Health Statistics in the Nordic Countries 2002
Helsestatistik for de nordiske lande 2002

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'Health Statistics in the Nordic Countries' may be ordered from:

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Omslag: **Brandt**design
Forsidefoto: Jörgen Wikstrand

Layout og grafik: Jesper Marcussen

Tryk: AN:Sats

ISBN 87–89702–49-2

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Data is always calculated in relation to the respective age groups	Data er altid udregnet i forhold til de respektive aldersgrupper	

Preface
Forord

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

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

Only a few changes have been made in relation to previous versions of the present publication.

Section B deals with equal access to health services in the Nordic countries.

On the NOMESCO homepage at www.nom-nos.dk you will find additional information, including an interactive database and detailed data on hospital discharges and causes of death.

Nordic Medico-Statistical Committee (NOMESCO)

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

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

I forhold til de forrige udgaver af publikationen er der kun foretaget få ændringer.

Sektion B omhandler lige vilkår for benyttelsen af behandlingssystemet i de nordiske lande.

På NOMESKO's hjemmeside på www.nom-nos.dk findes der supplerende informationer, blandt andet en interaktiv database samt detaljerede data om udskrivninger og dødsårsager.

Nordisk Medicinalstatistisk Komité (NOMESKO)

SECTION A

Health Statistics 2002
Helsestatistik 2002

CHAPTER I

Organization of health services
Organiseringen af sundhedsvæsenet

Introduction

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

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

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

Specialist medical treatment is also offered outside hospitals.

The health services are provided in accordance with legislation, and they are largely financed by public spending or through compulsory health insurance schemes.

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

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

Indledning

I de nordiske lande er sundhedsvæsenet et offentligt anliggende.

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

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

Speciallægebehandling tilbydes også uden for sygehusene.

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

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

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

Current and future changes in the health services

DENMARK:

In order to increase activity in the health services and to reduce waiting time for examination and treatment, the government allocated an extra DKK 1.5 billion to the health services in 2002. This has been followed up with an extra DKK 1.4 billion in 2003 and DKK 1.2 billion in 2004. This increased activity is combined with extra choices for patients. Among other things, it is now possible for patients to receive treatment at a private hospital or a hospital abroad that has a contract with the authorities, when waiting time for treatment at a public hospital is greater than two months.

These measures have had a considerable effect. The number of people who have had contact with hospital services has increased by 60 000 from 2001 to 2002. During the same period, the number of people who have had an operation of any type has increased by 55 000. Waiting times have been reduced by one fifth from July 2002 to December 2003 for 18 important operations. During the period 1 July 2002 to 1 October 2003, 20 000 patients have chosen to use their right to free choice of hospital.

At the beginning of 2004, the Ministry of the Interior and Health, the Ministry of Finance, Danish Regions and the Joint Metropolitan Hospital Service (HS) carried out an evaluation of the extended free choice of hospital arrangement. The evaluation showed that in general both patients and public and private hospitals are satisfied with the way the arrange-

Igangværende og kommende ændringer i sundhedsvæsenet

DANMARK:

For målrettet at øge aktiviteten i sundhedsvæsenet og nedbringe ventetiderne til undersøgelse og behandling tilførte regeringen i 2002 ekstra 1,5 mia. kr. til sundhedsvæsenet. I 2003 og 2004 er der blevet fulgt op med flere ekstrabevillinger til sundhedsvæsenet på hhv. 1,4 og 1,2 mia. kr. Den øgede aktivitet er kombineret med flere valgmuligheder for patienterne. Blandt andet har patienterne fået mulighed for at søge behandling på et privat sygehus eller et sygehus i udlandet, der har indgået aftale med det offentlige, når ventetiden til de offentlige sygehuse overstiger 2 måneder.

Indsatsen har haft en betydelig effekt. Fra 2001 til 2002 er antallet af personer, som har haft en kontakt med sygehusvæsenet øget med 60 000. I samme periode er antallet af personer, der har fået foretaget en eller anden form for operation, øget med 55 000. Ventetiderne er reduceret med godt 1/5 for 18 vigtige operationer fra juli 2002 til december 2003. I perioden fra 1. juli 2002 til 1. oktober 2003 har ca. 20 000 patienter valgt at benytte muligheden for udvidet frit sygehusvalg.

Indenrigs- og Sundhedsministeriet, Finansministeriet, Amtsrådsforeningen og H:S har i starten af 2004 foretaget en evaluering af den udvidede fritvalgsordning. Evalueringen viste, at der generelt blandt både patienter og offentlige og private sygehuse er tilfredshed med, hvordan ordningen fungerer. Der blev dog i evalueringen givet udtryk for enkel-

ment works. However, the evaluation indicated certain problems, mainly in relation to information and visiting patients.

te problemer vedr. hovedsageligt information og visitation af patienter.

According to the economic agreement for 2004, the government and Danish Regions have agreed that management of hospitals according to funding shall gradually be expanded. The counties determine the budget with the individual hospitals and the hospitals allocate funds to the different departments in an appropriate way, so as to achieve effective production of services. From 2004 the counties shall, one at a time, allocate a minimum of 20 per cent of their funds to their own hospitals directly on the basis of production.

Regeringen og Amtsrådsforeningen er i økonomiaftalen for 2004 blevet enige om, at anvendelsen af takststyring i forhold til sygehusene gradvist skal forøges. Amterne fastlægger afregningen med de enkelte sygehuse, og sygehusene skal i hensigtsmæssigt omfang kanalisere "takstmidlerne" videre ud på de udførende afdelinger for at understøtte en effektiv arbejdstilrettelæggelse. Fra 2004 skal amterne enkeltvist som minimum afregne 20 pct. af bevillingerne til egne sygehuse direkte på baggrund af præsteret aktivitet.

In 2005 experience gained from the counties' use of management according to funding and the effect of the system shall be evaluated. In the evaluation process an appropriate aim for the extent of management according to funding in the next few years will be discussed.

Der skal i 2005 gennemføres en evaluering af erfaringerne med amternes anvendelse af samt effekterne af takststyring. Som led i evalueringen drøftes en hensigtsmæssig målsætning for omfanget af takststyring i de kommende år.

In 2002, the government appointed a Structure Commission to put forward a proposal for better and simpler organization of the public sector for the benefit of the population.

Regeringen nedsatte i 2002 en Strukturkommission, der skulle beskrive forslag til en bedre og mere enkel indretning af den offentlige sektor til gavn for borgerne.

The Commission submitted its report in January 2004. The Commission proposes a range of possible models for the structure of the public sector, both models in which all tasks are placed in the municipalities and the state, and models in which three administrative levels are kept. Common for all the models is the recommendation that the present administrative units should be larger, in order to ensure sufficient professional resources for the tasks that need to be performed.

Kommissionen afgav sin betænkning i januar 2004. Kommissionen opstiller en række mulige modeller for den offentlige sektors struktur – herunder både modeller hvor alle opgaver placeres i kommunerne og staten, og modeller hvor der opretholdes tre forvaltningsled. Fælles for modellerne er anbefalingen af, at de nuværende forvaltningsenheder bliver større mhp. at sikre en tilstrækkelig faglig bæredygtighed i opgaveløsningen mv.

Political decisions about the future structure of the welfare state have yet to be made. In connection with deciding what view to take about the report of the Structure Commission, the government will propose a collective plan for a coordinated health service, to ensure, among other things, a smoother passage for patients through the different sectors in the system.

Der mangler endnu at blive truffet de politiske beslutninger om velfærdssamfundets fremtidige struktur. Regeringen vil i forbindelse med stillingtagen til Strukturkommissionens betænkning fremlægge en samlet plan for et sammenhængende sundhedsvæsen, der bl.a. skal sikre mere smidige patientforløb på tværs af sektorer.

In December 2003, the government published a "Strategy for the health service treatment services – Patients first". The Strategy clearly states the government's ambitions in the field of health.

Regeringen har i december 2003 udgivet en "Strategi for det behandlende sundhedsvæsen – Patienten først". Strategien gør det klart, hvad regeringens ambitioner er på sundhedsområdet.

In order to provide improved health services for the population, the government will require better documentation of quality and effectiveness, more speedy implementation of the best methods, better access to information and improved communication with the population.

For at give borgerne et bedre sundhedsvæsen vil regeringen skærpe kravene til dokumentation af kvalitet og effektivitet, hurtigere udbredelse af de bedste metoder, lettere adgang til information og en klarere kommunikation med borgerne.

The Strategy lists a range of concrete measures that shall be closely followed up, and that shall be continuously evaluated in terms of need for adjustments and concrete follow-up initiatives.

I strategien opstilles en række konkrete målepunkter som skal følges tæt, og som løbende skal vurderes mhp. behov for justeringer og konkrete, opfølgende initiativer.

The following are examples of some of the Government's concrete aims. Personal electronic medication profiles shall be introduced in 2004. Concrete proposals for increased use of effective methods of treatment shall be made. Examples of effective ways of working shall be collected systematically, and introduced.

Blandt regeringens konkrete mål kan bl.a. nævnes, at der skal implementeres personlige elektroniske medicinprofiler medio 2004, at der skal udarbejdes konkrete forslag til udbredelse af effektive behandlingsmetoder, og at der skal ske systematisk opsamling og udbredelse af eksempler på effektiv arbejdstilrettelæggelse.

FINLAND: The programme and the aims for the health and social sectors for 2004 to 2007 are as follows:

FINLAND: Programmet og målsætningerne indenfor social – og sundhedsområdet 2004 til 2007 er følgende:

In the programme and aims for the health and social sectors, the Finnish Government has laid down the most important aims for the health and social sectors for the next few years, and also recommendations for measures to achieve these aims.

The programme includes a project specifically aimed at treatment of disease and a development project for the social sector.

The programme and the aims are primarily directed towards the municipalities. The programme also includes recommendations for measures for government administration and other country-wide actors who support municipal services. The programme is normative in character. It has been developed in consultation with the Finnish Association of Local and Regional Authorities, several government bodies and organizations within the health and social sectors.

Provision of services and financing varies from municipality to municipality. Government grants are allocated within the framework of the annual national budget. Within the period of the programme, additional financing is determined, primarily according to the aims in the national health and health services project and the development project for the social sector. However, it is not possible to develop services only by allocating more resources to the area. A redistribution of resources has often also been necessary.

ICELAND: According to the new Act of March 2003 two databases on the dispensing of medicinal products will be established. The first database is a statisti-

I programmet med målsætningerne for social – og sundhedssektoren har regeringen fastlagt de vigtigste målsætninger indenfor social – og sundhedssektoren de nærmeste år ligesom der er forslag til foranstaltninger der kan henføres til disse.

I det samlede program findes der et projekt der i sær retter sig imod sygdomsbehandlingen og et udviklingsprojekt rettet mod det sociale område.

Målsætningen i programmet retter sig i første omgang mod kommunerne, men der indgår også forslag til foranstaltninger indenfor det statslige område samt andre landsdækkende aktører. Programmet er i sin karakter retningsgivende. Det er udarbejdet i samråd med Finlands kommuneforbund, et antal forvaltninger samt organisationer indenfor social- og sundhedsområdet.

Når det gælder serviceydelserne og finansieringen af disse, er situationen den at den varierer fra kommune til kommune. De statslige tilskud der gives er indenfor rammerne, af den samlede statsøkonomis råderum som fastsættes i de årlige finanslov. I programperioden er der fastlagt en tillægsfinansiering der først og fremmest retter sig imod det nationale sundhedsprogram og udviklingsprojektet inden for det sociale område, men det har ikke været muligt at give en bedre service alene ved at forøge ressourcerne til området, men det har ofte krævet en omfordeling af ressourcerne.

ISLAND: Som en følge af en ny lov fra marts 2003 vil der blive etableret to nye databaser vedrørende udlevering af lægemidler. Den ene database er til statisti-

cal database, without personal identification, and the second database has encrypted personal identification. The databases shall include information, submitted electronically by pharmacists to the State Social Security Institute, on the dispensing of medicinal products. The aim of these two databases is to meet the obligations of the State Social Security Institute, the Medical Director of Health and the Medical Control Agency regarding surveillance of prescriptions of habit-forming or narcotic medicinal products, and medical products in general. Furthermore, the aim of this Act is to monitor costs and to produce general statistics on the use of medicinal products. The relevant institutions had until January 1st 2004 to complete their preparatory work.

ske formål uden personidentifikation og den anden database har krypterede data med personidentifikation. Formålet med de to databaser er at gøre det lettere at følge Socialforsikringsdirektoratets, medicinaldirektørens samt kontrolmyndighederne for lægemidlers forpligtigelse til at overvåge receptudstedelser i almindelighed men især vanedannede og narkotiske stoffer. Det er også formålet med loven at der skal holdes et skarp øje med udgifterne samt udarbejdes statistik over forbruget af lægemidler. For at forberede arbejdet havde de relevante institutioner en tidsfrist frem til 1. januar 2004.

The State Epidemiologist in the Directorate of Health is responsible for the national recommended immunization schedule. From 2002 it was decided to include vaccination against meningococcal disease C in the recommended immunization schedule. This vaccination is to be administered at ages 6 and 8 months.

Statsepidemiologen i Sundhedsdirektoratet er ansvarlig for de nationale anbefalede vaccinationsprogrammer. Fra og med 2002 blev det besluttet at inkludere vaccinationer mod meningitis i det anbefalede vaccinationsprogram. Vaccinationen gives når barnet er fyldt 6 og 8 måneder.

In addition, a special programme was organized, with the assistance of the primary health care sector, to carry out a single vaccination of everyone under the age of 20. This programme proved to be successful and coverage is estimated to be around 90 per cent for this group.

Som et tillæg til programmet, blev der i samarbejde med det primære sundhedsvæsen udarbejdet et program for en éngangsvaccination til alle under 20 år. Disse anstrengelser synes at have været effektiv og er beregnet til at dække ca. 90 procent af denne aldersgruppe.

Previously, health centres have been run by the state. A project was carried out in 2003, in which tenders were invited for running a health centre. The health centre lies on the outskirts of the expanding capital city area, and will be manned by six primary physicians and other personnel.

Sundhedscentrene har tidligere kun været drevet af staten. I 2003 blev der gennemført en proces, som udliciterede et sundhedscenter. Centret er beliggende i udkanten af det stadigt voksende hovedstadsområde og vil blive bemandet med 6 almenlæger plus øvrigt personale.

The state (as employer) has provided the premises, furnished the premises and let it out for 25 years. Those who run the centre guarantee to provide traditional treatment for people in the area for the next eight years, after which they can submit a new tender.

Staten (som opdragsgiver)har skaffet lokalerne der er lejet i 25 år, ligesom man har stået for indretningen. De der driver centret garanterer traditionel sygdomsbehandling for området de kommende 8 år, med mulighed for forlængelse i yderligere 4 år, hvorefter der skal være en ny licitation.

Financing of the centre is partially through a block grant, partly in relation to the length of the patient list, and partly in relation to the number of visits to a physician or a nurse. In addition, there is a fee for school health services. Both the government and the primary physicians have high expectations of the project.

Betalingen til centret er delvis et fast beløb, delvis i forhold til patientlisten og delvis i forhold til antal besøg hos lægen eller sygeplejersken. Der ydes desuden en særskilt betaling for skolesundhedsplejen. Der er knyttet store forventninger til forsøget både fra staten og almenlægernes side.

NORWAY: During 2003 four new acts in the field of health have come into force: the Act of 27 June 2003 No. 64 relating to alternative treatment of disease etc., the Biotechnology Act, the Biobank Act and the Food Act. Some old acts and regulations have been revised.

NORGE: I løbet af 2003 er fire nye love indenfor sundhedsområdet trådt i kraft. Det drejer sig om loven om alternativ behandling af sygdomme m.v., bioteknologiloven, biobankloven og loven om fødevarer.

The Act relating to alternative treatment of disease etc. came into force on 01.01.04, and the 67-year-old Quackery Act was annulled. The Act involves a voluntary registration scheme for practitioners of alternative forms of treatment. A new regulation on the marketing of alternative treatment has also come into force.

Loven om alternativ behandling af sygdomme m.v. trådte i kraft den 01.01.04 og den 67 år gamle kvaksalverlov blev ophævet. Loven indebærer en frivillig registreringsordning for udøvere af alternativ behandling ligesom der er udarbejdet forskrifter om markedsføring af alternative behandlinger af sygdomme.

The new Biotechnology Act came partially into force on 01.01.04. The Act deals with, among other things, assisted fertilization and foetus diagnostics.

Den nye lov om bioteknologi trådte delvis i kraft den 01.01.04. Loven omfatter blandt andet kunstig befrugtning og fosterdiagnostik.

The Biobank Act regulates the use of material in biobanks, in a way that such material can be made use of for health purposes in an ethically acceptable way.

Biobankloven skal regulere at materiale i en biobank kan benyttes til sundhedsformål på en etisk forsvarlig måde.

The Food Act covers the whole production chain for food "from fjord and land to the table". The new Norwegian Food Safety Authority was established on 01.01.04.

Loven om fødevarer dækker hele produktionskæden for fødevarer "fra jord til bord". Det nye fødevaretilsyn blev oprettet fra den 01.01.04.

A new regulation – Regulation relating to the Prescription Register – came into force on 20.10.03. From 01.01.04, information is registered by pharmacies and sent to the Register.

En ny forskrift- Forskriften vedrørende receptregisteret – trådte i kraft den 20.10.03. Receptregisteret, der blev etableret den 01.01.04, indebærer at oplysninger der er indberetningspligtige registreres på apoteket og indsendes til registeret.

Changes were made to the Specialized Health Services Act from 01.01.04, such that the Health Authorities take over responsibility for specialized treatment of alcohol and drug abuse.

Ændringer i loven specialistbehandling og loven om social service, der trådte i kraft den 01.01.04 indebærer at de regionale sundhedskoncerner overtager alle amtskommunernes foranstaltninger overfor misbrugere af rusmidler.

SWEDEN: A report on highly specialized treatment has been presented to the Ministry of Health and Social Affairs. According to the report, the county councils shall continue to have responsibility for financing, providing and organizing highly specialized treatment. In addition, it is proposed, among other things, that the National Board of Health and Welfare should be given the task of defining which types of treatment should be nationwide, and where these should be located.

SVERIGE: Socialdepartementet har fået overdraget en rapport om den højt specialiserede sygdomsbehandling. Af rapporten fremgår det at landstingene også fremover skal have ansvaret for at bekoste, drive og organisere den højtspecialiserede sygdomsbehandling. Desuden foreslås det blandt andet at Socialstyrelsen bør få til arbejdsopgave at definere hvad der er landsdækkende sygdomsbehandling og hvor denne skal lokaliseres.

The government has appointed a national psychiatry coordinator, who shall identify and analyse problem areas and recommend measures for care, treatment and rehabilitation of people with psychiatric illness and mental handicap. The assignment shall be completed by 1 November 2006.

Regeringen har ansat en national psykiatrisamordner der skal identificere og analysere problemområdets samt komme med forslag til foranstaltninger indenfor plejen, omsorgen samt revalideringen af psykisk syge og psykisk funktionshæmmede. Arbejdsopgaven skal være afsluttet senest 1.november 2006.

A report on organ donation recommends that a national council for organ donation and transplantation should be established.

I udredningen om organdonation foreslås det at der nedsættes et nationalt råd for organdonation og transplantation.

Work has been begun to prepare recommendations for legislation for national quality registers for the health sector. The legislation shall contain regulations about the type of information that should be collected in the registers and what is needed in order to achieve this. A report will be produced in the autumn.

Der er iværksat en udredning der skal udarbejde forslag til lovgivning for nationale kvalitetsregister indenfor sundhedsområdet. Lovgivningen skal indeholde bestemmelser om hvilke oplysninger der må medtages i registeret og hvad der kræves for dette. Der vil komme en betænkning i løbet af efteråret.

Several working groups are currently working on issues related to elderly people. One of them is the government working group on Investigation of care for elderly people. Survey of treatment and care for elderly people 10 years after the Reform for Elderly People. This working group shall present its report in June 2004.

I øjeblikket er der flere udredninger der arbejder med spørgsmål vedrørende de ældre. Den ene er den statslige udredning: *Äldrevårdsutredningen - översyn av vård och omsorg för äldre 10 år efter Ädelreformen*. Denne udredning skal komme med sin rapport senest i juni 2004.

The working group SENIOR 2005 presented its report in October 2003: Future policy for elderly people. 100 steps to security and development with an ageing population.

Udredningen SENIOR 2005 kom med sin slutbetænkning i oktober 2003 med benævnelsen *Äldrepolitik för framtiden. 100 steg till trygghet och utvecklig med en åldrande befolkning* (Ældrepolitikken for fremtiden. 100 trin til tryghed og udvikling med en aldrende befolkning).

An evaluation of the Act concerning injuries to Patients has been carried out, and a report was presented during the first half of 2004.

Der har været en evaluering af patientskadeloven og der kom en betænkning i løbet af foråret 2004.

Since 1 July 2003 a county council and one or more municipalities can establish a common board for providing nursing and care services, in order to improve cooperation.

Siden 1. juli 2003 kan et landsting og en eller flere kommuner indrette et fælles nævn indenfor pleje og omsorgsområdet for at skabe mulighederne for et bedre samvirke.

From 1 July 2003, the age-limit for dentists and dental hygienists to receive public grants has been raised from 67 to 70 years. In addition, it is now possible to work within the dental insurance scheme after 70 years of age, after an individual

Fra 1. juli 2003 forhøjes aldersgrænsen fra 67 til 70 år for offentlig tilskud til tandlæger og tandplejere. Det skal desuden være muligt at arbejde indenfor tandforsikringen efter at være fyldt 70 år, efter en individuel bedømmelse. Der er

assessment. A recommendation about the age-limit for physicians and physiotherapists has also been proposed

også fremsat et forslag vedrørende aldersgrænsen for læger og fysioterapeuter.

According to a new Act, from 1 January 2004 the county employment offices, the health insurance offices, the county councils and the municipalities can cooperate for coordinating financial contributions for rehabilitation.

I følge en ny lov kan lensarbejdsnævnet, forsikringskasserne, landstingene og kommunerne samvirke, fra og med 1. januar 2004, for en finansiel samordning af revalideringsindsatser.

In November 2003, the Government presented a proposal to the parliament on infectious diseases.

I november 2003 overdrog regeringen et forslag til parlamentet vedrørende smitsomme sygdomme.

In December 2003, the Committee dealing with access to public documents and the secrecy act presented its report about a new act relating to "protection".

I december 2003 overdrog *Offentlighets- och sekretesskommittén* sin slutbetænkning angående en ny lov vedrørende "beskyttelse".

Organization and responsibility for the health sector

DENMARK: Responsibility for the health service is very decentralized. The main principles are as follows: The State is responsible for legislation, supervision and guidelines. County authorities are responsible for the hospital service, health insurance and special nursing homes. Municipalities are responsible for health care, home nursing, nursing homes and child and school health care.

Organisering og ansvar for sundhedsvirksomheden

DANMARK: Ansvaret for sundhedsvæsenet er bygget op over en meget decentral organisation. Hovedprincipperne er følgende: Staten er ansvarlig for lovgivning, tilsyn og retningslinier; amterne for sygehusvæsen, sygesikring og specielle plejehjem, mens kommunerne er ansvarlige for sundhedspleje, hjemmepleje, plejehjem samt børne- og skolesundhedstjeneste.

County authorities and municipalities have the operational responsibility.

Driftsansvaret påhviler amter og kommuner.

In the event of ordinary illness, the use of the health service by citizens is based on a century-long tradition of family doctors. The formal rules have been drawn up in accordance with the health insurance scheme, so that primary contact is always, in principle, with the general medical prac-

Ved almindelig sygdom er borgernes benyttelse af sundhedsvæsenet baseret på en århundredlang tradition for familielæger. De formelle regler er udformet i overensstemmelse hermed i sygeforsikringsloven, således at primærkontakten altid principielt rettes til den alment praktiserende

titioner. One can only use the hospital service as an alternative in cases of emergency.

Likewise, consultations with dentists are made with private dental practitioners. The public dental services only provide some dental care services for children.

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

Child health care is provided according to the Act relating to health visitors, and is organized by the health administration of the municipalities. Health examinations of children are carried out by general medical practitioners who have a contract with the health insurance scheme.

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

Immunization programmes are laid down by the Ministry of the Interior and Health and are implemented by general medical practitioners, for example during health examinations of children.

Advice concerning family planning is also provided, as every person or family is entitled to receive advice on questions of family planning. Advice is given either by a general medical practitioner or by a special department (usually outpatient clinic). Midwives and health visitors may also, within their range of competence, advise families. As a general rule, contraceptive products are not subsidized.

læge. Kun i skadestilfælde kan man som alternativ henvende sig til sygehusene.

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

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

Børnesundhedsplejen, der gives i henhold til loven om sundhedsplejerskeordninger, er knyttet til kommunernes sundhedsforvaltning, mens helbredsundersøgelser af børn udføres af de alment praktiserende læger efter overenskomst med sygesikringen.

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

Vaccinationsprogrammerne fastlægges af Indenrigs- og sundhedsministeriet og udføres af de praktiserende læger, fx i forbindelse med helbredsundersøgelser af børn.

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

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.

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

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

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

The hospital service is placed organizationally under the counties and the Joint Metropolitan Hospital Service. The county authorities and the management of the Joint Metropolitan Hospital Service are the responsible authorities. The counties own most of the hospitals. The hospitals in the City of Copenhagen and Frederiksberg municipality, and Rigshospitalet have been merged into the Joint Metropolitan Hospital Service. A few private hospitals have a contract with the county in which they are located, and a few small private hospitals operate totally independently of the public hospital service.

Sygehusvæsenet hører organisatorisk under amterne og Hovedstadens Sygehusfællesskab, og det er amtsrådene og bestyrelsen for Hovedstadens Sygehusfællesskab, der er den ansvarlige myndighed. Amterne ejer de fleste af sygehusene. Sygehusene i København og Frederiksberg kommuner samt Rigshospitalet, er samlet i Hovedstadens Sygehusfællesskab. Der er enkelte private sygehuse, som har en fast benyttelsesaftale med det amt hvori de ligger, mens nogle få mindre, private sygehuse fungerer helt uafhængigt af det offentlige sygehusvæsen.

Specialist hospitals are not organized separately. There are no health centres or similar institutions with hospital beds in Denmark.

Specialsygehusene er ikke særskilt organiseret. Der findes ingen sundhedscentre eller lignende institutioner med sengepladser i Danmark.

As a rule, patients have free choice of hospital where they wish to receive treatment. If the waiting list for treatment at a public hospital is more than two months, the patient can, according to the so-called extended free choice arrangement, choose to receive treatment at a private hospital or a hospital abroad that has a contract with the county in which the pa-

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

tient is resident. Certain types of treatment are exempt from this arrangement, such as organ transplantation, sterilization and psychiatric treatment.

er undtaget fra den udvidede fritvalgsordning, som eksempelvis organtransplantation, sterilisation og psykiatrisk behandling.

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

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

Ordinary nursing homes are run by the municipalities, but there are many private (independent) nursing homes, which receive residents according to a contract with the municipality where they are located. Certain specialized nursing homes are run by the counties, for example psychiatric nursing homes.

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

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

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

FAROE ISLANDS: The Faroe Islands Act concerning health care came into force in 1995, and according to that Act the Faroe Islands' home rule determines the rules concerning the tasks of the health service, benefits and administration. The hospital structure and its organization, specialist fields and their organization, and the primary health service and its organization largely follow the Danish system. The same applies to nursing homes, home nurses and home helps, and dental treatment.

FÆRØERNE: Lov om sundhedsvæsenet på Færøerne blev sat i kraft i 1995 hvorefter Færøernes hjemmestyre fastsætter regler om sundhedsvæsenets opgaver, ydelser og administration. Hospitalsstrukturen og organisationen, speciallægeordninger og deres organisation samt det primære sundhedsvæsen og dets organisation følger i alt væsentligt danske forhold. Det samme gør sig gældende for plejehjem, hjemmesygepleje og hjemmehjælp samt tandbehandling.

The Danish Act concerning central administration of health care came into for-

Den danske lov om sundhedsvæsenets centrale styrelse trådte i kraft for Færø-

ce in the Faroe Islands in 1995. The Danish Act concerning medical officers etc. also applies to the Faroe Islands.

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

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

Midwifery services are organized under the hospital services.

Physiotherapy services are provided by the hospital services. They are also provided by privately practising physiotherapists, who are remunerated by the public health benefit scheme, by private fees and by the social services. Pharmacies are run by public authorities.

GREENLAND: The most important legislation includes three acts: a) the Act concerning management and organization of health services, b) the Patient's Rights Act and c) the Health Services Act.

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

Health services are organized in 16 health districts, each with a health centre, where primary health services and preventive measures are provided. Other types of examination, for example blood tests and

erne i 1995. Desuden er den danske lov om embedslægeinstitutionen m.v. gældende på Færøerne.

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

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

Jordemoderordningerne er organiseret under sygehusvæsenet.

Fysioterapi foregår både i det offentlige sygehusvæsen, men også hos privatpraktiserende fysioterapeuter, som aflønnes af sygekasser, ved privat betaling og af socialvæsenet. Apotekervæsenet er drevet af det offentlige.

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

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

Sundhedsvæsenet er organiseret i 16 sundhedsdistrikter, hver med et sundhedscenter, som forestår den primære og forebyggende sundhedsindsats. Der findes mulighed for supplerende undersø-

radiographs, can be carried out. Acute operations can be performed and inpatient services can be provided. If necessary, or in complicated cases, patients can be sent to Dr. Ingrids Hospital in Nuuk or to a hospital in Denmark, or from the east coast of Greenland to Iceland.

gelser eks blod- og røntgen. undersøgelser, der kan foretages akutte operationer og ydes døgnpleje til indlagte patienter. Ved behov og komplicerede forløb visiteres til Dr. Ingrids Hospital i Nuuk eller til sygehus i Danmark, fra østkysten evt. til Island.

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

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

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

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

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

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

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

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

There are no pharmacies in Greenland. Pharmaceutical products are free and are dispensed by the health services. There is a small selection of over-the-counter medicines.

Der er ikke apotekervæsen i Grønland. Medicin er gratis og udleveres fra det behandlende sundhedsvæsen. Der findes et lille udbud af håndkøbsmedicin.

There are no occupational health services in Greenland.

Der er ikke indført BST – bedriftssundhedstjeneste i Grønland.

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

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

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

Moreover the municipalities must provide services for the mentally ill that can reasonably be offered in health centres.

Dental care includes information and prevention, and dental examination and treatment. Dental examination and treatment paid by the health insurance has been provided for the whole population since December 2002. Dental care is also provided in health centres for adults, particularly in rural municipalities. Most dental treatment for adults is provided by dentists in private practice. Young people under the age of 18 are entitled to dental care free of charge.

Municipalities are also required to provide ambulance services and to ensure

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

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

- Rådgivning og sundhedsforebyggelse, som omfatter børns sundhed, oplysningsarbejde, rådgivning angående svangerskabsforebyggelse, sundhedsundersøgelser og screening.
- Sygdomsbehandling som omfatter lægeundersøgelser og pleje samt medicinsk rehabilitering og førstehjælp. Den almindelige sygdomsbehandling gives ved sundhedscentrene, på sengeafdelinger eller som hjemmesygepleje.

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

Tandbehandlingen omfatter oplysning og forebyggelse samt undersøgelse og behandling af tænder. Undersøgelse og behandling af tænder betalt af sygeforsikringen gives til hele befolkningen efter 1. december 2002. Ved sundhedscentrene, især i landkommunerne, gives der desuden tandbehandling til voksne. Det meste af voksenbehandlingen udføres af privatpraktiserende tandlæger. Unge under 18 år har ret til tandbehandling uden brugerbetaling.

Kommunerne skal desuden tilvejebringe sygetransport og sørge for etableringen af

that occupational health services are established. Employers can either organize their occupational health service themselves or they can have an agreement with a health centre or with others who provide occupational health services.

bedriftssundhedstjenester. Arbejdsgiverne kan selv organisere bedriftssundhedstjenesten, eller de kan indgå aftale med et sundhedscenter eller andre der arbejder med bedriftssundhedstjenesten.

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

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

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

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

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

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

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

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

erly people also include primary medical care, prevention and rehabilitation. Long-term treatment and residential care for elderly people is provided in old people's homes and nursing homes.

ring. Langtidsbehandling/ophold for ældre findes ved alderdomshjem og plejecentre.

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

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

ÅLAND: According to the home rule for Åland, Åland has its own legislation for the health sector except for administrative interventions regarding personal freedom, contagious diseases, castration and sterilisation, induced abortion, assisted reproduction, forensic medicine, and general rules for companies offering health services.

ÅLAND: På grund af sit selvstyre har Åland sin egen lovgivning for sundhedsvæsenet, dog med undtagelse af bl.a. administrative indgreb i den personlige frihed, smitsomme sygdomme, kastrering og sterilisation, svangerskabsafbrydelse, kunstig befrugtning, retsmedicinske undersøgelser, samt regelsættene for virksomheder der udbyder sundhedsydelser.

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

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

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

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

The Åland Government has overall responsibility for ensuring that the population receives necessary medical care. The role of the municipalities is limited to financing certain defined types of treat-

Landskapsregeringen er hovedansvarlig og har ansvaret for at befolkningen får den nødvendige sygdomsbehandling. Kommunernes ansvar og indflydelse er begrænset til visse nærmere afgrænsede

ment. Specialist treatment, including psychiatric treatment, is one of two sectors in the ÅHS.

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

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

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

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

Dental treatment is part of the primary health service. The youngest age groups have the highest priority together with certain high-risk groups and preventive measures. If possible, other patient groups are also treated. The private sector is well established with a high capacity, and it provides an important supplement.

finansieringsforpligtigelser. Den specialiserede sygdomsbehandling, inkl. behandlingen af psykiatriske patienter, udgør den ene af to enheder i ÅHS.

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

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

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

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

Tandbehandlingen er en del af det primære sundhedsvæsen. Behandling af de yngre aldersgrupper og visse risikopatientgrupper samt forebyggende foranstaltninger har højeste prioritet. Såfremt det er muligt behandler man også andre patienter. Den private sektor er kapacitetsmæssigt veludbygget og udgør et vigtigt supplement.

Regulations for pharmacies are the same as in Finland.

ICELAND: The government is responsible for health services according to the Health Service Act of 1990. Other major acts are:

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

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

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

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

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

Reglerne for apotekervæsenet er det samme som i Finland.

ISLAND: Regeringen har ansvaret for sundhedsvæsenet i henhold til sundhedsloven fra 1990. De andre vigtigste love er følgende:

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

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

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

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

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

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

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

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

En vis del af fysioterapien foregår gennem sundhedscentrene, men det meste af behandlingen varetages af privatpraktiserende fysioterapeuter i byområderne.

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

Privatpraktiserende fysioterapeuter arbejder på kontrakt med SSI.

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

Hjemmesygeplejen drives fra sundhedscentrene mens hjemmehjælpen gives gennem det kommunale sociale servicesystem.

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

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

There was a public school dental service in Reykjavik from 1922, but it was closed down in the spring of 2002.

Der har været en skoletandplejeordning i Reykjavik siden 1922 men den blev afviklet i 2002.

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

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

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

Pharmacies are privately run.

NORWAY: The system of health care provision in Norway is based on a decentralized model. The state is responsible for policy design and overall capacity and quality of health care through budgeting and legislation. The state is also responsible for hospital services through state ownership of regional health authorities. Within the regional health authorities, somatic and psychiatric hospitals, and some hospital pharmacies, are organized as health trusts.

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

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

- Promotion of health and prevention of illness and injuries, including organizing and running school health services, health centres, child health care provided by health visitors, midwives and physicians. Health centres offer pregnancy check-ups and provide vaccinations according to the recommended immunization programmes.

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

Apoteker drives af private.

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

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

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

- Sundhedsfremme og forebyggelse af sygdomme og skader, herunder at organisere og drive skolesundhedsvæsenet og sundhedscentrene samt børnesundhedspleje udført af sundhedsplejersker, jordemødre og læger. Sundhedscentrene skal tilbyde svangerskabsopfølgning og -kontrol samt vaccinationer efter de anbefalede vaccinationsprogrammer.

- Diagnosis, treatment and rehabilitation. This includes responsibility for general medical treatment (including emergency services) physiotherapy and nursing (including health visitors and midwives).

- Nursing care in and outside institutions. Municipalities are responsible for running nursing homes, home nursing services and other services such as the home help service. The health services in and outside institutions are, to a varying degree, organized jointly within the same municipal department for treatment and care.

In Norway there is currently a National Mental Health Programme. The programme was originally for the period 1999 to 2006, and it has been prolonged until 2008. This programme aims at improving accessibility, quality and organization of mental health services and treatment on all levels. A central idea of the Mental Health Programme is to promote deinstitutionalization, with considerable emphasis on community-based psychiatry, where treatment is given closer to the patient's local community and primary health services. These community clinics represent an all-round psychiatric practice and consist of a network of services, such as multidisciplinary treatment and teamwork, in addition to programmes for accommodation, occupation and social support.

