European Social Charter | Charte Sociale Européenne

COUNCIL OF EUROPE | CONSEIL DE L'EUROPE

26/2/2013 RAP/Cha/DNK/32(2013)

# EUROPEAN SOCIAL CHARTER

32nd National Report on the implementation of the European Social Charter

submitted by

## THE GOVERNMENT OF DENMARK

(Articles 3, 11, 12, 13 and 14 and article 4 of the Additional Protocol for the period 01/01/2008 – 31/12/2011)

Report registered by the Secretariat on 19 February 2013

## CYCLE 2013

# EUROPEAN SOCIAL CHARTER

32nd report on the European Social Charter

Submitted by
**The Government of Denmark**

Concerning articles 3, 11, 12, 13, 14 and article 4 of the Additional Protocol
for the period 01.01.2008 – 31.12.2011

In accordance with article 23 of the Charter, copies of this report have been communicated to:
The Confederation of Danish Employers (DA)
The Danish Confederation of Trade Unions (LO)
The Confederation of Professionals in Denmark (FTF)
The Danish Confederation of Professional Associations (AC)

**Table of contents**


| | | |
|---|---|---|
| **Article 3** | | **3** |
| | Article 3, Paragraph 1 | 4 |
| | Article 3, Paragraph 2 | 11 |
| | Article 3, Paragraph 3 | 13 |
| | Supplementary Information on Article 3 | 15 |
| **Article 11** | | **21** |
| | Article 11, Paragraph 1 | 22 |
| | Article 11, Paragraph 2 | 31 |
| | Article 11, Paragraph 3 | 38 |
| | Supplementary Information on Article 11 | 49 |
| **Article 12** | | **53** |
| | Article 12, Paragraph 1 | 54 |
| | Article 12, Paragraph 2 | 62 |
| | Article 12, Paragraph 3 | 63 |
| | Article 12, Paragraph 4 | 63 |
| | Supplementary Information on Article 12 | 64 |
| **Article 13** | | **68** |
| | Article 13, Paragraph 1 | 69 |
| | Article 13, Paragraph 2 | 73 |
| | Article 13, Paragraph 3 | 73 |
| | Article 13, Paragraph 4 | 75 |
| | Supplementary Information on Article 13 | 77 |
| **Article 14** | | **80** |
| | Article 14, Paragraph 1 | 81 |
| | Article 14, Paragraph 2 | 85 |
| | Supplementary Information on Article 14 | 86 |
| **Article 4 of the 1988 Additional Protocol** | | **88** |
| | Supplementary Information on Article 4 of the 1988 Additional Protocol | 92 |

**Appendix 1:** Annual reports of the Labour Inspectorates
**Appendix 2:** Denmark's report to ILO on Convention No 102
**Appendix 3:** Links to the legislation

## Article 3

The right to safe and healthy working conditions

## Article 3 – The right to safe and healthy working conditions

### Article 3, Paragraph 1, Question 1

1. Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

**The Danish Working Environment Authority**
The labour inspectorate in Denmark is known as the Danish Working Environment Authority (WEA) (Arbejdstilsynet – AT).

A single legislative act for health and safety at work, the Working Environment Act, applies to all sectors of industry, but in certain sectors its enforcement falls under the responsibility of other government departments:

- Inspection of health and safety on seagoing ships falls under the responsibility of the Danish Maritime Authority in the Ministry of Business and Growth.
- Aviation falls under the responsibility of the Ministry of Transport.
- Health and safety on off-shore installations is monitored by inspectors from the Danish Energy Agency.
- The Ministry of Employment has an agreement with the Institute of Radiation Hygiene, part of the Department of Health, to monitor the use of ionising and non-ionising radiation at work.
- Responsibility for general fire matters at workplaces falls under the local fire authorities.

Apart from the above exceptions, the WEA has responsibility for inspection of health and safety in all sectors of industry, including the loading and unloading of ships in dock and flights on ground.

The Danish Working Environment Act, Consolidated Act no. 1072 of 7 September 2010, which was amended by Act no. 1538 of 21 December 2010 and Act no. 597 of 14 June 2011, only covers work performed on Danish territory, including loading and unloading of ships and shipyard work onboard ships.

*The Danish Working Environment Act encompasses work carried out for an employer. However, exception is made for:*

- Work in the private household of the employer.
- Work exclusively performed by the family of the employer, who belong to his household.
- Work performed by the military and which can be included under actual military service.

However, certain provisions in the Working Environment Act (the extended area) also apply to the exceptions listed above as well as to work which is not performed for an employer, i.e. by self-employed persons. This includes rules about performing work, technical equipment, and substances and materials.

The aim of the Working Environment Act is to create a safe and healthy working environment, which is at all times in accordance with the technical and social developments in society. Furthermore, the Act is intended to provide the framework for enterprises themselves to solve problems related to safety and health issues with guidance from the social partners and guidance and inspection from the Working Environment Authority (WEA).

***List of amendments to the main legislative acts and orders in the period from 1 January 2008 to 31 December 2011***

**A. Amendments under the Danish Ministry of Employment**

*New legislation implemented during 2008.*

Acts:

Act No 559 of 17 June 2008 amending the Working Environment Act No. 268 of 18 March 2005.

Consolidation Act No 907 of 11 September 2008 on fixed-term work.

Act No 1395 of 27 December 2008, amendment to the Working Environment (Consolidated Act).

Amendments to the Act include higher penalties for violation of the Working Environment Act.

The changes also include amendments to comply with the Council Directive 92/57/EEC of 24 June 1992 on the implementation of minimum safety and health requirements at temporary or mobile construction sites.

This important amendment aims at making sure that the client ensures the coordination during the project preparation stage. Before the amendment of the Act the client was responsible for ensuring the coordination on the construction site during the project execution stage.

The amendment makes the client responsible for appointing one or more coordinators for safety and health matters during the project preparation stage. The coordinators for safety and health matters shall among other things coordinate the implementation of the provisions concerning safety and health issues including the drawing up of a safety and health plan and the preparation of a file appropriate to the characteristics of the project containing relevant safety and health information to be taken into account during any subsequent work.

Better planning during the project preparation stage will benefit the working environment.

The Coordinator(s) for safety and health has/have to be appointed if there are two or more contractors engaged on the construction site. This is independent of the number of persons working on the site.

Executive Orders:

- Executive Order No 612 of 25 June 2008 on the construction of technical aids.
- Executive Order No 647 of 26 June 2008 on the recognition of professional qualifications acquired abroad.
- Executive Order No 629 of 27 June 2008 on the use and installation of elevators etc.
- Executive Order No 677 of 27 June 2008 on modification and major repair of elevators etc.
- Executive Order No 678 of 27 June 2008 on the construction of elevators.
- Executive Order No 806 of 8 July 2008 amending Executive Order No 1503 of 21 December 2004 on working environment courses.
- Executive Order No 910 of 11 September 2008 on gene technology and working environment.
- Executive Order No 1252 of 15 December 2008 amending Executive Order No 559 of 4 July 2002 on special obligations for manufacturers, suppliers and importers etc. of substances and materials in accordance with the Working Environment Act (amendments as a consequence of the "REACH Regulation").
- Executive Order No 1253 of 15 December 2008 amending Executive Order No 776 of 25 November 1991 on centrifuges.
- Executive Order No 1356 of 19 December 2008 on the Danish Working Environment Research Fund.
- Executive Order No 1357 on auditing of accounts of project grants from the Danish Working Environment Research Fund.
- Executive Order No 1416 of 27 December 2008 on the responsibilities of the client (in connection with the construction site).
- Executive Order No 1418 of 27 December 2008 amending Executive Order No 825 of 13 November 1998 on the rules of procedure of the Council of Appeal on Health and Safety at Work.
- Executive Order No 1419 of 27 December 2008 amending Executive Order No 255 of 20 March 2007 on disclosure of the working environment in the enterprises etc.
- Executive Order No 1420 of 27 December 2008 amending Executive Order No 1109 of 15 December 1992 on the use of technical aids.
- Executive Order No 1421 of 27 December 2008 amending Executive Order No 1101 of 14 December 1992 on lifting devices and winches.
- Executive Order No 1422 of 27 December 2008 amending Executive Order No. 574 of 21 June 2001 on the duties of the project supervisor and consultants in accordance with the working environment act.
- Executive Order No 1423 of 27 December 2008 amending Executive Order No 589 of 22 June 2001 on the design of construction sites and similar workplaces.
- Executive Order No 1424 of 27 December 2008 amending Executive Order No. 1109 of 17 December 2001 on responsibilities in accordance with the environment act in connection with tendering of services.
- Executive Order No 1425 of 27 December 2008 amending the Executive Order No 575 of 21 June 2001 on the safety and health arrangements in the enterprises.
- Executive Order No 1426 of 27 December 2008 amending the Executive Order No 259 of 20 March 2007 on the use of authorized health and safety consultants.

*New legislation implemented during 2009.*

No new acts were implemented in 2009

Executives Orders:
Executive Order No 20 of 12 January 2009 (Implementation of the REACH-regulation).
https://www.retsinformation.dk/Forms/R0710.aspx?id=114269

*New legislation implemented during 2010.*

Acts implemented in 2010:

The Danish Working Environment Act, Consolidated Act no. 1072 of 7 September 2010, legislative amendment of Act no. 1538 of 21 December 2010
https://www.retsinformation.dk/Forms/R0710.aspx?id=135215

Executive Orders:

Two new executive orders have been implemented concerning safety and health activities of the enterprises:
(Executive Order no. 1181) http://arbejdstilsynet.dk/da/regler/bekendtgorelser/s/samarbejde-om-sikkerhed-og-sundhed-1181.aspx and occupational safety and health training (Executive Order no. 840) http://arbejdstilsynet.dk/da/regler/bekendtgorelser/g/godkendelse-af-udbyderearbejdsmiljoeuddannelse.aspx

It is expected that the new rules will provide a basis for more preventive and dynamic working environment measures within the enterprises, where supervisors, managers and employees will, to a greater extent, be able to find their own ways to deal with co-operation in the working environment field.

The basis for the new rules is that they shall reflect the modern labour market. Emphasis has been placed on highlighting the collaborative process and increasing management priority as central elements of the future working environment organisation.

The new rules make the working environment a strategic and prioritised element within enterprises. It is therefore necessary that the members of the OSH (occupational safety and health committee) are able to perform the tasks at hand. The employer has a new duty to provide ongoing competency development that will contribute to making it attractive to participate in the OSH.

It will remain a fundamental principle that the employers, supervisors and employees in all enterprises co-operate on the working environment. However, the formal requirements for this co-operation are less detailed than previously. Each year the employer shall plan the safety and health of the enterprise for the coming year in co-operation with the employees. The objective is that an annual debate will provide a simple process that promotes and strengthens the working environment efforts of the enterprise.

*New legislation implemented during 2011.*

Acts:

Consolidated Act No. 1072 of 7 September 2010 and Act No 597 of 14 June 2011 amending the act on occupational health and safety (risk-based inspections, differentiated fines etc.).
http://arbejdstilsynet.dk/da/regler/love/sam-1072-arbejdsmiljoloven.aspx

Executive Orders:

The following executive Orders have been implemented concerning safety and health activities of the enterprises:

*Biological agents*
http://arbejdstilsynet.dk/da/regler/bekendtgorelser/b/biologiske-agenser-57.aspx

*Limits values of substances and materials*
http://arbejdstilsynet.dk/da/regler/bekendtgorelser/g/sam-graensevaerdier-for-stoffer-og-materialer.aspx

*Transportable pressure equipment*
http://arbejdstilsynet.dk/da/regler/bekendtgorelser/g/gennemfoerelse-direktiv-transportabelt-trykbaerende-udstyr-732.aspx

*Functional requirements of pesticide delivery equipment*
http://arbejdstilsynet.dk/da/regler/bekendtgorelser/d/delegation-af-opgaver-til-mst-pesticidudbringningsudstyr.aspx

*Professional health and safety education*
http://arbejdstilsynet.dk/da/regler/bekendtgorelser/a/arbejdsmiljoefaglige-uddannelser.aspx

*Risk-based inspection and certified companies*
http://arbejdstilsynet.dk/da/regler/bekendtgorelser/u/undtagelser-fra-risikobaseret-tilsyn.aspx

*Disclosure of the companies working environment*
http://arbejdstilsynet.dk/da/regler/bekendtgorelser/o/offentliggor-af-virksomhedernes-arbmiljoe.aspx

### Article 3, Paragraph 1, Question 2

> 2. Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework in consultation with employers' and workers' organisations.

### 2008

According to the "Performance Contract for the WEA 2008 to 2011", the purpose of the Authority is to "contribute to a safe, healthy and developing working environment through efficient inspection, targeted regulation and information," while the vision is to "focus on the most important working environment problems and target efforts towards enterprises with a problematic working environment." The main objectives are effective inspection, the encouragement of self-regulation in enterprises and keeping up to date in terms of monitoring, research and policy so as to advise the

Minister for Employment.

In 2005 the government announced that the four prioritised working environment targets for up to and including 2010 were:

- Industrial accidents – 20 percent reduction on current figures.
- Psycho-social working environment – 10 percent reduction.
- Noise – 15 percent reduction in hearing damage, 10 percent reduction in nuisance noise.
- Musculo-skeletal disorders – 10 percent reduction in total sickness absence due to musculo-skeletal difficulties at work.

The specific quantitative reduction targets that have been established for each of the four prioritised areas, contribute to putting emphasis on the working environment efforts, including that the inspectors can carry out targeted inspections at the individual enterprises focusing on these prioritised areas.

### *Focus on absenteeism due to sickness*

In 2008 the government and the social partners entered into an agreement about reducing the absenteeism due to sickness. Among other things this means that from 2009 the WEA must give priority to implementing the WEA's guidelines on "sickness absenteeism and return to work" in the special efforts.

### *Other measures*

Through continued development of the WEA's website, including development and dissemination of materials for the use in the enterprises' own working environment measures, the WEA seeks to underpin the focus and work of the enterprises in relation to specific working environment problems within the prioritised areas.

## *Specific actions, campaigns and priority topics during 2008*

### *European Campaign on Risk Assessment*

In connection with the implementation of the EU-campaign on Risk Assessment a Steering Group comprised of 25 representatives of the social partners and relevant government bodies and others was set up. The Steering group created a working group whose task was to arrange and implement the specific activities, e.g. a Stakeholder Conference with 100 participants and four regional meetings with approximately 500 participants. The four regional meetings were organised during the European Working Environment Week.

In connection with the meetings there was an introduction from the Danish Working Environment Authority, the social partners and the local enterprises about the usefulness of a good Risk Assessment. During these meetings there was fine media/press coverage in the local press as well as in the electronic media.

### *Building and Construction Actions*

In 2008 the WEA conducted four unannounced actions each targeting building and construction sites in different parts of Denmark. In addition to focusing on a particular working environment problem for each action (dangerous work in the height, access roads, noise as well as musculo-skeletal disorders) these actions had a special focus on foreign construction workers and newly appointed workers. The foreign enterprises are often not aware of the Danish working environment legislation which too often puts the construction workers into dangerous situations.

During each action up to 200 building sites were visited in order to conduct on-site inspections of the working environment. The total number of both improvement notices issued and the number of cessation of work activities during these actions were high especially in regard to the risk of falling from heights.

In 2008 a total of 707 construction sites were visited in connection with four unannounced actions. The total number of immediate improvement notices as well as prohibition notices/stop notices was 643.

Consequently, the lesson learnt is that generally speaking it is important to prioritise the building and construction sector and in particular to carefully monitor building and construction sites. The actions also clearly indicated that the employers must put much more effort into instructing foreign workers and newly appointed employees. Often accidents occur due to lack of understanding and instruction in safety and risk issues in a language they understand leading to many avoidable accidents at work. In 2008, tragically, there were 16 fatal accidents on construction sites in various parts of Denmark.

## 2009

*New working environment prioritisations up to 2020.*
In 2009 the WEA started preparing a new report with the purpose of constituting a technical foundation for future political prioritisation of working environment measures up to 2020. The background of the report was that the government's current prioritisation on working environment measures expired at the end of 2010.

## 2010

*New working environment prioritisations up to 2020.*
The report on the new environment prioritisations was finished in 2010. It gave a technical foundation for subsequent political identification of which working environment problems should be prioritised up to 2020 as part of the overall working environment measures and where other working environment problems required activities to be initiated, for example in certain jobs or sectors. Similarly, the report allowed the prioritisation of certain focus areas and constituted the foundation for decision-making on the development of relevant actions.

The report had three primary focal points. First and foremost, it assessed the working environment problems so that future prioritisation could be based on solid documentation of which problems were most significant in Denmark. As the technical foundation for a prioritisation up to 2020, it was also vital, however, to look ahead and not just focus on the information that were available on working environment problems up to 2010. Another focal point, therefore, was what the labour market would be like in the period leading up to 2020, and what implications this would have for the working environment. As a third focal point, the report had information on the effectiveness of actions. Actions are related to the future development of the labour market and future working environment problems. This provided the platform for future prioritisation and not only to identify significant working environment problems, but also to address what actions were needed to solve and prevent these working environment problems.

*New strategy for working environment measures up to 2020*

In September 2010 the government presented a new strategy for working environment efforts up to 2020 called "A New Way Towards a Better Working Environment". With this strategy the government wished to target its efforts towards those enterprises that had the most issues relating to the working environment. The new strategy consists of 19 specific initiatives, among others:

- Risk-based inspections focusing on enterprises with health and safety issues.
- Differentiated fines.
- Intensified dialogue with enterprises.
- More help for smaller enterprises.

In the strategy there is focus on the following working environment problems as part of the 2020 working environment efforts:

- Accident at work.
- Psychosocial working environment.
- Musculoskeletal disorders.

The strategy contains the following objectives regarding the working environment in 2020:

- The number of serious accidents at work is to be reduced by 25%.
- The number of employees who are psychologically overloaded is to be reduced by 20%.
- The number of employees who experience musculoskeletal disorders is to be reduced by 20%.

These objectives are to be achieved in the period beginning 2012 until the end of 2020.

The WEA has in 2010 completed initiatives as a part of the EU SLIC campaign of information and inspection for risk assessment on the use of hazardous substances in workplaces. Inspection within this risk assessment theme has been made in the following business sectors: bakeries, agriculture and garden centres.

**2011**

*New strategy for working environment measures up to 2020*
In the spring of 2011 a broad majority, in the Danish Parliament, passed the new strategy "A New Way towards a Better Working Environment". This new strategy superseded the old strategy by the end of 2011. With the strategy the government wished to target its efforts towards those enterprises that had the most issues relating to the working environment.

## Article 3, Paragraph 2, Question 1

1. Please describe the enforcement of safety and health regulations. Please specify the nature of, reasons for and extent of any reforms.

**2008**
The Danish Welfare Commission in 2006 decided that the WEA should carry through an intense inspection by way of a special effort in branches, where there is a danger of the workforce being worn

out.

The special efforts target enterprises with potential significant health and safety challenges. This is reflected in the above average number of employees who have a particular risk of any of the following:

- To go on disability pension.
- To go on early retirement.
- To go on long term sick leave.

In 2008 the following branches were subject to the special measures:

- Cleaning companies, laundries and dry cleaners.
- Transport of goods.
- Transport of passengers.
- Community Nursing.

**2009**

As in 2008 the WEA in 2009 carried out special intense inspections in enterprises and trades with potential health and safety challenges, expressed by the fact that employees risk to take disability pension, early retirement and to go on long term sick leave. In 2009 WEA has conducted special inspections of 1100 enterprises.

In 2009 the following additional branches were subject to special efforts:

- Building and constructions.
- Shipbuilding yards.

The purpose of these inspections was to put focus on the working environment problems particularly related to the exposure of musculo-skeletal disorders and the psychosocial working environment.

**2010**

As in 2008 and 2009 the WEA in 2010 carried out special intense inspections in enterprises and trades with potential health and safety challenges, expressed by the fact that employees have a risk of retiring pension, early retirement and to go on long term sick leave. In 2010 the WEA has conducted special inspections in 1100 enterprises.

In 2010 the following additional branches were subject to special efforts:

- Building and constructions.
- Child and youth care centres.
- Textile, garment and leather industry.
- Slaughterhouses for pigs and poultries.

These inspections have put focus on the working environment problems particularly related to exposure of musculoskeletal disorders and psychosocial working environment.

**2011**

As in 2008, 2009 and 2010 the WEA in 2011 carried out special intense inspections in enterprises and trades with potential health and safety challenges, expressed by the fact that employees risk to take

disability pension, early retirement and to go on long term sick leave.

In 2011 the WEA conducted special inspections in 2800 enterprises.

In 2011 the following additional branches were subject to special efforts:

- Building and constructions.
- Child and youth care centres.

These inspections have put focus on the working environment problems particularly related to the exposure of musculoskeletal disorders and psychosocial working environment.

### Article 3, Paragraph 2, Question 2

> 2. Please provide pertinent figures, statistics (for example Eurostat data) or any other relevant information on: the number of accidents at work, including fatal accidents, in absolute figures as well as in terms of standardized accident rates per 100,000 workers; on the number of health and safety inspection visits by the labour inspectorate and the proportion of workers and companies covered by the inspections; and on the number of breaches to health and safety regulations and the nature and type of sanctions imposed.

Please see the attached information (Annual reports of the Labour Inspectorates) sent to the EU Commission for the years 2008 – 2011 (Appendix 1).

| Accidents at work | **Year of registration** | | | | | |
|---|---|---|---|---|---|---|
| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
| **Gravity** | | | | | | |
| 1 Death | 61 | 66 | 44 | 44 | 39 | 41 |
| 2 Other serious accidents | 5,778 | 5,536 | 5,663 | 4,843 | 5,637 | 5,398 |
| 3 Other accidents | 42,863 | 43,211 | 43,809 | 37,637 | 38,669 | 37,128 |
| Total | 48,702 | 48,813 | 49,516 | 42,524 | 44,345 | 42,567 |

### Article 3, Paragraph 3, Question 1, 2 and 3

> 1. Please describe the consultation with employers' and workers' organizations on measures intended to improve industrial safety and health. Please specify the nature of, reasons for and extent of any reforms.
>
> 2. Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the consultation with employers' and workers' organizations.
>
> 3. Please provide pertinent figures, statistics or any other relevant information, if appropriate.

**National level - the Working Environment Council**

General surveillance of trends and developments in the working environment is provided by the tripartite Danish Working Environment Council, which advises the Minister for Employment and the WEA, and makes recommendations for priorities, improvements and legislative changes. An active dialogue is maintained among the parties. The twenty members of the Working Environment Council are appointed by the Minister from among the employers' organisations, the Trade Unions and the Local Authorities' Association. The appointments are for four-year terms and the Council meets monthly.

Under article 66 of the working environment act no 1072 of 7 September 2012, the Working Environment Council shall participate in the organisation and performance of all working environment work through providing consultancy for the Minister of Employment and issuing recommendations to the Minister of Employment on: The overall objectives and setting of priorities for working environment work.

1. Allocations of the resources which are made available under article 68 of the working environment act between sector working environment councils and the Working Environment Council.
2. Following up on the work of the Working Environment Council.

The Working Environment Council shall on its own initiative discuss matters which it finds of importance to the working environment and shall give its opinion on such matters to the Minister for Employment. For the purpose of the Council's political discussions and setting up of priorities, it may implement development and analysis activities of a cross-disciplinary nature. The Council shall issue opinions before the Minister for Employment approves sector working environment councils in pursuance of Section 14(1).

