

Health Statistics in the Nordic Countries 2005
Helsestatistik for de nordiske lande 2005

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Preface

Forord

The aim of NOMESCO is partly to establish a basis for comparable medical statistics in the Nordic countries, partly to initiate development projects of relevance to medical statistics, and to follow international trends in questions of medical statistics.

In this publication NOMESCO presents the latest available data from the health statistics of the Nordic countries.

This web version of the publication includes all the detailed statistics, whilst the book version only includes key statistics with time series, represented graphically and with standardized rates for the most important statistics.

Section B deals with Mental Health.

On the NOMESCO homepage at www.nom-nos.dk you will find, as mentioned above, a more extensive web version as a pdf. file, and additional information, including an interactive database and detailed data on hospital discharges, patients treated, procedures, new cases of cancer and causes of death.

*Nordic Medico-Statistical Committee
(NOMESCO)*

Målsætningen for NOMESKO er dels at skabe grundlag for sammenlignelig medicinalstatistik i de nordiske lande, dels at tage initiativ til udviklingsprojekter med medicinalstatistisk relevans og endelig at følge den internationale udvikling i medicinalstatistiske spørgsmål.

I denne publikation offentliggør NOMESKO de senest tilgængelige data fra de nordiske landes sundhedsstatistik.

Denne web-version af publikationen indeholder alle de detaljerede statistiske oplysninger, mens bogudgaven kun medtager de mest centrale oplysninger med tids-serier fremstillet grafisk og med standardiserede rater på de mest centrale områder.

Sektion B er et tema om mental helse.

På NOMESKO's hjemmeside på www.nom-nos.dk findes der som nævnt en udvidet bogudgave som pdf. fil og supplerende informationer, blandt andet en interaktiv database samt detaljerede data om udskrivninger, patienter behandlet, procedurer, nye tilfælde af cancer og dødsårsager.

*Nordisk Medicinalstatistisk Komité
(NOMESKO)*

SECTION A

Health Statistics 2005
Helsestatistik 2005

CHAPTER I

Organization of health services Organiseringen af sundhedsvæsenet

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Introduction

In the Nordic countries, the health services are a public matter.

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

The countries generally have well-developed hospital services with 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 compulsory health insurance schemes.

In all countries, however, there are some patient charges for treatment and pharmaceutical products.

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

1.1. Current and future changes in the health services

DENMARK: In order to increase activity in health services and to reduce waiting times for examination and treatment, the Danish

Indledning

I de nordiske lande er sundhedsvæsenet et offentligt anliggende.

Alle landene har et veletableret primært sundhedsvæsen. Som supplement til den almindelige lægepraksis er der iværksat forebyggende initiativer over for mødre og spædbørn og etableret skolesundhedsordninger og skoletandplejeordninger for børn og unge. Der er ligeledes etableret forebyggende bedriftssundhedstjenester og almindelige foranstaltninger til miljøbeskyttelse i alle landene.

Som helhed har landene et veludbygget sygehusvæsen med en højt udviklet specialistbehandling.

Speciallægebehandling tilbydes også uden for sygehusene.

Ydelserne i sundhedsvæsenet gives i henhold til love, og de fleste af dem er offentligt finansieret eller finansieret gennem lovpligtige sygeforsikringsordninger.

Der skal dog erlægges en vis egenbetaling for lægemidler og i en vis udstrækning også for behandling.

Under sygdom får lønmodtagere enten udbetalt en kontantydelse eller løn. Selvstændige erhvervsdrivende har mulighed for at forsikre sig ved sygdom.

1.1. Igangværende og kommende ændringer i sundhedsvæsenet

DANMARK: For målrettet at øge aktiviteten i sundhedsvæsenet og nedbringe ventetiderne til undersøgelse og behandling

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Government allocated an extra DKK 8.1 billion to health services in the period 2001 to 2005. From 2001 to 2007 an extra DKK 10.9 billion has been earmarked. Increased activity has been combined with extra choices for patients. Among other things, it is now possible for patients to receive treatment at a private hospital or a hospital abroad that has a contract with the public authorities, when waiting time for treatment at a public hospital is longer than two months. From 2007, patients will have the possibility to receive treatment at a private hospital when they have waited more than one month.

These measures have had a considerable effect. From 2001 to 2005, the number of people who have received treatment in somatic hospitals has increased by 363 000. During the period 2001 to 2005, the number of people who have had an operation has increased by 96 000. Waiting times have been reduced from 27 weeks to 20.6 weeks for 18 major surgical procedures from July 2002 to July 2006. During the period 1 July 2002 to the end of June 2006, 98.000 patients have chosen to make use of their extended right to free choice of hospital.

At the beginning of 2007, the new Danish regions were formed. The aim is to establish conditions under which the health sector can improve further. Great effort has been made to improve the efficiency of the Danish health sector, so that more patients can be treated and waiting times can be shortened. Continuously new specific initiatives are created. The result has been significant and noticeable improvements in the Danish health sector.

har regeringen i perioden 2001 til 2005 tilført knap 8,1 mia. DKK ekstra til det danske sundhedsvæsen. Fra 2001 til og med 2007 er der afsat i alt 10,9 mia. DKK. ekstra. Den øgede aktivitet er kombineret med flere valgmuligheder for patienterne. Blandt andet har patienterne fået mulighed for at søge behandling på et privat sygehus eller et sygehus i udlandet, der har indgået aftale med det offentlige, når ventetiden til de offentlige sygehuse overstiger 2 måneder. Fra 2007 vil patienternes mulighed for at søge behandling på et privat sygehus indtræde efter 1 måneds ventetid.

Indsatsen har haft en betydelig effekt. Fra 2001 til 2005 er antallet af personer, som har modtaget behandling i det somatiske sygehusvæsen, øget med 363.000. I perioden 2001 til 2005 er antallet af personer, der har fået foretaget en eller anden form for operation, øget med ca. 96.000. Ventetiderne er reduceret fra ca. 27 uger til ca. 20,6 uger for 18 vigtige operationer fra juli 2002 til juli 2006. I perioden fra den 1. juli 2002 til udgangen af juni 2006 har ca. 98.000 patienter valgt at benytte muligheden for udvidet frit sygehusvalg.

De nye og større regioner, der blev etableret den 1. januar 2007, skaber rammerne for sundhedsvæsenet, og det skal give bedre mulighed for at forbedre sundhedssektoren yderligere. Der er fokus på at forbedre effektiviteten af den danske sundhedssektor således, at flere behandles og ventetiden forkortes. Der bliver løbende sat konkrete initiativer i gang, der har givet markante og mærkbare resultater i det danske sundhedsvæsen.

In October 2006 the Ministry of the Interior and Health and the National Board of Health launched a homepage www.sundhedskvalitet.dk. The homepage gives access to a lot of comparable information about quality and services at the public hospitals and the ten biggest private hospitals. The aim of the homepage is to help patients with their free choice of hospital, and to motivate hospital staff to improve the quality of the services provided.

Productivity in the health care sector is continuously measured by the Ministry of the Interior and Health, the Ministry of Finance, the Danish Regions, and the National Board of Health. Measurement of productivity is a key instrument to ensure the optimal allocation of resources. The hospitals and regions have used the measures both internally and externally to evaluate performance and to learn from others. Nationwide, productivity in the health care sector has increased by 1.8 per cent from 2004 to 2005.

In 2007 there will be increased focus on the lifestyle of the Danish population. Smoking and physical activity are the main parameters for the health of the Danes. On the initiative of the government, the KRAM Study has been established (food, smoking, alcohol and exercise). The KRAM Study is a population survey of the health status of the Danish population with great emphasis on physical activity and physical fitness.

In June 2006 the revised Mental Health Act was adopted, and came into force on 1 January 2007. The aim of the changes in the legislation was to improve legal safeguards for people who receive mental

Indenrigs- og Sundhedsministeriet og Sundhedsstyrelsen åbnede i oktober 2006 hjemmesiden www.sundhedskvalitet.dk. Hjemmesiden giver adgang til en lang række sammenlignelige oplysninger om kvaliteten og servicen på de enkelte offentlige og de ti største private sygehuse. Formålet med lanceringen af hjemmesiden har været at understøtte patienternes frie sygehusvalg samt at give sygehuspersonalet en tilskyndelse til at forbedre og udvikle kvaliteten.

Der gennemføres løbende opgørelser af produktiviteten i sygesektoren af Indenrigs- og Sundhedsministeriet, Finansministeriet, Danske Regioner og Sundhedsstyrelsen. Produktivitetsopgørelser er et centralt redskab til at sikre den bedst mulige ressourceallokering. Disse målinger er blevet anvendt aktivt både internt og eksternt på sygehuse og i regionerne til at evaluere præstationer og lære af andre. Produktiviteten er på landsplan steget med 1,8 pct. fra 2004 til 2005.

I 2007 sættes der ekstra fokus på danskernes livsstil. Sammen med rygning er fysisk aktivitet den væsentligste faktor for danskernes sundhed. Regeringen har taget initiativ til KRAM-undersøgelsen (Kost, Rygning, Alkohol og Motion). KRAM-undersøgelsen er en befolkningsundersøgelse af danskernes sundhed med speciel vægt på fysisk aktivitet og kondition.

I juni 2006 blev lovforslaget om psykiatri-loven vedtaget og blev hermed ændret fra den 1. januar 2007. Formålet med lovændringen er at styrke retssikkerheden og retsstillingen for de mennesker,

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health care in Denmark. More than 30 sections in the Act have been changed. The legal safeguards of clients have been strengthened in the following ways: the introduction of obligatory follow-up consultations for clients who have received compulsory treatment, the appointment of patient counsellors when compulsory treatment is provided, increased medical supervision of patients with physical restraint, and external medical control of measures of restraint.

In 2002, the government appointed a Structure Commission to make a proposal for an improved and simpler organization of the public sector for the benefit of the population. The Commission submitted its report in January 2004. The Commission proposed a range of possible models for the structure of the public sector. Common to all the models is the recommendation that the present administrative units should be larger in order to ensure that sufficient professional resources are available for the tasks that need to be performed.

The government's plan for the Structure Reform was presented in June 2004. For the health services this meant that the counties were replaced by five new regions from 1 January 2007. At the same time the number of municipalities was reduced from 271 to 98. The municipalities and the regions have a duty to cooperate with each other in coordinating treatment, training, prevention and care. An example of this is that the municipalities have taken over responsibility for prevention and rehabilitation. For health services, the regions are financed partly through block grants and activity based grants from the state and partly

der behandles i den danske psykiatri. Psykiatriloven er i alt ændret på mere end 30 punkter. Patienternes retsstilling styrkes gennem obligatoriske eftersamtaler for patienterne efter ethvert tvangsindgreb, beskikkelse af patientrådgiver ved tvangsindgreb, øget lægeligt tilsyn til langvarigt bæltefikserede patienter og en ekstern lægelig efterprøvelse af indgrebet.

Regeringen nedsatte i 2002 en Strukturkommission, der skulle beskrive forslag til en bedre og mere enkel indretning af den offentlige sektor til gavn for borgerne. Kommissionen afgav sin betænkning i januar 2004, hvori en række mulige modeller blev opstillet for den offentlige sektors struktur. Fælles for modellerne er anbefalingen af, at de nuværende forvaltningsenheder bliver større med henblik på at sikre en tilstrækkelig faglig bæredygtighed i opgaveløsningen mv.

I juni 2004 forelå regeringens aftale om strukturreformen. For sundhedsområdet kom den til at betyde, at amterne blev erstattet af fem nye regioner med virkning fra den 1. januar 2007. Samtidig blev antallet af kommuner reduceret fra 271 til 98 kommuner. Kommuner og regioner forpligtes til at samarbejde om sammenhæng i behandling, træning, forebyggelse og pleje. Dette sker bl.a. ved, at kommunerne har overtaget ansvaret for forebyggelse og genoptræning. På sundhedsområdet bliver regionerne finansieret gennem dels et bloktilskud og et aktivitetsbaseret tilskud fra staten, dels et kommunalt bidrag. Det kommunale bi-

through a contribution from the municipalities. The contribution from the municipalities consists of a fixed grant per inhabitant plus a grant dependent on activity. Altogether, the reform means that the municipalities have been given a larger role in supplying health services.

The Liberal/Conservative Government's programme from February 2005 contains seven aims in the area of health. These include making waiting times shorter, developing a new action plan for cancer, and extending free choice of hospital by reducing the waiting time limit from two months to one month before private hospitals and hospitals abroad can be used. In addition, focus is directed at openness and transparency in health services, reorganization of specialist training, prevention of disease by improving lifestyle, and improvement of treatment of elderly patients.

FAROE ISLANDS: No new acts in the area of health have come into force, no changes have been made to existing acts, and no organizational changes have been made during 2006.

FINLAND: Part-time sickness benefit has been introduced as a voluntary arrangement between employees and employers. An employee or a self-employed person has the possibility to work part-time, and at the same time to receive part-time sickness benefit, when a period of sickness, for which the person is entitled to sickness benefit, lasts for at least 60 days. The aim of part-time sickness benefit is to help people to return to work after a long period of sickness. Their return to work shall take place in a way that does not represent a health risk for them. A

drag består dels af et fast tilskud pr. indbygger samt et aktivitetsafhængigt tilskud. Samlet indebærer reformen, at kommunerne tildeles en større rolle i sundhedsvæsenet.

Regeringsgrundlaget for VK-regeringen II fra februar 2005 indeholder syv målsætninger på sundhedsområdet. Disse koncentrerer sig blandt andet om forkortelsen af ventetider, en ny kræftbehandlingsplan og styrkelsen af det frie valg gennem nedsættelse af ventetidsgrænsen fra 2 til 1 måned, før private eller udenlandske sygehuse kan benyttes. Derudover sættes der fokus på øget åbenhed og gennemsigtighed i sundhedsvæsenet, omlægning af speciallægeuddannelsen, forebyggelse af folkesygdomme gennem forbedret livsstil og forbedringer i behandlingen af ældre medicinske patienter.

FÆRØERNE: Der er i løbet af 2006 ikke vedtaget nye love eller ændringer i love på sundhedsområdet og der blev heller ikke foretaget organisatoriske ændringer.

FINLAND: Der er indført delvis sygedagpenge som en frivillig ordning mellem arbejdstagere og arbejdsgivere. En arbejdstager eller en selvstændig erhvervsdrivende har mulighed for at arbejde på deltid samt modtage delvis sygedagpenge når en sygedagpengeperiode er på mindst 60 dage hvori man er berettiget til sygedagpenge. Formålet med delvis sygedagpenge er at støtte personers tilbagevenden til arbejde efter en længere sygeperiode. Tilbagevenden til arbejdet skal ske på en sådan måde at det ikke er nogen helbredsrisiko for den enkelte. En

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condition for ensuring that the person involved is able to adapt some of his or her work without risking his or her health, is that work time and salary are reduced by 40-60 per cent.

From July 2007 smoking is forbidden in all restaurants and cantines. However, smoking rooms are allowed, in which food and drinks are not allowed to be served.

ÅLAND: From 1 February 2007, smoking is forbidden in all restaurants and cantines. However, smoking is allowed in separate smoking rooms that are specially adapted for this purpose. The size of smoking rooms shall be at least 7 square metres. It is not compulsory for restaurants to have a smoking room. Serving of food and drink is not allowed in smoking rooms.

ICELAND: The Icelandic Parliament has passed a law which requires all bars and restaurants in Iceland to be smoke-free by 1 June 2007.

From 1 January 2006, the administration of all primary health care centres in the Capital area was merged to become the Primary Health Care of the Capital Area. The unit encompasses fifteen primary health care centres and eight specialized centres.

A register of primary health care data has been established at the Directorate of Health in Iceland. A minimum data set for primary health care, defined by the Directorate of Health, has been in effect since 2002. From 2005, all data from primary health care centres in the country has been collected electronically and in accordance with the defined minimum data set.

forudsætning for at den pågældende skal kunne passe en del af sine arbejdsopgaver uden helbredet sættes over styr er at arbejdstiden og lønnen bliver reduceret med 40-60 pct.

Fra 1. juli 2007 er det desuden forbudt at ryge i alle restauranter og kantiner. Der kan dog indrettes ryge rum hvori der ikke må serveres mad og drikke.

ÅLAND: Fra og med 1. februar 2007 er det forbudt at ryge i alle restauranter og kantiner. Rygning er dog tilladt i et separat rygerum der indrettes specielt til dette formål. Rygerummet skal være på mindst 7 kvadratmeter, men restauranterne afgør selv om de vil indrette et specielt rygerum. I rygerummet er det ikke tilladt at servere mad og drikke.

ISLAND: Det islandske parlament har vedtaget en ny lov som medfører at alle barer og restauranter skal være rygefri fra og med den 1. juni 2007.

Fra den 1. januar 2006 blev administrationen for det primære sundhedsvæsen i hovedstadsområdet sammenlagt til en enhed. Enheden består af 15 centre for det primære sundhedsvæsen (almen praksis) samt 8 centre for specialistbehandling.

Der er blevet etableret et register for det primære sundhedsvæsen i medicinaldirektoratet. I registeret findes der et minimumsdatasæt for det primære sundhedsvæsen, der er defineret af direktoratet og har fungeret siden 2002. Fra begyndelsen af 2005 er alle data fra det primære sundhedsvæsen blevet indsamlet elektronisk i overensstemmelse med kravene i minimumsdatasættet.

A new act on health services will come into force on 1 September 2007, replacing the act from 1990. The new act reflects the structural and functional changes that have taken place in the Icelandic health care system.

1. september 2007 træder en ny lov i kraft som erstatter loven fra 1990. Den nye lov tager hensyn til de strukturelle og funktionelle ændringer der har fundet sted i det islandske sundhedssystem.

A new Act Relating to the Medical Director of Health will also come into force on 1 September 2007. This is the first such act, since the Directorate of Health was formerly covered by a regulation dating back to 1973.

Der kommer ligeledes en ny lov for Sundhedsdirektoratet den 1. september 2007. Det er den første lov på området, idet direktoratet tidligere er reguleret via forordninger der går tilbage til 1973.

The new act defines the role of the Medical Director of Health more clearly, and provides an undisputable legal basis for several registers that are operated under his auspices.

Loven definerer sundhedsdirektoratets rolle herunder indiskutable regler for flere af de register der hører under direktoratets område.

NORWAY: During 2006 no new acts or changes to acts in the field of health came into force. No changes to the organization of health services were made.

NORGE: Der blev i løbet af 2006 ikke vedtaget nye love eller ændringer i love på sundhedsområdet og der blev heller ikke foretaget organisatoriske ændringer.

SWEDEN: In February 2007, the "Committee on the Division of Public Responsibilities" presented its final report on the evaluation of the structure and distribution of tasks of the organisation of society. The report has been sent out for comments.

SVERIGE: I februar 2007 afleverede "ansvarskommiteen" sin endelige betænkning vedrørende en vurdering af om strukturen og opgavefordelingen inden for "samhällsorganisationen". Betænkningen er sendt ud til høring.

A proposal for changes to the legislation relating to the running of hospitals was presented in February 2007. A proposal for increased subsidies for dental treatment for adults was presented in march 2007. Work has begun to coordinate and implement a national IT strategy.

I februar 2007 kom et lovforslag om driftsformerne for sygehusene, i marts 2007 kommer der et forslag om forbedrede tilskud til tandbehandling for voksne. Desuden er arbejdet med at samordne og siden gennemføre en national IT-strategi påbegyndt.

In the report about patient data, a new act is proposed that allows personal data to be registered in a database that others have access to, under certain conditions.

I udredningen af patientdata foreslås der en ny lov der gør det muligt at behandle persondata i et datasystem, som andre behandler, under visse forudsætninger

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A final report will be published in the middle of 2007.

får adgang til. Der kommer en endelig betænkning medio 2007.

A report with proposals for the regulation of pharmacies is being produced.

Der er desuden iværksat en udredning der skal komme med forslag om regulering af apotekermarkedet.

From 1 January 2007, some changes to the Health and Medical Services Act have come into force. Patients' needs for continuity and safety when receiving treatment in the health services shall now be met. In addition, arrangements for patients shall be coordinated in a standard way.

Fra og med 1. januar 2007 er der indført visse tillæg til *Hälso och sjukvårdslagen*. Fremover skal patienternes behov for kontinuerlighed og sikkerhed i behandlingen i sundhedsvæsenet tilgodeses. Desuden skal foranstaltninger overfor patienterne samordnes på en ensartet måde.

From 1. January 2007, the Committee for National Medical Care at the National Board of Health and Welfare shall decide which types of health services shall be designated as national, and which health service units shall be run as national health services.

Fra og med 1. januar 2007 skal *Rikssjukvårdsnämnden ved Socialstyrelsen* beslutte hvilke typer af virksomhed der skal betegnes som landsdækkende og herunder hvilke enheder der skal drives som landsdækkende sundhedsvirksomhed.

In November 2006, a final report was published about coordination of mental health services. The report contained a proposal for how treatment for patients with mental illness should be organized between the municipalities and the county councils. An earlier proposal was made to establish a research centre to work with the prevention of mental health problems among children and young people. In January 2007, the Ministry put forward a proposal regarding the consequences for people with mental health problems who commit crimes.

I november 2006 forelå den endelige betænkning om samordningen af psykiatrien. Heri var der blandt andet forslag om hvorledes behandlingen af patienter med psykiske lidelser skal organiseres mellem kommuner og landsting. Tidligere er der kommet forslag om at indrette et videnscenter der skal støtte børn og unge mod at få psykiske problemer. I januar 2007 blev der fremlagt et forslag fra departementet om konsekvenser for lovovertræder med psykiske problemer.

A proposal regarding reimbursement for health care provided in other EEC countries has been sent out for comments. A final report about a new act relating to gender affiliation in certain circumstances was published in March 2007. This relates to people who are transsexual and intersexual.

Der er udsendt et forslag til høring om refusion for behandling i et andet EES land til lov rådet. Desuden kom der en endelig betænkning til en ny lov om kønstilløringshet i visse tilfælde i marts 2007. Det drejer sig om transseksuelle og interseksuelle.

1.2 Organization and responsibility for the health sector

DENMARK: Responsibility for 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, nursing homes and child and school health services.

The regional authorities have operational responsibility for health services.

In the case of ordinary illness, people's use of health services is based on a century-long tradition of family doctors. The formal rules have been drawn up in accordance with the health insurance scheme, so that primary contact is always, in principle, with a general medical practitioner. Hospital services can only be used as an alternative in cases of emergency.

Similarly, dental services are provided by private dental practitioners. The public dental services only provide some dental care services for children.

Health care during pregnancy is the responsibility of the regions. All pregnant women are offered regular examinations according to need with a general medical practitioner, a specialist or a midwife.

Child health care is provided according to the Act Relating to Health Visitors,

1.2 Organisering og ansvar for sundhedsvirksomheden

DANMARK: Ansvar for sundhedsvæsenet er bygget op over en forholdsvis decentral organisation. Hovedprincipperne er følgende: Staten er ansvarlig for lovgivning, tilsyn og retningslinier; regionerne for sygehusvæsen, praksissektoren og specielle plejehjem, mens kommunerne er ansvarlige for sundhedspleje, hjemmepleje, forebyggelse, genoptræning efter sygehusophold, plejehjem samt børne- og skolesundhedstjeneste.

Driftsansvaret for sundhedsydelserne påhviler regionerne.

Ved almindelig sygdom er borgernes benyttelse af sundhedsvæsenet baseret på en århundredlang tradition for familielæger. De formelle regler er udformet i overensstemmelse hermed i sygeforsikringsloven, således at primærkontakten altid principielt rettes til den alment praktiserende læge. Kun i akutte skadestilfælde kan man som alternativ henvende sig til sygehusene.

På samme måde foregår konsultationer med tandlæger hos privat praktiserende tandlæger. Servicen er kun et offentligt anliggende inden for visse dele af børnetandplejen.

Svangerskabshygiejnen tilrettelægges under regionernes ansvar. Alle gravide tilbydes efter behov regelmæssige undersøgelser hos en alment praktiserende læge, speciallæge og jordemoder.

Børnesundhedsplejen, der gives i henhold til loven om sundhedsplejerskeord-

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and is administered by the municipalities. Health examinations of children are carried out by general medical practitioners who have a contract with the health insurance scheme.

Home nursing care is also provided by the municipalities. Care is provided free of charge, after referral by a physician.

Advice about family planning is given, as everyone has a right to receive such advice. This is provided either by general medical practitioners or in special outpatient departments. Midwives and health visitors can also provide advice within their areas of competence. As a general rule, birth control measures are not subsidized.

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.

As a main rule, patients may contact general medical practitioners, dentists, emergency wards and emergency and ambulance services without referral.

Hospital services are placed organizationally under the regions. The regions own most of the hospitals. A few private hospitals have a contract with the county in which they are located, and a few small private hospitals operate totally independently of the public hospital services.

ninger, er knyttet til kommunernes sundhedsforvaltning, mens helbredsundersøgelser af børn udføres af de alment praktiserende læger efter overenskomst med sygesikringen.

Hjemmesygeplejerskeordningerne er ligeledes knyttet til kommunerne, der yder vederlagsfri pleje efter lægehenvisninger.

Der ydes også rådgivning vedrørende familieplanlægning, idet enhver person eller familie har ret til rådgivning i familieplanlægningsspørgsmål. Rådgivningen gives enten af den praktiserende læge eller af en specialafdeling (særligt ambulatorium). Også jordemødre og sundhedsplejersker kan rådgive familier inden for deres kompetenceområde. Der gives som hovedregel ikke offentlige tilskud til præventionsmidler.

Skole- og bedriftssundhedstjenesten er reguleret ved lov. Kommunerne har ansvaret for skolesundhedstjenesten, som varetages af sundhedsplejersker og læger. Bedriftssundhedstjenesten er tilrettelagt i virksomhedsregi og ledes af udvalg med repræsentanter for både arbejdstagere og arbejdsgivere.

Som hovedregel kan patienter henvende sig uden henvisning til alment praktiserende læger, tandlæger, skadestuer samt lægevagten og ambulancetjenesten.

Sygehusvæsenet hører organisatorisk under regionerne, og det er regionsrådene, der er den ansvarlige myndighed. Regionerne ejer sygehusene. Der er enkelte private sygehuse, som har en fast benyttelsesaftale med det amt, hvori de ligger, mens nogle få mindre, private sygehuse fungerer helt uafhængigt af det offentlige sygehusvæsen.

Specialist hospitals are not organized separately, but are under the hospitals. In connection with the Structure Reform, several health centres were established in Denmark.

As a rule, patients have free choice of hospital where they wish to receive treatment. If the waiting list for treatment at a public hospital is more than two months, according to the so-called extended free choice arrangement, patients can choose to receive treatment at a private hospital or a hospital abroad that has a contract with the region in which the patient lives. Certain types of treatment are exempt from this arrangement, such as organ transplantation, sterilization and psychiatric treatment.

Most practising specialist physicians work according to a contract with the health insurance scheme, and most of their patients are referred from general medical practitioners. There are, however, certain exceptions to this rule, such as practising eye and ear specialists.

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 where 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 also subject to government regulation. The state regulates the number and the geographical location of pharmacies, their tasks, and the profit margin on pharmaceutical products.

Specialsygehusene er ikke særskilt organiseret, men er under sygehusene. Der er i forbindelse med strukturreformen blevet etableret sundhedscentre i Danmark.

Patienterne har som regel frit valg med hensyn til hvilket sygehus, de ønsker behandling på. Er ventetiden på behandling på de offentlige sygehuse mere end 2 måneder, kan patienten, efter den såkaldte udvidede fritvalgsordning, vælge at blive behandlet på et af de private eller udenlandske sygehuse der har indgået aftale med bopælsregionen. Visse behandlinger er undtaget fra den udvidede fritvalgsordning, som eksempelvis organtransplantation, sterilisation og psykiatrisk behandling.

Praktiserende speciallæger arbejder for flertallets vedkommende efter aftale med sygesikringen og modtager de fleste af deres patienter efter henvisning fra alment praktiserende læger. Der er dog visse undtagelser fra denne regel. Det gælder fx øjen- og ørespecialerne i praksissektoren.

De almindelige plejehjem drives af kommunerne, men der eksisterer et betydeligt antal private (selvejende) plejehjem, der modtager beboere i henhold til aftaler indgået med beliggenhedskommunerne. Visse specialplejehjem drives af regionerne. Det gælder fx psykiatriske plejehjem.

Apotekerne er organiseret som liberalt erhverv, men er undergivet en indgående statslig regulering. Staten regulerer antallet og placeringen af apoteker, deres opgaver samt avancen på lægemidler i apotekerleddet.

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FAROE ISLANDS: The Faroe Islands' home rule determines the rules concerning the tasks of the health service, benefits and administration. The organization of hospital services, specialist fields, and primary health services largely follows the Danish system. The same applies to nursing homes, home nurses and home helps, and dental treatment.

The Danish Act relating to central administration of health care also applies to the Faroe Islands. The Danish Act concerning medical officers etc. from 1973 still applies to the Faroe Islands.

The hospital services are run by the home government of the Faroe Islands, which is responsible for all expenditure related to running costs and property.

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

Midwifery services are organized under the hospital services.

Physiotherapy services are provided by the hospital services and by privately practising physiotherapists. Pharmacies are run by public authorities.

GREENLAND: The most important legislation includes three acts: a) the Act Relating to Management and Organization of Health Services, b) the Patient's Rights Act and c) the Health Services Act.

FÆRØERNE: Færøernes hjemmestyre fastsætter regler om sundhedsvæsenets opgaver, ydelser og administration. Hospitalsstrukturen og organisationen, speciallægeordninger og deres organisation samt det primære sundhedsvæsen og dets organisation følger i alt væsentligt danske forhold. Det samme gør sig gældende for plejehjem, hjemmesygepleje og hjemmehjælp samt tandbehandling.

Den danske lov om sundhedsvæsenets centrale styrelse er også gældende for Færøerne. Den danske lov om embedslægeinstitutioner fra 1973 gælder fortsat på Færøerne.

Sygehusvæsenet bliver drevet af Færøernes Landsstyrelse, som afholder alle udgifter til drift og anlæg.

De praktiserende læger er alle offentligt ansat, men bliver hovedsageligt aflønnet pr. ydelse fra de offentlige sygekasser. De praktiserende læger bliver administreret af både de kommunale myndigheder og af landsmyndighederne.

Jordemoderordningerne er organiseret under sygehusvæsenet.

Fysioterapi foregår både i det offentlige sygehusvæsen og hos privatpraktiserende fysioterapeuter. Apotekervæsenet er drevet af det offentlige.

GRØNLAND: Den vigtigste lovgivning er tre landstingsforordninger a) om sundhedsvæsenets styrelse og organisation, b) om patienters retsstilling og c) om sundhedsvæsenets ydelser.

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Health services are supervised by an independent chief medical officer, who gives advice and guidance, carries out supervision, collects medical statistics and deals with complaints.

Health services are organized in 16 health districts, each with a health centre, where primary health services and preventive measures are provided. Other types of examination, for example blood tests and radiographs, can be carried out. Acute operations can be performed and inpatient services can be provided. If necessary, or in complicated cases, patients can be sent to Dr. Ingrid's Hospital in Nuuk or to a hospital in Denmark, or from the east coast of Greenland to Iceland.

It is becoming increasingly difficult to recruit and keep authorized health care personnel. Too few health care personnel are educated in Greenland. There are therefore plans to reorganize health services, with fewer local hospitals, regionalization of hospitals, increased utilization of nurses in providing treatment, use of telemedicine etc.

In providing health services to villages and trading stations, there are serious problems with transport and there are too few health care personnel. As a result, the quality of the health services is too low.

The large municipalities have established health visitor and home nursing services, and district psychiatric services. The municipal social administration provides services for elderly people and disabled people, such as nursing homes, home helps and aids for disabled people.

Sundhedsvæsenet er under tilsyn af en uafhængig embedslægeinstitution som yder rådgivning, vejledning og kontrol samt forestår indsamling af medicinalstatistiske indberetninger og behandler klagesager.

Sundhedsvæsenet er organiseret i 16 sundhedsdistrikter, hver med et sundhedscenter, som forestår den primære og forebyggende sundhedsindsats. Der findes mulighed for supplerende undersøgelser, eksempelvis blod- og røntgenundersøgelser, der kan foretages akutte operationer og ydes døgnpleje til indlagte patienter. Ved behov og komplicerede forløb visiteres til Dr. Ingrid's Hospital i Nuuk eller til sygehus i Danmark, fra østkysten evt. til Island.

Der er tiltagende vanskeligheder med at rekruttere og fastholde autoriseret sundhedspersonale. Der uddannes for lidt autoriseret sundhedspersonale i Grønland. Derfor arbejdes med planer om omorganisering af sundhedsvæsenet med færre lokale sygehuse, regionalisering af sygehusene, mere inddragelse af sygeplejersker i behandling, anvendelse af telemedicin etc.

Ved betjening af bygder og udsteder er der store problemer med transport, personalesituationen er ringe, hvorfor kvaliteten af sundhedsydelser er for lav.

De større kommuner har udbygget sundheds- og hjemmesygepleje samt distriktpsychiatriske tilbud. Kommunernes socialforvaltninger forestår tilbud til ældre og funktionshæmmede, eksempelvis tilbud om plejehjem, hjemmehjælp og hjælpemidler.

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In each health district, dentists and dental surgery assistants provide dental care. All school children receive preventive dental care.

A National Pharmacy has been established in Nuuk, with a National Pharmacist, with country-wide functions related to import, distribution and trade of pharmaceutical products. The National Pharmacy produces statistics about pharmaceutical products, prices of non-prescription drugs, revision of the range of non-prescription drugs, licences for retail businesses, guidelines for people responsible for pharmaceutical services, and inspection of pharmaceutical stores and coastal hospitals. The Home Government has responsibility for authorization of pharmaceutical products. A pharmaceutical committee has responsibility for giving advice about use of pharmaceutical products, and recommends pharmaceutical products for authorization by the Home Government (the Directorate of Health). Medicines are free and are given out by the health services. There is a small selection of non-prescription medicines.

There are no occupational health services in Greenland.

FINLAND: Municipalities have responsibility for health services. The responsibility of municipalities is laid down in the *Public Health Act* (1972), in the *Specialist Treatment of Diseases Act* (1989), and in the *Treatment of the Mentally Ill Act* (1990).

In the *Public Health Act* and its statutes, the tasks of the municipal public health services are listed. Here it is stated that municipalities are responsible for:

I hvert sundhedsdistrikt ydes tandpleje ved tandlæger og tandklinikassistenter. Alle skolebørn ydes forebyggende tandpleje.

I Nuuk er etableret et Landsapotek med en Landsapoteker med landsdækkende funktioner i forbindelse med import, distribution og håndtering af lægemidler. Landsapoteket udarbejder medicin-statistik, priser på håndkøbsmedicin, revision af håndkøbssortiment, bevillinger til detailhandelsvirksomheder, vejledninger til lægemiddelansvarlige samt inspektion af medicindepoterne på kystsygehuse. Godkendelse af lægemidler tillægges Landsstyret. En Lægemiddelkomité varetager den overordnede faglige rådgivning om lægemiddelanvendelse, og indstiller lægemidler til godkendelse i Landsstyret (Direktoratet for Sundhed). Medicin er gratis og udleveres fra det behandlende sundhedsvæsen. Der findes et lille udbud af håndkøbsmedicin.

Der er ikke indført BST – bedriftssundhedstjeneste i Grønland.

FINLAND: Det er kommunerne, der har ansvaret for sundhedsvæsenet. Kommunernes ansvar for sundhedsvæsenet er fastsat i *Folkhälsolagen* (1972), i *Lag om specialiserad sjukvård* (1989) og i *Mentalvårdslagen* (1990).

I *Folkhälsolagen* og dennes forordninger opregnes de arbejdsopgaver, der hører under det kommunale folkesundhedsarbejde. Heri fastsættes det, at kommunerne har ansvaret for:

- Guidance and preventive health care, including children's health, health education, advice 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 centres, in inpatient departments or as home nursing care.
- Rådgivning og sundhedsforebyggelse, som omfatter børns sundhed, oplysningsarbejde, rådgivning angående svangerskabsforebyggelse, sundhedsundersøgelser og screening.
- Sygdomsbehandling som omfatter lægeundersøgelser og pleje samt medicinsk rehabilitering og førstehjælp. Den almindelige sygdomsbehandling gives ved sundhedscentre, på sengeafdelinger eller som hjemmesygepleje.

From March 2005, with the exception of cases of injury, patients shall be examined and treated within a given time. Patients shall be able to obtain immediate contact with a health centre on weekdays in normal working time, and shall also be able to visit the health centre. If an appointment at a health centre is deemed to be necessary, the patient shall be given an appointment within three working days from the time of contact with the health centre. Normally, treatment is provided at the health centre immediately at the first visit. Treatment that is not provided at the visit shall be started within three months. In cases where health centres provide specialized treatment, the same time-limits apply as those for specialized health services (six months).

Need for treatment, with the exception of cases of injury, shall be assessed within three weeks after referral to a hospital. If a doctor has examined a patient, and has established that treatment is needed, the treatment shall be started at the latest within six months.

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

Fra og med marts 2005 skal en patient, med undtagelse af skader, undersøges og behandles indenfor en fastsat tid. Patienten skal umiddelbart få kontakt med sundhedscentret, på hverdage i arbejdstiden, ligesom patienten også skal kunne besøge sundhedscentret. Hvis det bedømmes at der er behov for et besøg på sundhedscentret, skal patienten have en tid på sundhedscentret indenfor tre hverdage fra det tidspunkt patienten har taget kontakt. Normalt indledes behandlingen ved sundhedscentret med det samme ved det første besøg. Behandling der ikke gives ved besøg skal iværksættes inden tre måneder. I de tilfælde hvor sundhedscentre yder specialiseret behandling, tillempes de samme tidsgrænser som indenfor den specialiserede behandling (der er seks måneder).

Behovet for behandling, i de tilfælde der ikke drejer sig om skader, skal bedømmes indenfor tre uger efter henvisning til et sygehus. Hvis en læge der har undersøgt en patient, konstaterer at vedkommende har behov for behandling, skal denne indledes senest indenfor seks måneder.

Børn og unge skal modtage psykiatrisk behandling indenfor tre måneder hvis det skønnes nødvendig.

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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 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 who are mentally ill that can reasonably be offered in health centres.

Dental care includes information and prevention, and dental examination and treatment. Dental examination and treatment paid by the health insurance is provided for the whole population. Dental care is also provided in health centres for adults, particularly in rural municipalities. Most dental treatment for adults is provided by dentists in private practice. 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 have an agreement with a health 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 centres are usually specialists in general medical care. In the public health service system,

Tandbehandling, som anses for at være nødvendig, skal iværksættes indenfor en rimelig tid, og senest indenfor 6 måneder.

Hvis patientens egen sundhedscenter eller sygehus ikke kan behandle patienten, indenfor den fastsatte tid, skal behandlingen tilbydes enten i en anden kommune eller indenfor den private sygdomsbehandling, uden ekstra udgifter for patienten.

Kommunerne skal sørge for, at mentalt syge får ydelser, som med rimelighed kan tilbydes i sundhedscentre.

Tandbehandlingen omfatter oplysning og forebyggelse samt undersøgelse og behandling af tænder. Undersøgelse og behandling af tænder betalt af sygeforsikringen gives til hele befolkningen. Ved sundhedscentre, især i landkommunerne, gives der desuden tandbehandling til voksne. Det meste af voksenbehandlingen udføres af privatpraktiserende tandlæger. Unge under 18 år har ret til tandbehandling uden brugerbetaling.

Kommunerne skal desuden tilvejebringe sygetransport og sørge for etableringen af bedriftssundhedstjenester. Arbejdsgiverne kan selv organisere bedriftssundhedstjenesten, eller de kan indgå aftale med et sundhedscenter eller andre der arbejder med bedriftssundhedstjenesten.

I mange kommuner er den sociale service i de senere år blevet integreret med sundhedsydelserne.

Læger, der arbejder ved sundhedscentre, er normalt alment praktiserende specialister. I det offentlige sundhedssy-

patients need a referral for specialist treatment, except in the case of emergency. 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.

Specialized central and regional hospitals are run by groups of municipalities. 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 to live in their own homes, for example home help services and home nursing services, 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 elderly people 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: According to the home rule for Åland, Åland has its own legislation for the health sector except for administrative interventions regarding personal

stem skal patienterne have en henvisning til en specialist, dog ikke i akutte tilfælde. De fleste af de læger som arbejder i private klinikker er specialister. Patienterne behøver ingen henvisning for at opsøge disse specialister. Læger der arbejder i privatklinikker kan henvise patienter til enten private eller offentlige hospitaler.

De specialiserede centrale og regionale hospitaler styres af en sammenslutning af kommuner. Inden for den psykiatriske behandling bliver der lagt større og større vægt på ambulant behandling og brugen af institutioner er således faldende.

Kommunerne har ansvaret for social- og sundhedsydelserne til de ældre. Dette indbefatter ydelser det gør det muligt for de ældre at blive boende i eget hjem ved for eksempel hjemmehjælp og hjemmepleje, dagpleje og beskyttede boliger (hovedsagelig social service). For sundhedssektoren bliver personer støttet i at blive boende hjemme, med hjemmepleje, korttidsophold eller periodevis ophold/behandling på et sygehjem eller dagophold på et hospital. Servicen til de ældre inkluderer også den almindelig lægebehandling forebyggelse og revalidering. Langtidsbehandling/ophold for ældre findes ved alderdomshjem og plejecentre.

Apoteker er privatejede, men under statsligt tilsyn. Det er kun apotekerne der kan forhandle såvel receptpligtig medicin som håndkøbsmedicin.

ÅLAND: På grund af sit selvstyre har Åland sin egen lovgivning for sundhedsvæsenet, dog med undtagelse af bl.a. administrative indgreb i den personlige fri-

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freedom, contagious diseases, sterilisation, induced abortion, assisted reproduction, forensic medicine, and regulations for companies offering health services.

The tasks, structure and organization of the public health sector are regulated according to the Act for the Health Sector (1993). This Act is a general act that can be supplemented by public decree. Detailed rules concerning the sector are described annually in a sector plan. Issues that do not fall under the Åland legislation, or that are not regulated by separate legislation, follow Finnish legislation.

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

The Åland Government has overall responsibility for ensuring that the population receives necessary medical care. The role of the municipalities is limited to financing certain defined types of treatment. Primary health services and specialized health services are both part of the ÅHS.

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

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

hed, smitsomme sygdomme, kastrering og sterilisation, svangerskabsafbrydelse, kunstig befrugtning, retsmedicinske undersøgelser, samt regelsættene for virksomheder der udbyder sundhedsydelser.

Det offentlige sundhedsvæsens forpligtigelser, struktur og organisation reguleres i landskabsloven om sundhedsvæsenet (Lagen om hälso- och sjukvården 1993). Loven er en rammelov, som efter behov kan suppleres med bekendtgørelser. Detaljerede bestemmelser om virksomheden beskrives hvert år i en virksomhedsplan. Forhold som ikke hører under ålandsk lovgivning, eller som ikke har egen lovgivning, tilpasses finsk lovgivning.

Hele det offentlige sundhedsvæsen, er underordnet en samlet organisation, Ålands hälso- och sjukvård (ÅHS). Organisationen ledes af en politisk valgt styrelse.

Landskapsregeringen er hovedansvarlig og har ansvaret for at befolkningen får den nødvendige sygdomsbehandling. Kommunernes ansvar og indflydelse er begrænset til visse nærmere afgrænsede finansieringsforpligtigelser. Den primære sundhedsbehandling og den specialiserede behandling indgår i samme organisation ÅHS.

Service som ikke kan produceres af egne enheder købes af producenter i Finland og Sverige, enten hos privatpraktiserende, private institutioner eller universitets-sygehuse.

De ålandske sygehuse er specialiserede institutioner, der udfører såvel ambulant behandling og behandling af indlagte patienter.

Specialized treatment outside the hospitals is provided in the form of consultative support for primary health care and for private general medical practitioners.

The structure of primary health care corresponds functionally and ideologically to the Finnish public health care system. Advice concerning contraception and counselling for mothers and infants, and school 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.

With regard to dental treatment, priority is given to the youngest age groups, certain high-risk groups and preventive measures. If possible, other patient groups are also treated. The private sector is well established with a high capacity, and it provides an important supplement.

Regulations for pharmacies are the same as in Finland.

ICELAND: The government is responsible for health services according to the Health Service Act of 2007 from 1 September that year. Other major acts are:

- Patients' Rights Act
- Social Security Act
- Patient Insurance Act
- Communicable Diseases Act
- Physicians Act

Speciallægevirksomheden uden for sygehusene eksisterer i form af konsultativ bistand til den offentlige primære behandling og til de privatpraktiserende læger.

Det primære sundhedsvæsens struktur svarer ideologisk og driftsmæssigt til det finske folkesundhedsarbejde. Rådgivning vedrørende prævention, rådgivning til mødre og småbørn samt skolesundhedspleje, fungerer som i Finland. Vaccinationsprogrammer er frivillige, og anbefalingerne svarer til de finske. Fysioterapien inden for ÅHS er en fællesfunktion for både primærsektoren og sygehusene. Som et supplement er der et antal private fysioterapeuter som også anvendes af det offentlige.

Bedriftssundhedstjenesten organiseres som i Finland.

Indenfor tandbehandlingen er behandling af de yngre aldersgrupper og visse risikopatientgrupper samt forebyggende foranstaltninger der har højeste prioritet. Såfremt det er muligt behandler man også andre patienter. Den private sektor er kapacitetsmæssigt veludbygget og udgør et vigtigt supplement.

Reglerne for apotekervæsenet er det samme som i Finland.

ISLAND: Regeringen har ansvaret for sundhedsvæsenet i henhold til sundhedsloven fra 2007 som trådte i kraft 1. september. De andre vigtigste love er følgende:

- Lov om patientrettigheder
- Lov om social tryghed
- Lov om patientforsikringer
- Lov om smitsomme sygdomme
- Lægeloven

ORGANIZATION OF HEALTH SERVICES

The state employs most health care personnel and is responsible for the overall administration of health institutions.

Health centres are responsible for primary health services, including preventive services and general medical treatment. Preventive services include child health care, maternity care, school health care, immunization, family planning etc. Home nursing care is also the responsibility of the health centres.

In Reykjavík there are a few private general practitioners who work in private practice and provide medical treatment under a contract with the State Social Security Institute (SSI).

Specialist treatment is provided in the more densely populated areas, largely by private medical specialists, who work under a contract with the SSI. Specialists also make visits to health centres in the less densely populated areas. Outpatient specialist services are also provided by the hospitals. No referral is required for specialist treatment.

There are three types of hospitals: 1) highly specialized hospitals, one in Reykjavík and one in Akureyri, 2) regional hospitals with a certain degree of specialization, and 3) local hospitals. Many local hospitals also function as old people's homes and nursing homes. Other health institutions include rehabilitation hospitals and clinics for substance abusers.

Physiotherapy is partly provided in health centres, but mostly by privately practising physiotherapists in the urban

Størsteparten af sundhedspersonalet er ansat af staten der har det administrative ansvar for institutioner indenfor sundhedsvæsenet.

Sundhedscentrene har ansvaret for det primære sundhedsvæsen som både omfatter forebyggelse og almen sygdomsbehandling. Det forebyggende arbejde omfatter småbørn, mødre, skolesundhedsordninger, vaccinationer, familieplanlægning m.v. Hjemmesygeplejen hører også til sundhedscentrenes ansvarsområde.

I Reykjavík findes der nogle få private alment praktiserende læger der tilbyder behandling, og som arbejder efter kontrakt med Rigsforsikringen.

Speciallægebehandling findes i de mest tætbefolkede områder og udbydes i stort omfang af privatpraktiserende speciallæger der arbejder efter overenskomst med Rigsforsikringen. I mindre tætbefolkede områder besøger specialisterne også sundhedscentrene. Der tilbydes også speciallægebehandling fra ambulatorierne ved hospitalerne. Det er ikke påkrævet med en henvisning til speciallægebehandlingen.

Der er tre typer sygehuse: 1) højt specialiserede sygehuse, hvoraf et findes i Reykjavík og et i Akureyri, 2) regionale sygehuse med en vis specialisering og 3) et antal lokale sygehuse. De lokale sygehuse fungerer for det meste også som alderdoms- og sygehjem. Af andre institutioner kan nævnes revalideringssygehuse og alkoholklinikker.

En vis del af fysioterapien foregår gennem sundhedscentrene, men det meste af behandlingen varetages af privatprak-

areas. Physiotherapists in private practice work under a contract with the SSI.

tiserende fysioterapeuter i byområderne. Privatpraktiserende fysioterapeuter arbejder på kontrakt med Rigsforsikringen.

The health centres provide home nursing services, whereas home help services are part of the municipal social service system.

Hjemmesygeplejen drives fra sundhedscentre mens hjemmehjælpen gives gennem det kommunale sociale service-system.

Many nursing homes and old people's homes are run as independent institutions. They are run by municipalities, voluntary organizations etc. They are partly financed by user charges, but the major part of financing is provided by the government, either through the national pension scheme, as is the case for old people's homes, or through the health insurance scheme, as is the case for nursing homes.

De fleste pleje- og alderdomshjem fungerer som selvejende institutioner. De drives af kommuner, frivillige organisationer o.l. De finansieres delvis ved brugerbetaling; men den største del af finansieringen kommer dog fra staten, for alderdomshjemmenes vedkommende gennem pensionsforsikringen, for plejehjemmenes vedkommende gennem sygeforsikringen.

Most dental practices in Iceland are small and privately owned. Dental treatment is mainly provided by private dental practitioners.

Tandlægeklinikker i Island er små og næsten alle tandlæger er privatpraktiserende. Tandbehandlingen udføres for det meste af privatpraktiserende tandlæger.

Occupational health services are by law the responsibility of the employer. For large workplaces these services are provided by individual doctors, occupational health consultant firms or health centres.

Bedriftssundhedstjenesten er ifølge loven arbejdsgiverens ansvar. De større arbejdspladser får denne ydelse enten fra praktiserende læger, konsulent firmaer eller sundhedscentre.

Pharmacies are privately run.

Apoteker drives af private.

NORWAY: The system of health care provision in Norway is based on a decentralized model. The state is responsible for policy design and overall capacity and quality of health care through budgeting and legislation. The state is also responsible for 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.

NORGE: Udbudet af sundhedsydelser er i Norge baseret på en decentral model. Staten er ansvarlig for politiklægningen og via lovgivningen og budgetlægningen sikrer at de nødvendige ressourcer er til stede. Staten er også ansvarlig for hospitalssektoren ved at staten ejer de regionale udbydere af hospitalsydelser (regionale helseforetak). I de regionale enheder er såvel somatiske som psykiatriske hospitaler samt enkelte hospitalsapotekere organiseret som sundhedsvirksomheder (helseforetak).

ORGANIZATION OF HEALTH SERVICES

Within the limits of legislation and available economic resources, regional health authorities and the municipalities are formally free to plan and run public health services and social services as they like. However, in practice, their freedom to act independently is limited by available resources.

The municipalities have responsibility for primary health care, including both preventive and curative treatment such as:

- Promotion of health and prevention of illness and injuries, including organizing and running school health services, health centres, child health care provided by health visitors, midwives and physicians. Health centres offer pregnancy check-ups and provide vaccinations according to the recommended immunization programmes.
- Diagnosis, treatment and rehabilitation. This includes responsibility for general medical treatment (including emergency services) physiotherapy and nursing (including health visitors and midwives).
- Nursing care in and outside institutions. Municipalities are responsible for running nursing homes, home nursing services and other services such as the home help service. The health services in and outside institutions are, to a varying degree, organized jointly within the same municipal department for treatment and care.

In Norway there is currently a National Mental Health Programme. The programme was originally for the period 1999 to 2006, and it has been prolonged

Indenfor de begrænsninger lovgivningen og de økonomiske ressourcer sætter, er de regionale udbydere og kommunerne formelt set frit stillet til at tilrettelægge udbudet af sundhedsydelser og den sociale service som de selv vil. Dog, i praksis så sætter de økonomiske ressourcer grænser for deres frihedsgrader.

Det er kommunerne som har ansvaret for det primære sundhedsvæsen, som omfatter både forebyggende og kurativ behandling med henblik på:

- Sundhedsfremme og forebyggelse af sygdomme og skader, herunder at organisere og drive skolesundhedsvæsenet og sundhedscentre samt børnesundhedspleje udført af sundhedsplejersker, jordemødre og læger. Sundhedscentre skal tilbyde svangerskabsopfølgning og -kontrol samt vaccinationer efter de anbefalede vaccinationsprogrammer.
- Diagnosticering, behandling og rehabilitering. Dette omfatter ansvaret for den almindelige lægebehandling (inkl. lægevagtordninger), fysioterapi og sygepleje (inkl. sundhedsplejersker og jordemødre).
- Pleje og omsorg i og uden for institutionerne. Kommunerne har ansvaret for driften af sygehjemmene, hjemmesygepleje og andre ordninger (fx hjemmehjælp). Sundhedsydelserne i og uden for institutionerne er i varierende grad forankret i en fælles organisatorisk enhed i form af en fælles pleje- og omsorgsafdeling i kommunen.

Der findes i øjeblikket et nationalt program for psykiatrien. Programmet var oprindeligt for perioden 1999 til 2006, men er forlænget indtil 2008. Det er pro-

until 2008. This programme aims at improving accessibility, quality and organization of mental health services and treatment on all levels. A central idea of the Mental Health Programme is to promote deinstitutionalization, with considerable emphasis on community-based psychiatry, where treatment is given closer to the patient's local community and primary health services. These community clinics represent an all-round psychiatric practice and consist of a network of services, such as multidisciplinary treatment and teamwork, in addition to programmes for accommodation, occupation and social support.

The county authorities are responsible for providing public dental services for the following groups: 1. children and adolescents (under 21 years of age) 2. mentally handicapped adults, and 3. elderly people, disabled people, and people with chronic illnesses who live in institutions or who receive home nursing care. Dental services for the rest of the population are mainly provided by private general dental practitioners, and paid for by the patients.

There are several different ways in which occupational health services are organized. Some large companies have their own private service, organized independently. Another type of arrangement is that several companies have a joint arrangement with an occupational health services company, which sells occupational health services to the group.

Pharmacies are mainly privately owned, but are subject to strict public control.

grammets målsætning at der gives den nødvendige adgang for psykiatrisk behandling, kvalitetssikring og udbud af behandling på alle niveauer. Det er centralt for programmet at man fremmer en deinstitutionalisering af behandlingen med betydelig vægt på distriktspsykiatrien, hvor behandlingen gives i tæt kontakt til patientes lokale samfund og i tilknytning til den almene lægebehandling. Disse lokal-klinikker repræsenterer en bredt funderet psykiatrisk praksis og består af et netværk af udbud så som multidisciplinær behandling og teamwork sammen med programmer for bolig, beskæftigelse og social støtte.

Amterne (fylkene) har ansvaret for tandbehandling til følgende grupper; 1) børn og unge under 21 år 2) psykisk syge voksne og 3) ældre, funktionshæmmede og personer med kroniske sygdomme der lever på institutioner eller modtager hjemmesygepleje. Tandbehandling for resten af befolkningen gives hovedsageligt af privatpraktiserende tandlæger og patienterne betaler selv for behandlingen.

Bedriftssundhedstjenesten kan tilrettelægges på mange forskellige måder. Nogle af de store virksomheder organiserer deres egen bedriftssundhedstjeneste uafhængig af andre. Andre typer er, at flere virksomheder går sammen om ordningen og indgår aftale med en virksomhed der udbyder bedriftssundhedstjeneste.

Apotekerne er hovedsageligt privat drevne, men er underlagt en omfattende statslig kontrol.

ORGANIZATION OF HEALTH SERVICES

Health services and health care personnel are regulated by current legislation. The most important acts of relevance to the health sector are the following:

- Health Personnel Act
- Patients' Rights Act
- Patient Injury Act
- Specialized Health Services Act
- Municipal Health Services Act
- Health Authorities and Health Trusts Act
- Communicable Diseases Act
- Health Services Supervision Act
- Mental Health Care Act
- Dental Health Services Act
- Tobacco Act
- Pharmacy Act
- Medicinal Products Act
- Abortion Act

SWEDEN: The most important act is the Health and Medical Services Act. Other important acts include the Act Relating to Active Health Personnel and the Act Relating to Injuries to Patients.

According to the national treatment guarantee, the counties shall provide treatment within 90 days after a doctor has decided that treatment is required. The guarantee applies to all planned treatment.

Primary health care is run by 18 county authorities and three regions.

Primary health services include health centres with general medical practitioners, mother and child centres, district nursing health care, district physiotherapy, home visiting and community dental services. The purpose of the primary health service is to promote public health within a geographically defined area.

Sundhedsvæsenet og sundhedspersonale reguleres af den eksisterende lovgivning. De vigtigste regelsæt med betydning for sundhedsvæsenet er:

- Helsepersonelloven
- Pasientrettighedsloven
- Pasientskadeloven
- Specialisthelsetjenesteloven
- Kommunehelsetjenesteloven
- Helseforetaksloven
- Smittevernloven
- Helsetilsynsloven
- Psykisk helsevernloven
- Tannhelsetjenesteloven
- Tobakkskadeloven
- Apotekloven
- Legemiddelloven
- Abortloven

SVERIGE: Den vigtigste lov er Hälso- och sjukvårdslagen (HSL). Andre vigtige love er blandt andet Loven om erhvervsvirksomhed inden for sundhedsområdet samt Patientskadeloven.

I følge den nationale behandlingsgaranti skal landstingene tilbyde behandling indenfor 90 dage efter at lægen har taget beslutning om behandling. Garantien gælder al planlagt behandling.

Det primære sundhedsvæsen drives af de 18 landsting og tre regioner.

Det primære sundhedsvæsen omfatter sundhedscentre med almenmedicinske læger, børne- og mødrecentre, distriktsygepleje, distriktsfysioterapi, sygdomsbehandling i hjemmet og offentlig tandpleje. Det primære sundhedsvæsen har til opgave at arbejde for hele befolkningens sundhed inden for et afgrænset geografisk område.

School health services, home help, preventive measures and environmental health all come under the municipalities, which also have responsibility for the local nursing homes and part of the home nursing services.

The county and regional authorities still have responsibility for both outpatient and inpatient psychiatric treatment. However, within psychiatry there is also a trend towards increased collaboration with other agencies. Thus the municipalities, since 1995, have assumed greater responsibility for housing for psychiatric patients, and for general care and support.

Occupational health services are regarded as part of supervision of the work environment. The majority of physicians employed in occupational health services are linked to individual companies.

The National Board of Health and Welfare issues recommendations for immunization of children.

Privately produced, but publicly financed health care is provided on a limited scale. There are a few private hospitals. About 30 per cent of all medical consultations are with private medical practitioners. In addition, there are some physiotherapists who work in private practice. Half of the dentists are private practitioners. The Act concerning the fees, etc. of medical practitioners and physiotherapists in private practice lays down the conditions governing the rights of physicians and physiotherapists to practice with financial support from the county authorities.

The hospitals are run by the county and regional authorities.

Skolesundhedsvæsenet og hjemmehjælpen hører, ligesom det lokale miljø- og sygdomsforebyggende arbejde, under kommunerne, der også har ansvaret for de lokale sygehjem og en del af hjemme-sygeplejen.

Landstingene og regionerne har ligesom tidligere ansvaret for den psykiatriske behandling såvel inden for som uden for sygehusene. Også inden for psykiatrien pågår der en udvikling hen imod et større samarbejde med andre aktører. Dette har blandt andet medført at kommunerne fra og med 1995 fik et udstrakt ansvar for boligforhold samt støtte og omsorg til psykiatriske patienter.

Bedriftssundhedstjenesten betragtes som en del af arbejdstilsynet. Størstedelen af lægerne i bedriftssundhedstjenesten er tilknyttet de enkelte arbejdspladser.

Socialstyrelsen udarbejder den almindelige vejledning for vaccination af børn.

Privatproduceret men offentligt finansieret sygdomsbehandling udøves kun i begrænset omfang. Der findes et fåtal private sygehuse. Her ved 30 procent af alle lægebesøg foregår hos privatpraktiserende læger. Der findes endvidere privatpraktiserende fysioterapeuter. Inden for tandplejen er halvdelen af tandlægerne privatpraktiserende. Loven om vederlag m.v. til privatpraktiserende læger og fysioterapeuter fastsætter lægers og fysioterapeuters muligheder for at praktisere med finansiering fra landstingene.

Sygehusene drives af landstingene og regionerne.

ORGANIZATION OF HEALTH SERVICES

The county hospitals comprise both more specialized hospitals covering the whole county and hospitals covering only part of the county. Medical treatment is provided in most areas of specialization, partly in hospital departments, partly in outpatient clinics. Psychiatric treatment, which is often divided into sectors, comes under the provincial hospital services. More complicated and specialized treatment is provided by the regional hospital service. The county and regional authorities cooperate in six treatment regions, each with at least one regional hospital.

Pharmacies are run by the state.

The Pharmaceutical Benefits Board has responsibility for deciding whether a medicine or a specific pharmaceutical product shall be subsidized, and for determining the price of the product.

1.3 Supervision of health services

DENMARK: Supervision of health service is based partly on legislation of the health service and partly on special legislation of health care personnel. Supervision is carried out by the National Board of Health with the assistance of the offices of the chief medical officers.

There is one office of the chief medical officer in each region. These institutions are part of the National Board of Health and are thus independent, politically and administratively, of the regional and municipal authorities, which have responsibility for health services supplied to the general public. In this way, the chief

Lenssygehusene omfatter såvel mere specialiserede sygehuse, der dækker hele lenet, som sygehuse, der dækker dele af lenet. Sygdomsbehandlingen foregår inden for de fleste specialer dels ved sygeafdelinger (sluten vård), dels i ambulatorier (öppen vård). Psykiatrisk behandling, som ofte er sektoropdelt, henregnes under lenssygehusvæsenet. Mere krævende og specialiseret sygdomsbehandling foregår på de regionale sygehuse. Landstingene og regionerne samarbejder i seks behandlingsregioner, hver med mindst ét regionssygehus.

Apotekerne er statslige.

Läkemedelsförmånsnämnden (Nævnet for lægemidler) skal afgøre om der skal ydes refusion til et lægemiddel eller en bestemt vare, samt fastsætte prisen for denne.

1.3 Tilsyn med sundhedsvæsenet

DENMARK: Tilsynet med sundhedsvæsenet er dels baseret på loven om sundhedsloven, dels på lov om autorisation af sundhedspersoner og om sundhedsfaglig virksomhed. Tilsynet udføres af Sundhedsstyrelsen med bistand fra embedslægeinstitutionen.

Der er én embedslægeinstitution i hver region. Disse institutioner er en del af Sundhedsstyrelsen og således politisk og administrativt uafhængige af regioner og kommuner, der har ansvaret for sundhedsvæsenets betjening af befolkningen. Sundhedsstyrelsen kan således fungere som uafhængig rådgiver og er tilsynsfø-

medical officers work as independent advisers and supervisors at all levels. If the National Board of Health becomes aware of breaches in the legislation or deficiencies in the health sector it informs the relevant authorities. It can also inform the public when this is necessary in the interest of the health of the Danish population.

Supervision of health care personnel and their professional activity 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.

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.

In connection with the statutory planning of the preparation of guidelines and debates about adhering to them, supervision of health services is primarily carried out through collaboration between the decentralized authorities. Health services are monitored using reports of budgets and accounts from the regions and municipalities, and using statistical data reported to various centralized registers. Supervision concerning specific issues is only carried out in exceptional cases.

FAROE ISLANDS: The rules for supervision of health services are, by and large, the same as in Denmark, both concerning who has responsibility for supervision (the chief medical officer), regarding in which

rende på alle niveauer. Sundhedsstyrelsen kan, hvis styrelsen bliver bekendt med overtrædelser eller mangler på sundhedsområdet, orientere vedkommende myndighed i fornødent omfang samt orientere offentligheden, når særlige sundhedsmæssige forhold gør det nødvendigt.

Tilsynet med det medicinske personale og deres professionelle virksomhed udføres af Sundhedsstyrelsen i tæt samarbejde med de lokale embedslæger. Afgørelser vedrørende enkeltpersoner kan i sådanne sager indankes for den ansvarlige minister og eventuelt domstolene.

Klager over den faglige virksomhed, der udøves af personer inden for sundhedsvæsenet, indgives til Sundhedsvæsenets Patientklagenævn. Efter forbehandling af sagerne (partshøringer, faglig vurdering mv.) hos embedslægen træffes den endelige afgørelse af Patientklagenævnet.

Tilsynet med sundhedsvæsenets virksomhed udføres primært som et samarbejde mellem de decentrale myndigheder i forbindelse med det lovbestemte planlægningsarbejde om udformning af vejledende retningslinier og i en dialog om disses efterfølgelse. Desuden følges den løbende aktivitet gennem regionernes og kommunernes indberetning af specificerede budgetter og regnskaber og statistiske data til forskellige centrale registre. Der er kun undtagelsesvis anledning til at rejse tilsynssager om konkrete spørgsmål.

FÆRØERNE: Reglerne for tilsyn med sundhedsvæsenet er i alt væsentligt identiske med forholdene i Danmark, både hvad angår hvem der fører tilsynet (Embedslægen/Landslægen), hvilke områder

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areas supervision shall be carried out and procedures for complaints.

GREENLAND: The Office of the Chief Medical Officer, an independent institution under the Greenland Home Rule Government, is responsible for supervision of health services. The chief medical officer advises and assists the Greenland Home Rule Government and other authorities in questions of health. Areas of supervision include health care institutions, health care personnel, municipal institutions and other institutions. Complaints about health issues are addressed in writing to the Office of the Chief Medical Officer, which prepares the case and evaluates the complaint before forwarding it to the Danish Patients' Complaints Board of the Board of Health in Copenhagen. This board completes the preparation of the case, arranges a hearing and makes a decision. Complaints about health services and questions concerning compensation are dealt with by the Directorate of Health.

FINLAND: Supervision of health services in Finland is organized in a less formal way than in the other Nordic countries. Supervisory tasks are spread out among the whole health services system.

The most important channel for nationwide supervision of health and social services is through legislation and related nationwide plans for the health and social sector. Overall planning, coordination and supervision of the statutory services is the responsibility of the Ministry of Social Affairs and Health. Planning, managing and supervising services at the county level is the responsibility of the county authorities. The chief medical officers and the forensic pathologists act as medical advisers to the regional administration.

der føres tilsyn med samt vedrørende klageadgange/muligheder.

GRØNLAND: Tilsynsmyndigheden er Embedslægeinstitutionen i Grønland som er en sundhedsfagligt uafhængig institution under Grønlands Hjemmestyre. Embedslægeinstitutionen yder rådgivning og anden bistand i sundhedsfaglige spørgsmål til Landsstyret og andre myndigheder. Tilsynsområderne er sundhedsvæsenets institutioner, sundhedsfaglige personer samt kommunale og andre institutioner. Sundhedsfaglige klager rettes skriftligt til Embedslægeinstitutionen, som vurderer, forbereder og sagsfremstiller klagen, før den videresendes til Sundhedsvæsenets Patientklagenævn i København som foretager den endelige behandling, høring og afgørelse. Klager over service samt krav om erstatninger behandles af Direktoratet for Sundhed.

FINLAND: Tilsynet med sundhedsvæsenet er i Finland organiseret mindre formelt end i de andre nordiske lande. Arbejdsopgaverne er spredt ud i hele sundhedssystemet.

De vigtigste kanaler til den landsdækkende styring af social- og sundhedsvæsenet er lovgivning, dertil hørende forordninger og de landsdækkende planer for social- og sundhedsområdet. Den generelle planlægning, styring og tilsynet med de lovpligtige ydelser påhviler Social- och hälsovårdsministeriet. Planlægning, styring og tilsyn inden for lenene påhviler länsstyrelserne. Embedslægerne og retslægerne fungerer som lægelige rådgivere for den regionale administration.

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, then it may recommend how the deficiencies may be dealt with and give a time limit for when improvements shall be made.

Patients have many possibilities 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 centre. If further assistance is needed in order to solve the problem, there are two possibilities. The patient can contact either the Office of the Chief Medical Officer or the National Authority for Medicolegal Affairs. Both these bodies can give an expert opinion, or give sanctions if necessary.

ÅLAND: Supervision of health care personnel is carried out according to Finnish law.

Complaints concerning treatment can either be addressed, as in Finland, to the institution providing the treatment or to the national authorities - or to the Åland Government. In Åland, 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 committee cannot make a decision in individual cases.

Der er oprettet et landsdækkende grundrettighedsnævn (grundskyddsnämnd). Nævnet kan vurdere hvorvidt de enkelte kommuners service lever op til kravene. Hvis nævnet finder, at kommuners servicesystem er mangelfuldt, og at kommunerne bærer ansvaret herfor, kan nævnet anbefale kommunen hvordan manglerne skal udbedres og indenfor hvilken tidsramme det skal ske.

Patienterne har mange muligheder for at klage over den behandling eller service som de har modtaget. Den mest simple måde er at give udtryk for sin utilfredshed overfor den læge som har stået for behandlingen eller henvende sig til den læge som leder afdelingen eller sundhedscentret. Hvis det er nødvendigt med ekstern assistance for at løse problemet kan patienten enten henvende sig til embedslægen eller Rättsskyddscentralen för hälsovården. Begge har muligheder for at komme med udtalelser og sanktioner hvis det er påkrævet.

ÅLAND: Tilsynet med sundhedspersonalet sker efter finsk lovgivning.

Klager over behandlingen kan - som i Finland - enten indgives til de respektive behandlingsinstitutioner eller til de nationale myndigheder - eller til Landskapsregeringen. På Åland er patientombudsmanden ansat af Landskapsregeringen og er således uafhængig i forhold til de respektive behandlingsinstitutioner. Patientombudsmanden kan tage principielt vigtige spørgsmål op i "fortrolighedsnævnet" hvor spørgsmålene kan diskuteres og danne grundlag for afgørelser, men nævnet kan ikke afgøre de enkelte sager.

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ICELAND: The Medical Director of Health has overall responsibility for 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 Control Agency (IMCA) supervises pharmacies and pharmaceutical products.

Complaints concerning health services are addressed to the Medical Director of Health, who evaluates the complaints and makes decisions. The leadership in the institution involved must also be informed about the complaint. In case of conflict, the case can be dealt with by a special board (consisting of three persons appointed by the Supreme Court). Complaints can also be forwarded directly to this board.

NORWAY: The Norwegian Board of Health (centrally) and the Norwegian Board of Health in each county are responsible for supervision of health services and health care personnel.

These bodies are professional and independent supervision authorities, with competence in the fields of health service and health legislation.

Supervision of health services by the Norwegian Board of Health can be divided into three main areas: 1. general supervision, 2. supervision of health services and 3. supervision of health care personnel.

General supervision involves monitoring health services provision and observing trends in the health status of the popula-

ISLAND: Medicinaldirektøren fører fagligt tilsyn med sundhedsinstitutionerne, sundhedspersonalet, ordination af lægemidler (recepter), misbrugsbekæmpelse og kontrol med alle offentlige sundhedsforanstaltninger.

Lægemiddelstyrelsen fører det farmaceutiske tilsyn med apoteker og lægemidler.

Medicinaldirektøren modtager klager vedrørende sundhedsvæsenet og foretager de nødvendige undersøgelser og træffer afgørelserne. Sundhedsinstitutionernes ledelse skal dog gøres bekendt med klagen. Opstår en konflikt kan sagen tages op i et særligt nævn (nævnet består af tre personer som er udpeget af Højesteret). Klager kan også gå direkte til nævnet.

NORGE: Helsetilsynet (centralt) og Helsetilsynet i amterne (fylkene) fører tilsyn med sundhedsvæsenet og sundhedspersonale.

Disse organer skal være faglig kompetente og uafhængige tilsynsmyndigheder med forskellig kompetence indenfor sundhedsservice og sundhedslovgivning.

Helsetilsynets tilsynsopgaver overfor sundhedsvæsenet kan opdeles i 3 områder: 1. overordnet tilsyn 2. tilsyn med virksomhederne og 3. tilsyn med sundhedspersonale (hændelsesbaseret tilsyn).

Det overordnede tilsyn består af at føre kontrol med social- og sundhedsvæsenets ydelser samt følge med i befolkning-

tion. Such information is used to evaluate the supply of health services, both in relation to the needs of the population and in relation to national aims and priorities.

Supervision of health services is carried out as organizational audits: systematic appraisal of health care, to ascertain whether activities and results are in accordance with current laws and regulations, and whether internal control systems function in practice. Every institution providing health services has a duty to establish an internal control system to ensure that the institution is run in accordance with laws and regulations.

Surveys are also carried out: collection of data and information from health care institutions or about patient groups.

The Norwegian Board of Health in the counties process complaints against individual health care personnel. They can 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 (centrally).

If health care personnel do not comply with the regulations, the Norwegian Board of Health may give them a warning, or may suspend or recall their authorization or approval as health care personnel.

Patients can also address their complaints to the person in charge of an institution (e.g. the municipal board in the case of municipal health services), or to

gens behov, og derudfra vurdere behovsdækningen og tilbudsudformningen i forhold til de nationale mål og prioriteringer.

Tilsynet med sundhedsvæsenet sker ved systemrevision: Systematiske undersøgelser, for at fastslå om aktiviteter og tilhørende resultater er i overensstemmelse med de krav der fastsættes i henhold til love og forskrifter, samt om det interne kontrolsystem fungerer i praksis. Enhver virksomhed der udbyder sundhedsydelser har pligt til at etablere et internt kontrolsystem med henblik på at sikre at virksomheden drives i overensstemmelse med love og forskrifter.

Der bliver også gennemført kortlægning: Indsamling af data og oplysninger fra virksomheder eller om patientgrupper.

Helsetilsynet i amterne (fylkene) behandler klager rettet mod institutioner/virksomheder og den enkelte sundhedsmedarbejder. I tilfælde af, at der konstateres afvigelser fra regelsættene kan de rette kritik mod de aktuelle aktører.

Hvis der er et grundlag for at benytte strengere sanktioner oversendes klagen til Helsetilsynet (centralt).

Hvis sundhedspersonalet ikke overholder regelsættene kan Helsetilsynet give sundhedspersonalet en tilrettevisning eller advarsel, eller den kan suspendere eller tilbagekalde autorisation/godkendelse som sundhedsmedarbejder.

Patienterne vil også kunne klage til den ansvarlige for virksomheden (fx kommunalbestyrelsen når det gælder kommunale sundhedsydelser) eller til Norsk

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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 county and regional authorities are responsible for offering high quality health care for residents in their area. They are also responsible for community dental care (primarily for children and young persons).

Through legislation, the government sets the framework and supervises all activities.

The National Board of Health and Welfare is the central supervisory authority for health services and hospital services. According to the Act Relating to Active Health Personnel, the National Board of Health and Welfare has responsibility for supervision of all health services except for those provided by the army. The Board has six regional offices. In addition to the National Board of Health and Welfare, there are several central supervision authorities within environmental and health protection.

Pursuant to the Act Relating to Support and Service for Persons with Certain Functional Impairments, the municipalities have most of the responsibility for mentally handicapped people. The county and regional authorities have responsibility only for specific advice and personal support that requires special knowledge about the problems and life situation of people with severe and permanent disabilities.

The agencies with overall responsibility for health services have their own impartial (patient) boards that are independent

patientskadeerstatning, hvis der er tale om erstatning som følge af behandling i det offentlige sundhedsvæsen.

SVERIGE: Det er landstingene og regionerne som har ansvaret for at tilbyde en god sygdomsbehandling for indbyggerne i deres områder. De har ligeledes ansvaret for den offentlige tandpleje (først og fremmest for børn og unge).

Gennem lovgivning fastlægger staten rammerne for virksomheden og fører tilsyn med den.

Socialstyrelsen er statens centrale tilsynsmyndighed for sundheds- og sygehusvæsenet. I følge loven om erhvervsvirksomhed indenfor sundhedsområdet er Socialstyrelsen tilsynsmyndighed for hele sundhedsvæsenet, med undtagelse af sundhedsydelser inden for forsvaret. Styrelsen har seks regionale kontorer. Som et supplement til Socialstyrelsen er der et antal centrale tilsynsmyndigheder inden for miljø- og sundhedsbeskyttelse.

Ansvaret for de psykisk udviklingshæmmede er jf. loven om støtte og service til visse funktionssvigt i hovedsagen henlagt til kommunerne. Landstingene og regionerne har kun ansvaret for den særlige, aktiverende rådgivning og anden personlig støtte, som kræver særlig indsigt i problemer og livsbetingelser for personer med store og permanente funktionsnedsættelser.

De hovedansvarlige for sundhedsvæsenet har egne upartiske nævn (patientnævn) som er uafhængige af behand-

of health institutions. Patients' complaints may be addressed to these boards. The main aims of these boards are to provide sound information and to ensure acceptable solutions for patients.

The Medical Responsibility Board (HSAN) is an independent government authority that deals with complaints against health care personnel.

lingsstederne og hvortil man kan henvise klager fra patienterne. Hovedformålet med nævnene er at de skal bidrage med god information og at sikre løsninger som patienterne er indforståede med.

Hälso- och sjukvårdens ansvarsnämnd (HSAN) (Sundhedsvæsenets ansvarsnævn) er en uafhængig statslig myndighed som efterprøver klager over sundhedspersonale.

1.4 Financing of health services

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

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. The fee for service financing is based on the principle that a service producer (i.e. the hospital) is paid on the basis of services rendered. The scheme involves the state reimbursing a percentage of the average DRG expense (Diagnosis Related Groups) in connection with treatment of patients.

1.4 Finansiering af sundhedsvæsenet

I de nordiske lande finansieres sundhedsvæsenet hovedsageligt af det offentlige. I Island er det primært staten, der bidrager, mens finansieringen i de øvrige lande stammer fra amtskommunale og/eller kommunale skatter samt bloktilskud fra staten. I de nordiske lande yder staten et generelt bloktilskud til amter og/eller kommuner. Med undtagelse af Grønland bidrager borgerne i de nordiske lande direkte til finansieringen, dels gennem forsikringsordninger, dels ved brugerbetaling. Det er kun Danmark og Norge der anvender DRG i deres finansieringsmodeller.

For Norges vedkommende er der etableret en finansieringsmodel for de somatiske sygehuse (fra 1. juli 1997) som kombinerer bloktilskud og stykprisfinansiering. Ordningen bliver jævnligt evalueret og justeret. Stykprisfinansieringen bygger på det princip, at en serviceproducent (det vil sige sygehuset) får indtægter beregnet ud fra udførte serviceopgaver. Ordningen indebærer, at staten refunderer en vis procentandel af de gennemsnitlige DRG-udgifter (Diagnose Relaterede Grupper).

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In the case of Denmark, as a result of the Structure Reform, the newly established regions gained responsibility for the health sector from 1 January 2007. A new financial system for the regions was agreed upon. About three quarters of the regions' expenditure is 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.

For Danmarks vedkommende indebærer strukturreformen, at regionerne fik ansvaret for sundhedsvæsenet fra den 1. januar 2007. Dermed er der vedtaget et nyt finansieringssystem for regionerne. Omkring tre fjerdedele af udgifterne finansieres gennem bloktilskud fra staten. Det resterende finansieres gennem et grundbidrag fra kommunerne samt kommunale og statslige aktivitetsafhængige tilskud.

1.5 Charges for health care as per 1 January 2007

1.5 Egenbetaling for sundhedsydelser pr. 1. januar 2007

Consultation with a physician

Lægebesøg

DENMARK: As shown in the overview, there are no user charges in Denmark, the Faroe Islands and Greenland.

DANMARK: Som det fremgår af oversigten er der ingen egenbetaling i Danmark, på Færøerne og i Grønland.

FINLAND: The following charges may be made for outpatient treatment in health centres:

FINLAND: I forbindelse med den primære lægebehandling ved sundhedscentrene kan der opkræves følgende betaling:

- A fixed annual charge of max. EUR 22 within one year or:
- A fixed charge per visit of max. EUR 11. The charge is only made for the first three visits at the same health centre during one calendar year.

- En fast årlig betaling på højst 22 EUR inden for et år, eller:
- Et fast beløb pr. besøg, dog højst 11 EUR. Beløbet skal kun betales for de første tre besøg på et og samme sundhedscenter i løbet af samme kalenderår.

A charge of EUR 15 can be made for visits to a health centre on weekdays between the hours of 2000 and 0800, and on Saturdays, Sundays and public holidays.

Der kan opkræves en betaling på 15 EUR for besøg ved helsecentrene på hverdage mellem kl. 20 og kl. 8 samt lørdage, søndage og helligdage.

The charges do not apply to persons under 18 years of age.

De nævnte beløb opkræves ikke af personer under 18 år.

Reimbursements of private physicians' fees are based on fixed charges. The National Social Insurance Institution reimburses 60 per cent of the physician's fee. However, in most cases the actual charge is higher and thus the reimbursement is less than 40 per cent.

ÅLAND: For medical consultations within the primary health service at a clinic, or for home visits, there is a user charge of EUR 15. Outside the opening hours the charge for home visits is EUR 20. The fee for a visit to a specialist and a casualty department is EUR 25. The maximum patient contribution for primary health care and outpatient treatment is EUR 300 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 20 per day to EUR 10 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 125 per calendar year. After this amount has been reached all treatment, short stays in hospital departments for children and young people is free. The fee per day for a hospital stay for persons over 65 years of age is reduced from EUR 20 to EUR 10 for people 65 years and older. The activities included in the maximum user charge have been fixed beforehand. If there is a waiting period of 45 minutes or more in connection with a scheduled visit during normal opening hours, 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.

Tilskud til behandling hos en privatpraktiserende læge er baseret på et fast egenbetalingsbeløb. Folkpensionsanstalten refunderer 60 pct. af lægens honorar. I de fleste tilfælde er egenbetalingen dog større og refusionen derfor mindre end 40 pct.

ÅLAND: Egenbetaling for lægebesøg inden for det primære sundhedsvæsen i konsultationen eller ved hjemmebesøg er 15 EUR. Uden for åbningstiden er afgiften for hjemmebesøg 20 EUR. Besøg hos en specialist er 20 EUR og på skadestuer 25 EUR. Der er indført maksimal egenbetaling på 300 EUR for lægebesøg og ambulant behandling indenfor et kalenderår hvorefter der ikke betales den resterende del af året med undtagelse af kortvarig institutions/hospitalsophold hvor betalingen reduceres fra 20 EUR pr døgn til 10 EUR pr døgn. For børn og unge under 18 år samt personer 65 år og ældre er den maksimale egenbetaling 125 EUR per kalenderår, herefter er al behandling, inklusiv korttidsbehandling på en hospitalsafdeling for børn og unge gratis, mens døgnbetalingen reduceres fra 20 EUR til 10 EUR for personer 65 år og ældre. uden egenbetaling, inklusiv korttidsbehandling på en hospitalsafdeling. De aktiviteter som medregnes i den maksimale egenbetaling er fastlagt på forhånd. Hvis der er en ventetid på 45 minutter eller mere ved en aftalt besøg, indenfor åbningstiden, tilbagebetales egenbetalingen.

ISLAND: Lægebesøg af forebyggende karakter for gravide, mødre og deres børn samt skolesundhedsplejen er uden egenbetaling.

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The patient charge for a consultation in a health centre or with a private general medical practitioner during normal working hours is ISK 700. The charge is ISK 350 for children under 18, pensioners, disabled people, and long-term unemployed people. The charge is ISK 230 for children who are disabled or chronically ill. Outside normal working hours the charges are ISK 1 750, 800 and 500 respectively. Charges for home visits are ISK 1 850, 700 and 500 during the daytime and ISK 2 600, 1 000 and 700 in the evenings and at night.

The user charge for a consultation with a specialist is either ISK 2 700 plus 40 per cent of the remaining cost of the consultation, or ISK 900 plus 13.3 per cent of the remaining cost for the consultation. The user charge for disabled and chronically ill children is one ninth of the total charge, with a minimum of ISK 450. The maximum user charge for all groups is ISK 18 000. The same patient charges apply to outpatient treatment in hospitals. Different charges apply to laboratory tests and X-ray examinations.

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

NORWAY: There is a user charge for medical consultations with general medical practitioners and specialists, outpatient treatment in hospitals, and treatment in casualty clinics.

The user charges for a consultation with a physician and for casualty services are: primary physician: NOK 125 (day), NOK 210 (evening), specialist: NOK 150 (day), NOK 235 (evening).

Egenbetalingen for konsultation i sundhedscentrene eller ved en privat praktiserende læge er i dagtimerne 700 ISK og 350 ISK for børn under 18, pensionister, funktionshæmmede og langtidsløse. Funktionshæmmede og langtidssyge børn betaler 230 ISK. Konsultation udenfor dagtimerne er henholdsvis 1 750, 800 og 500 ISK. For hjemmebesøg er betalingen i dagtimerne 1 850, 700 og 500 ISK mens aften- og natkassen er 2 600, 1 000 og 700 ISK.

Egenbetalingen for besøg hos en specialist er enten 2 700 ISK plus 40 pct. af de resterende udgifter, eller 900 ISK og 13,3 pct. af de resterende udgifter. For funktionshæmmede og langtidssyge børn er egenbetalingen 1/9 af de samlede udgifter minimum 450 ISK. For alle grupper er maksimumbetalingen 18 000 ISK. Egenbetalingen er den samme ved behandling ved hospitalernes ambulatorier men en anden for laboratorieprøver og røntgenbehandling.

Egenbetaling for personer som har været arbejdsløse i en samlet periode på 6 måneder eller mere er den samme som for pensionister.

NORGE: Der er egenbetaling for lægebesøg hos både almene læger og speciallæger, ambulant behandling ved sygehuse og samt behandling hos lægevagten.

Egenbetalingen for konsultation hos en læge og hos lægevagten er følgende: Almenlæge: 125 NOK (dag) og 210 NOK (aften). Hos en specialist: 150 NOK (dag) og 235 NOK (aften).

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The user charges for a home visit are: primary physician: NOK 170 (day) and NOK 280 (evening), specialist: NOK 195 (day) and NOK 305 (evening).	Egenbetalingen ved sygebesøg er som følgende: Almen læge 170 NOK (dag) og 280 NOK (aften), speciallæger: 195 NOK (dag) og 305 NOK (aften).
The user charge for a consultation at a hospital out-patient department is NOK 265.	Egenbetalingen for ambulante patienter på et hospital er 265 NOK.
The user charge for laboratory tests, histological tests and cytological tests is NOK 47.	Egenbetalingen for laboratorie-, histologiske- og cytologiske prøver er 47 NOK.
The user charge for a radiograph or an ultrasound examination is NOK 200.	Egenbetaling for røntgen- og ultralydsundersøgelser er 200 NOK.

User charges for a consultation with a physician

	Are there consistent rules for the whole country?	Size of user charge	Deviations	User charge in relation to total cost of consultation
Denmark	Yes	-	No	-
Faroe Islands	Yes	-	No	-
Greenland	Yes	-	No	-
Finland	Yes	Public EUR 0-11 EUR 15 if the visit occurs between 2000 and 0800 or on a Saturday, a Sunday or a public holiday. Private min. 40 per cent	No charge for children under 18 years of age	..
Åland	Yes	EUR 15 Outside opening hours for home visits, and specialist EUR 20	Free treatment after paying EUR 300, EUR 125 for children below 18 and people 65 + EUR	..
Iceland	Yes	ISK 700-2 600 in primary care, other rules for specialized care	ISK 350-1 000 for children under 18 years of age, pensioners, disabled and long-term unemployed. For handicapped and chronically ill children ISK 230-700	Varies
Norway	Yes	Consultation with a primary physician: NOK 125 (day), NOK 210 (evening) Consultation with a specialist: NOK 150 (day) and NOK 235 (evening)	In the case of pregnancy, childbirth, treatment of industrial injuries, war injuries, for prison inmates, children under 12 years of age, in the case of psychotherapy for persons under 18 years of age and for treatment of dangerous contagious diseases	Approx 35 per cent
Sweden	No	SEK 100-300	Yes	..

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There is a user charge for assisted fertilization and sterilization. The rules for patient charges for sterilization do not apply if there are medical indications for the operation.

Der er desuden egenbetaling for kunstig befrugtning og sterilisering. Der er ingen egenbetaling for sterilisering, hvis indgrebet skyldes en medicinsk indikation.

The Health Insurance Scheme offers full reimbursement for treatment of children under the age of seven years, treatment of industrial injuries, war injuries, pregnancy and childbirth, and, in certain other cases (e.g. treatment of dangerous contagious diseases, psychotherapy for persons under the age of 18 years, and treatment of prison inmates).

Folketrygden yder fuld refusion ved behandling af børn under 7 år, ved behandling af arbejdsskader, krigsskader, svangerskab/fødsler og i enkelte andre tilfælde (fx behandling af farlige, smitsomme sygdomme, psykoterapeutisk behandling af personer under 18 år og behandling af indsatte i fængsler).

Egenbetaling for lægebesøg

	Er der ensartede regler i hele landet?	Egenbetalingens størrelse	Afvigelser	Egenbetalingens andel af de samlede udgifter til lægebesøg
Danmark	Ja	-	Nej	-
Færøerne	Ja	-	Nej	-
Grønland	Ja	-	Nej	-
Finland	Ja	Offentlig 0-11 EUR. 15 EUR for besøg mellem kl. 20-8 på hverdage, samt lørdage, søndage og helligdage Privat mindst 40 pct.	Ingen betaling for børn under 18 år	..
Åland	Ja	15 EUR 20 EUR for hjemmebesøg udenfor åbningstiderne og besøg hos specialist.	Fri behandling når der er betalt. 300 EUR, 125 EUR for børn under 18 år, samt personer 65 år og ældre	..
Island	Ja	700-2 600 ISK hos almen læge, andre regler for besøg hos specialist	350-1 000 ISK for børn under 18 år og for pensionister, handicappede og langtidsarbejdsløse. For handicappede og langtidssyge børn 230-700 ISK	Varierende
Norge	Ja	Hos almen læge: 125 NOK (dagtimer) 210 NOK (aften og nat) Konsultation hos en specialist: 150 NOK (dagtimer) og 235 NOK (aften og nat)	Ved svangerskab/fødsel, erhvervsskade, krigsskade, for indsatte i fængsel, børn under 12 år, ved psykoterapeutisk behandling af børn og unge under 18 år og ved farlige smitsomme sygdomme.	Ca. 35.pct.
Sverige	Nej	100- 300 SEK	Ja	..

SWEDEN: Local authorities (county and regional authorities) set the charges themselves. According to the law, the maximum amount a patient shall pay for out-patient treatment is SEK 900 during a 12-month period. For medical consultations in out-patient clinics and visits to a health centre or a general medical practitioner, the user charge varies from SEK 100 to 150. The patient charge for a medical consultation with a specialist (in hospitals or in private practice) varies from SEK 200 to 300.

In most counties/regions, children and young people under the age of 20 years may attend an outpatient clinic free of charge. In some counties children and young people pay a lower user charge than adults. In the regions, the age limit for paying user charges varies from 16 years to the calendar year in which a person turns 20. In one county, user charges are lower for persons 65 years of age and older.

