STATISTICS DENMARK

# Documentation of statistics for Health Insurance Statistics 2024

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STATISTICS DENMARK

# 1 Introduction

These statistics focus on the consumption of health care services within the primary public health care sector . The statistics are based on annual extracts from LUNA, which is the IT system used by the regions to settle accounts for health services with the individual providers (e.g., physicians, dentists, etc.). The statistics have been compiled since 1986 but are comparable from 2006 onwards.

# 2 Statistical presentation

The statistics cover visits to general practitioners and healthcare providers under the national health insurance. The statistics include the number of contacts, the associated fees, and the number of recipients.

## 2.1 Data description

The statistics compile the number of recipients, contacts, and expenses for treatments covered by the national health insurance over the course of a year. These are assessed with regard to gender, age, residence, origin, education, labour market attachmen, income level, relatives, and medical specialty/type of service.

## 2.2 Classification system

In connection with publications, the following classifications of Visits to physicians etc. are applied:

- Medical specialty/type of service, aggregate (code for type of physician, and breakdown of consultations with GP) with 21-grouping
- Medical specialty/type of service (more detailed breakdown by medical specialists etc.) with 47-grouping

The applied grouping of specialties/service types is based on the divisions in the fee schedules Furthermore, other classifications from other sets of statistics are applied:

- Labour market affiliation (Students, persons under 15 years and others; Employed; Unemployed; Long-term sick leave, vocational rehabilitation, etc.; Disability pensioner; Old-age pensioner)
- Income level (1st quartile; 2nd quartile; 3rd quartile; 4th quartile). Note: new version of The Income Register in the spring of 2015. In Visits to physicians etc. 2014, the statistics broken down by socio-economic grouping are recalculated for 2011-2013.
- Relatives (Lives with one parent; lives with two parents; has a partner and no other relatives; has a partner and other relatives; has no partner but has other relatives; has neither a partner nor other relatives)
- Ancestry (persons of Danish origin; immigrants; descendants)
- Educational level (Primary school; Upper secondary education; Vocational education and training; Short-cycle higher education; Medium-cycle higher education; Long-cycle higher education; PhD or equivalent; Unknown educational level)
- Geography (municipalities; provinces; regions)

STATISTICS DENMARK

## 2.3 Sector coverage

Primary health care sector in Denmark.

## 2.4 Statistical concepts and definitions

Contact with health care providers under the national health insurance: Includes consultations, telephone and email communications, and home visits. However, other services, such as laboratory tests, as well as additional services provided in connection with a consultation, are not counted as a contact. This can mean that even if a larger number of individual services are billed during a consultation, it will still be recorded as one contact

Person with contact to health care providers under the national health insurance: A person who has had at least one contact with a healthcare provider under the national health insurance.

Public health insurance expenses: Expenses for providers covered by the national health insurance.

## 2.5 Statistical unit

- Persons with contact/visits to physicians
- Contacts/visits to physicians
- Public expenditures in DKK 1,000

## 2.6 Statistical population

Contacts (visits to physicians etc. - including telephone and e-communication) in the primary public health service.

## 2.7 Reference area

Denmark.

## 2.8 Time coverage

The statistics cover the time period from 2006 and forward.

## 2.9 Base period

Not relevant for these statistics.

## 2.10 Unit of measure

- Number (contacts, persons)
- DKK 1,000 (expenditures)
- Contacts per person
- Share with contact

## 2.11 Reference period

The reference time is the financial year in which the service has been settled.

### 2.12 Frequency of dissemination

Yearly.

### 2.13 Legal acts and other agreements

There is no EU regulation concerning the statistics on visits to physicians etc.

### 2.14 Cost and burden

There is no response burden as the data are collected via the joint-municipal register for public health insurance.

### 2.15 Comment

Visits to Physicians.

## 3 Statistical processing

Data is received once a year from the Regions. It is assessed which services can be classified as contracts. Individuals with invalid CPR numbers are not included in the statistical tables. Corrections that cannot be associated with a registration in the respective year are deleted. Data is linked with background data from Statistics Denmark.

### 3.1 Source data

The primary source is LUNA, which is the IT system used by the regions to process reimbursements for health insurance services. Additionally, there are supplementary sources regarding services from the tariff folders.

Internal Statistics Denmark-sources:

- The register of population statistics (ancestry)
- The register of income statistics (level of income) for the previous year
- The Employment Classification Module (SOCIO13) as of December 31st of the previous year – Education (BUE): Highest completed level of education as of 30 September of the previous year.
- The Relatives Register (resident parents, relatives, partner)

### 3.2 Frequency of data collection

Yearly.

