Health Policy 119 (2015) 1005–1010

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Health reform monitor

Centralising acute stroke care and moving care to the community in a Danish health region: Challenges in implementing a stroke care reform☆

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ARTICLE INFO

Article history:
Received 19 August 2014
Received in revised form 19 May 2015
Accepted 27 May 2015

Keywords:
Denmark
Health care reform
Stroke care
Implementation
Centralisation
Moving care to the community
Integrated care

ABSTRACT

In May 2012, one of Denmark's five health care regions mandated a reform of stroke care. The purpose of the reform was to save costs, while at the same time improving quality of care. It included (1) centralisation of acute stroke treatment at specialised hospitals, (2) a reduced length of hospital stay, and (3) a shift from inpatient rehabilitation programmes to community-based rehabilitation programmes. Patients would benefit from a more integrated care pathway between hospital and municipality, being supported by early discharge teams at hospitals.

A formal policy tool, consisting of a health care agreement between the region and municipalities, was used to implement the changes. The implementation was carried out in a top-down manner by a committee, in which the hospital sector – organised by regions – was better represented than the primary care sector—organised by municipalities. The idea of centralisation of acute care was supported by all stakeholders, but municipalities opposed the hospital-based early discharge teams as they perceived this to be interfering with their core tasks. Municipalities would have liked more influence on the design of the reform.

Preliminary data suggest good quality of acute care. Cost savings have been achieved in the region by means of closure of beds and a reduction of hospital length of stay. The realisation of the objective of achieving integrated rehabilitation care between hospitals and municipalities has been less successful. It is likely that greater involvement of municipalities in the design phase and better representation of health care professionals in all phases would have led to more successful implementation of the reform.

1. Introduction

The Danish health care system can be characterised as decentralised. Planning and regulation of the health care system are organised at three administrative levels: national, regional and local. The health authorities in the five regions are responsible for hospital planning. The 98 municipalities are responsible for disease prevention,

☆ Open Access for this article is made possible by a collaboration between Health Policy and The European Observatory on Health Systems and Policies.

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http://dx.doi.org/10.1016/j.healthpol.2015.05.007

health promotion and rehabilitation. The general practitioners are the point of entrance to the health care system and act as gatekeepers, referring patients to hospital and specialist treatment [1].

The regional level is financed through state block grants (80%) and through co-payment from the municipalities (20%). The municipal co-payment was installed as an economic incentive for municipalities to invest in prevention and health promotion, in order to prevent hospital admission [2].

At the national policy level in Denmark, there is an ongoing process of specialisation and centralisation of care in Danish hospitals; resulting in the establishment of five super hospitals by 2020. Specialisation and centralisation of hospital services, early discharge, and moving care to the community is a global trend [3], and seen by many countries as a solution to make health care systems financially sustainable. This trend also requires effective coordination of care across sectors [4].

In May 2012, Central Denmark Region executed a stroke care reform that included specialisation and centralisation of acute stroke care, and moving inpatient rehabilitation care for patients with mild to moderate stroke symptoms to the municipality. The main rationale for the reform was to cut costs.

Before the reform, stroke care consisted of acute care and inpatient rehabilitation at five regional hospitals; two of these hospitals did not have a neurology department and referral was mainly defined geographically. The quality of acute stroke care varied across the region, as some patients received care at a specialised stroke unit and others did not [5]. In 2007, an expert group of neurologists stated that patients with the same need for specialised neurorehabilitation did not receive the same quality of health care services at different hospital departments in the region [6].

The Region's need to cut costs created a window of opportunity to reform stroke care in the region, with an emphasis on centralisation of acute stroke care and moving rehabilitation care to the community. This article describes the process of policy development and implementation of this mandated change. It is a change that in the end needs to result in coordination of care across sectors if the dual promise of saving costs and improving quality of care is to be fulfilled.

2. The stroke care reform

2.1. Purpose of the reform

The main purpose of the stroke care reform was to save money (€2.7 million; DKK 20 million) [7], but not by relying on short-term solutions. Cost reductions would be obtained by gradually closing 30% of the hospital beds for acute care and rehabilitation (Table 1). Acute care would be centralised at two specialised hospitals instead of five, and length of hospital stay would be reduced by moving rehabilitation care to the municipalities. Centralisation of acute care had the dual purpose of reducing costs and improving quality with lower mortality rates and improved health status at discharge [8]. Patients would also benefit from a more integrated care pathway between hospital and municipality. Early discharge teams at all five hospitals would support the transfer to and start of rehabilitation in the municipality [8]. Table 1 describes the changes brought on by the reform.

2.2. Political and economic background

In February 2011, the Regional Council in Central Denmark Region agreed upon a region-wide cost saving plan for health care. Savings were necessary, as health care consumption was higher than estimated due to the demographic and technological development, and the block grant provided by the national government was lower than expected [7]. The plan included saving two percent of the 2011 health care budget (€ 61 million; DKK 455 million).

Although the stroke care reform was decided at the regional level, part of the implementation of the reform concerning rehabilitation had to take place at the municipal level.

Transferring health services across sectors requires joint planning [9] and coordination [4]. Since 2007, there has been a statutory cooperation between municipalities and regions with regional health agreements ensuring coherence between treatment, prevention and care [10]. The agreements are made at the start of the regional and municipal election cycle every fourth years and cover six specific areas: Hospital admission and discharge processes, rehabilitation, medical devices and -aids, prevention and health promotion, mental health, and follow-up on adverse events [9].

Changes made during the 4-year period are described in separate agreements. These agreements describe the tasks transferred from the regional to the municipal level as well as the anticipated financial consequences of these changes.

3. Health policy processes

The stroke care reform broke radically with ideas of the past. The rationale of the reform of improving quality of care for stroke patients by concentrating acute care was supported by all stakeholders. There were no incentives or sanctions connected to the implementation of the reform. Table 2 provides an overview of the stakeholders and their involvement in the development of the reform.

Central Denmark Region (CDR) established a working group (February 2011) with representatives from the five hospitals in the region to discuss ways to save costs in the area of neurology. The Danish Society for Physiotherapists requested to be involved [12], but this request was declined. Front line health professionals and patient representatives have not been involved in any stage of the process. The explanation for not involving patient representatives was that the representatives of the hospitals meant that they knew 'what was best for patients' with respect to the main aim of this reform, centralising acute care. A reason for not involving other stakeholders than hospitals in the planning phase was the tight deadline for planning the policy (see Fig. 1).

The idea of centralising acute stroke care in specialised stroke centres stroke care was suggested by the university