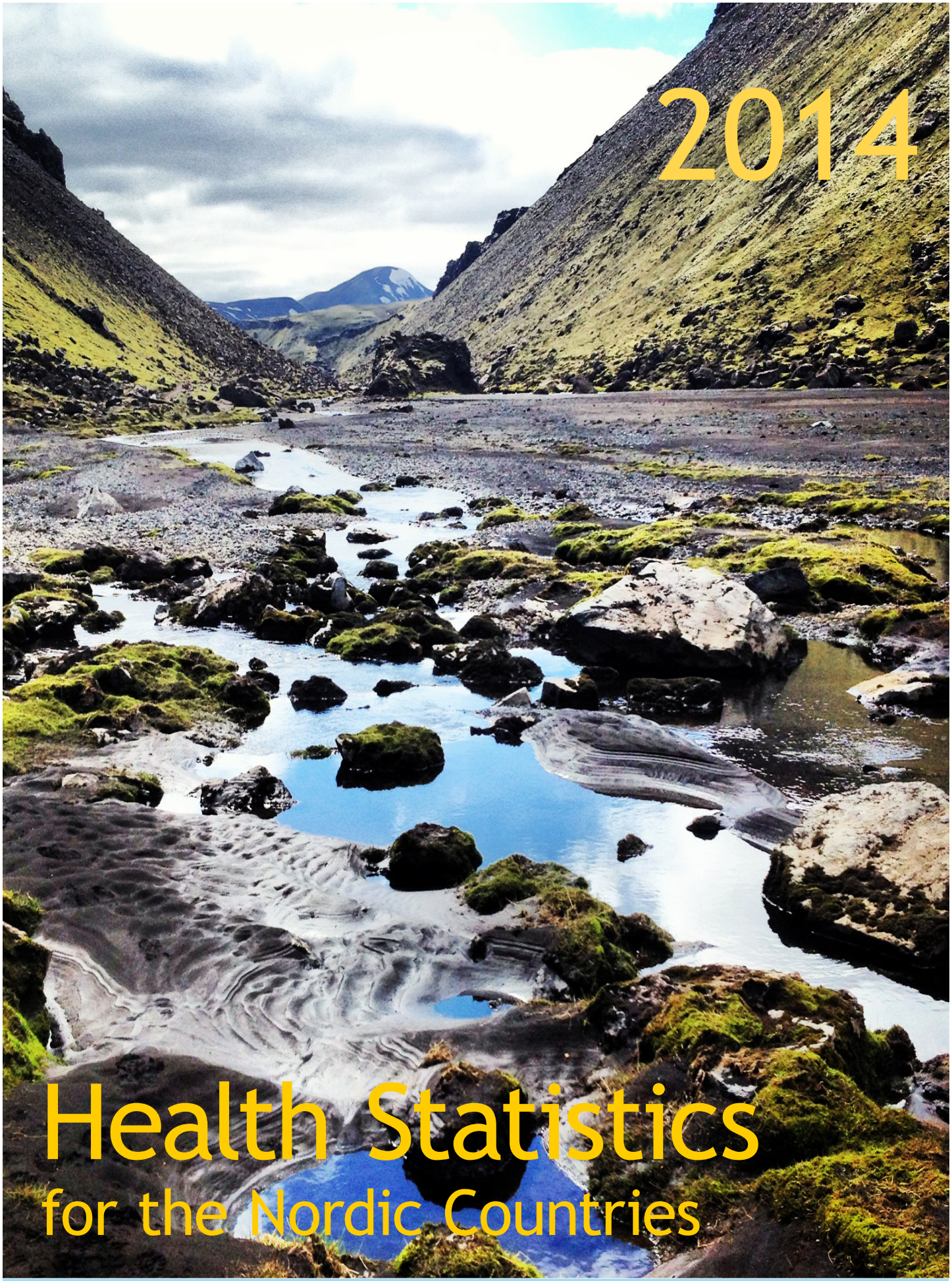


2014

Health Statistics

for the Nordic Countries

nomesco
Nordic Medico-Statistical Committee 102:2014

Health Statistics in the Nordic Countries 2014

Health Statistics in the Nordic Countries 2014

ISBN 978-87-89702-86-5

ISSN 2245-9626

Contents

Symbols used in the tables:

Figures not available or too unreliable for use	..
Information not applicable	.
Less than half of the unit used	0.0/0
Nothing to report (value nil)	-

Five year averages are always written as 20xx-xy

Two year averages are always written as 20xx/xy

Data are always calculated in relation to the respective age groups

Preface

The 2014 version of NOMESCO's Health Statistics in the Nordic Countries is now available.

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

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

This version comprises the latest available data as per the summer of 2014. The latest data year may consequently be 2013 or 2012. Previous versions are available at www.nowbase.org, where also our database and more specialized publications from projects carried out by NOMESCO can be found.

As from 2011, the publication will no longer be designated by the latest data year, but instead by the year of production. Therefore, the title is Health Statistics in the Nordic Countries 2014.

Nordic Medico-Statistical Committee (NOMESCO), January 2015

Chapter 1

Organization of Health Services

Introduction

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

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

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

Specialist medical treatment is also offered outside hospitals.

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

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

1.1 Current and future changes in the health care sector

DENMARK:

Introduction to diagnostic evaluation and treatment guarantee of psychiatric patients

In 2013, the Danish government proposed a bill regarding a change of the Health Act and the legislation regarding the access to appeals and compensations within the health care system. This Act introduces a diagnostic evaluation right of two months from September 1st 2014, which is reduced to one month (equalling the rights in all other parts of the health care system) from September 1st 2015. At the same time, a differentiated treatment right is introduced from September 1st 2014: One month at serious illness and two months at less serious illness. The diagnostic evaluation and treatment right will apply to both children and adults. The bill was passed in June 2014.

Visibility reform

The Government, KL - Kommunernes Landsforening (Local Government DK) and Danske Regioner (Danish Regions) have with the Financial Agreement for 2014 agreed upon a visibility reform. The purpose is to use health data in a more proactive way, which will propel the progress in the health care system and motivate the health care staff to create improvements in the treatment of patients. The reform is the framework for a continuous process with new initiatives and actions for a better use of data in the development of quality in the health area, which will be launched during the coming years. Over a period of four years, 32 million DKK has been allocated to this reform.

Increased quality and diminishment of coercion in psychiatry

In connection with the National Budget 2014, The Government and the political parties Venstre and Det Konservative Folkeparti have agreed to set a target about diminishing by 50 percent the use of coercion in psychiatry. 50 million DKK has been allocated for the establishment of collaborations with the Regions about reduction of coercion. Furthermore, 100 million DKK has been set aside to improve the physical environment within psychiatric health care.

New and improved treatment for children with cancer

In connection with the National Budget 2014, The Government and the political parties Venstre and Det Konservative Folkeparti have strengthened cancer treatment with a state grant of 275 million DKK for the establishment of a Danish centre for particle therapy at Aarhus University Hospital.

New health agreements to secure coherence in the health care system

The government's proposal for a bill on monitoring the evaluation of the local government reform was passed in December 2013. The bill implies that health care agreements as from January 1st 2014 have been simplified and strengthened. From here on after, only one health agreement is settled for each region, common and very specific objectives must be prepared for the development of the health area in

order to make the cooperation more binding, and - new to the agreements - psychiatry and somatic are being considered equal.

National objectives for partnership strategies and health of the Danes
In January 2014, the government announced seven national objectives for the health of the Danes for the next 10 years. Some of the objectives are social inequality in health, mental health for children and adults, smoking, alcohol, obesity among children, and physical activity. In order to achieve the national objectives, 120 million DKK has been allocated in the National budget for specific partnerships during the period 2014-2017.

Action plan and ambitious investments in psychiatry
In May 2014, the government announced an action plan for psychiatry, which aims to strengthen the efforts concerning people with mental disorders and focus on psychiatry based on equality. The government wants to invest 1.6 million DKK in improving the efforts in psychiatry during the next four years. As part of this investment, a permanent annual boost of 200 million DKK from 2016 applies.

FAROE ISLANDS:
In May 2012, the work on a new Faroese health plan was commenced. The purpose of the plan was to find new ways to reorganize the health system and make the health services more efficient. The work aimed at prioritizing preventive measures, thus to the greatest extent possible to decrease the need for expensive hospitalizations and treatments. The new efforts were categorised in the following terms: general health promoting efforts, earlier and more efficient efforts in primary health care, and more focus on strengthening the patients' abilities for self-care especially when dealing with chronical illnesses. These efforts were described and processed based on the Health Minister's very specific request to move the Faroese health care system away from a very fragmented system, conceptually as well as actually, towards a more integrated and holistic health care system.

In connection with the establishment of the health plan, the Health Minister organized a comprehensive hearing, where meetings were held with various stakeholders ranging from patients associations and trade unions over hospital managements and practising clinicians to municipalities and public institutions. In addition, citizens in general were encouraged to make suggestions that could improve the health services in the Faroe Islands, and a specific website was established for this purpose. From this hearing, a little less than 100 individual contributions and these were the basis of a report, which was presented to *Lagtinget* for debate in November 2013.

In recognition of the fact that hospital planning in the Faroe Islands, as in many other countries, is specifically controversial, because hospitals are heavily staffed, and therefore is of great importance to local economy, the Health Minister chose to make the area of hospital planning an individual part of the report. This deliberate and explicit choice to leave out hospital planning from the main report lead to a great deal of criticism. However, it undoubtedly also had the effect that the discussion about the report's description and processing of the rest of the health care system was more substantial than it would have been, had it been overshadowed by a

heated and emotional discussion about hospital planning. With this remains that hospital planning is not part of the health political strategy, which is currently in preparation on at the Faroe Islands.

Since the presentation of the report and the consequent debate at *Lagtinget*, which gave the impression that there is great political approval for the solutions stated in the report, the Ministry of Health has worked on implementing several of the new efforts. Examples of efforts that are already implemented or where implementation is on its way are:

- expansion of the offer for free dental care for children and adolescents
- establishment of local cross-disciplinary health centres
- strengthening of initiatives within child and youth psychiatry
- introduction of legal rights for rehabilitation
- offers on special counselling for polymedical citizens over 65

In general better quality assurance, thus strengthening patient safety including a coming accreditation of the Faroese hospitals.

The Danish laws on the health care systems' central administration and on health inspection institutions are still applicable for the Faroe Islands, as the Danish health and authorisations legislation has not yet entered into force for the Faroe Islands. In December 2013, a decree that states the effective date of the Act of authorisation of health personnel and of health professionals (the Danish Act of authorisation) in the Faroe Islands has entered into force. The consolidation Act entered into force in the summer of 2014. A decree stating the effective date of the Act of psychologists entered into force in the Faroe Islands in October 2014. The Faroese legislation regarding health personnel has been updated and is now equal to Danish laws.

The areas of nursing homes, home nursing services and home help are transferred from the home rule government to the municipalities on 1st January 2015.

FINLAND

New structure for social and health care services

On 23rd March 2014, the government in agreement with the opposition, decided to carry out an extensive social and health care reform with the objective of ensuring central welfare services for the Finnish citizens during the next ten years. The main goal is that the entire social and health care sector must be handled by five strong regional areas (Helsinki, Åbo, Tammerfors, Kuopio and Uleåborg). The areas are defined by the present uptake areas and lean against existing well working structures. For the future five social and health care areas will be taking care of all social and health care services. The funding comes from the municipalities in accordance with the weighted capitation principle, which takes into account the population density, age divisions in the area, and morbidity.

The proposition will be processed in parliament during the fall session 2014. According to the previous plan, the new responsibility areas within social and health care services must be initiated on 1st January 2017.

The choice of care facility increases
From 1st January 2014 the patients' rights to choose care facility was expanded. It is now possible within specialized health care for the patients to make their own choose regarding care facility, and they can choose to be treated at any public health center or hospital in Finland.

The electronic patient registers and archives of medical journals at the health centres and hospital within a health care district together compile a joint register of patient information. Without explicit consent from the patient, the staff that cares for the patient can use the information needed to properly care for the patient from the joint register.

Patients have the right to receive care from other EU countries with subsequent compensation of expenses
If a patient from Finland receives care abroad, the care expenses can be compensated under two conditions; if the patient on his own is seeking care in another country or if the care is required by a medical condition during travel. In both cases, the patient initially has to pay for the expenses. Afterwards the patient can apply the Social Insurance Institution for compensation of the expenses. The patient does not need to apply for this care before traveling abroad.

The patient has the right to receive compensation only for care services, which are a part of the services within the Finnish health care sector. Patients from other EU countries also have the right to receive care in Finland.

A contact at the Social Insurance Institution must inform citizens on how to find the proper care abroad, and how foreigners can apply for care in Finland.

European prescriptions entitles to purchase medicine in other EU countries
From the beginning of 2014, patients can purchase medicine prescribed in Finland at pharmacies in other EU and EMU countries.

A European prescription is mainly written because of the medicine's effect and the patient pays the entire amount of the medicinal product. Afterwards the patient can apply for a compensation at the Social Insurance Institution, if the prescribed drug is on the list of compensation drugs according to Finnish laws.

ICELAND
A new subsidy system for medicinal products was introduced in May 2013. According to this system, the public has to pay all expenses for medicine up to a certain limit (the subsidy limit). Hereafter the self-payment gradually decreases until annual expenses have reached a certain amount (the annual limit). After this, the expenses will be fully covered. The system is now going to be further developed and are to be expanded so it covers other parts of the health services.

Physical activity by prescription (FaR) was introduced in 2011 a pilot project with subsidies from the government. The project will now be implemented I all health centres. The objective is that general practitioners can refer chosen patients to an exercise offer as an alternative or a supplement to traditional medical treatment.

Parents are now able to register their children at a specific dentist, who will be responsible for regular check-ups, as well as preventive and necessary appointments. Payment for children will be set at a low rate for one annual visit.

This settlement will be initiated in seven steps and it will comprise all children under 18, as per January 2018.

Nationwide electronic patient journals must continuously be developed and linked to each other in order to promote safety and quality of service for patients.

The ministry have been working on establishing control of access within the health services, where general practitioners work as service coordinators for the health services at all levels. At the same time, the primary health sector must be strengthened and, to a higher extent, the general practitioners have to cooperate with the rest of the health care system.

A nationwide central 24 hour telephone advice service about health care sectors will be implemented. Furthermore, an interactive website with counselling and information about referrals in the health care system will be launched. The objective is to improve access to the health care services and to guide patients through the system.

The previous insurance scheme was in 2008 divided into Health insurance and social insurance. In general, there was a political intention to carry on the work of combining some institutions and achieve a clearer image of the relation between buyer and supplier of health services. Due to the financial crisis, which occurred in Iceland in October 2008, most of the planning and implementation was put aside.

The integration of health institutions in most recent years has been carried out in accordance with the country's division of seven health districts (cf. Health Act nr.40/2007). As of 1st October 2014, there is a health institution in each district as well as Landspitali in the capital region and Syghuset in Akureyri. The final integrations took place in Nord-landet, Vestfjordene and in Sud-landet.

The primary purpose of these integrations is to ensure that health services are available in all regions, both professionally and financially, as well as to eliminate the so-called small regions, where only a few doctors are employed. The objective is also to reduce the load of monitoring, binding commitment and isolation, to create stronger operational and administrative units that are able to solve most problems in the local area within the interference of the ministry. This way the merger will strengthen the cooperation and division of labour in the district, as soon as the service is stronger and more stable.

NORGE

In Norway, several large health reforms have been implemented, and over time, they have changed the structure of the health care system. Some general characteristics are seen in all the Nordic countries: re-evaluation of the state's and the market's role in health care system, decentralizing to a lower level in the public sector or to the private sector, greater influence and more rights and options for the patients, as well as more emphasis on preventive work and public health initiatives. The most comprehensive reforms are the RGP scheme of 2001, escalation plan for mental health from 1999-2008, stately takeover of the hospital sector and the specialist

health services from the municipalities in 2002, as well as the cooperation reform from 2012. None of these reforms have included dental health care.

The objective of the cooperation reform is to ensure more and better coordination between health care and nursing services as well as a greater effort in preventive measures and the limitation of illnesses. Therefore, an increase in assistance to self care, an increase in preventive and health promoting measures, and an extension of low term offers in the municipalities are under preparation. From 2012 the municipalities and the health businesses were imposed to enter into legally binding cooperation agreements which are to ensure cooperation about discharge ready patients and services of the proper level. However, the scheme of municipal co-funding has been suggested to be dismantled from 2015.

From 2016 the municipalities will have the responsibility of offering the citizens instant assistance as a 24 hour offer. This agreement means that some emergency patients with the need for 24 hour assistance can be treated in the municipalities instead of being hospitalized. A subsidiary plan is contributing to the gradual widening of this agreement.

Some services have moved closer to the end users, and municipal offers (e.g. the so-called healthy life centrals, which are contributing to prevention, so that the need for hospitalizations are reduced) have been established. The scheme of free choice of treatment institution, which most likely will be introduced in 2015, are to strengthen the patients' rights. This scheme have been allocated 150 million NOK. Initially this will be implemented in the areas of cross-functional specialized treatment within alcohol and drug abuse and mental health care. The objective of these effort is to reduce waiting lists and increase the free choice for patients.

Mental health care has been a strategic priority for a long time (cf. The escalation plan for mental health). In spite of this, there is still a need for strengthening the offers, especially within treatment of mild to moderate mental illnesses. In the government's action plan for 2014, it is stated that for this work 200 million NOK have to be allocated annually over the next four years.

With the alcohol and drug abuse treatment reform (2004) the responsibility of treating persons with alcohol and drug abuse was transferred to the state (carried out by the regional health businesses). Signs from the government tell that the 24 hour capacity for cross-functional specialized treatment for alcohol and drug abuse must be strengthened.

The patient – rights, access of complaints and free choice options

All treatment in public hospitals, district psychiatric centres as well as at private hospitals, which have an operation agreement with a regional health business, is included in the patient and user rights law regarding choice of treatment facility and the access of complaints. In June 2013, the government enacted changes in The Patient and User Rights Act. With this enactment, referrals of patients to specialist health services were cut down from 30 to 10 effective days. Furthermore, it stated that the special health services must inform the patients of when an appointment has been made for their diagnosing or when the treatment will begin.

The scheme of free choice of treatment facility gives the patients the right to choose their own treatment facility. This also applies to patients with mental and alcohol and drug abuse related illnesses (www.frittsykehusvalg.no/rettigheter). From next year, the patients will most likely be given the right to choose their own treatment provider. This scheme will contribute to the strengthening of the cooperation between the public and the private sectors. Those, who are in need of necessary health care, must be given an offer as soon as possible, either as a public or as a private service at a fee fixed by the state. This will be implemented in the area of alcohol and drug abuse treatment first, and then in the area of mental illnesses. This scheme has been in hearing in 2014, and is expected to be passed in 2015.

Electronic prescriptions: A system for electronic prescriptions *e-resept* has been taken into operation among most general practitioners in Norway, and now the system is to be made available at the hospitals. The regional health businesses (RHF) are well on their way in implementing *e-resept* at the hospitals. This work is expected to be ready at most hospitals by the end of 2015.

The adaptation of IT solutions are in progress, so that more users can take advantage of the *e-resept* system, e.g. dentists and midwifes with the right to prescribe contraceptives.

The Norwegian System of Patient Injury Compensation was established in 2033 and provides compensation for patients who are injured in the public health care sector. From 2009 the law of patient injury comprised the private health services, including dental health care services. Now private dentists are also included in this system.

Habilitation and rehabilitation

From 2012, regulations on habilitation and rehabilitation, individual plans and coordinators ensure services for groups with needs for social, psychosocial and medicinal habilitation and rehabilitation. Both the municipalities and the health businesses are required to establish a coordinating unit, which must contribute to ensure a holistic offer for patients and users with need for such services.

Dental health care services – introduction of price limits for treatments?

Today dentists can set their own prices for their services, and the prices varies a great deal from dentist to dentist. In the future, price models for dental care for adults must be settled in order to determine how much of the expenses the patient has cover. The Act of dental health care services is currently under evaluation. The government is evaluating a solution with price limits for dental health care for adults.

SWEDEN

The government has made an agreement on a new patient act with the objective to strengthen and clarify the patient's situation as well as further the patient's integrity, self-determination and participation. The new Act implies that patients must be given the possibility of choosing their own treatment provider in publicly funded primary care and open specialist care nationwide. The responsibility of the counties to offer open care is hereby expanded to include patients, who are comprised of another county's responsibility for health care.

The purpose of the government's action plan is to prevent and treat chronical illnesses in order to better the care for all persons with chronical illnesses. The measures apply to patient focused care, knowledge based care as well as prevention and early awareness. The action plan is part of the government's strategic priority of bettering the care for persons with chronical illnesses. The efforts in connection with this action plan has been determined in close cooperation between representatives for patients and vocational organizations, counties and related authorities.

The government has established a national group of experts in order to bring down waiting lists within cancer care. In the National Board of Social Services' report 'Waiting lists in cancer care' from October 2013, it is stated that the waiting lists within cancer care are very long and that there is a great difference between counties as regards to survival rates and treatment times for certain forms of cancer. Since 2009, the government has been working on a national cancer strategy with the main purpose to prevent cancer illnesses, to improve the quality of the care for cancer patients, and to extend the survival time and improve the life quality of cancer patients.

The government has appointed a special investigator to examine the highly specialized care in Sweden. The task must be finished before 25th November 2015. One of the objectives of this examination is to define the concept of highly specialized care, and to make suggestions to the criteria of how assessments, selections, decisions and implementing should be, and how follow-up and evaluations should be carried out for the highly specialized care. The objective is to obtain better care results, more equality and more cost efficiency in the area of highly specialized care.

On 1st January 2014, The Public Health Agency was established. The Public Health Agency's tasks are to ensure equal conditions for good health trough monitoring of the public's health status and analyse the contributing factors, to evaluate public health efforts, promote health, prevent illnesses and support the infection control efforts with epidemiological and microbiological analysis. This new authority will also have the obligation to evaluate the national monitoring of antibiotic resistance. The agency will have the overall responsibility of health issues on a national level and e.g. it will take over tasks from The Infectious Diseases Institute, The State Institute of Public Health and parts of the National Board for Social Services. Furthermore, the agency will be responsible for environmental health issues.

Also on 1st January 2014, the eHealth Agency was established and in connection to the establishment, the Agency took over tasks previously handled by *Apotekens Service AB*. eHealth Agency is responsible for registers and IT functions, which open care pharmacies and caretakers need access to. The Agency is a link in the e-prescription chain between care services and the pharmacies. All pharmacies in Sweden are able to retrieve all the information needed to process a prescription. The Agency is also going to coordinate the government efforts within e-health, as well as monitoring the development of the e-health area.

The government has initiated an assessment in order to evaluate the dental care reform. In 2008, the dental care services area was reformed with the intention of bettering dental health care in Sweden. The government imposed a general dental

care subsidy and a high cost maximum limit to give patients with vast dental care needs a possibility of receiving dental care at a reasonable price.

On 1st July 2014 new rules, which give the Dental and Pharmaceutical Benefits Agency (TLV) the possibility of lowering the prices for certain older medical products, came into effect. The TLV must be an even more active player in its work of developing the value based pricing system, in order to obtain an increase in cost effectiveness.

Currently the government is monitoring the area of alcohol, drug, doping and tobacco abuse (ANDT). This measure implies that the ANDT strategy must provide a structure for the monitoring of the development in consumption and abuse, of the medicinal and social adverse effects as well as activities and efforts in the area.

The Swedish Agency for Participation was established on 1st May 2014 and with this new agency parts of the activities of the Swedish Institute of Assistive Technology and of the Agency of handicap political coordination (HANDISAM) are combined, and operates under the new name. The new agency will be working on getting the disability policy to have an impact on the entire society. The progress will be monitored and analysed on national and international levels. The agency will bring forward new measures and guidelines, disseminate knowledge, and initiate research and other development work.

1.2 Organization and responsibility for the health sector

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

- In principle, primary contact shall always be with a general medical practitioner
- Dental services are provided by private dental practitioners. The services are only a public matter in some dental care services for children
- Health care during pregnancy is the responsibility of the regions
- Child health care is provided according to the Act Relating to Health Visitors and is administered by the municipalities, while health examinations of children are carried out by general medical practitioners
- Home nursing care is provided by the municipalities and is free of charge after referral by a physician
- School and occupational health services are regulated by legislation. Municipalities are responsible for school health services, which are provided by health visitors and physicians
- Occupational health services are organized by companies and are led by committees with representatives for both employees and employers
- Contact with the health services: As a main rule, patients may contact general medical practitioners, dentists, chiropractors, physiotherapists, chiropodists, psychologists, dental hygienists, emergency wards and emergency and ambulance services without referral
- Public hospitals: Public hospitals are owned by the regions
- Private hospitals: The regions have a contract with some private hospitals to provide treatment under the extended free choice of hospital arrangement. A few private hospitals operate totally independently of the public hospital services. Some specialized hospitals are organized under the hospitals, while others are owned by organizations
- Free choice of hospital: As a rule, patients are free to choose the hospital where they wish to receive treatment
- Practicing specialists: Most practicing specialist physicians work under a contract with the health insurance scheme, and most of their patients are referred from general medical practitioners
- Nursing homes: Ordinary nursing homes are run by the municipalities, but there are many private (independent) nursing homes, which receive residents according

to a contract with the municipality in which they are located. Certain specialized nursing homes are run by the regions, for example psychiatric nursing homes

- Pharmacies are organized as private companies, but are subject to government regulation. The state regulates the number and the geographical location of pharmacies, their tasks and the profit margin on pharmaceutical products

FAROE ISLANDS: The Home Government of the Faroe Islands lays down the rules concerning the tasks, benefits and administration of the health service. The organization of the hospital services, specialist fields and primary health services largely follows the Danish system. The same applies to nursing homes, home nursing services and home help as well as dental treatment. The areas of nursing homes, home nursing services and home help are transferred from the home rule government to the municipalities on 1st January 2015.

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

All practising physicians are public employees, but they are mainly remunerated by the public health insurance scheme (Heilsutrygd). However, they are also paid directly by the Faroese national budget. The practising physicians are administered by both the municipal authorities and the state authorities. The municipalities are responsible for the properties, their contents and instruments, while the counties are responsible for employment conditions and similar.

The midwifery service is organized under the hospital services.

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

Pharmacies are run by the public authorities.

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

The main principles are as follows:

- The Ministry of Health and Infrastructure is responsible for legislation and overall management
- The Chief Medical Officer is responsible for supervision of health services and for developing health care guidelines
- The health authorities together with the regional managements are responsible for running the health services. This includes the primary health services, specialized health services, distribution of pharmaceutical products, nursing, home nursing services in some districts, home mental health care, preventive services, rehabilitation and child and school health services
- The municipalities are responsible for home nursing services, preventive services and nursing homes
- In principle, primary contact shall always be with the regional hospital, local health centres, or with the medical practitioner clinic in Nuuk
- Dental services are provided in public dental clinics. There are some private dentists with no reimbursement arrangement

- Antenatal care is the responsibility of the health authority
- Child health services and health check-ups for children are provided by the health authority
- Home nursing services are provided by the health authority in most municipalities and by the municipal health authority in some municipalities
- School health services are provided by the health services

There are no occupational health services in Greenland.

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

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

Private hospitals: There are no private hospitals in Greenland.

Specialized hospitals: There are no specialized hospitals in Greenland.

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

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

Practising specialists: There are no practising specialists in Greenland.

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

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

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

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

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

health and welfare promoting measures, primary care and specialized nursing, and the municipalities are responsible for the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The structure of the primary health care corresponds functionally and ideologically to the Finnish public health care system. Counselling concerning contraception and for mothers and infants as well as school and student health services function as in Finland. Immunization programmes are voluntary and the recommendations are as in Finland. Physiotherapy under the ÅHS is a shared function both for the primary

health service and the hospitals. In addition, a number of private physiotherapists are used by the public sector.

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

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

Regulations for pharmacies are the same as in Finland.

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

The state is responsible for legislation, but the Ministry of Welfare is responsible for supervision and guidelines. Furthermore, the state has the main responsibility for ensuring that all citizens in Iceland have access to optimum health services (primary, secondary and tertiary health services).

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

Specialist medical treatment is largely carried out by specialist general practitioners under contract with the Health Insurance. Specialists operates in densely populated areas but they also serve at health centres in small towns. Specialist treatment is also offered at the outpatient clinics at hospitals.

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

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

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

Dental treatment is carried out at private dentists' practices.

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

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

According to law, occupational health services are the responsibility of the employer. Larger companies receives this benefit from practising physicians, consultancy firms, or from the health centres.

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

NORGE: 9,4 percent of GDP in Norway are allocated to funding of health businesses, and the public sector funds 84 percent of the health expenses. Private health insurance schemes are not particularly widespread, but the market is growing.

The public health services in Norway is based on a decentralized model. The services are organized nationally under the Ministry of Health and Care Services, regionally through four health businesses responsible for specialist health services within somatic, cross-functional and specialized treatment for alcohol and drug abuse and mental health care, and locally by 19 counties responsible for dental health care as well as 428 municipalities responsible for municipal health and care services. The system of health care provision in Norway is based on a decentralized model

The State is responsible for the following:

- Health care policies, capacity and quality of health care through budgeting, legislation and professional guidelines (e.g. for prioritization).
- Specialist health services; the state owns the regional health businesses (the RHF's). Specialized services within somatic, mental health care (psychiatric hospitals, district psychiatric services and mental health institutions for children and adolescents), cross-functional and specialized treatment for alcohol and drug abuse, parts of the ambulance services and some hospital pharmacies have been organized as health businesses within the RHF's. RHF also enter into agreements with private operators (institutions, independent specialists' businesses and ambulance services). In 2012, a pilot scheme was initiated. The scheme includes four health businesses and offers dental health care services at hospitals
- General practitioner services, including a regular general practitioner scheme
- Acute medical care
- Nursing services, including the health visitor service and the home nursing service
- Maternity services
- Nursing homes and other types of residential care
- Medical emergency call service
- Transport services for health care personnel (Municipal Health Services Act)

The counties are responsible for providing good and sound health care and social services to anyone in need, regardless of their age and diagnosis. The health care and social services in the counties include:

- RGP scheme
- deductibles

- care services
- care for alcohol and drug abuse
- social services in the counties (NAV)
- public physiotherapy services
- allocation of county services and access to complaints services
- habilitation and rehabilitation
- health stations and the school health services
- health promoting and preventive work

The county authorities are responsible for the following:

- Dental care services for children and adolescents, mentally disabled adults as well as the elderly, the long-term ill and the disabled who live in institutions or who receive home nursing. The Act of dental health care is under revision. The counties also have the possibility of offering dental care for adults. This is done largely in districts with no market for private services
- The state subsidizes the gradual construction of an organized dental health care plan for persons, who have experienced torture or abuse, or who suffer from odontophobia. The treatment teams are established in the public dental health care services and consist of dental health care personnel as well as psychologists. The treatment is free of charge for those who are eligible for this offer. In order to obtain an enactment for this dental health care plan, knowledge and experiences within the field are required

Private health services:

- Dental services for adults are mainly provided by private dentists and paid for by the patients. Approximately 90 percent of the dental specialists also work in the private sector
- Occupational health services: Some large companies have their own private services. Some companies have a joint arrangement with an occupational health services company, which sells occupational health services.
- Pharmacies are mainly privately owned, but are subject to strict public control
- Some private hospitals have an agreement with the region, and other private hospitals are run completely independently of the public health services
- Private nursing homes provide care for residents according to an agreement with the municipalities
- Some privately practicing specialists have a contract with the regional health businesses and receive most of their patients by referral from a general practitioner. Others work completely independently, and they are financed by patient self-payment

First line services: Patients can see general practitioners, dentists and emergency services without a referral.

A national solution for the handling of electronical prescriptions has been implemented. The method of the *E-recept* solution is that the doctor sends the prescription electronically to a central database. The pharmacy and the prosthetics retrieves the prescription, when the customer states his or her social secury number or name and date of birth. The citizens have access to an overview of their own prescriptions at website *helsenorge.no* through *Mine resepter* (My prescriptions).
e-resept has been implemented nationally at general practitioners, specialists, pharmacies and at prosthetics. *E-resept* will now also be implemented at hospitals. The objective is that *e-resept* is implemented at all hospitals by the end of 2015. *e-resept* will be further developed, and now a pilot version is coming, which carries out an electronical exchange of the patients list of used medicines. This applies to all patients connected to nursing and care services and for patients with a private agreement on multidose packaging.

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

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

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

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

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

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

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

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

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

Within child and youth psychiatry, the treatment guarantee is even more strengthened. The strengthened treatment guarantee implies that all regional municipalities, besides the basis requirements of the national treatment guarantee, must be able to offer an appointment for evaluation within 30 days, and hereafter, if decided, an in-depth diagnosing or treatment within 30 days.

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

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

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

The National Board of Health and Welfare make decisions about which vaccinations should be included in the national immunization programme in consultation with The Public Health Agency of Sweden and the Medical Products Agency.

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

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

The Public Health Agency of Sweden has a national responsibility for public health issues. This authority promotes good public health, evaluates the effects of the methods and strategies within the public health care area, and monitors the general public health in the population and the factors, which influences this. Through knowledge building and knowledge dissemination, the agency promotes health and prevents illnesses and injuries.

1.3 Supervision of health services and health care personnel

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

In the Faroe Islands, the Chief Medical Officer, who is employed by the Danish Ministry of Health, shares the responsibility with the Danish Board of Health for supervision of health services. The Chief Medical Officer is the consultant to Faroese and Danish authorities regarding health matters.

The Chief Medical Officer is an independent institution under the Government of Greenland and is responsible for supervision of health services in Greenland. The Chief Medical Officer advises and assists the Government of Greenland and other authorities in questions of health.

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

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

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

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

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

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

1.4 Complaints about health services and health care personnel

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

FAROE ISLANDS: To a certain extent, the Faroese health system is covered by the regular Danish complaints system. Complaints about health professional services carried out by authorised health personnel in the Faroe Islands are handled by *Sundhedsvæsenets Disciplinærnævn* in Denmark. Complaints about cases regarding rights of access to patient files are handled by the Danish Patient Ombud. Complaints about coercion in connection with psychiatric treatment are primarily handled in the Faroese psychiatric complaints board (Psykiatriska kærunevndin). The complaints Board's decisions can be appealed to The Psychiatric Appeals Board in Denmark. Complaints about non-health professional services in the Faroese health system are handled by the Faroese Complaints Board for Social and Health cases (Kærunevndin í almanna- og heilsumálum), except complaints about the rights of access to patient files, which, as already mentioned, are handled by the Danish Patient Ombud. Patients that are referred by the Faroese health care system, who receives treatment in the Danish hospital services, are fully covered by the Danish complaints system as it works in Denmark.

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

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

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

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

NORWAY: The Norwegian Board of Health Supervision in the counties deals with complaints against individual health care personnel. These offices may find that the conditions laid down in laws and regulations have not been met, and can give advice on how to make improvements. If there are grounds for more serious sanctions against health care personnel, the complaint may be forwarded to the Norwegian Board of Health Supervision (centrally). Patients can also send their complaints to the person in charge of an institution (e.g. the municipal board in the case of municipal health services), or to the Norwegian System for Compensation for Injuries to Patients, in the case of claims for compensation related to treatment in the public health service. Patients in both public and private health services as well as dental health care services can apply for such a compensation.

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

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

Chapter 2

Population and Fertility

Introduction

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

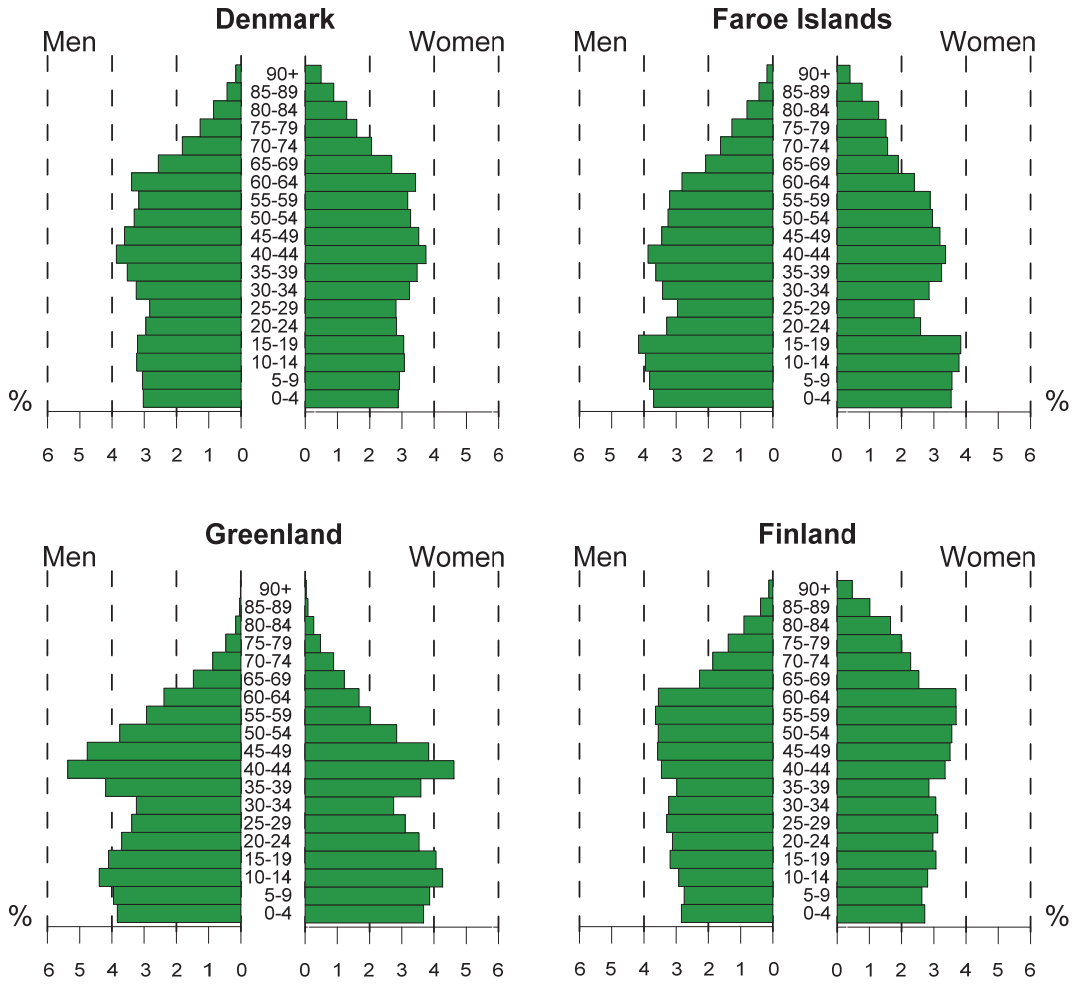
2.1 Population and Population Trends

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

The development in population growth varies somewhat among the Nordic countries. The natural increase has been largest in Iceland, the Faroe Islands and Greenland throughout the past decade. Denmark, Åland and Sweden have had the lowest natural increase. In 2013, net migration contributed to population growth in all the Nordic countries with the exception of Greenland. In addition, there is a large deficit of women of fertile age in the Faroe Islands.

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

Figure 2.1.1 Mean population by gender and age as a percentage of the total population 2013[1]



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

The Figure continues

Figure 2.1.1 Mean population by gender and age as a percentage of the total population 2013, continued

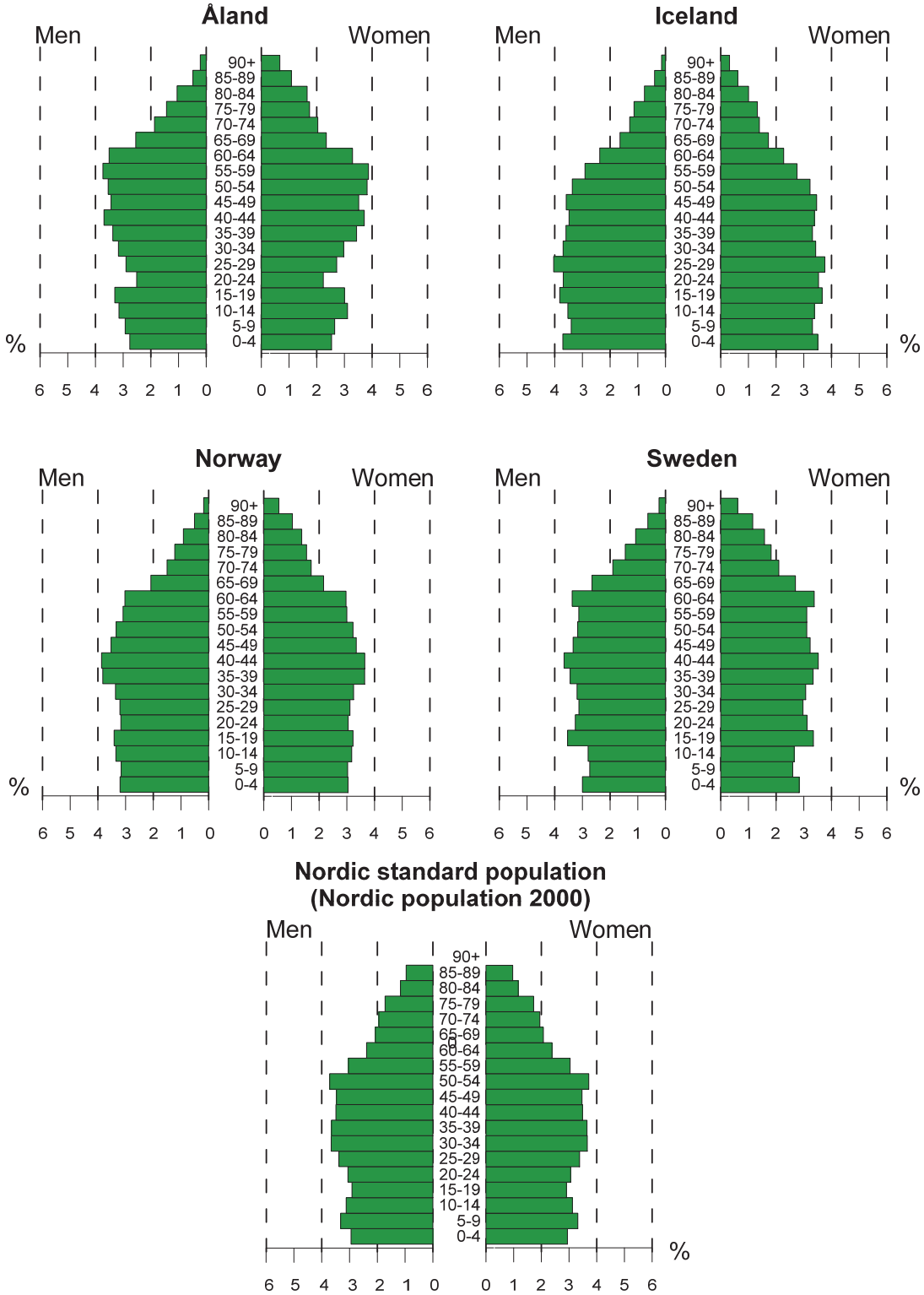


Table 2.1.1 Mean population 1960-2013

	Denmark	Faroe Islands	Greenland	Finland	Of which Åland	Iceland	Norway	Sweden
(1 000)								
Men								
1960	2 265	18	..	2 133	10	89	..	3 734
1970	2 432	20	..	2 225	11	103	..	4 016
1980[1]	2 529	22	27	2 311	11	115	..	4 118
1990	2 531	25	30	2 419	12	128	..	4 228
2000	2 639	24	30	2 526	13	141	2 224	4 386
2005	2 680	25	30	2 567	13	148	2 293	4 487
2010	2 748	25	30	2 632	14	160	2 444	4 670
2012	2 771	25	30	2 667	14	161	2 517	4 746
2013	2 779	25	30	2 680	14	162	2 552	4 790
Women								
1960	2 301	17	..	2 296	11	87	..	3 751
1970	2 474	18	..	2 381	10	101	..	4 027
1980[1]	2 593	20	23	2 469	11	113	..	4 193
1990	2 605	23	26	2 567	12	127		4 331
2000	2 700	22	26	2 650	13	140	2 267	4 486
2005	2 736	23	27	2 679	13	147	2 330	4 561
2010	2 796	23	27	2 732	14	158	2 445	4 708
2012	2 816	23	27	2 760	14	160	2 501	4 773
2013	2.824	23	27	2 771	14	161	2 528	4 810
Men and Women								
1960	4 566	35	..	4 430	21	176	..	7 485
1970	4 906	39	..	4 606	21	204	..	8 043
1980[1]	5 122	43	50	4 780	23	228	..	8 310
1990	5 135	48	56	4 986	24	255		8 559
2000	5 340	46	56	5 176	26	281	4 491	8 872
2005	5 416	48	57	5 246	27	296	4 623	9 048
2010	5 544	49	56	5 363	28	318	4 889	9 378
2012	5 587	48	57	5 427	29	321	5 019	9 519
2013	5 603	48	56	5 451	29	324	5 080	9 600

1 The Faroe Islands 1977

Source: DK, Statistics Denmark; FO, Statistics Faroe Islands; GL, Statistics Greenland; FI & ÅL, Statistics Finland; IS, Statistics Iceland; NO, Statistics Norway; SV, Statistics Sweden

Table 2.1.2 Mean population, by age groups as a percentage, 1960-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
1960[1]								
0-17 years	26.3	38.4	..	35.3	29.8	39.9	30.6	27.4
18-64 years	63.2	53.6	..	57.4	58.9	52.1	58.5	60.8
65+ years	10.5	8.1	..	7.3	11.4	8.0	10.9	11.8
1970								
0-17 years	31.0	36.9	..	30.2	26.7	38.9	29.3	24.9
18-64 years	56.8	54.3	..	60.7	60.1	52.4	57.9	61.4
65+ years	12.2	8.8	..	9.2	13.1	8.8	12.8	13.7
1980[2]								
0-17 years	25.8	34.9	37.9	25.1	24.3	33.7	27.0	23.9
18-64 years	59.9	55.4	58.4	62.9	60.2	56.4	58.3	59.9
65+ years	14.3	9.7	3.5	12.0	15.6	9.8	14.7	16.3
1990								
0-17 years	21.3	29.5	29.6	23.0	22.0	30.0	23.3	21.9
18-64 years	63.1	58.7	66.6	63.6	61.5	59.4	60.4	60.4
65+ years	15.6	11.8	3.8	13.5	16.6	10.6	16.3	17.8
2000								
0-17 years	21.6	27.9	31.2	21.9	22.0	27.7	23.5	21.9
18-64 years	63.6	58.5	63.8	63.1	61.6	60.7	61.3	60.9
65+ years	14.8	13.5	5.1	15.0	16.3	11.6	15.2	17.3
2010								
0-17 years	21.9	26.1	27.2	20.2	20.3	25.3	22.7	20.5
18-64 years	61.5	59.1	65.9	62.3	61.6	62.5	62.3	61.2
65+ years	16.6	14.8	6.9	17.5	18.1	12.1	15.0	18.3
2012								
0-17 years	21.4	26.1	26.2	20.2	20.0	24.9	22.3	20.2
18-64 years	60.9	59.1	66.5	62.3	60.9	62.3	62.1	60.8
65+ years	17.7	14.8	7.3	17.5	19.2	12.8	15.5	19.0
2013								
0-17 years	21.1	25.7	25.9	19.8	19.9	24.7	22.1	20.2
18-64 years	60.8	58.4	66.7	62.6	61.9	62.2	62.1	60.3
65+ years	18.1	15.9	7.4	17.6	18.2	13.1	15.8	19.4

1 Åland 1961
2 Faroe Islands 1977

Table 2.1.3 Vital statistics per 1 000 inhabitants, 2000-2013

	Live births	Deaths	Natural increase	Net migration	Population increase
Denmark					
2000	12.6	10.9	1.7	1.8	3.5
2005	11.9	10.2	1.7	1.2	2.9
2010	11.5	9.8	1.6	4.0	5.7
2012	10.4	9.4	1.0	4.3	5.3
2013	10.0	9.4	0.6	5.3	5.9
Faroe Islands					
2004-08	14.2	8.2	6.0	3.6	2.4
2009-13	12.7	7.8	5.0	6.0	1.0
Greenland					
2003-07	8.8	4.7	5.6	-7.2	-1.6
2008-12	14.8	8.0	6.8	-6.6	0.2
Finland					
2000	11.0	9.5	1.4	0.5	1.9
2005	11.0	9.1	1.9	1.7	3.6
2010	11.4	9.5	1.9	2.6	4.4
2012	11.0	9.6	1.4	3.2	4.7
2013	10.7	9.5	1.2	3.3	4.5
Åland					
2004-08	8.5	7.5	0.9	3.9	5.6
2009-13	10.1	9.6	0.5	6.5	8.8
Iceland					
2000	15.3	6.5	8.8	6.1	15.3
2005	14.5	6.2	8.3	13.0	21.3
2010	15.4	6.4	9.1	-6.7	2.6
2012	14.1	6.1	8.0	-1.0	7.1
2013	13.3	6.6	6.7	4.9	11.7
Norway					
2000	13.2	9.8	3.4	2.2	5.6
2005	12.3	8.9	3.4	4.0	7.3
2010	12.6	8.5	4.1	8.7	12.7
2012	12.0	8.4	3.6	9.4	13.0
2013	11.6	8.1	3.5	7.9	11.4
Sweden					
2000	10.2	10.5	-0.3	2.8	2.4
2005	11.2	10.2	1.1	3.0	4.0
2010	12.3	9.6	2.7	5.3	8.0
2012	11.9	9.7	2.2	5.4	7.7
2013	11.8	9.4	2.4	6.8	9.3

Source: DK, Statistics Denmark; FO, Statistics Faroe Islands; GL, Statistics Greenland; FI & ÅL, Statistics Finland; IS, Statistics Iceland; NO, Statistics Norway; SV, Statistics Sweden

Table 2.1.4 Average life expectancy, 2000-2013

	Men					Women				
Age	0	15	45	65	80	0	15	45	65	80
Denmark										
2000-04	74.7	60.3	31.7	15.3	6.8	79.4	64.9	35.6	18.3	8.5
2010	77.1	62.4	33.5	16.9	7.4	81.2	66.6	37.2	19.6	9.0
2012	77.9	63.3	34.2	17.3	7.7	81.9	67.2	37.9	20.0	9.2
2013	78.0	63.4	34.3	17.4	7.5	81.9	67.3	37.9	20.1	9.2
Faroe Islands										
2004-08	79.6	65.0	36.1	18.2	7.9	83.0	68.3	38.8	20.5	9.4
2009-13	78.8	64.4	35.3	17.8	7.8	83.2	69.1	39.7	21.5	9.8
Greenland										
2004-08	66.6	53.1	27.8	11.8	5.0	71.6	57.8	29.9	13.9	6.5
2009-13	68.6	55.1	29.3	13.2	5.8	73.7	59.5	31.6	15.1	6.6
Finland										
2000-04	74.8	60.2	32.1	15.9	6.9	81.6	67.0	37.8	19.8	8.5
2010	76.7	62.0	33.7	17.3	7.6	83.2	68.5	39.2	21.2	9.4
2012	77.5	62.8	34.3	17.6	7.8	83.4	68.7	39.5	21.3	9.5
2013	77.8	63.1	34.6	17.8	8.0	83.8	69.0	39.7	21.5	9.7
Åland										
2004-08	79.0	64.3	35.3	17.5	7.8	83.1	68.8	39.3	21.0	9.6
2009-13	..	..	..	..	..	..	..	..	..	..
Iceland										
2000-04	78.5	63.9	35.1	17.6	7.7	82.3	67.6	38.3	20.3	9.0
2010	79.5	64.8	36.0	18.2	7.7	83.5	68.8	39.3	20.8	9.4
2012	80.8	66.1	37.2	19.2	8.4	83.9	69.1	39.6	21.1	9.6
2013	80.8	66.0	37.1	19.1	8.2	83.7	68.9	39.5	21.0	9.5
Norway										
2000-04	76.6	62.1	33.7	16.5	7.0	81.7	67.2	37.9	20.0	8.8
2010	78.9	64.2	35.4	17.9	7.8	83.2	68.5	39.1	21.0	9.6
2012	79.4	64.8	35.8	18.2	7.8	83.4	68.7	39.2	21.0	9.5
2013	79.7	64.9	36.0	18.4	8.0	83.6	68.9	39.5	21.2	9.7
Sweden										
2000-04	77.8	63.2	34.3	17.0	7.3	82.3	67.6	38.3	20.2	9.0
2010	79.5	64.8	35.8	18.2	7.9	83.5	68.8	39.3	21.1	9.6
2012	79.9	65.2	36.2	18.4	7.9	83.5	68.8	39.4	21.0	9.5
2013	80.1	65.4	36.5	18.7	8.1	83.7	69.0	39.6	21.2	9.6

Source: DK, Statistics Denmark; FO, Statistics Faroe Islands; GL, Statistics Greenland; FI & ÅL, Statistics Finland; IS, Statistics Iceland; NO, Statistics Norway; SV, Statistics Sweden

Figure 2.1.3 Live births and natural increase per 1 000 inhabitants, 2000-2013

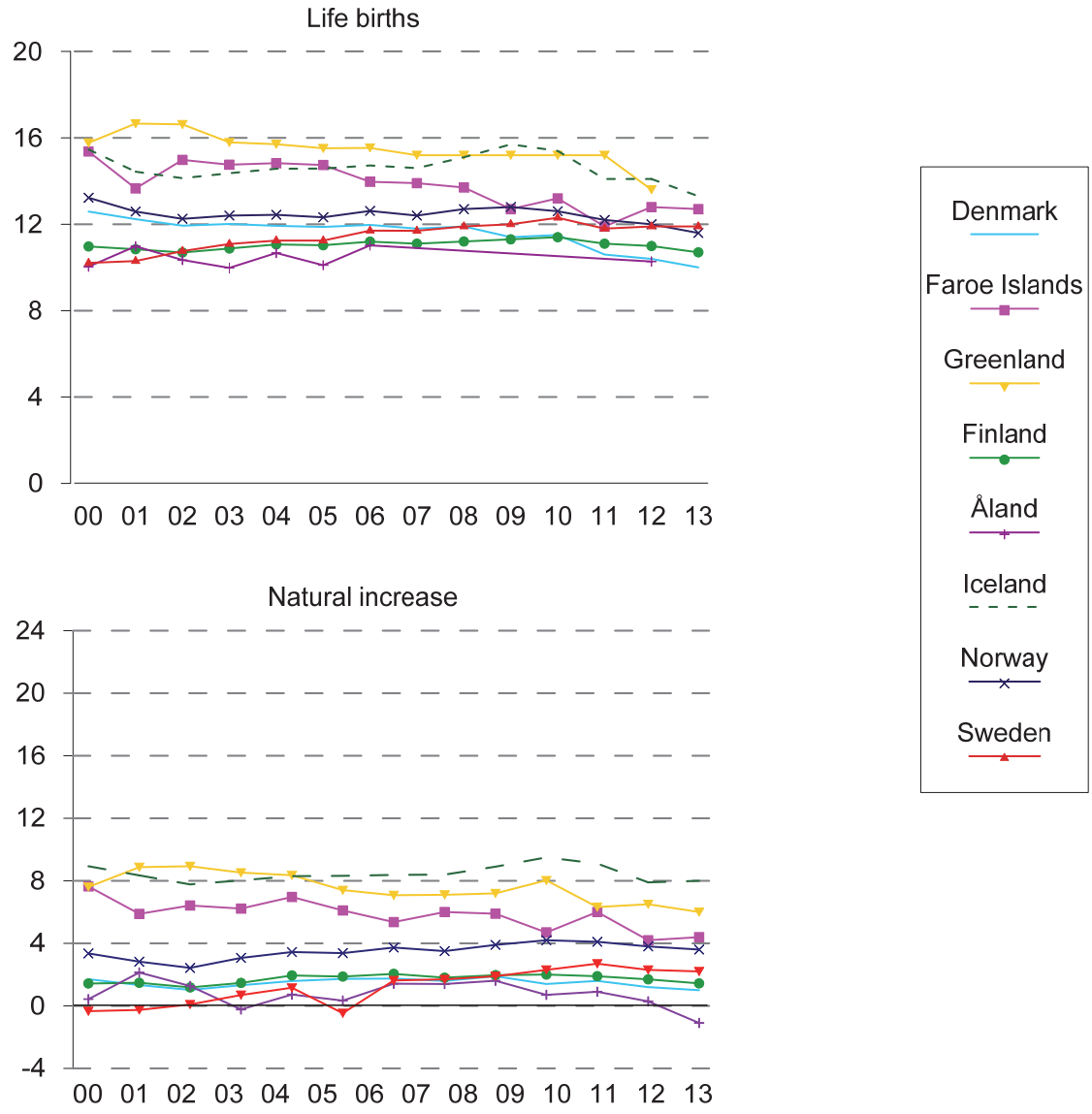
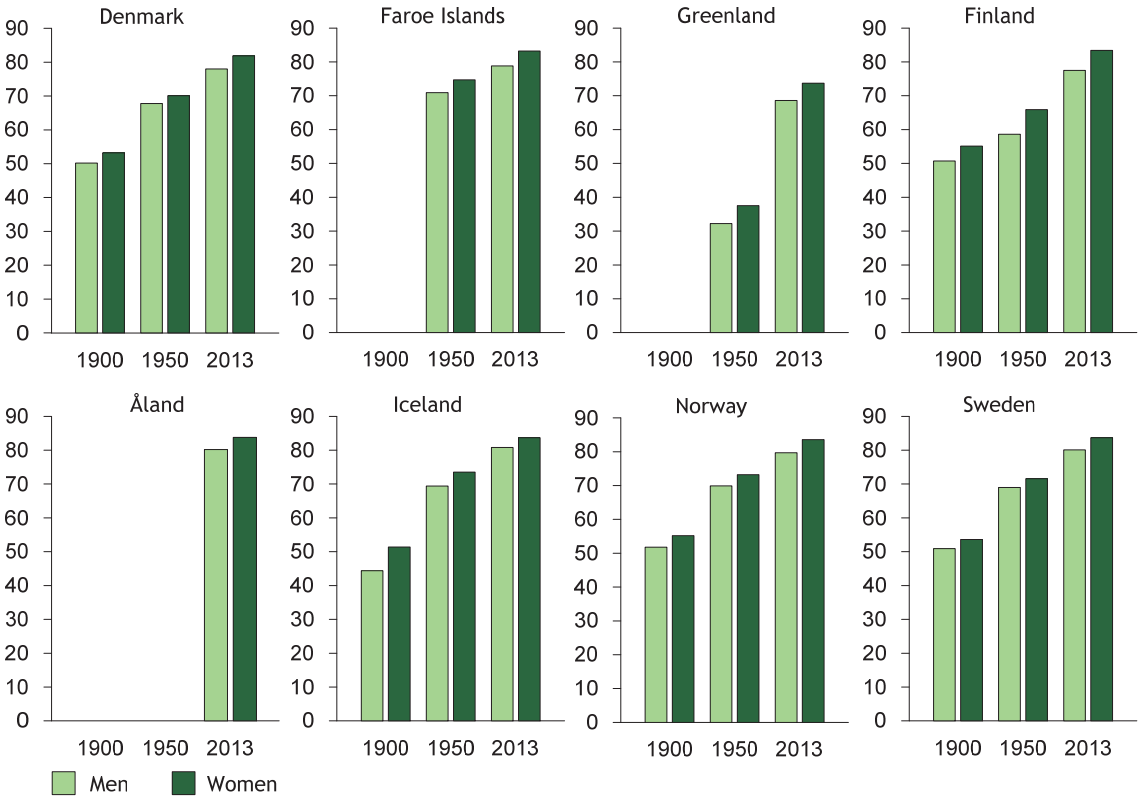


Figure 2.1.4 Life expectancy at birth 1900, 1950 and 2013



2.2 Fertility, Births, Infant Mortality and Contraception

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

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

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

Greenland also has the highest mortality rate for the first year of life. Iceland had the lowest mortality rate for the first year of life in 2012.

