

Health Statistics for the Nordic Countries

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Health Statistics in the Nordic Countries 2013

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Health Statistics in the Nordic Countries

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Symbols used in the tables:

Figures not available or too unreliable for use	..
Information not applicable	.
Less than half of the unit used	0.0/0
Nothing to report (value nil)	-
Five year averages are always written as 20xx-xy	
Two year averages are always written as 20xx/xy	
Data are always calculated in relation to the respective age groups	

Preface

The 2013 version of NOMESCO's Health Statistics in the Nordic Countries is now available.

Since 1966, NOMESCO has worked to promote and publish comparable Nordic health statistics. As a permanent part of the work, this annual publication is published with the latest data in the health area.

Health Statistics in the Nordic Countries presents data concerning population trends, illness, hospital treatment and causes of death. Furthermore, a description of the health sector in the Nordic countries, its structure and resources is provided. Health Statistics in the Nordic Countries consequently provides an annual cross section of the health care areas in the Nordic countries.

This version comprises the latest available data as per the summer of 2013. The latest data year may consequently be 2012 or 2011. Previous versions are available at www.nom-nos.dk, where also our database and more specialized publications from projects carried out by NOMESCO can be found.

As from 2011, the publication will no longer be designated by the latest data year, but instead by the year of production. Therefore the title is Health Statistics in the Nordic Countries 2013.

Nordic Medico-Statistical Committee (NOMESCO), October 2013

Chapter 1

Organization of Health Services

Introduction

In the Nordic countries, the health care sector is a public matter.

All the countries have well-established systems of primary health care. In addition to general medical practitioner services, preventive services have been established for mothers and infants, as well as school health care and dental care for children and young people. Preventive occupational health services and general measures for the protection of the environment have also been established in all the countries.

The countries generally have well-developed hospital sectors with highly advanced specialist treatment.

Specialist medical treatment is also offered outside hospitals.

The health services are provided in accordance with legislation, and they are largely financed by public spending or through statutory health insurance schemes. Some patient charges are, however, payable for pharmaceutical products and to some extent also for treatment.

Salary or cash allowances are payable to employees during illness. Self-employed people have the possibility of insuring themselves against illness.

1.1 Current and future changes in the health care sector

DENMARK: In Denmark, the following has been adopted:

Health reserve agreement for 2013: In October 2012 the Danish government entered into a health reserve agreement with the political parties Venstre, Dansk Folkeparti, Liberal Alliance and Det Konservative Folkeparti. The agreement allocates 228.9 million DKK during the period 2013-2016 to health services for socially marginalized people. 107.3 million DKK of this amount is earmarked for prevention and treatment of mental illnesses - for example to the pilot project on user controlled beds in psychiatry and strengthening of young people's mental health.

An ambitious investment in telemedicine: In August 2012, the government, KL - Kommunernes Landsforening (*Local Government DK*) and Danske Regioner (*Danish Regions*) published a national action plan for the propagation of telemedicine. The plan includes a national dissemination of telemedical wound evaluation and telemedical treatment of citizens with Chronic Obstructive Pulmonary Disease (COPD) in Northern Jutland. At the same time, the government allocated 80 million DKK for the propagation of telemedicine.

Increased equality in dental health care: In connection with the National Budget for 2013 the government, together with Enhedslisten, allocated 180 million DKK for greater equality in dental health care. Thus, people receiving social security, youth benefits etc. can look forward to receiving considerably lower dentist bills.

Establishment of a national emergency medical helicopter practice: In connection with the National Budget for 2013, the government and Enhedslisten allocated 41.4 million DKK in 2013 and 126.7 million DKK in 2014 and onwards to the establishment of a national emergency medical helicopter practice consisting of three emergency medical helicopters manned 24 hours a day. The permanent practice is expected to be put into operation from October 2014.

Diagnosing and treatment guarantee: The government's Act about the implementation of a diagnosing and treatment guarantee was passed in December 2012. The Act introduces a differentiated treatment guarantee, which focuses on the seriously ill, and at the same time it ensures that the patients receive a quick diagnosis, and that patients with symptoms of serious illness are diagnosed within 30 days.

Strengthened patient safety: The government's four Acts regarding strengthening of patient safety was passed in April 2013. The patient safety package consists of four Acts, which provides the Danish Health and Medicines Authority the extra tools to carry out its supervision. Also the rules for marketing of health services are tightened and the monitoring of the market for medical equipment is strengthened.

Health political initiative: In May 2013 the government proposed a health political initiative, 'More citizen, less patient - a strong common health care system'. The government's vision with this initiative is a health care system, which is coherent to the citizen, where the citizen's needs and own prerequisites constitutes the basis of the way in which the health care system works, and where patients and relatives are actively involved in the entire duration, from diagnosing to treatment - and back to the everyday life.

Modernising general practice: In May 2013 the government proposed a bill regarding general practice. The bill is expected to pass in June 2013. One of the purposes of the bill is to ensure that all people have access to a general practitioner in the near vicinity of their home, that all people receive treatment of equally high standard at the general practitioners, and that there is a better cooperation between the general practitioners, hospitals and home health care.

Strengthened municipal prevention: With the financial agreement for 2013, an annual amount of 300 million DKK has been allocated to strengthening the municipalities' work on prevention and every day rehabilitation for the elderly as well as the municipalities' measures regarding the chronically ill.

Future initiatives:

- *Growth plan for health and welfare solutions mid-2013.* With the growth plan for health and welfare solutions the government will create competitive conditions within areas, where we have established positions of strength, including the medicinal and pharmaceutical areas.

- *National objectives for health of the Danes.* The government will set up national objectives for the progress of the Danes' health conditions during the next 10 years and allocates 334 million DKK in the years 2014-2017 for the strengthening of prevention and equality in the entire health care system. The government allocates 120 million DKK in the years 2014-17 to enter into specific partnerships with volunteer associations, private participants and corporate businesses to support the fulfillment of the national objectives.
- *The psychiatry committee.* The committee's task is to offer proposals on how the efforts for the mentally ill can be organised and implemented in the best possible way. Based on these considerations and proposals, the government prepares a comprehensive, long-term plan for the future progress and expansion within the area. The committee's work is expected to be completed mid-2013.
- *Active involvement of patients and relatives.* The government will allocate 20 million DKK during the years 2014-17 to prepare a strategy for patient and relative involvement.
- *Visibility reform.* The government will allocate 32 million DKK for a visibility reform. There must be visibility about the good results and the best practice must be disseminated for the benefit of patients throughout the country.

FAROE ISLANDS: Because of the large increase in the expenditure on medicinal products, this expenditure has been removed from the hospitals' budgets from 1 January 2011 and placed in a special account in the public budget. This account administered by a special committee for medication that will prepare proposals for the Government concerning the use of particularly expensive medicinal products and on which indications.

From 1 January 2011, the maternity ward at Klaksvig Hospital was moved to the National Hospital, so that there are now only two maternity wards in the Faroe Islands, one at Suderø Hospital and the other at the National Hospital.

In January 2011, the new electronic patient record system (EJP) was implemented, so that all three hospitals and all doctors (general practitioners) now use the same system.

On 1 January 2012, a new law on the access to complain about the health care system and to be recompensed entered into force.

In May 2012, the work on a new Faroese health plan was commenced. The purpose of the plan is to reorganize the health system and make the health services more efficient. The work aims at prioritizing preventive measures, increasing activities concerning self-care in connection with chronic illness, a holistic view on the health system as well as taking account of hospitals being staff demanding and therefore of great importance to the local economy. Furthermore, emphasis will be put on the inclusion of all citizens in the treatment. The Danish laws on the health care systems' central administration, the laws on authorised health personnel and on health inspection institutions are still applicable for the Faroe Islands, as the Danish health and authorisations legislation has not yet entered into force for the Faroe Islands.

However, the preparation of applicable health legislation for the Faroe Islands is in progress, and a proposal for a new authorisation law has been sent to hearing and is expected to enter into force in 2013.

GREENLAND: The Greenlandic health service continues its work on the implementation of the rationalization of the health service. The aim of the health reform is to ensure that the health service provides modern services with a focus on community health, and uses economic, technological and staff resources as effectively as possible. It is quite a challenge to provide high quality health services to a small population spread over a large area within realistic financial frames. In several of the health regions, child births have been rationalised, so that they only take place at the regional hospital. The purpose is to ensure adequate quality and section readiness, but the consequence is that the pregnant woman has to go to the regional hospital already 2-3 weeks prior to due date in order to await the delivery.

In May 2012 amendments to the Act on management and organization of the health service, health care personnel and psychologists with a view to creating a legal basis for the Disciplinary Board was passed, and furthermore an appertaining consolidation Act, which forms part of the Danish Patients Ombudsman, taking over the handling of Greenlandic health complaints from patients was passed in September 2012.

In December 2012 a new Act regarding psychiatry was passed. It will come into effect on 1 July 2013.

FINLAND: According to health insurance patients are compensated for parts of the costs for prescribed medicine; the compensation is constituted by a basic compensation and a special compensation. The basic compensation has declined from 42 to 35 %. If a medicinal product has been approved to be included in the special compensations pool, the compensation from *Folkpensionsanstalten* is either 72 or 100 % (per 1. February 2013). The high special compensation rate remains at the previous level, but the low rate has been reduced to 65 %.

The situation for patients with high medical expenses is relieved by a reduction of the annual deductible to 670 Euro. After the expenses limit has been reached the deductible for prescribed medicine amounts to only 1.50 Euro per single purchase.

Prices for medicinal products are lowered, as the whole sales prices for medicinal products, which are not part of the reference price system, are reduced by 5 %. This reduction in medicinal product prices partially compensates the patients for the reduced percentage of damages, as the damages and the deductible are calculated on the basis of the reduced price.

Medical costs are covered even for private doctors' or dentists' fees, and for examinations and treatment prescribed by doctors and dentists. The damages system is simplified, so that in the future damages paid in Euros will be determined for doctors' and dentists' fees as well as for various examinations and treatments instead of the former system which was based on a percentage of the determined rate. With the exception of laboratory and radiological examinations the damages amounts remain at the previous levels.

Based on the medical insurance travel expenses in connection with travels to doctor, hospital or rehabilitation facilities are reimbursed. The patient only pays a de-

ductible per trip. The deductible per trip has been raised by 5 Euro, i.e. from 9.25 Euro to 14.25 Euro. Included in the travel expenses is an annual deductible, equalling the costs for 17 single trips. The expenses limit is still reached on the basis of the expenses for 17 single trips and thus increases from 157.25 Euro to 242.25 Euro.

More information: <http://www.stm.fi/tiedotteet/tiedote/-/view/1841168#sv>

ÅLAND: The work with new regulations according to the new Provincial Act on health care, which came into effect on 1 January 2012, has commenced.

Initiatives to restructure the system and to improve skills within the pre-hospital emergency health care are taking place.

During the fall of 2013 work on changing the tobacco legislation was initiated.

ICELAND: On 1 January 2011 the Ministry of Health and the Ministry of Social Affairs and Social Security were merged and now operate under the name the Ministry of Welfare. On 1. May same year the Directorate of Health (Landlæknisembættið) and the Public Health Institute (Lýðheilsustöð) became one institution. The new Directorate of Health (Embætti landlæknis) is now responsible for prevention, health promotion and public health, guidance and control of the health care system as well as knowledge gathering.

In April 2013 a new agreement on prophylactic dental treatment for children under the age of 18 was signed. Now parents can register their children at a specific dentist, who then will become responsible for regular dentist's appointments, prophylactic and necessary dental care. Payment for children will be determined at a low fee for one annual visit. The agreement will be implemented in seven stages and will comprise all children under the age of 18 in January 2018.

In Iceland a new system on subsidies was introduced on 4 May 2013. The system is similar to subsidy systems in the other Scandinavian countries (Denmark, Norway, and Sweden). According to this system the public has to pay all expenses to medicine up to a certain limit (the subsidy limit). Hereafter the self-payment gradually decreases until annual expenses have reached a certain amount (the annual limit). After this the expenses will be fully covered.

NORWAY: From 1 January 2012 the responsibility for the health and care services in the municipalities are gathered in one law, the law on municipal health and care services etc. (*The Health and Care Services Act*). This law was a replacement of the previous laws, *Law on Health Services in Municipalities* and *Law on Social Services* etc.

In *The Health and Care Services Act* the municipalities is given the obligation to enter into cooperation with the regional health companies.

The local government itself has to make cooperation agreements with the regional health company in the health region or with another specific health company determined by the regional health company. The local government can enter into the agreements alone or together with other local governments.

One of the objectives for this cooperation is its contribution to ensure that patients and service users receive a holistic offer on health and care services.

Furthermore, patient and service user experiences must be part of the assessment basis when preparing the agreement. Patient and service user organisations must also take part in the preparation of the agreements.

As a minimum the agreement has to include the following:

1. agreement on which health and care services tasks the individual administrative levels are required to take responsibility for and a common perception of which initiatives are to be carried out by which party,
2. guidelines for the cooperation regarding admission, discharge, habilitation, rehabilitation, training programs and activity services in order to ensure holistic and coherent health and care services for patients with the need for coordinated services,
3. guidelines for admission to hospital,
4. description of the local government's offer on inpatient emergency assistance
5. guidelines for the cooperation regarding patients, which are ready for discharge and are considered to be in need of municipal services after discharge,
6. guidelines for mutual knowledge and information transfer for professional networks and secondments,
7. cooperation on research, education, internships and apprenticeships,
8. cooperation on midwifery services,
9. cooperation on local IKT-solutions,
10. cooperation on prevention and
11. agreed contingency plans and plans for the emergency medical chain

An agreement on how to organize and finance the cooperation should be established.

According to the law, the municipalities are also responsible for the funding in connection with patients ready for discharge:

The municipality is obligated from day one to cover expenses for patients who are ready for discharge, but are residing in a private or public institution under the specialist health care services, pending a municipal health and care services offer. The municipality must enter into a cooperation agreement with regional health companies for discharge ready patients.

SWEDEN: The government has presented a strategy for the years 2012-16 for the strengthening of equality in health care. The government will follow the development in health care, account for the differences and make them visible. Special priority is given to areas with major challenges such as availability, increased patient influence, health promotion and prevention, specialist skills, pharmaceutical products as well as care related to cancer, cardiovascular diseases, mental illnesses, substance abuse and addiction, and dental care. In particular, differences in health care, when it comes to care and treatment of different sections of the population

are emphasised. Equality in health care means that treatment and care must be offered on equal terms to all persons regardless of their personal characteristics, residence, age, sex, disability, education, social status, ethnic or religious affiliation or sexual orientation.

The Health and Social Care Inspectorate (IVO) was established on 1. June 2013 and then took over the supervising and licensing activities from The National Board of Health and Welfare. In order to strengthen the supervision within health care and social services the government has initiated a new supervising authority.

The Government will appoint a special investigator to review the donation and transplantation issues. The purpose of the investigation is to ensure the continued functioning of donation and transplantation activities in Sweden and enable an increased number of donors and organs available. A new Act (2013:407) which came into effect on 1. July 2013 gives foreigners living in Sweden without the necessary permissions the same rights to receive health care and dental treatment as asylum seekers. The Act entitles undocumented persons to receive health care and dental treatment, provided that it is urgent. This concept includes all health care and dental treatment which is deemed to be of the utmost urgency, but also includes the cases where a slight delay may cause serious consequences and subsequently a more comprehensive course of treatment for the individual.

1.2 Organization and responsibility for the health sector

DENMARK: The responsibility for the health services is relatively decentralized. The main principles are as follows: The State is responsible for legislation, supervision and guidelines. The regions are responsible for hospital services, health insurance and special nursing homes. The municipalities are responsible for primary health care, home nursing, prevention, rehabilitation after hospitalization and child and school health services. The regional authorities have operational responsibility for the health services.

- In principle, primary contact shall always be with a general medical practitioner
- Dental services are provided by private dental practitioners. The services are only a public matter in some dental care services for children
- Health care during pregnancy is the responsibility of the regions
- Child health care is provided according to the Act Relating to Health Visitors and is administered by the municipalities, while health examinations of children are carried out by general medical practitioners
- Home nursing care is provided by the municipalities and is free of charge after referral by a physician
- School and occupational health services are regulated by legislation. Municipalities are responsible for school health services, which are provided by health visitors and physicians
- Occupational health services are organized by companies and are led by committees with representatives for both employees and employers

- **Contact with the health services:** As a main rule, patients may contact general medical practitioners, dentists, chiropractors, physiotherapists, chiropractors, psychologists, dental hygienists, emergency wards and emergency and ambulance services without referral
- **Public hospitals:** Public hospitals are owned by the regions
- **Private hospitals:** The regions have a contract with some private hospitals to provide treatment under the extended free choice of hospital arrangement. A few private hospitals operate totally independently of the public hospital services. Some specialized hospitals are organized under the hospitals, while others are owned by organizations
- **Free choice of hospital:** As a rule, patients are free to choose the hospital where they wish to receive treatment
- **Practicing specialists:** Most practicing specialist physicians work under a contract with the health insurance scheme, and most of their patients are referred from general medical practitioners
- **Nursing homes:** Ordinary nursing homes are run by the municipalities, but there are many private (independent) nursing homes, which receive residents according to a contract with the municipality in which they are located. Certain specialized nursing homes are run by the regions, for example psychiatric nursing homes
- **Pharmacies** are organized as private companies, but are subject to government regulation. The state regulates the number and the geographical location of pharmacies, their tasks and the profit margin on pharmaceutical products

FAROE ISLANDS: The Home Government of the Faroe Islands lays down the rules concerning the tasks, benefits and administration of the health service. The organization of the hospital services, specialist fields and primary health services largely follows the Danish system. The same applies to nursing homes, home nursing services and home help as well as dental treatment.

Hospital services are run by the Home Government of the Faroe Islands, which defrays all expenditure on the operation and maintenance.

All practising physicians are public employees, but they are mainly remunerated by the public health insurance scheme. They are administered by both the municipal authorities and the state authorities.

The midwifery service is organized under the hospital services.

Physiotherapy services are provided by the public hospital sector and by privately practising physiotherapists.

Pharmacies are run by the public authorities.

GRØNLAND: Health services are organized according to a relatively simple system.

The main principles are as follows:

- The Ministry of Health and Infrastructure is responsible for legislation and overall management.

- The Chief Medical Officer is responsible for supervision of health services and for developing health care guidelines
- The health authorities together with the regional managements are responsible for running the health services. This includes the primary health services, specialized health services, distribution of pharmaceutical products, nursing, home nursing services in some districts, home mental health care, preventive services, rehabilitation and child and school health services
- The municipalities are responsible for home nursing services, preventive services and nursing homes
- In principle, primary contact shall always be with the regional hospital, local health centres, or with the medical practitioner clinic in Nuuk
- Dental services are provided in public dental clinics. There are some private dentists with no reimbursement arrangement
- Antenatal care is the responsibility of the health authority
- Child health services and health check-ups for children are provided by the health authority
- Home nursing services are provided by the health authority in most municipalities and by the municipal health authority in some municipalities
- School health services are provided by the health services

There are no occupational health services in Greenland.

Contact with the health service: As a general rule, patients may contact regional hospital, local health centres, the medical practitioner clinic in Nuuk, dental clinics and the ambulance service without a referral.

Public hospitals: Greenland's Home Government owns the public hospitals.

Private hospitals: There are no private hospitals in Greenland.

Specialized hospitals: There are no specialized hospitals in Greenland.

Free choice of hospital: There is no free choice of hospital in Greenland. Patients are referred by the regional hospital or local health centres to treatment at Dronning Ingrid's Hospital (the National Hospital). The Referral Committee refers patients to treatment in hospitals outside Greenland.

- All obstetric services are organised under a joint obstetric management that has overall responsibility. With the help of patient records that are sent in, and with consultations locally, they decide which births shall be referred to special wards. In several of the health regions, child births have been rationalised, so that they only take place at the regional hospital. The purpose is to ensure adequate quality and section readiness, but the consequence is that the pregnant woman has to go to the regional hospital already 2-3 weeks prior to due date in order to await the delivery.

Practising specialists: There are no practising specialists in Greenland.

Nursing homes: Nursing homes are run by the municipalities. There are no private nursing homes or specialized nursing homes in Greenland.

A National Pharmacy has been established in Nuuk, with a National Pharmacist, with countrywide functions related to import, distribution and sale of pharmaceutical products. The National Pharmacy prepare statistics about pharmaceutical products, prices of non-prescription drugs, revision of the range of non-prescription drugs, licences to retail businesses, guidelines for people responsible for pharmaceutical services as well as inspection of pharmaceutical stores **in the health care system**.

The National Pharmacy is the secretariat for the Pharmaceutical Committee, which has authorization to approve new pharmaceutical products. It gives advice about use of pharmaceutical products and recommends pharmaceutical products for use in Greenland.

Medicines are free of charge and are dispensed by the health services. There is a small selection of non-prescription medicines.

FINLAND: Municipalities are responsible for health services. The Health Care Act (1326/2011) is applied to the provisions of the health care and nursing services for which the municipalities are responsible according to the Public Health Act (66/1972) and the Specialist Treatment of Diseases Act (1062/1989). Health care includes health and welfare promoting measures, primary care and specialized nursing, and the municipalities are responsible for:

- Guidance and preventive health care, including children's health, health education, counselling concerning contraceptive measures and health surveys and screening
- Medical treatment, including examination and care, medical rehabilitation and first aid. General medical treatment is provided in health care centres, in inpatient wards or as home nursing

With the exception of emergency cases, patients shall be examined and treated within a given time. Patients shall be able to obtain immediate contact with a health care centre on weekdays within normal working hours and shall also have the option of visiting the health care centre. If an appointment at a health care centre is deemed necessary, patients shall be given an appointment within three working days from the time of contact with the health care centre. Normally, treatment is provided at the health care centre immediately at the first visit. Treatment that is not provided at the visit shall be started within three months. In cases where health care centres provide specialized treatment, the same time-limits shall apply as those applying for specialized health services, i.e. six months.

The need for treatment shall be assessed within three weeks after referral to a hospital. If a physician has examined a patient and has established that treatment is needed, such treatment shall be started within six months.

Children and young people shall receive psychiatric treatment within three months if it is assessed to be necessary.

Dental treatment that is assessed to be necessary shall be started within a reasonable time and at the latest within six months.

If a patient's own health care centre or hospital cannot provide treatment within the given time, the patient shall be offered treatment either in another municipality or at a private institution, without extra cost to the patient.

The municipalities must provide services for people with mental illness that can reasonably be offered in health care centres.

Dental care includes information and prevention, dental examination and treatment. Dental care and treatment paid by the health insurance scheme is provided for the entire population. Dental care is also provided for adults in health care centres, particularly in rural municipalities. Most dental treatment for adults is provided by dentists in private practices. Young people under the age of 18 are entitled to dental care free of charge.

Municipalities are also required to provide ambulance services and to ensure that occupational health services are established. Employers can either organize their occupational health service themselves or they can enter into an agreement with a health care centre or with others who provide occupational health services.

In many municipalities, social welfare and health services have been integrated in recent years.

Physicians working in health care centres are usually general practitioners. In the public health service system, patients need a referral to specialist treatment, except in emergency cases. In private clinics, the physicians are mostly specialists. Patients need no referral to visit these private specialists. Physicians working in private clinics can refer their patients either to public or private hospitals.

Specialised central and regional hospitals are run by municipal boards. Within mental health care, more and more emphasis is placed on outpatient treatment, and the use of institutions is decreasing.

Municipalities are responsible for providing health and social services for elderly people. These services include measures to make it possible for elderly people to continue living in their own homes, for example home help and home nursing, day care services and sheltered housing (mainly social services). In the health care sector, support for people to live in their own homes is provided through home nursing services, short-term and periodic stays and treatment in nursing homes and day care in hospitals. Health services for elderly people also include primary medical care, prevention and rehabilitation. Long-term treatment and residential care for the elderly is provided in old people's homes and nursing homes.

Pharmacies are private, but under state supervision. Prescription drugs and over-the-counter drugs can only be sold by pharmacies.

ÅLAND: Due to its home rule, Åland has its own legislation for the health sector, except for administrative interventions in personal freedom, contagious diseases, sterilization, induced abortion, assisted reproduction, forensic medicine as well as private health care.

The tasks, structure and organization of the public health sector are regulated according to the Health Sector Act (2011). Issues that do not fall under the Åland legislation follow Finnish legislation.

The whole public health service falls under an overall organization called Åland's Health Care Organization (ÅHS). The organization is governed by a politically elected board.

The Åland Government has the overall responsibility for ensuring that the population receives necessary medical care. Primary health services and specialized health services are part of the same organization, ÅHS. In principle, the first contact shall be with the primary health service.

Services that cannot be provided locally are bought from Finland or Sweden, either from private practitioners, private institutions or university hospitals.

The Åland hospitals are specialized institutions that provide both outpatient and inpatient treatment.

Specialists working outside the hospitals can act as consultants for the public primary health care and for private general practitioners.

The structure of the primary health care corresponds functionally and ideologically to the Finnish public health care system. Counselling concerning contraception and for mothers and infants as well as school and student health services function as in Finland. Immunization programmes are voluntary and the recommendations are as in Finland. Physiotherapy under the ÅHS is a shared function both for the primary health service and the hospitals. In addition, a number of private physiotherapists are used by the public sector.

Occupational health services are organized in the same way as in Finland.

The public dental care system is providing for children and young people as well for patient groups that have priority on medical and social grounds. The private sector is well established with a high capacity and provides an important supplement.

Regulations for pharmacies are the same as in Finland.

ICELAND: The responsibility for the health care system is based on a relatively centralized organization. The main principles are as follows:

The Parliament, *Altinget*, is responsible for legislation, but the Ministry of Welfare is responsible for supervision and guidelines.

The health centres take care of the primary health services which comprise prevention and general treatment. Preventive measures include infants, mothers, school health programs, immunization, family planning etc. Home nursing also belong to the health centres' responsibility, while home care is provided through the municipal social service system. The primary contact should always be directed to the health centres.

Specialist medical treatment is largely carried out by specialist general practitioners under contract with the Health Insurance. However, the last collective agreement expired on 1. May 2011 and so far negotiations have not been successful. Therefore the specialists now work without a collective agreement. Specialists are mainly found in densely populated areas but they also serve health centres in small towns. Specialist treatment is also offered at the outpatient clinics at hospitals.

There are three types of hospitals: 1) specialised hospitals 2) regional hospital with some specialisation and 3) a number of local hospitals. Also the local hospitals mostly work as retirement and nursing homes.

In general, patients can go to the specialists, dentists, emergency rooms as well as emergency and ambulance services without referral.

Rehabilitation hospitals and alcohol clinics are independent institutions, but are partly financed by the state.

Dental treatment is carried out at private dentists' practices.

Some part of physiotherapeutic treatment is carried out through the health centres, but most of the treatment is handled by private practitioners in the urban areas. Private practitioners within physiotherapy work under contract with the Health Insurance.

Most retirement and nursing homes are independent institutions. They are run by municipalities, voluntary organizations and the like. They are financed partially by user charges, but the main part of the funding comes from the state. Retirement homes are funded through pension insurance, and nursing homes through the Health Insurance.

Occupational health services are organized by companies and led by committees with representatives of both workers and employers.

Pharmacies are organized by profession, but are also subject to regulation. Municipalities have the right to comment on the location of pharmacies but the government regulates their functions and medicinal product profits both at the wholesale and pharmacy level.

NORGE: The system of health care provision in Norway is based on a decentralized model.

The State is responsible for:

- Health care policies, capacity and quality of health care through budgeting, legislation and professional guidelines (e.g. for prioritization)
- Hospital services through State ownership of regional health authorities. Within the regional health authorities, somatic and psychiatric hospitals and some hospital pharmacies are organized as health trusts

The municipalities are responsible for:

- General practitioner services, including a regular general practitioner scheme
- Acute medical care
- Physiotherapy services
- Nursing services, including the health visitor service and the home nursing service
- Maternity services
- Nursing homes and other types of residential care
- Medical emergency call service
- Transport services for health care personnel (Municipal Health Services Act)

The county authorities are responsible for:

- Dental care services for children and adolescents, mentally disabled adults as well as the elderly, the long-term ill and the disabled who live in institutions or who receive home nursing.

Private health services:

- Dental services for adults are mainly provided by private dentists and paid for by the patients
- Occupational health services: Some large companies have their own private services. Some companies have a joint arrangement with an occupational health services company, which sells occupational health services
- Pharmacies are mainly privately owned, but are subject to strict public control
- Some private hospitals have an agreement with the region, and other private hospitals are run completely independently of the public health services
- Private nursing homes provide care for residents according to an agreement with the municipalities
- Some privately partitioning specialists have a contract with the regional health businesses and receive most of their patients by referral from a general practitioner. Others work completely independently.

Contact with health services: Patients can see general practitioners, dentists and emergency services without a referral.

Free choice of hospital: Patients who are referred to hospital have the right to choose which hospital they wish to go to.

SWEDEN: In the Swedish health care system, responsibility for health services is divided among the State, the county authorities and the municipal authorities. The State has overall responsibility for health policy.

The Health and Medical Service Act (Hälso- och sjukvårdslagen, HSL) lays down the division of responsibility for health services between the county authorities and the municipal authorities. The Act gives the county authorities and the municipal authorities a great deal of freedom as to how to organize health services.

Sweden is divided into 290 municipalities and 20 county councils. Skåne, Halland and Västra Götaland are formally counties but with an extended responsibility for regional development and with a right to call themselves regions. Gotland, an island in the Baltic Sea, is a municipality with the responsibilities and tasks normally associated with a county as well as regional development responsibility and is also entitled to be called a region.

The activities of the county councils are mainly financed by county taxes and also through state grants. Patient charges and other patient contributions make up a small part of the income of the county councils.

The county authorities have responsibility for organizing health services to ensure that all inhabitants have equal access to sound and adequate services.

The county authorities also have a duty to provide dental care for children and young people up to the age of 20.

The municipalities have responsibility for health services for elderly people in institutions and for school health services.

In 2005, a treatment guarantee was introduced. This means that patients have the right to:

- Obtain contact with the primary health service on the same day
- Get an appointment with a GP within seven days
- Get an appointment with the specialized health service within 90 days, either with a referral or on their own initiative, and
- Get treatment within 90 days after a decision has been made about treatment

The treatment guarantee for mental health services for children and young people is enhanced. A youth seeking help from the mental health service shall be contacted by telephone or personally on the same day and be given an appointment with a doctor within seven days. The youth shall also be given an appointment with a specialist in child psychiatry within 30 days, and treatment must be started within the next 30 days.

The Medical Products Agency has responsibility for approving and controlling medicinal products, herbal medicines and medical equipment.

The Dental and Pharmaceutical Benefits Agency (TLV) is a state authority whose remit is to determine which medicinal products and dental treatment shall be subsidized by the State.

Since 1 July 2009, it is possible for companies other than Apoteket AB to run a pharmacy. Retail sales outlets for medicinal products must apply for a licence from the Medical Products Agency. Retail sales outlets can buy and sell imported medicinal products at lower prices. Health service providers are responsible for ensuring that use of medicinal products is organized effectively and that hospitals are supplied with safe and effective medicinal products. For example, hospitals shall have a hospital pharmacy.

Decisions about which vaccinations shall be included in the national immunization programme are taken by the National Board of Health and Welfare in consultation with the Swedish Institute for Infectious Disease Control and the Medical Products Agency.

The Swedish Institute for Infectious Disease Control is a national authority with responsibility for control of infectious diseases and with a public health perspective.

The Swedish Council on Health Technology (SBU) is a state authority that examines the methods used by health services. It aims to identify interventions that offer the greatest benefits for patients while utilizing resources in the most efficient way. The aim is to provide a better knowledge base for everyone who makes decisions about how health care shall be organized.

1.3 Supervision of health services and health care personnel

In Denmark, supervision of health services is carried out by the National Board of Health with the assistance of the Chief Medical Officers from each region. These institutions are part of the National Board of Health and are thus independent, politically and administratively, of the regional and municipal health authorities. In this way, the Chief Medical Officers work as independent advisers and supervisors at all levels. Supervision of health care personnel and their professional activities is carried out by the National Board of Health in close cooperation with the local Chief Medical Officers. Decisions concerning individuals can be appealed to the responsible minister and, if necessary, to the courts.

In the Faroe Islands, the Chief Medical Officer, who is employed by the Danish Ministry of Health, shares the responsibility with the Danish Board of Health for supervision of health services. The Chief Medical Officer is the consultant to Faroese and Danish authorities regarding health matters. The Chief Medical Officer is an independent institution under the Government of Greenland and is responsible for supervision of health services in Greenland. The Chief Medical Officer advises and assists the Government of Greenland and other authorities in questions of health.

Supervision of health services in Finland is organized in a less formal way than in the other Nordic countries. Supervisory tasks are spread out in the whole health services system. A nationwide body for the protection of patients' rights has been established. The body may assess whether the services provided by a municipality are up to the required standards. If the body finds that the services are inadequate, and that the municipality is responsible for this, it may recommend how the deficiencies may be dealt with and give a time limit for when improvements shall be made.

Supervision of health care personnel in Åland is carried out according to Finnish law.

In Iceland, The Directorate of Health carries out the overall supervision of health institutions, health care personnel, prescription of pharmaceutical products, measures for combating substance abuse and control of all public health services. The Icelandic Medicines Agency carries out advisory and supervising tasks regarding pharmaceutical products to pharmacies, pharmaceutical companies and the public.

In Norway, the Norwegian Board of Health Supervision (centrally) and the supervisory authorities in each county are responsible for supervision of health services and health care personnel. These bodies are professional and independent supervisory authorities, with authority through explicit legislation and competence in the fields of health services and health legislation.

In Sweden, the Health and Social Care Inspectorate (IVO) is the national supervising authority for social services as well as for health services. The purpose of the supervision is to ensure that the citizens receive social care and health care which is safe, is of good quality and is carried out in accordance with existing laws and regulations. The Inspectorate's work also include presenting the supervised companies with the

results of the supervision, to provide feedback, advice and guidance regarding the supervision as well as to ensure that discrepancies and irregularities are corrected.

1.4 Complaints about health services and health care personnel

DENMARK: The Patients' Complaints Board for the health sector deals with complaints concerning authorized health care personnel. Following preliminary treatment of the cases (hearings of the parties, professional assessment, etc.) by the Chief Medical Officer, a final decision is reached by the Patients' Complaints Board.

FAROE ISLANDS: The Chief Medical Officer and the Danish National Agency for Patients' Rights and Complaints jointly handle complaints concerning the work of authorized health care personnel. The National Agency for Patients' Rights and Complaints makes the final decisions.

GREENLAND: Complaints concerning health issues must be addressed in writing to the National Board of Health, which prepares the case and make recommendations to a decision on the complaint. Hereafter the cases are sent to the Danish Patients' Complaints Board. The Disciplinary Board decides the cases. Complaints concerning services are submitted to the Health Management, and questions concerning compensation are dealt with by the Directorate of Health and Infrastructure.

FINLAND: Patients have several options when wanting to complain about the treatment or services they have received. The simplest way is to express dissatisfaction to the physician who provided the treatment, or to contact the physician in charge of the hospital department or health care centre. If further assistance is needed in order to solve the problem, there are two possibilities. The patient can contact either the Regional State Administrative Agency or the National Supervisory Authority for Welfare and Health (VALVIRA). Both these bodies can give a written expert opinion, or give sanctions if necessary.

ÅLAND: Complaints concerning treatment must, as in Finland, be addressed to the institution providing the treatment, or to the national authorities, or to the Åland Government. The Patient Ombudsman is employed by the Åland Government and is thus independent of the respective treatment institutions. The Patient Ombudsman may take up questions of principal significance with the "Patients Board of Trust" where the questions may be discussed and form the basis for decisions, although the Board cannot make a decision in individual cases.

ISLAND: Complaints regarding health services are sent to the Health Directorate, which will evaluate the complaints and decide their rightfulness. Decisions made by the Health Directorate can be appealed to the Ministry of Welfare.

NORWAY: The Norwegian Board of Health Supervision in the counties deals with complaints against individual health care personnel. These offices may find that the conditions laid down in laws and regulations have not been met and can give advice on how to make improvements. If there are grounds for more serious sanctions against health care personnel, the complaint may be forwarded to the Norwegian

Board of Health Supervision (centrally). Patients can also send their complaints to the person in charge of an institution (e.g. the municipal board in the case of municipal health services), or to the Norwegian System for Compensation for Injuries to Patients, in the case of claims for compensation related to treatment in the public health service.

SWEDEN: The Health and Social Care Inspectorate (IVO) is the authority handling consumer complaints regarding care.

Service providers now have clearer responsibilities according to the new Act for systematically improving patient safety. This includes the responsibility for investigating adverse events, to have health care personnel with the necessary qualifications, and to identify deficiencies in the service in order to prevent adverse events.

Chapter 2

Population and fertility

Introduction

This chapter begins with a general description of the population in the Nordic countries followed by a more detailed description of fertility, births, infant mortality and contraceptive methods.

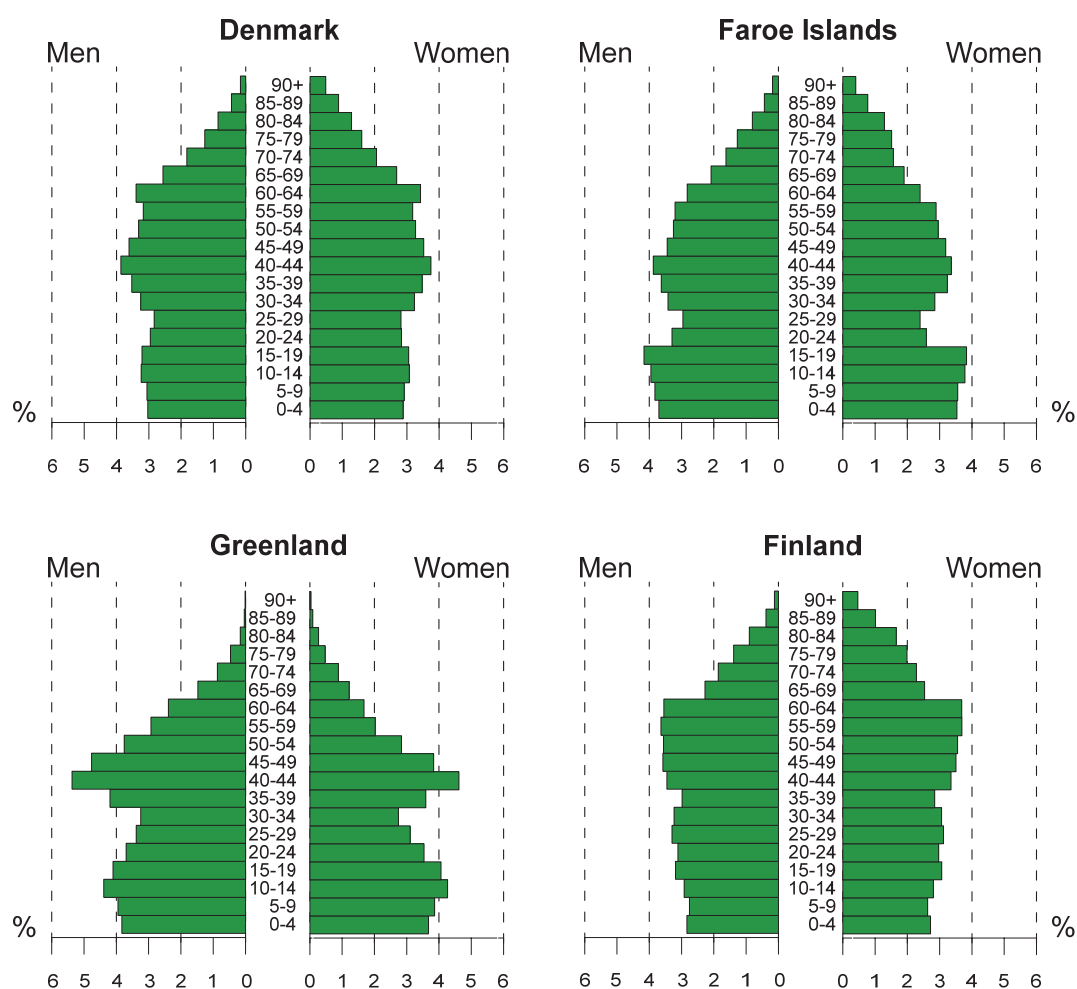
2.1 Population and Population Trends

The population structure varies somewhat among the Nordic countries, Sweden having the oldest and Greenland the youngest population.

The development in population growth varies somewhat among the Nordic countries. The natural increase has been largest in Iceland, the Faroe Islands and Greenland throughout the past decade. Denmark, Åland and Sweden have had the lowest natural increase. In 2009, net migration contributed to population growth in all the Nordic countries with the exception of Greenland, the Faroe Islands and Iceland. In 2009, after the economic crisis, the population increase turned negative in Iceland. In addition, there is a large deficit of women of fertile age in the Faroe Islands.

Life expectancy in the Nordic countries has increased significantly, and even though women generally live longer, the difference between the life expectancy of men and of women has been reduced.

Figure 2.1.1 Mean population by sex and age as a percentage of the total population 2012¹⁾



1 The Faroe Islands, Greenland and Åland: 2007-11

The Figure continues

Figure 2.1.1 Mean population by sex and age as a percentage of the total population 2012, continued

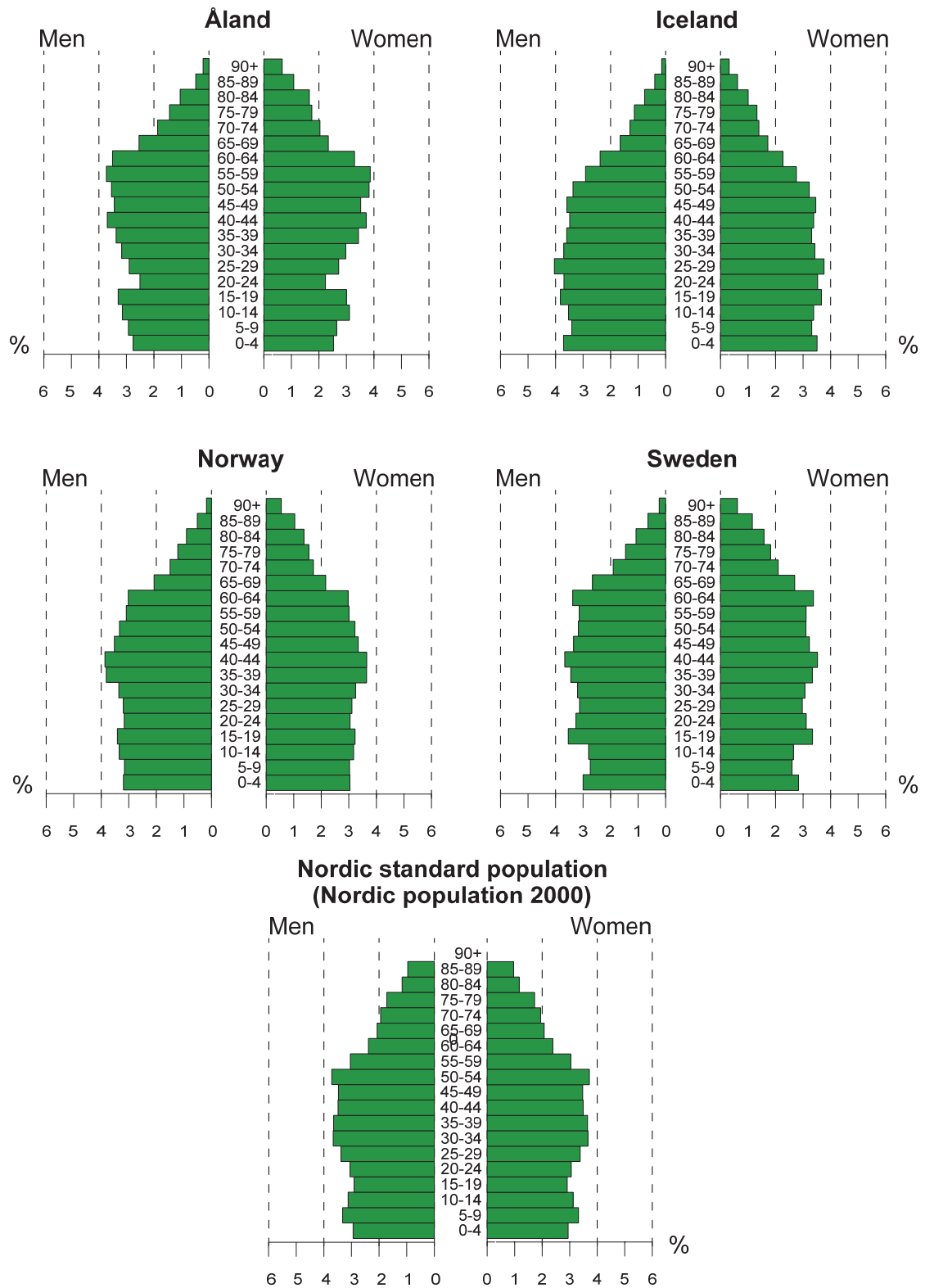


Table 2.1.1 Mean population 2000-2012

	Denmark	Faroe Islands	Greenland	Finland	Of which Åland	Iceland	Norway	Sweden
(1 000)								
<i>Men</i>								
1960	2 265	..	..	2 133	..	..	..	3 734
1970	2 432	..	..	2 225	..	..	..	4 016
1980	2 529	..	27	2 311	..	..	..	4 118
1990	2 531	..	30	2 419	..	..	..	4 228
2000	2 639	24	30	2 526	13	141	2 224	4 386
2005	2 680	25	30	2 567	13	148	2 293	4 487
2010	2 748	25	30	2 632	14	160	2 444	4 670
2011	2 760	25	30	2 653	14	160	2 480	4 708
2012	2 771	25	30	2 667	14	161	2 517	4 746
<i>Women</i>								
1960	2 301	..	..	2 296	..	..	..	3 751
1970	2 474	..	..	2 381	..	..	..	4 027
1980	2 593	..	23	2 469	..	..	..	4 193
1990	2 605	..	26	2 567	..	..	..	4 331
2000	2 700	22	26	2 650	13	140	2 267	4 486
2005	2 736	23	27	2 679	13	147	2 330	4 561
2010	2 796	23	27	2 732	14	158	2 445	4 708
2011	2 807	23	27	2 749	14	159	2 473	4 741
2012	2 816	23	27	2 760	14	160	2 501	4 773
<i>Men and Women</i>								
1960	4 566	..	..	4 430	..	..	..	7 485
1970	4 906	..	..	4 606	..	..	..	8 043
1980	5 122	..	50	4 780	..	..	..	8 310
1990	5 135	..	56	4 986	..	..	..	8 559
2000	5 340	46	56	5 176	26	281	4 491	8 872
2005	5 416	48	57	5 246	27	296	4 623	9 048
2010	5 544	49	56	5 363	28	318	4 889	9 378
2011	5 567	48	57	5 401	28	319	4 953	9 449
2012	5 587	48	57	5 427	29	321	5 019	9 519

Sources: The central statistical bureaus: D: Statistics Denmark; FI: Statistics Faroe Islands; G: Statistics Greenland; F & Å: Statistics Finland; I: Statistics Iceland; N: Statistics Norway; S: Statistics Sweden

Table 2.1.2 Mean population, by age groups as a percentage, 1990-2012,

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
1960 ¹⁾								
0-17 years	26.3	..	..	35.3	29.8	..	..	27.4
18-64 years	63.2	..	..	57.4	58.9	..	..	60.8
65+ years	10.5	..	..	7.3	11.4	..	..	11.8
1970								
0-17 years	31.0	..	..	30.2	26.7	..	..	24.9
18-64 years	56.8	..	..	60.7	60.1	..	..	61.4
65+ years	12.2	..	..	9.2	13.1	..	..	13.7
1980								
0-17 years	25.8	..	37.9	25.1	24.3	..	..	23.9
18-64 years	59.9	..	58.4	62.9	60.2	..	..	59.9
65+ years	14.3	..	3.5	12.0	15.6	..	..	16.3
1990								
0-17 years	21.3	29.5	29.6	23.0	22.0	30.0	23.3	21.9
18-64 years	63.1	58.7	66.6	63.6	61.5	59.4	60.4	60.4
65+ years	15.6	11.8	3.8	13.5	16.6	10.6	16.3	17.8
2000								
0-17 years	21.6	27.9	31.2	21.9	22.0	27.7	23.5	21.9
18-64 years	63.6	58.5	63.8	63.1	61.6	60.7	61.3	60.9
65+ years	14.8	13.5	5.1	15.0	16.3	11.6	15.2	17.3
2010								
0-17 years	21.9	26.1	27.2	20.2	20.3	25.3	22.7	20.5
18-64 years	61.5	59.1	65.9	62.3	61.6	62.5	62.3	61.2
65+ years	16.6	14.8	6.9	17.5	18.1	12.1	15.0	18.3
2012								
0-17 years	21.4	26.1	26.2	20.2	20.0	24.9	22.3	20.2
18-64 years	60.9	59.1	66.5	62.3	60.9	62.3	62.1	60.8
65+ years	17.7	14.8	7.3	17.5	19.2	12.8	15.5	19.0

1 Åland 1961

Table 2.1.3 Vital statistics per 1 000 inhabitants, 2000-2012

	Live births	Deaths	Natural increase	Net migration	Population increase
Denmark					
2000	12.6	10.9	1.7	1.8	3.5
2005	11.9	10.2	1.7	1.2	2.9
2010	11.5	9.8	1.6	4.0	5.7
2011	10.6	9.4	1.2	4.1	5.2
2012	10.4	9.4	1.0	4.3	5.3
Faroe Islands					
2003-07	14.4	8.3	6.1	-2.8	3.2
2008-12	12.8	7.8	5.0	-5.4	-0.3
Greenland					
2003-07	15.4	8.1	7.2	-7.3	-0.1
2007-11	13.6	10.9	5.8	2.5	1.1
Finland					
2000	11.0	9.5	1.4	0.5	1.9
2005	11.0	9.1	1.9	1.7	3.6
2010	11.4	9.5	1.9	2.6	4.4
2011	11.1	9.4	1.7	3.1	4.9
2012	11.0	9.6	1.4	3.2	4.7
Åland					
2003-07	10.5	9.7	0.7	4.8	6.3
2008-12	10.2	9.5	0.7	7.0	9.1
Iceland					
2000	15.3	6.5	8.8	6.1	15.3
2005	14.5	6.2	8.3	13.0	21.3
2010	15.4	6.4	9.1	-6.7	2.6
2011	14.1	6.2	7.9	-4.4	3.5
2012	14.1	6.1	8.0	-1.0	7.1
Norway					
2000	13.2	9.8	3.4	2.2	5.6
2005	12.3	8.9	3.4	4.0	7.3
2010	12.6	8.5	4.1	8.7	12.7
2011	12.2	8.4	3.8	9.5	13.2
2012	12.0	8.4	3.6	9.4	13.0
Sweden					
2000	10.2	10.5	-0.3	2.8	2.4
2005	11.2	10.2	1.1	3.0	4.0
2010	12.3	9.6	2.7	5.3	8.0
2011	11.8	9.5	2.3	4.8	7.1
2012	11.9	9.7	2.2	5.4	7.7

Sources: The central statistical bureaus

Table 2.1.4 Average life expectancy, 2000-2012

Age	Men					Women				
	0	15	45	65	80	0	15	45	65	80
Denmark										
2000-04	74.7	60.3	31.7	15.3	6.8	79.4	64.9	35.6	18.3	8.5
2010	77.1	62.4	33.5	16.9	7.4	81.2	66.6	37.2	19.6	9.0
2011	77.3	62.7	33.8	17.1	7.6	81.6	67.0	37.5	19.8	9.1
2012	77.9	63.3	34.2	17.3	7.7	81.9	67.2	37.9	20.0	9.2
Faroe Islands										
2003-07	79.1	64.6	35.5	18.0	7.8	84.3	69.7	40.2	21.9	10.2
2008-12	79.6	65.1	35.9	18.3	7.9	84.6	70.1	40.6	22.3	10.4
Greenland										
2002-06	66.3	52.9	27.8	11.8	5.1	71.3	57.7	29.9	14.0	6.8
2007-11	68.2	54.7	28.9	12.7	5.3	72.9	58.9	31.0	14.8	6.6
Finland										
2000-04	74.8	60.2	32.1	15.9	6.9	81.6	67.0	37.8	19.8	8.5
2010	76.7	62.0	33.7	17.3	7.6	83.2	68.5	39.2	21.2	9.4
2011	77.2	62.5	34.1	17.6	7.8	83.5	68.8	39.5	21.4	9.6
2012	77.5	62.8	34.3	17.6	7.8	83.4	68.7	39.5	21.3	9.5
Åland										
2003-07	78.1	63.8	34.7	17.1	7.4	83.7	69.2	39.7	21.3	9.4
2008-12	79.7	64.7	35.6	18.2	8.1	83.2	68.8	39.5	21.1	9.9
Iceland										
2000-04	78.5	63.9	35.1	17.6	7.7	82.3	67.6	38.3	20.3	9.0
2010	79.5	64.8	36.0	18.2	7.7	83.5	68.8	39.3	20.8	9.4
2011	79.9	65.2	36.3	18.3	7.8	83.6	68.9	39.4	21.0	9.5
2012	80.8	66.1	37.2	19.2	8.4	83.9	69.1	39.6	21.1	9.6
Norway										
2000-04	76.6	62.1	33.7	16.5	7.0	81.7	67.2	37.9	20.0	8.8
2010	78.9	64.2	35.4	17.9	7.8	83.2	68.5	39.1	21.0	9.6
2011	79.0	64.3	35.6	18.0	7.9	83.5	68.7	39.4	21.2	9.6
2012	79.4	64.8	35.8	18.2	7.8	83.4	68.7	39.2	21.0	9.5
Sweden										
2000-04	77.8	63.2	34.3	17.0	7.3	82.3	67.6	38.3	20.2	9.0
2010	79.5	64.8	35.8	18.2	7.9	83.5	68.8	39.3	21.1	9.6
2011	79.8	65.1	36.1	18.4	8.0	83.7	69.0	39.5	21.2	9.6
2012	79.9	65.2	36.2	18.4	7.9	83.5	68.8	39.4	21.0	9.5

Sources: The central statistical bureaus

Figure 2.1.3 Live births and natural increase per 1 000 inhabitants ,2000-2012

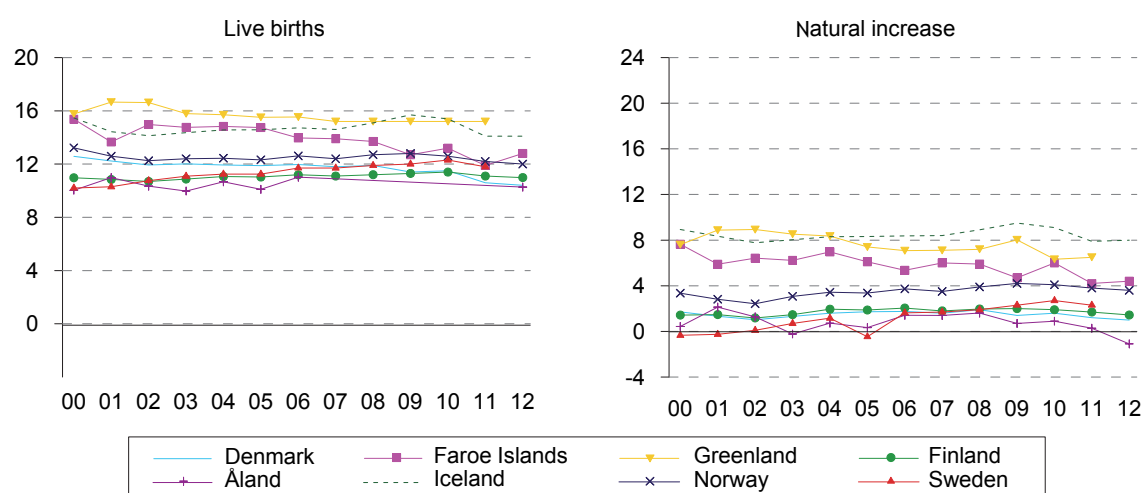
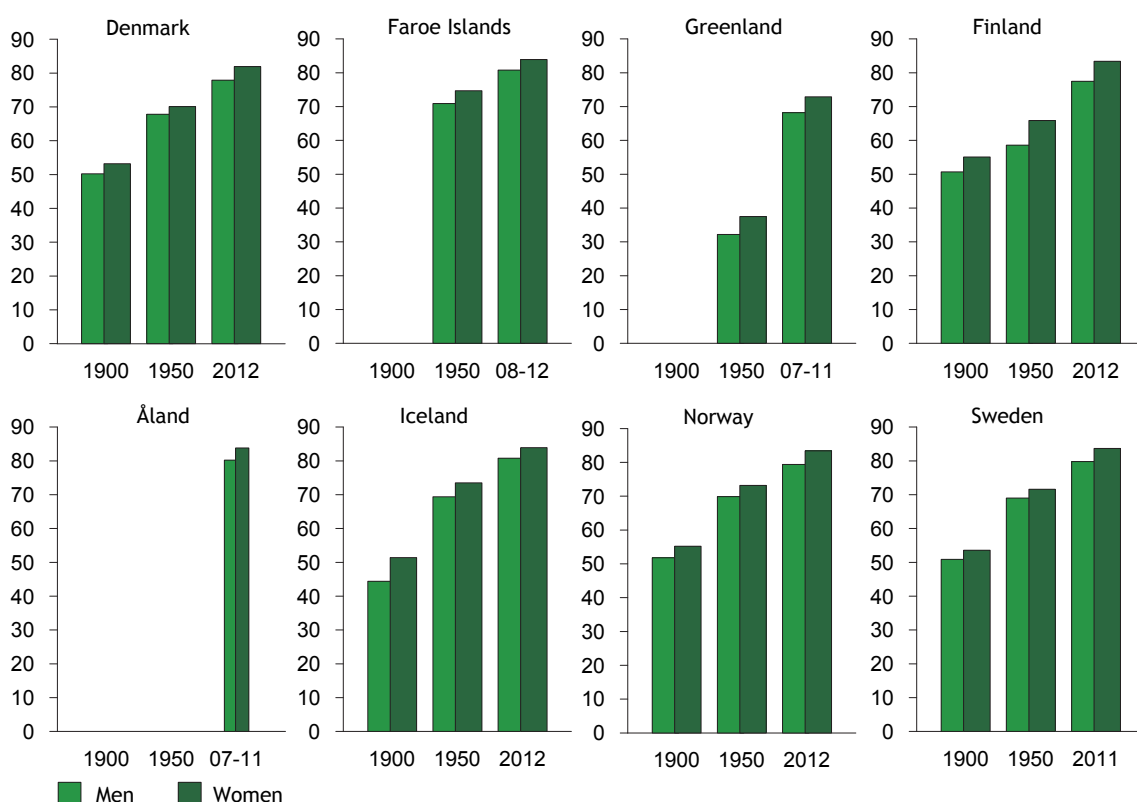


Figure 2.1.4 Life expectancy at birth, 1900, 1950 and 2012



2.2 Fertility, Births, Infant Mortality and Contraception

In recent years, the overall development in fertility has resulted in Denmark, Finland and Åland now having the lowest fertility rates in the Nordic countries, while the rates remain high in the Faroe Islands, Greenland and Iceland, particularly for the youngest age groups.

