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Against all odds? Understanding the emergence of accreditation of the Danish hospitals

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ABSTRACT

Despite intense critique from various parts of the medical professions, Danish hospitals have been subjected to a mandatory accreditation system known as the Danish Quality Model (Den Danske Kvalitetsmodel, DDKM) since 2009. The notion of government assemblage is employed to understand how and why, in the face of these obstacles, DDKM was ultimately implemented. It is argued that DDKM is the result of the emergence of hospital quality management assemblage in 1980s and 1990s made up by new methods of categorizing disease treatments, computerization of such treatments, concerns over cost-effectiveness, complaint registration, the availability of international hospital quality assessment systems, the mobilization of organized medical interest groups, and a tradition of consultative policymaking procedures. This assemblage was crucial for identifying quality as a problem in need of administrative intervention and for shaping the political struggle over how best to assure the quality of hospital services.

Introduction

Like other forms of procedural standardization of medical practice (Timmermans & Berg, 2003, p. 25), accreditation of healthcare services has spread rapidly over the last two decades. It first emerged in the USA in 1917 when the Hospital Standardization Program was established by the American College of Surgeons in order to improve the quality of healthcare at the hospitals (Rocberts, Coale, & Redman, 1987). Accreditation of hospitals first came to Europe in 1981 when it was introduced in the province of Catalonia in Spain (Roberts et al., 1987). During the 1990s accreditation started spreading to most though not all European countries (Fortes, de Mattos, & Baptista, 2011; Shaw, Kutryba, Braitwaite, Bedlicki, & Warunek, 2010; World Health Organization, 2003, pp. 107–113).

Since August 2009, all public Danish hospitals and clinics have been subjected to accreditation in shape of The Danish Quality Model (Den Danske Kvalitetsmodel, DDKM). Most private hospitals and clinics are included too as this is a precondition for receiving patients financed by public money. The idea of introducing accreditation in Danish hospitals has been met with widespread critique from various parts of the medical community including the nurses. As late as November 2011, around 1600 doctors and other medical staff signed an open letter to the Director of Health in the Capital Region criticizing excessive demands for documentation caused by poor IT-systems and in particular the two parallel accreditation systems operating in the Region (DDKM and the US Joint Commission model of accreditation). The criticism was endorsed by further 900 medical staff outside the Capital Region, even if they "only" had to deal with one accreditation system (DDKM).

At the most general level, the criticism of hospital accreditation launched by substantial, albeit far from all, parts of the medical profession revolves around two points. First, it has been argued that there is no scientific evidence that accreditation leads to better clinical results, at least if by evidence we understand randomized controlled trials (EVIDENS, 2011). Second, accreditation is criticized for wasting quite substantial resources on documentation and standardization which could have been better spent on medical staff and equipment. On the one hand, no systematic analyses of the costs of running accreditation have been conducted, neither in Denmark nor elsewhere (Greenfield & Braithwaite, 2008). On the other hand, certain non-validated estimates have circulated in the debate and served to fuel the critique against accreditation. Thus, during the height of the debate over accreditation in 1999, the head of research in the Danish Hospital Institute (DSI) claimed that the total running costs of operating accreditation at any particular hospital lie between one per mille and one per cent of total hospital costs, probably closer to one per cent (So ein ding müssen wir auch haben.1999). This was rapidly taken up in the debate by some doctors to estimate the costs of running accreditation in the

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hospitals of Copenhagen would amount to 80 million Kroner (in 1999 value) (Akkreditering møder massiv kritik fra læger, 1999).

These objections raised by what is usually regarded a quite powerful interest group, the medical profession(s), begs the question why hospital accreditation was introduced in Denmark. It may be argued that the case of implementation of healthcare accreditation in Denmark is a least likely case. If accreditation could emerge and be implemented in spite of fierce resistance – at least initially – from a strong interest group, the apparently substantial financial costs of the reform and a tradition of widespread political decentralization (also in the health area), then it could be implemented anywhere. At least, the fact that accreditation is not found in quite similar polities like Norway and Sweden makes the Danish case puzzling (Shaw, 2006, p. 267; Shaw et al., 2010, p. 343).

Accordingly, this paper seeks to shed light on the question: How can we understand the emergence and implementation of accreditation in the Danish hospital system? The paper essentially argues that the development of a Danish model of hospital accreditation may be understood as the emergence of hospital quality management assemblage in 1980s and 1990s made up by new methods of categorizing disease treatments, computerization of such treatments, concerns over cost-effectiveness, complaint registration, the availability of international hospital quality assessment systems, the mobilization of organized medical interest groups, and a tradition of consultative policymaking procedures.

