



The Health Benefit Basket in Denmark

*A description of benefits, entitlements, actors, and
decision-making processes in the Danish health sector*

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Preface

This report describes benefits and entitlements in the Danish health sector based on current legislation in Denmark. The report has been elaborated in fall/winter of 2004-2005 by the DSI Danish Institute for Health Services Research as part of Work Package II of the EU funded research project, “HealthBASKET” (EU-contract No. SP 21-2004-501588 under the Sixth Framework Programme). Interpretations and omissions are our own.

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1 Overview of Danish Health Benefit Basket

1.1 Introduction

The Danish health care system can be characterised as “a national health service”, or as a “publicly integrated” system. Health care is mainly financed through taxation and patient co-payment for pharmaceuticals, and specific ambulatory services, e.g. dentist’s services. The public funds are allocated to public regional and local authorities through global budgets and – from 2004 – a smaller activity-based part. Compared to other national health services, e.g. the NHS in the United Kingdom, the Danish system is highly decentralised. The local authorities are directly elected and have the right to taxation, so there is a local democratic control with the system. Through legislation passed by the central government, responsibility is delegated to lower levels of administration and decision-making, that is to the fourteen counties and the 275 municipalities¹. The counties and to some extent, the municipalities, have great influence on the health services available for their citizens. This means that there is a certain regional variation in the health services available to Danes.

However, although the responsibility for health services is decentralised, recent central initiatives, such as legislation allowing the patient a free choice of provider, influence the ability of the individual local authorities to control, plan and finance the basket of health services. “Free choice” in the health sector constitutes a persisting challenge to executive levels of health care: the counties and the municipalities.

Furthermore, the legislation passed by the parliament – the “Folketing” – or issued by the central government to a great extent leaves decisions about treatment to clinicians who are required to make decisions about treatments based on fair medical judgement. Here, the general practitioner plays a crucial role as the gatekeeper responsible for referring patients to basically all areas of the health sector.

In Denmark, care for the elderly and impaired in nursing homes and institutions are usually not perceived as being part of the health sector. The legislation lies under the auspices of the Ministry of Social Affairs and the care is perceived as social care. This means that in the Danish context, the boundaries of health care are somewhat narrower than in the OECD health account classification. In this report, however, the social sector will be included to the extent that it falls within the OECD functional health account classification.

Finally, it is necessary to mention that the current government has recently decided to embark on a major structural reform which will become effective in January 2007. The reform will change the current decentralised administrative and political structure in Denmark, and might enhance the decision-making power and control of health services of the central government and central authorities such as the National Board of Health.

The following description of benefits in the Danish health sector is based on the current structure and legislation.

¹ Including the municipalities of Copenhagen and Frederiksberg. They have a status both as a county and a municipality.

This introductory chapter will answer the questions 1-4 of the Health Basket project questionnaire, that is:

- On which level are entitlements to health services regulated (question 1)
- For how many regions and sectors of health care exist different regulatory regimes (question 2)
- What is the role of the central government (question 3)
- Which types of benefits are excluded (question 4).

Furthermore, in this chapter an overview of the four main laws influencing benefits will be provided and the structural reform envisaged for 2007 will be outlined briefly.

1.2 Regulation of Entitlements (question 1)

Benefits and entitlements in the Danish health sector are regulated by laws passed by the Parliament, the “Folketing”. Furthermore, the Minister is empowered by law to issue notices and circulars which are also legally binding for the bodies they are imposed on. These documents both explicitly and implicitly regulate benefits.

Bilateral negotiations in – especially – out-patient care influence implicitly the health care benefits. For instance, the Health Care Reimbursement Negotiation Committee negotiates fees and reimbursement conditions with the medical associations and the counties.

Agreements and contracts are widely used at the de-central level to establish the division of work between counties and municipalities for specific services, or between providers. These agreements may also have an implicit effect on health benefits.

The main legislation on health care provides a legal frame for planning and providing health services. The specification of services through the actual supply of services and the health plans in the individual county also implicitly regulate the benefits available to the citizens.

Furthermore, administrative, “judicial” bodies, such as the Patient’s Complaints Board, and the Social Appeals Board exert a control function in favour of patient benefits, either due to specific cases brought up by patients or due to the mere existence of these organisations. The complaints boards will use the legislation and administrative documents, e.g. guidelines in their settlements.

One law indirectly influences the legislation passed and the benefits made available to patients: the “Act on Legal Status of Patients (LOV 482 of 01/07/1998). As it is general to all sectors of health care, it is described here.

The overall purpose of this law is to regulate the relationship between patients and health personal and to ensure the dignity, integrity and autonomy of the patient.

According to the law, no treatment may be carried out without the informed consent of the patient. If the patient is permanently unable to give his informed consent, relatives or other health personal may provide this consent on behalf of the patient. If immediate treatment is necessary for the survival of the patient, and the patient is temporarily unable to give his consent, a treatment must be started.

Also according to the law, the patient has the right to receive any information about his state of health as well as his potential for cure. This also includes right of access to information in the patient record.

The law has had an influence on other legislation and guidelines in health care, especially with regard to the perception of the patient's role in deciding about which treatment to choose and especially not to choose.

1.3 Regional Variation of Benefit Catalogues (question 2)

The legislation on health care in Denmark is passed by the Parliament and further specified by the Minister for the Interior and Health, the Minister for Social Affairs, and to a certain extent the National Board of Health.

The law is uniform for all executing parties, in the sense that all counties and municipalities have to observe the (same) law when it is imposed on them. This means that although there are many de-central decision-makers in Denmark (14 counties, 275 municipalities) the statutory schemes are national, i.e. the same for all, in the legal sense.

Although the law is uniform, it is still for the main part of the health sector only a frame with very general clauses about roles, responsibilities and benefits. The very "picture" in the frame is drawn by the de-central decision-makers, the counties and municipalities, who through their own budgets, planning and provision of services specify which health services are to be available for their citizens. This is the case of in-patient and day care at hospitals, rehabilitative care and long-term care which constitute by far the majority of the health sector in terms of health care expenditure. This means that there is room for some regional variation of practice and provision within these three sectors.

However, in an international comparison, the regional variation in Denmark is more to be found in the way services are organised than in the level of services provided. At regional level, health plans, budgeting and control of supply of services combined with agreements and local guidelines for referral, organisation and performance work as regulatory regimes. At national level, financial incentives provided by the government through (additional) financial allocations to specific services or decisions about activity-based financing may work as regulatory regimes in terms of health care services. These mechanisms are described more closely in chapter 3 on in-patient curative care.

Other parts of the health care sectors, out-patient services and medical goods to out-patients are regulated at a national level, both with regard to statutory schemes and regulatory regimes and the regional variation of benefits available is not significant.

The following description of health care benefits by sector focuses on the centrally issued law and instructions, and analyses and assesses the "freedom" available for the executive parties in health care to carry out the law, giving examples – when appropriate – of availability of services.

1.4 Role of (Central) Government (question 3)

The Parliament, the "Folketing", is responsible for legislating.

The Ministry for the Interior and Health and, for some areas, the Ministry of Social Affairs is central institutions responsible for specifying the laws further, setting rules in certain areas, and for initiating reforms and bills. In case it is not explicitly mentioned in the law that the Minister (for the Interior and Health or Minister of Social Affairs) is empowered to specify the law, the law can only be changed by the “Folketing”.

Under the Ministry for the Interior and Health is the National Board of Health. The board is responsible for supervising the “health persons”², for elaborating and issuing guidelines and reference programmes, and for monitoring and documenting health services. The National Board of Health may also bring cases to the Patient Complaints Board which decides on administrative practice. The courts decide on legal practice. A specific responsibility for approving and registering medicines in Denmark lies with the Danish Medicines Agency under the Ministry for the Interior and Health.

The “health persons” are for their part obliged to show clinical diligence and act according to “best practice”. Guidelines from the National Board of Health define current best practice within specific health care programmes or interpret the law.

The National Board of Health supervises and comments on the health plans elaborated by and for the counties. They are however, not – in the legal sense – obliged to follow the advice provided by the National Board of Health.

The Danish Medicines Agency is be responsible for approving medicines and administering reimbursement rules, including deciding which medicines are included in the benefit package, and which are not.

1.5 Benefits which are excluded from the Benefit Basket (question 4)

In principle, no benefits are excluded from the Danish benefit basket if they are clinically indicated. If a patient is referred to a certain treatment by a GP or a hospital physician, this treatment should, in principle be offered and covered by public funds. This is also – in theory – the case of treatments “on the edges”, such as plastic surgery for cosmetic reasons and sex change operations. However, since the actual supply of health services is limited to what the counties can perform within their budget for health services, a referral in practice means that the patient is referred to a waiting list. Thus, priorities about which treatments to offer and not-to-offer on the county level are to a great extent set through capacity, supply control, and waiting lists.

It may be that a woman is referred to a breast enlargement operation by her GP because of the psychological distress she may suffer from the size of her breasts, but the waiting list for this operation at a public hospital may be life-long, because plastic surgery of this kind is not prioritised by the county. In practice, it means that the woman will either not have the operation, or will have to pay for it herself at a private clinic.

Also in the out-patient sector, benefits may be indirectly excluded if they are not part of the fee schedule. This is e.g. the case of certain types of laser surgery for which the specialists cannot be reimbursed.

² The Danish judicial word is “sundhedspersoner” (health persons). It refers to all types of health professionals.

There are very few, specific exclusions mentioned in the law:

- Unmarried women³ and women above 45 years of age cannot have IVF treatment.
- Sterilisation cannot be provided to people under 25 years of age
- Induced abortions after week 12 of pregnancy is only allowed after permission from the Minister of Justice, and upon medical or social indication.
- Specific groups of patients and treatments are exempt of the right to free choice of provider of in-hospital curative services, rehabilitative care and long-term out-patient care (see chapter 3, 4, 5).

Other services are not explicitly excluded by law, but are excluded implicitly as they are not mentioned in the law, on a positive list or in a fee schedule regulating benefits:

- Psychotherapist consultations are not included.
- Out-patient dietician consultations are not included.
- Birth preparation classes for pregnant women are not included.
- Alternative treatment and medicines are not included. However there are a few exceptions to this. They have been described later in the report.

Other services are only partly included by law, i.e. there is a patient co-payment or the services are only included for certain patient groups:

- Chiropodist services are only included for certain disease groups, e.g. diabetics, and still only partly (there is a co-payment).
- Physiotherapy is only fully covered by public funds for certain disease groups. For all other groups there is a patient co-payment.
- Chiropractic services are only partly included (patient co-payment)
- Medicines are subject to patient co-payment.
- Foetus diagnostics in maternity care, such as amniocentesis and CVS are only included if the initial risk assessment (test) is positive.⁴
- Dentist services for people over 18 years of age are only partly included (there is a patient co-payment)
- Consultations by an authorised psychologist are partly included (with a patient co-payment) if patient's the symptoms can be explained by a personal trauma (loss of relatives, personal attack etc). Otherwise, e.g. in case of un-explicable depressive symptoms, these services are not included.

1.6 Overview Table

As can be seen from the reference lists, benefits in the Danish health sector are regulated by many legal documents, counting app. 150 laws, government notices, circulars etc. These legal documents are issued and updated on an ad hoc basis when found necessary by central authorities and the legislating bodies.

³ This means that e.g. homosexual women cannot have IVF treatment.

⁴ One may argue that this is not different to all other services provided upon indication. However, the difference to other services, is that referral criteria are specifically set in the law /guidelines by central authorities and not by local/regional/clinical decision-makers.

The table on the next page provides an overview of the four most important laws regulating benefits in the Danish Health sector: The Hospital Act, The Public Health Insurance Act, the Medicines Act and The Social Services Act. These laws provide the legal frame and are accompanied by a significant number of ancillary laws which are also relevant in the definition of benefits. Furthermore, there are specific laws regulating individual services, e.g. Act on Preventive Health Services for Children and Young People. All laws are described in chapters 3-9 and schematic overviews of the legislation regulating each sector are provided in appendix I.

The Hospital Act (“Bekendtgørelse af lov om sygehusvæsenet, LBK 766 of 28.08.2003”), referred to in the next chapters as the “*Hospital Act*” provides the regulatory frame for hospitals and hospital care. The law delegates responsibility for planning, providing and financing hospital services to the county council. A number of ancillary laws further specify this law. The Hospital Act is relevant to all types of in-patient care and day case care provided at hospitals. Also patient transport, maternity care and rehabilitative care at hospitals are regulated by this law and ancillary laws.

The Public Health Insurance Act (LBK 509 of 01.07.1998 and amendments) is referred to in next chapters as the “*Public Health Insurance Act*” This law provides the regulatory frame for entitlements to health services in what in Denmark is referred to as the primary health sector. In the OECD definition context, this law covers out-patient care, and to some extent, rehabilitative care, ancillary services for out-patients, maternity and child care and reimbursement of pharmaceuticals.

The Medicines Act (“Lov om lægemidler, LBK 656 of 28.06.1995”) referred to as “*the Medicines Act*” regulates access to pharmaceuticals in Denmark and specifies the process of approval of medicines by the Danish Medicines Agency, marketing authorisations etc.

The Social Services Act (“Bekendtgørelse af Lov om Social Service, LBK 708 of 29.06.2004”) referred to as “*the Social Services Act*” provides the regulatory frame for social services. The law delegates the planning, financing and provision responsibility to counties for the specialised care and to municipalities for the less specialised care. This law covers long-term care at institutions, on an out-patient basis and in the patient’s home. It also deals with rehabilitative care not following hospital treatment. Furthermore, it regulates entitlements to therapeutic appliances, non-acute patient transport and other services.

For preventive services such as prevention of communicable diseases, there are a number of individual laws regulating benefits.

A parenthesis in the table is provided when the services in a certain context may be provided by the specific law.

The decision-makers in the Danish health sector are mainly the local governing bodies which by statute are responsible for the service – that is the county council or the municipal council and the city councils of Copenhagen and Frederiksberg.

The physicians and especially the general practitioner are also very important decision-makers due to their gate-keeper role.

		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	In-patient curative care	X		(X)		
HC.1.2	Day-cases of curative care	X		(X)		
HC.1.3	Out-patient care		X	(X)		
HC.1.4	Curative home care	X	X	(x)		
HC.2.1	In-patient rehabilitative care	X			(x)	
HC.2.2	Day cases of rehabilitative care	X	(X)		(x)	
HC.2.3	Out-patient rehabilitative care	(X)	X		X	
HC.2.4	Services of rehabilitative home care	(x)	(x)		X	X
HC.3.1	In-patient long-term care	X			X	
HC.3.2	Day cases of long term care	X			X	
HC.4.1	Clinical laboratory	X	X	X		
HC.4.2	Diagnostic imaging	X	X	X		
HC.4.3	Patient transport	X	X		X	
HC.4.9	All other miscellaneous services	X	X		(x)	
HC.5.1	Pharmaceuticals etc.		X	X		
HC.5.2	Therapeutic appliances etc	(x)	(x)		X	
HC.6.1	Maternal and child care	X	X		X	X
HC.6.2	School Health Services					X
HC.6.3	Prevention of communicable diseases		(x)			X
HC.6.4	Prevention of non-communicable diseases		(x)			X
HC.6.5	Occupational Health Services					X
HC.6.9	All other miscellaneous services					X
	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, co-payment	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	1	1 (2 and 3)	2 (and 3)	1 (2 and 3)	1, 2,3
	If itemised: goods /procedures/indications	not itemised	procedures (indications)	(goods)	(goods, indications)	Indications
	Updating	No	no	No	No	No
	Criteria used for defining benefits					
	Need	X	X	X	X	X
	Costs					
	Effectiveness			X		
	Cost-effectiveness					
	Budget	X				
	Other			X		

Table 1: Overview – main legislation

Most benefits are explicitly but very vaguely defined in the law, leaving it up to decision-makers to specify the services made available to patients. This is for instance the case of the Hospital Law, where it is stated that “every citizen has the right to free hospital treatment” (explicitly defined benefit) but there is no specification of what is actually meant by that statement, i.e. which services are covered for which groups. (“vague” formulation).

The degree of explicitness is described as “all necessary” (1) in all laws. Some laws further describe areas of care (2) and are linked to items (3). The Public Health Insurance Act, the Social Services Act and their ancillary legislation are to some extent explicit with regard to areas of care and are linked to items. This is also the case of most other specific legislation.

Benefits regarding pharmaceuticals are defined on a need-assessment basis, but also on the basis of effectiveness and cost-effectiveness, as these are criteria by the Danish Medicines Agency for listing medicines on the positive list for reimbursement.

Table 2 below provides an overview of agreements and lists that may be considered “benefit catalogues”.

		Fee Schedule – Health Care Reimbursement Scheme	Danish Medicines Agency Positive List
HC.1.1	In-patient curative care		
HC.1.2	Day-cases of curative care		
HC.1.3	Out-patient care	X	
HC.1.4	Curative home care	X	
HC.2.1	In-patient rehabilitative care		
HC.2.2	Day cases of rehabilitative care		
HC.2.3	Out-patient rehabilitative care	X	
HC.2.4	Services of rehabilitative home care	X	
HC.3.1	In-patient long-term care		
HC.3.2	Day cases of long term care		
HC.4.1	Clinical laboratory	X	
HC.4.2	Diagnostic imaging	X	
HC.4.3	Patient transport		
HC.4.9	All other miscellaneous services	X	
HC.5.1	Pharmaceuticals etc.		X
HC.5.2	Therapeutic appliances etc		
HC.6.1	Maternal and child care	X	
HC.6.2	School Health Services		
HC.6.3	Prevention of communicable diseases	X	
HC.6.4	Prevention of non-communicable diseases	X	
HC.6.5	Occupational Health Services		
HC.6.9	All other miscellaneous services		
	Legal status	Agreement	Issued according to a law
	Decision-maker	HCRNC ⁵ and medical associations (Minister for Health and the Interior)	Danish Medicines Agency, County and GP
	Purpose	Reimbursement	Medicines that are reimbursement
	Positive/negative definition of benefits	Positive	Positive
	Degree of Explicitness	1	1
	If itemised: goods /procedures/indications	Itemised (procedures/indications/criteria)	Goods
	Updating	Every 6 months (fees), every 3 years (items)	Every year
	Criteria used for defining benefits		
	Need	(X)	(X)
	Costs		
	Effectiveness		X
	Cost-effectiveness		
	Budget		(x)
	Other	X	

Table 2: Overview – “benefit catalogues”

⁵ Health Care Reimbursement Negotiating Committee

The notion of a “benefit catalogue” does not exist as such in Denmark. However, the fee schedule negotiated under the Health Care Reimbursement Scheme indirectly regulates benefits available to patients, since it indicates the services and procedures that the providers will get paid for, and it may therefore be considered a “benefit catalogue”. Criteria in the schedule for defining benefits are a result of a negotiation between the parties involved. This fee schedule has been described in detail in Chapter 9. The positive list for medicines that can be reimbursed is issued by the Danish Medicines Agency. The list together with the rules on reimbursement may also regulate prescription behaviour and the purchase of medicines outside hospitals, and is thus also an implicit “benefit catalogue”. The list has been described in Chapter 7.

1.7 Recent Developments – Structural Reform in 2007

In 2004, a bill proposing a structural reform was passed by a majority vote in the Danish “Folketing”. The reform will become effective in January 2007. This reform will significantly influence the way health services are financed and organised in Denmark. The current political layer of fourteen counties will be abolished and replaced by five regions responsible for providing hospital services but without the taxation rights 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 impact on health benefits is hard to predict, but there will be some changes as how the benefits are made explicit and described in the legislation.

Legally speaking, a bill proposing one law on health care, the “Health Act”, is currently under consideration in the parliament. Today, as mentioned health care is regulated by a very large number of legal documents and this bill, if it becomes law, will result in only one document.

The bill furthermore contains many clauses empowering the Minister for the Interior and Health to set specific rules, thus giving the Minister much more decision-making power on health services than the case is today. It has however, not been passed in the Folketing yet, so the final outcome of it is yet to be seen.

2 Description of Entitlements and Benefits by Sector: Introduction

2.1 Structure of chapters 3-10

The description in the next six chapters follows the questionnaire elaborated as part of Work Package I of the HealthBASKET project, and the definition of health care according to the OECD functional classification for health accounts. As answers to questions 1-4 have been provided in Chapter 1, the emphasis in the next chapters has been put on answering questions 5-8.

Thus, for each of the sectors of the OECD functional categories of health care, there is a description of

- the legislation in the area
- the actors deciding about the health benefit, their roles and responsibilities. (question 5)
- the process of deciding the benefits and a general outline of the contents of the benefits. (question 5 and 6)
- benefits “categorisation” (are benefits explicit, implicit, vaguely, specifically, positive or negatively formulated. Are they based on inclusion or exclusion of certain services /groups etc.) (question 6)
- benefits “classification” (question 7)
- payers of benefits (are they uniform for all payers) (question 8)

In cases where the legislation is identical for different subgroups of sectors, the description of these sectors has been compiled into one.

The Danish legislation does not follow the OECD definitions and therefore one law may cover several OECD “sectors” and another law may only cover a very specific area of an OECD sector. Furthermore, as previously mentioned, services which are perceived as “social care” in Denmark, are included in the description if they are part of the OECD definition.

Question 9 and 10 of the questionnaire deal with “benefit catalogues”. Benefit catalogues as such do not exist in the Danish health sector. However, positive lists and fee schedules may be regarded as benefit catalogues as they provide information to health care professionals and patients about the services that are reimbursed and thus implicitly regulate the benefits available. The positive list for reimbursement of medicines has been described in Chapter 7 under the description of non-durables medical appliances. An analysis of the fee schedule under the Health Care Reimbursement Scheme has been provided in Chapter 9 on benefit catalogues. Chapter 10 contains a discussion of the descriptions provided.

In the appendices to the report, an overview has been provided for each sector, answering the 10 questions for each law relevant to the specific sector.

2.2 Definitions used

The following definitions have been used in the description:

An “*Act on... ..*” refers to a specific law passed in the Danish parliament (“Folketing”). The law usually in very general terms establishes the legal frames of the area and delegates decision-making power and responsibility to lower levels of administration. The law may also contain clauses which delegate legislating power to lower levels. These “lower levels” are usually the Minister (for the Interior and Health or Social Affairs) who in the specific law is authorised to set rules. The Danish abbreviations used in the references are LBK (“Lovbekendtgørelse”), LOV or DSSK (“datasammenskrivning”).

A (*government*) *notice* is a legally binding document (a law) issued by the authority (e.g. the Minister) empowered to do so according to the law. The notice either specifies the law in question or specifies a certain service. The Danish abbreviation used is BEK (“bekendtgørelse”).

Circular and letters are notices issued by an authority, e.g. the Minister or the National Board of Health. They are legally binding if they are issued by a superior authority, e.g. the National Board of Health imposing duties on an authority of lower executive level e.g. in the counties. Or issued by the County Council imposing obligations on a certain hospital management. The Danish abbreviations used in the references are CIR (“cirkulære”) or SKR (“skrivelse”).

Guidelines issued by the National Board of Health may be legal guidelines outlining how the law should be interpreted for specific areas. Such guidelines are available for most laws. The abbreviations used for the legal guidelines are VEJ (“vejledning”) or RTL (“retningslinier”).

Sometimes, the law states that the National Board of Health should elaborate guidelines for organisation and planning of the services. These guidelines are evidence and/or consensus based and elaborated for the National Board of Health by a panel of experts. Guidelines may also be issued by other organisations e.g. a county council or a hospital management telling staff how to provide the service. Finally, there are several clinical guidelines aimed at health care professionals. These may come from the medical associations, from the industry or from the National Board of Health.

Guidelines from the central authorities are not binding in the strict judicial sense. However, according to the laws regulating the medical professions, “health persons”- physicians, nurses etc. – are obliged to carry out their medical professions with diligence and according to best practice. The National Board of Health supervises the medical professions and guidelines from this authority describe what is currently considered “best practice”. So, if there are complaints to the Patient Complaints Board or cases brought to court stating that the National Board of Health guidelines were not followed, this issue will influence the settlement. This mechanism means that National Board of Health guidelines are de facto binding for the actors involved.

3 Services of Curative Care (HC 1)

OECD Functional Classification of Health Care Definition:

This item comprises medical and paramedical services delivered during an episode of curative care. An episode of curative care is one in which the principal medical intent is to relieve symptoms of illness or injury, to reduce the severity of an illness or injury or to protect against exacerbation and /or complication of an illness and /or injury which could threaten life or normal function. Includes: obstetric services, cure of illness or provision of definitive treatment of injury, the performance of surgery; diagnostic or therapeutic procedures. Excludes: Palliative care

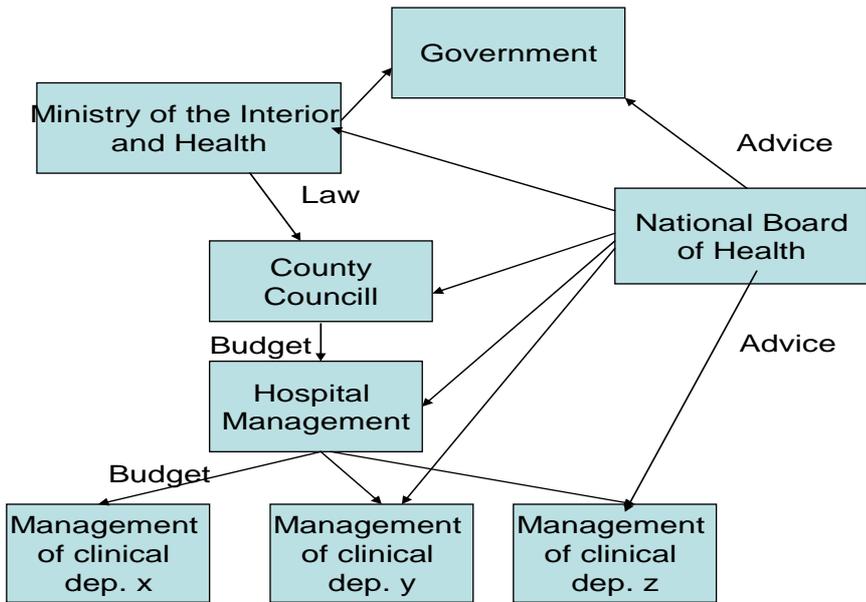
3.1 In-patient and day-cases of curative care (HC 1.1 and HC 1.2)

3.1.1 Introduction

As in-patient and day cases of curative care for somatic as well as mental patients are regulated in the same way, the categories HC.1.1 (in-patient curative care) and HC.1.2 (day cases of curative care) have been combined in the description below.

3.1.2 Actors responsible for defining benefits (question 5)

HC 1.1 and 1.2: In-patient curative care and day-cases of curative care



3.1.2.1 The role of the state

The financing and running of hospital care – in-patient as well as day cases within somatic, intensive and mental care are – to a large extent – the responsibility of the counties. The role of the state is to set out the general legislative framework, allowing regional authorities to decide on actual performance. Besides setting the legislative framework the task of the state is to initiate coordinate and advise the regions.

The role of the National Board of Health is to give clinical advice to the county authorities, and physicians employed by the hospitals. This task is carried out by sending out recommendations on which treatment should be centralised in a few highly specialised hospitals, which should be placed locally and which medical treatments are recommended for cancer patients.

Also, the county health plan (see below) should be submitted to the National Board of Health for comments. However, the counties are not obliged to follow their advice.

3.1.2.2 The Hospital Act

The main law concerning the hospital sector is the Hospital Act and ancillary legislation including notices and circulars specifying some paragraphs in the law. The law sets up general regulations for the Danish hospital sector as well as regulations for more specific areas.

Among other things, the Hospital Act regulates the following general conditions concerning hospitals in Denmark:

- The hospital services are the responsibility of the counties and the Copenhagen Hospital Corporation (§1).
- The institutions providing hospital services may be (§3):
 - county owned hospitals
 - other counties hospitals
 - private special institutions (i.e. hospices, rehabilitative institutions)
 - private hospitals
 - foreign hospitals
- The counties must provide free hospital treatment for residents of the county (§5)
- Patients have a free choice of (public) hospital (§5b). If there is a waiting time for more than 2 months, the free choice also includes private hospitals (in Denmark or abroad) (§5g).
- How counties pay for treatment of their residents at other counties hospitals (§5 stk.11).

More specifically the Hospital Act, among other things, regulates that:

- Some patient groups have to be treated within 2 months after referral (§5d)
- In principle, the counties should offer breast examination to women between 50 and 69 years. (§5e). (see chapter 8)
- For patients in need, a rehabilitation plan shall be made at discharge from hospital (§5f). (see chapter 4).

3.1.2.3 The role of the county

The counties are free to run their hospital sector within the framework set up by the Hospital Act. However, according to the Hospital Act, a plan for the hospital service in the county (§11) (as part of a Health Plan coordinating all preventive and curative health care activity in

the county) should be developed every four years. The hospital plan is not a benefit catalogue, but rather a plan that describes the physical capacity of the county hospital sector, including which specialities to be represented in the county hospitals, and which specialities to be covered by specialised hospitals situated in other counties. Furthermore, the plan should describe how many beds, employees etc. there should be within each speciality. The content and presentation of the health plan varies a great deal between counties.

3.1.2.4 The role of the hospitals and clinical department

The hospital managements are free to run their hospital within the framework set up by the state and the county council. Furthermore, the management of the clinical department (head physician and head nurse) is free to run the department within the framework (among other things the economic framework) set up by the state, county council and hospital management. For example, the head physician is free to establish treatment protocols and indications for treatment for different patient categories as well as setting up guidelines for prioritizing between patients in case of waiting lists.

3.1.2.5 Mental inpatient care

The psychiatric hospital sector is regulated as the somatic hospital sector. However, the free choice of hospital is limited for psychiatric patients (Hospital Act §5b art.2). As a supplement to the Hospital Act, a law (LBK nr. 849 02/12/1998) regulates confinement and use of force against patients with a mental illness. According to this law, a treatment plan has to be made for any patient admitted to a psychiatric hospital within one week after admission (§3 stk.3). Also a psychiatric patient who is hospitalized against his will has a right to a personal advisor (§24). At discharge from the psychiatric hospital, a plan for further treatment should be made in corporation with the patient and the primary health care sector, responsible for the future treatment of the patient (§3 stk. 4).

3.1.3 Definition of Benefits (question 6)

According to the Hospital Act, all citizens has the right to free hospital treatment (§5). This is an explicit but vaguely formulated benefit. In general, patients are entitled to any treatment that is clinically indicated. However, as the following sections will show, some treatments explicitly or implicitly are given a higher priority than others. This priority setting is made at national as well as county and hospital level.

3.1.3.1 National level

Definition of benefits should be seen at both national and county level. As the hospital sector is the responsibility of the counties, it is up to them to organise and define which hospital services to provide for their citizens. However, the national regulation does contain formal instruments or regulatory regimes which may regulate which services the counties should provide. These instruments include economic restrictions and incentives as well as laws and regulations concerning treatment of specific patient categories. The regulations are negative and positive as well as specific and general.

The regulatory schemes at national level are the following:

Positive definition of benefits

- For people suffering from a “life threatening” disease, defined as patients with certain heart conditions (Ischemic heart disease) or patients suffering from cancer, a maximum waiting time for treatment is defined.
- The county should offer breast examination for women between 50 and 65 years every 2 end. year. The date for implementation however not defined in the law, and only very few counties currently offer mammography screening. (see chapter 8 on preventive services HC 6)
- For patients who have a clinically defined need for rehabilitation at discharge from hospital, a plan for further rehabilitation should be made (see chapter 4 on rehabilitative care HC2).

Negative definition of benefits

- IVF is not allowed for women who are not married or not living with a man, and for women who are over 45 years.
- Free choice of private hospitals (in case of a waiting time for more than 2 month in county hospitals) does not include the following treatments: transplantation, sterilisation, reproductive health, hearing aid, cosmetic surgery, sex change, psychiatric treatment.
- Free choice of private hospitals does not include experimental and alternative treatment or treatment characterised as research.

Alternative treatment and medicine

Normally alternative treatment (defined as a new conventional treatments not documented or not tested in a trial), is not offered in the Danish health care system. However, an exception is made for patients suffering from life threatening cancer. If the traditional treatment protocol seems hopeless, as a last resort, the patient has the possibility of being referred to alternative treatment, either in a Danish hospital or in a hospital abroad.

In order to be referred to alternative treatment, an application (from the patient in collaboration with the clinic treating the patient) has to be sent to the National Board of Health, where an advisory board of specialists will assess these applications. In case an acceptance of the application is given by the National Board of Health, the expenses are covered by a special grant from the government.

Alternative, non-conventional treatment, spa therapy, zone therapy, homeopathy etc. is not included in the benefits package. However, acupuncture is used in eg. obstetric medicines as pain relief during delivery, but is only offered in some counties.

Financial incentives

Another instrument used by the government in order to regulate the benefits offered by the county hospital sector is financial incentives. Generally, the hospital sector is financed by the counties through tax income and through block grants from the state. Annually, there is a negotiation between the counties and the government on the recommended maximum level of county taxes and the size of the block grant from the state. These annual negotiations have increasingly been used by the government as a means to reaching agreement on the development of the health care sector. Special block grants have been given to high priority areas such as *heart surgery* and *cancer treatment*. As a supplement to these grants the National Board

makes recommendations for improving the treatment, expanding the treatment capacity for these areas (“Heart plan” and “Cancer plan”).

Also a special block grant is given to the counties with the aim of increasing the activity in the hospitals in order to reduce waiting lists. These grants are given only to counties that document an increase in activity. The grant is in form of activity based financing with the use of the DRG system. However the following treatments are *not* covered by the additional government grant: *sterilisation, reproductive health, alternative or experimental treatment, treatment for abuse of alcohol.*

Finally a *financial restriction* is imposed on the use of certain private special clinics. For each private hospital/clinic, a limit on the amount that the counties are obliged to pay is determined every year.

The private special hospital/clinics specified, include: *Hospices, epilepsy hospitals, scleroses hospitals, arthritis sanatoriums, brain rehabilitation hospital etc.*

3.1.3.2 County level

The counties can determine the content and cost of hospital activity through use of detailed budgets, enabling them to specify which treatments and what treatment capacity should be offered and also which technical remedies should be bought. So via the supply of hospital services, there is a regulation of the amount and kind of benefits available to the county inhabitants.

In principle, a county council can decide not to offer a certain treatment, for example an expensive medical cancer treatment, or that it will not offer IVF treatment to women who have already had one child by means of IVF treatment. However, the right to free choice of hospital limits this planning mechanism, because if patients choose treatment not covered by their county in another county, their own county has to pay for it.

