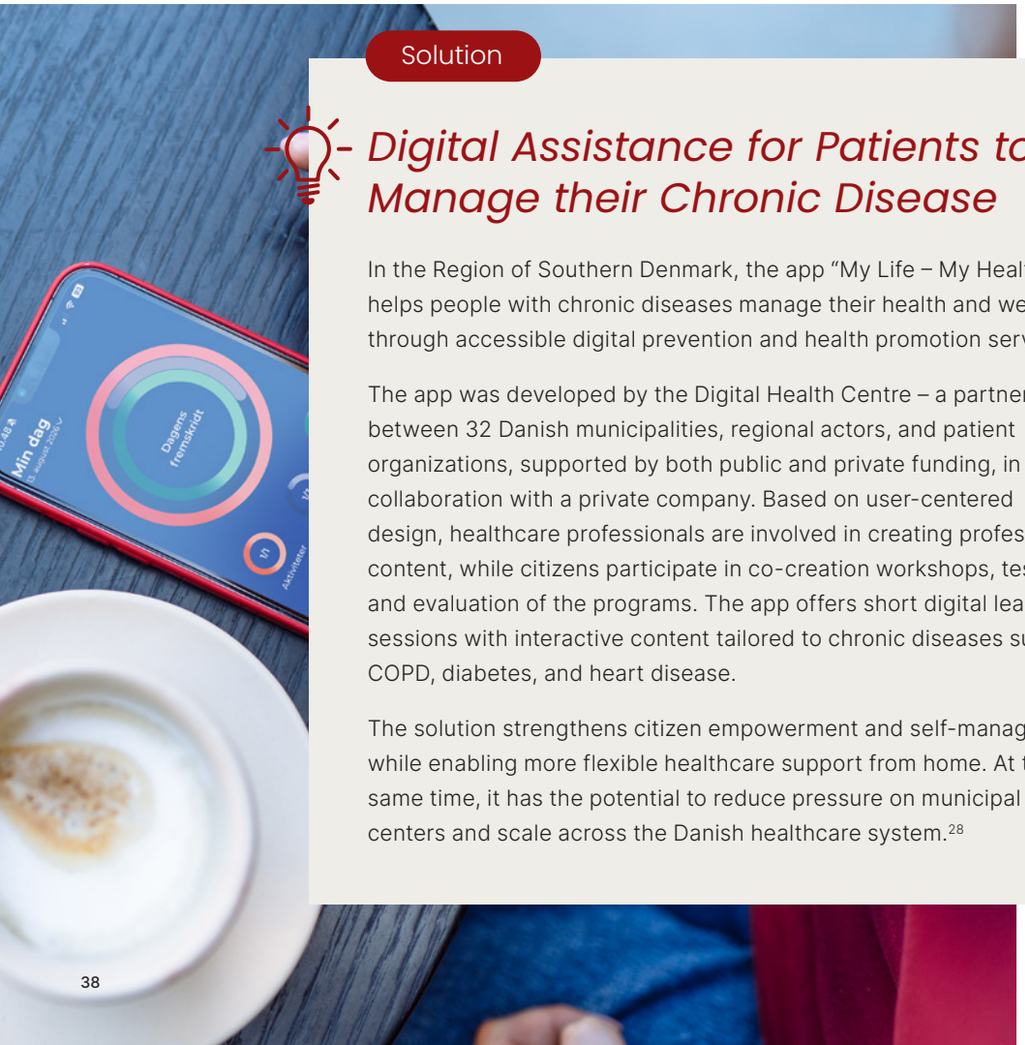
Supporting patients in assessing their need for contact



Supporting Self-Management

People living with chronic diseases need knowledge, practical tools and support to manage their condition in everyday life. Patient education and support for health literacy can help people build the understanding and confidence to make informed decisions and participate actively in their own care.

Digital solutions can support this in different ways. Digital learning tools provide information and guidance, while telemedicine enables people to monitor their condition at home and share measurements with healthcare professionals. Together, these approaches can support a more active role for patients while maintaining access to professional guidance and follow-up.



Solution

Digital Assistance for Patients to Manage their Chronic Disease

In the Region of Southern Denmark, the app “My Life – My Health” helps people with chronic diseases manage their health and wellbeing through accessible digital prevention and health promotion services.

The app was developed by the Digital Health Centre – a partnership between 32 Danish municipalities, regional actors, and patient organizations, supported by both public and private funding, in collaboration with a private company. Based on user-centered design, healthcare professionals are involved in creating professional content, while citizens participate in co-creation workshops, testing, and evaluation of the programs. The app offers short digital learning sessions with interactive content tailored to chronic diseases such as COPD, diabetes, and heart disease.

