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Specialist care in Denmark

- How is specialist care organized in Denmark?
- Who pays for it and what are the payment systems?
- How is quality assured in this delivery structure?

Specialist care in Denmark

- Hospital based in-patient care
- Hospital based outpatient care
- Privately practicing specialists

Specialist care in hospitals

- Population 5,6 million
- 54 public hospitals (some on multiple locations)
- 107.078 full time employed at the hospitals. 14% medical doctors (14,999)
- 33% nurses
- 10% other care personnel (nurse assistants etc)
- 13% other health staff (physiotherapy etc)
- 30% other (technical, administrative, cleaning etc)

Specialist care in hospitals

Hospitals in Denmark are publicly owned and run by the five Danish regions.

Hospital staff, including medical specialists, are employed on a salary basis and paid according to nationally negotiated salaries with limited scope for regional variation.

Average salary for junior doctors is around 1 million DKK (134.000 EUR) and 1,2 million DKK for managing specialists

Specialist care in hospitals

Most medical specialists work exclusively in the hospitals.

Part time work in private practice is discouraged, but not illegal.

A study from 2010 showed that 8,3% of hospital employed doctors had a second job in the private sector. 5.1% in a private hospital and 3% in private practice (Socha 2010).

How is quality controlled in hospitals

- Until 2015: The Danish Quality Assessment Model:

  Accreditation based model with standards and assessments at hospital and department level using a combination of organizational, patient related and clinical standards.

  Surveys by external accreditation experts

How is quality controlled in hospitals

- Clinical guidelines
- Clinical databases
- Patient satisfaction surveys
- General statistics based on national registries

How is quality controlled in hospitals

The government and regions announced an agreement in 2014 to abandon the DQAM and develop a scheme with fewer indicators emphasizing core (clinical) quality outcomes. Less emphasis on organizational and process dimension.

How is quality controlled in hospitals

Partly based on pressure from medical personnel and hospital departments complaining about the time consumption and the lack of clear documentation for clinical benefits

The official argument is that DQAM had served it purpose of raising standards and creating awareness.
– Now more targeted and outcome performance indicators are needed

How is quality controlled in hospitals

The regions are now experimenting with "value based payment" (pay for performance) schemes, emphasizing quality and "bundled patient pathways"

These schemes have not yet been evaluated

Specialist care private clinics

3510 general practioners and 901 practicing specialists operate under the general agreement with the Danish Regions.

A ”license” (ydernummer) is required to obtain funding from the public insurance scheme

The regions determine the number of “licenses” in their “practice plan” issued every four years.

Number of specialist practices within specialty areas

X-Ray	10	1%
Plastic surgery	12	1%
child psychiatry	16	2%
Anesthesiology	19	2%
Neurology	25	3%
Orthopedic surgery	25	3%
Pediatrics	28	3%
internal medicine	35	4%
Reumathology	36	4%
Surgery	44	5%
Gynecology	72	8%
Dermatology and venereology	103	12%
Psychiatry	125	14%
Otology	160	18%
Ophthalmology	162	19%
	872	100%

Number of patients in specialist practice 2009.

Speciale	2009
19 - Øjenlægehjælp	584.917
21 - Ørelægehjælp	527.666
04 - Dermato-venerologi	369.813
07 - gynækologi/obstetrik	174.896
09 - kirurgi	97.966
03 - Diagnostisk radiologi, kbh.	92.834
22 - patologi	70.657
20 - Ortopædisk kirurgi	67.751
06 - Reumatologi (Fysiurgi)	63.763
24 - psykiatri	56.562
18 - neuromedicin	51.328
01 - Anæstesiologi	49.594
08 - Intern medicin	47.907
25 - pædiatri	32.819
23 - plastikkirurgi	19.888
05 - Diagnostisk radiologi	14.886
26 - Børnepsykiatri	3.760
Samlet	**2.327.007**

note: Antal patienter dækker over det samlede antal borgere, opgjort på cpR-nummer, der har været i kontakt med speciallægepraksis inden for det pågæl- dende speciale i hhv. 2007, 2008 og 2009. kilde: cSc, Scandihealth.

Geographical bias

Tabel 1. Antal speciallægepraksis opgjort som fuldtidsenheder fordelt på regioner.