Through representatives appointed by the Council from amongst its members or from the outside, the Council shall participate in the drafting of rules and submit proposals for new rules, drawing their authority from this Act. Furthermore, the opinion of the Council shall be obtained before such rules are laid down.

Each year, the Working Environment Council shall issue a report to the Minister for Employment concerning developments in the working environment, and improvements which the Council considers desirable.

**Workplace level - Health and safety organisation (HSO)**

Collaboration between employer and employee is a fundamental element in the Danish Working Environment Act. The employer is the responsible party.

If an enterprise has ten or more employees, collaboration must be through a formal HSO. In small enterprises with less than ten employees, the employer must facilitate informal collaboration with employees.

All members of the HSO must complete *mandatory* occupational safety and health training (5 days during the first year) and later the members are entitled to complete *supplementary* training (1½ days per year after the first year).

All companies with employees shall conduct annual OSH discussions. In these discussions it should be assessed whether the goals of the previous year have been achieved and there should be laid down

goals for next year and determined how collaboration is to take place and finally all should be documented.

Two new orders have been implemented concerning safety and health activities of the enterprises:

(Executive Order no. 1181)
http://arbejdstilsynet.dk/da/regler/bekendtgorelser/s/samarbejde-om-sikkerhed-og-sundhed-1181.aspx and occupational safety and health training (Executive Order no. 840) http://arbejdstilsynet.dk/da/regler/bekendtgorelser/g/godkendelse-af-udbyderearbejdsmiljoeuddannelse.aspx

Furthermore it should be mentioned that in 2009 Denmark ratified the ILO Convention 187 – Promotional Framework for occupational Safety and Health.

## Supplementary Information to Article 3

In the text below are embodied the answers and supplementary information requested by the ECSR regarding the 28th Danish report.

*Question to paragraph 1 - Issue of safety and health regulations*

*Protection of workers against asbestos*

The Committee notes from the report that Directive 2003/18/EC2 of the European Parliament and the Council of 27 March 2003 which amends Council Directive 83/477/EEC3 on the protection of workers from the risks related to exposure to asbestos by introducing new limits on exposure as well as minimum health and safety measures, has been transposed into domestic law by Order No. 1502 of 21 December 2004. The situation is therefore in conformity with Article 3§1. However, in reply to the Committee's question about measures taken to draw up an inventory of all contaminated buildings and materials, the Committee notes that while the report indicates that any kind of activity (e.g. demolition, repairing, maintenance) where materials containing asbestos are handled must be reported to the WEA, no mention is made of an inventory of contaminated buildings. Bearing in mind the importance of this question in the light of the right to health of the population (Article 11**), the Committee asks for the next report to provide specific information on steps taken to this effect.**

Reply:

The WEA has to a substantial extent focused on asbestos since 2007. Among other things the WEA has a website on asbestos and a guide on asbestos. The guide contains information on what kind of buildings and from which period buildings are most likely to contain asbestos.

The WEA has no possibility of making an inventory of all contaminated buildings, since the WEA does not have the necessary information to make an inventory and we do not have the powers to ask for this information from all house owners in Denmark.

*Question to paragraph 2 - Provision for the enforcement of safety and health regulations by measures of supervision*

*Occupational accidents and diseases*

The Committee notes from the report that, after a decrease between 2002 and 2003, the total number of reported occupational accidents has increased between 2004 and 2007 (from 43 678 to 48 882). After a significant diminution of fatal accidents between 2002 and 2004 (from 61 to 45), figures have

been on the increase during the reference period and reached 66 in 2007. According to Eurostat, in 2005 the incidence rate of fatal accidents at work per 100 000 workers was 71, which remains well below the average of the EU-27 states (86). The report shows that other serious accidents figures have increased from 38 626 in 2004 to 43 273 in 2007. The Eurostat incidence rate for serious accidents shows that in 2005 Denmark's rate was 83, while the average of the EU-27 countries was 78. As regards occupational diseases, the report indicates that the number of claims for compensation based on occupational diseases was 18 368 in 2006 and 19 448 in 2007. **The Committee invites the next report to be more complete and specify the number of industrial accidents and occupational diseases for all categories of workers, along with the origin of the accident or illness.**

Reply:

The following tables show the number of industrial accidents and occupational diseases in Denmark in different sectors.

**Industrial accidents**

| TABLE: Industrial accidents | Reported | | | | Recognized | | | |
|---|---|---|---|---|---|---|---|---|
| Line of business/Year | 2008 | 2009 | 2010 | 2011 | 2008 | 2009 | 2010 | 2011 |
| Number of cases | | | | | | | | |
| Agriculture, hunting, forestry and fishery | 431 | 416 | 386 | 367 | 384 | 328 | 356 | 273 |
| Raw material extraction | 33 | 35 | 35 | 50 | 28 | 29 | 28 | 30 |
| Manufacturing | 3534 | 2705 | 2292 | 2083 | 2919 | 2654 | 2179 | 1646 |
| Electricity, gas, heat and water supply | 251 | 218 | 233 | 243 | 292 | 185 | 196 | 193 |
| Building and construction industry | 2325 | 2041 | 1805 | 1853 | 1910 | 1771 | 1698 | 1370 |
| Wholesale and retail | 2014 | 1817 | 1687 | 1766 | 1554 | 1520 | 1442 | 1188 |
| Hotel and catering | 425 | 401 | 313 | 319 | 304 | 333 | 265 | 216 |
| Transport agencies | 1918 | 1761 | 1707 | 1847 | 1541 | 1620 | 1442 | 1338 |
| Banking, financial institutions and insurance companies | 253 | 243 | 213 | 176 | 165 | 188 | 182 | 120 |
| Real estate, rental services etc. | 1322 | 1420 | 1399 | 1583 | 932 | 1121 | 1176 | 1066 |
| Public administration, defence and social security | 1322 | 1420 | 1399 | 1583 | 1646 | 1547 | 1665 | 1597 |
| Education | 1464 | 1522 | 1618 | 1656 | 1122 | 1214 | 1292 | 1138 |
| Health authorities and social organisations | 4001 | 4121 | 4114 | 3910 | 3261 | 3279 | 3384 | 2859 |
| Culture, entertainment and sports | 661 | 772 | 720 | 730 | 476 | 544 | 608 | 526 |
| Domestic work | 8 | 5 | 9 | 4 | 6 | 6 | 6 | 5 |
| Territorial organisations and institutions | 0 | 1 | 2 | 1 | 0 | 0 | 2 | 0 |
| Unknown | 877 | 485 | 475 | 563 | 620 | 417 | 295 | 226 |
| Total | 21,565 | 19,884 | 19,137 | 19,329 | 17,160 | 16,756 | 16,216 | 13,791 |

78.6 % of the cases, which were settled in 2011, regarding industrial accidents were recognised by authorities as an industrial accident.

The table below demonstrates the number of reported and recognised industrial accidents, broken down by type of injury.

| TABLE: Industrial accidents | Reported | Recognized |
|---|---|---|

| Year | 2008 | 2009 | 2010 | 2011 | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|---|---|
| Number of cases | | | | | | | | |
| **Type of injury** | | | | | | | | |
| Wounds, incised wounds etc. | 1681 | 1377 | 1242 | 1289 | 1667 | 1366 | 1191 | 1012 |
| Soft tissue injury | 1032 | 956 | 808 | 631 | 802 | 860 | 761 | 510 |
| Bone fracture | 2783 | 2557 | 2526 | 2662 | 2677 | 2544 | 2525 | 2292 |
| Sprains etc. | 10958 | 9701 | 9264 | 9153 | 8216 | 8097 | 7743 | 6411 |
| Amputation | 191 | 166 | 148 | 154 | 231 | 159 | 159 | 143 |
| Other | 2065 | 1822 | 1757 | 1752 | 1722 | 1611 | 1519 | 1237 |
| Injury from chok | 1005 | 853 | 838 | 851 | 614 | 618 | 548 | 489 |
| Death | 75 | 72 | 67 | 35 | 34 | 31 | 42 | 33 |
| Undisclosed | 1775 | 2380 | 2487 | 2802 | 1197 | 1470 | 1728 | 1664 |
| Total | 21,565 | 19,884 | 19,137 | 19,329 | 17,160 | 16,756 | 16,216 | 13,791 |

The recognition percentage for the various types of injury ranges from 66 to 97.3 percent for accidents recognised in 2011. The recognition percentage for smaller categories, such as death and amputation, may vary significantly, as individual cases are of great influence.

## Occupational diseases

An occupational disease is a disease or disorder that is caused by work or working conditions. This means that the disease must have developed due to exposures in the workplace and that the correlation between exposure and disease is well-documented by medical research. It must be beyond reasonable doubt that the disease was caused by the occupation.

*Examples of occupational diseases:*

- Tennis elbow
- Allergy
- Hearing loss
- Asthma

*Exposures in the workplace that may cause some of the above diseases:*

- Repetitive work movements
- Work with arms lifted above shoulder height
- Heavy lifting work
- Work in a very noisy environment
- Work with hazardous substances

When there is adequate medical documentation that a disease is caused by a certain exposure, the disease is included on the list of occupational diseases.

The list of occupational diseases is a list of work-related diseases which are recognised as industrial injuries if a person has had certain exposures in the workplace. The list is constantly updated so that it covers the most recent research. This is done by the Occupational Diseases Committee, which is

composed of representatives from, among others, the Danish Board of Health (Sundhedsstyrelsen), the Working Environment Authority (Arbejdstilsynet), and the social partners.

The table below demonstrates the number of reported and recognised occupational diseases, broken down by line of business.

| **TABLE: Occupational diseases** | **Reported** | | | | **Recognized** | | | |
|---|---|---|---|---|---|---|---|---|
| Line of business/Year | **2008** | **2009** | **2010** | **2011** | **2008** | **2009** | **2010** | **2011** |
| Number of cases | | | | | | | | |
| Agriculture, hunting, forestry and fishery | 332 | 279 | 293 | 271 | 102 | 102 | 113 | 90 |
| Raw material extraction | 31 | 38 | 53 | 45 | 18 | 22 | 23 | 14 |
| Manufacturing | 4583 | 4307 | 3640 | 3647 | 1655 | 1664 | 1649 | 1162 |
| Electricity, gas, heat and water supply | 216 | 202 | 176 | 153 | 75 | 61 | 75 | 48 |
| Building and construction industry | 1585 | 1511 | 1619 | 1577 | 588 | 621 | 687 | 573 |
| Wholesale and retail | 1606 | 1493 | 1540 | 1630 | 354 | 369 | 405 | 319 |
| Hotel and catering | 390 | 391 | 399 | 414 | 99 | 124 | 138 | 108 |
| Transport agencies | 1254 | 1041 | 950 | 909 | 240 | 201 | 210 | 156 |
| Banking, financial institutions and insurance companies | 228 | 272 | 256 | 241 | 21 | 17 | 40 | 25 |
| Real estate, rental services etc. | 1106 | 1052 | 1099 | 1112 | 160 | 198 | 228 | 149 |
| Public administration, defence and social security | 2492 | 2250 | 2226 | 2663 | 464 | 420 | 499 | 455 |
| Education | 946 | 890 | 742 | 689 | 86 | 90 | 142 | 79 |
| Health authorities and social organisations | 3198 | 3206 | 2638 | 2435 | 662 | 711 | 710 | 550 |
| Culture, entertainment and sports | 677 | 666 | 707 | 712 | 131 | 169 | 206 | 172 |
| Domestic work | 1 | 2 | 7 | 5 | 0 | 0 | 0 | 4 |
| Territorial organisations and institutions | 1 | 3 | 4 | 3 | - | - | - | - |
| Unknown | 403 | 406 | 584 | [1]1764 | 30 | 42 | 44 | 88 |
| Total | 19,049 | 18,009 | 16,933 | 18,270 | 4685 | 4811 | 5169 | 3992 |

When it comes to occupational diseases, an initial diagnosis is registered when the case is opened by the National Board of Industrial Injuries (Arbejdsskadestyrelsen). When the case has been processed and a decision has been made as to whether the case is to be recognised or rejected, an end diagnosis is registered. The end diagnosis is more detailed than the initial diagnosis, as it is registered on basis of the information that has been collected in the case. This means that when reported injury statistics are made, this happens on basis of the injuries reported, and when recognised injuries statistics are made, it happens on basis of the end diagnosis. As such, the two tables below cannot be compared directly.

[1] The high number of occupational diseases in the undisclosed category in 2011 is the result of not all cases having been categorised yet. Line of business must be disclosed before recognition/rejection.

## Table: Reported occupational diseases, broken down by reported diagnosis

| | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|
| | Number of cases | | | |
| Skin diseases | 1,907 | 1,924 | 2,131 | 2,660 |
| Hearing disorder | 1,888 | 1,888 | 1,813 | 2,183 |
| Lung conditions | 503 | 525 | 443 | 557 |
| Cancer | 755 | 732 | 600 | 612 |
| Shoulder and neck condition | 2,761 | 2,731 | 2,395 | 2,519 |
| Arm conditions | 2,549 | 2,192 | 1,782 | 1,707 |
| Other conditions in the locomotive apparatus | 1,043 | 1,094 | 1,126 | 1,193 |
| Back conditions | 1,807 | 1,705 | 1,716 | 1,604 |
| Mental illness/distress | 3,521 | 3,089 | 3,106 | 3,486 |
| Other | 1,956 | 1,875 | 1,569 | 1,593 |
| Undislosed | 359 | 292 | 252 | 156 |
| | | | | 18,270 |
| Total | 19,049 | 18,009 | 16,933 | 18,270 |

## Table: Recognised occupational diseases, broken down by end diagnosis

| | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|
| | Number of cases | | | |
| Cancer | 187 | 166 | 172 | 160 |
| Mental illnesses | 196 | 223 | 246 | 212 |
| Nervous disorders | 148 | 144 | 158 | 110 |
| Hearing disorders | 917 | 961 | 1,152 | 877 |
| Lung conditions | 321 | 336 | 343 | 265 |
| Skin diseases | 1,619 | 1,602 | 1,695 | 1,389 |
| Back conditions | 308 | 323 | 330 | 217 |
| Other conditions in the locomotive apparatus | 810 | 857 | 891 | 580 |
| Others | 116 | 133 | 140 | 125 |
| Undisclosed | 63 | 66 | 42 | 57 |
| Total | 4,685 | 4,411 | 5,169 | 3,992 |

**Article 11**
The right to protection of health

## Article 11 – The right to protection of health

In the 28th report on the implementation of the European Social Charter submitted by the Government of Denmark in 2008 a thorough description was given of health care services in Denmark, among other things by the then enclosed publication "Health Care in Denmark". The text below will focus on major changes which have taken place since 2008.

## Article 11, Paragraph 1, Question 1

1. Please describe the general public health policy and legal framework. Please specify the nature of, reasons for and extent of any reforms.

### General health policy

As stated in the report of 2008 all residents in Denmark are entitled to public health care benefits in kind. Persons staying in Denmark without permanent residence – lawfully or unlawfully – are entitled to acute hospital care free of charge in the event of accident, sudden illness and birth or aggravation of chronic diseases etc. If the patient according to the concrete circumstances can not or should not be repatriated further non-acute hospital treatment may be given – against payment or not as is considered appropriate in the concrete situation.

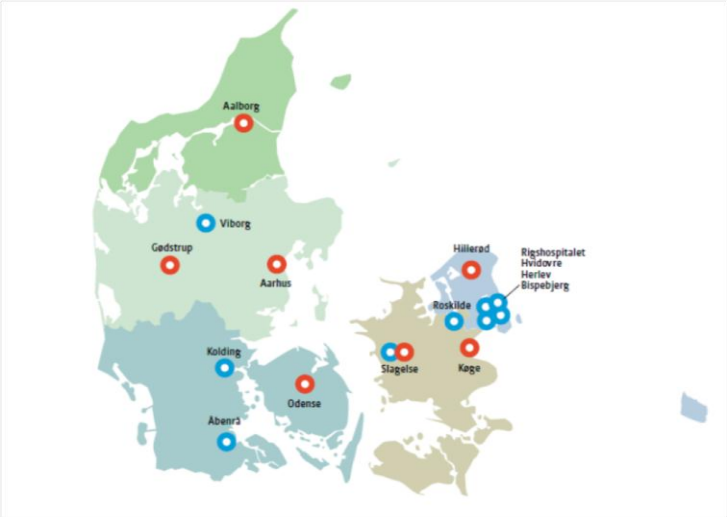
As was thoroughly described in the report submitted in 2008 the Local Government Reform which entered into force on 1 January 2007 had an effect on the distribution of tasks in the Danish health care system. The effects of the Local Government Reform are currently being evaluated.

### The future hospital structure

Over the next decade, the five regions of Denmark will be implementing significant changes to the Danish hospital service. More than DKK 40bn is being invested in new hospitals and extensions to existing hospitals over the period 2010-2020. This corresponds to the renewal of just under one third of hospital square metres in Denmark.

The hospital investments will modernise and future-proof the hospital service not least by consolidating emergency and specialised medical care within a smaller number of entities. To ensure the availability of modern healthcare nationwide and the ensuing quality boost as soon as possible, construction of the new buildings and extensions will commence over a period of a few years. A total of 16 hospital projects are planned. Investment in the new buildings is based on the requirement for flexibility regarding the financing of IT, devices and apparatus etc. This means that a billion-figure amount has been earmarked for the procurement and development of new devices and new technologies, which will be allocated on an ongoing basis over the next 10 years.

The 2010-2020 hospital plan is illustrated in the figure below.




Red circles = newbuilds on greenfield
Blue circles = modernisation projects/extensions/expansions

The new hospitals will be established in such a way that they are flexible, meet future demand for treatment, innovation and continuous operational efficiency improvements.

Once the hospital investments have been made, Denmark will have an even more modern and flexible hospital system, which compared with systems abroad, will consist of a relatively small number of high-capability units. This will mean high patient volume per unit, consolidation of expertise and improved capacity for the continuity of medical care.

**Planning of specialist functions in hospitals**
The planning of specialist functions is about planning of the Health Care System and the distribution of tasks within the different levels of specialization.

The purpose of planning of specialist function is to ensure a high level of professional quality in the treatment, continuation in the patient pathway and the best way to use resources. From the principle "practice-makes-perfect".

The planning of specialist functions should also improve the necessary development and continuation of expertise, research and development together with education in order to maintain and develop the services of the Health Care System.

Finally the planning of specialist functions should consider that health services of professional quality of a high level and efficient use of resources is to be delivered as close to the patient as possible. The planning of specialties is to ensure the necessary planning, coordination and co-operation between the parties of the Health Care System.

The functions of specialists involve two levels:
1. Main functions:
    - The majority of the basic tasks, the so-called main functions, will not be touched by the planning of specialties. The Danish Health and Medicines Authority will give advice about the main functions but will not decide the placing. This applies to 90 % of the functions.

2. Special functions corresponding to 10 % of functions:
    - Regional functions, which are functions that has a certain degree of complexity that relatively rarely occurs and/or requires many resources including i.e. cooperation with other specialties. A regional function is typically handled by 1-3 hospitals per region.
    - Highly specialized functions, which are functions that have a large degree of complexity are rarely occurring and require many resources i.e. cooperation with other specialties. A highly specialized function is handled by 1-3 hospitals nationwide.

The master plan was implemented in 2011. Continuous small adjustments have been made. Version 2.0 of the Planning of Specialized Care in Denmark will be implemented in 2013/14.

**Clinical guidelines**
Clinical guidelines have until now predominantly been developed on a non-governmental level by the different medical societies. With the passing of the government's annual budget for 2012 the development of clinical guidelines on a national level is to be upgraded. Approximately 5 clinical guidelines are to be developed in 2012 and approximately 15 guidelines each of the following years 2013-2015.

The Danish Health and Medicines Authority serves as Secretariat and will be responsible for developing the national clinical guidelines in close corporation with medical and other health professional societies.

The main objective of the national clinical guidelines is to secure that health practice at all levels of the Danish health sector follows the principles of Evidence Based Medicine. Furthermore national clinical guidelines will secure that medical treatment is carried out at the same high standard nationwide, thus, reducing the variation in health practice and in the quality of treatment.

**Cancer pathways**
In 2007 a political decision was taken to develop integrated cancer pathways as organizational and clinical standards for the diagnostics and treatment for all cancer types. National integrated cancer pathways focus on "the journey of the patient through the health care system" in order to create better pathways for cancer patients. The aim of the pathways is to reduce processing-times, in particular to reduce referral time, obtain faster diagnoses and quick onset of treatment. Furthermore it is the objective to ensure that all cancer patients are treated according to national clinical guidelines. All together the national integrated cancer pathways increase the quality of treatment and hereby the cancer survival rates.

**Planned initiatives regarding the diagnostic phase and freedom of choice**
A trial period has been proposed to the Danish Parliament regarding the diagnostic phase in public hospital treatment. The current plans involve a maximum time frame of one month for reaching a diagnosis after being referred to a hospital. Simultaneously, it is proposed to differentiate the existing rights for patients to choose free hospital treatment at private hospitals, so that this right becomes available when waiting times at public hospitals exceed one month for serious illnesses, and two months for less serious illnesses.

**Cooperation between the regional and local health authorities**
According to the Danish Health Care Act (§ 205), Health Agreements are to be entered between the regions and municipalities every four years. The aims of the health agreements are to improve the efficiency and the coordination of the different administrative levels in order to support the

coordination of care for patients who use multiple care providers.

The agreements describe the common responsibility as well as the responsibility for the regions and the municipalities concerning the handling of specific tasks within the area of health care. The health agreements must as a minimum cover six mandatory areas (admission and discharge procedures, rehabilitation, aid devices for disabled persons, disease prevention and health promotion, care for people suffering from mental illnesses and patient safety).

The Danish Health and Medicines Authority approve these agreements.

**Post-graduate medical education**
The Danish postgraduate medical system continues to follow the same framework as described in the 28th report from Denmark on the implementation of the European Social Charter.

**Patient Safety**
In January 2004, a national reporting system for adverse events was established. The purpose of the system is to improve patient safety and health care. In September 2010 the reporting system was expanded to cover adverse events occurring in the primary health care sector, including general practitioners and pharmacies. In September 2011 the reporting system was expanded furthermore in order to give patients and their relatives the possibility to report adverse events as well.

The reporting system aims to collect, analyze and communicate knowledge of adverse events in order to reduce the number of adverse events in the health care system. The act puts health care professionals under an obligation to report any adverse events they become aware of in connection with patients' treatment. The system is designed as a bottom-up process, where the majority of the work is locally rooted. This is based on the idea that adverse events which occur locally should be analyzed and corrected locally. This is also thought to have a positive impact on the development of a safety culture. Therefore, the responsible authorities – the regions or the municipalities – are obliged to receive and analyze reports of adverse events and afterwards forward the information to the National Agency for Patients' Rights and Complaints.

On the basis of the information from the local authorities the National Agency for Patients' Rights and Complaints advises the health care system concerning patient safety, thus supporting the development of learning from adverse events nationally. It is important to note that health care professionals reporting an adverse event will not as a result of the reporting be subjected to disciplinary investigations or measures by the appointing authority, supervisory reaction by the National Board of Health or criminal sanction by the courts. The reporting system is sanction-free.

**Patients' Rights**
*Legal rights*
In order to ensure patients' legal rights, a number of acts have been passed on patients' rights and the possibility of making complaints and receiving compensation for injuries caused by the health care system. The aim of these laws is to create a set of rules to ensure patients the best possible treatment and care in all situations. The main parts of patients' legal rights are gathered in the Health Care Act and in the Act on the Right to Complain and Receive Compensation within the Health Service.