Reimbursement for pharmaceutical products

DENMARK: There are no fixed percentages for reimbursement of fees for pharmaceutical products in Denmark, since 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.

SVERIGE: De lokale myndigheder (landstingene og regionerne) fastsætter selv taksterne. I følge loven skal patienter højest betale 900 SEK for ambulant behandling for en 12 måneders periode. For ambulant behandling, besøg på helsecentre eller hos huslægen varierer egenbetalingen fra 100 til 150 SEK, mens den varierer fra 200 til 300 SEK ved lægebesøg hos specialister (ved sygehusene eller hos privatpraktiserende læger).

I de fleste landsting/regioner kan børn og unge under 20 år gå til ambulant lægebehandling uden brugerbetaling. I nogle landsting betaler børn og unge en lavere egenbetaling end voksne. I regionerne varierer grænsen for at der ikke opkræves brugerbetaling mellem 16 år og det kalenderår hvor man fylder 20 år. I et landsting er egenbetalingen lavere for personer 65 år og ældre.

Tilskud til lægemidler

DANMARK: Tilskuddene i Danmark er ikke forsynet med en fast procentsats, da tilskuddet afhænger af størrelsen af den enkelte patients lægemiddelforbrug. Procentsatsen stiger i takt med patientens lægemiddelforbrug.

Lægemidler med tilskud er lægemidler med en sikker og værdifuld terapeutisk effekt på en velafgrænset indikation, hvor lægemidlets pris står i rimelig forhold til dets behandlingsmæssige værdi.

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An individually assessed subsidy may be granted by submitting an application through one's own doctor to the Danish Medicines Agency.	Der kan opnås individuelt tilskud til lægemidler uden generelt tilskud ved at indsende ansøgning til Lægemiddelstyrelsen gennem egen læge.
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 calculating the subsidy.	Lægemiddelstyrelsen udarbejder en tilskudspris for hver af de lægemiddelgrupper, der er omfattet af tilskudsprissystemet. Tilskudsprisen er den pris, der lægges til grund for beregning af tilskud.
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. There are no changes to subsidy based on need.	Beregningen af tilskud foretages ud fra den enkelte paknings tilskudspris. Der kan dog aldrig gives tilskud til mere end lægemidlets faktiske pris. Det behovsafhængige tilskud bevares uændret.
The aim of the system is that physicians and dentists shall 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.	Systemet tilstræber, at lægen/tandlægen vælger det billigste produkt på markedet (substitution). Lægen/tandlægen kan i særlige tilfælde fravælge substitution, når denne finder at substitution på apoteket er uhensigtsmæssigt.
Current prices are determined for all pharmaceutical products on the market that have a marketing licence.	Der udarbejdes løbende en specialitetstakst, som omfatter priser på alle markedsførte farmaceutiske specialiteter.
Since liberalization in October 2001 there are now more than 1 500 authorized agents for non-prescription pharmaceutical products for people or animals.	Siden liberaliseringen i oktober 2001 findes der i Danmark nu mere end 1 500 godkendte forhandlere af ikke apoteksforbeholdte håndkøbslægemidler til mennesker og/eller dyr.
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.	Fælles for de godkendte forretninger uanset sortiment af lægemidler er, at de skal respektere gældende regler vedrørende opbevaring og kvalitet samt forbud mod selvvalg og salg til børn under 15 år.

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 is to 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 health insurance contributions, and part is covered by patient contributions. Pensioners are reimbursed user charges exceeding a certain amount. The same applies to people who have been granted pharmaceutical products in accordance with the Social Security Act.

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.

FINLAND AND ÅLAND: There are three payment categories (42, 72 and 100 per cent) for prescription pharmaceutical products, and reimbursement is calculated separately for each purchase and for each category. 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), in special cases, are paid for by the hospital or

Forhandlere af håndkøbsmedicin til mennesker skal desuden være i besiddelse af et basissortiment fastsat ved lov. Af visse håndkøbslægemidler, f.eks. smertestillende, må der max. sælges én pakning pr. kunde pr. dag.

Lister over lægemidler, der må forhandles uden for apotek, er tilgængelig på Lægemiddelstyrelsens hjemmeside www.laegemiddelstyrelsen.dk.

FÆRØERNE: En del af medicinudgifterne dækkes af sygekassekontingent og en del af brugerbetaling. Pensionister får refunderet brugerbetalingen over et vist beløb. Medicin kan desuden bevilges efter forsørgsloven.

GRØNLAND: Al medicin distribueres gennem sundhedsvæsenet, bortset fra håndkøbsmedicin der i stærkt begrænset omfang forhandles fra enkelte dagligvarebutikker. Håndkøbsmedicin udleveres i varierende grad fra sundhedsvæsenet i distrikterne.

FINLAND OG ÅLAND: Der er tre betalingskategorier for receptpligtige lægemidler, (42, 72 og 100 pct.) og refusionen er beregnet separat for hvert indkøb og hver kategori. Der er dog en egenbetaling på 3 EUR på præparater med 100 procents refusion.

Nogle nye og meget dyre medikamenter (for eksempel mod demens og multipel sklerose) bliver i særlige tilfælde betalt af

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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 in relation to which products should be reimbursed.

In addition to reimbursement for medicines, reimbursement can also be given for diet 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 627.47 in the course of one calendar year.

ICELAND: Pharmaceutical products for the treatment of certain diseases are paid for entirely by the health insurance scheme. For other types of pharmaceutical products, patients pay the full cost themselves.

In special cases, reimbursement by the health insurance scheme may be higher, so that the patient contribution is lower than shown in the overview.

There is a reference price system. For generic drugs of the same type, strength and package size, the reimbursement is calculated in relation to the maximum reference price, i.e. the lowest priced generic product. The present reference price list covers about 12.6 per cent of registered drug products.

NORWAY: Most pharmaceutical products are reimbursed according to a system based on diagnoses and approved pharmaceutical products prescribed by a phy-

hospitalet eller kommunen. Der forekommer ingen automatisk accept af nye medikamenter i refusionssystemet og mange medikamenter bliver markedsført uden tilskud. Sundhedsøkonomerne har fået større og større indflydelse på hvilke medikamenter der skal gives tilskud til.

Ud over medicin kan der også gives tilskud til kost for nogle behandlingskrævende sygdomme ligesom til salver ved behandling af kroniske hudsygdomme.

Som hovedregel dækker sygeforsikringen de udgifter til receptpligtige lægemidler som overskrider et beløb på 627,47 EUR i løbet af et kalenderår.

ISLAND: Lægemidler til behandling af visse sygdomme betales fuldt ud af sygeforsikringen. For andre typer af medicin betaler patienterne selv det fulde beløb.

I særlige, individuelle tilfælde kan refusionen fra sygesikringen være højere og egenbetalingen dermed lavere end det fremgår af oversigten.

Der findes desuden et referenceprissystem. For synonympræparater med samme form, styrke og forpakning, beregnes tilskuddet i forhold til den maksimale referencepris, forstået som den laveste pris på synonympræparatet. Den nuværende referenceprisliste dækker ca. 12,6 pct. af de registrerede lægemidler.

NORGE: De fleste lægemidler refunderes efter et system baseret på diagnoser og godkendte præparater foreskrevet af en læge (den såkaldte blå recept). Udgangs-

sician (the so-called "blue prescription"). A condition is long-term need for the pharmaceutical product, medical equipment or medical item. The patient charge for these is 36 per cent of the cost, up to a maximum of NOK 510 per prescription. Children under seven years of age and persons who receive a minimum pension are exempt from patient charges for essential pharmaceutical products. For other pharmaceutical products, the patient pays the full price.

From 3 March 2003, the index price system was introduced for some pharmaceutical products available on "blue prescription". The arrangement with index price applies to pharmaceutical products that are exchangeable, that is to say medicines and drugs that have the same active ingredient. The purpose of the index price arrangement is to achieve increased use of the most reasonable alternative when the same medicines are available at different prices.

SWEDEN: The new Act on Pharmaceutical Benefits etc. came into force in 2002. A pharmaceutical product is subsidized only if it has been approved by the Pharmaceutical Benefits Board and is on the list of approved pharmaceutical products. There are certain conditions that must be met before a pharmaceutical product is added to the approved list and the price for the consumer is reduced. The code of the place of work must be on the prescription for reimbursement. The prescription must be for the cheapest product available from a pharmacy. The approved list of pharmaceutical products gives everyone the right to a reduced price for the approved product.

punktet er at man langvarigt har behov for lægemidlet, medicinsk udstyr eller forbrugsvarer. Egenbetalingen for disse er 36 pct., dog maksimalt 510 NOK pr. recept. Børn under 7 år og personer der modtager mindstepension betaler ikke for vigtige lægemidler. Andre lægemidler betales fuldt ud af patienten.

Fra den 3. marts 2003 er der indført et indexprissystem for en del medicin på "blå recept". Ordningen med indexregulering gælder lægemidler der er substituerbare, dvs. lægemidler der har den samme terapeutiske virkning. Formålet med indexreguleringen er at åbne for et større brug af rimelige alternativer idet der findes mange substanser med samme virkning men til en forskellig pris.

SVERIGE: I 2002 kom loven om lægemidler m.v. Det er en forudsætning at lægemiddelsnævnet har besluttet at lægemidlet skal omfattes af en godkendt liste over lægemiddelprodukter for at det kan gives tilskud til et lægemiddel. Desuden er der visse krav der skal opfyldes for at et lægemiddel skal kunne optages på den godkendte liste og give den enkelte forbruger en reduceret lægemiddelpris. Recepten skal være forsynet med en arbejdspladskode for at patienten kan få rabat. Lægemidler der bliver udleveret på recept skal udleveres som det billigste produkt der findes tilgængelig på apoteket. Den godkendte liste over lægemidler giver den enkelte ret til en reduceret pris på de godkendte produkter.

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The discount is calculated according to the value of the pharmaceutical product bought. The maximum user charge is SEK 1 800. Over this amount, the patient receives a card granting exemption from payment for the rest of the 12-month period. For purchases of up to SEK 900 over a 12-month period, the user pays the full cost. A discount is given for costs exceeding this amount. For costs between SEK 900 and SEK 1 700, there is a 50 per cent discount. Between SEK 1 700 and SEK 3 300 the discount is 75 per cent, and between SEK 3 300 and 4 300 the discount is 90 per cent. When pharmaceutical products have been purchased to the value of SEK 4 300, the maximum limit for user charges has been reached. At this level, the patient will have paid SEK 1 800 and receives a free pass for the rest of the 12-month period. The scheme covers discount approved pharmaceutical products on prescription, including contraceptives and products used for stoma. Insulin is free of charge.

Rabatten udregnes efter værdien på de lægemidler som købes. Den maksimale egenbetaling er 1 800 SEK. Derefter modtager patienterne et frikort for resten af 12 måneders perioden. For indkøb op til 900 SEK i en 12 måneders periode betaler man selv det hele. På udgifter derudover ydes der rabat. For udgifter mellem 900 SEK og 1 700 SEK gives der 50 pct. rabat. Mellem 1 700 og 3 300 SEK er rabatten 75 pct. og for udgifter mellem 3 300 SEK og 4 300 SEK er rabatten 90 pct. Når der er købt lægemidler for 4 300 SEK har man nået op på egenbetalingens maksimum. Patienten har ved dette niveau selv betalt 1 800 SEK og får så tildelt et frikort for resten af 12 måneders perioden. Ordningen omfatter rabatberettigede lægemidler på recept, inkl. P-piller og brugsartikler til stomier. Insulin er gratis.

User charges for pharmaceutical products

	Are there consistent rules for the whole country?	Size of user charge	Deviations	User charge in relation to total cost of pharmaceutical products
Denmark	Yes	Reimbursement in relation to the level of the patient's consumption of drugs in the primary sector	No	25 per cent
Faroe Islands	Yes	..	No	..
Greenland	Yes	-	No	-
Finland	Yes	58 per cent of the cost	For certain diseases 3 EUR or 28 per cent of the cost (disease specific)	..
Åland	Yes	As in Finland	As in Finland	-
Iceland	Yes	ISK 1 700+ 65/80 per cent of the remaining cost, but max. ISK 3 400/4 950	Pensioners and disabled: ISK 600 + 50 per cent of the remaining cost, but max. ISK 1 050/1 375	Approx. 34 per cent
Norway	Yes	36 per cent maximum NOK 510 per prescription	For children below 12 years and persons who receive a minimum pension: no user charge	..
Sweden	Yes	SEK 0-1 800	-	..

Egenbetaling for lægemidler

	Er der ensartede regler i hele landet?	Egenbetalingens størrelse	Afvigelser	Egenbetalingens andel af de samlede udgifter til lægemidler
Danmark	Ja	Tilskud afhængig af størrelsen af den enkelte patients lægemiddelforbrug i primærsektoren	Nej	25 pct.
Færøerne	Ja	..	Nej	..
Grønland	Ja	-	Nej	-
Finland	Ja	58 pct. af beløbet	Ved visse sygdomme betales 3 EUR eller 28 pct. af beløbet (sygdomsspecifikt)	..
Åland	Ja	Som i Finland	Som i Finland	-
Island	Ja	1 700 ISK + 65/80 pct. af den resterende pris, dog højst 3 400/4 950 ISK	Pensionister og handicappede: ISK 600 + 50 pct. af den resterende pris, dog højst 1 050/1 375 ISK	Ca. 34 pct.
Norge	Ja	36 pct. maksimum 510 NOK pr. recept	For børn under 12 år og personer som kun modtager mindstepension: ingen egenbetaling	..
Sverige	Ja	0-1 800 SEK	-	..

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, see 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 for the public health service, but according to somewhat different regulations in the different countries.

FINLAND OG ÅLAND: Patients pay a charge for admission to hospitals and health centres: EUR 26 (Åland EUR 20), and psychiatric departments: EUR 12. For short-term treatment there is a charge of EUR 15 per day. The charge for rehabilitation is EUR 9 per treatment day and the maximum user charge for day surgery is EUR 72 (Åland EUR 10) plus EUR 26, if the patient has to stay overnight. A series of treatments costs EUR 6 per visit (Åland EUR 5) (max. 45 times per year).

A ceiling has been introduced for the maximum user charge of EUR 590 (Åland EUR 300) during one calendar year, after which services are free of charge for the rest of the year, with the exception of short-term stays in institutions/hospitals, for which the user charge can be reduced from EUR 26 per day to EUR 12 per day. (Åland from EUR 20 to EUR 10 per day). In Åland, people under 18 years of age do not pay for short-term treatment when the maximum user charge has been reached.

Behandlinger ved sygehuse

Som det fremgår af skemaet er der ingen brugerbetaling for sygehusophold i Danmark, på Færøerne, i Grønland, Island og Norge. Dog betales der i Island og Norge for ambulant specialistbehandling ved hospitaler, jvf. afsnittet om lægesøg. Der findes private hospitaler i de fleste af de nordiske lande, som arbejder helt eller delvist for det offentlige, men efter noget forskellige regler fra land til land.

FINLAND OG ÅLAND: Patienterne betaler for indlæggelse på hospital og sundhedscentre 26 EUR (Åland 20 EUR), og psykiatrisk afdeling 12 EUR. For korttidsbehandling betales der 15 EUR pr behandlingsdag. Betaling for revalidering er 9 EUR pr behandlingsdag og den maksimale betaling for dagkirurgi er 72 EUR (Åland 10 EUR) plus 26 EUR, hvis der er behov for en overnatning. Seriel behandling koster 6 EUR per besøg (Åland 5 EUR) (max 45 gange per år).

Der er indført et loft på den maksimale egenbetaling på 590 EUR (på Åland 300 EUR) i løbet af et kalenderår, hvorefter ydelser er gratis resten af året, bortset fra kortvarige institutions/hospitalsoophold hvor egenbetalingen kan reduceres fra 26 EUR til 12 EUR pr døgn (Åland fra 20 til 10 EUR per døgn). På Åland betaler personer under 18 år ikke for kortvarig behandling når grænsen for den maksimale egenbetaling er nået.

SWEDEN: From 1998, the county and regional authorities may set the user charges for admitted patients at various levels, in relation to income levels, and on this basis they can decide to reduce user charges.

The maximum user charge is SEK 80 per day, but the payment varies between treatment boards. Some county and regional authorities differentiate user charges according to income, others according to age or to age and number of treatment days. Some have chosen a flat lower user charge with a ceiling for the size of the amount paid in total.

All county and regional authorities, with the exception of four of them, have agreed that children and young people under the age of 20 years receive free medical treatment (two county authorities have set the age limit for free treatment to the calendar year in which young people reach 19, and two county authorities has set the age limit up to and including 17 years).

SVERIGE: Fra og med 1998 kan landstingene og regionerne selv fastsætte egenbetalingen for indlagte patienter i forskellige niveauer, baseret på indkomstintervaller, og kan på det grundlag beslutte at nedsætte egenbetalingen.

Egenbetalingen er højst 80 SEK pr. dag men betalingen varierer mellem behandlingsnævne. Nogle landsting og regioner differentierer egenbetalingen efter indkomst, andre efter alder eller alder og antal behandlingsdage. Nogle har valgt en ensartet, lavere egenbetaling med et loft over den samlede egenbetalings størrelse.

Alle landsting og regioner på nær fire har besluttet at der skal ydes gratis sygdomsbehandling til børn og unge under 20 år (to landsting har fastsat grænsen til det kalenderår hvor de fylder 19 og i to landsting er det gratis til og med 17 år).

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User charges for hospitalization

	Are there consistent rules for the whole country?	Size of user charge	Deviations	User charges in relation to total cost of hospitalization
Denmark	Yes	-	No	-
Faroe Islands	Yes	-	No	-
Greenland	Yes	-	No	-
Finland	Yes	EUR 12 per day in short term care, EUR 26 per day in overnight care for day surgery EUR 72	Payment for long-term stay according to means. For children 0–17 years max. 7 days	..
Åland	Yes	EUR 20, EUR 10 for psychiatric wards EUR 40 for day surgery	Payment for long-term stay according to means	..
Iceland	Yes	-	No	-
Norway	Yes	-	No	-
Sweden	No	SEK 0–80 per day	..	..

Egenbetaling for indlæggelse på sygehus

	Er der ensartede regler i hele landet?	Egenbetalingens størrelse	Afvigelser	Egenbetalingens andel af de samlede udgifter til indlæggelse på sygehus
Danmark	Ja	-	Nej	-
Færøerne	Ja	-	Nej	-
Grønland	Ja	-	Nej	-
Finland	Ja	12 EUR pr sengedag for korttidsophold, 26 EUR per dag og for dagkirurgi 72 EUR	Betaling for langtidsophold efter betalingsevne, for børn 0–17 år dog max. i 7 dage	..
Åland	Ja	20 EUR, 10 EUR for indlæggelse på en psykiatrisk afdeling og 40 EUR for dagkirurgi.	Betaling for langtidsophold efter betalingsevne	..
Island	Ja	-	Nej	-
Norge	Ja	-	Nej	-
Sverige	Nej	0–80 SEK/dag	..	..

Reimbursement for dental treatment

DENMARK: Reimbursement is provided by the public health insurance scheme. Adults typically pay 60 per cent of the

Tilskud til tandbehandling

DANMARK: Tilskuddet til tandbehandling gives fra den offentlige sygesikring. Voksne betaler typisk 60 pct. af de over-

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agreed fees. No subsidy is granted for dentures.	enskomstfastsatte betalingstakster. Der ydes ikke tilskud til tandprotetik.
Municipal and regional dental services are regulated by health legislation.	Kommunal og regional tandpleje gives efter reglerne i sundhedsloven.
In addition, approximately 1.9 million Danes are covered by a private insurance scheme. Some schemes provide subsidies for dental treatment.	Derudover er ca. 1,9 millioner danskere dækket af en privat forsikringsordning som – afhængig af dækningsgrad og forsikringspræmie – giver tilskud til egenbetaling for tandlægehjælp.
Children and young people below 18 years of age receive free municipal dental care including orthodontic treatment. Children below 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 from 1 January 2007 there is a maximum annual charge of DKK 405. In addition, the municipalities provide a subsidy for dentures in cases of impaired function or disfigurement resulting from damage caused by accidents.	Der er vederlagsfri kommunal tandpleje, herunder tandregulering, for børn og unge under 18 år. Børn under 16 år, der ønsker et andet behandlingstilbud end det, kommunalbestyrelsen vederlagsfrit stiller til rådighed, kan – mod en vis grad af egenbetaling – vælge at modtage kommunal tandpleje i privat tandlægepraksis efter eget valg eller ved en anden kommunes tandklinik. Ældre personer, der bor på plejehjem eller i eget hjem med mange hjælpeforanstaltninger, tilbydes omsorgstandpleje, for hvilken der fra 1. januar 2007 maksimalt opkræves 405 DKK pr. år. Kommunen yder derudover støtte til tandproteser i tilfælde af funktionelt ødelæggende eller vansirende følger af ulykkesbetingede skader.
The municipality offers specialist dental treatment to persons, who because of psychiatric illness or mental handicap, 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 1st January 2007, charges the patient a maximum of DKK 1 515 per year.	Kommunen tilbyder specialiseret tandpleje til personer, der på grund af sindslidelser eller psykisk udviklingshæmning, ikke kan udnytte de eksisterende tandplejetilbud i børne- og ungdomstandplejen, voksentandplejen eller i omsorgstandplejen. For disse ydelser kan kommunen fra 1. januar 2007 opkræve en egenbetaling på 1 515 DKK årligt.
The region offers specialized dental care (regional dental service) or highly specialized dental care (in dental research	Regionen tilbyder specialiseret tandpleje (regionstandpleje) eller højt specialiseret tandpleje (i odontologisk landsdels- og

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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 to 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 2007, for these services the region can demand a user payment of a maximum of DKK 1 515 annually. Finally, the region provides highly specialized dental advice, examination and treatment (in dental research centres) for patients with rare diseases and handicaps, 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 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 by the health insurance scheme. The subsidy amounts to about half of the total cost of dental treatment for adults.

The municipalities provide a free dental service for children up to the age of 16.

videnscenter) til børn og unge med odontologiske lidelser, der ubehandlede medfører varig funktionsnedsættelse.

Regionen yder herudover et særligt tilskud til tandpleje for kræftpatienter, der enten på grund af strålebehandling i hoved og hals-region eller på grund af kemoterapi har betydelige dokumenterede tandproblemer samt til personer, der på grund af Sjögrens Syndrom har betydelige dokumenterede tandproblemer. For disse ydelser kan amtet fra 1. januar 2007 opkræve en egenbetaling på maksimalt 1 515 DKK årligt. Endelig yder regionen højt specialiseret odontologisk rådgivning, udredning og behandling (i odontologisk landsdels- og videnscenter) af patienter med sjældne sygdomme og handicap, hos hvem den tilgrundliggende tilstand giver anledning til specielle problemer i tænder, mund og kæbe.

Tand-, mund- og kæbekirurgisk behandling udføres på sygehusene og betales af regionerne efter sundhedsloven.

Ud over ovennævnte generelle regler kan kommunerne yde støtte til nødvendig tand-behandling i henhold til den sociale lovgivning.

FÆRØERNE: Tandbehandlingen foregår hovedsageligt hos privatpraktiserende tandlæger. Betalingen herfor er delvis privat og delvis tilskud (ca. halvdelen) fra sygekassen.

Der findes i kommunalt regi en gratis skoletandplejeordning til børn under 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 social legislation.

GREENLAND: All public dental care is free of charge. Outside the dentist's normal working hours, he or she may offer treatment against payment.

FINLAND: A basic fee of EUR 7 per visit (EUR 11 for a visit to a specialist) is charged for dental treatment at a health centre. In addition to this, user fees of EUR 5 – 130 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 8 with additional standard

år. Denne ordning omfatter også specialtandpleje, så som tandretning.

Til behandling af medfødte eller sygdomsforårsagende tandlidelser, kan der søges om dækning af udgifterne over sociallovgivningen.

GRØNLAND: Al offentlig tandpleje er gratis. Udenfor tandlægens arbejdstid, kan denne tilbyde behandling mod betaling.

FINLAND: Der betales et grundbeløb for tandbehandling ved sundhedscentrene på 7 EUR per besøg (hos specialtandlæger 11 EUR per besøg). Ud over grundbeløbet kan der opkræves en egenbetaling på 5-130 EUR, afhængig af undersøgelsens omfang.

Sygeforsikringen giver et tilskud på 60 pct. af behandlingsudgifterne indenfor de af Folkpensionsanstalten fastsatte takster til en årlig tandlægeundersøgelse i den private sektor. Der gives kun tilskud til tandregulering hvis dette er nødvendigt for at undgå andre sygdomme. Udgifter til proteser og tandtekniske foranstaltninger er ikke omfattet af tilskudssystemet.

Udgifterne til laboratorie- og røntgenundersøgelser rekvireret af en tandlæge, receptudskrivning samt rejseudgifter ved tandlægebesøg kan refunderes efter de samme regler som for recepter udskrevet af læger og rejseudgifter ved lægebesøg.

ÅLAND: Al offentlig tandbehandling for personer under 19 år er gratis. For andre koster et besøg 8 EUR med tillæg for udgifter til de enkelte foranstaltninger og

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fees for items of 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 national dental health insurance system in Iceland pays according to a public fee schedule set by the Minister of Health. These fees are generally different from the fees used by private dental practitioners, since private dentists in Iceland are allowed to set their own fees.

The national dental health insurance scheme offers partial reimbursement of the cost of dental treatment for children under 18 and adults aged 67 years or older. For children under 18, 75 per cent (according to the public fee schedule) of the cost of most dental treatment is reimbursed with the exception of gold crowns, bridges and orthodontic treatment.

The cost of orthodontic treatment can be reimbursed up to ISK 150 000 according to special rules. People with chronic illnesses, old-age pensioners and disability pensioners also have their costs covered in full or in part.

For this group 50, 75 or 100 per cent of the cost (according to the public fee schedule) of dental treatment may be covered. Full dentures and partial dentures are covered. Gold and porcelain crowns or bridges and implants can be reimbursed up to ISK 80 000 per year.

The cost of implants for use with attachments under dentures is partially reimbursed for pensioners who cannot use full dentures due to ridge resorption or other problems.

undersøgelser efter særlige takster. For tandregulering og proteser betales de faktiske udgifter. For besøg hos private tandlæger gælder de samme regler som i Finland.

ISLAND: Sygeforsikringen i Island betaler med en takst for tandbehandling som er bestemt af sundhedsministeren. Den takst er sædvanligvis forskellig fra den takst som de private tandlæger bruger, fordi de har lov til at fastsætte deres egen pris.

Sygeforsikringen yder refusion til en del af tandbehandling for børn i alderen under 18 år og pensionister 67 år og ældre. For børn yngre end 18, ydes der 75 pct. (af sygeforsikringens takst) til deres tandbehandling bortset fra guld- og porcelænskroner, broer og tandregulering.

Tandregulering kan refunderes med op til 150 000 ISK med specielle regler. Langtidssyge samt alders- og invalidepensionister får ligeledes dækket deres udgifter helt eller delvist.

Der kan til denne gruppe ydes 50, 75 eller 100 pct. dækning af udgifterne til tandbehandling (af sygeforsikringens takst). Helproteser og delproteser er dækket. Guld- og porcelænskroner eller broer og implantater kan refunderes med op til 80 000 ISK per år.

Implantater er også inkluderet for dem som ikke kan bruge en helprotese. Der ydes delvis tilskud til pensionister som ikke kan anvende helprotese på grund af dårlig resorbering eller andre problemer.

The cost of dental treatment (including orthodontic treatment), for congenital malformations and serious abnormalities such as cleft palate and aplasia, and the cost of dental treatment necessary because of accidents and illness, is reimbursed according to special rules. Dental treatment is not subsidized for the rest of the population. No private dental insurance is available either.

NORWAY: Adults over 20 years of age mainly pay for their own dental treatment. Prices for general dental practitioner services are not regulated. Dental treatment, except for orthodontic treatment, is free of charge for young people under the age of 18 years and all mentally handicapped people. Elderly people, people with chronic illnesses and disabled people who are either living in institutions or who receive home nursing services also receive free dental treatment from the public dental service.

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.

The National Insurance Scheme provides reimbursement for dental treatment when a specified medical condition, or treatment of the condition, has led to reduced oral health.

Patients with a rare medical condition can also receive reimbursement for dental treatment from the National Insurance Scheme.

For behandling (inkl. ortodonti) af medfødte misdannelser, større anomalier som fx ganespalte, samt for aplasier, ulykker og sygdom betales efter særlige regler. Der ydes ikke tilskud til tandbehandling for den øvrige del af befolkningen. Der findes heller ikke privat forsikring for tandbehandling.

NORGE: Voksne over 20 år betaler normalt selv for tandbehandling. Der er fri prisfastsættelse hos privatpraktiserende tandlæger. Tandbehandling, bortset fra tandregulering, er gratis for unge under 18 år og alle psykisk udviklingshæmmede. Ældre, kronisk syge og handicappede der enten bor på institution eller er modtagere af hjemmesygepleje, modtager også gratis behandling fra det offentlige tandplejesystem.

Unge i alderen 19-20 år modtager tandbehandling med refusion. Amterne (fylkene) betaler mindst 75 procent af udgifterne til behandling for denne aldersgruppe.

Folketrygden dækker dele af udgifterne ved nødvendig kæbekirurgisk behandling for børn op til 18 år.

Folketrygden giver tilskud til tandbehandling når en bestemt lidelse, eller behandling af denne lidelse, har ført til en dårligere tandsundhed.

Patienter med sjældne medicinske sygdomme kan også få tilskud til tandbehandling fra Folketrygden.

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It is also possible to receive reimbursement for the cost of treatment to replace teeth that have been lost as a result of periodontal disease.

SWEDEN: Dental treatment is free for children and young people under the age of 20 years.

All persons aged 20 years or more pay part of the cost for conservative treatment. The rest of the cost is paid by the state directly to the dentist. Dental fees are not regulated, which means that dentists decide the cost of the various types of treatment themselves. It is also possible to have a two-year contract for treatment at a fixed price. For persons aged 65 years or older the cost of prosthetic treatment is limited to SEK 7 700 plus the cost of materials. The dental treatment insurance pays the rest of the cost of treatment directly to the dentist. Reimbursement for dental treatment from a private dentist is limited to the public fees set by the county.

Persons who need extensive dental care as a result of diseases or disability are given a subsidy from the dental treatment insurance that is twice the amount of that normally given for conservative treatment.

In addition to providing free dental treatment for children and young persons, the county and regional authorities are responsible for:

- Oral surgery carried out in hospitals
- Dental treatment that is a part of the treatment of disease over a limited period of time

Det er også muligt at få tilskud til erstatning af tænder der er gået tabt på grund af periodontitis.

SVERIGE: Børn og unge under 20 år har gratis tandbehandling.

Alle personer som er 20 år eller ældre betaler en del af tandlægeregningen for den bevarende behandling. Det resterende beløb betales direkte til tandlægen af staten. Der er fri prisdannelse på tandbehandling hvilket medfører at tandlægerne selv bestemmer prisen for de enkelte behandlingstyper. Det er også muligt at indgå en toårig aftale om behandling til fast pris. For personer på 65 år eller ældre er udgifter til proteser fastsat til maksimalt 7 700 SEK plus udgifter til materialer. Forsikringen for tandbehandling betaler det resterende beløb direkte til tandlægen. For privatpraktiserende er tilskuddet begrænset til det offentliges takster i lenet.

Personer som har behov for udvidet tandpleje som følge af sygdomme eller handicap gives der et tilskud fra tandbehandlingsforsikringen som er dobbelt så højt som den man normalt giver til den bevarende tandbehandling.

Ud over gratis tandbehandling til børn og unge har landstingene og regionerne ansvaret for:

- Kirurgisk tandbehandling som udføres ved et sygehus
- Tandbehandling der er led i en sygdomsbehandling i en begrænset periode

- Dental treatment for certain elderly or disabled people who have difficulties maintaining their oral hygiene.

For these groups, the same user fee regulations apply as for out-patient treatment, that is, a maximum of SEK 900 for a 12-month period.

For patients belonging to one of the above groups, the same rules for user charges apply as for general outpatient medical treatment, i.e. a maximum of SEK 900 for a twelve-month period.

Maximum charges

DENMARK AND GREENLAND: There are no rules in Denmark for maximum user charges, with the exception of pharmaceutical products.

FAROE ISLANDS: Apart from pharmaceutical products and dental treatment, there are no user charges in the Faroe Islands (see the sections on reimbursement for pharmaceutical products and reimbursement for dental treatment).

FINLAND: If the total cost of pharmaceutical products exceeds EUR 627.47 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 80

- Tandbehandling til visse ældre og handicappede som har svært ved at klare mundhygiejne.

For disse grupper gælder samme egenbetalingsregler som i den ambulante almene sygdomsbehandling, dvs. højst 900 SEK for en 12 måneders periode.

For patienter som hører til en af ovennævnte grupper gælder samme egenbetalingsregler som i den ambulante almene sygdomsbehandling, dvs. højst 900 SEK for en tolv måneders periode.

Maksimal egenbetaling

DANMARK OG GRØNLAND: Der findes ingen regler om maksimal egenbetaling med undtagelse for medicin i Danmark.

FÆRØERNE: Bortset fra medicin og tandpleje er der ingen tvungen egenbetaling på Færøerne (se afsnit om tilskud til lægemidler og tilskud til tandbehandling).

FINLAND: Hvis den maksimale egenbetaling for medicin udgør 627,47 EUR pr. år og hvis udgifterne til transport i forbindelse med behandling overstiger 157,25 EUR pr. år vil Folkpensionsanstalten dække det overskydende beløb. Hvis evnen til at betale skat er nedsat på grund af sygdom gives der en særlig skattelettelse. Skattelettelsens størrelse beregnes i forhold til den pågældendes eller dennes families muligheder for at betale skat.

Egenbetalingen for langtidsophold på institution/hospital kan højest udgøre 80

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per cent of a patient's/resident's net income. However, a patient shall have at least EUR 80 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 590 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, outpatient 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. For treatment of illness, there is a maximum user charge for medical visits and outpatient treatment of no more than EUR 300 during one calendar year, after which all services are free of charge for the remaining part of the year, with the exception of short-term stays in institutions/hospitals, for which the charge is reduced from EUR 20 per day to EUR 10 per day. The maximum charge for children and young people under 18 years and 65+ of age is EUR 125 per calendar year, after which all treatment included in

pct. af patientens/beboerens nettoindkomst. Dog skal patienten have mindst 80 EUR per måned til personlige fornødheder. Det er den samme betaling som opkræves på alle typer af institutioner indenfor social- og sundhedssektoren.

Det såkaldte udgiftsloft på 590 EUR er taget i anvendelse for det kommunale social- og sundhedsvæsen. Når loftet i kalenderåret overskrides kan den pågældende i det store og hele benytte tilbudene uden betaling. Loftet omfatter lægeydelser i den primære sektor ved helsecentrene, fysioterapi, behandlingsforløb, besøg i ambulatorium, dagkirurgi samt korttidsinstitutionsophold indenfor social- og sundhedsvæsenet. Der betales fortsat for tandbehandling og sygetransport, attester, laboratorieundersøgelser og radiologiske undersøgelser som udføres efter henvisning fra en privatpraktiserende læge. Indkomstregulerede betalinger medregnes ikke i maksimumsbeløbet. Betaling for børn under 18 år medregnes i maksimumsbeløbet hos den der har betalt for det.

ÅLAND: Reglerne for den maksimale egenbetaling for medicin og transport til og fra behandling er den samme som i Finland. Ved sygdomsbehandling er der en maksimal egenbetaling ved lægebesøg og ambulant behandling på højest 300 EUR i løbet af et kalenderår hvorefter al service er gratis den resterende del af året med undtagelse af kortvarige institutions/hospitalsophold hvor betalingen reduceres fra 20 EUR pr døgn til 10 EUR pr døgn. For børn og unge under 18 år og 65+ er den maksimale egenbetaling 125 EUR per kalenderår hvorefter al behandling der indgår under den maksimale egenbetaling er gratis, inklusiv be-

the maximum user charge scheme is free, including hospital treatment for people under 18 years. As part of the maximum user charge, payment for outpatient 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: Within the present system, user charges are reimbursed for people aged 18-70 years of age, if the costs exceed ISK 18 000 during one calendar year. The same applies to children under 18 if charges exceed ISK 6 000. User charges exceeding ISK 4 500 are reimbursed for the following groups: 60-70 year-old senior citizens receiving a full basic pension, senior citizens 70 years and older, disabled persons, and persons who have been continually unemployed for 6 months or longer.

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.

handling på en hospitalsafdeling for børn og unge under 18 år. Til den maksimale egenbetaling medregnes også betaling for ambulant behandling og ydelser som er modtaget uden for landskabet. Derimod medregnes bl.a. tandbehandling, røntgen- og laboratorieundersøgelser ikke. Egenbetalingen kan fratrækkes i kommuneskatten.

ISLAND: I det nuværende system refunderes egenbetalingen for personer i alderen 18-70 år, hvis den i løbet af ét kalenderår overstiger 18 000 ISK. Det samme gælder for børn under 18 år hvis egenbetalingen overstiger 6 000 ISK. For følgende grupper refunderes egenbetalingen hvis den overstiger 4 500 ISK pr. år: Pensionister 60-70 år med fuld grundpension, pensionister 70 år og ældre, handicappede og personer, der har været arbejdsløse uafbrudt i 6 måneder eller længere.

Hvis der er ét eller flere børn under 18 år i samme familie, regnes de som én person i forhold til udgiftsloftet.

Når udgiftsloftet er nået, vil den sikrede få tildelt et rabatkort, som indebærer fuld eller delvis refusion for egenbetalingen i resten af året efter visse nærmere fastsatte regler.

Ordningen om udgiftsloft omfatter følgende ydelser: Besøg hos alment praktiserende læge eller speciallæge, besøg af læge i hjemmet, ambulant behandling på hospitaler og skadestuer, samt laboratorieundersøgelser og røntgenbehandling. Ordningen omfatter ikke behandling for in vitro fertilisering.

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NORWAY: Under the present scheme, reimbursement is granted for charges that exceed a certain annual amount.

User charges for the services that are included in the cost ceiling arrangement are noted on a card. When the cost ceiling is reached, patients receive a card granting them full reimbursement from the National Insurance Scheme for the rest of the year. The cost ceiling for one of the parents extends to children under the age of 16. No user charges are levied for children under the age of 12.

There are two separate reimbursement schemes in Norway.

The following services are included in reimbursement scheme 1:

- Examination and treatment by a doctor or psychologist
- Necessary pharmaceutical products (products prescribed on "blue prescription")
- Travel costs that are paid for by the National Insurance Scheme.

The following services are included in reimbursement scheme 2:

- Examination and treatment by a dentist for certain specified diseases
- Certain physiotherapy services
- Certain stays in approved training institutions
- Travel abroad for treatment under the auspices of Rikshospitalet University Hospital.

NORGE: I det nuværende system ydes der refusion for egenbetaling, hvis denne overstiger et vist beløb årligt.

Egenbetalingen for de ydelser, der er omfattet af ordningen om udgiftsloft, noteres på et kvitteringskort. Når udgiftsloftet er nået, tildeles patienten et frikort, hvorefter Folketrygden yder fuld refusion for udgifterne i resten af året. Børn og unge under 16 år er omfattet af udgiftsloftet hos én af forældrene. Børn under 12 år er fritaget for egenbetaling.

Der er to helt adskilte egenandelsordninger i Norge.

Følgende ydelser indgår i egenandelsloft nr. I:

- Undersøgelse og behandling hos læge eller psykolog
- Vigtige lægemidler (på "blå recept")
- Rejser, som Folketrygden betaler for.

Følgende ydelser indgår i egenandelsloft nr. II:

- Undersøgelser og behandling hos tandlæge for visse specificerede sygdomme
- Refusionsberettiget fysioterapi
- Visse ophold ved godkendte genoptræningsinstitutioner
- Behandlingsrejser til udlandet (klimarejser) i regi af Rigshospitalet.

In 2007, the cost ceiling for reimbursement scheme 1 was NOK 1 660 and for reimbursement scheme 2 NOK 2 500.

SWEDEN: From 1 January 1997, special maximum user charges for general medical treatment and pharmaceutical products were introduced.

The user charges for a consultation with a general medical practitioner or a specialist, for medical treatment and for articles used for incontinence are added up. If the user charges, over a 12-month period, together exceed SEK 900 (or a lower amount fixed by the county authority), a card entitling the holder to exemption from charges is issued. The card is valid for the remaining part of the period.

If user charges for prescribed pharmaceutical products exceed SEK 1 800, a card entitling the holder to free medication is issued. The card allows the person to buy pharmaceutical products free of charge for the remaining part of the 12-month period.

If one of the parents or both parents have several children under the age of 18 years, the children are exempt from paying user charges when the total purchase of pharmaceutical products for them exceeds the fixed maximum user charge. Some county and regional authorities have also determined a maximum user charge for patient transport.

Egen andelsloftet for 2007 for egen andelsloft I er 1 660 NOK og for egen andelsloft II 2 500 NOK.

SVERIGE: Siden 1. januar 1997 har der været særskilte takster for maksimal egenbetaling for almindelig lægebehandling og lægemidler.

Egenbetalingen for konsultationer hos almenmedicinsk læge eller specialist, for medicinsk behandling og for artikler, der anvendes ved inkontinens, sammentæles. Hvis den samlede egenbetaling over en 12-måneders periode overstiger 900 SEK (eller et lavere beløb, fastsat af Landstinget), udstedes der et frikort. Frikortet gælder for den resterende del af perioden.

Hvis egenbetalingen for lægemidler på recept overstiger 1 800 SEK, udstedes et frikort. Frikortet giver ret til køb af lægemidler uden egenbetaling i den resterende del af 12-måneders perioden, regnet fra det første lægemiddelindkøb.

Hvis én eller begge forældre tilsammen har flere børn under 18 år, er børnene fritaget for egenbetaling såfremt lægemiddelindkøbet til dem samlet overstiger det fastlagte maksimum for egenbetaling. Nogle landsting og regioner har også fastsat regler om maksimal egenbetaling for sygetransport.

CHAPTER II

Population and fertility

Befolkning og fertilitet

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Introduction

This chapter begins with a general description of the population in the Nordic countries and trends in population development 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 between the Nordic countries, Sweden having the oldest and Greenland the youngest population.

The development in population growth varies somewhat between the Nordic countries. The natural increase has been greatest in Iceland, the Faroe Islands and Greenland throughout the period. Sweden and Åland have the lowest natural increase. In 2005, net migration contributed to population growth in all the Nordic countries with the exception of Greenland and the Faroes Islands. In Iceland in particular, there has been a marked increase in immigration.

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

Indledning

I dette kapitel gives der først en generel beskrivelse af befolkningen i de nordiske lande, efterfulgt af en nærmere beskrivelse af fertilitet, fødsler, spædbørnsdødelighed og prævention.

2.1 Befolkning og befolkningsudvikling

Sammensætningen af befolkningen er noget forskellig fra land til land. Sverige har den ældste og Grønland den yngste befolkning.

Udviklingen i befolkningstilvæksten varierer en del de nordiske lande imellem. Fødselsoverskuddet har hele perioden igennem været størst i Island, Færøerne og Grønland. Sverige og Åland har det laveste fødselsoverskud. I 2005 bidrager nettomigrationen til en befolkningsforøgelse med undtagelse af Grønland og Færøerne. Især Island har en meget markant stigning i indvandringen.

Den forventede levetid i Norden er forøget markant, og selv om kvinder generelt lever længst, er forskellene mellem mænds og kvinders forventede levetid blevet reduceret.

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**Figure 2.1.0 Mean population by sex and age as a percentage of the total population
2005**

Middelfolketallet efter køn og alder i pct. af hele befolkningen 2005

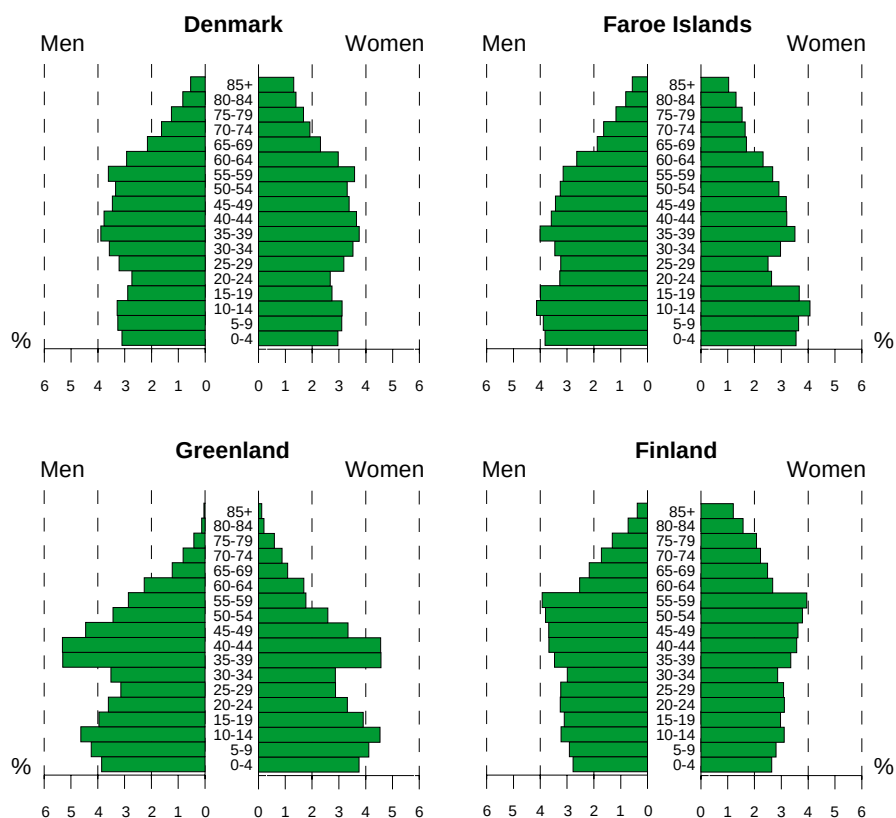
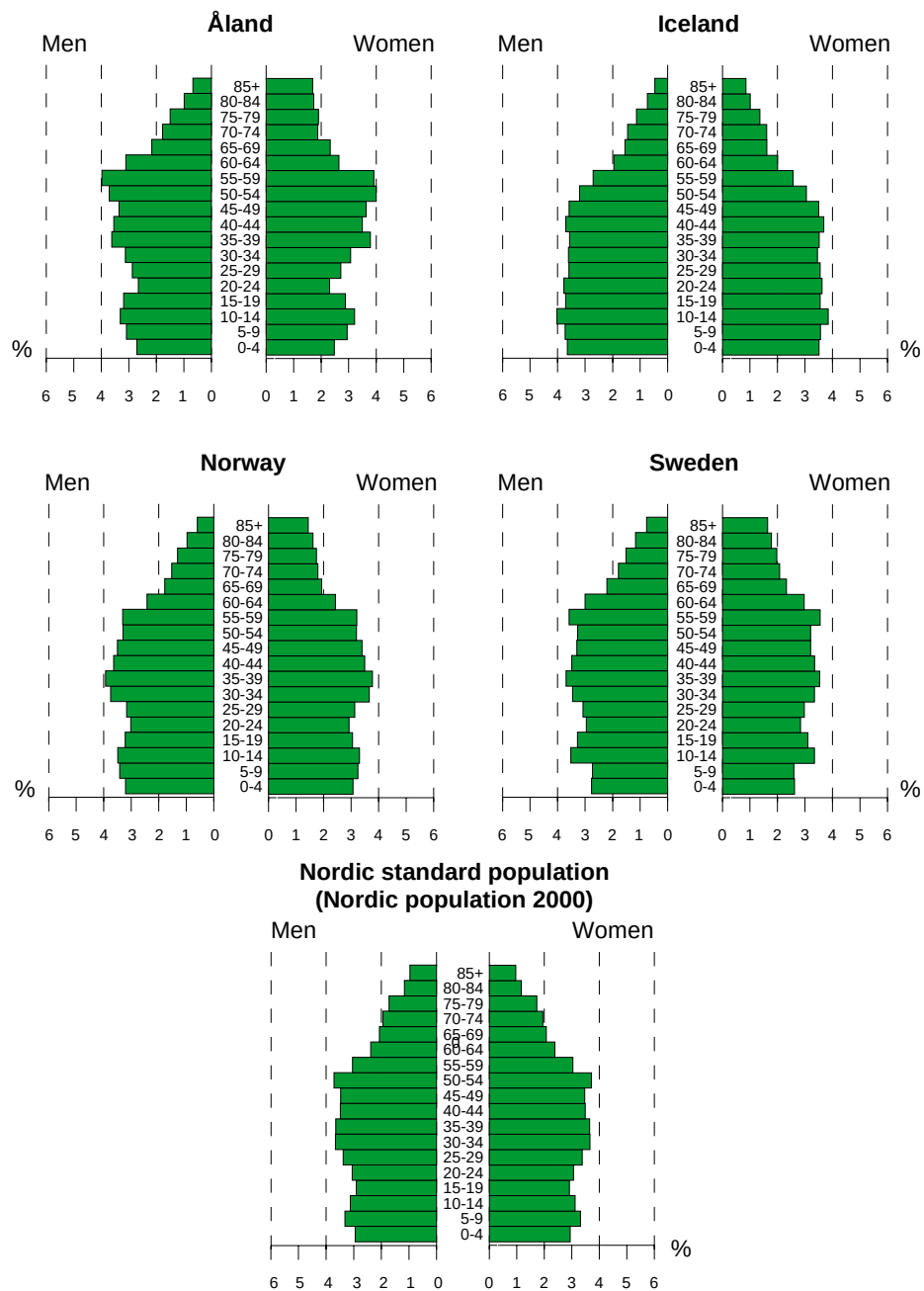


Figure 2.1.0 ... continued
... fortsat



POPULATION AND FERTILITY

Figure 2.1.1 Mean population by age groups 1995-2005 per cent
Middelfolketallet fordelt på aldersgrupper 1995-2005 pct.

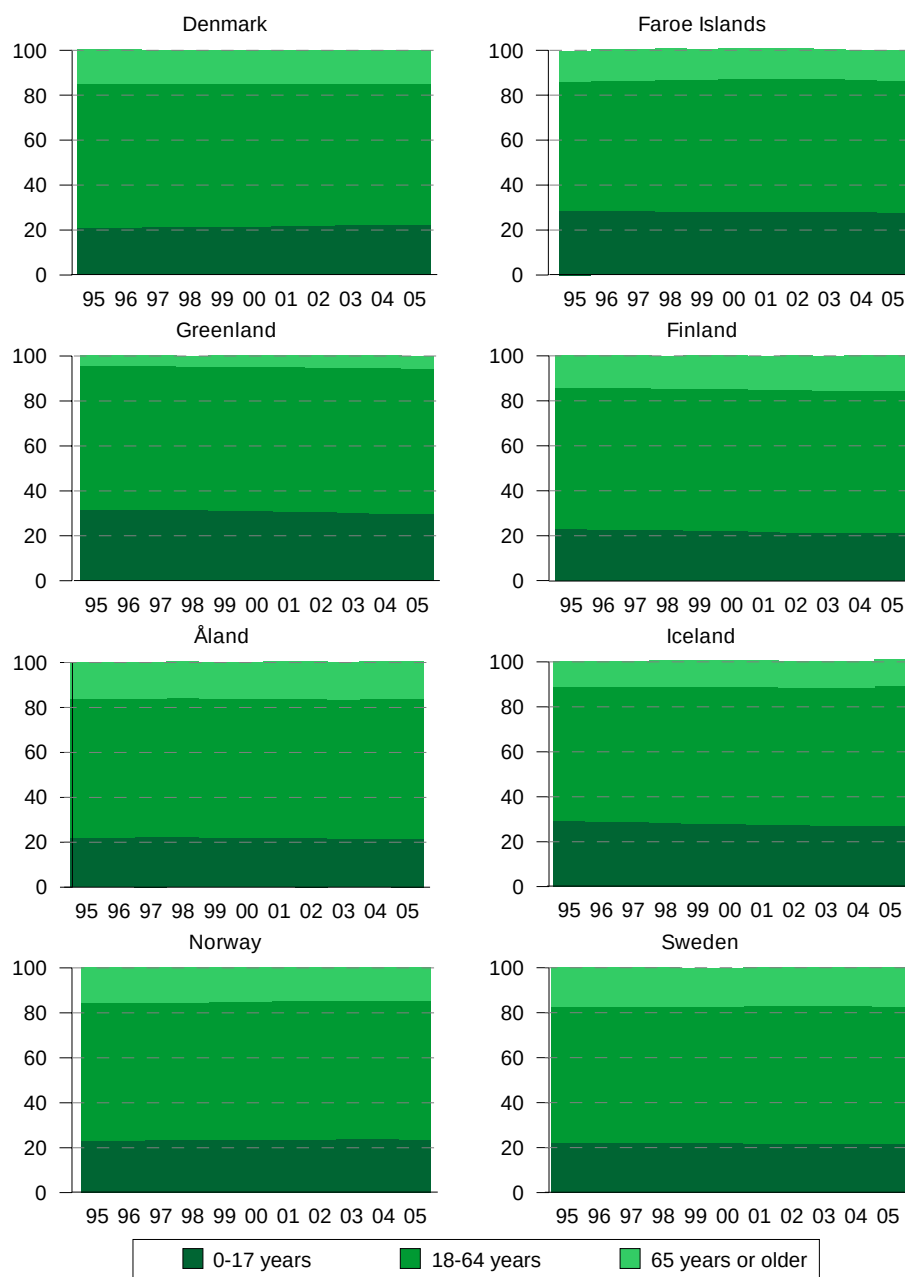


Table 2.1.1 Mean population 1995–2005
Middelfolketallet 1995–2005

	Denmark	Faroe Islands	Greenland	Finland	of which Åland	Iceland	Norway	Sweden
(1 000)								
<i>Men</i>								
Mænd								
1995	2 580	23	30	2 487	12	134	2 155	4 361
2000	2 639	24	30	2 526	13	141	2 224	4 386
2004	2 672	25	30	2 557	13	147	2 277	4 456
2005	2 680	25	30	2 567	13	148	2 293	4 487
<i>Women</i>								
Kvinder								
1995	2 648	21	26	2 621	13	133	2 204	4 466
2000	2 700	22	26	2 650	13	140	2 267	4 486
2004	2 729	23	27	2 671	13	146	2 315	4 537
2005	2 736	23	27	2 679	13	147	2 330	4 561
<i>Men and women</i>								
Mænd og kvinder								
1995	5 229	44	56	5 108	25	267	4 359	8 827
2000	5 340	46	56	5 176	26	281	4 491	8 872
2004	5 401	48	57	5 228	26	293	4 592	8 993
2005	5 416	48	57	5 246	27	296	4 623	9 048

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
 Kilder: De statistiske centralbureauer: D: Danmarks Statistik; FI: Hagstova Føroya; G: Grønlands Statistik; F & Å: Statistikcentralen; I: Hagstofa Íslands; N: Statistisk sentralbyrå; S: Statistiska centralbyrån

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Table 2.1.2 Vital statistics per 1 000 inhabitants 1995-2005

Befolkningens bevægelser pr. 1 000 indbyggere 1995-2005

	<i>Live births</i> Levendefødte	<i>Deaths</i> Døde	<i>Natural increase</i> Fødselsoverskud	<i>Net migration</i> Nettomigration	<i>Population increase</i> Befolkningstilvækst
Denmark					
1995	13.3	12.1	1.3	5.5	6.7
2000	12.6	10.9	1.7	1.8	3.5
2004	12.0	10.3	1.6	0.9	2.5
2005	11.9	10.2	1.7	1.2	2.9
Faroe Islands					
1995	14.7	8.3	6.4	-13.4	-7.0
2000	15.1	7.7	7.5	9.6	17.1
2004	14.8	7.9	6.9	-3.1	3.8
2005	14.8	8.7	6.1	-8.7	-2.6
Greenland					
1995	20.1	8.7	11.4	-8.3	3.1
2000	15.8	8.1	7.7	-3.6	4.1
2004	15.7	8.5	7.2	-5.4	1.8
2005	15.5	8.1	7.4	-7.9	-0.5
Finland					
1995	12.3	9.6	2.7	0.6	3.3
2000	11.0	9.5	1.4	0.5	1.9
2004	11.1	9.1	1.9	1.3	3.2
2005	11.0	9.1	1.9	1.7	3.6
Åland					
1995	13.4	10.2	3.2	-3.5	-0.3
2000	10.0	9.6	0.4	-1.2	3.1
2004	10.6	9.9	0.7	6.5	7.3
2005	10.1	9.7	0.3	5.6	5.9
Iceland					
1995	16.0	7.2	8.8	-5.3	3.7
2000	15.3	6.5	8.8	6.1	15.3
2004	14.5	6.2	8.2	1.8	10.0
2005	14.5	6.2	8.3	13.0	21.3
Norway					
1995	13.8	10.4	3.5	1.5	4.9
2000	13.2	9.8	3.4	2.2	5.6
2004	12.4	9.0	3.4	2.9	6.3
2005	12.3	8.9	3.4	4.0	7.3
Sweden					
1995	11.7	10.6	1.1	1.4	2.4
2000	10.2	10.5	-0.3	2.8	2.4
2004	11.2	10.1	1.2	2.8	4.0
2005	11.2	10.1	1.1	3.0	4.0

Sources: The central statistical bureaus
Kilder: De statistiske centralbureauer

Table 2.1.3 Average life expectancy 1996-2005
Middellevetiden 1996-2005

Age	Men					Women				
	0	15	45	65	80	0	15	45	65	80
Denmark										
1996-00	73.8	59.4	31.1	14.8	6.6	78.7	64.2	35.1	18.0	8.4
2003/04	75.2	60.7	32.1	15.7	6.9	79.9	65.4	36.1	18.7	8.7
2004/05	75.6	61.2	32.5	16.0	7.0	80.2	65.7	36.4	19.0	8.8
Faroe Islands										
1996-00	75.2	60.7	32.2	15.5	7.0	81.4	66.8	37.4	19.4	8.8
2000-04	77.1	62.5	33.7	16.9	7.4	81.5	66.7	37.6	19.7	8.7
2001-05	76.9	62.4	33.7	16.9	7.7	81.4	66.6	37.5	19.5	8.7
Greenland										
1996-00	62.8	50.3	26.2	11.1	5.0	68.0	55.0	27.6	12.5	5.3
2000-04	64.6	51.5	26.5	11.4	5.4	70.4	56.4	28.8	13.5	5.9
Finland										
1996-00	73.6	59.1	31.1	15.0	6.6	80.8	66.2	37.1	19.1	8.1
2004	75.3	60.8	32.6	16.5	7.3	82.3	67.6	38.4	20.5	9.0
2005	75.5	61.0	32.7	16.7	7.4	82.3	67.7	38.6	20.7	9.1
Åland										
1996-00	75.8	61.3	32.7	16.2	7.1	82.5	67.6	38.4	20.5	9.0
2000-04	77.7	63.4	34.7	17.5	7.5	83.9	69.4	39.9	21.3	9.4
2001-05	77.6	63.4	34.7	17.1	7.3	83.6	69.1	39.8	21.4	9.6
Iceland										
1996-00	77.1	62.6	34.0	16.7	7.3	81.4	66.8	37.4	19.6	8.6
2003/04	79.2	64.5	35.5	17.9	7.7	82.7	68.0	38.8	20.5	9.3
2004/05	79.2	64.5	35.5	18.0	7.7	83.1	68.4	39.0	20.7	9.4
Norway										
1996-00	75.5	61.1	32.7	15.7	6.7	81.1	66.6	37.4	19.5	8.5
2004	77.5	62.9	34.4	17.1	7.3	82.3	67.7	38.5	20.5	9.2
2005	77.7	63.2	34.5	17.1	7.3	82.5	67.9	38.6	20.6	9.3
Sweden										
1996-00	76.9	62.4	33.6	16.4	7.0	81.8	67.2	37.9	19.9	8.8
2004	78.4	63.7	34.8	17.4	7.5	82.7	68.0	38.7	20.6	9.3
2005	78.4	63.8	34.9	17.4	7.4	82.8	68.1	38.7	20.6	9.3

Sources: The central statistical bureaus
Kilder: De statistiske centralbureauer

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Figure 2.1.2 Live births and natural increase per 1 000 inhabitants 1990–2005
 Levendefødte og fødselsoverskud per 1 000 indbyggere 1990–2005

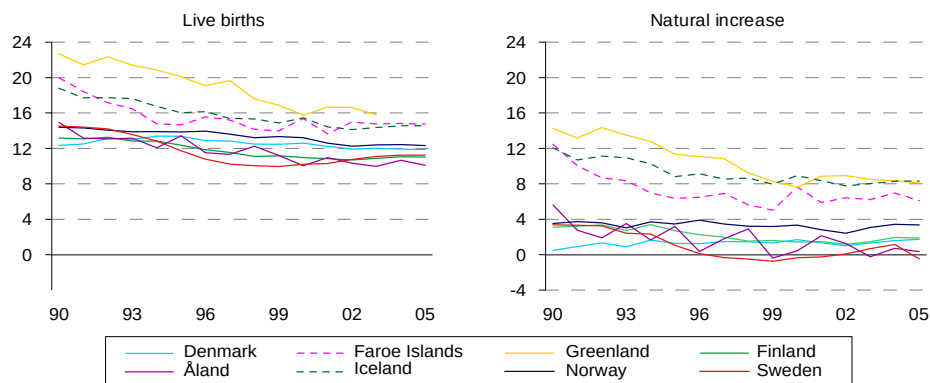
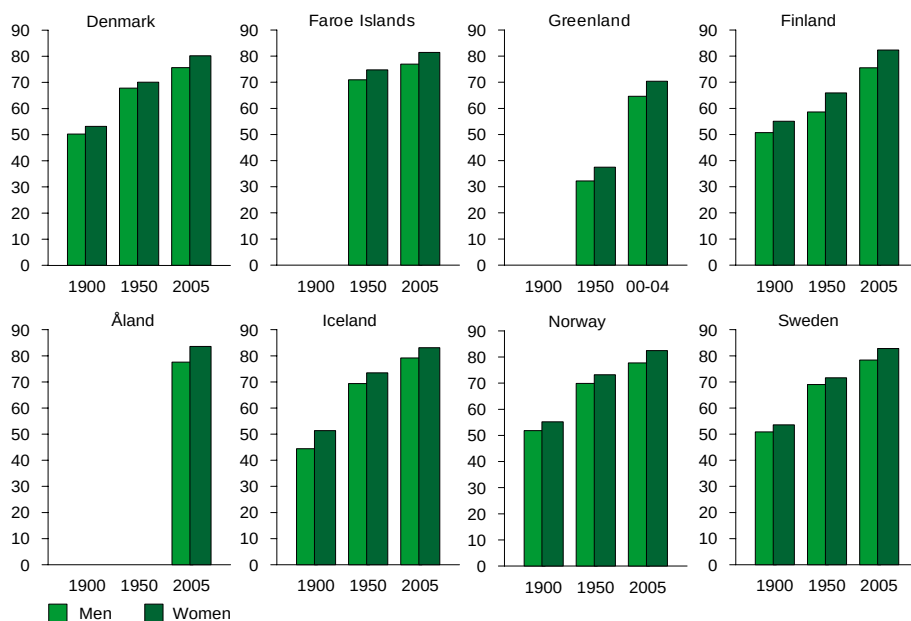


Figure 2.1.3 Life expectancy at birth 1900, 1950 and 2005
 Middellevetiden for nyfødte 1900, 1950 og 2005



2.2 Fertility, births, infant mortality and contraception

In recent years, the overall development in fertility has resulted in Åland and Sweden 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 IVF treatment than for other procedures). As shown in Table 2.2.2, more and more people are receiving such treatment, and a significant proportion of live births are the result of in vitro fertilization (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 among the Nordic countries. The other countries lie relatively close to each other.

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 2005.

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

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

2.2 Fertilitet, fødsler, spædbørnsdødelighed og prævention

Udviklingen i den samlede fertilitet har i de seneste år ført til, at fertilitetsraterne i Åland og Sverige nu er de laveste i Norden, mens det fortsat er høje rater på Færøerne, Grønland og i Island, navnlig i de yngste aldersklasser.

I alle de nordiske lande er det muligt at blive behandlet for barnløshed, betalt af det offentlige (i Island og Norge er der en betydelig højere egenbetaling for IVF behandling end for andre former for behandling). Som det ses af tabel 2.2.2 modtager flere og flere behandling og en ikke ubetydelig del af de levendefødte er et resultat af en IVF behandling. For fødsler efter IVF behandling er der fortsat et stort antal flerbarnsfødsler.

Internationalt er de nordiske lande kendetegnet ved at have en meget lav perinatal mortalitet. Grønland ligger højest blandt de nordiske lande. De øvrige lande ligger relativt tæt.

Grønland har ligeledes den højeste dødelighed for det første leveår. Island har den laveste dødelighed i det første leveår i 2005.

Omsætningen af hormonale præventionsmidler varierer væsentligt mellem de nordiske lande, men der er med tiden sket en vis udligning af forskellene.

Anvendelse af sterilisation som præventionsmiddel varierer ligeledes betydeligt mellem de nordiske lande. I de fleste af landene behøver man ingen tilladelse til at lade sig sterilisere efter det fyldte 25. år.

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There are no comparable Nordic statistics about 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 Denmark, the Faroe Islands, and Greenland. The low use in Denmark reflects the fact that Denmark has the highest number of women who use hormonal contraceptives.

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 in the other Nordic countries it must be performed before the end of the 12th week of gestation. However, induced abortion can also be carried out after the 12th and 18th weeks 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 in the Faroe Islands, Finland, Åland and Iceland permission is required. Such permission is given on the basis of social and/or medical criteria.

Abortion rates vary somewhat in the Nordic countries.

Der findes ingen sammenlignelig nordisk statistik om brugen af spiraler og kondomer som præventionsmiddel.

Nødprævention er relativ udbredt i de nordiske lande hvor forbruget er højest i Norge og lavest i Danmark, Færøerne og Grønland. Det lave forbrug i Danmark afspejler at der er flest kvinder der anvender hormonale præventionsmidler.

I de fleste af de nordiske lande har der siden midten af 1970'erne været adgang til svangerskabsafbrydelse. I Sverige er det en betingelse, at det sker før udgangen af den 18. graviditetsuge, mens svangerskabsafbrydelsen i de øvrige nordiske lande skal ske inden udgangen af den 12. svangerskabsuge. Fremkaldte aborter kan dog også foretages efter henholdsvis 12. og 18. svangerskabsuge; men da først efter særlig vurdering og tilladelse.

I Danmark, Grønland, Norge og Sverige er det alene op til den gravide kvinde at afgøre, om der skal foretages et abortindgreb, mens der på Færøerne, i Finland, Åland og Island kræves en tilladelse. En sådan gives ud fra sociale og/eller medicinske kriterier.

Der er en vis spredning mellem landene med hensyn til abortraterne.

Table 2.2.1 Live births and fertility rate 1996-2005
 Levendefødte og fertilitetsrate 1996-2005

	Number of live births Antal levende født	Live births per 1 000 women by age Levendefødte pr. 1 000 kvinder i alderen							Total fertility rate Samlet fertilitet
		15-19	20-24	25-29	30-34	35-39	40-44	45-49	
<i>Denmark</i>									
1996-00	66 951	8.0	54.7	129.7	109.3	41.3	6.0	0.2	1 746
2004	64 609	5.7	45.2	126.2	125.8	47.4	7.6	0.3	1 778
2005	64 282	5.7	43.2	123.9	127.4	48.5	8.4	0.3	1 802
<i>Faroe Islands</i>									
1996-00	657	19.3	108.0	166.0	129.1	58.1	11.1	0.3	2 459
2000-04	690	15.9	107.1	168.4	134.1	64.0	11.7	0.1	2 506
2001-05	694	13.5	109.8	174.1	138.7	64.8	12.0	0.4	2 566
<i>Greenland</i>									
1996-00	994	55.9	160.9	118.4	87.7	47.6	13.5	1.4	2 426
2005	884	66.5	147.2	118.4	90.6	38.8	7.3	1.0	2 349
<i>Finland</i>									
1996-00	58 295	9.5	61.4	119.8	101.6	44.7	8.8	0.5	1 735
2004	57 758	10.6	58.0	116.1	111.5	51.1	11.0	0.5	1 800
2005	57 745	10.3	57.4	116.3	112.9	51.5	10.7	0.6	1 803
<i>Åland</i>									
1996-00	286	4.9	42.7	122.0	106.3	50.1	8.5	0.6	1 665
2000-04	271	5.0	46.5	102.1	114.0	53.7	10.6	0.2	1 665
2001-05	273	4.8	51.9	103.4	116.5	52.6	11.5	0.4	1 702
<i>Iceland</i>									
1996-00	4 215	23.4	90.2	129.0	107.2	51.6	9.4	0.2	2 055
2004	4 234	13.0	75.7	132.6	117.9	55.9	11.2	0.4	2 033
2005	4 280	15.1	81.5	129.9	114.0	58.4	10.6	0.8	2 052
<i>Norway</i>									
1996-00	59 522	12.4	70.6	130.9	107.8	43.5	6.9	0.2	1 851
2004	56 951	8.2	59.6	123.9	117.1	49.1	7.9	0.3	1 828
2005	56 756	8.0	58.6	124.4	118.6	48.6	8.6	0.4	1 836
<i>Sweden</i>									
1996-00	90 688	7.1	51.7	107.9	93.4	40.3	7.3	0.3	1 540
2004	100 928	6.1	46.6	111.1	122.3	53.5	10.4	0.4	1 752
2005	101 346	6.2	46.6	109.5	124.9	55.9	10.3	0.5	1 769

Sources: The central statistical bureaus

Kilder: De statistiske centralbureauer

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Table 2.2.2 In vitro fertilization 1995-2005¹⁾
IVF-behandling 1995-2005¹⁾

	Denmark	Finland	Iceland	Norway ³⁾	Sweden ⁴⁾
<i>Treatments, IVF+ICSI</i>					
Behandlinger, IVF+ICSI					
1995-1999	..	4 569	324	..	..
2000-2004	7 487	4 448	301	4 309	7 447
2005	7 222	4 731	462	5 048	8 137
<i>Frozen embryo transfers, FET</i>					
Tilbageføring af nedfrosne æg, FET					
1995-1999	..	2 015	..	..	..
2000-2004	918	2 766	76	507	1 847
2005	1 500	2 960	161	1 051	2 636
<i>Number of live births, IVF+ ICSI + FET</i>					
Antal levendefødte, IVF+ ICSI + FET					
1995-1999	..	1 348	..	..	..
2000-2004	1 814	1 465	123	1 258	2 584
2005	1 786	1 537	167	1 488	2 690
<i>Treatments in 2005 per 1 000 women aged 15-49 years</i>					
Behandlinger i 2005 pr. 1 000 kvinder i alderen 15-49 år					
IVF + ICSI	5.8	3.9 ²⁾	6.3	4.7	4.0
FET	1.5	2.4	2.2	1.0	1.3
Total	7.8	6.4	8.5	5.7	5.3
<i>Multiple births, per cent of all births after IVF</i>					
Flerbarnsfødsler, procent af alle fødsler efter IVF-behandling	20.3	11.3 ²⁾	28.5	24.2	6.5
<i>Children born in multiple births, per cent of all children born after IVF</i>					
Børn født i flerbarnsfødsler, procent af alle børn født efter IVF-behandling	34.1	20.5 ²⁾	44.3	39.2	12.2
<i>IVF, ICSI and FET, per cent of all live births</i>					
IVF, ICSI and FET i procent af alle levendefødte	3.3	2.6 ²⁾	3.9	2.6	2.7

IVF = In vitro fertilization (reagensglasbefrugtning)

ICSI = Intracytoplasmic sperm injection (mikrobehandling)

FET = Frozen embryo transfer (tilbageføring af nedfrosne æg)

- | | |
|--|--|
| 1 Based on the year of treatment not on the year of birth. All births, not just live births. | 1 Beregnet ud fra behandlingsår, ikke fødselsår. Alle fødsler, ikke kun levende fødte. |
| 2 Based on the year of treatment not on the year of birth. | 2 Baseret på behandlingsåret ikke fødselsåret. |
| 3 Figures include the number of live births for all births in 2004. | 3 I Norge dækker antal levendefødte over alle fødsler i 2004. |
| 4 All figures = 2004. | 4 Alle tal = 2004. |

Source: D: National Board of Health; F: STAKES; I: Art Medica; N: Ministry of Health;
S: National Board of Health and Welfare

Table 2.2.3 Stillbirths and infant mortality¹⁾ 1996–2005
Dødfødte og dødelighed i første leveår¹⁾ 1996–2005

	<i>Number</i> Antal		<i>Per 1 000 births</i> Pr. 1 000 fødte		<i>Deaths per 1 000 live births</i> Døde pr. 1 000 levendefødte			
	<i>Stillbirths</i> Dødfødte	<i>Infant deaths</i> Døde i 1. leveår	<i>Stillbirths</i> Dødfødte	<i>Perinatal deaths</i> Perinatalt døde	<i>First 24 hours</i> Første 24 timer	<i>1–6 days</i> 1–6 dage	<i>7–27 days</i> 7–27 dage	<i>Total under 1 year</i> I alt under 1 år
Denmark								
1996–00	308	332	4.6	7.6	1.6	1.4	0.6	5.0
2001–05	281	292	4.4	7.2	1.6	1.3	0.6	4.5
2005	302	303	4.7	7.9	2.1	1.1	0.6	4.7
Faroe Islands								
1996–00	3.2	1.2	4.9	6.1	0.9	0.3	0.3	1.8
2001–05	1.6	2.2	2.3	4.0	0.9	0.9	0.6	3.2
Greenland								
1996–00	8	17	8.1	19.6	8.1	3.1	1.0	16.8
2001–05	5	15	5.4	14.2	6.0	2.6	0.4	16.9
2005	4	14	4.5	12.4	7.9	3.4	–	15.7
Finland								
1996–00	214	227	3.7	5.8	1.3	0.8	0.6	3.9
2001–05	187	191	3.2	5.2	1.1	0.8	0.5	3.3
2005	182	174	3.1	4.9	1.0	0.7	0.3	3.0
Åland								
1996–00	–	1	1.5	3.5	0.7	1.4	–	3.5
2001–05	1	1	3.7	6.6	1.5	1.5	–	3.7
Iceland								
1996–00	15	15	3.5	5.7	1.6	0.5	0.3	3.5
2001–05	9	10	2.2	3.6	0.7	0.7	0.2	2.5
2005	8	10	1.9	3.3	0.7	0.7	0.2	2.3
Norway ²⁾								
1996–00	244	244	4.1	6.2	1.0	1.1	0.6	4.1
2001–05	209	195	3.7	5.5	0.9	0.9	0.6	3.5
2005	182	175	3.2	4.8	0.7	1.0	0.5	3.1
Sweden								
1996–00	332	325	3.7	5.4	0.8	0.9	0.6	3.6
2001–05	329	303	3.5	5.0	0.7	0.9	0.5	3.1
2005	301	246	3.0	4.1	0.5	0.6	0.4	2.4

1 Calculated according to year of death.

2 Figures for infant death are preliminary figures.

1 Opgjort efter dødsår.

2 Spædbørnsdødelighed for Norge er foreløbige tal.

Sources: D: National Board of Health; FI: Chief Medical Officer in the Faroes; G: Chief Medical Officer; F & Å: Statistics Finland; I: Statistics Iceland; N: Statistics Norway ; S: Statistics Sweden

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Figure 2.2.1 Total fertility rate 1995-2005
Samlet fertilitetsrate 1995-2005

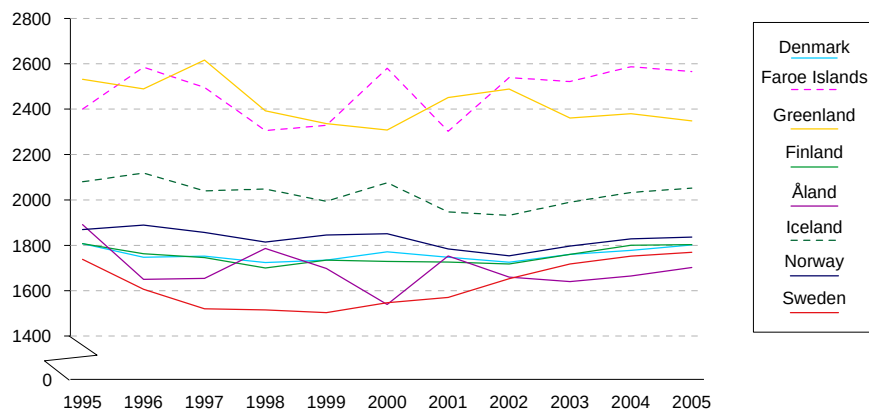
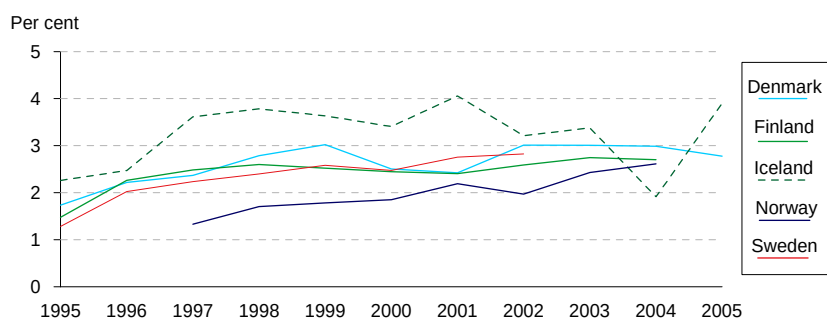


Figure 2.2.2 IVF, ICSI and FET, percentage of all live births 1995-2005
IVF, ICSI og FET i procent af alle levendefødte 1995-2005



Source: Tables 2.2.2
Kilde: Tabel 2.2.2

Figure 2.2.3 Perinatal deaths and infant mortality 1996-2005
Perinatal dødelighed og dødelighed i første leveår 1996-2005

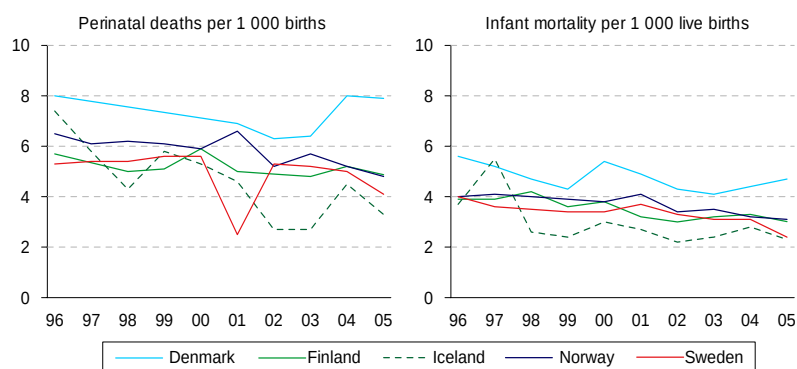


Table 2.2.4 Stillbirths and deaths during the first year of life per 1 000 births, with birthweight 1 000 grams and more, total figures and rates per 1 000 births¹⁾ 1995–2005

Dødfødte og døde i løbet af første leveår med en fødselsvægt på 1 000 gram og mere, i alt og pr. 1 000 fødte 1995–2005¹⁾

	Number Antal		Per 1 000 births Pr. 1 000 fødte		Deaths per 1 000 live births Døde pr. 1 000 levendefødte			
	Stillbirths Dødfødte	Infant deaths Døde i 1. leveår	Stillbirths Dødfødte	First 24 hours Første 24 timer	1-6 days 1-6 dage	7-27 days 7-27 dage	28 days to 1 year 28 dage til 1 år	Total under 1 year I alt under 1 år
Denmark								
1995	282	330	4.0	1.0	1.9	0.6	1.3	4.7
2000	183	238	2.9	0.6	1.3	0.5	1.2	3.6
2004	151	149	2.3	0.6	0.6	0.4	0.7	2.3
2005	123	164	1.9	0.8	0.7	0.5	0.7	2.6
Finland								
1995	189	168	3.0	0.5	0.7	0.5	1.0	2.7
2000	150	152	2.7	0.6	0.5	0.5	1.1	2.7
2004	113	124	2.0	0.4	0.6	0.3	0.9	2.2
2005	118	119	2.0	0.5	0.5	0.3	0.7	2.1
Iceland								
1995	7	13	1.6	0.9	0.7	-	1.4	3.0
2000	13	5	3.0	0.0	0.2	0.2	0.7	1.2
2004	13	10	3.1	0.7	0.2	0.2	1.2	2.4
2005	6	4	1.4	-	0.5	-	0.5	0.9
Norway								
1995	177	182	2.9	0.7	0.7	0.4	1.3	3.0
2000	195	149	3.3	0.6	0.5	0.3	1.1	2.5
2004	159	125	2.8	0.4	0.5	0.4	0.9	2.2
2005	142	104	2.5	0.5	0.4	0.3	0.6	1.8
Sweden								
1995	318	295	3.1	0.6	0.6	0.5	1.2	2.9
2000	318	215	3.6	0.5	0.7	0.4	0.9	2.4
2004	287	222	2.9	0.4	0.6	0.4	0.8	2.2
2005	263	182	2.6	0.4	0.4	0.2	0.9	1.8

1 Calculated according to year of birth.

1 Opgjort efter fødselsår.

Sources: D: National Board of Health F: Statistics Finland & STAKES; I: Medical Birth Registry of Iceland & Statistics Iceland; N: Medical Birth Registry of Norway; S: Medical Birth Registry, National Board of Health and Welfare

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Table 2.2.5 Sterilizations 1995–2005
Sterilisationer 1995–2005

	<i>Denmark¹⁾</i>	<i>Faroe Islands</i>	<i>Greenland</i>	<i>Finland</i>	<i>Of which Åland</i>	<i>Iceland</i>	<i>Norway</i>	<i>Sweden</i>
<i>Men</i>								
Mænd								
1995	5 256	3	4	792	-	87	2 697	1 507
2000	5 544	10	18	1 772	2	246	3 244	1 459
2004	5 119	18	8	1 614	1	216	3 155 ²⁾	5 573 ²⁾
2005	4 974	..	10	1 821	-	285	..	..
<i>Women</i>								
Kvinder								
1995	4 815	60	67	10 521	31	553	4 525	5 919
2000	5 101	29	127	8 699	31	519	4 512	4 533
2004	5 010	38	80	5 655	40	295	1 624 ²⁾	3 954 ²⁾
2005	4 044	29	109	5 102	48	274	..	..
<i>Total</i>								
I alt								
1995	10 071	63	71	11 313	31	640	7 222	7 426
2000	10 645	39	145	10 471	33	765	7 756	5 992
2004	10 129	56	88	7 269	41	511	4 779 ²⁾	5 573 ²⁾
2005	9 018	..	119	6 923	48	559	..	..
[2005]								
<i>Per 1 000 in the age group</i>								
Pr. 1 000 i alderen								
<i>Men</i>								
Mænd								
25–34	2.6	..	0.8	1.0	-	2.8	1.8 ²⁾	0.4 ²⁾
35–44	7.7	..	1.0	2.9	-	7.9	5.7 ²⁾	1.4 ²⁾
45–54	2.2	..	..	1.0	-	2.5	1.9 ²⁾	0.7 ²⁾
<i>Women</i>								
Kvinder								
25–34	3.5	1.9	11.7	3.7	2.0	3.0	1.6 ²⁾	1.4 ²⁾
35–44	6.5	6.5	11.9	10.3	21.8	9.2	3.0 ²⁾	4.7 ²⁾
45–54	0.5	0.0	0.6	0.6	1.5	0.8	0.3 ²⁾	0.4 ²⁾

1 Sterilizations performed in hospitals.

2 2003.

1 Sterilisationer udført på sygehuse.

2 2003.

Sources: D: National Board of Health; FI: Chief Medical Officer; G: Chief Medical Officer; F & Å: STAKES;

Kilder: I: Directorate of Health; N: Statistics Norway; S: National Board of Health and Welfare

**Table 2.2.6 Sales of hormonal contraceptives per 1 000 women aged 15–44 years
2000–2005. DDD per 1 000 women 15–44 years/day**
Salg af hormonale præventionsmidler pr. 1 000 kvinder i alderen 15–44 år
2000–2005. DDD pr. 1 000 kvinder i alderen 15–44 år /dag

ATC-code G02BB01, G03A incl. G03AA13	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2000	300	258	209	224	281	259	211	299
2003	318	286	236	225	243	259	228	294
2004	324	261	253	228	242	265	233	294
2005	325	283	314	225	218	263	235	286

Sources: D: Danish Medicines Agency; FI: Chief Pharmaceutical Officer; G: Medical Officer; F & Å: National Agency
Kilder: for Medicines; I: Icelandic Medicines Control Agency; N: WHO Collaborating Centre for Drug Statistics
Methodology; S: National Corporation of Swedish Pharmacies

Table 2.2.7 Number of sold packages of emergency prevention 2000–2005
Antal solgte forpackninger af nødprævention 2000–2005

ATC code G03A	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2000	30 549	104	–	42 706	176	1 978	27 700	10 880
2001	38 386	189	5	45 242	223	3 310	66 600	84 073
2003	60 000	418	310	87 955	349	3 956	99 500	146 183
2004	70 900	270	374	91 598	460	4 964	114 245	164 994
2005	76 685	542	515	91 416	464	6 425	128 107	167 230
Per 1 000 women aged 15–44								
2000	28.5	12.2	–	41.9	36.0	31.6	30.2	6.4
2001	35.9	21.8	0.4	44.7	45.8	52.5	72.7	49.6
2003	56.6	46.7	24.7	88.1	71.5	63.0	108.2	85.6
2004	67.1	30.1	29.7	92.1	94.4	79.0	123.9	96.0
2005	72.6	60.7	40.9	92.2	95.8	102.4	138.7	97.0

Sources: D: Danish Medicines Agency; FI: Chief Pharmaceutical Officer; G: Medical Officer; F & Å: National Agency
Kilder: for Medicines; I: Icelandic Medicines Control Agency; N: WHO Collaborating Centre for Drug Statistics
Methodology; S: National Corporation of Swedish Pharmacies

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Table 2.2.8 Number of induced abortions 1996–2005
Antal fremkaldte aborter 1996–2005

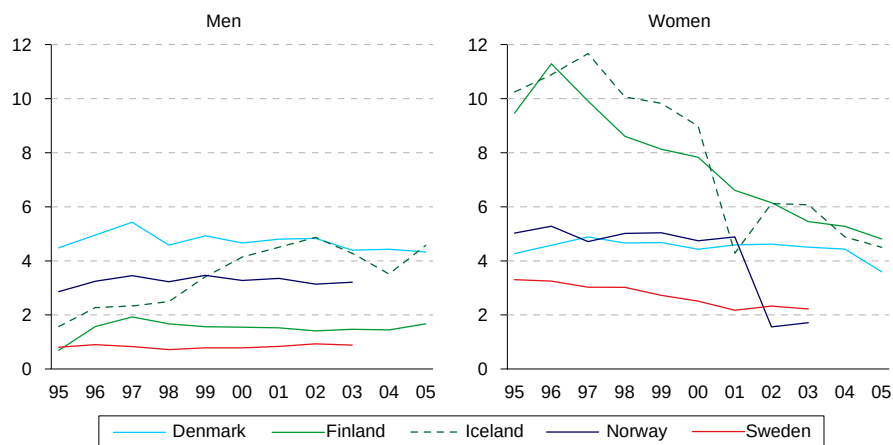
	Number of abortions Antal aborter	Abortions per 1 000 women by age Aborter pr. 1 000 kvinder i aldermen							Total abortion rate Samlet abortrate	Abortions per 1 000 live births Aborter pr. 1 000 levendefødte
		15-19	20-24	25-29	30-34	35-39	40-44	45-49		
Denmark										
1996-00	16 580	14.5	21.0	19.5	18.3	12.8	4.8	0.5	456.5	247.4
2001-05	15 288	14.9	20.7	17.6	16.7	13.1	4.9	0.4	441.5	238.2
2005	15 280	16.0	21.3	17.3	16.5	13.1	5.2	0.5	449.5	236.6
Faroe Islands										
1996-00	47	4.4	5.2	7.3	7.8	5.5	2.9	0.6	168.3	70.9
2001-05	40	4.3	5.3	6.3	4.3	5.2	1.8	0.3	146.3	57.9
2005	29	3.3	1.6	4.2	5.6	3.0	1.9	0.0	139.4	40.7
Greenland										
1996-00	881	114.6	138.7	87.7	57.8	28.0	9.2	1.1	2 185.5	888.6
2001-05	861	113.9	143.2	92.6	58.9	28.9	10.3	0.9	2 247.9	946.7
2005	899	112.7	141.3	97.7	69.8	31.1	8.9	0.5	2 310.0	1 010.1
Finland										
1996-00	10 638	12.8	15.0	13.3	10.9	7.4	2.9	0.3	312.9	196.0
2001-05	10 891	15.4	16.9	12.6	10.6	7.8	3.2	0.2	333.3	193.3
2005	10 931	14.9	18.2	12.7	10.3	7.9	3.3	0.2	337.5	191.9
Åland										
1996-00	64	16.6	20.8	12.9	14.0	10.0	4.8	0.8	398.9	224.6
2001-05	63	16.4	22.1	18.7	10.5	11.1	3.7	0.2	413.3	242.3
2005	68	17.9	24.4	24.7	6.2	12.1	4.3	-	448.0	266.7
Iceland										
1996-00	922	22.6	24.0	17.4	11.8	9.4	3.9	0.3	447.2	218.8
2001-05	915	19.4	23.7	16.9	13.4	9.1	4.5	0.3	435.9	220.1
2005	867	15.5	23.9	18.2	12.3	8.0	4.1	0.2	411.6	202.6
Norway										
1996-00	14 248	18.7	26.1	19.7	15.2	9.9	3.5	0.3	471.0	239.4
2001-05	13 879	16.4	26.9	19.5	15.1	10.6	3.9	0.3	465.1	245.8
2005	13 989	15.1	27.4	20.5	15.1	11.0	4.0	0.3	468.2	246.5
Sweden										
1996-00	31 250	18.2	27.0	23.4	20.2	15.0	5.9	0.6	551.5	344.4
2001-05	33 808	23.3	30.3	23.6	19.9	15.5	6.7	0.6	599.4	345.9
2005	34 978	23.4	31.4	24.3	19.8	16.0	7.8	0.7	617.0	345.1

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 of the current period.

Definition: Den samlede abort rate er antallet af aborter pr. 1 000 kvinder, der forventes at leve til de bliver 50 år, udregnet fra den aldersspecifikke abort i den bestemte periode.

