Eurofound

More and better jobs in home-care services

Denmark

Contents

Introduction

This country report gives an overview of the labour market policy in community-based care for adults with disabilities in Denmark. The main topics discussed are the context in which community care labour market instruments are implemented, the funding structure, the strategies used to recruit new employees and retain current workers in the sector and the resulting impacts and outcomes. Three case studies were carried out into initiatives in the field of labour market policies in community-based care to support adults with disabilities: job rotation, mentoring for students with a foreign background and further education in chronic disease. Annex 1 to this report contains summaries of the three case studies and analyses the main outcomes and success factors.

1 Policy background

Overview of the care sector in Denmark

The Danish long-term care system for people with disabilities, including home-help services, is a universal system. The Danish national government is responsible for determining the overall principles underpinning it. The regional authorities are responsible for treatment in the health system while community care falls under the political governance of the municipalities.

The 98 municipalities in Denmark are thus responsible for the delivery of long-term care services. The municipalities have the authority to determine the extent of the care services and are responsible for implementation. Municipalities can choose to deliver the services themselves or buy the services from either the five regional authorities or private service providers.

The Danish long-term system provides comprehensive coverage for a wide range of social services, including home adaptation, assistive technology and home help. One of the main aims of the social services for people with disabilities is to ensure that they can manage to live in their own homes. In cases where they cannot manage on their own, they can move to residential care homes and sheltered homes.

Eligibility is based on a needs assessment performed by the local authority. A basic principle of the Danish health and care system is that all citizens have equal and easy access to health and care services. Thus, all citizens have free access to hospital treatment and maternity care, as well as community care. An individual citizen's financial situation, labour market situation or other factors play no role in their access to health services.

Reasons for developing and maintaining community-based care services

The period before 1970 has been labelled the 'golden age' for health practitioners in Denmark, because the position of doctors was so strong that the development of the health system became a driving force for the development of the welfare state.

Up to 1970, the Danish healthcare system was governed almost exclusively by the National Board of Health in close dialogue with the medical profession (Magnussen et al, 2009). The local government reform of 1970 meant that the medical profession lost its monopolistic position in relation to healthcare policy in general and hospital development in particular.

The implementation of new models took place in a decentralised governance structure where county and local boards became important. Deinstitutionalisation, a trend reflected in Danish policy, was accelerated by this decentralisation in public administration (Magnussen et al, 2009).

In 2007, municipalities received a stronger role in governance, and launched initiatives in prevention and health promotion (Magnussen et al, 2009) while taking full responsibility of the community care system (which had previously been shared with the regional authorities). Focus shifted to empowerment and supporting people in communities. Introducing community-based care in Denmark meant that care would be based on less intrusive models. The provision of care was reframed as care for 'health consumers' rather than care for 'patients'. A shift in terminology from 'patient' or 'client' to 'citizen' exemplifies the approach. Empowerment of citizens with chronic diseases or disabilities focuses on strengthening and supporting their own resources and competences to deal with health and disability.

The theoretical background for empowering patients and citizens with disabilities is therefore to assist people help themselves to improve their quality of life, while at the same time trying to minimise the economic costs. More recently, the rationale for maintaining community-based care has been driven by economic realities (Ministry of Health, 2012).

New technologies are also making community-based care services a more appropriate choice, with some basic care models influenced by telemedicine and other assistive technology.

Types of community care services available

In terms of community care services, the municipalities offer:

- personal help and care in individuals' homes;
- practical domestic support;
- food delivery.

The municipality plans the visits as needed. The functions of the visits are:

- to prevent health problems from emerging;
- to improve individuals' social and personal functions;
- to improve the possibilities of the individual's self-realisation and empowerment through social contact, activity, treatment and care;
- to provide holistic services that can be adapted or adjusted as needed, including assisted living in residential areas.

At the local level, both local authorities and private providers supply personal and practical services. Local authorities are obliged by law to allow private providers to enter the market. Private providers are required to meet quality standards, and in some cases are bound to price requirements established by local authorities, according to the specific needs of each municipality.

The Consolidation Act of Social Services, fully implemented in 2010, gives the local authorities the option to arrange services by providing consumers with a service certificate, which they can use to employ their own personal helper (see below for further details). Eligible individuals may receive a cash benefit in order to pay for necessary assistance.

In Denmark, there are various forms and types of community-based and residential supports and services.

The various forms of long-term care services offered under Danish legislation include conventional nursing homes (care homes) and modern close-care accommodations (subsidised housing for older people with care facilities and associated care staff). In modern close-care accommodations, housing areas are separated from care services areas. Residents have to pay a monthly rent corresponding to the costs of running the housing estate, and have access to benefits depending on their income.

Long-term care services also includes home support services. Home help can be granted as temporary or permanent assistance. Temporary assistance may be charged; it is free only for people on the lowest income level. Permanent personal and practical assistance is free, although local councils may charge for expenses that are not staff related (for example, laundry coins and meal arrangements).

Other forms of long-term care services include subsidised housing and day support services. Subsidised housing is provided for either temporary or long-term stays, for the specified target group that needs more help with everyday activities or for care or treatment. Day support services are based on specific needs for people who are otherwise not able to function on their own.

A range of housing options exist. A group home is an apartment or house inhabited by several residents together with shared shower and toilet. In enhanced group homes, each resident has their own unit, but where there is a shared kitchen and living area. In shared housing, people with disabilities live in their own apartment with socioeducational support.

Community care services include assistive technology, district nursing services, home-care services and ambulatory care services.

Labour market situation

Due to the global economic and financial crisis, the problem concerning labour market shortages is considerably smaller than in the recent past. However, in the long term, there will be a shortage of community care workers, partly because of a growing elderly population and a shrinking labour force.

There is an imbalance in the distribution of older workers. Municipalities, where community care is organised, have a disproportionate number of older workers. In total, 54% of the Danish workforce in the private sector is aged under 40 years. However, only 40% of workers are below 40 years of age in the municipalities. Those aged 50–64 years make up 37% of the workforce in the municipalities but only 22% in the private sector. Overall, 40% of the staff in the social and health system are over 50 years old. This indicates that, in the coming years, the municipalities need to prioritise the retention and recruitment of community care workers. Another relevant factor is the high turnover among social and healthcare assistants compared to many other professions.

Attracting and retaining community care workers is especially difficult in rural areas. General labour market policies are in place to attract workers from all types of rural areas, with a high priority set for community care employees. However, because municipalities deliver community care services, significant discrepancies exist across regions, as demographic trends tend to favour urban areas or communities with large educational institutions.

PESTLE analysis

The research used the 'PESTLE' model to identify the external factors influencing the development of the labour market. The six dimensions in the PESTLE model are the *political*, *economic*, *social*, *technological*, *legal* and *environmental* dimensions. The PESTLE approach was originally a business-study model used to describe a framework of relevant factors at the macro level, used mainly for analysing the business environment of organisations. It is a means of measuring strengths and weaknesses against external factors and can help organisations develop strategies. In the same way, a PESTLE analysis can also be used for a contextual analysis of sectoral labour markets.

These six dimensions can greatly influence the sectoral labour market, although some are obviously more important than others. In the context of the research into the care sector, particular consideration must be given to the political and economic dimensions, as these have direct effect on the possibility of creating attractive and useful jobs in the community-based care sector. The financial dimension is of special importance in this context since this is not a commercial sector, but one generally financed with public money.

Since the situation in the different countries included in the research is different, the labour market discrepancy model connected to the PESTLE factors can identify where the issues lie in each country. The model provides, in a sense, a common language that describes the challenges faced by the different actors. As previous research has already shown that there is a general shortage of labour in the sector, and in some cases a shortage of jobs, it is to be expected that there are clear discrepancies. The model can swiftly record whether these are qualitative or quantitative, due to a lack of influx into the sector or too great an outflow than can be compensated for, or whether they are triggered by developments in one of the PESTLE dimensions. At the same time, the model offers a structured means of comparison.

Political and legal factors

The increasingly central role of local authorities in community care reflects the prioritisation of this issue, and the goal of strengthening preventive care and public health.

Economic factors

Because of the crisis, the problem of labour market shortages is considerably lower compared to the situation in 2007.

Social factors

An important social factor is the ageing of the Danish population.

Technological and environmental factors

Technology is now being promoted as a means of addressing anticipated labour shortages. Assistive technology is now being integrated into community care services to reduce the number of full-time professionals required to provide care to an ageing population.

Recruitment and retention of care workers

A 2010 report on the healthcare labour market made some relevant and important conclusions in relation to the specific factors that influence recruitment and retention of care workers (Jensen et al, 2010). The report highlighted the following important perceptions among workers in relation to retention.

- A good psychosocial working environment is crucial for workers' well-being at work and their job satisfaction.
- Cooperation and communication should be the basis of each organisation. This could lead to better possibilities for variation and new professional challenges, which are highly demanded by community care workers.
- The physical environment plays an important role because the role of a community care worker is often physically demanding. Therefore it is common to have supervisors that are educated in ergonomics and free access to occupational therapists and physiotherapists.
- Another factor that seems to play a role in retention is the worker's professional relationship with their line manager. There is a growing acknowledgment of 'frontline leadership' and of the importance of their ongoing professional development through an agreement of the social partners.
- A culture of cooperation is especially relevant for newly educated care workers. It has been found that working together in smaller teams will create comfort in the start-up phase of a career. These teams can also be a place for recent graduates to learn and get guidance from more experienced colleagues.
- It is important to newly trained workers that the workplace encourages professional development. This issue encompasses further education for social and health assistants, allowing them to move into more advanced positions.

A relevant principle of community care provision is that newly trained staff prioritise being challenged professionally, with adequate preparation for advanced methods and patient types.

2 Political and legal frameworks

Regulation and policies on recruitment in community care services

The Danish care sector is built upon the concept of the Nordic welfare state model. The state sets up the overall framework. Local authorities are responsible for programmes and measures directly targeted at citizens, thus becoming the main gateway to the public sector for citizens and companies.

The structural framework comprises five regions and 98 municipalities. This structure is fairly new, having been introduced in 2007, and puts less of a burden on local authorities to create greater financial and professional sustainability.