The doctors are obliged to inform the patient about the illness, the possibility of treatment, the side effects etc. with a view to gaining the patient's consent to the treatment, the so called "informed consent".

It is also possible to set up a "living will", informing doctors about one's wishes regarding pain, treatment and prolongation of life treatment if one is no longer able to communicate.

Patients have a right to see their own medical records free of charge, and doctors or other medically trained staff have the obligation to interpret case records if the patient so wishes.

Medical staff must not divulge any information regarding an individual patient. Such information can only be passed on to another authority/doctor according to the provisions in the Health Care Act.

### *The complaints system*

A complaints system was established in 1988 regarding professional treatment in the health service. In 2011 The Patients' Complaints Board was replaced by The National Agency for Patients' Rights and Complaints which functions as a single point of access for patients who wish to complain about the professional treatment in the Danish health service. The National Agency for Patients' Rights and Complaints is an impartial public authority, which may express criticism of health care professionals not acting in accordance with commonly agreed professional standards or submit particularly serious cases to the public prosecutor with a view to bringing the cases before a court.

When a patient has sent in a complaint the patient is offered a dialogue with the hospital. After this local dialogue the patient is to decide whether to abide the complaint and have it tried at the National Agency.

The Agency also deals with complaints about the disregard of patient rights and complaints about the Patient Insurance Association's decisions over compensation.

In addition, The National Agency for Patients' Rights and Complaints is responsible for the administration of the system for reporting inadvertent incidents within the health service, and helps to make sure that the knowledge gained from these incidents and patient and liability suits are used preventively.

Moreover, The National Agency for Patients' Rights and Complaints offers guidance on rights to healthcare in other countries in accordance with Danish legislation, EU regulations and other international agreements.

### *Compensation*

Patients may seek compensation for injuries caused by examination or treatment in hospitals or by authorized health care professionals in private practice through the Patient Insurance Scheme, which was set up in 1992. Decisions are made by the Patient Insurance Association.

According to the Act on the Right to Complain and Receive Compensation within the Health Service compensation will be granted in the following situations: If it may be assumed that an experienced specialist would in the given circumstances have acted differently thereby avoiding the injury; if the injury is due to the malfunction or failure of technical instruments; if the injury might have been avoided using another available and just as effective treatment technique or method; or if the injury occurs as the result of examination or treatment in the form of infections or other complications that are more extensive than the patient should reasonably have to endure.

Patients may also receive compensation for injuries caused by medical products.

Subsequently it is possible, easier and faster to receive damages for loss of pay, loss of economic capacity as well as compensation for permanent disability and for pain and suffering.

*Superintendence with health care professionals and health care institutions*
The Danish Health and Medicines Authority is the supreme authority in healthcare and regulatory control of medicines.

The Danish Health and Medicines Authority's overarching area of responsibility is to create a coherent healthcare sector with integrated care pathways for patients and to ensure and develop the quality of healthcare.

Among other things The Authority:

- Is responsible for the authorization of health care professionals.
- Certify foreign doctors to ensure their ability to perform as physicians according to Danish standards.
- Is obliged to superintend that treatments are conducted in a patient safe way by both the individual health care professional and by the health care institutions (for instance hospitals and nursing homes).
- Work out recommendations on how authorized health care personal exhibit the due diligence and contentiousness.

Based on their superintendence the Danish Health and Medicines Authority publish the names of health care professionals who has received an enforcement order, is under intensified superintendence, has restrictions in their authorization or has had their authorization taken.

Also The National Agency for Patients' Rights and Complaints publish decisions concerning health care professionals who seriously or repeatedly have disregarded patient rights.

**Number of pharmacies**[2]
Denmark has approximately 314 community pharmacies in total, of which 18 are supplementary units and 68 are branch pharmacies, all fully staffed to fulfill prescriptions directly. In addition there are approximately 125 pharmacy shops, 600 over-the-counter sales outlets and 200 medicine delivery facilities, which are all affiliated to one of the pharmacies. Moreover there are approximately 10 hospital pharmacies exclusively providing services to hospitals.

The location of community pharmacies is decided by the Minister for Health in order to secure good access to and advice about medicines even in sparsely populated areas. In order to be granted a pharmacy license one has to be a pharmacist and to be experienced in management, community pharmacy and economics. A pharmacy license cannot be sold or otherwise transferred to third parties, including heirs.

Upon retirement, the pharmacy license reverts back to the Minister for Health. The pharmacy license holder is required to run his/her business according to a very detailed set of regulations. Normally he/she may only be granted a license to run one pharmacy. But under special circumstances the Minister for Health can grant him/her a license to run up till 4 pharmacies. He/she is required to

[2] The numbers are collected by the Association of Danish Pharmacies (31. December 2011)

participate in an equalization system instituting fees in order to subsidize pharmacies located in sparsely populated areas.

The price for a medicinal product is uniform throughout the country. The pharmacy purchase price is set by competing pharmaceutical suppliers in a sort of tender every 14 days. The gross margin of pharmacies is regulated by the Minister for Health. Pharmacy license holders are obliged to charge the selling price in the official list of package-prices for medical products published by the Danish Health and Medicines Authority and to offer generic substitution to the cheapest package.

**Reimbursement**
According to the Danish Health Care Act a general reimbursement is granted for the costs of medical products which have been authorised for reimbursement by the Danish Medicines Agency and is based on individual needs.

**The Danish Health Quality Assessment Programme (the Danish Model)**
The Danish Quality Model (DDKM) is a national and interdisciplinary quality system for the health care system. The objects of DDKM are to ensure the ongoing development of quality in all publicly funded health services, to create better and more coherent patient courses, and to prevent errors and unintended events in the health care system. Through the objective of good quality in both individual services and transitions DDKM is to promote cooperation between the different health care sectors. Furthermore, DDKM is involving and using the knowledge gained through research and experience in daily practice, as well as it is documenting and highlighting the quality in the health care system.

All Danish hospitals, public as well as a number of privately owned units, are covered by the Danish Healthcare Quality Programme. This is also the case for all parts of the pre-hospital sector. The majority of all Danish pharmacies are covered by the Danish Healthcare Quality Programme. Also an edition of DDKM is available to municipal healthcare services, and editions for general practitioners and specialist doctors are in progress.

**Contact persons in hospitals**
According to the Danish Health Care Act (§ 90 a) all patients admitted to hospital shall be offered a contact person if their treatment takes more than two days. Patients with special needs – for instance chronically ill or patients suffering from cancer – shall be offered a contact person at an earlier stage even if they stay in hospital for less than two days. The purpose of the contact person scheme is to contribute to increasing quality and coordination in the hospital sector.

**Survey of patient's experience**
A key quality of care policy in Danish healthcare concerns patient experiences and continuing measurement of the patient perceived quality. The National Danish Survey of Patient Experiences (Danish acronym: LUP) is a questionnaire survey for assessing patients' experiences with the Danish health care system. LUP is carried out as an annual, nationwide survey, investigating the experiences of both inpatients and outpatients in Danish hospitals. The survey presents the results at four distinct levels: unit, hospital, regional and national level.

The main objective of LUP is to provide an input for improving patients' experiences. This is done by:

- Collecting data on patient experiences on specific topics.
- Benchmarking results among comparable units.
- Systematically monitoring the development in patient experiences and evaluations over time.

Every year approximately 240,000 questionnaires are distributed to patients subsequent to their discharge or end of treatment. The response rate was 60 % in the latest survey in 2011. The survey in 2011 showed that 93% of in-patients and 97% of out-patients had a good or very good overall impression of their hospitalization or out-patient treatment. This corresponds to the results from 2010.

**IT in health care**
In recent years, efforts have been concentrated on integrating and streamlining the way patient data are accessed and shared across the health system in order to make all relevant patient data accessible when needed.

In order to achieve more coordinated and speedy development, in June 2010 the Danish Regions and the Danish Government agreed on a number of changes in the organisational setup in the field of eHealth.

The main focus of the agreement is to ensure a clearer division of labour between all parties involved including the Ministry of Health and the five Danish regions. The agreement states that the Ministry is responsible for overall development and national coordination and prioritisation. Within this framework, the regions are responsible for investments in and the implementation of specific eHealth solutions.

The agreement contains a number of milestones for the development within eHealth till the end of 2013. The milestones include:

- An ambitious plan for the integration and consolidation of the EHR systems that have been in introduced at public hospitals over the years. In 2007 there were 27 different EHR systems in use across all public hospitals. This will be reduced to five coherent EHR landscapes (one in each of the five Danish regions) before the end of 2013.

- The establishment of The National Patient Index, which will give all health care professionals access to an overview of all relevant existing data on a patient irrespective of where in the health care system the data are stored. This system is planned to be integrated in EHR systems at hospitals before the end of 2013.

## Article 11, Paragraph 1, Question 2

> 2. Please indicate the measure taken (administrative arrangements, programmes action plans, projects etc) to implement the public health policy and the legal framework.

**Measure taken to implement public health policy and legal framework**
As was described thoroughly in the 28th report the Danish health care sector has three political and administrative levels: the state, the regions and the municipalities (national, regional and local levels). The health care service is organised in such a way that responsibility for services provided by the health service lies with the lowest possible administrative level. Services can thus be provided as close to the users as possible. See also aspects on implementation covered in connection with the answers given to article 11, paragraph 1, question 1.

**Health allowance**
Old age pensioners or anticipatory pensioners (pension granted before 1 January 2003) may qualify for a health allowance if they have no other income and no capital above DKK 59,900.The health allowance covers up to 85 % of the costs of medicine, dental care, physiotherapy, psychological assistance etc. which is also subject to contributions under the Health Act. The health allowance is a current benefit which is renewed every year. The health allowance is granted on the discretion of the local authorities.

**The rate adjustment pool (Satspuljen)**
The parties behind the rate adjustment pool have signed a new agreement allowing 229 mio. Danish kroner to health. The money must reinforce among other things, patients with chronic disease, vulnerable children and young people and people with mental health problems.

**Pregnancy and maternity**
The issue of pregnancy and maternity care is regulated in the Danish Health Care Act and the services are provided by the regions and the municipalities. In the National guidelines to maternity care in Denmark from the Danish Health and Medicines Authority there are specific recommendations regarding planning of care, number of contacts during the pregnancy, examinations and much more, for instance regarding treatment of pregnant woman with special needs. Furthermore there are initiatives which focus on maternity care for women, among other things, one program targets special vulnerable groups and another program concerns special hospital care units for pregnant woman addicted to drugs.

## Article 11, Paragraph 1, Question 3

3. Please supply with relevant statistics or other information on the main health indicators and on health services and professions (for example WHO and/or Eurostat data).

### Activity in the health sector – surgical procedures, discharges and average length of stay

Number of surgical procedures (in-patient and day cases) in Denmark per 1.000

| Year | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|
| **Surgical procedures per 1000** | 94 | 102 | 104 | 100 |

Source: The Danish National board of Health

Number of discharges in Denmark per 1000

| Year | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|
| **Discharges per 1000** | 219 | 231 | 239 | 240 |

Source: The Danish National board of Health

Average length of stay for in-patient care in Denmark

| Year | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|
| **Average length of stay** | 5.2 | 4.8 | 4.6 | 4.5 |

Source: OECD Health Database 2012

Death with reference to diseases

| Year | 2008 | 2009 | 2010 | 2011 |
|---|---|---|---|---|
| **Diseases of respiratory organs** | 5745 | 6271 | 6003 | 5959 |

| | | | | |
|---|---|---|---|---|
| **Diseases of digestive organs** | 2814 | 2830 | 2792 | 2548 |
| **Cancer** | 15,511 | 15,444 | 15,781 | 15,861 |
| **Heart diseases** | 10,097 | 9959 | 9698 | 8825 |
| **Diseases of circulatory organs** | 5323 | 5229 | 5126 | 4805 |

Source: The Danish National board of Health

Infant and neonatal mortality rates per 1000 live births

| **Year** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|
| **Infant mortality rate (per 1000 live births)** | 4 | 3.1 | 3.4 | - |
| **Neonatal mortality rate (per 1000 live births)** | 3.1 | 2.3 | 2.6 | - |

Source: OECD Health Database 2012

Number of beds

| **Year** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|
| **Number of beds** | 18,748 | 18,319 | 17,667 | 16,384 |

Source: The Danish National board of Health

Staff in the health care sector, per 1000 citizens

| **Year** | **2008** | **2009** | **2010** | **2011** |
|---|---|---|---|---|
| **Practising physicians** | 3.43 | 3.48 | - | - |
| **Practising dentists** | 0.79 | 0.78 | - | - |
| **Midwives** | 0.27 | 0.28 | - | - |
| **Practising nurses** | 14.73 | 15.44 | - | - |

Source: OECD Health Database 2012

## Article 11, Paragraph 2, Question 1

1. For States that have not accepted paragraph 1, please describe the general public health policy and legal framework. Please specify the nature of reasons for and extent of any reforms.

Reference is made to the report concerning article 11, paragraph 1.

## Article 11, Paragraph 2, Question 2

2. Please indicate the measures taken (administrative arrangements, programmes action plans, projects etc) to implement the public health policy and the legal framework.

**Preventive Health Schemes**

| **Prevention** | **Remarks** |
|---|---|
| **Tobacco** | • In 2004 it was prohibited by statute to sell tobacco and alcohol to persons under the age of 16.<br>• In 2008 the age limit for selling tobacco to persons was lifted to the age of 18.<br>• In 2012 total prohibitions on smoking in child care facilities, schools, boarding schools, college etc. Further, the tax on tobacco has been increased. |
| **Alcohol** | • In 2011 the age limit for selling alcohol altered. Young people over 16 can buy alcohol with an alcohol percent up to 16,5 %. For alcohol more than 16,5 % the young people must be 18 years old. |

| | |
|---|---|
| | • In 2012 the tax on alcohol has been increased |
| **Physical Activity** | • Recommendations from the Danish Health and Medicines Authority:<br>o Children and young people: at least 60 minutes a day.<br>o Adults: at least 30 minutes a day.<br>o Elderly least 30 minutes a day<br>• Overweight: at least 30 minutes a day. |
| **Nutrition** | • In 2012 the tax on unhealthy groceries has been increased. |
| **HIV/AIDS** | • The Danish AIDS policy is based on the principles that there should be no compulsion and that anonymity can be preserved. |
| **Narcotic drugs** | • The most important effort, takes place at local level, and is aimed at vulnerable young people who experiment with cannabis, heroin and other drugs. The Danish Health and Medicines Authority therefore support local prevention initiatives and is promoting evidence on effective prevention methods.<br>• October 2012 – establishment of an injection room to drug abusers in Copenhagen. Health Personnel will be present. |
| **Pregnancy and maternity** | • Preventive examinations and treatment are offered by general practitioners, midwives, and at hospitals in connection with pregnancy and childbirth.<br>• In connection with the medical examination, the doctor or the midwife must advise the pregnant woman on her lifestyle, including her work, diet, use of stimulants etc. and help her prepare for the birth as well as advice her regarding the care of a new-born baby.<br>• Many pregnant women are scanned with ultrasound during their pregnancy. If there is any suspicion of the foetus having contracted certain specific illnesses or having any serious defects, the pregnant woman and all pregnant women over the age of 35 have the right to an amniocentesis. In case of abnormalities, the pregnant woman has the possibility of seeking advice and having an abortion. Pregnant women can choose whether they wish to give birth at home or at a hospital. |
| **Preventive health schemes for children and young people** | • All children under school age are entitled to 7 free preventive health examinations by a general practitioner. The aim of the examination is to give the child the best conditions for developing healthily - physically, psychologically and socially. The costs are covered by the regions.<br>• The local council provides all children and young people of school age two free health screenings by a doctor. The Danish Health and Medicines Authority recommend these consultations appear in the first year of school and again in the last year of school. At the same time, students are offered health guidance throughout the school years. |
| **Child and adolescent dental care** | • All children and adolescents under the age of 18 have the right to free preventive dental care and treatment provided by the local authority. The dental care is provided in public clinics or by practising dentists, who have an agreement with the local authority. |
| **Vaccinations** | • All young people below the age of 18 who are Danish nationals or who are resident in Denmark can be vaccinated against whooping cough, diphtheria, tetanus, polio, measles, German measles, mumps and Haemophilus influenza type b.<br>• All children below the age of 2 who are Danish Nationals or who are resident in Denmark can be vaccinated against pneumococcal disease. (PCV 7).Every child under the age of two years, whose mother suffers from chronic hepatitis B and is a Danish national or resident in Denmark, may be vaccinated against hepatitis B free of charge.<br>• All females over the age of 18 who are Danish nationals or are resident in Denmark may be vaccinated free of charge against German measles.<br>• All females belonging to cohorts 1992-1985 who are Danish nationals or are resident in Denmark may be vaccinated free of charge against cervical cancer (HPV vaccination). |

| | |
|---|---|
| | • Persons aged 65 years and above and from 2007 also persons with some chronic diseases and persons, who have taken early retirement, can be vaccinated against influenza, free of charge. |

**Physical activity Campaigns (Information campaign)**
Each autumn in October, The Danish Health and Medicines Authority carries out a national campaign concerning the recommendations for physical activity. In 2011 the campaign moved from autumn to spring. From 2012 the campaign is carried out in spring.

The primary recommendation for kids and youth under 18 are 60 minutes of physical activity at moderate to high intensity per day (7 days a week). The primary recommendation for adults over 18 are 30 minutes of physical activity at moderate to high intensity per day (7 days a week).

The goal of the campaign is to make sure that the target group (children) knows the recommendations.

The Danish Health and Medicines Authority have carried out 6 campaigns the last 6 years (2005 to 2011) about the recommendations for kids and youth.

Information is directed to kids, youth and adults through TV. Information in TV is supported with material send directly to schools.

The price for a campaign is around 450,000 Euro. All 7 campaigns have been evaluated.

The last measure (December 2010) of the Danish kids and youth knowledge of the recommendations for physical activity is 66 % after the campaign.

**Alcohol Campaign (Information campaign)**
Each year since 1990, The Danish Health and Medicines Authority has carried out a national campaign in one week of October concerning the recommendations for alcohol consumption among adults.

The aim is to influence knowledge on health consequences of drinking and to disseminate the national recommendations on alcohol intake. The recommendations for low-risk consumption are no more than 14 drinks per week for men and no more than 7 for women. In addition the recommendations are not to drink more than 5 drinks on the same occasion.

Information is addressed to adults through TV, posters, internet and other materials. In addition materials are sent to community professionals and general practitioners. In 2010 the price for the campaign was 0.51 mio. euro. Every campaign has been evaluated.

**Passive smoking Information Campaign**
Since 2008 Denmark has carried out two STOP SMOKING campaigns based on the Australian concept "Every Cigarette is Doing You Damage" with additional Danish developed material. The first campaign took place 8 weeks from October 2009 to January 2010 and the second campaign 6 weeks from November 2011 to January 2012. The main part of the campaigns consisted of a series of TV-spots demonstrating the health hazards of smoking encouraging smokers to stop - and encouraging them to seek help at the national Quit telephone line or locally in the municipalities. The TV-spots was broadcasted nationally. The campaigns were carried out in close cooperation with NGO's, pharmacists and municipalities and received a lot of attention and response. The evaluation of the campaigns demonstrates considerable effect.

(See evaluation with English summary
http://www.sst.dk/publ/Publ2010/CFF/Tobak/RygestopKampagneEvaluering.pdf).

The budget for the first campaign was 1.3 mio. euro and for the second part 0.8 mio. euro

**Campaign focusing on obesity among children (information campaign)**
The aim of this campaign was to inform the public about the psycho-social problems related to childhood obesity, such as bullying, isolation and stigmatization, in addition to the well-known health consequences of obesity.

The primary target group for the campaign was families with obese children, but the campaign also aimed at informing professionals working with children in risk of obesity.

The campaign ran from 2008-2010 and was communicated through TV, an internet site and posters in relevant magazines. Furthermore, local activities in the communities were carried out to support the campaign message in the getting through to the target group. These activities were for instance information material sent to the day-care institutions and distributed to the parents.

The price for the campaign was approximately 450,000 euro per year, including evaluation of the campaign.

**Campaign focusing on the flu (information campaign)**
The aim of the campaign is to inform people in risk about flu vaccination and the reasons that they are recommended vaccination.

The target groups are elderly people (+ 65 years of age), people with chronic diseases like diabetes, persons with obesity and pregnant women. The campaign takes place annually in October and November.

The campaign has been communicated every year through TV, posters, prints and articles in local and national papers and magazines. A central part of the campaign has been to aid the local municipalities by providing information about the vaccination such as brochures, letters, etc.

The first national campaign was carried out in October and November 2007. The campaigns are evaluated every year with focus groups and surveys before and after the campaign.

**National Campaign focussing on avoiding alcohol when women are pregnant or thinking about becoming pregnant**
The aim of the campaign was to prevent teratogenecity because of alcohol consumption. Furthermore the campaign encouraged women who consider becoming pregnant to take folic acid as a supplement. The folic acid supplement goes on until the pregnant women are 3 months pregnant.

The primary target groups for the campaign were women between 20 – 40 years of age who are pregnant or considering becoming pregnant. The secondary target groups were the social network around the pregnant women. The campaign took place in 2008 and 2009. The campaigns were communicated through TV, posters, prints and websites. In 2009 the price for the campaign was 0,34 mio. Euro. The campaign was evaluated.

**National campaigns against Sexually Transmitted Infections (STI)**
For the last 7 years the Danish Health and Medicines Authority has carried out campaigns about sexually transmitted infections and the use of condoms for protection of STI´s. National mass media information was channeled through TV ads, internet-ads, posters, and print-materials. Approximately 300.000 campaign-condoms were distributed through schools, cafes and bars. The main target-group for the campaign is young people aged 18 – 22 years; the primary focus has been on promotion of condom-use.

Almost complete national coverage is reached through the collaboration between national authorities, NGOs, municipalities and private companies. The campaigns were hugely successful among the youth. The yearly budget is approx. 4-500,000 Euros.

**National campaign focusing on mental illness**
The purpose of the campaign ONE OF US is to de-stigmatize mental illness in Denmark. Knowledge and good advice about how to meet people with mental illness will improve this. That is what the campaign ONE OF US is launched to do. Specifically, the campaign will work to increase the Danes' knowledge about mental illness; lessen the distance, which leads to stigmatization, prejudices and social exclusion; create a better understanding of mental illness in schools, in the workplace and everywhere else where lives are led. The nation-wide campaign ONE OF US was officially launched on September 19th 2011 and continues to 2015. The effort is launched with a national campaign including targeted regional and local activities. The campaign will focus on five main themes, where the target groups are service users and relatives, young people (especially students), the workplace, staff in health and social services, the media and the general population.

(The partners behind the campaign are a strong network, namely "The Joint Effort", which was formed in 2010 by the parties: The Social Network of 2009, The Danish Mental Health Fund, TrygFonden, Danish Regions, the five regions, KL, The Ministry of Social Affairs and The Danish Health and Medicines Authority. A subcommittee has been formed, consisting of representatives from groups of service users and relatives, professional societies, professionals and the regional psychiatric information centers. The campaign is managed nationally by the ONE OF US-secretariat, which resides with The Danish Committee for Health Education in Copenhagen. To ensure local support, regional coordination groups have also been formed.).

**Screening programs in the adult population**
*Background*
Cancer and cardiovascular diseases are the most common causes of death in Denmark. The most common cancers with high mortality rates in Denmark are for women breast, colorectal, and lung cancer and for men prostate, lung, and colorectal cancer.