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

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

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

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

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

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

Abortion rates vary greatly in the Nordic countries.

Table 2.2.1 Live births and fertility rates, 2000-2013

		Live births per 1 000 women by age							
	Number of live births	15-19[1]	20-24	25-29	30-34	35-39	40-44	45-49[2]	Total fertility rate
Denmark									
2000-04	65 194	6.7	48.8	126.1	117.9	45.5	7.2	0.3	1 756
2005	64 282	5.7	43.2	123.9	127.4	48.5	8.4	0.3	1 802
2010	63 411	5.0	43.0	123.0	134.0	59.0	10.0	1.0	1 875
2012	58 335	4.5	39.1	114.9	122.4	54.3	10.0	0.6	1 733
2013	55 873	4.2	34.6	106.6	121.8	54.3	10.1	0.6	1 669
Faroe Islands									
2004-08	685	14.4	89.7	176.3	144.9	70.5	13.2	0.7	2 548
2009-13	618	16.5	86.3	164.0	136.0	68.0	13.3	0.8	2 490
Greenland									
2003-07	874	58.4	138.0	130.3	86.5	40.5	7.3	0.4	2 307
2008-12	836	50.8	113.1	131.7	89.9	42.5	8.1	0.2	2 179
Finland									
2000-04	56 575	10.5	58.5	114.8	105.2	48.4	10.1	0.5	1 747
2005	57 745	10.3	57.4	116.3	112.9	51.5	10.7	0.6	1 803
2010	60 980	8.4	57.1	116.8	120.3	58.6	11.6	0.6	1 870
2012	59 503	7.5	53.7	110.9	116.0	59.9	12.5	0.7	1 801
2013	58 134	7.3	50.7	105.8	114.5	59.1	12.5	0.6	1 747
Åland									
2004-08	1 424	3.8	50.5	111.3	118.9	65.0	11.6	0.2	1 809
2009-13	1 419	3.8	48.5	111.3	120.7	62.6	11.2	0.4	1 799
Iceland									
2000-04	4 166	17.8	79.0	127.9	110.6	52.9	10.7	0.4	1 996
2005	4 280	15.1	81.5	129.9	114.0	58.4	10.6	0.8	2 052
2010	4 907	12.9	72.9	137.7	127.5	73.7	14.6	0.2	2 197
2012	4 533	11.0	63.3	134.0	117.2	66.1	15.1	0.5	2 037
2013	4 325	7.1	62.2	117.7	117.0	65.8	14.9	1.8	1 932
Norway									
2000-04	56 955	10.0	61.6	124.3	111.6	46.4	7.5	0.3	1 803
2005	56 754	8.0	58.6	124.4	118.6	48.6	8.6	0.4	1 839
2010	61 435	8.4	59.0	124.0	128.0	57.7	10.8	0.6	1 943
2012	60 248	6.0	52.6	117.8	123.7	58.3	10.6	0.6	1 848
2013	58 993	5.7	49.0	117.8	122.8	56.1	10.7	0.5	1 813
Sweden									
2000-04	95 561	6.4	47.2	108.7	110.4	47.8	9.0	0.3	1 648
2005	101 346	6.2	46.6	109.5	124.9	55.9	10.3	0.5	1 769
2010	115 541	5.7	51.3	118.2	138.0	69.4	13.6	0.8	1 985
2012	113 177	5.0	47.6	112.5	133.1	68.0	13.9	0.9	1 906
2013	113 593	4.9	45.6	111.5	132.8	68.1	13.9	0.8	1 888

1 Births by women under 15 years are included
2 Births by women over 50 years are included
Source: DK, Statistics Denmark; FO, Statistics Faroe Islands; GL, Statistics Greenland; FI & ÅL, Statistics Finland; IS, Statistics Iceland; NO, Statistics Norway; SV, Statistics Sweden

Table 2.2.2 In vitro fertilization, 2000-2012[1]

	Denmark	Finland	Iceland	Norway	Sweden
Treatments, IVF+ICSI					
2000-2004	7 487	4 448	301	4 309	7 447
2005	7 222	4 731	462	5 067	8 062
2010	11 721	4 861	618	6 557	9 593
2012	11 248	4 785	501	..	9 794[3]
Frozen embryo transfers, FET					
2000-2004	918	2 766	76	507	1 847
2005	1 500	2 960	161	1 698	3 458
2010	2 275	3 280	257	2 046	4 948
2012	2 566	3 319	264	..	5 281[3]
Number of live births, IVF+ ICSI + FET					
2000-2004	1 814	1 465	123	1 258	2 584
2005	1 786	1 534	167	1 521	2 874
2010	2 123	1 858	192	1 885	3 882
2012	2 618[2]	1 690	138	..	3 850[3]
Treatments in 2012 per 1 000 Women aged 15-49 years					
IVF + ICSI	8.9	4.1	6.5	..	4.6
FET	2.0	2.9	3.4	..	2.5
Total	10.9	7.0	9.9	..	7.1
Multiple births, per cent of all births after IVF	13.7[2]	7.1	4.3	11.0	4.7
Children born in multiple births, per cent of all children born after IVF	23.9[2]	12.9	8.7	..	-
IVF, ICSI and FET per cent of all live births	4.5[2]	2.8	2.9	2.8	13.5

IVF = In vitro fertilization
ICSI = Intracytoplasmic sperm injection
FET = Frozen embryo transfer

1 Based on the year of treatment, not on the year of birth
2 Calculated on the basis of expected number of births and expected number of children born
3 Sweden 2011
Source: DK, Statens Serum Institut; FI, THL; IS, Art Medica; NO, Ministry of Health; SV, National Board of Health and Welfare

Table 2.2.3 Stillbirths and infant mortality [1], 2000-2012

	Number		Per 1 000 births		Deaths per 1 000 live births			
	Stillbirths	Infant deaths	Stillbirths	Perinatal deaths	First 24 hours	1-6 days	7-27 days	Total under 1 year
Denmark								
2000-04	280	305	4.3	7.1	1.6	1.3	0.6	4.7
2010	255	216	4.0	6.2	1.5	0.6	0.4	3.4
2012	236	202	4.1	5.3	1.6	0.9	0.5	3.5
Faroe Islands								
2003-07	1	3	1.7	4.3	0.6	2.0	0.3	4.9
2008-12	2	3	3.8	6.5	1.6	0.3	0.9	0.9
Greenland								
2003-07	4	14	4.6	12.8	5.9	3.3	0.5	15.5
2008-12	5	12	5.5	11.6	4.9	3.1	1.5	13.3
Finland								
2000-04	191	187	3.4	5.2	1.0	0.7	0.5	3.3
2010	181	140	3.0	4.1	0.6	0.5	0.4	2.3
2012	161	141	2.7	3.9	0.7	0.5	0.2	2.4
Åland								
2003-07	2	3	1.4	2.9	0.7	0.7	-	2.2
2008-12	2	2	1.4	2.1	0.7	-	-	1.4
Iceland								
2000-04	10	11	2.4	4.0	0.9	0.6	0.3	2.6
2010	9	11	1.8	2.9	0.8	0.2	0.2	2.2
2012	10	5	2.2	2.7	0.4	-	0.2	1.1
Norway								
2000-04	217	205	3.8	5.7	1.0	1.0	0.6	3.6
2010	190	157	3.1	4.4	0.6	1.3	0.5	2.4
2012	184	..	3.1	4.3	0.6	1.2	..	2.5
Sweden[2]								
2000-04	350	316	3.7	5.4	0.7	1.0	0.6	3.3
2010	426	294	3.7	4.8	0.5	0.6	0.4	2.5
2012	453	293	4.0	5.1	0.6	0.5	0.6	2.6

1 Calculated according to year of death
2 As of 1st July 2008 a child is considered stillborn before the 22nd pregnancy week
Source: DK, Statens Serum Institut; FO, Chief Medical Officer in the Faroe Islands; GL, Chief Medical Officer; FI & ÅL, Statistics Finland; IS, Statistics Iceland; NO, Statistics Norway; SV, Statistics Sweden

Figure 2.2.1 Total fertility rate, 2000-2013

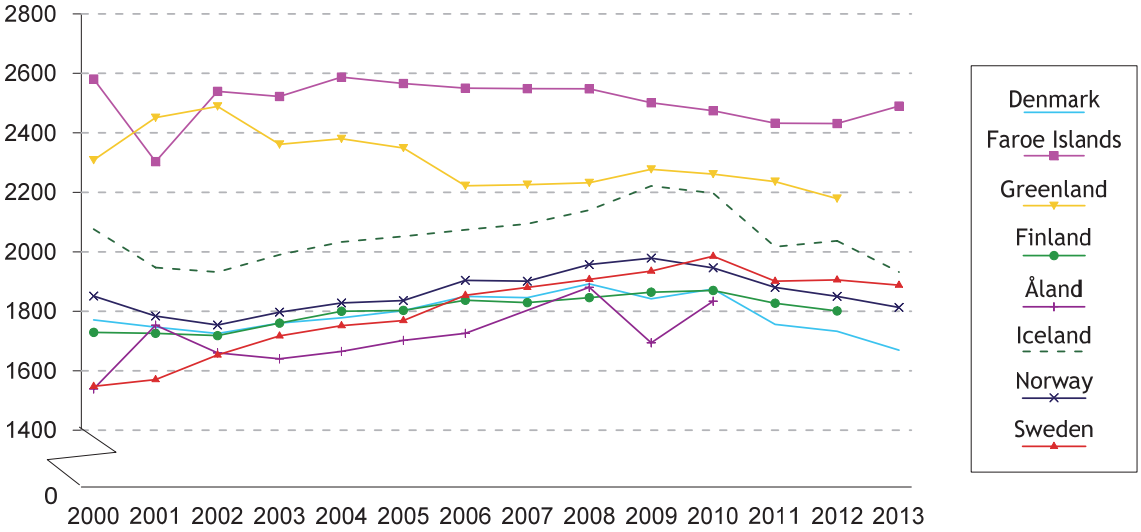


Figure 2.2.2 IVF, ICSI and FET, percentages of all live births 2000-2012

Per cent

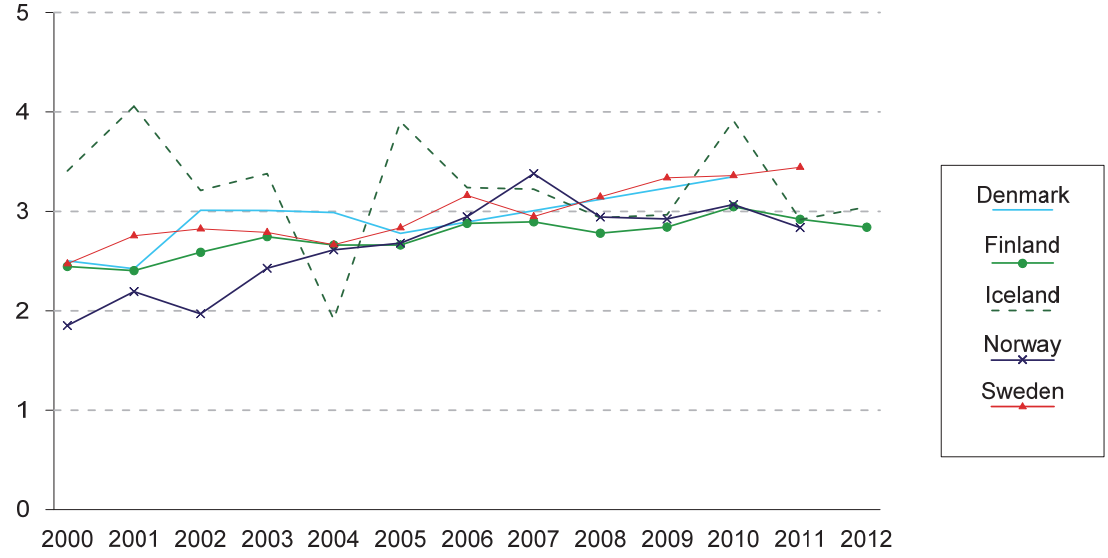


Figure 2.2.3 Perinatal deaths and infant mortality, 2000-2012

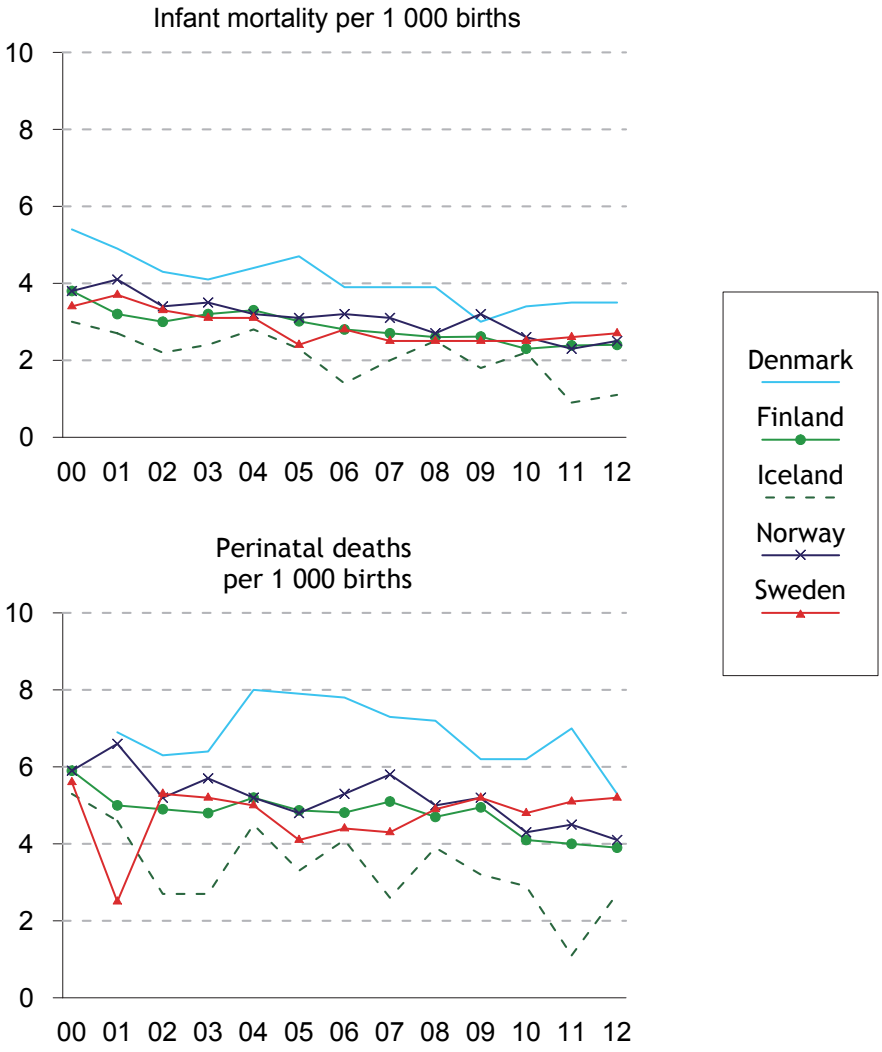


Table 2.2.4 Stillbirths and deaths during the first year of life per 1 000 births, with a birth weight of 1 000 grams or more, total and per 1 000 births, 2000-2012[1]

	Number	Per 1 000 births		Deaths per 1 000 live births				
	Stillbirths	Infant deaths	Stillbirths	First 24 hours	1-6 days	7-27 days	28 days to 1 year	Total under 1 year
Denmark								
2000	183	238	2.9	0.6	1.3	0.5	1.2	3.6
2005	123	174	1.9	0.8	0.7	0.5	0.8	2.7
2010	114	97	1.8	0.3	0.3	0.3	0.6	1.5
2012	103	87	1.8	0.4	0.4	0.2	0.4	1.5
Finland								
2000	149	150	2.6	0.5	0.5	0.5	1.1	2.7
2005	115	120	2.0	0.5	0.5	0.3	0.8	2.1
2010	114	97	1.9	0.3	0.4	0.3	0.7	1.6
2012	105	102	1.8	0.3	0.5	0.1	0.7	1.7
Iceland								
2000	13	5	3.0	0.0	0.2	0.2	0.7	1.2
2005	6	4	1.4	-	0.5	-	0.5	0.9
2010	7	9	1.4	0.2	0.2	0.2	1.2	1.9
2012	10	3	2.2	-	-	0.2	0.4	0.7
Norway								
2000	195	151	3.3	0.8	0.3	0.3	1.1	2.6
2005	141	105	2.5	0.6	0.3	0.4	0.6	1.8
2010	145	112	2.3	0.5	0.2	0.4	0.8	1.8
2012	139	91	2.3	0.4	0.4	0.2	0.5	1.5
Sweden								
2000	318	215	3.6	0.5	0.7	0.4	0.9	2.4
2005	263	182	2.6	0.4	0.4	0.2	0.9	1.8
2010	278	179	2.4	0.3	0.3	0.3	0.7	1.6
2012[2]	310	184	2.8	0.2	0.3	0.3	0.9	1.7

1 Calculated according to year of birth
2 Estimated value for 2012. Information from 2011 from the county of Värmland
Source: DK, Statens Serum Institut; FI, Statistics Finland & THL; IS, Medical Birth Registry of Iceland & Statistics Iceland; NO, CKAN Norway; SV, The National Board of Health and Welfare

Table 2.2.5 Consumption of hormonal contraceptives. DDD per 1 000 women aged 15-49 years/day [1], 2000-2013

	Denmark[2]	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2000	272	258	186	224	281	265	225	255
2005	293	238	314	189	182	192	201	260
2010	286	232	302	204	179	204	217	248
2012	277	208	285	210	199	208	222	243
2013	274	201	252	229	225	219	228	203

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

1 Excl. injections and implants. Excl. G03AD (Emergency contraceptives)
2 Excl. G03AC08
Source: DK, Statens Serum Institut; FO, Chief Pharmaceutical Officer; GL, National Pharmacy; FI & ÅL, FIMEA; IS, Icelandic Medicines Agency; NO, Norwegian Institute of Public Health; SV, National Corporation of Swedish Pharmacies

Table 2.2.6 Emergency contraceptives: number of sold packages per 1 000 women in the age 15-49 years, 2005-2013

ATC code G03AD	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	63	52	41	78	79	87	119	83
2010	81	81	53	83	84	91	140	100
2012	80	77	88	77	81	84	135	106
2013	82	85	68	87	88	..	134	106

Source: DK, Statens Serum Institut; FO, Chief Pharmaceutical Officer; GL, National Pharmacy; FI & ÅL, FIMEA; IS, Icelandic Medicines Agency; NO, Norwegian Institute of Public Health; SV, National Corporation of Swedish Pharmacies

Table 2.2.7 Number of induced abortions, 2000-2012

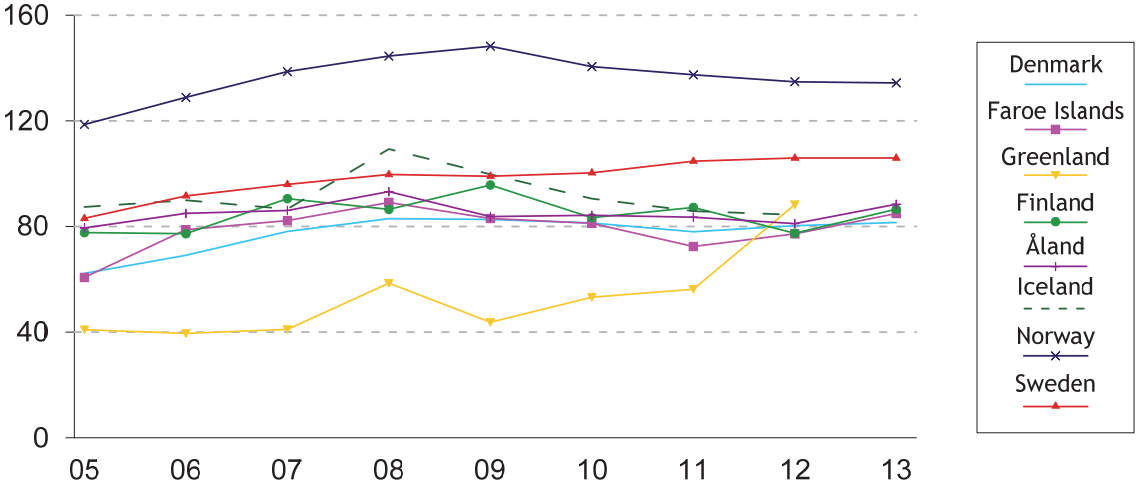
		Abortions per 1 000 women aged								
	Number of abortions	15-19[1]	20-24	25-29	30-34	35-39	40-44	45-49[2]	Total abortion rate	Abortions per 1 000 live births
Denmark										
2000-04	15 365	14.5	20.4	17.7	17.0	13.0	4.8	0.4	439	237
2010	16 362	15.0	25.6	19.5	17.1	13.0	5.3	0.5	480	258
2012	15 608	13.8	24.1	19.4	15.9	12.3	5.0	0.4	455	269
Faroe Islands										
2003-07	39	4.2	6.5	4.6	4.4	4.4	2.7	0.1	134	57
2008-12	38	3.5	8.5	4.1	4.3	4.3	1.8	0.4	134	60
Greenland										
2003-07	885	60.6	83.7	60.6	36.8	17.0	5.2	0.6	1 322	616
2008-12	815	98.5	127.4	86.8	52.3	27.8	7.5	0.5	2 015	979
Finland										
2000-04	10 869	15.3	16.4	12.6	10.7	7.7	3.1	0.2	330	192
2010	10 243	12.1	17.0	13.1	9.8	7.7	3.0	0.2	315	167
2012	10 061	10.9	17.5	12.9	9.7	7.2	3.0	0.3	308	169
Åland										
2003-07	65	9.0	14.8	14.1	5.7	5.8	2.1	0.2	258	140
2008-12	68	13.8	30.2	20.4	14.4	6.8	4.1	-	448	240
Iceland										
2000-04	940	21.4	23.4	17.3	13.6	9.2	4.6	0.3	449	225
2010	977	15.9	23.0	19.2	13.4	11.4	3.5	0.5	435	199
2012	980	13.8	26.0	19.5	14.6	9.2	3.9	0.4	437	216
Norway										
2000-04	14 008	17.3	27.1	19.4	15.1	10.6	3.8	0.3	470	246
2010	15 738	14.1	29.2	23.1	16.9	11.7	4.4	0.4	500	256
2012	15 232	11.4	26.6	22.6	16.5	11.6	4.2	0.4	467	253
Sweden										
2000-04	33 009	22.6	29.4	23.3	19.8	15.2	6.3	0.6	586	345
2010	37 696	20.3	33.3	26.7	21.5	16.3	7.0	0.8	630	326
2012	37 366	18.8	32.6	27.2	21.7	15.8	8.0		621	330

1 Abortions for women under 15 years are included
2 Abortions for Women over 49 years are included

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

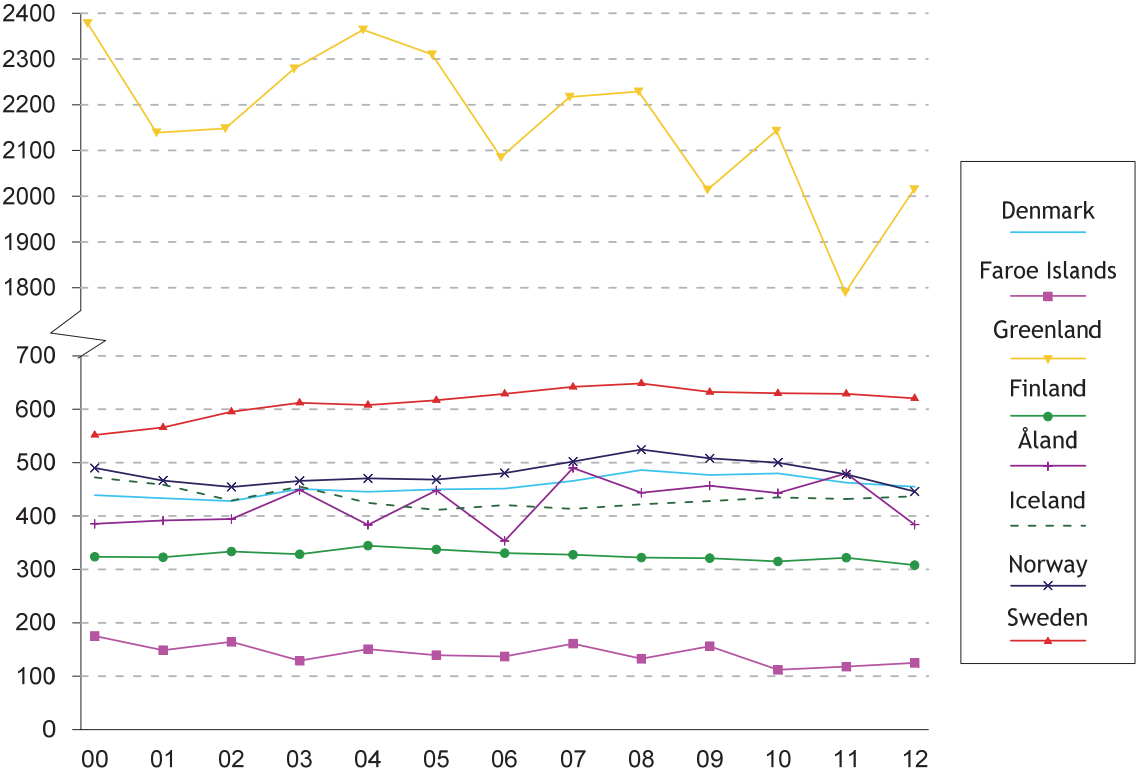
Source: The national abortion registers

Figure 2.2.4 Sales of emergency prevention per 1 000 women aged 15-49 years, 2005-2013[1]



1 2000-03: 15-44 years
Source: The national abortion registers

Figure 2.2.5 Total abortion rate, 2000-2012



Source: The national abortion registers

Chapter 3

Morbidity, Medical Treatment, Accidents and Medicinal Products

Extra material

Background tables Nowbase.org/Publications
The Nordic Cancer Union

Introduction

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

3.1 Diseases related to Lifestyle

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

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

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

Table 3.1.3: Nicotine in various pharmacolandical formulations (N07BA01) is used to alleviate withdrawal symptoms and to help in smoking cessation. In all Nordic countries, nicotine is among the ten best-selling substances calculated in terms of pharmacy retail prices. In Iceland, the consumption is at least three times higher than in the other countries.

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

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

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

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

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

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

A marked fall in the incidence of the traditional sexually transmitted diseases, gonorrhoea and syphilis, has been seen in all countries over the past 20 years. How-

ever, there are certain notable exceptions, with Greenland being radically different from the other countries.

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

	Denmark	Faroe Islands	Green-land	Finland[1]	Iceland[1,2]	Norway[3]	Sweden[3]
	2012	2013	2005	2012	2012	2012	2012
Share of people with BMI > 30, Men	14	15	19	16	21	11	12
Share of people with BMI > 30, Women	13	12	27	16	23	9	12

1 BMI >= 30 in per cent
2 Self-reported data from the survey: ”Health and Wellbeing of Icelanders 2012”. Covers the ages from 18 to 79 years
3 Age 16+

Source: National Boards of Health; FO, The Public Health Council; IS, A national dietary telephone survey 2010-2011. A random sample of the Icelandic population 18-80 years, 2000 persons; FI, THL; Health Behaviour and Health among the Finnish Adult Population 2011; SV, Statistics Sweden

Table 3.1.2 Percentage of daily smokers by gender 2012

	Denmark	Faroe Islands	Finland	Iceland	Norway	Sweden[1]
Alder	16+	15+	15-64	15+	16-74	16-84
Smoking men as a percentage of men in the age group	17	27	21	15	15	13
Smoking women as a percentage of women in the age group	17	28	18	13	14	13

1 2010

Source: DK, National Board of Health; FO, The Public Health Council; FI, THL; Health Behaviour and Health among the Finnish Adult Population 2011; IS, Public Health Institute of Iceland; NO, National Directorate for Health and Social Welfare; SV, Statistics Sweden

Figure 3.1.1 Rates for new cases of lung cancer per 1 000 000 inhabitants

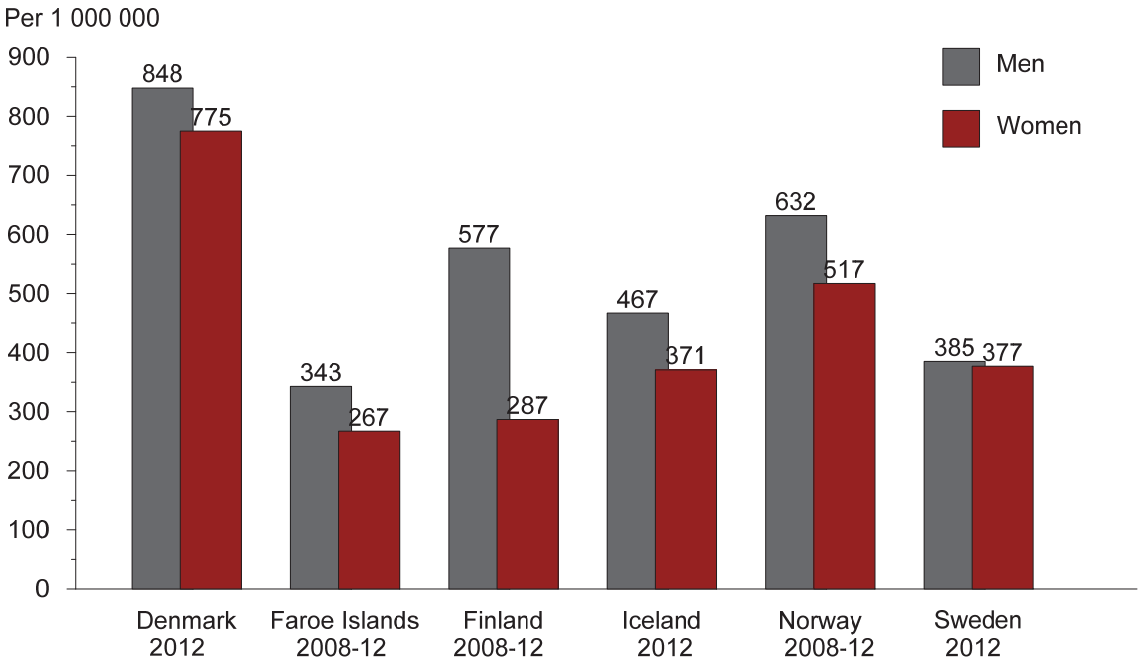


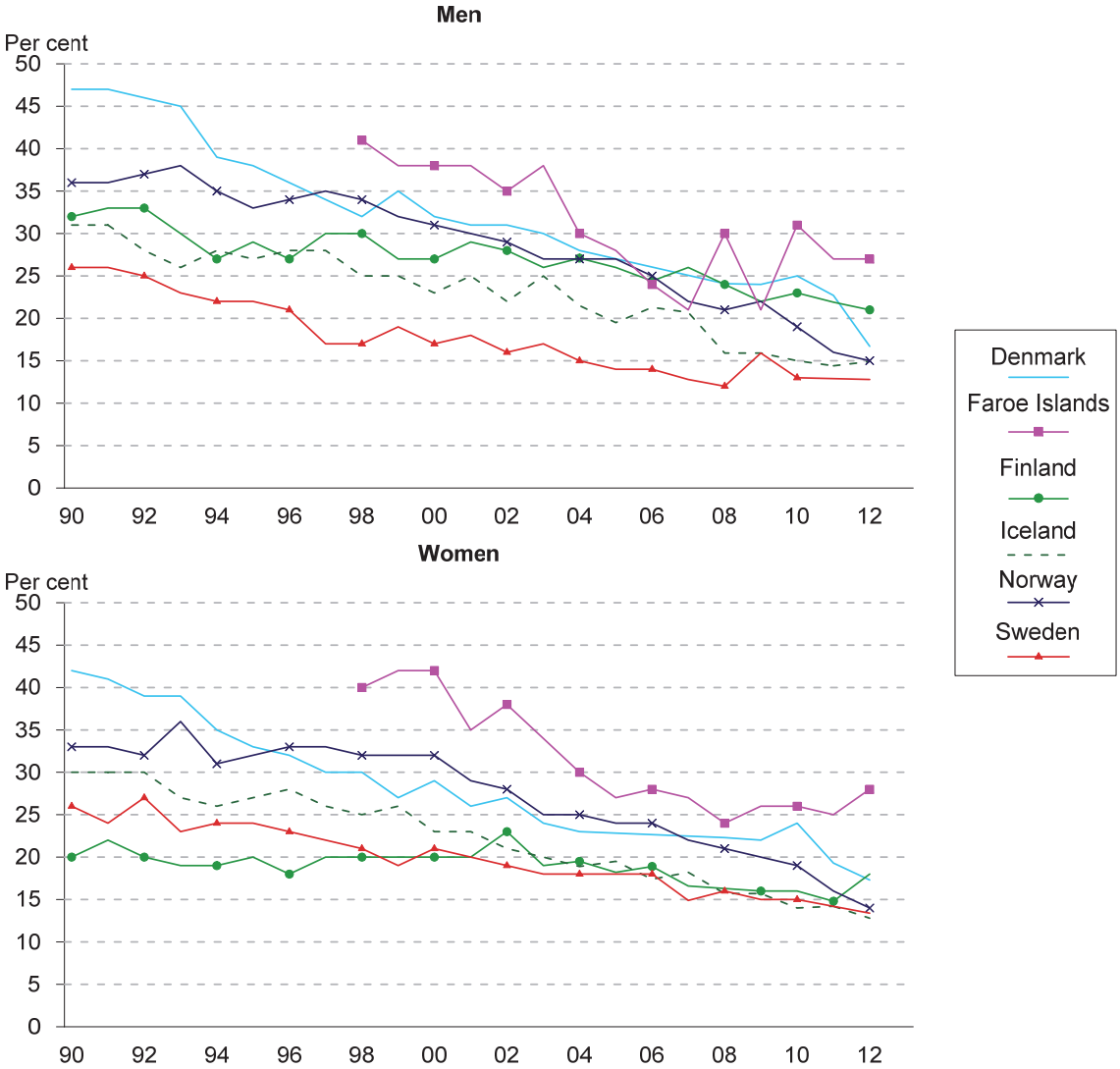
Table 3.1.3 Sales of drugs used for nicotine dependence (ATC-group N07BA), DDD/1 000 inhabitants/day, 2005-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N07BA01 Nicotine								
2005	7.6	3.7	1.7	5.3	5.6	19.4	3.7	6.7
2010	8.3	3.9	3.3	8.4	9.1	19.6	5.0	6.8
2012	9.6	4.0	4.9	9.8	9.1	21.1	5.6	7.0
2013	9.3	4.3	2.0	10.1	9.6	21.7	6.2	7.0
N07BA03 Varenicline[1]								
2010	0.5	1.0	0.1	0.4	0.1	1.0	0.9	0.5
2012	0.2	0.5	0.1	0.3	0.1	1.1	0.8	0.4
2013	0.2	0.4	0.1	0.3	0.1	1.0	0.7	0.4

1 Varenicline was introduced on the market in December 2006

Source: DK, Statens Serum Institut; FO, Chief Medical Officer; GL, The Central Pharmacy in Copenhagen County; FI & ÅL, FIMEA; IS, Icelandic Medicines Agency; NO, Norwegian Institute of Public Health; SV, National Corporation of Swedish Pharmacies

Figure 3.1.2 Percentage of daily smokers by gender, 2000-2012



Source: OECD, for 2001, 2002 and 2003. National Boards of Health; IS, A national dietary telephone survey 2010-2011. A random sample of the Icelandic population 18-80 years; FO, The Public Health Council; FI, THL; Health Behaviour and Health among the Finnish Adult Population 2011; SV, Statistics Sweden

Figure 3.1.3 Sales of drugs used for nicotine dependence (ATC-group N07BA), DDD/1 000 inhabitants/day, 2000-2013

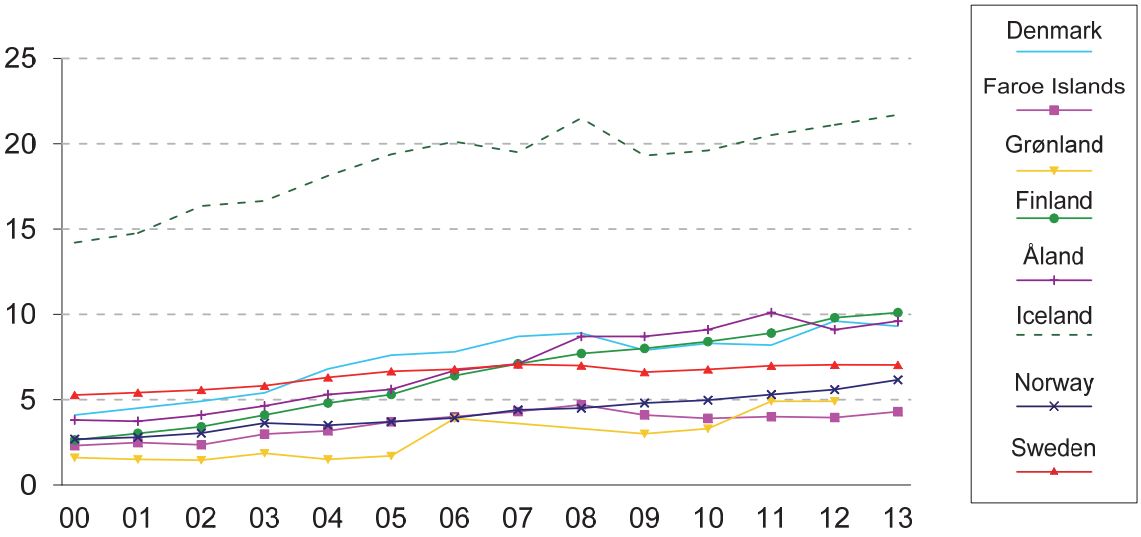
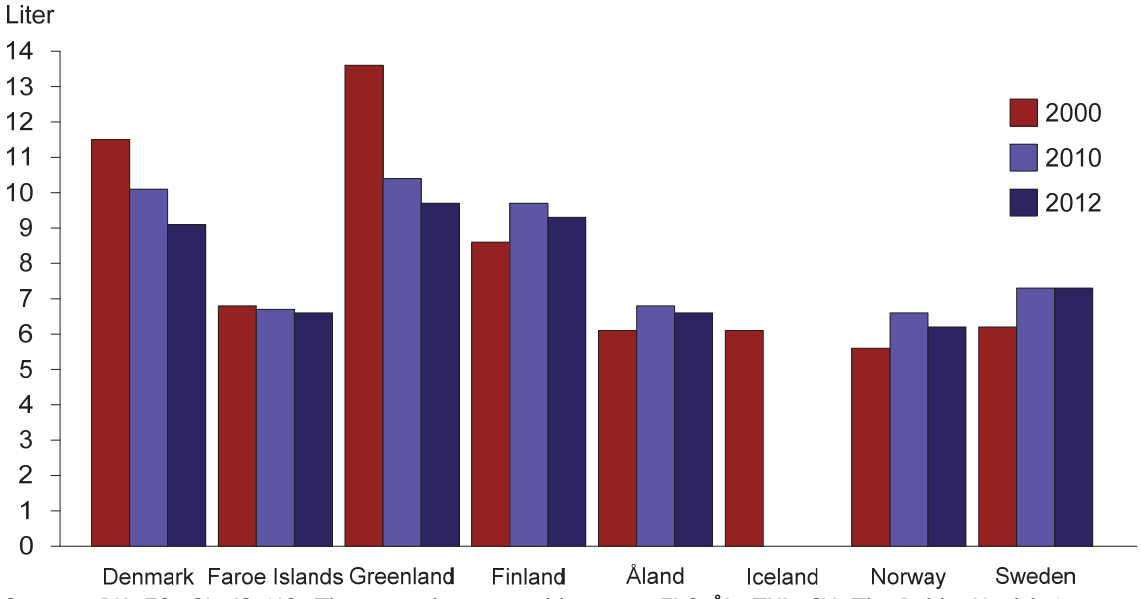


Table 3.1.4 Sales of alcoholic beverages in litres of 100 per cent pure alcohol per inhabitant aged 15 years and over, 2000-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2000	13.0	6.8	13.6	8.6	6.1	6.1	5.6	6.2
2005	12.8	6.6	12.1	10.0	6.6	7.1	6.4	6.6
2010	11.3	6.7	10.4	9.7	6.8	..	6.6	7.3
2012	9.1	6.6	9.7	9.3	6.6	..	6.2	7.3

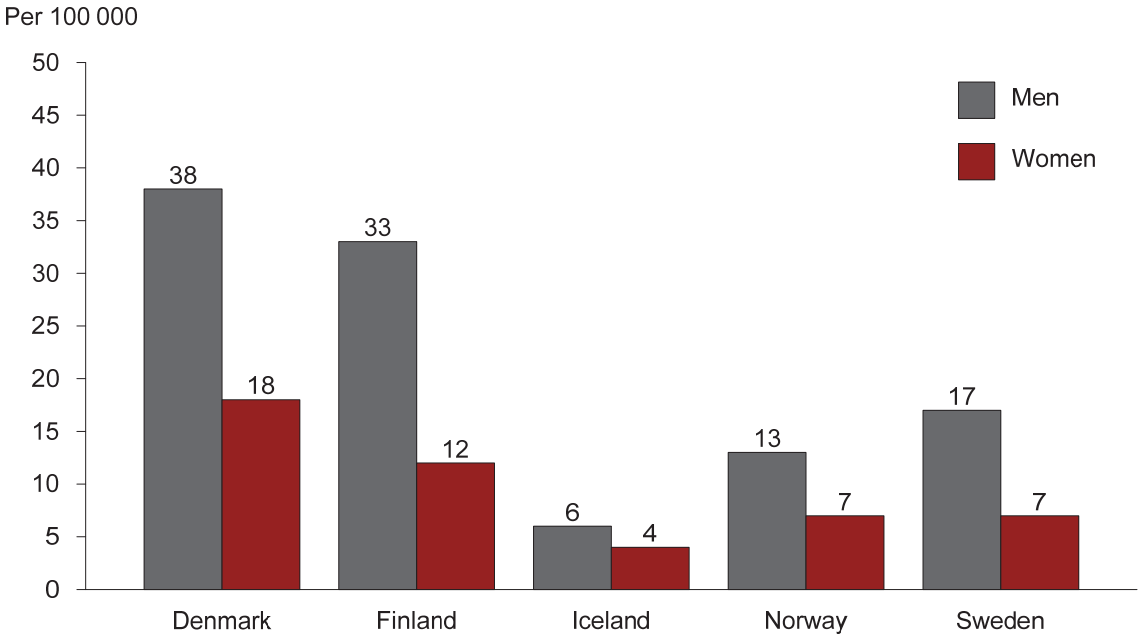
Source: DK, FO, GL, IS, NO: The central statistical bureaus; FI & ÅL: THL; SV: The Public Health Agency

Figure 3.1.4 Sales of alcoholic beverages in litres of 100 per cent pure alcohol per inhabitant aged 15 years and over, 2000, 2010 and 2012



Source: DK, FO, GL, IS, NO: The central statistical bureaus; FI & ÅL: THL; SV: The Public Health Agency

Figure 3.1.5 Patients treated in somatic hospitals for alcoholic liver disease per 100 000 inhabitants, 2012[1]



1 2009 for Iceland

Source: DK, Statens Serum Institut; FO, Ministry of Health; FI, THL; IS, Directorate of Health; NO, Norwegian Patient Register; SV, National Board of Health and Welfare

Table 3.1.5 Diagnosed cases of tuberculosis per 100 000 inhabitants, 2000-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
Men								
2000	12.1	20.8	50.0	12.4	7.9	2.8	5.8	5.2
2005	9.5	-	178.1	8.0	-	5.4	6.2	6.8
2010	7.8	-	220.5	6.9	-	5.0	7.9	8.0
2012	9.2	-	189.7	6.0	7.1	2.5	8.1	7.7
Women								
2000	8.5	4.5	111.0	8.5	-	6.4	6.2	5.2
2005	6.2	-	165.1	5.8	7.5	2.0	6.1	6.0
2010	5.3	8.7	192.3	5.0	-	8.9	6.7	6.6
2012	4.9	8.7	119.8	4.2	7.0	4.4	7.0	5.8

Source: DK, Statens Serum Institut; FO, Chief Medical Officer; GL, Chief Medical Officer; FI & ÅL, THL; IS, Directorate of Health; NO, Norwegian Institute of Public Health; SV, The Public Health Agency

Table 3.1.6 Confirmed new cases of HIV/AIDS[1], 2000-2013

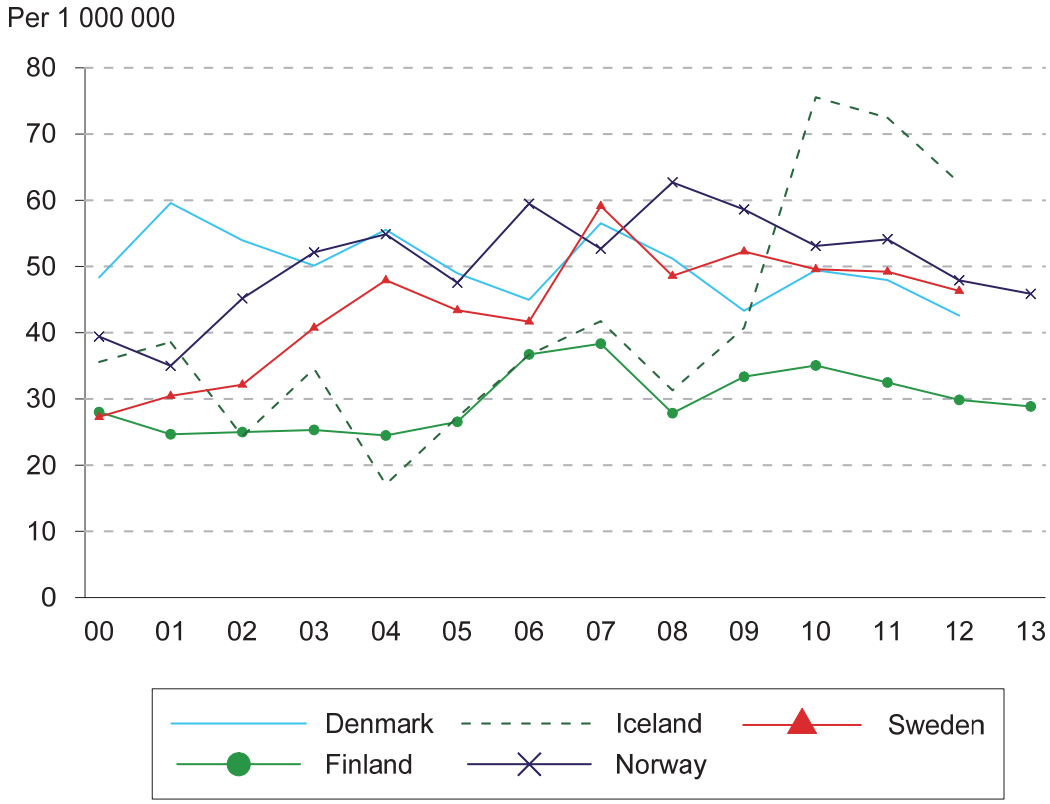
	Denmark	Faroe Islands	Greenland	Finland	Of which Åland	Iceland	Norway	Sweden
Men								
2000-04	..	-	5	95	.	6	124	198
2005	193	-	4	96	.	5	122	228
2010	201	1	2	132	.	18	173	285
2012	178	-	-	115	.	13	166	265
2013	..	-	-	102	.	8	158	..
Women								
2000-04	..	-	2	37	.	2	82	122
2005	71	-	2	35	.	3	97	164
2010	73	-	1	56	.	6	85	180
2012	60	-	3	47	.	7	76	175
2013	..	-	3	55	.	3	75	..
Total								
2000-04	287	1	7	131	1	9	206	320
2005	264	-	6	131	1	8	219	392[2]
2010	238	1	3	188	-	24	258	465[2]
2012	198	-	3	162	3	20	242	441[2]
2013	..	-	3	157	1	11	233	461[2]

1 AIDS, which is the end stage of the HIV infection, was an illness with report obligation from 1985-2000, and from 2000 it is a voluntary completion to the reporting of HIV. Screening affects the number of newly reported cases and how many people who develops AIDS. Included in the total may be cases, where information about gender is missing