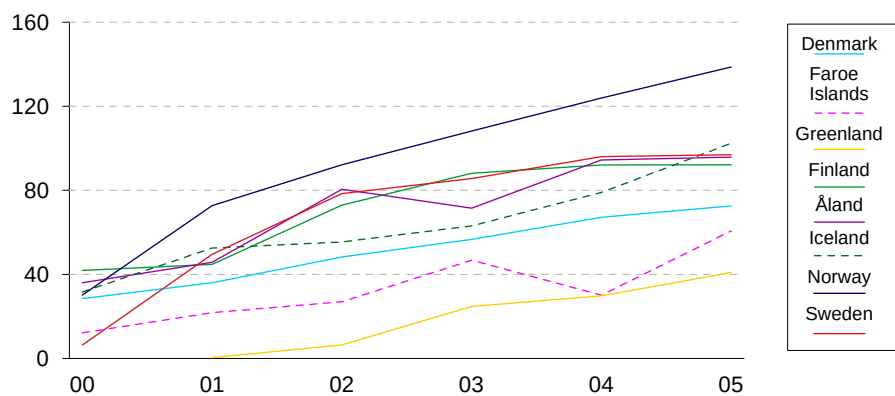
Sources: The national abortion registers
Kilder: De nationale abortregistre

Figure 2.2.4 Sterilizations per 1 000 inhabitants aged 25-54 1995-2005
 Sterilisationer pr. 1 000 indbyggere i alderen 25-54 år 1995-2005



Source: Tables 2.2.5
 Kilde: Tabel 2.2.5

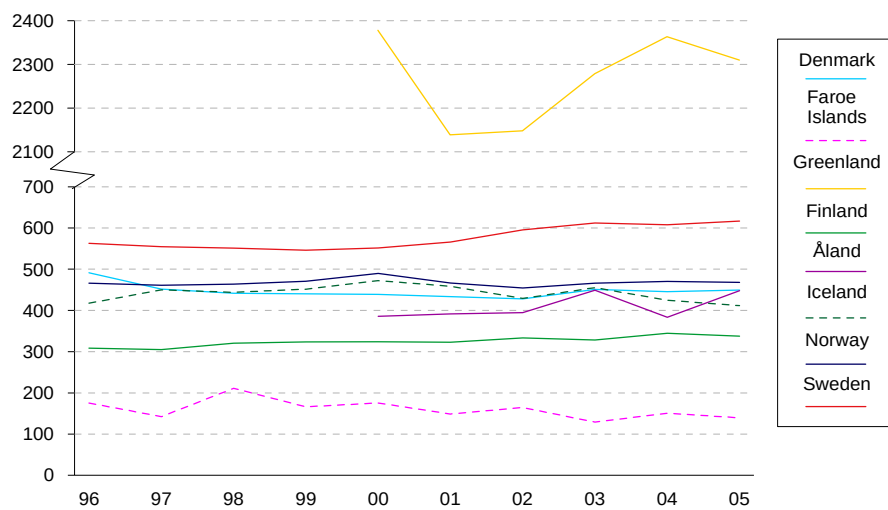
Figure 2.2.5 Sales of emergency prevention per 1 000 women aged 15-44 years 2000-2005
 Salg af nødprævention pr. 1 000 kvinder i alderen 15-44 år 2000-2005



Source: Table 2.2.7
 Kilde: Tabel 2.2.7

POPULATION AND FERTILITY

Figure 2.2.6 Total abortion rate 1996–2005
Samlet abortrate 1996–2005



Source: Table 2.2.8
Kilde: Tabel 2.2.8

Chapter III

Morbidity, medical treatment, accidents and medicinal products

Sygelighed, sygdomsbehandling, ulykker og medicin

Morbidity, medical treatment, accidents and medical products	Sygelighed, sygdomsbehandling, ulykker og medicin	
• Introduction	• Indledning	94
• 3.1 Diseases related to lifestyle	• 3.1 Sygdomme relateret til livsstil	94
• 3.2 Cancer	• 3.2 Cancersygdomme	104
• 3.3 Medical consultations and immunization schedules	• 3.3 Lægebesøg og vaccinationsprogrammer	116
• 3.4 Discharges, patients treated and average length of stay	• 3.4 Udskrivninger og gennemsnitlig liggetid	125
• 3.5 Surgical procedures	• 3.5 Kirurgiske indgreb	151
• 3.6 Accidents and selfinflicted injury	• 3.6 Ulykker og villet egenskade	171
• 3.7 Development in consumption of medicinal products	• 3.7 Udvikling i lægemiddelforbrug	174
Extra material	Supplerende materiale	
Reference group for Patient Statistics	Referencegruppe for patient statistik	
Discharge data	Data for udskrivningerne	
Shortlist for discharges	Kortliste for udskrivninger	
Surgery data	Data for kirugi	
Shortlist for surgery	Kortliste for kirugi	
The Nordic Cancer Union	Den nordiske cancerunion	

Introduction

This chapter begins with a description of a number of diseases that can be related to the lifestyle and social behaviour of people in the population, followed by data on the incidence of cancer. This is followed by a presentation of data on treatment provided outside hospitals and in hospitals, according to diagnostic group and for common surgical procedures. Following this, data on admissions to 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 that can 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 between countries. Among other things, this pattern of behaviour is reflected in the incidence of lung cancer, as shown in Figure 3.1.1.

Table 3.1.2: Nicotine in various pharmaceutical formulations (N07BA01) is used to alleviate withdrawal symptoms and to help in smoking cessation. In all Nordic countries it belongs to 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.

Indledning

I dette kapitel omtales først et antal sygdomme der kan relateres til befolkningens livsstil/socialt adfærd, efterfulgt af forekomsten af nye tilfælde af cancer. Herefter belyses den behandling der gives udenfor sygehusene, efterfulgt af en belysning af behandling ved sygehusene fordelt på diagnosegrupper og ved vigtige kirurgiske indgreb. Herefter omtales ulykkesforekomst og personer indlagt på sygehuse på grund af ulykker. Og til sidst omtales medicinforbruget.

3.1 Sygdomme relateret til livsstil

I dette afsnit belyses et antal sygdomme som kan henføres til befolkningernes livsstil/socialt adfærd og som enten behandles uden for sygehusene og/eller indenfor sygehusene.

Selvom antallet af rygere i de senere år er faldende i de nordiske lande, er der dog fortsat store forskelle i antallet af rygere, både hos mænd og kvinder og en vis forskel mellem landene. Dette adfærdsmønster afspejler sig blandt andet i forekomsten af nye tilfælde af lungecancer som det fremgår af figur 3.1.1.

Tabel 3.1.2 Nikotin i forskellige administrationsformer (N07BA01) bruges til at lindre abstinenser og til at hjælpe ved rygestop. I alle de nordiske lande ligger nikotin blandt de ti bedst sælgende stoffer opgjort i apotekernes udsalgspriser. I Island er forbruget mindst tre gange højere end i de andre lande.

Bupropion (N07BA02), 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 has 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, with the exception of Greenland, where there has been a marked increase.

The incidence of HIV infection is relatively stable, with the highest incidence in Denmark and the lowest in Finland. The trend is related to new methods of treatment. Because of these new methods, infected people have a longer period with HIV infection, and therefore a longer time before AIDS is established. This gives a greater number of potential carriers with the risk of infecting other people.

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 differ-

Bupropion (N07BA02), der oprindeligt var et antidepressiva, blev i 2000 lanceret som hjælpemiddel ved rygestop. Lægemidlet bruges meget lidt i alle landene.

Når det gælder forbruget af alkohol er statistikken mangelfuld, idet de tilgængelige data er hentet fra varestatistikken. Heraf fremgår det at det største forbrug/salg findes i Danmark og Grønland efterfulgt af Finland mens forbruget så nogenlunde er på samme niveau i de øvrige lande. Tilsvarende findes der også fleste behandlingsperioder/udskrivelser for alkoholiske leversygdomme i Danmark og Finland.

Der er tidligere i denne publikation medtaget data for forekomst af hepatitis B og C, men da landenes oplysninger ikke er sammenlignelige udgår denne tabel.

Diagnostiserede tilfælde af tuberkulose er relativt stabil i de nordiske lande med undtagelse af Grønland, hvor der har været en markant stigning.

Forekomsten af HIV smitte ligger relativt stabil med de højeste forekomster i Danmark og de laveste i Finland. Udviklingen skal ses i sammenhæng med de nye behandlingsmetoder der medfører en længere periode med HIV infektion og derfor længere tid inden der konstateres AIDS. Dette giver flere potentielle smittebærere med risiko for at smitte andre.

Chlamydiainfektion er helt givet den hyppigst forekommende blandt de seksuelt overførte sygdomme i de nordiske lande, og det er samtidig den almindeligste årsag til infertilitet hos kvinder. Der er en vis

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

ences between 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 last 20 years. However, there are certain notable exceptions, with Greenland being radically different from the other countries.

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

forskel mellem landene hvor Grønland dog skiller sig helt ud fra de øvrige lande. Sygdommen er ofte asymptomatisk, og derfor angiveligt underrapporteret.

For de traditionelle kønssygdomme, gonorré og syfilis, er der - målt over en 20-års periode - sket en markant nedgang i alle lande. Der er dog visse iøjnefaldende forskelle, hvor Grønland skiller sig helt ud fra de øvrige lande.

Andelen af personer der er overvægtige er et stigende problem i de nordiske lande. Der er flest overvægtige i Grønland og færrest i Norge.

Table 3.1.1 Percentage of daily smokers by sex 2005

Daglige rygere procentvis efter køn 2005

		Denmark	Faroe Islands	Finland	Iceland	Norway	Sweden
Age	Alder	13+	15+	15-64	15-79	16-74	16-84
<i>Smoking men as a percentage of men in the age group</i>							
Mænd, rygere, i pct. af mænd i aldersgruppen							
		28	28	26	20	27	14
<i>Smoking women as a percentage of women in the age group</i>							
Kvinder, rygere, i pct. af kvinder i aldersgruppen							
		24	27	18	20	24	18

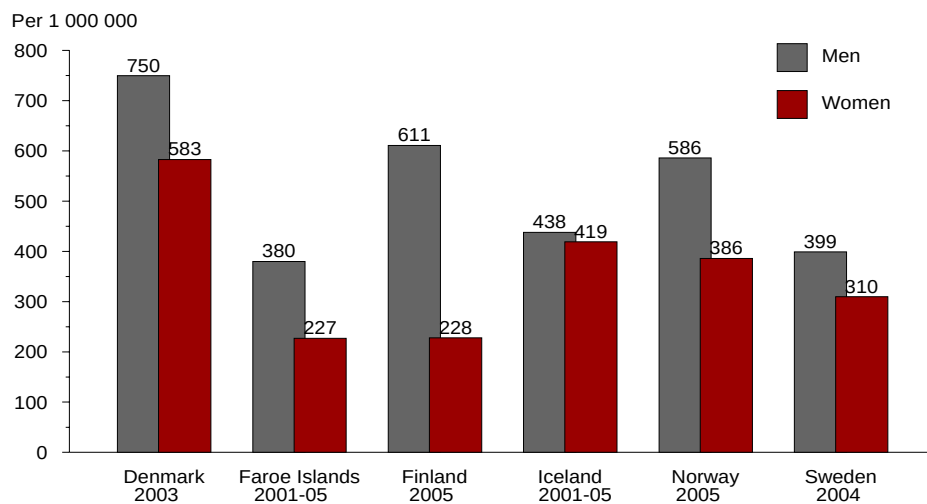
Sources: D: National Board of Health; FI: The National Council for Prevention; F: National Public Health Institute; I: Public Health Institute of Iceland; N: National Directorate for Health and Social Welfare; S: Statistics Sweden

Table 3.1.2 Sales of drug used in nicotine dependence (ATC-group N07BA), DDD/1 000 inhabitants/day, 1999-2005

Salg af midler mod nikotinafhængighed (ATC-gruppe N07BA), DDD/1 000 indbyggere/døgn 1999-2005

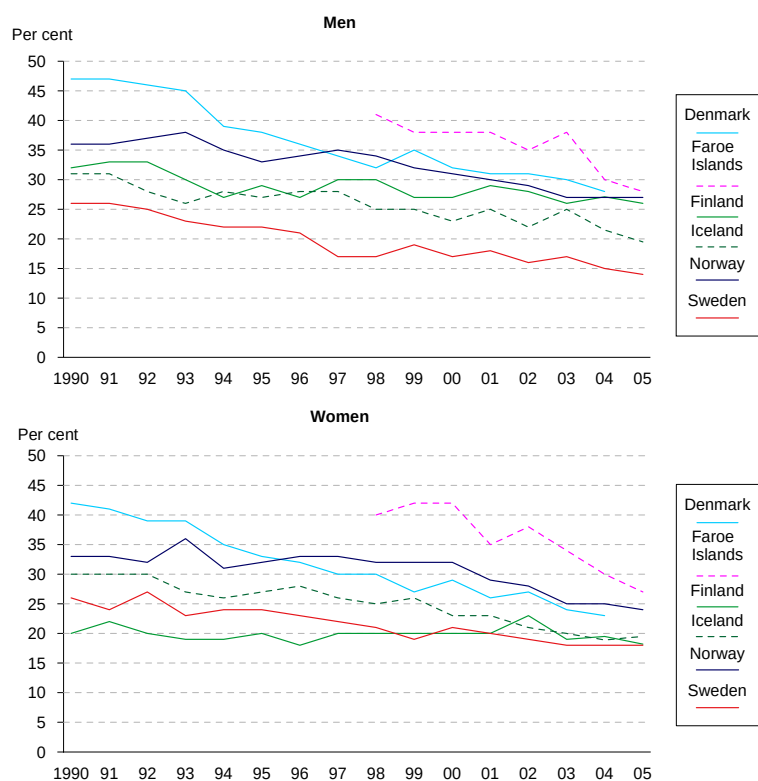
	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N07BA01								
<i>Nicotine</i>								
Nicotin								
1999	3.3	1.7	1.3	2.6	4.0	12.2	2.4	5.1
2000	4.1	2.3	1.6	2.6	3.8	14.2	2.7	5.3
2003	5.4	3.0	1.9	4.1	4.6	16.6	3.6	5.8
2004	6.5	3.2	1.5	4.8	5.3	18.1	3.4	6.3
2005	6.7	3.8	1.7	5.7	5.9	19.4	3.6	6.7
N07BA02								
<i>Bupropion</i>								
Bupropion								
1999	0.3	0.0	0.0	..	..	1.1	0.3	0.1
2000	0.3	0.1	0.0	..	..	1.6	0.6	0.2
2003	0.2	0.2	0.0	0.2	0.1	1.1	0.8	0.2
2004	0.2	0.2	0.1	0.4	0.2	1.1	0.3	0.3
2005	0.3	0.2	0.1	0.4	0.3	1.0	0.2	0.4
N07BC								
<i>Medication for opiate dependence</i>								
Midler imod opiodafhængighed								
2000	2.7	0.1	0.1	0.0	..	0.1	1.0	0.1
2003	3.0	0.1	0.1	0.2	0.0	0.2	3.1	0.3
2004	3.2	0.1	0.1	0.1	0.0	0.0	3.4	0.4
2005	2.7	0.2	0.0	0.1	0.1	0.0	3.9	0.4

Figure 3.1.1 Rates for new cases of lung cancer per 1 000 000 inhabitants
 Rater for nye tilfælde af lungecancer pr. 1 000 000 indbyggere



Source: Tables 3.2.1 and 3.2.2
 Kilde: Tabel 3.2.1 og 3.2.2

Figure 3.1.2 Percentage of daily smokers by sex 1990–2005
Daglige rygere procentvis efter køn 1990–2005



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

Table 3.1.3 Sales of alcoholic beverages in litres of 100 per cent pure alcohol per capita aged 15 years and over 1995–2005

Salg af alkoholiske drikke i liter 100 pct. ren alkohol pr. indbygger 15 år og der-
over 1995–2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
1995	12.1	6.3	12.6	8.3	5.8	4.8	4.8	6.2
2000	11.5	6.8	13.6	8.6	6.1	6.1	5.6	6.2
2004	11.0	6.7	11.7	9.9	6.6	6.7	6.2	6.5
2005	11.0	6.6	12.1	10.0	6.6	7.1	6.4	6.6

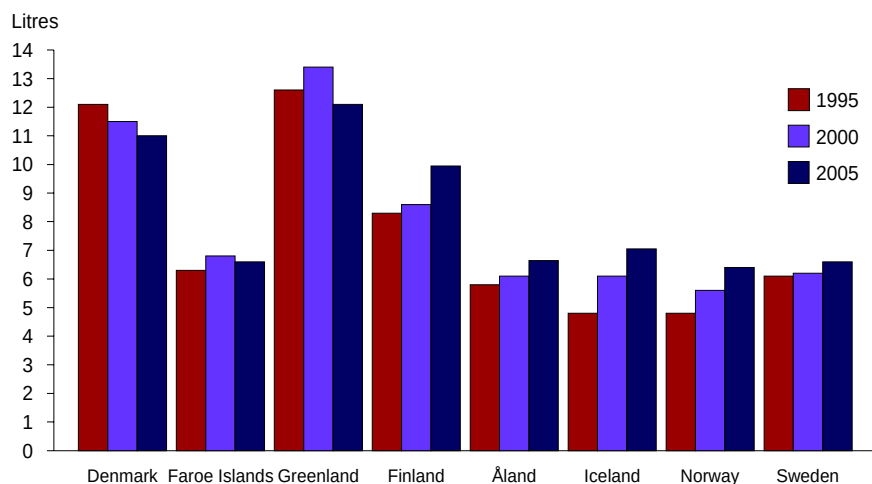
Sources: D, FI, G, I, N: The central statistical bureaus

Kilder: D, FI, G, I, N: De statistiske centralbureauer

F & Å: STAKES; S: National Institute of Public Health

Figure 3.1.3 Sales of alcoholic beverages in litres of 100 per cent pure alcohol per capita aged 15 years and over 1995, 2000 and 2005

Salg af alkoholiske drikke i liter 100 pct. ren alkohol pr. indbygger 15 år og derover 1995, 2000 og 2005



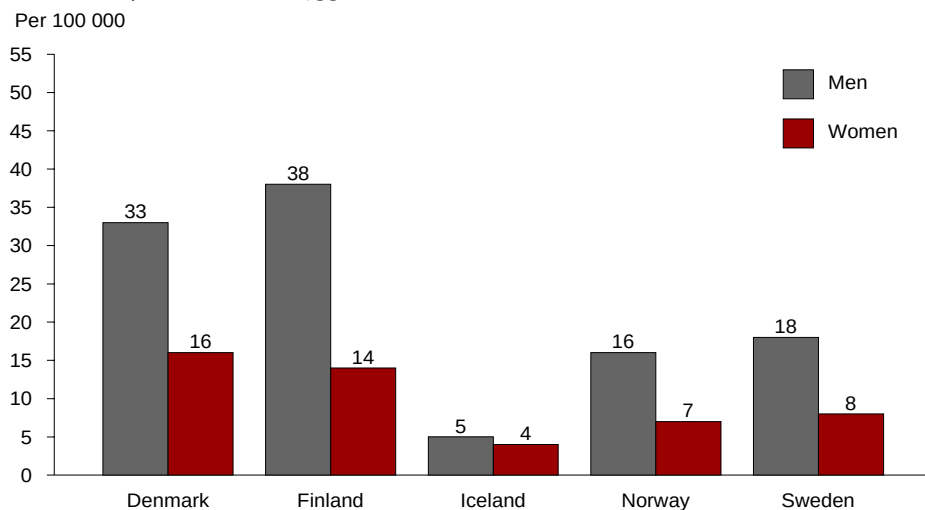
Sources: D, FI, G, I, N: The central statistical bureaus
 Kilder: D, FI, G, I, N: De statistiske centralbureauer
 F & Å: STAKES; S: National Institute of Public Health

Table 3.1.4 Overview of BMI (body mass index), obesity rate, population aged 15+
 Oversigt over BMI, fedme rate, indbyggere i alderen 15 år og opefter

	Denmark	Greenland	Finland	Iceland	Norway	Sweden
	2005	2005	2005	2002	2003	2004
Proportion of people with BMI > 30						
Andel personer med BMI > 30,	11.4	23.1	14.1	12.4	7.9	9.8

Source: Kvalitetsmåling i sundhedsvæsenet i Norden

Figure 3.1.4 Patients treated in somatic hospitals for alcoholic liver disease per 100 000 inhabitants 2005
 Patienter behandlet på somatiske sygehuse for alkoholisk leversygdom pr. 100 000 indbyggere 2005



Source: D: National Board of Health; FI: Ministry of Health; F: STAKES; 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 1995-2005
 Diagnosticerede tilfælde af tuberkulose pr. 100 000 indbyggere 1995-2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway ¹⁾	Sweden ¹⁾
<i>Men</i>								
Mænd					M+W			
1995	9.8	-	94.3	14.5	7.9	3.7	6.4	6.5
2000	12.1	21.7	50.0	12.3	3.9	2.8	5.8	5.2
2004	8.0	-	115.4	7.3	-	4.8	6.5	5.4
2005	9.5	-	178.1	8.0	3.7	4.0	6.6	6.8
<i>Women</i>								
Kvinder								
1995	7.5	9.5	76.8	11.5	.	3.7	4.5	6.3
2000	8.5	4.5	111.0	8.5	.	5.7	4.8	5.2
2004	6.3	-	128.2	5.5	.	2.7	6.7	4.9
2005	6.2	-	165.1	5.7	.	2.0	6.0	6.0

1 Including relapses.

1 Inklusive tilbagefald.

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

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE
Table 3.1.6 Confirmed new cases of HIV 1996-2005

Påviste nye tilfælde af HIV 1996-2005

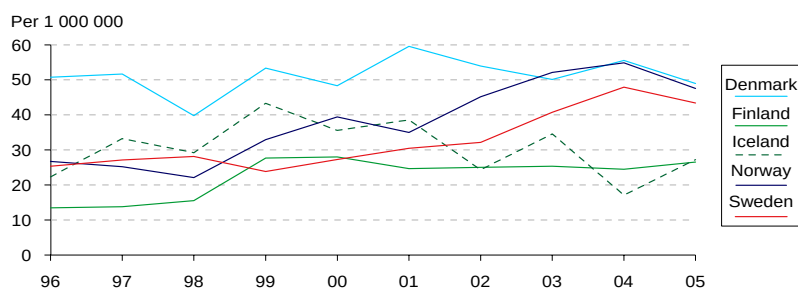
	Denmark	Faroe Islands	Greenland	Finland	Of which Åland	Iceland	Norway	Sweden
<i>Men Mænd</i>								
1996-00	180	0.0	6	76	-	6	81	155
2001-05	206	0.2	5	96	..	6	148	212
2005	193	-	4	98	..	5	122	228
<i>Women Kvinder</i>								
1996-00	80	-	4	24	-	3	49	78
2001-05	82	0.4	2	35	..	2	87	138
2005	72	-	2	41	..	3	97	163
<i>Total I alt</i>								
1996-00	260	0.0	9	102	-	9	130	233
2001-05	289	0.6	7	131	0.6	8	214	349
2005	265	-	6	139	2	8	219	391

Sources: See Table 3.1.5

Kilder: Se tabel 3.1.5

Figure 3.1.5 Confirmed new cases of HIV per 1 000 000 inhabitants 1996-2005

Påviste nye tilfælde af HIV per 1 000 000 indbyggere 1996-2005



Sources: See Table 3.1.6

Kilder: Se tabel 3.1.6

Table 3.1.7 Notified cases of gonorrhoea and syphilis per 100 000 inhabitants aged 15 years and over 2005

Anmeldte tilfælde af gonorré og syfilis pr. 100 000 indbyggere 15 år og derover 2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
<i>Gonorrhoea</i>								
Gonorré								
Men	18.1	4.0	1 534.9	9.3	7.6	12.2	12.4	15.7
Women	2.4	-	2 124.1	1.9	-	4.3	2.8	2.9
Total	10.1	2.0	1 805.4	5.5	3.7	8.2	7.5	9.2
<i>Syphilis</i>								
Syfilis								
Men	4.7	-	3.3	3.9	7.6	2.6	1.3	2.4
Women	0.6	-	3.8	2.6	-	0.9	0.1	0.5
Total	2.6	-	3.5	3.3	3.7	1.7	0.6	1.4

Sources: See Table 3.1.5

Kilder: Se tabel 3.1.5

Table 3.1.8 Diagnosed cases of chlamydia per 100 000 inhabitants 1995–2005
 Diagnosticerede tilfælde af chlamydia pr. 100 000 indbyggere 1995–2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland ¹⁾	Norway	Sweden ^{2,3)}
<i>Men</i>								
<i>Mænd</i>								
1995	124	..	1 509	138	48	368	..	131
2000	165	..	2 789	179	94	479	..	187
2004	287	..	2 446	199	..	440	..	314
2005	324	..	3 852	196	..	412	..	317
<i>Women</i>								
<i>Kvinder</i>								
1995	370	..	2 500	224	140	428	..	192
2000	384	..	4 802	271	206	781	..	246
2004	511	..	4 099	316	..	698	..	401
2005	554	..	5 797	286	..	643	..	411
<i>Men and women</i>								
<i>Mænd og kvinder</i>								
1995	249	67	1 971	182	95	398	215	156
2000	276	79	3 727	226	151	647	326	217
2004	400	304	3 214	256	354	593	382	361
2005	440	231	4 762	242	253	548	434	366

1 Notified cases. Since 1997 cases verified by laboratories. The total includes those with missing data about gender.

2 A mutant chlamydia gene, which is not detected in Abbott's test system, has been identified in the country of Halland, and has become distributed 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 2005, gender is not known for 45 people.

1 Anmeldte tilfælde. Fra 1997 er det tilfælde der er verificeret via laboratorier. Totalen inkluderer dem med uoplyst køn.

2 Et muteret klamydiagen, som ikke bliver opdaget i Abbotts testsystem, er opdaget i landstinget i Halland og har formentlig større geografisk spredning. Det rapporterede antal i 2006 (og sandsynligvis også 2005) er underrapporteret i størstedelen af landstingene på grund af problemer med klamydiadiagnostik. Kilde: Smittskyddsinstitutet.

3 For 2005 er kønnet ukendt for 45 personer.

Sources: See Table 3.1.5

Kilder: Se tabel 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 occupational hazards and factors in the environment have been shown to be cancer inducing.

The incidence of cancer increases with increasing 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 trend for 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

3.2 Cancersygdomme

De nordiske lande har befolkningsbase-rede cancerregistre med centraliseret kodning og klassifikation. Kodningen er dog ikke centraliseret i Sverige.

Årsagerne til kræft er både ydre og indre faktorer, som medfører ændringer i arvemassen. Nydelsesmidler, kostfaktorer, visse erhvervseksposeringer og faktorer i miljøet, har vist sig at være kræftfremkaldende.

Kræftforekomsten øges med stigende alder, og kræft er en sjælden sygdom før 30-års-alderen, hvor incidensen når 300 tilfælde per 1 000 000 indbyggere. Ved 70-års-alderen er det tilsvarende tal omkring 10 000 tilfælde per 1 000 000 indbyggere. Det årlige antal kræfttilfælde øges i samtlige nordiske lande, og denne tendens er stadig til stede, når der korrigeres for forskelle i befolkningsstørrelserne og alderssammensætningen.

Udviklingen i kræftsygdommene i de nordiske lande er analog for de fleste kræftformer, men der er interessante forskelle. Generelt er antallet af kræfttilfælde gennem tiden øget, med få undtagelser hvor forekomsten er faldende. Det gælder blandt andet for kræft i mavesækken. Forekomsten af livmoderhalskræft i de nordiske lande, skal ses i sammenhæng med befolkningsbaseret screening for forstadier og tidlig kræft, og disses behandling.

Bryst- og prostatacancer samt colorektal cancer stiger i næsten alle lande. Kostfaktorer er formentlig af væsentlig betydning for denne udvikling, men for bryst- og prostatacancer spiller hormonelle faktorer også en vigtig rolle. Fore-

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.

komsten af testikelkræft er igen stigende i de fleste af landene. Forekomsten af tobaksrelaterede kræftformer, såsom lungecancer er høje i alle landene Det skal dog bemærkes, at lungekræft blandt mænd er faldende.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.2.1.a New cases of cancer per 1 000 000 inhabitants, men
Nye tilfælde af cancer pr. 1 000 000 indbyggere, mænd

	<i>Total*</i> I alt*	<i>C62</i> <i>Testis</i> Testikler	<i>C61</i> <i>Prostate</i> Prostata	<i>C16</i> <i>Stomach</i> Mave	<i>C18-21</i> <i>Colon and</i> <i>rectum</i> Tyktarm og endetarm	<i>C25</i> <i>Pancreas</i> Pancreas	<i>C33-34</i> <i>Lungs</i> Lunger	<i>C43</i> <i>Melanoma</i> <i>of the skin</i> Melanom i hud
<i>Denmark¹⁾</i>								
1996-00	4 679	110	655	121	651	124	760	161
2003	4 927	103	893	120	709	134	750	200
<i>Faroe Islands²⁾</i>								
1996-00	3 136	78	408	191	443	148	365	35
2001-05	3 159	105	462	194	454	121	381	32
<i>Greenland</i>								
1996-00	..	54	54	207	237	130	681	15
1999-03	3 061	66	46	193	345	120	857	20
<i>Finland</i>								
1996-00	4 239	34	1 201	176	391	130	602	122
2003	4 945	40	1 658	166	451	145	607	140
2004	5 361	38	2 042	154	488	180	611	159
<i>Iceland</i>								
1996-00	4 012	61	1 096	199	480	98	469	98
2001-05	4 161	54	1 308	153	465	91	438	150
<i>Norway</i>								
1996-00	4 872	108	1 293	182	687	124	580	206
2004	5 758	116	1 677	152	771	129	604	213
2005	5 574	109	1 592	127	750	124	586	249
<i>Sweden</i>								
1996-00	4 657	55	1 528	156	600	101	381	183
2004	5 645	68	2 217	133	661	101	399	210
2005	5 557	63	2 207	129	635	100	405	242

Numbers refer to ICD-10.

* *The total covers chapter C, except C44 and C46.0. Including D09.0, D32, D33, D41.4, D42 and D43*
Totalen dækker kapitel C, undtagen C44 og C46.0. Inkludere D09.0, D32, D33, D41.4, D42 og D43

1 Figures for 2003 are preliminary.

1 2003 er foreløbige tal.

2 Based on 5 year average discharges from the patient register.

2 Baseret på udskrivelser for 5 års gennemsnit fra patientregisteret.

Sources: *The cancer registers in the Nordic countries*

Kilder: De nordiske cancerregistre

G: Danish Cancer Society

Table 3.2.1.b New cases of cancer age standardized per 1 000 000 men

Nye tilfælde af cancer alderstandardiserede rater, pr. 1 000 000 mænd

	<i>Total*</i> I alt*	<i>C62</i> <i>Testis</i> Testikler	<i>C61</i> <i>Prostate</i> Prostata	<i>C16</i> <i>Stomach</i> Mave	<i>C18-21</i> <i>Colon and</i> <i>rectum</i> Tyktarm og endetarm	<i>C25</i> <i>Pancreas</i> Pancreas	<i>C33-34</i> <i>Lungs</i> Lunger	<i>C43</i> <i>Melanoma</i> <i>of the skin</i> Melanom i hud
<i>Denmark¹⁾</i>								
1996-00	5 675	102	894	152	825	158	938	186
2003	5 468	100	1 027	136	807	148	819	213
<i>Faroe Islands²⁾</i>								
1996-00	3 877	80	596	229	556	176	430	37
2001-05	3 918	109	590	248	557	150	462	38
<i>Greenland</i>								
1999-03	6 074	59	89	339	694	243	1 987	28
<i>Finland</i>								
1996-00	6 091	34	1 891	269	574	207	930	154
2003	5 705	40	1 903	202	530	163	705	151
2004	6 054	37	2 293	177	551	209	687	169
<i>Iceland</i>								
1996-00	6 256	59	1 848	337	761	175	747	133
2001-05	5 624	52	1 830	222	661	124	585	181
<i>Norway</i>								
1996-00	5 959	97	1 666	234	871	158	716	240
2004	6 561	114	1 937	179	889	148	683	233
2005	6 336	109	1 824	151	861	139	662	276
<i>Sweden</i>								
1996-00	5 073	52	1 687	175	642	110	407	186
2004	5 503	68	2 138	131	651	98	384	206
2005	5 362	64	2 101	126	618	97	391	236

Numbers refer to ICD-10.

* The total covers chapter C, except C44 and C46.0. Including D09.0, D32, D33, D41.4, D42 and D43
 Totalen dækker kapitel C, undtagen C44 og C46.0. Inkludere D09.0, D32, D33, D41.4, D42 og D43

1 Figures for 2003 are preliminary.

1 2003 er foreløbige tal.

2 Based on 5 year average discharges from the patient register.

2 Baseret på udskrivninger for 5 års gennemsnit fra patientregisteret.

Sources: The cancer registers in the Nordic countries

Kilder: De nordiske cancerregistre

G: Danish Cancer Society

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

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

Nye tilfælde af cancer pr. 1 000 000 indbyggere, kvinder

	Total* I alt*	C50 Breast Bryst	C53 Cervix uteri Livmoder- hals	C16 Stomach Mave	C18-21 Colon and rectum Tyktarm og endetarm	C25 Pancreas Pancreas	C33-34 Lungs Lunger	C43 Melanoma of the skin Melanom i hud
<i>Denmark¹⁾</i>								
1996-00	4 975	1 381	160	73	641	131	537	197
2003	5 056	1 469	150	68	621	126	583	253
<i>Faroe Islands²⁾</i>								
1996-00	3 370	808	186	93	390	158	223	37
2001-05	3 363	909	114	105	550	201	227	70
<i>Greenland</i>								
1996-00	..	467	352	46	337	122	559	23
1999-03	2 928	441	243	68	434	190	555	8
<i>Finland</i>								
1996-00	4 104	1 281	61	140	419	138	179	115
2003	4 571	1 421	61	129	439	175	198	132
2004	4 623	1 462	61	129	464	164	228	145
<i>Iceland</i>								
1996-00	3 899	1 082	105	102	378	107	409	172
2001-05	4 016	1 185	115	94	396	62	419	229
<i>Norway</i>								
1996-00	4 434	1 077	140	113	710	140	311	223
2004	5 064	1 201	115	95	755	141	391	239
2005	4 978	1 198	126	97	736	124	386	243
<i>Sweden</i>								
1996-00	4 353	1 366	102	98	567	109	249	182
2004	5 606	1 526	96	88	600	105	310	223
2005	5 602	1 529	94	74	647	97	330	228

Numbers refer to ICD-10.

* The total covers chapter C, except C44 and C46.0. Including D09.0, D32, D33, D41.4, D42 and D43
Totalen dækker kapitel C, undtagen C44 og C46.0. Inkludere D09.0, D32, D33, D41.4, D42 og D43

1 Figures for 2003 are preliminary.

1 2003 er foreløbige tal.

2 Based on 5 year average discharges from the patient register.

2 Baseret på udskrivninger for 5 års gennemsnit fra patientregisteret.

Sources: The cancer registers in the Nordic countries
Kilder: De nordiske cancerregistre
G: Danish Cancer Society

Table 3.2.2.b New cases of cancer age standardized, per 1 000 000 women

Nye tilfælde af cancer alderstandardiserede rater, pr. 1 000 000 kvinder

	<i>Total* I alt*</i>	<i>C50 Breast Bryst</i>	<i>C53 Cervix uteri Livmoder- hals</i>	<i>C16 Stomach Mave</i>	<i>C18-21 Colon and rectum Tyktarm og endetarm</i>	<i>C25 Pancreas Pancreas</i>	<i>C33-34 Lungs Lunger</i>	<i>C43 Melanoma of the skin Melanom i hud</i>
<i>Denmark¹⁾</i>								
1996-00	4 828	1 312	158	70	620	129	538	195
2003	4 705	1 392	146	62	556	114	547	241
<i>Faroe Islands²⁾</i>								
1996-06	3 593	889	197	90	407	151	239	41
2001-05	3 536	947	121	101	565	205	241	76
<i>Greenland</i>								
1999-03	5 032	667	292	76	908	353	1 077	11
<i>Finland</i>								
1996-00	4 023	1 210	60	139	416	152	190	115
2003	4 039	1 298	57	109	373	147	168	120
2004	4 037	1 319	59	107	394	134	192	130
<i>Iceland</i>								
1996-00	4 824	1 345	116	138	494	155	557	201
2001-05	4 650	1 391	120	110	465	74	503	241
<i>Norway</i>								
1996-00	4 380	1 139	147	104	680	131	319	227
2004	4 766	1 188	115	86	676	124	381	233
2005	4 661	1 173	125	85	658	108	373	235
<i>Sweden</i>								
1996-00	3 985	1 205	99	83	468	95	232	169
2004	4 990	1 373	92	69	479	89	268	202
2005	4 957	1 358	90	58	518	81	281	205

Numbers refer to ICD-10.

* The total covers chapter C, except C44 and C46.0. Including D09.0, D32, D33, D41.4, D42 and D43
 Totalen dækker kapitel C, undtagen C44 og C46.0. Inkludere D09.0, D32, D33, D41.4, D42 og D43

1 Figures for 2003 are preliminary.

1 2003 er foreløbige tal.

2 Based on 5 year average discharges from the patient register.
 2 Baseret på udskrivninger for 5 års gennemsnit fra patientregisteret.

Sources: The cancer registers in the Nordic countries

Kilder: De nordiske cancerregistre

G: Danish Cancer Society

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.2.3 New cases of leukemia per 1 000 000 inhabitants, 0-14 year-olds
Nye tilfælde af leukæmi pr. 1 000 000 indbyggere, 0-14-årige

	Denmark ¹⁾	Finland	Iceland ²⁾	Norway	Sweden
<i>Boys Dreng</i>					
1996-00	47	47	48	53	54
2004	40	45	30	54	62
2005	..	..	24	37	62
<i>Girls Piger</i>					
1996-00	43	50	25	51	49
2004	41	58	31	45	52
2005	..	..	31	32	44
<i>Totalt alt</i>					
1996-00	45	49	37	53	52
2004	40	51	30	49	57
2005	..	..	27	34	53

The table covers the numbers C91-C95 in ICD-10.

Tabellen dækker numrene C91-C95 i ICD-10.

1 2004=2003 are preliminary figures.

1 2004=2003 og er foreløbige tal.

2 Only five year averages are presented. Figures for single years may be unstable because of low population. 2004= average 2000-2004, 2005 = average 2001-2005.

2 Kun femårs gennemsnit præsenteres. Tal for enkelte år kan være ustabile på grund af lav population. 2004 = gennemsnit 2000-2004 og 2005 = 2001-2005.

Sources: *The cancer registers in the Nordic countries*

Kilder: De nordiske cancerregistre

G: Danish Cancer Society

Table 3.2.4 New cases of cancer of the colon and rectum per 1 000 000 inhabitants
Nye tilfælde af cancer i tyktarm og endetarm pr. 1 000 000 indbyggere

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Iceland	Norway	Sweden
	2003	2001-05	1999-03	2004	2001-05	2005	2005
<i>Men Mænd</i>							
<i>Age Alder</i>							
0-24	1	-	-	12	-	3	5
25-44	67	59	-	54	42	73	48
45-64	739	651	874	539	519	806	589
65-84	3 733	2 357	3 451	2 406	3 000	3 941	2 989
85+	5 484	3 228	-	3 554	5 534	6 320	3 808
<i>Women Kvinder</i>							
<i>Age Alder</i>							
0-24	-	-	-	20	-	4	4
25-44	49	34	67	72	53	91	54
45-64	598	700	1 136	440	406	672	581
65-84	2 537	2 478	3 311	1 560	2 108	3 028	2 373
85+	3 407	2 839	5 682	2 830	3 548	4 231	2 993

1 Preliminary figures.

1 Foreløbige tal.

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

Tabellen dækker numrene C18-21 i ICD-10.

Sources: *The cancer registers in the Nordic countries*

Kilder: De nordiske cancerregistre

G: Danish Cancer Society

Table 3.2.5 New cases of lung cancer per 1 000 000 inhabitants
 Nye tilfælde af lungecancer pr. 1 000 000 indbyggere

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Iceland	Norway	Sweden
	2003	2001-05	1999-03	2004	2001-05	2005	2005
<i>Men Mænd</i>							
<i>Age Alder</i>							
0-24	1	-	-	-	-	1	1
25-44	47	-	150	18	42	18	19
45-64	923	548	1 808	654	582	676	447
65-84	4 009	2 129	9 002	3 278	2 972	3 256	1 891
85+	2 340	2 421	7 353	3 554	1 230	3 301	1 628
<i>Women Kvinder</i>							
<i>Age Alder</i>							
0-24	5	-	-	-	-	1	2
25-44	45	34	22	18	53	28	24
45-64	795	350	1 220	264	677	540	482
65-84	2 392	1 071	5 695	808	2 108	1 597	1 150
85+	770	-	-	859	1 352	808	415

1 Preliminary figures.

1 Foreløbige tal.

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

Tabellen dækker numrene C33-34 i ICD-10.

Sources: The cancer registers in the Nordic countries

Kilder: De nordiske cancerregistre

G: Danish Cancer Society

Table 3.2.6 New cases of cancer of the cervix uteri per 1 000 000 women
 Nye tilfælde af livmoderhalscancer pr. 1 000 000 kvinder

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Iceland	Norway	Sweden
	2003	2001-05	1999-03	2004	2001-05	2005	2005
<i>Age Alder</i>							
0-24	5	-	-	1	11	8	5
25-44	215	102	449	80	230	196	135
45-64	181	194	295	79	142	158	114
65-84	246	335	662	92	86	203	142
85+	228	-	-	159	253	59	158

1 Preliminary figures.

1 Foreløbige tal.

The table covers the number C53 in ICD-10.

Tabellen dækker numrene C53 i ICD-10.

Sources: The cancer registers in the Nordic countries

Kilder: De nordiske cancerregistre

G: Danish Cancer Society

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.2.7 New cases of cancer of the testis per 1 000 000 men
Nye tilfælde af testikelcancer pr. 1 000 000 mænd

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Iceland	Norway	Sweden
	2003	2001-05	1999-03	2004	2001-05	2005	2005
<i>Age</i>							
<i>Alder</i>							
0-24	38	66	17	27	25	53	32
25-44	237	176	113	81	113	249	142
45-64	68	103	90	22	44	65	42
65-84	23	76	-	3	14	19	17
85+	-	-	-	-	-	35	14

1 Preliminary figures.

1 Foreløbige tal.

The table covers the number C62 in ICD-10.

Tabellen dækker nummer C62 i ICD-10.

Sources: The cancer registers in the Nordic countries

Kilder: De nordiske cancerregistre

G: Danish Cancer Society

Table 3.2.8 New cases of melanoma of the skin per 1 000 000 inhabitants
Nye tilfælde af melanom i hud pr. 1 000 000 indbyggere

	Denmark ¹⁾	Faroe Islands	Finland	Iceland	Norway	Sweden
	2003	2001-05	2004	2001-05	2005	2005
<i>Men Mænd</i>						
<i>Age Alder</i>						
0-24	13	-	4	22	3	6
25-44	115	29	75	141	93	84
45-64	323	34	231	219	376	328
65-84	564	152	562	471	975	821
85+	978	-	551	769	1 299	1 218
<i>Women Kvinder</i>						
<i>Age Alder</i>						
0-24	29	-	3	60	15	13
25-44	232	136	95	354	168	180
45-64	363	-	200	316	371	304
65-84	471	268	337	271	588	484
85+	684	-	445	422	646	633

1 Preliminary figures.

1 Foreløbige tal.

The table covers the number C43 in ICD-10.

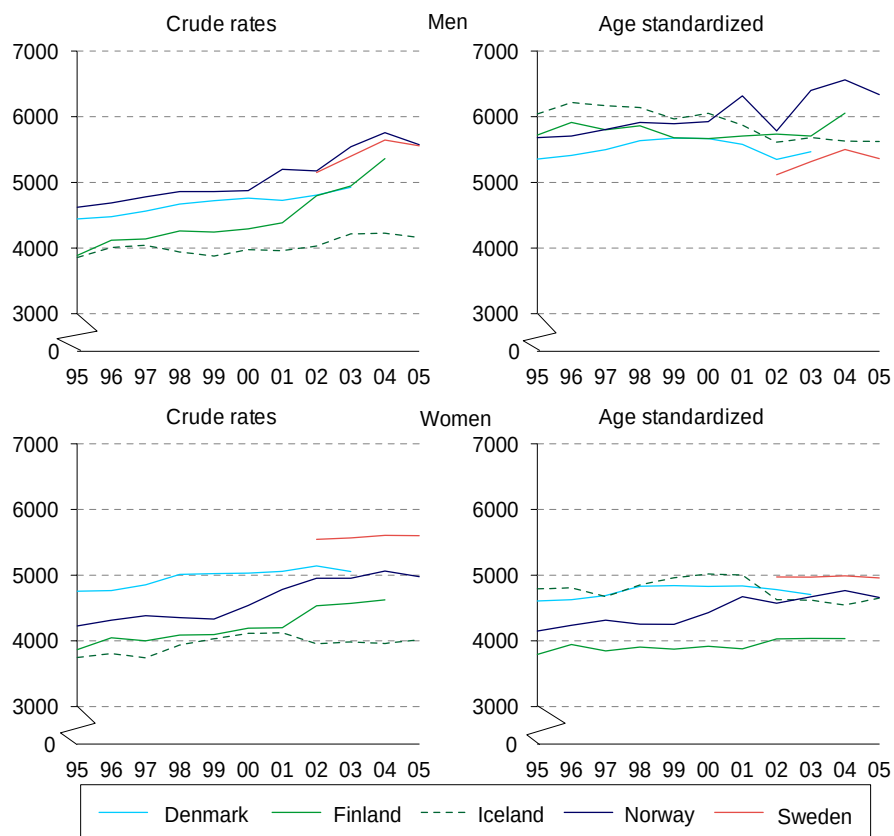
Tabellen dækker nummer C43 i ICD-10.

Sources: The cancer registers in the Nordic countries

Kilder: De nordiske cancerregistre

G: Danish Cancer Society

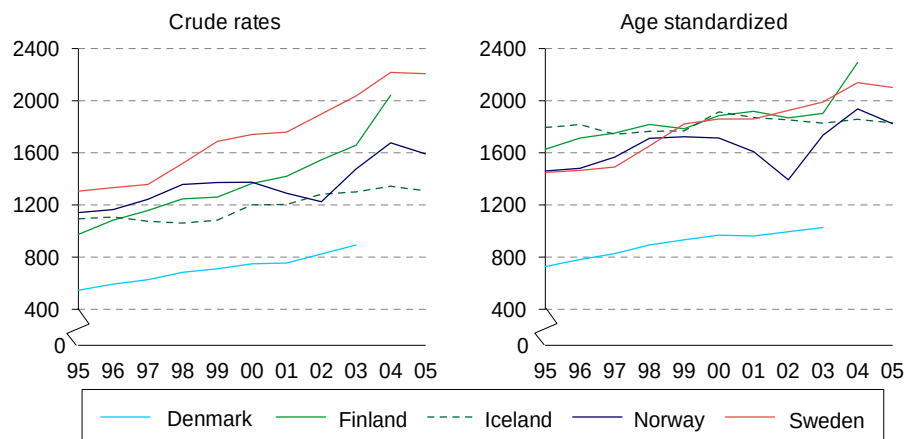
Figure 3.2.1 New cases of cancer crude rates and age standardized rates per 1 000 000 inhabitants 1995-2005
 Nye tilfælde af cancer summariske rater og aldersstandardiserede rater pr. 1 000 000 indbyggere 1995-2005



NB The figures for Iceland are 3-year averages.
 De islandske tal er treårs gennemsnit.

Sources: The Nordic Cancer Union
 Kilder: Den nordiske cancerunion

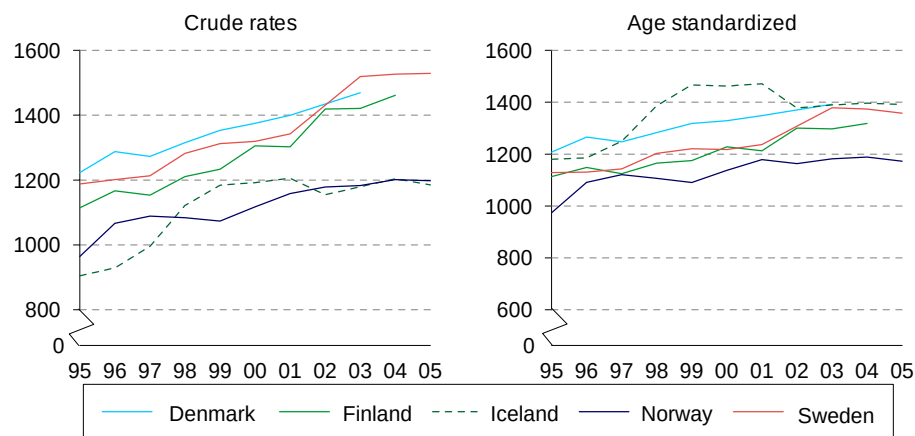
Figure 3.2.2 New cases of prostate cancer crude rates and age standardized rates per 1 000 000 inhabitants 1995-2005
Nye tilfælde af prostatacancer summariske rater og aldersstandardiserede rater pr. 1 000 000 indbyggere 1995-2005



NB The figures for Iceland are 3-year averages.
De islandske tal er treårs gennemsnit.

Sources: See Table 3.2.1.b
Kilder: Se tabel 3.2.1.b

Figure 3.2.3 New cases of breast cancer crude rates and age standardized rates per 1 000 000 inhabitants 1995-2005
Nye tilfælde af brystcancer summariske rater og aldersstandardiserede rater pr. 1 000 000 indbyggere 1995-2005

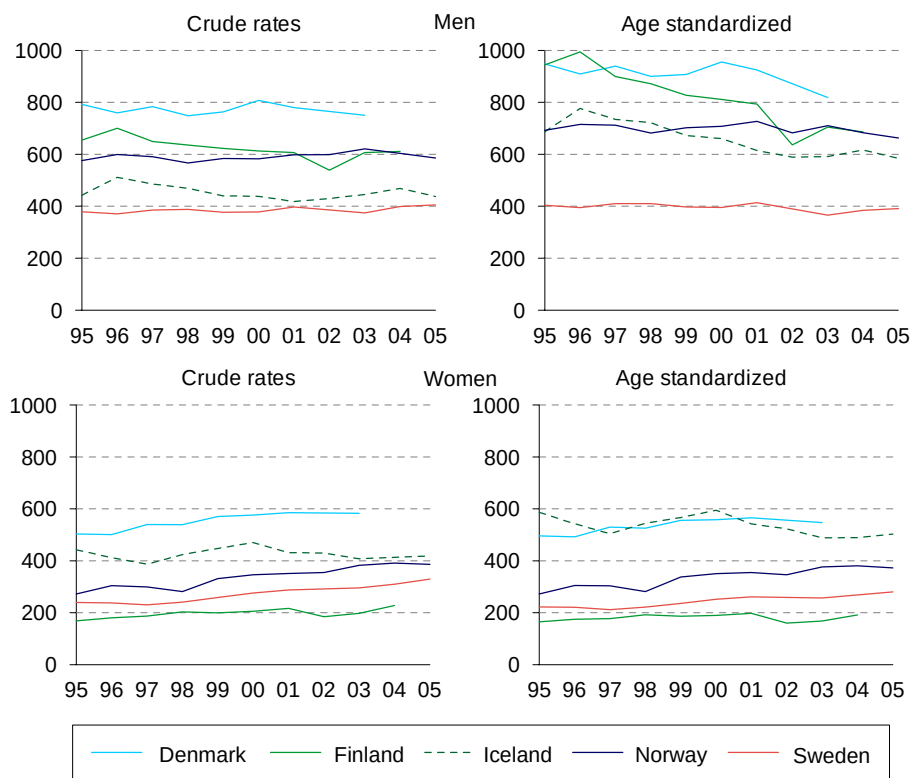


NB The figures for Iceland are 3-year averages.
De islandske tal er treårs gennemsnit.

Sources: See Table 3.2.2.b
Kilder: Se tabel 3.2.2.b

Figure 3.2.4 New cases of lung cancer crude rates and age standardized rates per 1 000 000 inhabitants 1995-2005

Nye tilfælde af lungecancer summariske rater og aldersstandardiserte rater pr. 1 000 000 indbyggere 1995-2005



NB The figures for Iceland are 3-year averages.
De islandske tal er treårs gennemsnit.

Sources: See Table 3.2.1.b and 3.2.2.b
Kilder: Se tabel 3.2.1.b og 3.2.2.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 country to country.

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 between 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 between the Nordic countries.

Tables 3.3.2 and 3.3.3 show number of consultations with a doctor according to

3.3 Lægebesøg og vaccinationsprogrammer

I de nordiske lande er det primære sundhedsvæsen forankret og finansieret af den offentlige sektor.

Men graden af decentralisering varierer, hvilket også gælder for forholdet mellem privatpraktiserende og offentligt ansatte læger i det primære sundhedsvæsen.

Der er endvidere forskel på integrationsgraden af lægebehandling, sygepleje, fysioterapi m.v. Lignende forskelle findes også for hjemmesygeplejen og hjemmehjælpen.

Registreringspraksis for lægebesøg er meget forskellig fra land til land.

Det er det mest almindelige, at patienterne opsøger lægen i lægekonsultationen, men i alle landene praktiseres der også via telefonkonsultationer, lægebesøg i hjemmet og skadestuebehandling.

Alle kontakter i Danmark registreres således som lægekontakter, på grund af betalingssystemet, mens en del af kontakterne i de andre lande er registrerede/ikke registrerede kontakter med andet sundhedspersonale. Her er det især kontrol af mødre og spædbørn der er en stor forskel mellem landene. Blandt andet disse forhold gør at statistikken om lægebesøg ikke er sammenlignelig mellem de nordiske lande.

Tabel 3.3.2 og 3.3.3 viser lægebesøg fordelt på alder hos henholdsvis almen læge

age, for general practitioners and specialists. Small children and elderly people are the largest groups. Tables 3.3.4 and 3.3.5 show number of consultations with a doctor according to diagnosis. Data for this are not available for Denmark. For general practitioners, respiratory tract infections is the largest group. Consultations with a specialist show a somewhat more varied pattern. The statistics in Tables 3.3.4 and 3.3.5 are based on sample data.

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.

og specialist, hvor det især er mindre børn og den ældste del af befolkningen der vejer tungest. Tabellerne 3.3.4 og 3.3.5 viser lægebesøg fordelt på diagnoser, hvor det ikke er muligt at få data fra Danmark. Hos den alment praktiserende læge vejer luftvejssygdomme tungest, mens besøg hos en specialist viser et noget mere uensartet mønster. Tallene i tabel 3.3.4 og 3.3.5 bygger på udvalgsdata.

Alle nordiske lande har anbefalede vaccinationsprogrammer med visse forskelle i vaccination mod tuberkulose, kighoste og valget af vaccine mod henholdsvis mæslinger og røde hunde.

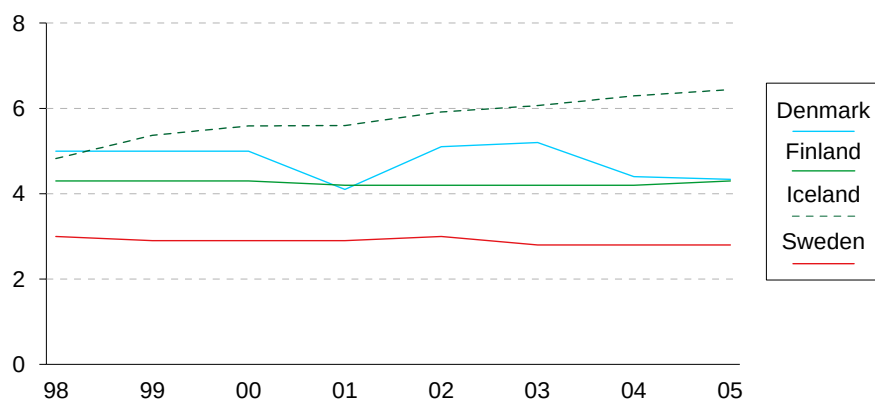
Dataindsamlingen for vaccinationerne varierer meget fra land til land, og ingen af landene, bortset fra Norge, har vaccinationsregistre der dækker hele landet.

Table 3.3.1 Number of doctors in general practice 2005
Antal læger der arbejder i almen praksis 2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
<i>Number of doctors in general practice</i> Antal alment praktiserende læger	4 203	30	50	3 680	16	228	4 535	5 051
<i>Number of inhabitants per doctor in general practice</i> Antal indbyggere pr. alment praktiserende læge	1 288	1 600	1 143	1 426	1 666	1 315	1 019	1 784

Sources: D: National Board of Health; F: STAKES; I: Directorate of Health; S: National Board of Health and Welfare
Kilder: fare

Figure 3.3.1 Consultations per capita 1998-2005
Konsultationer pr. person 1998-2005



Sources: See Table 3.3.1
Kilder: Se tabel 3.3.1

Table 3.3.2 Number of consultations with doctors in general practice, estimated for the whole country, per 1000 inhabitants in age group 2005

Konsultationer hos alment praktiserende læger, estimeret til nationalt niveau, pr 1 000 indbyggere i aldersgruppen 2005

	Denmark	Finland	Iceland ¹⁾	Norway	Sweden ²⁾
<1 year	4 440	3 354	7 811	279	743
1-4 year	4 002	2 653	3 640	2 119	1 294
5-14 year	1 972	1 482	1 620	917	736
15-24 year	2 908	1 485	2 247	1 387	877
25-44 year	3 225	1 485	2 276	2 326	1 036
45-64 year	3 714	1 619	2 987	2 599	1 242
65-74 year	5 336	2 410	4 580	3 273	1 659
75-84 year	6 202	2 913	5 444	3 935	2 090
85+	4 815	2 790	4 532	3 202	1 805
Total, per 1000 inhabitants	3 566	1 777	2 797	2 227	1 180
Total number of consultations	19 313 639	9 340 522	827 677	56 024	10 634 700

1 Total numbers. Not estimated for the whole country.

2 Consultations with doctors in general practice for 2004, registered in Västra Götaland Region, estimated for the whole country. Västra Götaland Region.

1 Totalt antal. Ikke estimeret til nationalt niveau.

2 Konsultationer til alment praktiserende læger 2004, vårdregistret i Västra Götalands region, estimeret til nationalt niveau. Västra Götalandsregionen.

Source: Denmark: National Board of Health; Finland: STAKES; Iceland: Directorate of Health; Sweden: Region Västra Götaland

Kilde: Danmark: Sundhedsstyrelsen; Finland: STAKES; Iceland: Medicinaldirektoratet; Sverige: Västra Götalandsregionen

Table 3.3.3 Number of consultations with specialists, estimated for the whole country, per 1000 inhabitants in age group 2005

Antal konsultationer hos speciallæger, estimeret til nationalt niveau, per 1 000 indbyggere i aldersgruppen 2005

	Denmark	Finland	Iceland ¹⁾	Sweden ²⁾
<1 year	435	1 563	..	1 996
1-4 years	1 060	791	..	1 192
5-14 years	560	772	..	834
15-24 years	487	1 003	..	870
25-44 years	633	1 189	..	1 030
45-64 years	822	1 457	..	1 452
65-74 years	1 167	1 953	..	2 315
75-84 years	1 418	2 117	..	2 891
85+	1 184	1 583	..	2 226
Total per 1 000 inhabitants	770	1 306	1 656	1 371
Total number of consultations	4 170 711	6 866 413	489 896	12 354 000

1 Consultations with specialists in private practice for 2005. Data from specialists in hospitals is not available. Age distributed information is not available.

2 Consultations with specialists in the patient register 2004, estimated for the whole country. Centre for Epidemiology, National Board of Health and Welfare.

1 Konsultationer hos speciallæger i private praksisser 2005. Data fra specialister ved hospitaler er ikke tilgængelige. Alders fordelt information er ikke tilgængelig.

2 Konsultationer til speciallæger fra patientregistret 2004, estimeret til nationalt niveau. Epidemiologisk Centrum, Socialstyrelsen.

Source: Denmark: National Board of Health; Finland: STAKES; Iceland: Directorate of Health; Sweden: Region Västra Götaland

Kilde: Danmark: Sundhedsstyrelsen; Finland: STAKES; Iceland: Medicinaldirektoratet; Sverige: Västra Götalandsregionen

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Table 3.3.4 Number of consultation with doctors in general practice by diagnostic group percent 2005

Konsultationer til almentpraktiserende læger fordelt på diagnose gruppe pct. 2005

	Finland ¹⁾	Iceland	Norway	Sweden ¹⁾
<i>Respiratory tract infections, incl. otitis</i>				
Luftvejsinfektioner	22.1	17.2	12.3	15.8
<i>Asthma</i>				
Astma	0.7	1.5	0.9	1.2
<i>Neck, shoulder and other enthesopathies/tendonitis</i>				
Problemer med nakke, skulder og arme	8.4	2.4	7.6	5.2
<i>Low back problems</i>				
Rygsmærter	4.3	1.0	4.2	3.3
<i>Psychiatric problems</i>				
Psykiatriske problemer	3.9	8.8	10.3	7.5
<i>Atopic and hypersensitivity problems</i>				
Allergi og vejrtrækningsproblemer	1.7	0.9	1.4	2.3
<i>Hypertension</i>				
Hypertension	4.2	5.7	5.1	5.0
<i>Ischemic heart disease and arrhythmias</i>				
Iskæmisk hjertesygdom og arytmier	2.4	2.1	4.7	2.2
<i>Diabetes</i>				
Diabetes	3.2	1.2	2.0	2.5
<i>Cancer</i>				
Cancer	0.4	0.6	1.2	0.4
<i>Female genital problems</i>				
Gynækologiske problemer	1.4	1.4	1.4	0.7
<i>Digestive system functional problems</i>				
Problemer med fordøjelsessystemet	4.1	4.4	3.4	3.6
<i>Skin infections</i>				
Hud infektioner	2.5	3.4	1.8	4.0
<i>Urinary diseases (cancer and injuries excluded)</i>				
Urinvejssygdomme (cancer og skader excluderet)	2.3	2.4	1.8	3.7
<i>Accidents and injuries</i>				
Ulykker og skader	6.1	8.3	2.7	5.5
<i>Pregnancy, family planning</i>				
Graviditet og familieplanlægning	1.7	2.7	4.8	0.1
<i>Vaccination, check-ups and other preventive matters</i>				
Vaccinationer, kontrol og anden forebyggelse	2.6	7.4	0.0	1.2
<i>All other diagnoses</i>				
Alle andre diagnoser	28.1	28.5	34.5	35.7

1 2005 = 2004.

1 2005 = 2004.

Source: Denmark: National Board of Health; Finland: STAKES; Iceland: Direktorat of Health; Sweden: Region Västra Götland

Kilde: Danmark: Sundhedsstyrelsen; Finland: STAKES; Iceland: Medicinaldirektoratet; Sverige: Västra Götalandsregionen

Table 3.3.5 Number of consultations with specialists by diagnostic group, percent 2005
Konsultationer til speciallæger fordelt på diagnose gruppe, pct. 2005

	Finland	Norway ¹⁾	Sweden ¹⁾
<i>Respiratory tract infections, incl. otitis</i>			
Luftvejsinfektioner	2.6	2.9	3.1
<i>Asthma</i>			
Astma	1.6	1.5	1.1
<i>Neck, shoulder and other enthesopathies/tendonitis</i>			
Problemer med nakke, skulder og arme	1.5	1.7	1.6
<i>Low back problems</i>			
Rygsmærter	2.0	1.3	1.2
<i>Psychiatric problems</i>			
Psykiatriske problemer	16.8	3.2	4.4
<i>Atopic and hypersensitivity problems</i>			
Allergi og vejrtrækningsproblemer	1.9	4.1	1.5
<i>Hypertension</i>			
Hypertension	0.4	0.8	0.5
<i>Ischemic heart disease and arrhythmias</i>			
Iskæmisk hjertesygdom og arytmier	2.4	2.6	2.1
<i>Diabetes</i>			
Diabetes	1.7	2.3	2.3
<i>Cancer</i>			
Cancer	9.2	4.1	6.3
<i>Female genital problems</i>			
Gynækologiske problemer	2.7	4.0	3.6
<i>Digestive system functional problems</i>			
Problemer med fordøjelsessystemet	2.7	2.3	3.4
<i>Skin infections</i>			
Hud infektioner	0.5	1.1	0.9
<i>Urinary diseases (cancer and injuries excluded)</i>			
Urinvejsproblemer (cancer og skader ekskluderet)	2.3	1.2	2.8
<i>Accidents and injuries</i>			
Ulykker og skader	5.3	4.8	8.3
<i>Pregnancy, family planning</i>			
Graviditet og familieplanlægning	4.5	6.0	3.1
<i>Vaccination, check-ups and other preventive matters</i>			
Vaccinationer, kontrol og anden forebyggelse	2.0	1.9	3.4
<i>All other diagnoses</i>			
Alle andre diagnoser	40.0	54.4	50.3

1 2005 = 2004.

1 2005 = 2004.

Source: See Table 3.3.4

Kilde: Se Tabel 3.3.4

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Table 3.3.6 Recommended immunization schedules per 1 January, 2007

	<i>Denmark</i>	<i>Finland</i>	<i>Iceland</i>	<i>Norway</i>	<i>Sweden</i>
BCG	-	Risk groups	-	Risk groups: First week of life. Negatives: 13-14 years	Risk groups
Pertussis	3, 5 and 12 months and 5 years	3, 5 and 12 months, 4 and 14-15 years	3, 5, 12 months, 5 years and 14 years	3, 5 and 11-12 months	3, 5 and 12 months, 5-6 years, 14-16 years
Tetanus	3, 5 and 12 months and 5 years	3, 5 and 12 months, 4 and 14-15 years	3, 5, 12 months, 5 and 14 years	3, 5 and 11-12 months, 11-12 years	3, 5 and 12 months, 5-6 years, 14-16 years
Diphtheria	3, 5 and 12 months and 5 years	3, 5 and 12 months, 4 and 14-15 years	3, 5, 12 months, 5 and 14 years	3, 5 and 11 months, 11-12 years	3, 5 and 12 months, 5-6 years, 14-16 years
Polio	IPV: 3, 5, 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 11 months, 6-8 and 14 years	IPV: 3, 5 and 12 months, 5-6 years
Measles, Mumps, Rubella	15 months, 12 years	14-18 months and 6 years	18 months and 12 years	15 months and 12-13 years	18 months and 6-8 years
Rubella, only	Women of fertile age	-	-	Seronegative women of fertile age	-
Measles, only	-	-	-	-	-
Haemophilus influenzae b	3, 5 and 12 months	3, 5 and 12 months	3, 5 and 12 months	3, 5 and 11 months	3, 5 and 12 months
Meningococcal disease gr. C	-	-	6, 8 months	-	-

IPV = Inactivated polio vaccine The Faroe Islands, Greenland and Åland have the same immunization schedules as Denmark and Finland respectively. In Greenland, however, BCG is included.

Sources: WHO/EPID: Statens seruminstitut; F: National Public Health Institute; I: Directorate of Health; N: Norwegian Institute of Public Health; S: The National Board of Health and Welfare

Tabel 3.3.6 Anbefalede vaccinationsprogrammer pr. 1. januar 2007

	Danmark	Finland	Island	Norge	Sverige
Tuberkulose	-	Risikogrupper	-	Risikogrupper: Første leveuge Negative: 13-14 år	Risikogrupper
Kighoste	3, 5 og 12 måneder og 5 år	3, 5 og 12 måneder, 4 og 14-15 år	3, 5, 12 måneder, 5 og 14 år	3, 5 og 11-12 måneder	3, 5 og 12 måneder, 5-6 og 14-16 år
Stivkrampe	3, 5 og 12 måneder og 5 år	3, 5 og 12 måneder, 4 og 14-15 år	3, 5, 12 måneder, 5 og 14 år,	3, 5 og 11-12 måneder, samt 11-12 år	3, 5 og 12 måneder, 5-6 og 14-16 år
Difteri	3, 5 og 12 måneder og 5 år	3, 5 og 12 måneder, 4 og 14-15 år	3, 5, 12 måneder, 5 og 14 år	3, 5 og 11 måneder samt 11-12 år	3, 5 og 12 måneder, 5-6 og 14-16 år
Polio	IPV: 3, 5, 12 måneder og 5 år	IPV: 3, 5 og 12 måneder + 4 år	IPV: 3, 5, 12 måneder og 14 år	IPV: 3, 5 og 11 måneder, 6-8 år og 14 år	IPV: 3, 5 og 12 måneder, 5-6 år
Mæslinger, fåresyge, røde hunde	15 måneder, 12 år	14-18 måneder og 6 år	18 måneder og 12 år	15 måneder og 12-13 år	18 måneder og 6-8 år
Røde hunde, alene	Kvinder i den fertile alder	-	-	Seronegative kvinder i den fertile alder	-
Mæslinger, alene	-	-	-	-	-
Haemophilus influenzae b	3, 5 og 12 måneder	3, 5 og 12 måneder	3, 5 og 12 måneder	3, 5 og 11 måneder	3, 5 og 12 måneder
Meningitis	-	-	6, 8 måneder	-	-

IPV = Inaktiveret polio vaccine Færøerne, Grønland og Åland har de samme vaccinationsprogrammer som henholdsvis Danmark og Finland. Vaccination mod tuberkulose er dog inkluderet i Grønland.

Kilder: WHO/EPID: Statens Seruminstitut; F: Folkhälsainstitutet; I: Landlæknisembættið; N: Nasjonalt folkehelseinstitutt; S: Socialstyrelsen

Table 3.3.7 Children under the age of two immunized according to immunization schedules (per cent) 2005

Børn under to år vaccineret i henhold til det anbefalede vaccinationsprogram (pct.) 2005

	Denmark	Faroe Islands ¹⁾	Finland ²⁾	Iceland	Norway ³⁾	Sweden
<i>BCG</i>						
Tuberkulose	..	..	98	–	..	16
<i>Pertussis</i>						
Kighoste	94	96	97	97	91	99
<i>Tetanus</i>						
Stivkrampe	94	96	97	97	91	99
<i>Diphtheria</i>						
Difteri	94	96	97	97	91	99
<i>Polio</i>						
Polio	94	96	97	97	91	99
<i>Rubella</i>						
Røde hunde	87	84	97	94	90	95
<i>Measles</i>						
Mæslinger	87	84	97	94	90	95

1 The numbers are based upon all registered children born in 2004 and collected in 2006.

2 Based on a random sample of 1 000 children born in 2001. Data collected in 2004.

3 The figures are underestimated due to low reporting in some municipalities.

1 Tallene er baseret på samtlige børn registreret med fødedato i 2004 og indsamlet i 2006.

2 Baseret på en tilfældig udtrukket stikprøve på 1 000 børn født i 2001. Data er indsamlet i 2004.

3 Tallene er underestimerede på grund af lav indberetning i nogle kommuner.

Sources: WHO/EPI; D: Statens Seruminstitut; FI: Ministry of Health and Social Affairs; F: National Public Health Institute; I: Directorate of Health; N: Norwegian Institute of Public Health; S: Swedish Institute for Infectious Disease Control

3.4 Discharges, patients treated and average length of stay

In this section, data on treatment in hospitals are presented, with data from selected diagnostic groups. The statistics based on diagnosis are first presented with the number of patients who have been treated during the year, the average length of stay, and the total number of discharges from hospitals according to the main chapters of ICD-10, both as crude rates and age standardized rates, according to the Nordic standard population. Then follow tables on hospital discharges, patients treated and average length of stay for 10 selected diagnostic groups.

The statistics from the patient registers in the five Nordic countries show some large differences between the countries that cannot solely be attributed to differences in disease patterns. For this reason, in 2000 NOMESCO performed a validity study of the diagnosis-related patient statistics. The results of this study were presented as a theme section in the 2000 version of this publication. A similar study of the surgical procedure statistics was presented in the 2002 publication. In the 2003 publication, a similar study of day surgery was presented.

From the diagnosis-related statistics, it can be seen that there is a certain variation in diagnosis and coding among the Nordic countries, in spite of the fact that they use the same classification system. The validity study identified different diagnostic cultures, differences in medical treatment and differences in the way in which treatment is organized.

3.4 Udskrivninger, patienter behandlet og gennemsnitlig liggetid

I dette afsnit gives der data for behandlingen ved sygehuse med data fra udvalgte diagnosegrupper. Den diagnosebaserede statistik vises først patienter der er behandlet i løbet af året, dernæst den gennemsnitlig liggetid, og det samlede antal udskrivninger fordelt efter ICD-10's hovedkapitler, både opgjort i sumerede rater og aldersstandardiserede rater efter den nordiske standardbefolkning. Herefter kommer tabeller om patienter behandlet og udskrivninger samt den gennemsnitlige liggetid for 10 udvalgte diagnosegrupper.

Statistikken fra patientregistre i de fem nordiske lande viser en del store forskelle mellem landene som ikke alene kan tilskrives forskelle i sygdomsforekomsten hvorfor NOMESCO i 2000 gennemførte et validitetsstudium af den diagnoserelaterede patientstatistik. Resultaterne derfra var medtaget som temasektion i 2000 udgaven af denne publikation. Et tilsvarende studie af procedure/operations-statistikken blev medtaget i 2002 udgaven. I 2003 udgaven var der medtaget et tilsvarende studie af dagkirurgi.

Det der kan konstateres ved den diagnoserelaterede statistik er, at der er en vis variation i diagnosticeringen og kodningen mellem de nordiske lande til trods for at man anvender den samme klassifikation. I validitetsstudiet blev der peget på forskellige diagnostiske kulturer, forskelle i den medicinske behandling samt forskelle i den måde hvorpå behandlingen er organiseret.

The quality of the data in the patient registers, such as representativity, completeness and reliability, is important for these statistics. The general picture in this respect is that the Nordic data have a high degree of coverage. In order to make the figures as comparable as possible, the data presented in this publication are from somatic hospital wards in general hospitals and specialist somatic hospitals. For Norway, however, it is not possible to present data for hospital wards, only for hospitals, which means that the Norwegian data are an underestimation compared to the data from the other countries.

However, it should be noted that the statistics concerning discharges, average length of stay and number of patients treated during the year are presented according to main diagnosis/diagnostic group. This means that the patient statistics do not represent all the individual cases of illness at the time of admittance, but only the diagnosis that was the main reason for the patient's admittance to/treatment in a hospital. The concept main diagnosis has been well defined by the WHO, but there is a certain variation among the Nordic countries in the way in which the main diagnosis is interpreted. In the national statistics there are also secondary diagnoses, but as these are different in the national systems of registration, statistics on the number of cases of the individual diagnoses are not comparable.

The figures for the Faroe Islands and Greenland are slightly under-estimated, since they are partly included in the Danish statistics.

Another important aspect is changes in the statistics in connection with the

Det som kan spille en væsentlig rolle for statistikken er kvaliteten af de data der findes i patientregistrene, såsom repræsentativitet, fuldstændighed og pålidelighed. Her er det generelle billede at de nordiske data har en høj dækningsgrad. For at gøre tallene så sammenlignelige som muligt er de data der vises i denne publikation fra somatiske hospitalsafdelinger på almindelige sygehuse samt somatiske specialsygehuse. For Norges vedkommende er det imidlertid ikke muligt at give data fra sygehusafdelinger men kun sygehuse i sin helhed, hvilket gør at de norske data er underestimerede sammenlignet med de andre lande.

Det som man imidlertid må være opmærksom på er, at statistikken om udskrivninger, gennemsnitlig liggetid samt personer der er behandlet i løbet af året er opgjort efter hoveddiagnose/diagnosegruppe. Det betyder at patientstatistikken ikke viser alle forekomster af de enkelte sygdomstilfælde ved indlæggelse, men kun den diagnose der var hovedårsagen til at den pågældende blev indlagt/behandlet ved et hospital. Begrebet hoveddiagnose er veldefineret af WHO, men der findes en vis variation mellem de nordiske lande i hvorledes hoveddiagnosen tolkes. I de nationale statistikker findes der også bidiagnoser, men da omfanget af disse er forskellige i de nationale registreringssystemer, vil statistik der tæller forekomsten af de enkelte diagnoser ikke give et sammenligneligt billede.

De Færøske og Grønlandske tal er noget underestimerede da de delvis indgår i den danske statistik.

Et andet væsentligt aspekt er ændringer i statistikken ved klassifikationsskiftet.

change in the classification. This is described in detail in Chapter 4 together with the causes of death. Today, all five Nordic countries use ICD-10, so that comparability is only a problem in the historic data. For example, the present Tables 3.4.1-3.4.3, calculated according to the main chapters in ICD-10, are not completely comparable with the previous corresponding tables calculated according to the main chapters in ICD-9.

When evaluating the statistics it is important to note that the wrong diagnosis may have been made, or the wrong code may have been used for the correct diagnosis. Nordic studies show, however, that when it comes to the main diagnosis, validity is good.

In several countries the introduction of diagnosis related groups (DRG) has been seen to influence diagnosis in hospitals, for example more secondary diagnoses are registered and the choice of main diagnosis has changed in certain cases.

One last aspect is the different ways in which countries organize their hospital sectors, including differences in treatment practice. Differences are typically seen in the extent of out-patient versus in-patient treatment.

Finally, it must be mentioned that there are great differences in the use of Z codes for factors that have significance for health status. In particular, codes Z03 and Z50 are used in Denmark.

Dette er omfattende beskrevet i kapitel 4 sammen med dødsårsagerne. I dag anvender alle 5 nordiske lande ICD-10 hvorfor det kun er i de historiske data der kan komme brist i sammenligneligheden. De nuværende tabeller 3.4.1-3.4.3 opgjort efter ICD-10's hovedkapitler kan eksempelvis ikke helt sammenlignes med de tidligere tilsvarende tabeller opgjort efter ICD-9's hovedkapitler.

Ved vurderingen af statistikken skal man også være opmærksom på, at der kan være oplyst forkert diagnose ligesom der kan være anvendt forkert kode til korrekt oplyst diagnose. Nordiske studier viser dog, at når det gælder hoveddiagnosen er der en god validitet.

Indførslen af de diagnoserelaterede grupperinger (DRG) har i flere lande vist sig at påvirke diagnosticeringen ved sygehusene, blandt andet ved at flere bi-diagnoser registreres og valget af hoveddiagnose i visse tilfælde ændres.

Et sidste forhold der gør sig gældende er landenes forskelle i organiseringen af sygehusvæsenet og herunder også forskelle i behandlingspraksis. Her kan der typisk være forskelle med hensyn til omfanget af ambulant behandling eller om behandlingen foregår under indlæggelse.

Endelig skal det nævnes, at der er stor forskel på hvor meget man anvender Z-koderne for faktorer der har betydning for sundhedstilstanden hvor især Danmark anvender Z03 og Z50.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE
Table 3.4.1.a Patients treated in hospitals* during 2005 by main diagnostic group, per 1 000 inhabitants (crude rates)

	<i>Denmark</i>	<i>Faroe Islands¹⁾</i>	<i>Finland²⁾</i>	<i>Åland¹⁾²⁾</i>
Certain infectious and parasitic diseases	4.6	4.3	4.0	5.9
Neoplasms	9.1	9.9	9.7	7.7
Diseases of the blood and blood-forming organs and certain disorders involving the immune system	1.9	2.2	0.9	0.9
Endocrine, nutritional and metabolic diseases	3.8	3.8	2.3	2.3
Mental and behavioural disorders	2.2	6.9	4.9	2.3
Diseases of the nervous system	3.5	4.9	5.7	6.0
Diseases of the eye and adnexa	2.0	5.5	8.7	1.5
Diseases of the ear and mastoid process	1.1	3.0	2.7	2.2
Diseases of the circulatory system	15.5	19.2	16.8	15.4
Diseases of the respiratory system	12.0	11.7	10.5	12.8
Diseases of the digestive system	11.9	25.0	12.5	13.6
Diseases of the skin and subcutaneous tissue	2.3	1.9	1.6	1.9
Diseases of the musculo-skeletal system and connective tissue	8.7	12.8	15.6	12.7
Diseases of the genito-urinary system	8.4	8.9	9.0	11.0
Pregnancy, childbirth and the puerperium	14.2	18.5	12.7	11.1
Certain conditions originating in the perinatal period	1.6	2.0	1.5	1.3
Congenital malformations, deformations and chromosomal abnormalities	1.2	1.4	1.4	0.6
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	13.1	11.6	9.3	12.5
Injury, poisoning and certain other consequences of external causes	15.3	15.5	14.5	15.6
Factors influencing health status and contact with health services	18.0	16.4	3.0	4.8
Total	114.9	181.0	125.4	94.8

* Comprises somatic departments in ordinary hospitals and in specialized somatic hospitals

1 Average 2001–2005.

2 Excluding departments in psychiatric hospitals and in non-specialized departments in health centres.

3 Excluding patients staying 90 days or longer.

4 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period.

Sources: The national in-patient registers

ICD-10 chapters.

Patienter behandlet ved sygehuse* i løbet af 2005, efter hoveddiagnosegrupper, pr. 1 000 indbyggere (crude rates) **Tabel 3.4.1.a**

<i>Iceland³⁾</i>	<i>Norway⁴⁾</i>	<i>Sweden</i>	
2.0	4.3	3.9	Visse infektions- og parasitære sygdomme
8.6	11.8	8.5	Svulster
1.0	1.0	1.0	Sygdomme i blod og bloddannende organer og visse lidelser i forbindelse med immunsystemet
2.0	2.5	2.4	Endokrine, ernærings- og stofskiftesygdomme
1.8	1.9	1.5	Psyriske og adfærdsmæssige lidelser
3.4	6.8	3.2	Sygdomme i nervesystem
1.5	1.7	0.8	Sygdomme i øje og øjenomgivelser
0.9	0.8	0.9	Sygdomme i øre og processus mastoideus
14.8	21.5	16.9	Sygdomme i kredsløbsorganer
8.4	13.5	7.9	Sygdomme i åndedrætsorganer
11.8	10.9	9.7	Sygdomme i fordøjelsesorganer
2.3	1.7	1.0	Sygdomme i hud og underhud
8.6	10.9	7.2	Sygdomme i knogler, bevægelsessystem og bindevæv
10.4	8.7	6.4	Sygdomme i urin- og kønsorganer
20.3	14.6	11.8	Svangerskab, fødsel og barsel
3.1	2.5	0.9	Visse årsager til sygdomme i perinatalperioden
1.4	1.5	0.8	Medfødte misdannelser og kromosomanomalier
6.0	11.1	12.5	Symptomer og abnorme fund ikke klassificeret andetsteds
8.9	17.4	13.1	Læsioner, forgiftninger og visse andre følger af ydre påvirkninger
20.5	7.5	5.3	Faktorer af betydning for sundhedstilstand og kontakter med sundhedsvæsen
137.8	152.7	94.6	I alt

* Omfatter somatiske afdelinger ved almindelige sygehuse og ved somatiske specialsygehuse

1 Gennemsnit for årene 2001-2005.

2 Eksklusiv psykiatiske hospitalsafdelinger og ikke-specialiserede afdelinger på sundhedscentraler.

3 Eksklusive patienter med liggetid på 90 dage eller mere.

4 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode.

Kilder: Landspatientregistrene

ICD-10 kapitler.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.4.1.b Patients treated in hospitals* during 2005 by main diagnostic group, per 1 000 inhabitants (age standardized)

	Denmark	Faroe Islands ¹⁾	Finland ²⁾	Åland ¹⁾²⁾
Certain infectious and parasitic diseases	4.6	4.1	4.0	6.0
Neoplasms	8.9	10.6	9.5	7.5
Diseases of the blood and blood-forming organs and certain disorders involving the immune system	1.9	2.3	0.9	0.8
Endocrine, nutritional and metabolic diseases	3.7	3.9	2.3	2.2
Mental and behavioural disorders	2.2	7.2	5.0	2.3
Diseases of the nervous system	3.4	5.1	5.5	6.3
Diseases of the eye and adnexa	2.0	5.3	8.3	1.3
Diseases of the ear and mastoid process	1.1	2.6	2.9	2.5
Diseases of the circulatory system	15.2	20.9	16.2	14.8
Diseases of the respiratory system	12.0	11.1	10.7	13.5
Diseases of the digestive system	11.8	26.0	12.2	13.4
Diseases of the skin and subcutaneous tissue	2.3	1.9	1.7	1.9
Diseases of the musculo-skeletal system and connective tissue	8.6	13.7	15.1	12.9
Diseases of the genito-urinary system	8.4	9.5	8.8	10.8
Pregnancy, childbirth and the puerperium	14.5	20.1	13.8	13.7
Certain conditions originating in the perinatal period	1.5	1.8	1.6	1.5
Congenital malformations, deformations and chromosomal abnormalities	1.2	1.3	1.5	0.7
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	13.1	11.5	9.2	12.5
Injury, poisoning and certain other consequences of external causes	15.3	15.9	14.5	15.5
Factors influencing health status and contact with health services	17.8	16.9	3.0	4.7
Total	114.5	187.6	126.2	107.4

* Comprises somatic departments in ordinary hospitals and in specialized somatic hospitals

1 Average 2001–2005.

2 Excluding departments in psychiatric hospitals and in non-specialized departments in health centres.

3 Excluding patients staying 90 days or longer.

4 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period.

Sources: See Table 3.4.1.a

Patienter behandlet ved sygehuse* i løbet af 2005, efter hoveddiagnosegrupper, pr. 1 000 indbyggere (alders standardiseret) **Tabel 3.4.1.b**

<i>Iceland³⁾</i>	<i>Norway⁴⁾</i>	<i>Sweden</i>	
2.1	4.3	3.7	Visse infektions- og parasitære sygdomme
10.2	12.0	7.7	Svulster
1.2	1.0	0.9	Sygdomme i blod og bloddannende organer og visse lidelser i forbindelse med immunsystemet
2.2	2.5	2.3	Endokrine, ernærings- og stofskiftesygdomme
2.2	1.8	1.4	Psyriske og adfærdsmæssige lidelser
3.8	6.9	3.0	Sygdomme i nervesystem
1.7	1.7	0.7	Sygdomme i øje og øjenomgivelser
0.9	0.8	0.8	Sygdomme i øre og processus mastoideus
18.3	21.6	14.7	Sygdomme i kredsløbsorganer
9.2	13.4	7.4	Sygdomme i åndedrætsorganer
13.2	11.0	9.1	Sygdomme i fordøjelsesorganer
2.5	1.7	0.9	Sygdomme i hud og underhud
9.9	11.1	6.6	Sygdomme i knogler, bevægelsessystem og bindevæv
11.5	8.8	5.9	Sygdomme i urin- og kønsorganer
19.2	14.6	12.5	Svangerskab, fødsel og barsel
2.6	2.4	1.0	Visse årsager til sygdomme i perinatalperioden
1.3	1.5	0.9	Medfødte misdannelser og kromosomanomalier
6.8	11.1	11.6	Symptomer og abnorme fund ikke klassificeret andetsteds
9.9	17.3	12.2	Læsioner, forgiftninger og visse andre følger af ydre påvirkninger
19.0	7.5	4.9	Faktorer af betydning for sundhedstilstand og kontakter med sundhedsvæsen
147.8	153.1	89.5	I alt

* Omfatter somatiske afdelinger ved almindelige sygehuse og ved somatiske specialsygehuse

1 Gennemsnit for årene 2001-2005.

2 Eksklusiv psykiatriske hospitalsafdelinger og ikke-specialiserede afdelinger på sundhedscentraler.

3 Eksklusive patienter med liggetid på 90 dage eller mere.

4 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode.

