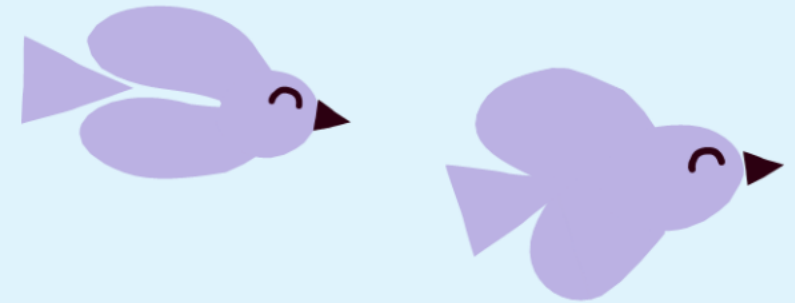


Mary Elizabeth Hospitals Center for Data og Effektforskning

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Lone Graff Stensballe

Overlæge i pædiatri, professor, centerleder



Konferencelogistik

- Tak fordi I er kommet 😊
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Do we know what we are doing?

- Kan vi finde ulogiske mønstre i den måde vi bruger sundhedsvæsenet?
- Hvad kan drive os mod overdiagnostik og overbehandling?
- Bruger vi for meget højt specialiseret behandling?
- Er nogle sygdomme "finere" end andre?
- Fordeler vi ressourcerne retfærdigt?
- Kan man dø for sent? Kan vi hjælpe folk mod en bedre død?
- Hvad skal vi konkret stoppe?
- **Breaking news**



Analysen når frem til, at det britiske sundhedsvæsen mellem 2000 og 2020 brugte 75 milliarder pund (knap 660 milliarder kroner) på nye lægemidler, for eksempel til behandling af infektioner, kræft og immunologiske sygdomme, hvilket resulterede i 3,75 millioner ekstra kvalitetsjusterede leveår. Men hvis de samme midler var blevet brugt på allerede kendte sundhedsydelser, såsom forebyggende indsatser mod hjertesygdomme, kunne man have opnået fem millioner kvalitetsjusterede leveår. Det giver et nettotab på 1,25 millioner leveår.



Population-health impact of new drugs recommended by the National Institute for Health and Care Excellence in England during 2000–20: a retrospective analysis



Huseyin Naci, Peter Murphy, Beth Woods, James Lomas, Jinru Wei, Irene Papanicolas

Summary

Background Health systems experience difficult trade-offs when paying for new drugs. In England, funding recommendations by the National Institute for Health and Care Excellence (NICE) for new drugs might generate health gains, but inevitably result in forgone health as the funds cannot be used for alternative treatments and services. We aimed to evaluate the population-health impact of NICE recommendations for new drugs during 2000–20.

Methods For this retrospective analysis, we identified technology appraisals for new drugs in England published in NICE's publicly available database of appraisals between 2000 and 2020. We excluded products with terminated appraisals, not recommended, or subsequently withdrawn from the market and excluded appraisals in programmes focusing on medical devices, diagnostics, or interventional procedures. We included drugs that underwent NICE appraisal within 5 years of initial regulatory approval. We collected data on drug name, appraised indication, and specific features of both the drug and its appraisal. We noted the value for money offered by new drugs, expressed as the incremental cost-effectiveness ratio (ICER), and data on health benefits, expressed as quality-adjusted life-years (QALYs). We estimated the number of patients receiving new drugs recommended by NICE using proprietary data on the total volumes of new drugs sold in England between Jan 1, 2000, and Dec 31, 2020. We calculated the net health effect of each appraisal using the difference between the incremental QALY gains from implementing the new drug within the National Health Service (NHS) and the estimated QALYs that could hypothetically be obtained by reallocating the same funds to other NHS services or treatments. We obtained forgone QALYs by dividing the incremental cost of the new drug by the health-opportunity cost of NHS expenditure.

Findings NICE appraised 332 unique pharmaceuticals between 2000 and 2020; 276 (83%) had positive recommendations. Of these 276, 207 (75%) had a NICE appraisal within 5 years of regulatory approval. We included 183 (88%) of 207 drugs in this analysis, after excluding drugs that did not meet eligibility criteria. The median QALY gain across all 339 appraisals was 0.49 (IQR 0.15–1.13), equivalent to an additional half a year in full health. Median ICER for recommending new drugs increased from £21545 (IQR 14175–26173) per QALY gained for 14 appraisals published between 2000 and 2004 to £28555 (19556–33712) for 165 appraisals published between 2015 and 2020 ($p=0.014$). Median ICER varied by therapeutic area, ranging from £6478 (3526–12912) for 12 appraisals of anti-infective drugs to £30000 (22395–45870) for 144 appraisals of oncology drugs ($p<0.0001$). New drugs generated an estimated 3.75 million additional QALYs across 19.82 million patients who received new drugs recommended by NICE. The use of new drugs resulted in an estimated additional cost to the NHS of £75.1 billion. If the resources allocated to new drugs had been spent on existing services in the NHS, an estimated 5.00 million additional QALYs could have been generated during 2000–20. Overall, the cumulative population-health impact of drugs recommended by NICE was negative, with a net loss of approximately 1.25 million QALYs.

Interpretation During 2000–20, NHS coverage of new drugs displaced more population health than it generated. Our results highlight the inherent trade-offs between individuals who directly benefit from new drugs and those who forgo health due to the reallocation of resources towards new drugs.

Funding The Commonwealth Fund.

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The gap in care

£4 of every £5 is spent on hospital care at end of life

5 Feb 2025 • 5 min read • All UK • By [Emma Maun, Marie Curie Quantitative Research Manager](#)

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How much money supports people in their last year of life?

Emergency hospital care tops the health care bill

The imbalance of spending can't continue

Securing financial health for dying people and their families

We're calling on UK governments to fix end of life care

But we can't make all this happen without your help

Footnotes

Knowing where money is spent is as important for governments as it is for families and individuals, but for the past decade, surprisingly little has been known about spending on dying people. That's why Marie Curie commissioned the Nuffield Trust and the Health Economics Unit to estimate public expenditure on people in their last year of life in the UK.

The research, titled [Public expenditure in the last year of life](#) reveals an astonishing 81% of public money spent on health care for people in their final year goes towards hospital costs. The report highlights big differences between where public money is currently spent and where evidence indicates it could enable better end of life care and support. This is something Marie Curie is determined to change.

