HealthManagement
Promoting Management and Leadership

Volume 10, Issue 5 / 2008 - Country Focus:Denmark

Healthcare in Denmark

Denmark, a Scandanavian country consisting of a mainland peninsula and a number of islands, is a small country (43,000 km2) with few inhabitants (5.5 million). The capital city, Copenhagen, has around one million citizens. There are two off-shore territories, Greenland and the Faroe Islands, granted home rule in 1979 and 1948. Contrary to the rest of Denmark, Greenland is geographically very large, 50 times larger than the other areas of Denmark.

The demographic development is similar to other western European countries, with an aging populati on; the GDP in 2006 was 275,227 million USD (202,8 million euros) and 47,759 USD (35,202 euros) per capita (2005), with a fairly equal distribution of income across the population. The general level of education is fairly high, with 32% and 18% of the population between 20 and 69 years having attended secondary and tertiary education.

Denmark has a constitutional monarchy and a parliamentary democracy. The current government, in power since 2001, is a coalition between the Liberal and Conservative Party. Denmark has been a member of the European Union (EU) since 1973. In terms of total health spending Denmark ranks above average in OECD countries, spending 9.5 % of GDP and 3,349 USD (2,468 euros) per capita in 2006. Health spending per capita in Denmark increased, in real terms, by 4,1% per year on average between 2000 and 2006. The public sector is the main source of health funding in most OECD countries and Denmark is no different, 83% of health spending was funded by public sources in 2002. In 2004, Denmark had 3,6 practicing physicians per 1,000 population, more than the OECD average of 3,1. The number of nurses per 1,000 population in Denmark was also well above average in 2006.

As in most OECD countries, the number of hospital beds per capita in Denmark has declined over time. The decline has coincided with a reduction of average length of stays in hospitals and an increase in number of surgical procedures performed on a same-day (or ambulatory) basis.

Like most OECD countries, Denmark has enjoyed large gains in life expectancy (75 years for men, 80 for women) over the past decade, thanks to improvements in living conditions, public health interventions and progress in medical care.

Organisational

The healthcare service can be divided into two sectors, primary healthcare and the hospital sector. Primary healthcare, available to all, deals with general health problems and its services. This sector can be divided into two parts, treatment and care, and prevention.

When ill the first point of contact is the primary healthcare sector. The hospital sector deals with medical conditions that require more specialised treatment, equipment and intensive care. In addition to treatment of patients, both general practitioners and hospitals are involved in preventative treatment as well as health personnel training and medical research.

General practitioners act as the gate-keepers of hospital treatment. Patients usually start by consulting their general practitioners, whose job it is to ensure that they are offered the treatment they need. Self-employed general practitioners are paid via a combination of capitation (30%) and fee for service.

It is normally necessary to be referred by a general practitioner to a hospital for medical examination and treatment, unless it is a question of accident or acute illness. The same goes for treatment by a specialist. Specialists are paid on a fee for service basis.

A new local government reform came into effect on 1 January 2007, replacing the old system of 15 counties and 271 municipalities (from 1970) with five regions primarily focused on the healthcare sector and 98 municipalities responsible for a broad range of welfare services. The task of the state in healthcare provision is to initiate, coordinate and advise and to establish the goals for a national policy.

The Ministry of Health and Prevention, in its capacity of principal health authority, is responsible for healthcare legislation and also supports efforts to improve productivity and efficiency by promoting the professional exchange of information and by the introduction of economic incentives and activity-based payment.

Financing

The Danish healthcare system is based on a principle of free equal access for all.

In 2005 the public expenditure constituted 84% of the total health expenditure and private expenditure constituted 16% of total health expenditure. Private healthcare expenditure covers out-of-pocket expenditure for pharmaceuticals and dentistry. To finance the majority of the regional and local healthcare expenditure, the state imposes a healthcare contribution tax (8% on taxable income).

Annual negotiations between the central government and the regions and municipalities result in agreements on the economic framework for the health sector, including levels of taxation and expenditure and resource allocation.

The Regions

Healthcare in the regions is financed by four kinds of subsidies. A block grant from the state (75%), a state activity-related subsidy (5 %), a local basic contribution (10%) and a local activity- related contribution (5%). The state block grant reflects expenditure needs e.g. demography and social structure of each region. The purpose of the state activity-related pool is to encourage the regions to increase the activity level at the hospitals, whereas the purpose of the local contributions is to encourage the municipalities to initiate efficient preventive measures.

At the regional and municipal level, various management tools are used to control expenditure, in particular contracts and agreements between hospitals and the regions, and ongoing monitoring of expenditure development.

Private Health Insurance

Around 36% of the population purchases complementary private health insurance covering statutory cost sharing from the not-forprofit organisation “Dan mark”.

This private health insurance offers access to care in private hospitals in Denmark and abroad. It covers 13,5% of the population and is mainly purchased by employers as a fringe benefit for employees. In 2005, private health insurance accounted for 1,6% of total health expenditure and is rapidly increasing.

The Danish Quality Improvement Model

A comprehensive standardsbased programme for assessing quality is currently being implemented aiming to incorporate all healthcare delivery organisations and include both organisational and clinical standards. Organisations are assessed on their ability to improve performance measured against standards for processes and outcomes.

The assessment programme is a system of regular accreditation based on annual self-assessment and external evaluation (every third year) by a professional accreditation body. Self-assessment involves reporting of performance against national input, process and outcome standards allowing comparison over time and between organisations.

The external evaluation begins with self-assessment and goes on to assess status for quality development. Some data from the quality evaluation are already being published on the internet (www.sundhedskvalitet.dk) to facilitate patient choice of hospital and encourage hospitals to raise standards.

Every second year the Danish Regions and the Ministry of Health and Prevention conduct a survey of the patients experiences for comparison purposes.

In January 2004, a national reporting patient safety system for adverse events was established. The purpose of the system, based on the Danish Healthcare Act, is to improve patient safety and healthcare obliging healthcare professionals to report any adverse events in connection with a patient’s treatment or stay in hospital.

The new National Strategy for Digitalisation of the Health Sector was adopted on 1 January 2008. The vision is that data shall follow the patient across organisational and sectoral boundaries.

To ensure patients' legal rights, new laws have been passed and new complaints and compensation procedures developed. Doctors are obliged to inform the patients about their illness, the treatment available and its side effects to gain the patient's "informed consent". It is also possible to set up a "living will". Patients also have a right to see their own medical records free of charge, and doctors or other medically trained staff are obliged to interpret case records if asked.

New Initiatives for the Future

The Danish government has introduced a reform for better services for citizens which includes the healthcare sector. There are 40 initiatives and almost 2 billion DKR (270 million euros) over a period of 4 years have been reserved for this purpose. Investments for the construction of specialised hospitals have also been made to ensure the hospital sector is future proof. For this purpose the government have reserved 25 billion DKR (3.3 billion euros).

The National Board of Health is also obliged to lay down requirements of health specialty planning.

This year the Danish Regions have set up a Committee assessing the future role of general practitioners in the Danish healthcare system to ensure easy access to high quality treatment and effective utilisation of resources. The Ministry of Health and Prevention have set up a working group to investigate the proportion of administrative tasks among the staff in public hospitals in an attempt to reduce bureaucracy in the future.

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Published on : Sat, 22 Nov 2008