

EWHNET
European women's health network



Women`s Health Network:

**State of Affairs, Concepts, Approaches, Organizations in
the Women`s Health Movement**

**Country report
Denmark**

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1. Introduction

Women have for a long period influenced upon political life in Denmark, they were granted right to vote and access to Parliament from 1915. Very early, women organizations got involved in activities to promote women's health. Equal access to gender-sensitised health care has always been a main topic in feministic policy. The Danish National Council of Women was established already in 1899, and included from the very beginning members of the health professions. Today it covers 48 different female organizations, including several female fractions of trade unions, youth organizations and the gender equality board of the different political parties, and a broad group of NGOs including religious and humanitarian groups.

The first female medical doctor graduated in 1885. The Association of Danish Female Medical Doctors was established in 1928. It became member of the Danish National Council of Women in 1946. In 1978, a group of female medical doctors founded the Female Medical Research Network that since has promoted gender-sensitised health research. In 1987, a chair in female medical research was set up at the Medical Faculty at University of Copenhagen. Since then, pre- and postgraduate multidisciplinary courses in female health problems are offered to all health personnel including medical doctors. Gender-sensitised health topics have been introduced in most postgraduate medical education.

In 1993 the Ministry of Health convened a panel of experts to analyse the trend in life expectancy in Denmark, and included a special analysis of the status of female morbidity and mortality in comparison with other European countries.

The present report on women's health and the health network in Denmark is concentrated on a description of the national health policy and the organization of medical care, the health status of women in Denmark, their major health problems, and their free access to professional health care. It also includes a description of the female health movement, the various NGOs involved in women's health and gives a few examples of the use of alternative "treatment" by women.

The Danish health policy is based upon the three main targets of WHO.

- To add years to life
- To add health to the years
- To improve quality of life

Compared to the first half of this century, the general mortality and the morbidity by cardiovascular diseases, a number of infectious diseases and reproductive disorders have diminished very much among women in Denmark. However, since the early 1980s the trend in life expectancy of women has been less favourable in Denmark than in other Western European countries and an increasing amount of health problems are reported in the population. Quality of life is not easily measured, hence no strict definition exists. In general, life quality in the Nordic countries is favoured by a high degree of social and gender equality, but some groups in the society have benefited less from the economical growth than the majority.

The fourth major target of WHO's health policy is

- Equity in health

This includes equal access to health care for all citizens, regardless of gender, socio-economic status and age.

The health care provision in Denmark promotes equal access to health care to the extent that it is a public task, financed through taxes. Any citizen has right to free primary medical care, including prevention and treatment of disease, and also to specialized medical care either in out-doors clinics or in hospitals. The health policy aims to give the same level of care to all socioeconomic groups, and with no distinction between men and women. Organization (priorities) of health care in Denmark may well be influenced by political currents, but less by economical considerations than in countries with a privatized health care system.

The present report is in its priorities influenced by the author's professional skills, political visions, and experiences within different branches of the female movement. The report includes information provided by several sources, including some NGOs. Furthermore, data were provided from the National Institute of Public Health), Danish Ministry of Health, Danish National Board of Health, European Commission' s report "State of Health of Women in the European Community, 1997", the Danish National Board of Women, and the Danish Equality Council.

The report was written by Karin Helweg-Larsen, MD. Specialist in human pathology and in public health. Senior Researc fellow at DICE, the National Institute of Public Health.

The Danish Institute for Clinical Epidemiology (DICE) is an independent institute under the Danish Ministry of Health. DICE is a so-called sectorial research institute its principal purpose being to plan and carry out research and reviews.

The institute also assists public authorities with statistical and epidemiological consultancy concerning analysis, evaluation, and planning of health promotion, health services etc. DICE also provides postgraduate training.

DICE's field of research may basically be divided into

- Research into health, diseases and mortality of the population. Description and analysis of health status, frequency of symptoms, disease, handi-caps and death are in focus. Also factors determining health and causes of disease are being studied.
- Research into health promotion, prevention and treatment. As regards treatment the efforts of the health sector is in focus, whereas the efforts of other sectors in society are involved when health promotion and preventive measures are concerned.

DICE's research has an epidemiological starting point in particular. This starting point - a so-called population statistical starting point - involves research into the entire population or into groups of the population.

The main line in the scope of work of the institute comprises:

- Research into the health of the population
- Health interview surveys of the population. Health pro-files.
- Epidemiological mortality investigations
- Health promotion studies. Life style and health behaviour. Environmental health studies
- Health services research. Evaluation
- Methodological- and development projects
- Reviews

2. Health and gender equality

The UN World Conferences on Women in Rio, Vienna, Cairo, Copenhagen and Beijing have stressed the importance of issues related to the improvement of the status of women. From each of these conferences emerged a more powerful recognition of the crucial role of women in sustainable development and protecting the environment; of the human rights of women as an inalienable, integral and indivisible part of universal human rights; of violence against women as an intolerable violation of these rights; of health, maternal care and family planning facilities; and of access to education and information, as essential to the exercise by women of their fundamental rights.

Among the strategic objectives of the Fourth World Conference in Beijing 1995 concerning women and health were:

- To design and implement, in co-operation with women and community-based organizations, gender-sensitive health programmes, including decentralised health services, that address the needs of women throughout their lives and take into account their multiple roles and responsibilities
- To include women, especially local and indigenous women, in the identification and planning of health-care priorities and programmes
- To remove all barriers to women's health services and provide a broad range of health-care services
- To strengthen and reorient health services, particularly primary health care, in order to ensure universal access to quality health services for women and girls
- To take all appropriate measures to eliminate harmful, medically unnecessary or coercive medical interventions, as well as inappropriate medication and over-medication of women, and to ensure that all women are fully informed of their options, including likely benefits and potential side-effects, by properly trained personnel

The Beijing Platform of Action recommended promoting research and disseminating information on women's health, and pointed to the necessity of gender-specified data collection in all policy-making, planning, monitoring and evaluation.

Further, to promote gender-sensitive and women-centered health research, treatment and technology, and to link traditional and indigenous knowledge with modern medicine, making information available to women to enable them to make informed and responsible decisions.

Governments must establish ministerial and inter-ministerial mechanisms for monitoring the implementation of women's health policy and programme reforms and establish, as appropriate, high-level focal points in national planning authorities responsible for monitoring to ensure that women's health concerns are mainstreamed in all relevant government agencies and programmes.

Denmark fulfils most of the goals of the Beijing Platform of Action.

2.1 Women and men in the Nordic countries; equal opportunities

In all Nordic countries, political unity prevails in the awareness that society can progress in a more democratic direction only when both women's and men's competence, knowledge, experiences, and values are recognised and allowed to influence and enrich development in all spheres of society.

The national goals for equal opportunities are that women and men have the same rights, responsibilities, and possibilities. Many steps have been taken in the Nordic countries in the promotion of equal opportunities of men and women, and the goals are the same in all Nordic countries. The Nordic plan for equal opportunities 1995-2000 has emphasised that the effort requires

- The integration of gender issues in each country into all spheres of policy at central, regional and local level
- Comparable statistics on women's and men's living conditions and health
- Research with a gender perspective

2.2 Danish policy on gender equality

The first legislation on equality was passed in 1976, with the Act of Equal Remuneration for Men and Women, and since, five laws on equal opportunities have been passed:

- The Act on Equal opportunities for Women and Men of 1978, and amended in 1988
- The Act of Equal Pay for Women and Men of 1976, and amended in 1992
- The Act on Equal Treatment of Women and Men as Regards Access to Employment, Maternity leave etc of 1978, and amended in 1998
- The Act on Equality of Women and Men in Appointing Members of Public Committees etc of 1985
- The Act on Equality of Women and Men in Appointing Certain Board Members in the Civic Services of 1990

2.3 Danish Equal Status Council

An Equal Status Council was established in 1975 as an administrative body under the Prime Minister's Office. Since 1978, legislation regulates the activities of the Council. The Council advises the Prime Minister and the state and has further as goal to examine disagreements of equal pay and equal treatment of women and men and thus to supervise the enforcement of the Equality Acts. Since 1998, the Council has published information relevant in the context of equal status on a web site www.lige.dk. Recently, in April 1999, a working group under the Prime Minister has proposed a new organization of the tasks of the Council by appointing a Minister for equality and establishing a special research center for equality that facilitate co-operation with different other national research units and NGOs .

The Council participates in international equal opportunities work. Among these activities are the annual UN assembly of the Commission of the Status of Women, the EU Commission's Office for Equal Opportunities for Women and Men, and for Issues concerning Families and Children, as well as the Nordic Council's co-operation in the field of equal status for men and women.

2.4 Statistics

All national statistics relating to individuals are collected, analysed and presented by sex and reflect gender issues in society. The Equal Status Council publishes in the annual report statistics that document existing gender inequalities and update knowledge about living conditions, morbidity and mortality of men and women in Denmark.

Denmark Statistics runs a large number of registers including information about all citizen's labour market affiliation, branch of trade, residence, family units etc. The Danish National Board of Health is responsible for a number of registers, including a patient discharge register,

that contains information about all indoor and outdoor hospital contacts since 1978. Both in Denmark Statistics and in the different health registers the unique Danish personnel number links all records. This makes it possible to perform a large number of nation-wide analyses of utilisation of health care by sex, age and e.g. socio-economic status. Such information is provided annually by Denmark Statistics.