Five new regions have responsibility for the health sector and regional development. These regions provide the basis for centralising more treatments, optimising specialisation and ensuring the best use of resources. At the same time, the five regions constitute a strong platform for planning and they pave the way for significantly enhancing the quality of treatments while allowing local municipalities more flexibility in planning community care.

The political framework involves social partners. The Danish labour market is mainly regulated by tripartite agreements. Social partners are also included as responsible partners in the vocational education and training (VET) system where social and healthcare workers and assistants are educated.

Recruitment strategies for community care workers

In Denmark, as in most countries, anticipated demographic changes have set the tone for the strategies of recruitment and retention in the community care sector. Political initiatives aim to stimulate recruitment and to increase the average age of retirement.

Stimulation of recruitment must be seen in the current context of a growing rate of unemployment. The government implemented three ‘youth packages’, in 2009, 2010 and 2011, which aim to prevent youth unemployment. These initiatives reached their goal of 95% of a generation engaged in second-level education. Each one involves different measures, but all three include the provision of interns for companies. For example, since December 2010, employers have had the opportunity to receive DKK 50,000 (€6,703) for appointing a student as part of their education (Ministry of Education, 2010a). Likewise, new models for internships have been introduced in the VET system, to make it more flexible and easy for companies to participate in educating a new generation.

In order to increase the average retirement age, in 2011 the age at which a person could receive their pension was increased by two years (Ministry of Employment, 2013). Acknowledging that some employees in the care sector have worked for many years and the physical strains in the work involved, social partners in the sector have agreed on policies for older people. The agreement recommends that employers should offer employees aged over 60 years, who are considering withdrawing from the labour market, work involving reduced hours or different duties.

There has been a clear focus on the working conditions in the community care sector. The national Fund for Better Working Environment and Labour Retention has targeted this sector.

3 Structural framework, funding and actors involved

Employment in the care sector

The size of the care sector may be estimated through employment statistics provided by Statistics Denmark. Employment statistics cannot always be analysed by type of services; the following figures cover more than NACE code 88.1 (classification system of economic activities).

Table 1: Employment by occupation, 2008–2011

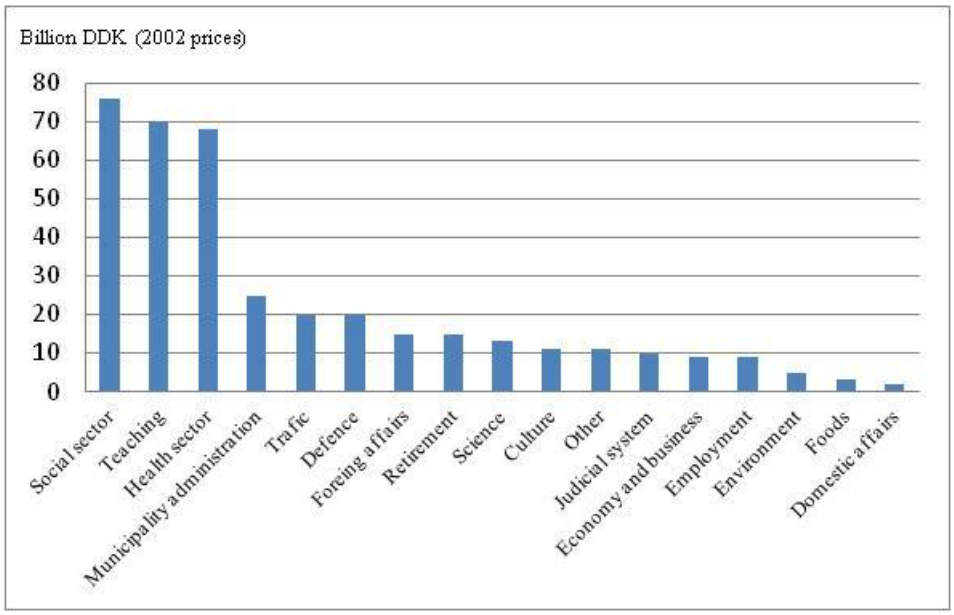
	2008	2009	2010	2011
Nurse (*Sygeplejerske*)	9,474	9,021	8,914	8,879
Physiotherapist (*Fysioterapeut*)	2,005	2,175	2,271	2,357
Occupational therapist (*Ergoterapeut mv*)	2,717	2,826	2,916	2,742
Teacher, educator (*Pædagog, lærer*)	0	0	0	19,350
Social educator (*Pædagog*)	17,860	18,429	19,050	–
Psychologist (*Psykolog*)	454	428	385	211
Social worker (*Socialrådgiver mv*)	845	849	885	841
Social educator assistants (*Pædagogmedhjælper*)	2,205	2,318	2,073	–
Social and healthcare worker (*Social- og sundhedshjælper*)	50,932	51,747	54,477	–
Assistant (*Social- og sundhedshælper, pædagogmedhjælper*)	–	–	–	67,088
Social and health assistant (*Social- og sundhedsassistent*)	33,153	35,210	34,845	21,450
Total	119,644	123,003	125,816	122,918

Source: Statistics Denmark Employment Database RES10

There is high mobility among social and healthcare workers and assistants. About 30% of the social and healthcare assistants change jobs or their place of work within a year, compared with 17% of the total workforce. Low barriers to entry, exit, and re-entry among some less skilled positions have been identified as a contributing factor (Jensen et al, 2010).

Illustrating the size of sector may also be done by comparing costs with other public sectors. As clearly shown in Figure 1, the social sector is the largest sector measured by costs. Community care is part of the social sector but does not solely account for the costs presnted in Figure 1.

Figure 1: Distribution of public cost on services and operation expenses



Source: Danish Ministry of Finance, 2003

Funding structure

The funding of the healthcare system comes from taxes, which means that most services are free of charge and the main actors, both purchasers and most suppliers, are public. Legislation allows local authorities some limited freedom in setting charges for home help and some other non-health-related expenses.

Publicly financed healthcare

A major administrative reform in 2007 gave the central government responsibility for financing healthcare. Healthcare is now financed mainly through a centrally collected tax set at 8% of taxable income, earmarked for healthcare. This replaces a mixture of progressive central income taxes and proportionate regional income and property taxes. The central government allocates this revenue to five regions (80%) and 98 municipalities (20%) using a risk-adjusted capitation formula and some activity-based payment. Public expenditure accounted for around 82% of total health expenditure in 2005 (World Health Organization and European Observatory on Health Systems and Policies, 2009).

Private health insurance

Complementary private health insurance has been common in the Danish health system since the 1970s. Complementary insurance has traditionally been used to cover co-payments in the statutory system (mostly for pharmaceuticals and dental care) and for services not fully covered by the state, such as physiotherapy. The not-for-profit organisation Danmark was the sole provider of such complementary insurance in the past. It covered around two million Danes in 2007, equivalent to 36% of the population (Commonwealth Fund, 2010). Today most insurance companies provide different forms of health insurance.

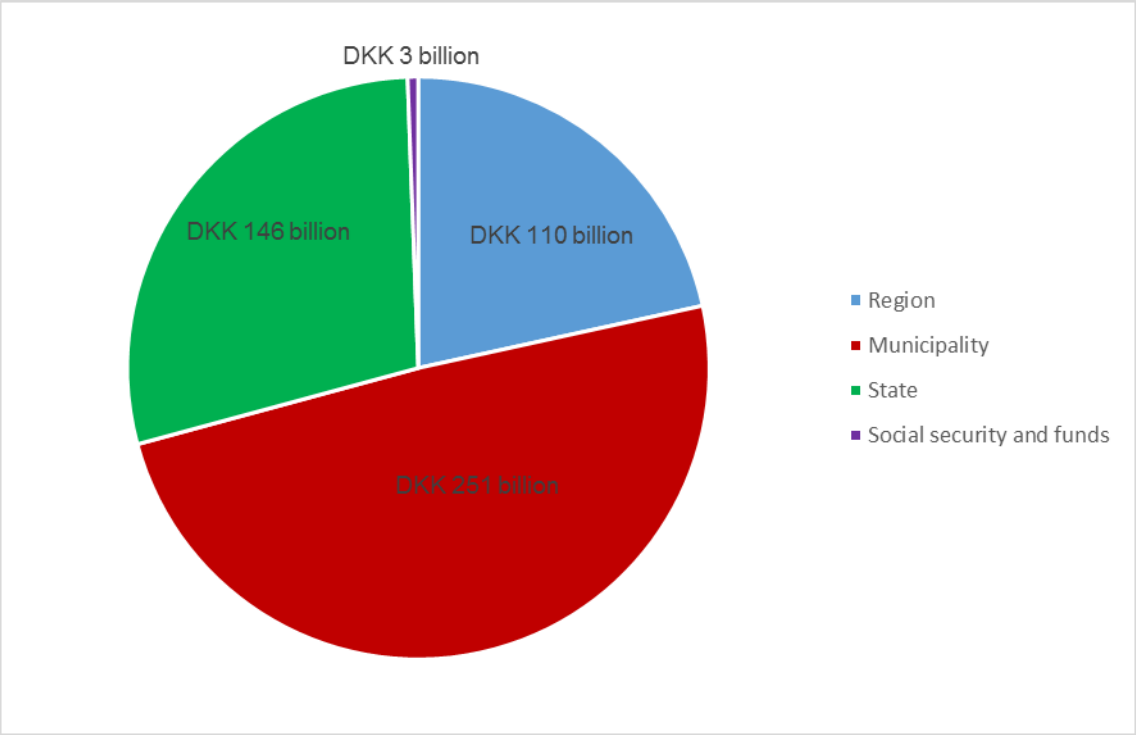
Long-term care

Danish long-term care rests on the basic principle of free and equal access to assistance. This means that all residents of Denmark have direct access to various services, when temporary or permanent physical or mental disability prevents them from doing certain tasks on their own.

Individual services for people with disabilities are allocated on the basis of application. The principle of local self-government means that the local council determines the service level and allocates the necessary economic resources within the legislative framework mentioned above.

Figure 2 illustrates the division of public funding between the three levels of authorities.

