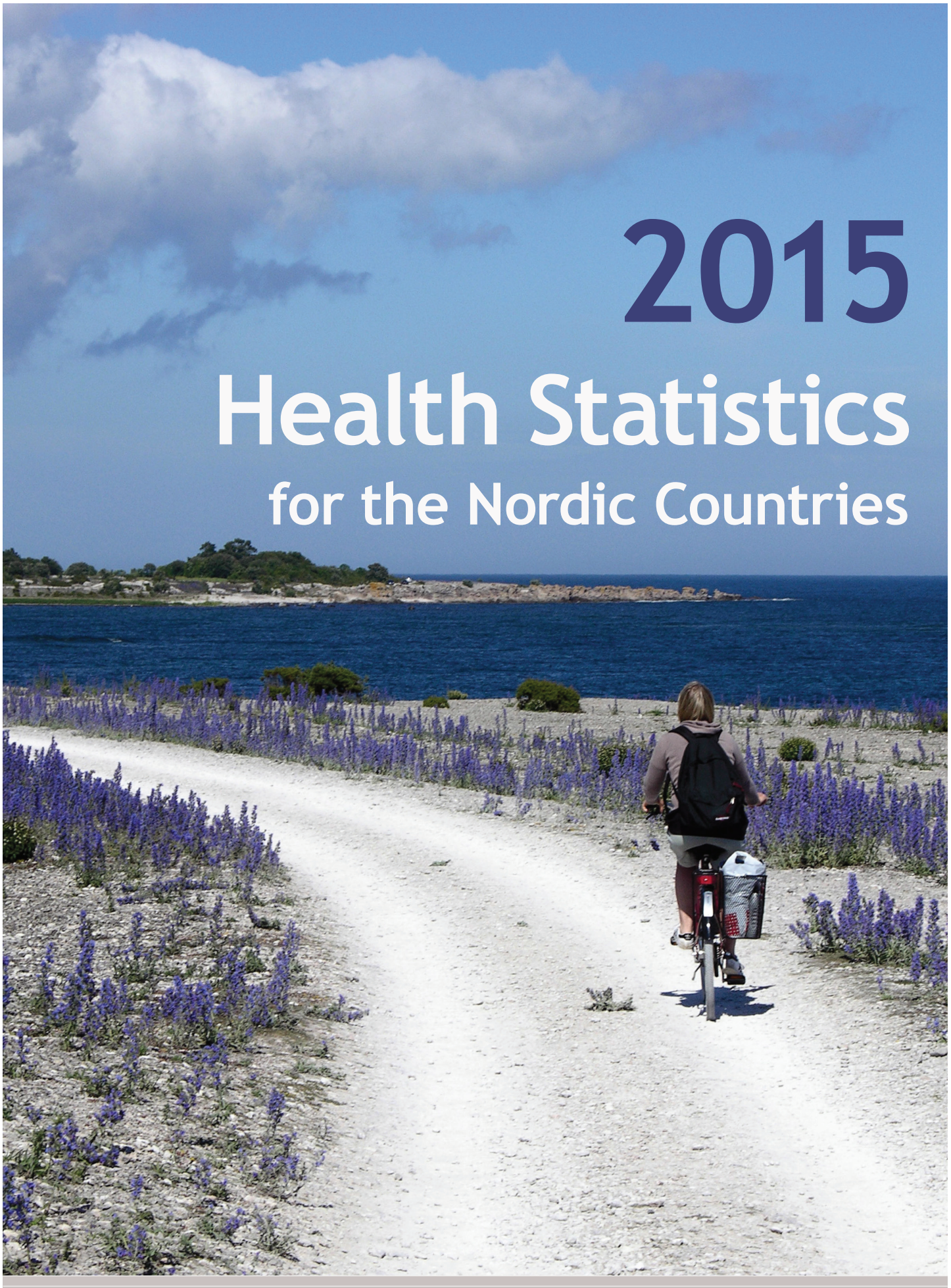

2015

Health Statistics

for the Nordic Countries

nomesco

Nordic Medico-Statistical Committee 103:2015

Health Statistics in the Nordic Countries 2015

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ISBN 978-87-89702-87-2

ISSN 2245-9626

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Symbols used in the tables:

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Information not applicable	.
Less than half of the unit used	0.0/0
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Preface

The 2015 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, their 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 15. October 2015. The latest data year may consequently be 2014 or 2013. Previous versions are available at www.nowbase.org, where our database and more specialized publications from projects carried out by NOMESCO can also be found.

Nordic Medico-Statistical Committee (NOMESCO), November 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

In August 2014, the Government launched the health strategy ”The sooner the better”. The overall aim of the strategy is that all Danes shall receive the best treatment from the health services. DKK 5 billion has been set aside for this strategy in the 2015 state budget, to be spent over the coming four years on the following initiatives:

- Improved treatment for cancer so that more people survive
- Improved measures for patients with diabetes, chronic obstructive lung disease and other chronic illnesses
- Measures to enable practicing physicians to detect cancer and chronic illnesses earlier
- Improved quality of health services through participation of patients and relatives
- Introduction of a new programme for quality in the health services focusing on visibility and transparency of results

In addition, in the 2015 budget the Government has set aside DKK 1.5 billion for health initiatives over the coming four years for measures to reduce over capacity in hospitals, to provide early support for vulnerable families and to increase preventive measures, for example to improve the quality of life of children and vulnerable adults.

The Rate Adjustment Pool Agreement (Satspuljeaftalen) 2015-2018 (spring 2014) deals with providing more help for people with mental illnesses. In the agreement, DKK 2.2 billion are earmarked for mental health services over the coming four years. The funds are to be spent on increasing capacity, reducing waiting times, preventing and reducing the use of coercive measures, and improving the facilities for patients in hospitals.

In October 2014, the Government and the parties in the Rate Adjustment Pool Agreement made a deal for the health sector for 2015-2018. DKK 246.5 million was granted for strengthening programmes for patients entering rehabilitation, terminally ill adults and children, people suffering from dementia, and children with parents suffering from mental illness.

The Government proposal for a revision of the law regulating the use of coercive measures in mental health services was approved in April 2015. The new law secures a focus on equality, patient participation, dialogue and collaboration in connection with admittance to mental health institutions, in-patient care and treatment. The aim of the law is also to reduce the use of coercive measures.

FAROE ISLANDS

In May 2012, work on a new Faroese health plan 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 giving priority to preventive measures, and thus to decrease the need for expensive hospitalization and treatment. The new measures were categorized in the following terms: general health promoting

measures, earlier and more efficient measures in primary health care, and more focus on improving patients' abilities for self-care especially when coping with chronic illnesses. These measures were described and processed based on the Health Minister's specific request to move the Faroese health care system away from a fragmented system, conceptually as well as in reality, towards a more integrated and holistic health care system.

Since the presentation of the report and the subsequent debate in the Parliament (Løgtingið), 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 measures. Examples of measures that have already been implemented and measures that are in progress are:

- expansion of the offer of free dental care for children and adolescents
- establishment of local inter-disciplinary health centres
- strengthening initiatives within child and youth psychiatry
- introduction of legal rights for rehabilitation
- offers of special counselling for people with multiple drug use over 75
- establishment of a Public Health Institute
- establishment of health services for people with diabetes and other patients with chronic diseases at local inter-disciplinary health centres
- a National Health Service development plan shall be made as decided by Løgtingið early this summer

FINLAND

Social welfare and health care reform

A solution was reached in June 2014 for key provisions of the act on the organization of social welfare and health care services and the next steps in the process. In the new model, organization and provision of services were separated, and the responsibility for organizing the services was delegated to five social welfare and health care regions. However, the Constitutional Committee of the Parliament interpreted the reform to be against the autonomy of the municipalities. Therefore, after the Parliamentary Election in April 2015, the new Government has to find another solution for decision making in providing social welfare and health care services.

Dual co-payment system for taxi trips

If a patient books a taxi from the centralized dispatch service (Kela), he or she pays only EUR 16. From 1 January onwards, if the taxi was not booked through Kela, the patient must first pay the full fare and then claim reimbursement from Kela afterwards. Furthermore, the co-payment will then be EUR 32, or double the normal amount, and it will not count towards the annual maximum limit for out-of-pocket travel expenses.

More information: www.kela.fi/web/en/transport-by-taxi

ICELAND

A new reimbursement system for medicinal products, which is similar to the Danish and Swedish system, was implemented on the 4th May 2013. The main goal was to increase equality between individuals, regardless of health status, and reduce the

burden of high expenses for medicinal products. Co-payment is a proportion of annual expenses, and there is a step-wise increase in reimbursement by the Health Insurance up to full reimbursement. Each individual pays proportionately less as expenses increase until a subsidy limit is reached. In the first step, the individual pays the full cost, in the second step 15% of the cost, and in the third step 7.5% of the cost of the medicinal product. The self-payment then gradually decreases until annual expenses have reached the annual limit. After this, the expenses are fully covered. The annual limit is lower for elderly people and disabled people (approximately EUR 300) than for the general public (approximately EUR 400). The system will be further developed and a similar system will be adopted in other parts of the health services.

Physical activity by prescription (FaR) was introduced in 2011 as a pilot project. The project has been implemented in all primary care service centres in the country. The objective is that general practitioners and other physicians can prescribe exercise to selected patients as part of their treatment programme. The exercise is specified and followed up, and is both an alternative and a supplement to traditional medical treatment.

A new system for providing dental care to children was introduced in May 2013 and are implemented in seven steps towards 2018. Parents now register their children with a family dentist, who is responsible for all dental treatment, prevention and recall of the child. Parents only pay a low co-payment once every 12 months. From 2018 it will cover all children under 18.

Nationwide electronic patient journals will be further developed and linked in order to promote safety and quality of services for patients.

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

The previous insurance scheme was divided into health insurance and social insurance in 2008. The goal was to amalgamate some institutions and achieve a clearer relationship between the state as buyer and the supplier of health services. Due to the financial crisis, which occurred in Iceland in October 2008, most of the planning and implementation was put on hold, but has now been revived.

The integration of health institutions has been carried out in accordance with the country's division of seven health districts (cf. Health Act nr.40/2007) in recent years. As of 1st October 2014, there is a health institution in each district, Landspitali University Hospital in the capital region, and Akureyri Hospital. The primary purpose of this integration is to ensure that health services are available in all regions, both professionally and financially, and 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, and to create stronger operational and administrative units that are able to solve most problems in the local area without the interference of the ministry. In this way the merger will strengthen cooperation and division of labour in the districts and in the services.

In 2016, a new formula funding financing model will be implemented in primary health care in the capital area. The funding will be based on the size and characteristics of the population and the goal is a transparent financing model, linked to written requirements for all primary health care centres.

NORWAY

There are many acts in the health field that have been revised or have come into force in recent years: the Public Health Act (folkehelseloven), the Health and Care Services Act (helse- og omsorgstjenesteloven) and the Patients and Users Rights Act (pasient- og brukerrettighetsloven). These acts aim to improve coordination between health care providers, especially between primary health care services provided by the municipality and specialist health services (hospitals). The changes involve issues related to quality of care, patient safety and empowerment of patients.

The Public Health Act came into force on 1 January 2012 and gave a new foundation for strengthening systematic public health work in the development of policies and planning, through better coordination of public health work horizontally across various sectors and actors, and vertically between authorities at the local, regional and national levels. A deliberate substitution policy has been pursued since the late 1980s, with the aim of replacing relatively expensive inpatient care with less costly outpatient and day care and bringing care closer to patients' homes. With the Coordination Reform (2012) the municipalities are responsible for delivering services for coordinated and integrated pathways, preventive services and early intervention close to where users live.

The Government launched a white paper on primary health and care services in 2015 concerning preventive care, low-threshold services and services for children and young people https://www.regjeringen.no/en/dokumenter/meld.-st.-26-20142015/id2409890/. The focus is on aspects related to quality of services, preventive care and cooperation with specialized health services. The goal is to reduce waiting times, increase capacity in the long-term care sector, and to give more priority to better treatment and preventive care within mental health care services and services for people with substance abuse. The goal is also to establish better routines for cooperation, both between services at different levels and between services and patients.

Improved patient rights

In 2015 a new reform of treatment rights within the specialized health services was introduced. The aim is to reduce waiting time, increase freedom of choice for patients and increase efficiency in public hospitals. The right to freedom of choice regarding treatment has been introduced for specialized substance abuse treatment, mental health care and selected areas within somatic health services.

Coordinated services for cancer patients

In the National Cancer Strategy (Nasjonal kreftstrategi (2013-2017) well-coordinated patient care pathways shall prevent unnecessary waiting time for examination and treatment. Standardized routines for treatment of cancer were introduced in 2015.

The goals are to establish centres for diagnosis in all regions and to improve cooperation with GPs.

Knowledge-based health services
There is a need to use new knowledge and to initiate research for innovation and better practices. The Government will invest in research and innovation through use of quality indicators, data and registers. The goal is that health data should be used in a proactive way, to motivate health personnel to provide better treatment and to improve the quality of services.

Mental health and substance abuse
The Government will expand services for patients with mental health disorders or substance abuse. An escalation plan has been introduced in 2015 to improve services for these groups, especially in the municipalities. NOK 200 million has been allocated to these services. Another NOK 10 million has been allocated to establish arrangements for more dignified transport of people with mental health disorders.

NOK 200 million has also been allocated to improve school health services and health services provided in health centres.

ICT and digitalization
Extensive planning and modernizing of the ICT-platform for the whole health and care sector in Norway is taking place. The goal of this work can be summed up thus: one citizen, one medical record. The goal is that health information will follow the patient though the whole patient care pathway. The system of electronic patient journals (EPJ) has been implemented both for general practitioner services and specialized health services. The public dental service and most private dental services also use EPJ. Some municipalities are participating in pilot studies with electronic medical records.

SWEDEN
The Government has decided that from 1 July 2015 the Swedish Council on Health Technology Assessment (Statens beredning för medicinsk utvärdering (SBU)) is to assess the scientific basis for methods in use in social services and activities supported by the Act on support and service for certain physically impaired people. This involves additional tasks for SBU, which until now has assessed methods in use in health services. SBU will take over this function from the National Board of Health and Welfare. The name of SBU will be changed to the Swedish Agency for Health Technology Assessment and Assessment of Social Services (Statens beredning för medicinsk och social utvärdering). Evaluations made by SBU are to include medical, economic, societal and ethical perspectives.

The Medical Responsibility Board (Hälso- och sjukvårdens ansvarsnämnd (HSAN)) will be transferred from Kammarkollegiet to the National Board of Health and Welfare on 1 July 2015. HSAN is a court-like state authority that deals with jurisdictional issues relating to the practice of authorized health personnel after investigation and notification by the Health and Social Care Inspectorate (Inspektionen för vård och omsorg (IVO)) or after application from the practitioner involved. The Parliamentary Ombudsmen and the Chancellor of Justice may also make applications. As the new

host agency, the National Board of Health and Welfare will manage the processing and administration for the Board.

1.2 Organization and responsibility for the health sector

DENMARK

Responsibility for health services is relatively decentralized. The main principles are as follows: The State is responsible for legislation, supervision and guidelines. The regions are responsible for hospital services, health insurance and special nursing homes. The municipalities are responsible for primary health care, home nursing, prevention, rehabilitation after hospitalization, and child and school health services. The regional authorities have operational responsibility for 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 con-tract 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 geographic 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 hospital services, specialist fields and primary health services largely follows the Danish system. The same applies to nursing homes, home nursing services, home help services and dental services. Nursing homes, home nursing services and home help services were transferred from the Home Rule Government to the municipalities on 1st January 2015.

Hospital services are run by the Home Rule Government of the Faroe Islands, which defrays all expenditure on 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 from the Faroese national budget. Physician services are administered by both the municipal authorities and the state authorities. The municipalities are responsible for properties, inventory and instruments, while the public health insurance scheme stipulates employment conditions and other similar conditions.

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.

FINLAND

Municipalities are responsible for health services. The Health Care Act (1326/2011) regulates the health care and nursing services that the municipalities are responsible for according to the Public Health Act (66/1972) and the Specialist Treatment of Diseases Act (1062/1989). Health care includes measures to promote health and welfare, primary care and specialized nursing.

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.
- If a patient’s own health 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.
- 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 centre. If an appointment at a health centre is deemed necessary, patients shall be given an appointment within three working days from the time of contact with the health centre. Normally, treatment is provided at the health centre immediately at the first visit. Treatment that is not provided at the visit shall be started within three months. In cases where health centres provide specialized treatment, the time limits are the same as 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.

- Municipalities are also required to provide ambulance services and to ensure that occupational health services are established. Employers can either organize their own occupational health service, or they can enter into an agreement with a health centre or with others who provide occupational health services.
- The municipalities must provide services for people with mental illness that can reasonably be offered in health centres.
- Children and young people shall receive mental health care within three months if it is assessed to be necessary.
- Dental treatment that is assessed to be necessary shall be started within a reason-able time and at the latest within six months.
- Dental care includes advice and prevention, dental examination and treatment.
- Dental care and treatment paid for by the health insurance scheme is provided for the entire population. Dental care is also provided for adults in health 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.

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

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 and private health care.

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

All public health services are organized by Åland's Health Care Organization (ÅHS). This organization is governed by a politically elected board.

The Åland Government has 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 public primary health care services and for private general practitioners.

The structure of primary health care corresponds functionally and ideologically to the Finnish public health care system. Counselling on contraception and maternal and infant health, and school and student health services function as in Finland. Immunization programmes are voluntary and the recommendations are the same as in Finland. Physiotherapy under the ÅHS is a shared function for the primary health service and the hospitals. In addition, a number of private physiotherapists work in the public sector.

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

The public dental service provides dental care for children and young people, and 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

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

The Parliament is responsible for legislation, but the Minister of Health, who is responsible for health care policy in the Ministry of Welfare, is responsible for regulation, supervision and guidelines. The Minister of Health has responsibility for ensuring that all citizens in Iceland have access to optimum health services (primary, secondary and tertiary).

The regional health care institutions are responsible for provision of health services. Health centres provide primary health services, which comprise both prevention and general treatment. Preventive measures include antenatal care, infant health care, school health programmes, immunization, family planning etc. Home nursing care is also provided by the health centres, while home help services are provided through the municipal social service system.

As a main rule primary contact should be made at health centres. However, patients can go to specialists and dentists, and can contact emergency and ambulance services without referral.

Specialist medical treatment is largely carried out by practising specialists who work under a contract with the health insurance. Specialists operate in densely populated areas but they also work in health centres in small towns. Specialist treatment is also offered in outpatient wards in hospitals.

Hospital services are provided in three types of facilities: 1) specialized hospitals 2) regional hospitals with some specialization and 3) a number of local health care facilities with a few hospital beds but with more long-term beds for elderly people. These hospitals have functions that are similar to nursing homes.

Dental treatment is provided in private dental practices.

Physiotherapy services are provided in health centres, but most treatment in urban areas is provided by private physiotherapists.

Private physiotherapists have a contract with the health insurance.

Most nursing homes are independent institutions, run by municipalities, voluntary organizations and the like. They are financed partly by user charges, but mainly by health insurance.

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

Pharmacies are organized by the pharmacy owners, in accordance with the legislation. Municipalities have the right to comment on the location of pharmacies but the Medicine Agency regulates their functions.

NORWAY

The Norwegian health care system is based on the principles of universal access, decentralization and free choice of provider. It is financed by taxation and user charges. All residents are covered by the National Insurance Scheme (Folketrygden, NIS), managed by the Norwegian Health Economics Administration (Helseøkonomiforvaltningen, HELFO).

While health care policy is controlled centrally, responsibility for provision of health care is decentralized. Local authorities at the municipal level organize and finance primary health care services. The Norwegian Government has overall supervision and financial responsibility for the hospital sector. Norway's four regional health authorities control the provision of specialized health services. Most hospitals in Norway are public hospitals, funded and owned by the state. A small number of hospitals are privately owned. Specialist health services include hospitals for patients with somatic or psychiatric/psychological disorders, outpatient departments, centres for training and rehabilitation, and institutions for drug addicts.

The municipalities are responsible for preventive health and for providing primary health services, while the County Authority provide dental care. Primary health services are financed through grants from the Norwegian Government, local tax revenues, reimbursements from the National Social Security System, and user charges. All consultations for children under 16 years of age are free.

The public dental health services (PDHS) are administered and funded by the county municipalities. Children under 18 years of age are entitled to free dental treatment except for orthodontic care.

All municipalities have an agreement with a Regional Health Authority. When patients are discharged from hospitals, they are followed up by the municipal health services. If the municipalities cannot provide health services to patients as soon as they are ready to be discharged, they must pay a fee from day one.

SWEDEN

The State has overall responsibility for health policy, but responsibility for health services is divided between the State, the county authorities and the municipal authorities. Regions are formally county authorities but with an expanded responsibility for regional development.

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 the task of ensuring that all inhabitants have equal access to sound and adequate services.

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

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, and get treatment within 90 days after a decision has been made about treatment.

Within child and youth psychiatry, the treatment guarantee is stricter. 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, in-depth diagnosis or treatment within 30 days.

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.

Since 1 July 2013, county authorities are bound by law (2013:407) to provide affordable health care to foreigners over 18 years of age who are living in Sweden without a residence permit, and who need urgent treatment. This also includes dental care, maternity care, contraception advice, abortion and subsidized medicines. Children and young people under 18 who are seeking asylum are entitled to the same free medical and dental care as other people living in the county.

The Medical Products Agency has responsibility for approving and controlling medicinal products and herbal medicines, and to have an overview of cosmetics, hygiene products and medical equipment. The agency is also the licensing and regulatory authority for the legal handling of narcotic drugs.

The Dental and Pharmaceutical Benefits Agency (TLV) has the task of deciding on the pricing and reimbursement of medicines and supplies and the rules for national dental care support. TLV is also responsible for pharmacies' trading margins and rules for the exchange of drugs, and for conducting follow-up and supervision under the Pharmaceutical Benefits Act.

The Public Health Agency of Sweden has responsibility for public health issues, and for ensuring that people have equal opportunities for good health. It does this through monitoring public health, analysing background factors, and evaluating public health initiatives. It also has responsibility for promoting health, preventing illness

and aiding the control of infectious diseases through epidemiological and microbiological.

The Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU) evaluates the scientific basis for methods currently in use and new methods used in health and social services, and for activities supported by the Act on support and service for certain physically impaired people. Evaluations made by SBU include medical, economic, societal and ethical perspectives.

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 Offices 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 responsibility with the Danish Board of Health for supervision of health services. The chief medical officer is the consultant to the Faroese and Danish authorities regarding health matters.

The Office of 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. This 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 can make recommendations about 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 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 supervisory tasks regarding pharmaceutical products to pharmacies, pharmaceutical companies and the public.

In Norway, supervision of health and social services is the responsibility of the Norwegian Board of Health Supervision (centrally)and the Offices of the County Governors in each county. The Norwegian Board of Health Supervision is a national public institution organized under the Ministry of Health and Care Services. The Offices of the County Governors are responsible for supervision of health services and health care personnel at the county level. The legislation provides the framework for supervision of health and care services (Supervision of Health and Care Services Act). The supervision authorities work independently of the political management.

The Offices of the County Governors deal with complaints against individual health care personnel. Supervision applies to all health services, irrespective of whether they are provided by municipalities, private businesses, publicly owned hospitals or health care personnel who run their own practice. The supervision authorities may find that the statutory requirements have not been met, and give advice on how to make improvements. If there are grounds for more serious sanctions against health care personnel, the case is forwarded to the Norwegian Board of Health Supervision.

In Sweden, the Health and Social Care Inspectorate (IVO) is the national supervising authority for social services and for health services. The purpose of supervision is to ensure that 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 includes presenting the supervised organizations with the results of supervision, to provide feedback, advice and guidance regarding the supervision and to ensure that discrepancies and irregularities are corrected.

The Act on patient safety (2010:659) regulates which measures IVO can and must carry out in the supervision of health personnel. If IVO decides upon inspection that health personnel are a danger to patient safety, IVO reports this to the Medical Responsibility Board (HSAN), which decides whether authorization to work within the health services shall be withdrawn or limited.

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 services carried out by authorised health personnel in the Faroe Islands are dealt with by the National Agency for Patients' Rights and Complaints (*Sundhedsvæsenets Disciplinærnævn*) in Denmark. Complaints about cases regarding rights of access to patient records are dealt with by the Danish Patient Ombudsman. Complaints about coercion in connection with mental health care are dealt with by the Faroese Psychiatric Complaints Board (Psykiatriska kærunevndin). The decisions of the Complaints Board can be appealed to the Psychiatric Appeals Board in Denmark. Complaints about non-health professional services are dealt with by the Faroese Complaints Board for Social and Health Cases (Kærunevndin í almanna- og heilsumálum), except complaints about the right of access to patient records, which, as already mentioned, are dealt with by the Danish Patient Ombudsman.
Patients who have been referred by the Faroese health care system, who receive treatment in the Danish hospital services, are fully covered by the Danish complaints system.

GREENLAND
Complaints concerning health issues must be addressed in writing to the National Board of Health, which prepares the case and makes recommendations about a decision on the complaint. The cases are then sent to the Danish Patients' Complaints Board where The Disciplinary Board makes a decision about 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 they wish to complain about the treatment or services they have received. The simplest way is to express dissatisfaction to the physician who provided the treatment, or to contact the physician in charge of the hospital department or health centre. If further assistance is needed in order to solve the problem, there are two possibilities. The patient can contact either the 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 treatment institutions. The Patient Ombudsman may take up issues of principal significance with the "Patients Board of Trust" where the issues may be discussed and form the basis for decisions, although the Board cannot make a decision in individual cases.

ICELAND

In accordance with the Patients' Rights Act, patients have the right to complain about health services. A patient can direct his complaints to the respective healthcare institution and to the Directorate of Health. Decisions of the Directorate of Health can be appealed to the Minister of health.

NORWAY

Patients can send complaints about health services to the institution where they were treated or to the municipal board in cases of municipal health services. Alternatively patients can send complaints to the Office of the County Governor. Serious cases are forwarded to the Norwegian Board of Health Supervision. Authorized health care personnel can be given a warning, their right to prescribe addictive drugs can be withdrawn, or their authorization can be withdrawn.

The role of the Health and Social Services Ombudsman is to take care of the needs, interests and statutory rights of patients and clients. The ombudsman can help patients who do not get the treatment they need. There is an ombudsman in each county.

In cases of injuries caused during treatment, the patient can apply for compensation to the Norwegian System for Compensation for Injuries to Patients (Norsk Pasientskadeerstatning). Patients with complaints about public and private health services and dental services can apply for compensation.

SWEDEN

The Health and Social Care Inspectorate (IVO) is the authority that deals with consumer complaints regarding care.

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

Chapter 2

Population and Fertility

Introduction

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

2.1 Population and Population Trends

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

The development in population growth varies somewhat among the Nordic countries. The natural increase has been largest in Iceland, the Faroe Islands and Greenland throughout the past decade. Denmark, Åland and Sweden have had the lowest natural increase. In 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 2014[1]

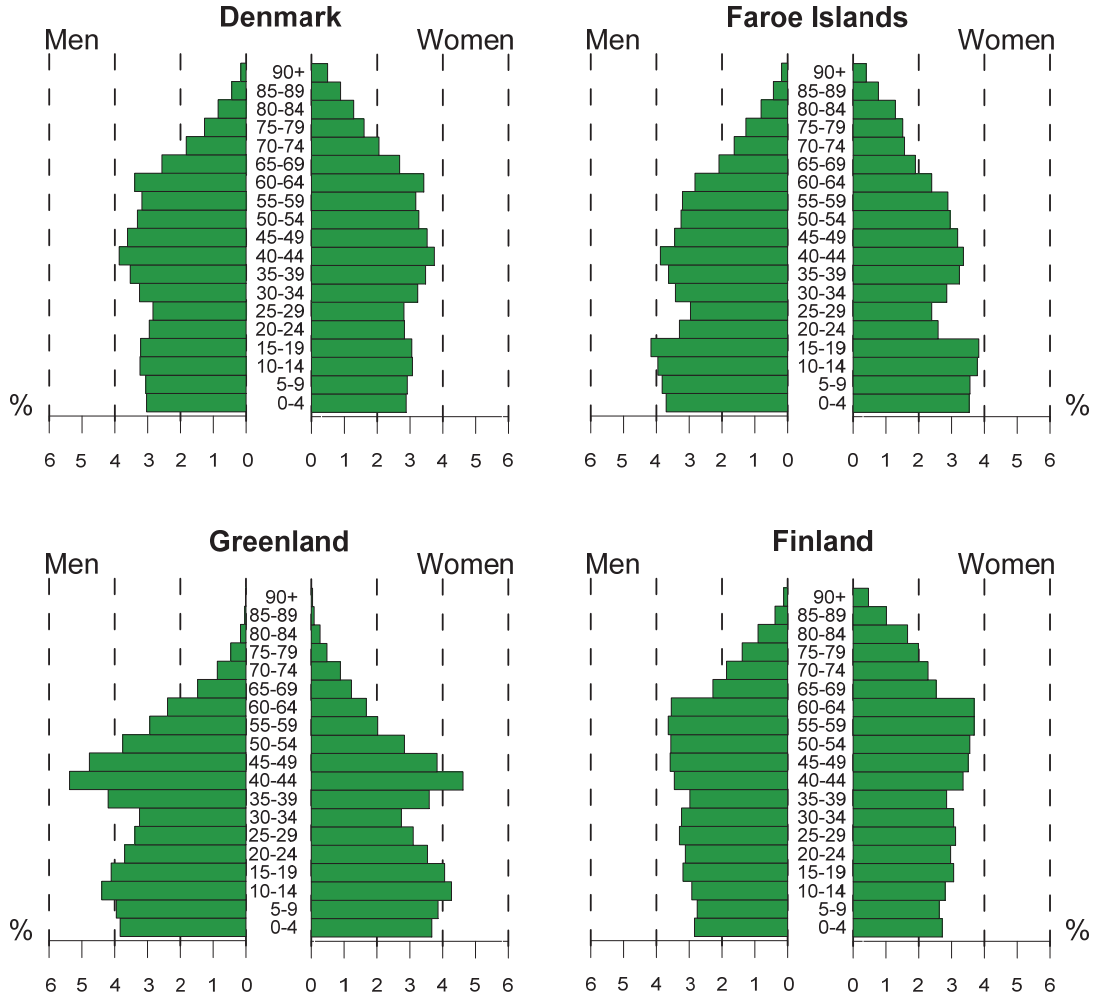

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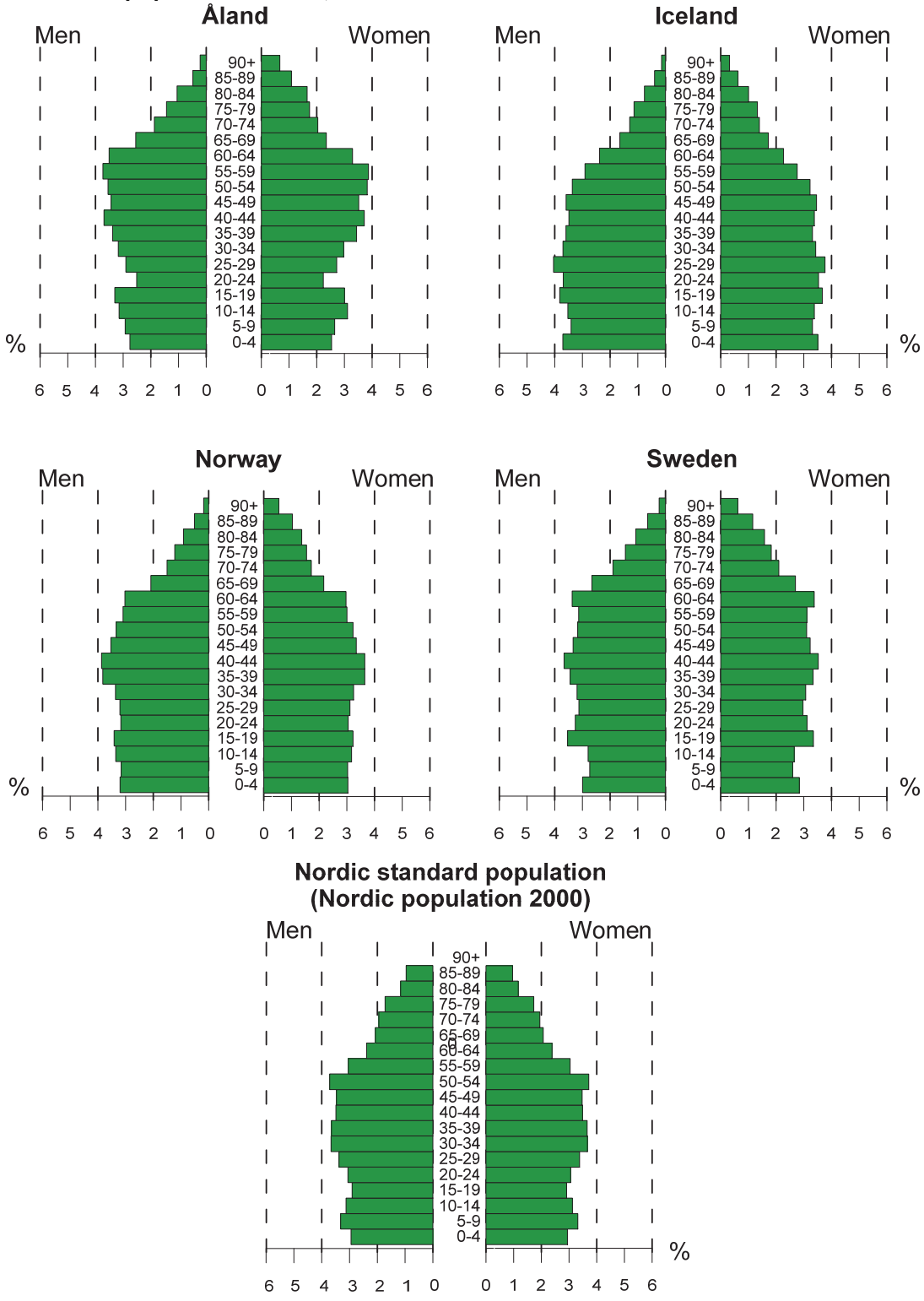
Figure 2.1.1 Mean population by gender and age as a percentage of the total population 2014[1], continued



1 The Faroe Islands, Greenland and Åland: 2008-12

Table 2.1.1 Mean population 1960-2014

	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
2010	2 748	25	30	2 632	14	160	2 444	4 670
2013	2 782	25	30	2 673	14	162	2 552	4 790
2014	2 799	25	30	2 692	13	164	2 583	4 843
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
2010	2 796	23	27	2 732	14	158	2 445	4 708
2013	2 826	23	27	2 765	14	161	2 528	4 810
2014	2 840	23	27	2 780	14	163	2 554	4 853
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
2010	5 544	49	56	5 363	28	318	4 889	9 378
2013	5 603	48	56	5 439	29	324	5 080	9 600
2014	5 640	48	56	5 472	29	327	5 137	9 696

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, 1960-2014

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
1960[1]								
0-17	26.3	38.4	..	35.3	29.8	39.9	30.6	27.4
18-64	63.2	53.6	..	57.4	58.9	52.1	58.5	60.8
65+	10.5	8.1	..	7.3	11.4	8.0	10.9	11.8
1970								
0-17	31.0	36.9	..	30.2	26.7	38.9	29.3	24.9
18-64	56.8	54.3	..	60.7	60.1	52.4	57.9	61.4
65+	12.2	8.8	..	9.2	13.1	8.8	12.8	13.7
1980[2]								
0-17	25.8	34.9	37.9	25.1	24.3	33.7	27.0	23.9
18-64	59.9	55.4	58.4	62.9	60.2	56.4	58.3	59.9
65+	14.3	9.7	3.5	12.0	15.6	9.8	14.7	16.3
1990								
0-17	21.3	29.5	29.6	23.0	22.0	30.0	23.3	21.9
18-64	63.1	58.7	66.6	63.6	61.5	59.4	60.4	60.4
65+	15.6	11.8	3.8	13.5	16.6	10.6	16.3	17.8
2000								
0-17	21.6	27.9	31.2	21.9	22.0	27.7	23.5	21.9
18-64	63.6	58.5	63.8	63.1	61.6	60.7	61.3	60.9
65+	14.8	13.5	5.1	15.0	16.3	11.6	15.2	17.3
2010								
0-17	21.9	26.1	27.2	20.2	20.3	25.3	22.7	20.5
18-64	61.5	59.1	65.9	62.3	61.6	62.5	62.3	61.2
65+	16.6	14.8	6.9	17.5	18.1	12.1	15.0	18.3
2013								
0-17	21.1	25.7	25.9	19.8	19.9	24.7	22.1	20.2
18-64	60.8	58.4	66.7	62.6	61.9	62.2	62.1	60.5
65+	18.1	15.9	7.4	17.6	18.2	13.1	15.8	19.3
2014								
0-17	20.8	25.6	25.6	19.7	19.8	24.4	22.2	20.3
18-64	60.8	58.1	66.9	60.6	60.1	62.2	62.1	60.2
65+	18.5	16.3	7.5	19.7	20.2	13.4	15.7	19.5

1 Åland 1961
2 Faroe Islands 1977

Table 2.1.3 Vital statistics per 1 000 inhabitants, 2000-2014

	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
2013	10.0	9.4	0.6	5.3	5.9
2014	10.1	9.1	1.0	6.6	7.6
Faroe Islands					
2005-09	13.7	8.2	5.6	-4.1	1.4
2010-14	12.8	7.8	5.0	-3.6	1.5
Greenland					
2004-08	12.0	6.3	7.2	-8.5	-1.3
2009-13	14.7	8.0	6.7	-5.9	0.8
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
2013	10.7	9.5	1.2	3.3	4.5
2014	10.5	9.5	1.0	3.2	4.2
Åland					
2005-09	10.4	9.3	1.1	5.2	7.5
2010-14	9.8	8.7	1.1	5.5	6.6
Iceland					
2000	15.2	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
2013	13.4	6.7	6.7	4.9	11.8
2014	13.4	6.3	7.1	3.4	10.5
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
2013	11.6	8.1	3.5	7.9	11.4
2014	11.6	8.0	3.7	7.5	11.2
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
2013	11.8	9.4	2.4	6.8	9.3
2014	11.9	9.2	2.7	7.8	10.6

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

Table 2.1.4 Average life expectancy, 2000-2014

	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
2013	78.0	63.4	34.3	17.4	7.5	81.9	67.3	37.9	20.1	9.2
2014	78.5	63.9	34.9	17.9	7.9	82.7	68.1	38.6	20.7	9.6
Faroe Islands										
2005-09	77.4	63.0	34.0	16.9	7.3	82.5	68.0	38.6	20.4	9.3
2010-14	78.8	64.3	35.3	18.0	7.8	83.7	69.2	40.0	21.6	10.1
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
2013	77.8	63.1	34.6	17.8	8.0	83.8	69.0	39.7	21.5	9.7
2014	78.2	63.5	34.9	18.0	8.0	83.9	69.1	39.8	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	79.2	64.2	35.1	17.9	8.1	84.2	69.5	40.0	21.2	10.0
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
2013	80.8	66.0	37.1	19.1	8.2	83.7	68.9	39.5	21.0	9.5
2014	80.6	65.9	36.9	19.0	8.2	83.6	69.1	39.7	21.3	9.8
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
2013	79.7	64.9	36.0	18.4	8.0	83.6	68.9	39.5	21.2	9.7
2014	80.0	65.4	36.4	18.7	8.2	84.1	69.3	39.8	21.5	9.9
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
2013	80.1	65.4	36.5	18.7	8.1	83.7	69.0	39.6	21.2	9.6
2014	80.4	65.6	36.7	18.9	8.2	84.1	69.3	39.8	21.5	9.8

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 2.1.2 Live births and natural increase per 1 000 inhabitants, 2000-2014

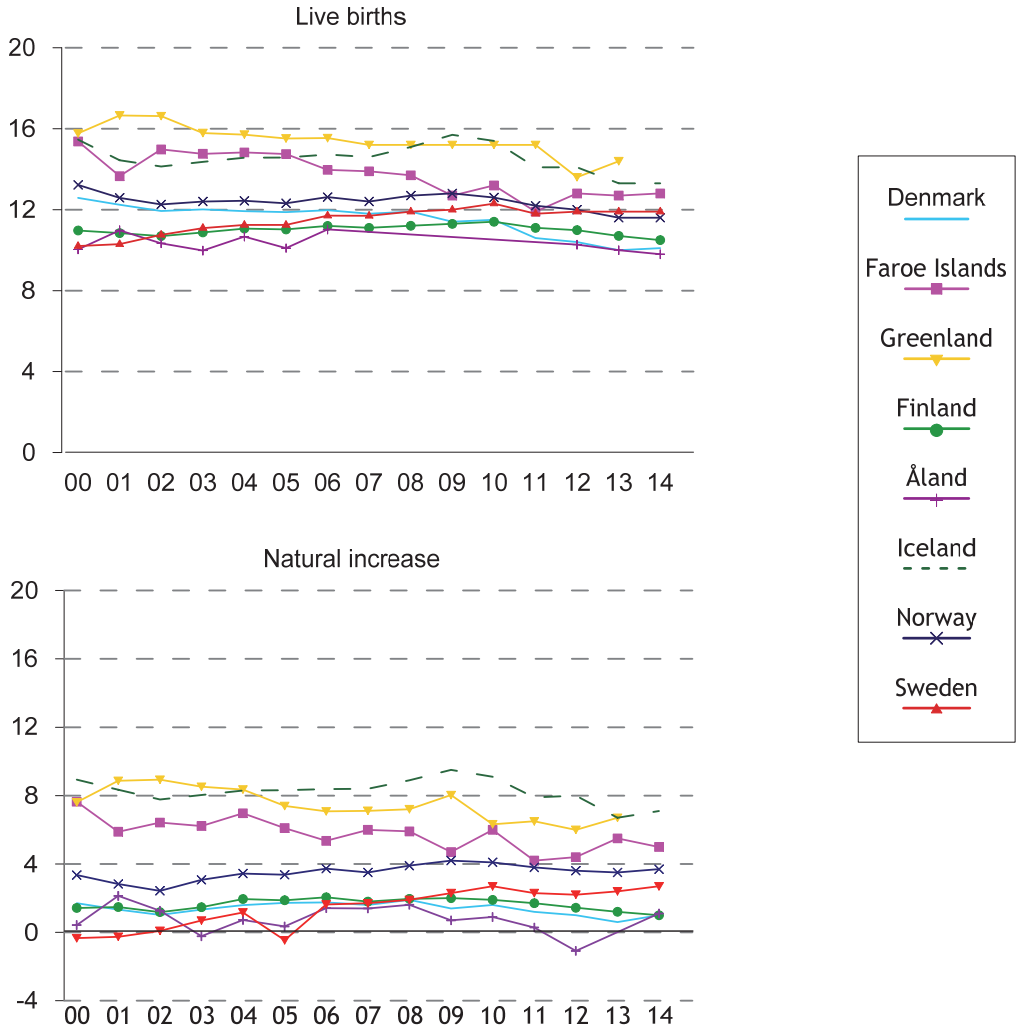
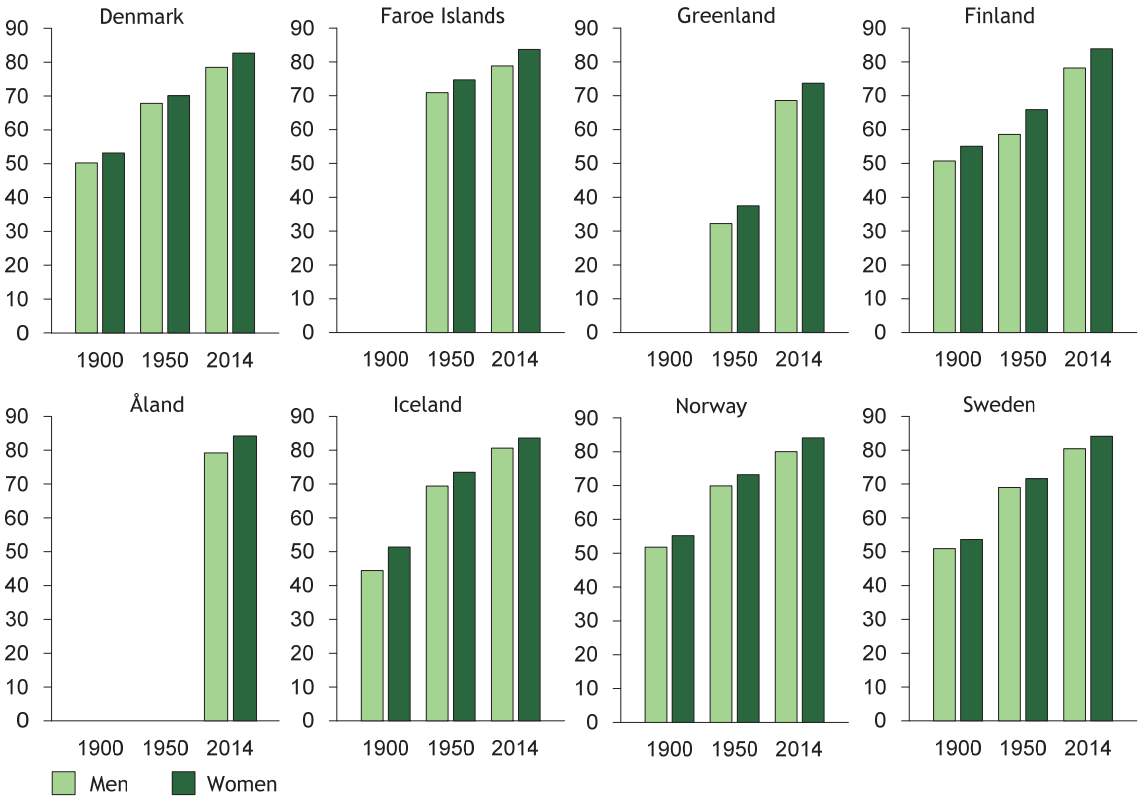


Figure 2.1.3 Life expectancy at birth 1900, 1950 and 2014



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, however, there is 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 the Nordic countries except for the Faroe Islands and Greenland, where the limit is 28 weeks.

Greenland also has the highest mortality rate for the first year of life. Åland, Finland and Iceland have the lowest mortality rate for the first year of life.

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 over.