3.1.3.3 Hospital level

As mentioned earlier, the hospitals and clinical department can determine the services offered by defining indications for treatment, and by deciding on criteria for prioritising between patients waiting for treatment. For example, most plastic surgery departments have a very low priority setting for patients referred (by their GP) to cosmetic surgery, resulting in a waiting time for many years. Or the department may simply have as an indication for treatment that only patients who need cosmetic surgery for mental reasons can be treated.

Special areas: transplantation, haemodialysis

There is no special regulation concerning transplantation and haemodialysis. Counties who do not offer these treatments in their own hospitals refer their patients to other (bigger) counties who have specialised hospitals, and the home county pays for the treatment, according to rules defined by the government.

3.1.4 Classification of benefits (question 7 and 8)

Benefits are uniform to all payers (question 8).

As there is no benefit catalogue in the Danish hospital sector, no benefit classification exists.

However, a number of classifications are used for documentation of the activity in the hospital sector. Most of the classifications are gathered in the “SKS” (Sundhedsvæsenets Klassifikations System). The SKS among other things covers:

- A hospital and clinical department classification (all hospitals and clinical department are identified by a number)
- The diagnosis classification (ICD10)
- Surgical classification (NOMESCO)
- Anaesthetic services
- Nursing activities
- Rehabilitation activities
- Medical procedures
- Etc.

For Laboratory services, IUPAC codes are used, and for pathology services SNOWMED are used.

Not all codes in the SKS are included in the Danish Minimum Basic Data Set (MBDS), and are therefore not mandatory.

The MBDS which contains the information about each patient that has to be recorded by all Danish hospitals, is partly based on the SKS. The basic record unit in the MBDS is a patient stay in/discharge from a clinical department (inpatients) or an episode of outpatient visits (day cases). Since 1974, information including the MBDS, covering all Danish public hospitals, has been gathered in the National Patient Register (“Landspatientregisteret”), which is administered by the National Board of Health.

3.1.4.1 The Danish case-mix system

The Danish case-mix systems for (somatic) care in the hospital sector consists of two classifications systems: The Danish DRG-system (DkDRG) for inpatient care and the Danish Ambulatory Grouping System (DAGS) for day cases (in Denmark day cases are called ambulatory visits). Both case-mix systems have been developed by the National Board of Health in collaboration with the relevant Medical Specialities Associations.

Both systems are currently updated according to the recommendation of the Medical Specialities Associations and according to medical and technological development.

3.1.4.1.1 DkDRG

The Danish Diagnostic Related Groups (DkDRG) are an extension of the Nordic Diagnosis Related Groups (NordDRG). Since 1998, the National Board of Health, in collaboration with the relevant Medical Specialities Associations, has been working on a validation of the NordDRG with the aim of incorporating Danish medical practice in the grouping. The result of this validation is a DRG-system consisting of 589 different groups (2005 version).

The DkDRG consists of 25 MDC (table 1) plus some groups outside the MDC and some groups of oncological treatments (Radiotherapy and Chemotherapy).

The grouping is based on the following patient characteristics:

- Sex
- Age
- Diagnosis (ICD10)
- Surgical Procedure (Nordic Classification of Surgical Procedure)
- Other Procedures (SKS ⁶ (i.e. Radiotherapy, Cardiac procedures such as implantation of Pacemaker, Respiration treatment, Rehabilitation, Mechanical Ventilation)).
- Diagnostic procedures (SKS ⁷ (i.e. CT-scans, Ultrasound, Angiography))
- Discharge status

Table 3: MDC-groups in DkDRG

No.	MDC group	No. of DRGs in the MDC
01	Diseases and Disorders of the Nervous System	37
02	Diseases and disorders of the eye	11
03	Ear, Nose, Mouth, and Craniofacial Diseases and Disorders	30
04	Diseases and Disorders of the Respiratory Organs	39
05	Diseases and Disorders of the Circulatory System	60
06	Diseases and Disorders of the Digestive System	49
07	Diseases and Disorders of the Hepatobiliary System and Pancreas	25
08	Diseases and Disorders of the Musculolettal System and Connective tissue	59
09	Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast	26
10	Endocrine, Nutritional and Metabolic Diseases and Disorders	18
11	Diseases and Disorders in the Kidney and Urinary Tract	39
12	Diseases and Disorders in the Male Reproductive System	9
13	Diseases and Disorders in the Female Reproductive System	10
14	Pregnancy, Childbirth and the Puerperium	8
15	Diseases and Disorders in the Perinatal Period	
16	Diseases and Disorders of Blood, Blood Forming Organs	17
17	Lymphatic and Hematopoitic Malignancies	18
18	Infectious and Parasitic Diseases	15
19	Mental Diseases and Disorders	11
20	Abuse of Alcohol and Drugs	2
21	Toxic effect, Poisonings and other injuries	17
22	Burns	4
23	Rehabilitation, aftercare, Other Factors influencing Health Status and other Health Care Contacts	7
24	Multiple Significant Trauma	4
25	HIV infections	2
	Outside MDC's	46
	Chemoterapy and Radiotherapy	12
	Total	589

⁶ SKS Sundhedsvæsenets Klassifikations System, a Danish klassifikation.

⁷

3.1.4.1.2 DAGS

The DAGS system is developed by the National Board of Health in order to describe ambulatory care in hospitals (day cases) with the inspiration of the APG (Ambulatory Patient Group-system). The case-mix system divides visits into three major types of visits:

1. Ambulatory visit
2. Emergency visit
3. Telephone consultation

Ambulatory visits are further divided into the following main categories (2005 version):

- Visits for patients with certain specified diagnosis (5 groups):
 - Cancer
 - HIV
 - Complex chronic pain disorders
 - Simple chronic pain disorders
 - Neurology

- Visits where a certain specified procedure has been carried out (78 groups):
 - Procedures of the Skin (9 groups)
 - Procedure of the Musculolettal System (3 groups)
 - Procedures of Respiratory organs (2 groups)
 - Procedures of Cardiac or Lymphatic system (1 group)
 - Procedures of Digestive System (7 groups)
 - Procedures of Urinary Tract (5 groups)
 - Procedures of the Male Reproductive System (1 group)
 - Procedures of the Female Reproductive System (4 groups)
 - Procedures of the Nervous System (3 groups)
 - Procedures of the Ear, Nose, Throat (3)
 - Other tests and procedures (1 group)
 - Miscellaneous treatments (12 groups)
 - Miscellaneous diagnostic procedures (19 groups)
 - Radiological procedures (8)

- Other visits (none of the specified diagnosis and procedures)

For references and further information about the Danish case-mix system, see www.sundhedsstyrelsen.dk, Takstsystem 2005. Vejledning. Sundhedsstyrelsen 2005.

3.2 Out-patient care (HC 1.3)

OECD Functional Classification of Health Care Definition:

This item comprises medical and paramedical services delivered to out-patients during an episode of curative care. Out-patient services comprise mainly services delivered to out-patients by physicians in establishments of the ambulatory health care industry.

3.2.1 Introduction

Out-patient health care services in Denmark are regulated by the Public Health Insurance Act and the Act on Public Dental Care (LBK 1261 15.12.2003). The former law regulates access and services (reimbursements) partly by specific provisions partly by authorising the Minister for the Interior and Health or a ministerial board to formulate provisions in government notices. The Public Health Insurance Act together with a number of ancillary, specific laws, constitute the legal basis of the Health Care Reimbursement Scheme in Denmark.

The Public Health Insurance Act encompasses basic medical and diagnostic services (provided by GP's), specialist health services (provided by specialist doctors) [HC 1.3.1], dental services by dentists [HC 1.3.2], chiropody, psychology treatment, chiropractic services, and physiotherapy [HC 1.3.3], and reimbursement for spectacles, tube nutrition, transportation, travel insurance, and burial help [HC 1.3.9]. Public dental care [HC 1.3.2] is provided according to a specific law. All of these out-patient services are regulated as part of the Health Care Reimbursement Scheme, and therefore the description following the OECD functional classification has been compiled into one description of out-patient services.

The Danish legislation is detailed, explicit and very specific regarding benefits within out-patient services. The following sections describe the main lines of the Health Care Reimbursement Scheme. In the appendices to this report, an overview of each legal document is provided with regard to benefits. In Chapter 9, an analysis of the Health Care Reimbursement Scheme Fee Schedule is given.

3.2.2 Roles of actors responsible for defining benefits (question 5)

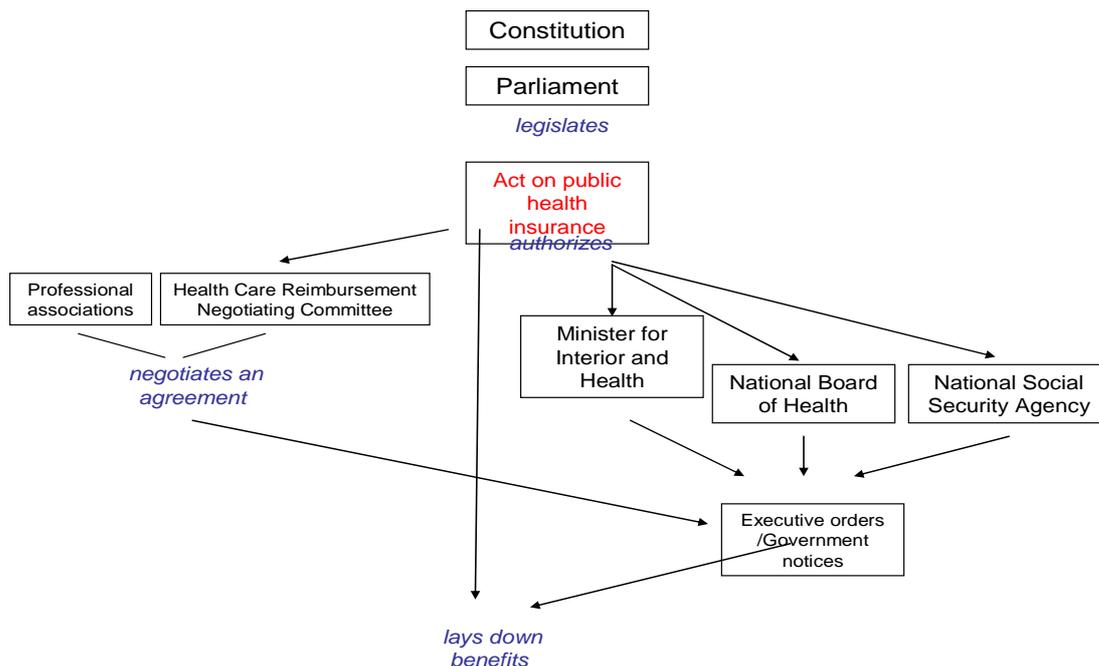
The main actors in the Health Care Reimbursement Scheme are:

The Minister for the Interior and Health, the counties, the Health Care Reimbursement Negotiating Committee, the health professional associations (health personnel trade unions), and a number of privately practising providers. Of these, the GP is central as the gatekeeper who is responsible for referring patients to most of the practising specialist doctors and to other parts of the health care system.

The Government is involved in decision-making concerning the Health Care Reimbursement Scheme in an indirect way as *the Minister for the Interior and Health* according to the Public Health Insurance Act has to approve all negotiated agreements between the Health Care Reimbursement Negotiating Committee and the health personal trade unions.

The *Health Care Reimbursement Negotiating Committee* is set up by the law to negotiate agreements with the health personnel trade unions on behalf of the counties. Its members are representatives for the counties. The agreements have to be approved by the Minister for the Interior and Health.

HC 1.3. Out-Patient Care



The county is responsible for the provision and financing of the publicly covered services.

The law prescribes that the county every four years in its health plan has to describe the following that has relevance to out-patient care:

- premise of the plan (including health status in the county)
- supply of health service, prevention
- co-operation between GP's, specialists, dentists etc.
- co-operation with municipalities
- ambulance services and local emergency services.

Out-patient care is provided by *hospitals as ambulatory care* (see description of HC.1.2 in previous sections) and *by a number of providers* within the primary health sector. The care is provided by independent tradesmen (general practitioners, specialist doctors, dentists, practising physiotherapists etc.) who are paid for their services, partly by the patients partly by the county (according to negotiated fees).

The benefits are either determined by a law, by agreements between the counties and the health personnel trade unions approved by the Minister for the Interior and Health, or by a government notice. The Health Care Reimbursement Scheme Fee Schedule contains the negotiated tariffs used (see Chapter 9) for reimbursement of providers. This fee schedule can to some extent be regarded as a benefit catalogue, as it may contain financial incentives indirectly influencing the health services and thus benefits provided to patients.

3.2.3 Definitions of benefits (question 6)

The Public Health Insurance Act states that primary health care is available to everyone with a permanent address in Denmark (with certain exceptions). Everyone has to choose between

insurance group I and II with a trade off in terms of free choice of provider and size of reimbursement.

Persons in group I, including more than 95% of the population, are entitled to free services from GP's and partial reimbursement of dentist services, physiotherapy treatment etc.

Persons in group II, including less than 5% of the population, have a wider choice of providers but are less entitled to receive reimbursement.

Everyone receives a personal card that proves entitlements to the services, and contains a personal identification code (CPR) which makes it possible to trace each individual service to the individual patient.

The benefit basket with regard to out-patient services is explicit and contains a number of services.

Some are very specific (e.g. a specific maximum amount in DKK for spectacle lenses and spectacle frames or specific dental services), while others are defined in more general or vague terms (e.g. per cent reimbursement of negotiated fee for physiotherapy treatment, or per cent reimbursement of negotiated rates of treatment by a dentist).

Some benefits are positively listed (e.g. spectacle lenses and frames), some are negatively listed (e.g. a number of treatments is excluded from (and others included in) reimbursement of the public travel insurance benefits).

Some benefits are listed as an enumeration of services (e.g. dental services); some are linked to specific conditions (e.g. a referral from a GP for physiotherapy treatment).

Some services are free-of charge for the patient (services by GP, ear-throat nose doctor, eye doctor, psychiatrist etc.) some are only partly covered by public funds (e.g. dentist services,) and some are regulated by the legislation but not included in the benefit basket, unless certain specific criteria are fulfilled (e.g. psychologist counselling, physiotherapy, chiropractic services).

It should be noted that other parts of Danish Law – the Active Act and the Act on Pensions – provide supplementary reimbursement of services which are subject to co-payment according to the Public Health Insurance Act. The criteria for receiving extra reimbursement are that the services shall be partly reimbursed under the Health Care Reimbursement Scheme and recipients must only have a certain income, e.g. be on pension. This is valid for specific out-patient services and medicines, but is only described here.

Alternative care is – with a few exceptions mentioned under the sections on in-patient care – not included in the Danish health basket.

Below some of the benefits available to the citizens with regard to out-patient services have been outlined.

When nothing else is said in the following text, “the law” signifies the Public Health Insurance Act.

3.2.3.1 Benefits regarding general practice

The free access to general practitioner services is described in a government notice (BEK 180 18.03.2003) with reference to a negotiated agreement between the counties (Health Care Reimbursement Negotiating Committee) and the Danish Medical Association. Type and amount of GP services are not specified in the legislation, but in the agreed fee schedule updated every 6 month, there is a specification of services. Group I persons are entitled to free services of a practising specialist provided there is a referral from a GP.

3.2.3.2 Benefits regarding dentist services

Reimbursement of dentist services is mentioned in the law but determined by the Minister for the Interior and Health after having discussed the matter with the National Board of Health. A specification of reimbursed services is given in a notice from the Minister for the Interior and Health (BEK 147 06.03.2004). Further specification is provided in the negotiated agreement between the Health Care Reimbursement Negotiating Committee and Danish Dental Association.

There is significant patient co-payment for dentist services.

As to dental care, there are exceptions to the co-payment rules in other parts of Danish law. The municipalities shall supply free dental care for particular vulnerable groups, such as children at school age people with reduced mobility, and physically and mentally disabled (LBK 1261 §4). This includes dental care for the elderly in the municipality. The counties provide specialised treatment to those who cannot use the services of the municipality due to mental disability (LBK 1261 §6a). In addition to this, the county shall supply dental treatment for patients with rare diseases or disabilities, and to cancer patients who due to chemotherapy or radiation treatment have dental problems (LBK 1261 §6c-d). These two groups will receive reimbursement from the National Health Reimbursement Scheme (LBK 1261, §6f). The county can decide to demand user payment, but the maximum amount is stated in the law (BEK 1073 §15)

3.2.3.3 Benefits regarding tube feeding and nutritional preparations

Reimbursement of tube feeding and nutritional preparations prescribed by a doctor is mentioned in the law but determined by a notice from the Minister for the Interior and Health (BEK 531 18.06.03).

3.2.3.4 Benefits regarding physiotherapy treatment (outside hospital)

According to the Public Health Insurance the Health Care Reimbursement Scheme reimburses part of physiotherapy treatment if the patient has been referred by a GP (§9). Reimbursement is further specified in a notice (BEK 405 18.05.01). This entitles patients with specific diagnoses, such as inflammatory muscular-skeletal conditions, to free physiotherapy (§7) (see chapter 4 on rehabilitative care).

Otherwise conditions of reimbursement are stated in the negotiated agreement between the Health Care Reimbursement Negotiating Committee and Association of Danish Physiotherapists.

If physiotherapy treatment provided on an out-patient basis by a privately practising physiotherapist (or other paramedic services for that matter) takes place as part of or following a hospital treatment, the treatment is fully covered according to the Hospital Act.

3.2.3.5 Benefits regarding out-patient mental care – psychiatrists and psychologists

Consultations by a psychiatrist are fully covered by the Health Reimbursement Scheme upon a referral by the GP. Psychiatrists are reimbursed for consultations (first consultation, second consultation, later consultation, telephone consultation, consultation with next-of-kinds), psychotherapy with 1-6 persons and talk therapy (children and youth).

Reimbursement of doctor prescribed visits to a psychologist for specially exposed groups of persons is mentioned in the law but determined by a notice by the Minister for the Interior and Health (BEK 472 18.06.02). Conditions for reimbursement are stated in the negotiated agreement between Health Care Reimbursement Negotiating Committee and The Danish Psychologist Association.

Reimbursement is offered for psychological services by a psychologist when a person has been subject to a crime (robbery, assault, and rape), a traffic accident, a serious mental illness of a close relative, an invalidating disease, death of a relative, an attempt at suicide, or women having an induced abortion after 12th week of pregnancy.

These services are however, not fully covered. There is a patient co-payment.

Treatment of general depressive symptoms through counselling/cognitive therapy by a psychologist is thus not included.

There are special reimbursement rates for visits. All services are included in the benefit basket upon GP referral.

3.2.3.6 Benefits regarding chiropody

Reimbursement of doctor prescribed chiropody is mentioned in the law but determined by a Minister for the Interior and Health notice (BEK 129 18.03.02). Conditions of reimbursement are stated in the negotiated agreement between Health Care Reimbursement Negotiating Committee and National Association of Danish Podiatrists.

Reimbursement is offered the patient, when he has been referred by a medical doctor to a chiropodist, and has had treatment in relation to diabetes, an ingrown toe nail or cicatricial tissue due to radiation treatment.

The services are not fully covered.

3.2.3.7 Benefits regarding chiropractic treatment

Reimbursement of chiropractic treatment is mentioned in the law but determined by a notice from the Minister for the Interior and Health (BEK 181 22.03.04). Conditions of reimbursement are stated in the negotiated agreement between the Health Care Reimbursement Negotiating Committee and the Danish Chiropractors Association.

The notice describes the reimbursement (in DKK) for chiropractic clinical basic service at first visit, at later visits, X-ray examinations and supplementary services. The services are only partly covered but a GP referral is not needed to receive reimbursement.

3.2.3.8 Ophthalmologists (eye doctors)

Practising ophthalmologists are reimbursed for consultations (first consultation, later consultation, and telephone consultation), examinations and operations. The 5 reimbursed examinations are: orthoptic assessments diagnose and control of retinal detachment change in diabetes, and examinations for glaucoma, automatic perimetrical examination, and measuring individual weak-sight optics. For the first respectively following operation the ophthalmologists are reimbursed for 18 types of operations, and for biopsy, fundus photography and fluorescein angiography.

There are special reimbursement rates for visits. The services are fully covered by public funds and there is direct access (no GP referral needed).

3.2.3.9 Otorhinolaryngologist (ear-nose-throat doctors)

Practising otorhinolaryngologists are reimbursed for consultations (first consultation, later consultation, and telephone consultation), 21 examinations (allergologic and skin, calorimetric examinations of sense of equilibrium, audiometric examinations, bronchoscopy, stroboscopy, acoustic rhinometry, voice analysis, fine-needle biopsy, adjustment of hearing aid) and 39 operations (tympanostomy, paracentesis, myringoplasty, removal of mucous polyp(us),sinoscopy, treatment of nose fracture, antrostomy, tonsillectomy, removal of tumour, and operation for jug-ears).

There are special reimbursement rates for visits. All services are included in the benefit basket and no GP referral is needed.

3.2.3.10 Dieticians

Services by privately practising dieticians are not part of the health basket, unless the services are provided as part of a hospital treatment. (www.diaetist.dk/tilskud).

3.2.3.11 Benefits regarding other specialists

Other specialists whose services are fully part of the benefit basket upon GP referral include: anaesthetists, specialists in dermatology and venereal diseases, specialists in diagnostic radiology, gynaecologists, obstetricians, specialists in medicine, practising surgeons and biochemists, neurologists, orthopaedics, pathological anatomy, specialists in plastic surgery, paediatricians, rheumatologists, specialists in tropical medicine, specialists in laboratory examinations, specialists in social medicine.

Benefits with regard to the services of these specialists are implicitly defined in the fee schedule. This schedule has been analysed in Chapter 9.

3.2.4 Classification of benefits, uniformity for payers (question 7 and 8)

Benefits are classified in a number of ways. Some are defined as service delivered (e.g. dentist services), some by individual good (e.g. spectacle lenses and frames), some by diseases (e.g. chiropractic services), some are not classified (e.g. medical services), some by expenses paid by the patient in a period (e.g. pharmaceuticals).

All primary health care benefits provided by the public health care system in Denmark are uniform i.e. access and supply of services is open for all residents. Choice of doctors to visit is determined by the chosen health insurance group. Supply of practising doctors and practising specialists in terms of number, localisation and speciality are decided by a committee set up by the Health Care Reimbursement Negotiating Committee and Organisation of General Practitioners in Denmark.

3.3 Services of curative home care (HC 1.4)

Both the Hospital Act and the Public Health Insurance Act contain provisions for curative home care. As previously explained, the Hospital Act is a legislative frame delegating treatment responsibility to the counties. In practice, some counties offer care at the patient's home by visiting health professionals, but to some extent these services may be perceived as long-term care, e.g. visiting oxygen nurses to patients with COPD (see the next chapter). The Act on Maternity Care provides a specific entitlement for the pregnant woman to give birth to the baby at home. The Public Health Insurance Act and the adherent legislative frame and contracts, e.g. agreements and the fee schedule, provide for home consultations by e.g. the GP, both on an emergency and non-emergency basis. This benefit is for patients who are considered not to be able to come to the GP consultation on their own e.g. impaired people or persons that have a (serious) acute disease but not serious enough to need an ambulance. Furthermore, GP telephone consultations are part of the benefit in general practice and widely used.

There are specific provisions with regard to home nursing by municipal nurses. (see chapter 5 on long-term care).

4 Services of Rehabilitative Care (HC 2)

OECD Functional Classification of Health Care Definition:

This item comprises medical and paramedical services delivered to a patient during episode of rehabilitative care. Rehabilitative care comprises services where the emphasis lie on improving the functional levels of persons served and where the functional limitations are either due to recent event of illness or injury or of recurrent nature (regression or progression).

Included are services delivered to persons where the onset of disease or impairment to be treated occurred further in the past or has not been subject to prior rehabilitative services. Rehabilitative care is more intensive than traditional nursing facility and less than acute (curative) care. Requires frequent patient assessment and review of clinical course and treatment plan for a limited time period, until condition is stabilised or a pre-determined treatment course is completed.

4.1 Introduction

According to the legislation, “rehabilitation” is aimed at patients or citizens with temporary or permanent (chronic) impairment, that is with decreased physical or mental functional capacity and ability to perform activities of daily living.

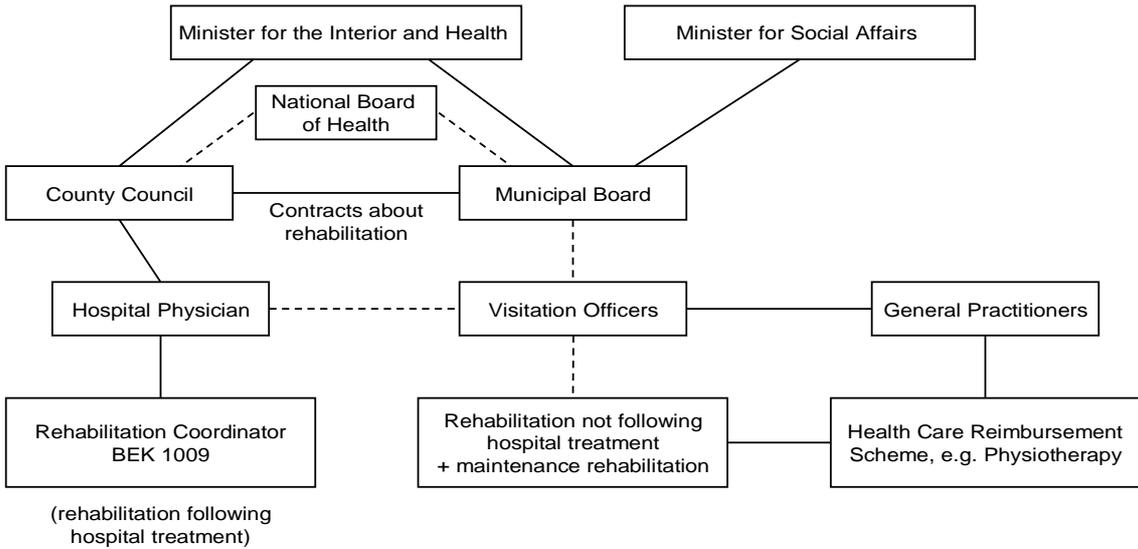
Entitlements are described in the Social Services Act and for in-patient rehabilitative care, in the Hospital Act. For ambulatory care, entitlements and benefits are part of the Health Care Reimbursement Scheme and described in the adherent legislation. These laws make the following distinction regarding entitlements to rehabilitative care:

- Rehabilitative care needed to improve functional capacity and ability to perform activities of daily living, *as part of – or following –* a hospital treatment (in-patient or day case). In this case, the hospital doctor undertakes the needs assessment. The hospital – that is the county – is responsible for the provision and finance of the services.
- Rehabilitative care needed to improve or maintain functional level and ability – *not following* a case of hospital treatment. The citizen’s municipality is responsible for the provision of the services. There is a user co-payment if the impairment is not permanent.
- Rehabilitative care or maintenance needed *to prevent deterioration of the current condition* with decreased physical or mental functional capacity. The citizen’s municipality is responsible for the provision of the services. The municipality will also finance the services if the condition is permanent. If it is a temporary condition there is a user co-payment.

Many decision-makers and authorities are responsible for providing and financing rehabilitative care services. Two ministries, the Ministry of the Interior and Health, and the Ministry of Social Affairs are responsible for legislation and for monitoring the quality of the services. Practice in Denmark shows that it is difficult with the current division of labour to co-ordinate

rehabilitative care so that the patient receives proper rehabilitation. Often he “falls between” two chairs, between the county services and the municipal services, and is sent from one authority to the other (“Mellem 2 stole”, Sundhedsministeriet 1994). Counties and municipalities try to improve their performance in this area through contracting specific rehabilitating services to ensure a proper rehabilitation course for the patient. However, not all authorities have signed contracts, and the contracts available differ to a great extent regionally, depending on local supply of rehabilitation services available. (See discussion in Chapter 10).

Rehabilitative Care HC 2



In the sections below, there will be one description for in-patient and day cases of rehabilitative care, one for out-patient, ambulatory and rehabilitative home care.

4.2 In-patient and day-cases of rehabilitative care (HC.2.1 and 2.2)

4.2.1 Actors responsible for defining benefits (question 5)

Entitlements with regard to in-patient rehabilitative care are regulated as in-patient curative care. In-patient rehabilitative care should take place as part of the hospital treatment, and be undertaken upon a clinical needs assessment by a hospital doctor.

The legal basis for this entitlement is the Hospital Act (LBK 766), § 5 (right to free hospital treatment). The articles §§5 b and 5g regarding free choice of hospital is also valid for rehabilitative care and entitle patients to choose another hospital to provide rehabilitation, e.g. after an operation. If the rehabilitation is a natural consequence of the treatment at another hospital this hospital shall provide the services (VEJ 9292 p.6-7). However, if the patient wishes rehabilitation in his own county, the two counties shall make an agreement about the service, and the patient’s own county has to provide the rehabilitative care needed. The decision-making process regarding in-patient rehabilitative care is described in chapter 3 on in-patient curative care.

The Hospital Act (LBK 766) §5 f authorises the Minister for the Interior and Health to impose on the county to provide a written rehabilitation plan to patients at the time of discharge based on a clinically assessed/justified need for rehabilitation.

The government notice (BEK 1009 of 01/06/2004) obliges the hospital (the county) to provide a plan for the rehabilitation of a discharged patient including when the training is to start, where it shall take place, and the name of a contact person who will co-ordinate activities between the hospital and the municipality in which the patient resides.

If day cases of rehabilitative care take place as part of or following a case of hospital treatment and aims at improving the patient's functional capacity, and ability to perform activities of daily living, entitlements are regulated as in-patient rehabilitative care (LBK 766) , but may be provided on a day case basis.

4.2.2 Definition, classification of benefits, uniformity for payers (question 6-8)

The entitlement to in-patient rehabilitation is explicitly described, but is also vague, leaving the specific benefit up to the needs assessment by the hospital physician, the contact person (rehabilitation coordinator) and to the GP. Payments are uniform for all payers. There is no classification of in-patient rehabilitative services.

4.3 Out-patient rehabilitative care and rehabilitative home care (HC 2.3 and 2.4)

4.3.1 Actors responsible for defining benefits (question 5)

If out-patient care takes place following a case of hospital treatment, it is regulated as in-patient rehabilitative care and is the responsibility of the *hospital /county*, until a *physician* assesses that the patient's level of functioning has sufficiently improved. In this case, the actors are the same as for in-patient rehabilitative care.

Other benefits regarding out-patient rehabilitative care appear from the Social Services Act, that is rehabilitative care needed for maintenance of functional level, or prevention of deterioration (§67, §71, and §73), or in case of a patient who has not been treated in a hospital, but still in need of rehabilitation (§73, a). In these cases, the *municipality* is the principal actor and has the responsibility for providing the services and also financing if patient has a permanent impairment. The Minister of Social Affairs monitors the services and is authorised by this Act to issue more specific laws. The municipality has its own visitation officers assessing the need for this type of rehabilitation. Often the GP is consulted and sends a recommendation to the municipality who then makes the final decision about the allocation of the service on an individual basis (§75 + § 75, 3) and sends a settlement in writing to the citizen (§75, 2)

The providers of municipal rehabilitative services may be ergo therapists, physiotherapists, a nurse etc. They may be directly employed by the municipality or be part of the Health Care Reimbursement Scheme, but if they are ordered by the municipality to perform the services, the responsibility for the services lies with the municipality and not with the county.

If rehabilitative services are performed by a privately practising physiotherapist, an ergo therapist or another paramedic regulated under the Health Reimbursement Scheme the rules and reimbursement, and actors follow this scheme.

4.3.2 Definition, classification of benefits, uniformity for payers (question 6-8)

In the Social Services Act, benefits are explicitly described, and “classified” according to need for rehabilitation (e.g. maintenance, improvement, prevention of deterioration, following- or not following hospital treatment). However, again the benefits are vaguely described, leaving the final decision about which service to allocate to the impaired, to the municipality and the GP.

In general, rehabilitation under §§ 71-73 of the Social Services Act are free of charge if the impairment is permanent. Furthermore, specific laws positively define a number of diagnoses, and types of impairment which will lead to free rehabilitation.

In BEK 405 (18.05.2001) on free physiotherapy and in adherent guidelines, benefits are both explicit and very specific including patients with a severe impairment and specific diagnoses, and are positively defined. As to rehabilitative home care, it can be provided upon indication. In the notice, there are rules as to the physiotherapist receiving reimbursement for transport costs. For instance, if she is to treat two family members she will only receive one “distance fee”.

BEK 882 of 17.12.1991 specifically lays down the entitlements and actors with regard to rehabilitation at the Karlslunde Rehabilitation Center. Again benefits are positively defined and classified according to diagnoses and types of impairment. The notice only concerns the counties that have an agreement with the Karlslunde Center.

The patient/citizen has a right to free choice of provider according to the Social Services Act. This is not the case however, for person residing in institutions, e.g. mental nursing homes. (see chapter five on long-term nursing care).

If the impairment is not permanent, there is a patient co-payment for municipal services, and for physiotherapy etc. under the Health Reimbursement Scheme. The co-payment for municipal services depends on the person’s income. Under the Health Reimbursement Scheme, physiotherapy is not free-of-charge, unless the patient falls under the criteria in the notice BEK on free physiotherapy.

For rehabilitation undertaken by “home nurses”, see next chapter on long term nursing care at home.