### 3.3 Data collection

Register.

STATISTICS DENMARK

### 3.4 Data validation

The data received are compared with data from the previous year, and any major fluctuations examined to reassure quality. For the purpose of statistical production data are analyzed thoroughly.

### 3.5 Data compilation

In general, services that are not specified as supplementary services in the tariff are categorized as contacts. However assessments are made to determine whether the services services without limitation, is contact in the agreement texts can only be provided once per contact and exclude other services of the same type—thereby requiring categorization as a contact. For specialty 49 (dental hygienist) and 50 (dental care), consultations and examinations, including preventive treatments, are categorized as contacts. The number of contacts is calculated as the sum of the variable "number of services" for those services that are categorized as contacts.Exceptions include the specialties of diagnostic radiology (05) and podiatry (54, 55, 59, and 60), where the service with the lowest service number (the last four digits of the special) per person per treatment date is counted as the contact. Thus, individuals can have only one contact with diagnostic radiology and podiatry (54, 55, 59, and 60) per day in our data. This method has been chosen as it is considered to provide the best estimate of the number of contacts. However, this also means that a service within these specialties can be categorized both as a contact and not as a contact. . Starting from 2006, gender and age imputation has been performed for the smaller group of children registered with child marking, and the person_id is set to unknown. Basic data (SSSY) is generated from the above data, and basic data is created, where the number of contacts (SSKO) and gross fees (SSHO) are aggregated at the person and service level. In these data, spec2 for contacts with general practitioners is further divided into the following categories: daytime consultation, evening consultation, daytime telephone consultation, evening telephone consultation, daytime visit, evening visit, e-communication (including with municipal care staff), other services, and prevention, etc. Additionally, an indicator for the basic fee is calculated. This is calculated as the sum of the calculated basic and practice cost fees distributed among group 1 insured persons who have received services from general practitioners (excluding persons marked as children). For SSSY, a variable spec80 has been introduced from 2023, which indicates the above division. However, "Other services and prevention, etc." does not appear in SSSY, but the algorithm can be obtained by contacting the statistical responsible party. Likewise, the basic fee is not specified in SSSY.

Before the data is uploaded to the Statbank Denmark, further data processing takes place. Individuals with invalid CPR numbers, individuals with child marking, and corrections (negative values for the service) that cannot be associated with a registration in the respective fiscal year are deleted. This means that corrections (negative entries) that do not match any registrations on the variables person_id, 'date of treatment' (date of service), 'specialty' (type of service), and "ydeltid" (time of service) are excluded. Registrations where the variable 'SIKGRUP' (Health Insurance Group) has the value 9 (Deceased) are deleted. All deleted observations are assigned a value of 0 for the variable statpop in SSSY. The first registered gender and the first registered age are used for individuals who appear in the data with multiple CPR numbers. Health insurance data is linked to other data on family relations, origin, education, labour market attachment, and income.

### 3.6 Adjustment

From 2005, the register was cleansed of observations for which there are no reimbursements via the public health insurance (the gross fee equals 0). This applies primarily to physiotherapy and dental treatment. Accordingly, data is assessed for 2005 both by the old method of assessment by which data is not cleansed, and the new assessment method by which data is cleansed. The chronic care honoraria (0130, 0131, 0132, 0133) are not deleted for specialty 80 (general practice). As of 1 January 2024, the structured care pathway for patients with multiple sclerosis was implemented under specialty 62. The new pathway services have the service codes 0211, 0212, 0213, 0214, and 0215. For patients enrolled in these pathways, all services are covered by the pathway honorarium, and therefore these services appear in the data with a gross honorarium equal to 0. These services are not deleted.

There is a very small number of records where the contacts are negative. In 2024, there are 147.290 negative records (equivalent to 0.14pct. of all records). This is due to billing-related corrections in the registry, meaning corrections that are not made by Danmarks Statistik. Starting from 2021, corrections that cannot be linked to a registration in the respective year will be deleted before the compilation of the statistics bank.

## 4 Relevance

The statistics are used by a wide range of users, including public institutions, researchers, private individuals, and journalists. These users utilize the statistics for various purposes, including public planning, research, and public debate.

