A GENERAL PRACTITIONER LOOKS AT DENMARK

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THE BRITISH general practitioner visiting another country can be just a tourist or he can use such an opportunity to look at medical services and make useful informative comparisons, helpful in today's concern about a future for family doctors. With the tide of general practice in the National Health Service at low ebb what can be learnt from a brief visit to another country with comparable Western European culture, and with a similar branching of medical care into hospital and general practice? Against the background in this country of wide variations in individual doctor's performance and in facilities available to him the visit was an opportunity to examine such similar aspects as the general practitioner and his organization and the relationship between him and hospital. This paper describes such a reconnaissance made during one week's visit to Denmark recently and what can be learnt from it.

Preparatory work

All the countries bordering the North Sea have broadly similar methods of providing medical services. The visit was planned in two stages:

1. To discover what the medical resources were, how these were deployed and to what effect. Recent annual reports of the Danish Medical Services, the Danish Medical Bulletin, the Danish Survey of Sickness, W.H.O. Epidemiological and Vital Statistics and the valuable paper by Chester and Hogarth (1960) were informative and helpful.

2. Attempts were made to view working conditions in general practice, including provision of direct-access diagnostic facilities, to obtain estimates of the work load and to examine the general-practitioner–hospital relationships.

Medical resources and how deployed

Denmark is a small country with about 4.7 million inhabitants;

and there are also about eight million pigs and two million mink. Agriculture ranks as a major industry in the use of manpower. In 1963 there were about 6,100 doctors in active medical work, 1 to 765 inhabitants (compared to U.K., 1 to 900). Nearly half are in general practice, approximately 1 to 1,800 inhabitants (in England and Wales, 1 to 2,362). Medical training takes about eight years, often longer; there is a statutory post-registration year and usually the young graduate gains three or four years varied hospital experience before entering general practice. Specialists, about a quarter of all doctors, have extra training of up to eight years depending less on examinations than on holding graded hospital posts. On qualification the Danish doctor takes the professional title of *laege*, a small proportion proceed to the postgraduate "Dr med" applicable in all specialties. Around 250 (1960, 242; 1962, 257) graduate each year; many emigrate to practise in Sweden.

Nurses

In 1962–63 there were 18,000 trained nurses in active practice, about 1 to 270 persons; of these 10,900 work in hospital, on average one nurse to three beds. In England and Wales (1963) the comparable figure was two nurses to five beds.

Hospitals

Denmark has about 30,000 general hospital beds. Ninety per cent of all hospitals are owned by county or municipal authorities with state-owned hospitals for mental disease. The average length of stay in the general hospital bed is now about 16.7 days, with a cost per patient/day about £5; discharges are about 118 per 1,000 population. Details given are for 1963, published 1965 (table I).

TABLE I

MEDICAL RESOURCES AND ANNUAL RATES OF USE PER 10,000 POPULATION, 1963 DENMARK, ENGLAND AND WALES

	All doctors	*Annual doctor contacts per person*	*Hospital beds (acute)*	*Annual admissions (acute and chronic)*	*Average days in acute hospital*
Denmark ..	13	5.4	65	1,180	17
England and Wales ..	11	4.7	39	950	15

(From Logan, R. F. L., and Eimerl, T. S. in Milbank Memorial Fund Quarterly, April 1965).

There is no Ministry of Health as we know it, necessary administration is delegated to county or town level and through other govern-

ment departments. There is a National Health Service (Board), a department concerned with professional standards and supervision. The state also provides preventive and public health care, with a network of clinics. All doctors in the hospital service are full-time, some private practice being allowed to heads of clinical departments. The second major difference, affecting family doctors particularly, is that *there are no outpatient referral clinics* as we know them. Some ambulant outpatients are seen at hospital; these are patients who on discharge are specially requested to return for supervision and follow-up. The numbers are small, it being routine practice for patients on discharge to be returned forthwith to the care of their own family doctor.

To what effect?