In all the Nordic countries, it is possible to obtain treatment for infertility, paid for by the public health services (in Iceland and Norway there is, however, a higher user charge for in vitro fertilization (IVF) treatment than for other types of treatment). As shown in Table 2.2.2, more and more people receive such treatment, and a significant proportion of live births is the result of IVF. A large number of births resulting from IVF are still multiple births.

Internationally, the Nordic countries are characterized by having very low perinatal mortality. Greenland has the highest perinatal mortality rate among the Nordic countries. The other countries lie relatively close to each other. Changes in perinatal mortality during this period are the result of changes in the definition of gestational ages. The time limit for spontaneous abortion and stillbirth is 22 weeks in all Nordic countries excluding the Faroe Islands and Greenland, where the limit is 28 weeks.

Greenland also has the highest mortality rate for the first year of life. Iceland had the lowest mortality rate for the first year of life in 2009.

The sale of hormonal contraceptives varies substantially among the Nordic countries, but these differences have become smaller over time.

The use of sterilization as a means of birth control also varies considerably among the Nordic countries. In most of the countries, no permission for sterilization is required if the person is aged 25 or more.

There are no comparable Nordic statistics on the use of coils and condoms.

Use of emergency contraception is relatively widespread in the Nordic countries. Use is highest in Norway and lowest in the Faroe Islands, Denmark and Greenland.

Since the middle of the 1970s, induced abortion has been available in most of the Nordic countries. In Sweden, it is a requirement that the abortion takes place before the end of the 18th week of gestation, while it in the other Nordic countries must be performed before the end of the 12th week of gestation. However, induced abortion may also be carried out after the 12th or 18th week of gestation, but only following special assessment and permission.

In Denmark, Greenland, Norway and Sweden, it is solely up to the pregnant woman herself to decide whether an abortion is to be performed, while permission is required in the Faroe Islands, in Finland, Åland and Iceland. Such permission is given on the basis of social and/or medical criteria.

Abortion rates vary greatly in the Nordic countries.

Table 2.2.1 Live births and fertility rates, 2000-2012

Annex 2.1.1. Live births and fertility rates, 2000-2012									
		Live births per 1 000 women by age							
	Number of live births	15-19 ¹⁾	20-24	25-29	30-34	35-39	40-44	45-49 ²⁾	Total fertility rate
Denmark									
2000-04	65 194	6.7	48.8	126.1	117.9	45.5	7.2	0.3	1 756
2005	64 282	5.7	43.2	123.9	127.4	48.5	8.4	0.3	1 802
2010	63 411	5.0	43.0	123.0	134.0	59.0	10.0	1.0	1 875
2011	58 998	4.6	38.6	113.7	126.7	55.6	9.8	0.5	1 756
2012	58 305	4.5	39.1	114.9	122.4	54.3	10.0	0.6	1 733
Faroe Islands									
2003-07	634	16.4	85.1	164.4	137.3	69.0	13.5	0.6	2 432
2008-12	622	16.2	85.3	170.6	133.3	66.1	13.7	1.0	2 431
Greenland									
2003-07	852	51.5	119.8	133.8	91.2	42.6	8.7	0.0	2 236
2008-12	..	..	..	..	..	..	..	..	..
Finland									
2000-04	56 575	10.5	58.5	114.8	105.2	48.4	10.1	0.5	1 747
2005	57 745	10.3	57.4	116.3	112.9	51.5	10.7	0.6	1 803
2010	60 980	8.4	57.1	116.8	120.3	58.6	11.6	0.6	1 870
2011	59 961	7.7	54.8	113.1	118.4	59.0	12.1	0.7	1 827
2012	59 494	7.5	53.7	110.9	116.0	59.9	12.5	0.7	1 801
Åland									
2003-07	278	5.4	50.5	104.4	126.5	52.2	12.9	0.6	1 847
2008-12	285	3.8	50.5	111.3	118.9	65.0	11.6	0.2	1 806
Iceland									
2000-04	4 166	17.8	79.0	127.9	110.6	52.9	10.7	0.4	1 996
2005	4 280	15.1	81.5	129.9	114.0	58.4	10.6	0.8	2 052
2010	4 907	12.9	72.9	137.7	127.5	73.7	14.6	0.2	2 197
2011	4 492	10.8	63.4	128.2	121.7	63.6	15.0	0.9	2 017
2012	4 533	11.0	63.3	134	117.2	66.1	15.1	0.5	2 037
Norway									
2000-04	56 955	10.0	61.6	124.3	111.6	46.4	7.5	0.3	1 803
2005	56 756	8.0	58.6	124.4	118.6	48.6	8.6	0.4	1 836
2010	61 442	8.4	59.0	124.0	128.0	57.7	10.8	0.6	1 946
2011	60 220	7.1	54.3	120.7	123.9	57.8	10.9	0.6	1 880
2012	60 255	6.0	52.6	117.8	123.7	58.3	10.6	0.6	1 850
Sweden									
2000-04	95 561	6.4	47.2	108.7	110.4	47.8	9.0	0.3	1 648
2005	101 346	6.2	46.6	109.5	124.9	55.9	10.3	0.5	1 769
2010	115 541	5.7	51.3	118.2	138.0	69.4	13.6	0.8	1 985
2011	111 770	5.5	48.5	112.2	131.7	67.8	13.8	0.7	1 901
2012	113 177	5.0	47.6	112.5	133.1	68.0	13.9	0.9	1 906

1 Births by women under 15 years are included

Sources: The central statistical bureaus

Table 2.2.2 In vitro fertilization 2000-2011¹⁾

	Denmark	Finland	Iceland	Norway ³⁾	Sweden
Treatments, IVF+ICSI					
2000-2004	7 487	4 448	301	4 309	7 447
2005	7 222	4 731	462	5 067	8 062
2010	11 721	4 861	618	6 557	..
2011	10 984	4 899	506	..	..
Frozen embryo transfers, FET					
2000-2004	918	2 766	76	507	1 847
2005	1 500	2 960	161	1 698	3 458
2010	2 275	3 280	257	2 046	..
2011	2 364	3 403	264	..	..
Number of live births, IVF+ ICSI + FET					
2000-2004	1 814	1 465	123	1 258	2 584
2005	1 786	1 534	167	1 521	2 874
2010	2 123	1 858	192	1 885	..
2011	2 123	..	131	..	..
Treatments in 2011 ^{2, 3)} per 1 000 Women aged 15-49 years					
IVF + ICSI	9.3	4.2	6.5	5.8	4.6
FET	1.8	2.9	3.4	1.8	2.1
Total	11.1	7.1	10.0	7.6	6.7
Multiple births, per cent of all births after IVF	15.5	6.0	9.9	11.0	5.2
Children born in multiple births, per cent of all children born after IVF	13.4	10.0	19.8	..	..
IVF, ICSI and FET per cent of all live births	3.3	2.9	2.9	3.1	12.2

IVF = In vitro fertilization

ICSI = Intracytoplasmic sperm injection

FET = Frozen embryo transfer

1 Based on the year of treatment, not on the year of birth

2 Denmark and Norway 2010

3 Sweden 2009

Sources: D: Statens Serum Institut; F: THL; I: Art Medica; N: Ministry of Health;

S: National Board of Health and Welfare

Table 2.2.3 Stillbirths and infant mortality ¹⁾, 2000-2011

	Number		Per 1 000 births		Deaths per 1 000 live births			
	Stillbirths	Infant deaths	Stillbirths	Perinatal deaths	First 24 hours	1-6 days	7-27 days	Total under 1 year
Denmark								
2000-04	280	305	4,3	7,1	1,6	1,3	0,6	4,7
2010	255	216	4,0	6,2	..	..	..	3,4
2011	..	..	..	..	..	..	..	..
Faroe Islands								
2002-06	1	3	2,0	4,0	0,6	1,4	0,6	4,0
2007-11	2	3	3,7	6,2	1,6	0,9	0,6	5,0
Greenland								
2002-06	..	..	..	..	..	..	..	..
2007-11	5	13	5,9	9,6	3,8	2,9	1,2	11,2
Finland								
2000-04	191	187	3,4	5,2	1,0	0,7	0,5	3,3
2010	181	140	3,0	4,1	0,6	0,5	0,4	2,3
2011	161	143	2,7	4,0	0,7	0,6	0,3	2,4
Åland								
2002-06	3	4	2,2	4,4	1,5	0,7	-	2,9
2007-11	1	2	0,7	1,4	0,7	-	-	1,4
Iceland								
2000-04	10	11	2,4	4,0	0,9	0,6	0,3	2,6
2010	9	11	1,8	2,9	0,8	0,2	0,2	2,2
2011	4	4	0,9	1,1	0,2	-	0,4	0,9
Norway								
2000-04	217	205	3,8	5,7	1,0	1,0	0,6	3,6
2010	190	157	3,1	4,3	0,6	0,6	0,5	2,6
2011	198	140	3,3	4,5	0,5	0,7	0,4	2,3
Sweden								
2000-04	350	316	3,7	5,4	0,7	1,0	0,6	3,3
2010	426	294	3,7	4,8	0,5	0,6	0,4	2,5
2011	429	235	3,8	4,7	0,5	0,4	0,5	2,1

1 Calculated according to year of death

Source: D: Statens Serum Institute; FI: Chief Medical Officer in the Faroe Islands; G: Chief Medical Officer; F & Å: Statistics Finland; I: Statistics Iceland; N: Statistics Norway; S: Statistics Sweden

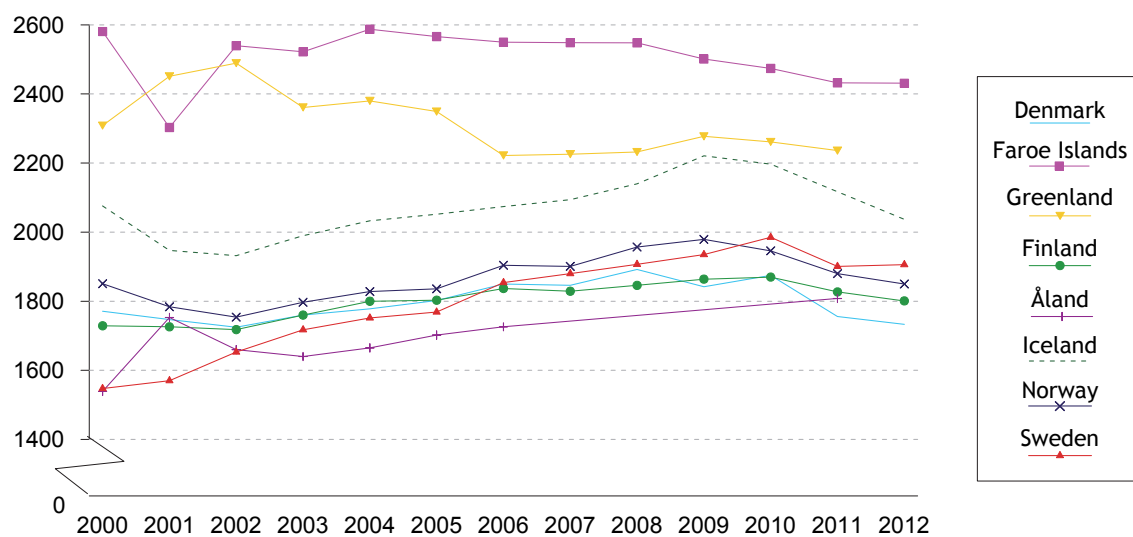
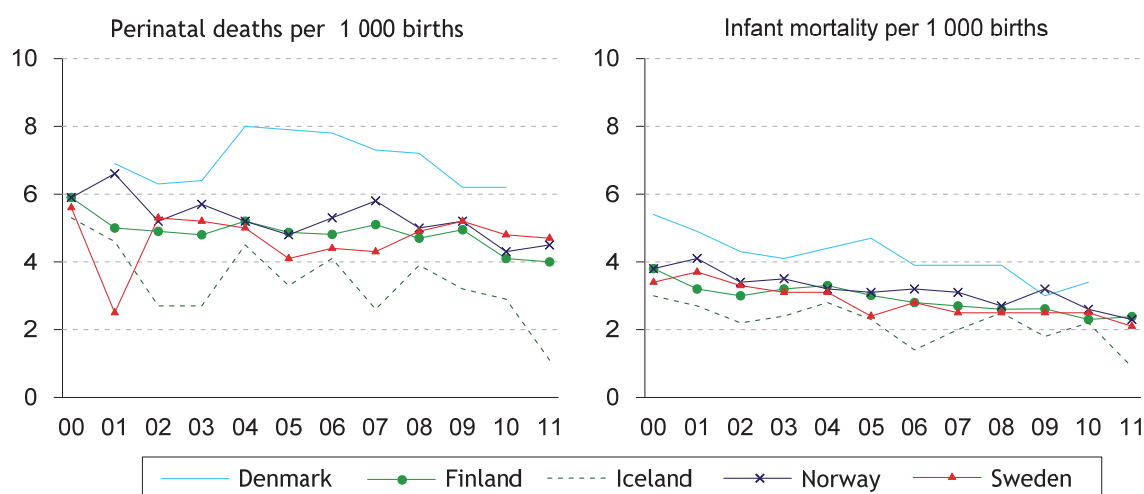
Figure 2.2.1 Total fertility rate, 2000-2012**Figure 2.2.2 IVF, ICSI and FET, percentages of all live births**

Figure 2.2.3 Perinatal deaths and infant mortality, 2000-2011**Table 2.2.4 Stillbirths and deaths during the first year of life per 1 000 births, with a birth weight of 1 000 grams or more, total and per 1 000 births, 2000-2011¹⁾**

	Number	Per 1 000 births		Deaths per 1 000 live births				
	Number	Infant deaths	Stillbirths	First 24 hours	1-6 days	7-27 days	28 days to 1 year	Total under 1 year
Denmark								
2000	183	238	2.9	0.6	1.3	0.5	1.2	3.6
2005	123	174	1.9	0.8	0.7	0.5	0.8	2.7
2010	..	..	..	..	..	..	..	..
2011	..	..	..	..	..	..	..	..
Finland								
2000	149	150	2.6	0.5	0.5	0.5	1.1	2.7
2005	115	120	2.0	0.5	0.5	0.3	0.8	2.1
2010	114	97	1.9	0.3	0.4	0.3	0.7	1.6
2011	100	96	1.4	0.3	0.5	0.2	0.6	1.6
Iceland								
2000	13	5	3.0	0.0	0.2	0.2	0.7	1.2
2005	6	4	1.4	-	0.5	-	0.5	0.9
2010	7	9	1.4	0.2	0.2	0.2	1.2	1.9
2011	4	4	0.9	0.2	0.0	0.4	0.2	0.9
Norway								
2000	195	149	3.3	0.6	0.5	0.3	1.1	2.5
2005	142	104	2.5	0.5	0.4	0.3	0.6	1.8
2010	122	129	2.0	0.7	0.2	0.4	0.8	2.1
2011	139	98	2.3	0.6	0.2	0.3	0.5	1.6
Sweden								
2000	318	215	3.6	0.5	0.7	0.4	0.9	2.4
2005	263	182	2.6	0.4	0.4	0.2	0.9	1.8
2010	278	178	2.4	0.3	0.3	0.3	0.7	1.6
2011	299	141	2.7	0.2	0.2	0.3	0.5	1.3

1 Calculated according to year of birth

Sources: D: Statens Serum Institut; F: Statistics Finland & THL; I: Medical Birth Registry of Iceland & Statistics Iceland; N: Medical

Table 2.2.5 Consumption of hormonal contraceptives. DDD per 1 000 women aged 15-49 years/day¹⁾

	Denmark ²⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2000	272	258	186	224	281	265	225	255
2005	293	238	314	189	182	192	201	260
2010	286	232	302	204	179	204	217	248
2011	287	226	312	210	217	207	223	247
2012	277	208	285	210	199	208	222	243

ATC-code: G03A, incl. patches from G03AA13 and intravaginal contraceptives (G02BB)

1 Excl. injections and implants. Excl. G03AD (Emergency contraceptives)

2 Excl. G03AC08

Sources: D: Statens Serum Institut; FL: Chief Pharmaceutical Officer; G: National Pharmacy;

F & Å: FIMEA; I: Icelandic Medicines Agency; N: Norwegian Institute of Public Health;

S: National Corporation of Swedish Pharmacies

Table 2.2.6 Emergency contraceptives: number of sold packages per 1 000 women in the age 15-49 years, 2000-2012

ATC kode G03AD	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2000 ¹⁾	28.5	12.2	-	41.9	36.0	31.6	30.2	6.4
2005	62.6	51.8	40.9	77.7	79.4	87.4	118.6	83.0
2010	81.3	81.2	53.2	83.3	84.2	90.5	140.5	100.3
2011	78.0	72.4	56.2	87.2	83.5	85.8	137.4	104.7
2012	80.3	77.2	88.3	77.4	81.1	84.4	134.8	105.9

1 Age 15-44 years

Sources: D: Statens Serum Institut; FL: Chief Pharmaceutical Officer; G: National Pharmacy; F & Å:

FIMEA; I: Icelandic Medicines Agency; N: Norwegian Institute of Public Health; S: National Corpora-

tion of Swedish Pharmacies

Table 2.2.7 Number of induced abortions, 2000-2011

	Number of abortions	Abortions per 1 000 women aged							Total abortion rate	Abortions per 1 000 live births
		15-19 ¹⁾	20-24	25-29	30-34	35-39	40-44	45-49 ²⁾		
Denmark										
2000-04	15 365	14.5	20.4	17.7	17.0	13.0	4.8	0.4	439	237
2010	16 362	15.0	25.6	19.5	17.1	13.0	5.3	0.5	480	258
2011	15 775	14.1	25.0	19.2	15.6	12.7	5.1	0.8	463	267
Faroe Islands										
2002-06	..	..	..	..	..	..	..	..	..	..
2007-11	40	3.8	9.1	3.9	4.7	4.1	2.2	0.4	142	63
Greenland										
2002-06	880	115.2	144.7	95.2	59.7	29.3	10.9	1.1	2 280	991
2007-11	835	101.3	131.9	90.9	54.5	27.2	7.3	0.6	2 078	984
Finland										
2000-04	10 869	15.3	16.4	12.6	10.7	7.7	3.1	0.2	330	192
2010	10 243	12.1	17.0	13.1	9.8	7.7	3.0	0.2	315	167
2011	10 491	12.4	18.2	12.8	10.3	7.5	3.0	0.2	322	175
Åland										
2002-06	62	14.7	22.7	18.1	11.0	10.4	3.7	0.4	404	234
2007-11	70	14.3	31.2	21.7	15.4	7.4	3.6	-	468	249
Iceland										
2000-04	940	21.4	23.4	17.3	13.6	9.2	4.6	0.3	449	225
2010	977	15.9	23.0	19.2	13.4	11.4	3.5	0.5	435	199
2011	969	15.6	24.9	16.6	15.3	10.2	3.4	0.4	432	216
Norway										
2000-04	14 008	17.3	27.1	19.4	15.1	10.6	3.8	0.3	470	246
2010	15 735	14.1	29.2	23.2	16.9	11.7	4.4	0.4	500	256
2011	15 343	12.7	27.6	22.6	16.6	11.3	4.4	0.4	478	255
Sweden										
2000-04	33 009	22.6	29.4	23.3	19.8	15.2	6.3	0.6	586	345
2010	37 696	20.3	33.3	26.7	21.5	16.3	7.0	0.8	..	326
2011	37 750	19.3	33.1	26.5	21.6	16.6	7.3	0.8	..	340

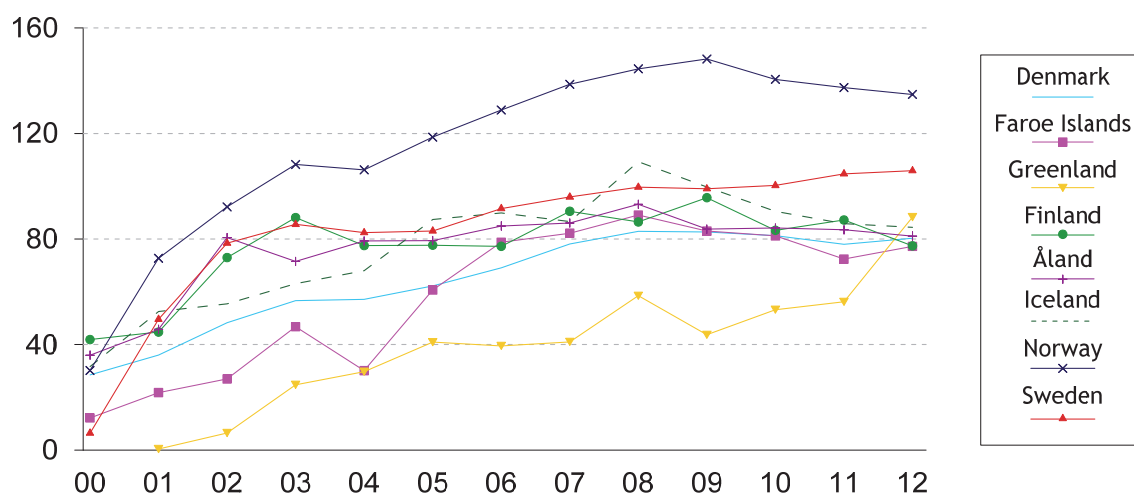
1 Births by women under 15 years are included

2 Abortions for Women over 49 years are included

Definition: The total abortion rate is the number of abortions per 1 000 women expected to live to be 50 years, calculated from the age specific abortion rates for the current period

Sources: The national abortion registers

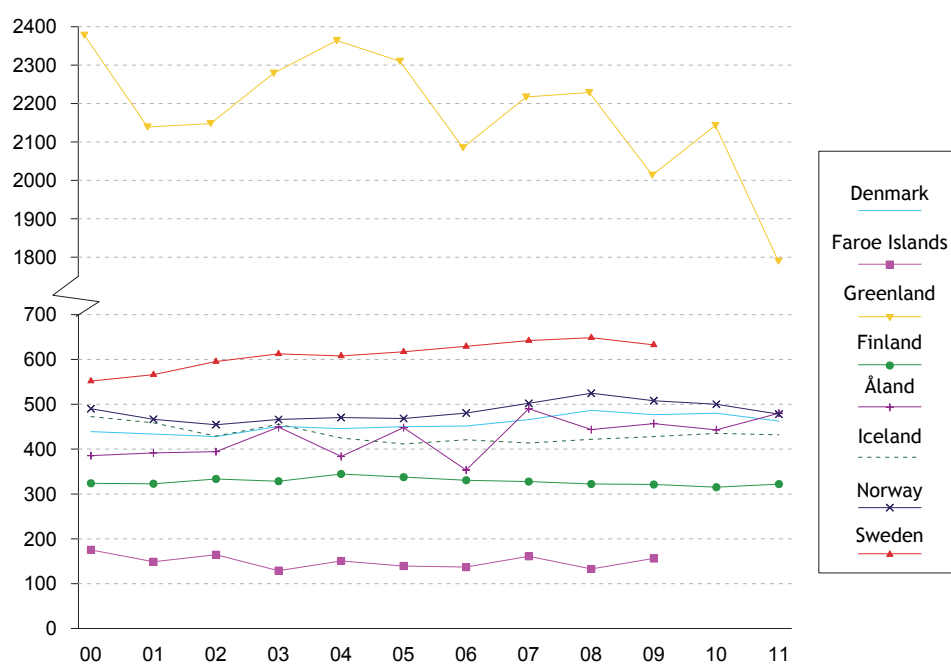
Figure 2.2.4 Sales of emergency prevention per 1 000 women aged 15-49 years, 2000-2012¹⁾



1 2000-03: 15-44 years

Source: Table 2.2.6

Figure 2.2.5 Total abortion rate 2000-2010



Source: Table 2.2.7

Chapter 3

Morbidity, Medical Treatment, Accidents and Medicinal Products

Extra material

[Reference group for Patient Statistics](#)

[Discharge data](#)

[ISHMT list of diagnoses](#)

[Surgery data](#)

[HDP2 list of procedures](#)

[The Nordic Cancer Union](#)

Introduction

This chapter begins with a description of a number of diseases that can be related to the population's lifestyle and social behaviour, followed by data on new incidences of cancer. This is followed by a presentation of the treatment provided outside hospitals and in hospitals by diagnostic group and in connection with major surgical procedures. Following this, data on accident occurrences and discharges from hospitals due to accidents are presented. Finally data on consumption of medicinal products are presented.

3.1 Diseases related to Lifestyle

This section deals with a number of diseases that can be related to the lifestyle and social behaviour of people in the population and be treated either outside hospitals or in hospitals.

Although the number of smokers in the Nordic countries has been decreasing during recent years, there continues to be large differences in the number of smokers, both for men and for women and some differences among countries. Among other things, this pattern of behaviour is reflected in the incidence of lung cancer, as shown in Figure 3.1.1, in which the rates reflect behaviour several years previously, however.

The share of people who are overweight is an increasing problem in the Nordic countries. The share is highest in Iceland and lowest in Norway.

Table 3.1.3: Nicotine in various pharmacological formulations (N07BA01) is used to alleviate withdrawal symptoms and to help in smoking cessation. In all Nordic

countries, nicotine is among the ten best-selling substances calculated in terms of pharmacy retail prices. In Iceland, the consumption is at least three times higher than in the other countries.

Bupropion (N06AX12), originally an antidepressant but introduced in 2000 to help smoking cessation, has a very small use in all countries.

With regard to alcohol consumption, the statistics are inadequate, as the available data are based on sales figures. These figures indicate that the largest consumption/sales are to be found in Denmark and Greenland, followed by Finland, whereas consumption/sales in the other countries is at about the same level. Accordingly, the number of treatment periods/discharges from hospital for alcoholic liver diseases is highest in Denmark and Finland.

This publication previously included data on the occurrence of hepatitis B and C, but as the information from the different countries is not comparable, this table has been left out.

The number of diagnosed cases of tuberculosis is relatively stable in the Nordic Countries.

The incidence of HIV infection is relatively stable, with the highest incidence in Norway and the lowest in Finland. The trend is related to the new methods of treatment that result in infected people having a longer period with HIV infection, and therefore a longer period of time before AIDS is established. This gives a greater number of potential carriers with the risk of infecting other people. In comparison, Figure 4.1.5 shows that mortality as a result of HIV/AIDS has been at a stable low level in all countries since the end of the 1990s.

Without doubt, chlamydia infection is the most common sexually transmitted disease in the Nordic countries. It is also the most common cause of infertility among women. There are some differences among the countries, but Greenland is radically different. The disease is often without symptoms, and is therefore probably under-reported.

A marked fall in the incidence of the traditional sexually transmitted diseases, gonorrhoea and syphilis, has been seen in all countries over the past 20 years. However, there are certain notable exceptions, with Greenland being radically different from the other countries.

Table 3.1.1 Overview of self-reported obesity rate, population aged 15+

	Denmark 2010	Faroe Islands 2011	Green- land 2005	Finland ¹⁾ 2011	Iceland ¹⁾ 2010-11	Norway ²⁾ 2011	Sweden 2010
Share of people with BMI > 30, men	14	14	19	18	23	11	13
Share of people with BMI > 30, women	13	10	27	16	19	9	13

1 BMI >= 30 in per cent

2 Age 16+

Sources: National Boards of Health; I: A national dietary telephone survey 2010-2011. A random sample of the Icelandic population 18-80 years, 2000 persons. F: THL; Health Behaviour and Health among the Finnish Adult Population (AVTK). S: Statistics Sweden; FI: The National Council for Prevention

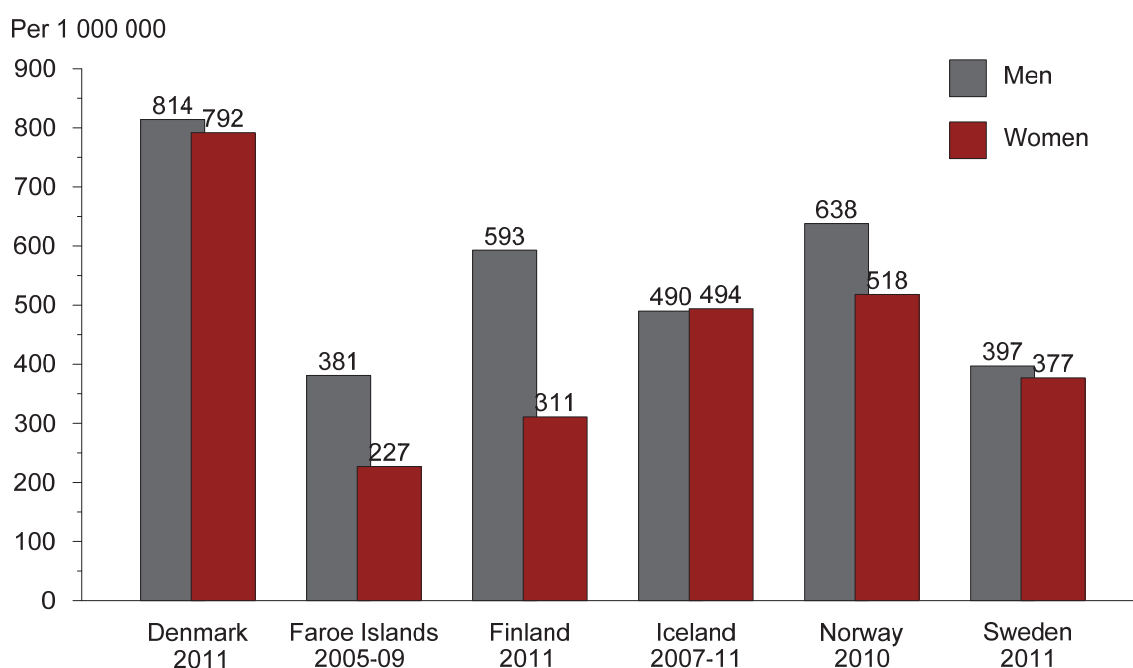
Table 3.1.2 Percentage of daily smokers by gender 2011

	Denmark ¹⁾ Age 16+	Faroe Islands 15+	Finland 15-64	Iceland 15+	Norway ²⁾ 16-74	Sweden ¹⁾ 16-84
Smoking men as a percentage of men in the age group	23	27	22	14	16	13
Smoking women as a percentage of women in the age group	19	25	15	14	16	15

1 2010

2 2012

Sources: D: National Board of Health; FI: The National Council for Prevention; F: THL Health Behaviour and Health among the Finnish Adult Population (AVTK); I: Public Health Institute of Iceland; N: National Directorate for Health and Social Welfare; S: Statistics Sweden

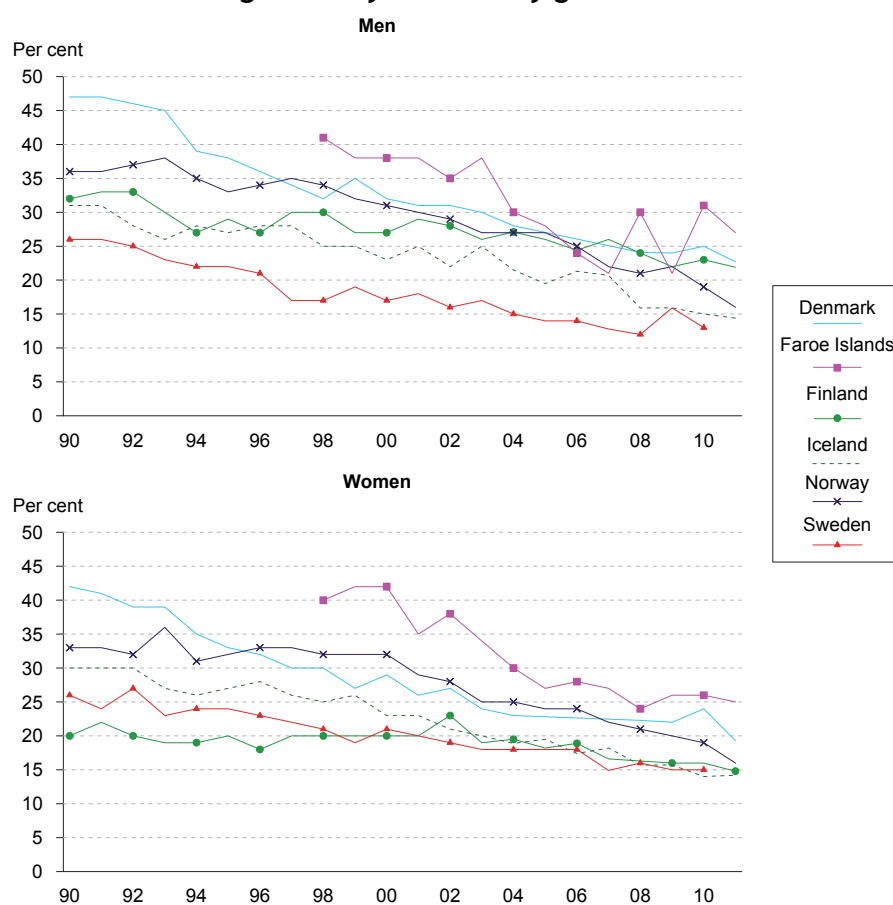
Figure 3.1.1 Rates for new cases of lung cancer per 1 000 000 inhabitants**Table 3.1.3 Sales of drugs used for nicotine dependence (ATC-group N07BA), DDD/1 000 inhabitants/day 2000-2012**

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N07BA01								
Nicotine								
2000	4.0	2.3	1.6	2.6	3.8	14.2	2.7	5.3
2005	7.6	3.7	1.7	5.3	5.6	19.4	3.7	6.7
2010	8.3	3.9	3.3	8.4	9.1	19.6	5.0	6.8
2011	8.2	4.0	4.9	8.9	10.1	20.5	5.3	7.0
2012	9.6	4.0	4.9	9.8	9.1	21.1	5.6	7.0
N07BA03								
Vareniclin ¹⁾								
2000	-	-	-	-	-	-	-	-
2005	-	-	-	-	-	-	-	-
2010	0.5	0.8	0.1	0.4	0.1	1.0	0.9	0.5
2011	0.5	0.8	0.2	0.4	0.1	1.0	0.9	0.5
2012	0.2	0.4	0.1	0.3	0.1	1.1	0.8	0.4

1 Varenicline was introduced on the market in December 2006

Sources: D: Danish Medicines Agency; FI: Chief Pharmaceutical Officer; G: The Central Pharmacy in Copenhagen County; F & Å: FIMEA; I: Icelandic Medicines Agency; N: Norwegian Institute of Public Health; S: National Corporation of Swedish Pharmacies

Figure 3.1.2 Percentage of daily smokers by gender 2000-2011



Sources: OECD, for 2001, 2002 and 2003. Other years Table 3.1.1. Faroe Islands: Statistics Faroe Islands

Figure 3.1.3 Sales of drugs used for nicotine dependence (ATC-group N07BA), DDD/1 000 inhabitants/day 2000-2012

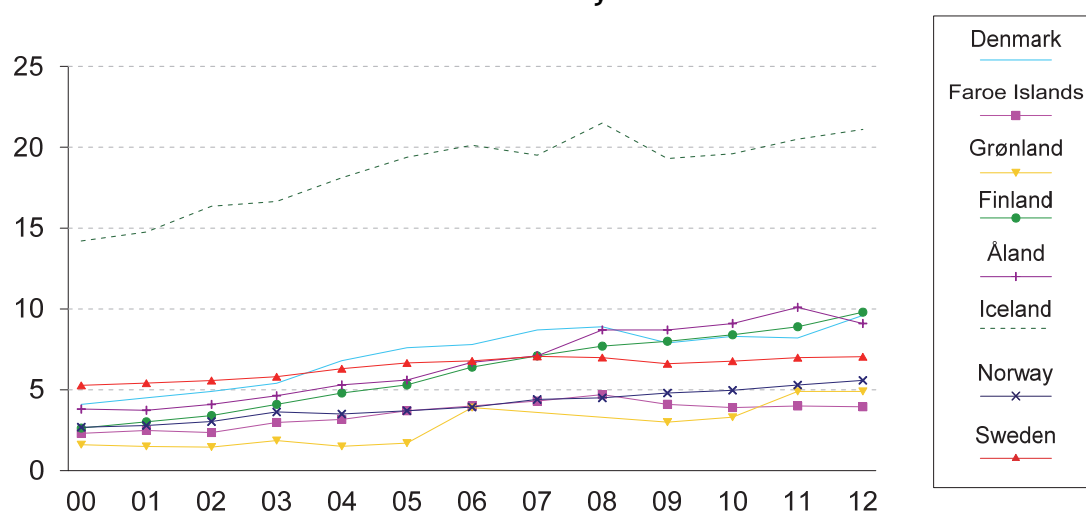
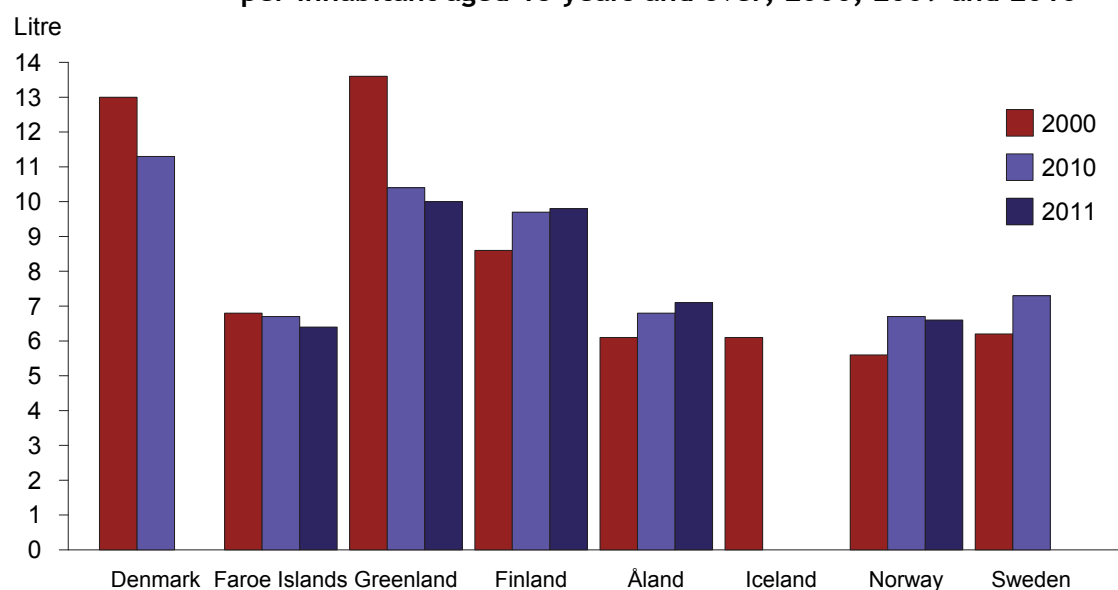


Table 3.1.4 Sales of alcoholic beverages in litres of 100 per cent pure alcohol per inhabitant aged 15 years and over, 2000-2011

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2000	13.0	6.8	13.6	8.6	6.1	6.1	5.6	6.2
2005	12.8	6.6	12.1	10.0	6.6	7.1	6.4	6.6
2010	11.3	6.7	10.4	9.7	6.8	..	6.6	7.3
2011	..	6.4	10.0	9.8	7.1	..	6.6	..

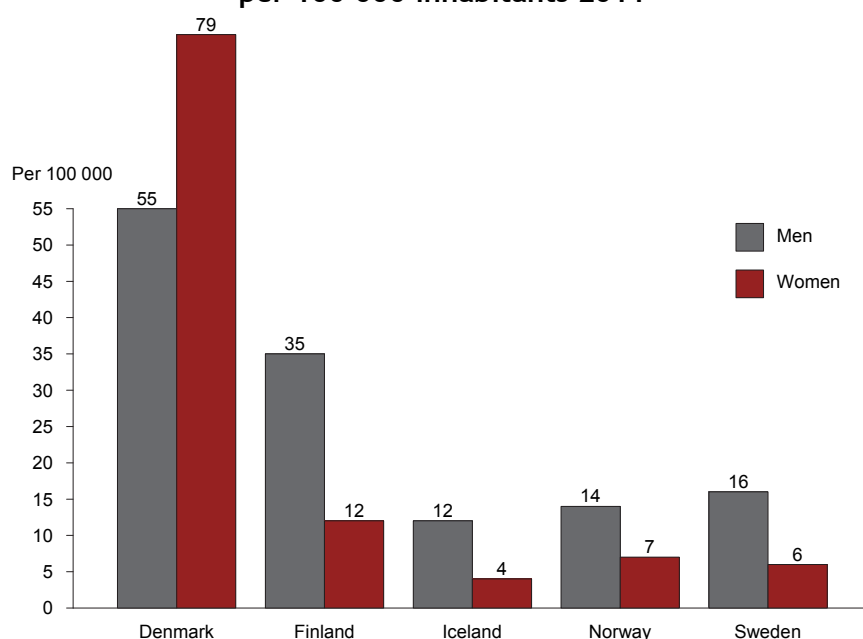
Sources: D, G, I, N: The central statistical bureaus; FI: Statistics Faroe Islands; F & Å: THL; S: National Institute of Public Health

Figure 3.1.4 Sales of alcoholic beverages in litres of 100 per cent pure alcohol per inhabitant aged 15 years and over, 2000, 2009 and 2010



Sources: D, FI, G, I, N: The central statistical bureaus; F & Å: THL; S: National Institute of Public Health

Figure 3.1.5 Patients treated in somatic hospitals for alcoholic liver disease per 100 000 inhabitants 2011¹⁾



1 2009 for Iceland

Sources: D: National Board of Health; FI: Ministry of Health; F: THL; I: Directorate of Health; N: Norwegian Patient Register; S: National Board of Health and Welfare

Table 3.1.5 Diagnosed cases of tuberculosis per 100 000 inhabitants, 2000-2011

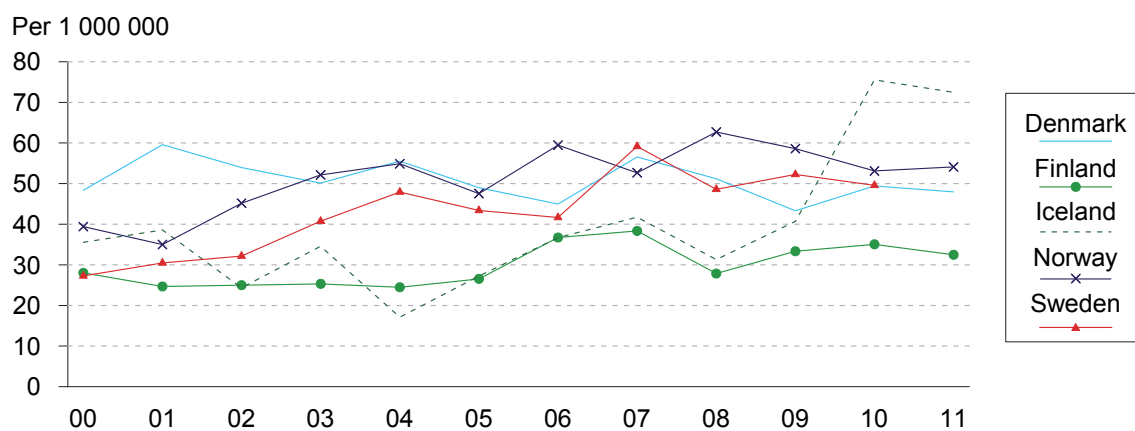
	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
Men					M+K			
2000	12.1	20.8	50.0	12.4	3.9	2.8	5.8	5.2
2005	9.5	-	178.1	8.0	3.8	5.4	6.2	6.8
2010	7.8	-	220.5	6.9	0.0	5.0	7.9	..
2011	8.2	-	207.1	6.0	7.1	..	8.1	..
Women								
2000	8.5	4.5	111.0	8.5	.	6.4	6.2	5.2
2005	6.2	-	165.1	5.8	.	2.0	6.1	6.0
2010	5.3	8.7	192.3	5.0	.	8.9	6.7	..
2011	5.3	8.7	198.7	4.2	.	5.7	7.0	..

Sources: D: Statens Serum Institut; FI: Chief Medical Officer; G: Chief Medical Officer; F & Å: THL; I: Directorate of Health; N: Norwegian Institute of Public Health; S: Swedish Institute for Infectious Disease Control

Table 3.1.6 Confirmed new cases of HIV/AIDS, 2000-2012

	Denmark	Faroe Islands	Greenland	Finland	Of which Åland	Iceland	Norway	Sweden
Men					M+K			
2000-04	..	0	5	95	.	6	124	198
2005	193	-	4	96	.	5	122	228
2010	201	1	2	132	.	18	173	285
2011	193	1	1	112	.	12	189	..
2012	..	..	0	115	.	..	166	..
Women								
2000-04	..	0	2	37	.	2	82	122
2005	71	-	2	35	.	3	97	163
2010	73	-	1	56	.	6	85	180
2011	74	1	-	63	.	11	79	..
2012	..	..	3	47	.	..	76	..
Total								
2000-04	287	1	7	131	0.6	9	206	320
2005	264	-	6	131	1	8	219	391
2010	274	1	3	188	-	24	258	465
2011	267	2	1	175	4	23	268	..
2012	..	..	3	162	3	..	242	..

Sources: See Table 3.1.5

Figure 3.1.6 Confirmed new cases of HIV/AIDS per 1 000 000 inhabitants, 2000-2012

Sources: See Table 3.1.6

Table 3.1.7 Notified cases of gonorrhoea and syphilis per 100 000 inhabitants aged 15 years and over, 2011

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden ¹⁾
<i>Gonorrhoea</i>								
Men	18	..	2 547	8	14	14	13	13
Women	4	..	3 702	3	-	4	2	5
Total	9	2	3 084	5	7	9	7	18
<i>Syphilis</i>								
Men	18	-	4	4	-	2	5	3
Women	2	-	5	3	-	0	0	1
Total	8	-	5	3	-	1	3	4

1 2010

Sources: See Table 3.1.5

Table 3.1.8 Diagnosed cases of Chlamydia per 100 000 inhabitants, 2000-2011

	Denmark	Faroe Islands	Greenland	Finland	Åland ¹⁾	Iceland ¹⁾	Norway	Sweden ²⁾³⁾
Men								
2000	165	.	2 791	180	.	479	.	187
2005	324	.	3 852	197	.	412	330	317
2010	384	286	5 277	202	.	551	351	..
2011	365	235	5 180	211	.	499	353	..
Women								
2000	384	.	4 817	272	.	781	.	246
2005	554	.	5 797	289	.	643	524	411
2010	623	403	8 762	276	.	852	567	..
2011	..	328	9 854		.	784	554	..
Total								
2000	276	79	3 727	226	152	647	326	217
2005	440	231	4 762	239	362	548	434	366
2010	505	342	6 893	254	224	722	461	..
2011	..	280	7 356	245	361	655	455	..

1 Notified cases. Since 1997, cases verified by laboratories. The total (men and women) includes those with missing data about gender

2 A mutant chlamydia gene, which is not detected in Abbot's test system, has been identified in the county of Halland and has presumably spread over a wide area. Cases in 2006 (and probably in 2005) are underreported in most of the counties because of problems associated with diagnosis of chlamydia. Source: Swedish Institute for Infectious Disease Control

3 For 2010, gender is not known for 3 people

Sources: See Table 3.1.5

3.2 Cancer

The Nordic countries have population-based cancer registers with centralized coding and classification. However, the coding is not centralized in Sweden.

Both external and internal factors that produce changes in the DNA material can cause cancer. Stimulants, foodstuffs, exposure to some occupational hazards and factors in the environment have been shown to be cancer inducing.

The incidence of cancer increases with age. Cancer is rare before the age of 30, where the incidence is 300 cases per 1 000 000 inhabitants. At the age of 70, the incidence is approximately 10 000 cases per 1 000 000 inhabitants. The annual number of cases of cancer is increasing in all the Nordic countries, and this trend remains after adjusting for differences in the size and age structure of the population.

The development of cancer diseases in the Nordic countries remains analogous for most forms of cancer, but there are interesting differences. In general, the number of cases has increased with time, with a few exceptions of decreasing incidence such as cancer of the stomach. The decrease in the incidence of cancer of the cervix in the Nordic countries is related to the public screening programmes to detect pre-cancerous lesions and early lesions, and the ensuing treatment.

The incidence of breast cancer, cancer of the prostate and colorectal cancer is increasing in almost all countries. Dietary factors are probably significant for this development, but for cancer of the breast and prostate, hormonal factors also play an important role. The incidence of cancer of the testis is again increasing in most of the countries. The incidence of tobacco-related cancers, such as lung cancer, is high in all the countries. However, the incidence of lung cancer among men is decreasing.

Table 3.2.1.a New cases of cancer per 1 000 000 inhabitants, Men

	Total	C62 Testis	C61 Prostate	C16 Stomach	C18-21 Colon and rectum	C25 Pancreas	C33-34 Lungs	C43 Melanoma of the skin
Denmark								
2000-04	4 978	103	880	121	713	141	794	186
2010	5 923	117	1 425	144	848	171	820	310
2011	6 269	104	1 543	124	819	189	814	356
Faroe Islands ¹								
2001-05	3 191	105	462	194	454	121	381	32
2006-10	3 636	159	1 146	56	589	207	294	103
Greenland ¹								
2002-06	..	..	..	..	..	..	..	..
2007-11	2 972	40	200	194	267	120	768	33
Finland								
2000-04	4 659	38	1 614	161	436	157	620	141
2010	5 391	49	1 753	149	530	192	636	240
2011	5 437	51	1 786	143	566	179	593	248
Åland ¹								
2002-06	6 981	46	3 184	184	597	214	612	138
2007-11	6 545	58	2 624	175	656	292	452	335
Iceland ¹								
2001-05	4 372	54	1 308	153	465	91	438	150
2007-11	4 309	63	1 330	111	444	82	490	127
Norway								
2000-04	5 072	108	1 423	156	738	131	606	212
2010	6 183	111	1 723	125	836	129	638	304
2011	6 478	116	1 992	127	768	129	647	342
Sweden								
2000-04	5 118	58	1 916	137	615	101	396	198
2010	5 560	64	2 077	110	690	111	392	314
2011	5 685	71	2 052	109	698	114	397	356

Numbers refer to ICD-10

* The total covers Chapter C, except C44 and C46.0. Includes D09.0; D32; D33; D41.4; D42 and D43

¹ Based on a 5-year average

Sources: The cancer registers in the Nordic countries; G: Danish Cancer Society

Table 3.2.1.b New cases of cancer, age-standardized rates per 1 000 000 men (Nordic population 2000)

	Total	C62 Testis	C61 Prostate	C16 Stomach	C18-21 Colon and rectum	C25 Pancreas	C33-34 Lungs	C43 Melanoma of the skin
Denmark								
2000-04	5 765	100	1 083	141	844	163	914	198
2010	6 099	92	1 445	139	887	177	831	303
2011	6 120	106	1 472	123	814	188	800	352
Faroe Islands ¹								
2001-05	3 918	109	590	248	557	150	462	38
2006-10	4 141	1 307	174	70	712	236	341	109
Greenland ¹								
2002-06	..	..	..	..	..	..	..	..
2007-11	4 574	57	323	222	366	158	1 459	41
Finland								
2000-04	5 860	37	2 024	209	545	189	733	157
2010	5 095	47	1 668	136	519	184	586	212
2011	5 270	53	1 702	142	557	175	572	242
Åland ¹								
2002-06								
2007-11	5 815	64	2 276	143	585	249	403	322
Iceland ¹								
2001-05	5 624	52	1 830	222	661	124	585	181
2007-11	5 331	61	1 684	138	554	100	627	148
Norway								
2000-04	6 059	105	1 741	193	897	159	724	240
2010	6 764	111	1 859	139	927	144	704	321
2011	6 986	115	2 104	142	849	141	704	360
Sweden								
2000-04	5 263	59	1 969	144	641	103	403	201
2005	5 362	64	2 101	126	618	97	391	236
2010	5 155	65	1 874	102	656	101	361	298
2011	5 232	73	1 832	102	650	103	362	341

Numbers refer to ICD-10

* The total covers Chapter C, except C44 and C46.0. Includes D09.0; D32; D33; D41.4; D42 and D43

¹ Based on a 5-year average

Sources: The cancer registers in the Nordic countries; G: Danish Cancer Society

Table 3.2.2.a New cases of cancer per 1 000 000 inhabitants, Women

	Total	C50 Breast	C53 Cervix uteri	C16 Stomach	C18-21 Colon and rectum	C25 Pancreas	C33-34 Lungs	C43 Melanoma of the skin
Denmark								
2000-04	5 162	1 426	145	68	660	149	613	228
2010	6 137	1 842	130	65	765	164	793	345
2011	6 154	1 669	144	67	808	170	792	417
Faroe Islands ¹								
2001-05	3 652	909	114	105	550	201	227	70
2006-10	3 108	861	146	69	448	86	241	164
Greenland ¹								
2002-06	..	..	..	..	..	..	..	..
2007-11	3 024	369	218	68	271	113	639	38
Finland								
2000-04	4 297	1 352	61	128	440	172	217	133
2010	5 270	1 779	53	100	503	195	288	243
2011	5 357	1 840	63	106	496	204	311	251
Åland ¹								
2002-06	5 266	1 470	122	138	674	214	321	245
2007-11	5 306	1 574	15	146	656	189	364	292
Iceland ¹								
2001-05	4 234	1 185	115	94	396	62	419	229
2007-11	3 999	1 258	102	73	383	93	494	175
Norway								
2000-04	4 666	1 163	128	99	738	146	368	237
2010	5 382	1 161	132	72	748	137	518	317
2011	5 516	1 244	122	80	780	150	492	347
Sweden								
2000-04	4 530	1 365	100	91	570	104	301	200
2010	5 877	1 682	91	69	637	103	370	287
2011	6 185	1 768	89	70	637	108	377	347

Numbers refer to ICD-10

* The total covers Chapter C, except C44 and C46.0. Includes D09.0; D32; D33; D41.4; D42 and D43

¹ Based on a 5-year average

Sources: The cancer registers in the Nordic countries; G: Danish Cancer Society

Table 3.2.2.b New cases of cancer, age-standardized rates per 1 000 000 Women (Nordic population 2000)

	Total	C50 Breast	C53 Cervix uteri	C16 Stomach	C18-21 Colon and rectum	C25 Pancreas	C33-34 Lungs	C43 Melanoma of the skin
Denmark								
2000-04	4 886	1 359	142	63	613	138	583	221
2010	5 357	1 619	126	56	647	139	679	324
2011	4 996	1 116	132	62	668	120	486	302
Faroe Islands ¹								
2001-05	3 536	947	121	101	565	205	241	76
2006-10	3 094	854	155	69	441	80	242	177
Greenland ¹								
2002-06	..	..	..	..	..	..	..	..
2007-11	4 272	405	245	104	424	173	1 009	33
Finland								
2000-04	4 072	1 302	58	116	403	146	185	124
2010	4 037	1 430	49	69	358	134	208	196
2011	4 236	1 501	61	79	375	148	235	210
Åland ¹								
2003-07	4 253	1 290	89	84	483	134	237	256
2007-11	4 134	1 312	13	123	448	139	289	249
Iceland ¹								
2001-05	4 650	1 391	120	110	465	74	503	241
2007-11	4 445	1 400	108	80	424	103	567	187
Norway								
2000-04	4 521	1 170	129	90	686	132	368	235
2010	4 996	1 116	132	62	668	120	486	302
2011	5 102	1 196	122	70	706	134	459	326
Sweden								
2000-04	4 014	1 250	97	75	473	90	268	185
2010	5 182	1 480	88	56	509	86	304	256
2011	5 467	1 548	87	58	512	88	308	313

Numbers refer to ICD-10

* The total covers Chapter C, except C44 and C46.0. Includes D09.0; D32; D33; D41.4; D42 and D431

¹ Based on a 5-year average

Sources: The cancer registers in the Nordic countries; G: Danish Cancer Society

Table 3.2.3 New cases of leukaemia per 1 000 000 inhabitants, 0-14 year-olds

	Denmark	Finland	Åland ¹⁾	Iceland	Norway	Sweden
Boys						
2000-04	59	55	.	30	52	51
2005	40	47	-	24	37	62
2010	55	48	.	53	37	75
2011	55	48	-	59	49	53
Girls						
2000-04	46	48	.	37	48	47
2005	41	56	-	31	32	44
2010	58	20	.	37	36	63
2011	46	69	-	49	53	48
Boys and girls						
2000-04	53	52	.	34	50	49
2005	40	51	42	27	34	53
2010	56	17	.	45	36	69
2011	50	59	-	54	51	51

The table covers numbers C91-C95 in ICD-10

1 2005 average 2002-2006, 2011 - average 2007-2011

Sources: The cancer registers in the Nordic countries; G: Danish Cancer Society

Table 3.2.4 New cases of cancer of the colon and rectum per 1 000 000 inhabitants

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2011	2006-10	2007-11	2011	2007-11	2007-11	2011	2011
Men								
Age								
0-24	2	22	-	9	-	7	5	9
25-44	58	-	115	48	168	60	75	75
45-64	848	646	364	560	562	559	785	612
65-84	3 635	3 088	2 168	2 443	2 672	2 582	3 743	2 952
85+	4 501	6 061	-	4 039	714	3 683	6 035	4 057
Women								
Age								
0-24	2	-	19	9	-	-	12	8
25-44	62	35	79	58	57	78	88	82
45-64	777	613	538	455	595	559	742	551
65-84	2 939	1 763	1 540	1 500	1 744	1 693	3 099	2 274
85+	3 707	2 418	2 545	2 435	5 207	2 616	4 225	2 542

The table covers the numbers C18-21 in ICD-10

Sources: The cancer registers in the Nordic countries; G: Danish Cancer Society

Table 3.2.5 New cases of lung cancer per 1 000 000 inhabitants

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2011	2006-10	2007-11	2011	2007-2011	2007-11	2011	2010
<i>Men</i>								
<i>Age</i>								
0-24	1	-	-	1	-	3	2	3
25-44	22	-	-	25	-	21	18	14
45-64	830	420	1 385	584	511	549	664	385
65-84	3 778	1 544	5 962	2 667	1 781	3 262	3 467	1 785
85+	3 669	1 347	20 000	3 815	3 011	3 208	3 297	1 341
<i>Women</i>								
<i>Age</i>								
0-24	4	-	-	-	-	-	1	2
25-44	42	35	53	20	-	32	21	17
45-64	891	397	1 140	302	694	3 466	581	408
65-84	3 029	1 045	5 172	1 195	918	2 723	2 136	1 467
85+	1 692	-	-	1 077	401	1 543	1 310	583

