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by Lars Engberg

There are some substantial differences between the Danish health care system and the health care system in the United States. Most importantly, Danish health care is free. As a Dane you do not pay when you visit a doctor or a hospital, knowing, of course, that as a taxpayer (and taxes are high in Denmark), a fairly large proportion of your taxes goes to keeping visits to hospitals and doctors free of charge. But some services in the health care system do cost you out-of-pocket when you use them. In Europe, in general, the co-payment rate, besides what you pay in taxes or insurance, is 15-20 percent. In Denmark it is 17-18 percent, but this co-payment is concentrated in the services of dentists, pharmaceutics, psychologists, and physical therapists.

Another important characteristic of the Danish health care system is that access to specialized health care is almost always by referral from a General Practitioner (GP). If you want to go to a specialist or hospital you have to go to your GP first. As a result, the GPs in Denmark are responsible for over 70 percent of all services in the health care system. Of course there are exceptions to this general rule. In an emergency you can call an ambulance without referral by the GP first. But in general, the Danish GPs function as gatekeepers to the health care system.

A remarkable difference between the Danish and American health care systems is that in Denmark 98 percent of health services are public, either directly run by public hospitals or funded through public tax revenues. The private sector in the Danish health care system hardly exists and is concentrated in orthopedic surgery. There are very few private hospitals in Denmark and even fewer practicing doctors without agreement with the public sector.

The responsibility for Danish public health care is shared between regions, municipalities, and the GPs. There are five regions in Denmark, each headed by a regional council of 41 elected politicians. The regions run all public hospitals and are in charge of reimbursing the GPs for their services. The municipalities, of which there are 98 across the

country, are responsible for physical and social rehabilitation after the hospital treatment, and for preventive initiatives. The GPs play their essential role as gatekeepers, but in fact they provide full treatment for the majority of patients.

The Danish health care system is inexpensive and efficient. According to the Organisation for Economic Co-operation and Development (OECD), an international organization for the industrialized world studying economic and development issues, Denmark uses 11.1 percent of its gross national product (GNP) on the health care system. The corresponding figure for the United States is 17.7 percent, with almost all Western European countries lying between these two figures. OECD has also looked into the efficiency of health care systems: what the health care system "produces" for the money it costs. Here, Denmark turns out to be one of the most efficient among OECD countries, in number of treatments, operations, consultations, etc. But is the quality also high? No doubt you can find hospitals in Europe and abroad that perform very well and even better than any Danish hospital. But the three university hospitals in Denmark all perform at international standards, while the quality of the services of Denmark's GPs is equivalent to or even better than in most other countries.

A final characteristic of the Danish health care system is the fact that medicine consumption in Denmark is relatively low. This may be due to the fact that medicine in Denmark is fairly expensive for the patient because of the high co-payment, as mentioned above. In general, pharmaceutics are not easily accessible, as most require a prescription from a doctor.

Success Stories of the Danish Health Care System

Besides the fact that the Danish health care system is inexpensive and efficient, as mentioned above, there are some other success stories that are the result of a deliberate policy across changing governments.

Compared with many other countries, the Danish health care system offers greater equality of access. This is so even though the present government has made it an issue in its health policy to fight for more equality--geographically, socially etc. It remains a fact that the advantages of the free health services at hospitals and from doctors are the same for everybody in Danish society.

One of the accomplishments in recent years is what is called "guarantee of treatment." In practice it means that a patient has the right to be treated within one month, for some diseases within two months (an acute patient is of course treated immediately). If the public hospital that treats you (and public hospitals treat almost 100 percent of patients) cannot meet this obligation, you have the right as a patient to seek treatment at another public hospital (as a patient you always have that right regardless of the treatment guarantee) or at a private hospital, and in that case, the public hospital that cannot fulfill the guarantee pays the bill. This patient right of treatment guarantee consequently results, of course, in making public hospitals more efficient and conscious of the quality of the treatment they offer. No public hospital wants to pay a private hospital for services it could offer itself.

The guarantee of treatment has resulted in much shorter waiting lists for operations and other non-emergency treatments. But what use is it to you as a patient to be guaranteed treatment within a relatively short period, if making a diagnosis of the need for treatment lasts for months or maybe even half a year or longer? Accordingly, the parliament recently passed a law giving patients a right to a diagnosis within one month, unless of course the disease is such that the doctor has to observe the patient for longer than one month. This "guarantee of diagnosis" is currently being implemented. Seen from the point of view of the patient, however, the guarantee of diagnosis is weaker than the guarantee of treatment, because as a patient seeking diagnosis, you cannot move to a private hospital if the public hospital is not able to observe the guarantee of diagnosis.

The structure of public hospitals in Denmark is changing radically. Denmark used to have around 80 hospitals spread all over the country. Now there are about 50, and within 10-20 years there will be only 20-22 hospitals. This is partly a result of an administrative reform from 2006, by which the 16 counties in Denmark, including Copenhagen and Frederiksberg, were made into five regions. But it is also the result of planning from the Ministry of Health that seeks to centralize hospitals. The idea is that fewer and bigger hospitals mean better professional surroundings and higher professional quality. Fewer and bigger hospitals mean new buildings for those hospitals that are among the surviving 20-22. For the time being there is a lot of construction work going on at Danish hospitals. The three university

hospitals are doubling in size and in three other cities the existing buildings are being replaced by new and bigger buildings elsewhere in the same city.