Estimating resources for medical care and looking briefly at how they are used provides some information. To put this in perspective the next step is to examine the effectiveness of medical care. This is not easy; there are many imponderables. Beside death rates there is the less clear pattern of morbidity from which some clues can be picked out. A valuable repository of information is the Danish Survey of Sickness, 1951–1954; and there are studies of general practice.

TABLE II

SOME INDICES OF MEDICAL CARE. DENMARK, ENGLAND AND WALES 1963

	Denmark	*England and Wales*
BIRTHS		
Live per 1,000 population	17.6	18.2
FERTILITY RATE	109	112
Born in hospital (per cent)	*53.0*	*65.0*
DEATHS		
All deaths per 1,000 population	9.8	12.2
MATERNAL MORTALITY		
Deaths per 100,000 births	21*	28
Still-births per 1,000 births	11.0	17.2
Neonatal deaths per 1,000 live births	14.8	14.3
Deaths under one year per 1,000 live births	19.1	21.1
Deaths in hospital (per cent)	*62.8*	*49.0*

*Latest available figure (1962).

Looking first at births, table II shows live births per 1,000 persons as slightly less in Denmark than in England and Wales; with slightly more persons under 45, 65.6 per cent compared with 62.4 per cent

for England and Wales (table III). The fertility rate offers a truer comparison; live births per 1,000 women aged 20–44 are 109 in Denmark and 112 in England and Wales. More babies are born at home (47 per cent all births, 35 per cent England and Wales). Their maternal mortality and their still-birth rate are lower than in England and Wales but not their neonatal mortality. When deaths under one year are compared Denmark, like other Scandinavian countries, has lower rates than England and Wales.

TABLE III

POPULATION—DENMARK, ENGLAND AND WALES 1962

Age group	*Denmark per cent*	*England and Wales per cent*
0–14	*24.3*	*22.4*
15–44	*41.3*	*40.0*
45–64	*23.6*	*25.5*
65 plus	*10.8*	*12.1*

The crude death rate for 1963 was 80 per cent that of England and Wales. Surprisingly more Danes die in hospital (62.8 per cent). Because of differences in population age-specific death rates are more informative. Table IV shows that though through life there is little difference in the rates for women in the two countries, there is a marked increase for men in England and Wales which becomes discernible at 35, from 45 the rates climb more steeply though the curve flattens slightly after 75. Age-specific death rates from 40 years onwards for men and women were compared for the three major killers, cancer, arteriosclerotic and degenerative heart disease (including coronary disease) and stroke, in table A (appendix).

TABLE IV

DEATH RATES PER 1,000 POPULATION, BY AGE AND SEX. DENMARK, ENGLAND AND WALES 1962/3

	Denmark		*England and Wales*	
	M.	*F.*	*M.*	*F*
5–14	0.55	0.25	0.44	0.28
15–24	0.90	0.45	0.99	0.39
25–34	1.10	0.70	1.10	0.74
35–44	2.30	1.60	2.47	1.79
45–54	6.10	4.00	7.45	4.50
55–64	16.70	9.80	22.60	10.90
65–74	40.90	28.90	55.30	30.50
75–84	102.90	87.30	128.00	88.60
85 plus	240.00	220.50	283.00	223.00

In women, from 40 to 60, cancer kills more in Denmark, but from 60 on the rise is tragically steeper in this country. At least twice as many men aged 40 and above die of cancer in the United Kingdom, the curve steepening with age until at 85 the increase is fivefold. For lesions of the cerebrovascular system in women the pattern is repeated; at 45 the rate is four times that in Danish women of the same age, and although the curve of comparative increase flattens with ageing, considerably more women die of stroke in the United Kingdom. In men, twice as many males aged 45–49 die of stroke here; the curve of relative increase levels off with age, yet overall more men die in this country of this condition.

Arteriosclerotic and degenerative heart disease, including coronary disease. Twice as many British women die from this condition compared to their Danish sisters and again the increase is clear and definite from 40 onwards. In men for the 45–49 age group, for every 90 who die in Denmark 150 die here. The disease continues its inexorable process through all ages, more than twice as many males dying from this in the United Kingdom compared with Denmark.