3. Women in Denmark

In 1998, 5.46 million men and women lived in Denmark. In the age groups below 65 years there was more men, but totally 2.679.000 women against 2.616.000 men.

Population by sex and age, 1998		
1998	Men	Women
0-4	177648	168644
5-9	166956	158361
10-14	143635	136944
15-19	151887	145570
20-24	181637	176283
25-29	196096	188301
30-34	220477	209420
35-39	195749	187803
40-44	189665	183475
45-49	188451	184361
50-54	204656	199150
55-59	150156	149696
60-64	120861	127510
65-69	103169	116009
70-74	88906	111133
75-79	67929	97894
80-84	41000	71812
85-89	20184	45272
90-94	5569	17524
95+	1038	4029
Source: Denmark Statistics Yearbook 1998		

3.1 Fertility and population prognoses

The fertility rate diminished very much during the 1970s to a minimum in the early 1980s, 1.4. In 1996 fertility had increased to 1.8. Increase in population is now mainly due to immigration. Population prognoses assume an increase in the proportion of elder people (65+) by 2030 from 17% in 1998 to 22% in 2030 among women and from 13% to 19%, respectively, among men.

Age distribution 1960, 1998 and 2030, women and men						
	Women			Men		
Year	1960	1998	Prognosis 2030	1960	1998	Prognosis 2030
Total	2.312	2.679 mio %	2.820 mio	2.273 mio	2.616 mio %	2.781 mio
Total	100	100	100	100	100	100
0-19 years	32	23	22	35	24	24
20-64	56	60	56	56	63	57
20-29	13	14	12	13	14	13
30-64	44	46	44	43	49	45
65 +	11	17	22	10	13	19
Source: Denmark Statistics: 1998:15						

3.2 Family structure

In Denmark during the late 1960s and early 1970s the divorce rate more than doubled. Fewer people got married, and although many lived in partnerships, more people remained single all their life. The proportion of persons living alone continued to increase from 1980 until 1994 but has since remained about unchanged. About 22% of families are without children, and the proportion of single women with children is about 4% of all registered families, and proportionally increased compared to all families with children.

Families with children by type of family 1980 – 1999.							
Presented as percentage of all families							
Total number of families	All fam.	Single	Single	Married	Not married	Children	
	With children	Women with children	Men with children	Cohabit. with children	Cohabiting with children	Living alone	
1980	2.546.774	28,8	3,4	0,5	22,9	2,1	1,0
1982	2.598.222	27,9	3,5	0,6	21,4	2,5	0,9
1984	2.658.077	26,4	3,5	0,6	19,5	2,8	0,8
1986	2.719.525	25,0	3,5	0,6	18,0	3,0	0,7
1988	2.753.347	24,4	3,5	0,6	17,1	3,2	0,6
1990	2.782.461	23,8	3,6	0,6	16,1	3,4	0,6
1992	2.815.723	23,1	3,6	0,6	15,3	3,7	0,5
1994	2.849.341	22,6	3,7	0,5	14,5	3,8	0,5
1996	2.869.899	22,5	3,7	0,5	14,4	3,9	0,5
1998	2.884.904	22,3	3,6	0,5	14,2	4,0	0,5
1999	2.886.203	22,4	3,6	0,5	14,2	4,0	0,5

3.3 Women's labour market affiliation

The most important change in society has been the increase in labour market participation by women, which has enabled Danish women to enter the labour market at a level that nearly matches the male employment. One of the consequences of such changes is that women now spend less time on household work than before, but that the total work-load has increased. Nowadays, Danish women enjoy some of the highest labour market participation rates anywhere in the world. Compared to the other Scandinavian countries the proportion of women working part-time is low, and the rate has declined during the last decade.

Figures from EU do not reflect all the differences in the proportion of female labour market participation, mostly because the data comprise all 16-74 year olds. In Denmark, more than 50% of young people follow school education until 18 years of age, and most adults are pensioned at the age of 60-65. In the last decade, a higher proportion of women has been pensioned either due to long lasting employment or disability by chronic diseases, among these many related to high work- load.

Labour market participation, women and men, and the gender differences, in EU, 1997 – Percentage			
	Women	Men	Gender difference
EU total	45,6	65,9	20,3
Sweden	56,5	65,3	8,8
Finland	54,9	65,9	11
Denmark	59	72,1	13,1
France	48,2	63,3	15,1
England	53,2	70,8	17,6
Portugal	49,4	67,1	17,7
Belgium	41	60,7	19,7
Germany	48,2	67,9	19,7
Austria	48,7	69,1	20,4
Holland	50,6	71,5	20,9
Spain	36,7	62,3	25,6
Ireland	42,7	68,5	25,8
Luxembourg	38,1	64,7	26,6
Greece	36,2	62,9	26,7
Italy	34,8	61,8	27
Source: Eurostat, Labour Force Survey 1997			

In the 1990s one in three women attend higher education, and will enter into the labour market with a medium or long vocational education. This was not the case in the 1960s, when the female labour market participation increased very steeply. Only 15% of all women had any vocational education, and very few had a higher education. It is well-known that low level of education is a risk factor of unemployment.

From mid 1970s up to 1995 the unemployment rate among women rose to about 15%, and was highest among the unskilled. More than 1/3 became temporary unemployed. Nowadays the unemployment rate, also among women, is relatively low, about 6%. However, there still exist socio-economic differences in risk of unemployment. The table shows female unemployment rates by income in 1998. The highest rate was found among women in low-income groups, and the lowest unemployment rate among those with a relatively high income. The very low-income groups include women on temporary financial support due to for example pregnancy.

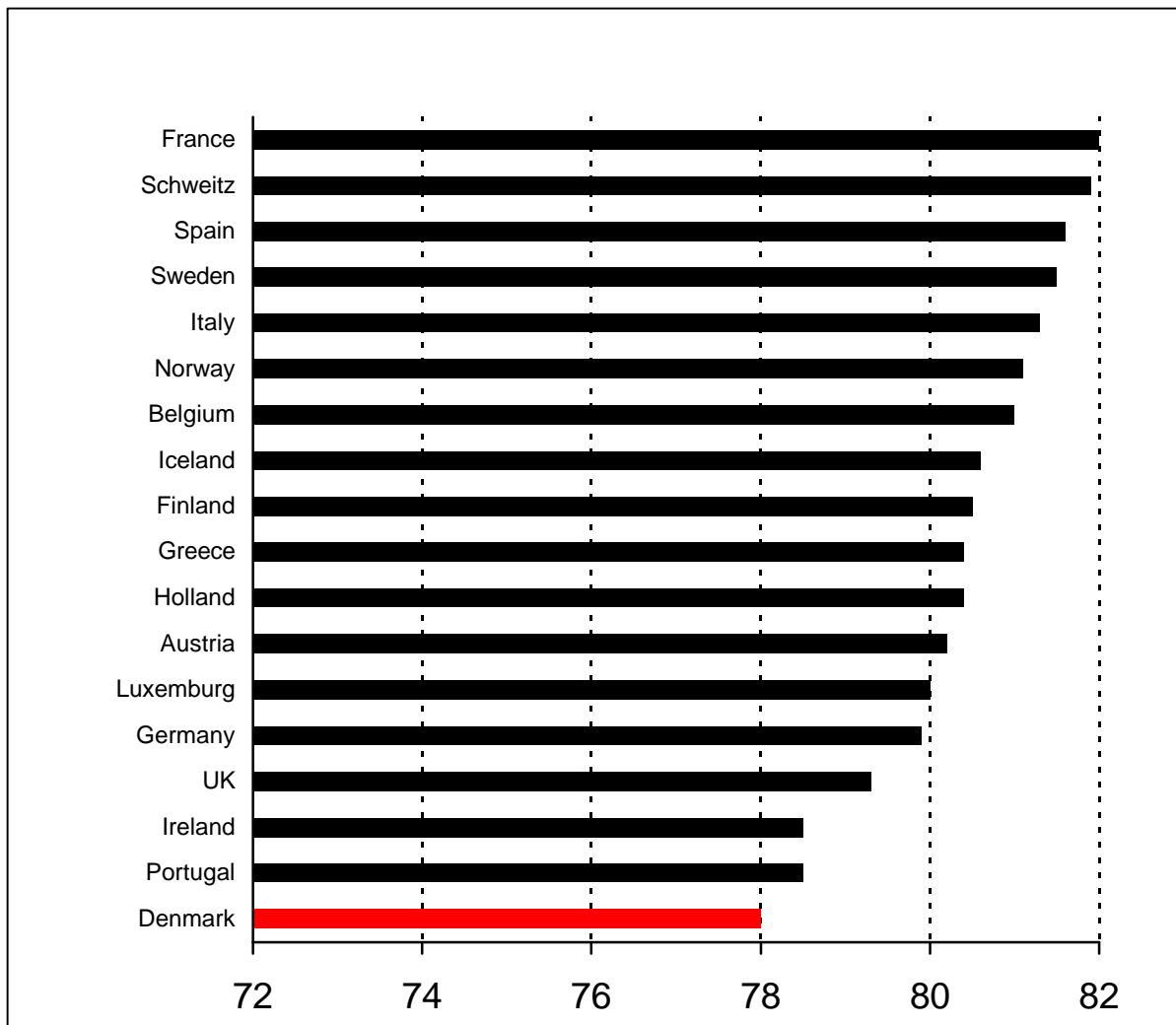
Female unemployment, rate per 100, by personnel income 1998			
	Labour force	Number of unemployed	Unemployment rate - percentage of total age group
	16-66 years	N	%
Women	1.297.806	308.761	6,6
< 25.000	48.597	4.951	3,4
25.001 - 50.000	48.124	7.182	4,3
50.001 - 75.000	80.920	18.618	6,7
75.001 - 100.000	129.788	42.090	10,3
100.001 - 125.000	189.730	81.567	14,1
125.001 - 150.000	235.627	81.844	9,1
150.001 - 175.000	200.417	39.276	4,0
175.001 - 200.000	143.733	17.851	2,4
200.001 - 225.000	92.911	7.849	1,8
225.001 - 250.000	53.702	3.433	1,5
250.001 - 275.000	27.260	1.682	1,6
275.001 - 300.000	15.460	859	1,6
> 300.000	31.537	1.559	1,7
Source: Denmark Statistics, 1999:20			

4. State of health among women in Denmark

Health of a nation or of any population group is traditionally measured by rate of mortality, morbidity or disability. It may also be described by the share of the population in good health, that fulfil WHO's definition of health: to be able to use all capacity free of illness and disability. Such figures, however, are less easily comparable internationally.