The county authorities are responsible for providing public dental services for the following groups: 1. children and adolescents (under 21 years of age) 2. mentally handicapped adults, and 3. elderly people, disabled people, and people with chronic illnesses who live in institutions or who re-

- Diagnosticering, behandling og revalidering. Dette omfatter ansvaret for den almindelige lægebehandling (inkl. lægevagtordninger), fysioterapi og sygepleje (inkl. sundhedsplejersker og jordemødre).

- Pleje og omsorg i og uden for institutionerne. Kommunerne har ansvaret for driften af sygehjemmene, hjemmesygepleje og andre ordninger (fx hjemmehjælp). Sundhedsydelserne i og uden for institutionerne er i varierende grad forankret i en fælles organisatorisk enhed i form af en fælles pleje- og omsorgsafdeling i kommunen.

Der findes i øjeblikket et nationalt program for psykiatrien. Programmet var oprindeligt for perioden 1999 til 2006, men er forlænget indtil 2008. Det er programmets målsætning at der gives den nødvendige adgang for psykiatrisk behandling, kvalitetssikring og udbud af behandling på alle niveauer. Det er centralt for programmet at man fremmer en deinstitutionalisering af behandlingen med betydelig vægt på distriktspsykiatrien, hvor behandlingen gives i tæt kontakt til patients lokale samfund og i tilknytning til den almene lægebehandling. Disse lokalklinikker repræsenterer en bredt funderet psykiatrisk praksis og består af et netværk af udbud så som multidisciplinær behandling og teamwork sammen med programmer for bolig, beskæftigelse og social støtte.

Amterne (fylkene) har ansvaret for tandbehandlingen til følgende grupper; 1)børn og unge under 21 år 2) psykisk syge voksne og 3) ældre, funktionshæmmede og personer med kroniske sygdomme der lever på institutioner eller modtager hjemmesygepleje. Tandbe-

ceive home nursing care. Dental services for the rest of the population are mainly provided by private general dental practitioners, and paid for by the patients.

handling for resten af befolkningen gives hovedsageligt af privatpraktiserende tandlæger og patienterne betaler selv for behandlingen.

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

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

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

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

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

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

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

- Helsepersonelloven
- Pasientrettighetsloven
- Pasientskadeloven
- Spesialisthelsetjenesteloven
- Kommunehelsetjenesteloven
- Helseforetaksloven
- Smittevernloven
- Tilsynsloven
- Psykisk helsevernloven
- Tannhelsetjenesteloven
- Tobakkskadeloven
- Apotekloven
- Legemiddelloven
- Abortloven

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

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

ORGANIZATION OF HEALTH SERVICES

Primary health care is run by 18 county authorities and three regions. Since 1991 there has been a pilot scheme, in which some municipalities have had responsibility for primary health services. The experiment will continue in one municipality during 2004.

Det primære sundhedsvæsen drives af de l8 landsting og tre regioner. Siden 1991 har der været iværksat forsøg hvor nogle kommuner har været hoved ansvarlig for det primære sundhedsvæsen. En kommune fortsætter forsøget i løbet af 2004.

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

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

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

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

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

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

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

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

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

Socialstyrelsen udarbejder den almindelige vejledning for vaccination af børn.

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

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

The hospitals are run by the county and regional authorities.

Sygehusene drives af landstingene og regionerne.

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

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

Pharmacies are run by the state.

Apotekerne er statslige.

The Pharmaceutical Benefits Board was established on 1 October 2002. The board has responsibility for deciding whether a medicine or a specific medical product shall be subsidized, and for determining the price of the product.

Läkemedelsförmånsnämden (Nævnet for lægemidler) er et nævn der har eksisteret siden 1. oktober 2002. Nævnet skal afgøre om der skal ydes refusion til et lægemiddel eller en bestemt vare, samt fastsætte prisen for denne.

Supervision of health services

DENMARK: Supervision of health service is based partly on legislation governing the central administration of the health service and partly on special legislation, first and foremost concerning the different groups of health care personnel (the Physicians' Act, the Nursing Act, etc.). Supervision is partly carried out by the National Board of Health and partly by medical officers.

The medical officers are employed by institutions for medical officers of which there is one in every county and one in the City of Copenhagen. These institutions are state-run and thus independent, politically and administratively, of the county and municipal authorities, which have responsibility for the health service supplied to the general public. In this way, the medical officers function as independent advisers and supervisors at all levels and are authorized to take necessary measures either by consultation or by handing over further treatment of a case to the central authorities. The institutions are attached to the National Board of Health, both professionally and financially.

Supervision of health care personnel and their professional activity is carried out by the National Board of Health in close collaboration with the local medical officers. Decisions concerning individuals may in such cases be appealed to the responsible minister and, if necessary, the courts.

The Patients' Complaints Board deals with complaints concerning authorized health

Tilsyn med sundhedsvæsenet

DANMARK: Tilsynet med sundhedsvæsenet er dels baseret på loven om sundhedsvæsenets centralstyrelse, dels på særlovgivning, først og fremmest om de forskellige grupper af medicinsk personale (lægeloven, sygeplejeloven, m.fl.). Tilsynet udføres dels af Sundhedsstyrelsen, dels af embedslægerne.

Embedslægerne er ansat ved embedslægeinstitutionerne, som der er én af i hvert amt, samt én i Københavns Kommune. Disse institutioner er statslige og således politisk og administrativt uafhængige af amter og kommuner, der har ansvaret for sundhedsvæsenets betjening af befolkningen. Embedslægerne kan således fungere som uafhængige rådgivere og er tilsynsførende på alle niveauer. Institutionerne er bemyndiget til at foretage det fornødne, enten i form af påtale eller ved videregivelse af sagens behandling til de centrale tilsynsmyndigheder. Såvel fagligt som budgetmæssigt er embedslægeinstitutionerne knyttet til Sundhedsstyrelsen.

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

Klager over autoriseret sundhedspersonale indgives til Patientklagenævnet. Ef-

care personnel. Following preliminary treatment of the cases (hearings of the parties, professional assessment, etc.) by the medical officer, a final decision is reached by the Patients' Complaints Board.

ter forbehandling af sagerne (partshøringer, faglig vurdering m.v.) hos embedslægen træffes den endelige afgørelse af Patientklagenævnet.

In connection with the statutory planning of the preparation of guidelines and debates about adhering to them, supervision of health services is primarily carried out through collaboration between the decentralized authorities. Daily activity is furthermore monitored through submission, by counties and municipalities, of specified budgets and accounts, and statistical data to various centralized registers. Supervision concerning specific issues is only brought up in exceptional cases.

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

FAROE ISLANDS: The rules for supervision of health service are, by and large, the same as in Denmark, both concerning who has responsibility for supervision (the chief medical officer) and regarding in which areas supervision shall be carried out and procedures for complaints.

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

GREENLAND: The Office of the Chief Medical Officer, an independent institution under the Greenland Home Rule Government, is responsible for supervision of health services. The chief medical officer advises and assists the Greenland Home Rule Government and other authorities in questions of health. Areas of supervision include health care institutions, health care personnel, municipal institutions and other institutions. Complaints about health issues are addressed in writing to the Office of the Chief Medical Officer, which prepares the case and evaluates the complaint before forwarding it to the Danish Patients' Complaints Board of the Board of Health in

GRØNLAND: Tilsynsmyndigheden er Embedslægeinstitutionen i Grønland som er en sundhedsfagligt uafhængig institution under Grønlands Hjemmestyre. Embedslægeinstitutionen yder rådgivning og anden bistand i sundhedsfaglige spørgsmål til Landsstyret og andre myndigheder. Tilsynsområderne er sundhedsvæsenets institutioner, sundhedsfaglige personer samt kommunale og andre institutioner. Sundhedsfaglige klager rettes skriftligt til Embedslægeinstitutionen, som vurderer, forbereder og sagsfremstiller klagen, før den videresendes til Sundhedsvæsenets Patientklagenævn i København som foretager den endelige be-

Copenhagen. This board completes the preparation of the case, arranges a hearing and makes a decision. Complaints about health services and questions concerning compensation are dealt with by the Directorate of Health.

handling, høring og afgørelse. Klager over service samt krav om erstatninger behandles af Direktoratet for Sundhed.

FINLAND: Supervision of health services in Finland is organized in a less formal way than in the other Nordic countries. There is no body that is authorized to carry out supervision of health services. Supervisory tasks are spread out among the whole health services system.

FINLAND: Tilsynet med sundhedsvæsenet er i Finland organiseret mindre formelt end i de andre nordiske lande. Der er ingen som officielt er autoriseret til at føre tilsyn med sundhedsvæsenet. Arbejdsopgaverne er spredt ud i hele sundhedssystemet.

The most important channel for nationwide supervision of health and social services is through legislation and related statutes. In addition, the government ratifies nationwide plans for the health and social sector for the following election period (four years). Overall planning, coordination and supervision of the statutory services is the responsibility of the Ministry of Social Affairs and Health. Planning, managing and supervising services at the county level is the responsibility of the county authorities. The chief medical officers and the forensic pathologists act as medical advisers to the regional administration of the Ministry of Social Affairs and Health. In addition there are six government institutions that contribute to supervision of health services.

De vigtigste kanaler til den landsdækkende styring af social- og sundhedsvæsenet er lovgivning og dertil hørende forordninger. Regeringen godkender desuden de landsdækkende planer for social- og sundhedsområdet for den kommende regeringsperiode (fire år). Den generelle planlægning, styring og tilsynet med de lovpligtige ydelser påhviler Social- och hälsovårdsministeriet. Planlægning, styring og tilsyn inden for lenene påhviler länsstyrelserne. Embedslægerne og retslægerne fungerer som lægelige rådgivere for Social- och hälsovårdsministeriets regionale administration. Hertil kommer seks statslige institutioner som medvirker ved tilsynet med sundhedsvæsenet.

A nationwide body for the protection of patients rights has been established. The body may assess whether the services provided by a municipality are up to the required standards. If the body finds that the services are inadequate, and that the municipality is responsible for this, then it may recommend how the deficiencies may be dealt with and give a time limit for when improvements shall be made.

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

Patients have many possibilities to complain about the treatment or services they have received. The simplest way is to express dissatisfaction to the physician who provided the treatment, or to contact the physician in charge of the hospital department or health centre. If further assistance is needed in order to solve the problem, there are two possibilities. The patient can contact either the Office of the Chief Medical Officer or the National Authority for Medicolegal Affairs. Both these bodies can give an expert opinion, or give sanctions if necessary.

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

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

ÅLAND: Tilsynet med sundhedspersonalet sker efter finsk lovgivning.

Complaints concerning treatment can either be addressed, as in Finland, to the institution providing the treatment or to the national authorities - or to the Åland Government. In Åland, the patient ombudsman is employed by the Åland Government and is thus independent of the respective treatment institutions. The patient ombudsman may table questions of principal significance in the "Patients Board of Trust" where the questions may be discussed and form the basis for decisions, although the committee cannot decide individual cases.

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

ICELAND: The Medical Director of Health has overall responsibility for supervision of health institutions, health care personnel, prescription of pharmaceutical products, measures for combating substance abuse and control of all public health services.

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

Icelandic Medicines Control Agency (IMCA) supervises pharmacies and pharmaceutical products.

Lægemiddelstyrelsen fører det farmaceutiske tilsyn med apoteker og lægemidler.

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

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

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

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

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

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

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

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

General supervision involves monitoring health services provision and observing trends in the health status of the population. Such information is used to evaluate the supply of health services, both in relation to the needs of the population and in relation to national aims and priorities.

Det generelle tilsyn består af at føre kontrol med social- og sundhedsvæsenets ydelser samt følge med i befolkningens behov, og derudfra vurdere behovsdækningen og tilbudsudformningen i forhold til de nationale mål og prioriteringer.

Supervision of health services is carried out in three ways:

Tilsynet med sundhedsvæsenet sker på tre måder:

1. Organizational audits: systematic appraisal of health care, to ascertain whether activities and results are in accordance with current laws and regulations, and whether internal control systems function in practice. Eve-

1. Systemrevision: Systematiske undersøgelser, for at fastslå om aktiviteter og tilhørende resultater er i overensstemmelse med de krav der fastsættes i henhold til love og forskrifter, samt om det interne kontrolsystem fungerer i praksis. En-

ry institution providing health services has a duty to establish an internal control system to ensure that the institution is run in accordance with laws and regulations.

2. Surveys: collection of data and information from health care institutions or about patient groups.

3. Verification: random checks to verify whether internal control systems function in practice, and whether activities are in accordance with the requirements laid down by the health authorities.

hver virksomhed der udbyder sundhedsydelser har pligt til at etablere et internt kontrolsystem med henblik på at sikre at virksomheden drives i overensstemmelse med love og forskrifter.

2. Kortlægning: Indsamling af data og oplysninger fra virksomheder eller om patientgrupper.

3. Verificering: Kontrollere at den interne kontrol fungerer i praksis og at aktiviteterne er i overensstemmelse med myndighedernes krav (hændelsesbaseret tilsyn).

Supervision of health care personnel:

The Norwegian Board of Health in the counties process complaints against individual health care personnel. They can find that the conditions laid down in laws and regulations have not been met and can give advice on how to make improvements.

If there are grounds for more serious sanctions against health care personnel, the complaint may be forwarded to the Norwegian Board of Health (centrally).

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

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

Tilsyn med sundhedspersonale:

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

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

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

Patienterne vil også kunne klage til den ansvarlige for virksomheden (fx kommunalbestyrelsen når det gælder kommunale sundhedsydelser) eller til Norsk patientskadeerstatning, hvis der er tale om erstatning som følge af behandling i

claims for compensation related to treatment in the public health service. The Patient Injury Act, which came into force on 1 January 2003, enhances patients' possibilities to complain, among other things by describing both the complaints procedure and patients' rights.

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

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

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

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

The agencies with overall responsibility for health services have their own impar-

det offentlige sundhedsvæsen. Patientskadeloven, der gælder fra og med 2003, styrker patienternes klageadgang i forhold til tidligere ordninger, blandt andet ved at klageordningen beskrives og ved at forskellige rettigheder omtales.

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

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

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

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

De hovedansvarlige for sundhedsvæsenet har egne upartiske nævn (patientnævn)

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

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

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

Sundhedsvæsenets ansvarsnævn (HSAN) er en uafhængig statslig myndighed som efterprøver klager over sundhedspersonale.

Financing of health services

In the Nordic countries, the health services are mainly financed by the public authorities. In Iceland, contributions are primarily made by the government, while financing in the other countries mainly consists of county and/or municipal taxes with general grants from the governments. In the Nordic countries, the governments issue block grants to the counties and/or municipalities. With the exception of Greenland, citizens in the Nordic countries contribute directly to financing, partly through insurance schemes, partly by paying user charges. A financing model for somatic hospitals was established in Norway (as from 1 July 1997) that combines block grants and fee for service financing. The scheme is regularly evaluated and adjusted. The fee for service financing is based on the principle that a service producer (i.e. the hospital) is paid on the basis of services rendered. The scheme involves the state reimbursing a percentage of the average DRG expense (Diagnosis Related Groups) in connection with treatment of patients in the counties.

Finansiering af sundhedsvæsenet

I de nordiske lande finansieres sundhedsvæsenet hovedsageligt af det offentlige. I Island er det primært staten, der bidrager, mens finansieringen i de øvrige lande stammer fra amtskommunale og/eller kommunale skatter samt bloktilskud fra staten. I de nordiske lande yder staten et generelt bloktilskud til amter og/eller kommuner. Med undtagelse af Grønland bidrager borgerne i de nordiske lande direkte til finansieringen, dels gennem forsikringsordninger, dels ved brugerbetaling. For Norges vedkommende er der etableret en finansieringsmodel for de somatiske sygehuse (fra 1. juli 1997) som kombinerer bloktilskud og stykprisfinansiering. Ordningen bliver jævnligt evalueret og justeret. Stykprisfinansieringen bygger på det princip, at en serviceproducent (det vil sige sygehuset) får indtægter beregnet ud fra udførte serviceopgaver. Ordningen indebærer, at staten refunderer en vis procentandel af de gennemsnitlige DRG-udgifter (Diagnose Relaterede Grupper) ved amtskommunal patientbehandling.

Charges for health care as per 1 January 2004

Consultation with a physician

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

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

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

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

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

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

ÅLAND: For medical consultations within the primary health service at the clinic or for home visits, there is a user

Egenbetaling for sundhedsydelser pr. 1. januar 2004

Lægebesøg

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

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

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

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

De nævnte beløb opkræves ikke af personer under 18 år.

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

ÅLAND: Egenbetaling for lægebesøg inden for det primære sundhedsvæsen i konsultationen eller ved hjemmebesøg er

charge of EUR 18. Outside the opening hours the charge is EUR 27.The maximum patient contribution for primary health care and outpatient treatment is EUR 450 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 27 per day to EUR 15 per day. For children and young people under 18, the maximum user charge is EUR 200 per calendar year, after which there is no user charge for further treatment, including short-term treatment in hospital. People over 18 years of age with an income below EUR 14 000, or EUR 22 000 for a husband and wife or partners, pay only EUR 225 per year, because of their low income. The activities included in the maximum user charge have been fixed beforehand. If there is a waiting period of 45 minutes or more in connection with a scheduled visit, within opening hours, the user charge is reimbursed.

ICELAND: Preventive health care consultations for pregnant women and mothers with infants, and school health care are free of charge.

The patient charge for a consultation in a health centre or with a private general medical practitioner during normal working hours is ISK 600 The charge is ISK 300 for children under 18, pensioners, disabled people, and long-term unemployed people. The charge is ISK 200 for children who are handicapped or chronically ill. Outside normal working hours the charges are ISK 1 500, 700 and 450 respectively. Charges for home visits are ISK 1 600, 600 and 450 during the daytime and ISK 2 300, 850 and 600 in the evenings and at night.

18 EUR. Uden for åbningstiden er det 27 EUR. Der er indført maksimal egenbetaling på 450 EUR for lægebesøg og ambulant behandling indenfor et kalenderår hvorefter der ikke betales den resterende del af året med undtagelse af kortvarig institutions/hospitalsophold hvor betalingen reduceres fra 27 EUR pr døgn til 15 EUR pr døgn. For børn og unge under 18 år er den maksimale egenbetaling 200 EUR per kalenderår, herefter er al behandling på grund af den maksimale egenbetaling uden egenbetaling, inklusiv korttidsbehandling på en hospitalsafdeling. Personer der er over 18 år med en indkomst på maksimalt 14 000 EUR, eller 22 000 EUR for ægtefæller eller samboende betaler kun 225 EUR per år på grund af den lave indkomst. De aktiviteter som medregnes i den maksimale egenbetaling er fastlagt på forhånd. Hvis der er en ventetid på 45 minutter eller mere ved en aftalt besøg, indenfor åbningstiden, tilbagebetales egenbetalingen.

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

Egenbetalingen for konsultation i sundhedscentrene eller ved en privat praktiserende læge er i dagtimerne 600 ISK og 300 ISK for børn under 18, pensionister, handicappede og langtidsarbejdsløse. Handicappede og langtidssyge børn betaler 200 ISK. Konsultation udenfor dagtimerne er henholdsvis 1 500, 700 og 450 ISK. For hjemmebesøg er betalingen i dagtimerne 1 600, 600 og 450 ISK mens aften- og nattaksten er 2 300, 850 og 600 ISK.

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

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

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

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

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

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

The user charges for a consultation with a physician are: primary physician: NOK 117 (day), NOK 185 (evening), regular medical practitioner who is a specialist in general practice: NOK 132 (day) and NOK 200 (evening), specialist: NOK 245.

Egenbetalingen for konsultation hos en læge er følgende: Almenlæge: 117 NOK (dag) og 185 NOK (aften). Hos en almenlæge der er specialist i almen medicin: 132 NOK (dag) og 200 NOK (aften). Konsultation hos en specialist 245 NOK.

From 1 July 2004, a fee of NOK 35 was introduced for all telephone consultations with a regular medical practitioner and private specialist.

Fra 1. juli 2004 er der indført en egenbetaling på 35 NOK på alle telefonkonsultationer hos en almenlæge og privatpraktiserende specialister.

The user charges for a home visit are: regular medical practitioner: NOK 170 (day) and NOK 260 (evening). Regular medical practitioner who is a specialist in general practice: NOK 185 (day) and NOK 275 (evening). Specialist: NOK 245.

Egenbetalingen ved sygebesøg er som følgende: Almen læge 170 NOK (dag) og 260 NOK (aften). Almenlæge der er specialist i almen medicin: 185 NOK (dag) og 275 NOK (aften). Specialist: 245 NOK.

User charges for a consultation with a physician

	Are there consistent rules for the whole country?	Size of user charge	Deviations	User charge in relation to total cost of consultation
Denmark	Yes	-	No	-
Faroe Islands	Yes	-	No	-
Greenland	Yes	-	No	-
Finland	Yes	Public EUR 0-11 EUR 15 if the visit occurs between 8 p.m. and 8. a.m. or on a Saturday, a Sunday or a public holiday. Private min. 40 per cent	No charge for children under 18 years of age	17 per cent
Åland	Yes	EUR 18 Outside opening hours EUR 27	Free treatment after paying EUR 450. EUR 200 for children below 18 and EUR 225 for persons with low income	..
Iceland	Yes	ISK 600-2 300 in primary care, other rules for specialized care	ISK 300-850 for children under 18 years of age, pensioners, disabled and long-term unemployed. For handicapped and chronically ill children ISK 200-600	Varies
Norway	Yes	NOK 117 (day), NOK 185 (evening) with a primary physician NOK 132 (day) NOK 200 (evening): consultation with a regular medical practitioner who is a specialist in general medicine NOK 245: consultation with specialist	In the case of pregnancy, childbirth, treatment of industrial injuries, war injuries, for prison inmates, children under 7 years of age, in the case of psychotherapy for persons under 18 years of age and for treatment of dangerous contagious diseases	Approx. 35 per cent
Sweden	No	SEK 100- 300		..

The user charge for laboratory tests, histological tests and cytological tests is NOK 40.

Egenbetalingen for laboratorie-, histologiske - og cytologiske prøver er 40 NOK.

The user charge for a consultation with a specialist at a hospital out-patient department is NOK 245 (NOK 117 for a consultation with a general medical practitioner). The user charge for a radiograph or an ultrasound examination is NOK 185.

Egenbetalingen for en konsultation hos en specialist på et ambulatorium er 245 NOK (117 NOK hvis det er en almenlæge). Egenbetaling for røntgen- og ultralydsundersøgelser er 185 NOK.

Egenbetaling for lægebesøg

	Er der ensartede regler i hele landet?	Egenbetalingens størrelse	Afvigelser	Egenbetalingens andel af de samlede udgifter til lægebesøg
Danmark	Ja	-	Nej	-
Færøerne	Ja	-	Nej	-
Grønland	Ja	-	Nej	-
Finland	Ja	Offentlig 0-11 EUR. 15 EUR for besøg mellem kl. 20-8 på hverdage, samt lørdage, søndage og helligdage Privat mindst 40 pct.	Ingen betaling for børn under 18 år	17 pct.
Åland	Ja	18 EUR 27 EUR udenfor åbningstiderne	Fri behandling når der er betalt 450 EUR,_200 EUR for børn under 18 år, 225 EUR for personer med lav indkomst	..
Island	Ja	600-2 300 ISK hos almen læge, andre regler for besøg hos specialist	300–850 ISK for børn under 18 år og for pensionister, handicappede og langtidsarbejdsløse. For handicappede og langtidssyge børn 200-600 ISK	Varierende
Norge	Ja	117 NOK (dagtimer) 185 NOK (aften og nat) hos almen læge 132 NOK (dagtimer) 200 NOK (aften og nat) hos en almenlæge der er specialist i almenmedicin 245 NOK for en konsultation hos en specialist	Ved svangerskab/fødsel, erhvervsskade, krigsskade, for indsatte i fængsel, børn under 7 år, ved psykoterapeutisk behandling af børn og unge under 18 år og ved farlige smitsomme sygdomme.	Ca. 35 pct.
Sverige	Nej	100-300 SEK		..

The user charges for casualty services are: consultation: NOK 206. Consultation, physician who is a specialist in general practice: NOK 221. Home visit: NOK 281. Home visit, physician who is a specialist in general practice: NOK 296.

There is a user charge for assisted fertilization and sterilization. Part of the cost for up to three attempts of assisted fertilization is refunded, and the patient pays a user charge of NOK 18 000. The rules for patient charges for sterilization do not apply if there are medical indications for the operation.

Egenbetalingen hos lægevagten er følgende: Konsultation: 206 NOK. Konsultation hos en almenlæge der er specialist i almen medicin: 221 NOK. Sygebesøg: 281 NOK. Sygebesøg af en almenlæge der er specialist i almenmedicin: 296 NOK.

Der er desuden egenbetaling for kunstig befrugtning og sterilisering. Der gives tilskud for op til tre forsøg med kunstig befrugtning hvor patienten selv må betale 18.000 NOK. Der er ingen egenbetaling for sterilisering, hvis indgrebet skyldes en medicinsk indikation.

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

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

In most counties/regions, children and young people under the age of 20 years may attend an outpatient clinic free of charge. In one region, children under 20 years of age pay half price. In the other regions, the age limit for paying user charges varies from 12 years to the calendar year in which a person turns 20.

Reimbursement for pharmaceutical products

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

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

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

I de fleste landsting/regioner kan børn og unge under 20 år gå til ambulant lægebehandling uden brugerbetaling. I en region betaler børn under 20 år halv pris. I de resterende varierer grænsen for at der ikke opkræves brugerbetaling mellem 12 år og det kalenderår hvor man fylder 20 år.

Tilskud til lægemidler

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

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.

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

An individually assessed subsidy may be granted by submitting an application through one's own doctor to the Danish Medicines Agency.

Der kan opnås individuelt tilskud til lægemidler uden generelt tilskud ved at indsende ansøgning til Lægemiddelstyrelsen gennem egen læge.

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

Lægemiddelstyrelsen udarbejder en tilskudspris for hver af de lægemiddelgrupper, der er omfattet af tilskudsprissystemet. Tilskudsprisen er den pris, der lægges til grund for beregning af tilskud.

The subsidy is calculated on the basis of the reference price of each packet. Thus, the subsidy cannot be higher than the actual cost of the medicinal product. There are no changes to subsidy based on need.

Beregningen af tilskud foretages udfra den enkelte paknings tilskudspris. Der kan dog aldrig gives tilskud til mere end lægemidlets faktiske pris. Det behovsafhængige tilskud bevares uændret.

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

Systemet tilstræber at lægen/tandlægen vælger det billigste produkt på markedet (substitution). Lægen/tandlægen kan i særlige tilfælde fravælge substitution, når denne finder at substitution på apoteket er uhensigtsmæssigt.

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

Der udarbejdes løbende en specialitetstakst, som omfatter priser på alle markedsførte farmaceutiske specialiteter.

Since liberalization in October 2001, there are now more than 1 300 authorized agents for non-prescription medicinal products for people or animals (products that are not restricted to pharmacies).

Siden liberaliseringen i oktober 2001, findes der i Danmark nu mere end 1 300 godkendte forhandlere af ikke apoteksforbeholdte håndkøbslægemidler til mennesker og/eller dyr.

All authorized businesses, irrespective of the selection of medicinal products that they sell, must follow the current regula-

Fælles for de godkendte forretninger uanset sortiment af lægemidler er, at de skal respektere gældende regler vedrø-

tions relating to storage and quality of medicinal products, and the prohibition against self-service sale and sale to children under 15 years of age.

rende opbevaring og kvalitet samt forbud mod selvvalg og salg til børn under 15 år.

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

Forhandlere af håndkøbsmedicin til mennesker skal desuden være i besiddelse af et basissortiment fastsat ved lov. Visse håndkøbslægemidler, f.eks. smertestillende, må ikke sælges mere end maksimum en pakning pr. kunde pr. dag.

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

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

FAROE ISLANDS: A health insurance contribution is still payable on the Faroe Islands. The contribution covers part of the cost of pharmaceutical products. In addition, direct user charges of 0 – 50 per cent of the costs of the reimbursable pharmaceutical products are payable. Pensioners are reimbursed user charges exceeding a certain amount. The same applies to people who have been granted pharmaceutical products in accordance with the Social Security Act.

FÆRØERNE: Der betales fortsat sygekassekontingent på Færøerne som dækker en del af medicinudgifterne. Derudover er der også direkte brugerbetaling på 0 til 50 pct. af udgifterne til den tilskudsberettige medicin. Pensionister får refunderet brugerbetalingen over et vist beløb. Det samme gælder personer der har fået bevilget medicin efter forsorgsloven.

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.

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

FINLAND AND ÅLAND: There are three payment categories for prescription pharmaceutical products, and reimbursement is calculated separately for each purchase and for each category.

FINLAND OG ÅLAND: Der er tre betalingskategorier for receptpligtige lægemidler, og refusionen er beregnet separat for hver indkøb og hver kategori.

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

Nogle nye og meget dyre medikamenter (for eksempel mod demens og multipel sklerose) bliver i særlige tilfælde betalt af hospitalet eller kommunen. Der forekommer ingen automatisk accept af nye medikamenter i refusionssystemet og mange medikamenter bliver markedsført uden tilskud. Sundhedsøkonomerne har fået større og større indflydelse på hvilke medikamenter der skal gives tilskud til.

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

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

As a main rule, the health insurance scheme reimburses expenditure on prescription pharmaceutical products exceeding EUR 604.72 in the course of one calendar year.

Som hovedregel dækker sygeforsikringen de udgifter til receptpligtige lægemidler som overskrider et beløb på 604,72EUR i løbet af et kalenderår.

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

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

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

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

There is a reference price system. For generic drugs of the same type, strength and package size, the reimbursement is calculated in relation to the maximum reference price, i.e. the lowest priced generic product. The present reference price list covers about 12 per cent of registered drug products.

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

User charges for pharmaceutical products

	Are there consistent rules for the whole country?	Size of user charge	Deviations	User charge in relation to total cost of pharmaceutical products
Denmark	Yes	Reimbursement in relation to the level of the patient's consumption of drugs in the primary sector	No	40 per cent
Faroe Islands	Yes	As in Denmark	No	..
Greenland	Yes	-	No	-
Finland	Yes	EUR 10 and 50 per cent of the cost exceeding EUR 10	For certain diseases, EUR 5 and 0/25 per cent of the cost exceeding EUR 5 is paid	45 per cent
Åland	Yes	As in Finland	As in Finland	-
Iceland	Yes	ISK 1 700+ 65/80 per cent of the remaining cost, but max. ISK 3 400/4 950	Pensioners and disabled: ISK 600 + 50 per cent of the remaining cost, but max. ISK 1 050/1 375	Approx. 37 per cent
Norway	Yes	36 per cent maximum NOK 400 per receipt	For children below 7 years and persons who receive a minimum pension: no user charge	..
Sweden	Yes	SEK 0- 1 800	-	..

Egenbetaling for lægemidler

	Er der ensartede regler i hele landet?	Egenbetalingens størrelse	Afvigelser	Egenbetalingens andel af de samlede udgifter til lægemidler
Danmark	Ja	Tilskud afhængig af størrelsen af den enkelte patients lægemiddelforbrug i primærsektoren	Nej	40 pct.
Færøerne	Ja	Som i Danmark	Nej	..
Grønland	Ja	-	Nej	-
Finland	Ja	10 EUR og 50 pct. af det beløb som overskrider 10 EUR	Ved visse sygdomme betales 5 EUR og 0/25 pct. af det beløb som overskrider 5 EUR.	45 pct.
Åland	Ja	Som i Finland	Som i Finland	-
Island	Ja	1 700 ISK + 65/80 pct. af den resterende pris, dog højst 3 400/4 950 ISK	Pensionister og handicappede: 600 ISK + 50 pct. af den resterende pris, dog højst 1 050/1 375 ISK	Ca. 37 pct.
Norge	Ja	36 pct. maksimum 400 NOK pr. recept	For børn under 7 år og minstepensjonister: ingen egenbetaling	..
Sverige	Ja	0 –1 800 SEK	-	..

NORWAY: Most pharmaceutical products are reimbursed according to a system based on diagnoses and approved pharmaceutical products prescribed by a physician (the so-called "blue prescription"). A condition is long-term need for the pharmaceutical product, medical equipment or medical item. The patient charge for these is 36 per cent of the cost, up to a maximum of NOK 400 per prescription. Children under seven years of age and persons who receive a minimum pension are exempt from patient charges for essential pharmaceutical products. For other pharmaceutical products, the patient pays the full price.

NORGE: De fleste lægemidler refunderes efter et system baseret på diagnoser og godkendte præparater foreskrevet af en læge (den såkaldte blå recept). Udgangspunktet er at man langvarigt har behov for lægemidlet, medicinsk udstyr eller forbrugsvarer. Egenbetalingen for disse er 36 pct., dog maksimalt 400 NOK pr. recept. Børn under 7 år og personer der modtager mindstepension betaler ikke for vigtige lægemidler. Andre lægemidler betales fuldt ud af patienten.

From 03.03.03, the index price system was introduced for some medicinal products available on "blue prescription". The arrangement with index price applies to medicinal products that are exchangeable, that is to say medicines and drugs that have the same active ingredient. The purpose of the index price arrangement is to achieve increased use of the most reasonable alternative when the same medicines are available at different prices.

Fra den 03.03.03 er der indført et indexprissystem for en del medicin på "blå recept". Ordningen med indexregulering gælder lægemidler der er substituerbare, dvs. lægemidler der har den samme terapeutiske virkning. Formålet med indexreguleringen er at åbne for et større brug af rimelige alternativer idet der findes mange substanser med samme virkning men til en forskellig pris.

The Medicinal Products Act was revised from 01.01.04. The state can now make a reimbursement contract with the licensee of a medicinal product, as a condition for authorization of the medicinal product for reimbursement (blue prescription).

Lægemiddelloven blev ændret fra den 01.01.04 for at give hjemmel til at der kunne indgås kontrakter om refusion mellem staten og de der har ophavsretten til lægemidlerne som grundlag for at staten godkender lægemidlet som tilskudsberettiget (blå recept).

SWEDEN: The new Act on Pharmaceutical Benefits etc. came into force in 2002. A medical product is subsidized only if it has been approved by the Pharmaceutical Benefits Board and is on the list of approved medicinal products. There are certain conditions that must be met before a

SVERIGE: I 2002 kom loven om lægemidler m.v. Det er en forudsætning at lægemiddelsnævnet har besluttet at lægemidlet skal omfattes af en godkendt liste over lægemiddelprodukter for at det kan gives tilskud til et lægemiddel. Desuden er der visse krav der skal opfyldes for at et læge-

medicinal product is added to the approved list and the price for the consumer is reduced. The code of the place of work must be on the prescription for reimbursement. The prescription must be for the cheapest product available from a pharmacy. The approved list of medicinal products gives everyone the right to a reduced price for the approved product.

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

Treatment in hospitals

As shown in the overview, there are no user charges for hospitalization in Denmark, the Faroe Islands, Greenland, Iceland and Norway. In Iceland and Norway, however, there is a charge for specialist out-patient treatment in hospitals, see the section on consultations with a physician.

middel skal kunne optages på den godkendte liste og give den enkelte forbruger en reduceret lægemiddelpris. Recepten skal være forsynet med en arbejdspladskode for at patienten kan få rabat. Lægemidler der bliver udleveret på recept skal udleveres som det billigste produkt der findes tilgængelig på apoteket. Den godkendte liste over lægemidler giver den enkelte ret til en reduceret pris på de godkendte produkter.

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

Behandlinger ved sygehuse

Som det fremgår af skemaet er der ingen brugerbetaling for sygehusophold i Danmark, på Færøerne, i Grønland, Island og Norge. Dog betales der i Island og Norge for ambulant specialistbehandling ved hospitaler, jvf. afsnittet om lægebesøg.

FINLAND AND ÅLAND: Patients pay a charge for admission to hospital (26 EUR) psychiatric wards (12 EUR). For short-term treatment there is a charge of EUR 12 per day (In Åland EUR 27). The charge for rehabilitation is EUR 9 per treatment day and the maximum user charge for day surgery is EUR72, Åland EUR 54, plus EUR 26, if the patient has to stay overnight. A ceiling has been introduced for the maximum user charge of EUR 590 (In Åland EUR 450, children under 18 EUR 200 and people with low income EUR 225) during one calendar year. Above these levels the services are free of charge for the rest of the year, with the exception of short-term stays in institutions/hospitals, for which the user charge can be reduced from EUR 26 (Åland EUR 27) per day to EUR 13 (Åland EUR 15) per day. In Åland, people under 18 years of age do not pay for short-term treatment when the maximum user charge has been reached.