The National Cancer Plan II and III (enclosed) describe the Danish national cancer screening programs. Further, breast cancer screening is regulated in the Act of Health (Sundhedsloven) article 85 and article 277. In the National Cancer Plan II from 2005 the Health and Medicine Authority (formerly the National Board of Health) recommended the following cancer screening programmes to be implemented based on international and national evidence:

- Cervix Cancer: women aged 23-59, every third year
- Breast Cancer: women aged 50-69, every second year

Further, it was recommended that screening for colorectal cancer for women and men aged 50-74 with faecal-occult-blood testing should be further investigated.

Since 2005 the following important developments have taken place:

- Cervix cancer screening: Updated national recommendations have been published and a national program for monitoring has been established.
- Breast cancer screening: All regions have established programmes for breast cancer screening as of 1st of January 2008, and all women aged 50-69 must be invited for screening at least once before 31st December2009. Clinical guidelines for breast cancer screening have been developed and a national program for monitoring has been established.
- Colorectal cancer screening: In June 2008 the Health and Medicine Authority has stated that there is a sufficient basis for a national screening program for colorectal cancer for men and women aged 50-74. The statement follows a health technology assessment from May 2008 which concludes that screening will be cost effective also at the low rate of participation that was seen in the pilot programmes which were conducted 2005-06. The Health and Medicine Authority submitted recommendations on a national screening program for colorectal cancer to the Ministry of Health in May 2010. As part of the National Cancer Plan III from 2010, the implementation of this screening program is in progress preparing the first screening round to start in 2014.
- Lung cancer screening: A clinical trial with lung cancer screening financed by the Ministry of Health and Prevention has finished. The trial involved 4.000 participants. The results are being evaluated together with comparable trials in The Netherlands and USA.
- Prostate cancer screening: International trials are currently going on. Available evidence does not support implementation of a national screening program at this time.
- Screening for cardiovascular diseases: There is currently no evidence that supports mass screening for cardiovascular disease. The Health and Medicine Authority follows the international literature on this subject.

In the following a short status of the two implemented screening programmes is provided followed by an overview of important indicators based on scientific papers. As part of the National Cancer Plan III there is increased focus on national monitoring and national quality assurance on the national screening programmes in purpose of evaluation and optimization of the programmes.

*Cervix cancer screening - Status of the program:*
In 1986 the National Board of Health published "Preventive Measures for Cervix Cancer" and since then, all regions in Denmark have implemented screening programmes for Cervix Cancer. A Medical Technology Report from 2005 showed that the implementation varied markedly across regions. In august 2006 the National Board of Health established a working committee to update the national recommendations for screening of Cervix Cancer which are now published on the website of the National Board of Health
http://www.sst.dk/publ/Publ2007/PLAN/Kraeft/Anbef_screen_livmoderhals.pdf.

Furthermore a national database with key indicators for the screening program has been established. This database, the Danish Quality Database for Cervical Cancer Screening, ensures national monitoring of the screening program and national data are available. The Health and Medicine Authority has revised the recommendations on the screening program for cervix cancer. Screening for Human Papilloma Virus (HPV) will be incorporated as the primary screening procedure in the program for women aged 60 + from 2013.

*Breast cancer screening - Status of the programme*
In the Act of Health of June 24th 2005 a paragraph is devoted to screening for breast cancer. It is

stated that screening by mammography should be offered by the regional board (Regionsrådet) to all women aged between 50 and 69 within the region every second year. It has been agreed that all regions must have established a breast cancer screening programme before 1st of January 2008 and all women must be invited at least once before 31st of December 2009.

Before 2007 breast cancer screening with mammography was implemented in three of the 14 former counties in Denmark and in the capital region of Copenhagen (after 2007 the Danish counties have been replaced by 5 regions).

In 2006 a health technology assessment was performed on mammography including the interaction between clinical mammography and screening. An English summary is available at http://www.sst.dk/publ/Publ2006/CEMTV/Klin_mammo/klinisk_mammografi_UK_sam.pdf.
National clinical guidelines for screening of breast cancer have been developed in 2008. Furthermore a national database with key indicators for the screening program has been established. This database, the Danish Quality Database for Breast Cancer Screening, ensures national monitoring of the screening program.

## Article 11, Paragraph 2, Question 3

> 3. Please supply any relevant statistics or other information, including on consultation and screening services in schools and for the rest of the population

**Screening programs in the adult population - Statistics**

*Cervix Cancer incidence*
The incidence of cervix cancer has dropped from 964 cases in 1966 to 413 in 2001 in the Danish population of approximately 5 million people. According to the National Cancer Register the incidence of cervix cancer was 369 in 2008, 395 in 2009 and 357 in 2010.

*Rates of participation and coverage*
The latest annual report (2011) from the Danish Quality Database for Cervical Cancer Screening shows a participation rate of 65.6% (January 12th 2010 - January 12th 2011).

The coverage rate is 75.5% (July 12th 2006 - January 12th 2012).

*Breast Cancer incidence*
According to the National Cancer Register the incidence of breast cancer in 2010 among women was reported to be 5047 in the Danish population of approximately 2.8 million women.

*Detection rate*
In Copenhagen a total of 106,933 screenings were undertaken from 1991-99, and 824 invasive breast carcinomas or carcinoma in situ were detected. The detection rate was 11.9 per 1000 participants in the first invitation round, and it continued to be high in subsequent rounds.

*Rates of participation and coverage*
According to the Danish Quality Database for Breast Cancer Screening the coverage rate was 77.4% in the first national round (mid-2007 to end-2010) and 70.3 % in the first half of the second round (mid-

2009 to end-2012).

In the first round the coverage rate was 76.0 %.

*Reduction in mortality rates*
In Copenhagen breast cancer mortality rates have been reduced by 25 % among all women when compared to a situation without breast cancer screening. For those participating in the screening program the mortality is reduced by 37 %.

*Rates of false positive results*
It is estimated that the cumulative risk for a false positive result for women who participate in 5 screening rounds in the screening program in Fuen is 9 % and in Copenhagen 16 %.

## Article 11, Paragraph 3, Question 1

> 1. For States that have accepted neither paragraph 1 nor paragraph 2, pleases describe the general public health policy and legal framework. Please specify the nature of, reasons for and extent of any reforms.

Reference is made to the report concerning article 11, paragraph 1 and 2.

## Article 11, Paragraph 3, Question 2

> 2. Please indicate the measures taken (administrative arrangements, programmes action plans, projects etc) to implement the public health policy and the legal framework.

### *a) Prevention of air pollution and prevention of water pollution*

Air
The Ministry of the Environment has laid down provisions for air quality in accordance with EU-directives. The air quality is monitored at 12 monitoring stations. There are problems in relation to one EU standard. The annual limit value of 40 µg/m3 NO2 have been exceeded at several locations. There are also still concentration levels of particulates above the WHO recommended levels.

In order to reduce air pollution a number of measures have been implemented. The most significant measures are:

- Low emission zones have been introduced in the five most densely populated municipalities. Here heavy lorries and busses are required to maintain the the newest vehicle standards or retrofit particle traps.
- Tax subsidies have been introduced in 2006 for light duty and passenger vehicles fitted with particle traps.
- A green Taxi act which set out rules for the vehicles to have a good environmental performance and energy efficiency.
- 32 mio. DKK have been allocated to reduce pollution from wood fired domestic stoves and boilers. New standards have also been introduced for these installations.

Further initiatives are under preparation including a possible expansion of the requirements in the low emission zones to cover light duty and passenger vehicles.

Water

The regulation for the protection of the drinking water resource in Denmark is a.o. given by the Water Supply Act, The Soil Protection Act and the Environmental Protection Act and associated Statutory Orders from the Ministry of the Environment.

*The Water Supply Act*, (No. 635 of 7. June 2010) focuses a.o. on regulations related to licences to abstract ground water, mapping of the groundwater resource, vulnerability assessments and planning of groundwater protection and protection of groundwater resources and regulates water resource planning.

The objective of the regulation for groundwater protection is thus, to ensure that the drinking water resource is protected and remains protected from activities and impacts posing a threat to the quality of our main water resource. Cleaning of groundwater for drinking water purposes is very seldom used in Denmark.

In the Statutory order "Water quality and supervisions of waterworks" (No 1024 of 31. October 2011) the maximum permissible concentration of constituents in water are stated. The values and the limits in this order are in accordance with the EU-directive 98/83/EC on the quality of water.

The Danish EPA has published health based guidelines on methods for establishing quality crirteriae for chemical substances in soil, air and drinking water (No. 5, 2006).

The Danish EPA has issued guidelines (no. 3, 2005 and no. 9243, 2010) for the municipal authorities monitoring of drinking water quality and supervision of water supplies as an amendment to Statutory order no.1024 mentioned above. The background for the guidelines are that water supply from especially private wells supplying a single household and to a lesser degree private water works often produce water of poor quality. Reasons for this are in part deficient technical installations and the borings location relative to pollution sources. The objective of the guidelines is to strengthen the procedures for water quality by increasing the local authorities' options for detecting deterioration in water quality and addressing the problem at an early stage. It is also the objective to improve the supervision of the effectiveness of water treatment.

Planned new activities in drinking water areas are covered by the Planning act and shall therefore be subject to an impact assessment of the activity pollution threat to the drinking water resource.

One of the objectives in The Soil Contamination Act is to prevent, eliminate or reduce soil contamination to hinder harmful impact of soil contamination to groundwater, human health and the general environment and the Environmental Protection Act focuses in terms of groundwater protection on the responsibility of owners of industrial, agricultural activities as well as land- and property owners in general to ensure that their activities do not give rise to a pollution threat to groundwater.

***b) Prevention of soil***

The Environmental Protection Act prohibits the discharge of polluting substances on the ground. This is however not sufficient as there are already existing contaminated sites or areas where the soil is contaminated. The Act No. 370 of June 1999 (with subsequent amendments) covers these

problems. The Act set rules for investigation, remediation/risk reduction and soil management. According to the act contaminated soil that possess a risk to residential houses, kindergartens, public playgrounds and present and future drinking water resources, should be remedied. In case of slightly contaminated soil (e.g. diffuse contamination in cities) it is in most cases not necessary to remedy the polluted soil. Instead the citizens are informed by the authority about how contact to the soil can be reduced. To ensure that contaminated soil does not create new problems when moved to another location, contaminated soil and soil from city areas that are excavated and moved to another location should be notified to the authorities.

Danish EPA has published a number of guidelines to support the regional and local authorities administration. The most important are: 1) Guideline no. 8, 2000 "Mapping of contaminated sites", 2) Guideline no. 6, 1998 (main text) and no. 7, 1998 (appendix) "Remedy of contaminated Sites", 3) Guideline no. 7, 2000 "Advices to citizen in sligthly contaminated Areas". The total yearly budget of the regions for investigation and remedy of contaminated sites is approximately 420 mio. DKK.

### *c) Protection against noise pollution*

Both the Spatial Planning Act and the Environmental Protection Act include prevention of noise annoyance in their objects clause. (Planloven: LBK 937 af 24/09/2009; Miljøbeskyttelsesloven: LBK 879 af 26/06/2010) The Working Environment Act consists the frame for protection against damaging and annoying noise at the workplace. (LBK 1072 af 07/09/2010 )

**Passive prevention**

According to the Spatial Planning Act, noise impacted areas cannot be planned for noise sensitive use, unless the plan includes means to reduce the noise (such as noise barriers). An area is noise impacted if the noise level exceeds the recommended noise limits published by the Danish Environmental Protection Agency. This rule prevents future dwellings, schools, and institutions etc. from being subject to noise pollution. In addition the Danish building legislation sets criteria for the indoor noise level from road and rail traffic, as well as to the noise from technical installations of the building and to noise insulation between dwellings.

**Active prevention**

Denmark has implemented the Directives 85/337/EØF from 27 June 1985 and 2003/35/EF from 26 May 2003, ensuring that environmental impact statements are made prior to several projects, including roads, railways, airports, and larger industries. For all projects, the noise impact is analysed whenever this is relevant, and emphasis is put to keeping of the recommended noise limits. The same aim is present in the road rules, which are guidelines for road construction published by the Road Directorate.

Many types of industries and enterprises are so-called “listed enterprises” and must as such apply for and obtain an environmental permit prior to going into operation according to the rules in the Environmental Protection Act. The environmental permit contains specific noise limits, and for new enterprises these are without exceptions identical to the recommended noise limits. If these limits are not expected to be met, relocation of the project must be considered. Airports and airfields are among the “listed enterprises” as well as many noisy leisure time installations (shooting ranges, motor racing tracks, etc).

**Measures against noise**

If an industry or an enterprise, which is not a “listed enterprise”, causes annoying noise, the Environmental Protection Act enables the authorities (generally the municipalities) to take measures

against the noise. Measures can also be taken against noise from workshops, shops, construction activities, restaurants, sports centres, recreation centres, etc. The decision is generally based on a comparison of the noise level to the recommended noise limits, and in the decision on which measures to take emphasis is put both to the noise impact and the practical and economical possibilities to reduce the noise.

The act cannot in general empower measures against noise produced by private individuals, or against noise from road or rail traffic.

**Reduction of traffic noise**

The major part of the environmental noise problems in Denmark are caused by road traffic. According to the latest estimate in the government's strategy against road traffic noise more than 786,000 dwellings are exposed to noise from roads in excess of the recommended limit (58 dB), corresponding to a third of all dwellings. As many as 191,000 dwellings are severely affected by noise (noise level above 68 dB).

The major part of the dwellings was situated near municipal roads (approx. 90%), only about 10% of the dwellings were exposed to noise from state roads. The number of dwellings exposed to noise and severely affected by noise has not changed significantly over the past 10-15 years. A national goal set up in 1993 to reduce the number of dwellings severely affected by noise from 150,000 to 50,000 by 2010 has not been approached.

The calculations in the Road Traffic Noise Strategy of the possibilities and consequences of achieving the 1993 goal show that extremely large investments (about DKK 7 billion) are needed – which is not cost-effective compared to implementing the needed measures over a longer period.

Other scenario calculations in the Strategy show that it is possible to reduce noise significantly with a smaller overall investment of DKK 2-3 billion, providing measures are organised over a longer period. Amongst other things, this involves first of all using noise reducing road paving as part of regular maintenance.

On this background the Road Traffic Noise Strategy concludes that efforts to mitigate road noise are to be planned over a longer time horizon so that they can be organised more cost-effectively.

The most important initiatives to mitigate noise in existing dwellings over the past ten years have been carried out along the state road network. From 1992 to 2012, the Road Directorate (Ministry of Transport) carried out noise abatement along the existing state road network, in particular construction of noise barriers, costing a total of about DKK 600 million. In follow-up of the Road Noise Strategy a supplementary DKK 100 million in the period to 2010 has been allocated for noise protection of state roads.

About 90 % of the noise exposed dwellings are located along municipal roads. It is estimated that the total investment of the municipalities on noise abatement during the period 2003 - 2008 has been less than 50 million DKK. During this period the state used approx. 100 million DKK on national roads, this ratio must to some extent be seen as an unbalance in the effort of reducing noise.

In 2009 the political agreement "En grøn transportpolitik" (a green transport policy) allocated 400 million. DDK for noise abatement at the existing state roads and railroads as well as for research in measures of noise abatement. The scope of noise abatement depends on the annual grants of the

Finance Act from 2009 to 2014. The most economically feasible projects reducing noise levels above 68 dB $L_{den}$ at dwellings will be granted.

Denmark has implemented the Noise Directive 2002/49/EF of 25 June 2002, and the second phase of noise mapping is almost completed. In succession to mapping the noise, the central or municipal authorities are obliged to make noise action plans, and the Danish Environmental Protection Agency has informed all municipalities about noise action plans and the possibilities they have to reduce road traffic noise. Even if a relative small number of municipalities have to make mandatory noise action plans, it is believed that knowledge about reduction of road traffic noise is well spread, and several municipalities have decided to use low-noise asphalt in general when maintaining roads.

A noise abatement programme for railways was launched in 1986, and is expected to be concluded by 2012. The scope of the programme is to reduce noise in dwellings along existing railways exposed to a noise level above 65 dB (LAeq). The abatement programme consists of establishing noise barriers and providing noise insulation of dwellings. The owners receive an offer to insulate their houses, especially the windows. The contribution from the programme is 50 – 90 % of the insulation costs, depending on noise levels. By the end of 2011 about 49 km of noise barriers have been built, financed by the noise abatement programme, and an additional 17 km have been constructed in conjunction with railway projects. The noise abatement programme is well advanced: The number of dwellings exposed to noise without having received either noise protection or an offer of noise protection has decreased from 17500 in 1986 to 3400 by the end of 2005. The noise barriers reduce the noise in 4300 homes. The owners of additionally 10500 homes have been offered support for noise insulation, where 3600 have accepted the offer. Until the end of 2005 a total of DKK 150 million has been spent on noise barriers and DKK 80 million on noise insulation.

**Noise at the workplace**
Denmark has implemented the Directive 2003/10/EF from 6 February 2003 regarding the exposure of workers to noise. The Working Environment Authority is enforced by the Working Environment Act to take measures against noise at the workplace. The Working Environment Authority has published general noise limits, but has the additional power to act against unnecessary noise. If the harmful noise cannot be reduced, hearing protectors shall be offered and must be used, and the employer shall instruct the employee about consequences of noise and the correct use of hearing protectors. Occupational medical tests are optional.

***d) Food hygiene inspection***
The aim of the Food Administration Agency is to promote safety, health and growth from earth to table.

This means that the Agency works to reduce the danger of pollutions detrimental to health to a minimum, for consumers to find a wide selection of healthy food stuffs in the shops and eat meals which to an ever greater extent comply with simple advice on nutrition.

Easily accessible advice and targeted marking schemes are supposed to make it easier for the consumers to choose among the many articles to be found on the shelves in Danish shops. The Food Administration Agency is to work for healthier eating habits and less people becoming sick from food.

Within the framework of the vision to promote healthy eating habits and improve the high rate of food safety the Food Administration Agency is currently implementing initiatives. These are:

- Adjustments – to make the product and the turnover of foodstuffs as safe and transparent as possible.
- Action plans to contribute to the combating of microbiological and zoonotic risks.
- Guidelines for businesses and private individuals - to give information, among other things, on safe food production and increase consumer awareness on food safety and health.
- Information campaigns to widen knowledge on healthy food, nutrition, advice on food and good routines as regards the production of food privately and with businesses.
- Dialogue with the customers of the Agency to give and collect information on the development in the area of the Agency.

Legislation concerning food hygiene covers the production process as well as the sale of all types of foodstuffs. In particular the rules concerning the hygienic conditions in the production process are very strict. The authorities keep control on all companies that produce or sell all types of foodstuffs. The control includes laboratory control on hygiene.

Both the food hygiene and the control provisions are laid down in compliance with international standards.

Within recent years the control systems have been modernised, on the basis of the "stable to table" philosophy and consequently the same authority keeps control on all hygienic conditions in all steps.

The legislation on hygiene of foodstuffs is laid down in Danish orders that complement the EU legislation. These orders are:

- Order on hygiene of foodstuffs (order no. 778 of 25 July 2008)
- Guideline on hygiene of foodstuffs (guideline no. 9025 of 17 January 2013)
- Order on mussels (order no. 1013 of 19 October 2011)
- Order on approval and registration of food business and own-check systems (order no. 1151 of 12 December 2011)
- Guideline on approval and registration of food business (guideline no. 9459 of 12 July 2006)
- Order on training in the hygiene of foodstuffs (order no. 123 of 15 February 2008, link:
- Guideline on training in the hygiene of foodstuffs (guideline no. 9066 of 29 February 2008)
- Guideline on microbiological criteria for foodstuffs (guideline no. 9459 of 23 December 2005)
- Circular on practise of the control in the meat establishments (circular no. 6911 of 16 December 2011)
- Order on food inspection and publication of food inspection results (order no. 1179 of 12 December 2012)
- Supplemented by guide on inspection frequencies, link: http://www.foedevarestyrelsen.dk/SiteCollectionDocuments/25_PDF_word_filer%20til%20download/02kontor/Frekvenser/Kontrolfrekvensvejledning%202012.pdf and
- The Inspection Manual, link: http://www.foedevarestyrelsen.dk/SiteCollectionDocuments/25_PDF_word_filer%20til%20download/02kontor/Kontrolvejledning2007/Samlet_kontrolvejledning.pdf

The most common zoonose in Denmark is Campylobacter. There has been taken measures to monitor and control Campylobacter and the occurrence of disease in humans caused by Campylobacter is

decreasing. Action/monitoring programmes have been established to fight salmonella in pigs, poultry, eggs and cattle. The programmes are laid down in Danish orders that complement the EU legislation. These orders are:

- Order on the control of salmonella in hatching egg layer flocks and pullets reared for them (order nr. 1463 of 16 December 2009)
- Order on salmonellosis in poultry and salmonella in poultry flocks and poultry meat (order no. 1462 of 16 December 2009)
- Order on the control of salmonella in table egg flocks and pullets reared for them (order no. 1260 of 15 December 2008)
- Order on salmonella in cattle (order no. 143 of 22 February 2012)
- Order on salmonella in pigs (order no. 404 of 8 May 2012)

The action/monitoring programmes have been successful and the occurrence of disease caused by Salmonella has dropped significantly within recent years. Denmark has a surveillance program for BSE/TSE in cattle, sheep and goat in accordance with EU-measures (Regulation (EC) No 999/2001 of the European Parliament and of the Council of 22 May 2001 laying down rules for the prevention, control and eradication of certain transmissible spongiform encephalopathies, link: http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CONSLEG:2001R0999:20110318:DA:PDF

The Danish programme is laid down in the following orders, guideline and circular:

- Order on surveillance and control of BSE/TSE in cattle (order no. 499 of 26 May 2011)
- Order on surveillance and control of TSE in sheep and goat (order no. 1288 of 20 December 2011)
- Guideline on handling specified risk material (guideline no. 9796 of 23 December 2005) Circular on control on handling specified risk material (circular no. 9823 of 23 December 2005)

A detailed description of Food Safety in Denmark can be found in the Country Profile of Denmark published by The European Commission, Health and Consumer Directorate- General, Food and Veterinary Office. You can find the Country Profile here: http://ec.europa.eu/food/fvo/country_profiles/CP_denmark.pdf

The directive 2000/13/EC of the European Parliament and of the Council on the approximation of the laws of the Member States relating to the labelling, presentation and advertising of foodstuffs has been implemented in Danish legislation, and the Danish order and guideline are:

- Order on labelling (order no. 1308 of 14 December 2005, link: https://www.retsinformation.dk/Forms/R0710.aspx?id=31582)
- Guideline on labelling (guideline of January 2013, link: http://www.foedevarestyrelsen.dk/SiteCollectionDocuments/25_PDF_word_filer%20til%20download/06kontor/Maerkning/Mærkningsvejledning,%20Januar%202013.doc)
- Guideline on labelling of food with allergenic ingredients (guideline of February 2011, link: http://www.foedevarestyrelsen.dk/Foedevarer/Maerkning/Faerdigpakkede_foedevarer/Documents/ea0d76cec08f42bf8ea47c201d3361bdVejledningommærkningaffødevarermedindholdafallerge.doc)

***e) Tobacco***

Denmark has a thorough regulation when it comes to tobacco control.