How much money supports people in their last year of life?

The research is based on publicly available data and statistics throughout the UK as well as expert stakeholder advice. It estimates up to £22 billion of UK governments money



Healthcare Costs at the End of Life for Patients with Non-cancer Diseases and Cancer in Denmark

Anne Høy Seemann Vestergaard¹ · Lars Holger Ehlers^{2,3} · Mette Asbjørn Neergaard⁴ · Christian Fynbo Christiansen¹ · Jan Brink Valentin⁵ · Søren Paaske Johnsen^{2,5}

Accepted: 6 July 2023 / Published online: 8 August 2023
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Abstract

Objectives To examine costs of care from a healthcare sector perspective within 1 year before death in patients with non-cancer diseases and patients with cancer.

Methods This nationwide registry-based study identified all Danish citizens dying from major non-cancer diseases or cancer in 2010–2016. Applying the cost-of-illness method, we included costs of somatic hospitals, including hospital-based specialist palliative care, primary care, prescription medicine and hospice expressed in 2022 euros. Costs of patients with non-cancer diseases and cancer were compared using regression analyses adjusting for sex, age, comorbidity, residential region, marital/cohabitation status and income level.

Results Within 1 year before death, mean total healthcare costs were €27,185 [95% confidence interval (CI) €26,970–27,401] per patient with non-cancer disease ($n = 109,723$) and €51,348 (95% CI €51,098–51,597) per patient with cancer ($n = 108,889$). The adjusted relative total healthcare costs, i.e. the ratio of the mean costs, of patients with non-cancer diseases was 0.64 (95% CI 0.63–0.66) at 12 months before death and 0.91 (95% CI 0.90–0.92) within 30 days before death compared with patients with cancer.

Mean costs of hospital-based specialist palliative care and hospice in the year leading up to death were €17 (95% CI €13–20) and €90 (95% CI €77–102) per patient with non-cancer disease but €1552 (95% CI €1506–1598) and €3411 (95% CI €3342–3480) per patient with cancer.

Conclusions Within 1 year before death, total healthcare costs, mainly driven by hospital costs, were substantially lower for patients with non-cancer diseases compared with patients with cancer. Moreover, the costs of hospital-based specialist palliative care and hospice were minimal for patients with non-cancer diseases.





Healthcare Costs at the End of Life for Patients with Non-cancer Diseases and Cancer in Denmark

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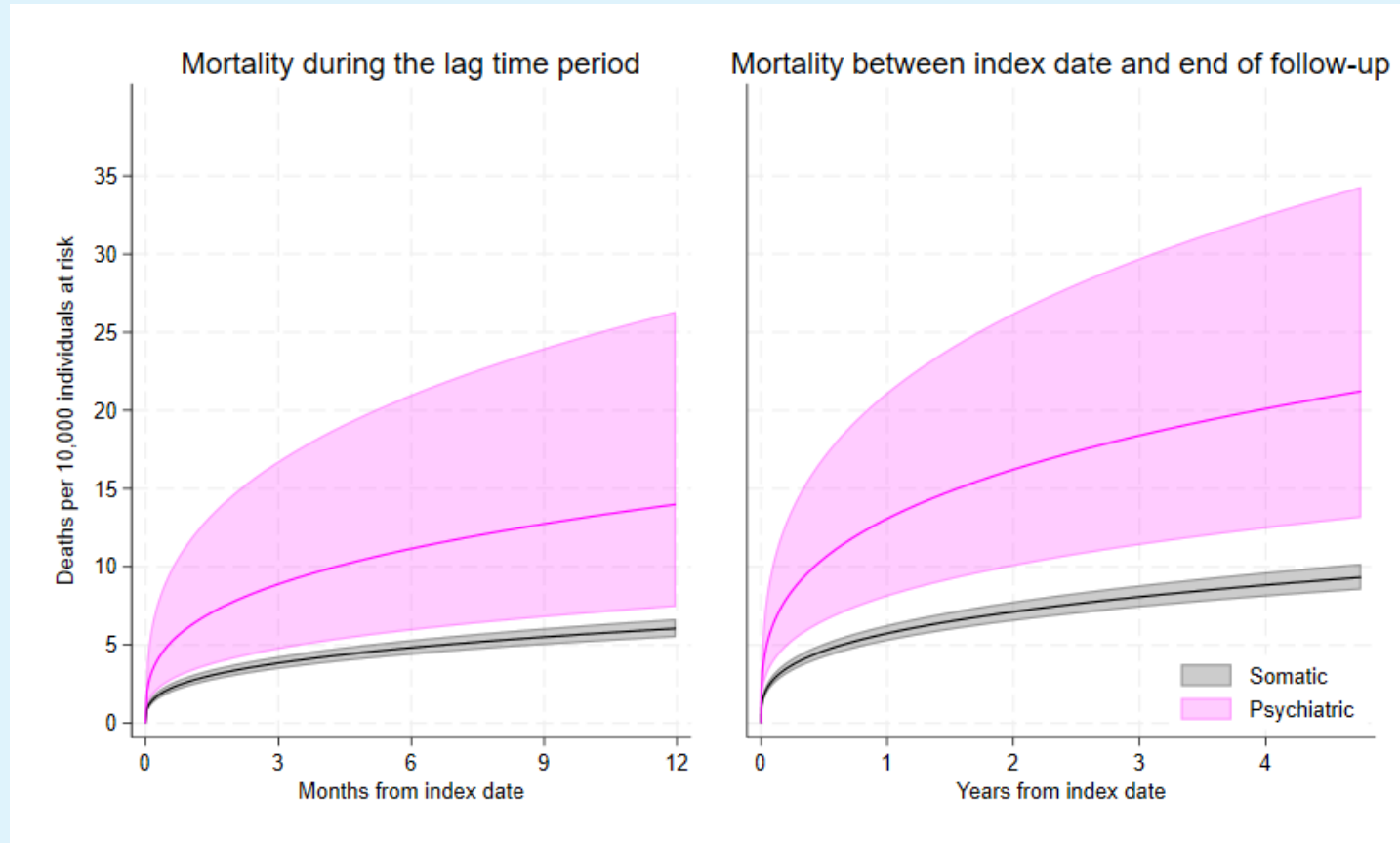
Methods This nationwide registry-based study identified all Danish citizens dying from major non-cancer diseases or cancer in 2010–2016. Applying the cost-of-illness method, we included costs of somatic hospitals, including hospital-based specialist palliative care, primary care, prescription medicine and hospice expressed in 2022 euros. Costs of patients with non-cancer diseases and cancer were compared using regression analyses adjusting for sex, age, comorbidity, residential region, marital/cohabitation status and income level.