FINLAND OG ÅLAND: Patienterne betaler for indlæggelse på hospital 26 EUR psykiatrisk afdeling 12 EUR. For korttidsbehandling betales der 12 EUR pr behandlingsdag (på Åland 27 EUR). Betaling for revalidering er 9 EUR pr behandlingsdag og den maksimale betaling for dagkirurgi er 72 EUR, Åland 54, plus 26 EUR hvis der er behov for en overnatning. Der er indført et loft på den maksimale egenbetaling på 590 EUR (på Åland 450 EUR, børn under 18 år 200 EUR samt personer med lav indkomst 225 EUR) i løbet af et kalenderår, hvorefter ydelser er gratis resten af året, bortset fra kortvarige institutions/hospitalsophold hvor egenbetalingen kan reduceres fra 26 EUR (Åland 27 EUR) pr døgn til 13 EUR (Åland 15 EUR) pr døgn. På Åland betaler personer under 18 år ikke for kortvarig behandling når grænsen for den maksimale egenbetaling er nået.

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

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

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

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

User charges for hospitalization

	Are there consistent rules for the whole country?	Size of user charge	Deviations	User charges in relation to total cost of hospitalization
Denmark	Yes	-	No	-
Faroe Islands	Yes	-	No	-
Greenland	Yes	-	No	-
Finland	Yes	EUR 26 per day, for psychiatric care EUR 9, EUR 72 for day surgery plus EUR 26 if overnight stay needed	Payment for long-term stay according to means. For children 0 – 17 years max. 7 days	10 per cent
Åland	Yes	EUR 27 – 15 per visit and EUR 54 for day surgery	Payment for long-term stay according to means	..
Iceland	Yes	-	No	-
Norway	Yes	-	No	-
Sweden	No	SEK 0-80 per day	Persons under the age of 40 receiving sickness benefit pay only half the cost for the first 30 days of each sickness period	..

Egenbetaling for indlæggelse på sygehus

	Er der ensartede regler i hele landet?	Egenbetalingens størrelse	Afvigelser	Egenbetalingens andel af de samlede udgifter til indlæggelse på sygehus
Danmark	Ja	-	Nej	-
Færøerne	Ja	-	Nej	-
Grønland	Ja	-	Nej	-
Finland	Ja	26 EUR pr sengedag, for psykiatri 9 EUR, 72 EUR for dagkirurgi plus 26 EUR hvis der er behov for overnatning	Betaling for langtidsophold efter betalingsevne, for børn 0- 17 år dog max. i 7 dage	10 pct.
Åland	Ja	27 – 15 EUR for korttidsophold, 54 EUR for dagkirurgi.	Betaling for langtidsophold efter betalingsevne	..
Island	Ja	-	Nej	-
Norge	Ja	-	Nej	-
Sverige	Nej	0-80 SEK/dag	Personer under 40 år, der modtager sygedagpenge betaler kun det halve i de første 30 dage af hver sygdomsperiode	..

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

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

Reimbursement for dental treatment

DENMARK: Reimbursement is provided by the public health insurance scheme. Adults pay between 30 and 65 per cent of the agreed fees. No subsidy is granted for gold restorations and dentures.

In addition, approximately one and a half million Danes are covered by a private insurance scheme, under which charges for both subsidized and non-subsidized treatment may be reimbursed. Municipal and county dental services are regulated by the Dental Health Services Act.

Children and young people under 18 years of age receive free municipal dental care including orthodontic treatment. 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 380. In addition, the municipalities provide a subsidy for dentures in cases of impaired function or disfigurement resulting from damage caused by accidents.

The counties offer specialist dental treatment (county dental service) to persons,

Tilskud til tandbehandling

DANMARK: Tilskuddet til tandbehandling gives fra den offentlige sygesikring. Voksne betaler mellem 30 og 65 pct. af de overenskomstfastsatte betalingstakster. Der ydes ikke tilskud til guldarbejder og proteser.

Derudover er ca. 1,5 million danskere dækket af en privat forsikringsordning, hvorefter der kan opnås tilskud til både behandlinger, som den offentlige sygesikring yder tilskud til, samt til behandlinger, der ikke er dækket af den offentlige sygesikring. Tandplejeloven regulerer den kommunale og amtskommunale tandpleje.

Der er vederlagsfri kommunal tandpleje, herunder tandregulering, for børn og unge under 18 år. Ældre personer, der bor på plejehjem eller i eget hjem med mange hjælpeforanstaltninger, tilbydes omsorgstandpleje, for hvilken der maksimalt opkræves 380 DKK pr. år. Kommunen yder derudover støtte til tandproteser i tilfælde af funktionelt ødelæggende eller vansirende følger af ulykkesbetingede skader.

Amtet tilbyder specialiseret tandpleje (amtstandpleje) til personer, der på grund

who because of psychiatric illness or mental handicap, cannot use the existing dental services for children and young people, for adults, or for people needing special care. For these services, the county, from 1 January 2004, charges the patient a maximum of DKK 1 420 per year.

af sindslidelser eller psykisk udviklingshæmning, ikke kan udnytte de eksisterende tandplejetilbud i børne- og ungdomstandplejen, voksentandplejen eller i omsorgstandplejen. For disse ydelser kan amtet fra 1. januar 2004 opkræve en egenbetaling på maksimalt 1 420 DKK årligt.

In addition, the county offers specialized dental care (county dental service) or highly specialized dental care (in dental research centres) to children and young people with dental conditions that would lead to a permanent functional reduction if left untreated.

Amtet tilbyder endvidere specialiseret tandpleje (amtstandpleje) eller højt specialiseret tandpleje (i odontologisk landsdels- og videnscenter) til børn og unge med odontologiske lidelser, der ubehandlede medfører varig funktionsnedsættelse.

In addition, the county grants a special reimbursement for dental care to cancer patients, who either due to radiation of the head and neck, or due to chemotherapy, suffer considerable documented dental problems, and to persons who due to Sjögrens syndrome suffer considerable documented dental problems. From 1. January 2004, for these services the county may charge a user payment of a maximum of DKK 1 420 annually. Finally, the counties provide highly specialized dental advice, examination and treatment (in dental research centres) for patients with rare diseases and handicaps, for whom the underlying condition can lead to special problems with their teeth, mouth or jaws.

Amtet yder herudover et særligt tilskud til tandpleje for kræftpatienter, der enten på grund af strålebehandling i hoved og halsregion eller på grund af kemoterapi har betydelige dokumenterede tandproblemer samt til personer, der på grund af Sjøgrens Syndrom har betydelige dokumenterede tandproblemer. For disse ydelser kan amtet fra 1. januar 2004 opkræve en egenbetaling på maksimalt 1 420 DKK årligt. Endeligt yder amtet højt specialiseret odontologisk rådgivning, udredning og behandling (i odontologisk landsdels- og videnscenter) af patienter med sjældne sygdomme og handicap, hos hvem den tilgrundliggende tilstand giver anledning til specielle problemer i tænder, mund og kæbe.

Oral and maxillo-facial surgery is carried out in the hospitals and is paid for by the counties in accordance with the legislation relating to hospitals.

Tand-, mund- og kæbekirurgisk behandling udføres på sygehusene og betales af amterne efter sygehuslovgivningen.

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.

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

FAROE ISLANDS: Dental treatment is mainly provided by privately practising dentists. Payment is therefore partly private, but compulsory membership of the health insurance scheme gives the right to a subsidy. The subsidy amounts to about half of the total cost of dental treatment for adults.

The municipalities provide a free dental service for children up to the age of 18, This services also provides special dental care, such as orthodontic treatment.

Specialist dental services are provided in the hospital services, after referral from one's own dentist or physician.

In the case of expensive treatment for congenital or disease-related dental conditions, reimbursement of expenses can be claimed according to social legislation.

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

FINLAND: 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. 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, and expenses for drugs prescribed by a dentist and travelling costs to visit a dentist, under the same terms as for medical prescriptions and travelling costs to visit a physician.

FÆRØERNE: Tandbehandlingen foregår hovedsageligt hos privatpraktiserende tandlæger. Betalingen herfor er delvis privat, men et tvunget medlemskab af sygekassen giver ret til tilskud til behandlingen. Tilskuddet beløber sig til ca. halvdelen af de samlede udgifter til tandlægebehandlingen af voksne.

Der findes i kommunalt regi en gratis skoletandplejeordning for børn op til 18 år. Denne ordning omfatter også specialtandpleje, så som tandretning.

I sygehusvæsenet er der en specialiseret tandplejeservice, som kræver henvisning fra egen tandlæge eller læge.

I tilfælde af dyre behandlinger af medfødte eller sygdomsforårsagende tandlidelser, kan der søges om dækning af udgifterne over sociallovgivningen.

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

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

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

ÅLAND: All public dental treatment for persons under 19 years of age is free of charge. For others, the cost of a dental visit is EUR 8, with additional standard fees for items of treatment and examinations. The patient pays the actual cost of orthodontic treatment and prosthetic treatment. The same rules as in Finland apply for treatment with private dentists.

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

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

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

For this group 50, 75 or 100 per cent of the cost (according to the public fee-schedule) of dental treatment may be covered. Full dentures and partial dentures are covered, but not gold or porcelain crowns or bridges.

The cost of implants for use with attachments under overdentures is partially

ÅLAND: Al offentlig tandbehandling for personer under 19 år er gratis. For andre koster et besøg 8 EUR med tillæg for udgifter til de enkelte foranstaltninger og undersøgelser efter særlige takster. For tandregulering og proteser betales de faktiske udgifter. For besøg hos private tandlæger gælder de samme regler som i Finland.

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

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

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

Der kan til denne gruppe ydes 50, 75 eller 100 pct. dækning af udgifterne til tandbehandling (af sygeforsikringens takst). Helproteser og delproteser er dækket, men ikke guld- og porcelænskroner eller broer.

Implantater er også inkluderet for dem som ikke kan bruge en helprotese. Der

reimbursed for pensioners who cannot use full dentures due to ridge resorption or other problems.

ydes delvis tilskud til pensionister som ikke kan anvende helprotese på grund af dårlig resorbering eller andre problemer.

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

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

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

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

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Maximum charges

DENMARK, FAROE ISLANDS AND GREENLAND: There are no rules for maximum user charges, with the following exceptions: medicinal products in Denmark, and prescription drugs for pensioners and certain groups with chronic diseases in the Faroe Islands.

FINLAND: If the total cost of pharmaceutical products exceeds EUR 604.72 per year, or if travelling costs for treatment exceed EUR 157.26 per year (151.37 for travelling costs related to rehabilitation), the Social Insurance Institution reimburses the excess costs. If a person's ability to pay taxes is reduced because of sickness, a special tax relief may be granted. The amount of the tax relief is calculated on the basis of the person's and his/her family's ability to pay taxes.

User charges for a long-term stay in an institution or a hospital cannot exceed 80 per cent of a patient's/resident's net income. The same charge is payable in all kinds of institutions within the social and health care sectors. Those admitted for a long-term stay in an institution must have a disposable amount of at least EUR 80 per month for personal necessities. Persons receiving a

Maksimal egenbetaling

DANMARK, FÆRØERNE OG GRØNLAND: Der findes ingen regler om maksimal egenbetaling med undtagelse for medicin i Danmark og for pensionister samt nogle grupper med kroniske sygdomme på Færøerne når det gælder receptpligtig medicin.

FINLAND: Hvis den maksimale egenbetaling for medicin udgør 604,72 EUR pr. år og hvis udgifterne til transport i forbindelse med behandling overstiger 157,26 EUR pr. år (151,37 for transport i forbindelse med revalidering), vil Folkpensionsanstalten dække det overskydende beløb. Hvis evnen til at betale skat er nedsat på grund af sygdom gives der en særlig skattelettelse. Skattelettelsens størrelse beregnes i forhold til den pågældendes eller dennes families muligheder for at betale skat.

Egenbetalingen for langtidsophold på institution/hospital kan højest udgøre 80 pct. af patientens/beboerens nettoindkomst. Det er den samme betaling som opkræves på alle typer af institutioner indenfor social- og sundhedssektoren. De der er indskrevet til et langvarigt institutionsophold skal mindst råde over et dispositionsbeløb på 80 EUR pr måned til personlige fornødenheder.

war supplement may keep that part of the amount that is in excess of the EUR 80.

The so-called user charge ceiling of EUR 590 is applied by the municipal social and welfare sectors. Once the ceiling 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 privately practising physicians must still be paid for. Income regulated payments are not included in the maximum amount. Since 2001, the maximum amount is calculated for the calendar year. Payments made for children under 18 years of age are added to the amount paid by the person who has paid the costs.

ÅLAND: The rules for maximum user charges for medicines and transport to and from treatment are the same as in Finland. For treatment of illness, there is a maximum user charge for medical visits and outpatient treatment of no more than EUR 450 during one calendar year, after which all services are free of charge for the remaining part of the year, with the exception of short-term stays in institutions/hospitals, for which the charge is reduced from EUR 27 per day to EUR 15 per day. The maximum charge for people over 18 years of age with low income is EUR 225. The maximum charge for children and young people under 18 years of age is EUR 200 per calendar year, after which all treatment included in the maximum user charge scheme is free, including hospital treatment. As part of the maximum user charge,

Personer der modtager krigstillæg, beholder dette beløb ud over de 80 EUR.

Det såkaldte udgiftsloft på 590 EUR er taget i anvendelse for det kommunale social- og sundhedsvæsen. Når loftet overskrides kan den pågældende i det store og hele benytte tilbuddene uden betaling. Loftet omfatter lægeydelser i den primære sektor ved helsecentrene, fysioterapi, behandlingsforløb, besøg i ambulatorium, dagkirurgi samt korttidsinstitutionsophold indenfor social- og sundhedsvæsenet. Der betales fortsat for tandbehandling og sygetransport, attester, laboratorieundersøgelser og radiologiske undersøgelser som udføres efter henvisning fra en privatpraktiserende læge. Indkomstregulerede betalinger medregnes ikke i maksimumsbeløbet. Maksimumsbeløbet er regnet i forhold til et kalenderår siden 2001. Betaling for børn under 18 år medregnes i maksimumsbeløbet hos den der har betalt for det.

ÅLAND: Reglerne for den maksimale egenbetaling for medicin og transport til og fra behandling er den samme som i Finland. Ved sygdomsbehandling er der en maksimal egenbetaling ved lægebesøg og ambulant behandling på højest 450 EUR i løbet af et kalenderår hvorefter al service er gratis den resterende del af året med undtagelse af kortvarige institutions/hospitalsophold hvor betalingen reduceres fra 27 EUR pr døgn til 15 EUR pr døgn. For personer med lav indkomst over 18 år er den maksimale egen betaling 225 EUR. For børn og unge under 18 år er den maksimale egenbetaling 200 EUR per kalenderår hvorefter al behandling der indgår under den maksimale egenbetaling er gratis, inklusiv behandling på en hospitalsafdeling. Til den maksimale egenbetaling medregnes også betaling for ambulant behand-

payment for outpatient treatment and services received outside the county are also included. Dental treatment, treatment in hospital departments, and x-ray and laboratory examinations are not included. User charges may be deducted from municipal tax.

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

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

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

The cost ceiling scheme covers the following services: consultation with a general medical practitioner or a specialist, home visit by a physician, outpatient 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: Under the present scheme, reimbursement is granted for charges that exceed a certain annual amount.

ling og ydelser som er modtaget uden for landskabet. Derimod medregnes bl.a. tandbehandling, behandling på hospitalsafdelinger, røntgen- og laboratorieundersøgelser ikke. Egenbetalingen kan fratrækkes i kommuneskatten.

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

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

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

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

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

User charges for the services that are included in the cost ceiling arrangement are noted on a card. When the cost ceiling is reached, patients receive a card granting them full reimbursement from the National Insurance Scheme for the rest of the year. The cost ceiling for one of the parents extends to children under the age of 16. No user charges are levied for children under the age of 7.

A new reimbursement scheme was introduced on 1. January 2003.

The previous reimbursement scheme is now called reimbursement scheme 1. This scheme includes:

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

The following services are included in reimbursement scheme 2:

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

Reimbursement schemes 1 and 2 are two completely separate schemes.

In 2003, the cost ceiling for reimbursement scheme 1 was NOK 1 350 and for re-imbursement scheme 2 NOK 4 500.

Egenbetalingen for de ydelser, der er omfattet af ordningen om udgiftsloft, noteres på et kvitteringskort. Når udgiftsloftet er nået, tildeles patienten et frikort, hvorefter Folketrygden yder fuld refusion for udgifterne i resten af året. Børn og unge under 16 år er omfattet af udgiftsloftet hos én af forældrene. Børn under 7 år er fritaget for egenbetaling.

En ny refusionsordning blev indført 1. januar 2003.

Den tidligere frikortordning bliver nu betragtet som egenandelsloft nr. I. Følgende ydelser er omfattet af dette loft:

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

Følgende ydelser indgår i egenandelsloft nr. II:

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

Egenandelsloft I og II er to helt adskilte ordninger.

Egenandelsloftet for 2003 for egenandelsloft I er 1 350 NOK og for egenandelsloft II 4 500 NOK.

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

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

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

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

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

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

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

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

CHAPTER II

Population and fertility
Befolkning og fertilitet

Introduction

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

Indledning

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

Population and population trends

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

The development in population growth varies somewhat between the Nordic countries. The natural increase has been greatest in Iceland, the Faroe Islands and Greenland throughout the period. Sweden has the lowest natural increase. In 2002, net migration contributed to population growth in all the Nordic countries with the exception of Greenland and Iceland.

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

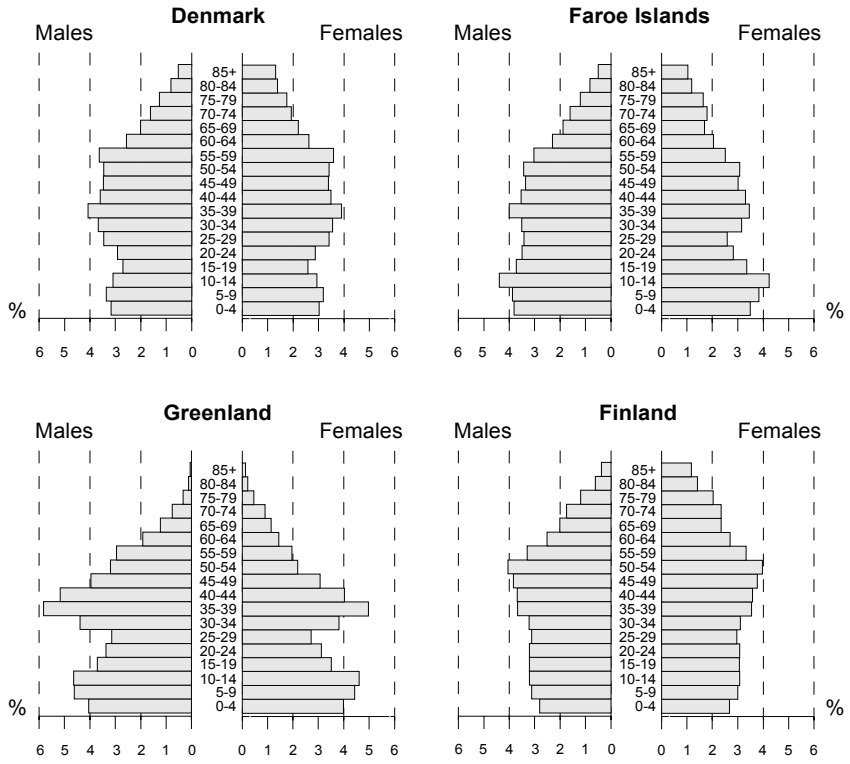
Befolkning og befolkningsudvikling

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

Udviklingen i befolkningstilvæksten varierer en del de nordiske lande imellem. Fødselsoverskuddet har hele perioden igennem været størst i Island, Færøerne og Grønland. Sverige har det laveste fødselsoverskud. I 2002 bidrager nettomigrationen til en befolkningsforøgelse med undtagelse af Grønland og Island.

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

Figure 2.1 Mean population by sex and age as a percentage of the total population 2002
Middelfolketallet efter køn og alder i pct. af hele befolkningen 2002



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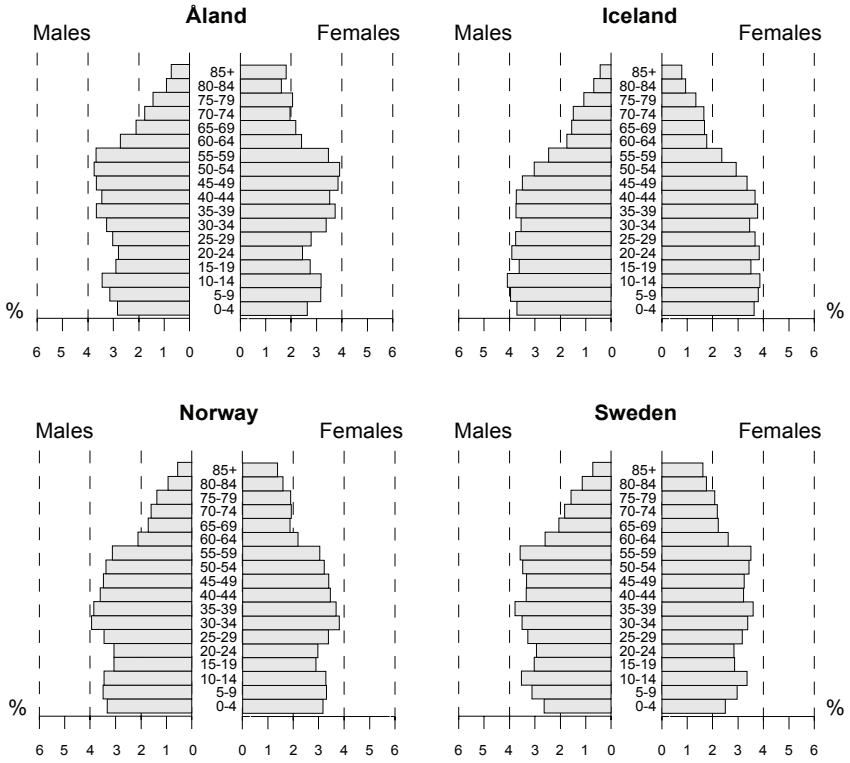


Table 2.1 Mean population 1995-2002
Middelfolketallet 1995-2002

	Denmark	Faroe Islands	Greenland	Finland	of which Åland	Iceland	Norway	Sweden
(1 000)								
Men								
Mænd								
1995	2 580	23	30	2 487	12	134	2 155	4 361
2000	2 639	24	30	2 526	13	141	2 224	4 386
2001	2 647	24	30	2 533	13	143	2 231	4 401
2002	2 657	25	30	2 541	13	144	2 249	4 418
Women								
Kvinder								
1995	2 648	21	26	2 621	13	133	2 204	4 466
2000	2 700	22	26	2 650	13	140	2 267	4 486
2001	2 708	23	26	2 655	13	142	2 272	4 495
2002	2 717	23	26	2 659	13	144	2 289	4 507
Men and women								
Mænd og kvinder								
1995	5 229	44	56	5 108	25	267	4 359	8 827
2000	5 340	46	56	5 176	26	281	4 491	8 872
2001	5 355	47	56	5 188	26	285	4 503	8 896
2002	5 374	47	57	5 201	26	288	4 538	8 925

Sources: *The central statistical bureaus: D: Statistics Denmark; FI: Statistics Faroe Islands; G: Statistics Greenland; F & Å: Statistics Finland; I: Statistics Iceland; N: Statistics Norway; S: Statistics Sweden*
Kilder: De statistiske centralbureauer: D: Danmarks Statistik; FI: Hagstova Føroya; G: Grønlands Statistik; F & Å: Statistikcentralen; I: Hagstofa Íslands; N: Statistisk sentralbyrå; S: Statistiska centralbyrån

Table 2.2 Vital statistics per 1 000 inhabitants 1995–2002
Befolkningens bevægelser pr. 1 000 indbyggere 1995-2002

	Live births Levendefødte	*Deaths* Døde	*Natural increase* Fødselsoverskud	*Net migration* Nettomigration	*Population increase* Befolkningstilvækst
Denmark					
1995	13.3	12.1	1.3	5.5	6.7
2000	12.6	10.9	1.7	1.8	3.5
2001	12.2	10.9	1.3	2.2	3.6
2002	12.2	10.9	1.3	2.2	3.6
Faroe Islands					
1995	14.7	8.3	6.4	-13.4	-7.0
2000	15.1	7.7	7.5	9.6	17.1
2001	13.5	7.7	5.8	12.0	17.2
2002	15.0	8.3	6.6	8.6	15.2
Greenland					
1995	20.1	8.7	11.4	-8.3	3.1
2000	15.8	8.1	7.7	-3.6	4.1
2001	16.6	7.8	8.8	-3.6	5.3
2002	16.6	7.7	8.9	-6.6	2.4
Finland					
1995	12.3	9.6	2.7	0.6	3.3
2000	11.0	9.5	1.4	0.5	1.9
2001	10.8	9.4	1.5	1.1	2.7
2002	10.7	9.5	1.2	1.0	2.2
Åland					
1995	13.4	10.2	3.2	-2.3	0.9
2000	10.0	9.6	0.4	2.3	2.7
2001	10.9	8.8	2.1	6.9	9.0
2002	10.3	9.0	1.3	8.5	9.7
Iceland					
1995	16.0	7.2	8.8	-5.3	3.5
2000	15.2	6.4	8.8	6.0	14.8
2001	14.4	6.1	8.3	3.4	11.7
2002	14.1	6.3	7.7	-1.0	6.7
Norway					
1995	13.8	10.4	3.5	1.5	4.9
2000	13.2	9.8	3.4	2.2	5.6
2001	12.6	9.8	2.8	1.8	4.6
2002	12.2	9.8	2.4	3.8	6.2
Sweden					
1995	11.7	10.6	1.1	1.3	2.4
2000	10.2	10.5	-0.3	2.8	2.4
2001	10.3	10.5	-0.3	3.2	3.0
2002	10.7	10.7	0.1	3.5	3.6

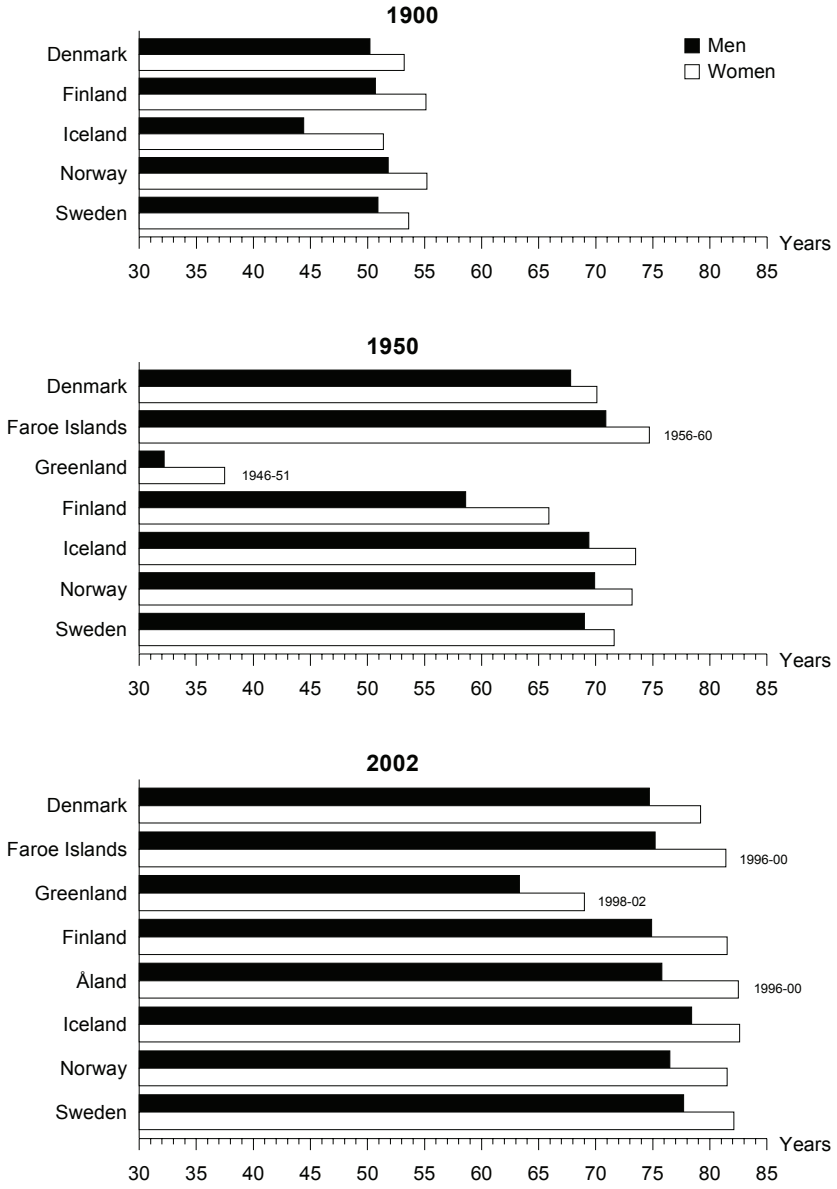
Sources: *The central statistical bureaus*
Kilder: De statistiske centralbureauer

Table 2.3 Average life expectancy 1996-2002
Middellevetiden 1996-2002

	Men		Mænd			*Women*		Kvinder		
Age	0	15	45	65	80	0	15	45	65	80
Denmark										
1996-00	73.8	59.4	31.1	14.8	6.6	78.7	64.2	35.1	18.0	8.4
2001/02	74.7	60.3	31.7	15.3	6.7	79.2	64.8	35.6	18.2	8.5
Faroe Islands										
1996-00	75.2	60.7	32.2	15.5	7.0	81.4	66.8	37.4	19.4	8.8
1998-02	76.2	61.6	33.2	16.2	7.4	81.6	67.0	37.7	19.7	8.8
Greenland										
1996-00	62.8	50.3	26.2	11.1	5.0	68.0	55.0	27.6	12.5	5.3
1998-02	63.3	50.5	26.0	11.3	5.4	69.0	55.6	28.2	13.1	5.9
Finland										
1996-00	73.6	59.1	31.1	15.0	6.6	80.8	66.2	37.1	19.1	8.1
2002	74.9	60.2	32.1	15.8	6.8	81.5	66.9	37.7	19.7	8.3
Åland										
1996-00	75.8	61.3	32.7	16.2	7.1	82.5	67.6	38.4	20.5	9.0
Iceland										
1996-00	77.1	62.6	34.0	16.7	7.3	81.4	66.8	37.4	19.6	8.6
2001/02	78.4	63.8	35.1	17.5	7.7	82.6	68.0	38.7	20.7	9.2
Norway										
1996-00	75.5	61.1	32.7	15.7	6.7	81.1	66.6	37.4	19.5	8.5
2002	76.5	61.9	33.5	16.3	6.9	81.5	67.0	37.7	19.8	8.7
Sweden										
1996-00	76.9	62.4	33.6	16.4	7.0	81.8	67.2	37.9	19.9	8.8
2002	77.7	63.1	34.3	16.9	7.2	82.1	67.5	38.1	20.0	8.8

Sources: *The central statistical bureaus*
Kilder: De statistiske centralbureauer

Figure 2.2 Life expectancy at birth 1900, 1950 and 2002
Middellevetiden for nyfødte 1900, 1950 og 2002



Fertility, births, infant mortality and contraception

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

In all the Nordic countries, it is possible to obtain treatment for infertility, paid for by the public health services (in Iceland and Norway there is, however, a certain user charge). As shown in Table 2.5, more and more people are receiving such treatment, and a significant proportion of live births (between 2.3-2.9 per cent) are the result of in vitro fertilization (IVF). A large number of births resulting from IVF are still multiple births, most in Sweden and fewest in Finland.

Internationally, the Nordic countries are characterized by having very low perinatal mortality. Greenland has the highest among the Nordic countries. The other countries lie relatively close to each other.

Greenland also has the highest mortality rate for the first year of life. Iceland had the lowest mortality rate for the first year of life in 2002.

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

The use of sterilization as a means of birth control also varies considerably between the Nordic countries. In most of the coun-

Fertilitet, fødsler, spædbørnsdødelighed og prævention

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

I alle de nordiske lande er det muligt at blive behandlet for barnløshed, betalt af det offentlige (i Island og Norge er der dog en vis egenbetaling). Som det ses af tabel 2.5 modtager flere og flere behandling og en ikke ubetydelig del af de levendefødte (fra 2,3 til 2,9 pct.) er et resultat af en IVF behandling. For fødsler efter IVF behandling er der fortsat et stort antal flerbarnsfødsler, flest i Sverige og færrest i Finland.

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

Grønland har ligeledes den højeste dødelighed for det første leveår. Island har den laveste dødelighed i det første leveår i 2002.

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

Anvendelse af sterilisation som præventionsmiddel varierer ligeledes betydeligt mellem de nordiske lande. I de fleste af

tries no permission for sterilization is required if the person is aged 25 or more.

landene behøver man ingen tilladelse til at lade sig sterilisere efter det fyldte 25. år.

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

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

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

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

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

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

Abortion rates vary somewhat in the Nordic countries.

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

Information about emergency contraception is included in this edition. Use of emergency contraception is relatively widespread in the Nordic countries. Use is highest in Norway and lowest in Denmark. The low use in Denmark reflects the fact that Denmark has the highest number of women who use oral contraceptives. A moderate fall in abortion rates can be detected in both Denmark and Norway, but not in the other Nordic countries. The results must, however, be interpreted with a certain caution.

Der er i denne udgave medtaget informationer om nødprævention som er relativ udbredt i de nordiske lande hvor forbruget er højest i Norge og lavest i Danmark. Det lave forbrug i Danmark afspejler at der er flest kvinder der anvender P-piller. Både i Danmark og Norge kan der spores et moderat fald i abortraterne hvilket til gengæld ikke er tilfældet i de øvrige lande. De fundne resultater må dog fortolkes med en vis forsigtighed.

Table 2.4 Live births and fertility rate 1996-2002
Levendefødte og fertilitetsrate 1996-2002

	Number of live births	*Live births per 1 000 women by age* Levendefødte pr. 1 000 kvinder i alderen							*Total fertility rate*
	Antal leven-defødte	15-19	20-24	25-29	30-34	35-39	40-44	45-49	Samlet fertilitet
Denmark									
1996-00	66 951	8.0	54.7	129.7	109.3	41.3	6.0	0.2	1 746
2001	65 450	7.6	51.7	126.7	113.1	44.0	6.8	0.2	1 746
2002	64 149	6.5	48.9	123.2	115.6	45.6	7.2	0.3	1 725
Faroe Islands									
1996-00	657	19.3	108.0	166.0	129.1	58.1	11.1	0.3	2 459
2001	631	13.6	117.8	147.4	115.6	57.7	8.5	0.0	2 303
2002	708	15.1	107.9	163.1	142.0	64.9	14.8	0.0	2 540
Greenland									
1996-00	994	55.9	160.9	118.4	87.7	47.6	13.5	1.4	2 426
2001	936	62.4	166.3	126.7	83.4	40.7	10.1	0.6	2 551
2002	940	51.9	154.2	146.8	96.5	38.7	9.7	0.6	2 492
Finland									
1996-00	58 295	9.5	61.4	119.8	101.6	44.7	8.8	0.5	1 735
2001	56 189	10.6	59.7	114.1	101.9	47.5	9.7	0.5	1 726
2002	55 555	11.2	57.2	112.5	102.9	47.9	9.8	0.6	1 718
Åland									
1996-00	286	4.9	42.7	122.0	106.3	50.1	8.5	0.6	1 665
2001	283	5.6	50.8	120.3	112.0	46.4	13.9	0.0	1 753
2002	269	4.2	48.6	107.2	102.0	61.6	7.6	0.0	1 660
Iceland									
1996-00	4 215	23.4	90.2	129.0	107.2	51.6	9.4	0.2	2 055
2001	4 091	19.3	79.6	125.9	100.4	54.2	10.0	0.3	1 948
2002	4 049	18.0	75.3	120.4	107.2	54.8	10.0	0.7	1 932
Norway									
1996-00	59 522	12.4	70.6	130.9	107.8	43.5	6.9	0.2	1 851
2001	56 696	11.0	62.7	123.6	107.9	45.6	7.0	0.3	1 784
2002	55 434	10.1	59.5	121.0	109.3	44.1	7.7	0.2	1 754
Sweden									
1996-00	90 688	7.1	51.7	107.9	93.4	40.3	7.3	0.3	1 540
2001	91 466	6.6	46.7	104.3	102.4	45.4	8.2	0.3	1 570
2002	95 815	6.6	47.7	109.2	110.7	47.3	8.9	0.3	1 653

Sources: *The central statistical bureaus*
Kilder: De statistiske centralbureauer

Table 2.5 In vitro fertilization 1995-2001
IVF-behandling 1995-2001

	Denmark	Finland	Iceland	Norway	Sweden
Treatments, IVF+ICSI					
Behandlinger, IVF+ICSI					
1995	4 275	3 801	260	..	4 922
1996	4 816	4 493	266	..	5 577
1997	5 447	5 090	363	3 173	5 691
1998	6 165	4 886	364	3 323	5 893
1999	6 317	4 577	365	3 736	6 247
2000	7 002	4 323	298	4 029	6 586
2001	..	4 244	309	4 045	7 115
Frozen embryo transfers, FET					
Tilbageføring af nedfrosne æg, FET					
1995	422	1 242	-	..	992
1996	726	1 924	2	..	1 135
1997	789	2 246	20	339	1 268
1998	993	2 273	55	267	1 090
1999	1 028	2 391	60	293	1 005
2000	975	2 488	83	301	1 208
2001	..	2 814	68	359	1 685
Number of live births, IVF+ ICSI + FET					
Antal levendefødte, IVF+ ICSI + FET					
1995	1 209	942	101	..	1 435
1996	1 501	1 355	107	..	1 927
1997	1 602	1 462	150	796[2)]	2 021
1998	1 844	1 474	158	994[2)]	2 137
1999	2 001	1 443	149	1 058[2)]	2 278
2000	2 085	1 372	147	1 097[2)]	2 237
2001	..	1 351	116	1 243[2)]	2 519
[2001]					
Treatments per 1 000 women aged 15-49 years				[3)]	
Behandlinger pr. 1 000 kvinder i alderen 15-49 år					
IVF+ICSI	5.6[1)]	3.5	4.3	3.8	3.6
FET	0.8[1)]	2.3	0.9	0.3	0.1
Total	6.4[1)]	5.8	5.2	4.1	4.4
Multiple births, per cent of all births after IVF					
Flerbarnsfødsler, procent af					
alle fødsler efter IVF-behandling	25.2[1)]	17.5	23.4	28.1	17.9
Children born in multiple births,					
per cent of all children born after IVF					
Børn født i flerbarnsfødsler, procent af					
alle børn født efter IVF-behandling	..	30.1	..	44.0	36.5
IVF, ICSI and FET, per cent of all live births					
IVF, ICSI and FET i procent af alle levendefødte	2.5[1)]	2.4	2.8	2.3	2.8

IVF = In vitro fertilisation (reagensglasbefrugtning)
ICSI = Intracytoplasmic sperm injection (mikrobehandling)
FET = Frozen embryo transfer (tilbageføring af nedfrosne æg)

Based on the year of treatment not on the year of birth. Beregnet udfra behandlingsår, ikke fødselsår.