As mentioned above, the quality of the health services in Denmark is generally high, even though you certainly can find university hospitals in the United States, France, or the United Kingdom with higher quality in particular areas than what you will find at Danish hospitals in those same areas. But all hospitals, all doctors want to do even better and improve quality. An innovation designed to facilitate this goal are the so-called "packages." These are guidelines for the best practice within a certain diagnosis, and guidelines for the optimal or maximal waiting time between the different stages of treatment. For the time being, packages have been completed for the most common types of cancer, heart disease, diabetes, and a few others.

Challenges to the Danish Health Care System

Life expectancy in Denmark is short, relatively speaking. In fact, if you live in our neighboring country, Sweden, you can expect to live two years longer, an astonishing fact, given that the two countries are so much alike. In an OECD context, the life expectancy of Danes is on a level with Chile and Slovenia. What is even more worrisome is the fact that the rise in life expectancy in Denmark over the last 25 years is among the lowest in Europe. Is that due to the lifestyle of the Danes? Or is the quality of the treatment from hospitals and doctors much worse in Denmark than in Sweden and most other European countries? Certainly the Danish life style is a factor, although we do not smoke as much as in Southern Europe and we do not hold the European record in alcohol consumption. And the quality of health care in Denmark? As mentioned above, the average level of quality in the health care system is quite good, but the short life expectancy in Denmark is a matter of great political concern.

Even though the Danish health care system, seen from the outside, may seem to treat the population in a very equal way, inequality in health care remains a political issue. It is true that there are areas in the country where it is impossible to get doctors to settle and open a general practice, especially in the western and northern parts of Jutland. Bearing in mind the very central role of the GP as a gatekeeper to the hospitals and specialized doctors, it is nearly a disaster for a

family not to be able to attend a local GP. It is this type of geographical inequality that preoccupies health care policy makers and politicians.

As mentioned above, responsibility for the Danish health care system is shared between the regions, the municipalities, and the GPs. Chronically ill patients—and there are increasing numbers of chronically ill patients, due to demographic shifts—will almost always have the experience that treatment for their chronic illness is divided between the hospital, the community, and the GP. This division of labor between the three may seem very clear on paper, but in practice there are many examples where important information is lost when a patient is discharged from the hospital and further treatment lies in the hands of a GP and/or the community. That often leads to incorrect treatment, wrong medication, delay of treatment etc.

This lack of coherence in the treatment of patients and the lack of coordination between the three responsible parties is maybe the most important challenge for the Danish health care system for the time being. It reinforces a more general tendency for specialized doctors to concentrate on their specialty and fail to see the chronically ill patient as a whole human being with a life besides the disease, with a job to attend to, and with a family. This tendency is accentuated by the structural reforms mentioned above, with fewer and bigger hospitals, divided into more and more specialized hospital departments.

There is also a lack of coherence in the treatment patients receive within the walls of the hospitals. Every doctor, every department does what they are good at and only that, often leaving the patient as the only one with a general view of the disease and the treatment. Many patients can overcome this coordinating function and even play a role in their own treatment, but of course, many cannot. Too often the lack of coherence in treatment leads to an overlap in treatment and wasted money.

The solution to this serious problem is a change of culture at hospitals and among doctors plus a more efficient technology that diminishes the risk of misinformation and wrong treatment when a patient is transferred between the three parties responsible for the health care system. These problems are not unique for Denmark, but rather common in western countries. Kaiser Permanente, which runs most of the health care in California, for example, has shown that you can create a health care system that works as a unit, with the patient in the center.

Research shows that if doctors involve their patients more in their own treatment, results will be better and patient satisfaction with their treatment tends to be higher. With increasing access to the Internet, it is only natural that patients, especially the younger ones, meet the doctors with some knowledge and hundreds of questions about their symptoms. Doctors have to respond to patients' desire to become part of the treatment. Countries like the United Kingdom, Australia, New Zealand, and Norway have come much further with patient involvement than we have in Denmark.

One last but huge challenge: psychiatric treatment has been neglected for many years. Much of the effort and resources in Danish health policy has been spent on making waiting lists shorter and improving the treatment of cancer, heart, and lung diseases in some measure at the expense of psychiatric patients. This has become a political issue recently, so there is hope for an improvement and more money to psychiatric treatment.

Final Words

The United States and Denmark have very different ways of organizing their health care systems. The American system is almost totally based on private insurance, which gives citizens/patients greater choice of treatment and doctors, but also comes with the risk of greater inequality. Obamacare, as the Affordable Care Act is commonly known, was designed to reduce these inequalities. The Danish system is almost totally based on tax money and public responsibility. This leaves the citizens with less free choice than in the United States and in France, for example, but inequality is also less. Most European countries find themselves in between the American and Danish ways of organizing the health care system, where they practice in a combination of public and private hospitals, and with a mixture of public and insurance financing all with some measure of co-payment.