Pneumonia and bronchitis are two other conditions important to the health and economy of Britain; it is instructive to compare death rates for them, remembering that both countries experience much westerly wind and rain; details given in table B (appendix) confirm that again Danes have a much lower mortality for pneumonia and bronchitis. In both sexes, more than twice as many die from pneumonia in this country and this increase appears early in the 40–44 age group. Similarly for bronchitis, women in this country have a sevenfold chance of dying from this cause; men have almost a tenfold risk. This risk appears at 40 and by 55 more than 20 men or women die of bronchitis for each Dane.

Survey of sickness: Denmark 1951–54

During 1951–54 a three per cent sample of the population aged 15 and over were interviewed about all illness in the previous month. Of the 100,000 persons approached 86,788 took part. 41.3 per cent had had some illness the previous month, 35.6 per cent for males, 46.9 per cent for females. There were 53,733 illnesses including 1,147 accidents. As a check on lay diagnosis each respondent's own doctor completed a 'control' questionary covering conditions named by his patient. The doctors confirmed 71 per cent, added more information in 6.5 per cent and refuted the diagnosis in but 6.2 per cent.

It is instructive to compare the Danish results with those of the similar survey of sickness in England and Wales. Table V gives the spells of illness by age group and by sex for the two countries; the marked differences between comparable groups are clearly seen.

TABLE V

SURVEY OF SICKNESS. DENMARK, ENGLAND AND WALES. SPELLS OF ILLNESS REPORTED

Denmark 1951–1954 per 1,000 respondents aged 15 and over			*England and Wales 1950–1951 per 1,000 respondents aged 16 and over*		
Age group	*Male*	*Female*	*Age group*	*Male*	*Female*
15–39	353.1	570.1	16–44	1,020.0	1,372.5
40–59	489.6	796.0	45–64	1,313.7	1,802.5
60 plus	1,777.1	1,087.2	65 plus	1,821.2	2,360.0
ALL	474.5	735.8	ALL	1,221.2	1,661.2

For all illness recalled in the past month in both surveys women appear to suffer more than men do with ageing increasing this. Older Danish men had proportionately more sickness than did men over 65 in England and Wales; it is remarkable that people here recalled over twice as much illness than the Danes did. Surely mere hypochondriasis is not the cause for our preoccupation with illness? Clinical form is given to the figures in table VI where the commonest conditions reported in both surveys are listed separately for men

TABLE VI

SURVEY OF SICKNESS. DENMARK, ENGLAND AND WALES. COMMONEST CONDITIONS REPORTED

Denmark 1951–1954				*England and Wales 1950–1951*			
Commonest conditions reported per 1,000 respondents aged 15 and over				*Commonest conditions reported : per cent of all conditions*			
Males		*Females*		*Males*	*Per cent*	*Females*	*Per cent*
Common cold	92.7	Common cold	90.0	Common cold	*10.4*	Muscular rheumatism	*11.7*
Muscular pain, rheumatism	31.2	Menstrual disorders	45.2	Bronchitis, Chronic pharyngitis Quinsy	*12.4*	Nervousness, debility	*8.9*
						Headache	*8.7*
Chronic bronchitis	28.3	Muscular pain	44.5	Muscular rheumatism	*9.1*	Common cold	*7.2*
Gastro-intestinal upsets	24.8	Nervous disorders	30.4	Gastro-intestinal upsets	*7.8*	Bronchitis chronic pharyngitis Quinsy	*6.5*
Influenza	15.0	Chronic bronchitis	30.3	Headache	*5.4*		

and for women. In Denmark, common colds, muscular rheumatism, bronchitis, gastro-intestinal upsets and influenza were most common in men; in women menstrual disorders and nervous disorders were reported more often. This picture is familiar to general practitioners in this country; the survey in England and Wales showed a broadly similar pattern, but empirical terms like headache, nervousness and debility were used more and menstrual disorders in women did not rank high in frequency. There is no major difference in the morbidity that brings the patient to the doctor and this is shown in table VII, where rank order of diagnosis is given for general practice in four countries, each with a different system of providing medical care, but all with a common denominator, the primary care doctor.