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 in the other Nordic countries it 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, 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, 2000-2014

		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									
2005	65 194	6.7	48.8	126.1	117.9	45.5	7.2	0.3	1 756
2010	64 282	5.7	43.2	123.9	127.4	48.5	8.4	0.3	1 802
2013	55 873	4.2	34.6	106.6	121.8	54.3	10.1	0.6	1 669
2014	56 238	3.7	35.2	112.3	120.5	55.3	11.0	0.5	1 691
Faroe Islands									
2005-09	665	14.9	87.4	171.2	143.1	70.5	12.4	0.6	2 501
2010-14	624	11.9	91.4	157.3	142.7	76.2	18.7	1.2	2 497
Greenland									
2004-08	..	56.0	133.7	132.1	87.4	39.3	8.3	0.3	2 285
2009-13	..	51.5	94.3	109.0	91.2	42.6	8.7	-	2 236
Finland									
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
2013	58 134	7.3	50.7	105.8	114.5	59.1	12.5	0.6	1 747
2014	57 232	7.2	49.5	103.6	111.0	58.1	12.3	0.8	1 710
Åland									
2005-09	1 410	4.9	49.4	109.2	124.8	56.5	13.5	0.8	1 799
2010-14	1 432	4.3	48.5	119.1	120.3	59.6	10.2	0.4	1 811
Iceland									
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
2013	4 325	7.1	62.2	117.7	117.0	65.8	14.9	1.8	1 932
2014	4 375	7.5	64.7	122.8	112.2	64.7	12.8	1.5	1 932
Norway									
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
2013	58 993	5.6	48.4	113.5	120.4	56.8	10.7	0.5	1 813
2014	59 079	5 0	44.9	110.3	120.5	58.4	11.1	0.7	1 767
Sweden									
2005	101 346	6.2	46.6	109.5	124.9	55.9	10.3	0.5	1 769
2010	115 641	5.7	51.3	118.2	138.0	69.4	13.6	0.8	1 985
2013	113 593	4.9	45.6	111.5	132.8	68.1	13.9	0.8	1 888
2014	114 906	4.7	43.8	113.2	131.2	67.8	14.6	0.9	1 881

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 Assisted reproduction technologies 2000-2013[1]

	Denmark	Finland	Iceland	Norway	Sweden
Treatments, IVF+ICSI					
2000	7 077	4 323	298	4 029	6 586
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	6 360	9 335
2013	11 212	4 561	476	..	..
Frozen embryo transfers, FET					
2000	792	2 488	83	301	1 208
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	2 208	5 054
2013	2 721	3 274	316	..	..
Number of live births, IVF+ ICSI + FET					
2000	1 678	1 382	147	1 097	2 237
2005	1 786	1 534	167	1 521	2 874
2010	2 123	1 858	192	1 885	3 882
2012[2]	2 618	1 690	138	1 825	3 820
2013[2]	2 553	1 679	135	..	..
Treatments in 2013 per 1 000 Women aged 15-49 years					
IVF + ICSI	8.9	4.0	6.2	5.4	4.4
FET	2.2	2.8	4.1	1.9	2.4
Total	11.1	6.8	10.3	7.3	6.8
Multiple births, per cent of all births after IVF[2]	13.6	6.5	7.4	11.1	5.0
Children born in multiple births, per cent of all children born after IVF[2]	24.0	12.0	14.8	20.0	-
IVF, ICSI and FET per cent of all live births[2]	5.1	2.9	3.1	3.0	12.8

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

1 Based on the year of treatment, not on the year of birth
2 Denmark, calculated on the basis of expected number of births and expected number of children born

Source: DK, Statens Serum Institut; FI, THL; IS, Art Medica; NO, Ministry of Health and Care Services; SV, National Board of Health and Welfare

Table 2.2.3 Stillbirths and infant mortality [1], 2000-2013

	Number		Per 1 000 births		Deaths per 1 000 live births			
	Still-births	Infant deaths	Still-births	Perinatal deaths[2]	First 24 hours	1-6 days	7-27 days	Total under 1 year
Denmark								
2005	302	303	4.7	7.9	2.1	1.1	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
2013	230	186	4.1	5.1	1.5	0.8	0.4	3.3
Faroe Islands[3]								
2004-08	2	4	2.6	5.5	0.9	2.0	0.3	5.0
2009-13	2	3	2.5	4.8	2.3	-	1.0	4.9
Greenland[3]								
2004-08	4	15	2.6	4.1	1.0	1.7	0.5	5.1
2009-13	4	10	4.8	13.4	7.6	1.7	1.2	12.7
Finland								
2005	182	174	3.1	4.9	1.0	0.7	0.3	3.0
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
2013	149	102	2.6	3.4	0.5	0.4	0.2	1.9
Åland								
2004-08	1	2	0.7	1.4	0.7	-	-	1.4
2009-13	2	1	1.4	2.1	0.7	-	-	0.7
Iceland[3]								
2005	8	10	1.9	3.3	0.7	0.7	0.2	2.3
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
2013	4	8	0.9	1.6	0.5	0.2	0.7	1.8
Norway[4]								
2005	230	171	4.0	5.5	1.0	0.5	0.5	3.0
2010	246	156	3.9	5.1	0.8	0.3	0.5	2.5
2012	227	152	3.7	5.0	0.8	0.5	0.5	2.5
2013	227	141	3.8	4.9	0.8	0.4	0.5	2.4
Sweden[4]								
2005	301	246	3.0	4.1	0.5	0.6	0.4	2.4
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
2013	441	306	3.9	5.2	0.7	0.7	0.3	2.7

1 Calculated according to year of death
2 Stillbirths and deaths in the first week of life
3 A child is considered stillborn at the 28th week of pregnancy or later
4 As of 1st July 2008, a child is considered stillborn at the 22nd week of pregnancy or later
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, 2000-2014

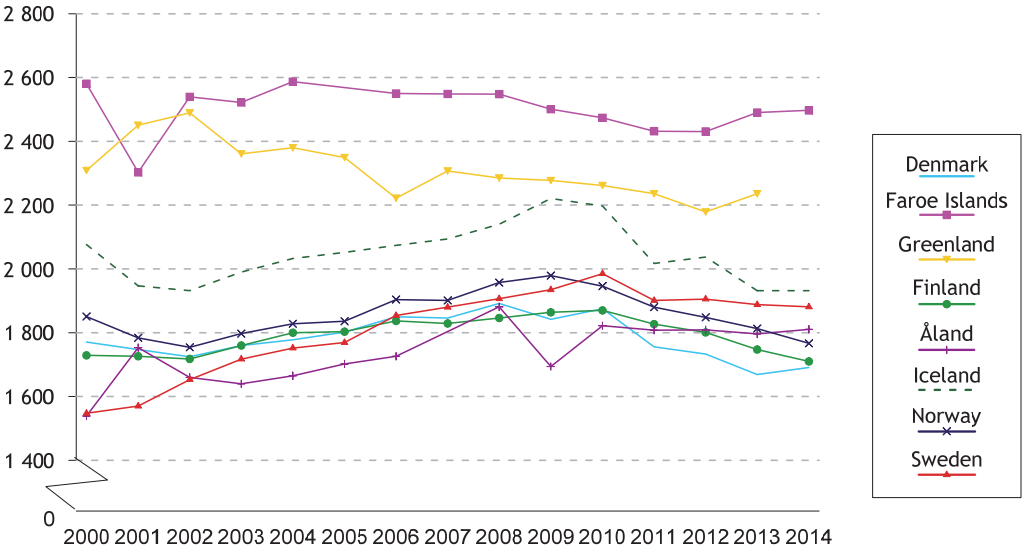


Figure 2.2.2 Assisted reproduction technologies, percentages of all live births 2000-2013

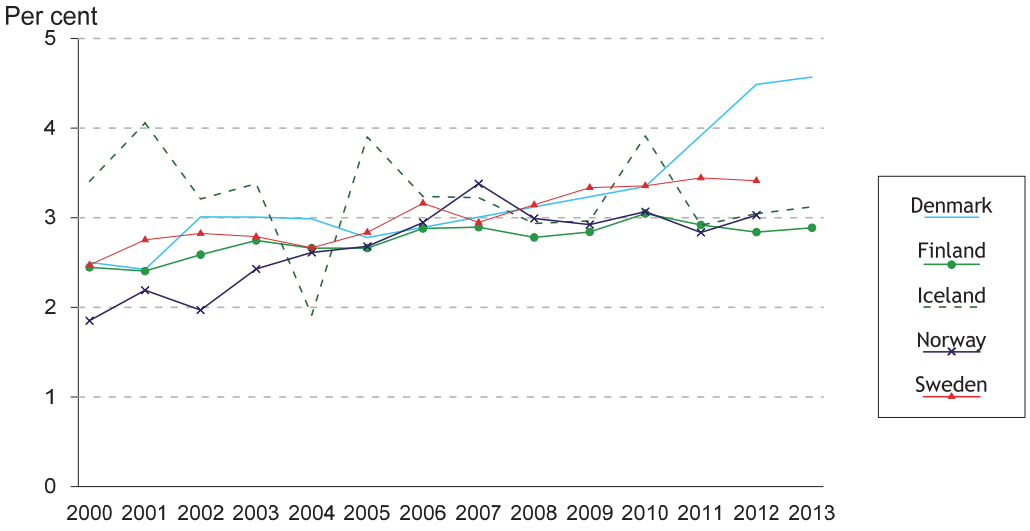
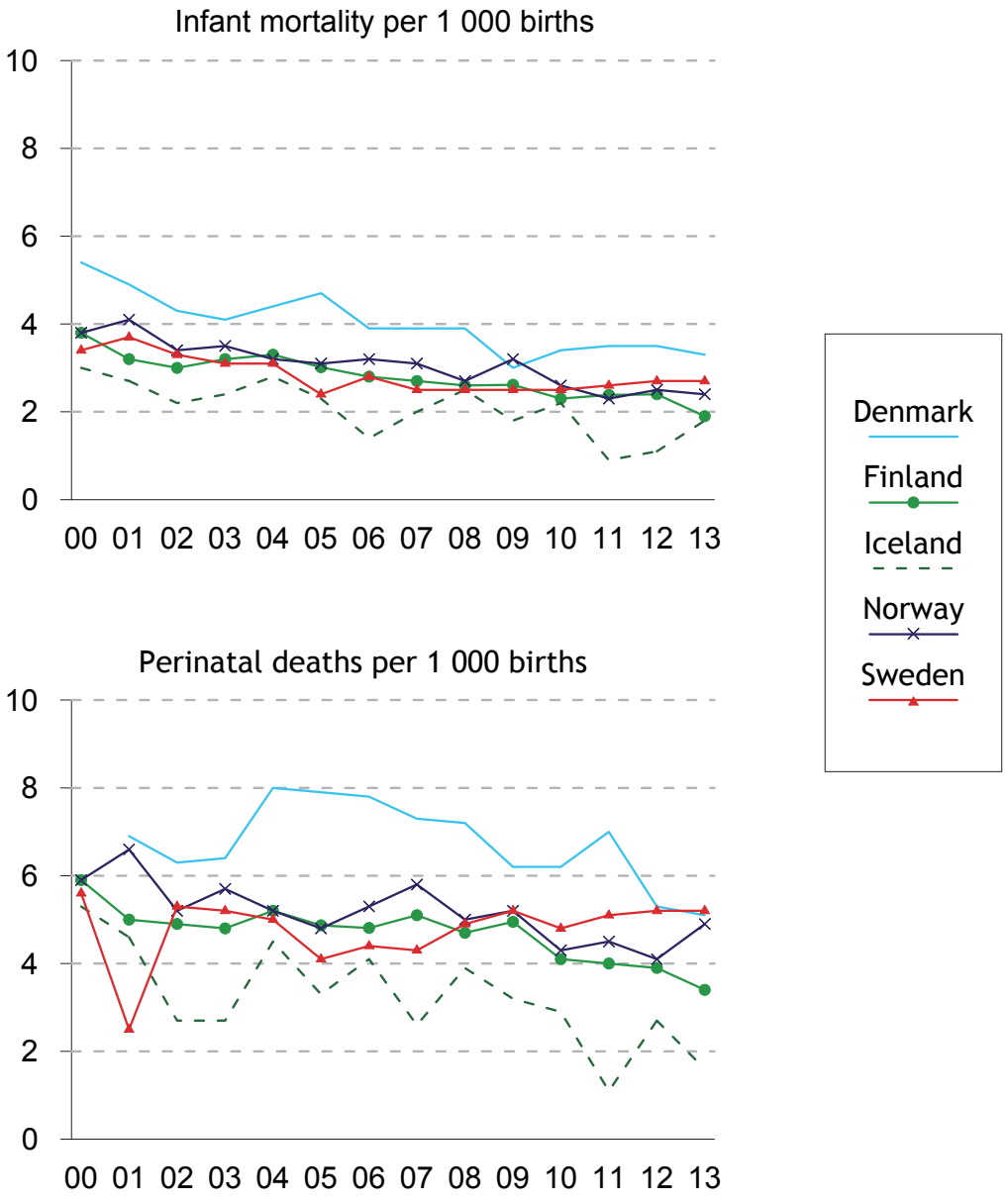


Figure 2.2.3 Infant deaths, and perinatal[1] deaths per 1 000 births, 2000-2013



1 Perinatal deaths are the total of stillbirths and deaths in the first week of life

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, 2000-2013[1]

	Number	Per 1 000 births		Deaths per 1 000 live births				
	Still-births	Infant deaths	Still-births	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
2013	104	72	1.9	0.3	0.3	0.2	0.5	1.3
Faroe Islands								
2000	-	7	-	2.7	4.1	1.3	1.3	9.7
2005	-	7	-	2.7	4.1	1.3	1.3	9.7
2010	4	2	6.1	1.5	-	-	1.5	3.1
2012	1	5	1.6	4.0	-	1.6	1.6	8.1
2013	-	1	-	-	-	1.6	-	1.6
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	106	102	1.8	0.3	0.5	0.1	0.7	1.7
2013	96	71	1.6	0.2	0.3	0.1	0.6	1.2
Iceland								
2000	13	5	3.0	-	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
2013	4	4	0.9	-	0.2	0.5	0.2	0.9
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	93	2.3	0.4	0.4	0.2	0.5	1.5
2013	133	84	2.2	0.4	0.3	0.3	0.5	1.4
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]	303	182	2.7	0.2	0.3	0.3	0.9	1.6
2013	294	170	2.6	0.4	0.4	0.2	0.6	1.5

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. ATC code G03A[1]. DDD per 1 000 women aged 15-49 years/day[2], 2005-2014

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	294	238	314	189	182	192	201	238
2010	287	232	302	204	179	204	217	220
2012	278	208	285	210	199	208	222	213
2013	274	201	252	229	225	219	228	207
2014	272	196	254	203	197	210	222	201

1 Incl. patches from G03AA13 and intravaginal contraceptives (G02BB)
2 Excl. injections and implants. Excl. G03AD (emergency contraceptives)
Source: DK, Statens Serum Institut; FO, Chief Pharmaceutical Officer; GL, National Pharmacy; FI & ÅL, Finnish Medicines Agency; IS, Icelandic Medicines Agency; NO, Norwegian Institute of Public Health; SV, Swedish eHealth Agency

Table 2.2.6 Emergency contraceptives ATC code G03AD: number of sold packages per 1 000 women in the age 15-49 years, 2005-2014

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	83	134	106
2014	79	78	69	87	85	75	121	105

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

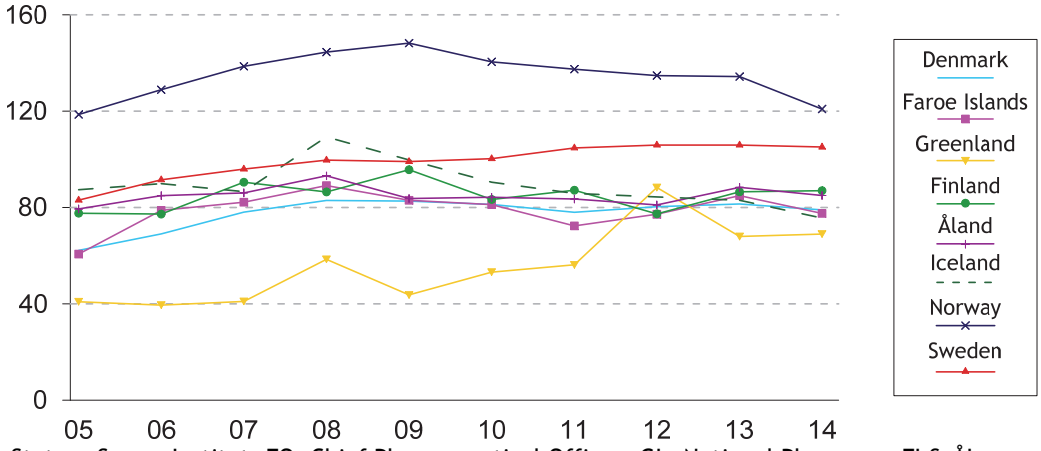
Table 2.2.7 Number of induced abortions, 2000-2013

	Number of abortions	Abortions per 1 000 women aged 15-19[1]	20-24	25-29	30-34	35-39	40-44	45-49[2]	Total abortion rate[3]	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
2005	15 295	16.0	21.3	17.4	16.6	13.1	5.2	0.5	450	238
2010	15 227	16.4	22.0	18.0	15.8	12.3	5.5	0.5	452	233
2013	15 073	12.7	23.1	18.7	15.8	11.7	4.6	0.4	435	270
Faroe Islands										
2004-08	39	3.8	6.4	4.4	4.6	5.0	2.7	0.3	136	58
2009-13	35	3.2	7.9	3.9	4.3	3.9	1.6	0.3	126	57
Greenland										
2004-08	815	98.5	127.4	86.8	52.3	27.8	7.5	0.5	2 015	979
2009-13	811	96.0	123.9	90.0	51.6	28.9	8.3	0.6	1 997	979
Finland										
2000-04	10 869	15.3	16.4	12.6	10.7	7.7	3.1	0.2	330	192
2005	10 972	15.0	18.2	12.8	10.4	7.9	3.4	0.2	338	190
2010	10 243	12.1	17.0	13.1	9.8	7.7	3.0	0.2	315	167
2013	10 120	10.5	17.5	12.7	9.9	7.7	3.0	0.3	308	173
Åland										
2004-08	64	12.9	20.1	17.8	8.7	6.7	3.2	0.2	348	187
2009-13	68	13.7	32.0	20.4	13.4	7.3	3.2	-	450	243
Iceland										
2000-04	940	21.4	23.4	17.3	13.6	9.2	4.6	0.3	449	225
2005	868	15.6	23.9	18.2	12.3	8.0	4.1	0.2	412	210
2010	978	16.0	23.0	19.2	13.4	11.4	3.5	0.5	435	199
2013	966	13.1	24.6	19.1	13.7	10.3	4.8	0.3	430	223
Norway										
2000-04	14 008	17.3	27.1	19.4	15.1	10.6	3.8	0.3	470	246
2005	13 991	15.4	27.4	20.5	15.1	11.0	4.0	0.3	468	247
2010	15 738	14.1	29.2	23.1	16.9	11.7	4.4	0.4	500	256
2013	14 748	10.1	24.5	21.8	16.9	11.1	4.5	0.3	446	250
Sweden										
2000-04	33 009	22.6	29.4	23.3	19.8	15.2	6.3	0.6	586	345
2005	34 978	23.4	31.4	24.3	19.8	16.0	7.8	0.7	617	345
2010	37 696	20.3	33.3	26.7	21.5	16.3	7.1	0.8	620	330
2013[4]	36 600	..	..	..	..	..	..	..	..	325

1 Abortions for women under 15 years are included
2 Abortions for women over 49 years are included
3 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
4 Due to concerns over the level of personal detail recorded, registration of statistics on abortions was halted during in spring 2013. It was begun again on January 1 2014 in a revised form. Approx. 36 000 abortions were carried out in 2013, but no age distribution recorded. This equals 20.3 abortions per 1 000 women aged 15-49

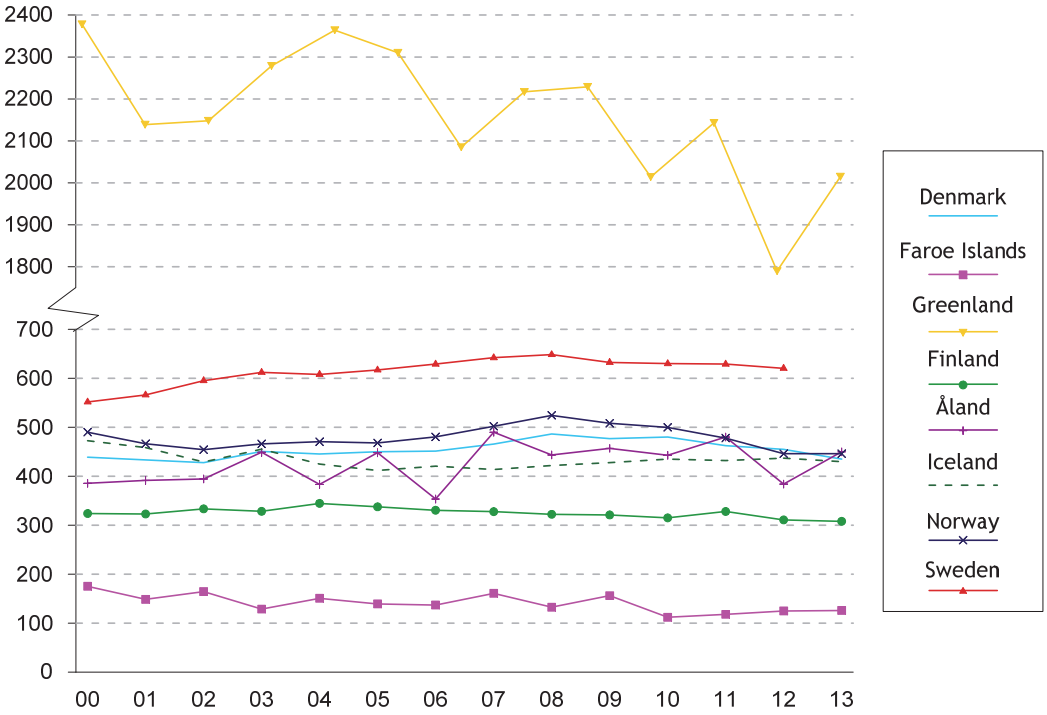
Source: The national abortion registers

Figure 2.2.4 Sales of emergency prevention per 1 000 women aged 15-49 years, 2005-2014



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, Swedish eHealth Agency

Figure 2.2.5 Total abortion rate, 2000-2013



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 lifestyle and social behaviour, followed by data on the incidence of cancer. This is followed by a presentation of treatment provided outside hospitals and in hospitals according to 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 that can be treated either outside hospitals or in hospitals.

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

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

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 in Denmark and Greenland, followed by Finland, whereas consumption/sales in the other countries is at about the same level. Accordingly, the number of treatment periods/discharges from hospital for alcoholic liver diseases is highest in Denmark and Finland.

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

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

The incidence of HIV infection is relatively stable, with the highest incidence in Norway and the lowest in Finland. The trend is related to the new methods of treatment that result in infected people having a longer period with HIV infection, and therefore a longer period of time before AIDS breaks out. 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 between 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 infections, gonorrhoea and syphilis, has been seen in all countries over the past 20 years. However, there are certain notable exceptions, with Greenland being radically different from the other countries.

Table 3.1.1 Self-reported obesity rate, population aged 15+, 2013

	Denmark	Faroe Islands	Green-land[1]	Finland[2]	Iceland[2, 3]	Norway	Sweden
Age					18-79	16+	16-84
Proportion of people with BMI ≥ 30, men	14	15	19	17	21	11	12
Proportion of people with BMI ≥ 30, women	14	12	27	16	23	9	11

1 2005
2 BMI ≥ 30 in per cent
3 2012

Source: DK, National Boards of Health; FO, Public Health Council; IS, Directorate of Health. Self-reported data from the survey Health and Wellbeing of Icelanders 2012;
FI, THL; Health Behaviour and Health among the Finnish Adult Population; SV, Statistics Sweden

Table 3.1.2 Percentage of daily smokers by gender 2013

	Denmark	Faroe Islands	Finland	Iceland	Norway	Sweden
Age	16+	15+	15-64	15+	16-74	16-84
Smoking men as a percentage of men in the age group	17	27	19	11	14	10
Smoking women as a percentage of women in the age group	17	27	16	12	13	12

Source: DK, National Board of Health; FO, Public Health Council; FI, THL; Health Behaviour and Health among the Finnish Adult Population; IS, Directorate of Health (from regular surveys on tobacco consumption); NO, Norwegian Directorate of Health; SV, Statistics Sweden

Table 3.1.3 Percentage of users of snuff by gender 2013

	Denmark	Faroe Islands[1]	Finland	Iceland[2]	Norway[3]	Sweden
Age	16+	15+	15-64	15-85	16-74	16-84
Men using snuff as a percentage of men in the age group	..	..	3	7	15	20
Women using snuff as a percentage of women in the age group	..	..	1	1	4	3

1 A survey from the Council of Public Health from March 2015 showed, that 38% of pupils in 9th grade have tried using snuff, of which 15% have tried it within the previous 30 days. The survey does not cover all of the population and was not subdivided by sex
2 Self-reported data from a telephone- and web survey. Regular oral use of snus
3 Daily use

Source: DK, National Board of Health; FO, Public Health Council; FI, THL; Health Behavior and Health among the Finnish Adult Population; IS, Directorate of Health (from regular surveys on tobacco consumption); NO, Statistics Norway; SV, Statistics Sweden

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

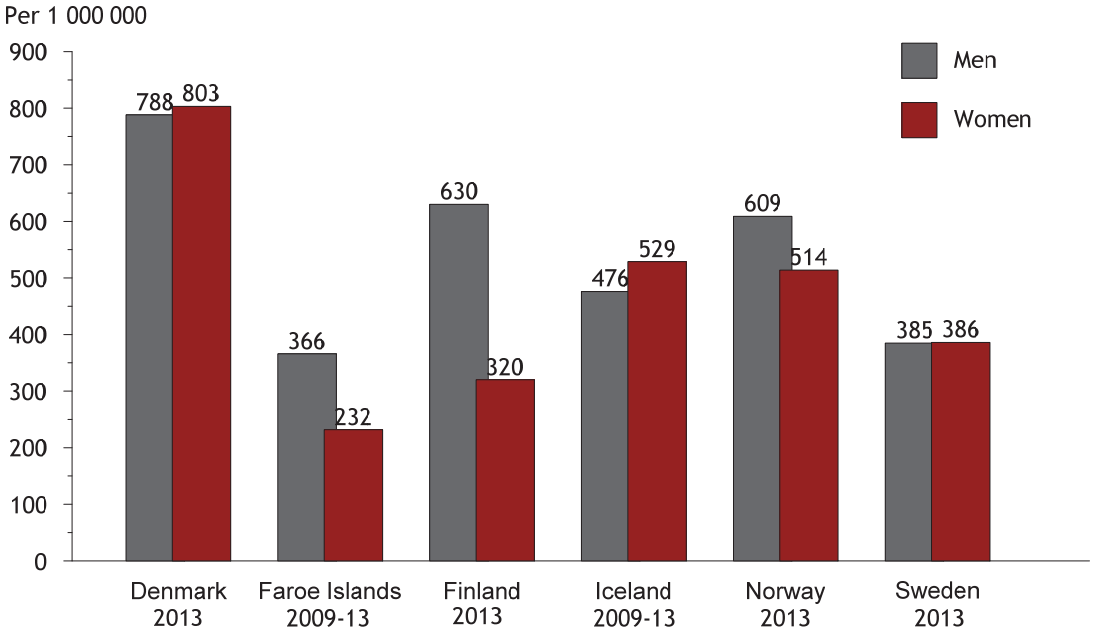


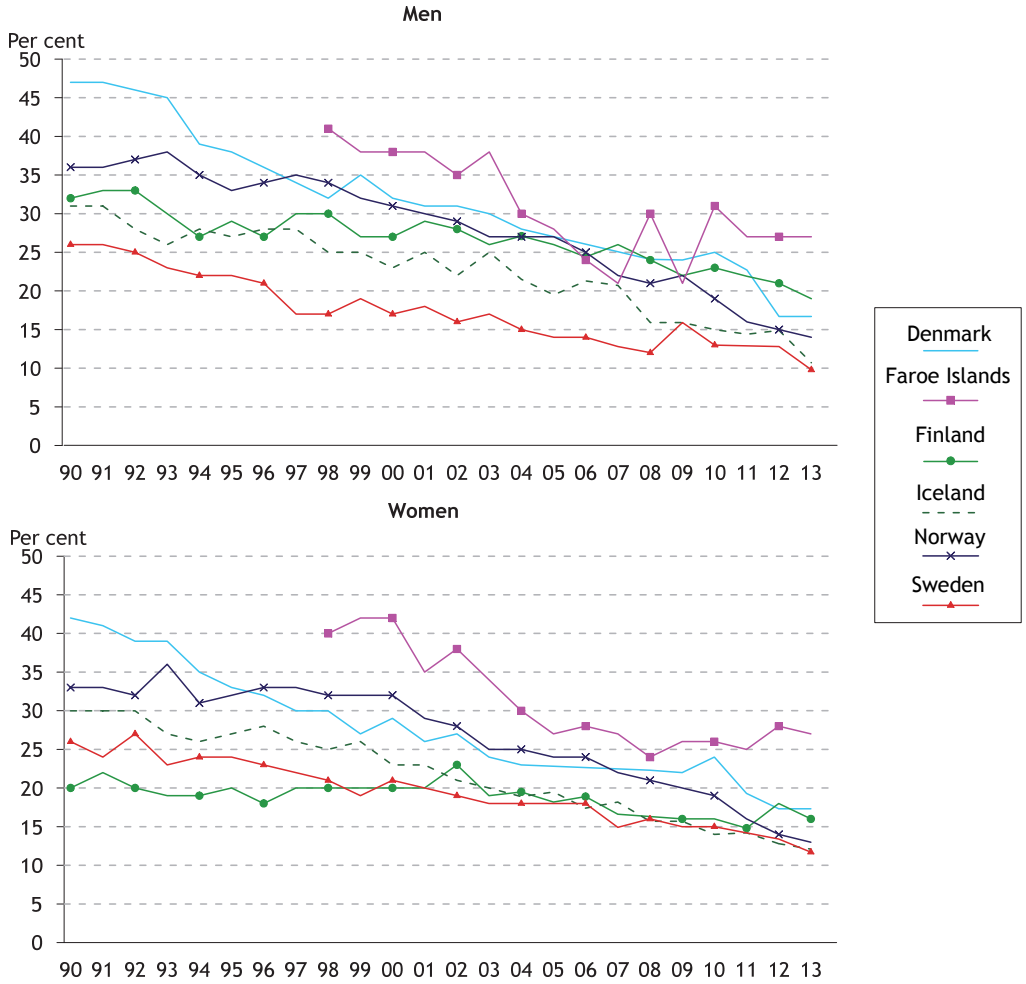
Table 3.1.4 Sales of drugs used for nicotine dependence (ATC-group N07BA), DDD/1 000 inhabitants/day, 2005-2014

	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
2013	9.3	4.3	2.0	10.1	9.6	21.7	6.2	7.0
2014	..	4.3	1.3	10.5	10.4	22.6	6.5	7.0
N07BA03 Varenicline[1]								
2010	0.7	1.0	0.1	0.4	0.1	1.0	0.9	0.5
2013	0.2	0.4	0.1	0.3	0.1	1.0	0.7	0.4
2014	0.2	0.4	0.1	0.2	0.2	0.8	0.5	0.4

1 Varenicline was introduced on the market in December 2006

Source: DK, Statens Serum Institut; FO, Chief Pharmaceutical Officer; GL, Central Pharmacy in Copenhagen County; FI & ÅL, Finnish Medicines Agency; IS, Icelandic Medicines Agency; NO, Norwegian Institute of Public Health; SV, Swedish eHealth Agency

Figure 3.1.2 Percentage of daily smokers by gender, 1990-2013



Source: OECD, and National Boards of Health; IS, Directorate of Health (from regular surveys on tobacco consumption); FO, Public Health Council; FI, THL; Health Behaviour and Health among the Finnish Adult Population; SV, Statistics Sweden

Figure 3.1.3 Sales of drugs used for nicotine dependence (ATC-group N07BA), DDD/1 000 inhabitants/day, 2000-2014

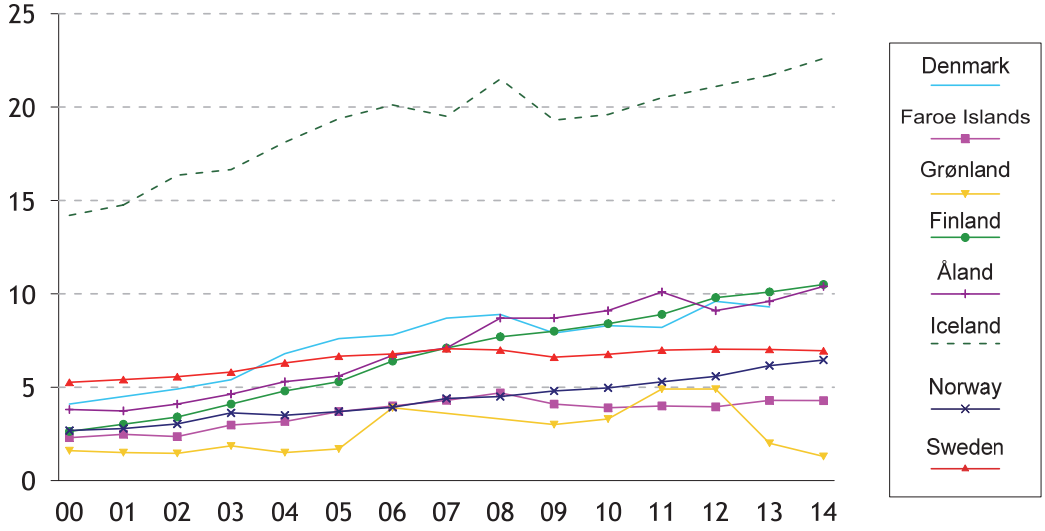
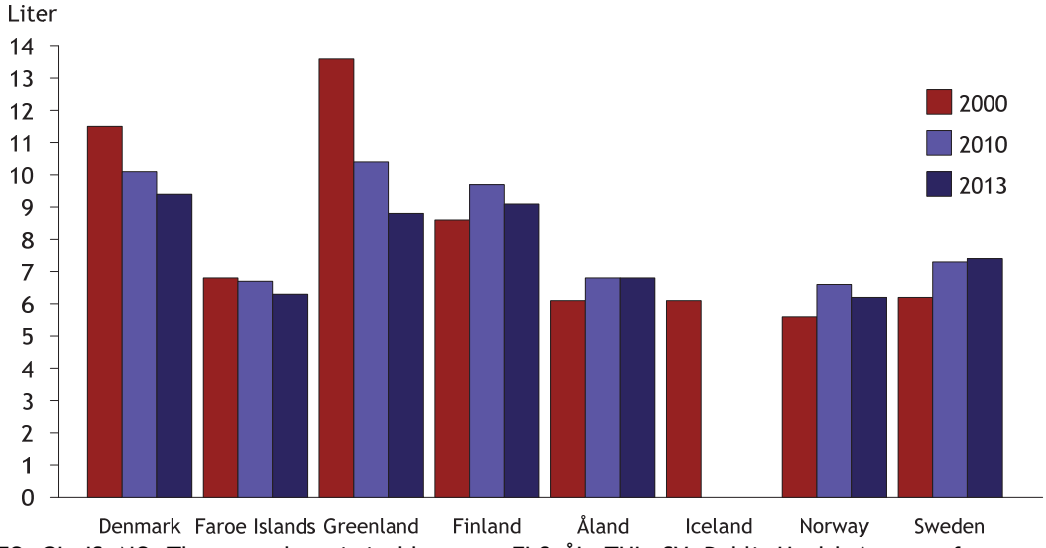


Table 3.1.5 Sales of alcoholic beverages in litres of 100 per cent pure alcohol per inhabitant aged 15 years and over, 2005-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2000	11.5	6.8	13.6	8.6	6.1	6.1	5.6	6.2
2005	11.3	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
2013	9.4	6.3	8.8	9.1	6.8	..	6.2	7.4

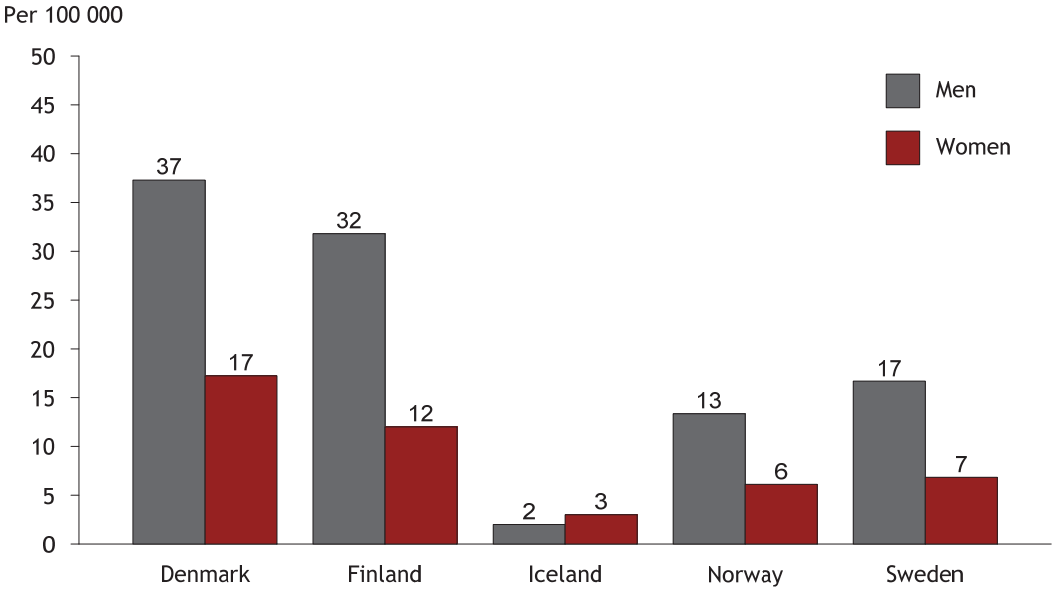
Source: DK, FO, GL, IS, NO: The central statistical bureaus; FI & ÅL: THL; SV: Public Health Agency of Sweden

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 2013



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

Figure 3.1.5 Patients treated in somatic hospitals for alcoholic liver disease per 100 000 inhabitants, 2013[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 3.1.6 Diagnosed cases of tuberculosis per 100 000 inhabitants, 2000-2013

	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	7.5	8.0
2013	8.4	4.2	201.1	6.2	-	..	8.1	7.2
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	6.3	6.6
2013	4.5	4.2	135.7	3.8	-	..	7.3	6.4

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, Public Health Agency of Sweden

Table 3.1.7 Confirmed new cases of HIV/AIDS[1], 2005-2014

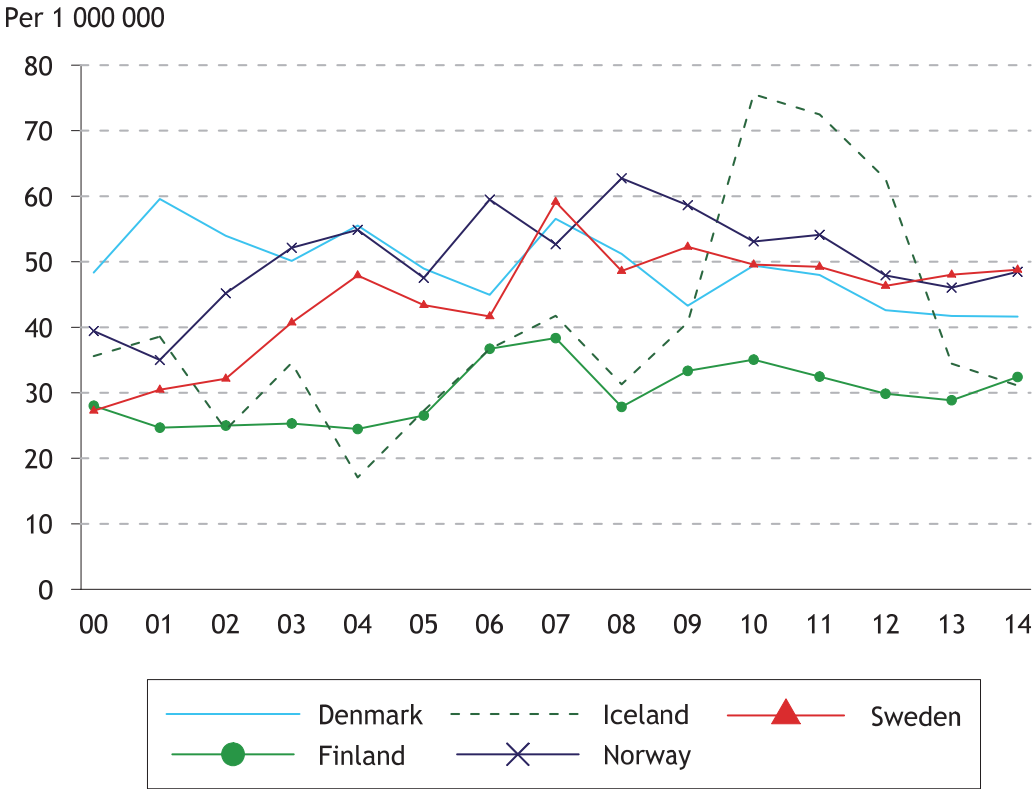
	Denmark	Faroe Islands	Greenland	Finland	Of which Åland	Iceland	Norway	Sweden[2]
Men								
2005	192	-	4	96	.	5	122	228
2010	201	1	2	132	.	18	173	285
2012	147	-	-	115	.	13	166	265
2013	178	-	-	102	.	8	158	294
2014	180	-	..	135	.	8	184	272
Women								
2005	71	-	2	35	.	3	97	164
2010	72	-	1	56	.	6	85	180
2012	52	-	3	47	.	7	76	175
2013	56	-	3	55	.	3	76	166
2014	55	-	..	42	.	2	65	199
Total								
2005	263	-	6	131	1	8	219	392
2010	273	1	3	188	-	24	258	465
2012	200	-	3	162	3	20	242	441
2013	234	-	3	157	1	11	234	461
2014	235	-	..	177	1	10	249	473

1 From 1985-2000, it was obligatory to report AIDS, which is the end stage of HIV infection. From 2000 reporting of AIDS is voluntary, as a completion to the reporting of HIV. Screening affects the number of newly-reported cases and how many people develop AIDS. Included in the total may be cases where information about gender is missing

2 HIV only

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 (MSIS); SV, Public Health Agency of Sweden

Figure 3.1.6 Confirmed new cases of HIV/AIDS per 1 000 000 inhabitants, 2000-2014



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, Public Health Agency of Sweden

Table 3.1.8 Notified cases of gonorrhoea 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
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	13	5
2012	22	8	-	-	2 674	3 895	8	3	7	-	13	4	16	2	16	7
2013	22	8	-	-	2 493	3 320	7	3	-	-	10	5	17	3	17	7

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

Table 3.1.9 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
2005	5	1	-	-	3	4	3	2	8	-	3	1	1	-	2	-
2010	16	2	-	-	..	..	5	3	-	-	2	1	6	0	3	1
2012	14	1	-	-	21	24	5	3	21	7	3	..	4	0	3	1
2013	12	1	2	-	68	83	4	2	7	-	2	1	3	1	5	1

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 (MSIS); SV, Public Health Agency of Sweden

Table 3.1.10 Diagnosed cases of Chlamydia per 100 000 inhabitants, 2000-2013

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland[1]	Norway	Sweden[2]
Men								
2000	165	79	2 791	180	95	479	326	187
2005	324	231	3 852	197	221	412	330	317
2010	383	286	5 277	202	196	551	351	340
2012	365	216	5 831	205	340	454	339	343
2013	361	..	5 282	203	267	552	364	321
Women								
2000	384	..	4 817	272	207	781	.	246
2005	554	.	5 797	289	499	643	524	411
2010	622	403	8 762	276	251	852	567	445
2012	577	345	10 816	283	443	710	554	449
2013	559	..	9 731	282	293	769	539	425
Total								
2005	440	231	4 762	239	362	548	434	366
2010	504	342	6 893	254	224	722	461	391
2012	472	278	8 153	245	391	582	428	395
2013	461	..	7 354	244	281	660	454	372

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

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

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

3.2 Cancer

All the Nordic countries have population-based cancer registers and all the countries except Sweden have centralized coding and classification.