5 Services of Long-Term Nursing Care (HC.3)

OECD Functional Classification of Health Care Definition:

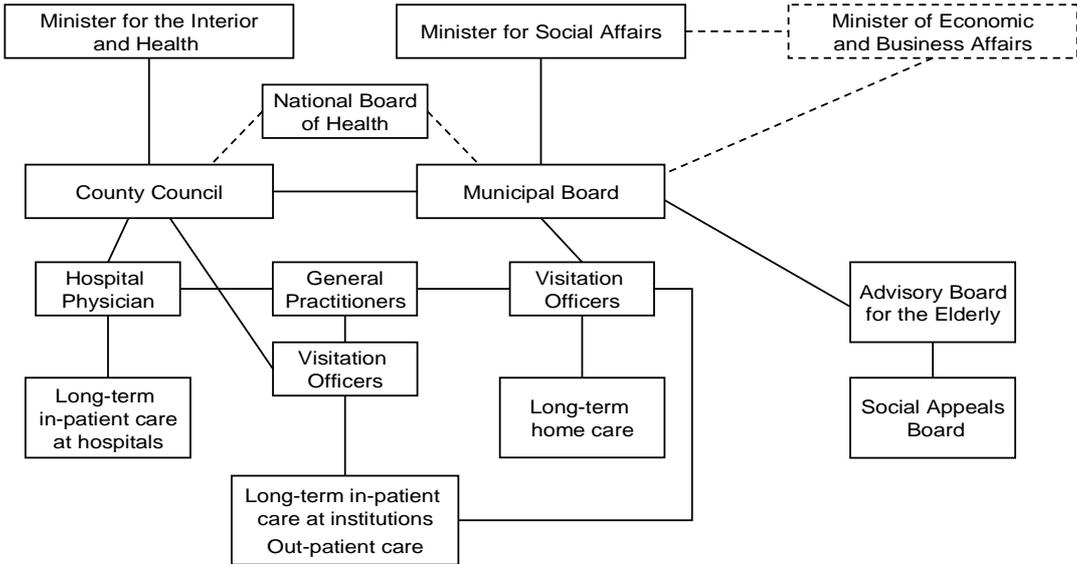
Long-term health care comprises ongoing health and nursing given to in-patients who need assistance on a continuing basis due to chronic impairments and a reduced degree of independence and activities of daily living. In-patient long term care is provided in institutions or community facilities. Long-term care is typically a mix of medical (incl. nursing care) and social services. Only the former is recorded in the System of Health Accounts under health expenditure.

5.1 Introduction

Long-term nursing care in Denmark is regulated in the legislation on health care, social care and – indirectly – housing. The responsibility for providing and purchasing the services lies with the counties as far as long term-medicine, specialised nursing care, (both in- and out-patient, and some home care) for the mentally and physically disabled are concerned. The municipalities are responsible for providing the less specialised in-patient and out-patient long-term care and long-term home care by nurses. The municipalities typically care for the elderly who requires general, not-specialised care. However, the borderline between the county’s and the municipality’s responsibility is drawn on a case-to-case basis.

The actors and decision-making process are illustrated in the diagram below:

Long-term Nursing Care HC 3



The area is supervised by three different ministries; the Ministry of the Interior and Health, the Ministry of Social Affairs, and – indirectly – the Ministry of Economic and Business Affairs (responsible for Housing). The respective ministers are authorised by the laws to set rules in the area, e.g. with regard to payment of the services.

Historically, there is a tendency to draw long-term medicine away from the hospitals, reduce the number of institutions, e.g. nursing homes, and to a larger extent provide protected housing and community housing where the elderly and impaired is a tenant and not a patient. “Home” in this case may be a protected home with facilities to care for and assist the physically or mentally impaired with activities of daily living.

The roles and responsibilities of the different actors have been described under each sector.

5.2 In-patient Long-term nursing care (HC.3.1)

5.2.1 Actors responsible for defining benefits (question 5)

5.2.1.1 Long-term in-patient hospital and hospice care

Long-term in-patient care and long-term mental treatment in hospitals are regulated in the Hospital Act and the guidelines (RTL nr. 103 of 08/06/1971). This includes hospice care. Thus, the actors in the decision-making process are the same as in curative in-patient services. (see chapter 3).

The Minister for the Interior and Health is authorised to issue specific laws, and does so on an ad hoc basis. The National Board of Health has a supervisory role, and is responsible for issuing guidelines and reference programmes regarding recommended treatment and organisation of the services.

Hospice care is provided by five private not-for profit institutions with a total of 57 beds and one palliative medical department at a public hospital. Furthermore, one hospice has a home hospice arrangement to provide the palliative care at the patient’s home.

The patients’ need for hospice care is assessed by the GP or the hospital physician and these actors and the patient himself or his family apply for admission to the hospice.

5.2.1.2 Traditional nursing homes versus modern nursing houses

Long-term nursing homes and care in protected homes are regulated in Social Services Act and adherent guidelines. Furthermore, a number of laws on housing apply.

There is a move away legally speaking from the institution-based long-term care provided in traditional nursing homes for the elderly, to “modern nursing homes”, defined as houses for the elderly with extended nursing, care and service functions available and accessible.

In 1987 (Act on Housing for the Elderly), the legal basis for housing of the elderly was transferred from the Ministry of Social Affairs to the Ministry of Economic and Business Affairs. This Ministry then became responsible for ensuring a sufficient supply of improved and bigger houses for the elderly and weak. Furthermore, an extended legal provision for home care

and nursing, and out-patient long-term care was provided in the Social Services Act which entered into force in 1998 (first version).

In the “modern nursing houses”, the resident is a tenant with a possibility of public reimbursement of the rent based on income, and with an increased supply of care and service functions provided by the municipality on the basis of an individual needs assessment. This means that the elderly and impaired citizens to a large extent can stay in their own homes.

However, traditional nursing homes still exist, although in a decreasing number. The Social Services Act §140 is a transitional clause stating that the county and the municipality operate the existing nursing homes. The interpretation of this vague formulation is that implicitly, the municipalities run the existing nursing homes for the elderly requiring general care and the county the specialised institutions for impaired requiring specialised care⁸. The latter are described in the next section.

The Minister of Social Affairs sets rules, e.g. payment rules, including user co-payment rules. Furthermore, the Ministry sets quality standards for the services and monitors the quality. The municipality/county has to report about the quality annually to the Ministry.

The municipality is responsible for referring the citizens in need (BEK 512 §3) to a suitable dwelling. The municipality sets the referral criteria according to local circumstances, e.g. the types and number of suitable dwellings available locally and the possibilities for providing help in the citizen’s own home. Further to this, the municipality undertakes an individual needs assessment based on the applicant’s ability to perform activities of daily living and his mental and physical level of functioning. The needs assessment is usually performed by the municipalities’ own visitation officers and /or the GP. It may also be that the municipality decides to make changes in the person’s own home so that he/she can stay there despite his impairment, (Social Services Act §102), instead of referring him/her to an institution.

The municipality is responsible for supervising the nursing homes and to react if the running of the nursing home is not consistent with municipal policies and with the goals and standards set by the municipality in collaboration with the Residents and Family Advisory Board.

Each *municipality* should establish an Advisory Board for the Elderly (“ælderåd”) consisting of representatives of the citizens aged 67 years or more. The board is responsible for supervising the services, including the long-term care services, offered for the elderly. It also deals with complaints about municipal decisions and settlements. People under 67 years of age can complain about municipal settlements to the Social Board (“Sociale nævn”) and in the last resort, the Social Appeals Board (“Sociale Ankestyrelse”).

Each *county* should establish an Advisory Board for the Users (“brugerråd”). This board handles complaints about county decisions (Act on Protection of Rights in the Social Sector). So there is a double control function both locally and centrally by the Ministry. This is valid for all services provided by the municipality under the Social Services Act, but is only described in this section.

⁸ Personal communication with Claus Camillus, Municipality of Vallensbaek.

5.2.1.3 In-patient long term care for mentally handicapped, physically handicapped, and psychiatric nursing homes, substance abusers etc.

While the traditional nursing homes are mainly for the elderly impaired, the modern nursing houses and other protected housing and institutions are for both the elderly, and the mentally and physically handicapped and substance abusers, of all ages.

The regulation in this area is mainly described in the Social Services Act and the adherent guidelines for social services for the different target users (old, young, adults, substance abusers etc.). The responsibility for this type of in-patient care is divided between the county and the municipality: the county provides and finances the most specialised care for mentally and physically handicapped, substance abusers and mentally afflicted patients (§§ 92 and 93) , and the municipality the less specialised care. The specific division of labour between the two authorities depends on local conditions, history and institutions available and there is great regional variation in the interpretation of the law. The municipality assesses the need for specialised in-patient long term care and sends an application to the county on behalf of the citizen.

According to the Social Services Act the *county* is responsible for providing a sufficient number of institutions and in-patient temporary or permanent places for

- children and young people “with social problems and considerable and permanently or temporarily reduced mental or physical level of functioning” who for that reason are not able to stay in their own home. (§ 51)
- substance abusers to be treated. The places shall be provided within two weeks from the application (§ 85)
- persons who need specialised long-term care and ADL training and assistance which cannot be provided otherwise and elsewhere (e.g. under the auspices of the municipality). This includes care for mentally and physically handicapped persons and for mentally afflicted persons who need permanent care (§ 92) or temporary care until their situation is stabilised. (§ 93 art.2)

In the decision about the application from the municipality, the county will take the level and type of specialised care applied for into account. In all cases, the responsibility always lies with the county if the cost of care exceeds DKK 635,000 per year. (§93, art.3)

The *municipality* can offer temporary stays in institutions for persons with reduced physical or mental level of functioning (§ 91). So the final division of labour and responsibility in this area is decided on an ad hoc basis, but may be specified to certain types of in-patient homes in notices issued by the Minister of Social Affairs.

Finally, *the state* operates and finances a number of institutions for mentally retarded people.

5.2.2 Definition and classification of benefits, uniformity for payers (question 6-8)

The Hospital Act (§5), states that all citizens in the county are entitled to free hospital treatment provided by the county. This includes all long-term care provided at the hospitals, including long-term palliative and mental care. § 5 no. 3 furthermore states that the county entitles citizens to treatment at specific and named private hospitals, including three hospices, epilepsy hospitals, arthritis sanatoriums, sclerosis hospitals etc.

The legislation on free choice of hospitals is also valid for hospice care, which means that the patient can apply for hospice care where in the country he wishes, that is, if there are such facilities available.

Although the entitlements to in-patient long term hospital care and hospice care are explicitly mentioned in the Hospital Act, they are still rather vague:

In a notice, BEK 627 of 20/06/2004 to enter into force on Jan. 1, 2005, the duty of the county council to provide free treatment at specific private hospitals including a number of hospices, is limited to a certain, specific financial frame.

This means in practice that although the entitlement to hospice care is explicitly stated in the law, not all patients in need for hospice care can be referred to a hospice unless they can pay for the stay themselves. They are instead referred to a waiting list or to other forms of terminal care, e.g. home care for the incurably ill or dying (see section on long-term home care).

The referral criteria for hospice care are set explicitly by the individual hospice, but are usually that the patient shall be incurably ill or dying, and that a physician shall assess whether this is the case or not.

The "classification" of benefits is based on the patient's individual need assessed by a physician, and is then implicitly linked to the patient's condition /indication.

5.2.2.1 Nursing homes

Generally, citizens residing in long-term care institutions and "modern nursing houses" have the same entitlements to health care as all other citizens in Denmark according to the Hospital Act and the Health Care Reimbursement Scheme. Thus, a citizen in a nursing home has his own GP for instance. They have the same entitlements to care and personal assistance laid down in the Social Services Act (§65 and §§ 71,72, 73) as persons staying in their own homes (see sections on out-patient and home long term care) and the need and care allocated will be based on an individual needs assessment. According to §75, the residents in nursing homes shall be informed about the municipal decision in writing and receive a plan for the total care and assistance to be provided. The plan is to be elaborated by the applicant, nearest family and the GP in collaboration.

Furthermore, the residents receive accommodation, meals, heat, laundry services, cleaning and other services (BEK 512 §5).

Referral criteria for nursing homes and housing with special care facilities depend on the local situation and the institutions and housing available. When assigning a person to a specific type of housing, the municipality looks at the level of functioning and ability to perform activities of daily living. Also the municipality shall consider the spouse and or family referring to housing so that to the widest extent possible, the spouses stay together (if they wish so). There is a right to move from nursing homes in one municipality to another, if the person then comes closer to his family.

Nursing homes for the weak elderly are not fully covered in the health basket, there is a certain user co-payment for accommodation and meals. (Social Services Act § 118).

There are waiting lists for many of the traditional nursing homes and the municipality sets the final priorities to choose between persons on the waiting list.

5.2.2.2 In-patient long term care for mentally and physically handicapped, substance abusers and mental nursing homes, substance abusers etc.

Entitlements and to some extent benefits are explicitly and positively described in the Act of Social Services and are specific with regard to age groups, user co-payment, and finance rules. Otherwise, they are vague with regard to referral criteria as this is up to the organisation responsible locally, the county and the municipality, to interpret what is meant by need and to decide the type of housing and care to be allocated to the person.

As a general principle, persons with a considerably reduced ability to perform activities of daily living and a reduced mental or physical level of functioning of a nature which makes it impossible to live in their home, are entitled to be admitted to long term in-patient care institutions. This both includes temporary and permanent mentally unstable conditions and physical impairment. The exact housing and care is allocated on the basis of an individual needs assessment by the municipality and for the more specialised types of housing and care, the county.

Benefits are “classified” in the Act of Social Services according to user groups e.g. children, adults, substance abusers, elderly (+67 year of age) and according to the administrative unit responsible for providing and financing the service.

The definitions of entitlement, benefits and payment rules are uniform by all payers. As to payment rules, the exact amount to be paid by each payer, the municipality or the county, in Danish Kroner are stated. Also the absolute limit amounts in Kroner to the municipality’s financial burden is stated and the relative financial burden in percent of the cost of a certain service to be charged to the municipality, the county and the state. The Minister of Social Affairs defines these rules.

5.3 Day cases of long-term nursing care (HC. 3.2)

5.3.1 *Actors responsible for defining benefits (question 5)*

Day cases of long-term nursing care or out-patient long-term care to patients who need assistance on a continuing basis due to chronic impairments and a reduced degree of independence and ability to perform activities of daily living are regulated in the Social Services Act.

Furthermore, the responsibilities, decision-making process, and entitlements are described in four guidelines on social services for different segments of users. The laws on the Health Care Reimbursement Scheme apply in this area too with regard to paramedic services, physiotherapy etc.

The responsibility for day cases or out-patient long term nursing care mainly lies with the municipality which shall provide services according to a number of articles in the law.

However, the *county* is responsible for day cases of long-term nursing care for persons residing in the long-term institutions they provide under the Social Services Act (§§ 92, 93) and for

services on a day case basis for substance abusers (§ 85). The county is also responsible for providing counselling to families with handicapped or socially impaired children (§34), and to provide special consultancy services and counselling to the municipality (§69).

Long-term in-patient care at hospitals can sometimes be provided as day-cases or moved to an out-patient service site. It is then regulated in the Hospital Act and the responsibility of the county and the specific hospital. This may be the case of stroke units and out-patient health centres (“sundhedscentre”) for chronically ill patients, community psychiatric treatment, such as assertive community teams for psychiatric patients.

According to the Social Services Act, the *municipality* is obliged to

- “make a special effort for adults with a reduced mental or physical level of functioning” (§ 67)
- make this effort with or without the patient’s consent (§67 a), (but there are special rules in the Law as to use of force)
- Provide free counselling and advice to the same persons (§68)
- Provide personal assistance and care and help with activities of daily living (§71) for people with temporary and chronic impairment (§71,2).
- Provide respite care (by a substitute and/or financial) to assist the spouse and family (§72)
- Provide facilities for care, rehabilitation and maintenance training for persons in need for this, e.g. persons with a reduced level of functioning (§73)
- The assistance and care services shall be available 24 hours a day (§ 74)
- If the municipality is not able to provide the service under §71 and §73 it may allocate a financial compensation so that the person in need can pay for the service himself.
- Employ and/or reimburse employment of nurses or caretakers for persons with a severe and permanent impairment (§77).
- Establish or reimburse services with an activating or preventive aim. The municipalities decides the guidelines and target groups themselves (§65).

The municipality decides on the services to be provided on the basis of an individual needs assessment, but shall consider all applications for help. How the out-patient or day case care is actually provided varies from municipality to municipality. Often, this type of care is offered in a some kind of day centre, or at the patient’s home.

The municipal decision and the reasons for the decision shall be forwarded to the recipient in writing and the assistance shall be provided within a reasonable delay (§75 b). Furthermore, the municipality shall name a contact person from the authorities. (art.2).

The municipality shall furthermore establish an *Advisory Board for the Elderly* (see section on in-patient long term care) and an impartial counselling arrangement. Both instances are to be consulted regularly (§70).

The *Ministry of Social Affairs* sets quality standards (§74a) . The municipal council shall explain the decisions made and the follow-up procedures used. Furthermore the Minister of Social Affairs sets the rules for payment and finance. (§82)

5.3.2 Definition, description and classification of benefits (question 6-8)

For day cases or out-patient long term nursing care, the benefits are explicitly and generally positively defined in the Social Services Act and are specific with regard to target groups and payment rules. Generally, the patient pays a certain proportion of the services provided by §§71-73 according to income etc, but is exempt of payment if the assistance and care provided is permanent (§82). Furthermore, the patient has the right to free choice of provider of the services (§75c). This does not however, include patients in nursing homes who receive the help provided by the institution – an example of a negatively defined benefit.

As in in-patient long-term nursing care, the definition of benefits for day cases is vague with regard to referral criteria, as they are based on an individual needs assessment by the authority in charge. The specific service provided is not described at all, but lies with the authorities to plan and specify.

The “classification”, if any, of the benefits is according to target groups (adults, children, elderly, and substance abusers) or according to the public authority responsible for providing the services. The clauses on payment and finance in the Social Services Act are classified according to the article in the law they refer to, and to the authority who pays.

5.4 Long-term nursing care: Home care (HC.3.3)

5.4.1 Actors responsible for defining benefits (question 5)

The legislation is explicit and specific with regard to home nurses and right to receive nursing care at home. Long-term nursing care at home is described in the Social Services Act about care and assistance arrangements for closely related dying or incurably ill relatives (§§103,104,105,106), and in various acts, notices and guidelines on home nursing arrangement (see references).

The Hospital Act applies in cases where in-patient treatment may be provided at the patient’s home, following a hospital treatment. This is the case with oxygen nurses sent from the hospital to provide care for patients with COPD (chronic obstructive pulmonary disease). The Public Health Insurance Act and ancillary laws establishing the Health Care Reimbursement Scheme apply when the GP or another professional in the Scheme regularly for a longer period visits the patient at home. There are specific fees in the fee schedule for home visits. The actors within hospital care and the Health Care Reimbursement Scheme have been described in Chapter 3.

As to home nursing arrangements and the entitlements laid down in the Act on Social Service, the main actors are the municipality, the Minister for the Interior and Health and the National Board of Health.

The *municipality* is responsible for providing free home care by registered nurses or other personnel with the necessary skills. This applies for all citizens when they are referred to this type of care by a *GP* (BEK 469 § 4). The municipality finances the services for people of 67 years of age or more, and 50% of the costs for people under 67 (the *county* finances the remaining 50%). However, the Minister for the Interior and Health can negotiate this distribution of financial burden with the different authorities.

The municipality shall furthermore ensure that the sufficient types and amount of medical aids are available for the care.

The Minister for the Interior and Health sets rules about the scope and demands to the municipal services and the National Board of Health issues guidelines on the organisation and operation of home nursing services, types and quality of nursing skills, medical aids etc (§2 of DSK 15010 of 01/02/1993) .

5.4.2 Definition and classification of benefits, uniformity for payers (question 6-8)

Persons residing in the municipality have the right to free home nurse care upon a referral by the GP (notice on home nursing §1). This is an explicitly but vaguely defined benefit.

In the Social Services Act there is a right for the spouse of the impaired to receive financial or in-kind relief (§72), or entitlement for the close relative to financial compensation for loss of income in case of care for the incurably ill or dying at home (§§103, 104,105,106). These benefits are explicitly defined and specific.

There is no classification of these benefits in the laws.

6 Ancillary Services to Health Care (HC 4)

OECD Functional Classification of Health Care Definition:

This item comprises a variety of services, mainly performed by paramedical or medical technical personnel with or without the direct supervision of a medical doctor, such as laboratory, diagnosis imaging and patient transport.

6.1 Introduction

This chapter describes benefits with regard to clinical laboratory services, diagnostic imaging, patient transportation and other miscellaneous services. Clinical laboratory services, diagnostic imaging and other miscellaneous services have been gathered in one description, and patient transportation is described independently.

6.2 Clinical Laboratory, Diagnostic Imaging, Other Miscellaneous Services (HC 4.1, 4.2, and 4.9)

6.2.1 Actors responsible for defining benefits (question 5)

6.2.1.1 General description of the organisation of the sector

Clinical laboratory tests and diagnostic imaging are provided for patients treated in the hospital sector and as well as in the primary health care sector. The latter is regulated by the Public Health Insurance Act.

The services are provided by public hospitals and by private institutions (including Statens Serum Institut, which is a state owned laboratory, run on market conditions). The private suppliers and the hospitals are to some extent complementary but also to some extent supplementary. Generally, private laboratories do not carry out more specialised tests, except for a few very specialised private laboratories that carry out some specialised tests not provided in the hospital sector (e.g. allergologic tests). The state-owned “Statens Serum Institute”, which has some special national responsibilities (within human bacteriology, virology and serology) (according to LBK 790 10/09/2003) carries out special tests. Concerning diagnostic imaging there are only a few private suppliers (situated mainly in the Copenhagen area).

Diagnostic services to patients treated in the *hospital sector* are mainly carried out by the laboratories in the hospitals sector. Diagnostic services to patients treated under the Health Care Reimbursement Scheme can be supplied by private laboratories, by a doctor’s clinic or by a hospital depending on rules laid down by the county council. Within the framework set up by the county council, the doctor (GP or specialist) can choose to send patients or blood samples to either hospitals or private suppliers.

6.2.1.2 The role of the actors defining benefits

The benefits concerning ancillary services provided in the hospitals are regulated by the Hospital Act, and benefits for ancillary services provided within the primary sector are regulated by Public Health Insurance Act. In the following, the regulation of the two sectors is described separately.

6.2.1.3 Ancillary services in the hospital sector

The role of the actors responsible for defining benefits in the hospital sector is described in detail in Chapter 3 on curative care. The regulatory schemes described in that chapter also apply for the ancillary services. Through the health plan and detailed budgets, the county council specifies the capacity and the resources available for the laboratories and the radiological departments. The hospitals and departments are free to organise laboratories and radiological department within the framework set up by the government and the county council.

6.2.1.4 Ancillary services in the primary health care sector

The general benefits regulated by the Health Care Reimbursement Scheme (Public Health Insurance Act) are explained in detail in Chapter 3.

The county council regulates whether laboratory tests and diagnostic imaging on patients treated in the primary health care sector should be supplied by the county hospitals or by private suppliers.

According to the Public Health Insurance Act (§26) negotiations between private suppliers take place between the institutions and the Health Care Reimbursement Negotiation Committee.

The public health insurance only reimburses tests and examinations provided by private suppliers who have an agreement with the county council. The agreement regulates which services the counties can buy from the private supplier, the price of the service, and how the price is regulated. The agreement may also regulate the total amount of services purchased per year.

Each county council decides whether it will join this general agreement. And the county can make separate negotiations with a private supplier in order to make local adjustments to the general agreement.

6.2.2 Definition of Benefits (question 6)

In the hospital sector benefits with regard to laboratory tests and clinical imaging are not defined explicitly. In general, patients are entitled to any laboratory test or diagnostic imaging examination ordered by the doctor treating the patient. However, a rationing may take place through the size of the capacity of the departments carrying out the tests and examinations at the hospitals. In the primary health sector, the Health Care Reimbursement Negotiation Committee negotiates prices and services with three specific laboratories. The prices are not stated in the agreements, but on lists that can be acquired directly at the laboratories. These are not benefit catalogues to the same extent as the fee schedule for out-patient (ambulatory) services. If a certain test is not available at the laboratory or according to the Health Care Reimbursement Scheme agreement, the doctor may refer the patient to a hospital for the test.

6.2.2.1 Hospital sector

The general priority setting in the Danish hospital sector at national (see Chapter 3), county and hospital/department level also has implications for the priority setting within ancillary services. Ancillary services for patients with a high priority have a correspondingly high priority. This is the case of e.g. CT-scans for cancer patients.

The capacity and the technology, and thereby the type and amount of examinations and tests available in the hospital, are determined by the county council via the hospital and/or department budgets. However, in case a doctor refers a patient to a test or an examination which is not offered by the hospital where the patient is treated, the test or examination can be provided by another (more specialised) hospital.

6.2.2.2 Health Care Reimbursement Scheme providers

As described in earlier sections, use of private providers of ancillary services is regulated by the county council. The benefits provided by the private providers are described in a positive way in form of a list of tests and examinations reimbursed by the Health Care Reimbursement Scheme, concerning each provider.

However, seen from the patient's point of view, there are no limits to the services offered, as the tests and examinations from the private supplier, which are not reimbursed, can be provided by the hospitals. So the GP or specialist simply sends the test to the hospital laboratory instead of a private laboratory.⁹

However the implicit rationing through the capacity described in Chapter 3 on the hospital sector also applies for tests and examinations that the hospital carries out for providers under the Health Care Reimbursement Scheme.

6.2.3 Classification of benefits (question 7)

As no benefits are defined, no benefit classification exists with clinical laboratory or imaging. However, for documentation purposes, a classification of imaging examinations is used in the hospital sector.

In the private sector the services reimbursed by the Health Care Reimbursement Scheme (the counties) are defined according to the type of test or the type of imaging examination.

6.2.3.1 Hospital sector

In the following sections a short description of the classifications used in the hospital sector for *documentation* purposes is given.

Clinical chemical

Clinical chemical tests are classified according to the international IUPAC-nomenclature. A further description of that nomenclature is found in the international literature.

⁹ Some hospitals may have restrictions concerning GP's right to order very specialised tests or examinations. Instead the patient should be admitted to a specialised hospital department, who has the right to order the test or examination in question.

Pathology

The international Snowmed classification is used. A description of the classification is found in the international literature.

Diagnostic imaging

A Danish classification is used. The classification is structured the following way:

Level 1.

Technology

Angiography	A
CT-scan	C
MR-scan	M
X-RAY	R
Ultrasound	U

Level 2

Anatomic site

Head	A
Neck	B
Thorax	
Abdomen	
Columnar	
Upper part of body	
Under part of body	

Level 3

Anatomic site in more detail

The classification for imaging services is part of the SKS-classification (Sundhedsstyrelsens Klassifikations System) and the overall identification of Radiological examinations in the SKS is UX

Example: X-ray of cranium: UXRA05

Private providers

The benefit catalogues for the private suppliers are described in the agreements with the Health Care Reimbursement Negotiation Committee.

An agreement has been made between the each single private laboratory and the Health Care Reimbursement Negotiation Committee and each agreement contains a list of which tests are reimbursed and at what prices.

If laboratory tests are provided by private specialists in their office, the agreement between the Danish Association of Medical Specialists and the Health Care Reimbursement Negotiation Committee contains a list of which tests are reimbursed and at what prices.

The private Radiologist has an agreement with the Health Care Reimbursement Negotiation Committee. This contract contains a list of which imaging services are reimbursed and at what price.

6.2.4 Uniformity for payers (question 8)

As there is only one payer – the county council – this question is not relevant for this category. However the classification is not uniform for all suppliers as the classification of services that are used by the hospitals are not used by the private suppliers.

6.3 Patient Transport and Emergency Rescue (HC.4.3)

OECD Functional Classification of Health Care Definition:

This item comprises transportation in a specially-equipped vehicle or in a designated air ambulance to and from facilities for the purposes of receiving medical and surgical care. It also includes transportation in conventional vehicles such as taxis, when the latter is authorised and the costs are reimbursed to the patient.

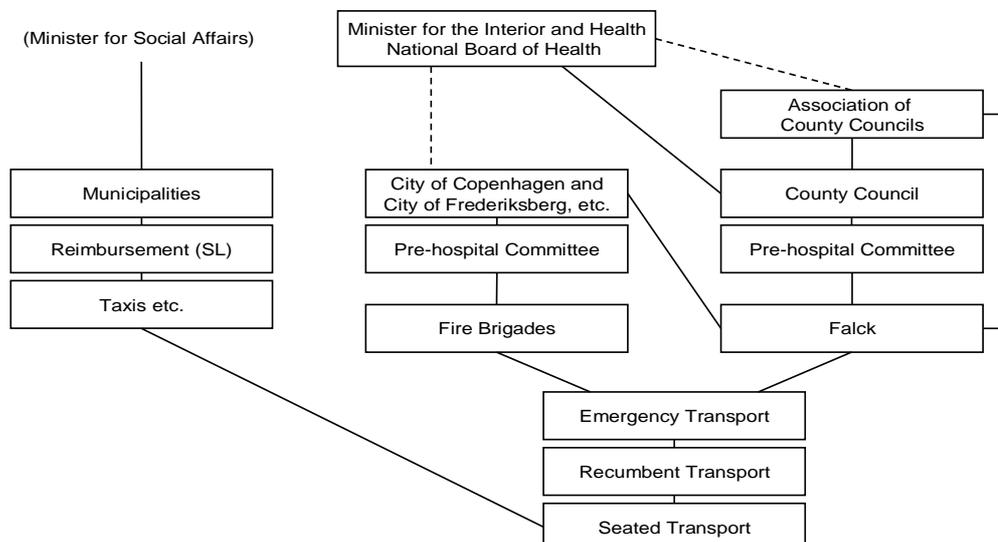
6.3.1 Introduction

The main law regulating entitlements and establishing the executive frame for organising patient transport in an ambulance in Denmark is the Hospital Act. Furthermore, a government notice (BEK 1039) contains rules about the planning of pre-hospital services, responsibility, education of the personnel etc. Finally, specific articles in the Social Services Act and ancillary laws provide non-acute transportation or reimbursement of transportation for specific person/patient groups.

Emergency patient transport services and non-emergency transport in an ambulance in Denmark are publicly financed (by the counties), but mainly provided by a private ambulance operator, Falck. Agreements on prices and performance are contracted between the purchasers and the provider, and the targets and payment agreements indirectly have an influence on the benefits available to the citizens.

6.3.2 Actors responsible for defining benefits (question 5)

Patient Transport Services HC 4.3



According to the Hospital Act and the Notice on Prehospital Treatment (BEK 1039), the county councils and the city council of Copenhagen and Frederiksberg are responsible for providing, planning and financing patient transport in ambulance vehicles.

The roles of the Ministry for the Interior and Health and the National Board of Health are regulated by the Hospital Act and other laws on health care. The Minister for the Interior and Health is authorised to issue specific laws, and the National Board of Health has a monitoring role.

6.3.2.1 Role of the County Council and the City Councils of Copenhagen and Frederiksberg

The county council and the two city councils shall elaborate a plan for the pre-hospital services in the county. This plan shall be co-ordinated with **the police**, with the emergency preparedness plan and with the global health plan of the county. (BEK 1039 §4).

The pre-hospital plan should describe the county targets regarding

- scope, quality and quality assurance of the services
- ambulance activity, effort, and types of vehicles, (e.g. acute cars, emergency teams)
- division of labour between hospitals, ambulance services and primary health services
- guidelines for the pre-hospital services, including disposal and visitation guidelines
- communication between the persons involved in the services

The county council has to nominate a pre-hospital committee with representatives of all actors (BEK 1039 § 7). The committee's main task is to co-ordinate the services between the different institutions and actors. Finally, the county council should appoint a manager of the pre-hospital services, who is also chairman of the committee. This person is mainly responsible for the clinical control and monitoring of the services (BEK 1039 §8).

6.3.2.2 Providers

Although the county councils are free to perform the services themselves or out-source them to other providers (BEK 1039 § 2,2), none of the counties carry out the services themselves. A private ambulance operator, "Falck Redningskorps", provides the majority of emergency ambulance services¹⁰ and has individual agreements with all counties.

The other providers in the market are the municipal fire brigades of Copenhagen, Frederiksberg and Gentofte covering their respective municipalities (inner city) and three small local providers covering some of the islands.

Furthermore, the police have a minor role in receiving the emergency calls and transferring them to the ambulance providers.

6.3.2.3 The role of the Association of County Councils

The Association of County Councils negotiates on behalf of the counties with Falck about payment and performance of the services and follows-up on the agreements made, based on input from the counties and Falck.

¹⁰ 80% of the total number of rides and covering 98% of the total geographical area of Denmark in 2002 (DSI Report)

The actual contract, denoted the "Standard Agreement between Falck and the Association of County Councils on ambulance preparedness and ambulance rides", became effective in 1995 and was revised in 1998. This contract is still in force.

Most counties use this agreement, but in addition, many counties have individual contracts with Falck, e.g. on specific "add-on" services such as physician equipped ambulances, acute cars. So the actual availability of different types of ambulance services varies from county to county.

6.3.2.4 Transportation under the Social Services Act and the Health Care Reimbursement Scheme

As to non-acute seated patient transport to and from treatment in e.g. taxis, the Social Services Act and ancillary laws refer to entitlements to reimbursement of transport services based on income or functional criteria. Here, the actors are the same as in long-term nursing care: the municipality, the county and the Minister of Social Affairs. Furthermore, there are specific benefits in the Health Care Reimbursement Scheme and the decision-makers regarding these benefits are thus the same as this scheme.

6.3.3 Definition of benefits (question 6)

The Hospital Act §6 entitles "everybody that has the right to free hospital treatment to free ambulance transportation if considered necessary".

Furthermore, according to the notice BEK 1039 §2 the county council is obliged to provide ambulance services to persons in need due to acute disease, accidents or delivery.

Again the benefit is explicitly, but not specifically formulated, leaving it to the regional planners to specify the services.

The same notice, BEK 1039, explicitly, specifically and positively defines by whom (what are the qualifications required) and how (requirements to equipment) ambulance vehicles shall be equipped. This implicitly indicates a benefit. What are e.g. the educational length and standards required for each of the two ambulance paramedics in an ambulance, and what are the actual tasks that these two persons are allowed to perform (e.g. assessment of patient condition, free airway flows, resuscitation by (and without) external defibrillator, ECG monitoring, anti chock treatment, delivery assistance, and some medical treatment.) Finally, the notices states the minimum equipment required to perform these activities in the ambulance.

Another parameter which implicitly has an influence on the benefit available to the citizen is the legal requirements with regard to ambulance expediency. Expediency is usually measured as response time, which is defined as the time from receipt of the call by an alarm centre till arrival of the ambulance at the scene of incident.

The notice on Pre-hospital Treatment obliges the counties to set response time targets, but does not – as in e.g. the UK and some German Länder – quantify these targets, so there is an explicit obligation to the county which is not specified. The Standard Agreement has quantified targets but each county is free to agree on other targets with Falck. The lower the time targets are, the higher the payment from the county to Falck. This means that the counties can change the targets according to the budget they wish to spend. This implicitly influences the

actual benefits available to the citizens of the county with regard to expediency of ambulance services and in the end – patient outcome.

For the non-acute recumbent and seated patient transport, there are specific rules in the ancillary laws to the Social Services Act, e.g. BEK 19 and VEJ 129, in the Hospital Act (BEK 1176) and in the Public Health Insurance Act (BEK 101 and 995). These laws explicitly, specifically, and positively define entitlements to transportation or reimbursement of transportation by the cheapest, justifiable means of transportation (BEK 1176) according to the patient's condition. Furthermore, benefits are based on needs, distance and the patient's socio-economic state (if he is in employment or not). The Health Care Reimbursement Scheme provides reimbursement of travelling abroad if the patient has been treated abroad (BEK 995).