### 4.1 User Needs

There are many users of the statistics: ministries, patient organizations, private companies, researchers, journalists, and private individuals. The statistics are used to provide insight into the use of the primary care sector and the health of the population. For example, journalists use figures from Statistics Denmark to write articles about who visits the doctor, researchers use microdata to identify users of the primary care sector, and politicians rely on data to inform health policy discussions.

However, there is also demand for data such as diagnoses made by general practitioners and the use of health services not covered by public health insurance – for example, services paid through private insurance. Unfortunately, this is data we currently do not have access to.

### 4.2 User Satisfaction

There is regular contact with users, either by email or by phone. Based on feedback, it is assessed that the users' needs are largely met. However, there is also demand for information on the reasons for the contacts and the expenses incurred by private households in connection with healthcare treatments.

### 4.3 Data completeness rate

Under preparation.

STATISTICS DENMARK

## 5 Accuracy and reliability

The data come from administrative registers with full coverage. Each year, Statistics Denmark manually categorizes the services in the public health insurance system as contacts. This affects the calculation of the number of contacts and the number of individuals with contacts.

### 5.1 Overall accuracy

Since the information originates from the statutory administration, the accuracy is considered to be high.

In assessing whether a service should be included under contacts, there is an element of lack of accuracy.

Physiotherapy is often provided as group training, allowing each physiotherapist to train multiple individuals at once. The training for each individual is recorded as a contact. The same applies when a psychologist conducts group therapy.

The register also includes information about services given to persons without a valid civil registration number – typically foreigners. For these persons, it is not possible to break down on sex and age.

### 5.2 Sampling error

Not relevant for these statistics.

### 5.3 Non-sampling error

There may be measurement errors when assessing whether new services qualify as contacts or not, and if services appear in the registry that are not listed in the fee schedules.

Up to and including 1995, 0-15 year-old children did not have their own national health insurance card, but were registered under the accompanying adult's civil registration number and given a special mark to indicate that the service was provided to a child. However, this has not been done in all instances. For this reason, the statistics include an unknown number of men and presumably even more women who should have been registered as children. Another issue that contributes to the underestimated number of children is the fact that an adult who has visited the physician with several children or with the same child on multiple occasions during the year, only appears as one person (one child). From 1996 onwards, all persons – except for unnamed new-born babies – have their own national health insurance card with their own civil registration number under which they should be registered. In spite of this, a minor group of children are still reported under the civil registration number of the accompanying adult. It implies a further risk of double counting of these children, as they may first have been registered under the civil registration number of an adult and subsequently under their own civil registration number.

## 5.4 Quality management

Statistics Denmark follows the recommendations on organisation and management of quality given in the Code of Practice for European Statistics (CoP) and the implementation guidelines given in the Quality Assurance Framework of the European Statistical System (QAF). A Working Group on Quality and a central quality assurance function have been established to continuously carry through control of products and processes.

## 5.5 Quality assurance

Statistics Denmark follows the principles in the Code of Practice for European Statistics (CoP) and uses the Quality Assurance Framework of the European Statistical System (QAF) for the implementation of the principles. This involves continuous decentralized and central control of products and processes based on documentation following international standards. The central quality assurance function reports to the Working Group on Quality. Reports include suggestions for improvement that are assessed, decided and subsequently implemented.

## 5.6 Quality assessment

Administrative data with full coverage are used. Changes in services included in the agreements from year to year, as well as the fact that Statistics Denmark manually classifies health insurance services as contacts each year, affect the precision—particularly of the number of contacts. The statistics are typically published shortly after, and at the latest half a year following the end of the reference year, making them timely. In general, user needs are met. However, there is demand for statistics on contacts with providers who not receive public subsidies, diagnoses made in the primary care sector, and private expenditures on health services—areas that cannot be covered due to a lack of data.

## 5.7 Data revision - policy

Statistics Denmark revises published figures in accordance with the Revision Policy for Statistics Denmark. The common procedures and principles of the Revision Policy are for some statistics supplemented by a specific revision practice.

## 5.8 Data revision practice

Only final figures are published. As an exception, In connection with the release of the 2024 figures and the new tables in May 2025, a review of services and the delineation of contacts from 2021 to 2024 has been carried out. This has, to a greater or lesser extent, affected the figures in the tables and the number of contacts in the registers.