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Forskel i dødelighed mellem psykiatriske og somatiske patienter (0-17 år), 2019-2023



Kilde: Lone Graff Stensballe, Andreas Jensen. *Pediatric Somatic and Psychiatric Hospital Contacts in Denmark: A National Overview of Risk Factors, Admissions, and Mortality*. 2025.





Blodprøver med værdi – også for patienterne

Kom til webinar og bliv inspireret til, hvordan vi sammen kan skære ned på unødvendige blodprøver – til gavn for både patienter og sundhedsvæsenet. Du får konkrete eksempler og idéer til, hvordan fagfolk og patienter kan arbejde sammen om at gøre det kloge valg til det oplagte valg.

Tilmeld dig



Gode råd til implementering

Hvordan implementerer man en anbefaling fra Vælg Klogt, så det passer til den lokale kontekst? Det har vi samlet en række gode råd til her.

[Find rådene >](#)



Bliv klogere på Vælg Klogt

Hvordan arbejder Vælg Klogt, hvem står bag, og hvorfor er det nødvendigt med en uafhængig organisation, der udvikler anbefalinger til, hvad sundhedsvæsenet skal undgå?

[Se spørgsmål og svar >](#)





See you in Copenhagen 2018!

The 2018 international Preventing Overdiagnosis conference will be held in Copenhagen, Denmark from August 20 to 22, 2018.

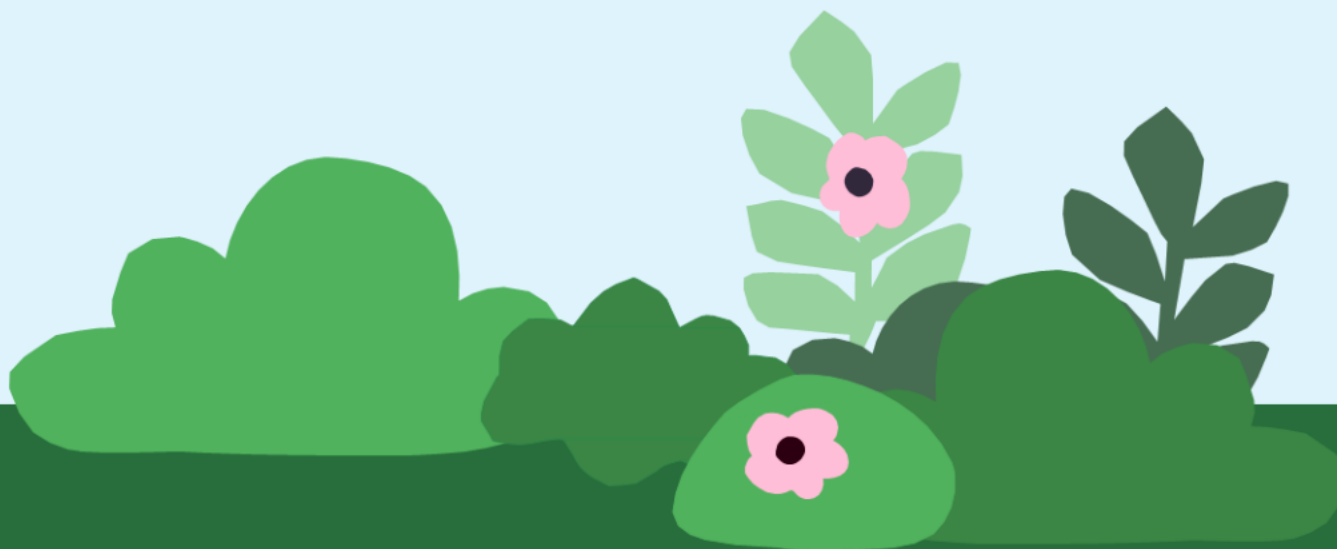
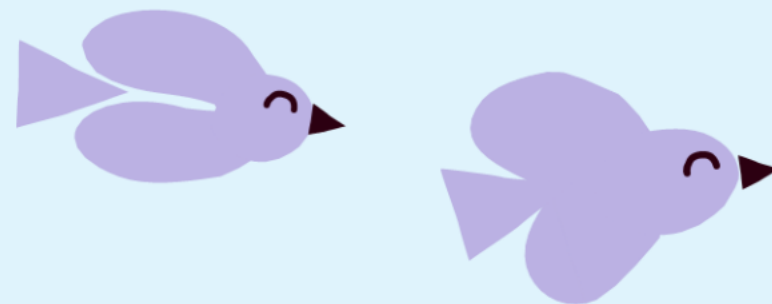
Venue is the Panum Building in Copenhagen.

Save the dates!



