

Background Briefing

Health Care Lessons from Denmark (2002)

Danish healthcare is both tax funded and almost entirely publicly provided. One factor which clearly distinguishes the Danish system from our own, is its basis on the regional and municipal levels of government. Does the location of control over healthcare at close proximity to users and voters change the nature of the relationship between tax payers, politicians and healthcare providers for the better? Also noteworthy, are the unusually high levels of reported satisfaction with the system among Danes. Regarded with some envy by many decision makers outside Denmark, what gives rise to such contentment?

OVERVIEW OF DANISH HEALTH CARE

The 'cornerstones' of the Danish healthcare system are: it is a public healthcare system predominantly financed through general taxes; healthcare is organised in such a way that responsibility for services provided lies within the lowest possible administrative level, usually the county councils (subsidiarity); there should be universal, free and equal access for all 5.4 Million citizens; it should promote efficiency, be of high quality, and enable free choice of provider by users.

Since 1970, most decisions regarding the form and content of health care activity have been made at county and municipal level. The ministry of health has a coordinating and supervisory role, but no operational responsibilities for health services. Working in close cooperation with the government and municipalities, the 14 counties are responsible for hospitals and primary care. Counties have wide powers to organise the health services for their citizens, according to regional wishes and possibilities and can adjust services and staff, etc., according to needs at the different levels. County council elections held every four years usually focus on local issues. There are important channels for co-ordination and negotiation between the state and the counties and municipalities and between the counties and the municipalities. In recent years, the political focus on controlling health care costs has encouraged a greater degree of formal co-operation¹.

FINANCIAL RESOURCES

Public Funding. In 1999 total expenditure on health care in Denmark accounted for 8.4 per cent of GDP. Public expenditure on health care accounted for 6.9 per cent of GDP. The vast majority of health care is financed from local (county and municipal) taxes - some 81 per cent of all public healthcare expenditure. Local taxes are levied proportionately on personal income and property. The average county and municipal tax rate for 2002 is 32.6 per cent² the highest local tax rate in the OECD. Local taxes are supplemented by state subsidies (from income tax and various indirect levies) that are calculated annually according to the size of local tax revenues. In addition, resources are transferred between counties and municipalities on the basis of a formula that takes into account age distribution and a number of socio-economic indicators. In 1999 health care accounted for about 75 per cent of county expenditure.

Private Funding. Private expenditure as a proportion of total expenditure on health care has risen from 12.2 per cent in 1980 to 17.8 per cent in 1999. **Co-payments** apply to dental care for adults (patients pay for 70 per cent of expenses), and pharmaceuticals prescribed in primary care subject to an annual ceiling. Pharmaceutical co-payments have risen recently, primarily as a cost-control measure. Even though there are some exemptions for those on low incomes, the fact that co-payments are important in Denmark, seems to contradict the explicit founding principle that care should be based on need not ability to pay. **Supplementary** (that is substitutive) and **complementary voluntary health insurance** (VHI) both play a role in Denmark. Nearly a third of Danes purchase complementary insurance to cover spectacles, dentistry and pharmaceutical co-payments. Around 150,000 people – less than 5 per cent of the population, have supplementary VHI to jump waiting lists. This insurance has developed rapidly in the past four years, largely due to the perceived

shortcomings of the statutory health care system, and the existence of tax incentives for employer-purchased insurance.

Financial Resource Allocation To Third Party Payers. In Denmark, the third party payers are the counties and local authorities. The most significant resource allocation mechanism is the national budget negotiation that takes place once a year between the Ministry of the Interior and Health, the Ministry of Finance, the Association of County Councils, and the National Association of Local Authorities. Counties and municipalities must provide health care within the targets for health care expenditure agreed at this annual negotiation. The central government has increasingly used the negotiation as a means of influencing the direction of the healthcare system. It does this by highlighting priority areas such as cardiac surgery, cancer treatment or waiting times, and making available earmarked grants to assist counties and municipalities in achieving targets. The practice of earmarking funds reduces local autonomy to set priorities – to the frustration of the counties. Nevertheless, the counties have relative freedom to decide how best to allocate their resources, provided any resulting variation in expenditure between different counties is ‘reasonable’.³

Financial Resource Allocation To providers. Since 1980 hospital services have been subject to very tight budgetary control. Primary health care and pharmaceutical expenditure have been more difficult to control owing to the clinical freedom of GPs. GPs are encouraged to serve their patients by mix of quarterly capitation and fees-per-service. Studies have shown that the mixed remuneration system has an impact on the professional duty of clinicians to act in the best interest of patients and does encourage ‘best practice’. Payments have encouraged the substitution of primary care for secondary care and therefore result in a more efficient allocation of resources. Ambulatory care is split between Group 1 and 2 – akin to French Sector 1 and 2, in that because GPs do not receive a capitation payment for patients in Group 2, they may charge patients an additional ‘reasonable’ charge above official fee schedules, while GPs treating Group 1 patients must accept HCRS payments as payment in full. In the hospital sector, recent reforms have seen the introduction of Diagnosis Related Groups (DRGs), to be the basis for activity-based financing. Rates are set nationally. The amount, content and costs of hospital activity including capital budgets are determined by the counties through the use of detailed global budgets, enabling them to specify which treatments should be offered and which technical procedures should be purchased. Hospital doctors are salaried; they do not operate under strong financial incentives. Rather, professionalism and pride induce them to treat patients well.