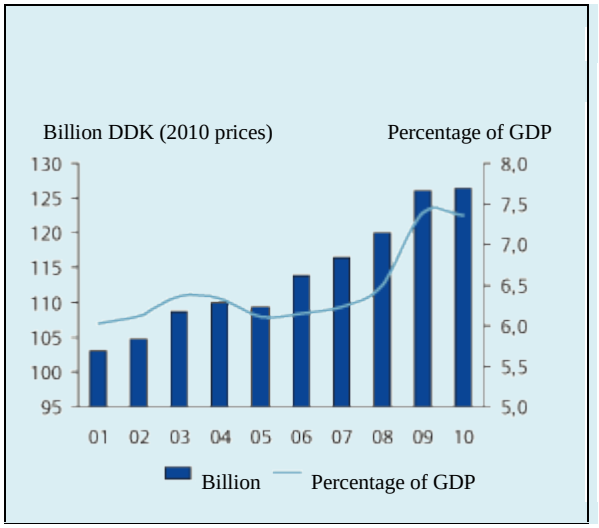
Figure 2: Public costs divided by state, region and municipalities, 2010



Source: Danish Ministry of Finance, 2011

In Denmark, as in most countries, public spending is intensely debated due to the economic crisis. Trends in spending in the social sector is illustrated below, in both actual costs and as a percentage of GDP. As shown, the actual costs have increased over the years but with a slight reduction of the sectors' share of the GDP. Again, community care only comprises a part of social expenses.

Figure 3: Spending in the social sector, 2001–2010



Source: Danish Ministry of Finance, 2010

In the debate on funding, the focus is not solely placed on the global economic crisis; it also relates to the issue of how best to provide community care services in the future, so as to meet the needs of an ageing population in the context of a decreasing workforce. For example, discussion takes place on whether services for people with disabilities should depend on individual income or be provided universally, free of charge.

There is also a trend towards including more voluntary work in the sector, which leads to intense debate on where and what voluntary work must involve. In Denmark there is no tradition for involving the voluntary sector in the operation of social services.

Organisations, actors and stakeholders involved

As already noted, the Danish labour market is highly regulated by tripartite agreements. The many stakeholders have a relatively strong influence. The main government departments involved are the Ministry of Health, the Ministry of Social Affairs and Integration and the Ministry of Education. The key public stakeholders are the regional authorities, Local Government Denmark (KL) and university departments of health and social education. Trade unions include the Danish Confederation of Trade Unions (LO), the Danish Nurses' Organisation (*Dansk Sygeplejeråd*), the Trade Union for Social and Healthcare Workers and Assistants (FOA), the National Federation of Social Educators (SL) and the Association of Danish Physiotherapists (*Danske Fysioterapeuter*).

4 Strategies for recruiting and retaining employees

Targeting labour reserves

One initiative in Denmark called 'job rotation' targets unemployed people. It involves the temporary replacement of employees during their training leave by people who are unemployed. In this way, employees benefit from continuing education while unemployed people gain temporary employment (Jobnet, 2013).

Another initiative targeting unemployed people (called *seks ugers selvvalgt uddannelse*) gives unemployed people the opportunity to get six weeks of education and thereby upgrade their skills and increase their chances of getting a job (Social og Sundhedsuddannelses Centret, 2013a).

The Consolidation Act of Social Services, fully implemented in 2010, enables local authorities to give service users a 'service certificate', which allows a person to employ their own personal helper. Local authorities can also give cash benefits (OECD, 2011). The aim of this initiative is to target unknown sources of labour.

Promoting education and training

In 2007, the Danish government and social partners made a political agreement to stimulate the education of social and healthcare assistants and educational assistants. The agreement obliged local public authorities to increase the number of available internships, since a lack of internship opportunities is often a key barrier for students in completing their VET education, and the reason for not choosing this education option in the first place. The central government in turn agreed to increase intake for VET education (Danske Regioner, 2010).

Another initiative facilitates a mentor system (*mentornetværk*) for social and health service students, which targets students with a foreign background. Mentoring is available to those needing help to complete social and health education based on barriers arising from difference in ethnic background (FOA, 2013).

Improving the situation of current employees

In Denmark, the situation of current employees can be optimised through continuing education. Social workers can obtain further education, including a postgraduate degree, in their field. Furthermore, social workers can avail of a shorter further education course, which lasts between one and four weeks. Social and healthcare workers and assistants can choose from different kinds of further education to help them advance their careers (Social og Sundhedsuddannelses Centret, 2013b).

The situation of current employees can also be improved by a focus on reducing sick leave (*sygefravær*), as in the municipality of Copenhagen, for example. In 2011, a new sick leave policy was launched. Efforts have been taken to ensure all employees know the framework for working with sick leave, and management has increased its focus on strategically reducing sick leave. There are three aspects to this:

- working conditions and social dialogue (Forebyggelse: ledere og medarbejdere har en dialog om det gode arbejdsliv);
- follow up (sygefraværssamtaler følger lederen løbende op på sygefraværet);
- retention – during sick leave, the employee must stay connected to work to find out whether they can return to work (Municipality of Copenhagen, 2011).

Another initiative called retirement reform (*tilbagetrækningsreformen*) prevents employees from leaving the sector. It allows for a transition from full-time work to an eventual phasing out of work over a three to five-year period (Pædagogernes Pensionskasse, 2012).

Improving operational management and labour productivity

Some initiatives of the Danish healthcare system focus on improving operational management and labour productivity. For example, it is currently focusing on transsectoral cooperation (*tværsektorielt samarbejde*) across professional categories, thereby increasing information exchange and reducing loss of information. The healthcare system is also currently exploring technological innovation. For instance, the Centre for Innovation and Research (CIR) acts as a point of entry for issues relating to innovation and research and commercialisation in the Capital Region of Denmark (Hovedstaden).

Assistive technology (*velfærdsteknologi*) is a key area receiving attention. For instance, the government has set up the Danish Public Welfare Technology Fund, which aims to streamline the public sector through the dissemination of new technologies, resulting in better service for less money. The fund focuses on major strategic initiatives and proven solutions to broad transsectoral initiatives. Therefore, it is not possible to apply to the fund for co-financing of projects since it is specifically for the government's commitment to promote well-developed technological solutions that have shown the greatest potential. It must ensure that the public sector will be required to use assistive technology in, for example, nursing homes and hospitals (Fonden for Velfærdsteknologi, 2011).

It is estimated that more than one in three adults in Denmark have a long-term illness. The Danish Health and Medicines Authority (*Sundhedsstyrelsen*) has identified chronic diseases that require special effort and attention, including many long-term disabilities such as musculoskeletal disorders and mental health disorders (Videnscenter for kroniske sygdomme og rehabilitering, 2013). Health workers across sectors in the Region of Southern Denmark, for example, can obtain further education about chronic disease to support their career and ease transition from an assistant role to a certified chronic disease management role (Region Syddanmark, 2012).

A general initiative focuses on 'frontline leaders', understood as operational management among frontline workers such as health and care workers and assistants. This level of management has many different designations such as 'team leader' and 'coordinator'. In 2007, the social partners agreed to spend DKK 21 million (€2.8 million) on educating these frontline leaders in management tasks that they more or less already have. The education initiative is a clear signal of acknowledgment of management on this level and acknowledgment of the impact of efficient management in the provision of services in people's homes.

5 Outcomes, results and impact of policies

The identified initiatives have not all been evaluated. However, there is some indication that such initiatives have had an impact on recruitment or retention.

The general reform of retirement policy is not fully implemented and no impact is expected yet. Nonetheless, there are some indications that retirement is being postponed. Looking to the employment rate during the economic crisis in 2008–2011, employees aged over 60 years have had a stable employment rate, while all other groups have a decreasing employment rate (Arbejderbevægelsens Erhvervsråd, 2012). In 2007, 421,000 people aged 54–64 years were employed, while in 2012 the figure was 429,999 (Danmarks Statistik, Statistikbanken, 2013a). It should be added that women in general retire a year earlier than men. Thus a potential trend towards later retirement is likely to have a smaller impact on the community care sector, where the majority of workers are women.

It is not known whether a tendency towards postponing retirement is caused by the political debate on the subject, and the related issue of the ageing population, or a greater focus on working conditions.

The number of sick leave days taken in the health and social care sectors, at regional and municipal level, has decreased a bit, from 6.06 days in 2007 to 5.92 days in 2011(Danmarks Statistik, Statistikbanken, 2013b). It is not known whether this is a natural decrease over the period or due to initiatives on working conditions.

Gender differences occur regarding sick leave. On average, the rate of sick leave among women is 40%–45% higher than it is among men (Beskæftigelsesministeriet, 2009). Again, an indication of a trend in lower sick leave rates must be relate to the sector's high share of female workers.

Internships are a core issue in relation to recruitment. The political agreement for 2007 on internships and intake in the educational system seems to have been fulfilled to some extent (Danish Ministry of Education, 2010b). The number of internships increased by 2% between 2011 and 2012 (Uni-C, Styrelsen for it og læring, 2012). The funding available for employers who recruit an intern fell from DKK 50,000 (€6,702) to DKK 33,000 (€4,424) in 2013. This suggests that this initiative was assessed as being too expensive (ATP, 2013).

The overall situation is improving slightly but there is no evidence that this is an outcome of specific initiatives.

6 Key trends, issues and policy pointers

This report provides a brief overview of Danish labour market policy in community-based care to support adults with disabilities, illustrated by three case studies (see Annex 1).

National context

The community-based care services in Denmark meant that care became based on less intrusive models. With the introduction of community-based care services, the provision of care was reframed as care for 'health consumers' rather than care for 'patients', reflected in a shift in terminology from 'patient' or 'client' to 'citizen'. The empowerment of citizens with chronic diseases or disabilities involves focusing on strengthening and supporting citizens' own resources and competences to deal with health and disability.

The theoretical background for empowering citizens emphasises assisting people to help themselves to improve their quality of life, while at the same time trying to minimise costs. More recently, the rationale for maintaining community-based care has been driven by economic realities.

New technologies are also making community-based care services a more appropriate choice, with some basic care models influenced by telemedicine and other assistive technology.