Sources: See Table 3.4.1.a

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.4.2 Average length of stay in hospitals* by main diagnostic group 2005

	<i>Denmark</i>	<i>Faroe Islands¹⁾</i>	<i>Finland²⁾</i>	<i>Åland¹⁾²⁾</i>
Certain infectious and parasitic diseases	5.0	6.1	5.5	5.1
Neoplasms	5.4	5.8	4.1	7.2
Diseases of the blood and blood-forming organs and certain disorders involving the immune system	3.9	2.2	3.9	5.6
Endocrine, nutritional and metabolic diseases	5.4	6.4	5.0	5.6
Mental and behavioural disorders	4.1	23.4	29.8	4.5
Diseases of the nervous system	5.0	3.7	4.2	4.4
Diseases of the eye and adnexa	2.2	0.6	1.2	1.2
Diseases of the ear and mastoid process	2.1	0.7	1.5	1.6
Diseases of the circulatory system	5.0	8.4	5.2	6.3
Diseases of the respiratory system	4.6	6.2	4.2	4.4
Diseases of the digestive system	4.5	2.2	3.6	4.3
Diseases of the skin and subcutaneous tissue	4.8	5.0	4.4	4.3
Diseases of the musculo-skeletal system and connective tissue	5.1	5.5	3.6	4.8
Diseases of the genito-urinary system	3.7	2.5	3.0	3.7
Pregnancy, childbirth and the puerperium	2.9	4.9	3.4	3.4
Certain conditions originating in the perinatal period	10.0	5.7	8.6	8.1
Congenital malformations, deformations and chromosomal abnormalities	3.7	5.7	3.9	18.7
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	3.0	2.9	2.7	2.7
Injury, poisoning and certain other consequences of external causes	4.5	5.3	4.3	4.7
Factors influencing health status and contact with health services	5.1	4.4	3.3	3.8
Total	4.5	5.6	4.8	4.7

* Comprises somatic departments in ordinary hospitals and in specialized somatic hospitals

1 Average 2001–2005.

2 Excluding departments in psychiatric hospitals and in non-specialized departments in health centres.

3 Excluding patients staying 90 days or longer.

Sources: See Table 3.4.1.a

Gennemsnitlig liggetid ved sygehuse* efter hoveddiagnosegrupper 2005 Tabel 3.4.2

<i>Iceland³⁾</i>	<i>Norway</i>	<i>Sweden</i>	
5.5	6.8	5.6	Visse infektions- og parasitære sygdomme
7.2	7.2	7.3	Svulster
3.0	4.2	4.7	Sygdomme i blod og bloddannende organer og visse lidelser i forbindelse med immunsystemet
6.9	4.7	5.7	Endokrine, ernærings- og stofskiftesygdomme
13.9	4.1	5.2	Psyriske og adfærdsmæssige lidelser
7.1	3.4	5.4	Sygdomme i nervesystem
2.3	2.5	2.6	Sygdomme i øje og øjenomgivelser
2.1	2.6	2.2	Sygdomme i øre og processus mastoideus
6.4	5.4	5.8	Sygdomme i kredsløbsorganer
6.2	6.1	5.1	Sygdomme i åndedrætsorganer
4.0	4.9	4.5	Sygdomme i fordøjelsesorganer
7.0	6.2	6.5	Sygdomme i hud og underhud
6.5	5.1	5.9	Sygdomme i knogler, bevægelsessystem og bindevæv
3.4	4.3	4.1	Sygdomme i urin- og kønsorganer
2.4	3.7	2.7	Svangerskab, fødsel og barsel
5.1	9.5	10.4	Visse årsager til sygdomme i perinatalperioden
4.7	4.7	4.8	Medfødte misdannelser og kromosomanomalier
3.8	2.2	2.5	Symptomer og abnorme fund ikke klassificeret andetsteds
6.4	4.8	5.1	Læsioner, forgiftninger og visse andre følger af ydre påvirkninger
4.3	7.0	5.7	Faktorer af betydning for sundhedstilstand og kontakter med sundhedsvæsen
5.1	5.1	5.0	I alt

* Omfatter somatiske afdelinger ved almindelige sygehuse og ved somatiske specialsygehuse

1 Gennemsnit for årene 2001-2005.

2 Eksklusiv psykiatiske hospitalsafdelinger og ikke-specialiserede afdelinger på sundhedscentraler.

3 Eksklusive patienter med liggetid på 90 dage eller mere.

Kilder: Se tabel 3.4.1.a

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE
Table 3.4.3.a Discharges from hospitals* by main diagnostic group, per 1 000 inhabitants (crude rates) 2005

	<i>Denmark</i>	<i>Faroe Islands¹⁾</i>	<i>Finland²⁾</i>	<i>Åland¹⁾²⁾</i>
Certain infectious and parasitic diseases	5.4	4.8	4.6	6.8
Neoplasms	18.7	20.7	21.8	14.0
Diseases of the blood and blood-forming organs and certain disorders involving the immune system	3.1	4.5	1.3	1.1
Endocrine, nutritional and metabolic diseases	4.9	4.8	2.9	3.3
Mental and behavioural disorders	2.9	9.7	7.2	3.2
Diseases of the nervous system	4.8	6.7	7.5	10.0
Diseases of the eye and adnexa	2.4	5.8	10.7	1.8
Diseases of the ear and mastoid process	1.2	3.1	2.9	3.0
Diseases of the circulatory system	25.4	22.9	24.9	26.5
Diseases of the respiratory system	17.3	14.0	13.1	17.6
Diseases of the digestive system	16.1	28.0	15.4	17.9
Diseases of the skin and subcutaneous tissue	2.9	2.2	2.0	2.1
Diseases of the musculo-skeletal system and connective tissue	10.6	13.9	19.0	17.6
Diseases of the genitor-urinary system	10.8	10.2	10.6	14.1
Pregnancy, childbirth and the puerperium	16.2	18.9	14.7	16.1
Certain conditions originating in the perinatal period	1.8	2.7	1.7	1.5
Congenital malformations, deformations and chromosomal abnormalities	1.8	1.8	2.1	0.9
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	15.5	13.3	10.8	15.2
Injury, poisoning and certain other consequences of external causes	18.5	17.4	17.6	19.1
Factors influencing health status and contact with health services	21.8	17.5	3.4	5.3
Total	200.8	218.1	194.3	197.3

* Comprises somatic departments in ordinary hospitals and in specialized somatic hospitals

1 Average 2001–2005.

2 Excluding departments in psychiatric hospitals and in non-specialized departments in health centres.

3 Discharges with a length of stay less than 90 days.

4 Figures are for discharges from hospitals, not for completed treatment in departments.

Sources: See Table 3.4.1.a

**Udskrivninger fra sygehuse* efter hoveddiagnosegrupper, Tabel 3.4.3.a
pr. 1 000 indbyggere (crude rates) 2005**

<i>Iceland³⁾</i>	<i>Norway⁴⁾</i>	<i>Sweden</i>	
2.2	4.6	4.5	Visse infektions- og parasitære sygdomme
14.0	17.9	15.1	Svulster
2.2	1.3	1.3	Sygdomme i blod og bloddannende organer og visse lidelser i forbindelse med immunsystemet
2.3	2.8	3.0	Endokrine, ernærings- og stofskiftesygdomme
2.3	2.1	1.7	Psyriske og adfærdsmæssige lidelser
4.6	8.3	4.1	Sygdomme i nervesystem
1.7	2.2	0.9	Sygdomme i øje og øjenomgivelser
1.0	0.9	0.9	Sygdomme i øre og processus mastoideus
18.3	24.7	25.7	Sygdomme i kredsløbsorganer
9.8	15.3	10.3	Sygdomme i åndedrætsorganer
13.5	12.4	12.2	Sygdomme i fordøjelsesorganer
2.6	1.9	1.2	Sygdomme i hud og underhud
10.2	12.4	8.5	Sygdomme i knogler, bevægelsessystem og bindevæv
11.7	9.8	7.5	Sygdomme i urin- og kønsorganer
21.2	14.9	13.9	Svangerskab, fødsel og barsel
3.8	2.5	1.6	Visse årsager til sygdomme i perinatalperioden
1.7	1.8	1.1	Medfødte misdannelser og kromosomanomalier
6.8	11.8	14.5	Symptomer og abnorme fund ikke klassificeret andetsteds
10.2	18.5	15.8	Læsioner, forgiftninger og visse andre følger af ydre påvirkninger
24.9	9.1	6.4	Faktorer af betydning for sundhedstilstand og kontakter med sundhedsvæsen
165.0	175.2	150.2	I alt

* Omfatter somatiske afdelinger ved almindelige sygehuse og ved somatiske specialsygehuse

1 Gennemsnit for årene 2001-2005.

2 Eksklusiv psykiatiske hospitalsafdelinger og ikke-specialiserede afdelinger på sundhedscentraler.

3 Udskrivninger med liggetid under 90 dage.

4 Opgørelsen vedrører udskrivninger fra sygehuse, ikke afsluttede behandlinger ved afdelinger.

Kilder: Se tabel 3.4.1.a

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE
Table 3.4.3.b Discharges from hospitals* by main diagnostic group, per 1 000 inhabitants (age standardized) 2005

	<i>Denmark</i>	<i>Faroe Islands¹⁾</i>	<i>Finland²⁾</i>	<i>Åland¹⁾²⁾</i>
Certain infectious and parasitic diseases	5.4	4.5	4.6	6.7
Neoplasms	18.3	22.2	20.6	12.9
Diseases of the blood and blood-forming organs and certain disorders involving the immune system	3.1	4.7	1.3	1.0
Endocrine, nutritional and metabolic diseases	4.8	4.8	2.8	1.0
Mental and behavioural disorders	2.9	10.1	7.2	3.2
Diseases of the nervous system	4.8	6.9	7.2	9.4
Diseases of the eye and adnexa	2.3	5.6	10.2	1.6
Diseases of the ear and mastoid process	1.2	2.7	3.2	3.2
Diseases of the circulatory system	25.0	24.8	23.7	23.6
Diseases of the respiratory system	17.3	13.4	13.1	17.4
Diseases of the digestive system	15.9	29.1	15.0	16.9
Diseases of the skin and subcutaneous tissue	2.9	2.1	2.0	2.1
Diseases of the musculo-skeletal system and connective tissue	10.4	14.9	18.2	16.6
Diseases of the genito-urinary system	10.7	10.8	10.3	13.2
Pregnancy, childbirth and the puerperium	16.6	20.5	15.9	18.2
Certain conditions originating in the perinatal period	1.8	2.4	1.9	1.7
Congenital malformations, deformations and chromosomal abnormalities	1.8	1.7	2.2	1.1
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	15.4	13.1	10.6	14.4
Injury, poisoning and certain other consequences of external causes	18.5	17.9	17.4	18.3
Factors influencing health status and contact with health services	21.7	18.1	3.5	5.1
Total	199.6	226.0	191.0	189.7

* Comprises somatic departments in ordinary hospitals and in specialized somatic hospitals

1 Average 2001–2005.

2 Excluding departments in psychiatric hospitals and in non-specialized departments in health centres.

3 Discharges with a length of stay less than 90 days.

4 Figures are for discharges from hospitals, not for completed treatment in departments.

Sources: See Table 3.4.1.a

**Udskrivninger fra sygehuse* efter hoveddiagnosegrupper, Tabel 3.4.3.b
pr. 1 000 indbyggere (alders standardiseret) 2005**

<i>Iceland³⁾</i>	<i>Norway⁴⁾</i>	<i>Sweden</i>	
2.3	4.5	4.2	Visse infektions- og parasitære sygdomme
16.7	18.3	13.8	Svulster
2.5	1.3	1.1	Sygdomme i blod og bloddannende organer og visse lidelser i forbindelse med immunsystemet
2.6	2.8	2.8	Endokrine, ernærings- og stofskiftesygdomme
2.7	2.1	1.6	Psyriske og adfærdsmæssige lidelser
5.2	8.4	3.9	Sygdomme i nervesystem
2.0	2.2	0.9	Sygdomme i øje og øjenomgivelser
1.0	0.9	0.9	Sygdomme i øre og processus mastoideus
22.6	24.8	22.4	Sygdomme i kredsløbsorganer
10.9	15.2	9.5	Sygdomme i åndedrætsorganer
15.1	12.4	11.4	Sygdomme i fordøjelsesorganer
2.8	1.9	1.1	Sygdomme i hud og underhud
11.7	12.6	7.8	Sygdomme i knogler, bevægelsessystem og bindevæv
12.8	9.8	6.9	Sygdomme i urin- og kønsorganer
20.0	14.9	14.7	Svangerskab, fødsel og barsel
3.2	2.4	1.8	Visse årsager til sygdomme i perinatalperioden
1.6	1.8	1.2	Medfødte misdannelser og kromosomanomalier
7.6	11.8	13.5	Symptomer og abnorme fund ikke klassificeret andetsteds
11.4	18.5	14.7	Læsioner, forgiftninger og visse andre følger af ydre påvirkninger
23.0	9.2	6.0	Faktorer af betydning for sundhedstilstand og kontakter med sundhedsvæsen
177.8	175.8	140.3	I alt

* Omfatter somatiske afdelinger ved almindelige sygehuse og ved somatiske specialsygehuse

1 Gennemsnit for årene 2001-2005.

2 Eksklusiv psykiatiske hospitalsafdelinger og ikke-specialiserede afdelinger på sundhedscentraler.

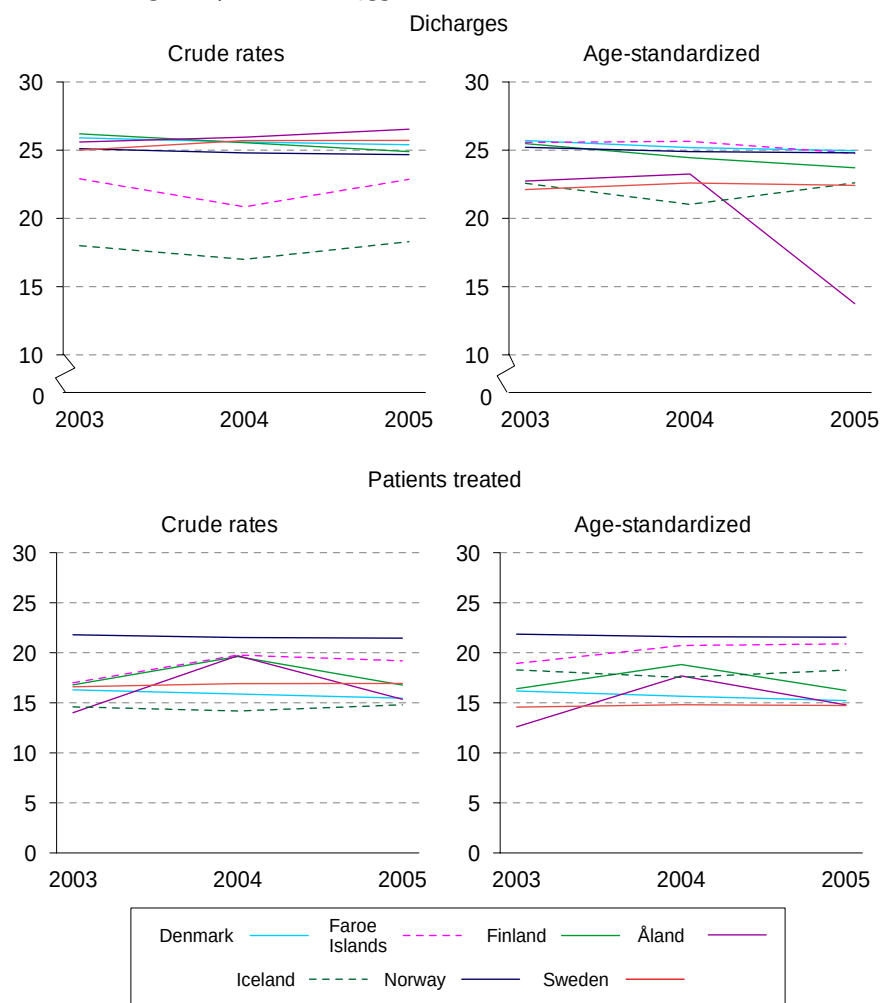
3 Udskrivninger med liggetid under 90 dage.

4 Opgørelsen vedrører udskrivninger fra sygehuse, ikke afsluttede behandlinger ved afdelinger.

Kilder: Se tabel 3.4.1.a

Figure 3.4.1 Discharges from hospitals and treatment during the year for diseases of the circulatory system, per 1 000 inhabitants 2003-2005

Udskrivninger og patienter behandlet i løbet af året for sygdomme i kredsløbsorganer, pr. 1 000 indbyggere 2003-2005

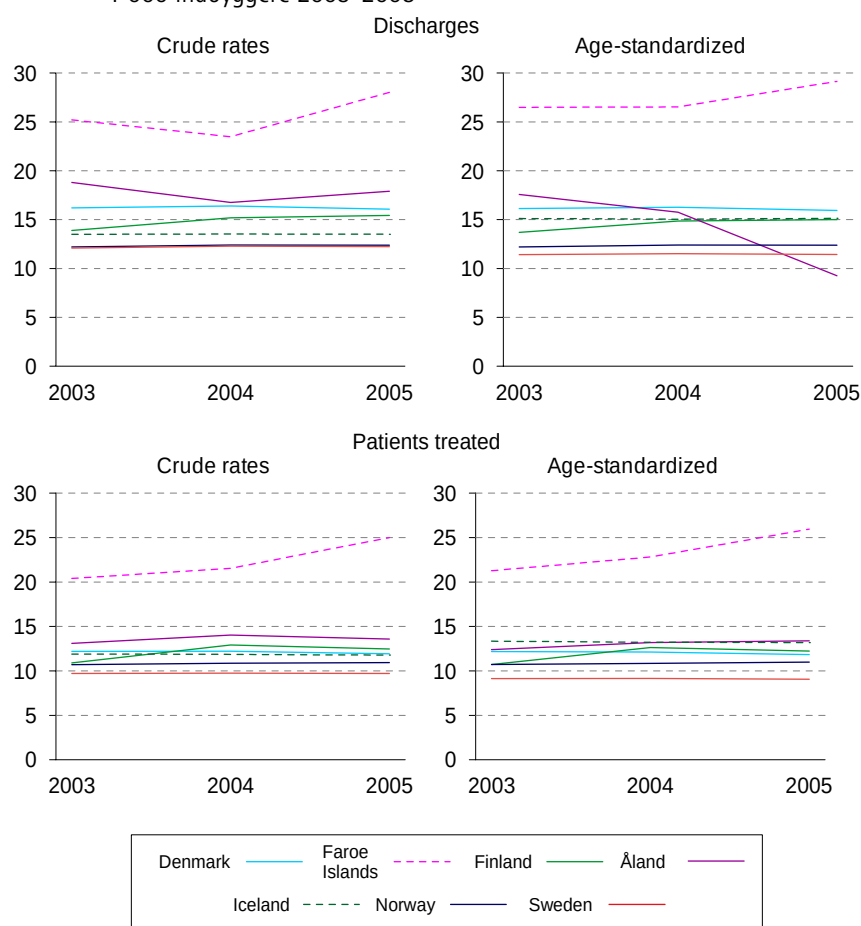


Sources: See Table 3.4.3.a and 3.4.3.b

Kilder: Se tabel 3.4.3.a og 3.4.3.b

Figure 3.4.2 Discharges from hospitals and treatment during the year for diseases of the digestive system, per 1 000 inhabitants 2003-2005

Udskrivninger og patienter behandlet for sygdomme i fordøjelsessystemet, pr. 1 000 indbyggere 2003-2005

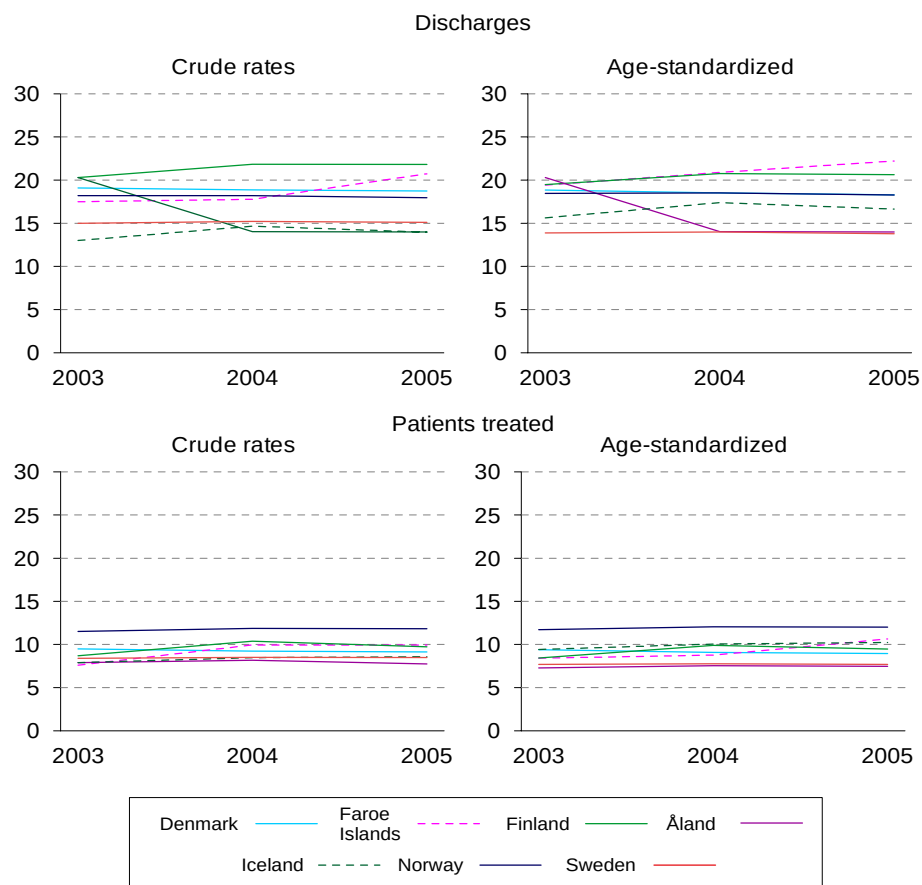


Sources: See Table 3.4.3.a and 3.4.3.b

Kilder: Se tabel 3.4.3.a og 3.4.3.b

Figure 3.4.3 Discharges from hospitals and patients treated during the year for neoplasms, per 1 000 inhabitants 2003-2005

Udskrivninger og patienter behandlet for ondartede svulster, pr. 1 000 indbyggere 2003-2005



Sources: See Table 3.4.3.a and 3.4.3.b
Kilder: Se tabel 3.4.3.a og 3.4.3.b

Table 3.4.4 Discharges, patients treated and average length of stay in hospital* for malignant neoplasm of breast, women 2005

Udskrivninger, patienter behandlet og gennemsnitlig liggetid ved sygehuse*
for kræft i bryst, kvinder 2005

	Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland	Norway ²⁾	Sweden
<i>Discharges, total</i> Udskrivninger, i alt	7 791	51	12 013	28	357	6 311	10 483
<i>Patients treated, total</i> Patienter behandlet, i alt	5 099	30	6 282	21	251	4 341	8 107
<i>Patients treated per 100 000 women in the age group</i> Patienter behandlet pr. 100 000 kvinder i alderen							
25-44	69	51	90	52	88	64	61
45-64	345	186	489	276	362	390	330
65+	447	485	439	380	495	434	398
<i>Total rate</i> Samlet rate	186	129	235	159	170	186	178
<i>Average length of stay per patient treated</i> Gennemsnitlig liggetid pr. behandlet patient							
	6.6	19.7	5.8	7.8	6.4	7.7	6.2
<i>Average length of stay per discharge</i> Gennemsnitlig liggetid pr. udskrivning							
	4.3	11.6	3.0	6.0	4.5	5.3	4.8

1 Average 2001-2005.

2 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period.

1 Gennemsnit for årene 2001-2005.

2 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode.

Source: Table 3.4.2.a
Kilde: Tabel 3.4.2.a

* Definition, see table 3.4.2.a
* Definition, se tabel 3.4.2.a

The Table includes ICD-10: C50.
Tabellen omfatter ICD-10: C50.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE
Table 3.4.5 Discharges, patients treated and average length of stay in hospital* for malignant neoplasm of trachea, bronchus and lung 2005

 Udskrivninger, patienter behandlet og gennemsnitlig liggetid ved sygehuse*
 for kræft i tracheae, bronkie og lunge 2005

		Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland	Norway ²⁾	Sweden
<i>Discharges</i>	<i>Udskrivninger</i>							
<i>Men, total</i>	<i>Mænd, i alt</i>	5 029	100	4 598	12	247	3 705	4 473
<i>Women, total</i>	<i>Kvinder, i alt</i>	4 524	68	1 943	4	177	2 589	3 961
<i>Patients treated</i>	<i>Patienter behandlet</i>							
<i>Men, total</i>	<i>Mænd, i alt</i>	2 172	17	1 817	6	111	2 189	2 454
<i>Women, total</i>	<i>Kvinder, i alt</i>	1 954	10	716	3	93	1 498	2 193
<i>Patients treated per 100 000 men in the age group</i>								
<i>Patienter behandlet pr. 100 000 mænd i alderen</i>								
0-24		-	-	-	-	-	-	1
25-44		5	-	4	-	2	4	3
45-64		106	83	91	59	102	123	61
65+		388	406	354	223	477	503	250
<i>Total rate</i>								
<i>Samlet rate</i>		81	68	71	49	75	95	55
<i>Patients treated per 100 000 women in the age group</i>								
<i>Patienter behandlet pr. 100 000 kvinder i alderen</i>								
0-24		-	-	-	-	-	-	-
25-44		6	-	3	-	2	4	4
45-64		108	93	38	37	124	99	73
65+		241	143	87	71	269	230	146
<i>Total rate</i>								
<i>Samlet rate</i>		71	43	27	22	63	64	48
<i>Average length of stay per patient treated</i>								
<i>Gennemsnitlig liggetid pr. behandlet patient</i>								
		14.5	22.9	13.3	20.5	21.7	15.5	18.6
<i>Average length of stay per discharge</i>								
<i>Gennemsnitlig liggetid pr. udskrivning</i>								
		6.3	3.7	5.2	11.9	10.4	9.1	10.2

1 Average 2001-2005.

2 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period.

1 Gennemsnit for årene 2001-2005.

2 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode.

 Source: See Tabel 3.4.2.a
 Kilde: Se Tabel 3.4.2.a

 * Definition: see Table 3.4.2.a.
 * Definition: se Tabel 3.4.2.a.

 The Table includes ICD-10: C33-C34.
 Tabellen omfatter ICD-10: C33-C34.

Table 3.4.6 Discharges, patients treated and average length of stay in hospital* for acute myocardial infarction 2005

Udskrivninger, patienter behandlet og gennemsnitlig liggetid ved sygehuse*
for akut hjerteinfarkt 2005

		Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland	Norway ²⁾	Sweden
<i>Discharges</i>	<i>Udskrivninger</i>							
<i>Men, total</i>	<i>Mænd, i alt</i>	10 436	82	7 523	54	370	11 801	21 485
<i>Women, total</i>	<i>Kvinder, i alt</i>	5 515	21	5 053	37	163	6 436	13 941
<i>Patients treated</i>	<i>Patienter behandlet</i>							
<i>Men, total</i>	<i>Mænd, i alt</i>	6 381	68	5 698	41	295	10 349	15 166
<i>Women, total</i>	<i>Kvinder, i alt</i>	3 715	19	4 007	28	133	5 766	10 509
<i>Patients treated per 100 000 men in the age group</i>								
<i>Patienter behandlet pr. 100 000 mænd i alderen</i>								
0-44		22	19	13	19	10	35	12
45-64		323	446	262	335	332	677	347
65+		1 053	1 285	1 093	1 433	1 087	2 056	1 591
<i>Total rate</i>								
<i>Samlet rate</i>		238	271	222	313	199	451	339
<i>Patients treated per 100 000 women in the age group</i>								
<i>Patienter behandlet pr. 100 000 kvinder i alderen</i>								
0-44		6	-	3	6	-	8	4
45-64		94	74	65	85	66	172	105
65+		629	428	697	973	585	1 191	1 038
<i>Total rate</i>								
<i>Samlet rate</i>		136	82	150	206	90	247	231
<i>Average length of stay per patient treated</i>								
<i>Gennemsnitlig liggetid pr. behandlet patient</i>								
		7.3	11.2	7.1	8.6	9.0	5.7	7.2
<i>Average length of stay per discharge</i>								
<i>Gennemsnitlig liggetid pr. udskrivning</i>								
		4.6	9.5	5.4	6.4	7.3	5.0	5.2

1 Average 2001-2005.

2 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period.

1 Gennemsnit for årene 2001-2005.

2 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode.

Source: See Table 3.4.2.a
Kilde: Se Tabel 3.4.2.a

* Definition, see Table 3.4.2.a
* Definition, se Tabel 3.4.2.a

The Table includes ICD-10: I21-I22.
Tabellen omfatter ICD-10: I21-I22.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.4.7 Discharges, patients treated and average length of stay in hospital* for cerebrovascular diseases 2005

Udskrivninger, patienter behandlet og gennemsnitlig liggetid ved sygehuse* for karsygdomme i hjerne 2005

		Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland	Norway ²⁾	Sweden
<i>Discharges</i>	<i>Udskrivninger</i>							
<i>Men, total</i>	<i>Mænd, i alt</i>	10 465	110	9 865	46	359	8 089	21 032
<i>Women, total</i>	<i>Kvinder, i alt</i>	10 149	53	8 350	42	251	7 734	19 680
<i>Patients treated</i>	<i>Patienter behandlet</i>							
<i>Men, total</i>	<i>Mænd, i alt</i>	8 029	99	7 268	32	289	7 478	16 067
<i>Women, total</i>	<i>Kvinder, i alt</i>	7 727	46	6 321	29	205	7 090	15 515
<i>Patients treated per 100 000 men in the age group</i>								
<i>Patienter behandlet pr. 100 000 mænd i alderen</i>								
	0-44	23	31	26	24	17	30	17
	45-64	334	462	351	218	210	320	296
	65-79	1 196	1 752	1 159	998	1 068	1 348	1 350
	80+	2 581	2 666	1 511	1 344	1 429	1 916	1 964
	<i>Total rate</i>							
	<i>Samlet rate</i>	300	395	284	243	195	326	359
<i>Patients treated per 100 000 women in the age group</i>								
<i>Patienter behandlet pr. 100 000 kvinder i alderen</i>								
	0-44	25	14	26	17	17	27	16
	45-64	207	111	196	96	90	219	177
	65-79	860	801	691	630	719	850	892
	80+	2 113	1 346	981	794	920	1 305	1 440
	<i>Total rate</i>							
	<i>Samlet rate</i>	282	198	236	214	139	304	341
<i>Average length of stay per patient treated</i>								
<i>Gennemsnitlig liggetid pr. behandlet patient</i>								
		12.0	28.1	11.9	17.7	13.7	11.2	14.7
<i>Average length of stay per discharge</i>								
<i>Gennemsnitlig liggetid pr. udskrivning</i>								
		9.2	25.0	8.9	12.2	11.1	10.3	11.4

1 Average 2001-2005.

2 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period.

1 Gennemsnit for årene 2001-2005.

2 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode.

Source: See Table 3.4.2.a
Kilde: Se Tabel 3.4.2.a

* Definition, see Table 3.4.2.a
* Definition, se Tabel 3.4.2.a

The Table includes ICD-10: I60-I69.
Tabellen omfatter ICD-10: I60-I69.

Table 3.4.8 Discharges, patients treated and average length of stay in hospital* for chronic obstructive pulmonary disease and bronchiectasis 2005

Udskrivninger, patienter behandlet og gennemsnitlig liggetid ved sygehuse*
for bronkit, emfysem og anden obstruktiv lungesygdom 2005

		Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland	Norway ²⁾	Sweden
<i>Discharges, total</i>	<i>Udskrivninger, i alt</i>	18 303	87	6 877	64	427	9 818	17 615
<i>Patients treated, total</i>	<i>Patienter behandlet, i alt</i>	11 177	56	4 416	31	317	7 097	10 803
<i>Per 100 000 in the age group</i>								
<i>Pr. 100 000 i alderen</i>								
0-4		29	254	8	-	5	16	3
5-14		3	13	1	-	2	6	1
15-24		3	15	1	-	2	4	1
25-64		92	41	40	52	38	79	42
65-74		815	422	322	398	605	613	398
75+		1 243	668	494	800	883	859	716
<i>Total rate</i>								
<i>Samlet rate</i>		206	116	84	116	107	154	120
<i>Average length of stay per patient treated</i>								
<i>Gennemsnitlig liggetid pr. behandlet patient</i>								
		9.2	16.2	9.0	14.4	13.2	11.3	10.1
<i>Average length of stay per discharge</i>								
<i>Gennemsnitlig liggetid pr. udskrivning</i>								
		5.6	10.4	5.8	6.9	9.8	8.1	6.2

1 Average 2001-2005.

2 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period.

1 Gennemsnit for årene 2001-2005.

2 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode.

Source: See Table 3.4.2.a
Kilde: Se Tabel 3.4.2.a

* Definition, see Table 3.4.2.a
* Definition, se Tabel 3.4.2.a

The Table includes ICD-10: J40-J44, J47.
Tabellen omfatter ICD-10: J40-J44, J47.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE
Table 3.4.9 Discharges, patients treated and average length of stay in hospital* for asthma 2005

Udskrivninger, patienter behandlet og gennemsnitlig liggetid ved sygehuse*
for astma 2005

		Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland	Norway ²⁾	Sweden
<i>Discharges, total</i>	<i>Udskrivninger, i alt</i>	8 319	121	5 777	42	101	3 706	5 262
<i>Patients treated, total</i>	<i>Patienter behandlet, i alt</i>	6 139	93	4 489	28	92	3 209	4 373
<i>Per 100 000 in the age group</i>								
<i>Pr. 100 000 i alderen</i>								
0-4		926	1 356	302	698	162	451	422
5-14		154	385	62	180	20	87	33
15-24		52	61	23	48	9	28	13
25-64		47	33	57	32	14	37	17
65-74		40	60	129	102	55	41	38
75+		46	64	244	276	85	46	88
<i>Total rate</i>								
<i>Samlet rate</i>		113	193	86	107	31	69	48
<i>Average length of stay per patient treated</i>								
<i>Gennemsnitlig liggetid pr. behandlet patient</i>								
		2.8	6.1	5.7	4.8	3.8	5.0	3.2
<i>Average length of stay per discharge</i>								
<i>Gennemsnitlig liggetid pr. udskrivning</i>								
		2.1	4.7	4.4	3.3	3.5	4.4	2.6

1 Average 2001-2005.

2 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period.

1 Gennemsnit for årene 2001-2005.

2 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode.

Source: See Table 3.4.2.a
Kilde: Se Tabel 3.4.2.a

* Definition, see Table 3.4.2.a
* Definition, se Table 3.4.2.a

The Table includes ICD-10: J45-J46.
Tabellen omfatter ICD-10: J45-J46.

Table 3.4.10 Discharges, patients treated and average length of stay in hospital* for intervertebral disc disorders 2005

Udskrivninger, patienter behandlet og gennemsnitlig liggetid ved sygehuse*
for diskusprolaps i halsens ryghvirvler og andre ryghvirvler 2005

		Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland	Norway ²⁾	Sweden
<i>Discharges, total</i>	<i>Udskrivninger, i alt</i>	6 133	27	6 260	28	491	6 002	3 813
<i>Patients treated, total</i>	<i>Patienter behandlet, i alt</i>	4 763	21	5 231	20	447	5 437	3 323
<i>Per 100 000 in the age group</i>								
<i>Pr. 100 000 i alderen</i>								
0-24		7	-	12	13	22	11	4
25-44		130	71	155	126	241	179	62
45-64		140	52	168	104	259	209	57
65+		78	93	59	50	124	75	24
<i>Total rate</i>								
<i>Samlet rate</i>		88	43	100	74	151	118	37
<i>Average length of stay per patient treated</i>								
<i>Gennemsnitlig liggetid pr. behandlet patient</i>								
		627	10.6	4.9	7.8	2.9	4.8	5.9
<i>Average length of stay per discharge</i>								
<i>Gennemsnitlig liggetid pr. udskrivning</i>								
		5.2	8.2	4.1	5.4	2.6	4.3	5.1

1 Average 2001-2005.

2 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period.

1 Gennemsnit for årene 2001-2005.

2 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode.

Source: See Table 3.4.2.a
Kilde: Se Tabel 3.4.2.a

* Definition, see Table 3.4.2.a
* Definition, se Tabel 3.4.2.a

The Table includes ICD-10: M50-M51.
Tabellen omfatter ICD-10: M50-M51.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE
Table 3.4.11 Discharges, patients treated and average length of stay in hospital* for fracture of femur 2005

 Udskrivninger, patienter behandlet og gennemsnitlig liggetid ved sygehuse*
for brud af lår 2005

		Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland	Norway ²⁾	Sweden
<i>Discharges</i>	<i>Udskrivninger</i>							
<i>Men, total</i>	<i>Mænd, i alt</i>	3 607	47	3 055	18	178	3 367	7 430
<i>Women, total</i>	<i>Kvinder, i alt</i>	7 851	64	5 700	39	319	7 882	15 956
<i>Patients treated</i>	<i>Patienter behandlet</i>							
<i>Men, total</i>	<i>Mænd, i alt</i>	3 181	39	2 477	14	140	3 200	6 198
<i>Women, total</i>	<i>Kvinder, i alt</i>	6 968	53	4 818	35	263	7 529	13 521
<i>Patients treated per 100 000 men in the age group</i>								
<i>Patienter behandlet pr. 100 000 mænd i alderen</i>								
0-44		24	50	35	21	16	30	21
45-64		77	149	70	43	67	74	56
65-74		251	354	202	229	262	279	247
75-79		629	512	473	554	588	743	645
80+		1 713	1 929	1 242	1 451	1 630	1 998	1 825
<i>Total rate</i>								
<i>Samlet rate</i>		119	155	97	105	94	140	138
<i>Patients treated per 100 000 women in the age group</i>								
<i>Patienter behandlet pr. 100 000 kvinder i alderen</i>								
0-44		6	14	12	14	7	14	9
45-64		79	93	54	48	57	86	67
65-74		435	432	241	376	414	493	400
75-79		1 135	1 334	720	952	1 252	1 303	1 031
80+		2 912	2 560	1 990	2 558	2 677	3 517	2 940
<i>Total rate</i>								
<i>Samlet rate</i>		255	229	180	258	178	323	297
<i>Average length of stay per patient treated</i>								
<i>Gennemsnitlig liggetid pr. behandlet patient</i>								
		11.5	16.0	7.9	16.2	14.8	10.2	12.1
<i>Average length of stay per discharge</i>								
<i>Gennemsnitlig liggetid pr. udskrivning</i>								
		10.2	13.3	6.5	13.8	12.0	9.8	10.2

1 Average 2001-2005.

2 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period.

1 Gennemsnit for årene 2001-2005.

2 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode.

 Source: See Table 3.4.2.a
Kilde: Se Tabel 3.4.2.a

 * Definition, see Table 3.4.2.a
* Definition, se Tabel 3.4.2.a

 The Table includes ICD-10: S72.
Tabellen omfatter ICD-10: S72.

Table 3.4.12 Discharges, patients treated and average length of stay in hospital* for alcoholic liver disease 2005

Udskrivninger, patienter behandlet og gennemsnitlig liggetid ved sygehuse*
for alkoholisk leversygdom 2005

		Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland	Norway ²⁾	Sweden
<i>Discharges</i>	<i>Udskrivninger</i>							
<i>Men, total</i>	<i>Mænd, i alt</i>	1 355	1	1 540	2	8	493	1 309
<i>Women, total</i>	<i>Kvinder, i alt</i>	675	1	579	2	6	253	595
<i>Patients treated</i>	<i>Patienter behandlet</i>							
<i>Men, total</i>	<i>Mænd, i alt</i>	897	1	972	1	8	357	785
<i>Women, total</i>	<i>Kvinder, i alt</i>	436	1	374	2	6	170	353
<i>Patients treated per 100 000 men in the age group</i>								
<i>Patienter behandlet pr. 100 000 mænd i alderen</i>								
	0-44	6	-	10	-	0	2	2
	45-64	87	17	95	21	15	42	43
	65+	48	-	42	21	19	31	32
	<i>Total rate</i>							
	<i>Samlet rate</i>	33	4	38	9	5	16	18
<i>Patients treated per 100 000 women in the age group</i>								
<i>Patienter behandlet pr. 100 000 kvinder i alderen</i>								
	0-44	4	-	4	-	0	1	1
	45-64	42	-	37	27	12	21	22
	65+	17	29	10	32	11	10	8
	<i>Total rate</i>							
	<i>Samlet rate</i>	16	4	14	12	4	7	8
<i>Average length of stay per patient treated</i>								
<i>Gennemsnitlig liggetid pr. behandlet patient</i>								
		14.0	7.5	12.1	27.4	12.3	12.7	13.5
<i>Average length of stay per discharge</i>								
<i>Gennemsnitlig liggetid pr. udskrivning</i>								
		9.2	7.5	7.7	18.2	12.3	9.0	8.1

1 Average 2001-2005.

2 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period.

1 Gennemsnit for årene 2001-2005.

2 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode.

Source: See Table 3.4.2.a
Kilde: Se Tabel 3.4.2.a

* Definition, see Table 3.4.2.a
* Definition, se Tabel 3.4.2.a

The Table includes ICD-10: K70.
Tabellen omfatter ICD-10: K70.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE
Table 3.4.13 Discharges, patients treated and average length of stay in hospital* for other diseases of liver 2005

Udskrivinger, patienter behandlet og gennemsnitlig liggetid ved sygehuse*
for ikke-alkoholisk leversygdom 2005

		Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland	Norway ²⁾	Sweden
<i>Discharges</i>	<i>Udskrivinger</i>							
<i>Men, total</i>	<i>Mænd, i alt</i>	1 167	9	829	2	25	580	1 264
<i>Women, total</i>	<i>Kvinder, i alt</i>	1 172	9	1 074	2	33	669	1 280
<i>Patients treated</i>	<i>Patienter behandlet</i>							
<i>Men, total</i>	<i>Mænd, i alt</i>	787	7	564	1	22	459	895
<i>Women, total</i>	<i>Kvinder, i alt</i>	814	6	735	1	28	553	911
<i>Patients treated per 100 000 men in the age group</i>								
<i>Patienter behandlet pr. 100 000 mænd i alderen</i>								
	0-44	11	25	11	-	6	11	7
	45-64	58	33	34	27	38	30	31
	65+	55	34	47	21	19	42	51
	<i>Total rate</i>							
	<i>Samlet rate</i>	29	28	22	11	15	20	20
<i>Patients treated per 100 000 women in the age group</i>								
<i>Patienter behandlet pr. 100 000 kvinder i alderen</i>								
	0-44	13	7	12	-	6	11	8
	45-64	54	37	44	11	36	38	29
	65+	49	86	50	32	53	48	41
	<i>Total rate</i>							
	<i>Samlet rate</i>	30	26	27	7	19	24	20
<i>Average length of stay per patient treated</i>								
<i>Gennemsnitlig liggetid pr. behandlet patient</i>								
		11.0	6.0	7.5	10.4	7.3	9.0	10.4
<i>Average length of stay per discharge</i>								
<i>Gennemsnitlig liggetid pr. udskriving</i>								
		7.5	4.3	5.1	6.9	6.3	7.3	7.4

1 Average 2001-2005.

2 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period.

1 Gennemsnit for årene 2001-2005.

2 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode.

Source: See Table 3.4.2.a
Kilde: Se Tabel 3.4.2.a

* Definition, see Table 3.4.2.a
* Definition, se Tabel 3.4.2.a

The Table includes ICD-10: K71-K77.
Tabellen omfatter ICD-10: K71-K77.

3.5 Surgical procedures

Tables 3.5.1-3.5.2 include information on selected surgical procedure groups, selected because of their high frequency and because the frequency of operations is influenced by differences in medical practice between the countries. Table 3.5.2b shows age standardized rates according to the Nordic Standard population.

In order to present a more complete picture, Table 3.5.3 covers the most frequent procedures carried out as day surgery.

In order to give more detail, the groups are presented by sex, and in some cases by age, in Tables 3.5.5-3.5.18. In this way, the differences between the countries appear more clearly.

Comparisons of operations between various geographic areas are however difficult, and the comparisons contain a number of potential sources of error, which in principle are the same as those mentioned for the diagnosis-related statistics.

In addition, there are differences from country to country in the way in which operations in hospitals are counted.

3.5 Kirurgiske indgreb

Tabellerne 3.5.1-5.5.2 indeholder oplysninger om udvalgte operationsgrupper, som er udvalgt fordi de er hyppigt forekommende og fordi operationsomfanget i forskellig grad påvirkes af forskelle i medicinsk praksis i landene. I tabel 3.5.2b vises de standardiserede rater efter den nordiske standardbefolkning.

For at få et mere fuldkomment billede er der i tabel 3.5.3 medtaget de mest forekommende indgreb som sker uden indlæggelse – dagkirurgisk.

For at få et mere komplet billede, er grupperne medtaget fordelt på køn og i visse aldersgrupper i tabellerne 3.5.5-3.5.18. Heraf fremgår forskellene mellem landene tydeligere.

Sammenligninger af operationer mellem geografiske områder er imidlertid vanskelige og indeholder en række potentielle fejlkilder, som i princippet er de samme som er nævnt for den diagnoserelaterede statistik.

Hertil kommer, at der er forskelle fra land til land i måden hvorpå operationer ved sygehuse tælles.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.5.1 Sixteen major surgical procedure groups, total numbers 2005
Seksten store operationsgrupper, i alt 2005

NCSP codes		Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland	Norway	Sweden
ABC 01-26	<i>Disc operations</i>							
	Disk-operationer	2 638	21	3 220	16	437	4 020	2 332
BAA 20-60	<i>Partial and total thyroid excision</i>							
	Resektion af thyreoidea	1 747	6	1 945	4	113	1 289	2 425
CJC, CJD, CJE, CJF00, CJF10	<i>Cataract surgery</i>							
	Kataraktoperationer	25 489	112	42 122	173	2 190	22 278	59 987
FNA; FNB; FNC; FND; FNE	<i>Coronary anastomosis surgery</i>							
	Coronararastomoser	2 606	30	3 907	1	156	3 905	8 928
FNG 02; FNG 05	<i>Percutaneous expansion of the coronary artery (PTCA)</i>							
	Perkutan coronar angioplastik (PTCA)	9 079	60	6 578	1	679	11 407	16 606
HAB	<i>Excision of mammary gland (women)</i>							
	Resektion af mammae (kvinder)	4 145	18	3 719	21	140	3 320	6 874
HAC 10-25; HAC 99	<i>Mastectomy (women)</i>							
	Ablatio mammae (kvinder)	2 194	12	2 431	16	61	1 467	3 877
JE A	<i>Appendectomy</i>							
	Appendektomi	5 895	46	7 487	50	437	5 365	10 782
JKA 20-21	<i>Cholecystectomy</i>							
	Kolecystektomi	7 245	47	9 172	57	623	4 717	13 236
KAS 10-20	<i>Kidney transplant</i>							
	Nyrettransplantation	160	2	158	1	10	231	385
KEC	<i>Radical prostatectomy</i>							
	Radikal prostatektomi	401	2	1 048	5	44	591	2 682
KED 22-72	<i>Prostatectomy, transurethral procedures</i>							
	Transurethral resektion af prostate	4 213	20	4 051	39	204	5 239	8 080
KED 00; KED 96	<i>Open prostatectomy</i>							
	Åben prostatektomi	98	1	50	0	5	177	239
LCC 10-20; LCD; LCE; LEF 13	<i>Hysterectomy (including supravaginal hysterectomy and exenteration of pelvis)</i>							
	Hysterektomi (inkl. supravaginal hysterektomi og bækkeneksentration)	6 170	30	8 766	59	472	5 152	9 689
MCA	<i>Caesarean section</i>							
	Kejsersnit	12 861	88	9 245	63	628	9 043	17 233
NFB; NFC	<i>Hip replacement</i>							
	Hofteledsplastik	10 454	73	11 064	60	515	9 378	19 259

The NCSP codes refer to NOMESCO Classification of Surgical Procedures. Version 1.9. NOMESCO 70:2005.

1 Average 2001-2005.

1 Gennemsnit for årene 2001-2005.

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

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.5.2.a Sixteen major surgical procedure groups, per 100 000 inhabitants 2005
 Seksten store operationsgrupper, pr. 100 000 indbyggere 2005

NCSP codes		Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland	Norway	Sweden
ABC 01-26	<i>Disc operations</i>							
	Disk-operationer	49	43	61	62	148	87	26
BAA 20-60	<i>Partial and total thyroid excision</i>							
	Resektion af thyreoidea	32	12	37	14	38	28	27
CJC, CJD, CJE, CJF00, CJF10	<i>Cataract surgery</i>							
	Kataraktoperationer	471	232	804	658	740	484	664
FNA; FNB; FNC; FND; FNE	<i>Coronary anastomosis surgery</i>							
	Coronararastomoser	48	62	75	3	53	85	99
FNG 02; FNG 05	<i>Percutaneous expansion of the coronary artery (PTCA)</i>							
	Perkutan coronar angioplastik (PTCA)	168	125	126	3	229	248	184
HAB	<i>Excision of mammary gland (women)²⁾</i>							
	Resektion af mammae (kvinder) ²⁾	152	79	139	150	95	143	151
HAC 10-25; HAC 99	<i>Mastectomy (women)²⁾</i>							
	Ablatio mammae (kvinder) ²⁾	80	53	91	116	41	63	85
JEA	<i>Appendectomy</i>							
	Appendektomi	109	94	143	189	148	116	119
JKA 20-21	<i>Cholecystectomy</i>							
	Kolecystektomi	134	97	175	216	211	102	147
KAS 10-20	<i>Kidney transplant</i>							
	Nyretransplantation	3	5	3	3	3	5	4
KEC	<i>Radical prostatectomy³⁾</i>							
	Radikal prostatektomi ³⁾	15	7	41	35	30	26	60
KED 22-72	<i>Prostatectomy, transurethral procedures³⁾</i>							
	Transurethral resekction af prostata ³⁾	157	81	158	296	137	229	181
KED 00; KED 96	<i>Open prostatectomy³⁾</i>							
	Åben prostatektomi ³⁾	4	3	2	2	3	8	5
LCC 10-20; LCD; LCE; LEF 13	<i>Hysterectomy (including supravaginal hysterectomy and exenteration of pelvis)²⁾</i>							
	Hysterektomi (inkl. supravaginal hysterektomi og bækkeneksentration) ²⁾	226	128	327	442	320	222	213
MCA	<i>Caesarean section⁴⁾</i>							
	Kejsersnit ⁴⁾	203	126	158	216	149	162	..
NFB; NFC	<i>Hip replacement</i>							
	Hofteledsplastik	193	151	211	226	174	204	213

The NCSP codes refer to NOMESCO Classification of Surgical Procedures. Version 1.9. NOMESCO 70:2005.

1 Average 2001-2005.

2 Per 100 000 women.

3 Per 100 000 men.

4 Per 1 000 deliveries.

1 Gennemsnit for årene 2001-2005.

2 Pr. 100 000 kvinder.

3 Pr. 100 000 mænd.

4 Pr. 1 000 fødsler.

Sources: See Table 3.5.1

Kilder: Se tabel 3.5.1

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.5.2.b Sixteen major surgical procedure groups, age standardized rates per 100 000 inhabitants 2005
 Seksten store operationsgrupper, aldersstandardiseret rater pr. 100 000 indbyggere 2005

NCSP codes		Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland	Norway	Sweden
ABC 01-26	<i>Disc operations</i>							
	Disk-operationer	48	46	61	62	154	88	26
BAA 20-60	<i>Partial and total thyroid excision</i>							
	Resektion af thyreoidea	32	12	35	13	41	28	26
CJC, CJD, CJE, CJF00, CJF10	<i>Cataract surgery</i>							
	Kataraktoperationer	468	255	763	..	..	471	567
FNA; FNB; FNC; FND; FNE	<i>Coronary anastomosis surgery</i>							
	Coronar Anastomoser	47	69	69	2	65	88	90
FNG 02; FNG 05	<i>Percutaneous expansion of the coronary artery (PTCA)</i>							
	Perkutan coronar angioplastik (PTCA)	163	136	116	3	..	257	167
HAB	<i>Excision of mammary gland (women)²⁾</i>							
	Resektion af mammae (kvinder) ²⁾	147	83	131	140	105	148	147
HAC 10-25; HAC 99	<i>Mastectomy (women)²⁾</i>							
	Ablatio mammae (kvinder) ²⁾	75	56	81	103	47	61	76
JE A	<i>Appendectomy</i>							
	Appendektomi	110	90	143	194	136	116	119
JKA 20-21	<i>Cholecystectomy</i>							
	Kolecystektomi	132	103	167	207	230	104	144
KAS 10-20	<i>Kidney transplant</i>							
	Nyretransplantation	3	5	3	3	3	5	4
KEC	<i>Radical prostatectomy³⁾</i>							
	Radikal prostatektomi ³⁾	14	8	37	30	38	27	54
KED 22-72	<i>Prostatectomy, transurethral procedures³⁾</i>							
	Transurethral resektion af prostate ³⁾	172	100	175	299	189	266	174
KED 00; KED 96	<i>Open prostatectomy³⁾</i>							
	Åben prostatektomi ³⁾	4	5	2	2	4	9	5
LCC 10-20; LCD; LCE; LEF 13	<i>Hysterectomy (including supravaginal hysterectomy and exenteration of pelvis)²⁾</i>							
	Hysterektomi (inkl. supravaginal hysterektomi og bækkeneksentration) ²⁾	113	137	312	414	346	228	211
NFB; NFC	<i>Hip replacement</i>							
	Hofteledsplastik	190	165	201	205	218	204	185

The NCSP codes refer to NOMESCO Classification of Surgical Procedures. Version 1.9. NOMESCO 70:2005.

1 Average 2001-2005.

2 Per 100 000 women.

3 Per 100 000 men.

1 Gennemsnit for årene 2001-2005.

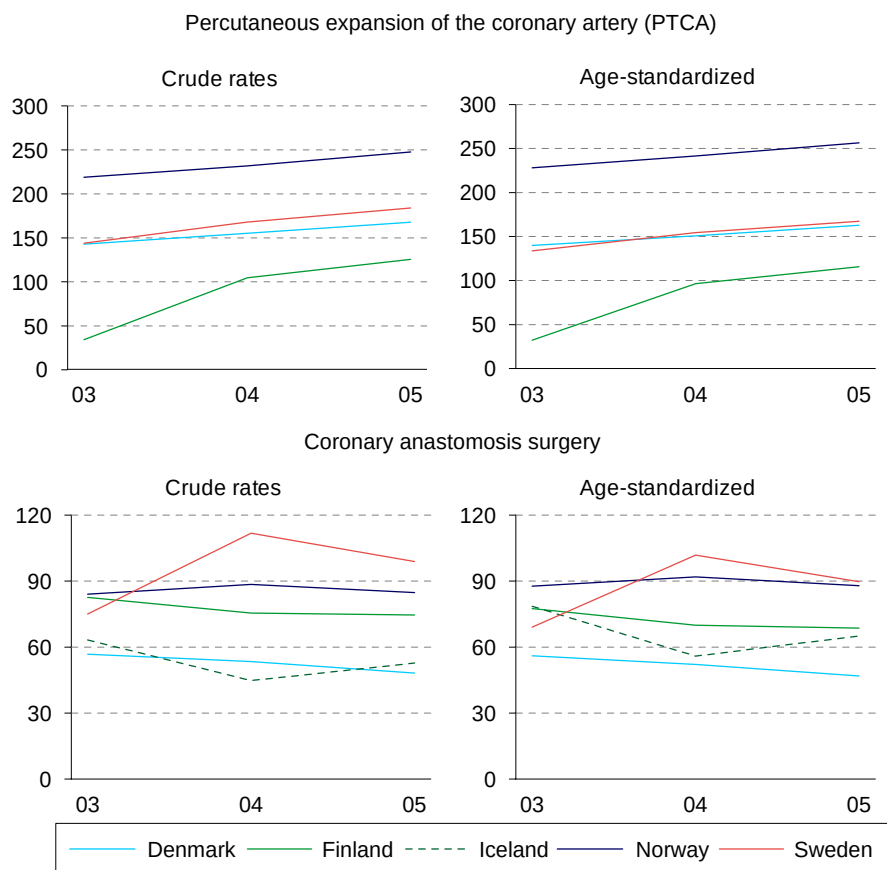
2 Pr. 100 000 kvinder.

3 Pr. 100 000 mænd.

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

Figure 3.5.1 PTCA and coronary anastomosis surgery, crude rates and age standardized rates per 100 000 inhabitants 2003–2005

PTCA og Coronaranastomoser, summariske rater og alderstandardiserede rater pr. 100 000 indbyggere 2003–2005



Sources: See Tables 3.5.2a and 3.5.2b

Kilder: Se tabel 3.5.2.a og 3.5.2.b

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE
Table 3.5.3 Fifteen surgical procedures partly carried out as day surgery in hospitals 2005

	NCSF codes	Denmark			Finland		
		Total number of procedures	Of which day surgery	Day surgery (per cent)	Total number of procedures	Of which day surgery	Day surgery (per cent)
<i>Carpal tunnel decompression of median nerve</i> Dekompression og lysis af medianus nerve	ACC51	4 666	3 946	84.6	8 657	7 142	82.5
<i>Cataract surgery</i> Kataraktoperation	CJC, CJD, CJE, CJF00, CJF10	25 489	24 400	95.7	41 670	38 765	93.0
<i>Tonsillectomy and/or adenoidectomy</i> Tonsillektomi og/eller adenoidektomi	EMB10, EMB20, EMB30	7 752	1 654	21.3	13 887	8 659	62.4
<i>Wedge resection of mammary gland (women only)</i> Segmentresektion af brystkirtel (kun kvinder)	HAB40	2 107	11	0.5	1 468	98	6.7
<i>Inguinal and femoral hernia</i> Brok-operationer	JAB, JAC	11 160	5 886	52.7	12 815	6 216	48.5
<i>Haemorrhoidectomy</i> Haemorrhoidectomia	JHB00	1 827	894	48.9	1 878	683	36.4
<i>Cholecystectomy, laparoscopic</i> Laparoskopisk cholecystektomi	JKA21	6 207	784	12.6	7 193	1 275	17.7
<i>Transurethral resection of prostate (TURP)</i> Transurethral resektion af prostata (TURP)	KED22	3 128	24	0.8	3 469	11	0.3
<i>Curettage and excision of endometrium in uterus and cervix uteri</i> Abrasio af endometrium i uterus og cervix uteri	LCA10-16, LCB28, LCB32, LDA10	9 907	7 104	71.7	4 154	2 740	66.0
<i>Termination of pregnancy</i> Abort-operationer	LCH	10 726	6 676	62.2	4 504	3 368	74.8
<i>Female sterilization</i> Sterilisation af kvinder	LGA	4 044	2 479	61.3	4 278	3 491	81.6
<i>Removal of implanted devices from bone</i> Fjernelse af osteosyntese	NAU, NBU, NCU, NDU, NEU, NFU, NGU, NHU	13 620	7 349	54.0	5 856	3 157	53.9
<i>Knee arthroscopy</i> Artroskopi af knæled	NGA11	8 218	6 164	75.0	4 118	2 765	67.1
<i>Arthroscopic operations on meniscus of knee</i> Artroskopisk meniskoperation på knæ	NGD01, NGD11, NGD21, NGD91	10 251	6 970	68.0	12 598	9 627	76.4
<i>Vein ligation and stripping on leg</i> Fjernelse af åreknuder på ben	PHB13-14, PHD	7 559	6 567	86.9	7 584	4 502	59.4

- 1 The figures are estimated based on a coverage of 80 per cent. Figures for cataract surgery are data for 2002 from the Swedish cataract register with a coverage of 95 per cent, including only CJC, CJD and CJE.
- 2 Day-surgery procedures are under-reported. The amount of missing data varies for different procedures. The amount of missing data is estimated to be on average 20 per cent, but is particularly large for cataract surgery. According to the Swedish Ophtalmologist Association, 771 940 cataract operations were carried out in 2004.

Source: See Table 3.5.1

**Femten kirurgiske indgreb, der delvist gennemføres som dagkirurgi Tabel 3.5.3
på sygehuse 2005**

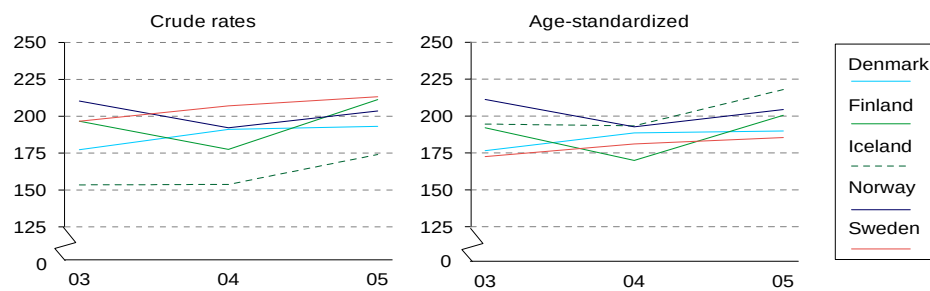
Norway			Sweden ¹⁾		
Total number of procedures	Of which day surgery	Day surgery (per cent)	Total number of procedures	Of which day surgery ²⁾	Day surgery (per cent)
6 781	6 386	94.2	10 773	10 370	96.3
22 278	20 844	93.6	59 753	58 152	97.3
14 455	7 578	52.4	13 869	6 581	47.5
2 041	920	45.1	4 732	1 435	30.3
7 748	4 796	61.9	18 397	13 353	72.6
2 779	1 942	69.9	2 278	1 459	64.0
4 154	725	17.5	10 056	1 568	15.6
4 466	103	2.3	6 827	122	1.8
5 556	3 922	70.6	13 319	10 618	79.7
13 560	13 156	97.0	14 778	13 327	90.2
1 768	901	51.0	3 743	3 138	83.8
9 415	4 318	45.9	14 302	9 510	66.5
5 280	4 087	77.4	6 840	6 069	88.7
17 417	15 736	90.3	12 492	11 668	93.4
7 576	6 397	84.4	6 096	5 380	88.3

1 Tallene er beregnet ud fra en 80 procents dækningsgrad. Tal for kataraktoperation er data for 2002 fra det svenske kataraktregister med 95 procent dækningsgrad. Kataraktregistret inkluderer kun CJC, CJD og CJE.

2 Der findes en underrapportering i antallet af dagkirurgiske indgreb. Størrelsen af dette varierer fra indgreb til indgreb, men er beregnet til ca. 20 pct. Det er især et stort bortfald af kataraktoperationer. Ifølge det svenske kataraktregister blev der i 2004 gennemført 771.840 operationer.

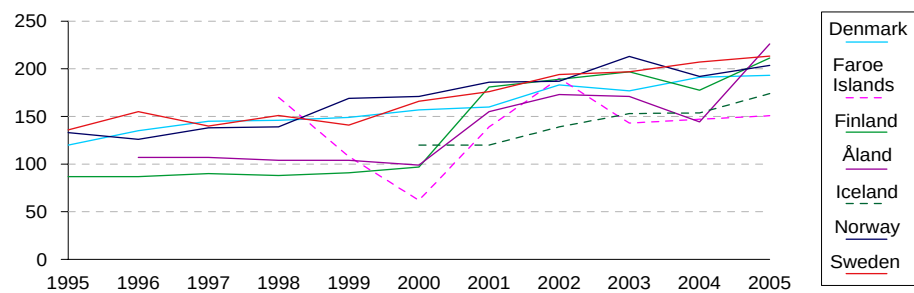
Kilde: Se tabel 3.5.1

Figure 3.5.2 Hip replacement per 100 000 inhabitants 2003-2005
 Hoftedeplastik, pr. 100 000 indbyggere 2003-2005



Sources: See Tables 3.5.2a and 3.5.2b
 Kilder: Se tabel 3.5.2.a og 3.5.2.b

Figure 3.5.3 Hip replacement per 100 000 inhabitants 1995-2005
 Hoftedeplastik, pr. 100 000 indbyggere 1995-2005



Sources: See Tables 3.5.2a
 Kilder: Se tabel 3.5.2.a

Table 3.5.4 Surgical procedures in connection with cancer diagnoses, total and per 100 000 inhabitants 2005

Operationer i forbindelse med kræftdiagnoser, i alt og pr. 100 000 indbyggere 2005

NCSP codes		Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland	Norway	Sweden
	<i>Total i alt</i>							
HAB	<i>Excision of the mammary gland (women)</i> Resektion af mammae (kvinder) (ICD-9: 174; ICD-10: C50)	2 031	16	2 568	15	81	1 840	3 686
HAC 10-25; HAC 99	<i>Mastectomy (women)</i> Ablatio mammae (kvinder) (ICD-9: 174; ICD-10: C50)	1 973	12	2 368	12	60	1 278	3 450
KEC	<i>Radical prostatectomy</i> Radikal prostatektomi (ICD-9: 185; ICD-10: C61)	397	2	1 040	-	45	587	2 663
KED 22-72	<i>Prostatectomy, transurethral procedures</i> Transurethral resektion af prostata (ICD-9: 185; ICD-10: C61)	503	6	478	4	53	751	1 310
LCC 10-20; LCD; LCE; LEF 13	<i>Hysterectomy (including supravaginal hysterectomy and exenteration of pelvis)</i> Hysterektomi (inkl. supravaginal hysterektomi og bækkeneksentrering) (ICD-9: 180-184; ICD-10: C51-58)	1 134	18	4 098	25	58	992	2 018
	<i>Per 100 000 inhabitants</i> Pr. 100 000 indbyggere							
	<i>Partial excision of the mammary gland (women)²⁾</i> Resektion af mammae (kvinder) ²⁾	74	71	96	115	55	79	81
	<i>Mastectomy (women)²⁾</i> Ablatio mammae (kvinder) ²⁾	72	53	89	91	41	55	76
	<i>Radical prostatectomy³⁾</i> Radikal prostatektomi ³⁾	15	7	41	-	30	26	59
	<i>Prostatectomy, transurethral procedures³⁾</i> Transurethral resektion af prostata ³⁾	19	22	19	29	36	33	29
	<i>Hysterectomy (including supravaginal hysterectomy and exenteration of pelvis)³⁾</i> Hysterektomi (inkl. supravaginal hysterektomi og bækkeneksentrering) ³⁾	41	77	153	188	39	43	44

The NCSP codes refer to NOMESCO Classification of Surgical Procedures. Version 1.9. NOMESCO 70:2005.

1 Average 2001-2005.

2 Per 100 000 women.

3 Per 100 000 men.

1 Gennemsnit for årene 2001-2005.

2 Pr. 100 000 kvinder.

3 Pr. 100 000 mænd.

Sources: See Table 3.5.1

Kilder: Se tabel 3.5.1

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Table 3.5.5 Disc operations by sex and age 2005

Disk-operationer fordelt på køn og alder 2005

	Denmark		Faroe Islands ¹⁾		Finland		Iceland		Norway		Sweden	
Age Alder	M	W	M	W	M	W	M	W	M	W	M	W
<15	2	1	-	-	-	1	-	-	-	1	3	5
15-24	38	36	1	-	100	60	17	7	85	62	47	36
25-44	687	527	4	4	971	607	121	84	1 077	783	626	519
45-64	616	470	4	3	680	546	94	80	1 008	718	461	417
65+	133	128	2	2	119	136	23	11	133	153	113	105
Total I alt	1 476	1 162	11	10	1 870	1 350	255	182	2 303	1 717	1 250	1 082
<i>Per 100 000</i>												
<i>in the age</i>												
<i>group</i>												
<i>Pr. 100 000</i>												
<i>i alderen</i>												
15-24	12	12	23	-	-	-	77	33	30	23	8	7
25-44	88	69	64	72	30	19	282	200	161	121	51	44
45-64	85	66	66	63	139	90	274	241	175	127	39	36
65+	38	28	61	57	93	74	146	58	47	39	17	12
Total I alt	55	43	44	41	36	27	172	123	101	74	28	24

1 Average 2001-2005.

1 Gennemsnit for årene 2001-2005.

NCSP codes covered: ABC 01-26.

Sources: See Table 3.5.1

Kilder: Se tabel 3.5.1

Table 3.5.6 Partial and total thyroid excision by sex and age 2005

Resektion af thyreoidea, fordelt på køn og alder 2005

	Denmark		Finland		Iceland		Norway		Sweden	
Age Alder	M	W	M	W	M	W	M	W	M	W
<15	1	6	1	6	-	-	-	4	3	20
15-24	4	42	7	60	-	6	3	36	23	111
25-44	84	521	59	412	5	43	57	366	100	677
45-54	83	375	73	404	3	26	53	224	83	405
55-64	79	308	92	420	3	16	70	211	110	363
65-74	45	115	51	223	2	5	31	132	78	253
75-84	17	57	26	101	1	2	22	68	29	153
85+	3	7	-	10	1	-	-	12	3	14
Total/ I alt	316	1 431	309	1 636	15	98	236	1 053	429	1 996
<i>Per 100 000</i>										
<i>in the age</i>										
<i>group</i>										
<i>Pr. 100 000</i>										
<i>i alderen</i>										
15-24	1	14	2	19	-	28	1	13	4	20
25-44	11	68	8	61	12	102	9	56	8	57
45-54	23	104	19	104	15	134	17	74	14	70
55-64	22	87	27	121	21	116	26	81	18	61
65-74	22	50	25	90	23	53	20	77	21	64
75-84	15	34	24	53	18	28	21	44	12	46
85+	10	10	-	16	71	-	-	18	4	9
Total/ I alt	12	52	12	61	10	66	10	45	10	44

NCSP codes covered: BAA 20-60.

Sources: See Table 3.5.1

Kilder: Se tabel 3.5.1

Table 3.5.7 Cataract surgery by sex and age 2005
Kataraktoperationer, efter køn og alder 2005

	Denmark		Faroe Islands ¹⁾		Finland		Norway		Sweden ²⁾	
Age Alder	M	W	M	W	M	W	M	W	M	W
<45	311	222	2	1	310	257	262	177	423	385
45-64	1 905	2 229	12	9	2 717	3 094	1 258	1 427	3 858	4 379
65-74	2 662	4 296	15	17	4 127	7 909	1 752	2 935	5 579	9 460
75-84	3 724	6 840	14	31	5 733	13 713	3 631	6 691	9 130	17 993
85+	1 026	2 274	3	7	1 078	3 184	1 292	2 853	2 963	5 817
Total I alt	9 628	15 861	47	65	13 965	28 157	8 195	14 083	21 953	38 034
<i>Per 100 000 in the age group</i>										
<i>Pr. 100 000 i alderen</i>										
45-64	264	311	198	160	372	421	218	253	324	374
65-74	1 301	1 881	907	1 036	2 023	3 208	1 149	1 711	1 535	2 374
75-84	3 286	4 121	1 444	2 275	5 378	7 189	3 446	4 330	3 797	5 367
85+	3 505	3 210	1 232	1 409	5 366	5 055	4 683	4 303	4 195	3 835
Total I alt	360	580	187	281	545	1 053	359	606	490	835

1 Average 2001-2005.

2 2002. Data from the Swedish cataract register with a coverage of 95 per cent. Including only CJC, CJD and CJE.

1 Gennemsnit for årene 2001-2005.

2 2002. Data fra det svenske kataraktregister med 95 procent dækningsgrad. Inkluderer kun CJC, CJD og CJE.

NCSP codes covered: CJC, CJD, CJE, CJF00, CJF10

Sources: See Table 3.5.1

Kilder: Se tabel 3.5.1

Table 3.5.8 Coronary anastomosis surgery by sex and age 2005
 Coronaranastomoser efter køn og alder 2005

	Denmark		Faroe Island ¹⁾		Finland		Iceland		Norway		Sweden	
Age Alder	M	W	M	W	M	W	M	W	M	W	M	W
<45	26	11	-	-	50	6	2	-	58	7	90	19
45-54	199	31	2	-	337	36	13	1	294	52	574	113
55-64	621	81	8	1	891	149	33	9	906	167	1 955	393
65-74	788	252	10	3	1 227	394	62	11	1 022	332	2 617	817
75-84	429	146	3	1	491	305	16	9	673	338	1 620	678
85+	14	8	-	-	11	10	-	-	34	22	33	19
Total I alt	2 077	529	24	6	3 007	900	126	30	2 987	918	6 889	2 039
Per 100 000 in the age group Pr. 100 000 i alderen												
45-54	54	9	68	14	86	9	64	5	94	17	97	20
55-64	175	23	268	57	263	43	233	65	343	64	326	66
65-74	385	110	613	173	602	160	707	117	670	194	720	205
75-84	379	88	346	102	461	160	288	128	639	219	674	202
85+	48	11	-	-	55	16	-	-	123	33	47	13
Total I alt	78	19	96	26	117	34	85	20	131	40	154	45

1 Average 2001-2005.

1 Gennemsnit for årene 2001-2005.

NCSP codes covered: FNA; FNB; FNC; FND; FNE.

Sources: See Table 3.5.1

Kilder: Se tabel 3.5.1

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Table 3.5.9 Percutaneous expansion of the coronary artery (PTCA) by sex and age 2005
Perkutan coronar angioplastik (PTCA) efter køn og alder 2005

	Denmark		Faroe Islands		Finland		Norway		Sweden ²⁾	
Age Alder	M	W	M	W	M	W	M	W	M	W
<45	356	85	3	-	161	33	441	81	371	93
45-54	1 097	264	9	2	784	175	1 527	321	1 688	368
55-64	2 153	564	16	4	1 469	379	2 739	677	3 847	1 023
65-74	1 854	806	13	6	1 420	670	2 249	918	3 599	1 517
75-84	1 000	636	3	4	717	644	1 325	842	2 266	1 394
85+	138	126	-	-	52	74	176	111	228	212
Total I alt	6 598	2 481	44	16	4 603	1 975	8 457	2 950	11 999	4 607
<i>Per 100 000 in the age group</i>										
<i>Pr. 100 000 i alderen</i>										
45-54	298	73	274	54	200	45	487	106	286	64
55-64	608	159	563	172	434	109	1 036	261	642	172
65-74	906	353	742	370	696	272	1 475	535	990	381
75-84	882	383	346	292	673	338	1 258	545	942	416
85+	471	178	145	39	259	117	638	167	323	140
Total I alt	246	91	176	69	180	74	370	127	268	101

1 Average 2001-2005.

2 NCSP: F00-F06.

1 Gennemsnit for årene 2001-2005.

2 NCSP: F00-F06.

NCSP codes covered: FNG 02; FNG 05.

Sources: See Table 3.5.1

Kilder: Se tabel 3.5.1

Table 3.5.10 Excision of mammary gland by age, women 2005

Resektion af mammae, kvinder, fordelt på alder 2005

Age Alder	Denmark	Faroe Islands ¹⁾	Finland	Iceland	Norway	Sweden
<15	9	-	-	-	-	3
15-24	164	1	161	4	81	211
25-44	934	4	598	36	587	1 256
45-64	2 094	7	2 095	69	1 874	3 651
65-74	654	3	591	19	531	1 266
75-84	237	2	218	10	203	396
85+	53	1	56	2	44	91
Total I alt	4 145	18	3 719	140	3 320	6 874
<i>Per 100 000 in the age group</i>						
<i>Pr. 100 000 i alderen</i>						
15-24	56	46	51	19	29	39
25-44	122	75	89	86	91	106
45-64	292	134	285	208	333	312
65-74	286	160	240	202	310	318
75-84	143	117	114	142	131	118
85+	75	196	89	79	66	60
Total I alt	152	79	139	95	143	151

1 Average 2001-2005.

1 Gennemsnit for årene 2001-2005.

NCSP codes covered: HAB.

Sources: See Table 3.5.1

Kilder: Se tabel 3.5.1

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Table 3.5.11 Mastectomy, women, by age 2005

Ablatio mammae, kvinder, fordelt på alder 2005

Age Alder	Denmark	Faroe Islands ¹⁾	Finland	Iceland	Norway	Sweden
<15	1	-	-	-	-	-
15-24	-	-	9	-	2	13
25-44	275	1	235	14	192	465
45-64	927	5	1 156	27	653	1.601
65-74	515	4	494	11	236	727
75-84	386	2	414	7	282	778
85+	90	1	123	2	102	293
Total I alt	2 194	12	2 431	61	1 467	3.877
<i>Per 100 000 in the age group</i>						
<i>Pr. 100 000 i alderen</i>						
15-24	-	-	3	-	1	2
25-44	36	10	35	33	30	39
45-64	129	93	157	81	116	137
65-74	225	222	200	117	138	182
75-84	233	175	217	99	183	232
85+	127	157	195	79	154	193
Total I alt	80	53	91	41	63	85

1 Average 2001-2005.

1 Gennemsnit for årene 2001-2005.

NCSP codes covered: HAC 10-25; HAC 99.

Sources: See Table 3.5.1

Kilder: Se tabel 3.5.1

Table 3.5.12 Appendectomy by sex and age 2005

Appendektomi fordelt på køn og alder 2005

	Denmark		Faroe Islands ¹⁾		Finland		Iceland		Norway		Sweden	
Age Alder	M	W	M	W	M	W	M	W	M	W	M	W
<15	713	549	7	6	551	467	49	70	470	389	1 291	915
15-24	602	598	6	6	789	806	68	66	702	645	1 358	1 151
25-44	809	818	6	5	1 160	1 145	60	52	894	827	1 647	1 359
45-64	475	662	4	3	817	955	25	24	446	500	903	1 100
65+	240	429	2	1	354	443	16	7	231	261	435	623
Total I alt	2 839	3 056	26	20	3 671	3 816	218	219	2 743	2 622	5 634	5 148
<i>Per 100 000 in the age group</i>												
<i>Pr. 100 000 i alderen</i>												
<15	137	111	116	104	118	104	147	219	101	88	160	119
15-24	198	204	181	183	237	253	308	311	244	234	239	212
25-44	103	107	93	85	166	170	140	124	134	128	133	114
45-64	66	92	69	52	112	130	73	72	77	89	76	94
65+	69	92	74	23	107	89	102	37	81	67	64	70
Total I alt	106	112	103	85	143	143	147	149	120	113	126	113

1 Average 2001-2005.

1 Gennemsnit for årene 2001-2005.

NCSP codes covered: JEA.

Sources: See Table 3.5.1

Kilder: Se tabel 3.5.1

Table 3.5.13 Cholecystectomy by sex and age 2005

Kolecystectomi fordelt på køn og alder 2005

	Denmark		Faroe Islands ¹⁾		Finland		Iceland		Norway		Sweden	
Age Alder	M	W	M	W	M	W	M	W	M	W	M	W
<25	50	326	-	3	48	234	3	46	45	191	89	517
25-44	500	2 181	3	16	467	1 668	34	161	328	1 306	998	3 186
45-64	882	1 949	5	13	1 322	2 688	78	165	576	1 209	1 849	3 544
65+	512	845	2	4	1 153	1 592	47	89	411	651	1 328	1 725
Total I alt	1 944	5 301	11	36	2 990	6 182	162	461	1 360	3 357	4 264	8 972
<i>Per 100 000 in the age group</i>												
<i>Pr. 100 000 i alderen</i>												
<25	6	41	4	38	6	31	5	86	6	27	6	40
25-44	64	286	44	266	67	248	79	383	49	202	81	268
45-64	122	272	83	242	181	366	227	497	100	215	155	303
65+	147	182	81	114	349	318	299	469	144	166	197	195
Total I alt	73	194	43	154	117	231	109	313	60	145	95	197

1 Average 2001-2005.

1 Gennemsnit for årene 2001-2005.

NCSP codes covered: JKA 20-21.

Sources: See Table 3.5.1

Kilder: Se tabel 3.5.1

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Table 3.5.14 Kidney transplants by sex and age 2005

Nyretransplantationer, fordelt på køn og alder 2005

	Denmark		Finland		Norway		Iceland		Sweden	
Age Alder	M	W	M	W	M	W	M	W	M	W
<15	3	4	4	2	7	4	-	2	5	4
15-24	5	2	5	2	6	3	-	-	17	7
25-44	39	20	38	13	30	24	4	1	68	45
45-54	16	17	24	21	26	13	1	-	49	26
55-64	26	11	19	14	47	18	1	1	89	40
65+	13	4	7	9	38	15	-	-	20	15
Total I alt	102	58	97	61	154	77	6	4	248	137
<i>Per 100 000 in the age group</i>										
<i>Pr. 100 000 i alderen</i>										
15-24	2	1	2	1	2	1	-	-	3	1
25-44	5	3	5	2	4	4	9	2	5	4
45-54	4	5	6	5	8	4	5	-	8	5
55-64	7	3	6	4	18	7	7	7	15	7
65+	4	1	2	2	13	4	-	-	3	2
Total I alt	4	2	4	2	7	3	4	3	6	3

NCSP codes covered: KAS 10-20.

Sources: See Table 3.5.1

Kilder: Se tabel 3.5.1

Table 3.5.15 Prostatectomy, transurethral procedures and open prostatectomy men by age 2005

Transurethral resektion af prostata og åben prostatektomi, mænd fordelt på alder 2005

Age Alder	Denmark	Faroe Islands ¹⁾	Finland	Iceland	Norway	Sweden
<45	49	-	22	-	17	28
45-64	1 365	4	1 792	62	1 517	3 503
65+	3 297	19	3 333	191	4 473	7 470
Total I alt	4 711	23	5 147	253	6 007	11 001
<i>Per 100 000 in the age group</i>						
<i>Pr. 100 000 i alderen</i>						
45-64	189	63	245	181	263	294
65+	949	643	1 008	1 214	1 567	1 107
Total I alt	176	91	201	170	263	246

1 Average 2001-2005.

1 Gennemsnit for årene 2001-2005.

NCSP codes covered: KEC, KED 00, KED 22-72, KED 96.

Sources: See Table 3.5.1

Kilder: Se tabel 3.5.1

Table 3.5.16 Hysterectomy (including supravaginal hysterectomy and exenteration of pelvis) women by age 2005

Hysterektomi (inkl. supravaginal hysterektomi og bækkeneksentration), kvinder fordelt på alder 2005

Age Alder	Denmark	Faroe Islands ¹⁾	Finland	Iceland	Norway	Sweden
<25	7	-	4	-	6	14
25-44	1 962	2	2 111	163	1 461	2 237
45-64	3 196	17	4 938	251	2 712	5 097
65+	1 005	5	1 704	58	973	2 341
Total I alt	6 170	30	8 757	472	5 152	9 689
<i>Per 100 000 in the age group</i>						
<i>Pr. 100 000 i alderen</i>						
25-44	257	137	313	388	225	188
45-64	446	316	672	757	481	436
65+	216	131	341	306	248	264
Total I alt	226	128	327	320	222	213

1 Average 2001-2005.

1 Gennemsnit for årene 2001-2005.

NCSP codes covered: LCC 10-20; LCD; LCE; LEF 13.

Sources: See Table 3.5.1

Kilder: Se tabel 3.5.1

Table 3.5.17 Caesarean section, by age, women 2005

Kejsersnit, kvinder fordelt på alder 2005

Age Alder	Denmark	Faroe Islands ¹⁾	Finland	Iceland	Norway	Sweden ²⁾
<15	2	-	1	-	-	2
15-24	1 057	17	1 276	123	936	1 535
25-34	8 785	53	5 616	362	5 723	10 622
35-44	2 994	17	2 316	141	2 354	4 617
45+	23	-	36	2	30	44
Total I alt	12 861	88	9 245	628	9 043	16 820
<i>Per 1 000 deliveries</i>						
<i>Pr. 1 000 fødsler</i>						
15-24	148	105	117	122	104	113
25-34	196	131	160	144	154	158
35-44	265	137	216	205	243	228
45+	426	333	327	250	545	444
Total I alt	203	126	158	149	162	167

1 Average 2001-2005.

1 Gennemsnit for årene 2001-2005.

2 2004.

2 2004.

NCSP codes covered: MCA.

Sources: See Table 3.5.1

Kilder: Se tabel 3.5.1

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Table 3.5.18 Hip replacement by sex and age 2005
Hofteledplastik fordelt på køn og alder 2005

	Denmark		Faroe Islands ¹⁾		Finland		Iceland		Norway		Sweden	
Age Alder	M	W	M	W	M	W	M	W	M	W	M	W
<25	10	6	-	-	3	12	-	-	5	7	14	13
25-44	154	129	1	1	159	128	7	6	105	85	175	196
45-64	1 380	1 251	8	11	1 446	1 509	67	69	787	1 246	2 117	2 396
65-74	1 218	1 812	7	14	1 462	1 878	59	105	788	1 792	2 197	3 153
75+	1 266	3 228	8	24	1 271	3 196	67	135	1 165	3 398	2 850	6 148
Total I alt	4 028	6 426	23	50	4 341	6 723	200	315	2 850	6 528	7 353	11 906
<i>Per 100 000 in the age group</i>												
<i>Pr. 100 000 i alderen</i>												
25-44	20	17	17	17	23	19	16	14	16	13	14	16
45-64	191	175	126	201	198	205	195	208	136	221	178	205
65-74	595	793	389	851	717	762	673	1 115	517	1 045	604	791
75+	888	1 363	603	1 286	1 003	1 260	963	1 411	876	1 539	916	1 263
Total I alt	150	235	92	215	169	251	135	214	125	281	164	261

1 Average 2001-2005.

1 Gennemsnit for årene 2001-2005.

NCSP codes covered: NFB; NFC.

Sources: See Table 3.5.1

Kilder: Se tabel 3.5.1

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. Since 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 between countries and for men and women.

3.6 Ulykker og villet egenskade

Patienter indlagt på grund af ulykker udnytter en væsentlig del af kapaciteten ved sygehusene.

Mens statistikken over dødsårsager er veludbygget i de nordiske lande, er registreringen af overlevende efter ulykker stadigvæk mangelfuld, og de tilgængelige data er vanskelige at sammenligne. Da kun Danmark og Island har sammenlignelig statistik for de ydre årsager ved ulykker er det ikke muligt at bringe nordisk statistik vedrørende dette.

Det er derfor valgt at medtage statistik over udskrivninger for de mest almindelige "større" ulykker som oftest vil kræve indlæggelse. Her ser man markante forskelle, både mellem landene og mænd og kvinder.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.6.1 Discharges from hospitals after treatment for injuries per 100 000 inhabitants by sex 2005¹⁾

Udskrivninger fra indlæggelser fra sygehuse efter behandling for skader per 100 000 indbygger og efter køn 2005¹⁾

	Denmark		Faroe Islands ²⁾		Greenland		Finland		Åland ²⁾		Iceland		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W	M	W	M	W
<i>Fracture of skull and intracranial injury</i> Kraniebrud og intrakraniel læsion ICD10: S02; S06	245	146	356	163	214	121	275	138	176	105	137	49	291	163	261	166
<i>Fracture at wrist and hand level</i> Brud i handled og hand ICD10: S62	60	22	65	26	37	12	55	18	14	7	18	5	59	19	25	10
<i>Superficial Injury of lower leg</i> Læsion af knæ og underben ICD10: S80-S89	238	202	500	292	239	232	533	395	179	173	146	150	233	195	158	160
<i>Superficial Injury of hip and thigh</i> Læsion af hofte og lår ICD10: S70-S79	160	325	169	335	109	139	223	423	109	198	141	241	180	386	198	398
<i>Poisoning</i> Forgiftning ICD10: T36-T65	163	233	68	78	88	130	88	103	35	41	28	52	111	152	88	144
<i>Burn and corrosion</i> Forbrænding og ætsning ICD10: T20-T32	18	8	22	9	19	16	42	19	17	5	13	12	37	16	22	9

1 Including violence and self-inflicted injury.

2 Average 2001–2005.

1 Inklusiv vold og villet egenskade.

2 Gennemsnit for årene 2001–2005.

Source: *The Inpatient Registers of the Nordic Countries*

Kilde: Patientregistre i de nordiske lande

**Table 3.6.2 Discharges from hospitals after treatment for injuries,
per 100 000 inhabitants, by sex and age 2005¹⁾**

Udskrivninger fra indlæggelse på sygehuse efter behandling for skader,
pr. 100 000 indbyggere efter køn og alder 2005¹⁾

	Denmark		Faroe Islands ²⁾		Finland		Iceland		Norway		Sweden	
Age Alder	M	W	M	W	M	W	M	W	M	W	M	W
0-14	669	455	1 715	1 061	1 095	689	534	331	1 185	784	1 238	850
15-24	900	392	2 688	1 021	2 240	992	1 113	599	2 345	1 438	1 435	814
25-64	668	394	1 886	978	2 459	1 434	859	694	1 691	1 176	1 260	924
65+	1 164	2 225	2 861	4 526	4 537	5 768	2 625	3 967	3 544	5 236	4 446	5 622
Total I alt	760	717	2 075	1 539	2 454	2 070	1 011	1 023	1 891	1 818	1 758	1 812

1 Including violence and self-inflicted injury.

2 Average 2001-2005.

1 Inklusiv vold og villet egenskade.

2 Gennemsnit 2001-2005.

Sources: *The Inpatient Registers of the Nordic Countries* ICD-10: S00-T98

Kilde: Patientregistrene i de nordiske lande

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 group. Sales of medicinal products are highest in Sweden, then Finland and Norway, while 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.

3.7 Udvikling i lægemiddelforbrug

I tabel 3.7.1 vises det samlede salg af lægemidler i de nordiske lande fordelt på ATC hovedgrupper. Det største salg ses i Sverige efterfulgt af Finland og Norge, mens Island, Åland and Danmark har et noget lavere salg. Salg af lægemidler på Færøerne er noget lavere end i Island, mens salget af lægemidler i Grønland er betydeligt lavere end i de andre lande.

Antacids and medicines for treatment of peptic ulcer

Table 3.7.2.: The sales of the ATC group A02 have since 1995 steadily increasing because of increasing use of proton pump inhibitors (A02BC), which outweighs the decreasing consumption of antacids (A02A) and histamine H2-receptor antagonists (A02BA). Since the late nineties, proton pump inhibitors have been the largest group of drugs used for peptic ulcer in all countries. In Iceland proton pump inhibitors are used about twice as often as in Denmark, Finland and Norway.

Syreneutraliserende midler og midler mod mavesår

Tabel 3.7.2: Salget af lægemidler i ATC gruppe A02 har været jævnt stigende siden 1995 primært på grund af et øget forbrug af protonpumpe-hæmmere (A02BC), der udligner det faldende forbrug af syreneutraliserende midler (antacida)(A02A) og histamin H2-receptor antagonist (A02BA). I slutningen af halvfemserne tegner protonpumpe-hæmmere sig for den største gruppe af midler anvendt mod mavesår i alle lande. I Island er forbruget af protonpumpe-hæmmere omkring dobbelt så højt som i Danmark, Finland og Norge.

Anti-obesity medicines

Table 3.7.3: Consumption and expenditure for this group was expected to rise rapidly when marketing authorizations were granted to new antiobesity agents: orlistat (A08AB01) that prevents fat absorption from the gut, and centrally acting sibutramine (A08A A10). However, this did not happen.

Midler mod overvægt

Tabel 3.7.3: Forbruget og udgifter til midler mod overvægt var forventet at stige kraftigt, med markedsføringstilladelsen af de nye midler mod overvægt: orlistat (A08AB01), der forhindrer fedtop-tagelse fra tarmen, og det centralt virkende sibutramine (A08A A10). Dette skete dog ikke.

Medicines used for the treatment of diabetes

Table 3.7.4: The incidence of both types of diabetes, type 1 and type 2, is increasing. In Western countries the prevalence of diabetes is 2-4 per cent of the population. The incidence rises with age; in Finland every tenth of those over 70 years old has diabetes. With an increasing share of elderly in the population, the number of diabetics and consumption of these medicines will rise.

Type 2 diabetics have a reduced sensitivity to insulin in their tissues, and the disease is associated with increased incidence of obesity. One reason for the increasing incidence may simply be the increased awareness and improved diagnosis of the disease.

Type 1 diabetics are treated with insulin (A10A), and as a main rule type 2 diabetics are treated with oral blood glucose lowering agents (A10B). In mild cases of type 2 diabetes a change of diet is sufficient. If the blood glucose (or glucose haemoglobin, HbA1C) is very high, the use of insulin is recommended in addition to changing the diet and taking oral blood glucose lowering agents.

Inhibitors of platelet aggregation

Table 3.7.5: The use of platelet aggregation inhibitors (ATC group B01AC) has steadily increased in all Nordic countries. The most commonly used substance in this group is low-dose acetylsalicylic acid that is used in the prophylaxis of arterial

Diabetesmidler

Tabel 3.7.4: Antallet af personer med type 1 og type 2 diabetes er stigende. I de vestlige lande er prævalensen af diabetes 2-4 procent af befolkningen. Incidensen stiger med alderen; i Finland har hver tiende over 70 år diabetes. Med en stigende andel ældre i befolkningen, vil antallet af diabetikere og brugen af midler mod diabetes også stige.

Type 2 diabetikere har en nedsat insulinfølsomhed i vævene og sygdommen er forbundet med en øget forekomst af fedme. En af årsagerne til den stigende incidens af diabetes kan ganske enkelt være en øget opmærksomhed og forbedret diagnose af lidelsen.

Type 1 diabetes behandles med insulin (A10A), og som hovedregel behandles type 2 diabetes med orale antidiabetika (A10B). I milde tilfælde af type 2 diabetes er en kostomlægning tilstrækkelig. Hvis niveauet af blod-glukose (eller glukose hæmoglobin, HbA1C) er meget høj, anbefales brugen af insulin sammen med en ændring af kosten og indtagelse af orale antidiabetika.

Aggregationshæmmende lægemidler

Tabel 3.7.5: Brugen af blodpladeaggregationshæmmere (ATC gruppe B01AC) er jævnt stigende i alle de nordiske lande. Det mest almindelig brugte stof i denne gruppe er lav-dosis acetylsalicylsyre ved sygdomsforebyggelse af ar-

thrombosis, to prevent stroke and cardiac infarction. The consumption of platelet aggregation inhibitors is highest in Finland where about 11 per cent of the population uses this medication.

teriel thrombose for at forhindre slagtilfælde og hjerteinfarkt. Forbruget af blodplade-aggregationshæmmere er højest i Finland, hvor omkring 11 procent af befolkningen bruger denne type medicin.

Cardiovascular medicines

Tables 3.7.6, 3.7.7. and 3.7.8: In all Nordic countries the consumption of cardiovascular agents (C) is growing, in particular due to increased consumption of agents acting on the renin-angiotensin system (C09) and lipid modifying agents (C10).

The group cardiac therapy (C01) constitutes a minor part of the consumption of cardiovascular agents and the consumption of this group is decreasing in all the Nordic countries.

The consumption in this group is higher in Sweden and Finland than in the other countries. The vasodilating nitrate preparations (C01D) used in ischemic heart disease are the dominating substances in cardiac therapy. The relative share of cardiac medication (C01) in group C is steadily falling.