The table covers the numbers C33-34 in ICD-10

Sources: The cancer registers in the Nordic countries; G: Danish Cancer Society

Table 3.2.6 New cases of cancer of the cervix uteri per 1 000 000 women

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2011	2006-10	2007-11	2011	2007-2011	2007-11	2011	2011
<i>Age</i>								
0-24	15	-	-	8	-	19	6	4
25-44	247	176	528	111	-	113	205	137
45-64	159	325	222	53	-	50	158	118
65-84	165	131	220	232	92	96	146	111
85+	233	345	-	70	-	61	154	119

The table covers the number C53 in ICD-10

Sources: The cancer registers in the Nordic countries; G: Danish Cancer Society

Table 3.2.7 New cases of cancer of the testis per 1 000 000 men

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2010	2006-10	2007-11	2011	2003-2007	2006-10	2011	2010
<i>Age</i>								
0-24	49	-	18	33	-	35	59	32
25-44	215	-	46	132	168	124	253	178
45-64	102	1 098	49	21	51	51	81	48
65-84	33	7 439	108	8	-	26	36	10
85+	-	2 694	-	-	-	-	28	24

The table covers the number C62 in ICD-10

Sources: The cancer registers in the Nordic countries; G: Danish Cancer Society

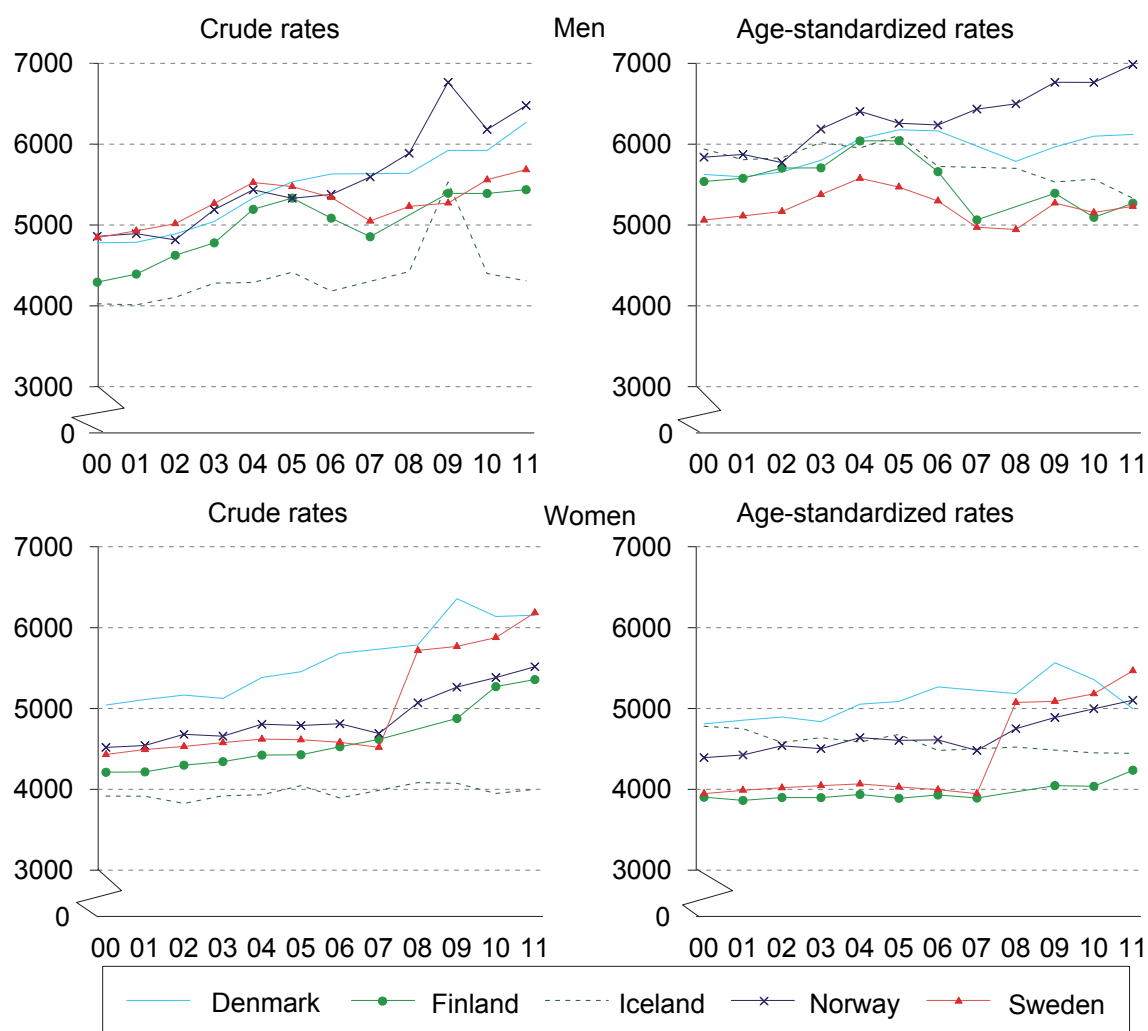
Table 3.2.8 New cases of melanoma of the skin per 1 000 000 inhabitants

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2011	2006-10	2007-11	2011	2003-2011	2007-11	2011	2011
<i>Men</i>								
<i>Age</i>								
0-24	27	22	18	8	-	10	10	12
25-44	204	90	23	99	336	60	129	137
45-64	462	226	49	292	511	200	480	427
65-84	1 066	140	108	853	495	527	1 277	1 168
85+	1 405	-	-	260	2 007	132	1 565	1 637
<i>Women</i>								
<i>Age</i>								
0-24	38	96	37	33	-	75	14	16
25-44	421	281	53	190	115	274	200	259
45-64	570	108	32	372	545	233	505	469
65-84	732	131	-	581	459	308	889	780
85+	891	691	-	242	801	180	1 220	762

The table covers the number C43 in ICD-10

Sources: The cancer registers in the Nordic countries; G: Danish Cancer Society

Figure 3.2.1 New cases of cancer, crude rates and age-standardized rates per 1 000 000 inhabitants 2000-2011

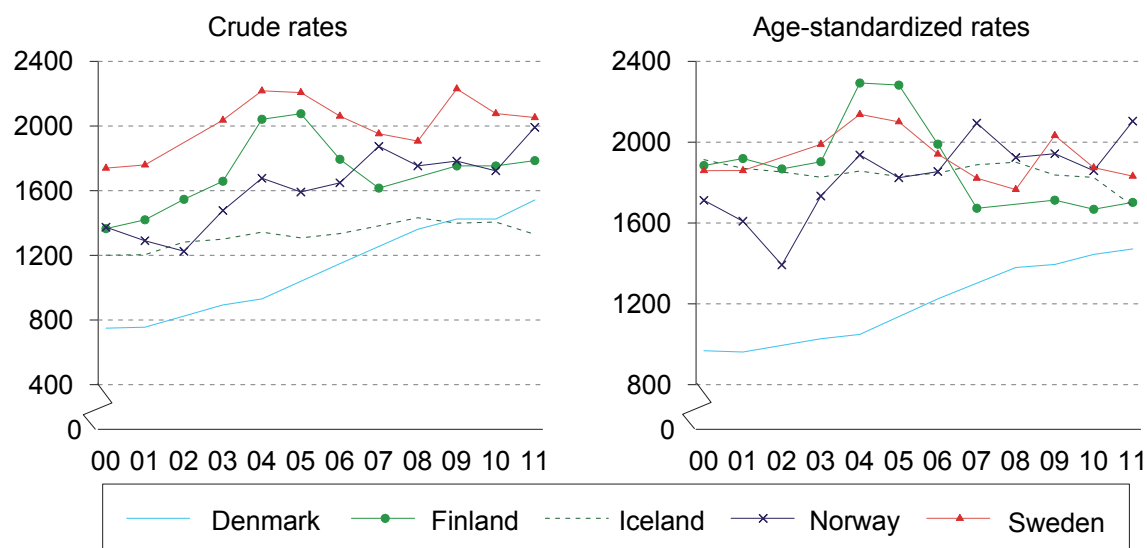


Age-standardized by the Nordic population 2000

The figures for Iceland are 5-year averages

Source: The Nordic Cancer Union

Figure 3.2.2 New cases of prostate cancer, crude rates and age-standardized rates per 1 000 000 inhabitants 2000-2011

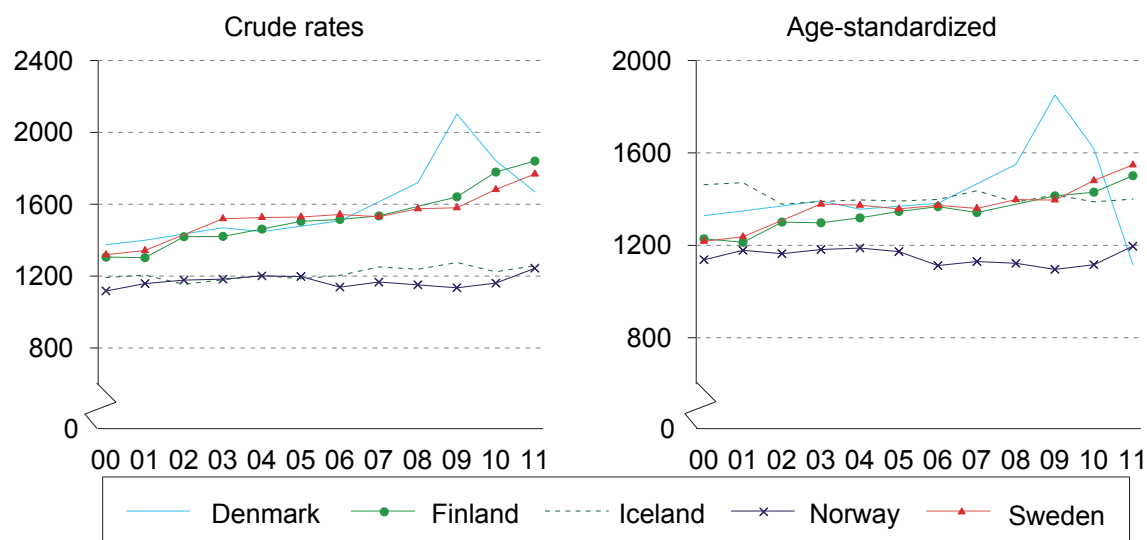


Age-standardized by the Nordic population 2000

The figures for Iceland are 5-year averages

Source: See Table 3.2.1.b

Figure 3.2.3 New cases of breast cancer, crude rates and age-standardized rates per 1 000 000 inhabitants 2000-2011

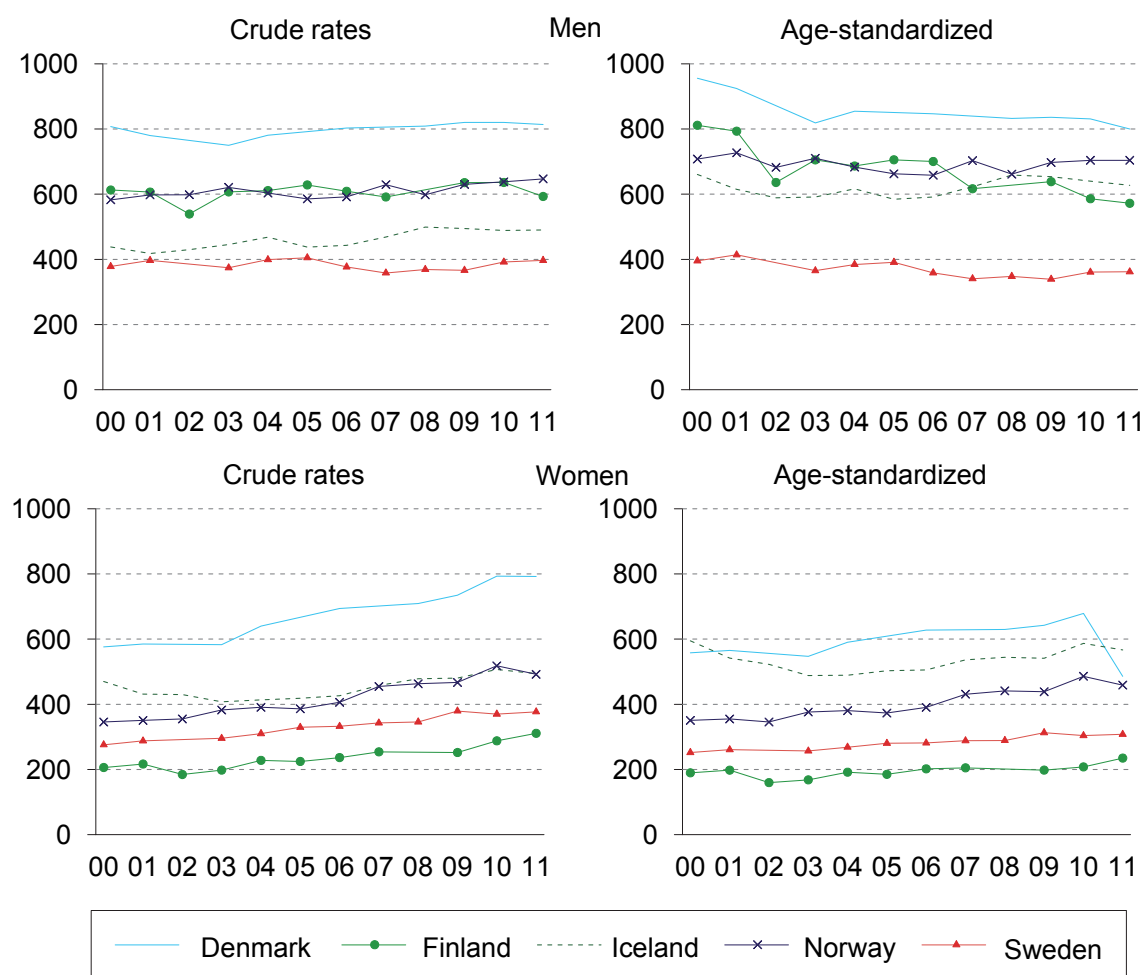


Age-standardized by the Nordic population 2000

The figures for Iceland are 5-year averages

Source: See Table 3.2.2.b

Figure 3.2.4 New cases of lung cancer, crude rates and age-standardized rates per 1 000 000 inhabitants, 2000-2011



Age-standardized by the Nordic population 2000

The figures for Iceland are 5-year averages

Source: See Table 3.2.1.b and Table 3.2.1.b

3.3 Medical Consultations and Immunization Schedules

In the Nordic countries, primary health services are organized and financed by the public sector.

However, the degree of decentralization varies, also regarding the relationship between private general practitioners and those publicly employed in the primary health care sector.

There are also differences in the level of integration of medical treatment, nursing, physiotherapy, etc. Similar differences are also found for home nursing and home help.

The registration practice for medical consultations differs substantially from one country to another.

Normally, patients visit the physician in his/her practice, but in all countries consultations can also be telephone consultations, home visits by a physician, and treatment in emergency wards.

All contacts in Denmark are registered as medical contacts because of the payment system, whereas some of the contacts in the other countries are registered or non-registered contacts with other health care personnel. In particular, there are differences among the countries with regard to check-ups for mothers and infants. Along with other factors, this means that the statistics on medical consultations are not directly comparable among the Nordic countries.

Table 3.3.2 shows the number of consultations with general practitioners by age. Small children and elderly people are the largest groups. Reliable data for consultations with specialists are currently not available.

All Nordic countries have recommended immunization programmes with some differences in vaccination against tuberculosis and whooping cough, and the choice of vaccines against measles and rubella.

Collection of data on immunization varies a lot from country to country, and none of the countries, except Norway, have immunization registers covering the country as a whole.

Table 3.3.1 Number of physicians in general practice, 2011

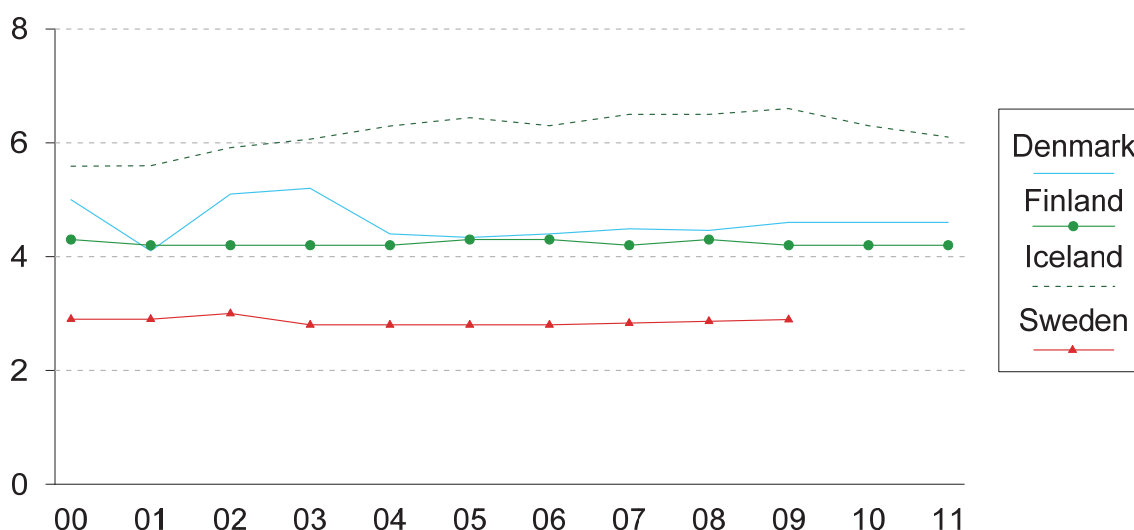
	Denmark	Faroe Islands	Greenland ¹⁾	Finland ²⁾	Åland	Iceland	Norway	Sweden ³⁾
Number of physicians in general practice	5 110	27	50	15 760	18	188	5 767	5 897
Number of inhabitants per physician in general practice	1 089	1 783	1 140	341	1 566	1 697	859	1 563

1 The number is indicated for District Medical Officers

2 Municipalities only

3 2010

Sources: D: Statens Serum Institut; F: THL; Å: Ålands landskapsregering; I: Directorate of Health; S: National Board of Health and Welfare

Figure 3.3.1 Consultations per capita, 2000-2011

Sources: See Table 3.3.1

Table 3.3.2 Number of consultations with physicians in general practice, estimated national level, per 1 000 inhabitants in the age group, 2011

	Denmark	Finland	Iceland ¹⁾	Norway
<1 year	281 169	2 236	7 465	47 167
1-4 years	895 489	1 964	3 865	511 753
5-14 years	1 298 801	1 296	1 619	687 419
15-24 years	1 976 029	1 205	2 104	1 139 615
25-44 years	4 579 443	1 021	2 183	3 485 287
45-64 years	5 674 975	1 131	2 486	3 849 084
65-74 years	3 133 524	1 822	3 367	1 661 917
75-84 years	2 048 797	2 437	4 110	1 265 296
85+ years	570 376	2 622	3 346	531 167
Total, per 1 000 inhabitants	3 679	1 360	2 526	2 661
Total number of consultations	20 458 603	7 347 664	805 901	13 180 716

1 Total numbers, all registered contacts with health care centres

Sources: D: Statens Serum Institut; F: THL; I: Directorate of Health

Table 3.3.3 Recommended immunization schedules per 1 January 2011

	Denmark	Greenland	Finland	Iceland	Norway	Sweden
Pneumococcus	3, 5 and 12 months	3, 5 and 12 months	3, 5 and 12 months + risk group children under 5 years	60+ years. Vaccination at 3, 5 and 12 months starts in April 2011	3, 5 and 12 months,	..
BCG	-	At birth	Only for risk group children under 7 years since 9/2006	-	Risk groups	Risk groups
Pertussis	3, 5 and 12 months and 5 years	3, 5 and 12 months and 5 years	3, 5 and 12 months, 4 and 14-15 years	3, 4, 12 months, 4 and 14 years	3, 5 and 12 months, 7-8 years	3, 5 and 12 months, 5-6 and 14-16 years
Tetanus	3, 5 and 12 months and 5 years	3, 5 and 12 months and 5 years	3, 5 and 12 months, 4 and 14-15 years	3, 4, 12 months, 4 and 14 years	3, 5 and 12 months, 7-8 and 15-16 years	3, 5 and 12 months, 5-6 and 14-16 years
Diphtheria	3, 5 and 12 months and 5 years	3, 5 and 12 months and 5 years	3, 5 and 12 months and 4 years	3, 4 and 12 months, 4 and 14 years	3, 5 and 12 months, 7-8 and 15-16 years	3, 5 and 12 months, 5-6 and 14-16 years
Polio	IPV: 3, 5 and 12 months and 5 years	IPV: 3, 5 and 12 months and 5 years	IPV: 3, 5 and 12 months and 4 years	IPV: 3, 5, 12 months and 14 years	IPV: 3, 5 and 12 months, 7-8 years and 15-16 years	IPV: 3, 5 and 12 months, 5-6 years
Measles, Mumps, Rubella	15 months, 12 years	15 months, 4 years	12-18 months and 6 years	18 months and 12 years	15 months and 11-12 years	18 months and 6-8 years
Rubella, only	Fertile women	Fertile women	-	-	Seronegative fertile women	-
Haemophilic influenza b	3, 5 and 12 months	3, 5 and 12 months	3, 5 and 12 months	3, 5 and 12 months	3, 5 and 12 months	3, 5 and 12 months
Rotavirus	-	-	2, 3 and 5 months	-	-	-
HPV	Girls: 12 years	3 vaccines of girls by their 12 th year (0, 2 and 6 months)	-	Girls: 12 years	12-13 years (girls only)	3 vaccines for girls born in 1999 or later (5 th -6 th grade) 2010
Meningococcal disease gr. C	-	-	-	6 and 8 months	-	-
Influenza 65+	65+ and risk groups	65+ and risk groups	65+ and risk groups	60+ years	65+ and risk groups	65+ and risk groups

IPV = Inactivated polio vaccine

The Faroe Islands and Åland have the same immunization schedules as Denmark and Finland respectively. In Åland TBE is included for children over 4 years. HPV for girls 13-15 years (since autumn 2011)

Sources:WHO/EPID: Statens Serum Institut; GR: The Chief Medical Officer; F: THL; I: Directorate of Health; N: Norwegian Institute of Public Health; S: The National Board of Health and Welfare

Table 3.3.4 Children under the age of two immunized according to recommended immunization schedules and elderly people vaccinated against influenza (per cent), 2011

	Denmark	Faroe Islands	Greenland	Finland ¹⁾	Iceland ²⁾	Norway ³⁾	Sweden ⁴⁾
BCG	..	-	..	NA	0	..	21
Pertussis	93	96	..	99	86	94	98
Tetanus	93	96	..	99	86	94	99
Diphtheria	93	96	..	99	86	94	98
Polio	93	96	..	99	86	94	98
Rubella	83	89	..	97	89	93	97
Measles	83	89	..	97	89	93	97
Influenza 65+	..	48	..	40	33	..	64

1 Based on a randomly chosen population of children in 2007. For the elderly, the figure is based on data from patient journal systems

2 Data based on birth cohort 2008

3 Data underestimated due to a low degree of reporting in some municipalities

4 January 2009. Influenza data 65+ concerns 2008

Sources: WHO/EPID: Statens Serum Institut; GR: The Chief Medical Officer; F: THL; I: Directorate of Health; N: Norwegian Institute of Public Health; S: The National Board of Health and Welfare

3.4 Discharges, Bed Days, Average Length of Stay and Patients Treated

Outline of this section

In this section, diagnosis-related data on hospital use are presented according to the main diagnosis that has been registered for each hospital stay in the national patient registers of the Nordic countries. The presentation of diagnoses is more detailed than in NOMESCO publications from before 2010. It is now based on the new list of diagnoses developed by the EU Hospital Data Project. This list has been adopted by WHO as the International Shortlist for Hospital Morbidity Tabulation (ISHMT). It is used also by Eurostat, OECD and the WHO Regional Office for Europe.

The ISHMT list (see link ISHMT list of diagnoses) comprises 149 groups. Thus, it is relatively long for a traditional table presentation. Therefore, in this section we apply, as a trial, an abbreviated list with selected groups from the full ISHMT list, among them the ICD-10 chapter-level groups that until now have been the principal grouping of diagnoses in the summary tables. Now 36 selected groups that are subgroups of the ICD-10 chapters have been added. Several principles have guided the choice of these groups. They are selected mainly because they are relatively common and/or of special interest for internordic comparison, e.g. because of new treatment possibilities. Some possible groups were not selected because hospital activities in those groups are better reflected in the statistics on procedures (cf. Section 3.5).

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groups of the ICD-10 chapters have been added. Several principles have guided the choice of these groups. They are selected mainly because they are relatively common and/or of special interest for internordic comparison, e.g. because of new treatment possibilities. Some possible groups were not selected because hospital activities in those groups are better reflected in the statistics on procedures (cf. Section 3.5).

While discharge rates illustrate how common certain groups of diagnoses are as reason for admission to hospital, bed-day rates better illustrate the load that these diagnoses imply on hospitals. The average length of stay for inpatients by diagnosis is shown in a third set of tables (Table 3.4.3). This is followed by figures that show the development over time of hospital use for three ICD chapters.

The section is concluded with ten detailed tables showing not only age distribution but also the relationship between number of discharges and number of patients treated in respect of certain diagnosis groups. Since the patient registers make it possible to link successive hospital spells with the same main diagnosis, it is possible to calculate, on a national level, the total number of people that have been treated in a year.

Quality and limitations of data

The quality of the data in the patient registers, such as representatively, completeness and reliability, is important for these statistics.

In 2000, NOMESCO performed a validity study of the diagnoses related to the patient statistics. The results were presented as a theme section in the 2000 version of this publication. The general picture was that Nordic hospital data have a high degree of coverage. Only a few private hospitals are not included in some of the countries. There are, however, organizational differences in the hospital systems that influence the statistics.

In order to make the statistics as comparable as possible, the data presented in this section are from somatic hospital departments (wards) in general hospitals and specialized somatic wards. Still, it is not possible to get completely comparable sets of hospital data. In Norway, discharges are not related to hospital departments (wards) but only to the hospital as a whole, which means that discharge rates are slightly underestimated compared to the other countries.

This does not influence the bed-day rates, however. Furthermore, data from the Faroe Islands are influenced by the fact that some types of treatment are provided in Denmark, and for Åland in Sweden.

The diagnosis-related statistics presented in this report are based on the main diagnosis for each hospital stay. The main diagnosis refers to the main condition treated or examined during each hospital stay. According to the ICD, it is defined as the condition, diagnosed at the end of the treatment period and primarily responsible for the patient's need for treatment or examination. This means that hospital statistics do not give a complete picture of the diseases treated in hospital, since the secondary diagnoses that has been attended to during a hospital stay does not show in the statistics. Hospital discharges, even when recalculated as patients treated, do not correspond to true incidence figures for the population because not all cases are

treated in hospitals. For certain diagnoses, incidence figures are available from other sources. This is the case for malignant neoplasms reported to the national cancer registers (cf. Section 3.2). Hospital data for cancer diagnoses are complementary to these in the sense that they illustrate how cancer morbidity is reflected in the activity and workload of hospitals.

Comparisons among countries are also hampered by the fact that there are some differences in the way the WHO definition of main condition is interpreted in the Nordic countries. The introduction of Diagnosis Related Groups (DRG) has influenced the choice of main diagnosis in all the countries, but slightly differently.

There are also national differences in diagnostic tradition (as will be shown below) as well as differences in registration and coding of diagnoses that influence comparability.

Healthy new-born babies are counted differently in the Nordic countries. In the ICD, there is a category (Z38) and in the ISHMT list, there is a group for healthy new-borns. In some of the countries, these babies are not registered as patients in their own right and thus not included in the patient registers. Therefore, healthy new-born babies are excluded from the tables in this section.

Comments to the tables

The overall discharge rates (cf. Table 3.4.1.a) vary somewhat among the Nordic countries. Highest rates are found for Denmark, the Faroe Islands and Finland and the lowest for Iceland with Norway and Sweden in between. There are marked differences, however, in hospital use among the countries for certain groups of diseases and specific diagnoses, both measured as rate of discharges and as rate of bed-days.

In all countries, there are high discharge rates for diseases of the circulatory system (ICD, Chapter IX), injuries (Chapter XIX) and neoplasms (Chapter II). In Iceland, however, pregnancy and childbirth (Chapter XV) accounts for the highest discharge rate, and in Denmark discharges for factors influencing health status and contact with health services (Chapter XXI) is the one most common of all ICD chapters.

In all the countries, the number of bed-days per 100 000 population (cf. Table 3.4.2.a) is high for diseases of the circulatory system, neoplasms and injuries. Exceptions are found for Denmark, where Chapter XXI has a very high rate and Finland where mental disorders (Chapter V) account for more of the bed-days than any of the other ICD chapters.

The average length of stay (cf. Table 3.4.3.a) varies among countries from 4.6 days in Denmark and Norway to 9.4 days in Finland.

For many diagnosis groups and for specific diagnoses, there is also great similarity in average length of stay. There are, however, some greater differences among the countries, such as for mental and behavioural disorders with long stays for the Faroe Islands, Finland and Åland. This reflects the fact that the somatic hospital data in these countries include some psychiatric patients. Long stays are also found for cerebrovascular diseases in the same countries, indicating the occurrence of some long-term care cases in short-term hospitals in these countries.

While some of the differences in hospital use may be due to slightly different disease patterns in the Nordic countries, it is obvious that many of the statistical differences are attributable to organizational differences in the hospital systems and to differences in the registration and coding of diagnoses in hospital.

A clear example of this is the very high Danish discharge rate for Chapter XXI and especially for medical observation and evaluation for suspected diseases and conditions (code Z03). As can be seen from Table 3.4.1, there are large differences among the countries in this area. Apparently, cases with a suspected but not quite confirmed diagnosis are coded differently. While such a case may be coded as a symptom or as a definite disease in other countries, in Denmark they are often coded as an observation case (Z03). Other examples of differences in coding practice refer to the use in Denmark and Norway of a Chapter XXI code for rehabilitation cases (code Z50, not specified in the tables). In other countries, rehabilitation cases seem to a greater extent to be coded to the underlying disorder.

The trends illustrated in Figures 3.4.1 - 3 do not show big changes in discharge rates over the years (except for the Faroe Islands and Åland, due to small populations). The other countries retain their relative position among themselves over the period studied.

In Tables 3.4.4 - 13, the possibilities of linking successive hospital stays for the same main diagnosis and the same person are being used, thus calculating the number of actual persons being treated, in the following called 'patients treated'. The Nordic countries are among the few countries in the world that can do this on a national level. As an example, from Table 3.4.4 on lung cancer it can be seen that for all countries and for both men and women the numbers of patients treated are about half the numbers of discharges.

It is also worth noting that the age-specific rates for patients treated for lung cancer are at the same level for both genders under the age of 65; men have higher rates only in the age group 65 and over.

The difference in the number of discharges and the number of patients treated varies by diagnosis. The difference is largest for chronic conditions such as chronic obstructive pulmonary disease (Table 3.4.8) and alcoholic liver disease (Table 3.4.10).

In all countries, the figure for patients treated amounts to about 60 per cent of the discharges for these two diseases. For most of the other diagnoses presented in the detailed tables, the reduced figures for patients treated correspond to 70-80 per cent of the number of discharges.

Table 3.4.1.a Discharges from hospitals per 100 000 population by main diagnosis, both genders

ICD-10 code Main diagnosis	Denmark 2011	Faroe Islands 2003-07	Finland 2011	Åland 2007-11	Iceland ¹⁾ 2009	Norway 2011	Sweden 2011
I: Certain infectious and parasitic diseases (<i>A00-B99</i>)	749	476	483	540	185	511	551
II: Neoplasms (<i>C00-D48</i>)	1 835	1 827	1 713	1 058	1 176	1 573	1 390
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (<i>D50-D89</i>)	310	463	139	131	140	164	165
IV: Endocrine, nutritional and metabolic diseases (<i>E00-E90</i>)	731	458	279	273	283	315	437
V: Mental and behavioural disorders (<i>F00-F99</i>)	1 163	944	752	228	213	275	1 136
VI: Diseases of the nervous system (<i>G00-G99</i>)	620	642	575	517	318	705	520
VII: Diseases of the eye and adnexa (<i>H00-H59</i>)	106	626	151	79	82	112	98
VIII: Diseases of the ear and mastoid process (<i>H60-H95</i>)	123	312	84	191	50	84	92
IX: Diseases of the circulatory system (<i>I00-I99</i>)	2 636	2 296	2 262	2 051	1 439	2 381	2 549
X: Diseases of the respiratory system (<i>J00-J99</i>)	2 059	1 444	1 337	1 231	741	1 398	1 055
XI: Diseases of the digestive system (<i>K00-K93</i>)	1 863	2 813	1 594	1 476	1 146	1 261	1 254
XII: Diseases of the skin and subcutaneous tissue (<i>L00-L99</i>)	338	250	189	121	228	166	127
XIII: Diseases of the musculoskeletal system and connective tissue (<i>M00-M99</i>)	1 337	1 408	1 832	1 199	896	1 121	986
XIV: Diseases of the genitourinary system (<i>N00-N99</i>)	1 235	978	1 028	1 076	700	926	759
XV: Pregnancy, childbirth and the puerperium (<i>O00-O99</i>)	1 415	1 799	1 425	1 189	1 836	680	1 477
XVI: Certain conditions originating in the perinatal period (<i>P00-P96</i>)	190	257	181	92	521	183	168
XVII: Congenital malformations, deformations and chromosomal abnormalities (<i>Q00-Q99</i>)	190	193	192	74	117	148	116
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (<i>R00-R99</i>)	2 187	1 323	1 029	1 367	592	1 388	1 565
XIX: Injury, poisoning and certain other consequences of external causes (<i>S00-T98</i>)	2 204	1 839	1 944	1 412	1 002	1 862	1 609
XXI: Factors influencing health status and contact with health services (<i>Z00-Z99</i>)	2 785	3 507	290	504	690	1 689	384
All causes (except. XX) (<i>A00-Z99</i> excluding <i>V, W, X</i> and <i>Y</i>)	25 143	23 374	19 208	14 810	12 239	16 941	17 442

1 Only discharges with a length of stay less than 90 days

Sources: The national in-patient registers

Table 3.4.1.b Discharges from hospitals per 100 000 population by main diagnosis, men

ICD-10 code Main diagnosis	Denmark 2011	Faroe Islands 2003-07	Finland 2011	Åland 2007-11	Iceland ¹⁾ 2009	Norway 2011	Sweden 2011
I: Certain infectious and parasitic diseases (<i>A00-B99</i>)	804	497	501	556	178	527	576
II: Neoplasms (<i>C00-D48</i>)	1 738	1 775	1 605	894	1 129	1 564	1 299
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (<i>D50-D89</i>)	303	474	127	100	106	145	145
IV: Endocrine, nutritional and metabolic diseases (<i>E00-E90</i>)	625	426	254	247	174	260	383
V: Mental and behavioural disorders (<i>F00-F99</i>)	1 202	1 012	794	251	187	298	1 216
VI: Diseases of the nervous system (<i>G00-G99</i>)	644	623	581	459	305	754	529
VII: Diseases of the eye and adnexa (<i>H00-H59</i>)	107	586	143	37	79	112	103
VIII: Diseases of the ear and mastoid process (<i>H60-H95</i>)	129	323	86	215	50	80	85
IX: Diseases of the circulatory system (<i>I00-I99</i>)	3 127	2 648	2 550	2 108	1 740	2 867	2 881
X: Diseases of the respiratory system (<i>J00-J99</i>)	2 149	1 494	1 519	1 343	695	1 460	1 087
XI: Diseases of the digestive system (<i>K00-K93</i>)	1 866	2 828	1 790	1 465	1 012	1 254	1 231
XII: Diseases of the skin and subcutaneous tissue (<i>L00-L99</i>)	390	294	217	130	220	175	129
XIII: Diseases of the musculoskeletal system and connective tissue (<i>M00-M99</i>)	1 216	1 361	1 609	956	764	979	846
XIV: Diseases of the genitourinary system (<i>N00-N99</i>)	993	761	768	671	459	843	678
XV: Pregnancy, childbirth and the puerperium (<i>O00-O99</i>)	.	.	.	.	.	.	.
XVI: Certain conditions originating in the perinatal period (<i>P00-P96</i>)	215	265	211	98	579	171	189
XVII: Congenital malformations, deformations and chromosomal abnormalities (<i>Q00-Q99</i>)	216	193	1 013	1 230	137	1 296	128
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (<i>R00-R99</i>)	2 063	1 331	2 190	1 451	504	1 873	1 472
XIX: Injury, poisoning and certain other consequences of external causes (<i>S00-T98</i>)	2 195	2 106	232	449	1 007	836	1 532
XXI: Factors influencing health status and contact with health services (<i>Z00-Z99</i>)	2 600	2 757	501	556	525	527	379
All causes (except. XX) (<i>A00-Z99 excluding V, W, X and Y</i>)	23 676	21 254	17 877	12 757	9 713	15 699	15 923

1 Only discharges with a length of stay less than 90 days

Sources: The national in-patient registers

Table 3.4.1.c Discharges from hospitals per 100 000 population by main diagnosis, women

ICD-10 code Main diagnosis	Denmark 2011	Faroe Islands 2003-07	Finland 2011	Åland 2007-11	Iceland ¹⁾ 2009	Norway 2011	Sweden 2011
I: Certain infectious and parasitic diseases (A00-B99)	695	453	464	514	193	496	526
II: Neoplasms (C00-D48)	1 930	1 884	1 812	1 199	1 224	1 582	1 481
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	317	452	151	159	176	183	185
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	835	493	302	293	395	369	489
V: Mental and behavioural disorders (F00-F99)	1 125	870	709	..	240	253	1 055
VI: Diseases of the nervous system (G00-G99)	596	662	566	563	330	656	511
VII: Diseases of the eye and adnexa (H00-H59)	105	670	157	118	85	113	94
VIII: Diseases of the ear and mastoid process (H60-H95)	117	300	81	163	50	87	100
IX: Diseases of the circulatory system (I00-I99)	2 152	1 915	1 978	1 952	1 130	1 894	2 220
X: Diseases of the respiratory system (J00-J99)	1 971	1 391	1 157	1 096	788	1 336	1 023
XI: Diseases of the digestive system (K00-K93)	1 861	2 797	1 400	1 457	1 284	1 268	1 278
XII: Diseases of the skin and subcutaneous tissue (L00-L99)	287	202	162	110	236	157	124
XIII: Diseases of the musculoskeletal system and connective tissue (M00-M99)	1 455	1 459	2 042	1 414	1 032	1 263	1 124
XIV: Diseases of the genitourinary system (N00-N99)	1 473	1 212	1 276	1 454	947	1 009	840
XV: Pregnancy, childbirth and the puerperium (O00-O99)	2 807	3 743	2 795	2 340	3 716	1 361	2 944
XVI: Certain conditions originating in the perinatal period (P00-P96)	166	249	155	86	462	160	147
XVII: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	164	194	174	48	98	124	104
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	2 309	1 314	1 041	1 473	682	1 480	1 658
XIX: Injury, poisoning and certain other consequences of external causes (S00-T98)	2 212	1 550	1 702	1 345	997	1 851	1 685
XXI: Factors influencing health status and contact with health services (Z00-Z99)	2 968	4 318	345	548	860	2 541	390
All causes (except. XX) (A00-Z99 excluding V, W, X and Y)	26 585	25 664	20 445	16 534	14 827	18 183	18 950

1 Only discharges with a length of stay less than 90 days

Sources: The national in-patient registers

Table 3.4.2.a Bed-days in hospitals per 100 000 population by main diagnosis, both genders

ICD-10 code Main diagnosis	Denmark 2011	Faroe Islands 2003-07	Finland 2011	Åland 2007-11	Iceland ¹⁾ 2009	Norway 2011	Sweden 2011
I: Certain infectious and parasitic diseases (<i>A00-B99</i>)	3 317	2 514	3 571	3 478	2009	3 086	2 906
II: Neoplasms (<i>C00-D48</i>)	7 765	8 639	10 360	8 792	1 063	10 087	9 065
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (<i>D50-D89</i>)	909	1 700	686	751	8 955	576	669
IV: Endocrine, nutritional and metabolic diseases (<i>E00-E90</i>)	2 537	3 285	1 737	1 899	792	1 190	1 799
V: Mental and behavioural disorders (<i>F00-F99</i>)	18 264	28 703	22 627	..	1 927	776	15 299
VI: Diseases of the nervous system (<i>G00-G99</i>)	2 971	2 790	6 314	3 729	3 173	2 427	2 579
VII: Diseases of the eye and adnexa (<i>H00-H59</i>)	223	659	429	201	3 137	356	235
VIII: Diseases of the ear and mastoid process (<i>H60-H95</i>)	213	225	341	474	225	176	213
IX: Diseases of the circulatory system (<i>I00-I99</i>)	9 842	21 690	18 160	14 452	133	10 601	13 675
X: Diseases of the respiratory system (<i>J00-J99</i>)	8 088	7 626	8 034	6 582	10 979	7 796	5 981
XI: Diseases of the digestive system (<i>K00-K93</i>)	6 626	7 046	6 370	7 667	5 207	5 377	5 540
XII: Diseases of the skin and subcutaneous tissue (<i>L00-L99</i>)	1 140	1 183	1 026	723	5 210	941	830
XIII: Diseases of the musculoskeletal system and connective tissue (<i>M00-M99</i>)	4 080	6 961	5 920	6 997	1 416	5 011	4 669
XIV: Diseases of the genitourinary system (<i>N00-N99</i>)	3 479	2 806	3 719	4 834	5 482	3 272	3 292
XV: Pregnancy, childbirth and the puerperium (<i>O00-O99</i>)	3 657	7 948	5 696	5 642	2 852	2 301	3 495
XVI: Certain conditions originating in the perinatal period (<i>P00-P96</i>)	1 689	1 215	1 519	805	4 113	1 766	1 774
XVII: Congenital malformations, deformations and chromosomal abnormalities (<i>Q00-Q99</i>)	588	814	791	1 101	2 341	658	585
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (<i>R00-R99</i>)	4 792	4 262	3 590	5 229	444	2 445	4 105
XIX: Injury, poisoning and certain other consequences of external causes (<i>S00-T98</i>)	7 444	8 340	10 315	8 427	2 474	8 033	8 700
XXI: Factors influencing health status and contact with health services (<i>Z00-Z99</i>)	12 903	8 832	1 127	1 899	6 550	8 007	2 573
All causes (except. XX) (<i>A00-Z99 excluding V, W, X and Y</i>)	102 743	126 494	112 331	85 219	4 668	74 883	96 747

1 Only discharges with a length of stay less than 90 days
Sources: The national in-patient registers

Table 3.4.2.b Bed-days in hospitals per 100 000 population by main diagnosis, men

ICD-10 code Main diagnosis	Denmark 2011	Faroe Islands 2003-07	Finland 2011	Åland 2007-11	Iceland ¹⁾ 2009	Norway 2011	Sweden 2011
I: Certain infectious and parasitic diseases (A00-B99)	3 610	2 556	3 801	3 680	1 159	3 245	2 906
II: Neoplasms (C00-D48)	7 947	8 727	9 964	7 495	9 175	10 529	9 134
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	831	2 182	635	673	630	534	586
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	2 312	3 405	1 608	1 662	1 284	1 033	1 609
V: Mental and behavioural disorders (F00-F99)	19 079	23 757	19 850	..	2 527	704	15 812
VI: Diseases of the nervous system (G00-G99)	3 134	3 377	5 047	3 412	3 212	2 443	2 688
VII: Diseases of the eye and adnexa (H00-H59)	226	547	407	127	254	359	236
VIII: Diseases of the ear and mastoid process (H60-H95)	211	212	444	507	118	159	179
IX: Diseases of the circulatory system (I00-I99)	11 524	24 305	18 348	14 995	12 500	12 314	14 892
X: Diseases of the respiratory system (J00-J99)	8 368	6 531	8 414	7 197	4 940	8 116	5 935
XI: Diseases of the digestive system (K00-K93)	6 588	6 818	6 762	7 583	4 412	5 241	5 350
XII: Diseases of the skin and subcutaneous tissue (L00-L99)	1 329	1 307	1 108	743	1 405	950	845
XIII: Diseases of the musculoskeletal system and connective tissue (M00-M99)	3 605	5 292	4 625	4 912	4 137	4 240	3 755
XIV: Diseases of the genitourinary system (N00-N99)	3 141	2 745	3 162	3 380	2 480	3 231	3 224
XVI: Certain conditions originating in the perinatal period (P00-P96)	1 876	1 264	1 696	917	2 656	2 004	1 947
XVII: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	664	830	765	1 652	469	759	608
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	4 595	4 171	3 408	4 906	2 082	2 216	3 843
XIX: Injury, poisoning and certain other consequences of external causes (S00-T98)	6 966	7 113	10 773	8 330	6 278	7 499	7 461
XXI: Factors influencing health status and contact with health services (Z00-Z99)	13 134	6 541	1 018	2 078	3 756	5 489	2 579
All causes (except. XX) (A00-Z99 excluding V, W, X and Y)	101 394	110 772	101 835	75 378	63 006	71 065	92 616

1 Only discharges with a length of stay less than 90 days

Sources: The national in-patient registers

Table 3.4.2.c Bed-days in hospitals per 100 000 population by main diagnosis, women

ICD-10 code <i>Main diagnosis</i>	Denmark 2011	Faroe Islands 2003-07	Finland 2011	Åland 2007-11	Iceland ¹⁾ 2009	Norway 2011	Sweden 2011
I: Certain infectious and parasitic diseases (A00-B99)	3 029	2 468	3 339	3 206	965	2 927	2 905
II: Neoplasms (C00-D48)	7 587	8 545	10 713	9 894	8 729	9 645	8 996
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	986	1 180	733	813	958	617	752
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	2 759	3 155	1 856	2 095	2 586	1 347	1 989
V: Mental and behavioural disorders (F00-F99)	17 463	34 049	25 238	..	3 835	848	14 789
VI: Diseases of the nervous system (G00-G99)	2 810	2 155	7 518	3 965	3 061	2 410	2 471
VII: Diseases of the eye and adnexa (H00-H59)	220	779	449	270	194	354	234
VIII: Diseases of the ear and mastoid process (H60-H95)	216	239	240	431	149	194	247
IX: Diseases of the circulatory system (I00-I99)	8 187	18 864	17 925	13 619	9 421	8 887	12 466
X: Diseases of the respiratory system (J00-J99)	7 812	8 811	7 643	5 840	5 481	7 476	6 027
XI: Diseases of the digestive system (K00-K93)	6 663	7 292	5 972	7 593	6 027	5 512	5 728
XII: Diseases of the skin and subcutaneous tissue (L00-L99)	954	1 049	944	689	1 427	932	816
XIII: Diseases of the musculoskeletal system and connective tissue (M00-M99)	4 547	8 766	7 150	8 914	6 861	5 782	5 577
XIV: Diseases of the genitourinary system (N00-N99)	3 812	2 872	4 246	6 173	3 233	3 314	3 359
XV: Pregnancy, childbirth and the puerperium (O00-O99)	7 254	16 540	11 172	11 101	8 326	4 604	6 966
XVI: Certain conditions originating in the perinatal period (P00-P96)	1 506	1 163	1 343	678	2 019	1 529	1 603
XVII: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	514	796	814	534	420	556	561
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	4 985	9 667	3 755	5 442	2 874	2 674	4 365
XIX: Injury, poisoning and certain other consequences of external causes (S00-T98)	7 914	4 360	9 843	8 350	6 830	8 567	9 931
XXI: Factors influencing health status and contact with health services (Z00-Z99)	12 676	11 309	1 229	1 682	5 602	10 526	2 567
All causes (except. XX) (A00-Z99 excluding V, W, X and Y)	104 070	143 488	122 121	93 192	78 578	78 702	100 849

1 Only discharges with a length of stay less than 90 days

Sources: The national in-patient registers

Table 3.4.3.a Average length of stay per discharge (in days) per 100 000 population by main diagnosis, both genders

ICD-10 code <i>Main diagnosis</i>	Denmark 2011	Faroe Islands 2003-07	Finland 2011	Åland 2007-11	Iceland ¹⁾ 2009	Norway 2011	Sweden 2011
I: Certain infectious and parasitic diseases (A00-B99)	4.4	5.3	7.4	6.4	5.7	6.0	5.3
II: Neoplasms (C00-D48)	4.2	4.7	6.0	8.3	7.6	6.4	6.5
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	2.9	3.7	4.9	5.7	5.6	3.5	4.1
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	3.5	7.2	6.2	7.0	6.8	3.8	4.1
V: Mental and behavioural disorders (F00-F99)	15.7	30.4	30.1	6.7	14.9	2.8	13.5
VI: Diseases of the nervous system (G00-G99)	4.8	4.3	11.0	7.2	9.9	3.4	5.0
VII: Diseases of the eye and adnexa (H00-H59)	2.1	1.1	2.8	2.6	2.7	3.2	2.4
VIII: Diseases of the ear and mastoid process (H60-H95)	1.7	0.7	4.1	2.5	2.7	2.1	2.3
IX: Diseases of the circulatory system (I00-I99)	3.7	9.4	8.0	7.0	7.6	4.5	5.4
X: Diseases of the respiratory system (J00-J99)	3.9	5.3	6.0	5.3	7.0	5.6	5.7
XI: Diseases of the digestive system (K00-K93)	3.6	2.5	4.0	5.2	4.5	4.3	4.4
XII: Diseases of the skin and subcutaneous tissue (L00-L99)	3.4	4.7	5.4	6.0	6.2	5.7	6.6
XIII: Diseases of the musculoskeletal system and connective tissue (M00-M99)	3.1	4.9	3.2	5.8	6.1	4.5	4.7
XIV: Diseases of the genitourinary system (N00-N99)	2.8	2.9	3.6	4.5	4.1	3.5	4.3
XV: Pregnancy, childbirth and the puerperium (O00-O99)	2.6	4.4	4.0	4.7	2.2	3.4	2.4
XVI: Certain conditions originating in the perinatal period (P00-P96)	8.9	4.7	8.4	8.7	4.5	9.7	10.6
XVII: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	3.1	4.2	4.1	14.9	3.8	4.5	5.0
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	2.2	3.2	3.5	3.8	4.2	1.8	2.6
XIX: Injury, poisoning and certain other consequences of external causes (S00-T98)	3.4	4.5	5.3	6.0	6.5	4.3	5.4
XXI: Factors influencing health status and contact with health services (Z00-Z99)	4.6	2.5	3.9	3.8	6.8	4.7	6.7
All causes (except. XX) (A00-Z99 excluding V, W, X and Y)	4.1	5.4	5.8	5.8	5.8	4.4	5.5

1 Only discharges with a length of stay less than 90 days

Sources: The national in-patient registers

Table 3.4.3.b Average length of stay per discharge (in days) per 100 000 population by main diagnosis, men

ICD-10 code <i>Main diagnosis</i>	Denmark 2011	Faroe Islands 2003-07	Finland 2011	Åland 2007-11	Iceland ¹⁾ 2009	Norway 2011	Sweden 2011
I: Certain infectious and parasitic diseases (A00-B99)	4.5	5.1	7.6	6.6	6.5	6.2	5.0
II: Neoplasms (C00-D48)	4.6	4.9	6.2	8.4	8.1	6.7	7.0
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	2.7	4.6	5.0	6.7	6.0	3.7	4.0
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	3.7	8.0	6.3	6.7	7.4	4.0	4.2
V: Mental and behavioural disorders (F00-F99)	15.9	23.5	25.0	4.5	13.5	2.4	13.0
VI: Diseases of the nervous system (G00-G99)	4.9	5.4	8.7	7.4	10.5	3.2	5.1
VII: Diseases of the eye and adnexa (H00-H59)	2.1	0.9	2.8	3.4	3.2	3.2	2.3
VIII: Diseases of the ear and mastoid process (H60-H95)	1.6	0.7	5.2	2.4	2.4	2.0	2.1
IX: Diseases of the circulatory system (I00-I99)	3.7	9.2	7.2	7.1	7.2	4.3	5.2
X: Diseases of the respiratory system (J00-J99)	3.9	4.4	5.5	5.4	7.1	5.6	5.5
XI: Diseases of the digestive system (K00-K93)	3.5	2.4	3.8	5.2	4.4	4.2	4.3
XII: Diseases of the skin and subcutaneous tissue (L00-L99)	3.4	4.4	5.1	5.7	6.4	5.4	6.5
XIII: Diseases of the musculoskeletal system and connective tissue (M00-M99)	3.0	3.9	2.9	5.1	5.4	4.3	4.4
XIV: Diseases of the genitourinary system (N00-N99)	3.2	3.6	4.1	5.0	5.4	3.8	4.8
XV: Pregnancy, childbirth and the puerperium (O00-O99)	.	.	.	.	.	.	.
XVI: Certain conditions originating in the perinatal period (P00-P96)	3.1	4.8	3.6	16.8	4.6	4.4	4.8
XVII: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	2.2	4.3	3.4	4.0	3.4	1.7	2.6
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	3.2	3.1	4.9	5.7	4.1	4.0	4.9
XIX: Injury, poisoning and certain other consequences of external causes (S00-T98)	5.1	3.4	4.4	4.6	6.2	6.6	6.8
XXI: Factors influencing health status and contact with health services (Z00-Z99)	4.3	2.4	7.6	6.6	7.2	6.2	5.8
All causes (except. XX) (A00-Z99 excluding V, W, X and Y)	4.5	5.2	5.7	5.9	6.5	4.5	5.0

1 Only discharges with a length of stay less than 90 days

Sources: The national in-patient registers

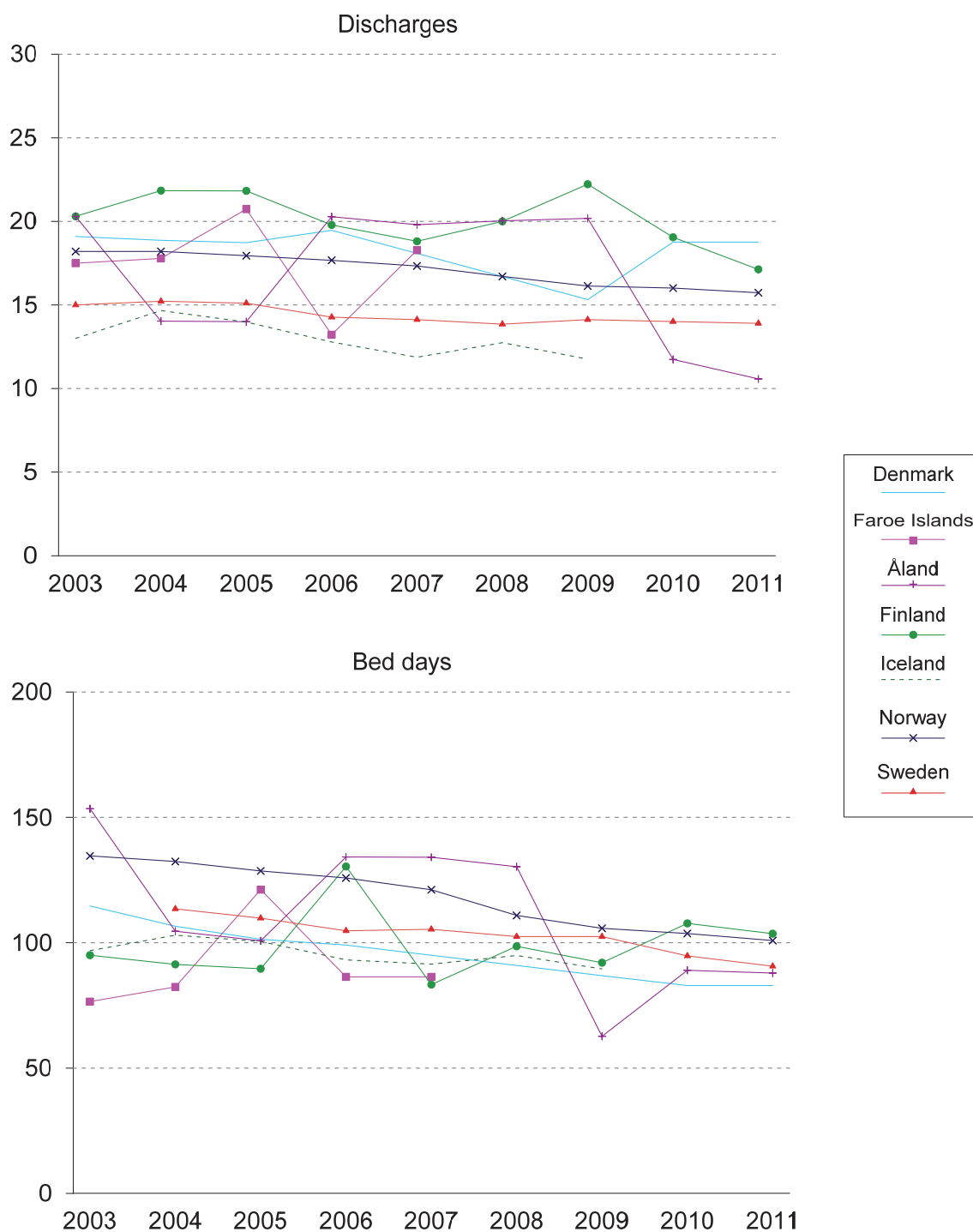
Table 3.4.3.c Average length of stay per discharge (in days) per 100 000 population by main diagnosis, women