In May 2007, the Danish Parliament adopted the Smoke-free Environments Act, Act. No. 512 of 6 June 2007. The purpose of the Act is to promote smoke-free environments with the aim of preventing harmful health effects from passive smoking and involuntary exposure to tobacco smoke. In June 2012, the Danish Parliament adopted a revision of the Smoke-free Environments Act, Act No. 607 of June 18 2012 implementing more stringent rules for smoke-free environments.

The Act applies to all public and private workplaces, institutions for children and adolescents, educational institutions, indoor facilities to which the public has access, including means of public transport (the public space) and hospitality establishments. As a general rule, smoking is not permitted indoors at these premises. Moreover as a general rule it is permitted to smoke outdoor at child-care centres, primary and lower secondary schools, leisure centres, educational institutions and the like that mainly have enrolled children and adolescents younger than 18 years.

In January 2002, a law which banned tobacco advertising – both direct and indirect – entered into force *(*Act no. 492 of June 7 2001). And in September 2003, more stringent rules concerning the manufacture, presentation and sale of tobacco products were implemented (Act no. 375 of 6 June 2002). The act transposes the EC directive 2001/37/EC concerning the manufacture, presentation and sale of tobacco products into Danish law.

In 2004 it was prohibited by statute to sell tobacco and alcohol to persons below the age of 16 (Act no. 213 of 31 March 2004). In 2008 the age limit for selling tobacco to persons was lifted to the age of 18 (Act no. 536 of 17 June 2008). In 2010 more stringent rules concerning sale of alcohol to persons under 18 were implemented (Act No. 707 of June 25 2010).

In 2012 the use of pictorial warnings on cigarettes was implemented from January 2012 and the use of pictorial warnings on other smoking tobacco products from and from July 2012 (Act No. 172 of February 2 2011).

In April 2012 a law which banned the sale of cigarettes in packets less than 20 apiece entered into force (Act No. 278 of March 27 2012).

These legal changes have been accompanied by a number of public campaigns to prevent smoking and encourage smoking cessation. Local tobacco addiction treatment clinics have been established in many municipalities.

The outcome is a decline in the number of daily smokers in Denmark – from 43 % in 19 90 to 18 % in 2011. Also the number of heavy smokers is declining. .

Denmark designed in June 2003 WHO's Framework convention on Tobacco Control.

### *f) Alcohol*

For the last 30 years the annual consumption of alcohol per inhabitant has remained constant at approx. 12 litres of pure alcohol per person above the age of 14. There has though within the last decade been a decrease in the annual consumption per inhabitant, so that the consumption is approx. 11 litres of pure alcohol per person.

It is a task of the health service to monitor developments with regard to alcohol and for developing information, teaching material and preventive campaigns. Each autumn, for instance, the National Board of Health carries out an anti-alcohol campaign.

In 1998, the Parliament passed a law which banned the sale of alcohol to people below 15 years of age. In 2004 the Parliament passed a law which raised the age limit for selling alcohol to people from 15 years to 16 years (Act. No. 213 of 31 March 2004 of prohibiting the sale of tobacco and alcohol to persons below 16years). And in 2010 the Parliament passed a law which raised the age limit for selling alcohol to people from 16 years to 18years for alcohol with alcohol volume stronger than 16,5% (Act. No. 707 of 25 June 2010 of prohibiting the sale of tobacco and alcohol to persons below 18years and sale of alcohol to persons below 16 years).

***g) Drug abuse***

In the 28th report on the implementation of the European Social Charter a number of initiatives aimed at reducing health risks related to drug abuse was described. Most of these initiatives – which were all the result of political agreements between the former Government and a majority of the Parliament on the allocation of substantial financial resources – were implemented on a permanent basis and are still in effect. This applies to:

- Guidelines on the treatment of patients who are undergoing substitution treatment.
- A quality assurance system following-up the above mentioned guidelines.
- A vaccination scheme involving early and free-of-charge vaccination against both hepatitis A and hepatitis B and a scheme involving free vaccination of drug abusers' relatives against hepatitis A and B.
- Expansion of the vaccination scheme involving early and free-of-charge vaccination against hepatitis so that also people who live with someone with chronic hepatitis B, people infected with hepatitis C and children under the age of 15 who frequent residential areas where there are many injecting drug users are now included in the scheme.
- An action plan aimed at stepping up efforts to prevent the spread of hepatitis C among drug abusers and to treat drug abusers already infected with hepatitis C.
- Addition of sterile water to the injecting equipment handed out as part of syringe- and needle-exchange programmes.
- A methadone injection scheme as a treatment option.
- A heroine prescription scheme for drug abusers as a supplement to the existing substitution treatment measures.

After the submission of the 28th report on the implementation of the European Social Charter, the former Government and a majority of the Parliament agreed on the allocation of substantial financial resources for more initiatives aimed at reducing health risks related to drug abuse:

- A significant prevention programme in the shape of a three-year development project involving eight municipalities.
- Projects in the biggest cities to introduce low threshold special health care programmes for the most marginalised drug users and projects to establish low threshold special health care and social support facilities in local areas with street level drug use.
- Guidelines on the treatment of the abuse of cocaine and other stimulants.

- Guidelines to medical staff in emergency wards on the treatment of acute poisoning cases.

The Government which was formed in October 2011 is determined to maintain and develop prevention and harm reduction and the Government has a special focus on the prevention and reduction of drug related deaths. The Government's determination and focus have been expressed e.g. in the government platform "A Denmark That Stands Together" from October 2011.

Accordingly, in 2012 the legal foundation for drug consumption rooms has been established. Drug consumption rooms will make it possible to get in contact with drug users who are normally hard to reach and to use this contact to e.g. offer these drug users different health and social services.

A project aiming at distributing naloxone to drug users and training them in the administration of naloxone and in other life-saving practices in the case of overdose has been carried out by and in the City of Copenhagen. The initial experiences with the project have been positive and expansion of the project to other cities is now under preparation."

## Article 11, Paragraph 3, Question 3

3. Please supply any relevant statistics or other information on the percentage of smokers in the general population, trends in alcohol consumption and the rates of vaccination cover for infectious and epidemic diseases.

**Percentage of smokers in the general population**
The number of daily smokers in Denmark is declining – from 43 % in 1990 to 17 % in 2012 (15 year age +). 5 % reported to be occasional smokers. The number of heavy smokers is also declining. In 2012 the number of heavy smokers in the population was 8 % (15 years +). The amount of daily smokers among young persons (15 – 19 years) is 16 % (2010).

**Trends in alcohol consumption**
As for the alcohol consumption of pure alcohol per citizen over 14 years (average number of liters) over the last 10 years alcohol consumption is decreasing from 13 liter per. citizen over 14 years in 2001 to 11.2 liter in 2010.

**Vaccinations**
*Vaccination programs*
As for the Danish childhood vaccination programme the vaccination coverage is on level with earlier reports: for NMR between 88-90% and for DTaP-IPV/Hib between 84 and 88%.

The vaccination coverage for Pneumococcal vaccination which was introduced from October 1st in 2007 is between 84 and 92%.

For influenza vaccinations the coverage of free vaccinations for persons over the age of 65 has been as follows: 2008: 54%, 2009: 53%, 2010: 50% and 2011: 51%.

The vaccination coverage for cervical cancer (HPV vaccination) which was introduced to all females over the age of 12 from 1 October 2008 was for the first years 85%.

## Supplementary Information on Article 11

In the text below are embodied the answers and supplementary information requested by the ECSR regarding the 28th Danish report.

*Question to paragraph 1 – Removal of the causes of ill-health*

*Infant and maternal mortality*

The infant mortality rate has continued to decrease since the last conclusion (Conclusions XVII-2) – in 2007 it was 4.0 deaths per 1 000 live births10 (the EU 27 rate in 2006 was 4.7 per 1 00011). **The Committee asks for the next report to describe the main causes of infant mortality.**

Reply:

The main causes of the Danish infant mortality rate are related to transitory disorders of carbohydrate metabolism specific to newborn (ICD-10 code P70).

*Question to paragraph 1 – Removal of the causes of ill-health*

The Committee notes that the maternal mortality rate was 3 deaths per 100 000 live births in 2005 according to WHO12 – which would be one of the lowest in Europe – and 7.7 deaths per 100 000 live births according to the report. **The Committee asks for the next report to explain this difference and describe the main causes of maternal mortality.**

Reply:

Denmark is not informed of the way in which the WHO registers and processes its data and cannot account for the figure 3 registered deaths in 2005. The figure 7.7 denotes ICD codes 630 – 676 (number of maternal deaths, all causes, per 100.000 live births).

This measure indicates the likelihood that a pregnant woman will die from maternal causes. The number of live births used in the denominator is an approximation of the population of the pregnant women who are at risk of a maternal death. The figure 7,7 denotes the number of women who have given birth or have aborted and have been given an obstetrical diagnosis up to 42 days before their death divided by the number of living women who have given birth or aborted.

The difference in figures might be related to differences in the registration and processing of data. Denmark is unfortunately not able to extract data to describe the main causes of maternal mortality.

*Question to paragraph 1 – Removal of the causes of ill-health*

*Health care system*

*Access to health care*

There are two types of data on waiting times, retrospective and prospective data. Retrospective data relate to waiting times actually experienced and make it possible to determine whether waiting times

have increased or decreased. For instance, according to the report, waiting times for operations have decreased from 90 to 60 days. **The Committee asks for the next report to provide the data on waiting times recorded for the main types of care so as to be able to determine whether waiting times have increased or decreased.**

Reply:

Retrospective data on waiting times (for elective surgery) indicates that waiting times has decreased further from 90 days in 2001 to 54 days in 2011, on average.

*Question to paragraph 1 – Removal of the causes of ill-health*

According to another source, the privatisation of health care led in practice to unequal access to health care, in particular between workers and people who do not work**. The Committee asks for the next report to study the consequences of the privatisation of health care on equal access.**

Reply: The government has taken a number of steps to prevent unequal access to health care due to previous developments toward privatization of health care. The right for employers to exempt private health insurance from taxation for their employees has been suspended from 1 January 2012. Furthermore, the government proposes to differentiate the current rights for patients to choose free hospital treatment at private hospitals, so that this right becomes available when waiting times at public hospitals exceed one month for serious illnesses, and two months for less serious illnesses.

*Question to paragraph 1 – Removal of the causes of ill-health*

*Health care professionals and facilities*

There were 3.62 hospital beds per 1 000 inhabitants in 2006 (the average number of hospital beds in Europe (EU 27) was 5.90 per 1 000 inhabitants in 200515). The Committee notes that this number is low, has been steadily decreasing. To attempt to put the number into perspective, the report points out that hospital beds are used very efficiently and that the average length of stay per in-patient is one of the lowest in the OECD, having decreased from 6.1 days in 2001 to 5.2 days in 2007.**The Committee asks if measures are planned to halt the decrease in the number of hospital beds and if the decrease in length of stay stems from the lack of beds or from other causes.**

Reply:

The Committee rightly notes that the number of hospital beds in Denmark has been steadily decreasing and that this also goes for the length of stay per in-patient. This is a development which is expected to continue. The decreasing length of stay per in-patient is among other things due to the increasing use of fast-track surgery and the fact that an increasing number of diagnosis are treated outpatient. Both developments are well-founded on evidence showing that this leads to faster recovery and better results for the patients. Hence, the decreasing length of stay is not connected to a lack of beds.

As it is described in the answer to Article 11, Paragraph 1, Question 1, Denmark is currently investing heavily in new hospitals and extensions to existing hospitals. This is intended to result in a flexible hospital system which will meet future demand for treatment, innovation and continuous operational efficiency improvements.

*Question to paragraph 1 – Removal of the causes of ill-health*

In 2004, there were 4 530 dentists (8 per 10 000 inhabitants) and 3 564 pharmacists (7 per 10 000 inhabitants) 19, as well as 54 073 nurses and midwives (101 per 10 000 inhabitants), a density comparable to that observed in other European countries. **The Committee asks for the next report to provide more recent data .**

Reply:

The table below lists central groups of the health workforce in Denmark as of 1 January 2009.

| Health Professionals | Amount | Per 10,000 inhabitants |
|---|---|---|
| Doctors | 21,263 | 39 |
| Dentists | 5,161 | 9 |
| Pharmacists | 3,831 | 7 |
| Nurses | 60,301 | 109 |
| Midwives | 1,800 | 3 |

*Question to paragraph 2 - Advisory and educational facilities*

*Health education*

*Public information and awareness-raising*

The Committee refers to the document "Health Care in Denmark" appended to the report for a description of Denmark's preventive care and health promotion measures (see chapter 5, pp. 22-29). Of particular significance is the "Healthy throughout life" programme, which focuses on risk factors such as smoking, alcohol, accidents, poor eating habits and lack of physical exercise, as well as preventive measures linked to HIV/AIDS and drugs, and advice on contraception methods, pregnancy and maternity. Since 2007, the main responsibility for preventive health care and health promotion lies with the municipalities. **The Committee asks for the next report to describe and assess the measures taken since 2008.**

Reply:

Reference is made to the reporting on Article 11, Paragraph 2, Question 2, where the measures taken concerning the public health policy are described.

*Question to paragraph 2 - Advisory and educational facilities*

The Committee refers to the report for detailed descriptions of various other campaigns designed, among other things, to promote physical activity and spread information on alcohol, passive smoking, child obesity, flu, sexually transmitted diseases and the effects of alcohol on pregnant women. There has also been a campaign since 2001 to encourage people to eat more fruit and vegetables. **The Committee asks if there are public information campaigns on the environment.**

Reply:

The following campaigns on health related environmental issues has been executed:

- Efficient use of wood-stoves in private homes.
- Chemical exposure for hair-dressers.
- Chemistry Day
- Elimination of old pestices.
- How to avoid exposure to mercury from broken energy-saving bulbs.
- Cocktail effect of chemicals.
- Promotion of www.subsport.eu/
- How to avoid chemicals when you are pregnant.

*Question to paragraph 2 - Advisory and educational facilities*

*Health education in schools*

The National Health Board has produced an education pack designed to discourage 13 to 15-year-olds from smoking, drinking or taking drugs. It was tested in 150 schools in six geographical areas between 2005 and 2008. Healthy eating and the need for physical activity are taught in primary schools and the initial years of secondary school, along with health and sex education, which are compulsory subjects. **The Committee asks if road safety is taught at school and, if so, whether it is taught to all pupils.**

Reply:

Road safety is taught at schools, from an early stage. In primary school the pupils are mainly taught how to walk in traffic, and traffic awareness.

Later on, in secondary, the focus is especially centered on learning how to bike safely, and to watch out while driving through traffic.

When the pupils reach upper middelschool, they are taught to be aware of the effects on drinking and driving - both bike and scooters. They are also taught how riskfull driving and moving around in traffic can be, if one does not pay attention. Many schools choose to invite people that have been involved in accidents, and make an effort to work with prevention of accidents - and how to react in case of emergency. It is mandatory for the schools to teach Road saftey throughout all the school years, and first aid teaching became mandatory in 2009.

## Article 12
The right to social security

## Article 12, Paragraph 1, Question 1 - 3

1. Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms
2. Please indicate the measures taken (administrative arrangements, programmes, action plans, projects etc.) to implement the legal framework.
3. Please provide pertinent figures, statistics or any other relevant information, if appropriate.

**Medical Care**

The reimbursement system in Denmark is based on individual need, and the reimbursement rate for reimbursable medical products depends on a given patient's prior consumption of medicine within an individual reimbursement period of one year. E.g. the reimbursed amount depends on the total cost – calculated on the basis of reimbursement prices (see below) – of reimbursable medical products which the given patient has purchased within a period of one year reckoned from the date of the first purchase. A new period of one year shall commence the first time the patient purchases reimbursable medical products after the expiration of the preceding period. All reimbursable medical products have an equal status from the point of view of reimbursement.

According to the reimbursement system there is no reimbursement for persons over 18 years of age if their expenditure for reimbursable pharmaceuticals does not exceed 865 DKK within a year.

- If a patient's expenditure exceeds 865 DKK but is below 1,410 DKK within a year, 50% of the expenditure between 865 and 1,410 DKK will be reimbursed.
- If a patient's expenditure lies between 1,410 and 3,045 DKK, 75% of the expenditure between 1,410 and 3,045 DKK will be reimbursed.
- And if expenditure for reimbursable medicine exceeds 3,045DKK, the amount exceeding 3,045 will be reimbursed at the rate of 85%.

Persons under 18 years of age are not covered by the lower limit of 865 DKK. For children and young people there is a reimbursement of 60% of expenditure up to 1,410 DKK. In the case of expenditure over 1,410 DKK reimbursement rates are similar to the rates that apply to persons over 18.

On application from the treating physician the Danish Medicines Agency may determine that for persons with an extensive, permanent and professionally well-documented need for medical products, the reimbursement rate shall be 100% of the part of the total *co-payment* which is in excess of 3,555 DKK per year (i.e. in excess of total cost of DKK 16,436 for persons over 18).

On application from the treating physician the Danish Medicines Agency shall grant reimbursement of 100% of *all* medical products prescribed by a physician for patients who are terminally ill and who, according to a physician's prognosis, will not live much longer and will not benefit from hospital treatment.

For all reimbursable products a "reimbursement price" is set. The reimbursement price is used when calculating reimbursement and co-payment. The reimbursement price of the generic group is the price of the cheapest product in the group.

According to The Health Act the Minister for Health and Prevention shall lay down regulations on the adjustment of the general cost limits and the ceiling on co-payment for persons with and extensive, permanent and professionally well-documented need for medical products mentioned above. *The cost limits and the price ceiling are changed 1st January each year, and the limits mentioned above are for 2011*

Reference is made to the report concerning article 11, paragraph 1 (question 1).

**Unemployment benefits**

In Denmark unemployment insurance is a voluntary scheme administered by the unemployment insurance funds. The unemployment insurance funds are private associations of employees or self-employed persons organised for the sole purpose of ensuring economic support in the event of unemployment. Unemployment benefits are, however, largely financed by the State.

To be entitled to unemployment benefits persons who become unemployed, must have had at least 52 weeks of work within the last three years and have been a member of an unemployment insurance fund for at least one year.

Unemployment benefits are provided for up to five days per week according to fixed rules. Unemployment benefits can be paid up to a maximum of 90% of the member's previous work income, however, no more than the maximum rate of unemployment benefits of DKK 3.940 per week (2012 level). A member has a right to unemployment benefits for a maximum of two years in total within three years. The right to unemployment benefits ceases two years before entitlement to pension.

The Danish system differentiates between the situation for the unemployed insured persons and the unemployed uninsured persons. It is up to the individual whether to join an unemployment scheme and thus be insured against unemployment. Uninsured persons have to apply for social assistance benefit at their local municipality.

*Unemployment insurance – amendments*

Act No 703 of June 25th 2010 on the amendment of the act on unemployment insurance. The act introduced a reduction of the period in which an unemployed person is entitled to unemployment benefits from 4 to 2 years.

Act No 912 of July 13th 2010 on amendment of the act on unemployment insurance. The act introduced a harmonization of the period of work needed for requiring and reacquiring the right to unemployment benefits.

Act No 152 of February 28th 2012 on amendment of the act on unemployment insurance. The act introduced a simplification of the rules e.g. for the enrolment and transfer of membership in an unemployment insurance fund as well as abolition of the combi-insurance (for workers who is both employed and self-employed), educational benefits etc.

Act No 267 of March 27th 2012 on amendment of the act on unemployment insurance and the act on an active employment measures. The act concerns a temporary extension of the period in which an unemployed can receive unemployment benefits.

**Flexi-job (Flexi-job Scheme)**
No changes have been made in the legal framework of the flexi-job scheme since 2008.
In 2010, the Ministry of Employment has conducted an examination of the flexi-job scheme focusing on the local municipalities, private companies and the people in the flexi-job scheme.

The Ministry of Employment has supported projects in 13 jobcentres focusing on job search and job creation for people in the flexi-job scheme.

In June 2012 a political agreement was made to reform the flexi-job scheme. The flexi-job scheme will be organised so that the employer only pays for work that is actually conducted, and the flexi-job worker receives a wage subsidy from the municipality. People with very limited working capacity can also benefit from the scheme in future. The largest subsidies will no longer be paid to flexi-job workers with the highest pay but to flexi-job workers with the lowest pay and with the least working capacity. The new legislation entered into force January 1 2013.

In 2010, 67,000 persons were comprised by the flexi-jobs scheme. This is 27,500 persons more than expected when the scheme was introduced in 2000.

Yearly, the flexi-job scheme costs approximately 12 mill d.kr. There is an unemployment rate of almost 25 pct. in the flexi-job scheme. It is primarily women and people over the age of 50 that are in the scheme. Very few people leave the scheme – and those who do, are often transferred to the social pension scheme.

**Family Benefits**
Cash family benefits comprise family allowances (child and youth allowances, awarded to all families with children) and child allowances (a range of benefits primarily awarded to single parents, see details below).

The benefit system also includes a range of additional benefits, several of which are targeted at special groups or provides benefits of higher levels for families with children. These benefits are immediately available to all families residing in Denmark. They include, but are not limited to, housing benefits, social assistance, subsidies towards the cost of day care facilities, and help towards reasonable expenses in situations of emergency. In themselves, subsidies towards the cost of day care facilities amount to more than the total amount of family and child allowances.

Both family and child allowances are tax exempted and are generally independent of income. However, special child benefits to pensioners and students child allowance are means tested.

Rates of child and family benefits as at January 2012:

*Family allowance* amounts to:
- 0 – 2-year old child: DKK 17,064 annually.
- 3 – 6-year-old child: DKK 13,500 annually.
- 7 – 17-year old child: DKK 10,632 annually.

*Child allowances* include the following allowances and benefits:
- **Ordinary child benefit** is payable to single parents and to parents who both receive a pension under the Act on Social Pensions. The allowance is DKK 5,104 annually.

- **Extraordinary child benefit** is payable as a supplement to the ordinary child allowance to a single parent who has the child living with him/her. The allowance is DKK 5,200 annually irrespective of the number of children.
- **Special child benefit** is payable to children who have lost one parent or both parents, or when paternity has not been determined. Furthermore, a child may qualify for the benefit if one or both parents receive a pension under the Act on Social Pensions and in some other situations. The benefit is DKK 14,736 annually per child. An orphan, however, receives twice this amount.
- **Multiple birth allowance** is granted in the event of multiple births and until the children reach the age of 7. The multiple birth allowance is DKK 8,412 annually for each child, except for the first.
- **Adoption allowance** is granted to adopters of a foreign child through one of the recognised adoption organisations. The allowance is DKK 48,458 and is payable as a lump sum to cover some of the expenses incurred in connection with the adoption.
- **Students child allowance:** Parents pursuing an education and having a child living with them are entitled to an allowance of DKK 6,696 annually. A parent can only receive one such allowance and there is only paid one allowance per child.

A parent entitled to receiving child maintenance from the other parent under the Act on Child Maintenance has the right to have the maintenance paid in advance by the State if maintenance is not paid on time by the other parent. The advance payment cannot exceed the standard amount of child maintenance, DKK 14,736 annually (2012-level).

The rules on child and family allowances are laid down in the Act on Child and Youth Allowance (formerly the Act on Family Allowance) and the Act on Child Benefits and Advance Payment of Child Maintenance.

### *Changes to the rules on child and family benefits*

In 2010, the rules on family allowance and child allowances were amended by introducing a qualifying period. According to the new rules, it is a precondition for entitlement to the full benefit that the applicant has had at least 2 years of residence or employment in Denmark in a 10 year reference period prior to each benefit instalment. (Benefits are generally paid out in quarterly instalments.)