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 for 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 precancerous 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 (ICD10 Chapter C, except C44 and C46.0, incl. D09-0, D32, D33, D41.4 and D43) per 1 000 000 inhabitants, men

	Total	C62 Testis	C61 Prostate	C16 Stomach	C18-21 Colon and rectum	C25 Pancreas	C33-34 Lungs	C43 Melanoma of the skin
Denmark								
2005	6 534	99	1 597	123	918	163	818	340
2010	5 923	117	1 425	144	848	171	820	310
2012	6 438	113	1 557	115	866	184	848	358
2013	6 293	95	1 538	118	884	157	788	327
Faroe Islands								
2004-08	3 266	135	908	88	502	135	295	120
2009-13	3 971	143	1 225	119	637	223	366	72
Greenland								
2004-08	3 087	33	212	146	364	159	795	20
2009-13	3 248	33	220	207	307	153	867	40
Finland								
2005	5 282	53	2 076	152	495	165	628	160
2010	5 391	49	1 753	149	530	192	636	240
2012	5 455	56	1 730	123	569	190	596	266
2013	5 804	65	1 886	131	582	190	630	273
Åland								
2004-08	7 147	30	3 250	226	497	271	722	226
2009-13	6 479	114	2 726	114	557	214	485	300
Iceland								
2004-08	4 424	63	1 312	145	461	113	470	141
2009-13	4 295	57	1 247	104	462	91	476	111
Norway								
2005	5 574	109	1 592	127	750	124	586	249
2010	6 183	111	1 723	125	836	129	638	304
2012	6 503	128	1 940	113	812	154	632	347
2013	6 097	132	1 893	117	828	138	609	328
Sweden								
2005	5 557	63	2 207	129	635	100	405	242
2010	5 560	64	2 077	110	690	111	392	314
2012	5 480	73	1 893	92	702	112	385	360
2013	5 798	77	2 020	117	691	126	385	354

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

Table 3.2.1.b New cases of cancer (ICD10 Chapter C, except C44 and C46.0, incl. D09-0, D32, D33, D41.4, D42 and D43), age-standardized rates per 1 000 000 men (Nordic population 2000)

	Total	C62 Testis	C61 Prostate	C16 Stomach	C18-21 Colon and rectum	C25 Pancreas	C33-34 Lungs	C43 Melanoma of the skin
Denmark								
2005	5 661	103	1 249	140	845	172	856	239
2010	6 099	92	1 445	139	887	177	831	303
2012	6 199	117	1 454	113	850	173	818	347
2013	5 959	100	1 408	115	858	149	746	313
Faroe Islands								
2004-08	3 833	144	1 079	108	631	158	350	126
2009-13	4 176	155	1 254	134	690	236	385	79
Greenland								
2004-08	6 299	62	464	254	746	271	1 929	23
2009-13	4 914	29	342	266	441	246	1 427	45
Finland								
2005	5 842	53	2 282	178	552	186	706	170
2010	5 095	47	1 668	136	519	184	586	212
2012	5 168	57	1 600	121	547	181	560	257
2013	5 415	67	1 703	123	549	182	584	259
Åland								
2004-08	6 889	30	3 076	199	482	253	665	223
2009-13	5 800	119	2 330	100	495	189	454	274
Iceland								
2004-08	5 701	59	1 901	173	645	118	659	154
2009-13	5 135	56	1 512	129	555	107	589	127
Norway								
2005	6 336	109	1 824	161	861	139	662	276
2010	6 764	111	1 859	139	927	144	704	321
2012	6 965	127	2 025	123	885	167	682	366
2013	6 448	131	1 963	126	896	151	654	345
Sweden								
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
2013	5 236	79	1 759	108	634	113	343	331

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

Table 3.2.2.a New cases of cancer (ICD10 Chapter C, except C44 and C46.0, incl. D09-0, D32, D33, D41.4, D42 and D43), per 1 000 000 inhabitants, women

		C50	C53	C16	C18-21	C25	C33-34	C43
	Total	Breast	Cervix uteri	Stomach	Colon and rectum	Pancreas	Lungs	Melanoma of the skin
Denmark								
2005	6 257	1 725	135	61	781	174	829	396
2010	6 137	1 842	130	65	765	164	793	345
2012	5 999	1 615	126	64	784	164	775	380
2013	6 057	1 670	131	59	756	168	803	383
Faroe Islands								
2004-08	3 388	905	138	103	603	121	241	207
2009-13	3 410	945	137	52	490	103	232	94
Greenland								
2004-08	3 404	531	311	68	243	152	720	45
2009-13	3 619	533	255	120	428	150	676	53
Finland								
2005	4 449	1 505	47	101	452	176	225	140
2010	5 270	1 779	53	100	503	195	288	243
2012	5 115	1 704	53	87	503	190	287	223
2013	5 350	1 739	58	96	539	200	320	253
Åland								
2004-08	5 515	1 607	74	162	560	236	398	280
2009-13	5 440	1 488	71	99	708	170	368	368
Iceland								
2004-08	4 082	1 238	92	84	425	84	479	195
2009-13	4 064	1 308	104	82	394	93	529	152
Norway								
2005	4 978	1 198	126	97	736	124	386	243
2010	5 382	1 161	132	72	748	137	518	317
2012	5 410	1 175	131	73	780	152	517	348
2013	5 180	1 272	111	63	820	150	514	348
Sweden								
2005	5 602	1 529	94	74	647	97	330	228
2010	5 877	1 682	91	69	637	103	370	287
2012	6 287	1 779	101	64	635	114	377	348
2013	6 611	1 897	97	64	645	124	386	346

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

Table 3.2.2.b New cases of cancer (ICD10 Chapter C, except C44 and C46.0, incl. D09-0, D32, D33, D41.4, D42 and D43), age-standardized rates per 1 000 000 women (Nordic population 2000)

		C50	C53	C16	C18-21	C25	C33-34	C43
	Total	Breast	Cervix uteri	Stomach	Colon and rectum	Pancreas	Lungs	Melanoma of the skin
Denmark								
2005	4 894	1 350	148	57	628	133	619	268
2010	5 357	1 619	126	56	647	139	679	324
2012	5 240	1 435	125	54	662	136	656	353
2013	5 245	1 469	129	49	630	138	672	358
Faroe Islands								
2004-08	3 449	929	151	102	610	119	256	229
2009-13	3 220	881	133	43	455	97	225	99
Greenland								
2004-08	5 703	716	324	122	574	259	1 328	45
2009-13	5 099	647	280	231	612	211	1 131	56
Finland								
2005	3 864	1 347	45	86	379	146	185	127
2010	4 037	1 430	49	69	358	134	208	196
2012	4 107	1 419	52	66	383	139	217	191
2013	4 250	1 433	57	71	407	145	234	221
Åland								
2004-08	4 586	1 383	73	132	430	165	321	251
2009-13	4 427	1 253	64	80	559	125	298	339
Iceland								
2004-08	4 522	1 387	93	89	468	93	544	204
2009-13	4 340	1 392	108	82	418	100	589	159
Norway								
2005	4 661	1 173	125	85	658	108	373	235
2010	4 996	1 116	132	62	668	120	486	302
2012	4 994	1 121	130	63	704	133	477	329
2013	4 801	1 216	112	56	733	134	472	331
Sweden								
2005	4 957	1 358	90	58	518	81	281	205
2010	5 182	1 480	88	56	509	86	304	256
2012	5 548	1 549	100	52	505	91	305	309
2013	5 829	1 660	96	51	512	99	308	310

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

Table 3.2.3 New cases of leukaemia (ICD10 C91-C95) per 1 000 000 inhabitants, 0-14 year-olds

	Denmark	Finland	Åland[1]	Iceland[1]	Norway	Sweden
Boys			M+W			
2005	67	47	.	24	37	62
2010	55	48	.	53	37	75
2012	40	44	.	59	34	40
2013	70	68	-	53	69	69
Girls						
2005	63	56	.	31	32	44
2010	58	20	.	37	36	63
2012	50	30	.	46	42	35
2013	65	53	-	46	40	42
Total						
2005	65	51	42	27	34	53
2010	56	17	-	45	36	69
2012	45	37	-	58	38	38
2013	68	60	-	53	55	56

1 Based on 5-year averages

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 (ICD10 C18-21) per 1 000 000 inhabitants

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2013	2009-13	2009-13	2013	2009-13	2009-13	2013	2013
Men, Age								
0-24	3	22	-	4	-	7	7	8
25-44	61	-	24	68	112	58	102	77
45-64	809	623	484	543	355	594	888	636
65-84	3 790	3 342	2 292	2 348	2 459	2 583	3 880	2 817
85+	5 579	3 686	5 618	4 071	2 719	2 813	5 384	3 399
Women, Age								
0-24	5	-	19	15	-	-	13	6
25-44	84	-	82	67	116	371	109	75
45-64	660	74	826	477	680	454	693	538
65-84	2 675	616	2 653	1 648	2 082	1 798	3 242	2 269
85+	3 934	1 926	-	2 661	3 860	2 870	4 803	2 659

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

Table 3.2.5 New cases of lung cancer (ICD10 C33-34) per 1 000 000 inhabitants

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2013	2009-13	2009-13	2013	2009-13	2009-13	2013	2013
Men, age								
0-24	2	-	-	1	-	-	2	1
25-44	25	-	-	13	-	27	22	16
45-64	768	436	1 406	586	710	147	600	327
65-84	3 506	1 955	6 876	2 663	1 639	2 981	3 154	1 747
85+	3 118	614	-	4 354	1 812	2 704	3 334	1 199
Women, age								
0-24	2	-	-	-	-	-	3	2
25-44	31	37	55	8	58	37	21	17
45-64	900	445	944	292	437	692	536	385
65-84	3 020	808	5 836	1 086	1 301	2 872	2 296	1 517
85+	1 717	-	2 381	1 209	386	1 061	1 407	583

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

Table 3.2.6 New cases of cancer of the cervix uteri (ICD10 C53) per 1 000 000 women

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2013	2009-13	2009-13	2013	2009-13	2009-13	2013	2013
Age								
0-24	4	-	57	3	-	-	8	7
25-44	234	111	494	96	116	5	178	171
45-64	151	240	295	63	49	53	154	109
65-84	157	249	318	81	87	110	137	118
85+	192	598	669	66	386	192	103	125

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

Table 3.2.7 New cases of cancer of the testis (ICD10 C62) per 1 000 000 men

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2013	2009-13	2009-13	2013	2009-13	2009-13	2013	2013
Age								
0-24	39	-	55	33	49	28	61	41
25-44	229	450	24	164	168	115	57	180
45-64	81	62	23	29	101	56	68	55
65-84	19	126	-	27	211	12	19	19
85+	-	-	-	28	-	-	82	12

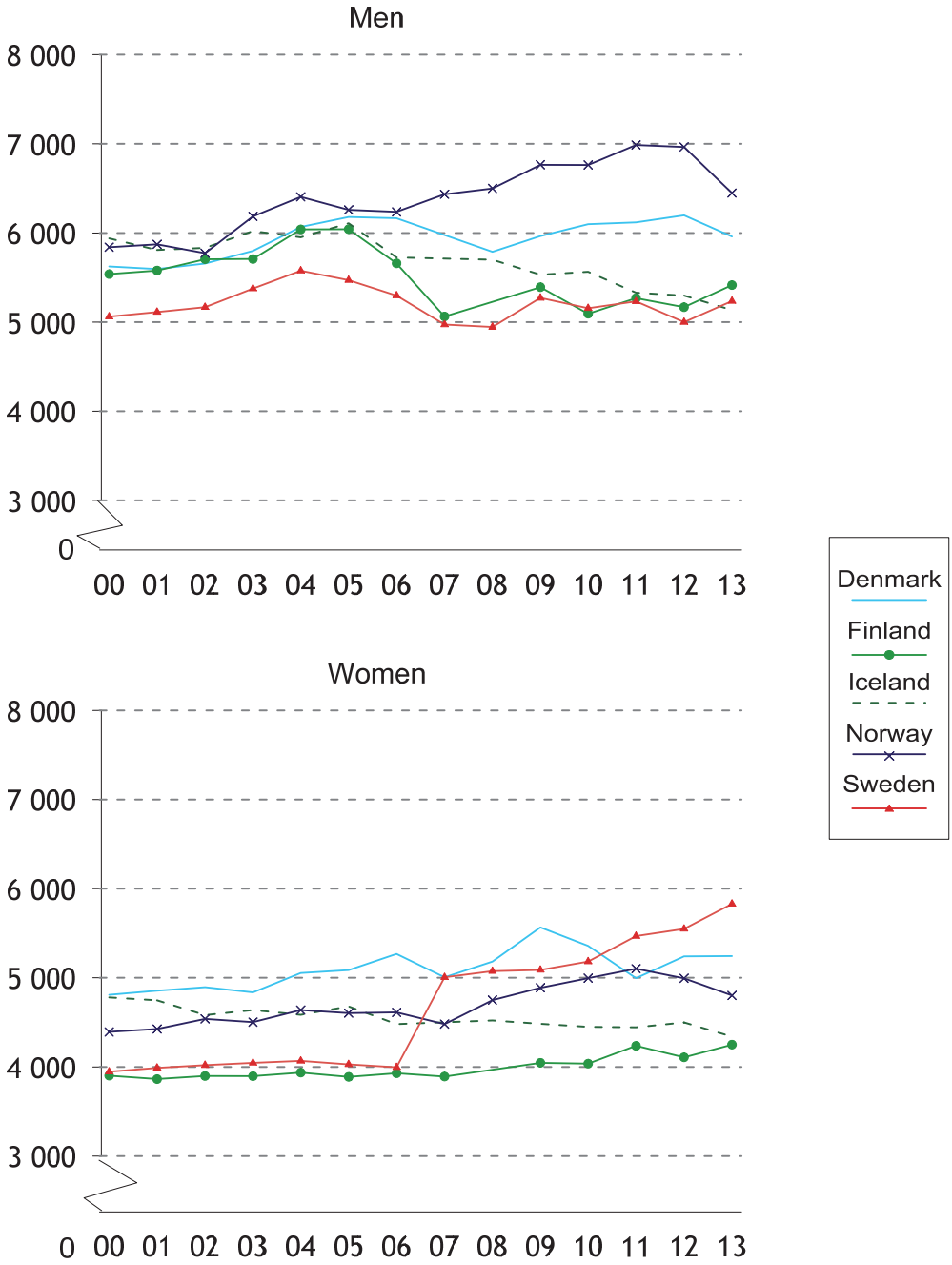
Source: The cancer registers in the Nordic countries; GL, Danish Cancer Society

Table 3.2.8 New cases of melanoma of the skin (ICD10 C43) per 1 000 000 inhabitants

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2013	2009-13	2009-13	2013	2009-13	2009-13	2013	2013
Men, age								
0-24	14	-	18	9	-	10	5	7
25-44	184	32	24	86	224	71	88	137
45-64	419	125	69	312	456	152	467	431
65-84	977	252	100	923	637	447	1 258	1 121
85+	1 149	-	-	1 555	906	325	1 585	1 583
Women, age								
0-24	34		38	12	-	40	26	16
25-44	379	25	82	194	358	175	227	252
45-64	552	185	59	305	645	238	49-	493
65-84	674	68	-	559	669	230	828	687
85+	730	62	-	616	772	312	1 227	982

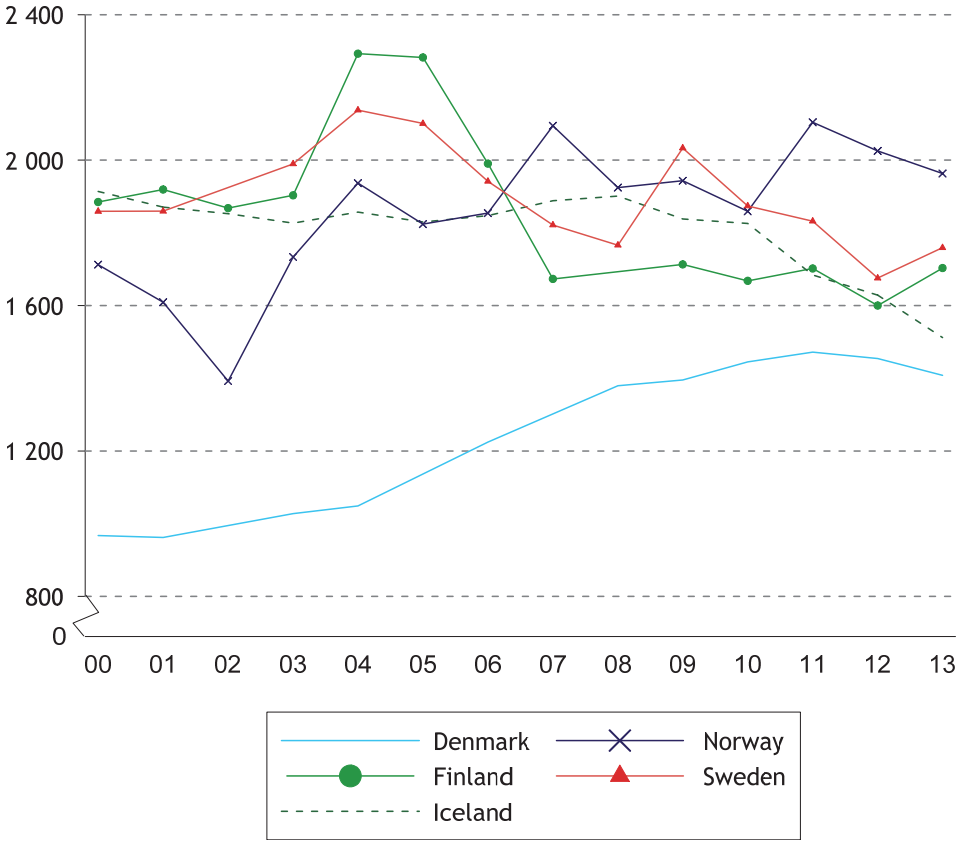
Source: The cancer registers in the Nordic countries; GL, Danish Cancer Society

Figure 3.2.1 New cases of cancer, age-standardized rates per 1 000 000 inhabitants, 2000-2013



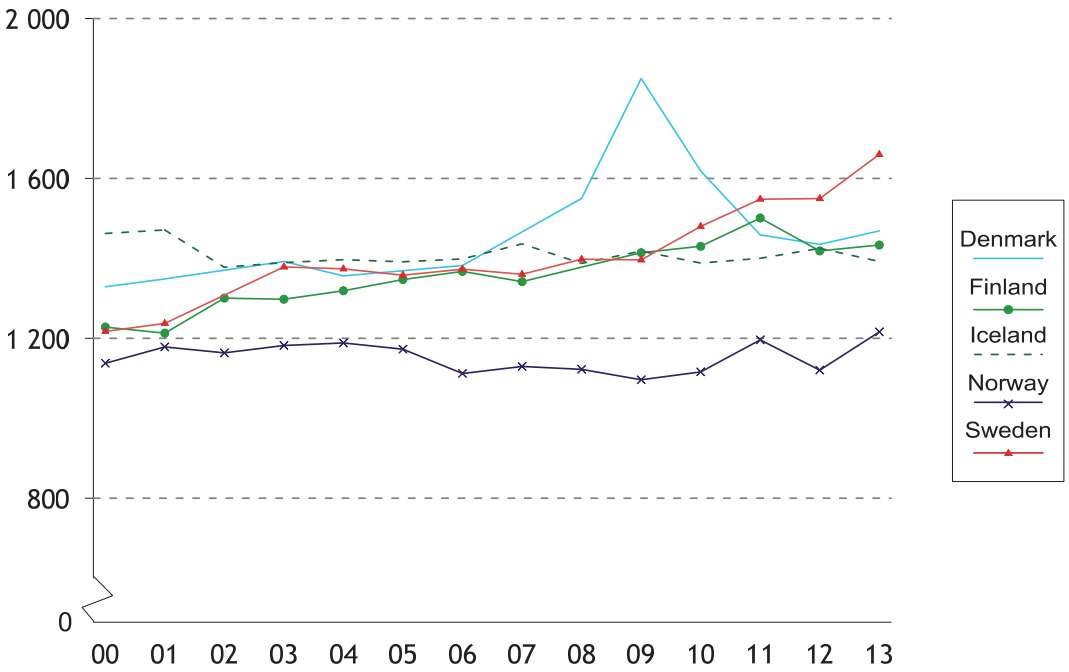
Age-standardized by the Nordic population 2000
The figures for Iceland are 5-year averages
Source: The cancer registers in the Nordic countries

Figure 3.2.2 New cases of prostate cancer (men), age-standardized rates per 1 000 000 inhabitants 2000-2013



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

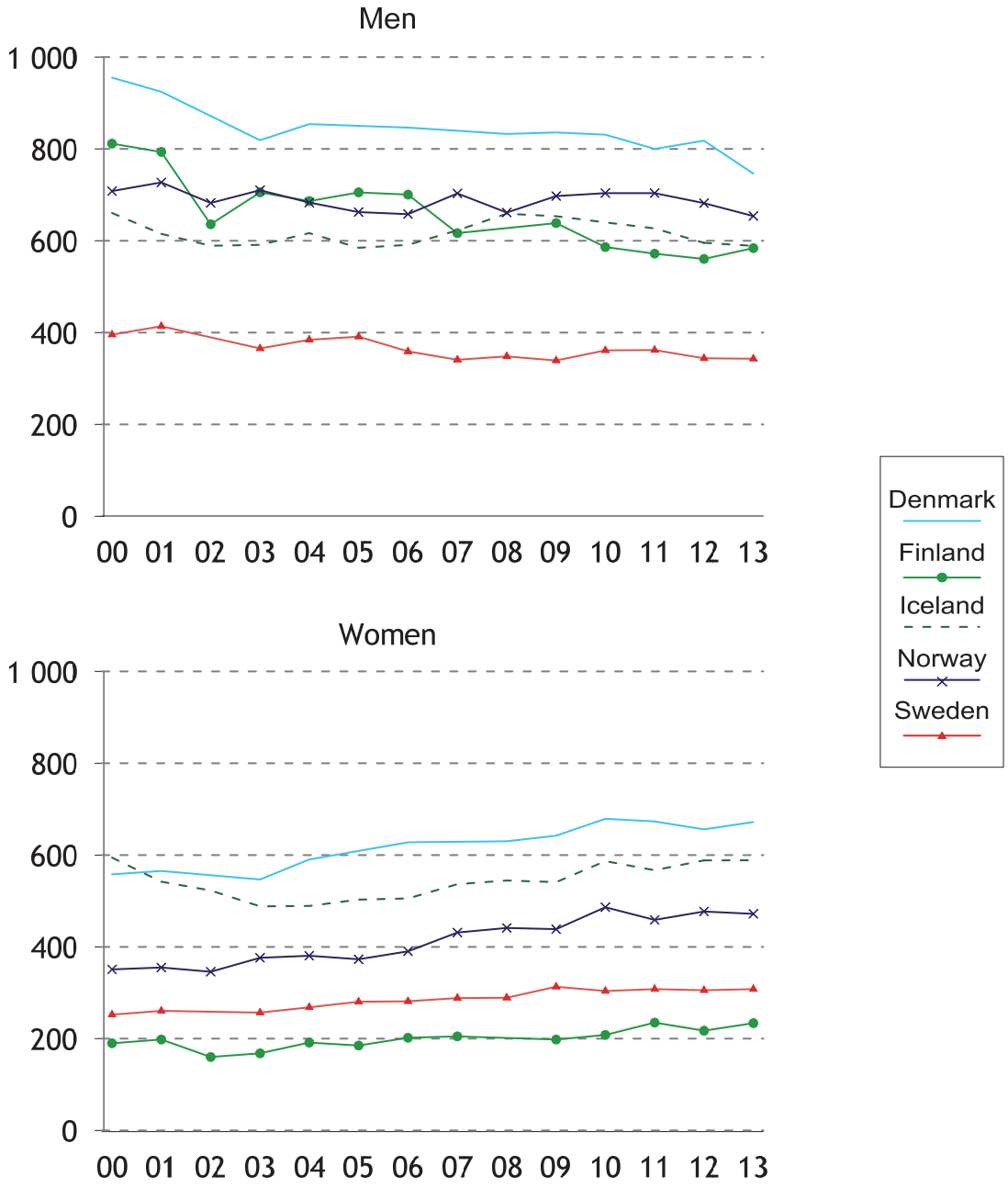
Figure 3.2.3 New cases of breast cancer (women), age-standardized rates per 1 000 000 inhabitants, 2000-2013



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

The reason for the very large fluctuation in Figure 3.2.3 for Denmark is 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, 2000-2013



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 the 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 Finland and Norway, have immunization registers covering the country as a whole.

Table 3.3.1 Recommended immunization schedules per 1 January 2015[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, 4 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)	Girls: 12-13 years	Girls: 12 years	12-13 years (girls only)	3 immuniza-tions for girls 10-12 years
Meningococcal disease gr. C	-	-	-	6 and 8 months	-	-
Hepatitis b	..	At birth, 3, 5 and 12 months	Risk groups only	..	..	..
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. However, the Faroe Islands give Influenza vaccination for age groups 67+. 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, 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), 2013

	Denmark	Faroe Islands[1]	Finland[2]	Iceland[3]	Norway[4]	Sweden
Pertussis	92	94	97	..	94	26
Tetanus	92	94	97	88	94	98
Diphtheria	92	94	97	88	94	98
Polio	92	94	97	88	94	98
Rubella	86	90	95	89	93	98
Measles	86	90	95	89	93	97
Influenza 65+, in season 2013-14	10	50	41	..	..	26

1 67+ 2014
2 Based on a random sample of children born in 2012. For elderly people, the figure is based on data from patient journal systems in 2013-2014
3 The number of persons vaccinated against pertussis, tetanus, diphtheria and polio is based on a birth cohort 2010, which received three doses of vaccine. The number for vaccinations against the measles is based on a birth cohort, which received one dose. For influenza 60+ the number is based on the number of persons vaccinated during the winter of 2012-2013
4 The data is underestimated due to a low level 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, Public Health Agency of Sweden

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 also used 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, as a trial, we use 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 inter-Nordic comparison, e.g. because of new treatment possibilities. Some possible groups were not selected because hospital activities in those groups are reflected better 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 the reason for admission to hospital, bed-day rates give a better illustration of the load these diagnoses have 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 for 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 representativeness, completeness and reliability, is important for these statistics.

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

tries. However, there are 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, the data are influenced by the fact that some types of treatment for the Faroe Islands 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 have been attended to during a hospital stay do not show in the statistics. Hospital discharges, even when recalculated as number of 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 between 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) and differences in registration and coding of diagnoses that influence comparability.

Healthy new-born babies are counted differently in the Nordic countries. In the ICD, there is a category (Z38) and in the ISHMT list, there is a group for healthy new-born babies. In some of the countries, these babies are not registered as patients in their own right and thus they are 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 between 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 between 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 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 between countries from 4.6 days in Denmark and Norway to 9.4 days in Finland.

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

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

A clear example of this is the very high discharge rate for Denmark 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 between 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 positions in relation to each other over the period studied.

In Tables 3.4.4 – 3.4.13, the possibilities of linking successive hospital stays for the same main diagnosis and the same person have been 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 is about half the number 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 number of patients treated amounts to about 60 per cent of the number of discharges for these two diseases. For most of the other diagnoses presented in the detailed tables, the number of patients treated correspond to 70-80 per cent of the number of discharges.

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

ICD-10 code Main diagnosis	Denmark	Faroe Islands	Finland	Åland	Iceland[1]	Norway	Sweden
	2013	2003-07	2013	2009-13	2013	2013	2013
I: Certain infectious and parasitic diseases *(A00-B99)*	796	476	486	529	149	441	504
II: Neoplasms *(C00-D48)*	1 375	1 827	1 575	1 084	991	1 497	1 236
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism *(D50-D89)*	290	463	125	144	107	165	148
IV: Endocrine, nutritional and metabolic diseases *(E00-E90)*	743	458	275	238	212	329	378
V: Mental and behavioural disorders *(F00-F99)*	1 199	944	752	366	208	279	1 216
VI: Diseases of the nervous system *(G00-G99)*	639	642	562	505	356	674	487
VII: Diseases of the eye and adnexa *(H00-H59)*	87	626	133	42	62	111	90
VIII: Diseases of the ear and mastoid process *(H60-H95)*	113	312	70	146	41	81	89
IX: Diseases of the circulatory system *(I00-I99)*	2 568	2 296	2 192	2 028	1 159	2 305	2 348
X: Diseases of the respiratory system *(J00-J99)*	2 150	1 444	1 021	1 193	598	1 326	1 148
XI: Diseases of the digestive system *(K00-K93)*	1 950	2 813	1 247	1 424	788	1 274	1 284
XII: Diseases of the skin and subcutaneous tissue *(L00-L99)*	331	250	143	101	172	160	140
XIII: Diseases of the musculoskeletal system and connective tissue *(M00-M99)*	1 307	1 408	1 091	1 336	613	1 133	984
XIV: Diseases of the genitourinary system *(N00-N99)*	1 272	978	786	1 041	578	929	796
XV: Pregnancy, childbirth and the puerperium *(O00-O99)*	1 284	1 799	1 308	1 176	1 517	635	1 428
XVI: Certain conditions originating in the perinatal period *(P00-P96)*	186	257	170	95	505	168	149
XVII: Congenital malformations, deformations and chromosomal abnormalities *(Q00-Q99)*	189	193	140	61	138	142	104
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified *(R00-R99)*	2 590	1 323	932	1 451	610	1 430	1 602
XIX: Injury, poisoning and certain other consequences of external causes *(S00-T98)*	2 125	1 839	1 531	1 421	803	1 842	1 621
XXI: Factors influencing health status and contact with health services *(Z00-Z99)*	2 835	3 507	219	693	775	1 713	625
All causes (except. XX) *(A00-Z99 excluding V, W, X and Y)*	25 367	23 374	14 758	15 075	10 244	16 634	17 356

1 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
	2013	2003-07	2013	2009-13	2013	2013	2013
I: Certain infectious and parasitic diseases *(A00-B99)*	858	497	506	542	134	462	519
II: Neoplasms (C00-D48)	1 377	1 775	1 533	891	924	1 491	1 165
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	284	474	111	145	95	148	130
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	647	426	240	218	134	261	308
V: Mental and behavioural disorders (F00-F99)	1 268	1 012	779	351	166	315	1 309
VI: Diseases of the nervous system (G00-G99)	662	623	576	468	342	696	486
VII: Diseases of the eye and adnexa (H00-H59)	87	586	130	21	64	113	96
VIII: Diseases of the ear and mastoid process (H60-H95)	114	323	71	156	45	76	81
IX: Diseases of the circulatory system (I00-I99)	3 109	2 648	2 464	2 062	1 422	2 766	2 687
X: Diseases of the respiratory system (J00-J99)	2 270	1 494	1 162	1 341	577	1 372	1 172
XI: Diseases of the digestive system (K00-K93)	1 988	2 828	1 348	1 425	708	1 253	1 271
XII: Diseases of the skin and subcutaneous tissue (L00-L99)	370	294	159	108	165	165	142
XIII: Diseases of the musculoskeletal system and connective tissue (M00-M99)	1 201	1 361	930	1 087	495	988	866
XIV: Diseases of the genitourinary system (N00-N99)	1 073	761	651	609	380	854	756
XV: Pregnancy, childbirth and the puerperium (O00-O99)	.	.	.	.	.	.	.
XVI: Certain conditions originating in the perinatal period (P00-P96)	212	265	195	99	538	185	166
XVII: Congenital malformations, deformations and chromosomal a normalities (Q00-Q99)	218	193	153	73	146	159	116
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	2 441	1 331	918	1 274	539	1 324	1 514
XIX: Injury, poisoning and certain other consequences of external causes (S00-T98)	2 118	2 106	1 583	1 426	717	1 843	1 563
XXI: Factors influencing health status and contact with health services (Z00-Z99)	2 719	2 757	187	555	613	885	593
All causes (except. XX) (A00-Z99 excluding V, W, X and Y)	24 319	21 254	13 697	12 851	8 061	15 357	15 951

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
	2013	2003-07	2013	2009-13	2013	2013	2013
I: Certain infectious and parasitic diseases (A00-B99)	735	453	467	506	164	420	489
II: Neoplasms (C00-D48)	1 373	1 884	1 615	1 253	1 058	1 504	1 307
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	296	452	139	140	119	181	166
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	838	493	307	254	291	399	449
V: Mental and behavioural disorders (F00-F99)	1 131	870	727	373	250	242	1 123
VI: Diseases of the nervous system (G00-G99)	617	662	548	532	370	651	487
VII: Diseases of the eye and adnexa (H00-H59)	87	670	137	62	60	110	85
VIII: Diseases of the ear and mastoid process (H60-H95)	112	300	69	132	38	87	97
IX: Diseases of the circulatory system (I00-I99)	2 036	1 915	1 930	1 953	893	1 840	2 010
X: Diseases of the respiratory system (J00-J99)	2 032	1 391	886	1 022	620	1 279	1 124
XI: Diseases of the digestive system (K00-K93)	1 913	2 797	1 148	1 393	869	1 295	1 298
XII: Diseases of the skin and subcutaneous tissue (L00-L99)	292	202	128	93	180	155	139
XIII: Diseases of the musculoskeletal system and connective tissue (M00-M99)	1 412	1 459	1 246	1 557	732	1 279	1 102
XIV: Diseases of the genitourinary system (N00-N99)	1 469	1 212	916	1 449	778	1 005	836
XV: Pregnancy, childbirth and the puerperium (O00-O99)	2 549	3 743	2 573	2 319	3 041	1 276	2 851
XVI: Certain conditions originating in the perinatal period (P00-P96)	161	249	145	89	471	150	131
XVII: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	160	194	127	49	131	124	92
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	2 737	1 314	946	1 597	680	1 538	1 689
XIX: Injury, poisoning and certain other consequences of external causes (S00-T98)	2 131	1 550	1 480	1 388	888	1 841	1 680
XXI: Factors influencing health status and contact with health services (Z00-Z99)	2 949	4 318	249	817	938	2 548	658
All causes (except. XX) (A00-Z99 excluding V, W, X and Y)	26 399	25 664	15 784	16 977	12 440	17 924	18 756

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
	2013	2003-07	2013	2009-13	2013	2013	2013
I: Certain infectious and parasitic diseases *(A00-B99)*	3 393	2 514	3 500	3 632	920	2 456	2 737
II: Neoplasms *(C00-D48)*	6 165	8 639	9 488	9 532	7 373	8 748	8 470
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism *(D50-D89)*	770	1 700	599	905	601	564	647
IV: Endocrine, nutritional and metabolic diseases *(E00-E90)*	2 420	3 285	1 584	1 764	1 562	1 172	1 632
V: Mental and behavioural disorders *(F00-F99)*	16 378	28 703	22 194	4 713	2 901	658	15 859
VI: Diseases of the nervous system *(G00-G99)*	2 707	2 790	5 042	12 950	2 876	2 313	2 424
VII: Diseases of the eye and adnexa *(H00-H59)*	176	659	360	134	169	336	218
VIII: Diseases of the ear and mastoid process *(H60-H95)*	176	225	217	375	134	165	201
IX: Diseases of the circulatory system *(I00-I99)*	9 086	21 690	15 870	16 284	9 650	9 635	12 702
X: Diseases of the respiratory system *(J00-J99)*	8 241	7 626	6 477	6 984	4 399	7 105	6 022
XI: Diseases of the digestive system *(K00-K93)*	6 487	7 046	6 042	7 252	3 965	5 085	5 462
XII: Diseases of the skin and subcutaneous tissue *(L00-L99)*	1 012	1 183	1 006	752	1 020	876	842
XIII: Diseases of the musculoskeletal system and connective tissue *(M00-M99)*	4 044	6 961	5 256	6 538	3 778	4 611	4 439
XIV: Diseases of the genitourinary system *(N00-N99)*	3 466	2 806	3 524	4 780	2 067	3 178	3 257
XV: Pregnancy, childbirth and the puerperium *(O00-O99)*	3 230	7 948	5 348	5 492	3 068	2 111	3 465
XVI: Certain conditions originating in the perinatal period *(P00-P96)*	1 558	1 215	1 448	856	2 148	1 668	1 509
XVII: Congenital malformations, deformations and chromosomal abnormalities *(Q00-Q99)*	527	814	710	503	473	598	507
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified *(R00-R99)*	5 025	4 262	3 377	5 497	2 817	2 499	4 098
XIX: Injury, poisoning and certain other consequences of external causes *(S00-T98)*	6 716	8 340	9 316	9 382	5 866	7 125	7 973
XXI: Factors influencing health status and contact with health services *(Z00-Z99)*	12 618	8 832	1 271	6 180	5 233	7 544	2 387
All causes (except. XX) *(A00-Z99 excluding V, W, X and Y)*	97 023	126 494	102 631	104 506	60 548	68 448	93 214

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
	2013	2003-07	2013	2009-13	2013	2013	2013
I: Certain infectious and parasitic diseases (A00-B99)	3 702	2 556	3 596	3 973	800	2 629	2 829
II: Neoplasms (C00-D48)	6 651	8 727	9 374	8 839	7 321	9 116	8 358
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	765	2 182	545	1 060	520	544	596
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	2 199	3 405	1 583	1 467	1 152	971	1 480
V: Mental and behavioural disorders (F00-F99)	15 923	23 757	20 257	3 472	2 334	623	16 818
VI: Diseases of the nervous system (G00-G99)	2 815	3 377	4 592	7 308	2 787	2 280	2 473
VII: Diseases of the eye and adnexa (H00-H59)	164	547	341	81	181	340	214
VIII: Diseases of the ear and mastoid process (H60-H95)	172	212	231	377	140	150	174
IX: Diseases of the circulatory system (I00-I99)	10 918	24 305	16 412	14 412	11 212	11 412	13 945
X: Diseases of the respiratory system (J00-J99)	8 599	6 531	7 181	7 812	4 112	7 311	6 075
XI: Diseases of the digestive system *(K00-K93)*	6 510	6 818	6 359	7 246	3 331	4 943	5 297
XII: Diseases of the skin and subcutaneous tissue *(L00-L99)*	1 160	1 307	1 069	851	1 068	882	832
XIII: Diseases of the musculoskeletal system and connective tissue *(M00-M99)*	3 410	5 292	4 233	4 700	2 853	3 984	3 647
XIV: Diseases of the genitourinary system *(N00-N99)*	3 154	2 745	3 003	3 305	1 560	3 119	3 246
XVI: Certain conditions originating in the perinatal period *(P00-P96)*	1 652	1 264	1 618	974	2 281	1 811	1 635
XVII: Congenital malformations, deformations and chromosomal abnormalities *(Q00-Q99)*	609	830	824	710	501	659	549
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified *(R00-R99)*	4 790	4 171	3 257	4 904	2 584	2 326	3 809
XIX: Injury, poisoning and certain other consequences of external causes *(S00-T98)*	6 413	7 113	9 303	10 370	4 877	6 944	7 024
XXI: Factors influencing health status and contact with health services *(Z00-Z99)*	13 144	6 541	1 198	4 814	4 459	5 318	2 324
Total (ekskl. kap. XX) *(A00-Z99 ekskl. V, W, X og Y)*	95 474	110 772	94 975	86 675	53 589	65 359	90 051

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
	2013	2003-07	2013	2009-13	2013	2013	2013
I: Certain infectious and parasitic diseases (A00-B99)	3 089	2 468	3 407	3 219	1 041	2 282	2 645
II: Neoplasms (C00-D48)	5 686	8 545	9 598	10 027	7 424	8 377	8 582
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	775	1 180	652	732	682	585	697
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	2 637	3 155	1 584	2 024	1 973	1 376	1 782
V: Mental and behavioural disorders (F00-F99)	16 826	34 049	24 068	5 849	3 472	693	14 904
VI: Diseases of the nervous system (G00-G99)	2 602	2 155	5 477	18 287	2 965	2 347	2 375
VII: Diseases of the eye and adnexa (H00-H59)	188	779	379	184	157	332	223
VIII: Diseases of the ear and mastoid process (H60-H95)	179	239	204	366	129	180	227
IX: Diseases of the circulatory system (I00-I99)	7 282	18 864	15 346	17 813	8 078	7 842	11 465
X: Diseases of the respiratory system (J00-J99)	7 890	8 811	5 796	6 021	4 686	6 897	5 969
XI: Diseases of the digestive system *(K00-K93)*	6 464	7 292	5 737	7 110	4 603	5 229	5 627
XII: Diseases of the skin and subcutaneous tissue *(L00-L99)*	867	1 049	945	639	973	869	852
XIII: Diseases of the musculoskeletal system and connective tissue *(M00-M99)*	4 667	8 766	6 244	8 229	4 709	5 244	5 228
XIV: Diseases of the genitourinary system *(N00-N99)*	3 773	2 872	4 028	6 147	2 577	3 238	3 269
XV: Pregnancy, childbirth and the puerperium *(O00-O99)*	6 410	16 540	10 519	10 831	6 135	4 241	6 916
XVI: Certain conditions originating in the perinatal period *(P00-P96)*	1 466	1 163	1 284	722	2 013	1 523	1 384
XVII: Congenital malformations, deformations and chromosomal abnormalities *(Q00-Q99)*	446	796	600	288	444	536	464
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified *(R00-R99)*	5 257	9 667	3 493	5 975	3 051	2 673	4 385
XIX: Injury, poisoning and certain other consequences of external causes *(S00-T98)*	7 015	4 360	9 329	8 212	6 860	7 309	8 919
XXI: Factors influencing health status and contact with health services *(Z00-Z99)*	12 100	11 309	1 343	7 410	6 012	9 791	2 451
All causes (except. XX) (A00-Z99 excluding V, W, X and Y)	98 549	143 488	110 033	120 085	67 541	71 566	96 364

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
	2013	2003-07	2013	2009-13	2013	2013	2013
I: Certain infectious and parasitic diseases (A00-B99)	4.3	5.3	7.2	6.9	6.2	5.6	5.4
II: Neoplasms (C00-D48)	4.5	4.7	6.0	8.8	7.4	5.8	6.9
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	2.7	3.7	4.8	6.3	5.6	3.4	4.4
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	3.3	7.2	5.8	7.4	7.4	3.6	4.3
V: Mental and behavioural disorders (F00-F99)	13.7	30.4	29.5	12.9	13.9	2.4	13.0
VI: Diseases of the nervous system (G00-G99)	4.2	4.3	9.0	25.6	8.1	3.4	5.0
VII: Diseases of the eye and adnexa (H00-H59)	2.0	1.1	2.7	3.2	2.7	3.0	2.4
VIII: Diseases of the ear and mastoid process (H60-H95)	1.6	0.7	3.1	2.6	3.2	2.0	2.3
IX: Diseases of the circulatory system (I00-I99)	3.5	9.4	7.2	8.0	8.3	4.2	5.4
X: Diseases of the respiratory system (J00-J99)	3.8	5.3	6.3	5.9	7.4	5.4	5.2
XI: Diseases of the digestive system *(K00-K93)*	3.3	2.5	4.8	5.1	5.0	4.0	4.3
XII: Diseases of the skin and subcutaneous tissue *(L00-L99)*	3.1	4.7	7.0	7.4	5.9	5.5	6.0
XIII: Diseases of the musculoskeletal system and connective tissue *(M00-M99)*	3.1	4.9	4.8	4.9	6.2	4.1	4.5
XIV: Diseases of the genitourinary system *(N00-N99)*	2.7	2.9	4.5	4.6	3.6	3.4	4.1
XV: Pregnancy, childbirth and the puerperium *(O00-O99)*	2.5	4.4	4.1	4.7	2.0	3.3	2.4
XVI: Certain conditions originating in the perinatal period *(P00-P96)*	8.4	4.7	8.5	9.0	4.3	9.9	10.1
XVII: Congenital malformations, deformations and chromosomal abnormalities *(Q00-Q99)*	2.8	4.2	5.1	8.2	3.4	4.2	4.9
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified *(R00-R99)*	1.9	3.2	3.6	3.8	4.6	1.7	2.6
XIX: Injury, poisoning and certain other consequences of external causes *(S00-T98)*	3.2	4.5	6.1	6.6	7.3	3.9	4.9
XXI: Factors influencing health status and contact with health services *(Z00-Z99)*	4.5	2.5	5.8	8.9	6.8	4.4	3.8
All causes (except. XX) (A00-Z99 excluding V, W, X and Y)	3.8	5.4	7.0	6.9	5.9	4.1	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
	2013	2003-07	2009-13	2009-13	2013	2013	2013
I: Certain infectious and parasitic diseases (A00-B99)	4.3	5.1	7.1	7.3	6.0	5.7	5.4
II: Neoplasms (C00-D48)	4.8	4.9	6.1	9.9	7.9	6.1	7.2
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	2.7	4.6	4.9	7.3	5.5	3.7	4.6
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	3.4	8.0	6.6	6.7	8.6	3.7	4.8
V: Mental and behavioural disorders (F00-F99)	12.6	23.5	26.0	9.9	14.0	2.0	12.8
VI: Diseases of the nervous system (G00-G99)	4.3	5.4	8.0	15.6	8.1	3.3	5.1
VII: Diseases of the eye and adnexa (H00-H59)	1.9	0.9	2.6	3.9	2.8	3.0	2.2
VIII: Diseases of the ear and mastoid process (H60-H95)	1.5	0.7	3.3	2.4	3.1	2.0	2.2
IX: Diseases of the circulatory system (I00-I99)	3.5	9.2	6.7	7.0	7.9	4.1	5.2
X: Diseases of the respiratory system (J00-J99)	3.8	4.4	6.2	5.8	7.1	5.3	5.2
XI: Diseases of the digestive system *(K00-K93)*	3.3	2.4	4.7	5.1	4.7	3.9	4.2
XII: Diseases of the skin and subcutaneous tissue *(L00-L99)*	3.1	4.4	6.7	7.9	6.5	5.3	5.9
XIII: Diseases of the musculoskeletal system and connective tissue *(M00-M99)*	2.8	3.9	4.6	4.3	5.8	4.0	4.2
XIV: Diseases of the genitourinary system *(N00-N99)*	2.9	3.6	4.6	5.4	4.1	3.7	4.3
XV: Pregnancy, childbirth and the puerperium *(O00-O99)*	.	.	.	.	.	.	.
XVI: Certain conditions originating in the perinatal period *(P00-P96)*	7.8	4.8	8.3	9.8	4.2	9.8	9.8
XVII: Congenital malformations, deformations and chromosomal abnormalities *(Q00-Q99)*	2.8	4.3	5.4	9.8	3.4	4.2	4.7
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified *(R00-R99)*	2.0	3.1	3.5	3.8	4.8	1.8	2.5
XIX: Injury, poisoning and certain other consequences of external causes *(S00-T98)*	3.0	3.4	5.9	7.3	6.8	3.8	4.5
XXI: Factors influencing health status and contact with health services *(Z00-Z99)*	4.8	2.4	6.4	8.7	7.3	6.0	3.9
All causes (except. XX) (A00-Z99 excluding V, W, X and Y)	3.9	5.2	6.9	6.7	6.6	4.3	5.6

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

Source: The national in-patient registers

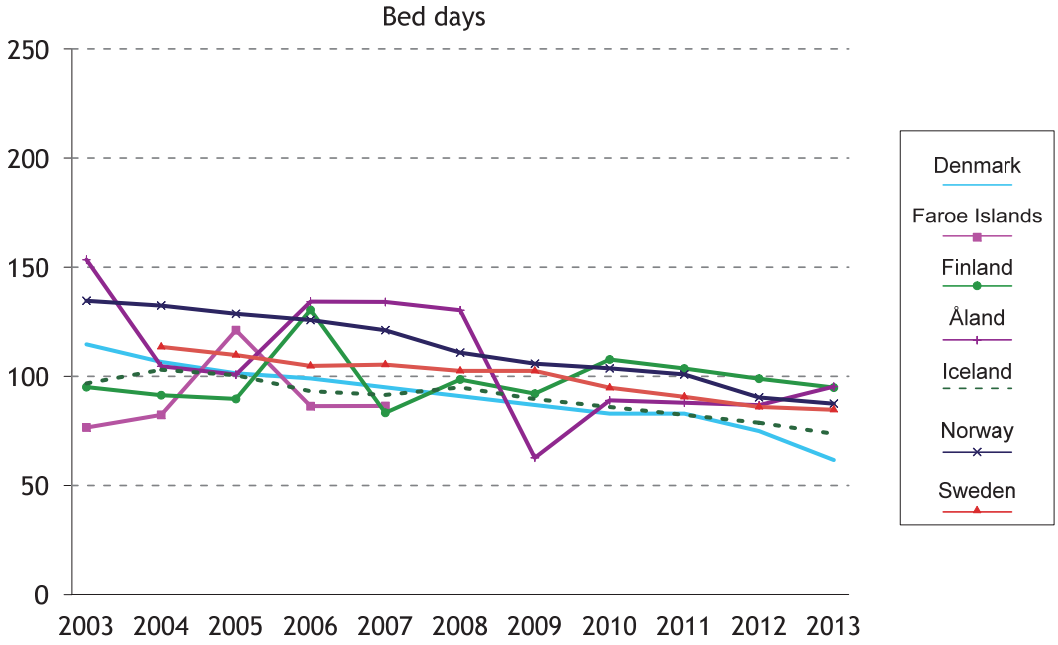
Table 3.4.3.c Average length of stay per discharge (in days) per 100 000 population by main diagnosis, women

ICD-10 code Main diagnosis	Denmark	Faroe Islands	Finland	Åland	Iceland[1]	Norway	Sweden
	2013	2003-07	2013	2009-13	2013	2013	2013
I: Certain infectious and parasitic diseases (A00-B99)	4.2	5.5	7.3	6.4	6.4	5.4	5.4
II: Neoplasms (C00-D48)	4.1	4.5	5.9	8.0	7.0	5.6	6.6
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	2.6	2.6	4.7	5.2	5.7	3.2	4.2
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	3.1	6.4	5.2	8.0	6.8	3.4	4.0
V: Mental and behavioural disorders (F00-F99)	14.9	39.1	33.1	15.7	13.9	2.9	13.3
VI: Diseases of the nervous system (G00-G99)	4.2	3.3	10.0	34.4	8.0	3.6	4.9
VII: Diseases of the eye and adnexa (H00-H59)	2.2	1.2	2.8	3.0	2.6	3.0	2.6
VIII: Diseases of the ear and mastoid process (H60-H95)	1.6	0.8	3.0	2.8	3.4	2.1	2.3
IX: Diseases of the circulatory system (I00-I99)	3.6	9.8	8.0	9.1	9.0	4.3	5.7
X: Diseases of the respiratory system (J00-J99)	3.9	6.3	6.5	5.9	7.6	5.4	5.3
XI: Diseases of the digestive system *(K00-K93)*	3.4	2.6	5.0	5.1	5.3	4.0	4.3
XII: Diseases of the skin and subcutaneous tissue *(L00-L99)*	3.0	5.2	7.4	6.9	5.4	5.6	6.1
XIII: Diseases of the musculoskeletal system and connective tissue *(M00-M99)*	3.3	6.0	5.0	5.3	6.4	4.1	4.7
XIV: Diseases of the genitourinary system *(N00-N99)*	2.6	2.4	4.4	4.2	3.3	3.2	3.9
XV: Pregnancy, childbirth and the puerperium *(O00-O99)*	2.5	4.4	4.1	4.7	2.0	3.3	2.4
XVI: Certain conditions originating in the perinatal period *(P00-P96)*	9.1	4.7	8.9	8.1	4.3	10.1	10.5
XVII: Congenital malformations, deformations and chromosomal abnormalities *(Q00-Q99)*	2.8	4.1	4.7	5.9	3.4	4.3	5.1
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified *(R00-R99)*	1.9	3.3	3.7	3.7	4.5	1.7	2.6
XIX: Injury, poisoning and certain other consequences of external causes *(S00-T98)*	3.3	6.2	6.3	5.9	7.7	4.0	5.3
XXI: Factors influencing health status and contact with health services *(Z00-Z99)*	4.1	2.6	5.4	9.1	6.4	3.8	3.7
All causes (except. XX) (A00-Z99 excluding V, W, X and Y)	3.7	5.6	7.0	7.1	5.4	4.0	5.1

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

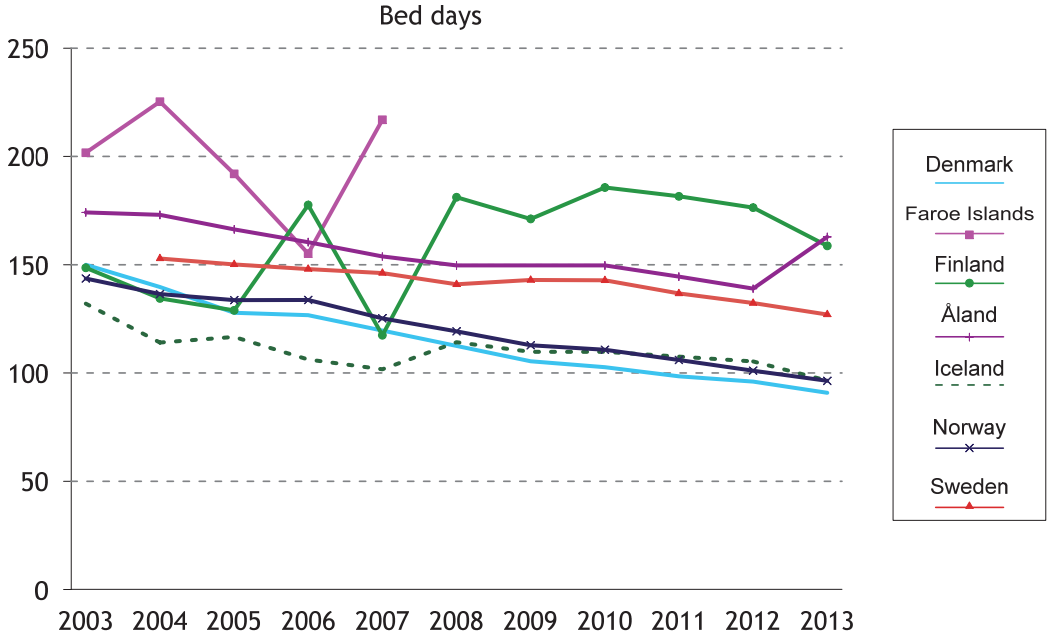
Source: The national in-patient registers

Figure 3.4.1 Number of bed days for cancer (ICD10 C00-D48), per 1 000 inhabitants, 2003-2013[1]