1 2000.
2 For live births read all births.
3 Excluding FETs.

1 2000.
2 Alle fødsler, ikke kun levendefødte.
3 Eksklusiv FET.

Source: D: National Board of Health; F: STAKES; I: Landspítali - University Hospital; N: Ministry of Health; S: National Board of Health and Welfare.

Table 2.6 Stillbirths and infant mortality[1] 1996-2002

Dødfødte og dødelighed i første leveår[1] 1996-2002

	Number Antal		*Per 1 000 births* Pr. 1 000 fødte		*Deaths per 1 000 live births* Døde pr. 1 000 levendefødte			
	Stillbirths Dødfødte	*Infant deaths* Døde i 1. leveår	*Stillbirths* Dødfødte	*Perinatal deaths* Perinatalt døde	*First 24 hours* Første 24 timer	*1-6 days* 1-6 dage	*7-27 days* 7-27 dage	*Total under 1 year* I alt under 1 år
Denmark								
1996-00	308	332	4.6	7.6	1.6	1.4	0.6	5.0
2001	280	321	4.3	6.9	1.1	1.5	0.9	4.9
2002	259	285	4.0	6.9	1.6	1.3	0.6	4.4
Faroe Islands								
1996-00[2]	3	1	4.9	6.1	..	1.2	..	1.8
2002	2	1	2.8	4.2	..	1.4	..	2.8
Greenland								
1996-00	8	17	8.1	19.6	8.1	3.1	1.0	16.8
2001	6	15	6.4	16.0	6.4	1.1	1.1	16.1
2002	7	18	7.4	19.0	4.3	5.3	0.0	19.1
Finland								
1996-00	214	227	3.7	5.8	1.3	0.8	0.6	3.9
2001	185	181	3.3	5.0	1.0	0.8	0.4	3.2
2002	176	168	3.2	4.9	1.1	0.6	0.5	3.0
Åland								
1996-00	-	1	1.5	3.5	0.7	1.4	-	3.5
2001	2	1	7.1	10.5	3.5	-	-	3.5
2002	1	1	3.8	7.4	3.7	-	-	3.7
Iceland								
1996-00	15	15	3.5	5.7	1.3	0.8	0.3	3.5
2001	11	11	2.7	4.6	0.7	1.2	0.0	2.7
2002	7	9	1.7	2.7	0.5	0.5	0.2	2.2
Norway								
1996-00	244	244	4.1	6.2	1.0	1.1	0.6	4.1
2001	241	230	4.2	6.6	1.3	1.1	0.6	4.1
2002	197	186	3.5	5.2	0.8	0.8	0.7	3.4
Sweden								
1996-00	332	325	3.7	5.4	0.8	0.9	0.6	3.6
2001	349	334	3.8	5.7	0.9	1.0	0.6	3.7
2002	352	313	3.7	5.3	0.6	1.0	0.5	3.3

1 Computed by year of death.
2 1-6 days = 0-6 days.

1 Opgjort efter dødsår.
2 1-6 dage = 0-6 dage.

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

Table 2.7 Stillbirths and deaths during first year of life per 1 000 births 1995–2002, with birthweight 1 000 grams and more, total figures and rates per 1 000 births[1)]

Dødfødte og døde i løbet af første leveår med en fødselsvægt på 1 000 gram og mere, i alt og pr. 1 000 fødte 1995-2002[1)]

	Number Antal		*Per 1 000 births* Pr. 1 000 fødte	*Deaths per 1 000 live births* Døde pr. 1 000 levendefødte				
	Stillbirths Dødfødte	*Infant deaths* Døde i 1. leveår	*Stillbirths* Dødfødte	*First 24 hours* Første 24 timer	*1-6 days* 1-6 dage	*7-27 days* 7-27 dage	*28 days to 1 year* 28 dage til 1 år	*Total under 1 year* I alt under 1 år
Denmark								
1995	282	330	4.0	1.0	1.9	0.6	1.3	4.7
2000	183	238	2.9	0.6	1.3	0.5	1.2	3.6
2001	216	208	3.3	0.4	0.9	0.6	1.3	3.2
2002	183	173	2.9	0.7	0.7	0.4	0.9	2.7
Finland								
1995	189	168	3.0	0.5	0.7	0.5	1.0	2.7
2000	150	152	2.7	0.6	0.5	0.5	1.1	2.7
2001	136	121	2.4	0.4	0.5	0.3	0.9	2.2
2002	132	107	2.4	0.5	0.5	0.3	0.6	1.9
Iceland								
1995	7	13	1.6	0.9	0.7	-	1.4	3.0
2000	13	5	3.0	0.0	0.2	0.2	0.7	1.2
2001	12	6	2.9	0.0	0.7	0.0	0.7	1.5
Norway								
1995	177	182	2.9	0.7	0.7	0.4	1.3	3.0
2000	196	144	3.3	0.7	0.4	0.4	1.1	2.5
2001	207	136	3.6	0.6	0.7	0.4	0.7	2.4
2002	158	117	2.8	0.5	0.4	0.4	0.8	2.1
Sweden								
1995	318	286	3.1	0.5	0.6	0.5	1.2	2.8
2000	318	215	3.6	0.5	0.7	0.4	0.9	2.4
2001	301	270	3.4	1.1	0.5	0.4	1.1	3.0
2002	289	221	3.1	0.7	0.6	0.4	0.7	2.4

1 Computed by year of birth.

1 Opgjort efter fødselsår.

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

Table 2.8 Sterilizations 1995-2002
Sterilisationer 1995-2002

	Denmark[1]	*Faroe Islands*	*Greenland*	*Finland*	*Of which Åland*	*Iceland*[2]	*Norway*[3]	*Sweden*
Men Mænd								
1995	5 256	3	4	792	-	87	2 697	1 507
2000	5 544	14	18	1 771	2	246	3 244	1 463
2001	5 686	9	8	1 762	-	252	3 322	..
2002	5 671	..	7	1 589	-	298	3 093	..
Women Kvinder								
1995	4 815	60	67	10 521	31	553	4 525	5 919
2000	5 101	29	127	8 699	31	519	4 512	4 931
2001	5 271	32	77	7 259	43	406	4 652	..
2002	5 275		92	6 728	41	365	1 477	..
Total I alt								
1995	10 071	63	71	11 313	31	640	7 222	7 426
2000	10 645	43	145	10 470	33	765	7 756	6 394
2001	10 957	41	85	9 021	43	658	7 974	..
2002	10 946	..	99	8 317	41	663	5 570	..
[2002] *Per 1 000 in the age group* Pr. 1 000 i aldermen *Men* Mænd								
25-34	2.9	..	..	1.0	-	..	1.9	..
35-44	8.7	..	..	2.4	-	..	6.4	..
45-54	2.4	..	..	0.7	-	..	2.1	..
Women Kvinder						..		
25-34	4.7	..	..	4.8	4.3	..	1.6	..
35-44	8.3	..	..	13.6	15.8	..	3.3	..
45-54	0.5	..	..	0.7	2.0	..	0.2	..

1 Includes sterilizations performed in hospitals.
2 Figures 2000-2002 are preliminary.
3 For 2002 excluding a county with 10 per cent of Norwegian population. 100 per cent user charge introduced in 2002.

1 Omfatter sterilisationer udført på sygehuse.
2 Tal for 2000-2002 er foreløbige.
3 Tal for et fylke med 10 procent av Norges befolkning mangler for 2002. 100 procent egenbetaling indført fra 2002.

Sources: D: National Board of Health; FI: Chief Medical Officer; G: Chief Medical Officer; F & Å: STAKES;
Kilder: I: Directorate of Health; N: Statistics Norway; S: National Board of Health and Welfare

Table 2.9 Sales of oral contraceptives per 1 000 women aged 15-44 years 1995-2002. DDD per 1 000 women 15-44 years per day
Salg af p-piller pr. 1 000 kvinder i alderen 15-44 år 1995-2002. DDD pr. 1 000 kvinder i alderen 15-44 år pr. dag

ATC code G03A	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
1995	280	214	143	201	257	226	198	258
2000	319	258	186	226	284	265	225	298
2001	331	246	179	226	275	287	236	290
2002	336	279	187	226	267	279	246	295

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

Table 2.10 Number of sold packages of emergency prevention 2000-2002
Antal solgte forpakninger af nødprævention 2000-2002

ATC code G03A	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2000	30 549	104	-	42 706	176	1 978	27 700	12 784
2001	38 386	189	5	45 242	223	3 310	66 600	88 597
2002	51 118	238	81	73 896	392	3 488	84 500	135 714
Per 100 000 women age 15-44								
2000	2 845	1 218	-	4 188	3 596	3 162	3 017	755
2001	3 592	2 177	40	4 472	4 578	5 253	7 269	5 225
2002	4 801	2 695	646	7 361	8 054	5 541	9 217	7 980

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

Table 2.11 Number of induced abortions 1996-2002
Antal fremkaldte aborter 1996-2002

	Number of abortions	*Abortions per 1 000 women by age* Aborter pr. 1 000 kvinder i alderen							*Total abortion rate*	*Abortions per 1 000 live births*
	Antal aborter	15-19	20-24	25-29	30-34	35-39	40-44	45-49	Samlet abortrate	Aborter pr. 1 000 levendefødte
Denmark										
1996-00	16 877	14.5	21.2	19.7	18.5	13.0	4.8	0.5	457.3	250.6
2001	15 315	14.0	19.6	18.1	17.0	13.0	4.6	0.5	433.5	239.1
2002	14 991	13.8	20.1	17.2	16.5	13.1	4.5	0.4	428.1	238.7
Faroe Islands										
1996-00	47	4.4	5.2	7.3	7.8	5.5	2.9	0.6	168.3	70.9
2001	42	2.6	6.1	6.7	3.9	7.6	2.6	0.0	147.9	66.6
2002	48	6.9	5.2	6.6	6.0	6.1	1.3	0.7	164.4	67.8
Greenland										
1996-00	881	114.6	138.7	87.7	57.8	28.0	9.2	1.1	2 185.5	888.6
2001	812	116.0	136.2	89.9	49.5	29.0	6.2	0.6	2 139.0	870.0
2002	822	112.3	139.4	81.5	52.9	28.4	14.5	0.6	2 148.0	873.5
Finland										
1996-00	10 637	12.8	15.0	13.3	10.9	7.4	2.9	0.3	312.9	183.2
2001	10 700	15.2	14.8	13.0	10.6	7.5	3.2	0.2	322.8	191.8
2002	10 907	16.1	16.3	12.5	10.7	7.6	3.3	0.2	333.5	197.1
Åland										
1996-00	64	16.6	20.8	12.9	14.0	10.0	4.8	0.8	398.9	224.6
2001	59	21.0	19.9	18.1	6.4	9.7	3.2	0.0	391.7	220.9
2002	61	9.7	18.7	23.3	15.8	8.2	3.3	0.0	394.4	233.7
Iceland[1)]										
1996-00	922	..	..	..	..	..	..	..	..	218.9
2001	984	..	..	..	..	..	..	..	..	240.5
2002	926	..	..	..	..	..	..	..	..	228.7
Norway										
1996-00	14 248	18.7	26.1	19.7	15.2	9.9	3.5	0.3	471.0	239.4
2001	13 888	18.5	26.3	19.2	14.8	10.2	3.7	0.3	466.5	245.0
2002	13 557	16.6	26.8	19.1	14.4	9.8	3.6	0.3	454.5	244.6
Sweden										
1996-00	31 250	18.2	27.0	23.4	20.2	15.0	5.9	0.6	551.5	344.4
2001	31 772	21.5	28.1	23.1	19.6	14.6	5.7	0.6	566.0	347.4
2002	33 365	24.1	30.0	23.0	19.6	15.3	6.2	0.6	594.0	347.7

1 Figures 1998-2002 are preliminary.

1 Tal for 1998-2002 er foreløbige.

Sources: *The national abortion registers*
Kilder: De nationale abortregistre

CHAPTER III

Morbidity, medical treatment, accidents and medicine
Sygelighed, sygdomsbehandling, ulykker og medicin

Introduction

In the Nordic countries, statistical data on morbidity are incomplete. This chapter begins with a description of a number of diseases that can be related to the lifestyle and social behaviour of people in the population, followed by data on the incidence of cancer. This is followed by a presentation of data on treatment provided outside hospitals and in hospitals, according to diagnostic group and for common surgical procedures. Following this, data on admissions to hospitals due to accidents are presented. Finally data on consumption of medicinal products are presented.

Indledning

De nordiske lande har mangelfulde statistiske oplysninger når det gælder sygelighed i befolkningen. I dette kapitel omtales først et antal sygdomme der kan relateres til befolkningens livsstil/sociale adfærd, efterfulgt af forekomsten af nye tilfælde af cancer. Herefter belyses den behandling der gives udenfor sygehusene, efterfulgt af en belysning af behandling ved sygehusene fordelt på diagnosegrupper og ved vigtige kirurgiske indgreb. Herefter omtales ulykkesforekomst og personer indlagt på sygehuse på grund af ulykker. Og til sidst omtales medicinforbruget.

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 smok-

Sygdomme relateret til livsstil

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

Selvom antallet af rygere i de senere år er faldende i de nordiske lande, er der dog fortsat store forskelle i antallet af rygere, både hos mænd og kvinder. Der findes

ers, both for men and for women. The number of smokers is still highest in Denmark and the Faroe Islands and lowest in Sweden, but the pattern has now become the same in Norway as in Sweden. Among other things, this pattern of behaviour is reflected in the incidence of lung cancer, as shown in Figure 3.1.

fortsat flest tobaksbrugere i Danmark og Færøerne og de færreste i Sverige, men mønsteret er efterhånden samme i Norge som i Sverige. Dette adfærdsmønster afspejler sig blandt andet i forekomsten af nye tilfælde af lungecancer som det fremgår af figur 3.1.

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

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

There are significant differences in the prevalence of diagnosed cases of both hepatitis B and C. However, some of this may be explained by differences in registration practice.

Der er markante forskelle i forekomsten af diagnosticerede tilfælde af både hepatitis B og C. En del af forskellene kan dog tilskrives forskelle i registreringspraksis.

The Hepatitis B Virus (HBV) infects only humans. Sexual transmission is common. Transmission from mother to child may occur in utero or, more often, during the delivery. HBV is said to be 100 times more infective than HIV.

Hepatitis B virus (HBV) smitter kun mennesker. Det er almindeligt at smitten overføres sexuelt, ligesom der kan forekomme smitte fra mor til barn, i livmoderen, men mere ofte ved fødslen. HBV anses for at være 100 gange mere smittefarlig end HIV.

Treatment of hepatitis B is not necesarry in most cases but 5 –10 per cent of patients develop chronic inflammation of the liver and continue they can infect other peopele. Chronically infected persons may develop liver cancer. However, a vaccine effective against HBV is available. Vaccination is recommended for persons with a higher risk than others of exposure to the virus.

I de fleste tilfælde er det ikke nødvendigt med behandling, men 5-10 pct. af patienterne udvikler dog en kronisk leverbetændelse i kombination med at de stadig kan smitte andre. Kronisk hepatitis B giver en høj risiko for leverkræft. Det er dog muligt at vaccinere mod HBV. Vaccinen gives hovedsageligt til personer der løber en større risiko end andre for at blive udsat for hepatit B.

Hepatitis C is the most common type of hepatitis in most countries. It is caused by the Hepatitis C Virus (HCV). Hepatitis C was a common cause of transfusion hepatitis during the period when blood products were not screened for HCV.

Hepatitis C er den mest almindeligt forekomne form for Hepatitis i de fleste lande. Forekomsten skyldes Hepatitis C virus (HCV). Hepatitis C var en almindeligt forekommen årsag til transfusionshepatit førend man begyndte screning af blodprodukter for HCV.

Cases of hepatitis and tuberculosis are found particularly among refugees and immigrants in the Nordic countries. However, these diseases are also relatively common among drug abusers with poor living conditions. Greenland is atypical with regard to the number of diagnosed cases of tuberculosis. The number of diagnosed cases is increasing in some countries and decreasing in others.

Forekomsten af såvel hepatitis som tuberkulose findes især hos flygtninge/ indvandrere i de nordiske lande, men det er også sygdomme som er relativt hyppigt forekommende blandt misbrugere med dårlige levevilkår. For så vidt angår diagnosticerede tilfælde af tuberkulose er det især Grønland der adskiller sig fra de øvrige landes hvor der i nogle lande spores en stigning, i andre et fald.

The incidence of HIV infection is relatively stable, with the highest incidence in Denmark and the lowest in Finland. There has been a greater increase in the incidence in women, in Denmark, Finland, Norway and Sweden. The trend is related to new methods of treatment, Because of these new methods, infected people are healthier.

Forekomsten af HIV smitte ligger relativt stabil med de højeste forekomster i Danmark og de laveste i Finland. Både i Danmark, Finland, Norge og Sverige har der vist sig en større stigning blandt kvinder. Udviklingen skal ses i sammenhæng med de nye behandlingsmetoder der giver flere raske smittebærere.

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. The disease is often without symptoms.

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

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

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

Table 3.1 Percentage of daily smokers by sex 2002
Daglige rygere procentvis efter køn 2002

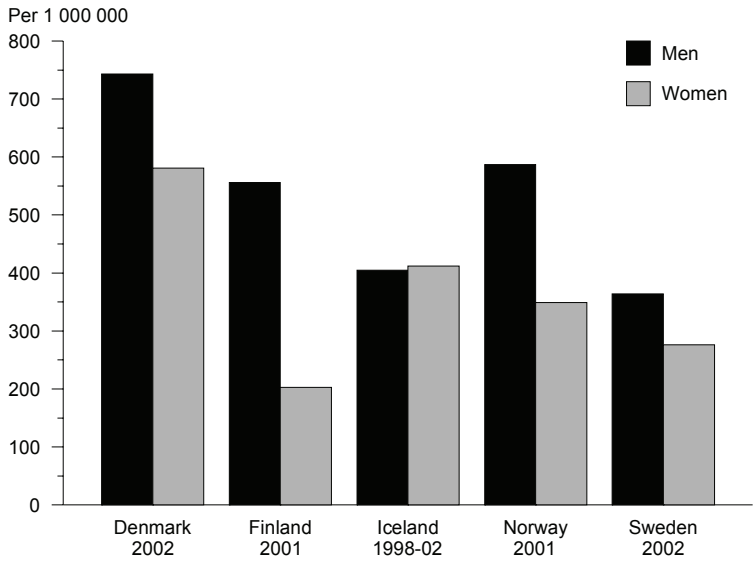
	Denmark[1)]	*Faroe Islands*	*Finland*[2)]	*Iceland*[3)]	*Norway*[4)]	*Sweden*[5)]
Smoking men as a percentage of men 15 years and over Mænd, rygere, i pct. af mænd 15 år og derover	31	35	28	22	29	16
Smoking women as a percentage of women 15 years and over Kvinder, rygere, i pct. af kvinder 15 år og derover	27	38	23	21	28	19

1 13+ years.
2 15-64 years.
3 15-79 years.
4 16-74 years.
5 16-84 years.

1 13+ år.
2 15-64 år.
3 15-79 år.
4 16-74 år.
5 16-84 år.

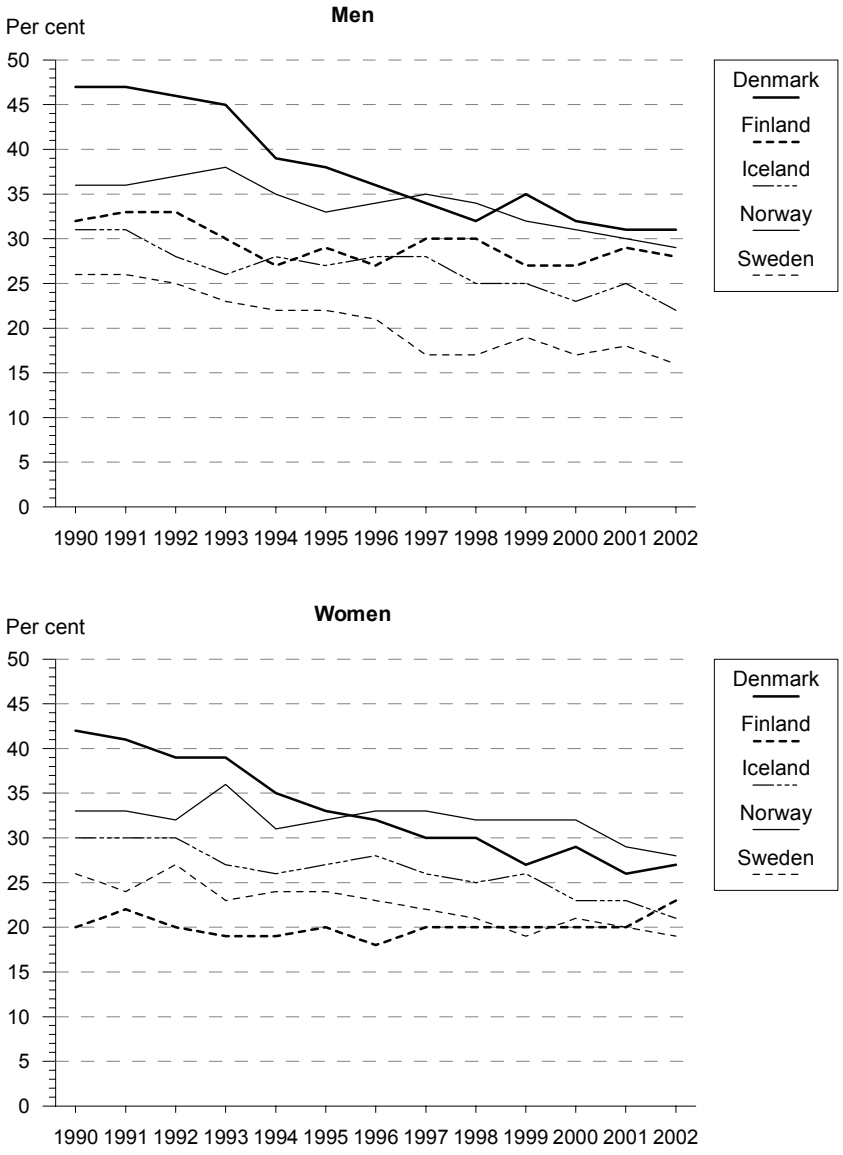
Sources: D: National Board of Health; FI: The national council for prevention; F: National Public Health Institute; I: Committee for Tobacco Use Prevention; N: National Directorate for Health and Social Welfare; S: Statistics Sweden
Kilder:

Figure 3.1 Rates for new cases of lung cancer per 1 000 000 inhabitants
Rater for nye tilfælde af lungecancer pr. 1 000 000 indbyggere



Source: *Tables 3.8 and 3.9*
Kilde: Tabel 3.8 og 3.9

Figure 3.2 Percentage of daily smokers by sex 1990-2002
Daglige rygere procentvis efter køn 1990-2002



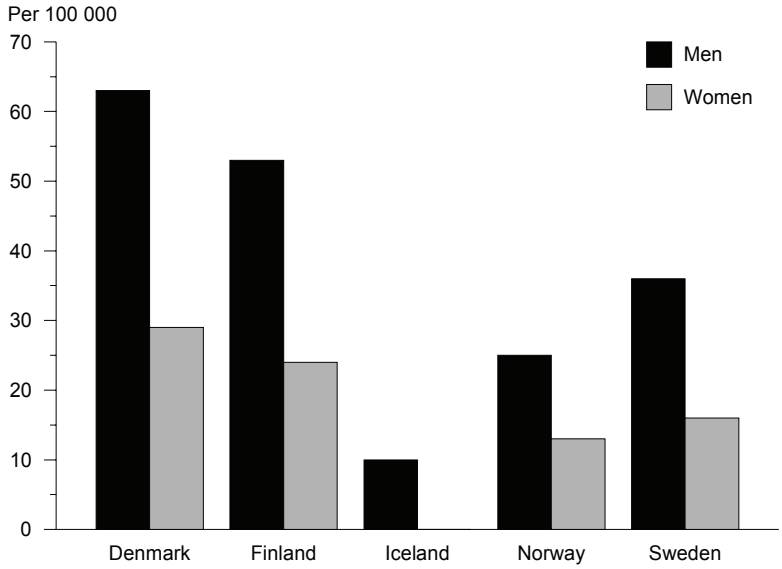
Source: OECD, for 2001 and 2002 Table 3.1

Table 3.2 Sales of alcoholic beverages in litres of 100 per cent pure alcohol per capita aged 15 years and over 1995-2002
Salg af alkoholiske drikke i liter 100 pct. ren alkohol pr. indbygger 15 år og derover 1995-2002

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
1995	12.1	6.3	12.6	8.3	5.8	4.8	4.8	6.1
2000	11.5	6.8	13.4	8.6	6.1	6.1	5.6	6.2
2001	11.6	6.9	12.5	9.0	6.3	6.3	5.5	6.5
2002	11.3	7.0	12.3	9.2	6.4	6.5	5.9	6.9

Sources: *D, FI, G, I, N & S: The Central Statistical Bureaus*
Kilder: D, FI, G, I, N & S: De statistiske centralbureauer
F & Å: STAKES; S: National Institute for Public Health (1994-)

Figure 3.3 Discharges from somatic hospitals.
Alcoholic liver disease per 100 000 inhabitants 2002
Udskrivninger fra somatiske sygehuse.
Alkoholisk leversygdom pr. 100 000 indbyggere 2002



Note : No cases for women in Iceland 2002.

Source: *Table 3.30*
Kilde: *Tabel 3.30*

Table 3.3 Diagnosed cases of hepatitis B and C per 100 000 inhabitants by sex 1995–2002
Diagnosticerede tilfælde af hepatitis B og C pr. 100 000 indbyggere efter køn 1995-2002

	Denmark		Faroe Islands	Green-land	Finland[1)]	Åland[1)]	Iceland[2)]		Norway		Sweden[4)]	
	M	W	M+W	M+W	M+W	M+W	M	W	M	W	M	W
Hepatitis B												
1995	2.8	1.4	2.8	3.6	2.2	3.9	1.5	5.2	3.4	1.2	4.6	2.1
2000	1.6	0.7	0.0	1.8	4.6	-	13.5	11.4	7.7	4.0	3.3	1.8
2001	1.2	0.6	0.0	1.8	2.5	3.9	16.1	12.6	6.1	2.9	3.3	1.5
2002	1.4	1.0	-	0.0	3.4	3.8	15.3	6.2	5.4	2.7	4.4	2.1
Hepatitis C												
1995	0.3	0.1	0.3	..	26.6	11.9	21.6	8.2	0.9	0.5	46.0	19.2
2000	0.3	0.1	0.0	1.8	2.1	-	41.2	18.5	0.5[3)]		31.4	13.6
2001	0.2	0.1	0.0	0.0	2.5	-	29.4	23.0	0.8[3)]		30.6	13.8
2002	0.1	0.1	-	0.0	1.7	-	25.7	11.1	0.5[3)]		31.9	14.0

1 Both acute and chronic in 1995.
2 Both acute and chronic.
3 Both men and women.
4 Hepatitis C: Both acute and chronic. Hepatitis B: acute.

1 Både akutte og kroniske i 1995.
2 Både akutte og kroniske.
3 Tal for både mænd og kvinder.
4 Hepatitis C: Både akutte og kroniske. Hepatitis B: akutte.

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

Table 3.4 Diagnosed cases of tuberculosis per 100 000 inhabitants 1995–2002
Diagnosticerede tilfælde af tuberkulose pr. 100 000 indbyggere 1995-2002

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway[1)]	Sweden
Men Mænd					M+W			
1995	9.8	-	94.3	14.5	7.9	4.5	6.4	6.5
2000	12.1	21.7	50.0	12.3	3.9	2.8	5.8	5.2
2001	10.2	-	156.5	10.8	7.8	5.6	7.3	4.6
2002	8.6	-	143.3	9.8	7.8	1.4	5.9	4.3
Women Kvinder								
1995	7.5	9.5	76.8	11.5	.	4.5	4.5	6.3
2000	8.5	4.5	111.0	8.5	.	6.4	4.8	5.2
2001	8.9	8.7	217.4	8.2	.	4.2	5.9	5.0
2002	7.0	-	153.8	8.4	.	2.8	5.4	4.9

1 Including relapses.

1 Inklusiv residiver.

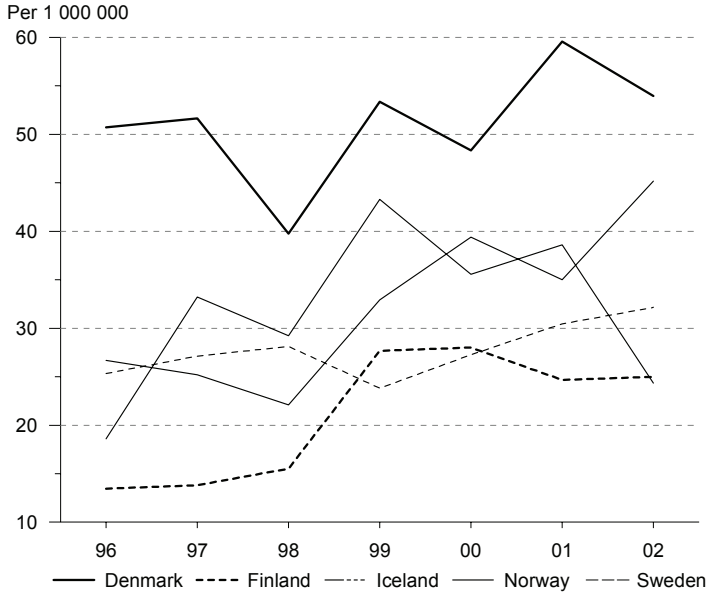
Sources: *See Table 3.3*
Kilder: Se tabel 3.3
I: Directorate of Health

Table 3.5 Confirmed new cases of HIV 1996-2002
Påviste nye tilfælde af HIV 1996-2002

	Denmark	Faroe Islands	Greenland	Finland	Of which Åland	Iceland	Norway	Sweden
Men								
Mænd								
1996-00	180	0	6	76	0	6	81	155
2001	228	-	4	95	-	9	102	169
2002	189	-	5	93	-	5	122	175
Women								
Kvinder								
1996-00	80	-	4	24	0	3	49	78
2001	91	-	2	33	-	2	56	108
2002	101	-	2	37	-	2	83	112
Total								
I alt								
1996-00	260	0	9	102	0	9	130	233
2001	319	-	6	128	-	11	158	271
2002	290	-	7	130	-	7	205	287

Sources: *See Table 3.3*
Kilder: Se tabel 3.3

Figure 3.4 Confirmed new cases of HIV per 1 000 000 inhabitants 1996-2002



Sources: *See Table 3.3*
Kilder: Se tabel 3.3

Table 3.6 Notified cases of gonorrhoea and syphilis per 100 000 inhabitants aged 15 years and over 2002
Anmeldte tilfælde af gonorré og syfilis pr. 100 000 indbyggere 15 år og derover 2002

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
Gonorrhoea								
Gonorré								
Men	8.6	-	1 546	6.7	9.6	4.5	11.7	11.5
Women	1.6	-	1 534	2.4	-	0.9	1.7	2.5
Total	5.2	-	1 540	4.4	4.7	3.6	6.6	6.9
Syphilis								
Syfilis								
Men	1.5	-	3.3	3.8	9.6	3.6	3.5	2.8
Women	0.1	-	0.0	2.5	-	0.9	0.1	0.6
Total	0.8	-	1.8	3.1	4.7	3.2	1.8	1.7

Sources: *See Table 3.3*
Kilder: Se tabel 3.3

Table 3.7 Diagnosed cases of chlamydia per 100 000 inhabitants 1995-2002
Diagnosticerede tilfælde af chlamydia pr. 100 000 indbyggere 1995-2002

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland[1)]	Norway[2)]	Sweden
Men		M+W			M+W			
Mænd								
1995	124	67	..	138	95	368	157	131
2000	165	79	2 791	179	151	481	326[2)]	187
2001	167	158	3 330	183	190	541	330[2)]	218
2002	196	169	2 660	204	179	491	336[2)]	240
Women								
Kvinder								
1995	370	.	..	224	.	428	276	192
2000	384	.	4 817	271	.	793	.[2)]	246
2001	397	.	6 173	283	.	896	.[2)]	281
2002	405	.	4 454	318	249	920	.[2]	311

1 Notified cases. Since 1997 cases verified by laboratories.
2 Figures for 2000, 2001 and 2002 are for both men and women.

1 Anmeldte tilfælde. Fra 1997 er det tilfælde der er verificeret via laboratorier.
2 Tallene for 2000, 2001 og 2002 er for både mænd og kvinder.

Sources: *See Table 3.3*
Kilder: Se tabel 3.3

Cancer

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

While in earlier publications, NOMESCO has only given incidence rates in the World standard, in this publication data is given for crude rates, supplemented by tables showing age-specific rates.

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

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

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

Cancersygdomme

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

Mens NOMESKO i de tidligere publikationer alene har vist incidensrater i World standard, er der i denne publikation medtaget data i crude rates suppleret med tabeller med aldersspecifikke rater.

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

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

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

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 decreasing 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.

Bryst- og prostatacancer samt colorektal cancer stiger i næsten alle lande. Kostfaktorer er formentlig af væsentlig betydning for denne udvikling, men for bryst- og prostatacancer spiller hormonelle faktorer også en vigtig rolle. Forekomsten af testikelkræft er faldende i de fleste af landene. Forekomsten af tobaksrelaterede kræftformer, såsom lungecancer er høje i alle landene Det skal dog bemærkes, at lungekræft blandt mænd er faldende.

Differences in cancer incidence between the Nordic countries and the autonomous areas the Faroe Islands, Greenland and Åland must be interpreted with caution, as the size of the population in these countries is small, such that incidence rates are unstable. At the Nordic cancerunion at ncu.cancer.dk/ancr you will find more detailed information concerning cancerinsidens in the Nordic countries.

Forskelle i kræftforekomst mellem de nordiske lande og de autonome områder Færøerne, Grønland og Åland må bedømmes med forsigtighed, da befolkningernes størrelse i disse områder er små, hvilket fører til ustabile incidensrater. Hos den nordiske cancerunion på adressen ncu.cancer.dk/ancr findes der mere detaljerede informationer om cancerforekomst i de nordiske lande.