Six months of residence or employment in Denmark in the reference period entitles the applicant to 25 % of the full benefit, one year of residence or employment an entitlement of 50 %, 18 months an entitlement of 75 %, and 2 years an entitlement of 100 %.

The new rules entered into force on 1 January 2012 and apply to both Danish and foreign nationals.

### *Effective coverage of the population for family benefits*

*Family allowance* is given to every family with children under the age of 18 years subject to the fundamental criteria of residency, tax residency etc. This results in an effective coverage for this benefit of 100 %.

The various *child allowances* are targeted to special groups and the recipient has to fulfil the fundamental criteria of residency etc. The most important of these allowances are aimed at orphans, old age pensioners and single parents. Child allowances to orphans and old age pensioners are granted automatically and thus have an effective coverage of these sub-populations of 100 %. Because child allowances to single parents are only granted upon application the effective coverage of this sub-population is approximately 90 %.

**Old Age Pensions**
The following form shows the level of old age pension per month as at January 2012

| The level of old age pension per month as at January 2012 | | |
|---|---|---|
| | Non-single persons | Single persons |
| Basic amount | DDK 5,713 | DDK 5,713 |
| Pension supplement | DDK 2,868 | DDK 5,933 |
| Total | DDK 8,581 | DDK 11,646 |

Supplementary pension allowance amounts to DKK 11,200 annually in 2012.

In the reference period the following amendments were made to the old age pensions system under the Act on Social Pension:

*Increasing the pension age*
The 'Welfare Reform' from 2006 – described in the 28th report – increased the eligible age for old age pension from 65 to 67 years of age and also introduced an indexation mechanism to allow further increases of the pension age in the event of continued increases in life expectancy in Denmark. While these provisions entered into force on 1 July 2009, the change in the pension age was to take effect by an increase of the pension age by 6 months each year from 2024-2027. It follows from the indexation mechanism that the pension age is reviewed every 5 years against the life expectancy of 60 year old persons to give an expected period of public old age pension of 14½ years. The pension age may be increased with a maximum of 1 year every 5 years. If the review results in an increase in the pension age, this increase will take effect 15 years later. The first review will take place in 2015 which means that the first potential increase in the pension age will take effect in 2030.

The 'Retirement Reform' from 2011 brings forward the increase in the pension age already planned in the 2006 'Welfare reform'. This increase will now take effect successively from 2019 to 2022, instead of from 2024 to 2027. The indexation mechanism remains unchanged.

*Improving the incentives to work*
The 'Jobplan' from 2008 – described in the 28th report – is aimed at elderly persons who already receive old age pension and who wish to have an additional income from work, and at elderly persons who wish to defer old age pension while staying in the labour market. In order to create an incentive for pensioners to work, the first DKK 30,000 of income from work will not be taken into consideration in the calculation of means tested pension allowances (i.e. pension supplement, personal allowance, supplementary pension allowance and health allowance). In order to increase the incentive to defer old age pension while staying in the labour market, the number of compulsory annual working hours was reduced from 1,500 hours to 1,000 hours. The 'Jobplan' entered into force on 1 July 2008.

The 'Retirement Reform' from 2011 further increases the incentives that are part of the 'Jobplan'. The amount of annual work income not taken into consideration in the calculation of means tested pension allowances is increased from DKK 30,000 to DKK 60,000. The compulsory annual working hours for deferred old age pension is reduced from 1,000 hours to 750 hours. The reform will enter into force on 1 January 2014.

SFI– The Danish National Centre for Social Research has evaluated the effects of the Jobplan. The evaluation is based on a survey conducted around the turn of 2011-12. The findings have been published in a report (only in Danish): "Evaluering af jobplanen" in 2012. The evaluation shows that the changes introduced by the Jobplan have not been crucial for the pensioners willingness to work.

The modest effects of the Jobplan according to the evaluation may to some extent be due to the short time span from the implementation of the new law till the survey was conducted.

*Improving conditions for pensioners with low supplementary earnings or liquid assets*

In 2008, the supplementary pension allowance was increased from DKK 7,800 to DKK 10,000 (2008-level). The supplementary pension allowance is means-tested and paid out annually in January. This entered into force on 1 January 2009.

In 2009, the pension supplement was increased by DKK 2,000 annually (2009-level). This increase entered into force on 1 January 2010.

Eligibility to supplementary pension allowance and health allowance is contingent on the pensioner having liquid assets below a certain level. In 2009 this level was increased from DKK 64,100 to DKK 74,100 (2010-level). This entered into force on 1 January 2010.

*The right of refugees to old age pension*

Entitlement to the full old age pension presupposes 40 years of residence in Denmark between 15 years of age and the pension age. A pensioner with less than 40 years of residence receives a pension proportional to the number of residence years divided by 40. When calculating the number of residence years for a person who has been granted refugee status in Denmark, residence years in the refugee's home country and in other countries where the person has been considered a refugee, is equivalent to residence years in Denmark.

By 1 January 2011, this rule on equivalence of residence years for a refugee applying for old age pension was repealed. This entered into force on 1 January 2011. However, persons with refugee status in Denmark who have entered the country before 1 January 2011 and who reach the pension age before 1 January 2021 are still covered by the former equivalence rule.

**Anticipation Pension**

The following form shows the monthly level of anticipatory pension per month as at January 2012:

| **The monthly level of anticipatory pension as at January 2012** | |
|---|---|
| **New anticipatory pension scheme (after 2003):** | |
| Single persons: | DKK 17,075 |
| Non-single persons: | DKK 14,514 |
| | |
| **Old anticipatory pension scheme (before 2003):** | |
| Single persons: | |
| - Ordinary | DKK 14,424 |
| - Increased ordinary | DKK 14,424 |
| - Intermediate | DKK 14,424 |
| - Highest | DKK 18,258 |
| Non-single persons: | |
| - Ordinary | DKK 11,359 |
| - Increased ordinary | DKK 11,359 |
| - Intermediate | DKK 11,359 |
| - Highest | DKK 15,193 |

In the reference period the following amendments were made to the anticipatory pension scheme under the Act on the Highest, Intermediate, Increased Ordinary and Ordinary Anticipatory Pension.

*Improving the incentives to work*
The 'Jobplan' from 2008 (referred to above under Old Age Pensions) introduced the right for anticipatory pensioners under the old scheme to work without loosing their right to anticipatory pension. This entered into force on 1 July 2008 and is described in the 28th report.

The 'Retirement Reform' from 2011 (mentioned above under Old Age Pensions) increases the eligible age for VERP (Voluntary Early Retirement Pay) and shortens the VERP-period from 5 to 3 years. In conjunction with this, provisions for a 'senior anticipatory pension' have been established for persons over the age of 60 years with a long attachment to the labour market. The purpose of the new provisions is to create a less bureaucratic decision-making process in relation to anticipatory pension for persons with an inability to work after having had a long attachment to the labour market. The criteria regarding inability to work will be the same for senior anticipatory pension as for "normal" anticipatory pension. The provisions enter into force on 1 January 2014.

*Improving conditions for pensioners with low supplementary earnings or liquid assets*
One of the allowances under the old anticipatory pension scheme is the pension supplement which is of the same amount as old age pension, see above. In 2009, the pension supplement was increased by DKK 2,000 annually (2009-level). This increase – which also took effect for pension supplement for old age pension – entered into force on 1. January 2010.

Another allowance under the old anticipatory pension scheme is health allowance. Eligibility to health allowance is contingent on the pensioner having liquid assets below a certain level. In 2009 this level was increased from DKK 64,100 to DKK 74,100 (2010-level). This increase – which also took effect for supplementary pension allowance and health allowance for old age pension – entered into force on 1 January 2010.

**Right to equal treatment**
The relations with other member states of the enlarged European Union (EU) as regards social security are governed by Regulation (EEC) No. 1408/71 and Regulation (EEC) No. 574/72. Council Regulation (EC) No. 859/2003 allows Regulation No. 1408/71 to be applied to nationals of third countries and members of their families provided they are legally resident in the territory of a member state and are in a situation which is not confined in all respects within a single member state (Article 1). However, Council Regulation No. 859/03 does not apply to Denmark.

Denmark has multilateral or bilateral agreements on social security covering a large number of the Member States of the Council of Europe. Unfortunately, previous reports on Article 12§4 did not contain information on all these agreements:

1) Through the European Union legal framework and a number of Nordic Conventions Denmark has international agreements on social security with the EU Member States and the Nordic Countries.
2) Denmark has bilateral agreements with Turkey, Croatia, the former Yugoslav Republic of Macedonia, Serbia and Montenegro, Bosnia and Herzegovina, and Switzerland:
    - In 1976 Denmark and Turkey made a bilateral agreement on social security.
    - In 1977 Denmark agreed on a convention on social security with the Socialist Federal Republic of Yugoslavia. As parts of general agreements on succession to treaties Denmark has agreed with Croatia (1998), the former Yugoslav Republic of Macedonia (2000), Serbia and Montenegro (2003), and Bosnia and Herzegovina

(2005) that that the 1977-Convention should continue to be in force between Denmark and these states.

- In 1983 Denmark and Switzerland made a bilateral agreement on social security.

Some of these agreements have afterwards been supplemented or replaced by new agreements.

For the moment Denmark is not contemplating negotiating social security agreements with Albania, Armenia, Georgia or the Russian Federation.

As stated in the 28th report it is the general Danish policy that setting up a bilateral agreement on social security requires a mutual interest and willingness from the states in question and that an agreement will apply to a reasonable number of persons.

Denmark has multilateral or bilateral agreements on social security covering a large number of the Member States of the Council of Europe, thus guaranteeing equal treatment with Danish nationals of the nationals of these states.

Furthermore, as a main rule residence or employment in Denmark for a period of time is not a condition for the right to social security. Thus any person lawfully resident in Denmark is entitled to a number of social security benefits based on residence in Denmark, regardless of nationality.

However, as mentioned above the right to certain kinds of social security requires having had residence in Denmark for a period of time. This applies for example to anticipatory pension for persons with disabilities and ordinary old-age pension.

Anticipation pension for persons with disabilities and ordinary old-age pension are granted regardless of the financial situation of the pensioner. As it appears from the answers to questions 1-3 to Article 12§1 these pensions are of significant amounts and they are purely tax funded. Thus, Denmark finds it necessary that there is a close link between Denmark and the pensioner for entitlement to the pensions.

Requiring 10 years of residence in Denmark is a long time, but when assessing the situation for persons who are not entitled to the pensions because of the residence requirement it must be taken into account that such persons may be entitled to other kinds of benefits which may secure them a decent income.

For example, a person not eligible for anticipatory pension solely because of the residence requirement, is in most situations eligible for social assistance if the person together with his or her spouse does not have the necessary means to sustain themselves. Furthermore, a person having reached retirement age (in the voluntary early retirement scheme) without being eligible for social pension (anticipatory pension as well as old age pension) solely because of the residence requirement is entitled to special social assistance.

## Article 12, Paragraph 2, Question 1 and 2

> 1. Please describe the general legal framework. Please specify the nature of reasons for and extent any reforms.
>
> 2. Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, ect.) to implement the legal framework.

**Unemployment benefits – rates**
Maximum unemployment benefits in 2010 amounted to approximately DKK 195,520 per annum (DKK 752 per day for full-time insured persons).

Minimum unemployment benefits in 2010 amounted to approximately DKK 160,420 per annum (DKK 617 per day for full-time insured persons).

Maximum unemployment benefits in 2011 amounted to approximately DKK 199,160 per annum (DKK 766 per day for full-time insured persons).

Minimum unemployment benefits in 2011 amounted to approximately DKK 163,280 per annum (DKK 628 per day for full-time insured persons).

**Unemployment insurance – amendments**
Act No 483 of June 12th 2009 on amendment of the act on responsibility and regulation of active employment measures, the act on an active employment measures. The act establishes a one-stop employment system in the municipalities.

Act No 476 of May 30th 2012 on amendment of the act on unemployment insurance. The act concerns less activation measures for certain groups who receive unemployment benefits in a period of 6 weeks or less. This means fewer obligations for the recipient of benefits and a more flexible system.

## Article 12, Paragraph 2, Question 3

> 3. Please provide pertinent figures statistic or any other relevant information, in particular on the extent for which the branches of social security in your country fulfils (or goes beyond or falls short of) requirements of ILO convention No. 102

Denmark ratified the ILO's Convention No 102 on Social Security (Minimum Standards) in 1955.

Denmark regularly reports to the ILO about compliance with the convention. The most recent report covering the period up until May 31st 2011 was submitted to the ILO on 7 December 2011. A copy of the report is attached (Appendix 2).

**Article 12, Paragraph 3, Question 1 – 3**

> 1. Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.
>
> 2. Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.
>
> 3. Please provide pertinent figures, statistics or any other relevant information on the improvement of the social security system as well as on any measures taken to restrict the system.

Most of the social security benefits described in the reporting on article 12, paragraph 1 (question 1-3) follow the general, annual increases in wages. The rate of increase was 2.9 % in 2012. However, family allowance follows the general increase in the price index.

**Article 12, Paragraph 4, Question 1 – 3**

> 1. Please describe the legal framework, in particular the complete list of bilateral and multilateral agreements or any other means such as unilateral, legislation proposed or adopted, or administrative measures and indicate how they allow for the various social benefits the implementation of the principles provided in sub-paragraphs a) and b).
>
> 2. Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.
>
> 3. Please provide pertinent figures or any other relevant information, Please, indicate also the length of residence requirements when applicable.

Reference is made to the answers to the requests for Supplementary Information to Article 12.

## Supplementary Information on Article 12

In the text below are embodied the answers and supplementary information requested by the ECSR regarding the 28th Danish report.

*Question to paragraph 1 - Existence of a social security system*

*Risks covered, financing of benefits and personal coverage*

The Committee refers to its previous conclusions for the description of the Danish social security system (Conclusions XVII-1 and XVIII) and notes that it continues to cover the branches of social security corresponding to all traditional risks: medical care, sickness, unemployment, old age, employment injury, family, maternity, invalidity and survivors. It also continues to rest on collective funding: it is funded by taxation, with the exception of unemployment insurance which is voluntary but largely subscribed to by employees and self-employed. To assess whether a significant proportion of the total and/or active population in Denmark is guaranteed an effective right to social security with respect to the benefits provided under each branch, the Committee asked for figures in percentage indicating the personal coverage of each branch of social security.

In reply, the report highlights that in 2007:

100% of the population (lawfully resident) is entitled to public health care in kind, to old age pensions and to family benefits.

100 % of the active population (regularly working) is covered for sickness, maternity, unemployment, work accidents and occupational disease and:

- 16% of the workforce claimed sickness benefits.
- 5% of the workforce claimed maternity/paternity benefits.
- 8% of the workforce claimed unemployment benefits.
- 0.7% of the workforce claimed compensation benefits for accidents at work.
- 0.67% of the workforce claimed compensation benefits for occupational diseases. As to the latter compensation benefits, the report underlines that the percentage coverage recognised for accidents at work as well as for occupational disease increased in 2007 as compared to 2006.

**On the basis of the above, the Committee notes that the personal coverage of the social security system is satisfactory and requests that the next report continue to provide the relevant up-to-date figures.**

Reply: In 2011, 100% of the population (lawfully resident) was entitled to public health care in kind, to old age pensions and to family benefits.

100 % of the active population (regularly working) is covered for sickness, maternity, unemployment, work accidents and occupational disease and:

- 16% of the workforce claimed sickness benefits.
- 6% of the workforce claimed maternity/paternity benefits.
- 13% of the workforce claimed unemployment benefits.

- 0.7% of the workforce claimed compensation benefits for accidents at work.
- 0.7% of the workforce claimed compensation benefits for occupational diseases.

*Question to paragraph 1 - Existence of a social security system*

*Adequacy of benefits*

**The Committee asks the next report to indicate how often an official job offer is declined and unemployment benefits are suspended.**

Reply:

Reporting show 7 cases in 2011, where an unemployed benefit recipient has declined an official job offer from the job centre, and where the unemployed therefore have lost unemployment benefits for a period of time.

The government would like to emphasize, that the focus of the Danish active employment measures is that the unemployed and potential employers establishes a contact without help from the government, for instance through the internet based job-database: www.jobnet.dk. Official job offers from the jobcentre are therefore only used as one out of several active measures.

*Question to paragraph 3 - Development of the social security system*

*Unemployment*

The report lists various Acts adopted between December 2006 and June 2008 to amend the Act on unemployment insurance and the Act on active employment measures. The Committee notes that an aim of these amendments is to adjust retirement to longer life expectancy. The report states that more flexible early retirement schemes should strengthen employment. **The Committee asks the next report to provide details, including figures, in this regard.**

Reply:

**Agreement on the Retirement Reform 2011**

Denmark has a working force whose average age increases, causing the working population to decrease. In the coming years the percentage of the population 65+ will increase and the percentage of the working force of the population will be reduced. The Agreement on Later Retirement, 13th May 2011 is an attempt to meet to the demographic challenge.

Denmark is also facing economic challenges, and the Agreement on the Retirement Reform intends to meet the financial crisis and improve the Danish economy by 2020.

The main points of the Agreement on the retirement reform of 13th May 2011 are:

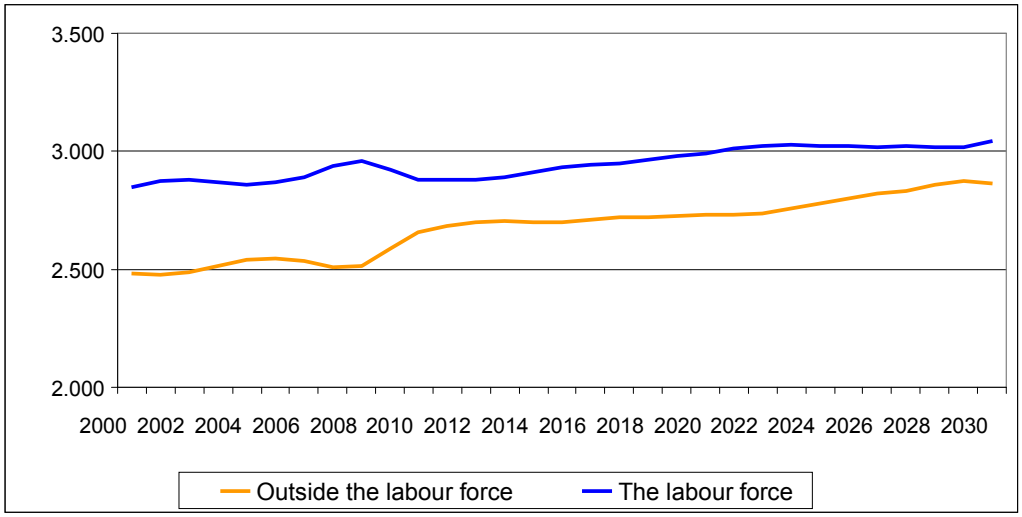
- The official retirement age in Denmark will be raised from 65 to 67 in the years 2019-2022. Thus, the implementation is five years earlier than agreed in 2006 in the Welfare Reform.
- The benefit period of Voluntary Early Retirement Scheme (VERS) will be reduced from five to three years.

- A person's own retirement savings will reduce the VERS by a higher percentage than today. And it will not possible to avoid reductions in the VERS, by working and wait a few years to apply for VERS.
- The required number of hours of work will be reduced from 1000 hours a year to 750 hours a year in the deferred pension scheme.
- The work income that does not affect the amount of social pension will increase from 30,000 DKK to 60,000 DKK a year.
- Finally the reform introduced an early retirement for seniors, that secure elderly, that have less than five years to the official retirement age, a fast administrative decision on whether or not, they are entitled to early retirement pension.

The legislation to enforce the Retirement Reform of 13th May 2011 was passed in December 2011. The effect of the reform is estimated to increase employment by 65,000 persons in 2020.

Despite the impact of the Retirement Reform, the population outside the labor force will increase faster than the labor force. And the gap between the two curves will generally be reduced.

**Trends in population and workforce in Denmark, 2000-2030. 1000 persons.**




Source: Statistics Denmark and Ministry of Finance

Most of the elements in the Agreement on Later Retirement have not yet been enforced. It is still too early to evaluate the reform.

Reference is made to the reporting on article 12§1 regarding the old age pension system and the adjustments to longer life expectancy.

*Question to paragraph 3 - Development of the social security system*

*Sickness*

The Daily Cash Benefits (Sickness) Act was amended in June 2006 by Act No. 563. According to the report, employers' obligation to pay sickness benefit was extended from 15 to 21 days; the period during which an employer with a chronically ill employee can have his expenses for the sickness

benefits covered was doubled from 1 to 2 years; the sickness benefit entitlement period for employees awaiting or undergoing medical treatment may be extended up to 2 years beyond the usual 52 weeks.

The report also indicates that in June 2008 (outside the reference period), the Government presented a strategy to deal with sickness absence focusing on the following four target areas: (i) preventing sick leave; (ii) proactive stance against long term absence; (iii) increased use of labour market activation of unemployed workers on sick leave and (iv) better coordination between Ministry of Health and Ministry of Employment.

**The Committee asks the next report to inform it of the results of these reforms in practice, bearing in mind that any changes to a social security system must nevertheless ensure a basic compulsory social security system which is sufficiently extensive.**

Reply:

Publication of the evaluation of the agreement of 2008 on absence owing to sickness is expected during the first half of 2013. As part of the evaluation a review on the effects of the measures for sick persons aiming at facilitating employment, has been published. The review contains the most important results from Danish and international studies highlighting the effects of measures aiming at facilitating sick persons' chances of returning to work.

The main conclusions of the Review are:

- There is evidence that measures based in workplaces have a positive employment effect for sick persons suffering from muscular and skeleton difficulties, and indication that measures involving the workplace, increase the chances for sick persons with mental health problems.
- Persons reported able to assume part-time work – and notifications of part-time sickness - have positive effects on employment. Early contact between the employer and the sick person also has a positive employment effect. Involvement of the place of work increases the effects of measures undertaken under the health care system, and in some cases they are a pre-condition for a positive effect.

Act No 563 from June 2006 has not been evaluated independently.

# Article 13
The right to social and medical assistance

**Article 13, Paragraph 1, Question 1**

1. Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

**Health care**
Reference is made to the text concerning article 11, paragraph 1, question 1.

**Medical assistance**
The reimbursement system is based on individual need, and the reimbursement rate for reimbursable medicial products depends on a given patient's prior consumption of pharmaceuticals within an individual reimbursement period of one year. See the reporting on article 11 and 12, Paragraph 1, Question 1. Further information on Pharmaceuticals and reimbursement can be found at www.sst.dk.

**Social assistance**
Concerning the general legal framework the right to assistance is first of all laid down in the Danish Constitution (article 75, paragraph 2).

Fundamental rules are laid down by the Danish Parliament (Folketinget). The intention is to prevent any person, lawfully resident in Denmark, facing or who risk being faced with difficulties as regards remaining in their jobs, from needing financial support and to establish a financial safety net for any person who is otherwise unable to provide for him/herself and his or her family.

The system in Denmark is decentralized. The Danish Parliament lays down framework legislation which is carried out decentrally (local authorities). The Minister for Employment issues regulations and guidelines are therefore common for management purposes.

The basic executive institution for managing the system is the municipal authorities. Every citizen has the right to have the case reviewed in the administrative appeals system, which are central authorities, but independent of government interference.

The legal framework is the Act on an Active Social Policy. When providing financial support the aim is to enable recipients to become self-supporting. Therefore, recipients and their spouses must make all efforts to improve and develop their working capacity, e.g. by accepting offers of employment or activation.