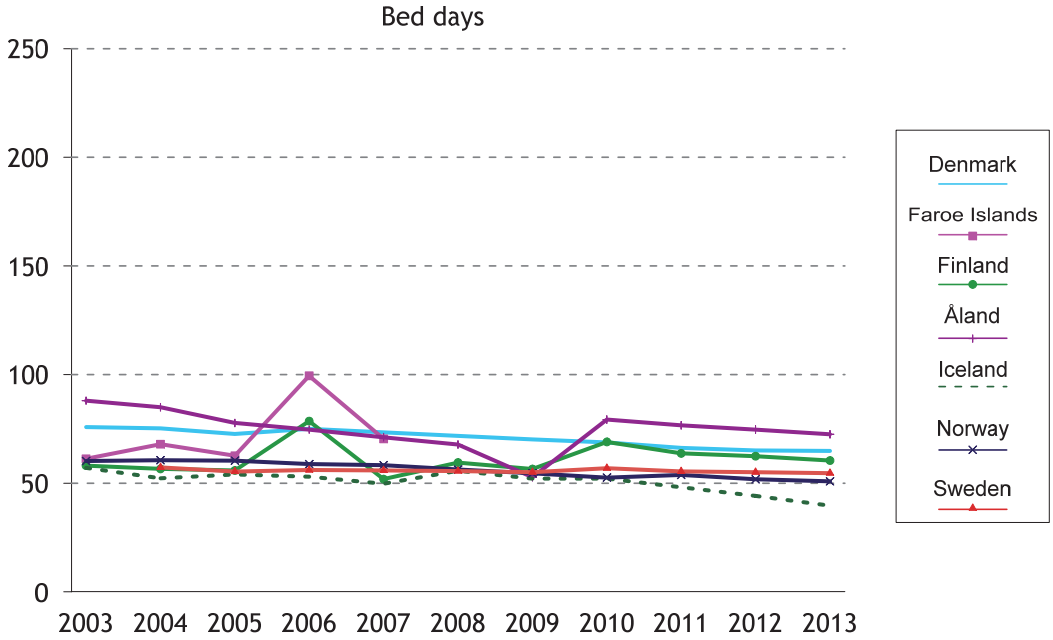
1 Iceland: Only discharges with a length of stay less than 90 days
Source: The national in-patient registers

Figure 3.4.2 Bed days during the year for diseases of the circulation organs (ICD10 I00-I99), per 1 000 inhabitants, 2003-2013[1]



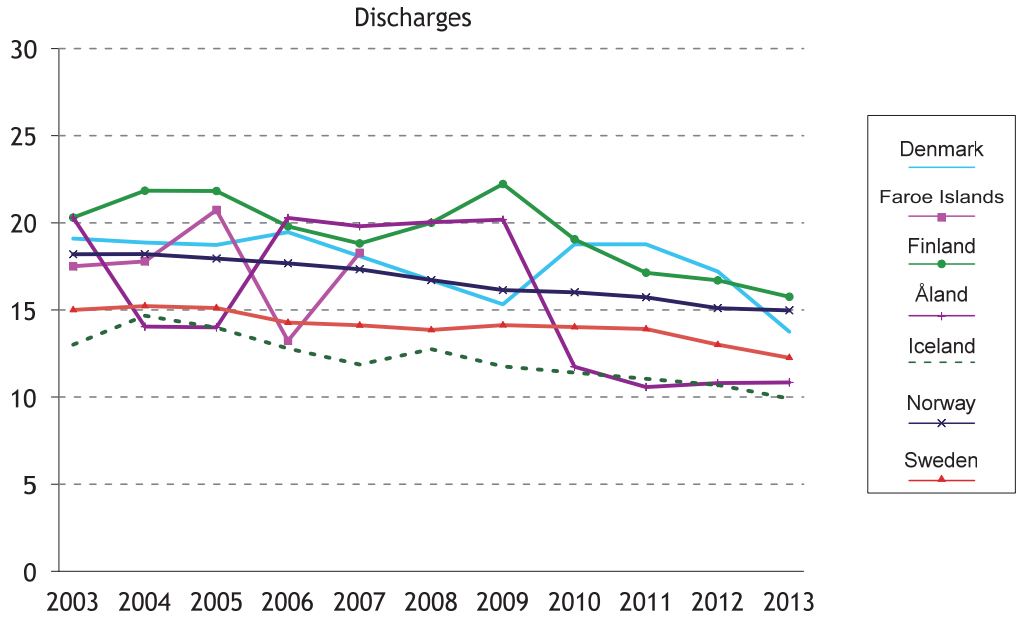
1 Iceland: Only discharges with a length of stay less than 90 days
Source: The national in-patient registers

Figure 3.4.3 Bed days for diseases of the digestive system (ICD10 K00-K93), per 1 000 inhabitants 2003-2013[1]



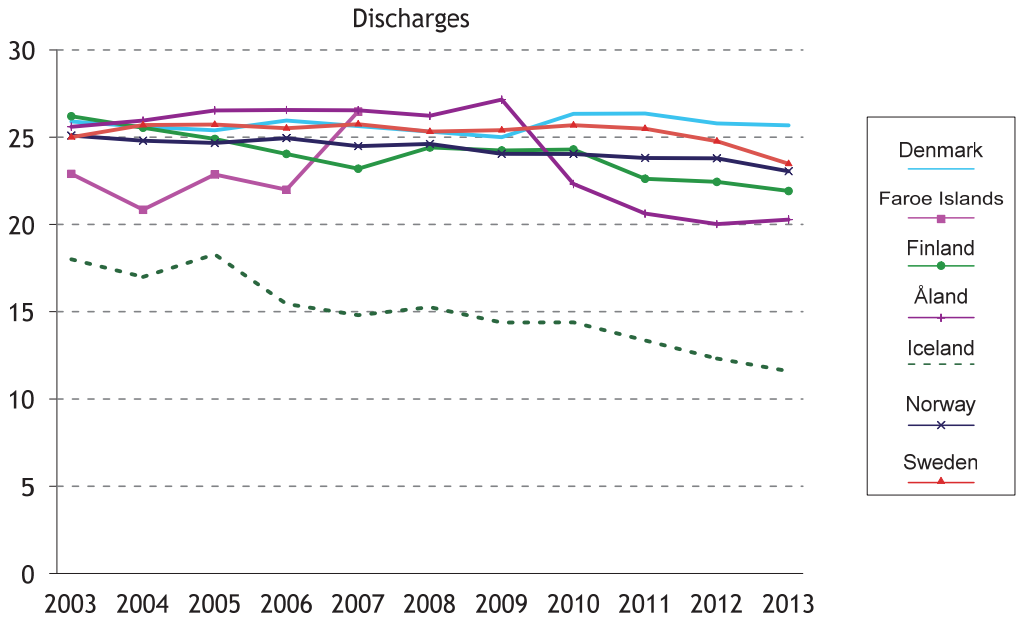
1 Iceland: Only discharges with a length of stay less than 90 days
Source: The national in-patient registers

Figure 3.4.4 Discharges for cancer (ICD10 C00-D48), per 1 000 inhabitants 2003-2013[1]



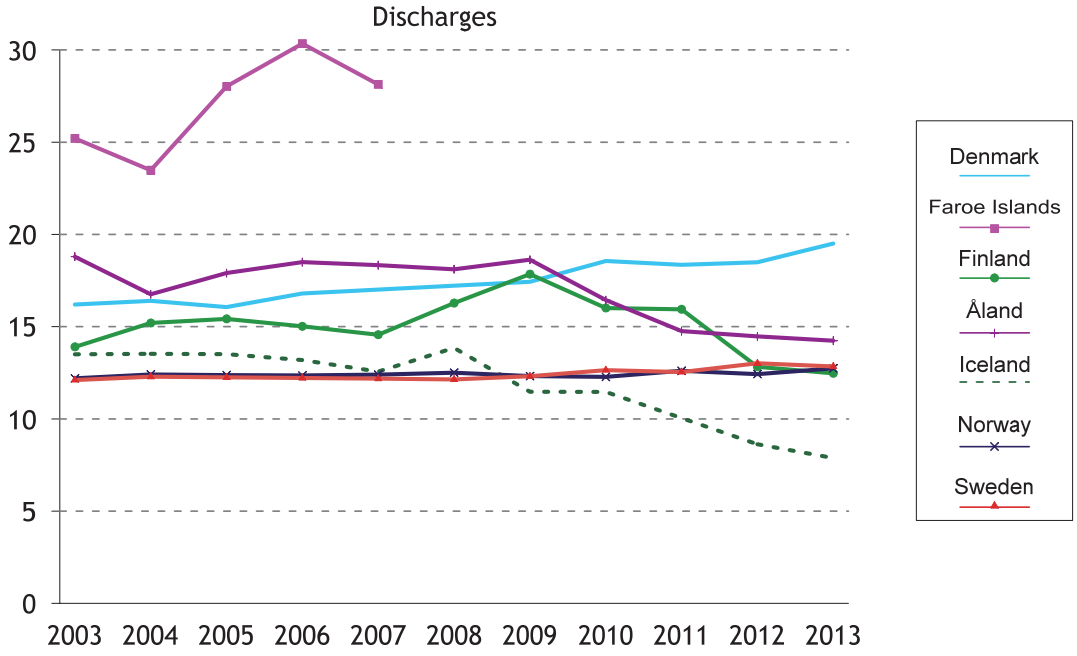
1 Iceland: Only discharges with a length of stay less than 90 days
Source: The national in-patient registers

Figure 3.4.5 Discharges during the year for diseases of the circulation organs (ICD10 I00-I99), per 1 000 inhabitants, 2003-2013[1]



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

Figure 3.4.6 Discharges for diseases of the digestive system (ICD10 K00-K93), per 1 000 inhabitants 2003-2013[1]



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

Table 3.4.4 Discharges, bed days and average length of stay in wards in ordinary hospitals and special hospitals, 2013

	Denmark	Faroe Islands[1]	Green-land[2]	Finland	Åland[3]	Iceland	Norway[4]	Sweden
Discharges per 1 000 inhabitants								
Somatic wards	254	210	326	173	175	116	169	163
Psychiatry wards	9	13	2	7	9	8	13	11
Total	263	224	329	180	185	124	182	174
Bed days per 1 000 inhabitants								
Somatic wards	970	1 063	1 705	698	971	640	694	776
Psychiatry wards	139	291	59	258	193	91	284	156
Total	1 112	1 354	1 764	956	1 163	730	977	932
Average length of stay								
Somatic wards	3.8	10.1	5.2	4.0	5.5	5.5	4.1	4.8
Psychiatry wards	15.1	22.4	25.7	36.5	20.3	11.7	21.3	14.5
Total	4.2	5.0	5.4	5.3	6.3	5.9	5.4	5.4

1 Average 2003-2007
2 Somatic ward is included DIH and the coast
3 Average 2009-2013
4 Figures for psychiatry include activity in psychiatric hospitals, psychiatric wards and district psychiatric centres Beds for adults, children and people receiving treatment for addiction are included. Figures for somatic wards include activity in somatic hospitals (not including rehabilitation)

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 (ICD10 C33-C34), 2013

	Denmark	Faroe Islands[1]	Finland	Åland[2]	Iceland[3]	Norway	Sweden
Discharges							
Men, total	2 676	63	3 137	12	146	3 304	3 893
Women, total	2 846	38	1 636	11	202	2 812	4 178
Patients treated							
Men, total	1 815	13	1 625	7	96	1 761	2 308
Women, total	1 717	7	883	5	120	1 528	2 468
Patients treated per 100 000 men in the age group							
25-44	2	-	2	5	4	3	2
45-64	80	76	64	50	83	71	37
65+	264	276	263	183	354	354	217
Total rate	65	51	61	47	69	69	48
Patients treated per 100 000 women in the age group							
25-44	2	-	2	0	5	3	3
45-64	69	63	35	67	100	69	49
65+	216	108	103	95	345	242	183
Total rate	61	31	32	37	74	60	51
Average length of stay per discharge	5.9	34	7.9	10.4	9.3	7.1	9.8

1 Average 2003-07
2 Average 2009-13
3 Only discharges with a length of stay less than 90 days
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 (ICD10 C50), women 2013

	Denmark	Faroe Islands[1]	Finland	Åland[2]	Iceland[3]	Norway	Sweden
Discharges							
Total	6 716	82	8 157	31	372	4 829	8 076
Patients treated							
Total	5 080	29	6 246	25	283	3 698	7 123
Patients treated per 100 000 women in the age group							
25-44	66	38	66	63	58	59	43
45-64	303	250	408	268	331	278	230
65+	430	375	467	402	558	348	380
Total rate	180	124	226	173	175	146	148
Average length of stay per discharge	2.4	5.6	4.5	6.5	5.4	3.4	3.3

1 Average 2003-07
2 Average 2009-13
3 Only discharges with a length of stay less than 90 days
Source: The national in-patient registers

Table 3.4.7 Discharges, patients treated and average length of stay in hospital for acute myocardial infarction (ICD10 I21-I22), 2013

	Denmark	Faroe Islands[1]	Finland	Åland[2]	Iceland[3]	Norway	Sweden
Discharges							
Men, Total	10 709	68	7 407	39	309	12 778	19 021
Women, Total	5 078	32	4 454	32	119	6 214	11 115
Patients treated							
Men, Total	5 879	58	5 680	30	272	7 488	12 817
Women, Total	2 978	26	3 531	24	106	4 034	7 689
Patients treated per 100 000 men in the age group							
0-44	17	20	10	8	12	22	9
45-64	306	352	257	234	286	428	293
65+	726	1 116	822	789	737	1 205	1 068
Total rate	211	230	212	208	167	293	268
Patients treated per 100 000 women in the age group							
0-44	7	-	2	0	6	6	3
45-64	95	82	66	101	68	118	88
65+	391	620	505	661	323	724	652
Total rate	105	113	128	164	66	159	160
Average length of stay per discharge	3.0	10.8	6.3	5.5	5.5	3.5	4.2

1 Average 2003-07
2 Average 2009-13
3 Only discharges with a length of stay less than 90 days
Source: The national in-patient registers

Table 3.4.8 Discharges, patients treated and average length of stay in hospital for cerebrovascular diseases (ICD10 I60-I69), 2013

	Denmark	Faroe Islands[1]	Finland	Åland[2]	Iceland[3]	Norway	Sweden
Discharges							
Men, Total	9 623	98	10 487	46	277	7 849	20 904
Women, Total	8 526	61	9 367	47	255	6 961	18 521
Patients treated							
Men, Total	7 183	78	7 493	35	226	6 400	15 030
Women, Total	6 379	51	6 866	35	213	5 705	13 814
Patients treated per 100 000 men in the age group							
0-44	23	30	26	23	13	18	16
45-64	288	316	281	200	148	232	233
65-79	843	1 465	957	793	628	958	992
80+	1 152	2 163	1 280	1 160	953	1 413	1 482
Total rate	258	313	280	243	139	251	314
Patients treated per 100 000 women in the age group							
0-44	23	6	25	11	15	17	15
45-64	191	142	172	163	103	153	147
65-79	565	890	592	545	504	608	635
80+	838	1 445	898	881	795	956	1 044
Total rate	226	219	248	240	132	225	287
Average length of stay per discharge	5.2	30.9	12.9	17.6	13.9	7.8	10.0

1 Average 2003-07
2 Average 2009-13
3 Only discharges with a length of stay less than 90 days
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 (ICD10 J40-J44, J47), 2013

	Denmark	Faroe Islands[1]	Finland	Åland[2]	Iceland[3]	Norway	Sweden
Discharges							
Total	19 910	97	5 524	55	413	11 352	20 607
Patients treated							
Total	11 499	64	3 541	34	315	7 362	11 872
Per 100 000 in the age group							
0-4	87	341	2	-	-	8	3
5-14	2	8	1	-	-	5	1
15-24	2	3	1	-	-	2	1
25-64	88	57	29	49	40	62	32
65-74	575	478	225	433	391	565	345
75+	1 306	673	318	630	818	871	819
Total rate	205	132	65	119	97	145	124
Average length of stay	3.6	8.1	7.1	7.1	9.2	6.6	5.6

1 Average 2003-07
2 Average 2009-13
3 Only discharges with a length of stay less than 90 days
Source: The national in-patient registers

Table 3.4.10 Discharges, patients treated and average length of stay in hospital for asthma (ICD10 J45-J46), 2013

	Denmark	Faroe Islands[1]	Finland	Åland[2]	Iceland[3]	Norway	Sweden
Discharges							
Total	6 113	106	3 169	20	50	3 278	4 779
Patients treated							
Total	4 573	82	2 583	18	48	2 838	3 908
Per 100 000 in the age group							
0-4	472	1 224	163	398	39	281	305
5-14	116	279	33	95	5	65	33
15-24	62	55	13	31	15	28	11
25-64	51	38	27	21	11	34	16
65-74	39	48	61	55	30	52	30
75+	47	121	155	139	26	64	72
Total rate	82	171	47	64	15	56	41
Average length of stay	1.8	3.0	5.6	3.4	4.5	6.1	2.4

1 Average 2003-07
2 Average 2009-13
3 Only discharges with a length of stay less than 90 days
Source: The national in-patient registers

Table 3.4.11 Discharges, patients treated and average length of stay in hospital for alcoholic liver disease (ICD10 K70), 2013

	Denmark	Faroe Islands[1]	Finland	Åland[2]	Iceland[3]	Norway	Sweden
Discharges							
Men, Total	1 867	3	1 499	3	5	541	1 368
Women, Total	847	2	549	1	6	304	489
Patients treated							
Men, Total	1 038	2	850	3	4	341	800
Women, Total	487	2	332	1	5	155	329
Patients treated per 100 000 men in the age group							
0-44	5	-	5	-	-	2	2
45-64	93	20	77	60	10	33	36
65+	59	34	48	8	-	28	37
Total rate	37	9	32	18	2	13	17
Patients treated per 100 000 women in the age group							
0-44	2	1	2	-	-	1	1
45-64	43	7	31	10	5	14	14
65+	27	28	12	14	13	11	14
Total rate	17	7	12	6	3	6	7
Average length of stay per discharge	6.9	5.5	7.5	13.9	15.3	6.9	7.4

1 Average 2003-07
2 Average 2009-13
3 Only discharges with a length of stay less than 90 days
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 (ICD10 K71-77), 2013

	Denmark	Faroe Islands[1]	Finland	Åland[2]	Iceland[3]	Norway	Sweden
Discharges							
Men, Total	1 678	10	1 041	3	21	769	1 522
Women, Total	1 569	10	995	2	21	815	1 261
Patients treated							
Men, Total	1 041	6	666	2	20	536	996
Women, Total	1 005	8	696	2	16	604	912
Patients treated per 100 000 men in the age group							
0-44	10	14	7	8	5	8	6
45-64	69	27	42	25	23	32	30
65+	80	67	56	40	30	56	56
Total rate	37	23	25	17	12	21	21
Patients treated per 100 000 women in the age group							
0-44	13	10	11	11	1	10	6
45-64	59	71	36	14	13	35	24
65+	67	74	46	34	44	54	46
Total rate	36	34	25	17	10	24	19
Average length of stay per discharge	5.4	7.4	5.5	9.9	8.6	7.1	7.2

1 Average 2003-07
2 Average 2009-13
3 Only discharges with a length of stay less than 90 days
Source: The national in-patient registers

Table 3.4.13 Discharges, patients treated and average length of stay in hospital for intervertebral disc disorders (ICD10 M50-51), 2013

	Denmark	Faroe Islands[1]	Finland	Åland[2]	Iceland[3]	Norway	Sweden
Discharges							
Men, Total	3 666	18	2 684	6	48	3 272	2 632
Women, Total	3 563	16	2 511	5	81	2 776	2 518
Patients treated							
Men, Total	3 075	15	2 270	5	48	2 759	2 188
Women, Total	2 965	11	2 110	5	69	2 345	2 060
Patients treated per 100 000 men in the age group							
0-24	10	4	12	0	2	10	6
25-44	152	111	135	77	36	138	65
45-64	193	80	134	35	53	198	77
65+	103	74	58	32	51	107	39
Total rate	111	60	85	34	30	108	46
Patients treated per 100 000 women in the age group							
0-24	8	2	11	5	2	11	5
25-44	160	62	129	63	53	126	67
45-64	171	101	112	38	80	158	67
65+	93	63	57	27	58	91	37
Total rate	105	49	76	33	43	93	43
Average length of stay per discharge							
Men	2.7	7.0	3.5	6.6	2.0	3.4	3.3
Women	3.2	8.6	4.0	7.1	4.3	3.7	3.9

1 Average 2003-07
2 Average 2009-13
3 Only discharges with a length of stay less than 90 days
Source: The national in-patient registers

Table 3.4.14 Discharges, patients treated and average length of stay in hospital for fracture of femur (ICD10 S72), 2013

	Denmark	Faroe Islands[1]	Finland	Åland[2]	Iceland[3]	Norway	Sweden
Discharges							
Men, Total	4 190	43	3 464	17	142	3 627	8 142
Women, Total	8 421	70	7 071	26	322	7 633	16 150
Patients treated							
Men, Total	3 150	33	2 718	14	114	3 396	6 405
Women, Total	6 345	53	5 458	23	262	7 176	12 763
Patients treated per 100 000 men in the age group							
0-44	18	44	24	23	11	22	16
45-64	74	103	65	55	43	78	51
65-74	209	326	187	199	158	252	213
75-79	481	474	398	414	507	691	541
80+	1 535	1 682	1 194	844	1 136	1 947	1 853
Total rate	113	131	102	95	70	133	134
Patients treated per 100 000 women in the age group							
0-44	7	11	10	8	3	9	7
45-64	71	67	54	34	53	79	51
65-74	314	455	233	181	275	451	301
75-79	911	1 139	660	588	693	1 100	848
80+	2 624	2 782	1 928	1 600	2 574	3 353	2 881
Total rate	225	228	197	161	162	284	265
Average length of stay per discharge	5.8	12.8	9.7	12.1	1.7	6.3	8.8

1 Average 2003-07
2 Average 2009-13
3 Only discharges with a length of stay less than 90 days
Source: The national in-patient registers

Figure 3.4.7 Average bed days for somatic wards, 2000-2013

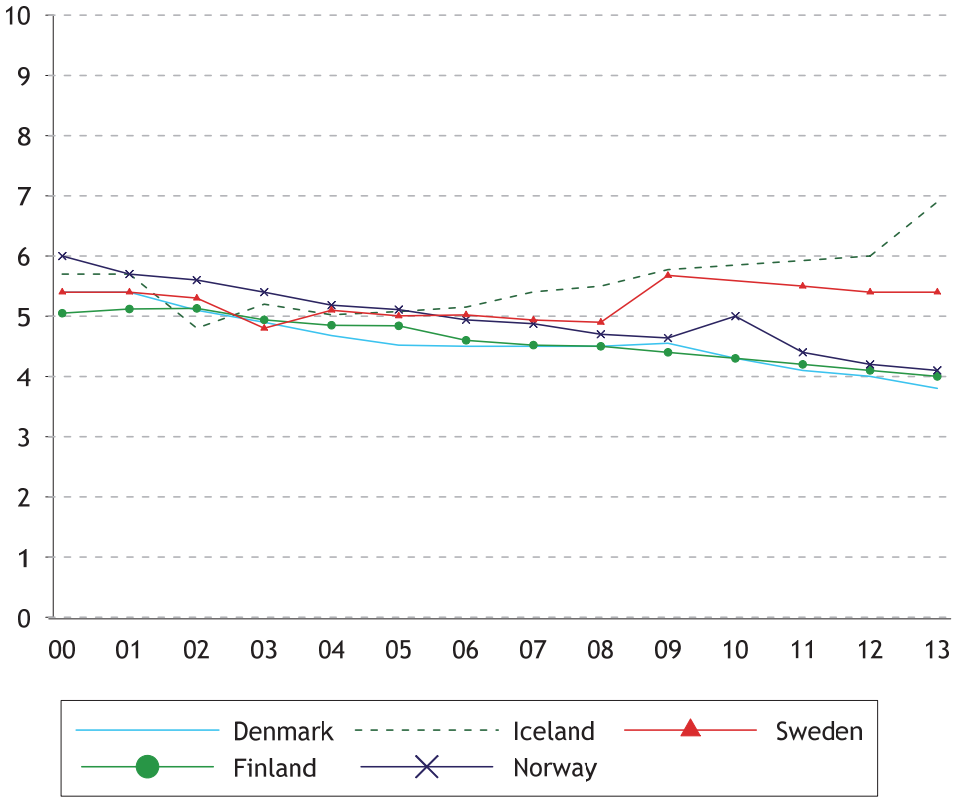


Table 3.4.15 In-patient treatment in psychiatric wards, by age and gender, 2013

	Denmark	Faroe Islands	Finland	Åland[1]	Iceland[2]	Norway	Sweden
Discharges, total	51 717	..	38 384	273	2 499	66 963	103 326
Discharges per 1 000 inhabitants	9.2	..	7.1	9.5	7.7	13.0	10.8
Total bed days	780 404	..	1 401 166	5 535	29 351	1 423 345	1 495 853
Bed days per 1 000 inhabitants	139.1	..	257.6	192.6	90.7	284.0	155.8
Treated patients, total	26 017	..	24 766	149	1 536	36 423	51 790
Treated patients, per 1 000							
Men							
0-14	0.4	..	2.1	0.2	1.2	1.0	0.2
15-29	5.8	..	6.2	8.0	7.3	9.6	7.1
30-44	7.0	..	5.8	6.2	6.3	11.3	7.2
45-64	6.1	..	4.7	7.9	4.5	8.8	8.0
65-79	3.1	..	3.1	4.1	2.2	4.5	4.5
80+	4.0	..	3.2	2.1	1.7	3.8	3.7
Total	4.7	..	4.5	5.5	4.5	7.4	5.5
Women							
0-14	0.6	..	1.8	0.2	0.7	0.8	0.4
15-29	6.9	..	7.7	9.2	8.8	11.1	8.2
30-44	5.6	..	5.2	4.8	6.3	9.1	6.2
45-64	5.2	..	4.6	5.8	5.3	8.3	6.0
65-79	3.8	..	4.2	5.0	3.6	5.4	4.2
80+	4.1	..	3.6	2.4	1.7	4.7	3.9
Total	4.5	..	4.6	4.9	5.0	7.1	5.1
Men and women							
0-14	0.5	..	2.0	0.2	1.0	1.0	0.3
15-29	6.3	..	7.0	8.5	8.0	10.3	7.6
30-44	6.3	..	5.5	5.5	6.3	10.2	6.7
45-64	5.6	..	4.6	6.9	4.9	8.5	7.0
65-79	3.5	..	3.7	4.6	2.9	5.0	4.4
80+	4.0	..	3.5	2.3	1.7	4.4	3.8
Total	4.6	..	4.6	5.2	4.7	7.3	5.3
Average length of stay per discharge	15.1	..	36.5	20.3	11.7	21.3	14.5

1 Average 2009-13
2 Only discharges with a length of stay less than 90 days
Source: The national in-patient registers

Table 3.4.16 Discharges from hospitals[1] per 1 000 inhabitants, by age and gender, 2013

Age	Denmark	Faroe Islands[2]	Finland	Åland[3]	Iceland[4]	Norway	Sweden
Men							
0-14	209	233	79	77	58	86	131
15-44	108	104	56	47	26	70	61
45-64	243	249	139	113	80	166	141
65-69	418	485	259	230	185	322	263
70-74	537	557	342	326	247	414	356
75-79	674	638	444	383	356	525	485
80+	964	760	591	661	509	714	764
Total	243	227	137	129	81	154	160
Women							
0-14	185	205	65	66	55	71	120
15-44	211	262	134	139	118	155	150
45-64	214	215	118	123	90	149	125
65-69	326	345	193	187	178	253	207
70-74	411	482	254	268	241	320	283
75-79	543	536	336	342	344	405	387
80+	762	556	467	600	452	554	624
Total	264	272	158	170	124	179	188

1 Includes somatic wards in regular hospitals and in somatic special hospitals
2 Average 2007-11
3 Average 2009-13
4 Only discharges with a length of stay less than 90 days
Source: The national in-patient registers

Table 3.4.17 Bed days for hospitals[1] per 1 000 inhabitants, by age and gender, 2013

Age	Denmark	Faroe Islands[2]	Finland	Åland[3]	Iceland[4]	Norway	Sweden
Men							
0-14	488	626	397	292	415	308	769
15-44	494	514	393	246	182	218	349
45-64	969	1 050	901	651	612	684	747
65-69	553	555	529	1 491	403	1 513	1 326
70-74	2 247	2 469	2 290	2 274	3 739	2 104	1 872
75-79	2 900	3 268	3 312	2 865	4 671	2 720	2 826
80+	4 225	4 436	5 577	6 678	14 030	3 675	4 770
Total	955	998	950	867	1 084	654	901
Women							
0-14	477	618	333	247	406	266	730
15-44	682	896	688	671	534	467	539
45-64	829	1 229	671	818	718	596	609
65-69	1 330	2 330	1 240	1 092	1 843	1 192	1 081
70-74	1 786	3 639	1 810	1 758	3 155	1 540	1 559
75-79	2 445	5 458	2 628	2 488	4 459	2 065	2 277
80+	3 500	7 126	5 413	6 800	11 920	2 772	4 139
Total	985	1 508	1 100	1 201	1 364	716	964

1 Includes somatic wards in regular hospitals and in somatic special hospitals
2 2006
3 Average 2009-13
4 Only discharges with a length of stay less than 90 days
Source: The national in-patient registers

Figure 3.4.8 Bed days for hospitals[1] per 1 000 inhabitants, by age and gender, 2013, continued

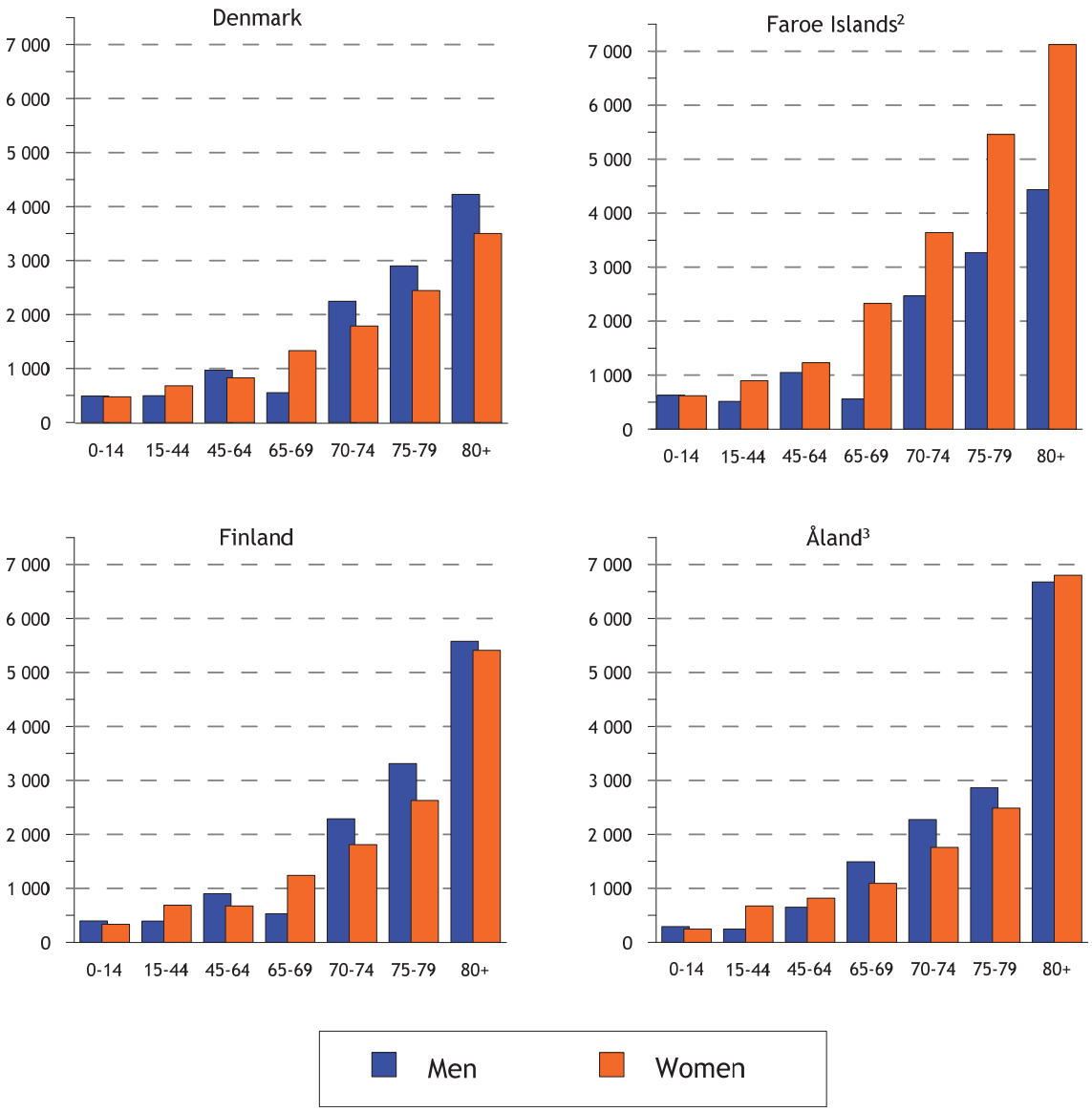
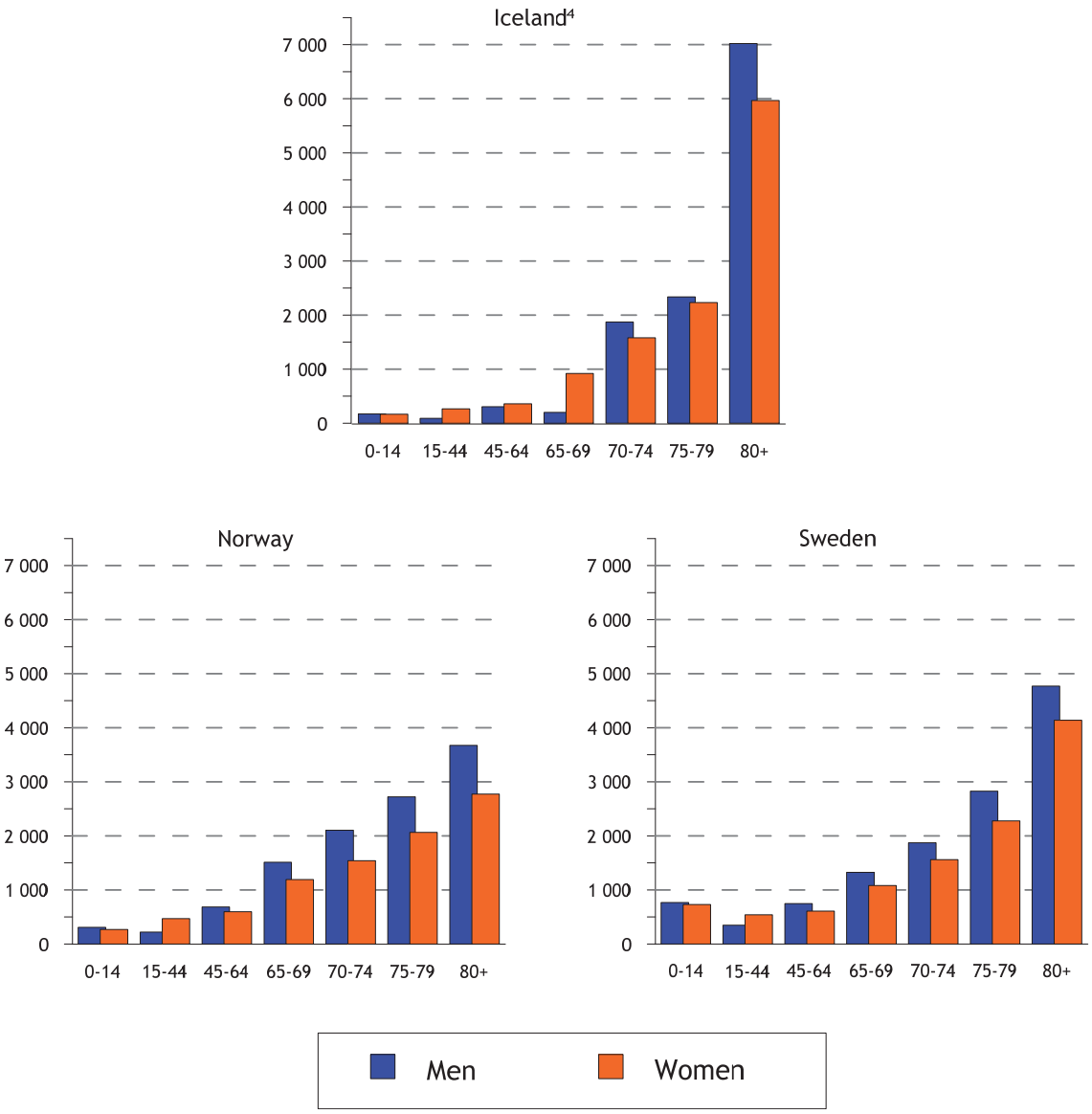


Figure 3.4.8 Bed days for hospitals[1] per 1 000 inhabitants, by age and gender, 2013, continued



1 Includes somatic wards in regular hospitals and in somatic special hospitals
2 2006
3 Average 2009-13
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 in short-term somatic hospitals are presented. The selected list of procedures used here was developed for international comparison by the EU Hospital Data Project (HDP2).

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.

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 proportions 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, which shows the proportion of the total number of these procedures that are carried out as day surgery. 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 the number of operations and population rates with age distributions for males and females, similar to the statistics presented in earlier editions of Health Statistics. 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 improving 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 in 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 between 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 for which the date of admission and the date of discharge are the same. However, some of these stays may refer to patients who were transferred to another hospital or who died, and thus are 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 hospitals in 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 2013, Denmark has had some difficulties in separating day treatment and outpatient treatment. Known under-reporting in the national patient registers is also caused by some private hospitals not reporting centrally.

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

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 give a complete picture of surgical procedures that are often performed on an outpatient basis, e.g. cataract surgery, colonoscopy and hernia surgery. Several of the more common surgical procedures that are performed on inpatients, tend to show almost the same rates in all countries (with the exception of Åland, which has a small number of inhabitants). These are, for example, transluminal coronary angioplasty and hysterectomy. The difference between the genders are already known in all the countries, where the numbers are higher for men for heart surgery and hernia operations, and higher for women for thyroidectomy, cholecystectomy and 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 hernia operations for men in Finland and for cholecystectomy for women in Iceland.

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
	2013	2009-13	2013	2009-13	2013	2013	2013
1: Extirpation, excision and destruction of intra-cranial lesion (AAB00-AAB20, AAB99)	19.6	..	19.7	15.4	19.9	18.5	17.6
2: Evacuation of subdural haematoma and intra-cranial haemorrhage (AAB30, AAD05-AAD15)	21.4	..	35.0	43.3	11.8	23.3	23.3
3: Discectomy (ABC)	157.8	..	135.0	81.0	55.9	141.1	77.2
4: Thyroidectomy (BAA20-BAA60)	17.4	..	16.2	8.4	11.2	12.7	12.2
5: Cataract surgery (CJC, CJD, CJE, CJF)	10.5	..	19.3	23.7	4.3	16.3	19.4
6: Cochlear implantation (DFE00)	5.8	..	2.2	2.8	0.6	1.2	3.0
7: Tonsillectomy (EMB10-EMB20)	62.4	..	41.9	107.6	19.3	74.3	54.7
8: Pulmectomy (GDB20-21, GDC, GDD)	15.7	..	10.1	4.2	13.0	11.6	8.1
9: Diagnostic bronchoscopy with or without biopsy (UGC)	89.9	..	56.7	19.6	69.6	109.9	44.1
10: Transluminal coronary angioplasty (FNG02, FNG05)	194.0	..	230.5	12.6	238.5	334.6	266.1
11: Coronary artery bypass graft (FNC, FND, FNE)[2]	56.9	..	53.5	2.8	85.1	71.6	51.6
12: Carotid endarterectomy (PAF20-PAF22)	12.1	..	15.4	4.2	7.5	12.5	12.2
13: Infrarenal aortic aneurysm repair (PDG10-PDG24, PDQ10)	22.6	..	16.6	9.8	11.2	24.4	11.6
14: Femoropopliteal bypass (PEH)	8.8	..	14.7	18.2	9.3	6.2	5.4
15: Stem cell transplantation (not included[3])	8.1	..	5.2	-	-	-	-
16: Colonoscopy with or without biopsy (JFA15, UJF32, UJF35, UJF42, UJF45)	282.7	..	56.8	39.1	159.6	187.9	116.2
17: Colectomy (JFB20-JFB64, JFH)	77.4	..	61.3	62.9	54.0	72.9	119.0
Of which:							
17A: Laparoscopic colectomy (JFB21, JFB31, JFB34, JFB41, JFB44, JFB47, JFB51, JFB61, JFB64, JFH01, JFH11)	30.9	..	20.2	2.8	9.9	25.3	6.3

The table continues

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

Surgical procedures (NCSP-E codes in brackets)	Denmark	Faroe Islands	Finland	Åland	Iceland	Norway	Sweden
	2013	2009-13	2013	2009-13	2013	2013	2013
18: Appendectomy (JEA)	104.9	..	131.5	150.9	144.1	124.0	131.6
Of which:		..					
18A: Laparoscopic appendectomy (JEA01)	91.5	..	40.0	5.6	89.4	98.9	55.5
19: Cholecystectomy (JKA20, JKA21)	52.2	..	87.3	95.0	82.0	44.2	79.9
Of which:		..					
19A: Laparoscopic cholecystectomy (JKA21)	40.7	..	65.8	67.1	75.8	37.7	60.0
20: Repair of inguinal hernia (JAB)	70.9	..	133.0	150.9	49.7	79.9	62.5
Of which:		..					
20: Laparoscopic repair of inguinal hernia (JAB11, JAB97)	24.0	..	15.4	23.7	14.3	28.5	1.8
21: Transplantation of kidney (KAS00-KAS20)	4.9	..	5.1	4.2	2.5	7.6	5.3
22: Open prostatectomy (KEC, KED00, KED96)	37.2	..	43.9	78.2	33.5	72.1	62.3
23: Transurethral prostatectomy (KED22, KED52-KED72, KED98)	92.3	..	137.0	155.1	93.2	134.4	103.8
24: Hysterectomy (LCC, LCD)	..	..	0.8	..	0.6	..	..
Of which:							
24A: Laparocopic hysterectomy (LCC01, LCC11, LCC97, LCD01, LCD04, LCD11, LCD31, LCD40, LCD97)	..	..	0.8	..	0.6	..	..
25: Caesarean section (MCA)	..	..	..	..	..	..	..
26: Arthroscopic excision of meniscus of knee (NGD01, NGD11)	6.1	..	14.1	12.6	-	18.9	4.2
27: Hip replacement (NFB, NFC)	183.2	..	195.3	180.2	140.4	169.4	167.7
Of which:							
27A: Secondary hip replacement (NFC)	23.3	..	27.0	18.2	19.3	20.2	18.9
28: Total knee re-placement (NGB20-NGB40)	104.6	..	132.4	121.5	-	69.7	93.8
29: Partial excision of mammary gland (HAB00, HAB30, HAB40, HAB99)	0.4	..	0.6	-	0.6	0.4	0.5
30: Total mastectomy (HAC10-HAC25, HAC99)	4.3	..	2.9	1.4	1.9	2.2	1.8

1 The NCSP codes refer to the NOMESCO Classification of Surgical Procedures. NCSP-E-version 1.13:2009 NOMESCO 83:2008
2 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
3 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
	2013	2009-13	2013	2009-13	2013	2013	2013
1: Extirpation, excision and destruction of intra-cranial lesion (AAB00-AAB20, AAB99)	21.9	..	22.6	19.4	18.2	19.2	19.4
2: Evacuation of subdural haematoma and intra-cranial haemorrhage (AAB30, AAD05-AAD15)	11.2	..	16.1	11.1	10.7	9.6	10.0
3: Discectomy (ABC)	151.2	..	130.8	106.7	74.1	130.6	77.5
4: Thyroidectomy (BAA20-BAA60)	62.3	..	64.6	76.2	49.0	49.7	51.2
5: Cataract surgery (CJC, CJD, CJE, CJF)	11.4	..	22.3	55.5	1.3	16.1	18.6
6: Cochlear implantation (DFE00)	5.9	..	2.7	2.8	1.3	1.9	4.0
7: Tonsillectomy (EMB10-EMB20)	69.1	..	40.4	116.4	21.4	72.9	52.3
8: Pulmectomy (GDB20-21, GDC, GDD)	18.2	..	7.3	2.8	23.9	10.3	8.7
9: Diagnostic bronchoscopy with or without biopsy (UGC)	60.1	..	35.9	12.5	60.3	-	32.4
10: Transluminal coronary angioplasty (FNG02, FNG05)	68.3	..	94.0	2.8	70.4	-	96.0
11: Coronary artery bypass graft (FNC, FND, FNE)[2]	12.7	..	15.5	-	19.5	-	12.9
12: Carotid endarterectomy (PAF20-PAF22)	6.1	..	6.5	4.2	4.4	-	6.0
13: Infrarenal aortic aneurysm repair (PDG10-PDG24, PDQ10)	4.6	..	2.4	2.8	3.1	-	3.1
14: Femoropopliteal bypass (PEH)	5.7	..	10.9	16.6	1.3	-	3.4
15: Stem cell transplantation (not included[3])	5.3	..	4.7	-	-	-	-
16: Colonoscopy with or without biopsy (JFA15, UJF32, UJF35, UJF42, UJF45)	275.7	..	59.0	45.7	202.3	-	128.9
17: Colectomy (JFB20-JFB64, JFH)	78.6	..	67.1	74.9	67.2	86.2	133.9
Of which:							
17A: Laparoscopic colectomy (JFB21, JFB31, JFB34, JFB41, JFB44, JFB47, JFB51, JFB61, JFB64, JFH01, JFH11)	31.2	..	24.1	1.4	15.7	28.4	6.5

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
	2013	2009-13	2013	2009-13	2013	2013	2013
18: Appendectomy (JEA)	113.3	..	130.3	117.8	138.8	120.2	128.0
Of which:		..					
18A: Laparoscopic appendectomy (JEA01)	93.5	..	68.0	38.8	96.1	94.9	64.7
19: Cholecystectomy (JKA20. JKA21)	87.3	..	134.1	191.3	161.4	92.7	138.1
Of which:							
19A: Laparoscopic cholecystectomy (JKA21)	77.0	..	119.5	167.7	156.4	87.2	119.7
20: Repair of inguinal hernia (JAB)	12.4	..	17.0	16.6	6.9	11.3	7.5
Of which:		..					
20: Laparoscopic repair of inguinal hernia (JAB11. JAB97)	7.4	..	2.4	1.4	1.9	2.8	0.6
21: Transplantation of kidney (KAS00-KAS20)	2.7	..	2.0	1.4	2.5	3.4	3.1
22: Open prostatectomy (KEC. KED00. KED96)	..	..	..	..	..	0.1	..
23: Transurethral prostatectmy (KED22. KED52-KED72. KED98)	..	..	..	..	..	..	..
24: Hysterectomy (LCC. LCD)	182.4	..	185.1	350.7	224.3	173.6	168.7
Of which:							
24A: Laparocopic hysterectomy (LCC01. LCC11. LCC97. LCD01. LCD04. LCD11. LCD31. LCD40. LCD97)	86.0	..	95.0	22.2	47.7	69.3	29.4
25: Caesarean section (MCA)	436.4	..	332.1	481.0	412.1	383.0	391.4
26: Arthroscopic excision of meniscus of knee (NGD01. NGD11)	6.9	..	11.4	23.6	-	14.7	2.6
27: Hip replacement (NFB. NFC)	265.8	..	287.1	238.4	234.9	335.5	245.5
Of which:							
27A: Secondary hip replacement (NFC)	29.9	..	41.6	26.3	31.4	33.8	20.5
28: Total knee re-placement (NGB20-NGB40)	154.5	..	238.4	183.0	1.3	110.9	128.6
29: Partial excision of mammary gland (HAB00. HAB30. HAB40. HAB99)	74.6	..	79.7	43.0	79.8	64.7	77.8
30: Total mastectomy (HAC10-HAC25. HAC99)	73.4	..	82.3	117.8	70.4	69.9	60.4

1 The NCSP codes refer to the NOMESCO Classification of Surgical Procedures. NCSP-E-version 1.13:2009 NOMESCO 83:2008
2 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
3 Not included in NCSP-E but can be defined through other non-surgical national classifications

Source: The national in-patient registers

Table 3.5.2 Eight surgical procedures often carried out as day surgery; total rate and day surgery rate per 100 000 inhabitants and day surgery as a percentage of all procedures by gender 2013[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	686.1	945.5	581.0	887.5	336.4	502.2	568.1	831.2
Of which day surgery	675.6	934.1	561.7	865.2	320.1	486.1	548.7	812.6
Day surgery as a percentage of total	98.5	98.8	96.7	97.5	95.1	96.8	96.6	97.8
Tonsillectomy (EMB10-20)								
Total rate per 100 000 population	98.1	123.5	143.8	164.2	152.2	172.4	107.3	106.7
Of which day surgery	35.6	54.4	101.9	123.8	77.9	99.5	52.6	54.3
Day surgery as a percentage of total	36.4	44.0	70.8	75.4	51.2	57.7	49.0	50.9
Diagnostic bronchoscopy with or without biopsy (UGC)								
Total rate per 100 000 population	275.4	217.8	59.5	37.0	185.9	133.5	123.2	101.1
Of which day surgery	185.5	157.7	2.7	1.1	76.0	60.5	79.2	68.7
Day surgery as a percentage of total	67.4	72.4	4.6	3.0	40.9	45.3	64.2	67.9
Colonoscopy with or without biopsy (JFA15. UJF32. UJF35. UJF42. UJF45)								
Total rate per 100 000 population	1 949.8	2 058.3	65.2	74.7	1 177.1	1 349.0	874.3	980.9
Of which day surgery	1 667.0	1 782.6	8.4	15.7	989.2	1 144.4	758.0	851.9
Day surgery as a percentage of total	85.5	86.6	12.9	21.0	84.0	84.8	86.7	86.9
Laparoscopic cholecystectomy (JKA 21)								
Total rate per 100 000 population	77.7	184.9	84.8	180.6	52.0	132.4	76.9	163.0
Of which day surgery	37.1	107.9	19.0	61.1	14.3	45.2	16.9	43.3
Day surgery as a percentage of total	47.7	58.4	22.5	33.8	27.5	34.1	22.0	26.6
Repair of inguinal hernia (JAB)								
Total rate per 100 000 population	359.9	41.4	363.3	39.5	244.7	29.0	247.3	19.5
Of which day surgery	289.0	29.1	230.3	22.5	164.7	17.7	184.8	11.9
Day surgery as a percentage of total	80.3	70.1	63.4	56.9	67.3	61.0	74.7	61.3
Arthroscopic excision of meniscus of knee (NGD01. NGD11)								
Total rate per 100 000 population	331.8	220.1	249.3	154.0	346.8	242.6	121.7	70.6
Of which day surgery	325.7	213.2	235.2	142.6	327.8	227.9	117.5	68.0
Day surgery as a percentage of total	98.2	96.9	94.3	92.6	94.5	93.9	96.6	96.3
Excision of mammary gland (women only) (HAB)								
Total per 100 000 population	2.9	199.5	2.1	123.2	2.6	128.4	2.2	153.9
Of which day surgery	2.5	124.9	1.6	43.6	2.3	63.7	1.7	76.1
Day surgery as a percentage of total	86.3	62.6	73.7	35.4	86.6	49.6	77.1	49.5

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 shown in Table 3.5.2, cataract surgery shows the highest percentage of day surgery in all the countries (96-98 per cent). The difference in the total rates per inhabitant for cataract surgery is mainly due to lack of reporting in all the countries. There are problems with the definition of day surgery and problems with reporting from private hospitals and clinics. This is illustrated in the numbers from Sweden, where the number of cataract operations in the inpatient register

in 2008 makes up only 82 per cent of the actual number according to numbers from the national inpatient register specifically for cataract surgery.