All legal documents also set limits (define negative benefits) as to reimbursement of transportation to an from a treatment site which the patient is not referred to but has chosen himself (free choice of provider and hospital), or if his condition allows him to use public transport.

The transport to and from treatment at hospital and out-patient sites, specified in BEK 1176, is free of charge, and the transport specified under BEK 19 and VEJ 129 under the Social Service Act has a minimum co-payment by the patient.

Helicopter ambulance services are not yet part of pre-hospital services, but legislation incorporating the availability of helicopter transport in the Danish health basket, is underway.

6.3.4 Classification of Benefits (question 7)

Within ambulance services and patient transport, there is a classification of ambulance services following international clinical or medico-technical standards to document activity. This is not a benefit classification. The Standard Agreement has a classification which follows the payment agreement with the provider, and which is used to categorise and document the activity.

The Standard Agreement distinguishes between

- Category 1 rides: emergency ride to – and transportation of – the patient following an accident or acute disease from the scene of incident to treatment, or emergency transfer of patients from one treatment site to another.
- Category 2 rides: Recumbent patient transport at night – non acute
- Category 3 rides: Ambulance rescue – support function to ambulance services e.g. release of persons at accidents.
- Out of category, separate account: recumbent transport and seated transport at daytime.

Furthermore, the Standard Agreement distinguishes between number of rides, number of calls, response times, and person hours spent in the ambulance. Payment to the provider consists of a core payment plus an activity-based part, based on a combination of person hours and number of drives performed.

Benefits stated in the Social Services Act with regard to provision and reimbursement of sitting patient transport e.g. taxi bills etc. are classified according to need (ability to function) and income and in some cases age.

6.3.5 Are benefits uniform for all payers (question 8)

At the law-level, benefits are uniform for all payers, in that the laws are the same for all payers. However at contract level, benefits are not uniform as there are different contracts and payment systems available for the different providers.

7 Medical Goods Dispensed to Out-Patients (HC 5)

OECD Functional Classification of Health Care Definition:

This item comprises medical goods dispensed to out-patients and the services connected with dispensing, such as retail trade, fitting, maintaining and renting of medical goods and appliances. Included are services of public pharmacies, opticians, sanitary shops and other specialised or non-specialised retail traders including mail ordering and teleshopping. The group of goods covers medicaments, prostheses, medical appliances and equipment and other health related products provided to individuals, either with or without prescription, usually from dispensing chemists, pharmacists or medical equipment suppliers and intended for consumption or use by a single individual or household outside a health facility or institution.

Excludes: pharmaceuticals, prostheses, and other medical and health-related goods supplied to in-patients and day-care patients or products delivered to out-patients as part of treatment provided within the facilities of ambulatory care.

7.1 Introduction

The analysis of medical goods is divided in pharmaceuticals including medical non-durables, and therapeutic appliances and medical durables.

Import, approval, control, clinical testing and marketing of pharmaceuticals are regulated by the Medicines Act and later revisions and amendments.

Entitlements concerning pharmaceuticals are mainly described in the Public Health Insurance Act.

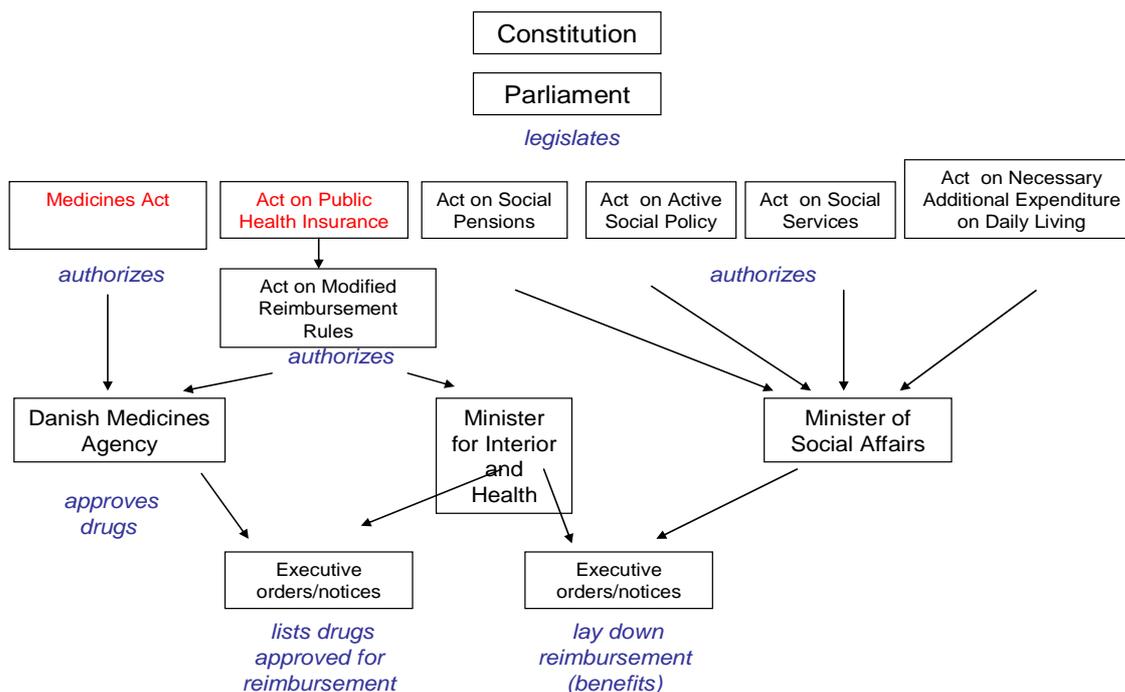
Rules and regulations concerning therapeutic appliances are mainly described in the Social Services Act, while entitlements are described in a notice from the Minister of Social Affairs (BEK 19.11.01.2005).

7.2 Pharmaceuticals and other medical non-durables (HC 5.1)

7.2.1 Actors responsible for definition of entitlements (question 5)

Drugs are regulated by the Medicines Act (LBK 656 28.06.1995) given by the Minister for the Interior and Health. According to this law, the Minister is empowered to specify regulations concerning pharmaceuticals in circulars, regulations and recommendations.

The Danish Medicines Agency has to approve all drugs, before they can be sold on the Danish market. If the drug is approved and a marketing permission (valid for five years at a time) is given, the agency decides if the drug needs a prescription to be sold or not i.e., over the counter.



Regulations concerning the quality of drugs are decided by the Danish Medicines Agency and listed in a pharmacopoeia.

Generally, sales of prescribed drugs can only be performed by pharmacies and sales of OTC products can be sold by pharmacies and by other shops approved by the Danish Medicines Agency. The Danish Medicines Agency is empowered to forbid sales and dispense of drugs under certain circumstances.

Nobody is allowed to produce, import, export, trade, dispense, distribute or pack drugs without approval of The Danish Medicines Agency. Hospitals and similar institutions handling of drugs for treatment, general practitioners and practicing specialists, dentists and veterinarians purchase, distribution and dispense of drugs, and private persons use of drugs for own consumption are excluded.

The Danish Medicines Agency keeps a register of drugs applying for approval and drugs given approval in form of a marketing permission. This includes prescribed products and OTC products.

The regulations concerning reimbursement for drugs are given in the Public Health Insurance Act (§7), in a government notice on reimbursement of medicine (BEK 63 24.01.2000), and on reimbursement of doses dispensed drugs (BEK 824 18.09.2001, §7d).

The Danish Medicines Agency's criteria for including medicines on the positive list for products that can be reimbursed are clinical effectiveness and the intended market price. Applicants send an "expert assessment" to the Agency consisting of the evaluation of the drug in a clinical trial and the market price they wish to charge. These are minimum requirements to the application. However, applicants may also include a cost-effectiveness analysis to support

their argument that the drug deserves to be subject to reimbursement, and many companies do so, although it is not compulsory¹¹

7.2.2 Definitions of benefits (question 6)

7.2.2.1 Prescribed medicines (HC 5.1.1)

The benefit basket concerning drugs mainly consists of reimbursement for purchase of prescription drugs and in some cases also of over-the-counter drugs. Benefits concerning prescribed drugs are explicitly and specifically defined by a positive list of reimbursable prescribed medicines.

Reimbursement are determined by the Public Health Insurance Act, the Act on Social Pensions (LBK 1219 07.12.2004), Act on Active Social Policy (LBK 709 13.08.2003), and the Social Services Act, including a government notice on necessary extra expenditure for daily living (BEK 869 23.10.2002).

According to the Public Health Insurance Act, general reimbursement is given for drugs on a list produced by The Danish Medicines Agency and published once a year in the “Ministeri-altidende”¹². All drugs eligible for subsidy are listed by WHO ATC code (Anatomical Therapeutic Chemical Classification System)¹³.

7.2.2.1.1 General reimbursement¹⁴

General reimbursement of a medicinal product means that the health insurance reimbursement is automatically subtracted from the price of the medicinal product when a patient buys the medicinal product at the pharmacy on prescription. The majority of prescription-only medicines are subject to general reimbursement.

When the Danish Medicines Agency evaluates whether general reimbursement should be given to a medicinal product, the effect of the medicinal product is evaluated in relation to the price.

The medicines subject to general reimbursement are listed on a positive list of medicines.

The reimbursement constitutes 50%, 75%, 85% or 100% of the price of the medicinal product. There is a ceiling of DKK 520 (app. 70 Euro) which will not be reimbursed. The more a patient has spent on prescribed medicines above this ceiling per, the higher the percentage of reimbursement.

Within groups of the same generic medicines but different brands, the reimbursement price is calculated on the basis of the cheapest product in the group and the patient will only receive reimbursement according to the cheapest product, even if he has been prescribed a more expensive brand.

¹¹ Personal communication with Karen Kolenda, Head of Reimbursement Section, Danish Medicines Agency

¹² Latest edition: SKR 98 10.11.2004

¹³ [ATC codes have five levels: (1) main anatomic groups, (2) therapeutic main groups, (3) therapeutic/pharmacologic subgroups, (4) chemical/therapeutic/pharmacologic subgroups, and (5) chemical substance.]

¹⁴ The following descriptions on reimbursement criteria (7.2.2.1.1 – 7.2.2.1.5) come from the Danish Medicines Agency website www.dkma.dk

This means the patient has to pay the extra expense himself, which is the difference between the prices of the prescribed product the reimbursement price. The reimbursement can therefore amount to less than the above-mentioned percentages.

General reimbursement for some prescription drugs is subject to the proviso that it is used for treatment of specified diseases.

The reimbursement rates are stated in the Public Health Insurance Act (§7b), revised in Act on Amendment of Public Health Insurance Act (LOV 495 07.06.2001), but are regulated yearly by the Minister for the Interior and Health in a notice, recently as of January 1, 2004 (BEK 933 21.11.2003).

7.2.2.1.2 Single reimbursement

The doctor (or dentist) can apply for single reimbursement for the individual patient for medicinal products which are not subject to general reimbursement. It might be prescription drugs, over-the-counter drugs, drugs specially prepared for the patient by the pharmacy, or drugs not to be sold in Denmark without special permission from the Danish Medicines Agency.

The Danish Medicines Agency evaluates the applications for reimbursement and attaches importance in the settlement to the role of the medicine in the patient's treatment, the effect of the treatment on the patient, whether other relevant methods of treatment have been found to be insufficient or inappropriate in this particular case.

The reimbursement rates are stated in the Public Health Insurance Act (§7b), revised in Act of Amendments of Public Health Insurance Act (LOV 495 07.06.2001), but are regulated yearly by the Minister of Health in a notice, recently per January 1, 2004 (BEK 933 21.11.2003).

7.2.2.1.3 Reimbursement for chronically and terminally ill

The general practitioner can apply for reimbursement for the chronically ill, if the patient has a prolonged and medically well documented consumption of medicinal products entitled to reimbursement. 100% reimbursement is obtainable when the patients total annual expenses exceed DKK 3,805.

Terminally ill patients who wish to spend their last moments at home, or in a hospice, can get all expenses covered for medicines prescribed by a doctor – whether the medicinal product is entitled to reimbursement or not.

The doctor can apply for reimbursement for the terminally ill at the Danish Medicines Agency. The patient is then informed of the extent to which full reimbursement has been given for a medicinal product prescribed by the doctor.

The reimbursement rates are stated in the Public Health Insurance Act (§7c), revised in Act of Amendments of Public Health Insurance Act (LOV 495 07.06.2001), but are regulated yearly by the Minister of Health in an notice, recently per January 1, 2004 (BEK 933 21.11.2003).

Reimbursement due to socio-economic conditions

Reimbursement is also offered by the municipality to pensioners in straitened economic circumstances (Act on Social Pensions LBK 1219 07.12.2004, §17), to people in economic need (Act on Active Social Policy LBK 709 13.08.2003, §82) and to handicapped persons living in their own home (Social Services Act, §28 and §84) including a government notice on necessary extra expenditure for daily living (BEK 869 23.10.2002).

All benefits are defined explicitly and positive in the form of written reimbursement rates. The definitions are rather specific.

7.2.2.1.4 Increased reimbursement

If a patient for medical reasons – for example, allergy caused by additives – has to use a relatively expensive brand which has a relatively lower reimbursement, the general practitioner can apply to the Danish Medicines agency for increased reimbursement.

Increased reimbursement means that reimbursement is based on the actual price of the medicinal product instead of at the reimbursement price listed.

A patient cannot receive increased reimbursement for a medicinal product just because the patient does not want to use the cheaper (but otherwise equally effective) medicinal product, or because the patient feels more secure with the more expensive medicinal product.

The Danish Medicines Agency can also decide that specific over-the-counter drugs can be reimbursed, given that the doctor or dentist prescribes it to persons receiving pension (according to Act of Social Pensions, LBK 1219 07.12.2004).

7.2.2.1.5 Substitution

Substitution (replacement) means that the pharmacy may dispense another and cheaper medicinal product than the one the doctor has prescribed. These medicinal products contain the same active substance in the same amount and the same form. The medicines therefore have the same effect, even though they look differently and are sold under a different brand.

The pharmacy can – instead of the medicinal product prescribed – dispense either a medicinal product, which is produced by another pharmaceutical company and has another name, or a medicinal product manufactured by the same firm and possibly has another name (parallel imported medicinal product).

The medicinal products which can substitute the medicinal product prescribed are listed by The Danish Medicines Agency (www.medicinpriser.dk), which professionally evaluates all these medicinal products.

The pharmacy must dispense a cheaper medicinal product, unless the doctor has decided against substitution by writing "ej S" (not S) on the prescription. The patient can, however, also decide for himself if he does not want a cheaper medicinal product.

If neither the patient nor the doctor has decided not to choose substitution, the patient will receive the cheapest medicinal product. But if the price difference between the cheapest and the prescribed medicinal product is within certain limits – DKK 5 to 20 depending on the price of the medicinal product – the patient will receive the medicinal product that the doctor

has prescribed.

7.2.2.2 Over the counter medicines (HC 5.1.2)

OTC products, including vitamins, herbal medicines, and homeopathic drugs, are subject to approval by the Danish Medicines Agency before they can be sold in Denmark.¹⁵ They are not part of the health basket, as they are not reimbursed. They may however, be prescribed, and are then reimbursed according to the rules for prescribed drugs.

7.2.3 Classification of benefits, uniformity for payers (question 7 and 8)

Reimbursement is dependent on type of drug (prescription drug eligible for subsidy) and the total amount of a patient's purchased drugs in a period of one year. The reimbursement is based on the actual price of the drug, unless the drugs belong to an arrangement concerning European prices or an arrangement with subsidy prices.

If a drug is more expensive in Denmark than in other European countries the reimbursement is calculated from an average of *European prices*.

Among a group of identical drugs (i.e. drugs with identical active chemical substances in the same amount, and which is used in the same way – i.e. tablets and capsules, both to be taken orally) the reimbursement is given at a so-called *subsidy price*, if the subsidy price is lower than the actual price of the drug.

The rates of reimbursement vary according age (over and under 18 years) and sum of purchase per year. The rates are regulated every January 1 (BEK 933 21.11.2003).

Reimbursement for drugs provided by the public health care system in Denmark is uniform, i.e. it is open for all residents.

All reimbursements are registered in the “Lægemiddelstyrelsens Centrale Tilskudsregister (CTR)” [The Danish Medicines Agency Central Reimbursement Register] based on information from all pharmacies in Denmark (BEK 139 01.03.2001).

7.3 Therapeutic appliances and other medical durables (HC 5.2)

7.3.1 Introduction

The area of therapeutic appliances and other medical durables is very specific and detailed in the Danish legislation. In order to give a comprehensive view of the legislation, the following description of the actors on this area is therefore structured across the different categories in HC 5.2. Description of benefits is given in more detail.

The main legislation in the area is aimed at therapeutic appliances and other medical durables to chronically impaired individuals. Chronically impaired individuals are positively defined as

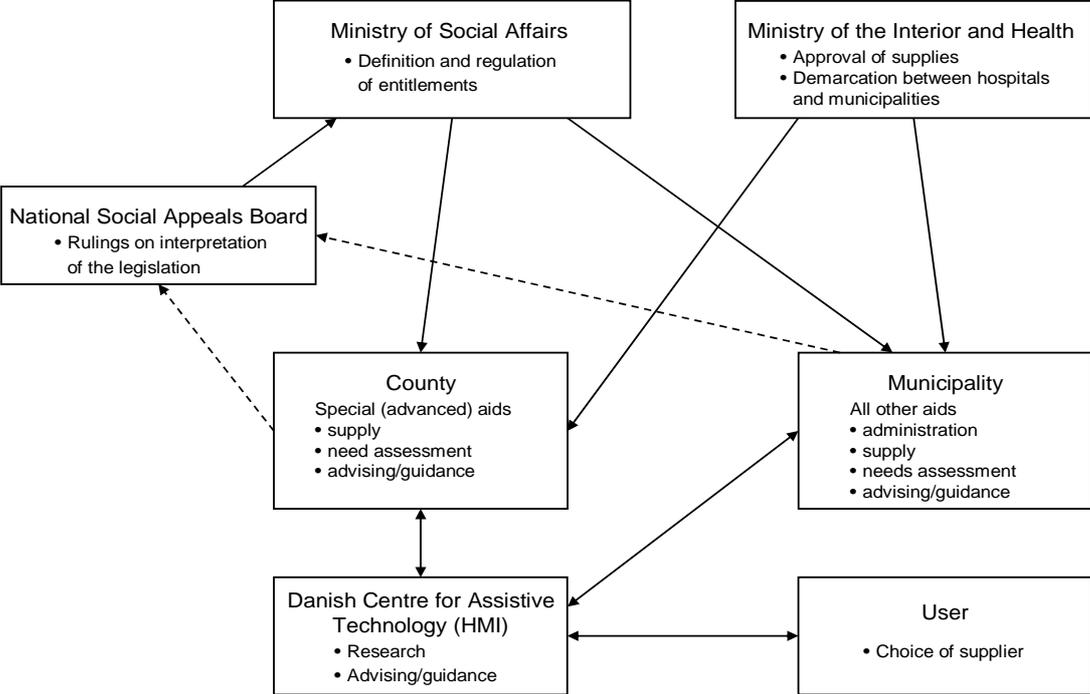
¹⁵ (BEK 567 18.06.1996 Vitamins- og mineral products)
(BEK 790 21.09.1992 herbal medicines)
(BEK 632 05.07.1994 Homeopathic drugs)

people suffering from disease or impairment with no prospect of health improvement within the foreseeable future and with a need to relieve the consequences of the impairment for a long time in the future (VEJ 52, 5.1.2, 20).

The main purpose of the legislation on reimbursement of therapeutic appliances and other medical durables is to ensure that the impaired individual can live as normal as life as possible, and increase their independence (VEJ 52, 5.1.1 (19) and VEJ 129, 8,9,10, 11, 39 and BEK 19). Entitlement to benefits is generally based on the rather vague formulation that the aid should either compensate for or relieve the impairment. There are no specific definitions as to when an aid compensates or relieves impairment (www.social.dk)

Actors responsible for defining benefits

Therapeutic Appliances and other Medical Durables HC 5.2



Entitlements to therapeutic appliances and other medical durables are mainly regulated in the Social Services Act. This law entitles the Ministry of Social Affairs to regulate benefits, the amount of user payment and the division between the responsibilities of the counties and municipalities. This ministry provides rules and regulations as well as guidelines. The guidelines are affected by rulings of the National Social Appeals Board. These rulings are referred to in guidelines from the Ministry of Social Affairs, and therefore serve as guidelines for municipalities and counties in interpreting the law (see VEJ 129).

Responsibility for the allocation of benefits is divided between municipalities and counties (LBK 708 §97). This division is based on benefit type or function. The county is generally responsible for the more advanced appliances or medical durables, specifically stated as vision products, hearing aids, orthopaedic appliances and technological aids. All other benefits are provided by the municipality. Therapeutic appliances are however also supplied to people with temporary impairment. All aids which are part of a treatment are supplied by the county,

whereas all other aids in principle are supplied by the municipality. The distinction between aids as part of treatment and “all others” is, however, quite fluid and vague¹⁶ (CIR 21 af 20/02/1975, LBK 766 of 28/08/2003 and LBK 708 29/06/2004 §71).

The allotment of benefits is based on an individual overall assessment of the whole situation. This means that the county and municipality are obliged to take family relations, work, education, social problems etc. in to consideration when making the individual assessment (VEJ 52).

The users also play a part in the definition of benefits. The framework for user influence on definition of benefits lies in the Social Services Act. It is the county and municipalities that are legally responsible for suppliers etc, but it is explicitly stated that user representatives should have influence on quality, supply, selection etc. (§ 97 and VEJ 129, 46). It is, however, relatively vague formulated; the municipality and the county are responsible for the user representatives having real influence, but the term real influence is not specified.

7.3.2 Definition of Benefits (question 6-8)

Generally the legislation on therapeutic appliances and other medical durables is explicit, very specific and both positive and negative. On most areas, there is a long list of positive benefits or beneficiaries, which is followed by a negative list. The benefits are first and foremost classified on the basis of the administrative body who is responsible for supplying them – municipality or county. Another central classification is the distinction between personal and non-personal aids, which will be elaborated on later. Furthermore, the classification of benefits is based on function and needs assessment.

It is explicitly formulated, that benefits can take three different forms; they can either be allocated as leasing, cash or in-kind. Reimbursement is allocated to the most suitable and cheapest aid (BEK 19 §4) General maintenance is excluded from reimbursement, with a few exceptions. These exceptions are positively and specifically stated as for example batteries for hearing aids (VEJ 129, 42, 44). Reparation of aids is, however, included.

The type of benefits and entitlements vary according to whether the benefit is classified as a personal aid or not. Personal aids are listed explicitly in the legislation in a positive and rather specific list. Personal aids are specifically defined as aids that need personal adjustment and are body levelled, such as wheelchairs, orthopaedic appliances, hearing aids etc. Particular rules and regulations, which are stated explicitly in the legislation, apply to these personal aids (BEK 19, LBK 708). For instance users have free choice of supplier, when it comes to personal aids.

Co-payment from users is defined explicitly in the notice. For most aids, the exact amount of the maximum reimbursement or the maximum user payment is stated.

Below, benefits regarding glasses and vision products, orthopaedic appliances and other prosthetics, hearing aids and medico-technical devices are described in more detail.

¹⁶ Kilde: Indenrigs- og Sundhedsministeriet, Jakob Møller Jacobsen.

Glasses and vision products (HC 5.2.1)

Reimbursement for visual aids is regulated in the Social Services Act, and it is specifically stated that reimbursement is not given on pure optical identification (BEK 19 of 11.01.2005, §14). The counties supply optical vision aids for persons with permanently reduced eyesight, or a permanent medical ophthalmic disease.

Different rules apply to children. It is stated in the Public Health Insurance Act under the Health Care Reimbursement Scheme that the Ministry of the Interior and Health defines the reimbursement of spectacle lenses and glasses for children. The reimbursement for children is not conditioned by optical identification (DSK 9226, §10) and reimbursement rates are determined by a National Social Agency notice (BEK 543 08.12.1980).

Orthopaedic appliances and other prosthetics (HC 5.2.2)

According to the Act of Social Services and an notice from the Minister of Social Affairs (BEK 19 11.01.2005) the counties supply orthopaedic appliances and other prosthetics.

The benefits are explicitly and specifically stated in the law by type of appliance: arm and leg prosthesis, breast prosthesis, brace corset, orthopaedic shoes and arch supports and specific cases of dental plates. The benefits are positively defined. When it comes to breast prosthesis statements are vaguer and a few exclusions are made.

As to most of the other benefits regarding therapeutic appliances, the specific amount of reimbursement is stated. An illustrative example is orthopaedic shoes where it is listed in the notice that all users over 18 years old should pay 670 DKK for each pair of shoes, and that the amount for users under 18 years is 360 DKK (BEK 19, §10).

Hearing aids (HC 5.2.3)

It is explicitly mentioned in the Social Services Act and a notice from the Minister of Social Affairs (BEK 19 11.01.2005) that the counties provide hearing-aids. However, it is not specifically defined who is entitled to hearing aids.

The maximum reimbursement is stated explicitly and specifically in the legislation, and entitlements are specified according to choice of provider. If you are under 18 and you choose your own provider, you are not entitled to cash reimbursement (BEK 19 §16 and VEJ 129 s. 147-151).

It is also mentioned explicitly that individuals are entitled to replacement of their hearing aid after 4 years. There are a few explicit exceptions, where replacement can take place before the end of 4 years: theft, change in hearing and bodily changes (BEK 19 §5, VEJ 129).

Medico-technical devices incl. electrical wheel chairs (HC 5.2.4)

This includes different kinds of transportation for people with disabilities, such as wheelchairs, disability cars individual carriages etc. Overall, the criteria for receiving benefits are not diagnosis but individual need.

Cars and wheelchairs are provided by the county, whereas individual carriages are supplied by the municipalities. Wheelchairs are considered loans, so that the user has no ownership (BEK

19 §15). Benefits are positively defined but with a few exclusions, such as for people only using wheelchairs for transport. Definition of benefits regarding individual carriages, such as for instance motorized tricycles, is explicit but very vague. The municipalities decide the amount of reimbursement regarding individual carriages (Social Services Act §99 and VEJ 52 chap.12).

Included in medico-technical devices are also specialised IT aids, which are supplied by the county. The benefits here are based on both inclusion and exclusion. (VEJ 52 and VEJ 129)

The counties also provide or reimburse injection and test material, such as syringes, needles, insulin pens, dipsticks, and blood sugar measurement devices, to insulin dependent diabetics (BEK 19 11.01.2005).

Other miscellaneous medical durables (HC 5.2.9)

Numeral other aids and medical durables are stated explicitly in the legislation. Definition of these benefits is mainly specific and both positive and negative. Some aids are explicitly included, some explicitly excluded. The aids specifically mentioned are provided by the county. Aids that are not mentioned in any of the above categories or below are supplied by the municipality according to the Social Services Act (§99)

One example is that counties are responsible for skin preparations to hide frightening birthmarks and scar formations on head and neck, and for skin protecting creams for head and neck following skin transplant or burns. Furthermore, reimbursement or full supply is given for elastic stockings, alarms that depend on a phone line, aids for patient with ostomy, flow-tron pumps and special clothing (rain cover for people in wheelchairs, swimming trunks for incontinent people etc) (BEK 19 11.01.2005).

8 Prevention and Public Health Services (HC 6)

OECD Functional Classification of Health Care Definition:

Prevention and public health comprise services designed to enhance the health status of the population as distinct from the curative services, which repair health dysfunction. Typical services are vaccination campaigns and programmes.

8.1 Maternal and Child Health, Family Planning and Counselling (HC 6.1)

OECD Functional Classification of Health Care Definition:

Maternal and child health covers a wide range of health care services such as genetic counselling and prevention of specific congenital abnormalities, prenatal and postnatal medical attention, baby health care, pre-school, and school child health and vaccinations.

8.1.1 Introduction

In the description below, maternity care entails health services to the pregnant and delivering woman and her newborn baby from the time the pregnancy is confirmed by the GP till the baby is born and the mother (and baby) discharged from hospital. The description of maternity care does not comprise treatment of a newborn baby with complications who are referred to a paediatric or neonatal department or treatment of intra-partum complications of the mother, e.g. eclampsia or serious maternal haemorrhage. Entitlements to these treatments are indeed part of the Danish health basket, but are not part of the regulation on maternity care but are regulated as in-patient care. (see chapter 3).

Maternity care, family planning and counselling are regulated in the Act on Maternity Care (LBK 622 of 19/07/1995 and amendments in LBK 462 of 1997). This law and adherent guidelines describe the entitlements of pregnant and delivering women to health care services, entitlements to counselling on contraception, and the roles of the different actors.

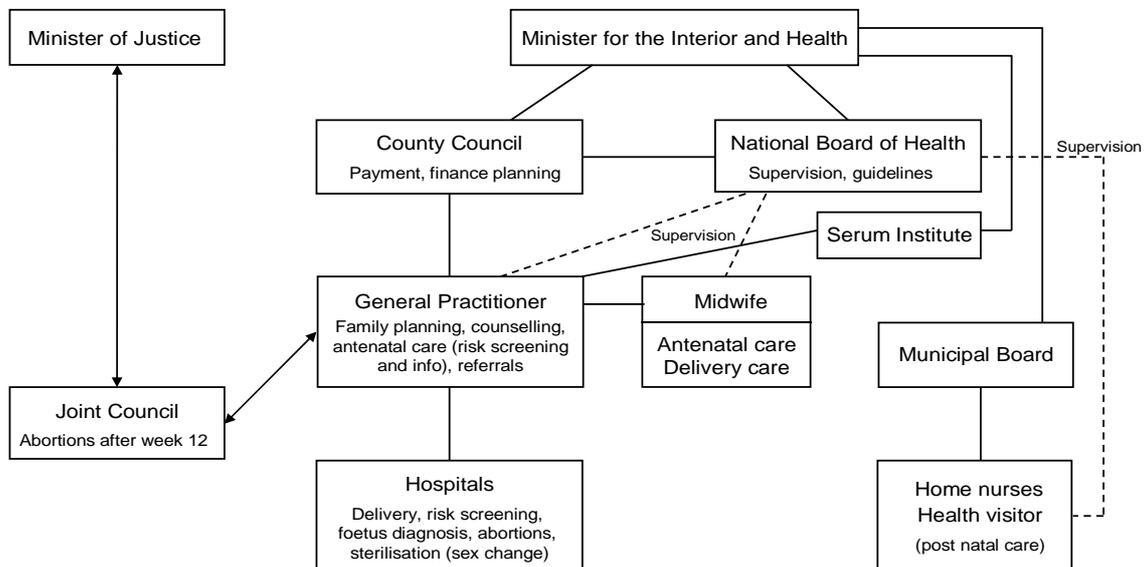
Abortions are regulated in the Act on Abortions (LBK 541) and adherent legislation (BEK 540).

IVF treatment, embryo reductions, and sterilisations are regulated independently and explicitly. IVF treatment is described in Chapter 3. Benefits with regard to sex change are implicitly regulated in the Hospital Act and Act on Sterilisation and Castration.

The description of child health services comprises entitlements to community and ambulatory health services for children from they are born until they start nursery class at the age of six. Excluded in this description are in-patient services for children, ad hoc ambulatory care (see chapter 3, on HC1) or vaccination programmes for children (see 6.3). Child Health Services are regulated in the legislation on Home Nurse Arrangements (REF) and Act on Preventive Health Services for Children and Young People (Act 438 of 14/06/1995 and 344 of 17/05/2002, and BEK 846 of 14/10/2002).

8.1.2 Actors responsible for defining benefits (question 5)

Maternal and Child Health, Family Planning and Counselling HC 6.1



8.1.2.1 Role of the counties and municipalities of Frederiksberg and Copenhagen

The counties and the municipalities of Frederiksberg and Copenhagen are responsible for providing maternity care free of charge (Act on Maternity Care LBK 622). This responsibility includes antenatal care, e.g. preventive examinations, genetic counseling and risk screening – partum care (deliveries), and postnatal health check-ups of the mother and the baby and pre-school child by a GP.

Furthermore, the same law obliges the counties to provide free advice on family planning and contraception.

The county is obliged to specify explicitly in its' health plan (see section on in-patient care) how it will implement the legislation and organise antenatal and delivery care.

Also, the provision and financing of abortions are part of the counties' obligations. Finally, the county shall also provide and finance treatment with regard to IVF, sex change operation, sterilization and castration to the extent that the patient falls under the inclusion criteria and are referred to this treatment by a physician.

Furthermore, the counties should report maternity care activity and outcome according to rules set by the National Board of Health.

8.1.2.2 Statens Serum Institut and the Minister for Health and the Interior

The Statens Serum Institut is obliged to provide laboratory tests needed to perform antenatal care (LBK 622, §1 and §9). The tests and the circumstances in performing them will be specified by the Minister for Health and the Interior. However, the Minister may order other laboratories to perform the tests. The Minister is furthermore responsible for information and campaigns on contraception targeted at the population or at specific groups.

8.1.2.3 Role of the National Board of Health

The National Board of Health issues guidelines for maternity care, including guidelines regarding the number of antenatal check-ups (622§2) and advice on family planning, counseling and contraception (622 §11). Within maternity care, three guidelines are currently in force: Guidelines on maternity care from 1998, guidelines on prenatal genetic information, counseling and examinations from 1994, and a revision to these recently published "Guidelines on foetus diagnostics" from 2004. (See references).

The guidelines are primarily targeted at the counties, which are responsible for implementing them. In practice, there is inter-county variation in the extent to which the current guidelines are implemented.

The guidelines are not mandatory, only the law is, but if the county does not sufficiently give reasons for not implementing the guidelines according to the health plan, the county will receive a protest from the National Board of Health.¹⁷

The National Board of Health monitors the services and collects reports on activity from the counties. In the new guidelines on foetus diagnostics from 2004, the National Board of Health has explicated its monitoring role, stressing the importance of reporting on – and evaluating – the implementation of the guidelines, including test results, user satisfaction, and outcome.

Furthermore, the National Board of Health supervises the municipal health visitors (see below).

8.1.2.4 Role of the Ministry of Justice and Joint Council

The Ministry of Justice sets rules on abortions and embryo reduction¹⁸, as well as guidelines as how to rule and decide in these areas (LBK 541, §12).