Policy and legal frameworks

The implementation of new models took place in a decentralised governance structure where county and local boards became important. Deinstitutionalisation, a trend reflected in Danish policy, was accelerated by this decentralisation in public administration. In 2007, municipalities received a stronger role in governance, and launched initiatives in prevention and health promotion while taking over full responsibility of the community care system, which had previously been shared with the regional authorities.

Structural framework and funding structure

The Danish long-term care system for people with disabilities, including home-help services, is a universal one. The Danish national government is responsible for determining the overall principles underpinning the long-term care system. The regional authorities are responsible for treatment in the health system while community care falls under the political governance of the municipalities. The 98 municipalities in Denmark are responsible for the delivery of long-term care services. The municipalities have the authority to determine the extent of the care services and are responsible for implementation. Municipalities can choose to deliver the services themselves or buy the services from either the five regional authorities or private service providers.

Strategies used to recruit and retain employees

There is increasing pressure on the health system to recruit and retain employees. There is currently an imbalance in the distribution of workers, with a high need to recruit younger workers into the sector. Overall, 40% of social and healthcare workers are over 50 years old.

A full range of policies are used to address recruitment and retention needs. A number of policies are used to target labour reserves, functioning to access those who have traditionally faced barriers in accessing the labour market, or to encourage unemployed people to pursue a career in community care. This includes job rotation to facilitate access to jobs and short courses and service certificates to allow unemployed people to perform basic tasks in community care.

Other policies are aimed at stimulating and facilitating education. Many of these approaches are indirect, addressing support measures that improve the transition of students into the workforce. This includes increasing the number of available internships for some students, and creating mentoring systems for others.

Improving operational management and labour productivity is linked to organisational innovations, such as transsectoral cooperation and new approaches to chronic disease management, as well as technological solutions, such as commercialising and encouraging the uptake of new assistive technology. Improving the situation for current employees includes focusing on supporting career advancement and strategic efforts to reduce sick leave.

One initiative focuses on 'frontline leaders', understood as operational management among frontline workers such as health and care workers and assistants. In 2007, the social partners agreed to spend DKK 21 million (€2.8 million) on educating these workers in management tasks that they essentially already have. The education initiative is a clear signal of acknowledgment of management on this level and its impact in improving the efficiency in the provision of services in people's homes.

Retirement reform is also a priority, allowing for a gradual exit from full-time work while retaining the services of experienced employees.

Outcome and impact of policies

There has been mixed evidence on the cumulative effect of these policies and programmes. At project level, there are clear examples of successful measures for recruiting students into health and social care fields, especially from groups that are traditionally faced with barriers to entry, such as long-term unemployed people and those from ethnic minority groups. Based on the available evidence, recruitment into the field has been improving, as has the link between education and the labour market. There is less evidence regarding retention. Major attention has been paid to supporting career development and thereby increasing the existing workforce's capacity to shift with the changing community care landscape. Career advancement is also – it is believed – a key component in making careers more appealing, which could potentially assist in retaining employees. While the evidence is incomprehensive, there are demonstrated examples of increased job satisfaction and reduced stress in dealing with changing job functions.

Case studies for Denmark

Three case studies illustrate the Danish labour market policy in community-based care to support adults with disabilities; these focus on:

- job rotation;
- a mentoring scheme for students with a foreign background;
- further education in chronic disease.

These three initiatives appear to be successful in terms of supporting recruitment and retention. The job rotation measure is a blend of both recruitment and retention, the mentoring scheme is focused primarily on recruitment and the further education in chronic disease initiative is aimed at career progression, with the intention of supporting retention objectives. The models underpinning the three measures are sound, and the available evidence on the impact of job creation or retention is positive.

Based on the relative success of the examples, a number of recommendations can be made. *Focus on flexibility*: The care model is shifting away from institutional care and towards community-based care, and job functions are realigning around this. Because creating and recruiting new categories of health professionals is difficult, especially in some less populated

regions, creating flexibility in the workforce is necessary. As care models evolve, the workforce is required to keep pace in order to avoid undue stress or lack of capacity.

Prioritise new sources of labour, such as long-term unemployed people or people with other ethnic backgrounds: Some traditionally disconnected segments of the labour market can be recruited through relatively inexpensive and simple initiatives. One major social advantage to expanding the workforce is that it achieves broad integration objectives. However, at a more immediate level, the cases suggest that there is an untapped segment of society that can be redirected to jobs in community care through proactive engagement.

Think small: Creating flexibility and measures at a small-scale project level can help embed new systems into the overall community care system. The case studies from Denmark reflect a Nordic approach of pilot testing changes and scaling up successful measures.

Develop skills: Training opportunities are useful for improving the quality of community care services. However, they have also been found to increase job satisfaction through two ways. First, career progression allows employees to move into higher pay scales and makes them more employable overall. Second, employees are more comfortable managing new responsibilities when they have good qualifications.

Ultimately, it is difficult to generalise on the impact of the projects, especially in the cases mentioned above, due to the small sample size and the highly flexible nature of implementation in Denmark. Nevertheless, where evidence is available, it points to positive impacts in terms of recruitment and retention. Given that the projects have resulted in positive outcomes and have highly sustainable and flexible programme models, it is likely that there is scope to expand them elsewhere in Denmark and in other European contexts.

Bibliography

Arbejderbevægelsens Erhvervsråd (2012), *De ældre bliver på arbejdsmarkedet på trods af krisen*, available at http://www.ae.dk/analyse/de-aeldre-bliver-pa-arbejdsmarkedet-pa-trods-krisen.

Arbejdsmarkedsstyrelsen (2004), *Isbryderordningen: Løntilskud til nyuddannede med handicap*, available at http://www.ams.dk/Publikationer/2004/pub209.aspx.

ATP (2013), *EUD-aftaler indgået i 2013*.

Beskæftigelsesministeriet (2009), *Kvinder og mænd på arbejdsmarkedet 2009*, Beskæftigelsesministeriet, Copenhagen.

Commonwealth of Australia (2003), 'Denmark: Continuity, autonomy and use of personal resources', in Commonwealth of Australia, *Review of pricing arrangements in residential aged care. Long term aged care. International perspectives*, pp. 65–79.

Danmarks Statistik, Statistikbanken (2013a), 'AKU100: Arbejdsmarkedstilknytning efter beskæftigelsesstatus, alder og køn', available at http://www.statistikbanken.dk/statbank5a/default.asp?w=1366.

Danmarks Statistik, Statistikbanken (2013b), 'FRA033: Fravær efter sektor, køn, fraværsårsag, branche (db07) og fraværsindikator'.

Danske Regioner (2010), 'Finansiering af 330 ekstra praktikpladser i regionerne'.

Eurofound, EIRO (2011), *Denmark: Industrial relations in the health care sector*, Eurofound, Dublin, available at http://www.eurofound.europa.eu/eiro/studies/tn1008022s/dk1008029q.htm.

FOA (2013), 'Mentornetværk', available at http://www.foa.dk/Afdelinger/SOSU/Integration/Mentornetvaerk.

Fonden for Velfærdsteknologi (2011), 'Formål', available at http://www.ffvt.dk/Om-fonden/Formaal.

Health-EU, 'Long-term care', available at http://ec.europa.eu/health-eu/care_for_me/long_term_care/ms_dk_en.htm.

Jensen, T. P., Lauritzen, H. B. and Larsen, B. Ø. (2010), *Social- og sundhedsansattes veje på arbejdsmarkedet*, Anvendt Kommunal Forskning, Copenhagen.

Jobnet (2013), 'Jobrotation og uddannelse af medarbejdere', available at https://info.jobnet.dk/arbejdsgiver/fakta+om+jobcentrenes+tilbud/jobrotation+og+uddannelse+af+medarbejdere.

Magnussen, J., Vrangbæk, K. and Saltman, R. B. (2009), *Nordic health care systems: Recent reforms and current policy challenges*, McGraw-Hill/European Observatory on Health Systems and Policies Series.

Ministry of Education (2010a), *Establish an apprenticeship and get up to 50,000 kroner*, Ministry of Education, Copenhagen.

Ministry of Education (2010b), *Regeringsudspil: Flere praktikpladser 2011*, Ministry of Education, Copenhagen.

Ministry of Employment (2013), 'Aftale om en tilbagetrækningsreform', available at http://bm.dk/da/Aktuelt/Politiske%20aftaler/Tilbagetrakningsreform.aspx.

Ministry of Finance (2003), *Budgetredegørelse 2003*, Ministry of Finance, Copenhagen.

Ministry of Finance (2010), *Budgetredegørelse 2010*, Ministry of Finance, Copenhagen.

Ministry of Finance (2011), 'Kommuner og regioner', available at http://www.fm.dk/arbejdsomraader/kommuner-og-regioner/.

Ministry of Health (2012), 'Krisebevidstheden blandt EU's sundhedsministre styrket', Press release, 24 April 2012.

Municipality of Copenhagen (2011), *Redegørelse for Socialforvaltningens sygefraværsindsats* [Statement of social management absenteeism effort], Copenhagen.

OECD (2011), *Long-term care: Country profile for Denmark*, available at www.oecd.org.

Pædagogernes Pensionskasse (2012), 'Fakta: Den nye tilbagetrækningsreform', available at http://pbu.dk/Nyheder/Sider/FaktaDennyetilbagetr%C3%A6kningsreform.aspx.

Region Syddanmark (2012), 'Kronikerindsats: Kompetenceudvikling af sundhedspersonale', available at http://www.regionsyddanmark.dk/wm314750.

Schulz, E. (2010), *The Long-Term Care System in Denmark*, Deutsches Institut für Wirtschaftsforschung, Discussion paper no. 1038, Berlin.

Social og Sundhedsuddannelses Centret (2013a), 'Tilmelding for ledige', available at http://www.sosuc.dk/kursusenheden/tilmelding-for-ledige.aspx.

Social og Sundhedsuddannelses Centret (2013b), 'Velkommen til Kursusenheden i Herlev', available at http://www.sosuc.dk/kursusenheden.aspx.

The Commonwealth Fund (2010), *International profiles of health care systems: Australia, Canada, Denmark, England, France, Germany, Italy, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United States*, The Commonwealth Fund, New York.