Tonsillectomy is performed as day surgery to various extents and with different totals per capita, which is interesting in connection with clinical controversy about the indications for this type of surgery and the need for follow-up after the operation. The very low numbers per capita in Finland for bronchoscopy and colonoscopy are because these procedures do not have to be reported nationally. The number of procedures carried out as day surgery 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 have higher rates for day surgery for partial breast resection.

Table 3.5.3 Proportion of laparoscopic procedures and secondary hip replacements on in-patients by gender, 2013

Procedure	Denmark		Finland		Åland[1]		Iceland[1]		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W
Per cent laparoscopic												
Colectomy	40	40	33	36	4	2	18	23	35	33	5	5
Appendectomy	87	83	30	52	4	33	62	69	80	79	42	51
Cholecystectomy	78	88	75	89	71	88	92	97	85	94	75	87
Repair of inguinal hernia	34	60	12	14	16	8	29	27	36	25	3	7
Hysterectomy	.	47	.	51	.	6	.	21	.	40	.	17
Per cent secondary												
Hip replacement	13	11	14	14	10	11	14	13	12	10	11	8

1 Average 2009-13

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 divergence requires closer examination and further consideration as to why this relatively new surgical method has been performed so differently in the Nordic countries. 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 that are reported here, are not secondary to the primary hip replacements performed in 2009, but mostly secondary to surgery performed many year before.

The detailed Tables 3.5.4–3.5.17 include both surgery on inpatients and surgery carried out as day surgery, which explains the higher rates reported here compared to the per capita numbers shown in Table 3.5.1, which only includes surgery on inpatients.

Table 3.5.4 Discectomy by age and gender, 2013

	Denmark		Finland		Åland[1]		Norway		Sweden	
Age	M	W	M	W	M	W	M	W	M	W
Total number of procedures										
<15	1	1	4	5	-	-	2	2	-	8
15-24	77	47	87	80	-	0	112	72	76	71
25-44	1 023	928	952	735	3	3	1 036	824	711	669
45-64	2 097	1 700	1 602	1 391	3	4	1 655	1 390	1 402	1 421
65-74	924	1 034	710	872	3	4	741	729	989	911
75-84	456	608	394	600	2	3	293	438	545	649
85+	46	88	33	66	0	1	52	48	69	80
Total	4 624	4 406	3 782	3 749	12	15	2 891	3 503	3 815	3 809
Per 100 000 in the age group										
< 15	-	-	1	1	-	-	-	-	-	1
15-24	21	13	26	25	-	26	33	22	12	12
25-44	145	133	138	112	93	97	144	121	57	55
45-64	280	228	214	184	80	101	252	220	115	118
65-74	315	333	261	284	213	293	337	319	194	173
75-84	352	367	294	303	213	278	282	322	221	207
85+	126	113	161	258	128	143	206	165	117	90
Total	166	156	141	136	82	107	152	138	80	79

1 Average 2009-13

NCSP: ABC

Source: The national in-patient registers

Table 3.5.5 Thyroidectomy by age and gender, 2013

	Denmark		Finland		Åland[1]		Norway		Sweden	
Age	M	W	M	W	M	W	M	W	M	W
Total number of procedures										
<15	3	5	4	7	0	0	2	5	1	15
15-24	8	49	19	68	0	0	9	39	15	144
25-44	116	517	81	471	0	4	76	399	132	827
45-54	142	475	81	383	0	3	61	325	137	511
55-64	99	357	110	387	0	3	75	246	123	410
65-74	84	266	92	317	0	1	71	179	114	403
75-84	32	102	41	147	0	0	38	71	48	151
85+	1	16	6	23	0	0	3	13	8	26
Total	485	1 787	434	1 803	1	11	335	1 277	589	2 487
Per 100 000 in the age group										
< 15	1	1	1	2	0	0	0	1	0	2
15-24	2	14	6	21	0	13	3	12	2	24
25-44	16	74	12	72	5	102	11	59	10	68
45-54	35	119	22	104	20	127	17	97	21	81
55-64	29	102	29	100	10	132	25	84	21	71
65-74	29	86	34	103	27	98	32	78	22	77
75-84	25	62	31	74	0	43	37	52	19	48
85+	3	21	17	25	0	0	8	17	9	15
Total	17	63	16	65	8	76	13	50	12	52

1 Average 2009-13

NCSP: BAA 20-60

Source: The national in-patient registers

Table 3.5.6 Cataract surgery by age and gender, 2013

Age	Denmark		Faroe Islands[1]		Finland		Åland[1]		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W
Total number of procedures												
< 45	308	280	..	..	255	223	0	-	222	183	372	341
45-64	3 264	3 810	..	..	2 847	3 155	2	1	1 325	1 562	4 120	4 942
65-74	6 758	9 730	..	..	5 042	7 829	2	1	2 488	3 745	8 984	13 064
75-84	6 952	10 072	..	..	5 912	10 521	2	3	3 290	5 090	10 210	16 286
85+	1 811	2 828	..	..	1 477	2 815	0	3	1 268	2 131	3 528	5 350
Total	19 093	26 720	..	..	15 533	24 543	6	8	8 593	12 711	27 214	39 983
Per 100 000 in the age group												
< 45	20	18	..	..	17	16	3	-	14	13	14	13
45-64	435	510	..	..	380	417	45	19	201	248	337	411
65-74	2 304	3 135	..	..	1 852	2 554	106	84	1 133	1 637	1 764	2 484
75-84	5 371	6 074	..	..	4 408	5 309	320	342	3 168	3 739	4 131	5 191
85+	4 953	3 624	..	..	4 176	3 095	158	498	3 465	2 751	4 107	3 183
Total	686	945	..	..	581	887	45	55	336	502	568	831

1 Average 2009-13

NCSP: CJC. CJD. CJE. CJF

Source: The national in-patient registers

Table 3.5.7.a Transluminal coronary angioplasty (PTCA, PCI) by age, men 2013

Age	Denmark	Faroe Islands	Finland	Norway	Sweden
Total number of procedures					
<45	306	..	174	342	320
45-54	1 187	..	841	1 348	1 521
55-64	2 023	..	1 869	2 698	3 649
65-74	2 262	..	1 978	2 797	4 891
75-84	1 179	..	1 326	1 492	2 779
85+	217	..	205	271	592
Total	7 174	..	6 393	8 948	13 752
Per 100 000 in the age group					
<45	19	..	12	22	12
45-54	293	..	225	378	235
55-64	587	..	498	895	632
65-74	771	..	727	1 274	960
75-84	911	..	989	1 437	1 124
85+	593	..	580	741	689
Total	258	..	239	350	287

NCSP: FNG 02; FNG 05

Source: The national in-patient registers

Table 3.5.7.b Transluminal coronary angioplasty (PTCA, PCI) by age, women 2013

Age	Denmark	Faroe Islands	Finland	Norway	Sweden
Total number of procedures					
<45	80	..	37	70	77
45-54	283	..	182	285	329
55-64	512	..	485	597	837
65-74	789	..	795	907	1 618
75-84	683	..	892	759	1 500
85+	192	..	280	232	506
Total	2 539	..	2 671	2 850	4 867
Per 100 000 in the age group					
<45	5	..	3	5	3
45-54	71	..	49	85	52
55-64	147	..	125	203	145
65-74	254	..	259	396	308
75-84	412	..	450	558	478
85+	246	..	308	300	301
Total	90	..	97	113	101

NCSP: FNG 02; FNG 05

Source: The national in-patient registers

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

Table 3.5.8.a Coronary artery bypass graft by age, men 2013

Age	Denmark	Faroe Islands	Finland	Norway	Sweden
Total number of procedures					
<45	19	..	11	28	13
45-54	137	..	112	186	169
55-64	397	..	385	565	619
65-74	677	..	584	674	1 071
75-84	343	..	329	349	577
85+	11	..	10	26	25
Total	1 584	..	1 431	1 828	2 474
Per 100 000 in the age group					
<45	1	..	1	2	4
45-54	34	..	30	52	26
55-64	115	..	103	187	107
65-74	231	..	215	307	210
75-84	265	..	245	336	233
85+	30	..	28	71	29
Total	57	..	54	72	52

NCSP: FNC. FND. FNE

Source: The national in-patient registers

Table 3.5.8.b Coronary artery bypass graft by age, women 2013

Age	Denmark	Faroe Islands	Finland	Norway	Sweden
Total number of procedures					
<45	4	..	3	7	4
45-54	20	..	14	22	36
55-64	73	..	66	80	86
65-74	147	..	153	170	264
75-84	113	..	182	136	215
85+	4	..	12	14	16
Total	361	..	430	429	621
Per 100 000 in the age group					
<45	0	..	0	1	0
45-54	5	..	0	7	6
55-64	21	..	17	27	15
65-74	47	..	50	74	50
75-84	68	..	92	100	69
85+	5	..	13	18	10
Total	13	..	16	17	13

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 men and 75-84-year-old men, and slightly higher for 75-84-year-old women.

Table 3.5.9.a Appendectomy by age, men 2013

Age	Denmark	Faroe Islands	Finland	Åland[1]	Norway	Sweden
Total number of procedures						
<15	659	..	379	4	499	1 011
15-24	803	..	689	5	748	819
25-44	893	..	1 259	6	951	1 976
45-64	566	..	833	4	588	1 147
65+	332	..	376	2	325	626
Total	3 253	..	3 536	22	3 244	6 320
Per 100 000 in the age group		..				
<15	132	..	83	163	105	121
15-24	219	..	205	295	218	130
25-44	126	..	182	176	133	157
45-64	75	..	111	105	89	94
65+	72	..	85	88	90	74
Total	117	..	132	152	127	132

1 Average 2009-13

NCSP: JEA

Source: The national in-patient registers

Table 3.5.9.b Appendectomy by age, women 2013

Age	Denmark	Faroe Islands	Finland	Åland[1]	Norway	Sweden
Total number of procedures						
<15	526	..	289	3	367	730
15-24	778	..	737	4	822	1 348
25-44	933	..	1 158	5	962	1 771
45-64	743	..	1 007	2	619	1 461
65+	500	..	445	2	362	888
Total	3 480	..	3 636	17	3 132	6 198
Per 100 000 in the age group		..				
<15	111	..	66	150	81	92
15-24	222	..	229	273	253	227
25-44	133	..	177	154	142	146
45-64	99	..	133	48	98	121
65+	90	..	75	68	82	88
Total	123	..	131	118	124	129

1 Average 2009-13

NCSP: JEA

Source: The national in-patient registers

Table 3.5.10.a Cholecystectomy by age, men 2013

Age	Denmark	Faroe Islands	Finland	Åland[1]	Norway	Sweden
Total number of procedures						
<25	90	..	47	0	40	162
25-44	613	..	462	3	352	1 047
45-64	1 062	..	1 122	6	640	1 915
65+	736	..	1 221	4	464	1 520
Total	2 501	..	2 852	14	1 496	4 644
Per 100 000 in the age group		..				
<25	10	..	6	5	5	11
25-44	87	..	67	71	49	83
45-64	142	..	150	160	97	156
65+	160	..	276	175	129	180
Total	90	..	107	95	59	97

1 Average 2009-13

NCSP: JKA 20-21

Source: The national in-patient registers

Table 3.5.10.b Cholecystectomy by age, women 2013

Age	Denmark	Faroe Islands	Finland	Åland[1]	Norway	Sweden
Total number of procedures						
<25	368	..	252	1	237	637
25-44	2 045	..	1 496	8	1 340	3 126
45-64	2 128	..	2 226	12	1 285	3 238
65+	1 014	..	1 437	6	635	1 748
Total	5 555	..	5 411	28	3 497	8 749
Per 100 000 in the age group		..				
<25	45	..	33	26	30	46
25-44	292	..	228	233	90	258
45-64	285	..	294	292	204	269
65+	183	..	241	211	144	173
Total	197	..	196	191	138	182

1 Average 2009-13

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 group 65+, while the rates are higher for women in the age group 45-64 and in Denmark as early as in the age group 25-44.

Table 3.5.11 Transplantation of kidney by age and gender, 2013

	Denmark		Finland		Åland[1]		Norway		Sweden	
Age	M	W	M	W	M	W	M	W	M	W
Total number of procedures										
<15	6	4	7	3	-	-	4	3	15	7
15-24	9	8	5	3	-	-	2	2	14	8
25-44	38	25	26	12	-	-	39	26	57	26
45-54	32	13	31	8	-	-	38	19	62	44
55-64	35	18	38	18	-	-	42	22	69	36
65+	18	10	30	10	-	-	68	16	47	30
Total	138	78	137	54	1	-	193	88	264	151
Per 100 000 in the age group										
< 15	1	1	2	1	-	-	1	1	2	1
15-24	2	2	1	1	-	-	1	1	2	1
25-44	5	4	4	2	-	-	5	4	5	2
45-54	8	3	8	2	10	-	11	6	10	7
55-64	10	5	10	5	-	9	14	7	12	6
65+	4	2	7	2	16	-	19	4	6	3
Total	5	3	5	2	4	1	8	3	6	3

1 Average 2009-13

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. Whether this reflects differences in morbidity between men and women or whether it is a possible effect of gender discrimination should be addressed.

Table 3.5.12 Open prostatectomy by age, men 2013

Age	Denmark	Faroe Islands	Finland	Åland[1]	Norway	Sweden
Total number of procedures						
<45	5	..	6	-	6	12
45-64	496	..	637	7	853	1 304
65-74	529	..	508	4	930	1 548
75-84	11	..	21	-	71	124
85+	0	..	2	-	16	6
Total	1 041	..	1 174	11	1 876	2 995
Per 100 000 in the age group		..				
<45	0	..	-	-	-	0,4
45-64	66	..	85	175	130	107
65-74	180	..	187	279	424	304
75-84	8	..	16	-	68	50
85+	0	..	6	-	44	7
Total	37	..	44	78	73	63

1 Average 2009-13

NCSP: KEC; KED00; 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 2013

Age	Denmark	Faroe Islands	Finland	Åland[1]	Norway	Sweden
Total number of procedures						
<45	8	..	11	-	5	3
45-64	655	..	719	6	643	1 034
65-74	1 245	..	1 572	8	1 460	2 173
75-84	840	..	1 242	6	1 076	1 628
85+	151	..	274	1	314	390
Total	2 899	..	3 818	22	3 498	5 228
Per 100 000 in the age group		..				
<45	1	..	1	-	-	-
45-64	87	..	96	155	98	84
65-74	425	..	577	545	665	427
75-84	649	..	926	853	1 036	659
85+	413	..	775	554	858	454
Total	104	..	143	155	137	109

1 Average 2009-13

NCSP: KED22; KED52-KED72; 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 2013

Age	Denmark	Faroe Islands	Finland	Åland[1]	Norway	Sweden
Total number of procedures						
<25	12	..	5	0	14	21
25-44	1 684	..	1 151	12	1 298	2 012
45-64	3 171	..	2 893	28	2 387	4 155
65+	1 334	..	1 128	11	933	2 256
Total	6 201	..	5 177	51	4 632	8 444
Per 100 000 in the age group		..				
<25	1	..	1	5	2	2
25-44	241	..	176	347	191	166
45-64	424	..	383	665	379	345
65+	241	..	189	361	211	224
Total	219	..	187	352	183	176

1 Average 2009-13

NCSP: LCC; LCD

Source: The national in-patient registers

Table 3.5.15 Caesarean section by age, women 2013

Age	Denmark	Faroe Islands	Finland	Åland[1]	Norway	Sweden
Total number of procedures						
<15	3	..	1	-	1	1
15-24	1 176	..	1 140	35	907	1 825
25-34	7 774	..	5 555	202	5 809	11 038
35-44	3 469	..	2 445	108	2 994	5 859
45+	63	..	42	2	46	114
Total	12 485	..	9 183	347	9 757	18 837
Per 1 000 deliveries[2]		..				
<15	-	..	333	-	-	250
15-24	171	..	119	205	102	112
25-34	211	..	151	226	151	153
35-44	289	..	211	341	262	237
45+	477	..	375	1 000	561	407
Total	223	..	158	250	165	166

1 Average 2009-13

2 Sweden and Norway 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 with Caesarean section (22 per cent) and the highest rate in each age group, excluding Åland.

Table 3.5.16.a Hip replacement by age, men 2013

Age	Denmark	Faroe Islands	Finland	Åland[1]	Norway	Sweden
Total number of procedures						
<25	16	..	10	-	20	10
25-44	159	..	135	1	106	153
45-64	1 476	..	1 610	8	1 085	2 042
65-74	1 833	..	1 739	9	1 326	2 742
75+	1 694	..	1 735	8	1 825	3 112
Total	5 178	..	5 229	26	4 362	8 059
Per 100 000 in the age group		..				
<25	2	..	1	-	2	1
25-44	22	..	20	16	15	12
45-64	197	..	215	210	165	167
65-74	625	..	639	571	604	538
75+	1 020	..	1 024	817	1 300	934
Total	186	..	196	180	171	168

1 Average 2009-13

NCSP: NFB; NFC

Source: The national in-patient registers

Table 3.5.16.b Hip replacement by age, women 2013

Age	Denmark	Faroe Islands	Finland	Åland[1]	Norway	Sweden
Total number of procedures						
<25	16	..	5	-	13	19
25-44	132	..	106	-	118	150
45-64	1 460	..	1 805	8	1 593	2 239
65-74	2 455	..	2 255	12	2 513	3 593
75+	3 577	..	3 779	14	4 300	5 849
Total	7 640	..	7 950	34	8 537	11 850
Per 100 000 in the age group		..				
<25	2	..	1	-	2	1
25-44	19	..	16	11	17	12
45-64	195	..	239	182	253	186
65-74	791	..	736	836	1 098	683
75+	1 467	..	1 307	961	2 013	1 214
Total	270	..	287	238	337	246

1 Average 2009-13

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 replacement 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 2013

Age	Denmark	Faroe Islands	Finland	Åland[1]	Norway	Sweden
Total number of procedures						
<25	1	..	-	-	1	-
25-44	33	..	29	-	20	34
45-64	990	..	1 265	6	613	1 378
65-74	1 254	..	1 345	8	764	1 898
75+	668	..	913	3	397	1 194
Total	2 946	..	3 552	17	1 795	4 504
Per 100 000 in the age group		..				
<25	0	..	-	-	-	-
25-44	5	..	4	-	3	3
45-64	132	..	169	160	93	113
65-74	428	..	494	505	348	373
75+	402	..	539	339	283	358
Total	106	..	133	122	70	94

1 Average 2009-13

NCSP: NGB 20; NGB 30; NGB 40

Source: The national in-patient registers

Table 3.5.17.b Total knee replacement by age, women 2013

Age	Denmark	Faroe Islands	Finland	Åland[1]	Norway	Sweden
Total number of procedures						
<25	2	..	1	-	-	1
25-44	36	..	55	-	30	47
45-64	1 400	..	1 986	10	851	1 887
65-74	1 772	..	2 471	10	1 104	2 366
75+	1 200	..	2 091	7	839	1 894
Total	4 410	..	6 604	27	2 824	6 195
Per 100 000 in the age group		..				
<25	-	..	-	-	-	-
25-44	5	..	8	-	4	4
45-64	187	..	263	235	135	157
65-74	571	..	806	669	483	450
75+	492	..	723	481	393	393
Total	156	..	239	184	112	129

1 Average 2009-13

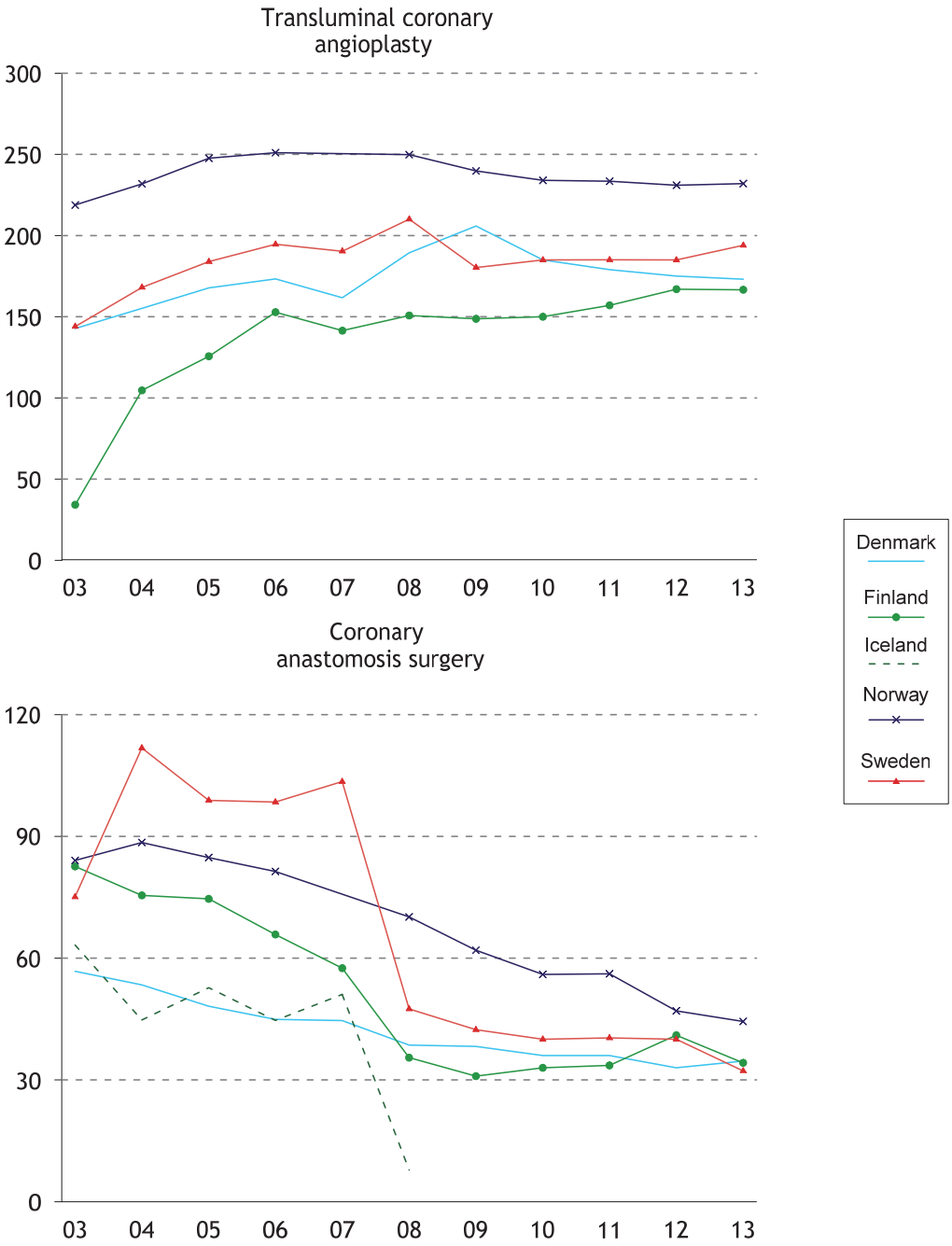
NCSP: NGB 20; NGB 30; NGB 40

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 procedure in all age groups above 45 years.

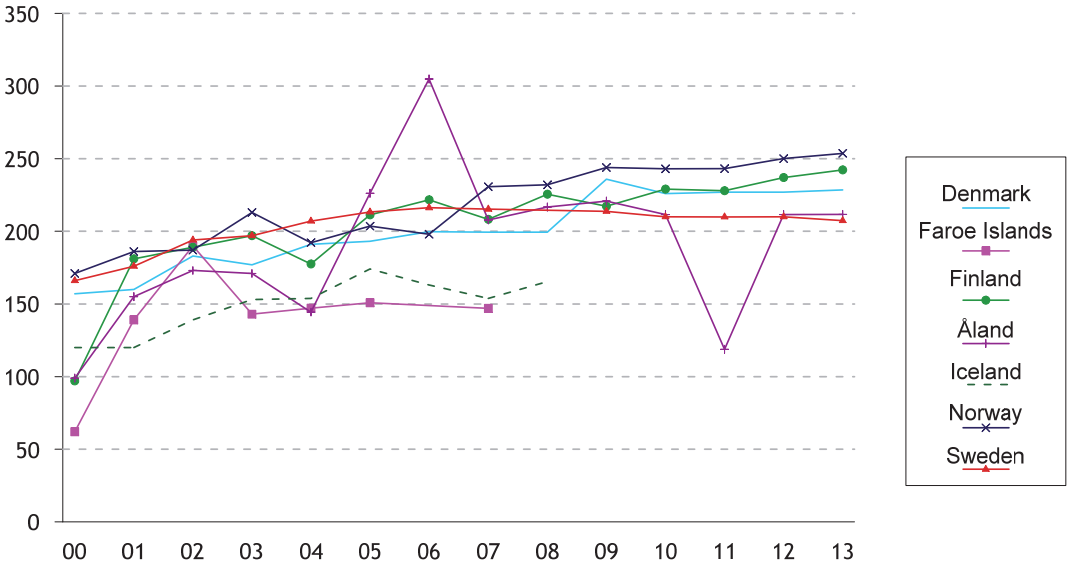
Figure 3.5.1 shows increased rates for percutaneous transluminal coronary angioplasty (PTCA) and slightly decreased rates for coronary anastomosis operations for the period 2003-2009. In general, the countries maintain their relative position over time. The HDP2 list defines coronary anastomosis operations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

Figure 3.5.1 Transluminal coronary angioplasty and coronary anastomosis surgery, total rates per 100 000 inhabitants, 2003-2013



Source: The national in-patient registers

Figure 3.5.2 Hip replacement per 100 000 inhabitants, 2000-2013



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 between countries and between men and women.

Table 3.6.1 Discharges from hospitals after treatment for injuries per 100 000 inhabitants and by gender, 2013[1]

	Denmark		Faroe Islands[2]		Greenland[3]		Finland		Åland[3]		Iceland		Norway		Sweden	
(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)*	190	116	..	..	389	395	301	181	257	151	77	42	245	154	175	119
Fracture at wrist and hand level *(S62)*	70	28	..	..	63	39	68	28	50	12	6	7	40	15	19	9
Injury of lower leg *(S80-S89)*	194	195	..	..	388	702	488	405	366	290	97	115	166	164	116	139
Injury of hip and thigh *(S70-S79)*	184	343	..	..	145	269	238	441	191	274	104	215	171	328	165	306
Poisoning *(T36-T65)*	176	236	..	..	176	442	87	101	39	55	18	29	87	120	80	117
Burn and corrosion *(T20-T32)*	15	8	..	..	47	48	35	14	28	10	14	5	26	13	13	6

1 Including violence and self-inflicted injury
2 Average 2009-13
Source: The national in-patients registers

Table 3.6.2 Discharges from hospitals after treatment for injuries per 100 000 inhabitants by age and gender, 2013[1]

	Denmark		Faroe Islands[2]		Finland		Iceland		Norway		Sweden	
Age	M	W	M	W	M	W	M	W	M	W	M	W
0-14	445	392	..	..	908	665	303	239	1 184	882	1 005	707
15-24	915	838	..	..	1 887	1 101	454	396	1 640	1 069	1 277	1 086
25-64	725	565	..	..	1 930	1 249	655	576	1 372	1 078	1 327	1 111
65+	1 509	2 374	..	..	2 768	3 629	2 037	3 509	2 813	4 118	4 925	5 918
Total	829	925	..	..	1 886	1 651	720	892	1 576	1 573	1 897	2 048

1 Including violence and self-inflicted injury
2 Average 2009-13
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: Central Pharmacy in Copenhagen County; Finland and Åland: Finnish Medicines Agency; Iceland: Icelandic Medicines Agency; Norway: Norwegian Institute of Public Health; Sweden: Swedish eHealth Agency

Table 3.7.1 Sales of medicinal products in total, DDD/1 000 inhabitants/day by ATC-group, 2014[1]

	Denmark[2]	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A Alimentary tract and metabolism	162	205	118	270	197	175	200	231
B Blood and blood-forming organs	118	139	53	139	139	152	127	269
C Cardiovascular system	540	579	273	552	410	370	407	480
G Genito-urinary system	101	78	73	134	127	106	106	102
H Systemic hormonal preparations excl. sex hormones and insulins	32	31	13	53	55	43	45	44
J Anti-infectives for systemic use	22	18	19	22	18	23	21	16
L Antineoplastic and immunomodulating agents	17	16	9	18	16	16	18	18
M Musculo-skeletal system	65	50	25	99	70	88	60	58
N Nervous system	272	205	111	265	210	357	224	278
P Antiparasitic products, insecticides and repellents	1	1	2	2	2	2	1	1
R Respiratory system	129	116	58	164	138	132	193	151
S Sensory organs	12	11	4	21	20	15	19	23

1 Only ATC groups with WHO DDDs assigned are included. A11 Vitamins is excluded due to different definitions of medicinal products in the Nordic countries
2 2013

Table 3.7.2 Sales of drugs for acid related disorders (ATC group A02), DDD/1 000 inhabitants/day, 2005-2014

	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	84,7	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
2014	..	83.4	45.3	68.6	58.3	106.0	57.0	74.5
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	4.5	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
2014	..	3.4	1.9	2.2	2.5	7.4	1.3	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	80.2	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
2014	..	80.0	43.5	66.4	55.9	98.2	55.8	72.9
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	4.5	5.8	3.2
2012	1.1	1.0	-	1.9	4.3	3.7	5.3	2.5
2013	1.0	1.0	-	1.5	4.6	3.4	4.9	2.3
2014	..	1.0	-	1.4	4.2	3.2	4.6	2.1
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
2014	..	78.2	43.4	63.8	50.0	94.9	50.6	69.8
A02BX Other drugs for peptic ulcer and gastro-oesophageal reflux disease								
2005	0.5	1.1	0.3	1.4	1.6	-	0.4	1.1
2010	0.4	0.8	-	1.2	1.5	-	0.4	0.8
2012	0.5	0.8	-	1.1	1.7	-	0.5	0.9
2013	0.5	0.8	-	1.1	1.5	-	0.6	0.9
2014	..	0.9	-	1.1	1.6	-	0.6	0.9

Figure 3.7.1 Sales of drugs for treatment of peptic ulcer and gastro-oesophageal reflux disease (ATC-group A02BA, A02BB and A02BC), DDD/1 000 inhabitants/day, 2005-2014

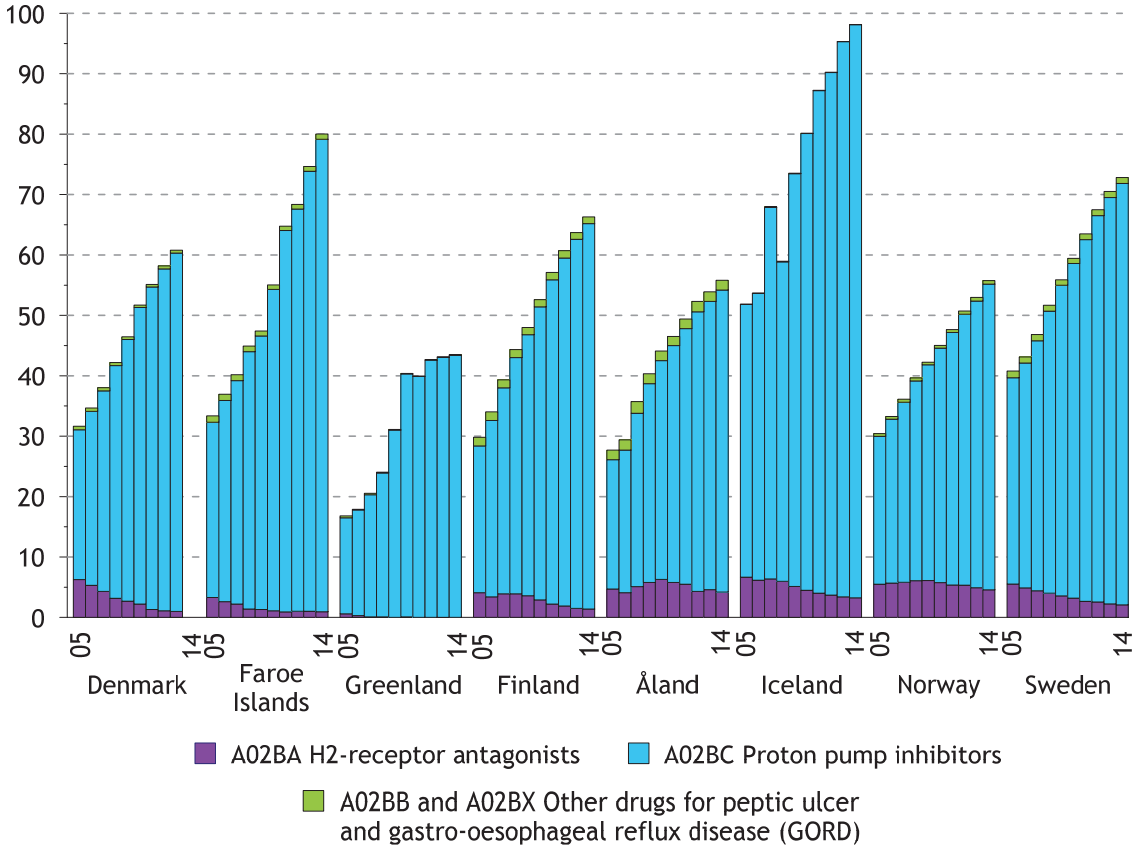


Table 3.7.3 Proportion of the population per 1 000 (one-year prevalence), receiving at least one drug for treatment of ulcer, oesophageal inflammation and pyrosis (proton pump inhibitors, ATC group A02BC) by age and gender, 2014[1]

	Denmark		Faroe Islands		Finland		Iceland		Norway		Sweden	
Age	M	W	M	W	M	W	M	W	M	W	M	W
0-14	7	8	6	6	6	6	19	19	8	7	6	7
15-24	21	42	23	43	19	34	37	66	18	28	17	36
25-44	54	68	54	67	67	88	73	88	48	53	37	62
45-64	114	141	127	146	132	176	159	209	104	118	93	132
65-74	188	212	241	278	187	233	262	340	166	190	172	215
75+	257	284	333	404	255	311	303	350	205	213	254	287

1 Prescribed medicine only

Table 3.7.4 Sales of anti-obesity preparations (ATC-group A08), DDD/1 000 inhabitants/day, 2005-2014

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	0.7	0.4	-	0.6	0.3	1.3	2.6	2.3
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
2014	0.5	0.3	-	0.2	0.2	-	0.4	0.4

Table 3.7.5 Sales of drugs used in diabetes (ATC-group A10), DDD/1 000 inhabitants/day, 2005-2014

	Denmark	Faroe Islands	Green-land	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
2012	51.1	56.9	15.5	85.0	52.6	39.8	48.5	54.1
2013	51.8	59.9	16.4	86.0	52.0	42.6	48.8	55.8
2014	52.5	62.4	18.9	88.2	54.2	42.1	49.9	56.8
A10A Insulins and analogues								
2005	13.3	10.4	2.7	21.7	15.1	6.5	17.4	22.6
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
2014	18.3	14.3	4.7	31.8	21.5	11.4	19.2	27.8
A10AB Insulins and analogues for injection, fast-acting								
2005	4.1	2.9	..	5.5	5.3	..	6.0	8.1
2012	5.5	5.2	..	8.5	6.5	4.5	7.2	9.4
2013	5.7	5.1	..	8.8	6.7	4.7	7.5	9.7
2014	5.8	5.5	1.0	9.0	6.9	4.5	7.6	9.8
A10AC Insulins and analogues for injection, intermediate-acting								
2005	4.7	2.8	..	9.6	6.0	..	8.2	5.3
2012	3.2	0.5	..	2.1	7.1	1.3	6.7	5.0
2013	3.1	0.5	..	1.8	7.2	1.4	6.6	5.2
2014	3.0	0.5	1.6	1.5	7.5	1.3	6.6	5.4
A10AD Insulins and analogues for injection, inter-mediate- or long-acting combined with fast-acting								
2005	3.6	4.4	..	2.8	1.7	..	2.6	5.7
2012	3.8	4.9	..	1.4	2.0	1.6	1.9	6.4
2013	3.6	4.5	..	1.1	1.5	1.5	1.8	6.3
2014	3.4	4.5	1.5	0.9	1.3	1.3	1.6	6.1
A10AE Insulins and analogues for injection, long-acting								
2005	0.8	0.5	..	3.9	2.0	..	0.6	3.6
2012	5.1	3.1	..	18.7	5.4	3.5	3.1	6.0
2013	5.5	3.4	..	19.7	5.6	4.1	3.3	6.2
2014	6.0	3.8	0.7	20.4	5.9	4.4	3.3	6.5

The table continues

Table 3.7.5 Sales of drugs used in diabetes (ATC-group A10), DDD/1 000 inhabitants/day, 2005-2014, 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
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
2014	34.2	48.1	14.2	56.3	32.7	30.7	30.7	29.0
A10BA Biguanides								
2005	7.9	6.7	4.3	18.5	10.1	7.7	9.7	11.8
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
2014	19.2	23.3	10.4	31.6	19.3	13.7	14.4	19.4
A10BB Sulphonamides, urea derivatives								
2005	12.0	15.7	3.3	24.1	13.1	7.2	11.1	7.7
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
2014	6.7	13.8	3.5	3.9	6.1	13.0	8.3	4.2
A10BD Combinations of oral blood glucose lowering								
2005	0.2	..	-	0.8	0.1	0.5	0.1	0.2
2012	1.5	-	-	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
2014	2.2	0.1	-	5.5	0.2	0.8	3.0	0.4
A10BG Thiazolidinediones								
2005	0.1	0.1	-	1.1	0.1	1.7	0.8	1.0
2012	-	-	-	1.3	1.4	0.5	0.3	0.3
2013	-	-	-	1.0	1.2	0.4	0.3	0.3
2014	-	-	-	1.0	1.2	0.4	0.2	0.3
A10BH Dipeptidyl peptidase 4 (DPP-4) inhibitors								
2005	-	..	-	..	..	-	-	..
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
2014	2.3	4.0	-	11.8	5.4	1.6	2.5	2.3
A10BX Other oral blood glucose lowering drugs, excl. insulins								
2005	0.3	-	-	0.2	0.2	0.4	0.1	1.2
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
2014	3.9	7.0	0.2	2.6	0.6	1.2	2.3	2.4

Figure 3.7.2 Sales of insulins and other blood glucose lowering drugs (ATC-groups A10A and A10B), DDD/1 000 inhabitants/day, 2005-2014

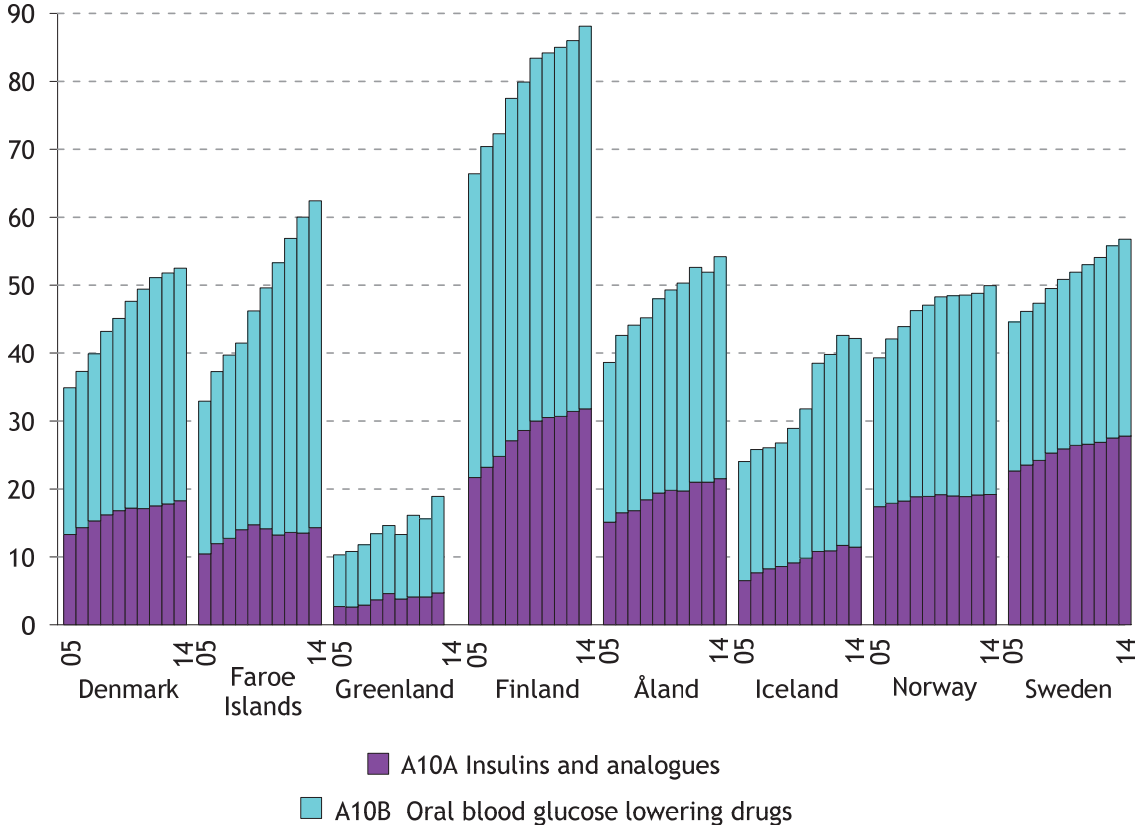


Table 3.7.6 Proportion of the population per 1 000 (one-year prevalence) receiving at least one drug used in diabetes (ATC-group A10) by age and gender, 2014

	Denmark		Faroe Islands		Finland		Iceland		Norway		Sweden	
Age	M	W	M	W	M	W	M	W	M	W	M	W
0-14	2	2	1	2	5	4	1	2	2	2	3	3
15-24	5	7	6	9	11	10	5	11	6	7	8	7
25-44	14	16	14	15	19	18	12	24	14	14	13	12
45-64	68	45	70	41	99	64	56	30	57	38	66	41
65-74	139	89	173	94	207	138	129	80	116	75	151	94
75+	148	104	210	125	220	176	142	85	119	85	169	119

Table 3.7.7 Sales of antithrombotic agents (ATC-group B01), DDD/1 000 inhabitants/day, 2005-2014

	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
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
2014	..	86.7	39.7	113.5	86.8	89.1	101.8	92.9
B01AA Vitamin K antagonists								
2005	6.4	6.1	..	10.7	17.9	..	10.3	7.5
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
2014	8.6	6.9	2.1	17.0	16.1	7.7	9.2	11.4
B01AB Heparin group								
2005	2.0	1.2	..	3.2	3.1	..	3.6	3.6
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
2014	3.5	3.3	1.3	6.9	5.4	3.3	5.9	6.2
B01AC Platelet aggregation inhibitors excl. heparin								
2005	77.1	45.5	31.8	110.7	65.1	65.1	66.5	74.4
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
2014	..	66.5	32.0	87.0	64.9	71.1	76.5	70.2
B01AE Direct thrombin inhibitors								
2005	-	..	..	-	..	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
2014	3.6	2.1	4.2	1.0	0.3	2.1	2.7	1.2
B01AF Direct factor Xa inhibitors								
2005	-	..	..	..	..	..	..	..
2012	0.3	0.9	..	..	..	0.0	0.1	-
2013	1.9	4.1	..	..	..	1.0	3.7	0.9
2014	4.5	8.0	-	1.5	0.1	2.9	7.5	3.9

Figure 3.7.3 Sales of cardiovascular drugs (ATC-group C), DDD/1 000 inhabitants/day, 2005-2014

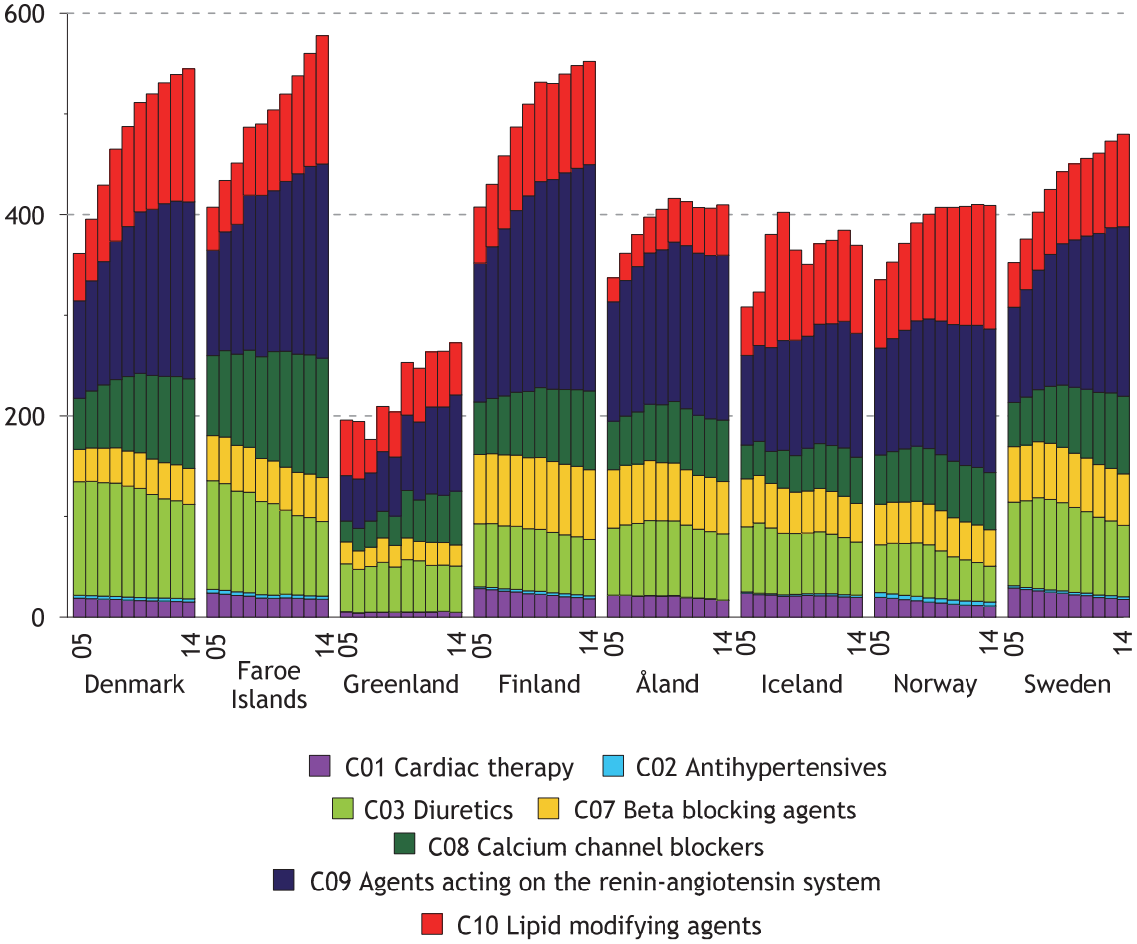


Table 3.7.8 Sales of drugs for cardiac therapy (ATC group C01), DDD/1 000 inhabitants/day, 2005-2014