The solution strengthens citizen empowerment and self-management while enabling more flexible healthcare support from home. At the same time, it has the potential to reduce pressure on municipal health centers and scale across the Danish healthcare system.[28]

Solution

From Routine Visits to Needs-based Follow-up in Chronic Care

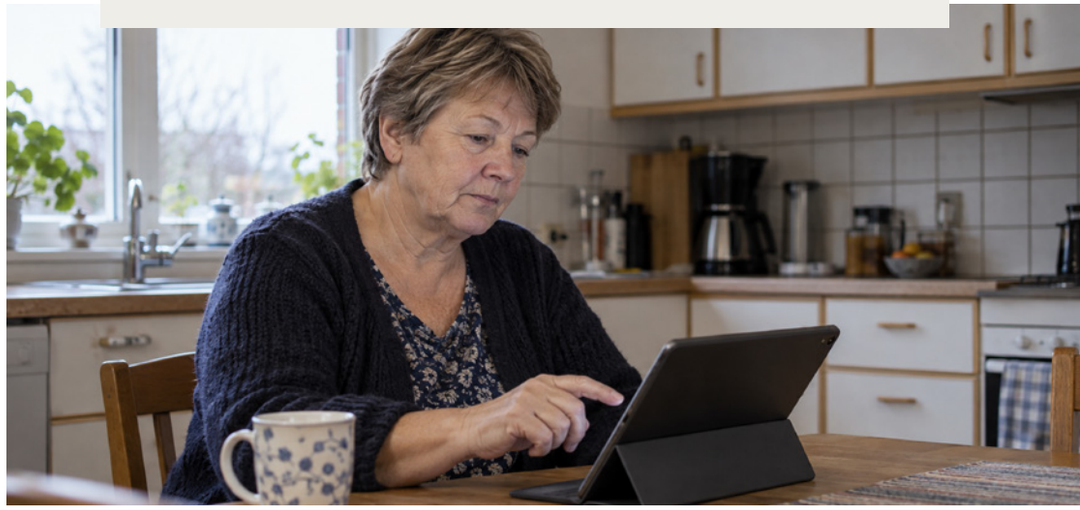
In the Central Denmark Region and the North Denmark Region, people living with chronic diseases can stay in contact with their healthcare team without routine hospital visits.

Through the AmbuFlex model, patients regularly report on their symptoms and wellbeing from home using digital questionnaires.

These patient-reported outcomes (PRO) provide insight into the patient’s health status and support needs-based follow-up.

Clinical decision support algorithms assess the responses and identify patients who may need follow-up. This helps prioritize patients with the greatest need and allows patients with stable conditions to avoid unnecessary outpatient visits and contact with the hospital. The approach improves convenience for patients and enables more efficient use of healthcare resources.

Today, the model is used across a wide range of chronic diseases and healthcare specialties, demonstrating how needs-based follow-up can support more flexible and sustainable healthcare services.[29]





Solution

A National Telemedicine Platform for Chronic Care

Telma is Denmark's national telemedicine platform for citizens living with chronic diseases such as COPD and heart failure (the initiative is called TeleCOPD and TeleHeart across the country). Telma makes it possible for healthcare professionals to monitor patients remotely through home measurements, digital communication and real-time data sharing. Telma demonstrates how digital health solutions can help create more proactive, accessible and sustainable chronic care.

By using Telma to monitor early changes in a patient's condition, healthcare professionals can act before hospitalization is needed. At the same time, patients gain greater insight into and ownership of their disease management, reducing the need for frequent hospital visits.

The solution is developed through close collaboration between regions, municipalities and technology partners, reflecting Denmark's strong tradition of integrated and cross-sectoral healthcare innovation. Pilot results have shown fewer hospital admissions, shorter hospital stays and increased patient confidence in managing chronic disease.[30]