2 HIV

Source: DK, Statens Serum Institut; FO, Chief Medical Officer; GL, Chief Medical Officer; FI & ÅL, THL; IS, Directorate of Health; NO, Norwegian Institute of Public Health; SV, The Public Health Agency

Figure 3.1.6 Confirmed new cases of HIV/AIDS per 1 000 000 inhabitants, 2000-2013



Source: DK, Statens Serum Institut; FO, Chief Medical Officer; GL, Chief Medical Officer; FI & ÅL, THL; IS, Directorate of Health; NO, Norwegian Institute of Public Health; SV, The Public Health Agency

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

	Denmark		Faroe Islands		Greenland		Finland		Åland		Iceland[1]		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W	M	W	M	W
2000	..	..	17	-	..	..	8	2	-	-	..	..	..	..	..	..
2005	18	2	4	-	1 535	2 124	7	2	8	-	12	4	12	3	16	3
2010	17	5	-	-	2 307	3 456	7	2	7	-	7	3	19	2	..	..
2012	22	8	-	-	2 674	3 895	8	3	7	-	13	4	16	2	16	7

1 Not included: gonorrhoea, 1 case without gender specification

Source: DK, Statens Serum Institut; FO, Chief Medical Officer; GL, Chief Medical Officer; FI & ÅL, THL; IS, Directorate of Health; NO, MSIS; SV, The Public Health Agency

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

	Denmark		Faroe Islands		Greenland		Finland		Åland		Iceland		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W	M	W	M	W
2000	..	..	-	-	..	..	5	3	-	-	..	..	..	..	..	..
2005	5	1	-	-	3	4	3	2	8	-	3	1	1	-	2	1
2010	16	2	-	-	..	..	5	3	-	-	2	1	6	0	..	..
2012	14	1	-	-	21	24	5	3	21	7	3	..	4	0	3	1

1 Not included: syphilis, 1 case without gender specification

Source: DK, Statens Serum Institut; FO, Chief Medical Officer; GL, Chief Medical Officer; FI & ÅL, THL; IS, Directorate of Health; NO, MSIS; SV, The Public Health Agency

Table 3.1.8 Diagnosed cases of Chlamydia per 100 000 inhabitants, 2000-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland[1]	Norway	Sweden[2]
Men								
2000	165	79	2 791	180	95	479	.	187
2005	324	231	3 852	197	221	412	330	317
2010	384	286	5 277	202	196	551	351	340
2012	365	216	5 831	205	340	454	339	343
Women								
2000	384	.	4 817	272	207	781	.	246
2005	554	.	5 797	289	499	643	524	411
2010	623	403	8 762	276	251	852	567	445
2012	577	345	10 816	283	443	710	554	449
Total								
2000	276	79	3 727	226	152	647	326	217
2005	440	231	4 762	239	362	548	434	366
2010	505	342	6 893	254	224	722	461	393
2012	472	278	8 153	245	391	582	428	396

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

2 Possible underrepresentation in 2005, due to a mutated form of chlamydia, which was undiagnosable at the time

Source: DK, Statens Serum Institut; FO, Chief Medical Officer; GL, Chief Medical Officer; FI & ÅL, THL; IS, Directorate of Health; NO, MSIS; SV, The Public Health Agency

3.2 Cancer

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

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

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

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

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

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

		C62	C61	C16	C18-21	C25	C33-34	C43
	Total[1]	Testis	Prostate	Stomach	Colon and rectum	Pancreas	Lungs	Melanoma of the skin
Denmark								
2000-04	4 978	103	880	121	713	141	794	186
2010	5 923	117	1 425	144	848	171	820	310
2012	6 438	113	1 557	115	866	184	848	358
Faroe Islands								
2003-07	3 157	144	535	120	535	136	328	40
2008-12	3 708	104	1 172	104	646	223	343	80
Greenland								
2003-07	3 227	46	212	152	384	146	835	27
2008-12	2 929	40	180	173	267	127	694	33
Finland								
2000-04	4 659	38	1 614	161	436	157	620	141
2010	5 391	49	1 753	149	530	192	636	240
2012	5 455	56	1 730	123	569	190	596	266
Åland								
2003-07	6 790	15	3 141	177	545	246	505	165
2008-12	6 473	101	2 652	159	605	274	577	303
Iceland								
2003-07	4 502	65	1 382	139	507	82	469	135
2008-12	4 341	61	1 312	106	454	79	467	124
Norway								
2000-04	5 072	108	1 423	156	738	131	606	212
2010	6 183	111	1 723	125	836	129	638	304
2012	6 503	128	1 940	113	812	154	632	347
Sweden								
2000-04	5 118	58	1 916	137	615	101	396	198
2010	5 560	64	2 077	110	690	111	392	314
2012	5 480	73	1 893	92	702	112	385	360

Numbers refer to ICD-10

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

Source: The cancer registers in the Nordic countries; GL, Danish Cancer Society

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

	Total[1]	C62 Testis	C61 Prostate	C16 Stomach	C18-21 Colon and rectum	C25 Pancreas	C33-34 Lungs	C43 Melanoma of the skin
Denmark								
2000-04	5 765	100	1 083	141	844	163	914	198
2010	6 099	92	1 445	139	887	177	831	303
2012	6 199	117	1 454	113	850	173	818	347
Faroe Islands								
2003-07	3 753	153	661	150	653	162	373	45
2008-12	4 013	114	1 238	120	731	243	381	93
Greenland								
2003-07	5 854	65	419	249	754	228	1 696	31
2008-12	4 402	36	221	166	275	140	973	34
Finland								
2000-04	5 860	37	2 024	209	545	189	733	157
2010	5 095	47	1 668	136	519	184	586	212
2012	5 168	57	1 600	121	547	181	560	257
Åland								
2003-07	6 790	15	3 141	177	545	246	505	165
2008-12	5 842	106	2 287	147	553	240	533	295
Iceland								
2003-07	5 725	62	1 888	200	698	114	623	164
2008-12	5 298	60	1 628	133	561	94	596	144
Norway								
2000-04	6 059	105	1 741	193	897	159	724	240
2010	6 764	111	1 859	139	927	144	704	321
2012	6 965	127	2 025	123	885	167	682	366
Sweden								
2000-04	5 263	59	1 969	144	641	103	403	201
2005	5 362	64	2 101	126	618	97	391	236
2010	5 155	65	1 874	102	656	101	361	298
2012	5 000	75	1 676	86	651	101	344	337

Numbers refer to ICD-10

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

Source: The cancer registers in the Nordic countries; GL, Danish Cancer Society

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

		C50	C53	C16	C18-21	C25	C33-34	C43
	Total[1]	Breast	Cervix uteri	Stomach	Colon and rectum	Pancreas	Lungs	Melanoma of the skin
Denmark								
2000-04	5 162	1 426	145	68	660	149	613	228
2010	6 137	1 842	130	65	765	164	793	345
2012	5 999	1 615	126	64	784	164	775	380
Faroe Islands								
2003-07	3 110	812	69	78	484	164	207	43
2008-12	3 379	914	155	69	500	103	267	121
Greenland								
2003-07	3 548	549	316	68	353	195	684	45
2008-12	3 196	421	233	68	323	120	669	30
Finland								
2000-04	4 297	1 352	61	128	440	172	217	133
2010	5 270	1 779	53	100	503	195	288	243
2012	5 115	1 704	53	87	503	190	287	223
Åland								
2003-07	5 058	1 468	89	104	608	193	297	282
2008-12	5 357	1 471	29	143	700	200	386	286
Iceland								
2003-07	4 233	1 251	92	88	412	59	458	205
2008-12	3 753	880	39	137	567	156	371	98
Norway								
2000-04	4 666	1 163	128	99	738	146	368	237
2010	5 382	1 161	132	72	748	137	518	317
2012	5 410	1 175	131	73	780	152	517	348
Sweden								
2000-04	4 530	1 365	100	91	570	104	301	200
2010	5 877	1 682	91	69	637	103	370	287
2012	6 287	1 779	101	64	635	114	377	348

Numbers refer to ICD-10

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

Source: The cancer registers in the Nordic countries; GL, Danish Cancer Society

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

	Total[1]	C50 Breast	C53 Cervix uteri	C16 Stomach	C18-21 Colon and rectum	C25 Pancreas	C33-34 Lungs	C43 Melanoma of the skin
Denmark								
2000-04	4 886	1 359	142	63	613	138	583	221
2010	5 357	1 619	126	56	647	139	679	324
2012	5 240	1 435	125	54	662	136	656	353
Faroe Islands								
2003-07	3 056	832	74	79	488	162	222	41
2008-12	3 240	872	157	64	469	95	264	125
Greenland								
2003-07	5 674	699	350	121	747	310	1 232	43
2008-12	4 531	506	270	92	499	176	1 106	27
Finland								
2000-04	4 072	1 302	58	116	403	146	185	124
2010	4 037	1 430	49	69	358	134	208	196
2012	4 107	1 419	52	66	383	139	217	191
Åland								
2003-07	4 253	1 290	89	84	483	134	237	256
2008-12	4 348	1 249	23	117	530	153	318	261
Iceland								
2003-07	4 604	1 436	95	100	472	70	536	216
2008-12	4 500	1 425	113	77	429	105	588	174
Norway								
2000-04	4 521	1 170	129	90	686	132	368	235
2010	4 996	1 116	132	62	668	120	486	302
2012	4 994	1 121	130	63	704	133	477	329
Sweden								
2000-04	4 014	1 250	97	75	473	90	268	185
2010	5 182	1 480	88	56	509	86	304	256
2012	5 548	1 549	100	52	505	91	305	309

Numbers refer to ICD-10

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

Source: The cancer registers in the Nordic countries; GL, Danish Cancer Society

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

	Denmark	Finland	Åland[1]	Iceland	Norway	Sweden
Boys			M+K			
2000-04	59	55	.	30	52	51
2005	40	47	.	24	37	62
2010	55	48	.	53	37	75
2012	40	44	.	59	34	40
Girls						
2000-04	46	48	.	37	48	47
2005	41	56	.	31	32	44
2010	58	20	.	37	36	63
2012	50	30	.	46	42	35
Total						
2000-04	53	52	-	34	50	49
2005	40	51	42	27	34	53
2010	56	17	-	45	36	69
2012	45	37	-	58	38	38

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

1 2005 average 2002-2006, 2012 - average 2008-2012

Source: The cancer registers in the Nordic countries; GL, Danish Cancer Society

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

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2012	2008-12	2008-12	2012	2008-12	2008-12	2012	2012
Men, Age								
0-24	7	22	18	14	-	7	9	10
25-44	59	-	118	83	112	56	69	79
45-64	803	538	638	542	508	550	756	638
65-84	3 793	3 709	726	2 350	2 468	2 655	4 118	2 889
85+	5 528	4 516	-	3 705	3 831	3 411	5 583	3 808
Women, Age								
0-24	8	-	19	4	-	-	8	4
25-44	77	73	27	64	58	73	80	66
45-64	748	731	672	457	589	526	762	556
65-84	2 793	1 730	1 939	1 570	2 057	1 783	3 070	2 215
85+	3 781	2 512	2 494	2 531	5 090	2 651	4 151	2 737

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

Source: The cancer registers in the Nordic countries; GL, Danish Cancer Society

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

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2012	2008-12	2008-12	2012	2008-12	2008-12	2012	2012
Men, age								
0-24	2	-	-	-	-	3	2	3
25-44	38	-	165	12	-	30	24	8
45-64	820	380	1 536	550	661	515	631	358
65-84	3 798	1 921	3 217	2 672	2 278	2 991	3 254	1 724
85+	4 250	1 290	6 250	3 705	2 874	3 070	3 841	1 316
Women, age								
Age								
0-24	1	-	-	4	-	-	1	1
25-44	24	36	81	21	58	32	31	13
45-64	893	452	1 039	296	589	678	580	409
65-84	2 964	1 089	5 493	1 110	1 163	2 871	2 234	1 437
85+	1 602	-	2 494	1 010	392	1 358	1 435	660

The table covers the numbers C33-34 in ICD-10
Source: The cancer registers in the Nordic countries; GL, Danish Cancer Society

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

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2012	2008-12	2008-12	2012	2008-12	2008-12	2012	2012
Age								
0-24	7	-	19	11	-	-	1	9
25-44	206	182	458	102	-	5	223	181
45-64	162	244	275	43	-	66	173	110
65-84	155	256	431	178	179	119	150	118
85+	154	628	708	57	-	206	207	149

The table covers C53 in ICD-10
Source: The cancer registers in the Nordic countries; GL, Danish Cancer Society

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

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2012	2008-12	2008-12	2012	2008-12	2008-12	2012	2012
Age								
0-24	45	-	54	27	49	24	58	40
25-44	258	313	47	149	168	126	285	173
45-64	105	63	24	25	51	56	96	51
65-84	24	66	-	13	221	25	32	12
85+	28	-	-	-	-	-	55	12

The table covers C62 in ICD-10
Source: The cancer registers in the Nordic countries; GL, Danish Cancer Society

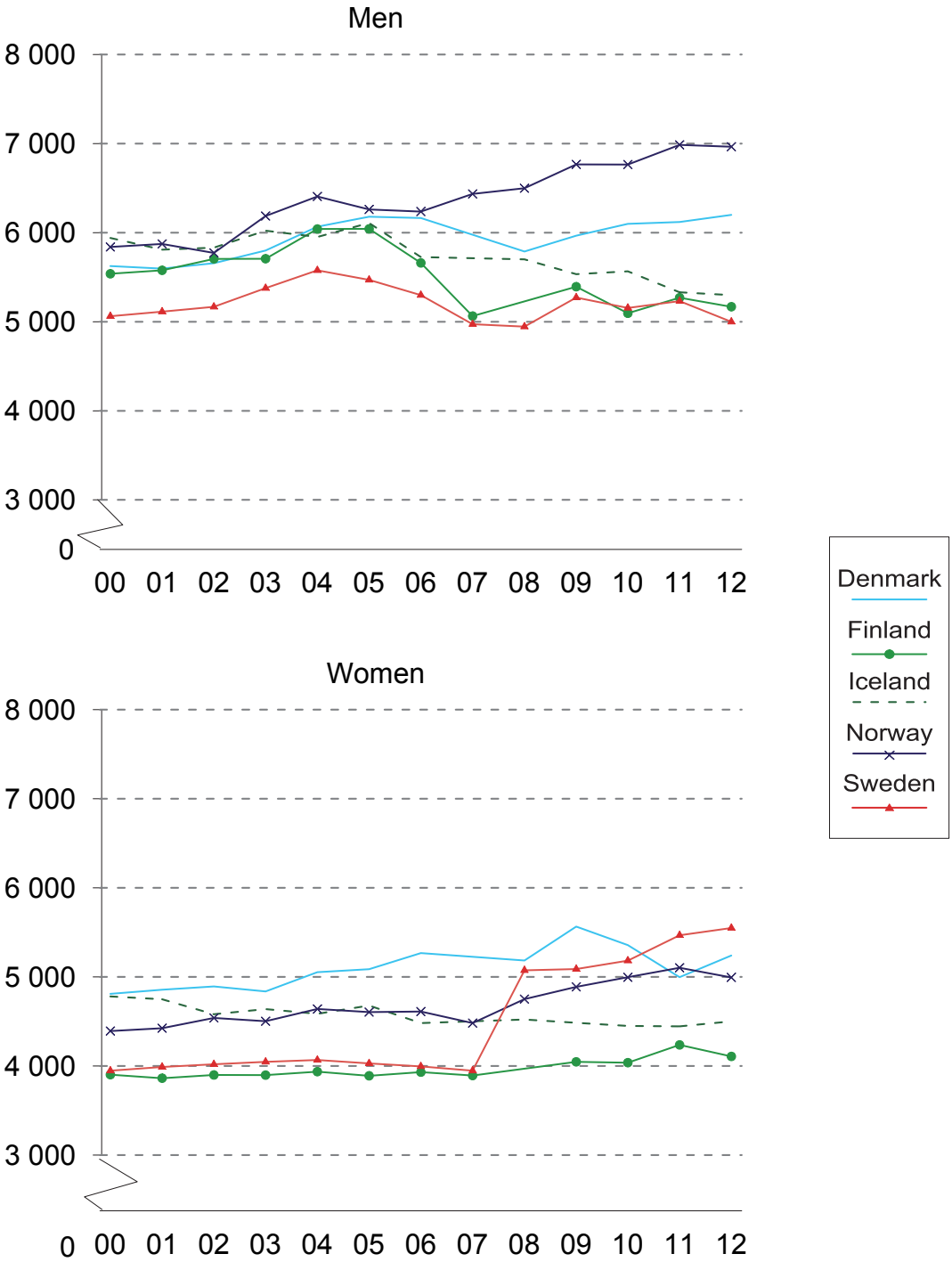
Table 3.2.8 New cases of melanoma of the skin per 1 000 000 inhabitants

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2012	2008-12	2008-12	2012	2008-12	2008-12	2012	2012
Men, age								
0-24	23	-	18	13	-	14	7	10
25-44	188	63	24	75	224	65	149	130
45-64	476	127	47	304	508	178	430	455
65-84	1 062	265	104	952	569	536	1 321	1 150
85+	1 278	-	-	1 355	958	341	1 879	1 563
Women, age								
0-24	55	49	37	17	-	47	15	20
25-44	358	145	54	148	269	206	240	244
45-64	531	139	-	253	453	237	500	474
65-84	673	128	-	507	539	258	881	735
85+	820	628	-	726	392	323	918	982

The table covers the numbers C43 in ICD-10

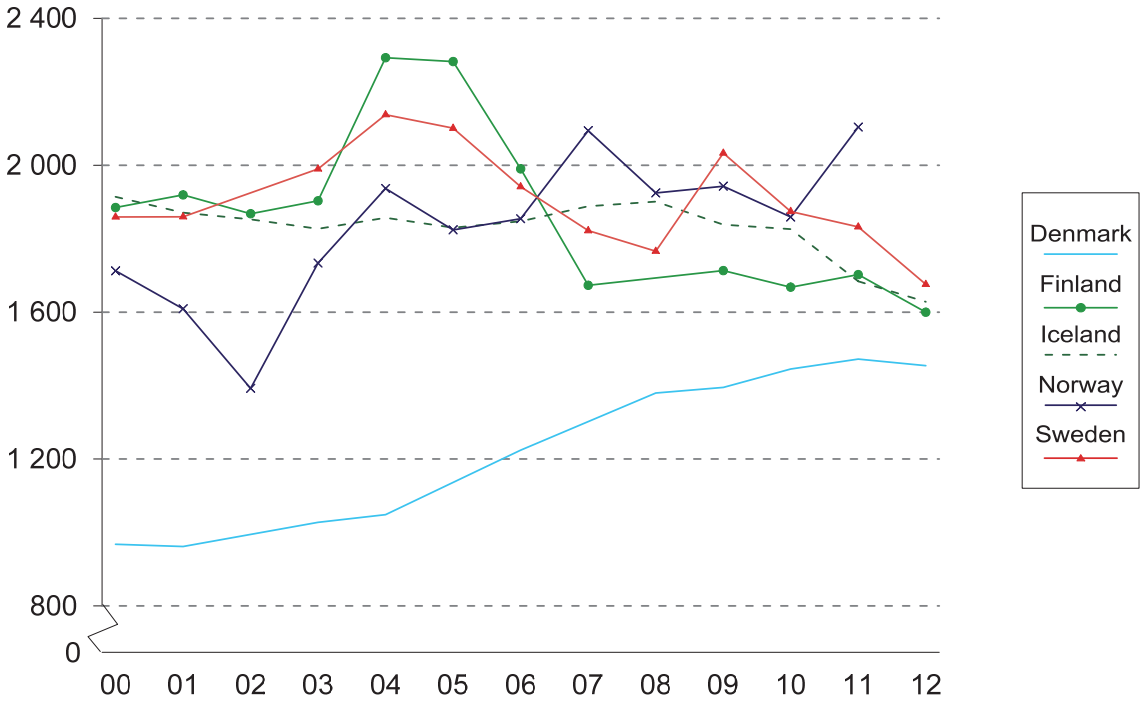
Source: The cancer registers in the Nordic countries; GL, Danish Cancer Society

Figure 3.2.1 New cases of cancer, age-standardized rates per 1 000 000 inhabitants, 2000-2012



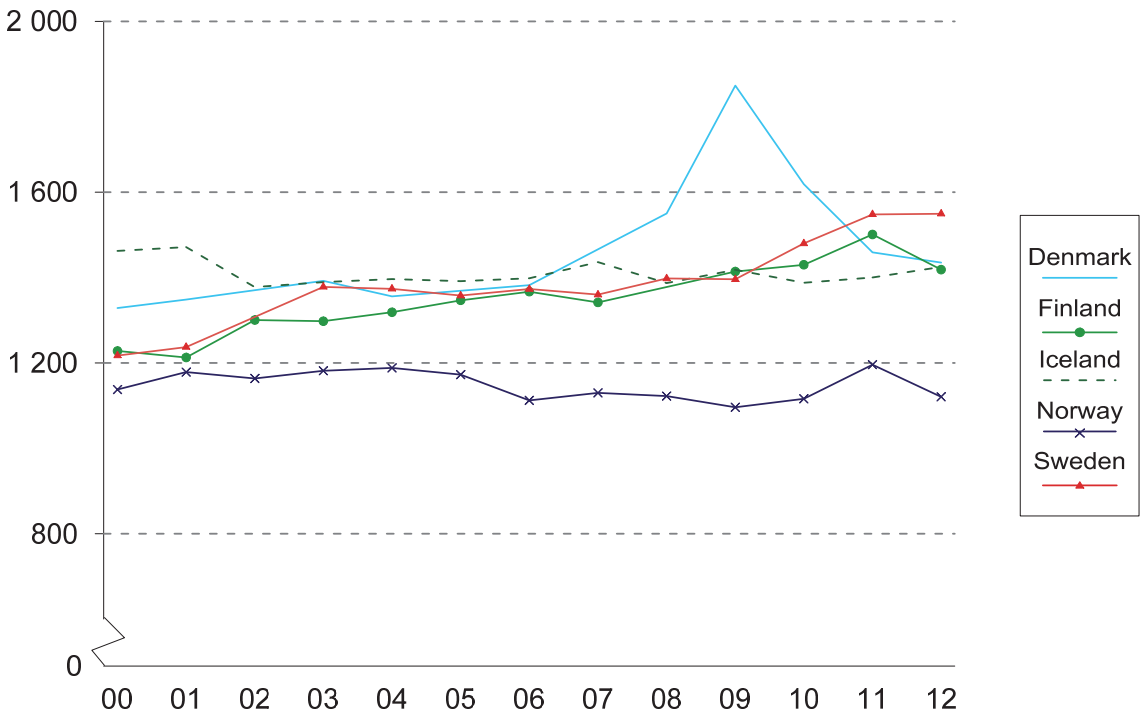
Age-standardized by the Nordic population 2000
The figures for Iceland are 5-year averages
Source: The cancer registers in the Nordic countries

Figure 3.2.2 New cases of prostate cancer, age-standardized rates per 1 000 000 inhabitants 2000-2012



Age-standardized by the Nordic population 2000
The figures for Iceland are 5-year averages
Source: The cancer registers in the Nordic countries

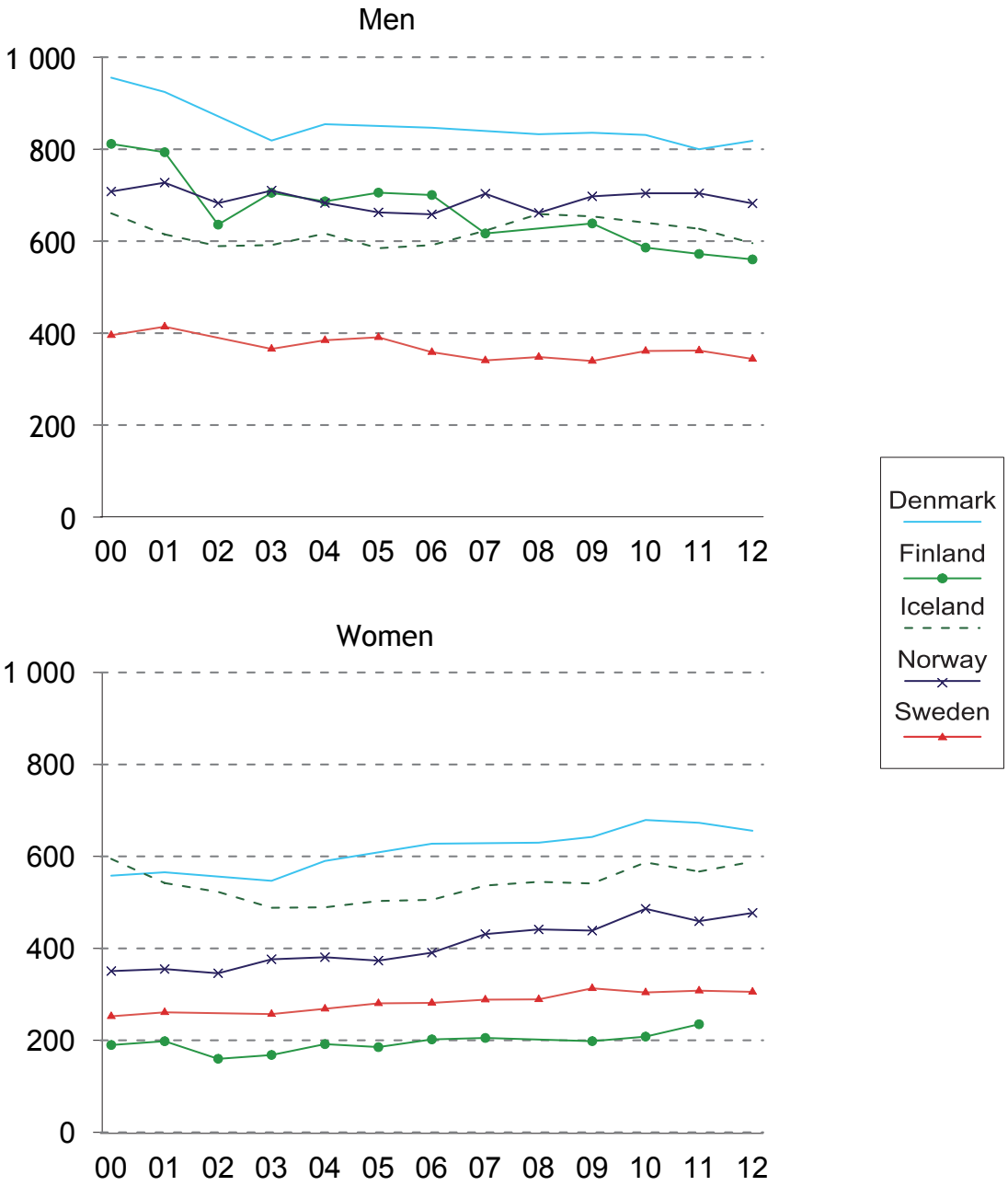
Figure 3.2.3 New cases of breast cancer, age-standardized rates per 1 000 000 inhabitants, 2000-2012



Age-standardized by the Nordic population 2000
The figures for Iceland are 5-year averages
Source: The cancer registers in the Nordic countries

The very large fluctuation in Figure 3.2.3 for Denmark occurs, because screening for breast cancer became nationwide at the end of 2007.

Figure 3.2.4 New cases of lung cancer, age-standardized rates per 1 000 000 inhabitants, 2000-2012



Age-standardized by the Nordic population 2000
The figures for Iceland are 5-year averages
Source: The cancer registers in the Nordic countries; GL, Danish Cancer Society

3.3 Immunization Schedules

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, has immunization registers covering the country as a whole.

Table 3.3.1 Recommended immunization schedules per 1 January 2014[1]

	Denmark	Greenland	Finland	Iceland	Norway	Sweden
Pneumococcus	3, 5 and 12 months	3, 5 and 12 months	3, 5 and 12 months + risk group children under 5 years	60+ years. Vaccination at 3, 5 and 12 months starts in April 2011	3, 5 and 12 months, 65+ years	..
BCG	-	At birth	Only for risk group children under 7 years since 9/2006	-	Risk groups	Risk groups
Pertussis	3, 5 and 12 months and 5 years	3, 5 and 12 months and 5 years	3, 5 and 12 months, 4 and 14-15 years	3, 4, 12 months, 4 and 14 years	3, 5 and 12 months, 7-8 years	3, 5 and 12 months, 5-6 and 14-16 years
Tetanus	3, 5 and 12 months and 5 years	3, 5 and 12 months and 5 years	3, 5 and 12 months, 4 and 14-15 years	3, 4, 12 months, 4 and 14 years,	3, 5 and 12 months, 7-8 years 15-16 years	3, 5 and 12 months, 5-6 and 14-16 years
Diphtheria	3, 5 and 12 months and 5 years	3, 5 and 12 months and 5 years	3, 5 and 12 months, 4 and 14-15 years	3, 4, 12 months, 4 and 14 years	3, 5 and 12 months, 7-8 years 15-16 years	3, 5 and 12 months, 5-6 and 14-16 years
Polio	IPV: 3, 5, 12 months and 5 years	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 12 months, 7-8 years 15-16 years	IPV: 3, 5 and 12 months, 5-6 years
Measles, Mumps, Rubella	15 months, 12 years	15 months, 4 years	12-18 months and 6 years	18 months and 12 years	15 months and 11-12 years	18 months and 6-8 years
Rubella, only	Fertile women	Fertile women	-	-	Seronegative fertile women	-
Haemophilic influenza b	3, 5 and 12 months	3, 5 and 12 months	3, 5 and 12 months	3, 5 and 12 months	3, 5 and 12 months	3, 5 and 12 months
Rotavirus	-		2, 3 and 5 months			
HPV	Girls: 12 years	3 vaccines of girls by their 12th year (0, 2 and 6 months)	3 vaccines of girls 11-15 years (0, 1 and 6 months)	Girls: 12 years	12-13 years (girls only)	3 vaccines of girls born in 1999 or later (5^{th}-6^{th} grade) 2010
Meningococcal disease gr. C	-	-	-	6 and 8 months	-	-
Influenza 65+	65+ and risk groups	65+ and risk groups	65+ and risk groups	60 + years	65+ and risk groups	65+ and risk groups

1 Basically, the Faroe Islands and Åland have the same immunization schedules as Denmark and Finland respectively. In Åland TBE is included for children over 4 years

Source: WHO/EPID, DK, Statens Serum Institut; GL, The Chief Medical Officer; FI, THL; IS, Directorate of Health; NO, Norwegian Institute of Public Health; SV, The National Board of Health and Welfare

Table 3.3.2 Children under the age of two immunized according to recommended immunization schedules and elderly people vaccinated against influenza (per cent), 2012

	Denmark	Faroe Islands[1]	Finland[2]	Iceland[3]	Norway[4]	Sweden
		-	..	NA	..	
Pertussis	93	96	98	89	95	98
Tetanus	93	96	98	89	95	98
Diphtheria	93	96	98	89	95	98
Polio	93	96	98	89	95	98
Rubella	87	89	97	92	94	97
Measles	87	89	97	92	94	97
Influenza 65+	..	48	35	32	..	..

1 2011
2 Based on a randomly chosen population of children in 2007. For the elderly, the figure is based on data from patient journal systems
3 Number of persons vaccinated against Pertussis, Tetanus, Diphtheria and Polio is based on a birth cohort 2010, which received three doses of vaccine. Number for vaccinations against the Measles is based on a birth cohort, which received one dose. For Influenza 60+ the number is based on number of persons vaccinated during the winter of 2011/2012
4 Data underestimated due to a low degree of reporting in some municipalities

Source: WHO/EPI; DK, Statens Serum Institut; FO, Ministry of health affairs; FI, THL; IS, Directorate of Health; NO, Norwegian Institute of Public Health; SV, The Public Health Agency

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

Outline of this section

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

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

The presentation of the diagnosis related statistics starts with tables of the total number of discharges (table 3.4.1) and bed days (table 3.4.2) per 100 000 inhabitants. Besides the tables for both genders, separate tables for men and women are now included. This makes it possible to compare the two genders. However, age standardized tables for discharges and surgery procedures are not included (section 3.5).

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

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

Quality and limitations of data

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

In 2000, NOMESCO performed a validity study of the diagnoses related to the patient statistics. The results were presented as a theme section in the 2000 version of this publication. The general picture was that Nordic hospital data have a high de-

gree of coverage. Only a few private hospitals are not included in some of the countries. There are, however, organizational differences in the hospital systems that influence the statistics.

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

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

The diagnosis-related statistics presented in this report are based on the main diagnosis for each hospital stay. The main diagnosis refers to the main condition treated or examined during each hospital stay. According to the ICD, it is defined as the condition, diagnosed at the end of the treatment period and primarily responsible for the patient's need for treatment or examination. This means that hospital statistics do not give a complete picture of the diseases treated in hospital, since the secondary diagnoses that has been attended to during a hospital stay does not show in the statistics. Hospital discharges, even when recalculated as patients treated, do not correspond to true incidence figures for the population because not all cases are treated in hospitals. For certain diagnoses, incidence figures are available from other sources. This is the case for malignant neoplasms reported to the national cancer registers (cf. Section 3.2). Hospital data for cancer diagnoses are complementary to these in the sense that they illustrate how cancer morbidity is reflected in the activity and workload of hospitals.

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

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

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

Comments to the tables

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

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

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

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

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

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

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

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

In Tables 3.4.4 – 13, the possibilities of linking successive hospital stays for the same main diagnosis and the same person are being used, thus calculating the num-

ber of actual persons being treated, in the following called ‘patients treated’. The Nordic countries are among the few countries in the world that can do this on a national level. As an example, from Table 3.4.4 on lung cancer it can be seen that for all countries and for both men and women the numbers of patients treated are about half the numbers of discharges.

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

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

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

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

ICD-10 code Main diagnosis	Denmark	Faroe Islands	Finland	Åland	Iceland[1]	Norway	Sweden
	2012	2003-07	2012	2008-12	2012	2012	2012
I: Certain infectious and parasitic diseases *(A00-B99)*	760	476	471	515	165	497	502
II: Neoplasms *(C00-D48)*	1 722	1 827	1 667	1 080	1 069	1 514	1 298
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism *(D50-D89)*	290	463	131	135	126	164	151
IV: Endocrine, nutritional and metabolic diseases *(E00-E90)*	702	458	278	248	210	335	370
V: Mental and behavioural disorders *(F00-F99)*	1 168	944	756	201	217	281	1 240
VI: Diseases of the nervous system *(G00-G99)*	620	642	568	515	386	693	506
VII: Diseases of the eye and adnexa *(H00-H59)*	94	626	130	62	62	108	95
VIII: Diseases of the ear and mastoid process *(H60-H95)*	116	312	77	164	51	84	94
IX: Diseases of the circulatory system *(I00-I99)*	2 579	2 296	2 244	2 002	1 232	2 374	2 477
X: Diseases of the respiratory system *(J00-J99)*	2 026	1 444	1 101	1 175	680	1 381	1 181
XI: Diseases of the digestive system *(K00-K93)*	1 849	2 813	1 282	1 447	862	1 243	1 301
XII: Diseases of the skin and subcutaneous tissue *(L00-L99)*	317	250	148	109	210	158	133
XIII: Diseases of the musculoskeletal system and connective tissue *(M00-M99)*	1 286	1 408	1 172	1 296	820	1 122	1 012
XIV: Diseases of the genitourinary system *(N00-N99)*	1 222	978	802	1 067	586	907	805
XV: Pregnancy, childbirth and the puerperium *(O00-O99)*	1 323	1 799	1 349	1 165	1 634	661	1 456
XVI: Certain conditions originating in the perinatal period *(P00-P96)*	187	257	180	96	556	171	172
XVII: Congenital malformations, deformations and chromosomal abnormalities *(Q00-Q99)*	189	193	140	64	160	143	111
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified *(R00-R99)*	2 396	1 323	919	1 366	677	1 446	1 654
XIX: Injury, poisoning and certain other consequences of external causes *(S00-T98)*	2 079	1 839	1 559	1 419	919	1 829	1 649
XXI: Factors influencing health status and contact with health services *(Z00-Z99)*	2 921	3 507	228	553	702	1 707	660
All causes (except. XX) *(A00-Z99 excluding V, W, X and Y)*	24 871	23 374	15 202	14 679	11 166	16 820	17 813

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

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

ICD-10 code Main diagnosis	Denmark	Faroe Islands	Finland	Åland	Iceland[1]	Norway	Sweden
	2012	2003-07	2012	2008-12	2012	2012	2012
I: Certain infectious and parasitic diseases *(A00-B99)*	835	497	490	526	157	512	524
II: Neoplasms (C00-D48)	1 685	1 775	1 574	897	975	1 501	1 214
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	280	474	122	125	109	143	132
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	617	426	249	226	140	266	314
V: Mental and behavioural disorders (F00-F99)	1 250	1 012	797	206	187	315	1 340
VI: Diseases of the nervous system (G00-G99)	659	623	583	470	391	733	510
VII: Diseases of the eye and adnexa (H00-H59)	99	586	125	28	62	109	100
VIII: Diseases of the ear and mastoid process (H60-H95)	122	323	76	189	47	78	86
IX: Diseases of the circulatory system (I00-I99)	3 146	2 648	2 525	2 031	1 487	2 842	2 819
X: Diseases of the respiratory system (J00-J99)	2 179	1 494	1 261	1 307	685	1 422	1 204
XI: Diseases of the digestive system (K00-K93)	1 911	2 828	1 384	1 457	787	1 215	1 282
XII: Diseases of the skin and subcutaneous tissue (L00-L99)	364	294	163	114	220	167	138
XIII: Diseases of the musculoskeletal system and connective tissue (M00-M99)	1 191	1 361	998	1 016	648	978	885
XIV: Diseases of the genitourinary system (N00-N99)	1 036	761	643	620	396	822	749
XV: Pregnancy, childbirth and the puerperium (O00-O99)	.	.	.	.		.	.
XVI: Certain conditions originating in the perinatal period (P00-P96)	223	265	207	105	607	188	193
XVII: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	223	193	153	79	166	162	123
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	2 306	1 331	911	1 201	565	1 346	1 558
XIX: Injury, poisoning and certain other consequences of external causes (S00-T98)	2 127	2 106	1 642	1 422	843	1 835	1 593
XXI: Factors influencing health status and contact with health services (Z00-Z99)	2 819	2 757	200	477	542	858	629
All causes (except. XX) (A00-Z99 excluding V, W, X and Y)	24 156	21 254	14 102	12 497	8 849	15 493	16 365

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

Source: The national in-patient registers

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

ICD-10 code Main diagnosis	Denmark	Faroe Islands	Finland	Åland	Iceland[1]	Norway	Sweden
	2012	2003-07	2012	2008-12	2012	2012	2012
I: Certain infectious and parasitic diseases (A00-B99)	720	453	454	491	174	481	481
II: Neoplasms (C00-D48)	1 833	1 884	1 757	1 234	1 164	1 527	1 381
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	312	452	140	142	143	185	169
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	815	493	305	264	280	405	427
V: Mental and behavioural disorders (F00-F99)	1 138	870	717	190	248	247	1 141
VI: Diseases of the nervous system (G00-G99)	609	662	554	546	380	652	501
VII: Diseases of the eye and adnexa (H00-H59)	93	670	135	93	63	108	89
VIII: Diseases of the ear and mastoid process (H60-H95)	116	300	78	135	54	90	101
IX: Diseases of the circulatory system (I00-I99)	2 133	1 915	1 972	1 922	975	1 903	2 138
X: Diseases of the respiratory system (J00-J99)	1 963	1 391	946	1 015	674	1 339	1 159
XI: Diseases of the digestive system (K00-K93)	1 869	2 797	1 183	1 400	937	1 270	1 320
XII: Diseases of the skin and subcutaneous tissue (L00-L99)	283	202	133	101	200	149	129
XIII: Diseases of the musculoskeletal system and connective tissue (M00-M99)	1 436	1 459	1 340	1 540	993	1 267	1 139
XIV: Diseases of the genitourinary system (N00-N99)	1 458	1 212	955	1 483	777	993	861
XV: Pregnancy, childbirth and the puerperium (O00-O99)	2 683	3 743	2 651	2 289	3 280	1 325	2 905
XVI: Certain conditions originating in the perinatal period (P00-P96)	161	249	155	85	505	154	152
XVII: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	162	194	127	47	154	125	98
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	2 588	1 314	928	1 494	791	1 547	1 751
XIX: Injury, poisoning and certain other consequences of external causes (S00-T98)	2 122	1 550	1 479	1 380	996	1 824	1 705
XXI: Factors influencing health status and contact with health services (Z00-Z99)	3 147	4 318	255	614	861	2 562	691
All causes (except. XX) (A00-Z99 excluding V, W, X and Y)	26 651	25 664	16 265	16 466	13 497	18 156	19 252

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

Source: The national in-patient registers

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

ICD-10 code Main diagnosis	Denmark	Faroe Islands	Finland	Åland	Iceland[1]	Norway	Sweden
	2012	2003-07	2012	2008-12	2012	2012	2012
I: Certain infectious and parasitic diseases *(A00-B99)*	3 308	2 514	3 425	3 314	962	2 771	2 735
II: Neoplasms *(C00-D48)*	7 491	8 639	9 889	8 682	7 870	9 035	8 602
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism *(D50-D89)*	807	1 700	690	847	735	557	652
IV: Endocrine, nutritional and metabolic diseases *(E00-E90)*	2 450	3 285	1 712	1 687	1 408	1 205	1 680
V: Mental and behavioural disorders *(F00-F99)*	17 059	28 703	22 185	1 413	3 030	719	16 260
VI: Diseases of the nervous system *(G00-G99)*	2 913	2 790	6 484	3 797	3 388	2 344	2 511
VII: Diseases of the eye and adnexa *(H00-H59)*	193	659	391	173	181	329	225
VIII: Diseases of the ear and mastoid process *(H60-H95)*	200	225	239	417	161	172	209
IX: Diseases of the circulatory system *(I00-I99)*	9 599	21 690	17 635	13 890	10 535	10 109	13 228
X: Diseases of the respiratory system *(J00-J99)*	7 955	7 626	7 376	6 344	5 039	7 443	6 107
XI: Diseases of the digestive system *(K00-K93)*	6 510	7 046	6 241	7 464	4 412	5 176	5 504
XII: Diseases of the skin and subcutaneous tissue *(L00-L99)*	1 047	1 183	1 017	676	1 277	870	811
XIII: Diseases of the musculoskeletal system and connective tissue *(M00-M99)*	4 237	6 961	5 833	6 857	5 167	4 730	4 740
XIV: Diseases of the genitourinary system *(N00-N99)*	3 433	2 806	3 713	4 708	2 262	3 153	3 305
XV: Pregnancy, childbirth and the puerperium *(O00-O99)*	3 440	7 948	5 542	5 535	3 184	2 234	3 559
XVI: Certain conditions originating in the perinatal period *(P00-P96)*	1 611	1 215	1 521	886	2 317	1 692	1 753
XVII: Congenital malformations, deformations and chromosomal abnormalities *(Q00-Q99)*	553	814	702	743	542	651	539
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified *(R00-R99)*	4 918	4 262	3 519	5 201	3 442	2 524	4 126
XIX: Injury, poisoning and certain other consequences of external causes *(S00-T98)*	6 860	8 340	9 625	8 153	6 626	7 291	8 175
XXI: Factors influencing health status and contact with health services *(Z00-Z99)*	12 737	8 832	1 296	2 206	4 483	7 675	2 490
All causes (except. XX) *(A00-Z99 excluding V, W, X and Y)*	99 423	126 494	109 037	82 992	66 478	70 680	95 436

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

Source: The national in-patient registers

Table 3.4.2.b Bed days in hospitals per 100 000 population by main diagnosis. Men

ICD-10 code Main diagnosis	Denmark	Faroe Islands	Finland	Åland	Iceland[1]	Norway	Sweden
	2012	2003-07	2012	2008-12	2012	2012	2012
I: Certain infectious and parasitic diseases (A00-B99)	3 608	2 556	3 571	3 536	993	3 005	2 828
II: Neoplasms (C00-D48)	7 702	8 727	9 763	7 429	7 743	9 379	8 552
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	763	2 182	684	918	631	502	593
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	2 200	3 405	1 579	1 498	1 140	1 001	1 550
V: Mental and behavioural disorders (F00-F99)	17 073	23 757	19 608	1 008	2 490	671	17 059
VI: Diseases of the nervous system (G00-G99)	3 080	3 377	5 658	3 589	3 491	2 407	2 540
VII: Diseases of the eye and adnexa (H00-H59)	201	547	350	94	152	331	227
VIII: Diseases of the ear and mastoid process (H60-H95)	187	212	248	446	108	154	178
IX: Diseases of the circulatory system (I00-I99)	11 324	24 305	17 456	14 259	12 444	11 935	14 254
X: Diseases of the respiratory system (J00-J99)	8 347	6 531	8 073	7 103	4 675	7 641	6 099
XI: Diseases of the digestive system *(K00-K93)*	6 532	6 818	6 627	7 523	3 843	4 922	5 304
XII: Diseases of the skin and subcutaneous tissue *(L00-L99)*	1 201	1 307	1 093	678	1 276	872	803
XIII: Diseases of the musculoskeletal system and connective tissue *(M00-M99)*	3 549	5 292	4 618	4 658	3 657	4 059	3 859
XIV: Diseases of the genitourinary system *(N00-N99)*	3 114	2 745	3 111	3 001	1 864	3 097	3 279
XVI: Certain conditions originating in the perinatal period *(P00-P96)*	1 783	1 264	1 726	1 074	2 560	1 805	1 876
XVII: Congenital malformations, deformations and chromosomal abnormalities *(Q00-Q99)*	619	830	805	1 152	604	732	599
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified *(R00-R99)*	4 664	4 171	3 275	4 772	2 940	2 300	3 834
XIX: Injury, poisoning and certain other consequences of external causes *(S00-T98)*	6 528	7 113	9 415	7 851	5 624	7 131	7 206
XXI: Factors influencing health status and contact with health services *(Z00-Z99)*	13 088	6 541	1 274	2 197	3 866	5 291	2 427
Total (ekskl. kap. XX) *(A00-Z99 ekskl. V, W, X og Y)*	97 743	110 772	98 935	72 785	59 494	67 234	91 804

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

Source: The national in-patient registers

Table 3.4.2.c Bed days in hospitals per 100 000 population by main diagnosis. Women

ICD-10 code Main diagnosis	Denmark	Faroe Islands	Finland	Åland	Iceland[1]	Norway	Sweden
	2012	2003-07	2012	2008-12	2012	2012	2012
I: Certain infectious and parasitic diseases (A00-B99)	3 012	2 468	3 285	3 011	931	2 535	2 642
II: Neoplasms (C00-D48)	7 283	8 545	10 011	9 703	7 997	8 689	8 651
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	851	1 180	696	755	840	612	710
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	2 696	3 155	1 841	1 832	1 677	1 410	1 809
V: Mental and behavioural disorders (F00-F99)	17 045	34 049	24 674	1 779	3 573	767	15 466
VI: Diseases of the nervous system (G00-G99)	2 749	2 155	7 282	3 906	3 283	2 280	2 482
VII: Diseases of the eye and adnexa (H00-H59)	185	779	431	247	211	328	223
VIII: Diseases of the ear and mastoid process (H60-H95)	212	239	231	377	215	190	240
IX: Diseases of the circulatory system (I00-I99)	7 902	18 864	17 808	13 171	8 612	8 271	12 207
X: Diseases of the respiratory system (J00-J99)	7 570	8 811	6 703	5 430	5 403	7 244	6 114
XI: Diseases of the digestive system *(K00-K93)*	6 487	7 292	5 869	7 215	4 984	5 431	5 703
XII: Diseases of the skin and subcutaneous tissue *(L00-L99)*	896	1 049	943	657	1 278	869	819
XIII: Diseases of the musculoskeletal system and connective tissue *(M00-M99)*	4 914	8 766	7 006	8 859	6 686	5 405	5 615
XIV: Diseases of the genitourinary system *(N00-N99)*	3 747	2 872	4 293	6 278	2 663	3 209	3 331
XV: Pregnancy, childbirth and the puerperium *(O00-O99)*	6 825	16 540	10 893	10 875	6 389	4 482	7 098
XVI: Certain conditions originating in the perinatal period *(P00-P96)*	1 441	1 163	1 322	677	2 071	1 579	1 631
XVII: Congenital malformations, deformations and chromosomal abnormalities *(Q00-Q99)*	488	796	604	320	479	570	480
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified *(R00-R99)*	5 167	9 667	3 755	5 493	3 946	2 750	4 416
XIX: Injury, poisoning and certain other consequences of external causes *(S00-T98)*	7 186	4 360	9 827	8 245	7 633	7 453	9 139
XXI: Factors influencing health status and contact with health services *(Z00-Z99)*	12 393	11 309	1 318	2 159	5 104	10 074	2 552
All causes (except. XX) (A00-Z99 excluding V, W, X and Y)	101 077	143 488	118 791	90 987	73 499	74 148	99 047

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

Source: The national in-patient registers

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

ICD-10 code Main diagnosis	Denmark	Faroe Islands	Finland	Åland	Iceland[1]	Norway	Sweden
	2012	2003-07	2012	2008-12	2012	2012	2012
I: Certain infectious and parasitic diseases (A00-B99)	4.4	5.3	7.3	6.4	5.8	5.6	5.4
II: Neoplasms (C00-D48)	4.3	4.7	5.9	8.0	7.4	6.0	6.6
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	2.8	3.7	5.3	6.3	5.8	3.4	4.3
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	3.5	7.2	6.2	6.8	6.7	3.6	4.5
V: Mental and behavioural disorders (F00-F99)	14.6	30.4	29.3	7.0	13.9	2.6	13.1
VI: Diseases of the nervous system (G00-G99)	4.7	4.3	11.4	7.4	8.8	3.4	5.0
VII: Diseases of the eye and adnexa (H00-H59)	2.1	1.1	3.0	2.8	2.9	3.0	2.4
VIII: Diseases of the ear and mastoid process (H60-H95)	1.7	0.7	3.1	2.5	3.2	2.0	2.2
IX: Diseases of the circulatory system (I00-I99)	3.7	9.4	7.9	6.9	8.6	4.3	5.3
X: Diseases of the respiratory system (J00-J99)	3.9	5.3	6.7	5.4	7.4	5.4	5.2
XI: Diseases of the digestive system *(K00-K93)*	3.5	2.5	4.9	5.2	5.1	4.2	4.2
XII: Diseases of the skin and subcutaneous tissue *(L00-L99)*	3.3	4.7	6.9	6.2	6.1	5.5	6.1
XIII: Diseases of the musculoskeletal system and connective tissue *(M00-M99)*	3.3	4.9	5.0	5.3	6.3	4.2	4.7
XIV: Diseases of the genitourinary system *(N00-N99)*	2.8	2.9	4.6	4.4	3.9	3.5	4.1
XV: Pregnancy, childbirth and the puerperium *(O00-O99)*	2.6	4.4	4.1	4.8	1.9	3.4	2.4
XVI: Certain conditions originating in the perinatal period *(P00-P96)*	8.6	4.7	8.4	9.2	4.2	9.9	10.2
XVII: Congenital malformations, deformations and chromosomal abnormalities *(Q00-Q99)*	2.9	4.2	5.0	11.7	3.4	4.5	4.9
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified *(R00-R99)*	2.1	3.2	3.8	3.8	5.1	1.7	2.5
XIX: Injury, poisoning and certain other consequences of external causes *(S00-T98)*	3.3	4.5	6.2	5.7	7.2	4.0	5.0
XXI: Factors influencing health status and contact with health services *(Z00-Z99)*	4.4	2.5	5.7	4.0	6.4	4.5	3.8
All causes (except. XX) (A00-Z99 excluding V, W, X and Y)	4.0	5.4	7.2	5.7	6.0	4.2	5.4

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

Source: The national in-patient registers

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

ICD-10 code Main diagnosis	Denmark	Faroe Islands	Finland	Åland	Iceland[1]	Norway	Sweden
	2012	2003-07	2012	2008-12	2012	2012	2012
I: Certain infectious and parasitic diseases (A00-B99)	4.3	5.1	7.3	6.7	6.3	5.9	5.4
II: Neoplasms (C00-D48)	4.6	4.9	6.2	8.3	7.9	6.2	7.0
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	2.7	4.6	5.6	7.3	5.8	3.5	4.5
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	3.6	8.0	6.3	6.6	8.1	3.8	4.9
V: Mental and behavioural disorders (F00-F99)	13.7	23.5	24.6	4.9	13.3	2.1	12.7
VI: Diseases of the nervous system (G00-G99)	4.7	5.4	9.7	7.6	8.9	3.3	5.0
VII: Diseases of the eye and adnexa (H00-H59)	2.0	0.9	2.8	3.4	2.5	3.0	2.3
VIII: Diseases of the ear and mastoid process (H60-H95)	1.5	0.7	3.3	2.4	2.3	2.0	2.1
IX: Diseases of the circulatory system (I00-I99)	3.6	9.2	6.9	7.0	8.4	4.2	5.1
X: Diseases of the respiratory system (J00-J99)	3.8	4.4	6.4	5.4	6.8	5.4	5.1
XI: Diseases of the digestive system *(K00-K93)*	3.4	2.4	4.8	5.2	4.9	4.0	4.1
XII: Diseases of the skin and subcutaneous tissue *(L00-L99)*	3.3	4.4	6.7	6.0	5.8	5.2	5.8
XIII: Diseases of the musculoskeletal system and connective tissue *(M00-M99)*	3.0	3.9	4.6	4.6	5.6	4.2	4.4
XIV: Diseases of the genitourinary system *(N00-N99)*	3.0	3.6	4.8	4.8	4.7	3.8	4.4
XV: Pregnancy, childbirth and the puerperium *(O00-O99)*	.	.	.	.	.	.	.
XVI: Certain conditions originating in the perinatal period *(P00-P96)*	8.0	4.8	8.4	10.2	4.2	9.6	9.7
XVII: Congenital malformations, deformations and chromosomal abnormalities *(Q00-Q99)*	2.8	4.3	5.2	14.7	3.6	4.5	4.9
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified *(R00-R99)*	2.0	3.1	3.6	4.0	5.2	1.7	2.5
XIX: Injury, poisoning and certain other consequences of external causes *(S00-T98)*	3.1	3.4	5.7	5.5	6.7	3.9	4.5
XXI: Factors influencing health status and contact with health services *(Z00-Z99)*	4.6	2.4	6.4	4.6	7.1	6.2	3.9
All causes (except. XX) (A00-Z99 excluding V, W, X and Y)	4.0	5.2	7.0	5.8	6.7	4.3	5.6