	Den-mark	Faroe Islands	Green-land	Finland	Åland	Iceland	Norway	Sweden
C01 Cardiac therapy								
2005	18.8	23.9	5.3	28.3	21.6	23.7	19.6	29.0
2012	15.9	18.6	5.1	20.3	18.7	21.1	11.9	19.5
2013	15.5	18.1	5.7	19.5	18.0	20.1	11.6	18.6
2014	15.1	17.7	4.7	18.2	16.7	19.6	11.0	17.5
C01A Cardiac glycosides								
2005	6.0	3.7	1.9	6.0	5.4	3.0	4.1	5.9
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
2014	3.9	2.4	1.2	3.2	3.8	2.5	1.5	2.6
C01B Antiarrhytmics, class I and III								
2005	1.6	1.3	..	1.7	1.9	3.4	1.4	..
2012	1.6	1.2	0.5	2.0	2.5	4.0	2.0	..
2013	1.6	1.1	0.5	2.1	2.5	4.2	2.0	..
2014	1.6	1.2	0.6	2.1	2.6	4.1	2.0	1.4
C01D Vasodilators used in cardiac diseases								
2005	10.5	18.6	2.8	19.5	13.1	17.2	14.0	21.6
2012	9.1	14.0	2.6	13.6	11.5	14.4	8.2	14.8
2013	8.9	13.9	3.3	12.8	10.2	13.2	7.4	14.0
2014	8.8	13.7	2.7	12.1	9.7	12.8	7.0	13.1

Table 3.7.9 Sales of cardiovascular drugs (ATC-group C02; C03; C07; C08; C09), DDD/1 000 inhabitants/day, 2005-2014

	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
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
2014	3.1	3.1	0.1	2.9	0.3	2.3	4.0	2.8
C03 Diuretics								
2005	112.9	108.0	47.5	62.5	66.5	64.5	47.4	89.4
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
2014	94.0	74.2	46.1	56.1	65.8	52.7	35.7	70.9
C03A Low-ceiling diuretics, thiazides								
2005	49.1	53.6	29.5	5.6	4.4	8.8	9.0	19.4
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
2014	38.3	31.3	36.9	6.5	8.3	5.5	6.5	21.7
C03C High-ceiling diuretics								
2005	53.5	39.6	15.9	33.5	25.9	21.2	30.1	50.7
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
2014	48.5	35.0	7.1	37.1	30.7	22.7	23.9	36.9
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
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
2014	3.0	0.6	-	9.7	24.0	21.5	3.8	8.1
C07 Beta blocking agents								
2005	32.1	44.9	22.0	68.9	58.1	47.8	40.4	55.1
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
2014	35.7	43.9	20.8	69.4	51.9	38.3	36.1	51.1
C08 Calcium channel blockers								
2005	50.7	79.3	20.5	52.2	48.1	33.6	48.9	44.0
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
2014	89.0	118.6	53.6	78.1	61.0	45.9	56.9	77.1
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
2012	81.4	115.4	47.4	72.0	58.3	40.4	53.0	69.5
2013	83.7	116.4	46.2	74.1	56.9	43.3	54.3	73.1
2014	85.4	116.7	52.7	76.1	59.7	41.4	54.4	75.2

The table continues

Table 3.7.9 Sales of cardiovascular drugs (ATC-group C02; C03; C07; C08; C09), DDD/1 000 inhabitants/day, 2005-2014, 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
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
2014	3.6	1.9	0.9	2.0	1.3	4.5	2.5	1.9
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
2012	171.6	179.3	86.2	215.2	161.2	121.1	139.2	157.7
2013	174.3	187.3	87.7	219.9	162.1	125.7	141.1	164.0
2014	175.7	192.8	95.5	224.8	163.9	123.1	142.4	168.4
C09A ACE-inhibitors, plain								
2005	55.5	68.2	41.3	75.3	79.9	32.2	42.9	57.3
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
2014	89.4	118.8	79.8	103.8	74.1	41.3	44.4	82.6
C09B ACE-inhibitors, combinations								
2005	6.7	5.3	0.1	14.7	4.2	7.7	7.3	3.6
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
2014	18.3	15.3	-	13.9	5.3	6.1	5.8	8.7
C09C Angiotensin II antagonists								
2005	22.1	20.7	3.8	31.0	27.8	23.8	30.6	24.6
2012	39.0	41.8	11.4	64.9	58.9	35.0	48.3	49.5
2013	41.9	44.7	13.0	70.5	60.8	37.4	50.3	55.2
2014	45.0	47.4	15.4	75.5	65.3	36.9	52.3	60.4
C09D Angiotensin II antagonists, combinations								
2005	12.5	10.5	0.1	16.8	6.7	25.5	25.4	9.1
2012	20.7	9.8	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
2014	22.7	11.1	0.2	31.6	19.1	38.6	39.9	16.7
C09X Other agents acting on the rennin-angiotensin system								
2005	-	-	-	-	-	-	-	-
2012	0.4	0.3	-	-	-	0.3	-	-
2013	0.3	0.2	-	-	-	0.3	-	-
2014	0.2	0.2	-	-	-	0.2	-	-

Table 3.7.10 Sales of serum lipid modifying agents (ATC-group C10), DDD/1 000 inhabitants/day, 2005-2014

	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
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
2014	132.4	127.7	51.7	102.6	50.1	87.5	122.4	92.0
C10AA HMG CoA reductase inhibitors (statins)								
2005	46.5	42.3	55.0	53.9	23.1	87.3	67.2	47.8
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
2014	129.4	126.1	51.6	98.8	48.7	86.4	118.1	88.8
C10AX Other lipid modifying agents								
2005	0.1	0.1	-	1.0	0.3	0.5	0.6	0.9
2012	1.9	1.0	0.1	2.7	1.1	0.7	3.4	2.2
2013	2.0	1.0	0.2	3.0	1.2	0.7	3.8	2.2
2014	2.1	1.2	0.1	3.2	1.2	0.6	4.1	2.3

Table 3.7.11 Proportion of the population per 1 000 (one-year prevalence) receiving at least one serum lipid modifying agent (ATC-group C10), by age and gender, 2014

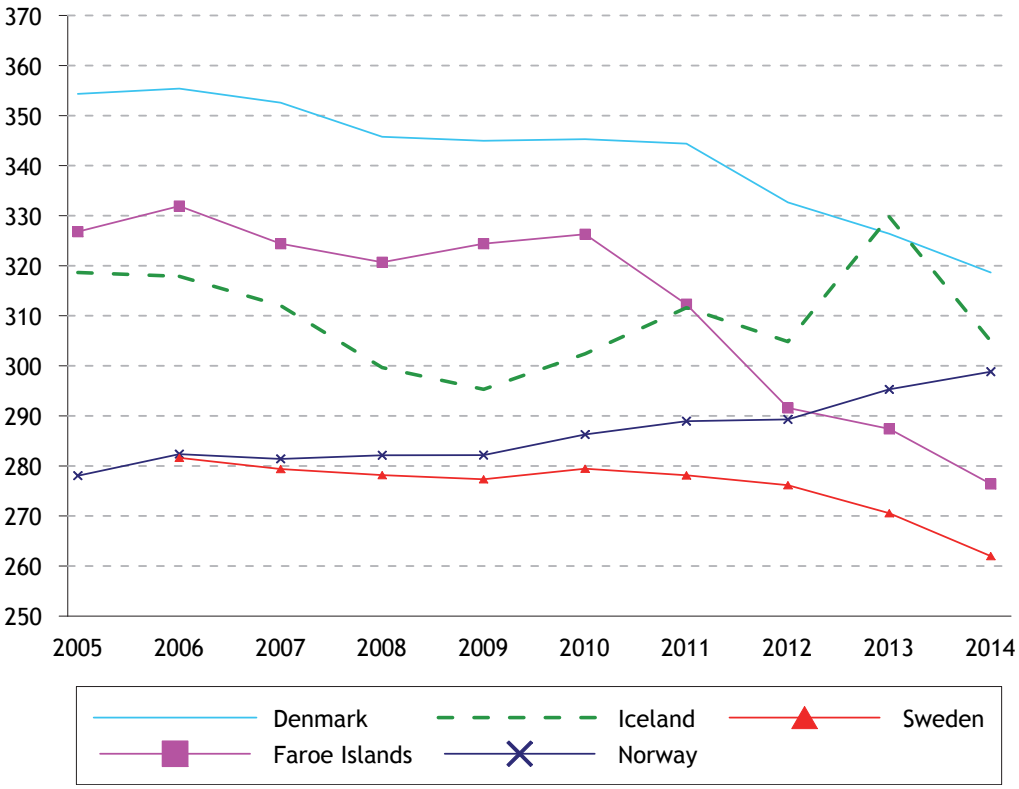
Age	Denmark		Faroe Islands		Finland		Iceland		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W
0-14	-	-	-	-	-	-	-	-	-	-	-	-
15-24	1	1	1	1	1	1	-	1	1	2	1	1
25-44	19	11	23	14	18	7	14	7	18	8	11	5
45-64	166	131	199	144	183	121	198	117	165	115	127	81
65-74	381	331	414	347	392	333	489	343	391	333	348	262
75+	429	353	467	345	466	391	519	362	434	342	418	294

Table 3.7.12 Proportion 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, 2014[1]

Age	Denmark	Faroe Islands	Iceland	Norway	Sweden
15-19	518	450	484	416	331
20-24	598	517	569	594	453
25-29	444	339	382	419	347
30-34	298	249	265	261	227
35-39	212	179	200	167	174
40-44	143	145	142	101	143
45-49	82	93	90	52	102

1 Excl. implants and G03AD

Figure 3.7.4 Proportion of women/1 000 between 15 and 49 years old (one year prevalence) receiving at least one type of hormonal contraceptive and intra-vaginal contraceptive (ATC-groups G03A and G02BB), 2005-2014



1 Excl. implants and G03AD

Table 3.7.13 Sales of estrogens (ATC group G03C) and progestogens and estrogens in combination ATC group G03F), systemically effective, DDD/1 000 women/day, 2005-2014

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
Estrogens (G03C), progestogens and estrogens in combination (G03F)								
2005	27.8	29.4	..	66.2	51.3	64.9	35.9	33.0
2012	15.4	17.9	4.9	46.7	38.5	47.1	21.3	16.5
2013	14.5	17.7	3.9	36.6	39.0	44.6	20.4	15.9
2014	14.2	19.0	4.1	42.6	38.9	42.9	21.1	15.4

Table 3.7.14 Sale of estrogens (ATC group G03C), vaginally effective, DDD/1 000 women/day 2005-2014[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
2012	12.0	13.0	2.4	19.9	22.9	32.9	9.3	17.3
2013	12.2	13.4	3.4	20.1	26.3	31.5	9.0	18.6
2014	9.5	9.5	2.9	19.7	28.6	30.3	8.7	22.0

1 Vaginal tablets, vaginal gel and vaginal insert

Table 3.7.15 Sales of drugs for urinary frequency and incontinence (ATC-group G04BD), DDD/1 000 inhabitants/day, 2005-2014

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	3.0	2.1	..	3.2	3.1	3.2	4.7	3.9
2012	5.7	5.0	0.9	5.0	3.8	7.6	8.8	5.3
2013	5.8	5.0	0.5	5.3	4.8	7.8	8.9	5.4
2014	5.8	5.1	0.5	5.5	4.9	8.0	9.4	5.7

Table 3.7.16 Sales of drugs used in erectile dysfunction (ATC-group G04BE), DDD/1 000 men/year, 2005-2014

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	821	438	256	1 460	511	1 081	943	868
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
2014	2 168	912	1 047	4 459	1 677	1 579	1 671	1 408

Table 3.7.17 Sales of antibacterials for systemic use (ATC-group J01), DDD/1 000 inhabitants/day, 2005-2014

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
J01 Antibacterials for systemic use								
2005	16.3	18.0	20.4	19.6	16.5	23.0	18.1	16.5
2012	18.2	17.1	18.7	20.1	15.9	22.3	20.9	15.5
2013	18.5	17.0	17.8	19.1	15.6	21.7	19.6	14.7
2014	17.9	16.5	16.0	19.0	15.5	21.2	19.2	14.1
J01A Tetracyclines								
2005	1.3	1.2	3.1	4.2	3.4	5.4	3.1	3.5
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
2014	1.7	1.7	0.9	4.3	3.8	4.5	3.4	2.9
J01C Beta-lactam antibacterials, penicillins								
2005	10.1	11.5	11.8	6.3	7.9	11.8	7.6	7.3
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
2014	11.7	9.4	10.4	7.0	7.6	11.2	8.1	7.2
J01CA Penicillins with extended spectrum								
2005	3.2	3.0	4.0	3.4	5.0	4.3	2.5	1.6
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
2014	3.9	1.8	3.8	4.0	4.4	3.3	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
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
2014	4.6	5.6	4.0	1.4	1.6	2.2	3.8	3.4
J01CF Beta-lactamase resistant penicillins								
2005	1.2	1.2	0.9	0.1	0.4	1.4	0.5	1.4
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
2014	1.6	1.4	1.5	0.1	0.8	1.2	0.8	1.9

The table continues

Table 3.7.17 Sales of antibacterials for systemic use (ATC-group J01), DDD/1 000 inhabitants/day, 2005-2014, 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	-	0.2
2012	1.3	0.5	0.8	1.6	0.8	4.1	-	0.3
2013	1.5	0.6	1.0	1.4	0.9	4.3	-	0.3
2014	1.6	0.7	1.0	1.5	0.8	4.5	0.1	0.4
J01D Other betalactam anti-bacterials and cephalosporins								
2005	0.3	0.5	1.0	3.1	1.7	0.5	0.6	0.7
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
2014	0.4	0.6	0.4	3.2	1.1	0.7	0.5	0.3
J01E Sulphonamides and Trimethoprim								
2005	0.9	1.0	0.6	1.9	1.0	1.9	1.1	0.9
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
2014	0.9	1.7	0.6	1.3	0.7	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
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
2014	1.9	1.5	2.5	1.3	0.7	1.7	1.7	0.6
J01M Quinolone anti-bacterials								
2005	0.5	0.3	0.2	1.3	1.1	0.8	0.6	1.2
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
2014	0.7	0.6	0.6	1.2	0.9	1.0	0.6	0.9
J01X[1] Other Anti-bacterials								
2005	0.9	1.3	0.8	0.7	0.3	0.7	3.0	2.2
2012	0.9	1.0	0.5	0.7	0.6	1.0	4.0	1.7
2013	0.9	0.9	0.6	0.7	0.5	1.1	4.1	1.7
2014	0.9	1.1	0.7	0.7	0.7	1.2	4.1	1.7

1 Including J01XX05 metenamin, antiseptic used for long-term prophylactic treatment of urinary tract infection

Figure 3.7.5 Sales of antibacterials for systemic use (ATC-group J01), DDD/1 000 inhabitants/day, 2005-2014[1]

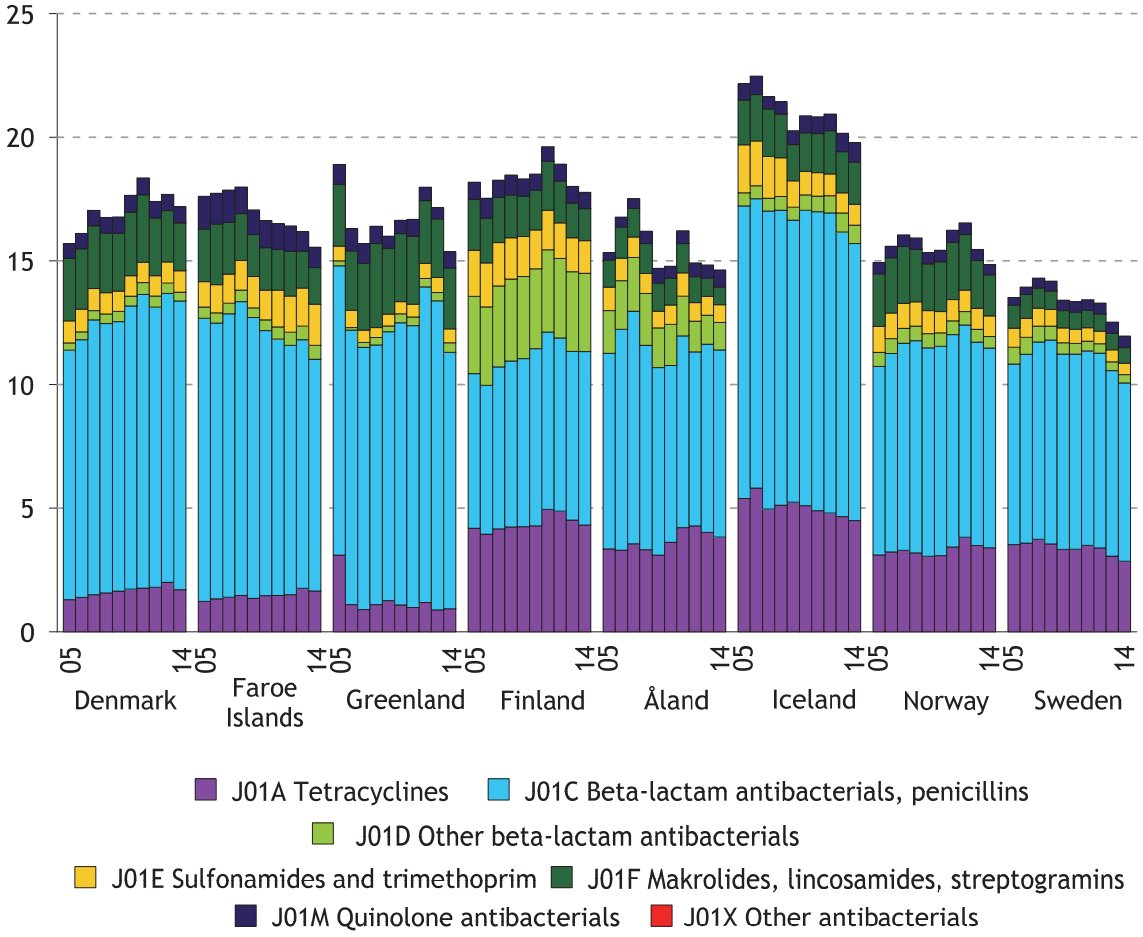


Figure 3.7.6 Sales of penicillins (ATC-group J01C), DDD/1 000 inhabitants/day, 2005-2014

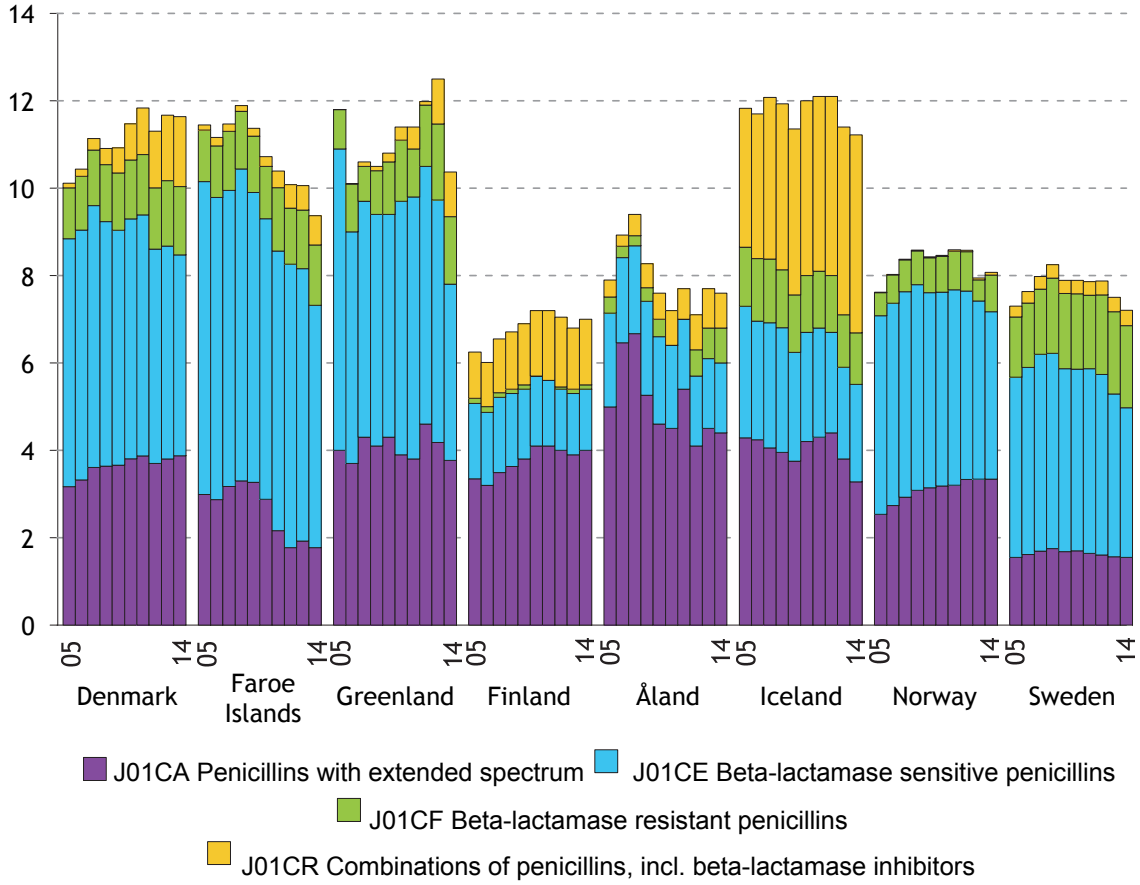


Table 3.7.18 Proportion of the population per 1 000 (one-year prevalence) receiving at least one penicillin (ATC-group J01C) by age and gender, 2014

	Denmark		Faroe Islands		Finland		Iceland		Norway		Sweden	
Age	M	W	M	W	M	W	M	W	M	W	M	W
0-14	202	205	184	169	242	228	262	270	117	119	154	148
15-24	123	242	149	222	116	211	176	289	88	190	79	150
25-44	152	259	169	244	125	204	184	280	101	189	85	153
45-64	182	243	177	214	120	184	207	289	115	180	97	148
65-74	240	274	223	245	121	177	237	323	161	218	131	180
75+	329	360	270	255	141	226	232	273	212	254	176	220

Table 3.7.19 Sales of antimycotics for systemic use (ATC group J02A), DDD/1 000 inhabitants/day, 2005-2014

	Denmark	Faroe Islands	Green-land	Finland	Åland	Iceland	Norway	Sweden
J02 Antimycotics								
2005	0.5	0.5	0.3	0.4	0.4	0.4	0.2	0.2
2012	0.7	0.6	0.2	0.5	0.4	0.4	0.3	0.3
2013	0.7	0.5	0.3	0.5	0.4	0.5	0.3	0.3
2014	0.7	0.5	0.3	0.5	0.3	0.5	0.2	0.3

Table 3.7.20 Sales of antivirals for systemic use (ATC group J05), DDD/1 000 inhabitants/day, 2005-2014

	Denmark	Faroe Islands	Green-land	Finland	Åland	Iceland	Norway	Sweden
J05 Antivirals								
2005	1.3	0.2	1.9	0.7	0.3	0.9	0.9	1.1
2012	2.0	0.5	1.5	1.0	0.4	1.1	1.3	1.5
2013	2.0	0.6	1.5	1.1	0.4	1.1	1.4	1.5
2014	2.1	0.5	1.4	1.1	0.5	1.0	1.4	1.6

Table 3.7.21 Sales of antineoplastic agents (ATC-group L01), Euro at 2014 prices, 2005-2014

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
L01 Antineoplastic agents								
2005	21 419	7 971	..	16 721	29 937	..	16 464	15 374
2012	38 739	22 895	..	30 854	34 908	..	27 875	26 142
2013	43 650	19 230	..	31 456	37 081	..	29 663	29 310
2014	50 798	19 249	14 239	32 483	40 933	..	31 137	29 129

Table 3.7.22 Sales of immunomodulating agents (ATC-group L02, L03, L04), DDD/1 000 inhabitants/day, 2005-2014

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
L02 Endocrine therapy								
2005	4.3	2.5	..	4.7	6.1	4.8	5.0	5.8
2012	6.5	4.8	..	6.7	6.1	5.5	6.0	7.6
2013	6.7	5.5	..	7.0	6.1	5.9	6.2	7.9
2014	6.8	5.2	..	7.0	5.6	5.0	6.0	8.3
L03 Immunostimulants								
2005	0.8	0.3	..	0.9	0.5	1.1	0.8	1.0
2012	1.3	0.8	..	1.4	0.7	0.8	0.9	0.9
2013	1.3	0.8	..	1.2	0.5	0.8	0.9	0.8
2014	1.1	0.7	..	1.1	0.6	0.7	0.7	0.7
L04 Immunosuppressants								
2005	4.4	4.0	..	5.2	7.5	4.5	5.1	4.8
2012	8.1	8.5	..	8.5	9.5	8.9	9.3	8.5
2013	8.6	9.1	..	8.9	9.8	9.5	9.8	9.0
2014	9.1	9.8	..	9.8	9.7	10.2	10.6	9.4
L04AB Tumour necrosis factor alpha (TNF-α) inhibitors								
2005	0.6	0.7	..	0.6	2.5	..	1.3	0.9
2012	2.1	3.0	..	1.8	3.7	3.1	3.0	2.2
2013	2.3	3.4	..	2.0	4.0	3.5	3.3	2.4
2014	2.5	4.0	..	2.2	3.6	3.9	3.7	2.6

Table 3.7.23 Sales of analgesics (ATC-groups M01A, N02A and N02B), DDD/1 000 inhabitants/day, 2005-2014

	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
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	53.6
2014	..	33.9	19.9	78.8	53.6	74.6	45.9	52.1
N02A Opioids								
2005	18.5	6.9	4.5	15.1	9.1	17.4	19.5	20.8
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
2014	20.4	8.2	7.3	15.9	9.8	20.4	18.9	17.7
N02B Other analgesics and antipyretics								
2005	71.2	54.7	44.3	20.6	36.3	30.9	29.8	49.5
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	55.7
2014	..	51.6	46.1	35.1	43.2	38.8	37.9	58.5
N02BA Salicylic acid and derivatives								
2005	12.9	14.3	0.8	5.5	9.9	3.5	0.5	9.8
2012	8.3	9.7	0.1	3.0	7.5	3.0	0.2	4.9
2013	7.5	8.4	0.1	2.6	6.9	3.3	0.2	7.5
2014	..	7.2	0.1	2.4	6.9	3.3	0.2	10.3
N02BB Pyrazolones								
2005	0.6	-	-	-	-	-	3.2	0.1
2012	0.3	-	-	-	-	-	1.9	0.1
2013	0.2	-	-	-	-	-	1.8	0.1
2014	..	-	..	-	-	-	1.6	0.1
N02BE Anilides								
2005	57.7	40.3	24.6	15.1	26.4	27.4	26.0	39.7
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	48 1
2014	..	44.5	46.0	32.7	36.3	35.5	36.0	48.2

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, 2005-2014

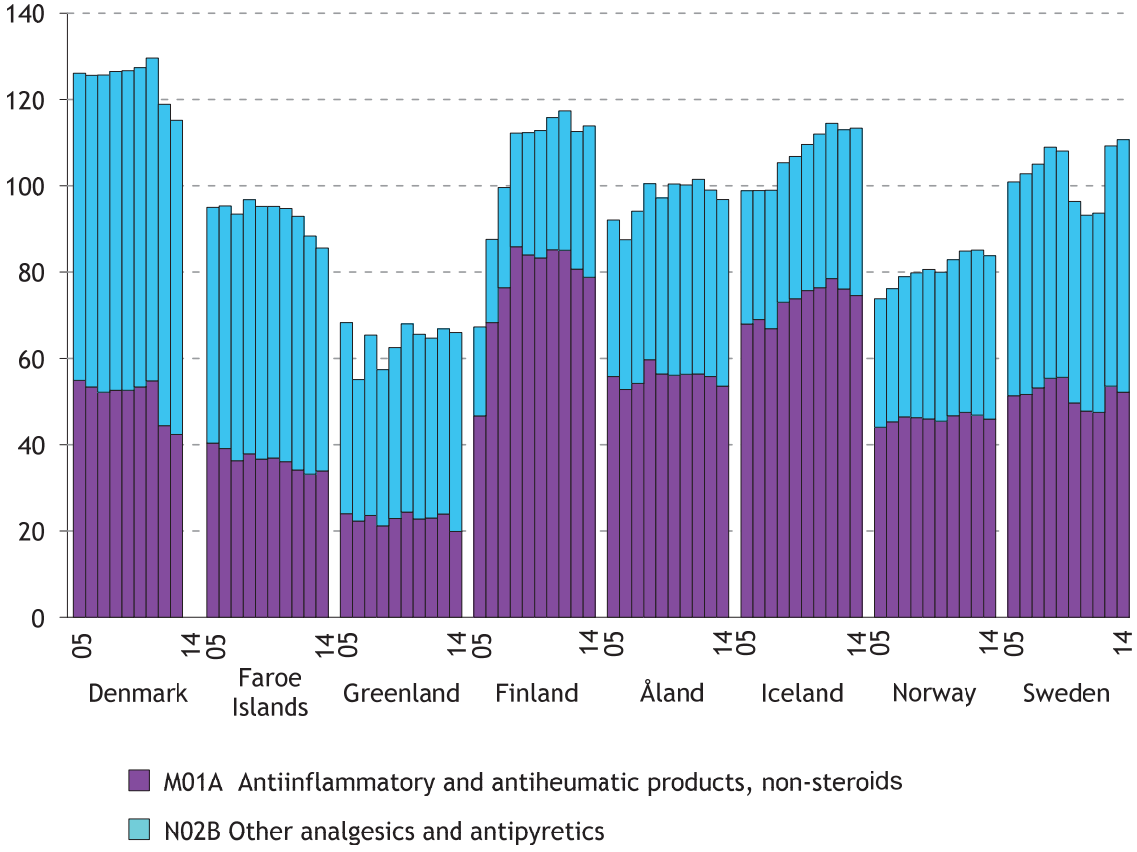


Figure 3.7.8 Sales of opioid analgesics (ATC-group N02A), DDD/1 000 inhabit-ants/day, 2005-2014

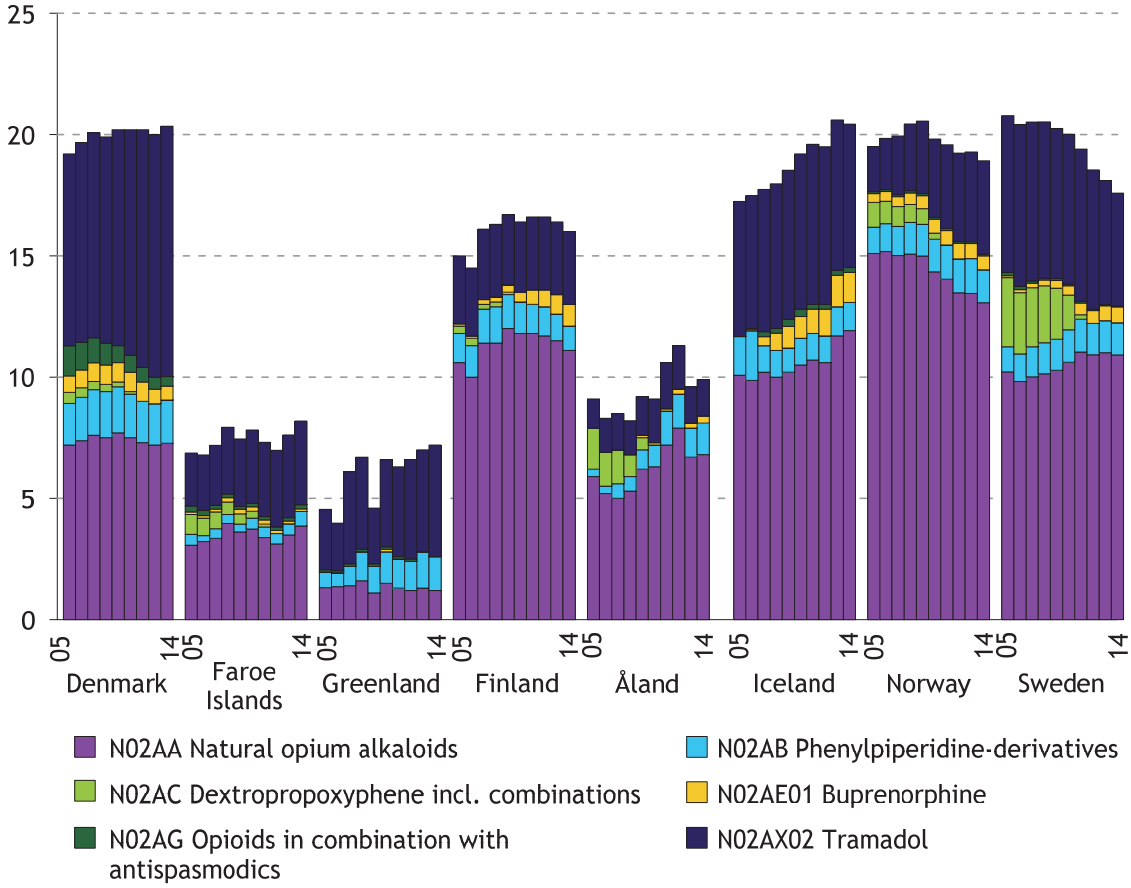


Table 3.7.24 Sales of antimigraine preparations (ATC-group N02C), DDD/1 000 inhabitants/day, 2005-2014

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	2.5	2.1	..	1.1	2.0	1.5	3.2	3.1
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
2014	3.1	2.3	1.5	2.0	1.9	1.8	3.8	2.9

Table 3.7.25 Sales of antiepileptics (ATC-group N03), DDD/1 000 inhabitants/day, 2005-2014

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	11.6	9.0	..	12.5	8.4	11.9	10.2	9.1
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
2014	18.0	14.5	10.9	19.9	12.5	19.1	15.7	14.4

Table 3.7.26 Sales of anti-parkinson drugs (ATC-group N04), DDD/1 000 inhabitants/day, 2005-2014

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	3.5	5.0	..	4.5	2.9	4.1	3.0	3.7
2012	4.3	4.4	3.0	4.9	3.7	4.6	3.8	4.0
2013	4.4	4.3	3.0	4.7	3.8	4.7	3.8	4.0
2014	4.4	4.6	3.1	5.2	3.8	4.3	3.8	4.0

Table 3.7.27 Sales of antipsychotics (ATC-group N05A), DDD/1 000 inhabitants/day, 2005-2014

	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
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
2014	14.1	13.0	15.4	21.8	9.6	12.4	10.9	10.4

Table 3.7.28 Sales of anxiolytics (ATC-group N05B), DDD/1 000 inhabitants/day, 2005-2014

	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
2012	10.3	10.3	2.4	25.6	10.9	23.4	17.2	15.6
2013	9.6	10.2	2.3	24.3	10.5	23.2	16.4	15.4
2014	9.0	10.1	2.5	23.0	11.1	22.2	15.5	15.0
N05BA Benzodiazepine derivates								
2005	19.6	17.0	5.3	29.5	8.0	24.6	20.1	13.6
2012	10.0	10.0	2.4	23.9	8.4	21.8	15.6	12.1
2013	9.3	9.9	2.3	22.4	7.9	21.6	14.8	11.7
2014	8.7	9.9	2.5	21.1	8.3	20.6	14.0	11.2

Table 3.7.29 Sales of hypnotics and sedatives (ATC-group N05C), DDD/1 000 inhabitants/day, 2005-2014[1]

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N05C Hypnotics and sedatives								
2005	31.4	30.5	8.8	54.4	34.2	66.7	41.4	51.6
2012	18.0	19.2	6.2	42.0	34.0	74.0	39.0	52.6
2013	16.7	18.2	5.7	39.2	33.8	71.8	39.0	52.5
2014	16.3	17.5	4.6	36.1	35.0	69.5	38.1	51.8
N05CD Benzodiazepine derivates								
2005	10.5	7.1	0.5	20.9	4.3	12.1	8.5	6.7
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
2014	2.5	2.4	0.1	10.7	3.2	5.3	3.3	2.7
N05CF Benzodiazepine-related drugs								
2005	20.9	23.4	8.3	33.1	29.3	54.5	32.8	30.4
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
2014	13.7	15.1	4.5	25.1	31.4	60.9	34.7	36.0

1 Sales excluding melatonin (N05CH01)

Figure 3.7.9 Sales of hypnotics and sedatives (ATC groups N05CD and N05CF), DDD/1000 inhabitants/day, 2005-2014

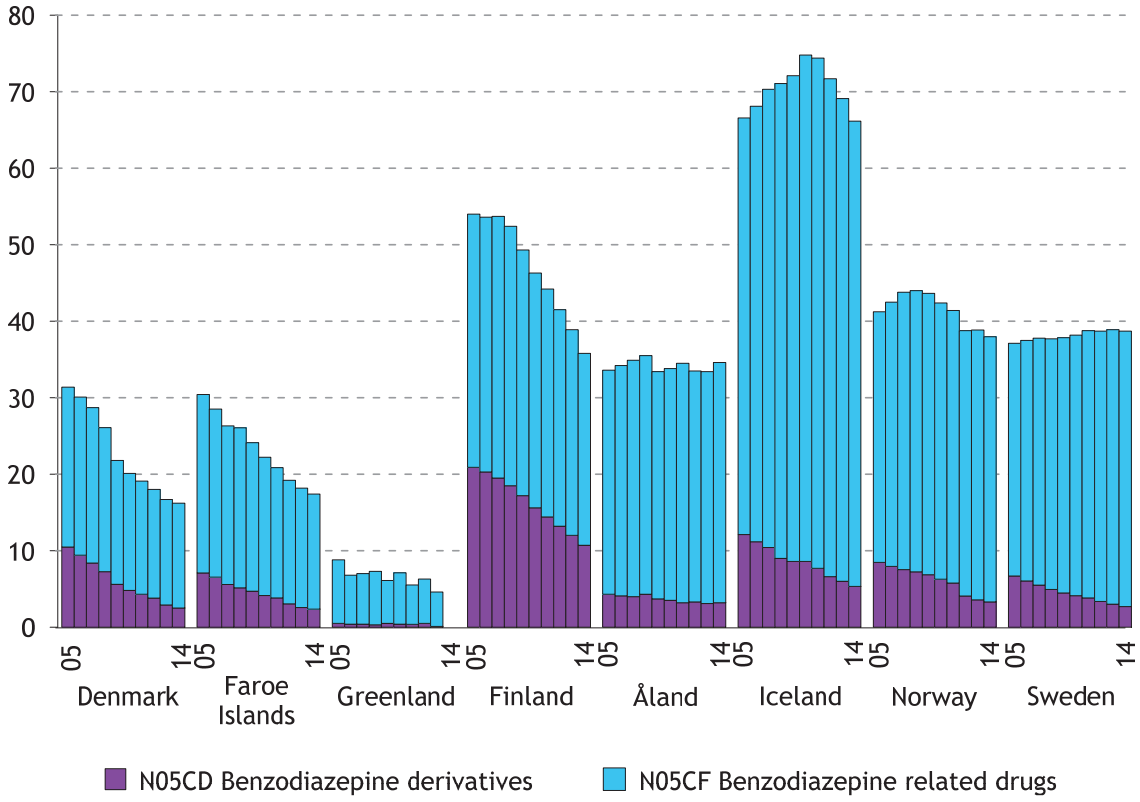


Table 3.7.30 Sales of antidepressants (ATC-group N06A), DDD/1 000 inhabitants/day, 2005-2014

	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
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
2014	76.7	61.8	23.3	68.8	61.0	118.0	55.7	87.8
N06AA Non-selective monoamine reuptake inhibitors								
2005	4.3	2.1	1.1	4.2	3.2	8.1	3.8	3.8
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
2014	4.5	1.7	1.1	4.2	3.2	5.5	3.5	3.3
N06AB Selective serotonin reuptake inhibitors								
2005	41.7	26.4	16.0	35.3	30.4	64.8	34.8	48.4
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
2014	47.5	43.3	15.7	40.8	39.9	86.1	36.4	59.8
N06AG Monoamine oxidase type A inhibitors								
2005	0.1	-	-	0.7	0.2	0.8	0.3	0.2
2012	-	-	-	0.5	0.1	0.4	0.2	0.1
2013	-	-	-	0.4	0.1	0.4	0.1	0.1
2014	-	-	-	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
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
2014	24.5	16.8	6.6	23.4	17.8	26.1	15.7	24.7

Figure 3.7.10 Sales of antidepressants (ATC-group N06A), DDD/1 000 inhabitants/day, 2005-2014

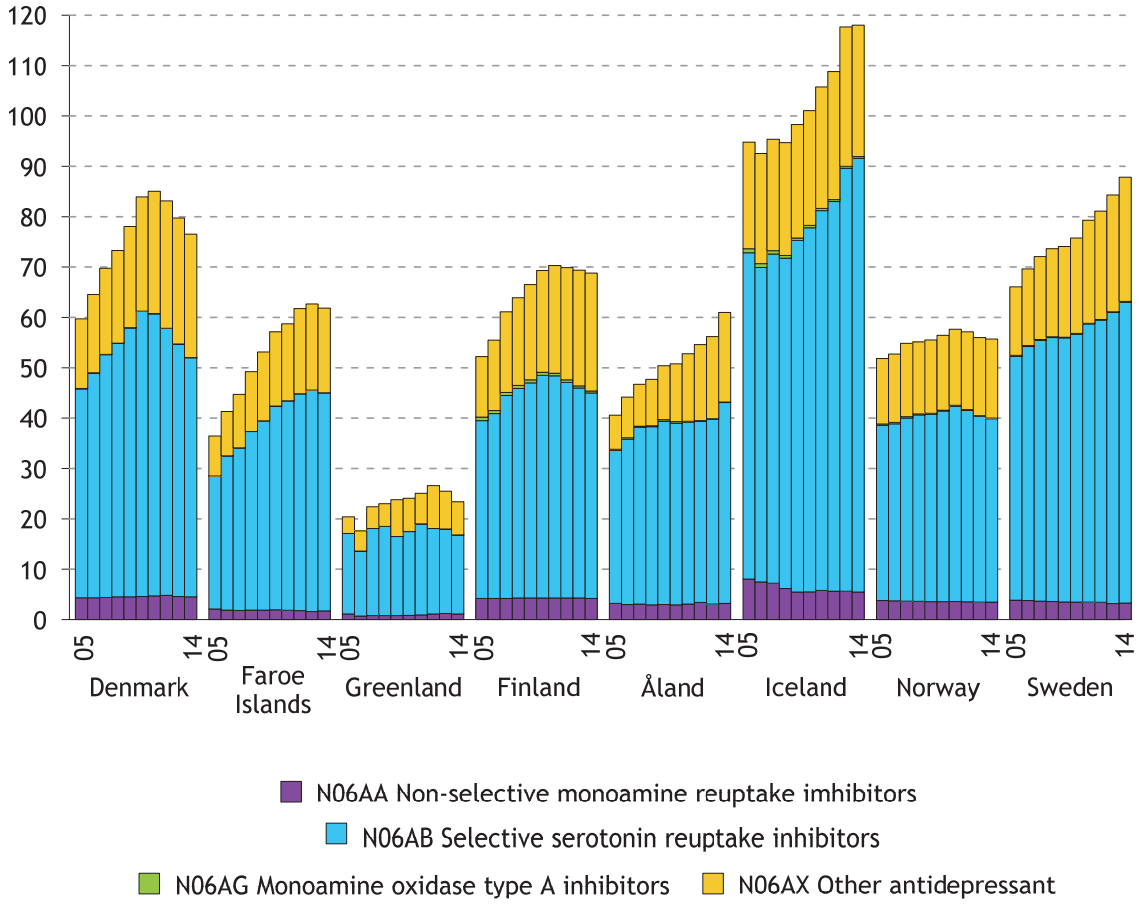


Table 3.7.31 Proportion of the population per 1 000 (one-year prevalence) receiving at least one antidepressant (ATC-group N06A) by age and gender, 2014

	Denmark		Faroe Islands		Finland		Iceland		Norway		Sweden	
Age	M	W	M	W	M	W	M	W	M	W	M	W
0-14	1	1	1	2	2	2	23	21	1	1	2	2
15-24	21	46	27	60	34	67	75	136	19	39	34	65
25-44	54	93	42	74	69	105	101	178	44	76	64	122
45-64	75	125	51	99	78	126	120	229	63	120	82	155
65-74	83	131	75	127	70	108	155	273	66	131	86	155
75+	136	214	135	242	110	170	187	286	85	154	151	247

Table 3.7.32 Proportion of the population per 1 000 (one-year prevalence) receiving at least one centrally acting sympathomimetic (ATC group N06BA[1]) by gender and age, 2014

	Men	Women	Total
Denmark			
0-4	0.1	-	-
5-9	12.7	3.7	8.3
10-14	33.5	10.9	22.5
15-19	26.3	15.2	20.9
20-24	15.7	11.7	13.8
25-29	12.9	9.4	11.2
30-39	9.4	7.8	8.6
Faroe Islands			
0-4	1.2	-	0.6
5-9	11.1	2.9	7.1
10-14	22.3	8.0	15.4
15-19	18.3	19.2	18.8
20-24	13.3	12.3	12.9
25-29	6.2	5.7	6.0
30-39	4.8	4.9	4.8
Finland			
0-4	0.2	0.1	0.1
5-9	23.4	4.8	14.3
10-14	33.1	6.4	20.1
15-19	11.0	4.2	7.7
20-24	12.6	4.7	8.7
25-29	3.7	2.3	3.0
30-39	2.7	2.1	2.4
Iceland			
0-4	0.9	0.4	0.7
5-9	64.8	22.3	44.2
10-14	127.0	50.1	89.0
15-19	72.0	43.7	58.2
20-24	33.3	25.6	29.5
25-29	28.2	26.2	27.2
30-39	27.4	27.9	14.1
Norway			
0-4	-		-
5-9	11.6	3.7	7.7
10-14	39.4	14.8	27.4
15-19	29.0	16.0	22.7
20-24	12.3	11.5	11.9
25-29	9.0	9.2	9.1
30-39	7.2	7.1	7.1
Sweden			
0-4	0.1	-	0.1
5-9	14.0	4.3	9.3
10-14	51.9	17.7	35.3
15-19	40.4	24.8	32.9
20-24	15.2	14.8	15.0
25-29	12.1	11.3	11.7
30-39	9.7	8.4	9.1

1 Excl. N06BA07

Table 3.7.33 Proportion of the population 0-39 (one-year prevalence) receiving at least one centrally acting sympathomimetic (ATC group N06BA[1]), 2005- 2014

	Denmark	Faroe Islands	Finland	Iceland	Norway	Sweden
2005	2	1	..	10	6	..
2012	12	7	14	19	10	12
2013	12	8	15	22	11	13
2014	12	9	..	23	12	15

1 Excl. N06BA07

Table 3.7.34 Sales of anti-dementia drugs (ATC-group N06D), DDD/1 000 inhabitants/day, 2005-2014

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	2.0	1.1	0.1	6.5	2.5	2.7	3.1	3.0
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
2014	3.7	4.9	0.4	15.6	3.8	3.6	2.9	4.5

Table 3.7.35 Sales of drugs for obstructive airway diseases (ATC group R03), DDD/1 000 inhabitants/day, 2005-2014

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
R03 Drugs for obstructive airway diseases								
2005	60.1	38.1	37.4	51.8	50.6	45.0	61.0	50.4
2012	59.0	35.2	33.9	64.2	52.9	42.8	63.2	49.6
2013	58.3	35.6	31.7	65.6	55.0	42.2	63.5	50.6
2014	58.6	36.9	34.7	69.2	54.8	41.6	63.6	52.4
R03A Adrenergics, inhalants								
2005	36.8	21.4	17.6	28.4	28.7	31.2	36.5	27.4
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
2014	35.8	20.7	16.3	37.1	33.6	27.6	37.7	28.9
R03AC Selective beta-2-adrenoceptor agonists								
2005	22.3	18.3	17.1	11.3	9.4	13.2	18.0	16.5
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
2014	18.4	11.4	13.4	13.8	9.0	13.8	16.5	13.9
R03AK Adrenergics comb. w. corticosteroids/other drugs, ex. anticholin-ergics								
2005	14.5	2.9	0.5	15.2	13.3	18.0	18.6	10.9
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
2014	15.7	8.7	2.7	22.4	18.5	13.8	20.7	14.5
R03B Other drugs for ob-structive airway dis-eases. inhalants								
2005	20.1	15.5	18.0	17.3	16.4	11.3	18.5	19.6
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
2014	19.7	15.3	17.4	23.9	15.6	12.4	20.1	19.9
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
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
2014	3.2	0.7	0.7	8.1	5.5	1.5	5.7	3.3

Figure 3.7.11 Sales of drugs for obstructive airway diseases (ATC-Group R03), DDD/1 000 inhabitants/day, 2005-2014

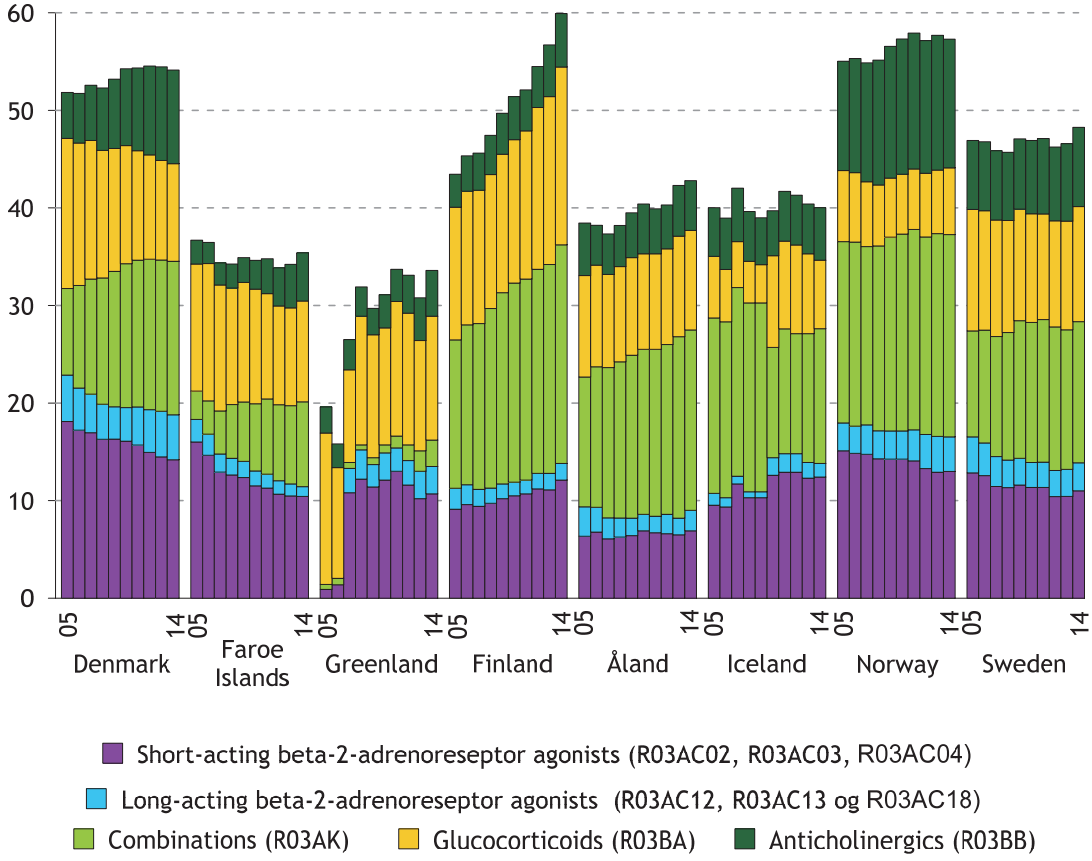


Table 3.7.36 Proportion of the population per 1 000 (one-year prevalence) receiving at least one inhalant for obstructive airway diseases (ATS-groups R03A and R03B) by age and gender, 2014

	Denmark		Faroe Islands		Finland		Iceland		Norway		Sweden	
Age	M	W	M	W	M	W	M	W	M	W	M	W
0-14	83	59	98	73	110	74	160	127	88	63	87	60
15-24	40	48	45	61	63	78	53	80	44	56	46	58
25-44	47	55	38	58	66	102	62	95	45	61	49	67
45-64	68	92	50	74	86	132	97	171	72	105	66	100
65-74	106	130	84	126	117	146	118	273	122	153	96	142
75+	160	153	95	113	154	150	195	224	144	129	132	142

Table 3.7.37 Sales of antihistamines (ATC-group R06A), DDD/1 000 inhabitants/day, 2005-2014

	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
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
2014	..	35.4	17.7	54.0	37.6	50.2	68.2	47.0

Chapter 4

Mortality and Causes of Death

Extra material

Nowbase.org - Background tables for Health Statistics

Coding practice and comparability

Differences in national coding practices is an important factor for comparability between countries of causes of death.