Table 3.8 New cases of cancer per 1 000 000 inhabitants, men
Nye tilfælde af cancer pr. 1 000 000 indbyggere, mænd

	*Total** I alt*	C62 *Testis* Testikler	C61 *Prostate* Prostata	C16 *Stomach* Mave	C18-21 *Colon and rectum* Tyktarm og endetarm	C25 *Pancreas* Pancreas	C33-34 *Lungs* Lunger	C43 *Melanoma of the skin* Melanom i hud
Denmark[1)]								
1996-00	5 626	110	655	121	651	124	760	161
2001	5 727	92	715	116	697	124	742	166
2002	5 755	99	752	116	667	124	743	173
Faroe Islands[2)]								
1996-00	3 586	86	405	172	474	138	465	34
1997-01	3 422	83	290	191	456	174	456	41
1998-02	3 291	101	320	177	463	160	429	42
Greenland								
1996-00	2 575	54	54	207	237	130	681	15
2001	3 464	67	-	167	366	100	1 132	33
2002	2 651	33	66	199	298	99	861	-
Finland								
1996-00	4 210	34	1 201	176	391	130	602	122
2000	4 353	38	1 353	163	393	131	576	128
2001	4 386	33	1 400	153	410	132	556	134
Iceland								
1996-00	4 108	61	1 096	199	480	98	469	98
1998-02	4 061	56	1 165	166	455	94	405	107
Norway								
1996-00	5 064	108	1 293	182	687	124	580	206
2000	5 155	110	1 368	164	723	120	581	211
2001	5 166	119	1 288	163	729	131	587	215
Sweden								
1996-00	5 140	55	1 528	156	600	101	381	183
2000	5 361	56	1 739	136	599	94	380	182
2001	5 426	62	1 753	143	621	105	392	205
2002	5 465	60	1 781	133	635	95	364	220

Numbers refer to ICD-10.
* *The total covers chapter C.*
Totalen dækker kapitel C.

1 2001 and 2002 are preliminary figures.
2 Based on 5 year average discharges from the patient register.

1 2001 og 2002 er foreløbige tal.
2 Baseret på udskrivninger for 5 års gennemsnit fra patientregisteret.

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

Table 3.9 New cases of cancer per 1 000 000 inhabitants, women
Nye tilfælde af cancer pr. 1 000 000 indbyggere, kvinder

	*Total** I alt*	C50 *Breast* Bryst	C53 *Cervix uteri* Livmoder-hals	C16 *Stomach* Mave	C18-21 *Colon and rectum* Tyktarm og endetarm	C25 *Pancreas* Pancreas	C33-34 *Lungs* Lunger	C43 *Melanoma of the skin* Melanom i hud
Denmark[1)]								
1996-00	6 021	1 381	160	73	641	131	537	197
2001	6 198	1 465	149	69	633	145	559	216
2002	6 188	1 536	133	56	622	134	581	203
Faroe Islands[2)]								
1996-00	3 946	922	221	101	470	175	267	37
1997-01	3 613	980	196	107	472	160	240	45
1998-02	3 912	1 066	154	117	452	208	280	81
Greenland								
1996-00	4 463	467	352	46	337	122	559	23
2001	2 250	191	114	114	153	305	229	-
2002	3 300	569	266	76	303	152	759	-
Finland								
1996-00	4 184	1 281	61	140	419	138	179	115
2000	4 325	1 391	61	133	414	140	188	126
2001	4 292	1 377	60	127	431	143	203	124
Iceland								
1996-00	3 947	1 082	105	102	378	107	409	172
1998-02	4 101	1 170	106	101	395	78	412	211
Norway								
1996-00	4 587	1 077	140	113	710	140	311	223
2000	4 768	1 111	124	107	740	146	349	237
2001	4 764	1 144	133	93	721	149	349	230
Sweden								
1996-00	4 855	1 366	102	98	567	109	249	182
2000	4 954	1 420	100	99	576	101	276	183
2001	5 028	1 454	98	88	579	101	283	209
2002	5 016	1 469	103	95	590	102	276	206

Numbers refer to ICD-10.
* *The total covers chapter C.*
Totalen dækker kapitel C.

1 2001 and 2002 are preliminary figures.
2 Based on 5 year average discharges from the patient register.

1 2001 og 2002 er foreløbige tal.
2 Baseret på udskrivninger for 5 års gennemsnit fra patientregisteret.

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

Table 3.10 New cases of leukemia per 1 000 000 inhabitants, 0–14 year-olds
Nye tilfælde af leukæmi pr. 1 000 000 indbyggere, 0-14-årige

	Denmark[1)]	Finland	Iceland[2)]	Norway	Sweden[3)]
Boys Drenge					
1996-00	47	47	48	53	54
2001	69	53	30	45	50
2002	50	..	..	..	51
Girls Piger					
1996-00	43	50	25	51	49
2001	43	29	31	41	53
2002	45	..	..	..	51
Total I alt		.			
1996-00	45	49	37	53	52
2001	56	41	31	43	52
2002	48	..	..	..	51

The table covers the numbers C91-C95 in ICD-10.
Tabellen dækker numrene C91-C95 i ICD-10.

1 2001 and 2002 are preliminary figures.
2 Only five year averages are presented. Figures for single years may be unstable because of low population. 2001 = average 1998-1992.
3 Only covers C91 in ICD-10.

1 2001 og 2002 er foreløbige tal.
2 Kun femårs gennemsnit præsenteres. Tal for enkelte år kan være ustabile på grund af lav population. 2001 = gennemsnit 1998-2002.
3 Dækker kun C91 i ICD-10.

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

Table 3.11 New cases of cancer of the colon and rectum per 1 000 000 inhabitants
Nye tilfælde af cancer i tyktarm og endetarm pr. 1 000 000 indbyggere

	Denmark[1)]	Faroe Islands	Greenland	Finland	Iceland	Norway	Sweden
	2002	1998-02	2002	2001	1998-02	2001	2001
Men Mænd							
Age Alder							
0-24	2	-	-	10	4	1	6
25-44	43	91	-	50	33	58	52
45-64	737	802	596	434	542	780	565
65-84	3 564	2 044	750	2 123	3 143	4 008	3 019
85+	4 479	3 690	-	3 947	3 818	5 657	3 741
Women Kvinder							
Age Alder							
0-24	5	-	-	9	-	3	11
25-44	54	35	113	61	87	65	49
45-64	572	544	415	370	442	734	471
65-84	2 711	1 869	1 991	1 609	2 074	2 873	2 189
85+	2 642	3 570	-	2 508	3 101	4 153	2 683

1 Preliminary figures.

1 Foreløbige tal.

The table covers the numbers C18-21 in ICD-10.
Tabellen dækker numrene C18-21 i ICD-10.

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

Table 3.12 New cases of lung cancer per 1 000 000 inhabitants
Nye tilfælde af lungecancer pr. 1 000 000 indbyggere

	Denmark[1)]	Faroe Islands	Greenland	Finland	Iceland	Norway	Sweden
	2002	1998-02	2002	2001	1998-02	2001	2001
Men Mænd							
Age Alder							
0-24	2	-	-	-	-	1	1
25-44	40	30	189	28	43	25	10
45-64	902	656	1 638	594	597	705	428
65-84	4 049	2280	9 745	3 149	2 636	3 344	1 960
85+	2 414	2767	-	3 263	2 158	2 334	1 116
Women Kvinder							
Age Alder							
0-24	1	-	-	1	-	-	4
25-44	44	35	-	16	63	26	25
45-64	832	544	1 244	216	763	533	440
65-84	2 278	1135	9 290	776	1 921	1 360	935
85+	1 051	-	-	743	1 642	711	357

1 Preliminary figures. 1 Foreløbige tal.

The table covers the numbers C33-34 in ICD-10.
Tabellen dækker numrene C33-34 i ICD-10.

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

Table 3.13 New cases of cancer of the cervix uteri per 1 000 000 women
Nye tilfælde af livmoderhalscancer pr. 1 000 000 kvinder

	Denmark[1)]	Faroe Islands	Greenland	Finland	Iceland	Norway	Sweden
	2002	1998-02	2002	2001	1998-02	2001	2001
Age Alder							
0-24	3	0	-	-	4	1	4
25-44	180	139	453	65	213	206	132
45-64	171	293	622	69	128	187	125
65-84	233	134	-	135	115	185	152
85+	142	0	-	149	182	114	189

1 Preliminary figures. 1 Foreløbige tal.

The table covers the number C53 in ICD-10.
Tabellen dækker numrene C53 i ICD-10.

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

Table 3.14 New cases of cancer of the testis per 1 000 000 men
Nye tilfælde af testikelcancer pr. 1 000 000 mænd

	Denmark[1)]	Faroe Islands	Greenland	Finland	Iceland	Norway	Sweden
	2002	1998-02	2002	2001	1998-02	2001	2001
Age Alder							
0-24	33	45	-	26	15	43	28
25-44	228	243	94	67	133	266	144
45-64	71	73	-	11	42	73	42
65-84	13	-	-	21	15	27	9
85+	-	-	-	-	-	40	16

The table covers the number C62 in ICD-10.
Tabellen dækker nummer C62 i ICD-10.

1 Preliminary figures. 1 Foreløbige tal.

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

Table 3.15 New cases of melanoma of the skin per 1 000 000 inhabitants
Nye tilfælde af melanom i hud pr. 1 000 000 indbyggere

	Denmark[1)]	Faroe Islands	Greenland	Finland	Iceland	Norway	Sweden
	2002	1998-02	2002	2001	1998-02	2001	2001
Men Mænd							
Age Alder							
0-24	5	-	-	10	15	9	8
25-44	125	30	-	56	104	106	89
45-64	295	73	-	195	201	357	282
65-84	429	157	-	492	268	744	690
85+	560	-	-	579	332	998	864
Women Kvinder							
Age Alder							
0-24	18	-	-	9	45	13	15
25-44	190	139	-	80	363	200	148
45-64	306	42	-	164	292	348	307
65-84	387	200	-	294	204	506	445
85+	355	446	-	429	365	474	497

The table covers the number C43 in ICD-10.
Tabellen dækker nummer C43 i ICD-10.

1 Preliminary figures. 1 Foreløbige tal.

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

Medical consultations and immunization schedules

In the Nordic countries, the primary health services is rooted and financed of the public sector.

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

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

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

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

In 1997, NOMESCO carried out a pilot study of reasons for contact between patients and general practitioners in the five Nordic countries. The results of this survey were presented in Section B of the 1998 version of this publication. Even though the results should be interpreted with caution, the report substantiates conditions already known, such as that registration practice differs between the Nordic countries, partly due to the payment systems and partly because of organizational differences. All contacts in Denmark are registered as medical contacts, because of the payment system, whereas some of the contacts in the other

Lægebesøg og vaccinationsprogrammer

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

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

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

Registreringspraksis for lægebesøg er meget forskellig fra land til land.

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

I 1997 gennemførte NOMESKO en pilotundersøgelse om kontaktårsagerne i almen praksis i de fem nordiske lande. Resultaterne af denne undersøgelse var medtaget som Sektion B i denne rapport i 1998. Selv om de fundne resultater må tages med forbehold, underbygger rapporten de kendte forhold om at registreringspraksis er forskellig i de nordiske lande hvilket dels afspejler betalingsreglerne og dels organisatoriske forskelle. Alle kontakter i Danmark registreres således som lægekontakter, på grund af betalingssystemet, mens en del af kontakterne i de andre lande er registrerede/ikke regi-

countries are registered or non-registered contacts with other health staff. Along with other factors, this means that the statistics on medical consultations are not directly comparable between the Nordic countries.

strerede kontakter med andet sundhedspersonale. Blandt andet disse forhold gør at statistikken om lægebesøg ikke er sammenlignelig mellem de nordiske lande.

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

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

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

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

Table 3.16 Medical consultations[1] 2002
Lægekonsultationer[1] 2002

	Denmark	Finland	Iceland[2]	Sweden[3]
Total number of consultations (millions) Konsultationer i alt (mill.)	27.4	22.1	1.5	26.4
of which: heraf:				
Consultations with a general practitioner Besøg hos alment praktiserende læge i konsultationen	17.7	12.0	0.7	12.4
Consultations with a specialist Besøg hos specialist	9.7	10.1	0.8	14.0
Consultations per capita Besøg pr person	5.1	4.2	5.3	3.0

1 Excl. consultations by telephone, home visits by physicians. Consultations with a specialist include outpatient treatment in hospitals.
2 2001.
3 Incl. home visits, excl. consultations in day care at hospitals.

1 Ekskl. telefonkonsultationer, lægebesøg i hjemmet. Besøg hos specialister omfatter også ambulant behandling på sygehuse.
2 2001.
3 Inkl. hjemmebesøg, ekskl. dagbehandling på hospitaler.

Sources: D: National Board of Health; F: STAKES; I: Directorate of Health; S: Federation of Swedish County
Kilder: Councils

Table 3.17 Children under the age of two immunized according to immunization schedules (per cent) 2002
Børn under to år vaccineret i henhold til det anbefalede vaccinationsprogram (pct.) 2002

	Denmark	Faroe Islands	Finland	Iceland	Norway[1)]	Sweden
BCG Tuberkulose	-	.	98	-	..	16
Pertussis Kighoste	98	99	95	97	93	98
Tetanus Stivkrampe	98	99	95	97	94	99
Diphtheria Difteri	98	99	95	97	93	99
Polio Polio	98	99	96	97	93	99
Rubella Røde hunde	100	91	97	93	87	91
Measles Mæslinger	100	91	97	93	86	91

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

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

Source: WHO/EPI; D: Statens Seruminstitut; F: National Public Health Institute; I: Directorate of Health; N: Norwegian Institute of Public Health; S: Swedish Institute for Infectious Disease Control
Kilde:

Table 3.18 Recommended immunization schedules per 1 January, 2004

	Denmark	*Finland*	*Iceland*	*Norway*	*Sweden*
BCG	-	< 7 days	-	Risk groups: First week of life. Negatives: 13-14 years	Risk groups
Pertussis	3, 5 and 12 months and 5 years	Children born before 1997: 3, 4, 5 and 20-24 months, Children born 1997 or later: 3, 4, 5 and 20-24 months and 6 years	3, 5, 12 months and 5 years	3, 5 and 11-12 months	3, 5 and 12 months
Tetanus	3, 5 and 12 months and 5 years	Children born before 1997: 3, 4, 5 and 20-24 months, 11-13 years; Children born 1997 or later: 3, 4, 5 and 20-24 months, 6 years and 14-16 years	3, 5, 12 months, 5 and 14 years	3, 5 and 11-12 months, 11-12 years	3, 5 and 12 months, 10 years
Diphtheria	3, 5 and 12 months and 5 years	Children born before 1997: 3, 4, 5 and 20-24 months, 11-13 years; Children born 1997 or later: 3, 4, 5 and 20-24 months, 6 years and 14-16 years	3, 4, 12 months, 5 and 14 years	3, 5 and 11 months, 11-12 years	3, 5 and 12 months, 10 years
Polio	IPV: 3, 5 and 12 months	IPV: 6, 12 and 20-24 months + 6-7 years	IPV: 3, 5, 12 months and 14 years	IPV: 3, 5 and 11 months, 6-8 and 14 years	IPV: 3, 5 and 12 months, 5-6 years
Measles, Mumps, Rubella	15 months. 12 years	14-18 months and 6 years	18 months and 9 years	15 months and 12-13 years	18 months and 12 years
Rubella, only	Women of fertile age	-		Seronegative women of fertile age	-
Measles, only	-	-	-	-	-
Haemophilus influenzae b	3, 5 and 12 months	4, 6 and 14-18 months	3, 5 and 12 months	3, 5 and 11 months	3, 5 and 12 months
Meningococcal disease gr. C			6, 8 months		

IPV = Inactivated polio vaccine

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

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

Tabel 3.18 Anbefalede vaccinationsprogrammer pr. 1. januar 2004

	Danmark	Finland	Island	Norge	Sverige
Tuberkulose	-	< 7 dage	-	Risikogrupper: Første leveuge Negative: 13-14 år	Risikogrupper
Kighoste	3, 5 og 12 måneder og 5 år	Børn født før 1997: 3, 4, 5 og 20-24 måneder; Født efter 1997: 3,4,5 og 20-24 måneder samt 6 år.	3, 5, 12 måneder og 5 år	3, 5 og 11-12 måneder	3, 5 og 12 måneder
Stivkrampe	3, 5 og 12 måneder og 5 år	Børn født før 1997: 3, 4, 5 og 20-24 måneder, 11-13 år; Født efter 1997: 3, 4, 5 og 20-24 måneder, 14-16 år	3, 5,12 måneder, 5 år og 14 år,	3, 5 og 11-12 måneder, samt 11-12 år	3, 5 og 12 måneder, 10 år
Difteri	3, 5 og 12 måneder og 5 år	Børn født før 1997: 3, 4, 5 og 20-24 måneder, 11-13 år; Født efter 1997: 3, 4, 5 og 20-24 måneder, 14-16 år	3, 4, 12 måneder, 5 og 14 år	3, 5 og 11 måneder samt 11-12 år	3, 5 og 12 måneder, 10 år
Polio	IPV: 3, 5 og 12 måneder	IPV: 6, 12 og 20-24 måneder + 6-7 år	IPV: 3, 5, 12 måneder og 14 år	IPV: 3, 5 og11 måneder,6-8 år og 14 år	IPV: 3, 5 og 12 måneder, 5-6 år
Mæslinger, fåresyge, røde hunde	15 måneder, 12 år	14-18 måneder og 6 år	18 måneder og 9 år	15 måneder og 12-13 år	18 måneder og 12 år
Røde hunde, alene	Kvinder i den fertile alder	-		Seronegative kvinder i den fertile alder	-
Mæslinger, alene	-	-	-	-	-
Haemophilus influensae b	3, 5 og 12 måneder	4, 6 og 14-18 måneder	3, 5, 12 måneder	3, 5 og 11 måneder	3, 5 og 12 måneder
Meningitis			6, 8 måneder		

IPV = Inaktiveret polio vaccine

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

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

Discharges, average length of stay and surgical procedures

In this section, data on treatment in hospitals are presented, with data from selected diagnostic groups and with data on surgery according to 16 major surgical procedure groups. The statistics based on diagnosis are first presented with the total number of discharges from hospitals, the average length of stay, and the number of patients who have been treated during the year, according to the ICD-10's main chapters. Then follow tables on hospital discharges and average length of stay for 10 selected diagnostic groups. On the NOMESCO homepage at www.nom-nos.dk you will find detailed data on the total number of discharges according to the 61 groups in the Nordic abbreviated list of morbidity.

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

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

Udskrivninger, gennemsnitlig liggetid og kirurgiske indgreb

I dette afsnit gives der data for behandlingen ved sygehuse med data fra udvalgte diagnosegrupper og med data for operationer opgjort efter 16 hovedoperationsgrupper. Den diagnosebaserede statistik vises først med det samlede antal udskrivninger, den gennemsnitlig liggetid, samt patienter der er behandlet i løbet af året, fordelt efter ICD-10´s hovedkapitler. Herefter kommer tabeller om udskrivninger samt den gennemsnitlige liggetid for 10 udvalgte diagnosegrupper. På NOMESKO's hjemmeside på www.nom-nos.dk findes der detaljerede data om det samlede antal udskrivninger fordelt på de 61 grupper i den nordiske forkortede morbiditetsliste.

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

Det der kan konstateres ved den diagnoserelaterede statistik er, at der er en vis variation i diagnosticeringen og kodningen mellem de nordiske lande til trods for at man anvender den samme klassifikation. I validitetsstudiet blev der peget

agnostic cultures, differences in medical treatment and differences in the way in which treatment is organized.

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

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

på forskellige diagnostiske kulturer, forskelle i den medicinske behandling samt forskelle i den måde hvorpå behandlingen er organiseret.

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

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

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

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

Another important aspect is changes in the statistics in connection with the change in the classification. This is described in detail in Chapter 5 together with the causes of death. Today, all five Nordic countries use ICD-10, so that comparability is only a problem in the historic data. For example, the present tables 3.19-3.21, calculated according to the main chapters in ICD-10, are not completely comparable with the previous corresponding tables calculated according to the main chapters in ICD-9.

Et andet væsentligt aspekt er ændringer i statistikken ved klassifikationsskiftet. Dette er omfattende beskrevet i kapitel 5 sammen med dødsårsagerne. I dag anvender alle 5 nordiske lande ICD-10 hvorfor det kun er i de historiske data der kan komme brist i sammenligneligheden. De nuværende tabeller 3.19-3.21 opgjort efter ICD-10´s hovedkapitler kan eksempelvis ikke helt sammenlignes med de tidligere tilsvarende tabeller opgjort efter ICD-9`s hovedkapitler.

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

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

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

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

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

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

Tables 3.32 -3.34 include information on selected surgical procedure groups, selected because of their high frequency

Tabellerne 3.32-3.34 indeholder oplysninger om udvalgte operationsgrupper. som er udvalgt fordi de er hyppigt fore-

and because the frequency of operations is influenced by differences in medical practice between the countries.

In order to present a more complete picture, Table 3.35 covers the most frequent procedures carried out as day surgery.

In order to give more detail, the 14 groups are presented by sex, and in some cases by age, in Tables 3.36-3.51. In this way, the differences between the countries appear more clearly.

Comparisons of operations between various geographic areas are however difficult, and the comparisons contain a number of potential sources of error, which in principle are the same as those mentioned for the diagnosis-related statistics.

In addition, there are differences from country to country in the way in which operations in hospitals are counted.

kommende og fordi operationsomfanget i forskellig grad påvirkes af forskelle i medicinsk praksis i landene.

For at få et mere fuldkomment billede er der i tabel 3.35 medtaget de mest forekommende indgreb som sker uden indlæggelse – dagkirurgisk.

For at få et mere komplet billede, er de 14 grupper medtaget fordelt på køn og i visse aldersgrupper i tabellerne 3.36-3.51. Heraf fremgår forskellene mellem landene tydeligere.

Sammenligninger af operationer mellem geografiske områder er imidlertid vanskelige og indeholder en række potentielle fejlkilder, som i princippet er de samme som er nævnt for den diagnoserelaterede statistik.

Hertil kommer, at der er forskelle fra land til land i måden hvorpå operationer ved sygehuse tælles.

Table 3.19 Discharges from hospitals* by main diagnostic group, per 1 000 inhabitants 2002

	Denmark	*Faroe Islands*	*Finland*[1)]	*Åland*[1)]
Certain infectious and parasitic diseases	5.2	4.9	5.0	5.5
Neoplasms	19.6	22.9	21.5	18.0
Diseases of the blood and blood-forming organs and certain disorders involving the immune system	2.7	4.6	1.6	1.1
Endocrine, nutritional and metabolic diseases	4.7	4.8	2.8	3.4
Mental and behavioural disorders	2.7	2.9	2.0	2.2
Diseases of the nervous system	4.7	6.4	8.1	5.7
Diseases of the eye and adnexa	1.4	4.2	9.5	2.7
Diseases of the ear and mastoid process	1.3	3.0	2.9	3.0
Diseases of the circulatory system	26.5	28.8	26.8	24.5
Diseases of the respiratory system	16.4	16.2	14.8	13.1
Diseases of the digestive system	16.4	26.5	15.8	19.3
Diseases of the skin and subcutaneous tissue	2.9	2.9	2.4	2.3
Diseases of the musculo-skeletal system and connective tissue	10.6	18.8	19.9	19.3
Diseases of the genito-urinary system	10.7	11.1	11.5	16.0
Pregnancy, childbirth and the puerperium	16.3	19.9	15.6	16.0
Certain conditions originating in the perinatal period	1.8	0.8	1.5	1.6
Congenital malformations, deformations and chromosomal abnormalities	1.8	3.0	2.1	2.3
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	13.8	12.9	12.5	10.9
Injury, poisoning and certain other consequences of external causes	19.3	20.3	17.5	19.3
Factors influencing health status and contact with health services	18.7	18.9	4.0	3.9
Total	197.7	233.8	197.8	190.1

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

1 Excluding wards in psychiatric hospitals and in non-specialized departments in health centres.
2 Discharges with a length of stay less than 90 days.
3 Figures are for discharges from hospitals, not for finished treatment at wards.

Sources: The national in-patient registers

Udskrivninger fra sygehuse* efter hoveddiagnosegrupper, pr. 1 000 indbyggere 2002 **Tabel 3.19**

Iceland[2)]	*Norway*[3)]	*Sweden*	
4.2	3.9	4.5	Visse infektions- og parasitære sygdomme
12.7	17.7	15.5	Svulster
1.6	1.1	1.2	Sygdomme i blod og bloddannende organer og visse lidelser i forbindelse med immunsystemet
2.0	2.5	3.3	Endokrine, ernærings- og stofskiftesygdomme
2.7	1.9	1.7	Psykiske og adfærdsmæssige lidelser
4.8	5.9	4.3	Sygdomme i nervesystem
0.9	2.0	1.1	Sygdomme i øje og øjenomgivelser
1.9	0.8	0.9	Sygdomme i øre og processus mastoideus
18.0	23.7	26.5	Sygdomme i kredsløbsorganer
12.4	13.4	9.9	Sygdomme i åndedrætsorganer
12.4	11.5	12.3	Sygdomme i fordøjelsesorganer
2.9	1.9	1.2	Sygdomme i hud og underhud
9.5	11.4	8.1	Sygdomme i knogler, bevægelsessystem og bindevæv
10.7	8.6	7.4	Sygdomme i urin- og kønsorganer
20.2	14.7	13.4	Svangerskab, fødsel og barsel
3.7	2.3	1.4	Visse årsager til sygdomme i perinatalperioden
1.8	1.9	1.2	Medfødte misdannelser og kromosomanomalier
8.3	10.4	14.5	Symptomer og abnorme fund ikke klassificeret andetsteds
11.4	16.9	15.2	Læsioner, forgiftninger og visse andre følger af ydre påvirkninger
18.4	8.6	5.3	Faktorer af betydning for sundhedstilstand og kontakter med sundhedsvæsen
160.6	161.2	149.1	I alt

* Omfatter somatiske afdelinger ved almindelige sygehuse og ved somatiske specialsygehuse

1 Ekslusiv psykiatriske hospitalsafdelinger og ikke-specialiserede afdelinger på sundhedscentraler.
2 Udskrivninger med liggetid under 90 dage.
3 Opgørelsen vedrører udskrivninger fra sygehuse, ikke afsluttede behandlinger ved afdelinger.

Kilder: Landspatientregistrene

Table 3.20 Average length of stay in hospitals* by main diagnostic group 2002

	Denmark	*Faroe Islands*	*Finland*[1)]	*Åland*[1)]
Certain infectious and parasitic diseases	5.1	5.9	5.8	6.2
Neoplasms	6.3	4.4	4.7	6.7
Diseases of the blood and blood-forming organs and certain disorders involving the immune system	4.5	2.8	4.2	6.4
Endocrine, nutritional and metabolic diseases	6.3	7.2	5.8	6.6
Mental and behavioural disorders	4.6	2.6	8.8	4.8
Diseases of the nervous system	5.6	5.1	4.3	5.6
Diseases of the eye and adnexa	2.4	2.8	1.3	1.5
Diseases of the ear and mastoid process	2.5	1.0	1.6	2.0
Diseases of the circulatory system	6.0	8.0	5.8	6.1
Diseases of the respiratory system	5.1	4.9	4.2	3.2
Diseases of the digestive system	4.8	3.0	3.9	4.4
Diseases of the skin and subcutaneous tissue	5.6	5.6	4.8	2.8
Diseases of the musculo-skeletal system and connective tissue	6.0	6.2	3.9	3.8
Diseases of the genito-urinary system	4.0	3.5	3.2	3.5
Pregnancy, childbirth and the puerperium	3.3	4.6	3.5	3.6
Certain conditions originating in the perinatal period	11.5	15.4	9.7	8.4
Congenital malformations, deformations and chromosomal abnormalities	4.2	2.3	4.1	27.9
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	3.2	2.5	3.0	3.1
Injury, poisoning and certain other consequences of external causes	5.2	6.1	5.0	5.4
Factors influencing health status and contact with health services	5.9	1.7	2.7	3.5
Total	5.1	4.4	4.3	4.9

* Definition, see Table 3.19

1 Excluding wards in psychiatric hospitals and in non-specialized departments in health centres.
2 Excluding patients staying over 90 days.

Sources: See Table 3.19

Gennemsnitlig liggetid ved sygehuse* efter hoveddiagnosegrupper 2002 Tabel 3.20

Iceland[2)]	*Norway*	*Sweden*	
3.2	6.5	5.4	Visse infektions- og parasitære sygdomme
7.4	7.9	7.4	Svulster
3.2	4.8	5.2	Sygdomme i blod og bloddannende organer og visse lidelser i forbindelse med immunsystemet
7.1	5.1	6.2	Endokrine, ernærings- og stofskiftesygdomme
12.8	4.1	5.7	Psykiske og adfærdsmæssige lidelser
6.0	4.3	5.5	Sygdomme i nervesystem
3.9	3.7	2.8	Sygdomme i øje og øjenomgivelser
1.7	2.7	2.6	Sygdomme i øre og processus mastoideus
6.5	5.8	6.2	Sygdomme i kredsløbsorganer
5.0	6.0	5.4	Sygdomme i åndedrætsorganer
4.5	5.2	4.8	Sygdomme i fordøjelsesorganer
6.2	7.0	7.1	Sygdomme i hud og underhud
6.0	5.8	6.2	Sygdomme i knogler, bevægelsessystem og bindevæv
3.7	4.6	4.4	Sygdomme i urin- og kønsorganer
2.7	4.1	3.0	Svangerskab, fødsel og barsel
5.0	10.3	11.3	Visse årsager til sygdomme i perinatalperioden
4.8	5.0	4.7	Medfødte misdannelser og kromosomanomalier
3.0	2.5	2.6	Symptomer og abnorme fund ikke klassificeret andetsteds
6.0	5.1	5.6	Læsioner, forgiftninger og visse andre følger af ydre påvirkninger
2.7	8.3	5.8	Faktorer af betydning for sundhedstilstand og kontakter med sundhedsvæsen
4.8	5.6	5.3	I alt

* Definition, se tabel 3.19

1 Ekslusiv psykiatriske hospitalsafdelinger og ikke-specialiserede afdelinger på sundhedscentraler.
2 Eksklusiv patienter med liggetid over 90 dage.

Kilder: Se tabel 3.19

Table 3.21 Patients treated in hospitals* during 2002 by main diagnostic group, per 1 000 inhabitants

	Denmark	*Faroe Islands*	*Finland*[1)]	*Åland*[1)]
Certain infectious and parasitic diseases	4.5	4.3	4.4	6.2
Neoplasms	9.7	8.0	9.9	11.0
Diseases of the blood and blood-forming organs and certain disorders involving the immune system	1.7	1.9	1.0	1.3
Endocrine, nutritional and metabolic diseases	3.7	3.5	2.2	3.2
Mental and behavioural disorders	2.1	2.1	1.7	2.9
Diseases of the nervous system	3.4	4.1	6.0	11.0
Diseases of the eye and adnexa	1.2	3.2	8.1	2.1
Diseases of the ear and mastoid process	1.2	2.8	2.6	2.8
Diseases of the circulatory system	16.6	19.4	17.5	18.7
Diseases of the respiratory system	11.6	12.9	11.8	16.1
Diseases of the digestive system	12.4	22.9	12.9	15.5
Diseases of the skin and subcutaneous tissue	2.4	2.4	1.9	2.3
Diseases of the musculo-skeletal system and connective tissue	8.7	13.5	16.1	18.8
Diseases of the genito-urinary system	8.4	9.0	9.7	14.1
Pregnancy, childbirth and the puerperium	14.5	19.2	13.2	13.7
Certain conditions originating in the perinatal period	1.6	0.5	1.3	1.3
Congenital malformations, deformations and chromosomal abnormalities	1.2	1.4	1.5	1.3
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	12.0	10.9	10.7	11.6
Injury, poisoning and certain other consequences of external causes	15.8	16.3	14.3	16.7
Factors influencing health status and contact with health services	15.9	17.7	3.5	4.1
Total	148.4	175.9	127.7	145.0

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

1 Excluding wards in psychiatric hospitals and in non-specialized departments in health centres.
2 Excluding patients staying over 90 days.
3 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period.

Sources: The national in-patient registers

Patienter behandlet ved sygehuse* i løbet af 2002, efter hoveddiagnosegrupper, pr. 1 000 indbyggere **Tabel 3.21**

Iceland[2)]	*Norway*[3)]	*Sweden*	
3.8	3.7	4.0	Visse infektions- og parasitære sygdomme
7.1	11.2	8.3	Svulster
0.8	0.9	0.9	Sygdomme i blod og bloddannende organer og visse lidelser i forbindelse med immunsystemet
1.6	2.1	2.6	Endokrine, ernærings- og stofskiftesygdomme
2.2	1.7	1.5	Psykiske og adfærdsmæssige lidelser
3.5	4.9	3.3	Sygdomme i nervesystem
0.8	1.7	0.9	Sygdomme i øje og øjenomgivelser
1.7	0.7	0.8	Sygdomme i øre og processus mastoideus
12.4	20.6	17.1	Sygdomme i kredsløbsorganer
9.6	11.9	7.5	Sygdomme i åndedrætsorganer
9.9	10.1	9.8	Sygdomme i fordøjelsesorganer
2.3	1.7	1.0	Sygdomme i hud og underhud
7.3	9.8	6.7	Sygdomme i knogler, bevægelsessystem og bindevæv
9.0	7.7	6.2	Sygdomme i urin- og kønsorganer
17.3	14.4	11.3	Svangerskab, fødsel og barsel
3.0	2.3	0.9	Visse årsager til sygdomme i perinatalperioden
1.5	1.6	0.8	Medfødte misdannelser og kromosomanomalier
7.2	9.7	12.4	Symptomer og abnorme fund ikke klassificeret andetsteds
9.9	15.9	12.7	Læsioner, forgiftninger og visse andre følger af ydre påvirkninger
16.4	7.4	4.4	Faktorer af betydning for sundhedstilstand og kontakter med sundhedsvæsen
108.8	140.0	113.1	I alt

* Omfatter somatiske afdelinger ved almindelige sygehuse og ved somatiske specialsygehuse

1 Ekslusiv psykiatriske hospitalsafdelinger og ikke-specialiserede afdelinger på sundhedscentraler.
2 Eksklusiv patienter med liggetid over 90 dage.
3 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode.

Kilder: Landspatientregistrene

Table 3.22 Discharges and average length of stay in hospitals*. Malignant neoplasm of the breast, women 2002
Udskrivninger og gennemsnitlig liggetid ved sygehuse*. Kræft i bryst, kvinder 2002

	Denmark	Faroe Islands[1)]	Finland	Åland[1)]	Iceland	Norway	Sweden
Discharges Udskrivninger							
Total I alt	8 562	133	10 813	45	340	6 899	11 689
Per 100 000 women in the age group Pr. 100 000 kvinder i alder- men							
25-44	128	148	213	53	69	109	88
45-64	632	1 654	881	792	601	689	523
65+	683	976	628	614	712	624	532
Total rate Samlet rate	315	602	407	340	237	300	259
Average length of stay Gennemsnitlig liggetid	5.6	3.4	3.7	7.1	5.8	6.4	4.9

1 Average 1998-2002.

1 Gennemsnit for årene 1998-2002.

The table includes ICD-9: 174-175 and ICD-10: C50.
Tabellen omfatter ICD-9: 174-175 og ICD-10: C50.

*Source: * Definition, see Table 3.19*
Kilde: * Definition, se tabel 3.19

Table 3.23 Discharges and average length of stay in hospitals*. Malignant neoplasm of the larynx, trachea, bronchus and lung 2002
Udskrivninger og gennemsnitlig liggetid ved sygehuse*.
Kræft i strubehoved, luftrør, bronkie og lunge 2002

	Denmark	Faroe Islands[1)]	Finland	Åland[1)]	Iceland	Norway	Sweden
Discharges Udskrivninger							
Men Mænd							
Total I alt	5 897	39	5 116	32	152	4 202	5 083
Per 100 000 men in the age group							
Pr. 100 000 mænd i alderen							
0-24	1	0	-	-	0	-	1
25-44	20	6	12	-	9	14	6
45-64	337	335	285	355	162	259	149
65+	997	724	971	1 146	650	955	501
Total rate							
Samlet rate	222	163	201	256	106	186	115
Women Kvinder							
Total I alt	4 385	30	1 865	12	135	2 346	3 745
Per 100 000 women in the age group							
Pr. 100 000 kvinder i alderen							
0-24	0	0	1	-	0	-	1
25-44	18	63	8	-	14	8	10
45-64	278	293	122	148	157	176	133
65+	498	360	193	291	446	341	238
Total rate							
Samlet rate	161	136	70	93	94	144	83
Average length of stay							
Gennemsnitlig liggetid	7.3	5.3	6.0	10.6	10.1	10.3	9.9

1 Average 1998-2002.

1 Gennemsnit for årene 1998-2002.

The table includes ICD-9: 161-162 and ICD-10: C32-C34.
Tabellen omfatter ICD-9: 161-162 og ICD-10: C32-C34.