During the past two decades progress has been made in the diagnostics and treatment of cardiovascular diseases. Hypertension is recognized not only as a disease but as a risk factor, and the interest, as well as the possibilities for preventive measures, is increasing. In the eighties ACE inhibitors (C09) and calcium channel blockers (C08) were marketed as alternatives to the conventional anti-hypertensive agents (C02, C03, C07). Currently they are used also in the treat-

Midler mod sygdomme i hjerte og kredsløb

Tabel 3.7.6, 3.7.7 og 3.7.8: I alle de nordiske lande er forbruget af midler mod sygdomme i hjerte og kredsløb (C) stigende, specielt grundet et stigende forbrug af midler med virkning på renin-angiotensin systemet (C09) og de lipid-modificerende midler (C10).

I alle de nordiske lande udgør lægemidler til hjerteterapi (C01) en mindre del af det samlede forbrug af lægemidler til hjerte og kredsløb og forbruget af denne type lægemidler er faldende i alle de nordiske lande.

I Sverige og Finland er forbruget af lægemidler til behandling af hjerte-karsygdomme højere end i de øvrige lande. De mest anvendte lægemidler til behandling af hjerte- og kredsløbssygdomme er midler mod angina pectoris (C01D). Den relative andel af lægemidler til hjerteterapi (C01) i lægemiddelgruppe C er jævnt faldende.

I løbet af de sidste 10-20 år er der sket fremskridt i diagnosticering og behandling af hjerte- og kredsløbssygdomme. Hypertension (forhøjet blodtryk) betragtes ikke kun som en sygdom, men også som en risikofaktor, og interessen såvel som mulighederne for forebyggende foranstaltninger er øget. I firserne blev ACE-hæmmere (C09) og calciumantagonister (C08) lanceret som alternativer til konventionelle blodtryks-sænkende midler (C02, C03, C07). I dag bliver ACE-hæmmere og cal-

ment of heart failure and in the secondary prophylaxis of myocardial infarction, as well as in patients suffering from cardiovascular diseases with risk factors such as diabetes.

The use of angiotensin II antagonists in combination with diuretics (C09D) was low in 1995 but a rapid increase took place during the first years of this millennium. The highest consumption of these combinations is seen in Iceland and Norway.

ciumantagonister brugt i behandlingen af hjerteinsufficiens og i sekundær profylakse af myokardieinfarkt, såvel som til patienter, der lider af hjerte- og karsygdomme med risikofaktorer såsom diabetes.

Brugen af angiotensin II antagonister i kombination med diuretika (C09D) var lav i 1995, men er steget kraftigt i de første år af dette årtusinde. Island og Norge har det højeste forbrug af disse kombinationer.

Oestrogens and progestogens

Table 3.7.9: In the late nineties, oestrogens were increasingly recommended for women's menopausal complaints and for the prophylaxis of osteoporosis. The marketing of improved formulations of oestrogens and progestogens in combination reinforced this development. In all countries except Denmark the consumption of both oestrogens and oestrogens in combination with progestogens increased. In 1999, oestrogens were among the 10 most sold medicines in terms of DDD in both Finland and Iceland.

The consumption of oestrogens (G03C) alone and in combination with progestogens (G03F) has declined since 1999 in Iceland, Sweden and Norway. In Denmark and Finland the decline has been smaller than in other countries.

Medicines used for treatment of erectile dysfunction

Table 3.7.10: The sales of medicines used to treat erectile dysfunction

Østrogen og gestagen

Tabel 3.7.9: I slutningen af halvfemserne blev østrogen i stigende grad anbefalet til kvinder med ubehag i forbindelse med overgangsalderen og for at mindske risikoen for osteoporose. Markedsføringen af forbedrede formuleringer af østrogen og gestagen i kombination har forstærket denne udvikling. I alle de nordiske lande, undtagen Danmark, er forbruget af både østrogen og østrogen i kombination med gestagen øget. I 1999 var østrogen blandt de 10 mest solgte lægemidler målt i DDD i både Finland og Island.

Forbruget af østrogen (G03C) alene og i kombination med gestagener (G03F) er faldet siden 1999 i Island, Sverige og Norge. I Danmark og Norge har faldet været mindre end i de andre lande.

Midler anvendt ved erektionsforstyrrelser

Tabel 3.7.10: Salget af lægemidler anvendt i behandlingen af erektionsforstyr-

(G04BE) increased to threefold between the years 1999 and 2005 in all countries except Sweden, where the use in 2005 was about half of the use in 1999. Sales of the new, orally administered medicines are responsible for the increase in the consumption.

relser (G04BE) er steget til det tredobbelte fra 1999 til 2005 i alle de nordiske lande undtagen Sverige, hvor forbruget i 2005 næsten var halveret i forhold til 1999. Salget af nye orale midler er årsagen til stigningen i forbruget.

Antibacterial medicines

Table 3.7.11: During the past years the consumption of antibacterials has been closely scrutinized, due to the increasing risk of developing resistance by increasing use, in particular of broad spectrum antibacterials. In all countries it is generally recommended that the use of antibacterials should be limited, and narrow spectrum antimicrobial agents should be the first line of treatment when ever possible. Iceland and Denmark seem to follow the guidelines well at least in that aspect, having the highest use of narrow-spectrum penicillins.

There is relatively little variation between the Nordic countries in the total sales of antibacterials for systemic use (J01). Iceland and Finland have the largest, Denmark and Sweden the lowest consumption.

Antibakterielle midler

Tabel 3.7.11: Gennem de senere år er forbruget af antibiotika blevet fulgt tæt, grundet den stigende risiko for resistensudvikling ved et højt forbrug af især bredspektret antibiotika. I alle lande er det generelt blevet anbefalet at forbruget af antibiotika bliver begrænset og at anvende smalspektret antibiotika der hvor det er muligt. Island og Danmark synes at følge anbefalingerne bedst, i hvert fald har disse to lande det højeste forbrug af smalspektrede penicilliner.

Der er en relativ lille forskel mellem de nordiske lande i forhold til det totale forbrug af antibakterielle midler til systemisk brug (J01). Island og Finland har det højeste forbrug, Danmark og Sverige har det laveste.

Medicines for the treatment of pain

Table 3.7.12: Paracetamol and nonsteroidal anti-inflammatory analgesics (NSAIDs, inhibitors of prostaglandin synthesis) are the most important drugs in the treatment of mild to moderate pain. Opioids are indicated for more severe pain.

Smertestillende midler

Tabel 3.7.12: De vigtigste smertestillende midler til behandling af mild til moderat smerte er paracetamol og NSAID (midler imod gigt). Opioider (stærke smertestillende midler) er indiceret ved stærke smerter.

Finland has clearly the highest consumption of NSAIDs (M01A) and lowest consumption of opioids. Iceland has similar consumption pattern as Finland, whereas in the other countries paracetamol (in the group N02BE) belongs to the most used analgesics.

Finland har klart det største forbrug af NSAID (M01A) og det laveste forbrug af opioider. Islands forbrugsmønster minder om Finlands, hvor paracetamol (i gruppe N02BE) i de andre lande er det mest brugte smertestillende middel.

There was a very rapid increase in the consumption of coxibs (M01AH) during the first years of this millennium, especially in Norway, Iceland and Finland. Soon thereafter, an increased risk of stroke associated with the use of rofecoxib was found. This started evaluation of the cardiovascular risk of all anti-inflammatory analgesics, rofecoxib and valdecoxib were withdrawn from the market in 2004, and the consumption of the whole group fell steeply.

I de første par år af dette årtusinde steg forbruget af coxibs (M01AH) kraftigt, specielt i Norge, Island og Finland. Kort herefter blev der fundet en øget risiko for slagtilfælde associeret til brugen af rofecoxib. Dette medførte en evaluering af af den kardiovaskulære risiko ved alle antiinflammatoriske smertestillende midler. Rofecoxib og valdecoxib blev trukket tilbage fra markedet i 2004, medførende et markant fald i forbruget for hele gruppen.

Antipsychotic medicines

Table 3.7.13: Consumption of antipsychotic medicines (N05A) is fairly stable from the year 2004 to 2005 with a minor increase in all the Nordic countries. Finland has the highest and Sweden the lowest use of these medicines.

Antipsykotika

Tabel 3.7.13: Forbruget af antipsykotiske lægemidler (N05A) har ligget ret stabilt fra 2004 til 2005 med en mindre stigning i alle de nordiske lande. Finland har det højeste og Sverige det laveste forbrug af disse midler.

Anxiolytics, hypnotics, and sedatives

Tables 3.7.14 and 3.7.15: The benzodiazepines (N05BA) clearly dominate the use of anxiolytics in all the Nordic countries. Their use has slightly decreased in Denmark and Sweden since 1995, and in 2005, the increase in their consumption has stopped in the other Nordic countries as well.

Midler mod neuroser og sovemidler

Tabel 3.7.14 og 3.7.15: I alle de nordiske lande udgør benzodiazepiner (N05BA) hovedparten af forbruget af angstdæmpende midler. Forbruget af angstdæmpende midler har været svagt faldende siden 1995 i Danmark og Sverige. I 2005 stoppede stigningen i forbruget af midlerne også i de øvrige nordiske lande.

As sedatives and hypnotics the classical benzodiazepines (N05CD) have lost their dominant share when benzodiazepine-related drugs (N05CF) have taken their place as the most consumed hypnotics. They are marketed as having less addictive potential and fewer adverse effects than the benzodiazepines, although any real differences hardly exist. In almost all countries the use of these benzodiazepine-related drugs is still increasing, but the total consumption of hypnotics has grown much less than during the previous years, or it has even slightly decreased from the year 2004 to 2005 (in Denmark and Finland).

Benzodiazepiners dominerende rolle som beroligende midler og sovemidler (N05CD) er blevet overtaget af de benzodiazepinrelaterede midler (N05CF) som det mest brugte sovemiddel. De er blevet markedsført som værende mindre afhængighedsskabende og med færre bivirkninger end benzodiazepiner, selvom der næsten ingen forskel er. I næsten alle de nordiske lande er forbruget af benzodiazepinrelaterede midler stadig stigende, men det totale forbrug af sovemidler er steget væsentligt mindre i løbet af de sidste år og der har endda været et mindre fald fra 2004 til 2005 (i Danmark og Finland).

Antidepressants

Table 3.7.16: The steady increase in the consumption of antidepressants is continuing in all the Nordic countries, except in Norway. Depression may be recognized and "accepted" more easily than earlier, and the threshold for drug treatment has become low. The estimated prevalence of depression is around 10 per cent. Much of the increased consumption of antidepressants is due to the powerful marketing of selective serotonin inhibitors. In comparison to older tricyclic antidepressants, they are equally effective but have a better safety profile. Another reason for increased use is the introduction of new indications for some antidepressants, including e.g. panic disorder, bulimia, obsessive-compulsive neurosis and treatment of pain.

In all countries the use of medicines belonging to the group of N06AX, other antidepressants, has approximately doubled since the year 2000. This group in-

Antidepressiva

Tabel 3.7.16: Forbruget af antidepressiva stiger fortsat jævnt i alle de nordiske lande med undtagelse af Norge. Depression er blevet mere anerkendt og bliver lettere accepteret end tidligere og grænsen for medicinsk behandling er blevet lavere. Den estimerede forekomst af depression er omkring 10 procent. En stor del af stigningen af forbruget af antidepressiva skyldes en kraftig markedsføring af selektive serotonin genoptagelses hæmmere. Sammenlignet med ældre tricykliske antidepressiva er de selektive serotonin genoptagelses hæmmere ligeså effektive, men har en bedre sikkerhedsprofil. En anden årsag til det øgede forbrug er nye anvendelsesområder for nogle antidepressiva, eksempelvis panikanfald, bulimi, tvangsnuroser og smertebehandling.

I alle landene er forbruget af andre antidepressiva (N06AX), tilnærmelsesvist fordoblet siden år 2000. Denne gruppe inkluderer relativt nylancerede lægemid-

cludes relatively recently launched antidepressants, such as mirtazapine, venlafaxine, reboxetine and duloxetine.

ler såsom mirtazapin, venlafaxin, reboxetin og duloxetin.

Medicines for treatment of Alzheimer's disease

Table 3.7.17: First anti-dementia drugs (N06D), which increase cholinergic activity in the brain (donepezil, rivastigmine and galantamine), became available in the late nineties. Their effect is modest at its best but, since no alternative treatment exists, their use increases slowly. The consumption is highest in Finland and lowest in Denmark. A more recently introduced drug in this group is memantine, an NMDA-receptor antagonist.

Lægemedler til behandling af demens

Tabel 3.7.17: De første lægemidler mod demens (N06D), der øger cholinerg aktivitet i hjernen, (donepezil, rivastigmin og galantemin), blev tilgængelige i slutningen af halvfemserne. Effekten af disse lægemidler er moderat, men siden der ikke findes nogle alternative behandlingsformer, er brugen af dem langsomt steget. Forbruget er højest i Finland og lavest i Danmark. Et nyligt lanceret lægemiddel i denne gruppe er memantin, der er en NMDA-receptor antagonist.

Medicines for the treatment of asthma and chronic obstructive pulmonary disease

Table 3.7.19: Medicines for obstructive airway diseases (R03) – asthma and chronic obstructive pulmonary disease (COPD) – are divided into two main groups. Corticosteroids (R03BA) are the basic treatment for management of the lower airway inflammation that is present in obstructive pulmonary diseases. The other group is bronchodilating medicines, which are used especially in the treatment of acute asthma attacks, but also to prevent bronchoconstriction in asthma and COPD. These include beta-2-agonists (R03AC), theophyllines (R03DA), and anticholinergics (R03BB).

Since the year 2000, there has been a steep increase in consumption of combination preparations (R03AK), which

Midler mod astma og kronisk obstruktiv lungesygdom

Tabel 3.7.19: Lægemedler mod obstruktive luftvejssygdomme (R03), astma og kronisk obstruktiv lungesygdom (KOL), er inddelt i to hovedgrupper. Glucokortikoider (R03BA) er grundbehandlingen for at kontrollere inflammation i de nedre luftveje der er tilstede ved kronisk luftvejssygdom. Den anden gruppe virker bronkieudvidende og bruges specielt i forbindelse med behandling af akutte astmaanfald, men også til at forhindre bronkiesammensnøring ved astma og KOL. Denne gruppe inkluderer beta-2-hæmmere (R03AC), theophyllin (R03DA) og anticholinergica (R03BB).

Siden år 2000 har der været en kraftig stigning i forbruget af kombinationer med adrenergika og andre lægemiddel-

should be used only if the patient has a constant need for both corticosteroid and bronchodilating medication. In Sweden the consumption of these combinations is about half of their consumption in Finland.

stoffer til obstruktive luftvejssygdomme (R03AK), som kun bør bruges hvis patienten har et konstant behov for både glucokortikoider og bronkieudvidende medicin. I Sverige er forbruget af disse kombinationer omkring det halve af forbruget i Finland.

Antihistamines

Table 3.7.20: Sales of antihistamines (R06A) vary a lot between the Nordic countries. Norway has by far the highest sales, Denmark the lowest. In 2005, the increase in antihistamine consumption was very modest compared to increase during earlier years.

Antihistaminer

Tabel 3.7.20: Salget af antihistaminer (R06A) varierer meget blandt de nordiske lande. Norge har det højeste forbrug og Danmark det laveste. I 2005 var stigningen i forbruget af antihistaminer meget moderat sammenlignet med stigningen de tidligere år.

Table 3.7.1 Sales of medicinal products in total, DDD/1 000 inhabitants/day by ATC-group, 2005

Salg af lægemidler-i alt i DDD/1 000 indbyggere/døgn fordelt på ATC-grupper 2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
<i>A Alimentary tract and metabolism</i>								
Fordøjelse og stofskifte	137	122	57	195	161	112	193	213
<i>B Blood and blood-forming organs</i>								
Blod og bloddannende organer	84	73	36	145	155	90	112	294
<i>C Cardiovascular system</i>								
Hjerte og kredsløb	403	449	197	449	363	348	398	398
<i>G Genito-urinary system and sex hormones</i>								
Kønshormoner m.m.	103	85	80	126	105	141	94	104
<i>H Systemic hormonal preparations, excl. sex hormones and insulins</i>								
Hormoner til systemisk brug	28	26	12	39	47	30	38	40
<i>J Anti-infectives for systemic use</i>								
Infektionssygdomme	18	19	27	23	23	24	19	18
<i>L Antineoplastic and immunomodulating agents</i>								
Cancermidler m.m.	9	7	8	11	14	10	11	9
<i>M Musculo-skeletal system</i>								
Muskler, led og knogler	64	40	32	96	67	79	59	63
<i>N Nervous system</i>								
Nervesystemet	247	182	121	227	164	298	202	243
<i>P Antiparasitic products, insecticides and repellents</i>								
Parasitmidler	1	1	3	1	2	1	1	1
<i>R Respiratory system</i>								
Åndedrætsorganer	116	91	60	121	110	109	169	143
<i>S Sensory organs</i>								
Sanseorganer	9	8	16	14	15	11	17	17
<i>Total</i>								
I alt	1 219	1 103	649	1 447	1 226	1 254	1 313	1 542

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

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.

**Figure 3.7.1 Sales of medicinal products for the cardiovascular system (ATC-group C),
DDD/1 000 inhabitants/day, 2001–2005**

Salg af medicinal produkter til hjerte og kredsløb (ATC-gruppe C),
DDD/1 000 indbyggere/døgn, 2001–2005

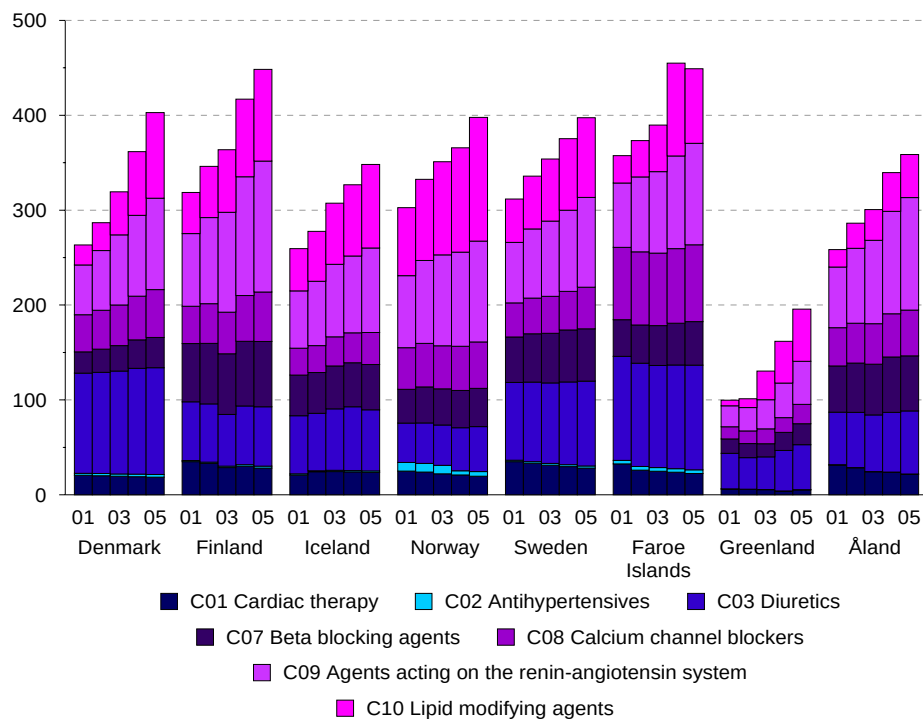
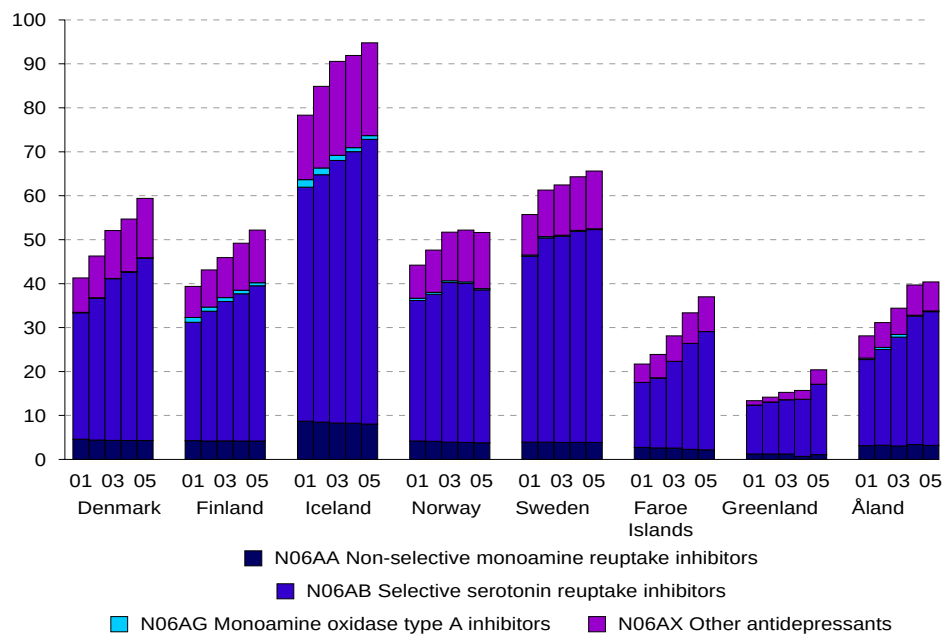


**Figure 3.7.2 Sales of antidepressants (ATC-Group N06A),
DDD/1 000 inhabitants/day 2001-2005**
Salg af antidepressiver (ATC-gruppe N06A),
DDD/1 000 indbyggere/døgn 2001-2005



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**Table 3.7.2 Sales of drugs for gastric acid related disorders (ATC-group A02),
DDD/1 000 inhabitants/day 1995-2005**

Salg af midler mod mavesyre-relaterede lidelser (ATC-gruppe A02),
DDD/ 1 000 indbyggere/døgn 1995-2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A02								
<i>Drugs for gastric acid related disorders</i>								
Midler mod mavesyre- relaterede forstyrrelser								
1995	29.1	17.1	..	16.2	..	24.9	19.4	26.7
2000	28.1	27.4	14.8	19.7	22.1	39.0	24.5	38.4
2003	34.1	39.3	20.5	30.9	31.1	49.5	29.0	40.4
2004	35.8	36.4	16.7	29.9	30.0	52.0	30.5	40.2
2005	38.4	38.3	18.9	32.7	30.5	54.2	32.5	43.1
A02A								
<i>Antacids</i>								
Syreneutraliserende midler								
1995	8.7	6.6	..	3.3	..	2.9	4.9	4.7
2000	7.5	5.4	1.7	2.8	3.7	2.6	3.3	3.1
2003	7.5	4.7	1.5	2.6	2.8	2.5	2.5	2.6
2004	7.2	4.4	1.8	2.6	2.8	2.4	2.3	2.7
2005	7.0	4.2	2.1	2.8	2.7	2.4	2.1	2.6
A02B								
<i>Drugs for peptic ulcer and gastro-oesophageal reflux disease (GORD)</i>								
Midler mod ulcus (mavesår) og gastroøsofagal reflux								
1995	12.1	9.1	..	9.6	..	22.1	11.3	21.8
2000	20.6	22.0	12.3	17.0	18.5	36.4	21.2	35.3
2003	26.6	34.6	18.3	28.3	28.3	47.0	26.5	37.8
2004	28.6	32.0	14.9	27.3	27.2	49.6	28.2	37.5
2005	31.4	34.1	16.8	29.9	27.8	51.9	30.4	40.5
A02BA								
<i>H2-receptor antagonists</i>								
H2-receptor antagonistier								
1995	7.0	4.5	..	4.6	..	14.2	6.7	7.0
2000	6.5	3.8	2.5	5.1	6.2	9.6	5.9	7.1
2003	6.0	3.6	1.1	4.1	5.0	7.7	5.6	5.3
2004	6.4	3.7	0.6	3.9	4.8	7.2	5.5	5.2
2005	6.3	3.4	0.6	4.1	4.7	6.6	5.5	5.2
A02BC								
<i>Proton pump inhibitors</i>								
Protonpumpe hæmmere								
1995	4.8	4.5	..	2.6	..	7.6	4.5	12.5
2000	13.4	16.9	9.5	9.8	9.3	26.6	14.7	26.8
2003	20.0	30.0	16.8	22.5	21.4	39.2	20.5	31.3
2004	21.6	27.2	14.1	21.9	20.5	42.3	22.2	31.1
2005	24.6	29.6	15.9	24.3	21.4	45.2	24.5	34.2

The table continues ...

Table 3.7.2 continued

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A02BX								
<i>Other drugs for peptic ulcer and gastro-oesophageal reflux disease (GORD)</i>								
Andre midler mod mavesår og gastroøsofagal reflux								
1995	0.2	0.2	..	2.3	..	0.3	0.1	2.0
2000	0.7	1.3	0.3	1.9	2.9	0.1	0.5	1.3
2003	0.6	1.1	0.3	1.6	1.8	0.0	0.4	1.1
2004	0.5	1.1	0.2	1.5	1.8	0.0	0.4	1.1
2005	0.5	1.1	0.3	1.4	1.6	0.0	0.4	1.1

**Table 3.7.3 Sales of antiobesity preparations, excl. dietary products
(ATC-group A08), DDD/1 000 inhabitants/day 1995–2005**
 Salg af midler mod fedme (ATC-gruppe A08),
 DDD/1 000 indbyggere/døgn 1995–2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A08								
<i>Antiobesity preparations, excl. dietary products</i>								
Midler mod fedme ekskl. slankepulvere								
1995	6.2	2.9	..	0.1	..	0.0	0.0	0.0
2000	4.9	3.3	0.6	0.6	0.6	1.2	1.1	4.0
2003	0.5	0.5	0.0	0.4	0.4	1.5	1.9	1.4
2004	0.6	0.4	0.0	0.5	0.2	1.4	2.6	2.2
2005	0.6	0.4	0.0	0.6	0.3	1.3	2.6	2.3

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**Table 3.7.4 Sales of drugs used in diabetes (ATC-group A10),
DDD/1 000 inhabitants/day 1995-2005**
Salg af diabetesmidler (ATC-gruppe A10), DDD/1 000 indbyggere/døgn 1995-2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A10								
<i>Drugs used in diabetes</i>								
Midler ved diabetes								
1995	14.6	16.0	..	30.8	..	9.9	18.0	28.8
2000	22.0	23.0	6.1	42.6	25.3	15.3	27.0	37.0
2003	28.6	23.7	9.0	58.0	32.4	21.1	33.7	42.2
2004	31.3	24.7	10.0	64.4	36.6	22.2	36.5	43.6
2005	33.8	26.1	10.3	65.5	38.5	24.0	39.3	44.6
A10A								
<i>Insulins and analogues</i>								
Insulin								
1995	6.7	5.7	1.1	11.8	..	3.4	10.9	15.0
2000	9.4	8.1	1.8	15.9	11.8	5.0	14.3	19.6
2003	11.3	9.6	2.4	20.2	12.9	5.9	16.5	21.7
2004	12.2	10.2	2.6	20.9	15.0	5.9	17.1	22.3
2005	13.2	10.6	2.7	21.7	15.1	6.5	17.4	22.6
A10B								
<i>Oral blood glucose lowering drugs</i>								
Blodglukose sænkende mid- ler til oralt brug								
1995	7.9	10.3	1.7	19.0	..	6.5	7.1	13.8
2000	12.6	14.8	4.3	26.7	13.5	10.3	12.7	17.5
2003	17.2	14.2	6.5	37.8	19.5	15.2	17.2	20.5
2004	19.1	14.5	7.4	41.6	21.7	16.3	19.4	21.4
2005	20.6	15.4	7.6	43.8	23.4	17.5	21.9	22.0
A10BA								
<i>Biguanides</i>								
Biguanider								
1995	1.3	1.2	..	3.1	..	2.9	0.8	2.6
2000	2.8	3.1	1.0	9.3	4.2	4.7	3.7	5.5
2003	5.5	4.8	2.9	14.1	8.0	6.7	7.4	9.4
2004	6.8	5.8	3.4	16.3	9.2	7.3	8.6	10.7
2005	7.9	6.9	4.3	18.5	10.1	7.7	9.7	11.8
A10BB								
<i>Sulfonamides, urea derivatives</i>								
Sulfonamider, derivater af urea								
1999	8.9	11.2	2.5	18.3	8.4	4.6	8.2	11.2
2000	9.4	11.7	3.2	17.4	9.2	5.4	8.6	11.2
2003	11.1	9.2	3.7	23.4	11.4	6.7	9.4	9.3
2004	11.8	8.6	4.0	24.6	12.3	6.9	10.3	8.5
2005	12.0	8.5	3.3	24.1	13.1	7.2	11.1	7.7

The table continues ...

Table 3.7.4 continued

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A10BD								
<i>Combinations of oral blood glucose lowering drugs</i>								
2004	0.10	0.00	0.00	0.12	..	0.11	0.00	0.04
2005	0.20	0.00	0.00	0.83	0.07	0.48	0.05	0.20
A10BG								
<i>Thiazolinediones</i>								
Thiazolindioner								
1999	..	0.0	0.0	0.0	0.0	0.0	..	0.0
2000	0.0	0.0	0.0	0.0	0.0	0.0	..	0.0
2003	0.1	0.1	0.0	0.2	0.1	1.4	0.1	0.7
2004	0.1	0.0	0.0	0.5	0.1	1.6	0.3	0.9
2005	0.1	0.1	0.0	1.1	0.1	1.7	0.8	1.0
A10BX								
<i>Other oral blood glucose lowering drugs</i>								
Andre blodglukose sænken- de midler til oralt brug								
1999	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.2
2000	0.3	0.0	0.0	0.0	0.0	0.0	0.1	0.5
2003	0.4	0.0	0.0	0.1	0.1	0.4	0.1	1.0
2004	0.3	0.0	0.0	0.1	0.1	0.4	0.1	1.1
2005	0.3	0.0	0.0	0.2	0.2	0.4	0.1	1.2

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Tabel 3.7.5 Sales of platelet aggregation inhibitors excl. heparin (ATC/group B01AC), DDD/1 000 inhabitants/day, 1995-2005

Salg af blodplade-aggregations-hæmmere ekskl. heparin (ATC-gruppe B01AC), DDD/1 000 indbyggere/døgn 1995-2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
1995	40.6	9.5	0.2	75.6	39.2	42.2	45.4	56.0
2000	42.3	14.3	4.9	80.6	43.6	46.0	48.7	58.9
2003	51.9	33.1	20.9	96.1	57.5	54.7	59.1	69.2
2004	56.8	16.5	24.6	101.6	63.9	56.3	63.3	72.3
2005	60.6	46.4	31.8	110.7	65.1	60.3	66.5	74.4

Table 3.7.6 Sales of drugs for cardiac therapy (ATC group C01), DDD/1 000 inhabitants/day, 1995-2005

Salg af lægemidler til hjerteterapi (ATC-gruppe C01), DDD/1 000 indbyggere/døgn 1995-2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
C01								
<i>Cardiac therapy</i>								
<i>Hjerteterapi</i>								
1995	20.7	38.3	..	45.5	..	22.5	29.3	38.8
2000	21.1	34.8	5.4	35.0	33.0	22.2	25.9	35.8
2003	19.6	24.9	5.4	31.5	24.2	24.5	22.1	31.3
2004	19.1	23.8	3.9	30.0	23.6	24.1	20.9	29.8
2005	18.6	22.5	5.3	28.3	21.6	23.7	19.6	28.3
C01A								
<i>Cardiac glycosides</i>								
<i>Hjerteglykosider</i>								
1995	9.0	13.2	2.6	15.7	..	5.8	8.3	13.0
2000	7.9	8.8	3.2	9.7	10.2	2.0	5.8	9.3
2003	6.6	2.2	1.7	7.2	6.2	3.4	4.6	7.2
2004	6.3	1.9	1.2	6.6	5.9	3.2	4.4	6.5
2005	6.0	1.9	1.9	6.0	5.4	3.0	4.1	5.9
C01D								
<i>Vasodilators used in cardiac diseases</i>								
<i>Midler mod angina pectoris (hjertekramper)</i>								
1995	10.5	24.1	1.8	26.3	..	14.5	20.1	23.7
2000	11.3	25.1	1.7	21.9	18.1	17.5	18.9	24.4
2003	10.8	21.2	3.2	21.4	14.8	17.9	16.0	22.6
2004	10.7	20.3	2.3	20.5	14.5	17.6	15.0	21.8
2005	10.4	19.0	2.8	19.5	13.1	17.2	14.0	20.9

Table 3.7.7 Sales of antihypertensives, diuretics, beta-blocking agents, calcium channel blockers and ACE inhibitors (ATC-group C02, C03, C07, C08, C09), DDD/1 000 inhabitants/day, 1995-2005

Salg af midler mod forhøjet blodtryk, diuretika, beta-receptorblokerende midler, calciumantagonister og ACE-hæmmere (ATC-gruppe C02, C03, C07, C08, C09), DDD/1 000 indbyggere/døgn 1995-2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
C02								
<i>Antihypertensives</i>								
Midler mod forhøjet blodtryk								
1995	1.1	2.4	..	2.2	..	0.6	6.4	0.9
2000	1.8	3.2	0.2	1.1	0.4	1.4	9.3	1.2
2003	2.5	3.8	0.1	1.5	0.3	1.2	9.0	1.8
2004	2.7	3.8	0.1	1.7	0.3	1.4	4.4	1.9
2005	2.9	3.7	0.1	1.9	0.3	1.4	4.9	2.1
C03								
<i>Diuretics</i>								
Vanddrivende midler (diuretika)								
1995	102.0	88.8	27.4	62.6	..	56.8	41.9	86.5
2000	103.9	108.4	31.7	60.5	53.6	58.9	41.2	82.5
2003	108.3	107.8	34.6	61.6	59.7	64.9	42.4	84.7
2004	111.5	109.2	42.8	61.9	63.0	67.3	45.4	87.3
2005	112.4	110.4	47.5	62.5	66.5	64.5	47.4	89.4
C03A								
<i>Low-ceiling diuretics, thiazides</i>								
Thiazider								
1995	36.8	37.6	..	3.9	..	7.9	2.9	9.0
2000	38.6	50.7	14.3	4.1	1.2	6.9	3.1	9.9
2003	43.7	52.7	19.2	4.8	2.2	8.5	4.9	13.2
2004	47.1	53.3	24.1	5.2	3.4	8.7	7.0	16.1
2005	48.8	54.8	29.5	5.6	4.4	8.8	9.0	19.4
C03C								
<i>High-ceiling diuretics</i>								
Loop-diuretika								
1995	50.5	40.9	..	21.4	..	20.5	29.6	57.4
2000	53.2	44.1	15.7	27.1	17.1	21.9	30.8	54.9
2003	53.1	40.1	14.3	30.9	23.0	23.6	29.8	53.0
2004	53.2	40.0	17.2	32.0	22.3	24.1	30.2	52.0
2005	53.3	40.5	15.9	33.5	25.9	21.2	30.1	50.7
C03E								
<i>Diuretics and potassium-sparing agents in combination</i>								
Diuretika i komb. med kaliumsbesparende midler								
1995	10.0	2.1	..	34.1	..	26.7	7.3	10.5
2000	7.7	1.7	0.6	26.7	33.3	27.9	6.0	10.7
2003	6.8	1.2	0.2	23.1	32.0	30.8	6.0	12.1
2004	6.5	1.3	0.2	21.8	34.3	32.5	6.5	13.1
2005	5.5	1.0	0.1	20.7	33.3	32.6	6.7	13.5

The table continues ...

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE
Table 3.7.7 continued

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
C07								
<i>Beta blocking agents</i>								
Beta-receptorblokerende midler								
1995	15.5	31.2	7.5	43.3	..	34.3	25.6	36.7
2000	20.3	37.1	11.3	57.2	45.8	40.2	33.2	45.0
2003	27.2	42.0	13.9	65.8	53.4	45.1	38.1	52.5
2004	29.9	44.1	19.0	68.1	58.3	46.4	39.4	54.7
2005	31.9	45.9	22.0	68.9	58.1	47.8	40.4	55.1
C07A								
<i>Beta blocking agents, plain</i>								
Beta-receptor-blokerende midler uden kombination								
1995	14.3	30.4	..	42.8	..	34.3	25.6	36.0
2000	19.3	36.4	11.3	51.9	44.8	39.9	33.2	43.3
2003	25.8	41.7	13.9	57.8	52.0	44.6	38.0	50.8
2004	28.5	43.8	19.0	59.5	56.9	46.0	38.9	53.1
2005	30.4	45.5	22.0	59.9	56.6	47.2	39.7	53.6
C08								
<i>Calcium channel blockers</i>								
Calciumantagonister								
1995	28.2	38.2	0.0	31.0	..	21.3	33.8	32.5
2000	37.2	71.0	7.8	36.7	35.9	26.7	41.5	34.9
2003	42.9	76.4	15.6	44.9	42.7	30.7	45.3	38.9
2004	46.2	78.5	15.5	48.3	45.6	31.5	46.6	40.7
2005	50.4	81.0	20.5	52.2	48.1	33.6	48.9	44.0
C08C								
<i>Selective calcium channel blockers with mainly vascular effects</i>								
Selektive kalsiumantagonister med primær effekt på karrerne								
1995	18.2	30.8	..	17.7	..	14.0	26.6	23.4
2000	28.8	65.3	5.9	28.5	33.3	20.5	34.9	28.6
2003	35.5	72.2	14.5	39.0	40.8	24.1	39.7	34.0
2004	39.1	74.6	14.6	43.0	43.6	25.4	41.2	36.2
2005	43.6	77.4	19.3	47.6	46.4	27.4	43.8	39.8
C08D								
<i>Selective calcium channel blockers with direct cardiac effects</i>								
Selektive kalsiumantagonister med direkte effekt på hjertet								
1995	10.0	7.5	..	13.3	..	7.2	7.2	9.1
2000	8.4	5.7	1.9	8.2	2.7	6.2	6.6	6.3
2003	7.4	4.1	1.1	5.9	1.9	6.5	5.7	4.9
2004	7.1	3.9	0.9	5.2	2.0	6.2	5.4	4.5
2005	6.8	3.6	1.2	4.6	1.7	6.2	5.1	4.1

The table continues ...

Table 3.7.7 continued

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
C09								
<i>Agents acting on the renin- angiotensin system</i>								
Midler med virkning på rennin-angiotensin systemet								
1995	22.3	21.8	..	40.6	..	27.8	35.8	31.2
2000	45.4	59.2	19.8	65.7	55.0	51.4	65.1	56.2
2003	74.1	86.0	30.7	107.8	87.9	76.4	96.0	79.1
2004	85.1	97.7	36.5	125.3	107.9	80.9	99.1	85.6
2005	96.3	107.0	45.2	137.9	118.6	89.2	106.2	94.7
C09A								
<i>ACE-inhibitors, plain</i>								
ACE-hæmmere ekskl. Kom- binationer								
1995	20.2	21.6	..	35.6	..	26.5	33.8	29.7
2000	29.4	52.5	19.4	42.8	46.2	29.6	35.2	42.3
2003	43.6	60.1	28.7	64.9	64.9	31.3	42.1	51.0
2004	49.0	64.8	33.8	72.3	75.2	30.3	42.0	53.1
2005	55.1	69.8	41.3	75.3	79.9	32.2	42.9	57.3
C09B								
<i>ACE-inhibitors, combinations</i>								
ACE-hæmmere i kombina- tioner								
1995	0.7	0.0	..	5.0	..	0.4	0.2	0.7
2000	1.8	0.1	0.0	11.6	1.8	4.2	6.6	2.1
2003	3.5	2.4	0.1	13.9	2.9	6.2	7.5	2.5
2004	5.2	4.1	0.1	14.4	3.5	6.8	7.2	3.1
2005	6.7	5.4	0.1	14.7	4.2	7.7	7.3	3.6
C09C								
<i>Angiotensin II antagonists</i>								
Angiotensin II antagonist ekskl. kombinationer								
1995	1.4	0.1	..	..	..	1.0	1.8	0.8
2000	10.6	5.9	0.5	8.2	6.0	12.9	15.6	9.8
2003	18.0	16.2	2.0	18.6	16.5	21.2	26.7	19.5
2004	19.9	19.4	2.5	24.9	23.7	22.2	28.0	21.8
2005	22.0	21.2	3.8	31.0	27.8	23.8	30.6	24.6
C09D								
<i>Angiotensin II antagonists, combinations</i>								
Angiotensin II antagonist, kombinationer								
1995	0.0	..	..	..	..	0.0	..	0.0
2000	3.6	0.7	0.0	3.1	1.0	4.7	7.7	2.0
2003	9.0	7.3	0.0	10.4	3.6	17.8	19.7	6.2
2004	10.9	9.5	0.0	13.7	5.5	21.6	21.8	7.7
2005	12.5	10.7	0.1	16.8	6.7	25.5	25.4	9.1

**Table 3.7.8 Sales of lipid modifying agents (ATC-group C10A),
DDD/1 000 inhabitants/day, 1995-2005**
Salg af lipidmodifiserende midler (ATC-gruppe C10A),
DDD/1 000 indbyggere/døgn 1995-2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
C10A								
<i>Lipid modifying agents</i>								
Lipidmodifiserende midler								
1995	3.1	0.9	..	5.7	..	6.2	11.1	8.0
2000	16.2	19.3	3.2	32.1	14.1	34.2	59.6	36.7
2003	45.38	49.0	30.1	67.0	32.4	64.4	98.2	65.5
2004	67.2	61.8	43.9	81.7	40.9	75.2	110.0	75.2
2005	90.2	78.5	55.1	96.7	45.4	88.1	130.3	83.9
C10AA								
<i>HMG CoA reductase inhibitors (statins)</i>								
HMG CoA reductase- hæmmere								
1995	2.4	0.8	..	4.6	..	6.2	10.8	5.8
2000	15.6	19.2	3.1	31.2	13.9	34.0	59.3	34.9
2003	44.9	49.0	29.9	66.1	32.2	64.5	97.8	63.8
2004	66.6	61.4	43.7	80.5	40.4	74.6	109.4	73.1
2005	89.6	78.0	55.0	94.9	44.6	87.3	129.6	81.6

**Table 3.7.9 Sales of oestrogens and oestrogens in combination with progestogens
(ATC group G03C, G03DG05 and G03F), DDD/1 000 inhabitants/day
1995-2005**

Salg af østrogener og kombinationer af østrogener og progestogener (ATC-
gruppe G03C, G03DG05 og G03F), DDD/1 000 indbyggere/døgn 1995-2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
G03C and G03DG05								
<i>Oestrogens and tibolones</i>								
Østrogener								
1995	13.5	10.5	..	23.9	..	20.3	15.0	..
2000	15.1	11.7	2.7	34.7	30.8	34.7	20.7	28.6
2003	14.6	10.7	2.9	32.1	27.6	27.3	17.2	21.7
2004	11.4	9.9	2.4	30.8	27.9	26.1	16.1	18.5
2005	11.3	10.0	3.8	29.7	26.7	23.8	14.6	16.1
G03F								
<i>Progestogens and oestro- gens in combination</i>								
Progestogener og østro- gener i kombination								
1995	14.8	9.9	..	13.3	..	23.4	19.9	16.8
2000	15.6	13.6	5.0	20.7	19.3	27.0	25.9	22.6
2003	13.4	12.2	5.1	18.9	14.2	15.6	16.1	15.0
2004	8.2	9.0	2.7	16.1	11.6	12.7	12.9	10.3
2005	7.0	8.9	2.0	15.0	7.1	10.5	10.2	7.6

**Table 3.7.10 Sales of drugs used in erectile dysfunction (ATC group G04BE),
DDD/1 000 males/day 1999-2005**
Salg af midler mod erektionsforstyrrelser (ATC-gruppe G04BE),
DDD/1 000 mænd/døgn 1999-2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
1999	0.6	0.1	0.2	1.4	0.6	0.6	0.9	2.1
2000	0.7	0.2	0.2	1.7	0.8	1.2	1.1	2.5
2003	1.6	0.4	0.3	3.0	1.2	2.4	2.2	1.9
2004	1.9	0.6	0.7	3.7	1.6	2.8	2.5	1.1
2005	2.2	0.7	0.7	4.0	1.4	3.0	2.6	1.2

**Table 3.7.11 Sales of antibacterials for systemic use (ATC-group J01),
DDD/1 000 inhabitants/day, 1995-2005**
Salg af antibakterielle midler til systemisk brug (ATC-gruppe J01),
DDD/1 000 indbyggere/døgn 1995-2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
J01								
<i>Antibacterials for systemic use</i>								
Antibakterielle midler til systemisk brug								
1995	13.5	15.7	18.4	24.7	..	21.9	17.3	18.8
2000	13.5	17.4	20.9	22.6	21.0	20.3	16.3	17.2
2003	15.0	18.2	19.4	22.3	21.2	20.1	17.1	16.3
2004	15.6	17.1	16.5	20.6	21.7	21.6	17.2	16.2
2005	16.3	18.6	20.4	21.6	22.1	23.0	18.2	16.6
J01A								
<i>Tetracyclines</i>								
Tetracykliner								
1995	1.6	1.2	3.1	5.6	..	5.2	4.1	3.8
2000	1.0	1.1	5.9	4.9	3.0	4.7	3.2	3.5
2003	1.1	1.2	5.7	4.1	3.1	4.7	3.0	3.3
2004	1.2	1.3	1.7	3.7	3.3	5.2	3.0	3.3
2005	1.3	1.3	3.1	4.2	3.4	5.4	3.1	3.5
J01C								
<i>Beta-lactam antibacterials, penicillins</i>								
Penicilliner								
1995	7.7	10.5	10.5	7.0	..	10.4	7.3	8.8
2000	8.3	10.7	9.8	6.1	8.0	10.3	7.0	8.0
2003	9.3	11.2	9.0	6.3	8.4	10.3	7.3	7.4
2004	9.7	10.4	9.6	5.6	8.3	11.1	7.2	7.2
2005	10.0	11.7	11.8	6.3	7.9	11.8	7.6	7.3

The table continues ...

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Table 3.7.11 continued

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
J01CA								
<i>Penicillins with extended spectrum</i>								
Penicilliner med udvidet spectrum								
1995	2.8	3.3	4.2	3.4	..	4.8	1.7	1.4
2000	2.6	3.0	3.8	3.2	4.2	4.2	2.0	1.4
2003	2.8	2.8	3.4	3.3	4.8	4.0	2.3	1.4
2004	2.9	2.9	3.4	2.9	5.1	4.1	2.4	1.5
2005	3.1	3.1	4.0	3.4	5.0	4.3	2.5	1.6
J01CE								
<i>Beta-lactamase sensitive penicillins</i>								
Beta-lactamase følsomme penicilliner								
1995	4.6	6.8	5.7	3.3	..	3.7	5.4	5.9
2000	5.0	6.7	5.5	2.3	3.3	3.1	4.7	5.0
2003	5.4	7.0	4.7	1.9	2.8	2.5	4.4	4.3
2004	5.5	6.3	5.5	1.7	2.4	2.9	4.2	4.1
2005	5.6	7.3	6.9	1.7	2.2	3.0	4.5	4.1
J01CF								
<i>Beta-lactamase resistant penicillins</i>								
Beta-lactamase resistente penicilliner								
1995	0.3	0.4	0.6	0.1	..	1.2	0.2	1.3
2000	0.7	0.9	0.5	0.1	0.2	1.3	0.4	1.3
2003	1.0	1.1	0.9	0.1	0.3	1.3	0.6	1.4
2004	1.1	1.1	0.7	0.1	0.5	1.3	0.6	1.4
2005	1.2	1.2	0.9	0.1	0.4	1.4	0.5	1.4
J01CR								
<i>Combinations of penicillins, incl. beta-lactamase inhibitors</i>								
Komb. af penicilliner, inkl. beta-lactamase hæmmere								
1995	0.0	0.0	..	0.2	..	0.7	0.0	0.2
2000	0.0	0.1	0.0	0.5	0.3	1.8	0.0	0.2
2003	0.1	0.1	0.0	1.0	0.4	2.4	0.0	0.2
2004	0.1	0.1	0.0	0.9	0.3	2.7	0.0	0.2
2005	0.1	0.1	0.0	1.1	0.4	3.2	0.0	0.2
J01D								
<i>Other beta-lactam antibacterials</i>								
Cefalosporiner, monobakterer og carbapenemer								
1995	0.0	0.2	..	3.5	..	0.5	0.5	1.1
2000	0.2	0.3	0.1	3.0	1.6	0.6	0.5	0.8
2003	0.2	0.6	0.1	3.1	1.8	0.5	0.6	0.7
2004	0.3	0.5	0.2	3.0	1.7	0.5	0.6	0.7
2005	0.3	0.5	0.2	3.1	1.7	0.5	0.6	0.7

The table continues ...

Table 3.7.11 continued

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
J01E								
<i>Sulfanamides and trimethoprim</i>								
Sulfonamider og trimethoprim								
1995	0.8	1.4	..	2.9	..	2.7	1.8	0.9
2000	0.8	1.2	0.6	2.3	1.4	2.2	1.2	0.8
2003	0.8	1.2	0.5	2.0	1.0	1.9	1.1	0.8
2004	0.9	1.0	0.7	2.0	1.1	1.9	1.1	0.8
2005	0.9	1.0	0.6	1.9	1.0	1.9	1.1	0.8
J01F								
<i>Macrolides, lincos-amides and streptogramins</i>								
Makrolider, lincosamider og streptograminer								
1995	2.1	2.1	2.2	2.0	..	1.6	1.6	1.4
2000	2.1	2.8	3.8	2.3	0.8	1.6	1.6	1.0
2003	2.2	2.6	3.4	2.6	1.0	1.6	1.9	0.9
2004	2.3	2.2	3.4	2.1	0.9	1.7	1.9	0.9
2005	2.5	2.5	3.6	2.1	1.1	1.8	2.1	0.9
J01M								
<i>Quinolone antibacterials</i>								
Quinoloner								
1995	0.3	0.1	..	0.9	..	0.4	0.3	1.5
2000	0.2	0.1	0.1	1.0	1.1	0.6	0.3	1.2
2003	0.4	0.2	0.2	1.3	1.3	0.7	0.5	1.2
2004	0.4	0.2	0.2	1.3	1.3	0.8	0.5	1.2
2005	0.5	0.3	0.2	1.3	1.1	0.8	0.6	1.2

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Table 3.7.12 Sales of non-steroids anti-inflammatory and antihreumatic products (NSAID) and other analgesics (ATC-group M01A, N02A and N02B) DDD/1 000 inhabitants/day, 1995-2005

Salg af NSAID og andre smertestillende midler (ATC-gruppe M01A, N02A og N02B), DDD/1 000 indbyggere/døgn 1995-2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
M01A								
<i>Anti-inflammatory and antirheumatic products, non-steroids</i>								
NSAID								
1995	29.7	28.8	17.1	52.7	..	36.7	24.6	33.6
2000	31.0	22.3	15.4	60.6	45.5	51.3	33.8	40.9
2003	41.3	31.7	21.9	70.0	50.0	69.6	48.3	51.1
2004	56.3	34.1	17.9	74.8	54.8	74.9	52.0	53.1
2005	53.2	32.2	24.0	76.7	55.8	68.0	43.9	51.4
M01AH								
<i>Coxibs</i>								
Coxibs								
1999	0.0	0.0	0.0	0.0	0.0	0.0	..	0.3
2000	1.6	0.6	0.0	0.7	0.3	4.0	1.8	4.1
2003	8.4	9.1	4.5	10.2	4.7	12.8	19.9	7.6
2004	6.2	4.8	0.6	14.5	5.2	15.2	21.8	7.1
2005	0.6	1.5	0.0	6.3	2.0	4.0	3.8	2.0
N02A								
<i>Opioids</i>								
Stærke smertestillende midler (opioider)								
1995	9.6	3.2	..	5.7	..	6.9	14.6	26.9
2000	14.9	3.9	2.7	10.4	6.6	14.8	16.7	26.4
2003	17.1	4.7	3.7	14.0	7.6	15.6	19.1	23.5
2004	17.8	6.4	4.6	13.9	8.7	15.8	19.1	21.9
2005	18.5	6.9	4.5	15.4	9.2	17.4	19.5	20.8
N02B								
<i>Other analgesics</i>								
Andre smertestillende midler								
1995	61.7	38.7	30.7	18.7	..	31.5	25.6	43.0
2000	69.1	44.0	37.5	13.3	27.9	29.2	26.4	45.5
2003	70.1	57.4	18.9	16.2	28.9	28.0	27.6	47.0
2004	70.4	54.2	39.9	17.7	31.7	28.4	27.8	47.6
2005	71.6	55.8	44.3	20.6	36.3	30.9	29.5	49.5
N02BA								
<i>Salicylic acid and derivatives</i>								
Salicylsyre-derivater								
1995	22.0	20.9	..	14.6	..	9.2	3.2	16.3
2000	18.0	19.5	9.9	7.3	12.4	4.4	1.3	12.5
2003	14.9	18.2	0.8	5.5	8.8	3.3	0.8	10.5
2004	14.3	14.7	7.0	5.7	9.0	3.2	0.6	10.1
2005	13.4	14.5	7.4	5.5	9.9	3.5	0.5	9.8

The table continues ...

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.7.12 continued

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N02BB								
<i>Pyrazolones</i>								
Pyrazoloner								
1995	2.6	0.3	..	0.4	..	0.7	5.9	0.3
2000	1.8	0.1	0.0	0.0	0.0	0.4	4.2	0.1
2003	1.3	0.1	0.0	0.0	0.0	0.0	3.6	0.1
2004	0.8	0.0	0.0	0.0	0.0	0.0	3.5	0.1
2005	0.8	0.0	0.0	0.0	0.0	0.0	3.2	0.1
N02BE								
<i>Anilides</i>								
Anilider								
1995	37.1	17.4	..	3.4	..	21.6	16.5	26.4
2000	49.4	24.3	27.5	6.0	15.5	24.4	20.8	32.8
2003	53.9	39.0	18.1	10.7	20.1	24.8	23.3	36.3
2004	55.3	39.5	33.0	12.0	22.7	25.1	23.7	37.4
2005	57.4	41.2	36.9	15.1	26.4	27.4	25.8	39.7

Table 3.7.13 Sales of antipsychotics (ATC-group N05A), DDD/1 000 inhabitants/day, 1995-2005

Salg af antipsykotiske midler (ATC-gruppe N05A),
DDD/1 000 indbyggere/døgn 1995-2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
1995	6.6	7.7	9.4	15.2	..	8.4	8.7	8.8
2000	10.0	8.5	11.8	15.3	8.7	9.5	9.0	8.6
2003	11.9	9.5	11.7	16.1	9.5	10.5	9.9	8.7
2004	12.5	10.6	12.1	16.7	9.8	11.0	10.3	9.0
2005	13.0	10.6	14.6	17.4	9.3	11.5	10.6	9.2

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Table 3.7.14 Sales of anxiolytics (ATC-group N05B), DDD/1 000 inhabitants/day, 1995-2005

Salg af angstdæmpende midler (ATC-gruppe N05B),
DDD/1 000 indbyggere/døgn 1995-2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N05B								
<i>Anxiolytics</i>								
Angstdæmpende midler								
1995	26.6	19.6	5.2	28.9	..	23.0	18.9	17.2
2000	22.8	16.2	5.1	30.1	10.6	24.6	19.0	17.1
2003	21.5	16.0	4.6	32.0	9.9	24.9	20.4	16.3
2004	20.8	16.3	4.3	31.9	9.4	26.1	21.0	16.4
2005	19.7	16.0	5.3	31.2	9.9	25.8	21.3	16.4
N05BA								
<i>Benzodiazepine derivatives</i>								
Benzodiazepin-derivater								
1995	26.5	..	..	27.5	..	22.4	18.3	15.1
2000	22.5	16.1	5.1	28.3	8.9	23.6	18.0	14.9
2003	21.3	15.8	4.6	30.3	8.1	23.9	19.3	13.9
2004	20.6	16.1	4.3	30.1	7.3	25.0	19.8	13.8
2005	19.4	15.8	5.3	29.5	8.0	24.6	20.1	13.6

**Table 3.7.15 Sales of hypnotics and sedatives (ATC-group N05C),
DDD/1 000 inhabitants/day, 1995-2005**
Salg af sovemidler og beroligende midler (ATC-gruppe N05),
DDD/1 000 indbyggere/døgn 1995-2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N05C								
<i>Hypnotics and sedatives</i>								
Sovemidler og beroligende midler								
1995	44.4	43.1	5.1	39.5	..	41.2	25.9	40.7
2000	32.5	33.3	5.4	49.0	35.2	55.4	31.8	47.2
2003	32.7	33.3	6.4	55.9	37.7	61.8	36.9	49.0
2004	32.2	31.6	9.3	55.0	33.9	64.9	39.0	50.4
2005	31.2	31.0	8.8	54.4	34.2	66.7	41.4	51.6
N05CD								
<i>Benzodiazepine derivatives</i>								
Benzodiazepin-derivater								
1995	32.6	..	..	20.1	..	38.3	21.7	22.8
2000	15.6	13.3	0.9	21.0	7.0	28.8	13.6	13.3
2003	12.8	10.5	0.5	22.2	5.7	14.9	9.2	8.3
2004	11.6	7.8	0.5	21.6	4.6	13.3	8.7	7.4
2005	10.5	7.1	0.5	20.9	4.3	12.1	8.5	6.7
N05CF								
<i>Benzodiazepine related drugs</i>								
Benzodiapine lignende midler								
1995	11.9	..	..	17.7	..	2.3	4.2	7.1
2000	16.8	20.0	4.5	27.4	27.2	26.5	18.1	21.6
2003	19.9	22.8	5.9	33.2	31.3	46.8	27.6	27.2
2004	20.5	20.5	8.8	32.9	28.6	51.4	30.2	29.0
2005	20.7	23.8	8.3	33.1	29.3	54.5	32.8	30.4

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**Table 3.7.16 Sales of antidepressants (ATC-group N06A),
DDD/1 000 inhabitants/day, 1995-2005**
Salg af antidepressive midler (ATC-gruppe N06A),
DDD/1 000 indbyggere/døgn 1995-2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N06A								
<i>Antidepressants</i>								
<i>Antidepressive midler</i>								
1995	18.3	10.6	3.9	20.3	..	33.0	22.5	27.8
2000	34.7	18.2	10.1	35.5	23.8	70.5	41.0	48.8
2003	52.3	28.3	15.3	45.9	34.4	90.6	51.7	62.5
2004	54.9	33.5	15.7	49.1	39.7	91.9	52.2	64.3
2005	59.5	37.1	20.4	52.1	40.4	94.8	51.6	65.7
N06AA								
<i>Non-selective monoamine reuptake inhibitors</i>								
<i>Ikke-seltekative monoamin genoptagelseshæmmere</i>								
1995	5.3	4.1	..	5.0	..	9.7	6.3	5.4
2000	4.6	2.8	1.6	4.4	3.4	8.6	4.5	4.0
2003	4.3	2.6	1.2	4.2	3.0	8.2	3.9	3.9
2004	4.3	2.3	0.7	4.2	3.4	8.2	3.9	3.9
2005	4.3	2.2	1.1	4.2	3.2	8.1	3.8	3.8
N06AB								
<i>Selective serotonin reuptake inhibitors</i>								
<i>Selektive serotonin genoptagelseshæmmere</i>								
1995	11.9	5.7	..	12.1	..	18.9	11.2	21.0
2000	23.9	12.1	8.2	24.2	16.8	49.2	29.9	37.1
2003	36.8	19.8	12.4	31.9	25.0	59.8	36.3	46.9
2004	38.3	24.1	13.0	33.5	29.2	61.8	36.1	48.0
2005	41.5	26.9	16.0	35.3	30.4	64.8	34.8	48.4
N06BA								
<i>Centrally acting Sympathomimetics</i>								
<i>Centralt virkende sympato- mimetika</i>								
2000	0.2	0.1	0.2	..	..	2,3	0.8	0.2
2003	0.4	0.1	0.5	0.1	0.0	5,6	1.9	0.7
2004	0.6	0.3	0.7	0.2	0.1	7,4	2.7	1.0
2005	0.8	0.4	0.8	0.4	0.2	9,7	3.7	1.3
N06AG								
<i>Monoamine oxidase type A inhibitors</i>								
<i>Monoamin-oxidase type A hæmmere</i>								
1995	0.3	0.1	..	1.6	..	2.0	1.9	0.7
2000	0.1	0.0	0.0	1.3	0.3	2.0	0.6	0.4
2003	0.1	0.0	0.0	0.9	0.6	1.2	0.4	0.3
2004	0.1	0.0	0.0	0.8	0.2	0.9	0.3	0.2
2005	0.1	0.0	0.0	0.7	0.2	0.8	0.3	0.2

The table continues ...

Table 3.7.16 continued

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N06AX								
<i>Other antidepressants</i>								
<i>Andre antidepressiva</i>								
1995	0.6	0.6	..	0.2	..	2.4	3.0	0.7
2000	6.0	3.3	0.4	5.6	3.3	10.7	6.1	7.3
2003	10.9	5.8	1.7	9.1	6.0	21.4	11.1	11.5
2004	12.0	7.0	2.0	10.7	6.9	20.9	11.8	12.2
2005	13.5	7.9	3.3	12.0	6.6	21.2	12.8	13.1

**Table 3.7.17 Sales of anti-dementia drugs (ATC-group N06D),
DDD/1 000 inhabitants/day, 1999-2005**

Salg af midler mod demens (ATC-gruppe N06D), DDD/1 000 indbyggere/dag,
1999-2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
1999	0.30	0.15	0.02	0.63	0.41	0.95	0.34	0.86
2000	0.46	0.32	0.01	1.12	0.42	1.37	0.73	1.20
2003	1.45	0.74	0.01	3.70	1.14	2.35	2.39	2.59
2004	1.80	0.79	0.06	5.23	2.14	2.68	2.95	3.00
2005	2.00	1.12	0.10	6.50	2.50	2.75	3.10	3.02

**Table 3.7.18 Sales of drugs for obstructive airway diseases (ATC-group R03),
DDD/1 000 inhabitants/day, 1995-2005**

Salg af midler til obstruktive luftvejssygdomme (ATC-gruppe R03),
DDD/1 000 indbyggere/døgn 1995-2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
R03								
<i>Drugs for obstructive airway diseases</i>								
Midler til obstruktive luftvejssygdomme								
1995	59.2	27.1	..	42.9	..	43.8	57.2	64.7
2000	64.0	35.9	31.7	49.9	47.9	48.2	62.1	56.4
2003	62.0	36.0	28.5	51.0	49.7	44.9	61.0	51.7
2004	61.9	37.4	32.7	50.9	52.9	44.1	60.2	51.0
2005	60.5	38.6	37.4	51.8	50.6	45.0	61.0	50.4
R03A								
<i>Adrenergics, inhalants</i>								
Adrenergika til inhalation								
1995	28.3	..	..	15.6	..	20.4	26.2	29.4
2000	32.8	18.3	16.8	20.2	19.3	22.1	30.7	25.6
2003	34.4	18.3	15.1	25.6	24.9	28.1	34.8	26.6
2004	35.5	20.1	15.0	27.2	28.6	29.6	35.5	27.3
2005	35.9	21.7	17.6	28.4	28.7	31.2	36.5	27.4

The table continues ...

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE
Table 3.7.18 continued

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
R03AC								
<i>Selective beta-2-adrenoceptor agonists</i>								
<i>Selektive beta-2-adrenoceptor agonister</i>								
1995	27.2	14.4	10.0	15.6	..	20.4	26.2	29.2
2000	25.0	18.3	16.7	15.3	14.1	20.6	24.9	22.7
2003	23.0	17.9	14.8	12.3	10.7	15.0	19.6	18.4
2004	22.5	17.6	14.7	11.4	10.5	13.7	18.4	17.4
2005	21.5	18.5	17.1	11.3	9.4	13.2	18.0	16.5
R03AK								
<i>Adrenergics and other drugs for obstructive airway diseases</i>								
<i>Adrenergika og andre midler ved obstruktive luftvejssygdomme</i>								
1995	2.2	..	..	0.8	..	0.0	..	0.0
2000	7.8	0.1	0.2	4.9	5.2	1.5	5.8	2.8
2003	11.4	0.3	0.3	13.4	14.2	13.1	15.2	8.2
2004	12.9	2.5	0.3	15.8	18.1	15.9	17.1	9.8
2005	14.4	3.2	0.5	17.1	19.3	18.0	18.6	10.9
R03B								
<i>Other drugs for obstructive airway diseases, inhalants</i>								
<i>Andre midler ved obstruktive luftvejssygdomme til inhalation</i>								
1995	19.6	8.3	5.8	20.7	..	18.6	23.6	29.1
2000	22.7	15.4	11.7	23.7	21.1	22.3	26.2	25.9
2003	21.8	16.2	11.0	19.4	18.6	13.9	20.5	21.6
2004	21.3	16.1	15.4	17.8	18.6	11.9	19.1	20.3
2005	19.9	15.8	18.0	17.2	16.4	11.3	18.5	19.6
R03C								
<i>Adrenergics for systemic use</i>								
<i>Adrenergika midler til systemisk brug</i>								
1995	5.2	1.6	..	0.9	..	0.6	2.1	2.5
2000	3.1	0.8	1.2	0.6	0.8	0.2	0.8	1.3
2003	2.1	0.7	0.6	0.4	0.5	0.1	0.6	0.9
2004	1.8	0.6	0.6	0.3	0.3	0.1	0.6	0.8
2005	1.5	0.6	0.9	0.3	0.4	0.1	0.5	0.7
R03D								
<i>Other systemic drugs for obstructive airway diseases</i>								
<i>Andre midler ved obstruktive luftvejssygdomme, til systemisk brug</i>								
1995	7.3	2.7	..	5.7	..	4.3	5.3	3.8
2000	5.3	1.3	2.0	5.5	6.8	3.6	4.4	3.7
2003	3.8	0.9	1.7	5.6	5.6	2.7	5.1	2.6
2004	3.4	0.6	1.7	5.6	5.4	2.5	5.0	2.7
2005	3.1	0.5	1.0	5.9	5.2	2.4	5.4	2.7

**Table 3.7.19 Sales of antihistamines for systemic use (ATC-group R06A),
DDD/1 000 inhabitants/day, 1995-2005**
Salg af antihistaminer til systemisk brug (ATC-gruppe R06A),
DDD/1 000 indbyggere/døgn 1995-2005

	Denmark	Faroe Islands	Greenland	Finland	Aland	Iceland	Norway	Sweden
1995	10.7	10.9	..	12.5	..	19.4	32.9	20.3
2000	14.1	13.8	2.8	21.0	21.9	24.9	39.3	25.5
2003	17.6	16.9	5.1	27.4	24.1	28.3	49.2	27.3
2004	19.0	20.9	6.4	27.5	25.1	29.5	51.3	29.3
2005	20.1	19.5	7.5	27.7	23.5	30.0	54.8	30.8

CHAPTER IV

Mortality and causes of death

Dødelighed og dødsårsager

Extra material

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

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

EUROSTAT:

www.eurostat.eu

Supplerende materiale

[Den forkortede europæiske dødsårsagsliste](#)

[Data fra den europæiske
forkortede dødsårsagsliste](#)

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 description 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 between 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 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 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.

Den internationale sygdomsklassifikation (ICD)

Den internationale sygdomsklassifikation (ICD), som udarbejdes af Verdenssundhedsorganisationen (WHO), har som sin vigtigste anvendelse at være instrument for statistiske beskrivelser af sygelighed og dødelighed. Det er et system som på meningsfuld måde grupperer sygdomme og dødsårsager, så der kan gives overskuelige statistiske opstillinger og analyser, som for eksempel sammenligninger mellem forskellige lande over en tidsperiode. ICD's historie er over 100 år, og klassifikationen er blevet revideret ca. hvert tiende år for at den kan afspejle den medicinske udvikling. Den seneste, tiende revision (ICD-10) blev godkendt af WHO i 1990, men blev først taget i brug i de fleste lande adskillige år senere. I de nordiske lande blev ICD-10 taget i brug til dødsårsagsregistrering i 1994 i Danmark, i Finland, Island og Norge i 1996, og i Sverige i 1997. Der foretages en fortløbende revision af ICD-10, via WHO's opdateringsprocedurer, og en revideret version af ICD-10 blev udgivet i 2004.

Revision af klassifikationen vanskeliggør statistiske sammenligninger over tid mellem lande, når de på samme tid anvender forskellige versioner af ICD. Det er derfor vigtigt at forsøge at forstå hvilke fejlkilder et klassifikationsskifte kan medføre for analysen af morbiditets- og mortalitetsstatistikken samt hvorledes problemet kan håndteres. Det seneste klassifikationsskifte har frem for alt medført en større detaljeringsgrad i ICD. Der er medtaget et stort antal nye diagnoser som følge af den medicinske udvikling. Samtidig er enkelte sygdomme og sygdomsgrupperinger flyttet til andre kapitler for at det bedre kan afspejle det medicinske vidensniveau.

Sources of error

Statistical analyses are carried out on aggregated data, for example at the level of the chapter. There are 21 chapters in ICD-10. The basic structure of ICD has generally remained the same through the revisions and most chapters have the same name. 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 for circulatory diseases in ICD-9 to the chapter for nervous system diseases in ICD-10. Certain symptoms have also been moved from the chapter for symptoms to the system 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. With reference 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 between countries.

It is commonly believed that a direct translation of codes in different versions of ICD can solve the problem of changes

Fejlkilder

Statistiske analyser foretages på et aggregeret niveau. Dette niveau kan være kapitelinndelingen i ICD-10, som i alt består af 21 kapitler. Grundstrukturen i ICD er dog i det store og hele blevet bevaret uforandret igennem de forskellige revisioner og de fleste kapitler har beholdt det samme navn. Det er imidlertid vigtigt at indse, at selvom et kapitel hedder det samme i ICD-10 som i ICD-9, kan der findes forskelle ved at diagnoser er flyttet fra et kapitel til et andet. Et eksempel i nogle lande er HIV og AIDS som præliminært blev placeret blandt immunsygdommene i ICD-9 men blev placeret under infektionssygdomme i ICD-10. Et andet eksempel er flytningen af cerebral transitorisk iskæmi fra cirkulationssystemets sygdomme i ICD-9 til nervesystemets sygdomme i ICD-10. Visse symptomer er også blevet flyttet mellem symptomkapitlet og de såkaldte organkapitler.

En anden fejlkilde er at visse regler og anvisninger for brugen af ICD er ændret i forbindelse med klassifikationsskiftet. Indenfor dødsårsagsstatistikken er for eksempel visse regler for valg af den underliggende dødsårsag blevet ændret, hvilket for eksempel kan påvirke frekvensen af pneumoni som dødsårsag. Ved siden af de internationale regelændringer kan de nationale tilpasninger ændres i forbindelse med et klassifikationsskifte, hvilket både påvirker sammenligningerne over tid i det samme land og sammenligninger mellem flere lande.

Det er ikke usædvanligt at tro, at en automatisk oversættelse af koderne i forskellige ICD versioner kan løse problemerne ved et

in classification. However, this is not so 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 both according to 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 between 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 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 give an indication of how much a certain group of diseases (e.g. the ICD chapter for circulatory diseases) has increased or decreased as a result of the change in classification itself. 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.

klassifikationsskifte. Dette er imidlertid ikke en nemt fremkommelig vej. Kun for en tredjedel af koderne i ICD-9 og ICD-10 er der en direkte og entydig oversættelse mellem koderne. I stedet for bør man stræbe efter, at de aggregerede grupper man anvender til statistiske sammenligninger konstrueres så det er muligt at eliminere nogle af de problemer, klassifikationsændringerne har skabt. De såkaldte kortlister som anvendes i denne publikation for mortalitet er defineret både i relation til ICD-9 og ICD-10 ud fra tanken om sammenlignelighed.

Klassifikationsskifte

Man må imidlertid altid være klar over at en observeret forskel over tid eller mellem lande kan være effekten af et klassifikations-skifte samt andre metodologiske problemstillinger. En måde hvorpå man kan kvantificere betydningen af et klassifikationsskifte er den såkaldte "bridge kodning". Dette indebærer at man koder samme materiale, så som dødsattester og sygehusjournaler, to gange, uafhængig af hinanden, først efter den tidligere klassifikation og derefter efter den nye. De forskelle som fremkommer når man siden hen sammenligner de statistiske grupperinger baseret på de to kodninger, giver en opfattelse af hvor meget en vis sygdomsgruppe (eksempelvis ICD-kapitlet om cirkulationsorganernes sygdomme) stiger eller falder som en direkte følge af klassifikationsskiftet. Denne type studier er dog ressourcekrævende og der er kun gennemført et fåtal begrænsede bridgekodningsstudier i forbindelse med overgangen fra ICD-9 til ICD-10.

Coding practice

Differences in the national coding practices is another factor of importance to the comparability of causes of death between countries. 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; 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 and the quality of that material (death certificates, etc.).

Kodningspraksis

Et andet forhold af stor betydning for sammenligneligheden af dødsårsagerne mellem flere lande, er den kodningspraksis, der er etableret i de enkelte lande. Det som vises i statistikken er den underliggende dødsårsag, hvor WHO har udarbejdet retningslinier for valget af den underliggende dødsårsag, hvilket vil sige den sygdom eller skade som starter rækken af sygelige tilstande der leder direkte til døden, eller ydre omstændigheder ved en ulykke eller voldshandling som var årsag til den dødelige skade. Det problematiske for sammenligneligheden er, at i nogle tilfælde, hvor der er opført to eller flere dødsårsager på dødsattesten, bliver valget af den underliggende dødsårsag forskellig fra land til land, fordi reglerne giver mulighed for forskellig fortolkning.

Udover at ICD's regler for mortalitetskodning giver plads for fortolkning kan der også være tale om udvikling af nationale traditioner for valget af den underliggende dødsårsag. Som eksempel kan nævnes brugen af diagnosegruppen "mangelfuldt definerede tilstande" (koderne I469, I959, I99; J960, J969; P285.0; R000-R948; R96-99). Anvendelsen af disse koder som underliggende dødsårsag er mere udbredt i Danmark end i de andre nordiske lande i situationer hvor der også er oplyst mere specifikke dødsårsager på dødsattesten. (Jfr. tabel 4.1.11).

Men der er også flere andre forhold der påvirker sammenligneligheden, blandt andet hvilken type af information statistikproducenten har tilgang til, herunder kvaliteten på dette materiale (dødsattester og andre oplysninger).

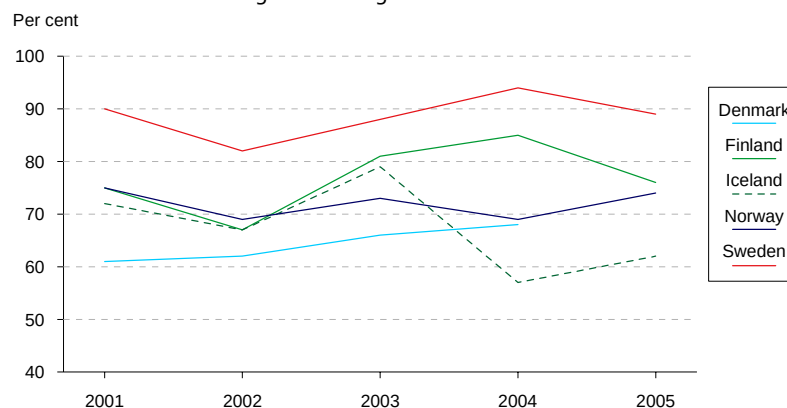
In order to support the choice of the underlying cause of death, the American programme, ACME (Automated Classification of Medical Entities) has been developed. This system is used in Sweden and the other Nordic countries are in the process of taking ACME into use. Denmark has used data from 2002, Iceland has used ACME for a few years to check manual coding, and Norway and Finland have used ACME with data for 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 between more countries.

For at støtte valget af den underliggende dødsårsag, er der udviklet et amerikansk program ACME (Automated Classification of Medical Entities). Blandt de nordiske lande anvendes systemet af Sverige mens de andre nordiske lande er på vej til at anvende ACME, Danmark med data fra 2002, Island har anvendt ACME til kontrol med manuel kodning i nogle år og Norge og Finland har anvendt ACME med data fra 2005. Indtil da anvendes edb-støttet kodning. Automatisk kodning giver ikke nødvendigvis et mere korrekt billede af dødsårsagsmønsteret end manuel kodning. Derimod vil automatisk kodning give en bedre stabilitet i kodningen og dermed bidrage til en bedre sammenlignelighed mellem flere lande.

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 (see Figure 4.1). When making comparisons, the ACME classification system is used as the standard.

Siden 2001 har det nordiske klassifikationscenter foretaget årlige sammenligninger af hvorledes landene klassificerer et udvalg af dødsårsager. Udvalget er relativt lille (200-250 dødsattester per år) men resultatet giver dog et fingerpeg af hvorledes sammenligningen er (jfr. Nedenstående figur). Ved sammenligningen er det den klassificering som ACME systemet giver, der anvendes som standard.

Figure 4.1 National coding compared to ACME 2001–2005
National kodning sammenlignet med ACME 2001–2005



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.

Kulturelle forskelle i rapporteringen af bestemte tilstande kan også påvirke sammenligneligheden. Hvis læger i et land er langt mere tilbageholdende med at anvende for eksempel selvmord på dødsattesten, end læger i andre lande, kan det vanskeliggøre sammenligneligheden. I flere af de nordiske lande findes der imidlertid rutiner for at kontakte lægen eller sygehuset i de tilfælde hvor de ydre årsager til skaden er uklar. Sådanne kvalitetssikringsrutiner er med til at kompensere for de manglende informationer på dødsattesten.

Autopsy rate

Another factor influencing the quality of the statistics on causes of death is the decreasing autopsy rate (in 2005 8 per cent in Denmark as the lowest and 32 per cent in Finland as the highest). The autopsy rate has 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.

Obduktioner

En yderligere faktor der spiller ind på dødsårsagsstatistikens kvalitet er de faldende rater for obduktion (i 2005 8 pct. i Danmark som det laveste og 32 pct. i Finland som det højeste). Anvendelsen af obduktion ved dødsfald er mere end halveret i de nordiske lande over de seneste årtier. Studier har vist, at i ca. 30 pct. af tilfældene med obduktion, har obduktionen medført at den underliggende dødsårsag er blevet ændret.

The reliability of the statistics Statistikkens pålidelighed

Considering the reservations in relation to the comparability of causes of death over time and between countries, the data presented here should be interpreted with caution. This is especially the case for 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 recoded 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 to the other Nordic countries, because there are only a few cases of insufficiently defined conditions.

Det er klart, at med de forbehold der er taget her over for sammenligneligheden af dødsårsagerne over tid og mellem landene, må de præsenterede data fortolkes med forsigtighed. Det vil især dreje sig om mindre diagnosegrupper i den europæiske forkortede liste, der anvendes i denne publikation. Når det drejer sig om de helt store grupper, hjerte-karsygdomme for sig og cancer for sig, tegner der sig dog et noget mere stabilt billede. Tilsvarende gælder også de alkohol og narkotikarelaterede dødsårsager hvor der er et velkendt uensartet mønster. For dødsfald ad AIDS skyldes de dramatiske fald ny livsforlængende medicin, hvor der til gengæld er en svag stigning af nye tilfælde i alle de nordiske lande. De større forekomster af cancer som underliggende dødsårsag i Danmark skyldes dog også til en vis grad kodningspraksis.

En anden forekomst er faldulykker der i langt højere grad kodes i Danmark end i Sverige og derfor er med til at gøre sammenligningen dødsårsagsstatistikken vedrørende ulykker ringe. Når det gælder alle ulykker er forekomsten størst i Finland.

For de mangelfuldt definerede tilstande er det især Finland og Island der adskiller sig fra de øvrige nordiske lande, fordi der kun er få tilfælde af mangelfulgt definerede tilstande.

MORTALITY AND CAUSES OF DEATH

Table 4.1.1 Deaths by sex and age per 100 000 inhabitants 1995–2005

Døde efter køn og alder pr. 100 000 indbyggere 1995–2005

Age	Alder	Total I alt		Under 1 year ¹⁾ Under 1 år ¹⁾		1–14 years 1–14 år		15–24 years 15–24 år		25–64 years 25–64 år		65+ years 65+ år	
Sex	Køn	M	W	M	W	M	W	M	W	M	W	M	W
<i>Denmark</i>													
	1995	1 212	1 203	557	452	25	17	79	33	506	338	7 114	5 724
	2000	1 069	1 099	607	456	17	12	79	30	444	294	6 368	5 455
	2004	1 030	1 038	459	410	17	14	62	27	451	276	5 934	5 177
	2005	1 001	1 030	509	359	14	9	58	19	425	275	5 761	5 131
<i>Faroe Islands</i>													
	1995	960	704	608	312	40	-	61	37	428	181	6 107	3 873
	2000	772	769	275	-	-	39	60	35	328	208	5 054	4 203
	2004	750	825	-	882	-	-	29	-	310	170	5 029	4 855
	2005	835	824	1 337	1 180	-	40	113	-	340	196	5 784	4 852
<i>Greenland</i>													
	1995	942	795	1 805	3 610	111	100	493	240	814	430	9 746	8 188
	2000	853	772	2 138	1 659	110	14	446	169	720	529	7 547	7 552
	2005	848	784	1 235	1 020	58	150	464	97	730	528	6 809	7 173
<i>Finland</i>													
	1995	977	955	431	355	21	16	93	26	530	218	6 263	4 752
	2000	952	954	424	324	14	14	96	34	504	222	5 545	4 606
	2004	934	894	408	256	20	17	88	35	507	225	4 948	4 123
	2005	934	888	333	286	18	13	69	29	517	229	4 838	4 045
<i>Åland</i>													
	1995	929	1 125	649	1 242	88	-	64	-	415	196	5 012	5 299
	2000	852	1 063	-	885	-	-	137	-	457	202	4 255	5 035
	2004	1 021	984	649	-	44	92	130	-	486	194	5 021	4 609
	2001–05	945	963	567	152	35	37	53	-	315	163	5 294	4 614
<i>Iceland</i>													
	1995	733	705	717	488	38	47	85	29	298	203	5 493	4 702
	2000	644	653	456	141	13	10	120	43	272	187	4 591	4 317
	2004	656	590	276	292	6	20	82	19	244	160	4 850	3 871
	2005	636	606	275	191	6	10	77	19	241	150	4 659	4 051
<i>Norway</i>													
	1995	1 068	1 006	491	314	22	16	86	30	361	200	6 393	4 858
	2000	974	985	427	329	18	15	93	33	339	201	6 052	4 965
	2004	880	917	343	313	15	16	81	32	314	195	5 530	4 747
	2005	877	906	329	283	18	11	73	31	307	198	5 533	4 846
<i>Sweden</i>													
	1995	1 091	1 038	470	357	15	11	52	26	347	208	5 942	4 631
	2000	1 041	1 065	399	281	15	12	59	24	305	200	5 829	4 854
	2004	988	1 029	286	272	12	12	27	13	297	192	5 466	4 747
	2005	996	1 026	215	206	17	13	48	21	298	195	5 420	4 725

1 Per 100 000 live births.

1 Pr. 100 000 levendefødte.

Source: The national central statistical bureaus

Kilde: De nationale centrale statistikbureauer

MORTALITY AND CAUSES OF DEATH

Table 4.1.2 Death rates from malignant neoplasms per 100 000 by age 1996-2005
Dødeligheden af ondartede svulster pr. 100 000 efter alder 1996-2005

		Denmark	Faroe Islands ¹⁾	Greenland	Finland	Åland ¹⁾	Iceland	Norway ²⁾	Sweden ²⁾
<i>Men Mænd</i>									
<i>Age Alder</i>									
0-14	1996-00	4	-	3	3	-	4	3	3
	2000	3	-	-	2	-	3	3	3
	2005	3	7	14	3	-	-	2	2
15-34	1996-00	9	6	9	7	6	8	7	7
	2000	9	-	11	6	32	7	7	8
	2005	6	3	12	6	13	-	5	6
35-44	1996-00	34	-	47	26	44	31	29	23
	2000	33	-	51	22	-	38	32	20
	2005	29	17	50	23	21	9	22	20
45-54	1996-00	148	39	136	107	170	100	120	97
	2000	145	32	230	105	196	102	127	91
	2005	121	107	267	97	63	84	96	79
55-64	1996-00	471	303	801	348	371	362	365	305
	2000	462	214	985	320	471	227	348	294
	2005	424	371	617	323	320	346	315	277
65-74	1996-00	1 216	903	1 525	953	1 001	970	1 007	861
	2000	1 189	312	1 525	902	204	900	953	826
	2005	1 071	874	1 715	752	1 124	844	924	825
75+	1996-00	2 405	2 258	3 942	2 062	2 081	2 216	2 215	1 947
	2000	2 440	1 043	3 113	1 947	1 830	1 888	2 142	1 935
	2005	2 454	1 834	3 313	1 808	2 598	2 083	2 222	1 966
<i>Women Kvinder</i>									
<i>Age Alder</i>									
0-14	1996-00	3	-	5	3	-	4	3	3
	2000	2	-	-	2	-	3	4	3
	2005	1	7	14	4	9	6	4	3
15-34	1996-00	9	11	12	6	6	9	7	7
	2000	9	-	13	7	-	2	6	9
	2005	7	11	14	6	7	5	7	7
35-44	1996-00	48	14	113	34	75	30	45	24
	2000	41	-	104	36	-	19	39	21
	2005	39	44	77	27	21	19	34	30
45-54	1996-00	175	113	312	108	184	124	141	99
	2000	164	36	109	106	340	113	126	94
	2005	149	84	177	99	128	108	115	111
55-64	1996-00	440	306	811	235	275	350	325	303
	2000	425	297	542	237	150	396	319	296
	2005	372	359	710	236	236	247	292	297
65-74	1996-00	895	698	1 355	511	531	727	605	743
	2000	905	589	1 427	505	557	775	600	719
	2005	828	800	1 695	457	401	648	591	578
75+	1996-00	1 433	997	2 302	1 071	1 198	1 348	1 149	1 211
	2000	1 460	685	2 600	1 077	1 362	1 285	1 184	1 210
	2005	1 492	1 224	2 863	1 004	1 049	1 045	1 188	1 149

1 2005=2001-2005.

2 2005=2004.

1 2005=2001-2005.

2 2005=2004.

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

Source- The national registers for causes of death

Kilde: De nationale dødsårsagsregistre

MORTALITY AND CAUSES OF DEATH

Table 4.1.3 Death rates from circulatory diseases per 100 000 by age 1996-2005
Dødeligheden af kredsløbssygdomme pr. 100 000 efter alder 1996-2005

		Denmark	Faroe Islands ¹⁾	Greenland	Finland	Åland ¹⁾	Iceland	Norway ²⁾	Sweden ²⁾
Men	Mænd								
Age	Alder								
0-34	1996-00	3	-	13	4	7	2	3	3
	2000	3	-	6	5	-	3	3	3
	2005	4	5	-	3	-	3	3	3
35-44	1996-00	22	6	50	50	11	23	27	25
	2000	23	-	51	44	-	38	25	21
	2005	21	34	33	39	21	14	23	21
45-54	1996-00	76	104	168	181	170	80	112	105
	2000	95	96	179	184	98	113	93	104
	2005	83	81	134	144	146	55	74	82
55-64	1996-00	274	367	491	529	445	329	343	341
	2000	326	299	473	481	538	209	282	303
	2005	233	332	274	403	160	254	228	255
65-74	1996-00	981	1 405	1 875	1 538	1 105	1 007	1 247	1 224
	2000	1 095	1 059	1 049	1 378	509	877	1 065	1 101
	2005	831	874	1 544	1 046	795	627	798	832
75+	1996-00	5 456	4 875	5 570	5 051	4 674	4 572	4 928	5 102
	2000	4 467	2 609	5 058	4 766	3 791	3 963	4 681	4 851
	2005	3 871	4 593	6 627	3 917	3 662	3 290	3 891	4 347
Women	Kvinder								
Age	Alder								
0-34	1996-00	2	9	8	2	-	1	2	2
	2000	2	18	7	3	-	1	2	1
	2005	2	4	7	2	4	4	2	1
35-44	1996-00	20	7	41	16	11	8	10	11
	2000	14	33	42	17	-	10	11	11
	2005	11	6	58	10	-	5	6	8
45-54	1996-00	68	23	91	42	31	28	33	34
	2000	41	-	109	48	-	24	36	34
	2005	39	21	266	37	10	15	24	29
55-64	1996-00	225	74	274	132	97	136	107	117
	2000	131	198	271	129	75	198	102	112
	2005	100	138	304	92	62	36	80	82
65-74	1996-00	770	309	1 412	624	402	427	525	522
	2000	561	118	1 427	551	464	419	471	469
	2005	409	436	1 427	404	310	340	348	385
75+	1996-00	3 348	3 700	5 965	4 196	3 944	3 752	3 954	4 157
	2000	3 722	2 284	8 038	4 090	3 584	3 421	3 794	4 059
	2005	3 211	3 550	2 863	3 463	3 955	2 885	3 467	3.743

1 2005=2001-2005.

2 2005=2004.

1 2005=2001-2005.

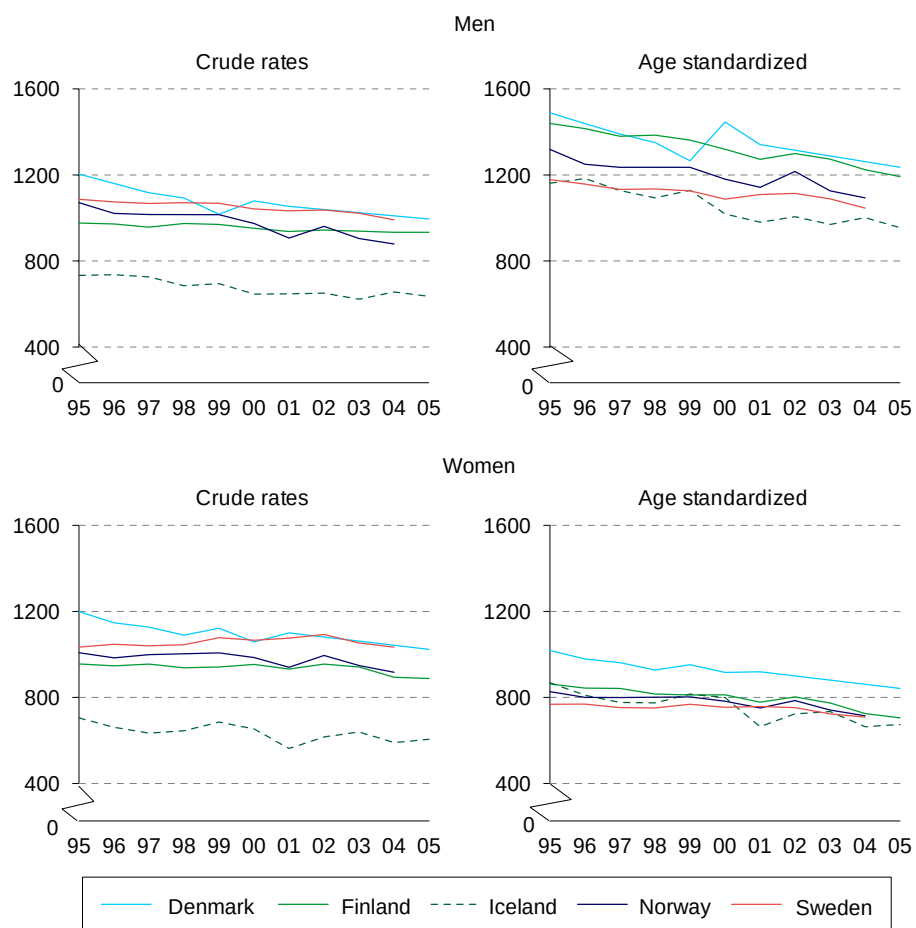
2 2005=2004.