The system is based on the condition that every citizen is responsible under public law for maintaining him/herself, his or her spouse and any children under the age of 18.

## Article 13, Paragraph 1, Question 2

> 2. Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

**Social Assistance**

There have been no significant reforms of the system during the period of reference. In October 2011 a new Government took office and benefits such as starting allowance, introduction allowance, the ceiling for assistance recipient and the 300 hour-rule (cash assistance is not payable unless a person has worked for a minimum of 300 hours within 2 years) was abolished and replaced by ordinary social assistance. But the statutory effective date was 1st. January 2012 and is not within the report period.

The number of persons who for a shorter or longer period of time received social assistance is displayed in the scheme below.

Recipients of social assistance. Number of beneficiaries and beneficiaries receiving benefit full-time (calculated measure) in percent of the labor force.

| | | Number of beneficiaries | beneficiaries receiving benefit full-time (calculated measure) in percent of the labor force, 16-66 years of age |
|---|---|---|---|
| Denmark | 2008 | 151.763 | 3,3 |
| | 2009 | 176.454 | 4,0 |
| | 2010 | 187.858 | 4,5 |
| | 2011 | 195.787 | 4,8 |

Source: Jobindsats.dk

Beneficiaries who where receiving starting allowance for immigrants or introductory before December 31st of 2011 are included.

Beneficiaries in percent of the labour force are full-time beneficiaries in percent of the labour force and therefore it has been taken into account for how long a period of time during the year the beneficiary has received benefits.

The scheme below displays the number of periods with benefit that has ended. The scheme also displays the length of each period with benefit. A period with benefit ends when the recipient experience just one day without benefit or if the recipient moves to another municipality.

Recipients of cash benefit. Number of periods with benefit that has ended divided into the length of the period with benefit

| | | Number of periods with benefit that has ended divided into the length of the period with benefit | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Less than 2 weeks | 2-4 weeks | 5-13 weeks | 14-26 weeks | 27-39 weeks | 40-52 weeks | More than 52 weeks | Total |
| Denmark | 2008 | 8.229 | 25.328 | 29.764 | 18.248 | 9.305 | 6.334 | 25.970 | 123.178 |
| | 2009 | 9.083 | 27.171 | 37.923 | 23.349 | 10.916 | 6.626 | 20.360 | 135.428 |
| | 2010 | 8.367 | 27.423 | 37.748 | 25.277 | 12.896 | 8.530 | 26.766 | 147.007 |
| | 2011 | 9.442 | 28.448 | 40.188 | 27.028 | 13.223 | 8.612 | 29.498 | 156.439 |

Source: Jobindsats.dk

The consolidation act on an active social policy from 2012 (not including starting allowance etc.:

https://www.retsinformation.dk/Forms/R0710.aspx?id=140126

The consolidation act on an active social policy from 2009 includes starting allowance etc.

https://www.retsinformation.dk/Forms/R0710.aspx?id=127214

## Article 13, Paragraph 1, Question 3

> 3. Please provide pertinent figures, statistics or any other relevant information, in particular: evidence that the level of social assistance is adequate, i.e. the assistance should enable any person to meet his/her basic needs and the level of the benefits should not fall below the poverty threshold. Information must therefore be provided on basic benefits, additional benefits and on the poverty threshold in the country, defined as 50% of the median equivalised income and calculated on the basis of the poverty risk threshold value published by Eurostat.

### Social assistance

In general Denmark is considered as providing a high level of assistance allowance compared to European standards, also when taking into account the costs of living in Denmark

The table below shows the rates of social assistance 2011:

**Table 4.4: Social assistance 2011**

| | Reference | Rate |
|---|---|---|
| ***Social assistance*** | | |
| Over 25 years, provides for children | Act section 25, subsection 1, no 1 | DKK/month 13.345 |
| Over 25 years, others | Act section 25, subsection 1, no 2 | DKK/month 10.044 |
| Under 25 years, living away | Act section 25, subsection 1, no 3 | DKK/month 6.472 |
| Under 25 years, living away, reduced assistance | Act section 25f, subsection 2, no 1 | DKK/month 5.486 |
| Under 25 years, living away, supplement according to special needs (max) | Act section 25f, subsection 3 | DKK/month 986 |
| Under 25 years, living at home | Act section 25, subsection 1, no 4 | DKK/month 3.123 |
| Under 25 years, living at home, reduced assistance | Act section 25f, subsection 2, no 2 | DKK/month 2.728 |
| Under 25 years, living at home, supplement according to special needs (max) | Act section 25f, subsection 3 | DKK/month 395 |
| Under 25 years, with children | Act section 25, subsection 2, no 1 | DKK/month 13.345 |
| Under 25 years, mentally ill, with children | Act section 25, subsection 2, no 2 | DKK/month 13.345 |

| | | |
|---|---|---|
| Under 25 years, mentally ill, living away | Act section 25, subsection 2, no 3 | DKK/month 10.044 |
| Under 25 years, pregnant | Act section 25, subsection 3 | DKK/month 10.044 |
| Under 25 years, maintenance obligation, maximum assistance including supplements (max) | Act section 25, subsection 4 | DKK/month 13.345 |
| Reduced social assistance | Act section 25, subsection 5 | DKK/month 634 |
| ***Cap on social assistance (abolished as at 1 January 2011)*** | | |
| Married and cohabiting | Act section 25b, subsection 1, no 1 | DKK/month 13.345 |
| Married and cohabiting, not providers | Act section 25b, subsection 1, no 2 | DKK/month 10.044 |
| Singles, providers | Act section 25b, subsection 1, no 3 | DKK/month 16.648 |
| Singles, not providers | Act section 25b, subsection 1, no 4 | DKK/month 13.345 |
| Maximum reduction, married (added) | Act section 25c, subsection 2 | DKK/month 2.395 |
| Maximum reduction, others (per person) | Act section 25c, subsection 2 | DKK/month 1.586 |
| ***Starting allowance (abolished as at 1 January 2011)*** | | |
| Over 25 years, married and cohabiting | Act section 25, subsection 12, no 1 | DKK/month 5.367 |
| Over 25 years, single | Act section 25, subsection 12, no 2 | DKK/month 6.472 |
| Under 25 years, living away | Act section 25, subsection 12, no 3 | DKK/month 5.367 |
| Under 25 years, living at home | Act section 25, subsection 12, no 4 | DKK/month 2.668 |
| Supplement for providers, singles | Act section 25, subsection 13 | DKK/month 1.619 |
| Supplement for providers, married and cohabiting | Act section 25, subsection 13 | DKK/month 1.342 |
| ***One-off assistance*** | | |
| Over 25 and people under 25, living away (max) | Act section 25a, subsection 2 | DKK/month 5.367 |
| Living at home under 25 år (maximum) | Act section 25a, subsection 3 | DKK/month 2.668 |

Denmark has no official definition of poverty or a poverty line. Hence, on May 11 2012, the Government set up an expert committee with the aim of identifying various methods to measure poverty and suggest a possible Danish poverty line. The Committee is due to deliver a report by 2013.

Attention should be drawn to the fact that one of the problems by using the 50 cent median equivalised income threshold is that people who voluntarily work part time and (newly) self-employed as well as students may have incomes that fall below the threshold, without publicly being considered as being poor. Furthermore it should be taken into account, that ordinary social assistance in many cases constitutes a basic allowance. Depending on each individual case, different forms of supplying allowances can be offered. It is a person's or family's overall situation – the sum of own income(s) and

government assistance - which may show if a person or a family has enough for his/hers or their own subsistence. And it would often be relevant to include collaterals (capital).

Moreover it should be taken into account, that the OECD uses three poverty thresholds, which are 40, 50 and 60 per cent of the medium income. EU has chosen the threshold to be 60 per cent of the medium income.

As mentioned above the introduction allowance and the starting allowance has been abolished 31th December 2011.

### Article 13, Paragraph 2, Question 1 – 2

> 1. Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.
>
> 2. Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

Receiving social or health assistance does not result in any limitations on the recipient's political or social rights.

### Article 13, Paragraph 2, Question 3

> 3. Please provide pertinent figures, statistics or any other relevant information, if appropriate.

**Social assistance**
Reference is made to the reporting on article 13§1 (question 1. 2. and 3).
The legislation does not contain provisions, saying that persons receiving such assistance for that reason shall suffer from a diminution of their political or social rights.

### Article 13, Paragraph 3, Question 1 – 3

> 1. Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.
>
> 2. Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.
>
> 3. Please provide pertinent figures, statistics or any other relevant information, if appropriate.

**Social Assistance**
The overall legal framework is the same as described in the reporting concerning article 13§1.

When a person files a claim for assistance, the municipal authority shall immediately assess any need on the claimant's part for advice about the way in which he/she may be able to deal with any present or future financial problems, preferably unassisted. The advice may consist in information about the way in which the claimant may improve his/her employment or training prospects.

Where a person needs financial support in case of unemployment, the municipal authority may normally presume that the need can be satisfied by means of social assistance and activation.

The municipal authority shall constantly follow up on cases under the Act on an Active Social Policy to ensure continued compliance with the requirements for granting assistance. At the same time the municipal authority is required to ascertain whether there is a basis for granting other types of assistance.

As a general rule the municipal authority shall follow up on a case within 3 months of the first payment of assistance.

**Social Services**

According to Sections 10-12 of the Act on Social Services the municipalities shall ensure that everybody is given the opportunity to obtain free counseling. The object of such counseling is to prevent social problems and to help the person to overcome immediate difficulties and in the longer term enable the person to deal with problems as they arise. The municipalities shall provide counseling as to the choice of technical aids and consumer products as well as instructions in the use thereof. In connection to the counseling the municipalities shall consider if the recipient is in need of any other assistance.

The municipalities shall also ensure that parents and other persons having the actual care of a child are offered free family-related counseling designed to resolve any problem or difficulty in the family. The municipalities shall offer such counseling through fieldwork specifically targeted at persons who must be assumed to be in need of counseling due to particular circumstances. The offer of counseling shall also apply to expectant parents.

Furthermore, the municipalities shall provide free counseling, examination and treatment of children and young persons with behavioral difficulties or substantial impairment of physical and mental function as well as their families. These obligations may be discharged in cooperation with other municipalities.

Counseling may be provided on an anonymous and open basis.

The municipalities shall establish a family counseling scheme designed specifically for families with children under the age of 18 years with considerably and permanently impaired physical or mental function. Counseling shall be offered within three months after the date on which the municipality is informed that such impairment has been established.

Finally, the municipalities shall offer free counseling of adults with impaired physical or mental function or with special social problems. Such free counseling shall include fieldwork.

In addition to these general rules on counseling the Act also contains rules on counseling targeted at specific groups.

For general information about elderly persons' access to free counseling see the answers to questions 1-3 to Article 13§3 in the 28th report. On 1 January 2009, a change to the Act on Social Services entered into force, which gave all recipients of home-care service – including elderly persons – the right to have a permanent contact person, to whom they can turn for advice and guidance if they have questions about home care. The purpose of the appointment of a permanent contact person is to facilitate the access to the municipal authority for recipients of home-care services thereby creating security and continuity for the individual.

The Act on Social Services was also changed through the Children's Reform. One of the key elements of the reform which entered into force the 1 January 2011 is to secure early efforts to improve children's opportunities. The reform emphasised the right for disadvantaged children placed in accommodation outside their home to specialised support and the importance of specialised support to parents.

According to Section 2(1) of the Act on Social Services any person who is lawfully resident in Denmark is entitled to assistance under the Act, including counseling described above.

**Health Care**
In general, municipalities and regions are obliged to give guidance about health care services to citizens, according to the general administrative guidance duty and Administration Act § 7.

Furthermore, the Danish regions have established patient offices, see Health Act, chapter 11. The patient offices are established in order to strengthen patients' legal position through an improved and independent free counselling and assistance and in order to ensure a unified path for appeal and damages. Patient offices tasks are specified in Departmental Order No. 1750 of 21/12/2006 on the regional patient offices tasks and functions.

Patient offices are responsible for informing, guiding and advising patients about health care services and patient rights, waiting times, etc. and rules on complaints and damages in the health care system.

Patient offices also inform general practitioners and specialists on their patients' rights to choose in the health care system.

Patient offices can receive complaints and inquiries from patients about the above and shall upon request assist in preparing and sending requests to the appropriate authority.

Patient offices contribute to clarify misunderstandings between patients and healthcare professionals in patient care.

## Article 13, Paragraph 4, Question 1 – 3

1. Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

2. Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

3. Please provide pertinent figures, statistics or any other relevant information, if appropriate.

**Social Assistance**

Art. 3 (1) of the Act on active social policy lays down the overall conditions for receipt of social assistance in accordance with other provisions of the Act:

Any person lawfully resident in Denmark is entitled to assistance under this Act.
(2). To be eligible for permanent financial support a claimant must be -

(i) a Danish national;
(ii) a national of an EU/EEA member state, or a member of the family of such a person entitled to residence under Community law; or
(iii) be subject to an agreement under section 4, below.

(3). Financial support shall be deemed to be of a permanent nature if payable for more than half a year or if payments must be expected to last for more than half a year.
(4). If a national of a country not covered by subsection (2), paragraphs (ii) and (iii) hereof, needs permanent assistance, the Danish Immigration Authority shall decide whether the person in question shall be returned to his or her own country. Provided always that the Authority shall not decide on the return under this Act of any person referred to in subsection (2) (ii) and (iii) who has lawfully been living in Denmark for more than the past seven years with a view to obtaining permanent residence. For a person who has been subject to the Integration Act and who does not hold a permanent residence permit, the seven-year limit provided for under the second sentence hereof shall only run from the date on which the introductory period is completed.
(5). Persons covered by the Nordic Convention on Social Assistance and Social Services cannot be returned to their own country, if they have been living lawfully in Denmark for more than the past three years. Persons covered by the European Convention on Social and Health of 11 December 1953 shall only be returned to their own country in accordance with the Convention.
(6). In making decisions under subsection (4), first sentence, hereof, the Agency shall have regard to, for example, -

(i) whether the person is married to and is cohabiting with a Danish citizen, a refugee or a non-citizen who has lawfully been living in Denmark for more than three years with a view to obtaining permanent residence;
(ii) the duration of his/her stay in Denmark;
(iii) his/her medical condition;
(iv) any family connection or other ties to Denmark as compared to the country of origin; and
(v) whether any person having undertaken to maintain the non-citizen is or should be observing that duty.

The wording of this provision is almost identical with the wording of the obligations laid down in the European Convention on Social and Medical Assistance, signed at Paris on 11 December 1953, the

Convention referred to in article 13, paragraph 4. Article 7 in the European Convention on Social and Medical Assistance, signed at Paris on 11 December 1953 says, that "a Contracting Party may repatriate a national of another Contracting Party" if certain conditions are fulfilled.

## Supplementary information to Article 13

In the text below are embodied the answers and supplementary information requested by the ECSR regarding the 28th Danish report.

*Question to paragraph 3 - Prevention, abolition or alleviation of need*

The Committee takes note of the information contained in the report submitted by Denmark.
It notes the measures taken in the framework of the Act on Social Services which sets out the general legal framework for the target group of socially disadvantaged adults. In its previous conclusion (Conclusions XVIII-1) Committee asked about specific information concerning the number of employees engaged in services covered by Article 13§3, namely services offering advice and personal assistance to persons without adequate resources or at risk of becoming so. The Committee recalls that these services are different from those covered by Article 14 as they should be specifically designed to inform individuals of their rights concerning social assistance and enable them to overcome difficulties arising from their need, avoid benefit de-pendency and reestablish their autonomy.
**The Committee now asks the following questions:**

- **What mechanisms exist to ensure that those in need may receive advice and personal help services;**
- **Are services and institutions adequately distributed on geographical basis;**
- **Are services and institutions provided with sufficient means to give appropriate assistance as necessary.**

Reply:

There are 98 municipalities in Denmark and many of them have established local offices which provide counseling to persons living in the area. Each municipality has an obligation to provide the counseling described above. See the reporting on article 13§3 concerning counseling offered on social assistance.

*Question to paragraph 3 - Prevention, abolition or alleviation of need*

**The Committee asks whether foreign nationals legally resident or regularly working in Denmark are guaranteed equality of treatment with nationals regarding access to advice and personal help services.**

Reply:

According to Section 2(1) of the Act any person who is lawfully resident in Denmark is entitled to assistance under the Act, including counseling and personal help. Reference is made to the reporting on article 13§3 concerning counseling offered on social assistance under the Act on Social Services.

*Question to paragraph 4 - Specific emergency assistance for non-residents*

The Committee recalls that the personal scope of Article 13§4 differs from that of other Charter provisions. The beneficiaries of this right to social and medical assistance are foreign nationals who are lawfully present in a particular state but do not have resident status and ones who are unlawfully present. States are required to provide for those concerned to cope with an immediate state of need (accommodation, food, emergency care and clothing). They are not required to apply the guaranteed income arrangements under their social protection systems.

From the supplementary information provided by the Danish Government the Committee observes that foreign nationals present in Denmark, either lawfully or unlawfully, are entitled to emergency hospital care free of charge in the event of accident, sudden illness, aggravation of chronic diseases etc. As regards emergency social assistance, any foreign national in need is entitled to such assistance. For lawfully present persons, it is the relevant local municipality which provides assistance towards unforeseen expenses which cannot be met by the person him/herself. The Danish Immigration Service provides assistance to unlawfully present persons. **The Committee asks what is the nature and extent of the assistance which is provided in such situations, and whether a clear legal basis exists for the provision of this form of social assistance.**

Reply:

Anyone staying in Denmark without permanent residence – lawfully or unlawfully – is entitled to acute hospital care free of charge in the event of accident, sudden illness and birth or aggravation of chronic diseases etc. If the patient according to the concrete circumstances can not or should not be repatriated further non-acute hospital treatment may be given – against payment or not as is considered reasonable in the concrete situation.

Denmark's answers to supplementary questions to the 28th report contain general information on emergency social assistance provided to foreign nationals staying in Denmark – lawfully or unlawfully.

The legal basis for providing social services to persons lawfully resident in Denmark is the Act on Social Services. According to Section 2 of this Act any person who is lawfully resident in Denmark is entitled to assistance under the Act.

The Act contains no provisions specifically aimed at emergency situations but a number of the services provided for under the Act may be relevant in such situations, and these services are all available to anybody who is lawfully resident in Denmark.

Services relevant for emergency situations include:

- Counseling (see the answers to questions 1-3 to Article 13§3).
- Personal care and assistance to practical work in the home is offered to persons in need thereof due to temporary or permanent impairment of physical or mental function or special social problems.

- Treatment of drug addiction.
- Temporary accommodation facilities for women who have been exposed to violence, threats of violence or a corresponding crisis in relation to family or cohabitation relationships. These women may be accompanied by children, and they will receive care, support, and counseling during their stay.
- Temporary accommodation in facilities for persons with special problems who have no home or who cannot stay in their own home, and who are in need of accommodation and activating support, care and subsequent assistance.

According to Section 3 of the Active Social Policy Act any person who is lawfully resident in Denmark is entitled to assistance under the Act. Chapter 10 of the Act contains rules on assistance in special cases, which also apply in emergency situations. Generally, the assistance covers various reasonable and necessary expenses. The Chapter contains specific rules on expenses for medical care and medicine and on moving expenses. Under the Act a person lawfully resident in Denmark includes a person who during his presence in Denmark applies for residency and is entitled to stay in Denmark while the application is being processed (procedural residence). Persons lawfully present in Denmark in pursuance of community law concerning residence for first time job seekers and persons entitled to stay in Denmark for up to three months without administrative conditions (tourists) may only receive assistance under the Act in connection with their journey home.

According to Section 42 a of the Aliens Act, unlawfully present persons are entitled to have any expenses of their stay and necessary healthcare services defrayed by the Immigration Service if necessary for the maintenance of the person. The assistance provided by the Immigration service to unlawfully present persons consists of inter alia accommodation and cash allowances and/or food in

## Article 14
The Right to Benefit from Social Welfare Services

## Article 14, Paragraph 1, Questions 1-2

1. Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.
2. Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

**Elderly Persons**

The Act on Social Services is – i.a. – aimed at satisfying needs resulting from impaired physical or mental function or from special social problems. In respect of elderly persons, services must be provided as "help to recipients to help themselves". This means that assistance must be planned in close cooperation with the recipient and that the main object of the assistance is to enable the recipient to manage on his or her own and to perform as many tasks as possible alone. In addition, prevention plays a key role in the Danish elderly policy.

In the reference period the following amendments were made to the rules on social services for elderly persons under the Act on Social Pension and the following initiatives were taken to better social services for elderly persons:

*Dissemination of best practice on rehabilitation and preventive issues*

An initiative to support persons in staying healthy, active and in control of their own lives by dissemination of best practice on rehabilitation preventive issues has received funding from the Rate Adjustment Pool-agreement.

In 2011, about 90 % of the municipalities used training as an alternative to conventional compensatory home-care services. Several municipalities already report that their increased focus on training and rehabilitation helps increase quality of life by making the persons less dependant and more independent of social services as well as it helps limit the resources spent on elderly care. For 2012 - 2015, DKK 26.5 million are allocated to qualify the work with rehabilitation in the municipalities. During the same period, DKK 8.5 million are allocated to a project that aims to qualify the preventive work of the municipalities for the elderly persons.

*National Diet Action Plan for elderly*

In 2011, work was initiated to develop a national diet action plan that will give the municipalities a number of specific recommendations for food service offers to the benefit of elderly persons. The main purpose of the action plan is to gather experience and evidence-based knowledge in the field of food and meals for elderly persons. The purpose of the plan is also to raise awareness of the impact meals have on health and quality of life of elderly persons. It will support the local efforts to ensure quality of food service for elderly persons. The action plan shall be ready in the autumn of 2012.

See also the answers to questions 1-2 to Article 4 of the Additional Protocol for information about the Commission on Quality of Life and Self-determination in Nursing Homes, the Commission on Home Care Services and the Strategy on Dementia.

*Regulatory policy for home care services*
As of 1 July 2011, the municipalities are obliged to prepare and publish a regulatory policy for home care services with clear guidelines and procedures for organization of supervision of and assistance to home care recipients. The purpose of this is to ensure that all municipalities fulfil their obligations to supervise home care and to provide more transparency for recipients of home care. The new rules supplement the already existing supervisory rules in this area.

*Prices ceiling for payments for food services*
In 2009 and 2010, the Government introduced a price ceiling for payments for food services for residents in care homes and for persons living in their own homes, regardless of their income and assets. The ceiling includes all meals in care homes every day to a maximum rate of DKK 3,262 monthly, and an offer of a daily main meal to a maximum rate of DKK 47 for persons living in their own homes (2012 level).

*Permanent contact person*
See the report concerning article 13§3.

**Children and Families**
By 1 January 2011 a reform of the social welfare services aimed at children – the Children's Reform – was implemented. The objective of the Reform is to make it possible for disadvantaged children to lead a normal life during childhood and adolescence. The Reform improves initiatives targeting disadvantaged children who should have the same possibilities for personal expression, development and good health as their peers. No child should be denied a good life because it grew up in difficult circumstances.

The aim of the Reform is to make sure that a greater number of exposed children get an education and get healthier, including eliminating or reducing drug addictions etc. The children should experience stability in the social services they receive and when placed outside their home they should experience stability in their relationship with adults. The children should be prepared to establish social relationships.

The Reform aims at preventing problems from arising and establishes therefore a system where children with problems are discovered at an earlier stage and offered relevant social services, thereby reducing their problems and solving them easier. The Reform stresses that when offering social services to a child the focus should be on the best interests of the child. The services offered should be adjusted to the needs of the child in question.