Uni-C, Styrelsen for it og læring (2012), 'Praktikpladsstatistik', available at http://uvm.dk/Service/Statistik/Statistik-om-erhvervsuddannelserne/Praktikpladsstatistik.

Videnscenter for kroniske sygdomme og rehabilitering (2013), *Kroniske sygdomme* [Chronic diseases].

World Health Organization and the European Observatory on Health Systems and Policies (2009), *Financing health care in the European Union: Challenges and policy responses*, available at http://www.euro.who.int.

Weblinks

Statistics Denmark Employment Database, 'Staff in in care and care, full-time employees by region, occupation and head office' (*Personale i omsorg og pleje, fuldtidsbeskæftigede efter område, arbejdsfunktion og hovedkonto*), accessed through the Statbank, available at http://www.dst.dk/en/Statistik/statistikbanken.aspx.

Annex 1: Case studies

This annex presents the results of the three Danish case studies on initiatives in the field of labour market policies in community-based care to support adults with disabilities. The three case studies are:

- Case study 1: Job rotation;
- Case study 2: Mentoring scheme for students with a foreign background;
- Case study 3: Further education in chronic disease.

Each case study includes a description of the initiative, definition of the problem, approach and implementation and contextual factors. This is followed by an analysis of the outcomes and results of the initiative. Finally, the lessons learnt and factors regarding the sustainability and transferability of the initiative are presented.

Case study 1: Job rotation

Description of the initiative

This case study focuses on the Danish initiative, 'job rotation', which aims at professional development for existing employees and provides access to employment for unemployed people and recent graduates in community care. Emphasis is placed on a local example of this initiative: a project in the municipality of Mariagerfjord.

Job rotation is a national initiative that is funded by the state; through it, individual job rotation projects operate at local level. In 2012, the national budget earmarked more than €24 million for this initiative. An additional €9.5 million was added in 2012, and in the same year the government's youth package added a further €4.8 million (Fagbladet 3F, 2012). Due to the local implementation of this project, participation varies by local requirements and by the needs of the workplace involved. Job rotation is therefore a flexible instrument that varies according to the individual needs of workplaces and location.

Overall objectives

Essentially, the job rotation system is used to allow existing employees to pursue further training opportunities on a temporary basis. Their jobs are held for them while they are enrolled in training, and are filled by temporary employees. In this way, it serves as both a retention and recruitment measure.

Definition of the problem

Policy background

Job rotation is not a new phenomenon in Denmark. Recently, however, there has been an increased focus on job rotation to address higher levels of unemployment while encouraging job-seekers to further their careers in healthcare, as these are pressing issues in specific municipalities. In the government's budget negotiations (*finanslovsforhandlinger*) in 2012, it was agreed that the situation of unemployed people should be improved.

Role of the social partners

Social partners and intermediary organisations play a significant role in the job rotation initiative. The role of social partners varies according to the specific project. The example of the municipality of Mariagerfjord involves significant inputs from a trade union for health and social assistants, Trade and Labour (*Fag og Arbejde*, FOA), who take part in steering committee meetings. The United Federation of Trade Workers (*Fagligt Fælles Forbund* (3F) helps recruit unemployed people, as does the Danish Metalworkers' Union (Dansk Metal). Finally, the Union of Commercial and Clerical Employees (*Fag, Uddannelse og Meninger*, HK) contributes to the recruitment of unemployed and underemployed people who are interested in working in community care.

Other partners include the municipal job centre, which recruits unemployed people and ensures job plans for temporary workers and approval of business practices, and the health and social care department of a university, which is involved in course planning, delivery and the preparation of course material.

Issues at stake

The job rotation initiative addresses multiple problems, the main one being the high unemployment rate in Denmark. Almost equally important is the need to upgrade the skills of the community care workforce. Currently, 21% of the current community care workforce in the municipality of Mariagerfjord is aged over 55 years; this means that both recruitment and retention represent serious challenges.

Issues relating to unemployed and underemployed people include enabling entry into the profession by supporting social and health education, the recruitment of new staff members once the programme is complete and addressing the need for more community care positions.

Approach and implementation

Overall approach

Job rotation refers to a temporary replacement of existing employees during training leave by unemployed people. The employee enrolled in further education or training receives the same salary as they did while at work. Temporary workers receive a standard wage. The employer receives a 'job rotation allowance' (*Jobrotationsydelse*) from the local job centre that referred the job-seeker. This covers the costs of training for employees and the salary for the temporary workers. Temporary workers must be unemployed in order to be eligible. The initiative encourages unemployed people to work in community care, both in order to reduce unemployment and to address worker shortages in this sector.

Aim of initiative

This initiative aims to improve the situation for both employees and people who are unemployed, including recent graduates. It facilitates training and professional development for the existing workforce, thereby lowering barriers to upgrading skills. Specifically, the initiative supplements the income of those seeking further training while also assuring that a position will be available once training is completed: in this way, two major barriers are addressed. For job-seekers (those who are underemployed, unemployed, and those seeking work experience, recent graduates), the initiative provides temporary work in their chosen field, which makes it easier for them to find work in that area. It provides easy access to employment opportunities for unemployed people, including recent graduates, on a trial basis, at a level that would otherwise be difficult to reach without experience.

Local initiatives tailor themselves to the specific needs of participating companies.

Recruitment versus retention

The instrument targets recruitment and retention. Job rotation recruits unemployed people, including recent graduates, and those who are employed retain their jobs.

Specific target groups

The instrument can be used in both the private and public sector. Two target groups benefit from the programme: current employees and job-seekers receiving temporary work placement.

Formal versus non-formal employment

The instrument does not address non-formal employment.

Project implementation

As noted, the government allocated funds for job rotation in 2012. Funding for the scheme increased over the past five years, with significant increases made in the past two budgets due to the pressures of higher unemployment. It began with a budget of slightly less than €1 million in 2008 and increased rapidly to a budget of over €13 million. The number of participants increased in line with the budget, with a rapid expansion over the past two years. In 2012, an estimated 770 participants were placed in temporary positions (Mørkeberg, 2012; Information, 2012; Ugebrevet A4, 2012).

Project level

The employees involved are social and health assistants in three home support networks and eight day centres, about 880 in total. Work placements are limited to those who have been without employment for at least three months. They are recruited by their employment insurance fund (*A-kasser*), in collaboration with the local job centre.

Initially, the unemployed people take part in an information meeting, followed by a job interview. Those selected participate in four weeks of training and orientation for their assigned job. The course addresses the relevant professional skills, including working with clients, good communication, diet and exercise, and pathology.

Following the training process, the unemployed participants are placed in an intensive four-week internship in the organisation with the temporary job vacancy. If successful, they are then offered a one-year job contract. Initially, these participants will be assigned an onsite supervisor. Afterwards, participants are offered further social and healthcare training based on their area of interest.

The employees involved are offered a set training programme that includes optional courses, allowing participants to choose certain courses. Normally, choices are based on staff development needs in the municipality. Courses include: rehabilitation; dealing with neglect and abuse; diet; conflict management; patient safety and adverse events; chronic pulmonary obstruction disease (COPD); dementia; and the ‘Marte Meo’ approach to supporting people with dementia. For some courses, employees of participating companies are as teachers.

Monitoring and evaluation

As the measure is funded by the state, ongoing monitoring and regular evaluation are required. An evaluation has taken place of 687 job rotation projects in the North Denmark Region (COWI, 2012). An upcoming evaluation is scheduled for the municipality of Mariagerfjord, which will be based on the experience of leaders, the employees and the unemployed participants.

Contextual factors

The financial crisis has led to a focus on employment. The programme is aligned with the overall goals of increasing employment opportunities and retaining community care workers. A growing focus on youth employment has also been partially addressed by this programme.
It is also relevant that the participating employees need training because the health system has shifted toward community-based models of care. This leads to greater demands on long-term care staff in relation to the rehabilitation of patients, but also in relation to the specific care that the patient needs after hospitalisation (Municipality of Mariagerfjord, 2011b). The municipality of Mariagerfjord needs to recruit staff in home care and nursing homes. In addition, rehabilitation has been a major priority in the municipality and has led to organisational changes in the municipality. Therefore, there is a need for staff to attend courses in rehabilitation, and managers have decided that the course should be mandatory for employees.

Outcomes and results

Type and numbers of job created

The job rotation programme has led to increased employment opportunities for participants. As already noted, there has been an evaluation of job rotation projects in Mariagerfjord's region, the North Denmark Region (COWI, 2012). It found that 78% of job rotation temporary workers (out of a total of 291 workers) who completed a job rotation project were employed within two weeks after the project had ended. Additionally, 63% of job rotation temporary workers (out of 286) who completed a job rotation project were employed after the rotation was completed, compared to an average of 43% for a comparison group (of 1,430 people) who were not enrolled in the programme.[1] Job rotation thus appears to improve work opportunity by 20 percentage points. Available data only allow for the measurement of short-term effect, although the programme seems to lead to stronger employment opportunities.

Other relevant outcomes

The programme can be used to help recruit new community care workers. This is the case in the municipality of Mariagerfjord. According to interviewees, benefits for unemployed participants include gaining work experience before seeking a place on a training programme and providing a bridge to a new position in the participating company.

Main results

The results of the programme are aligned with the objectives of the initiative. In addition to increased employment, they include: greater job satisfaction for the existing workforce; a better qualified workforce, ready to move towards new models of rehabilitation in community care settings; reduced unemployment through higher rates of employment for participants; and a greater interest in pursuing a career in community care among unemployed people.

Lessons learnt

Success and fail factors

Unemployed people must be motivated in order for an initiative like this to work. One success factor, therefore, was the fact that the initiative targeted unemployed people. It is also important that unemployed participants see the value of participating. In this case study in Mariagerfjord, participants knew that further education would be supported after the project period.

Unemployed people must be supported throughout the duration of an initiative such as this one. Therefore, it was an advantage that they had a supervisor at the workplace.

Other success factors include good cooperation with social partners, awareness of the unemployment situation and a strong steering committee that is involved and committed.