4.1 Life expectancy of women in Denmark

Comparing the state of health of different nations, life expectancy or cause specific, age adjusted mortality is very often used. As previous stated, since 1980, the trend in life expectancy of women in Denmark has been less favourable than in comparable countries. The figure shows different European countries ranked by life expectancy of women in 1996. Women in Denmark had the lowest life expectancy among all Western European countries, for example 4 years shorter life expectancy than that of women in France.



Women live longer than men, also in Denmark. However, during the last decade the sex ratio of mortality has diminished, and the gap in life expectancy is now less than in the late 1970s.

Life expectancy, women and men, Denmark 1966-1996		
	Women	Men
Year		
1966-67	74,9	70,3
1969-70	75,7	70,8
1973-74	76,6	70,8
1977-78	77,5	71,5
1981-82	77,4	71,4
1985-86	77,5	71,6
1989-90	77,7	72,0
1993-94	77,8	72,5
1995-96	78,0	72,9

4.2 Age related mortality

The Mean Life Committee convened by the Danish Ministry of Health in 1993 proved that the different trend in life expectancy of women in Denmark compared to other European countries mainly was due to a higher mortality among women aged 45-74 years. Given that the mortality of women in Denmark had been the same as in Norway and Sweden, in 1985-89 an excess of 2.400 deaths in these age groups would have been spared, as the relative excess mortality was about 60%. Recent analyses have shown that the excess mortality among women in Denmark compared to Sweden has increased in 1991-1994 to 65% among 65-74 year-olds, with annually 3.320 excess deaths among 45-74 year-olds. The total annual number of deaths among 45-74 year old women in Denmark is about 9.200.

The mortality in the younger age groups is also higher than in the other Nordic countries, between 20% among 1-34 year-olds, and 50% among 35-44 year-olds.

4.3 Cause specific mortality

It is a higher mortality by lung cancer, cardiovascular diseases, breast cancer, other cancer diseases, liver cirrhosis and by suicide and accidents that explains the differences in total mortality in Denmark, Sweden and Norway. The table demonstrates the trend in excess cause specific mortality from 1980-84 to 1993-95 among women in Denmark compared to Norway and Sweden. The excess mortality from lung cancer, other cancers than lung and breast cancer, and from cardiovascular diseases and chronic lung diseases have increased in the period. In contrary it has diminished concerning suicide and accidents.

Denmark compared to Norway and Sweden, women age groups 0-74, number of excess death per year in Denmark, compared to if the mortality had been similar to Norway and Sweden, 1980-1995.

Cause of mortality	1980-84	1985-89	1990-92	1993-95
Cancer of throat and larynx	38	43	47	61
Lung cancer	332	422	480	546
Breast cancer	230	297	293	318
Cancer of colon and rectum	154	142	149	114
Other cancers	331	336	388	379
Cardiovascular diseases	569	634	766	924
Chronic lung diseases (astma, bronchitis)	195	346	463	561
Liver cirrhosis	47	96	114	119
Other diseases	120	190	233	466
Suicide	260	219	120	77
Accidents	104	122	66	130
Total	2.379	2.848	3.118	3.695

Source: Knud Juel, National Institute of Public Health

4.4 Health behaviour and excess mortality

It is well known that tobacco smoking, high alcohol consumption; low physical activity and high-saturated food are risk factors of morbidity and premature mortality. It is also known that since the 1950s there has been a higher proportion of smoking women in Denmark than in other Western European countries. The share of women smoking daily has diminished during the last years, and is now about 30%, however, the proportion of heavy smokers, more than 15 cigarettes per day, has not diminished, and is still about 17%. It was calculated that among women 5.588 deaths in 1995 was related to tobacco smoking, corresponding to 1/5-1/6 of all female deaths.

Compared to other Nordic countries, but not France, Austria and Spain, the consumption of alcohol is relative high in Denmark. In a recent health survey, 1994, 35 % of women aged 35-64 had daily alcohol intake, however less than 10% had a weekly consumption over 14 units.

Level of physical activity in a population is more difficult to compare internationally. By tradition some type of activity is not comprised in questionnaires, for example physical activity by doing cleaning and other housework. In some countries, transport by food is the normal, in others by bicycles, and these activities may not be reported as physical activity. In addition, low physical activity may be due to illness, and therefor in statistical analyses found to be a strong predictor of morbidity and mortality.

The consumption of fat is relatively high in Denmark, and the composition of the food may explain part of the higher mortality by cardiovascular diseases among women in Denmark compared to for example France, and other Southern European countries.

4.5 Health behaviour, socio-economic factors and mortality

Mortality is higher in socially disadvantaged groups, both among men and women. Part of this fact can be explained by health behaviour related to social class. However, statistical analyses based upon data in a Danish health survey, 1986, showed that social differences in behaviour only explained minor part of the social differences in mortality. For example, among unemployed women adjusting for behavioural factors (smoking, high alcohol consumption,

low physical activity, and high body mass index) only reduced the relative excess mortality by 15%. This indicates that, independent of social differences in risky health behaviour, those socio-economic factors influence strongly upon mortality.

Women in Denmark, especially birth cohorts from 1910 to 1940, have been influenced by great transitions in living conditions. They experienced high workload when they had dependent children, got often divorced, due to low level of vocational training they had low job influence, and many became unemployed. By their 50 years, about 50% of women with no vocational training had become pensioners; often due to chronic illness and burnout. It is among this group of women, most of the excess mortality is found.

4.6 Morbidity of women in Denmark

Morbidity in a population may be measured by contacts to the health care system or by self-reported health, illness and disability in health surveys. The Danish National Patient Discharge Register publish annually gender specified data by diseases and injuries, and the register can be used for a large number of sophisticated analyses.

4.6.1. Hospital discharges

In 1997, 13% of all women were hospitalised at least once, and the highest rate was among 25-34 year-olds, 21% per year, due to reproduction. Excluding these causes, the hospitalisation rate was at the same level as men's. In average women were hospitalised 9,6 days, the longest stay was among the elder women, 16 days for 75-84 year-olds.

The distribution of main causes of hospitalisation differs, naturally, by age. The table shows data from the national patient discharge register, 1997, concerning 25-34, 35-44, 55-64, 65-74 and 75+ old women.

Main cause of hospitalisation in different age groups, 1997					
	-Percentage-				
Diagnosis	25-34	35-44	45-54	55-64	65-74
Cancer	1.9	7.6	18.8	19.4	18.9
Mental disorders	0.4	1.3	2.1	1.6	1.4
Nervous system disorders	1.4	3.2	5.1	5.3	6.2
Cardiovascular diseases	1.3	4.6	10.8	17.6	23.9
Respiratory diseases	2.2	3.4	5.3	9.6	12.6
Gastrointestinal disorders	4.0	7.9	12.9	13.6	13.3
Uro-genital diseases	6.7	12.5	16.1	9.8	7.5
Reproduction, pregnancy, births etc	73.9	33.8	0.6		
External causes, accidents, violence	4.3	8.0	11.4	11.5	13.3
All other causes	5.9	25.7	37.1	11.6	12.9
Total	100	100	100	100	100

Among all women, the most common cause of contact to hospitals is related to reproduction, either abortion, pregnancy, birth or gynaecological diseases. The second most common cause is cardiovascular diseases and ill-defined symptoms.

The level of activity at Danish hospitals shows that there is very little change in the pattern of illnesses. If disregarding births, the dominant illnesses dealt with in hospitals are cardiovascular diseases and tumours, and brain and other neurological diseases count for most days of hospitalisation.

4.6.2. Self-reported mortality

Among women 75.6% rates their health as really good or good, 84.4% among 25-44 year-olds, and 52.9% among 65+ year-olds. This is one of the results of the Danish national Health Survey conducted in 1994 by the National Institute of Public Health. But 29.0% of women aged 25-44, 46.6% of 45-66 year-olds suffer from any longstanding illness.

Recent research into morbidity amongst Danes shows a rise within the population in the last few years. The rise has been amongst both women and men, and in all age groups. The percentage of the population suffering from one or more prolonged illnesses is also increasing. The most common of the prolonged illnesses are muscular and skeletal diseases, diseases of the respiratory organs, cardiovascular diseases, neural diseases and mental disorders.