ICD-10 code <i>Main diagnosis</i>	Denmark 2011	Faroe Islands 2003-07	Finland 2011	Åland 2007-11	Iceland ¹⁾ 2009	Norway 2011	Sweden 2011
I: Certain infectious and parasitic diseases (A00-B99)	4.4	5.5	7.2	6.2	5.0	5.9	5.5
II: Neoplasms (C00-D48)	3.9	4.5	5.9	8.3	7.1	6.1	6.1
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	3.1	2.6	4.9	5.1	5.5	3.4	4.1
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	3.3	6.4	6.2	7.1	6.5	3.6	4.1
V: Mental and behavioural disorders (F00-F99)	15.5	39.1	35.6	9.5	16.0	3.4	14.0
VI: Diseases of the nervous system (G00-G99)	4.7	3.3	13.3	7.0	9.3	3.7	4.8
VII: Diseases of the eye and adnexa (H00-H59)	2.1	1.2	2.9	2.3	2.3	3.1	2.5
VIII: Diseases of the ear and mastoid process (H60-H95)	1.9	0.8	2.9	2.6	3.0	2.2	2.5
IX: Diseases of the circulatory system (I00-I99)	3.8	9.8	9.1	7.0	8.3	4.7	5.6
X: Diseases of the respiratory system (J00-J99)	4.0	6.3	6.6	5.3	7.0	5.6	5.9
XI: Diseases of the digestive system (K00-K93)	3.6	2.6	4.3	5.2	4.7	4.3	4.5
XII: Diseases of the skin and subcutaneous tissue (L00-L99)	3.3	5.2	5.8	6.3	6.0	5.9	6.6
XIII: Diseases of the musculoskeletal system and connective tissue (M00-M99)	3.1	6.0	3.5	6.3	6.6	4.6	5.0
XIV: Diseases of the genitourinary system (N00-N99)	2.6	2.4	3.3	4.2	3.4	3.3	4.0
XV: Pregnancy, childbirth and the puerperium (O00-O99)	2.6	4.4	4.0	4.7	2.2	3.4	2.4
XVI: Certain conditions originating in the perinatal period (P00-P96)	9.1	4.7	8.6	7.9	4.4	9.6	10.9
XVII: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	3.1	4.1	4.7	11.1	4.3	4.5	5.4
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	2.2	3.3	3.6	3.7	4.2	1.8	2.6
XIX: Injury, poisoning and certain other consequences of external causes (S00-T98)	3.6	6.2	5.8	6.2	6.9	4.6	5.9
XXI: Factors influencing health status and contact with health services (Z00-Z99)	4.3	2.6	3.6	3.1	6.5	4.1	6.6
All causes (except. XX) (A00-Z99 excluding V, W, X and Y)	3.9	5.6	6.0	5.6	5.3	4.3	5.3

1 Only discharges with a length of stay less than 90 days

Sources: The national in-patient registers

Figure 3.4.1 Discharges and number of bed days for neoplasms, per 1 000 inhabitants, 2003-11¹⁾

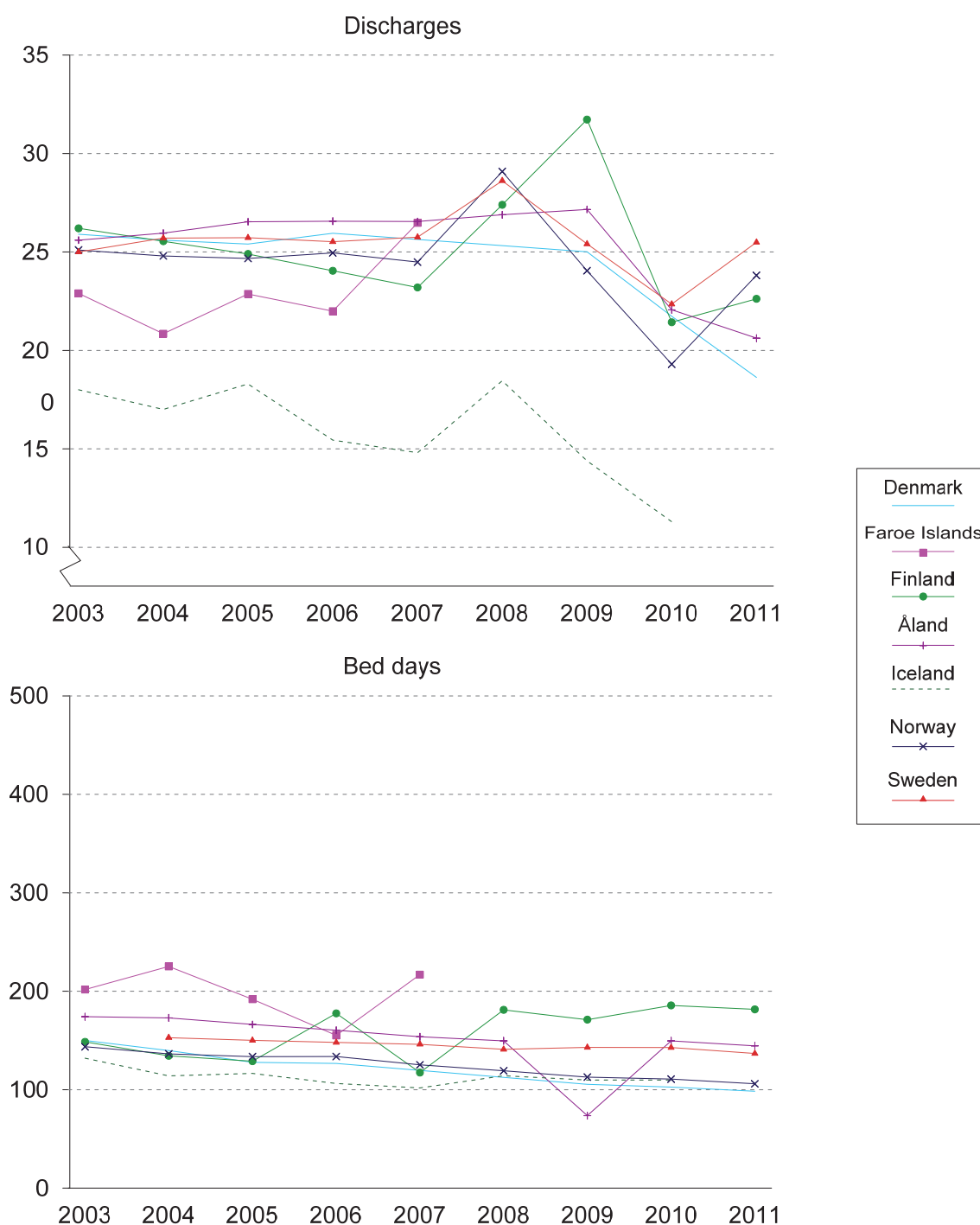


1 Iceland: Only discharges with a length of stay less than 90 days

Sources: See Tables 3.4.1.a and 3.4.2.a

ICD-10 codes included: I00-I99

Figure 3.4.2 Discharges and bed days for diseases of the digestive system, per 1 000 inhabitants, 2004-2011¹⁾

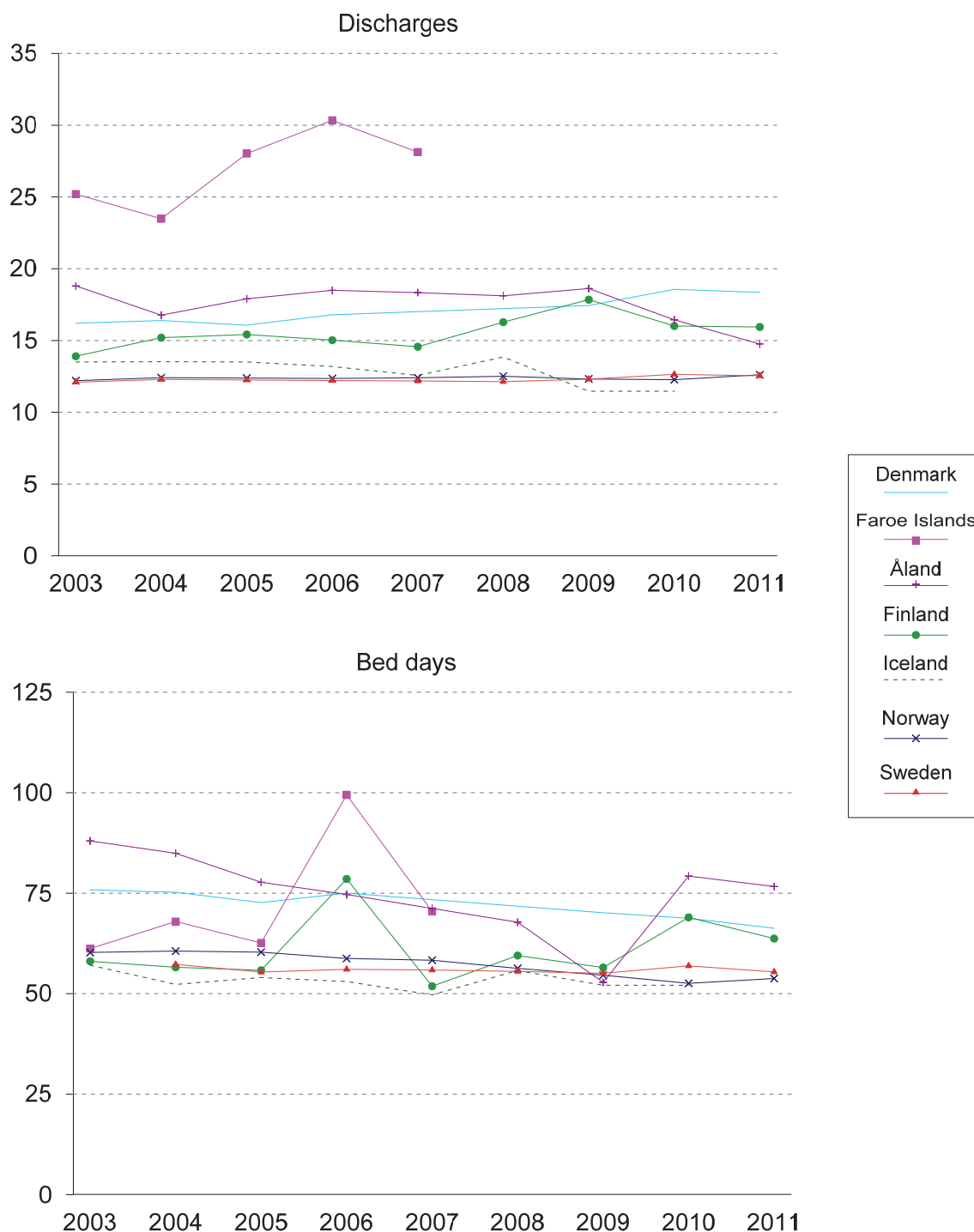


1 Iceland: Only discharges with a length of stay less than 90 days

Sources: See Tables 3.4.1.a and 3.4.2.a

ICD-10 codes included: K00-K93

Figure 3.4.3 Discharges, patients treated and average length of stay in hospital for malignant neoplasm of trachea, bronchus and lungs, 2004-2011¹⁾



1) Iceland: Only discharges with a length of stay less than 90 days

Sources: See Tables 3.4.1.a and 3.4.2.a

ICD-10 codes included: K00-K93

Table 3.4.4 Discharges, patients treated and average length of stay in hospital for malignant neoplasm of trachea, bronchus and lungs, 2011

	Denmark	Faroe Islands ¹⁾	Finland	Åland ²⁾	Iceland ^{3,4)}	Norway	Sweden
<i>Discharges</i>							
Men, Total	3 543	63	3 494	10	202	3 535	4 580
Women, Total	3 438	38	1 834	11	226	2 731	4 486
<i>Patients treated</i>							
Men, Total	1 998	13	1 718	6	110	1 837	2 491
Women, Total	1 970	7	922	6	117	1 421	2 430
<i>Patients treated per 100 000 men in the age group</i>							
25-44	3	-	3	5	4	2	2
45-64	82	76	73	45	87	77	46
65+	328	276	282	164	431	408	239
Total rate	72	51	65	41	68	75	53
<i>Patients treated per 100 000 women in the age group</i>							
25-44	6	-	2	-	7	3	2
45-64	91	63	38	73	104	77	51
65+	244	108	110	100	368	223	185
Total rate	70	31	34	41	74	58	51
Average length of stay per discharge	5.7	34	7.6	9.9	8.8	8.0	9.4

1 Average 2003-07

2 Average 2007-11

3 Only discharges with a length of stay less than 90 days

4 2009

The table includes ICD-10: C33-C34

Sources: see Table 3.4.1.a

Table 3.4.5 Discharges, patients treated and average length of stay in hospital for malignant neoplasm of breast, women 2011

	Denmark	Faroe Islands ¹⁾	Finland	Åland ²⁾	Iceland ^{3,4)}	Norway	Sweden
<i>Discharges</i>							
Total	9 227	82	9 668	32	376	4 452	9 387
<i>Patients treated</i>							
Total	5 656	29	6 921	27	282	3 393	7 500
<i>Patients treated per 100 000 women in the age group</i>							
25-44	75	38	74	62	72	56	53
45-64	358	250	484	317	356	261	255
65+	483	375	480	437	574	339	392
Total rate	202	124	252	193	179	138	158
Average length of stay per discharge	2.2	5.6	4.6	6.2	5.3	4.1	3.1

1 Average 2003-07

2 Average 2007-11

3 Only discharges with a length of stay less than 90 days

4 2009

The table includes ICD-10: C50

Sources: see Table 3.4.1.a

Table 3.4.6 Discharges, patients treated and average length of stay in hospital for acute myocardial infarction, 2011

	Denmark	Faroe Islands ¹⁾	Finland	Åland ²⁾	Iceland ^{3,4)}	Norway	Sweden
<i>Discharges</i>							
Men, Total	10 258	68	7 373	42	345	13 685	20 406
Women, Total	5 211	32	4 555	31	184	6 618	12 136
<i>Patients treated</i>							
Men, Total	2 106	58	5 559	30	305	7 979	13 563
Women, Total	3 039	26	3 541	24	159	4 409	8 446
<i>Patients treated per 100 000 men in the age group</i>							
0-44	14	20	12	13	13	25	10
45-64	110	352	241	226	307	474	314
65+	248	1 116	875	871	996	1 406	1 195
Total rate	76	230	209	215	189	324	288
<i>Patients treated per 100 000 women in the age group</i>							
0-44	16	-	2	-	7	5	3
45-64	114	82	62	83	96	116	97
65+	371	620	539	745	569	869	744
Total rate	108	113	129	170	101	179	178
<i>Average length of stay per discharge</i>	3.4	10.8	6.8	5.7	6.8	3.8	4.4

1 Average 2003-07

2 Average 2007-11

3 Only discharges with a length of stay less than 90 days

4 2009

The table includes ICD-10: I21-I22

Sources: see Table 3.4.1.a

Table 3.4.7 Discharges, patients treated and average length of stay in hospital for cerebrovascular diseases, 2011

	Denmark	Faroe Islands ¹⁾	Finland	Åland ²⁾	Iceland ^{3,4)}	Norway	Sweden
<i>Discharges</i>							
Men, Total	9 877	98	11 445	50	346	8 027	21 686
Women, Total	9 311	61	9 961	46	222	7 228	20 404
<i>Patients treated</i>							
Men, Total	13 477	78	7 516	36	251	6 503	15 657
Women, Total	10 133	51	7 308	38	183	5 985	14 437
<i>Patients treated per 100 000 men in the age group</i>							
0-44	76	30	25	21	18	20	18
45-64	616	316	302	276	156	246	245
65-79	1 635	1 465	995	788	845	1 081	1 091
80+	1 977	2 163	1 336	1 087	1 468	1 518	1 608
Total rate	488	313	283	259	155	264	333
<i>Patients treated per 100 000 women in the age group</i>							
0-44	62	6	24	14	13	18	16
45-64	293	142	185	176	104	155	161
65-79	1 018	890	664	645	409	684	698
80+	1 412	1 445	994	1 017	1 176	1 034	1 137
Total rate	361	219	266	265	116	243	305
Average length of stay per discharge	5.9	30.9	16.1	11.6	13.9	8.6	10.0

1 Average 2003-07

2 Average 2007-11

3 Only discharges with a length of stay less than 90 days

4 2009

The table includes ICD-10: I60-I69

Sources: see Table 3.4.1a

Table 3.4.8 Discharges, patients treated and average length of stay in hospital for chronic obstructive pulmonary disease and bronchiectasis, 2011

	Denmark	Faroe Islands ¹⁾	Finland	Åland ²⁾	Iceland ^{3,4)}	Norway	Sweden
<i>Discharges</i>							
Total	19 359	97	5 612	58	490	10 544	18 966
<i>Patients treated</i>							
Total	4 949	64	3 668	39	331	6 728	11 359
<i>Per 100 000 in the age group</i>							
0-4	72	341	2	-	4	10	5
5-14	37	8	1	-	-	5	1
15-24	103	3	1	-	-	2	2
25-64	107	57	32	66	42	63	34
65-74	79	478	234	448	471	545	359
75+	47	673	343	720	922	819	775
Total rate	89	132	68	140	104	137	120
<i>Average length of stay</i>	3.9	8.1	7.4	6.9	10.2	7.0	6.1

1 Average 2003-07

2 Average 2007-11

3 Only discharges with a length of stay less than 90 days

4 2009

The table includes ICD-10: J40-J44, J47

Sources: see Table 3.4.1.a

Table 3.4.9 Discharges, patients treated and average length of stay in hospital for asthma, 2011

	Denmark	Faroe Islands ¹⁾	Finland	Åland ²⁾	Iceland ^{3,4)}	Norway	Sweden
<i>Discharges</i>							
Total	6 387	106	4 072	17	115	3 708	5 806
<i>Patients treated</i>							
Total	4 053	82	2 941	16	82	3 186	4 274
<i>Per 100 000 in the age group</i>							
0-4	276	1 224	210	375	69	359	354
5-14	164	279	38	76	18	78	34
15-24	161	55	16	26	6	30	13
25-64	31	38	32	17	15	36	17
65-74	5	48	67	68	36	61	33
75+	3	121	162	100	121	67	77
Total rate	73	171	54	56	26	65	45
<i>Average length of stay</i>	1.8	3.0	4.8	3.5	3.5	5.6	2.2

1 Average 2003-07

2 Average 2007-11

3 Only discharges with a length of stay less than 90 days

4 2009

The table includes ICD-10: J45-J46

Sources: see Table 3.4.1.a

Table 3.4.10 Discharges, patients treated and average length of stay in hospital for alcoholic liver disease, 2011

	Denmark	Faroe Islands ¹⁾	Finland	Åland ²⁾	Iceland ^{3,4)}	Norway	Sweden
<i>Discharges</i>							
Men, Total	2 013	3	1 644	3	31	567	1 307
Women, Total	933	2	608	2	9	249	501
<i>Patients treated</i>							
Men, Total	1 509	2	941	3	19	351	758
Women, Total	2 218	2	322	1	7	162	307
<i>Patients treated per 100 000 men in the age group</i>							
0-44	17	-	8	-	3	1	2
45-64	80	20	85	60	20	35	34
65+	154	34	44	9	47	34	37
Total rate	55	9	35	19	12	14	16
<i>Patients treated per 100 000 women in the age group</i>							
0-44	9	1	3	-	1	1	1
45-64	111	7	29	29	13	15	14
65+	241	28	11	7	5	12	12
Total rate	79	7	12	10	4	7	6
<i>Average length of stay per discharge</i>	6.7	5.5	7.3	15.5	9.0	7.6	7.6

1 Average 2003-07

2 Average 2007-11

3 Only discharges with a length of stay less than 90 days

4 2009

The table includes ICD-10: K70

Sources: see Table 3.4.1.a

Table 3.4.11 Discharges, patients treated and average length of stay in hospital for other diseases of liver, 2011

	Denmark	Faroe Islands ¹⁾	Finland	Åland ²⁾	Iceland ^{3,4)}	Norway	Sweden
<i>Discharges</i>							
Men, Total	1 724	10	1 048	2	37	709	1 359
Women, Total	1 530	10	1 212	2	31	726	1 325
<i>Patients treated</i>							
Men, Total	3 701	6	653	2	30	499	934
Women, Total	2 981	8	766	2	28	558	885
<i>Patients treated per 100 000 men in the age group</i>							
0-44	87	14	9	8	7	8	6
45-64	168	27	40	15	41	33	26
65+	258	67	52	26	41	52	56
Total rate	134	23	25	13	19	20	20
<i>Patients treated per 100 000 women in the age group</i>							
0-44	68	10	10	8	6	9	7
45-64	95	71	44	24	32	33	23
65+	237	74	49	14	49	54	44
Total rate	106	34	28	14	18	23	19
<i>Average length of stay per discharge</i>	5.4	7.4	5.3	12.1	9.0	7.6	7.6

1 Average 2003-07

2 Average 2007-11

3 Only discharges with a length of stay less than 90 days

4 2009

The table includes ICD-10: K71-K77

Sources: see Table 3.4.1.a

Table 3.4.12 Discharges, patients treated and average length of stay in hospital for intervertebral disc disorders, 2011

	Denmark	Faroe Islands ¹⁾	Finland	Åland ²⁾	Iceland ^{3,4)}	Norway	Sweden
<i>Discharges</i>							
Men, Total	3 906	18	3 341	5	272	3 136	2 678
Women, Total	3 789	16	2 897	8	187	2 540	2 285
<i>Patients treated</i>							
Men, Total	588	15	2 390	5	253	2 675	1 991
Women, Total	1 033	11	2 078	7	171	2 130	1 845
<i>Patients treated per 100 000 men in the age group</i>							
0-24	7	4	11	0	17	11	4
25-44	8	111	148	66	241	152	60
45-64	22	80	138	40	269	193	72
65+	72	74	55	26	140	91	38
Total rate	21	60	90	33	157	109	42
<i>Patients treated per 100 000 women in the age group</i>							
0-24	13	2	11	5	11	9	5
25-44	24	62	128	56	189	128	60
45-64	36	101	113	73	174	147	62
65+	95	63	51	50	78	74	32
Total rate	37	49	76	46	108	87	39
<i>Average length of stay per discharge</i>							
Men	2.5	7.0	3.2	9.3	1.7	3.4	3.6
Women	3.1	8.6	3.6	7.2	2.2	3.8	4.4

1 Average 2003-07

2 Average 2007-11

3 Only discharges with a length of stay less than 90 days

4 2009

The table includes ICD-10: M51-M51

Sources: see Table 3.4.1.a

Table 3.4.13 Discharges, patients treated and average length of stay in hospital for fracture of femur, 2011

	Denmark	Faroe Islands ¹⁾	Finland	Åland ²⁾	Iceland ^{3,4)}	Norway	Sweden
<i>Discharges</i>							
Men, Total	3 264	43	3 736	17	172	3 738	8 261
Women, Total	5 687	70	7 213	30	336	7 802	16 901
<i>Patients treated</i>							
Men, Total	3 138	33	2 713	14	136	3 437	6 514
Women, Total	1 812	53	5 322	27	259	7 229	13 282
<i>Patients treated per 100 000 men in the age group</i>							
0-44	125	44	27	31	28	22	17
45-64	88	103	69	40	46	74	56
65-74	91	326	186	147	170	270	219
75-79	107	474	444	477	193	746	557
80+	225	1 682	1 168	1 107	1 564	2 144	1 940
Total rate	114	131	102	100	84	140	138
<i>Patients treated per 100 000 women in the age group</i>							
0-44	57	11	11	8	2	9	8
45-64	47	67	58	63	59	84	58
65-74	63	455	237	229	362	421	321
75-79	10	1 139	644	614	969	1 130	928
80+	215	2 782	1 904	1 746	2 545	3 446	2 962
Total rate	65	228	193	187	164	294	280
Average length of stay per discharge	2.0	12.8	10.8	12.5	10.8	8.1	9.5

1 Average 2003-07

2 Average 2007-11

3 Only discharges with a length of stay less than 90 days

4 2009

The table includes ICD-10: S72

Sources: see Table 3.4.1.a

3.5 Surgical Procedures

A new list of procedures

In this section, data on selected surgical procedures performed at short-term somatic hospitals are presented. The presentation differs somewhat from those in NOMESCO publications from before 2010. The selected list of procedures used here was developed for international comparison by the EU Hospital Data Project (HDP2) and published in its final report 2008 after being tested in a pilot study with data from some 15 countries. It has then been proposed for use by Eurostat, OECD and the WHO Regional Office for Europe. Recognizing the value of standardization in international reporting, NOMESCO has decided to use the HDP2 list for its annual statistical report. The list may be modified in the future due to experience from its use and changing treatment methods and surgical techniques.

The HDP2 list consists of 30 selected procedures or procedure groups (with six sub-groups) within a broad range of medical specialities. Several criteria were combined for the selection of procedures, such as how common a procedure is, its potential for day surgery, changing technique over time, cost, public health importance and continuity with existing statistics. The complete list with definitions of the procedures, the main reasons for selection of the different procedures and some caveats for the interpretation of the statistics is presented in one document (See link HDP2 list of procedures at the start of the chapter). All the procedures are also defined with codes from the NOMESCO Classification of Surgical Procedures (NCSP-E), which is the common English language version of the NCSP.

Many of the procedures that NOMESCO has reported on earlier are included in the new list. Some are defined slightly differently, however, but continuity of the NOMESCO statistics has most often been kept.

Outline of this section

The presentation starts with two summary tables (Table 3.5.1a+b) showing the number per 100 000 population for each procedure on the selected list, performed on male and female inpatients. Laparoscopic techniques are increasingly being used for five procedures on the list. Table 3.5.3 shows the shares of these that are performed laparoscopically and also the relative frequency of secondary hip replacements. Eight of the procedures on the list that are often performed as day surgery are presented in Table 3.5.2, showing the proportions of day surgery of the total number of these procedures. Two figures (Figures 3.5.1 and 3.5.2) show the development over time for three common procedures.

Finally, in a series of tables (3.5.4 - 3.5.17) data on some of the procedures are presented in greater detail, showing number of operations and population rates with age distributions for males and females, similar to what NOMESCO has presented in earlier Health Statistics re-ports. These tables show the total number of procedures that are reported, both inpatient surgery and day surgery taken together.

Quality and limitations of the data

In its annual report in 2002, NOMESCO presented a theme section dealing with validity and comparability of Nordic hospital statistics on surgical procedures, and in 2003, a corresponding report on day surgery statistics. Based on the recommendations of these studies, some changes were made in the reporting procedure, aiming at better comparability. In its report, the EU Hospital Data Project (HDP2) also presented a thorough analysis of the methodological difficulties involved in achieving valid and comparable data on hospital procedures.

How procedures should be counted is one of the problems. In the Nordic countries, there is no common concept such as a principal procedure, if more than one procedure is performed during the same hospital stay (corresponding to a main diagnosis as the basis for diagnosis-related statistics). Procedure statistics are therefore based on any procedure registered during a hospital stay and reported to the national patient register. This could result in a hospital stay being counted twice, if more than one procedure on the list is performed during the same stay, e.g. a colonoscopy that is followed by a colectomy. Since both are on the selected list, both will be counted.

The fact that the Nordic countries use the same procedure classification makes comparisons easier. The relevant NCSP-E codes for each procedure are listed in all tables.

In order to describe surgical activities at hospitals, it is necessary to include both inpatient surgery and day surgery, which constitutes an increasing part. The HDP2 list includes both procedures mainly performed on inpatients and procedures often performed as day surgery. Formal definitions of day treatment and day surgery differ somewhat among countries. Day treatment involves patients who are formally admitted to the hospital for examination or treatment and discharged the same day. Without exact definitions of day treatment, it may be necessary to approximate and count as day treatment all stays with date of admission and date of discharge being the same. Some of these stays may, however, refer to patients who were discharged to another hospital or who died, and thus not day patients in a real sense. There is also a blurred border between day treatment and outpatient treatment provided at the hospital. Furthermore, some of the procedures on the list are also performed outside of hospitals at specialist centres and private clinics and these may not be reported to the national patient registers.

These difficulties are reflected in the Nordic statistics. While Iceland has not been able to report on day surgery at all for 2009, Denmark and Finland have had some difficulties in separating day treatment and outpatient treatment. Known under-reporting in the national patient registers is also caused by some private hospitals not reporting centrally.

Thus organizational differences may influence the reporting. There are also different rules for reporting to national registers, e.g. in Finland where reporting of minor procedures, such as diagnostic colonoscopy, is not necessary. Some of these problems are reflected in the caveats in the HDP2 list.

Comments on the tables

Table 3.5.1a+b shows rates per 100 000 population for males and females for all the procedures on the new list. It covers only inpatients, however, and thus does not give a complete picture of the procedures often performed as day surgery, such as cataract operations, colonoscopy and hernia repair. Several of the common inpatient procedures tend to have about the same rates in all the countries (except Åland due to its small population), such as transluminal coronary angioplasty and hysterectomy. Differences between genders are already known in all countries with higher rates for males for heart operations and hernia repair and higher female rates for thyroidectomy, cholecystectomy and hip replacement. The low rates for discectomy in Sweden are explained to some extent by under-reporting from three specialized private hospitals. Some strikingly high rates are found for hernia repair on men in Finland and cholecystectomy on women in Iceland.

The use of laparoscopic methods is illustrated in Table 3.5.3. Laparoscopic cholecystectomy is very common in all countries, and almost all cholecystectomies in Iceland are laparoscopic. Finland has the highest proportion of laparoscopic colectomy and hysterectomy but the lowest proportion of laparoscopic appendectomy, for which Sweden also shows low percentages. Such differences call for further study and considerations about why this relatively new surgical approach has been adopted so differently by the Nordic countries. Of course, it is of special interest to follow the development over time. Table 3.5.3 also shows that the proportion of secondary hip replacements is similar in all countries. It should be noted that the secondary replacements reported here are not secondary to primary replacements carried out in 2009 but, mostly, to those performed many years earlier.

Of the procedures reported in Table 3.5.2, cataract operations show the highest percentage of day surgery in all the countries (96-98 per cent). The variation in the overall population rate of cataract surgery is mainly due to the fact that under-reporting is a fact in all the countries. There are definition problems regarding day surgery and difficulties with reporting from private hospitals and clinics. This can be illustrated by Sweden where the number of cataract operations in the national patient register in 2008 constitutes only 82 per cent of the actual number according to figures from the specialized national cataract register.

Tonsillectomies are performed as day surgery to a varying extent and also with different overall population rates, which is of interest with regard to clinical controversies about the indications for this operation and the need for post-surgical supervision. The very low population rates in Finland for bronchoscopy and colonoscopy are due to the fact that these procedures do not have to be reported nationally. The proportion of day surgery for laparoscopic cholecystectomy varies somewhat among countries with higher figures in Denmark and with lower figures in Finland for hernia repair. For excision of mammary gland, Norway and Sweden show higher proportions of day surgery.

The trends illustrated in Figure 3.5.1 show increasing rates for transluminal coronary angioplasty (PTCA) and slightly decreasing rates for coronary anastomosis surgery for the period 2003-2009. The countries largely retain their relative position

over time. The HDP2 list de-fines coronary anastomosis surgery slightly narrower than NOMESCO's earlier statistics, but this does not explain the lower 2008 and 2009 figures.

The detailed Tables 3.5.4 - 3.5.17 include both inpatient surgery and day surgery which explains the higher rates reported here in relation to the population rates presented in Table 3.5.1a+b, which only includes procedures on inpatients.

From the age distributions shown in these tables, some diversity can be noted. Table 3.5.7 shows that the highest rates for transluminal coronary angioplasty are found for both men and women in the age group 75-84 years in all countries, while coronary artery bypass graft (Table 3.5.8) show approximately the same rates for men at the age of 65-74 years and 75-84 years, with slightly higher rates for women aged 75-84 years. The somewhat higher overall rates in Iceland for appendectomy seem to be explained mainly by the higher operation rates in the youngest age group (Table 3.5.9). The highest rate for cholecystectomy among men is found in the age group 65 years and over, while it among women is highest in the age group 45-64 years and in Denmark already at the age of 25-44 years (Table 3.5.10).

In almost all countries, kidney transplantation is performed more often on men than on women (Table 3.5.11). This seems to be true for almost all age groups. If this reflects morbidity differences between men and women or a possible effect of gender discrimination in the health services ought to be discussed.

Table 3.5.12 shows that open prostatectomy is most common in the age group 65-74 years, while the transurethral procedure shows higher rates in the two oldest age groups (Table 3.5.13).

In Table 3.5.15, Caesarean section is related to the number of deliveries. Denmark shows the highest overall proportion of deliveries by Caesarean section (22 per cent) and also has the highest figure in every age group. Iceland, with the highest population rate for Caesarean section (cf. Table 3.5.1b), has the lowest proportion of Caesarean sections (13 per cent). This is caused by the high fertility rate in Iceland.

Norway has not only the highest overall rate for hip replacement for women (Table 3.5.16b) but also the highest rate in every age group over 45 years, while Finland has the highest overall rate for total knee replacement (Table 3.5.17) and the highest rate for this operation in every age group over 45 years.

Table 3.5.1a Surgical procedures performed on in-patients per 100 000 inhabitants by list of selected procedures, men¹⁾

Surgical procedures (NCSP-E codes in brackets)	Denmark 2011	Faroe Islands 2007-11	Finland 2011	Åland 2007-11	Iceland 2009	Norway 2011	Sweden 2011
1: Extirpation, excision and destruction of intra-cranial lesion (AAB00-AAB20, AAB99)	18.4	..	19.0	7.1	17.3	17.2	15.1
2: Evacuation of subdural haematoma and intra-cranial haemorrhage (AAB30, AAD05-AAD15)	21.9	..	35.9	34.2	12.4	19.4	22.1
3: Discectomy (ABC)	171.2	..	131.5	81.2	193.8	131.5	74.5
4: Thyroidectomy (BAA20-BAA60)	15.5	..	14.7	..7.1	9.3	10.9	10.6
5: Cataract surgery (CJC, CJD, CJE, CJF)	14.6	..	18.9	24.2	11.8	14.2	17.7
6: Cochlear implantation (DFE00)	4.9	..	1.6	1.4	0.6	1.7	2.6
7: Tonsillectomy (EMB10-EMB20)	89.2	..	67.0	152.5	47.0	86.5	46.7
8: Pulmectomy (GDB20-21, GDC, GDD)	16.4	..	9.3	2.9	14.2	10.0	7.8
9: Diagnostic bronchoscopy with or without biopsy (UGC)	103.5	..	55.2	34.2	61.9	108.1	51.3
10: Transluminal coronary angioplasty (FNG02, FNG05)	214.0	..	222.2	8.6	290.9	300.9	264.8
11: Coronary artery bypass graft (FNC, FND, FNE)	59.8	..	53.7	1.4	96.6	87.9	64.7
12: Carotid endarterectomy (PAF20-PAF22)	10.1	..	16.5	4.3	9.9	13.1	15.6
13: Infrarenal aortic aneurysm repair (PDG10-PDG24, PDQ10)	25.7	..	18.2	7.1	12.4	22.6	15.2
14: Femoropopliteal bypass (PEH)	10.3	..	14.0	.. ¹⁾	2.5	9.4	5.7
15: Stem cell transplantation (not included ²⁾)	8.0	..	4.9	0.0	-	0.0	0.0
16: Colonoscopy with or without biopsy (JFA15, UJF32, UJF35, UJF42, UJF45)	281.4	..	50.2	48.5	180.8	186.2	124.3
17: Colectomy (JFB20-JFB64, JFH)	73.4	..	61.0	62.7	48.9	74.5	123.7
Of which:		..					
17A: Laparoscopic colectomy (JFB21, JFB31, JFB34, JFB41, JFB44, JFB47, JFB51, JFB61, JFB64, JFH01, JFH11)	24.1	..	17.3	1.4	11.8	19.2	2.9

1 In Åland aorta coronary bypass operations are not performed. In most cases, patients are transferred to Sweden for these procedures, and the treatment is not registered in Åland

The table continues

Table 3.5.1a Surgical procedures performed on in-patients per 100 000 inhabitants by list of selected procedures, men¹⁾, continued

Surgical procedures (NCSP-E codes in brackets)	Denmark 2011	Faroe Islands 2007-11	Finland 2011	Åland 2007-11	Iceland 2009	Norway 2011	Sweden 2011
18: Appendectomy (JEA)	102.2	..	128.6	136.8	154.8	117.2	122.8
<i>Of which:</i>							
18A: Laparoscopic appendectomy (JEA01)	84.6	..	19.4	1.4	65.0	76.7	31.9
19: Cholecystectomy (JKA20. JKA21)	49.4	..	89.1	106.9	93.5	42.6	80.3
<i>Of which:</i>							
19A: Laparoscopic cholecystectomy (JKA21)	37.7	..	66.7	74.1	87.3	36.6	54.9
20: Repair of inguinal hernia (JAB)	82.9	..	154.2	166.8	50.1	80.1	78.4
<i>Of which:</i>							
20: Laparoscopic repair of inguinal hernia (JAB11. JAB97)	29.8	..	22.3	14.3	5.0	13.0	7.8
21: Transplantation of kidney (KAS00-KAS20)	5.2	..	3.9	2.9	1.9	7.8	5.0
22: Open prostatectomy (KEC. KED00. KED96)	36.4	..	37.8	64.1	37.8	57.8	61.4
23: Transurethral prostatectomy (KED22. KED52- KED72. KED98)	96.2	..	126.2	195.3	103.4	159.3	122.7
24: Hysterectomy (LCC. LCD)	.	.	.	.	.	.	.
<i>Of which:</i>							
24A: Laparoscopic hysterectomy (LCC01. LCC11. LCC97. LCD01. LCD04. LCD11. LCD31. LCD40. LCD97)	.	.	.	.	.	.	.
25: Caesarean section (MCA)	.	.	.	.	.	.	.
26: Arthroscopic excision of meniscus of knee (NGD01. NGD11)	12.5	..	31.7	22.8	0.6	26.0	5.5
27: Hip replacement (NFB. NFC)	181.4	..	181.7	183.9	133.7	161.1	166.5
<i>Of which:</i>							
27A: Secondary hip replacement (NFC)	21.6	..	24.3	22.8	15.5	18.8	19.8
28: Total knee re-placement (NGB20-NGB40)	103.1	..	124.5	84.1	69.9	60.9	90.6
29: Partial excision of mammary gland (HAB00. HAB30. HAB40. HAB99)	0.4	..	1.2	0.0	1.2	0.1	0.4
30: Total mastectomy (HAC10- HAC25. HAC99)	5.8	..	2.1	2.9	3.1	1.8	1.9

1 The NCSP codes refer to the NOMESCO Classification of Surgical Procedures. NCSP-E-version 1.13:2009
NOMESCO 83:2008

2 Not included in NCSP-E but can be defined through other non-surgical national classifications

Source: The national in-patients registers

Table 3.5.1b Surgical procedures performed on in-patients per 100 000 inhabitants by list of selected procedures Women ¹⁾

Surgical procedures (NCSP-E codes in brackets)	Denmark 2011	Faroe Islands 2007-11	Finland 2011	Åland 2007-11	Iceland 2009	Norway 2011	Sweden 2011
1: Extirpation, excision and destruction of intra-cranial lesion (AAB00-AAB20, AAB99)	19.3	..	26.5	9.9	14.6	18.1	16.9
2: Evacuation of subdural haematoma and intra-cranial haemorrhage (AAB30, AAD05-AAD15)	10.1	..	15.3	7.0	3.2	8.6	9.2
3: Discectomy (ABC)	160.9	..	121.8	88.7	165.5	116.2	72.7
4: Thyroidectomy (BAA20-BAA60)	62.8	..	60.3	64.8	60.2	44.6	45.4
5: Cataract surgery (CJC, CJD, CJE, CJF)	18.2		24.0	95.8	6.3	15.3	18.4
6: Cochlear implantation (DFE00)	4.7	..	2.5	0.0	0.0	1.6	2.9
7: Tonsillectomy (EMB10-EMB20)	110.1	..	61.9	140.9	53.3	82.6	50.3
8: Pulmectomy (GDB20-21, GDC, GDD)	17.6		6.1	4.2	15.9	8.3	8.6
9: Diagnostic bronchoscopy with or without biopsy (UGC)	67.7	..	33.0	9.9	64.0	73.4	36.8
10: Transluminal coronary angioplasty (FNG02, FNG05)	76.1	..	86.6	2.8	102.7	97.4	95.2
11: Coronary artery bypass graft (FNC, FND, FNE)	13.0	..	14.0	1.4	16.5	21.8	15.9
12: Carotid endarterectomy (PAF20-PAF22)	5.1	..	7.4	4.2	3.2	6.0	7.3
13: Infrarenal aortic aneurysm repair (PDG10-PDG24, PDQ10)	4.9	..	3.2	2.8	2.5	6.3	4.2
14: Femoropopliteal bypass (PEH)	7.0	..	9.2	.. ¹⁾	1.9	4.9	4.3
15: Stem cell transplantation (not included ²⁾)	4.0	..	3.7	0.0	-	0.0	0.0
16: Colonoscopy with or without biopsy (JFA15, UJF32, UJF35, UJF42, UJF45)	290.1	..	51.3	69.0	249.2	205.5	140.3
17: Colectomy (JFB20-JFB64, JFH)	83.7	..	63.7	83.1	57.1	82.8	143.6
Of which:		..					
17A: Laparoscopic colectomy (JFB21, JFB31, JFB34, JFB41, JFB44, JFB47, JFB51, JFB61, JFB64, JFH01, JFH11)	26.2	..	20.2	0.0	12.0	21.7	3.7

1 In Åland aorta coronary bypass operations are not performed. In most cases, patients are transferred to Sweden for these procedures, and the treatment is not registered in Åland

The table continues

Table 3.5.1b Surgical procedures performed on in-patients per 100 000 inhabitants by list of selected procedures, women¹⁾. Continued

Surgical procedures (NCSP-E codes in brackets)	Denmark 2011	Faroe Islands 2007-11	Finland 2011	Åland 2007-11	Iceland 2009	Norway 2011	Sweden 2011
18: Appendectomy (JEA)	109.7	..	130.9	107.1	137.6	116.2	113.4
<i>Of which:</i>		..					
18A: Laparoscopic appendec- tomy (JEA01)	83.7	..	53.1	29.6	82.4	79.9	42.8
19: Cholecystectomy (JKA20. JKA21)	100.4	..	148.2	177.5	253.6	89.1	147.9
<i>Of which:</i>		..					
19A: Laparoscopic cholecystec- tomy (JKA21)	88.3	..	128.4	159.2	244.8	82.7	120.1
20: Repair of inguinal hernia (JAB)	14.3	..	18.9	15.5	3.2	11.8	10.2
<i>Of which:</i>		..					
20: Laparoscopic repair of inguinal hernia (JAB11. JAB97)	6.9	..	3.1	1.4	0.6	1.6	1.6
21: Transplantation of kidney (KAS00-KAS20)	3.2	..	2.7	1.4	2.5	3.1	3.0
22: Open prostatectomy (KEC. KED00. KED96)	.	..	.	.	.	.	.
23: Transurethral prostatectomy (KED22. KED52-KED72. KED98)	.	..	.	.	.	.	.
24: Hysterectomy (LCC. LCD)	208.6	..	200.7	350.7	276.5	183.9	177.9
<i>Of which:</i>		..					
24A: Laparoscopic hysterectomy (LCC01. LCC11. LCC97. LCD01. LCD04. LCD11. LCD31. LCD40. LCD97)	50.1	..	87.1	15.5	43.1	42.5	13.6
25: Caesarean section (MCA)	443.9	..	347.8	464.8	502.2	403.3	408.2
26: Arthroscopic excision of meniscus of knee (NGD01. NGD11)	11.8	..	24.5	29.6	1.3	17.1	4.3
27: Hip replacement (NFB. NFC)	267.9	..	271.3	233.8	212.4	322.9	251.2
<i>Of which:</i>		..					
27A: Secondary hip replace- ment (NFC)	29.2	..	37.4	23.9	18.4	34.3	23.1
28: Total knee re-placement (NGB20-NGB40)	157.0	..	234.0	133.8	112.9	103.8	129.1
29: Partial excision of mamma- ry gland (HAB00. HAB30. HAB40. HAB99)	101.6	..	93.4	36.6	95.1	58.6	79.8
30: Total mastectomy (HAC10- HAC25. HAC99)	72.3	..	103.4	133.8	76.7	69.3	54.6

1 The NCSP codes refer to the NOMESCO Classification of Surgical Procedures. NCSP-E-version 1.13:2009
NOMESCO 83:2008

2 Not included in NCSP-E but can be defined through other non-surgical national classifications

Source: The national in-patients registers

Table 3.5.2 Eight surgical procedures often carried out as day surgery; total rate and day surgery rate per 100 000 inhabitants and day surgery as per cent of all procedures by gender 2011¹⁾

	Denmark		Finland		Norway		Sweden	
	M	W	M	W	M	W	M	W
Cataract surgery (CJC. CJD. CJE. CJF)								
Total rate per 100 000 population	679.0	959.1	615.3	987.8	341.5	518.4	497.8	755.9
Of which day surgery	664.4	941.0	596.4	963.8	327.3	503.2	480.1	737.5
Day surgery as per cent of total	97.8	98.1	96.9	97.6	95.8	97.1	96.4	97.6
Tonsillectomy (EMB10-20)								
Total rate per 100 000 population	118.3	150.4	171.0	177.3	164.5	169.6	78.6	88.0
Of which day surgery	29.1	40.3	104.1	115.3	77.9	87.0	31.9	37.7
Day surgery as per cent of total	24.6	26.8	60.9	65.1	47.4	51.3	40.6	42.8
Diagnostic bronchoscopy with or without biopsy (UGC)								
Total rate per 100 000 population	255.0	197.7	56.6	34.0	186.3	135.2	127.2	101.1
Of which day surgery	151.5	130.0	1.5	1.0	78.2	61.8	75.9	64.3
Day surgery as per cent of total	59.4	65.8	2.6	3.0	42.0	45.7	59.7	63.6
Colonoscopy with or without biopsy (JFA15. UJF32. UJF35. UJF42. UJF45)								
Total rate per 100 000 population	1762.9	1903.6	54.6	59.3	1 067.1	1215.9	804.4	913.8
Of which day surgery	1481.5	1613.5	4.3	8.0	880.9	1010.4	680.1	773.5
Day surgery as per cent of total	84.0	84.8	7.9	13.4	82.6	83.1	84.5	84.6
Laparoscopic cholecystectomy (JKA 21)								
Total rate per 100 000 population	67.8	178.5	81.1	179.6	48.0	122.4	68.2	151.9
Of which day surgery	30.1	90.2	14.4	51.3	11.5	39.7	13.3	31.8
Day surgery as per cent of total	44.4	50.5	17.8	28.5	23.9	32.4	19.4	20.9
Repair of inguinal hernia (JAB)								
Total rate per 100 000 population	340.4	37.5	383.8	40.6	245.9	29.2	300.0	30.6
Of which day surgery	257.5	23.2	229.6	21.7	165.7	17.5	221.6	20.4
Day surgery as per cent of total	75.6	61.9	59.8	53.4	67.4	59.8	73.9	66.6
Arthroscopic excision of meniscus of knee (NGD01. NGD11)								
Total rate per 100 000 population	340.9	235.5	297.7	193.2	359.7	241.4	147.9	82.6
Of which day surgery	328.4	223.7	265.9	168.7	333.7	224.4	142.4	78.3
Day surgery as per cent of total	96.3	95.0	89.3	87.3	92.8	92.9	96.3	94.8
Excision of mammary gland (women only) (HAB)								
Total per 100 000 Women	2.9	200.7	3.2	129.8	2.5	124.7	2.7	138.2
Of which day surgery	2.5	99.1	2.0	36.3	2.4	66.1	2.3	58.4
Day surgery as per cent of total	87.5	49.4	63.1	28.0	96.7	53.0	85.7	42.2

1 The NCSP codes refer to the NOMESCO Classification of Surgical Procedures. NCSP-E-version 1.13:2009 NOMESCO 83:2008

Sources: See Table 3.5.1

Table 3.5.3 Share of laparoscopic procedures and secondary hip replacements on in-patients by gender, 2011

Procedure	Denmark		Finland		Åland ¹⁾		Iceland ²⁾		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	w
<i>Per cent laparoscopic</i>												
Colectomy	33	31	28	32	2	0	24	21	26	26	2	3
Appendectomy	83	76	15	41	1	28	42	60	65	69	26	38
Cholecystectomy	76	88	75	87	69	90	93	97	86	93	68	81
Repair of inguinal hernia	36	48	14	16	9	9	10	20	16	14	10	16
Hysterectomy	.	24	.	43	.	4	.	16	.	23	.	8
<i>Per cent secondary</i>												
Hip replacement	12	11	13	14	12	10	12	9	12	11	12	9

1 Average 2007-11

2 2009

Sources: See Table 3.5.1

Table 3.5.4 Discectomy by gender and age, 2011

Age	Denmark		Faroe Islands		Finland		Åland ¹⁾		Iceland		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W	M	W
<i>Total number of procedure</i>														
<15	3	2	..	..	1	3	-	-	..	..	1	9	-	6
15-24	88	53	..	..	88	65	0	0	..	..	105	67	51	70
25-44	1 139	884	..	..	986	731	4	2	..	..	1 070	793	876	746
45-64	2 150	1 849	..	..	1 566	1 330	4	5	..	..	1 492	1 213	1 400	1 278
65+	1 528	1 823	..	..	1 007	1 320	4	5	..	..	800	937	1 258	1 428
Total	4 908	4 611	..	..	3 648	3 449	11	13	..	..	3 468	3 019	3 629	3 528
<i>Per 100 000 in the age group</i>														
<15	1	0	..	..	0	1	0	0	..	..	0	2	-	1
15-24	25	16	..	..	26	20	12	13	..	..	33	22	8	12
25-44	158	124	..	..	143	111	99	56	..	..	155	120	70	62
45-64	288	249	..	..	205	172	100	127	..	..	237	199	115	107
65+	358	347	..	..	249	235	155	186	..	..	254	230	164	151
Total	828	735	..	..	137	125	81	89	..	..	143	124	78	75

1 Average 2007-11

NCSP codes covered: ABC

Sources: See Table 3.5.1

Table 3.5.5 Thyroidectomy by gender and age, 2011

Age	Denmark		Finland		Åland ¹⁾		Iceland		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W
<i>Total number of procedures</i>												
<15	1	6	3	4	-	-	..	..	2	2	-	23
15-24	10	61	14	58	-	-	..	..	4	39	15	148
25-44	90	551	76	450	0	2	..	..	72	398	115	692
45-54	122	487	61	357	0	2	..	..	62	233	88	438
55-64	97	325	115	400	0	3	..	..	63	209	115	416
65-74	85	242	74	252	0	1	..	..	42	152	107	286
75-84	27	91	46	155	0	0	..	..	21	67	39	169
85+	3	20	3	13	-	-	..	..	3	8	7	24
Total	435	1 783	392	1 689	1	9	..	..	269	1 108	504	2 196
<i>Per 100 000 in the age group</i>												
< 15	0	1	1	1	-	-	..	..	0	0	-	3
15-24	3	18	4	18	-	-	..	..	1	13	2	24
25-44	12	77	11	68	6	68	..	..	10	60	9	58
45-54	31	125	16	96	10	90	..	..	19	73	14	73
55-64	28	91	30	101	10	162	..	..	21	72	19	70
65-74	31	84	30	91	15	92	..	..	24	79	24	61
75-84	22	57	36	79	27	43	..	..	20	48	17	54
85+	9	26	9	15	-	-	..	..	9	10	8	14
Total	16	64	15	61	7	65	..	..	11	46	11	47

1 Average 2007-11

NCSP: BAA 20-60

Sources: See Table 3.5.1

Table 3.5.6 Cataract surgery by gender and age, 2011

Age	Denmark		Faroe Islands		Finland		Åland ¹⁾		Iceland		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W	M	W
<i>Total number of procedures</i>														
< 45	327	320	..	..	309	222	0	1	..	..	250	205	382	463
45-64	3 566	4 150	..	..	3 294	3 643	1	1	..	..	1 348	1 476	4 013	4 586
65-74	6 338	9 343	..	..	5 098	8 250	1	2	..	..	2 057	3 204	7 068	10 457
75-84	6 739	9 936	..	..	6 192	11 914	2	7	..	..	3 285	5 359	8 653	14 889
85+	1 770	3 171	..	..	1 434	3 147	1	4	..	..	1 348	2 361	2 994	5 196
Total	18 740	26 920	..	..	16 327	27 176	5	14	..	..	8 288	12 605	23 247	35 591
<i>Per 100 000 in the age group</i>														
< 45	21	21	..	..	21	16	5	8	..	..	17	14	14	18
45-64	477	558	..	..	431	472	20	24	..	..	214	242	331	383
65-74	2 345	3 245	..	..	2 091	2 961	103	153	..	..	1 154	1 673	1 579	2 239
75-84	5 525	6 193	..	..	4 825	6 069	273	702	..	..	3 206	3 840	3 665	4 751
85+	5 074	4 096	..	..	4 441	3 629	262	770	..	..	3 975	3 068	3 613	3 115
Total	679	959	..	..	615	988	37	101	..	..	342	518	498	756

1 Average 2007-11

NCSP: CJC, CJD, CJE, CJF

Sources: See Table 3.5.1

Table 3.5.7.a Transluminal coronary angioplasty (PTCA, PCI) by age, Men 2011

Age	Denmark	Faroe Islands	Finland	Iceland	Norway	Sweden
<i>Total number of procedures</i>						
<45	293	..	197	..	394	347
45-54	1 211	..	845	..	1 404	1 574
55-64	2 182	..	1 810	..	2 759	3 726
65-74	2 230	..	1 781	..	2 300	4 142
75-84	1 178	..	1 225	..	1 458	2 552
85+	234	..	184	..	234	408
Total	7 328	..	6 042	..	8 549	12 756
<i>Per 100 000 in the age group</i>						
<45	18	..	13	..	27	13
45-54	306	..	224	..	420	255
55-64	621	..	469	..	931	624
65-74	825	..	731	..	1 290	925
75-84	966	..	955	..	1 423	1 081
85+	671	..	570	..	690	492
Total	265	..	228	..	352	273

NCSP: FNG 02; FNG 05
Sources: See Table 3.5.1

Table 3.5.7.b Transluminal coronary angioplasty (PTCA, PCI) by age, Women 2011

Age	Denmark	Faroe Islands	Finland	Iceland	Norway	Sweden
<i>Total number of procedures</i>						
<45	89	..	30	..	77	77
45-54	306	..	185	..	272	363
55-64	521	..	411	..	595	940
65-74	812	..	711	..	866	1 434
75-84	675	..	895	..	778	1 438
85+	216	..	202	..	207	344
Total	2 619	..	2 434	..	2 795	4 596
<i>Per 100 000 in the age group</i>						
<45	6	..	2	..	5	3
45-54	79	..	50	..	85	61
55-64	147	..	103	..	205	158
65-74	282	..	255	..	452	307
75-84	421	..	456	..	558	459
85+	279	..	233	..	269	206
Total	93	..	88	..	115	98

NCSP: FNG 02; FNG 05
Sources: See Table 3.5.1

Table 3.5.8.a Coronary artery bypass graft by age, men, 2011

Age	Denmark	Faroe Islands	Finland	Iceland	Norway	Sweden
<i>Total number of procedures</i>						
<45	24	..	20	..	39	39
45-54	152	..	122	..	235	224
55-64	466	..	417	..	690	811
65-74	663	..	548	..	782	1.199
75-84	336	..	303	..	424	728
85+	11	..	15	..	17	30
Total	1 652	..	1 425	..	2 187	3 031
<i>Per 100 000 in the age group</i>						
<45	2	..	1	..	3	1
45-54	38	..	32	..	70	36
55-64	133	..	108	..	233	136
65-74	245	..	225	..	439	268
75-84	275	..	236	..	414	308
85+	32	..	46	..	50	36
Total	60	..	54	..	90	65

NCSP: FNC, FND, FNE

Sources: See Table 3.5.1

Table 3.5.8.b Coronary artery bypass graft by age, women, 2011

Age	Denmark	Faroe Islands	Finland	Iceland	Norway	Sweden
<i>Total number of procedures</i>						
<45	4	..	2	..	6	9
45-54	15	..	17	..	36	40
55-64	56	..	56	..	111	143
65-74	154	..	142	..	211	270
75-84	127	..	161	..	164	276
85+	9	..	8	..	13	14
Total	365	..	386	..	541	752
<i>Per 100 000 in the age group</i>						
<45	0	..	0	..	0	0
45-54	4	..	0	..	11	7
55-64	16	..	14	..	38	24
65-74	53	..	51	..	110	58
75-84	79	..	82	..	118	88
85+	12	..	9	..	17	8
Total	13	..	14	..	22	16

NCSP: FNC, FND, FNE

Sources: See Table 3.5.1

Table 3.5.9.a Appendectomy by age, men 2011

Age	Denmark	Faroe Islands	Finland	Åland ¹⁾	Iceland	Norway	Sweden
<i>Total number of procedures</i>							
<15	632	..	406	4	..	491	45
15-24	722	..	722	5	..	709	680
25-44	796	..	1 180	6	..	965	1 731
45-64	525	..	773	4	..	494	1 021
65+	320	..	338	1	..	268	575
Total	2 995	..	3 419	19	..	2 927	5 849
<i>Per 100 000 in the age group</i>							
<15	125	..	89	147	..	104	6
15-24	203	..	214	279	..	221	106
25-44	110	..	171	165	..	140	138
45-64	70	..	101	105	..	78	84
65+	75	..	84	43	..	85	75
Total	109	..	129	138	..	121	125

1 Average 2007-11

NCSP: JEA

Sources: See Table 3.5.1

Table 3.5.9.b Appendectomy by age, women 2011

Age	Denmark	Faroe Islands	Finland	Åland ¹⁾	Iceland	Norway	Sweden
<i>Total number of procedures</i>							
<15	559	..	306	3	..	347	689
15-24	686	..	747	4	..	785	1 219
25-44	805	..	1 150	6	..	832	1 550
45-64	730	..	996	2	..	626	1 293
65+	428	..	415	1	..	298	716
Total	3 208	..	3 614	15	..	2 888	5 467
<i>Per 100 000 in the age group</i>							
<15	116	..	70	115	..	78	91
15-24	202	..	231	255	..	256	201
25-44	113	..	175	158	..	126	129
45-64	98	..	129	44	..	103	108
65+	81	..	74	50	..	73	76
Total	114	..	131	107	..	119	116

1 Average 2007-11

NCSP: JEA

Sources: See Table 3.5.1

Table 3.5.10.a Cholecystectomy by age, men 2011

Age	Denmark	Faroe Islands	Finland	Åland ¹⁾	Iceland	Norway	Sweden
<i>Total number of procedures</i>							
<25	65	..	46	-	..	29	86
25-44	552	..	454	3	..	346	1 064
45-64	940	..	1 133	8	..	582	1 784
65+	652	..	1 121	5	..	362	1 376
Total	2 209	..	2 754	15	..	1 319	4 388
<i>Per 100 000 in the age group</i>							
<25	8	..	6	-	..	4	6
25-44	76	..	66	71	..	50	85
45-64	126	..	148	196	..	92	147
65+	153	..	277	198	..	115	179
Total	80	..	104	107	..	54	94

1 Average 2007-11

NCSP: JKA 20-21

Sources: See Table 3.5.1

Table 3.5.10.b Cholecystectomy by age, women 2011

Age	Denmark	Faroe Islands	Finland	Åland ¹⁾	Iceland	Norway	Sweden
<i>Total number of procedures</i>							
<25	403	..	262	1	..	192	626
25-44	2 039	..	1 482	10	..	1 243	3 042
45-64	2 007	..	2 409	9	..	1 110	3 154
65+	926	..	1 352	5	..	593	1 693
Total	5 375	..	5 505	25	..	3 138	8 515
<i>Per 100 000 in the age group</i>							
<25	49	..	34	37	..	25	46
25-44	286	..	225	270	..	188	254
45-64	270	..	312	229	..	182	264
65+	176	..	241	172	..	145	179
Total	192	..	200	177	..	129	181

