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The "Health Benefit Basket" in Denmark

A description of entitlements, actors, and decision-making processes in the curative health sector

The Danish health care system offers a vast amount of benefits and entitlements to persons living in Denmark. The benefits are more or less specified health services provided at hospitals or in primary and tertiary health care institutions. Entitlements are rights to receive these services free of charge or against a fee covering a part of the costs. The benefits and entitlements altogether form the so-called "health benefit basket" or "basic package of health services" [1]. Although the notion of a benefit basket is not commonly used in Denmark, health benefits are indeed described in the legislation. The following pages provide an overview of the laws regulating health benefits and a description of the regulatory mechanism for the provision of curative care in hospitals and in primary care offices. Curative care services are financed and planned by the 14 counties and the municipal authorities of Copenhagen and Frederiksberg, and there are considerable differences between in- and outpatient services in the way in which benefits are regulated and services are provided and reimbursed.

Table 1 provides an overview of the four most important laws regulating benefits in the Danish health sector:

- The Hospital Act establishes the regulatory framework for all types of inpatient care and day care, patient transport, maternity care, ambulatory and rehabilitative care provided at hospitals (Bekendtgørelse af lov om sygehusvaesenet, LBK 766, 28 March 2003). The law delegates the responsibility for the planning, providing, and financing of hospital services to the county council. A number of executive orders and directives further specify this law.
- The Public Health Insurance Act (PHIA) and its supplementary legislation provides the regulatory frame for entitlements to outpatient care and to some extent to rehabilitative care, ancillary services for outpatients, maternity and child care, and reimbursement of pharmaceuticals (Lov om offentlig sygesikring, LOV 509, 1 July 1998; og DSK 9926, 20 January 1999; og LOV 467 og 469, 31 May 2000; og LOV 495, 7 June 2001; og LOV 1031, 23 November 2000; og LOV 1045, 23 December 1998; og LOV 1118, 29 December 1999; og LOV 1207, 27 December 2003; og LOV 1431, 22 December 2004). Benefits and services are further specified in a number of executive orders as well as in the used fee schedule.
- The Medicines Act regulates the population's access to pharmaceuticals and specifies the process of approval of medicines by the Danish Medicines Agency, marketing authorizations, etc. (Bekendtgørelse af lov om laegemidler, LBK 656, 28 July 1995).
- The Consolidated Social Services Act provides the regulatory frame for social services (Bekendtgørelse af lov om social service, LBK 708, 29 June 1998). The law delegates the planning, financing and provision responsibility to the counties for the specialized care and to municipalities for the less specialized care. This law covers the long-term inpatient, outpatient and home care. It also describes the provision responsibility for rehabilitative care not following a hospital treatment and also regulates the entitlement to therapeutic devices, nonacute patient transport, and other services.

Danish legislation on health care furthermore contains a number of specific laws dealing with preventive services, for example, for children (Forebyggende sundhedsordninger for børn og unge, LOV 438, 14 June 1995), with explicit and specific definitions of benefits. The main decision makers in the Danish health sector at political and administrative levels are the local governing bodies responsible for the service, hence the elected politicians for the county and the municipal councils. At clinical level especially the general practitioner plays a very important gate-keeper role, but hospital physicians are also important in defining medical needs. Most benefits are explicitly but vaguely defined by the law, leaving it to decision makers to speci-

fy which services to offer to patients. The Hospital Act states that "the county shall provide hospital treatment free of charge for its citizens" (Sect. 5). The degree of explicitness is described as "all necessary" (1) by all laws; some laws further describe areas of care (2) and some are linked to items (3). The PHIA and the Social Services Act are to some extent more explicit, by linking benefits to items.

This contribution is confined to curative health services, and the description of benefits in curative health services in Denmark is divided into three sections. First, the main actors along with their roles and responsibilities are outlined and differences between in- and outpatient services are emphasized. Second, benefits in the hospital sector are described and third, an outline of benefits under the Health Care Reimbursement Scheme (HCRS) for outpatient services is provided. Benefits are described with regard to the legislation and other regulatory mechanisms defining them, how they are classified, and how the fee schedule under the HCRS, a benefit "catalogue," is structured.