Solution

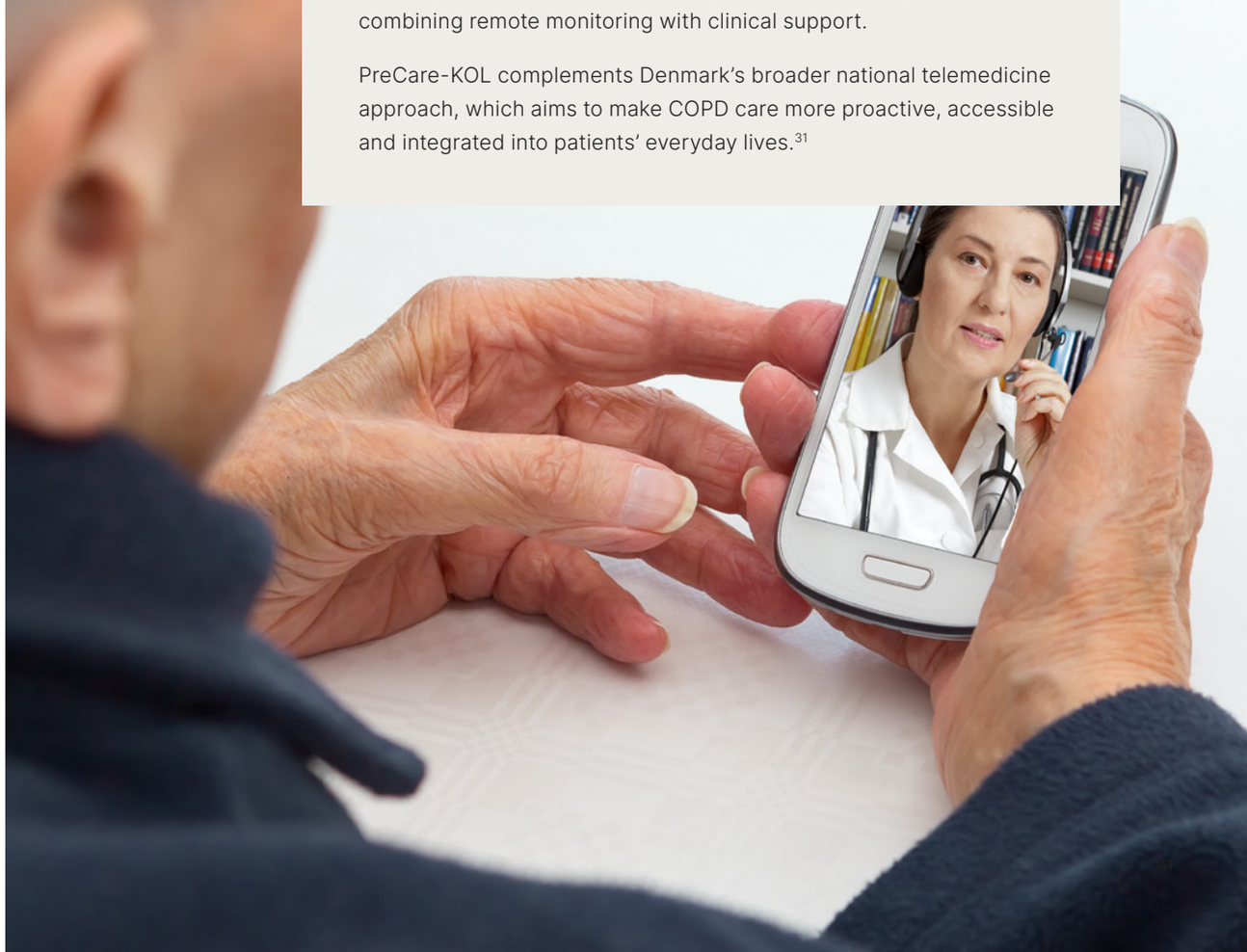
Proactive Digital Care for People with COPD

People living with chronic obstructive pulmonary disease (COPD) risk sudden exacerbations that can lead to emergency contacts and hospital admissions. Denmark is addressing this through telemedicine and proactive, home-based care.

In Region Zealand, PreCare-KOL enables patients to monitor clinical indicators at home and receive follow-up from specialized nurses. This supports earlier intervention and helps patients take a more active role in managing their condition.

A study of 362 patients found 30.8% fewer hospital admissions within 90 days of enrollment and a 70.9-hour reduction in average hospital stay. As the study had no control group, the results should be interpreted with caution, but they demonstrate the potential of combining remote monitoring with clinical support.

PreCare-KOL complements Denmark's broader national telemedicine approach, which aims to make COPD care more proactive, accessible and integrated into patients' everyday lives.[31]



Prevention and Timely Care

Prevention and Timely Care

In Denmark, prevention is considered an investment in both public health and society, supporting quality of life, workforce participation, and the long-term sustainability of the healthcare system.[10,32] As many chronic diseases develop gradually and are influenced by lifestyle, obesity, and social factors[33], prevention focuses not only on reducing the risk of disease, but also on delaying progression, preventing complications, and helping people live well with chronic diseases.

Timely care means recognizing disease and emerging problems early and ensuring that people receive appropriate treatment and support before these problems have a greater impact on everyday life.

Preventing diseases and addressing health inequalities

Prevention in Denmark is built on strong primary care, municipal prevention and rehabilitation services, nationwide digital health infrastructure, and the systematic use of health data to support earlier intervention and more targeted prevention efforts.

National prevention packages provide municipalities with practical recommendations on tobacco and nicotine, alcohol, physical activity, healthy eating, and mental health.

Effective prevention combines support for individuals and families with measures that make healthy living easier in everyday settings, including schools, workplaces and local communities.
However, the risk and consequences of chronic disease are not evenly distributed across the population. In Denmark, people with shorter education are more likely to develop conditions such as type 2 diabetes and COPD and often experience poorer outcomes following diagnosis. Understanding these differences is essential for targeting prevention and healthcare services according to population needs.[34]

Addressing these inequalities also requires adapting information, follow-up and support to each person's health literacy, language, resources and everyday circumstances. People who find it difficult to navigate services or manage several treatments may need additional guidance and more proactive contact.