1 Average 2007-11

NCSP: JKA 20-21

Sources: See Table 3.5.1

Table 3.5.11 Transplantation of kidney by gender and age, 2011

Age	Denmark		Finland		Åland ¹⁾		Iceland		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W
<i>Total number of procedures</i>												
<15	3	1	4	3	-	-	..	..	2	2	41	5
15-24	10	5	4	8	-	-	..	..	11	7	12	10
25-44	42	31	23	15	-	-	..	..	40	21	70	46
45-54	38	28	28	20	-	-	..	..	34	15	54	29
55-64	38	20	24	19	-	-	..	..	53	17	58	37
65+	14	5	20	9	-	-	..	..	51	18	33	14
Total	145	90	103	74	-	-	..	..	191	80	274	141
<i>Per 100 000 in the age group</i>												
< 15	1	0	1	1	-	-	..	..	0	0	5	1
15-24	3	1	1	2	-	-	..	..	3	2	2	2
25-44	6	4	3	2	-	-	..	..	6	3	6	4
45-54	10	7	7	5	10	-	..	..	10	5	9	5
55-64	11	6	6	5	-	10	..	..	18	6	10	6
65+	3	1	5	2	9	-	..	..	16	4	4	1
Total	5	3	4	3	3	1	..	..	8	3	6	3

1 Average 2007-11

NCSP: KAS00-KAS20

Sources: See Table 3.5.1

Table 3.5.12 Open prostatectomy by age, men 2011

Age	Denmark	Faroe Islands	Finland	Åland ¹⁾	Iceland	Norway	Sweden
<i>Total number of procedures</i>							
<45	4	..	4	-	..	10	12
45-64	517	..	626	7	..	866	1 380
65-74	476	..	366	2	..	659	1 381
75-84	18	..	9	-	..	52	89
85+	-	..	-	-	..	11	5
Total	1 015	..	1 005	9	..	1 598	2 868
<i>Per 100 000 in the age group</i>							
<45	0	..	0	-	..	1	0
45-64	69	..	82	171	..	137	114
65-74	176	..	150	162	..	370	308
75-84	15	..	7	-	..	51	38
85+	-	..	-	-	..	32	6
Total	37	..	38	64	..	66	61

1 Average 2007-11

NCSP: KEC; KED 00; KED96

Sources: See Table 3.5.1

Table 3.5.13 Transurethral prostatectomy by age, men 2011

Age	Denmark	Faroe Islands	Finland	Åland ¹⁾	Iceland	Norway	Sweden
<i>Total number of procedures</i>							
<45	17	..	5	-	..	14	8
45-64	791	..	768	7	..	829	1 145
65-74	1 261	..	1 395	10	..	1 483	2 308
75-84	845	..	1 106	8	..	1 335	2 043
85+	180	..	219	3	..	367	491
Total	3 094	..	3 493	27	..	4 028	5 995
<i>Per 100 000 in the age group</i>							
<45	1	..	0	-	..	0,9	0,3
45-64	106	..	100	166	..	131	94
65-74	466	..	572	708	..	832	516
75-84	693	..	862	1 119	..	1 303	865
85+	516	..	678	1 312	..	1 082	592
Total	112	..	132	195	..	166	128

1 Average 2007-11

NCSP: KED 22; KED52-KED 72; KED98

Sources: See Table 3.5.1

Table 3.5.14 Hysterectomy by age, women 2011

Age	Denmark	Faroe Islands	Finland	Åland ¹⁾	Iceland	Norway	Sweden
<i>Total number of procedures</i>							
<25	16	..	10	0	..	13	30
25-44	1 891	..	1 315	11	..	1 421	2 030
45-64	3 199	..	3 144	30	..	2 431	4 220
65+	1 325	..	1 147	10	..	914	2 215
Total	6 431	..	5 616	50	..	4 779	8 495
<i>Per 100 000 in the age group</i>							
<25	2	..	1	5	..	2	2
25-44	265	..	200	298	..	215	169
45-64	430	..	408	727	..	399	353
65+	252	..	204	344	..	224	234
Total	229	..	204	354	..	197	180

1 Average 2007-11

NCSP: LCC; LCD

Sources: See Table 3.5.1

Table 3.5.15 Caesarean section by age, women 2011

Age	Denmark	Faroe Islands	Finland	Åland ¹⁾	Iceland	Norway	Sweden
<i>Total number of procedures</i>							
<15	2	..	1	-	..	-	3
15-24	1 191	..	1 238	7	..	1 148	1 904
25-34	7 880	..	5 907	41	..	6 056	11 120
35-44	3 497	..	2 384	22	..	3 062	6 093
45+	44	..	40	0	..	59	109
Total	12 614	..	9 570	73	..	10 325	19 229
<i>Per 1 000²⁾ deliveries</i>							
<15	-	..	0	-	..	-	600
15-24	165	..	123	202	..	120	114
25-34	202	..	153	227	..	156	156
35-44	276	..	214	344	..	260	244
45+	419	..	320	0	..	551	363
Total	214	..	160	250	..	171	170

1 Average 2007-11

2 Sweden and Norway 2012

NCSP: MCA

Sources: See Table 3.5.1

Table 3.5.16.a Hip replacement by age, men 2011

Age	Denmark	Faroe Islands	Finland	Åland ¹⁾	Iceland	Norway	Sweden
<i>Total number of procedures</i>							
<25	14	..	5	-	..	6	11
25-44	143	..	127	0	..	110	180
45-64	1 481	..	1 554	9	..	1 034	2 055
65-74	1 775	..	1 489	8	..	1 117	2 508
75+	1 642	..	1 655	8	..	1 660	3 048
Total	5 055	..	4 830	26	..	3 927	7 808
<i>Per 100 000 in the age group</i>							
<25	2	..	1	-	..	1	0,8
25-44	20	..	18	11	..	16	14
45-64	198	..	203	231	..	164	169
65-74	657	..	611	575	..	626	560
75+	1 047	..	1 030	874	..	1 217	956
Total	183	..	182	184	..	162	167

1 Average 2007-11

NCSP: NFB; NFC

Sources: See Table 3.5.1

Table 3.5.16.b Hip replacement by age, women, 2011

Age	Denmark	Faroe Islands	Finland	Åland ¹⁾	Iceland	Norway	Sweden
<i>Total number of procedures</i>							
<25	8	..	13	-	..	11	21
25-44	112	..	108	1	..	146	192
45-64	1 499	..	1 778	7	..	1 552	2 315
65-74	2 407	..	2 006	11	..	2 194	3 432
75+	3 538	..	3 568	14	..	3 982	5 918
Total	7 564	..	7 473	33	..	7 885	11 878
<i>Per 100 000 in the age group</i>							
<25	1	..	2	-	..	1	2
25-44	16	..	16	28	..	22	16
45-64	201	..	231	171	..	255	194
65-74	836	..	720	856	..	1 146	735
75+	1 487	..	1 261	943	..	1 839	1 232
Total	269	..	272	234	..	324	252

1 Average 2007-11

NCSP: NFB; NFC

Sources: See Table 3.5.1

Table 3.5.17.a Hip replacement by age, men 2011

Age	Denmark	Faroe Islands	Finland	Åland ¹⁾	Iceland	Norway	Sweden
<i>Total number of procedures</i>							
<25	1	..	2	-	..	-	1
25-44	46	..	24	-	..	13	22
45-64	1 016	..	1 235	5	..	542	1 321
65-74	1 205	..	1 208	4	..	551	1 696
75+	612	..	845	3	..	391	1 194
Total	2 880	..	3 314	12	..	1 497	4 234
<i>Per 100 000 in the age group</i>							
<25	0	..	0	-	..	-	0
25-44	6	..	3	-	..	2	2
45-64	136	..	162	115	..	86	109
65-74	446	..	495	295	..	309	379
75+	390	..	526	333	..	287	374
Total	104	..	125	84	..	62	91

1 Average 2007-11

NCSP: NGB 20; NGB 30; NGB 40

Sources: See Table 3.5.1

Table 3.5.17.b Hip replacement by age, women 2011

Age	Denmark	Faroe Islands	Finland	Åland ¹⁾	Iceland	Norway	Sweden
<i>Total number of procedures</i>							
<25	3	..	1	-	..	3	4
25-44	56	..	39	-	..	24	43
45-64	1 443	..	2 071	7	..	728	1 774
65-74	1 724	..	2 297	6	..	968	2 329
75+	1 213	..	2 041	6	..	820	1 944
Total	4 439	..	6 449	19	..	2 543	6 094
<i>Per 100 000 in the age group</i>							
<25	0	..	0	-	..	0	0
25-44	8	..	6	-	..	4	4
45-64	194	..	269	161	..	120	148
65-74	599	..	825	489	..	505	499
75+	510	..	721	404	..	379	405
Total	158	..	234	134	..	105	129

1 Average 2007-11

NCSP: NGB 20; NGB 30; NGB 40

Sources: See Table 3.5.1

Figure 3.5.1 Transluminal coronary angioplasty and coronary anastomosis surgery, total rates per 100 000 inhabitants, 2003-2011

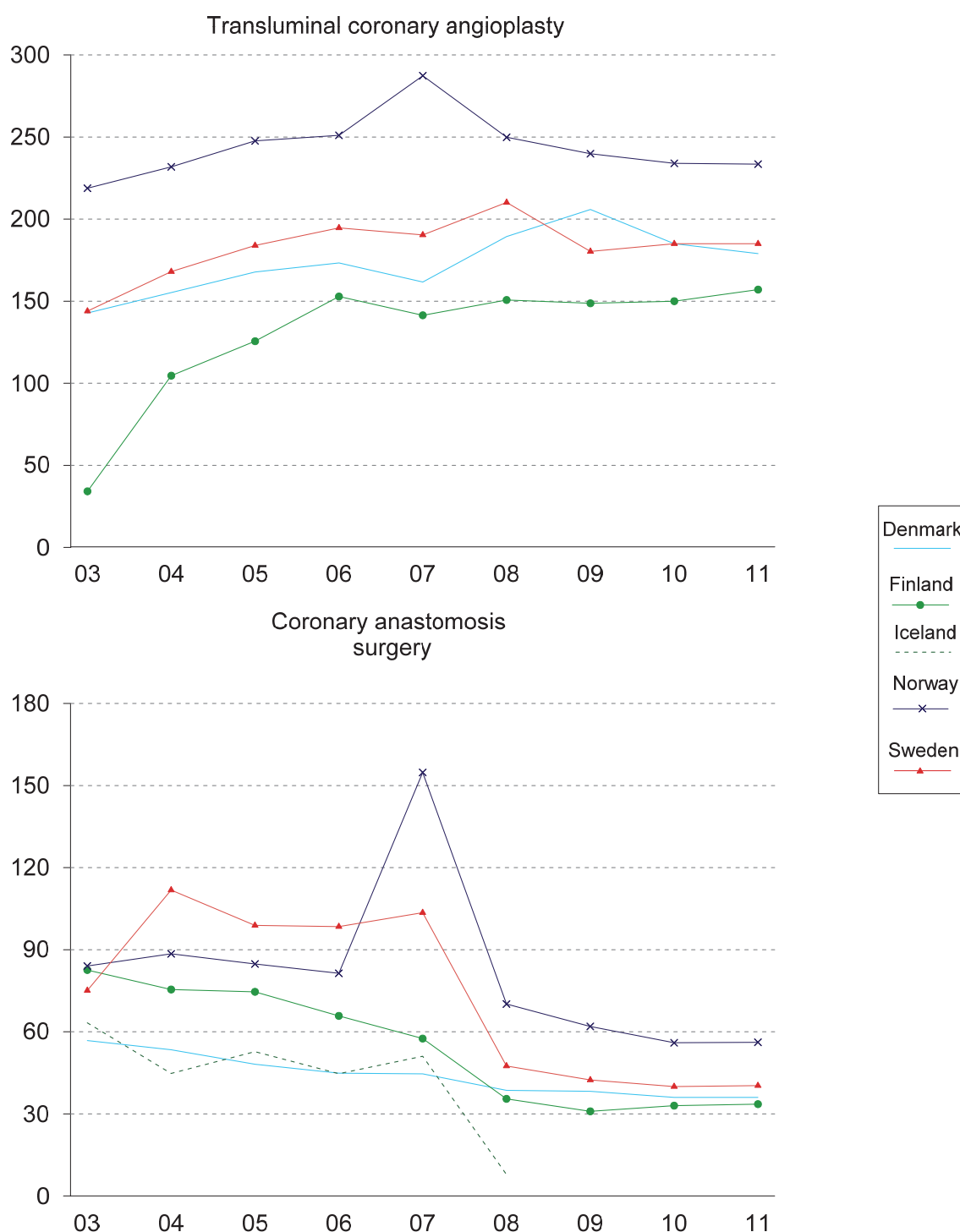


Figure 3.5.2 Hip replacement per 100 000 inhabitants, 2000-2011



3.6 Accidents and self-inflicted injury

Patients admitted to hospital because of accidents occupy a substantial part of the capacity in hospitals.

While statistics on causes of death are highly developed in the Nordic countries, registration of survivors following accidents is still incomplete, and the available data are difficult to compare. As only Denmark and Iceland have comparable statistics on external causes of accidents, it is not possible to present Nordic statistics on this.

Therefore statistics are presented for hospital discharges for the most common serious accidents that usually require admission. The statistics show marked differences, both among countries and among men and women.

Table 3.6.1 Discharges from hospitals after treatment for injuries per 100 000 inhabitants and by gender, 2011¹⁾

(ICD10-codes)	Denmark		Faroe Islands ²⁾		Greenland ²⁾		Finland		Åland ³⁾		Iceland		Norway		Sweden ⁴⁾	
	M	W	M	W	M	W	M	W	M	WW	M	W	M	W	M	W
Fracture of skull and intracranial injury (S02; S06)	227	136	323	142	106	52	199	123	179	106	111	56	251	153	224	139
Fracture at wrist and hand level (S62)	69	30	88	30	20	10	59	22	35	10	25	7	43	16	20	8
Injury of lower leg (S80-S89)	241	231	443	211	122	137	443	327	332	277	128	133	178	169	146	168
Injury of hip and thigh ICD10: (S70-S79)	177	320	175	129	49	88	151	252	148	240	124	230	175	341	214	414
Poisoning (T36-T65)	208	273	76	82	51	82	86	91	33	41	27	44	93	116	98	145
Burn and corrosion (T20-T32)	16	8	44	17	9	5	26	10	19	6	20	8	28	15	22	10

1 Including violence and self-inflicted injury

2 Average 2002-06

3 Average 2007-11

4 2010

Sources: The Inpatient Registers of the Nordic Countries

Table 3.6.2 Discharges from hospitals after treatment for injuries per 100 000 inhabitants by gender and age, 2011¹⁾

Age	Denmark		Faroe Islands ²⁾		Finland		Iceland ³⁾		Norway		Sweden ⁴⁾	
	M	W	M	W	M	W	M	W	M	W	M	W
0-14	492	456	705	502	910	644	456	350	986	705	1 075	764
15-24	1 141	1 110	1 343	1 074	1 975	1 032	892	553	1 727	1 121	1 433	1 086
25-64	853	659	1 217	391	1 963	1 226	914	639	1 389	1 023	1 374	1 122
65+	1 598	2 363	1 532	1 784	2 786	3 542	2 731	4 003	3 271	4 547	4 738	6 085
Total	939	998	1 165	772	1 907	1 582	1 008	1 001	1 606	1 574	1 883	2 059

1 Including violence and self-inflicted injury

2 Average 2002-06

3 2009

4 2010

Sources: The Inpatient Registers of the Nordic Countries

3.7 Development in consumption of medicinal products

Table 3.7.1 presents total sales of medicinal products in the Nordic countries by ATC main groups. Sales of medicinal products are highest in Sweden and Finland, while Norway, Iceland, Åland and Denmark have slightly lower sales. Sales in the Faroe Islands are slightly lower than in Iceland, while sales in Greenland are substantially lower than in the other countries.

In this report, only tables without comments are furthermore included. For a broader perspective on the consumption of medicinal products, see the NOMESCO publication *Medicines Consumption in the Nordic Countries 2004-2008*.

Data sources in this section: Denmark: Statens Serum Institut; Faroe Islands: Chief Pharmaceutical Officer; Greenland: The Central Pharmacy in Copenhagen County; Finland and Åland: FIMEA; Iceland: Icelandic Medicines Agency; Norway: Norwegian Institute of Public Health; Sweden: National Corporation of Swedish Pharmacies.

Table 3.7.1 Sales of medicinal products in total, DDD/1 000 inhabitants/day by ATC-group, 2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A Alimentary tract and metabolism	164	193	..	260	190	165	192	222
B Blood and blood-forming organs	121	127	..	139	137	154	128	308
C Cardiovascular system	526	539	..	540	408	375	408	462
G Genito-urinary system	102	80	..	132	116	111	101	99
H Systemic hormonal preparations excl. sex hormones and insulins	33	28	..	50	53	39	44	43
J Anti-infectives for systemic use	22	18	..	24	19	24	23	18
L Antineoplastic and immunomodulating agents	16	14	..	17	16	15	17	17
M Musculo-skeletal system	66	48	..	105	69	92	61	61
N Nervous system	279	206	..	268	203	342	227	272
P Antiparasitic products, insecticides and repellents	1	1	..	2	2	2	1	1
R Respiratory system	128	107	..	155	133	127	188	145
S Sensory organs	11	10	..	18	18	16	19	22

Note: Sales of B05 and D are excluded from this table because no official DDDs are assigned in these groups. A11 is excluded because of differences in the definitions of medicinal and non-medicinal products. In group S, only S01E is included

Table 3.7.2 Sales of reimbursed medicines by gender and age, DDD/1 000 inhabitants/day, 2012

Age	Denmark		Faroe Islands		Finland		Iceland		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W
0-14	74	49	53	48	88	64	139	97	92	59	88	63
15-24	100	115	119	160	187	273	230	717	146	167	189	430
25-44	197	249	340	365	478	569	450	834	297	359	383	654
45-64	878	926	1 431	1 239	1 583	1 626	1 539	1 915	1 185	1 153	1 502	1 686
65-74	2 174	2 079	3 526	2 864	3 047	2 748	3 346	3 496	2 652	2 369	3 582	3 402
75+	3 193	3 282	4 549	4 089	4 089	4 044	4 082	3 902	3 237	2 848	5 610	5 495

Table 3.7.3 Sales of drugs for acid related disorders (ATC group A02), DDD/1 000 inhabitants/day, 2005-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A02								
Drugs for acid related disorders								
2005	38.9	37.6	18.9	32.7	30.5	54.2	32.5	43.1
2010	58.8	58.3	41.9	55.0	48.9	85.6	46.5	61.1
2011	62.2	67.9	41.7	59.4	51.9	93.0	49.0	65.3
2012	65.6	71.6	44.5	63.0	54.9	96.6	52.1	69.2
A02A								
Antacids								
2005	7.3	4.2	2.1	2.8	2.7	2.4	2.1	2.6
2010	7.1	3.2	1.4	2.3	2.3	5.3	1.4	1.7
2011	7.2	3.1	1.7	2.3	2.4	5.7	1.4	1.8
2012	7.3	3.1	1.8	2.3	2.5	6.3	1.4	1.7
A02B								
Drugs for peptic ulcer and gastro-oesophageal reflux disease								
2005	31.6	33.4	16.8	29.9	27.8	51.9	30.4	40.8
2010	51.7	55.1	40.4	52.7	46.6	80.3	45.0	59.5
2011	55.1	64.8	40.0	57.1	49.5	87.2	47.6	63.5
2012	58.3	68.5	42.8	60.8	52.4	90.3	50.7	67.5
A02BA H2-receptor antagonists								
2005	6.3	3.3	0.6	4.1	4.7	6.6	5.5	5.5
2010	2.2	1.1	0.1	2.9	5.8	4.6	5.8	3.2
2011	1.3	0.9	0.0	2.2	5.5	4.0	5.4	2.7
2012	1.1	1.0	0.0	1.9	4.3	3.7	5.3	2.5
A02BC								
Proton pump inhibitors								
2005	24.8	29.0	15.9	24.3	21.4	45.2	24.5	34.2
2010	49.1	53.2	40.2	48.5	39.2	75.6	38.8	55.4
2011	53.4	63.1	39.9	53.7	42.3	83.2	41.8	59.9
2012	56.6	66.7	42.6	57.6	46.3	86.5	44.9	64.0
A02BX								
Other drugs for peptic ulcer and gastro-oesophageal reflux disease (GORD)								
2005	0.5	1.1	0.3	1.4	1.6	0.0	0.4	1.1
2010	0.4	0.8	0.0	1.2	1.5	0.0	0.4	0.8
2011	0.4	0.7	0.0	1.2	1.6	0.0	0.4	0.9
2012	0.5	0.8	0.0	1.1	1.7	0.0	0.5	0.9

Figure 3.7.1 Sales of drugs for treatment of peptic ulcer and gastro-oesophageal reflux disease, DDD/1 000 inhabitants/day, 2005-2012

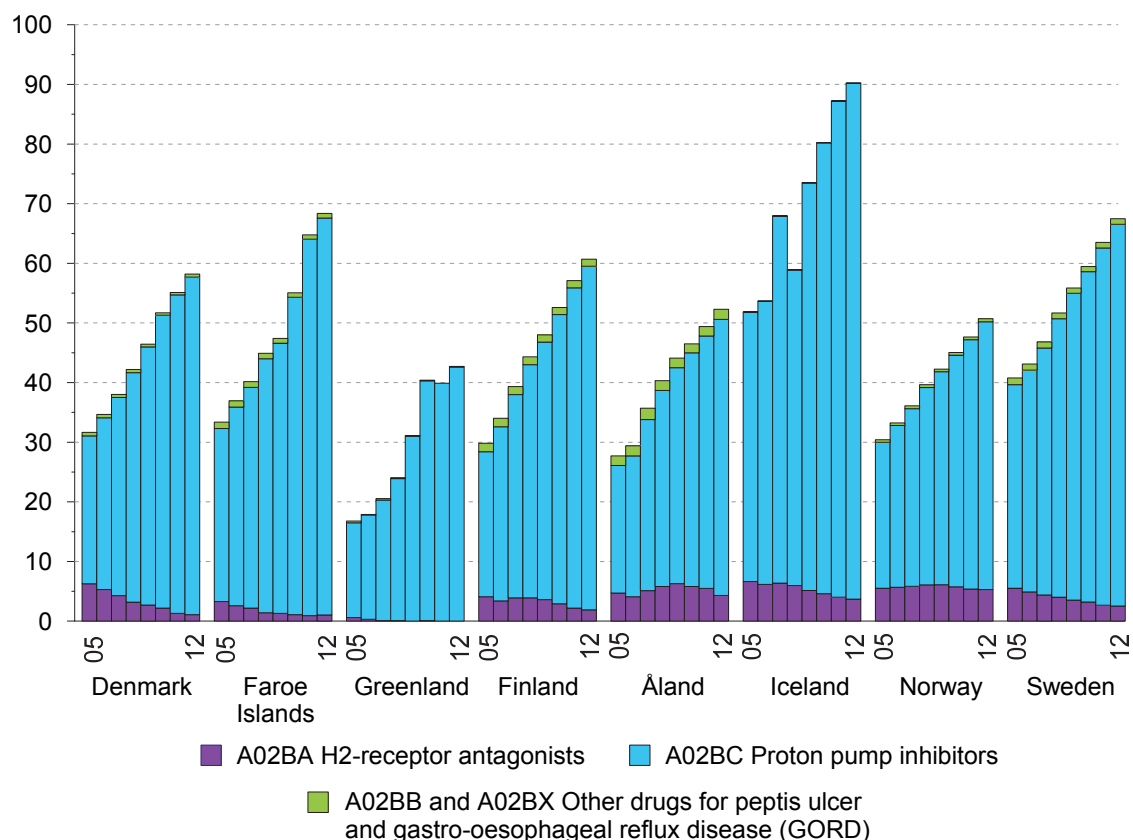


Table 3.7.4 Share of the population (one-year prevalence) who took at least one medicinal product for treatment of peptic ulcer and gastro-oesophageal reflux disease (ATC-groups A02BA and A02BC) by gender and age, 2012

Age	Denmark		Faroe Islands		Finland		Iceland		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W
0-14	0.0	0.1	0.0	0.2	0.2	0.3	6.8	6.7	1.3	1.4	1.1	1.3
15-24	0.1	0.3	0.0	0.0	0.4	1.0	0.7	1.9	3.5	6.9	1.0	2.8
25-44	0.3	0.6	0.5	0.8	1.4	2.9	1.3	1.9	7.1	9.6	1.5	2.9
45-64	1.0	1.3	1.1	1.2	3.7	5.0	3.2	4.6	12.7	18.1	3.2	5.4
65-74	2.0	2.4	3.8	2.6	6.5	7.9	7.6	8.2	19.4	25.4	5.9	8.3
75+	3.1	3.0	5.0	1.0	9.0	10.4	9.3	11.4	22.5	27.3	7.9	9.9

Note: Only prescribed medicines

Table 3.7.5 Share of the population per 1 000 (one-year prevalence), who took at least one medicinal product for treatment of ulcer, esophageal inflammation and pyrosis (proton pump inhibitors, ATC group A02BC) by gender and age, 2012

Age	Denmark		Faroe Islands		Finland		Iceland		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W
0-14	5.4	6.7	4.5	3.6	4.9	4.9	19.1	19.9	7.0	5.8	5.5	6.5
15-24	20.6	41.3	17.9	27.3	17.2	30.1	36.3	61.3	14.7	24.4	15.6	35.9
25-44	52.7	66.8	54.4	57.4	63.3	84.0	73.5	84.1	44.7	46.9	36.4	58.9
45-64	110.3	135.6	118.7	132.6	126.5	169.5	153.1	202.7	95.4	106.9	92.1	129.6
65-74	179.4	206.8	231.4	252.2	180.1	226.7	254.6	334.9	150.0	173.0	168.9	212.9
75+	247.7	272.9	300.8	378.3	242.9	295.6	289.5	343.5	183.8	189.4	243.4	274.8

Note: Prescribed medicine only

Table 3.7.6 Sales of anti-obesity preparations (ATC-group A08), DDD/1 000 inhabitants/day, 2005-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	0.7	0.4	0.0	0.6	0.3	1.3	2.6	2.3
2010	1.0	1.2	0.0	0.7	0.3	0.0	1.2	1.3
2011	0.9	0.8	0.0	0.4	0.3	0.1	0.8	0.8
2012	0.6	0.6	0.0	0.3	0.2	0.1	0.4	0.5

Table 3.7.7 Sales of medicines used for diabetes (ATC-group A10), DDD/1 000 inhabitants/day, 2005-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A10								
Drugs used for diabetes								
2005	34.9	32.9	10.3	66.4	38.6	24.0	39.3	44.6
2010	47.6	49.6	13.2	83.4	49.3	31.7	48.3	51.9
2011	49.4	53.3	16.1	84.2	50.3	38.5	48.4	53.0
2012	51.1	56.9	15.5	85.0	52.6	39.8	48.5	54.1
A10A								
Insulins and analogues								
2005	13.3	10.4	2.7	21.7	15.1	6.5	17.4	22.6
2010	17.2	14.2	3.8	30.0	19.8	9.8	19.2	26.4
2011	17.1	13.2	4.1	30.5	19.7	10.8	19.0	26.6
2012	17.5	13.6	4.1	30.7	21.0	10.9	18.9	26.9

The table continues

Table 3.7.7 Sales of medicines used for diabetes (ATC-group A10), DDD/1 000 inhabitants/day, 2005-2011, continued

	Denmark	Faroe Islands	Green-land	Finland	Åland	Iceland	Norway	Sweden
A10B								
Blood glucose lowering drugs, excl. insulins								
2005	21.6	22.5	7.6	44.7	23.5	17.5	21.9	22.0
2010	30.4	35.5	9.5	53.4	29.5	22.0	29.1	25.5
2011	32.3	40.1	12.0	53.7	30.6	27.7	29.5	26.4
2012	33.6	43.3	11.5	54.3	31.6	28.9	29.7	27.2
A10BA								
Biguanides								
2005	7.9	6.7	4.3	18.5	10.1	7.7	9.7	11.8
2010	15.5	12.5	6.3	32.0	17.8	11.4	14.7	17.5
2011	17.3	14.8	8.5	32.2	18.0	13.1	14.6	18.4
2012	18.6	18.1	8.2	31.8	18.4	13.3	14.6	18.9
A10BB								
Sulphonamides, urea derivatives								
2005	12.0	15.7	3.3	24.1	13.1	7.2	11.1	7.7
2010	15.5	21.0	3.0	12.2	8.5	8.1	11.5	4.7
2011	17.3	20.3	3.4	9.1	8.3	12.0	10.7	4.6
2012	8.7	18.0	3.1	6.6	7.6	12.4	9.8	4.4
A10BD								
Combinations of oral blood glucose lowering								
2005	0.2	..	-	0.8	0.1	0.5	0.1	0.2
2010	1.1	0.0	0.1	3.0	0.3	0.3	1.1	0.4
2011	1.2	-	-	3.7	0.1	0.5	1.8	0.2
2012	1.5	0.0	0.0	4.6	0.1	0.6	2.1	0.3
A10BG Thiazolidinediones								
2005	0.1	0.1	-	1.1	0.1	1.7	0.8	1.0
2010	0.1	0.0	-	1.8	1.9	0.7	0.6	0.6
2011	-	0.0	-	1.4	1.6	0.5	0.3	0.4
2012	0.0	0.0	0.0	1.3	1.4	0.5	0.3	0.3
A10BH								
Dipeptidyl peptidase 4 (DPP-4) inhibitors								
2005	-	..	-	..	..	-	-	..
2010	1.2	0.7	-	4.0	0.6	1.0	0.9	0.9
2011	1.5	1.8	-	6.6	2.2	1.2	1.5	1.2
2012	1.7	2.5	0.0	8.6	3.7	1.4	1.7	1.5
Other oral blood glucose lowering drugs, excl. insulins								
2005	0.3	0.0	-	0.2	0.2	0.4	0.1	1.2
2010	1.3	1.3	-	0.5	0.5	0.3	0.2	1.3
2011	2.3	3.1	0.1	0.8	0.5	0.4	0.6	1.4
2012	3.0	4.6	0.1	1.5	0.4	0.6	1.0	1.7

Figure 3.7.2 Sales of insulins and other blood glucose lowering drugs (ATC-groups A10A and A10B), DDD/1 000 inhabitants/day, 2005-2012

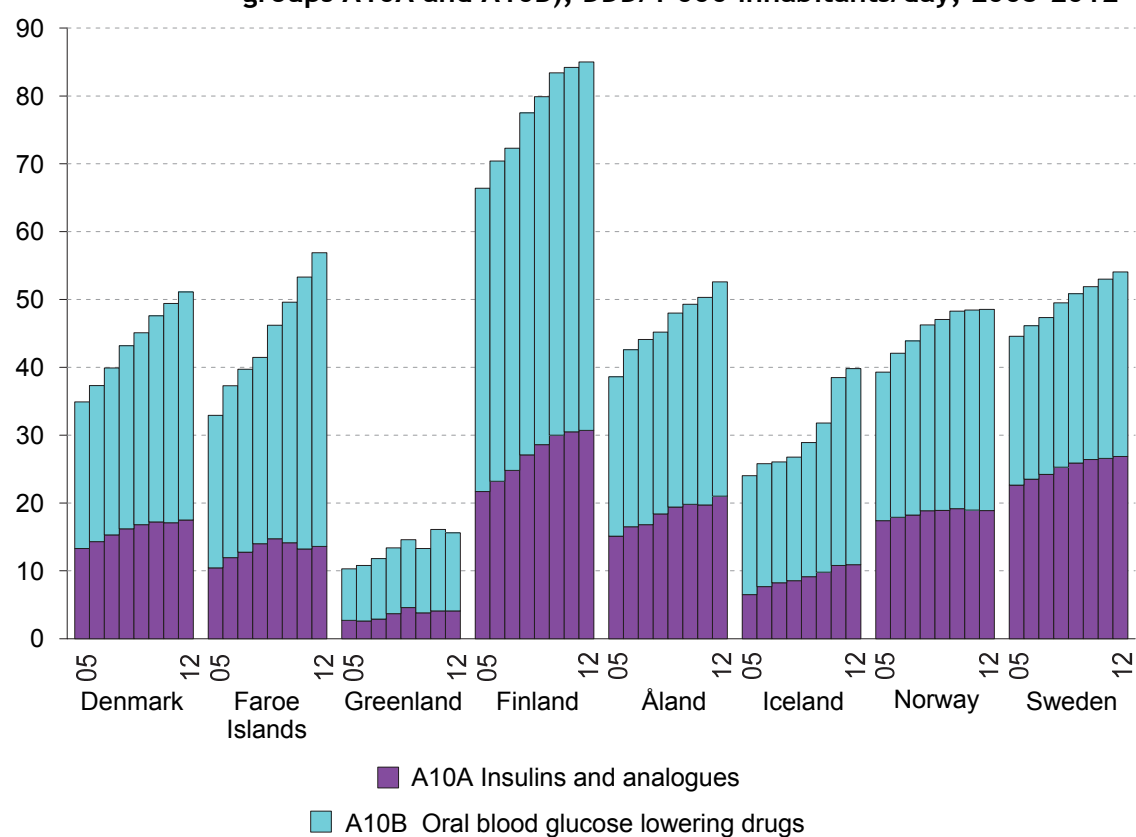


Table 3.7.8 Share of the population per 1 000 (one-year prevalence) taking at least one kind of medical product for diabetes (ATC-group A10) by gender and age, 2012

Age	Denmark		Faroe Islands		Finland		Iceland		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W
0-14	1.8	1.9	1.1	2.2	4.6	4.0	1.3	1.5	2.0	2.0	2.7	2.6
15-24	5.1	6.9	5.6	7.8	10.1	9.0	4.8	10.1	6.2	6.5	7.7	6.9
25-44	14.8	17.1	14.1	13.1	18.9	16.8	12.2	22.0	13.4	14.0	12.9	11.3
45-64	70.1	45.7	68.5	37.9	96.4	62.3	57.2	37.1	55.8	36.9	65.3	39.8
65-74	138.0	90.5	161.0	102.5	197.7	133.6	126.9	78.7	112.3	74.2	145.4	91.8
75+	135.9	99.7	196.7	113.2	209.2	171.4	130.1	89.1	114.0	85.1	160.8	116.9

Figure 3.7.3 Sales of cardiovascular drugs (ATC-group C), DDD/1 000 inhabitants/day, 2005-2012

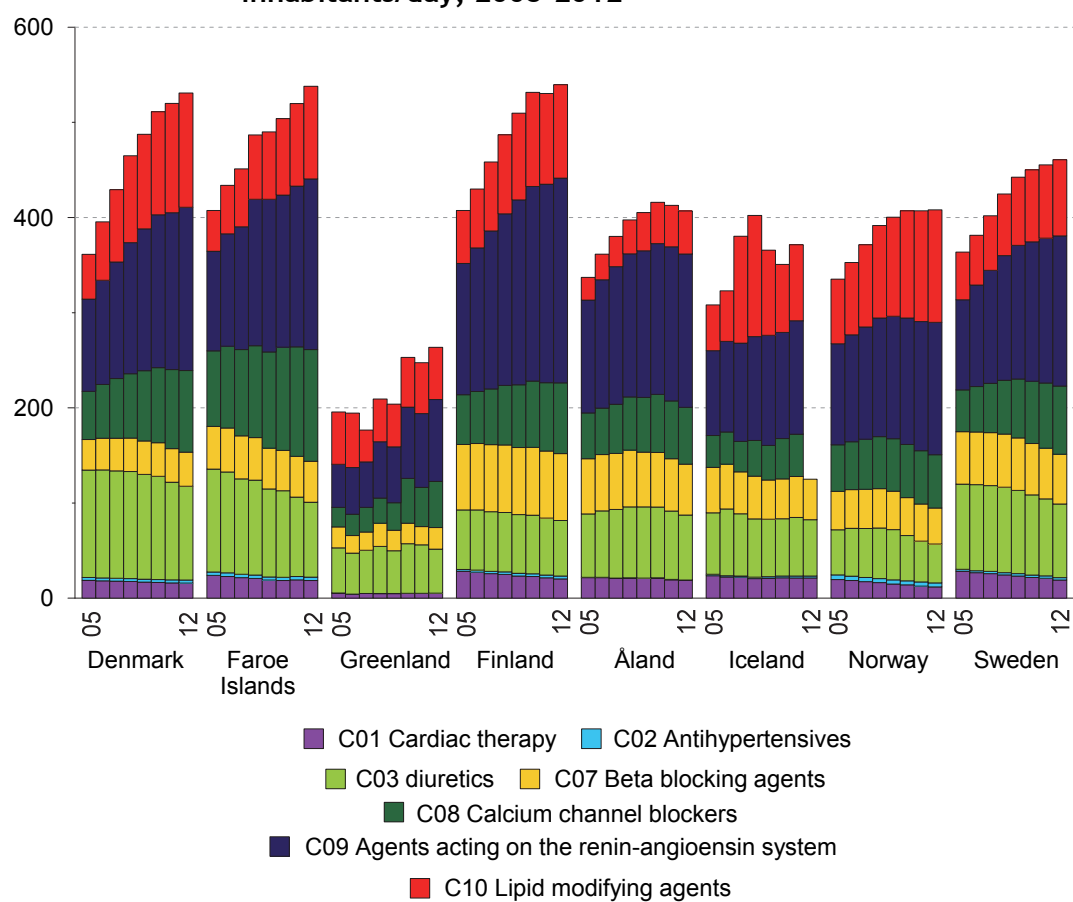


Table 3.7.9 Sales of Antithrombotic agents (ATC-group B01), DDD/1 000 inhabitants/day, 2005-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
B01A								
Antithrombotic agents								
2005	85.6	52.8	..	124.7	86.0	..	80.4	85.6
2010	99.5	75.2	42.0	118.7	85.2	..	95.6	93.5
2011	100.0	77.0	43.7	116.7	85.6	..	96.8	93.2
2012	100.7	80.1	41.6	115.4	87.4	86.7	98.0	93.1
B01AA								
Vitamin k antagonists								
2005	6.4	6.1	..	10.7	17.9	..	10.3	7.5
2010	8.1	7.3	3.2	13.9	14.4	..	11.2	9.3
2011	8.5	7.5	3.6	14.7	14.1	..	11.6	10.1
2012	8.8	7.9	3.7	15.6	14.5	8.4	11.7	11.0
B01AB								
Heparin group								
2005	2.0	1.2	..	3.2	3.1	..	3.6	3.6
2010	2.5	1.2	0.7	5.3	5.6	..	5.1	5.3
2011	2.7	1.5	1.0	5.7	6.4	..	5.7	5.7
2012	3.0	2.1	0.9	6.1	5.7	3.0	6.1	6.0
B01AC								
Platelet aggregation inhibitors excl. heparin								
2005	77.1	45.5	31.8	110.7	65.1	65.1	66.5	74.4
2010	88.8	66.5	38.1	99.3	65.2	70.7	79.3	78.8
2011	88.5	67.7	39.0	96.0	65.2	73.9	79.4	77.4
2012	86.9	67.9	36.6	92.9	67.2	74.3	79.6	75.7

Table 3.7.10 Sales of drugs for cardiac therapy (ATC group C01), DDD/1 000 inhabitants/day, 2005-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
C01								
Cardiac therapy								
2005	18.8	23.9	5.3	28.3	21.6	23.7	19.6	28.3
2010	16.5	18.6	5.0	22.7	21.0	21.4	14.0	21.8
2011	16.1	19.2	5.0	21.5	19.3	21.2	12.7	20.9
2012	15.9	18.6	5.1	20.3	18.7	21.1	11.9	19.1
C01A								
Cardiac glycosides								
2005	6.0	3.7	1.9	6.0	5.4	3.0	4.1	5.9
2010	4.7	2.8	1.5	4.2	4.9	2.6	2.4	3.5
2011	4.5	2.9	1.5	4.0	4.3	2.5	1.6	3.2
2012	4.3	3.0	1.5	3.7	4.2	2.5	1.4	3.0
C01D								
Vasodilators used in cardiac diseases								
2005	10.5	18.6	2.8	19.5	13.1	17.2	14.0	20.9
2010	9.4	14.3	2.5	15.5	12.8	15.2	9.5	16.7
2011	9.2	14.7	2.6	14.6	12.2	14.7	8.9	16.0
2012	9.1	14.0	2.6	13.6	11.5	14.4	8.2	14.4

Table 3.7.11 Sales of cardiovascular drugs (ATC-group C02; C03; C07; C08; C09), DDD/1 000 inhabitants/day, 2005-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
C02								
Antihypertensives								
2005	2.9	3.6	0.1	1.9	0.3	1.4	4.9	2.1
2010	3.0	3.3	0.1	2.9	0.4	1.8	4.3	2.5
2011	3.1	3.6	0.1	2.8	0.5	2.1	4.3	2.5
2012	3.1	3.4	0.1	2.9	0.4	2.1	4.2	2.5
C03								
Diuretics								
2005	112.9	108.0	47.5	62.5	66.5	64.5	47.4	89.4
2010	108.5	91.0	52.1	61.6	74.3	60.3	47.5	84.2
2011	102.6	83.3	50.9	59.8	71.7	61.5	42.9	81.0
2012	98.6	78.8	46.3	58.5	68.2	59.1	40.9	77.3
C03A								
Low-ceiling diuretics. thiazides								
2005	49.1	53.6	29.5	5.6	4.4	8.8	9.0	19.4
2010	49.2	43.9	37.5	6.9	9.0	6.3	11.8	25.2
2011	44.5	36.9	38.0	6.8	8.3	6.9	8.8	24.8
2012	41.5	33.5	37.1	6.7	8.5	6.5	7.9	23.7
C03C								
High-ceiling diuretics								
2005	53.5	39.6	15.9	33.5	25.9	21.2	30.1	50.7
2010	50.9	36.8	12.8	37.8	31.7	23.7	28.4	42.8
2011	50.1	36.9	10.7	37.3	32.1	24.0	27.3	41.1
2012	49.3	36.3	7.3	37.5	31.0	23.6	26.5	39.6
C03E								
Diuretics and potassium-sparing agents in combination								
2005	5.5	1.0	0.1	20.7	33.3	32.6	6.7	13.5
2010	4.1	0.6	0.2	14.1	30.6	28.0	5.9	11.6
2011	3.8	0.6	-	12.7	28.5	28.0	5.2	10.7
2012	3.6	0.6	0.1	11.5	26.0	26.5	4.9	9.7
C07								
Beta blocking agents								
2005	32.1	44.9	22.0	68.9	58.1	47.8	40.4	55.1
2010	35.4	42.4	21.7	71.3	57.4	42.1	39.8	54.1
2011	35.4	42.9	19.3	70.6	55.1	43.2	38.9	53.3
2012	35.9	43.0	22.8	70.2	53.6	42.7	37.7	52.3
C08								
Calcium channel blockers								
2005	50.7	79.3	20.5	52.2	48.1	33.6	48.9	44.0
2010	78.9	108.5	47.1	69.7	61.1	42.2	55.8	65.5
2011	83.0	115.1	41.1	71.8	60.6	44.4	56.0	68.5
2012	85.7	117.5	48.3	74.3	59.6	45.5	56.0	71.7
C08C								
Selective calcium channel blockers with mainly vascular effects								
2005	43.8	75.8	19.3	47.6	46.4	27.4	43.8	39.8
2010	74.0	106.3	46.5	66.9	59.5	37.0	52.2	62.8
2011	78.4	112.9	40.4	69.3	59.3	39.1	52.8	66.0
2012	81.4	115.4	47.4	72.0	58.3	40.3	53.0	69.5

The table continues

Table 3.7.11 Sales of cardiovascular drugs (ATC-group C02; C03; C07; C08; C09), DDD/1 000 inhabitants/day, 2005-2012, continued

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
C08D								
Selective calcium channel blockers with direct cardiac effects								
2005	6.8	3.5	1.2	4.6	1.7	6.2	5.1	4.1
2010	5.0	2.2	0.7	2.8	1.6	5.4	3.6	2.7
2011	4.6	2.2	0.7	2.5	1.3	5.3	3.3	2.5
2012	4.3	2.1	0.9	2.3	1.3	5.1	3.0	2.2
C09								
Agents acting on the renin-angiotensin system								
2005	96.8	104.7	45.2	137.9	118.6	89.2	106.2	94.7
2010	160.5	159.8	74.8	204.5	158.4	111.5	132.9	146.4
2011	164.9	168.8	77.6	208.4	162.0	119.2	135.8	152.1
2012	171.6	179.3	86.2	215.2	161.2	121.1	139.2	157.7
C09A								
ACE-inhibitors, plain								
2005	55.5	68.2	41.3	75.3	79.9	32.2	42.9	57.3
2010	90.9	104.2	64.3	104.5	86.2	38.4	45.2	83.1
2011	91.3	108.2	64.9	103.6	83.4	43.5	45.5	84.2
2012	92.1	113.2	74.5	104.3	79.2	43.3	45.5	84.6
C09B								
ACE-inhibitors, Combinations								
2005	6.7	5.3	0.1	14.7	4.2	7.7	7.3	3.6
2010	19.2	11.9	0.1	16.4	5.1	11.0	6.6	8.2
2011	19.6	13.9	0.1	15.9	5.2	7.5	6.5	8.5
2012	19.5	14.3	0.1	15.3	5.3	5.5	6.3	8.6
C09C								
Angiotensin II antagonists								
2005	22.1	20.7	3.8	31.0	27.8	23.8	30.6	24.6
2010	32.1	33.4	10.2	54.7	53.1	30.6	44.1	41.2
2011	34.7	37.0	12.4	59.0	57.3	33.0	45.9	45.0
2012	39.0	41.8	11.4	64.9	58.9	35.0	48.3	49.5
C09D								
Angiotensin II antagonists, combinations								
2005	12.5	10.5	0.1	16.8	6.7	25.5	25.4	9.1
2010	17.3	9.8	0.1	28.9	14.0	31.1	36.9	14.0
2011	18.7	9.4	0.2	29.9	16.1	34.8	37.9	14.4
2012	20.7	9.78	0.2	30.7	17.7	37.0	39.1	15.1
C09X								
Other agents acting on the rennin-angiotensin system								
2005	-	-	-	-	-	-	-	-
2010	1.0	0.5	0.1	-	-	0.3	0.0	-
2011	0.6	0.4	0.1	-	-	0.4	0.0	-
2012	0.4	0.3	0.0	0.0	0.0	0.3	0.0	0.0

Table 3.7.12 Sales of serum lipid modifying agents (ATC-group C10), DDD/1 000 inhabitants/day, 2005-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
C10								
Lipid modifying agents								
2005	47.2	42.8	55.1	55.7	23.9	48.1	67.9	50.1
2010	108.4	80.4	52.3	98.8	43.3	71.5	112.7	75.6
2011	114.8	86.8	53.4	95.4	43.6	79.9	116.4	77.1
2012	120.0	97.4	54.8	98.2	45.2	82.8	118.2	80.0
C10AA								
HMG CoA reductase inhibitors (statins)								
2005	46.5	42.3	55.0	53.9	23.1	47.2	67.2	47.8
2010	105.9	78.7	52.2	95.5	41.8	70.2	109.9	72.5
2011	112.2	85.4	53.2	92.3	42.0	78.4	113.0	74.0
2012	117.3	96.0	54.6	94.9	43.7	81.4	114.2	76.8

Table 3.7.13 Share of the population (one year prevalence) taking at least one type of hormonal contraceptives and intra-vaginal contraceptives (ATC-groups G03A and G02BB) by age, 2012¹⁾

	Denmark	Faroe Islands	Finland	Iceland	Norway	Sweden
15-19	512.5	424.7	..	521.1	430.1	387.1
20-24	621.2	545.6	..	587.0	595.8	511.2
25-29	478.0	363.3	..	390.6	419.1	380.7
30-34	327.1	274.3	..	287.2	274.7	273.0
35-39	234.2	226.9	..	221.3	178.9	223.5
40-44	158.3	156.7	..	148.4	111.3	183.2
45-49	93.6	100.2	..	79.4	59.9	130.1

1 Excl. implants

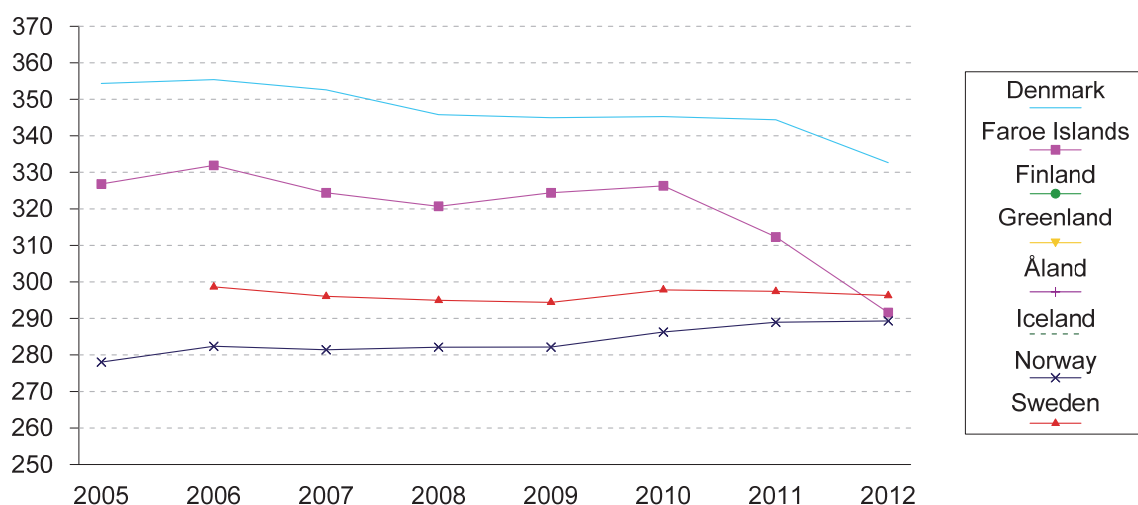
Figure 3.7.4 Share of Women/1 000 between 15 and 49 years old (one year prevalence) taking at least one type of hormonal contraceptives and intra-vaginal contraceptives (ATC-groups G03A and G02BB) by age, 2005-2012

Table 3.7.14 Sales of estrogens and estrogen-progesteron combinations (ATC groups G03C and G03F), DDD/1 000 women/day, 2005-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
G03C								
Oestrogens								
2005	22.7	20.3	3.8	29.7	26.7	23.8	22.8	37.9
2010	20.3	19.2	3.6	27.9	28.0	18.9	18.3	30.5
2011	19.8	19.1	2.1	26.9	28.0	18.4	17.1	26.6
2012	19.7	20.7	4.9	44.8	51.6	35.5	14.4	26.0
G03F								
Progestogens and oestrogens in combination								
2005	13.9	18.0	2.0	15.0	7.1	10.5	15.9	14.9
2010	8.7	12.6	1.2	11.4	5.5	7.3	10.3	8.4
2011	8.2	11.2	1.3	11.0	5.2	7.4	10.0	8.0
2012	7.6	10.2	2.4	21.8	9.9	14.2	9.6	7.8

Table 3.7.15 Sales of drugs for urinary frequency and incontinence (ATC-gruppe G04BD) i DDD/1 000 inhabitants/day, 2005-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	3.0	2.1	..	3.2	3.1	..	4.7	3.9
2010	5.0	4.2	0.6	4.5	3.3	6.5	7.8	5.0
2011	5.3	4.4	0.6	4.8	3.1	6.9	8.4	5.2
2012	5.7	5.0	0.9	5.0	3.8	7.3	8.8	5.3

Table 3.7.16 Sales of drugs used in erectile dysfunction (ATC-group G04BE), DDD/1 000 men/year, 2005-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	821	438	256	1 460	511	1 081	943	868
2010	1 129	461	492	2 242	786	939	1 284	1 044
2011	1 163	523	572	3 051	1 234	1 101	1 376	1 076
2012	1 218	564	742	3 547	1 349	1 304	1 444	1 106

Table 3.7.17 Sales of antimicrobial agents for systemic use (ATC-group J01), DDD/1 000 inhabitants/day, 2005-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
J01								
Antibacterials for systemic use								
2005	16.6	18.0	20.4	19.6	16.5	23.0	15.6	16.6
2010	18.8	17.3	17.3	19.7	15.9	22.2	16.2	14.3
2011	19.3	17.2	17.4	20.9	17.4	22.3	17.0	14.4
2012	18.5	17.1	18.7	20.1	15.9	22.3	17.4	14.2
J01A								
Tetracyclines								
2005	1.3	1.2	3.1	4.2	3.4	5.4	3.1	3.5
2010	1.7	1.5	1.1	4.3	3.6	5.1	3.1	3.3
2011	1.8	1.5	1.0	5.0	4.2	4.9	3.4	3.5
2012	1.8	1.5	1.2	4.9	4.3	4.8	3.8	3.4
J01C								
Beta-lactam antibacterials.								
Penicillins								
2005	10.1	11.5	11.8	6.3	7.9	11.8	7.6	7.3
2010	11.5	10.7	11.4	7.2	7.2	12.0	8.5	7.9
2011	11.8	10.4	11.4	7.2	7.8	12.1	8.6	7.9
2012	11.3	10.1	12.8	7.0	7.0	12.1	8.6	7.9
J01CA								
Penicillins with extended Spectrum								
2005	3.2	3.0	4.0	3.4	5.0	4.3	2.5	1.6
2010	3.8	2.9	3.9	4.1	4.5	4.2	3.2	1.7
2011	3.9	2.2	3.8	4.1	5.4	4.3	3.2	1.6
2012	3.7	1.8	4.6	4.0	4.1	4.4	3.3	1.6
J01CE								
Beta-lactamase sensitive penicillins								
2005	5.7	7.2	6.9	1.7	2.2	3.0	4.5	4.1
2010	5.5	6.4	5.8	1.6	1.9	2.5	4.4	4.2
2011	5.5	6.4	6.0	1.5	1.6	2.5	4.5	4.2
2012	4.9	6.5	5.9	1.4	1.6	2.3	4.3	4.1
J01CF								
Beta-lactamase resistant penicillins								
2005	1.2	1.2	0.9	0.1	0.4	1.4	0.5	1.4
2010	1.3	1.2	1.4	-	-	1.3	0.8	1.7
2011	1.4	1.5	1.4	-	-	1.3	0.9	1.7
2012	1.4	1.3	1.4	0.1	0.6	1.3	0.9	1.8
J01CR								
Combinations of penicilins, incl. beta-lactamase inhibitors								
2005	0.1	0.1	-	1.1	0.4	3.2	0.0	0.2
2010	0.8	0.2	0.3	1.5	0.8	4.0	0.0	0.3
2011	1.1	0.4	0.5	1.6	0.7	4.0	0.0	0.3
2012	1.3	0.5	0.8	1.6	0.8	4.1	0.0	0.3

The table continues

**Table 3.7.17 Sales of antimicrobial agents for systemic use (ATC-group J01),
DDD/1 000 inhabitants/day, 2005-2012, continued**

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
J01D								
Other betalactam								
Anti-bacterials and								
cephalosporins								
2005	0.3	0.5	0.2	3.1	1.7	0.5	0.6	0.7
2010	0.4	0.4	0.4	3.2	1.7	0.6	0.5	0.4
2011	0.4	0.5	0.3	3.3	1.6	0.6	0.6	0.4
2012	0.4	0.5	0.3	3.2	1.2	0.7	0.5	0.4
J01E								
Sulphonamides and								
Trimethoprim								
2005	0.9	1.0	0.6	1.9	1.0	1.9	1.1	0.9
2010	0.8	1.2	0.5	1.6	0.8	0.9	0.9	0.6
2011	0.8	1.5	0.5	1.6	1.0	1.0	0.9	0.5
2012	0.8	1.5	0.6	1.4	0.8	0.9	0.9	0.5
J01F								
Macrolides, lincosamides								
and streptogramins								
2005	2.5	2.1	3.6	2.1	1.1	1.8	2.1	0.8
2010	2.6	1.7	2.7	1.6	1.1	1.6	2.0	0.7
2011	2.7	1.6	2.7	2.0	1.2	1.6	2.3	0.7
2012	2.3	1.8	2.5	1.7	1.1	1.7	2.2	0.7
J01M								
Quinolone anti-								
bacterials								
2005	0.5	0.3	0.2	1.3	1.1	0.8	0.6	1.2
2010	0.8	0.5	0.5	1.2	1.1	1.0	0.7	0.9
2011	0.8	0.6	0.6	1.3	1.1	1.1	0.7	0.9
2012	0.8	0.6	0.5	1.2	0.9	1.0	0.7	0.9
J01X								
Other antibacterials								
2005	0.6	0.9	0.8	0.7	0.3	0.7	0.5	0.3
2010	0.7	1.0	0.5	0.7	0.5	1.0	0.5	0.4
2011	0.7	1.0	0.7	0.6	0.5	1.0	0.5	0.4
2012	0.6	0.9	0.5	0.7	0.6	1.00	0.5	0.4

Note: J01XX05 methenamine is not included

Figure 3.7.5 Sales of antimicrobials agents for systemic use (ATC-group J01), DDD/1 000 inhabitants/day, 2005-2012