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

Source: The national in-patient registers

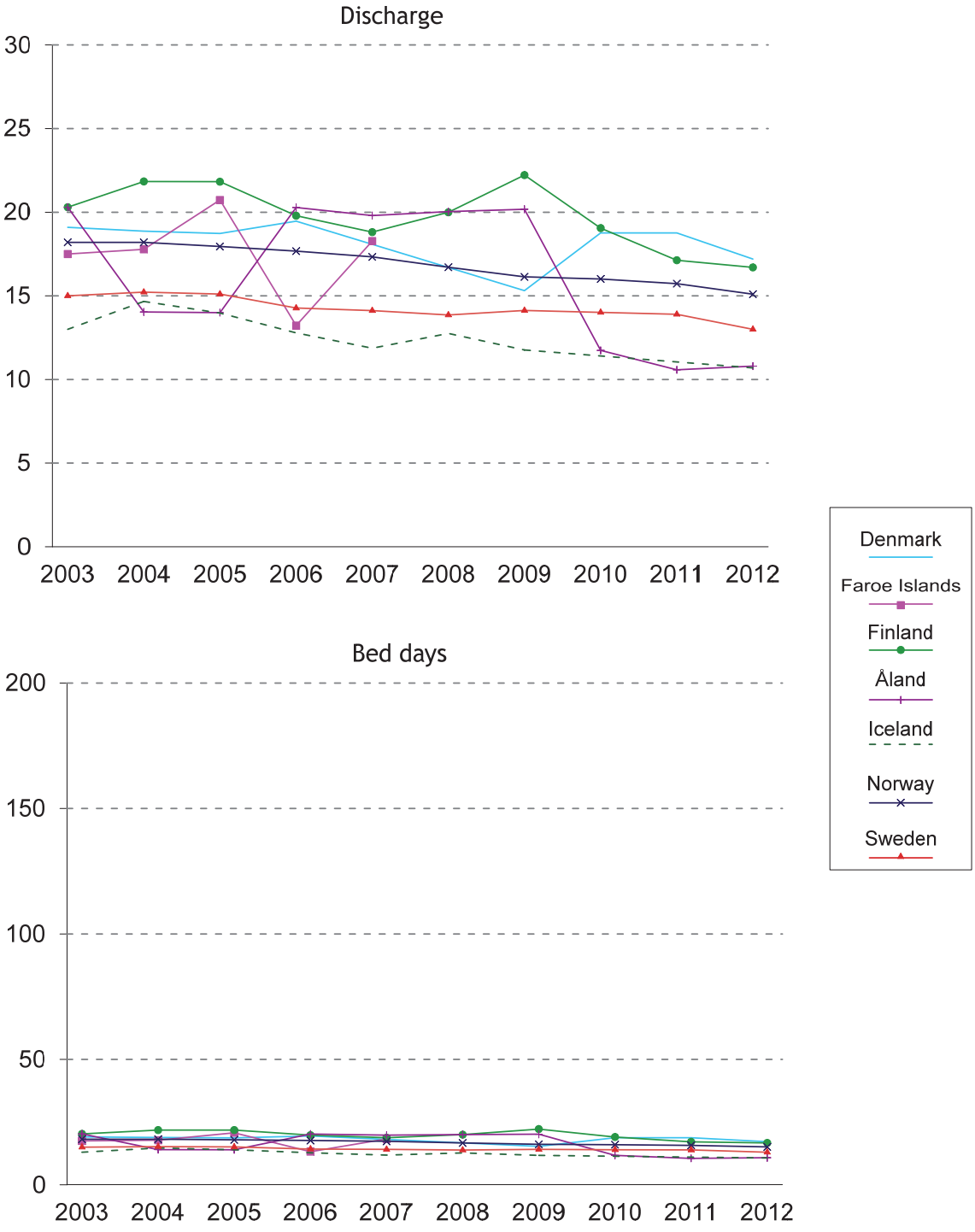
Table 3.4.3.c Average length of stay per discharge (in days) per 100 000 population by main diagnosis. Women

ICD-10 code Main diagnosis	Denmark	Faroe Islands	Finland	Åland	Iceland[1]	Norway	Sweden
	2012	2003-07	2012	2008-12	2012	2012	2012
I: Certain infectious and parasitic diseases (A00-B99)	4.2	5.5	7.2	6.1	5.4	5.3	5.5
II: Neoplasms (C00-D48)	4.0	4.5	5.7	7.9	6.9	5.7	6.3
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	2.7	2.6	5.0	5.3	5.9	3.3	4.2
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	3.3	6.4	6.0	6.9	6.0	3.5	4.2
V: Mental and behavioural disorders (F00-F99)	15.0	39.1	34.4	9.3	14.4	3.1	13.6
VI: Diseases of the nervous system (G00-G99)	4.5	3.3	13.2	7.2	8.6	3.5	5.0
VII: Diseases of the eye and adnexa (H00-H59)	2.0	1.2	3.2	2.7	3.3	3.0	2.5
VIII: Diseases of the ear and mastoid process (H60-H95)	1.8	0.8	3.0	2.8	4.0	2.1	2.4
IX: Diseases of the circulatory system (I00-I99)	3.7	9.8	9.0	6.9	8.8	4.3	5.7
X: Diseases of the respiratory system (J00-J99)	3.9	6.3	7.1	5.4	8.0	5.4	5.3
XI: Diseases of the digestive system *(K00-K93)*	3.5	2.6	5.0	5.2	5.3	4.3	4.3
XII: Diseases of the skin and subcutaneous tissue *(L00-L99)*	3.2	5.2	7.1	6.5	6.4	5.8	6.3
XIII: Diseases of the musculoskeletal system and connective tissue *(M00-M99)*	3.4	6.0	5.2	5.8	6.7	4.3	4.9
XIV: Diseases of the genitourinary system *(N00-N99)*	2.6	2.4	4.5	4.2	3.4	3.2	3.9
XV: Pregnancy, childbirth and the puerperium *(O00-O99)*	2.5	4.4	4.1	4.8	1.9	3.4	2.4
XVI: Certain conditions originating in the perinatal period *(P00-P96)*	9.0	4.7	8.5	8.0	4.1	10.2	10.7
XVII: Congenital malformations, deformations and chromosomal abnormalities *(Q00-Q99)*	3.0	4.1	4.8	6.8	3.1	4.6	4.9
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified *(R00-R99)*	2.0	3.3	4.0	3.7	5.0	1.8	2.5
XIX: Injury, poisoning and certain other consequences of external causes *(S00-T98)*	3.4	6.2	6.6	6.0	7.7	4.1	5.4
XXI: Factors influencing health status and contact with health services *(Z00-Z99)*	3.9	2.6	5.2	3.5	5.9	3.9	3.7
All causes (except. XX) (A00-Z99 excluding V, W, X and Y)	3.8	5.6	7.3	5.5	5.4	4.1	5.1

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

Source: The national in-patient registers

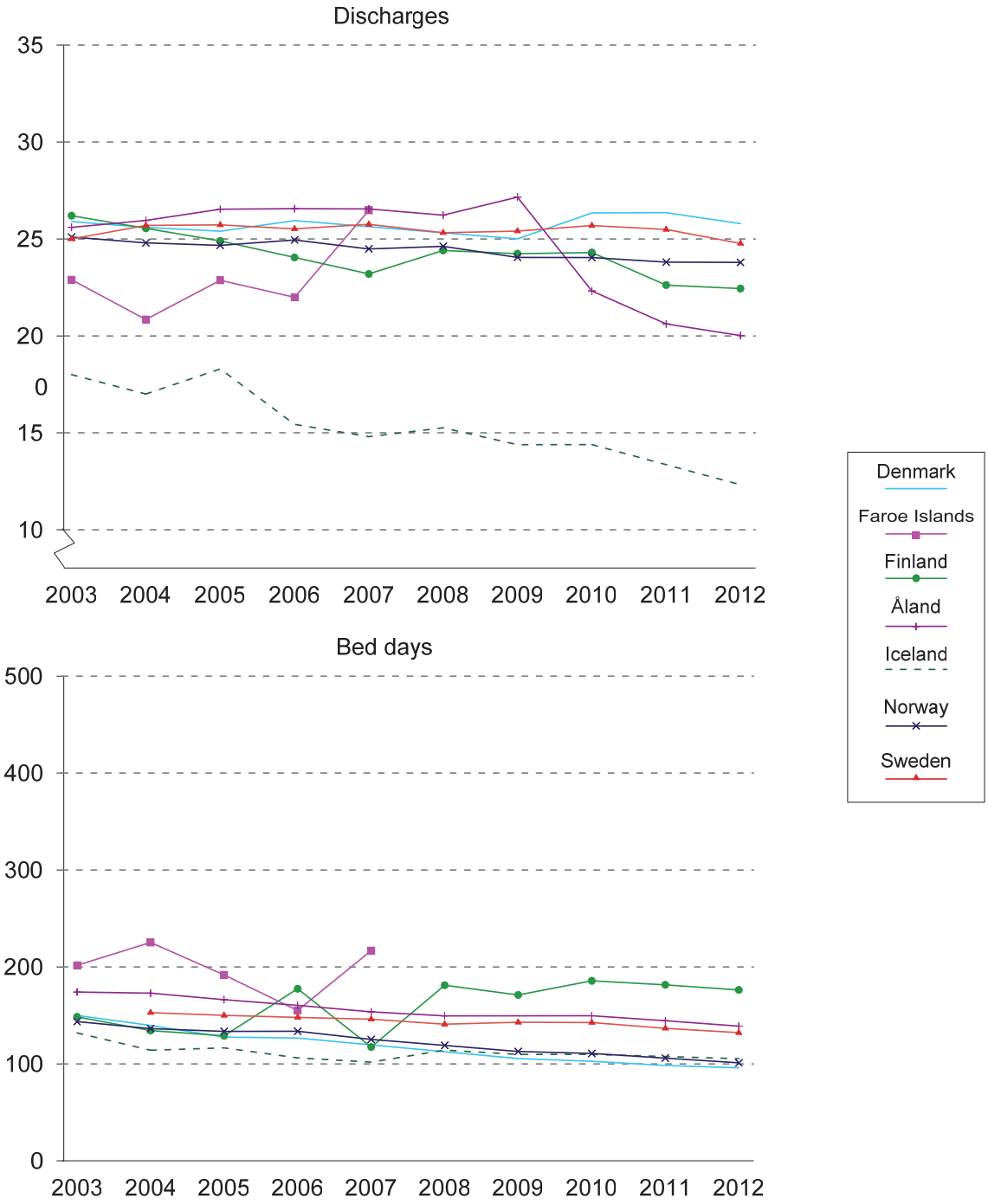
Figure 3.4.1 Discharges and number of bed days for cancer, per 1 000 inhabitants 2003-2012[1]



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

Includes ICD-10 codes: C00-D48

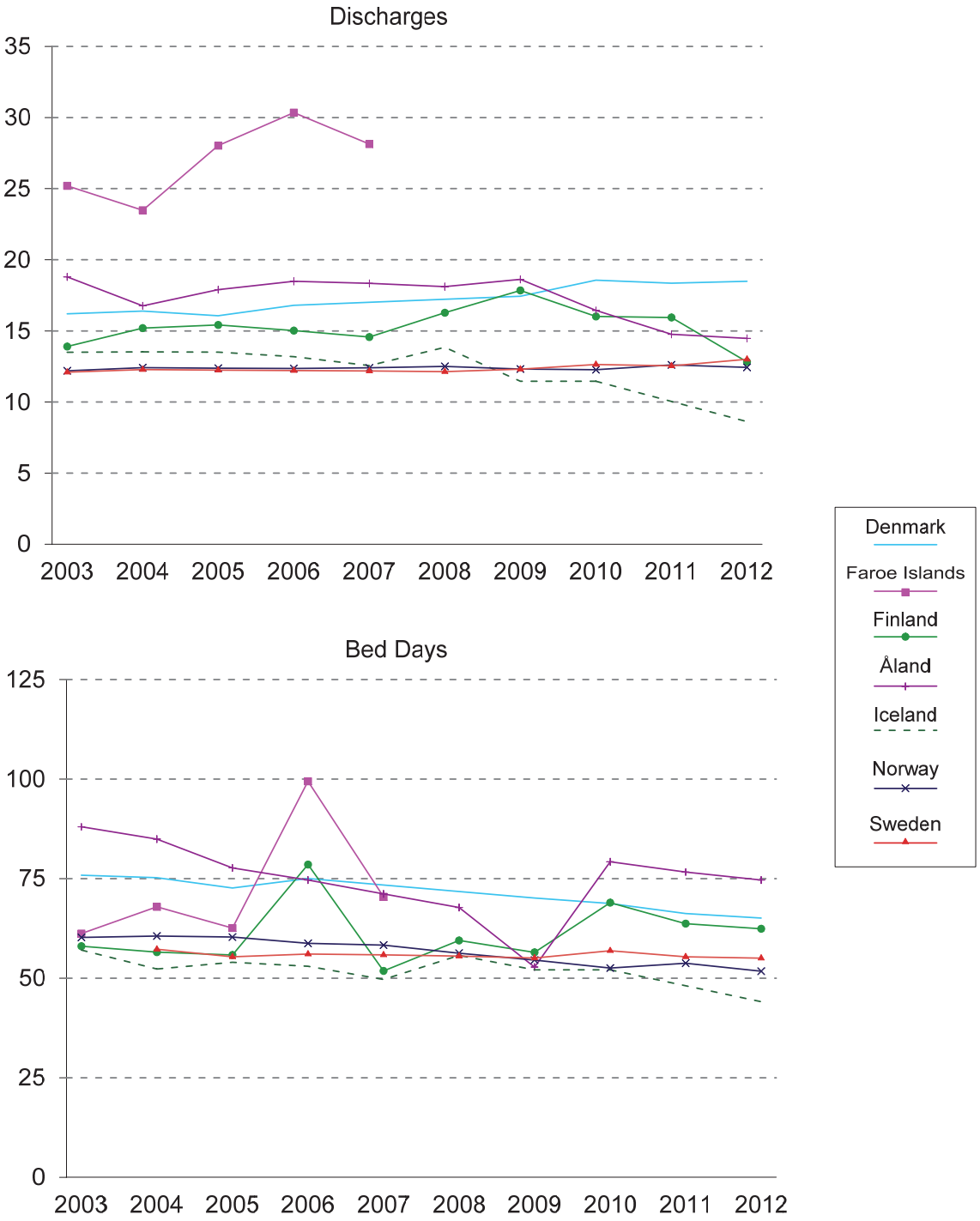
Figure 3.4.2 Discharges and bed days during the year for diseases of the circulation organs, per 1 000 inhabitants, 2003-2012[1]



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

Includes ICD-10 codes: I00-I99

Figure 3.4.3 Discharges and bed days for diseases of the digestive system, per 1 000 inhabitants 2003-2012[1]



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

Includes ICD-10 codes: K00-K93

Table 3.4.4 Discharges, bed days and average length of stay in wards at ordinary hospitals and special hospitals, 2012

	Denmark	Faroe Islands[1]	Green-land[2]	Finland	Åland[3]	Iceland	Norway[4]	Sweden
Discharges per 1 000 inhabitants								
Somatic wards	254	210	292	176	172	125	168	512
Psychiatry	9	13	3	7	11	8	15	33
Total	263	224	295	184	183	133	183	578
Bed days per 1 000 inhabitants								
Somatic wards	994	1 063	1 312	728	863	698	707	2 431
Psychiatry	143	291	66	257	187	90	292	495
Total	1 137	1 354	1 378	985	1 050	788	999	3 250
Average length of stay								
Somatic wards	3.9	10.1	4.5	4.1	5.0	5.6	4.2	4.8
Psychiatry	15.7	22.4	21.2	35.0	17.7	12.0	19.5	14.9
Total	4.3	5.0	4.7	5.4	5.7	5.9	5.5	5.6

1 Average 2005-09
2 Somatic ward is included DIH and the coast
3 Average 2008-12
4 Figures for beds within mental health services, substance abuse treatment also. This includes both beds in hospitals and psychiatric centers (DPS)

Source: The national in-patient registers

Table 3.4.5 Discharges, patients treated and average length of stay in hospital for malignant neoplasm of trachea, bronchus and lungs, 2012

	Denmark	Faroe Islands[1]	Finland	Åland[2]	Iceland[3]	Norway	Sweden
Discharges							
Men, total	3 187	63	3 258	10	198	3 149	4 198
Women, total	3 194	38	1 787	11	226	2 708	4 414
Patients treated							
Men, total	1 921	13	1 661	6	104	1 691	2 395
Women, total	1 910	7	893	5	123	1 492	2 429
Patients treated per 100 000 men in the age group							
25-44	3	-	2	5	9	2	2
45-64	75	76	68	35	56	70	41
65+	305	276	274	181	414	352	228
Total rate	69	51	62	42	65	67	50
Patients treated per 100 000 women in the age group							
25-44	4	-	2	0	9	3	2
45-64	89	63	39	67	73	72	51
65+	231	108	103	97	410	236	181
Total rate	68	31	32	38	77	60	51
Average length of stay per discharge	5.8	34	8.0	9.3	8.4	7.3	9.3

1 Average 2003-07
2 Average 2008-12
3 Only discharges with a length of stay less than 90 days

The table includes ICD-10: C33-C34

Source: The national in-patient registers

Table 3.4.6 Discharges, patients treated and average length of stay in hospital for malignant neoplasm of breast, women 2012

	Denmark	Faroe Islands[1]	Finland	Åland[2]	Iceland[3,4]	Norway	Sweden
Discharges							
Total	6 835	82	9 160	32	392	4 294	8 383
Patients treated							
Total	5 147	29	6 674	26	308	3 380	7 167
Patients treated per 100 000 women in the age group							
25-44	67	38	71	62	74	54	42
45-64	312	250	453	294	350	257	236
65+	442	375	484	416	647	327	388
Total rate	183	124	242	183	193	135	150
Average length of stay per discharge	2.5	5.6	4.5	6.3	4.4	3.4	3.3

1 Average 2003-07
2 Average 2008-12
3 Only discharges with a length of stay less than 90 days

The table includes ICD-10: C50

Source: The national in-patient registers

Table 3.4.7 Discharges, patients treated and average length of stay in hospital for acute myocardial infarction, 2012

	Denmark	Faroe Islands[1]	Finland	Åland[2]	Iceland[3]	Norway	Sweden
Discharges							
Men, Total	10 134	68	7 388	40	346	13 115	20 652
Women, Total	5 035	32	4 774	31	153	6 553	12 260
Patients treated							
Men, Total	5 704	58	5 579	29	295	7 860	13 557
Women, Total	3 085	26	3 693	24	124	4 347	8 418
Patients treated per 100 000 men in the age group							
0-44	17	20	11	10	10	23	9
45-64	293	352	253	224	328	456	315
65+	730	1 116	829	790	860	1 312	1 159
Total rate	206	230	209	204	183	312	286
Patients treated per 100 000 women in the age group							
0-44	7	-	2	-	2	5	3
45-64	97	82	68	96	106	123	98
65+	419	620	544	686	405	810	726
Total rate	110	113	134	165	78	174	176
Average length of stay per discharge	3.3	10.8	6.4	5.4	6.3	3.7	4.1

1 Average 2003-07
2 Average 2008-12
3 Only discharges with a length of stay less than 90 days

The table includes ICD-10: I21-I22

Source: The national in-patient registers

Table 3.4.8 Discharges, patients treated and average length of stay in hospital for cerebrovascular diseases, 2012

	Denmark	Faroe Islands[1]	Finland	Åland[2]	Iceland[3]	Norway	Sweden
Discharges							
Men, Total	10 210	98	10 772	50	313	8 143	21 300
Women, Total	9 182	61	9 851	51	236	7 022	19 184
Patients treated							
Men, Total	7 543	78	7 662	36	237	6 595	15 373
Women, Total	6 683	51	7 163	35	189	5 785	14 305
Patients treated per 100 000 men in the age group							
0-44	24	30	28	21	12	20	17
45-64	301	316	292	229	187	250	249
65-79	921	1 465	988	879	689	999	1 033
80+	1 241	2 163	1 356	1 199	801	1 470	1 551
Total rate	272	313	287	255	147	262	324
Patients treated per 100 000 women in the age group							
0-44	24	6	23	8	14	16	15
45-64	198	142	182	178	124	147	158
65-79	601	890	655	596	442	614	660
80+	911	1 445	956	956	696	993	1 107
Total rate	237	219	259	246	118	231	300
Average length of stay per discharge	5.7	30.9	15.4	11.6	14.9	7.9	9.9

1 Average 2003-07
2 Average 2008-12
3 Only discharges with a length of stay less than 90 days

The table includes ICD-10: I60-I69

Source: The national in-patient registers

Table 3.4.9 Discharges, patients treated and average length of stay in hospital for chronic obstructive pulmonary disease and bronchiectasis, 2012

	Denmark	Faroe Islands[1]	Finland	Åland[2]	Iceland[3]	Norway	Sweden
Discharges							
Total	20 181	97	5 875	55	504	11 023	20 807
Patients treated							
Total	11 566	64	3 670	35	347	7 184	11 947
Per 100 000 in the age group							
0-4	74	341	2	-	0	12	2
5-14	2	8	1	-	2	4	1
15-24	4	3	1	-	2	3	2
25-64	93	57	31	56	41	62	34
65-74	598	478	228	418	525	567	357
75+	1 315	673	349	666	890	860	830
Total rate	207	132	68	123	108	143	126
Average length of stay	3.7	8.1	7.6	6.7	10.2	6.8	5.6

1 Average 2003-07
2 Average 2008-12
3 Only discharges with a length of stay less than 90 days

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

Source: The national in-patient registers

Table 3.4.10 Discharges, patients treated and average length of stay in hospital for asthma, 2012

	Denmark	Faroe Islands[1]	Finland	Åland[2]	Iceland[3]	Norway	Sweden
Discharges							
Total	6 549	106	3 541	17	72	3 354	5 152
Patients treated							
Total	5 066	82	2 868	15	63	2 869	4 185
Per 100 000 in the age group							
0-4	529	1 224	176	371	55	261	329
5-14	139	279	41	88	5	71	39
15-24	74	55	19	25	15	32	15
25-64	54	38	29	17	13	35	17
65-74	37	48	73	50	18	57	32
75+	45	121	164	90	110	69	71
Total rate	91	171	53	54	20	57	44
Average length of stay	1.8	3.0	5.5	3.3	3.2	5.6	2.4

1 Average 2003-07
2 Average 2008-12
3 Only discharges with a length of stay less than 90 days

The table includes ICD-10: J45-J46

Source: The national in-patient registers

Table 3.4.11 Discharges, patients treated and average length of stay in hospital for alcoholic liver disease, 2012

	Denmark	Faroe Islands[1]	Finland	Åland[2]	Iceland[3]	Norway	Sweden
Discharges							
Men, Total	1 912	3	1 502	3	12	530	1 414
Women, Total	809	2	634	1	13	252	545
Patients treated							
Men, Total	1 064	2	888	3	9	336	806
Women, Total	493	2	337	1	6	178	342
Patients treated per 100 000 men in the age group							
0-44	5	-	7	-	1	2	2
45-64	94	20	81	60	18	33	37
65+	67	34	44	8	5	28	38
Total rate	38	9	33	18	6	13	17
Patients treated per 100 000 women in the age group							
0-44	2	1	3	-	1	1	1
45-64	46	7	32	24	5	17	16
65+	25	28	11	7	14	14	13
Total rate	18	7	12	8	4	7	7
Average length of stay per discharge	6.8	5.5	7.4	15.9	12.4	7.5	7.5

1 Average 2003-07
2 Average 2008-12
3 Only discharges with a length of stay less than 90 days

The table includes ICD-10: K70

Source: The national in-patient registers

Table 3.4.12 Discharges, patients treated and average length of stay in hospital for other diseases of liver, 2012

	Denmark	Faroe Islands[1]	Finland	Åland[2]	Iceland[3]	Norway	Sweden
Discharges							
Men, Total	1 674	10	962	3	14	630	1 446
Women, Total	1 603	10	1 121	2	27	902	1 344
Patients treated							
Men, Total	1 052	6	621	2	10	478	971
Women, Total	1 073	8	777	2	19	647	932
Patients treated per 100 000 men in the age group							
0-44	12	14	9	10	3	7	7
45-64	67	27	38	20	5	31	29
65+	83	67	50	33	26	49	56
Total rate	38	23	23	15	6	19	20
Patients treated per 100 000 women in the age group							
0-44	13	10	12	11	2	10	8
45-64	60	71	40	19	18	36	26
65+	80	74	53	28	50	64	42
Total rate	38	34	28	17	12	26	20
Average length of stay per discharge	5.4	7.4	6.0	10.6	9.5	6.9	7.2

1 Average 2003-07
2 Average 2008-12
3 Only discharges with a length of stay less than 90 days

The table includes ICD-10: K71-77

Source: The national in-patient registers

Table 3.4.13 Discharges, patients treated and average length of stay in hospital for intervertebral disc disorders, 2012

	Denmark	Faroe Islands[1]	Finland	Åland[2]	Iceland[3]	Norway	Sweden
Discharges							
Men, Total	3 947	18	2 766	6	85	3 234	2 728
Women, Total	3 696	16	2 468	6	102	2 696	2 556
Patients treated							
Men, Total	3 273	15	2 385	5	76	2 742	2 171
Women, Total	3 110	11	2 033	5	93	2 291	2 017
Patients treated per 100 000 men in the age group							
0-24	8	4	12	-	2	9	5
25-44	169	111	150	66	57	139	65
45-64	204	80	133	50	88	196	79
65+	109	74	61	33	79	118	38
Total rate	118	60	89	35	47	109	46
Patients treated per 100 000 women in the age group							
0-24	9	2	9	-	2	11	6
25-44	158	62	125	51	79	135	70
45-64	185	101	113	43	114	153	64
65+	103	63	50	42	64	81	34
Total rate	110	49	74	33	58	92	42
Average length of stay per discharge							
Men	2.6	7.0	3.9	7.4	2.6	3.6	3.6
Women	3.5	8.6	4.1	7.1	3.2	3.8	4.1

1 Average 2003-07
2 Average 2008-12
3 Only discharges with a length of stay less than 90 days

The table includes ICD-10: M50-51

Source: The national in-patient registers

Table 3.4.14 Discharges, patients treated and average length of stay in hospital for fracture of femur, 2012

	Denmark	Faroe Islands[1]	Finland	Åland[2]	Iceland[3]	Norway	Sweden
Discharges							
Men, Total	4 086	43	3 506	17	187	3 541	8 178
Women, Total	8 022	70	7 124	29	352	7 647	16 453
Patients treated							
Men, Total	3 167	33	2 666	14	131	3 303	6 281
Women, Total	6 291	53	5 421	26	227	7 122	12 691
Patients treated per 100 000 men in the age group							
0-44	20	44	25	26	21	22	17
45-64	73	103	64	50	53	69	51
65-74	218	326	181	153	212	241	195
75-79	541	474	412	418	455	624	536
80+	1 519	1 682	1 168	1 060	1 384	2 065	1 889
Total rate	114	131	100	98	81	131	132
Patients treated per 100 000 women in the age group							
0-44	7	11	10	11	12	11	7
45-64	76	67	56	48	46	81	52
65-74	315	455	234	233	280	387	304
75-79	94	1 139	644	557	882	1 147	873
80+	2 582	2 782	1 937	1 747	2 719	3 384	2 849
Total rate	223	228	196	182	142	285	266
Average length of stay per discharge	6.4	12.8	10.5	11.8	12.2	6.6	9.0

1 Average 2003-07
2 Average 2008-12
3 Only discharges with a length of stay less than 90 days

The table includes ICD-10: S72

Source: The national in-patient registers

Figure 3.4.4 Average bed days at somatic wards, 2000-2012

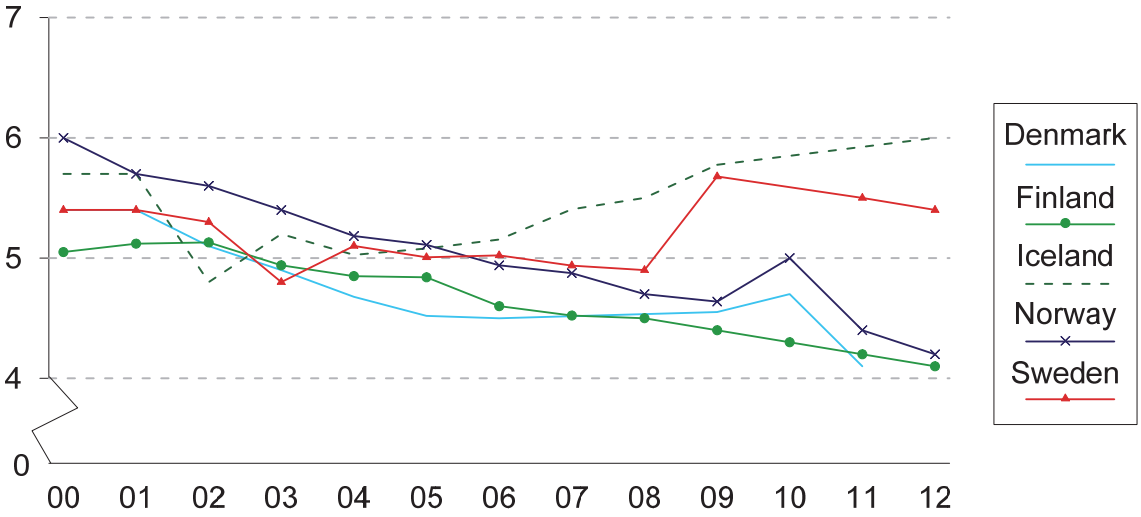


Figure 3.4.5 Discharges from somatic wards, per 1 000 inhabitants, 2000-2012

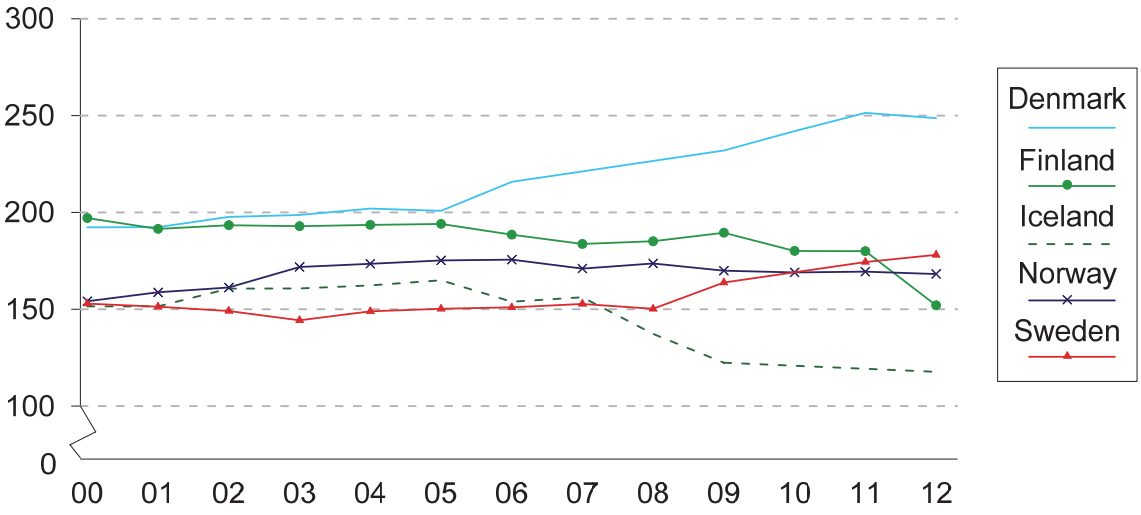


Table 3.4.15 Hospital treatments at psychiatric wards, by gender and age, 2012

	Denmark	Faroe Islands	Finland	Åland[1]	Iceland	Norway[1]	Sweden
Discharges, total	50 668	..	39 943	302.8	2 419	74 958	316 137
Discharges per 1 000 inhabitants	9.1	..	7.4	10.6	7.5	14.9	33.2
Total bed days	796 632	..	1 397 155	5 360	29 021	1 466 526	4 715 616
Bed days per 1 000 inhabitants	142.6	..	257.3	187.2	90.5	292.2	495.4
Treated patients, total	25 671	..	25 771	151.2	1 533	34 831	52 366
Treated patients, per 1 000							
Men							
0-14	0.4	..	2.2	0.1	1.7	0.8	0.2
15-29	6.0	..	6.2	8.6	6.9	9.3	7.0
30-44	7.2	..	6.4	6.0	7.2	10.5	7.2
45-64	5.8	..	5.1	8.6	5.0	8.3	8.3
65-79	3.0	..	3.3	4.1	2.9	4.3	4.7
80+	3.7	..	3.3	3.2	1.9	4.1	4.2
Total	4.7	..	4.7	5.7	4.9	7.0	5.8
Women							
0-14	0.6	..	1.6	0.1	0.8	0.7	0.4
15-29	6.8	..	7.8	8.4	7.3	10.1	8.2
30-44	5.8	..	5.3	5.0	5.6	8.8	6.3
45-64	5.0	..	4.8	5.7	5.6	7.9	6.2
65-79	3.6	..	4.3	5.5	4.0	5.2	4.3
80+	4.2	..	3.9	2.8	1.2	5.1	4.2
Total	4.5	..	4.8	4.8	4.7	6.7	5.2
Men and women							
0-14	0.5	..	1.9	0.1	1.2	0.8	0.3
15-29	6.4	..	7.0	8.5	7.1	9.7	7.6
30-44	6.5	..	5.9	5.5	6.4	9.7	6.7
45-64	5.4	..	4.9	7.1	5.3	8.1	7.2
65-79	3.3	..	3.8	4.8	3.5	4.8	4.5
80+	4.0	..	3.7	2.9	1.5	4.7	4.2
Total	4.6	..	4.7	5.3	4.8	6.9	5.5
Average length of stay per discharge	15.7	..	35.0	17.7	12.0	19.5	14.9

1 Figures for beds within mental health services, substance abuse treatment also. This includes both beds in hospitals and psychiatric centers (DPS)
2 Average 2008-12
Source: The national in-patient registers

Table 3.4.16 Discharges from hospitals[1] per 1 000 inhabitants, by gender and age, 2012

Age	Denmark	Faroe Islands[2]	Finland	Åland[3]	Iceland[4]	Norway	Sweden
Men							
0-14	211	233	83	82	63	89	132
15-44	111	104	58	45	29	72	63
45-64	241	249	145	111	87	168	147
65-69	420	485	270	227	226	327	273
70-74	530	557	356	312	278	420	371
75-79	684	638	461	367	387	521	491
80+	938	760	603	636	563	721	782
Total	242	227	141	125	88	155	164
Women							
0-14	186	205	65	70	54	74	121
15-44	217	262	137	133	128	157	151
45-64	217	215	125	119	100	150	130
65-69	322	345	201	185	198	256	217
70-74	423	482	266	274	282	324	295
75-79	553	536	344	332	381	407	398
80+	753	556	478	561	488	560	632
Total	267	272	163	165	135	182	193

1 Includes somatic wards at regular hospitals and at somatic special hospitals
2 Average 2007-11
3 Average 2008-12
4 Only discharges with a length of stay less than 90 days
Source: The national in-patient registers

Table 3.4.17 Bed days at hospitals[1] per 1 000 inhabitants, by gender and age, 2012

Age	Denmark	Faroe Islands[2]	Finland	Åland[3]	Iceland[4]	Norway	Sweden
Men							
0-14	499	626	432	331	210	317	786
15-44	529	514	408	209	115	226	369
45-64	1 002	1 050	901	610	494	697	752
65-69	567	555	513	1 461	279	1 597	1 362
70-74	2 258	2 469	2 509	1 876	2138	2 173	1 966
75-79	3 019	3 268	3 356	2 428	3570	2 773	2 767
80+	4 215	4 436	6 170	4 599	6257	3 888	4 861
Total	977	998	989	728	595	672	918
Women							
0-14	467	618	329	267	192	275	732
15-44	712	896	705	599	314	482	548
45-64	860	1 229	709	638	520	619	642
65-69	1 340	2 330	1 355	1 082	1354	1 224	1 124
70-74	1 858	3 639	1 856	1 714	2134	1 632	1 606
75-79	2 554	5 458	2 867	2 119	3368	2 119	2 378
80+	3 588	7 126	6 286	3 837	5543	2 891	4 213
Total	1 011	1 508	1 188	910	735	741	990

1 Includes somatic wards at regular hospitals and at somatic special hospitals
2 2006
3 Average 2008-12
4 Only discharges with a length of stay less than 90 days
Source: The national in-patient registers

3.5 Surgical Procedures

A new list of procedures

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

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

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

Outline of this section

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

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

Quality and limitations of the data

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

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

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

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

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

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

Table 3.5.1a Surgical procedures performed on in-patients per 100 000 inhabitants by list of selected procedures. Men[1]

Surgical procedures (NCSP-E codes in brackets)	Denmark	Faroe Islands	Finland	Åland	Iceland	Norway	Sweden
	2012	2007-11	2012	2008-12	2009	2012	2012
1: Extirpation, excision and destruction of intra-cranial lesion (AAB00-AAB20, AAB99)	21.1	..	19.8	9.8	17.3	19.7	15.1
2: Evacuation of subdural haematoma and intra-cranial haemorrhage (AAB30, AAD05-AAD15)	21.5	..	37.3	44.9	12.4	21.8	22.1
3: Discectomy (ABC)	160.3	..	141.3	81.4	193.8	143.7	74.5
4: Thyroidectomy (BAA20-BAA60)	17.3	..	15.9	4.2	9.3	12.1	10.6
5: Cataract surgery (CJC, CJD, CJE, CJF)	12.8	..	15.4	22.5	11.8	16.1	17.7
6: Cochlear implantation (DFE00)	5.5	..	2.4	1.4	0.6	1.1	2.6
7: Tonsillectomy (EMB10-EMB20)	76.5	..	53.2	123.5	47.0	79.8	46.7
8: Pulmectomy (GDB20-21, GDC, GDD)	16.5	..	10.6	5.6	14.2	11.9	7.8
9: Diagnostic bronchoscopy with or without biopsy (UGC)	99.6	..	57.5	30.9	61.9	105.1	51.3
10: Transluminal coronary angioplasty (FNG02, FNG05)	204.3	..	233.8	12.6	290.9	332.7	264.8
11: Coronary artery bypass graft (FNC, FND, FNE)	54.1	..	64.7	1.4	96.6	75.8	64.7
12: Carotid endarterectomy (PAF20-PAF22)	11.3	..	15.2	4.2	9.9	13.1	15.6
13: Infrarenal aortic aneurysm repair (PDG10-PDG24, PDQ10)	22.8	..	17.3	7.0	12.4	23.3	15.2
14: Femoropopliteal bypass (PEH)	8.8	..	13.5	19.6	2.5	7.9	5.7
15: Stem cell transplantation (not included[2)])	8.7	..	5.5	-	-	-	0.0
16: Colonoscopy with or without biopsy (JFA15, UJF32, UJF35, UJF42, UJF45)	278.0	..	54.8	50.5	180.8	-	124.3
17: Colectomy (JFB20-JFB64, JFH)	76.0	..	59.5	63.2	48.9	-	123.7
Of which: 17A: Laparoscopic colectomy (JFB21, JFB31, JFB34, JFB41, JFB44, JFB47, JFB51, JFB61, JFB64, JFH01, JFH11)	27.5	..	16.0	1.4	11.8	-	2.9

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

The table continues

Table 3.5.1a Surgical procedures performed on in-patients per 100 000 inhabitants by list of selected procedures. Men. Continued [1]

Surgical procedures (NCSP-E codes in brackets)	Denmark	Faroe Islands	Finland	Åland	Iceland	Norway	Sweden
	2012	2007-11	2012	2008-12	2009	2012	2012
18: Appendectomy (JEA)	105.9	..	132.2	144.6	154.8	125.2	122.8
Of which:							
18A: Laparoscopic appendectomy (JEA01)	90.2	..	31.2	4.2	65.0	97.7	31.9
19: Cholecystectomy (JKA20. JKA21)	51.5	..	90.3	99.7	93.5	43.6	80.3
Of which:							
19A: Laparoscopic cholecystectomy (JKA21)	40.3	..	67.6	66.0	87.3	37.2	54.9
20: Repair of inguinal hernia (JAB)	74.0	..	142.4	148.8	50.1	77.2	78.4
Of which:							
20: Laparoscopic repair of inguinal hernia (JAB11. JAB97)	25.0	..	19.2	16.8	5.0	21.3	7.8
21: Transplantation of kidney (KAS00-KAS20)	4.7	..	4.8	5.6	1.9	7.6	5.0
22: Open prostatectomy (KEC. KED00. KED96)	39.7	..	41.5	74.4	37.8	73.9	61.4
23: Transurethral prostatectomy (KED22. KED52-KED72. KED98)	92.3	..	134.9	178.3	103.4	143.1	122.7
24: Hysterectomy (LCC. LCD)	-	..	0.7	-	.	0.4	-
Of which:							
24A: Laparocopic hysterectomy (LCC01. LCC11. LCC97. LCD01. LCD04. LCD11. LCD31. LCD40. LCD97)	.	.	.	.	.	.	.
25: Caesarean section (MCA)	.	.	.	.	.	.	.
26: Arthroscopic excision of meniscus of knee (NGD01. NGD11)	9.6	..	25.7	16.8	0.6	20.3	5.5
27: Hip replacement (NFB. NFC)	179.8	..	191.0	178.3	133.7	169.6	166.5
Of which:							
27A: Secondary hip replacement (NFC)	24.2	..	26.2	19.6	15.5	21.3	19.8
28: Total knee re-placement (NGB20-NGB40)	105.7	..	138.1	96.8	69.9	67.6	90.6
29: Partial excision of mammary gland (HAB00. HAB30. HAB40. HAB99)	0.3	..	0.7	-	1.2	0.2	0.4
30: Total mastectomy (HAC10-HAC25. HAC99)	4.4	..	2.2	1.4	3.1	2.4	1.9

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

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

Source: The national in-patient registers

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

Surgical procedures (NCSP-E codes in brackets)	Denmark	Faroe Islands	Finland	Åland	Iceland	Norway	Sweden
	2012	2007-11	2012	2008-12	2009	2012	2012
1: Extirpation, excision and destruction of intra-cranial lesion (AAB00-AAB20, AAB99)	20.5	..	24.2	15.3	14.6	20.1	16.9
2: Evacuation of subdural haematoma and intra-cranial haemorrhage (AAB30, AAD05-AAD15)	9.3	..	15.1	9.7	3.2	9.4	9.2
3: Discectomy (ABC)	154.8	..	125.9	105.6	165.5	134.3	72.7
4: Thyroidectomy (BAA20-BAA60)	57.8	..	67.9	77.8	60.2	49.9	45.4
5: Cataract surgery (CJC, CJD, CJE, CJF)	13.7		18.7	75.1	6.3	16.8	18.4
6: Cochlear implantation (DFE00)	5.7	..	3.3	1.4	0.0	1.9	2.9
7: Tonsillectomy (EMB10-EMB20)	84.1	..	47.0	134.8	53.3	82.4	50.3
8: Pulmectomy (GDB20-21, GDC, GDD)	17.7		6.6	2.8	15.9	10.2	8.6
9: Diagnostic bronchoscopy with or without biopsy (UGC)	65.1	..	32.3	12.5	64.0	73.2	36.8
10: Transluminal coronary angioplasty (FNG02, FNG05)	72.4	..	93.2	2.8	102.7	107.3	95.2
11: Coronary artery bypass graft (FNC, FND, FNE)	12.2	..	17.7	-	16.5	17.5	15.9
12: Carotid endarterectomy (PAF20-PAF22)	6.0	..	6.1	6.9	3.2	5.8	7.3
13: Infrarenal aortic aneurysm repair (PDG10-PDG24, PDQ10)	5.2	..	2.3	2.8	2.5	6.3	4.2
14: Femoropopliteal bypass (PEH)	7.1	..	10.3	18.1	1.9	3.7	4.3
15: Stem cell transplantation (not included[2)])	4.4	..	4.3	-	-	-	0.0
16: Colonoscopy with or without biopsy (JFA15, UJF32, UJF35, UJF42, UJF45)	282.5	..	58.1	61.2	249.2	203.2	140.3
17: Colectomy (JFB20-JFB64, JFH)	84.2	..	68.6	75.1	57.1	87.8	143.6
Of which:							
17A: Laparoscopic colectomy (JFB21, JFB31, JFB34, JFB41, JFB44, JFB47, JFB51, JFB61, JFB64, JFH01, JFH11)	31.1	..	23.3	-	12.0	27.1	3.7

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

The table continues

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

Surgical procedures (NCSP-E codes in brackets)	Denmark	Faroe Islands	Finland	Åland	Iceland	Norway	Sweden
	2012	2007-11	2012	2008-12	2009	2012	2012
18: Appendectomy (JEA)	108.8	..	128.5	111.2	137.6	121.8	113.4
Of which:		..					
18A: Laparoscopic appendectomy (JEA01)	86.2	..	61.8	32.0	82.4	94.4	42.8
19: Cholecystectomy (JKA20. JKA21)	93.0	..	138.6	171.0	253.6	91.2	147.9
Of which:		..					
19A: Laparoscopic cholecystectomy (JKA21)	82.0	..	121.2	152.9	244.8	84.6	120.1
20: Repair of inguinal hernia (JAB)	12.5	..	19.3	15.3	3.2	10.4	10.2
Of which:		..					
20: Laparoscopic repair of inguinal hernia (JAB11. JAB97)	7.3	..	3.3	1.4	0.6	2.4	1.6
21: Transplantation of kidney (KAS00-KAS20)	2.9	..	2.4	1.4	2.5	4.4	3.0
22: Open prostatectomy (KEC. KED00. KED96)	.	.	.	.	.	.	.
23: Transurethral prostatectmy (KED22. KED52-KED72. KED98)	.	.	.	.	.	.	.
24: Hysterectomy (LCC. LCD)	189.1	..	195.7	344.7	276.5	175.0	177.9
Of which:		..					
24A: Laparocopic hysterectomy (LCC01. LCC11. LCC97. LCD01. LCD04. LCD11. LCD31. LCD40. LCD97)	65.8	..	93.0	16.7	43.1	61.1	13.6
25: Caesarean section (MCA)	430.9	..	342.8	479.5	502.2	396.6	408.2
26: Arthroscopic excision of meniscus of knee (NGD01. NGD11)	8.4	..	19.7	27.8	1.3	14.8	4.3
27: Hip replacement (NFB. NFC)	266.1		280.2	239.1	212.4	330.4	251.2
Of which:		..					
27A: Secondary hip replacement (NFC)	31.3	..	38.8	27.8	18.4	32.7	23.1
28: Total knee re-placement (NGB20-NGB40)	156.9	..	241.2	155.7	112.9	111.2	129.1
29: Partial excision of mammary gland (HAB00. HAB30. HAB40. HAB99)	80.5	..	89.4	33.4	95.1	65.0	79.8
30: Total mastectomy (HAC10-HAC25. HAC99)	68.5	..	89.9	125.1	76.7	63.8	54.6

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

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

Source: The national in-patient registers

Table 3.5.1 shows the rates per 100 000 inhabitants for men and women for all surgical procedures on the new list. However, it only covers hospitalized patients and therefore does not show a complete picture of the surgical procedures, which are often performed on an outpatient bases, e.g. cataract surgeries, colonoscopy and hernia surgeries. Several of the more common surgical procedures, which are performed on inpatients, tend to show almost the same rates in all countries (with the exception of Åland, which has a low number of inhabitants). These are for instance transluminal coronary angioplasty and hysterectomies. The difference between the genders are already known in all the countries, where the number for men are higher for heart surgery and hernia operations, and higher for women for thyroidectomy, cholecystectomy and deployment of joint replacement of the hip joint. The low rates for decompression of bone marrow and nerve roots in Sweden are to some degree due to lack of reporting from three private special hospitals. Strikingly high rates are seen for male hernia operations in Finland and for cholecystectomy for women in Iceland.

The tendency seen in figure 3.5.1, shows increased rates for percutaneous transluminal coronary angioplasty (PTCA) and slightly decreased rates for coronary anastomosis operations for the period 2003-2009. In general, the countries maintain their relative position over time. The HDP2 list defines coronary anastomosis operations a little less wide than NOMESCO's earlier statistical data, but it does not explain the lower rates for 2008 and 2009.

Table 3.5.2 Eight surgical procedures often carried out as day surgery; total rate and day surgery rate per 100 000 inhabitants and day surgery as per cent of all procedures by gender 2012[1]

	Denmark		Finland		Norway		Sweden	
	M	W	M	W	M	W	M	W
Cataract surgery (CJC. CJD. CJE. CJF)								
Total rate per 100 000 population	707.8	1 008.9	579.9	884.7	355.0	522.6	497.8	755.9
Of which day surgery	695.0	995.2	564.4	865.9	338.9	505.8	480.1	737.5
Day surgery as per cent of total	98.2	98.6	97.3	97.9	95.5	96.8	96.4	97.6
Tonsillectomy (EMB10-20)								
Total rate per 100 000 population	106.3	133.5	166.5	176.1	154.4	177.0	78.6	88.0
Of which day surgery	29.7	49.4	113.4	129.1	74.6	94.6	31.9	37.7
Day surgery as per cent of total	28.0	37.0	68.1	73.3	48.3	53.5	40.6	42.8
Diagnostic bronchoscopy with or without biopsy (UGC)								
Total rate per 100 000 population	273.1	211.6	60.3	33.6	184.1	137.2	127.2	101.1
Of which day surgery	173.5	146.5	2.8	1.2	79.0	64.0	75.9	64.3
Day surgery as per cent of total	63.5	69.2	4.6	3.7	42.9	46.7	59.7	63.6
Colonoscopy with or without biopsy (JFA15. UJF32. UJF35. UJF42. UJF45)								
Total rate per 100 000 population	1 792.7	1 956.3	61.6	69.3	1 121.8	1 317.5	804.4	913.8
Of which day surgery	1 514.7	1 673.8	6.7	11.3	936.5	1 114.3	680.1	773.5
Day surgery as per cent of total	84.5	85.6	11.0	16.2	83.5	84.6	84.5	84.6
Laparoscopic cholecystectomy (JKA 21)								
Total rate per 100 000 population	75.3	181.5	86.8	180.7	51.7	128.7	68.2	151.9
Of which day surgery	35.1	99.5	19.2	59.5	14.5	44.1	13.3	31.8
Day surgery as per cent of total	46.6	54.8	22.1	32.9	28.1	34.3	19.4	20.9
Repair of inguinal hernia (JAB)								
Total rate per 100 000 population	343.8	37.5	372.7	42.7	245.1	29.4	300.0	30.6
Of which day surgery	269.8	25.0	230.3	23.5	168.0	19.0	221.6	20.4
Day surgery as per cent of total	78.5	66.6	61.8	55.0	68.5	64.5	73.9	66.6
Arthroscopic excision of meniscus of knee (NGD01. NGD11)								
Total rate per 100 000 population	336.2	227.3	272.0	173.3	301.1	207.3	147.9	82.6
Of which day surgery	326.6	218.9	246.3	153.6	280.7	192.5	142.4	78.3
Day surgery as per cent of total	97.2	96.3	90.5	88.7	93.2	92.9	96.3	94.8
Excision of mammary gland (women only) (HAB)								
Total per 100 000 Women	2.5	192.1	2.4	130.3	2.5	136.1	2.7	138.2
Of which day surgery	2.2	111.6	1.7	40.9	2.3	71.0	2.3	58.4
Day surgery as per cent of total	87.1	58.1	70.3	31.4	90.5	52.2	85.7	42.2

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

Source: The national in-patient registers

Of the surgical procedures in table 3.5.2, cataract surgery shows the highest percentage of day surgery in all the countries (96-98 percent). The difference in the total rates per inhabitants for cataract surgeries is mainly due to lack of reporting in all the countries. There are definition problems regarding day surgery and problems with reporting form private hospitals and clinics. This is illustrated in the numbers from Sweden, where the number of cataract surgeries in the in-patients register in

2008 make up only 82 percent of the actual number according to numbers from the national in-patient register specifically for cataract surgeries.

Tonsillectomy is performed as day surgery to various extents and with different total per capita, which is interesting in connection to clinical controversy about the indications for this surgery as well as the need for follow-up after the operation. The very low Finnish per capita numbers for bronchoscopy and colonoscopy are because these procedures do not have to be nationally reported. The number of day surgeries varies a great deal from country to country with higher rates in Denmark for laparoscopic cholecystectomy and with lower rates in Finland for hernia surgery. Norway and Sweden show higher rates of day surgery when it comes to partial breast resection.

Table 3.5.3 Share of laparoscopic procedures and secondary hip replacements on in-patients by gender, 2012

Procedure	Denmark		Finland		Åland[1]		Iceland[2]		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W
Per cent laparoscopic												
Colectomy	36	37	27	34	2	0	24	21	14	13	2	3
Appendectomy	85	79	24	48	3	29	42	60	25	38	26	38
Cholecystectomy	78	88	75	87	66	89	93	97	100	0	68	81
Repair of inguinal hernia	34	59	13	17	11	9	10	20	11	23	10	16
Hysterectomy	.	35	.	48	.	5	.	16	.	14	.	8
Per cent secondary												
Hip replacement	13	12	14	14	11	12	12	9	88	6	12	9

1 Average 2008-12
2 2009
Source: The national in-patient registers

The use of laparoscopic methods is shown in table 3.5.3. Laparoscopic cholecystectomy is very common in all the countries, and almost all cholecystectomies in Iceland are laparoscopic. Finland has the highest rate of laparoscopic colectomy and hysterectomy, but the lowest rate of laparoscopic appendectomy, whereas Sweden has low percentages for these procedures. Such divergences require a closer examination and further consideration as to why this relatively new surgical method has been performed so differently in the Nordic countries. Naturally, it will be most interesting to follow the progress over time. Furthermore, table 3.5.3 shows that the numbers for secondary hip replacement are the same for all the countries. It should be noted that the secondary hip replacements, which are reported here, are not secondary to the primary hip replacements performed in 2009, but mostly secondary to those surgeries performed many year before.