Planning is important; for example, the project involves invitations to information meetings and filling out forms. However, the unemployed participants were doing their internship during the summer months, when the existing employees were on vacation. This made it difficult to train them and might be described as a fail factor. Planning was also made difficult by the fact that employees could participate in a range of different courses. It would have been be easier if the employees had a fixed number of courses to choose from.

[1] Measurement intervals varied per person, but at least two weeks had passed before data were collected.

Sustainability and transferability

An important question is how to secure the success factors and transfer them to other contexts.

Job rotation projects can continue as long as the government supports them. Workplaces must be made aware of the initiative, the advantages and the possible outcomes. It is also important that it is supported by the unions, the employment insurance system and local job centres.

Job rotations projects can easily be implemented in other contexts. The concept is already used for social and healthcare workers, nurses, physiotherapists and occupational therapists in other municipalities. Some occupations, however, require relevant educational qualifications; the initiative is not transferable to those sectors.

Job rotation could work in other countries, but its transferability depends on a country's social and healthcare system as well as its education. A close dialogue between social partners is necessary.

Conclusions

Job rotation aims at professional development for existing employees and access to employment for unemployed people. The initiative addresses both recruitment and retention. Job rotation recruits unemployed people and retains people working in the care sector by supporting their career progression. The quality of care is improved through the measure as care workers improve their skills. Job-seekers however enjoy temporary employment in their chosen field, which lowers barriers to future entry in the sector.

Job rotation is a major initiative of the current government. Spending on the job rotation programme increased between 2007 and 2012, with significant increases in the two most recent budgets due to the pressures of higher unemployment rates.

The job rotation programme increased employment opportunities in Northern Denmark, Mariagerfjord's region. While data do not exist on the impact of retention, the increased satisfaction and growth opportunities for existing employees in the community care sector suggests that retention has been supported.

Job rotation is designed to be flexible and is applied at the local level based on community need. In Denmark, the programme has been used to address a diverse range of needs and local, context-specific issues. This suggests that an initiative of this type could be of value in other countries. Ultimately, coordination, planning, and availability of resources are its critical success factors, which can be addressed in a variety of contexts.

Bibliography

Beskæftigelsesregion Nordjylland (2011), *Nyhedsmagasinet EFFEKT*, No. 3, Aalborg.

Bredgaard, T., Jørgensen, H. H., Madsen, R., Dahl, M. R. and Hansen, C. (2011), *Hvad virker i aktiveringsindsatsen?*, New Insight, Copenhagen, Center for Arbejdsmarkedsforskning and Forskningscenter for Evaluering, Aalborg.

COWI (2012), *Analyse af jobrotation i Nordjylland*, Kongens Lyngby.

Fagbladet 3F (2012), 'Knap to tusind ledige kommer i jobrotation'.

Information (2012), **'**Få ledige er i jobrotation', available at http://www.information.dk/309746.

Municipality of Mariagerfjord (2012), 'Mariagerfjords indsats virker for de langtidsledige', available at http://www.ihobro.dk.

Municipality of Mariagerfjord (2011a), *Projektbeskrivelse: Jobrotationsprojekt Ældreområdet*, unpublished.

Municipality of Mariagerfjord (2011b), *Pressemeddelse: Dygtigere ansatte, bedre ældrepleje og jobs til ledige*, unpublished.

Mploy A/S (2012), *Håndbog i jobrotation*, Copenhagen.

Møller, N. F. (2012), *Orientering om jobrotationsordningen*, Arbejdsmarkedsstyrelsen, Copenhagen.

Mørkeberg, S. (2012), 'Jobrotation får ledige i arbejde', *Fagbladet FOA*, No. 10, pp. 9–10.

Rambøll (2011), *Screening af jobrotationsprojekter fra 25 kommuner*, Copenhagen.

Ugebrevet A4 (2012), **'**Jobrotation skal kickstartes', available at http://www.ugebreveta4.dk/2012/201220/Mandag/Jobrotation_skal_kickstartes.aspx.

Case study 2: Mentoring for students with a foreign background

Description of the initiative

This case study focuses on a Danish mentoring initiative for students with a foreign background. The initiative aims to retain students in social and healthcare education. These courses are part of the VET system, where education takes place in colleges and through internships in the labour market.

This mentoring system is led by the Social and Health School (SOSU) in collaboration with individual municipalities (Brøndby, Gladsaxe and Herlev). Funding is provided by the Ministry of Integration (*Integrationsministeriet*). The first annual contribution amounted to €20,000 (LXP Consulting, 2007). From November 2008 to October 2010, the mentoring system was part of the project financed by the capital regional authorities (Brandstrup and Michelsen, 2010). Since 2010, the mentoring has been financed by the schools themselves. Beginning with 15 pairs in 2004, by 2010 the programme had up to 100 pairs of mentors and mentees; at present there are 50 mentor–mentee pairs.

Overall objectives

Despite significant attempts to address the issue, cultural and linguistic barriers continue to keep foreign workers out of the labour market. This programme is for students who need help to complete their education as social and healthcare workers and social and healthcare assistants. It is available for all community care students with a minority ethnic background. This programme therefore meets labour market and integration objectives.

Definition of the problem

Policy background

The mentoring system started in 2004 when schools were provided with additional funds from the Ministry of Integration's 'fund for educational guidance'. In 2006, it was funded by the 'fund for enhanced employment for family reunification and refugee and immigrant women'. The funds were allocated as a means of advancing integration efforts in the face of social pressure caused by higher unemployment levels in newly settled immigrant populations. The initiative was part of a larger package of initiatives to increase labour participation among groups that have traditionally faced barriers to employment.

Role of the social partners

When the mentoring started in 2004, the mentors were recruited through the trade union, *Fag og Arbejde* (FOA). This trade union has 200,000 members, which includes many professional community care workers.

Issues at stake

The central problem that the initiative seeks to address is the range of barriers faced by foreign students when trying to gain work. Three factors prompted SOSU to initially apply for funding from the Ministry of Integration. First, school administrators noticed that many students felt isolated both in theoretical and practical training, and were not interacting with students with a Danish background. Secondly, there appeared to be many people who were willing to help people with an immigrant background integrate into society, education, and the labour market.

Thirdly, at the time of application, more than one-third of students in social and healthcare education were from minority ethnic backgrounds (LXP Consulting, 2007).

Approach and implementation

Overall approach

The mentoring system is coordinated by the mentor network, which consists of mentor coordinators who provides the practical work experience and act as contacts between mentor and mentee (Municipality of Brøndby Mentor Network SOSU C, 2009a). When the mentoring started, the mentees were students with a foreign background who had a limited social network and who were experiencing difficulties in their education. The mentors were typically volunteers who were working or retired; some were teachers at the college. Now, while all students are eligible to participate, most have a foreign background.

Aim of initiative

The initiative aims to improve retention of students, thereby increasing the number of workers recruited. By supporting students to complete their social and healthcare education, drop-out rates are reduced and students are better prepared for their careers in community care.

Recruitment versus retention

The initiative is aimed at both the retention of students and the recruitment of workers.

Specific target groups

In the beginning the target group comprised students with a foreign background. Now the target group comprises all students, but most participating students have a foreign background.

Formal versus non-formal employment

The initiative does not aim at a transfer of non-formal to formal employment.

Project implementation

When the mentoring system started in 2004, the goal was to strengthen the sociocultural competencies of minority ethnic students, by supporting their education and thus their participation in education and the labour market (LXP Consulting, 2007). This goal was implemented by offering these students a mentor.

At time of writing, there are 50 mentor–mentee pairs. It seems the mentoring system has been implemented and is working well, as it has existed for many years and is well established in the college involved. The mentors are mostly students but some are currently employed or retired. Mentors undergo nine hours of mentoring training (*mentoruddannelse*) in issues such as cultural differences, conflict resolution, empathy, responsiveness and power dynamics.

Typically, the mentor and mentee meet one a month, at a time that is convenient to both. The mentor listens, guides and cooperates. The meetings focus on the educational and cultural requirements of working in the community care sector. At the meetings, the mentor provides support and advice on: learning to speak Danish; learning about the Danish work culture and Danish culture in general; homework, examinations and education in general; the course content and the internship; job applications; and private subjects or problems.

Meetings between a mentee and mentor can take place at different locations. Normally, they meet at a neutral place like the library, but meetings could also take place at a restaurant or, if more suitable, in their homes. Both mentees and mentors can participate in café afternoons,

which are arranged four times a year. In the café, they discuss their experiences with mentoring. There are also presentations about subjects such as the mentoring system, learning to speak Danish and working in the community care sector.

Monitoring and evaluation

An evaluation has taken place of the initiative, under two of the Ministry of Integration's funding (LXP Consulting, 2007; Frederiksen et al, 2010). At project level, the mentor coordinators do not have a formal procedure for evaluating the mentoring system. At the café events, they ask the mentor–mentee pairs how their mentoring is going.

Contextual factors

Historically, cultural and linguistic barriers have kept foreign workers out of the labour market. These barriers influence both the education and subsequent career of these workers. According to interviews with project stakeholders the following factors make the mentoring system necessary.

- The students at social and health schools often drop out.
- Some students with a foreign background are not integrated into Danish society. For example, some of the students with other minority ethnic backgrounds had never been in a Danish home.
- Some students with a minority ethnic background need knowledge about Danish culture and the Danish educational system, and they need to practice speaking Danish, in order to have successful careers in community care.
- It is difficult for people with a foreign background to enter the labour market.

Outcomes and results

Type and numbers of job created

Overall, the mentoring system may lead to people being recruited to the community care sector. This is because it can retain students at social and health schools, and act as a bridge to a position within the community care system.

Other relevant outcomes

As noted earlier, the mentoring initiative has been evaluated at programme level (LXP Consulting, 2007). The evaluation concluded that there is no doubt that the funds contribute to the retention of students. Over two-thirds (70%) of the students surveyed stated that their mentor had been a significant support for them in finishing their educational programme, and 46% of the managers of funded projects stated that the project resulted in more young people with immigrant backgrounds successfully completing their academic programme. In the long term, the projects have helped to increase cultural integration in Denmark and encouraged young people with minority ethnic backgrounds to complete an education. Nearly three out of four of the young mentees said they believe that the project has had a very good or good impact on their academic achievement.