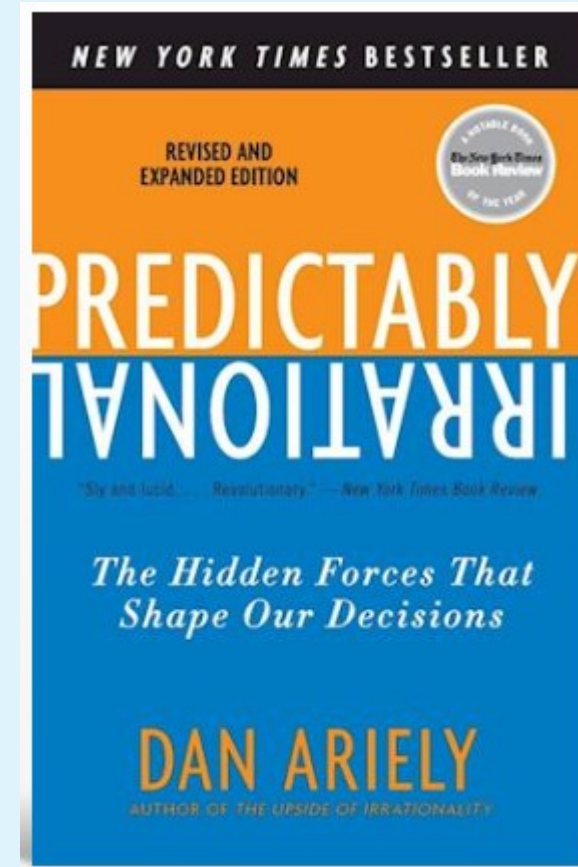
Hospitalernes raske-børn epidemi

Lone Graff Stensballe



Indikation versus andet på spil

- Følelser
- Specialister
- Forsigtighedsprincip
- Fokus fx på infektioner



Ulogiske mønstre

- Børnedødeligheden falder 0.49 (0.36-0.66)
- Antal totale sundhedskontakter stiger minimalt 1.02 (1.02-1.03)
- Antal totale kontakter *falder* for børn med alvorlig, kronisk sygdom 0.94 (0.93-0.94)
- Antal ambulante kontakter stiger 1.62 (1.60-1.63)
- Antal indlæggelser stiger 1.26 (1.24-1.27)
- Antal kontakter med specialister stiger 1.43 (1.42-1.43)
- Antal kontakter med egen læge *falder* 0.82 (0.82-0.82)



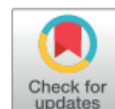
RESEARCH ARTICLE

Too much? Mortality and health service utilisation among Danish children 1999-2016: A register-based study

Andreas Jensen^{1*}, Per Kragh Andersen², John Sahl Andersen³, Gorm Greisen⁴, Lone Graff Stensballe¹

1 Department of Paediatrics and Adolescent Medicine, Rigshospitalet, Copenhagen University Hospital, Copenhagen, Denmark, **2** Section of Biostatistics, Department of Public Health, University of Copenhagen, Copenhagen, Denmark, **3** Section of General Practice, Department of Public Health and Research Unit for General Practice, University of Copenhagen, Copenhagen, Denmark, **4** Department of Neonatology, Rigshospitalet, Copenhagen University Hospital and the University of Copenhagen, Copenhagen, Denmark

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Matcher behov og forbrug?

Behov målt som risiko for død-score

Godt match for

- Totalt antal kontakter
- Indlæggelser > 1 døgn
- Kontakt til egen læge
- Medicinforbrug

Dårligt match for

- Ambulante kontakter
- Kontakter til specialister
- Vacciner

PLOS ONE

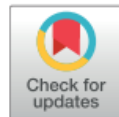
RESEARCH ARTICLE

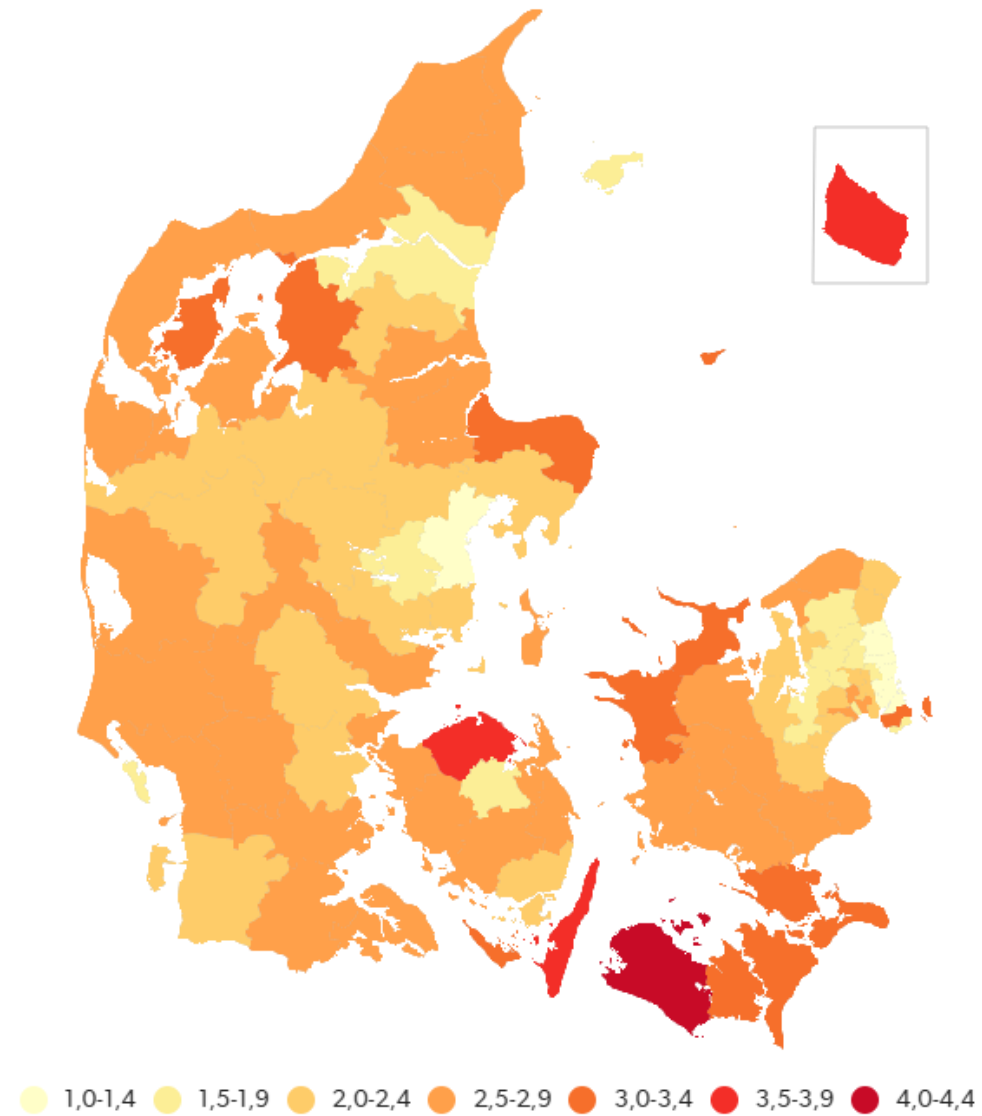
The match between need and use of health services among healthy under-fives in Denmark: A register-based national cohort study

Andreas Jensen^{1*}, Per Kragh Andersen², John Sahl Andersen³, Gorm Greisen⁴, Lone Graff Stensballe¹

1 Department of Paediatrics and Adolescent Medicine, Rigshospitalet, Copenhagen University Hospital, Copenhagen, Denmark, **2** Section of Biostatistics, Department of Public Health, University of Copenhagen, Copenhagen, Denmark, **3** Section of General Practice and Research Unit for General Practice, Department of Public Health, University of Copenhagen, Copenhagen, Denmark, **4** Department of Neonatology, Rigshospitalet, Copenhagen University Hospital and the University of Copenhagen, Denmark

* andreas.jensen.01@regionh.dk





FORKLARING: Tallet er beregnet ud fra det enkelte barns risikofaktorer. I en given kommune viser det, hvor mange gange større risiko et barn har for at miste livet (fra fødslen til fem år) i forhold et barn fra Frederiksberg Kommune, som har den bedste risikoprofil i gennemsnit.