To identify population needs and target prevention efforts, Denmark uses the Danish National Health Profile, a nationwide survey used to monitor population health, identify risk factors, and help target prevention initiatives and healthcare resources where they are needed most.



Solution

The National Health Profile – Using Data to Strengthen Prevention[35]

The National Health Profile is Denmark's nationwide population health survey and is conducted jointly by regions, municipalities, and national authorities. It provides a shared evidence base for preventing chronic diseases by identifying health challenges, monitoring trends, and supporting better planning of prevention initiatives and healthcare services.

The survey provides insight into:

- → Health behaviors such as smoking, alcohol use, diet, physical activity, and obesity
- → Physical and mental illness
- → Social inequalities in health across different population groups
- → The prevalence of chronic diseases and other long-term health conditions

The results help authorities to:

- → Identify risk factors for chronic disease
- → Target prevention initiatives where they are needed most
- → Monitor changes in population health over time
- → Prioritize healthcare resources based on population needs

Solution

Preventing Chronic Diseases in Municipalities

To reduce the risk of obesity-related diseases such as type 2 diabetes and cardiovascular disease, many municipalities invest in early interventions aimed at promoting physical, mental, and social health from childhood onwards and preventing chronic diseases.

In Gladsaxe Municipality, children and families are offered support based on the internationally recognized Holbæk Model, originally developed at Holbæk Hospital. The approach focuses on sustainable lifestyle changes tailored to each family's everyday life rather than strict diets or short-term interventions. Healthcare professionals work closely with children and parents to identify practical changes related to meals, physical activity, sleep, and daily routines.

The Holbæk Model is supported by an integrated digital platform that helps healthcare professionals deliver personalized obesity prevention and management across different stages of life. Gladsaxe has also adapted the approach to support pregnant women with a BMI of 30 or above, recognizing that prevention can begin before birth.[36]

Detecting Disease Early

Detecting chronic disease at an early stage is an important part of prevention. Earlier diagnosis enables earlier treatment, helping to prevent disease progression and reduce the risk of complications. In Denmark, general practitioners play a key role in identifying signs of disease, arranging diagnostic tests and referring patients to specialist care when needed.

Municipal health and care staff also contribute by recognizing changes in citizens' health and supporting contact with their GP. This aligns with the healthcare reform's emphasis on strengthening care closer to home. New digital diagnostic tools are making testing more accessible while simplifying patient pathways.



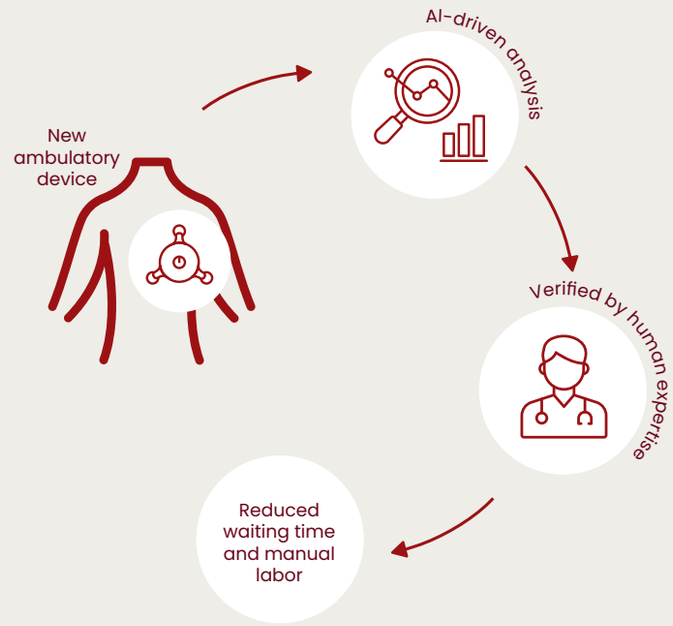
Solution

Simplifying ECG, Transforming Patient Pathways

Cardiac patient pathways can be complex and time-consuming, with multiple steps and handovers along the way. In Denmark, innovative solutions are helping to address this challenge. A study from Frederiksberg and Bispebjerg Hospital shows how the pathway can be significantly shortened using Cortrium's ECG solution.

By simplifying the workflow, patients can have a compact ECG device fitted during a single GP visit, wear it for about a week, and return it with ease. Data is then automatically analyzed, enabling a report within 48 hours. Fewer steps, less back-and-forth, and a much faster route to diagnosis.

This not only improves efficiency but also expands where care can take place, bringing monitoring closer to patients and enabling earlier detection of conditions such as atrial fibrillation - supporting earlier intervention and better clinical outcomes.[37]



Preventing Complications through Patient Education

Prevention is not only about reducing the risk of developing chronic disease. Once a diagnosis has been made, prevention focuses on slowing disease progression, preventing complications, and helping people maintain their health and independence. In Denmark, rehabilitation, patient education, self-management support, and innovative healthcare solutions all contribute to this approach.

