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Data on cost of violence and identification of violence victims in Denmark

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Abstract:

Denmark has very good options for identifying victims of violence, because of the variety of register data that can be linked using the social security number. Data on costs can be linked to this information as well, however the cost data are of varying quality.

Using register data (individual-level data) enables us to analyse costs from a bottom-up perspective, ensuring a high degree of precision in the estimates. Also, all register data are at population level, so attrition is minimised.

The existing Danish research on the costs of violence against women applied the attributable cost approach, where victims are matched with a comparable group of non-victims, and their costs are compared. Costs comprise health care costs, productivity costs, costs in the legal system, and shelter costs.

1. Current knowledge in Denmark

Quantitative research on violence in Denmark relies on two sources: registers and surveys. The register based violence research started about 20 years ago with identification of victims via emergency room records (Brink, Bitch, Petersen, & Charles, 2002; Helweg-Larsen & Kruse, 2003). Similarly, questions on violence have been included in national health interview surveys, although with some variations as to the specific instruments used. The latest results on self-reported violence was published 2018 and based on the National Health Interview Survey of 2017 (Deen, Johansen, Møller, & Laursen, 2018).

The costs of violence against women have been the topic of a Danish-language report (Helweg-Larsen, Kruse, Sørensen, & Brønnum-Hansen, 2010) and some scientific papers (Helweg-Larsen & Kruse, 2003; Helweg-Larsen, Sørensen, Brønnum-Hansen, & Kruse, 2011; Kruse, Sørensen, Brønnum-Hansen, & Helweg-Larsen, 2011). The cost assessment has not been repeated on Danish data since then.

2. Available data for identification of victims

2.1 Health care

Emergency room data are among the most used sources for the identification of victims of violence. Registration of ER patients became mandatory in 1995. The registrations of ER contacts are included in the National Patient Register (Lynge, Sandegaard, & Rebolj, 2011) with information on date and time, diagnosis and treatment. Like all Danish registers, the National Patient Register includes the social security number of the patient, enabling linkage across all registers.

Although this data source is of high quality and validity, and covers the entire population, it encompasses a challenge in relation to international comparisons. The X and Y-chapters of the ICD10 classification (which comprise the external causes of injury, e.g. violence) are not used on living patients but only in the causes of death registration. Instead, Danish ER's register a so-called reason-for-contact code, which could be, *inter alia*, disease or illness, violence, or accident. This code is used for identifying victims of violence, which means it relies completely on the cause reported by the patient upon contact to the ER and is not altered by the diagnosing clinician.

2.2 Police data

Victims of violence are identified in registers, mainly the victim register which includes victims of all person-related crime. Perpetrators are identified in the other crime registers: the police reports register, the charges register, the penalty register.

2.3 Shelter data

The Danish National Association of Shelters (LOKK) collects self-reported data from women visiting their shelters. They publish an annual report (LOKK, 2020) with their findings. For a few years, they collected the social security number of their visitors, which would enable a linkage with other registers and easier identification, however, this collection appears to have ended.

2.4 Other sources

Questions on violence have been included in the national health surveys but not regularly. The report (Helweg-Larsen et al., 2010) included data from the 2005 HIS (Ekholm et al., 2007), but violence has been infrequently reported since then.

The causes of death register (Helweg-Larsen, 2011) includes information on primary and other causes of death, ICD10-codes, as well as a 'manner of death'-variable which also includes violence.

3. Costs of violence data

Data on costs are usually deducted from the same sources as the identification. Health care costs in particular are well documented and registered in the health care

registers. Police data are valued using unit costs. In the 2010 report (Helweg-Larsen et al., 2010) these were suggested by a policeman. The report also applied unit costs for shelter data, provided by LOKK.

Generally, the attributable costs of violence are of greater interest than the costs of the actual violence. This means, that victims incur higher costs to the health care sector and the society (productivity costs etc.) because they are victims but not because of the actual violence. The 2010 report adopted the attributable costs approach. Productivity costs are defined as the costs or losses to society because of a health problem. This could be that victims of violence have a lower participation in the labour market, more sickness leave, or that they leave the labour market earlier than non-victims. To assess productivity costs, a comparable comparison group is necessary, because several other factors impact on labour market affiliation. The comparison group was a matched control group (in Helweg-Larsen et al., 2010); such that the impact of other covariates (education, residence, age and marital status, among other things) was minimised.

4. Summary and linkage to Finnish study

In some areas, there are very good Danish data, and it is definitely possible to make a comparative study to the Finnish. In other areas there are some challenges, notably that shelter data can't be linked to other data and that costs for police data and shelter data are assessed using the top-down approach; but Denmark would be able to provide some data in all areas.

The Danish data could be improved if shelter data had social security numbers, such that these data could be linked to other registers, which would provide important knowledge of the trajectories through the system and overlap. The cost of violence computation would be enhanced by bottom-up analyses in all areas.

Recommendations for studies on costs of violence:

1. Use a comparison group, such that unrelated costs are not falsely regarded as costs of violence.
2. Apply a long time horizon, the costs of violence are often incurred at a later stage than the actual violence. Time frame should be 1-2 years as minimum, and analyses comprising effects on children and general health much longer.
3. Self-reported violence is very different from violence recorded by ER's, shelters and police. People who respond to surveys are often quite representative of the background population, while this is not the case for those who seek help. By solely relying on survey data, important aspects relating to inequality would be overlooked.
4. Gender-based violence is important and therefore data for both gender should be collected, to allow for comparison between men and women. More men than women are victims of violence but violence against men is of a different nature (most often by a stranger).

5. However, gender is not the only line along which one can be discriminated against or mistreated. Minorities in terms of colour, religion, disability, sexual orientation, etc. are more often subject to violence than majorities. Although most of these characteristics are not registered, the awareness towards gender-based violence should be expanded to include other characteristics as well.

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