An evaluation was also carried out on a related project (REKOMENT), which included five schools that participated in the mentoring initiative (Cubion, 2010). With respect to the goal of making the school more appealing and thereby reducing drop-out rates, this evaluation showed that students find the educational environment attractive and that this influences retention. It found that:

- 87% of the students are happy to go to school;
- 87% are doing well in class;
- 90% would recommend others to apply for a place in the school;
- 90% would like to complete the programme at their current school;
- 97% believe that a good educational environment is very important for completing their education, which has significant implications for retention.

Main results

In addition to the high satisfaction levels, a number of specific results have been identified through interviews. The project leaders, mentor coordinator, mentee and mentor all identified the following results related to school retention and recruitment into the community care sector:

- support in school, resulting in fewer barriers and reduced drop-out levels;
- improved social interaction;
- an improvement in mentees' self-confidence.

Lessons learnt

Success and fail factors

The following success and fail factors were identified through the interviews conducted as part of this case study.

There were a number of success factors.

- The mentor coordinators visited classes to explain the mentoring system.
- The mentor coordinators informed the teachers about the mentoring system to ensure that it was used effectively.
- The mentor coordinators were engaged and available full time, and also remained open minded regarding the mentee's cultural background.
- It can be an advantage if the mentor and mentee live close to each other.
- It can also be an advantage if the age difference between mentor and mentee is not too big.
- Each mentor–mentee must make a good match; they must share similar expectations.
- Support from the schools' management is important.

However, some fail factors also emerged.

- When the project started, voluntary work was not very widespread in Denmark. It was difficult to explain to the mentors that they were not going to be paid for their work.
- It may be difficult for the mentors to find time to meet with the mentee.
- One mentor requested that all of the mentors meet (without the mentees) and share their experiences.

Sustainability and transferability

Important questions include how to maintain the positive aspects of the initiative and how to transfer them to other contexts.

The mentoring system is already well established at the SOSU. The key to continuing the programme is to provide further support to the coordinators.

The initiative can be used in other educational institutions and in other contexts. Indeed, it is being implemented throughout the rest of the professional educational system. It has also been suggested that the programme could be implemented in workplaces.

Conclusions

This case study focused on mentoring for students with a foreign background. This initiative aims to retain students in social and healthcare education, and functions as a bridging mechanism between education and recruitment into community care. It was launched in 2004 to address cultural and linguistic barriers that continue to keep foreign workers out of the labour market. This programme therefore meets labour market and integration objectives through: supporting students to complete their social and health education, which reduces drop-out rates, while also preparing them to begin a career in community care.

Several evaluations have been carried out, which have consistently highlighted a positive impact regarding the retention of students in education and their recruitment into community care positions. Because community-based care is highly personal, cultural and linguistic barriers, which have traditionally acted as barriers to many people with a foreign background, are particularly significant in the community care sector. This programme has been shown to reduce these barriers.

Bibliography

Boel, M. and Fenger, M. (2010), *Metodekatalog: Metodekatalog til en forstærket beskæftigelsesindsats over for familiesammenførte samt flygtninge- og indvandrerkvinder*, CABI (Center for Aktiv Beskæftigelsesindsats), Århus.

Brandstrup, O. and Michelsen, L. (2010), *Livstræer, mentorer og aktive valg: Konkrete erfaringer med mentorordninger og kompetenceafklaring på fem SOSU-skoler*, REKOMENT ved SOSU C, Brøndby.

Cubion (2010), *Projekt REKOMENT: Afsluttende evalueringsrapport*, Copenhagen.

Frederiksen, P. R., Boel, M. and Fenger, M. (2010), *Evaluering af puljen Forstærket beskæftigelsesindsats: Resultater og metoder i Integrationsministeriets satspulje for familiesammenførte samt flygtninge- og indvandrerkvinder*, CABI (Center for Aktiv Beskæftigelsesindsats), Århus.

LXP Consulting (2007), *Evaluering af Integrationsministeriets pulje for uddannelsesguides*, Copenhagen.

Municipality of Brøndby Mentor Network SOSU C (2009a), *Mentor-netværk SOSU C: Mentor guide*, unpublished.

Municipality of Brøndby Mentor Network SOSU C (2009b), *Mentee interview guide*, unpublished.

Municipality of Brøndby Mentor Network SOSU C (2009c), *Mentor interview guide*, unpublished.

Municipality of Brøndby Mentor Network SOSU C (2009d), *Mentor discussion*, unpublished.

Case study 3: Further education in chronic disease

Description of the initiative

This study focuses on the Danish initiative, 'further education in chronic disease'. The initiative aims at career development for health professionals in general practice, community-based care in municipalities and hospitals, and includes a number of courses and training modules to increase the capacity of the existing workforce to manage chronic disease in community-based care, with stronger linkages to clinical practice.

The initiative is a regional programme in the Region of Southern Denmark, in cooperation with educational institutions. However, the national government, through the Ministry of Health, finances the programme as part of a national effort to manage the increasing incidence of chronic disease. The budget for the programme over three years is nearly €2 million (Andersen, 2009; Nors and Andersen, 2009). The Region of Southern Denmark has chosen to allocate this budget towards a skill-development programme. The goal is that 3,000 health professionals, including professionals in community care, municipalities and hospitals in the Region of Southern Denmark, will obtain further education in the period 2010–2012.

Due to the flexibility of the programme, with local authorities and educational authorities able to manage it based on local needs and the availability of local resources, participation varies across the country and is dependent on the nature of the local programme and the target groups included.

Overall objectives

The state's objective, in funding this initiative, is to address chronic disease. However, due to the flexibility of its funding arrangements, the Region of Southern Denmark is addressing two problems: the high incidence of chronic disease; and the need to train healthcare workers in new care models.

Definition of the problem

Policy background

The incidence of chronic disease is rising significantly, while the general trend in health and care services is towards a community-based model with interdisciplinary teams. The Region of Southern Denmark received funding from the Ministry of Health to address chronic disease and promote the skills of health workers across sectors. Health treatment is managed by the regional authorities while community-based care is placed at the municipal level, although the shift also includes a need for cross-sectoral initiatives between levels of authorities and professions.

Role of the social partners

The project is organised by a cross-sector coordination group, with representatives from general practice, hospitals, and community care in the municipalities. Its task is to discuss and provide input on the content of competence development. Social partners do not have a direct role in the projects, although they are involved in employment-related aspects of community care.

Issues at stake

The central problem the initiative addresses is the high incidence of chronic disease and the resultant need to develop the skills of healthcare professionals in community care, home care and hospitals in managing chronic disease. Due to the difficulty of recruiting additional workers,

retaining employees is of fundamental importance, and the Region of Southern Denmark has therefore created a broad-based programme to develop skills across the workforce to shift to new models of care.

Approach and implementation

Overall approach

The premise of the programme is that skills development should be offered on an inter-sectoral basis with a team-based chronic disease management approach, which is person-centred and tailored to individual needs. Therefore, training is offered to all professional groups rather than by sector (Christensen, 2012). The courses are designed to better prepare the existing workforce to manage the transition to community-based care, reducing stress for the workforce and improving their capacity to perform new roles. The courses are practice-oriented, with many involving guest teachers working in the relevant field.

Aim of the initiative

This initiative aims to provide workers with continuous career development in chronic disease. This leads to an increase in the number of workers qualified in chronic disease management, with a focus on cross-sectoral collaboration, including community-based care and preventative care. It also increases cooperation between workers in general practice, municipalities and hospitals.

Recruitment versus retention

The initiative can involve both the recruitment of health professionals across clinical and community-based services and the retention of health professionals caring for people with a chronic disease.

Specific target groups

The courses are for health professionals in general practice, municipalities and hospitals in the Region of Southern Denmark.

Formal versus non-formal employment

The initiative does not aim to transfer non-formal employment to formal employment.

Project implementation

At a regional level, the initiative's objective is that 3,000 employees will participate in skills development in the period 2010–2012. The business plan also includes the development of courses and the involvement of relevant clinical staff. Depending on the topic, this will be done either by subsidising the salary of some individuals to participate in the project, designing courses or setting up a working group.

The Region of Southern Denmark's midterm evaluation shows that the courses are in high demand, especially motivational interviewing, health education and the diagnosis- related courses (Bjerrehøj, 2011a; Bjerrehøj, 2011b). The new courses include collaboration, workflow around people with chronic conditions, occupational rehabilitation, motivational interviewing, and health education. For example, a typical course on chronic obstructive pulmonary disease (COPD) for social and health assistants includes diagnosis and treatment, a focus on prevention, the integration of rehabilitation, and community-based care (Region Syddanmark, 2012; Region Syddanmark and the Social and Health Schools, undated). During the course, the employee receives a normal salary, for which the employer receives an 80% subsidy.

Monitoring and evaluation

A final evaluation is planned in March 2013, when the project ends. However, monitoring and evaluation have taken place of some of the immediate impacts of the initiative. This found that: competence is increased after participation; competences can be used in the daily work of participants; and the participating of people from different sectors was essential for learning (Christensen, 2012).

At the three social and health schools, the courses are evaluated through interviews and a questionnaire, with 80% reporting that they were very satisfied with them.

Contextual factors

It is estimated that more than one in three adults in Denmark live with a long-term illness. Because of the increasing number of people with chronic illness, new requirements will be set for health professionals working with these patients (Videnscenter for kroniske sygdomme og rehabilitering, 2013). In addition, there is an emphasis on moving care out of hospitals and into the community. Consequently, more treatment and care options are available in the client's own home, which places greater demands on staff in social and healthcare.

Social and health assistants are not trained to perform some care tasks. They need new skills to remain in their profession and to function without creating undue stress for themselves or the clients in community care.

Outcomes and results

Type and numbers of job created

As already noted, this initiative has to potential to retain employees in the social and health sector. This is because, firstly, an increasing focus on community-based care requires a shift in resources; the courses help workers make the transition to filling new roles. Secondly, training and skill in providing new services will reduce stress. Thirdly, better knowledge of the area of chronic illness will create a greater desire to work with the area. Fourthly, cooperation with other sectors will lead to stronger collaboration overall and could encourage a better working environment for employees.