Main actors in defining benefits: their roles and responsibilities

The Danish Parliament (Folketing) legislates on health care. The Minister for the Interior and Health is responsible for further specifying the law, setting rules in certain areas and initiating reforms and bills. Unless it is explicitly mentioned that the Minister is empowered to specify the law, it can only be changed by the Folketing. Regarding outpatient care the Minister must approve all negotiated agreements between the Health Care Reimbursement Negotiation Committee (HCRNC) and the health personnel trade unions.

The National Board of Health (NBH) is a subdivision of the Ministry of the Interior and Health. The NBH is responsible for supervising and providing advice to "health care persons" (the Danish word *sundhedspersoner* used in the legislation refers to all types of health care professionals) and health administrative authorities, for elaborating and issuing guidelines and reference programs as well as for monitoring and documenting health services. Guidelines from the NBH define the current best practice within specific health care programs or interpret the law. The "health care persons" are for their part obliged to show clinical diligence and act according to "best practice."

According to the Hospital Act, the counties and the Copenhagen Hospital Corporation are responsible for the planning and financing of hospital services (Sect. 1) and for providing free hospital treatment for their citizens (Sect. 5). The providers of hospital services may be county-owned hospitals, private hospitals, or foreign hospitals (Sect. 3). Regarding outpatient care the county reimburses the services provided by private specialists and general practitioners (GPs). County representatives in a subcommittee under the HCRNC decide on the actual supply of services, for example, who is allowed to establish a private practice in which county.

A county health plan coordinating health services in the county is to be elaborated every 4 years (Hospital Act, Sect. 11; PHIA Sect. 27e). The plan includes a description of the county's population health status (premise of the plan), the physical capacity of the county hospitals, including how and where specialties are represented, and the number of beds and employees etc. in each specialty. Furthermore, preventive services, outpatient services, and cooperation between GPs, specialists, dentists, and the hospital sector, cooperation with municipalities, ambulance services, and local emergency services are coordinated and described in the plan. The NBH supervises and comments on the plan. However, the counties are not, in any legal sense, obliged to follow the advice provided by the NBH.

Hospital and clinical department managers have considerable freedom within the legal, clinical, and economic framework set by their superiors at national and county level. The heads of department may therefore establish treatment protocols and indications for treatment for different patient categories as well as set up guidelines for prioritizing between patients on waiting lists.

In general the Danish legislation is rather vague with regard to the specification of services and very often leaving decisions about benefits to medical judgement. Thus physicians play a certain role in the definition of benefits. Especially, the GP is important, as she/he is responsible for referring patients from general practice to practically all parts of the health sector.

Definition of benefits

Hospital care

Benefits provided in the Danish hospital sector are defined at four levels of decision making: at national level by means of legislation, at county level by planning and supply control, and at hospital and clinical level by local guidelines and clinical decision making. According to the Hospital Act, citizens have the right to free hospital treatment (Sect. 5) at any hospital in the country (Sect. 5b) which they choose. If the waiting time for treatment exceeds 2 months, they have the right to be treated at a private hospital in Denmark or abroad at their county's expense (Sect. 5 g). The Act includes inpatient care, hospital ambulatory (day) care and in some cases home care for somatic and mental patients. Benefits are explicitly but vaguely formulated by the law. In principle, patients are entitled to any treatment that is clinically indicated, but in practice limitations apply. At national level the Hospital Act and its amendments directly or indirectly specify which services to offer (positive definition of benefits) or not to offer (negative definitions of benefits) to whom and under which circumstances:

Positive definition of benefits (examples):

- For persons suffering from a "life-threatening" disease, defined as patients with certain heart conditions or cancer patients, a maximum national waiting time is defined.
- The county offers a breast examination (mammography) to women aged 50–69 years every second year (Hospital Act; Sect. 5e). However, this benefit is accompanied by a clause stating that the Minister will decide when this service is to be implemented in the counties. The service is expected to be implemented by 2008. Today it is only offered in three counties.

- Patients with a clinically defined need for rehabilitation have the right to receive a plan from the hospital describing when and where rehabilitation is to take place at discharge, and who will coordinate between the county and municipal providers (Hospital Act; Bekendtgørelse om udarbejdelse af genoptraeningsplaner ved udskrivning fra sygehus, BEK 1009, 9 December 2003).