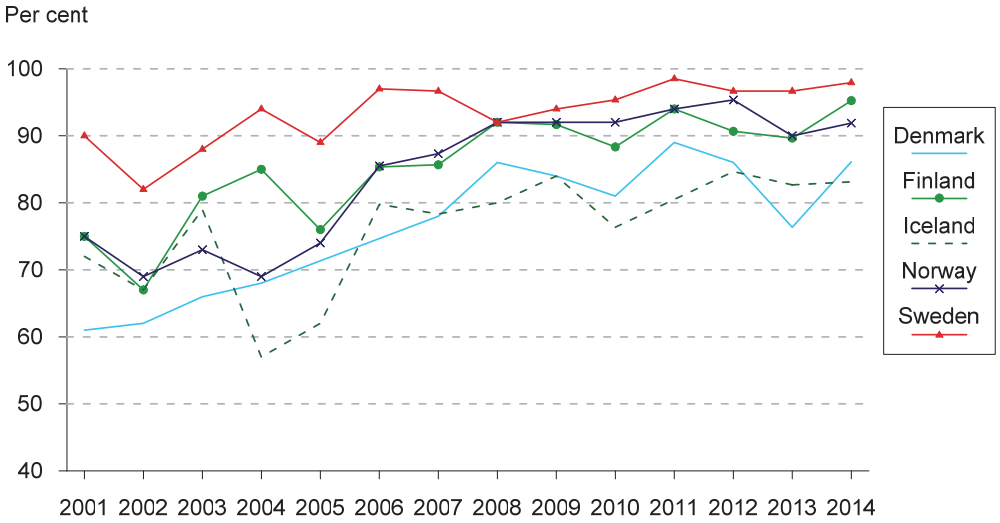
What is shown in statistics is the underlying cause of death. WHO has drawn up guidelines for the choice of underlying cause of death, i.e. the disease or injury that initiated the chain of morbid events leading directly to death, or the circumstances of the accident or violence that produced the fatal injury. The problem for comparability in some cases is that, 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 cause 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).

Several other factors also influence comparability, such as the type of information the statistician has access to and the quality of the material (death certificates, etc.).

In order to aid the choice of 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 from the data year 2002, Iceland has used ACME for a few years to check manual coding, and Norway and Finland have used ACME 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 manual coding, but it does give more consistency in the coding and thus contributes to better comparability between 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 between 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 decreasing autopsy rates (in 2013, the Danish rate was the lowest at 4 per cent, and the Finnish rate was the highest at 24 per cent). Autopsy rates have been more than halved in the Nordic countries over the last few decades. Studies have shown that in about 30 per cent of cases, the result of the autopsy has caused the underlying cause of death to be altered.

The reliability of the statistics

Considering the reservations in relation to the comparability of causes of death over-time and between 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 age and gender per 100 000 inhabitants, 2000-2013

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
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
2013	938	933	332	367	11	7	32	16	367	224	4 463	4 138
Faroe Islands												
2004-08	821	729	11	11	2	3	6	2	177	72	625	640
2009-13	1 000	873	6	7	4	5	5	5	184	99	801	757
Greenland												
2004-08	1 308	953	33	25	22	33	90	31	550	320	613	555
2009-13	1 259	946	19	11	14	11	79	37	515	290	632	594
Finland												
2000	952	954	424	324	14	14	96	34	504	222	5 545	4 606
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
2013	959	935	184	152	10	9	58	26	424	199	4 355	3 842
Åland												
2004-08	916	987	134	148	18	47	38	14	299	169	4 960	4 696
2009-13	973	962	-	145	-	10	48	40	330	169	4 584	4 321
Iceland												
2000	644	653	456	141	13	10	120	43	272	187	4 591	4 317
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
2013	672	659	94	273	13	10	41	22	227	154	4 462	4 080
Norway												
2000	974	985	427	329	18	15	93	33	339	201	6 052	4 965
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
2013	788	845	258	231	8	8	55	34	271	172	4 522	4 227
Sweden												
2000	1 041	1 065	399	281	15	12	59	24	305	200	5 829	4 854
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
2013	913	972	292	253	10	7	48	21	260	169	4 360	4 204

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

Table 4.1.2a Death rates from malignant neoplasms (ICD10, C00-C97) per 100 000 men by age, 2000-2013

		Denmark	Faroe Islands [1,2,3,4]	Greenland [2,3,4]	Finland	Åland [2,3,4]	Iceland	Norway	Sweden
Age									
0-14	2000	3	..	..	2	..	3	3	3
	2010	1	-	6	3	-	3	3	2
	2012	2	-	6	2	-	..	2	3
	2013	1	-	6	2	-	..	1	2
15-34	2000	9	..	..	6	..	7	7	8
	2010	5	7	7	6	6	6	5	5
	2012	5	3	9	7	6	..	3	6
	2013	3	3	9	8	6	..	6	5
35-44	2000	33	..	.	22	..	38	32	20
	2010	23	27	47	19	10	18	16	19
	2012	21	23	48	18	10	..	18	19
	2013	21	23	46	21	10	..	19	18
45-54	2000	148	..	..	107	170	100	120	97
	2010	110	78	133	84	42	78	77	63
	2012	98	65	163	79	62	..	74	64
	2013	89	76	177	66	93	..	66	62
55-64	2000	462	..	..	320	..	227	348	294
	2010	385	314	596	316	342	256	300	260
	2012	365	282	568	276	278	..	289	238
	2013	365	261	563	268	270	..	277	241
65-74	2000	1 189	..	..	902	..	900	953	826
	2010	970	928	1 868	747	940	766	850	678
	2012	926	855	1 579	761	817	..	730	649
	2013	873	802	1 417	750	949	..	720	649
75+	2000	2 440	..	..	1 947	..	1 888	2 142	1 935
	2010	2 298	2 077	3 109	1 780	1 890	2 021	2 231	1 920
	2012	2 232	2 119	2 550	1 677	2 131	..	2 174	1 920
	2013	2 149	2 066	2 642	1 682	2 038	..	2 047	1 850

1 2010 = 2007-10
2 2010 = 2006-10
3 2012 = 2008-12
4 2013 = 2009-13

Source: the national central statistical bureaus

Table 4.1.2b Death rates from malignant neoplasms (ICD10 C00-C97) per 100 000 women, by age, 2000-2013

		Denmark	Faroe Islands [1,2,3,4]	Greenland [2,3,4]	Finland	Åland [2,3,4]	Iceland	Norway	Sweden
Age									
0-14	2000	2	..	..	2	..	3	4	3
	2010	1	5	3	3	18	3	1	2
	2012	1	12	-	2	18	..	4	2
	2013	2	4	-	2	9	..	2	2
15-34	2000	9	..	..	7	..	2	6	9
	2010	7	4	18	4	-	-	7	5
	2012	7	4	12	6	-	..	5	5
	2013	6	4	10	6	7		4	4
35-44	2000	41	..	..	36	..	19	39	21
	2010	36	-	50	30	21	38	27	24
	2012	29	6	42	28	42	..	28	26
	2013	30	13	50	28	42	..	30	28
45-54	2000	164	..	..	106	..	113	126	94
	2010	130	68	203	89	61	79	97	85
	2012	116	71	206	79	70	..	88	87
	2013	100	77	190	82	59	..	84	85
55-64	2000	425	..	..	237	..	396	319	296
	2010	342	314	644	223	249	259	286	258
	2012	312	328	615	212	249	..	248	230
	2013	299	286	583	209	238	..	249	234
65-74	2000	905	..	..	505	..	775	600	719
	2010	714	447	1 552	477	605	612	583	547
	2012	702	510	1 589	487	599	..	573	536
	2013	631	588	1 474	465	527	..	536	543
75+	2000	1 460	..	..	1 077	..	1 285	1 184	1 210
	2010	1 485	1 180	1 457	1 023	1 259	1 262	1 252	1 148
	2012	1 477	1 217	1 806	999	1 359	..	1 230	1 202
	2013	1 454	1 080	1 890	1 018	1 282	..	1 179	1 192

1 2010 = 2007-10
2 2010 = 2006-10
3 2012 = 2008-12
4 2013 = 2009-13

Source: the national central statistical bureaus

Table 4.1.3a Death rates from circulatory diseases (ICD10, I00-I99) per 100 000 men, by age, 2000-2013

		Denmark	Faroe Islands [1,2,3,4]	Greenland [2,3,4]	Finland	Åland[2,3,4]	Iceland	Norway	Sweden
Age									
0-34	2000	3	..	6	5	..	3	3	3
	2010	2	2	5	4	-	1	2	2
	2012	2	2	5	3	-	..	3	2
	2013	2	3	4	3	-	..	3	3
35-44	2000	23	..	51	44	..	38	25	21
	2010	22	20	47	28	10	-	23	13
	2012	16	11	61	28	10	..	17	17
	2013	11	17	51	25	21	..	15	14
45-54	2000	95	..	179	184	..	113	93	104
	2010	64	47	88	117	63	73	65	63
	2012	55	59	106	105	62	..	57	59
	2013	58	64	100	92	62	..	50	62
55-64	2000	326	..	473	481	..	209	282	303
	2010	197	216	373	385	171	163	187	217
	2012	180	174	341	327	179	..	182	196
	2013	262	140	361	323	180	..	152	195
65-74	2000	1 095	..	1 049	1 378	..	877	1 065	1 101
	2010	557	663	1 552	897	701	582	526	592
	2012	466	586	1 382	804	788	..	463	557
	2013	450	544	1 316	770	800	..	445	536
75+	2000	4 467	..	5 058	4 766	..	3 963	4 681	4 851
	2010	2 948	3 654	4 363	3 808	3 939	3 879	3 148	3 946
	2012	2 598	3 135	4 235	3 633	3 413	..	3 020	3 731
	2013	2 437	2 993	3 984	3 423	3 418	..	2 805	3 476

1 2010 = 2007-10
2 2010 = 2006-10
3 2012 = 2008-12
4 2013 = 2009-13

Source: the national central statistical bureaus

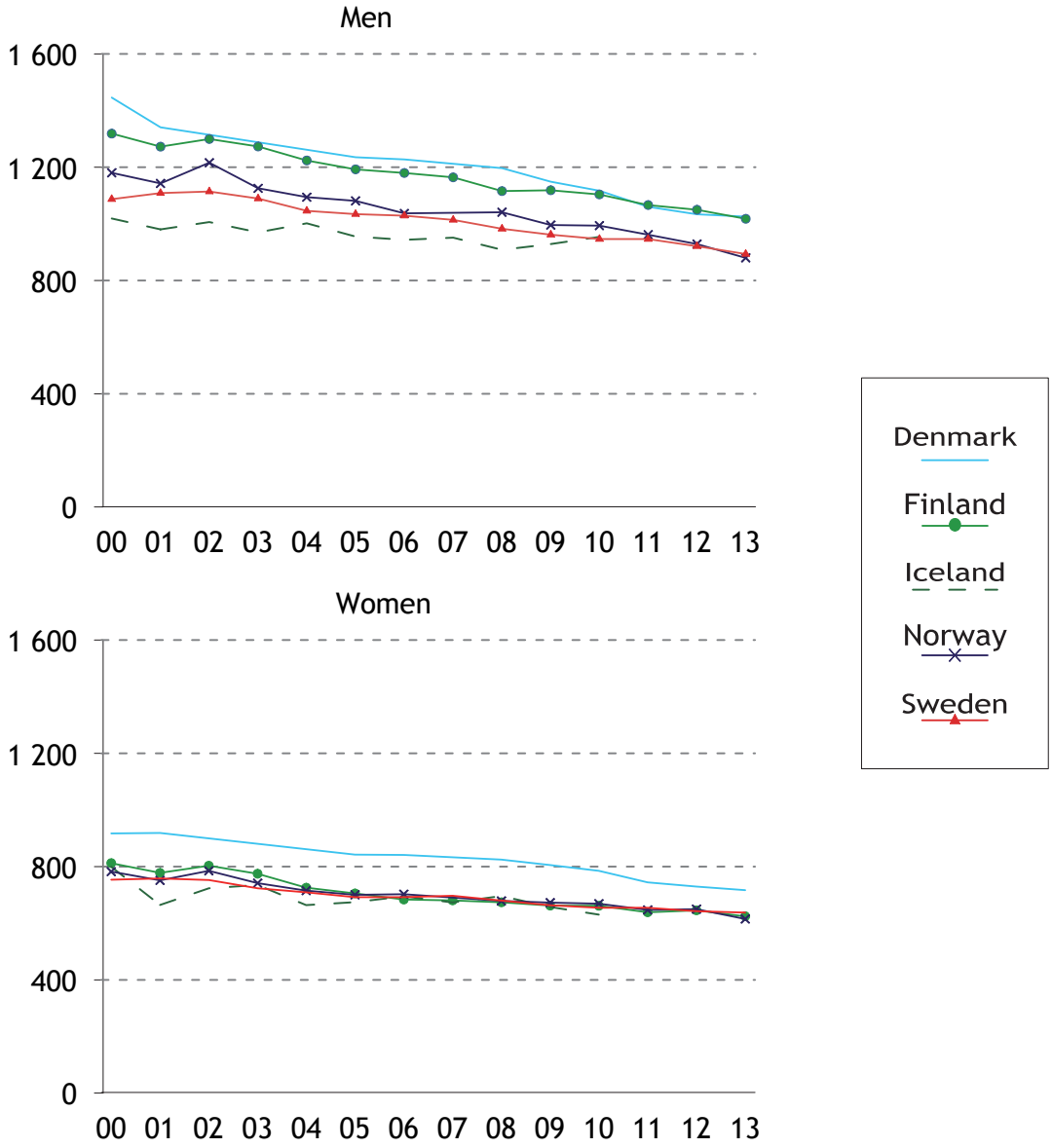
Table 4.1.3b Death rates from circulatory diseases (ICD10 I00-I99) per 100 000 women, by age, 2000-2013

		Denmark	Faroe Islands[1,2,4]	Greenland[2,3,4]	Finland	Åland[2,3,4]	Iceland	Norway	Sweden
Age									
0-34	2000	2	..	7	2	..	3	4	3
	2010	1	5	-	3	18	2	1	2
	2012	2	18	7	3	7	..	2	2
	2013	1	15	7	3	7	..	1	3
35-44	2000	14	..	42	17	..	10	11	11
	2010	8	-	14	9	-	-	7	6
	2012	6	-	16	72	-	..	4	6
	2013	8	-	6	8	-	..	5	6
45-54	2000	41	..	109	48	..	24	36	34
	2010	25	17	116	31	10	14	21	21
	2012	23	39	70	25	10	..	21	22
	2013	23	45	63	22	10	..	16	25
55-64	2000	41	..	271	48	..	24	36	34
	2010	76	52	262	91	80	54	61	77
	2012	68	30	325	89	86	..	59	74
	2013	66	22	245	84	76	..	56	73
65-74	2000	561	..	1 427	551	..	419	471	469
	2010	273	262	801	297	213	194	236	269
	2012	222	239	763	298	270	..	207	270
	2013	199	220	645	257	228	..	197	253
75+	2000	3 722	..	8 038	4 090	..	3 421	3 794	4 059
	2010	2 635	2 492	3 302	3 345	3 492	2 657	2 907	3 537
	2012	2 335	2 221	3 154	3 221	3 653	..	2 956	3 404
	2013	2 111	2 069	3 000	3 057	3 620	..	2 699	3 243

1 2010 = 2007-10
2 2010 = 2006-10
3 2012 = 2008-12
4 2013 = 2009-13

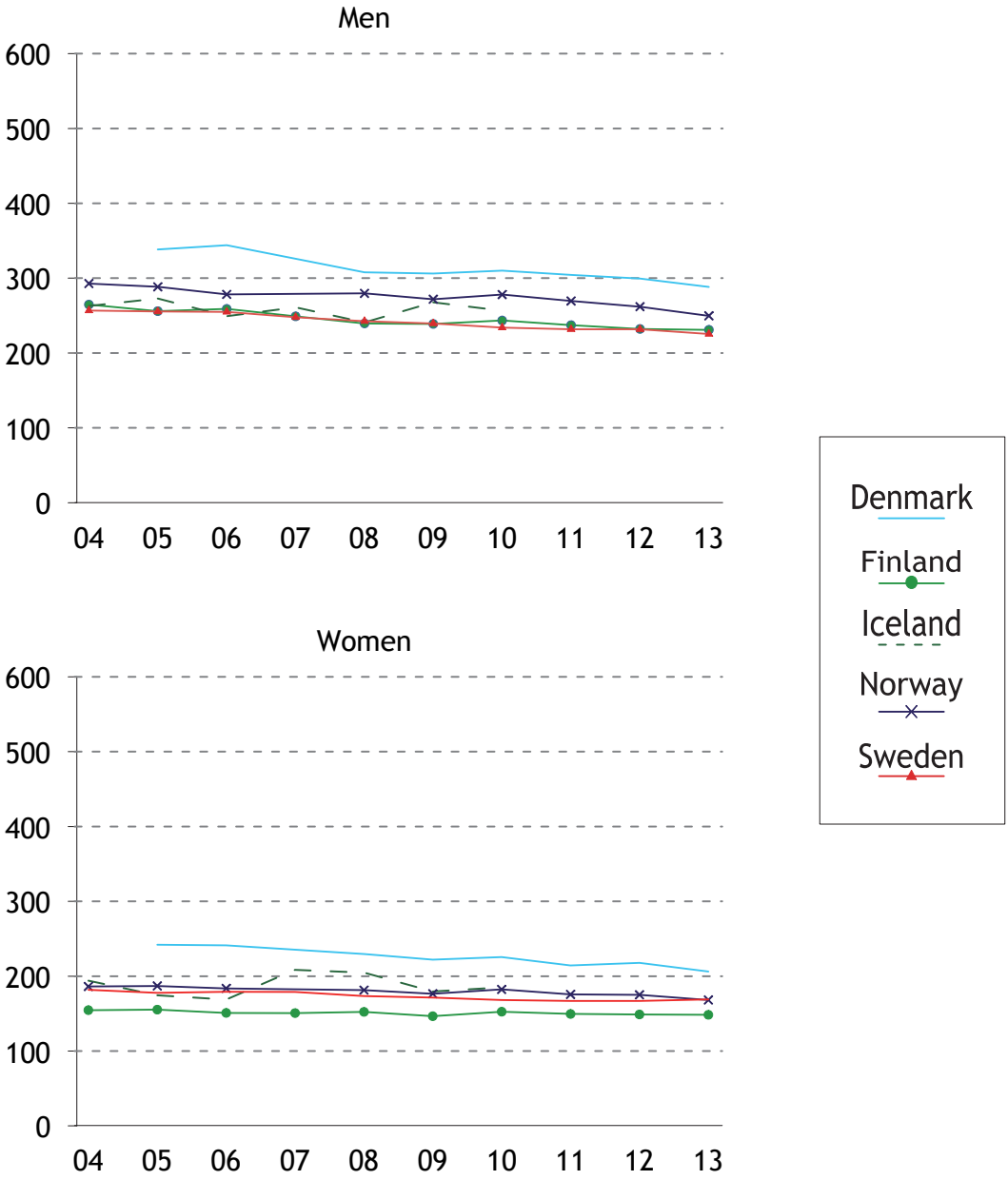
Source: the national central statistical bureauS

Figure 4.1.2 Deaths per 100 000 inhabitants by gender, age standardized rates 2000-2013



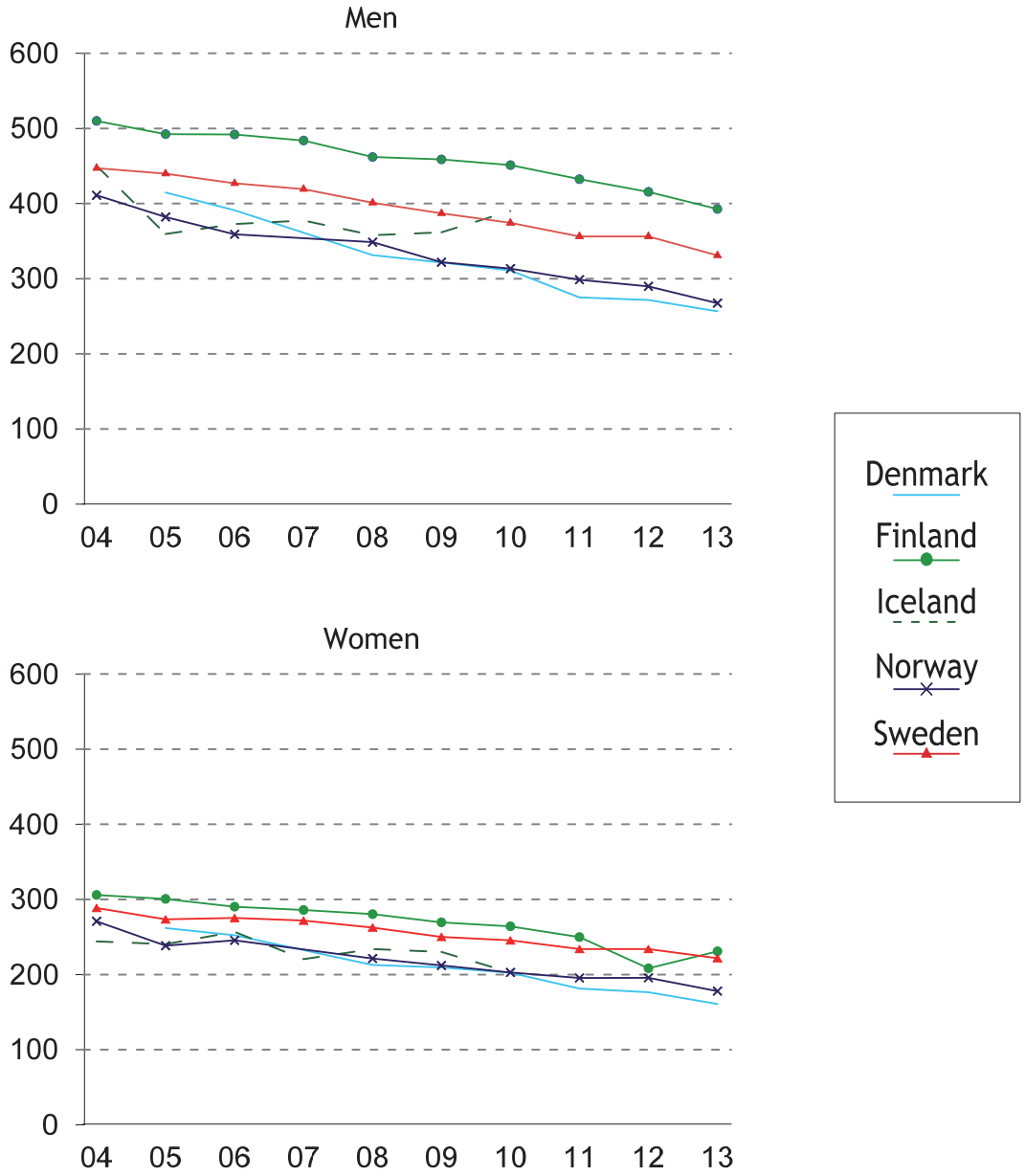
Age-standardized by the Nordic population 2000
Source: the national central statistical bureaus

Figure 4.1.3 Deaths from malignant neoplasms per 100 000 inhabitants by gender, age standardized rates, 2004-2013



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, 2004-2013



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

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
ICD-10 code	2013	2009-13	2009-13	2013	2009-13	2010	2013	2013
Malignant neoplasm of the oesophagus (C15)	5.0	31.1	61.3	2.9	6.2	3.3	2.6	3.1
Malignant neoplasm of the trachea, bronchus and lung (C32-C34)	41.7	120.0	297.3	28.1	31.8	26.7	27.5	24.1
Malignant neoplasm of cervix uteri [1] (C53)	2.4	14.1	46.2	1.1	-	1.4	2.1	2.3
Diabetes (E10-E14)	9.4	31.1	32.4	4.8	2.3	1.7	4.0	6.5
Cerebrovascular diseases (I60-I69)	14.4	55.5	176.6	19.6	18.6	7.7	10.8	12.9
Obstructive lung diseases (J40-J44)	19.0	40.0	72.1	8.5	7.8	7.7	13.0	8.5
Asthma[2] (J45-J46)	5.0	31.1	61.3	2.9	6.2	3.3	2.6	3.1
Chronic liver disease and cirrhosis (K70; K73-K74)	41.7	120.0	297.3	28.1	31.8	26.7	27.5	24.1

1 Per 100 000 women
2 0-14 years old

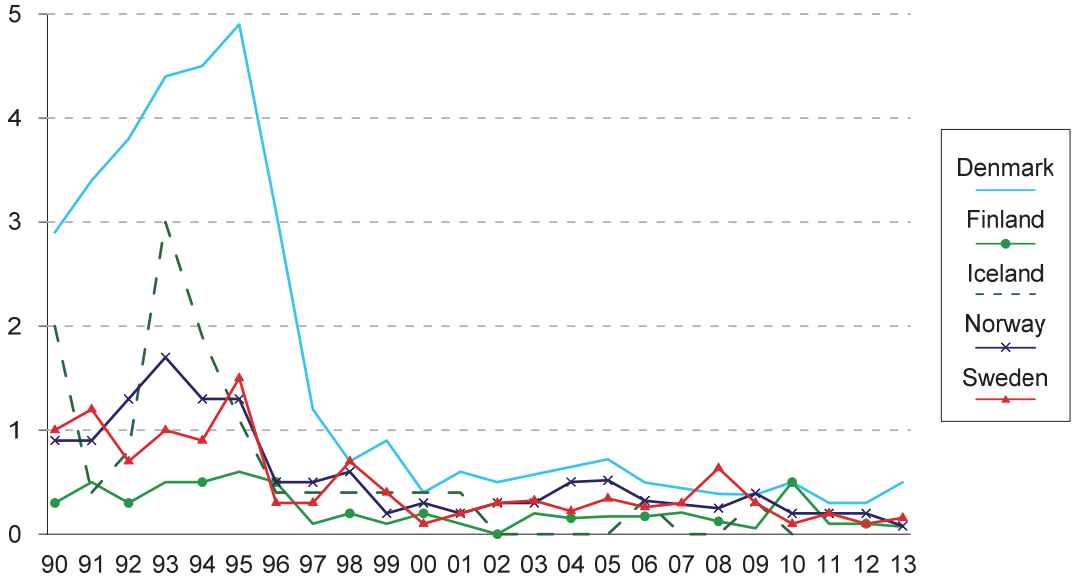
Source: the national central statistical bureaus

Table 4.1.5 Deaths from HIV/AIDS (ICD10 B20-B24), in total and per 100 000 inhabitants, 2000-2013

	Denmark	Faroe Islands[1]	Greenland[1]	Finland	Åland[1]	Iceland	Norway	Sweden
Number								
2000	21	-	5	10	-	1	15	13
2010	29	-	2	7	-	-	10	11
2012	26	1	1	7	-	..	10	14
2013	28	-	1	4	-	..	4	15
Per 100 000 inhabitants								
2000	0.4	-	8.9	0.2	-	0.4	0.3	0.1
2010	0.5	0.4	3.5	0.1	-	-	0.2	0.1
2012	0.5	0.4	1.4	0.1	-	..	0.2	0.1
2013	0.5	2.1	7.1	0.1	-	..	0.1	0.2

1 2013 = average 2009-13. 2010 = average 2006-10. 2012= average 2008-12
Source: the national registers for causes of death

Figure 4.1.5 Deaths from HIV/AIDS per 100 000 inhabitants, 1990-2013



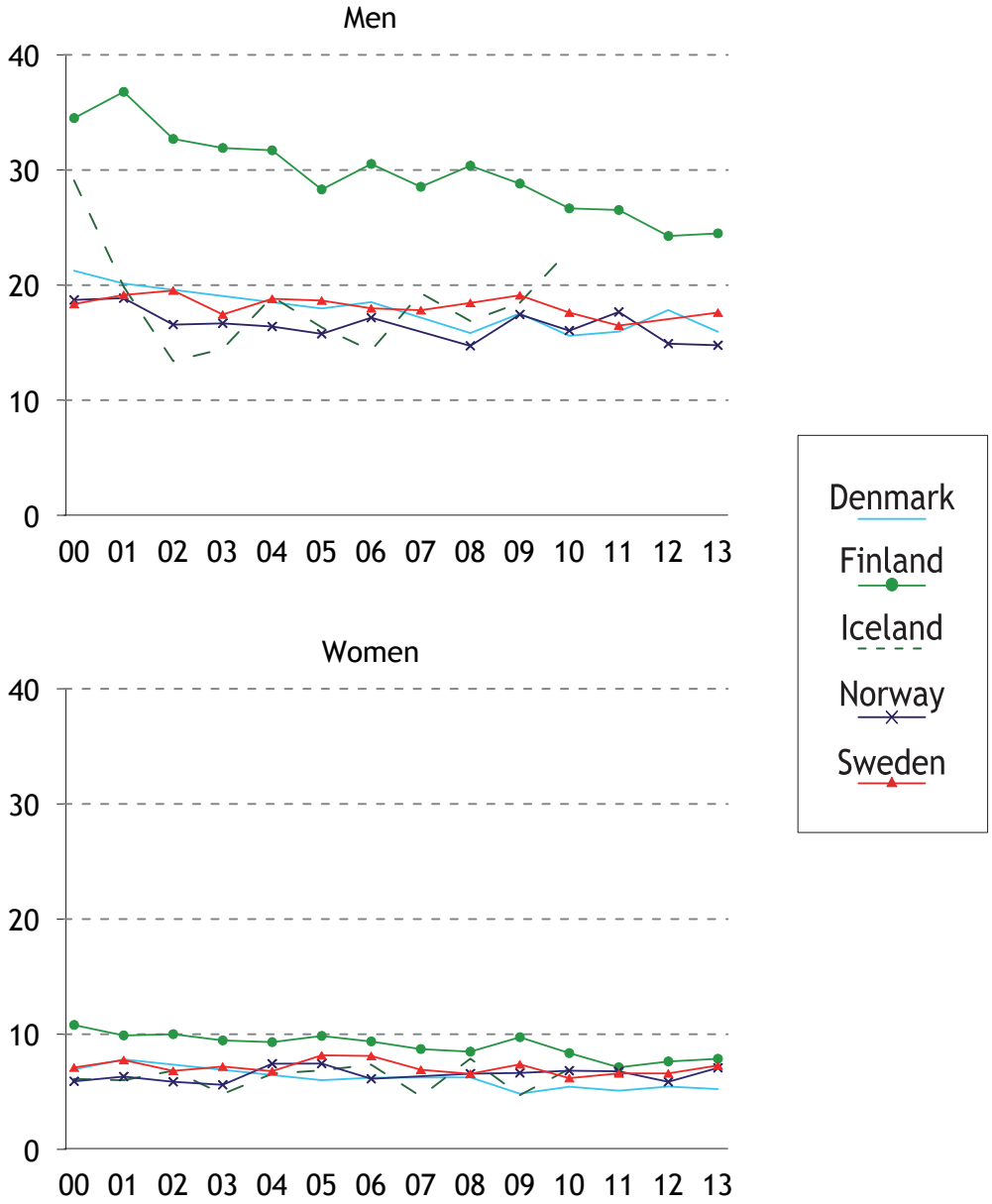
Source: the national registers for causes of death

Table 4.1.6 Deaths from suicide per 100 000 inhabitants by age and gender (ICD10 X60.X84), 1990-2013

	Men						Women					
	Total	10-19	20-24	25-64	65-79[1]	80+	Total	10-19	20-24	25-64	65-79[1]	80+
Denmark												
1990	32.2	4.8	19.8	41.3	58.9	..	16.4	1.2	5.6	19.8	31.0	..
2000	20.2	4.4	16.0	23.8	34.2	70.1	7.2	2.5	1.2	8.1	10.6	23.3
2010	14.7	3.4	3.0	18.5	25.4	38.1	5.7	1.2	3.7	6.8	10.4	7.5
2012	17.8	3.9	11.2	22.9	25.8	37.8	5.9	1.2	2.3	7.1	10.4	10.2
2013	16.1	3.4	5.4	20.0	24.9	47.8	5.6	1.8	3.9	6.5	8.6	11.5
Faroe Islands												
2004-08	23.8	-	-	38.8	-	..	25.7	-	-	17.7	82.3	..
2009-13	9.5	-	11.6	14.2	14.6	-	1.7	5.7	-	-	6.2	-
Greenland												
2004-08	53.6	-	-	59.1	300.3	..	45.3	15.4	69.0	50.7	61.9	..
2009-13	110.0	143.8	303.2	113.1	10.6	122.0	46.6	114.5	53.6	42.6	10.6	-
Finland												
1990	49.4	20.6	60.3	63.9	58.0	91.5	12.5	2.6	15.8	16.7	15.2	8.6
2000	34.6	7.3	41.8	46.6	34.2	50.7	10.9	4.1	9.4	15.3	11.4	7.1
2010	27.2	9.6	44.9	33.8	24.4	37.8	8.6	2.9	13.2	11.2	8.4	7.5
2012	24.6	9.5	32.0	30.2	30.1	35.8	7.9	4.6	11.0	11.0	6.5	2.2
2013	24.9	6.8	27.6	32.0	6.5	42.5	8.0	4.4	11.4	10.3	7.9	3.3
Åland												
2004-08	18.1	11.5	-	16.3	50.3	..	10.3	-	32.8	8.2	23.5	..
2009-13	14.3	-	25.1	18.6	10.6	38.3	5.7	-	30.4	7.9	-	-
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	..
2010	22.5	17.3	25.4	29.7	14.9	46.4	6.3	-	8.7	9.8	5.6	-
2012	..	..	..	..	..	..	..	..	..	..	..	..
2013	..	..	..	..	..	..	..	..	..	..	..	..
Norway												
1990	..	..	..	33.0	33.0	..	..	..	..	10.3	11.1	..
2000	18.4	11.3	29.9	22.5	21.0	28.0	5.8	3.0	4.4	8.0	7.8	3.1
2010	15.8	6.1	25.7	18.9	24.0	20.6	6.7	1.3	6.0	10.1	6.0	4.9
2012	14.7	4.6	18.7	19.7	12.4	26.2	5.8	3.2	7.3	7.8	4.8	6.4
2013	14.8	5.8	14.9	19.2	19.0	18.6	7.0	1.9	8.4	10.2	5.8	1.3
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	33.1	45.5	7.3	3.2	3.9	9.2	9.8	3.1
2010	17.9	5.6	17.7	21.9	23.1	39.9	6.4	2.6	6.3	7.9	9.3	6.7
2012	17.2	4.2	18.1	21.0	23.7	34.3	7.0	2.7	7.5	9.1	7.2	9.3
2013	18.0	5.5	21.0	21.3	25.8	33.0	7.6	3.1	10.1	9.0	9.6	11.3

For Faroe Islands, Greenland and Åland 65-80+
Source: the national registers for causes of death

Figure 4.1.6 Deaths from suicide per 100 000 inhabitants by gender, age standardized rates, 2000-2013



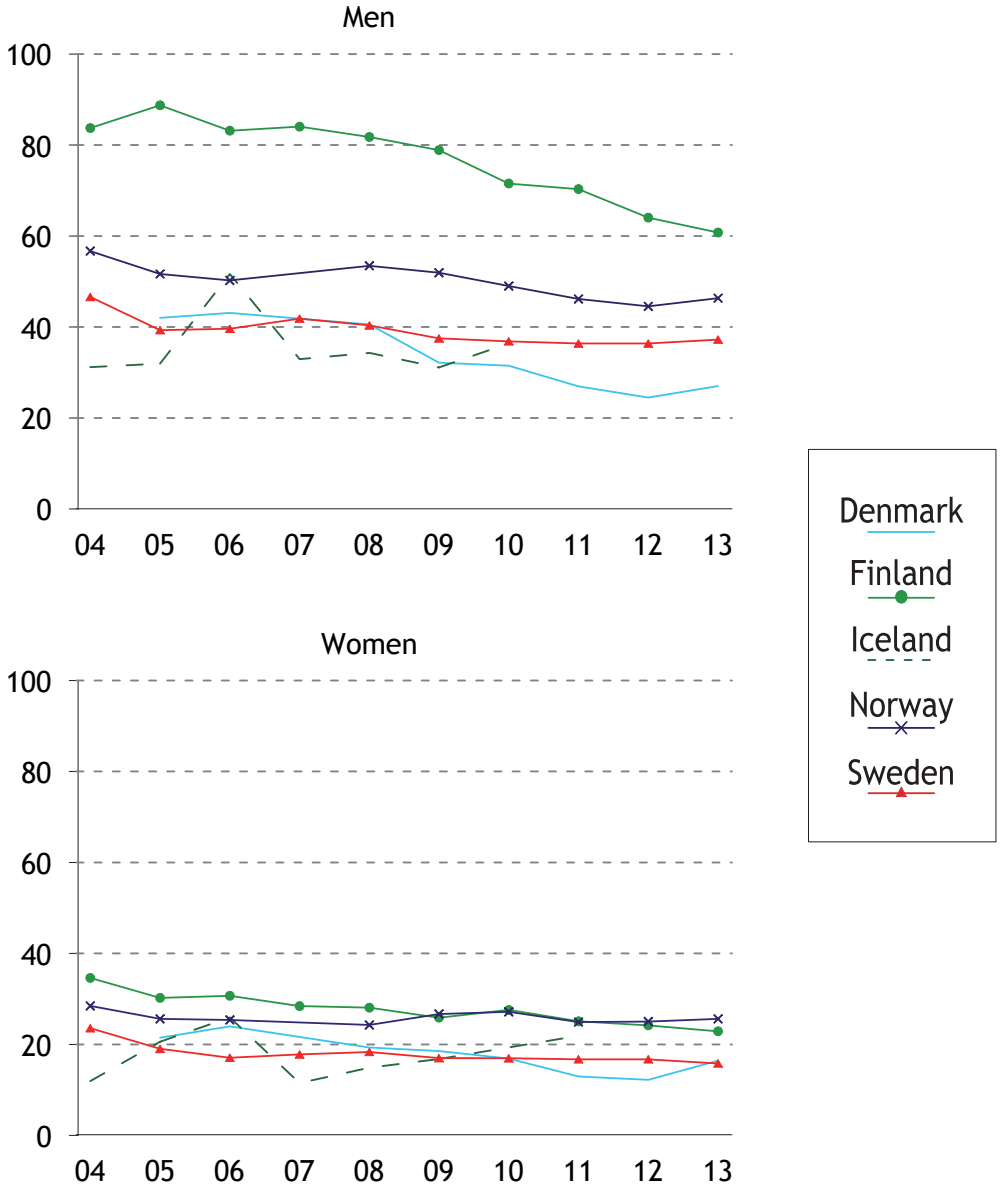
Age-standardized by the Nordic population, 2000
Source: the national registers for causes of death

Table 4.1.7 Deaths from accidents per 100 000 inhabitants by age and gender, (ICD10, V01-X59) 2000-2013

	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
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
2013	24.6	2.4	9.3	20.7	34.5	242.7	21.3	1.7	3.1	6.3	22.6	272.6
Faroe Islands												
2004-08	23.8	-	-	38.8	-	142.9	25.7	-	-	17.7	82.3	162.3
2009-13	41.4	7.4	16.6	39.6	109.2	186.8	12.9	-	12.9	5.3	-	155.4
Greenland												
2004-08	53.6	-	-	59.1	300.3	806.5	45.3	15.4	69.0	50.7	61.9	-
2009-13	53.3	18.7	43.8	50.7	149.0	853.7	26.3	6.5	22.4	17.1	95.8	535.1
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
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
2013	60.4	2.2	21.4	56.4	107.3	382.5	31.5	1.1	6.2	14.4	42.5	258.0
Åland												
2004-08	66.2	16.7	25.6	54.4	170.1	304.7	20.6	8.8	-	2.7	24.4	218.1
2009-13	52.8	-	24.0	45.2	116.1	267.9	35.4	-	-	2.6	73.7	367.8
Iceland												
2000	38.4	3.0	46.0	36.7	76.6	274.6	12.8	-	23.7	10.1	30.2	21.5
2010	29.4	2.9	8.4	29.7	22.4	371.5	22.1	-	21.8	9.8	20.7	295.8
2012	..	..	..	..	..	..	..	..	..	..	..	..
2013	..	..	..	..	..	..	..	..	..	..	..	..
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
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
2013	41.1	1.0	19.5	31.3	60.2	470.3	34.4	1.8	6.8	9.5	35.5	433.2
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
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
2013	37.5	1.4	14.6	22.6	58.6	396.9	24.4	2.1	2.5	5.6	27.0	267.2

Source: the national central statistical bureaus

Figure 4.1.7 Deaths from accidents per 100 000 inhabitants by gender, age standardized rates, 2004-2013



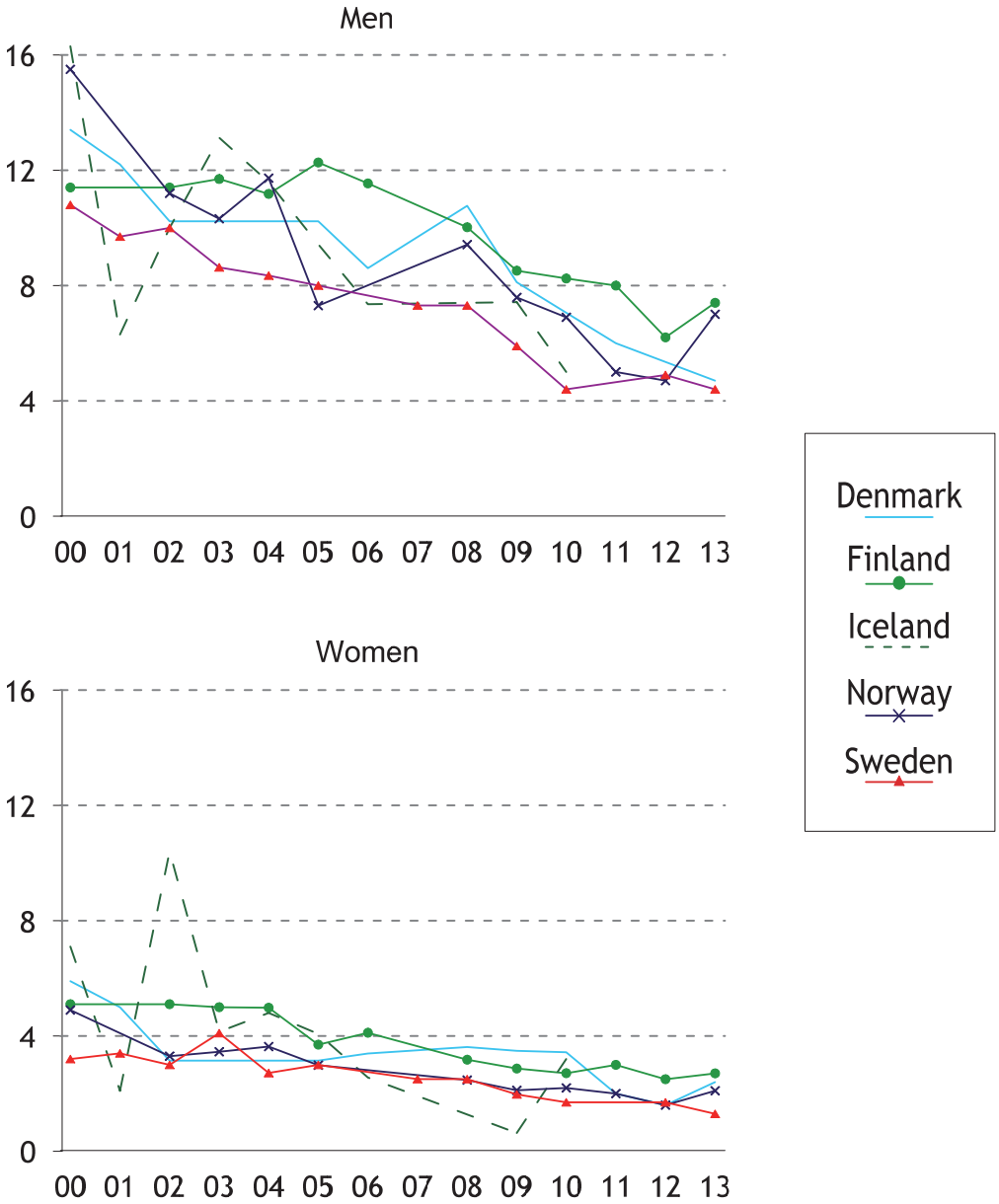
Age-standardized by the Nordic population, 2000
Source: the national registers for causes of death