The most common complaints and symptoms during a 14-day period are pains or aches in the neck or the shoulders; pains or aches in the back or the small of the back; pains in the limbs, hips or joints; headaches, tiredness, and colds, or coughing. Two groups of illness stand out from the others: firstly, asthma, hay fever and other allergic head colds, and secondly, muscular and skeletal diseases. As regards preventive work, both groups of illnesses have had high priority in recent years.

To suffer from stress, seems to increase the risk of morbidity. In the Danish Health Survey of 1994, 42.4% of all women complained about occasionally stress in everyday life. The percentage was highest among 25-44 year-olds, thus among women in reproductive age.

4.6.3. Gender-specific morbidity

Breast cancer incidens is relatively high among women in Denmark, the standardised rate per 100.000 women was 77.9 in 1994. Totally 3.245 new cases were diagnosed. Cervix, uterine and ovarian cancer accounts for 1.857 of all 14.922 cancers among women in 1994.

AIDS defined illness increased most among men in Denmark during the period 1985-1993, and has since declined significantly. Among women a total of 240 cases have been diagnosed, and the incidens is also declining among women.

Chlamydia, gonorrhoea, syphilis and other sexual transmitted infections have decreased strongly since the early 1980s. However, Chlamydia still remains a problem in view of chronic infections and subsequent infertility problems.

Infertility among women is an increasing problem. Part of it is due to postponing of pregnancy, but also sequels to pelvic infection plays an important role. It is believed that about 15% or all couples will have problems of having children.

4.6.4. Morbidity of women in Denmark and health care networks

Given the relatively high self reported illness among women, there is need for prevention and also for access to competent health care. In the following parts, the Danish public health care system is described, and figures are presented about women's use of the public health system and of alternative care.

Special attention is paid to reproductive and maternal health and social care.

5. Public health care in Denmark

In Denmark priority has been given to free access to most health services for all regardless of their economic situation. The majority of the health sector, including the hospital services, is run as publicly owned institutions. Financing and running of the services are thereby integrated.

Preventive care, health promotion and health care have for decades been public tasks, and there is only little tradition for private health services. Further, the few existing NGO-related activities, like crisis centers for victimised women, Red Cross activities, and Health city activities are to a large extent economically supported by the state or organised in co-operation with local authorities. There are no private health shops.

There exist very few private hospitals, mainly for plastic and orthopaedic surgery, and very few private clinics outside the state health insurance system.

The Danish health care service, thus, is characterised both by being publicly financed through taxes and, for most of the services being run directly by the public authorities. In a number of Western European countries there is a much larger private element in the health care service, a large number of the hospitals being run by private organizations. The financing is, on the other hand, mainly public, although this may be in the form of compulsory insurance schemes rather than in the form of general taxes.

The medical professions, and other health care professionals, have very special power, as they (often) are those who define illness and decide upon the individual need for diagnostic procedures and medical treatment. Compared to the costs of the relatively privatised health care in the United States and for example Germany, the Danish health care system is relatively inexpensive. Privatisation of health care might well be more costly due to looser diagnostic and treatment indications when earnings are dependent of the patient flow.

In the Danish publicly integrated model, those providing health services are civil servants receiving a fixed salary. The integrated model with budgetary restrictions and fixed salaries gives budget security, but in itself it does not necessarily give the staff any intrinsic incentive towards efficiency. Efficiency is ensured through other mechanisms such as continuous vocational training, professional ethics and good management.

The next parts of the reports describe the organization of health care in Denmark, the primary health care service, the hospital service and the preventive health care and health promotion. The report relies on information from Ministry of Health.

5.1 Organization of health care in Denmark

All residents in Denmark are covered by the public Health Care Reimbursement Scheme in case of illness. The citizens do not pay any special contributions to the Health Care Reimbursement Scheme, as this is financed through county taxes. The counties administer both the Hospital Authority and the Health Care Reimbursement Scheme.

Children under the age of 16 are covered by the insurance of their parents. All those who have the right to Health Care Reimbursement services receive a Health Care Reimbursement card. Since 1998, children have their own insurance card. The insurance card, also, ensures acute medical treatment abroad, and the costs to be reimbursed by the Danish State.

All general practitioners, specialists, dentists, physiotherapists, chiropractors etc. are licensed by the State. The Health Care Reimbursement Scheme subsidises treatment given by general practitioners, specialists etc. who have joined collective agreements with the Health Care Reimbursement Scheme. The Health Care Reimbursement Scheme enters into collective agreements with the organizations that represent the different professions. However, such an agreement is only valid when agreed upon by the Minister for Health. The Negotiation Committee of Public Health Security is made up of politicians from the counties and from the local authorities of the capital.

The public Health Insurance Scheme pays for all or part of the treatment given by specialists. People have the right to free medical help from specialists when they are referred by their general practitioners.

The Danish health care service can be divided into 2 sectors: Primary health care and the hospital sector.

When contracting an illness, the population first comes into contact with primary health care. The hospital sector deals with medical conditions that require more specialised treatment, equipment and intensive care.

In addition to the treatment of patients, both general practitioners and hospitals are involved in preventive treatment as well as in training of health personnel and medical research.

5.1.1. Primary health care

The primary sector deals with general health problems and its services are available to all. The sector can be divided into 2 parts: One which chiefly deals with treatment and care: general practitioners, practising specialists, practising dentists, physiotherapists etc. (the practising sector) and home nursing; One part which is predominantly preventive and deals with preventive health schemes, health care and child dental care

General practitioners

The general practitioners act as "gatekeepers" with regard to hospital treatment and treatment by specialists. This means that patients usually start by consulting their general practitioners, whose job it is to ensure that they are offered the treatment they need and that they will not be treated on a more specialist level than necessary. It is normally necessary to be referred by a general practitioner to a hospital for medical examination and treatment, unless in question of an accident or an acute illness. It will also normally be necessary to be referred by a general practitioner for treatment by a specialist.

Besides referring patients to a hospital or a specialist, the general practitioners refer patients to other health professionals working under agreement with the health care service and arrange for home nursing to be provided.

The general practitioners occupy a central position in the Danish health service. This is of course due to the fact that general practitioners are the patients' primary contact with the health service. The general practitioner must ensure that the patient is given the right treatment and sent to the right professionals in the health service. The general practitioner is thus the coordinator and the person with professional responsibility for referring patients to hospitals, specialists and other professionals.

In Denmark there are about 3,700 general practitioners. Each general practitioner has about 1,600 patients. Children under the age of 16 generally register with the same general practitioner as their parents.

People have the right to free medical help from their general practitioner, or his substitute. They may also, free of charge, visit another general practitioner while they are temporarily staying outside their own general practitioner's area in the case of sudden illness, worsened illness, accidents etc.

As the average length of stay in hospitals has been reduced due to increased out-patient treatment, general practitioners play a more important role as co-ordinators of the treatment offered to patients by the various professional groups practising within the Health Care Reimbursement Scheme, e.g. practising specialists, physiotherapists and home nursing. Moreover, general practitioners increasingly co-ordinate between treatment in primary health care and treatment in hospitals as it has become possible to treat a growing number of patients in primary health care either by general practitioners or by practising specialists. The number of general practitioners and specialists has increased by about 30% in the period 1980 to 1996.

Dental service

All residents in Denmark are free to choose their own dentist. There are approx. 3,800 dentists in Denmark. For those who are 18 years old or more, the public Health Care Reimbursement Scheme partly pays for preventive and other dentistry treatment. Reference by a general practitioner is not required. Children under the age of 18, the partly disabled or those with serious physical or mental disabilities are normally offered dentistry free of charge.

The number of dentists increased by 62% from 1980 to 1996. This increase should be seen in the light of the fact that, unlike general practitioners and specialists, dentists are free to set up clinics in Denmark. The counties do not control the provision of dental services, and dental treatment is not free of charge for patients. The treatment is only partly subsidised; approx. 70% of adult dental expenses are paid by the patients themselves, with the possibility of a partly reimbursement from private health insurance.

Physiotherapists

There are approx. 1,400 physiotherapists in Denmark. The Health Care Reimbursement Scheme partly pays for treatment by physiotherapists, but people who have serious physical disabilities due to illness may receive free physiotherapy. The treatment is only subsidised if it has been prescribed by a general practitioner.

Chiropractors

The Health Insurance Scheme partly pays for treatment by chiropractors. It is not necessary to be referred by a general practitioner in order to receive a subsidy. There are approx. 250 chiropractors in Denmark.

Number of service providers in the primary health care sector								
	General Practitioners		Specialists		Dentists		Dentists employed by	
	Per 1,000		Per 1,000		Per 1,000		local authorities Per 1,000	
1980	2,876	0,56	683	0,13	2,321	0,45	-	-
1985	3,220	0,63	803	0,16	3,776	0,74	1,271	0,25
1989	3,350	0,65	834	0,16	3,843	0,75	1,180	0,23
1994	3,729*	0,72	886*	0,17	3,760	0,72	1,106	0,21

Source: Statistical Year Book, various years. The figures marked with * are from National Survey of Doctors 1994, National Board of Health.