Negative definition of benefits (examples):

- Induced abortions after week 12 of pregnancy are only allowed after permission from the Minister of Justice and upon medical or social indication (Bekendtgørelse af lov om svangerskabsafbrydelse og fosterreduktion, LBK 541, 16 June 2004, og BEK 540, 16 June 2004, og VEJ 57, 16 June 2004). Sterilization cannot be provided to persons below the age of 25 years (Bekendtgørelse af Lov om sterilisation og kastration, LBK 661, 12 July 1994, og BEK 1131, 13 December 1996).
- Unmarried women and women over the age of 45 years are exempt from in vitro fertilization treatment by a physician (specialist; Lov om Kunstig befrugtning i forbindelse med laegelig behandling, diagnostik, forskning mv, LOV 460, 10 June 1997; Bekendtgørelse om kunstig befrugtning, BEK 728, 17 September 1997).
- Free choice of private hospitals (in the case the waiting time for treatment at county hospitals exceeds the limit of 2 months) does not include transplantation, sterilization, reproductive health services, hearing aid, cosmetic surgery, sex change, psychiatric treatment, alternative treatment, or treatment characterized as research (Bekendtgørelse om amtskommuners betaling for sygehusbehandling ved en anden amtskommunes sygehusvaesen, BEK 594, 23 June 2003).

In general, conventional treatments not included in the benefit package are not offered. For patients suffering from life-threatening cancer a referral needs to be approved by a board of specialists, a "Second Opinion Panel" established under the NBH (information available at: http://www.sst.dk/planlaegning_og_behandling/second opinion.aspx, accessed 4 August 2005). If the alternative such as conventional treatment is approved by the board, the expenses are covered by a special government grant. However, nonconventional treatment, such as a spa therapy, zone therapy, and homeopathy are not included in the benefit package [2].

Financial instruments

Hospitals are financed by the counties through tax revenue and block grants from the state. Following the annual negotiations between the counties and the government on the level of taxation and size of block grant the government has introduced new financial measures as a means to influence the development of the health sector. Special block grants are earmarked to high priority areas such as heart surgery and cancer treatment. These grants accompany recommendations from the NBH on treatment improvements and expansion of the capacity, as described in the "Heart Plan" and the "Cancer Plan." Furthermore, with the aim of shortening waiting lists, a provision of activity-based funding for additional production has been made available from 2002 for counties which can document an increase in their activity (Hospital Act; (Cirkulaer om udbetaling af statstilskud i 2004 til øget aktivitet på sygehusområdet CIR 6, 5 January 2004. Bekendtgørelse om økonomiske rammer for frit valg til private specialsygehuse, BEK 627, 20 June 2004.). Financial restrictions are imposed on the counties as their obligation to finance care at certain private hospitals including hospices, sclerosis hospitals, arthritis sanatoria, and brain rehabilitation hospitals is limited to a certain annual amount. Thus patients are either referred to a waiting list or must pay for the treatment themselves at a private clinic. At county level the counties determine the content and costs of hospital activity through the use of detailed budgets, enabling them to specify treatments offered, technologies used, service standards, and capacity available. There is an indirect regulation of benefits available to county inhabitants through the control of the sup-

Abstract

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The "Health Benefit Basket" in Denmark. A description of entitlements, actors, and decision-making processes in the curative health sector

Abstract
Until 2007, when the new legislation on health care becomes effective, the right to receive free health care services in Denmark, or "health benefits," are described in a comprehensive set of legislation, including laws, executive orders and legal guidelines. This contribution provides an overview of the current main legislation regulating the Danish "health benefit basket" and describes the regulatory mechanisms for the provision of curative care at Danish hospitals and primary health care offices. Although the services are both financed and planned by the counties, they differ substantially in the way that benefits are regulated.