The detailed tables 3.5.4–3.5.17 comprise both surgeries on inpatients and day surgery, which explains the higher rates reported here, compared to the per capita numbers shown in table 3.5.1, which only comprises surgery on inpatients.

Table 3.5.4 Discectomy by gender and age, 2012

	Denmark		Faroe Islands		Finland		Åland[1]		Iceland		Norway		Sweden	
Age	M	W	M	W	M	W	M	W	M	W	M	W	M	W
Total number of procedures														
<15	3	1	..	..	3	6	-	-	..	..	4	2	-	6
15-24	69	51	..	..	104	65	-	-	..	..	87	73	51	70
25-44	1 070	856	..	..	1 059	731	3	3	..	..	1 020	879	876	746
45-64	2 054	1 789	..	..	1 676	1 403	4	6	..	..	1 613	1 375	1 400	1 278
65+	1 415	1 747	..	..	1 080	1 390	4	7	..	..	1 077	1 177	1 258	1 428
Total	4 611	4 444	..	..	3 922	3 595	12	15	..	..	3 801	3 506	3 629	3 528
Per 100 000 in the age group														
<15	1	-	..	..	1	1	-	-	..	..	1	0	0	1
15-24	19	15	..	..	31	20	-	-	..	..	26	23	8	12
25-44	150	122	..	..	153	111	87	84	..	..	144	131	70	62
45-64	274	240	..	..	221	183	105	135	..	..	248	221	115	107
65+	318	323	..	..	254	240	173	229	..	..	311	272	164	151
Total	762	699	..	..	147	130	81	106	..	..	151	140	78	75

1 Average 2008-12

NCSP: ABC

Source: The national in-patient registers

Table 3.5.5 Thyroidectomy by gender and age, 2012

	Denmark		Finland		Åland[1]		Iceland		Norway		Sweden	
Age	M	W	M	W	M	W	M	W	M	W	M	W
Total number of procedures												
<15	5	8	-	4	-	-	..	..	0	6	7	23
15-24	10	43	14	68	-	-	..	..	8	49	15	148
25-44	107	441	88	482	-	4	..	..	78	407	115	692
45-54	123	453	75	366	-	2	..	..	66	300	88	438
55-64	116	350	125	481	-	4	..	..	57	260	115	416
65-74	97	239	90	315	-	1	..	..	72	181	107	286
75-84	24	98	32	167	-	-	..	..	26	63	39	169
85+	3	18	2	23	-	-	..	..	2	5	7	24
Total	485	1 650	426	1 906	1	11	..	..	309	1 271	504	2 196
Per 100 000 in the age group												
< 15	1	2	-	1	-	-	..	..	0	1	0	3
15-24	3	12	4	21	-	-	..	..	2	15	2	24
25-44	15	63	13	73	5	107	..	..	11	60	9	58
45-54	31	115	20	99	-	99	..	..	19	91	14	73
55-64	33	100	33	122	10	170	..	..	19	89	19	70
65-74	34	79	35	107	14	102	..	..	35	83	24	61
75-84	19	60	24	85	-	42	..	..	25	46	17	54
85+	8	23	6	26	-	-	..	..	6	6	8	14
Total	18	59	16	69	4	78	..	..	12	51	11	47

1 Average 2008-12

NCSP: BAA 20-60

Source: The national in-patient registers

Table 3.5.6 Cataract surgery by gender and age, 2012

Age	Denmark		Faroe Islands		Finland		Åland[1]		Iceland		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W	M	W
Total number of procedures														
< 45	326	291	..	..	245	197	-	-	..	..	213	172	382	463
45-64	3 561	4 088	..	..	2 925	3 131	1	1	..	..	1 366	1 615	4 013	4 586
65-74	6 857	10 145	..	..	4 934	7 798	1	2	..	..	2 521	3 528	7 068	10 457
75-84	6 962	10 685	..	..	5 905	10 475	2	4	..	..	3 382	5 415	8 653	14 889
85+	1 908	3 201	..	..	1 461	2 841	1	4	..	..	1 454	2 342	2 994	5 196
Total	19 614	28 410	..	..	15 470	24 442	6	11	..	..	8 936	13 072	23 247	35 591
Per 100 000 in the age group														
< 45	21	19	..	..	16	14	3	5	..	..	14	12	14	18
45-64	475	548	..	..	386	409	25	24	..	..	210	259	331	383
65-74	2 420	3 372	..	..	1 906	2 658	84	145	..	..	1 209	1 612	1 579	2 239
75-84	5 558	6 565	..	..	4 498	5 307	321	466	..	..	3 303	3 981	3 665	4 751
85+	5 300	4 103	..	..	4 254	3 178	323	636	..	..	4 040	3 018	3 613	3 115
Total	708	1 009	..	..	580	885	39	79	..	..	355	523	498	756

1 Average 2008-12

NCSP: CJC. CJD. CJE. CJF

Source: The national in-patient registers

Table 3.5.7.a Transluminal coronary angioplasty (PTCA, PCI) by age, Men 2012

Age	Denmark	Faroe Islands	Finland	Iceland	Norway	Sweden
Total number of procedures						
<45	307	..	204	..	350	347
45-54	1 219	..	877	..	1 408	1 574
55-64	1 941	..	1 891	..	2 614	3 726
65-74	2 304	..	1 933	..	2 685	4 142
75-84	1 201	..	1 274	..	1 442	2 552
85+	204	..	244	..	276	408
Total	7 176	..	6 423	..	8 775	12 756
Per 100 000 in the age group						
<45	19	..	14	..	23	13
45-54	303	..	233	..	402	255
55-64	560	..	495	..	872	624
65-74	813	..	747	..	1 288	925
75-84	959	..	971	..	1 408	1 081
85+	567	..	711	..	767	492
Total	259	..	241	..	349	273

NCSP: FNG 02; FNG 05
Source: The national in-patient registers

Table 3.5.7.b Transluminal coronary angioplasty (PTCA, PCI) by age, Women 2012

Age	Denmark	Faroe Islands	Finland	Iceland	Norway	Sweden
Total number of procedures						
<45	90	..	51	..	65	77
45-54	292	..	173	..	272	363
55-64	531	..	475	..	595	940
65-74	747	..	783	..	880	1 434
75-84	746	..	927	..	770	1 438
85+	201	..	241	..	222	344
Total	2 607	..	2 650	..	2 804	4 596
Per 100 000 in the age group						
<45	6	..	4	..	4	3
45-54	74	..	47	..	82	61
55-64	151	..	121	..	203	158
65-74	248	..	267	..	402	307
75-84	458	..	470	..	566	459
85+	258	..	270	..	286	206
Total	93	..	96	..	112	98

NCSP: FNG 02; FNG 05
Source: The national in-patient registers

Table 3.5.7 show that the highest rates for PTCA are to be found for both men and women in the age 75-84 years for all countries.

Table 3.5.8.a Coronary artery bypass graft by age. Men 2012

Age	Denmark	Faroe Islands	Finland	Iceland	Norway	Sweden
Total number of procedures						
<45	17	..	12	..	22	39
45-54	123	..	131	..	178	224
55-64	394	..	472	..	551	811
65-74	601	..	708	..	756	1 199
75-84	346	..	389	..	382	728
85+	19	..	15	..	19	30
Total	1 500	..	1 727	..	1 908	3 031
Per 100 000 in the age group						
<45	1	..	1	..	1	14
45-54	31	..	35	..	51	36
55-64	114	..	124	..	184	136
65-74	212	..	273	..	363	268
75-84	276	..	296	..	373	308
85+	53	..	44	..	53	36
Total	54	..	65	..	76	65

NCSP: FNC. FND. FNE
Source: The national in-patient registers

Table 3.5.8.b Coronary artery bypass graft by age, women 2012

Age	Denmark	Faroe Islands	Finland	Iceland	Norway	Sweden
Total number of procedures						
<45	6	..	7	..	6	9
45-54	27	..	16	..	27	40
55-64	63	..	80	..	86	143
65-74	124	..	159	..	168	270
75-84	115	..	207	..	131	276
85+	8	..	20	..	19	14
Total	343	..	489	..	437	752
Per 100 000 in the age group						
<45	0	..	-	..	0	0
45-54	7	..	-	..	8	7
55-64	18	..	20	..	29	24
65-74	41	..	54	..	77	58
75-84	71	..	105	..	96	88
85+	10	..	22	..	24	8
Total	12	..	18	..	17	16

NCSP: FNC. FND. FNE
Source: The national in-patient registers

The rates for coronary artery bypass graft, in table 3.5.8, are almost the same for 65-74-year-old and 75-84-year-old men and slightly higher for 75-84-year-old women.

Table 3.5.9.a Appendectomy by age, men 2012

Age	Denmark	Faroe Islands	Finland	Åland[1]	Iceland	Norway	Sweden
Total number of procedures							
<15	663	..	386	4	..	444	45
15-24	771	..	711	5	..	795	680
25-44	883	..	1 224	6	..	918	1 731
45-64	558	..	882	4	..	585	1 021
65+	326	..	340	1	..	314	575
Total	3 201	..	3 543	21	..	3 211	5 849
Per 100 000 in the age group		..			..		
<15	132		85	179		94	6
15-24	213	..	210	285	..	235	106
25-44	124	..	177	170	..	130	138
45-64	74	..	116	100	..	90	84
65+	73	..	80	58	..	91	75
Total	116	..	133	146	..	128	125

1 Average 2008-12

NCSP: JEA

Source: The national in-patient registers

Table 3.5.9.b Appendectomy by age, women 2012

Age	Denmark	Faroe Islands	Finland	Åland[1]	Iceland	Norway	Sweden
Total number of procedures							
<15	464	..	261	3	..	338	689
15-24	836	..	824	4	..	785	1 219
25-44	914	..	1 139	5	..	930	1 550
45-64	652	..	962	2	..	672	1 293
65+	475	..	386	2	..	374	716
Total	3 341	..	3 572	16	..	3 099	5 467
Per 100 000 in the age group		..			..		
<15	97		60	132		75	91
15-24	242	..	254	263	..	244	201
25-44	130	..	173	152	..	138	129
45-64	87	..	126	43	..	108	108
65+	88	..	67	62	..	86	76
Total	119	..	129	111	..	124	116

1 Average 2008-12

NCSP: JEA

Source: The national in-patient registers

The slightly higher total rates in table 3.5.9 in Iceland for appendectomy are most likely to be explained by the higher surgery rates in the youngest age group.

Table 3.5.10.a Cholecystectomy by age, men 2012

Age	Denmark	Faroe Islands	Finland	Åland[1]	Iceland	Norway	Sweden
Total number of procedures							
<25	78	..	56	-	..	49	164
25-44	604	..	477	3	..	388	1 064
45-64	1 024	..	1 186	7	..	577	1 784
65+	719	..	1 207	4	..	454	1 376
Total	2 425	..	2 926	14	..	1 468	4 388
Per 100 000 in the age group		..			..		
<25	9	..	7	5	..	6	11
25-44	85		69	71		55	85
45-64	137	..	156	174	..	89	147
65+	162	..	284	181	..	131	179
Total	88	..	110	100	..	58	94

1 Average 2008-12

NCSP: JKA 20-21

Source: The national in-patient registers

Table 3.5.10.b Cholecystectomy by age, women 2012

Age	Denmark	Faroe Islands	Finland	Åland[1]	Iceland	Norway	Sweden
Total number of procedures							
<25	400	..	263	2	..	262	626
25-44	2 085	..	1 510	9	..	1 209	3 042
45-64	1 968	..	2 262	10	..	1 299	3 154
65+	998	..	1 463	4	..	620	1 693
Total	5 451	..	5 498	25	..	3 390	8 515
Per 100 000 in the age group		..			..		
<25	48	..	35	42	..	34	46
25-44	296		230	248		90	254
45-64	264	..	296	236	..	209	264
65+	184	..	252	152	..	143	179
Total	194	..	199	171	..	136	181

1 Average 2008-12

NCSP: JKA 20-21

Source: The national in-patient registers

Table 3.5.10 shows the highest rates for cholecystectomy for men in the age of 65+, while the rates are higher for women in the age of 45-64 and in Denmark already in the age of 25-44.

Table 3.5.11 Transplantation of kidney by gender and age, 2012

	Denmark		Finland		Åland[1]		Iceland		Norway		Sweden	
Age	M	W	M	W	M	W	M	W	M	W	M	W
Total number of procedures												
<15	2	1	3	4	-	-	..	..	4	5	47	5
15-24	10	8	5	2	-	-	..	..	4	3	12	10
25-44	33	25	29	17	-	-	..	..	41	23	70	46
45-54	43	17	31	12	0	-	..	..	33	19	54	29
55-64	29	25	42	19	-	0	..	..	62	33	58	37
65+	15	7	19	11	0	-	..	..	50	29	33	14
Total	132	83	129	65	1	0	..	..	194	112	274	141
Per 100 000 in the age group												
< 15	-	-	1	1	-	-	..	..	1	1	5	1
15-24	3	2	1	1	-	-	..	..	1	1	2	2
25-44	5	4	4	3	-	-	..	..	6	3	6	4
45-54	11	4	8	3	20	-	..	..	9	6	9	5
55-64	8	7	11	5	-	9	..	..	21	11	10	6
65+	3	1	4	2	17	-	..	..	14	7	4	1
Total	5	3	5	2	6	1	..	..	8	4	6	3

1 Average 2008-12

NCSP: KAS00-KAS20

Source: The national in-patient registers

As shown in table 3.5.11, kidney transplants are performed in almost all of the countries more often on men than women. Apparently, this also applies to all age groups. If this reflects differences in morbidity among men and women or is a possible effect of gender discrimination should be addressed.

Table 3.5.12 Open prostatectomy by age, men 2012

Age	Denmark	Faroe Islands	Finland	Åland[1]	Iceland	Norway	Sweden
Total number of procedures							
<45	1	..	4	-	..	5	12
45-64	535	..	662	7	..	1 023	1 380
65-74	553	..	428	3	..	1 054	1 381
75-84	18	..	12	-	..	60	89
85+	2	..	-	-	..	5	5
Total	1 109	..	1 106	11	..	2 147	2 868
Per 100 000 in the age group							
<45	-	..	-	-	..	-	-
45-64	71	..	87	179	..	158	114
65-74	195	..	165	237	..	506	308
75-84	14	..	9	-	..	59	38
85+	6	..	-	-	..	14	6
Total	40	..	41	74	..	85	61

1 Average 2008-12

NCSP: KEC; KED 00; KED96

Source: The national in-patient registers

Table 3.5.12 shows that open prostatectomy is most common in the age of 65-74.

Table 3.5.13 Transurethral prostatectomy by age, men 2012

Age	Denmark	Faroe Islands	Finland	Åland[1]	Iceland	Norway	Sweden
Total number of procedures							
<45	16	..	3	-	..	9	8
45-64	679	..	862	6	..	768	1 145
65-74	1 252	..	1 481	10	..	1 407	2 308
75-84	826	..	1 150	8	..	1 173	2 043
85+	162	..	261	2	..	339	491
Total	2 935	..	3 757	25	..	3 696	5 995
Per 100 000 in the age group							
<45	1	..	-	-	..	1	-
45-64	91	..	114	154	..	118	94
65-74	442	..	572	669	..	675	516
75-84	659	..	876	1 042	..	1 145	865
85+	450	..	760	726	..	942	592
Total	106	..	141	178	..	147	128

1 Average 2008-12

NCSP: KED 22; KED52-KED 72; KED98

Source: The national in-patient registers

Table 3.5.13 shows that transurethral prostatectomy has the highest rates for the two oldest age groups.

Table 3.5.14 Hysterectomy by age, women 2012

Age	Denmark	Faroe Islands	Finland	Åland[1]	Iceland	Norway	Sweden
Total number of procedures							
<25	11	..	7	-	..	6	30
25-44	1 684	..	1 271	12	..	1 414	2 030
45-64	3 082	..	3 114	28	..	2 361	4 220
65+	1 322	..	1 104	10	..	882	2 215
Total	6 099	..	5 496	50	..	4 663	8 495
Per 100 000 in the age group		..			..		
<25	1		1	5		1	2
25-44	239	..	193	326	..	210	169
45-64	413	..	407	684	..	379	353
65+	244	..	190	340	..	204	234
Total	217	..	199	347	..	186	180

1 Average 2008-12

NCSP: LCC; LCD

Source: The national in-patient registers

Table 3.5.15 Caesarean section by age, women 2012

Age	Denmark	Faroe Islands	Finland	Åland[1]	Iceland	Norway	Sweden
Total number of procedures							
<15	1	..	-	-	..	-	3
15-24	1 137	..	1 199	6	..	1 004	1 904
25-34	7 624	..	5 808	40	..	5 966	11 120
35-44	3 452	..	2 425	23	..	2 964	6 093
45+	52	..	41	0	..	57	109
Total	12 266	..	9 473	69	..	9 991	19 229
Per 1 000 deliveries[2]							
<15		..	-	-	..	-	750
15-24	156	..	120	178	..	112	116
25-34	198	..	154	224	..	155	154
35-44	277	..	211	344	..	158	181
45+	406	..	297	1 000	..	5	4
Total	210	..	159	248	..	169	169

1 Average 2008-12

2 Sweden and Norway 2012

NCSP: MCA

Source: The national in-patient registers

In table 3.5.15, caesarean sections are connected to the number of births. Denmark has the highest total number of births at caesarean sections (22 percent) and the highest rate in each age group. Iceland, which has the highest per capita number for caesarean sections (cf. table 3.5.1), has the lowest rate of caesarean sections (13 percent). This is due to the high rate of fertility in Iceland.

Table 3.5.16.a Hip replacement by age, men 2012

Age	Denmark	Faroe Islands	Finland	Åland[1]	Iceland	Norway	Sweden
Total number of procedures							
<25	25	..	13	-	..	12	17
25-44	160	..	149	1	..	106	180
45-64	1 394	..	1 621	9	..	1 113	2 055
65-74	1 752	..	1 614	9	..	1 216	2 508
75+	1 738	..	1 702	8	..	1 827	3 048
Total	5 069	..	5 099	25	..	4 274	7 808
Per 100 000 in the age group							
<25	3	..	2	-	..	1	1
25-44	22	..	22	16	..	15	14
45-64	186	..	214	214	..	171	169
65-74	618	..	623	600	..	583	560
75+	1 078	..	1 028	763	..	1 320	956
Total	183	..	191	178	..	170	167

1 Average 2008-12

NCSP: NFB; NFC

Source: The national in-patient registers

Table 3.5.16.b Hip replacement by age, women, 2012

Age	Denmark	Faroe Islands	Finland	Åland[1]	Iceland	Norway	Sweden
Total number of procedures							
<25	6	..	7	-	..	19	21
25-44	106	..	105	1	..	114	192
45-64	1 471	..	1 753	7	..	1 526	2 315
65-74	2 355	..	2 175	12	..	2 329	3 432
75+	3 676	..	3 711	14	..	4 286	5 918
Total	7 614	..	7 751	34	..	8 274	11 878
Per 100 000 in the age group							
<25	1	..	1	-	..	2	2
25-44	15	..	16	23	..	17	16
45-64	197	..	229	173	..	245	194
65-74	783	..	741	902	..	1 064	735
75+	1 527	..	1 294	927	..	2 006	1 232
Total	270	..	281	239	..	331	252

1 Average 2008-12

NCSP: NFB; NFC

Source: The national in-patient registers

Table 3.5.16 shows that Norway not only has the highest total rate for hip replacements for women, but also has the highest number in all the age groups above 45 years.

Table 3.5.17.a Total knee replacement by age, men 2012

Age	Denmark	Faroe Islands	Finland	Åland[1]	Iceland	Norway	Sweden
Total number of procedures							
<25	2	..	-	-	..	2	1
25-44	36	..	20	-	..	27	22
45-64	1 025	..	1 405	5	..	595	1 321
65-74	1 204	..	1 352	6	..	694	1 696
75+	690	..	919	3	..	387	1 194
Total	2 957	..	3 696	14	..	1 705	4 234
Per 100 000 in the age group							
<25	-	..	-	-	..	0	0
25-44	5	..	3	-	..	4	2
45-64	137	..	185	129	..	92	109
65-74	425	..	522	418	..	333	379
75+	428	..	555	261	..	280	374
Total	107	..	139	97	..	68	91

1 Average 2008-12

NCSP: NGB 20; NGB 30; NGB 40

Source: The national in-patient registers

Table 3.5.17.b Total knee replacement by age, women 2012

Age	Denmark	Faroe Islands	Finland	Åland[1]	Iceland	Norway	Sweden
Total number of procedures							
<25	1	..	-	-	..	0	4
25-44	65	..	44	-	..	30	43
45-64	1 437	..	2 065	8	..	772	1 774
65-74	1 727	..	2 316	8	..	1 171	2 329
75+	1 217	..	2 250	6	..	815	1 944
Total	4 447	..	6 675	23	..	2 788	6 094
Per 100 000 in the age group							
<25	-	..	-	-	..	0	0
25-44	9	..	7	-	..	4	4
45-64	193	..	270	197	..	124	148
65-74	574	..	789	596	..	535	499
75+	505	..	785	411	..	382	405
Total	158	..	242	157	..	111	129

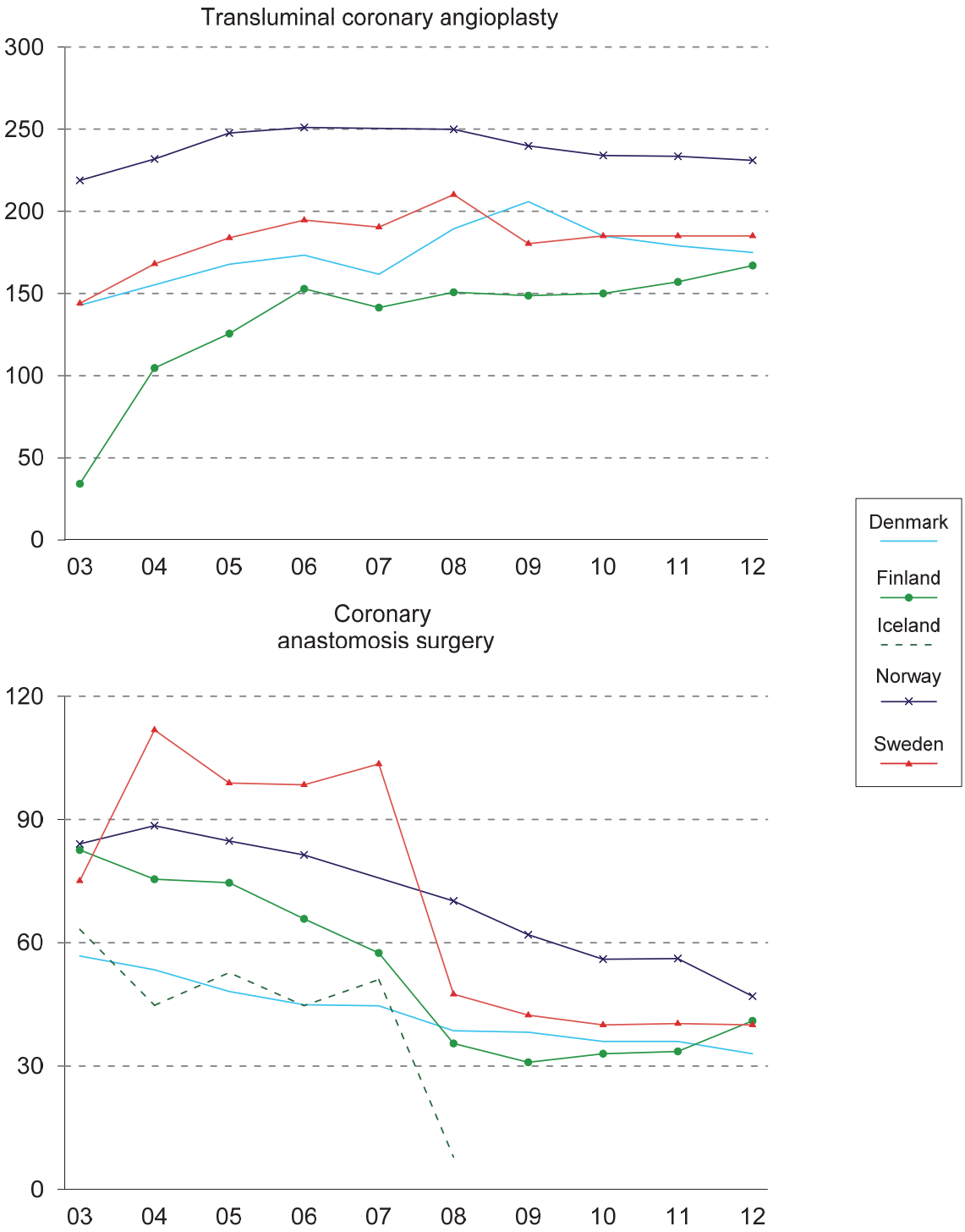
1 Average 2008-12

NCSP: NGB 20; NGB 30; NGB 40

Source: The national in-patient registers

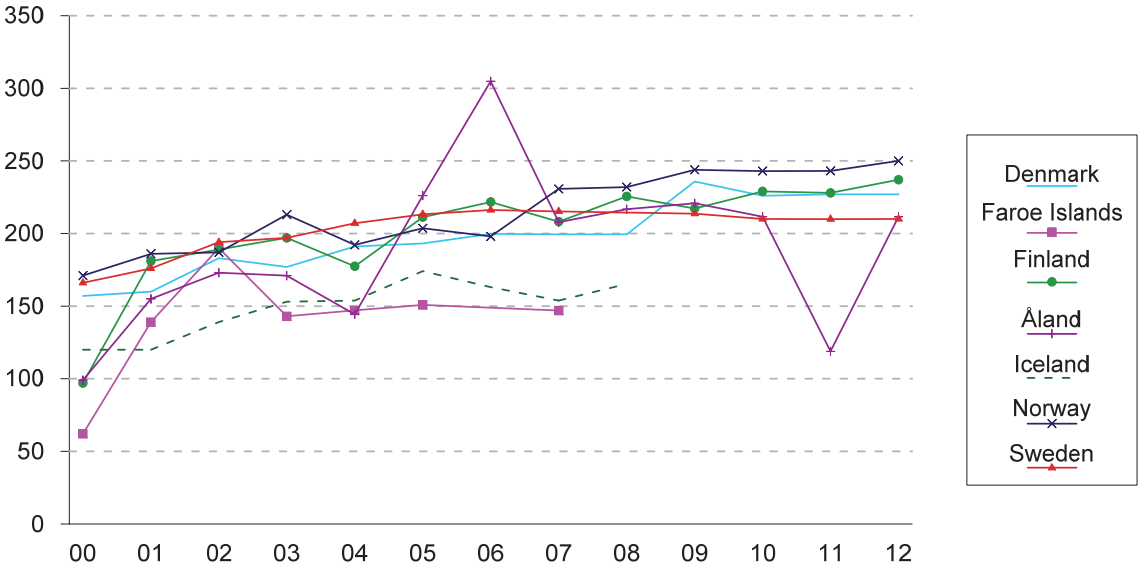
Table 3.5.17 shows that Finland has the highest total rate for knee replacements and the highest rate for this surgery in all age groups above 45 years.

Figure 3.5.1 Transluminal coronary angioplasty and coronary anastomosis surgery, total rates per 100 000 inhabitants, 2003-2012



Source: The national in-patient registers

Figure 3.5.2 Hip replacement per 100 000 inhabitants, 2000-2012



Source: The national in-patient registers

3.6 Accidents and self-inflicted injury

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

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

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

Table 3.6.1 Discharges from hospitals after treatment for injuries per 100 000 inhabitants and by gender, 2012[1]

	Denmark		Faroe Islands[2]		Greenland[3]		Finland		Åland[3]		Iceland		Norway		Sweden[4]	
(ICD10-codes)	M	W	M	W	M	W	M	W	M	W	M	W	M	W	M	W
Fracture of skull and intracranial injury *(S02; S06)*	205	115	323	142	666	719	201	130	181	122	107	42	248	154	180	119
Fracture at wrist and hand level *(S62)*	73	29	88	30	103	73	64	23	36	11	6	3	43	15	19	9
Injury of lower leg *(S80-S89)*	214	200	443	211	710	1 298	430	322	310	272	124	161	169	159	120	139
Injury of hip and thigh *(S70-S79)*	184	330	175	129	225	392	150	259	145	236	144	242	167	331	164	309
Poisoning *(T36-T65)*	185	250	76	82	326	767	80	93	35	43	22	36	95	116	85	121
Burn and corrosion *(T20-T32)*	14	8	44	17	100	78	24	11	15	8	11	7	23	15	13	6

1 Including violence and self-inflicted injury
2 Average 2002-06
3 Average 2008-12
4 2010

Source: The national in-patients registers

Table 3.6.2 Discharges from hospitals after treatment for injuries per 100 000 inhabitants by gender and age, 2012[1]

	Denmark		Faroe Islands[2]		Finland		Iceland		Norway		Sweden[3]	
Age	M	W	M	W	M	W	M	W	M	W	M	W
0-14	467	397	705	502	907	645	387	259	1 048	748	1 011	731
15-24	1 022	938	1 343	1 074	1 897	1 036	669	488	1 669	1 090	1 382	1 121
25-64	781	592	1 217	391	1 902	1 215	705	690	1 396	996	1 359	1 134
65+	1 522	2 315	1 532	1 784	2 795	3 617	2 513	3 792	2 962	4 290	4 895	5 953
Total	875	933	1 165	772	1 871	1 607	846	999	1 585	1 528	1 912	2 065

1 Including violence and self-inflicted injury
2 Average 2002-06
3 2010

Source: The national in-patients registers

3.7 Development in consumption of medicinal products

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

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

Table 3.7.1 Sales of medicinal products in total, DDD/1 000 inhabitants/day by ATC-group, 2013[1]

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A Alimentary tract and metabolism	162	205	..	265	191	173	196	225
B Blood and blood-forming organs	118	128	..	141	138	152	131	285
C Cardiovascular system	540	561	..	548	407	385	410	473
G Genito-urinary system	101	81	..	136	124	111	103	99
H Systemic hormonal preparations excl. sex hormones and insulins	32	30	..	51	53	41	45	43
J Anti-infectives for systemic use	22	19	..	23	18	24	21	17
L Antineoplastic and immunomodulating agents	17	15	..	17	16	16	17	18
M Musculo-skeletal system	65	48	..	101	71	90	62	59
N Nervous system	272	206	..	266	202	355	228	276
P Antiparasitic products, insecticides and repellents	1	1	..	2	2	2	1	1
R Respiratory system	129	111	..	151	131	127	188	144
S Sensory organs	12	10	..	20	19	16	19	23

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

Table 3.7.2 Sales of drugs for acid related disorders (ATC group A02), DDD/1 000 inhabitants/day, 2005-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A02 Drugs for acid related disorders								
2005	38.9	37.6	18.9	32.7	30.5	54.2	32.5	43.1
2010	58.8	58.3	41.9	55.0	48.9	85.6	46.5	61.1
2012	65.6	71.6	44.5	63.0	54.9	96.6	52.1	69.2
2013	68.2	77.8	45.2	66.0	56.4	102.4	54.3	72.2
A02A Antacids								
2005	7.3	4.2	2.1	2.8	2.7	2.4	2.1	2.6
2010	7.1	3.2	1.4	2.3	2.3	5.3	1.4	1.7
2012	7.3	3.1	1.8	2.3	2.5	6.3	1.4	1.7
2013	7.4	3.2	1.6	2.2	2.5	7.0	1.4	1.7
A02B Drugs for peptic ulcer and gastro-oesophageal reflux disease								
2005	31.6	33.4	16.8	29.9	27.8	51.9	30.4	40.8
2010	51.7	55.1	40.4	52.7	46.6	80.3	45.0	59.5
2012	58.3	68.5	42.8	60.8	52.4	90.3	50.7	67.5
2013	60.8	74.7	43.5	63.8	53.9	95.4	52.9	70.5
A02BA H2-receptor antagonists								
2005	6.3	3.3	0.6	4.1	4.7	6.6	5.5	5.5
2010	2.2	1.1	0.1	2.9	5.8	4.6	5.8	3.2
2012	1.1	1.0	0.0	1.9	4.3	3.7	5.3	2.5
2013	1.0	1.0	0.0	1.5	4.6	3.4	4.9	2.3
A02BC Proton pump inhibitors								
2005	24.8	29.0	15.9	24.3	21.4	45.2	24.5	34.2
2010	49.1	53.2	40.2	48.5	39.2	75.6	38.8	55.4
2012	56.6	66.7	42.6	57.6	46.3	86.5	44.9	64.0
2013	59.3	72.8	43.4	61.1	47.7	91.9	47.5	67.3
A02BX Other drugs for peptic ulcer and gastro-oesophageal reflux disease								
2005	0.5	1.1	0.3	1.4	1.6	0.0	0.4	1.1
2010	0.4	0.8	0.0	1.2	1.5	0.0	0.4	0.8
2012	0.5	0.8	0.0	1.1	1.7	0.0	0.5	0.9
2013	0.5	0.8	0.0	1.1	1.5	0.0	0.6	0.9

Figure 3.7.1 Sales of drugs for treatment of peptic ulcer and gastro-oesophageal reflux disease, DDD/1 000 inhabitants/day, 2005-2013

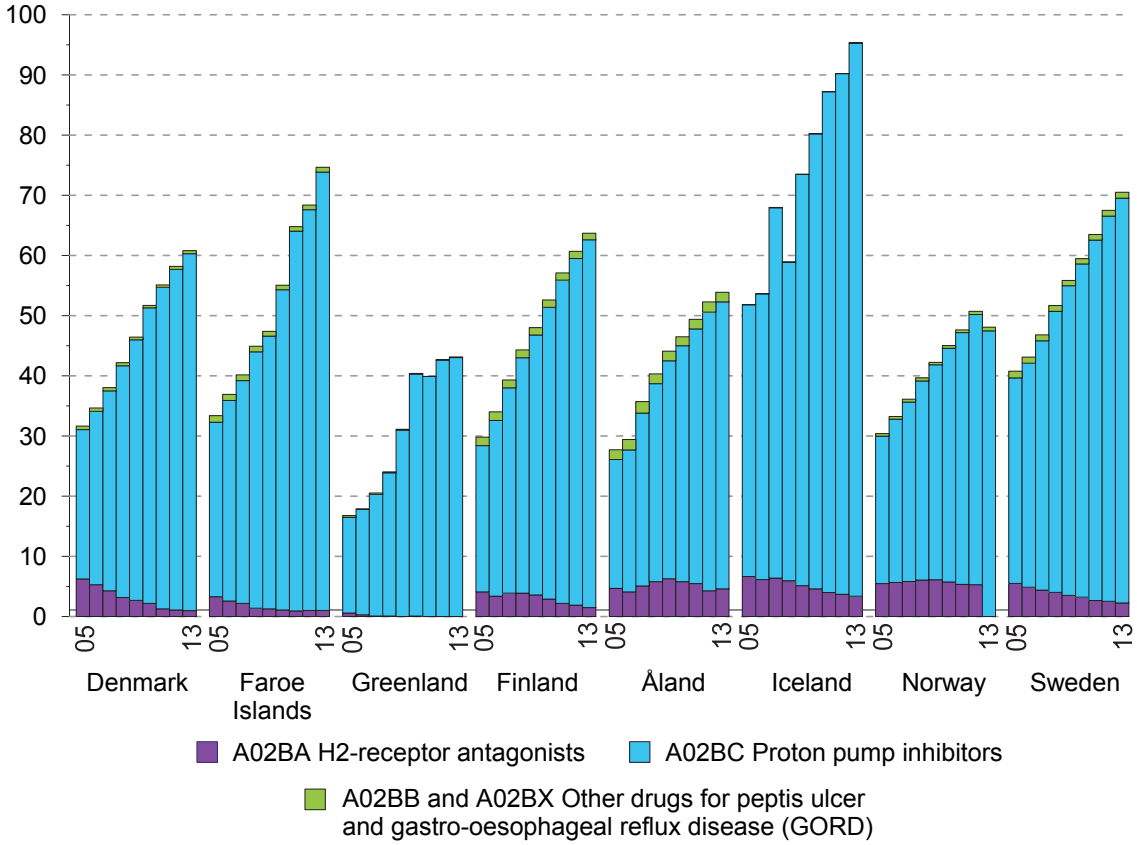


Table 3.7.3 Share of the population per 1 000 (one-year prevalence), receiving at least one drug for treatment of ulcer, esophageal inflammation and pyrosis (proton pump inhibitors, ATC group A02BC) by gender and age, 2013[1]

	Denmark		Faroe Islands		Finland		Iceland		Norway		Sweden	
Age	M	W	M	W	M	W	M	W	M	W	M	W
0-14	5.7	6.9	4.3	6.7	5.3	5.5	19.5	20.8	7.6	6.6	6.0	6.9
15-24	20.8	40.8	20.6	35.5	18.1	32.6	37.4	63.2	16.2	26.3	15.9	36.6
25-44	53.2	66.9	54.8	60.8	66.3	86.6	73.5	86.4	46.7	50.4	36.8	60.4
45-64	112.5	138.4	125.5	140.0	130.4	173.1	159.7	204.9	100.2	112.7	92.1	130.3
65-74	184.6	210.2	246.0	265.4	184.3	231.5	265.0	343.8	158.0	181.9	170.7	214.2
75+	252.1	278.9	329.9	410.1	248.8	304.7	295.8	350.3	193.7	201.6	249.2	282.2

1 Prescribed medicine only

Table 3.7.4 Sales of anti-obesity preparations (ATC-group A08), DDD/1 000 inhabitants/day, 2005-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	0.7	0.4	-	0.6	0.3	1.3	2.6	2.3
2010	1.0	1.2	-	0.7	0.3	0.0	1.2	1.3
2012	0.6	0.6	-	0.3	0.2	0.1	0.4	0.5
2013	0.5	0.4	-	0.2	0.2	0.1	0.4	0.4

Table 3.7.5 Sales of medicines used for diabetes (ATC-group A10), DDD/1 000 inhabitants/day, 2005-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A10 Drugs used for diabetes								
2005	34.9	32.9	10.3	66.4	38.6	24.0	39.3	44.6
2010	47.6	49.6	13.2	83.4	49.3	31.7	48.3	51.9
2012	51.1	56.9	15.5	85.0	52.6	39.8	48.5	54.1
2013	58.8	59.9	16.4	86.0	52.0	42.6	48.8	55.8
A10A Insulins and analogues								
2005	13.3	10.4	2.7	21.7	15.1	6.5	17.4	22.6
2010	17.2	14.2	3.8	30.0	19.8	9.8	19.2	26.4
2012	17.5	13.6	4.1	30.7	21.0	10.9	18.9	26.9
2013	17.8	13.5	3.9	31.4	21.0	11.7	19.1	27.5

The table continues

Table 3.7.5 Sales of medicines used for diabetes (ATC-group A10), DDD/1 000 inhabitants/day, 2005-2013, continued

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A10B								
Blood glucose lowering drugs, excl. insulins								
2005	21.6	22.5	7.6	44.7	23.5	17.5	21.9	22.0
2010	30.4	35.5	9.5	53.4	29.5	22.0	29.1	25.5
2012	33.6	43.3	11.5	54.3	31.6	28.9	29.7	27.2
2013	34.0	46.5	12.5	54.6	30.9	30.9	29.7	28.3
A10BA Biguanides								
2005	7.9	6.7	4.3	18.5	10.1	7.7	9.7	11.8
2010	15.5	12.5	6.3	32.0	17.8	11.4	14.7	17.5
2012	18.6	18.1	8.2	31.8	18.4	13.3	14.6	18.9
2013	19.0	21.5	8.6	31.2	18.1	14.2	14.3	19.4
A10BB Sulphonamides, urea derivatives								
2005	12.0	15.7	3.3	24.1	13.1	7.2	11.1	7.7
2010	15.5	21.0	3.0	12.2	8.5	8.1	11.5	4.7
2012	8.7	18.0	3.1	6.6	7.6	12.4	9.8	4.4
2013	7.6	15.7	3.8	5.1	6.5	13.1	9.1	4.4
A10BD Combinations of oral blood glucose lowering								
2005	0.2	..	-	0.8	0.1	0.5	0.1	0.2
2010	1.1	0.0	0.1	3.0	0.3	0.3	1.1	0.4
2012	1.5	0.0	0.0	4.6	0.1	0.6	2.1	0.3
2013	1.8	0.1	-	5.2	0.1	0.7	2.5	0.3
A10BG Thiazolidinediones								
2005	0.1	0.1	-	1.1	0.1	1.7	0.8	1.0
2010	0.1	0.0	-	1.8	1.9	0.7	0.6	0.6
2012	0.0	0.0	0.0	1.3	1.4	0.5	0.3	0.3
2013	0.0	0.0	-	1.0	1.2	0.4	0.3	0.3
A10BH Dipeptidyl peptidase 4 (DPP-4) inhibitors								
2005	-	..	-	..	..	-	-	..
2010	1.2	0.7	-	4.0	0.6	1.0	0.9	0.9
2012	1.7	2.5	-	8.6	3.7	1.4	1.7	1.5
2013	2.0	3.6	-	10.4	4.5	1.6	2.1	1.9
A10BX Other oral blood glucose lowering drugs, excl. insulins								
2005	0.3	-	-	0.2	0.2	0.4	0.1	1.2
2010	1.3	1.3	-	0.5	0.5	0.3	0.2	1.3
2012	3.0	4.6	0.1	1.5	0.4	0.6	1.0	1.7
2013	3.5	5.6	0.1	1.8	0.5	0.9	1.4	2.0

Figure 3.7.2 Sales of insulins and other blood glucose lowering drugs (ATC-groups A10A and A10B), DDD/1 000 inhabitants/day, 2005-2013

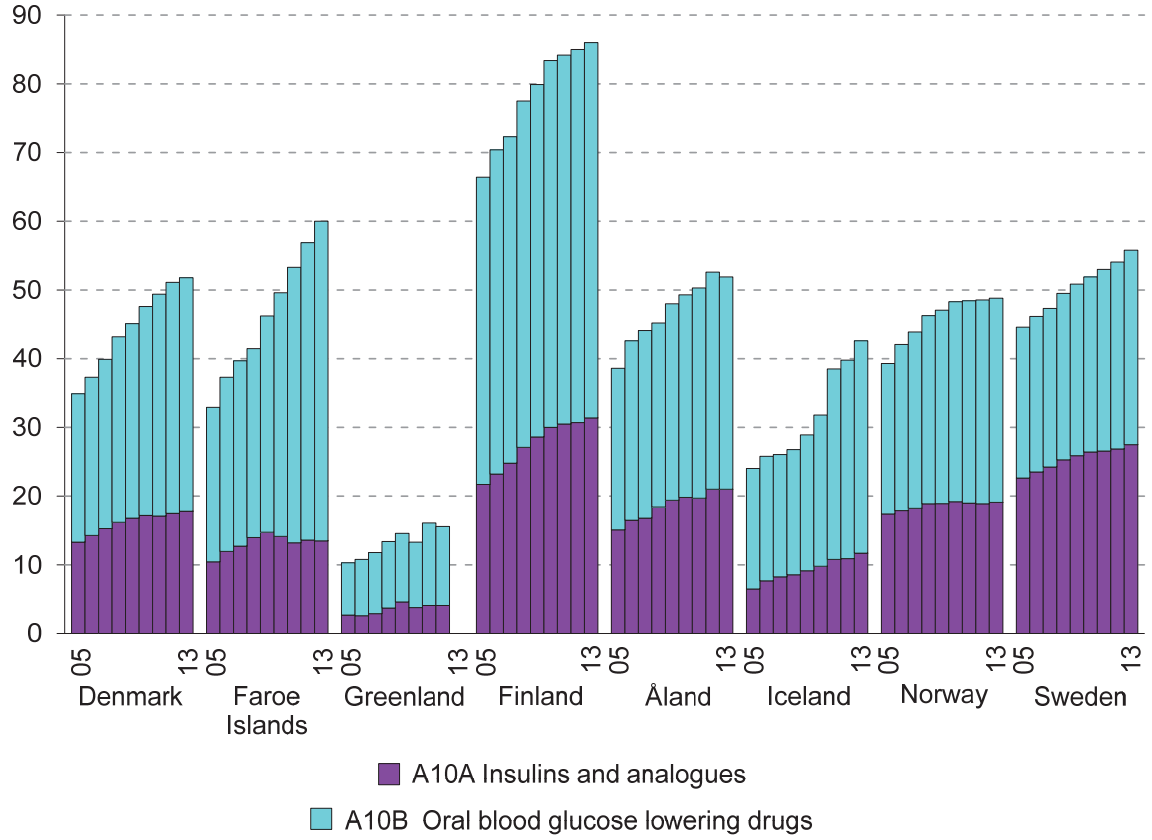


Table 3.7.6 Share of the population per 1 000 (one-year prevalence) receiving at least one drug used for diabetes (ATC-group A10) by gender and age, 2013

	Denmark		Faroe Islands		Finland		Iceland		Norway		Sweden	
Age	M	W	M	W	M	W	M	W	M	W	M	W
0-14	1.8	1.9	1.3	2.2	4.5	4.0	1.5	1.4	2.1	2.0	2.8	2.7
15-24	5.2	7.0	4.8	10.9	10.4	9.3	5.5	11.0	6.3	6.7	7.9	7.0
25-44	14.8	17.1	13.6	13.2	19.0	17.2	12.8	22.6	13.5	14.0	13.1	11.5
45-64	69.8	45.9	71.5	40.3	97.6	63.5	60.2	40.2	56.4	37.0	65.8	40.4
65-74	138.5	90.4	165.7	101.4	202.7	135.8	134.1	81.7	114.3	75.0	149.6	93.6
75+	139.6	100.9	210.8	123.0	214.6	174.2	138.4	84.2	115.7	84.7	165.8	118.6

Figure 3.7.3 Sales of cardiovascular drugs (ATC-group C), DDD/1 000 inhabitants/day, 2005-2013

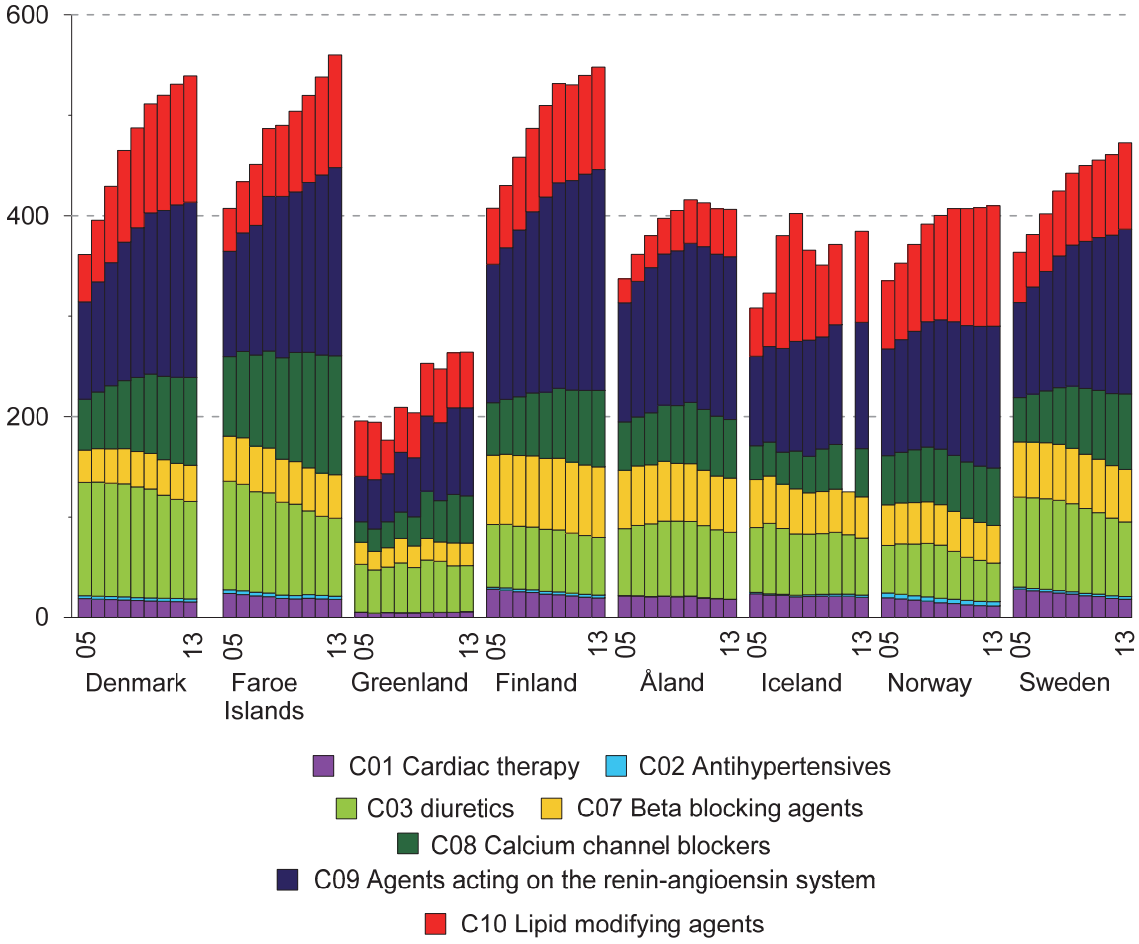


Table 3.7.7 Sales of Antithrombotic agents (ATC-group B01), DDD/1 000 inhabitants/day, 2005-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
B01A Antithrombotic agents								
2005	85.6	52.8	..	124.7	86.0	..	80.4	85.6
2010	99.5	75.2	42.0	118.7	85.2	..	95.6	93.5
2012	100.7	80.1	41.6	115.4	87.4	86.7	98.0	93.1
2013	100.2	83.9	47.8	116.4	85.7	86.1	100.8	93.1
B01AA Vitamin k antagonists								
2005	6.4	6.1	..	10.7	17.9	..	10.3	7.5
2010	8.1	7.3	3.2	13.9	14.4	..	11.2	9.3
2012	8.8	7.9	3.7	15.6	14.5	8.4	11.7	11.0
2013	8.8	7.4	3.4	16.5	15.6	8.1	10.5	11.6
B01AB Heparin group								
2005	2.0	1.2	..	3.2	3.1	..	3.6	3.6
2010	2.5	1.2	0.7	5.3	5.6	..	5.1	5.3
2012	3.0	2.1	0.9	6.1	5.7	3.0	6.1	6.0
2013	3.2	2.3	1.0	6.5	5.4	3.1	6.1	6.1
B01AC Platelet aggregation inhibitors excl. heparin								
2005	77.1	45.5	31.8	110.7	65.1	65.1	66.5	74.4
2010	88.8	66.5	38.1	99.3	65.2	70.7	79.3	78.8
2012	86.9	67.9	36.6	92.9	67.2	74.3	79.6	75.7
2013	83.5	68.4	41.2	92.1	64.6	72.1	78.3	73.7
B01AE Direct thrombin inhibitors								
2005	-	0.1	..	-	..	0.1	-	-
2010	-	0.1	-	0.1	-	-	-	-
2012	1.7	1.2	0.5	0.5	0.1	0.9	0.5	0.3
2013	2.7	1.7	2.3	0.7	0.1	1.7	2.3	0.8
B01AF Direct factor Xa inhibitors								
2005	-		..					
2010	0.1		..				-	-
2012	0.3	0.9	..				0.1	-
2013	1.9	4.1	..				3.7	0.9

Table 3.7.8 Sales of drugs for cardiac therapy (ATC group C01), DDD/1 000 inhabitants/day, 2005-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
C01 Cardiac therapy								
2005	18.8	23.9	5.3	28.3	21.6	23.7	19.6	28.3
2010	16.5	18.6	5.0	22.7	21.0	21.4	14.0	21.8
2012	15.9	18.6	5.1	20.3	18.7	21.1	11.9	19.1
2013	15.5	18.1	5.7	19.5	18.0	20.1	11.6	18.2
C01A Cardiac glycosides								
2005	6.0	3.7	1.9	6.0	5.4	3.0	4.1	5.9
2010	4.7	2.8	1.5	4.2	4.9	2.6	2.4	3.5
2012	4.3	3.0	1.5	3.7	4.2	2.5	1.4	3.0
2013	4.1	2.6	1.6	3.5	4.5	2.5	1.8	2.8
C01B Antiarrhytmics, class I and III								
2005	1.6	..	..	..	..	..	1.4	..
2010	1.5	..	..	..	..	..	1.8	..
2012	1.6	..	..	..	..	..	2.0	..
2013	1.6	..	..	..	..	..	2.0	..
C01D Vasodilators used in cardiac diseases								
2005	10.5	18.6	2.8	19.5	13.1	17.2	14.0	20.9
2010	9.4	14.3	2.5	15.5	12.8	15.2	9.5	16.7
2012	9.1	14.0	2.6	13.6	11.5	14.4	8.2	14.4
2013	8.9	13.9	3.3	12.8	10.2	13.2	7.4	13.6