Copenhagen

	Region nordjylland	Region Midtjylland	Region Syddanmark	Region Sjælland	Region Hovedstaden
Samlet antal praktise- rende speciallæger, opgjort som "fuldtids- enhed"	**66,9**	**154,3**	**158,7**	**121,9**	**422,5**
Antal "fuldtidsenhe- der" pr. 100.000 ind- byggere	**11,55**	**12,30**	**13,22**	**14,85**	**25,14**

Clinics/1000 inhabitants

note: Opgørelsen er pr. 26-10-2010.
Det anvendte indbyggertal er antal sikrede pr. region, dvs. det antal borgere, som har ret til tilskud til speciallægehjælp. kilde: Speciallægefortegnelsen [illegible]anmarks Statistik

Payment scheme

Regions provide treatment free of charge to persons in the public health insurance group 1 (99% of the population) *upon referral* from a general practioner. – (Acces to ear, nose and throat specialist does not require referral).

Persons in public health insurance group 2 have direct access, but may be charged an out of pocket payment for price exceeding the tariff for group 1

Payment scheme

Practicing specialists can also treat patients that pay fully out of pocket or through private insurance.

The magnitude of this is not known, but the private specialists have entered a voluntary code of conduct, which implies that they must deliver a reasonable selection and volume of services within the agreement with the regions (to avoid cream-skimming and to maintain capacity).

Payment of practicing specialists

Practicing specialists are paid on a fee for service basis according to the national agreements.

However, they are subject to limitations in total earnings, and will only receive 40% payment for activities beyond a given threshold (knækgrænse). – Part time practices do not receive any payment for activities beyond the threshold.

Payment of practicing specialists

The regions monitor the volume and composition of services delivered by each practicing specialist clinic.

Deviations from the average may be lead to a ”friendly chat” and potential limitations on payments for selected services

Governance of practicing specialists

The national agreements state that the regions may enter specific agreements with practicing specialists to provide extra payments e.g. for prevention, coordination, and educational activities

Governance of practicing specialists

National agreements also contain rules about:

- Electronic communication with the rest of the health care system
- Advisory functions in regards to general practitioners
- Right to refer to regional diagnostic facilities and laboratories
- Discharge letters and communication to general practice
- Referrals from GPs to practicing specialists

Examples of collaboration forms where hospital treatments are moved into private specialist practice

- Special agreements on increased activity to reduce waiting times (particularly minor surgery ad diagnostics). – Typically for a limited time.

- Shared care agreements to ensure coherent patient flows across sectors.- E.g. on diagnostics within gynecology. – This practice reduces the number of visits to outpatient hospital departments.

Examples of collaboration forms where hospital treatments are moved into private specialist practice

- Package pathways for heart diseases
- Moving less specialized tasks from hospitals to practicing specialists
- Direct referral from hospitals to practicing specialists

Organizational structures to strengthen the integration of practicing specialists with the rest of the HC system

- Regional specialist council: Advisory function within each specialty
- Tripartite councils/groups: Formal coordination groups with hospitals, specialist practice and general practice
- Participation in medical specialty meetings at hospitals
- Exchanges between hospital and practice personnel

Quality assurance practicing specialists

Agreement between regions and association of praciting specialists to introduce DQAM. – An accreditation based quality development scheme basedon ISQua methods.

Curently developing and implementating a tailored version of DQAM (1. round 2015-2018). – Based on previous projects

Assesment by external surveyors.

Accreditation standards

- Mangement and operational processes
- Patient safety
- Accidents and near-accidents
- Sedation of patients
- Patient records
- Patient identification
- Paraclinical examination: http://www.ikas.dk/Sundhedsfaglig/Praktiserende-speciallæger/Akkrediteringsstandarder-1.-version/08-Parakliniske-undersøgelser-.aspx
- Basic heart/lung resuscitation
- Visitation and referral
- Hygiene
- Equipment for diagnosis and treatment
- Personal information and protection
- Handling of utensils and pharmceuticals
- Hiring and training
- Patient experience of quality

Quality management continued

Clinical guidelines

Reporting to national databases via ”Datafangst”

- (7.500 DKK as a one time incentive for joining the system. – This requires conformity of IT systems to national standards)
- Reporting is mandatory when indicators and clinical databases have been developed

Patient satisfaction surveys

-> The regions are <u>not</u> allowed to publish data on individual clinics. - But they have access to data and may invite to a ”dialogue” in case of deviations.

Quality management continued

The National Board of health is the overall regulatory body and is responsible for surveillance, licensing and intervention in case of malpractice or misconduct