Keywords
Health benefit plans · Denmark · Health services · Health priorities · National health programs

Table 1

The Danish "health benefit basket": overview of main legislation

	Hospital Act (and ancillary legislation)	Public Health Insurance Act (and ancillary legislation)	Medicines Act (and ancillary legislation)	Social Services Act (and ancillary legislation)	Other (specific) legislation
HC.1.1 Inpatient curative care	+	–	(+)	–	–
HC.1.2 Day-cases of curative care	+	–	(+)	–	–
HC.1.3 Outpatient care	(+)	+	(+)	–	–
HC 1.4 Curative home care	+	+	(+)	–	–
HC.2.1 Inpatient rehabilitative care	+	–	–	(+)	–
HC.2.2 Day cases of rehabilitative care	+	(+)	–	(+)	–
HC 2.3 Outpatient rehabilitative care	(+)	+	–	+	–
HC 2.4 Services of rehabilitative home care	(+)	(+)	–	+	+
HC.3.1 Inpatient long-term care	+	–	–	+	–
HC.3.2 Day cases of long-term care	+	–	–	+	–
HC 4.1 Clinical laboratory	+	+	+	–	–
HC.4.2 Diagnostic imaging	+	+	+	–	–
HC.4.3 Patient transport	+	+	–	+	–
HC.4.9 All other miscellaneous services	+	+	–	(+)	–
HC.5.1 Pharmaceuticals, etc.	–	+	+	–	–
HC 5.2 Therapeutic devices etc.	(+)	(+)	–	+	–
HC.6.1 Maternal and child care	+	+	–	(+)	+
HC 6.2 School health services	–	–	–	–	+
HC.6.3 Prevention of communicable diseases	–	(+)	–	–	+
HC.6.4 Prevention of noncommunicable diseases	–	(+)	–	–	+
HC.6.5 Occupational health services	–	–	–	–	+
HC.6.9 All other services	–	–	–	–	+
Legal status	Law	Law	Law	Law	Laws
Decision maker	County + physician	County + GP	County, GP (physician)	Municipality + county	County + municipality + GP
Purpose	Entitlements, delegation and defining responsibility of counties	Entitlements, reimbursement, copayment	Role of Danish Medicines Agency, process of approval of medicines	Entitlements, delegation and defining responsibility of counties and municipalities	Entitlements, defining roles and responsibilities of actors etc
Positive/negative definition of benefits	Positive	Positive	Positive	Positive	Positive
Degree of explicitness[a]	1	1 (2 and 3)	2 (and 3)	1 (2 and 3)	1, 2, 3
If itemized: goods, procedures, indications	Not itemized	Procedures (indications)	(Goods)	(Goods, indications)	Indications
Updating	No	No	No	No	No

Table 1 (continued)

The Danish "health benefit basket": overview of main legislation						
	Hospital Act (and ancillary legislation)	Public Health Insurance Act (and ancillary legislation)	Medicines Act (and ancillary legislation)	Social Services Act (and ancillary legislation)	Other (specific) legislation
Criteria used for defining benefits					
• Need	+	+	+	+	+
• Costs	–	–	–	–	–
• Effectiveness	–	–	+	–	–
• Cost-effectiveness	–	–	–	–	–
• Budget	+	–	–	–	–
• Other	–	+	–	–	–

[a] 1, *"All necessary"*; 2, *areas of care are described*; 3, *services are linked to specific items*

ply. In principle, the county can decide not to offer a certain treatment, for example, in vitro fertilization treatment to women who have already had one child by this means, or an expensive cancer treatment. However, the patient can choose to be treated in another county due to the right of free choice of hospital with the home county having to pay for it, which actually displays certain limitations to the county's planning freedom. In the hospital sector there are no benefit "catalogues" as such. However, a wide number of classifications are used to document the activity and prices based on diagnosis-related groups (DRG). DRGs are used for the remuneration of hospital services provided in other counties or at private hospitals.