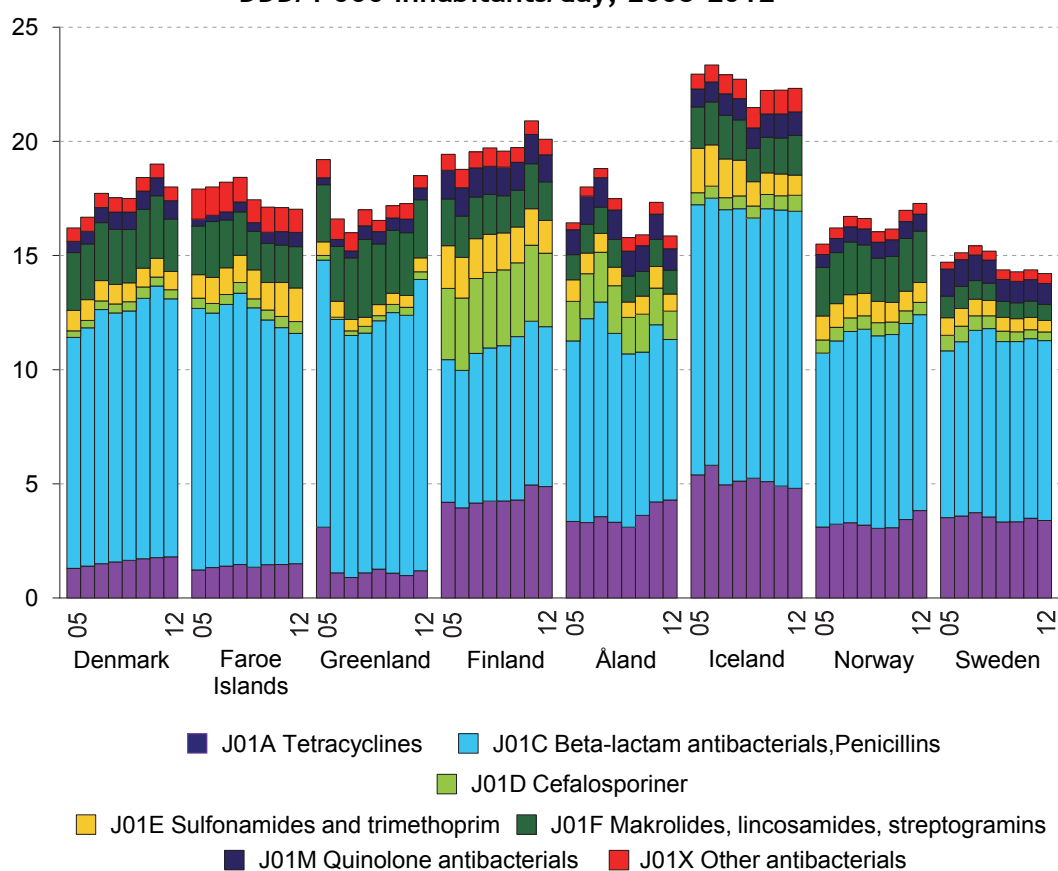
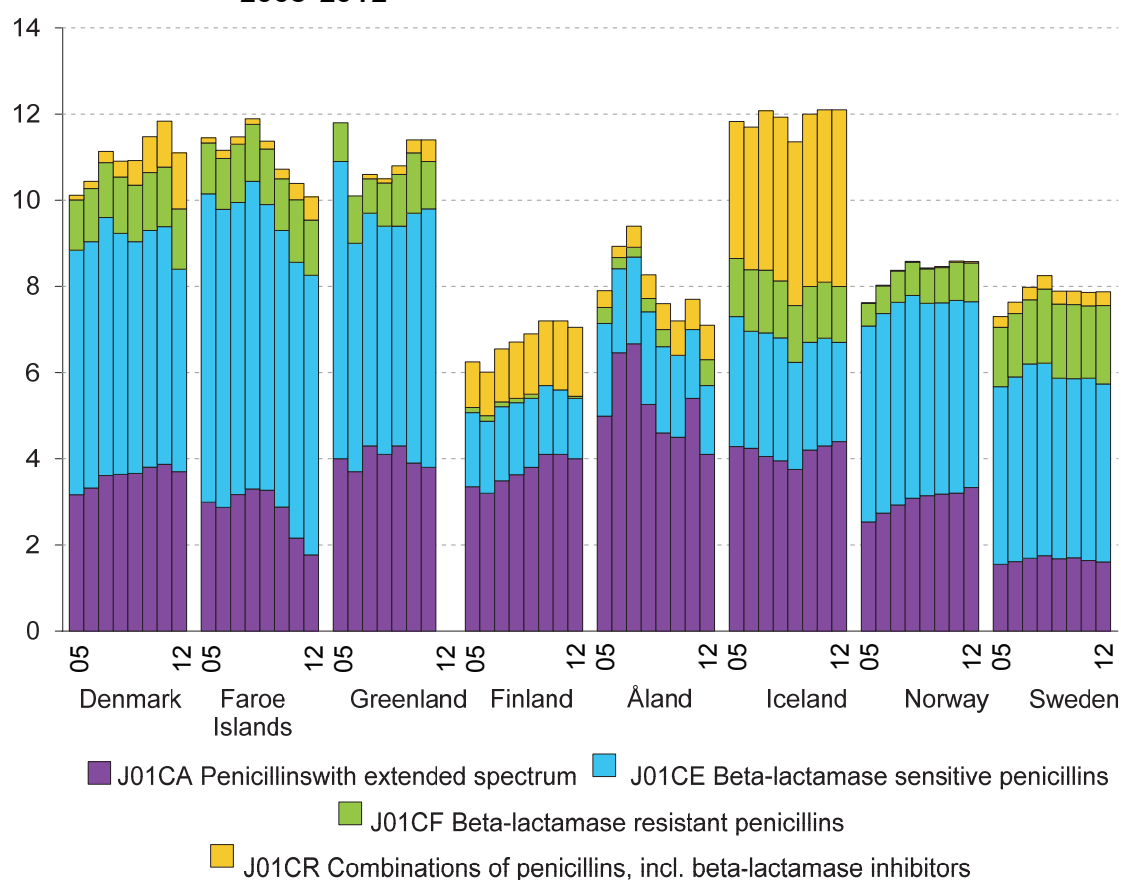


Figure 3.7.6 Sales of penicillins (ATC-group J01C), DDD/1 000 inhabitants/day, 2005-2012**Table 3.7.18 Share of the population (one-year prevalence) taking at least one type of penicillin (ATC-group J01C) by gender and age, 2012**

Age	Denmark		Faroe Islands		Finland		Iceland		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W
0-14	220.6	223.5	239.7	239.8	248.7	235.3	309.8	316.3	128.4	130.6	195.3	188.7
15-24	128.9	244.8	162.4	226.1	118.3	215.8	188.3	295.2	96.4	195.6	95.4	171.1
25-44	161.1	265.3	187.6	260.8	123.3	210.3	199.3	297.0	110.4	199.5	99.6	172.0
45-64	190.2	249.0	193.9	235.7	118.6	188.2	221.8	309.6	124.1	187.8	108.7	162.8
65-74	250.4	281.5	255.9	267.7	121.1	179.5	267.6	338.9	167.3	222.4	143.5	195.4
75+	339.0	362.9	290.2	283.2	136.3	227.4	253.3	292.7	220.4	255.2	177.6	225.6

Table 3.7.19a Sales of antimycotics for systemic use (ATC group J02A), DDD/1 000 inhabitants/year, 2005-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway ¹⁾	Sweden
J02								
Antimycotics								
2005	189.8	166.1	118.5	161.8	138.2	116.2	58.9	88.6
2010	260.4	171.4	114.2	157.4	99.4	124.1	83.6	101.7
2011	268.7	154.9	93.1	182.5	124.7	142.4	84.5	104.2
2012	272.9	200.1	86.0	197.1	138.7	..	93.9	106.5

Table 3.7.19b Sales of antivirals for systemic use (ATC group J05), DDD/1 000 inhabitants/year, 2005-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
J05								
Antivirals								
2005	489.4	66.5	683.0	250.8	123.0	326.9	323.4	389.8
2010	614.6	140.1	559.1	310.5	112.3	295.7	399.4	510.1
2011	784.2	128.7	566.7	335.6	132.8	332.2	430.4	527.3
2012	730.0	194.6	542.0	368.7	135.1	..	478.3	557.4

Table 3.7.20 Sales of antineoplastic and immunomodulating agents (ATC-group L) including tumour necrosis factor alpha (TNF-α) inhibitors, in euro/1 000 inhabitants/year at 2012 prices, 2005-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
L01								
Antineoplastic agents								
2005	20 451	7 628	4 685	16 028	28 697	21 380	16 569	13 815
2010	39 893	12 606	12 711	-	-	30 274	24 565	25 905
2011	37 609	17 172	10 602	-	-	30 597	25 662	26 598
2012	37 633	22 350	9 609	29 816	33 734	31 191	26 876	25 712
L02								
Endocrine therapy								
2005	6 502	4 491	307	6 678	8 489	10 550	11 653	7 178
2010	7 352	5 291	615	-	-	7 436	6 720	6 081
2011	6 119	5 767	643	-	-	6 483	6 273	5 018
2012	4 110	3 971	384	4 051	4 949	5 829	7 266	4 941
L03								
Immunostimulants								
2005	10 245	2 859	100	8 891	7 974	10 845	11 010	8 454
2010	13 111	8 226	733	-	-	9 871	10 287	10 102
2011	13 232	7 778	526	-	-	8 967	9 747	9 830
2012	12 713	6 228	935	10 689	4 809	8 895	9 640	9 159
L04								
Immunosuppressants								
2005	14 971	16 409	6 043	11 670	31 332	16 940	35 156	15 131
2010	39 913	39 413	20 001	-	-	41 461	48 325	35 268
2011	42 293	45 139	23 948	-	-	41 708	50 442	39 890
2012	45 901	44 601	23 364	25 760	46 090	48 144	54 576	43 740
L04AB								
Tumour necrosis factor alpha (TNF-α) inhibitors								
2005	10 294	9 620	5 085	7 593	28 232	12 750	27 238	10 816
2010	29 055	34 386	17 396	-	-	30 748	35 828	23 964
2011	30 182	39 283	20 701	-	-	29 445	37 311	26 783
2012	31 828	39 438	23 239	19 999	39 034	34 748	39 002	28 745

Table 3.7.21 Sales of analgesics (ATC-groups M01A, N02A and N02B), DDD/1 000 inhabitants/day, 2005-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
M01A								
Anti-inflammatory and antirheumatic products, non-steroids								
2005	54.9	40.3	24.0	76.7	55.8	68.0	44.0	51.4
2010	53.4	36.9	24.4	83.3	56.1	75.7	45.5	49.7
2011	54.8	36.1	22.8	84.9	56.3	76.4	46.7	47.8
2012	44.4	34.1	23.0	85.1	56.4	78.5	47.5	47.5
N02A								
Opioids								
2005	18.5	6.9	4.5	15.1	9.1	17.4	19.5	20.8
2010	20.2	7.8	6.5	16.5	9.1	19.0	19.8	20.0
2011	20.1	7.3	6.3	16.5	10.6	19.7	19.6	19.4
2012	20.3	7.0	6.6	16.5	11.3	19.5	19.3	18.6
N02B								
Other analgesics and antipyretics								
2005	71.2	54.7	44.3	20.6	36.3	30.9	29.8	49.5
2010	74.0	58.3	43.6	29.5	44.3	33.9	34.5	46.8
2011	74.8	58.7	42.8	30.6	43.9	35.6	36.1	45.4
2012	74.5	58.8	41.7	32.3	45.1	36.0	37.4	46.2
N02BA								
Salicylic acid and derivatives								
2005	12.9	14.3	0.8	5.5	9.9	3.5	0.5	9.8
2010	8.9	11.1	0.2	3.6	7.7	2.9	0.3	6.1
2011	8.8	10.6	0.1	3.3	7.7	3.1	0.3	5.5
2012	8.3	9.7	0.1	3.0	7.5	3.0	0.2	4.9
N02BB								
Pyrazolones								
2005	0.6	0.0	-	-	-	-	3.2	0.1
2010	0.3	0.0	-	-	-	-	2.3	0.1
2011	0.3	0.0	-	-	-	-	2.0	0.1
2012	0.3	0.0	0.0	0.0	0.0	0.0	1.9	0.1
N02BE								
Anilides								
2005	57.7	40.3	24.6	15.1	26.4	27.4	26.0	39.7
2010	64.8	47.2	43.4	25.9	36.6	31.0	31.9	40.6
2011	65.7	48.0	42.7	27.2	36.3	32.4	33.8	39.9
2012	65.9	49.1	41.6	29.3	37.6	33.0	35.2	41.2

Note: Sales of OTC medicines in the group N02BE for 2005 and 2006 in Greenland are not available

Figure 3.7.7 Sales of non-opioid analgesics (ATC-groups M01A and N02B), DDD/1 000 inhabitants/day, 2005-2011

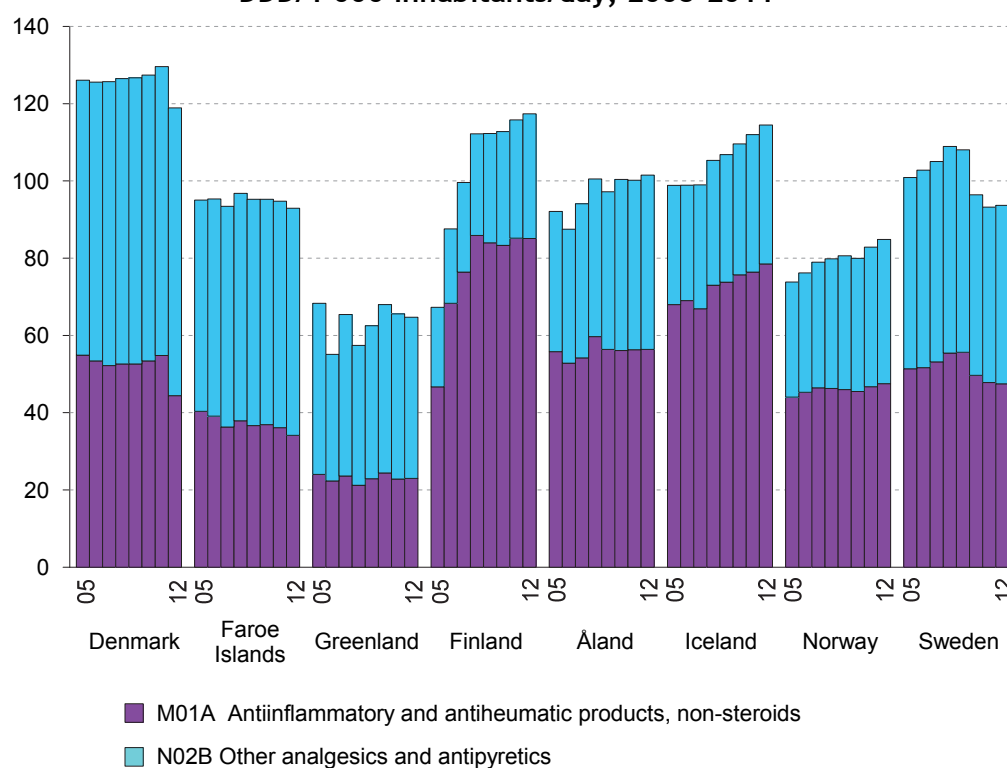


Figure 3.7.8 Sales of opioid analgesics (ATC-group N02A), DDD/1 000 inhabitants/day, 2005-2012

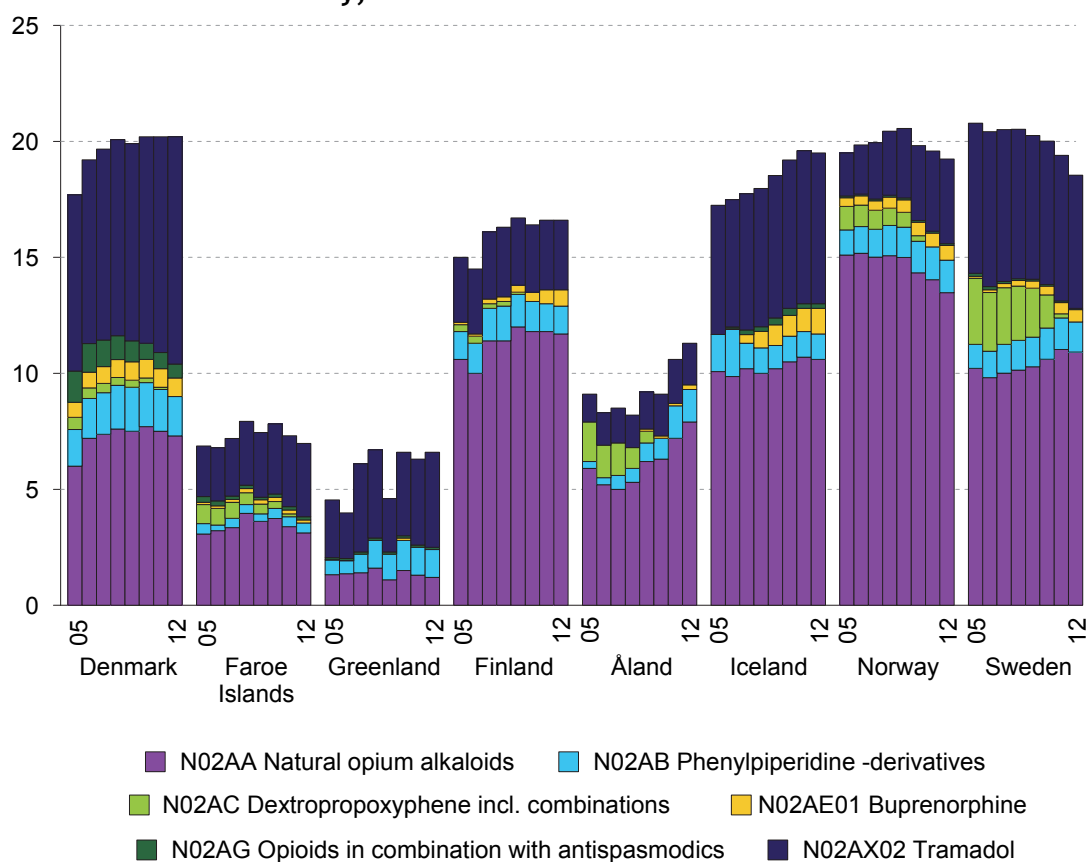


Table 3.7.22 Sales of antipsychotics (ATC-group N05A), DDD/1 000 inhabitants/day, 2005-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	13.0	10.4	14.6	17.4	9.3	11.5	10.6	9.2
2010	13.9	12.7	16.0	20.7	9.6	11.2	10.8	9.8
2011	14.3	12.8	14.8	21.2	9.5	11.8	11.0	10.0
2012	14.7	13.0	15.6	21.3	9.5	12.1	11.1	10.3

Table 3.7.23 Sales of anxiolytics (ATC-group N05B), DDD/1 000 inhabitants/day, 2005-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N05B								
Anxiolytics								
2005	19.9	17.1	5.3	31.2	9.9	25.8	21.3	16.4
2010	11.8	11.5	2.9	28.0	10.7	24.7	19.5	16.2
2011	10.8	11.0	2.9	26.7	11.1	24.6	18.1	16.2
2012	10.3	10.3	2.4	25.6	10.9	..	17.2	15.6
N05BA								
Benzodiazepine derivatives								
2005	19.6	17.0	5.3	29.5	8.0	24.6	20.1	13.6
2010	11.5	11.2	2.1	26.2	8.5	24.6	18.0	12.8
2011	10.5	10.7	2.1	25.0	8.5	24.5	16.5	12.7
2012	10.0	10.0	2.4	23.9	8.4	23.4	15.6	12.1

Table 3.7.24 Sales of hypnotics and sedatives (ATC-group N05C), DDD/1 000 inhabitants/day, 2005-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N05C								
Hypnotics and sedatives								
2005	31.4	31.0	8.8	54.4	34.2	66.7	41.4	51.6
2010	20.3	23.3	7.1	46.8	34.3	75.9	42.5	52.2
2011	19.1	22.4	5.5	44.7	34.9	75.8	41.6	52.8
2012	18.0	21.2	6.2	42.0	34.0	73.8	39.0	52.6
N05CD								
Benzodiazepine derivatives								
2005	10.5	7.1	0.5	20.9	4.3	12.1	8.5	6.7
2010	4.8	4.2	0.4	15.6	3.5	8.6	6.3	4.1
2011	4.3	3.8	0.4	14.4	3.2	7.7	5.8	3.8
2012	3.8	3.1	0.5	13.2	3.3	6.6	4.1	3.4
N05CF								
Benzodiazepine-related drugs								
2005	20.9	23.4	8.3	33.1	29.3	54.5	32.8	30.4
2010	15.3	18.1	6.7	30.7	30.3	66.2	36.1	34.1
2011	14.8	17.1	5.1	29.8	31.3	66.7	35.6	34.9
2012	14.2	16.2	5.8	28.3	30.2	65.1	34.7	35.3

Note: Sales excluding melatonin (N05CH01)

Figure 3.7.9 Sales of hypnotics and sedatives (ATC-group N05C), DDD/1 000 inhabitants/day, 2005-2012

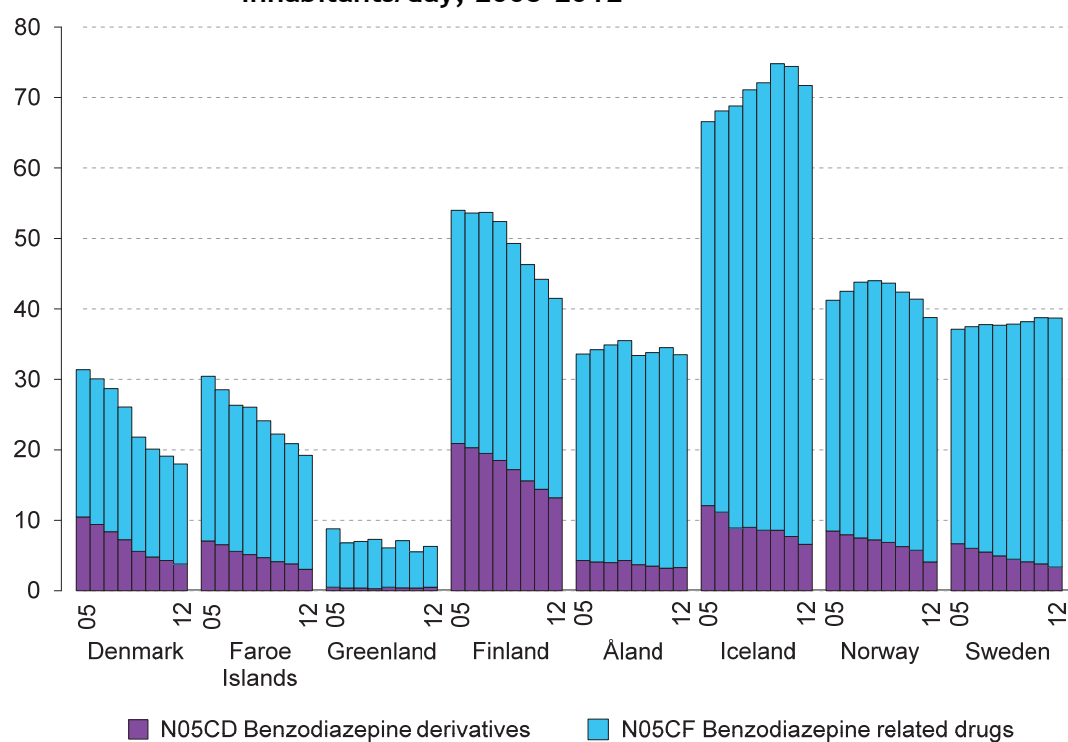


Table 3.7.25 Sales of antidepressants (ATC-group N06A), DDD/1 000 inhabitants/day, 2005-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N06A								
Antidepressants								
2005	60.1	36.5	20.4	52.1	40.7	94.8	51.8	66.1
2010	84.0	57.2	24.1	69.2	50.9	101.1	56.4	75.8
2011	85.2	58.7	25.7	70.2	52.7	105.8	57.7	79.4
2012	83.2	61.8	26.6	69.8	54.6	108.8	57.2	81.1
N06AA								
Non-selective monoamine reuptake inhibitors								
2005	4.3	2.1	1.1	4.2	3.2	8.1	3.8	3.8
2010	4.6	1.9	0.8	4.3	2.9	5.5	3.6	3.5
2011	4.7	1.8	0.9	4.3	3.1	5.8	3.6	3.5
2012	4.8	1.8	1.1	4.3	3.4	5.6	3.5	3.4
N06AB								
Selective serotonin reuptake inhibitors								
2005	41.7	26.4	16.0	35.3	30.4	64.8	34.8	48.4
2010	56.6	40.5	16.6	44.2	36.1	72.3	37.8	53.2
2011	56.0	41.6	18.1	44.1	36.1	75.4	38.8	55.3
2012	53.0	43.1	17.0	42.8	36.0	77.4	38.0	56.0
N06AG								
Monoamine oxidase type A inhibitors								
2005	0.1	-	-	0.7	0.2	0.8	0.3	0.2
2010	-	-	-	0.6	0.3	0.5	0.2	0.1
2011	-	-	-	0.5	0.2	0.5	0.2	0.1
2012	0.0	0.0	0.0	0.5	0.1	0.4	0.2	0.1
N06AX								
Other antidepressants								
2005	13.9	8.0	3.3	12.0	6.8	21.2	13.0	13.6
2010	22.7	14.8	6.6	20.2	11.5	22.8	14.8	19.0
2011	24.3	15.3	6.1	21.4	13.4	24.1	15.1	20.5
2012	25.3	16.9	8.5	22.3	15.1	25.4	15.5	21.5

Figure 3.7.10 Sales of antidepressants (ATC-group N06A), DDD/1 000 inhabitants/day, 2005-2012

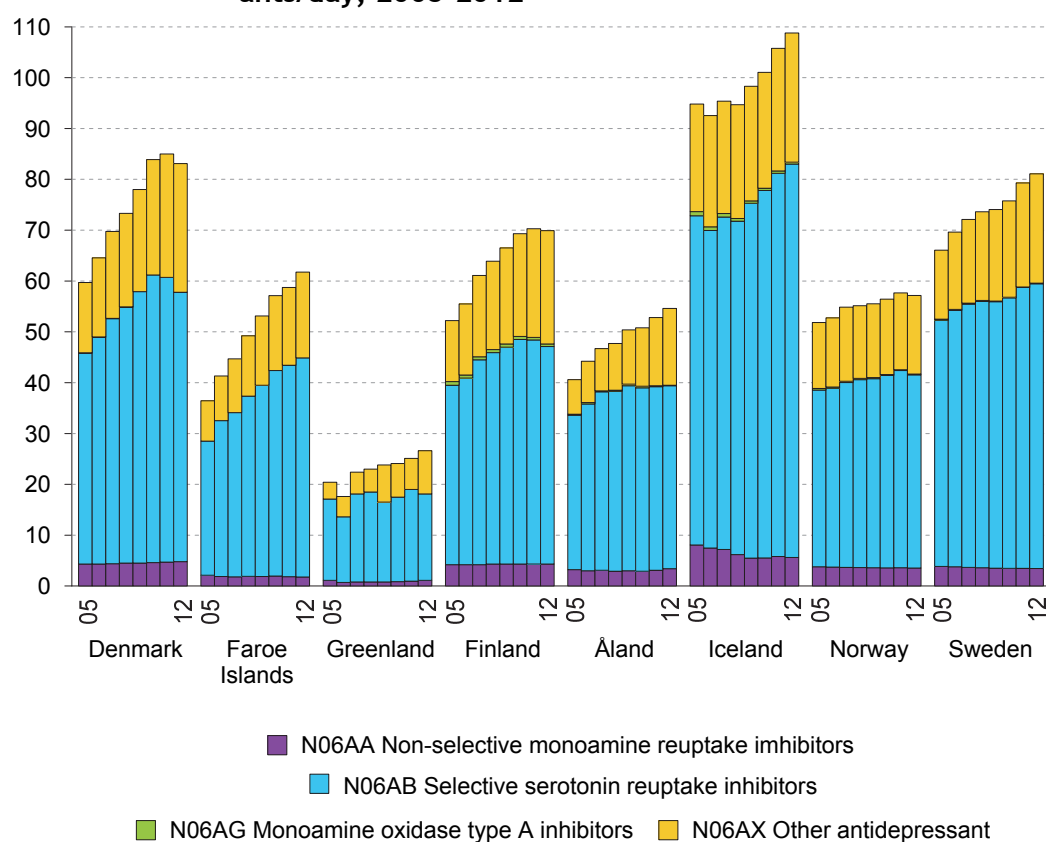


Table 3.7.26 Share of the population (one-year prevalence) taking at least one type of antidepressants (ATC-group N06A) by gender and age, 2012

Age	Denmark		Faroe Islands		Finland		Iceland		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W
0-14	1.6	1.6	0.7	4.0	1.6	1.8	21.7	17.5	0.9	0.6	2.0	1.6
15-24	27.2	58.7	25.7	59.9	32.4	66.3	66.9	108.1	19.0	37.3	29.2	55.3
25-44	61.7	106.1	47.7	81.4	70.8	110.1	94.7	166.9	44.8	76.5	58.2	108.6
45-64	81.2	133.8	56.5	101.1	83.2	136.0	121.6	230.0	63.3	120.2	77.9	146.9
65-74	90.4	143.2	80.3	120.7	75.7	117.5	154.3	272.7	65.1	131.3	82.9	151.6
75+	151.1	233.6	147.9	243.5	111.4	172.9	190.6	281.1	88.1	155.3	147.9	240.9

Table 3.7.27 Share of the population (one-year prevalence) taking at least one medicinal product of centrally acting sympathomimetics (ATC group N06BA ¹⁾) 2005- 2012

	Denmark	Faroe Islands	Green-land	Finland	Åland	Iceland	Norway	Sweden
2005	5.5	2.6	..	..	..	..	11.7	..
2006	7.2	4.6	..	..	..	..	14.5	6.8
2007	9.0	5.1	..	..	..	..	15.4	8.7
2008	12.0	5.0	..	..	..	52.6	16.7	10.6
2009	15.1	7.2	..	..	..	57.5	17.9	13.2
2010	17.9	8.5	..	..	..	61.2	19.0	16.2
2011	18.7	8.6	..	..	..	63.7	19.9	19.3
2012	18.7	12.7	..	13.7	..	66.0	20.0	21.6

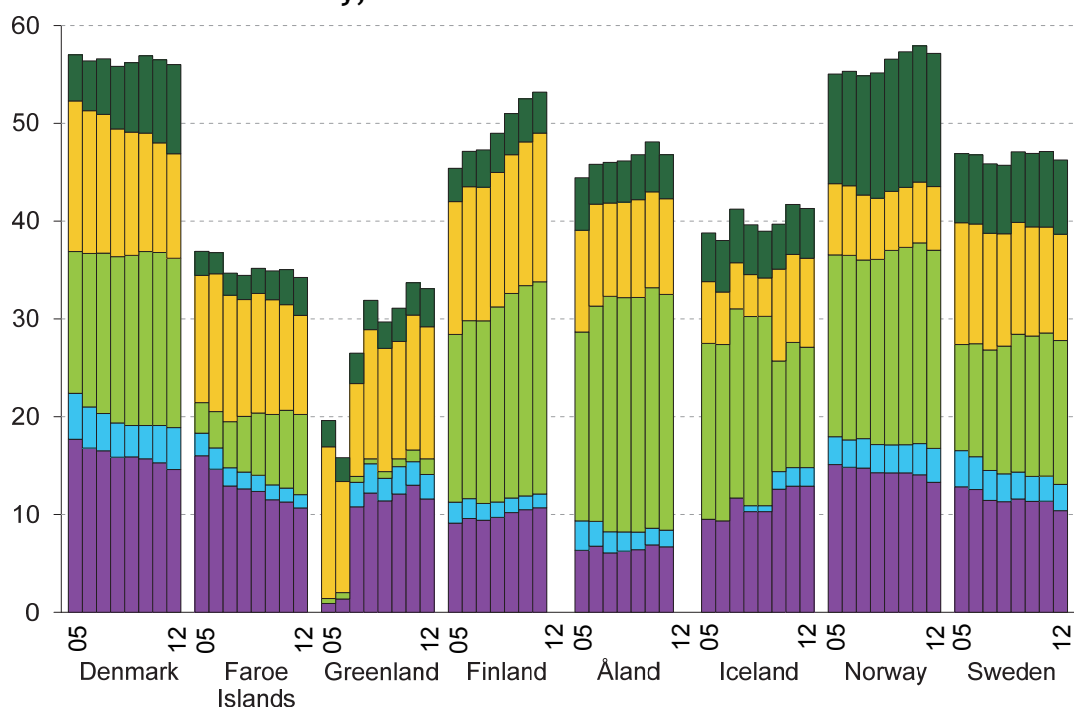
1 Excl. NOXBA07

Table 3.7.28 Sales of anti-dementia drugs (ATC-group N06D), DDD/1 000 inhabitants/day, 2005-2012

	Denmark	Faroe Islands	Green-land	Finland	Åland	Iceland	Norway	Sweden
2005	2.0	1.1	0.1	6.5	2.5	2.7	3.1	3.0
2010	2.9	2.3	0.2	12.1	4.5	2.9	3.0	3.6
2011	3.0	2.8	0.1	13.0	4.3	3.0	3.3	3.8
2012	3.2	3.5	0.3	14.3	4.0	3.1	3.4	4.0

Table 3.7.29 Sales of anti-asthmatics (ATC group R03), DDD/1 000 inhabitants/day, 2005-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
R03								
Drugs for obstructive airway diseases								
2005	60.5	38.1	37.4	51.8	50.6	45.0	61.0	50.4
2010	60.5	35.9	32.2	60.4	53.3	41.3	63.4	50.1
2011	60.2	36.1	34.8	61.1	51.8	43.2	64.0	50.4
2012	59.4	35.2	33.9	63.4	52.9	42.8	63.2	49.6
R03A								
Adrenergics. inhalants								
2005	36.8	21.4	17.6	28.4	28.7	31.2	36.5	27.4
2010	36.8	20.2	15.8	33.4	33.2	25.7	37.3	28.3
2011	36.8	20.7	16.6	33.8	32.4	27.6	37.8	28.6
2012	36.1	20.2	15.7	34.7	33.3	27.1	37.0	27.8
R03AC								
Selective beta-2-adrenoceptor agonists								
2005	22.3	18.3	17.1	11.3	9.4	13.2	18.0	16.5
2010	19.0	13.0	14.9	11.9	8.7	14.4	17.1	13.9
2011	19.1	12.7	15.4	12.1	8.4	14.8	17.3	13.9
2012	18.8	12.0	14.1	12.8	8.6	14.8	16.8	13.1
R03AK								
Adrenergics and other drugs for obstructive airway diseases								
2005	14.5	3.1	0.5	17.1	19.3	18.0	18.6	10.9
2010	17.8	7.2	0.8	21.5	24.6	11.3	20.2	14.4
2011	17.7	8.0	1.2	21.7	24.1	12.8	20.5	14.6
2012	17.3	8.2	1.6	21.9	24.7	12.3	20.3	14.7
R03B								
Other drugs for obstructive airway diseases. inhalants								
2005	20.1	15.5	18.0	17.3	16.4	11.3	18.5	19.6
2010	19.9	14.7	15.3	19.3	15.4	14.0	20.0	18.7
2011	19.7	14.4	17.1	19.6	14.7	14.1	20.2	18.6
2012	19.8	14.0	17.4	20.9	14.6	14.1	20.1	18.5
R03D								
Other systemic drugs for obstructive airway diseases								
2005	3.1	0.5	1.0	5.9	5.2	2.4	5.4	2.7
2010	3.2	0.7	0.8	7.5	4.5	1.5	5.8	2.7
2011	3.2	0.7	0.8	7.4	4.5	1.5	5.8	2.9
2012	3.1	0.8	0.8	7.7	4.8	1.5	5.8	3.0

Figure 3.7.11 Sales of anti-asthmatics (ATC-Group R03), DDD/1 000 inhalants/day, 2005-2012

- Short-acting beta-2-adrenoreceptor agonists (R03AC02, R03AC03, R03AC04)
■ Long-acting beta-2-adrenoreceptor agonists (R03AC12, R03AC13 og R03AC18)
■ Kombinationer (R03AK) ■ Glucocorticoider (R03BA) ■ Anticholinergica (R03BB)

Table 3.7.30 Share of the population (one-year prevalence) taking at least one type of anti-asthmatic inhalants (ATC-groups R03A and R03B) by gender and age, 2012

Age	Denmark		Faroe Islands		Finland		Iceland ¹⁾		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W
0-14	85.0	60.8	98.2	75.2	103.5	68.1	188.8	147.9	87.6	62.5	82.4	56.5
15-24	40.5	49.4	41.9	56.3	61.3	75.1	60.7	82.9	46.0	55.0	45.1	57.2
25-44	45.8	56.0	36.5	57.6	61.9	96.9	63.6	99.1	43.6	60.5	45.0	63.6
45-64	65.0	91.2	50.5	76.4	81.0	124.8	96.1	173.4	70.1	102.3	62.5	96.4
65-74	107.4	133.2	81.7	118.1	115.4	140.9	184.1	268.3	118.4	148.7	94.2	137.1
75+	162.5	147.2	85.6	99.6	150.7	139.7	207.7	219.6	141.5	121.8	127.8	134.6

1 2009

Table 3.7.31 Sales of antihistamines (ATC-group R06A), DDD/1 000 inhabit-ants/day, 2005-2011

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	20.4	20.7	7.5	31.2	24.8	30.0	54.8	30.8
2010	27.0	25.2	10.6	42.6	31.4	38.4	58.8	36.8
2011	29.1	27.6	13.1	42.9	36.9	40.4	60.0	38.4
2012	30.1	27.7	12.6	48.7	35.1	44.9	62.2	41.3

Chapter 4

Mortality and Causes of Death

Extra material

[European short list for causes of death](#)

[Data from the European short list for causes of death](#)

The International Classification of Diseases (ICD)

The main use of the International Classification of Diseases (ICD), developed by the World Health Organization (WHO), is as an instrument for statistical descriptions of morbidity and mortality. The ICD is a system that groups diseases and causes of death in a meaningful way in order to provide statistical overviews and analyses, such as comparisons among countries over a period of time. The history of the ICD goes back more than a hundred years, and the classification has been revised approximately every ten years in order to reflect developments within medicine. The most recent revision, the tenth (ICD-10), was adopted by WHO in 1990 but was only implemented in most countries several years later. The Nordic countries began to use ICD-10 for registration of mortality in the following years: Denmark in 1994, Finland, Iceland and Norway in 1996 and Sweden in 1997. ICD-10 is continually revised, through WHO's revision procedures, and a revised version of ICD-10 was published in 2004.

Revisions of the classification make statistical comparisons of countries over time difficult, when different versions of ICD are used at the same time. It is therefore important to have an understanding of the possible sources of error that a change in classification introduces in the morbidity and mortality statistics, and of how to handle these problems. The most recent revision has above all meant an increase in the level of detail in ICD. Many new diagnoses have been added as a result of developments in medicine. Also, certain diseases or groups of diseases have been transferred to other chapters in order to reflect new medical knowledge.

Sources of error

Statistical analyses are carried out on aggregated data, for example at chapter level. There are 21 chapters in ICD-10. The basic structure of ICD has generally remained the same through the revisions, and most chapters have kept their former names. However, it is important to realize that even if the name of a chapter is the same in ICD-10 as in ICD-9, differences in content may exist due to the transfer of diagnostic

codes from one chapter to another. For example, HIV and AIDS were originally placed among diseases of the immune system in ICD-9 but were moved to the chapter for infectious diseases in ICD-10. Another example is the transfer of transitory ischemic attacks from the chapter on circulatory diseases in ICD-9 to the chapter on nervous system diseases in ICD-10. Certain symptoms have also been moved from the chapter on symptoms to the so-called organ chapters.

Another potential source of error is that certain rules and guidelines for the use of ICD have been changed in connection with the new revision. As to mortality statistics, certain rules for the selection of underlying cause of death have been altered, which may, for example, affect the frequency of pneumonia as a cause of death. Beside changes in the international rules, national rules for applying the classification may also be modified in connection with a classification change, which will affect both comparisons over time within a country and comparisons among countries.

It is commonly believed that a direct translation of codes in different versions of ICD can solve the problem of changes in classification. However, it is not that simple. A direct, unambiguous translation is possible only for about one third of the codes in ICD-9 and ICD-10. Instead, an attempt must be made to make the aggregated groups of codes used for statistical presentations as comparable as possible, so as to eliminate some of the effects of the changes in classification. The so-called short lists used in this publication for mortality statistics have been defined according to both ICD-9 and ICD-10 with comparability in mind.

Change in classification

However, one must always be aware of the fact that an observed difference over time or among countries may be the result of a change in classification or other methodological issues. One way of quantifying the effect of a classification change is the so-called bridge coding. In such studies, the same material, such as death certificates or hospital records, is coded twice independently: first according to the previous classification and then according to the new classification. The differences observed when comparing the two sets of statistics indicate how much a certain group of diseases (e.g. the ICD chapter on circulatory diseases) has increased or decreased as a direct result of the classification change. This type of study demands a great deal of resources and only a few, limited bridge-coding studies have been carried out on the change from ICD-9 to ICD-10.

Coding practice

Differences in the national coding practises are another factor of importance to the comparability among countries of causes of death. What is shown in the statistics is the underlying cause of death. WHO has drawn up guidelines for the choice of the underlying cause of death, i.e. the disease or injury that initiated the chain of morbid events leading directly to death, or the circumstances of the accident or violence that produced the fatal injury. The problem in connection with comparability is that, in some cases where two or more causes of death have been recorded on the death

certificate, the choice of the underlying cause of death will differ from country to country, since the rules can be interpreted differently.

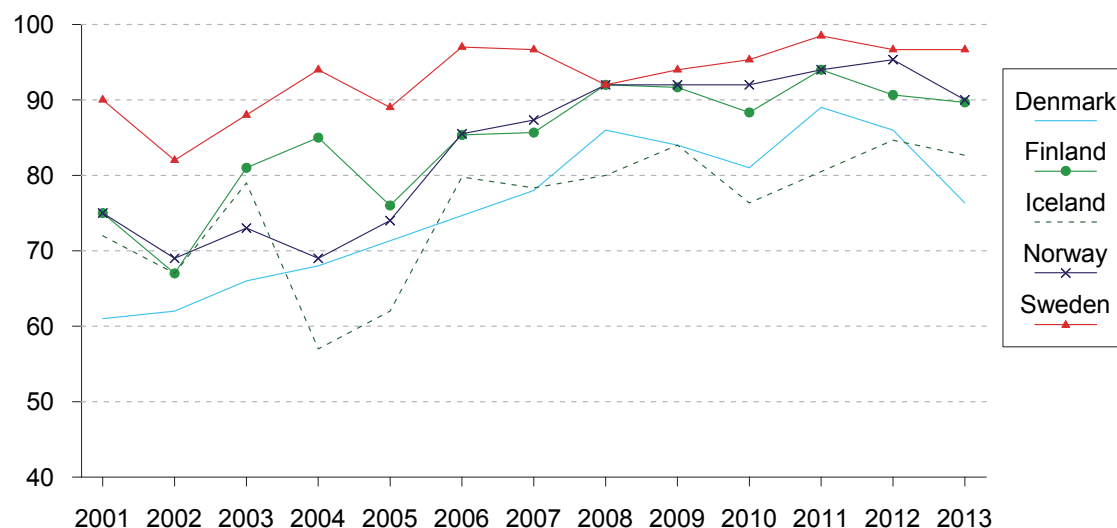
Apart from the fact that the ICD rules governing mortality coding give room for interpretation, different national traditions for the choice of underlying cause of death may also develop. An example of this is the use of the diagnostic group "insufficiently defined conditions" (codes I469, I959, I99; J960, J969, P285.0, R000-R948 and R96-99). The use of these codes as underlying causes of death is more widespread in Denmark than in the other Nordic countries in situations where more specific causes of death are also recorded on the death certificate (See Table 4.1.11).

However, several other factors also influence comparability, such as the type of information the statistics producer has access to as well as the quality of that material (death certificates, etc.).

In order to support the choice of the underlying cause of death, the American programme ACME (Automated Classification of Medical Entities) has been developed. This system is used in most of the Nordic countries. Denmark has used ACME as from the data year 2002, Iceland has used ACME for a few years to check manual coding, and Norway and Finland have used ACME as from the data year 2005. Otherwise, computer-aided coding has been used. Automatic coding does not necessarily result in a more correct picture of the pattern of causes of death than does manual coding, but it does give more consistency in the coding and thus contributes to better comparability among more countries.

Figure 4.1.1 National coding compared to ACME 2001-2013

Per cent



Since 2001, the Nordic Classification Centre has carried out annual comparisons of how the countries classify a sample of causes of death. The sample is relatively small (200-250 death certificates per year), but the results still give an indication of how comparable the statistics are. When making comparisons, the ACME classification system is used as the standard.

This comparison, and Nordic coding practice in general, is discussed at annual meetings. As seen in Figure 4.1.1., the coding in the different countries is not only getting closer to ACME's coding, but the differences in coding among the countries are also getting smaller. This indicates that the use of automatic coding and cooperation between the Nordic countries leads to a higher degree of comparability of mortality statistics.

Cultural differences in the reporting of certain conditions may also influence comparability. For example, if doctors in one country are far more reluctant to register suicide on the death certificate than are doctors in other countries, this can make comparisons difficult. However, in several of the Nordic countries, there are routines for contacting the doctor or the hospital in cases where the external cause of an injury is unclear. Such quality-control practices help to compensate for lack of information on the death certificate.

Autopsy rates

Another factor influencing the quality of the statistics on causes of death is the decreasing autopsy rates (in 2009, the Danish rate was the lowest at 5 per cent, and the Finnish rate was the highest at 31 per cent). The autopsy rates have been more than halved in the Nordic countries over the last few decades. Studies have shown that in about 30 per cent of cases, the result of the autopsy has caused the underlying cause of death to be altered.

The reliability of the statistics

Considering the reservations in relation to the comparability of causes of death over time and among countries, the data presented here should be interpreted with caution. This is especially the case for the small diagnostic groups in the European short list that is used in the present publication. The picture is more stable for the large groups, such as cardiovascular diseases and cancer. This also applies to alcohol and drug-related deaths, for which it is well known that the pattern is heterogeneous. The dramatic fall in the number of deaths from AIDS is related to new, life-prolonging medication. However, there has been a slight increase in the number of new cases in all the Nordic countries. The high incidence of cancer as an underlying cause of death in Denmark is also partly the result of coding practice.

Falls are coded much more often in Denmark than in Sweden. This makes comparison of death statistics for accidents unreliable. The incidence of accidents in total is highest in Finland.

For insufficiently defined conditions, Finland and Iceland are atypical compared with the other Nordic countries, because there are only a few cases of insufficiently defined conditions.

Table 4.1.1 Deaths by gender and age per 100 000 inhabitants, 2000-2012

Age	Total		Under 1 year ¹⁾		1-14 years		15-24 years		25-64 years		65+ years	
Gender	M	W	M	W	M	W	M	W	M	W	M	W
<i>Denmark</i>												
2000	1 069	1 099	607	456	17	12	79	30	444	294	6 368	5 455
2005	1 001	1 030	509	359	14	9	58	19	425	275	5 761	5 131
2010	965	984	363	320	9	7	41	21	408	254	4 936	4 622
2012	935	938	342	338	10	8	29	10	369	235	4 648	4 278
<i>Faroe Islands</i>												
2002-06	817	806	..	..	15	8	93	27	338	194	5 313	4 623
2007-11	810	741	..	..	22	24	17	33	380	319	7 517	6082
<i>Greenland</i>												
2002-06	860	724	..	..	89	64	520	179	690	490	7 383	6 632
2007-11	860	703	..	..	93	66	509	159	784	805	10 311	9 421
<i>Finland</i>												
2000	952	954	424	324	14	14	96	34	504	222	5 545	4 606
2005	934	888	333	286	18	13	69	29	517	229	4 838	4 045
2009	971	929	259	192	12	11	80	27	484	217	4 719	4 047
2011	957	920	255	213	13	11	70	26	460	209	4 550	3 949
<i>Åland</i>												
2002-06	945	992	417	153	35	37	39	-	318	155	5 228	4 789
2007-11	902	937	-	296	-	29	37	27	267	176	4 648	4 309
<i>Iceland</i>												
2000	644	653	456	141	13	10	120	43	272	187	4 591	4 317
2005	636	606	275	191	6	10	77	19	241	150	4 659	4 051
2010	666	604	198	252	13	13	54	31	228	133	4 805	3 965
2011	624	621	..	..	22	13	37	26	213	152	4 366	3 973
<i>Norway</i>												
2000	974	985	427	329	18	15	93	33	339	201	6 052	4 965
2005	877	906	329	283	18	11	73	31	307	198	5 533	4 846
2010	817	878	277	229	12	9	58	30	293	187	4 922	4 581
2011	808	860	287	168	10	10	68	31	284	182	4 761	4 442
<i>Sweden</i>												
2000	1 041	1 065	399	281	15	12	59	24	305	200	5 829	4 854
2005	996	1 026	215	206	17	13	48	21	298	195	5 420	4 725
2010	941	990	273	242	10	10	50	22	283	180	4 747	4 429
2011	926	978	..	..	13	11	47	21	258	166	4 632	4 346

1 Pr. 100 000 live births

Sources: The national central statistical bureaus

Table 4.1.2a Death rates from malignant neoplasms per 100 000 men by age, 2000-2011

		Denmark	Faroe Islands 1,2,3)	Greenland 1,3,4)	Finland	Åland ^{1,3,4)}	Iceland	Norway	Sweden
<i>Age</i>									
0-14	2000	3	..	..	2	..	3	3	3
	2005	3	7	3	3	-	-	3	4
	2010	1	-	5	3	-	..	3	2
	2011	3	-	6	2	-	..	1	2
15-34	2000	9	..	..	6	..	7	7	8
	2005	6	3	12	6	19	-	5	5
	2010	5	7	7	6	6	..	5	5
	2011	6	6	10	5	6	..	5	4
35-44	2000	33	..	..	22	..	38	32	20
	2005	29	17	39	23	-	9	20	20
	2010	23	27	40	19	10	..	16	19
	2011	22	22	45	20	10	..	20	20
45-54	2000	148	..	..	107	170	100	120	97
	2005	145	106	166	105	196	102	127	91
	2010	110	78	151	84	42	..	77	63
	2011	89	80	140	77	53	..	76	64
55-64	2000	462	..	..	320	..	227	348	294
	2005	424	349	793	323	347	346	324	281
	2010	385	314	631	316	342	..	300	260
	2011	380	291	573	297	279	..	284	248
65-74	2000	1 189	..	..	902	..	900	953	826
	2005	1 071	888	1 844	752	910	844	861	811
	2010	970	928	2 194	747	940	..	850	678
	2011	930	973	1 661	737	923	..	787	695
75+	2000	2 440	..	..	1 947	..	1 888	2 142	1 935
	2005	2 454	1 787	3 446	1 808	2 443	2 083	2 239	1 973
	2010	2 298	2 077	3 801	1 780	1 890	..	2 231	1 920
	2011	2 294	2 149	2 822	1 736	2 047	..	2 221	1 880

1 2005 = 2001-05

ICD-9: 140-208 and ICD-10: C00-C97

2 2010 = 2007-10

Sources: The national registers for causes of death

3 2011 = 2007-11

4 2010 = 2006-10

Table 4.1.2b Death rates from malignant neoplasms per 100 000 women, by age, 2000-2011

		Denmark	Faroe Islands 1,2,3)	Greenland 1,3,4)	Finland	Åland ^{1,3,4)}	Iceland	Norway	Sweden
<i>Age</i>									
0-14	2000	2	..	..	2	..	3	4	3
	2005	1	0	6	4	9	6	1	2
	2010	1	5	3	3	18	..	1	2
	2011	2	4	-	3	18	..	4	3
15-34	2000	9	..	..	7	..	2	6	9
	2005	7	11	13	6	-	5	4	5
	2010	7	4	19	4	-	..	7	5
	2011	5	4	13	5	-	..	6	6
35-44	2000	41	..	..	36	..	19	39	21
	2005	39	44	66	27	21	19	35	30
	2010	36	-	43	30	21	..	27	24
	2011	32	-	44	26	21	..	24	27
45-54	2000	164	..	..	106	..	113	126	94
	2005	149	83	293	99	147	108	120	105
	2010	130	68	243	89	61	..	97	85
	2011	118	67	189	78	61	..	99	86
55-64	2000	425	..	..	237	..	396	319	296
	2005	372	337	626	236	171	247	300	291
	2010	342	314	694	223	249	..	286	258
	2011	323	326	555	233	243	..	276	243
65-74	2000	905	..	..	505	..	775	600	719
	2005	828	807	1 672	457	405	648	569	586
	2010	714	447	1 656	477	605	..	583	547
	2011	663	502	1 351	465	566	..	512	528
75+	2000	1 460	..	..	1 077	..	1 285	1 184	1 210
	2005	1 492	1 210	2 151	1 004	1 065	1 045	1 214	1 112
	2010	1 485	1 180	1 763	1 023	1 259	..	1 252	1 148
	2011	1 467	1 312	1 504	1 018	1 152	..	1 256	1 157

1 2005 = 2001-05

ICD-9: 140-208 and ICD-10: C00-C97

2 2010 = 2007-10

Sources: The national registers for causes of death

3 2011 = 2007-11

4 2010 = 2006-10

Table 4.1.3a Death rates from circulatory diseases per 100 000 men, by age, 2000-2011

		Denmark	Faroe Islands 1,2,3)	Greenland 1,3,4)	Finland	Åland ^{1,3,4)}	Iceland	Norway	Sweden
<i>Age</i>									
0-34	2000	3	..	6	5	..	3	3	3
	2005	4	3	-	3	-	3	3	3
	2010	2	2	5	4	-	..	2	2
	2011	2	2	5	4	-	..	2	2
35-44	2000	23	..	51	44	..	38	25	21
	2005	21	28	29	39	22	14	25	18
	2010	22	20	40	28	10	..	23	13
	2011	20	22	41	27	10	..	16	14
45-54	2000	95	..	179	184	..	113	93	104
	2005	83	81	133	144	164	55	77	79
	2010	64	47	101	117	63	..	65	63
	2011	61	55	94	121	53	..	63	63
55-64	2000	326	..	473	481	..	209	282	303
	2005	233	319	411	403	252	254	211	243
	2010	197	216	395	385	171	..	187	217
	2011	183	191	322	357	179	..	164	204
65-74	2000	1 095	..	1 049	1 378	..	877	1 065	1 101
	2005	831	864	1 757	1 046	771	627	706	794
	2010	557	663	1 823	897	701	..	526	592
	2011	501	611	1 194	859	711	..	498	568
75+	2000	4 467	..	5 058	4 766	..	3 963	4 681	4 851
	2005	3 871	4 443	5 137	3 917	3 879	3 290	3 653	4 397
	2010	2 948	3 654	5 334	3 808	3 939	..	3 148	3 946
	2011	2 569	3 529	3 874	3 664	3 648	..	3 095	3 783

1 2005 = 2001-05

2 2010 = 2007-10

3 2011 = 2007-11

4 2010 = 2006-10

ICD-9: 390-459 and ICD-10: I00-I99

Sources: The national registers for causes of death

Table 4.1.3b Death rates from circulatory diseases per 100 000 women, by age, 2000-2011

		Denmark	Faroe Islands 1,2,3)	Greenland 1,3,4)	Finland	Åland ^{1,3,4)}	Iceland	Norway	Sweden
<i>Age</i>									
0-34	2000	2	..	.	2	..	3	4	3
	2005	1	0	6	4	9	6	1	2
	2010	1	5	3	3	18	..	1	2
	2011	2	14	-	2	7	..	2	2
35-44	2000	14	..	42	17	..	10	11	11
	2005	11	6	27	10	-	5	9	6
	2010	8	-	12	9	-	..	7	6
	2011	7	-	15	10	-	..	16	5
45-54	2000	41	..	109	48	..	24	36	34
	2005	39	21	102	37	10	15	23	28
	2010	25	17	140	31	10	..	21	21
	2011	27	27	87	26	20	..	18	24
55-64	2000	41	..	271	48	..	24	36	34
	2005	39	133	236	37	10	15	23	28
	2010	76	52	282	91	80	..	61	77
	2011	74	49	264	84	87	..	62	76
65-74	2000	561	..	1 427	551	..	419	471	469
	2005	409	428	993	404	313	340	311	346
	2010	273	262	854	297	213	..	236	269
	2011	239	287	731	288	220	..	203	239
75+	2000	3 722	..	8 038	4 090	..	3 421	3 794	4 059
	2005	3 211	3 469	5 211	3 463	4 017	2 885	3 085	3 648
	2010	2 635	2 492	3 995	3 345	3 492	..	2 907	3 537
	2011	2 365	2 309	2 914	3 241	3 485	..	2 917	3 435