Table 3.7.9 Sales of cardiovascular drugs (ATC-group C02; C03; C07; C08; C09), DDD/1 000 inhabitants/day, 2005-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
C02 Antihypertensives								
2005	2.9	3.6	0.1	1.9	0.3	1.4	4.9	2.1
2010	3.0	3.3	0.1	2.9	0.4	1.8	4.3	2.5
2012	3.1	3.4	0.1	2.9	0.4	2.1	4.2	2.5
2013	3.1	3.2	0.1	2.9	0.3	2.3	4.2	2.7
C03 Diuretics								
2005	112.9	108.0	47.5	62.5	66.5	64.5	47.4	89.4
2010	108.5	91.0	52.1	61.6	74.3	60.3	47.5	84.2
2012	98.6	78.8	46.3	58.5	68.2	59.1	40.9	77.3
2013	97.0	77.7	45.9	57.4	66.6	56.7	38.5	74.3
C03A Low-ceiling diuretics, thiazides								
2005	49.1	53.6	29.5	5.6	4.4	8.8	9.0	19.4
2010	49.2	43.9	37.5	6.9	9.0	6.3	11.8	25.2
2012	41.5	33.5	37.1	6.7	8.5	6.5	7.9	23.7
2013	41.1	33.7	33.8	6.8	8.3	6.0	7.2	22.8
C03C High-ceiling diuretics								
2005	53.5	39.6	15.9	33.5	25.9	21.2	30.1	50.7
2010	50.9	36.8	12.8	37.8	31.7	23.7	28.4	42.8
2012	49.3	36.3	7.3	37.5	31.0	23.6	26.5	39.6
2013	48.3	35.5	9.5	37.1	30.3	23.1	25.5	38.3
C03E Diuretics and potassium-sparing agents in combination								
2005	5.5	1.0	0.1	20.7	33.3	32.6	6.7	13.5
2010	4.1	0.6	0.2	14.1	30.6	28.0	5.9	11.6
2012	3.6	0.6	0.1	11.5	26.0	26.5	4.9	9.7
2013	3.3	0.7	0.3	10.6	25.2	24.8	4.2	9.0
C07 Beta blocking agents								
2005	32.1	44.9	22.0	68.9	58.1	47.8	40.4	55.1
2010	35.4	42.4	21.7	71.3	57.4	42.1	39.8	54.1
2012	35.9	43.0	22.8	70.2	53.6	42.7	37.7	52.3
2013	35.9	43.3	22.3	70.1	54.0	41.1	37.4	52.2
C08 Calcium channel blockers								
2005	50.7	79.3	20.5	52.2	48.1	33.6	48.9	44.0
2010	78.9	108.5	47.1	69.7	61.1	42.2	55.8	65.5
2012	85.7	117.5	48.3	74.3	59.6	45.5	56.0	71.7
2013	87.6	118.4	47.0	76.2	58.2	48.0	57.2	75.2
C08C Selective calcium channel blockers with mainly vascular effects								
2005	43.8	75.8	19.3	47.6	46.4	27.4	43.8	39.8
2010	74.0	106.3	46.5	66.9	59.5	37.0	52.2	62.8
2011	81.4	115.4	47.4	72.0	58.3	40.3	53.0	69.5
2012	83.7	116.4	46.2	74.1	56.9	43.3	54.3	73.1

The table continues

Table 3.7.9 Sales of cardiovascular drugs (ATC-group C02; C03; C07; C08; C09), DDD/1 000 inhabitants/day, 2005-2013, continued

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
C08D Selective calcium channel blockers with direct cardiac effects								
2005	6.8	3.5	1.2	4.6	1.7	6.2	5.1	4.1
2010	5.0	2.2	0.7	2.8	1.6	5.4	3.6	2.7
2012	4.3	2.1	0.9	2.3	1.3	5.1	3.0	2.2
2013	3.9	2.0	-	2.1	1.3	4.7	2.8	2.0
C09 Agents acting on the renin-angiotensin system								
2005	96.8	104.7	45.2	137.9	118.6	89.2	106.2	94.7
2010	160.5	159.8	74.8	204.5	158.4	111.5	132.9	146.4
2012	171.6	179.3	86.2	215.2	161.2	121.1	139.2	157.7
2013	..	187.3	87.7	219.9	162.1	125.7	141.1	164.0
C09A ACE-inhibitors, plain								
2005	55.5	68.2	41.3	75.3	79.9	32.2	42.9	57.3
2010	90.9	104.2	64.3	104.5	86.2	38.4	45.2	83.1
2012	92.1	113.2	74.5	104.3	79.2	43.3	45.5	84.6
2013	91.3	117.6	47.4	103.8	76.9	39.8	45.0	84.1
C09B ACE-inhibitors, combinations								
2005	6.7	5.3	0.1	14.7	4.2	7.7	7.3	3.6
2010	19.2	11.9	0.1	16.4	5.1	11.0	6.6	8.2
2012	19.5	14.3	0.1	15.3	5.3	5.5	6.3	8.6
2013	19.0	14.2	0.1	14.5	5.5	5.9	6.2	8.7
C09C Angiotensin II antagonists								
2005	22.1	20.7	3.8	31.0	27.8	23.8	30.6	24.6
2010	32.1	33.4	10.2	54.7	53.1	30.6	44.1	41.2
2012	39.0	41.8	11.4	64.9	58.9	35.0	48.3	49.5
2013	..	44.7	13.0	70.5	60.8	37.4	50.3	55.2
C09D Angiotensin II antagonists, combinations								
2005	12.5	10.5	0.1	16.8	6.7	25.5	25.4	9.1
2010	17.3	9.8	0.1	28.9	14.0	31.1	36.9	14.0
2012	20.7	9.78	0.2	30.7	17.7	37.0	39.1	15.1
2013	21.8	10.6	0.2	31.1	18.9	39.8	39.7	16.1
CO9X Other agents acting on the rennin-angiotensin system								
2005	-	-	-	-	-	-	-	-
2010	1.0	0.5	0.1	-	-	0.3	-	-
2012	0.4	0.3	-	-	-	0.3	-	-
2013	0.3	0.2	-	-	-	0.3	-	-

Table 3.7.10 Sales of serum lipid modifying agents (ATC-group C10), DDD/1 000 inhabitants/day, 2005-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
C10 Lipid modifying agents								
2005	47.2	42.8	55.1	55.7	23.9	48.1	67.9	50.1
2010	108.4	80.4	52.3	98.8	43.3	71.5	112.7	75.6
2012	120.0	97.4	54.8	98.2	45.2	82.8	118.2	80.0
2013	125.7	112.1	55.4	101.9	47.1	90.5	120.0	85.9
C10AA HMG CoA reductase inhibitors (statins)								
2005	46.5	42.3	55.0	53.9	23.1	87.3	67.2	47.8
2010	105.9	78.7	52.2	95.5	41.8	70.2	109.9	72.5
2012	117.3	96.0	54.6	94.9	43.7	81.4	114.2	76.8
2013	122.8	110.7	55.1	98.3	45.7	89.2	115.7	82.8

Table 3.7.11 Share of the population per 1 000 (one-year prevalence) receiving at least one serum lipid modifying agent (ATC-group C10), by gender and age, 2013

Age	Denmark		Faroe Islands		Finland		Iceland		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W
0-14 years	0	0	0	0	0	0	0	0	0	0	0	0
15-24 years	1	1	1	1	1	1	0	1	1	2	1	1
25-44 years	20	12	19	11	19	7	15	7	19	8	12	5
45-64 years	171	137	191	136	192	129	207	120	167	119	128	83
65-74 years	384	339	410	334	401	347	499	360	388	335	347	266
75+ years	408	335	428	324	464	396	524	379	425	337	406	287

Table 3.7.12 Share of the population per 1 000 women (one year prevalence) receiving at least one type of hormonal contraceptives and intravaginal contraceptives (ATC-groups G03A and G02BB) by age, 2013[1]

Age	Denmark	Faroe Islands	Finland	Iceland	Norway	Sweden
15-19 years	533.2	432.7	..	526.9	362.9	344.3
20-24 years	606.6	524.1	..	602.3	550.4	476.3
25-29 years	458.4	367.1	..	405.5	343.6	360.6
30-34 years	311.0	260.8	..	282.0	206.3	238.4
35-39 years	222.2	189.8	..	216.9	142.6	180.0
40-44 years	149.9	157.8	..	150.3	97.8	143.6
45-49 years	86.7	103.1	..	83.6	55.1	104.5

1 Excl. implants

Figure 3.7.4 Share of Women/1 000 between 15 and 49 years old (one year prevalence) receiving at least one type of hormonal contraceptives and intravaginal contraceptives (ATC-groups G03A and G02BB) by age, 2005-2013

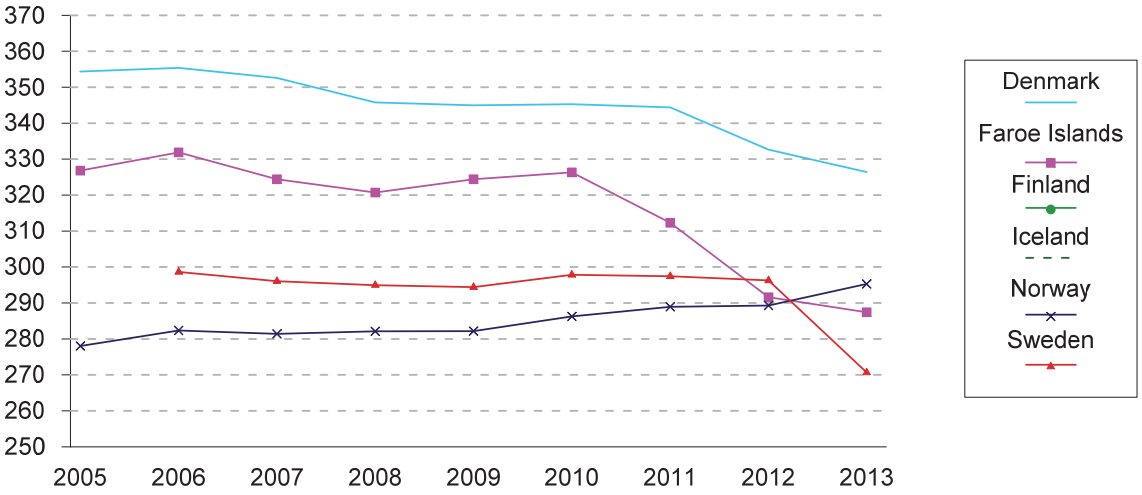


Table 3.7.13a Sales of estrogens and progestogens and estrogens in combination (systemically effective, ATC groups G03C and G03F), DDD/1 000 women/day, 2005-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
G03C and G03F Estrogens, progestogens and estrogens in combination								
2005	27.8	29.4	..	66.2	51.3	64.9	35.9	33.0
2010	18.2	20.8	6.0	50.8	38.0	50.1	20.7	18.1
2012	15.9	17.9	4.9	46.7	38.5	47.1	21.3	16.5
2013	14.7	17.7	3.9	36.6	39.0	44.6	20.4	15.9

Table 3.7.13b Sale of estrogens (vaginally effective, ATC group G03C), DDD/1 000 women/day 2005-2013[1]

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
G03C Estrogens								
2005	8.8	9.2	..	21.4	15.6	43.5	13.4	19.9
2010	10.8	10.9	2.6	29.3	29.4	35.2	13.2	20.7
2012	11.5	13.0	2.4	19.9	22.9	32.9	9.3	17.3
2013	12.0	13.4	3.4	20.1	26.3	31.5	9.0	18.6

1 G03C vaginally effective (vaginal tablets, vaginal gel and vaginal insert)

Table 3.7.14 Sales of drugs for urinary frequency and incontinence (ATC-group G04BD), DDD/1 000 inhabitants/day, 2005-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	3.0	2.1	..	3.2	3.1	..	4.7	3.9
2010	5.0	4.2	0.6	4.5	3.3	6.5	7.8	5.0
2012	5.7	5.0	0.9	5.0	3.8	7.3	8.8	5.3
2013	5.8	5.0	0.5	5.3	4.8	7.5	8.9	5.4

Table 3.7.15 Sales of drugs used in erectile dysfunction (ATC-group G04BE), DDD/1 000 men/year, 2005-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	821	438	256	1 460	511	1 081	943	868
2010	1 129	461	492	2 242	786	939	1 284	1 044
2012	1 218	564	742	3 547	1 349	1 304	1 444	1 106
2013	1 513	711	833	4 057	1 460	1 453	1 557	1 171

Table 3.7.16 Sales of antimicrobial agents for systemic use (ATC-group J01), DDD/1 000 inhabitants/day, 2005-2013

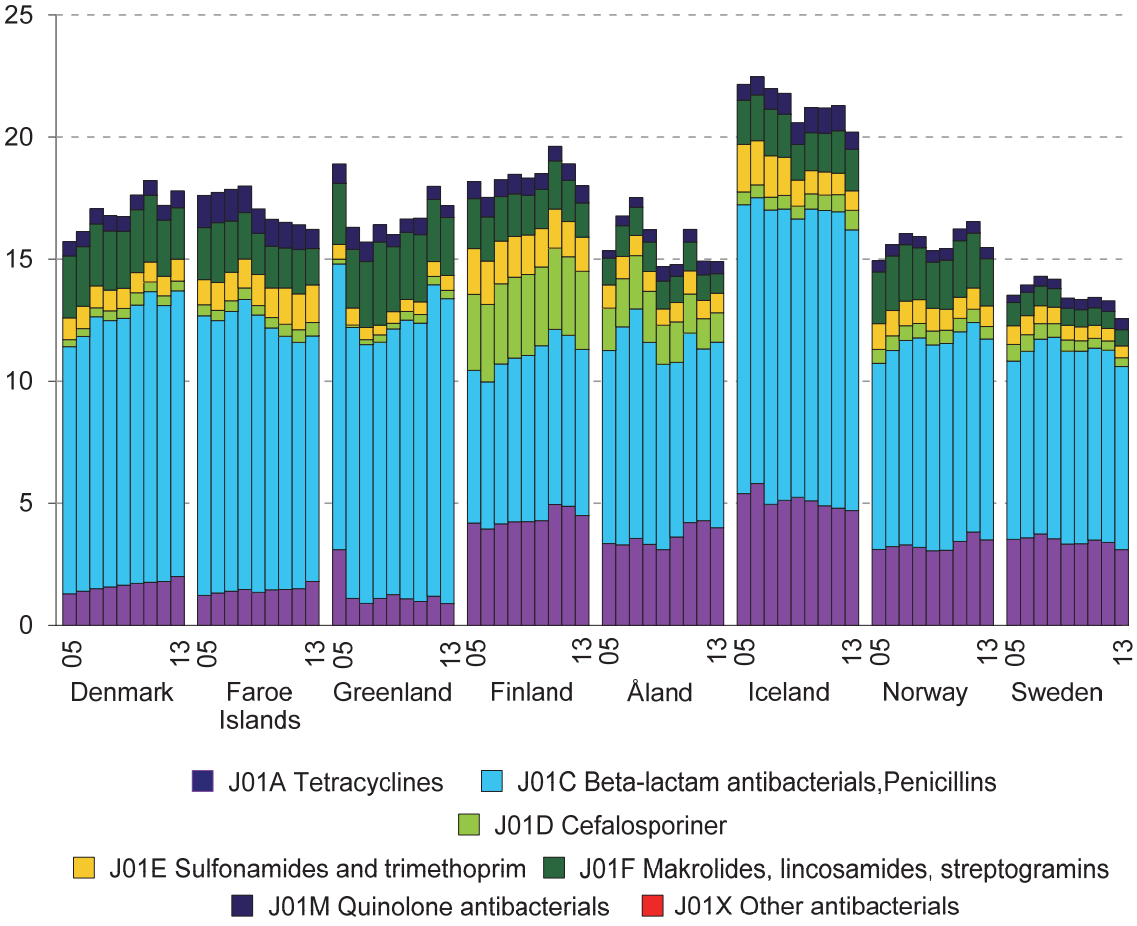
	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
J01 Antibacterials for systemic use								
2005	16.6	18.0	20.4	19.6	16.5	23.0	15.6	16.6
2010	18.8	17.3	17.3	19.7	15.9	22.2	16.2	14.3
2012	18.5	17.1	18.7	20.1	15.9	22.3	17.4	14.2
2013	18.7	17.0	17.8	19.1	15.6	21.7	16.2	13.4
J01A Tetracyclines								
2005	1.3	1.2	3.1	4.2	3.4	5.4	3.1	3.5
2010	1.7	1.5	1.1	4.3	3.6	5.1	3.1	3.3
2012	1.8	1.5	1.2	4.9	4.3	4.8	3.8	3.4
2013	2.0	1.8	0.9	4.5	4.0	4.7	3.5	3.1
J01C Beta-lactam antibacterials, penicillins								
2005	10.1	11.5	11.8	6.3	7.9	11.8	7.6	7.3
2010	11.5	10.7	11.4	7.2	7.2	12.0	8.5	7.9
2012	11.3	10.1	12.8	7.0	7.0	12.1	8.6	7.9
2013	11.7	10.1	12.5	6.8	7.6	11.5	8.2	7.5
J01CA Penicillins with extended Spectrum								
2005	3.2	3.0	4.0	3.4	5.0	4.3	2.5	1.6
2010	3.8	2.9	3.9	4.1	4.5	4.2	3.2	1.7
2012	3.7	1.8	4.6	4.0	4.1	4.4	3.3	1.6
2013	3.8	1.9	4.2	3.9	4.5	3.8	3.3	1.6
J01CE Beta-lactamase sensitive penicillins								
2005	5.7	7.2	6.9	1.7	2.2	3.0	4.5	4.1
2010	5.5	6.4	5.8	1.6	1.9	2.5	4.4	4.2
2012	4.9	6.5	5.9	1.4	1.6	2.3	4.3	4.1
2013	4.9	6.2	5.5	1.4	1.6	2.1	4.1	3.7
J01CE Beta-lactamase sensitive penicillins								
2005	5.7	7.2	6.9	1.7	2.2	3.0	4.5	4.1
2010	5.5	6.4	5.8	1.6	1.9	2.5	4.4	4.2
2012	4.9	6.5	5.9	1.4	1.6	2.3	4.3	4.1
2013	4.9	6.2	5.5	1.4	1.6	2.1	4.1	3.7
J01CF Beta-lactamase resistant penicillins								
2005	1.2	1.2	0.9	0.1	0.4	1.4	0.5	1.4
2010	1.3	1.2	1.4	0.0	..	1.3	0.8	1.7
2012	1.4	1.3	1.4	0.1	0.6	1.3	0.9	1.8
2013	1.5	1.3	1.7	0.1	0.7	1.2	0.8	1.9

The table continues

Table 3.7.16 Sales of antibacterials for systemic use (ATC-group J01), DDD/1 000 inhabitants/day, 2005-2013, continued

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
J01CR Combinations of penicilins incl. beta-lactamase inhibitors								
2005	0.1	0.1	-	1.1	0.4	3.2	0.0	0.2
2010	0.8	0.2	0.3	1.5	0.8	4.0	0.0	0.3
2012	1.3	0.5	0.8	1.6	0.8	4.1	0.0	0.3
2013	1.5	0.6	1.0	1.4	0.9	4.3	0.0	0.3
J01D Other betalactam anti-bacterials and cephalosporins								
2005	0.3	0.5	1.0	3.1	1.7	0.5	0.6	0.7
2010	0.4	0.4	0.4	3.2	1.7	0.6	0.5	0.4
2012	0.4	0.5	0.3	3.2	1.2	0.7	0.5	0.4
2013	0.4	0.6	0.3	3.2	1.2	0.8	0.5	0.4
J01E Sulphonamides and Trimethoprim								
2005	0.9	1.0	0.6	1.9	1.0	1.9	1.1	0.9
2010	0.8	1.2	0.5	1.6	0.8	0.9	0.9	0.6
2012	0.8	1.5	0.6	1.4	0.8	0.9	0.9	0.5
2013	0.9	1.5	0.6	1.4	0.8	0.8	0.8	0.5
J01F Macrolides, lincosamides and streptogramins								
2005	2.5	2.1	3.6	2.1	1.1	1.8	2.1	0.8
2010	2.6	1.7	2.7	1.6	1.1	1.6	2.0	0.7
2012	2.3	1.8	2.5	1.7	1.1	1.7	2.2	0.7
2013	2.1	1.5	2.4	1.4	0.8	1.7	1.9	0.7
J01M Quinolone anti-bacterials								
2005	0.5	0.3	0.2	1.3	1.1	0.8	0.6	1.2
2010	0.8	0.5	0.5	1.2	1.1	1.0	0.7	0.9
2012	0.8	0.6	0.5	1.2	0.9	1.0	0.7	0.9
2013	0.7	0.6	0.5	1.1	0.7	1.1	0.7	0.9
J01X Other anti-bacterials								
2005	0.6	0.9	0.8	0.7	0.3	0.7	0.5	0.3
2010	0.7	1.0	0.5	0.7	0.5	1.0	0.5	0.4
2012	0.6	0.9	0.5	0.7	0.6	1.00	0.5	0.4
2013	0.7	0.8	..	0.7	0.5	0.7	0.4	0.5

Figure 3.7.5 Sales of antimicrobials agents for systemic use (ATC-group J01), DDD/1 000 inhabitants/day, 2005-2013[1]



1 Methenamin not included

Figure 3.7.6 Sales of penicillins (ATC-group J01C), DDD/1 000 inhabitants/day, 2005-2013

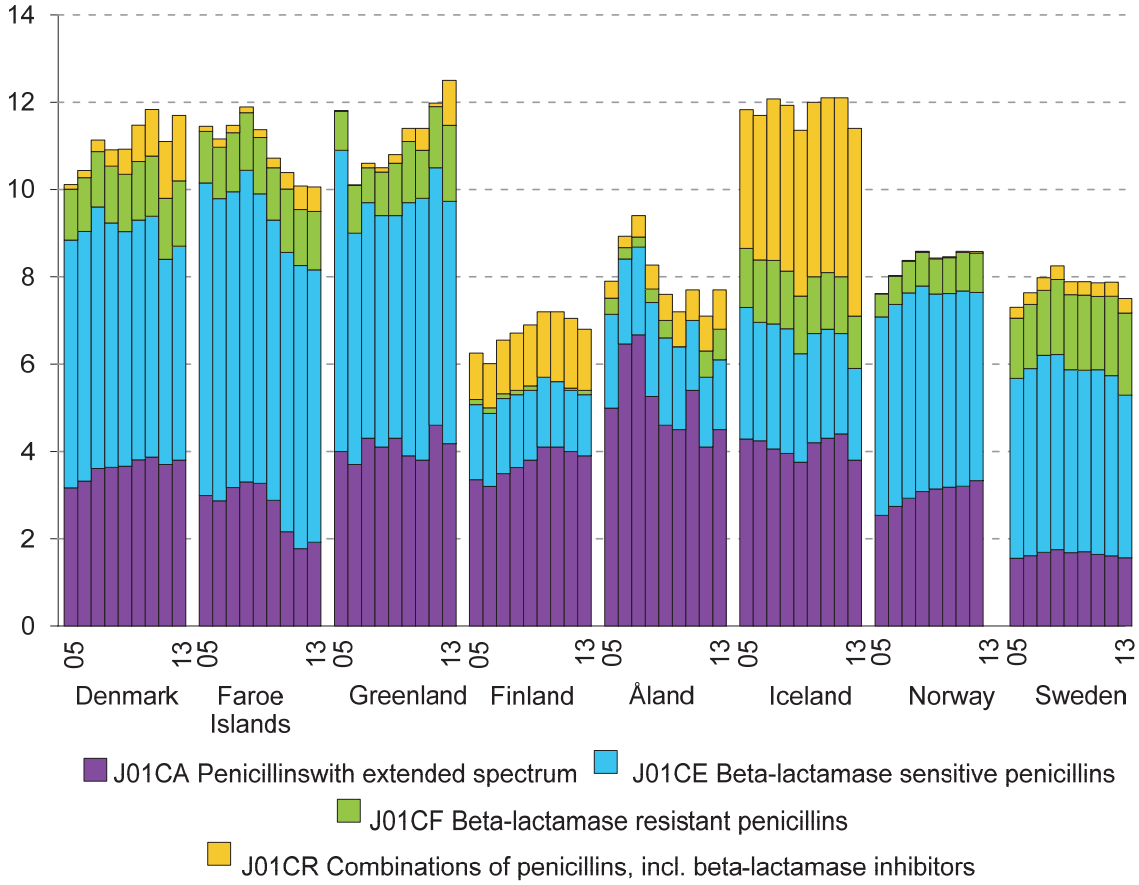


Table 3.7.17 Share of the population per 1 000 (one-year prevalence) receiving at least one penicillin (ATC-group J01C) by gender and age, 2013

	Denmark		Faroe Islands		Finland		Iceland		Norway		Sweden	
Age	M	W	M	W	M	W	M	W	M	W	M	W
0-14	208.3	208.9	220.8	210.8	234.6	219.8	283.3	286.9	117.5	119.3	166.0	159.8
15-24	122.7	238.6	146.7	202.8	114.9	210.4	171.8	291.2	89.0	188.9	83.7	155.3
25-44	159.0	264.6	179.0	249.5	124.4	203.3	193.2	291.4	102.8	193.6	90.2	159.2
45-64	192.2	251.5	203.0	248.6	120.6	185.7	224.9	304.0	119.9	184.7	103.9	155.4
65-74	252.6	285.8	232.1	242.3	121.9	177.2	251.8	335.8	162.8	220.0	137.6	188.7
75+	348.9	372.6	281.3	269.9	138.3	227.5	254.9	288.2	214.4	252.5	177.6	223.8

Table 3.7.18a Sales of antimycotics for systemic use (ATC group J02A), DDD/1 000 inhabitants/year, 2005-2013

	Denmark	Faroe Islands	Green-land	Finland	Åland	Iceland	Norway	Sweden
J02 Antimycotics								
2005	189.8	166.1	118.5	161.8	138.2	116.2	58.9	88.6
2010	260.4	171.4	114.2	157.4	99.4	124.1	83.6	101.7
2012	272.9	200.1	86.0	197.1	138.7	..	93.9	106.5
2013	273.3	183.0	96.3	194.1	142.4	175.5	92.2	106.9

Table 3.7.18b Sales of antivirals for systemic use (ATC group J05), DDD/1 000 inhabitants/year, 2005-2013

	Denmark	Faroe Islands	Green-land	Finland	Åland	Iceland	Norway	Sweden
J05 Antivirals								
2005	489.4	66.5	683.0	250.8	123.0	326.9	323.4	389.8
2010	614.6	140.1	559.1	310.5	112.3	295.7	399.4	510.1
2012	730.0	194.6	542.0	368.7	135.1	..	478.3	557.4
2013	725.2	220.3	539.3	391.2	146.2	415.1	505.9	564.2

Table 3.7.19 Sales of antineoplastic and immunomodulating agents (ATC-group L), in euro/1 000 inhabitants/year at 2012 prices, 2005-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
L01 Antineoplastic agents								
2005	20 451	7 628	4 685	16 028	28 697	21 380	16 569	13 815
2010	39 893	12 606	12 711	26 420	35 038	30 274	24 565	25 905
2012	37 633	22 350	9 609	29 816	33 734	31 191	26 876	25 712
2013	43 029	19 030	11 866	30 998	36 541	29 934	29 433	28 177
L02 Endocrine therapy								
2005	6 502	4 491	307	6 678	8 489	10 550	11 653	7 178
2010	7 352	5 291	615	4 764	6 364	7 436	6 720	6 081
2012	4 110	3 971	384	4 051	4 949	5 829	7 266	4 941
2013	6 129	5 734	496	5 316	7 304	6 019	7 800	4 805
L03 Immunostimulants								
2005	10 245	2 859	100	8 891	7 974	10 845	11 010	8 454
2010	13 111	8 226	733	10 670	3 540	9 871	10 287	10 102
2012	12 713	6 228	935	10 689	4 809	8 895	9 640	9 159
2013	12 566	7 344	1 214	10 159	6 011	8 795	8 593	7 849
L04 Immunosuppressants								
2005	14 971	16 409	6 043	11 670	31 332	16 940	35 156	15 131
2010	39 913	39 413	20 001	22 347	42 260	41 461	48 325	35 268
2012	45 901	44 601	23 364	25 760	46 090	48 144	54 576	43 740
2013	50 702	49 305	32 236	31 168	49 159	55 927	56 011	45 813
L04AB Tumour necrosis factor alpha (TNF-α) inhibitors								
2005	10 294	9 620	5 085	7 593	28 232	12 750	27 238	10 816
2010	29 055	34 386	17 396	16 141	37 218	30 748	35 828	23 964
2012	31 828	39 438	23 239	19 999	39 034	34 748	39 002	28 745
2013	30 074	43 703	27 860	21 384	42 288	39 696	38 984	30 104

Table 3.7.20 Sales of analgesics (ATC-groups M01A, N02A and N02B), DDD/1 000 inhabitants/day, 2005-2013

	Denmark	Faroe Islands	Greenland[1]	Finland	Åland	Iceland	Norway	Sweden
M01A Anti-inflammatory and antirheumatic products non-steroids								
2005	54.9	40.3	24.0	76.7	55.8	68.0	44.0	51.4
2010	53.4	36.9	24.4	83.3	56.1	75.7	45.5	49.7
2012	44.4	34.1	23.0	85.1	56.4	78.5	47.5	47.5
2013	42.4	33.2	24.0	80.7	55.8	76.1	46.9	46.0
N02A Opioids								
2005	18.5	6.9	4.5	15.1	9.1	17.4	19.5	20.8
2010	20.2	7.8	6.5	16.5	9.1	19.0	19.8	20.0
2012	20.3	7.0	6.6	16.5	11.3	19.5	19.3	18.6
2013	20.1	7.6	7.1	16.3	9.6	20.6	19.3	18.2
N02B Other analgesics and antipyretics								
2005	71.2	54.7	44.3	20.6	36.3	30.9	29.8	49.5
2010	74.0	58.3	43.6	29.5	44.3	33.9	34.5	46.8
2012	74.5	58.8	41.7	32.3	45.1	36.0	37.4	46.2
2013	72.9	55.2	42.9	31.9	43.2	36.9	38.2	47.0
N02BA Salicylic acid and derivatives								
2005	12.9	14.3	0.8	5.5	9.9	3.5	0.5	9.8
2010	8.9	11.1	0.2	3.6	7.7	2.9	0.3	6.1
2012	8.3	9.7	0.1	3.0	7.5	3.0	0.2	4.9
2013	7.5	8.4		2.6	6.9	3.3	0.2	4.3
N02BB Pyrazolones								
2005	0.6	-	-	-	-	-	3.2	0.1
2010	0.3	-	-	-	-	-	2.3	0.1
2012	0.3	-	-	-	-	-	1.9	0.1
2013	0.2	-	-	-	-	-	1.8	0.1
N02BE Anilides								
2005	57.7	40.3	24.6	15.1	26.4	27.4	26.0	39.7
2010	64.8	47.2	43.4	25.9	36.6	31.0	31.9	40.6
2012	65.9	49.1	41.6	29.3	37.6	33.0	35.2	41.2
2013	65.0	46.8	42.8	29.3	36.3	33.6	36.2	42.6

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

Figure 3.7.7 Sales of non-opioid analgesics (ATC-groups M01A and N02B), DDD/1 000 inhabitants/day, 2005-2013

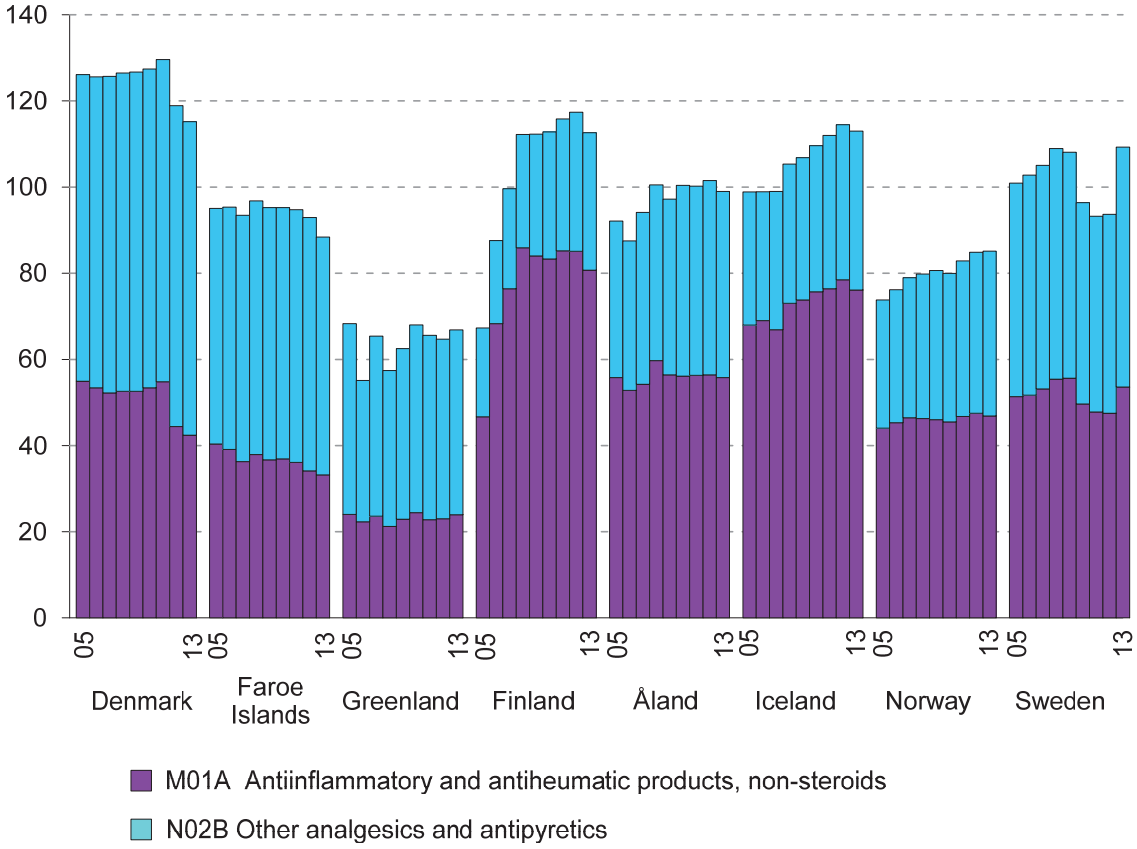


Figure 3.7.8 Sales of opioid analgesics (ATC-group N02A), DDD/1 000 inhabitants/day, 2005-2013

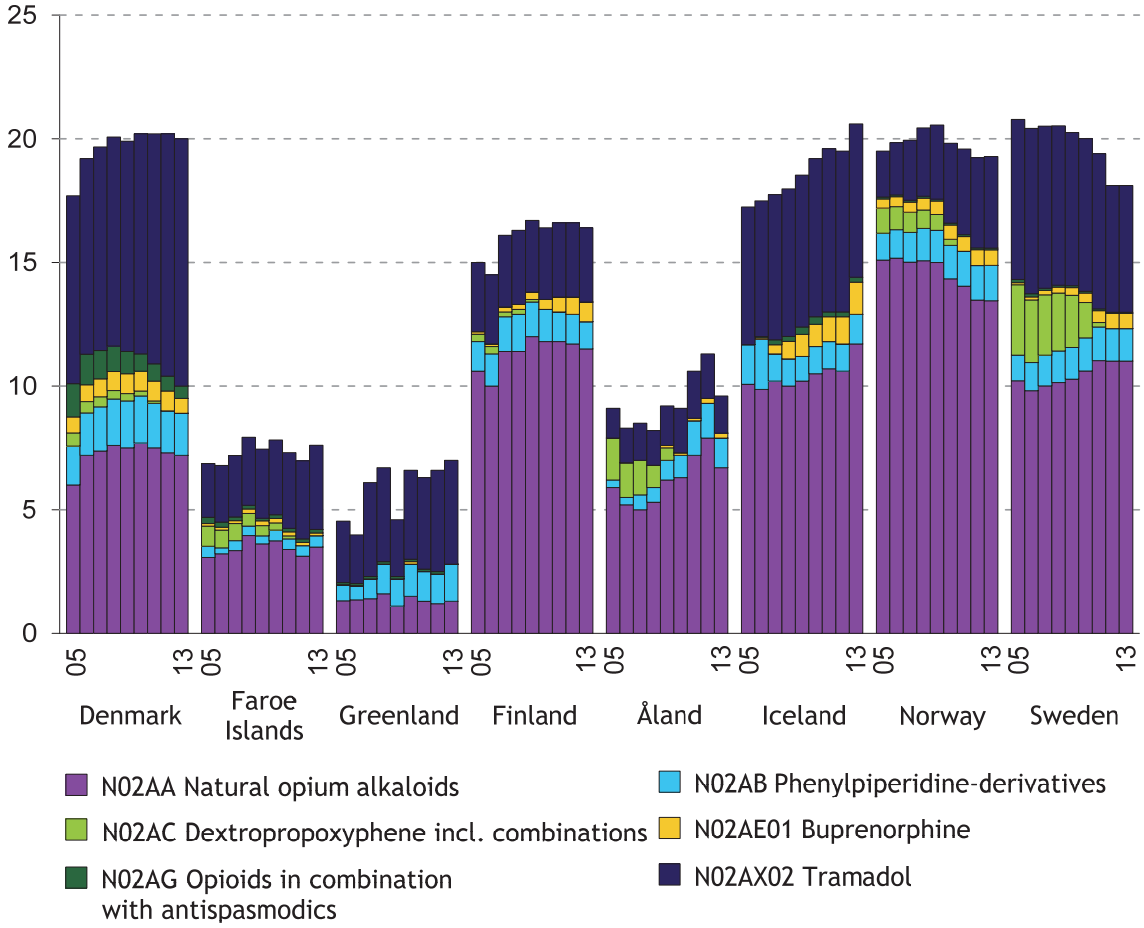


Table 3.7.21 Sales of antimigraine preparations (ATC-group N02C), DDD/1 000 inhabitants/day, 2005-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	2.5	2.1	..	1.1	2.0	1.5	3.2	3.1
2010	2.9	2.4	1.3	1.5	2.2	1.7	3.5	3.0
2012	2.9	2.2	1.2	1.8	2.3	1.8	3.6	3.0
2013	3.0	2.3	1.4	1.9	2.1	1.7	3.7	3.0

Table 3.7.22 Sales of antiepileptics (ATC-group N03), DDD/1 000 inhabitants/day, 2005-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	11.6	9.0	..	12.5	8.4	11.9	10.2	9.1
2010	14.7	11.5	9.7	18.0	11.2	17.2	14.5	13.0
2012	16.5	12.5	9.6	19.0	11.9	18.2	15.4	13.6
2013	17.3	13.8	10.6	19.9	12.5	18.9	15.6	14.2

Table 3.7.23 Sales of anti-parkinson drugs (ATC-group N04), DDD/1 000 inhabitants/day, 2005-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	3.5	5.0	..	4.5	2.9	4.1	3.0	3.7
2010	4.1	4.4	2.7	4.9	3.7	4.8	3.5	3.9
2012	4.3	4.4	3.0	4.9	3.7	4.6	3.8	4.0
2013	4.5	4.3	3.0	4.7	3.8	4.7	3.8	4.0

Table 3.7.24 Sales of antipsychotics (ATC-group N05A), DDD/1 000 inhabitants/day, 2005-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	13.0	10.4	14.6	17.4	9.3	11.5	10.6	9.2
2010	13.9	12.7	16.0	20.7	9.6	11.2	10.8	9.8
2012	14.7	13.0	15.6	21.3	9.5	12.1	11.1	10.3
2013	14.3	12.8	15.7	21.5	9.2	12.4	10.9	10.4

Table 3.7.25 Sales of anxiolytics (ATC-group N05B), DDD/1 000 inhabitants/day, 2005-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N05B Anxiolytics								
2005	19.9	17.1	5.3	31.2	9.9	25.8	21.3	16.4
2010	11.8	11.5	2.9	28.0	10.7	24.7	19.5	16.2
2012	10.3	10.3	2.4	25.6	10.9	..	17.2	15.6
2013	9.6	10.2	2.3	24.3	10.5	23.2	16.4	15.4
N05BA Benzodiazepine derivates								
2005	19.6	17.0	5.3	29.5	8.0	24.6	20.1	13.6
2010	11.5	11.2	2.1	26.2	8.5	24.6	18.0	12.8
2012	10.0	10.0	2.4	23.9	8.4	23.4	15.6	12.1
2013	9.3	9.9	2.3	22.4	7.9	21.6	14.8	11.7

Table 3.7.26 Sales of hypnotics and sedatives (ATC-group N05C), DDD/1 000 inhabitants/day, 2005-2013[1]

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N05C Hypnotics and sedatives								
2005	31.4	31.0	8.8	54.4	34.2	66.7	41.4	51.6
2010	20.3	23.3	7.1	46.8	34.3	75.9	42.5	52.2
2012	18.0	21.2	6.2	42.0	34.0	73.8	39.0	52.6
2013	16.7	20.1	5.7	39.2	33.8	69.4	39.0	52.5
N05CD Benzodiazepine derivates								
2005	10.5	7.1	0.5	20.9	4.3	12.1	8.5	6.7
2010	4.8	4.2	0.4	15.6	3.5	8.6	6.3	4.1
2012	3.8	3.1	0.5	13.2	3.3	6.6	4.1	3.4
2013	2.9	2.6	0.3	12.0	3.1	6.0	3.6	3.0
N05CF Benzodiazepine-related drugs								
2005	20.9	23.4	8.3	33.1	29.3	54.5	32.8	30.4
2010	15.3	18.1	6.7	30.7	30.3	66.2	36.1	34.1
2012	14.2	16.2	5.8	28.3	30.2	65.1	34.7	35.3
2013	13.8	15.6	5.4	26.9	30.3	63.1	35.2	35.9

1 Sales excluding melatonin (N05CH01)

Figure 3.7.9 Sales of hypnotics and sedatives (ATC-group N05C), DDD/1 000 inhabitants/day, 2005-2013

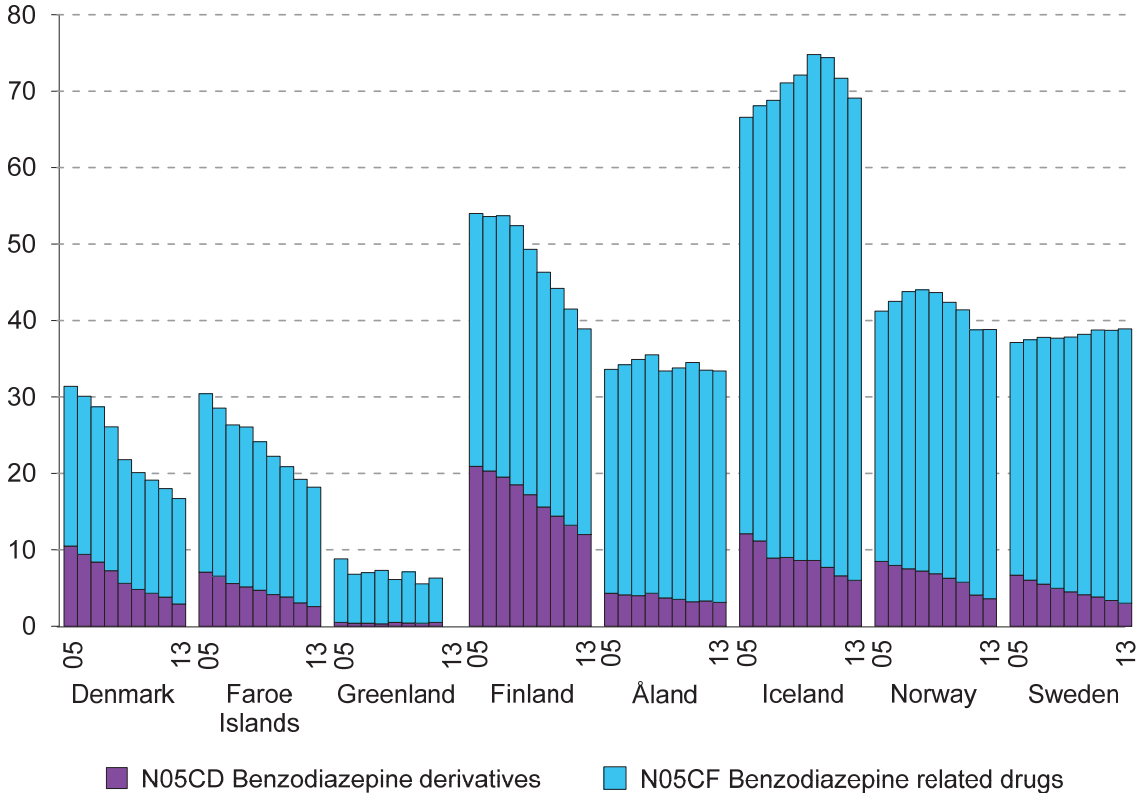


Table 3.7.27 Sales of antidepressants (ATC-group N06A), DDD/1 000 inhabitants/day, 2005-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N06A Antidepressants								
2005	60.1	36.5	20.4	52.1	40.7	94.8	51.8	66.1
2010	84.0	57.2	24.1	69.2	50.9	101.1	56.4	75.8
2012	83.2	61.8	26.6	69.8	54.6	108.8	57.2	81.1
2013	80.0	62.6	25.5	69.4	56.3	117.7	56.1	84.3
N06AA Non-selective monoamine reuptake inhibitors								
2005	4.3	2.1	1.1	4.2	3.2	8.1	3.8	3.8
2010	4.6	1.9	0.8	4.3	2.9	5.5	3.6	3.5
2012	4.8	1.8	1.1	4.3	3.4	5.6	3.5	3.4
2013	4.6	1.6	1.2	4.3	3.1	5.6	3.5	3.2
N06AB Selective serotonin reuptake inhibitors								
2005	41.7	26.4	16.0	35.3	30.4	64.8	34.8	48.4
2010	56.6	40.5	16.6	44.2	36.1	72.3	37.8	53.2
2012	53.0	43.1	17.0	42.8	36.0	77.4	38.0	56.0
2013	50.1	44.0	16.8	41.7	36.7	84.0	36.9	57.8
N06AG Monoamine oxidase type A inhibitors								
2005	0.1	-	-	0.7	0.2	0.8	0.3	0.2
2010	-	-	-	0.6	0.3	0.5	0.2	0.1
2012	-	-	-	0.5	0.1	0.4	0.2	0.1
2013	-	-	-	0.4	0.1	0.4	0.1	0.1
N06AX Other antidepressants								
2005	13.9	8.0	3.3	12.0	6.8	21.2	13.0	13.6
2010	22.7	14.8	6.6	20.2	11.5	22.8	14.8	19.0
2012	25.3	16.9	8.5	22.3	15.1	25.4	15.5	21.5
2013	25.0	17.1	7.5	23.0	16.3	27.7	15.5	23.2

Figure 3.7.10 Sales of antidepressants (ATC-group N06A), DDD/1 000 inhabitants/day, 2005-2013

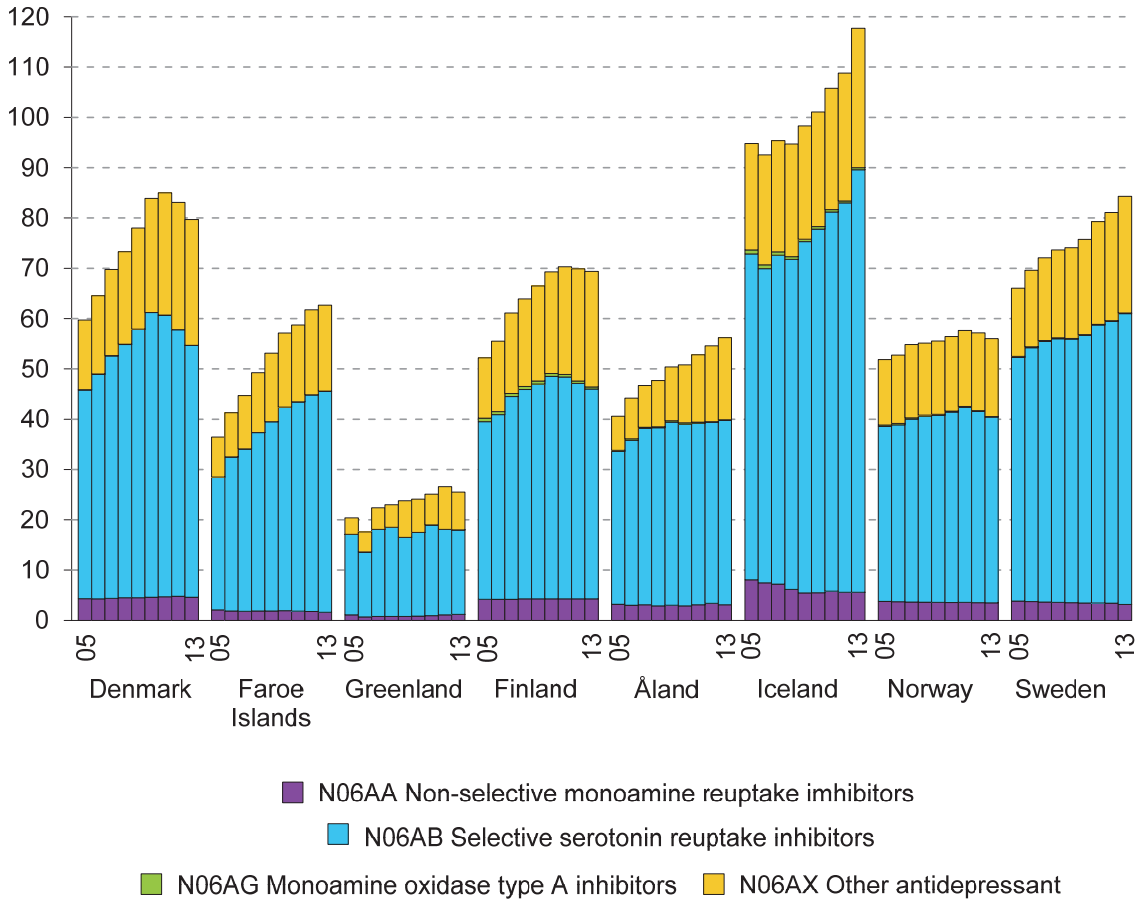


Table 3.7.28 Share of the population per 1 000 (one-year prevalence) receiving at least one antidepressant (ATC-group N06A) by gender and age, 2013

	Denmark		Faroe Islands		Finland		Iceland		Norway		Sweden	
Age	M	W	M	W	M	W	M	W	M	W	M	W
0-14	1.5	1.5	1.3	3.0	1.7	1.9	22.5	20.6	0.8	0.7	2.2	1.8
15-24	24.1	52.7	26.5	64.2	33.0	67.0	74.5	129.4	18.9	38.7	31.2	60.3
25-44	58.2	100.5	45.4	76.5	68.8	106.5	99.1	177.4	44.7	76.2	61.2	114.5
45-64	78.1	129.9	56.2	99.0	79.3	127.6	123.6	232.1	63.1	119.8	79.1	149.4
65-74	87.0	137.5	79.5	123.4	69.7	108.9	158.4	276.7	65.2	131.5	83.6	152.1
75+	143.7	223.9	143.1	243.0	108.9	168.0	190.5	288.0	86.3	153.9	148.8	242.7

Table 3.7.29 Share of the population per 1 000 (one-year prevalence) receiving at least one centrally acting sympathomimetic (ATC group N06BA[1]) by gender and age, 2013

	Men	Women	Total
Denmark			
0-5 years	0.4	0.2	0.3
6-10 years	19.9	5.7	13.0
11-15 years	34.3	11.3	23.1
16-19 years	25.3	15.2	20.4
20-29 years	14.5	10.0	12.3
30-40 years	8.7	7.1	7.9
Faroe Islands			
0-5 years	0.5	-	0.3
6-10 years	12.3	5.2	8.9
11-15 years	27.9	14.1	21.3
16-19 years	12.5	12.4	12.5
20-29 years	9.9	6.1	8.3
30-40 years	3.0	4.3	3.6
Greenland			
0-5 years	..	..	..
6-10 years	..	..	..
11-15 years	..	..	..
16-20 years	..	..	..
Finland			
0-5 years	0.2	0.1	0.1
6-10 years	20.9	4.1	12.7
11-15 years	30.3	5.6	18.2
16-20 years	10.0	3.3	6.7
Iceland			
0-4 years	0.7	0.3	0.5
5-9 years	60.0	20.7	40.8
10-14 years	122.7	46.0	84.7
15-19 years	71.0	42.5	57.1
Norway			
0-5 years	0.2	0.0	0.1
6-10 years	17.5	5.8	11.8
11-15 years	40.4	15.5	28.2
16-20 years	23.9	14.3	19.2
Sweden			
0-5 years	0.3	0.1	0.2
6-10 years	21.4	6.4	14.1
11-15 years	50.5	17.7	34.5
16-19 years	33.9	22.1	28.2
20-29 years	12.1	11.1	11.6
30-40 years	8.24	7.26	7.76

1 Excl. N06BA07

Table 3.7.30 Share of the population (one-year prevalence) receiving at least one centrally acting sympathomimetic (ATC group N06BA[1]), 2005-2013

	Denmark	Faroe Islands	Finland	Iceland	Norway	Sweden
2005	5.5	2.6	..	..	11.7	..
2006	7.2	4.6	..	..	14.5	6.8
2007	9.0	5.1	..	..	15.4	8.7
2008	12.0	5.0	..	52.6	16.7	10.6
2009	15.1	7.2	..	57.5	17.9	13.2
2010	17.9	8.5	..	61.2	19.0	16.2
2012	18.7	12.7	13.7	66.0	20.0	21.6
2013	21.4	15.1	15.4	62.3	20.0	23.9

1 Excl. N06BA07

Table 3.7.31 Sales of anti-dementia drugs (ATC-group N06D), DDD/1 000 inhabitants/day, 2005-2013

	Denmark	Faroe Islands	Green-land	Finland	Åland	Iceland	Norway	Sweden
2005	2.0	1.1	0.1	6.5	2.5	2.7	3.1	3.0
2010	2.9	2.3	0.2	12.1	4.5	2.9	3.0	3.6
2012	3.2	3.5	0.3	14.3	4.0	3.1	3.4	4.0
2013	3.4	4.2	0.6	15.3	3.9	3.7	3.3	4.2

Table 3.7.32 Sales of anti-asthmatics (ATC group R03), DDD/1 000 inhabitants/day, 2005-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
R03 Drugs for obstructive airway diseases								
2005	60.5	38.1	37.4	51.8	50.6	45.0	61.0	50.4
2010	60.5	35.9	32.2	60.6	53.3	41.3	63.4	50.1
2012	59.4	35.2	33.9	64.2	52.9	42.8	63.2	49.6
2013	58.6	35.6	31.7	65.6	55.0	42.2	63.5	50.6
R03A Adrenergics, inhalants								
2005	36.8	21.4	17.6	28.4	28.7	31.2	36.5	27.4
2010	36.8	20.2	15.8	33.4	33.2	25.7	37.3	28.3
2012	36.1	20.2	15.7	34.7	33.3	27.1	37.0	27.8
2013	35.4	20.2	15.2	35.2	33.4	27.2	37.4	28.1
R03AC Selective beta-2-adrenoceptor agonists								
2005	22.3	18.3	17.1	11.3	9.4	13.2	18.0	16.5
2010	19.0	13.0	14.9	11.9	8.7	14.4	17.1	13.9
2012	18.8	12.0	14.1	12.8	8.6	14.8	16.8	13.1
2013	18.7	11.7	12.9	12.8	8.4	14.0	16.6	13.2
R03AK Adrenergics in combination with corticosteroids or other drugs exclusive anticholinergics								
2005	14.5	2.9	0.5	15.2	13.3	18.0	18.6	10.9
2010	17.8	6.9	0.8	20.4	16.9	11.3	20.2	14.4
2012	17.3	7.8	1.6	20.9	17.4	12.3	20.3	14.7
2013	15.5	8.0	2.1	21.4	18.6	13.2	20.8	14.3
R03B Other drugs for obstructive airway diseases. inhalants								
2005	20.1	15.5	18.0	17.3	16.4	11.3	18.5	19.6
2010	19.9	14.7	15.3	19.3	15.4	14.0	20.0	18.7
2012	19.8	14.0	17.4	20.9	14.6	14.1	20.1	18.5
2013	19.8	14.5	15.7	22.6	15.9	13.3	20.3	19.1
R03D Other systemic drugs for obstructive airway diseases								
2005	3.1	0.5	1.0	5.9	5.2	2.4	5.4	2.7
2010	3.2	0.7	0.8	7.5	4.5	1.5	5.8	2.7
2012	3.1	0.8	0.8	7.7	4.8	1.5	5.8	3.0
2013	3.1	0.7	0.7	7.7	5.5	1.7	5.6	3.1

Figure 3.7.11 Sales of anti-asthmatics (ATC-Group R03), DDD/1 000 inhal-ants/day, 2005-2013

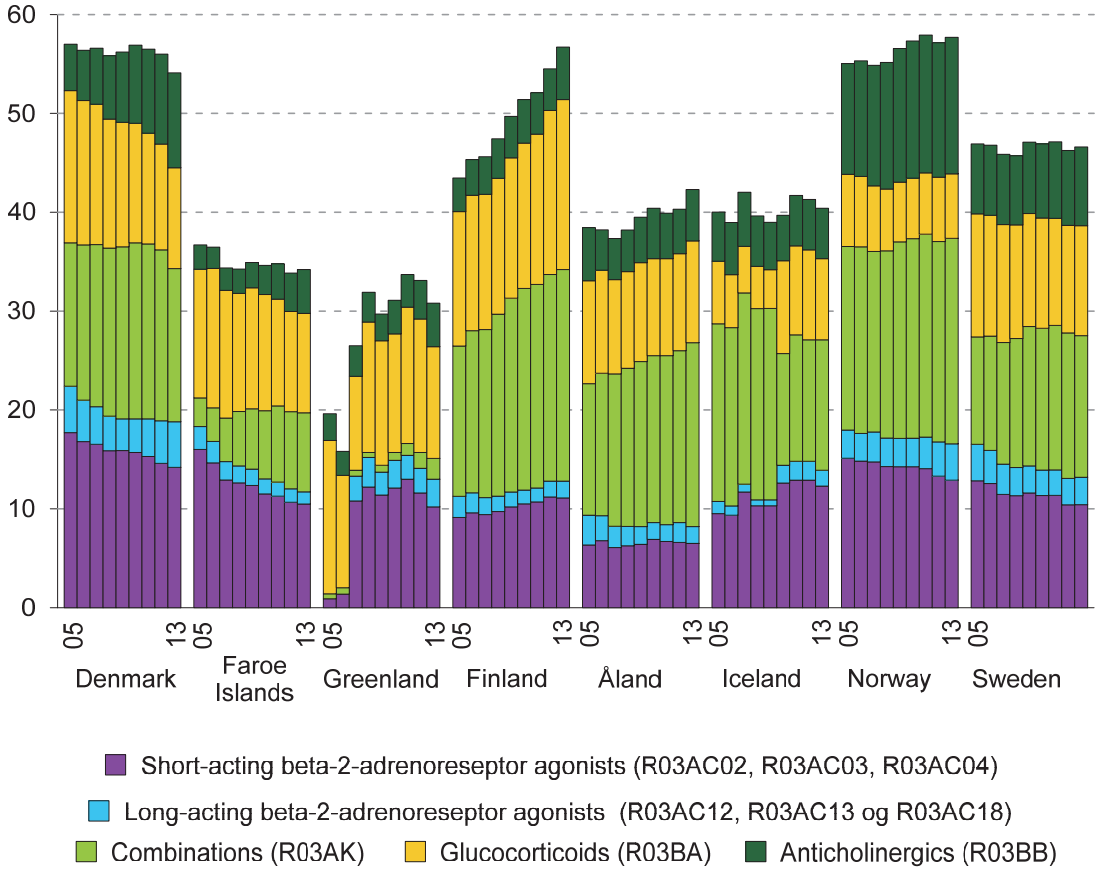


Table 3.7.33 Share of the population per 1 000 (one-year prevalence) receiving at least one anti-asthmatic inhalant (ATC-groups R03A and R03B) by gender and age, 2013

	Denmark		Faroe Islands		Finland		Iceland[1]		Norway		Sweden	
Age	M	W	M	W	M	W	M	W	M	W	M	W
0-14	80.1	55.8	87.4	72.6	96.5	64.7	177.2	142.0	84.6	59.9	79.0	55.0
15-24	37.3	46.2	44.8	57.6	52.5	67.5	55.5	75.9	43.3	54.4	41.1	53.4
25-44	43.5	52.9	36.5	58.6	56.0	89.7	61.2	94.6	43.1	60.0	41.8	60.9
45-64	65.3	90.5	50.0	76.9	81.2	124.4	100.3	177.6	71.2	102.9	61.7	95.6
65-74	106.9	131.9	84.0	129.0	115.3	142.2	186.1	286.5	120.5	150.7	95.2	140.0
75+	162.6	150.0	99.2	108.9	152.0	144.4	210.3	234.3	143.0	125.2	130.4	138.5

1 2009

Table 3.7.34 Sales of antihistamines (ATC-group R06A), DDD/1 000 inhabit-ants/day, 2005-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	20.4	20.7	7.5	31.2	24.8	30.0	54.8	30.8
2010	27.0	25.2	10.6	42.6	31.4	38.4	58.8	36.8
2012	30.1	27.7	12.6	48.7	35.1	44.9	62.2	41.3
2013	31.4	30.9	13.0	46.1	32.2	45.9	62.8	41.3

Chapter 4

Mortality and Causes of Death

Extra material

Nowbase.org -Background tables for Health Statistics Health Statistics

The International Classification of Diseases (ICD)

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

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

Sources of error

Statistical analyses are carried out on aggregated data, for example at chapter level. There are 21 chapters in ICD-10. The basic structure of ICD has generally remained the same through the revisions, and most chapters have kept their former names. However, it is important to realize that even if the name of a chapter is the same in ICD-10 as in ICD-9, differences in content may exist due to the transfer of diagnostic codes from one chapter to another. For example, HIV and AIDS were originally placed among diseases of the immune system in ICD-9 but were moved to the chapter for infectious diseases in ICD-10. Another example is the transfer of transitory ischemic

attacks from the chapter on circulatory diseases in ICD-9 to the chapter on nervous system diseases in ICD-10. Certain symptoms have also been moved from the chapter on symptoms to the so-called organ chapters.

