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Hospital centralization and performance in Denmark—Ten years on☆

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ABSTRACT

Denmark implemented a major reform of the administrative and political structure in 2007 when the previous 13 counties were merged into five new regions and the number of municipalities was reduced from 271 to 98. A main objective was to create administrative units that were large enough to support a hospital structure with few acute hospitals in each region and to centralize specialized care in fewer hospitals. This paper analyses the reorganization of the somatic hospital sector in Denmark since 2007, discusses the mechanisms behind the changes and analyses hospital performance after the reform. The reform focused on improving acute services and quality of care. The number of acute hospitals was reduced from about 40–21 hospitals with new joint acute facilities, which include emergency care wards. The restructuring and geographical placement of acute hospitals took place in a democratic process subject to central guidelines and requirements. Since the reform, hospital productivity has increased by more than 2 per cent per year and costs have been stable. Overall, indicators point to a successful reform. However, it has also been criticized that some people in remote areas feel “left behind” in the economic development and that hospital staff are under increased workload pressure. Concurrent with the centralization of hospitals municipalities strengthened their health service with an emphasis on prevention and health promotion.

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1. Background and aim

Denmark implemented a major reform of the administrative and political structure in 2007 [1,2,3,32,41]. At that time, the country had three administrative levels – the state, county and municipal – each with the authority to levy taxes. The background for the reform was that the administrative structure was seen as being composed of too many small units at both the municipal and county levels to be able to provide services of a satisfactory quality. In particular, it was a cause for concern that hospitals with a small volume of surgical patients were not able to provide surgery of a high quality due to limited surgeon experience [35]. Moreover, having larger municipal units would allow for a decentralization of tasks from the state or the regions. Bigger units were seen as a condition for better prioritization and coordination of activities in the public sector. Some stakeholders found that three administrative levels with the authority to levy taxes in a small country of just 5.6 million inhabitants were too many, and cost savings could be achieved by reducing the number of levels to two [1,2,32].

In brief, the aim of the reform related to health care was threefold: 1) to create larger administrative units at the second level (former county level), which would allow the creation of larger hospital units and were expected to increase the quality of treatments. Likewise, an increase in size would allow municipalities to take responsibility for more tasks related to health; 2) to increase efficiency through administrative rationalization; and 3) to strengthen the governance of health care, including governmental regulation of the health care sector. More specific aims for the health care sector were formulated by the National Board of Health (NBoH), including the central planning of specialties (hospital service planning), improved acute services with joint acute facilities, increased local prevention and health promotion as well as a nationwide electronic patient record system [2]. The principle of easy and equal access for everyone was maintained as a fundamental value.

The reform merged the previous 13 counties (and three municipalities with county functions) into five new regions rather than abolishing the second administrative level, and it reduced the number of municipalities from 271 to 98. The reform also changed the responsibility and financing of health care, and the authority of the national level to regulate the health care sector through the NBoH was strengthened [15] (Box 1).

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Box 1: Hospitals.
The hospital sector in Denmark is predominantly public. Following a structural reform in 2007, each of the five regional governments owns and operates the public hospitals within its region besides contracting with general practitioners and other health providers outside hospitals. One hospital in each region serves as a university hospital. Having ownership allows the regions to operate their hospitals in a coordinated fashion with respect to specialization and geographical placement as well as relations to providers outside hospitals, such as general practitioners. A substantial share of hospital care is delivered as outpatient care within the hospitals. Hospitals are financed through a mix of global budgets and case-based payments based upon a DRG system (grouping of patients into diagnosis related groups).

While the policy process behind the Structural Reform has been analysed elsewhere [32,1,2], there are important outstanding questions about the implementation and outcomes of the reform. The aims of this paper are to analyse the reorganization of the somatic hospital sector in Denmark since 2007, to present evidence about the performance of hospitals after the reform and to discuss the mechanisms behind the changes. This is highly relevant, as many European countries are considering centralization reforms as a way to improve the efficiency of hospital services.