PROVISION OF CARE

Primary care. Self employed GPs, of which there are roughly 3,700 (23 per cent of doctors), technically private practices, operate wholly within the public healthcare system, acting as gatekeepers to specialists and hospitals. Patients must register with a GP of their choice practising within 10 km of their home. They have the right to change their GP every 6 months, but in practice Danes rarely change doctor. Each GP has about 1,600 patients. The number of practising GPs in each county is subject to collective agreements negotiated between the counties and the GP section of the Danish Medical Association. The result is an even distribution across the population.

Hospital care. Since 1993, Danes have been able to ‘choose among all public hospitals which offer appropriate treatment, together with a number of small specialist hospitals owned by associations which have agreements with the public authority’.⁴ Counties are obliged to provide free hospital treatment for residents and emergency treatment for all in need; this accounts for 73 per cent (1999) of their public health expenditure⁵. The number of hospitals has fallen from 117 in 1980 to 71 in 2000. This amounts to 3.7 beds per 1,000 population (2000). The OECD reports that Denmark had 3.3 acute beds per 1,000 population in 1998, while the UK had 2.4. The number of beds in private clinics is very small. Specialists may only engage in private practice outside public hospitals, with costs paid by insurers or patients. The result is that private work is undertaken in a doctor’s spare time.

MEDICAL OUTCOMES

In an international perspective, health status in Denmark can generally be characterised as good. However, over the last 20 years it has declined and is no longer among the top few in Europe.⁶ Danish life expectancy increases have fallen behind other EU countries. Denmark demonstrates high premature (middle-aged) mortality owing to too much smoking, too high fat intake, too little exercise and too high alcohol consumption.⁷ Middle aged women fare particularly poorly in comparison to other EU countries, especially in the incidence of breast and lung cancer.

REFORMS, PATH DEPENDENCY

With the exception of the odd tinkering incremental reform, the system has essentially remained unchanged since 1970. Despite the recent general election, at which health was again a major issue, there were no major differences of opinion on the structure of Danish health services. The current government's expression of intent to increase private sector activity is generally regarded as rhetorical (Jensen and Ginnerup 2002). 'A lid has been kept on that sort of thing'. The prevailing attitude appears to be 'don't experiment with new solutions (the private sector), in case the experiment works'.⁸

So why this inertia? The short answer is that there are no major driving forces for reform, as the system is widely thought to be performing fairly well. Described as a "governance system of negotiated order"⁹, there is political consensus regarding future public provision of healthcare and as such there is little political scope, nor media or public demand for major reform. Moreover, the counties have been extremely reluctant to cede any of their considerable powers. The result is path dependency typical of all bureaucracies and highlighted in many publicly funded systems, which also rely on public provision. Nevertheless, there are signs of more radical change. The new liberal/conservative government has a more ideological focus, and is more 'top down' controlling and centralising than any before, for example, bypassing the association of 14 counties in political decision making processes. There is also a stronger focus on waiting lists. The counties and many experts in Denmark and in the international scene argue that through centralisation, Denmark is in danger of ruining a system that works pretty well.

PATIENT SATISFACTION

The 1998 Euro Barometer survey prepared by the European Commission in collaboration with the London School of Economics and Political Science, showed that 90 per cent of Danes were satisfied with their health care services, more (by a large margin) than residents in any other EU member state. Many caution however, that such comparative satisfaction surveys should be taken with a pinch of salt.

On a national level, satisfaction figures over the past decade are interesting. The Danish Ministry of Finance publishes current analyses of citizens' views of the public sector, including satisfaction with health care. On a scale of 1-5, satisfaction of hospital users in 1993 was 4.3, but fell sharply to 3.4 in 2000. Meanwhile, satisfaction of hospital non-users fell from 4.1 to 3.3. By contrast, at 4.2 in 2000, the contentment of GP users has remained pretty stable over the last ten years.¹⁰

Why does satisfaction with GPs remain so high? Though Thomson asks whether the free choice of providers for Group 2 patients is influential, she rules out the existence of Group 2 as a major factor, as only 1.7 per cent of Danes opt for that Group 2.¹¹ Others suggest that the mere existence of Group 2 as an option, whether or not people choose to join that Group (98.3 per cent do not), empowers all individuals. However, the reality of that choice is income based. Analysis of those who opt for Group 2 reveals the wealthy, older, and largely those resident in Copenhagen.

If Group 2 is not the reason for high satisfaction, perhaps it is linked to free choice of hospitals?