5.1.2. Hospital service

As medical science and the specialisation associated with it have developed, the work of the hospitals has changed more and more towards intensive examination, treatment and care of patients. At the same time, patients are only hospitalised for short periods or treated in out-door clinics, and fewer patients are kept in hospitals when their need for care is of a social nature. The result of this development is reflected in a continuous fall in the average length of stay and number of bed days, and an increase in the number of patients treated in out-door wards. In the period from 1980 to 1994 the number of somatic hospitals has fallen from 117 to 83, and the number of psychiatric hospitals from 16 to 13. The fall in the average length of stay in hospital has resulted in a large reduction in the number of beds in the somatic hospitals. Thus, in the period from 1980 to 1994 the number of beds fell from 32,269 to 23,905. Similarly, in the psychiatric field there has been a development towards less and shorter hospitalisation and more out-door activity. This development has been made possible by the introduction of district psychiatric help close to the patient's home, and has resulted in a fall in the number of beds in psychiatric hospitals from 9,352 to 4,259 in the period 1980 to 1994.

Capacity and activity in somatic hospitals, 1980-1994				
	1980	1985	1989	1994
No. of hospitals	117	102	94	83
Fixed no. of beds	32,269	28,332	26,235	23,905
(of these psychiatric beds)	1,302	1,290	1,230	2,035
Discharges	916,000	996,005	1,065,445	1,111,983
Bed days	9,045,600	8,398,429	7,660,916	7,391,291
Out-patient visits	3,295,336	3,533,974	3,680,336	4,534,884
Average length of stay	9.9	8.1	6.9	6.6
Source: Hospital activities 1994.				

Capacity and activity in psychiatric hospitals				
	1980	1985	1989	1994
No. of hospitals	16	17	17	13
Fixed no. of beds 1	9,352	7,644	5,202	4,259
Discharges	23,000	22,491	18,208	13,325
Bed days	2,911,000	2,476,000	1,242,200	746,699
Out-patients visits	89,000	85,000	96,341	134,256
Source: Hospital Activities 1994				

The hospital service in Denmark is the responsibility of the counties and Copenhagen Hospital Co-operation. The counties and Copenhagen Hospital Co-operation must provide free hospital treatment for the residents of the individual county and emergency treatment for persons in need who are temporarily resident.

In the vast majority of cases the counties' obligation to provide its citizens with hospital treatment will be fulfilled by the county's own hospitals, and to a certain extent in hospitals in other counties. Furthermore, private hospitals are used to a certain degree, especially specialised hospitals that have an agreement with one or several counties.

Since January 1993, the citizens who are in need of hospital treatment have had the possibility, within certain limits, to choose freely which hospital they wish to be treated in. The citizens may choose among all public hospitals that offer basic treatment, together with a number of small specialist hospitals owned by private associations that have agreements with the public a choice between the hospitals which offer treatment on a highly specialised level.

The counties and the Copenhagen Hospital Co-operation are obliged to make agreements regarding the use of highly specialised departments, with a view to ensuring the inhabitants equal access to necessary specialised treatment. This reflects the fact that the individual counties cannot be expected to cover all hospital treatment in their own hospitals.

Furthermore, the counties may, after the authorisation of the National Board of Health, refer patients to highly specialised treatment abroad.

As well as the publicly owned hospitals and the private hospitals owned by associations, which have made agreements with the counties, there are a limited number of private paying hospitals completely outside the public health service. At present this sector is very modest (0.2% of the total number of beds).

The hospitals are responsible for specialised examinations, treatment and care of somatic and mental illnesses which it would not be more expedient to treat in the primary or social sector because of the requirements for specialist knowledge, equipment or intensive care and surveillance. The principal framework for how the counties provide hospital services is established in a plan setting out the counties' activities in the health area. Recently, special preventive health care units have been integrated in hospitals.

Apart from treating illnesses, the Hospital service gives diagnostic support to the "practice sector" in the form of laboratory analyses and image diagnoses etc.

Furthermore, another important element is the hospitals' state of readiness, in that the hospitals are generally manned all round the clock in order to deal with acute illnesses or accidents.

The hospital service plays an important role regarding the training of staff for the whole of the health care service and in the field of research; and it is normal in the hospital service that research results are put into clinical practice.

5.2 Administrative levels

The health care sector has 3 political and administrative levels: the State, the counties and the municipalities (national, regional and local levels). Responsibility for services provided by the health service lies with the lowest possible administrative level. Services can thus be provided as close to the users as possible.

5.2.1. The municipalities

The 273 Danish municipalities, together with the municipalities of the capital, Copenhagen city and Frederiksberg, are local administrative bodies. The municipalities have a number of tasks, of which health represents only a small part. The municipalities are responsible for home nursing, public health care, and school-health care and child dental treatment. The municipalities are also responsible for a majority of the social services, some of which (old people's homes, old people's housing) have to do with the health care service and are of great importance for the functioning of the health care service.

5.2.2. The Counties

The 14 Danish counties are also responsible for the primary health sector, practitioners, practising specialists etc.; however, this responsibility lies with the local authorities in the capital. The counties have wide-ranging powers to organise the health service for their citizens, according to regional wishes and possibilities, without the intervention of the government. Thus the individual counties can adjust services according to need at the different levels, enabling them to ensure the correct number of staff in practice and in hospitals, and the procurement of the appropriate equipment, both for practice and hospital.

Thus, the responsibility of hospitals lies with the 14 counties. However, a special administrative body runs hospitals in the capital: The Copenhagen Hospital Co-operation.

5.2.3. The State

The State initiate, co-ordinate and advice the municipalities and the counties regarding health care provision. One of the main tasks is to establish the goals for a national health policy, including prevention policy, priorities in health care, and monitoring the efforts. Since 1985, a Ministry of Health is the administrative political body of health care. The Ministry also runs a statistical department, which provides data for health service planning at state, community and municipal level. The central health registers, the national patient discharge register, the register of causes of death, the national birth register and the cancer register are a-journed by the National Board of Health, which as administrative chair has a medical doctor. The Ministry of Health has access to data in all the registers, but not at the level of the personnel number.

The Ministry of Health, in its capacity of principal health authority, is responsible for legislation of health care. This includes legislation on health provisions, personnel, hospitals and pharmacies, pharmaceuticals, foodstuffs, vaccination, pregnancy health care, child health care and patients' rights. The legislation delimits the duties of the counties and the local authorities regarding health care to the population, and guidelines for the running of the health care service are passed for plan periods, normally of 4 years. Thus, the counties and the local authorities must (every fourth year) formulate a health care plan that co-ordinates the efforts of the different administrative levels involved in health care to improve productivity and efficiency.

5.3 The financing of health care services

In Denmark the vast majority of health services are free of charge for the users. Of the total expenditure on health care in Denmark public expenditure constitutes 83% and private expenditure approx. 17%. Private health care expenditure mainly covers user payments for pharmaceuticals, dentistry and physiotherapy. The total public and private health care expenditure corresponds to roughly 6% of the gross national product (GNP).

The total public expenditure on health care measured in fixed prices has increased by 13% from 1980 to 1995. The expenditure in the primary sector has risen by 33%; hospital expenditure has risen by 7% and the citizens' own health services expenses have risen by 42% in the period 1980-1995. The large increase in primary sector expenditure is mainly due to the significant increase in expenditure on pharmaceuticals between 1980 and 1995. In spite of growth in real health care expenditure, the proportion of GNP spent on health care decreased by 0.5% between 1980 and 1995.

In most health care services throughout the world there is a "third party payer" which deals with the actual payment of the health services. This is partly based on a wish to safeguard against unforeseen health expenditure, partly to ensure that even people who cannot pay have access at least to urgent treatment. The "third party payer" can be an insurance company, a public authority or a similar financial source.

In Denmark, as far as the publicly paid part of the health services is concerned (83%), "third party payers" are the counties or municipalities. The counties and the local authorities finance the health care services partly through taxes, which they levy themselves, partly through block grants from the Government. The block grants are allocated to the counties and the local authorities according to objective criteria, which among other things include demography, and health statistics provided from the different national registers.

Most private expenditure on health care is paid directly to the service providers, for example dental care and pharmaceuticals products. However, about 27% of the population are covered by private health insurance, which reimburses part of patient's own expenditures. Among other things private health insurance reimburses most of the expenses to pharmaceuticals and dentistry.

Most providers of health care services in Denmark are salaried employees in public institutions. The counties set hospitals' budgets, and hospitals are expected to organise and conduct their affairs within the limits of these budgets. All employees within the health care sector, including doctors, are salaried according to collective agreements between the County Councils Association and the respective unions.

Under the Health Care Reimbursement Scheme self-employed professionals such as general practitioners, specialists, dentists, physiotherapists, etc provide services. These services are provided in accordance with collective agreements between the counties and the relevant unions. Collective agreements include prices of individual services, which are covered by the Health Care Reimbursement Scheme. They also include the extent to which the service is covered by the Health Care Reimbursement Scheme, either in full or in part. If there is only part cover, the balance is paid by the patient. The provider of a service is not permitted to demand extra payment in addition to that stipulated by the collective agreement.

General practitioners are paid both a fixed fees for each person attached to the practice, and by fees for the individual services. Specialists, dentists, and others who provide services under the Health Care Reimbursement Scheme are paid fees for each individual service.

Pharmacies operate on the basis of public authorisations that are allocated by the Minister for Health. The total number of these authorisations is limited, and they are therefore allocated so that they give balanced geographical coverage throughout the country. For prescribed pharmaceuticals, the pharmacies only charge the patients the amount in excess of the public subsidy. Pharmacists charge the same price for pharmaceuticals throughout the country. The Ministry of Health regulates the calculating consumer prices of pharmaceuticals. The pharmacists' collective profit is set for two years at a time in negotiations between the Ministry of Health and the Danish Pharmaceutical Association.