It is well known that top-down reforms may be stifled or have unexpected consequences at the decentral levels. Institutional theory points to path dependency, incrementalism and "status quo bias" [4]. This is based on risk aversion, uncertainty [4] and the pervasiveness of norms and routines tied to the existing structures [5]. Vested interests and formalized interest group representation can further bias the political economy against radical changes [6]. Furthermore, general ambitions can be stifled in the implementation phase if the choice of instruments is inappropriate, or the there is a lack of will or ability to follow through on central decisions [7,8].

In our case, we investigate whether the potential barriers against hospital reorganizations have indeed affected the outcome of the reform. We argue that the end result depends on how the reform and the following processes affected the political economy for regional decision-makers and whether reorganizations are backed by sufficient political pressure and convincing narratives [6].

2. Methods

Our investigation is based on descriptive statistics, publicly available documents and the scattered evaluations of reform aspects that have been published so far. While there have been concurrent health policy changes over the past decade, the Structural Reform provided the institutional infrastructure for such subsequent changes. It is therefore reasonable to argue that mergers and reorganizations and, more indirectly, the performance of Danish hospitals can be related to the Structural Reform and the institutional governance conditions created by the reform.

An independent, comprehensive evaluation of the Structural Reform has never been conducted due to the complexity of the reform (covering all parts of the welfare state) and the many simultaneous changes. The government concluded in a report in 2013 [42] that the reform was generally a success. However, further efforts were needed with regard to financing models to support integrated care (revision of the municipal co-financing), health agreements and follow-up with general practitioners, integrated IT systems, prevention (municipalities), rehabilitation (municipalities) and psychiatry.

The rest of the paper is structured as follows: First we look at instruments and processes of the reform, stakeholders, evidence for reform decisions and the role of the municipalities after the reform. We then present detailed information about developments after the reform with regards to: hospital investments, reorganization of acute care, financing and hospital payment schemes, digitalization and quality control. Finallywe present evidence about the performance of the Danish hospitals after the reform. We discuss the political and institutional conditions that facilitated the reorganization of hospitals in Denmark before we present the overall conclusion.

3. Results

3.1. Instruments and processes

With the administrative structure in place an important task at the regional level was to redesign hospital structure and functions. The reform increased the power of the NBoH and centralized the economic power to the national level. This meant that the pursuit of the general aims of the reform became strongly influenced by national authorities. While the NBoH issued general guidelines with respect to specialty planning, an important task for the democratically elected politicians in each regional board was to initiate local specialty planning to comply with national guidelines. The specialty planning by the NBoH included a definition of which specialties should be present at the regional level, and which should be available at a smaller number of hospitals to serve patients across regions. In this process it was decided which specialties should be present in regions at which hospitals, which hospital were to have changed functions and which should be closed. Compliance with the guidelines was a prerequisite to receive funding for the renewal of hospitals, and this gave the regions an incentive to comply. The process took place over several years and involved negotiations between each region and the NBoH before a final plan was issued by the NBoH. The clinical community was involved in the process by participating in a dialogue with each region and also at the national level by guiding the NBoH with respect to what was feasible for a country like Denmark [35: 123]. Although it was a difficult process to change the hospital infrastructure, the OECD notes that "there was a remarkable level of consensus and goodwill surrounding these efforts in Denmark" and suggests that this may reflect the fact that the "regions found themselves uniquely responsible for health and more financially dependent on the centre" [35: 120–121].

3.2. Stakeholders

The hospital reform was part of a larger administrative reform that influenced all parts of the public sector. Main stakeholders in the process of re-organizing hospitals were politicians and policy makers, public authorities like the NBoH, Danish Regions (the national association of regions), Local Government Denmark (the national association of municipalities), health care professionals, hospital managers, patient associations and the population at large. The role of some of the stakeholders changed in connection with the reform: The NBOH got a stronger role in shaping the hospital landscape, while the power of the regions was reduced as they were left without authority to levy taxes and with less room for prioritizing compared to the situation of the former counties which could prioritize between health care and other public services.

3.3. Evidence and information

The evidence in the international literature about the size of specialized hospitals was mixed [35]. However, some guidance could be found by using registers of routinely collected hospital data on volume and quality, and such data, besides assessments by clinical experts, were used by the NBoH to formulate guidelines. Changing

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