A joint council is established to decide whether or not the woman's indications to have an abortion after week 12 of pregnancy are sufficient to give permission (LBK 541, p 4). Each county has a joint council with three members (two physicians and one county representative) appointed by the Ministry of Justice.

8.1.2.5 Role of the municipalities

The municipalities are responsible for the health visitors, that is they shall provide free of charge a certain specified number of visits by a specially trained health visitor to the family's home when the baby is born¹⁹. Her main task is to provide advice to the mother/father and examine the baby. She will visit the family at regularly intervals until the baby reaches nursery school age (Act 438 of 14/06/1995 on Preventive Medical Services for Children and Young People).

Furthermore, if special maternity care by a nurse is needed when the mother is discharged from hospital or following a home birth, the Act on Home nurse arrangements applies. (DSK

¹⁷ Personal communication with the National Board of Health.

¹⁸ the Danish word is "fosterreduktion" (foetus reduction) but the delimitations of "foetus" and embryo are not clear in the legislation.

¹⁹ Health visitors in Denmark are registered nurses with supplementary training on care for children and families.

nr. 15010 of 01/02/1993) and the municipality should provide the necessary care by a home nurse.

8.1.2.6 Role of the GP

The GP is responsible for antenatal checks and postnatal health examinations. He shall advise the pregnant woman about a healthy life style and risk factors in pregnancy, perform the most simple examinations e.g. measure blood pressure and refer her to risk tests and obstetric examinations, (LBK 622 + adherent legislation), if she wishes to proceed with tests.

The GP shall advise specifically about risks during pregnancy as to congenital abnormalities and chromosome defects of the foetus, and about the tests on offer for the pregnant women e.g. risk assessment (serum and neck-fold markers) and obstetric ultrasound scans in late pregnancy. The purpose of this information is to give the pregnant women an informed choice with regard to diagnostics. (2004 guidelines on foetal diagnostics).

Furthermore, the GP refers the pregnant women who wish to terminate her pregnancy to an abortion at a hospital (before week 12) or to a decision by joint council if the abortions has to take place after week 12 of the pregnancy.

Finally, the GP is responsible for the preventive examinations and vaccination programmed for small children under school age. (LOV 438 14/06/1995)

8.1.2.7 Role of the Midwife

Like the GP, the midwife plays a central role in maternity care.

She is responsible for preparing the woman to give birth, to measure and to supervise the foetus externally in the womb, advice about pain relief and to assist the woman deliver her baby. Each woman has a midwife "responsible" for her pregnancy. If work hours allow it and if the delivery is not expected to be complicated, the midwife will also be assisting delivery. For complicated births, the midwife shall be assisted by a physician, e.g. an obstetrician or a pediatrician.

8.1.2.8 Role of the pregnant woman

The pregnant woman herself is an important player in deciding maternity care. A parliament decision from 2003 (ref guidelines 2004), states that the purpose of foetus diagnostics and maternity care should no longer be to prevent complicated pregnancies, the birth of children with chromosome defects and abnormalities, but to give the woman an "informed" choice during pregnancy. The focus should be moved away from the technical possibilities of tests of detecting these defects, to information provided to the woman with ethics in focus.

This will put responsibility on the woman to choose for herself whether or not she wishes to be informed about her risk, have tests, and in case diagnostics are positive, give birth to a handicapped child. Also the woman has an "informed choice" about whether or not to terminate her pregnancy through an induced abortion, about where to deliver her baby, how to deliver (e.g. caesarean or vaginal delivery), and which type of pain relief to choose during delivery.

Finally, she may refuse delivery assistance by a particular midwife, if she does not feel comfortable with her and have her replaced by another midwife.

8.1.2.9 Role of Health visitors and Home Nurses

Another relevant player is the health visitor who will visit the family at home after the birth of the child to examine the child and discuss health and care issues with the mother and father.

Finally, the municipal home nurse deals with postnatal care for the mother and the baby at home, if the mother/the baby condition require extra care.

8.1.2.10 Role of the State University Hospital (Rigshospitalet).

The only clinic in Denmark for sex change operations and treatment is placed at the State University Hospital and patients will be referred to this clinic from a GP, examined and if there are sufficient indications of sex change treatment, he/she will be referred to the waiting list. The legislation relevant to this type of benefit is the Hospital Act.

8.1.3 Definition of Benefits (question 6)

8.1.3.1 Benefits in Maternity Care

The legislation on maternity care explicitly and specifically defines the benefits available to the pregnant and delivering women.

The Act on Maternity Care (LBK 622) covers all women staying in the country. This law is specific with regard to the number of antenatal checks, transportation in relation to deliveries, and delivery assistance. The woman may choose to deliver at a hospital, or at home if the pregnancy is considered uncomplicated. In the case of home delivery, a midwife will assist the delivering woman.

The guidelines on maternity care and foetus diagnostics (most recent from 1998 and 2004) specify the purpose and types of prenatal tests and examinations to be made available by the counties, who will perform them, and what are the criteria for receiving them (e.g. risk).

All women have the right to have the foetus gestational age established through an ultrasound scan, and have their risk of having a malformed foetus or foetus with chromosome anomalies examined (positive benefit).

Furthermore, there is a basis package of examinations and tests available to all women e.g. blood pressure measurement, regular measurement of the heart rhythm of the foetus etc. Some tests, e.g. amniocentesis, blood test for venereal diseases, blood sugar tests etc. are only available for women who after the initial screening are assessed to be at high risk (positive benefits). Also, other high-risk women, e.g. pregnant drug users, and pregnant women with social problems or very young women are entitled to extra care, both antenatal and postnatal.

Again the antenatal care benefits are “offers”: the woman is free to accept or reject them after she has been thoroughly informed by the professionals about risks, tests, etc. (Guidelines of Foetus Diagnostics 2004, Guidelines on Maternity Care 1998).

If a woman decides to give birth to a handicapped baby, her income or social conditions must not be a barrier to this, that is, the public authorities will be responsible for providing financial, social support and care for the child.

Health preparation classes aiming at training the mother (and father) psychologically and physiologically are not part of the health basket, but are organised in most municipalities in evening schools and partly reimbursed by the municipalities.

The guidelines recommend vaginal deliveries and the health professionals involved shall inform about the pros and cons of the different types of deliveries. Caesareans are usually only recommended upon indications, but in practice doctors rarely refuse if the woman wishes to have a caesarean²⁰. The mother may freely choose the hospital in which she wishes to deliver (Hospital Act). Also, she can choose the type of pain relief to use during delivery (if it is available at the hospital) after being thoroughly informed by the midwife about the pros and cons of the different types of relief.

At the hospital, the nurses shall see that breastfeeding, if possible, and other care of the baby works for the mother. If she has a home birth or an ambulatory birth at the hospital and is discharged the following-day, she will receive extra visits by the municipal health visitor who will then help the mother start breastfeeding and take care of the baby.

The legislation on maternity care contains positive benefits (e.g. entitlements to specific tests and examinations, free choice of delivery site, mode and pain relief etc.), but also negatively defined benefits, e.g. specific blood tests are only available for specific groups, e.g. HIV tests for women from third world countries (Guidelines 1998). Invasive diagnostic tests during pregnancy are only available if the initial risk assessment test shows an increased risk.

8.1.3.2 Benefits to the child

The newborn baby is entitled to a post-natal examination by the midwife (e.g. calculation of Apgar score) . Furthermore, the baby will receive a number of tests (e.g. PKU) and a vitamin K treatment (guidelines 1998). The baby/child will be visited by a health visitor at home five times during the first one and a half year, and once every year until he reaches school age. She will examine him, provide advice on breastfeeding and nutrition etc. (LOV 438, Lov 344, BEK 846, RTL 15082) Furthermore, the child is entitled to a number preventive GP examinations and an extensive vaccination programme during the first years of his life (see section 6.3). The GP tasks, frequency and timing of GP examination and vaccination programme are explicitly, specifically, and positively described in the legislation.

8.1.3.3 Benefits regarding contraception

All citizens of Denmark are entitled to receive advice on contraception by the GP free of charge (LBK 622, §11), including specific advice at the first medical examination by a GP after successful pregnancy (LBK 622, §2,2). Also, school children (teenagers) are entitled to receive instructions on how to use contraception. However, contraception is not part of the health basket, unless it is part of a medical treatment (e.g. the pill or hormones). In this case, the Danish Medicines Agency can authorise reimbursement based on an application from the GP/physician in charge of the treatment (BEK 63 and Medicines Act §7,4). Although it cannot

²⁰ Current debate in the media

be reimbursed, the pill is only available on prescription. OTC contraception, e.g. condoms is not part of the basket.

8.1.3.4 Benefits regarding Abortions

All pregnant women are allowed to have their pregnancy terminated free of charge before week 12 without stating any reason, after referral by the GP (Act 350 of 13/06/1973). Abortions after week 12 are only available upon medical or social indication after a decision by the local joint council (§3,3 and §3,6). That is if there is a danger that the baby will suffer from serious physical or mental impairment due to congenital factors or disease (p 3,3), if the pregnancy and/or the birth of the child constitutes a significant and unbearable burden to the mother and/or the family (p3,6). Specifically excluded are induced abortions after week 12 due to the sex of the baby, unless it is connected with serious disease (negative benefit). Only few abortions are carried out.²¹ The decision to seek termination is made by the mother, the father has no rights in this regard (negative benefit)

8.1.3.5 Benefits regards Sex Change treatment

Sex change treatment is available at the Sexological Clinic at the State University Hospital upon indication. This treatment is regulated by the Hospital Act and in the Act on Sterilisation and Castration. Benefits with regard to sex change are only implicitly and vaguely formulated in this law. There are specific age criteria for the two other interventions that are 25 years as a minimum for sterilisation and 21 for castration. Sterilisation is a benefit available to all above 25 years, but the latter is only available upon indication, e.g. if the patient is referred to a sex change operation, or in case of conviction for sexual crime.

8.1.4 Classification of Benefits, Uniformity for payers (question 7 and 8)

Benefits are classified according to the following criteria:

- Responsible administrative organisation, e.g. county, municipality, laboratory
- Responsible health care professional e.g. midwife, GP, health visitor,
- Timing in pregnancy or baby's life, week 12 abortion, week 18 scan etc., week 6 examination of baby, 2.5 year examination by health visitor etc.
- Risk, high risk /low risk, cut-off values of tests etc.
- Indication (some examinations in pregnancy are only available upon indication).
- Purpose and performance of test and examination.
- Target group: overweight woman, woman from third world countries, baby, father etc.

Payments are uniform for all payers.

²¹ National Board of Health: preliminary figures for 2003: number of abortions before end of week 12: 14,963, number of abortions after end of week 12: 604 (Source:” Sundhedsstyrelsen: Nye tal fra Sundhedsstyrelsen, legal provokerede aborter 2003, foreløbige tal”).

8.2 School Health Services (HC 6.2)

OECD Functional Classification of Health Care Definition:

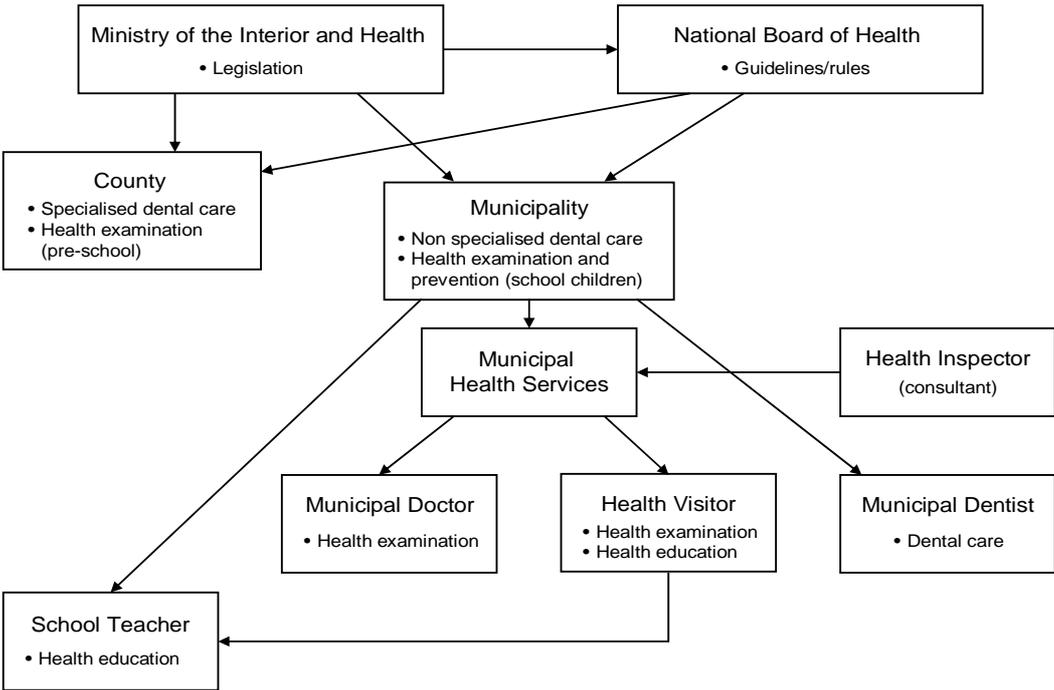
This item comprises a variety of services of health education and screening (for example by dentists), disease prevention, and lifestyles provided in school. This includes basic medical treatment if provided as an integral part of the public health function, such as dental treatment. Includes: interventions against smoking, alcohol and substance abuse. Excludes Vaccination programmes (HC 6.3).

8.2.1 Introduction

The main purpose of school health services is to ensure a healthy childhood for children and prepare them for a healthy adult life. The central means for this is health prevention and promotion, health education and dental care.

8.2.2 Actors responsible for defining benefits

HC 6.2. School Health Services



The main legislation on school health services is found in the Act on Preventive Health Services for Children and Young people. This law specifies which types of health promoting and preventive services should be supplied for children who are subject to compulsory school attendance (LOV nr. 438 of 14/06/1995). Another central law is the Act on Dental Care (LBK 1261 of 15/12/2003). Both laws contain definitions of entitlements and delegations to counties and in particular municipalities. The laws are formulated by the Ministry of the Interior and Health.

Regarding health services to children at school age, the main actor is the *municipality – and the municipality health personnel*. The municipality co-ordinates and organises the school health services according to the benefits stated in the Act on Preventive Health Services for Children and Young People. The school health services in this law are co-ordinated through the Municipal Health Services (“Kommunal Sundhedstjeneste”), which primarily consists of doctors, nurses and health visitors (RTL 15082, § 10).

The *medical officer of health* (“embedslægen”) acts as a professional consultant to the municipal health services (BEK 846 §18). These are the central actors in supplying school health services.

The municipalities also co-ordinate dental care for children and young people. They have the authority to decide whether to organise the dental care for children in public (municipal) clinics or to make contracts with private dentists (BEK 1073 §3).

However, since the county is responsible for any health promotion and prevention that takes place at the GP and for the specialised dental treatment, the county and the municipality are obliged by the law to co-ordinate their efforts (LOV 438 of 14/06/1995, LBK 1261 of 15/12/2003).

Teachers also play a central role in school health services, mainly as health educators. Health education, sexual education and family relations are mandatory subjects in the Danish public school. Topics included are for example alcohol, tobacco, drugs, venereal diseases, HIV/Aids etc. (www.faellesmaal.dk)

8.2.3 Definition of benefits (question 6-8)

Entitlements are stated explicitly in the Act on Prevention for Children and Young People and are based on rules for compulsory school attendance (LOV. 438 of 14/06/1995). This means that any child who is subject to compulsory school attendance is entitled to the benefits listed below. Benefits are therefore explicit and specific and they positively include the target group. However, it is also explicitly defined that children under the age of 18 are entitled to free dental care even though they may no longer be attending school (LOV nr. 438 of 14/06/1995, §5). Finally, it is stressed that entitlements depend on needs, so that children with special needs have extra rights (BEK 846 of 14/10/2002, §11)

Benefits are stated explicitly but are quite vague in the Act on Health Preventive Services for Children and Young People. The main benefits for school children are health examinations by a doctor employed by the municipality at the beginning and end of school, regular examinations by a health visitor (eye sight, weight, height etc.) and health education (health prevention and promotion). These benefits are specified in great detail in the guidelines (RTL 15082). It is also explicitly stated that there should be extra examinations and guidance of children with special needs by either doctor or health visitor (RTL nr. 15082, page 16).

The benefits in the area of general health prevention are classified on the basis of which professional is responsible for supplying and conveying them, e.g. the GP or the health visitor.

The benefits on dental care are also explicitly defined and based on positive inclusion. However, once again the specification of benefits is quite vague. The overall purpose of dental care is to ensure through prevention and treatment that the public will develop good dental care

habits and healthy teeth that will last throughout life (LBK 1261, §1). The benefits that all children under 18 are entitled to are defined as general and individual dental prevention, dental examinations and dental treatments (BEK 1073 of 11/12/2003 §2).

8.3 Prevention of Communicable Diseases (HC 6.3)

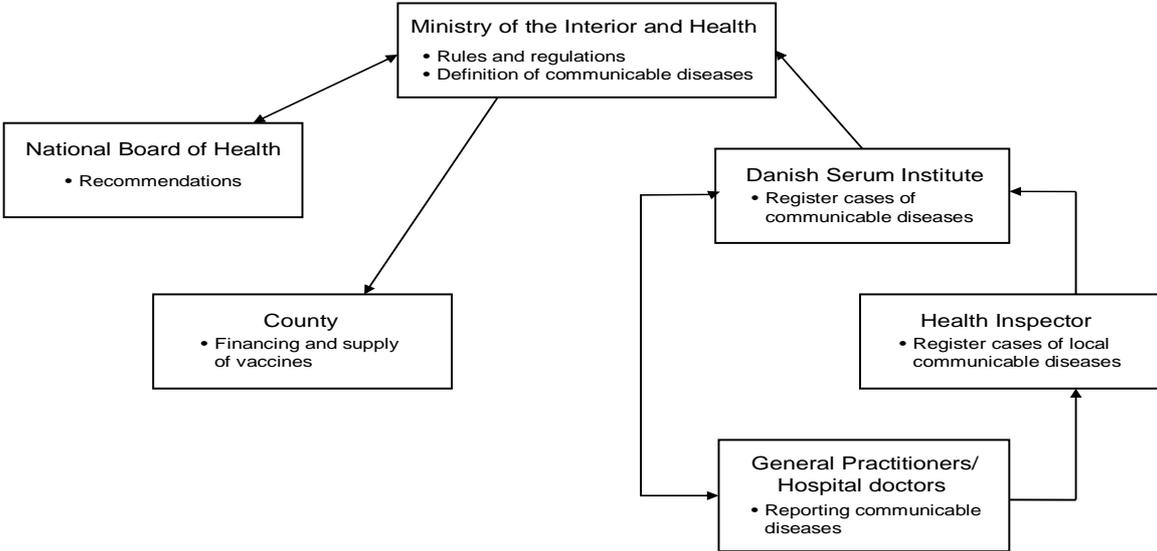
OECD Functional Classification of Health Care Definition:
This item comprises compulsory reporting and notification of certain communicable diseases and epidemiological enquiries into communicable disease: efforts to trace possible contacts and origin of disease; prevention of tuberculosis and tuberculosis control (including systematic screening of high risk groups), Immunisation /vaccination programmes (compulsory and voluntary), vaccination under maternity and child health care. Excludes: vaccination for occupational health and for travel and tourism on the patient’s own initiative.

8.3.1 Introduction

The legislation on prevention of communicable diseases is quite specific when it comes to benefits and entitlements, but the main focus it is not so much on benefits for the individual citizen as it is on the obligations of the different health professionals.

8.3.2 Actors responsible for defining benefits (question 5)

Communicable Diseases HC 6.3



Two laws are central to the prevention of communicable diseases in Denmark. One is the Act on Free Vaccination Against Communicable Diseases, where focus is on entitlements for vaccinations (LOV nr. 634 of 17/12/1976). In this law, the Minister for the Interior and Health is the main actor, since it is he who sets rules and regulations on vaccinations and definitions of diseases which are considered general communicable diseases and therefore subject to the Act

on Prevention of Communicable Diseases. The National Board of Health also plays a central role since it is on their recommendation that diseases are added or removed from the list of general communicable diseases or that rules of vaccination are changed (BEK nr. 305 of 13/05/1993). The county has the financial responsibility for vaccinations.

The other central law is the Act on Actions Against Communicable Diseases (DSK nr. 15015 of 29/03/1994). The main focus in this law is the obligation towards reporting communicable diseases etc. A central actor here is the Statens Serum Institut, since they register all cases of communicable diseases mentioned in the law. Doctors (both GP's and hospital physicians) report cases to the Serum Institute and in some cases also to the medical officer of health (BEK 277 of 14/04/2000).

8.3.3 Definition of benefits (question 6-8)

Vaccinations are mainly aimed at children, and the entitlements are explicitly stated in the legislation. Children under 16 years of age should be vaccinated against whooping cough, diphtheria, tetanus, measles, parotitis epidemica (mumps) and German measles. These vaccinations are voluntary. It is recommended that the vaccination of children follows the health examinations at the GP (see description on HC 6.1) (VEJ 199, BEK nr. 305 and the National Board of Health publication: "Sundhedsstyrelsen (2004) "Børnevaccinationsprogrammet i Danmark").

Besides children, elderly people over 65 years of age are the only citizens entitled to be vaccinated against influenza free of charge²² (BEK nr. 709 of 30/06/2004). The legislation on vaccination is thus explicit, positive, and specific.

The rest of the legislation is mainly centered on obligations towards securing that generally dangerous communicable diseases do not spread in Denmark. The generally dangerous diseases are defined explicitly in an appendix to the Act on Actions Against Communicable Diseases. The legislation only apply to the explicitly stated diseases, but the Minister of Interior and Health has authority to add or remove diseases (DSK nr. 15015, §2). Included in the appendix is for example tuberculosis and hepatitis (DSK nr. 15015, appendix). This law does not apply to sexually transmitted diseases.

Obligations are mainly aimed at doctors (both GP's and others). Doctors are obliged to report communicable diseases to either Statens Serum Institute or to the medical officers of health in order to monitor the occurrence of diseases such as for example HIV, hepatitis, tuberculosis etc. (BEK 277 of 14/04/2000 and VEJ nr. 60 of 14/04/2004).

How and when to report is explicitly and specifically defined, and the definitions of diseases that should be reported are based on inclusion in a positive list. In the guidelines it is stressed that presumed way of infection should be stated (such as infection risk, mode of transmission, source of infection, risk behaviour etc.) (VEJ nr. 60 of 14/04/2004).

Tuberculosis has increased in Denmark in recent years. Vaccination of children against tuberculosis was stopped in Denmark between 1976 and 1980²³. However, if a person is infected

²² The notice is temporary and only valid until the end of 2004 , but according to the Ministry of Interior and Health the free vaccination of people over 65 years old will continue until 2006, since it is part of the agreement of the government budget.

²³ The website of Statens Serum Institut on tuberculosis <http://www.ssi.dk/sw665.asp>

with TB, a systematic search for others that could be infected will be conducted, and they will be given the Mantoux test²⁴. This, however, is not stated explicitly in the legislation but in guidelines from health professionals. It is stated explicitly though that the National Board of Health can set rules regarding which groups to test for tuberculosis (DSK nr. 15015, §25).

The legislation on how to handle communicable diseases coming to Denmark is very vague and not explicit – immigrants, asylum seekers etc. are not explicitly mentioned in the Act on Actions Against Communicable Diseases (DSK 15015). However, the National Board of Health has made guidelines for the health examinations of immigrants and asylum seekers. In these it is explicitly stated that asylum seekers have a health examination by a nurse when they arrive in Denmark. People from high risk areas, which is not defined, are examined by a doctor and if found necessary tested for tuberculosis and HIV. There's no systematic screening of other immigrants or adopted children, however the National Board of health recommends health examinations of all people from third world countries arriving in Denmark²⁵.

8.4 Prevention of Non-Communicable Diseases (HC 6.4)

OECD Functional Classification of Health Care Definition:

This item comprises public health services of health education, disease prevention, and the promotion of healthy living conditions and lifestyles such as services provided by centres for disease surveillance and control; and programmes for the avoidance of risks incurred and the improvement of the health status of nations even when not specifically directed towards communicable diseases. Includes: interventions against smoking, alcohol and substance abuse, such as anti-smoking campaigns, activities of community workers, services provided by self-help groups, general health education and health information of the public; health education campaigns; campaigns in favour of healthier lifestyles, safe sex, etc.: information exchanges: e.g. alcoholism, drug addiction. Excludes: public health environmental surveillance and public information on environmental conditions.

8.4.1 Introduction

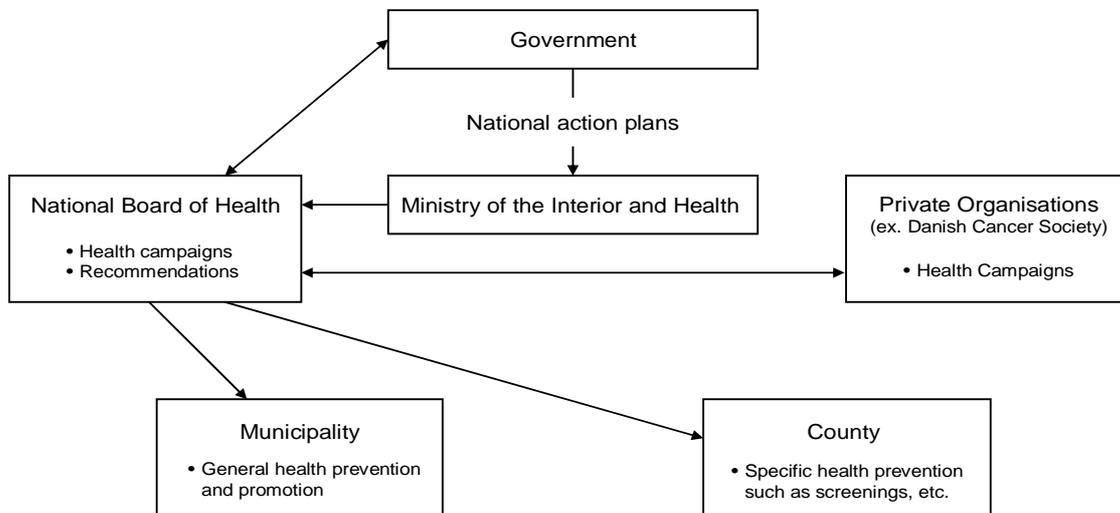
Prevention of non-communicable diseases in Denmark is only scarcely regulated in the legislation. The main framework for this kind of prevention lies in action plans and guidelines. Decisions on initiatives of health prevention are therefore decentralised. The activities directed towards the prevention of non-communicable diseases are anchored in the National Board of Health, the counties and the municipalities.

²⁴ Health Inspectors website on tuberculosis http://www.eli.dk/Smitsomme_sygdomme/Om_de_enkelte_smit-somme_sygdomme/Tuberkulose.aspx?lang=da

²⁵ (Sundhedsstyrelsen (2002): "Redegørelse for sundhedsbetjening af flygtningen og indvandrere, der kommer til Danmark, hvad angår smitsomme sygdomme").

8.4.2 Actors responsible for defining benefits (question 5)

Non Communicable Diseases HC 6.4



The main framework for prevention of non-communicable diseases and general public health is the government programme on public health. This programme is an action plan with goals and strategies for public health from 2002 until 2010. It aims at health prevention and promotion across different sectors and beyond traditional responsibilities – the educational and social sector should also be involved in health prevention and promotion. Focus is on selected prevalent diseases and risk factors, which will be discussed further in the following section on benefits. (Regeringen (2002): "Sund hele livet: De nationale mål og strategier for folkesundheden 2002-10").

The National Board of Health provides guidelines and information for other actors in field of preventing non-communicable diseases. An example is a large scale project on prevalent diseases, where the purpose is to increase the systematic health prevention and to come up with new specific suggestions for health prevention interventions (Sundhedsstyrelsen (2004): "Sundhedsstyrelsens Folkesygdomsprojekt. Sammenfatning"). Furthermore the Minister of Interior and Health appoints a National Council for Public Health. The purpose of this council is to contribute to the debate on public health and to supervise or advise the Minister for the Interior and Health (LOV 141 of 05/03/2001).

The main activities regarding prevention of non-communicable diseases take place in the municipalities and to some extent in the counties. There is regional variation in the activities, since these are not regulated by law. This also means that municipalities have the authority to plan and organise health prevention. Since there is very little legislation in this area, health prevention is often not prioritised by the municipalities when budgets are made. (Det Nationale Råd for Folkesundhed (2004): "Det Nationale Råd for Folkesundhed – beretning 2001-2003"). However, most counties and municipalities do attempt to follow the guidelines from the National Board of Health in most areas.

8.4.3 Definition of Benefits (question 6-8)

As mentioned above, prevention of non-communicable diseases is only in a few cases regulated by law. This also means that there are only few specific entitlements and benefits. Therefore benefits in this section are interpreted broadly.

In the government programme several specific risk factors and highly prevalent diseases are listed as the main targets for the effort towards prevention of non-communicable diseases. For each lifestyle-related risk factor – smoking, alcohol, diet, exercise and obesity – strategies and goals are outlined. An illustrative example is smoking, where the goal is to reduce the number of smokers in general and the strategy is to create smoke-free environments, provide counselling and other stop-smoking interventions and reduce the number of new smokers. These formulations are explicit but still quite vague.

However, some aspects of smoking are regulated in the law, such as prohibition of smoking in public schools for the children and limitations of smoking in public transport (LOV 436 and LOV 1313).

The government programme focuses on specific prevalent diseases that are affected by the above mentioned risk factors. The diseases specifically mentioned are diabetes, cancer, cardiovascular disease, osteoporosis, allergies, musculoskeletal diseases and COPD (Chronic Obstructive Pulmonary Disease). Part of the strategy of prevention of these diseases are focus on the before mentioned risk factors. Otherwise, the strategies on prevention of these prevalent diseases are very vague. (Regeringen (2002): "Sund hele livet: de nationale mål og strategier for folkesundheden 2002-10").

Screening for different types of cancer is one benefit that is part of the prevention of non-communicable diseases. In Denmark, the screening effort is mainly focused on cervix cancer and breast cancer.

Screening for cervix cancer is offered in all counties, but is not regulated explicitly in the legislation. It is based on international recommendations and recommendations from the National Board of Health (source Ministry of Interior and Health²⁶).

Screening for breast cancer is regulated explicitly in the legislation, where it is stated that all counties should supply mammography screenings for all women between 50 and 69 years old (LBK nr. 766 af 28/08/2003 §5e). This is though modified by an exemption in the law that the Minister for the Interior and Health can decide when this legislation should take effect. It has not yet taken effect but the goal is to oblige the counties to provide this screening by the year 2007 (Ministry of Interior and Health²⁷). So even though the legislation on mammography screening is explicit, it is also very vague.

Another central benefit or target area when it comes to general prevention of non-communicable diseases is health campaigns. These are not regulated in legislation but are most often initiated by the National Board of Health and various private organisations often in corporation with the Ministry of Interior and Health. The main areas of health campaigns are exercise, diet, alcohol and tobacco. The private organisations, such as the Danish Lung Associa-

²⁶ Hans Lynggaard Jørgensen

²⁷ Hans Lynggaard Jørgensen

tion, the Danish Cancer Society and the Danish Heart Foundation, also organise their own campaigns and in general play a central role in health prevention and promotion in Denmark²⁸.

All benefits on prevention of non-communicable diseases do not have specific criteria, although there are target groups for some of the efforts and campaigns.

8.5 Occupational Health Care (HC 6.5)

OECD Functional Classification of Health Care Definition:

Occupational health care comprises a wide variety of health services such as surveillance of employee health (routine medical check-ups) and therapeutic care (including emergency health care services) on or off-business premises (including government and non-profit institutions serving households). This excludes however, remuneration-in-kind of health services and goods that constitute household actual final consumption rather than intermediate consumption of business.

8.5.1 Actors responsible for defining benefits (question 5)

Occupational Health Services in Denmark are regulated by the Act on Working Environment (LBK . 784 of 11/10/1999 and LOV 1415 of 22/12/2004). The law sets up a framework leaving the actual implementation to the Minister of Employment and the National Working Environment Authority (a special state agency) who specifies the regulations in a number of circulars, regulations and recommendations. The specification of the framework is to a great extent carried out through negotiations with employers and employees organisations.

According to the law, the employer shall see that working conditions are in proper state in order to secure the health and safety of the employed. However, the employees are obliged to co-operate with the employer in securing safe working condition.

The responsibility for surveillance, controlling and maintaining standards of health and safety are delegated to a special state agency, the National Working Environment Authority, which provides advice, sets standards and inspects working sites.

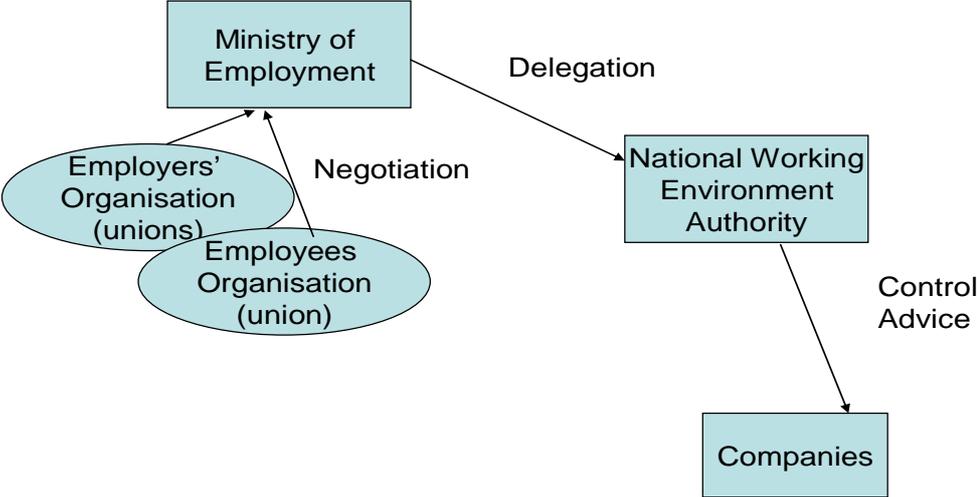
According to the OECD Functional Classification, occupational health care comprises health services such as surveillance of employee health (routine medical check-ups) and therapeutic care (including emergency health care services). Occupational health activities to improve ergonomics, safety and health and environmental protection at the workplace, accident prevention etc., however should not be recorded under health care activities. The following description of entitlements and benefits is based on this demarcation.

