The Danish Health Care Quality Programme

Country: Denmark
Partner Institute: University of Southern Denmark, Odense
Survey no: (14) 2009
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Health Policy Issues: Quality Improvement

Current Process Stages

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<th>Idea</th>
<th>Pilot</th>
<th>Policy Paper</th>
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<th>Implementation</th>
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<th>Change</th>
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1. Abstract

The Danish Health Care Quality Programme aims at persistent promotion of good quality in health care across the entire health care sector. It provides standards for good quality and methods for monitoring and accreditation. The Danish Institute of Quality and Accreditation is in charge of promoting and supporting the process.

2. Purpose of health policy or idea

The Danish Health Care Quality Programme (DDKM) is a method to generate persistent quality development across the entire health care sector in Denmark. It provides standards for good quality and methods to monitor this quality. The standards are developed in a cooperation between the Danish Institute for Quality and Accreditation in Health Care (IKAS), established in 2005, and representatives of professions from various sectors involved in health care.

The objectives of the Danish Health Care Quality Programme are (www.ikas.dk):

- to promote the quality of patient pathways
- to promote the development of clinical, organizational and patient experienced quality
- to make the quality of health care visible
- to create a culture where institutions and employees constantly learn from themselves and each other and thus create a continuous quality development.

The programme builds on a model for systematic quality development which can be illustrated by a quality circle including four steps (www.ikas.dk):

1. "Plan" - the institutions must have written guidelines which describe how a given quality target can be reached.
2. "Do" - the institution must ensure the implementation of the guidelines.
3. "Study" - the institution must monitor the quality of the institution's structure, processes and services provided.
4. "Act" - the institution must assess the results of monitoring, prioritizing and implementing actions to remedy quality failures.
IKAS and the Danish Health Care Quality Programme deliver a web-based IT-system, known as TAK, containing all standards that support and facilitate the process from the time of receipt of standards to final accreditation. TAK is developed in collaboration with the users (www.ikas.dk).

The Danish Health Care Quality Programme combines existing register data with interviews and observations. Existing register data include national quality data bases such as The Danish Patient Safety Data Base, the National Indicator Project Data Base, and national patient satisfaction surveys.

During the development of the first version of the Danish Healthcare Quality Programme, IKAS received support from the international accreditation organisation CHKS Healthcare Accreditation & Quality Unit. The Danish Healthcare Quality Programme was certified in 2008 by the International Society for Quality in healthcare (ISQua).

It is planned that during the coming years the hospitals and the rest of the health care sector will introduce norms of good standards and will be evaluated against these standards. Accreditation presupposes that a minimum level of good quality is achieved within a number of areas. Each hospital and organization introduce their own standards and perform self-evaluation. The accreditation process includes an external survey by a team of medical professionals who will evaluate compliance to the standards. These standards will be revised every 3 years.

An accreditation model for acute hospitals was released in August 2009. A model for pharmacies and for municipalities has also been released.

The Danish Model for hospitals includes three main themes with 37 areas and a total of 106 accreditation standards. The three themes cover organizational standards, general patient standards, and illness-specific standards. As an example, general patient standards include “Hygiene” as an area with 5 standards. The second standard is “Hygiene policy” and requires:

1. **standard**: that the institution has a hygiene policy to prevent infections
2. **goal**: to prevent infections of patients, visitors, personnel and suppliers
3. **responsible**: all leaders and the hygiene group
4. **area**: the whole institution
5. **fulfillment**: use of indicators for evaluation of standards as described for each of 4 steps in the quality circle

- **step 1 (guiding documents)**: that there exists a hygiene policy with a content further specified
- **step 2 (implementation and use of the guiding documents)**: that the leaders and employees live up to the hygiene policy
- **step 3 (quality surveillance)**: No indicators are developed in the first version
- **step 4 (quality improvement)**: No indicators are developed in the first version

6. **references**: References to relevant literature

It is expected that the programme will result in

- fewer adverse events (in medication, surgery, communication, etc.)
- a uniform and high level of quality across sectors involved in health care
- an improved coherence in patient pathways
- a systematic use of new knowledge in all treatments
- more transparent quality in health care for citizens.
Main objectives
The Danish Quality in Health Care Programme is created to generate a persistent quality improvement across the entire health care sector in Denmark. It provides standards of good quality and methods to monitor the quality, including an accreditation process. The Danish Institute for Quality and Accreditation in Health Care was established to support the programme.

Type of incentives
No direct economic incentives are involved in the programme, but transparency of quality across suppliers of health care makes comparisons easier, and this may function as an incentive for suppliers to improve quality.