Hospitals

With this background information in mind, what of hospital care in Denmark? Those visited in city and small town, I was told, were typical. Whether the buildings were new or modified, the appearances were modern, with good facilities. An obvious integral factor is the high quality of standards maintained in spotless cleanliness, tidiness, availability of equipment. There are commonly first-class canteen facilities where all the staff eat. The advantages of advanced home-based industrial design in lighting, furniture, cutlery and crockery, are fully deployed and demonstrated in routine use.

TABLE VII

COMPARISON OF RANKING OF DIAGNOSES IN GENERAL PRACTICE

Diagnosis	*Czecho-slovakia 1959*[1]	*Denmark 1956*[2]	*United Kingdom*		*Australia 1962–3*[5]
			N.M.S. 1955–6[3]	*R.C.G.P. 1962*[4]	
Respiratory	1	1	1	1	1
Eyes, Ears, CNS ..	2	4	2	2	5
Skin	3	3 or 7*	4	3	3
Accidents	4	2	5	5	2
Digestive	5	5	3	8	4
Infectious and parasitic	6	6	8	4	8
Musculoskeletal ..	7	7 or 3*	7	7	7
Cardiovascular ..	8	9	6	9	6
Mental	9	8	9	6	9

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*Skin, musculoskeletal disorders partly mixed.

Nurses' quarters are good, often much superior in standards to those in Britain; for example, a hospital in a small town visited provides self-contained flats for nurses with, in each, hall, modern stainless-steel equipped small kitchen, washing, showers and toilet facilities and pleasant bed-sitting room. To attract suitable staff, salaries are competitive. In the hospitals visited, I saw no open wards but only two, three or four bedded rooms off main corridors of wards. Separate levels of nursing care were provided; for example, a medical division had an intensive care section with many skilled nurses, ordinary bed-care and ambulant care sections with, in the latter, only one trained nurse on duty.

Patients are admitted for treatment directly or, less often, following a short period of investigation in hospital. The diagnosis on admission has normally been made by the family doctor after carrying out his own necessary investigations.

The relations between hospital doctors and family doctors are good. Chiefs of departments and their junior staff recognize the clinical competence of their colleagues in family practice as they, in turn, recognize their specialized skills.

The family doctor

There are about 2,700 general practitioners, it is not easy to define the total with accuracy; about ten per cent, probably more now, are in partnerships of two or three principals and the proportion is increasing. There is a growing tendency to form groups, this helps to obtain better facilities for all and to provide better off-duty for each. The family doctor concept is an integral factor of Danish medical care; almost all Danish general practitioners are in contract with the Sickness Insurance Funds Organization—the official source of payment for individual patient care. Adult (over 16 years of age) patients receive care for themselves and for their children, but the family doctor is paid only for the adults and is expected to attend the children when required: the fees he receives include an extra allowance for this part of his normal work. For prescriptions patients pay about a quarter of the cost.

Several practices were visited (and I was privileged to sit in with the doctor during consultation); these varied from practices in Copenhagen, in Odense, to those in a small town. All premises seen, which I was told were typical, had consulting-room, waiting room often attractively furnished, examination room, facilities for secretary and necessary office accommodation. It was not unusual to find two examination rooms (or at least two examination couches, one in the consulting-room and one in the examination room), both well equipped, to serve one practitioner. The second room often was used only for preventive care: immunization, antenatal and

infant welfare. The range of equipment for diagnosis and for treatment was impressive, it was obviously in use; and both range and quantity were greater than that found as standard today in this country. An interesting and surprising aspect was that many suites of professional rooms are on the first floor of buildings, often above shops so that they are centrally placed for the areas served. Patients find little difficulty in climbing stairs and doctors do not think it essential always to be at ground level. We would do well to ponder the significance of this.

Direct access diagnostic facilities

Parallel with the absence of outpatient referral clinics, the local hospital provides the general practitioner with diagnostic facilities in the laboratory to the same extent as the hospital doctor. In Copenhagen special arrangements exist, these are described in some detail because of their significance for high quality general practice.