1 2005 = 2001-05

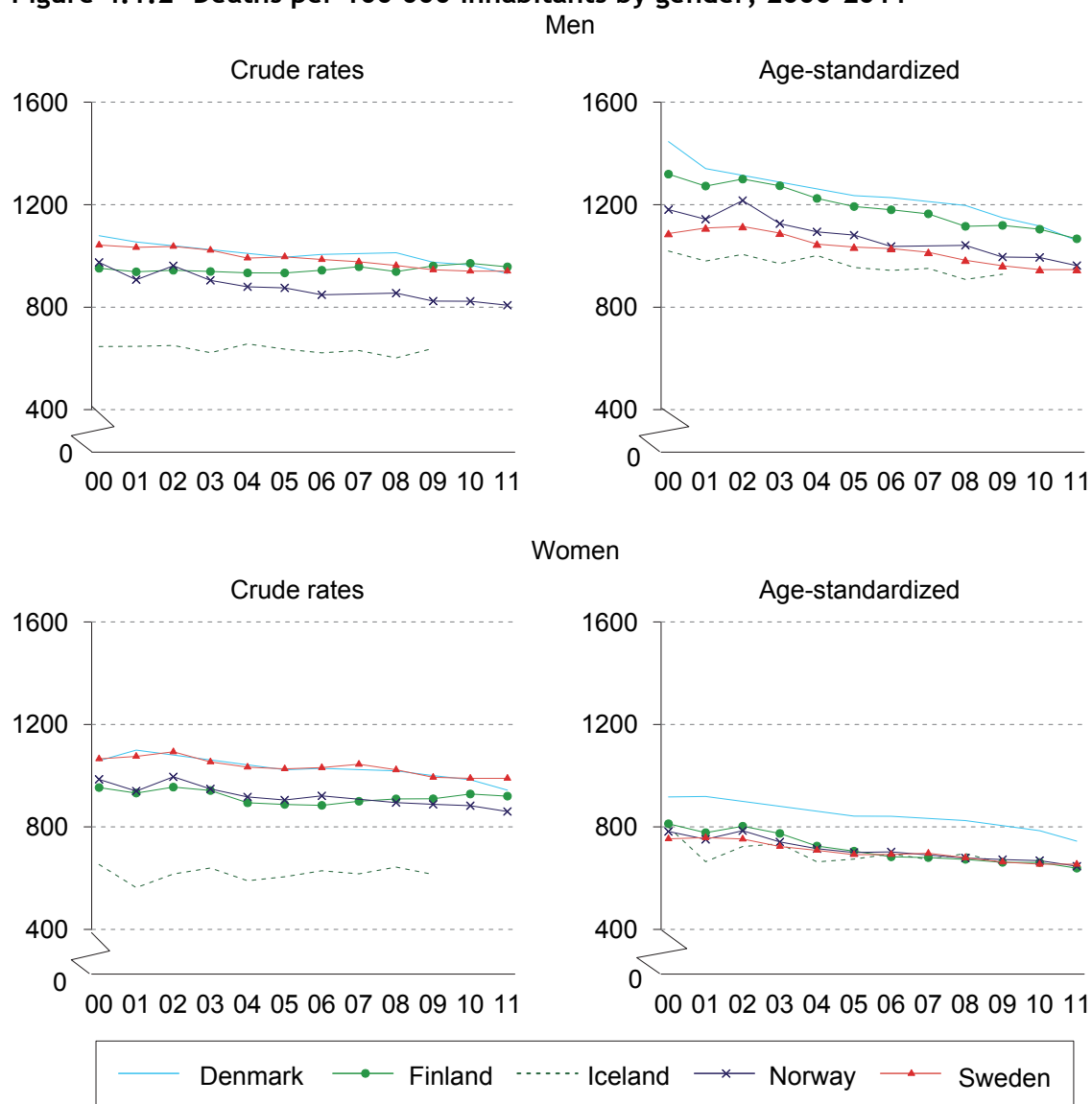
2 2010 = 2007-10

3 2011 = 2007-11

4 2010 = 2006-10

ICD-9: 390-459 and ICD-10: I00-I99

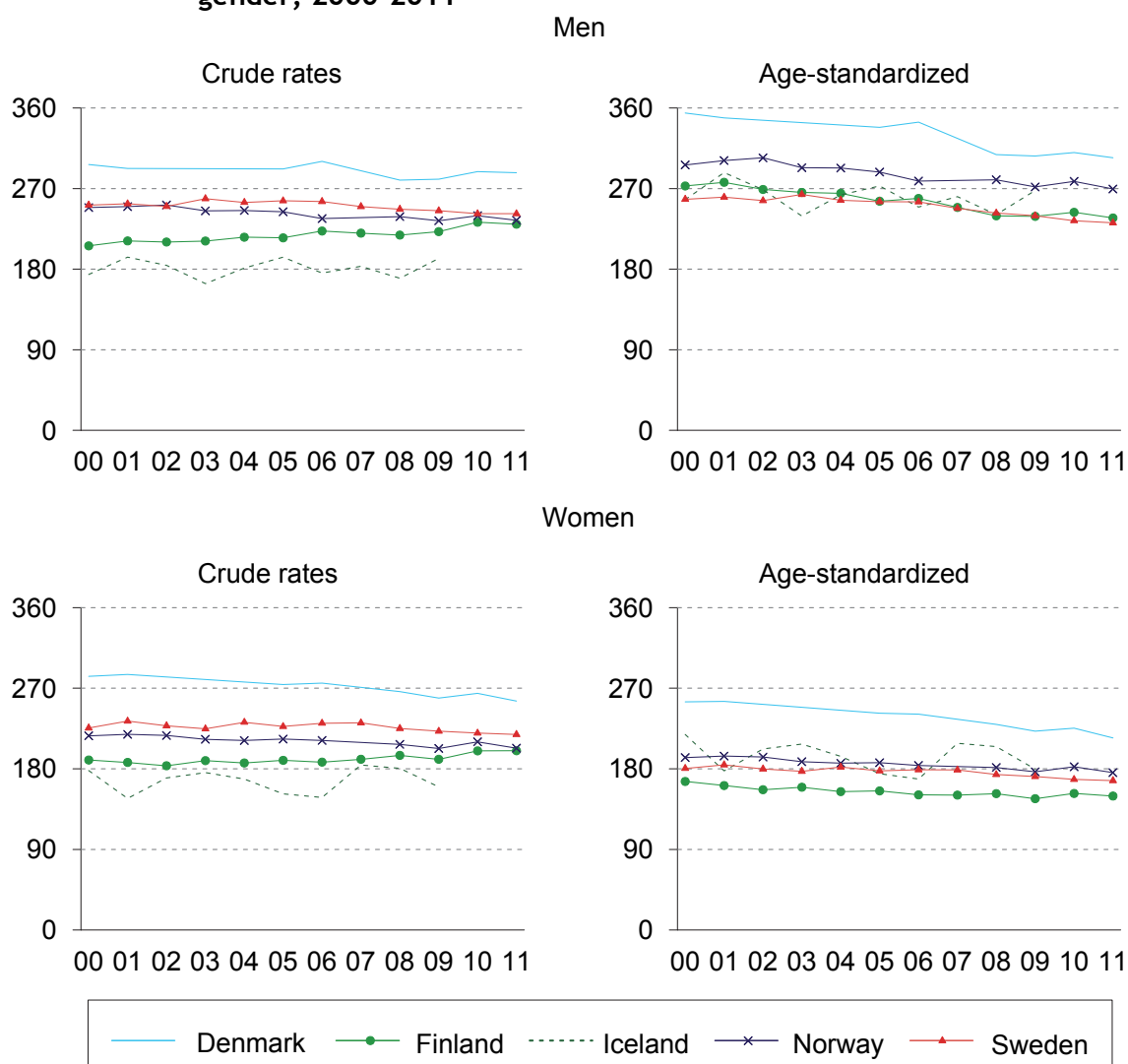
Sources: The national registers for causes of death

Figure 4.1.2 Deaths per 100 000 inhabitants by gender, 2000-2011

Age-standardized by the Nordic population 2000

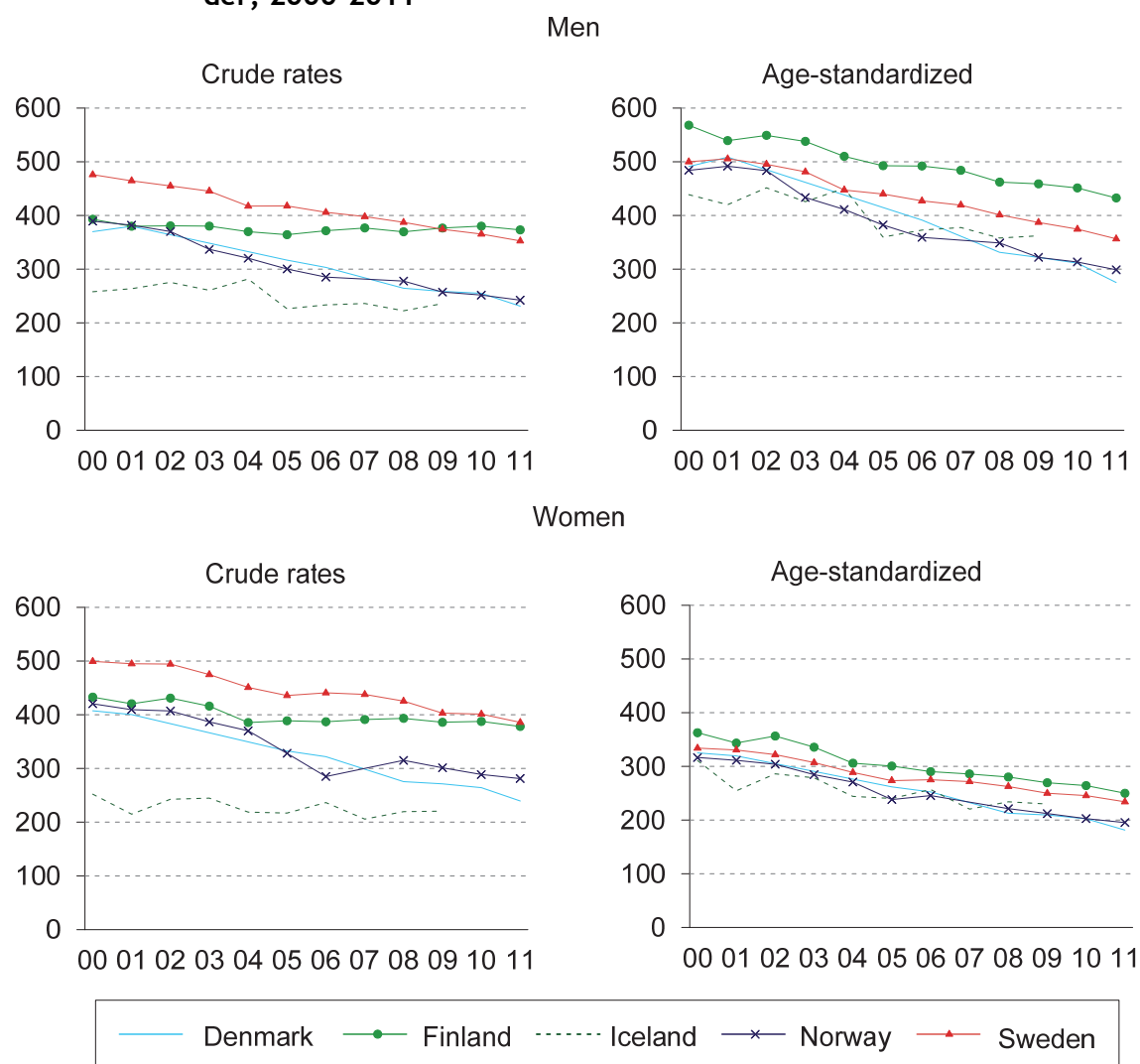
Source: Table 4.1.1

Figure 4.1.3 Deaths from malignant neoplasms per 100 000 inhabitants by gender, 2000-2011



Age-standardized by the Nordic population, 2000
Source: Table 4.1.2

Figure 4.1.4 Deaths from circulatory diseases per 100 000 inhabitants by gender, 2000-2011



Age-standardized by the Nordic population, 2000
Source: Table 4.1.3

Table 4.1.4 Deaths from avoidable causes per 100 000 inhabitants aged 0-74 years *

ICD-10 code	Denmark 2011	Faroe Islands 2007-11	Green- land 2007-11	Finland 2011	Åland 2007-11	Iceland 2009	Norway 2011	Sweden 2010
Malignant neo- plasm of the oesophagus (C15)	5.0	4.9	10.8	3.1	1.1	3.3	2.2	2.9
Malignant neo- plasm of the trachea, bronchus and lung (C32- C34)	42.3	24.8	59.1	26.6	5.9	26.6	27.8	23.9
Malignant neo- plasm of cervix uteri ¹⁾ (C53)	1.8	-	8.5	1.2	-	1.4	1.8	2.2
Diabetes mellitus (E10-E14)	9.6	7.1	5.8	4.1	0.3	4.0	3.9	6.1
Cerebrovascular diseases (I60-I69)	15.7	12.4	38.2	19.6	4.4	9.0	11.3	12.9
Obstructive lung diseases (J40-J44)	0.8	8.0	1.1	9.1	1.9	9.6	12.1	9.0
Asthma (J45-J46)	-	-	0.0	0.1	-	-	-	-
Chronic liver dis- ease and cirrhosis (K70; K73-K74)	13.4	3.1	2.2	21.4	1.3	1.7	3.3	5.2

1 Per 100 000 Women

* Asthma: 0-14 years old

Sources: The national registers for causes of death

Table 4.1.5 Deaths from HIV/AIDS, in total and per 100 000 inhabitants, 2000-2011

	Denmark	Faroe Islands ¹⁾	Green- land ²⁾	Finland	Åland ²⁾	Iceland	Norway	Sweden
<i>Number</i>								
2000	21	-	5	10	-	1	15	13
2005	39	0	3	9	0	-	24	31
2010	29	0	2	7	0	..	10	11
2011	18	0	2	5	0	..	12	23
<i>Per 100 000 inhabitants</i>								
2000	0.4	-	8.9	0.2	-	0.4	0.3	0.1
2005	0.7	0.4	6.0	0.2	0.0	-	0.5	0.3
2010	0.5	0.4	3.5	0.1	0.0	..	0.2	0.1
2011	0.3	0.4	2.8	0.1	0.0	..	0.2	0.2

1 2005 = average 2001-2005. 2010 = average 2006-2010. 2011= average 2007-2011

Sources: The national registers for causes of death

ICD-10: B20-B24

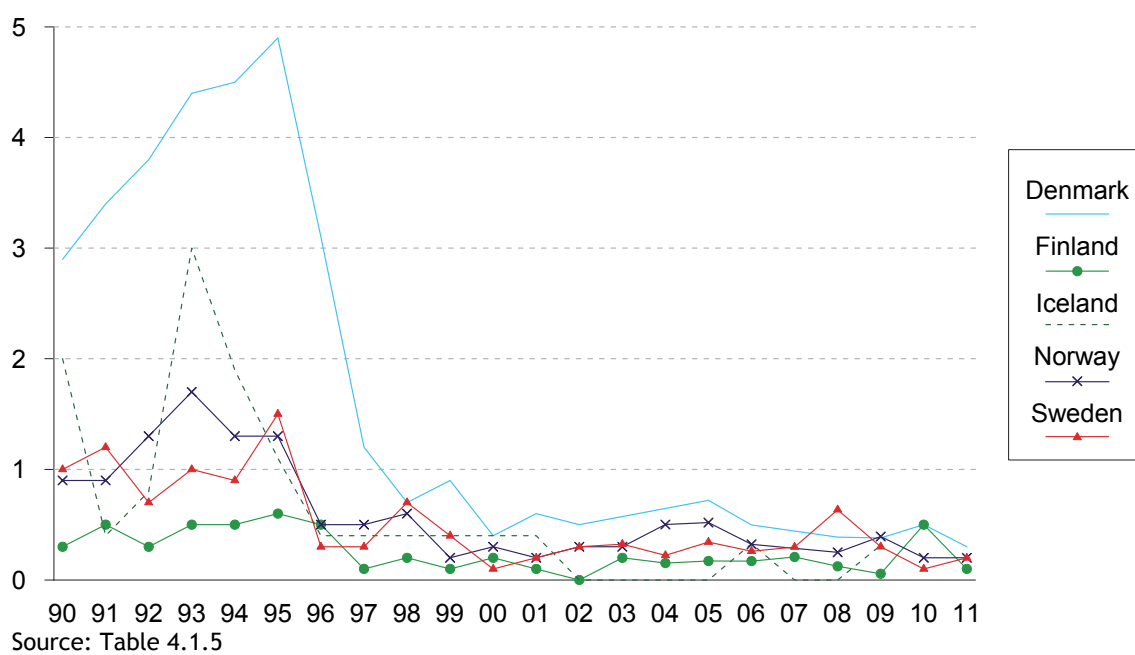
Figure 4.1.5 Deaths from HIV/AIDS per 100 000 inhabitants, 1990-2011

Table 4.1.6 Deaths from suicide per 100 000 inhabitants by gender and age, 2000-2011

	Men					Women				
	Total	10-19	20-24	25-64	65+	Total	10-19	20-24	25-64	65+
Denmark										
1990	32.2	4.8	19.8	41.3	58.9	16.4	1.2	5.6	19.8	31.0
2000	23.3	4.4	16.0	23.8	41.8	8.3	2.5	1.2	8.2	15.0
2005	16.9	3.3	8.8	18.9	41.8	6.3	0.6	3.5	6.8	14.2
2010	14.7	3.4	3.0	18.5	27.9	5.7	1.2	3.7	6.8	9.6
2011	15.8	2.5	9.8	21.1	23.6	5.4	1.2	4.2	6.3	9.3
Faroe Islands¹⁾										
2002-06	1.6	0.0	0.0	3.1	0.0	0.9	0.0	0.0	1.8	0.0
2007-11	8.0	0.0	12.3	12.5	6.6	0.9	0.0	0.0	0.0	5.6
Greenland										
2001-05	124.2	154.6	532.7	106.5	96.1	44.5	64.3	132.0	45.1	12.3
2007-11	110.2	128.9	319.5	105.1	117.3	45.9	118.4	66.1	33.1	42.2
Finland										
1990		20.6	60.3	63.9	64.2		2.6	15.8	16.7	13.7
2000	34.6	10.5	41.8	46.6	36.8	11.0	4.1	9.4	15.5	17.5
2005	28.1	4.8	30.5	36.5	39.0	10.0	4.7	12.3	13.5	8.6
2010	27.2	9.6	44.9	33.8	30.5	8.6	2.9	13.2	11.2	8.1
2011	26.8	11.3	32.5	33.0	34.1	7.3	2.9	11.2	10.0	5.4
Åland										
2002-06	19.9	11.7	28.1	22.1	31.9	4.5	0.0	0.0	2.8	15.9
2007-11	8.7	-	-	5.3	36.0	10.1	-	12.9	10.6	7.5
Iceland										
1990	..	..	..	33.9	33.1	..	..	..	6.7	0.0
2000	29.8	22.9	73.4	38.1	13.6	5.7	-	9.4	8.6	5.6
2005	16.2	8.7	9.2	27.2	-	6.1	-	-	12.0	-
2010	..	..	..	..	..	..	..	..	..	..
2011	..	..	..	..	..	..	..	..	..	..
Norway										
1990	..	..	..	33.0	33.0	..	..	..	10.3	11.1
2000	18.4	11.3	29.9	22.5	22.6	5.8	3.0	4.4	7.9	6.3
2005	15.8	6.9	24.7	18.6	16.9	7.3	4.3	7.2	9.8	5.4
2010	15.8	6.1	25.7	18.9	23.2	6.7	1.3	6.0	10.1	5.6
2011	17.5	6.1	24.8	22.6	21.0	6.6	3.9	6.9	9.3	5.0
Sweden										
1990	24.1	5.0	20.9	28.8	45.7	10.4	2.5	6.1	13.7	14.5
2000	18.3	4.0	15.9	21.2	36.0	7.3	3.2	3.9	9.2	10.1
2005	18.6	3.8	18.2	22.3	32.3	8.4	3.1	8.5	10.4	11.2
2010	17.9	5.6	17.7	21.9	27.1	6.4	2.6	6.3	7.9	8.4
2011	16.7	6.8	15.2	21.2	22.2	6.8	4.3	4.8	8.4	8.6

1 The total covers both men and women

Sources: The national registers for causes of death

ICD-10: X60-X84

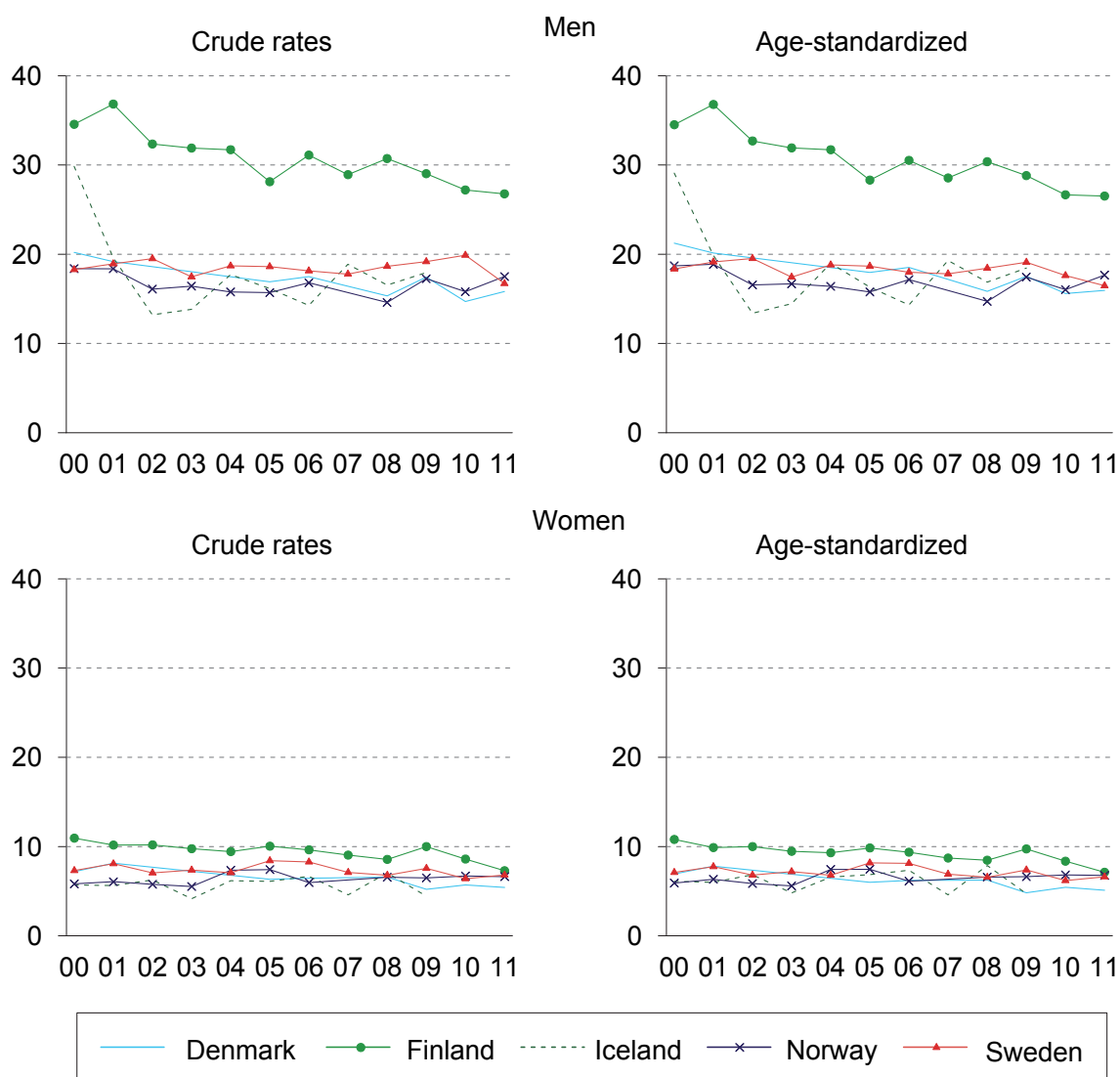
Table 4.1.7 Deaths from accidents per 100 000 inhabitants by gender and age, 2000-2011

	Men						Women					
	Total	0-14	15-24	25-64	65-79	80+	Total	0-14	15-24	25-64	65-79	80+
Denmark												
2000	45.3	6.3	37.7	30.2	80.2	544.7	43.6	2.9	10.3	11.3	64.2	525.9
2005	35.4	3.4	28.6	28.0	52.4	373.0	26.7	2.2	4.4	8.2	32.3	328.7
2009	27.8	2.5	18.6	24.9	31.2	264.0	21.0	1.6	3.9	7.0	31.3	238.5
2011	24.3	2.4	16.3	21.0	33.4	213.7	16.1	1.0	4.7	6.6	20.6	175.9
Faroe Islands												
2002-06	45.0	21.1	45.8	34.4	88.3	305.3	20.8	3.7	6.6	12.6	33.5	198.8
2007-11	43.1	14.2	5.6	42.0	110.1	264.2	21.5	3.7	6.5	8.9	33.0	242.3
Greenland												
2002-06	88.6	43.7	76.1	92.9	283.6	396.8	41.4	22.5	14.9	33.4	218.9	509.2
2007-11	66.1	19.1	57.1	70.8	241.1	595.2	34.6	5.6	34.8	29.0	109.5	916.5
Finland												
2000	70.8	6.0	30.8	75.6	137.1	471.2	34.4	3.0	9.3	18.9	53.2	310.8
2005	80.9	7.7	27.8	87.3	153.0	464.7	35.8	2.7	6.6	22.7	51.7	285.7
2009	68.9	2.6	28.5	68.6	131.1	387.3	35.5	2.3	5.9	18.5	52.7	279.6
2011	67.6	2.9	27.6	65.7	118.0	424.4	32.8	2.1	7.4	15.6	53.4	250.0
Åland												
2002-06	43.2	24.6	13.2	44.7	56.7	186.3	16.5	8.6	0.0	5.6	12.4	156.8
2007-11	55.4	0.0	24.8	42.7	92.8	483.5	28.8	0.0	0.0	2.7	57.2	300.6
Iceland												
2000	38.4	3.0	46.0	36.7	76.6	274.6	12.8	-	23.7	10.1	30.2	21.5
2005	25.6	-	36.2	14.2	82.1	253.0	17.6	-	4.7	13.3	44.5	163.9
2009	..	..	..	..	..	..	..	..	..	..	..	..
2011	..	..	..	..	..	..	..	..	..	..	..	..
Norway												
2000	43.9	4.8	35.4	31.8	81.0	442.9	34.2	5.0	9.4	8.1	44.6	381.3
2005	45.0	3.7	34.8	37.4	65.9	418.4	33.0	2.0	11.1	11.7	32.2	357.9
2009	43.1	1.7	23.7	34.8	64.1	450.8	35.1	1.1	10.5	11.6	43.3	389.1
2011	40.7	2.1	20.7	31.0	59.5	458.0	34.1	0.9	5.7	9.7	30.4	430.6
Sweden												
2000	36.2	3.1	27.1	25.5	66.9	310.0	22.7	1.6	6.4	6.5	28.4	227.4
2005	38.1	2.4	21.2	25.6	67.3	345.1	27.6	4.3	5.3	8.4	34.0	265.0
2009	36.3	1.6	15.3	22.1	60.3	375.7	25.4	4.1	4.6	6.0	29.8	266.2
2011	36.1	2.1	16.0	22.1	50.0	394.8	25.6	4.7	5.3	5.8	22.6	282.7

Sources: The national registers for causes of death

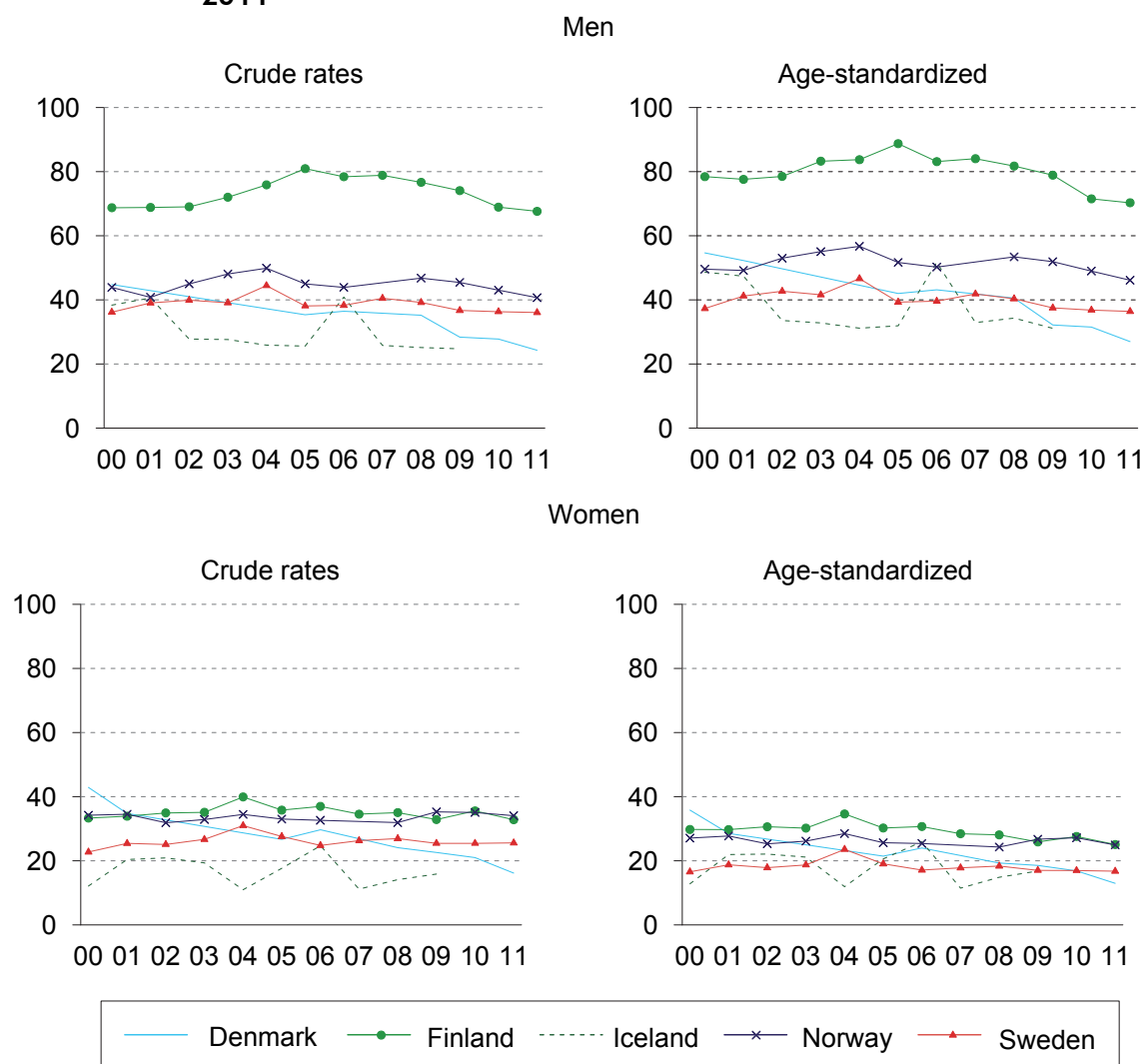
ICD-10: V01-X59

Figure 4.1.6 Deaths from suicide per 100 000 inhabitants by gender, 2000-2011



Age-standardized by the Nordic population, 2000
Source: Table 4.1.6

Figure 4.1.7 Deaths from accidents per 100 000 inhabitants by gender, 2000-2011



Age-standardized by the Nordic population, 2000
Source: Table 4.1.7

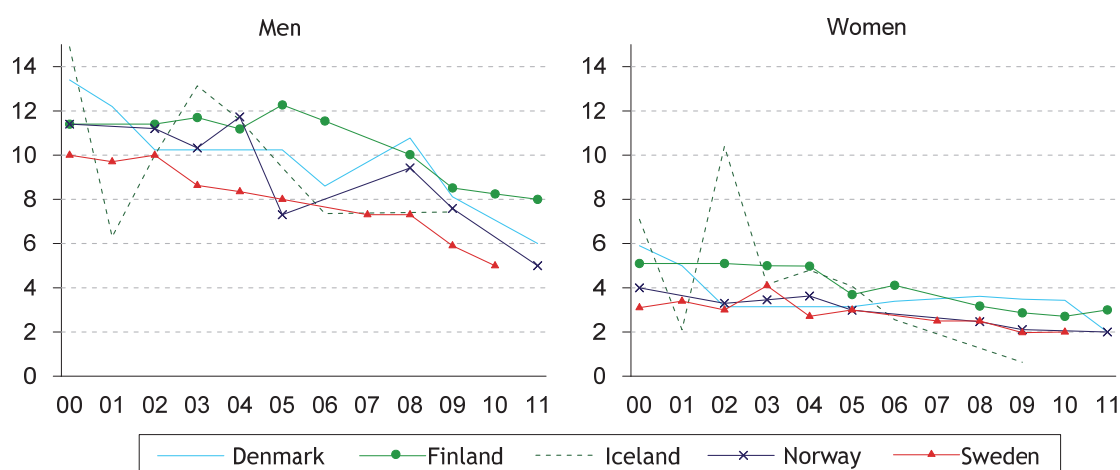
Table 4.1.8 Deaths from land transport accidents per 100 000 inhabitants by gender and age, 2000-2011

	Men					Women				
	Total	0-14	15-24	25-64	65+	Total	0-14	15-24	25-64	65+
Denmark										
2001	12.2	2.7	24.1	11.2	20.5	4.5	1.7	6.7	3.6	9.1
2005	10.2	1.3	21.0	9.7	16.4	3.1	1.8	2.7	2.5	6.9
2010	7.1	1.4	10.9	7.2	10.3	3.4	1.2	3.0	2.4	8.8
2011	5.8	1.2	8.7	5.4	9.8	2.0	0.6	2.9	1.2	4.8
Faroe Islands										
2002-06	10.4	7.0	34.3	6.3	6.8	3.5	3.7	0.0	3.6	5.7
2007-11	6.4	-	5.6	7.8	13.1	3.4	-	6.5	1.8	11.2
Finland										
2000	11.3	2.3	13.3	11.4	24.0	5.1	2.2	5.6	4.1	10.7
2005	12.3	4.1	14.7	11.9	22.8	3.7	1.3	4.4	3.2	6.8
2010	8.2	0.7	14.0	7.8	13.8	2.7	1.4	2.8	2.2	5.0
2011	8.2	0.9	14.8	7.6	12.9	2.7	1.2	3.1	1.8	6.3
Åland										
2002-06	18.4	8.3	13.1	19.4	31.9	3.0	0.0	0.0	2.8	7.9
2007-11	7.3	0.0	12.4	5.3	18.0	2.9	0.0	0.0	0.0	14.9
Iceland										
2000	16.3	-	32.2	16.9	27.3	7.1	-	19.0	5.8	11.2
2005	9.4	-	31.7	6.5	12.7	4.1	-	4.7	5.3	5.3
2010	..	..	..	..	..	..	..	..	..	..
2011	..	..	..	..	..	..	..	..	..	..
Norway										
2000	12.5	2.6	26.4	12.2	16.3	4.6	2.5	7.9	3.4	8.3
2005	7.4	1.1	15.9	7.0	10.4	3.3	0.7	6.1	3.1	4.6
2010	6.9	0.4	11.2	6.8	12.4	2.2	0.2	4.6	1.9	3.4
2011	5.3	1.3	6.6	5.3	9.6	2.3	0.2	3.2	2.4	3.3
Sweden										
2000	10.8	1.4	19.1	10.7	16.6	3.2	1.0	4.2	2.6	6.1
2005	8.2	0.7	12.8	8.4	12.2	2.8	0.4	3.6	2.6	4.7
2010	4.4	0.9	6.6	4.5	5.7	1.7	0.5	2.5	1.3	3.1
2011	4.9	0.6	7.5	4.6	7.8	1.5	0.4	2.8	1.0	2.9

Sources: The national registers for causes of death

ICD-10: V01-V89

Figure 4.1.8 Deaths from land transport accidents per 100 000 inhabitants by gender and age, 2000-2011



Sources: The national registers for causes of death

Table 4.1.9 Deaths from alcohol-related causes per 100 000 inhabitants by gender and age

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2011	2007-11	2007-11	2011	2007-11	2009	2011	2011
Men								
0-34	1.1	1.7	0.0	3.1	-	-	0.5	0.3
35-44	14.7	28.0	4.1	30.5	-	-	4.8	4.3
45-64	88.3	28.6	55.9	120.8	71.5	10.2	26.6	17.0
65-74	92.9	93.0	151.0	107.0	60.5	21.3	43.4	24.2
75+	58.7	59.3	382.6	42.2	22.2	-	29.2	9.9
Total	38.9	22.2	28.7	52.4	27.7	3.7	12.9	8.2
Women								
0-34	-	-	2.8	0.6	-	-	0.1	0.1
35-44	3.6	-	9.7	10.2	-	-	0.6	0.5
45-64	31.9	14.1	31.7	38.9	9.9	5.3	6.3	6.2
65-74	38.5	33.7	79.5	27.4	31.4	-	11.1	7.4
75+	19.3	0.0	125.4	6.8	-	9.6	4.2	2.5
Total	14.5	6.0	17.3	15.8	5.8	1.9	3.0	2.7
M+W								
0-34	0.6	0.9	1.4	1.9	-	-	0.3	0.2
35-44	9.2	14.9	6.7	20.5	-	-	2.8	2.4
45-64	60.1	21.7	45.4	79.6	40.3	7.8	16.7	11.6
65-74	64.8	64.7	117.9	64.5	46.3	10.3	26.8	15.6
75+	35.0	24.2	228.4	19.6	8.7	5.5	13.9	5.5
Total	26.6	14.4	23.4	33.8	16.7	2.8	8.0	5.5

Sources: The national registers for causes of death

ICD-10: E244, F10, G312, G621, G721, I426, K292, K700-709, K860, O354, P043, Q860, Y15, X45

Table 4.1.10 Deaths from drug-related causes per 100 000 inhabitants by gender and age

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2011	2007-11	2007-11	2011	2007-11	2009	2011	2010
Men								
0-34	4.5	-	1.3	3.4	3.5	8.5	9.3	8.9
35-44	14.9	-	-	7.1	-	17.7	22.3	14.5
45-64	9.5	6.4	2.4	2.4	-	15.4	18.4	18.9
65-74	1.1	-	-	1.2	-	32.0	8.7	12.1
75+	2.6	-	-	0.6	-	-	8.0	8.1
Total	6.9	1.6	1.3	3.2	1.5	12.4	13.5	12.5
Women								
0-34	0.6	-	-	1.3	-	3.8	1.9	3.2
35-44	3.3	-	-	0.9	-	4.7	5.9	5.9
45-64	4.3	-	-	1.4	-	21.4	10.4	9.8
65-74	1.0	-	-	1.1	-	-	7.2	9.8
75+	0.4	-	-	-	-	-	4.2	5.8
Total	2.0	-	-	1.1	-	7.6	5.2	6.2
M+W								
0-34	2.6	-	0.7	2.4	1.8	6.2	5.6	6.1
35-44	9.2	-	-	4.1	-	11.4	14.3	10.2
45-64	6.9	3.3	1.4	1.9	-	18.3	14.4	14.4
65-74	1.1	-	-	1.2	-	15.5	7.9	11.0
75+	1.3	-	-	0.2	-	-	5.7	6.7
Total	4.4	0.8	0.4	2.2	0.7	10.0	9.3	9.3

Sources: The national registers for causes of death

ICD-10: F11-F16, F18-F19, O35.5, P04.4, X40-X49, X60-X69, Y10-Y19, T40.0-T40.3, T40.5-T40.9, T43.6

Table 4.1.11 Deaths from incompletely defined causes on the death certificates per 100 000 inhabitants by gender and age

	Denmark	Faroe Islands	Green-land	Finland	Åland	Iceland	Norway	Sweden
	2011	2007-11	2007-11	2011	2007-11	2009	2011	2011
<i>Men</i>								
0-44	0	-	3	-	-	-	0	4
45-64	4	19	32	0	-	-	2	24
65-74	15	21	82	-	-	11	10	69
75+	84	252	383	3	22	26	107	280
Total	7	20	20	0	2	2	7	22
No death certificate	44	..	..	2	18	1	12	13
<i>Women</i>								
0-44	-	3	1	-	-	-	-	3
45-64	3	14	10	-	-	-	1	9
65-74	12	45	32	-	-	-	6	30
75+	88	143	188	3	-	38	204	379
Total	10	21	9	0	-	3	19	33
No death certificate	51	..	..	1	1	-	19	12
<i>M+W</i>								
0-44	0	1	2	-	-	-	0	3
45-64	4	17	22	0	-	-	2	17
65-74	13	32	59	-	-	5	8	49
75+	86	188	267	3	9	33	166	339
Total	9	20	15	0	1	2	13	27
No death certificate	47	..	..	2	9	1	16	13

Sources: The national registers for causes of death

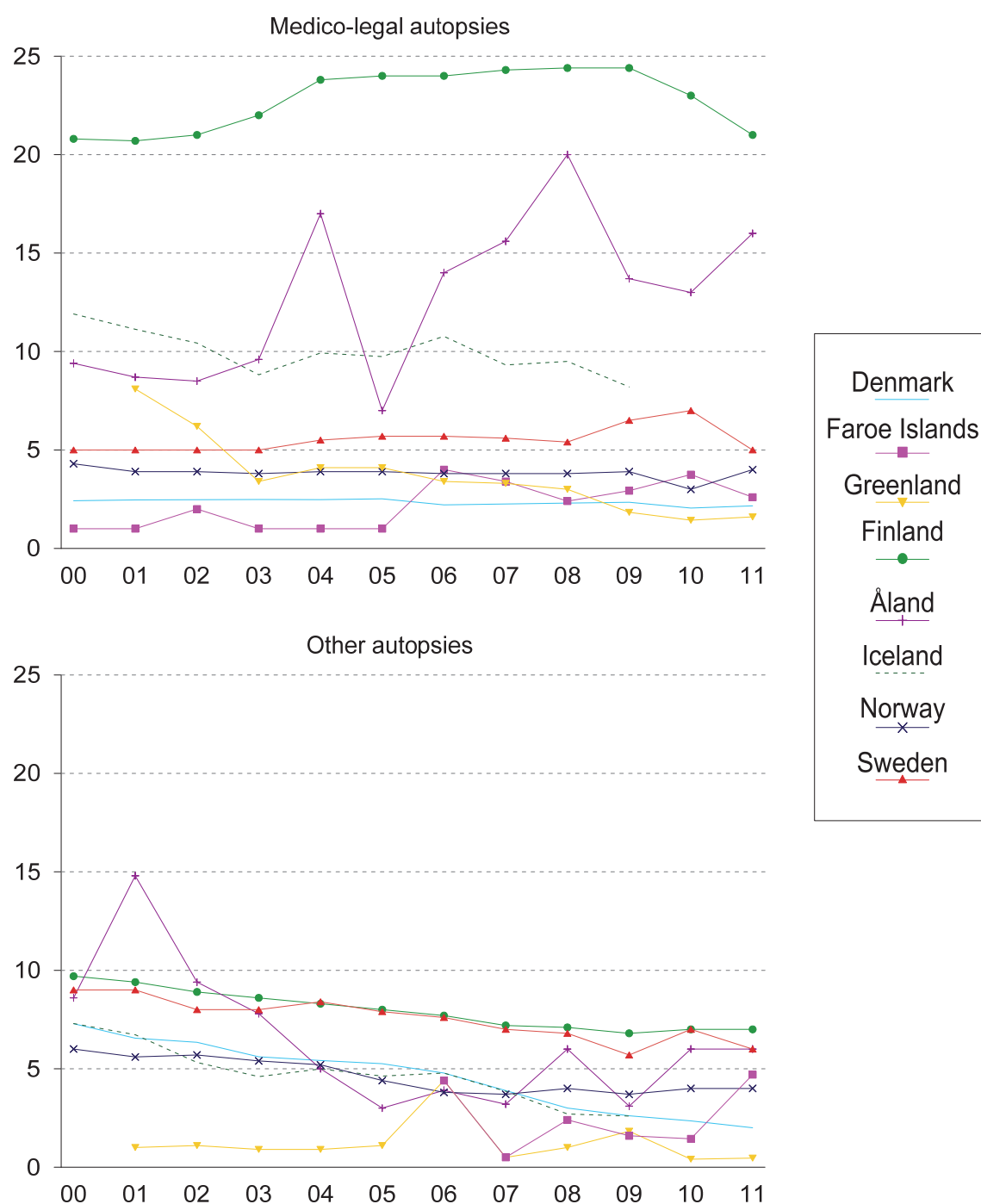
ICD-10: I469, I959, I99, J960, J969, P285.0, R000-R948, R99

Table 4.1.12 Autopsy rates as a percentage of all deaths, 2000-2011

	Denmark	Faroe Islands	Green-land	Finland	Åland	Iceland	Norway	Sweden
<i>Medico-legal autopsies</i>								
2000	2	1	..	21	9	12	4	5
2005	3	1	4	24	7	10	4	6
2009	2	3	2	24	14	8	4	7
2010	2	3	1	23	13	..	3	7
2011	2	3	2	21	16	..	4	5
<i>Other autopsies</i>								
2000	7	..	..	10	9	7	6	9
2005	5	1	1	8	3	5	4	8
2009	3	3	2	7	3	3	4	6
2010	2	1	0	7	6	..	4	6
2011	2	5	0	7	6	..	4	7

Source: The national registers for causes of death

Figure 4.1.9 Autopsy rates as a percentage of all deaths, 2000-2011



Source: Table 4.1.12

Chapter 5

Resources

Extra material

OECD: www.oecd.org

Introduction

This chapter describes available resources and utilization of resources in the health sector. It begins with a description of the financing of health services, including user charges. Then follows an overview of the total health care expenditure, then a detailed description of the expenditure on pharmaceutical products, followed by a description of health care personnel, and capacity and services in hospitals.

5.1 Financing of Health Services

In the Nordic countries, health services are mainly financed by the public authorities. In Iceland and Greenland, financing is primarily provided by the government, while financing in the other countries mainly comes from county and/or municipal taxes and block grants from the governments. With the exception of Greenland, citizens in the Nordic countries contribute directly to the financing, partly through insurance schemes, partly by paying user charges. Only Denmark and Norway use DRG (diagnosis-related groups) in their financing models.

DENMARK: In the case of Denmark, the Structure Reform resulted in the regions becoming responsible for the health sector from 1 January 2007. A new financial system for the regions was consequently agreed upon. About three quarters of the regions' expenditure are financed through block grants from the state. The rest is financed through a basic contribution from the municipalities, along with municipal and state subsidies that are dependent on activities.

FINLAND: The health care system is highly decentralised. Responsibility for providing health care is devolved to the municipalities (local government). The publicly funded system is divided into three levels. Alongside this is a much smaller private health care system. The three different health care levels that receive public funding are municipal health care, private health care and occupational health care systems.

Municipal financing is based on taxes while the National Health Insurance financing is based on compulsory insurance fees. Municipalities fund municipal health care services (except out-patient pharmaceutical product and transport costs) and the National Health Insurance funds for example private health care, occupational health

care, out-patient pharmaceutical products and transport costs, as well as most health-related benefits, such as sickness benefits and maternity benefits.

NORWAY: A financing model for somatic hospitals was established in Norway (as from 1 July 1997) that combines block grants and fee-for-service financing. The scheme is regularly evaluated and adjusted. Fee-for-service financing is based on the principle that a service provider (i.e. the hospital) is paid on the basis of services rendered. The scheme involves the state reimbursing a percentage of the average DRG expenses (Diagnosis Related Groups) in connection with treatment of patients.

SWEDEN: The state is responsible for the overall health policy and provides block grants to the county authorities for provision of health services. The largest proportion of funding for health services comes from taxes. Most of the funding for services provided by the county authorities comes from county taxes, and the rest from block grants from the state. Each county authority decides the level of county taxes itself, and how funding shall be allocated. The county authorities also receive revenue from patient fees and sale of services. The largest proportion of the budget of the county authorities is used to provide health services and dental services.

5.2 Charges for Health Care Services per 1 January 2013

Medical visits

DENMARK: As can be seen from the overview, no user charges are payable in Denmark, the Faroe Islands and Greenland.

FINLAND: The following charges are payable for primary care at health care centres:

- A fixed annual charge of no more than EUR 27.50 in a year, or
- A fixed charge per visit of no more than EUR 13.80. The charge is payable for the first three visits to the same health care centre in the same calendar year only

A charge of 18.90 EUR is payable for visits to health care centres on working days between 8 pm and 8 am and for visits on Saturdays, Sundays and holidays.

The charges do not apply to people under the age of 18.

Reimbursement of private physicians' fees is based on fixed charges. The National Social Insurance Institution reimburses a fixed amount of the physician's fee, an amount which is considerably lower than the actual charge.

ÅLAND: For medical consultations within the primary health service at a clinic, at specialized health care clinics and for home visits, there is a user charge of EUR 25. The fee for a visit to a casualty department is EUR 40. Children and young people under the age of 18 pay half of the fee.

If there is a waiting period of 45 minutes or more in connection with a scheduled visit, the user charge is reimbursed.

ICELAND: Preventive health care consultations for pregnant women and mothers with infants and school health care are free of charge. The user charge for a consultation

in a health care centre or with a private general medical practitioner during normal working hours is ISK 1 000, and ISK 800 for 67-69-year-olds who do not have a pension or who have a reduced pension. The charge is ISK 500 for other pensioners, disabled people and long-term unemployed people. There is no user charge for children under 18. Outside normal working hours, the charges are ISK 2 600, ISK 2 080 and ISK 1 300. Charges for home visits are ISK 2 800, ISK 2 200 and ISK 1 400 during day time, while charges for evenings and nights are ISK 3 800, ISK 3 200 and ISK 1 850.

The user charge for a consultation with a specialist is either ISK 4 500 plus 40 per cent of the remaining cost of the consultation, or ISK 3 500 or 1 600 plus 13.3 per cent of the remaining cost for the consultation. The user charge for children under 18 years is one ninth of the total charge with a minimum of ISK 720. There is no user charge for disabled and chronically ill children. The maximum charge is ISK 31 100 in all instances.

The same user charges apply for out-patient treatment in hospitals (with the exception of children, for whom there is no charge). Different charges apply for treatment in emergency units and with other physicians, and for laboratory tests, radiographs and diagnostic examinations.

User charges for persons who have been continuously unemployed for a period of 6 months or longer are the same as for pensioners.

SWEDEN: In Sweden, county authorities can decide themselves the level of user charges for different types of visits and treatment. In 1981, the cost ceiling system was introduced in the health care services. The cost ceiling is regulated in the Act on health care services and applies to all counties. The present system was introduced in 1997, with separate cost ceilings for out-patient visits to the doctor (SEK 900) and for pharmaceutical products (SEK 1 800) with a successive reduction of patient fees for pharmaceutical products. If a parent has several children under 18 years of age, the children are exempt from charges when the total expenses reach SEK 900.

User charges for primary health care vary from SEK 100 to SEK 200 per visit. An extra charge of between SEK 0-150 is payable for home visits, and of SEK 0-100 for telephone prescriptions.

Table 5.2.1 User charges for a consultation with a physician

	Are there consistent rules for the whole country?	Amount of user charge	Deviations	Share of user charge of the total cost of medical visits
Denmark	Yes	-	No	-
Faroe Islands	Yes	-	No	-
Greenland	Yes	-	No	-
Finland	Yes	Public: EUR 0-13.80. EUR 18.90 for visits between 8 pm and 8 am on weekdays or on Saturdays, Sundays or public holidays. Private: min. 60 per cent	No charge for children under the age of 18 years	13 per cent
Åland	Yes	EUR 25. Children and youth under the age of 18 years are half the price	Free treatment after paying EUR 375. Free treatment for children under 18 and people 65+ and disability pensioners after paying EUR 120	..
Iceland	Yes	ISK 1 000-3 800 in primary care, other fees for specialized care	Half the amount of ISK 500-1 850 for pensioners, disabled and long-term unemployed people. ISK 800-3 200 for 67-69-year-olds with no or a reduced pension. No charge for children under the age of 18 years	Varies
Norway	Yes	Consultation with: a general practitioner: NOK 140 (day), NOK 235 (evening), with a specialist: NOK 318	No charge for children under 16 years	Approx. 35 per cent
Sweden	No	100-300 SEK	Yes	..

User charges for out-patient consultations with a specialist vary from SEK 230 to SEK 320. If the patient has a referral from the primary health service, the patient fee is between SEK 80 and SEK 300 per visit.

User charges for visits to an emergency unit vary from SEK 200 to SEK 300. Nearly all the county authorities have decided that children and young people under the age of 20 are exempt from paying user charges for out-patient treatment. This exemption lasts until the young person's 20th birthday.

Reimbursement for Pharmaceuticals

DENMARK: There are no fixed percentages for reimbursement of fees for pharmaceutical products in Denmark, as the reimbursement depends on the amount of pharmaceutical products used by the individual patient. The percentage of reimbursement increases proportionally with the patient's use of pharmaceutical products.

Reimbursable pharmaceutical products are products with a documented and valuable therapeutic effect for a clear indication, where the price of the pharmaceutical product is reasonable in relation to its therapeutic value.

An individually assessed subsidy may be granted for pharmaceuticals that are not subject to a general subsidy by submitting an application through one's own doctor to the Danish Medicines Agency.

The Danish Medicines Agency determines a reference price for each group of pharmaceutical products covered by the reference price system. The reference price forms the basis for the calculation of the subsidy.

The subsidy is calculated on the basis of the reference price of each packet. Thus, the subsidy cannot be higher than the actual cost of the pharmaceutical product. Subsidies based on need are not changed.

The aim of the system is that physicians and dentists choose the cheapest product on the market (substitution). In special cases, the physician or dentist can choose not to substitute, if he or she finds that substitution by the pharmacy is not appropriate.

Current prices are determined for all pharmaceutical products on the market that have a marketing licence.

Since the liberalization in October 2001, there are now more than 1 500 authorized agents for non-prescription pharmaceutical products for people and/or animals.

All authorized businesses, irrespective of the selection of pharmaceutical products which they sell, must follow the current regulations relating to storage and quality of pharmaceutical products, and the prohibition against self-service sale and sale to children under 15 years of age.

In addition, agents for non-prescription pharmaceutical products for people shall offer a basic selection of goods, determined by legislation. For certain non-prescription pharmaceutical products, such as drugs for pain relief, no more than one packet can be sold per customer per day.

A list of pharmaceutical products that can be sold outside pharmacies can be found on the web site of the Danish Medicines Agency: www.laegemiddelstyrelsen.dk

FAROE ISLANDS: Part of the cost of pharmaceutical products is covered by the public sector, and part is covered by user charges. Only pharmaceutical products which are on the subsidies list will be reimbursed. The subsidies list is administered by the Chief Pharmaceutical Officer. The reimbursements on the Faroe Islands are not provided with a fixed percentage, as the reimbursement is depending on how large the pharmaceutical products consumption is for each patient. The percentage increases with the patient's pharmaceutical products consumption, so that for an annual purchase under DKK 500, the annual pharmaceutical products consumption is fully self-funded, while pharmaceutical products purchases of more the DKK 4 000 is fully sub-

sidized by the public sector. However, patients over the age of 67 years and under 18 years are fully subsidized from DKK 2 380. In accordance with the Social Security Act, subsidies for pharmaceutical products purchase are also granted to persons, who are not able to bear the costs themselves. Pharmaceutical products prescribed at hospitals are always free of charge.

GREENLAND: All pharmaceutical products are distributed through the health service except for certain non-prescription pharmaceutical products. These are available, to a very limited degree, from certain general stores. Non-prescription pharmaceutical products are distributed to a varying degree by district health services. Pharmaceuticals distributed by the health services are free.

FINLAND AND ÅLAND: There are three payment categories (35, 65 and 100 per cent) for prescription pharmaceutical products, and reimbursement is calculated separately for each purchase and for each category since 1 February 2013. However, there is a user charge of EUR 3 for pharmaceutical products with 100 per cent reimbursement.

Some new and expensive drugs (e.g. for dementia and multiple sclerosis) are in special cases paid for by the hospital or municipality. New drugs are not automatically covered by the reimbursement scheme, and many drugs are marketed without any reimbursement. Health economists have gained more and more influence as to which products should be reimbursed.

In addition to reimbursement for medicines, reimbursement can also be given for special diets for some treatment-intensive diseases and for ointments used in the treatment of chronic skin diseases.

As a main rule, the health insurance scheme reimburses expenditure on prescription pharmaceutical products exceeding EUR 670 in the course of one calendar year (excluding user charges of EUR 1.50 per product per purchase).

ICELAND: In Iceland a new system on subsidies was introduced on 4 May 2013. The system is similar to subsidy systems for pharmaceutical products in the other Scandinavian countries (Denmark, Norway, and Sweden). According to this system the public has to pay all expenses to medicine up to a certain limit (the subsidy limit). Hereafter the self-payment gradually decreases until annual expenses have reached a certain amount (the annual limit). After this the expenses will be fully covered.

The patients have to pay the initial ISK 24 075. Hereafter the patient pays 15 per cent of the costs until his share reaches ISK 34 908. The patient then pays 7.5 per cent until his total annual costs reach ISK 69 415. If the costs exceed this amount, the patients will be fully subsidized. The annual limits for subsidies to pensioners, the disabled, children and the young under the age of 22 years are lower. These groups pay the initial ISK 16 050 themselves, and will be fully subsidized, when the costs reach ISK 46 277.

NORWAY: There are two types of reimbursement schemes for pharmaceutical products: reimbursement authorized in advance (blue prescription) and partial reimbursement with contribution (white prescription).

Blue prescription: Most pharmaceutical products are reimbursed according to a system based on diagnoses and approved pharmaceutical products prescribed by a physician.

User charges for pharmaceutical products on blue prescription are 38 per cent of the prescription cost, up to a maximum of NOK 520 per prescription up to a quantity corresponding to 3 months' use.

White prescription: Normally the patient pays the full cost of pharmaceutical products on a white prescription. In some cases, the cost can be partially reimbursed through the reimbursement scheme. The patient pays the full cost of the pharmaceutical product at the pharmacy. When the cost has reached a maximum amount, the patient can apply to have further costs reimbursed.

The National Insurance Scheme covers 90 per cent of expenses exceeding the maximum limit.

The maximum limit for ordinary reimbursement is NOK 1 667.

Table 5.2.2 User charges for pharmaceutical products

	Are there consistent rules for the whole country?	Amount of user charge	Deviations	Share of user charge of the total cost of pharmaceutical products
Denmark	Yes	Reimbursement dependent on the level of the patient's consumption of drugs in the primary sector	No	..
Faroe Islands	Yes	Reimbursement dependent on the level of the patient's consumption of drugs in the primary sector	Reimbursement is higher for persons over the age of 67 years and under the age of 18 years	..
Greenland	Yes	-	No	-
Finland	Yes	65 per cent of the cost	For certain diseases EUR 3 or 35 per cent of the cost are paid (disease specific)	44 per cent
Åland	Yes	As in Finland	As in Finland	-
Iceland	Yes	Reimbursement dependent on the level of the patient's consumption of drugs in the primary sector	Pensioners, children (under 18 years), young people (18-22 years old) and the disabled pays two thirds of the costs	Approx. 37 per cent
Norway	Yes	38 per cent of the cost, maximum NOK 520 per prescription	No user charge for children under 16 years	..
Sweden	Yes	SEK 0-1 800	-	..

SWEDEN: Certain pharmaceutical products are included in the cost ceiling arrangement. This means that part of the cost of the pharmaceutical product is refunded by the state through taxation. The Dental and Pharmaceutical Benefits Agency (TLV) is a state authority whose remit is to determine which medicinal products, disposable items and dental treatment shall be included in the cost ceiling arrangement. Different types of pharmaceutical products are included in the cost ceiling arrangement, including disposable items and contraceptives. Besides, some non-prescription pharmaceuticals are included in the cost ceiling arrangement.

According to the legislation, pharmacies have a duty to substitute pharmaceutical products with cheaper generic alternatives. Generic alternatives are pharmaceutical products that have been approved by the Medical Products Agency as having the same function, quality and safety as the original pharmaceutical product.

User charges, i.e. the part of the cost paid for by the patient, are as follows:

- the whole cost up to SEK 900
- 50 per cent of the cost in the range SEK 900 1 700
- 25 per cent of the cost in the range SEK 1 700 3 300
- 10 per cent of the cost in the range SEK 3 300 4 300
- 0 per cent of costs exceeding SEK 4 300

When a patient has paid a total of SEK 1 800 in a 12-month-period, the patient receives pharmaceutical products and disposable items free of charge for the rest of the period.

Treatment in hospitals

As shown in the overview, there are no user charges for hospitalization in Denmark, the Faroe Islands, Greenland, Iceland and Norway. In Iceland and Norway, however, there is a charge for specialist out-patient treatment in hospitals, cf. the section on consultations with a physician. There are private hospitals in most of the Nordic countries, which provide all or some of their services to the public health service, but according to somewhat different regulations in the different countries.

FINLAND: Patients pay a charge for admission to hospitals and health care centres: EUR 32.60; and psychiatric departments: EUR 15. The charge for rehabilitation is EUR 11.30 per treatment day, and the maximum user charge for day surgery is EUR 90.30 plus EUR 32.60, if the patient has to stay overnight. A series of treatment costs EUR 7.50 per visit (max. 45 times per year).