Outpatient services: the Health Care Reimbursement Scheme

Unlike hospital services, benefits regarding outpatient services are under the HCRS explicitly and specifically detailed by the law and in a fee schedule negotiated on services and prices between the private providers and the HCRNC. The PHIA states that primary health care is available to (almost) everyone with a permanent address in Denmark. All citizens must choose between insurance groups I and II with a trade-off in terms of free choice of the provider and the size of reimbursement. Persons in group I, more than 98% of the population, are entitled to free services from GPs and to partial reimbursement of dentist services, physiotherapy treatment, etc. With a few exceptions public reimbursement of specialist and paramedic services are subject to GP referral. Persons in group II, fewer than 2% of the population, have a wider choice of providers, but are less entitled to reimbursement. Everyone receives a personal card clearly stating the entitlements to the services (PHIA; Bekendtgørelse om valgfri indplacering i sygesikringsgrupper, udstedelse af sygesikringsbevis mv, BEK 198, 21 March 2003; Bekendtgørelse om begraensning i adgang til ydelser efter sygesikringsloven for visse persongrupper, BEK 119, 17 March 1976, og BEK 115 af 21 February 1990). A large number of executive orders and the fee schedule for reimbursement of private providers further specify entitlements and benefits laid down by the PHIA (PHIA; Bekendtgørelse om befordringsgodtgørelse efter sygesikringsloven, BEK 3, 3 January 2001; Bekendtgørelse om tilskud efter sygesikringsloven til fodbehandling, BEK 129, 18 March 2003; Bekendtgørelse om tilskud efter sygesikringsloven til kiropraktisk behandling, BEK 181, 22 March 2004; Bekendtgørelse om tilskud efter sygesikringsloven til fysioterapeutisk behandling, BEK 405, 18 May 2001; Bekendtgørelse om tilskud efter sygesikringsloven til psykologbehandling for saerligt udsatte grupper, BEK 472, 18 June 2002; Bekendtgørelse om tilskud efter sygesikringsloven til sondeernaering og andre ernaeringspraeparater, BEK 531, 18 June 2003; Bekendtgørelse om tilskud efter den offentlige sygesikring til betaling af briller til børn under 16 år, BEK 543, 8 December 1980; Bekendtgørelse af lov om tandpleje, LBK 1261, 15 December 2003, og BEK 1073, 11 December 2003; Bekendtgørelse om tilskud efter sygesikringsloven til tandpleje, BEK 147, 6 March 2004; Bekendtgørelse om adgang til laegehjaelp efter sygesikringsloven, BEK 180, 18 March 2003).

Some benefits are defined very explicitly, e.g., a specific maximum amount in Danish crowns to be covered for spectacle lenses and spectacle frames; (BEK 543, 8 Decemberr 1980, see above), while others are defined in more general or vague terms, e.g., proportional reimbursement of negotiated fee for physiotherapy treatment (PHIA; BEK 405, 18 May 2001, see above), or proportional reimbursement of negotiated rates for dental treatment (LBK 1261, 15 December 2003; og BEK 1073, 11 December 2003, see above; BEK 147, 6 March 2004, see above). There are positively defined benefits (e.g., the right to spectacle lenses and frames) and exclusions through negatively defined benefits, e.g., a service excluded from reimbursement from the public travel insurance benefits (Bekendtgørelse om befordringsgodtgørelse efter sygesikringsloven, BEK 3, 3 January 2001). While, for example, GP services, ear nose and throat medicine, psychiatric, and oculist services are free of charge for patients, dentist services are only partly covered by public funds. Some services are regulated by legislation but not included in the benefit basket, unless certain specific criteria

Table 2

Benefits regarding outpatient services according to the Health Care Reimbursement Scheme. Services fully, partially or not covered by public funds

Type of service/provider	Coverage by public funds	Coverage for special groups	Referral from GP required (Group I insured)
General practice	Full	–	–
Dentist services	Partial	Full coverage for children at school age, disabled, low income elderly	No
Tube feeding/nutritional preparations	Full	–	Yes
Physiotherapy	Partial	Full coverage for patients with specific diagnoses (muscular-skeletal)	Yes
Psychiatrist	Full	–	Yes
Psychologist	None/ (partial)	Partial coverage for persons exposed to traumatic incidents	Yes
Chiropodist	Partial	Partial coverage for diabetics and low-income elderly	Yes
Chiropractor	Partial	–	Yes
Opthalmologists	Full	–	No
Ear-nose-throat physicians	Full	–	No
Dieticians	None	–	No
Other specialists	Full	–	Yes

are fulfilled (e.g., psychologist counseling, chiropody, and chiropractic services (BEK 129, af 18 March 2003, see above; BEK 181, af 22 March 2004, see above; BEK 472, 18 June 2002, see above). **Table 2** provides an overview of the main services under the HCRS, showing the extent and criteria for coverage and whether the services are subject to a referral from the GP.