In 1922 general practitioners in Copenhagen set up their own organization for laboratory services. By agreement with the Sickness Insurance Funds Organization, patients pay nothing nor do the referring doctors. In discussion with the present director, Dr Jørgensen, I learnt that facilities available are equal to those in a large modern hospital; including ECG's (5 lead or 12 lead), and EEG recordings; the latter read by a visiting neurologist. The patient attends the laboratory at the doctor's request, reports are mailed and in emergency telephoned to the doctor concerned. During 1964 the laboratory provided 367,000 items of service, some of these were also for doctors working in Copenhagen hospitals. The laboratory is self supporting. The income derives from a charge made on the Sickness Insurance Funds for each item of service, e.g. a Hb estimation is costed at one point, about 2s 6d, a 5 lead ECG at eight points, about £1. The laboratory is centrally placed, well organized and intensively used, providing an essential service with speed and relative economy. And every family doctor using it is given a loose-leaf handbook of up-to-date diagnostic procedures containing information presented primarily from the aspect of a practising clinician's needs.

In Copenhagen and throughout the country, there is access to high quality diagnostic radiology (this may vary by area); thus the family doctor is enabled and expected to examine and investigate and diagnose his patient's condition to a far greater extent than is now customary in Britain. Patients, too, expect this standard as a necessary part of the service provided by their family doctor.

Preventive care

Antenatal care, with child welfare, is carried out for a set number of examinations in pregnancy, infancy and childhood by the general

practitioner as agent for the state. There is a network of clinics attended by midwife and nurse. As in Britain, the place of preventive care in the adult, screening of vulnerable groups, pre-symptomatic diagnosis and surveillance has yet to be established.

Medical records

A disadvantage is the absence of a continuous personal medical record, one of the few major advantages of the N.H.S. However, most practitioners asked about this stated that they would send details of patient care to another colleague on request, for example when a patient moved. The hospital letters I was shown were detailed and full, no attempt being made to 'interpret' the findings into a simpler form for transmission to the practitioner; it is assumed he is competent and comprehends what is made available to him. In general the paper-work of general practice appeared more complex. For example, prescription forms were in three colours, each form providing different benefits; but I gained the impression from observing what took place and by discussion, that the Danish general practitioner does not have the same quantitative load of providing certificates and other forms as we do even though our forms are simpler.

The Sickness Insurance Funds

Fees for direct medical care of insured members, 90 per cent of the population, are paid on a basis agreed between profession and the Sickness Insurance Funds' Board. Fees are also paid to hospitals for direct access diagnostic services, consultations with specialists at the general practitioner's request. I was led to believe that as a working principle the authorities consider it more economical to pay the costs of necessary patient investigation by the family doctor and are helpful in providing this whenever possible. When a patient enters hospital more than 90 per cent of the cost is paid from state funds.

The work of the Danish general practitioner

In recent years the Danish Medical Association has carried out a detailed and national survey of family doctor services; the report was published in 1962. The survey lasted one year; in each quarter a different, randomized sample of doctors (about 15 per cent), recorded much of the quantitative non-clinical detail of their work, but doctors practising in Copenhagen were not included because of special factors affecting this group. Altogether about 57 per cent of available doctors took part. Some of the highlights of the survey showed that the normal working day is from 8.00 a.m. to 6.00 p.m. (08.00–18.00) for a year of 279 working days. The doctor is expected to take holidays and in fact receives payment for this only when the vacation is taken. Details of the range of services provided for those fully covered by the state insurance scheme are given in table VIII.

TABLE VIII

ITEMS OF SERVICE, DENMARK (1962)

	Per cent	
OFFICE		
1. Consultations	56	79
2. Telephone consultations	11	
3. Renewing prescriptions	12	
HOME		
Visits		21

Home visits were only 21 per cent of all consultations but 12 per cent of all were for renewal of prescriptions. A feature of the Danish system is the availability of consultation by telephone at specified times—and this represented about 11 per cent of all consultations. The provision of this facility to the patient provides obvious advantages and we would do well to look at it more closely.