Surveillance of employee health is regulated by the Act on Working Environment, while therapeutic health care of workers is regulated in line with other health care services in Denmark. This means that entitlements and financing of health care services do not depend on whether you got sick during work or due to bad working conditions. Health services to employees are provided by the health sector in general. Under the Health Care Reimbursement Scheme, the services are provided by GP and specialists. In the hospital sector, the service is

²⁸ Source; website of The National Board of Health: <http://www.sst.dk/Forebyggelse/Kampagner.aspx?lang=da>

provided by the medical speciality relevant for the medical problem. In addition, most counties have an Occupational Health Clinic which may assist in the diagnosing and treatment of patients with a work related illness.

Decision making on benefits concerning Occupational Health (HC 6.5) in Denmark



8.5.2 Definition of benefits (question 6-8)

According to the Act on Working environment (LBK 784) the Minister of Employment can make decisions concerning medical examination of workers employed in industries in which special risk for the health of the worker may exist (§63). The health examination could take place before the employment of the worker, during employment – on a regularly basis – or after the employment has stopped.

As an example of a ministerial decision concerning medical examination is a regulation concerning work with ionizing radiation (BEK 206 23/03/1990). According to the regulation any person who is working under conditions that may expose that person for ionizing radiation above a specified limit, should be examined before start of the work. Further the person should undergo medical check-up on a regularly basis, at minimum once every year. The expenses should be paid by the employer.

Therapeutic care, including emergency care is provided by the general health sector on the same conditions as all other patients. This means that the expenses are regulated and paid by the counties, and that the benefits are the same as for all other patients (described in chapter 3, 4,5,and 6).

8.6 All other Miscellaneous Public Health Services (HC 6.9)

OECD Functional Classification of Health Care Definition:

This item comprises a variety of miscellaneous public health services, such as operation and administration of blood and organ banks, and the preparation and dissemination of information on public health matters not classified elsewhere. Includes: public health environmental surveillance and public information on environmental conditions.

8.6.1 Introduction

In this section only selected benefits regarding public health is presented. The main focus is on general health prevention for the elderly people, since there is specific legislation on this area.

8.6.2 Actors responsible for defining benefits (question 5)

The central legislation on the area of health prevention for the elderly is the Social Services Act under the auspices of the Ministry of Social Affairs, and the Act on Preventive Home Visits for the Elderly (LOV 1117 of 20/12/1995), which lie under the auspices of the Ministry of Interior and Health. This means that both the Ministry of Social Affairs and the Ministry of Interior and Health define and regulate benefits regarding general health prevention for the elderly. The main actors are the municipalities since they provide and organise the benefits.

8.6.3 Definition of benefits (question 6-8)

The municipality should supply preventive home visits at least twice a year for people older than 75 years (LOV nr. 1117 of 20/12/1995). The purpose of these home visits is to help the elderly people to make complete use of their own resources and to preserve their functional level as long as possible. The purpose is both general health prevention and health promotion. The elderly can decline the offer of a home visit. The municipality plan and organise the visits, but they cannot hand the responsibility for the home visits over to any other actor. (VEJ 59 of 06/03/1998, chap. 4.)

The municipality can also supply general activities with the purpose of health prevention or health promotion. The municipality decides whether they will initiate and organise activities or give reimbursement towards it. The purpose of such activities is to increase the possibility for the elderly to take care of themselves (VEJ nr. 59 of 06/03/1998, chap. 6 and Social Services Act §65).

9 Description of Benefit Catalogues, Involved Actors and Decision Criteria

9.1 Introduction

The purpose of this chapter is to describe the structure of benefit catalogues. As explained in the introduction to the report in chapter 1, benefit catalogues as such do not exist in the Danish health sector.

However, some documents regulate benefits implicitly. One example is the positive list of medicines that are reimbursed, provided by the Danish Medicines Agency. This list has been described in chapter 7. Another example is the fee schedule under the Health Reimbursement Scheme. This document regulates the services available for patients as the providers will only get payment for services which are included in the fee schedule. It is regulatory for provider behaviour as it is unlikely that providers will perform services that they are not paid for. Therefore the schedule may implicitly regulate benefits available to patients and is described below in the next section.

It could be discussed whether the fee catalogue for hospitals which is issued every year by the Ministry of for the Interior and Health might be considered a benefit catalogue. This fee catalogue provides the prices based on Diagnosis-Related-Groups (DK-DRG) which are used for payments between counties and also for financing part of the hospital activity (20% of the activity from 2004). However, since this only partly finances hospital activity, its implicit effect on benefits is considered relatively insignificant, and therefore a description of this catalogue is not included here.

The Danish DRG system and the principles of calculating the DRG cost weights will be described in detail as part of the next work package in the project.

The questions that will be answered for the fee schedule under the Health Care Reimbursement Scheme are

- what is the purpose and update procedures of the fee schedule? (question 9)
- how are benefits classified, i.e. itemised by service delivered or individual good? (question 10)
- description of the taxonomy (question 11)
- who are the decision-makers and how is the decision-making process? (question 12-13)

9.2 The Fee Schedule under the Health Care Reimbursement Scheme

9.2.1 Purpose and update procedures (question 9)

All tariffs negotiated between the Health Care Reimbursement Negotiating Committee (HCRNC) and health care personnel trade unions are published by the HCRNC in a catalogue, revised when the government orders it, but usually every six months. The last revision is

dated April 1, 2005. The aim of the catalogues is to provide an overview of the tariffs a number of health personnel groups can use for reimbursement.

HCRNC's provides fees for: general practice, eye doctors, ear nose and throat doctors, other specialist doctors (in anaesthesia, diagnostic radiology, dermatology- venereology, rheumatology, gynaecology/obstetrics, medicine, surgery, clinical chemistry, neurosurgery, neurology, orthopaedics, pathology, plastic surgery, psychiatry, paediatrics, child psychiatry, and tropical medicine), dentists, physiotherapists, treatment of muscular diseases, chiropractics, opticians, chiropodists, and psychologists.

9.2.2 Classification of benefits (question 10)

The benefit catalogue is primarily reimbursement schedules for doctors within each speciality, dentists, physiotherapists, chiropractors, opticians, chiropodists, and psychologists. Benefits may vary according to the patients' choice of social insurance group (group 1 and 2)

The fee schedules in general practice are divided by time (day time) and (on call time), the on call time fees are different for the Copenhagen area and the rest of Denmark, and the reimbursements depend on the kind of on call: On call A (Monday-Friday, Saturday) and On call B (Monday-Friday, Saturday, Sundays and public holidays).

Below a description of the specific benefits – services reimbursed – is provided.

General practice

In general practice, for day time services, there are specific reimbursement rates per type of consultation (normal consultation, preventive consultation, preventive consultation concerning ischemic heart disease, e-mail consultation, and telephone consultation). There are also specific reimbursement rates for home visits graduated according to geographical distance from the doctor's office.

For on call services evening and night there are specific fees for consultation, telephone consultation with respectively without visit/consultation, and visits.

For special services offered in office or at a visit the doctor is reimbursed according to a catalogue with 55 items. Examples from the list: collection of blood, collection of sample for cytological testing, treatment of warts, urethral catheterisation, removal of foreign bodies, rectoscopy, anoscopy, issue of a certificate etc.

There is also a reimbursement scheme for 32 laboratory examinations in doctor's office. Examples are: photometry for B-glucose and B-haemoglobin, urinalysis by stix, microscopy of biological material, culture of biological material, ECG, pulmonary function examination, leukocyte counts etc.

Social medicine services are reimbursed according to telephone enquiry and participation in meetings with the municipal health administration.

There is a special reimbursement rate for talk therapy.

There are special reimbursement rates for preventive services, i.e. patient talks with other staff members, investigative activities, talk therapy, preventive services including general health examinations.

There are special reimbursement rates for guidance concerning methods of contraception.

There are special reimbursement rates for services concerning issue of certificates to patients with chronically diseases, and for applications for subsidy to terminally ill patients.

There are special reimbursement rates for preventive examinations, such as health examination of pregnant women, various laboratory examinations, participation in committees, child examinations, and child vaccinations.

Ophthalmologists (eye doctors)

Practising ophthalmologists are reimbursed for consultations (first consultation, later consultation, and telephone consultation), examinations and operations. The 5 reimbursed examinations are: orthoptic assessments, diagnose and control of retinal detachment, change in diabetes, and examinations for glaucoma, automatic perimetrical examination, and measuring individual weak-sight optics. For first respectively following operation the ophthalmologists are reimbursed for 18 operations, and for biopsy, fundus photography and fluorescein angiography.

There are special reimbursement rates for visits.

Otorhinolaryngologist (ear-nose-throat doctors)

Practising otorhinolaryngologists are reimbursed for consultations (first consultation, later consultation, and telephone consultation), 21 examinations (allergologic and skin, calorimetric examinations of sense of equilibrium, audiometric examinations, bronchoscopy, stroboscopy, acoustic rhinometry, voice analysis, fine-needle biopsy, adjustment of hearing aid) and 39 operations (tympanostomy, paracentesis, myringoplasty, removal of mucous polyp(us),sinoscopy, treatment of nose fracture, antrostomy, tonsillectomy, removal of tumour, and operation for jug-ears).

There are special reimbursement rates for visits.

Anaesthetists

Practising anaesthetists are reimbursed for consultations including treatment for pains (first consultation, later consultation, and telephone consultation), 12 blocks (muscular blocks, intra articular injections, acupuncture, transcutaneous nerve stimulation, various blocks, epidural injections), extended pulmonary function examinations, and assistance to ophthalmologists and otorhinolaryngologists.

Psychiatrists (children and youth)

Psychiatrists are reimbursed for consultations and talk therapy.

There are special reimbursement rates for visits.

Specialists in dermatology and venereal diseases

Practising specialists in dermatology and venereal diseases are reimbursed for consultations (dermatology, allergology, venereology, eczema examination), 14 examinations (biopsies,

intra lesional injections, iontophoresis, Smears, anoscopy), and 8 operations (cyst incision, abscess incision, removal of tumour in skin and mucosa, removal of nail, laser treatment, pinch-graft transplantation) and tar bath, bran bath, photodynamic therapy (PDT) of cancers and warts.

Specialists in diagnostic radiology

Practising specialists in diagnostic radiology are reimbursed for various examinations of different parts of the body (3 reimbursement rates incl. half price if second examination is performed at the same time) and a number of special examinations (tomography, intra venous cholangiography, urography, sialography, phlebography, and phlebography).

Gynaecologists and obstetricians

Practising specialists in gynaecology and obstetrics are reimbursed for consultations (first consultation, later consultation, and telephone consultation), 22 diagnostic services (biopsy, uterine curettage, anoscopy, colposcopy, rectoscopy, cystoscopy, Smear, hysteroscopy, sonography, uroflowmetry, cystometry, hystero-salping-ultrasonography), 11 fertility services (consultations, sonography, insemination, perturbation, puncture of ovary cyst), 28 treatments (cyst incision, abrasio, dilatation of cervical channel, incision of abscess, thermal or cryo treatment of cervix uteri, removal of tumour from skin, urethral dilatation, evacuatio uteri, conisation, plastic surgery, removal of polyps, setting up intrauterine devices, shift of doughnut pessary, blocks).

Specialists in medicine

Practising specialists in medicine are reimbursed for consultations (first consultation, later consultation, and telephone consultation), 31 examinations (biopsy, skin test, pulse oximetry, pulmonary function examination, stereomicroscopy, breath test, rectoscopy, cardiological examinations (eccocardiography, sonography of peripheral arteries), gastroenterological examinations (oesophagoscopy, gastroscopy, duadenoscopy, sigmoidscopy, coloscopy), pulmonary medicine (allergen provocation, bronchial provocation, diffusion capacity, total pulmonary capacity), 8 treatment services (allergy vaccination, work ECG, removal of polyps, eccocardiography, DC conversion, bone density measurement).

Practicing surgeons

Practising surgeons are reimbursed for consultations (first consultation, later consultation, and telephone consultation), 18 examinations (biopsy, cystometry, uroflowmetry, blocks, sonography, coloscopy, pulse oximetry, oesophago-, gastro- and duodenoscopy, anoscopy, rectoscopy, cystoscopy), and 36 operations (incisions, treatment of haemorrhoids, hydrocele, removal of nail, aspiration cytology, removal of skin tumour, removal of breast tumour, plastic skin operations, trigger finger, ganglion operation, anal surgery, removal of polyps, phimosis, hernia, varicose veins, vasectomy).

Practising biochemists

Practising biochemists are reimbursed for consultations (first consultation, later consultation, and telephone consultation).

Neurologists

Practising neurologists are reimbursed for neurological and neurosurgical consultations (first consultation, later consultation, and telephone consultation) and electroencephalography (EEG).

Orthopaedics

Practising orthopaedics are reimbursed for consultations (first consultation, later consultation, and telephone consultation), examinations (biopsy, pulse oximetry, casting) and 17 operations (wound cleaning, removal of nail, removal of skin tumour, hammertoe correction, amputation of finger and toe, swollen finger correcting skin operations, trigger finger, ganglion, bunion removal, treatment of fractures, synovectomy in hand, fusion of joint, hallux osteoarthritis, Dupuytren's contracture, reposition of ulnar head, varicose veins).

Pathological anatomy

Practising specialists in pathological anatomy are reimbursed for vaginal cytological examinations, tissue microscopy, cytological examinations, immune histochemical colouring of preparations, and cone examination).

Specialists in plastic surgery

Practising specialists in plastic surgery are reimbursed for consultations (first consultation, later consultation, and telephone consultation), examinations (biopsy), 10 operations (trigger finger, phimosis, removal of ganglion, free removal of skin, correction of deformity of nose and ear, hair transplantation).

Psychiatrists

Practising psychiatrists are reimbursed for consultations (first consultation, second consultation, later consultation, telephone consultation, consultation with next-of-kinds), and psychotherapy with 1-6 persons.

Paediatricians

Practising paediatricians are reimbursed for consultations (first consultation, second consultation, later consultation, and telephone consultation), examinations (skin, provocation tests, pulmonary function examinations).

Rheumatologists

Practising rheumatologists are reimbursed for consultations (first consultation, later consultation, and telephone consultation), 14 examinations (puncture of joint, nerve blocks, manipulation, acupuncture, instruction in exercise therapy, sonography, treatment control for chronic inflammation).

Specialists in tropical medicine

Practising specialists in tropical medicine are reimbursed for consultations (first consultation, second consultation, later consultation, and telephone consultation), and 8 examinations (parasitological examination, bronchoscopy, oesophagoscopy, gastroscopy, cystoscopy, rectoscopy, biopsy).

Specialists in laboratory examinations

Practising specialists in laboratory examinations are reimbursed for 108 examinations.

Specialists in social medicine

Practising specialists in social medicine are reimbursed for enquiries from the municipality and for participation in meetings.

Practising dentists

Practising dentists are reimbursed for diagnostic examinations, tooth-cleaning, x-ray, preventive service, preventive treatment, operative extractions, tooth filling, stepwise excavation with amalgam, plastic, pulp cutting, apical amputation and root filling, extractions, paradentosis treatment, cleaning of root of a tooth.

Physiotherapists

Practising physiotherapists are reimbursed for first consultation, normal treatment, and short treatment and follow up training therapy. Special agreement for horseman therapy at riding schools.

There are special reimbursement rates for visits.

Specialist in rehabilitation

A particular agreement exist for rehabilitation by Teddy Øfeldt including reimbursement for function examination of disabled, rehabilitation of disabled, function examination and treatment of myopathies.

Chiropractors

Chiropractors are reimbursed for basic services and treatment at first visit respectively succeeding visits for first time and chronically ill patients.

Chiropodists

Chiropodists are reimbursed for treatment of patients with diabetes (chiropody, orthoses) in-growing nails (orthoses) and cicatricial tissue due to radiation treatment (orthoses, insoles).

There are special reimbursement rates for visits.

Psychologists

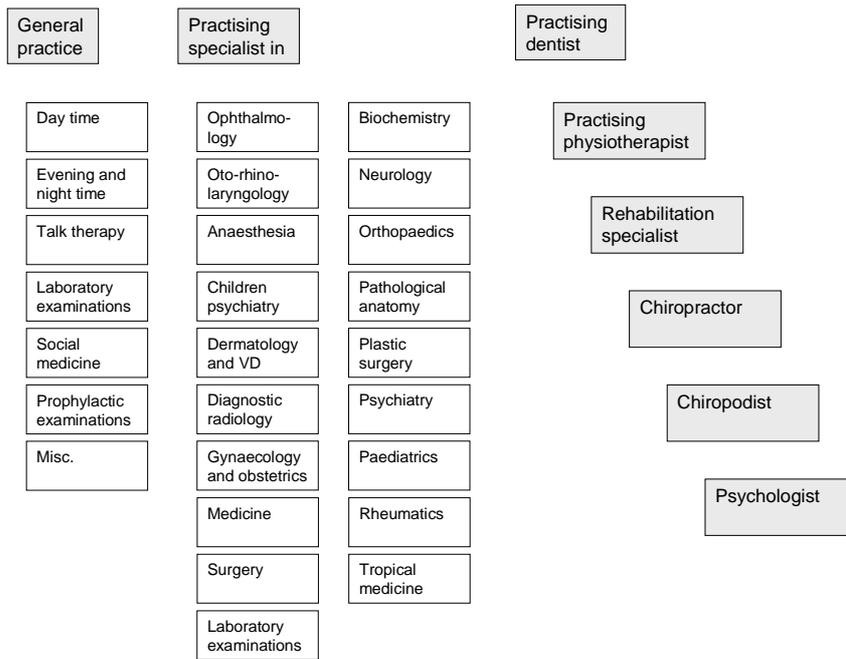
Practising psychologists are reimbursed for consultations with one, two or more persons.

There are special reimbursement rates for visits.

9.2.3 Taxonomy (question 11)

The table below shows the overall structure of the catalogue.

Overall structure of the fee schedule
(specialities in bold are at an equal level (chapter) in the schedule)



The catalogue has at least two levels: 1) Speciality (medical and other) offering the service and 2) Type of service offered. A third level is found for GP's, as the benefits are divided in basic, supplementary, laboratory and miscellaneous services.

In the table below, the type of service provided is noted for each speciality.

<i>Speciality</i>	<i>Visit(s)</i>	<i>Examination(s)</i>	<i>Operation</i>	<i>Treatment</i>
GP	x	X		x
Anaesthetist		X		x
Biochemical specialist	x			
Child/youth psychiatrist	x			
Diagnostic radiologist		X		
Ear/nose/throat specialist	x	x	x	
Eye specialist	x	x	x	
Gynaecologist	x	x	x	x
Laboratory specialist		x		
Medicine specialist	x	x		x
Neurologist	x	x		
Orthopaedic surgeon	x	x	x	
Paediatrician	x	x		
Pathologist		x		
Plastic surgeon	x		x	
Psychiatrist	x			
Psychologist	x			
Rheumatologist	x	x		x
Skin and VD specialist	x	x	x	X
Specialist in tropical medicine	x	x		
Surgical specialist	x	x	x	
Dentist	x	x	x	x
Physiotherapist	x			
Chiropractor	x			x
Chiropodist				x

The catalogues is divided into specialites each with a speciality number according to the agreement with the Health Care Reimbursement Scheme Negotiating Committee and the medical associations, eg. general medicines are in the 80's, where 80 is general practice, 82 is general practice under the emergency services in Copenhagen etc Furthermore, under each speciality, there are several item numbers (each item a separate number), although the same item number may be under different specialities and thus the speciality code has to be indicated along with the item code, for the system to recognise the item correctly.

Items may be linked directly to the legislation, in the cases where the legislation specifies the benefits, eg. antenatal care consultation or first child health check-up at 5 weeks of age (general practice) and are also directly linked to the logic applied by the legislation, e.g following certain age groups, certain timing (week 12, 1st and 2nd consultation etc.), or to the specific agreement on e.g. working hours or transport fees for the professional group involved. Where the legislation does not specify the benefits, items are either linked to goods (eg. laboratory tests) to procedures (eg. spirometry) or – in rare cases – to indications (e.g. podiatry for diabetics). With a few exceptions (ICD 10 criteria for diagnosing depression /Hamilton's depression scale for follow-up) there is generally no specification of the technology to be used.

9.2.4 Decision-makers, decision-process (question 12 and 13)

The general structure of the fee catalogue is set up by the Health Care Reimbursement Negotiating Committee, being responsible for agreements with the professional organisations (medical associations /trade unions).

The committee is based on § 26 of the Public Health Insurance Act. It has seven members – six elected by the Association of County Councils and one by the two city councils in the capital. They are all appointed for four years. One representative from the Ministry of Finance, one from the Ministry for the Interior and Health and two from Local Government Denmark (Kommunernes Landsforening) participate in the committee meetings. All agreements negotiated by the committee have to be approved by the Minister for the Interior and Health.

The items listed and the fee-schedule is a result of negotiations between the parties. Evidence documentation; health technology assessments, cost-effectiveness analyses, clinical studies may be brought forward by professional committees and included in the negotiation, but is it not mandatory or a systematic process.

Criteria for decisions concerning inclusion or exclusion of an item for reimbursement are neither systematic nor public. Arguments for inclusion might be facilitation of professional development, for exclusion it might be modernisation, i.e. substitution with more up-to-date procedures or means of treatment. If benefits are stated specifically in the law, as e.g. contraceptive advice at the GP office, there is usually a reimbursement rate²⁹.

Negotiations take place every three years concerning items on the list, and twice a year concerning the fee-schedule.

²⁹ Personal communication with Annette Bonne, Health Care Reimbursement Negotiation Committee.

10 Conclusion and Discussion

Three main areas

The Danish health care sector may roughly be divided into three main areas:

- *The hospital sector* providing curative care – somatic as well as mental – in hospitals. The sector is regulated by the Hospital Act and ancillary laws.
- *The primary health care sector* providing out-patient services delivered by private entrepreneurs i.e. GP, private specialists, dentists, and physiotherapists. The sector is regulated by the Public Health Insurance Act and ancillary laws.
- Finally the third sector, which may be called *the social services health sector*, providing primary health care services such as: long term care outside hospitals, home nursing, rehabilitation outside hospitals. These services – in Denmark considered part of the social sector – are regulated by the Social Services Act and ancillary laws.

Decentralisation

Generally, in all of the three sectors, the laws provide a framework leaving the actual definition of benefits to local authorities.

Benefits in the hospital sector are decided by the counties and in the end the hospital clinicians.

Benefits in the social health sector are mainly decided by the municipalities but also for the more specialised care, by the counties.

Benefits in the primary health sector are partly decided centrally through a negotiation between representatives for the counties and the providers and partly locally by the counties, as they can control the supply, e.g. the number and types of specialists available in the county. The general practitioner is also very influential in deciding benefits in Denmark due to his gatekeeper role.

The legal framework set up by the Folketing and the Ministry of the Interior and Health and the Ministry of Social Affairs makes explicit a number of minimum benefits at a very superior level, such as who is entitled to the services, patient co-payment etc.

However, the laws may also be very specific. Some laws specify areas of care and items, e.g. a maximum waiting time for treatment of certain patient categories, medical goods, e.g. reimbursement of medicines and durable appliances. These specific laws may be targeted at particularly weak groups whose rights need to be ensured such as children or the elderly, or the regulation may be made within areas of specific political attention, e.g. waiting lists, patients suffering from cancer.

Finally, specific regulatory schemes may be set in areas with private providers as under the Health Care Reimbursement Scheme. Here the regulatory schemes are decided at a national level, provided by private specialists and financed at the local level by the county.

Especially in the areas where the laws provide a general frame letting local decision-makers define the picture, there is a certain local and regional variation in the way health services are organised and – marginally – in health care benefits.

Few benefit catalogues

Except for the positive list for reimbursed medicines and the Health Care Reimbursement Negotiation Committee fee schedule, there are no benefit catalogues in Denmark. Instead services are rationed through controlling the capacity, i.e. physical capacity and number of staff employed.

Out-patient services offered by the private providers (GP, specialists etc) are defined through negotiation between the counties and provider representatives. Only services included in the negotiated contracts are reimbursed by the Health Care Reimbursement Scheme. The list of services included in the contracts may be considered a benefit catalogue,. However, as the primary sector to great extent works as a supplement to the hospital sector³⁰, in reality there is no limitation in the benefits offered to the single patient. Services not supplied (reimbursed) in the private specialist sector, are offered by the hospital sector³¹.

In the hospital sector, patients are entitled to any treatment that is “clinically indicated” (prescribed by a doctor). However, because of excess demand for many treatments, waiting lists constitute a real problem in the Danish hospital sector. And through prioritising between patients on a waiting list, some treatments implicitly have a higher priority than others.

In the primary health sector, some specialists, e.g. eye doctors have long waiting lists.

Also services supplied in the social health sector are to a great extent defined through the capacity available (i.e. number of nursing homes), or the decision is left to the municipal officer on the basis of local guidelines. This sector also has waiting lists for services.

This means that although the law may not set very many limits to the benefits available, the actual provision or availability of services is limited due to the wide existence of waiting lists. And there is an implicit priority setting through capacity control.

“Grey zones services”

The provision and financing of health services in Denmark, is to a great extent decentralised to the counties and the municipalities. However, the boundaries of responsibility for each of the two parties are not always clear. For some health services it may be a matter of interpretation that is responsible. For economic reasons, this may have as a consequence that neither one, nor the other authority takes the responsibility – the patients “fall between two chairs”. Examples of such service areas – often referred to as “grey zones” – are rehabilitative care and some long term services for elderly people.

Transaction costs and public awareness of benefit package.

The Danish health system is a national health service and there are not so many players as in a social health insurance system, due to the uniformity of the law for all local authorities and

³⁰ Except for the GP who is the gate-keeper for the rest of the health care sector.

³¹ There is regional variation in the size of the primary health care sector, as the number of specialists varies from county to county. In some counties there simply are no private specialists of certain specialities.

payers, and (almost) non-existence of third party payers. Also there are only few benefit catalogues. Therefore, the transaction costs of benefit catalogues are assessed to be relatively low in Denmark compared to other countries.

There are no discussions in the media about benefit packages, as the notion is practically inexistent in Denmark. However, if the law is not observed regarding benefits the media will bring it up. Therefore, although not denoted as benefits the Danish public is still very aware of peoples' rights and entitlements.

Does the benefit package mean anything or does it exist only on paper?

Most of the Danish health benefit basket is explicitly but very vaguely defined in the legislation, leaving it to local authorities to define the contents. There are only few excluded benefits, and services which are not explicitly excluded by law, are in theory included in the basket.

However, the real world is different due to a capacity control, which implicitly sets priorities between services to be made available locally, and due to excess demand of specific services.

Although the government has allocated extra funds and made provisions for operations at private hospitals to bring down waiting lists for elective surgery, waiting lists still constitute a barrier to access to treatment in Denmark.

An example of excess demand or under supply regards treatment at a hospice which is included in the benefit package. Extra funds have been allocated to hospice care in the Finance Act for 2005, as the current provision of hospice beds only responds to app. 20% of the demand. The extra funds are not, however, sufficient to cope with demand. (www.hospiceforum.dk).

Another example of the same is that in many Danish hospitals, the radiological department is considered a bottleneck, because of lack of capacity mainly due to lack of personnel and therefore long waiting times for examinations, which are included in the basket (Amtspress, 25.02.05).

Also, there are examples in the media of the law not being followed. E.g. school children do not get the preventive health examinations by a doctor they are entitled to by law (Amtspress 23.02.05). The reason given for this is municipal budget restraint and thus implicit priority setting.

However, to say that the basket exist only on paper and that health actors act more liberally is an exaggeration, since the sector works fairly well to international standards. It may be said that since the Danish law in this area is so vaguely formulated it is fairly easy to observe by the actors involved. Also, the law itself to a great extent imposes on the actors to act liberally so by far and large it may be said that the Danish health basket exists on paper and in the real world.

Structural reform

The structural reform might lead to some changes in the autonomy of the local authorities from 2007. One of the rationales behind the proposals from the government was a wish to achieve more central control of the health sector. Specifically it was wished to strengthen the

role and power of the National Board of Health and the Minister for the Interior and Health, enabling him to impose rules on the local authorities without bringing the matters up in the Folketing.

References

HC 1.1 and 1.2: In-patient and day cases of curative care

Type	Nr.	Issue Date	Danish title	English Title
LOV	460	10/06/1997	Lov om kunstig befrugtning i forbindelse med lægelig behandling, diagnostik og forskning mv.	Act on artificial insemination in relation to medical treatment, diagnostic and research etc.
LBK	766	28/08/2003	Bekendtgørelse af lov om sygehusvæsenet	Hospital Act
LBK	849	02/12/1998	Bekendtgørelse af lov om frihedsberøvelse og anden tvang i psykiatrien	Act on confinement and other use of force in psychiatry
BEK	564	20/06/2003	Bekendtgørelse om ret til sygehusbehandling og fødselshjælp mv	Notice on right to hospital treatment and maternity care
BEK	594	23/06/2003	Bekendtgørelse om amtskommuners betaling for sygehusbehandling ved en anden amtskommunes sygehusvæsen.	Notice on the payment by a county for hospital treatment at a hospital in another county
BEK	627	20/06/2004	Bekendtgørelse om økonomiske rammer for frit valg til private specialsygehuse	Notice on financial framework for free choice of private hospitals
BEK		17/09/1997	Bekendtgørelse om kunstig befrugtning	Notice on artificial insemination
BEK	743	22/08/2001	Bekendtgørelse om behandling af patienter med livstruende kræftsygdomme m.v.	Notice on treatment of patient with life-threatening cancer diseases etc
BEK	1009	09/12/2003	Bekendtgørelse om udarbejdelse af genoptræningsplaner ved udskrivning fra sygehus	Notice on written plans for rehabilitation when discharged from hospital
CIR	202	08/12/199	Cirkulære om behandlingsplaner for patienter indlagt på psykiatriske afdelinger	Circular on written plans of treatment for patient hospitalised on psychiatric wards

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HC 1.3 Outpatient curative care

Type	Nr.	Issue Date	Danish Title	English Title
LOV	467	31.05.2000	Lov om ændring af lov om offentlig sygesikring (Adgang til tilskud til ydelser købt eller leveret i et andet EU-/EØS-land)	Act on Amendment of Public Health Insurance Act (services abroad)
LOV	469	31.05.2000	Lov om ændring af lov om offentlig sygesikring (Ændring af medicintilskudsregler – europæiske gennemsnitspriser)	Act on Amendment of Public Health Insurance Act (reimbursement)
LOV	495	07.06.2001	Lov om ændring af lov om offentlig sygesikring (Ændring af medicintilskudsregler)	Act on Amendment of Public Health Insurance Act (reimbursement)
LOV	509	01.07.1998	Lov om offentlig sygesikring (Sygesikringsloven)	Public Health Insurance Act
LOV	1031	23.11.2000	Lov om ændring af lov om offentlig sygesikring (Midlertidig ophævelse og indførelse af medicintilskudsregler)	Act on Amendment of Act of Public Health Insurance
LOV	1045	23.12.1998	Lov om ændring af lov om offentlig sygesikring og lov om social service (Ændring af medicintilskudsregler)	Act on change of Act of Public Health Insurance and Act of Social Service
LOV	1118	29.12.1999	Lov om ændring af lov om offentlig sygesikring (Ændring af regler om begravelseshjælp)	Act on change of Act of Public Health Insurance (funeral aid)
LOV	1207	27.12.2003	Lov om ændring af lov om offentlig sygesikring (Afvikling af det statslige tilskud til den særlige sygesikringsordning for søfarende)	Act on change of Act of Public Health Insurance
LBK	1261	15.12.2003	Bekendtgørelse af lov om tandpleje mv.	Notice on Act of Dental Care
LOV	1431	22.12.2004	Lov om ændring af lov om offentlig sygesikring, lov om social pension, lov om højeste, mellemste, forhøjet almindelig og almindelig førtidspension mv. og lov om lægemidler	Act on change of Public Health Insurance Act and other acts
DSK	9226	20.01.1999	Datasammenskrivning af lov om offentlig sygesikring (Sygesikringsloven)	Compilation of data concerning Public Health Insurance Act
BEK	3	03.01.2001	Bekendtgørelse om ansøgning om medicintilskud	Notice on application of drug reimbursement
BEK	63	24.01.2000	Bekendtgørelse om medicintilskud	Notice on drug reimbursement
BEK	101	27.02.1996	Bekendtgørelse om befordringsgodtgørelse efter sygesikringsloven	Notice on allowance for travelling expenses
BEK	115	21.02.1990	Bekendtgørelse om ændring af bekendtgørelse om begrænsning i adgang til ydelser efter sygesikringsloven for visse persongrupper	Notice on change of notice on delimitation of access to services
BEK	119	17.03.1976	Bekendtgørelse om begrænsning i adgang til ydelser efter sygesikringsloven for visse persongrupper	Notice on delimitation of access to services
BEK	129	18.03.2002	Bekendtgørelse om tilskud efter sygesikringsloven til fodbehandling	Notice on reimbursement for chiropody treatment
BEK	147	06.03.2004	Bekendtgørelse om tilskud efter sygesikringsloven til tandpleje	Notice on reimbursement for dental care
BEK	176	15.03.2000	Bekendtgørelse om beregning og udbetaling af begravelseshjælp efter lov om offentlig sygesikring	Notice on calculation and payment of contributions towards funeral expenses
BEK	180	18.03.2003	Bekendtgørelse om adgang til lægehjælp efter sygesikringsloven	Notice on access to medical assistance by doctors