Through collaboration between hospitals, general practitioners, and municipal services, people with chronic diseases receive coordinated support throughout their care pathway. This supports people in managing their symptoms, participating actively in their care, and maintaining quality of life.



Solution

Learning to Cope: Strengthening Self-Management of Chronic Diseases in Denmark

Many people with chronic diseases need support not only with treatment, but also with managing symptoms, maintaining healthy habits and staying active in everyday life.

To address this challenge, Danish municipalities offer LÆR AT TACKLE (“Learning to Cope”), based on Stanford University’s evidence-based Chronic Disease Self-Management Program and adapted to Danish conditions by the Danish Committee for Health Education.

The workshops are highly participatory and help participants build confidence in their ability to manage their health and maintain active and fulfilling lives. Participants learn practical tools for managing symptoms such as pain, fatigue, and stress, while peer support and shared experiences play a central role.

Studies have demonstrated positive effects on symptoms, health behaviors, self-efficacy, and quality of life. At the same time, peer-led workshops make the program more cost-effective, with costs estimated at approximately one-third of similar programs facilitated by healthcare professionals.[38,39,40]

Timely Care

In Denmark, care for people living with chronic disease includes preventing complications and supporting everyday life. The approach combines treatment with rehabilitation and patient education. By providing practical tools, knowledge, and support from healthcare professionals, these services help people manage symptoms and maintain their independence and quality of life. This also applies to people living with lasting effects of cancer treatment, where identifying ongoing problems and providing personalized support are important parts of follow-up care.



Solution

Take Back Bowel Control after Colorectal Cancer

Around 30% of adults worldwide live with bowel issues including symptoms such as accidentally leaking stool and/or long-term constipation[41]. Chronic bowel disorders arise from a wide range of causes, including late effects of colorectal cancer.

3 out of 4 patients experience bowel dysfunction after colorectal cancer surgery[42], significantly affecting their autonomy and quality of life.

Timely recognition and personalized bowel care are therefore essential. Several management options are available, of which Transanal irrigation (TAI) has shown to be a helpful solution for, among others, people experiencing bowel issues due to late effects of colorectal cancer[43].

TAI works by introducing water into the colon through a rectal catheter, enabling controlled bowel emptying and improved symptom management. For patients with late effects of colorectal cancer, TAI has shown to improve bowel symptoms in more than 2 out of 3[44], while also reducing the number of daily visits to the toilet and overall time spent on bowel management[43].

Pelvic radiotherapy and/or rectal surgery performed as part of the cancer treatment can leave patients with a vulnerable bowel. In collaboration with colorectal surgeons and nurses, Coloplast has developed the Peristeen® Plus TAI cone catheter, designed specifically to meet the needs of patients with a history of rectal surgery. Owing to its anatomical design, it is considered a suitable option for this group, potentially enabling more patients with late effects of colorectal cancer to benefit from symptom relief with TAI[43].

To continuously listen and respond to clinical insights and patients' needs, Coloplast also collaborate with specialized Danish clinics and patient education programs as well as provide direct patient support through the Coloplast Care Service.

Innovation as a Strategy for Managing Chronic Disease

Innovation as a Strategy for Managing Chronic Disease

Recognizing that future healthcare challenges cannot be solved through organizational reforms alone, Denmark has made innovation a strategic priority. The Danish Life Science Strategy towards 2030 aims to accelerate the development, testing, implementation, and scaling of innovative health solutions that improve prevention, diagnosis, treatment, rehabilitation, and long-term management of chronic diseases.

A key part of this strategy is Denmark's strong tradition of public-private collaboration. Healthcare providers, researchers, companies, patient organizations, and public authorities work closely together to develop, test, and implement new solutions. The close link between clinical practice, research, and industry enables innovations to be evaluated in real-world healthcare settings and supports the generation of real-world evidence. The following examples show how these partnerships are translating research and innovation into better care for people living with chronic diseases.

