From Professional to Regulatory driven Quality Improvement in Danish Healthcare

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The Situation in Danish Health Care

An increase in Governmental driven regulation of quality

The professional autonomy - and the space for decisionmaking by leaders at the decentralized level - are under pressure.

From:
- **voluntary option to an obligation**
- **soft to harder regulation**

From development to control of quality ?

NU SKAL VI LIGE HA NOGLE BITTESMÅ KRYDSER I DET HER SKEMA

"Now we just need to fill in some tiny "x"s in this form"

"

Does it strengength or take away the focus from the patient ?

The Understanding of Regulation of Quality in Health care

"A sustained and focused control exercised by a public agency over activities with the aim of improving quality, from the perspective of the society"

Modified after P. Selznick , 1985

Quality in Danish Health Care: - a joint responsibility

Reform 2007: fewer actors within a more centralized structure

The State:
Ministry and Board of Health
- Legislation, and regulation of quality
- Define the financial limit

5 Regions
- Responsible for planning and practice at hospitals/ practice sector

98 Municipalities
- Responsible for quality in relation to rehabilitation, prevention, etc.

< 3% Private providers

Quality in Danish Health Care

Strong focus on quality and patient safety
Many joint and nationwide initiatives

But:
- Increasing geographical fragmentation
- Lack of continuity: Safety problems
- Significant knowing – doing gap, and lack of quality data
- Not taking "soft-values" seriously
- No systematic involvement of patients or families

Patients loosing confidence in the health care system

Quality Improvement since 1993

Voluntary	→	Mandatory
Professional responsibility	→	Leadership
Local standards	→	National standards
Beliefs	→	Datadriven
Private data	→	Public data

From self determined to external driven

Govermental Regulation - examples

Nationwide Patient Experience survey (2001----)

Contact person at departmental level (2002---)

The Danish Accreditation Model (2002)

The Patient Safety Act (2004,).

Publication of identity of responsible health professionals in relation to serious failures (2006)

Star rating System for Hospitals (2005)

Legislation: Mandatory to work with quality (2007)

Managed Care programs for Chronic conditions (2007)

Managed Cancer pathways (2007)

Ex : Contact person
- From soft to harder regulation

2001: Patients hospitalized more than 24 hours

2003: Expanded to patients in ambulatory setting

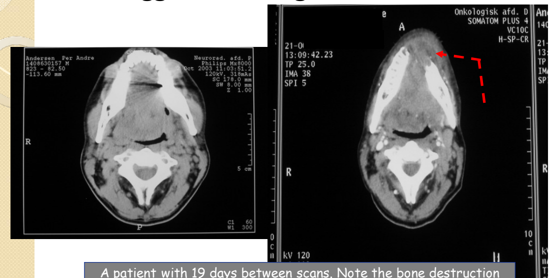
2006: Monitoring. Results to the Ministry of Health

2008: Legislation – *a patient right*

2010: Part of the Danish Accreditation scheme

What comes next ?

Ex.: A Trigger for Change in Cancer



A patient with 19 days between scans. Note the bone destruction

"We have valid data that clearly show, that even short waiting times entail a risc of significant reduction of the possibility of curation … cancer is an acute disease – and must be treated as such.
"

Prof. J.Overgaard , 6th of March 2007

Building a Consensus Towards Improvement

12th of October 2007 an agreement between the Danish Goverment and the Regions entails:

1. ***Managed Cancerpatient pathways.***

National development and local implementation of 34 clinical cancer pathways by the end of 2008.

2. ***Ongoing monitoring***

3. ***Contact person for each patient***

From 2010 part of the Danish Accreditation scheme

Danish Accreditation Model

- The result of the financial agrement for 2002
- A unik model
- A very long birth. First hospital survey in 2010

- Is mandatory
- Covers all institutions delivering public financed care
- Institute of Quality and Safety : the regulatory body.

- Aiming improvement, equity and accountabily

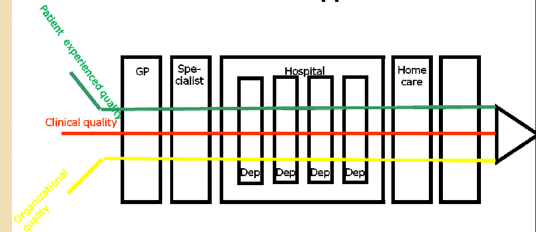
Weakness or strength ?
- The CEO of the National Board of Health chair the board together with the hospitalowners
- Publication of accreditation reports

Conclusion (1)
Regulation in Danish Health care - so far.

- Mainly building on tools developed by health care professionals
- Often the result of a financial agreement between Goverment and hospital owners
- Aiming towards transparancy, equity and a higher level of quality – especially continuum of care
- Mainly a compliant approach – no sanctions

Conclusion (2)
Regulation forces health care to approach high quality and the continuum of care.

But does it happen?



Reflexions

Regulation is traditionally a "one fits all model".

Is this the right way, if we want to achieve **engagement** in organizations with different challenges?

How do we ensure the impact is being evaluated as a basis for **keeping the focus on the patients need?**

Thank you for your attention