In September 2022, the basic data (SSSY) was expanded with the variables registration time and treatment date, and the statistical tables for 2021 were reissued. This was due to minor changes in the statistical production: Individuals with invalid CPR numbers, individuals with child markings, and corrections (negative values for services) that cannot be associated with a registration in the respective fiscal year are deleted. The first registered gender and the first registered age are used for individuals appearing in the registry with multiple CPR numbers. Registrations where the variable 'SIKGRUP' (Health Insurance Group) has the value 9 (Deceased) are deleted.

STATISTICS DENMARK

## 6 Timeliness and punctuality

The statistics are published 5-6 months after the end of the year. The punctuality is high.

### 6.1 Timeliness and time lag - final results

Only final numbers are compiled. The statistics are published within 6 months after the end of the reference period. In some cases there have been delays which cause the statistics to be published later.

### 6.2 Punctuality

The statistics are usually published without delay in relation to the scheduled date.

## 7 Comparability

Sundhedsdatastyrelsen produces statistics on general practice, specialist practice, and other practices. Delimitations and definitions of contacts (or the use of services instead of contacts) can result in statistics that may not appear directly comparable. Typically, any - often minor - differences could be explained by methodology and delimitation. The overall picture is clear

### 7.1 Comparability - geographical

For comparable international data, we recommend that you look at data from Eurostat and the OECD, which make comparable data collections and publish data (e.g. OECD´s publication Health at a Glance) that is comparable to a certain extent in this field. There are a number of organisational and institutional conditions that we must keep in mind when analysing any differences.

### 7.2 Comparability over time

Since an increasing number of service providers have joined the system through the years, you should exercise caution when comparing over time.

In 2025, a review was carried out of the services and the definition of contacts for the period 2021 to 2024. This review has had varying degrees of impact on the number in the tables and the number of contacts recorded in the registers – but for some specialties, it resulted in a relatively significant change.

In 2022, the statistical production was changed, including a modification where corrections that cannot be associated with a registration in the respective fiscal year are deleted.

In 2021 is characterized by a new data supplier on Consultations of physicians and discontinued from some of the contact types cf. the revised types of benefits catalog from 2019. The biggest change is that types of benefits Diagn. radiologi Kbh. is deleted and added here Diagnost. Radiologi.

In 2021, groups of young people who can receive free psychological assistance if referred for anxiety or depression were expanded to include those aged 22-24.

In October 2019, a new agreement for psychologists in cancer care came into effect. This has meant the introduction of new services, while others have been discontinued. In addition, it was decided

(for state fund grants) to make the existing scheme for persons with anxiety aged between 29 and 38 years and persons with depression over 37 years permanent. At the same time, the age limit for anxiety was removed, so that everyone over 18 can be treated for anxiety if referred by their physician. Finally, it was also agreed to extend the existing free trial scheme for anxiety and depression to include 21-year-olds.

In April and May 2019, a modernization of the ear, nose and throat specialty as well as laboratory services was implemented. This led to a revision of the service catalog, resulting in the introduction of new services and phasing out of others.

In July 2018, young people between 18-20 years have been able to receive free psychological help if referred for anxiety or depression under the psychologist scheme.

In January 2018, a larger fee for home visits by physicians was introduced under the collective agreement. This has led to a large increase in these contacts.

In 2018, a differentiated basic fee and a chronic care fee for general practitioners were introduced. Both are currently paid manually, so they cannot be seen in the health insurance register. The chronic care fee implies that services covered by the chronic care fee are not registered separately. This means that in the count of consultations, only consultations for persons not covered by the chronic care fee are counted. There is therefore a shadow figure that is unknown.

In 2017, a smaller decline was seen in contacts and expenses for psychologists, caused by exceeding the financial framework in 2015 and 2016, which led psychologists to repay part of their subsidies. This may have caused particular caution in 2017.

In 2017, expenses to the State Serum Institute (SSI) fell by 85 percent due to the state's divestment of SSI's vaccine production and SSI Diagnostica per 1 October 2016 and 16 January 2017.

In 2017, specialty 64 - Chiropractic (chronic patients) saw a large 50 percent drop in contacts and a 20 percent decrease in expenses. This is attributed to the new collective agreement effective 1 April 2017, which involved changes in services, subsidies, care packages, as well as quality accreditation and systematic continuing education of chiropractors.

In 2017, a decline in contacts to internal medicine and pediatrics was observed, due to a revision of the service catalog within the allergy area. For example, skin prick tests – which previously were recorded as one service per prick – now count as one service (contact) for the entire test (typically 15 -20 pricks). This modernization process will continue in other specialties in the future.