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

Source: The national registers for causes of death

Kilde: De nationale dødsårsagsregistre

Figure 4.1.2 Deaths per 100 000 inhabitants by sex 1995-2005
 Døde pr. 100 000 indbyggere efter køn 1995-2005



Source: Table 4.4.1
 Kilde: Tabel 4.4.1

MORTALITY AND CAUSES OF DEATH

Figure 4.1.3 Deaths from malignant neoplasms per 100 000 inhabitants by sex 1999-2005

Døde som følge af ondartede svulster pr. 100 000 indbyggere efter køn 1999-2005

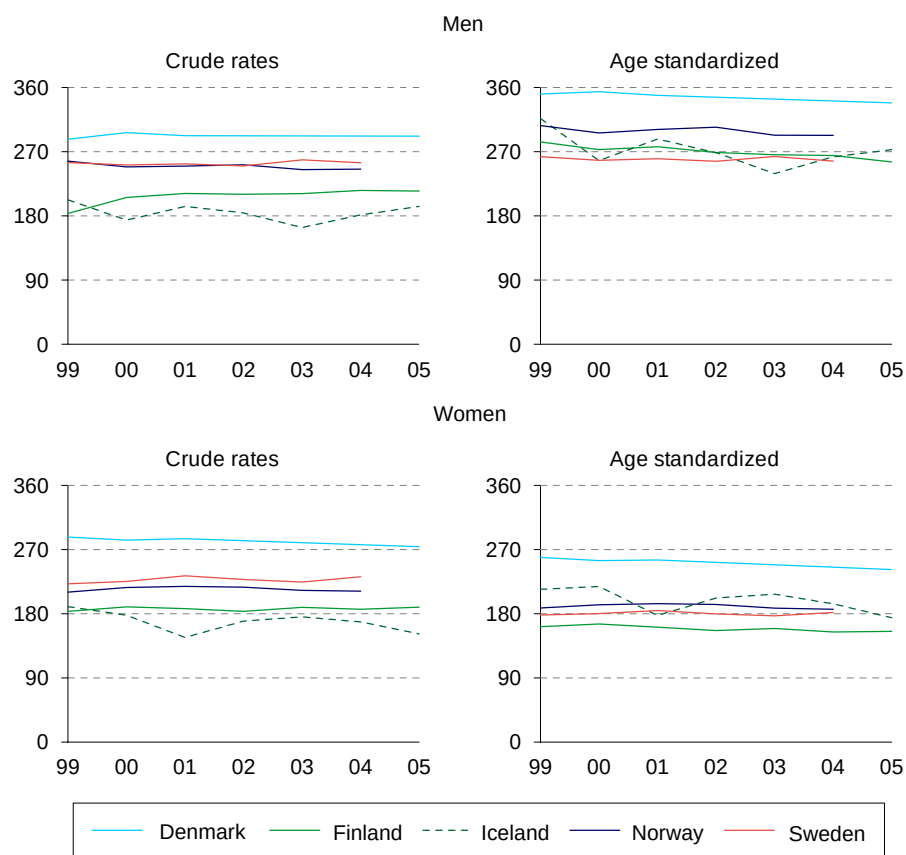
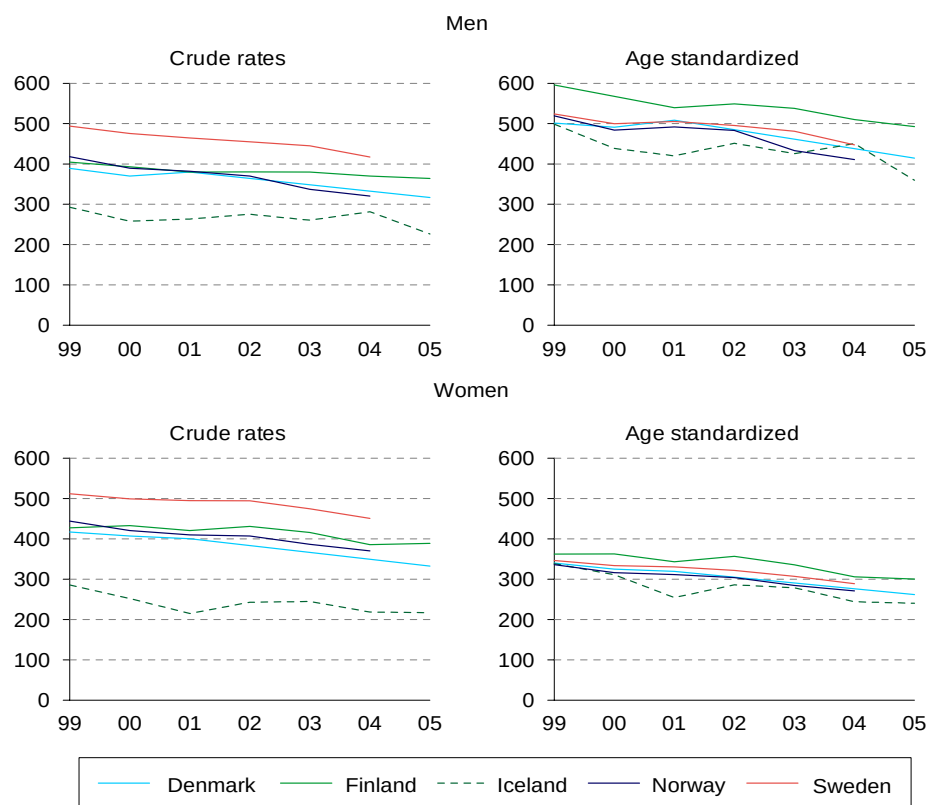


**Figure 4.1.4 Deaths from circulatory diseases per 100 000 inhabitants by sex
1999-2005**

Døde som følge af kredsløbsygdomme pr. 100 000 indbyggere efter køn 1999-2005



MORTALITY AND CAUSES OF DEATH

Table 4.1.4 Deaths from avoidable causes per 100 000 inhabitants
Undgåelige dødsfald pr. 100 000 indbyggere

ICD10 codes		Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
		2005	2001-05	2005	2005	2001-05	2005	2004	2004
	Age								
	Alder								
C15	0-74 Malignant neoplasm of the oesophagus								
	Kræft i spiserør	5.3	3.6	7.1	2.5	1.7	2.9	2.6	2.9
C32- C34	0-74 Malignant neoplasm of the trachea, bronchus and lung								
	Kræft i luftrør, bronkie og lunge	46.7	21.8	58.8	24.1	20.8	30.4	29.5	24.9
C53	0-74 Malignant neoplasm of cervix uteri ¹⁾								
	Kræft i livmoderhalsen ¹⁾	3.7	4.8	7.7	1.2	1.7	0.0	2.6	2.5
E10- E14	0-74 Diabetes mellitus								
	Sukkersyge	10.7	5.9	7.1	5.3	4.2	1.8	4.2	7.1
I60- I69	0-74 Cerebrovascular diseases								
	Sygdom i hjernen	21.1	20.4	53.5	23.1	10.0	8.9	16.1	17.7
J40- J44	0-74 Obstructive lung diseases								
	Rygerlunger	18.6	8.4	28.5	7.8	11.5	25.4	10.7	0.1
J45- J46	0-14 Asthma								
	Astma	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
K70; K73- K74	0-74 Chronic liver disease and cirrhosis								
	Kronisk leversygdom og skrumpelever	15.1	4.1	1.8	20.3	8.3	3.6	5.0	5.7

1 Per 100 000 women.

1 Pr. 100 000 kvinder.

Source: The national registers for causes of death

Kilde: De nationale dødsårsagsregistre

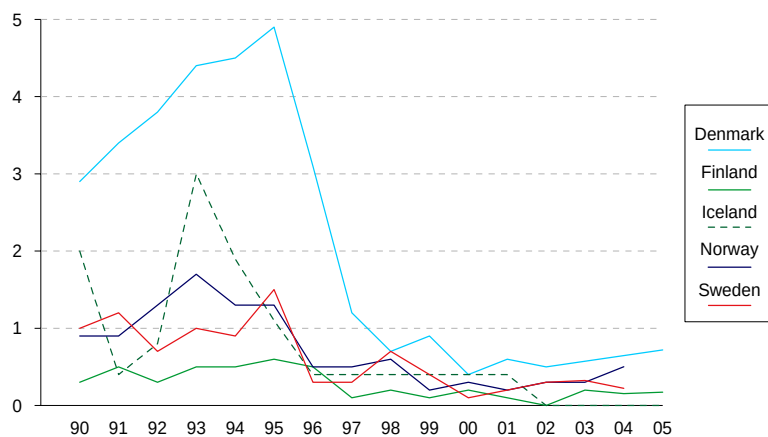
Table 4.1.5 Deaths from HIV/AIDS, in total and per 100 000 inhabitants 1996-2005
Dødsfald som følge af HIV/AIDS, i alt og pr. 100 000 indbyggere 1996-2005

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
<i>Number</i>								
Antal								
1996-00	63	-	4	12	-	1	25	39
2000	21	-	5	10	-	1	15	13
2004	..	-	..	8	-	-	23	20
2005	39	-	3	9	-	-	..	..
<i>Per 100 000 inhabitants</i>								
Pr. 100 000 indbyggere								
1996-00	1.0	-	7.1	0.2	-	0.3	0.6	0.4
2000	0.4	-	8.9	0.2	-	0.4	0.3	0.1
2004	..	-	..	0.2	-	-	0.5	0.2
2005	0.7	-	5.3	0.2	-	-	..	..

ICD-10: B20-B24

Sources: The national registers for causes of death
Kilder: De nationale dødsårsagsregistre

Figure 4.1.5 Deaths from HIV/AIDS per 100 000 inhabitants 1990-2005
Døde som følge af HIV/AIDS pr. 100 000 indbyggere 1990-2005



Source: Table 4.1.5
Kilde: Tabel 4.1.5

MORTALITY AND CAUSES OF DEATH

Table 4.1.6 Deaths from suicide per 100 000 inhabitants by sex and age 1995-2005
Selvmord pr. 100 000 indbyggere efter køn og alder 1995-2005

	Men					Women				
	Total I alt	10-19	20-24	25-64	65+	Total I alt	10-19	20-24	25-64	65+
Denmark										
1995	27.7	5.3	16.7	29.1	48.9	12.7	0.7	3.3	12.5	24.6
1999	23.3	4.4	16.0	23.8	41.8	8.3	2.5	1.2	8.2	15.0
2001	19.2	5.7	13.9	22.5	39.6	8.1	0.7	3.1	8.8	18.5
2005	16.9	3.3	8.8	18.9	41.8	6.3	0.6	3.5	6.8	14.2
Faroe Islands										
1996-00	5.2	11.3	-	6.8	-	2.8	-	-	5.9	-
2001-05	11.5	5.3	12.3	17.6	7.1	0.9	-	-	1.8	-
Greenland										
1996-00	171.6	199.4	427.1	146.8	68.1	53.7	41.7	47.5	47.4	34.0
2000-04	145.3	179.3	463.8	105.4	101.6	57.6	70.5	103.8	52.7	12.6
2005	89.1	61.3	438.2	86.9	-	86.3	62.4	370.6	79.6	121.6
Finland										
1995	43.4	13.1	48.9	58.5	53.3	11.8	1.9	13.5	16.7	17.5
2000	34.6	10.5	41.8	46.6	36.8	11.0	4.1	9.4	15.5	17.5
2004	31.7	10.0	47.7	39.1	42.3	9.4	4.1	11.7	12.7	8.3
2005	28.1	4.8	30.5	36.5	39.0	10.0	4.7	12.3	13.5	8.6
Åland										
1996-00	30.4	12.8	26.9	37.8	47.1	12.3	-	-	14.7	24.4
2001-05	23.2	11.9	27.9	33.5	10.9	4.5	-	-	2.8	15.9
Iceland										
1995	16.4	9.3	18.9	24.3	14.8	3.7	-	-	4.7	12.1
2000	29.8	22.9	73.4	38.1	13.6	5.7	-	9.4	8.6	5.6
2004	17.7	8.9	35.7	19.8	32.2	6.2	-	9.2	10.8	-
2005	16.2	8.7	9.2	27.2	-	6.1	-	-	12.0	-
Norway										
1995	19.1	12.9	24.6	22.4	28.8	6.2	3.9	5.1	8.1	7.4
2000	18.4	11.3	29.9	22.5	22.6	5.8	3.0	4.4	7.9	6.3
2003	16.6	9.0	25.8	20.9	18.8	5.6	3.9	6.7	7.3	5.4
2004	15.8	6.9	24.7	18.6	16.9	7.3	4.3	7.2	9.8	5.4
Sweden										
1995	21.5	5.8	16.2	27.4	35.1	9.3	2.0	6.6	11.5	14.2
2000	18.3	4.0	15.9	21.2	36.0	7.3	3.2	3.9	9.2	10.1
2003	17.5	3.7	14.8	21.5	29.8	7.4	2.5	9.0	9.2	9.2
2004	18.7	5.1	23.3	22.1	30.9	7.1	3.5	6.3	8.6	9.3

Source: The national registers for causes of death
Kilde: De nationale dødsårsagsregistre
G: Chief Medical Officer

ICD-9: E950-E959 and ICD-10: X60-X84

Table 4.1.7 Deaths from accidents per 100 000 inhabitants by sex and age 1995–2005Dødsfald som følge af ulykker pr. 100 000 indbyggere efter køn og alder
1995–2005

	Men						Women					
	Total I alt	0–14	15–24	25–64	65–79	80+	Total I alt	0–14	15–24	25–64	65–79	80+
Denmark												
1995	51.2	7.3	42.7	33.2	102.6	578.0	43.3	3.4	8.5	12.8	42.0	327.9
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
2001	42.9	4.9	32.2	32.0	76.8	467.6	34.8	2.3	8.1	9.6	54.4	414.6
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
Faroe Islands												
1997–01	44.0	7.4	72.1	29.1	64.4	479.4	25.8	7.7	7.2	3.9	88.4	257.7
2001–05	36.8	7.0	70.4	27.2	63.2	225.8	19.4	3.7	6.9	11.0	33.1	191.0
Greenland												
1996–00	94.3	51.3	71.9	105.2	..	..	29.9	13.2	35.6	27.7	..	..
2000	86.6	39.1	0.0	87.0	659.0	-	45.8	26.7	84.2	44.1	-	510.2
2005	82.5	55.1	46.4	75.3	356.1	1 063.8	52.5	28.3	24.3	79.6	-	-
Finland												
1995	72.6	7.0	33.2	81.7	155.6	386.6	32.0	3.6	7.4	16.3	33.9	235.5
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
2004	75.9	9.4	33.1	78.7	155.4	429.4	39.9	7.3	11.6	24.8	60.6	302.8
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
Åland												
1996–00	59.6	4.1	19.2	62.1	..	..	21.0	-	7.0	10.5	..	..
2001–05	43.2	24.6	13.2	44.7	56.7	186.3	16.5	8.6	-	5.6	12.4	156.8
Iceland												
1995	51.5	26.9	47.0	56.3	74.0	186.1	35.2	34.6	14.6	31.1	65.4	115.5
2000	38.4	3.0	46.0	36.7	76.6	274.6	12.8	-	23.7	10.1	30.2	21.5
2004	25.9	-	36.4	19.8	91.6	114.5	11.0	12.4	-	5.4	29.8	74.5
2005	25.6	-	36.2	14.2	82.1	253.0	17.6	-	4.7	13.3	44.5	163.9
Norway												
1995	44.7	7.3	38.3	30.9	82.1	478.5	31.8	3.6	9.7	7.9	48.0	368.0
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
2003	48.4	4.9	34.9	40.4	86.6	417.9	33.1	3.2	9.0	12.3	37.3	349.2
2004	49.9	6.2	42.1	42.5	80.5	403.9	34.5	4.7	12.4	17.4	38.8	311.6
Sweden												
1995	33.0	4.8	21.0	24.3	58.5	295.0	22.2	3.4	6.0	6.7	16.1	143.9
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
2003	39.1	4.0	22.3	27.8	66.2	347.0	26.7	1.5	7.9	7.2	28.5	270.4
2004	44.5	9.8	26.8	32.0	68.3	371.2	31.0	8.1	9.3	14.0	35.8	247.4

Source: The national registers for causes of death

ICD-9: E800–E929 and ICD-10: V01–X59.

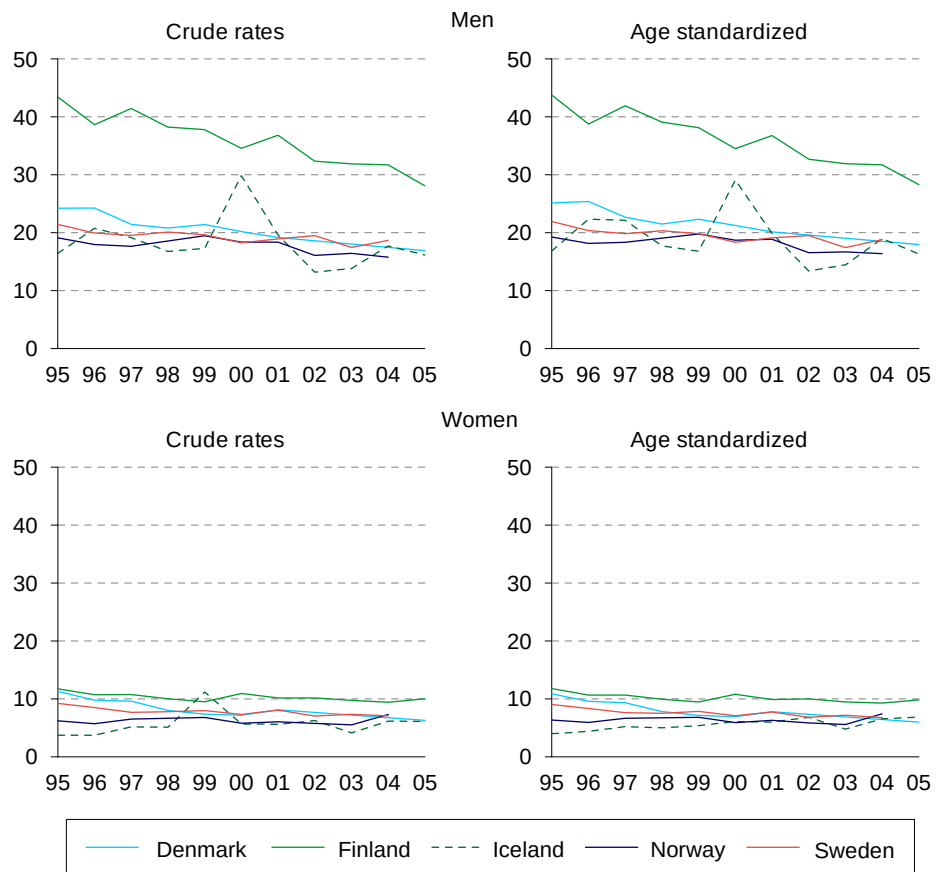
Kilde: De nationale dødsårsagsregistre

G: Chief Medical Officer

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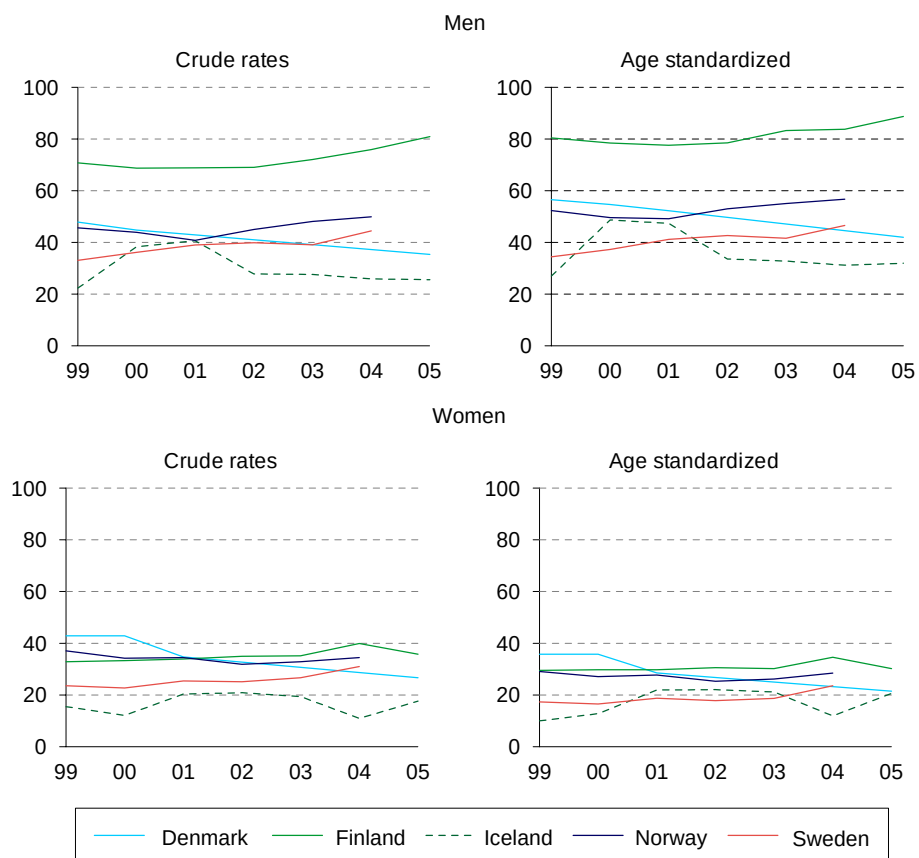
Figure 4.1.6 Deaths from suicide per 100 000 inhabitants by sex 1995-2005

Døde som følge af selvmord pr. 100 000 indbyggere efter køn 1995-2005



Source: Table 4.1.6
Kilde: Tabel 4.1.6

Figure 4.1.7 Deaths from accidents per 100 000 inhabitants by sex 1999–2005
Døde som følge af ulykker pr. 100 000 indbyggere efter køn 1999–2005



Source: Table 4.1.7
Kilde: Tabel 4.1.7

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Table 4.1.8 Deaths from land transport accidents per 100 000 inhabitants by sex and age

Dødsfald i landtransportulykker pr. 100 000 indbyggere efter køn og alder

	<i>Men</i>					<i>Women</i>				
		<i>Mænd</i>					<i>Kvinder</i>			
	<i>Total I alt</i>	0-14	15-24	25-64	65+	<i>Total I alt</i>	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
Faroe Islands										
1997-01	12.1	3.7	66.1	1.7	7.4	6.5	3.8	7.2	3.9	17.5
2001-05	10.6	3.5	58.7	3.2	-	2.6	3.7	-	3.7	-
Finland										
2000	11.3	2.3	13.3	11.4	24.0	5.1	2.2	5.6	4.1	10.7
2004	11.2	1.9	20.4	9.7	21.5	5.0	1.3	7.9	3.6	10.5
2005	12.3	4.1	14.7	11.9	22.8	3.7	1.3	4.4	3.2	6.8
Åland										
1996-00	9.8	-	12.3	9.0	24.6	3.1	-	-	-	16.2
2001-05	13.9	8.2	13.2	19.5	0.0	3.0	0.0	0.0	2.8	8.0
Iceland										
2000	16.3	0.0	32.2	16.9	27.3	7.1	0.0	19.0	5.8	11.2
2004	11.6	0.0	27.3	9.2	25.8	4.8	9.3	0.0	1.4	16.0
2005	9.4	0.0	31.7	6.5	12.7	4.1	0.0	4.7	5.3	5.3
Norway										
2000	12.5	2.6	26.4	12.2	16.3	4.6	2.5	7.9	3.4	8.3
2003	11.9	3.2	19.6	11.9	18.8	3.7	1.8	4.5	3.0	7.1
2004	11.7	2.9	20.9	10.8	14.6	3.6	2.1	5.2	2.9	5.6
Sweden										
2003	8.6	1.5	15.1	8.8	11.8	2.9	0.9	6.2	2.3	4.1
2004	8.3	1.8	14.6	7.4	14.6	2.7	0.3	3.8	2.0	6.0

Source: The national registers for causes of death

ICD9: E800-E829; ICD-10: V01-V89

Kilde: De nationale dødsårsagsregistre

G: Chief Medical Officer

Table 4.1.9 Deaths from alcohol-related causes per 100 000 inhabitants

Alkoholrelaterede dødsårsager per 100 000 indbyggere

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
Year	2005	2001-05	2005	2005	2001-05	2005	2004	2004
<i>Men</i>								
Mænd								
0-34	1.3	-	-	3.3	-	-	0.8	0.1
35-44	22.9	16.6	33.0	48.9	31.7	4.7	4.3	4.3
45-64	107.4	54.7	67.5	144.4	48.4	14.9	36.2	19.3
65-74	103.1	72.0	171.5	101.0	75.3	11.3	47.5	23.8
75+	47.0	-	301.2	44.2	24.4	14.6	37.0	8.7
Total	43.5	20.2	33.0	60.0	26.0	5.4	15.5	8.3
<i>Women</i>								
Kvinder								
0-34	0.6	-	-	0.6	-	-	0.2	0.1
35-44	7.5	-	19.2	11.0	-	9.5	2.7	1.1
45-64	34.9	3.9	37.4	41.1	21.5	6.1	7.9	7.6
65-74	34.6	12.2	178.4	30.0	35.9	31.8	14.0	7.3
75+	11.0	-	190.8	3.2	14.2	-	4.5	1.6
Total	14.3	1.7	22.5	16.1	10.4	4.8	3.8	3.0
<i>M+W</i>								
M+K								
0-34	1.0	-	-	2.0	-	-	0.5	0.1
35-44	15.3	8.8	26.7	30.3	15.7	7.1	3.5	2.8
45-64	71.3	30.9	54.8	92.7	34.9	10.6	22.2	13.5
65-74	67.0	42.4	174.9	62.1	55.1	21.9	29.7	15.2
75+	24.5	-	233.6	16.8	17.9	6.1	16.7	4.4
Total	28.8	11.3	28.1	37.6	18.1	5.1	9.6	5.6

Source: The national registers for causes of death

Kilde: De nationale dødsårsagsregistre

ICD-10: E244, F10, G312, G621, G721, I426, K292, K700-709, K860, Q354, P043, Q860, Y15, X45

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Table 4.1.10 Deaths from drug-related causes per 100 000 inhabitants
Misbrugsrelaterede dødsfald per 100 000 indbyggere

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
Year	2005	2001-05	2005	2005	2001-05	2005	2004	2004
<i>Men</i>								
Mænd								
0-34	8.0	6.4	26.0	2.0	-	5.2	9.0	5.9
35-44	21.2	-	-	3.7	-	9.4	21.3	13.5
45-64	17.0	10.3	-	2.3	-	3.0	7.0	17.1
65-74	7.8	12.0	-	2.0	-	11.3	1.3	10.1
75+	9.8	16.5	-	-	-	-	-	6.8
Total	12.5	7.3	13.2	2.2	-	5.4	9.4	10.3
<i>Women</i>								
Kvinder								
0-34	1.7	1.8	13.8	0.4	-	0.0	2.6	2.1
35-44	9.2	6.2	-	1.1	-	4.7	8.4	6.5
45-64	11.2	-	18.7	0.8	-	33.7	3.9	9.7
65-74	9.6	-	89.2	0.8	-	31.8	0.6	7.6
75+	8.4	-	-	-	-	-	-	5.3
Total	6.5	1.7	15.0	0.6	-	10.2	3.4	5.5
<i>M+W</i>								
M+K								
0-34	4.9	4.2	20.1	1.2	-	2.7	5.9	4.0
35-44	15.3	2.9	-	2.4	-	7.1	15.0	10.0
45-64	14.1	5.5	7.8	1.6	-	18.1	5.5	13.4
65-74	8.8	6.1	43.7	1.3	-	21.9	0.9	8.8
75+	9.0	6.5	-	-	-	-	-	5.9
Total	9.5	4.6	14.0	1.4	-	7.8	6.3	7.9

Source: The national registers for causes of death
Kilde: De nationale dødsårsagsregistre

ICD-10: 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 certificate per 100 000 inhabitants

Dødsfald af personer med dødsattester der har mangelfuldt definerede tilstande per 100 000 indbyggere

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
Year	2005	2001-05	2005	2005	2001-05	2005	2004	2004
<i>Men Mænd</i>								
0-44	0.2	1.2	-	0.1	-	1.0	0.1	1.9
45-64	6.1	-	27.0	-	-	5.8	3.5	13.1
65-74	33.7	12.0	-	-	-	11.4	8.6	35.6
75+	197.1	131.8	903.6	0.8	122.8	28.7	104.3	201.6
Total	14.8	8.1	16.5	0.1	7.7	4.0	7.6	21.5
<i>No death certificate, number</i>								
Uden dødsattest, antal	257	0.6	..	76	2	..	301	250
<i>Women Kvinder</i>								
0-44	0.1	1.4	-	-	-	-	0.1	1.1
45-64	2.4	-	-	-	-	-	0.7	5.3
65-74	14.0	-	89.2	-	-	-	5.3	17.0
75+	296.8	227.2	954.2	3.2	141.1	41.8	192.4	317.5
Total	27.5	19.2	22.5	0.3	15.0	2.7	19.0	37.5
<i>No death certificate, number</i>								
Uden dødsattest, antal	295	1	..	42	4	..	234	221
<i>M+WM+K</i>								
0-44	0.1	1.3	-	-	-	0.5	0.1	1.5
45-64	4.2	-	15.7	-	-	3.0	2.1	9.3
65-74	23.3	6.1	43.7	-	-	5.5	6.8	25.8
75+	259.3	189.7	934.6	2.4	134.7	36.3	159.4	272.5
Total	21.3	13.4	19.3	0.2	11.4	3.4	13.3	29.6
<i>No death certificate, number</i>								
Uden dødsattest, antal	552	1.6	..	118	6	..	535	471

Source: The national registers for causes of death

Kilde: De nationale dødsårsagsregistre

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

Table 4.1.12 Autopsy rates as a percentage of all deaths 1995-2005

Obduktionsrater i procent af alle døde 1995-2005

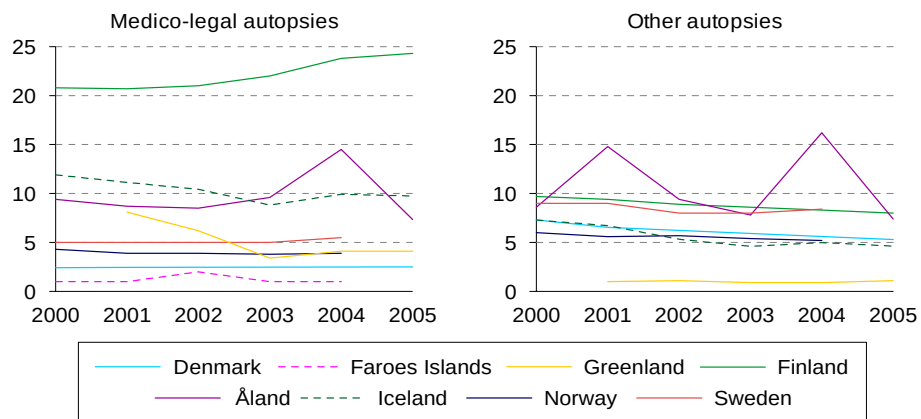
	Denmark	Faroe Islands	Finland	Åland	Iceland	Norway	Sweden
<i>Medico- legal autopsies</i>							
Retsmedicinske obduktioner							
1995	2	2	19	10	..	..	5
2000	2	1	21	9	12	4	5
2003	..	1	22	10	9	4	5
2004	..	1	24	15	10	4	6
2005	3	1	24	7	10	..	..
<i>Other autopsies</i>							
Andre obduktioner							
1995	10	..	12	9	..	..	13
2000	7	..	10	9	7	6	9
2003	..	..	9	8	5	5	8
2004	..	..	8	16	5	5	8
2005	5	..	8	7	5	..	..

Source: The national registers for causes of death

Kilde: De nationale dødsårsagsregistre

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Figure 4.1.8 Autopsy rates as a percentage of all deaths 2000-2005
Obduktionsrater i pct. af alle døde 2000-2005



CHAPTER V

Resources

Ressourcer

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Extra material	Supplerende materiale	
OECD:		
www.oecd.org		

Introduction

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

Indledning

I dette kapitel gives der en samlet belysning af ressourcer og ressourceforbruget inden for sundhedsvæsenet. Først omtales de samlede sundhedsudgifter, med særlig omtale af udgifter til medicin, efterfulgt af sundhedspersonalet, kapacitet og ydelser i sygehusvæsenet.

5.1. Health care expenditure 5.1. Sundhedsudgifter

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 OECD, the reason for this concern is that health services are mainly publicly financed. Thus 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 health care expenditure is publicly financed. In 2004, the level of public financing was lowest in Finland with 75 per cent, while the proportion in the other Nordic countries was over 80 per cent.

Udviklingen i sundhedsudgifterne

Sundhed angår folks hverdag og har en central placering i folks bevidsthed. Dermed bliver temaet til genstand for debat og sundhedsspørgsmål får en mere dominerende plads i pressen. Der sættes især fokus på det stigende pres på forbruget af sundhedsydelser. Der stilles spørgsmål om sundhedsvæsenet er tilstrækkelig og i forlængelse af dette stilles der spørgsmål om hvad sundhedsvæsenet koster det offentlige og den enkelte. Stigende sundhedsudgifter er årsag til bekymring i mange lande. I følge OECD er årsagen til dette at det offentlige finansierer største delen af udgifterne. Stigende sundhedsudgifter bliver derved en ekstra byrde på de offentlige budgetter og vil, hvis der ikke foretages en omprioritering i budgetterne, medføre at skattetrykket for både borgere og virksomheder stiger.

I de nordiske lande finansierer det offentlige mellem 75 og 85 procent af sundhedsudgifterne. I 2004 var det offentliges andel lavest i Finland med 75 procent mens andelen i de andre nordiske lande var godt og vel 80 procent.

Measured in relation to gross domestic product (GDP), health care expenditure has been relatively stable or has shown a slight increase during the second half of the 1990s and the beginning of this century. Health care expenditure represents between 7 and 10 per cent of GDP.

Målt i forhold til bruttonationalproduktet (BNP) har sundhedsudgifterne været relativt stabile eller svagt stigende i den sidste halvdel af 1990'erne og i begyndelsen af det nye årtusind. Sundhedsudgifternes andel af BNP er mellem ca. 7 og 10 procent.

Table 5.1.3 shows health care expenditure per inhabitant, which was highest in Norway and lowest in the Faroe Islands.

Tabel 5.1.3. viser sundhedsudgifterne per indbygger, som var højest i Norge og lavest på Færøerne.

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. Expenditure can be financed both privately and publicly, including by households. Examples of health care expenditure by households are the cost of spectacles, orthopaedic items, medicinal products, dental treatment, medical treatment, physiotherapy services and other health services. Other types of expenditure include national insurance or private insurance reimbursements for use of health services, and public expenditure (net) on hospitals and primary health services.

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 expendi-

Ændring af opgørelsesmetoden for sundhedsudgifterne

Udgifterne til sundhedsformål omfatter alle udgifter, både private og offentlige, der går til forbrug eller investeringer i sundhedsvæsenet m.v. Udgifterne kan finansieres både af offentlige og private kilder, inklusiv husholdningerne. Som sundhedsudgifter regnes eksempelvis husholdningernes køb af briller og ortopædisk udstyr, lægemidler, tandbehandling, lægebehandling, forbrug af fysioterapi og andre sundhedsydelser, samt det offentliges, eller forsikringernes refusion for brugen af sundhedsydelserne samt det offentliges udgifter (netto) til drift af sygehuse og det primære sundhedsvæsen m.v.

Det offentliges udgifter til forbyggende foranstaltninger samt administration af sundhedsvæsenet er ligeledes inkluderet. Det samme gælder udgifter til drift af private sygehuse m.v. som ligger udenfor de offentlige budgetter.

Sundhedsudgifterne omfatter også dele af udgifterne til pleje og omsorg for ældre og funktionshæmmede. Ifølge internationale retningslinier gælder dette den del af pleje og omsorgsudgifterne der kan specificeres

RESOURCES

ture 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 a clear demarcation 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 demarcations.

In order to ensure the best possible comparability of statistics, international organizations such as OECD, UN and EUROSTAT work on producing classifications, standards and definitions. For example, OECD have 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

som udgifter til sundhedsformål. Ydelserne til ældre og funktionshæmmede er ofte integrerede og det kan være vanskeligt at sætte klare grænser for hvad der skal defineres som sundhedsudgifter og hvad der er udgifter til social omsorg. Dette kan være en kilde til forskellig afgrænsning af hvad der medtages som sundhedsudgifter i de enkelte lande.

Der vil altid komme sådanne problemer når man sammenligner statistik for flere lande. Dette betyder dog ikke at sammenligningen er værdiløs, men man må tage hensyn til nogle af de forskelle der observeres der kan skyldes forskellige definitioner og afgrænsninger.

For at sikre den bedst mulige sammenlignelighed, arbejder internationale organisationer som OECD, FN og EUROSTAT med at etablere klassifikationer, standarder og definitioner. OECD har blandt andet udviklet et system for sundhedsregnskab ("A System of Health Accounts") Regnskabssystemet er udviklet for at møde politiske behov for data såvel behovet hos forskere på området. Den fælles ramme som systemet er bygget op på, vil sikre den bedst mulige sammenlignelighed af data mellem lande over tid. Systemet er også udviklet således at det giver sammenlignelige tal uafhængig af hvorledes sundhedsvæsenet er organiseret i landene.

Alle de nordiske lande har eller er i færd med at indføre OECD's system for sundhedsregnskab, og tallene i denne publikation baserer sig på dette system. Alle landene er ikke kommet lige langt i implementeringen af systemet, men på det ag-

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 demarcation of what is included as health care expenditure on care of the elderly may be different from in the other countries. At the same time, Table 5.1.3 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 NOSOSKO 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.

gregerede niveau som data præsenteres her, vurderes de at være sammenlignelige. Man må alligevel tage forbehold over for de vanskeligheder der står tilbage, og som landene måske har løst forskelligt. Der er blandt grund til at stille spørgsmålstegn ved om der er forskellige afgrænsninger af ældreområdet der gør at Finland har sundhedsudgifter per indbygger der rundt regnet er 30 pct. lavere end gennemsnittet i de andre nordiske lande. Samtidig ser man i tabel 5.1.3 at Norge har udgifter per indbygger som ligger væsentlig højere end i de andre lande. Det er vigtigt at være klar over at OECD's sundhedsregnskabssystem og dermed data om sundhedsudgifter adskiller sig væsentlig fra sundhedsudgifter der publiceres af EUROSTAT efter ESSPROS - systemet og som også publiceres af NOSOSKO i publikationen *Social tryghed i de nordiske lande*.

ESSPROS omfatter alle sociale ordninger, enten de drives af offentlige eller private. Statistikken omfatter også pensionskasser og fonde, forsikringer, humanitære organisationer og andre velgørende organisationer. Forsikringsordningerne er medtaget hvis de er kollektive. Det betyder at udgifter til sygdom også vil omfatte sygedagpenge (sygedagpenge eller løn under sygdom) herunder sygedagpenge betalt af arbejdsgiveren. Dette er kontantydelse som ikke medregnes som sundhedsudgifter i OECD's system, hvor det kun er udgifterne til den sundhedsmæssige service der er medtaget.

Developments in expenditure on medicinal products

Table 5.1.4 shows the total sales of medicinal products according to ATC group for each of the Nordic countries 2005. In order to have a better basis for comparison, expenditure in Table 5.1.5 is presented in EUR per capita.

The medicinal products for which expenditure is high are largely the same in all the Nordic countries.

It is difficult to compare expenditure on medicinal products in the hospital sector between countries, since hospitals pay very different prices for the same medicines, and prices are very different from prices in pharmacies in the primary health sector.

Measured in EUR per capita, expenditure on medicinal products is considerably higher in Iceland than in the other countries. The greatest difference in expenditure on medicinal products is for ATC group N. User charges are highest in Iceland followed by Finland and Norway.

Udvikling i lægemiddeludgifter

I tabel 5.1.4 ses de samlede udgifter til lægemidler i de enkelte nordiske lande fordelt på ATC-hovedgrupper 2005. For at få et bedre sammenligningsgrundlag er udgifterne i tabel 5.1.5 omregnet til EUR per capita.

I alle landene er det i stor udstrækning de samme lægemidler, som vejer tungt i udgifterne.

Det er dog generelt set svært at sammenligne udgifterne i denne sektor mellem landene, da sygehusene erhverver sig lægemidler til vidt forskellige priser og til helt andre priser end apotekerne i den primære sektor.

Målt i EUR per capita har Island betydeligt større udgifter til lægemidler og Grønland det mindste i forhold til de øvrige lande hvor den mest markante forskel for Islands vedkommende findes i udgifterne til gruppe N. Egenbetalingen er højest i Island efterfulgt af Finland og Norge.

Table 5.1.1 Health care expenditure (million KR/EUR) 2005
 Udgifter til sundheds- og sygepleje (mio. KR/EUR) 2005

	Denmark ¹⁾	Faroe Islands ²⁾	Greenland	Finland ³⁾	Iceland	Norway	Sweden ¹⁾
	DKK	DKK	DKK	EUR	ISK	NOK	SEK
<i>Public financing</i>							
Offentlig finansiering	104 678	734	897	9 217	79 497	147 123	198 274
<i>Private financing</i>							
Privat finansiering	20 302	90	4	26 36	16 827	28 908	35 176
<i>Total health care expenditure</i>							
Samlede udgifter til sundheds- og sygepleje	124 980	824	901	11 854	96 325	176 031	233 450

1 Preliminary estimates for 2004.

2 2003.

3 Finnish figures include Åland.

1 Foreløbige tal for 2004.

2 2003.

3 Finske tal inkluderer Åland.

Source: OECD HEALTH DATA 2006

Kilde: FI: Statistics Faroe Islands; G: Directorate of Health

Table 5.1.2 Health care expenditure (EUR/capita) 2005
 Udgifter til sundheds- og sygepleje (EUR/capita) 2005

	Denmark ¹⁾	Faroe Islands ²⁾	Greenland	Finland ³⁾	Iceland	Norway	Sweden ¹⁾
<i>Public financing</i>							
Offentlig finansiering	2 605	2 057	2 115	1 757	3 439	3 929	2 416
<i>Private financing</i>							
Privat finansiering	505	252	9	502	728	772	429
<i>Total health care expenditure</i>							
Samlede udgifter til sundheds- og sygepleje	3 110	2 309	2 125	2 260	4 166	4 701	2 845

1 Preliminary estimates for 2004.

2 2003.

3 Finnish figures include Åland.

1 Foreløbige tal for 2004.

2 2003.

3 Finske tal inkluderer Åland.

Source: OECD HEALTH DATA 2006

Kilde: FI: Statistics Faroe Islands; G: Directorate of Health

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Table 5.1.3 GDP and health care expenditure in total and per capita 1995–2005

BNP og udgifter til sundheds- og sygepleje i alt og pr. indbygger 1995–2005

	Denmark ¹⁾⁴⁾	Faroe Islands ²⁾	Greenland	Finland ³⁾	Iceland	Norway ¹⁾⁴⁾	Sweden ¹⁾
	DKK	DKK	DKK	EUR	ISK	NOK	SEK
<i>Total expenditure per capita 2005</i>							
Samlede udgifter pr. indbygger 2005	24 232	17 818	15 835	2 260	268 696	36 638	25 956
<i>GDP (million) 2005</i>							
BNP (mio.) 2005	1 467 311	9 764	10 210	157 377	1 021 510	1 743 041	2 573 176
<i>Expenditure in 2005-prices (million)</i>							
Udgifter i 2005-priser (mio.)							
1995	99 829	683	1010	9 354	53 656	.	162 732
2000	116 880	635	965	10 052	76 866	124 728	197 720
2004	130 877	..	915	11 547	94 303	159 572	233 450
2005	..	..	897	11 854	96 325	168 237	..
<i>Expenditure as a percentage of GDP</i>							
Udgifter i pct. af BNP							
1995	8.2	7.0	9.9	5.9	5.3	.	8.1
2000	8.4	8.5	9.5	6.4	7.5	7.2	8.4
2004	8.9	..	9.0	7.3	9.2	9.2	9.1
2005	..	..	8.8	7.5	9.4	9.7	..

1 Preliminary estimates for 2004.

2 Expenditures 2003 in 2004 prices.

3 Finnish figures include Åland.

4 Changes in method of calculation from 2003 for Denmark and from 2000 for Norway.

1 Foreløbige tal for 2004.

2 Udgifter 2003 i 2004 priser.

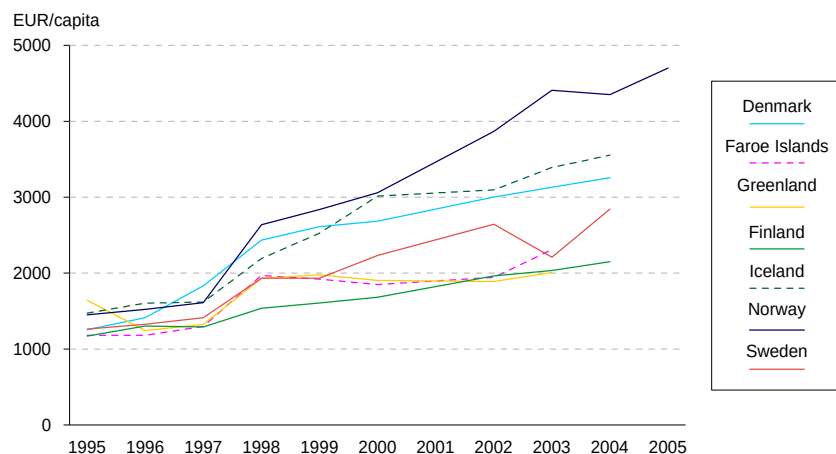
3 Finske tal inkluderer Åland.

4 Ændringer i opgørelsesmetode fra 2003 for Danmark og for Norge fra 2000.

Source: OECD HEALTH DATA 2006

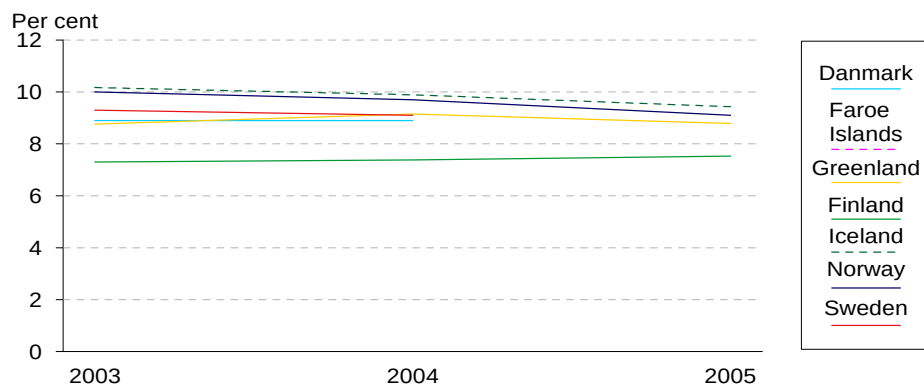
Kilde: FO: Statistics Faroe Islands; G: Directorate of Health

Figure 5.1.1 Total health care expenditure (EUR/capita) 1995 -2005
 Samlede udgifter til sundheds- og sygepleje (EUR/capita) 1995 -2005



Sources: Table 5.1.3
 Kilder: Tabel 5.1.3

Figure 5.1.2 Health care expenditure as a percentage of GDP 1995-2005
 Udgifter til sundheds- og sygepleje i pct. af BNP 1995-2005



Sources: OECD HEALTH DATA 2006
 Kilder: FO: Statistics Faroe Islands; G: Directorate of Health

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Table 5.1.4 Sales of medicinal products by ATC-group, calculated in pharmacy retail prices (million EUR), 2005

Salg af lægemidler fordelt på ATC-grupper, apotekernes salgspris (mio. EUR) 2005

	Denmark	Faroe Islands	Greenland ¹⁾	Finland ²⁾	of which Åland ²⁾	Iceland	Norway	Sweden
A Alimentary tract and metabolism								
Fordøjelse og stofskifte	211	1.9	0.4	280	1.1	19	230	396
B Blood and blood-forming organs								
Blod og bloddannende organer	154	1.4	0.3	122	0.5	9	122	286
C Cardiovascular system								
Hjerte og kredsløb	242	3.3	0.3	401	1.7	24	300	364
D Dermatologicals								
Hudmidler	44	0.3	0.4	62	0.2	5	48	100
G Genito-urinary system and sex hormones								
Kønshormoner m.m.	122	0.8	0.3	171	0.7	10	102	169
H Systemic hormonal preparations, excl. sex hormones and insulins								
Hormoner til systemisk brug	44	0.3	0.1	45	0.2	3	48	87
J Anti-infectives for systemic use								
Infektionssygdomme	182	1.2	0.9	158	1.1	15	126	203
L Antineoplastic and immunomodulating agents								
Cancermidler m.m.	247	1.3	0.5	238	2.0	15	244	389
M Musculo-skeletal system								
Muskler, led og knogler	89	0.5	0.2	167	0.7	10	96	142
N Nervous system								
Nervesystemet	525	3.3	1.7	481	1.7	54	418	651
P Antiparasitic products, insecticides and repellents								
Parasitmidler	11	0.1	0.0	6	0.0	-	7	9
R Respiratory system								
Åndedrætsorganer	212	1.3	0.4	205	1.0	15	224	270
S Sensory organs								
Sanseorganer	36	0.3	0.2	48	0.2	3	49	64
V Various								
Diverse	29	0.2	0.5	17	0.1	2	21	52
Total I alt	2 146	16.1	6.2	2 401	11.2	185	2 036	3 183
Of which user charges	620	4.9	-	964	4.1	67	613	606

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

1 Calculated on the basis of the purchase prices paid to the Hospital Pharmacy in the County of Copenhagen by Greenland's health service. 2005 refers to 2004.

2 For Finland and Åland, sales in the primary health sector are calculated in PRP (pharmacy retail prices) and in the hospital sector in PPP (pharmacy purchase prices).

1 Beregnet på grundlag af indkøbsprisen fra amtshospitalet i København til Grønlands Sundhedsvæsen 2005 tal er 2004.

2 I Finland og Åland er salget i den primære sektor beregnet som apotekernes detail salg (Apotekernes salgspriser) og i hospitalssektoren som hospitalernes indkøbspriser.

Table 5.1.5 Sales of medical products by ATC-group, EUR/capita 2005 - based on pharmacy retail prices

Salg af lægemidler fordelt på ATC-grupper, EUR/capita 2005 - baseret på apotekernes salgspris

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A <i>Alimentary tract and metabolism</i>								
Fordøjelse og stofskifte	39	40	7	53	41	65	50	44
B <i>Blood and blood-forming organs</i>								
Blod og bloddannende organer	29	29	5	23	18	30	26	32
C <i>Cardiovascular system</i>								
Hjerte og kredsløb	45	68	6	76	62	80	65	40
D <i>Dermatologicals</i>								
Hudmidler	8	7	7	12	8	16	11	11
G <i>Genito-urinary system and sex hormones</i>								
Kønshormoner m.m.	23	16	6	32	25	35	22	19
H <i>Systemic hormonal preparations, excl. sex hormones and insulins</i>								
Hormoner til systemisk brug	8	7	3	9	8	10	10	10
J <i>Anti-infectives for systemic use</i>								
Infektionssygdomme	34	25	16	30	42	51	27	22
L <i>Antineoplastic and immunomodulating agents</i>								
Cancermidler m.m.	46	27	10	45	76	52	53	43
M <i>Musculo-skeletal system</i>								
Muskler, led og knogler	16	10	3	32	26	33	21	16
N <i>Nervous system</i>								
Nervesystemet	97	69	30	92	65	184	91	72
P <i>Antiparasitic products, insecticides and repellents</i>								
Parasitmidler	2	1	1	1	2	1	1	1
R <i>Respiratory system</i>								
Åndedrætsorganer	39	28	6	39	36	50	49	30
S <i>Sensory organs</i>								
Sanseorganer	7	5	3	9	7	11	11	7
V <i>Various</i>								
Diverse	5	4	9	3	3	6	4	6
Total I alt	397	335	110	457	420	625	442	353
Of which user charges	115	104	-	183	154	227	133	67

Sources: See Table 5.1.4

Kilder: Se tabel 5.1.4

5.2 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 is done for 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 pharmacists. Furthermore for physicians a group is included with physicians who

5.2 Sundhedspersonale

Det har i mange år været vanskeligt at fremskaffe sammenlignelige data om sundhedspersonale for de nordiske lande, især fordi kildegrundlaget har været meget forskelligt.

Derfor nedsatte NOMESKO i 2003 en arbejdsgruppe, med henblik på at skaffe data med mere ensartet kildegrundlag, samt definere sundhedspersonalet med samme afgrænsning som findes for sundhedsøkonomien i OECD's A System for Health Accounts.

Til det brug har man fundet det mest hensigtsmæssigt at anvende erhvervsklassifikationen (NACE's) definitioner og afgrænsninger, sammenkoblet med de personer der findes i autorisationsregistre, hvorved man har fundet mere sammenlignelige data, selvom der stadigvæk findes fejl og mangler.

Med de nye definitioner og afgrænsninger er oplysningerne om sundhedspersonale fra tidligere år (før 2004) ikke sammenlignelige med de nuværende oplysninger, ligesom der er medtaget data for nye personalegrupper.

Her skal det bemærkes at gruppen *qualified auxiliary nurses*, tidligere benævnt sygehjælpere på dansk, nu er opdelt i gruppen sygeplejerskeassistenter for de der har en uddannelse på mindst 18 måneder og de der har en uddannelse på under 18 måneder er medtaget i gruppen andet plejepersonale. Da Sverige kun har data for ansat i det offentlige er der ikke medtaget data for disse personalekategorier. Andet sundhedspersonale med en højere uddannelse er defineret som personale med en universitetsuddannelse så som ernæringsfysiologer og farmaceuter. Endvidere er

do not work in the social and health care sectors, and not with medicine.

der for læger, medtaget en gruppe som ikke arbejder indenfor social og sundhedssektoren, herunder ikke med deres fag.

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

De medtagne data er desuden en opgørelse på et givet tidspunkt i året.

Note that the Finnish figures only cover the public sector. Figures from Åland both cover the public and the private sector.

Desuden skal det bemærkes at de finske data kun gælder den offentlige sektor. De ålandske data gælder både den offentlige og den private sektor.

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Table 5.2.1 Employed health care personnel in health and social services 2005 (NACE 85.1 and 85.3)
Erhvervsaktivt sundhedspersonale indenfor sundheds- og socialområdet 2005
(NACE 85.1 og 85.3)

	Denmark	Faroe Islands ¹⁾	Greenland	Finland	Åland	Iceland	Norway	Sweden
<i>Physicians</i>								
Læger	17 350	90	89	11 612	69	1 104	17 082	30 067
<i>Dentists</i>								
Tandlæger	4 634	40	26	2 379	22	289	3 916	7 425
<i>Dental hygienists</i>								
Tandplejere	1 189	..	..	3 712	25	25	771	3 079
<i>Dental surgery assistants</i>								
Tandlægeassistenter	3 948	44	76	..	-	301	2 948	..
<i>Psychologists</i>								
Psykologer	2 917	5	4	1 894	6	..	3 434	4 518
<i>Qualified nurses</i>								
Sygeplejersker	52 843	354	248	48 187	298	2 546 ¹⁾	71 151	89 233
<i>Radiographers</i>								
Radiografer	1 125	5	..	1 934	7	91	2 068	325 ³⁾
<i>Qualified auxiliary nurses</i>								
Sygeplejerskeassistenter	27 072	118	191	36 762	458	1 600 ²⁾	73 030	..
<i>Other health care personnel</i>								
Andet plejepersonale	55 821	..	..	19 531	89	..	-	..
<i>Midwives</i>								
Jordemødre	1 304	19	17	1 761	12	..	2 361	6 286
<i>Physiotherapists</i>								
Fysioterapeuter	6 480	17	13	2 609	17	420	7 892	10 389
<i>Occupational therapists</i>								
Ergoterapeuter	4 763	10	5	698	7	156	2 393	7 125
<i>Hospital laboratory technicians</i>								
Hospitalslaboranter	5 416	35	22	3 917	19	301	4 172	..
<i>Other health care personnel with a higher education</i>								
Andet sundhedspersonale med en højere uddannelse	564	..	..	10 546	15	..	3 266	..

1 Refers to 2003.

2 Estimate.

3 Includes only radiographers who have obtained a license after 2000. The majority of radiographers do not have a license and are included in the group qualified nurses.

1 Refererer til 2003.

2 Estimeret.

3 Indeholder kun radiografer der har opnået deres licens siden 2000. Størstedelen af radiograferne har ingen licens og er medregnet som sygeplejersker.

Source: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: STAKES; Å: Government of the Åland Islands; I: Directorate of Health; N: Statistics Norway; S: National Board of Health and Welfare

**Table 5.2.2 Employed health care personnel in health and social services 2005
per 100 000 inhabitants (NACE 85.1 and 85.3)**
Erhvervsaktivt sundhedspersonale indenfor sundheds- og socialområdet per
100 000 indbyggere 2005 (NACE 85.1 og 85.3)

	Denmark	Faroe Islands ¹⁾	Greenland	Finland	Åland	Iceland	Norway	Sweden
<i>Physicians</i>								
Læger	321	188	156	222	259	368	369	334
<i>Dentists</i>								
Tandlæger	86	83	46	45	83	96	85	82
<i>Dental hygienists</i>								
Tandplejere	22	..	..	71	94	8	17	34
<i>Dental surgery assistants</i>								
Tandlægeassistenter	73	92	134	..	-	100	64	..
<i>Psychologists</i>								
Psykologer	54	10	8	36	23	..	74	50
<i>Qualified nurses</i>								
Sygeplejersker	977	738	437	920	1 118	849 ¹⁾	1 539	990
<i>Radiographers</i>								
Radiografer	21	10	..	37	26	30	45	4 ³⁾
<i>Qualified auxiliary nurses</i>								
Sygeplejerskeassistenter	500	246	336	702	1 718	534 ²⁾	1 580	..
<i>Other health care personnel</i>								
Andet plejepersonale	1 032	..	..	373	335	..	-	..
<i>Midwives</i>								
Jordemødre	24	40	29	34	45	..	51	70
<i>Physiotherapists</i>								
Fysioterapeuter	120	35	23	50	64	140	171	115
<i>Occupational therapists</i>								
Ergoterapeuter	88	21	8	13	26	52	52	79
<i>Hospital laboratory technicians</i>								
Hospitalslaboranter	100	73	38	75	72	100	90	..
<i>Other health care personnel with a higher education</i>								
Andet sundhedspersonale med en højere uddannelse	10	..	..	201	57	..	71	..

1 Refers to 2003.

2 Estimate.

3 Includes only radiographers who have obtained a license after 2000. The majority of radiographers do not have a license and are included in the group qualified nurses.

1 Refererer til 2003.

2 Estimat.

3 Indeholder kun radiografer der har opnået deres licens siden 2000. Størstedelen af radiograferne har ingen licens og er medtaget som sygeplejersker.

Source: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: STAKES; Å: Government of the Åland Islands; I: Directorate of Health; N: Statistics Norway; S: National Board of Health and Welfare

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**Table 5.2.3 Employed physicians by specialty in health and social services 2005
(NACE 85.1 and 85.3)**

Erhvervsaktive læger fordelt på specialer indenfor social - og sundhedsområdet
2005 (NACE 85.1 og 85.3)

	Denmark	Faroe Islands ¹⁾	Greenland	Finland ²⁾	Åland	Iceland ³⁾	Norway	Sweden
<i>General practice</i>								
Almen medicin (alment praktiserende læger)	4 156	27	51	1 230	9	180	2 087	5 051
<i>Internal medicine</i>								
Intern medicin	1 272	..	3	1 250	10	153	1 272	1 143
<i>Paediatrics</i>								
Pædiatri	323	..	1	155	5	55	411	852
<i>Surgery</i>								
Kirurgi	767	..	3	845	3	70	711	1 171
<i>Plastic surgery</i>								
Plastik kirurgi	74	..	..	5	..	8	70	118
<i>Gynaecology and obstetrics</i>								
Gynækologi og obstetric	484	..	3	350	4	37	504	1 179
<i>Orthopaedic surgery, incl. hand surgery</i>								
Ortopædisk kirurgi, inkl. Hånd-kirurgi	566	..	3	30	2	33	331	979
<i>Ophthalmology</i>								
Øjensygdomme	287	..	..	175	1	30	308	641
<i>Ear, nose and throat</i>								
Øre næse hals	322	..	1	205	..	18	260	505
<i>Psychiatry</i>								
Psykiatri	859	3	2	730	6	82	1 081	1 451
<i>Skin and sexually transmitted diseases</i>								
Hud og kønssygdomme	147	..	..	85	..	16	120	318
<i>Neurology</i>								
Neurologi	198	..	..	180	..	16	224	264
<i>Oncology</i>								
Onkologi	84	..	..	90	1	16	117	277
<i>Anaesthetics</i>								
Anæstesiologi	816	..	2	505	3	56	620	1 256
<i>Radiology</i>								
Radiologi	438	..	2	395	1	37	471	927
<i>Clinical laboratory specialties incl. pathology</i>								
Kliniske/laboratoriespecialer, inkl. patologi	476	..	..	350	..	49	380	749
<i>Other specialties</i>								
Andre specialer	136	35	..	170	5	24	562	4 827
<i>Specialists in total</i>								
Specialister i alt	11 405	65	71	6 800	50	880	9 529	21 708
<i>Physicians without specialist authorization</i>								
Læger uden specialistgodkendelse	5 945	25	11	4 370	19	224	7 553	8 359
<i>Physicians in total within NACE 85.1 and 85.3</i>								
Læger i alt indenfor NACE 85.1 og 85.3	17 350	90	82	11 170	69	1 104	17 082	30 067

1 2003.

2 2004.

3 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.

1 2003.

2 2004.

3 Data er baseret på Helsedirektoratets register. Den nyeste specialisering er valgt, hvor der er flere end en specialisering.

Source: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: STAKES; Å: Government of the Åland Islands; I: Directorate of Health; N: Statistics Norway; S: National Board of Health and Welfare

Table 5.2.4 Employed physicians by specialty in health and social services per 100.000 inhabitants 2005 (NACE 85.1 and 85.3)
Erhvervsaktive læger fordelt på specialer indenfor social - og sundhedsområdet per 100.000 indbyggere 2005 (NACE 85.1 og 85.3)

	Denmark	Faroe Islands ¹⁾	Greenland	Finland ²⁾	Åland	Iceland ³⁾	Norway	Sweden
<i>General practice</i>								
Almen medicin (alment praktiserende læger)	77	56	90	24	34	60	45	56
<i>Internal medicine</i>								
Intern medicin	24	.	5	24	38	51	28	13
<i>Paediatrics</i>								
Pædiatri	6	..	2	3	19	18	9	9
<i>Surgery</i>								
Kirurgi	14	..	5	16	11	23	15	13
<i>Plastic surgery</i>								
Plastik kirurgi	1	..	..	0	..	3	2	1
<i>Gynaecology and obstetrics</i>								
Gynækologi og obstetrik	9	..	5	7	15	12	11	13
<i>Orthopaedic surgery incl. hand surgery</i>								
Ortopædisk kirurgi, inkl håndkirurgi	10	..	5	1	8	11	7	11
<i>Ophthalmology</i>								
Øjensygdomme	5	..	..	3	4	10	7	7
<i>Ear, nose and throat</i>								
Øre næse hals	6	..	2	4	..	6	6	6
<i>Psychiatry</i>								
Psykiatri	16	6	4	14	23	27	23	16
<i>Skin and sexually transmitted diseases</i>								
Hud og kønssygdomme	3	..	..	2	..	5	3	4
<i>Neurology</i>								
Neurologi	4	..	..	3	..	5	5	3
<i>Oncology</i>								
Onkologi	2	..	..	2	4	5	3	3
<i>Anaesthetics</i>								
Anæstesiologi	15	..	4	10	11	19	13	14
<i>Radiology</i>								
Radiologi	8	..	4	8	4	12	10	10
<i>Clinical laboratory specialities incl. pathology</i>								
Kliniske/laboratoriespecialer, inkl patologi	9	..	..	7	..	16	8	8
<i>Other specialities</i>								
Andre specialer	3	73	..	3	19	8	12	54
<i>Specialists in total</i>								
Specialister i alt	211	136	125	130	188	293	206	241
<i>Physicians without specialist authorization</i>								
Læger uden specialistgodkendelse	110	52	19	84	72	75	163	93
<i>Physicians in total within NACE 85.1 and 85.3</i>								
Læger i alt indenfor NACE 85.1 og 85.3	321	188	144	214	260	368	369	334

1 2003.

2 2004.

3 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.

1 2003.

2 2004.

3 Data er baseret på Helsedirektoratets lægeregister. Den nyeste specialisering er valgt, hvor der er flere end en specialisering.

Source: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: STAKES; Å: Government of the Åland Islands; I: Directorate of Health; N: Statistics Norway; S: National Board of Health and Welfare

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Table 5.2.5 Employed physicians 2005
Erhvervsaktive læger 2005

	Denmark	Faroe Islands ¹⁾	Greenland	Finland	Åland	Iceland	Norway	Sweden
<i>Physicians employed in hospitals (NACE 85.1 and 85.3)</i> Læger beskæftiget på hospitaler (NACE 85.1 og 85.3)	11 755	63	82	7 760	43	816	10 215	..
<i>General practitioners (NACE 85.1 and 85.3)</i> Læger der arbejder som alment praktiserende læger (NACE 85.1 og 85.3)	4 203	27	..	3 680	16	228 ²⁾	4 535	5 051
<i>Of which those without specialist authorization</i> Heraf uden specialistgodkendelse								
<i>Other physicians employed outside hospitals (mainly privately practising specialists) (NACE 85.1 and 85.3)</i> Andre læger der arbejder udenfor hospitaler (hovedsageligt privat praktiserende speciallæger) (NACE 85.1 og 85.3)	1 392	-	..	2 850	8	..	1 929	..
<i>Physicians employed in administrative medicine (NACE 75.1)</i> Læger beskæftiget med administrativ medicin (NACE 75.1)	186	1	2	..	2	..	472	791
<i>Physicians employed in medical research, teaching etc. (NACE 80.3, 73.1 and 24.4)</i> Læger beskæftiget med medicinsk forskning, undervisning m.v. (NACE 80.3, 73.1 og 24.4)	747	-	..	..	..	..	770	1 429
<i>Physicians employed within all other NACE codes</i> Læger beskæftiget på alle andre NACE-koder	1 037	-	..	..	..	..	1 300	1 520

1 2003.

2 Includes only physicians who have general practice as their main employment. The others are placed under "Other physicians employed outside hospitals (mainly privately practising specialists) (NACE 85.1 and 85.3)".

1 2003.

2 Omfatter kun læger som har almen praksis som sin hovedbeskæftigelse. De øvrige vil være placeret under "Andre læger der arbejder udenfor hospitaler (hovedsageligt privat praktiserende speciallæger) (NACE 85.1 og 3)".

Source: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: STAKES; Å: Government of the Åland Islands; I: Directorate of Health; N: Statistics Norway; S: National Boards of Health and Welfare

5.3 Capacity and services in hospitals

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 have been closed down, however, to varying degrees.

Hospital beds are organized somewhat differently in Finland, Iceland and Greenland than in the other countries. A number of beds are attached to health 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 about hospital discharges and average length of stay apply to patients admitted to ordinary hospitals and specialized hospitals. This limitation has been

5.3 Kapacitet og ydelser i sygehusvæsenet

Det er et kendetegn ved de nordiske landes sygehusvæsen, at der i en årrække er blevet færre sengepladser, og ressourcerne er blevet samlet på færre enheder, og oftest med en arbejdsdeling på de mest specialiserede områder. Ofte er det tale om en organisatorisk administrativ sammenlægning, som ikke nødvendigvis behøver at medfører færre fysiske enheder. I Norge er der ikke nedlagt hospitaler de seneste år, men de eksisterende hospitaler er ofte blevet mindre.

Det er ligeledes et kendetegn, at egentlige psykiatriske hospitaler er under afvikling i de nordiske lande, dog i forskelligt tempo.

I Grønland, Finland og Island er strukturen dog lidt anderledes, idet der til sundhedscentrene er knyttet et antal sengepladser, som i tabellerne er rubriceret under andre hospitaler. En del af disse sengepladser er dog plejepladser, som i de andre lande findes ved alderdoms- og plejehjemmene. Dette medfører, især for Finland og Islands vedkommende, at man får et betydeligt større antal sengepladser i forhold til befolkningen, end i de andre lande.

Sengepladserne ved sygehusene er fordelt på medicin, kirurgi, psykiatri og andet. Det fremgår klart, at det først og fremmest er Finland og Island som under rubrikken 'Andet' medregner aktiviteter, som ikke medtages af de øvrige lande.

Tabellerne over udskrivninger og gennemsnitlig liggetid omfatter indlagte patienter ved almindelige sygehuse og specialsygehuse. Denne afgrænsning er foreta-

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done in order to improve comparability between the countries.

get for at fremme sammenligneligheden mellem landene.

The trend is that the number of treatment places and the average length of stay have been reduced in ordinary hospitals.

Within psychiatric treatment there has been a trend towards the use of more outpatient treatment, so that the number of psychiatric beds has been reduced.

Tendensen er, at antallet af behandlingspladser og den gennemsnitlige liggetid reduceres på de almindelige sygehuse. Inden for den psykiatriske behandling har der været en udvikling hen imod mere ambulante behandlingsformer, hvorfor antallet af psykiatriske sengepladser er blevet reduceret.

Table 5.3.1 Available hospital beds by speciality 2005

Disponible sengepladser ved sygehuse efter specialer 2005

	Denmark	Faroe Islands ¹⁾	Greenland	Finland ³⁾	Åland	Norway	Sweden
<i>Number</i>							
<i>Antal</i>							
<i>Medicine</i>							
Medicin	9 077	88	40	6 515	59	6 885	14 044
<i>Surgery</i>							
Kirurgi	6 438	76	72	5 028	47	6 119	8 086
<i>Medicine and surgery in total</i>							
Medicin og kirurgi ialt	15 515	148	112	11 543	106	13 004	22 131
<i>Psychiatry</i>							
Psykiatri	3 346	60	12	4 876	32	2 774	4 347
<i>Other</i>							
Andet	-	-	286 ²⁾	20 455	98	366	-
<i>Total</i>							
I alt	18 861	224	410	36 874	236	16 144	26 478
<i>Beds per 100 000 inhabitants</i>							
<i>Sengepladser pr. 100 000 indbyggere</i>							
<i>Medicine</i>							
Medicin	167	182	70	124	221	149	155
<i>Surgery</i>							
Kirurgi	119	157	127	96	176	132	89
<i>Psychiatry</i>							
Psykiatri	62	124	21	93	120	60	48
<i>Other</i>							
Andet	-	-	503	390	368	8	-
<i>Total</i>							
I alt	348	464	721	703	885	349	293

1 Prescribed number of hospital beds.

2 Excl. patient hotel.

3 The number of beds has been calculated by dividing the total number of bed days by 365.

1 Normerede sengepladser.

2 Ekskl. patienthotel.

3 Antallet af senge er beregnet ved at dividere det totale antal sengedage med 365.

Source: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: STAKES; Å: Government of the Åland Islands; N: Statistics Norway; S: Swedish Association of Local Authorities and Regions

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Table 5.3.2 Discharges, bed days and average length of stay in wards in ordinary hospitals and specialized hospitals 2005

Udskrivninger, sengedage og gennemsnitlig liggetid på afdelinger ved almindelige sygehuse og specialsygehuse 2005

	Denmark	Faroe Islands	Greenland ¹⁾	Finland	Åland	Iceland	Norway	Sweden ²⁾
<i>Discharges per 1 000 inhabitants</i>								
<i>Udskrivninger pr. 1 000 indbyggere</i>								
<i>Medicine</i>								
Medicin	108	104	29	75	92	70	86	72
<i>Surgery</i>								
Kirurgi	95	106	72	112	111	99	86	70
<i>Psychiatry</i>								
Psykiatri	7	8	5	8	26	7	6	9
<i>Total</i>								
I alt	210	219	106	196	229	176	181	161
<i>Bed days per 1 000 inhabitants</i>								
<i>Sengedage pr. 1 000 indbyggere</i>								
<i>Medicine</i>								
Medicin	548	616	255	387	482	542	471	363
<i>Surgery</i>								
Kirurgi	370	457	487	328	391	317	385	292
<i>Psychiatry</i>								
Psykiatri	210	428	116	343	282	93	199	158
<i>Total</i>								
I alt	1 128	1 501	858	1 058	1 156	952	1 094	949
<i>Average length of stay</i>								
<i>Gennemsnitlig liggetid</i>								
<i>Medicine</i>								
Medicin	5	6	9	5	5	8	6	5
<i>Surgery</i>								
Kirurgi	4	4	7	3	4	3	5	4
<i>Psychiatry</i>								
Psykiatri	..	52	23	40	11	13	38	18
<i>Total</i>								
I alt	9	7	8	5	5	5	6	6

1 Figures for average length of stay only refer to Dronning Ingrid's Hospital.

2 2004.

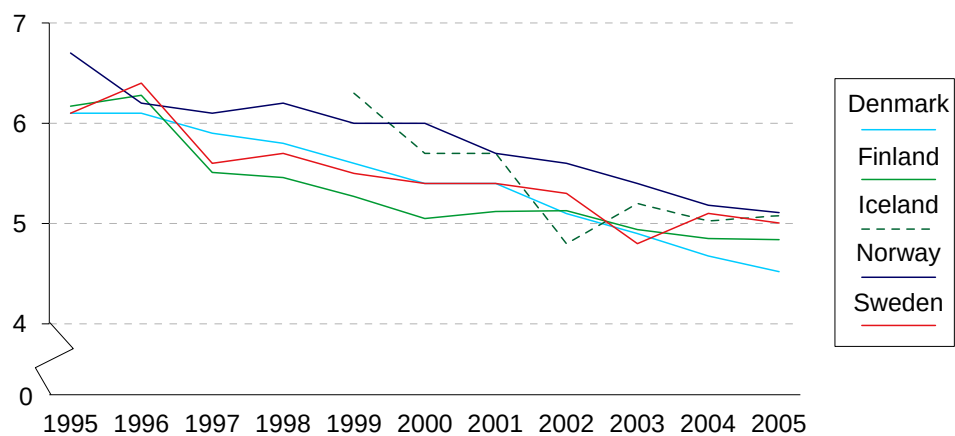
1 Tallene for den gennemsnitlige liggetid omfatter kun Dronning Ingrid's Hospital.

2 2004.

Source: The national in-patient registers

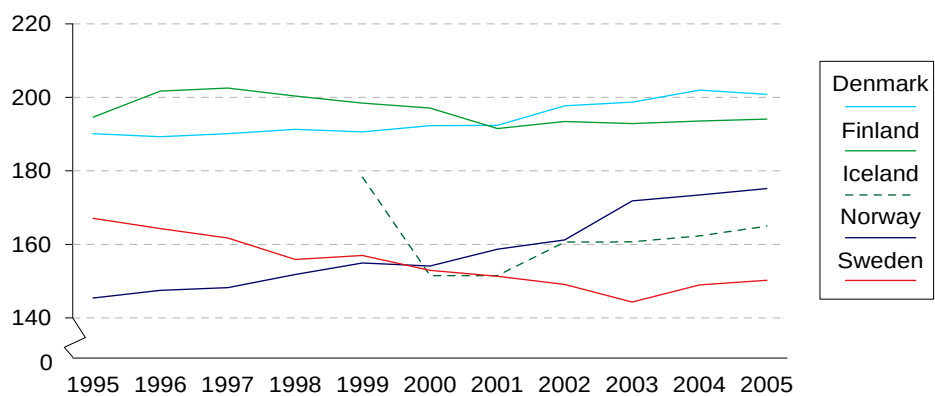
Kilde: De nationale patientregistre

Figure 5.3.1 Average length of stay in somatic wards 1995-2005
 Gennemsnitlig liggetid på somatiske afdelinger 1995-2005



Source: Table 3.4.2
 Kilde: Tabel 3.4.2

Figure 5.3.2 Number of discharges from somatic wards, per 1 000 inhabitants 1995-2005
 Udskrivninger fra somatiske afdelinger pr. 1 000 indbyggere 1995-2005



Source: Table 3.4.3
 Kilde: Tabel 3.4.3

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Table 5.3.3 Discharges from hospitals* by sex and age, per 1 000 inhabitants in the age group 2005

Udskrivninger fra sygehuse* efter køn og alder, pr. 1 000 indbyggere i aldersgruppen 2005

	Denmark	Faroe Islands	Finland	Åland	Iceland ¹⁾	Norway	Sweden
<i>Age</i> <i>Alder</i>							
<i>Men</i>							
Mænd							
0-14	133	167	122	133	138	100	71
15-44	85	98	88	78	48	80	50
45-64	203	233	207	159	126	182	136
65-69	383	474	353	331	291	348	281
70-74	493	527	445	437	416	427	377
75-79	620	691	562	576	493	540	488
80+	788	766	692	813	680	727	671
<i>Total</i>							
I alt	186	204	179	175	130	163	136
<i>Women</i>							
Kvinder							
0-14	109	148	96	106	126	80	57
15-44	190	214	174	191	198	160	131
45-64	180	228	197	173	159	167	124
65-69	298	351	283	240	282	273	222
70-74	386	425	359	330	348	322	290
75-79	464	467	447	444	435	410	375
80+	600	571	495	646	544	548	533
<i>Total</i>							
I alt	216	239	209	219	201	189	164

1 Discharges for stays in hospital shorter than 90 days.

1 Kun udskrivninger ved indlæggelsestider på mindre end 90 dage.

* Comprises somatic wards in ordinary hospitals and in specialized somatic hospitals.

* Omfatter somatiske afdelinger ved almindelige sygehuse og ved somatiske specialsygehuse.

Source: The national in-patient registers

Kilde: De nationale patientregistre

**Table 5.3.4 Bed days in hospitals* by sex and age,
per 1 000 inhabitants in the age group 2005**

Sengedage på sygehuse* efter køn og alder,
pr. 1 000 indbyggere i aldersgruppen 2005

	Denmark	Faroe Islands	Finland	Åland	Iceland ¹⁾	Norway	Sweden
<i>Age Alder</i>							
<i>Men</i>							
Mænd							
0-14	369	294	486	476	418	397	266
15-44	261	470	447	211	180	281	159
45-64	918	1 271	992	650	631	864	621
65-69	1 997	2 794	1 740	1 697	1 904	2 067	1 523
70-74	2 790	4 080	2 225	2 814	3 008	2 675	2 213
75-79	3 701	3 889	2 873	3 503	4 034	3 671	3 041
80+	5 039	7 875	5 653	5 954	7 125	5 129	4 538
<i>Total</i>							
I alt	838	1 087	912	837	726	834	694
<i>Women</i>							
Kvinder							
0-14	329	441	357	267	372	331	229
15-44	544	903	718	579	521	569	372
45-64	774	1 238	820	699	702	815	559
65-69	1 624	2 229	1 408	1 152	1 824	1 619	1 190
70-74	2 339	3 475	1 715	1 816	2 616	2 082	1 729
75-79	3 097	4 407	2 488	2 994	4 081	2 812	2 466
80+	4 472	6 428	3 022	4 959	6 289	4 000	3 914
<i>Total</i>							
I alt	977	1 386	960	1 018	951	962	812

1 Bed days of discharges for stays in hospital shorter than 90 days.

1 Sengedage for udskrivninger ved indlæggelsestider på mindre end 90 dage.

* Definition, see Table 3.4.2

* Definition, se tabel 3.4.2

Source: The national in-patient registers

Kilde: De nationale patientregistre

THEME SECTION

SECTION B

Mental Health in the Nordic countries

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• What has been done to improve mental health care?	• Vad har gjorts för att förbättra den psykiska hälsovården?	263
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Extra Materials

Terminology

Finland

The Act on Specialized Medical Care

Sweden

The Swedish legislation

MINDFUL mental health indicator database

HP-source database

European Commission. Mental Well-being. Special Eurobarometer, 2006

European Commission. Mental health promotion and mental disorder prevention across European Member States: a collection of country stories, 2006

Supplerende Materiale

Terminologi

Finland

Lagen om specialiserad sjukvård

Sverige

Svensk lagstiftning

MINDFUL-databasen över indikatorer på psykisk hälsa

HP-källdatabasen

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Why is mental health important?

"There is no health without mental health". This was the motto when promoting mental health on the European Agenda 1999 during the first Finnish presidency in the EU. The importance of this can be seen from both a positive and a negative point of view.

Den nordiska referensgruppen

Marianne Christensen (Danmark)

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Varför är psykisk hälsa viktig?

"Det finns ingen hälsa utan psykisk hälsa". Detta var mottot när man införde psykisk hälsa på den europeiska agendan 1999 under den första finländska ordförandeskapsperioden i EU. Betydelsen av detta kan ses både ur en positiv och ur en negativ synvinkel.

This is the first NOMESCO report in which mental health is dealt with specifically. In this report we have tried to see mental health more widely than just as the presence or absence of mental illness. Mental health as a special theme in a NOMESCO report has been postponed because of the fear that insufficient useful, reliable and comparable statistics are available in the Nordic countries. This is partly true, but it is, however, possible to present information about mental health in the Nordic countries and to expose the obvious shortcomings in the statistics. We have excluded intellectual disabilities from this theme section because these people are mostly treated in social sector. More information on Alzheimer's disease and other dementia is provided in the theme section 2008 on the elderly.

Detta är den första NOMESCO-rapporten i vilken psykisk hälsa har fått en särställning. I rapporten har vi försökt se psykisk hälsa som något mer än förekomst eller avsaknad av psykisk sjukdom. Psykisk hälsa har inte tidigare funnits som ett specialtema i NOMESCO-rapporterna p.g.a. farhågan att det inte finns tillräckligt med användbar, pålitlig och jämförbar statistik tillgänglig i de nordiska länderna. Detta är delvis sant, men det är ändå möjligt att ge information om psykisk hälsa i de nordiska länderna och även föra fram de uppenbara bristerna i statistiken. Information om förståndshandikapp finns inte med på detta tema eftersom de vårdas oftast av socialtjänsten. Mera information om Alzheimer och andra demens kommer att publiceras i temasektionen 2008 om de äldres hälsa.

Mental health as a resource

Mental health is an essential component of general health. The World Health Organisation (WHO) defines health as a state of complete physical, mental and social well-being. Mental health is a result of various predisposing factors (e.g. biological factors and early childhood experiences), precipitating factors (e.g. stressful life events), social support, and individual resources (e.g. self-esteem) and experiences. Socio-economic factors, notably education, employment, income distribution and housing, also play an important role. Mental health is more than the absence of symptoms of mental illness or distress. Mental health refers to a positive sense of well being and a belief in one's own worth and the dignity and worth of others.

Psykisk hälsa som en resurs

Den psykiska hälsan är en viktig del av den allmänna hälsan. Världshälsoorganisationen (WHO) definierar hälsa som ett tillstånd av fullständigt fysiskt, psykiskt och socialt välbefinnande. Psykisk hälsa är ett resultat av olika predisponerande faktorer (t.ex. biologiska faktorer och tidiga barndomsupplevelser), oväntade faktorer (t.ex. stressutlösande händelser i livet), socialt stöd och individuella resurser (t.ex. självkänsla) och upplevelser. Socioekonomiska faktorer, i synnerhet utbildning, arbete, inkomstfördelning och boende, har även stor betydelse. Psykisk hälsa innebär mera än avsaknad av symptom på psykisk sjukdom eller smärta. Psykisk hälsa innebär en positiv känsla av välbefinnande och en tro på vårt eget och andra människors värde.

Positive mental health includes the capacity to perceive, comprehend and interpret our surroundings, to adapt to them and to change them if necessary, and to communicate with each other. Mental health also contributes to our ability to cope with and manage changes, transitions and life events: the birth of a child, unemployment, bereavement, or physical ill health. Mental health is mediated by the quality of interaction with others, societal structures and resources, and cultural values. Positive mental health also increases productivity.

Mental health and well-being are issues of everyday life and should be of interest to every citizen and every employer, and to all care, education, and administration sectors. Mental health is influenced, enhanced, and jeopardised in families and schools, on the streets and in workplaces – where people can feel safe, respected, included, and able to participate, or may be in fear, marginalized, and excluded. It is the result of, among other things, the way we are treated by others, and the way we treat other people and ourselves. Everyone has mental health needs, whether or not they have a diagnosis of mental illness. Mental health promotion is therefore relevant to everyone.

The burden of mental disorders

Mental disorders are major causes of disability throughout the world. In all the Nordic countries, the group neuropsychiatric conditions is the leading disability group, accounting for from one

Positiv psykisk hälsa innefattar förmågan att uppfatta, förstå och tolka vår miljö, att anpassa sig till den och ändra den om nödvändigt samt förmågan att kommunicera med varandra. Psykisk hälsa bidrar även till vår förmåga att klara av förändringar, övergångsskeden och olika händelser i livet: ett barns födelse, arbetslöshet, sorg eller fysisk sjukdom. Psykisk hälsa byggs upp av kvaliteten på samspelet med andra människor, samhällsstrukturer och resurser och kulturella värden. Positiv psykisk hälsa ökar även förmågan till produktivitet.

Psykisk hälsa och mentalt välbefinnande är frågor som hör till det vardagliga livet och som borde vara av intresse för varje invånare och arbetsgivare, samt inom vård-, utbildnings- och förvaltningssektorer. Psykisk hälsa påverkas, höjs eller äventyras i familjer och skolor, på gatan och på arbetsplatsen – där människor kan känna sig trygga, respekterade, tillhöra en social gemenskap och med möjlighet att delta eller också rädda, marginaliserade och uteslutna från social gemenskap. Den är ett resultat av, bland annat, det sätt på vilket vi behandlas av andra och det sätt på vilket vi behandlar andra och oss själva. Alla har behov av psykisk hälsa, vare sig de har en diagnos på en psykisk sjukdom eller inte. Att främja den psykiska hälsa är därför relevant för alla.

Bördan av psykiska störningar

Psykisk ohälsa är en betydande orsak till handikapp runtom i världen. I alla nordiska länder utgör neuropsykiatriska tillstånd den största handikappgruppen, omfattande från en fjärdedel till en tred-

fourth to one third of the total years lost due to disability (24-28 per cent for men and 26-34 per cent for women according to WHO calculations). Poor mental health contributes to physical diseases and to poor compliance with prevention and treatment programmes. Parental mental disorders may have emotional consequences for the next generation. Mental ill health is also a major contributory factor to premature mortality, and suicide alone is the tenth leading cause of death in the world.

Both the direct and indirect costs of mental disorders are rising. The indirect costs are actually greater than the direct costs. Nordic studies on the costs linked to specific disorders such as depression and schizophrenia have been carried out. Unfortunately there are no comprehensive studies of all the costs of mental disorders. A Swedish dissertation about the costs of depression (1) and a Finnish article about the costs of schizophrenia are referred to below (2).

A new approach was developed to assess the societal costs of depression in Europe. The results showed that more than 21 million Europeans suffer from depression and that depression costs European society more than SEK 1 000 000 millions per year. Two-thirds of these costs are incurred outside the health care system. The cost of depression amounts to SEK 2 300 per inhabitant in Europe, corresponding to one per cent of the European national incomes (1). The estimates about the costs of schizophrenia vary greatly from country to country and from researcher to researcher. The cost of care is estimated to be 20-50 per cent of the

jedel av alla år förlorade p.g.a. handikapp (24-28 procent för män och 26-34 procent för kvinnor enligt WHO:s beräkningar). Nedsatt psykisk hälsa bidrar till fysiska sjukdomar och till bristande respons på förebyggande program och behandlingsprogram. Om föräldrarna är psykisk sjuka kan detta leda till emotionella konsekvenser för följande generation. Nedsatt psykisk hälsa är också en betydande orsak till för tidig död, och självmord utgör i sig den tionde största dödsorsaken i världen.

Både direkta och indirekta kostnader orsakade av psykisk ohälsa formas av direkta och indirekta kostnader. De indirekta kostnaderna är de facto högre än de direkta. Det har gjorts särskilda nordiska studier av kostnaderna för specifika störningar som depression och schizofreni. Tyvärr finns det inga uttömmande studier över de totala kostnaderna för psykisk ohälsa. Som exempel citeras här kort en svensk avhandling över kostnaderna för depression (1) och en finländsk artikel som berör kostnaderna för schizofreni (2).

Ett nytt tillvägagångssätt har utvecklats för att uppskatta de samhälleliga kostnaderna för depression i Europa. Resultaten visar att mer än 21 miljoner européer lider av depression och att denna sjukdom kostar det europeiska samhället mer än 1000 miljarder SEK per år, varav två tredjedelar hänförs till kostnader utanför hälsovårdssystemet. Kostnaderna för depression uppgår till 2300 SEK per invånare i Europa, motsvarande en procent av de europeiska nationalinkomsterna (1). Uppskattningarna av kostnaderna för schizofreni varierar stort från land till land och från forskare till forskare. Kostnaderna för vården uppskattas till 20-50 pro-

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total cost of schizophrenia. It has been estimated that the cost of schizophrenia for the health budget is two per cent of the total health budget (2).

The indirect costs of not tackling mental disorders efficiently and effectively arise from:

- Lost production from people with mental illness being unable to work in the short, medium or long term, including sick leave, early retirement and other costs for society.
- Reduced productivity from people being ill while at work.
- Supporting dependants of mentally ill people.
- Unemployment, exclusion, and crime in young people whose childhood problems (e.g. depression and conduct disorders) were not adequately addressed for them to benefit fully from education.
- The cost of not properly addressing the consequences of dyslexia, mild intellectual disabilities and other special educational needs in childhood.
- Poor cognitive development in children who have parents who are mentally ill.
- Higher costs incurred when disorders are not tackled early or when they remain untreated.

cent av de totala kostnaderna för schizofreni. Det har uppskattats att kostnaderna för schizofreni utgör 2 procent av den totala hälsovårdsbudgeten (2).

De indirekta kostnaderna orsakade av att psykisk ohälsa inte behandlas adekvat och effektivt består av:

- Förlorad produktion för de personer som p.g.a. psykisk sjukdom på kort, medellång eller lång sikt är arbetsoförmögna, även inbegripet sjukfrånvaro och förtidspension samt andra kostnader för samhället.
- Sänkt produktivitet för personer som lider av sjukdom när de är i arbete.
- Stöd av anhöriga till den psykiskt sjuka personen.
- Arbetslöshet, uteslutning och brottslighet för unga personer vars barnomsproblem (t.ex. depression, beteendestörningar) inte tillräckligt väl behandlades för att de till fullo skulle kunna tillgodogöra sig utbildning.
- Kostnader beroende på att konsekvenserna av dyslexi, mild lättare förståndshandikapp och andra speciella behov under barndomen inte beaktats på rätt sätt.
- Svag kognitiv utveckling för barn med psykiskt sjuka föräldrar.
- Högre kostnader som ett resultat av att störningar inte behandlas tillräckligt snabbt eller förblir obehandlade.

