Executive summary

Denmark is rightly seen as a pioneer in health care quality initiatives among OECD countries. Over many years, it has developed a sophisticated array of quality assurance mechanisms. Yet, like all other countries, it faces a number of ***health care challenges*** including increasing public and political expectations around the continuity of care; increased specialisation in the hospital sector, which translates into shorter stays and earlier discharge back into the community; and a rise in the number of elderly patients with multiple long-term conditions, requiring safe and effective co-ordination of care and avoiding unnecessary hospitalisation. This quality review assesses how well Denmark's quality assurance mechanisms are placed to address these challenges.

Denmark has impressive ***quality monitoring and improvement initiatives***. It has extensive databases on the processes and outcomes of care and a strong agenda to strengthen its information infrastructure; it can also boast many local clinical guidelines, national guidelines and standards developed as part of disease management programmes and pathways. Perhaps as a consequence, though, the challenge remains to create more linkages and synergy between these diverse initiatives, with the aim of improving quality of care for the health care system as a whole. At the same time, more could be done to develop clinical guidelines and indicators which fully address the realities of patients with multi-morbid conditions, improve the measurement of patient experiences and develop better quality metrics for primary and long-term care

Primary care is a particular area of concern. While Danish GPs have fulfilled the primary care function well over many years, the challenges outline above demand a different, stronger and modernised primary care sector, which has not yet emerged. Health system reforms in recent years have focused on efforts to improve quality and efficiency in the hospital sector – relegating modernisation of the primary care sector to a cautious and incremental path. There are few mechanisms to reward quality and continuity of the care that GPs provide, whether through financial or other instruments. Going forward, specific quality initiatives in primary care should focus on co-ordination between primary and secondary care and

creating incentives for primary care professionals to take a high level of responsibility for quality and outcomes across the whole patient pathway. Success will depend upon radically developing the data infrastructure underpinning primary care. At present, the lack of data on primary care activity, compared to other health care sectors, makes it difficult to know how effectively GPs and other primary care professionals are meeting community health care needs.

A prominent feature of recent health policy in Denmark are the far-reaching reforms to its ***hospital sector***. Hospital beds have fallen from around 25 000 in 1996 to 18 000 by 2009, with Danish regions pro-actively managing the trend by closing small hospitals and concentrating specialised services into a handful of major hospitals across the country. The balance struck between national guidance and regional planning, and the extensive engagement of clinicians in the decision-making process, offer an impressive model for other countries to follow if seeking a similar rationalisation of their hospital sector. It is likely that improvements in quality will naturally flow from preventing highly specialised services to operate in relatively inexperienced centres. Accompanying technological and capital investments should also help lift quality. But these reforms require careful monitoring to ensure that they do not adversely affect certain patient groups or clinical training. In particular, Danish policy makers ought to continue with efforts to strengthen pre-hospital care (such as ambulances or physician-manned mobile emergency units); encourage hospitals to monitor internally the performance of individual clinicians; and support the exchange of best hospital practices throughout the country.

Health equity is a stated priority of Danish public life and indeed, compared to most OECD countries, health inequalities in Denmark are low. Yet, until recently, there have been few policies or interventions specific to the health sector to address inequity. Although gaps in data make it difficult to get a full picture across all areas, evidence suggests that there are socioeconomic disparities in health status, access to health care and health outcomes - some of which are growing. Policy makers should not therefore take for granted that a well-established principle of equal access and a high share of public spending on health will automatically safeguard equity. A better data infrastructure would leave Danish authorities better equipped to assure health equity. Unique patient identifiers across health and social care and civil administration databases, provide an incredibly rich source of information for Denmark and should be marshalled so as to better monitor health care equity across population groups. Better data gathered from GPs that captures care quality and outcomes across socioeconomic groups could be used to inform interventions addressing inequities. Other issues would be to review co-payments and cost-sharing policies to steer health behaviours

towards the desired direction in target groups, such as encouraging compliance with prescribed medical treatment, as well as monitor travel times faced by patients.

Over many years, whether at national or institutional level or led by individual pioneers, Denmark has demonstrated a commitment to monitoring and continuously improving the quality of its health system. Its initiatives and reforms serve as a model to other countries looking to prioritise health care quality. The next phase of Denmark's quality agenda must be one of consolidation – ***creating coherence across these many initiatives***, with a special focus on measuring and maximising the contribution made by primary care. Whilst restructuring of the hospital sector is likely to yield a natural quality dividend, and health inequity is less of a problem in Denmark than elsewhere, neither of these facts should be taken for granted and a relentless quality focus should be maintained for both.