Type	Nr.	Issue Date	Danish Title	English Title
BEK	181	22.03.2004	Bekendtgørelse om tilskud efter sygesikringsloven til kiropraktisk behandling	Notice on reimbursement for chiropractic treatment
BEK	198	21.03.2003	Bekendtgørelse om valgfri indplacering i sygesikringsgrupper, udstedelse af sygesikringsbeviser mv.	Notice on free choice of social insurance group
BEK	405	18.05.2001	Bekendtgørelse om tilskud efter sygesikringsloven til fysioterapeutisk behandling	Notice on reimbursement for physiotherapeutic treatment
BEK	472	18.06.2002	Bekendtgørelse om tilskud efter sygesikringsloven til psykologbehandling for særligt udsatte grupper	Notice on reimbursement for treatment by a psychologist
BEK	531	18.06.2003	Bekendtgørelse om tilskud efter sygesikringsloven til sondeernæring og andre ernæringspræparater	Notice on reimbursement for tube feeding and nutritional preparations
BEK	536	15.06.2000	Bekendtgørelse om adgangen til tilskud efter sygesikringsloven til varer og tjenesteydelser, der er købt eller leveret i et andet EU/EØS-land	Notice on reimbursement for goods and services bought or delivered abroad
BEK	543	08.12.1980	Bekendtgørelse om tilskud fra den offentlige sygesikring til betaling af briller til børn under 16 år	Notice on reimbursement for glasses to children under 16 years
BEK	834	11.11.1999	Bekendtgørelse om tolkebistand i forbindelse med lægehjælp efter lov om offentlig sygesikring	Notice on interpretation assistance
BEK	933	21.11.2003	Bekendtgørelse om regulering af udgiftsgrænser i det behovsafhængige medicin-tilskudssystem pr. 1. januar 2004	Notice on regulation of expense limits for reimbursement
BEK	995	15.12.1997	Bekendtgørelse om den offentlige rejse-sygesikring	Notice on public travel insurance
BEK	1073	11.12.2003	Bekendtgørelse om tandpleje	Notice on dental care
BEK	1244	12.12.2003	Bekendtgørelse om rederiers bidrag til sygesikring for søfarende	Notice on shipping companies contribution to reimbursement
SKR	98	10.11.2004	Skrivelse om tilskudsberettigede lægemidler	Letter on reimbursable drugs
CIS	123	12.11.2003	Cirkulæreskrivelse om regulering for 2004 af begraveshjælp efter lov om offentlig sygesikring	Circular on regulation of contributions towards funeral expenses
CIR	204	09.12.1982	Cirkulære om befordringsgodtgørelse i henhold til lov om offentlig sygesikring	Circular on allowance for travel expenses

HC 2 Services of rehabilitative care

Type	Nr.	Issue Date	Danish title	English Title
LBK	708	29/06/1998	Bekendtgørelse af lov om social service (Serviceloven)	Act on Social Services
LBK	766	28/8/2003	Bekendtgørelse af lov om sygehusvæsenet	Hospital Act
BEK	405	18/05/2001	Bekendtgørelse om tilskud efter sygesikringsloven til fysioterapeutisk behandling	Reimbursement for physiotherapy treatment acc.to the HCRS
BEK	882	17/12/1991	Bekendtgørelse om tilskud efter sygesikringsloven til optræning af handicappede og behandling af muskellidelser på optræningscentret i Karlslunde	Notice on reimbursement for rehabilitation at the Karlslunde Rehabilitation-Center
BEK	1009	09/12/2003	Bekendtgørelse om udarbejdelse af genoptræningsplaner ved udskrivning fra sygehus	Preparation of written plans for rehabilitation when discharged from hospital
VEJ	9292	10/06/2004	Vejledning om træning i amter og kommuner	Guidelines on training in counties and municipalities

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HC 3 Long-term nursing care

Type	Nr.	Issue Date	Danish title	English Title
LBK	664	08/08/2002	Bekendtgørelse af lov om boliger for ældre og personer med handicap	Act on housing for the elderly and persons with a handicap
LOV	489	07/06/2001	Lov om ændring af lov om social service og lov om hjemmesygeplejerskeordninger	Act on amendment of act on social services and act on home nursing arrangements
LBK	708	29/06/2004	Bekendtgørelse af lov om social service	Act on Social Services (SL p 103.a., 104, 105, 106)
LBK	708	29/06/2004	Bekendtgørelse af lov om social service	Act on Social Services (Chap 18 on housing and Section VI on administration and financing)
LBK	72	06/02/2004	Bekendtgørelse af lov om retssikkerhed og administration på det sociale område	Act on legal protection and administration in the social sector
BEK	91	06/02/1998	Bekendtgørelse om betaling for botilbud mv. efter servicelovens kapitel 18, samt om flytteret i forbindelse med botilbud efter § 92	Notice on payment for housing services according to the Act on Social Services, Chap 18 and right to move according to §92
BEK	512	24/06/2002	Bekendtgørelse om plejehjem og beskyttede boliger	Notice on nursing homes and protected housing
BEK	918	10/12/1999	Bekendtgørelse om drift og tilsyn med boliger og hjem for gamle, syge og svagelige samt lette kollektivboliger	Notice on operation and supervision of houses for the elderly, ill and weak, and light community houses
BEK	469	16/06/2002	Bekendtgørelse om hjemmesygepleje	Notice on home nursing
VEJ	43	05/03/1998	Vejledning om sociale tilbud til børn og unge med handicap	Guidelines on social services for children and young people with a handicap
VEJ	45	10/03/1998	Vejledning om Den sociale indsats for de mest udsatte voksne: Sindslidende stof- og alkoholmisbrugere, hjemløse m.fl.	Guidelines on the social effort for the most exposed adults: Mentally afflicted, substance- and alcohol abusers, homeless etc.
VEJ	58	05/03/1998	Vejledning om sociale tilbud til voksne med handicap	Guidelines on social services for adults with a handicap
VEJ	59	06/03/1998	Vejledning om Sociale tilbud til ældre m.fl.	Guidelines on social services for the elderly
DSK	15010	01/02/1993	Datasammenskrivning af lov om hjemmesygeplejerskeordninger	Summary of Act on home nurse arrangements

HC 4.1 and 4.2 Clinical laboratory and diagnostic imaging

Type	Nr.	Issue Date	Danish title	English Title
LBK	766	28/8/2003	Bekendtgørelse af lov om sygehusvæsenet	Hospital Act
LOV	509	01.07.1998	Lov om offentlig sygesikring (Sygesikringsloven)	Public Health Insurance Act
			Lov om Statens Serum Institut	Act on Statens Serum Institut

Other Literature

- Miscellaneous health care reimbursement scheme agreements with private laboratories.

HC 4.3 Patient transport

Type	Nr.	Issue Date	Danish title	English Title
LBK	708	29/06/2004	Bekendtgørelse af lov om social service	Act on Social Services
LBK	766	28/8/2003	Bekendtgørelse af lov om sygehusvæsenet	Hospital Act
BEK	19	11/01/2005	Bekendtgørelse om ydelse af hjælpemidler og forbrugsgoder efter serviceloven	Notice on supply of durable aids and consumer goods by the act on Social Services
BEK	100	27/01/1996	Bekendtgørelse om ændring af bekendtgørelse om ydelse af befordring eller befordringsgodtgørelse i henhold til lov om sygehusvæsenet og lov om svangerskabshygiejne og fødselshjælp	Notice on change of notice on transportation or reimbursement of transportation according to the Hospital Act and Act on maternity care
BEK	1039	24/11/2000	Bekendtgørelse om planlægning af den præhospitale indsats og uddannelse af ambulancepersonale m.v.	Notice on organisation and planning of the prehospital effort and education of ambulance personnel etc.
BEK	1097	12/12/2003	Bekendtgørelse om dækningsområdet for lov om patientforsikring	Notice on the coverage areas for the Act on Patient Insurance
BEK	1176	21/12/1995	Bekendtgørelse om ydelse af befordring eller befordringsgodtgørelse i henhold til lov om sygehusvæsenet og lov om svangerskabshygiejne og fødselshjælp	Notice on transportation or reimbursement of transportation according to the Hospital Act and Act on maternity care
CIR	67	09/04/1996	Cirkulære om ydelse af befordring eller befordringsgodtgørelse i henhold til lov om sygehusvæsenet og lov om svangerskabshygiejne og fødselshjælp	Circular on transportation or reimbursement of transportation according to Hospital Act and Act on maternity care
VEJ	9224	01/01/1998	Sundhedsministeriets vejledning for planlægning af sundhedsberedskabet	The Ministry of Health's guidelines for the planning of the health preparedness
VEJ	129	14/12/2004	Vejledning om støtte til hjælpemidler og forbrugsgoder	Guidelines on support for durable aids and consumer goods

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HC 5.1 Pharmaceuticals and other medical non-durables

Type	Nr.	Issue Date	Danish title	English Title
LOV	422	10.06.2003	Lov om arbejdsskadesikring	Act on industrial injury insurance
LBK	656	28.07.1995	Bekendtgørelse af lov om lægemidler (Lægemiddeloven)	Notice on Act on Pharmaceuticals
LBK	708	29.06.2004	Bekendtgørelse af lov om social service (Serviceloven)	Notice on Act on Social Service
LBK	709	13.08.2003	Bekendtgørelse af lov om aktiv socialpolitik	Notice on Act of Active Social Policy
LBK	766	28.08.2003	Bekendtgørelse af lov om sygehusvæsenet (Sygehusloven)	Notice on Act of Hospitals
LOV	1219	07.12.2004	Bekendtgørelse af lov om social pension	Notice on Act of Social Pension
DSK	9699	23.02.1999	Datasammenskrivning af lov om lægemidler (Lægemiddeloven)	Compilation of data concerning Act on Pharmaceuticals
BEK	19	11.01.2005	Bekendtgørelse om ydelse af hjælpemidler og forbrugsgoder efter serviceloven	Notice on aids and consumer durables
BEK	40	27.01.2004	Bekendtgørelse om betaling af udgifter til sygebehandling og hjælpemidler efter lov om arbejdsskadesikring	Notice on payment of expenses for treatment and aids
BEK	139	01.03.2001	Bekendtgørelse om Lægemiddelstyrelsens Centrale Tilskudsregister (CTR)	Notice on the central reimbursement register of the Danish Medicine Agency
BEK	567	18.06.1996	Bekendtgørelse om vitamin- og mineralpræparater mv.	Notice on vitamins and mineral preparations
BEK	632	05.07.1994	Bekendtgørelse om homøopatiske lægemidler mv.	Notice on homoeopathic drugs
BEK	790	21.09.1992	Bekendtgørelse om naturlægemedler	Notice on herbal medicines
BEK	824	18.09.2001	Bekendtgørelse om medicintilskud til dosisdispenserede lægemidler	Notice on reimbursement of doses dispensed pharmaceuticals
BEK	834	26.09.1994	Bekendtgørelse om dækning af udgifter til sygebehandling og optræning samt proteser mm. efter lov om forsikring mod følger af arbejdsskade	Notice on expenses for medical treatment, rehabilitation and artificial limbs
BEK	869	23.10.2002	Bekendtgørelse om nødvendige merudgifter ved den daglige livsførelse efter servicelovens § 84	Notice on incremental expenses of daily living
CIR	21	20.02.1975	Cirkulære om afgrænsningen af behandlingsredskaber, hvortil udgiften afholdes af sygehusvæsenet	Circular on delimitation of tools of treatment to be paid by hospitals

HC 5.2 Therapeutic appliances and other medical durables

Type	Nr.	Issue Date	Danish title	English Title
LBK	708	29/06/1998	Bekendtgørelse af lov om social service	Social Services Act
BEK	19	11/01/2005	Bekendtgørelse om ydelse af hjælpemidler og forbrugsgoder efter serviceloven	Notice on supply of durable aids and consumer goods by the act on Social Services
CIR	21	20/02/1975	Cirkulære om afgrænsningen af behandlingsredskaber, hvortil udgiften afholdes af sygehusvæsenet	Circular on definition of treatment aids of which hospitals are financially responsible
VEJ	52	05/03/1998	Vejledning om Støtte til hjælpemidler, biler, boligindretning m.v.	Guidelines on support for durable aids, cars, interior design etc.
VEJ	129	14/12/2004	Vejledning om støtte til hjælpemidler og forbrugsgoder	Guidelines on support for durable aids and consumer goods

Other Literature

- Socialministeriet (2005): "Hjælpemidler"
http://www.social.dk/handicap/personlig_hjaelp_og_bistand/Hjaelpemidler.html
(access date 27/01/2005)

HC 6.1 Maternal and child health, family planning and counselling

Type	Nr.	Issue Date	Danish title	English Title
LOV	482	01/07/1998	Lov om patienters retsstilling	Act on Patients' Rights (regarding maternity care).
LBK	541	16/06/2004	Bekendtgørelse af lov om svangerskabsafbrydelse og fosterreduktion	Act on pregnancy termination and embryo reduction
LBK	622	19/07/1995	Bekendtgørelse af lov om svangerskabshygiejne og fødselshjælp	Act on Maternity Care
LBK	661	12/07/1994	Bekendtgørelse af lov om svangerskabsafbrydelse og fosterreduktion	Act on Sterilization and Castration
DSK	15010	01/02/1993	Datasammenskrivning af lov om hjemmesygeplejerskeordninger	Summary of act on home nurse arrangements
BEK	540	16/06/2004	Bekendtgørelse om svangerskabsafbrydelse og fosterreduktion	Notice on pregnancy termination and Embryo reduction
BEK	564	20/06/2003	Bekendtgørelse om ret til sygehusbehandling og fødselshjælp mv.	Notice on right to hospital treatment and delivery assistance
BEK	1131	13/12/1996	Bekendtgørelse om sterilisation og kastration	Notice on Sterilization and Castration
VEJ	57	16/06/2004	Vejledning om svangerskabsafbrydelse og fosterreduktion	Guidelines on pregnancy termination and embryo reduction
VEJ	60257	17/09/1998	Vejledning vedrørende medicinsk behandling af kvinder, som er eller påtænker at blive gravide	Guidelines on medical treatment for pregnant women or women who envisage a pregnancy
VEJ	60310	01/01/1994	Vejledning om prænatal genetisk information, rådgivning og undersøgelse.	Guidelines on prenatal genetic information counselling and examination (1994) (some parts still valid)
RTL	65	26/03/1985	Retningslinier for svangerskabshygiejne og fødselshjælp	Guidelines on maternity care (1985)– (some parts still valid)
RTL	15082	31/12/1995	Forebyggende sundhedsordninger for børn og unge – retningslinier	Guidelines on health prevention for children and young people.
RTL	15955	31/03/1987	Retningslinier om tilrettelæggelse af hjemmesygeplejerskeordninger (om barselspleje, sundhedsplejersker).	Planning of home nurse arrangements

Other Literature

- Sundhedsstyrelsen (2002): "Notat vedr. amternes implementering af Sundhedsstyrelsens retningslinier for svangreomsorgen." København.
- Sundhedsstyrelsen (1998): "Svangreomsorg, retningslinier og redegørelse. Sundhedsvæsenets indsats i forbindelse med graviditet, fødsels og barselsperioden. 1. juli 1998" København 1998. (supersedes RTL 65 from 1985)
- Sundhedsstyrelsen (2004): "Retningslinier for fosterdiagnostik – prænatal information, risikovurdering, rådgivning og diagnostik." København.

HC 6.2 School Health Services

Type	Nr.	Issue Date	Danish title	English Title
LOV	438	14/06/1995	Lov om forebyggende sundhedsordninger for børn og unge	Act on health prevention for children and young people
LBK	1261	15/12/2003	Bekendtgørelse af lov om tandpleje m.v.	Act on dental care
BEK	846	14/10/2002	Bekendtgørelse om forebyggende sundhedsordninger for børn og unge	Notice on health prevention for children and young people
BEK	1073	11/12/2003	Bekendtgørelse om tandpleje	Notice on dental care
RTL	15082	31/12/1995	Forebyggende sundhedsordninger for børn og unge – Retningslinier	Guidelines on health prevention for children and young people
VEJ	11855	29/03/2001	Sundhedsstyrelsens retningslinier for omfanget af og kravene til den kommunale og amtskommunale tandpleje	Guidelines for the extent of and demands to the county and municipal dental care

HC 6.3 Prevention of communicable diseases

Type	Nr.	Issue Date	Danish title	English Title
LOV	634	17/12/1976	Lov om tilbud om gratis vaccination mod visse sygdomme.	Act on free vaccination against certain communicable diseases
DSK	15015	29/03/1994	Datasammenskrivning af Lov om foranstaltninger mod smitsomme sygdomme	Summary of Act on actions against communicable diseases
BEK	277	14/04/2000	Bekendtgørelse om lægers anmeldelse af smitsomme sygdomme m.v.	Notice on doctors' report of communicable diseases
BEK	305	13/05/1993	Bekendtgørelse om gratis vaccination mod visse smitsomme sygdomme m.v.	Notice on free vaccination against certain communicable diseases
BEK	709	30/06/2004	Bekendtgørelse om midlertidig gratis influenzavaccination til alle over 65 år	Notice on temporary free influenza-vaccine to people over 65
BEK	922	19/10/2001	Bekendtgørelse om ændring af bekendtgørelse om gratis vaccination mod visse smitsomme sygdomme m.v.	Notice on change of notice on free vaccination against certain communicable diseases
VEJ	60	14/04/2000	Vejledning om lægers anmeldelse af smitsomme sygdomme m.v.	Guidelines on doctors' report of communicable diseases
VEJ	199	11/12/1996	Vejledning om gratis vaccination mod visse smitsomme sygdomme mv.	Guidelines on free vaccination against certain communicable diseases

Other Literature

- Sundhedsstyrelsen (2002): "Redegørelse for sundhedsbetjening af flygtningen og indvandrere, der kommer til Danmark, hvad angår smitsomme sygdomme". København.
- Sundhedsstyrelsen (2004) "Børnevaccinationsprogrammet i Danmark." København.
- Statens Serum Instituts (2005): "Tuberkulose". SSI's website on tuberculosis <http://www.ssi.dk/sw665.asp>
- Health Inspectors (2005): "Tuberkulose". HI's website on tuberculosis. http://www.eli.dk/smitsomme_sygdomme/Om_de_enkelte_smitsomme_sygdomme/Tuberkulose.aspx?lang=da

HC 6.4 Prevention of non-communicable diseases

Type	Nr.	Issue Date	Danish title	English Title
LOV	141	05/03/2001	Lov om ændring af lov om sundhedsvæsenets centralstyrelse m.v. med flere love og om ophævelse af lov om et forebyggelsespolitisk råd og et tobaksskaderåd	Act on change of act on the central administration of the health system etc. and on the dissolution of the national board on health prevention and the tobacco council
LOV	436	14/06/1995	Lov om røgfri miljøer i offentlige lokaler, transportmidler og lignende	Act on smoke free environments in public premises, transportation etc.
LBK	766	28/08/2003	Bekendtgørelse af lov om sygehusvæsen	Hospital Act
LOV	1313	20/12/2000	Lov om ændring af lov om røgfri miljøer i offentlige lokaler, transportmidler og lignende	Act on change of act on smoke free environments in public premises, transportation etc.

Other Literature

- Det Nationale Råd for Folkesundhed (2004): "Det Nationale Råd for Folkesundhed – beretning 2001-2003." København.
- Regeringen (2002): "Sund hele livet: de nationale mål og strategier for folkesundheden 2002-10." København.
- Sundhedsstyrelsen (2004): "Sundhedsstyrelsens Folkesygdomsprojekt. Sammenfatning." København.
- Sundhedsstyrelsen (2004): "Sundhedsstyrelsen anbefaler organiseret mammographiscreening." København.

HC 6.5 Occupational Health

Type	Nr.	Issue Date	Danish title	English Title
LBK	766	28/08/2003	Bekendtgørelse af lov om sygehusvæsen	Hospital Act
LBK	784	11/10/1999	Bekendtgørelse af lov om arbejdsmiljø	Act on working environment
LOV	1415	22/12/2004	Lov om ændring af lov om arbejdsmiljø	Act on change of act on working environment
BEK	1165	16/12/1992	Bekendtgørelse om arbejdsmedicinske undersøgelser efter lov om arbejdsmiljø	Notice on work medical studies by act on work environment
RTL	134	27/06/1977	Vejledende retningslinier vedrørende sygehusvæsenets arbejdsmedicinske ambulatorier og klinikker	Guidelines on work medical ambulatoriums and clinics in hospitals

Other literature

- Grosbøll, Anders & Hørsted, Toke: "Arbejdsmiljø". Portal om arbejdsmiljø i Danmark. www.aoffakta.dk

HC 6.9 All other miscellaneous public health services

Type	Nr.	Issue Date	Danish title	English Title
LOV	1117	20/12/1995	Lov om forebyggende hjemmebesøg til ældre.	Act on preventive home visits for the elderly
VEJ	59	06/03/1998	Vejledning om Sociale tilbud til ældre m.fl.	Guidelines on social services for the elderly

Schematic Overview of Laws by Sector

BEK 564. Regulation on entitlements for hospital treatment and maternity care

CIR 83 on state subsidy for increased hospital activity

BEK 743 Notice on treatment of patients with a life threatening disease

LBK nr. 849 Act on confinement and use of force in the psychiatry

CIR 202 Circular on treatment plans for patient in psychiatric wards.

LBK 766 Act on Hospitals

HC 1. Services of curative care

HC.1.1	<i>In patient curative care</i>	x	X	x	x	x	x
HC.1.2	<i>Day cases of curative care</i>	x	X	x	x	x	x
1	<i>Legal status</i>	Notice	Circular	Notice	Act of Parliament	Circular	Act of Parliament
2	<i>Coverage</i>	all counties	all counties	all counties	all counties	all counties	all counties
3	<i>Delegation from government</i>	The National Board of Health and counties	The National Board of Health and counties	The National Board of Health and counties	The National Board of Health, counties and hospitals	The National Board of Health, counties and hospitals	Counties, H:S and Bornholms municipalities
4	<i>Exclusions</i>	none	n.a.	none	none	n.a.	none
4,1	<i>Purpose</i>	To specify which citizens have the rights to hospital services	To finance a documented increase in hospital activity	To specify maximum waiting time for patients with a life threatening disease	To regulate confinement and use of force against psychiatric patients	To Regulate patients' rights for a treatment plan	To regulate organisations of hospitals and entitlements
5	<i>Actors</i>	Minster of Interior and Health, national board of health, county council	Minster of Interior and Health, national board of health, county council	Minster of Interior and Health, national board of health, county council	Minster of Interior and Health, county council, hospital doctor	Minster of Interior and Health, National board of health, county council, hospital doctor	Minister of Interior and Health (rules and regulations), Counties (planning and organising)
6	<i>Definition of benefits</i>	Entitlements to hospital treatment, free choice of hospital, information on waiting lists and treatment abroad.	State subsidy to counties/hospitals for increased activity on certain areas.	Entitlements to treatments at local hospitals, other hospitals and hospitals abroad	Entitlements to influence and complaints, and definition of when confinement and force can be used	Treatment plans and full access to documents	entitlements to hospital treatment, rehabilitation, transport etc.
6,1	<i>Explicit/implicit</i>	explicit	implicit	explicit	explicit	explicit	explicit
6,2	<i>Specific/vague</i>	vague	specific	specific	specific	specific	vague
6,3	<i>Inclusion/exclusion</i>	inclusion	exclusion	inclusion and exclusion	inclusion	none	inclusion
6,4	<i>Criteria</i>	Registered residents in Denmark	diagnoses	diagnosis	diagnosis (insanity)	Hospitalized psychiatric patients	resident in Denmark for more than 6 weeks
6,5	<i>Co-payment</i>	none	none	none	none	none	none
7	<i>Classification</i>	for documentation only	n.a.	n.a. (diagnosis)	function (force, confinement, etc) and diagnosis (insanity)	n.a. (hospitalization)	n.a
8	<i>Uniform definitions</i>	yes	yes	yes	yes	yes	yes
9	<i>Document date</i>	20.06.2003	27.06.2003	22.08.2003	02.12.1998	08.12.1998	28.08.2003

HC 1. Services of curative care

DSK 9226 Summary of act on Public Health Insurance

BEK 933 Notice on regulation of expense limits for reimbursement

BEK 543 Notice on reimbursement for glasses to children under 16 years

BEK 176 Notice on calculation and payment of contributions towards funeral expenses

BEK 101 Notice on allowance for travelling expenses

BEK 995 Notice on public travel insurance

BEK 405 Notice on reimbursement for physiotherapeutic treatment

HC.1.3	Out-patient care	x	x	x	x	x	x	x
HC.1.3.1	Basic services	x	x	x	x	x	x	x
HC.1.3.2	Dental care							
HC.1.3.3	Other specialised care	x						
HC.1.3.9	Other curative care	x						
HC.1.4	Curative home care							
1	Legal status	Act of Parliament	Notice	Notice	Notice	Notice	Notice	Notice
2	Coverage	All counties	All counties	All counties	All Municipalities	All counties	All counties	All counties
3	Delegation from government to	Danish Medicines Agency, Board of Reimbursement for Pharmaceuticals (Medicintilskudsnet), HCRNC, National Board of Health, Municipal County	none	National Social Security Agency	Municipal Counties	none	County Councils	County councils, HCRNC, and Danish Association of physiotherapists
4	Exclusions	none	none	none	none	none	none	none
4,1	Purpose	Entitlements, reimbursement, target-setting	To define when expense limits are regulated	Specification of reimbursement	Specification of reimbursement	Specification of reimbursement	Specification of reimbursement	Specification of reimbursement
5	Actors	Minister of Interior and Health (rules and regulations), National Board of Health (Guidelines), Danish Medicines Agency (demand to approval of drugs for reimbursement, register of information)	Minister of Interior and Health (regulation)	Minister of Interior and Health, County Councils (provider), National Social Security Agency (definition of benefits)	Minister of Interior and Health (regulations), Municipal Councils (provider)	Minister of Interior and Health (Rules and regulations)	Minister of Interior and Health, County Councils (provider)	Minster of Interior and Health, County councils (approval of clinics), HCRNC, and Danish Association of physiotherapists (agreement on services eligible for reimbursement)
6	Definitions of benefits	Health services at GP free of charge, treatment with specialised doctors, reimbursement for medicine, funeral expenses, treatment abroad, travelling expenses	Reimbursement amounts (indirectly)	Reimbursement for spectacle glasses and frames	Reimbursement for funeral costs	Reimbursement for transport.	Health insurance during the first month of travelling. Treatment for maximum 3 months	Reimbursement (39.3 %) for physiotherapeutic treatment. For people with specific diagnosis 100% reimbursement is given.
6,1	Explicit/implicit	explicit	explicit	explicit	explicit	explicit	explicit	explicit
6,2	Specific/vague	vague	specific	specific	specific	specific	specific	specific
6,3	Inclusion/exclusion	inclusion	none	inclusion	inclusion	inclusion	inclusion and exclusion	Inclusion and exclusion (physiotherapy in hospitals)
6,4	Criteria	permanent address in Denmark	n.a.	under 16 years	Permanent address in Denmark and over/under 18 years and private means	Permanent address in Denmark	Permanent address in Denmark	GP referral and diagnosis yes (depending on diagnosis)
6,5	Co-payment	yes	n.a.	yes	yes	yes	no	no
7	Classification	reimbursement by interval of expenses	reimbursement by interval of expenses	type of spectacles	Age	over > 50 km, minimum (60, 25 DKK) amount requested	all expenditures	diagnosis
8	Uniform definitions	yes	yes	yes	yes	yes	yes	yes
9	Document date	20.01.1999	21.11.2003	08.12.1980	15.03.2000	27.02.1996	15.12.1997	18.05.2001

HC 1. Services of curative care		BEK 129 Notice on reimbursement for chiropody treatment	BEK 472 Notice on reimbursement for treatment by a psychologist	BEK 147 Notice on reimbursement for dental care	BEK 181 Notice on reimbursement for chiropractic treatment	BEK 180 Notice on access to medical assistance by doctors	BEK 531 Notice on reimbursement for tube feeding and nutritional preparation
HC.1.3	Out-patient care	x	x	x	x	x	x
HC.1.3.1	Basic services	x	x				
HC.1.3.2	Dental care			x			
HC.1.3.3	Other specialised care				x		x
HC.1.3.9	Other curative care						
HC.1.4	Curative home care						
1	Legal status	Notice	Notice	Notice	Notice	Notice	Notice
2	Coverage	All counties	All counties	All counties	All counties	All counties	All counties
3	Delegation from government to	HCRNC and the Danish Association of Chartered Chiropodist	HCRNC and The Danish Association of Psychologist	HCRNC and the Danish Association of Dentists	HCRNC and the Danish Association of Chiropractors	HCRNC, Danish Medical Association and the Danish Association of Specialist doctors	National Board of Health
4	Exclusions	none	none	none	none	none	none
4,1	Purpose	Specification of reimbursement	Specification of reimbursement	Specification of reimbursement	Specification of reimbursement	Specification of entitlements and reimbursement	Specification of reimbursement
5	Actors	Minster of Interior and Health, HCRNC and the Danish Association of Chartered Chiropodist (agreement on services eligible for reimbursement)	Minster of Interior and Health, HCRNC and The Danish Association of Psychologist (agreement on services eligible for reimbursement)	Minister of Interior and Health, HCRNC and the Danish Association of Dentists (agreement on services eligible for reimbursement)	Minister of Interior and Health, HCRNC and the Danish Association of Chiropractors (Agreement on services eligible for reimbursement)	Minster of Interior and Health, HCRNC, Danish Medical Association and the Danish Association of Specialist doctors (national agreement)	Minster of Interior and Health National Board of Health (approval of devices)
6	Definitions of benefits	Reimbursement for chiropody - amount based on diagnosis	60% reimbursement of psychologist fee for 12 consultations	Reimbursement for preventive dental care and dental treatment	Reimbursement for chiropractor treatment	Access to GPs and specialists, reimbursement for specialist care	Reimbursement for prescribed tube feeding and nutritional preparations
6,1	Explicit/implicit	explicit	explicit	explicit	explicit	Explicit	explicit
6,2	Specific/vague	specific	specific	specific	specific	vague	specific
6,3	Inclusion/exclusion	Inclusion and few exclusions	inclusion	inclusion (few exclusions)	inclusion and exclusion (children and young people receiving municipal dental care)	inclusion	inclusion
6,4	Criteria	GP referral and diagnosis	GP referral and diagnosis	over 18 years old	Diagnosis and chiropractor should follow national agreement between The Negotiation Committee and the Danish Association of Chiropractors	Persons should be registered by a doctor	Prescription by GP
6,5	Co-payment	yes	yes	yes	yes	no and Yes (regarding specialists)	yes
7	Classification	diagnosis	diagnosis	percentage of rates, specific amounts per service in DKK	chronic diseases in motor apparatus / other diseases	percentage of bill, maximum amount	percentage of expenditure
8	Uniform definitions	yes	yes	yes	yes	yes	yes
9	Document date	18.03.2002	18.06.2002	06.03.2004	22.03.2004	18.03.2003	18.06.2003

HC 2. Services of rehabilitative care		LBK 766 Act on Hospitals	LBK 708 Act on Social Services	BEK 1009 Rehabilitation Plans	VEJ 9292 Guidelines on rehabilitation in counties and municipalities	BEK 405 Reimbursement for physiotherapy treatment (LBK 509)	BEK 882 Rehabilitation at the Karlslunde Rehab.Center (LBK 509)	Guidelines on free physiotherapy for physically handicapped
HC.2.1	In-patient rehabilitative care	x		x	x			
HC.2.2	Day cases of rehabilitative care	x	x	x	x			
HC.2.3	Out-patient rehabilitative care	x	x	x	x	x		x
HC.2.3.1	Ambulatory rehabilitative care	x	x	x	x	x	x	x
HC 2.4.	Rehabilitative home care	x	x	x	x	x		x
1	Legal status	Act of Parliament	Act of Parliament	Notice	Guidelines	Notice	Notice	Guidelines
2	Coverage	All counties	all counties /municipalities	all counties	all counties /municipalities	all counties (municipalities)	Copenhagen, Roskilde, Frederiksborg Counties, Copenhagen, Frederiksberg Municipalities + other with agreement	all counties /municipalities
3	Delegation from government	MIFIH is authorised to set rules, delegation to counties	to set rules, delegation to counties /municipalities	MIFIH	MIFIH, MiFSA	MIFIH, HCRNC	MIFIH approves agreement	MIFIH
4	Exclusions	none	none	none	none	physiotherapist + family	none	none
4.1	Purpose	entitlements, delegation of planning responsibilities	entitlements, division of labour, (reimbursement)	reimbursement	legal foundations for rehabilitation, entitlements, division of labour between counties	entitlement/reimbursement	entitlements/reimbursement	entitlements/reimbursement
5	Actors	Parliament, county councils, hospital physician	Parliament, MiFSA, county/municipal councils, GP, physicians	MolH, Municipal Councils, hospital physician, rehab. coordinator	MolH, MiFSA, Municipal and county councils, physicians (GPs)	MolH, county/municipal councils, GP	Teddy Oefeldt (Karlslunde), counties, municipalities, HCRNC, GP	GP
6	Definition of benefits	rehabilitation needed as part of or following hospital treatment	rehabilitation needed not following hospital stay, when hospital treatment finished, maintenance of functional level	rehab. needed following hospital stay	all rehabilitating care			
6.1	Explicit/implicit	explicit	explicit	explicit	explicit	explicit	explicit	explicit
6.2	Specific/vague	vague	vague	vague	vague	specific	specific	specific
6.3	Inclusion/exclusion	inclusion	inclusion	inclusion	inclusion	inclusion	inclusion	inclusion
6.4	Criteria	permanent address, need for hospital treatment	Legal stay or residence in Denmark, temporary or chronic physical or mental impairment	need for rehab. following hospital treatment	As in LBK 766, LBK 708, BEK 1009, BEK 405 etc., general principle: rehab. at least, most effective, and cost-effective level of care	GP (physician) referral, clinic is authorised	muscular diseases, considerable physical impairment, paralytics	referral from GP, severe physical impairment etc. and congenital/hereditary, neurological, inflammatory arthritis diagnoses or physical impairment following accidents.
6.5	Co-payment	no	no	no	no		muscular diseases, if not under BEK 405 (40% reimbursement), if under 405 (100% coverage)	
7	Classification	n.a	n.a	n.a	n.a	per diagnosis and reimbursement	per reimbursement	per diagnosis
8	Uniform definitions	yes	yes	yes	yes	yes	yes	yes
9	Document data	28.08.2003	29.06.2004	09.12.2003	10.06.2004	01.07.1998	17.12.1991	01.03.2000