- Lost production from premature mortality from suicide and other causes of death.
- Burden for the family.
- Förlorad produktion beroende på för tidig död p.g.a. självmord och andra dödsorsaker.
- Belastning för familjen.

What has been done to improve mental health care?

Mental health and mental health services have been given priority in the Nordic countries during the last 20 years. This has been done by the government authorities, especially the health and social ministries and boards, carrying out projects and implementing programmes. The main topics have often been psychiatric services and mental health in primary health care. However, even though mental health has been given priority, it has been undervalued and neglected compared to somatic health.

FINLAND: The National Schizophrenia Project (1981–1988) created the basis for the deinstitutionalization process in psychiatric care by developing a treatment model for acute schizophrenic patients and a stepwise psycho-social rehabilitation model for long-term schizophrenic patients.

The National Suicide Prevention Programme (1987–1996) strongly supported multi-sectorial collaboration and networking in mental health work, and has contributed to the decrease of suicide rates in Finland.

The National Depression Project (1994–1998) stimulated discussion about the importance of depression in public health.

Vad har gjorts för att förbättra den psykiska hälsovården?

Psykisk hälsa och psykisk hälsovård har prioriterats i de nordiska länderna under de senaste 20 åren. Detta har skett genom projekt och program som förverkligats av statliga myndigheter, speciellt social- och hälsovårdsministerierna och -styrelserna. Huvudtemana har ofta varit den psykiatriska vården och psykisk hälsa inom primärvården. Samtidigt som detta prioriterats har området dock undervärderats och försumrats i jämförelse med somatisk hälsa.

FINLAND: Det nationella schizofreniprojektet (1981–1988) utgjorde grunden för avinstitutionaliseringen inom den psykiatriska vården genom att utveckla en behandlingsmodell för akuta schizofrena patienter samt en stegvis psykosocial rehabiliteringsmodell för långtidssjuka schizofrena patienter.

Det nationella programmet för förebyggande av självmord (1987–1996) främjade starkt multisektoriellt samarbete och nätverksbyggande inom arbetet för psykisk hälsa och har bidragit till en minskning av antalet självmord i Finland.

Det nationella depressionsprojektet (1994–1998) bidrog till diskussionen om den reella betydelsen av depression för den allmänna hälsan.

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The Meaningful Life! Programme (1998–2002) focussed strongly on multi-sectorial collaboration in promoting mental health. The main focus was on the management of everyday life activities by people with mental problems. Nine out of twelve ministries participated in the implementation of the programme.

Mental Health in Primary Health Care (1999–2001) supported the development of models in mental health care in primary care.

During the last few years there has been a shift in Finland from national projects and programmes to regional and local projects. However, these are still supported and partly financed by the Ministry of Health and Social Affairs.

Recently, the Ministry of Health and Social Affairs appointed an expert group to prepare a national plan for mental health and addiction problems in 2007 to 2008.

ICELAND: During the last decade, the emphasis on mental health services has shifted from inpatient care to outpatient care. The Ministry of Health and Social Security and the Ministry of Social Affairs have been working on a special project (2006–2010) with the aim to enable mentally handicapped persons to live in the community with support from professionals and others. For several years, primary health care services have provided mental health nursing in the home care services. The University Hospital has recently established an outreach mental health care team.

Meningsfullt liv! –programmet (1998–2002) hade starkt fokus på multisektoriellt samarbete för att främja psykisk hälsa. Tyngdpunkten låg på att hjälpa personer med psykiska problem att klara av vardagliga saker. Nio av tolv ministerier deltog i förverkligandet av programmet.

Psykisk hälsa inom primärvården (1999–2001) främjade utvecklandet av modeller för psykisk hälsovård inom primärvården.

Under de senaste åren har det i Finland skett en övergång från nationella projekt och program till regionala och lokala projekt, vilka dock fortfarande understöds och delvis finansieras via social- och hälsovårdsministeriet.

Social- och hälsovårdsministeriet har nyligen utsett en expertgrupp för att förbereda en nationell plan för problem rörande psykisk hälsa och missbruk under 2007 och 2008.

ISLAND: Under det senaste årtiondet har tyngdpunkten inom den psykiska hälsovården förflyttats från anstaltsvård till öppenvård. Ministeriet för hälsa och social trygghet och ministeriet för sociala ärenden arbetar på ett specialprojekt (2006–2010) med målsättningen att möjliggöra för psykiskt funktionshindrade personer att leva i samhället med stöd från vårdpersonal och andra. Primärvården har under några år erbjudit psykisk sjukvård inom hemsjukvården. Universitetssjukhuset har nyligen grundat ett mobilt psykiatriskt team.

The Ministry of Health and Social Security has given priority to mental health services for children, both hospital services and primary care services. In 2006 special resources were allocated to this project.

Ministeriet för hälsa och social trygghet har prioriterat en ökning av psykisk hälsovård för barn både vad gäller sjukhusvård och primärhälsovård. Under 2006 tilldelades detta projekt specialresurser.

The Mental Health Promotion Project started in 2000 in cooperation with the Directorate of Health, the University Hospital, the Mental Health Alliance and Primary Care Services supported by the Ministry of Health and Social Security and various NGOs. The aim of the project is to educate and empower people to be able to enhance their mental health and to combat prejudices. Since 2004, the project has been coordinated by the Public Health Institute.

Ett projekt för att främja psykiska hälsan startade år 2000 i samarbete med hälsodirektoratet, universitetssjukhuset, en allians för mental hälsa och primärvården understött av ministeriet för hälsa och social trygghet och olika NGOs. Projektets mål är att utbilda människor och göra det möjligt för dem att förbättra sin psykiska hälsa och kämpa mot fördomar. Projektet koordineras sedan 2004 av det statliga Folkhälsoinstitutet.

The National Depression Prevention Project was established in 2003 under the auspices of the Directorate of Health. The aim of the project is to educate professionals, patients and the public about the causes and symptoms of depression and what can be done to reduce the suffering of those with the disease. It is a multi-professional and multi-sectorial project with the emphasis on training trainers all over the country. In connection with this project a National Suicide Prevention Project has been carried out, using the same resources and means.

Ett nationellt depressionsprojekt startades 2003 på initiativ av hälsodirektoratet. Målet för projektet är att utbilda vårdpersonalen, patienterna och allmänheten i symptomen på depression och i vad som kan göras för att minska lidandet för dem som lider av sjukdomen. Det är ett projekt som spänner över flera yrkesgrupper och sektorer och som har tyngdpunkten på att utbilda utbildare över hela landet. I anknytning till detta projekt har ett nationellt projekt för att förebygga självmord drivits, med samma resurser och medel.

Hugarafl is a mental empowerment group of former patients and occupational therapists, with the philosophy of empowerment as its guiding mission. The aim of the group is to share experiences of mental health services with people who want to improve the services, and to identify ways of promoting healing, with the participation of patients.

Hugarafl är en grupp bestående av tidigare patienter och personer som arbetar som terapeuter. Ledstjärnan för gruppen är filosofin om att ge kraft och styrka. Målsättningen är att dela erfarenheter från den psykiska hälsovården med alla som vill förbättra den och att lyfta fram sätt att stöda ett tillfrisknande genom patienternas medverkan. Man vill även be-

Other aims are to combat prejudices by being visible, and to create new ways for patients and former patients to participate in working life. Since 2006, the University Hospital has had a former patient working to enhance the quality of mental health services in the hospital. Geysir is a group of patients that works according to the philosophy of Fountain House, and aims to strengthen individuals and support them to be active in their life. The Mental Health Alliance is an alliance of people who have had or have a mental disorder, their families and all those who are concerned about mental health matters.

NORWAY: *National Programme for Mental Health.* In 1998 the Storting (the Norwegian Parliament) adopted a National Health Programme for Mental Health, calling for major investments, expansion and reorganization of the services. Implementation of the programme will take place between 1999 and 2008. The programme aims at strengthening the users' position, increasing public awareness through information programmes, strengthening community based services, expanding and restructuring specialized services for adults, children and adolescents, improving labour market services and assisting with accommodation and housing. Education and research will be stimulated.

SWEDEN: A special government investigation in the early 1990s of the conditions of people with long-term psychiatric illness concluded that the care and social support of these persons was insufficient. A proposal was submitted that involved reforms for the target group, including changes in existing legislation

kämpa fördomar genom att vara synlig och genom att skapa nya sätt för patienter och tidigare patienter att delta i arbetslivet. Universitetssjukhuset har sedan 2006 haft en tidigare patient som arbetat för att höja kvaliteten på den psykiska hälsovården på sjukhuset. Geysir är en annan grupp av patienter som arbetar enligt Fountain House-filosofin och som strävar mot att styrka individerna och stöda dem att vara aktiva i sitt eget liv. Vidare finns Alliansen för mental hälsa som är en sammanslutning av personer som lider eller har lidit av psykisk ohälsa, deras familjer och alla andra som är engagerade i frågor om psykisk hälsa.

NORGE: *Det nationella programmet för psykisk hälsa.* 1998 godkände den norska riksdagen ett nationellt program för psykisk hälsa, vilket krävde omfattande investeringar samt utökning och omorganisation av vården. Verkställandet av programmet kommer att ske mellan 1999 och 2008. Programmet strävar till att stärka brukarnas ställning, öka allmänhetens medvetenhet genom informationsprogram, stärka den samhällsbaserade servicen, utöka och omstrukturera specialhälsovården för vuxna, barn och ungdomar, förbättra arbetsmarknadsservicen samt hjälpa till med bostadsfrågor. Utbildning och forskning ska stimuleras.

SVERIGE: En särskild regeringsutredning i början av 1990-talet rörande tillståndet för människor med långvarig psykiatrisk sjukdom fastslog att vården av och det sociala stödet till dessa människor var otillräcklig. Ett förslag om reformer för målgruppen framlades, innefattande ändringar i existerande lagstiftning och

and the introduction of some new legislation. In 1995, legislative changes and an increase in funding for the target group together constituted what was called the Mental Health Care Reform.

The aim of the reform was to bring people who were undergoing long-term treatment in psychiatric hospitals or nursing homes home to their local community and to make social services agencies and psychiatric units coordinate their care and support efforts for these people. The social services were responsible for housing, daily activities and rehabilitation of all individuals in the community with long-term psychiatric disorders.

According to the reform, social services shall make it possible for people in the target group to live outside institutions. Specialized psychiatric care within the county council organization shall adapt its efforts and develop adequate treatment methods. Social services and psychiatric care organizations must support each other in their work with the target group. Involvement of individuals and families in the rehabilitation process is given particular emphasis. The objective is social integration and the best possible life for people who are mentally ill, on equal terms with the rest of the population.

The reduction in the number of hospital beds for psychiatric patients and discharges of patients due to the reform, especially those with long-term disorders, has been met by an increase in housing institutions provided by social services. Almost the same number of people was living in institutions from 1994–2002. The institutions provided by

införande av en viss ny lagstiftning. Under 1995 genomfördes lagändringar och ett ökat anslag för målgruppen, vilket tillsammans kom att kallas psykiatrireformen.

Målsättningen för reformen var att ta hem de personer med långvarig behandling på psykiatriska sjukhus eller vårdhem till sitt hemkommun och ålägga de sociala myndigheterna och de psykiatriska enheterna att koordinera sina vård- och stödresurser för dessa människor. De sociala myndigheterna skulle även ansvara för boende, dagliga aktiviteter och rehabilitering för alla individer i samhället med långvarig psykisk ohälsa.

I enlighet med reformen ska de sociala myndigheterna göra ett liv utanför institutionerna möjligt för målgruppen. Den specialiserade psykiatriska vården inom landstinget måste anpassa sina resurser och utveckla adekvata behandlingsmetoder. De sociala myndigheterna och den psykiatriska vården måste stöda varandra i sitt arbete med målgruppen. Speciellt skall individer och familjerna involveras i rehabiliteringsprocessen. Målet är social integration och det bästa möjliga livet för de psykiskt sjuka, på samma villkor som för den övriga befolkningen.

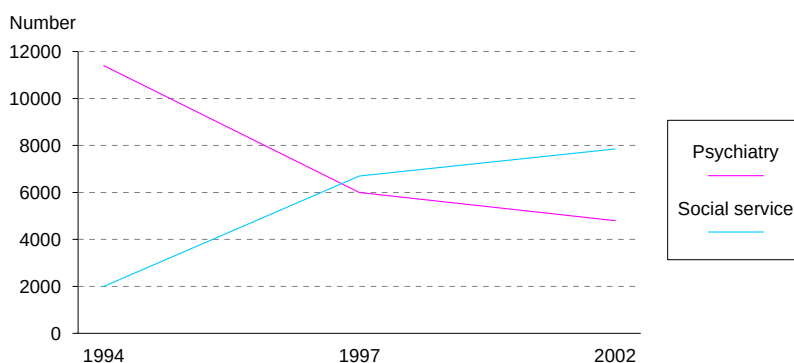
Minskningen i antalet vårdplatser för psykiatriska patienter och utslussning av patienter i enlighet med reformen, speciellt långtidssjuka, har bemötts med en ökning i boendeinstitutioner som de sociala myndigheterna erbjuder. Närapå samma antal personer institutionaliserades under perioden 1994–2002. Institutionerna som lyder under de sociala

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social services are usually more homelike than former psychiatric inpatient institutions. This development is shown in Figure 1.

myndigheterna är vanligen mera hemliknande än tidigare psykiatriska institutionsvård. Utvecklingen av denna övergång visas i figur 1.

Figure 1 Number of people in night and day care provided by psychiatric care and social services in 1994, 1997 and 2002 in Sweden



Source: National Board of Health

Investigations have shown that the reform process was not satisfactory. Again, the government decided to strengthen the process by providing grants to psychiatric care organizations and social services. In 2004, a special coordinator was appointed with the task of stimulating measures for people with long-term psychiatric disorders. The final report of his work was published in 2006 (3).

Utredningar har visat att reformprocessen inte var tillfredsställande. Regeringen beslöt därför att åter understöda processen genom att anslå medel till de psykiatriska vårdorganisationerna och de sociala myndigheterna. År 2004 utnämndes en särskild samordnare med uppdrag att stimulera åtgärder för personer med långvarig psykisk ohälsa. Den slutliga rapporten över koordinators arbete offentliggjordes 2006 (3).

Mental health services

Grunderna för den psykiska hälsovården

Legislation

DENMARK: The key act relating to mental health services is the Health Act (Sundhedsloven, Act 546 of 24 June, 2005). There is special legislation about

Lovgivning

DANMARK: Den væsentligste lovgivning vedrørende sundhedsvæsenets indsats i forhold til psykiske lidelser findes i Sundhedsloven (Lov nr. 546 af

the use of restraint in psychiatry: the Danish Psychiatric Act (Act 1111 of November 2006).

The Health Act contains all the rules and regulations regarding health issues, including mental health services. The Health Act describes patients' rights in general, the organization of health services and responsibilities for delivering services in primary health care and secondary health care, prevention, safety of patients etc. The Health Act entered into force on 1 January 2007 with the Danish Structural Reform.

The Danish Psychiatric Act was amended in June 2006 and entered into force on 1 January 2007. All alterations introduced since the previous amendments in 1998, including the changes from 1 June 2006 have been combined in the consolidated act no. 1111 of 1 November 2006 on the use of restraint in psychiatry.

The aim of the amendment of the Danish Psychiatric Act is to strengthen the legal status of patients and to protect patients' legal rights in a number of areas relating to application of restraint in psychiatry. The Psychiatric Act also contains the concept of a good psychiatric hospital standard, patient care, staff skills and policies towards relatives and patients.

FINLAND: The key acts defining the arrangement of mental health services are the Mental Health Act (1116/1990), the Public Health Act (66/1972) and the Act on Specialized Medical Care (1062/1989).

24.06.2005) og samt endvidere alene for så vidt angår anvendelse af tvang i psykiatrien findes en særlig lovgivning: Lov om anvendelse af tvang i psykiatrien (Lov nr. 1111 af november 2006).

Med vedtagelsen af Sundhedsloven der trådte i kraft 1. januar 2007 samledes lovgivningen på sundhedsområdet i én lov. Sundhedsloven omfatter således bl.a. patienters retsstilling, den offentlige sygesikring og sygehusvæsenet, forebyggende sundhedsordninger, patientsikkerhed mv. Lovens indholdsmæssige ændringer er først og fremmest en følge af den gennemførte kommunalreform, der ligeledes trådte i kraft d. 1. januar 2007.

Psykiatriloven ændredes i juni 2006 med ikrafttræden d. 1. januar 2007. De samlede gældende bestemmelser omfattende alle ændringer gennemført siden 1998 samt de gennemførte ændringer fra juni 2006 er samlet i en lovbekendtgørelse om anvendelse af tvang i psykiatrien (nr. 1111 af 1. november 2006).

Målet med ändringen i den danska psykiatrilagen är att stärka patienternas juridiska ställning och att skydda deras lagliga rättigheter på ett flertal områden som hör ihop med tvångsvården inom psykiatrin. Psykiatrilagen innehåller även principen om en god standard på mentalsjukhusen, patientvården, personalens kompetens och relationen till anhöriga och patienter.

FINLAND: Huvudlagarna som reglerar av den psykiska hälsovården är mentalvårdslagen (1116/1990), folkhälsolagen (66/1972) och lagen om specialiserad sjukvård (1062/1989).

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The Mental Health Act is an outline law which defines the concepts, content, supervision, provision obligation and principles of provision of mental health work. In addition it contains special provisions concerning state mental hospitals, involuntary treatment in a mental hospital and forensic examinations.

Under the Public Health Act, mental health services are included in primary health care. "In view of what is provided in the Mental Health Act, local authorities will organize as part of their primary health care such mental health services needed by their residents as it is expedient to provide at a health centre."

The Act on Specialized Medical Care lays down provisions about the organization of specialized medical care and related operations. In order to organize specialized medical care in accordance with this obligation, each local authority must belong to a hospital district joint municipal board. The Act also specifies time frames for access to non-urgent specialist care. Assessment of the need for psychiatric treatment must be done within three weeks, and treatment must be initiated within six months for adults and within three months for children and adolescents.

The legislation is available on the Internet at: <http://www.finlex.fi>.

At present there is a discussion about revising the Mental Health Act to add criteria for compulsory outpatient care in specific cases.

Mentalvårdslagen är en allmän lag som definierar begrepp, innehåll, övervakning, förpliktelser och principer för tillhandahållandet av mentalvårdstjänster. Dessutom innehåller den specialbestämmelser om statliga psykiatriska sjukhus, vård oberoende av patientens vilja och rättspsykiatriska utredningar.

I folkhälsolagen inkluderas den psykiatriska hälsovården i primärvården. "Inom folkhälsoarbetet åligger det kommunen att förverkliga det mentalvårdsarbete som avses i mentalvårdslagen genom att ordna sådant förebyggande mentalvårdsarbete och sådana mentalvårdstjänster som kommuninvånarna behöver och som det är ändamålsenligt att ordna vid en hälsovårdscentral".

Lagen om specialiserad sjukvård fastslår villkoren för organiseringen av den specialiserade sjukvården och därtill hörande verksamhet. För att kunna organisera specialistsjukvård i enlighet med denna skyldighet måste varje kommun höra till en samkommun för ett sjukvårdsdistrikt. Lagen specificerar även tidsframar för tillgång till icke-brådskande specialvård. Bedömningen av behovet av psykiatrisk vård måste ske inom tre veckor, och behandlingen måste påbörjas inom sex månader inom vuxenpsykiatri och inom tre månader inom barn- och ungdomspsykiatri.

Lagstiftningen finns tillgänglig på Internet på adressen <http://www.finlex.fi>.

För tillfället förs en diskussion om att revidera mentalvårdslagen med avsikten att tillägga kriterier för rätt till öppen vård oberoende av patientens vilja i särskilda fall.

ICELAND: There is no special law concerning mental health. The main act regarding mental health is the Act relating to health care services, no. 97/1990, but in September this year a new act will enter into force, no. 40/2007. Other acts concerning the rights of people with mental illness are: the Act relating to patients' rights, no. 74/1997, the Social Assistance Act, no. 117/1993, the Act relating to the Medical Directorate of Health, no. 41/2007 and the Act relating to the affairs of disabled persons, nr. 59/1992.

The Act relating to health care services contains all rules and regulation concerning health care services. It states that all inhabitants have the right to the best possible services that it is possible to provide to protect their mental, physical and social health. The act describes the organization and provision of health care services, the role of the health authorities and quality assurance.

The objective of the Act relating to patients' rights is to ensure specific rights for patients in accordance with general human rights and human dignity, and thus to strengthen their legal status regarding the health service, and to support the confidential relationship which must exist between patients and health workers. Discrimination against patients on the grounds of gender, religion, beliefs, nationality, race, skin colour, financial status, family relationships or other kinds of status is prohibited. The patient has the right to the best health service available at any time. The patient has the right to health services relative to his condition and prognosis at any time and the best knowledge available. The health worker shall en-

ISLAND: Det finns ingen specifik lag som gäller psykisk hälsa. Huvudlagen som berör psykisk hälsa är en lag om hälsovårdstjänster, nr 97/1990, men i september detta år kommer en ny lag att träda i kraft, nr 40/2007. Andra lagar som berör psykiatriska patienters rättigheter är: en lag om patientens rättigheter, nr. 74/1997, en lag om socialt bistånd, nr. 117/1993, en lag som gäller hälsodirektoraten, nr. 41/2007, och en lag som gäller ärenden som berör handikappade personer, nr. 59/1992.

Lagen om hälsovårdsservice innehåller alla bestämmelser rörande hälsovårdsservicen. Den stadgar att alla invånare har rätt till den bästa möjliga vården som kan tillhandahållas för att bevara deras psykiska, fysiska och sociala hälsa. Lagen beskriver organiseringen och tillhandahållandet av hälsovårdsservicen, hälsovårdsmyndigheternas roll samt kvalitetssäkringen.

Målet för lagen om patienternas rättigheter är att garantera särskilda rättigheter för patienterna i enlighet med allmänna mänskliga rättigheter och människovärdet och därigenom stärka deras rättsliga status inom hälsovården, samt att understöda det konfidentiella förhållande som måste existera mellan patienter och vårdpersonal. Det är förbjudet att diskriminera patienter på basis av kön, religion, trosuppfattning, nationalitet, ras, hudfärg, ekonomisk status, familjerelationer eller status i annat avseende. Patienten har rätt till den bästa möjliga vård som kan tillhandahållas vid det aktuella tillfället. Patienten har rätt till vård som står i relation till hans eller hennes tillstånd och prognos vid det aktuella tillfället och till den bästa tillgängliga kunskapen. Vårdpersonalen

deavour to establish a sound relationship with the patient. The patient has the right to continuous service and co-operation between all health workers and institutions involved in the treatment. Other rights include the right for information and consent, the right for confidentiality and secrecy, the right for treatment, the rights of sick children and the right to complain.

Social benefits in accordance with the Social Assistance Act include maternity and paternity allowance, child pension regarding education or vocational training for young people aged 18-20, home care benefits, rehabilitation pension, spouses' benefits, widows' and widowers' benefits, household supplement, supplements arising from special circumstances, supplement for the operating costs of an automobile, grants for the purchase of an automobile, and reimbursement for substantial expenses on medical assistance and medication.

The Act relating to the Medical Directorate of Health describes the role of the organization to supervise the quality of health care services, to ensure the safety of patients, to collect and publish health data, to deal with complaints, and to supervise the prescription of drugs.

The Act relating to the affairs of disabled persons aims to secure disabled persons equal rights and equivalent living conditions as others in society, and to create the conditions to enable them to live a normal life. Those who have the right to services according to this act are individuals who are mentally or physically disabled and therefore need specialized service or support.

ska sträva till att skapa ett sunt förhållande till patienten. Patienten har rätt till kontinuerlig vård och kontinuerligt samarbete mellan all vårdpersonal och alla institutioner som är involverade i behandlingen. Andra rättigheter är till exempel rätten till information och till att ge sitt samtycke, rätten till konfidentialitet och sekretess, rätten till behandling, sjuka barns rättigheter och rätten att lämna in klagomål.

Lagen om socialt bistånd omfattar moderskaps- och faderskapsunderstöd, understöd till barn vad gäller utbildning eller yrkesträning för ungdomar i åldern 18-20, hemvårdsunderstöd, rehabiliteringsunderstöd, understöd till makar, änkepensioner, hushållstillägg, tillägg på basis av speciella omständigheter, tillägg för driftsutgifterna för en bil, bidrag för inköp av en bil och ersättning för läkarevård och mediciner.

Lagen som berör hälsodirektoraten beskriver som organisationens uppgifter att övervaka kvaliteten på hälsovårdsservicen, att garantera patientsäkerheten, att samla in och publicera hälsovårdsstatistik, att behandla klagomål och att övervaka ordinerings av mediciner.

Lagen om ärenden som berör handikappade personer strävar till att garantera handikappade personer samma rättigheter och likvärdiga levnadsvillkor som andra i samhället och att skapa de förutsättningar som möjliggör för dem att leva ett normalt liv. Rätten till service enligt denna lag har de individer som är psykiskt eller fysiskt handikappade och därför behöver specialservice eller -stöd.

NORWAY: The organization of mental health care is based on the principle of integration. Services for people with mental health problems shall be provided by the agencies responsible for providing services for people in general. The legislation focuses on voluntary treatment. According to the principle of integration, most mental health services are regulated by the same legislation as other health services. The exception is the use of compulsory admission and treatment, which is covered by separate legislation.

*1. Act relating to municipal health services
Act relating to social services.*

In the mental health programme, emphasis has been placed on primary health care, social services and the labour market. The municipalities have responsibility for prevention and provision of primary health care and social services. They play a key role in the provision and coordination of services for people with mental health problems. From 2001 all citizens have the right to have a personal doctor (GP).

2. Act relating to specialized health services.
It is emphasised that specialized mental health services are to be integrated with, and run according to the same principles as other specialized health care services. In 2002 the responsibility for specialized health care was transferred from the counties to the central government. Five regional health authorities (RHA) are now responsible for providing specialized health services for people in the region. A system for quality assurance is being implemented in the specialized services. This system strongly emphasises indicators measuring users' experience and satisfaction with services.

NORGE: Organiseringen av psykisk helsevern i Norge bygger på prinsippet at tjenestene så langt det er mulig, gis av de samme organer som gir tjenester til befolkningen totalt sett. Tjenestene skal bygge på prinsippene om integrering og desentralisering. Lovgivningen er basert på frivillig behandling. Det er bare når det gjelder tvang at det er egen lovgivning for psykisk helsevern. Som en konsekvens av denne brede tilnærmingen er tilgangen på tjenester innen området mental helse lovhjemlet i en rekke lover.

1. Lov om kommunehelsetjenesten og lov om sosialtjenester.

Kommunene har ansvaret for primærhelsetjenesten, både forebygging og kurative tjenester, rehabilitering, pleie og omsorg og omfatter legetjenester, sykepleie og fysioterapi. Sosiale tjenester er også kommunenes ansvar hjemlet i egen lov. De senere års praksis med å overføre psykiatriske pasienter fra institusjoner til kommunalt nivå har vært en stor utfordring for kommunenes helse- og sosialtjeneste.

2. Lov om spesialisthelsetjenesten mm.

Loven regulerer spesialisthelsetjenesten som i Norge er statens ansvar. Loven omfatter også psykisk helsevern. Det er lagt vekt på at psykisk helsevern skal være integrert i og drives etter samme prinsipper som annen spesialisttjeneste. I 2002 ble ansvaret for spesialisthelsetjenesten overført fra fylkeskommunene til staten. Spesialisthelsetjeneste er organisert i fem regionale helseforetak som skal sørge for spesialiserte tjenester for befolkningen i regionen. Det er innført et system for bruk av kvalitetsindikatorer. Systemet legger stor vekt på indikatorer som måler brukernes erfaringer og tilfredshet med tjenestene.

3 Mental Health Act. This act covers the use of compulsory admission, treatment and other forms of coercion. The act was implemented in 2001 and some changes were made in 2006. Compulsory admission and treatment requires that patients have a serious mental illness and that at least one of two additional criteria is met: a) the possibility of cure or considerable improvement will be lost, or b) the patient represents a considerable danger to himself or to others. According to the act, acceptable voluntary solutions shall be tried whenever possible. Complaints concerning compulsory admission and treatment are dealt with by a special Control Commission appointed by the Ministry of Health and Care Services.

4. Act relating to patients' rights. A new law laying down and expanding patients' rights has been implemented. These rights include a) the right to necessary treatment and care, b) the right to an evaluation of the need for treatment within a maximum of 30 days, c) the right to an individual plan for treatment and care, d) the right to a second opinion, e) the right to choose where to receive treatment, and f) the right to see one's medical journal.

5. Act relating to supervision of health services. According to this act the Norwegian Board of Health Supervision has overall responsibility for supervision of health services and health personnel. The Board of Health Supervision has a department in each county with responsibility to carry out supervision and to deal with complaints. Complaints concerning compulsory admission and treatment are dealt with by a special Control Commission appointed by the Ministry of Health and Care Services (the legislation concerning compulsion).

3. Lov om etablering og gjennomføring av psykisk helsevern (psykisk helsevernloven). I opptrappingsplanen legges det stor vekt på at primærhelsetjenesten og sosialtjenesten har stor betydning for psykisk helse. Kommunene har ansvaret for primærhelsetjenesten, både forebygging og kurative tjenester, rehabilitering, pleie og omsorg og omfatter legetjenester, sykepleie og fysioterapi. Sosiale tjenester er også kommunenes ansvar hjemlet i egen lov. De senere års praksis med å overføre psykiatriske pasienter fra institusjoner til kommunalt nivå har vært en stor utfordring for kommunenes helse- og sosialtjeneste. Fra 2001 har alle innbyggere en fast promørløse.

4. Pasientrettighetsloven. Lovens formål er å sikre befolkningen lik tilgang på helsehjelp av god kvalitet ved å gi pasienter rettigheter overfor helsetjenesten. Rettighetene omfatter rett til nødvendig helsehjelp, rett til vurdering av behandlingsbehov innen 30 dager, rett til individuell plan for behandling og pleie, rett til second opinion og rett til fritt sykehusvalg og rett til å se egen pasientjournal.

5. Lov om statlig tilsyn med helsetjenesten. Loven bestemmer at Statens helsetilsyn har overordnet tilsyn med all helsetjeneste og at helsetilsynet i fylkene (lagt til fylkesmannen) har ansvaret for tilsyn med helsetjeneste og helsepersonell i fylket. Klager på helsetjenester og helsepersonell behandles av helsetilsynet. Klager knyttet til tvang i psykisk behandles av en egen kontrollkomisjon i hvert fylke og som oppnevnes av Helsedepartementet.

SWEDEN: *Legislation related to mental health services.*

There are laws regulating mental health care, social services and benefits for persons with psychiatric disorders or disabilities due to long-term mental illness. These laws regulate the authorities that are responsible for measures for people who are mentally ill.

The *Health and Medical Services Act* provides for the treatment of people in need of medical or psychiatric treatment, either by nurses in sheltered homes run by the social services or through specialized psychiatric care in these homes, in clinics or in primary health care.

The *Compulsory Psychiatric Care Act* and the *Forensic Psychiatric Care Act* regulate compulsory care, which is the responsibility of the psychiatric care organization.

The 1994 *Act concerning support and services for persons with certain functional impairments (LSS)* aims to provide support and services for people with functional impairments, including those with impairments due to psychiatric disorders. The Act sets out a number of specific forms of assistance that people with psychiatric disorders can receive, including counselling and support, personal assistance, housing with special services, personal contacts and companions. The act is complementary legislation, and does not entail curtailment of assistance that the individual is entitled to according to other laws. It is also civil rights legislation and decisions can therefore be appealed in the administrative courts. In 2003, 2 800 people with psychiatric disorders received help under the Act.

SVERIGE: *Lagstiftning i anslutning till psykiatrisk hälso- och sjukvård*

Det finns lagar som reglerar den psykiatiska vården och socialvården samt olika förmåner för personer med psykisk ohälsa eller psykiska funktionshinder beroende på långvarig psykisk sjukdom. Dessa lagar styr de olika myndigheter som har ansvaret för åtgärder riktade till psykiskt sjuka personer.

Hälso- och sjukvårdslagen reglerar om behandlingen av personer i behov av medicinsk eller psykiatrisk behandling, antingen av sjukskötare i stödboenden inom socialtjänsten eller genom specialiserad psykiatrisk vård i dessa boendeformer, på kliniker eller inom primärvården.

Lagen om psykiatrisk tvångsvård och lagen om rättspsykiatrisk vård reglerar tvångsvården, som den psykiatriska vårdorganisationen ansvarar för.

Lagen om stöd och service till funktionshindrade (LSS) från 1994 strävar till att erbjuda stöd och vård till människor med funktionshinder, inkluderande funktionshinder beroende på psykisk ohälsa. Lagen stadgar om ett antal specifika hjälpformer som personer med psykisk ohälsa kan er hålla, bl.a. rådgivning och stöd, personlig assistans, boende med specialservice, personliga kontakter och ledsagare. Lagen är sekundär och innebär inte någon inskränkning i sådant bistånd som individen har rätt till enligt andra lagar. Den är också en rättighetslag och beslut gjorda i enlighet med denna lag kan därför överklagas i förvaltningsdomstolarna. Under 2003 erhöll 2 800 personer med psykisk ohälsa hjälp via denna lag.

According to the *Social Services Act*, the municipal social services have a duty to conduct outreach activities among people with psychiatric disorders. Social services also have a duty to plan assistance programmes for these individuals in consultation with the psychiatric care organization and other public bodies and organizations.

According to the *Municipal Financial Responsibility Act* (1995), the municipalities have a duty to pay for the care of patients who, after three consecutive months of inpatient treatment by a psychiatrist, are assessed as having completed their treatment within the psychiatric inpatient system, but are still being cared for in hospital because they cannot be mainstreamed into community-based independent living or sheltered housing. One of the aims of municipal financial responsibility is to stimulate the development of new forms of housing within the community for mentally disabled people who have been under long-term institutional care.

Insurance benefits (sick pay, sickness benefits, activity benefits and sickness allowances) are regulated by the Insurance Act administered by governmental institution (Swedish Social Insurance Agency).

The Swedish legislation is available in the Internet: <http://www.lagrummet.se>.

Socialtjänstlagen ålägger de kommunala sociala myndigheterna att ordna uppsökande verksamhet bland personer med psykisk ohälsa. De sociala myndigheterna bör även planera sina hjälpprogram för sådana personer i samråd med den psykiatriska vårdorganisationen och andra offentliga instanser och organisationer.

Lagen om kommunernas betalningsansvar (1995) ålägger kommunerna att betala för vården av sådana patienter som efter tre fortlöpande månader av psykiatrisk slutenvård (anstaltsvård) av en psykiater har bedömts vara färdigbehandlade inom denna vårdform men som fortsättningsvis vårdas där eftersom de inte kan slussas ut till eget boende eller stödboende i samhället. En av målsättningarna med det kommunala betalningsansvaret är att stimulera utvecklandet av nya boendeformer i samhället för psykiskt funktionshindrade människor som har varit i långvarig institutionsvård.

Försäkringsförmånerna (sjuklön, sjukpenning, aktivitetsersättning och sjukersättning) regleras av lagen om allmän försäkring och administreras av statlig institution (Försäkringskassan).

Svensk lagstiftning finns tillgänglig på Internet: <http://www.lagrummet.se>.

Organization of the services

DENMARK: The Structural Reform and the Health Act regulate responsibilities regarding mental health services. The

Organisation

DENMARK: Kommunalreformen og Sundhedsloven fastlægger ansvaret for praksissektoren og sygehusvæsenets op-

five regions have responsibility for both primary health care services and secondary health care services; that is, mental health services in hospital departments, inpatient care and outpatient clinics, community based psychiatry and specialized outreach teams e.g. psychiatric teams for elderly people, psychosis teams.

Through the public health insurance system the regions also have responsibility for delivering services provided by private psychiatrists and psychologists, who, with general practitioners, provide treatment for patients with common mental disorders and uncomplicated long-term mental illness.

The local authorities, the 98 municipalities, provide health promotion and primary prevention, social, educational and occupational services, and housing and rehabilitation for mentally ill patients. The municipalities also have responsibility for providing treatment for people with drug and alcohol problems.

According to the Health Act, the regional and local authorities must cooperate to provide treatment for people with mental disorders and diseases. The two levels are thus obliged to make agreements of cooperation.

FINLAND: In Finland the health system is clearly decentralized. Local authorities, 416 municipalities, have responsibility for providing various mental

gaver i 5 regioner, der har afløst de tidligere 15 amter. Regionerne varetager således den sygehusbaserede psykiatri omfattende psykiatriske afdelinger/stationær psykiatri og dag/ deldøgnsindlæggelser, psykiatriske skadestuer og for de ambulante psykiatriske tilbud i form af ambulatorier/klinikker, distriktpsychiatriske ordninger og opsøgende og udgående teams f.eks. gerontopsykiatriske teams og opsøgende psykoseteam mv.

Endvidere har regionerne via den offentlige sygesikring ansvaret for psykiatrisk og børne-ungdomspsykiatrisk speciallægepraksis samt de alment praktiserende læger og praktiserende psykologer, som varetager en række opgaver vedr. lettere eller mere ukomplicerede psykiske lidelser.

Kommunerne som nu er samlet til 98 varetager de kommunale sundhedsydelser der bl.a. omfatter sundhedspleje, forebyggelse og sundhedsfremme samt genoptræning/ rehabilitering. De sociale opgaver er ligeledes placeret i kommunerne tillige med misbrugsbehandling. Den kommunale indsats omfatter således typisk sociale, undervisnings- og beskæftigelsesmæssige tilbud, botilbud og fritidstilbud mv. samt rehabilitering.

Samarbejdet mellem den regionale og den kommunale indsats skal sikres ved at det i Sundhedsloven kræves, at der indgås samarbejdsaftaler om indsatsen for mennesker med sindslidelser såkaldte sundhedsaftaler.

FINLAND: I Finland är vårdssystemet klart decentraliserat. De lokala myndigheterna, 416 kommuner, bär ansvaret för att tillhandahålla olika former av

health services for their residents. The main services related to mental health problems or disorders include outpatient visits to health centres or specialized medical care, different types of specialized inpatient care provided by the hospital districts, and support in housing and coping for those requiring long-term and multiple psychiatric care. In addition to the public service system, non-governmental organizations (NGOs) provide a range of support services for daily life, crises and other special situations. Typically they offer low threshold services. They have a wide range of knowledge about the needs of special groups, such as migrants, substance abusers and the next-of-kin of mental health patients. Private services are mainly limited to outpatient visits by private psychiatrists and accommodation services for patients with long-term illness provided by private practitioners.

The spectrum of mental health services is extensive. These services vary from support and counselling services related to various life situations to intensive and demanding treatment for people who are seriously ill. The interdependence between service supply and demand is extremely complex. It is difficult to draw conclusions about needs and particularly about the prevalence of problems or disorders on the basis of changes in the supply of services. Service needs are the sum of many factors and not a direct consequence of, for example, the prevalence of mental disorders among population. It has been estimated that there are significant regional differences in service availability, particularly as Finland is geographically

mental hälsovårdstjänster för sina invånare. Huvudservicen i anslutning till psykiska hälsoproblem eller ohälsa inkluderar öppen vård vid hälsovårdscentraler eller specialiserad hälsovård, olika former av specialiserad anstaltsvård som ordnas av sjukvårdsdistrikten, samt stöd med boende och annat för dem som behöver långvarig och mångsidig psykiatrisk vård. Utöver det offentliga vårdssystemet erbjuder frivilliga organisationer ett vitt spektrum av stödservice för det dagliga livet, kriser och andra speciellsituationer. Normalt är tröskeln låg till dessa serviceformer och de erbjuder en omfattande kunskap om specialgruppers behov, såsom invandrare, drogmissbrukare och anhöriga till psykiskt sjuka patienter. Den privata sektorns roll avgränsas huvudsakligen till besök inom öppenvården hos privata psykiatriker samt boendeservice för långtidssjuka patienter som ordnas av privata företag.

Den psykiska hälsovårdsservicen omfattar ett brett spektrum. Den innehåller allt från stöd och rådgivning som hör ihop med olika livssituationer till intensiva och krävande behandlingar för personer som är allvarligt sjuka. Sambandet mellan vårdutbudet och efterfrågan är extremt komplext. Det är svårt att dra slutsatser om behoven och speciellt om omfattningen av olika problem eller störningar på basis av förändringar i vårdutbudet. Vårdbehovet utgörs av en summa av många faktorer och är inte en direkt konsekvens av, t.ex., förekomsten av mental ohälsa i befolkningen. Det har uppskattats att det finns signifikanta regionala skillnader i vårdtillgängligheten, speciellt eftersom Finland är ett geografiskt stort land och har

large and has an uneven population distribution. To date, there is no reliable information about how these differences affect people's well-being.

ICELAND: The health system is centralized and mostly financed by taxation. It is regulated by the Act relating to health care services. The Minister of Health and Social Security is responsible for the administration and the policy of the health services. The principle of the organization of the services is that services should be provided at the relevant level and that primary care in most cases should be the first point of contact.

The Medical Directorate of Health serves as adviser to the minister and to the government on everything concerning health. It supervises the activities of health professionals and health institutions, collects statistics and publishes statistical reports. The Directorate of Health deals with complaints or charges arising from the relationship between the general public and the health services.

The State Social Security Institute (SSSI) is charged with the administration of pension insurance, occupational injury insurance and health insurance in accordance with the Act Relating to Social Security.

Health care centres throughout the country provide primary care, including general medicine, nursing and preventive services.

Hospitals provide emergency services and specialized services. The University Hospital and the Hospital in Akureyri have special mental health units and thus provide most of the inpatient services for

en ojämn befolkningsfördelning. I dagens läge finns ingen pålitlig information över hur dessa skillnader påverkar människornas välbefinnande.

ISLAND: Vårdsystemet är centraliserat och finansieras huvudsakligen med skattemedel. Det regleras genom en lag om hälsovårdsservice. Social- och hälsovårdsministern ansvarar för administrationen och den politiska linjen i hälsovården. Organiseringen av vården följer principen att vård bör erbjudas på en relevant nivå och att primärvården i de flesta fall borde utgöra den första vårdkontakten.

Hälsodirektoraten fungerar som rådgivare till ministern och regeringen när det gäller hälsofrågor. Den övervakar vårdpersonalens verksamhet och institutioner, samlar in och publicerar statistiska rapporter. Hälsodirektoratet är skyldig att behandla klagomål som uppkommer i relationen mellan allmänheten och hälsovården.

Ett statligt socialförsäkringsinstitut (SSSI) har hand om administrationen av pensionsförsäkringar, arbetsolycksförsäkringar och sjukvårdsförsäkringar i enlighet med socialförsäkringslagen.

Vårdcentraler över hela landet erbjuder primärhälsovård inkluderande allmänmedicin, sjukvård och förebyggande vård.

Sjukhusen erbjuder akutvård och specialvård. Universitetssjukhuset och sjukhuset i Akureyri har särskilda psykiatriska avdelningar och står således för huvuddelen av anstaltsvården vid psy-

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people with mental disorders. They also provide ambulatory services and rehabilitation.

Most specialist outpatient care is provided by private practitioners, i.e. psychiatrists, nurses, psychologists, physiotherapists and occupational therapists. Private practitioners are the most rapidly growing part of the health care sector regarding volume. They work on a fee-for-service basis most often negotiated by their professional association and the health authorities.

Most treatment for alcohol and drug abuse is provided by NGOs with support from the state.

The Ministry of Social Affairs and the municipalities are responsible for social and occupational services and housing for people with mental disorders and diseases.

Many NGOs provide a range of support services for daily life such as the Red Cross, the Mental Health Alliance, Hugarfl, and Geysir. They work with patients and their families to assist them to cope with life, to find an occupation, or provide education.

NORWAY: Municipal services (prevention and primary care). The organization is based on the principle of integration and decentralization. Services for people with mental problems shall be provided by the agencies responsible for providing services for people in general. Increased emphasis has been placed on primary health services, social services and labour marked services.

kisk ohälsa. De erbjuder även ambulansvård och rehabilitering.

Största delen av den specialiserade öppna vården erbjuds av privata yrkesutövare, dvs. psykiatriker, sjukskötare, psykologer, fysioterapeuter och arbetsterapeuter. De privata yrkesutövarna utgör den snabbast växande delen av vårdsektorn vad gäller antalet. Deras arbete grundar sig på en vårdavgiftsgrund som oftast förhandlats fram av deras specialistförbund och hälsovårdsmyndigheterna.

Största delen av behandlingen för drog- och alkoholmissbruk ges av frivilliga organisationer med understöd från staten.

Ministeriet för sociala ärenden och kommunerna ansvarar för socialvården och boendeservicen för personer med psykiska störningar och sjukdomar.

Många frivilliga organisationer erbjuder ett urval av stödtjänster för det dagliga livet, t.ex. Röda korset, Alliansen för mental hälsa, Hugarfl och Geysir. De arbetar med patienter och deras familjer och hjälper dem att hantera sin livssituation genom att hitta ett arbete eller erbjuda utbildning.

NORGE: Kommunal service (förebyggande insatser och primärvård). Organiseringen av vården baserar sig på principen om integration och decentralisering. Vård till personer med psykiska problem ska erbjudas av de instanser som ansvarar för ordnandet av vård till allmänheten. Tonvikten har lagts på primärhälsovården såväl som på socialtjänsten och arbetsmarknadsorganisationerna.

The municipalities are responsible for preventive measures, primary health care and social services. They play a key role in providing and coordinating services.

For adults special emphasis has been placed on: a) user participation in treatment and services, b) satisfactory housing with sufficient assistance, c) the possibility of participating in the labour market or other meaningful activities, d) the possibility of social contact and integration, as well as cultural and physical activities, and e) necessary health and social services.

For children, special attention has been given to preventive measures and to children who already have problems or are in the danger zone.

Specialized mental health services are the responsibility of the central government. In 2002 responsibility for specialized health care was transferred from the counties to the central government. Five regional health authorities (RHAs) are now responsible for providing specialized health services. The RHAs are separate legal entities, controlled by the central government in the capacity of owner of health institutions and provider of health services.

Services for adults account for 85 per cent of the total cost, and inpatient services account for 80 per cent of these costs. The services are based on three pillars: 1. Hospital departments shall provide highly specialized services (acute units, specialized functions), 2. District psychiatric centres (DPSs) provide less specialized services on a more

Kommunerna ansvarar för att erbjuda förebyggande åtgärder och primärhälsovård såväl som socialtjänst och innehåller en nyckelroll genom att erbjuda och koordinera vård.

För vuxna har tyngdpunkten lagts på a) klientens deltagande i behandling och vård, b) tillfredsställande boendeservice med tillräcklig assistans, c) möjligheten att delta i arbetsmarknadsaktiviteter eller andra meningsfulla aktiviteter, d) möjligheten till sociala kontakter och integration såväl som kulturella och fysiska aktiviteter samt e) nödvändig hälso- och socialvård.

För barn har speciell uppmärksamhet getts förebyggande åtgärder och de personer som redan har utvecklat problem eller befinner sig i farozonen.

Specialiserad psykiatrisk hälsovård är centralförvaltningens ansvar. Under 2002 förflyttades ansvaret för den specialiserade sjukvården från länen till centralförvaltningen. Fem regionala hälsomyndigheter är nu ansvariga för att driva specialistsjukvården. Dessa är skilda juridiska enheter som kontrolleras av centralförvaltningen såsom ägare och resursfördelare.

Vården för vuxna utgör 85 procent av de totala kostnaderna, och anstaltsvården utgör i sin tur 80 procent av dessa kostnader. Vården baseras på tre pelare: 1. Sjukhusavdelningarna ska erbjuda långt specialiserad vård (akutvård, specialfunktioner), 2. Distriktpsychiatricenter erbjuder mindre specialiserad vård på en mera decentraliserad nivå och 3.

MENTAL HEALTH IN THE NORDIC COUNTRIES

decentralized level, and 3. Psychiatrists and psychologists in private practice provide services in cooperation with other mental services.

Inpatient services account for less than half of services for children and adolescents. Mental health services for these groups have traditionally been provided on an outpatient basis. 95 per cent of patients receive their treatment in this way.

SWEDEN: *Psychiatric care and support*
The Swedish care system for people with psychiatric ill health is supported and governed at three political levels – the state, the counties and the municipalities.

The State is responsible for legislation, higher education (universities), research funding and the health insurance system, including disability pensions for people with long-term mental illness, and general and specific subsidies to counties and municipalities to help them implement various public service measures.

The 18 counties and two regions are responsible for operative specialized health care services for people with psychiatric or somatic illness. This includes hospitals and primary health care services (GPs) and the medical professions working there.

The 290 municipalities are among other things responsible for social services for elderly people and disabled people, including people with long-term psychiatric disorders. These services include social support, rehabilitation measures and medical care up to and including nursing

Psykiatriker och psykologer inom den privata sektorn erbjuder vård i samarbete med den övriga psykiska hälsovården.

Anstaltsvården utgör mindre än hälften av vården för barn och ungdomar. Psykisk hälsovård för dessa grupper har traditionellt ordnats på öppenvårdsbasis. 95 procent av patienterna vårdas på detta sätt.

SVERIGE: *Psykiatrisk vård och psykiatriskt stöd.* Det svenska vårdsystemet för personer med psykisk ohälsa understöds och regleras på tre nivåer – staten, landstingen och kommunerna.

Staten ansvarar för lagstiftning, högre utbildning (universitet), forskningsanslag och sjukförsäkringssystem, inkluderande sjuk- och förtidspensioner med långvarig psykisk ohälsa såväl som generella och riktade statsbidrag till landstingen och kommunerna för att hjälpa dem att implementera olika vårdinsatser till allmänheten.

De 18 landstingen och två regionerna är ansvariga för den operativa specialiserade sjukvården för personer med psykiska eller somatiska sjukdomar. Denna inkluderar sjukhus och primärhälsovård (allmänläkare) samt vårdpersonal inom dessa vårdformer.

De 290 kommunerna bland annat ansvarar för sociala insatser för äldre och handikappade, inkluderande personer med långvarig psykisk ohälsa. Dessa insatser omfattar socialt stöd, rehabiliteringsåtgärder och medicinsk vård upp till och med sjukvårdsnivå. Dessa ansvars-

level. These responsibilities were the focus of the Social Services Act of 1982.

Individuals with long-term psychiatric illness receive care from psychiatric care organizations and public social service agencies. A survey, based on one fourth of municipalities in Sweden, found that the target group included about 43 000 individuals in 1997.

områden upptogs i socialtjänstlagen från 1982.

Personer med långvarig psykiatrisk sjukdom får vård såväl via psykiatriska vårdorganisationer som via offentliga socialvårdsinstanser. En undersökning, som bygger på en fjärdedel av kommunerna i Sverige, gav vid handen att denna målgrupp omfattade omkring 43 000 individer år 1997.

Historical landmarks, example from Sweden

In 1967, responsibility for mental hospitals was transferred from the state to the county councils.

During the seventies, strategies such as sectorization, deinstitutionalization, development of outpatient care, collaboration and increased influence of patients and their families, were set up by the National Board of Health and Welfare. The strategies were implemented at different times (4).

Sectorization of services

Sectorization, i.e. the unification of all psychiatric services in a geographically defined catchment area of between 30 000 and 120 000 inhabitants, was introduced in order to increase availability and accessibility for patients in need. (5). Sectorization was completed in about 1985. At that time, Sweden was divided into 135 catchment areas, each served by a clinic which had (and has) responsibility for all outpatient services, based on about 600 outpatient units and inpatient (hospital) services. Due to

Historiska milstolpar, Sverige som exempel

År 1967 överfördes ansvaret för mentalsjukhusen från staten till landstingen.

Under sjuttioalet lade Socialstyrelsen fram strategier om sektorisering, avinstitutionalisering, utveckling av öppenvården, samarbete och ökat inflytande för patienter och deras familjer upp. Strategierna förverkligades i stor utsträckning vid olika tidpunkter (4).

Sektorisering av vården

Sektoriseringen, dvs. koncentrationen av all psykiatrisk öppen- och slutenvård till ett geografiskt avgränsat, upptagningsområde som omfattar mellan 30 000 och 120 000 invånare, infördes för att uppnå en bättre tillgänglighet för patienter med psykiatriskt vårdbehov (5). Sektoriseringen slutfördes omkring 1985. Vid den tiden var Sverige uppdelat i ca 135 upptagningsområden, vart och ett med en klinik som hade (och har) ansvaret för såväl alla patienter inom öppenvården, baserad på ca 600 öppenvårdsmottagningar, som för

rationalization and concentration into bigger units, the number of clinics was reduced to just over 100 by 2005.

Deinstitutionalization

Most of the isolated mental hospitals are now (2006) closed and replaced by in-patient care in psychiatric clinics in general hospitals, supplemented by small nursing homes and half-way houses. In-patient care has decreased. In 1967 there were about 4.0 psychiatric beds for every 1000 inhabitants. In 1997 the figure was 0.75, but in 2006 it was 0.50. This has been accomplished partly by transferring demented patients to geriatric units. But there has also been a dramatic decrease in the rate of hospitalization of long-term mentally ill persons, mostly schizophrenic patients. Due to the reform, they have been transferred to the municipalities.

Outpatient services

Outpatient services have been developed, located in the community, in apartments in ordinary housing areas or located with health centres. Their number has expanded through developing teamwork with the involvement of all kinds of personnel in patient care. A dissertation (6) concluded that the reallocation of resources to outpatient facilities is not enough to establish community-based services. Much more emphasis has to be placed on integration and cooperation between care-givers within the organization and between other caregivers.

sluten vården (sjukhusvården). På grund av rationalisering och koncentrerings till större enheter hade antalet kliniker minskat till strax över 100 år 2005.

Avinstitutionalisering

De avskilda mentalsjukhusen är nu (2006) stängda och ersatta av slutenvård vid psykiatriska avdelningar vid allmänna sjukhus, kompletterade med små vårdhem och utslussningshem. Slutenvården har minskat; 1967 fanns det ca 4,0 psykiatriska vårdplatser per 1000 invånare, 1997 var siffran 0,75 och 2006 0,50. Detta har uppnåtts delvis genom att förflytta dementa patienter till geriatrika avdelningar, men det har även skett en dramatisk minskning av slutenvårdade av långvarigt psykiskt sjuka personer, främst schizofrena patienter. På grund av reformen har de överförts till kommunerna.

Öppenvården

Öppenvården har utvecklats och mottagningarna har lokaliserats i samhället, i lägenheter antingen i vanliga bostadsområden eller samlokariserade med vårdcentraler. Vårdformen har expanderat genom utvecklingsteamarbete där alla typer av vårdpersonal varit involverade. En avhandling (6) har fastslagit att reallokeringen av resurser till inrättningar inom öppenvården inte sig är tillräcklig för att grunda en samhällsbaserad vård. Man måste satsa mycket mera på integrering och samarbete mellan vårdgivare inom organisationen såväl som mellan andra vårdgivare.

The availability of useful data

All the Nordic countries have advanced national health information systems, which are based on personal-level register data. Common data sources include cause-of-death registers, hospital discharge registers, registers on medication, and registers on pensions and other social benefits. However, the main problem in preparing this theme section has been the lack of comparable data on mental health in the Nordic countries.

The Nordic registers on inpatient services and causes of death have been used for reporting national psychiatric care but not for international comparisons.

Statistics on consumption of medicine have been published, but it is only since 2005 that all countries can provide data at the individual level.

Information on outpatient mental health care is still very limited. Nordic data on positive mental health, psychosocial well-being, and on mental health promotion and prevention of mental disorders has not been reviewed before.

The European Union has financed several projects with the aim of improving the status of mental health information within the European Union. The most suitable data for use in this theme section are the mental health indicators developed in the Mindful project: <http://www.stakes.fi/mindful/>. The MINDFUL mental health indicator database comprises a set of 35 mental health indicators (7).

Tillgången till användbar statistik

Alla nordiska länder har avancerade nationella system för hälsoinformation, vilka baseras på registerdata på personnivå. Vanliga datakällor är dödsorsaksregister, sjukhusregister över utskrivningar, läkemedelsregister, register över pensioner och andra förmåner. Ändå har huvudproblemet vid framtagande av denna temasektion varit bristen på jämförbar statistik på psykisk hälsa i de nordiska länderna.

De nordiska registren över anstaltsvård och dödsorsaker har använts för rapportering av nationell psykiatrisk vård men inte räckt till för internationella jämförelser.

Statistiken över medicinanvändning har publicerats trots att statistik på individnivå kunnat erhållas från alla länder först från och med år 2005.

Informationen om den psykiatriska öppenvården är fortfarande mycket begränsad. Nordisk statistik över positiv psykisk hälsa, psykosocialt välbefinnande och främjande av den psykiska hälsan samt förebyggande av psykisk ohälsa har inte tidigare visats.

Europeiska unionen har finansierat ett flertal projekt med målsättningen att förbättra statusen på informationen om psykisk hälsa inom EU. Mest användningsbara för denna temasektion är de indikatorer på mental hälsa som utvecklats i projektet Mindful: <http://www.stakes.fi/mindful/>. MINDFUL-databasen över indikatorer på psykisk hälsa innehåller 35 indikatorer (7).

Reliable and comprehensive data are available through NOMESCOs routine data collection on causes of death, utilization of inpatient services and consumption of psychotropic medication. In addition, we used country-specific surveys, if available.

In summary, there is shortage of comparable information for many of the indicators used in this report. This problem has been solved by reporting the situation only from the countries with relevant information. For some themes, only one country is used as an example.

Pålitlig och uttömmande statistik finns tillgänglig via NOMESCOs rutindata-samling över dödsorsaker, användningen av anstaltsvård och konsumtionen av psykotropiska läkemedel. Vi har även samlat in nationsvisa survey-undersökningar om sådana funnits tillgängliga.

Sammanfattningsvis finns det en brist på jämförbar statistik för många av de indikatorer som använts i denna rapport. Detta problem har lösts genom att återge situationen enbart från de länder med relevant statistik och för vissa teman har endast ett land använts som exempel.

What do indicators tell us about mental health in the Nordic countries?

Vad berättar indikatorerna om psykisk hälsa i de nordiska länderna?

Mental health status

Psykiska hälsans ställning

Mental well-being

Reliable and comparable surveys on mental well-being are few. A Special Euro-barometer on mental well-being covering all current 27 EU member states was published by the European Commission in May 2006 (8). Of the five Nordic countries Denmark, Finland and Sweden were included, but Iceland and Norway were not. The questionnaire for this survey was based, among other instruments, on items from the SF-36 Health Survey.

This survey showed that people in the Nordic countries feel happier and less

Psykiskt välbefinnande

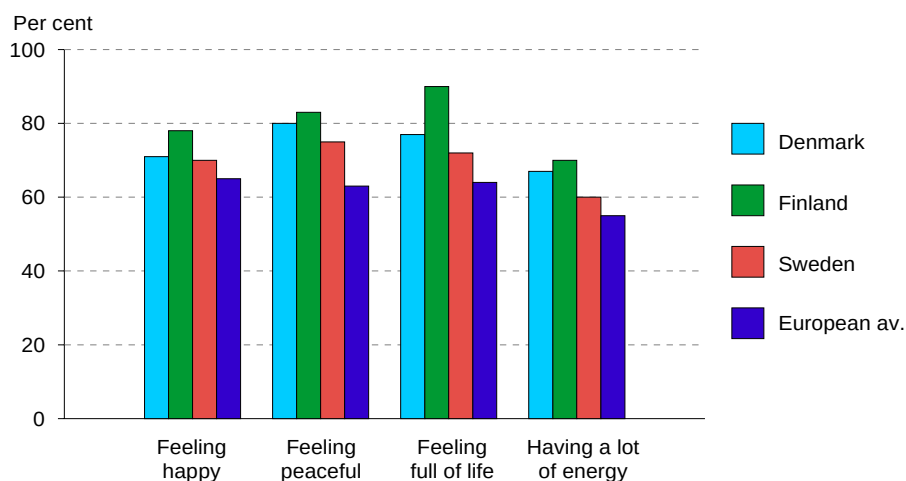
Det finns få pålitliga och jämförbara undersökningar om psykiskt välbefinnande. En särskild Eurobarometer över psykiskt välbefinnande som täcker alla nuvarande 27 EU-medlemsstater publicerades av Europeiska kommissionen i maj 2006 (8). Av de fem nordiska länderna fanns Danmark, Finland och Sverige med, men inte Island och Norge. Frågeformuläret för denna undersökning baserades, förutom på andra hjälpmedel, på uppgifter från hälsoundersökningen SF-36.

Denna undersökning visar att mänskorna i de nordiska länderna känner sig

tired than average Europeans. When looking at positive feelings (Figure 2), 78 per cent of Finnish, 71 per cent of Danish and 70 per cent of Swedish respondents felt happy all the time or most of time, while the European average was 65 per cent.

lyckligare och mindre trötta än medel-européerna. När man ser på de positiva känslorna (figur 2), har 78 procent av de finländska, 71 procent av de danska och 70 procent av de svenska respondenter känt sig lyckliga hela tiden eller för det mesta, medan det europeiska genomsnittet var 65 procent.

Figure 2 Mental well-being in the Nordic countries compared to the European average 2006



Source: Eurobarometer (8)

The Finns had the highest scores when asked about feeling calm and peaceful with 83 per cent. The Danes were second with 80 per cent and Swedes were fourth with 75 per cent. The average for Europeans was 63 per cent. The figures were similar when looking at energy/vitality.

Finländarna hade högst värde var i topp vad gäller känsla av lugn och fridfullhet med 83 procent. Danskarna följde efter med 80 procent och svenskarna var fjärde med 75 procent. Det europeiska medeltalet var 63 procent. Statistiken var likartad vad gäller energi/vitalitet.

The Finnish people had again high scores when asked if they felt full of life. 90 per cent of the Finnish respondents answered all or most of the time. The Danes were second with 77 per cent

Finländarna hade åter höga tal när man frågade om de hade känt sig ha ett meningsfullt liv. 90 procent av finländarna svarade hela tiden eller för det mesta. Danskarna var andra med 77 procent

MENTAL HEALTH IN THE NORDIC COUNTRIES

and the Swedes after them with 72 per cent. These were both higher than the European average of 64 per cent.

In reporting the amount of energy they had, 70 per cent of Finns, 67 per cent of Danes and 60 per cent of Swedes had lots of energy all or most of the time, while the average for Europeans was 55 per cent.

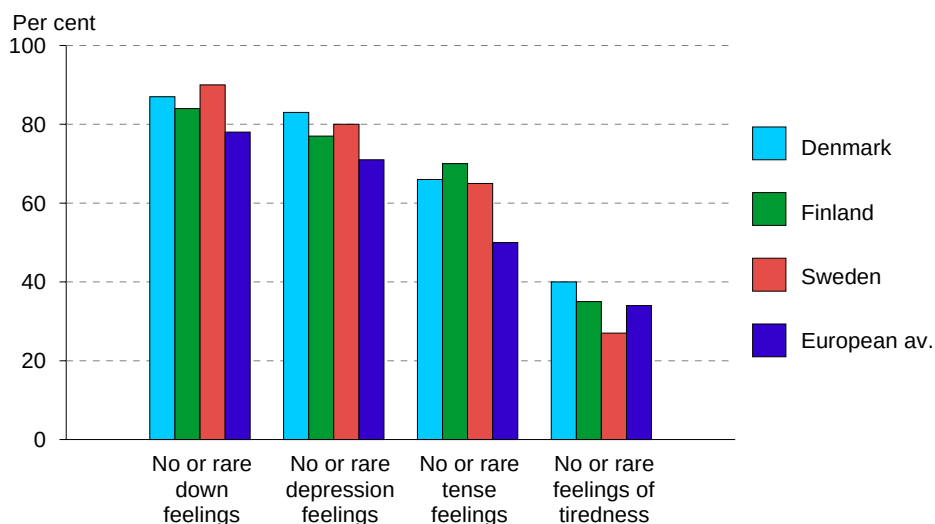
When looking at negative feelings (Figure 3), 90 per cent of Swedes never or rarely felt so down in the dumps that nothing could cheer them up. The number for Danes was 87 per cent and for Finns 84 per cent, while the average for Europeans was 78 per cent.

och svenskarna efter dem med 72 procent. Båda dessa tal var högre än det europeiska genomsnittet på 64 procent.

Vad gäller känslan av energi gav 70 procent av finländarna, 67 procent av danskarna och 60 procent av svenskarna att de hade mycket energi hela tiden eller för det mesta, medan medeltalet för européerna var 55 procent.

När man ser på negativa känslor (figur 3) kände sig 90 procent av svenskarna aldrig eller sällan så nere att ingenting kunde muntra upp dem. Andelen för danskarna var 87 procent och för finländarna 84 procent, medan medeltalet för européerna var 78 procent.

Figure 3 Mental well-being in the Nordic countries compared to the European average 2006



Source: Eurobarometer (8)

In total, 83 per cent of Danes, 80 per cent of Swedes and 77 per cent of Finns

Totalt sade 83 procent av danskarna, 80 procent av svenskarna och 77 procent av

said that they have never or rarely felt downhearted or depressed, whereas this was the case for 71 per cent for all Europeans. The three Nordic countries again appear at the top of the table when feeling no or rare tense is discussed. 70 per cent of Finns, 66 per cent of Danes and 65 per cent of Swedes asserted that they have felt tense only rarely, while the average for Europeans was 50 per cent. For the energy/vitality dimension, it can be clearly observed that Europeans often feel tired. 40 per cent of Danes, 35 per cent of Finns and 27 per cent of Swedes stated that they never or rarely felt tired, while the average for Europeans was 34 per cent.

In addition to the Eurobarometer and MINDFUL databases, there is national information on mental well-being from Norway from 2002 (with about 10 000 respondents). Norwegians report least psychological distress (80 compared to 71-76 in the three Nordic EU countries) and most social support (11 compared to 9-10). Finns report the least social support but most energy/vitality (72 compared to 60-63). Danes report the least psychological distress and Swedes are in the middle for every indicator (Table 1).

finländarna att de aldrig eller sällan hade känt sig nedstämda eller deprimerade medan detta var fallet för 71 procent av alla européer. De tre nordiska länderna uppvisar igen höga värden vad gäller att aldrig och sällan känna sig spänd. 70 procent av finländarna, 66 procent av danskarna och 65 procent av svenskarna menade att de endast sällan har känt sig spända, när det europeiska medeltalet var 50 procent. Vad gäller aspekten energi/vitalitetdimensionen, mätt med känsla av trötthet att européer ofta känner sig trötta. 40 procent av danskarna, 35 procent av finländarna och 27 procent av svenskarna påstår att de aldrig eller sällan känner sig trötta, medan det europeiska medelvärdet är 34 procent.

Förutom Eurobarometern och databasen MINDFUL finns det nationell statistik om mentalt välbefinnande från Norge från 2002 (med ca 10 000 svarande). Enligt denna statistik är det norrmännen som uppvisar minst psykisk belastning (80 jämfört med 71-76 i de tre nordiska EU-länderna) och mest socialt stöd (11 jämfört med 9-10). Finländarna uppvisar minst socialt stöd men mest energi/vitalitet (72 jämfört med 60-63). Danskarna uppvisar minst psykisk belastning och svenskarna är i mitten för varje indikator (tabell 1).

How common are psychiatric disorders in the Nordic countries?

Comparable reliable information about the prevalence of psychiatric disorders in the different Nordic countries was not available. We assume that the differences in the prevalences of the major

Hur vanlig är psykisk ohälsa i de nordiska länderna?

Jämförbar pålitlig information över förekomsten av psykisk ohälsa i olika nordiska länder fanns inte att tillgå. Vi utgår från att skillnaderna i förekomst för de huvudsakliga psykiska sjukdomar:

psychiatric disorders, major depression, anxiety and schizophrenia, are insignificant in the Nordic countries. The Finnish Health 2000 study is used as an example here (9).

The Health 2000 study to assess the prevalence of mental disorders among people over 29 years old in Finland was based on the internationally well-established Composite International Diagnostic Interview (CIDI) method. The interviews were conducted between September 2000 and July 2001. Interviewees were asked questions about symptoms of mental disorders that they had experienced during the year preceding the interview, and they were given a diagnosis when possible using established diagnostic criteria. This and earlier studies show that about one quarter of Finns suffer from psychological symptoms with adverse effects at some point in their lives (9). An estimated 15–20 per cent had suffered over the past year from a diagnosable mental disorder (10, 11). The most common diagnoses included depressions, anxiety disorders and alcohol-related disorders (Table 2). The study shows that the number of people with mental disorders has not increased over the past decades, contrary to what the public has at times been led to believe (10, 11). The prevalence of major depression was 4.9 per cent and of some type of depression 6.5 per cent among Finnish people. The prevalence of some type of anxiety disorder was 4.2 per cent and some type of alcohol use disorder 4.3 per cent. The lifetime prevalence for schizophrenia was 0.9 per cent.

svår depression, ångest och schizofreni, är obetydliga i de nordiska länderna. Som ett exempel har här använts den finländska Hälsa 2000-studien (9).

Hälsa 2000-studien som syftade till att uppskatta förekomsten av psykisk ohälsa bland befolkningen över 29 år i Finland baserades på den internationellt väletablerade Composite International Diagnostic Interview (CIDI)-metoden. Intervjuerna utfördes mellan september 2000 och juli 2001. De svarande fick frågor om symptom på psykisk ohälsa som de hade upplevt under året före intervjun och gav en diagnos när det var möjligt enligt etablerade diagnoskriterier. Denna och tidigare studier visar att omkring en fjärdedel av finländarna lider av psykologiska symptom med skadliga effekter vid någon tidpunkt i livet (9). Uppskattningsvis 15–20 procent hade under det senaste året lidit av en diagnostiserad psykisk sjukdom (10, 11). De vanligaste var depressioner, ångestsyndrom och alkoholrelaterade störningar (tabell 2). Studien visar att psykisk ohälsa inte har ökat under de senaste årtiondena, i motsats till vad man tidvis låtit allmänheten tro (10, 11). Förekomsten av svår depression var 4,9 procent och förekomsten av någon typ av depression 6,5 procent av finländarna. Förekomsten av någon typ av ångestsyndrom var 4,2 procent och förekomsten av någon form av alkoholmissbruk var 4,3 procent. Risken för en enskild finländare att drabbas av schizofreni någon gång under sin livstid var 0,9 procent.

Table 1 Mental well-being (psychological distress and energy/vitality), and social and cultural determinants of health (social support and negative life events) 2002, per cent

	Denmark*	Finland*	Norway	Sweden*
Psychological distress	71.3	75.8	80.0	74.0
Energy/vitality	63.2	71.5	60.1	61.3
Social support	9.5	8.5	11.1	9.5
Negative life events	NA	0.9	0.7	NA

NA = Not available.

Source: MINDFUL data

Psychological distress

Description: A non-specific dimension of psychopathology, indicates that something is wrong but does not yield diagnostic assessment, comprised usually of anxiety and depression-related distress states. Distress is associated with high use of health services and is a predictor of mortality

Definition: A health interview survey indicator. Occurrence and extent of psychological distress during past month. Mean score of the Mental Health Index (MHI-5) from the RAND-36 questionnaire.

Energy, vitality

Description: The sense of energy and vitality is an important indicator of positive mental health. It is measured with questions about the degree of both energy and tiredness, as well as the overall degree of happiness.

Definition: A health interview survey indicator. Occurrence and extent of energy and vitality during past month. Age and sex adjusted mean score of the Energy and Vitality Index (EVI) from the RAND-36 questionnaire.

Social support

Description: Social support is defined as availability of people who the individual trusts and who make one feel cared for and valued as a person. Low level of support is associated with ill-health (both e.g. depression and somatic diseases).

Definition: A health interview survey indicator. Current occurrence and extent of social support. Age and sex adjusted mean score of the 3-item Oslo Social Support Scale (OSS-3).

Negative life events

Description: Negative life events are associated with ill-health - both mental disorders (e.g. depression) and somatic diseases. Negative life events can be defined as major occurrences in one's life that require psychological adjustment to a certain degree.

Definition: A health interview survey indicator. Age and sex adjusted prevalence of cases having experienced two or more events during the past 6 months according to the 12-item Threatening Life Events (LTE) questionnaire.

Table 2 Prevalence of the most common types of mental disorder among Finnish people over 29 years of age. Health 2000 survey, winter 2000–2001

	Men (n = 2 748)	Women (n = 3 257)	All (n = 6 005)
	Per cent	Per cent	Per cent
<i>Depressive disorders</i>			
Major depressive disorder	3.4	6.3	4.9
Chronic depression	1.6	2.2	1.9
Some type of depression	4.5	8.2	6.5
<i>Anxiety disorders</i>			
Panic disorder	1.4	2.4	1.9
Social phobia	1.1	0.9	1.0
Agoraphobia	1.2	1.4	1.3
General anxiety disorder	1.3	1.3	1.3
Some type of anxiety disorder	3.7	4.8	4.2
<i>Alcohol-related disorders</i>			
Alcohol dependence	6.5	1.4	3.9
Alcohol abuse	0.7	0.0	0.3
Some type of alcohol use disorder	7.3	1.4	4.3

Source: Pirkola et al. 2005 (11)

How mental health and mortality are connected to each other

Mortality is often incorrectly not seen as crucial in psychiatric disorders. However, increased age-adjusted mortality risk is clear, and is linked to psychiatric disorders in a complex way. Suicides are the main explanation but

Hur är psykisk hälsa och dödlighet relaterade?

Dödlighet ses ofta inte som en väsentlig faktor i psykisk ohälsa, vilket är felaktigt. En ökad ålderstandardiserad dödlighetsrisk, korrigerad med år nämligen tydlig och är länkad till psykisk ohälsa på ett komplext sätt. Huvudförklaringen är

not the only one. People with mental disorders also have an increased risk of death due to physical disorders (12). Alcohol and drug abuse and psychiatric disorders themselves are also connected to increased mortality.

Different practices in cause of death coding make the use of diagnoses in Chapter F in ICD-10 (mental and behavioural disorders) invalid for international comparisons. This chapter does not include suicides, since they are coded under deaths from external causes.

In the Nordic countries, mortality due to mental and behavioural disorders (Chapter F) varies from 20 per 100 000 (in Iceland 2001–2005) to 60 per 100 000 (in Sweden 2004). The majority of these deaths is related to Alzheimer's disease and other dementias. The dementia statistics will be dealt with in more detail in the theme section in the 2008 publication on the health of elderly people. (Table 3).

Mortality due to psychoactive substance abuse (ICD-10 codes: F10-19) is highest in Denmark (14 per 100 000 in 2005), both for men (23 per 100 000) and women (6 per 100 000). The Faroe Islands (data for 2001–2005), Sweden (2004) and Norway (2004) have similar rates around 5-7 per 100 000. (Table 4).

The picture is different when taking account other causes of deaths related to substance use (Tables 4.1.9 and 4.1.10 in Section A). For alcohol-related causes, the countries with the highest alcohol consumption per capita

själv mord, men inte den enda. Personer med psykiska sjukdomar har även en större risk att dö p.g.a. somatiska sjukdomar (12). Alkohol- och drogmissbruk och psykiska störningar är i sig också förbundna med ökad dödlighet.

Olika praxis i kodifieringen av dödsorsaker gör det omöjligt att göra en internationell jämförelse av diagnoser i kapitel F i ICD 10-klassificeringen (psykiska och beteendestörningar). Detta kapitel inkluderar inte självmord, eftersom dessa kodas som dödsfall p.g.a. externa orsaker.

I de nordiska länderna varierar dödligheten på grund av psykiska och beteendestörningar (kapitel F) från 20 per 100 000 (i Island 2001–2005) till 60 per 100 000 (i Sverige 2004). Majoriteten av dessa dödsfall är relaterade till sjukdomen Alzheimer och andra former av demens. Statistiken över demenssjukdomar kommer att behandlas närmare i temasektionen 2008 om de äldres hälsa (tabell 3).

Dödligheten p.g.a. användning av psychoaktiva ämnen (ICD 10-koder: F10-19) är högst i Danmark (14 per 100 000 år 2005), både för män (23 per 100 000) och kvinnor (6 per 100 000). Färöarna (data för 2001–2005), Sverige (2004) och Norge (2004) har liknande siffror, omkring 5-7 per 100 000 (tabell 4).

Bilden ser annorlunda ut när man tar i beaktande andra dödsorsaker relaterade till missbruk (tabellerna 4.1.9 och 4.1.10 i sektion A). När det gäller alkoholrelaterade orsaker har länderna med högst alkoholkonsumtion per person

have the highest mortality rates: Finland 36/100 000 in 2004 and Denmark 25/100 000 in 2001. No data is available for Greenland. The lowest mortality rates are recorded for Iceland (2/100 000 in 2003). Men have up to three-fold mortality rates compared with women. (Table 5).

Since 1995, the number of alcohol-related deaths has increased in three countries: by 9 per cent in Sweden (until 2004), by 33 per cent in Denmark (until 2001) and by 64 per cent in Finland (until 2005).

Drug-related deaths are most common in Norway, Denmark and Sweden, approximately 9-10 deaths per 100 000 inhabitants, while the rates in Finland and the Faroe Islands are less than 2 per 100 000. Even though men had higher rates, the gender differences are smaller for drug-related deaths than for alcohol-related deaths.

One of the best documented mental health indicators is suicide rate (Table 4.1.6 in Section A). There are reliable time series from the 1980s with statistics by age group and gender. There are some clear trends in all the countries. First, suicide rates have decreased in all the Nordic countries. Second, men commit suicide more often than women. Third, people under 30 years of age commit suicide less often than people over 30 years of age. Fourth, there is less dispersion between different countries for people over 65 years. An exception to this general picture is Greenland with very high rates.

In some countries there has been an increase in suicide rates in specific age

också högst dödlighetstal: Finland 36 per 100 000 år 2004 och Danmark 25 per 100 000 år 2001. Ingen statistik finns tillgänglig för Grönland. Det lägsta dödlighetstalet uppvisar Island (2 per 100 000 år 2003). Männens dödlighetstal är upp till tre gånger högre än kvinnornas (tabell 5).

Sedan 1995 har antalet alkoholrelaterade dödsfall ökat i tre länder: med 9 procent i Sverige (fram till 2004), med 33 procent i Danmark (fram till 2001) och med 64 procent i Finland (fram till 2005).

Drogrelaterade dödsfall är vanligast i Norge, Danmark och Sverige, uppskattningsvis 9-10 dödsfall per 100 000 invånare, medan dödlighetstalen i Finland och Färöarna är mindre än 2 per 100 000. Trots att männen har högre siffror är skillnaderna mellan könen mindre för drogrelaterade dödsfall än för alkoholrelaterade dödsfall.

En av de bäst dokumenterade indikatorerna på psykisk hälsa är självmordsgraden (tabell 4.1.6 i sektion A). Det finns pålitliga tidsserier från 1980-talet med statistik över åldersgrupper och kön. Det finns vissa bestämda trender i alla länder. För det första har självmordstalet minskat i alla nordiska länder. För det andra begår män oftare självmord än kvinnor. För det tredje begår personer under 30 år mer sällan självmord än personer över 30. För det fjärde är spridningen mellan länderna mindre vad gäller personer över 65 år. Ett undantag från den allmänna bilden är Grönland med mycket höga självmordstal.

I vissa länder har det också skett en ökning i antalet självmord i vissa ålderska-

groups. This is the case for Icelandic women aged 15-59 years. The suicide rate for Swedish women aged 15-29 years has also increased slightly.

tegorier. Detta är fallet speciellt vad gäller isländska kvinnor i åldern 15-59 år. Även i Sverige har självmordstalen hos kvinnor i åldern 15-29 år ökat något.

Table 3 All deaths in Chapter F per 100 000 inhabitants

	Denmark	Faroe Islands	Finland	Åland	Iceland	Norway	Sweden
	2005	2001-05	2005	2001-05	2001-05	2004	2004
<i>Men</i>							
0-44	5	3	2	5	1	2	2
45-64	59	38	14	5	4	18	23
65-79	88	54	80	85	47	49	81
80 +	557	290	837	512	540	333	715
Total	43	23	33	31	18	21	44
<i>Women</i>							
0-44	2	0	1	0	1	1	0
45-64	16	0	6	5	3	4	6
65-79	60	8	50	87	22	33	67
80 +	695	439	1 109	896	558	503	984
Total	49	21	70	72	23	35	77
<i>M + W</i>							
0-44	3	1	1	3	1	1	1
45-64	37	20	10	5	4	11	14
65-79	73	30	63	86	34	41	74
80 +	648	384	1 031	771	551	445	887
Total	46	22	52	52	20	28	60

Source: National Cause-of-Death Registers

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Table 4 Deaths related to Alzheimer's disease and dementia (F00-03, G30-31) per 100 000 inhabitants

	Denmark	Faroe Islands	Finland	Åland	Iceland	Norway	Sweden
	2005	2001-05	2005	2001-05	2001-05	2004	2004
<i>Men</i>							
0-44	0	0	0	0	0	0	0
45-64	1	0	0	0	1	0	1
65-79	34	18	64	57	40	24	62
80 +	497	290	819	512	528	305	682
Total	18	9	26	23	16	12	33
<i>Women</i>							
0-44	0	0	0	0	0	0	0
45-64	0	0	1	0	0	0	2
65-79	36	8	41	74	19	27	57
80 +	641	439	1 088	874	546	489	952
Total	39	21	66	68	21	32	72
<i>M + W</i>							
0-44	0	0	0	0	0	0	0
45-64	0	0	1	0	0	0	1
65-79	35	13	51	66	29	25	60
80 +	592	384	1 011	756	539	427	855
Total	28	15	46	46	18	22	53

Source: National Cause-of-Death Registers

Table 5 Deaths related to substance abuse (F10-19) per 100 000 inhabitants

	Denmark	Faroe Islands	Finland	Åland	Iceland	Norway	Sweden
	2005	2001-05	2005	2001-05	2001-05	2004	2004
<i>Men</i>							
0-44	4.3	2.5	2.0	5.4	0.8	1.5	1.9
45-64	53.2	38.4	11.8	5.4	3.1	15.7	21.2
65-79	46.4	36.1	12.0	14.2	3.3	24.0	15.2
80 +	29.3	0.0	5.0	0.0	6.0	18.2	10.4
Total	22.6	13.9	6.0	6.2	1.7	7.7	8.8
<i>Women</i>							
0-44	1.0	0.0	0.2	0.0	0.4	0.7	0.3
45-64	12.5	0.0	2.8	5.5	2.6	2.5	3.1
65-79	15.9	0.0	2.8	12.4	3.0	3.2	3.8
80 +	9.5	0.0	0.0	0.0	3.9	0.7	1.6
Total	6.2	0.0	1.3	3.0	1.2	1.4	1.6
<i>M + W</i>							
0-44	2.7	1.3	1.1	2.7	0.6	1.1	1.1
45-64	33.0	20.5	7.3	5.5	2.9	9.2	12.2
65-79	30.0	17.3	6.8	13.2	3.1	12.7	9.1
80 +	16.2	0.0	1.4	0.0	4.7	6.6	4.8
Total	14.3	7.2	3.6	4.6	1.4	4.5	5.2

Source: National Cause-of-Death Registers

Table 6 Deaths from other causes in Chapter F (F04-09 and F20-99) per 100 000 inhabitants

	Denmark	Faroe Islands	Finland	Åland	Iceland	Norway	Sweden
	2005	2001-05	2005	2001-05	2001-05	2004	2004
<i>Males</i>							
0-44	0.3	0.0	0.3	0.0	0.0	0.2	0.2
45-64	4.6	0.0	1.6	0.0	0.6	1.6	0.8
65-79	8.0	0.0	4.7	14.2	3.3	1.9	3.8
80 +	30.6	0.0	13.4	0.0	6.0	9.8	22.0
Total	3.1	0.0	1.5	1.5	0.6	1.0	1.6
<i>Women</i>							
0-44	0.5	0.0	0.4	0.0	0.2	0.0	0.2
45-64	2.9	0.0	1.9	0.0	0.6	1.6	1.0
65-79	8.4	0.0	5.9	0.0	0.0	3.2	6.1
80 +	44.3	0.0	20.9	22.4	7.7	12.9	30.3
Total	4.4	0.0	2.7	1.5	0.6	1.5	3.2
<i>M + W</i>							
0-44	0.4	0.0	0.4	0.0	0.1	0.1	0.2
45-64	3.7	0.0	1.8	0.0	0.6	1.6	0.9
65-79	8.2	0.0	5.4	6.6	1.6	2.6	5.1
80 +	39.7	0.0	18.8	15.1	7.1	11.8	27.3
Total	3.8	0.0	2.1	1.5	0.6	1.3	2.4

Source: National Cause-of-Death Registers

Mental health promotion and prevention activities

In 2006, the European Commission published a document: Mental health promotion and mental disorder prevention across European Member States: a collection of country stories (13). In this report, four Nordic countries - Denmark, Finland, Norway and Sweden - are included, with reports on their mental health promotion and prevention activities. In this report it is possible to find some common priorities such as: suicide prevention activities, activities for reducing alcohol and drug consumption, specific programmes in schools aiming at reducing bullying, and programmes in workplaces addressing stress at work. Also all the countries have highlighted

Främjande av psykisk hälsa och förebyggande åtgärder

År 2006 publicerade Europeiska kommissionen ett dokument: Mental health promotion and mental disorder prevention across European Member States: a collection of country stories (13). I denna rapport ingår fyra nordiska länder – Danmark, Finland, Norge och Sverige – med rapporter över deras hälsofrämjande och förebyggande åtgärder. I rapporten kan man se några gemensamma prioriteringar: bl.a. självmordsförebyggande åtgärder, åtgärder för att minska alkohol- och drogkonsumtionen, speciella program i skolorna för att minska mobbning och stressinriktade program på arbetsplatserna. Alla länder har också lyft fram att implementeringen av ett främjande av

that the implementation of mental health promotion and prevention activities requires participation and commitment from all sectors, not only from the health and social sectors. For these activities, we deal with welfare policy issues. From these country stories it is easy to see that the need for mental health promotion and prevention activities is clearly recognized, but at the same time there are difficulties and problems in implementing these activities.

More information can be found in the HP-source database (<http://www.hp-source.net>), which includes country-specific structured information on mental health promotion activities for Finland, Norway and Sweden.

psykisk hälsa och av olika förebyggande åtgärder kräver deltagande och engagemang från alla sektorer, inte bara från hälso- och den sociala sektorn. Dessa åtgärder är klart förbundna med frågor om välfärdspolitik. Av informationen från dessa länder är det lätt att se att behovet av ett främjande av psykisk hälsa och av förebyggande åtgärder tydligt har erkänts, men samtidigt finns det svårigheter och problem med implementeringen av dessa åtgärder.

Ytterligare information finns på HP-källdatabasen (<http://www.hp-source.net>), som innehåller landsvis grupperad information om åtgärder för främjande av den mentala hälsan i Finland, Norge och Sverige.

Mental health services in the Nordic countries

This theme is divided into two topics: resources and utilization of services. The services are divided into inpatient, intermediate and outpatient services. Inpatient services and consumption of psychotropic medication are documented best. The indicators are reported both in time series as trends and as cross-sectional data for 2005.

Psykisk hälsovård i de nordiska länderna

Detta tema har delats upp i två områden: resurser och användning av vården. Vården indelas i anstaltsvård, mellanvård och öppenvård. Bäst dokumenterad är anstaltsvården samt konsumtionen av psykotropiska läkemedel. Indikatorerna redogörs för både i tidsserier som trender och som tvärsnitt för år 2005.

What are the resources in mental health care?

There are several trends in the number of available psychiatric beds in 1990–2004 (Figure 4). First there is a clear decrease in available beds from a mean of 1.7 per 1000 inhabitants in 1990 to 0.7 per 1000 in 2004. The major part of

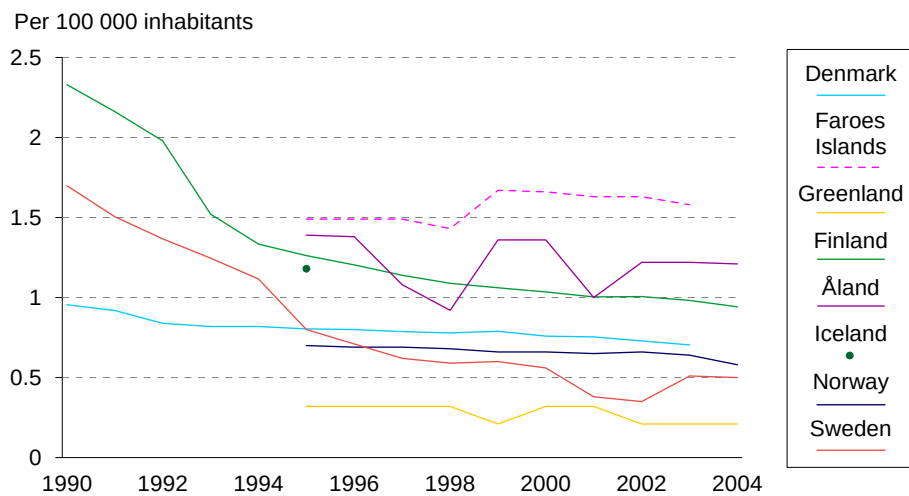
Vilka resurser finns inom psykisk hälsovården?

Det finns vissa trender vad gäller antalet tillgängliga vårdplatser inom psykiatri under åren 1990–2004 (figur 4). För det första har det skett en klar minskning av de tillgängliga vårdplatserna från ett medeltal på 1,7 per 1000 invånare 1990 till

this reduction took place during the years 1990–1995. Second, there have been quite large differences in the number of available psychiatric beds. For example Finland had 2.3 and Denmark 0.9 beds per 1000 inhabitants in 1990. However, these differences became less: in 2003 Finland had 1.0 and Denmark 0.7 beds per 1000 inhabitants. The number of beds per 1000 inhabitants is highest in the Faroe Islands and Åland, and lowest in Greenland, Sweden, Norway and Denmark. The decrease in beds has been greatest in Sweden and Finland and least in Denmark and Norway.

0,7 per 1000 invånare 2004. Huvuddelen av denna minskning genomfördes de facto under åren 1990–1995. För det andra har skillnaderna i antalet tillgängliga vårdplatser varit ganska stora. Finland hade t.ex. 2,3 och Danmark 0,9 platser per 1000 invånare 1990. Dessa skillnader har dock minskat: 2003 hade Finland 1,0 och Danmark 0,7 platser per 1000 invånare. Antalet platser i förhållande till folkmängden är störst på Färöarna och Åland och lägst på Grönland, i Sverige, Norge och Danmark. Platsminskningen har varit störst i Sverige och Finland och lägst i Danmark och Norge.

Figure 4 Number of psychiatric beds, per 100 000 inhabitants 1990–2004



Source: NOMESCO year books

The proportion of available psychiatric beds compared to all hospital beds has been quite stable (except in Greenland and the Faroe Islands) and the differences in the proportions are quite small. The proportion of psychiatric beds of all hospital beds is about 15 per cent.