Kilde: Jensen et al., 2020

scientific reports



OPEN

Pediatric health service utilization at tertiary hospitals in Denmark 2000–2018

Pi Vejsig Madsen^{1✉}, Andreas Jensen^{1,2}, Frank Eriksson³ & Lone Graff Stensballe^{1,2,4}

Pediatric health service differs between and within countries. To prioritize limited resources, data-driven studies on pediatric tertiary hospital contacts are warranted. This population-based register study identified all contacts with four Danish tertiary hospitals 2000–2018 by 0–17-year-old patients. During 2000–2018, 2,496,001 individuals resided in Denmark while 0–17 years old, and the study described 829,562 inpatient and 3,932,744 outpatient contacts at tertiary hospitals by hospital, sex, age, diagnosis, department, and residence. Male patients accounted for more contacts overall (inpatient 55.51%, outpatient 52.40%) and more contacts with severe chronic disease (inpatient 56.24%, outpatient 54.41%). Median (interquartile range) patient age was 3.09 (0.26–9.96) and 8.48 (2.78–13.70) years for in- and outpatient contacts. Overall, 28.23% and 21.02% of in- and outpatient contacts included a diagnosis of a severe chronic disease, but the proportions differed across hospitals. A pattern of pediatric healthcare directed towards less severe diseases was observed: While the total number of outpatient visits at tertiary hospitals increased from 2000 to 2018, the proportion of these contacts which had a diagnosis of a severe chronic disease decreased. Future comparisons between hospitals regarding pediatric outcomes should consider potential differences in terms of uptake and diagnosis severity. Such findings may have implications for future pediatric organization, nationally and internationally.

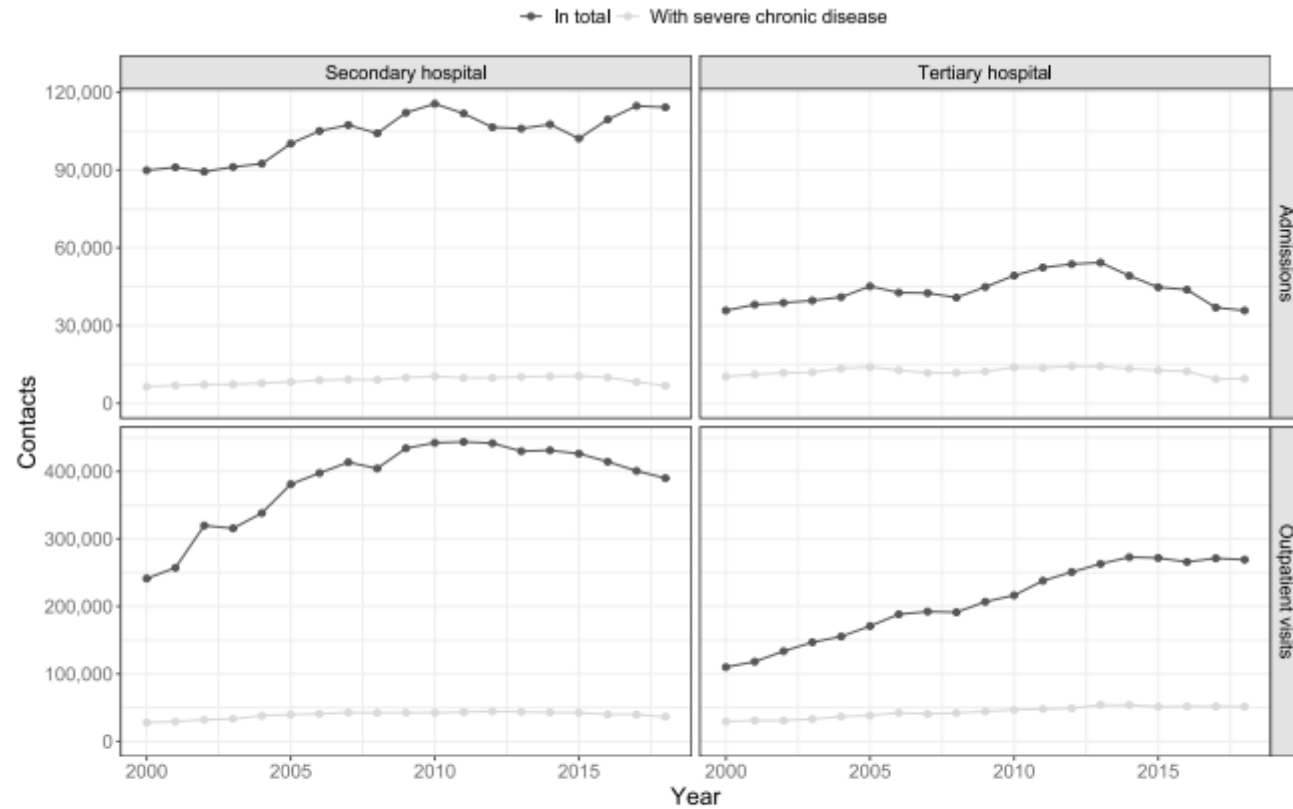
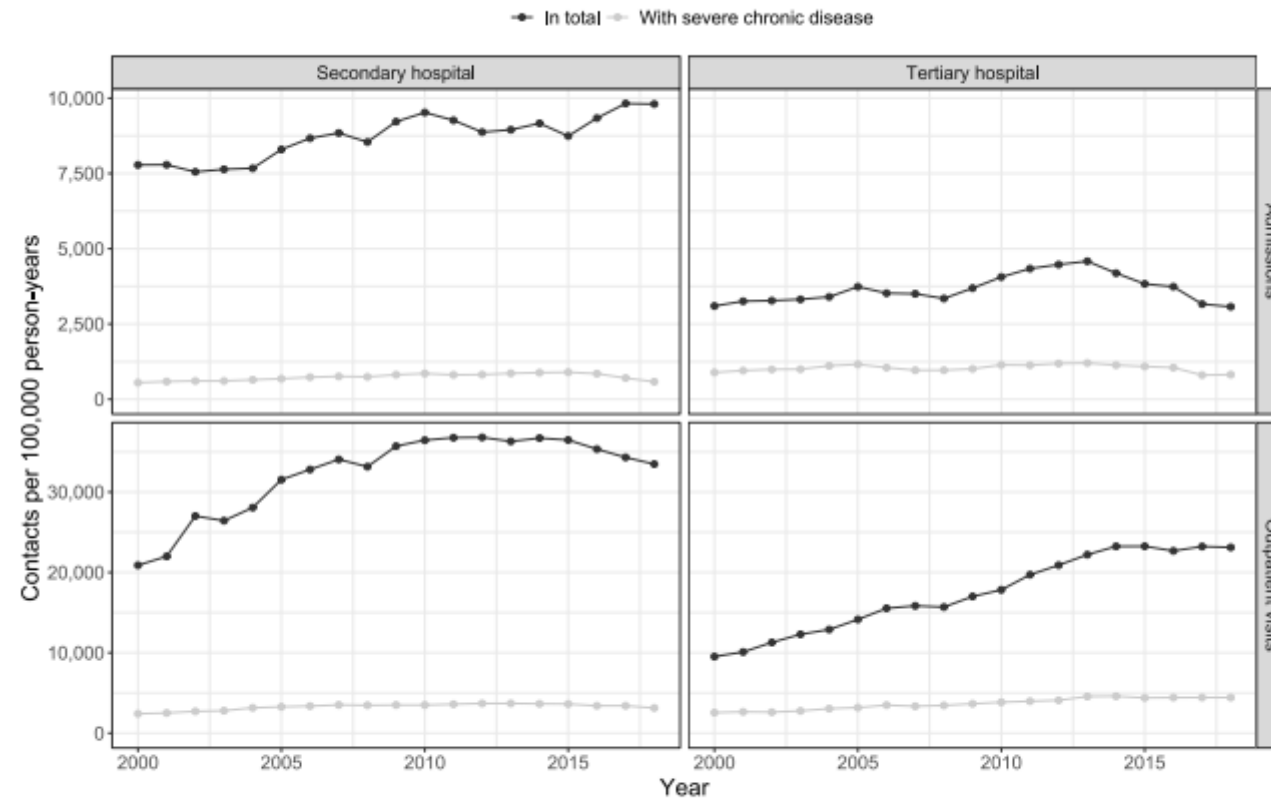