Table IX provides a comparison of some interest. The Danish survey showed that 93 per cent of all services given were within working hours—i.e., weekdays, 08.00–18.00 and not Sundays or public holidays. In a study carried out among 134 general practitioners in Merseyside and North Wales in the winter of 1965, (Eimerl, Pearson), 96 per cent of all services were provided within the period 08.00 Monday to lunch time on Saturday; though of course our figures included night calls in the week and the Danish ones did not.

TABLE IX

GENERAL PRACTICE. SERVICES PROVIDED IN WORKING WEEK

Denmark (1962 report)	*Per cent*	*Britain 1965**	*Per cent*
Services provided in day working hours (08.00–18.00) ..	93	Services provided in working week	96
Outside day working hours ..	7	At weekend	4

*Working week: 08.00 Monday to lunchtime Saturday. Includes weekday night calls.

TABLE X

GENERAL PRACTITIONER SERVICES IN DENMARK—PROPORTIONS BY AGE GROUP

Age group	*Actual distribution* *Per cent*	*Proportion, corrected for size of population (Services to 15–64 as unity)* *Per cent*
Under 15 ..	17	70
15–64	65	—
65 plus	17	130

Also in the Danish survey an attempt was made to relate the age of the patient to services given (table X); taking services to patients

aged 15–64 as unity, children under 15 have less (70 per cent), and the elderly have more attention (130 per cent).

Lastly, night calls outside normal working hours and work on public holidays were estimated separately and found to be about seven per cent of all services given; three-quarters of home visits were within two kilometres of the doctor's office or home.

Postgraduate facilities

An increasing proportion of Danish practitioners attend regular and local postgraduate sessions; the cost of providing these is met from official funds.

Discussion

The visit to Denmark with a look at general practice, complements similar and repeated visits to Holland and to Norway during 1960–1965. A wide variety of practices, city and country, group and solo in these countries has been visited, including sitting-in during consultations and going on home visits, visiting patients in hospital, attending clinics and other normal practitioner activities. During the same period there has been opportunity to visit many different practices in England.

Each of these countries bordering the North Sea has a belief in the value of the general practitioner to the community; this is demonstrably clear. As a family doctor examining problems one soon feels very much at home in each country.

Denmark possesses more doctors and they look after a smaller number of patients. There are no direct referral outpatient facilities but there are generally available good quality direct-access diagnostic facilities and the family doctor is encouraged to use them freely.

Fry (1961) after his visit considered that there was little difference between the two countries in the standard of and quality of services from general practice. This view I find difficult to accept. Comparison between here and Denmark in terms of standards of equipment and facilities enjoyed, the standard of care and personal attention the family doctors indicated their patients expect to receive, shows clearly that we in England do not normally now provide for ourselves premises and equipment of the same calibre. And if suitable premises and technical equipment are not available or used by the general practitioner then what of the standard of care?

Chester and Hogarth (1960) in their detailed review of medical care services in Denmark show clearly that it is official policy to place the family doctor at the centre with facilities and organization being directed to provide him with what he needs to carry out high quality care. Certainly the experience of Denmark with no outpatient clinics, with mortality indices superior to ours (although a

more rural economy), with similar morbidity in general practice, with a system geared towards high quality family doctoring, shows that general practitioners can provide at the very least as good a service as that here and maybe at lower cost to the community. And in mentioning cost, apart from economic factors, is it not possible that with more time and a higher standard expected of him the Danish family doctor has the advantage in maintaining himself as an earlier and better diagnostician?

Although death rates are disturbing in their implications for us, these and such morbidity details as are now available in developed countries may be of less value when estimating the effectiveness of medical care. Such indices are signposts only. There is a need to discover not only what medical care provides but also what is being missed in these days when science can do so much more and the patient expects more.

Conclusion

The visit was helpful in learning how another country manages similar general-practitioner services and the place these occupy in the provision of medical care.

Denmark with many similarities has surprising differences: 20 per cent more doctors, about 50 per cent more acute beds and about 24 per cent more admissions to them. There are no outpatient-referral clinics but high quality direct-access diagnostic facilities are available to hospital doctors and general practitioners.