In 2016, services within gynecology/obstetrics related to fertility and abortion were discontinued. This led to approximately 73,000 fewer recorded contacts in 2016.

In 2016, child psychiatry saw an increase in expenses partly attributable to the assistance package introduced in 2015. Furthermore, practicing psychiatrists were obliged to treat 10 percent more patients in 2015.

As of 1 January 2016, all blood sample analyses from general practitioners were transferred from "Copenhagen General Practitioners' Laboratory" to the region's hospitals, leading to the exclusion of these expenses.

In December 2017, a revision of psychologist data for 2011 was made due to repeated inquiries. The revision involved certain service codes (0211 and 0311) from 2011 which were only included as contacts from 2012, causing an underestimation for 2011. These contacts are now included for 2011. This revision resulted in roughly 90,000 (25 percent) more psychologist contacts than before. Furthermore, this revision caused shifts in socio-economic groups in all tables, due to changes in socio-economic status related to the revision of the Register-based Labour Force Statistics (RAS).

In 2013, the number of dental contacts dropped by 22 percent as the scope was narrowed, limiting future subsidies to tooth cleaning only, while subsidies for check-ups on diagnostic findings were discontinued.

In 2013, Statistics Denmark was informed by CSC Scandihealth that minor inaccuracies were found in the submitted data for October, November, and December 2013, as corrections in the Central Denmark Region were calculated with incorrect signs.

In 2014, socio-economic groups (soc_stil to soc_status) were revised in the Register-based Labour Force Statistics, and the period 2009-2013 was recalculated, resulting in a break in socio-economic grouping between 2008 and 2009.

In 2014, the income register was revised, and the period 2011-2013 was recalculated, but with no significant impact on the distribution by income quartiles.

In 2011, a large increase was seen in contacts to chiropodists after a prolonged conflict was resolved with a collective agreement on 1 June 2011. (For a long time, it was not possible to calculate contacts to chiropodists due to difficulties distinguishing contacts from other services and the absence of a collective agreement from June 2005 to June 2011. During this time, most fees were settled outside the public health insurance system and thus excluded from statistics.)

In 2011, a large decline occurred in general practitioner prevention services, due to the discontinuation of service code "0106 Aftalt forebyggelseskonsultation" and stricter requirements for the new code "0120 Aftalt specifik forebyggende indsats."

In 2011, the number of psychologist contacts was underestimated by about 20,000 because specific services not included in the tariff folder should have been counted as contacts; this was corrected only from 2012.

In 2012, additional service codes for psychologists, not explicitly mentioned in the tariff folder, were included. Since these codes were not included in previous years, the increase from 2011 to 2012 is somewhat overstated.

In 2012, due to a pilot project on Bornholm, the number of general practitioner contacts was underestimated by about 112,000. Interpreter assistance is included in the 2012 tariff folder but does not affect the number of contacts. After careful review, interpreter expenses for 2012 were excluded.

In 2009, a large decline in dental contacts was observed, which was not real but due to the exclusion of two preventive treatment services ('502920', '502930') following the Danish Dental Association's recommendation. This affects the apparent development in dental contacts from 2008 to 2009 by about 500,000.

From 2006, the register includes an imputed amount for general practitioners' basic fees, distributed proportionally among service recipients based on gross fees.

For dental visits, only the first visit (including examination) is registered as a contact; subsequent visits within the same treatment episode are not counted.

Physiotherapy is often provided as group training where one physiotherapist trains multiple patients simultaneously; each patient's training counts as a contact. For riding physiotherapy, contact calculations are uncertain for the same reasons.

From 2006, a revision in the calculation of contacts was implemented.

The number of contacts statistics can be problematic when comparing over time because several

methods have been used to delimit which services count as contacts. This has caused some data breaks, especially between years before 2005 and from 2006 onwards.

Originally, agreements were typically held by physicians with the former counties. Over time, new service providers such as psychologists and physiotherapists have entered agreements and are now included in the statistics.

For the years 1984, 1985 and 1986, the register relied on a 10 percent sample containing services for persons born on day 14, 15 or 16 of a month. From 1987 onwards, the register includes all services and persons covered by agreements between the regions and organisations representing the various service providers.

### 7.3 Coherence - cross domain

Total health expenditure appears from the regional accounts, table REGR31 in Statbank Denmark. The total amount for the health insurance reimbursements appears from the regional accounts. The Danish Health Authority published statistics on the population's use of the public health insurance. Both of these assessments are exclusive of the background information that exists in the Health Insurance Register of Statistics Denmark.