Other relevant outcomes

Outcomes for the employees include increased job satisfaction, reduced feelings of isolation and increased empowerment to collaborate with professionals from other disciplines. Interviews identified a number of contributing factors to increased satisfaction. The most important of these is career development for health professionals, through training that has led to knowledge about chronic disease, treatment and care, and cooperation between the health professionals, all of which facilitates career progression. Health professionals receive the most up to date information on the topic concerned and are therefore more comfortable conducting their work. In addition, participants are generally in an enhanced position for seeking a new job, as their employability within the sector has improved.

Interviewees also identified outcomes for the social and health sector. Firstly, the initiative increases cooperation between workers in general practice, municipalities and hospitals. Secondly, some workers said that a course had motivated them to work in other sectors, resulting in a more flexible workforce. Thirdly, it is cost effective to train an existing workforce, especially in rural regions where recruiting a specialised workforce is difficult and the likelihood of retaining employees is higher.

Main results

The goal of the initiative was that 3,000 people will be taught in the period 2010–2012. This was to include 1,000 GPs and specialists, 1,000 care workers from municipalities and 1,000 from hospitals. The end result was that 5,834 people participated (Region Syddanmark, 2012), a far higher figure than originally envisaged. According to representatives of the initiative, a number of results can be identified. These include a better transition towards filling new functions for the workforce, the development of relevant skills among workers, which reduces stress, greater collaboration between relevant healthcare providers and a better working environment for employees.

Lessons learnt

Success and fail factors

One important success factor is that funding from the Ministry of Health made the initiative possible.

Another is that the teachers should be engaged, committed and have relevant practical experience. For example, at some courses guest teachers are practitioners; this allows participants to see how they can apply their new knowledge to real life situations.

Small class sizes enable communication between participants from other sectors. Similarly, if several employees from one workplace attend the same course, they can discuss it afterwards and expand their networks with people from other sectors.

The courses are regularly evaluated, and continuously adapted to participants' wishes and needs.

The only fail factor identified is that it is challenging to tailor courses so that they meet the varying needs of participants from different sectors.

Sustainability and transferability

The initiative, further education in chronic disease, is aligned with trends in the Danish care system, which places a greater emphasis on community-based care and collaboration.

The initiative ended in 2012. The Region of Southern Denmark was to base its decision on how it may continue on the findings of the final evaluation, which was to be published in March 2013 (Region Syddanmark, Afdelingen for Sundhedssamarbejde og Kvalitet, 2012). The following key factors for its sustainability have been identified:

- that courses takes place in the workplace of the participating company, and that the company pays the teachers;
- that tools for e-learning and distance learning are improved;
- that the role of social and health schools is extended, specifically those that already have free courses for the target group, especially for employees with lower levels of education qualifications (Christensen, 2012).

Regarding transferability, it is likely that the initiative can be used in other contexts. It is recommended that educational institutions are involved in offering courses. They can play a role in the development of courses and in marketing. They can also tailor courses to meet the varying needs of participants.

The initiative can be used in other countries that have also experienced a high incidence of chronic disease combined with a shift to community care. However, its success depends on the flexibility and coordination of partners, which is a hallmark of many Danish programmes.

Conclusions

This study focused on the Danish initiative, 'further education in chronic disease'. The initiative aimed at career development for health professionals in general practice, municipalities and hospitals. It includes a number of courses and training modules to increase the capacity of the existing workforce to manage chronic disease.

The central problem addressed by the initiative is the high incidence of chronic disease, which leads to a need to improve the capacity of professionals in community care, home care, and hospitals to manage chronic disease. Due to the difficulty of recruiting additional workers, the Region of Southern Denmark developed this initiative to improve skills across the workforce rather than recruit new employees.

The programme is based on the premise that additional career development within chronic disease will increases the size of the workforce that can take care of people with a chronic disease, with a focus on community-based care and preventative care. The training improves employees' capacity to meet new roles, while making them more employable, which facilitates career progression.

Outcomes from the ongoing evaluation suggest that the initiative is operating as intended, and is introducing more flexibility into the system to support the shift to interdisciplinary, community-based care. Participants have reported feeling better prepared and more comfortable in their new roles, more adaptable, and better prepared for career progression. The implications for retention cannot be quantified, but the increased satisfaction with new job functions is relevant, especially in rural areas where recruitment of specialised staff is difficult.

Bibliography

Andersen, K. (2009), *Bilag med uddybende projektbeskrivelser til udmøntningsplan for puljer til en forstærket indsats for patienter med kronisk sygdom i 2010–2012 i Region Syddanmark*, Region Syddanmark, Afdelingen for Kommunesamarbejde.

Bjerrehøj, B. (2011a), *Midtvejsevalueringsskema - for puljeprojekter under den styrkede indsats for patienter med kronisk sygdom*, Region Syddanmark, Afdelingen for Kommunesamarbejde.

Bjerrehøj, B. (2011b), *Bilag 1: Beskrivelse og status på projekt nr. 54679: Forløbsprogrammer i Region Syddanmark*, Region Syddanmark, Afdelingen for Kommunesamarbejde.

Christensen, R. F. (2012), *Notat vedr. kronikerprojekt kompetenceudvikling og tværsektoriel kompetenceudvikling*, Region Syddanmark, Personaleudvikling.

Johansen, E. S. (2011a), 'Temadag: Kronikerindsats og motivationssamtalen', *Fokus*, No. 6, pp. 6–8.

Johansen, E. S. (2011b), 'Motivationssamtalen: 360 sundhedsfaglige medarbejdere skal lære ny samtalestil', *Fokus*, No. 6, pp. 9.

Nors, M. U. and Andersen, K. (2009), *Udmøntningsplan for puljer til en forstærket indsats for patienter med kronisk sygdom i 2010–2012 i Region Syddanmark*, Region Syddanmark, Afdelingen for Kommunesamarbejde.

Region Syddanmark (2012), 'Kronikerindsats: Kompetenceudvikling af sundhedspersonale', available at http://www.regionsyddanmark.dk/wm314750.

Region Syddanmark, Afdelingen for Sundhedssamarbejde og Kvalitet (2012), 'Fælles viden fremmer samarbejdet', *Dialog om forebyggelse*, No. 8, pp. 18–19.

Region Syddanmark and the Social and Health Schools, 'Kroniker kurser for hjælpere og assistenter', available at

http://www.sosufyn.dk/da-DK/Efter--og-videreuddannelse/SOSU-efter--og-videreuddannelse/Kronikeruddannelser.aspx .

Schnedler, H. (2009), *Indkaldelse af ansøgninger om økonomisk tilskud fra puljer i Ministeriet for Sundhed og Forebyggelse til en forstærket indsats for patienter med kronisk sygdom i 2010–2012*, Ministeriet for Sundhed og Forebyggelse, Copenhagen.

Videnscenter for kroniske sygdomme og rehabilitering (2013), 'Kroniske sygdomme'.

Vis Kvalitet (2013), 'Kursisttilfredshed: Skoler'.

Annex 2: Interviewees

National context

Name	Title and organisation
Birgit Milling	Head of human resources, municipality of Copenhagen
Lise Keller	Human resource consultant, 3BAR

Case study 1: Job rotation

Name	Title and organisation
Birgitte Nissen	Manager from participating home-care workplace, municipality of Mariagerfjord
Dorthe Blixt Boe Kristensen	Employee, participant in job rotation project, municipality of Mariagerfjord
Maria Lybek Christensen	Unemployed, participant in job rotation project, municipality of Mariagerfjord
Vera Larsen	Enterprise consultant, Department Health and Social Care, municipality of Mariagerfjord

Phone interviews

Name	Title and organisation
Anne Aarup Mikkelsen	Business coordinator, the job centre in Mariagerfjord
Hanne Nørgaard Laursen	Business consultant, the job centre in Brønderslev
Stine Beck Christensen	Business consultant, the job centre in Hjørring
Tom Levi Larsen	Business consultant, the job centre in Aalborg
Rasmus Madsen	Job rotation coordinator
Klavs Thye-Petersen	Employment coordinator, Centre for Autism and Attention Deficit and Hyperactivity Disorder

Case study 2: Mentoring for students with a foreign background

Name	Title and organisation
Bente Kofoed	Project manager on the first project in 2004, teacher, Social and Health School, Brøndby
Marianne Munk Nielsen	Organising role on the first project in 2004, teacher, Social and Health School, Brøndby
Maimuna Sanyang	Mentee, Social and Health School, Brøndby
Margerete Smidt	Mentor, Social and Health School, Brøndby
Pia Madsen	Mentor coordinator, teacher, Social and Health School, Brøndby

Phone interviews

Name	Title and organisation

Chris De Jean	Mentor, Social and Health School, Brøndby

Email correspondence

Name	Title and organisation
Jette Waagner Ryt-Hansen	Mentor coordinator, teacher, Social and Health School, Gladsaxe
Sanne Ørtoft	Mentor coordinator and teacher, Social and Health School, Brøndby

Case study 3: Further education in chronic disease

Name	Title and organisation
Helle Damgård Hansen	Participant at three courses, social and healthcare worker in the municipality of Esbjerg
Lone Brøndum	Teacher of several courses, Social and Health School, Esbjerg
Jane Kuchler	Course coordinator, teacher, Social and Health School, Fyn
Tommy Carlsen	Social policy consultant, FOA, Department of Social and Health Care

Phone interviews

Name	Title and organisation
Lene Mackenhauer	Consultant, Social and Health School, Esbjerg
Gitte Kloster	Course secretary, Social and Health School, Esbjerg
Inge Uldbæk	Teacher, Social and Health School, Esbjer
Anni Hedager	Secretary, Social and Health School, Fyn
Helle Jessen	Course coordinator, teacher, Social and Health School South

Email correspondence

Name	Title and organisation
Lars Oberländer	Senior consultant in human resources and workforce development, the Region of Southern Denmark
Lone Grau	Course secretary, Social and Health School South

Helle Ourø Nielsen, Oxford Research

EF/13/53/EN 4