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

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

Change in classification

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

Coding practice

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

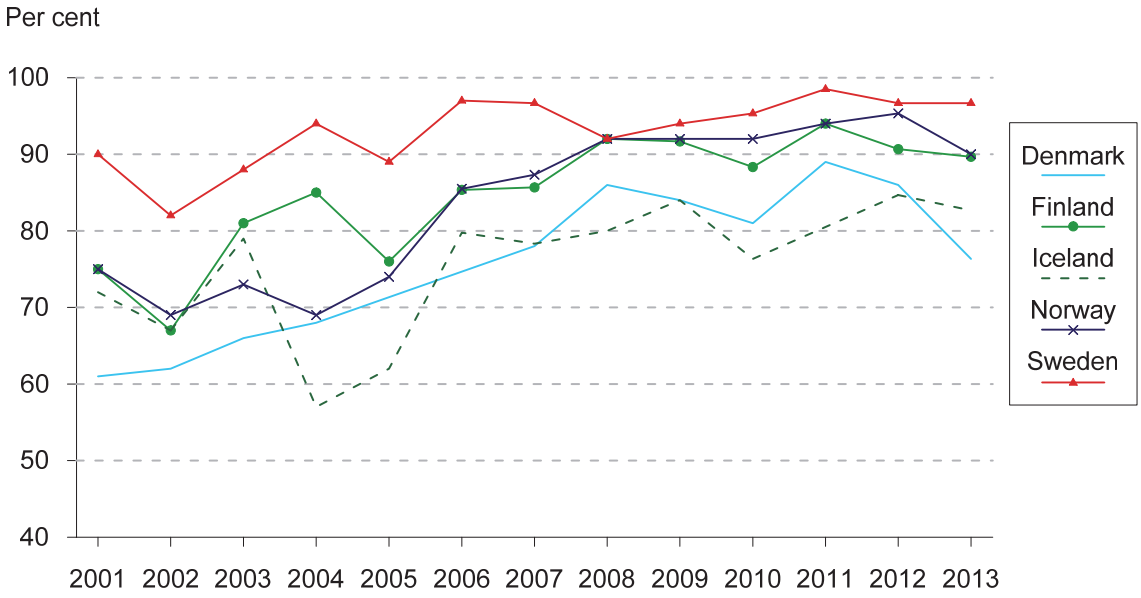
Apart from the fact that the ICD rules governing mortality coding give room for interpretation, different national traditions for the choice of underlying cause of death

may also develop. An example of this is the use of the diagnostic group "insufficiently defined conditions" (codes I469, I959, I99; J960, J969, P285.0, R000-R948 and R96-99). The use of these codes as underlying causes of death is more widespread in Denmark than in the other Nordic countries in situations where more specific causes of death are also recorded on the death certificate (See Table 4.1.11).

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

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

Figure 4.1.1 National coding compared to ACME 2001-2013



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

This comparison, and Nordic coding practice in general, is discussed at annual meetings. As seen in Figure 4.1.1., the coding in the different countries is not only getting closer to ACME's coding, but the differences in coding among the countries

are also getting smaller. This indicates that the use of automatic coding and cooperation between the Nordic countries leads to a higher degree of comparability of mortality statistics.

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

Autopsy rates

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

The reliability of the statistics

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

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

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

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

Age	Total		Under 1 year[1]		1-14 years		15-24 years		25-64 years		65+ years	
Gender	M	W	M	W	M	W	M	W	M	W	M	W
Denmark												
2000	1 069	1 099	607	456	17	12	79	30	444	294	6 368	5 455
2005	1 001	1 030	509	359	14	9	58	19	425	275	5 761	5 131
2010	965	984	363	320	9	7	41	21	408	254	4 936	4 622
2012	927	935	347	344	9	8	36	13	363	232	4 525	4 205
Faroe Islands												
2003-07	920	747	679	354	34	16	68	13	357	175	5 410	4 697
2008-12	853	716	438	752	20	17	16	45	307	178	4 648	4 089
Greenland												
2002-06	860	724	..	..	89	64	520	179	690	490	7 383	6 632
2008-12	1 256	965	26	19	15	12	78	35	499	305	638	594
Finland												
2000	952	954	424	324	14	14	96	34	504	222	5 545	4 606
2005	934	888	333	286	18	13	69	29	517	229	4 838	4 045
2010	971	929	259	192	12	11	80	27	484	217	4 719	4 047
2012	964	947	241	233	11	12	66	30	436	207	4 505	3 975
Åland												
2003-07	767	805	414	-	27	37	26	-	261	129	4 163	3 880
2008-12	967	980	414	0	27	37	39	14	310	156	5 333	4 724
Iceland												
2000	644	653	456	141	13	10	120	43	272	187	4 591	4 317
2005	636	606	275	191	6	10	77	19	241	150	4 659	4 051
2010	666	604	198	252	13	13	54	31	228	133	4 805	3 965
2012	592	627	86	135	10	7	29	9	244	147	3 867	3 983
Norway												
2000	974	985	427	329	18	15	93	33	339	201	6 052	4 965
2005	877	906	329	283	18	11	73	31	307	198	5 533	4 846
2010	817	878	277	229	12	9	58	30	293	187	4 922	4 581
2012	797	876	280	214	11	12	47	17	276	171	4 622	4 518
Sweden												
2000	1 041	1 065	399	281	15	12	59	24	305	200	5 829	4 854
2005	996	1 026	215	206	17	13	48	21	298	195	5 420	4 725
2010	941	990	273	242	10	10	50	22	283	180	4 747	4 429
2012	934	999	287	231	11	9	47	20	262	172	4 558	4 374

1 Per 100 000 live births
Source: The national central statistical bureaus

Table 4.1.2a Death rates from malignant neoplasms per 100 000 men by age, 2000-2012

		Denmark	Faroe Islands [1,2,3,4]	Greenland [1,3,4]	Finland	Åland[1,3,4]	Iceland	Norway	Sweden
Age									
0-14	2000	3	..	..	2	..	3	3	3
	2005	3	7	3	3	-	-	3	4
	2010	1	-	6	3	-	..	3	2
	2012	2	-	6	2	-	..	2	3
15-34	2000	9	..	..	6	..	7	7	8
	2005	6	3	12	6	19	-	5	5
	2010	5	7	7	6	6	..	5	5
	2012	5	3	9	7	6	..	3	6
35-44	2000	33	..	.	22	..	38	32	20
	2005	29	17	39	23	-	9	20	20
	2010	23	27	47	19	10	..	16	19
	2012	21	23	48	18	10		18	19
45-54	2000	148	..	..	107	170	100	120	97
	2005	145	106	166	105	196	102	127	91
	2010	110	78	133	84	42	..	77	63
	2012	98	65	163	79	62	..	74	64
55-64	2000	462	..	..	320	..	227	348	294
	2005	424	349	793	323	347	346	324	281
	2010	385	314	596	316	342	..	300	260
	2012	365	282	568	276	278	..	289	238
65-74	2000	1 189	..	..	902	..	900	953	826
	2005	1 071	888	1 844	752	910	844	861	811
	2010	970	928	1 868	747	940	..	850	678
	2012	926	855	1 579	761	817	..	730	649
75+	2000	2 440	..	..	1 947	..	1 888	2 142	1 935
	2005	2 454	1 787	3 446	1 808	2 443	2 083	2 239	1 973
	2010	2 298	2 077	3 109	1 780	1 890	..	2 231	1 920
	2012	2 232	2 119	2 550	1 677	2 131	..	2 174	1 920

1 2005 = 2001-05
2 2010 = 2007-10
3 2010 = 2006-10
4 2012 = 2008-12

ICD-9: 140-208 and ICD-10: C00-C97
Source: The national central statistical bureaus

Table 4.1.2b Death rates from malignant neoplasms per 100 000 women, by age, 2000-2012

		Denmark	Faroe Islands [1,2,3,4]	Greenland [1,3,4]	Finland	Åland[1,3,4]	Iceland	Norway	Sweden
Age									
0-14	2000	2	..	..	2	..	3	4	3
	2005	1	0	6	4	9	6	1	2
	2010	1	5	3	3	18	..	1	2
	2012	1	12	-	2	18	..	4	2
15-34	2000	9	..	..	7	..	2	6	9
	2005	7	11	13	6	-	5	4	5
	2010	7	4	18	4	-	..	7	5
	2012	7	4	12	6	-	..	5	5
35-44	2000	41	..	..	36	..	19	39	21
	2005	39	44	66	27	21	19	35	30
	2010	36	-	50	30	21	..	27	24
	2012	29	6	42	28	42	..	28	26
45-54	2000	164	..	..	106	..	113	126	94
	2005	149	83	293	99	147	108	120	105
	2010	130	68	203	89	61	..	97	85
	2012	116	71	206	79	70	..	88	87
55-64	2000	425	..	..	237	..	396	319	296
	2005	372	337	626	236	171	247	300	291
	2010	342	314	644	223	249	..	286	258
	2012	312	328	615	212	249	..	248	230
65-74	2000	905	..	..	505	..	775	600	719
	2005	828	807	1 672	457	405	648	569	586
	2010	714	447	1 552	477	605	..	583	547
	2012	702	510	1 589	487	599	..	573	536
75+	2000	1 460	..	..	1 077	..	1 285	1 184	1 210
	2005	1 492	1 210	2 151	1 004	1 065	1 045	1 214	1 112
	2010	1 485	1 180	1 457	1 023	1 259	..	1 252	1 148
	2012	1 477	1 217	1 806	999	1 359	..	1 230	1 202

1 2005 = 2001-05
2 2010 = 2007-10
3 2010 = 2006-10
4 2012 = 2008-12

ICD-9: 140-208 and ICD-10: C00-C97
Source: The national central statistical bureaus

Table 4.1.3a Death rates from circulatory diseases per 100 000 men, by age, 2000-2012

		Denmark	Faroe Islands [1,2,3,4]	Greenland [1,3,4]	Finland	Åland[1,3,4]	Iceland	Norway	Sweden
Age									
0-34	2000	3	..	6	5	..	3	3	3
	2005	4	3	-	3	-	3	3	3
	2010	2	2	5	4	-	..	2	2
	2012	2	2	5	3	-	..	3	2
35-44	2000	23	..	51	44	..	38	25	21
	2005	21	28	29	39	22	14	25	18
	2010	22	20	47	28	10	..	23	13
	2012	16	11	61	28	10	..	17	17
45-54	2000	95	..	179	184	..	113	93	104
	2005	83	81	133	144	164	55	77	79
	2010	64	47	88	117	63	..	65	63
	2012	55	59	106	105	62	..	57	59
55-64	2000	326	..	473	481	..	209	282	303
	2005	233	319	411	403	252	254	211	243
	2010	197	216	373	385	171	..	187	217
	2012	180	174	341	327	179	..	182	196
65-74	2000	1 095	..	1 049	1 378	..	877	1 065	1 101
	2005	831	864	1 757	1 046	771	627	706	794
	2010	557	663	1 552	897	701	..	526	592
	2012	466	586	1 382	804	788	..	463	557
75+	2000	4 467	..	5 058	4 766	..	3 963	4 681	4 851
	2005	3 871	4 443	5 137	3 917	3 879	3 290	3 653	4 397
	2010	2 948	3 654	4 363	3 808	3 939	..	3 148	3 946
	2012	2 598	3 135	4 235	3 633	3 413	..	3 020	3 731

1 2005 = 2001-05
2 2010 = 2007-10
3 2010 = 2006-10
4 2012 = 2008-12

ICD-9: 390-459 and ICD-10: I00-I99
Source: The national central statistical bureaus

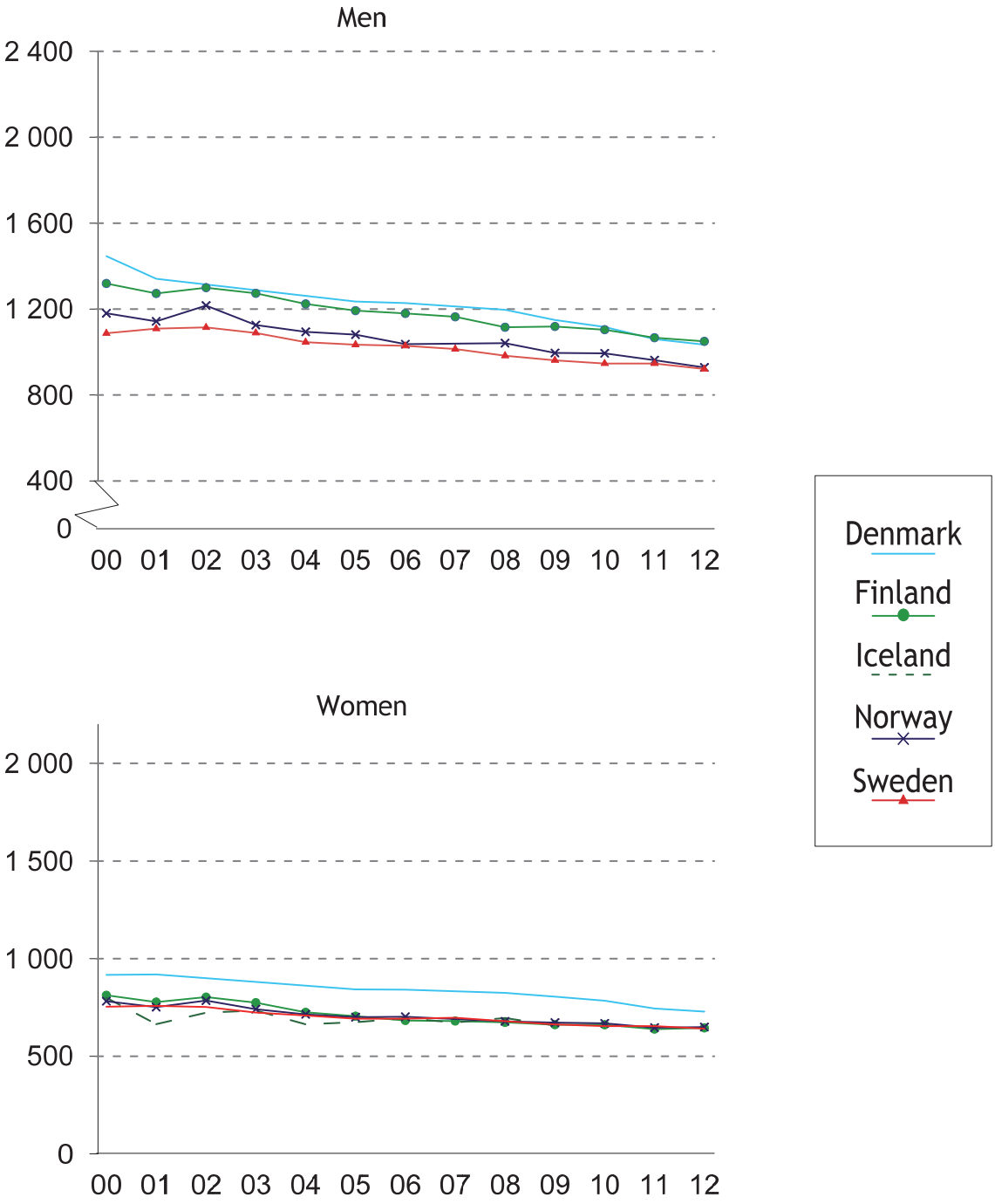
Table 4.1.3b Death rates from circulatory diseases per 100 000 women, by age, 2000-2012

		Denmark	Faroe Islands[1,2,3]	Greenland[1,3,4]	Finland	Åland[1,3,4]	Iceland	Norway	Sweden
Age									
0-34	2000	2	..	7	2	..	3	4	3
	2005	1	-	13	4	9	6	1	2
	2010	1	5	-	3	18	..	1	2
	2012	2	18	7	3	7	..	2	2
35-44	2000	14	..	42	17	..	10	11	11
	2005	11	6	27	10	-	5	9	6
	2010	8	-	14	9	-	..	7	6
	2012	6	-	16	72	-	..	4	6
45-54	2000	41	..	109	48	..	24	36	34
	2005	39	21	102	37	10	15	23	28
	2010	25	17	116	31	10	..	21	21
	2012	23	39	70	25	10	..	21	22
55-64	2000	41	..	271	48	..	24	36	34
	2005	39	133	236	37	10	15	23	28
	2010	76	52	262	91	80	..	61	77
	2012	68	30	325	89	86	..	59	74
65-74	2000	561	..	1 427	551	..	419	471	469
	2005	409	428	993	404	313	340	311	346
	2010	273	262	801	297	213	..	236	269
	2012	222	239	763	298	270	..	207	270
75+	2000	3 722	..	8 038	4 090	..	3 421	3 794	4 059
	2005	3 211	3 469	5 211	3 463	4 017	2 885	3 085	3 648
	2010	2 635	2 492	3 302	3 345	3 492	..	2 907	3 537
	2012	2 335	2 221	3 154	3 221	3 653	..	2 956	3 404

1 2005 = 2001-05
2 2010 = 2007-10
3 2010 = 2006-10
4 2012 = 2008-12

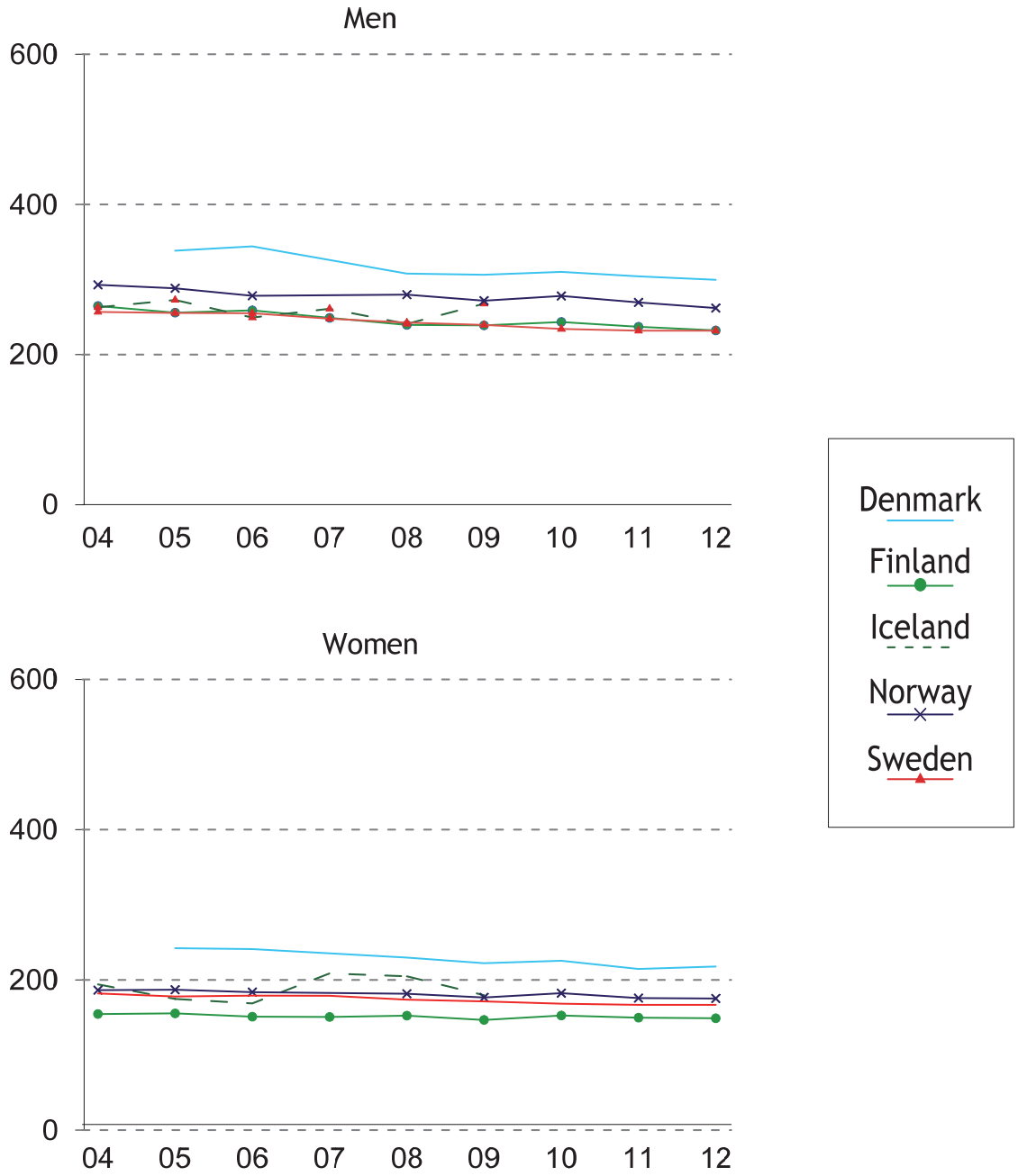
ICD-9: 390-459 and ICD-10: I00-I99
Source: The national central statistical bureaus

Figure 4.1.2 Deaths per 100 000 inhabitants by gender, in age standardized rates 2000-2012



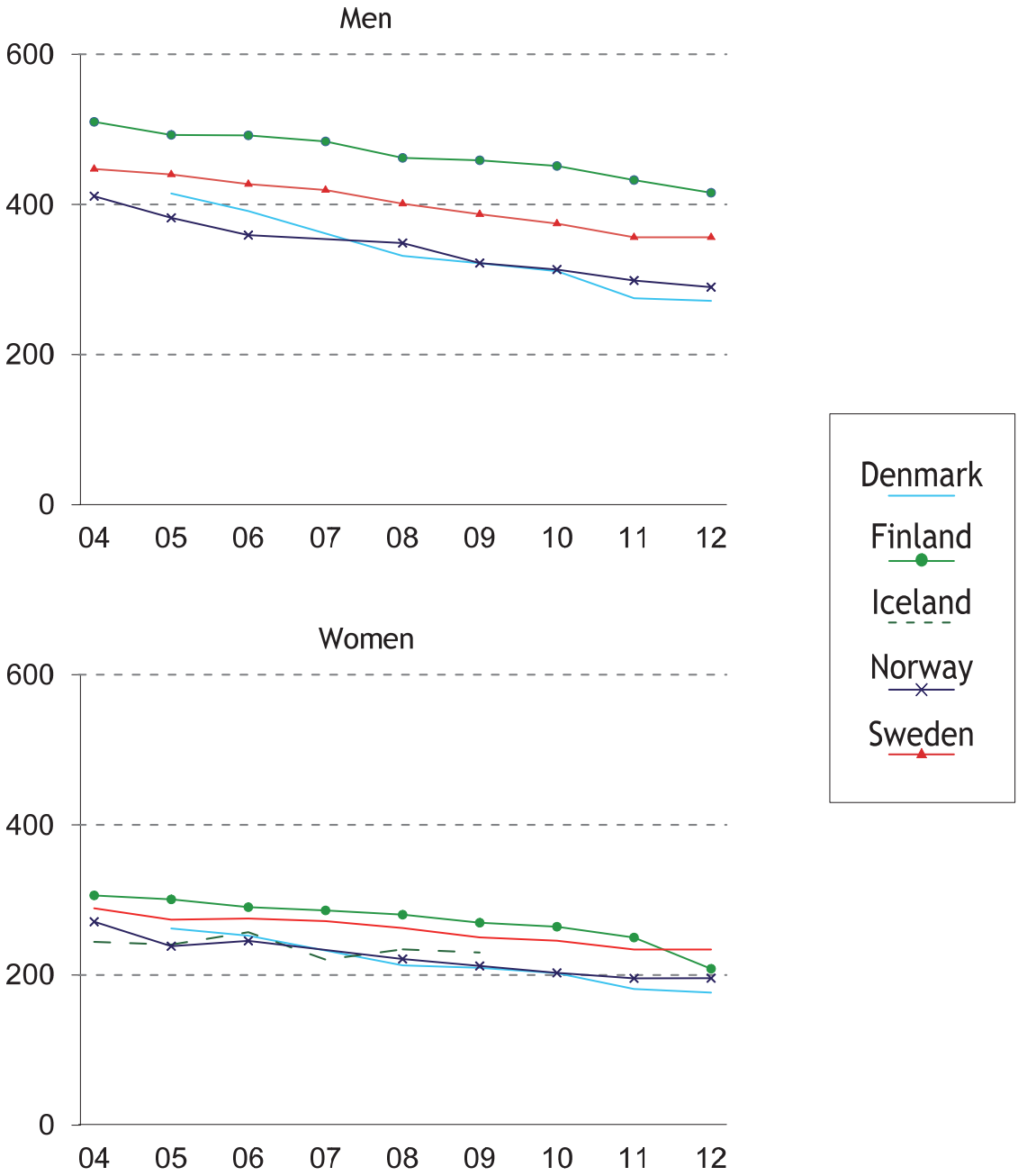
Age-standardized by the Nordic population 2000
Source: The national central statistical bureaus

Figure 4.1.3 Deaths from malignant neoplasms per 100 000 inhabitants by gender, age standardized rates, 2000-2012



Age-standardized by the Nordic population, 2000
Sources: The national registers for causes of death

Figure 4.1.4 Deaths from circulatory diseases per 100 000 inhabitants by gender, age standardized rates, 2000-2012



Age-standardized by the Nordic population, 2000
Sources: The national registers for causes of death

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

ICD-10 code	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2012	2008-12	2008-12	2012	2008-12	2009	2012	2012
Malignant neoplasm of the oesophagus (C15)	5.6	5.8	13.0	3.4	4.7	3.3	2.7	2.9
Malignant neoplasm of the trachea, bronchus and lung (C32-C34)	42.8	24.4	61.6	27.4	29.0	26.6	27.1	23.3
Malignant neoplasm of cervix uteri [1] (C53)	2.6	1.9	8.5	1.3	-	1.4	2.0	1.7
Diabetes mellitus (E10-E14)	9.5	7.1	6.1	4.7	0.8	4.0	4.8	6.4
Cerebrovascular diseases (I60-I69)	15.3	12.4	37.8	19.2	19.6	9.0	10.8	13.0
Obstructive lung diseases (J40-J44)	0.8	7.5	16.9	8.7	10.2	9.6	13.2	9.0
Asthma[2] (J45-J46)	-	-	-	-	-	-	-	0.1
Chronic liver disease and cirrhosis (K70; K73-K74)	12.8	1.8	2.2	22.5	7.0	1.7	3.2	6.2

1 Per 100 000 women
2 0-14 years old
Source: The national central statistical bureaus

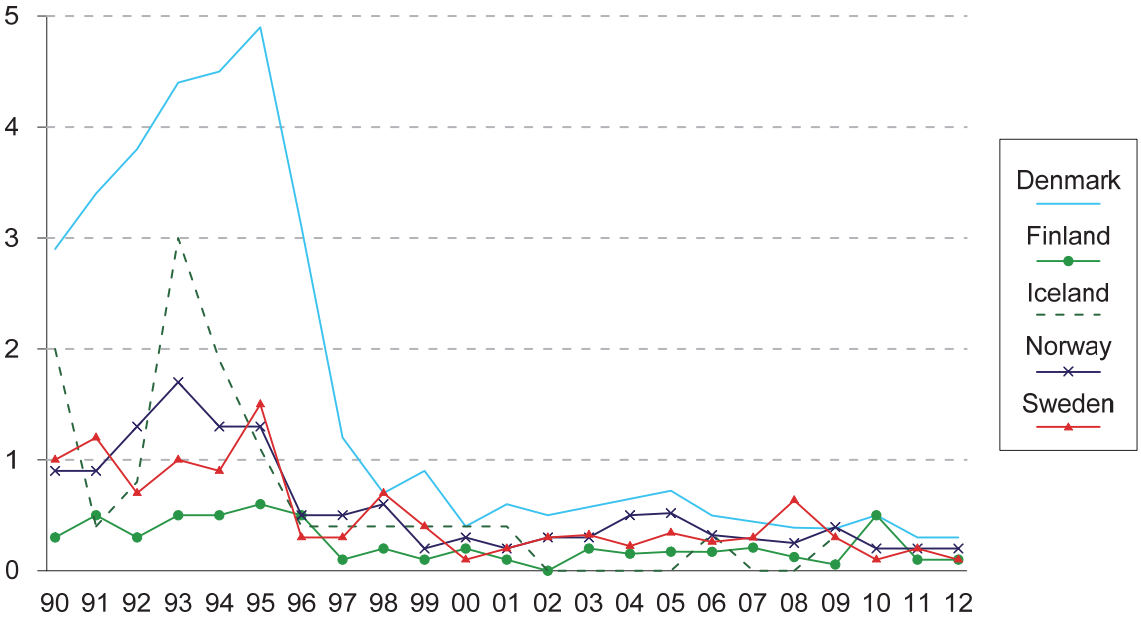
Table 4.1.5 Deaths from HIV/AIDS, in total and per 100 000 inhabitants, 2000-2012

	Denmark	Faroe Islands[1]	Greenland[1]	Finland	Åland[1]	Iceland	Norway	Sweden
Number								
2000	21	-	5	10	..	1	15	13
2005	39	0	3	9	0	-	24	31
2010	29	0	2	7	0	-	10	11
2012	26	1	1	7	-	-	10	14
Per 100 000 inhabitants								
2000	0.4	-	8.9	0.2	..	0.4	0.3	0.1
2005	0.7	0.4	6.0	0.2	0.0	-	0.5	0.3
2010	0.5	0.4	3.5	0.1	0.0	-	0.2	0.1
2012	0.5	0.4	1.4	0.1	-	-	0.2	0.1

1 2005 = average 2001-2005. 2010 = average 2006-2010. 2012= average 2008-2012
Source: The national registers for causes of death

ICD-10: B20-B24

Figure 4.1.5 Deaths from HIV/AIDS per 100 000 inhabitants, 1990-2012



Source: The national registers for causes of death

Table 4.1.6 Deaths from suicide per 100 000 inhabitants by gender and age, 2000-2012

	Men					Women				
	Total	10-19	20-24	25-64	65+	Total	10-19	20-24	25-64	65+
Denmark										
1990	32.2	4.8	19.8	41.3	58.9	16.4	1.2	5.6	19.8	31.0
2000	23.3	4.4	16.0	23.8	41.8	8.3	2.5	1.2	8.2	15.0
2005	16.9	3.3	8.8	18.9	41.8	6.3	0.6	3.5	6.8	14.2
2010	14.7	3.4	3.0	18.5	27.9	5.7	1.2	3.7	6.8	9.6
2012	17.8	3.9	11.2	22.9	28.1	5.9	1.2	2.3	7.1	10.3
Faroe Islands[1]										
2002-06	1.6	-	-	3.1	-	0.9	-	-	1.8	-
2008-12	8.7	-	11.7	12.6	11.8	1.7	5.6	-	-	5.2
Greenland										
2002-06	124.2	154.6	532.7	106.5	96.1	44.5	64.3	132.0	45.1	12.3
2008-12	109.4	140.3	318.6	109.6	30.6	42.8	98.4	54.8	40.1	10.3
Finland										
1990	49.4	20.6	60.3	63.9	64.2	12.5	2.6	15.8	16.7	13.7
2000	34.6	10.5	41.8	46.6	36.8	11.0	4.1	9.4	15.5	17.5
2005	28.1	4.8	30.5	36.5	39.0	10.0	4.7	12.3	13.5	8.6
2010	27.2	9.6	44.9	33.8	30.5	8.6	2.9	13.2	11.2	8.1
2012	24.6	9.5	32.0	30.2	31.3	7.9	4.6	11.0	11.0	5.2
Åland										
2003-07	19.9	11.7	28.1	22.1	31.9	4.5	-	-	2.8	15.9
2008-12	15.9	-	26.4	21.3	17.3	10.0	-	31.3	13.2	7.3
Iceland										
1990	..	..	..	33.9	33.1	..	..	..	6.7	-
2000	29.8	22.9	73.4	38.1	13.6	5.7	-	9.4	8.6	5.6
2005	16.2	8.7	9.2	27.2	-	6.1	-	-	12.0	-
2010	..	..	..	..	..	..	..	..	..	..
2012										
Norway										
1990	..	..	..	33.0	33.0	..	..	..	10.3	11.1
2000	18.4	11.3	29.9	22.5	22.6	5.8	3.0	4.4	7.9	6.3
2005	15.8	6.9	24.7	18.6	16.9	7.3	4.3	7.2	9.8	5.4
2010	15.8	6.1	25.7	18.9	23.2	6.7	1.3	6.0	10.1	5.6
2012	14.7	4.6	18.7	19.7	15.6	5.8	3.2	7.3	7.8	5.3
Sweden										
1990	24.1	5.0	20.9	28.8	45.7	10.4	2.5	6.1	13.7	14.5
2000	18.3	4.0	15.9	21.2	36.0	7.3	3.2	3.9	9.2	10.1
2005	18.6	3.8	18.2	22.3	32.3	8.4	3.1	8.5	10.4	11.2
2010	17.9	5.6	17.7	21.9	27.1	6.4	2.6	6.3	7.9	8.4
2012	17.2	4.2	18.1	21.0	26.2	7.0	2.7	7.5	9.1	7.9

Source: The national registers for causes of death

ICD-10: X60-X84

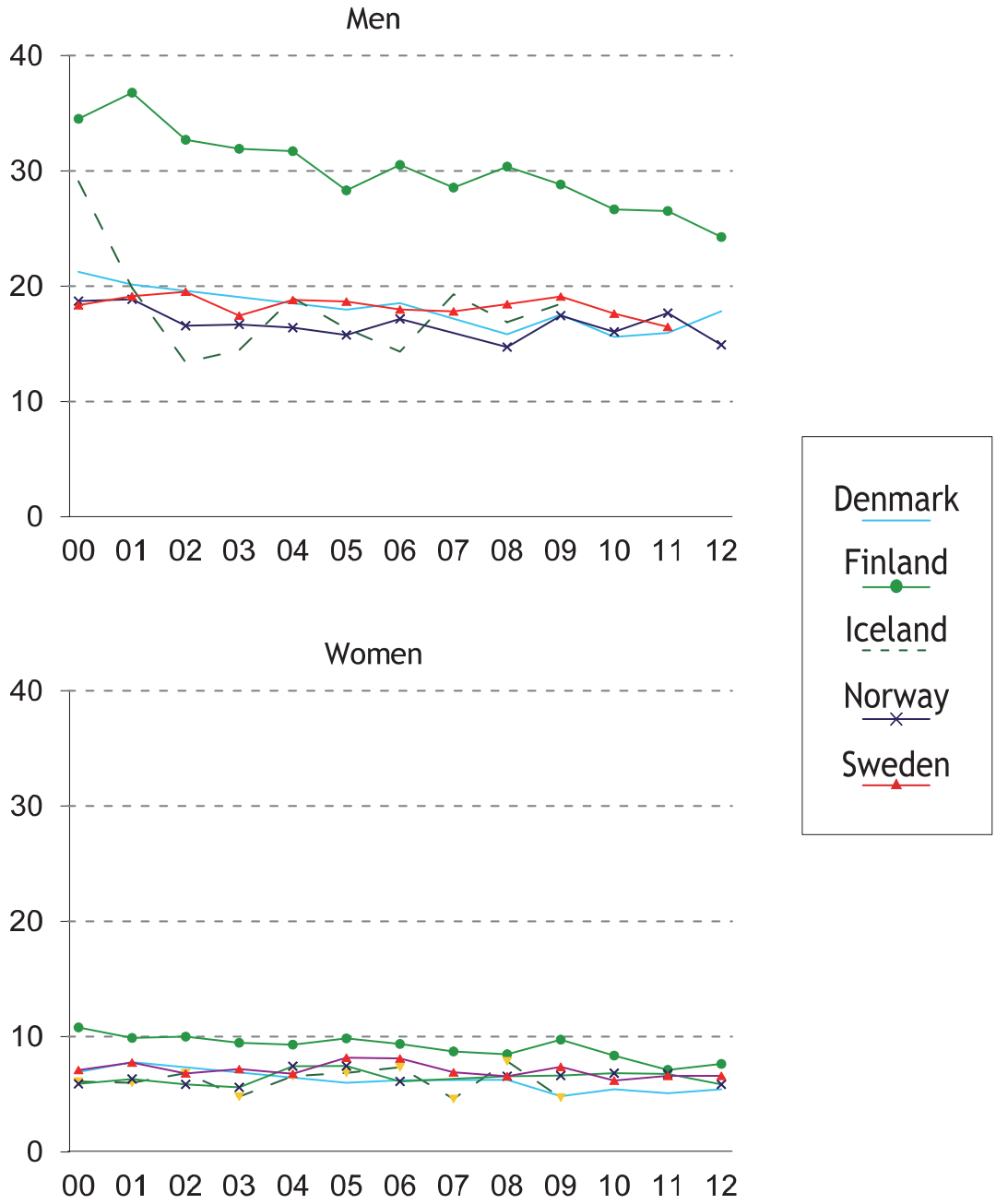
Table 4.1.7 Deaths from accidents per 100 000 inhabitants by gender and age, 2000-2012

	Men						Women					
	Total	0-14	15-24	25-64	65-79	80+	Total	0-14	15-24	25-64	65-79	80+
Denmark												
2000	45.3	6.3	37.7	30.2	80.2	544.7	43.6	2.9	10.3	11.3	64.2	525.9
2005	35.4	3.4	28.6	28.0	52.4	373.0	26.7	2.2	4.4	8.2	32.3	328.7
2010	27.8	2.5	18.6	24.9	31.2	264.0	21.0	1.6	3.9	7.0	31.3	238.5
2012	22.5	3.2	11.0	19.6	31.9	196.3	15.3	1.9	3.2	6.3	18.3	167.8
Faroe Islands												
2002-06	45.0	21.1	45.8	34.4	88.3	305.3	20.8	3.7	6.6	12.6	33.5	198.8
2008-12	27.0	3.7	5.5	28.3	82.7	82.1	10.3	-	12.8	8.9	7.9	63.0
Greenland												
2002-06	88.6	43.7	76.1	92.9	283.6	396.8	41.4	22.5	14.9	33.4	218.9	509.2
2008-12	54.0	18.4	39.5	53.0	165.9	792.6	29.3	6.4	31.4	20.0	108.8	495.8
Finland												
2000	70.8	6.0	30.8	75.6	137.1	471.2	34.4	3.0	9.3	18.9	53.2	310.8
2005	80.9	7.7	27.8	87.3	153.0	464.7	35.8	2.7	6.6	22.7	51.7	285.7
2010	68.9	2.6	28.5	68.6	131.1	387.3	35.5	2.3	5.9	18.5	52.7	279.6
2012	62.5	2.9	20.8	60.0	114.0	381.0	32.8	2.8	7.4	14.9	38.7	279.3
Åland												
2003-07	56.2	16.6	25.9	43.9	148.3	268.1	22.2	8.8	-	5.5	24.6	219.4
2008-12	60.5	0.0	12.2	53.2	121.7	393.1	34.3	0.0	0.0	2.6	66.0	366.1
Iceland												
2000	38.4	3.0	46.0	36.7	76.6	274.6	12.8	-	23.7	10.1	30.2	21.5
2005	25.6	-	36.2	14.2	82.1	253.0	17.6	-	4.7	13.3	44.5	163.9
2010	..	..	..	..	..	..	..	..	..	..	..	..
2012	..	..	..	..	..	..	..	..	..	..	..	..
Norway												
2000	43.9	4.8	35.4	31.8	81.0	442.9	34.2	5.0	9.4	8.1	44.6	381.3
2005	45.0	3.7	34.8	37.4	65.9	418.4	33.0	2.0	11.1	11.7	32.2	357.9
2010	43.1	1.7	23.7	34.8	64.1	450.8	35.1	1.1	10.5	11.6	43.3	389.1
2012	39.0	1.3	18.0	28.6	54.7	475.8	34.0	1.8	3.4	10.1	32.0	429.0
Sweden												
2000	36.2	3.1	27.1	25.5	66.9	310.0	22.7	1.6	6.4	6.5	28.4	227.4
2005	38.1	2.4	21.2	25.6	67.3	345.1	27.6	4.3	5.3	8.4	34.0	265.0
2010	36.3	1.6	15.3	22.1	60.3	375.7	25.4	4.1	4.6	6.0	29.8	266.2
2012	36.0	1.0	15.3	23.3	48.9	386.3	25.2	3.3	3.5	6.0	25.4	275.2

Source: The national central statistical bureaus

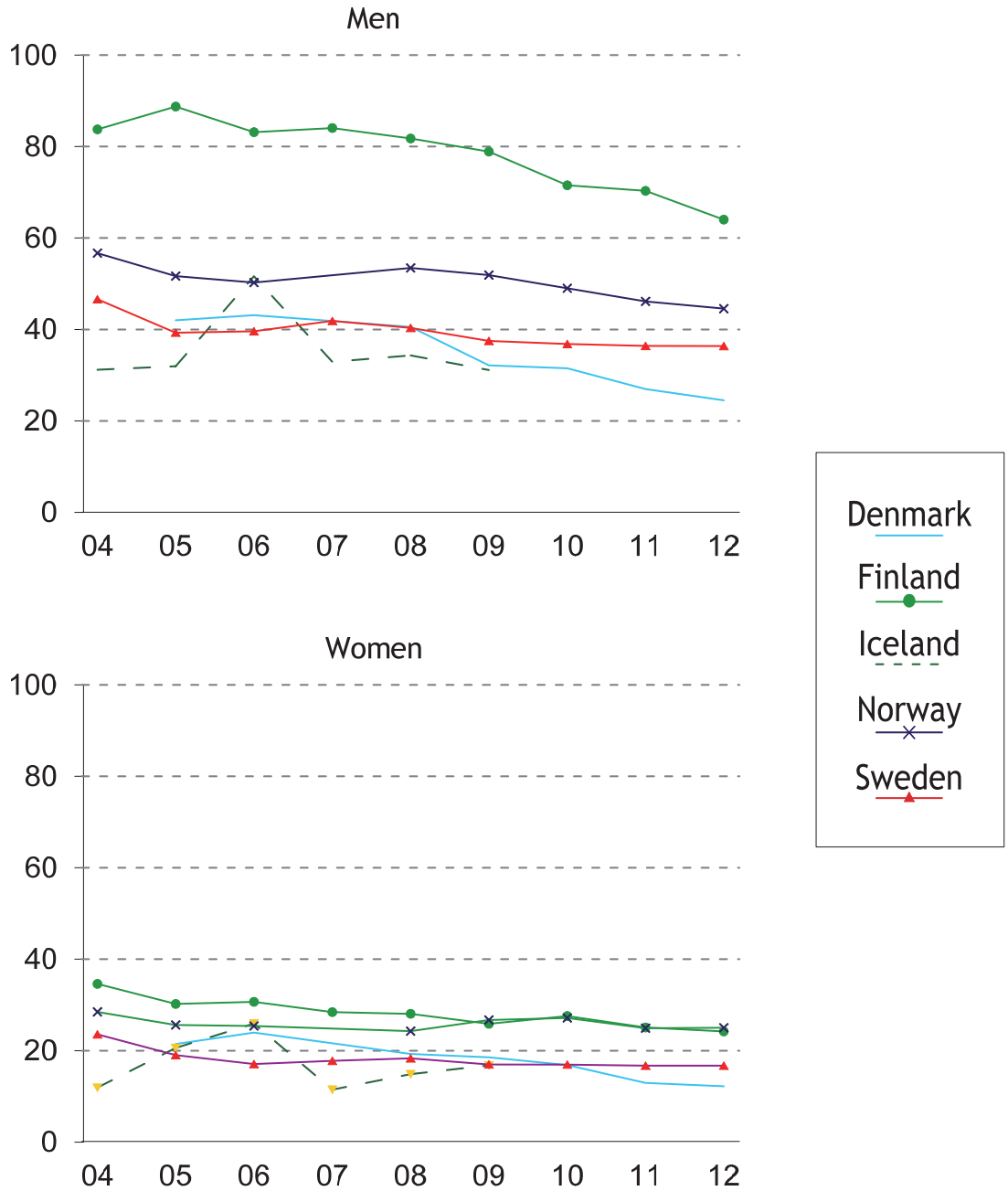
ICD-10: V01-X59

Figure 4.1.6 Deaths from suicide per 100 000 inhabitants by gender, in age standardized rates, 2000-2012



Age-standardized by the Nordic population, 2000
Source: The national registers for causes of death

Figure 4.1.7 Deaths from accidents per 100 000 inhabitants by gender, in age standardized rates, 2004-2012



Age-standardized by the Nordic population, 2000
Source: The national registers for causes of death

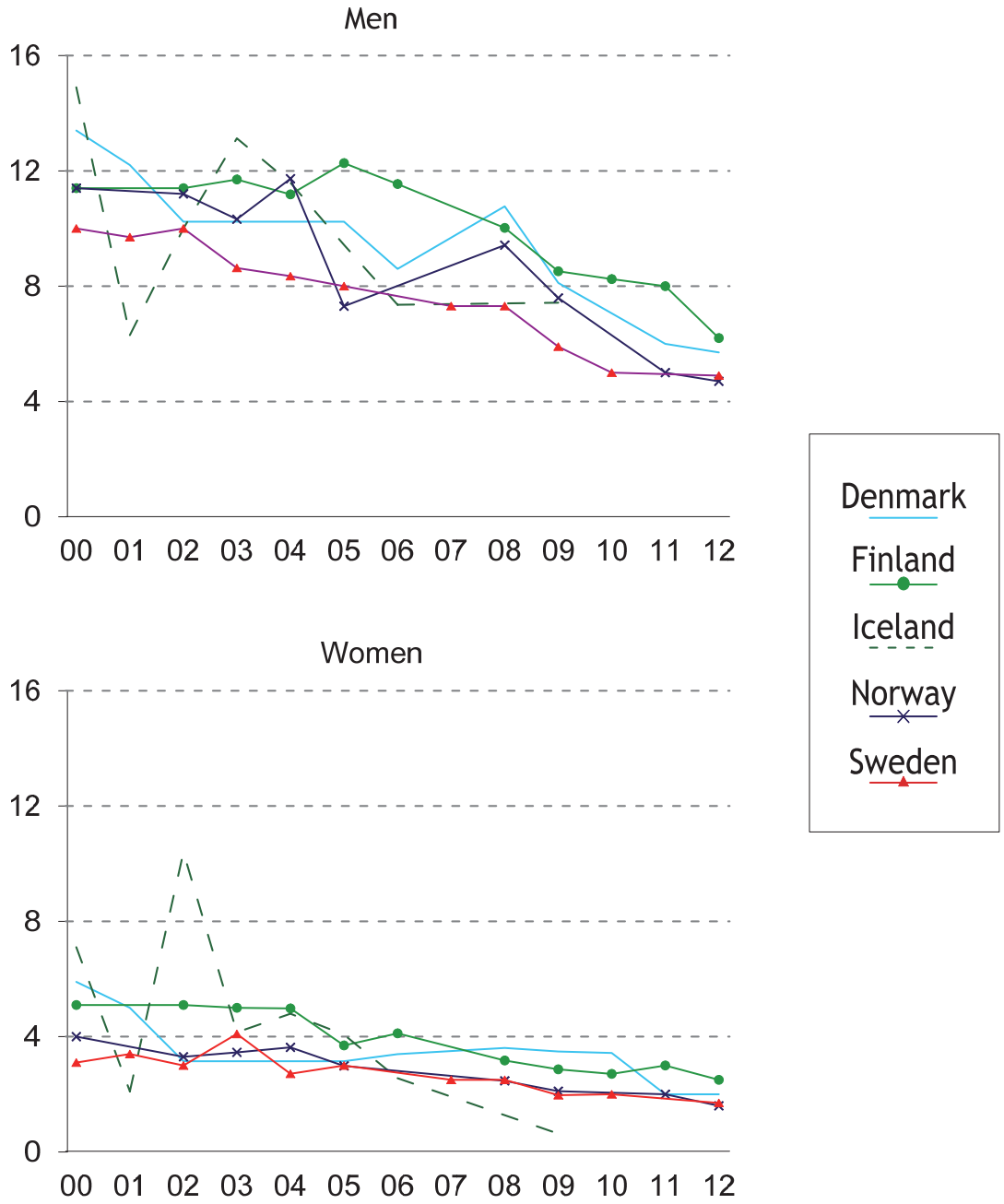
Table 4.1.8 Deaths from land transport accidents per 100 000 inhabitants by gender and age, 2000-2012