Andelen tillgängliga platser inom psykiatri jämfört med det totala antalet sjukhusplatser har varit ganska permanent (förutom på Grönland och Färöarna) och skillnaderna är ganska små. Andelen psykiatriska vårdplatser av alla sjukhusplatser är omkring 15 procent.

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There are two types of information about professional resources: 1. the number of registered professionals and 2. the number of professionals working in social and health care. The rates of registered psychiatrists and child and adolescent psychiatrists are documented best. WHO has collected global data about resources in 2001 and 2005 (Table 7).

Det finns två typer av statistik över personalresurserna: 1. antalet registrerade yrkesmänniskor och 2. antalet yrkesmänniskor som arbetar inom social- och hälsovården. Bäst dokumenterade är uppgifterna om registrerade psykiatriker samt barn- och ungdomspsykiatriker. WHO har samlat in världsomspännande statistik över resurserna under 2001 och 2005 (tabell 7).

Table 7 The number of relevant professionals per 100 000 inhabitants in 2001 and 2005

	Denmark		Finland		Iceland		Norway		Sweden	
	2001	2005	2001	2005	2001	2005	2001	2005	2001	2005
Psychiatrists	16	16	16	22	25	25	20	20	20	20
Psychiatric nurses	59	59	176	180	43	33	42	42	32	32
Psychologists	85	85	76	79	55	60	68	68	76	76

Note that the definitions do not necessarily follow the NACE definitions given in Chapter 5.

Source: WHO 2001 and 2005 (14 and 15)

From these figures it is easy to see that the Nordic countries have reasonably good resources in mental health. The number of psychiatrists and psychologists is similar in all the Nordic countries. Denmark has slightly fewer psychiatrists than other countries. The countries have reported great differences in the number of psychiatric nurses. Finland seems to have the highest resources in these country profiles.

The trends in the number of adult psychiatrists and child and adolescent psychiatrists (Figure 5) show that the numbers have increased continuously in Denmark, Finland and Sweden. The number of psychiatrists in relation to the population is almost the same in Finland and in Denmark and slightly less in Swe-

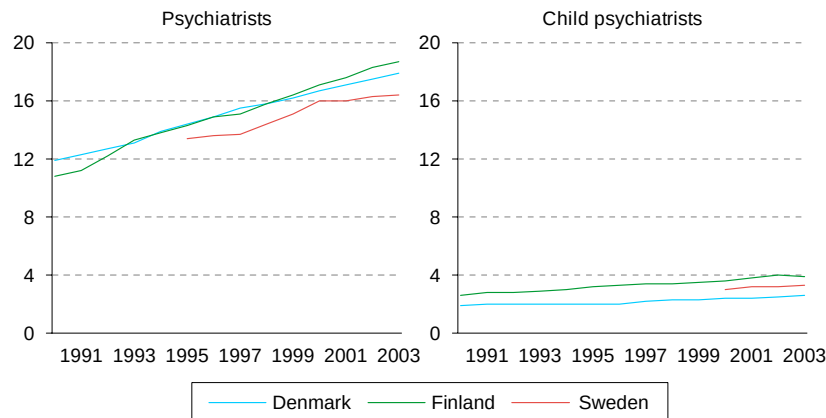
Av denna statistik ser man klart att de nordiska länderna har relativt bra resurser i psykisk hälsa. Antalet psykiatriker och psykologer är ungefär på samma nivå i alla nordiska länder. Danmark har något färre psykiatriker än de övriga länderna. Vad gäller antalet sjukskötare inom psykiatrin finns det stora skillnader. Finland ser enligt denna statistik ut att ha bäst resurser.

Trenderna både i antalet psykiatriker inom vuxenvård och antalet barn- och ungdomspsykiatriker (figur 5) visar att dessa har ökat kontinuerligt i Danmark, Finland och Sverige. Andelen psykiatriker i förhållande till befolkningen är nästan densamma i Finland och Danmark och något lägre i Sverige. Finland

den. Finland has slightly more child and adolescent psychiatrists than Denmark and Sweden. However, the differences in the number of psychiatrists and child psychiatrists are small. Iceland reported 21.3 psychiatrists and 2.1 child psychiatrists per 100 000 inhabitants in 2003.

har något fler barn- och ungdomspsykiatriker än Danmark och Sverige. Skillnaderna är dock små, både vad gäller antalet psykiatriker och antalet barnpsykiatriker. Island rapporterade 21,3 psykiatriker och 2,1 barnpsykiatriker per 100 000 invånare.

Figure 5 The number of psychiatrists and child psychiatrists in the Nordic countries per 100 000 inhabitants 1990–2003



Source: MINDFUL data

Utilization of mental health services is mainly reported as utilization of inpatient services. There is a shortage of data about outpatient and intermediate services. The indicators used are number of patients treated, discharges (the number of inpatient episodes), bed days, average length of stay and number of long-stay patients. The data are also shown as number of patients treated per diagnostic group.

Trends in the number of inpatients treated in psychiatric units yearly are not available for all the Nordic countries. In Finland, the number has been nearly the same during the last 15 years, about 32 000 patients. In 2005

Användningen av psykisk hälsovård rapporteras huvudsakligen som användningen av anstaltsvård. Det råder en brist på statistik över öppen vård och mellanvård. Indikatorerna som använts är behandlade patienter, utskrivningar (antalet vårdperioder), vård dagar, genomsnittlig vårdlängd och antalet långtidspatienter. Statistiken visas också i form av behandlade patienter per diagnosgrupp.

Årliga uppgifter om antalet intagna patienter som behandlats på psykiatriska avdelningar finns inte att tillgå från alla nordiska länder. I Finland har antalet varit nästan detsamma under de senaste 15 åren, omkring 32 000 patienter.

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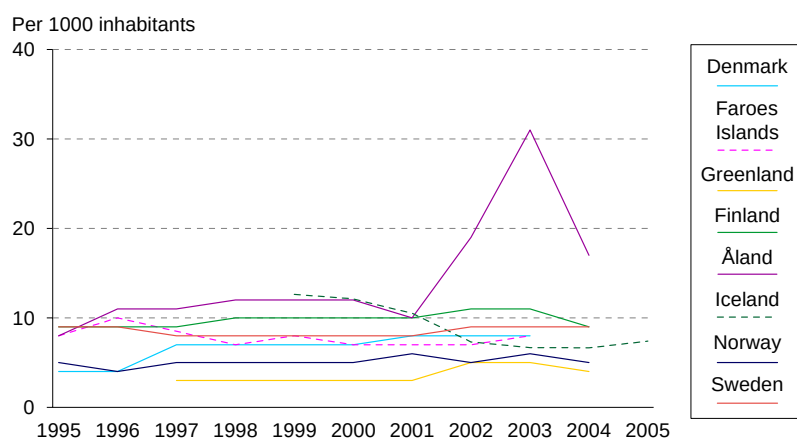
the rates in the Nordic countries were very similar, varying from 6.9 per 1000 in the Faroe Islands to 3.4 per 1000 in Åland. Iceland had 6.3, Finland 5.6, Norway 5.8, Sweden 5.4 and Denmark slightly less, 4.6 per 1000 inhabitants. Except in the Faroe Islands, where men attended psychiatric units more often than women, there were no gender differences (Table 8).

The number of discharges from psychiatric units (Figure 6) has been quite stable during the last ten years (1995–2004). Åland has consistently had the highest discharge rates, and Greenland and Norway the lowest. In 2005, the rates (except for Åland) were at the same level, varying from 7.2 to 9.7 per 1000 inhabitants. Men and women have the same discharge rates. With regard to age group, the level of discharges is similar for the age groups 15–29, 30–44, and 45–64, except for Åland, where the rate is high for the age group 30–44 years (Table 8).

År 2005 var andelen i de olika nordiska länderna ganska nära varandra, varierande från 6,9 per 1000 på Färöarna till 3,4 per 1000 per Åland. Island hade 6,3, Finland 5,6, Norge 5,8 och Sverige och Danmark något lägre andel, 4,6 per 1000 invånare. Med undantag för Färöarna, där männen oftare vistades på psykiatriska avdelningar, fanns det inga skillnader mellan könen (tabell 8).

Andelen utskrivningar från psykiatriska avdelningar (figur 6) har varit ganska stabil under de senaste tio åren (1995–2004). Åland har konstant den högsta andelen utskrivningar och Grönland och Norge de lägsta. Under 2005 var andelen på samma nivå, varierande (med undantag för Åland) från 7,2 till 9,7 per 1000 invånare. Män och kvinnor skrivs ut i samma utsträckning. Vad gäller åldersgrupper är andelen utskrivna ungefär densamma i grupperna 15–29, 30–44 och 45–64 förutom på Åland där andelen är hög i åldersgruppen 30–44 år (tabell 8).

Figure 6 Discharges (completed inpatient episodes) from psychiatric units, per 1 000 inhabitants 1995–2005

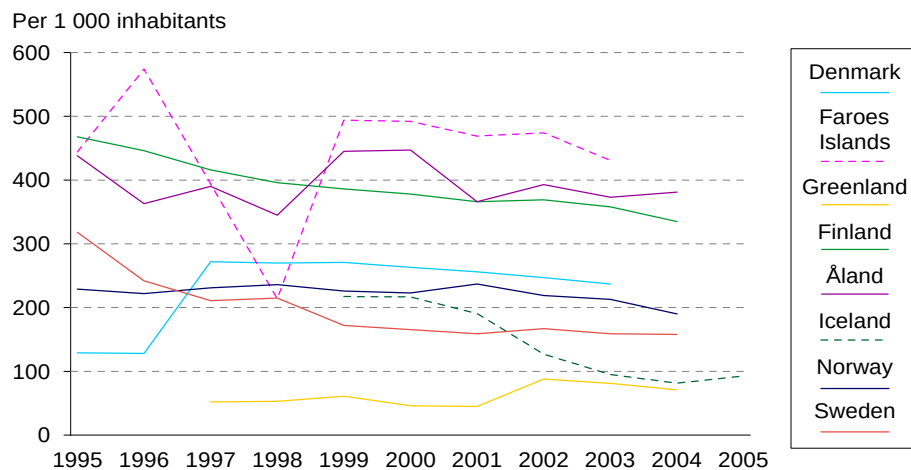


Source: NOMESCO year books

The trend in bed days in psychiatric units (Figure 7) during the years 1995–2004 has declined slightly. The Faroe Islands, Finland and Åland have higher rates, and Denmark, Sweden, Norway and especially Greenland have lower rates. In 2005 Finland had clearly the highest rate, 348 days per 1000 inhabitants. The rate in Iceland was 120, in Sweden 158, in Norway 202 and in Denmark 207 days per 1000 inhabitants. The gender differences are small (Table 8).

Trenden i antalet vård dagar på psykiatriska avdelningar (figur 7) under åren 1995–2004 har varit en aning sjunkande. Färöarna, Finland och Åland har högre siffror, och Danmark, Sverige, Norge och speciellt Grönland lägre siffror. Under 2005 hade Finland den klart högsta siffran, 348 dagar per 1000 invånare. Andelen i Island var 120, i Sverige 158, i Norge 202 och Danmark 207 dagar per 1000 invånare. Skillnaderna mellan könen är små (tabell 8).

Figure 7 Beds days per 1 000 inhabitants in psychiatric units 1995–2005



Source: NOMESCO year books

The average length of stay (Figure 8) in psychiatric units has become shorter in most countries. This is linked to the fact that the number of patients has been the same, but the number of bed days has decreased greatly. In 2005, the average length of stay in psychiatric units was 40 days in Finland, while it was 19 days in Sweden, 26 days in

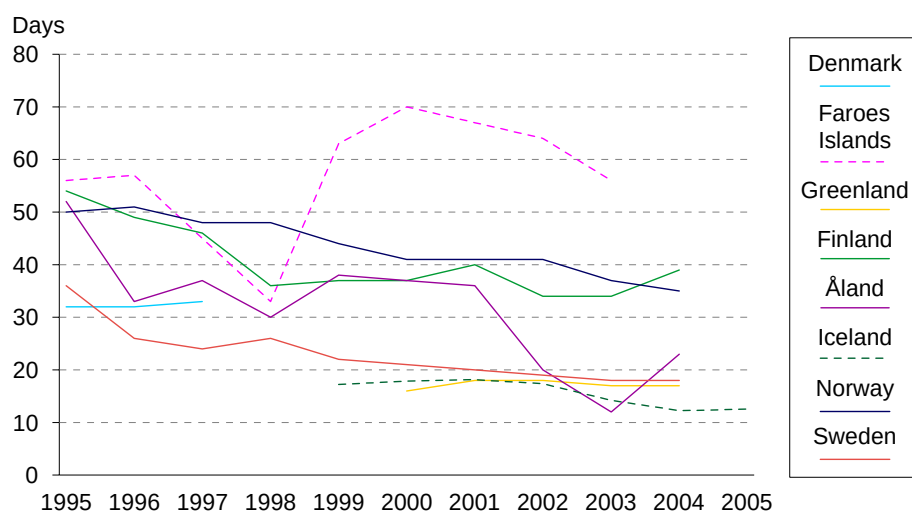
Den genomsnittliga vårdtiden (figur 8) på psykiatriska avdelningar har förkortats i de flesta länder. Detta hör ihop med det faktum att antalet patienter har varit detsamma, men vård dagarna har minskat kraftigt i antal. Under 2005 var den genomsnittliga vårdtiden på psykiatriska avdelningar i Finland 40 dagar, medan den var 19 i Sverige, 26 i Norge

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Norway and 29 days in Denmark. The shortest stays were in Åland (17 days) and Iceland (13 days) (Table 8).

och 29 i Danmark. De kortaste vårdtiderna fanns på Åland och Island, 17 respektive 13 dagar (tabell 8).

Figure 8 Average length of stay in psychiatric units 1995–2005

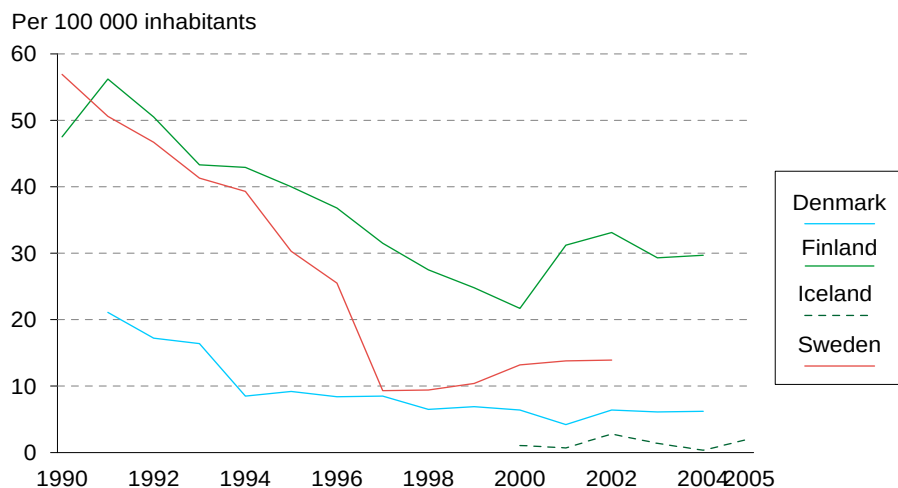


Source: NOMESCO year books

There has been a clear decrease in the number of long-stay patients in psychiatric units (over one year continuous stay) (Figure 9), especially in Sweden and Finland. The number in Finland decreased from 48 long-stay patients per 100 000 inhabitants in 1990 to 30 in 2004. In Sweden there were 57 long-stay patients per 100 000 inhabitants in 1990 and 14 in 2002 (Table 8).

Det har skett en klar minskning i antalet långtidsvårdade patienter (över ett års oavbruten vistelse) på psykiatriska avdelningar (figur 9), speciellt i Sverige och Finland. Minskningen i Finland var från 48 långtidsvårdade patienter per 100 000 invånare år 1990 till 30 år 2004. Motsvarande siffror för Sverige var 57 per 100 000 invånare år 1990 och 14 år 2002 (tabell 8).

Figure 9 Number of mental health patients staying in hospitals continuously for more than 1 year, per 100 000 inhabitants 1990–2005



Source: WHO-Health-for-all database

As shown in Table 9 (figures according to diagnosis), Finland has the highest rates for inpatient care for substance abuse (2.1 per 1000 for men and 2.0 per 1000 for women in 2005), schizophrenia (0.6 per 1000 and 0.8 per 1000) and other psychoses (0.4 per 1000 and 0.3 per 1000), while Denmark has most hospitalized patients for mood disorders (1.0 per 1000 and 1.7 per 1000).

The Nordic Council of Ministers has suggested a list of quality indicators in health care (16). These include three indicators for mental health:

- The number of compulsory admissions (per 1000 inhabitants) and the proportion of compulsory admissions of the total number of admissions.

Som framgår av den diagnosspecifika tabell 9, har Finland inom anstaltsvården den högsta andelen patienter intagna för missbruk (2,1 per 1000 för män och 2,0 per 1000 för kvinnor under 2005), schizofreni (0,6 per 1000 och 0,8 per 1000) och andra psykoser (0,4 per 1000 och 0,3 per 1000), medan Danmark har flest anstaltsvård p.g.a. affektiva störningar (1,0 per 1000 och 1,7 per 1000).

Nordiska ministerrådet har föreslagit en lista över kvalitetsindikatorer inom hälsovården (16). I denna ingår tre indikatorer på mental hälsa:

- Antall tvangsinnleggelser (per 1000 innbyggere) og andel tvangsinnleggelser av totalt antall innleggelser.

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- | | |
|--|--|
| <ul style="list-style-type: none"> - Mean waiting time (number of day) for a first consultation at a psychiatric outpatient clinic for children and young people - Proportion of suicides during admission in a psychiatric institution/department, per 1000 admissions in a psychiatric institution/department, per total number of suicides and per 100 000 inhabitants. | <ul style="list-style-type: none"> - Gjennomsnittlig ventetid (antall dager) til 1. konsultasjon ved psykiatrisk poliklinikk (øppenvård) for barn og ungdom. - Andel selvmord under opphold i psykiatrisk institusjon/psykiatrisk avdeling, per 1000 innleggelser på psykiatrisk institusjon/psykiatrisk avdeling, pr. selvmord i alt og per 100 000 innbyggere. |
|--|--|

In the first data collection exercise, data for 2004 and 2005 were available for four countries (no data for Sweden, no suicide data for Denmark).

Via den første datainnsamlingen fikk man fram statistikk for årene 2004 og 2005 for fire lander (ingen statistikk for Sverige, ingen selvmordsstatistikk for Norge).

These preliminary data suggest that the percentage of involuntary treatment is higher in Finland (32 per cent) than in Norway (22 per cent), Denmark (21 per cent) or Iceland (6 per cent). By population, the rates are higher in Norway (2.2 per 1000) and Finland (2.0 per 1000) than in Denmark (0.9 per 1000) and Iceland (0.4 per 1000).

Den preliminnære statistikk antyder at andelen tvangsbehandlingar er større i Finland (32 prosent) enn i Norge (22 prosent), Danmark (21 prosent) og Island (6 prosent). I relasjon til folkmengden er siffrorna h  re f  r Norge (2,2 per 1000) og Finland (2,0 per 1000) enn f  r Danmark (0,9 per 1000) og Island (0,4 per 1000).

Data on mean waiting time for psychiatric care for minors is available only for Norway (83 days) and Iceland (105 days).

Statistikk   ver medelv  ntetiden til psykiatrisk v  rd f  r minder  rige finns tilg  ngelig endast f  r Norge (83 dagar) og Island (105 dagar).

There were major differences in suicide rates in psychiatric units. The rates for Norway (1.1 per 1000 hospitalizations, 1.1 per 100 000 inhabitants) were higher than in Finland (0.1 per 1000 and 0.1 per 100 000) and Iceland (no cases). Suicides committed by people in institutionalized care contributed to 9.6 per cent of all suicides in Norway and 0.3 per cent in Finland.

Det fannst store skillnader i selvmordstalen p   psykiatriske avdelningar. Andelen i Norge (1,1 per 1000 intagna, 1,1 per 100 000 inv  nare) var h  re enn i Finland (0,1 per 1000 og 0,1 per 100 000) og Island (inga rapporterte fall). Selvmord beg  ngne under anstaltsv  rd utgjorde i Norge 9,6 prosent av alle selvmord og i Finland 0,3 prosent.

Even though the provision of mental health services has shifted from inpatient care to outpatient care since the 1990s, no comparable data on outpatient care is available in the Nordic countries. In 2006, NOMESCO's theme section on outpatient care (17) included diagnostic data only from Finland and Sweden. Finns had 0.26 outpatient care visits per inhabitant, which was much more than in Sweden, 0.15 visits per inhabitant. Finns had more specialized care than Swedes (0.22 and 0.06), but fewer GP visits than Swedes (0.04 and 0.09). Part of this discrepancy may, however, be caused by incomplete diagnostic coding in Swedish outpatient care. Also, the Finnish sample was limited to only a few health care centres, which may hamper international comparisons.

National data from Finland show almost two million outpatient visits in primary and secondary care in 2005. Of these visits, 0.69 million were with mental health professionals in Finnish health care centres (0.13 visits per inhabitant). In total, 14 per cent of the visits were with physicians and the rest were with other health care personnel. The Finnish statistics for psychiatric specialized outpatient care showed 0.12 million visits for minors and 1.13 million visits for adults (0.11 and 0.27 outpatient visits per minor and adult, respectively). These data do not include visits due to mental problems to GPs in primary care. Neither are data from Åland included. Local 2004 data from Åland included 14 282 visits in outpatient care, equivalent to 0.53 visits per inhabitant.

Trots att utbudet av psykisk hälsovård har förändrats i riktning från anstaltsvård till öppen vård sedan 1990-talet, finns inte någon jämförbar statistik över den öppna vården tillgänglig i de nordiska länderna. För år 2006 inkluderade NOMESCO's temasektion om öppenvårdsstatistik diagnostisk data enbart från Finland och Sverige. Finländarna hade 0,26 vårdbesök per invånare, vilket var mycket mer än i Sverige, 0,15 besök per invånare. Finländarna utnyttjade även specialiserad vård mera än svenskarna (0,22 och 0,06), men besökte allmänläkare mer sällan (0,04 och 0,09). En del av denna skillnad kan dock förklaras genom ofullständig diagnoskodning i den svenska databasen över öppen vård. Det finländska urvalet var dessutom begränsat till endast ett fåtal hälsovårdscentraler, vilket kan försvåra internationella jämförelser.

Nationell statistik från Finland visar att det gjordes nästan två miljoner besök inom primär- och sekundärvårdens öppenvård under 2005. Av dessa besök gjordes 0,69 miljoner hos mentalvårdspersonal på hälsovårdscentraler (0,13 besök per invånare). Totalt sett gjordes 14 procent av besöken hos läkare och resten hos övrig vårdpersonal. Den finländska statistiken över öppenvårdsbesök inom den specialiserade psykiatriska vården visar 0,12 miljoner besök för minderåriga och 1,13 miljoner besök för vuxenpsykiatri (0,11 och 0,27 öppenvårdsbesök per minderårig respektive vuxen). Denna statistik innehåller inte besök p.g.a. psykiska problem hos allmänläkare inom primärvården. Statistik från Åland finns inte heller med. Lokal statistik från Åland för 2004 visar 14 282 besök inom öppenvården, motsvarande 0,53 besök per invånare.

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Norwegian data from 2005 show 1.09 million psychiatric consultations for minors and 3.52 million psychiatric consultations for adults. This is equivalent to 0.40 and 0.25 outpatient visits per inhabitant.

Norsk statistik från 2005 visar 1,09 miljoner psykiatriska besök för minderåriga och 3,52 miljoner besök inom vuxenpsykiatri. Detta motsvarar 0,40 och 0,25 besök per invånare.

Reliable comparable data on utilization of intermediate services are unavailable. An example of utilization of intermediate services is the trend in the number of clients in sheltered housing in Finland.

Pålitlig jämförbar statistik över användningen av mellanvårdsformer saknas. Som ett exempel på användningen av mellanvård ges trenderna i antalet klienter i stödboende i Finland.

Table 8.a Hospital treatment in psychiatric units by age and sex, 2005

	Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland ²⁾	Norway ³⁾	Sweden
Discharges	38 563	469	45 432	473	2 601	35 828	76 015
<i>Discharges per 1 000</i>							
Men							
0-14	0.3	4.2	3.6	0.0	1.1	1.3	0.3
15-29	7.5	8.3	9.2	10.2	9.0	7.9	8.3
30-44	11.0	13.1	12.7	34.5	9.8	9.5	12.6
45-64	8.7	14.7	10.4	24.3	10.0	7.9	14.1
65-79	4.8	14.9	6.0	20.0	11.0	7.7	6.5
80+	5.5	19.3	5.4	40.4	29.5	16.9	4.5
Total	6.9	10.8	8.8	19.5	8.3	7.2	8.9
Women							
0-14	0.5	4.6	1.9	0.0	0.9	1.1	0.7
15-29	9.5	8.2	11.2	14.4	10.9	11.1	11.7
30-44	9.7	4.5	10.7	42.3	10.3	10.0	10.6
45-64	9.0	15.6	10.4	11.6	9.9	7.5	9.6
65-79	7.3	8.4	7.5	9.8	14.5	10.0	6.1
80+	7.5	10.6	6.0	12.3	24.9	17.6	4.6
Total	7.4	8.5	8.5	16.2	9.5	8.4	7.9
M + W							
0-14	0.4	4.4	2.8	0.0	1.0	1.2	0.5
15-29	8.5	8.3	10.2	12.2	9.9	9.5	10.0
30-44	10.4	9.1	11.7	38.4	10.1	9.8	11.6
45-64	8.9	15.1	10.4	17.9	10.7	7.7	11.9
65-79	6.1	11.6	6.9	14.6	12.8	8.9	6.3
80+	6.8	13.8	5.8	21.5	26.7	17.3	4.6
Total	7.2	9.7	8.7	17.8	8.9	7.8	8.4

1 Åland and Faroe Islands 2001-2005.

2 Iceland 2003-2005.

3 Norway: Data are incomplete (about 98 per cent coverage for discharges and 80 per cent coverage for bed-days and diagnoses).

1 Åland och Färöarna 2001-2005.

2 Island 2003-2005.

3 Norge: Data är inte fullständigt (omkring 98 procent av utskrivningar och 80 procent av sängdagar och diagnoser är med).

Source: National Hospital Registers

Table 8.b Hospital treatment in psychiatric units by age and sex, 2005

	Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland ²⁾	Norway ³⁾	Sweden
Bed-days	1 119 776	10 952	1 821 558	8 065	35 067	931 092	1 422 581
<i>Bed-days</i>							
<i>per 1 000</i>							
Men							
0-14	16.4	11.3	153.8	0.0	26.1	79.2	4.4
15-29	259.6	179.4	357.4	149.4	104.2	283.3	165.1
30-44	318.9	233.0	457.5	247.6	101.3	234.5	273.7
45-64	212.9	348.4	434.2	483.5	121.3	197.4	205.8
65-79	136.3	202.8	324.5	340.1	211.9	139.6	120.3
80+	147.1	704.7	575.9	825.9	690.5	172.5	139.1
Total	197.3	209.8	364.4	281.9	112.3	191.9	164.2
Women							
0-14	34.0	7.0	76.6	0.0	16.0	40.5	10.7
15-29	286.6	314.9	419.3	246.9	100.8	341.9	216.2
30-44	262.0	100.0	341.0	345.3	98.5	228.1	199.4
45-64	244.6	475.8	355.1	275.2	145.1	205.8	178.6
65-79	243.8	318.9	421.9	478.6	302.9	220.8	135.3
80+	222.3	466.0	462.7	1 206.8	577.4	319.9	107.7
Total	216.0	245.2	332.0	325.6	127.4	212.2	151.0
M + W							
0-14	25.0	9.2	116.0	0.0	21.2	60.3	7.5
15-29	272.9	241.3	387.6	195.7	102.6	312.1	190.1
30-44	290.8	171.0	400.3	296.6	99.9	231.4	237.3
45-64	228.7	408.4	394.6	379.2	133.0	201.5	192.3
65-79	194.0	262.0	379.6	413.4	259.9	183.6	128.4
80+	196.9	555.1	495.0	1 082.2	621.9	269.7	119.1
Total	206.8	226.8	347.9	304.0	119.9	202.1	157.5

1 Åland and Faroe Islands 2001–2005.

2 Iceland 2003–2005.

3 Norway: Data are incomplete (about 98 per cent coverage for discharges and 80 per cent coverage for bed-days and diagnoses).

1 Åland och Färöarna 2001–2005.

2 Island 2003–2005.

3 Norge: Data är inte fullständigt (omkring 98 procent av utskrivningar och 80 procent av sängdagar och diagnoser är med).

Source: National Hospital Registers

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Table 8.c Hospital treatment in psychiatric units by age and sex, 2005

	Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland ²⁾	Norway ³⁾	Sweden
Patients	24 711	335	29 176	91	1 834	26 782	48 392
<i>Patients per 1 000</i>							
Men							
0-14	0.3	2.8	2.2	0.0	1.1	1.2	0.2
15-29	4.8	6.7	6.2	3.3	6.6	6.6	5.6
30-44	6.8	8.0	7.8	5.1	7.1	7.3	7.7
45-64	5.5	11.9	6.8	4.5	6.7	6.1	8.2
65-79	3.5	11.0	4.0	4.9	8.4	5.6	4.5
80+	4.8	17.8	4.3	5.0	22.9	10.9	3.8
Total	4.4	8.1	5.7	3.6	6.0	5.6	5.6
Women							
0-14	0.5	2.0	1.3	0.0	0.7	0.9	0.5
15-29	5.9	7.3	7.2	3.7	7.1	8.5	7.1
30-44	5.8	3.6	6.3	3.4	6.7	7.5	6.6
45-64	5.6	9.1	6.6	3.3	7.4	5.7	6.4
65-79	5.1	6.3	5.1	4.6	11.1	6.1	4.5
80+	5.4	8.8	4.6	6.6	21.5	10.9	3.8
Total	4.7	5.7	5.5	3.2	6.5	6.0	5.1
M + W							
0-14	0.4	2.4	1.7	0.0	0.9	1.0	0.3
15-29	5.3	7.0	6.7	3.5	6.8	7.5	6.3
30-44	6.3	6.0	7.1	4.3	6.9	7.4	7.2
45-64	5.6	10.6	6.7	3.9	7.0	5.9	7.3
65-79	4.4	8.6	4.6	4.7	9.8	5.9	4.5
80+	5.2	12.2	4.5	6.1	22.0	10.9	3.8
Total	4.6	6.9	5.6	3.4	6.3	5.8	5.4

1 Åland and Faroe Islands 2001–2005.

2 Iceland 2003–2005.

3 Norway: Data are incomplete (about 98 per cent coverage for discharges and 80 per cent coverage for bed-days and diagnoses).

1 Åland och Färöarna 2001–2005.

2 Island 2003–2005.

3 Norge: Data är inte fullständigt (omkring 98 procent av utskrivningar och 80 procent av sängdagar och diagnoser är med).

Source: National Hospital Registers

Table 8.d Hospital treatment in psychiatric units by age and sex, 2005

	Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland ²⁾	Norway ³⁾	Sweden
<i>Average length of stay per discharge</i>							
Men							
0-14	55	3	42	-	23	60	14
15-29	35	22	39	15	12	36	20
30-44	29	18	36	7	10	25	22
45-64	24	24	42	20	12	25	15
65-79	29	14	54	17	19	18	18
80+	27	37	106	20	23	10	31
Total	29	19	41	14	14	27	18
Women							
0-14	63	2	41	-	19	38	16
15-29	30	38	38	17	9	31	18
30-44	27	22	32	8	10	23	19
45-64	27	30	34	24	13	27	19
65-79	33	38	56	49	21	22	22
80+	30	44	77	98	23	18	23
Total	29	29	39	20	13	25	19
M + W							
0-14	60	2	42	-	21	50	16
15-29	32	29	38	16	10	33	19
30-44	28	19	34	8	10	24	20
45-64	26	27	38	21	12	26	16
65-79	32	23	55	28	20	21	20
80+	29	40	85	50	23	16	26
Total	29	23	40	17	13	26	19

1 Åland and Faroe Islands 2001–2005.

2 Iceland 2003–2005.

3 Norway: Data are incomplete (about 98 per cent coverage for discharges and 80 per cent coverage for bed-days and diagnoses).

1 Åland och Färöarna 2001–2005.

2 Island 2003–2005.

3 Norge: Data är inte fullständigt (omkring 98 procent av utskrivningar och 80 procent av sängdagar och diagnoser är med).

Source: National Hospital Registers

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Table 9 Treated patients per 1000 inhabitants in psychiatric units by sex and diagnostic group, 2005 (Åland and Faroe Islands 2001–2005)

	Denmark		Faroe Islands		Finland		Åland		Iceland		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W	M	W
F10-19														
Substance abuse	1.4	0.9	1.6	1.2	2.1	2.0	0.6	0.8	0.9	0.6	0.9	0.7	0.9	0.9
F20-25														
Schizophrenia	0.4	0.5	0.4	0.5	0.6	0.8	0.2	0.4	0.2	0.2	0.3	0.4	0.3	0.5
F28-29														
Other psychosis	0.1	0.0	0.0	0.0	0.4	0.3	0.1	0.1	0.0	0.1	0.1	0.0	0.2	0.2
F30-39														
Mood disorders	1.0	1.7	0.4	0.5	0.3	0.5	0.3	0.5	0.4	0.9	0.6	1.1	0.6	0.9

1 Åland and Faroe Islands 2001–2005.

2 Norway: Data are Incomplete (about 80 per cent coverage).

1 Åland och Färöarna 2001–2005.

2 Norge: Data är inte fullständigt (omkring 80 procent av diagnoser är med).

Source: National Hospital Registers

Table 10 Patients in psychiatric housing services per 31 December 1994–2003, Finland

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Provided by social services	569	523	577	631	188	231	354	356	449	384
Provided by health services	404	468	522	530	202	214	169	152	163	261
Provided by the private sector	863	889	1 075	1 172	1 701	2 512	2 567	3 131	3 567	4 090
Total	1 836	1 880	2 174	2 333	2 091	2 957	3 090	3 639	4 179	4 735

Source: 1994–1997 Statistics on Municipal Activities (Statistics Finland), Health Care Activity Statistics (Association of Finnish Local and Regional Authorities) and the Care Register for Social Welfare from 1998 (STAKES)

Table 10 shows that as the number of long-stay patients in psychiatric units decreased, the number of patients living in sheltered housing increased. The increase has been exclusively in the private sector. There is no reason to doubt similar trends in the other countries.

Tabell 10 visar att samtidigt som antalet långtidsvårdade patienter på psykiatriska avdelningar har minskat, har antalet patienter i stödboende ökat. När man ser på vem som tillhandahåller denna service har ökningen skett uteslutande inom den privata sektorn. Det finns ingen orsak att tro att trenden skulle vara annorlunda i de övriga länderna.

The Special Eurobarometer 248 survey on mental well-being (7) also shows self-reported use of health services due to psychological or emotional health

Eurobarometer 248-undersökningen om mentalt välbefinnande (7) ger även information om användningen av hälso-vårdsservice enligt svarandena själva vad

problems in 2005. 13 per cent of all Europeans sought help, while 17 per cent of Danes, 13 per cent of Swedes and 10 per cent of Finns sought help. This is interesting in the sense that in the statistics of utilization of both inpatient and outpatient services, the Finnish people seem to utilize most mental health services. In the Finnish Health 2000 study (8), the comparable figure was 5.4 per cent.

gäller psykologiska eller känslomässiga hälsoproblem under 2005. Medan 13 procent av alla européer sökte hjälp i något skede, var siffrorna för danskarna 17 procent, för svenskarna 13 procent och för finländarna 10 procent. Detta är intressant i det avseendet att finländarna enligt statistiken över användningen av både anstalts- och öppenvård verkar använda mest psykisk hälsovård. I den finländska Hälsa 2000-studien var motsvarande andel 5,4 procent.

Pensions and sick-leave

Data on pensions due to incapacity for work cannot be compared between the Nordic countries due to differences in legislation and statistical systems, especially concerning diagnosis. In 2005, such pensions were granted for more than 9 000 Finns, almost 15 000 Danes and more than 60 000 Swedes of working age. Mental health disorders were the main cause: 41 per cent of cases in Denmark, and 32 per cent in Finland and Sweden.

In all countries, the percentage of pensions because of mental health disorders of all pensions due to incapacity for work was the highest in the age group 18-29 years, for which mental health disorders were the main cause for three out of four benefit recipients (approximately 50 per cent in Sweden). Also in the age group 30-39 years, the percentage was higher than 50 per cent (46 per cent in Sweden), but significantly lower in the older age groups, with more benefit recipients with somatic health problems than mental health problems as the main diagnosis.

Pensioneringar och sjukskrivningar

Statistik över pensioneringar p.g.a. arbetsförmåga i de nordiska länderna kan inte jämföras p.g.a. skillnader i lagstiftnings- och statistiksystemen, speciellt vad gäller diagnoser. År 2005 beviljades mer än 9 000 finländare i arbetsför ålder sjukpension, nästan 15 000 danskar och mer än 60 000 svenskar. Psykisk ohälsa var huvudorsaken för 41 procent av de danska fallen och 32 procent av de svenska och finländska.

I alla länder var den procentuella andelen pensioneringar p.g.a. psykisk ohälsa av alla sjukpensioneringar högst i åldersgruppen 18-29 år, där psykisk ohälsa var huvudorsaken för tre av fyra förmånstagare (uppskattningsvis 50 procent i Sverige). Även i åldersgruppen 30-39 år var den procentuella andelen högre än 50 procent (46 procent i Sverige), men märkbart lägre i de äldre åldersgrupperna där det fanns fler förmånstagare med somatiska hälsoproblem än psykiska hälsoproblem som huvuddiagnos.

By diagnosis, the Swedish data show that for men under 50 years of age, and for women under 40 years of age, the main mental disorder diagnosis is neurosis, while depression is the leading cause for men over 50 years of age and women over 40 years of age.

Statistics on sick leave are not comparable due to differences in legislation and statistical systems.

Den svenska statistiken visar att den huvudsakliga diagnosen på psykisk ohälsa för män under 50 och kvinnor under 40 är neuros, medan depression är den huvudsakliga orsaken för män över 50 och kvinnor över 40.

Statistiken över sjukledigheter är inte jämförbar p.g.a. skillnader i lagstiftnings- och statistiksystemen.

Psychotropic medication

Perhaps the most reliable statistics on the utilization of mental health services can be found on the use of psychotropic medication: use of antidepressants, antipsychotics, anxiolytics and hypnotics. In 1990–2005, it is possible to observe clear trends. The use of antipsychotics (Figure 10) has been quite stable with some increase during the last years, but the use of antidepressants (Figure 11) has markedly increased all the time in all countries. The use of anxiolytics (Figure 12) has been stable in Finland and Sweden, but decreased in Denmark.

Psykotropiska läkemedel

Den mest pålitliga statistiken vad gäller användningen av den psykiatriska hälsovården är kanske den över användningen av psykotropiska läkemedel (psykofarmaka): antidepressiva medel, antipsykotiska mediciner, anxiolytika och sömnmedel. Från 1990 till 2005 kan man se tydliga trender. Användningen av antipsykotiska mediciner (figur 10) har varit ganska stabil under de senaste åren, men användningen av antidepressiva medel (figur 11) har ökat konstant och mångfaldigats i alla länder. Användningen av anxiolytika (figur 12) har varit stabil i Finland och Sverige, men minskat i Danmark.

Table 11 Consumption of medication 2005 DDD/1 000 inhabitants/day

	Denmark	Finland	Åland	Iceland	Norway	Sweden
Total sales including medication in hospitals						
<i>N05 and N06</i>						
Men	89.1	101.1	49.0	129.5	91.7	104.2
Women	151.9	135.3	82.9	201.4	148.7	177.4
M + W	120.8	118.6	66.1	165.4	120.4	141.6
<i>Antipsychotics</i>						
<i>N05AA-N05AG</i>						
Men	4.3	4.8	2.5	2.7	2.8	3.1
Women	4.3	4.1	2.7	2.1	3.2	3.1
M + W	4.3	4.5	2.6	2.4	3.0	3.1
<i>Diazepines, oxazepines and thiazepines</i>						
<i>N05AH</i>						
Men	4.7	7.3	2.0	2.8	3.6	2.7
Women	3.5	6.3	1.5	2.5	2.9	2.1
M + W	4.1	6.8	1.7	2.6	3.2	2.4
<i>Lithium</i>						
<i>N05AN</i>						
Men	0.9	1.0	1.5	1.4	1.3	1.4
Women	1.2	0.9	1.3	1.4	1.5	1.6
M + W	1.1	0.9	1.4	1.4	1.4	1.5
<i>Anxiolytics</i>						
<i>N05B</i>						
Men	13.7	20.3	3.8	14.5	16.0	12.6
Women	23.9	18.7	4.9	23.5	23.2	18.3
M + W	18.8	19.5	4.4	19.0	19.6	15.5
<i>Hypnotics and sedatives</i>						
<i>N05C</i>						
Men	20.9	27.9	14.3	34.7	26.1	35.6
Women	38.4	41.3	23.2	61.7	49.5	62.4
M + W	29.7	34.8	18.8	48.2	37.9	49.2
<i>Selective serotonin reuptake inhibitors</i>						
<i>N06AB</i>						
Men	27.5	21.5	15.9	39.8	21.3	31.0
Women	53.4	38.5	35.3	71.8	43.7	63.6
M + W	40.6	30.2	25.7	55.8	32.6	47.5
<i>Antidepressants</i>						
<i>N06A Other than N06AB</i>						
Men	12.5	12.0	6.4	19.7	12.2	12.6
Women	22.4	16.0	10.1	31.0	19.3	20.7
M + W	17.5	14.0	8.2	25.3	15.8	16.7

Source: National Registers on Prescribed Medicine

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Table 11b Consumption of medication 2005 DDD/1 000 inhabitants/day

	Denmark	Finland	Åland	Iceland	Norway	Sweden
<i>Total sales including medication in hospitals</i>						
N05 and N06						
<i>Men</i>						
0-14 years	6.0	2.6	0.9	37.9	16.7	5.7
15-29 »	34.0	44.1	15.2	64.7	42.1	36.7
30-44 »	84.5	102.0	44.9	117.1	88.3	91.4
45-64 »	132.4	150.0	57.8	201.6	120.6	148.0
65-79 »	183.5	186.4	103.3	323.1	174.7	201.9
80+ »	295.0	332.0	248.8	343.0	242.3	384.4
Total	89.1	101.1	49.0	129.5	91.7	104.2
<i>Women</i>						
0-14 years	2.2	0.8	0.1	15.4	4.3	1.9
15-29 »	48.7	45.1	22.3	81.7	42.5	55.7
30-44 »	109.1	106.4	68.2	196.8	116.2	140.9
45-64 »	213.6	190.4	91.8	355.0	194.5	243.8
65-79 »	328.7	246.1	169.8	485.4	314.1	312.8
80+ »	473.6	385.6	281.3	380.9	360.7	537.9
Total	151.9	135.3	82.9	201.4	148.7	177.4
<i>M + W</i>						
0-14 years	4.2	1.7	0.5	26.8	10.6	3.9
15-29 »	41.2	44.6	18.6	73.1	42.3	46.5
30-44 »	96.6	104.2	56.4	156.6	102.0	116.5
45-64 »	172.9	170.2	74.9	277.0	179.9	195.8
65-79 »	261.8	220.0	138.1	408.4	249.5	261.5
80+ »	413.3	370.0	270.5	366.0	319.5	482.7
Total	120.8	118.6	66.1	165.4	120.4	141.6

Source: National Registers on Prescribed Medicine

Table 11c Consumption of medication 2005 DDD/1 000 inhabitants/day

	Denmark	Finland	Åland	Iceland	Norway	Sweden
<i>Total sales including medication in hospitals</i>						
Antipsychotics N05AA-N05AG						
<i>Men</i>						
0-14 years	0.1	0.0	0.0	0.2	0.0	0.0
15-29 »	2.1	0.7	0.5	1.3	3.0	0.7
30-44 »	6.1	4.7	2.6	3.7	6.4	3.1
45-64 »	7.7	10.4	4.0	5.8	5.1	6.1
65-79 »	3.9	6.2	4.0	3.0	2.2	4.8
80+ »	2.7	2.7	8.3	1.0	1.1	4.1
Total	4.3	4.8	2.5	2.7	2.8	3.1
<i>Women</i>						
0-14 years	0.0	0.0	0.0	0.1	0.0	0.0
15-29 »	1.7	0.4	0.1	0.7	1.9	0.6
30-44 »	5.0	3.1	3.1	2.2	4.2	2.6
45-64 »	7.6	8.8	4.0	4.8	4.9	5.6
65-79 »	6.1	6.6	5.0	3.1	2.9	5.4
80+ »	4.3	3.3	4.8	1.4	1.5	5.3
Total	4.3	4.1	2.7	2.1	3.2	3.1
<i>M + W</i>						
0-14 years	0.0	0.0	0.0	0.2	0.0	0.0
15-29 »	1.9	0.5	0.3	1.0	1.0	0.7
30-44 »	5.6	3.9	2.9	3.0	3.1	2.9
45-64 »	7.6	9.6	4.0	5.3	5.9	5.9
65-79 »	5.1	6.4	4.5	3.1	4.9	5.1
80+ »	3.8	3.1	5.9	1.3	3.2	4.9
Total	4.3	4.5	2.6	2.4	3.0	3.1

Source: National Registers on Prescribed Medicine

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Table 11d Consumption of medication 2005 DDD/1 000 inhabitants/day

	Denmark	Finland	Åland	Iceland	Norway	Sweden
<i>Total sales including medication in hospitals</i>						
Diazepines, oxazepines and thiazepines						
N05AH						
<i>Men</i>						
0-14 years	0.1	0.0	0.0	0.1	0.0	0.0
15-29 »	3.9	5.8	0.3	2.6	3.0	1.6
30-44 »	8.3	13.0	3.9	5.3	6.4	4.5
45-64 »	6.3	10.4	3.2	3.8	5.1	4.4
65-79 »	2.9	4.2	1.5	1.8	2.2	1.9
80+ »	3.1	2.6	0.2	1.0	1.1	1.1
Total	4.7	7.3	2.0	2.8	3.6	2.7
<i>Women</i>						
0-14 years	0.0	0.0	0.0	0.1	0.0	0.0
15-29 »	2.1	4.0	0.7	1.5	1.9	1.0
30-44 »	4.5	9.8	3.4	3.7	4.2	2.9
45-64 »	5.3	10.0	1.6	4.8	4.9	3.5
65-79 »	4.1	5.4	1.6	2.7	2.9	2.3
80+ »	5.3	3.6	0.6	1.0	1.5	1.8
Total	3.5	6.3	1.5	2.5	2.9	2.1
<i>M + W</i>						
0-14 years	0.0	0.0	0.0	0.1	0.0	0.0
15-29 »	3.1	4.9	0.5	2.1	2.5	1.3
30-44 »	6.4	11.4	3.7	4.5	5.3	3.7
45-64 »	5.8	10.2	2.4	4.3	5.0	4.0
65-79 »	3.6	4.9	1.6	2.2	2.6	2.1
80+ »	4.5	3.3	0.5	1.0	1.4	1.6
Total	4.1	6.8	1.7	2.6	3.2	2.4

Source: National Registers on Prescribed Medicine

Table 11e Consumption of medication 2005 DDD/1 000 inhabitants/day

	Denmark	Finland	Åland	Iceland	Norway	Sweden
<i>Total sales including medication in hospitals</i>						
Lithium						
N05AN						
<i>Men</i>						
0-14 years	0.0	0.0	0.0	0.0	0.0	0.0
15-29 »	0.2	0.3	0.7	0.9	0.5	0.5
30-44 »	0.9	1.4	2.4	2.1	1.7	1.6
45-64 »	1.9	1.9	2.4	2.6	2.5	2.7
65-79 »	1.5	0.8	1.5	1.2	1.8	1.9
80+ »	0.6	0.2	1.6	0.3	0.6	0.7
Total	0.9	1.0	1.5	1.4	1.3	1.4
<i>Women</i>						
0-14 years	0.0	0.0	0.0	0.0	0.0	0.0
15-29 »	0.3	0.3	0.6	0.7	0.5	0.5
30-44 »	1.0	1.1	1.6	2.1	1.7	1.8
45-64 »	2.3	1.8	1.7	3.0	2.9	3.2
65-79 »	2.0	0.8	2.1	1.4	2.1	2.2
80+ »	1.2	0.2	2.8	0.5	0.6	0.9
Total	1.2	0.9	1.3	1.4	1.5	1.6
<i>M + W</i>						
0-14 years	0.0	0.0	0.0	0.0	0.0	0.0
15-29 »	0.3	0.3	0.7	0.8	0.5	0.5
30-44 »	1.0	1.2	2.0	2.1	1.7	1.7
45-64 »	2.1	1.9	2.0	2.8	2.7	3.0
65-79 »	1.8	0.8	1.8	1.3	2.0	2.1
80+ »	1.0	0.2	2.4	0.4	0.6	0.8
Total	1.1	0.9	1.4	1.4	1.4	1.5

Source: National Registers on Prescribed Medicine

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Table 11f Consumption of medication 2005 DDD/1 000 inhabitants/day

	Denmark	Finland	Åland	Iceland	Norway	Sweden
<i>Total sales including medication in hospitals</i>						
Anxiolytics						
N05B						
<i>Men</i>						
0-14 years	0.3	0.2	0.5	0.5	0.3	0.3
15-29 »	2.4	12.1	1.1	2.8	5.8	3.1
30-44 »	11.9	24.3	3.0	11.0	17.6	11.1
45-64 »	25.3	32.5	5.4	29.9	27.6	21.4
65-79 »	28.3	26.9	7.7	46.4	29.6	23.3
80+ »	27.8	27.1	13.6	28.8	27.5	32.5
Total	13.7	20.3	3.8	14.5	16.0	12.6
<i>Women</i>						
0-14 years	0.3	0.2	0.1	0.4	0.2	0.2
15-29 »	1.9	4.4	0.6	3.4	3.5	3.5
30-44 »	11.9	14.2	4.9	18.4	16.1	12.5
45-64 »	41.0	32.6	7.3	47.7	40.3	27.9
65-79 »	62.6	33.1	8.3	70.4	54.6	35.2
80+ »	54.7	31.8	10.6	41.5	47.8	51.2
Total	23.9	18.7	4.9	23.5	23.2	18.3
<i>M + W</i>						
0-14 years	0.3	0.2	0.3	0.5	0.3	0.2
15-29 »	2.2	8.3	0.8	3.1	4.7	3.3
30-44 »	11.9	19.4	3.9	14.7	16.9	11.9
45-64 »	33.1	32.6	6.4	38.7	33.8	24.7
65-79 »	46.8	30.4	8.0	59.0	43.1	29.7
80+ »	45.6	30.4	11.6	36.5	40.7	44.5
Total	18.8	19.5	4.4	19.0	19.6	15.5

Source: National Registers on Prescribed Medicine

Table 11g Consumption of medication 2005 DDD/1 000 inhabitants/day

	Denmark	Finland	Åland	Iceland	Norway	Sweden
<i>Total sales including medication in hospitals</i>						
Hypnotics and sedatives						
N05C						
<i>Men</i>						
0-14 years	0.0	0.1	0.0	0.0	0.2	0.1
15-29 »	2.5	3.0	0.1	4.5	4.1	5.0
30-44 »	12.4	12.6	5.7	18.6	16.2	19.5
45-64 »	29.9	38.1	13.0	57.7	37.4	47.4
65-79 »	63.5	88.6	46.0	146.4	76.5	91.9
80+ »	110.7	179.5	122.6	181.0	130.4	195.1
Total	20.9	27.9	14.3	34.7	26.1	35.6
<i>Women</i>						
0-14 years	0.1	0.1	0.0	0.0	0.1	0.1
15-29 »	2.4	2.2	0.1	6.2	4.0	7.4
30-44 »	12.7	12.6	3.0	34.4	21.4	28.9
45-64 »	49.7	47.3	16.9	112.1	67.9	79.3
65-79 »	111.8	110.8	69.1	221.0	135.9	138.6
80+ »	172.2	192.7	139.0	202.4	189.4	255.1
Total	38.4	41.3	23.2	61.7	49.5	62.4
<i>M + W</i>						
0-14 years	0.0	0.1	0.0	0.0	0.2	0.1
15-29 »	2.5	2.6	0.1	5.3	4.1	6.4
30-44 »	12.5	12.6	4.4	26.4	18.7	24.4
45-64 »	39.8	42.7	15.0	84.4	52.5	63.3
65-79 »	89.6	101.1	58.1	185.6	108.4	117.0
80+ »	151.4	188.8	133.5	194.0	168.8	233.5
Total	29.7	34.8	18.8	48.2	37.9	49.2

Source: National Registers on Prescribed Medicine

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Table 11h Consumption of medication 2005 DDD/1 000 inhabitants/day

	Denmark	Finland	Åland	Iceland	Norway	Sweden
<i>Total sales including medication in hospitals</i>						
Selective serotonin reuptake inhibitors						
N06AB						
<i>Men</i>						
0-14 years	0.8	0.4	0.0	4.5	0.5	0.8
15-29 »	14.2	15.1	7.7	30.5	11.3	16.6
30-44 »	28.5	28.8	19.2	48.7	25.8	34.7
45-64 »	38.3	30.9	18.6	61.6	33.3	42.8
65-79 »	53.5	25.2	22.7	67.9	32.4	48.0
80+ »	93.8	38.9	78.0	69.5	39.5	90.9
Total	27.5	21.5	15.9	39.8	21.3	31.0
<i>Women</i>						
0-14 years	0.9	0.3	0.0	4.4	0.3	0.7
15-29 »	30.1	26.5	19.0	52.7	21.1	33.9
30-44 »	51.8	47.8	43.0	97.0	49.3	69.9
45-64 »	71.4	57.0	42.9	116.7	70.2	89.7
65-79 »	88.7	40.9	46.3	109.1	67.3	84.4
80+ »	146.4	60.5	85.7	68.7	65.1	141.4
Total	53.4	38.5	35.3	71.8	43.7	63.6
<i>M + W</i>						
0-14 years	0.8	0.4	0.0	4.5	0.4	0.8
15-29 »	22.0	20.7	13.1	41.4	16.6	25.2
30-44 »	40.0	38.1	31.0	72.6	37.8	52.2
45-64 »	54.8	44.0	30.8	88.7	51.9	66.1
65-79 »	72.4	34.1	35.1	89.6	51.5	67.6
80+ »	128.7	54.2	83.1	69.0	56.7	123.2
Total	40.6	30.2	25.7	55.8	32.6	47.5

Source: National Registers on Prescribed Medicine

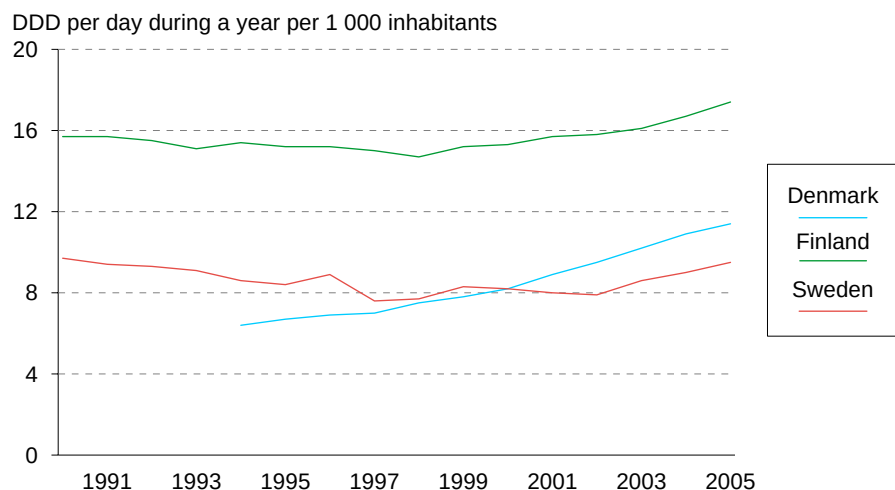
Table 11i Consumption of medication 2005 DDD/1 000 inhabitants/day

	Denmark	Finland	Åland	Iceland	Norway	Sweden
<i>Total sales including medication in hospitals</i>						
Antidepressants						
N06A other than N06AB						
<i>Men</i>						
0-14 years	0.1	0.0	0.0	4.9	0.0	0.0
15-29 »	4.8	5.0	2.1	10.7	5.1	5.3
30-44 »	13.0	13.3	6.0	19.3	13.8	14.1
45-64 »	20.3	20.9	9.6	33.5	21.0	20.2
65-79 »	22.5	16.4	12.1	42.2	20.0	19.1
80+ »	30.9	20.1	18.0	35.6	17.7	27.3
Total	12.5	12.0	6.4	19.7	12.2	12.6
<i>Women</i>						
0-14 years	0.1	0.0	0.0	2.0	0.0	0.0
15-29 »	8.0	6.3	1.3	11.6	6.3	7.0
30-44 »	19.2	14.9	6.9	31.1	18.2	20.3
45-64 »	33.2	26.4	14.2	60.1	33.2	31.6
65-79 »	43.3	23.9	24.5	66.5	36.9	32.2
80+ »	58.8	28.2	22.3	48.2	29.2	46.0
Total	22.4	16.0	10.1	31.0	19.3	20.7
<i>M + W</i>						
0-14 years	0.1	0.0	0.0	3.5	0.0	0.0
15-29 »	6.4	5.7	1.7	11.1	5.9	6.2
30-44 »	16.0	14.1	6.5	25.2	16.2	17.3
45-64 »	26.7	23.6	11.9	46.6	27.2	25.9
65-79 »	33.7	20.6	18.6	55.0	29.3	26.2
80+ »	49.4	25.9	20.9	43.2	25.4	39.3
Total	17.5	14.0	8.2	25.3	15.8	16.7

Source: National Registers on Prescribed Medicine

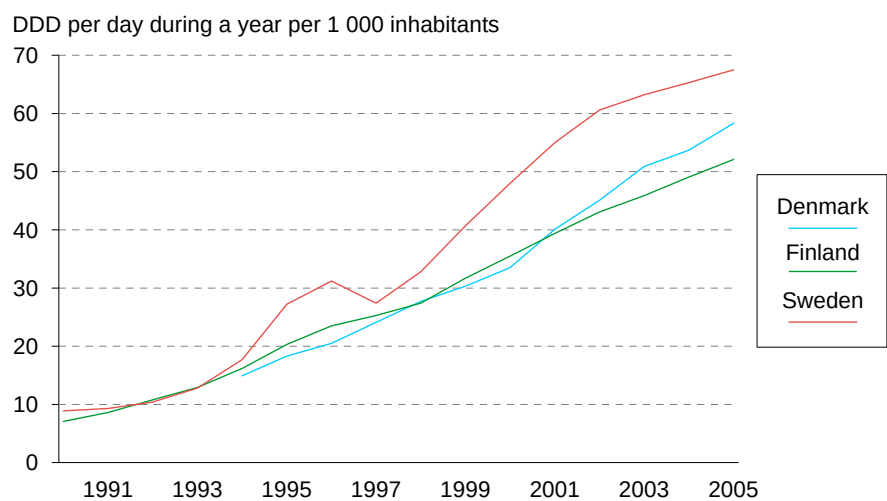
MENTAL HEALTH IN THE NORDIC COUNTRIES

Figure 10 Use of antipsychotics, DDD per day during a year per 1 000 inhabitants 1990–2005



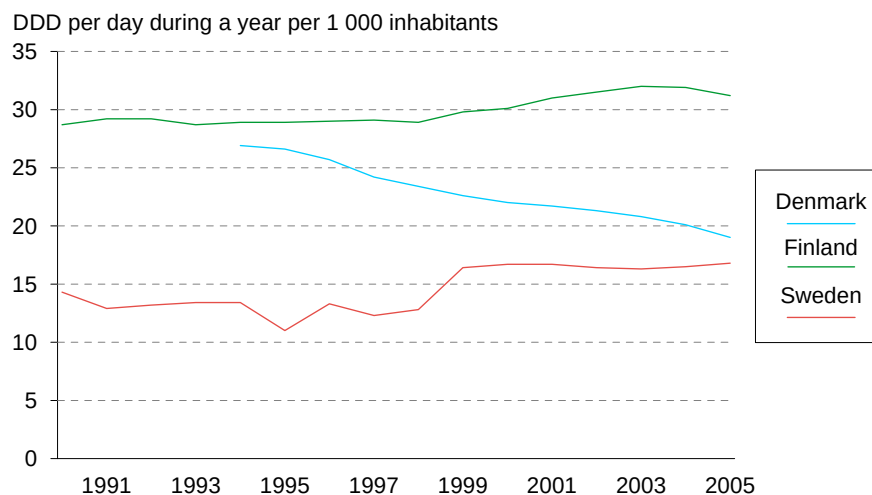
Source: MINDFUL data

Figure 11 Use of antidepressants, DDD per day during a year per 1 000 inhabitants 1990–2005



Source: MINDFUL data

Figure 12 Use of anxiolytics, DDD per day during a year per 1 000 inhabitants 1990–2005



Source: MINDFUL data

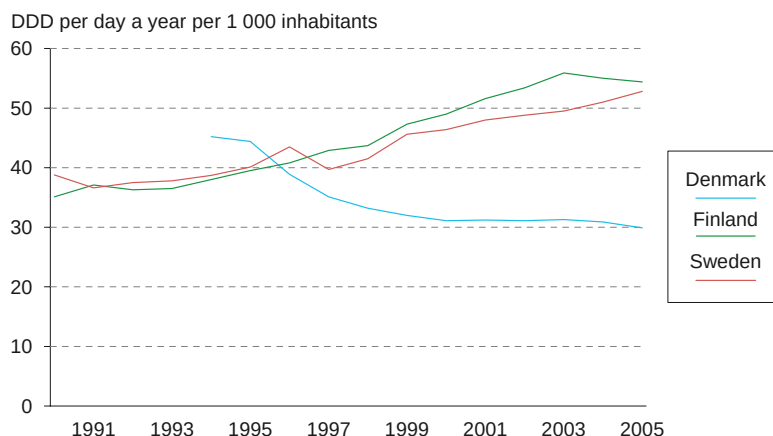
The use of hypnotics (Figure 13) has increased in Finland and Sweden, but decreased in Denmark.

In Finland all the time the use of antipsychotics has been at a higher level than in Sweden and Denmark. The same is true for the use of anxiolytics. For the use of antidepressants, Sweden, Denmark and Finland are almost at the same level. For the use of hypnotics, Finland and Sweden are at the same level, but Danish people use fewer hypnotics.

Användningen av sömnmedel (figur 13) har ökat i Finland och Sverige, men minskat i Danmark.

I Finland har användningen av antipsykotiska mediciner alltid varit på en högre nivå än i Sverige och Danmark. Samma gäller användningen av lugnande medel. Vad gäller användningen av sömnmedel ligger Finland och Sverige på samma nivå, medan danskarna använder mindre sömnmedel.

Figure 13 Use of hypnotics, DDD per day during a year per 1 000 inhabitants 1990–2005



Source: MINDFUL data

When calculating the consumption of medication as DDD per 1000 inhabitants per day, Finns, Danes and Norwegians (119–121 per 1000) use less psychotropics (N05 and N06) than Swedes (142 per 1000) and Icelanders (165 per 1000). The higher consumption level in Sweden is caused by the higher use of hypnotics and sedatives (N05C), and antidepressants, especially selective serotonin reuptake inhibitors (N06AB). The consumption in Åland is much lower than in the other Nordic countries (66 per 1000). Consumption of anxiolytics (N05B) and hypnotics and sedatives (N05C) are particularly low in Åland. (Table 11, Tables 11b–i in the Internet version only).

For all countries, consumption levels for women are 55–70 per cent higher than for men in all countries. Only for children and adolescents aged less than 15 years, boys use more of these kinds of medication than girls.

När man beräknar användningen av medicin som DDD (definierad daglig dos) per 1000 invånare per dag, använder finländare, danskar och norrmän (119–121 per 1000) mindre psykotropsika läkemedel (N05 och N06) än svenskar (142 per 1000) och islänningar (165 per 1000). Den högre användningen i Sverige förklaras av högre användning av sömnmedel och sedativer (N05C), antidepressiva medel, speciellt selektiva serotoninåterupptagshämmare (N06AB). Användningen på Åland är mycket lägre än i övriga Norden (66/1000). Speciellt användningen av lugnande medel (N05B) och sömnmedel och sedativer (N05C) är låg på Åland. (tabell 11, tabellerna 11b–i endast på internetversionen)

I alla länder är användningsgraden bland kvinnor ca 55–70 procent högre än för män. Endast bland barn och ungdomar under 15 år använder pojkar mer av dessa mediciner än flickor.

The gender differences are similar, except for antipsychotics (N05AA-N05AG), where the differences are small, and for diazepines, oxazepines and thiazepines (N05A) for which consumption for men is higher than for women.

Skillnaderna mellan könen är liknande förutom när det gäller antipsykotiska medel (N05AA-N05AG), där skillnaderna är små och när det gäller diazepiner, oxazepiner och thiazepiner (N05A), där användningen är högre för män än för kvinnor.

What the statistics and registers tell us about the gender differences

Certain differences can easily be found. Females suffer more often from depression and anxiety disorders. Males suffer more often from personality disorders and alcohol abuse.

Although males suffer less from depression than females, they commit suicide more often. However, the decrease in suicide rates is greater for males, and in some countries (especially Iceland and Sweden) the suicide rate for young women under 30 years of age has increased.

With regard to utilization of mental health services, there are no clear gender differences generally in the use of inpatient services. However, there has been a clear increase in the use of inpatient services for adolescent girls in Finland. This is not so clear for adolescent boys. There is a common belief that females use more outpatient mental health services. This is also true in the Finnish Health 2000 study, where 5.4 per cent of 7000 respondents reported utilization of mental health services during the last 12 months. The difference between females (6.9 per cent) and males (4.0 per cent) was significant.

Vad berättar statistiken och registren om skillnader mellan könen?

Vissa skillnader kan lätt ses. Kvinnor lider oftare av depression och ångestsyndrom. Män lider oftare av personlighetsstörningar och alkoholmissbruk.

Fastän män lider mindre av depression än kvinnor, begår de oftare självmord. Minskningen i självmordstalen är dock större för män, och i vissa länder (i synnerhet Island och Sverige) har unga kvinnor under 30 ökad självmordsbenägenhet.

När man ser på användningen av psykisk hälsovård finns det allmänt sett inga klara könsskillnader vad gäller anstaltsvården. En klar ökning finns dock vad gäller unga kvinnors utnyttjande av anstaltsvård i Finland. Denna trend är inte lika tydlig bland unga män. Det finns en allmän bild av att kvinnor använder sig mera av den öppna psykiatriska vården än män. Detta stämmer också överens med den finländska Hälsa 2000-studien, där 5,4 procent av 7000 svarande sade sig ha använt psykisk hälsovård under de senaste 12 månaderna. Skillnaden mellan kvinnor (6,9 procent) och män (4,0 procent) var märkbar.

What is it possible to say about mental health in the Nordic countries?

The position of mental health in policy and legislation in the Nordic countries has been conflicting. Mental health has been given priority, but at the same time, there is a lot of ignorance about mental health compared to somatic health.

Legislation and the organization of mental health services vary somewhat in different countries, but the main elements are similar. There are differences regarding who is in charge of providing services: municipalities, regional authorities, or the state.

Based on the registers and statistics that have been used, it is difficult to say whether there are real differences in the psychosocial well-being of the population. It seems as though people in the Nordic countries feel quite well compared to other Europeans, although mental health disorders are common. Almost one person in five has had some psychological symptom during a year that is enough to give a psychiatric diagnosis.

With regard to mental health-related deaths, the number of alcohol-related deaths has decreased during the last ten years (at least in Finland). At the same time, however, suicide rates have decreased and interestingly the consumption of antidepressants has increased greatly. It is impossible to say how much this increase, which means better medical treatment for patients with depression, explains the decrease in suicide rates.

Vad kan sägas om den psykiska hälsan i de nordiska länderna?

Den psykiska hälsans ställning inom politiken och lagstiftningen i de nordiska länderna har varit motstridig. Å ena sidan prioriteras mentalvården, men å andra sidan finns det samtidigt mycket okunnsghet om psykisk hälsa speciellt i jämförelse med den somatiska vården.

Lagstiftningen och organiseringen av den mentala hälsovårdstjänsten varierar något i olika länder, men huvudelementen är dock så gott som lika. Skillnaderna har att göra med vem som tillhandahåller vården: kommunerna, regionala myndigheter eller staten.

På basen av de register och den statistik som använts är det svårt att säga om det finns några verkliga skillnader i det psykosociala välbefinnandet i befolkningen. Det ser ut som om människorna i Norden mår rätt bra jämfört med andra européer, trots att psykisk ohälsa ändå är vanlig. Nästan en person av fem har under ett år något psykologiskt symptom som är tillräckligt för att ge en psykiatrisk diagnos.

När man ser på dödsfall relaterade till den mentala hälsan kan man konstatera att antalet alkoholrelaterade dödsfall har ökat under de senaste tio åren (åtminstone i Finland). Samtidigt har dock självmordsdödligheten minskat och intressant nog har användningen av antidepressiva medel ökat märkbart. Det är omöjligt att säga i vilken grad denna ökning, som innebär bättre medicinsk behandling för deprimerade patienter, förklarar minskningen i självmord.

With regard to the role and utilization of different services, relevant data are only available for inpatient services. Unfortunately it is impossible to say to what extent primary health care takes care of patients with depression, anxiety or alcohol problems. It seems that primary health services provide treatment for these patients, but not enough. Also, reliable data about private services and services provided by NGOs is unavailable. It seems as though mental health services have diversified and the number of providers has increased. This is also true for services for children and adolescents.

With regard to inpatient services, the number of available psychiatric beds decreased greatly from 1990–1995, but the decrease has been much more moderate since then. All the time the level of available beds has been highest in Finland, the Faroe Islands, Iceland and Åland, and the lowest level has been in Greenland. In Finland the average length of stay has been longest. Generally islands use more inpatient services than the more populated countries. One explanation is that these hospitals also provide care for patients other than "pure" psychiatric patients, such as mentally handicapped people and patients with dementia. The number of long-stay patients in psychiatric units has decreased greatly, as well as the average length of stay. However, many of these "deinstitutionalized" patients are now cared for by the social sector in sheltered housing (Figure 1).

The registers and statistics show that deinstitutionalization in psychiatric care has taken place in the Nordic

När det gäller olika vårdformers roll och användning finns det relevant statistik endast för anstaltsvården. Tyvärr är det omöjligt att säga i vilken utsträckning primärvården tar hand om patienter med depression, ångestsyndrom eller problem med alkoholmissbruk. Det ser ut som om primärvården behandlar dessa patienter, men inte i tillräckligt stor utsträckning. Pålitlig statistik över den privata vården och vård som tillhandahålls av frivilliga organisationer (NGO) saknas också. Det ser även ut som om den psykiska hälsovårdsservicens spektrum har diversifierats och antalet vårdproducenter har ökat. Detta gäller även för vården riktad till barn och ungdomar.

Vad beträffar anstaltsvården minskade antalet tillgängliga vårdplatser kraftigt ännu 1990–1995, men efter det har minskningen varit mycket mer måttlig. Antalet tillgängliga platser har hela tiden varit högre i Finland, på Färöarna och Åland och lägst på Grönland. I Finland har den genomsnittliga vårdtiden varit längst. Generellt använder öarna mer anstaltsvård än de befolkningsrikare länderna. En förklaring till detta är att dessa sjukhus vårdar även andra patienter än "rent psykiatriska" patienter, såsom psykiskt funktionshindrade personer och personer med demens. Antalet långtidsvårdade patienter på psykiatriska avdelningar har minskat kraftigt, precis som medelvårdtiden. Många av dessa "avinstitutionaliserade" patienter vårdas numera på stödboenden inom den sociala sektorn (figur 1).

Registren och statistiken visar att avinstitutionaliseringen inom den psykiatriska vården är ett faktum i de nordiska län-

countries, but they are unable to show whether a real shift to community-based mental health care and services has also taken place. This means that there is a real need for better data for outpatient care, intermediate care and care at social sector.

Finally, with regard to the development in treatment methods, the only available reliable data are on consumption of psychotropic medication. A huge increase is evident in the use of antidepressants and a more moderate increase in the use of anxiolytics and hypnotics. Unfortunately, no useful data are available on other treatment methods such as the use of and trends in different types of psychotherapy.

Recommendation for NOMESCO:

Our theme section has shown that mortality data are not useful for measuring mental health, with the exception of data on suicides and deaths related to substance abuse (alcohol and drugs).

Variation in social security systems and legislation in the Nordic countries makes the collection of comparable data on pensions and sick leave due to mental health problems difficult.

Statistics on psychiatric treatment should be collected annually. The best measure is the number of treated patients per 1000 inhabitants according to age, gender and main ICD diagnosis (4 groups).

derna, men länderna kan inte bevisa att en verklig övergång till samhällsbaserad psykisk vård och service också har ägt rum. Detta innebär att det finns ett verkligt behov av bättre datainsamling inom den öppna vården, mellanvården och socialtjänst.

Slutligen, vad beträffar utvecklingen av behandlingsmetoder, behandlar den enda tillgängliga pålitliga statistiken användningen av psykotropiska läkemedel. En stor ökning är uppenbar vad gäller användningen av antidepressiva medel, och en mera måttlig ökning vad gäller användningen av lugnande medel och sömnmedel. Tyvärr finns det ingen användbar pålitlig statistik över andra behandlingsmetoder såsom användningen av och trenderna för olika typer av psykoterapi.

Rekommendation för NOMESCO:

Denna temasektion har visat att dödlighetsstatistiken inte är användbar för att mäta den psykiska hälsan, med undantag för statistiken över självmord och missbruksrelaterade dödsfall (alkohol och droger).

Skillnader i socialförsäkringssystemen och lagstiftningen i de nordiska länderna gör en insamling av jämförbar data över pensioneringar och sjuklskrivningar p.g.a. psykisk ohälsa svår.

Statistik över psykiatrisk vård borde insamlas årligen. Det bästa sättet är att beräkna antalet behandlade patienter per 1000 invånare och kombinera detta med ålder och kön och huvuddiagnos enligt ICD (4 grupper).

Improved statistics are needed for out-patient care in psychiatry and mental health services within primary health care and other care givers.

NOMESCO should collect and publish indicators on the quality of mental health care on a routine basis, but only after the comparability of the indicators has been assured.

Statistics on the use of medication should be published annually by using the number of DDDs per day per 1000 inhabitants as the main indicator and dividing this data by age, gender and main ATC groups (7 groups).

Data on mental health resources should include both health personnel resources and hospital beds. Information on mental health expenditure can be obtained as soon as countries have introduced a DRG-system for psychiatric care and improved their national data on health care expenditure.

Data on positive mental health and psychological distress from national surveys should be introduced as soon as comparable data are available from all the Nordic countries. Hopefully, the introduction of a common European Health Interview Survey will make these data more available in the future.

Bättre statistik behövs vad gäller den öppna vården inom psykiatrin liksom den psykiatriska vården inom primärvård och andra vård- och stödgivare.

NOMESCO borde rutinmässigt samla in och publicera indikatorer på kvaliteten på den psykisk hälsovård, men endast efter det att jämförbarheten har säkrats.

Statistik över konsumtionen av medicin borde publiceras årligen genom att använda antalet DDD per dag per 1000 invånare som huvudindikator och dela upp dessa enligt ålder, kön och huvudsakliga ATC-grupper (7 grupper).

Statistiken över resurserna inom den psykiska hälsovården borde inkludera både resurser i vårdpersonal och sjukhusplatser. Statistik över kostnaderna för denna vård kan erhållas så snart som länderna har infört ett DRG-system för den psykiatriska vården och förbättrat sin nationella statistik över kostnaderna för hälsovården.

Uppgifter på positiv psykisk hälsa och psykologisk belastning borde införas i nationella undersökningar så snart som jämförbar statistik finns tillgänglig från alla nordiska länder. Införandet av en allmän europeisk studie över hälsa kommer förhoppningsvis att underlätta tillgängligheten till dessa uppgifter i framtiden.

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SECTION C

Appendices
Bilag

Appendix 1

Additional information at www.nom-nos.dk

On NOMESCO's homepage, the following additional information can be found:

- Obstetric definitions
- Hospital definitions
- Overview of medical, surgical and psychiatric specialities that are included in the statistics in this publication
- Short list and statistics on causes of death
- Short list and statistics on discharges from somatic hospitals
- Short list and statistics on surgical procedures

The detailed statistics on the homepage are presented according to gender and 5-year age groups.

In addition, an interactive database is to be found, with the most important data that is available, presented graphically and in maps. The database can be found under the icon *Social and Health Indicators*.

Supplerende oplysninger på www.nom-nos.dk

På NOMESCO's hjemmeside findes følgende supplerende oplysninger:

- Obstetriske definitioner
- Sygehusdefinitioner
- Oversigt over medicinske, kirurgiske og psykiatriske specialer som indgår i statistikken i denne publikation
- Kortliste samt statistik over dødsårsager
- Kortliste samt statistik over udskrivninger ved somatiske sygehusafdelinger
- Kortliste samt statistik over kirurgiske procedurer

Den detaljerede statistik på hjemmesiden er fordelt på køn og 5-års-aldersgrupper

Desuden findes der en interaktiv database med de vigtigste data hvor det er muligt med såvel grafisk præsentation samt præsentation ved brug af kort. Databasen findes under ikonet *Social and Health Indicators*.

Further information

Yderligere oplysninger om de statistikansvarlige i de nordiske lande

The following offices responsible for statistics can be contacted for further information concerning the statistics in this publication.

Denne oversigt over statistikansvarlige i de nordiske lande kan bruges til at søge yderligere oplysninger vedrørende statistikken i denne bog.

Denmark

Statistics Denmark
Sejrøgade 11
DK-2100 Copenhagen Ø
Phone: +45 39 17 39 17
Fax: +45 39 17 39 99
E-mail: dst@dst.dk
Website: www2.dst.dk

Have responsibility for:

- Population statistics
- Statistics on alcohol consumption
- Statistics on health care economy
- Statistics on alcohol consumption

National Board of Health
Islands Brygge 67
DK-2300 Copenhagen S
Phone: 72 22 74 00
Fax: 72 22 74 11
E-mail: sst@sst.dk
Website: www.sst.dk

Have responsibility for:

- Statistics on births
- Statistics on abortions
- Statistics on malformations
- Statistics on causes of death
- Statistics on hospital services
- Statistics on health personnel
- Statistics on the use of tobacco

Statens Seruminstitut
Artillerivej 5
DK-2300 Copenhagen S
Phone: +45 32 68 32 68
Fax: +45 32 68 38 68
E-mail: serum@ssi.dk
Website: www.serum.dk/dk

Have responsibility for:

- Statistics on infectious diseases
- Statistics and information on vaccinations

FURTHER INFORMATION

Danish Medicines Agency
Axel Heides Gade 1
DK-2300 København S
Phone: +45 44 88 95 95
Fax: +45 44 88 95 99
E-mail: dkma@dkma.dk
Website: www.dkma.dk

Have responsibility for:

- Statistics on medicinal products

Faroe Islands

Statistics Faroe Islands
P.O. Box 2068
FO-165 Argir
Phone: +298 35 28 00
Fax: +298 35 28 01
E-mail: hagstova@hagstova.fo
Website: www.hagstova.fo

Have responsibility for:

- Population and vital statistics
- Statistics on health care economy

Chief Medical Officer
P.O. Box 9
FO-110 Tórshavn
Phone: +298 31 18 32
Fax: +298 31 76 60
E-mail: hdj@foe.eli.dk
www.landslaeknin.fo

Have responsibility for:

- Statistics on infectious diseases
- Statistics on forensics
- Statistics on births
- Statistics on causes of death

Chief Pharmaceutical Officer
P.O. Box 187
FR-110 Tórshavn
Phone: +298 35 01 50
Fax: +298 35 01 51
www.apotek.fo

Have responsibility for:

- Statistics on medicinal products

Ministry of Social and Health Affairs
Eiragardur 2
FO-100 Tórshavn
Phone: +298 30 40 50
Fax: +298 5 40 48
E-mail: ahr@ahr.fo
Website: www.ahs.fo

Have responsibility for:

- Statistics on health personnel
- Statistics on hospital services
- Statistics on abortions
- Statistics and information on vaccinations

FURTHER INFORMATION

Greenland

Statistics Greenland
P.O. Box 1025
DK-3900 Nuuk
Phone: +299 34 50 00
Fax: +299 32 29 54
E-mail: stat@gs.gh.gl
Website: www.statgreen.gl

Have responsibility for:

- Population and vital statistics
- Statistics on health personnel
- Statistics on hospital services
- Statistics on health care economy

Chief Medical Officer
P.O. Box 120
DK-3900 Nuuk
Phone: +299 34 5192
Fax: +299 32 51 30
E-mail: eli@gh.gl

Have responsibility for:

- Statistics on births
- Statistics on abortions
- Statistics on malformations
- Statistics on infectious diseases
- Statistics and information on vaccinations

National Board of Health in Denmark
Islands Brygge 67
P.O. Box 1881
DK-2300 Copenhagen S
Phone: 72 22 74 00
Fax: 72 22 74 11
E-mail: sst@sst.dk
Website: www.sst.dk

Have responsibility for:

- Statistics on causes of death

The Central Pharmacy in Copenhagen
County
Marielundsvej 25
DK-2730 Herlev
Phone: +45 44 57 77 00
Fax: +45 44 57 77 09

Have responsibility for:

- Statistics on medicinal products

The Directorate for Health
P.O. Box 1160
DK-3900 Nuuk
Phone: +299 34 50 00
Fax: +299 32 55 05

Have responsibility for:

- Statistics on hospital services
- Statistics on health care economy
- Statistics on health personnel

Finland

Statistics Finland
Työpajankatu 13
FIN-00022 Tilastokeskus
Phone: +358 9 173 41
Fax: +358 9 173 42 750
Website: www.stat.fi

Have responsibility for:

- Population and vital statistics
- Statistics on causes of death
- Statistics on the use of tobacco
- Statistics on road traffic accidents

STAKES (National Research and Development Centre for Welfare and Health)
P.O. Box 220
FIN-00531 Helsinki
Phone: +358 9 396 71
Fax: +358 9 761 307
Website: www.stakes.fi

Have responsibility for:

- Register of Institutional Care
- Medical Birth Register and IVF 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 health care expenditure
- Definitions and classifications in health care
- Statistics on primary health care

Finnish National Public Health Institute
Mannerheimintie 166
FIN-00300 Helsinki
Phone: +358 9 474 41
Fax: +358 9 474 48 408
Website: www.ktl.fi

Have responsibility for:

- 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
Mannerheimintie 103b
P.O. Box 55
FIN-00301 Helsinki
Phone: +358 9 473 341
Fax: +358 9 714 469
Website: www.nam.fi

Have responsibility for:

- Registration of medicinal products and sales licences
- Register on Adverse Drug Reactions
- Statistics on pharmacies

FURTHER INFORMATION

Social Insurance Institution of Finland
Nordenskiöldinkatu 12
FIN-00250 Helsinki
Phone: +358 20 634 11
Fax: +358 20 634 50 58
Website: www.kela.fi

Have responsibility for:

- Sickness insurance benefits and allowances, reimbursements for medicine expenses, and disability pensions

Finnish Cancer Registry
Liisankatu 21B
FIN-00170 Helsinki
Phone: +358 9 135 331
Fax: +358 9 135 1093
Website: www.cancer.fi

Have responsibility for:

- Statistics on cancer

Finnish Centre for Pensions
Fin-00065 Eläketurvakeskus
Phone: +358 9 107511
Fax: + 358 9 14 81172
Website: www.etk.fi

Have responsibility for:

- Pensions due to reduced capacity to work

Åland

The Åland Government
P.O. Box 1060
Ax-22111 Mariehamn
Phone: +358 18 250 00
Fax: +358 18 191 55

Have responsibility for:

- Statistics on infectious diseases
- Statistics on health personnel
- Statistics on hospital services
- Statistics on health care economy

Social Insurance Institution of Finland
Statistics Finland
STAKES
National Agency for Medicines
Finnish National Public Health Institute
Finnish Cancer Registry

See Finland

Iceland

Statistics Iceland
 Borgartún 21a
 IS-150 Reykjavík
 Phone: +354 528 1000
 Fax: +354 528 1199
 E-mail: hagstofa@hagstofa.is
 Website: www.statice.is

Have responsibility for:

- Population and vital statistics
- Statistics on causes of death
- Statistics on alcohol consumption
- Statistics on health care expenditure
- National accounts

Directorate of Health
 Austurströnd 5
 IS-170 Seltjarnarnes
 Phone: +354 510 1900
 Fax: +354 510 1919
 E-mail: postur@landlaeknir.is
 Website: www.landlaeknir.is

Have responsibility 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 personnel

Icelandic Medicines Control Agency
 Eiðistorg 13-15
 172 Seltjarnarnes
 Phone: +354 520 2100
 Fax: +354 561 2170
 E-mail: imca@imca.is
 Website: www.imca.is

Have responsibility for:

- Statistics on pharmaceutical products

Public Health Institute of Iceland
 Laugarvegur 116
 IS-105 Reykjavík
 Phone: +354 5 800 900
 Fax: +354 5 800 901
 E-mail: lydheilsustod@lydheilsustod.is
 Website: www.lydheilsustod.is

Have responsibility for:

- Statistics on the use of tobacco

Icelandic Cancer Register
 Skógarhlíð 8
 IS-105 Reykjavík
 Phone: +354 540 1900
 Fax: +354 540 1910
 E-mail: jongl@krabb.is; laufeyt@krabb.is;
 Website: www.krabb.is

Have responsibility for:

- Statistics on cancer

FURTHER INFORMATION

Norway

Statistics Norway
P.O. Box 8131 Dep.
N-0033 Oslo
Phone: +47 21 09 00 00
Fax: +47 21 09 49 73
E-mail: ssb@ssb.no
Website: www.ssb.no

Have responsibility 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 personnel
- Statistics on hospital services
- Statistics on sterilizations
- Statistics on induced abortions
- Statistics on alcohol consumption
- Statistics on health care economy

Norwegian Institute of Public Health
P.O. Box 4404 Nydalen
N-0403 Oslo
Phone: +47 22 04 22 00
Fax: +47 23 40 81 46
E-mail: folkehelseinstituttet@fhi.no
Website: www.fhi.no

Have responsibility for:

- Statistics on sexually transmitted diseases and infectious diseases
- Statistics on tuberculosis
- Statistics on immunization
- Statistics on sale of medicinal products
- Statistics on drug prescribing

Norwegian Institute of Public Health
Department of Medical Birth Registry
Kalfarveien 31
N-5018 Bergen
Phone: +47 53 20 40 00
Fax: +47 53 20 40 01
E-mail: mfr@uib.no
Website: www.uib.no/mfr

Have responsibility for:

- Statistics on births and infant deaths

SINTEF Health Research
Norwegian Patient Register
Olav Kyrresgate 3
N-7465 Trondheim
Phone: +47 40 00 25 90
Fax: +47 932 70 500
E-mail: npr@sintef.no
Website: www.npr.no

Have responsibility for:

- Statistics on hospital services

FURTHER INFORMATION

National Directorate for Health and
Social Affairs
P.O.Box. 7000 St Olavs plass
N-0130 Oslo
Phone: +47 810 200 50
Fax: +47 24 16 30 01
E-mail: postmottak@shdir.no
Website: www.shdir.no

Have responsibility for:

- Statistics on use of tobacco

Cancer Registry of Norway
Institute of population-based cancer
research
Montebello
N-0310 Oslo
Phone: +47 22 45 13 00
Fax: +47 22 45 13 70
E-mail: kreftregisteret@kreftregisteret.no
Website: www.kreftregisteret.no

Have responsibility for:

- Statistics on cancer

Ministry of Health and Care Services
P.O. Box 8011 Dep.
N-0030 Oslo
Phone: + 47 22 24 90 90
E-mail: postmottak@hod.dep.no
Website: www.hod.no

- Statistics on in vitro fertilization

Sweden

Statistics Sweden
P.O. Box 24 300
SE-104 51 Stockholm
Phone: +46 8 506 940 00
Fax: +46 8 661 52 61
E-mail: scb@scb.se
Website: www.scb.se

Have responsibility for:

- Population and vital statistics
- Statistics on health care economy

National Board of Health and Welfare
SE-106 30 Stockholm
Phone: +46 75 247 30 00
Fax: +46 75 247 33 27
E-mail: socialstyrelsen@socialstyrelsen.se
Website: www.socialstyrelsen.se

Have responsibility for:

- Statistics on births
- Statistics on abortions
- Statistics on sterilizations
- Statistics on in-patients
- Statistics on cancer
- Statistics on causes of deaths

FURTHER INFORMATION

Swedish Institute for Infectious Disease
Control
SE-171 82 Solna
Phone: +46 8 457 23 00
Fax: +46 8 32 83 30
E-mail: smittskyddsinstitutet@smi.ki.se
Website: www.smittskyddsinstitutet.se

Have responsibility for:

- Statistics on infectious diseases
- Statistics and information on vaccinations

National Corporation of Swedish
Pharmacies
SE-131 88 Stockholm
Phone: +46 8 466 10 00
Fax: +46 8 466 15 15
Website: www.apoteket.se

Have responsibility for:

- Statistics on drug sales and drug prescribing

Swedish Association of Local Authorities
and Regions
SE-118 82 Stockholm
Phone: +46 8 452 70 00
Fax: +46 8 452 70 50
E-mail: info@skl.se
Website: www.skl.se

Have responsibility for:

- Statistics on health personnel
- Statistics on hospital capacity
- Statistics on health care economy

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56. Health Statistics in the Nordic Countries 1997. NOMESCO, Copenhagen 1999.
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61. Health Statistics in the Nordic Countries 1999. NOMESCO, Copenhagen 2001.
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64. Health Statistics in the Nordic Countries 2000. NOMESCO, Copenhagen 2002.
65. NOMESCO Classification of Surgical Procedures, Version 1.7. Copenhagen 2003
66. Health Statistics in the Nordic Countries 2001. NOMESCO, Copenhagen 2003
67. Sustainable Social and Health Development in the Nordic Countries. Seminar 27th May 2003, Stockholm. NOMESCO, Copenhagen 2003
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70. NOMESCO Classification of Surgical Procedures, Version 1.9:2005. Copenhagen 2004
71. Nordic/Baltic Health Statistics 2002. NOMESCO, Copenhagen 2004.
72. Medicines Consumption in the Nordic Countries 1999-2003. NOMESCO, Copenhagen 2004.
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Copenhagen 2005
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2006.
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Countries. Historic development in a national and international perspective
2006. NOMESCO, Copenhagen 2006
77. NOMESCO Classification of Surgical Procedures, Version 1.11:2007
Copenhagen 2006
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6th April 2006, Oslo. Seminar Report. NOMESCO, Copenhagen 2006
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edition. NOMESCO, Copenhagen 2007
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