ÅLAND: The daily fee for patients who are hospitalized is EUR 33. When the maximum limit is achieved (EUR 375 for persons between 18 and 64 years, EUR 120 for persons at the age of 65 and older and for people with a disability pension) the daily fee is reduced to EUR 15. The daily fee for persons under the age of 18 is EUR 18 and when the maximum limit (EUR 120) has been reached, health care at the hospital ward is free of charge. The fee for day surgery is EUR 66. At medical rehabilitation the daily fee is EUR 20, and when then the patient has reached the maximum limit, health care is free of charge.

The fee for long-term care at the hospital ward is charged on the basis on the patient's means to pay.

Table 5.2.3 Egenbetaling for indlæggelse på sygehus

	Are there consistent rules for the whole country?	Amount of user charge	Deviations	Share of user charges of the total cost of hospitalization
Denmark	Yes	-	No	-
Faroe Islands	Yes	-	No	-
Greenland	Yes	-	No	-
Finland	Yes	EUR 32.60 per day in overnight care, and for day surgery EUR 90.30	For children 0-17 years max. for 7 days. Payment for long-term stay according to means	7 pct.
Åland	Yes	EUR 33; EUR 18 for people under the age of 18 years and for day surgery EUR 66	Payment for long-term stay according to means	..
Iceland	Yes	-	No	-
Norway	Yes	-	No	-
Sweden	No	0-80 SEK/dag	County councils and regions decide charges	..

SWEDEN: To a large extent, the county authorities and the municipalities can decide themselves about patient charges for a visit to the doctor and for other health services. For a hospital stay, there is a charge per day of a maximum of SEK 80. The amount varies in different counties from SEK 0 to 80, depending on the patient's income, age and length of stay.

Most county authorities have no user charges for in-patient treatment in hospitals for persons under 20 years of age.

Reimbursement for dental treatment

In all countries, part of the cost of dental treatment is refunded in the following cases: dental treatment that is necessary to prevent serious complications due to infection in the teeth and periodontium, for immuno-compromised patients, such as patients with leukaemia or head and neck cancer, patients waiting for a transplant, patients who need bone marrow transplants, and patient groups with similar problems.

DENMARK: Reimbursement is provided by the public health insurance scheme. Adults typically pay 60 per cent of the agreed fees. No subsidy is granted for dentures.

Municipal and regional dental services are regulated by the health legislation.

In addition, approximately 1.9 million Danes are covered by a private insurance scheme. Some schemes provide subsidies for dental treatment.

Children and young people under 18 years of age receive free municipal dental care including orthodontic treatment. Children under 16 years of age, who wish to have treatment that is not provided free of charge by the municipal council, may - by paying a user charge - choose to be treated in a private clinic of their own choice or at a public dental clinic in another municipality. Elderly people who live in a nursing home or in their own home with technical aids are offered dental care for which there is a maximum annual charge of DKK 465 from 1 January 2012. In addition, the municipalities provide a subsidy for dentures in cases of impaired function or disfigurement resulting from damage caused by accidents.

The municipality offers specialist dental treatment to persons, who because of psychiatric illness or mental disability cannot use the existing dental services for children and young people, for adults, or for people needing special care. For these services, the region, from 1 January 2012, charges the patient a maximum of DKK 1 725 per year.

The region offers specialized dental care (regional dental service) or highly specialized dental care (in dental research centres) to children and young people with dental conditions that would lead to a permanent functional reduction if left untreated.

In addition, the region grants a special reimbursement for dental care for cancer patients, who either due to radiation of the head and neck or due to chemotherapy suffer from considerable documented dental problems, and to persons who due to Sjögrens syndrome suffer from considerable documented dental problems. From 1 January 2012, the region can demand a user payment of a maximum of DKK 1 725 annually for these services. Finally, the region provides highly specialized dental advice, examination and treatment (in dental research centres) for patients with rare diseases and disabilities, for whom the underlying disease can lead to special problems with their teeth, mouth or jaws.

Oral and maxillofacial surgery is carried out in the hospitals and is paid for by the regions in accordance with the health legislation.

In addition to the general rules outlined above, the municipalities can provide support for necessary dental treatment in accordance with the legislation relating to social services.

FAROE ISLANDS: Dental treatment is mainly provided by private dentists. Payment is therefore partly private, and partly subsidized (about half of the costs) by the public services. The specific amount of the subsidy is regulated by the agreement between the home rule government and the Faroese Dental Association. There is no maximum user charge for dental treatment, as there is for subsidized medicine.

The municipalities provide a free dental service for children up to the age of 16. This service also provides special dental care, such as orthodontic treatment.

Reimbursement of expenses for treatment of congenital diseases or disease-related dental conditions can be claimed according to the social legislation.

GREENLAND: All public dental care is free of charge. There is limited access to private dentists. All private dental treatment is paid for by the patient.

FINLAND: There is a basic fee of EUR 7.50 per visit for dental treatment at a health care centre, EUR 9.60 per visit to a dentist, and EUR 14.00 for a visit to a specialist. In addition to this, user fees of EUR 6.20-163.00 can be charged, dependent on the type of treatment provided.

The health insurance scheme reimburses 60 per cent of the treatment costs within the rates fixed by the Social Insurance Institution for one annual dental examination in the private dental service. Orthodontic treatment is only reimbursed if the treatment is necessary to prevent other illnesses. Expenditure on dentures and dental laboratory costs are not included in the reimbursement scheme.

Expenses for laboratory and X-ray examinations ordered by a dentist are refundable. Expenses for drugs prescribed by a dentist and travelling costs to visit a dentist are refundable under the same terms as for medical prescriptions and travelling costs to visit a physician.

ÅLAND: All public dental treatment for persons under 19 years of age is free of charge. For others, the cost of a dental visit is EUR 12 with additional standard fees for treatment and examinations. The patient pays the actual cost of orthodontic treatment and prosthetic treatment. The same rules as in Finland apply for treatment with private dentists.

ICELAND: The health insurance scheme in Iceland pays according to a rate fixed by the health insurance scheme. This rate is generally different from the rate used by private dentists, as private dentists in Iceland are allowed to set their own fees.

The health insurance scheme offers partial reimbursement of the cost of dental treatment for persons aged 67 years or older.

In April 2013 a new agreement on prophylactic dental treatment for children under the age of 18 was signed. Now parents can register their children at a specific dentist, who then will become responsible for regular dentist's appointments, prophylactic and necessary dental care. Payment for children will be determined at a low fee for one annual visit. The agreement will be implemented in seven stages. In May 2013 the agreement comprises children at the age of 15 to 17 years. In September 2013 the age group 12 to 17 years as well as 3 year olds are included. On 1 January, until 1 January 2018, two age groups will be added annually, until the same agreement applies to all children under the age of 18 years. If a child cannot afford the necessary dental treatment, a special grant will be given so that they can receive dental treatment at the fixed cost.

For other children's dental treatment, a 75 per cent subsidy is provided (according to health insurance rates), with the exception of gold and porcelain crowns, dental bridges and orthodontic treatment.

Subsidies to orthodontic treatments can reach ISK 150 000 ISK according to special rules. People suffering from chronic illnesses as well as pensioners and disability pensioners will also receive a partial or full subsidy for their costs.

For this group, subsidies of 50, 75 or 100 per cent is provided for the dental treatment costs (according to health insurance rates). Full dentures and partial dentures are covered. Gold and porcelain crowns, dental bridges and implants can be reimbursed by up to ISK 80 000 annually.

Implants are also included for those who cannot use a full denture. A partial subsidy is provided for pensioners who cannot use a full denture due to poor resorption or other problems.

95 per cent of the costs for treatment (incl. orthodontics) of congenital disfiguration and serious anomalies such as cleft palate and aplasia, as well as accidents and illnesses, are reimbursed by special rules.

No subsidy is provided for dental treatment to the rest of the population. Furthermore, there is no private dental insurance.

NORWAY: Most people pay the cost of dental treatment themselves.

Adults over 20 years of age normally pay for their own dental treatment.

When dental treatment is needed because of several defined diseases/conditions /injuries, the patient can receive reimbursement/benefit from the National Insurance Scheme. The public dental service offers free treatment to the following groups:

- children and young people under the age of 18 years
- people with mental disabilities
- elderly people, people with chronic illnesses and disabled people who are either living in institutions or receiving home nursing services
- other groups of people with special needs, e.g. people in prison

Adolescents 19-20 years of age receive subsidized dental care. The county authorities cover a minimum of 75 per cent of the cost of dental treatment for this group.

The National Insurance Scheme covers part of the cost of necessary orthodontic treatment for children up to the age of 18.

SWEDEN: According to the Act relating to dental services, children and young people have the right to regular and comprehensive dental care until and including the calendar year in which they reach 19 years of age.

Regular dental care means that young people under 20 years of age shall receive dental treatment so often that good oral health can be maintained. Comprehensive dental care means that young people under 20 years of age shall receive general dental care and specialist dental care.

People of 20+ years have to pay for their dental treatment themselves. People between the ages of 20 and 29 receive a general subsidy in the form of a single grant from the Swedish Social Insurance Agency of SEK 600 every other year. People between the ages of 30 and 75 receive a grant of SEK 300 every other year, and people over 75 receive a grant of SEK 600 every other year.

All adults are also included in the cost ceiling arrangement. This means that patients pay 50 per cent of the cost between SEK 3 000 and SEK 15 000, and 15 per cent of the cost for expenses above this amount.

Adults mainly have to pay for their dental treatment themselves. However, some people with specific illnesses, elderly people and people with functional disabilities, have the right to receive reimbursements for dental treatment from the county authorities. This includes reimbursement for preventive care, necessary treatment, dental treatment that is part of the treatment of a disease, and dental aids.

Apart from providing free dental treatment for children and young people, the county authorities and the regions have responsibility for: oral surgery in hospitals, dental treatment that is part of the treatment of a disease, and dental treatment for people who have difficulty in maintaining their own oral health. Special regulations for reimbursement of dental expenses apply for these groups.

Maximum user charges

DENMARK: There are no rules for maximum user charges, with the exception of pharmaceutical products and dental treatment in Denmark (cf. the section on reimbursement for dental treatment).

GREENLAND: There are no user charges in Greenland with the exception of non-prescriptive medicines and some forms of dental treatment (cf. the sections on reimbursement for pharmaceutical products and reimbursement for dental treatment). There are no rules concerning maximum user charges.

FAROE ISLANDS: For subsidized medicine, there is a maximum user charge at the amount of DKK 4 000 annually (lower amount for children and pensioners). There is no maximum user charge for dental treatment. Apart from pharmaceutical products and dental care, there are no user charges in the Faroe Islands (cf. the sections on reimbursement for pharmaceutical products and reimbursement for dental treatment).

FINLAND: If the total cost of pharmaceutical products exceeds EUR 700.92 per year, or if travelling costs for treatment exceed EUR 157.25 per year, the Social Insurance Institution reimburses the excess costs.

If a person's ability to pay taxes is reduced because of sickness, a special tax relief may be granted. The amount of the tax relief is calculated on the basis of the person's and his/her family's ability to pay taxes.

User charges for a long-term stay in an institution or a hospital cannot exceed 85 per cent of a patient's/resident's net income. If the spouse with the highest income is hospitalised, the fee for the hospitalisation cannot exceed 42.5 per cent of the spouses' joint net income per month. A patient must have at least EUR 99 per month for personal necessities. The same charge is payable in all kinds of institutions within the social and health care sectors.

The so-called user charge ceiling of EUR 636 is applied by the municipal social and welfare sectors. Once the ceiling for the present calendar year is exceeded, the user may generally utilize services free of charge. The ceiling applies to physician services in the primary health care sector, physiotherapy, out-patient treatment, day surgery and short-term stays in institutions in the social and health sectors. Dental care, patient transport, certificates, laboratory tests and radiological examinations requisitioned by private physicians must still be paid for. Income-regulated payments are not included in the maximum amount.

Payments made for children under 18 years of age are added to the amount paid by the person who has paid the costs.

ÅLAND: The rules for maximum user charges for medicines and transport to and from treatment are the same as in Finland.

The maximum user charge for health care and out-patient treatment is EUR 375 within one calendar year, after which there is no charge for the remainder of the year, with the exception of short-term stays in institutions/hospitals, where the charge is reduced from EUR 33 per day to EUR 15 per day.

For children and young people under the age of 18 and people over the age of 65, the maximum amount for patient fees is EUR 120 per calendar year. After this amount has been reached, all treatment for children and young people is free. The fee per day for a hospital stay for persons aged 65 years and older is reduced from EUR 33 to EUR 15.

As part of the maximum user charge, payment for out-patient treatment and services received outside the county are also included. Dental treatment and X-ray and laboratory examinations are not included. User charges may be deducted from municipal tax.

ICELAND: User charges for people aged 18-70 years and for unemployed people are reimbursed, if the costs exceed ISK 31 100 during one calendar year.

The same applies to children under 18 if charges exceed ISK 9 400.

User charges exceeding ISK 23 600 are reimbursed for people aged 67-69 who have either no pension or reduced pension.

User charges exceeding ISK 7 400 are reimbursed for the following groups: people aged 60-70 who receive a full basic pension, pensioners aged 70 years or older, and disabled people.

If there are one or more children under the age of 18 in one family, they count as one person in relation to the cost ceiling.

When the cost ceiling has been reached, an insured person receives a discount card, which guarantees full or partial reimbursement for the rest of the year, according to certain rules.

The cost ceiling scheme covers the following services: consultation with a general medical practitioner or a specialist, home visit by a physician, out-patient treatment in a hospital or a casualty department, and laboratory examinations and X-ray treatment. The scheme does not cover treatment for in vitro fertilization.

NORWAY: When a patient has paid user charges up to a certain amount, he or she receives an ex-emption card. All further treatment is then free for the rest of the year.

There are two exemption card arrangements in Norway, exemption scheme 1 and exemption scheme 2. They cover different health services.

The following types of treatment and health services are included in exemption scheme 1:

- physician
- psychologist
- out-patient treatment
- X-ray examination

- travel costs
- pharmaceutical products (blue prescription)

The following types of treatment and health services are included in exemption scheme 2:

- examination and treatment by a physiotherapist
- certain types of dental treatment
- stays in approved rehabilitation institutions
- travel abroad for treatment under the auspices of Rikshospitalet University Hospital

The cost ceiling was NOK 2 040 for exemption scheme 1 and NOK 2 620 for exemption scheme 2 in 2013.

SWEDEN: Special regulations apply for the cost ceiling arrangement for pharmaceutical products and health care.

5.3 Health Care Expenditure

Development of health care expenditure

Health plays a central role in peoples' everyday life and is an issue that people are concerned about. Thus, health is often a topic for debate, and health issues receive much attention in the press. Attention is particularly focussed on production of health services. Questions are asked about whether health services are adequate and about what health care costs society and individuals. The increasing cost of health care is an issue of concern in many countries. According to the OECD, the reason for this concern is that health services are mainly publicly financed and so increasing health care expenditure is an extra burden on public budgets and, if priorities are not changed, this will lead to higher taxes for both citizens and companies.

In the Nordic countries, between 75 and 85 per cent of the health care expenditure is publicly financed. In 2010, the level of public financing was lowest in Finland.

Measured in relation to gross domestic product (GDP), health care expenditure has been relatively stable or has shown a slight increase in the second half of the 1990s and the beginning of this century. Health care expenditure represents between 8 and 9 per cent of GDP.

Table 5.3.3 shows health care expenditure per inhabitant, which was highest in Norway and lowest in Greenland.

Changes in the recording of health care expenditure

Health care expenditure includes all expenditure, both private and public, on consumption or investment in health services, etc. The expenditure can be financed by both private and public sources, including by households. Examples of health care expenditure by households are the cost of spectacles, orthopaedic items, pharmaceutical products, dental treatment, medical treatment, physiotherapy services and other health services. Other types of expenditure include national insurance or pri-

vate insurance reimbursements for use of health services, and public expenditure (net) on hospitals and primary health services, etc.

Public expenditure on preventive measures and administration of health services is included. Expenditure on running private hospitals that are not included in the public budget is also included.

Health care expenditure also includes part of the expenditure on nursing and care for elderly people and people with disabilities. According to international guidelines, this applies to the part of expenditure on nursing and care that can be specified as expenditure related to health. Services for elderly people and people with disabilities are often integrated, and it can be difficult to draw clear boundaries between what should be defined as expenditure on health services and what should be defined as expenditure on social services. What is included as expenditure on health services can vary for the different countries.

There will always be such problems when one compares statistics from several countries. This does not mean that comparisons are worthless, but one must be aware that some of the observed differences can be the result of different definitions and boundaries.

In order to ensure the best possible comparability of statistics, international organizations such as the OECD, the UN and EUROSTAT work on producing classifications, standards and definitions. The OECD have for example developed "A System of Health Accounts". This accounting system has been developed in order to meet the political needs for data, and also the needs of researchers in this area. The common framework that the system is built on will ensure that the comparability of data between countries and over time is as good as possible. The system is also developed to provide comparable statistics, independently of how health services are organized in the countries.

All the Nordic countries have implemented, or are in the process of implementing, OECD's system of health accounts, and the Figures presented in this publication are based on this system. Not all the countries have come equally far in implementing the system, but at the aggregated level on which the data are presented here, the data are assessed as being comparable. However, the unsolved problems faced by the countries, and the different solutions they have found, must be taken into account when interpreting the data. For example, the reason that per capita health care expenditure in Finland is 30 per cent lower than in the other countries, may be because the boundary for what is included as health care expenditure on care of the elderly may be different from that in the other countries. At the same time, Table 5.3.3 shows that health care expenditure per capita in Norway is substantially higher than in the other countries. It is important to be aware of the fact that OECD's system of health accounts and EUROSTAT's ESSPROS system are very different. Thus data on health care expenditure from these two sources are very different. EUROSTAT data are published by NOSOSCO in the publication Social Protection in the Nordic Countries.

ESSPROS includes all social arrangements, both public and private. The statistics include pension schemes, insurance schemes, humanitarian organizations and other

charitable organizations. Insurance schemes are included if they are collective. This means that expenditure on health also includes sickness benefits (or salary paid during sickness) including sickness benefits paid by employers. These cash payments are not included in OECD's system, in which only expenditure on actual health services is included.

Table 5.3.1 Total health care expenditure (million KR/EUR) 2011

	Denmark	Faroe Islands ¹⁾	Greenland	Finland ²⁾	Iceland	Norway	Sweden
	DKK	DKK	DKK	EUR	ISK	NOK	SEK
Public financing	158 934	..	1 180	12 244	118 404	208 650	255 056
Private financing	28 609	..	-	4 022	28 915	37 163	57 558
Total health care expenditure	187 543	998	1 180	16 266	147 318	245 813	312 614

1 2009

2 Finnish data include Åland

Sources: OECD HEALTH DATA. FO: Statistics Faroe Islands; G: Directorate of Health

Table 5.3.2 Total health care expenditure (EUR/capita) 2011

	Denmark	Faroe Islands ¹⁾	Greenland	Finland ²⁾	Iceland	Norway	Sweden
Public financing	3 832	..	2 797	2 272	2 285	5 405	2 989
Private financing	690	..	-	746	558	963	675
Total health care expenditure	4 522	2 761	2 797	3 019	2 843	6 368	3 664

1 2009

2 Finnish data include Åland

Sources: OECD HEALTH DATA. FO: Statistics Faroe Islands; G: Directorate of Health

Table 5.3.3 GDP and health care expenditure in total and per capita, 2000-2011

	Denmark ¹⁾	Faroe Islands	Greenland	Finland ²⁾	Iceland	Norway	Sweden
	DKK	DKK	DKK	EUR	ISK	NOK	SEK
Total expenditure per capita 2011	33 689	20 571	20 843	3 019	458 935	49 628	33 084
GDP (million) 2011	1 791 518	..	12 295	189 489	1 631 969	2 749 963	3 499 914
Expenditure in 2011 prices (million)							
2000	138 883	..	..	10 874	110 265	180 642	213 678
2005	166 086	939	..	14 215	138 723	220 033	270 325
2010	189 050	..	1 140	15 770	147 043	246 199	302 497
2011	187 543	..	1 180	16 266	147 318	245 813	312 614
Expenditure as a percentage of GDP							
2000	8.3	8.5	8.9	6.9	9.3	7.8	7.8
2005	9.3	8.7	8.8	8.0	9.4	8.5	8.7
2010	10.7	..	9.2	8.6	9.3	9.1	9.0
2011	10.5	..	9.0	8.6	9.0	8.9	8.9

1 Changes in method of calculation from 2003 for Denmark, from 2000 for Norway and from 2001 for Sweden

2 Finnish data include Åland

Sources: OECD HEALTH DATA. FO: Statistics Faroe Islands; G: Directorate of Health

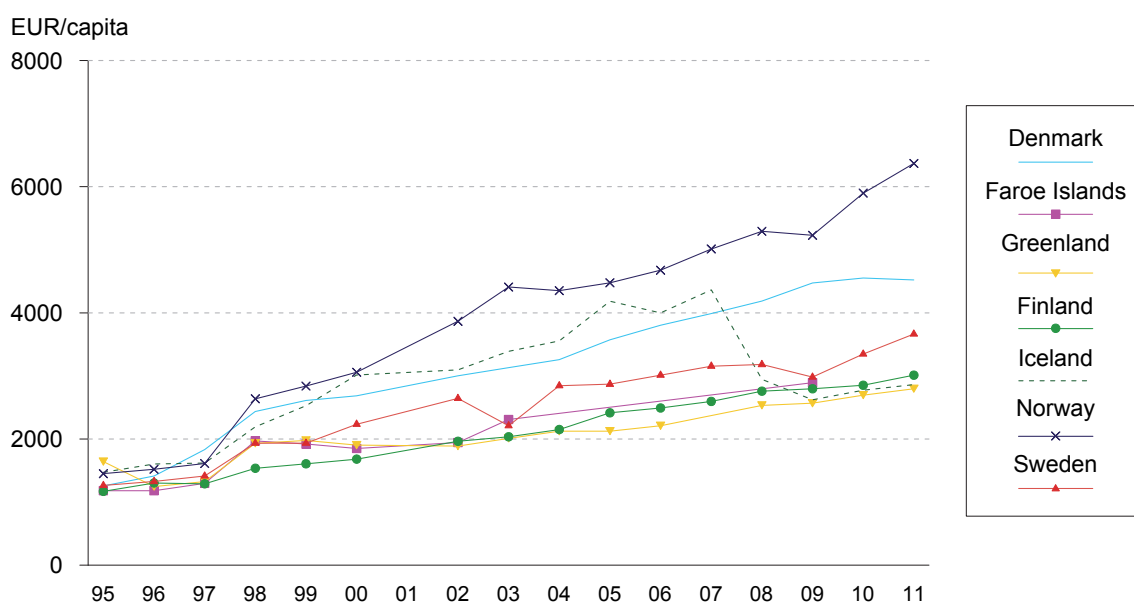
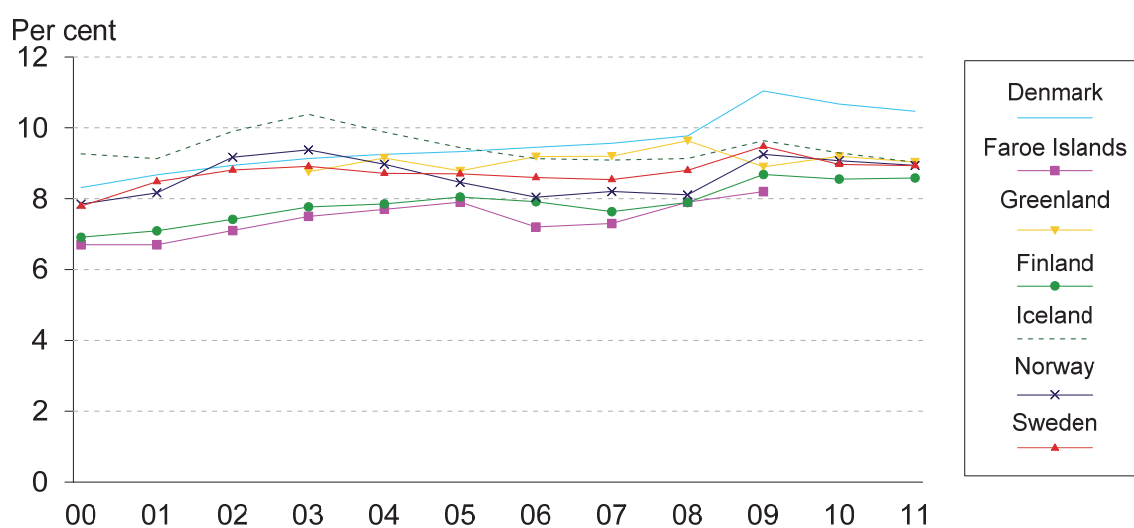
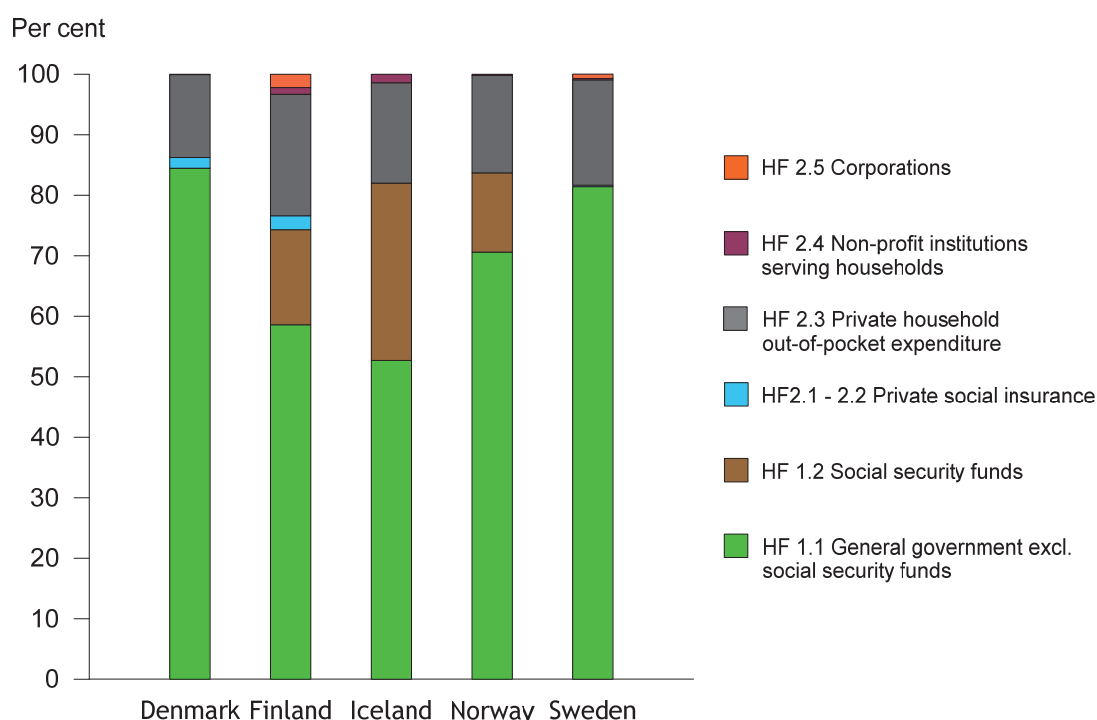
Figure 5.3.1 Total health care expenditure (EUR/capita) 1995-2011**Figure 5.3.2 Health care expenditure as a percentage of GDP 2000-2011**

Figure 5.3.3 Health care expenditure by financing agent, 2010 per cent

Source: OECD Health Data 2013

5.4 Health Care Personnel

For many years, it has been difficult to obtain comparable data about health care personnel in the Nordic countries, because the sources for the data have been very different.

Therefore, in 2003, NOMESCO appointed a working group to obtain more comparable data, and to define health care personnel in the way that it is done for the health economy in OECD's "A System for Health Accounts".

For this purpose, it has been found to be most appropriate to use NACE's classification of occupations, linked to the registers of authorization for health care personnel. These registers are more comparable, though the data are still incomplete and there are some inaccuracies.

With the new definitions and groups, data on health care personnel for previous years (before 2004) are not comparable with more recent data, since data for new groups of health care personnel are included.

It should be noted that the group 'qualified auxiliary nurses' is now subdivided. Those with an education of at least 18 months remain in this group, while those with an education of less than 18 months are included in the group 'other health care personnel'. Since Sweden only has data for employees in the public service, data for these categories are not included. 'Other health care personnel with a higher education' is defined as personnel with a university degree, such as dieticians and pharma-

cists. Furthermore, for physicians a group is included with physicians who do not work in the social and health care sectors, and not with medicine.

Besides, the included data are registered at a given time of the year.

Table 5.4.1 Employed health care personnel in health and social services, 2011 (NACE 85.1 and 85.3)

	Denmark ¹⁾	Faroe Islands	Greenland	Finland ¹⁾	Åland	Iceland ²⁾	Norway	Sweden ⁴⁾
Physicians	19 173	107	96	16 300	82	1 120	20 744	35 374
Dentists	4 333	39	28	3 990	25	283	4 380	7 548
Dental hygienists	1 459	0	80	1 480	12	15	957	3 805
Dental surgery assistants	4 548	44	27	..	22	320	3 348	..
Psychologists	4 794	24	2	3 330	10		4 453	5 432
Qualified nurses	55 342	388	251	58 080	369	2 765	81 238	99 358
Radiographers	1 437	9		2 700	7	118	2 629	3 367
Qualified auxiliary nurses	35 365	131	151	72 820	519	1 963 ³⁾	67 009	..
Other health care personnel	59 191	60	84	68 720	48	-	157 492	..
Midwives	1 644	23	19	2 170	18	278 ³⁾	2 652	6 843
Physiotherapists	8 104	19	15	8 060	28	470	8 960	11 529
Occupational therapists	5 826	7	4	..	8	213	2 755	8 131
Hospital laboratory technicians	5 611	38	6	5 280	22	299	4 798	..
Other health care personnel with a higher education	626	-		18 860	24	-	5 774	..

1 2010

2 Physicians licensed to practice in Iceland, up to 70 years old at end of year, with permanent residence and registered domicile in Iceland

3 Prognosis

4 November 2009

Sources: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: THL; Å: The Åland Government; I: Directorate of Health; N: Statistics Norway; S: National Board of Health and Welfare

Table 5.4.2 Employed health care personnel in health and social services per 100 000 inhabitants, 2011 (NACE 85.1 and 85.3)

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
Physicians	348	222	169	303	291	353	419	374
Dentists	79	81	50	74	89	89	88	80
Dental hygienists	26	..	140	27	43	5	19	40
Dental surgery assistants	83	91	48	..	78	..	..	..
Psychologists	87	50	4	62	36	..	..	57
Qualified nurses	1 004	805	443	1 078	1 310	871	1 640	1 051
Radiographers	26	19	0	50	25	37	53	36
Qualified auxiliary nurses	642	272	266	1 351	1 842		1 353	
Other health care personnel	1 056	124	148	1 275	170	..	..	..
Midwives	30	48	34	40	64		54	72
Physiotherapists	147	39	26	150	99	148	181	122
Occupational therapists	106	15	8	..	28	67	56	86
Hospital laboratory technicians	102	79	10	98	78	94	97	..
Other health care personnel with a higher education	11	0	0	350	85	..	..	..

1 2010

Sources: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: THL; Å: The Åland Government; I: Directorate of Health; N: Statistics Norway; S: National Board of Health and Welfare

Notes: See Table 5.4.1

**Table 5.4.3 Employed physicians by specialty in health and social services, 2011
(NACE 85.1 and 85.3)**

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland ²⁾³⁾	Norway	Sweden
General practice	4 110	27	50	1 794	18	184	2 496	5 643
Internal medicine	1 509	8	4	1 521	11	150	1 492	4 167
Paediatrics	374	3	2	553	2	53	469	1 312
Surgery	839	5	3	888	3	76	759	1 874
Plastic surgery	93	1	0	91		11	87	145
Gynaecology and obstetrics	502	2	3	660	5	39	548	1 300
Orthopaedic surgery, incl. hand surgery	627	4	3	443	5	39	471	1 254
Ophthalmology	285	3	1	451	2	32	342	685
Ear, nose and throat	320	1	1	355	1	20	283	629
Psychiatry	942	1	3	1 352	6	74	1 389	1 909
Skin and sexually transmitted diseases	152	0	0	193		18	137	352
Neurology	281	0	0	474		16	277	345
Oncology	123	0	4	150	1	15	169	418
Anaesthetics	903	4	4	760	4	57	753	1 501
Radiology	474	3	1	679	2	34	603	1 197
Clinical laboratory specialties incl. pathology	482	1	0	267		36	442	937
Other specialties	156	1	0	958	6	28	573	1 061
Specialists in total	12 172	64	79	11 589	66	882	11 290	24 729
Physicians without specialist authorization	7 001	44	17	4 711	15	238	9 454	10 645
Physicians in total within NACE 85.1 and 85.3	19 173	108	96	16 300	81	1 120	20 744	35 374

1 2010

2 Data based on the register of physicians at the Directorate of Health. The most recent specialty is chosen for those with more than one specialty

3 Physicians licensed to practice in Iceland, up to the age of 70 years at year-end, with permanent residence and registered domicile in Iceland

Sources: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: Finnish Medical Association; Å: The Åland Government; I: Directorate of Health; N: Statistics Norway; S: National Board of Health and Welfare

Table 5.4.4 Employed physicians by specialty in health and social services per 100 000 inhabitants, 2011 (NACE 85.1 and 85.3)

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
General practice	75	56	88	34	64	58	52	60
Internal medicine	27	17	7	29	39	47	31	44
Paediatrics	7	6	4	10	7	17	10	14
Surgery	15	10	5	17	11	24	16	20
Plastic surgery	2	1	0	2	-	3	2	2
Gynaecology and obstetrics	9	4	5	12	18	12	11	14
Orthopaedic surgery, incl. hand surgery	11	8	5	8	18	12	10	13
Ophthalmology	5	6	2	8	7	10	7	7
Ear, nose and throat	6	2	2	7	4	6	6	7
Psychiatry	17	2	5	25	21	23	29	20
Skin and sexually transmitted diseases	3	0	0	4	-	6	3	4
Neurology	5	0	0	9	-	5	6	4
Oncology	2	0	7	3	4	5	4	4
Anaesthetics	16	8	7	14	14	18	16	16
Radiology	9	6	2	13	7	11	13	13
Clinical laboratory specialties incl. pathology	9	2	0	5	-	11	9	10
Other specialties	3	2	0	18	21	9	12	11
Specialists in total	221	131	140	218	234	276	235	264
Physicians in total within NACE 85.1 and 85.3	127	91	30	88	53	75	197	114
	348	223	170	306	287	351	432	377

1 2010

Sources: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: THL; Å: The Åland Government; I: Directorate of Health; N: Statistics Norway; S: National Board of Health and Welfare

Table 5.4.5 Physicians in work, 2011

	Denmark	The Faroe Islands	Greenland	Finland ¹⁾	Åland	Iceland	Norway	Sweden ³⁾
Physicians employed in hospitals (NACE 85.1 and 85.3)	13 218	78	96	8 680	52	817 ²⁾	11 957	..
General practitioners (NACE 85.1 and 85.3)	4 277	27	..	7 080	15	188	5 767	5 634
Of whom working without specialist authorization	371	..	..		14	..	2 716	..
Other physicians working outside hospitals (mainly privately practising specialists) (NACE 85.1 and 85.3)	1 678	1	5	3 340	13	..	3 020	..
Physicians employed in administrative medicine (NACE 75.1)	220	1	..		2	..	399	926
Physicians employed in medical research, teaching etc. (NACE 80.3, 73.1 and 24.4)	858	1	..	324		..	941	1 372
Physicians employed within all other NACE codes	1 241	0	91	1 148	52	..	1 533	1 864

1 2010

2 Total no. of physicians (1120)-Physicians working as general practitioners (188)-Physicians working only in institutions (115)=817

3 2009

Sources: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: THL; Å: The Åland Government; I: Directorate of Health; N: Statistics Norway; S: National Boards of Health and Welfare

5.5 Capacity and Services in the Hospital Sector

For many years, there has been a trend in the Nordic countries towards fewer hospital beds. Resources have been concentrated in fewer units, often involving a division of work in the most specialized areas. Units have often been merged administratively, not necessarily leading to fewer physical units. No hospitals have been closed down in Norway during the last few years, but some of the existing hospitals have become smaller.

Another trend in the Nordic countries is that psychiatric hospitals are being closed down, however, to varying speed.

The structure is, however, somewhat different in Finland, Iceland and Greenland than in the other countries. A number of beds are attached to health care centres, and these beds appear in the tables as beds in "other hospitals". Some of these beds are for care of elderly people, and they are similar to beds in nursing homes and old peoples' homes in the other countries. Particularly for Finland and Iceland, this gives a larger number of beds in relation to the population than in the other countries.

Hospital beds are divided into medical, surgical, psychiatric and other beds. It is clearly indicated that, particularly for Finland and Iceland, the category 'other', includes activities that are not included in the other countries.

The tables on hospital discharges and average length of stay apply to patients admitted to ordinary hospitals and specialized hospitals. This limitation has been done in order to improve comparability between the countries.

The trend is that the number of treatment places and the average length of stay are reduced in ordinary hospitals. Within psychiatric treatment, there has been a trend towards the use of more out-patient treatment, for which reason the number of psychiatric beds has been reduced.

Table 5.5.1 Available hospital beds by speciality, 2011

	Denmark ¹⁾	The Faroe Islands	Greenland	Finland ²⁾	Åland ^{2,3)}	Iceland	Norway	Sweden
<i>Number</i>								
Somatic wards	12 750	193	104	9 227	170	779	14 358	21 204
Psychiatry	2 843	55	12	3 830	23	152	4 517	4 449
Other	.	-	338	16 715	-	128	1 903	-
Total	15 593	248	454	29 772	193	1 059	20 778	25 653
<i>Beds per 100 000 inhabitants</i>								
Somatic wards	229	401	184	172	604	..	288	229
Psychiatry	51	114	21	71	82	..	91	48
Other	.	-	597	312	-	..	38	-
Total	280	515	802	555	685	..	417	276

1 Total number of available beds reported by hospitals/regions per 31 December 2011

2 Number of bed-days divided by 365

3 2007-2011

4 Beds for long-term care in hospitals (health facilities with 24-hour access to hospital physicians)

Sources: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: THL; Å: The Åland Government; N: Statistics Norway; S: Swedish Association of Local Authorities and Regions

Figure 5.5.1 Available hospital beds per 1 000 inhabitants, per 100 000, 2000-2011

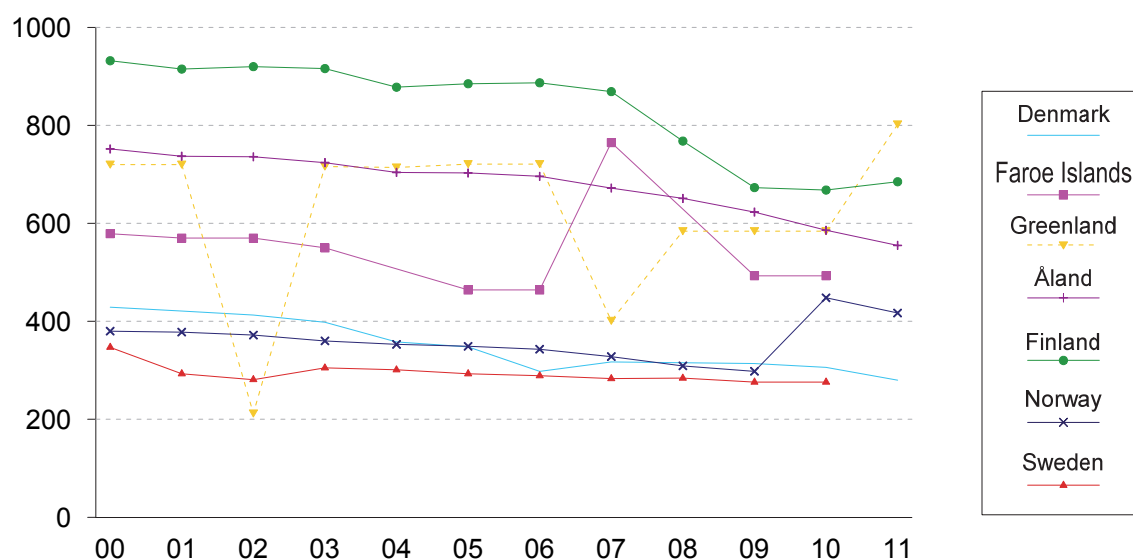


Table 5.5.2 Discharges, bed days and average length of stay in wards in general hospitals and specialized hospitals, 2011

	Denmark ¹⁾	Faroe Islands ²⁾	Greenland ³⁾	Finland	Åland ⁴⁾	Iceland ²⁾	Norway	Sweden
<i>Discharges per 1 000 inhabitants</i>								
Somatic wards	242	210	374	180	175	136	166	510
Psychiatry	9	13	3	8	12	7	8	33
Total	250	224	377	188	187	143	174	543
<i>Bed days per 1 000 inhabitants</i>								
Somatic wards	1 038	1 063	1 297	652 324	3 489	735	755	2 503
Psychiatry	148	291	71	26 434	148	90	124	476
Total	1 186	1 354	1 368	671 623	3 593	825	879	2 979
<i>Average length of stay</i>								
Total	4.3	10.1	4.6	748	889	5.4	4.5	4.9
<i>Discharges per 1 000 inhabitants</i>								
Somatic wards	17.3	22.4	25.8	255	208	12.0	16.0	14.6
Somatic wards	4.7	5.0	4.8	1 004	1 096	5.4	5.0	5.5

1 2010

2 Average 2005-2009

3 Data for average length of stay refer to Dronning Ingrid's Hospital only

4 Average 2007-2011

Sources: The national in-patient registers

Figure 5.5.2 Average length of stay in somatic wards 2000-2011

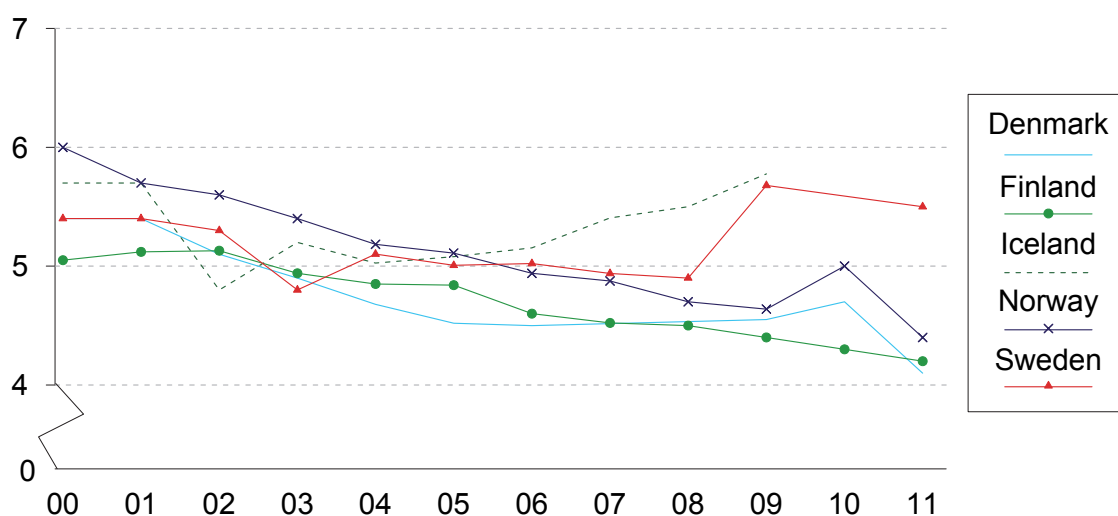


Figure 5.5.3 Number of discharges from somatic wards per 1 000 inhabitants 2000-2011

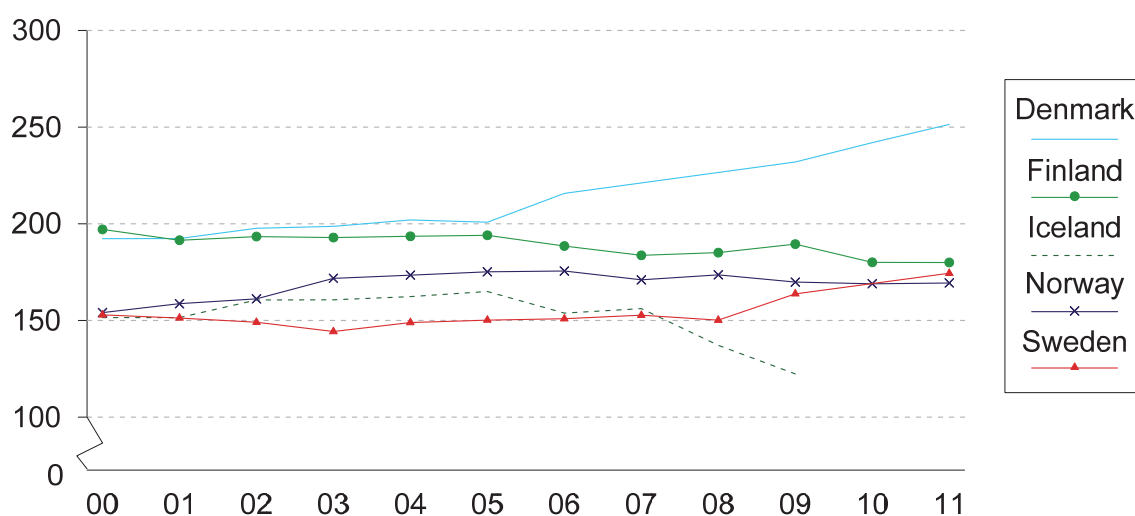


Table 5.5.3 Hospital treatment in psychiatric units by gender and age, 2011

	Denmark ¹⁾	Faroe Islands ²⁾	Finland	Åland	Iceland ²⁾	Norway	Sweden
Discharges, total	47 446	632	41 224	345	2 386	38 043	307 128
Discharges per 1 000 capita	8.6	13.0	8	12	7.5	8	33
Bed-days, total	818 618	14 172	1 378 586	5 864	28 749	607 727	4 491 912
Bed-days per 1 000, total	148	291	255	208	90	124	475
Patients treated, total	24 808	278	26 434	148	1 411	20 498	51 992
Men							
0-14	0.4	..	2.4	0.1	1.5	0.2	0.24
15-29	5.5	..	6.1	9.1	6.2	5.7	6.83
30-44	6.9	..	6.6	6.2	5.8	6.2	7.10
45-64	5.6	..	5.3	8.9	4.8	4.8	8.53
65-79	3.0	..	3.6	4.5	3.5	3.3	4.74
80+	3.7	..	3.5	3.7	1.2	4.2	4.24
I alt	4.5	..	4.9	6.0	4.4	4.2	5.82
Women							
0-14	0.5	..	1.6	0.1	0.8	0.2	0.37
15-29	6.5	..	7.8	7.9	5.7	5.6	7.89
30-44	5.5	..	5.4	4.9	6.1	5.3	6.18
45-64	5.1	..	5.0	5.2	5.2	4.8	6.20
65-79	4.0	..	4.6	5.0	4.7	4.1	4.40
80+	4.1	..	4.0	2.4	1.4	4.7	4.12
I alt	4.4	..	4.9	4.5	4.4	4.1	5.19
Men and Women							
0-14	0.4	..	2.0	0.1	1.2	0.2	0.30
15-29	6.0	..	6.9	8.5	6.0	5.6	7.35
30-44	6.2	..	6.0	5.5	5.9	5.8	6.65
45-64	5.3	..	5.1	7.0	5.0	4.8	7.37
65-79	3.5	..	4.2	4.8	4.2	3.7	4.56
80+	3.9	..	3.8	2.9	1.4	4.5	4.16
I alt	4.5	..	4.9	5.2	4.4	4.2	5.50
Average length of stay per discharge	17.3	22.6	33.4	17.0	..	16.0	14.6

1 2010

2 2009

Sources: The National Patient Registers

Table 5.5.4 Discharges from hospitals* per 1 000 inhabitants by gender and age, 2011

Age	Denmark	Faroe Islands ¹⁾	Finland	Åland ²⁾	Iceland ³⁾	Norway	Sweden
<i>Men</i>							
0-14	213	233	121	87	64	93	141
15-44	110	104	86	48	37	73	61
45-64	240	249	195	113	102	170	146
65-69	412	485	299	227	246	352	279
70-74	520	557	413	315	334	413	364
75-79	683	638	535	375	431	526	495
80+	890	760	659	666	633	721	749
Total	237	227	179	128	97	157	161
<i>Women</i>							
0-14	189	205	94	75	51	77	129
15-44	220	262	168	134	143	158	146
45-64	218	215	179	115	118	148	131
65-69	331	345	239	181	233	274	224
70-74	422	482	330	267	320	320	295
75-79	542	536	445	343	425	399	389
80+	716	556	525	575	516	553	608
Total	266	272	204	165	148	182	191

* Comprises somatic wards in ordinary hospitals and in specialized somatic hospitals

1 2006

2 Average 2007-11

3 2009. Only discharges for stays in hospital shorter than 90 days

Sources: The National Patient Registers

Table 5.5.5 Bed days in hospitals* per 1 000 inhabitants by gender and age, 2011

Age	Denmark	Faroe Islands ¹⁾	Finland	Åland ²⁾	Iceland ³⁾	Norway	Sweden
<i>Men</i>							
0-14	511	626	454	355	214	333	823
15-44	597	514	410	227	148	236	359
45-64	1 029	1 050	928	653	564	730	771
65-69	562	555	467	1 435	1 641	1 789	1 478
70-74	2 316	2 469	2 616	1 909	2 661	2 211	2 016
75-79	3 156	3 268	3 745	2 473	3 827	3 022	2 983
80+	4 297	4 436	6 658	4 907	6 825	4 277	4 931
Total	1 014	998	1 018	754	630	711	930
<i>Women</i>							
0-14	489	618	341	327	164	282	771
15-44	732	896	731	592	365	488	549
45-64	885	1 229	742	633	572	636	659
65-69	1 454	2 330	1 389	1 090	1 543	1 401	1 193
70-74	1 937	3 639	1 901	1 767	2 393	1 755	1 699
75-79	2 646	5 458	3 065	2 223	3 901	2 227	2 431
80+	3 665	7 126	6 446	4 012	5 954	3 270	4 291
Total	1 041	1 508	1 221	932	786	787	1 015

* Comprises somatic wards in ordinary hospitals and in specialized somatic hospitals

1 2006

2 Average 2007-11

3 2009. Only discharges for stays in hospital shorter than 90 days

Sources: The National Patient Registers

Appendix

Further Information on the Bodies Responsible for Statistics in the Nordic Countries

The following bodies responsible for statistics in the Nordic countries can be contacted for further information concerning the statistics in this publication.

Denmark

Statistics Denmark

www.dst.dk

Responsible for:

- Population statistics
- Statistics on alcohol consumption
- Statistics on health care economy

Statens Serum Institut

www.ssi.dk

Responsible for:

- Statistics on births
- Statistics on abortions
- Statistics on malformations
- Statistics on causes of death
- Statistics on hospital services
- Statistics on health care personnel
- Statistics on infectious diseases
- Statistics and information on vaccinations
- Statistics on medicinal products

National Board of Health

www.sst.dk

Responsible for:

- Statistics on the use of tobacco

Faroe Islands

Hagstova Føroya

www.hagstova.fo

Responsible for:

- Population and vital statistics

Chief Medical Officer

www.landslaeknin.fo

Responsible for:

- Statistics on infectious diseases
- Statistics on forensics
- Statistics on births
- Statistics on causes of death

Chief Pharmaceutical Officer

www.apotek.fo

Responsible for:

- Statistics on medicinal products

Ministry of Health Affairs

www.hmr.fo

Responsible for:

- Statistics on health care personnel
- Statistics on hospital services
- Statistics on abortions
- Statistics and information on vaccinations

Statens Serum Institut

www.ssi.dk

Responsible for:

- Statistics on causes of death
- Statistics on health care economy

Greenland

Statistics Greenland

www.stat.gl

Responsible for:

- Population and vital statistics
- Statistics on health care personnel
- Statistics on hospital services
- Statistics on health care economy

National Board of Health

www.nanoq.gl

E-mail: eli@gh.gl

Responsible for:

- Statistics on births
- Statistics on abortions
- Statistics on malformations
- Statistics on infectious diseases
- Statistics and information on vaccinations

Statens Serum Institut

www.ssi.dk

Responsible for:

- Statistics on causes of death
- Statistics on cancer

The Central Pharmacy in Copenhagen County

Responsible for:

- Statistics on medicinal products

The Department of Health & Infrastructure

Responsible for:

- Statistics on hospital services
- Statistics on health care economy
- Statistics on health care personnel

Finland

Statistics Finland

www.stat.fi

Responsible for:

- Population and vital statistics
- Statistics on causes of death
- Statistics on road traffic accidents

National Institute for Health and Welfare (THL)

www.thl.fi

Responsible for:

- Register of Institutional Care
- Medical Birth Register and ART statistics
- Register of Abortions and Sterilizations
- Statistics on health care personnel
- Statistics on public health care
- Statistics on private health care
- Statistics on labour force in health care
- Statistics on the use of alcohol and drugs
- Statistics on the use of tobacco
- Statistics on health care expenditure
- Definitions and classifications in health care

	• Statistics on primary health care • Register of Infectious Diseases • Register of Coronary Heart Disease and Stroke • Statistics and information on vaccinations • Survey on health behaviour among adults and elderly • Public Health Report
National Agency for Medicines (FIMEA) www.fimea.fi	Responsible for: • Registration of medicinal products and sales licences • Register on Adverse Drug Reactions • Statistics on pharmacies
Social Insurance Institution of Finland (FPA) www.kela.fi	Responsible for: • Sickness insurance benefits and allowances, reimbursements for medicine expenses, and disability pensions
Finish Centre for Pensions Website: www.cancer.fi	Responsible for: • Statistics on cancer
Finish Centre for Pensions (ETK) www.etk.fi	Responsible for: • Pensions due to reduced capacity for work
<i>Åland</i>	
The Åland Government www.regeringen.ax	Responsible for: • Statistics on health care personnel • Statistics on hospital services, such as capacity (no. of beds) • Statistics on health care economy - regarding charges within health care
Statistics Finland National Institute for Health and Welfare National Agency for Medicines Finnish Cancer Registry Social Insurance Institution of Finland	See Finland

Iceland

Hagstofa Íslands www.statice.is	Responsible for: • Population and vital statistics • Statistics on causes of death • Statistics on alcohol consumption • Statistics on health care expenditure • National accounts
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Directorate of Health
www.landlaeknir.is

Responsible for:

- Medical statistics on births
- Statistics on abortions
- Statistics on sterilizations
- Statistics on primary health care
- Statistics on hospital services
- Statistics on infectious diseases
- Statistics on vaccinations
- Statistics on health care personnel
- Statistics on use of tobacco

Icelandic Medicines Control Agency
www.imca.is

Responsible for:

- Statistics on pharmaceutical products

Icelandic Cancer Register
 Website: www.krabb.is

Responsible for:

- Statistics on cancer

Norway

Statistics Norway
www.ssb.no

Responsible for:

- Population and vital statistics
- Statistics on causes of death
- Statistics on health and social conditions
- Statistics on health and social services
- Statistics on health care personnel
- Statistics on alcohol consumption
- Statistics on health care economy
- Statistics on use of tobacco

Norwegian Institute of Public Health
www.fhi.no

Responsible for:

- Statistics on sexually transmitted diseases and infectious diseases
- Statistics on tuberculosis
- Statistics on immunization
- Statistics on sale of medicinal products
- Statistics on prescribed drugs
- Statistics on births and infant deaths
- Statistics on induced abortions

Norwegian Directorate of Health
www.helsedirektoratet.no

Responsible for:

- Statistics on hospital services

Cancer Registry of Norway
www.kreftregisteret.no

Responsible for:

- Statistics on cancer

Ministry of Health and Care Services
www.regjeringen.no/en/dep/hod

Responsible for:

- Statistics on in vitro fertilization

Sweden

Statistics Sweden

www.scb.se

Responsible for:

- Population and vital statistics
- Statistics on health care economy

National Board of Health and Welfare

www.socialstyrelsen.se

Responsible for:

- Statistics on births
- Statistics on abortions
- Statistics on in-patients
- Statistics on cancer
- Statistics on causes of deaths
- Statistics on prescribed drugs

Swedish Institute for Infectious Disease Control

www.smittskyddsinstitutet.se

Responsible for:

- Statistics on infectious diseases
- Statistics and information on vaccinations

National Corporation of Swedish Pharmacies

www.apoteket.se

Responsible for:

Statistics on drug sales and prescribed drugs

Swedish Association of Local Authorities and Regions

www.skl.se

- Swedish Association of Local Authorities and Regions

NOMESCO's Publications since 2000

Recurring Publications

Each year, NOMESCO publishes the *Helsestatistik for de Nordiske lande*. Up until and including 2011, this was a bi-lingual publication in Danish (Nordic languages) and English with the title *Health Statistics in the Nordic Countries*. From 2012, the English and the Danish versions will be published separately.

Key tables from Health Statistics in the Nordic Countries have been gathered in a booklet each year.

In cooperation with the Nordic Centre for Classification of Health Services (Nordclass), NOMESCO publishes NOMESCO Classification of Surgical Procedures. The publication has been updated annually for a number of years and is now available in version 1.16.

In cooperation with the Baltic countries, the publication Nordic/Baltic Health Statistics has been published four times, the latest version with data from 2006.

Moreover, a number of theme publications have been published. These are shown below with their number in NOMESCO's publication list.

58. Nordiske læger og sygeplejersker med autorisation i et andet nordisk land. Copenhagen 2000.
67. Sustainable Social and Health Development in the Nordic Countries. Seminar 27th May 2003, Stockholm. NOMESCO, Copenhagen 2003
72. Medicines Consumption in the Nordic Countries 1999-2003. NOMESCO, Copenhagen 2004.
76. Smedby, Björn and Schiøler Gunner: Health Classifications in the Nordic Countries. Historic development in a national and international perspective 2006. NOMESCO, Copenhagen 2006
78. Sustainable Social and Health Development in the Nordic Countries. Seminar, 6th April 2006, Oslo. Seminar Report. NOMESCO, Copenhagen 2006
79. NOMESCO Classification of External Causes of Injuries. Fourth revised edition. NOMESCO, Copenhagen 2007
88. Medicines Consumption in the Nordic Countries 2004-2008. NOMESCO, Copenhagen 2010
90. Temasektion vedrørende kvalitetsindikatorer, NOMESCO's Helsestatistik for de Nordiske lande 2009, NOMESCO, Copenhagen 2010
92. NOMESCO Report on Mortality Statistics - Theme section 2010, NOMESCO, Copenhagen 2010
98. Hälso- och sjukvårdens finansiering i Norden, NOMESCO 2013