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Ten years of structural reforms in Danish healthcare

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ABSTRACT

A major structural reform of the Danish public sector took place in 2007 when the number of administrative units at the regional and municipal levels was reduced. The larger administrative units allowed for a new hospital structure with a reduced number of acute hospitals covering a population of between 200,000 and 400,000 inhabitants. The restructuring involves creation of acute hospitals with a 24-h acute service by a range of specialists. The idea was to weight quality higher than geographical closeness to the nearest hospital. Concurrently, the pre-hospital service will be expanded. The National Board of Health was given authority to approve regional plans for specialties rather than provide guidelines. The use of private hospitals was increased as a means to fulfil a waiting time guarantee of between 2 and 1 month. Increased use of private insurance also increased use of private hospitals. A new way of financing health care was intended to give municipalities incentives to invest in health prevention and health promotion. Concurrent reforms included economic incentives to increase hospital production as measured by DRGs; quality programmes to secure high quality and patient safety; and electronic patient records and increased use of IT systems.

1. Introduction

After more than 30 years of relative stability in which Denmark followed a path with only occasional minor turns [1,2], in 2007 a major structural reform of the public sector was launched, giving rise to larger administrative units at regional and local levels. This structural reform has facilitated a subsequent reform of the healthcare sector.

Denmark is characterized by having a decentralized public sector in which municipalities have the primary role of providing public services, while the next level is responsible for providing more specialized services, and the State sets legal frameworks, monitors and evaluates the services, and ensures an equalization of fiscal potential among units at the two lower levels. Before the reform, Denmark comprised 13 counties and 271 municipalities within a country of slightly more than 5 million inhabitants.

The healthcare system is tax financed with some user payments, and it provides universal coverage through a Health Security scheme. Most hospitals are public, and general practitioners work as private entrepreneurs under a contract with the regions.

It is the purpose of the present paper to describe and analyze how the comprehensive structural reform of the Danish public sector allowed major changes in the health care sector. To complete the picture, a short overview of concurrent reforms is also provided.

2. The structural reform

A structural reform was contemplated in the late 1990s for various reasons. It was increasingly recognized that smaller municipalities faced problems in providing specialized services of satisfactory quality. Moreover, counties

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were too small to provide an efficient specialized hospital service. The number of administrative units at both levels were therefore regarded as too large, and the distribution of tasks between the State and the two levels was also seen as sub-optimal. Among other reasons were negative statements in the media over many years of the service provided by the healthcare system (even if not fully justified [3]), unsolved structural problems in metropolitan areas, and some political parties and the Confederation of Danish Industries questioning of the necessity for three administrative levels, each with the authority to collect taxes, in a country as small as Denmark [4]. Still, there was only limited public debate on the need for a structural reform [5], and a recent public report [6] did not see a need to reform the governance structure.

A coalition government composed of the Liberal Party (Venstre) and the Conservatives took office in 2001 after having attained majority in parliament with the support of the Danish People's Party (DF). The Conservatives and the DF were both skeptical about retaining the county level, for various reasons. A restructuring of the administrative system was not an issue during the 2001 election campaign, however. In turn, the Liberal Party was keen to improve the healthcare sector by, in particular, increasing healthcare budgets [4]. Moreover, the Liberal Party held the majority in many municipal and county boards and hence was able to elect the local mayors, and they could expect this position to be lost in a new structure with larger geographical units at both levels.

A Government Advisory Committee on Improvement of Efficiency in the Healthcare Sector was commissioned by the new government in 2001. In its reports from 2002 and 2003 it outlined various structural solutions, but stressed that diverse initiatives were required rather than just structural reforms [7,8]. In its report published in early in 2003, the committee pointed to a smaller number of counties, private involvement in providing hospital care, compulsory accreditation, use of activity-based financing, and increased power accruing to the National Board of Health (NBoH); all of which were welcomed by the government. Others who touched upon structural problems included the The Danish Economic Council [9] and the OECD [10].

3. A commission on administrative structure

After the newspaper *Berlingske Tidende* had conveyed the position of the Confederation of Danish Industries to simplify the governance structure, and younger politicians from the Liberal Party brought the structural issue to the attention of the media in the summer of 2002, the debate increased, and problems and possible solutions were debated [4]. A window of opportunity [11] for the government thereby opened, which the government used to form a Commission on Administrative Structure, whose composition was closely controlled by the government rather than matching the make-up of parliament as is the custom [4]. The commission's brief was to assess the advantages and disadvantages of alternative models for the organization of the public sector with a particular view to organizing the hospital structure. A possible reason for establishing a commission was that the Liberal Party was not ready to discuss the specifics of a reform yet [5]. The commission presented its report in early 2004 in which it outlined various models for the future structure of the public sector [12].

4. New administrative structure

Shortly after publication of the report, the government used its majority in parliament to enact a reform law reducing the number of municipalities from 271 to 98, and a replacement of the 13 counties by five regions. Both administrative levels were intended to have elected boards, but only the municipalities were given the authority to collect taxes. Thus, the regions were to be financed through government grants rather than regional taxes and through payment from municipalities for use of the regional health service. A number of tasks were moved from the former counties to the municipalities, while the main role of the regions was to run the hospitals and the health insurance. The reform took effect from 2007. The size of the average municipality increased from a mean of about 19,000 (with large variation) to about 55,000 inhabitants [13].

In this process the Minister of Interior and Health, who represented the Liberal Party, played a central role as a policy entrepreneur, given his experience as a former mayor of one of the counties. It is remarkable that the decision process took only a few months, considering that this was probably the largest administrative reform ever seen in Denmark [14].

5. Reorganizing the health care sector

The reform, adopted in 2004, was followed by a new Health Act in 2005 which gave power to the NBoH in setting requirements for the future planning of hospital specialties; previously it had merely set guidelines. (Likewise, the NBoH was given authority to approve mandatory agreements between a region and its municipalities concerning the coordination of health care among hospitals, general practitioners, and municipalities.) The NBoH was therefore given authority to approve regional plans for the distribution of specialties. The first step by the NBoH was to issue reports on the acute service in 2006 and early 2007 [15,16]. The underlying assumption was that high quality requires a high volume of patients, and that high quality should take priority over geographical distance. The NBoH consequently required that an acute hospital service should be available 24 h a day with the most vital specialties available, namely internal medicine, orthopedic surgery, general surgery, anesthesiology with an intensive department, diagnostic radiology, and clinical biochemistry in addition to services in gynecology, obstetrics, and pediatrics when providing delivery services. According to the NBoH this would require a population base of between 200,000 and 400,000 in order to ensure an efficient volume. As an estimate, this would mean a reduction of the number of acute hospitals from about 40 to 25. The initiative focused on somatic patients, but it was envisaged that psychiatric patients would be included in future planning.

As the reorganization would imply increased distance to the nearest acute hospital for citizens living in remote