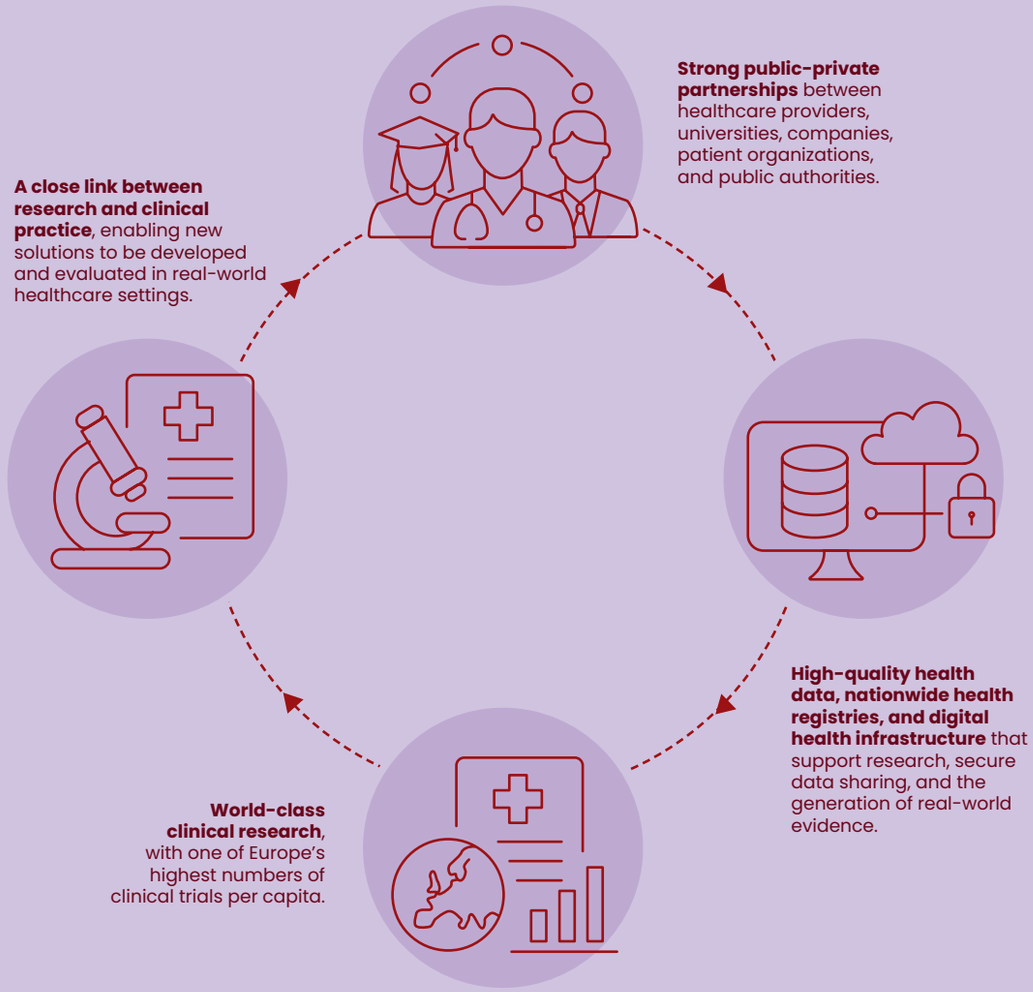




Read more here.

Key Features of Denmark's Life Science Ecosystem

Denmark offers favorable conditions for developing and testing innovative healthcare solutions through:



Solution

Connecting Data to Understand Migraine in Everyday Life

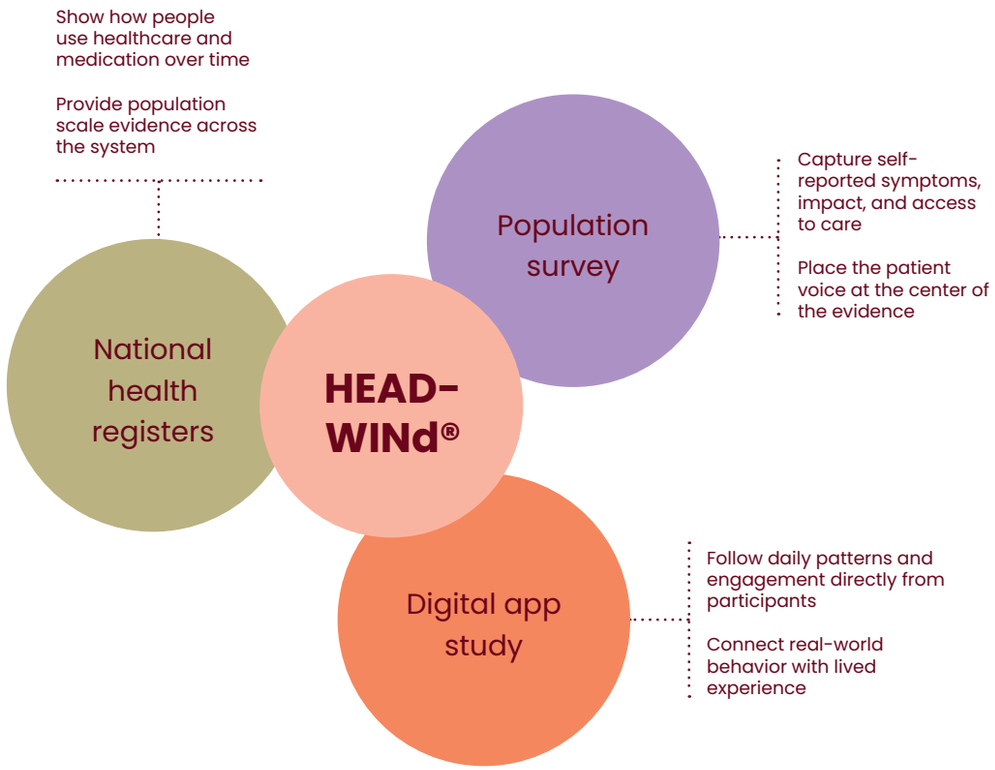
HEAD-WINd® is a Danish public–private partnership research study between the Danish Knowledge Center on Headache Disorders and H. Lundbeck A/S. It demonstrates how Denmark can address under-recognized chronic diseases such as migraine through data-driven collaboration.