The aim then is to understand how and why DDKM, in the face of the said obstacles, was ultimately implemented. In order to do so, the article first reviews some of the key political science and sociological explanations of the development of standards in the healthcare services. It is argued that Michel Foucault's notion of government assemblage seems a viable analytical framework. This is followed by a methods section explicating the data collected. By employing the notion of government assemblage, the ensuing results section traces the genesis of the accreditation of Danish hospitals by unravelling – in a chronological order - the emergence of and relations between seven distinct elements of this assemblage. It is concluded that the notion of government assemblage may prove useful in other instances of politics of healthcare quality management, though further methodological development is needed.

Literature review

The political science and especially the sociology of medicine literature offer a number of more or less distinct explanations of the proliferation of standards and quality management systems in healthcare services. The term standard is used here in a rather broad sense to include clinical and non-clinical guidelines and procedures used both by medical staff and non-medical staff in the delivery of healthcare services. After going through some of the most proliferate explanations, the particular utility of Michel Foucault's notion of government assemblage at least in the Danish case, but possibly also in other ones, is explained.

We may distinguish between at least four major explanations of the adoption of standards in medical practice (cf. Weisz et al., 2007). First, a common explanation is to see the development of healthcare service standards as the result of *politicians' and administrators' attempt to control growing public health expenditures* (Durand-Zaleski, Colin, & Blum-Boisgard, 1997). This is linked to the general trend of New Public Management reforms favouring cost-effectiveness, performance management and customer service orientation (Dent, 2006; Light, 2001). This public management reform trend is often read as a political movement of authority from a previously very strong medical profession to an increasingly influential layer of accountants, managers and politicians. Inspired by the systems theory of Niklas Luhmann, it has been argued that the DDKM produces a certain form of blindness to information that is potentially destructive to its survival (Knudsen, 2011). This production of blindness is thus the politico-administrative organisation's strategy against the medical profession and its reluctance to adopt accreditation. However, in the present case the argument that healthcare standards be seen as the politicians' and administrators' attempt to control costs suffers from the fact that one of the key arguments raised against accreditation is that it will increase rather than decrease costs.

A closely linked but almost reverse interpretation reads this emergence of standards as the *medical professions' attempt to protect their autonomy* from other hospital managers, politicians and other professions claiming influence on how medical services should be designed (Day, Klein, & Miller, 1998; Timmermans & Berg, 2003, p. 16). This argument takes its cue from the thesis of regulatory capture, i.e. the explanation of public regulation in terms of its capture by private interest groups with a view to accommodate the interests of the latter (for an overview: Mitnick, 2011). This argument has been presented convincingly in the Danish context (Jespersen, 2001; Kirkpatrick, Jespersen, Dent, & Neogy, 2009). While this approach may provide insights into the countries decision to voluntarily adopt accreditation, it does suffer from the conceptual problem that it is difficult to talk about the medical profession in terms of a consistent self or interest group. More importantly, while the assertion that the medical profession is driven by concerns over their autonomy seems plausible it is no predictor of the profession's position vis-à-vis standards. It could go either way depending on the content of the standards and on the nature of the political process leading to these standards. Thus, parts of the medical profession in Denmark changed their position during the political process of formulating the standards of the DDKM because they were included and a (limited) say in this process.

A third explanation is based not on actors, but on how *institutions* in the sense of rules, norms and cognitive frameworks impinge on spread and implementation of organizational standards and management reforms (DiMaggio & Powell, 1983; Meyer & Rowan, 1991). Mary Douglas has succinctly argued that institutions filter and order and filter knowledge in order both to simplify our space of possible actions and to naturalize and ultimately legitimize the decisions made within that space (Douglas, 1987). This conception has inspired the understanding of public health systems as complex social institutions that can be reduced neither to state regulations nor to the laws of (an imaginary) market for health services (Mackintosh, 2000). In particular, isomorphic pressures entail that local organisations are accumulating legitimacy by mimicking more or less global organisational standards. Concretely, it seems fair to assume that the WHO's health strategy 1984, which urged all members to adopt quality assurance mechanisms, contributed to shaping the quality agenda in the Danish health sector (Jespersen, 2001, p. 34). Also, the longstanding experiences with healthcare accreditation in the US, Canada and Australia (Scrivens, 1995, pp. 14–27) may very well have contributed to convincing Danish health authorities (the Ministry of Health and the County Councils responsible for the hospitals) that this may be the way to go about quality assurance. The Capital's Hospital Association decision to introduce the US Joint Commission model and the Southern Jutland County's decision to introduce the British Health Quality Service modes testifies to concrete influence. However, quality assurance systems in hospitals were debated at least since the late 1980s and were followed by the development of several quality systems that had little if anything to do with accreditation. Moreover, the isomorphic pressure thesis would predict more or less wholesale copying