HC 3. Services of long-term nursing care (LTNC)	LBK 766 Act on Hospitals	LBK 708 Act on Social Services	BEK 627 Economic framework for free choice of private special hospitals	DSK 16010 Act on Home nurse arrangements (par 242)	LOV 489 Amendment of Act on Social Services and Act on Home Nurse Services	BEK 469 Nursing care at home	RTL 15965 organisation of home nurse services	LBK 664 Act on Housing for Elderly and Persons with a handicap	BE 512 Notice on Nursing homes and protected housing/home	BEK 91 Payment for housing according to chapter 18 + right to move § 92	VEJ 519 Social services for the Elderly etc
HC.3.1 In-patient LTNC	x	x	x		x			x	x	x	
special Hospice Care	x		x								
Day cases of LTNC	(x)	x	x		x						x
HC.3.2 LTNC - Home care	(x)	x		x	x	x	x				x
HC.3.3	(x)	x		x	x	x	x				x
1 Legal status	Act of Parliament	Act of Parliament	Notice	Summary of act (s)	Act of Parliament	Notice	Guidelines	Act of Parliament	Notice	Notice	guidelines
2 Coverage	All counties	All counties and municipalities.	all counties	All counties and municipalities.	all counties (municipalities)	all municipalities	all municipalities, counties, community physicians institutions	All counties and municipalities.	all municipalities	All counties and municipalities.	All counties and municipalities.
3 Delegation from government	to set rules, delegation to counties	authorised to set rules, delegation to counties	MioHI to Counties	MIFIH, NBH	Association of Municipalities, MiSA	NBH, municipal council	NBH, municipal council	Minister of Economic and Business Affairs	MoSA, municipal council	MIFIH - counties	MoSA/MIFIH to municipal council (county)
4 Exclusions	none	none	indirectly	none	none	none	persons staying in institutions		none	none	"elderly" persons
4.1 Purpose	Entitlements, delegation of planning responsibilities	entitlements, division of labour, (reimbursement)	economic limit to free hospital treatment	entitlement, division of financial responsibility between counties/municipalities	amendments to previous laws, Division of financial responsibility + basic fees	entitlements/reimbursement	responsibility, target patients, personnel groups, organisation, management, education of auxiliary nurses	rules on waiting list, free choice	access to nursing homes, free choice, waiting lists, user information, payment, finance	payment/finance + right to move between municipalities	Summarize the law, describe municipal /county obligations with regards to elderly, entitlements, applications of services etc.
5 Actors	Parliament, county councils, hospital physician	Parliament, county/municipal councils,	MIFIH counties, a number of named specialised private hospitals, including hospices	MIFIH, NBH, Municipal and county councils, authorised nurses	MiFSA, county/municipal councils, GP	MIFIH, NBH, Municipal Council, GP, nurses	MIFIH, NBH, municipal council	MiFSA, municipal council	Counties	MiSA, municipal council, counties, MIEBA, Social Complaints	
6 Definition of benefits	long-term medicine implicitly included	nursing homes + housing incl. treatment for persons with temporary or permanent mental or physical impairment, day cases of long-term care (rehab. Etc) for handicapped	a limit to free access to hospital treatment			residence/stay in municipality, GP referral	home nursing of patients in need of continuous nursing + post-natal nursing services residence/stay in municipality, GP referral	visitation by municipality, free choice, criteria for waiting list, payment (income based), but 67+ free of charge			
6.1 Explicit/implicit	explicit	explicit	implicit	explicit	explicit	explicit	explicit	explicit	implicit	explicit/implicit	
6.2 Specific/vague	vague	vague	vague	vague	specific	specific	vague	specific	vague	vague/specific	
6.3 Inclusion/exclusion	inclusion	inclusion	inclusion	inclusion	inclusion	inclusion	both	inclusion (exclusion)	inclusion	inclusion	
6.4 Criteria	permanent address, need for hospital treatment	Legal stay or residence in Denmark, temporary or chronic physical or mental impairment, psychiatric conditions following abuse, cure for abuse	Sets a limit in right to free hospital treatment: Defines maximum budgetary allocation of public funds to specific private specialised hospitals	municipalities are obliged to provide this service when referral from GP (physician)	n.a.	GP referral, Municipality makes final decision,	excluding persons in nursing homes and institutions, all persons in need for home health care + medical aids (incl. Terminal patients), postnatal nursing, upon GP referral	residents in municipality are prioritized first (may exclude residents from other municipalities), Municipal referral, 67+ are financed by municipality	payment and co-payment in temporary or longer municipal housing (due to impairment), income based, right to move for family, religious or victim of ww2 occupation	Elderly (but no age quantification)	
6.5 Co-payment	no	yes (income based, children and 67+ are exempt of payment)	no	no	no	no	no	yes income based, 67+ free of charge	n.a.	yes	
7 Classification	n.a	n.a	n.a	under 67, 67 +	level of impairment, age, reimbursement	n.a.	n.a.	n.a.	temporary/longer stay		
8 Uniform definitions	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	
9 Document data	28.08.2003	29.06.2004	20.06.2004	01.02.1993	07.06.2001	16.06.2002	31.03.1987	08.08.2002	24.06.2002	06.02.1998	06.03.1998

HC 4. Ancillary services to health care		LBK 766 Hospital Act	LBK 1031 Public Health Insurance Act	BEK 1039 Planning of prehospital services and education of ambulance personnel etc.	BEK 1176 Reimbursement of transportation according to Hospital Act and Act on Maternity Care + BEK 100	CIR 67 On reimbursement of transportation according to BEK 1176	Standard Contract Association of County Councils and Falck	VEJ 9224 MOH guidelines on planning of health preparedness	BEK 19 and VEJ 129
HC 4.3	Patient Transport	x	x	x	x	x	x	x	x
1	Legal status	Act of Parliament		Notice	Notice	Circular	standard contract	Guidelines	Notice + guidelines
2	Coverage	All counties		all counties, Copenhagen and Frederiksberg	Counties + Copenhagen Hospital Corporation	counties + municipalities	voluntary for counties within Falck's coverage area	all counties and municipalities	all counties and municipalities
3	Delegation from	MiFiH is authorised to set rules, delegation		none, but referral to Hospital and Public Health Insurance Acts		MiFiH, counties may define specific rules	delegation from counties	MOH, MiFiH	MiFSA is authorised to set rules, delegation to
4	Exclusions	none		none	none	some	none	none	none
4,1	Purpose	Entitlements, delegation of planning responsibilities		definitions, responsibility, planning of effort, prehospital committee, education and tasks of ambulance personnel + ambulance equipment	defining reimbursement rules more closely according to Hospital Act and Act on Maternity Care, e.g.. implications of free choice of hospitals	Defining persons entitled to reimbursement, and in which cases, institutions covered by rules, who pays?, administration of rules	Reimbursement, payment schedule	Definitions of preparedness for acute changes in demand for health care e.g. at accidents, catastrophes etc, responsibilities, interpreting Public Health Insurance Act Chap 6, Preparedness Act § 25, Hospital Act § 16a.	Provision of medical aids according to ASS § 22, reimbursement of Transportation
5	Actors	Parliament, county councils, hospital physician		County council, police, municipal councils of Copenhagen and Frederiksberg	Counties, (municipalities)	MiFiH, counties, municipalities, public and private hospitals /departments/private out-patient specialists/GP	Association of County Councils, Falck, Counties	MoH, municipal and councils, medical officer of health	county/municipal councils,
6	Definition of benefit	Entitlements to free transportation		only implicitly	entitlement to free transportation, specifically defined			elaboration of health plans, ensuring medical assistance in catastrophic situations	rules for reimbursement especially due to "free choice of
6,1	Explicit/implicit	explicit		implicit	explicit	explicit	implicit	implicit	explicit
6,2	Specific/vague	vague		vague	specific	specific	vague	vague	specific
6,3	Inclusion/exclusion	inclusion		inclusion	inclusion /(exclusion)	inclusion /exclusion	inclusion	inclusion	inclusion /exclusion
6,4	Criteria	right to free ambulance transportation, if considered necessary		at least two ambulance persons, description of skills +tasks + ambulance equipment (=what treatment /assistance to be expected in an ambulance)	transportation from home to treatment site with cheapest, defensible, vehicle, based on distance, patient' condition, people receiving pension, etc.	upon indication, necessary distance >50 km (including referral to treatment abroad), Exclusion if able to use public transport. + person accompanying patient reimbursed if accompany is necessary	category 1,2,3 rides + recumbent transport		At free choice of provider: reimbursement of transport not exceeding distance as to service provided within the municipality /county
6,5	Co-payment	no		no	yes (amendment BEK 100)	yes	no		yes, only reimbursement above 60 DKK
7	Classification	no		n.a	indication/condition, distance to treatment site	patient condition/indication	according to level of emergency	per diagnosis and reimbursement	n.a
8	Uniform definition	yes		yes	yes	yes	no	yes	yes
9	Document data	28.08.2003	23.11.2000	24.11.2000	21.12.1995	09.04.1996	1998	10.01.1998	11.01.2005

HC 5. Medical goods dispensed to out-patients		DSK 9699 Summary of Act on Pharmaceuticals	DSK 9226 Summary of act on Public Health Insurance	LOV 1431 Act on change of Act on Insurance and other acts	BEK 63 Notice on drug reimbursement	SKR 98 Letter on drugs eligible for subsidy	LBK 1219 Act of Social Pension	LBK 709 Act on Active Social Policy	BEK 869 Notice on incremental expenses of daily living
HC.5	Medical goods dispensed to out-patients		x						
HC.5.1	Pharmaceuticals		x						
HC.5.1.1	Prescribed medicines	x		x	x	x	x	x	x
HC.5.1.2	OTC medicines	x	x	x					
HC.5.2	Therapeutic appliances		x						
HC.5.2.4	Medico-technical devices								
1	Legal status	Act of Parliament	Act of Parliament	Act of Parliament	Notice	Letter	Act of Parliament	Act of Parliament	Notice
2	Coverage	all counties	All counties	all counties	all counties	all	All Counties and municipalities	All Counties and municipalities	All Counties and municipalities
3	Delegation from government to	Danish Medicines Agency	Danish Medicines Agency, Board of Reimbursement for Pharmaceuticals, HCRNC, National Board of Health, Municipal County	Danish Medicines Agency	Danish Medicines Agency	none	Municipalities	Municipalities	Minister of Social Affairs
4	Exclusions	none	none	none	none	none	none	none	none
4.1	Purpose	Regulations on approval and sale of pharmaceuticals	Entitlements, reimbursement, target-setting	Specification of reimbursement	Specification of reimbursement	Drugs approved for reimbursement	Specification of extra reimbursement for people living on social pensions (§ 14A)	Specification of reimbursement for services and product not covered by the National Reimbursement Scheme (§82)	Specification of reimbursement for services and product not covered by the National Reimbursement Scheme
5	Actors	Minister of Interior and Health, Danish Medicines Agency (quality standards, approval etc.)	Minister of Interior and Health (rules and regulations), National Board of Health (Guidelines), Danish Medicines Agency (demands for approval of drugs for reimbursement, register of information)	Minister of Interior and Health, Danish Medicines Agency (decision on reimbursement - both general and singular)	Danish Medicines Agency	Danish Medicines Agency	Minister of Social Affairs (rules and regulations) Municipalities (provider)	Minister of Social Affairs, municipalities	Minister of Social Affairs (rules and regulations), Municipalities (provider)
6	Definitions of benefits	Approval of pharmaceuticals	Health services at GP free of charge, treatment with specialised doctors, reimbursement for medicine, funeral expenses, treatment abroad, travelling expenses	Reimbursement for pharmaceuticals	Reimbursement for pharmaceuticals - general and singular reimbursement	Explicit list of all pharmaceuticals eligible for subsidy	Extra reimbursement is given to people living of social pensions, to product already included in the National Reimbursement Scheme. Reimbursement is 85% of the individuals expenses	Extra reimbursement can be given to medicine etc which is not covered by other legislation for people on social benefits.	Reimbursement towards for example medication beyond what the National Reimbursement Scheme covers.
6.1	Explicit/implicit	Explicit	explicit	explicit	explicit	explicit	explicit	explicit	explicit
6.2	Specific/vague	specific/vague	vague	Specific/vague	specific	specific	vague	vague	vague
6.3	Inclusion/exclusion	Exclusion and inclusion	inclusion	inclusion	inclusion and exclusion	inclusion	inclusion and exclusion	inclusion	inclusion
6.4	Criteria	n.a.	permanent address in Denmark	Yearly purchase of drugs for minimum 520 DKK	approval by Danish medicines agency, purpose and effect of pharmaceutical	n.a.	living on social pension, private means	treatment should be necessary and based on health reasons	Mental or physical disability, that gives extra expenses. Reimbursement not covered by any other legislation
6.5	Co-payment	n.a.	yes	yes	yes	n.a.	yes	n.a.	yes
7	Classification	n.a.	reimbursement by interval of expenses	reimbursement by interval of yearly purchase	general / singular reimbursement yes/no	ATC codes	n.a.	needs based	needs based
8	Uniform definitions	yes	yes	yes	yes	yes	yes	yes	yes
9	Document data	23.02.1999	20.01.1999	22.12.2004	24.01.2000	10.11.2004	07.12.2004	13.08.2003	23.10.2002

HC 5. Medical goods dispensed to out-patients		VEJ 52 Guidelines on support for durable aids, cars, interior design etc.	LBK 708 Act on Social Services	BEK 19 Notice on supply of durable aids and consumer goods by the act on Social Services	VEJ 129 Guidelines on support for durable aids and consumer goods	CIR 21 Guidelines on support for durable aids and consumer goods
HC 5.2	<i>Therapeutic appliances</i>	x	x	x	x	x
HC 5.2.1	<i>Glasses and vision</i>	x	x	x	x	
HC 5.2.2	<i>Orthopaedic appliances</i>	x	x	x	x	
HC 5.2.3	<i>Hearing aids</i>	x	x	x	x	
HC 5.2.4	<i>Medico-technical devices</i>	x	x	x	x	
HC 5.2.9	<i>All other miscellaneous durables</i>	x	x	x	x	
1	<i>Legal status</i>	Guidelines	Act of Parliament	Notice	Guidelines	Circular
2	<i>Coverage</i>	all counties and municipalities	all counties and municipalities	Municipalities and in specific cases counties	all counties and municipalities	All counties and Municipalities
3	<i>Delegation from government</i>	Counties and municipalities	counties and municipalities	Counties and municipalities	Counties and municipalities	Counties and municipalities
4	<i>Exclusions</i>	few	none	yes	yes	yes
4,1	<i>Purpose</i>	interpretation of LBK 708 - explicit guidelines of benefits, entitlements division of financial responsibilities between counties, municipalities and the individual	Entitlements, division of financial responsibility between counties, municipalities and the individual	Definition of benefits, financial division between county, municipality and user, entitlements	interpretation of LBK 708 - explicit guidelines of benefits, entitlements division of financial responsibilities between counties, municipalities and the individual	Demarcation between municipalities and Counties when it comes to aids that are part of an treatment
5	<i>Actors</i>	Counties and municipalities	MiFSA (rules and regulations), Counties and Municipalities	Counties and municipalities	Counties and municipalities	Counties (Hospitals) and Municipalities
6	<i>Definition of benefits</i>	All medical and non-medical aids to out-patients permanently impaired.	medical aids to out-patients permanently impaired.	All medical and non-medical aids to out-patients permanently impaired.	All medical and non-medical aids to out-patients permanently impaired.	Medical aids as part of treatment
6,1	<i>Explicit/implicit</i>	explicit	explicit	explicit	explicit	explicit
6,2	<i>Specific/vague</i>	specific	vague	specific	specific	specific
6,3	<i>Inclusion/exclusion</i>	both	inclusion	both	both	both
6,4	<i>Criteria</i>	Chronic impaired - interpretation of what that means. When specified then linked to condition. Legal residence in Denmark (not citizenship)	chronic impaired. When specified then linked to condition. Legal residence in Denmark (not citizenship)	Chronic impaired individuals. When specified then linked to condition. Legal residence in Denmark (not citizenship)	Chronic impaired individuals. When specified then linked to condition. Legal residence in Denmark (not citizenship)	temporary impaired
6,5	<i>Co-payment</i>	yes	Yes	yes	yes	no
7	<i>Classification</i>	By responsible actor (municipality or county), personal or non-personal aid, function based and needs based	By responsible actor (municipality or county), personal or non-personal aid, function based and needs based	By responsible actor (municipality or county), personal or non-personal aid, function based and needs based	By responsible actor (municipality or county), personal or non-personal aid, function based and needs based	Function based
8	<i>Uniform definitions</i>	yes	Yes	yes	yes	yes
9	<i>Document data</i>	05.03.1998	29.06.1998	05.03.1998	14.12.2004	21.02.1975

HC 6.1	HC 6. Prevention and public health services	LBK 622 Act on Maternity Care	Maternity Care - Guidelines and Outline	RTL 15955 Planning of home nurse arrangements (DSK 15010)	Guidelines on embryo/foetus diagnostics	LBK 541 Act on pregnancy termination and embryo reduction	BEK 540 Notice on pregnancy termination and embryo reduction	VEJ 577 Guidelines on pregnancy termination and embryo reduction	LBK 661 Act on Sterilization and castration	BEK 1131 Notice on Sterilization and castration	RTL 15082 Guidelines on health prevention for children and young people
	Maternal and child health	x	x	x	x	x	x	x	x	x	x
1	Legal status	Act of Parliament	Guidelines	Guidelines	Guidelines	Act of Parliament	Notice	Notice	Act of Parliament	Notice	guidelines
2	Coverage	all counties + Copenhagen and Frederiksberg	all counties + Copenhagen and Frederiksberg	all municipalities	all counties + Copenhagen and Frederiksberg	all counties + Copenhagen and Frederiksberg	all counties + Copenhagen and Frederiksberg	all counties + Copenhagen and Frederiksberg	all counties + Copenhagen and Frederiksberg	all counties + Copenhagen and Frederiksberg	all counties and municipalities
3	Delegation from government	Delegation to counties, and to National Board of Health (issues guidelines, supervises)	Delegation to counties, and to National Board of Health (supervises)	MIFIH, National Board of Health (visiting nurse supervisor), municipality	Delegation to counties, and to National Board of Health (supervises)	Minister of Justice, Minister for Interior and Health, National Board of Health	Minister of Justice, Minister for Interior and Health, National Board of Health	Minister of Justice, Minister for Interior and Health, National Board of Health	Minister of Justice	Minister of Justice	Delegation to counties, municipalities (the municipal health service), GP's, Medical officer of health, visiting nurse
4	Exclusions	Men (for maternity care)	(men)	none	none	none	none	none	none	none	none
4.1	Purpose	Roles and responsibilities of actors, Definition of Benefits within maternity care, family planning and contraception, coverage.	organisation of maternity care, roles and responsibilities, (benefits) basic package + extra packages offered	Entitlements to postnatal nursing care, responsibility and roles	purpose of foetus diagnostics and genetic counselling, recommendations based on review of evidence, roles /responsibility, organisation of services	Entitlements with regards to abortion and embryo reduction	specifications of entitlements, benefits and procedures laid down in LBK 541	specifications of entitlements, benefits and procedures laid down in LBK 541	Entitlements to sterilization, castration (implicitly sex change treatment). Criteria, roles of joint council and appeals boards	specifications of entitlements, benefits and procedures laid down in LBK 661	interpretation of entitlements and benefits stated in LBK 438 and BEK 846 laid down by the National Health Board.
5	Actors	National Board of Health, counties, GP, Midwife	National Board of Health, GP, Midwife, counties	Municipality, National Board of Health	National Board of Health, counties, GP, midwife, pregnant woman, etc.	Ministry of Justice, Counties and 3 municipalities,	Ministry of Justice	Ministry of Justice	Ministry of Justice	Ministry of Justice	Municipalities, counties, GP, Municipal employed doctor, visiting nurse.
6	Definition of benefits	Right to antenatal care: (5 GP check-ups, midwife consultations), delivery assistance at hospital or at home, right to advice on contraception	Basic package of antenatal care, additional care for high risk groups, delivery care, post-natal care	Postnatal care of mother					Sterilisation for 25+ free access upon referral, and for 25-upon indication. Castration for 21+ upon indication (sexual crime, serious mental affliction or social disarmament)		Regular health examination by both doctor and visiting nurse, health education etc. in school.
6.1	Explicit/implicit	explicit	explicit	explicit	explicit	Explicit	explicit	explicit	implicit (sex change) explicit for the rest	implicit (sex change) explicit for the rest	explicit
6.2	Specific/vague	specific	specific	vague	specific		specific	specific	vague (sex change)	vague (sex change)	very specific
6.3	Inclusion/exclusion	inclusion	inclusion	inclusion	inclusion	inclusion	inclusion	inclusion	both (sterilisation: inclusion: anyone age over 25, Exclusion: mentally ill)	both (inclusion: anyone age over 25, Exclusion: mentally ill)	inclusion
6.4	Criteria	All pregnant women, and all people living in Denmark (with regards to contraceptive advice)	pregnant woman + high risk (indication)	need for home care of the mother (baby) post-natal, referral from municipal board	The pregnant's own wish after information about the offers	abortion no later than 12th week of gestation, indication (embryo reduction and abortion after week 12))	all women requesting abortion	all women requesting abortion	Danish citizen	Danish citizen	needs and age (school attendance)
6.5	Co-payment	none	none	none	none	none	none	none	none	none	no
7	Classification	n.a.	based on timing in pregnancy (week), risk etc	n.a	n.a				n.a.		provider
8	Uniform definitions	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
9	Document data	19.07.1995	01.07.1998	31.03.1987	xx.09.2004	16.06.2004	16.06.2004	16.06.2004	12.07.1997	13.12.1996	31.12.1995

HC 6. Prevention and public health services		LOV 438 Act on health prevention for children and young people	BEK 846 Notice on health prevention for children and young people	RTL 15082 Guidelines on health prevention for children and young people	LBK 1261 Act on dental care	BEK 1073 Notice on dental care	VEJ 11855 Guidelines for the extent of and demands to the county and municipal dental care
HC 6.2	School Health Services	x	x	x	x	x	x
1	Legal status	Act of Parliament	Notice	guidelines	Act of Parliament	Notice	Guidelines
2	Coverage	All counties and municipalities	All counties and municipalities	All counties and municipalities	All counties and municipalities	All counties and municipalities	All counties and municipalities
3	Delegation from government	Counties and municipalities and the National Board of Health	Counties, municipalities (the municipal health service), GP's, Medical officer of health	Counties, municipalities (the municipal health service), GP's, Medical officer of health, visiting nurse	Municipalities and counties	National Board of Health, municipalities and counties	Municipalities and counties
4	Exclusions	none	none	none	none	none	none
4.1	Purpose	Entitlements and benefits as well as financial responsibilities.	Specification of entitlements and benefits stated in LOV nr. 438	interpretation of entitlements and benefits stated in LBK 438 and BEK 846 laid down by the National Health Board.	Entitlements and benefits	specifications of entitlements, benefits and responsibilities	Interpretation of entitlements and benefits stated in LBK 1261 and BEK 1073
5	Actors	NBH draws up guidelines for how to organize benefits according to the law, and rules of education of health personnel employed in the municipality. Counties and Municipalities are responsible for organising health promoting activities. GP's and visiting nurses carry out regular health prevention examinations.	NBH (guidelines) County, municipality (municipal health service) GP's, visiting nurse	Municipalities, counties, GP, Municipal employed doctor, visiting nurse.	Ministry of Interior and Health (rules and regulations), Municipalities and counties (supply of benefits).	NBH (guidelines), counties and municipalities.	counties and municipalities
6	Definition of benefits	health prevention to ensure a healthy childhood and prepare for a healthy adult life. More specific: health preventions examinations and dental care	definition of contents of health prevention examinations, vaccination and dental care	regular health examination by both doctor and visiting nurse, health education etc in school.	preventive dental care and dental treatment for children	preventive dental care (general and individual), dental examination and treatment.	preventive dental care (general and individual), dental examination and treatment.
6.1	Explicit/implicit	explicit	explicit	explicit	explicit	explicit	explicit
6.2	Specific/vague	Specific (number of health prevention examinations) and vague (not specified what these examinations should include)	specific	very specific	vague	vague	vague
6.3	Inclusion/exclusion	Inclusion	inclusion	inclusion	inclusion	inclusion	inclusion
6.4	Criteria	Being a child under 18 years old	need-based (children with special needs should have extra supervision and health promotion) Age-based (children subject to compulsory school attendance and children under 18)	needs and age (school attendance)	children under the age of 18,	Children under the age of 18 registered in the municipality. (different rules regarding free choice for children between 16 and 18 and for children under 16)	children under the age of 18
6.5	Co-payment	no	no	no	yes (if under 16's choose own dentist)	yes (if under 16's choose own dentist)	yes (if under 16's choose own dentist)
7	Classification	supplier	supplier	supplier	age	age	age
8	Uniform definitions	yes	yes	yes	yes	yes	yes
9	Document data	14.06.1995	14.10.2002	31.12.1995	15-12-2003	11-12-2003	29-03-2001

HC 6. Prevention and public health services		LOV 634 Act on free vaccination against certain communicable diseases	BEK 305 Notice on free vaccination against certain communicable diseases	VEJ 199 Guidelines on free vaccination against certain communicable diseases	BEK 922 Notice on change of free vaccination against certain communicable diseases	BEK 709 Notice on temporary vaccine to people over 65	DSK 15015 Summary of Act on actions against communicable diseases	BEK 277 Notice on doctors' report of communicable diseases	VEJ 60 Guidelines on doctors' report of communicable diseases
HC 6.3	Prevention of communicable diseases	x	x	x	x	x	x	x	x
1	Legal status	Act of parliament	Notice	Guidelines	notice	Notice	Act of Parliament	Notice	Guidelines
2	Coverage	All counties, Copenhagen, Frederiksberg and Bornholm municipalities	All counties, Copenhagen, Frederiksberg and Bornholm municipalities	All counties, Copenhagen, Frederiksberg and Bornholm municipalities	All counties, Copenhagen, Frederiksberg and Bornholm municipalities	All counties, Copenhagen, Frederiksberg and Bornholm municipalities	All counties, Copenhagen, Frederiksberg and Bornholm municipalities	All doctors in the country	All doctors in the country
3	Delegation from government	MIFIH delegates responsibilities to NBH, counties and Copenhagen, Frederiksberg and Bornholm municipalities	MIFIH delegates responsibilities to NBH, counties and Copenhagen, Frederiksberg and Bornholm municipalities	MIFIH delegates responsibilities to NBH, counties and Copenhagen, Frederiksberg and Bornholm municipalities			MIFIH delegates responsibilities to NBH and counties	To doctors, Statens Serum Institut and Health Inspectors	To doctors, Statens Serum Institut and Health Inspectors
4	Exclusions	none	none	none	none	none	none	none	none
4.1	Purpose	Framework to describe who defines entitlements and benefits, and to set financial responsibilities	Definition of benefits and entitlements	specification and advice on benefits	Inclusion of extra benefit and entitlement	Inclusion of extra benefit and entitlement	Rules and regulation on how to prevent spreading of communicable diseases.	Rules on when to report communicable diseases, how to do it and with which diseases to do it.	guidelines on when to report communicable diseases, how to do it and with which diseases to do it.
5	Actors	NBH (guidelines), counties and Copenhagen, Frederiksberg and Bornholm municipalities (definition of entitlement in negotiation with MIFIH and financial responsibility)	Counties (financing) and Statens Serum Institut (supplying the vaccinations)	Counties (financing) and Statens Serum Institut (supplying the vaccinations)	MIFIH	MIFIH	MIFIH (definitions of diseases); NBH (Recommendations and rules), counties and Copenhagen, Frederiksberg and Bornholm municipalities	Doctors (hospital and GP), laboratory workers (reporting) Statens Serum Institut (gathering of information), Health Inspectors (gathering of information)	Doctors (hospital and GP), laboratory workers (reporting) Statens Serum Institut (gathering of information), Health Inspectors (gathering of information)
6	Definition of benefits	none	Vaccination of children against communicable diseases and women over 12 years old against german measles	Vaccination of children against communicable diseases and women over 12 years old against german measles	Vaccination of children under 2 years old born by a woman with chronic hepatitis B.	Free influenza vaccinations to everybody over 65 years old	Authority of the Commissions of Epidemics	reporting communicable diseases	reporting communicable diseases
6.1	Explicit/implicit	explicit	explicit	explicit	explicit	explicit	explicit	Explicit	Explicit
6.2	Specific/vague	vague	specific	specific	specific	specific	specific	specific	specific
6.3	Inclusion/exclusion	none	inclusion	inclusion	inclusion	inclusion	n.a.	Inclusion	Inclusion
6.4	Criteria	none	Age (either under 18, over 12 or under 6 years old depending on benefit) and either Danish citizenship or residence in Denmark	Age (either under 18, over 12 or under 6 years old depending on benefit) and either Danish citizenship or residence in Denmark	age under 2	Age over 65	n.a.	diagnosis	diagnosis
6.5	Co-payment	no	no	no	no	no	no	no	no
7	Classification	none	by age/disease	by age/disease	by age/disease	by age/disease	n.a.	Diagnosis	diagnosis
8	Uniform definitions	yes	yes	yes	yes	yes	yes	yes	yes
9	Document data	17.12.1976	13.05.1993	11.12.1996	19.10.2001	30.06.2004	29.03.1994	14.04.2000	14.04.2000

HC 6. Prevention and public health services		LOV 117 Act on preventive home visits for the elderly	VEJ 59 Guidelines on social benefits for the elderly etc.	LBK 766 Notice on act on hospital service	LOV 141 Act on change of act on the central administration of the health system etc.	LOV 436 Act on smoke free environments in public premises, transportation etc.	LOV 1313 Act on change of act on smoke free environments in public premises, transportation etc.
HC 6.4	Prevention of non-communicable diseases			x	x	x	x
HC 6.9	All other miscellaneous public health services	x	x				
1	Legal status	Act of parliament	Guidelines	Notice	act of parliament	act of parliament	act of parliament
2	Coverage	All municipalities	all counties and municipalities	All counties	National Board of Health and national council for public health	all counties and municipalities	all counties and municipalities
3	Delegation from government	MiFIH delegates responsibility to the municipalities	MiFIH delegates responsibility to the counties and municipalities	MiFIH delegates responsibility to the counties	MiFIH delegates responsibility to National Board of Health and National Council of Public Health	Minster of Interior and Health delegates responsibilities to municipalities and government.	Minster of Interior and Health delegates responsibilities to municipalities and government.
4	Exclusions	none	none	none	none	none	none
4.1	Purpose	Specifications of benefits	Specifications of benefits and entitlements stated in LOV 117 on preventive health visits and in LBK 708 on social services	Only § 5: definition of entitlements	§ 23a and 23b: the appointment of a National Council of Public Health, that replaces to former councils on health promotion and on tobacco.	To set limits on smoking in order to reduce the nuisance of passive smoking	To prohibit smoking for children in public institutions (school, youth leisure centres etc) and to regulate adult smoking in the same institutions
5	Actors	MiFIH (delegation of responsibility and definition of entitlement), MiSA (definition of entitlements) and municipalities (supply of benefits)	MiFIH and MiSA (definition of entitlements and benefits), counties and municipalities (supply of benefits)	MiFIH and counties	National Council of Public Health	MiFIH (both delegations and regulations) and counties/municipalities (specification and interpretation of regulations)	MiFIH (rules and regulations)
6	Definition of benefits	Preventive home visits to all elderly people from 75 years and up.	Different kinds of social benefits (activities) for elderly people	Mammography screening	n.a.	Smoke free environments in public areas	Smoke free environments in public institutions
6.1	Explicit/implicit	explicit	explicit	explicit	n.a.	explicit	explicit
6.2	Specific/vague	vague	vague	vague	n.a.	vague	specific
6.3	Inclusion/exclusion	inclusion	inclusion	inclusion	n.a.	inclusion	inclusion
6.4	Criteria	age 75 or older	age and functional capacity	female, age between 50 and 69	n.a.	public areas	public institutions
6.5	Co-payment	no	sometimes	no	no	no	no
7	Classification	Age	age and functional capacity	age and disease	n.a.	n.a.	n.a.
8	Uniform definitions	yes	yes	yes	n.a.	yes	yes
9	Document data	20.12.1995	06.06.1998	28.08.2003	05/03/2001	14.06.1995	20.12.2000

HC 6. Prevention and public health services		LBK 784 Act on Working environment	BEK 206 Notice on work with ionizing radiation	LBK 766 Act on Hospitals	RTL 134 Recommendations concerning Occupational Health Clinics in the Hospital sector
HC.6.5	<i>Occupational Health</i>	x	x	x	x
1	<i>Legal status</i>	Act on parliament	Notice	Act on parliament	recommandation
2	<i>Coverage</i>	National/all working sites	National/all working sites	All counties	All counties
3	<i>Delegation from government to</i>	National Working Environment Athority	National Working Environment Athority	Delegation to counties	counties
4	<i>Exclusions</i>	None	None	None	None
4,1	<i>Purpose</i>	To secure a safe working environment	To secure medical check-ups for persons working with ionizing radiation	Entitlements, delegation of planning responsibility	To advice counties on how to establish Occupational Health clinics in the hospitals
5	<i>Actors</i>	Ministry of Employment, National Working Environment authority, Employer and employee organisations, Working Site	Ministry of Employment, National Working Environment authority, Employer and employee organisations, Working Site	MiFSA, County Cousil, Hospitals, Clinical departments	Ministry of the Interior and Health, National Bord of Health, County Counsel
6	<i>Definition of benefits</i>	Inititives to secure a safe working environment, Medical check-ups for persons working in risky industries	Medical examination on a routine basis	diagnostik and treatment of work related deseases/accidents	n.a.
6,1	<i>Explicit/implicit</i>	explicit	explicit	implicit	implicit
6,2	<i>Specific/vague</i>	specific	specific	vague	n.a
6,3	<i>Inclusion/exclusion</i>	including	including	inclusion	n.a.
6,4	<i>Criteria</i>	employed	Employed	permant citizen of a	n.a.
6,5	<i>Co-payment</i>	Yes (the employers)	yes (the employers)	None	none
7	<i>Classification</i>	n.a.	n.a	yes for documentation	n.a.
8	<i>Uniform definitions</i>	yes	yes	yes	yes
9	<i>Document data</i>	11-10-1999	23.03.1990	28-08-2003	27-06-1977

<p>1 Legal status Constitution Law Decree Administration order Contract</p> <p>2 Coverage Sectors Regions</p> <p>3 Delegation Supervision Formal approval Governmental decision</p> <p>4 Excluded categories</p> <p>4,1 Purpose Entitlements Reimbursement Target-setting</p> <p>5 Actors Parliament Ministry of the Interior and Health (MoIH) Minister of the Interior and Health (MioIH) Nat.Board.of Helth Danish Medicines Agency Ministry of Social Affairs (MSA) Minister of Social Affairs (MiSA) County council Municipal council Health Care Reimbursement Negotiation Committee (HCRNC) MiEBA ??</p> <p>6 Definition of benefits</p> <p>6,1 Explicit/implicit "All necessary" Areas of care Items</p> <p>6,2 Specific/vague</p> <p>6,3 Inclusion/exclusion</p> <p>6,4 Conditions</p> <p>7 Classification By service delivered By individual good Case-based per provider Case-based per time period</p> <p>8 Uniform definitions</p>	<p>9 Document data Passed by Updated</p> <p>10 ...</p> <p>11 Taxonomy Levels Logics</p> <p>12 Decision makers</p> <p>13 Decision criteria</p>
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Document data