By leveraging Denmark's integrated health and social data infrastructure, the study generates population-level real-world evidence on disease burden, treatment patterns, unmet needs, and the impact of migraine on everyday life and working lives.

By capturing both diagnosed and undiagnosed individuals, including people not currently engaged with the healthcare system, HEAD-WINd® provides a more accurate understanding of disease burden and treatment gaps. This can support earlier identification, improved care pathways, and more equitable access to treatment.

The study combines nationwide survey data, smartphone-based symptom tracking, and national registries to capture how headache disorders are experienced and managed in everyday life. Patient organizations have contributed to the design and content of the digital tools, helping ensure relevance, usability, and trust.

By establishing a comprehensive population-based cohort of Danish adults, HEAD-WINd® provides a robust platform for understanding burden, lived experience, and disparities in migraine care. It enables more informed decision-making across healthcare planning, clinical practice, and policy.[45]





Clinical Research for Better Chronic Disease Care

In 2025, Denmark ranked #1 in Europe for clinical trials per capita[46], reflecting a strong clinical research ecosystem and close collaboration between authorities, healthcare providers, researchers, and life science companies[47]. Clinical research plays a vital role in improving prevention, diagnosis, and treatment of chronic diseases by developing new medicines, medical devices, and models of care that can improve quality of life and long-term disease management.

Denmark's nationwide health data, registries, biobanks, and digital infrastructure provide a strong foundation for clinical research. By combining these resources with close collaboration across the healthcare system, researchers can better understand disease progression, evaluate treatment outcomes, and generate evidence that supports more personalized and effective chronic disease care.

To further strengthen clinical research, Denmark is establishing a national "one point of entry" for access to health data, making it easier and more efficient for researchers to securely access Danish health data.

How Denmark built a strong clinical research ecosystem targeting chronic diseases

Denmark's position as one of Europe's leading countries for clinical research is built on:

- **Strong political commitment** to clinical research and health innovation[48]
- **Unique health data infrastructure**, including nationwide registries and biobanks[49,50]
- **Cross-sector collaboration** between healthcare providers, researchers, life science companies, and public authorities[46]
- **High levels of patient trust and participation**, supporting efficient, high-quality clinical research[51]

INNOVATION AS A STRATEGY FOR MANAGING CHRONIC DISEASE



Solution

Paving the Way for Better Chronic Disease Treatment through Patient Data

People with **chronic diseases can contribute to developing new treatment beyond the hospital setting**.

This is the ambition behind PhaseV, an innovation project developing a digital platform where patients contribute data through apps, smartphones and wearables. These data are combined with clinical and registry data to provide a more comprehensive understanding of treatment effects over time.

PhaseV is being tested across three widespread and resource-intensive conditions: severe obesity, diabetic foot ulcers and chronic urticaria. By moving data collection closer to patients' everyday lives, the project aims to support more precise and personalized treatment - while also supporting faster clinical studies with fewer dropouts.

Innovation Fund Denmark has invested DKK 24 million in the project through the Grand Solutions program and the consortium behind the project consists of 11 partners.[52,53]

Solution

Strengthening Clinical Research in Chronic Disease

Clinical research is essential to improving outcomes for people living with chronic diseases. As chronic diseases place growing pressure on healthcare systems worldwide, clinical trials are key to better treatments, earlier access to innovation, improved disease control, and better quality of life.

Denmark has built a strong national framework for clinical research, and Trial Nation plays a central role. Through nationwide clinical networks, Trial Nation provides life science companies with one coordinated entry point to Denmark's healthcare system, ensuring fast study start-up, efficient patient recruitment, and high-quality trial delivery across multiple sites.

Trial Nation's Network for Respiratory Medicine shows how it works in practice. By connecting specialized sites across Denmark, the network transforms Denmark's clinical expertise and collaborative healthcare model into coordinated national trial capacity.