Municipal health services, such as school health care, are governed by framework budgets, in the same way as hospitals. Employees are also salaried according to collective agreements between the National Association of Local Authorities and the respective unions.

5.4 Management mechanisms in the health care service

In the Danish health care service, one authority combines political responsibility for tax levels (financing) and for the level of service provided. This gives the authorities the opportunity for financial management. However, central government sets a framework for national economic policy. Every year, the economic framework is agreed for the following year between the state, the counties and local authorities. Agreements are typically in the form of recommendations for local and regional tax rates. This, of course, limits the responsible authorities' room for freely planning the development of the health care services.

Hospitals and local authority health schemes are, as mentioned above, managed through framework budgets. In principle, capacity is determined by what the financing authorities choose to supply. To change supply, therefore requires a political decision especially if an increase in the overall economic framework is necessary.

For example, within the area of the Health Care Reimbursement Scheme, expenditure is controlled via payment agreements, and through the distribution of permits to operate a clinic under the Health Care Reimbursement Scheme.

In Denmark, as in other countries, expenditure on pharmaceutical subsidies has increased significantly in recent years. A number of different measures have been implemented to limit the increase. Generic substitution has been introduced to promote sales of cheap pharmaceuticals. Subsidy schemes have been converted into a so-called 'reference price system', which involves calculations of the Health Care Reimbursement Scheme subsidies being based on prices for the cheapest in a group of equivalent pharmaceuticals. These measures have promoted price competition and helped to limit the growth of public expenditure on pharmaceuticals.

In 1994, the Minister for Health and the pharmaceutical industry agreed to place an annual ceiling on the price of pharmaceuticals. This agreement was replaced in spring 1995 by a two-year agreement that prices of all pharmaceuticals subject to a subsidy would be reduced by 5%. The price of other pharmaceuticals should be reduced by 2% according to the agreement. Prices should not be increased during the period of the agreement. From 1 January 1996, public subsidy of antibiotics was reduced from 75% to 50%. It is anticipated that this will lead to a certain shift in consumption from the relatively expensive resistance-inducing, wide-spectrum antibiotics, to relatively cheaper, narrow-spectrum antibiotics. Changes in subsidies will also help to curb growth in public sector expenditure on pharmaceuticals.

Several counties have tried to supplement budgets with other management systems. Some counties have entered into contracts with individual hospitals concerning the services to be supplied within a given financial framework. One of the objectives with contract management is to increase competition between individual suppliers (hospital wards).

Health care sector expenditure, specific years, fixed 1990-prices; DKK millions					
	Primary Health care services	Hospitals	Total Public Health Expenditure	Citizens' Own Expenditure	Total Health Care Expenditure
1980	7,842	32,496	40,931	7,155	48,086
1985	8,979	31,850	41,449	7,608	49,057
1990	10,161	31,572	42,434	9,155	51,589
1995	10,416	34,809	46,111	10,171	56,282

Source: Ten-year Statistical Review 1996

5.4.1. Home nursing

Home nursing is provided free of charge by the local authorities when prescribed by a general practitioner. All those who live in the local authority have a right to home nursing. It is the job of the local authority to establish a depot with the necessary appliances and aids which must be provided free of charge to home nursing patients. Home nursing policy is to offer patients who have a temporary or chronic illness, or who are close to dying, the possibility of remaining in their own home.

5.4.2. Other services

Other forms of treatment and subsidies are also subsidised by the Health Care Reimbursement Scheme for example treatment by a chiropodist of diabetics, rehabilitation of those disabled from paralysis, and to some extent help from a psychologist.

Children under the age of 16 needing glasses will receive a subsidy. It is not necessary to be referred by a general practitioner.

If a person dies who had the right to Health Care Reimbursement services prior to decease, then the local authority will pay part of the cost of the funeral. People aged 18 or above receive funeral help according to their financial circumstances.

5.4.3. Pharmaceuticals

In Denmark all pharmaceuticals is sold by pharmacies that are authorised by the State. It is the Ministry of Health who decides the number of pharmacies and where they may be situated. There are approx. 300 pharmacies in Denmark.

The Health Care Reimbursement Scheme subsidises certain pharmaceuticals, which are prescribed by doctors or by dentists. The subsidy represents 50 to 75% of the price of the pharmaceuticals. However, certain insulin products, which are prescribed by a doctor, will be paid for in their entirety by the Health Care Reimbursement Scheme.

Some pharmaceuticals that can be bought without a prescription will only be subsidised if they are for pensioners, people who receive a pension due to disability, people who have retired early, or those suffering from long-term illnesses.

6. Health professions

In Denmark anyone can, in principle, offer treatment to people who are ill. However, there are a number of treatments and health services that are reserved for those who have obtained the authorisation by the health authorities to practice a particular profession via the skills they have obtained by formalised training. Within the authorisation system the titles of doctor, physiotherapist etc. are reserved for those who are authorised.

For example, a person who is not an authorised doctor can be punished if he treats people who are ill and thereby exposes them to discernible danger. A person who is not a doctor must not perform surgery, anaesthetise, or treat infectious diseases. Nor may he use pharmaceuticals that must be prescribed.

Pre-graduate training is centrally controlled by the Ministry of Education, together with a number of councils. Among these are the Health Training Council in co-operation with the Ministry of Health, the National Board of Health and others. The training takes place at three universities, a number of nursing colleges, specialised schools etc.

Post-graduate training in the health sector e.g. for specialists, nurses with diplomas and masters of public health is the responsibility of the Ministry of Health, but criteria are set by the National Board of Health. Regarding the specialisation of medical doctors, the education is part of the conditions of appointment and in part paid by the county authorities.

Total no. of staff in hospitals	82,284
Doctors	9,193
Nurses	25,883
Other trained nursing staff	13,967
Others	33,241
Local Authority Nurses and Health Visitors ²	10,671
Total no. of staff under Health Insurance Scheme* ³	8,375
General Practitioners	3,729
Specialists	886
Dentists	3,760
Total no. of staff in Preventive Health Schemes ²	4,600
Child Dentistry	1,430
Other Schemes	3,170
Total no. of Health Staff	105,930

6.1 Women in the health professions

By tradition nurses are women and doctors are men. This picture is nowadays changing, mostly regarding the medical profession.

6.1.1. Medical profession

The first female medical doctor graduated in 1885, For decades the percentage of female doctors remained very low, and among new medical doctors in 1965 only 10% was women. By 1991 more than half of the new doctors were women, and in 1997 the percentage had increased to 64%.

However, the share of female administrative physicians, e.g. head of clinics and departments, still is low, in 1995 only 15%, and among medical professors only 5% are women. Among the specialities the share of women differs very much, and is lowest in neuro-surgery, ortopedic-surgery and internal medicine, but also low in gynaecology and obstetrics. Recently, an important increase in the number of female specialists in gynaecology is expected to change the gender profile in reproductive health care.

6.2 Nurses and paramedics

The majority of nurses is female. Among the few male nurses many occupy leading positions. Most physiotherapists are women, and among midwives still there is no men.

6.3 Alternative care

In Denmark, like in most countries a huge number of alternative therapy are offered to the population. Most of these "treatment" is not supported by the State, or by local authorities. Only, acupuncture and limited types of zonal therapy may receive financial support. Some remedies are approved by health authorities, most are not. The Internet contains information about a number of alternative care. Recently, it was planned to set up an institute to follow the use and the consequences of alternative therapy, including validation of the effects of various types of alternative "treatment". The National Board of Health published in 1997 a survey on alternative therapy.

The national health survey of 1994 included information about use of alternative therapy, e.g. healing, acupuncture, zonal therapy, so called natural medicine and manipulations. Women used this remedies more than men, and the highest use was among 25-44 year old women, 21% during the last year. Among all women 17% informed about such use.

7. Preventive health care and health promotion

By May 1999, the Health Ministry published the State's new public health programme for 1999-2008. The two major targets are

- to improve life expectancy by adding years with better health to the life of the population,
- and to reduce social inequality in health.

Over the last 10-15 years preventive health and health promotion have been given higher priority in Denmark. This is due to recognition of the fact that diseases like cancer and cardiovascular diseases that, in part, are characterised by modifiable risk factors today dominate health problems. Only a limited part of total preventive health care and health promotion lies within the health sector and thus with the central health authorities. But, recently, prevention has also become an integrated part of health care in hospitals.

Developments in the environment, the working environment, the housing sector, traffic safety and product safety (and more indirectly in the educational and social sector) are of great importance for the general health status of the population. This is recognised in the new public health programme, which therefor involves all Ministries.

The programme has no special focus upon women's health problems. This must be seen as a consequence to the fact that the unfavourable trend in life expectancy of women in Denmark in large part is caused by the same risk factors as for men. However, secondary prevention by for example special screening programmes is directed towards female reproductive health, cervix cancer and breast cancer. These programmes will be separately described.

It is primarily on a local level, in counties and local authorities, in institutions and at work places that primary preventive work takes place. Preventive measures on a local level are to a certain extent financed centrally, e.g. through support of local projects and experiments. The central health authorities' preventive health measures are not limited to visible information campaigns, which are realised in different subject areas; other important tools are legislation, organizational changes and overall formulation of policy.