### 7.4 Coherence - internal

Data are internally consistent.

## 8 Accessibility and clarity

Nyt fra Danmarks Statistik and Statbank Denmark

Annual publications (selected sections): Statistical Ten-Year Review.

### 8.1 Release calendar

The publication date appears in the release calendar. The date is confirmed in the weeks before.

### 8.3 User access

Statistics are always published at 8:00 a.m. at the day announced in the release calendar. No one outside of Statistics Denmark can access the statistics before they are published.

### 8.2 Release calendar access

The Release Calender can be accessed on our English website: Release Calender.

### 8.4 News release

Further information is available at: Health Insurance Statistics

STATISTICS DENMARK

## 8.5 Publications

The statistics are presented in Statistical Ten-Year Review and Denmark in Figures, which can be found in Statistics Denmark's web pages.

## 8.6 On-line database

The statistics are published in the StatBank under the subject in the following tables:

- SYGP1: Number of persons with contacts covered by public health insurance by region, type of benefits, age and sex
- SYGPS1: Recievers og public health insurance by region, type of benefits, age and sex
- SYGK1: Contacts covered by the public health insurance by region, type of benefits, age and sex
- SYGKS1: Contacts covered by the public health insurance by region, type of benefits, age and sex
- SYGU1: Public health insurance expenses by region, type of benefits, age and sex
- SYGUS1: Public health insurance expenses by region, type of benefits, age and sex
- SYGP2: Number of persons with contacts covered by public health insurance by region, type of benefits, age and sex
- SYGPS2: Recievers og public health insurance by region, type of benefits, age and sex
- SYGK2: Contacts covered by the public health insurance by region, type of benefits, age and sex
- SYGKS2: Contacts covered by the public health insurance by region, type of benefits, age and sex
- SYGU2: Public health insurance expenses by region, type of benefits, age and sex
- SYGUS2: Public health insurance expenses by region, type of benefits, age and sex
- SYGHER: Population by key figures, type of benefits, ancestry, sex, age and time
- SYGIND: Population by key figures, type of benefits, income level, sex, age and time
- SYGARB: Population by key figures, type of benefits, labour market attachment, sex and age
- SYGUDD: Population by key figures, type of benefits, highest level of education completed, sex and age
- SYGSIK: Population by region, health insurance group and time
- LIGEHB6: Consultations with the general practitioner by region, sex, age, family type and time
- LIGEHI6: Gender equality indicator of consultation with the general practitioner by indicator, region, age, family type and time
- PAAROE30: Population (0-17 years) by family situation, key figures, age and sex
- PAAROE31: Population (18 years or over) by family situation, key figures, age and sex

## 8.7 Micro-data access

External access to de-identified micro-data is only available via Statistics Denmark's Research Services.

## 8.8 Other

The health insurance register with de-identified micro-data exists in PSD (Statistics Denmark internal database) and as module data (SD internal database), and data can be made available to employees in e.g. Statistics Denmark's Research Services and SD Consulting on application in this regard.

### 8.9 Confidentiality - policy

Publication from the register will be in accordance to the data privacy policy of Statistics Denmark: Data privacy policy.

### 8.10 Confidentiality - data treatment

The statistics have been anonymised using Tau-Argus, with a suppression threshold of 3 individuals. Tau-Argus does not only suppress cells with fewer than 3 individuals, but also those from which such small numbers can be indirectly derived. This is referred to as secondary suppression. However, the tables SYGPS1, SYGKS1, SYGUS1, SYGPS2, SYGKS2, and SYGUS2 are primarily suppressed.

### 8.11 Documentation on methodology

The basis and contents of the statistics are described (in Danish) in "Statistiske Efterretninger, Sociale forhold, sundhed og retsvæsen". Statistical Information for 2012 is the last version of this. Furthermore, the content of the register of health insurance is documented (in Danish) in Statistics Denmark's documentation system (TIMES) including selected variables such as Højkvalitetsdokumentation (high quality documentation): Højkvalitetsdokumentation.

### 8.12 Quality documentation

Results from the quality evaluation of products and selected processes are available in detail for each statistics and in summary reports for the Working Group on Quality.

## 9 Contact

The administrative placement of these statistics is in the division of Personal Finances and Welfare, Social Statistics. The contact person is Jonas Kirchheiner-Rasmussen, tel.: + 45 6150 2380, and e-mail: RAS@dst.dk.