There are two important reservations: lack of truly comparable international studies make it difficult to relate one country's experience to another; attempting interpretation of the complex interaction of professional relationships in and out of hospital and with public and patient is neither easy nor safe. Yet certain conclusions are inescapable.

The obvious better preparation for his work which the intending Danish general practitioner is expected to and does undertake. This is in strong contrast to attitudes here (Eimerl 1962). Second, the absence of pressure on the Danish family doctor, compared with his British colleagues, while at work. He is not 'pushed' as we are, though often he works hard and for long periods. Above all I was impressed by the high standard of work of the Danish family doctor. The patient expects this, hospital colleagues expect it equally of him as of themselves, he expects it of himself: and so it is provided.

The Danish experience of much lower mortality for major killers coupled with a roughly similar morbidity presenting to the general practitioner in both countries should make us question whether we are making the best possible use of our own medical resources. To

help in answering this, more truly comparable studies at international level are needed; for example:

What is the community attitude to medical care?
What is the uptake of medical resources?
What is the content of the general practitioner's week?
What equipment and diagnostic facilities does the general practitioner have, how does he view and use them?

These investigations should be the next step; they require the use of household interview procedures, the clinical assessment of comparable samples in hospital beds: and for the general practitioner, the use of simple questionary and interview plus clinical assessment of comparable samples of patients under his care.

Summary

This paper described a visit to Denmark, looking at general practice. Available resources for providing medical care, how these are used and to what effect are examined; marked differences in death rates for the major killers, morbidity and other aspects are compared with those of the United Kingdom and the implications for this country noted. Differences of surprising degree in standards of equipment used by and facilities available to general practitioners are described. Denmark is geared towards high quality family doctoring. We would do well to explore further if we are to raise and to maintain higher standards in general practice.

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APPENDIX A

DEATH RATES, BY AGE AND SEX, PER 100,000 PERSONS: DENMARK, UNITED KINGDOM, 1961

1. All cancer (B18)
2. Vascular lesions of C.N.S. (B22)
3. Arteriosclerotic and degenerative heart disease, including coronary disease (B26)

	All cancer				*Vascular lesions of C.N.S.*				*Arteriosclerotic/degenerative heart disease (including C.A.T.)*			
	Denmark		*United Kingdom*		*Denmark*		*United Kingdom*		*Denmark*		*United Kingdom*	
	M	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*
ALL AGES ..	216.5	210.4	597.5	622.4	111.8	125.4	139.4	192.5	168.2	135.1	347.4	287.0
40–44.. ..	61.3	123.2	110.0	54.4	7.9	4.5	14.4	14.0	48.4	6.9	69.4	11.6
50–54.. ..	214.9	363.9	403.1	176.9	37.6	28.6	58.9	60.1	168.9	37.6	277.1	52.9
60–64.. ..	568.0	423.2	1,229.2	626.9	146.2	126.0	257.9	192.2	523.2	168.0	834.2	271.8
70–74.. ..	1,232.4	897.9	3,565.8	2,389.7	656.8	657.8	895.3	765.0	1,243.1	349.4	2,029.8	1,106.8

APPENDIX B

DEATH RATES, BY AGE AND SEX, PER 100,000 PERSONS: DENMARK, UNITED KINGDOM, 1961

4. Pneumonia (B31)
5. Bronchitis (B32)

	Pneumonia				*Bronchitis*			
	Denmark		*United Kingdom*		*Denmark*		*United Kingdom*	
	M	*F*	*M*	*F*	*M*	*F*	*M*	*F*
ALL AGES ..	23.3	24.1	63.0	63.8	10.3	3.4	99.4	38.5
40–44.. ..	3.3	1.3	8.2	6.9	—	1.3	7.9	4.2
50–54.. ..	6.8	5.3	24.2	12.8	3.4	1.3	53.0	11.9
60–64.. ..	18.6	19.2	89.2	47.6	18.6	5.0	291.7	46.6
70–74.. ..	88.9	70.3	331.3	183.4	43.7	13.3	683.9	162.4