Groups affected
Patients, Suppliers of health care across all sectors

3. Characteristics of this policy

<table>
<thead>
<tr>
<th>Degree of Innovation</th>
<th>traditional</th>
<th>innovative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree of Controversy</td>
<td>consensual</td>
<td>highly controversial</td>
</tr>
<tr>
<td>Structural or Systemic Impact</td>
<td>marginal</td>
<td>fundamental</td>
</tr>
<tr>
<td>Public Visibility</td>
<td>very low</td>
<td>very high</td>
</tr>
<tr>
<td>Transferability</td>
<td>strongly system-dependent</td>
<td>system-neutral</td>
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4. Political and economic background

The programme was created on the background of an increasing awareness of the existence of adverse incidents in health care among health care professionals and in the general public.

5. Purpose and process analysis

| Idea | Pilot | Policy Paper | Legislation | Implementation | Evaluation | Change |

Origins of health policy idea
The idea of a Danish Health Care Quality Programme originated in 2002 on the background of, among other, previous articles in the media suggesting that 5000 patients die yearly in Danish hospitals due to poor quality or adverse events. The number of 5000 was not documented by Danish observations, though, but calculated on the background of observations reported in the international literature. A pilot study from 2001 documented an extent of adverse events in acute Danish hospitals comparable to findings reported from the US, Australia and the UK (Schiøler
The Danish Board of Health implemented a system of reporting of adverse events in hospitals in 2004. Meanwhile, some hospitals had already started an accreditation process using foreign systems (Hundborg 2009). A model description for a comprehensive quality model was published by the Board of Health in 2004 (Sundhedsstyrelsen 2004).

An Institute for Quality and Accreditation in Health Care (IKAS) was established in 2005 by the Board of Health, the Ministry of Health and Danish Counties (now Danish Regions). The purpose of this institute was to develop a quality programme in cooperation with key actors (the Board of Health, the Ministry of Health, Danish Regions) and later to be responsible for running a continuous quality assurance in the whole health care sector. The institute has a board composed of representatives from The Ministry of Health, the Board of Health, and Danish Regions. The Association of Danish Municipalities and Danish Pharmacies are associated the board. An accreditation committee to be appointed during the fall of 2009 decides whether national standards have been met.

**Initiators of idea/main actors**

- Government: It is required in the Health Law (2008) that Regions and Municipalities should secure high quality of health care
- Providers: In general, associations of health professionals welcomed the initiative, although minor changes were suggested
- Patients, Consumers: Patient Association

**Approach of idea**

The approach of the idea is described as: renewed: The requirement by law that adverse incidents should be reported to the National Board of Health, and various audit projects can be seen as forerunners to ensure high quality.

**Innovation or pilot project**

Else - The programme will be implemented in steps, and hospitals will be asked to participate in an accreditation process during the coming years.

**Stakeholder positions**

A policy paper "The Danish Quality of Health Care Programme" (Den Danske Kvalitetsmodel for Sundhedsvæsenet) was published by the National Board of health in 2004. The content was developed by the board of health in cooperation with Danish regions and Danish municipalities in close connection with health professionals.

**Actors and positions**

Description of actors and their positions

**Government**

- National Board of health: very supportive
- Danish regions: very supportive
- Danish municipalities: very supportive

**Providers**

- Associations of Health Professionals: very supportive

**Patients, Consumers**

- Patient Association: very supportive

**Influences in policy making and legislation**
No legislative process was involved except for a general requirement in the Health Law (2008) that regions and municipalities should secure high quality in health care.

Legislative outcome

success

Actors and influence

Description of actors and their influence

**Government**

- National Board of health: very strong
- Danish regions: very strong
- Danish municipalities: very strong

**Providers**

- Associations of Health Professionals: very strong

**Patients, Consumers**

- Patient Association: very strong

Positions and Influences at a glance

Adoption and implementation

Stakeholders include Danish regions and municipalities who are responsible for running secondary and primary health care. The process will be moderated by the Danish Institute for Quality and Accreditation in Health Care. The programme has been developed more or less in consensus among stakeholders, although some scepticism has been voiced by health care professionals in particular due to the administrative burden associated with registrations. The
programme will be implemented gradually.

Monitoring and evaluation
Standards for good quality will be revised every 3rd year. Quality assurance and accreditation is seen as a continuous process.

No systematic evaluation of the whole programme is foreseen.

6. Expected outcome

The programme can be expected to increase quality and institutional culture as to learning for adverse incidences. This has to be weighted against increased costs due to programme implementation.

<table>
<thead>
<tr>
<th>Quality of Health Care Services</th>
<th>marginal</th>
<th>fundamental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Equity</td>
<td>system less equitable</td>
<td>system more equitable</td>
</tr>
<tr>
<td>Cost Efficiency</td>
<td>very low</td>
<td>very high</td>
</tr>
</tbody>
</table>

The implementation of the policy will require extra resources for running the monitoring of health care at the local level.

7. References

Sources of Information

- Danish Institute for Quality and Accreditation (IKAS). www.ikas.dk

Author/s and/or contributors to this survey

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