Figure 2. Admissions and outpatient visits at secondary and tertiary hospitals. Contacts starting prior to 2000 are not shown. See Supplementary Fig. S8 for the corresponding incidence rates.

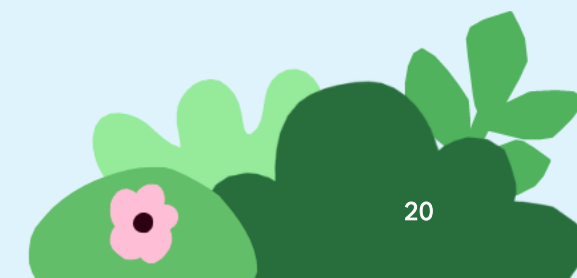


Supplementary Figure S8. Incidence rates of admissions and outpatient visits at secondary and tertiary hospitals. See Supplementary Table S5 for the person-time. Figure 2 shows the corresponding absolute numbers



Supplementary Table S15. The ten most common diagnoses of a severe chronic disease (3-digit ICD-10 code) for admissions. Note that the severe chronic disease is not necessarily the main diagnosis for the admission, and thus admissions can have more than one such diagnosis attached. Percentages are relative to the total number of admissions with a severe chronic disease

	ICD-10		n (%)
For the hospitals combined			
1	C91	Lymphoid leukemia	37,641 (16.07)
2	G40	Epilepsy	13,407 (5.72)
3	Q21	Congenital malformations of cardiac septa	12,138 (5.18)
4	Q62	Congenital obstructive defects of renal pelvis and congenital malformations of ureter	9,168 (3.91)
5	C71	Malignant neoplasm of brain	8,179 (3.49)
6	G80	Cerebral palsy	7,183 (3.07)
7	Q25	Congenital malformations of great arteries	7,103 (3.03)
8	Q37	Cleft palate with cleft lip	5,276 (2.25)
9	Q43	Other congenital malformations of intestine	4,973 (2.12)
10	G91	Hydrocephalus	4,964 (2.12)
For Rigshospitalet			
1	C91	Lymphoid leukemia	16,371 (16.00)
2	Q21	Congenital malformations of cardiac septa	4,763 (4.66)
3	Q37	Cleft palate with cleft lip	4,240 (4.14)
4	G40	Epilepsy	4,112 (4.02)
5	C71	Malignant neoplasm of brain	3,694 (3.61)
6	Q62	Congenital obstructive defects of renal pelvis and congenital malformations of ureter	3,612 (3.53)
7	Q25	Congenital malformations of great arteries	2,767 (2.70)
8	G80	Cerebral palsy	2,618 (2.56)
9	E84	Cystic fibrosis	2,612 (2.55)
10	G91	Hydrocephalus	2,552 (2.49)
For Odense University Hospital			
1	C91	Lymphoid leukemia	4,566 (11.12)
2	G40	Epilepsy	3,710 (9.03)
3	Q21	Congenital malformations of cardiac septa	2,784 (6.78)
4	Q43	Other congenital malformations of intestine	2,471 (6.02)
5	K21	Gastro-esophageal reflux disease	2,284 (5.56)
6	E10	Type 1 diabetes mellitus	1,572 (3.83)
7	G80	Cerebral palsy	1,501 (3.65)
8	Q25	Congenital malformations of great arteries	1,423 (3.46)
9	C71	Malignant neoplasm of brain	1,353 (3.29)
10	Q39	Congenital malformations of esophagus	1,239 (3.02)
For Aarhus University Hospital			
1	C91	Lymphoid leukemia	12,430 (17.68)
2	Q62	Congenital obstructive defects of renal pelvis and congenital malformations of ureter	4,645 (6.61)
3	Q21	Congenital malformations of cardiac septa	3,695 (5.26)
4	G40	Epilepsy	2,835 (4.03)
5	C40	Malignant neoplasm of bone and articular cartilage of limbs	2,662 (3.79)
6	Q25	Congenital malformations of great arteries	2,468 (3.51)
7	C71	Malignant neoplasm of brain	2,320 (3.30)
8	G80	Cerebral palsy	2,098 (2.98)
9	Q05	Spina bifida	1,656 (2.36)
10	Q64	Other congenital malformations of urinary system	1,549 (2.20)
For Aalborg University Hospital			
1	C91	Lymphoid leukemia	4,274 (20.81)
2	G40	Epilepsy	2,750 (13.39)
3	E10	Type 1 diabetes mellitus	1,329 (6.47)
4	G80	Cerebral palsy	966 (4.70)
5	Q21	Congenital malformations of cardiac septa	896 (4.36)
6	C71	Malignant neoplasm of brain	812 (3.95)
7	K50	Crohn disease	691 (3.36)
8	G82	Paraplegia and tetraplegia	565 (2.75)
9	G91	Hydrocephalus	536 (2.61)
10	Q25	Congenital malformations of great arteries	445 (2.17)