*Source: * Definition, see Table 3.19*
Kilde: * Definition, se table 3.19

Table 3.24 Discharges and average length of stay in hospitals*. Acute myocardial infarction 2002
Udskrivninger og gennemsnitlig liggetid ved sygehuse*. Akut hjerteinfarkt 2002

		Denmark	Faroe Islands[1)]	Finland	Åland[1)]	Iceland	Norway	Sweden
Discharges	Udskrivninger							
Men	Mænd							
Total	I alt	10 215	70	8 327	46	353	9 852	20 916
Per 100 000 men in the age group								
Pr. 100 000 mænd i alderen								
0-44		33	21	17	26	13	35	19
45-64		552	438	380	435	467	629	491
65+		1 722	1 536	1 732	1 638	1 300	2 084	2 253
Total rate								
Samlet rate		384	293	328	363	245	437	473
Women	Kvinder							
Total	I alt	5 645	35	6 445	31	179	5 753	13 742
Per 100 000 women in the age group								
Pr. 100 000 kvinder i alderen								
0-44		10	1	3	4	5	6	5
45-64		154	134	97	53	114	165	150
65+		956	830	1 178	1 172	761	1 218	1 354
Total rate								
Samlet rate		208	159	242	237	125	251	305
Average length of stay								
Gennemsnitlig liggetid		5.7	7.9	7.3	7.7	6.7	6.7	6.1

1 Average 1998-2002.

1 Gennemsnit for årene 1998-2002.

The table includes ICD-9: 410 and ICD-10: I21-I22.
Tabellen omfatter ICD-9: 410 og ICD-10: I21-I22.

*Source: * Definition, see Table 3.19*
Kilde: * Definition, se tabel 3.19

Table 3.25 Discharges and average length of stay in hospitals*. Cerebrovascular diseases 2002
Udskrivninger og gennemsnitlig liggetid ved sygehuse*. Karsygdomme i hjerne 2002

		Denmark	Faroe Islands[1)]	Finland	Åland[1)]	Iceland	Norway	Sweden
Discharges	Udskrivninger							
Men	Mænd							
Total	I alt	11 792	109	10 016	46	342	7 306	21 039
Per 100 000 men in the age group								
Pr. 100 000 mænd i alderen								
0-44		37	24	44	38	14	29	25
45-64		508	558	513	378	256	327	413
65-79		1 935	2 450	1 707	1 410	1 290	1 404	1 878
80+		3 467	3 631	2 514	2 810	2 991	3 043	3 876
Total rate								
Samlet rate		444	458	394	366	238	324	476
Women	Kvinder							
Total	I alt	11 589	77	9 388	50	232	7 518	20 338
Per 100 000 women in the age group								
Pr. 100 000 kvinder i alderen								
0-44		38	24	36	33	10	32	26
45-64		339	281	304	390	150	245	273
65-79		1 353	1 170	1 098	1 029	662	946	1 230
80+		2 995	3 240	2 110	2 090	1 776	2 444	3 145
Total rate								
Samlet rate		427	350	353	383	161	327	451
Average length of stay								
Gennemsnitlig liggetid		11.9	27.2	10.7	13.7	13.9	9.4	12.0

1 Average 1998-2002.

1 Gennemsnit for årene 1998-2002.

The table includes ICD-9: 430-434. 436-438 and ICD-10: I60-I69.
Tabellen omfatter ICD-9: 430-434 og ICD-10: I60-I69.

*Source: * Definition, see Table 3.19*
Kilde: * Definition, se tabel 3.19

Table 3.26 Discharges and average length of stay in hospitals*. Asthma, bronchitis, emphysema and other chronic obstructive pulmonary disease 2002
Udskrivninger og gennemsnitlig liggetid ved sygehuse*.
Astma, bronkit, emfysem og anden obstruktiv lungesygdom 2002

		Denmark	Faroe Islands[1)]	Finland	Åland[1)]	Iceland	Norway	Sweden
Discharges	Udskrivninger							
Total	I alt	28 636	189	15 270	111	794	11 898	23 396
Per 100 000 in the age group								
Pr. 100 000 i alderen								
0-4		1 043	1 794	247	1 160	559	572	562
5-14		187	350	43	351	115	103	33
15-24		61	68	38	63	52	45	18
25-64		243	171	80	133	113	126	100
65-74		1 914	858	447	826	969	809	802
75+		2 192	1 043	617	2 080	1 721	1 648	1 208
Total rate								
Samlet rate		533	411	147	431	276	261	262
Average length of stay								
Gennemsnitlig liggetid		5.4	6.2	5.3	6.1	8.2	..	5.6

1 Average 1998-2002.

1 Gennemsnit for årene 1998-2002.

The table includes ICD-9: 490-493. 496 and ICD-10: J40-J46. *Source: * Definition, see Table 3.19*
Tabellen omfatter ICD-9: 490-493. 496 og ICD-10: J40-J46. Kilde: * Definition, se tabel 3.19

Table 3.27 Discharges and average length of stay in hospitals*. Cervical and other intervertebral disc disorders 2002
Udskrivninger og gennemsnitlig liggetid ved sygehuse*.
Diskusprolaps i halsens ryghvirvler og andre ryghvirvler 2002

		Denmark	Faroe Islands[1)]	Finland	Åland[1)]	Iceland	Norway	Sweden
Discharges	Udskrivninger							
Total	I alt	6 346	76	7 003	40	415	5 789	3 419
Per 100 000 in the age group								
Pr. 100 000 i alderen								
0-24		7	12	17	24	13	15	4
25-44		179	240	202	221	252	197	67
45-64		190	306	223	253	273	226	58
65+		95	213	90	123	66	71	23
Total rate								
Samlet rate		118	166	135	155	144	127	38
Average length of stay								
Gennemsnitlig liggetid		6.5	9.0	4.3	6.4	2.3	5.0	5.7

1 Average 1998-2002.

1 Gennemsnit for årene 1998-2002.

The table includes ICD-9: 722 and ICD-10: M50-M51. *Source: * Definition, see Table 3.19*
Tabellen omfatter ICD-9: 722 og ICD-10: M50-M51. Kilde: * Definition, se tabel 3.19

Table 3.28 Discharges and average length of stay in hospitals*. Osteoporosis and osteomalacia, women 2002
Udskrivninger og gennemsnitlig liggetid ved sygehuse*. Osteoporose og osteomalaci, kvinder 2002

		Denmark	Faroe Islands[1)]	Finland	Åland[1)]	Iceland	Norway	Sweden
Discharges	Udskrivninger							
Women	Kvinder							
Total	I alt	1 225	9	382	9	82	903	1 427
Per 100 000 women in the age group								
Pr. 100 000 kvinder i alderen								
0-44		1	9	1	-	0	1	1
45-64		13	13	6	12	13	7	7
65-74		111	94	28	186	104	75	49
75-79		275	418	70	372	442	209	162
80+		420	245	131	511	1 029	395	278
Total rate								
Samlet rate		45	41	14	61	57	39	32
Average length of stay								
Gennemsnitlig liggetid		10.5	10.8	12.3	7.6	16.3	7.6	10.1

1 Average 1998-2002.

1 Gennemsnit for årene 1998-2002.

The table includes ICD-9: 268.2. 733.0-733.1 and ICD-10: M80-M83.
Tabellen omfatter ICD-9: 268.2. 733.0-733.1 og ICD-10: M80-M83.

*Source: * Definition, see Table 3.19*
Kilde: * Definition, se tabel 3.19

Table 3.29 Discharges and average length of stay in hospitals*. Fracture of the neck of the femur 2002
Udskrivninger og gennemsnitlig liggetid ved sygehuse*. Brud af lår 2002

		Denmark	Faroe Islands[1)]	Finland	Åland[1)]	Iceland	Norway	Sweden
Discharges	Udskrivninger							
Men	Mænd							
Total	I alt	3 291	27	2 436	10	88	2 632	6 173
Per 100 000 men in the age group								
Pr. 100 000 mænd i alderen								
0-44		10	18	13	3	5	8	7
45-64		75	91	69	23	32	60	55
65-74		313	347	264	201	240	259	272
75-79		819	765	656	513	355	741	712
80+		1 981	1 536	1 605	1 308	1 277	1 931	2 043
Total rate								
Samlet rate		124	112	96	80	61	117	140
Women	Kvinder							
Total	I alt	8 180	57	6 041	31	257	6 932	14 661
Per 100 000 women in the age group								
Pr. 100 000 kvinder i alderen								
0-44		3	3	6	11	3	5	3
45-64		81	88	51	30	77	70	55
65-74		524	683	347	186	385	471	450
75-79		1 405	1 908	982	743	806	1 347	1 229
80+		3 510	2 629	2 754	2 694	3 290	3 330	3 294
Total rate								
Samlet rate		301	256	227	237	179	302	325
Average length of stay								
Gennemsnitlig liggetid		12.1	15.9	9.3	13.1	11.8	10.4	11.5

1 Average 1998-2002.

1 Gennemsnit for årene 1998-2002.

The table includes ICD-9: 820 and ICD-10: S72.0-S72.2.
Tabellen omfatter ICD-9: 820 og ICD-10: S72.0-S72.2.

*Source: * Definition, see Table 3.19*
Kilde: * Definition, se tabel 3.19

Table 3.30 Discharges and average length of stay in hospitals*. Alcoholic liver disease 2002
Udskrivninger og gennemsnitlig liggetid ved sygehuse*. Alkoholisk leversygdom 2002

		Denmark	Faroe Islands[1)]	Finland	Åland[1)]	Iceland	Norway	Sweden
Discharges	Udskrivninger							
Men	Mænd							
Total	I alt	1 684	6	1 341	6	15	573	1 564
Per 100 000 men in the age group								
Pr. 100 000 mænd i alderen								
0-44		16	1	12	3	7	6	4
45-64		160	88	132	132	23	69	82
65+		89	43	72	69	7	39	79
Total rate							25	35
Samlet rate		63	26	53	47	10		
Women	Kvinder							
Total	I alt	800	1	630	2	-	309	740
Per 100 000 women in the age group								
Pr. 100 000 kvinder i alderen								
0-44		8	0	7	6	-	2	3
45-64		74	17	52	35	-	35	35
65+		34	12	32	32	-	24	31
Total rate								
Samlet rate		29	5	24	18	-	13	16
Average length of stay								
Gennemsnitlig liggetid		8.5	7.1	8.4	15.3	5.1	8.7	8.3

1 Average 1998-2002.

1 Gennemsnit for årene 1998-2002.

The table includes ICD-10: K70; K74 except K74.3, K74.4, K74.5.
Tabellen omfatter ICD-10: K70; K74 undtagen K74.3, K74.4, K74.5.

*Source: * Definition, see Table 3.19*
Kilde: * Definition, se tabel 3.19

Table 3.31 Discharges and average length of stay in hospitals*. Non-alcoholic liver disease 2002
Udskrivninger og gennemsnitlig liggetid ved sygehuse*. Ikke-alkoholisk leversygdom 2002

		Denmark	Faroe Islands[1)]	Finland	Åland[1)]	Iceland	Norway	Sweden
Discharges	Udskrivninger							
Men	Mænd							
Total	I alt	840	7	631	1	9	403	821
Per 100 000 men in the age group								
Pr. 100 000 mænd i alderen								
0-44		14	19	17	-	6	11	9
45-64		60	47	38	7	10	27	28
65+		55	36	34	29	0	33	40
Total rate							18	19
Samlet rate		32	28	25	6	6		
Women	Kvinder							
Total	I alt	882	10	858	2	33	519	993
Per 100 000 women in the age group								
Pr. 100 000 kvinder i alderen								
0-44		14	9	14	3	10	12	11
45-64		54	75	51	29	33	34	30
65+		61	163	50	20	71	45	44
Total rate								
Samlet rate		32	47	32	13	23	23	22
Average length of stay								
Gennemsnitlig liggetid		7.6	7.5	4.9	6.5	6.9	7.3	7.6

1 Average 1998-2002.

1 Gennemsnit for årene 1998-2002.

The table includes ICD-10: K71-K73; K75-K77 plus K74.3, K74.4, K74.5.
Tabellen omfatter ICD-10: K71-K73; K75-K77 plus K74.3, K74.4, K74.5.

*Source: * Definition, see Table 3.19*
Kilde: * Definition, se tabel 3.19

Table 3.32 Sixteen major surgical procedure groups, total numbers 2002
Seksten store operationsgrupper, i alt 2002

NCSP codes		*Denmark*	*Faroe Islands*	*Finland*	*of which Åland*[1)]	*Iceland*	*Norway*	*Sweden*
ABC 01-26	*Disc operations* Disk-operationer	2 423	13	3 690	16	360	3 028	2 086
BAA 20-60	*Partial and total thyroid excision* Resektion af thyreoidea	1 602	5	1 843	5	88	1 164	2 189
CJC, CJD, CJE, CJF00, CJF10	*Cataract surgery* Kataraktoperationer	24 211	118	37 430	48	1 629	21 535	76 000
FNA; FNB; FNC; FND; FNE	*Coronary anastomosis surgery* Coronaranstamoser	3 326	31	4 221	1	155	3 869	6 623
FNG 02; FNG 05	*Percutaneous expansion of the coronary artery (PTCA)* Perkutan coronar angioplastik (PTCA)	6 682	37	2 469	-	568	8 525	11 256[2)]
HAB	*Excision of mammary gland (women)* Resektion af mammae (kvinder)	4 520	16	3 882	18	90	2 670	6 704
HAC 10-25; HAC 99	*Mastectomy (women)* Ablatio mammae (kvinder)	2 973	9	2 145	10	100	1 736	3 374
JEA	*Appendectomy* Appendektomi	6 589	54	7 774	46	419	5 206	10 933[3)]
JKA 20-21	*Cholecystectomy* Kolecystektomi	6 931	45	8 719	44	477	4 142	12 357
KAS 10-20	*Kidney transplant* Nyretransplantation	167	1	163	1	0	210	309
KEC	*Radical prostatectomy* Radikal prostatektomi	218	0	622	2	22	207	1 188
KED 22-72	*Prostatectomy, transurethral procedures* Transurethral resektion af prostata	5 039	11	3 847	25	195	4 375	7 964
KED 00; KED 96	*Open prostatectomy* Åben prostatektomi	113	0	76	0	0	177	181
LCC 10-20; LCD; LCE; LEF 13	*Hysterectomy (including supravaginal hystrectomy and exenteration of pelvis)* Hysterektomi (inkl. supravaginal hysterektomi og bækkeneksentration)	6 925	27	10 859	41	450	5 080	9 707
MCA	*Caesarean section* Kejsersnit	11 881	126	9 024	49	648	8 453	15 243
NFB; NFC	*Hip replacement* Hofteledsplastik	9 835	90	9 817	45	400	8 493	17 277

The NCSP codes refer to NOMESCO Classification of Surgical Procedures. Version 1.5. NOMESCO 59:2001.

1 Average 1998-2002.
2 NCSP: FNG00-FNG06.
3 Incl. en passent operations.

1 Gennemsnit for årene 1998 til 2002.
2 NCSP: FNG00-FNG06.
3 Inkl. en passent-operationer.

Sources: D: National Board of Health; F & Å: STAKES; I: Directorate of Health; N: Norwegian Patient Register; S:
Kilder: National Board of Health and Welfare

Table 3.33 Sixteen major surgical procedure groups, per 100 000 inhabitants 2002
Seksten store operationsgrupper, pr. 100 000 indbyggere 2002

NCSP codes		*Denmark*	*Faroe Islands*	*Finland*	*of which Åland*[1)]	*Iceland*	*Norway*	*Sweden*
ABC 01-26	*Disc operations* Disk-operationer	45	27	71	62	125	67	23
BAA 20-60	*Partial and total thyroid excision* Resektion af thyreoidea	30	11	35	19	30	26	25
CJC, CJD, CJE, CJF00, CJF10	*Cataract surgery* Kataraktoperationer	451	249	720	185	566	473	852
FNA; FNB; FNC; FND; FNE	*Coronary anastomosis surgery* Coronaranstamoser	62	65	81	4	54	85	74
FNG 02; FNG 05	*Percutaneous expansion of the coronary artery (PTCA)* Perkutan coronar angioplastik (PTCA)	124	78	47	-	205	187	126[5)]
HAB	*Excision of mammary gland (women)*[2)] Resektion af mammae (kvinder)[2)]	166	70	146	138	63	116	149
HAC 10-25; HAC 99	*Mastectomy (women)*[2)] Ablatio mammae (kvinder)[2)]	109	39	81	77	70	76	75
JEA	*Appendectomy* Appendektomi	123	114	150	177	146	114	122[6)]
JKA 20-21	*Cholecystectomy* Kolecystektomi	129	95	168	169	166	91	138
KAS 10-20	*Kidney transplant* Nyretransplantation	3	2	3	4	0	5	3
KEC	*Radical prostatectomy*[3)] Radikal prostatektomi[3)]	8	0	24	15	15	9	27
KED 22-72	*Prostatectomy, transurethral procedures*[3)] Transurethral resektion af prostata[3)]	190	45	151	192	136	194	180
KED 00; KED 96	*Open prostatectomy*[3)] Åben prostatektomi[3)]	2	0	3	0	0	8	4
LCC 10-20; LCD; LCE; LEF 13	*Hysterectomy (including supravaginal hystrectomy and exenteration of pelvis)*[2)] Hysterektomi (inkl. supravaginal hysterektomi og bækkeneksentration)[2)]	255	118	408	315	313	221	215
MCA	*Caesarean section*[4)] Kejsersnit[4)]	185	178	163	188	160	152	159
NFB; NFC	*Hip replacement* Hofteledsplastik	183	190	189	173	139	187	194

The NCSP codes refer to NOMESCO Classification of Surgical Procedures. Version 1.5. NOMESCO 59:2001.

1 Average 1998-2002.
2 Per 100 000 women.
3 Per 100 000 men.
4 Per 1 000 live births.
5 NCSP: FNG00-FNG06.
6 Incl. en passent operations.

1 Gennemsnit for årene 1998-2002.
2 Pr. 100 000 kvinder.
3 Pr. 100 000 mænd.
4 Pr. 1 000 levendefødte.
5 NCSP: FNG00-FNG06.
6 Inkl. en passent-operationer.

Sources: D: National Board of Health; F & Å: STAKES; I: Directorate of Health; N: Norwegian Patient Register;
Kilder: S: National Board of Health and Welfare

Table 3.34 Surgical procedures in connection with cancer diagnoses, total and per 100 000 inhabitants 2002
Operationer i forbindelse med kræftdiagnoser, i alt og pr. 100 000 indbyggere 2002

NCSP codes		*Denmark*	*Faroe Islands*[1)]	*Finland*	*Åland*[2)]	*Iceland*	*Norway*	*Sweden*
	Total **I alt**							
HAB	*Excision of the mammary gland (women)* Resektion af mammae (kvinder) (ICD-9: 174; ICD-10: C50)	1 744	7	1 793	8	73	1 414	3 638
HAC 10-25; HAC 99	*Mastectomy (women)* Ablatio mammae (kvinder) (ICD-9: 174; ICD-10: C50)	2 497	11	1 974	9	89	1 541	3 103
KEC	*Radical prostatectomy* Radikal prostatektomi (ICD-9: 185; ICD-10: C61)	216	0	614	2	22	197	1 175
KED 22-72	*Prostatectomy, transurethral procedures* Transurethral resektion af prostata (ICD-9: 185; ICD-10: C61)	794	5	351	5	40	743	1 507
LCC 10-20; LCD; LCE; LEF 13	*Hysterectomy (including supravaginal hystrectomy and exenteration of pelvis)* Hysterektomi (inkl. supravaginal hysterektomi og bækkeneksentration) (ICD-9: 180-184; ICD-10: C51-58)	1 161	5	882	3	39	974	2 101
	Per 100 000 inhabitants **Pr. 100 000 indbyggere**							
	Partial excision of the mammary gland (women)[3)] Resektion af mammae (kvinder) [3)]	64	32	67	62	51	62	81
	Mastectomy (women) [3)] Ablatio mammae (kvinder) [3)]	92	50	74	69	62	67	69
	Radical prostatectomy[4)] Radikal prostatektomi[4)]	8	2	24	15	15	9	27
	Prostatectomy, transurethral procedures[4)] Transurethral resektion af prostata[4)]	30	23	14	38	28	33	34
	Hysterectomy (including supravaginal hystrectomy and exenteration of pelvis)[4)] Hysterektomi (inkl. supravaginal hysterektomi og bækkeneksentration)[4)]	43	23	33	23	27	42	47

The NCSP codes refer to NOMESCO Classification of Surgical Procedures. Version 1.5. NOMESCO 59:2001.

1 Average 19..-20...
2 Average 1998-2002.
3 Per 100 000 women.
4 Per 100 000 men.

1 Gennemsnit for årene 1996 til 2000.
2 Gennemsnit for årene 1998-2002.
3 Pr. 100 000 kvinder.
4 Pr. 100 000 mænd.

Sources: *See Table 3.32*
Kilder: Se tabel 3.32

Table 3.35 Fifteen surgical procedures partly carried out as day surgery in hospitals 2002

		Denmark			Finland		
	NCSP codes	Total number of procedures	Of which day surgery	Day surgery (per cent)	Total number of procedures	Of which day surgery	Day surgery (per cent)
Carpal tunnel decompression of median nerve Dekompression og lysis af medianus nerve	ACC51	3 637	2 685	73.8	5 901	5 238	88.8
Cataract surgery Kataraktoperation	CJC, CJD, CJE, CJF00, CJF10	24 211	21 920	90.5	37 615	34 592	92.0
Tonsillectomy and/or adenoidectomy Tonsillektomi og/eller adenoidektomi	EMB10, EMB20, EMB30	8 384	1 585	18.9	19 309	11 764	60.9
Wedge resection of mammary gland (women only) Segmentresektion af brystkirtel (kun kvinder)	HAB40	1 761	57	3.2	1 201	74	6.2
Inguinal and femoral hernia Brok-operationer	JAB, JAC	12 302	6 191	50.3	12 124	5 705	47.1
Haemorrhoidectomy Haemorrhoidectomia	JHB00	4 228	2 453	58.0	1 809	327	18.1
Cholecystectomy, laparoscopic Laparoskopisk cholecystektomi	JKA21	5 646	501	8.9	8 322	431	5.2
Transurethral resection of prostate (TURP) Transurethral resektion af prostata (TURP)	KED22	4 408	9	0.2	3 216	6	0.2
Curettage and excision of endometrium in uterus and cervix uteri Abrasio af endometrium i uterus og cervix uteri	LCA10-16, LCB28, LCB32, LDA10	9 757	6 692	68.6	6 117	4 085	66.8
Termination of pregnancy Abort-operationer	LCH	13 223	8 100	61.3	5 232	4 837	92.5
Female sterilization Sterilisation af kvinder	LGA	5 275	3 426	64.9	5 473	4 399	80.4
Removal of implanted devices from bone Fjernelse af osteosyntese	NAU, NBU, NCU, NDU, NEU, NFU, NGU, NHU	11 851	5 532	46.7	5 774	3 625	62.8
Knee arthroscopy Artroskopi af knæled	NGA11	8 725	5 875	67.3	4 655	3 439	73.9
Arthroscopic operations on meniscus of knee Artroskopisk meniskoperation på knæ	NGD01, NGD11, NGD21, NGD91	9 450	5 879	62.2	11 182	9 250	82.7
Vein ligation and stripping on leg Fjernelse af åreknuder på ben	PHB13-14, PHD	7 425	3 759	50.6	7 809	4 618	59.1

1 The figures are estimated based on a coverage of 80 per cent.

Source: See Table 3.32

Femten kirurgiske indgreb, der delvist gennemføres som dagkirurgi på sygehuse 2002 **Tabel 3.35**

Iceland			Norway			Sweden[1)]		
Total number of procedures	Of which day surgery	Day surgery (per cent)	Total number of procedures	Of which day surgery	Day surgery (per cent)	Total number of procedures	Of which day surgery	Day surgery (per cent)
33	..	..	5 253	4 820	91.8	11 489	11 053	96.2
1 629	..	..	21 535	19 023	88.3	76 000	62 577	82.2
689	..	..	12 582	5 395	42.9	12 681	5 516	43.5
79	..	..	1 455	608	41.8	4 833	1 278	26.5
171	..	..	7 914	4 655	58.8	17 328	12 294	70.9
19	..	..	2 142	1 073	50.1	2 041	1 096	53.7
468	..	..	3 565	461	12.9	9 836	1 638	16.7
195	..	..	3 990	8	0.2	6 800	85	1.3
201	..	..	5 714	3 737	65.4	16 786	13 159	78.4
817	..	..	13 074	12 626	96.6	17 172	15 781	91.9
149	..	..	1 761	866	49.2	4 102	3 408	83.1
149	..	..	7 976	3 040	38.1	12 464	7 664	61.5
14	..	..	4 706	3 366	71.5	7 515	6 791	90.4
35	..	..	12 133	10 291	84.8	11 299	10 581	93.6
150	..	..	7 627	6 020	78.9	6 966	6 122	87.9

1 Tallene er beregnet udfra en 80 procents dækningsgrad.

Kilde: Se tabel 3.32

Table 3.36 Disc operations by sex and age 2002
Disk-operationer fordelt på køn og alder 2002

	Denmark		*Faroe Islands*[1)]		*Finland*		*Iceland*		*Norway*		*Sweden*	
Age Alder	M	W	M	W	M	W	M	W	M	W	M	W
<10			-	-	-	-	-	-	-	-	1	-
10-19	7	8	-	-	26	29	1	-	13	19	9	21
20-29	120	99	1	0	200	154	30	19	144	102	107	73
30-39	362	274	2	2	644	368	53	36	509	341	330	235
40-49	407	299	3	2	658	424	67	50	497	447	317	274
50-59	268	241	2	1	448	316	30	37	348	288	236	189
60-69	123	105	2	0	175	122	11	15	138	80	102	79
70-79	36	55	0	0	65	67	8	1	43	47	52	36
80-84	7	6	-	-	1	7	2	-	5	5	8	9
85+	2	4	-	-	2	1	-	-	1	1	5	3
Total I alt	1 332	1 091	10	7	2 219	1 488	202	158	1 698	1 330	1 167	919
Per 100 000 in the age group Pr. 100 000 i alderen												
<10	-	-	-	-	-	-	-	-	-	-	0	-
10-19	2	3	-	-	8	9	5	-	4	7	2	4
20-29	35	29	38	8	61	49	136	88	49	36	19	14
30-39	87	68	64	72	180	107	253	173	143	100	51	38
40-49	107	81	88	82	168	111	322	248	154	143	53	48
50-59	70	64	69	49	117	83	190	243	117	100	37	31
60-69	50	41	84	23	74	47	116	151	78	43	24	18
70-79	23	28	31	25	43	29	108	12	32	27	17	9
80-84	16	8	-	-	3	10	103	-	12	7	8	6
85+	7	6	-	-	10	2	-	-	4	2	8	2
Total I alt	50	40	43	31	87	56	140	110	75	58	26	20

1 Average 1998-2002.

1 Gennemsnit for årene 1998 til 2002.

NCSP codes covered: ABC 01-26.

Sources: See Table 3.32
Kilder: Se tabel 3.32

Table 3.37 Partial and total thyroid excision by sex and age 2002
Resektion af thyreoidea, fordelt på køn og alder 2002

	Denmark		*Finland*		*Iceland*		*Norway*		*Sweden*	
Age Alder	M	W	M	W	M	W	M	W	M	W
<15	3	4	-	6	-	-	-	5	5	12
15-24	9	49	14	65	-	6	8	29	25	110
25-44	75	521	61	394	6	30	44	337	100	622
45-54	88	356	79	454	3	17	52	253	83	400
55-64	66	226	69	355	2	3	41	178	97	303
65-74	37	97	46	200	6	9	28	106	54	185
75-84	12	52	20	81	-	6	19	54	30	135
85+	1	6	1	4	-	-	2	8	4	24
Total I alt	291	1 311	290	1 559	17	71	194	970	398	1791
Per 100 000 in the age group Pr. 100 000 i alderen										
<15	1	1	-	1	-	-	-	1	1	2
15-24	3	17	4	20	-	28	3	11	5	22
25-44	9	67	9	58	14	72	7	52	8	52
45-54	24	97	19	113	16	94	17	84	14	67
55-64	20	68	23	113	17	25	17	73	18	55
65-74	19	44	24	82	68	94	19	62	16	47
75-84	11	31	21	45	-	92	18	34	12	39
85+	4	9	5	7	-	-	8	13	6	17
Total I alt	11	48	11	59	12	49	9	42	9	40

NCSP codes covered: BAA 20-60.

Sources: *See Table 3.32*
Kilder: Se tabel 3.32

Table 3.38 Cataract surgery by sex and age 2002
Kataraktoperationer, efter køn og alder 2002

	Denmark		*Faroe Islands*[1)]		*Finland*		*Iceland*		*Norway*		*Sweden*	
Age Alder	M	W	M	W	M	W	M	W	M	W	M	W
<50	463	387	4	2	492	494	..	..	342	294	678	689
50-54	277	306	2	2	474	451	..	..	149	147	641	741
55-64	1 152	1 384	7	6	1 557	2 195	..	..	651	748	3 199	3 760
65-74	2 333	4 041	17	18	3 405	7 319	..	..	1 565	2 690	6 479	11 699
75-84	3 257	7 165	18	34	4 701	12 372	..	..	3 549	7 138	12 638	25 742
85+	964	2 482	6	7	1 130	3 082	..	..	1 204	3 058	4 241	9 620
Total I alt	7 983	15 378	55	68	11 759	25 913	..	..	7 460	14 075	27 876	52 251
Per 100 000 in the age group Pr. 100 000 i alderen												
<50	26	22	25	12	29	30	..	..	22	19	23	25
50-54	149	167	154	165	225	218	..	..	98	101	206	243
55-64	346	414	299	278	515	700	..	..	267	309	579	688
65-74	1 194	1 820	1 079	1 061	1 741	3 004	..	..	1 040	1 570	1 866	2 980
75-84	2 910	4 247	1 933	2 588	4 994	6 898	..	..	3 380	4 534	5 221	7 522
85+	3 369	3 530	2 583	1 562	5 880	5 045	..	..	4 650	4 819	6 546	6 680
Total I alt	300	565	230	308	463	974	..	..	331	613	631	1 159

1 Average 1998-2002.

1 Gennemsnit for årene 1998 til 2002.

NCSP codes covered: CJC, CJD, CJE, CJF00, CJF10

Sources: See Table 3.32
Kilder: Se tabel 3.32

Table 3.39 Coronary anastomosis surgery by sex and age 2002
Coronaranstamoser efter køn og alder 2002

	Denmark		*Faroe Islands*[1)]		*Finland*		*Iceland*		*Norway*		*Sweden*	
Age Alder	M	W	M	W	M	W	M	W	M	W	M	W
<45	46	18	0	-	63	16	1	1	57	19	83	20
45-54	300	62	2	0	447	74	8	2	347	37	540	124
55-64	814	159	9	2	979	197	28	1	907	158	1 452	304
65-74	988	308	8	2	1 203	447	57	20	1 018	339	1 857	602
75-84	423	193	2	0	463	320	26	9	617	335	1 100	508
85+	9	6	-	-	6	7	2	-	21	14	23	10
Total I alt	2 580	746	21	4	3 161	1 061	122	33	2 967	902	5 055	1 568
Per 100 000 in the age group Pr. 100 000 i alderen												
<45	3	1	1	-	4	1	1	1	4	1	3	1
45-54	81	17	51	12	109	18	43	11	112	12	89	21
55-64	244	48	392	91	324	63	232	8	371	65	263	56
65-74	506	139	508	97	615	183	650	208	677	198	535	153
75-84	621	205	236	34	492	178	515	138	588	213	454	148
85+	12	4	-	-	31	11	159	-	81	22	36	7
Total I alt	97	28	90	19	124	40	85	23	132	39	114	35

1 Average 1998-2002.

1 Gennemsnit for årene 1998 til 2002.

NCSP codes covered: FNA; FNB; FNC; FND; FNE.

Sources: See Table 3.32
Kilder: Se tabel 3.32

Table 3.40 Percutaneous expansion of the coronary artery (PTCA) by sex and age 2002
Perkutan coronar angiplastik (PTCA) efter køn og alder 2002

	Denmark		*Faroe Islands*[1)]		*Finland*		*Norway*		*Sweden*[2)]	
Age Alder	M	W	M	W	M	W	M	W	M	W
<45	326	87	4	-	88	19	392	74	354	74
45-54	966	245	9	2	397	94	1 388	265	1 324	319
55-64	1 634	459	11	5	578	164	2 128	551	2 731	764
65-74	1 243	643	12	4	479	264	1 631	669	2 334	1 122
75-84	623	362	3	3	180	183	870	458	1 247	847
85+	47	47	-	-	11	11	60	39	73	67
Total I alt	4 839	1 843	37	7	1 733	736	6 469	2 056	8 063	3 193
Per 100 000 in the age group Pr. 100 000 i alderen										
<45	20	6	26	-	6	1	28	5	14	3
45-54	259	67	271	72	97	23	446	88	218	54
55-64	490	137	448	223	191	52	871	227	494	140
65-74	636	290	713	206	245	108	1 084	390	672	286
75-84	915	384	268	231	191	102	829	291	515	247
85+	65	33	-	-	57	18	232	61	113	47
Total I alt	182	68	156	32	68	28	287	90	183	71

1 Average 1998-2002.
2 NCSP: F00-F06.

1 Gennemsnit for årene 1998 til 2002.
2 NCSP: F00-F06.

NCSP codes covered: FNG 02; FNG 05.

Sources: See Table 3.32
Kilder: Se tabel 3.32

Table 3.41 Excision of mammary gland by age, women 2002
Resektion af mammae, kvinder, fordelt på alder 2002

Age Alder	*Denmark*	*Faroe Islands*[1)]	*Finland*	*Iceland*	*Norway*	*Sweden*
<20	67	-	42	2	22	112
20-29	218	2	176	-	64	231
30-39	550	2	319	3	196	468
40-49	1 081	3	813	12	531	1 211
50-59	1 177	2	1 281	25	929	2 013
60-69	761	3	801	19	644	1 502
70-79	342	3	336	19	193	844
80-84	89	1	73	8	56	202
85+	62	0	16	2	35	121
Total I alt	4 347	15	3 882	90	2 670	6 704
Per 100 000 in the age group Pr. 100 000 i alderen						
<20	11	-	7	5	4	11
20-29	65	65	56	-	22	43
30-39	137	59	92	14	57	75
40-49	292	116	213	59	170	210
50-59	313	73	337	164	323	326
60-69	293	150	305	192	347	348
70-79	173	173	148	221	113	222
80-84	119	113	69	298	77	129
85+	88	89	34	88	55	84
Total I alt	160	68	146	63	116	149

1 Average 1998-2002.

1 Gennemsnit for årene 1998 til 2002.

NCSP codes covered: HAB.

Sources: *See Table 3.32*
Kilder: Se tabel 3.32

Table 3.42 Mastectomy, women, by age 2002
Ablatio mammae, kvinder, fordelt på alder 2002

Age Alder	*Denmark*	*Faroe Islands*[1)]	*Finland*	*Iceland*	*Norway*	*Sweden*
<20	1	-	-	1	1	1
20-29	9	-	5	-	3	16
30-39	128	1	74	6	75	147
40-49	360	2	359	16	257	437
50-59	671	2	520	24	473	811
60-69	666	3	491	27	370	708
70-79	573	3	430	17	291	673
80-84	207	1	150	7	149	363
85+	120	0	116	2	117	218
Total I alt	2 735	12	2 145	100	1 736	3 374
Per 100 000 in the age group Pr. 100 000 i alderen						
<20	0	-	-	2	0	0
20-29	3	-	2	-	1	3
30-39	32	33	21	29	22	24
40-49	97	62	94	79	82	76
50-59	179	73	137	158	165	131
60-69	257	184	187	272	199	164
70-79	289	185	189	197	170	177
80-84	278	150	123	261	205	232
85+	171	45	190	88	184	151
Total I alt	101	53	81	70	76	75

1 Average 1998-2002.

1 Gennemsnit for årene 1998 til 2002.

NCSP codes covered: HAC 10-25; HAC 99.

Sources: *See Table 3.32*
Kilder: Se tabel 3.32

Table 3.43 Appendectomy by sex and age 2002
Appendektomi fordelt på køn og alder 2002

	Denmark		*Faroe Islands*[1)]		*Finland*		*Iceland*		*Norway*		*Sweden*	
Age Alder	M	W	M	W	M	W	M	W	M	W	M	W
<10	337	307	3	4	237	218	20	20	207	171	499	390
10-19	815	757	9	8	874	862	86	72	628	533	1614	1294
20-29	560	550	5	3	731	868	45	33	565	510	1132	988
30-39	477	483	2	2	654	628	37	22	450	399	900	719
40-49	272	429	3	3	465	508	20	22	303	335	572	514
50-59	244	420	2	2	412	443	11	11	200	277	474	550
60-69	180	258	2	1	245	247	2	6	127	153	327	294
70-79	109	227	0	1	160	158	9	1	113	127	231	227
80-84	40	62	0	-	27	41	-	1	24	44	64	66
85+	26	36	-	0	14	28	1	-	17	23	26	52
Total I alt	3 060	3 529	27	22	3 819	4 001	231	188	2 634	2 572	5 839	5 094
Per 100 000 in the age group Pr. 100 000 i alderen												
<10	96	92	72	103	77	74	91	94	67	58	97	80
10-19	261	256	241	230	262	270	389	340	210	189	275	233
20-29	163	163	171	122	222	277	204	153	193	178	204	184
30-39	115	121	58	65	182	182	176	106	127	117	138	115
40-49	72	116	94	89	119	133	96	109	94	107	96	89
50-59	64	112	69	73	108	117	70	72	67	96	75	89
60-69	73	100	116	35	104	94	21	61	72	82	78	68
70-79	70	115	15	37	105	69	122	12	84	74	76	60
80-84	91	83	112	-	85	57	-	37	56	60	63	42
85+	91	51	-	45	73	46	79	-	66	36	40	36
Total I alt	115	130	112	100	150	150	161	131	117	112	132	113

1 Average 1998-2002.

1 Gennemsnit for årene 1998 til 2002.

NCSP codes covered: JEA.