"Other specialists" whose services are fully part of the benefit basket upon GP referral include: anesthetists, specialists in dermatology and venereal diseases, specialists in diagnostic radiology, gynecologists, obstetricians, internists, surgeons, biochemists, neurologists, orthopedics, specialists in pathological anatomy or plastic surgery, pediatricians, rheumatologists, and specialists in tropical medicine or laboratory examinations.

The fee schedule

Whereas the laws describe mainly the extent to which outpatient services are included in the benefit basket, for example, the proportion of public funding and the criteria for coverage, the fee schedule negotiated between the HCRNC and the health personnel trade unions specifies the services for which the providers are paid. Since the schedule lists services which are reimbursed from public funds and are therefore provided free of charge to the patients, the fee schedule may – in an indirect way – be regarded as a benefit catalogue (Sygesikringens Forhandlingsudvalg, takstkatalog, April 2005).

Items in the fee schedule are negotiated every 3 years while the tariffs are revised twice a year. Health technology assessments, cost-effectiveness analyses, and clinical studies are adduced by the professional committees and included in the negotiation but they are not mandatory. Criteria for the decisions concerning the inclusion or the exclusion of an item are neither systematic nor public. An example of an argument over the inclusion of services regards progress in treatment methods (substitution of outdated services with more up-to-date procedures). There is usually a reimbursement rate when benefits such as those for contraceptive advice from the GP are specifically stated by the law (A. Bonne, HCRNC, personal communication).

The catalogue is divided into specialties with a subdivision into type of services offered (items). Items may be directly linked to the legislation that specifies the benefits, for example, antenatal care consultation and first child health check-up at the age of 5 weeks (general practice). They are also directly linked to the logic applied by the legislation, for example, following certain age groups, certain timing (week 12, first and second consultations, etc.), or specific agreement, such as on working hours or transport fees for the professional group involved. When the legislation does not specify the benefits, items are either linked to consultation type (visits), goods (e.g., laboratory tests) procedures (e.g., spirometry) or even indications (e.g., podiatry for diabetics) in some rare cases. There is generally no specification of the technology to be used with a few exceptions.

Concluding remarks

The Danish benefit basket for curative services is regulated directly by law and influenced indirectly by more "soft" regulatory mechanisms. In the hospital sector which is the main part of the health sector in terms of expenditure, the law delegates the responsibility for providing, financing, organizing, and planning services to the 14 counties. Thus there may be regional variations in the services offered. Benefits are explicitly defined but not specified by the law. In principle, all clinically indicated hospital services are included in the benefit basket. However, central initiatives, such as legislation on the patient's free choice of hospital, waiting time guarantees for some patient groups and financial constraints influence the counties' decisions and narrow the room for regional variation. Regarding outpatient services the picture differs slightly as benefits in the HCRS are regulated at central level through explicit and specific legislation while being further specified in agreements about items and tariffs between county and provider representatives.

In 2007 the Danish health sector will be subject to a structural reform which will significantly influence the way in which health services are financed and organized. The current political layer of 14 counties will be abolished and be replaced by five regions responsible for providing hospital services but without the taxation rights that they have today. The municipalities will merge into fewer units, assume financing responsibilities for more health services than today and will purchase hospital services from the regions.

The reform's immediate impact on health benefits is hard to predict, but there will be some modification as to legislation at least. A law, "the Health Act" (Sundhedsloven, LOV nr. 546, 24 June 2005), recently passed by the Folketing, collects the previous vast amount of legislation on health care into a single document. Among other things the goals of Danish health care services, for example, that citizens should have easy and equal access to health care, have now been made explicit. The rights to health care services do not change fundamentally, nor do decision makers and their roles and responsibilities. The Act contains many clauses empowering the Minister for the Interior and Health to set specific rules, thus giving the Minister much more decision-making power than today. However, the Health Act provides a regulatory framework with explicitly mentioned rights to health services not being different from what is outlined here. The specification of benefits will still take place at the lower levels of decision making, by specifications of the law by the Minister, by the National Board of Health, in agreements between regions and municipalities, through a payment schedule, or at clinical level.

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