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Original article

Impact of COVID-19 on testing, positive cases, patient characteristics, and hospital contacts for respiratory syncytial virus, influenza, and pneumococcus in Danish children



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ABSTRACT

Background: Respiratory infections substantially impact pediatric health. The COVID-19 pandemic introduced widespread non-pharmaceutical interventions, which influenced the incidence of common respiratory infections. This comprehensive study investigates the impact of these interventions on the incidence of respiratory syncytial virus, influenza, and invasive pneumococcal disease in Danish children.

Methods: We conducted a descriptive study based on a cohort of 1,790,464 Danish children from 2012 to 2022. We analyzed data from microbiology tests and hospital contacts to assess infection rates and testing patterns before, during, and after the COVID-19 pandemic. The relationships between testing and sex, age groups, chronic disease status, and hospital contacts were analyzed.

Results: We observed a marked decrease in cases of respiratory syncytial virus, influenza, and pneumococcus disease during the lockdown period. Once restrictions were lifted, there was a substantial resurgence in these infections. The frequency of testing for respiratory pathogens increased over time, with a rising proportion of healthy individuals without underlying chronic disease being tested. The proportion of positive tests linked to hospital contacts varied: there was a notable decline for respiratory syncytial virus and influenza post-lockdown, while pneumococcus cases continued to be strongly linked to hospital contacts.

Conclusion: The study highlights the impact of COVID-19 interventions on the epidemiology of pediatric respiratory infections, revealing a pattern of decreased incidence during lockdowns followed by a resurgence. More tests were carried out among an increasing proportion of healthy individuals. Such changes in testing practices and changing characteristics of tested populations have implications for understanding post-pandemic infection trends and healthcare resource allocation.

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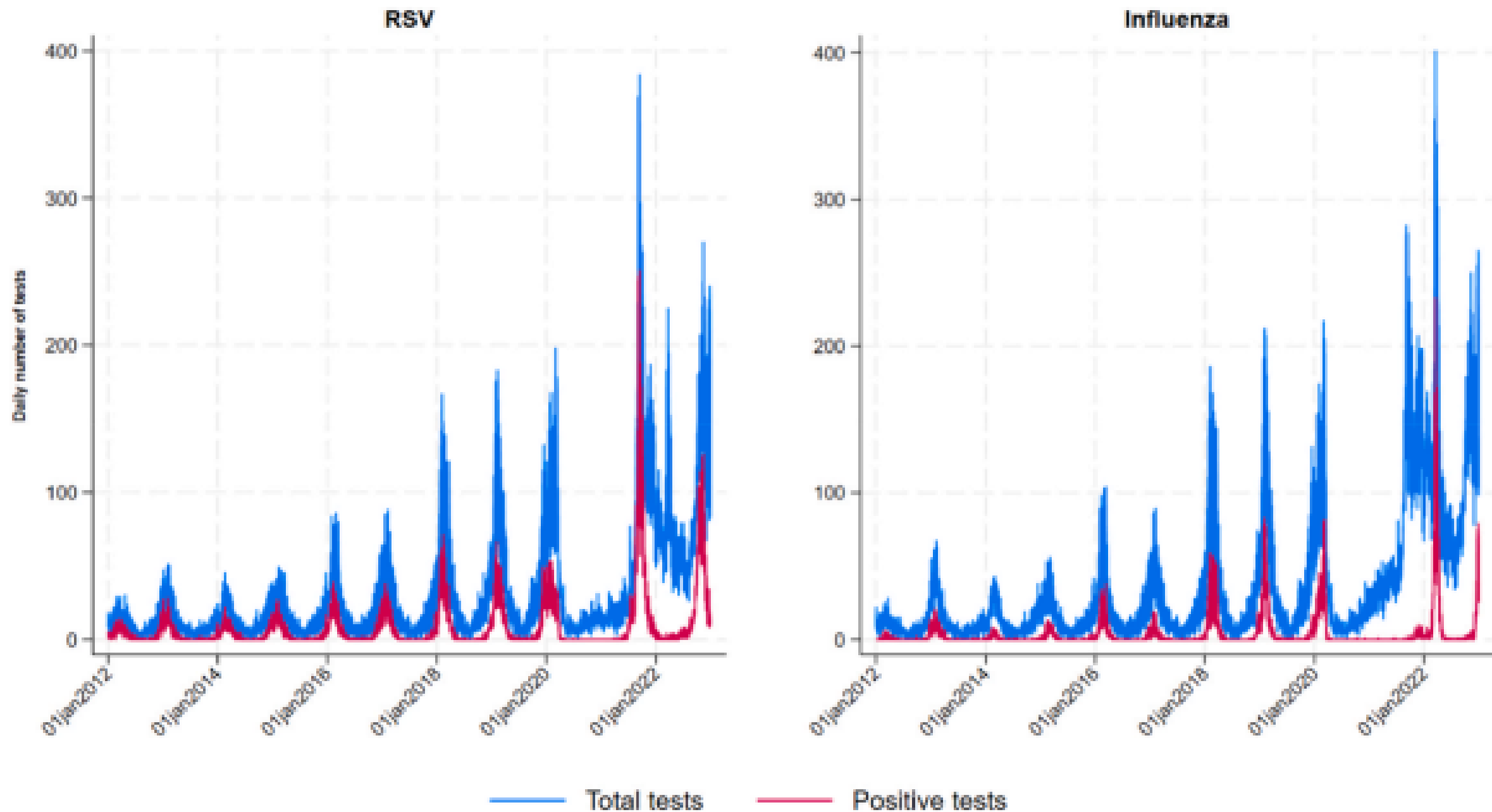


Fig. 6. Daily number of RSV and influenza tests in Danish children aged 0–17 years, 2012–2022.