Sources: *See Table 3.32*
Kilder: Se tabel 3.32

Table 3.44 Cholesystectomy by sex and age 2002
Kolecystectomi fordelt på køn og alder 2002

	Denmark		*Faroe Islands*[1)]		*Finland*		*Iceland*		*Norway*		*Sweden*	
Age Alder	M	W	M	W	M	W	M	W	M	W	M	W
<30	90	802	0	5	79	501	10	48	61	522	177	1 101
30-39	284	1 201	0	7	234	952	10	67	144	585	492	1 628
40-49	331	925	2	4	388	1083	15	67	162	475	630	1 473
50-59	442	1 055	1	6	657	1 351	21	73	252	639	910	1 945
60-69	373	635	1	4	658	1 042	26	44	197	431	782	1 286
70-79	253	380	2	2	585	830	23	45	192	286	653	752
80-84	46	66	0	1	109	190	8	9	44	93	159	209
85+	17	31	0	-	37	74	3	8	22	37	67	93
Total I alt	1 836	5 095	8	28	2 747	6 023	116	361	1 074	3 068	3 870	8 487
Per 100 000 in the age group Pr. 100 000 i alderen												
<30	9	83	4	58	8	54	15	75	7	61	11	70
30-39	68	300	12	228	65	276	48	323	41	171	76	261
40-49	87	250	63	137	99	283	72	332	50	152	106	256
50-59	116	281	42	236	172	356	133	480	85	222	144	315
60-69	152	245	74	230	279	397	274	444	112	232	188	298
70-79	163	192	154	99	383	365	312	523	142	167	215	198
80-84	105	89	112	113	341	258	410	335	103	128	157	133
85+	59	44	92	-	193	121	238	352	85	58	103	65
Total I alt	69	188	34	128	108	226	81	251	48	134	88	188

1 Average 1998-2002.

1 Gennemsnit for årene 1998 til 2002.

NCSP codes covered: JKA 20-21.

Sources: *See Table 3.32*
Kilder: Se tabel 3.32

Table 3.45 Kidney transplant by sex and age 2002
Nyretransplantationer, fordelt på køn og alder 2002

	Denmark		*Finland*		*Norway*		*Sweden*	
Age Alder	M	W	M	W	M	W	M	W
<15	5	2	6	4	10	2	8	6
15-24	7	3	5	-	6	2	9	7
25-44	41	26	22	16	34	25	75	43
45-54	28	12	36	12	28	16	50	26
55-64	28	9	27	17	32	18	48	23
65-74	4	2	8	10	24	7	12	2
75-84	-	-	-	-	5	1	-	-
85+	-	-	-	-	-	-	-	-
Total I alt	113	54	104	59	139	71	202	107
Per 100 000 in the age group Pr. 100 000 i alderen								
<15	1	0	1	1	2	0	1	1
15-24	2	1	1	-	2	1	2	1
25-44	5	3	3	2	5	4	6	4
45-54	8	3	9	3	9	5	8	4
55-64	8	3	9	5	13	7	9	4
65-74	2	1	4	4	16	4	3	1
75-84	-	-	-	-	5	1	-	-
85+	-	-	-	-	-	-	-	-
Total I alt	4	2	4	2	6	3	5	2

NCSP codes covered: KAS 10-20.

Sources: *See Table 3.32*
Kilder: Se tabel 3.32

Table 3.46 Prostatectomy, transurethral procedures by age, men 2002
Transurethral resektion af prostata, mænd fordelt på alder 2002

Age Alder	*Denmark*	*Faroe Islands*	*Finland*	*Iceland*	*Norway*	*Sweden*
< 50	97	..	65	1	53	67
50-59	524	..	478	8	333	731
60-69	1 358	..	1 213	47	1 033	1 906
70-79	2 055	..	1 524	78	1 810	3 357
80-84	723	..	410	38	750	1 326
85+	282	..	181	23	396	577
Total I alt	5 039	..	3 871	195	4 375	7 964
Per 100 000 in the age group Pr. 100 000 i alderen						
< 50	5	..	4	1	3	2
50-59	138	..	125	51	112	116
60-69	552	..	515	495	586	457
70-79	1 322	..	997	1 057	1 342	1 104
80-84	1 649	..	1 284	1 950	1 749	1 309
85+	986	..	942	1 824	1 530	891
Total I alt	190	..	152	136	194	180

NCSP codes covered: KED 22-72.

Sources: *See Table 3.32*
Kilder: Se tabel 3.32

Table 3.47 Radical prostatectomy by age, men 2002
Radikal prostatektomi, mænd fordelt på alder 2002

Age Alder	*Denmark*	*Finland*	*Iceland*	*Norway*	*Sweden*
< 50	4	16	-	8	16
50-59	68	199	3	67	391
60-69	131	352	15	110	677
70-79	15	57	4	21	102
80-84	-	1	-	-	2
85+	-	-	-	1	-
Total I alt	218	625	22	207	1 188
Per 100 000 in the age group Pr. 100 000 i alderen					
< 50	0	1	-	1	1
50-59	18	52	19	22	62
60-69	53	150	158	62	162
70-79	10	37	54	16	34
80-84	-	3	-	-	2
85+	-	-	-	4	-
Total I alt	8	25	15	9	27

NCSP codes covered: KEC.

Sources: *See Table 3.32*
Kilder: Se tabel 3.32

Table 3.48 Open prostatectomy by age, men 2002
Åben prostatektomi, mænd fordelt på alder 2002

Age Alder	*Denmark*	*Finland*	*Iceland*	*Norway*	*Sweden*
< 50	1	1	-	2	3
50-59	9	10	-	11	12
60-69	30	31	-	46	44
70-79	56	22	-	86	96
80-84	14	7	-	19	22
85+	3	5	-	13	4
Total I alt	113	76	-	177	181
Per 100 000 in the age group Pr. 100 000 i alderen					
< 50	0	0	-	0	0
50-59	2	3	-	4	2
60-69	12	13	-	26	11
70-79	36	14	-	64	32
80-84	32	22	-	44	22
85+	11	26	-	50	6
Total I alt	4	3	-	8	4

NCSP codes covered: KED 00; KED 96.

Sources: *See Table 3.32*
Kilder: Se tabel 3.32

Table 3.49 Hysterectomy (including supravaginal hysterectomy and exenteration of pelvis) by age, women 2002
Hysterektomi (inkl. supravaginal hysterektomi og bækkeneksentration), kvinder fordelt på alder 2002

Age Alder	*Denmark*	*Faroe Islands*[1)]	*Finland*	*Iceland*	*Norway*	*Sweden*
< 30	51	0	43	4	38	48
30-39	852	3	792	50	454	809
40-49	2 781	15	4 125	207	1 959	3 169
50-59	1 782	6	3 270	112	1 339	2 668
60-69	778	1	1 424	45	633	1 451
70-79	523	3	965	25	450	1 090
80-84	118	0	210	4	148	326
85+	40	-	72	3	59	146
Total I alt	6 925	28	10 901	450	5 080	9 707
Per 100 000 in the age group Pr. 100 000 i alderen						
< 30	5	4	5	6	4	3
30-39	213	85	230	241	133	130
40-49	752	500	1 079	1 025	628	550
50-59	474	253	861	736	466	432
60-69	300	81	543	454	341	336
70-79	264	185	424	290	263	287
80-84	158	38	285	149	203	208
85+	57	-	118	132	93	101
Total I alt	255	128	410	313	221	215

1 Average 1998-2002. 1 Gennemsnit for årene 1998 til 2002.

NCSP codes covered: LCC 10-20; LCD; LCE; LEF 13.

Sources: *See Table 3.32*
Kilder: Se tabel 3.32

Table 3.50 Caesarean section, by age, women 2002
Kejsersnit, kvinder fordelt på alder 2002

Age Alder	*Denmark*	*Faroe Islands*[1)]	*Finland*	*Iceland*	*Norway*	*Sweden*
< 15	1	-	1	-	1	-
15-24	1 192	21	1 342	112	976	1 482
25-34	8 097	53	5 331	376	5 440	9 885
35-44	2 579	21	2 357	156	2 005	3 840
45+	12	-	40	4	31	33
Total I alt	11 881	94	9 071	648	8 453	15 240
Per 1 000 live births Pr. 1 000 levendefødte						
15-24	141	126	123	110	104	124
25-34	181	137	158	161	145	156
35-44	236	194	223	224	234	190
45+	261	-	342	571	608	210
Total I alt	185	143	163	160	152	159

1 Average 1998-2002.

1 Gennemsnit for årene 1998 til 2002.

NCSP codes covered: MCA.

Sources: *See Table 3.32*
Kilder: Se tabel 3.32

Table 3.51 Hip replacement by sex and age 2002
Hofteledplastik fordelt på køn og alder 2002

	Denmark		*Faroe Islands*[1)]		*Finland*		*Iceland*		*Norway*		*Sweden*	
Age Alder	M	W	M	W	M	W	M	W	M	W	M	W
<30	20	24	0	0	17	25	-	1	16	17	23	23
30-39	49	53	0	0	51	47	6	2	34	54	67	86
40-49	187	138	1	2	167	178	7	3	105	148	225	236
50-59	617	582	4	5	613	606	22	20	328	582	950	969
60-69	1 030	1 258	4	10	1 033	1 214	42	54	510	1 260	1 724	2 019
70-79	1 141	2 025	5	16	1 142	2 247	44	88	867	2 190	2 148	3 635
80-84	350	992	3	6	305	1 022	23	38	339	1 079	850	1 922
85+	317	1 052	2	6	225	987	10	40	185	779	583	1 817
Total I alt	3 711	6 124	20	45	3 553	6 326	154	246	2 384	6 109	6 570	10 707
Per 100 000 in the age group Pr. 100 000 i aldermen												
<30	2	3	2	4	2	3	-	2	2	2	1	1
30-39	12	13	6	7	14	14	29	10	10	16	10	14
40-49	49	37	44	75	43	47	34	15	33	47	38	41
50-59	162	155	152	196	160	160	140	131	110	203	151	157
60-69	419	485	232	564	439	463	442	545	290	678	414	467
70-79	734	1 022	369	1 013	747	988	596	1 022	643	1 281	707	957
80-84	799	1 331	899	1 050	955	1 388	1 180	1 416	791	1 482	839	1 226
85+	1 108	1 496	738	1 249	1 171	1 616	793	1 762	715	1 228	900	1 262
Total I alt	140	225	85	203	140	238	107	171	106	266	149	238

1 Average 1998-2002.

1 Gennemsnit for årene 1998 til 2002.

NCSP codes covered: NFB; NFC.

Sources: *See Table 3.32*
Kilder: Se tabel 3.32

Accidents and self-inflicted injury

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

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

Therefore, in this publication, statistics are presented for hospital discharges for the most common "serious" accidents that usually require admission. The statistics show marked differences, both between contries and for men and women.

Ulykker og villet egenskade

Patienter indlagt på grund af ulykker udnytter en væsentlig del af kapaciteten ved sygehusene.

Mens statistikken over dødsårsager er veludbygget i de nordiske lande, er registreringen af overlevende efter ulykker stadigvæk mangelfuld, og de tilgængelige data er vanskelige at sammenligne. Da kun Danmark og Island har sammenlignelig statistik for de ydre årsager ved ulykker er det ikke muligt at bringe nordisk statistik vedrørende dette.

I denne udgave er der derfor valgt at medtage statistik over udskrivninger for de mest almindelige "større" ulykker som oftest vil kræve indlæggelse. Her ser man markante forskelle, både mellem landene og mænd og kvinder.

Table 3.52 Patients discharged after treatment for injuries per 100 000 inhabitants by sex 2002[1)]
Udskrivninger fra sygehuse efter behandling for skader per 100 000 indbygger og efter køn 2002[1)]

	Denmark		*Faroe Islands*[2)]		*Finland*		*Åland*[2)]		*Norway*		*Sweden*	
	M	W	M	W	M	W	M	W	M	W	M	W
Fracture of skull and intracranial injury Kraniebrud og intrakraniel læsion ICD10: S02; S06	311	171	394	159	266	138	331	198	270	145	262	173
Fracture at wrist and hand level Brud i handled og hånd ICD10: S62	56	19	64	23	50	15	32	15	42	14	23	9
Superficial injury of lower leg Læsion af knæ og underben ICD10: S80-S89	288	218	482	262	514	371	442	328	218	177	155	152
Superficial injury of hip and thigh Læsion af hofte og lår ICD10: S70-S79	178	382	151	306	234	497	173	443	167	376	191	396
Poisoning Forgiftning ICD10: T36-T65	156	203	64	76	96	106	87	84	121	145	77	124
Burn and corrosion Forbrænding og ætsning ICD10: T20-T32	17	10	27	9	44	19	32	15	39	17	22	11

1 Including violence and self-inflicted injury.
2 Average 1998-2002.

1 Inklusiv vold og villet egenskade.
2 Gennemsnit for årene 1998-2002.

Table 3.53 Patients discharged after treatment for injuries, per 100 000 inhabitants, by sex and age 2002[1)]
Udskrivninger fra sygehuse efter behandling for skader, pr. 100 000 indbyggere efter køn og alder 2002[1)]

	Denmark		*Finland*		*Norway*		*Sweden*	
Age Alder	M	W	M	W	M	W	M	W
0-14	797	552	1 086	663	1 116	775	1 226	800
15-24	1 149	472	2 250	854	2 144	1 285	1 396	751
25-64	785	435	2 113	1 269	1 562	1 048	1 188	858
65+	1 374	2 613	4 560	5 996	3 102	4 743	3 980	5 346
Total I alt	903	830	2 237	1 976	1 734	1 654	1 634	1 711

1 Including violence and self-inflicted injury.

1 Inklusiv vold og villet egenskade.

Sources: The Inpatient Registers of the Nordic Countries
Kilde:

Development in consumption of medicinal products

Table 3.54 presents total sales of medicinal products in the Nordic countries, by ACT main group. Sales of medicinal products are highest in Sweden, then Finland and Norway, while Denmark and Iceland have slightly lower sales. Sales in the Faroe Islands are slightly lower than in Iceland, while sales in Greenland are substantially lower than in the other countries.

In 2004, NOMESCO has received special funding from the Nordic Council of Ministers to carry out a detailed study of the consumption and cost of medicinal products. The study is a follow-up study of the study on this topic that was presented in a previous theme section, and the results will be published as a separate publication. Thus, in this edition of Health Statistics in the Nordic Countries, only the table on total sales, mentioned above, is presented.

Udvikling i lægemiddelforbrug

I tabel 3.54 ses det samlede lægemiddelforbrug i de nordiske lande fordelt på ATC-hovedgrupper. Forbruget af lægemidler er højest i Sverige, dernæst kommer Finland og Norge, mens Danmark og Island har et lidt lavere forbrug. Åland er stort set på højde med Finland. Forbruget på Færøerne er lidt lavere end i Island, mens forbruget i Grønland er markant lavere end i de øvrige lande.

I 2004 har NOMESKO modtaget særskilte midler fra Nordisk Ministerråd for at foretage en dyberegående studie af lægemiddelforbruget og lægemiddeludgifterne. Studiet er en opfølgning på tidligere temasektion om samme emne og vil blive udgivet som selvstrændig publikation. Derfor er der i denne udgave af Helsestatistikken kun medtaget ovennævnte oversigtstabel.

Table 3.54 Sales of medicinal products in total, DDD/1 000 inhabitants/day by ATC-group, 2002
Salg af lægemidler i alt i DDD/1 000 indbyggere/døgn fordelt på ATC-grupper 2002

	Denmark	*Faroe Islands*	*Greenland*	*Finland*	*Åland*	*Iceland*	*Norway*	*Sweden*
A *Alimentary tract and metabolism* Fordøjelse og stofskifte	131	124	55	163	147	110	175	311
B *Blood and blood-forming organs* Blod og bloddannende organer	72	49	17	121	113	27	100	116
C *Cardiovascular system* Hjerte og kredsløb	287	366	103	348	295	278	333	337
G *Genito-urinary system and sex hormones* Kønshormoner m.m.	112	84	71	136	124	155	106	122
H *Systemic hormonal preparations, excl. sex hormones and insulins* Hormoner til systemisk brug	26	23	9	35	43	20	36	38
J *Anti-infectives for systemic use* Infektionssygdomme	16	18	32	23	23	21	18	18
L *Antineoplastic and immuno-modulating agents* Cancermidler m.m.	5	3	1	6	8	6	7	8
M *Musculo-skeletal system* Muskler, led og knogler	45	35	21	80	58	67	57	59
N *Nervous system* Nervesystemet	228	153	106	200	149	266	181	234
P *Antiparasitic products, insecticides and repellents* Parasitmidler	1	1	3	1	2	1	1	1
R *Respiratory system* Åndedrætsorganer	117	79	50	121	115	101	162	143
S *Sensory organs* Sanseorganer	8	6	13	13	13	10	17	15
Total I alt	1 049	941	481	1 249	1 090	1 062	1 193	1 402

Sources: D: Danish Medicines Agency; FI: Chief Pharmaceutical Officer; G: The Central Pharmacy in Copenhagen County; F & Å: National Agency for Medicines; I: Ministry of Health and Social Security; N: WHO Collaborating Centre for Drug Statistics Methodology; S: National Corporation of Swedish Pharmacies
Kilder:

Note: Sales of B05 and D are excluded from this table because of differences in the use of national DDDs. A11 is excluded because of differences in the definitions of medicinal and non-medicinal products.

CHAPTER IV

Mortality and causes of death
Dødelighed og dødsårsager

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

Den internationale sygdomsklassifikation (ICD), som udarbejdes af Verdenssundhedsorganisationen (WHO), har som sin vigtigste anvendelse at være instrument for statistiske beskrivelser af sygelighed og dødelighed. Det er et system som på meningsfuld måde grupperer sygdomme og dødsårsager, så der kan gives overskuelige statistiske opstillinger og analyser, som for eksempel sammenligninger mellem forskellige lande over en tidsperiode. ICD´s historie er over 100 år, og klassifikationen er blevet revideret ca. hvert tiende år for at den kan afspejle den medicinske udvikling. Den seneste, tiende revision (ICD-10) blev godkendt af WHO i 1990, men blev først taget i brug i de fleste lande adskillige år senere. I de nordiske lande blev ICD-10 taget i brug til dødsårsagsregistrering i 1994 i Danmark, i Finland, Island og Norge i 1996, og i Sverige i 1997.

Revisions of the classification make statistical comparisons of countries over time difficult, when different versions of ICD are used at the same time. It is therefore important to have an understanding of the possible sources of error that a change in classification introduces in the morbidity and mortality statistics, and how to handle these problems. The most recent revision has above all meant an increase in the level of detail in ICD. Many new diagno-

Revision af klassifikationen vanskeliggør statistiske sammenligninger over tid mellem lande, når de på samme tid anvender forskellige versioner af ICD. Det er derfor vigtigt at forsøge at forstå hvilke fejlkilder et klassifikationsskifte kan medføre for analysen af morbiditets- og mortalitetsstatistikken samt hvorledes problemet kan håndteres. Det seneste klassifikationsskifte har frem for alt medført en større detaljeringsgrad i ICD. Der er medtaget et stort

ses have been added as a result of developments in medicine. Also, certain diseases or groups of diseases have been transferred to other chapters in order to reflect new medical knowledge.

Statistical analyses are carried out on aggregated data, for example at the level of the chapter. There are 21 chapters in ICD-10. With the change to ICD-10 the number of chapters increased from 17 to 21 due to the splitting up of certain chapters. The basic structure of ICD has generally remained the same through the revisions and most chapters have the same name. However, it is important to realize that even if the name of a chapter is the same in ICD-10 as in ICD-9 differences in content may exist due to the transfer of diagnostic codes from one chapter to another. For example, HIV and AIDS were originally placed among diseases of the immune system in ICD-9 but were moved to the chapter for infectious diseases in ICD-10. Another example is the transfer of transitory ischemic attacks from the chapter for circulatory diseases in ICD-9 to the chapter for nervous system diseases in ICD-10. Certain symptoms have also been moved from the chapter for symptoms to so-called organ chapters.

Another potential source of error is that certain rules and guidelines for the use of ICD have been changed in connection with the new revision. With reference to mortality statistics, certain rules for the selection of underlying cause of death have been altered, which may, for example, affect the frequency of pneumonia as a cause of death. For morbidity statistics, new rules for dual coding of manifestation (asterisk code) and etiology (dagger code) may also have an effect on the statistics. Beside

antal nye diagnoser som følge af den medicinske udvikling. Samtidig er enkelte sygdomme og sygdomsgrupperinger flyttet til andre kapitler for at det bedre kan afspejle det medicinske vidensniveau.

Statistiske analyser foretages på et aggregeret niveau. Dette niveau kan være kapitelinddelingen i ICD-10, som i alt består af 21 kapitler. Ved overgangen fra ICD-9 til ICD-10 steg antallet af kapitler fra 17 til 21 ved at visse kapitler blev opdelt. Grundstrukturen i ICD er dog i det store og hele blevet bevaret uforandret igennem de forskellige revisioner og de fleste kapitler har beholdt det samme navn. Det er imidlertid vigtigt at indse, at selvom et kapitel hedder det samme i ICD-10 som i ICD-9, kan der findes forskelle ved at diagnoser er flyttet fra et kapitel til et andet. Et eksempel er HIV og AIDS som præliminært blev placeret blandt immunsygdommene i ICD-9 men blev placeret under infektionssygdomme i ICD-10. Et andet eksempel er flytningen af cerebral transitorisk iskjæmi fra cirkulationssystemets sygdomme i ICD-9 til nervesystemets sygdomme i ICD-10. Visse symptomer er også blevet flyttet mellem symptomkapitlet og de såkaldte organkapitler.

En anden fejlkilde er at visse regler og anvisninger for brugen af ICD er ændret i forbindelse med klassifikationsskiftet. Indenfor dødsårsagsstatistikken er for eksempel visse regler for valg af den underliggende dødsårsag blevet ændret, hvilket for eksempel kan påvirke frekvensen af pneumoni som dødsårsag. For sygdomsstatistikken kan de nye regler om dobbeltkodning af både manifestation (asterixkoder) og ætiologi (daggerkoder) ligeledes påvirke statistikken. Ved siden af de inter-

changes in the international rules, national rules for applying the classification may also be modified in connection with a classification change, which will affect both comparisons over time within a country and comparisons between countries.

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

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

nationale regelændringer kan de nationale tilpasninger ændres i forbindelse med et klassifikationsskifte, hvilket både påvirker sammenligningerne over tid i det samme land og sammenligninger mellem flere lande.

Det er ikke usædvanligt at tro, at en automatisk oversættelse af koderne i forskellige ICD versioner kan løse problemerne ved et klassifikationsskifte. Dette er imidlertid ikke en nemt fremkommelig vej. Kun for en tredjedel af koderne i ICD-9 og ICD-10 er der en direkte og entydig oversættelse mellem koderne. I stedet for bør man stræbe efter, at de aggregerede grupper man anvender til statistiske sammenligninger konstrueres så det er muligt at eliminere nogle af de problemer, klassifikationsændringerne har skabt. De såkaldte kortlister som anvendes i denne publikation for mortalitet og morbiditet er defineret både i relation til ICD-9 og ICD-10 ud fra tanken om sammenlignelighed.

Man må imidlertid altid være klar over at en observeret forskel over tid eller mellem lande kan være effekten af et klassifikationsskifte samt andre metodologiske problemstillinger. En måde hvorpå man kan kvantificere betydningen af et klassifikationsskifte er den såkaldte "bridge kodning." Dette indebærer at man koder samme materiale, så som dødsattester og sygehusjournaler, to gange, uafhængig af hinanden, først efter den tidligere klassifikation og derefter efter den nye. De forskelle som fremkommer når man sidenhen sammenligner de statistiske grupperinger baseret på de to kodninger, giver en opfattelse af hvor meget en vis sygdomsgruppe (eksempelvis ICD-kapitlet om cirkulationsorganernes sygdomme) stiger eller falder som en direkte følge af klassifikationsskiftet. Denne type

and only a few, limited bridge-coding studies have been carried out on the change from ICD-9 to ICD-10.

studier er dog ressourcekrævende og der er kun gennemført et fåtal begrænsede bridge-kodnings-studier i forbindelse med overgangen fra ICD-9 til ICD-10.

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

Et andet forhold af stor betydning for sammenligneligheden af dødsårsagerne mellem flere lande, er den kodningspraksis, der er etableret i de enkelte lande. Det som vises i statistikken er den underliggende dødsårsag, hvor WHO har udarbejdet retningslinier for valget af den underliggende dødsårsag, hvilket vil sige den sygdom eller skade som starter rækken af sygelige tilstande der leder direkte til døden, eller ydre omstændigheder ved en ulykke eller voldshandling som var årsag til den dødelige skade. Det problematiske for sammenligneligheden er, at i nogle tilfælde, hvor der er opført to eller flere dødsårsager på dødsattesten, bliver valget af den underliggende dødsårsag forskellig fra land til land, fordi reglerne giver mulighed for forskellig fortolkning.

In order to support the choice of the underlying cause of death, a number of automatic coding systems have been developed. The most widely used system is the American programme, ACME (Automated Classification of Medical Entities). This system is used in Sweden. The other Nordic countries use computer-aided coding. Automatic coding does not necessarily result in a more correct picture of the pattern of causes of death than does manual coding, but it does give more consistency in the coding and thus contributes to better comparability between more countries. However, several other factors also influence comparability, such as the type of information the statistics producer has access to and the quality of that material (death certificates, etc.).

For at støtte valget af den underliggende dødsårsag, er der udviklet flere automatiske kodningssystemer. Det mest anvendte er det amerikanske program ACME (Automated Classification of Medical Entities). Blandt de nordiske lande anvendes systemet af Sverige. I de andre nordiske lande anvender man edb-støttet kodning. Automatisk kodning giver ikke nødvendigvis et mere korrekt billede af dødsårsagsmønsteret end manuel kodning. Derimod vil automatisk kodning give en bedre stabilitet i kodningen og dermed bidrage til en bedre sammenlignelighed mellem flere lande. Men der er også flere andre forhold der påvirker sammenligneligheden, blandt andet hvilken type af information statistikproducenten har tilgang til, herunder kvaliteten på dette materiale (dødsattester og andre oplysninger).

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; R99). The use of these codes as underlying causes of death is more widespread in Denmark than in the other Nordic countries, in situations where more specific causes of death are also recorded on the death certificate.

Udover at ICD´s regler for mortalitetskodning giver plads for fortolkning kan der også være tale om udvikling af nationale traditioner for valget af den underliggende dødsårsag. Som eksempel kan nævnes brugen af diagnosegruppen "mangelfuldt definerede tilstande" (koderne I469, I959, I99; J960, J969; P285.0; R000-R948; R99). Anvendelsen af disse koder som underliggende dødsårsag er mere udbredt i Danmark end i de andre nordiske lande i situationer hvor der også er oplyst mere specifikke dødsårsager på dødsattesten.

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

Kulturelle forskelle i rapporteringen af bestemte tilstande kan også påvirke sammenligneligheden. Hvis læger i et land er langt mere tilbageholdende med at anvende for eksempel selvmord på dødsattesten, end læger i andre lande, kan det vanskeliggøre sammenligneligheden. I flere af de nordiske lande findes der imidlertid rutiner for at kontakte lægen eller sygehuset i de tilfælde hvor de ydre årsager til skaden er uklar. Sådanne kvalitetssikringsrutiner er med til at kompensere for de manglende informationer på dødsattesten.

Another factor influencing the quality of the statistics on causes of death is the decreasing autopsy rate. The autopsy rate has been more than halved in the Nordic countries over the last few decades. Studies have shown that in about 30 per cent of cases, the result of the autopsy has caused the underlying cause of death to be altered.

En yderligere faktor der spiller ind på dødsårsagsstatistikkens kvalitet er de faldende rater for obduktion. Anvendelsen af obduktion ved dødsfald er mere end halveret i de nordiske lande over de seneste årtier. Studier har vist, at i ca. 30 pct. af tilfældene med obduktion, har obduktionen medført at den underliggende dødsårsag er blevet ændret.

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

Det er klart, at med de forbehold der er taget her over for sammenligneligheden af dødsårsagerne over tid og mellem landene, må de præsenterede data fortolkes

caution. This is especially the case for small diagnostic groups in the European short list that is used in the present publication. The picture is more stable for the large groups, such as cardiovascular diseases and cancer.

Detailed data on causes of death according to the European short list are to be found on the NOMESCO homepage at www.nom-nos.dk.

med forsigtighed. Det vil især dreje sig om mindre diagnosegrupper i den europæiske forkortede liste, der anvendes i denne publikation. Når det drejer sig om de helt store grupper, hjerte-karsygdomme for sig og cancer for sig, tegner der sig dog et noget mere stabilt billede.

På NOMESKO's hjemmeside på www.nom-nos.dk findes der detaljerede data om dødsårsager opgjort efter den europæiske forkortede liste.

Table 4.1 Deaths by sex and age per 100 000 inhabitants 1995-2002
Døde efter køn og alder pr. 100 000 indbyggere 1995-2002

Age Alder	*Total* I alt		*Under 1 year*[1)] Under 1 år[1)]		*1-14 years* 1-14 år		*15-24 years* 15-24 år		*25-64 years* 25-64 år		*65+ years* 65+ år	
Sex Køn	M	W	M	W	M	W	M	W	M	W	M	W
Denmark												
1995	1 212	1 203	557	452	25	17	79	33	506	338	7 114	5 724
2000	1 069	1 099	607	456	17	12	79	30	444	294	6 368	5 455
2001	1 073	1 105	480	484	20	17	63	22	447	291	6 387	5 504
2002	1 066	1 115	485	397	16	13	71	27	452	286	6 274	5 600
Faroe Islands												
1995	960	704	608	312	40	-	61	37	428	181	6 107	3 873
2000	772	769	275	-	-	39	60	35	328	208	5 054	4 203
2001	795	752	576	312	19	-	41	-	357	196	5 013	4 255
2002	814	851	575	-	56	-	29	103	342	229	5 317	4 788
Greenland												
1995	942	795	1 805	3 610	111	100	493	240	814	430	9 746	8 188
2000	853	772	2 138	1 659	110	14	446	169	720	529	7 547	7 552
2001	893	766	2 174	3 007	83	14	436	332	792	566	7 547	6 383
2002	851	701	2 101	1 724	142	58	525	187	659	475	7 260	6 273
Finland												
1995	977	955	431	355	21	16	93	26	530	218	6 263	4 752
2000	952	954	424	324	14	14	96	34	504	222	5 545	4 606
2001	938	932	415	226	16	10	91	28	487	217	5 412	4 484
2002	944	955	305	289	16	11	88	30	481	215	5 399	4 579
Åland												
1995	929	1 125	649	1 242	88	-	64	-	415	196	5 012	5 299
2000	852	1 063	-	885	-	-	137	-	457	202	4 255	5 035
2001	925	845	694	-	-	-	68	-	298	172	5 367	3 989
2002	871	920	-	769	43	-	67	-	281	127	4 990	4 472
Iceland												
1995	733	705	717	488	38	47	85	29	298	203	5 493	4 702
2000	644	653	456	141	13	10	120	43	272	187	4 591	4 317
2001	647	563	239	301	16	13	111	28	240	161	4 817	3 690
2002	649	617	339	101	16	33	32	24	259	181	4 803	4 016
Norway												
1995	1 068	1 006	491	314	22	16	86	30	361	200	6 393	4 858
2000	974	985	427	329	18	15	93	33	339	201	6 052	4 965
2001	967	982	434	350	16	10	97	34	331	201	6 078	4 984
2002	961	995	325	347	20	17	81	32	331	199	6 099	5 129
Sweden												
1995	1 088	1 042	453	349	15	11	52	26	347	208	5 942	4 631
2000	1 041	1 065	337	251	15	12	59	24	305	200	5 829	4 854
2001	1 032	1 075	354	280	14	14	58	22	310	194	5 751	4 938

1 Per 100 000 live births.

1 Pr. 100 000 levendefødte.

Source: The national central statistical bureaus.
Kilde: De nationale centrale statistikbureauer.

Table 4.2 Death rates from malignant neoplasms per 100 000 by age 1996-2001
Dødeligheden af ondartede svulster pr. 100 000 efter alder 1996-2001

		Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
Men	Mænd								
Age	Alder								
0-14	1996-00	4	0	3	3	0	4	3	3
	2000	3	0	0	2	0	3	3	3
	2001	..	..	..	3	0	0	1	3
15-34	1996-00	9	6	9	7	6	8	7	7
	2000	9	0	11	6	32	7	7	8
	2001	..	..	..	6	64	7	6	6
35-44	1996-00	34	0	47	26	44	31	29	23
	2000	33	0	51	22	0	38	32	20
	2001	..	..	..	25	0	37	30	21
45-54	1996-00	148	39	136	107	170	100	120	97
	2000	145	32	230	105	196	102	127	91
	2001	..	..	..	101	50	110	106	83
55-64	1996-00	471	303	801	348	371	362	365	305
	2000	462	214	985	320	471	227	348	294
	2001	..	..	..	318	253	382	333	291
65-74	1996-00	1 216	903	1 525	953	1 001	970	1 007	861
	2000	1 189	312	1 525	902	204	900	953	826
	2001	..	..	..	846	1 309	1 232	953	828
75+	1996-00	2 405	2 258	3 942	2 062	2 081	2 216	2 215	1 947
	2000	2 440	1 043	3 113	1 947	1 830	1 888	2 142	1 935
	2001	..	..	..	2 059	2 417	1 770	2 242	1 959
Women	Kvinder								
Age	Alder								
0-14	1996-00	3	0	5	3	0	4	3	3
	2000	2	0	0	2	0	3	4	3
	2001	..	..	..	2	0	9	2	3
15-34	1996-00	9	11	12	6	6	9	7	7
	2000	9	0	13	7	0	2	6	9
	2001	..	..	..	6	0	10	8	7
35-44	1996-00	48	14	113	34	75	30	45	24
	2000	41	0	104	36	0	19	39	21
	2001	..	..	..	37	107	24	39	22
45-54	1996-00	175	113	312	108	184	124	141	99
	2000	164	36	109	106	340	113	126	94
	2001	..	..	..	111	147	166	125	85
55-64	1996-00	440	306	811	235	275	350	325	303
	2000	425	297	542	237	150	396	319	296
	2001	..	..	..	219	140	350	313	294
65-74	1996-00	895	698	1 355	511	531	727	605	743
	2000	905	589	1 427	505	557	775	600	719
	2001	..	..	..	492	369	581	608	726
75+	1996-00	1 433	997	2 302	1 071	1 198	1 348	1 149	1 211
	2000	1 460	685	2 600	1 077	1 362	1 285	1 184	1 210
	2001	..	..	..	1 050	1 136	1 134	1 200	1 230

ICD-9: 140-208 and ICD-10: C00-D09.