Following the 'free choice reform' of 1992, hospitals in theory compete with others across county lines. It was hoped that choice would increase productivity and quality of hospital care, as well as

reduce hospital waiting lists. But nearly a decade later Danes are not actively choosing alternative hospitals. Why not? Four reasons are often cited.¹² First, there was not enough additional funding - patients must pay transport costs to hospitals in other counties. Second, there was not enough information for GPs or patients regarding quality, waiting times, or patient satisfaction, though after initial difficulties in collecting data, a Ministry of health website shows the wait to see specialist following referral, and the wait between seeing the specialist any receiving inpatient treatment. Third, there were not enough incentives for hospitals; more recently, however, the funding system has been changed in such a way that money really can follow the patient from one county to a hospital department in another county. Fourth, proximity to hospital is a priority for many patients – for ease of access and proximity to family and friends. **Perhaps knowledge of the right to exercise choice is more important than actually doing so.**

Satisfaction and Waiting Time. Although the length of waiting lists and waiting times is not a clinically serious problem (91% of all patients are treated within 1-2 months), frequent media interest often in light of outlying individual cases, has forced politicians to adopt a series of waiting time guarantees. During the 1990s the Danish Government's efforts to introduce a three-month maximum wait failed, and it resorted to extra funding specific targets to reduce waiting times for CHD treatments such as heart by-pass surgery and angioplasty. In June 2001, it announced similar funding for cancer. In theory, patients can go private if public hospital cannot provide care within a given period. However, DRG payment is to be the same, and as a result, so far, no private providers have signed contracts – all complaining that payments would not cover costs.

Despite the introduction of waiting list targets, the percentage of the population waiting has not fallen. Likely reasons for this are well established. One such being that in a system with a strong gatekeeping function, GPs refer patients when they know treatment will follow shortly after. That is to say, the greater the likelihood of treatment, the greater the propensity of GPs to refer for treatment.

Satisfaction and two-tier care. Unlike the United Kingdom, two tier health care is not a major issue in Denmark. About 99 per cent of hospital beds are in the public sector and access to a high standard of inpatient care is relatively equitable because wealthy and powerful people use the same public hospitals as the poorest people. Private alternatives do not offer much advantage in terms of improved amenities, as most wards in public hospitals only contain two beds, and opting for private health care to jump waiting lists is not regarded as acceptable behaviour by many Danish people.¹³

Satisfaction and provider incentives. The proportion of public financing in Denmark is not unusual in an international perspective; however, the almost complete reliance on public provision is. The financing and running of services is fully integrated, a fact which has benefits and dis-benefits. Budgetary restrictions and fixed physician salaries give budget security, but do not give staff any incentives towards efficiency, and incentives for patient-oriented care in hospital were relatively weak – thus there was a reliance on professional ethics. Alongside this reliance on professional ethics, patients' rights are legally enshrined in Denmark. A number of laws have been passed regulating patients' rights, the possibility of making complaints and receiving damages. The Patients' Board of Complaints, an independent public authority complaints system, has been established to guarantee professional treatment in the health service.¹⁴ In addition, the Danish healthcare system now encourages doctors to serve patients by giving patients free choice of doctor, by paying GPs through combined capitation and fees for service. Hospitals have seen the introduction of payment and incentive systems, alongside waiting time guarantees and information systems for patients.

Satisfaction and local tax funding of health care. *Tax is tax is tax, isn't it?* Vrangbaek argues that although Danes know what they pay, they do not pay much attention to the administrative level at which tax is levied.¹⁵ But does the unusually large element of local taxation make a difference? Yes. There is greater transparency as the link between amount levied and spending is greater and as such local tax is similar to hypothecation. There can be improved accountability as spending decisions of local politicians are closer to the electorate. Responsiveness to local preferences is improved, so that

local needs can guide health spending. Finally, local taxation separates health care from competing national priorities.¹⁶

However, there are potential disadvantages. A system based on local taxation may generate local political inertia. Decentralisation also causes some concerns about efficient resource allocation and priority setting.¹⁷ The possibility of horizontal inequity is not borne out in reality, as there is a broadly similar service level and organisation between counties (effectively negotiated by a cartel). Unlike those seen in Sweden, (Stockholm), there are no major differences in between counties. The government has tried to iron out uneven care by introducing waiting times and choice of hospitals.

LESSONS FOR THE UK

It is clear that Danish health care is founded upon a strong political and public commitment to a system based on equal access for equal need and health care provided free at the point of use. The following should be noted by policy makers in the United Kingdom:

- Decentralisation of most health care responsibilities to county level plays a key role in the Danish health care system. The counties are marked by a strong sense of their own autonomy, which means that central initiatives are often resisted at the local level. The resulting tensions foster a consensus approach that has long been a positive feature of politics in Denmark.
- Current centralising tendencies are in danger of ruining a system that works fairly well.
- Contributions in Denmark are more visible than those in the UK, but perhaps not as visible as those made under social or private health insurance systems.
- Danes have a limited control over how much of their own money is spent on health care. The national government, counties and municipalities receive the tax taken from individuals. Influence is primarily exerted through the ballot box. Such control encourages the third party payer to serve patient interests, to a degree that may be contrasted with that in Britain where the Treasury takes the taxes and treats the money as its own.
- The strength of local involvement in funding and providing health care in Denmark may also lead to (generally acceptable) geographical inequalities in access to health care
- Choice may not be a priority for patients. Access to care is likely to be most important.
- Choice of hospital is unlikely to increase responsiveness without good information, additional funds, and incentives for hospitals¹⁸

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