The point of departure for the prevention of the important social diseases such as different cancer diseases (lung-, gastrointestinal-, skin- and liver cancer), cardiovascular diseases, allergies and muscle-skeletal diseases is to modify (reduce) the identified risk factors, primary lifestyle factors. A large consumption of tobacco and alcohol, very little or no exercise and a deficient diet are the most important lifestyle factors behind the development of these illnesses.

7.1 Healthy cities network

Denmark's Healthy Cities Network currently includes 6 of Denmark's 14 counties and 8 of its 275 municipalities. The Municipality of Horsens and the City of Copenhagen, which became members of the WHO European Healthy Cities network in 1987-1988, initiated Denmark's network in 1991. The Healthy Cities have established information centers open for the public, and have run a large number of local health promoting campaigns. Focus has been on prevention of accidents and better health in workplaces. This includes prevention of health problems that are met by women. The health city initiative is a State and municipality effort, while health shops or health centers in many other countries are initiated and run by private groups, and local women health networks.

The network has an important national role in developing and testing ideas related to health promotion and disease prevention. The network has succeeded in developing fruitful co-operation with local authorities and NGOS, and through national multidisciplinary plans to promote safety by preventing accidents and to promote health in workplace.

Increasing attention is being focused on whether the effects of health promotion and disease prevention activities can be measured by traditional scientific evidence, such as controlled trials. Nevertheless, to prove that specific activities are responsible for general effects on the health status of a population is difficult. Plans are therefore being developed for evaluating the effects of narrowly defined disease prevention activities. Preventing falls among elderly people has been selected as a theme for a pilot project modelled on multicenter trials and action plans that co-ordinates the efforts of several municipalities in preventing health problems based on the same protocol.

7.2 Tobacco smoking

In May 1995 Parliament passed a law on no-smoking areas. The aim of this law is to ensure that no one is forced against his will to be a passive smoker. The law covers public transport, institutions, hospitals, work places and rooms to which the public has access, in state, county and local authority buildings. At present, it is considered to forbid smoking in public schools, and other institutions with children and adolescents.

Information campaigns regarding the health risks of passive as well as active smoking are organised by the State through the independent, authoritative Danish Council on Smoking and Health. In recent years the Council has had its budget increased, so that it can continue its information campaign directed towards children, young people and pregnant mothers, where the focus has been especially on passive smoking (including the risk of developing asthma and allergies) and the importance of not starting smoking. In addition, the Council can also give priority to campaigns to persuade people to give up smoking. The number of smokers is decreasing in Denmark, especially amongst young people, but there is still a high prevalence of smoking among Danish women compared to other countries. The smoking prevalence now is higher among female than male teen-agers. Therefore, the recent campaigns focus on women.

On the basis of EU directives, regulations have been introduced in Denmark regarding the labelling of tobacco products with a warning as well as the establishment of a maximum level for the amount of tar in cigarettes of 15 mg per cigarette. Beyond this the Ministry of Health has entered into a voluntary agreement with the tobacco industry which limits the advertising of tobacco products in the printed media. Law forbids all advertisements for tobacco products on radio and television.

As is also the case with alcohol, the customs duty on tobacco products is very high in Denmark. One of the reasons for this is that a high price for such stimulants is considered to have a limiting effect on consumption, especially the consumption of tobacco and alcohol by young people.

7.3 Alcohol

In Denmark the main effort to combat alcohol abuse takes place via the counties and the local authorities. It is a task of the health service to monitor developments with regard to alcohol in order to gain a scientific basis for prioritising present and future activities. The health service is also the central authority responsible for prevention of alcohol abuse, and for developing

information and teaching material and preventive campaigns. Many private organizations work on a voluntary basis to combat alcohol abuse, often in close co-operation with public authorities.

The average consumption of alcohol per inhabitant over a 14-year period doubled in the years from 1960 to 1973. Since then annual consumption has remained constant at approx. 12 litres of pure alcohol per person above the age of 14. The 1999-2008 Public Health Programme aims at reducing the number of persons with alcohol consumption over the weekly recommended 14 units for women, and 21 units for men. Furthermore, alcohol use among children and adolescents shall be minimised. It is esteemed that 10% of all women drink more than the recommended amount, and that alcohol abuse is an increasing health problem among women.

7.4 Drug abuse

In 1994, the Government presented a policy report to the Danish Parliament. The Parliament subsequently passed legislation which places full responsibility for treating drug addicts on the counties both medical treatment with methadone, which was previously carried out by general practitioners, and social treatment such as nursing, care, support, rehabilitation, and reintegration. The objective is to ensure coherent treatment, adapted to the needs of the individual addict. The National Board of Health is centrally responsible for the prevention of drug abuse, development of information and education material, and prevention campaigns. The most important effort, however, takes place at local level, and is aimed at vulnerable young people who experiment with hashish, heroin and other drugs. The National Board of Health therefore very much supports local prevention initiatives, and has set up training programmes for local key figures on the prevention of alcohol and drug abuse.

It is estimated that in Denmark there are about 10,000 drug addicts with a long record of abuse. The definition of drug addict is not strict. Most often, drug addiction comprises illegal drugs, e.g. heroin and cocaine. However, among women drug addiction often involves prescribed drugs, like tranquilizers and analgetics. The share of women among hard drug addicts is estimated to be low, contrary drug abuse or drug dependency is relatively frequent among middle-aged women in Denmark. In the recent years, health authorities and medical organizations have campaigned to reduce prescription of diazepam and other medicaments to women. This has resulted in a reduction in the use of diazepam.

8. Reproductive preventive health care and promotion

A number of preventive health schemes are available to all women resident in Denmark free of charge. The aim of these schemes are to ensure women's reproductive rights, inclusive the right to competent guidance on contraception, the right to abortion within the first 12 weeks of gestation, and right to free prenatal care and maternal leave with wedge compensation. Furthermore, the scheme includes postnatal controls, and preventive programmes to ensure the health of infants and children. This includes regulated visits to general practitioner and medical examination at the start and end of public school.

8.1 Guidance of methods of contraception

Public school curriculum includes education in reproduction, contraception, sexual transmitted diseases and to some extent child care practices. The counties must ensure that anyone who is interested can receive free guidance on the use of contraceptives from general practitioners. Guidance can be offered to people below the age of 18 without parental consent. A number of counties have established open clinics that offer guidance about contraception. Some of these clinics are run in co-operation with the Danish Federation for Planned Parenthood.

In the 1920s a group of female medical doctors established an organization, which aim was to improve the knowledge about contraception among women. Politically, they became involved in the promotion of right to induced abortion. They were co-operating with other activists and created the organization "Mødrehjælpen" [Mothers' Aid) that still exists. This establishment had from the start in the 1930s supported young and single women, advocated for the right to abortion, and offered shelter for socially disabled women. The female medical doctor fraction created The Organization for Family Planning. Today, this organization still is active and a member of the International Planned Parenthood Federation, and work in close connection with WHO.

8.2 Induced abortion

Any woman resident in Denmark has the right to have an unwanted pregnancy terminated within the first 12 weeks of gestations. On medical indication abortion may be permitted up to 24 weeks of gestation. A special board, which members are a psychiatrist, a gynaecologist and a judicial person, decides upon these late abortions.

The present Abortion legislation was passed in 1973, and has since remained unchanged. Abortions can only be induced in hospitals, and by physicians. Counselling about possible social and economical support must be given to the woman before she finally decides upon abortion. The abortion is free of charge, and the woman will receive special guidance on contraception after the abortion.

The annual number of induced abortions peaked in 1975, where the abortion rate was 23.7 per 1000 women aged 15-49 years. In 1996 the rate had declined to 13.8. The abortion rate among teen-agers has also decreased very much, from 22 in 1976 to 10 in 1996 among 15-17 year-olds.

8.3 Infertility and treatment by IVF

Infertility is treated by the public health care system and by private clinics. Legislation of IVF and other treatments of infertility was amended in 1996, and gives now right to infertile couples to receive three free IVF-treatments in public hospitals on well defined indications. It is forbidden to use both donor eggs and donor semen. The maximum period for keeping fertilised eggs, the use of donor eggs and donor semen are regulated by law. In principle lesbians are not offered IVF treatment, but the question is under debate. The public policy is not to treat women over 40 years of age, but the regulation do not forbid it.

Contrary to the Abortion Legislation that regulates induced abortion only to be performed in hospitals, IVF can be done in private clinics. The age distribution of women treated in public hospitals and private clinics differ. More elder women are found among the clients in private clinics, and these clinics have no limit in the number of treatments offered.

Legislation demands that all treatments, both public and private, be reported to the National Board of Health that runs an IVF Register. According to this register, in 1994 and 1995 9.471 treatment were given resulting in 2.245 born children. The success rate was 20% for "normal" IVF and 16% for IVF by intracytoplasmatic sperm injection. The success rate was highest among women below 30 years of age.

8.4 Pregnancy and maternity

Women have right to a number of preventive examinations and treatment during pregnancy and in connection to childbirth. In 1999 a new regulation of preventive health care in pregnancy and maternity was passed. It recommended further focus upon identified risk pregnancy, and less medication of normal pregnancies. Among risk are social disadvantaged women. The current policy in normal pregnancies is to offer guidance and control by the family practitioner, in addition a number of visits to midwife, and limit the number of hospital controls. The current policy is to offer 3 examinations by family doctor, minimum 7 by midwife and one at the planned place of birth. Furthermore, the pregnant will see the visiting nurse who shall control the baby after birth by regularly visits in the home. The father is invited to join the examinations. In 1995, 4.9% of the pregnant received 1-6 examinations, 15.3% more than 13 examinations and the rest, 79.8% between 7 and 12 examinations.