		Men					Women			
	Total	0-14	15-24	25-64	65+	Total	0-14	15-24	25-64	65+
Denmark										
2001	12.2	2.7	24.1	11.2	20.5	4.5	1.7	6.7	3.6	9.1
2005	10.2	1.3	21.0	9.7	16.4	3.1	1.8	2.7	2.5	6.9
2010	7.1	1.4	10.9	7.2	10.3	3.4	1.2	3.0	2.4	8.8
2012	4.4	1.4	7.4	3.8	7.6	1.6	0.6	2.3	1.4	2.6
Faroe Islands										
2002-06	10.4	7.0	34.3	6.3	6.8	3.5	3.7	0.0	3.6	5.7
2008-12	4.0	-	5.5	3.1	11.8	3.4	-	12.8	1.8	5.2
Greenland										
2008-12	3.3	6.1	-	3.5	-	3.0	3.2	13.5	-	-
Finland										
2000	11.3	2.3	13.3	11.4	24.0	5.1	2.2	5.6	4.1	10.7
2005	12.3	4.1	14.7	11.9	22.8	3.7	1.3	4.4	3.2	6.8
2010	8.2	0.7	14.0	7.8	13.8	2.7	1.4	2.8	2.2	5.0
2012	6.2	0.7	9.2	6.2	9.7	2.5	1.4	4.0	1.3	5.5
Åland										
2003-07	15.2	8.3	25.9	13.7	20.7	3.0	-	-	2.7	7.9
2008-12	7.2	-	-	8.0	17.3	4.3	-	-	-	21.8
Iceland										
2000	16.3	-	32.2	16.9	27.3	7.1	-	19.0	5.8	11.2
2005	9.4	-	31.7	6.5	12.7	4.1	-	4.7	5.3	5.3
2010	..	..	..	..	..	..	..	..	..	..
2012	..	..	..	..	..	..	..	..	..	..
Norway										
2000	12.5	2.6	26.4	12.2	16.3	4.6	2.5	7.9	3.4	8.3
2005	7.4	1.1	15.9	7.0	10.4	3.3	0.7	6.1	3.1	4.6
2010	6.9	0.4	11.2	6.8	12.4	2.2	0.2	4.6	1.9	3.4
2012	4.7	0.8	7.1	5.2	5.8	1.6	0.2	1.6	1.6	3.2
Sweden										
2000	10.8	1.4	19.1	10.7	16.6	3.2	1.0	4.2	2.6	6.1
2005	8.2	0.7	12.8	8.4	12.2	2.8	0.4	3.6	2.6	4.7
2010	4.4	0.9	6.6	4.5	5.7	1.7	0.5	2.5	1.3	3.1
2012	4.9	0.5	7.6	5.3	6.1	1.7	0.6	2.5	1.3	2.8

Source: The national central statistical bureaus

ICD-10: V01-V89

Figure 4.1.8 Deaths from land transport accidents per 100 000 inhabitants by gender, 2000-2012



Source: The national registers for causes of death

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

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2012	2008-12	2008-12	2012	2008-12	2009	2012	2012
Men								
0-34	0.4	1.7	-	2.9	-	-	0.2	0.2
35-44	12.5	11.2	4.1	34.2	-	-	4.6	3.1
45-64	85.2	31.8	48.6	127.8	76.2	10.2	22.6	22.7
65-74	107.6	72.3	192.2	108.1	57.3	21.3	28.8	40.5
75+	58.9	29.6	334.8	47.7	21.7	-	18.1	19.0
Total	39.4	17.4	28.1	55.3	28.8	3.7	10.0	11.8
Women								
0-34	0.3	-	2.8	0.7	-	-	-	0.1
35-44	3.9	-	9.7	7.8	-	-	1.4	1.1
45-64	29.5	10.5	25.3	37.9	14.7	5.3	6.7	7.3
65-74	35.6	22.5	79.5	30.1	30.0	-	10.5	13.2
75+	15.0	0.0	62.7	8.8	0.0	9.6	4.7	4.8
Total	13.6	4.3	14.3	15.8	7.1	1.9	3.2	3.9
M+W								
0-34	0.4	0.9	1.4	1.8	-	-	0.1	0.1
35-44	8.2	6.0	6.7	21.3	-	-	3.0	2.1
45-64	57.4	21.7	38.5	82.6	44.9	7.8	14.9	15.1
65-74	70.5	48.5	140.1	66.7	43.9	10.3	19.4	26.6
75+	32.6	12.1	171.3	23.0	8.6	5.5	9.9	10.5
Total	26.4	11.1	21.6	35.2	17.9	2.8	6.6	7.9

Source: The national registers for causes of death

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

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

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2012	2008-12	2008-12	2012	2008-12	2009	2012	2012
Men								
0-34	2.5	-	2.7	2.7	3.5	8.5	8.4	4.9
35-44	10.9	-	-	5.6	-	17.7	16.9	7.8
45-64	7.1	9.5	4.9	1.5	-	15.4	17.6	5.5
65-74	0.7	-	-	0.8	-	32.0	6.2	2.6
75+	-	-	-	1.2	-	-	10.1	1.5
Total	4.6	2.4	2.7	2.4	1.4	12.4	11.9	5.0
Women								
0-34	1.0	-	-	1.6	-	3.8	2.5	1.0
35-44	2.4	-	-	1.2	-	4.7	8.0	2.6
45-64	3.2	-	-	1.3	-	21.4	11.4	3.2
65-74	0.3	-	-	-	-	-	9.1	1.0
75+	1.7	-	-	0.4	-	-	4.7	0.8
Total	1.7	-	-	1.2	-	7.6	6.2	1.7
M+W								
0-34	1.8	-	1.4	2.1	1.8	6.2	5.5	3.0
35-44	6.7	-	-	3.5	-	11.4	12.6	5.2
45-64	5.1	5.0	2.8	1.4	-	18.3	14.5	4.4
65-74	0.5	-	-	0.4	-	15.5	7.7	1.8
75+	1.0	-	-	0.7	-	-	6.8	1.1
Total	3.2	1.2	1.4	1.8	0.7	10.0	9.1	3.4

Source: The national registers for causes of death

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

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

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2012	2008-12	2008-12	2012	2008-12	2009	2012	2012
Men								
0-44	0	-	3	0	-	-	0	2
45-64	6	22	34	1	-	-	4	11
65-74	22	21	11	0	-	11	11	22
75+	69	193	335	9	22	26	142	171
Total	8	17	21	1	1	2	10	18
No death certificate	39	..	..	5	22	1	..	12
Women								
0-44	0	3	1	0	-	-	0	1
45-64	1	14	6	0	-	-	2	4
65-74	11	45	32	0	-	-	8	16
75+	6	153	94	1	1	38	19	445
Total	8	21	6	2	1	3	21	32
No death certificate	37	..	..	3	7	-	..	14
M+K								
0-44	0	1	1	0	-	-	0	1
45-64	4	18	15	0	-	-	3	9
65-74	30	32	44	1	-	5	15	31
75+	5	169	533	1	1	33	13	20
Total	8	19	17	1	1	2	15	25
No death certificate	38	..	..	4	14	1	..	13

Source: The national registers for causes of death

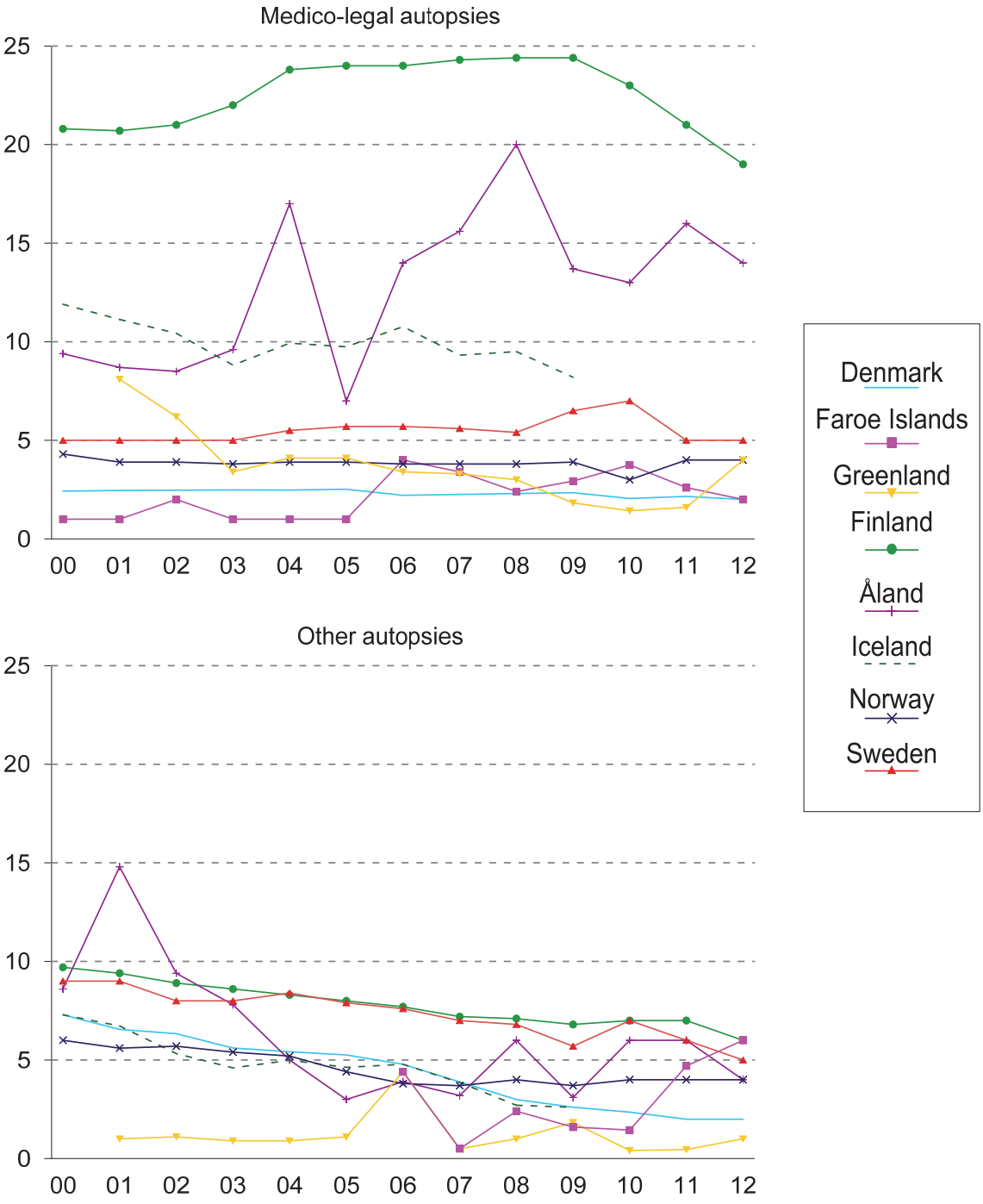
ICD-10: I469, I959, I99, J960, J969, P285.0, R000-R948, R99

Table 4.1.12 Autopsy rates as a percentage of all deaths, 2000-2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
Medico-legal autopsies								
2000	2	1	..	21	9	12	4	5
2005	3	1	4	24	7	10	4	6
2009	2	3	2	24	14	8	4	7
2010	2	3	1	23	13	..	3	7
2012	2	2	4	19	14	..	4	5
Other autopsies								
2000	7	..	..	10	9	7	6	9
2005	5	1	1	8	3	5	4	8
2009	3	3	2	7	3	3	4	6
2010	2	1	0	7	6	..	4	6
2012	2	6	1	6	4	..	4	5

Source: The national registers for causes of death

Figure 4.1.9 Autopsy rates as a percentage of all deaths, 2000-2012



Source: The national registers for causes of death

Chapter 5

Resources

Extra material
OECD: www.oecd.org

Introduction

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

5.1 Financing of Health Services

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

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

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

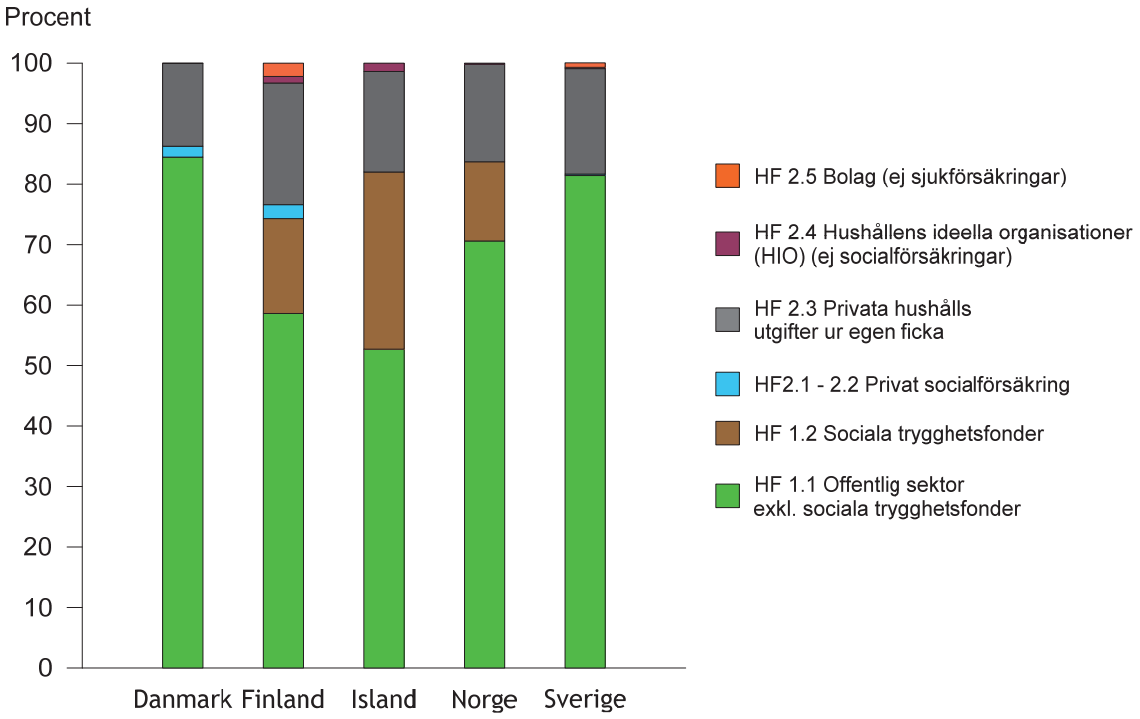
FINLAND: The health care system is highly decentralised. Responsibility for providing health care is devolved to the municipalities (local government). The publicly funded system is divided into three levels. Alongside this is a much smaller private health care system. The three different health care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

Municipal financing is based on taxes while the National Health Insurance financing is based on compulsory insurance fees. Municipalities fund municipal health care services (except outpatient pharmaceutical product and transport costs) and the National Health Insurance funds for example private health care, occupational health care, outpatient pharmaceutical products and transport costs, as well as most health-related benefits, such as sickness benefits and maternity benefits.

ÅLAND: Åland's health care unit (ÅHS) under Åland's county is responsible for the public health care in Åland.

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

Figure 5.1.1 Distribution of health expenses after funding, percentage of total expenses, 2010



Source: OECD Health Statistics

5.2 Charges for Health Care Services per 1 January 2014

Medical visits

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

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

- A fixed annual charge of no more than EUR 29.50 in a year, or
- A fixed charge per visit of no more than EUR 14.70. The charge is payable for the first three visits to the same health care centre in the same calendar year only

A charge of EUR 20.20 is payable for visits to health care centres on working days between 8 pm and 8 am and for visits on Saturdays, Sundays and holidays.

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

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

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

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

ICELAND: Preventive health care consultations for pregnant women and mothers with infants and school health care are free of charge. The user charge for a consultation in a health care centre or with a private general medical practitioner during normal working hours is ISK 1 200, and ISK 960 for 67-69-year-olds who do not have a pension or who have a reduced pension. The charge is ISK 600 for other pensioners, disabled people and long-term unemployed people. There is no user charge for children under 18. Outside normal working hours, the charges are ISK 3 100, ISK 2 400 and ISK 1 500. Charges for home visits are ISK 3 400, ISK 2 600 and ISK 1 600 during day time, while charges for evenings and nights are ISK 4 500, ISK 3 800 and ISK 1 600.

The user charge for a consultation with a specialist (from 7th July 2014) is either ISK 5 400 plus 40 per cent of the remaining cost of the consultation, or ISK 4 200 or 1 950 plus 13.3 per cent of the remaining cost for the consultation. The user charge for children under 18 years is one ninth of the total charge with a minimum of ISK 850. There is no user charge for disabled and chronically ill children. From 7th July 2014, the maximum charge is ISK 33 600 in all instances.

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

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

NORWAY: User charges apply for consultations at general practitioners and specialists, polyclinical treatment at hospitals, and treatment at a doctor on call.
User charges for consultation at general practitioners/doctor on call are:
General practitioner: 140 NOK (day) and 235 NOK (night).
User charges are 186 NOK and 277 NOK respectively, if the doctor is a specialist in general practice. For other medical specialists the user charges is 315 NOK.
User charges at house calls are: General practitioners 185 NOK (day) and 301 NOK (night). Specialist in general practice: 217 NOK (day) and 333 NOK (night).
User charge for laboratory tests, histological tests and cytology tests is 48 NOK.
User charge for x-rays and ultrasound examinations is 224 NOK.

Children under 16 years are exempt form paying user charges for the above-mentioned services. At treatment at psychologist, children and adolescents under 18 years as well as patients with HIV infection are exempt form paying user charges.

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

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

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

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

Table 5.2.1 User charges for a consultation with a physician

	Are there consistent rules for the whole country?	Amount of user charge	Deviations	Share of user charge of the total cost of medical visits
Denmark	Yes	-	No	-
Faroe Islands	Yes	-	No	-
Greenland	Yes	-	No	-
Finland	Yes	Public: EUR 0-14.70. EUR 20.20 for visits between 8 pm and 8 am on weekdays or on Saturdays, Sundays or public holidays. Private: min. 60 per cent	No charge for children under the age of 18 years	13 per cent
Åland	Yes	EUR 25. Children and youth under the age of 18 years are half the price	Free treatment after paying EUR 375. Free treatment for children under 18 and people 65+ and disability pensioners and persons receiving full-time rehabilitation benefits after paying EUR 120	..
Iceland	Yes	ISK 1 000-3 800 in primary care, other fees for specialized care	Half the amount of ISK 500-1 850 for pensioners, disabled and long-term unemployed people. ISK 800-3 200 for 67-69-year-olds with no or a reduced pension. No charge for children under the age of 18 years	Varies
Norway	Yes	Consultation with: a general practitioner: NOK 140 (day), NOK 235 (evening), with a specialist: NOK 315	No charge for children under 16 years	Approx. 35 per cent
Sweden	No	100–300 SEK	Yes	..

Reimbursement for Pharmaceuticals

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

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

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

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

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

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

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

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

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

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

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

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

funded, while pharmaceutical products purchases of more the DKK 5 300 is fully subsidized by the public sector. However, patients over the age of 67 years are fully subsidized from DKK 2 380. Children under 18 years are fully subsidized from the first DKK and therefore they are not paying for prescribed medicine that are eligible for subsidy. In accordance with the Social Security Act, subsidies for pharmaceutical products purchase are also granted to persons, who are not able to bear the costs themselves. Pharmaceutical products prescribed at hospitals are always free of charge.

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

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

The reimbursement amount depends on whether or not the pharmaceutical product is part of the reference pricing system. According to the reference pricing system the pharmaceutical products are categorized. Products that belong to the same reference pricing group contain equal amounts of the same drug substance and are biologically equivalent, which make them interchangeable.

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

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

As a main rule, the health insurance scheme reimburses expenditure on prescription pharmaceutical products exceeding EUR 610 in the course of one calendar year (excluding user charges of EUR 1.50 per product per purchase).

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

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

groups pay the initial ISK 16 050 themselves, and will be fully subsidized, when the costs reach ISK 46 277.

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

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

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

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

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

The maximum limit for ordinary reimbursement is NOK 1 667

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

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

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

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

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

Table 5.2.2 User charges for pharmaceutical products

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

Treatment in hospitals

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

FINLAND: Patients pay a charge for admission to hospitals and health care centres: EUR 29.30; and psychiatric departments: EUR 16.10. The charge for rehabilitation is EUR 12.10 per treatment day, and the maximum user charge for day surgery is EUR 96.40 plus EUR 29.30, if the patient has to stay overnight. A series of treatment costs EUR 8.00 per visit (max. 45 times per year).

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

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

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

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

Table 5.2.3 User charges for hospitalization

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

Reimbursement for dental treatment

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

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

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

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

Children and young people under 18 years of age receive free municipal dental care including orthodontic treatment. Children under 16 years of age, who wish to have treatment that is not provided free of charge by the municipal council, may – by paying a user charge – choose to be treated in a private clinic of their own choice or at a public dental clinic in another municipality. Elderly people who live in a nursing home or in their own home with technical aids are offered dental care for which there is a maximum annual charge of DKK 475 from 1 January 2014. In addition, the municipalities provide a subsidy for dentures in cases of impaired function or disfigurement resulting from damage caused by accidents.

The municipality offers specialist dental treatment to persons, who because of psychiatric illness or mental disability cannot use the existing dental services for children and young people, for adults, or for people needing special care. For these services, the region, from 1 January 2014, charges the patient a maximum of DKK 1 775 per year.

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

In addition, the region grants a special reimbursement for dental care for cancer patients, who either due to radiation of the head and neck or due to chemotherapy suffer from considerable documented dental problems, and to persons who due to Sjögrens syndrome suffer from considerable documented dental problems. From 1 January 2014, the region can demand a user payment of a maximum of DKK 1 775 annually for these services. Finally, the region provides highly specialized dental advice, examination and treatment (in dental research centres) for patients with rare diseases and disabilities, for whom the underlying disease can lead to special problems with their teeth, mouth or jaws.

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

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

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

The municipalities provide a free dental service for children up to the age of 18. Until 2014, this service applied only to children up to the age of 16, but the age limit was raised in 2014. This service also provides special dental care, such as orthodontic treatment.

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

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

FINLAND: There is a basic fee of EUR 8.00 per visit for dental treatment at a health care centre, EUR 10.20 per visit to a dentist, and EUR 14.90 for a visit to a specialist. In addition to this, user fees of EUR 6.60-173.90 can be charged, dependent on the type of treatment provided.

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

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

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

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

The health insurance scheme offers partial reimbursement of the cost of dental treatment for persons aged 67 years or older.
In April 2013, a new agreement on prophylactic dental treatment for children under the age of 18 was signed. Now parents can register their children at a specific dentist, who then will become responsible for regular dentist's appointments, prophylactic and necessary dental care. Payment for children will be determined at a low fee

for one annual visit. The agreement will be implemented in seven stages. From and including January 2014, the agreement includes 10-17 year-olds and 3 year-olds.

On 1 January, until 1 January 2018, two age groups will be added annually, until the same agreement applies to all children under the age of 18 years. If a child cannot afford the necessary dental treatment, a special grant will be given so that they can receive dental treatment at the fixed cost.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Maximum user charges

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

FAROE ISLANDS: For subsidized medicine, there is a maximum user charge at the amount of DKK 2 025 annually (lower amount for children and pensioners). There is no maximum user charge for dental treatment. Apart from pharmaceutical products and dental care, there are no user charges in the Faroe Islands (cf. the sections on reimbursement for pharmaceutical products and reimbursement for dental treatment).

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

FINLAND: If the total cost of pharmaceutical products exceeds EUR 601.00 per year, or if travelling costs for treatment exceed EUR 242.25 per year, the Social Insurance Institution reimburses the excess costs.

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

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

The so-called user charge ceiling of EUR 679 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.

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

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

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

ICELAND: User charges for people aged 18-70 years and for unemployed people are reimbursed, if the costs exceed ISK 33 600 during one calendar year.

The same applies to children under 18 if charges exceed ISK 10 200.

User charges exceeding ISK 26 900 are reimbursed for people aged 67-69 who have either no pension or reduced pension.

User charges exceeding ISK 8 500 are reimbursed for the following groups: people aged 60-70 who receive a full basic pension, pensioners aged 70 years or older, and disabled people.

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

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

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

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

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

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

- physician
- psychologist
- Out-patient treatment
- X-ray examination
- travel costs
- pharmaceutical products (blue prescription)

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

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

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

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

5.3 Health Care Expenditure

Development of health care expenditure

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

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

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

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

Changes in the recording of health care expenditure

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

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

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

There will always be such problems when one compares statistics from several countries. This does not mean that comparisons are worthless, but one must be

aware that some of the observed differences can be the result of different definitions and boundaries.

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

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

ESSPROS includes all social arrangements, both public and private. The statistics include pension schemes, insurance schemes, humanitarian organizations and other charitable organizations. Insurance schemes are included if they are collective. This means that expenditure on health also includes sickness benefits (or salary paid during sickness) including sickness benefits paid by employers. These cash payments are not included in OECD's system, in which only expenditure on actual health services is included.

Table 5.3.1 Total health care expenditure (million KR/EUR) 2012

	Denmark	Faroe Islands	Greenland	Finland[1]	Iceland	Norway	Sweden
	DKK	DKK	DKK	EUR	ISK	NOK	SEK
Public financing	164 823	1 046	1 213	12 457	123 693	219 750	261 366
Private financing	28 555	-	-	4 204	29 916	38 917	60 436
Total health care expenditure	193 378	1 046	1 213	16 661	153 609	258 667	321 802

1 Finnish data include Åland
Source: OECD HEALTH STATISTICS. FO: Statistics Faroe Islands; G: Directorate of Health

Table 5.3.2 Total health care expenditure (EUR/capita) 2012

	Denmark	Faroe Islands	Greenland	Finland[2]	Iceland	Norway	Sweden
Public financing	3 955	2 894	2 876	2 301	2 399	5 875	3 142
Private financing	685	-	-	776	580	1 040	727
Total health care expenditure	4 640	2 894	2 876	3 077	2 979	6 915	3 868

1 Finnish data include Åland

Source: OECD HEALTH STATISTICS. FO: Statistics Faroe Islands; G: Directorate of Health

Table 5.3.3 GDP and health care expenditure in total and per capita, 2000-2012

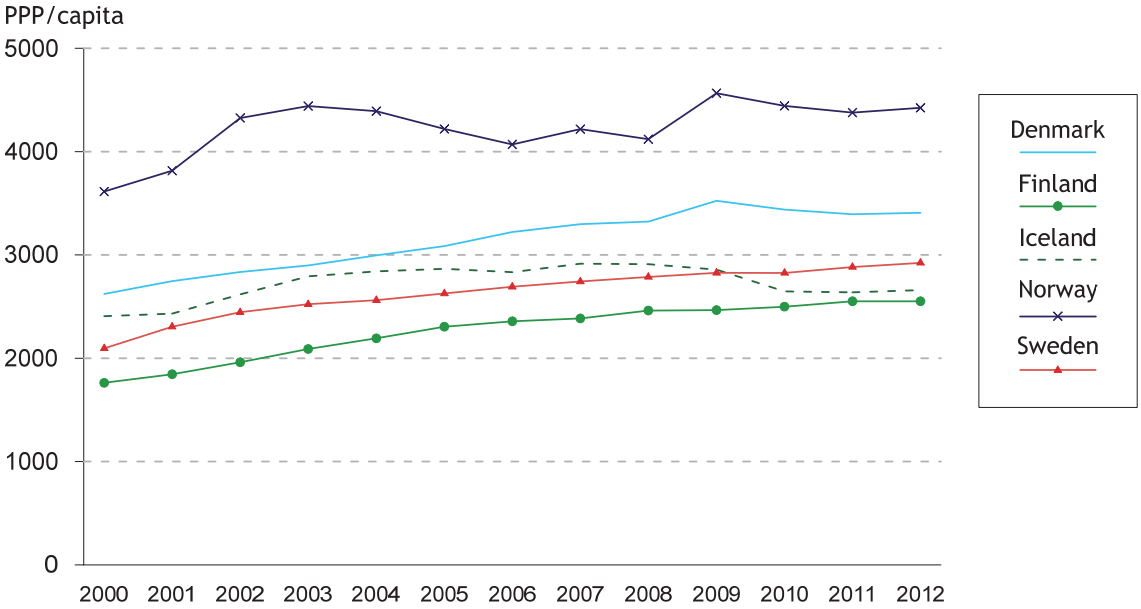
	Denmark[1]	Faroe Islands	Greenland	Finland[2]	Iceland	Norway	Sweden
	DKK	DKK	DKK	EUR	ISK	NOK	SEK
Total expenditure per capita 2012	33 689	21 560	21 375	3 019	458 935	49 628	33 084
GDP (million) 2012	1 825 582	13 650	13 789	192 350	1 699 401	2 908 924	3 549 709
Expenditure in 2012 prices (million)							
2000	141 934	..	..	11 186	113 554	185 425	215 124
2005	169 735	1 105	..	14 622	142 861	225 860	272 155
2010	193 203	1 035	1 215	16 218	151 429	252 719	304 544
2012	193 378	1 046	1 213	16 661	153 609	258 667	321 802
Expenditure as a percentage of GDP							
2000	8.3	8.5	8.9	6.9	9.3	7.8	7.8
2005	9.3	8.7	8.8	8.0	9.4	8.5	8.7
2010	10.7	7.8	9.2	8.6	9.3	9.1	9.0
2012	10.6	7.7	8.8	8.7	9.0	8.9	9.1

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

2 Finnish data include Åland

Source: OECD HEALTH STATISTICS. FO: Statistics Faroe Islands; G: Directorate of Health

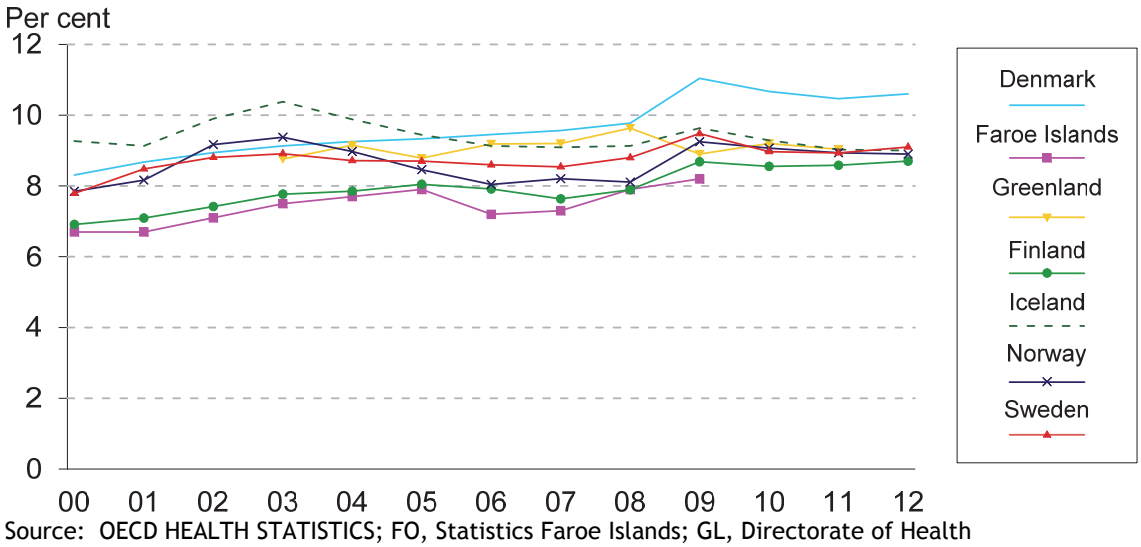
Figure 5.3.1 Total health care expenditure (PPP/capita) in 2012 prices [1]



1 PPP, purchasing power parities, is an expression for the different currencies' relative purchasing powers

Source: OECD HEALTH STATISTICS

Figure 5.3.2 Health care expenditure as a percentage of GDP 2000-2012



Source: OECD HEALTH STATISTICS; FO, Statistics Faroe Islands; GL, Directorate of Health

5.4 Health Care Personnel

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

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

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

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

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

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

Table 5.4.1 Employed health care personnel in health and social services, 2012 (NACE 85.1 and 85.3)

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland[1]	Norway	Sweden[2]
Physicians	20 239	113	99	16 300	83	1 144	21 238	36 122
Dentists	4 372	44	29	3 990	26	270	4 340	7 622
Dental hygienists	1 629	0	69	1 480	11	14	974	3 895
Dental surgery assistants	4 505	44	10	..	25	320	3 346	..
Psychologists	5 311	25	2	3 330	10	-	4 618	5 481
Qualified nurses	57 489	534	260	58 080	381	2 909	82 939	100 345
Radiographers	1 644	7	2	2 700	9	109	2 713	3 417
Qualified auxiliary nurses	38 922	266	158	72 820	526	1 954	64 099	..
Other health care personnel	54 469	465	162	68 720	45	-	159 718	..
Midwives	1 827	20	21	2 170	19	256	2 722	6 847
Physiotherapists	9 156	45	14	8 060	27	498	8 986	11 551
Occupational therapists	6 334	15	2	..	11	237	2 794	8 154
Hospital laboratory technicians	5 609	38	30	5 280	22	297	4 821	..
Other health care personnel with a higher education	673	0	..	18 860	26	-	6 116	..

1 Physicians licensed to practice in Iceland, up to 70 years old at end of year, with permanent residence and registered domicile in Iceland
2 November 2011
Source: DK, Statens Serum Institut; FO, Ministry of Health Affairs; GL, Chief Medical Officer; FI, THL; ÅL, The Åland Government; IS, Directorate of Health; NO, Statistics Norway; SV, National Board of Health and Welfare

Table 5.4.2 Employed health care personnel in health and social services per 100 000 inhabitants, 2012 (NACE 85.1 and 85.3)

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
Physicians	362	234	175	304	292	357	423	379
Dentists	78	91	51	74	91	84	86	80
Dental hygienists	29	..	121	28	39	4	19	41
Dental surgery assistants	81	91	17	..	88	..	..	0
Psychologists	95	52	4	62	35	..	..	58
Qualified nurses	1 029	1 107	458	1 083	1 340	907	1 653	1 054
Radiographers	29	15	4	50	32	34	54	36
Qualified auxiliary nurses	697	551	277	1 358	1 850	609	1 277	0
Other health care personnel	975	964	286	1 281	158	..	..	0
Midwives	33	41	37	40	67	80	54	72
Physiotherapists	164	93	24	150	95	155	179	121
Occupational therapists	113	31	4	..	39	74	56	86
Hospital laboratory technicians	100	79	53	98	77	93	96	0
Physicians	12	0	0	532	91	..	..	0

1 Physicians licensed to practice in Iceland, up to 70 years old at end of year, with permanent residence and registered domicile in Iceland
2 November 2011
Source: DK, Statens Serum Institut; FO, Ministry of Health Affairs; GL, Chief Medical Officer; FI, THL; ÅL, The Åland Government; IS, Directorate of Health; NO, Statistics Norway; SV, National Board of Health and Welfare

Table 5.4.3 Number of general practitioners 2012

	Denmark	Faroe Islands	Greenland[1]	Finland[2]	Åland[3]	Iceland[3]	Norway[4,5]	Sweden[6]
Number of general practitioners	4 242	29	53	6 211	18	188	5 971	5 897
Number of inhabitants per general practitioner	1 316	1 662	1 071	873	1 566	1 697	851	1 563

1 County practitioners
2 Only municipalities
3 2011
4 Numbers for somatics includes only consultations with general practitioner
5 Number for specialist consultations includes only polyclinical consultations at hospital (not psychiatric hospital), and not at private specialists
6 November 2011
Source: DK, Statens Serum Institut; FO, Ministry of Health Affairs; GL, Chief Medical Officer; FI, THL; ÅL, The Åland Government; IS, Directorate of Health; NO, Statistics Norway; S Directorate of Health, National Board of Health and Welfare

Table 5.4.4 Employed physicians by specialty in health and social services, 2012 (NACE 85.1 and 85.3)

	Denmark	Faroe Islands[1]	Greenland	Finland	Åland	Iceland[2,3]	Norway	Sweden[4]
General practice	4 256	29	53	1 794	18	183	2 584	5 645
Internal medicine	1 640	9	4	1 521	9	157	1 477	3 970
Paediatrics	391	3	2	553	2	56	466	1 313
Surgery	914	5	4	888	3	75	754	1 993
Plastic surgery	104	1	-	91	-	10	91	145
Gynaecology and obstetrics	536	3	3	660	5	40	559	1 300
Orthopaedic surgery, incl. hand surgery	688	4	2	443	5	40	483	1 254
Ophthalmology	328	3	-	451	2	33	357	687
Ear, nose and throat	332	1	1	355	1	21	293	629
Psychiatry	999	3	3	1 352	6	71	1 410	1 909
Skin and sexually transmitted diseases	159	1	-	193	-	18	150	352
Neurology	303	1	-	474	-	15	268	345
Oncology	149	1	-	150	1	15	161	459
Anaesthetics	965	5	5	760	4	57	763	1 501
Radiology	502	3	2	679	2	33	604	1 197
Clinical laboratory specialities incl. pathology	524	1	-	267	-	34	430	932
Other specialities	154	3	-	958	8	29	563	1 109
Specialists in total	12 944	75	79	11 589	66	887	11 413	24 740
Physicians without specialist authorization	7 295	38	22	4 711	15	257	9 825	11 382
Physicians in total within NACE 85.1 and 85.3	20 239	113	101	16 300	83	1 144	21 238	36 122

1 Converted to full-time, of which 6 full-time positions are consultancies
2 Data based on the register of physicians at the Directorate of Health. The most recent specialty is chosen for those with more than one specialty
3 Physicians licensed to practice in Iceland, up to the age of 70 years at year-end, with permanent residence and registered domicile in Iceland
4 November 2011
Source: DK, Statens Serum Institut; FO, Ministry of Health Affairs; GL, Chief Medical Officer; FI, Finnish Medical Association; ÅL, The Åland Government; IS, Directorate of Health; NO, Statistics Norway; SV, National Board of Health and Welfare

Table 5.4.5 Number of employed physicians by specialty in health and social services per 100 000 inhabitants, 2012 (NACE 85.1 and 85.3)

	Denmark	Faroe Islands[1]	Greenland	Finland	Åland	Iceland[2,3]	Norway	Sweden[4]
General practice	76	29	93	33	63	57	51	59
Internal medicine	29	19	7	28	32	49	29	42
Paediatrics	7	6	4	10	7	17	9	14
Surgery	16	10	7	16	11	23	15	21
Plastic surgery	2	2	-	2	-	3	2	2
Gynaecology and obstetrics	10	6	5	12	18	12	11	14
Orthopaedic surgery, incl. hand surgery	12	8	4	8	18	12	10	13
Ophthalmology	6	6	-	8	7	10	7	7
Ear, nose and throat	6	2	2	7	4	7	6	7
Psychiatry	18	5	5	25	21	22	28	20
Skin and sexually transmitted diseases	3	1	-	4	-	6	3	4
Neurology	5	2	-	9	-	5	5	4
Oncology								
Anaesthetics	17	10	9	14	14	18	15	16
Radiology	9	6	4	13	7	10	12	13
Clinical laboratory specialities incl. pathology	9	2	0	5	0	11	9	10
Other specialities	3	6	0	18	0	9	11	12
Specialists in total	232	155	139	214	0	277	227	260
Physicians without specialist autorization	131	79	39	87	0	80	196	120
Physicians in total within NACE 85.1 and 85.3	362	233	178	301	0	357	423	379

1 Converted to full-time, of which 6 full-time positions are consultancies
2 Data based on the register of physicians at the Directorate of Health. The most recent specialty is chosen for those with more than one specialty
3 Physicians licensed to practice in Iceland, up to the age of 70 years at year-end, with permanent residence and registered domicile in Iceland
4 November 2011
Source: DK, Statens Serum Institut; FO, Ministry of Health Affairs; GL, Chief Medical Officer; FI, Finnish Medical Association; ÅL, The Åland Government; IS, Directorate of Health; NO, Statistics Norway; SV, National Board of Health and Welfare

Table 5.4.6 Employed physicians 2012

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden[2]
Physicians employed in hospitals (NACE 85.1 and 85.3)	14 042	72	85	8 680	53	833	11 631	..
General practitioners (NACE 85.1 and 85.3)	3 994	38[1]	12	7 080	15	..	5 971	5 645
- Of whom working without specialist authorization	392	38	..	..	14	..	2 846	..
Other physicians working outside hospitals (mainly privately practising specialists) (NACE 85.1 and 85.3)	1 811	1	0	3 340	14	..	3 636	..
Physicians employed in administrative medicine (NACE 75.1)	212	1	4	..	2	..	428	751
Physicians employed in medical research, teaching etc. (NACE 80.3, 73.1 and 24.4)	952	1	0	324	..	..	1 192	1 385
Physicians employed within all other NACE codes	1 136	0	..	1 148	..	..	1 595	2 238

1 Of which 9 in training positions
2 November 2011
Source: DK, Statens Serum Institut; FO, Ministry of Health Affairs; GL, Chief Medical Officer; FI, Finnish Medical Association; ÅL, The Åland Government; IS, Directorate of Health; NO, Statistics Norway; SV, National Board of Health and Welfare

5.5 Capacity and Services in the Hospital Sector

For many years, there has been a trend in the Nordic countries towards fewer hospital beds. Resources have been concentrated in fewer units, often involving a division of work in the most specialized areas. Units have often been merged administratively, not necessarily leading to fewer physical units. No hospitals have been closed down in Norway during the last few years, but some of the existing hospitals have become smaller.

Another trend in the Nordic countries is that psychiatric hospitals are being closed down, however, to varying speed.

The structure is, however, somewhat different in Finland, Iceland and Greenland than in the other countries. A number of beds are attached to health care centres, and these beds appear in the tables as beds in "other hospitals". Some of these beds are for care of elderly people, and they are similar to beds in nursing homes and old peoples' homes in the other countries. Particularly for Finland and Iceland, this gives a larger number of beds in relation to the population than in the other countries.

Hospital beds are divided into medical, surgical, psychiatric and other beds. It is clearly indicated that, particularly for Finland and Iceland, the category 'other', includes activities that are not included in the other countries.

The tables on hospital discharges and average length of stay apply to patients admitted to ordinary hospitals and specialized hospitals. This limitation has been done in order to improve comparability between the countries.

The trend is that the number of treatment places and the average length of stay are reduced in ordinary hospitals. Within psychiatric treatment, there has been a trend towards the use of more outpatient treatment, for which reason the number of psychiatric beds has been reduced.

Table 5.5.1 Available hospital beds by speciality, 2012

	Denmark[1]	Faroe Islands	Greenland	Finland[2]	Åland[2,3]	Iceland	Norway[4]	Sweden
Number								
Somatic wards	12 750	193	104	8 965	56	735	11 739	20 911
Psychiatry	2 843	55	12	3 727	14	145	6 075	4 387
Other[4]	-	-	348	16 012	65	167	2 123	-
Total	15 593	248	464	28 705	135	1 047	19 937	25 298
Beds per 100 000 inhabitants								
Somatic wards	229	400	184	165	197	230	234	220
Psychiatry	51	114	21	69	48	46	121	46
Other	-	-	616	295	226	52	42	-
Total	280	515	821	529	471	328	397	266

1 Total number of available beds reported by hospitals/regions per 31 December 2011
2 Number of bed-days divided by 365
3 2008-2012
4 Figures for beds within mental health services, substance abuse treatment also. This includes both beds in hospitals and psychiatric centers (DPS)
5 Beds for long-term care in hospitals (health facilities with 24-hour access to hospital physicians)
Source: DK, Statens Serum Institut; FO, Ministry of Health Affairs; GL, Chief Medical Officer; FI, Finnish Medical Association; ÅL, The Åland Government; IS, Directorate of Health; NO, Statistics Norway; SV, National Board of Health and Welfare

Appendix

Further Information on the Bodies Responsible for Statistics in the Nordic Countries

The following bodies responsible for statistics in the Nordic countries can be contacted for further information concerning the statistics in this publication.

Denmark

Statistics Denmark
www.dst.dk

Responsible for:
- Population statistics
- Statistics on alcohol consumption
- Statistics on health care economy

Statens Serum Institut
www.ssi.dk

Responsible for:
- Statistics on births
- Statistics on abortions
- Statistics on malformations
- Statistics on causes of death
- Statistics on hospital services
- Statistics on health care personnel
- Statistics on infectious diseases
- Statistics and information on vaccinations
- Statistics on medicinal products

National Board of Health
www.sst.dk

Responsible for:
- Statistics on the use of tobacco

Faroe Islands

Statistics Faroe Islands
www.hagstova.fo

Responsible for:
- Population and vital statistics

Chief Medical Officer
www.landslaeknin.fo

Responsible for:
- Statistics on infectious diseases
- Statistics on forensics
- Statistics on births
- Statistics on causes of death

Chief Pharmaceutical Officer
www.apotek.fo

Responsible for:
- Statistics on medicinal products

Ministry of Health Affairs
www.hmr.fo

Responsible for:
- Statistics on health care personnel
- Statistics on hospital services
- Statistics on abortions
- Statistics and information on vaccinations

Statens Serum Institut
www.ssi.dk

Responsible for:
- Statistics on causes of death
- Statistics on health care economy

Greenland

Statistics Greenland www.stat.gl	Responsible for: • Population and vital statistics • Statistics on health care personnel • Statistics on hospital services • Statistics on health care economy
National Board of Health www.nanoq.gl E-mail: eli@gh.gl	Responsible for: • Statistics on births • Statistics on abortions • Statistics on malformations • Statistics on infectious diseases • Statistics and information on vaccinations
Statens Serum Institut www.ssi.dk	Responsible for: • Statistics on causes of death • Statistics on cancer
Landsapotekeren www.peqqik.gl E-mail: apotek@peqqik.gl	Responsible for: • Statistics on medicinal products
The Department of Health & Infrastructure	Responsible for: • Statistics on hospital services • Statistics on health care economy • Statistics on health care personnel

Finland

Statistics Finland www.stat.fi	Responsible for: • Population and vital statistics • Statistics on causes of death • Statistics on road traffic accidents
National Institute for Health and Welfare www.thl.fi	Responsible for: • Statistics on institutional care • Statistics on births • Statistics on Abortions and sterilizations • Statistics on health care personnel • Statistics on public health care • Statistics on private health care • Statistics on labour force in health care • Statistics on the use of alcohol and drugs • Statistics on the use of tobacco • Statistics on health care expenditure

	• Definitions and classifications in health care • Statistics on primary health care • Statistics on Infectious Diseases • Statistics and information on vaccinations • Survey on health behaviour among adults and elderly • Public Health Report
National Agency for Medicines (FIMEA) www.fimea.fi	Responsible for: • Registration of medicinal products and sales licences • Statistics on Adverse Drug Reactions • Statistics on pharmacies
Social Insurance Institution of Finland (FPA) www.kela.fi	Responsible for: • Sickness insurance benefits and allowances, reimbursements for medicine expenses, and disability pensions
The Cancer Register www.cancer.fi	Responsible for: • Statistics on cancer
Finish Centre for Pensions (ETK) www.etk.fi	Responsible for: • Statistics on pensions due to reduced capacity for work

Åland

The Åland Government www.regeringen.ax	Responsible for: • Statistics on health care personnel • Statistics on hospital services, such as capacity (no. of beds) • Statistics on health care economy – regarding charges within health care
Statistics Finland National Institute for Health and Welfare National Agency for Medicines Finnish Cancer Registry Social Insurance Institution of Finland Finnish Centre for Pensions	See Finland

Island

Statistics Iceland www.statice.is	Responsible for: • Population and vital statistics • Statistics on causes of death • Statistics on alcohol consumption • Statistics on health care expenditure • National accounts

Directorate of Health www.landlaeknir.is	Responsible for: • Medical statistics on births • Statistics on abortions • Statistics on sterilizations • Statistics on primary health care • Statistics on hospital services • Statistics on infectious diseases • Statistics on vaccinations • Statistics on health care personnel • Statistics on use of tobacco
Icelandic Medicines Control Agency www.imca.is	Responsible for: • Statistics on pharmaceutical products
Icelandic Medicines Control Agency www.krabb.is	Responsible for: • Statistics on cancer

Norway

Statistics Norway www.ssb.no	Responsible for: • Population and vital statistics • Statistics on causes of death • Statistics on health and social conditions • Statistics on health and social services • Statistics on health care personnel • Statistics on alcohol consumption • Statistics on health care economy • Statistics on use of tobacco
Norwegian Institute of Public Health www.fhi.no	Responsible for: • Statistics on sexually transmitted diseases and infectious diseases • Statistics on tuberculosis • Statistics on immunization • Statistics on sale of medicinal products • Statistics on prescribed drugs • Statistics on births and infant deaths • Statistics on induced abortions • Statistics on causes of death
Norwegian Directorate of Health www.helsedirektoratet.no	Responsible for: • Statistics on hospital services
Cancer Registry of Norway www.kreftregisteret.no	Responsible for: • Statistics on cancer
Ministry of Health and Care Services www.regjeringen.no/en/dep/hod	Responsible for: • Statistics on in vitro fertilization

Sweden

Statistics Sweden www.scb.se	Responsible for: • Population and vital statistics • Statistics on health care economy • Statistics on use of tobacco • Study on Living Conditions (ULF/SILC)
National Board of Health and Welfare www.socialstyrelsen.se	Responsible for: • Statistics on births • Statistics on abortions • Statistics on in-patients • Statistics on cancer • Statistics on causes of deaths • Statistics on prescribed drugs • Statistics on authorized health personnel
Public Health Agency of Sweden www.folkhalsomyndigheten.se	Responsible for: • Statistics on infectious diseases • Statistics and information on • Vaccinations • Statistics on alcohol abuse
National Corporation of Swedish Pharmacies www.apoteket.se	Responsible for: Statistics on drug sales and prescribed drugs
Swedish Association of Local Authorities and Regions www.skl.se	Responsible for: • Statistics on health personnel • Statistics on hospital capacity • Statistics on health economics

NOMESCO's Publications since 2000

Recurring Publications

Each year, NOMESCO publishes the *Helsestatistik for de Nordiske lande*. Up until and including 2011, this was a bi-lingual publication in Danish (Nordic languages) and English with the title *Health Statistics in the Nordic Countries*. From 2012, the English and the Danish versions will be published separately.

In cooperation with the Nordic Centre for Classification of Health Services (Nordclass), NOMESCO publishes NOMESCO Classification of Surgical Procedures. The publication has been updated annually for a number of years and is now available in version 1.16.

In cooperation with the Baltic countries, the publication Nordic/Baltic Health Statistics has been published four times, the latest version with data from 2006.

Moreover, a number of theme publications have been published. These are shown below with their number in NOMESCO's publication list.

98. Hälso- och sjukvårdens finansiering i Norden, Nomesco 2013
92. NOMESCO Report on Mortality Statistics – Theme section 2010, NOMESCO, Copenhagen 2010
90. Temasektion vedrørende kvalitetsindikatorer, NOMESCO's Health Statistics in the Nordic countries 2009, NOMESCO, Copenhagen 2010
88. Medicines Consumption in the Nordic Countries 2004-2008. NOMESCO, Copenhagen 2010
82. Ældres Helse, Temasektion, Health Statistics in the Nordic countries 2006
80. Mental Helse, Temasektion, Health Statistics in the Nordic countries 2005
79. NOMESCO Classification of External Causes of Injuries. Fourth revised edition. NOMESCO, Copenhagen 2007
78. Sustainable Social and Health Development in the Nordic Countries. Seminar, 6th April 2006, Oslo. Seminar Report. NOMESCO, Copenhagen 2006
76. Smedby, Björn and Schiøler Gunner: Health Classifications in the Nordic Countries. Historic development in a national and international perspective 2006. NOMESCO, Copenhagen 2006
72. Medicines Consumption in the Nordic Countries 1999-2003. NOMESKO, Copenhagen 2004
75. Patienter I Öppen Värd, Temasektion, Health Statistics in the Nordic countries 2004
73. Barns Helse, Temasektion, Health Statistics in the Nordic countries 2003

69. Vård på lika villkor, Temasektion, Health Statistics in the Nordic countries 2002

66. Validitet och jämförbarhet i NOMESKO:s dagkirurgistatistik, Section B, Health Statistics in the Nordic countries 2001

67. Sustainable Social and Health Development in the Nordic Countries. Seminar 27th May 2003, Stockholm. NOMESCO, Copenhagen 2003

64. Validitet og sammenlignbarhet av statistikk over kirurgiske inngrep ved nordiske sykehus, Temasektion, Health Statistics in the Nordic countries 2000

58. Nordiske læger og sygeplejersker med autorisation i et andet nordisk land. Copenhagen 2000