Table 4.1.8 Deaths from land transport accidents (ICD10, V01-V89) per 100 000 inhabitants by age and gender, 2000-2013

	Men						Women					
	Total	0-14	15-24	25-64	65-79[1]	80+	Total	0-14	15-24	25-64	65-79[1]	80+
Denmark												
2000	13.4	3.8	28.0	11.7	20.7	28.6	5.9	1.2	9.3	4.6	9.4	19.7
2010	7.1	1.4	10.9	7.2	6.7	24.6	3.4	1.2	3.0	2.4	7.1	12.9
2012	4.4	1.4	7.4	3.8	5.6	16.6	1.6	0.6	2.3	1.4	2.0	4.1
2013	4.7	1.0	5.4	5.1	6.2	10.5	2.4	1.3	2.9	1.5	5.2	7.7
Faroe Islands												
2004-08	16.6	-	119.1	-	-		-	-	-	-	-	-
2009-13	7.2	-	11.1	7.9	7.3	26.7	1.7	-	12.9	-	-	-
Greenland												
2004-08	10.1	-	-	5.9	111.8		7.6	-	46.0	-	-	
2009-13	6.0	6.2	-	5.9	-	243.9	1.5	3.3	4.5	-	-	-
Finland												
2000	11.3	2.3	13.3	11.4	22.1	54.9	5.1	2.2	5.6	4.1	9.4	14.1
2010	8.2	0.7	14.0	7.8	13.1	16.4	2.7	1.4	2.8	2.2	5.1	4.6
2012	6.2	0.7	9.2	6.2	7.5	18.5	2.5	1.4	4.0	1.3	5.0	6.7
2013	7.4	1.1	9.8	7.4	9.9	20.1	2.7	0.5	3.1	1.6	5.7	7.7
Åland												
2004-08	15.0	8.4	25.6	10.9	39.3	-	1.5	-	-	-	12.2	-
2009-13	7.1	-	12.0	8.0	10.6	-	5.7	-	-	-	34.7	-
Iceland												
2000	16.3	-	32.2	16.9	27.3	..	7.1	-	19.0	5.8	11.2	..
2010	5.0	-	4.2	7.1	-	23.2	3.2	-	13.1	1.2	5.6	-
2012	..	..	..	..	..	..	..	..	..	..	..	..
2013	..	..	..	..	..	..	..	..	..	..	..	..
Norway												
2000	14.5	2.6	27.8	15.0	16.0	28.0	4.9	2.5	8.7	3.6	9.3	7.0
2010	6.9	0.4	11.2	6.8	9.7	20.6	2.2	0.2	4.6	1.9	2.6	4.9
2012	4.7	0.8	7.1	5.2	4.5	10.0	1.6	0.2	1.6	1.6	2.4	4.9
2013	7.0	0.8	9.3	7.6	9.0	16.1	2.1	-	3.1	1.8	3.3	-
Sweden												
2000	10.8	1.4	19.1	10.7	15.4	20.5	3.2	1.0	4.2	2.6	5.7	14.6
2010	4.4	0.9	6.6	4.5	4.8	8.7	1.7	0.5	2.5	1.3	2.8	3.5
2012	4.9	0.5	7.6	5.3	5.1	9.7	1.7	0.6	2.5	1.3	3.0	2.6
2013	4.4	0.6	5.6	4.5	6.7	7.5	1.3	0.1	1.3	1.3	2.5	-

1 For Faroe Islands and Greenland 65-80+
Source: the national registers for causes of death

Figure 4.1.8 Deaths from land transport accidents per 100 000 inhabitants by gender, 2000-2013



Source: the national registers for causes of death

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

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2013	2009-13	2009-13	2013	2009-13	2010	2013	2013
Men								
0-34	0.2	-	-	2.7	-	-	0.4	0.2
35-44	14.8	58.1	23.2	27.7	-	4.6	3.5	3.0
45-64	79.7	155.8	207.4	123.9	279.0	7.7	22.5	20.0
65-74	90.7	286.6	759.1	121.2	271.2	10.2	31.0	33.2
75+	52.4	142.5	1 082.7	46.6	106.1	-	24.2	19.5
Total	36.3	79.6	120.0	54.7	114.2	3.1	10.5	10.5
Women								
0-34	0.2	-	-	0.2	-	-	0.1	-
35-44	2.1	-	55.6	6.2	-	4.7	0.3	1.1
45-64	26.0	17.1	88.5	35.3	97.2	2.6	10.0	8.0
65-74	39.0	104.9	383.9	29.7	213.8	9.7	12.7	12.4
75+	18.9	-	450.0	10.0	-	-	6.1	4.4
Total	13.1	12.9	60.1	14.8	49.6	1.9	4.2	3.9
M+W								
0-34	0.2	-	-	1.5	-	-	0.3	0.1
35-44	8.5	30.8	38.0	17.2	-	4.7	1.9	2.1
45-64	52.9	89.7	155.3	79.4	186.1	5.2	16.4	14.0
65-74	64.1	200.1	589.8	72.7	243.2	10.0	21.6	22.6
75+	32.4	59.2	710.4	23.5	42.3	-	13.3	10.6
Total	24.6	47.5	91.8	34.4	81.8	2.5	7.4	7.2

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 age and gender

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2013	2009-13	2009-13	2013	2009-13	2010	2013	2013
Men								
0-34	2.2	-	13.4	-	-	41.5	8.2	5.4
35-44	10.8	-	-	0.3	-	12.8	18.0	8.3
45-64	8.7	46.7	23.0	0.1	-	71.5	18.5	5.8
65-74	0.3	-	-	-	-	12.6	7.3	1.2
75+	1.2	-	-	-	-	0.6	7.8	0.9
Total	4.9	11.9	13.3	1.1	-		12.2	5.1
Women								
0-34	0.2	-	-	-	-	19.0	2.9	1.1
35-44	2.1	-	-	-	-	-	7.4	2.3
45-64	2.5	-	-	-	-	58.3	12.2	2.9
65-74	1.6	-	-	-	-	9.4	6.1	1.3
75+	0.4	-	-	-	-	-	4.2	1.5
Total	1.2	-	-	0.5	7.1		6.2	1.7
M+W								
0-34	1.2	-	6.8	0.6	-	30.4	5.6	3.3
35-44	6.5	-	-	2.0	-	6.5	12.9	5.3
45-64	5.6	24.5	12.9	0.7	-	64.7	15.4	4.4
65-74	1.0	-	-	1.4	-	10.8	6.7	1.3
75+	0.7	-	-	1.5	-	0.3	5.6	1.7
Total	3.0	6.2	7.1	0.1	-	10.7	9.2	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 age and gender

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2013	2009-13	2009-13	2013	2009-13	2013	2013	2013
Men								
0-44	0.4	-	15.6	-	-	-	0.3	1.7
45-64	5.9	77.9	172.9	0.3	-	-	3.5	9.9
65-74	19.1	47.8	253.0	-	-	10.2	10.5	30.0
75+	83.7	855.2	1 515.8	1.2	-	88.4	116.1	161.2
Total	8.8	71.6	96.7	0.1	-	5.0	8.4	17.9
No death certificate	63.7	71.6	96.7	0.1	-	5.0	8.4	17.9
Women								
0-44	110.1	22.1	5.4	0.2	-	-	0.1	0.9
45-64	2.4	56.3	39.4	-	-	-	1.1	4.4
65-74	18.7	131.1	222.8	-	-	11.6	15.4	22.9
75+	6.5	44.8	7.4	0.4	6.8	4.3	16.7	26.6
Total	71.2	12.9	-	-	7.1	3.2	11.7	17.8
No death certificate	61.1	12.9	-	-	7.1	3.2	11.7	17.8
M+W								
0-44	0.2	10.5	10.3	0.1	-	-	0.2	1.3
45-64	6.7	82.4	199.7	0.2	-	-	4.2	10.6
65-74	75.9	125.7	595.7	-	-	14.6	38.6	88.6
75+	5.9	46.6	15.9	0.3	3.6	4.3	11.8	19.4
Total	8.6	6.2	-	-	-	0.9	2.8	3.8
No death certificate	62.4	6.2	-	-	-	0.9	2.8	3.8

Source: the national registers for causes of death

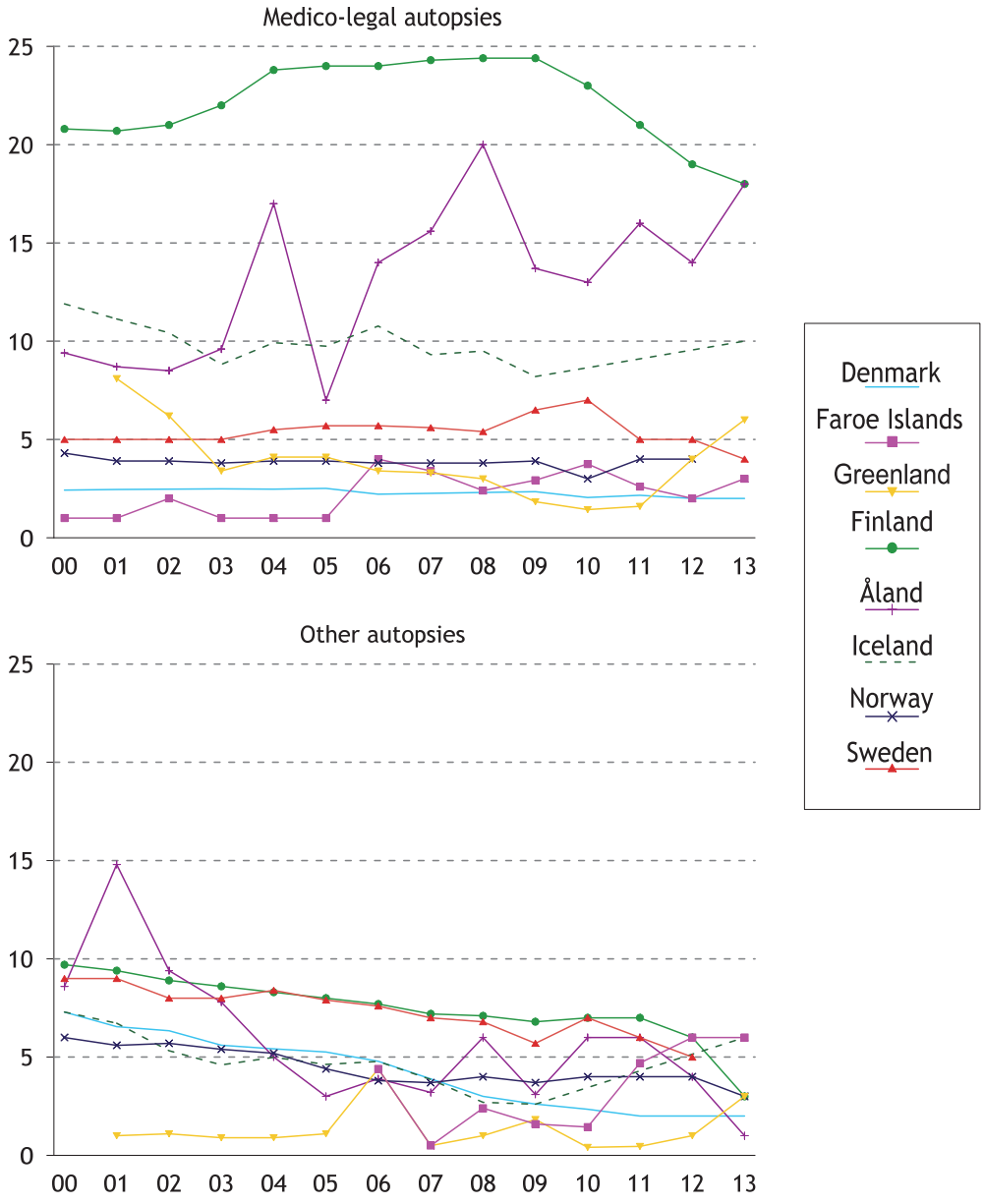
ICD-10: I469. I959. I99. J960. J969. P285.0. R000-R948. R99

Table 4.1.12 Autopsy rates as a percentage of all deaths, 2000-2013

	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
2010	2	3	1	23	13	..	3	7
2012	2	2	4	19	14	..	4	5
2013	2	3	2	18	10	..	4	6
Other autopsies								
2000	7	..	..	10	9	7	6	9
2005	5	1	1	8	3	5	4	8
2010	2	1	-	7	6	..	4	6
2012	2	6	1	6	4	..	4	5
2013	2	3	1	6	3	..	3	6

Source: the national registers for causes of death

Figure 4.1.9 Autopsy rates as a percentage of all deaths, 2000-2013



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 total health care expenditure and 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 is financed through block grants from the state. The rest is financed through a basic contribution from the municipalities, along with municipal and state subsidies that are dependent on activity.

FINLAND

The health care system is highly decentralized. Responsibility for providing health care is devolved to the municipalities (local government). The publicly funded system is divided into three levels: municipal health care, private health care and occupational health care. Alongside this is a much smaller private health care system.

Municipal financing is based on taxes while the National Health Insurance financing is based on compulsory insurance fees. Municipalities fund primary health care services and the National Health Insurance funds for example private health care, occupational health care, outpatient pharmaceutical products and transport costs. Also most health-related benefits, such as sickness benefits and maternity benefits, are funded through the National Health Insurance Scheme.

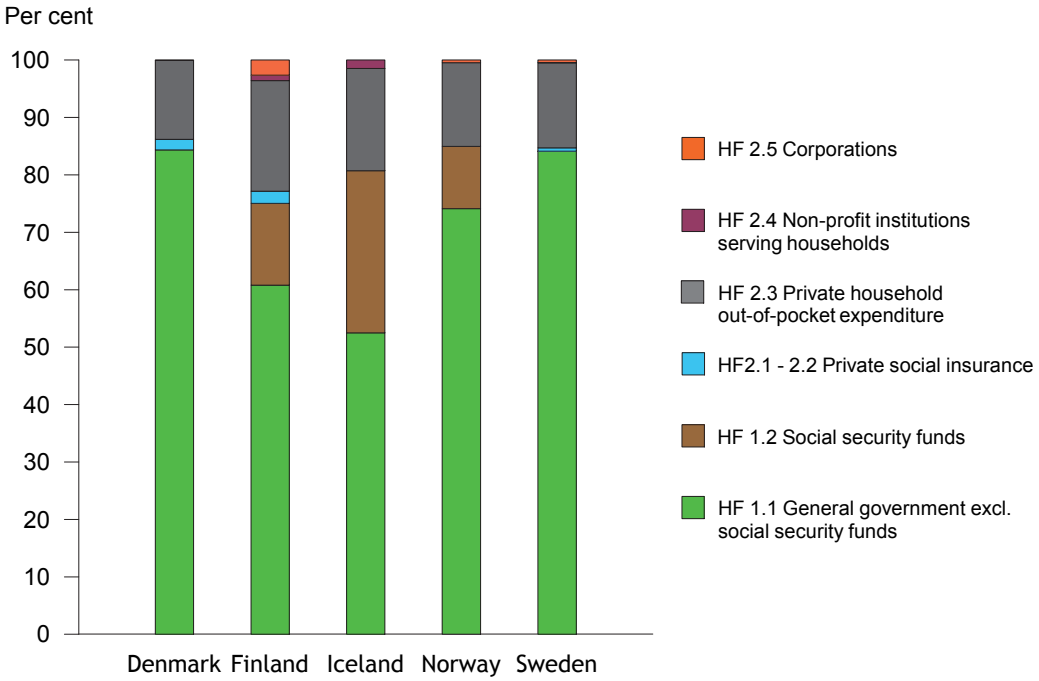
ÅLAND

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

SWEDEN

The state is responsible for 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 user charges 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, 2013



Source: OECD Health Statistics

5.2 Charges for Health Care Services per 1 January 2015

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 centres:

- A fixed annual user charge of no more than EUR 32.10 in a year, or
- A fixed user charge per visit of no more than EUR 16.10. The user charge is payable for the first three visits to the same health centre in the same calendar year only

A user charge of EUR 22.10 is payable for visits to health centres on working days between 8 pm and 8 am and for visits on Saturdays, Sundays and public 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 centres and for home visits, there is a user charge of EUR 27. The user charge for a visit to a casualty department is EUR 40. Children and young people under the age of 18 pay half of the user charge. 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 are free of charge and so is school health care. The user charge for a consultation in a health centre and with a private general medical practitioner during normal working hours is ISK 1 200, ISK 960 for 67-69-year-olds who do not have a pension or who have a reduced pension and 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 user charges for evenings and nights are ISK 4 500, ISK 3 800 and ISK 2 200.
The user charge for a consultation with a specialist is ISK 5 400 plus 40 per cent of the remaining cost of the consultation, ISK 4 200 plus 13.3 per cent of the remaining cost of the consultation for 67-69-year-olds who do not have a pension or who have a reduced pension, ISK 1 950 plus 13.3 per cent of the remaining cost of the consultation for other pensioners, disabled people and long-term unemployed people. 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.

The maximum charge is ISK 33 600 in all cases. The same user charges apply for outpatient treatment in hospitals (with the exception of children, for whom there is no user charge). Different user 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

As a member of the National Insurance scheme, patients only pay a fixed part of the cost of public health services. This applies to medical treatment, buying medicines on a refundable prescription (a so-called blue prescription), physiotherapy, seeing a psychologist and travel expenses to consultations and treatment appointments. If patient have paid a certain amount in user charges, they are eligible for an exemption card. This means that they are exempt from paying user charges for the rest of the calendar year. There are two types of exemption card. The amounts are set annually by the Norwegian Parliament, the Storting. The exemption card for user charge group 1 covers approved user charges paid to doctors, psychologists and outpatient clinics, and for x-rays, patient travel and blue prescription medicine and equipment. The exemption card for user charge group 2 covers approved user charges for physiotherapy, certain dental diseases, treatment in approved rehabilitation institutions and travel for treatment abroad organized by Oslo University Hospital HF - Rikshospitalet.

Patients are exempt from user charges in connection with check-ups during pregnancy, examinations and treatment for children under the age of 16, psychotherapy for children and young people under the age of 18 and treatment of infectious diseases that are a danger to public health or suspicion of such diseases.

User charges apply for consultations with general practitioners and specialists, outpatient treatment at hospitals, and treatment from a doctor on call. User charges for consultation with general practitioners/doctors on call are: general practitioner: NOK 141 (day) and NOK 238 (night). User charges are NOK 187 (day) and NOK 282 (night) if the doctor is a specialist in general practice. For other medical specialists the user charge is NOK 320. User charges for home visits are: general practitioners NOK 190 (day) and NOK 304 (night), specialist in general practice: NOK 222 (day) and NOK 336 (night). The user charge for laboratory tests, histological tests and cytology tests is NOK 50. The user charge for x-rays and ultrasound examinations is NOK 227.

SWEDEN

In Sweden, county authorities can decide the level of user charges for different types of visit 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 user charges 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 user charge 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	User charge as a percentage of the total cost of medical visits
Denmark	Yes	-	No	-
Faroe Islands	Yes	-	No	-
Greenland	Yes	-	No	-
Finland	Yes	Public: EUR 0-16.10. EUR 22.10 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 27. Children and young people under the age of 18 years pay 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 1 200-4 500 in primary care, other fees for specialized care	Half the amount of ISK 600-2 200 for pensioners, disabled and long-term unemployed people. ISK 960-3 800 for 67-69-year-olds with no or a reduced pension. No charge for children under the age of 18 years	
Norway	Yes	Consultation with: a general practitioner: NOK 141 (day), NOK 238 (evening/night), with a specialist: NOK 320	No charge for children under 16 years	35 per cent
Sweden	No	100–300 SEK	Yes	..

Reimbursement for Pharmaceutical Products

DENMARK

There are no fixed percentages for reimbursement of for the cost of 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 pharmaceutical products 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, that 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 that are on the subsidies list are reimbursed. The subsidies list is administered by the Chief Pharmaceutical Officer. Reimbursements on the Faroe Islands are not a fixed percentage of the cost, as they are dependent on the level of consumption of the pharmaceutical product for each patient. The subsidy is adjusted according to the consumer price index. The percentage increases with the patient's consumption of pharmaceutical products. For

an annual purchase under DKK 516, the full cost of the pharmaceutical products is paid by the consumer, while costs of more than DKK 5 469 are fully subsidized by the public sector (maximum user cost after subsidy is DKK 2 090). However, the costs for patients over the age of 67 years are fully subsidized from DKK 2 456, and the maximum cost for the user after subsidy for persons 67+ is DKK 1 340. Costs for children under 18 years are fully subsidized from the first DKK, and therefore children pay nothing for prescribed medicine that are eligible for subsidy. In accordance with the Social Security Act, subsidies for purchase of pharmaceutical products are also granted to persons who are not able to bear the costs themselves. Pharmaceutical products prescribed in 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. Pharmaceutical products 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. Pharmaceutical products are categorized according to the reference pricing system. Products that belong to the same reference pricing group contain equal amounts of the same drug substance and are biologically equivalent, which makes them interchangeable.

Some new and expensive drugs (e.g. for dementia and multiple sclerosis) are paid for by the hospital or municipality in special cases. 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 612.62 in the course of one calendar year (excluding user charges of EUR 1.50 per product per purchase).

ICELAND
The subsidy system for pharmaceutical products in Iceland is similar to the one in the other Scandinavian countries (Denmark, Norway and Sweden). The system builds on payment contribution steps, where the individual pays proportionally less as the costs for pharmaceutical products increase during a 12-month period. The individual pays all expenses for pharmaceutical products up to a certain limit (the subsidy limit). Then his

or her payment gradually decreases until annual expenses have reached a maximum amount (the annual limit). After this the expenses are fully covered.

The 12-month payment period starts with an individual's first purchase of a pharmaceutical product. The patient pays the initial ISK 22 000, then 15 per cent of the costs up to ISK 31 750, then 7.5 per cent of the costs up to ISK 62 000. If the costs exceed this amount, a doctor can apply to the Health Insurance for the patient's costs to be fully subsidized for the rest of the year, if specified conditions are fulfilled. The annual limits for subsidies to pensioners, disabled people, children and young people under the age of 22 years are lower than for other people. These groups pay the initial ISK 14 500, and their costs are fully subsidized when they have paid ISK 41 000.

All pharmaceutical products authorized by the Health Insurance scheme are included in the payment system. Other pharmaceutical products fall outside the payment system.

NORWAY

There are two types of reimbursement scheme 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 pharmaceutical 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. Some non-prescription pharmaceutical products are also 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 1 100
- 50 per cent of the cost in the range SEK 1 100 – 2 100
- 25 per cent of the cost in the range SEK 2 101 – 3 900
- 10 per cent of the cost in the range SEK 3 900 – 5 400
- 0 per cent of costs exceeding SEK 4 300

When a patient has paid a total of SEK 2 200 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	User charge as a percentage of the total cost of the pharmaceutical product
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 or 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 disabled people pay two thirds of the costs	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 centres: EUR 32.10 for policlinic visit and EUR 38.10 for overnight care in somatic department and EUR 17.60 in psychiatric departments. The charge for rehabilitation is EUR 13.20 per treatment day, and the maximum user charge for day surgery is EUR 105.50 plus EUR 38.10, if the patient has to stay overnight. A series of treatment costs EUR 8.80 per visit (max. 45 times per year).

ÅLAND
The user charge per day for patients who are hospitalized is EUR 33. When the maximum limit has been reached, the user charge is reduced to EUR 15. The maximum limit is EUR 375 for persons between 18 and 64 years, EUR 120 for persons aged 65 and older and for people with a disability pension.

The user charge per day for persons under the age of 18 is EUR 18. When the maximum limit (EUR 120) has been reached, health care in hospitals is free of charge.

The user charge for day surgery is EUR 66. For medical rehabilitation the user charge per day is EUR 20. When the maximum limit has been reached, health care is free of charge.

The user charge for long-term care in a hospital is calculated on the basis of the patient's ability to pay.

NORWAY
Inpatient hospital treatment is free to all who qualify, but there are user charges for visits to doctors and specialists and for prescription medicines. Citizens must also pay for radiology and laboratory tests and for non-emergency transportation. There are a number of exemptions, for example for people who suffer from chronic diseases, pregnant women and women who have just given birth.

SWEDEN
The county authorities and the municipalities can largely decide themselves about user charges for a visit to the doctor and for other health services. For a hospital stay, there is a user 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	User charges as a percentage of the total cost of hospitalization
Denmark	Yes	-	No	-
Faroe Islands	Yes	-	No	-
Greenland	Yes	-	No	-
Finland	Yes	EUR 38.10 per day for overnight care EUR 105.35 for day surgery	For children 0–17 years max. for 7 days. Payment for long-term stay according to means	7 per cent
Åland	Yes	EUR 33; EUR 18 for people under the age of 18 years EUR 66 for day surgery	Payment for long-term stay according to means	..
Iceland	Yes	-	No	-
Norway	Yes	-	No	-
Sweden	No	SEK 0-80/day	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. From 1 January 2014, 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. 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 health disorders 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 reduction in function 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 pharmaceutical products.

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 user charge of EUR 8.00 per visit for dental treatment at a health centre, EUR 10.20 per visit to a dentist, and EUR 14.90 for a visit to a specialist. In

addition to this, user charges 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 user charge for 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.

In April 2013, a new agreement on prophylactic dental treatment for children under the age of 18 was signed. Now parents can register their child with a specific dentist, who is then responsible for regular dental appointments, prophylaxis 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 each year, until 1 January 2018, two age groups will be added annually, until the 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 a fixed cost.

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

Subsidies for orthodontic treatment can reach ISK 150 000 according to special rules.

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

People suffering from chronic illnesses, 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 are provided for the cost of dental treatment (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 resorption or other problems.

95 per cent of the cost of treatment (incl. orthodontics) of congenital disfiguration and serious anomalies such as cleft palate and aplasia, and of the damage caused by accidents and illnesses, are reimbursed according to special rules.

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

NORWAY

Most people pay the cost of dental treatment themselves.

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

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

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

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

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

SWEDEN

According to the Act relating to dental services, children and young people have the right to regular and comprehensive dental care until and including the calendar year in which they reach 19 years of age. Comprehensive dental care means that young people under 20 years of age shall receive general dental care and specialist dental care.

The current dental subsidy system was introduced 1 July 2008 and expanded with support for certain patient groups 1 January 2013.

The system consists of:

- A general dental subsidy
- A special dental subsidy
- A cost ceiling.

The aim of the general subsidy is to encourage adults to regularly visit a dentist for examination and preventive care. The annual subsidy depends on age:

- For 20–29 year-olds the subsidy is 300 SEK
- For 30–74 year-olds the subsidy is 150 SEK
- For 75 years and older the subsidy is 300 SEK

All adults are also included in the cost ceiling arrangement. The cost ceiling means that patients have to pay only a part of the cost for expensive treatment. The Dental and Pharmaceutical Benefits Agency regulates which care is covered. For every treatment measure covered by the cost ceiling, a reference price is specified from which reimbursement is calculated. For costs above 3 000 SEK the patient is reimbursed the following:

- 50 per cent of costs exceeding 3 000 SEK, calculated from the reference price
- 85 per cent of costs exceeding 15 000 SEK, calculated from the reference price

Adults 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 in Denmark for maximum user charges, with the exception of pharmaceutical products and dental treatment (cf. the section on reimbursement for dental treatment).

FAROE ISLANDS
For subsidized medicine, there is a maximum user charge of DKK 2 090 annually (no charges for children under 18 years and DKK 1 340 for 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-prescription medicines and some types of dental treatment (cf. the sections on reimbursement for pharmaceutical products and reimbursement for dental treatment). There are no maximum user charges.

FINLAND
If the total cost of pharmaceutical products exceeds EUR 612.62 per year, or if travelling costs for treatment exceed EUR 272 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 per month. If the spouse with the highest income is hospitalized, the user charge for the hospitalization cannot exceed 42.5 per cent of the spouse's joint net income per month. A patient must have at least EUR 99 per month for personal necessities. The same user charge is payable in all kinds of institutions within the social and health care sectors.

A 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.

User charges for children under 18 years of age are added to the amount paid by the person who has paid the user charges.

ÅLAND

The rules for maximum user charges for pharmaceutical products 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 user charges is EUR 120 per calendar year. After this amount has been reached, all treatment for children and young people is free. The user charge 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 user 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 user charge ceiling.

When the user charge 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 user charge 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.

User charges for the following are included in exemption scheme 1:

- treatment from a medical practitioner
- treatment from a psychologist
- outpatient treatment
- x-ray examination
- travel costs
- pharmaceutical products (blue prescription)

User charges for the following 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 Oslo University Hospital HF Rikshospitalet.

The cost ceiling is NOK 2185 for exemption scheme 1 and NOK 2670 for exemption scheme 2 in 2015.

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 lives 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. If priorities are not changed, this will lead to higher taxes for both citizens and companies.

In the Nordic countries, between 75 and 85 per cent of health care expenditure is publicly financed. In 2013, 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.

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. For example, the OECD have developed "A System of Health Accounts". This accounting system has been developed in order to meet the political needs for data, and also the needs of researchers in this area. The common framework that the system is built on will ensure that the comparability of data between countries and over time is as good as possible. The system has also been 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, and it is not certain at the moment how comparable the various national health accounts are. Therefore, 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 national currency) 2013

	Denmark	Faroe Islands	Green-land	Finland[1]	Iceland	Norway	Sweden
	DKK	DKK	DKK	EUR	ISK	NOK	SEK
Public financing	165 478	1 083	..	13 084	132 815	232 861	348 827
Private financing	30 708	..	..	4 354	31 717	41 217	65 829
Total health care expenditure	196 187	..	..	17 438	164 531	274 078	414 656

1 Finnish data include Åland
Source: OECD HEALTH STATISTICS. FO: Statistics Faroe Islands; GL: Directorate of Health

Table 5.3.2 Total health care expenditure (EUR/capita) 2013

	Denmark	Faroe Islands	Greenland	Finland[2]	Iceland	Norway	Sweden
Public financing	3 952	3 016	..	2 406	2 526	5 872	4 200
Private financing	733	..	..	800	603	1 039	793
Total health care expenditure	4 685	..	..	3 206	3 130	6 912	4 992

1 Finnish data include Åland

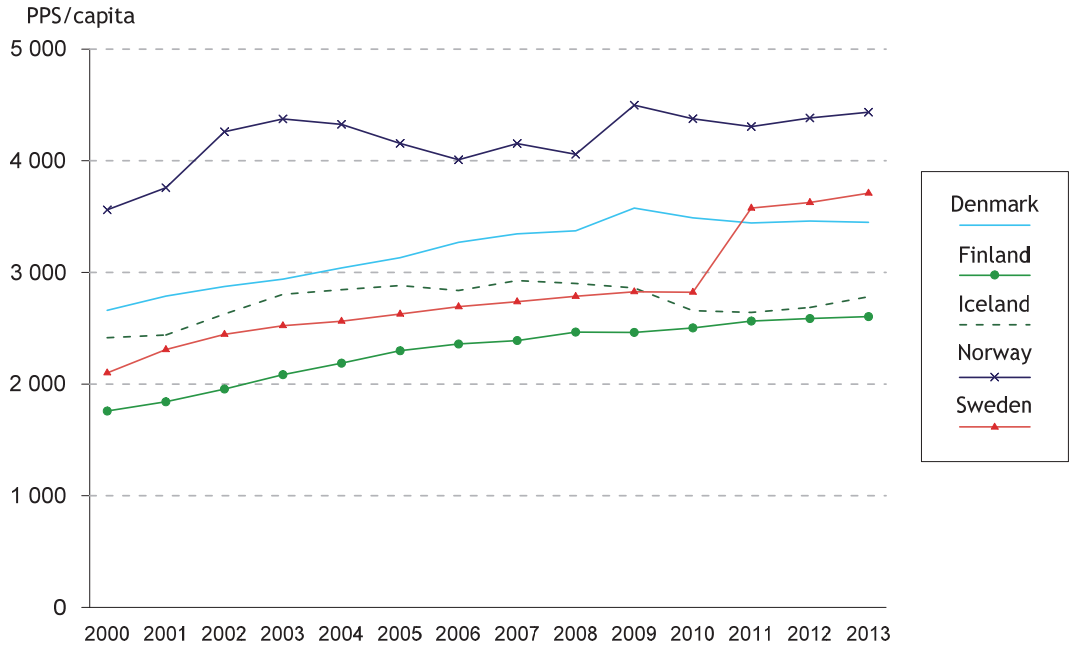
Source: OECD HEALTH STATISTICS. FO: Statistics Faroe Islands; G: Directorate of Health

Table 5.3.3 GDP and health care expenditure in total and per capita, 2000-2013

	Denmark[1]	Faroe Islands[2]	Greenland	Finland[3]	Iceland	Norway	Sweden
	DKK	DKK	DKK	EUR	ISK	NOK	SEK
Total expenditure per capita 2013	34 940	1 083	..	3 206	508 183	53 956	43 192
GDP (million) 2013	1 886 393	14 678	..	201 995	1 880 893	3 068 801	3 775 016
Expenditure in 2013 prices (million)							
2000	143 964	..	..	11 217	124 073	194 463	216 837
2010	196 172	1 048	1 215	16 568	154 321	260 273	308 183
2012	196 030	1 045	1 213	17 241	157 329	267 617	401 770
2013	196 187	1 083	..	17 438	164 531	274 078	414 656
Expenditure as a percentage of GDP							
2000	8.1	8.5	8.9	6.7	9.0	7.7	7.4
2010	10.4	7.8	9.2	8.2	8.8	8.9	8.5
2012	10.4	7.7	8.8	8.5	8.7	8.8	10.8
2013	10.4	7.4	..	8.6	8.7	8.9	11.0

1 Changes in method of calculation from 2003 for Denmark, from 2000 for Norway and from 2001 for Sweden
2 Only public health expenditure
3 Finnish data include Åland
Source: OECD HEALTH STATISTICS. FO: Statistics Faroe Islands; GL: Directorate of Health

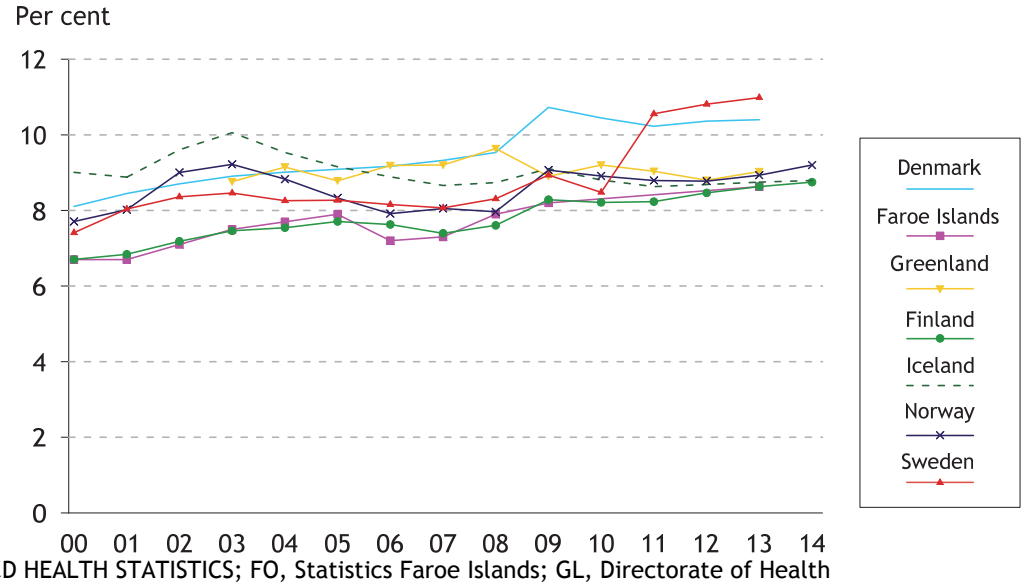
Figure 5.3.1 Total health care expenditure (PPS/capita) in 2013 prices [1]



1 PPS, purchasing power parities, is an expression for the different currencies' relative purchasing power

Source: OECD HEALTH STATISTICS

Figure 5.3.2 Health care expenditure as a percentage of GDP 2000-2013



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, 2013 (NACE 85.1 and 85.3)

	Denmark[1]	Faroe Islands	Greenland	Finland	Åland	Iceland[2]	Norway[3]	Sweden[4, 5]
Physicians	20 239	125	99	16 859	86	1 173	21 874	37 025
Dentists	4 372	44	25	3 990	26	272	4 434	7 686
Dental hygienists	1 629	26	46	1 585	8	14	1 020	3 968
Dental surgery assistants	4 505	83	17	..	27	304	3 358	..
Psychologists	5 311	25	2	3 373	10	-	4 805	5 933
Qualified nurses	57 489	387	263	61 309	370	3 025	84 664	101 402
Radiographers	1 644	6		2 774	9	114	2 767	1 274
Qualified auxiliary nurses	38 922	107	160	77 012	611	1 978	59 678	..
Other health care personnel	54 469	17	155	..	39	-	2 913	..
Midwives	1 827	19	23	..	18	264	2 762	6 975
Physiotherapists	9 156	17	14	8 389	29	515	9 123	11 876
Occupational therapists	6 334	7	2	..	11	235	2 913	8 277
Hospital laboratory technicians	5 609	40	31	5 438	22	304	4 904	..
Other health care personnel with a higher education	673	0	..	..	30	-	6 535	..

1 2012
2 Physicians licensed to practice up to 70 years old at end of year, with permanent residence and registered domicile in Iceland
3 Active health personnel in health and social services
4 The data apply to November 2012
5 An additional 2 207 qualified nurses are specialized and employed as radiographers
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, 2013 (NACE 85.1 and 85.3)

	Denmark[1]	Faroe Islands	Greenland	Finland	Åland	Iceland[2]	Norway[3]	Sweden[4, 5]
Physicians	362	259	174	310	300	362	430	386
Dentists	78	91	44	73	91	84	87	80
Dental hygienists	29	54	82	29	28	4	20	41
Dental surgery assistants	81	172	29	..	94	94	66	-
Psychologists	95	52	4	62	35	-	94	62
Qualified nurses	1 029	803	466	1 127	1 291	934	1 665	1 056
Radiographers	29	13	-	51	31	35	54	13
Qualified auxiliary nurses	697	223	283	1416	2 131	611	1 174	-
Other health care personnel	975	35	274	..	136	-	57	-
Midwives	33	40	40	..	63	82	54	73
Physiotherapists	164	36	24	154	101	159	179	124
Occupational therapists	113	13	4	..	38	73	57	86
Hospital laboratory technicians	100	83	56	100	77	94	96	-
Other health care personnel with a higher education	12	0	-	..	105	-	129	-

1 2012
2 Physicians licensed to practice up to 70 years old at end of year, with permanent residence and registered domicile in Iceland
3 Active health personnel in health and social services
4 The data apply to November 2012
5 An additional 2 207 qualified nurses are specialized and employed as radiographers
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 2013

	Denmark	Faroe Islands	Greenland [1, 2]	Finland[3]	Åland[4]	Iceland	Norway[2]	Sweden
Number of general practitioners	4 268	30	53	5 090	18	188	5 971	5 814
Number of inhabitants per general practitioner	1 314	1 610	1 071	1 028	1 566	1 722	851	1 651

1 County practitioners
2 2012
3 Includes GPs in health centres and occupational health services
4 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, Directorate of Health, National Board of Health and Welfare

Table 5.4.4 Employed physicians by specialty in health and social services, 2013 (NACE 85.1 and 85.3)

	Denmark[1]	Faroe Islands[2]	Green-land[1]	Finland	Åland	Iceland[3,4]	Norway	Sweden[5]
General practice	4 256	31	93	1 762	16	188	2 630	5 814
Internal medicine	1 640	9	7	962	11	157	1 547	1 361
Paediatrics	391	3	4	575	3	55	488	966
Surgery	914	6	7	891	4	83	769	1 277
Plastic surgery	104	1	-	100		9	96	149
Gynaecology and obstetrics	536	3	5	686	6	46	556	1 310
Orthopaedic surgery, incl. hand surgery	688	5	4	473	5	39	490	1 319
Ophthalmology	328	4	-	468	2	32	365	693
Ear, nose and throat	332	2	2	348	1	21	301	575
Psychiatry	999	3	5	1 356	6	74	1 428	1 570
Skin and sexually transmitted diseases	159	1	-	197	-	18	154	366
Neurology	303	2	-	482	-	16	279	370
Oncology	149	-	-	162	1	13	178	416
Anaesthetics	965	5	9	786	4	55	806	1 560
Radiology	502	4	4	681	2	33	637	1 085
Clinical laboratory specialities incl. pathology	524	1	-	185	-	33	443	848
Other specialities	154	2	-	1 701	10	28	559	
Specialists in total	12 944	82	139	11 815	71	900	11 726	25 684
Physicians without specialist authorization	7 295	43	39	5 044	14	273	10 148	11 341
Physicians in total within NACE 85.1 and 85.3	20 239	125	178	16 859	85	1 173	21 874	37 025

1 2012
2 Full-time equivalents, of which 11 specialists had full-time positions as consultants. The figure for 2013 is not comparable with the figure for 2012. The number of specialist consultants was too low in the last report. The number of physicians without specialization (specifically general practice trainee) was 6 full-time equivalents too low last year.
3 Data based on the register of physicians at the Directorate of Health. The most recent specialty is chosen for those with more than one specialty.
4 Physicians licensed to practice in Iceland, up to the age of 70 years at the end of the year, with permanent residence and registered domicile in Iceland
5 The data apply to November 2012
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, 2013 (NACE 85.1 and 85.3)

	Denmark[1]	Faroe Islands[2]	Green-land[1]	Finland	Åland	Iceland[3,4]	Norway	Sweden[5]
General practice	76	64	93	33	56	59	52	61
Internal medicine	29	19	7	18	39	49	31	14
Paediatrics	7	6	4	11	11	17	10	10
Surgery	16	12	7	16	14	26	15	13
Plastic surgery	2	2	.	2	-	3	2	2
Gynaecology and obstetrics	10	6	5	13	21	14	11	14
Orthopaedic surgery, incl. hand surgery	12	10	4	9	18	12	10	14
Ophthalmology	6	8	.	9	7	10	7	7
Ear, nose and throat	6	4	2	6	4	7	6	6
Psychiatry	18	6	5	25	21	23	28	16
Skin and sexually transmitted diseases	3	2	.	4	-	6	3	4
Neurology	5	4	.	9	-	5	6	4
Oncology	3	0		3	4	4	4	4
Anaesthetics	17	10	9	15	14	17	16	16
Radiology	9	8	4	13	7	10	13	11
Clinical laboratory specialities incl. pathology	9	2	-	3	-	10	9	9
Other specialities	3	4	-	31	35	9	11	-
Specialists in total	232	170	139	218	250	281	234	270
Physicians without specialist authorization	131	89	39	93	49	85	202	119
Physicians in total within NACE 85.1 and 85.3	362	259	178	311	299	366	436	389

1 2012
2 Full-time equivalents, of which 11 specialist's full-time positions are consultancies. Data not compatible with last years number. Counting of specialist consultants was too low in last report. Physicians without specialisation (specifically General practice Trainee) were counted 6 full time equivalents too low last year
3 Data based on the register of physicians at the Directorate of Health. The most recent specialty is chosen for those with more than one specialty
4 Physicians licensed to practice in Iceland, up to the age of 70 years at year-end, with permanent residence and registered domicile in Iceland
5 The data applies to November, 2012
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 2013

	Denmark	Faroe Islands	Green-land[1]	Finland	Åland[1]	Iceland	Norway	Sweden
Physicians employed in hospitals (NACE 85.1 and 85.3)	14 042[1]	95	85[3]	7 800	53	861	11 874	
General practitioners (NACE 85.1 and 85.3)	3 994	30	12	5 650	15	..	6 097	5 814
- of whom working without specialist authorization	392	45[2]	..	3 273	14	..	3 903	..
Other physicians working outside hospitals (mainly privately practising specialists) (NACE 85.1 and 85.3)	1 811	1	-	..	14	..	1 622	..
Physicians employed in administrative medicine (NACE 75.1)	212	1	4	..	2	..	430	1 125
Physicians employed in medical research, teaching etc. (NACE 80.3, 73.1 and 24.4)	952	1	-	..	..	..	1 230	383
Physicians employed within all other NACE codes	1 136	0	..	..	..	..	..	37 025

1 2012
2 Of which 9 in training positions
3 The general practitioners outside Nuuk also treat inpatients at the health centres and regional hospitals

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, but to a varying degree.

However, the structure is somewhat different in Finland, Iceland and Greenland than in the other countries. A number of beds are attached to health centres, and these beds appear in the tables as beds in "other hospitals". Some of these beds are for care of elderly people, and they are similar to beds in nursing homes and old peoples' homes in the other countries. Particularly for Finland and Iceland, this gives a larger number of beds in relation to the population than in the other countries.

Hospital beds are divided into medical, surgical, psychiatric and other beds. 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 have been reduced in ordinary hospitals. Within mental health care 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, 2013

	Denmark[1]	Faroe Islands[2]	Greenland[3]	Finland[4]	Åland[2,4]	Iceland[5]	Norway[6]	Sweden
Number								
Somatic wards	12 894	193	104	8 596	62	733	11 664	20 760
Psychiatry wards	2 955	55	12	3 458	13	150	5 881	4 394
Other[4]	..	.	348	14 394	51	161	2123	..
Total	15 849	248	464	26 447	126	1 044	19 668	29 405
Beds per 100 000 inhabitants								
Somatic wards	230	400	184	158	214	230	232	214
Psychiatry wards	53	114	21	64	46	47	117	46
Other	..	.	616	265	177	51	41	..
Total	283	515	821	486	437	327	392	260

1 Total number of available beds reported by hospitals/regions per 30/6-2013
2 2009-2013
3 2012
4 Number of bed-days divided by 365
5 Other beds are beds for long-term care in hospitals (health facilities with 24-hour access to hospital physicians)
6 Figures include beds within mental health care services and substance abuse treatment. This includes both beds in hospitals and community mental health care centres (DPS)

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

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

The Danish Health Data Authority
http://sundhedsdatastyrelsen.dk/

Responsible for:
- Statistics on births
- Statistics on induced abortions
- Statistics on congenital anomalies
- 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 pharmaceutical 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 pharmaceutical products

Ministry of Health and the Interior
www.himr.fo

Responsible for:
- Statistics on health care personnel
- Statistics on hospital services
- Statistics on induced abortions
- Statistics and information on vaccinations

The Danish Health Data Authority
http://sundhedsdatastyrelsen.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 induced abortions • Statistics on congenital anomalies • Statistics on infectious diseases • Statistics and information on vaccinations
The Danish Health Data Authority http://sundhedsdatastyrelsen.dk/	Responsible for: • Statistics on causes of death • Statistics on cancer
Landsapotekeren www.peqqik.gl E-mail: apotek@peqqik.gl	Responsible for: • Statistics on pharmaceutical products
The Department of Health and 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 congenital anomalies • Statistics on induced 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 hospital care and surgery • Statistics on infectious diseases • Statistics and information on vaccinations • Health surveys • Public Health Report
National Agency for Medicines (FIMEA) www.fimea.fi	Responsible for: • Registration of pharmaceutical 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 for pharmaceutical products, and disability pensions
The Cancer Register www.cancer.fi	Responsible for: • Statistics on cancer and cancer screening
Finnish 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 (number of beds) • Statistics on health care economy – user charges for 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

Iceland

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 induced 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 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 • Statistics on tuberculosis • Statistics on immunization • Statistics on sale of pharmaceutical products • Statistics on prescription 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 • Study on Living Conditions (ULF/SILC)
National Board of Health and Welfare www.socialstyrelsen.se	Responsible for: • Statistics on births • Statistics on induced abortions • Statistics on in-patients • Statistics on cancer • Statistics on causes of death • Statistics on prescription 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
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 *Health Statistics in the Nordic Countries*. Up until and including 2011, this was a bi-lingual publication in Danish (Nordic languages) and English.

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.

99. Financing of Health Care in the Nordic Countries, 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