See the report concerning article 13§3 (question 1 -3).

The cost of the Reform was 210 – 250 million DKK a year (2010-level).

**Socially Disadvantaged Adults**
A strategy aiming at reducing homelessness in Denmark has been established. The program under the

strategy runs for 2009-2013 with a budget at DKK 500 million. The strategy consists of four overall and long-term objectives:

- No one should live a life on the street.
- Young person should not stay in care homes but should be offered alternative solutions.
- Persons who are ready to move into their own homes with the necessary support should – before the move – be allowed to stay in care homes or shelters for a longer period.
- Release from prison or discharge form treatment or hospitals must presuppose that there is a solution to the housing situation of the person involved.

**Persons with Disabilities**

Denmark ratified the UN Convention on the Rights of Persons with Disabilities on 24 August 2009 without exemptions. In ratifying the Convention, the States Parties commit themselves to design national legal rules and administrative practices that comply with the Convention.

As part of the implementation of the Convention, the government has launched the work of a new long-term, multi-disciplinary action plan for the disability area. The plan must contribute to setting up clear political and economic priorities for disability-policy initiatives across policy areas and must function as a framework for the continued work of implementing the Convention.

As an additional aspect of implementing the Convention, the government has launched nationwide communication activities to make persons with disabilities aware of the Convention and the rights of the individual. The Convention has been communicated in easy-reading, sign-language and audio-visual formats. Special theme meetings were held for persons with mental disabilities nationwide.

Material has also been developed by the National Board of Social Services to provide information and best practices at local level on how to address and implement the Convention. The material targets users and staff at local and regional levels for persons with disabilities.

National implementation and monitoring of the UN Convention on the Rights of Persons with Disabilities Article 33(1) of the Convention requires States Parties to establish a structure for coordinating national implementation.

The Ministry of Social Affairs and Integration was appointed as the national nexus for matters related to implementing the Convention. The reason for the appointment is that the Ministry of Social Affairs and Integration is the Coordinating Ministry for disability matters. As Coordinating Ministry for disability matters, the Ministry exercises its function as the national nexus in close contact and coordination with the other parts of the Government and organisations in the disability area.

The Minister for Social Affairs and Integration holds responsibility for the Interministerial Committee of Civil Servants on Disability Matters, which assists the Government in coordinating between sector areas. The terms of reference for the Committee provide that the Committee is tasked with the Central Administration's coordinating function to facilitate interministerial activities in different sectors and at different levels aimed at implementing the Convention. The Committee seats representatives from all ministries. Disability organisations are involved in the committee work as needed.

The task of promoting, protecting and monitoring under Article 33(2) of the Convention was placed with the Institute for Human Rights. The Institute is Denmark's national human rights institution and is accredited as a National Human Rights Institution (NHRI).

According to Article 33(3) of the Convention, civil society, in particular persons with disabilities and their representative organisations must be involved and participate fully in the monitoring process. Involvement will be effected through the Disability Council, already tasked with advising the Government on disability issues. As a result of Denmark's accession to the Convention, the Council has, for instance, been tasked with discussing and assessing developments in society for persons with disabilities on the basis of the Convention.

The Parliamentary Ombudsman contributes to monitoring the disability area by continuing his current work of monitoring developments in equal treatment.

Thus, together, the Institute of Human Rights, the Disability Council and the Parliamentary Ombudsman constitute the framework for promoting, protecting and monitoring the Convention in accordance with the obligations stipulated in Article 33(2) of the Convention.

## Article 14, Paragraph 1, Question 3

> 3. Please provide pertinent figures, statistics or any other relevant information to demonstrate the effective access to social services (beneficiaries in total and per category of social welfare services, number and geographical distribution of services, staff number and qualifications).

As of 1 January 2012, 5,580,516 persons were living in Denmark. 1,202,289 of these persons were below the age of 18 years (21.5 % of the population).

The number of children placed outside their home was 12,565 in 2010. The number of placements was slightly reduced compared to previous years. In comparison to the population aged 0-18 years, 1-2 % was placed outside their home.

Statistics on elderly persons may be found in the report concerning Article 4 of the Additional Protocol (question 3).

Information on the number of persons with reduced physical or mental functional capacity living in Denmark is not available, as persons are not registered according to functional capacity, and as it is impossible to make a clear-cut definition of when a person has reduced functional capacity. However, the number below of persons receiving social services aimed at persons with reduced physical or mental functional may provide an indication on the number of persons with reduced physical or mental functional capacity in Denmark.

| **Number of recipients in 2011 of the most important social services provided due to reduced physical or mental functional capacity**<br>(Please note that the same person may receive several kinds of the social services mentions) | |
|---|---|
| Escort schemes for physically disabled persons | 8,515 |
| Assistant scheme | 1,480 |
| Contact person for deafblind persons | 338 |
| Sheltered employment | 9,217 |
| Activity and social activity offers | 22,865 |
| Socio-pedagogic assistance | 29,585 |
| Long-term residential accommodation | 6,461 |
| Temporary residential accommodation | 3,569 |

Finally, as of the 6th week of 2011 the total number of homeless persons in Denmark was 5,290.

## Article 14, Paragraph 2, Questions 1-3

> 1. Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.
> 2. Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.
> 3. Please provide pertinent figures, statistics or any other relevant information to demonstrate the participation of the voluntary sector to the provision of social services, as well as the effective access of individuals to these services.

Reference is made to the 28th report for information on the Council for Volunteer Action, the Centre for Voluntary Social Work, Section 18 of the Act on Social Services, the PUF Fund (the Fund for Voluntary Social Work for the Benefit of Persons with Social Problems), and the non-profit voluntary sector in Denmark.

In 2011, DKK 149.9 million was distributed to the municipalities according to Section 18 of the Act on Social Services. For 2012, the PUF Fund has DKK 49.3 million for voluntary social work. DKK 4.5 million are available for education and courses for volunteers every year.

The Rate Adjustment Pool-agreement for 2011 and 2012 earmarked DKK 1,032 million and DDK 1.843,1 million for the improvement of the conditions of vulnerable and socially disadvantaged groups for the periods 2011-2014 and 2012-2015.

Finally, the government financially supports voluntary organisations, including organisations in the social sector, with means allocated from betting and lottery funds. In 2012, DKK 183.1 million is available for this purpose from these funds.

## Supplementary Information to Article 14

In the text below are embodied the answers and supplementary information requested by the ECSR regarding the 28th report.

*Question to paragraph 1 - Provision or promotion of social welfare services*

*Quality of services*

At regional level, the county authorities regularly monitor the provision of social services in accordance with the Act on Social Services. Monitoring arrangements differ according to whether the services are for elderly people, persons with particular needs (people with disabilities, homeless people or drug addicts) or children.

As to people with particular needs (people with disabilities, homeless people or drug addicts), authorisation for private service providers to offer housing or care facilities is issued by county authorities in accordance with quality standards laid down in the Act on Social Services, according to users' needs.

**Provision of social services in particular for children is mainly monitored by the National Social Appeals Board, which publishes regular studies and statistics on this subject. The report also states that five state prefects supervise social service provision by the local authorities**. **The Committee asks for further information on the subject.**

Reply:

Decisions on social services for children are usually taken by the municipalities. Normally, these decisions may be appealed to one of the five regional Social Complaints Boards. The Regional State Administrations provide secretarial assistance to the boards. According to Section 63 of the Act on Legal Protection and Administration in Social Matters decisions taken by the Social Complaints Boards are not subject to appeal. However, the National Social Appeals Board may accept to deal with a complaint against a decision taken by the Social Complaints Boards, provided that the case is deemed to be of fundamental or general public importance.

Decisions on the placement of children outside their home without consent etc. are taken by the local children and young persons committee. Decisions taken by the committee may be appealed to the National Social Appeals Board.

According to Section 63 of the Constitution all administrative decision – including decisions taken by the Social Complaints Boards or the National Social Appeals Board – are subject to a

review by the courts.

*Question to paragraph 1 - Provision or promotion of social welfare services*

The state also monitors the activities of local authorities in the area of the integration of refugees, under the Integration Act of 2007. Every year, the local authorities are required to submit a report on the use of the funds granted to them by the state for this purpose. There is a system of financial incentives and grants for municipalities which succeed in placing refugees in work. The state carries out a general survey every four or five years on the implementation of the Integration Act by the local authorities. **The Committee asks how much is spent on social services in total. It also asks whether there is any legislation on the protection of users' personal data.**

Reply:

In 2011 Denmark spent DKK 246 billion on social services.

Directive 95/46/EC of the European Parliament and of the Council on the protection of individuals with regard to the processing of personal data and on the free movement of such data was implemented into Danish law though the Act on the Processing of Personal Data. The Act provides protection for the personal data concerning parties involved in social service cases.

**Article 4 of the 1988 Additional Protocol**
Right of Elderly Persons to Social Protection

## Article 4 of the Additional Protocol, Question 1 - 2

1. Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.
2. Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

1) As described in the report concerning article 14§1 the Act on Social Services is the primary legal framework for services for elderly persons in Denmark. For further information see the 28th report.

In the reporting period several new measures has been taken in order to provide better social protection for elderly persons:

2) ***Commission on Quality of life and self-determination in nursing homes***
In the beginning of 2011, a Commission on Quality of Life and Self-determination in Nursing Homes was established. The Commission has through 2011 analyzed and discussed how nursing homes, with the involvement of relatives, may support the quality of life and self-determination amongst elderly persons. In February 2012, the Commission presented its findings, setting up five core values: "Impact on own life", "Respect for diversity", "Humanity", "Good experiences every day" and "A dignified end of life". In 2012 DKK 40 million are allocated to follow up on these recommendations.

***Commission on Home Care Services***
In the spring of 2012 the Government established a Commission on Home Care Services. The purpose of the Commission is to analyze the future challenges in taking care of the elderly persons and to make recommendations for a better utilization of the resources. The Commission shall present its analyze and recommendations in 2013.

***Strategy on dementia***
In 2010, a new dementia strategy with 14 specific recommendations to strengthen and improve performance for persons with dementia was unveiled. The key points in the strategy are:

- Better efforts towards demented persons with severe behavioural disorders.
- Development of clinical guidelines for assessment and treatment of dementia.
- Specific programs of dementia in all regions.
- National information campaign on dementia.

Furthermore in the recent years funds has been made available for intensifying efforts in the field of dementia. The funds have been used to support a number of activities for persons suffering from dementia and their families and to reinforce education, method development, etc.

***Promotion of equal opportunities and participation***
Public administration in Denmark is based on a principle of non-discrimination. This means that in

taking decisions on for example social assistance and services, administrative authorities may not discriminate in relation to a number of matters, including sex, ethnicity, and age, unless it is based on factual circumstances.

The European Commission has tabled a proposal for a Council Directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation. The aim of the proposal is to implement the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation outside the labour market. It sets out a framework for the prohibition of discrimination on these grounds and establishes a uniform minimum level of protection within the European Union for persons who have suffered such discrimination.

During 2012, the European Year of active ageing and solidarity between generations, Denmark has focused very much and raised awareness on older people's possibilities to contribute to society – also outside the labour market. Not only do older people have the same access to aspects of society, cultural, educational, health etc as other citizens. Every municipality has a democratically elected seniors' council, where matters of concern to older people are dealt with before decisions are made.

The administration and payment of benefits is based on needs. Equality of treatment is not a matter of age.

These are all aspects which are also highlighted by major important organisations for older people.

***Quality indictors in long-term care***

Efforts of monitoring the quality in the elderly care have increased in recent years in Denmark. Below some of the initiatives that have been taken in recent years in order to enhance the monitoring of quality in Denmark is described.

- *Documentation on the area of the elderly*

In 2006, the Government and Local Government Denmark (the association of municipalities) decided to initiate a joint project to improve, simplify and secure more coherent documentation on central areas of public service. In order to ensure possibilities for future steering initiatives to be founded on focus on effects rather than on detailed regulation, it was agreed that documentation should be oriented towards results and monitoring on effects. The area of elderly persons was chosen as the primary area of attention.

As part of a national documentation project the Government and Local Government Denmark agreed on an annual national survey of satisfaction among the recipients of social services provided for elderly persons. The aim is to collect information about the social services and thereby establish knowledge about outcomes and effects of the social performances. The first national survey was carried out in 2007 and showed a high rate of satisfaction among the receivers - almost 90 % were satisfied or very satisfied. Results from 2008 and 2009 validate the high rate of satisfaction.

- *Comparable user contentment surveys: quality-assured tools to carry out surveys of user contentment with services provided by the municipalities*

In 2009, it was agreed that all municipalities should employ surveys of user contentment systematically in their management and development. On this basis, tools to carry out comparable surveys of user contentment were developed. The municipalities are free to choose whether they want to use the tools on comparable surveys of user contentment, but all municipalities are encouraged to use the tools and

to present to the public the local user-contentment.

Everybody may make use of the information from the surveys of user contentment in order to compare the level of satisfaction in various institutions or home-care areas. Comparing results may contribute to putting a new perspective on the results in individual municipalities or institutions and may thus contribute to enhancing the quality of the services provided. Good examples may be highlighted for others to take inspiration from. The surveys cannot on their own show the way to creating better quality. In order to obtain a complete quality assessment, it is necessary to supplement these results with the knowledge gathered from inspections made by supervisory authorities

- *National framework of mechanisms to monitor quality*

As a way of ensuring a high standard of social services for elderly persons, a national framework of mechanisms to monitor quality in the elderly care has been developed. The goal is to ensure that services for elderly persons on an individual level are designed on the basis of knowledge of the results of prior actions.

The aim of the project is thus to ensure professional quality of information designed to offer a catalogue of tools that employees and managers may use to measure and compare the professional quality of elderly care. The knowledge deducted from the indicators applied in this catalogue can also be used by politicians, government and citizens.

## Article 4 of the Additional Protocol, Question 3

> 3. Please provide pertinent figures, statistics or any other relevant information on measures taken to ensure that elderly persons have access to adequate benefits in cash or in kind; on the level of public expenditure for social protection and services for the elderly, on the accessibility of measures and the number of elderly people benefiting from them; on the number of places available in institutions for elderly persons, on the number of elderly living in such institutions, and on whether a shortage of places is reported.

The number of persons in Denmark aged 67 years and over was 835,000 as of 1 July 2012.

In 2011, 137,000 persons over the age of 67 received permanent home care services. Around 475,000 hours of home care service were available each week.

The number of residents aged 67 years and over living in assisted living accommodation or care homes (including sheltered housing) was 47,400 as of April 2011.

The total amount spent on social protection and services (excluding social pensions) for elderly persons was DKK 37 billion in 2011 (2012 price level).

See the answers to questions 1-3 to Article 12§1 for information on old age benefits.

## Supplementary Information to Article 4 of the 1988 Additional Protocol

In the text below are embodied the answers and supplementary information requested by the ECSR regarding the 28th Danish report.

*Question*

*Legislative framework*

The Committee recalls that the Act on Social Services is the main piece of legislation related to the social protection of elderly persons. Overall responsibility for the elderly in Denmark lies with the Ministry of Social Welfare (formerly the Ministry of Social Affairs) but implementation of concrete measures belongs to local authorities. There is a senior citizens' council within each local authority that supervises the manner in which personal and practical assistance is provided to elderly persons.

Concerning the Committee's request for information on assisted decision making for elderly persons, the report makes reference to the possibility of appointment by the regional state administration of a legal guardian under the Legal Guardianship Act. This applies, for example, in situations where the person concerned has reduced mental functions. **The Committee asks the next report to provide additional information on whether there are safeguards to prevent the arbitrary deprivation of autonomous decision-making by elderly persons.**

Reply:

The Act on Social Services is the primary legal framework for social assistance and services for elderly persons in Denmark. The object of the assistance provided under the Act is to improve the capability of the individual recipient to be self-reliant, or to facilitate his or her daily life and enhance the quality of life. The assistance provided is based on the individual recipient's personal responsibility and the responsibility for his or her family. The assistance will be provided on the basis of the recipient's particular needs and conditions and in consultation with the recipient.

Thus, the Act is based upon the right of self-determination for recipients of social assistance and services - a person decides for himself or herself whether or not to ask for social assistance and services. Receiving social assistance and services does not mean that the recipient loose his or her right of self-determination.

Only in very specific situations may a person be deprived of the right of self-determination:

- A legal guardian may be appointed under the Legal Guardianship Act for a person – including an elderly person – who is not capable of taking care of his or her personal and/or financial affairs. Decisions on appointment of legal guardians are taken by the courts. In some situations they may also be taken by the Regional State Administrations, subject to a review by the courts.

- The Act on Social Services (Sections 124 – 137) empowers the municipalities to restrict the right of self-determination of persons with substantial and permanent impairment of mental function. According to the Act the use of such restrictions shall be limited to the bare minimum and such restrictions shall never be used as substitutes for care, attention or socio-pedagogical assistance. Prior to effectuating restrictions of the right of self-determination, the municipalities shall seek to procure the person's voluntary consent to any necessary measure. Decisions on restriction of the right of self-determination taken by the municipalities may be appealed to one of the five regional Social Complaints Boards. According to Section 63 of the Act on Legal Protection and Administration in Social Matters decisions taken by the Social Complaints Boards are not subject to appeal. However, the National Social Appeals Board may accept to deal with complaints against decisions taken by the Social Complaints Boards, provided that the case is deemed to be of fundamental or general public importance. According to Section 63 of the Constitution all administrative decision – including decisions taken by the Social Complaints Boards or the National Social Appeals Board – are subject of a review by the courts.

*Question*

*Prevention of elder abuse*

The Committee recalls that elder abuse is defined in the Toronto Declaration on the Global Prevention of Elder Abuse (2002) as „a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person. It can take various forms: physical, psychological or emotional, sexual, financial or simply reflect intentional or unintentional neglect. The World Health Organization (WHO) and the International Network of the Prevention of Elder abuse (INPEA) have recognised the abuse of older people as a significant global problem. Hundred thousands of older people in Europe encounter a form of elder abuse each year. They are pressed to change their will, their bank account is plundered, they are pinched or beaten, called names, threatened and insulted and sometimes they are raped or sexually abused.

**The Committee wishes to know what the Government is doing to evaluate the extent of the problem, to raise awareness on the need to eradicate elder abuse and neglect, and if any legislative or other measures have been taken or are envisaged in this area.**

Reply:

Elder abuse and neglect is an issue which is taken care of in the specific circumstances in which it appears and by the competent authorities, including the police, the courts, hospitals, general practitioners etc.

In the area of social assistance and services one of the objects of the Act on Social Services is to offer counselling and support so as to prevent social problems and to satisfy needs resulting from impaired physical or mental function or special social problems. Thus, the Act may help solve problems of elder abuse and neglect. For example, according to Sections 81-82 of the Act the municipalities shall grant assistance to persons with substantial impairment of mental function who are unable to attend to their own interests. Furthermore, according to Sections

148-151c of the Act the municipalities shall supervise the facilities and activities under the Act, including facilities and activities aimed at elderly persons, and Section 16 of the Act on Legal Protection and Administration in Social Matters stipulates that the municipalities shall supervise the discharge of their duties, including the content as well as the implementation of the facilities provided. See also the new rules of regulatory policy for help provided to persons in their own home, described in the report concerning Article 14§1 (question 1 -2).

Finally, as described in the report concerning Article 13§3 (question 1 – 3), the municipalities shall offer free counseling of adults with impaired physical or mental function or with special social problems, including fieldwork.

Thus, competent authorities are in place with an adequate legal framework to deal with elder abuse and neglect.

*Question*

*Services and facilities*

Pursuant to the Act on Social Services a citizen can obtain personal assistance (e.g., personal hygiene, getting into and out of bed) or practical assistance (e.g. cleaning, laundering or shopping) if he or she is an adult residing in Denmark who cannot perform such tasks alone. The right to home help services is irrespective of whether the person is living in his/her own house or in assisted living accommodation. The local authority's decision on whether an elderly per-son is entitled to receive such services is based on an individual assessment. The Committee refers to its last conclusion on Article 4 of the Additional Protocol for detailed information on the provision of home help services (Conclusions XVII-2).

**The report mentions that one of the envisaged reforms in the old age care sector is a government bill aimed at ensuring that recipients of home help services are entitled to one permanent contact person who must be close to the citizen. The Committee wishes to be kept informed of the passing into law of this bill.**

Reply: 1st of January 2009 new legislation entered into force, which gave all recipients of home-care service the right to have a permanent contact person, to whom they can turn for advice and guidance if they have questions about home care.

The purpose of the appointment of a permanent contact person is to facilitate the access to the municipal authority for recipients of home-care services thereby creating security and continuity for the individual.

The person appointed as permanent contact person should be aware of the help the recipient is assigned to and should know the relevant facts about the citizen and the municipality's offer of personal and practical help, which is relevant to the citizen. The permanent contact person should help the citizen to find answers to questions regarding the help and advises the citizen about its rights.

*Question*

*Housing*

Pursuant to the Act on Social Housing, social housing for the elderly can take the form of an independent dwelling, assisted living accommodation or shared housing arrangements. The dwelling must be specially suited for elderly and disabled persons, including being suited for wheelchairs and having a layout/access adapted to walking-impaired persons. It must also have a private toilet and shower.

Social housing for the elderly must be rented to elderly and disabled persons. The local council has a right of allotment for this type of housing, irrespective of who own it. The local council individually assesses and decides to whom the dwellings should be rented. **The Committee asks for information on rental prices of social housing, as well as on any housing allowances, benefits or subsidies that are available for the elderly to meet the costs of their housing.**

Reply: Existing care homes and sheltered flats may continue to be run under a temporary provision in the Act on Social Services. However, they will gradually decrease because local authorities can no longer build care homes or sheltered housing, the emphasis now being placed on social housing/retirement housing.

According to the report as from 1 January 2009 the local authority must offer a dwelling in social housing or a place in a care home to elderly persons who need such a dwelling or place. Once the need has been established there is a time limit of 2 months for the authority to make the offer.

*Question*

*Institutional care*

The Committee recalls that the emphasis in Denmark is to provide housing with associated services and care rather than nursing home type institutions. Thus, no conventional nursing type homes have been created in Denmark since 1987 but have been rather replaced by the building of social housing for the elderly. The Committee refers to its last conclusion for an overview of the operation, inspection, complaints procedure, etc. in institutional type facilities (Conclusions XVII-2).

As already mentioned above, with effect from 1 January 2009 a place in a care home must be offered to elderly people who need such type of accommodation. Noting however that nursing homes are not being built in Denmark since 1987, **the Committee asks how the expected shortage of places in institutional care will be solved.**

Reply:

A large-scale reform in terms of housing for elderly persons was implemented in 1988. Before 1988 residential accommodation for elderly persons was thought of as "old person's homes". The basic principle of the reform was on the one hand to make it possible for elderly persons to stay as long as possible in their own homes, on the other hand to ensure higher standards in residential accommodation.

As is the case with home care services the municipalities determine if an elderly person requires a kind of help that cannot be given in the private home. If an elderly person is offered residential accommodation she or he may choose between different options within the local municipality or even in another municipality.

A care home guarantee took effect at 1 January 2009 aiming at making sure that elderly persons eligible for nursing homes or residential accommodation will have to wait no more than two months for a place to stay. The guarantee has had a noticeable effect on the number of constructed dwellings for the elderly.

Each year the number of newly build social housing for the elderly is more than enough to replace the traditional nursing homes. Thus, the stock of social housing for the elderly is rising in order to satisfy the increasing demand for housing.