Many pregnant women are scanned with ultrasound during their pregnancy. Ultrasonic examination is only done on indication, not as routine. However, a large part of pregnancy will be controlled either due to uncertainty of week of gestation or suspicion of abnormalities. In 1995, ultrasonic examination was performed in 87% of all pregnancies.

If there is any suspicion of the foetus having contracted certain specific illnesses or having any serious defects, then the pregnant woman have the right to an amniocentesis. Women over 35 years of age are also offered cytogenetic tests by chorion villus biopsy or amnion liquor examination. In 1995, a total of 9,2% of all pregnancies was examined. Triple test for cromozomal abnormalities are widely used, likewise alpha-foetoprotein examination for neural defects, in 1995 7.7% of all pregnancies.

The counties are responsible for the free health check-ups by doctors and midwives before and immediately after pregnancy. In connection with the medical examination the doctor or the midwife should give advice to the woman regarding her lifestyle, including her work, diet, use of stimulants etc. and help the pregnant woman to prepare for the birth as well as advise her

regarding the care of a new-born baby. Currently, an epidemiological survey is conducted in Denmark that aims to examine risk factors of birth defects and infant morbidity. It will include 100.000 women and their babies.

8.5 Pregnancy and mother shelters

Each county has established shelters for vulnerable mothers, e.g. single young women, drug addicts and victims of domestic violence. Some of these shelters are run by NGOs with State economical support.

8.6 Private organizations "Børn og Forældre" [Children and Parents]

Activists in the female movement established in the 1970s an organization to improve the situation of pregnant women and young mothers. Due to a relatively high perinatal mortality in Denmark, the trend among obstetrics and health authorities were to concentrate births in specialised units, and to control most pregnancy and birth by medical technology, like CTG, amniocenteses etc. The organization "Børn og Forældre", went into dialogue with the responsible authorities to change this trend. Co-operation was established with the female medical research group and groups of midwives. It may well be believed that the different activities of the organization had great impact on the development in Denmark. Currently, the policy is the least possible interference in normal pregnancies and births.

8.7 Births

Women can choose whether they wish to give birth at home or at a hospital. In the last decades, in many hospitals special delivery clinics have been set up. Midwives exclusively run them, and only if complications occur will a physician be involved in the birth.

In 1995, about 95% of all deliveries took place in hospitals, 82% in specialised obstetric departments. Only 2.2% of all births was planned home births, further 1% occurred not planned in the home or under transportation. Women giving birth at home have free access to midwife, and if necessary medical assistance.

Normally first time mothers may stay in the hospital for 4-5 days, but most only 1-2 days. However, an increasing number of births take place in out-door clinics, and the mother will leave the clinic within 24 hours.

8.8 Maternity

Any woman is granted a maternity leave of 24 weeks. Most trade unions include the right to maternity leave with full wedge compensation in the collective contracts. Unemployed women are paid by the State up to 90% of minimum salary. The father has the right to take 2 weeks leave by the birth, and further 4 weeks during the maternity period.

All infants are seen at home shortly after birth by specially trained nurses. Infants at risk are controlled as required. The home visiting nurse arrange mother groups that are used by the majority of young mothers.

8.9 Preventive health care of children

All children under school age are entitled to 7 free preventive health examinations by a general practitioner. The aim of the examination is to give the child the best conditions for developing healthily, physically, psychologically and socially. The counties cover the costs.

Through the health visitors the local authorities, as part of their health care programme, are responsible for giving free advice, assistance and health examinations to check functional deficiencies of school children until the end of their compulsory education.

The local authority also covers a health examination by a doctor employed by the local authority of all children in the first year of school, and an examination of all children before leaving school. Furthermore, there are examinations by a doctor throughout the school years of children who are considered to need such examinations.

All young people below the age of 18 who are Danish nationals or who are resident in Denmark can be vaccinated against whooping cough, diphtheria, tetanus, polio, measles, German measles and mumps. Furthermore, all females over the age of 12 who are Danish nationals or are resident in Denmark may be vaccinated free of charge against German measles. The vaccinations are carried out by the general practitioners, and the counties cover the cost.

9. Screening - secondary preventive health care

Primary prevention means to eliminate factors which provoke disease, or to prevent accident and violence. Screening programs are aimed at finding disease as early as possible. WHO has set up principles to be fulfilled for initiation of any screening programme. However, these principles are not always followed in the programme offered to women.

Screening for cervix cancer began already more than 60 years ago. It is estimated that the screening accounts for a large part of the positive trend in mortality from cervix cancer. For decades it has been debated in Denmark whether or not to offer screening for breast cancer to all women, certain age groups or women at risk of breast cancer. It is still under debate

In a number of countries it is "good policy" to promote screening programs to women for various diseases. In the American "Guide to clinical preventive services" from 1996 a total of 53 different diseases are listed, which today are the objectives for screening. If the guidelines are followed, a woman will have 278 contacts to the health system between the age of 20 and 70 years.

The health authorities in Denmark hesitate to open for screening programmes when the cost benefit still is dubious. In female NGOs the opinion about the benefits of regular mammography differs, and also among politicians.

9.1 Screening for cervix cancer

Most counties offer 23-59 year old women examination for cervix cancer by smears. The results from these examinations together with examinations from other controls are computerised in registers to minimise re-examinations within too short time period.

9.2 Breast cancer and mammography

As previous reported there is no nation wide screening programme. However, some counties offer free screening programmes, others try to regulate the use of mammography that is to secure examination to certain age groups and risk populations. Mammography can be obtained by any woman in a number of private clinics. Female groups value in general self-examination of breasts more than mammography. This is also the case for Female Medical Research Network.

9.3 Ovarian cancer

There is no screening program.

9.4 Osteoporose

An unknown number of women is screened in private clinics for osteoporose. No public preventive programme has been set up or is being planned. The 1999-2008 public health programme focus the value of physical activity, similar a number of studies have shown that physical activity may prevent bone lose and thus effectively prevent osteoporose.

10. Violence against women

Globally, violence against women is the 6th major cause of disability and loss of healthy life among women. In Denmark, the prevalence of domestic and sexual violence is not known. A recent survey of the living conditions of the population included some questions on violence during the last year. About 0.5% of all 25-34 year old women had annually been victimised by domestic violence.

WHO has since 1996 focused upon the health sequels of violence against women, and recommended actions to take place in society and in the health care system.

10.1 Women network and shelters

In Denmark, shelters for victimised women have been established since the 1970s. Most counties have one or more crisis center that is open over 24 hours for women and children victimised by domestic violence. The centers are run partly by voluntary workers, however with support from professionals, social authorities and with financial support from the State. The centers can offer access to psychological guidance, and judicial help.

A network of crisis centers is established that works in close co-operation with the Danish National Board of Women. The co-ordinator of the network, LOKK, is also working in social services of a municipality. Contact adress: lokk@post5.tele.dk

Partly private centers for victims of sexual abuse are established in several counties.

10.2 Public health care to victimised women

Women victimised by rape or other sexualised violence may address the different shelters. However, these centers do not perform medical examinations or offer professional medical care. If a woman report an offence to the Police, she is examined by the staff at the Institute of Forensic Medicine to secure evidence for an eventual trial. Up to now, there has been no mandatory provisions of medical counselling, psychological aid or follow up to prevent health sequels of the violence. It is believed that a number of women suffer from physical and psychological complaints that could have been prevented by a primary care and counselling.

Female NGOs, primarily from the crisis center in Copenhagen and the National Council of Women have for years been active to strengthen the support to victimised women. Among the initiatives have been to put pressure on political parties to promote the establishing of open centers in the public health care system for victimised women. Such centers were opened in Norway in 1985, and in the early 1990s in the other Nordic countries.

Since 1998, the Parliament supports the establishing of health care centers for victims of violence, and recommends them to be situated in the public health care system. The State has granted financial support to a national center and urges the counties to establish free service for victims of violence within the hospitals. The services will be build on the Nordic model that is to offer free access to professional, skilled medical examination and documentation of the violence, and furthermore, free access to psychological, social and medical counselling and judicial support. If the woman report the case to police, the filing in of the case will be done in the center.

The national center will conduct research to clarify the extent of violence against women in Denmark, the magnitude of health consequences to violence and the effect of prevention. The center will be part of a Nordic Research network supported by the Nordic Council, NorVold. The network aims at strengthen the competence in the health care system in view of fulfilling the demands of victimised women and men.

11. Conclusions

The establishing of the above described health care function in the Danish public health care system is done in co-operation with politicians, the Ministry of Health, the National Board of Health, the Society of Gynaecologists and Obstetricians, and was initiated and supported by female activists groups. It is a fresh example of the impact and importance of female health network, and it also demonstrates the Danish welfare model that is to promote equity in access to health care.

This is best done in a public health care system. The long tradition for female political movements in Denmark facilitates influence upon the organization of female health care. By the establishing of a chair in female medical science at the Faculty of Medicine gender sensitised research in health problems has been promoted. Scientifically based knowledge of risk factors that may be prevented is crucial to promote the health of women, in general.