This strengthens Denmark's ability to attract international trials, accelerate new treatments, and improve care for people living with chronic disease.[51]



INNOVATION AS A STRATEGY FOR MANAGING CHRONIC DISEASE

Towards the Next Generation of Chronic Care

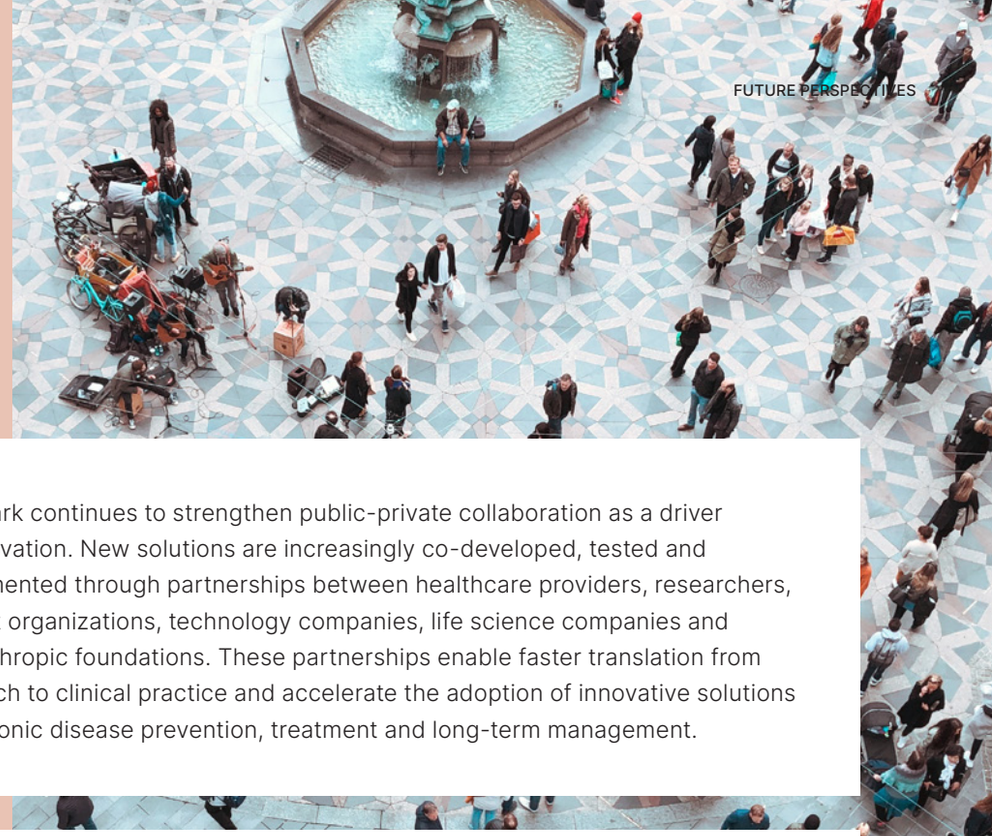
Towards the Next Generation of Chronic Care

The next phase of Denmark's healthcare transformation is likely to be defined not by a single reform or technology, but by a new way of thinking about chronic care and health. Increasingly, health is viewed not only as a cost to be managed, but as an investment in people, productivity and long-term societal resilience.

Preventing chronic disease, delaying complications, and enabling people to live healthier, more independent lives are becoming strategic priorities alongside delivering high-quality treatment. Making this transformation possible requires the convergence of four Danish strengths.

1 Denmark has one of the world's most integrated digital health infrastructures, enabling health data to be used securely across hospitals, general practice and municipalities. This creates the foundation for more coordinated, proactive and personalized care for and with people living with chronic diseases.

2 Artificial intelligence is rapidly becoming an integral part of healthcare. Across Denmark, hospitals, municipalities, universities, startups and established companies are developing and implementing AI solutions that support earlier diagnosis, clinical decision-making, personalized treatment, remote monitoring and more efficient use of healthcare resources. Rather than representing a single technology, AI is expected to become a key enabler of predictive, preventive and personalized chronic care, supporting earlier intervention, continuous disease management, and more tailored care for people living with chronic diseases.



3 Denmark continues to strengthen public-private collaboration as a driver of innovation. New solutions are increasingly co-developed, tested and implemented through partnerships between healthcare providers, researchers, patient organizations, technology companies, life science companies and philanthropic foundations. These partnerships enable faster translation from research to clinical practice and accelerate the adoption of innovative solutions for chronic disease prevention, treatment and long-term management.

4 **Finally**, growing investments in prevention, including new policy initiatives to strengthen preventive efforts and measure the broader societal value of health investments, reflect a wider recognition that healthier populations contribute not only to better health outcomes but also to economic growth, workforce participation and resilient societies. As the prevalence of chronic diseases continues to rise, prevention and early intervention will become increasingly important to improve quality of life while ensuring long-term sustainability of healthcare systems.

Together, these strengths position Denmark as more than a highly digital healthcare system. The next step is to translate these ambitions into consistent improvements in everyday care. New approaches should be assessed not only for clinical outcomes and resource use, but also for patient experience, accessibility and continuity across services. Implementation must account for workforce capacity and people's different needs and resources. By sharing both promising results and remaining challenges, Denmark seeks to learn from other countries and contribute to better care for people living with chronic diseases.

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