Ulogiske mønstre

- Mange flere prøver
 - Hvorfor?
- Op mod 30 % af prøverne ikke knyttet til en hospitalskontakt
 - Hvorfor er de taget?
- Antal prøver som ikke er taget ved hospitalskontakt falder
 - Mange flere kommer på hospital og får taget prøven
- Antal korte hospitalskontakter i forbindelse med prøverne stiger
 - Ja, flere kommer kortvarigt på hospital – hvorfor?



Breaking news: Blodprøver 2017-2024

Laboratory and radiological testing in Danish children with and without severe chronic disease, 2017–2024



Blodprøver fordelt på køn



Blodprøver for infektioner stiger



Regionshospital har sparet en halv million blodprøver væk

Mange af os bonner ud med mistænkelige værdier i blodprøver uden grund.



For mange blodprøver viser afvigelser, som der ingen grund er til at bekymre sig om. Hver 20. blodprøve viser den slags afvigelser, og det koster penge i sundhedsvæsenet at undersøge afvigelserne nærmere. Derfor har Sygehusenhed Midt sparet 500.000 blodprøver væk. (Foto: © Henning Bagger, Ritzau Scanpix)

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Af
Steen Færgemand

I dag kl. 08:12

Regionsenhed Midt - der dækker Viborg, Skive og Silkeborg - har siden sommeren 2024 sparet en halv million blodprøver væk.

Radiologi er stabil



RESEARCH ARTICLE

Surgical procedures in Danish children 1999–2018

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Abstract

Objective

To assess if the overall utilisation of surgery in Danish children 0–5 years of age increased in the period 1999–2018 in line with the development within specialised medical services. The epidemiology on surgical procedures is scarce.

Methods

National register-based cohort study of all Danish children born 1994–2018 (n = 1,599,573) using data on surgery in public and private hospitals from The National Patient Register and data on surgery in private specialist practice from The Health Service Register. Incidence rate ratios were calculated using Poisson regression with 1999 as the reference year.

Results

During the study period 115,573 different children (7.2% of the cohort) underwent surgery. The overall incidence of surgical procedures was stable, but the use of surgery increased in neonates mainly due to an increase in frenectomy. Boys underwent more surgery than girls. In children with severe chronic disease the rate of surgery decreased in public hospitals and increased in private specialist practices.

Conclusion

The utilisation of surgical procedures in Danish children 0–5 years of age did not increase from 1999 to 2018. The use of available register data in the present study may inspire surgeons to conduct further studies to enhance the knowledge within the area of surgical procedures.

Kirurgi er også stabil



OPEN ACCESS

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Data Availability Statement: Restrictions imposed by Danish law to protect patient privacy imply that the data sets used in the present study are only available through a trusted third party—in this case Statistics Denmark. Statistics Denmark is a state

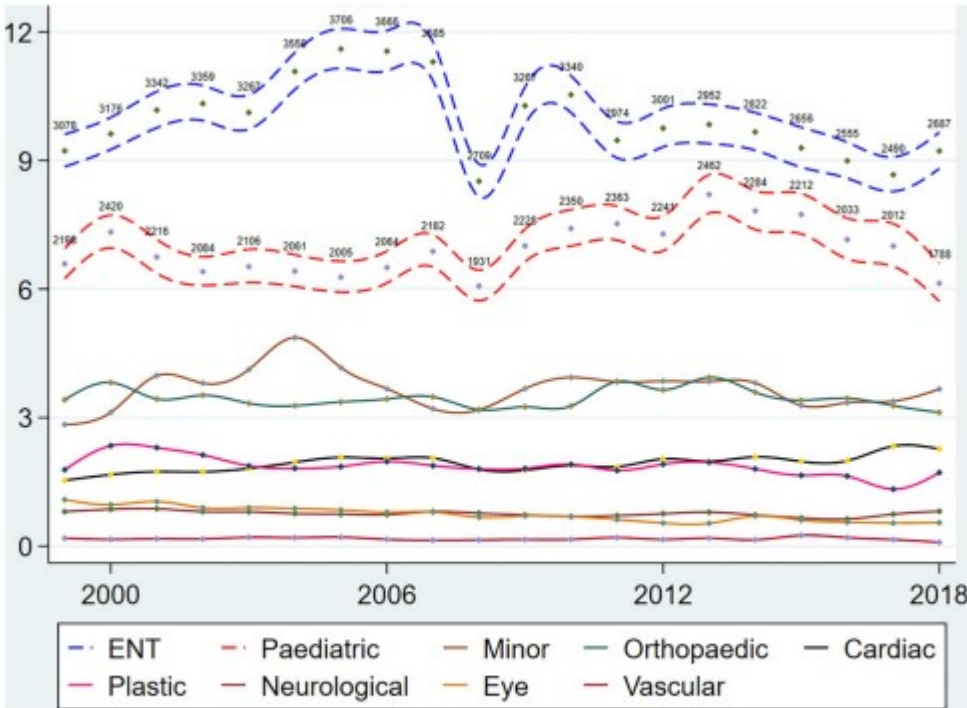


Fig 1. Surgical procedures in public hospitals per 1000 person-years, Danish children 0–5 years of age, 1999–2018. The curves represent the surgical specialties (sorted by incidence in the legend). The 95% pointwise confidence limits and the absolute numbers are only provided for the most frequent procedures to enhance the visual appearance.

Konklusion

- Flere raske børn og unge kommer på hospital og til specialist; færre til egen læge
- Der bliver taget flere mikrobiologiske test og blodprøver for infektion
- Bekymring og forsigtighedsprincip medfører flere prøver
- Forbruget af radiologi og kirurgi hos danske børn og unge er stabile



