

The Danish Health Care System

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Who is covered?

Coverage is universal and compulsory. All those registered as resident in Denmark are entitled to health care that is largely free at the point of use.

What is covered?

Services: The publicly-financed health system covers all primary and specialist (hospital) services based on medical assessment of need.

Cost-sharing: There are relatively few cost-sharing arrangements for publicly-covered services. Cost-sharing applies to dental care for those aged 18 and over (co-insurance of 35% to 60% of the cost of treatment), outpatient drugs and corrective lenses. An individual's annual outpatient drug expenditure is reimbursed at the following levels: below DKK 465 (\$90) – no reimbursement (50% reimbursement for children); DKK 465-1125 (\$90-217) – 50% reimbursement; DKK 1125-2645 (\$217-511) – 75% reimbursement; above DKK 2645 (\$511) – 85% reimbursement (MISSOC 2007). In 2005, out-of-pocket payments, including cost-sharing, accounted for about 14% of total health expenditure (World Health Organization 2007).

Safety nets: Chronically ill patients with a permanently high use of drugs can apply for full reimbursement of drug expenditure above an annual ceiling of DKK 3410 (\$658). People with very low income and those who are dying can also apply for financial assistance, and the reimbursement rate may be increased for some very expensive drugs. Complementary private health insurance provided by a not-for-profit organization reimburses cost-sharing for pharmaceuticals, dental care, physiotherapy and corrective lenses. In 1999 it covered about 30% of the population. Coverage is relatively evenly distributed across social classes.

How is the health system financed?

Publicly-financed health care: A major administrative reform in 2007 gave the central government responsibility for financing health care. Health care is now mainly financed through a centrally-collected tax set at 8% of taxable income and earmarked for health. The new proportionate earmarked tax replaces a mixture of progressive central income taxes and proportionate regional income and property taxes. The central government allocates this revenue to five regions (80%) and 98 municipalities (20%) using a risk-adjusted capitation formula and some activity-based payment. Public expenditure accounted for around 82% of total health expenditure in 2005 (World Health Organization 2007).

Private health insurance: Around 30% of the population purchase complementary private health insurance covering statutory cost sharing from the not-for-profit organization 'Danmark.' Supplemental private health insurance provided by for-profit companies offers access to care in private hospitals in Denmark and abroad. It covers around 5% of the population and is mainly purchased by employers as a fringe benefit for employees. In 2005, private health insurance accounted for 1.6% of total health expenditure (World Health Organization 2007).

How is the delivery system organized?

Government: The five regions are responsible for providing hospital care and own and run hospitals and prenatal care centers. The regions also finance general practitioners, specialists, physiotherapists, dentists and pharmaceuticals. The 98 municipalities are responsible for nursing homes, home nurses, health visitors, municipal dentists (children's dentists and home dental services for physically and/or mentally disabled people), school health services, home help and the treatment of alcoholics and drug addicts. Professionals involved in delivering these services are paid a salary.

Physicians: Self-employed general practitioners act as gatekeepers to secondary care and are paid via a combination of capitation (30%) and fee-for-service. Hospital physicians are employed by the regions and paid a salary. Non-hospital based specialists are paid on a fee-for-service basis.

Hospitals: Almost all hospitals are publicly owned (99% of hospital beds are public). They are paid partly via fixed budgets determined through soft contracts with the regions and partly on a fee for service basis.

What is being done to ensure quality of care?

A comprehensive standards-based program for assessing quality is currently being implemented. The program is systemic in scope, aiming to incorporate all health care delivery organizations and including both organizational and clinical standards. Organizations are assessed on their ability to improve standards in processes and outcomes. The core of the assessment program is a system of regular accreditation based on annual self-assessment and external evaluation (every third year) by a professional accreditation body. The self-assessment involves reporting of performance against national input, process and outcome standards, which allows comparison over time and between organizations. The external evaluation begins with the self assessment and goes on to assess status for quality development. Some quality data is already being published on the Internet (www.sundhedskvalitet.dk) to facilitate patient choice of hospital and encourage hospitals to raise standards.

What is being done to improve efficiency?

In the last few years, many national and regional initiatives have aimed to improve efficiency, with a particular focus on hospitals. For example, Denmark has been at the forefront of efforts to reduce average lengths of stay and to shift care from inpatient to outpatient settings. The administrative reforms of 2007 aimed to enhance the coordination of service delivery and to benefit from economies of scale by centralizing

some functions and enabling the closure of small hospitals. The reforms lowered the number of regions from 14 to five, and the number of municipalities from 275 to 98. The introduction of a Danish DRG (diagnosis-related groups) system in the late 1990s has facilitated various partially-activity-based payment schemes (for example, for patients crossing county borders) and benchmarking exercises. The national Ministry of Health also publishes regular hospital productivity rankings.

How are costs controlled?

Annual negotiations between the central government and the regions and municipalities result in agreement on the economic framework for the health sector, including levels of taxation and expenditure. The negotiations contribute to control of public spending on health by instituting a national budget cap for the health sector. They also form the basis for resource allocation from the central government. At the regional and municipal level, various management tools are used to control expenditure, in particular contracts and agreements between hospitals and the regions, and ongoing monitoring of expenditure development. Policies to control pharmaceutical expenditure include generic substitution by doctors and/or pharmacists, prescribing guidelines and systematic assessment of prescribing behavior. Health technology assessment (HTA) is now an integral part of the health system, with assessments carried out at central, regional and local levels.

References

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