Source: The National Registers for Causes of Death
Kilde: De nationale dødsårsagsregistre

Table 4.3 Death rates from cardiovascular diseases per 100 000 by age 1996–2001
Dødeligheden af hjerte-karsygdomme pr. 100 000 efter alder 1996-2001

		Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
Men	Mænd								
Age	Alder								
0-34	1996-00	3	0	13	4	7	2	3	3
	2000	3	0	6	5	0	3	3	3
	2001	..	..	..	4	0	0	2	3
35-44	1996-00	22	6	50	50	11	23	27	25
	2000	23	0	51	44	0	38	25	21
	2001	..	..	..	42	55	9	24	20
45-54	1996-00	76	104	168	181	170	80	112	105
	2000	95	96	179	184	98	113	93	104
	2001	..	..	..	162	151	55	99	100
55-64	1996-00	274	367	491	529	445	329	343	341
	2000	326	299	473	481	538	209	282	303
	2001	..	..	..	437	126	261	285	298
65-74	1996-00	981	1 405	1 875	1 538	1 105	1 007	1 247	1 224
	2000	1 095	1 059	1 049	1 378	509	877	1 065	1 101
	2001	..	..	..	1 290	1 511	1 004	995	1 023
75+	1996-00	5 456	4 875	5 570	5 051	4 674	4 572	4 928	5 102
	2000	4 467	2 609	5 058	4 766	3 791	3 963	4 681	4 851
	2001	..	..	..	4 593	2 799	4 032	4 607	4 753
Women	Kvinder								
Age	Alder								
0-34	1996-00	2	9	8	2	0	1	2	2
	2000	2	18	7	3	0	1	2	1
	2001	..	..	..	1	0	0	2	1
35-44	1996-00	20	7	41	16	11	8	10	11
	2000	14	33	42	17	0	10	11	11
	2001	..	..	..	13	0	0	11	8
45-54	1996-00	68	23	91	42	31	28	33	34
	2000	41	0	109	48	0	24	36	34
	2001	..	..	..	33	0	11	31	36
55-64	1996-00	225	74	274	132	97	136	107	117
	2000	131	198	271	129	75	198	102	112
	2001	..	..	..	111	0	114	98	110
65-74	1996-00	770	309	1 412	624	402	427	525	522
	2000	561	118	1 427	551	464	419	471	469
	2001	..	..	..	506	462	478	410	467
75+	1996-00	3 348	3 700	5 965	4 196	3 944	3 752	3 954	4 157
	2000	3 722	2 284	8 038	4 090	3 584	3 421	3 794	4 059
	2001	..	..	..	3 981	3 125	2 865	3 751	4 018

ICD-9: 390-398; 401-405; 410-438, 440-459 and ICD-10: I00.0-I199; G45.0-G46.8; M30.0-M31.9.

Source: The National Registers for Causes of Death
Kilde: De nationale dødsårsagsregistre

Table 4.4 Avoidable deaths per 100 000 inhabitants
Undgåelige dødsfald pr. 100 000 indbyggere

ICD10 codes			Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
			2000	2000	2000	2002	2002	2001	2002	2001
	Age Alder									
C53	1-74	*Cancer in the cervix uteri*[1)] Kræft i livmoder-halsen[1)]	3.9	7.0	11.9	1.2	-	2.3	3.2	2.2
C81	1-74	*Hodgkin's disease* Hodgkins sygdom	0.7	0.0	0.0	0.3	-	0.8	0.2	0.2
I05-I09	1-74	*Chronic rheumatic heart disease* Kronisk reumatisk hjertesygdom	0.1	2.3	1.8	0.5	-	0.4	0.5	0.5
E10-E14	1-74	*Diabetes mellitus* Sukkersyge	12.8	4.7	3.7	5.1	4.2	3.0	5.0	6.3
J00-J99	1-14	*Diseases of the respiratory system* Sygdomme i ånde-drætsorganer	0.1	0.0	0.0	0.2	-	1.6	0.6	0.0
J45-J46	1-14	*Asthma* Astma	0.2	0.0	0.0	-	-	0.0	0.1	0.0
K35-K37	1-74	*Appendicitis* Blindtarms-betændelse	0.4	0.0	0.0	0.1	-	0.0	0.1	0.0
K40-K46	1-74	*Hernia* Brok	0.3	4.7	3.7	0.4	-	0.0	0.1	0.2
I10-I15	1-74	*Hypertensive disease* Hypertensionssygdom	3.7	7.0	5.5	2.1	8.5	0.8	2.5	1.5
I60-I69	1-74	*Cerebrovascular disease* Sygdom i hjernen	25.0	42.2	33.0	27.5	8.5	16.2	17.3	20.5
C33-C34	1-74	*Malignant neoplasm of the trachea, bronchus and lung* Kræft i luftrør, bronkie og lunge	45.4	75.1	58.6	23.5	12.7	28.5	28.1	23.9
C15	1-74	*Malignant neoplasm of the oesophagus* Kræft i spiserør	5.5	9.4	7.3	2.4	-	1.9	2.4	2.4
K70-K71; K73-K74	1-74	*Chronic liver disease and cirrhosis* Kronisk leversygdom og skrumpelever	15.2	7.0	5.5	14.8	12.7	1.1	4.7	5.7
V01-V79; V892	1-74	*Motor vehicle traffic accidents* Motortrafikulykker	7.9	2.3	1.8	7.8	4.2	8.3	7.1	5.8

1 Per 100 000 women.

1 Pr. 100 000 kvinder.

Source: The National Registers for Causes of Death
Kilde: De nationale dødsårsagsregistre

Table 4.5 Deaths caused by HIV/AIDS, in total and per 100 000 inhabitants 1996–2002
Dødsfald som følge af HIV/AIDS, i alt og pr. 100 000 indbyggere 1996-2002

Five year average Femårsgen-nemsnit	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
Number Antal								
1996-00	63	1	4	12	-	1	24	195
2000	21	-	5	10	-	1	17	13
2001	29	-	4	5	-	1	11	20
2002	24	..	5	1	-	-	11	22
Per 100 000 inhabitants Pr. 100 000 indbyggere								
1996-00	1.0	0.4	7.1	0.2	-	0.3	0.5	0.4
2000	0.4	-	8.9	0.2	-	0.4	0.4	0.1
2001	0.6	-	7.1	0.1	-	0.4	0.2	0.2
2002	0.5	..	8.9	0.0	-	-	0.3	0.3

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

Table 4.6 Suicides per 100 000 inhabitants by sex and age 1995-2002
Selvmord pr. 100 000 indbyggere efter køn og alder 1995-2002

	Men					*Women*				
	Mænd					Kvinder				
	Total I alt	10-19	20-24	25-64	65+	*Total* I alt	10-19	20-24	25-64	65+
Denmark										
1995	27.7	5.3	16.7	29.1	48.9	12.7	0.7	3.3	12.5	24.6
1999	24.7	5.4	15.2	25.7	42.4	8.4	0.4	3.5	8.5	14.9
2000	23.3	4.4	16.0	23.8	41.8	8.3	2.5	1.2	8.2	15.0
Faroe Islands[1)]										
1996-00	3.1	..	..	..	..	..	..	..	..	..
2000	2.2	..	..	..	..	..	..	..	..	..
Greenland										
1996-00	171.6	199.4	427.1	146.8	68.1	53.7	41.7	47.5	47.4	34.0
2000	135.7	237.9	172.6	104.1	183.8	53.3	51.1	0.0	64.4	0.0
Finland										
1995	43.4	13.1	48.9	58.5	53.3	11.8	1.9	13.5	16.7	11.3
2000	34.6	10.5	41.8	46.6	36.8	11.0	4.1	9.4	15.5	10.3
2001	36.8	9.3	39.6	50.8	38.0	10.2	3.5	7.5	14.4	9.8
2002	32.4	8.4	43.2	41.3	44.0	10.2	1.9	10.6	14.5	9.3
Åland										
1996-00	30.4	12.8	26.9	37.8	47.1	12.3	-	-	14.7	24.4
2000	23.7	-	144.1	14.3	57.5	30.6	30.6	-	28.9	81.2
Iceland										
1995	16.4	9.3	18.9	24.3	14.8	3.7	-	-	4.7	12.1
1999	17.3	4.6	28.6	27.3	7.0	5.1	4.8	9.7	5.9	5.7
2000	29.8	22.9	73.4	38.1	13.6	5.7	–	9.4	8.6	5.6
2001	19.6	13.6	45.2	22.1	26.9	5.6	–	–	9.9	5.5
Norway										
1995	19.1	12.9	24.6	22.4	28.8	6.2	3.9	5.1	8.1	7.4
1999	19.5	10.1	36.4	23.4	25.6	6.8	6.4	5.8	8.6	7.5
2000	18.4	11.3	29.9	22.5	22.6	5.8	3.0	4.4	7.9	6.3
2001	18.4	7.3	28.7	22.6	26.6	6.0	2.9	8.9	8.6	3.8
2002	16.1	6.8	22.3	20.0	23.5	5.8	2.9	5.2	8.0	5.6
Sweden										
1995	21.5	5.8	16.2	27.4	35.1	9.3	2.0	6.6	11.5	14.2
1999	19.7	5.9	18.3	23.5	35.0	8.0	2.5	7.4	10.3	10.3
2000	18.3	4.0	15.9	21.2	36.0	7.3	3.2	3.9	9.2	10.1
2001	21.5	3.0	16.7	22.6	35.5	9.1	1.9	4.3	10.5	11.2

1 The total covers both men and women.

1 Totalen dækker både mænd og kvinder.

Source: The national registers for causes of death
Kilde: De nationale dødsårsagsregistre
G: Chief Medical Officer

ICD-9: E950-E959 and ICD-10: X60-X84, X85-Y09

Table 4.7 Deaths from accidents per 100 000 inhabitants by sex and age 1995–2002
Dødsfald i ulykker pr. 100 000 indbyggere efter køn og alder 1995-2002

	Men			Mænd		*Women*			Kvinder	
	Total I alt	0-14	15-24	25-64	65+	*Total* I alt	0-14	15-24	25-64	65+
Denmark										
1995	51.2	7.3	42.7	33.2	200.0	43.3	3.4	8.5	12.8	196.9
1999	48.8	7.9	36.4	30.8	203.6	43.8	3.6	6.7	11.5	210.4
2000	45.3	6.3	37.7	30.2	180.7	43.6	2.9	10.3	11.3	209.9
Faroe Islands										
1996-00	50.3	18.5	54.0	36.2	169.7	26.9	7.7	7.2	5.9	134.8
2000	37.9	0.0	60.2	33.1	108.9	22.6	18.6	35.7	0.0	87.0
Greenland										
1996-00	94.3	51.3	71.9	105.2	289.2	29.9	13.2	35.6	27.7	122.5
2000	86.7	38.9	0.0	86.8	629.4	53.6	26.6	85.6	58.8	65.7
Finland										
1995	72.6	7.0	33.2	81.7	199.4	32.0	3.6	7.4	16.3	125.5
2000	70.8	6.0	30.8	75.6	200.4	34.4	3.0	9.3	18.9	127.7
2001	70.5	5.5	38.4	73.2	199.1	34.8	2.4	9.3	19.2	128.1
2002	70.8	6.7	36.9	70.9	205.6	35.6	3.1	8.5	17.0	138.2
Åland										
1996-00	59.6	4.1	19.2	62.1	168.4	21.0	-	7.0	10.5	77.0
2002	31.1	40.7	-	28.1	55.4	15.1	-	-	-	79.9
Iceland										
1995	51.5	26.9	47.0	56.3	96.4	35.2	34.6	14.6	31.1	78.5
1999	25.9	3.0	32.3	17.2	111.4	11.6	3.2	4.8	5.9	56.7
2000	38.4	3.0	46.0	36.7	116.0	12.8	0.0	23.7	10.1	33.6
2001	30.8	14.8	13.8	31.8	87.5	14.1	3.1	14.2	5.7	66.0
Norway										
1995	44.7	7.3	38.3	30.9	161.9	31.8	3.6	9.7	7.9	140.3
1999	44.4	7.0	37.3	26.8	195.6	33.2	4.2	7.8	8.2	175.2
2000	43.9	4.8	35.4	31.8	167.1	34.2	5.0	9.4	8.1	159.6
2001	40.8	4.5	32.2	26.3	171.7	34.5	3.2	7.9	8.8	163.9
2002	45.0	4.7	32.8	33.3	174.5	31.9	2.9	8.6	8.8	150.0
Sweden										
1995	33.0	4.8	21.0	24.3	110.5	22.2	3.4	6.0	6.7	87.0
1999	33.1	4.5	17.1	23.1	119.5	23.5	3.0	6.0	6.1	97.3
2000	36.2	3.1	27.1	25.5	125.4	22.7	1.6	6.4	6.5	93.5
2001	39.0	3.0	27.5	30.2	127.0	25.4	2.5	7.4	7.9	102.4

Source: *The national registers for causes of death*
Kilde: De nationale dødsårsagsregistre
G: Chief Medical Officer

ICD-9: E800-E949 and ICD-10: V01-V99; W00-W99; X00-X59; Y40.0-Y89.9

Table 4.8 Deaths from road traffic accidents per 100 000 inhabitants by sex and age 1995-2002

Dødsfald i vejtrafikulykker pr. 100 000 indbyggere efter køn og alder 1995-2002

	Men			Mænd		*Women*			Kvinder	
	Total I alt	0-14	15-24	25-64	65+	*Total* I alt	0-14	15-24	25-64	65+
Denmark										
1995	16.9	3.6	35.7	13.3	31.0	7.7	2.5	7.9	5.3	19.4
1999	15.0	5.6	3-	12.8	24.6	5.2	1.7	6.8	4.1	11.0
2000	13.4	3.8	28.0	11.7	22.4	5.9	1.2	9.3	4.6	12.6
Faroe Islands										
1995	8.9	-	-	8.9	37.8	4.8	-	-	10.0	-
1999	21.4	-	119.9	8.4	-	13.8	19.0	-	19.4	-
2000	4.2	-	30.1	-	-	4.5	-	35.7	-	-
Greenland										
1996-00	6.7	-	-	11.6	-	-	-	-	-	-
2000	3.3	-	-	5.8	-	-	-	-	-	-
Finland										
1995	14.0	3.8	19.5	12.2	35.1	5.0	2.1	5.8	3.8	10.9
2000	11.4	2.3	13.3	11.4	24.0	5.1	2.2	5.6	4.1	10.7
2001	13.1	2.9	24.4	11.3	24.5	5.2	1.7	6.5	4.4	10.0
2002	13.3	2.1	19.2	12.1	29.5	4.5	2.2	5.3	3.7	8.7
Åland										
1996-00	9.8	-	12.3	9.0	24.6	3.1	-	-	-	16.2
2002	12.1	-	6.4	11.8	36.1	3.1	-	-	1.5	12.2
Iceland										
1995	12.7	9.0	18.8	12.2	14.8	7.5	3.1	4.9	10.9	6.0
1999	9.4	3.0	23.1	8.6	7.0	2.9	0.0	4.8	2.9	5.7
2000	14.9	0.0	32.2	14.1	27.3	7.1	0.0	19.0	5.8	11.2
2001	6.3	11.8	9.2	2.8	6.7	2.1	3.1	4.7	–	5.5
Norway										
1995	10.2	3.0	23.3	7.7	17.0	4.5	1.5	6.6	3.0	10.3
2000	11.4	2.4	25.7	10.7	14.8	4.0	1.4	6.4	3.1	7.8
2001	8.9	0.4	19.5	8.3	15.3	3.9	0.9	5.7	2.8	9.4
2002	11.2	1.7	23.8	10.9	15.3	3.3	1.6	4.1	2.9	6.1
Sweden										
1995	8.1	1.9	12.0	7.4	15.3	3.7	2.1	4.3	3.0	6.4
1999	8.5	2.8	11.9	8.7	12.2	3.5	1.9	4.8	2.5	6.9
2000	10.0	1.4	18.9	9.6	15.3	3.1	1.0	4.2	2.5	6.1
2001	9.7	1.2	18.8	9.6	13.7	3.4	1.5	4.2	2.9	5.9

Source: *The national registers for causes of death*
Kilde: De nationale dødsårsagsregistre
G: Chief Medical Officer

ICD-10: V01-V06, V09, V10-V18, V19, V20-28, V29, V30-V38, V39, V40-V48, V49, V50-V58, V59, V60-V68, V69, V70-V78, V79, V81-V82, V83-V86, V87, V89

ICD-9: E810-E819, E826-E829

CHAPTER V

Resources
Ressourcer

Introduction

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

Indledning

I dette kapitel gives der en samlet belysning af ressourcer og ressourceforbruget inden for sundhedsvæsenet. Først omtales de samlede sundhedsudgifter, med særlig omtale af udgifter til medicin, efterfulgt af sundhedspersonalet, kapacitet og ydelser i sygehusvæsenet.

Health care expenditure

Sundhedsudgifter

Development of health care expenditure

Health plays a central role in peoples' everyday life and is an issue that people are concerned about. Thus health is often a topic for debate, and health issues receive much attention in the press. Attention is particularly focussed on production of health services. Questions are asked about whether health services are adequate and about what health care costs society and individuals. The increasing cost of health care is an issue of concern in many countries. According to OECD, the reason for this concern is that health services are mainly publicly financed. Thus increasing health care expenditure is an extra burden

Udviklingen i sundhedsudgifterne

Sundhed angår folks hverdag og har en central placering i folks bevidsthed. Dermed bliver temaet til genstand for debat og sundhedsspørgsmål får en mere dominerende plads i pressen. Der sættes især fokus på det stigende pres på forbruget af sundhedsydelser. Der stilles spørgsmål om sundhedsvæsenet er tilstrækkelig og i forlængelse af dette stilles der spørgsmål om hvad sundhedsvæsenet koster det offentlige og den enkelte. Stigende sundhedsudgifter er årsag til bekymring i mange lande. I følge OECD er årsagen til dette at det offentlige finansierer største delen af udgifterne. Stigende sundhedsudgifter bliver derved en

on public budgets and, if priorities are not changed, this will lead to higher taxes for both citizens and companies.

ekstra byrde på de offentlige budgetter og vil, hvis der ikke foretages en omprioritering i budgetterne, medføre at skattetrykket for både borgere og virksomheder stiger.

In the Nordic countries, between 75 and 85 per cent of health care expenditure is publicly financed. In 2002, the level of public financing was lowest in Finland with 75 per cent, while the proportion in the other Nordic countries was over 80 per cent.

I de nordiske lande finansierer det offentlige mellem 75 og 85 procent af sundhedsudgifterne. I 2002 var det offentliges andel lavest i Finland med 75 procent mens andelen i de andre nordiske lande var godt og vel 80 procent.

Measured in relation to gross domestic product (GDP), health care expenditure has been relatively stable or has shown a slight increase during the second half of the 1990s and the beginning of this century. With the exception of Finland, health care expenditure represents between 8 and 9 per cent of GDP. The proportion in Finland has been about 7 per cent. Iceland has the highest proportion, with just over 9 per cent.

Målt i forhold til bruttonationalproduktet (BNP) har sundhedsudgifterne været relativt stabile eller svagt stigende i den sidste halvdel af 1990erne og i begyndelsen af det nye årtusind. Med undtagelse af Finland er sundhedsudgifternes andel af BNP mellem 8 og 9 procent. I Finland har sundhedsudgifternes andel af BNP været ca. 7 pct. Island har den højeste andel med lidt over 9 pct.

Table 5.4 shows that health care expenditure as a percentage of GDP has varied in Norway. Health care expenditure increased somewhat more than the economy at the end of the 1990s, among other things because of priority given to elderly people and health.

Af tabel 5.4 fremgår det at sundhedsudgifternes andel af BNP har varieret i Norge. Sundhedsudgifterne havde en noget stærkere vækst end økonomien i slutningen af 1990erne, blandt andet på grund af flere store satsninger på ældre og sundhed.

Table 5.3 shows that expenditure in 2002-prices has increased since 1995 by between 3 and 4 per cent per year in all the Nordic countries, with the exception of Iceland, where the increase has been over 6 per cent per year.

Af tabel 5.3 fremgår at siden 1995 har udgifterne i faste priser steget med mellem 3 og 4 procent per år i alle de nordiske lande, med undtagelse af Island hvor stigningen har været på over 6 pct. per år.

Change in the recording of health care expenditure

Health care expenditure includes all expenditure, both private and public, on consumption or investment in health services etc. Expenditure can be financed both privately and publicly, including by households. Examples of health care expenditure by households are the cost of spectacles, orthopaedic items, medicinal products, dental treatment, medical treatment, physiotherapy services and other health services. Other types of expenditure include national insurance or private insurance reimbursements for use of health services, and public expenditure (net) on hospitals and primary health services.

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

Health care expenditure also includes part of the expenditure on nursing and care for elderly people and people with disabilities. According to international guidelines, this applies to the part of 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 a clear demarcation between what shall be defined as expenditure on health services and what shall be defined as expenditure on social services. What is included as expenditure on health services can vary for the different countries.

Ændring af opgørelsesmetoden for sundhedsudgifterne

Udgifterne til sundhedsformål omfatter alle udgifter, både private og offentlige, der går til forbrug eller investeringer i sundhedsvæsenet m.v. Udgifterne kan finansieres både af offentlige og private kilder, inklusiv husholdningerne. Som sundhedsudgifter regnes eksempelvis husholdningernes køb af briller og ortopædisk udstyr, lægemidler, tandbehandling, lægebehandling, forbrug af fysioterapi og andre sundhedsydelser, samt det offentliges, eller forsikringernes refusion for brugen af sundhedsydelserne samt det offentliges udgifter (netto) til drift af sygehuse og det primære sundhedsvæsen m.v.

Det offentliges udgifter til forbyggende foranstaltninger samt administration af sundhedsvæsenet er ligeledes inkluderet. Det samme gælder udgifter til drift af private sygehuse m.v som ligger udenfor det offentlige budgetter.

Sundhedsudgifterne omfatter også dele af udgifterne til pleje og omsorg for ældre og funktionshæmmede. Ifølge internationale retningslinier gælder dette den del af pleje og omsorgsudgifterne der kan specificeres som udgifter til sundhedsformål. Ydelserne til ældre og funktionshæmmede er ofte integrerede og det kan være vanskeligt at sætte klare grænser for hvad der skal defineres som sundhedsudgifter og hvad der er udgifter til social omsorg. Dette kan være en kilde til forskellig afgrænsning af hvad der medtages som sundhedsudgifter i de enkelte lande.

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

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

All the Nordic countries have implemented, or are in the process of implementing, OECD's system of health accounts, and the figures presented in this publication are based on this system. Not all the countries have come equally far in implementing the system, but at the aggregated level on which the data are presented here, the data are assessed as being comparable. However, the unsolved problems faced by the countries and the different solutions they have found must be taken into account when interpreting the data. For example, the reason that per capita health care expenditure in Finland is 30 per cent lower than in the other countries, may be because the demarcation of what is included as health care expenditure on care of the elderly may be different from

Der vil altid komme sådanne problemer når man sammenligner statistik for flere lande. Dette betyder dog ikke at sammenligningen er værdiløs, men man må tage hensyn til nogle af de forskelle der observeres der kan skyldes forskellige definitioner og afgrænsninger.

For at sikre den bedst mulige sammenlignelighed, arbejder internationale organisationer som OECD, FN og EUROSTAT med at etablere klassifikationer, standarder og definitioner. OECD har blandt andet udviklet et system for sundhedsregnskab ("A System of Health Accounts") Regnskabssystemet er udviklet for at møde politiske behov for data såvel behovet hos forskere på området. Den fælles ramme som systemet er bygget op på, vil sikre den bedst mulige sammenlignelighed af data mellem lande over tid. Systemet er også udviklet således at det giver sammenlignelige tal uafhængig af hvorledes sundhedsvæsenet er organiseret i landene.

Alle de nordiske lande har eller er i færd med at indføre OECD´s system for sundhedsregnskab, og tallene i denne publikation baserer sig på dette system. Alle landene er ikke kommet lige langt i implementeringen af systemet, men på det aggregerede niveau som data præsenteres her vurderes til at være sammenlignelige. Man må alligevel tage forbehold over for de vanskeligheder der står tilbage, og som landene måske har løst forskelligt. Der er blandt grund til at stille spørgsmålstegn ved om der er forskellige afgrænsninger af ældreområdet der gør at Finland har sundhedsudgifter per indbygger der rundt regnet er 30 pct. lavere end gennemsnittet i de andre nordiske lande. Samtidig ser man i tabel 5.2 at Norge har udgifter per

in the other countries. At the same time, Table 5.2 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*.

indbygger som ligger væsentlig højere end i de andre lande. Det er vigtigt at være klar over at OECD´s sundhedsregnskabssystem og dermed data om sundhedsudgifter adskiller sig væsentlig fra sundhedsudgifter der publiceres af EUROSTAT efter ESSPROS - systemet og som også publiceres af NOSOSKO i publikationen *Social tryghed i de nordiske lande*.

ESSPROS 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 are included.

ESSPROS omfatter alle sociale ordninger, enten de drives af offentlige eller private. Statistikken omfatter også pensionskasser og fonde, forsikringer, humanitære organisationer og andre velgørende organisationer. Forsikringsordningerne er medtaget hvis de er kollektive. Det betyder at udgifter til sygdom også vil omfatte sygedagpenge (sygedagpenge eller løn under sygdom) herunder sygedagpenge betalt af arbejdsgiveren. Dette er kontantydelser som ikke medregnes som sundhedsudgifter i OECD´s system, hvor det kun er udgifterne til den sundhedsmæssige service der er medtaget.

Developments in expenditure on medicinal products

Table 5.4 shows the total sales of medicinal products according to ATC group for each of the Nordic countries. In order to have a better basis for comparison, expenditure in Table 5.6 is presented in EUR per capita.

The medicinal products for which expenditure is high are largely the same in all the Nordic countries.

Udvikling i lægemiddeludgifter

I tabel 5.4. ses de samlede udgifter til lægemidler i de enkelte nordiske lande fordelt på ATC-hovedgruppe. For at få et bedre sammenligningsgrundlag er udgifterne i tabel 5.6 omregnet til EUR per capita.

I alle landene er det i stor udstrækning de samme lægemidler, som vejer tungt i udgifterne.

RESOURCES

It is difficult to compare expenditure on medicinal products in the hospital sector between countries, since hospitals pay very different prices for the same medicines, and prices are very different from prices in pharmacies in the primary health sector.

Det er dog generelt set svært at sammenligne udgifterne i denne sektor mellem landene, da sygehusene erhverver sig lægemidler til vidt forskellige priser og til helt andre priser end apotekerne i den primære sektor.

Measured in EUR per capita, expenditure on medicinal products is considerably higher in Iceland than in the other countries. The greatest difference in expenditure on medicinal products is for ATC group N. User charges are highest in Iceland followed by Finland and Åland.

Målt i EUR per capita har Island betydeligt større udgifter til lægemidler end de øvrige lande hvor den mest markante forskel findes i udgifterne til gruppe N. Egenbetalingen er højest i Island efterfulgt af Finland og Åland.

Table 5.1 Health care expenditure (million KR/EUR) 2002
Udgifter til sundheds- og sygepleje (mio. KR/EUR) 2002

	Denmark	Faroe Islands[1)]	Greenland[1)]	Finland[2)]	Iceland	Norway	Sweden
	DKK	DKK	DKK	EUR	ISK	NOK	SEK
Public financing Offentlig finansiering	99 744	601	791	7 723	64 645	112 593	184 999
Private financing Privat finansiering	20 353	73	0	2 485	12 336	19 471	31 779
Total health care expenditure Samlede udgifter til sundheds- og sygepleje	120 097	674	791	10 208	76 981	132 064	216 778

1 2001.
2 Finnish figures include Åland.

1 2001.
2 Finske tal inkluderer Åland.

Source: OECD HEALTH DATA 2004
Kilde: FI: Statistics Faroe Islands; G: Directorate for Health

Table 5.2 Health care expenditure (EUR/capita) 2002
Udgifter til sundheds- og sygepleje (EUR/capita) 2002

	Denmark	Faroe Islands[1)]	Greenland[1)]	Finland[2)]	Iceland	Norway	Sweden
Public financing Offentlig finansiering	2 493	1 734	1 888	1 485	2 600	3 296	2 256
Private financing Privat finansiering	509	211	0	478	496	570	388
Total health care expenditure Samlede udgifter til sundheds- og sygepleje	3 001	1 944	1 888	1 963	3 096	3 866	2 644

1 2001.
2 Finnish figures include Åland.

1 2001.
2 Finske tal inkluderer Åland.

Source: OECD HEALTH DATA 2004
Kilde: FI: Statistics Faroe Islands; G: Directorate for Health

Table 5.3 The GDP and health care expenditure total and per capita 1995-2002
BNP og udgifter til sundheds- og sygepleje i alt og pr. indbygger 1995-2002

	Denmark	Faroe Islands	Greenland	Finland[3)]	Iceland	Norway	Sweden
	DKK	DKK	DKK	EUR	ISK	NOK	SEK
Total expenditure per capita 2002 Samlede udgifter pr. indbygger 2002	22 340	14 466	14 071[2)]	1 963	267 760	29 101	24 289
GDP (million) 2002 BNP (mio.) 2002	1 360 710	9 528	9 088[2)]	139 803	778 960	1 522 176	2 347 400
Expenditure in 2002-prices (million)[1)] Udgifter i 2002-priser (mio.)							
1995	95 350	532	660	8 057	50 181	98 178	157 961
2000	110 757	600	792	9 040	69 836	113 331	192 142
2001	116 420	627	791	9 543	72 392	121 355	202 394
2002	120 097	674	..	10 208	76 981	132 064	216 778

1 Health expenditure in 2001 prices using GDP-wide deflator.
2 2001.
3 Finnish figures include Åland.

1
2 2001.
3 Finske tal inkluderer Åland.

Source: OECD HEALTH DATA 2004
Kilde: FI: Statistics Faroe Islands; G: Directorate for Health

Table 5.4 Health care expenditure as a percentage of GDP 1995-2002
Udgifter til sundheds- og sygepleje i pct. af BNP 1995-2002

	Denmark	Faroe Islands	Greenland	Finland[1)]	Iceland	Norway	Sweden
1995	8.2	10.4	9.4	7.5	8.4	7.9	8.1
2000	8.4	8.0	9.2	6.7	9.2	7.7	8.4
2001	8.6	7.6	8.7	7.0	9.2	8.1	8.8
2002	8.8	7.5	..	7.3	9.9	8.7	9.2

1 Finnish figures include Åland.

1 Finske tal inkluderer Åland.

Source: OECD HEALTH DATA 2004
Kilde: FI: Statistics Faroe Islands; G: Directorate for Health

Table 5.5 Sales of medicinal products by ATC-group, calculated in pharmacy retail prices (million euro), 2002
Salg af lægemidler fordelt på ATC-grupper, apotekernes salgspris (mio. euro) 2002

	Denmark	Faroe Islands	Greenland[1]	Finland[2]	of which Åland[2]	Iceland	Norway	Sweden
A *Alimentary tract and metabolism*								
Fordøjelse og stofskifte	186	0.2	0.3	222	1	17.6	182	426
B *Blood and blood-forming organs*								
Blod og bloddannende organer	84	1.3	0.1	90	0.6	7.7	74	244
C *Cardiovascular system*								
Hjerte og kredsløb	275	3.3	0.5	399	1.6	20.7	326	459
D *Dermatologicals*								
Hudmidler	47	0.3	0.3	61	0.2	4.1	43	97
G *Genito-urinary system and sex hormones*								
Kønshormoner m.m.	109	0.6	0.3	146	0.6	10.3	79	163
H *Systemic hormonal preparations, excl. sex hormones and inulins*								
Hormoner til systemisk brug	33	0.2	0.1	39	0.2	2.7	36	85
J *Anti-infectives for systemic use*								
Infektionssygdomme	150	1.3	0.8	147	0.7	14.6	78	212
L *Antineoplastic and immuno-modulating agents*								
Cancermidler m.m.	106	0.6	0.1	137	1	9.7	112	246
M *Musculo-skeletal system*								
Muskler, led og knogler	74	0.5	0.1	140	5.9	8.8	97	134
N *Nervous system*								
Nervesystemet	465	2.7	1.3	368	1.5	44.2	320	630
P *Antiparasitic products, insecticides and repellents*								
Parasitmidler	9	0.0	0.0	5	0.3	0.3	5	8
R *Respiratory system*								
Åndedrætsorganer	190	1.2	0.3	186	1	13.4	190	251
S *Sensory organs*								
Sanseorganer	31	0.2	0.1	38	0.2	2.9	38	61
V *Various*								
Diverse	18	0.1	0.4	16	0.1	1.4	15	37
Total I alt	1 776	12.4	4.7	1 994	9.3	158.6	1 595	3 053
Of which user charges	577	..	.	848	3.8	95.5	..	605

Sources: D: Danish Medicines Agency; FI: Chief Pharmaceutical Officer; G: The Central Pharmacy in Copenhagen
Kilder: County; F & Å: National Agency for Medicines; I: Ministry of Health and Social Security; N: WHO Collaborating Centre for Drug Statistics Methodology; S: National Corporation of Swedish Pharmacies

1 Calculated on the basis of the purchase prices paid to the Hospital Pharmacy in the County of Copenhagen by Greenland's health service.
2 For Finland, sales in the primary health sector are calculated in PRP (pharmacy retail prices) and in the hospital sector in PPP (pharmacy purchase prices).

Table 5.6 Sales of medicinal products by ATC-group, EUR/capita 2002 - based on pharmacy retail prices
Salg af lægemidler fordelt på ATC-grupper, EUR/capita 2002 - baseret på apotekernes salgspris

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A *Alimentary tract and metabolism* Fordøjelse og stofskifte	35	4	5	43	38	61	40	48
B *Blood and blood-forming organs* Blod og bloddannende organer	16	27	2	17	23	27	16	27
C *Cardiovascular system* Hjerte og kredsløb	51	69	8	77	61	72	72	52
D *Dermatologicals* Hudmidler	9	7	6	12	8	14	9	11
G *Genito-urinary system and sex hormones* Kønshormoner m.m.	20	13	6	28	22	36	17	18
H *Systemic hormonal preparations, excl. sex hormones and inulins* Hormoner til systemisk brug	6	5	2	7	8	9	8	9
J *Anti-infectives for systemic use* Infektionssygdomme	28	26	14	28	26	51	17	24
L *Antineoplastic and immuno-modulating agents* Cancermidler m.m.	20	12	1	26	39	34	25	28
M *Musculo-skeletal system* Muskler, led og knogler	14	10	2	27	22	30	21	15
N *Nervous system* Nervesystemet	87	56	23	71	58	153	71	71
P *Antiparasitic products, insecticides and repellents* Parasitmidler	2	1	1	1	1	1	1	1
R *Respiratory system* Åndedrætsorganer	35	25	6	36	37	47	42	28
S *Sensory organs* Sanseorganer	6	4	2	7	6	10	8	7
V *Various* Diverse	3	3	8	3	3	5	3	4
Total I alt	330	260	84	383	354	550	350	343
Of which user charges	107	..	.	163	144	331	..	68

Sources: *See Table 5.5*
Kilder: Se tabel 5.5

Health care personnel

Statistics on health care personnel in the health services are very incomplete, and it is therefore difficult to compare the situation in the Nordic countries.

In connection with the publication of this edition, a working group was set up to try to obtain statistics that are more comparable than those that have been presented previously. Some of the previous statistics were based only on information from trade unions. In this edition, as far as possible, statistics have been obtained on the number of people of working age from registers of authorized health care personnel. These data have been compared, where possible, with data from employment registers, but all the data are limited to, and defined in relation to, the international classification of health care personnel, employed in the health or social sectors. In addition, data on the number of physicians employed in teaching, research and administration are presented.

There are large differences in the use of health care personnel in different countries, both in total and for the different categories of health personnel. It should be noted that, because of the change in method for obtaining the data used in this edition, the data are substantially different from those presented in previous editions. However, the comparability of the data has been improved.

Sundhedspersonale

De statistiske oplysninger om personaleforbruget i sundhedsvæsenet er yderst mangelfulde, og det kan derfor være vanskeligt at give et sammenligneligt billede af forholdene i de nordiske lande.

I forbindelse med denne udgave af publikationen har der været nedsat en arbejdsgruppe, der skulle forsøge at komme frem med en mere sammenlignelig statistik end tidligere, hvor en del af statistikken var baseret på fagforeningernes oplysninger alene. I denne udgave er det valgt, så vidt muligt, at få statistik for personer der er i den erhvervsaktive alder fra autorisationsregistrene. Disse data er sammenholdt med oplysningerne fra erhvervsregistrene, hvor det har været muligt, men alle data er afgrænset og defineret i henhold til den internationale brancheklassifikation for sundhedspersonale der henholdsvis arbejder i social eller sundhedssektoren. For læger er der yderligere specificeret hvor mange der arbejder indenfor henholdsvis undervisning, forskning og administration.

Der er betydelige forskelle i personaleforbruget, både totalt set og inden for de enkelte personalekategorier mellem landene. Det skal bemærkes, at ved valget af opgørelsesmetoden i denne publikation adskiller de fundne resultater sig betydeligt fra tidligere års udgivelser, dog anses resultatet for at være mere sammenligneligt end tidligere.

Table 5.7 Active health personnel in health and social services 2002
Erhvervsaktivt sundhedspersonale indenfor social- og sundhedsområdet 2002

	Denmark[1)]	Faroe Islands[2)]	Greenland[3)]	Finland[4)]	Åland	Iceland[5)]	Norway	Sweden[1)]
Physicians								
Læger	15 598	90	84	13 400	61	1 029	15 586	28 194
Dentists								
Tandlæger	4 619	38	33	4 200	21	283	3 853	7 213
Qualified nurses								
Sygeplejersker	51 669	366	208	31 500	316	2 342	62 945	83 853
Qualified auxiliary nurses								
Sygehjælpere	39 197	79	166	27 250	470	1 474[6)]	64 200	122 914[7)]
Midwives								
Jordemødre	1 308	20	7	1 450	10	200	2 123	5 985
Physiotherapists								
Fysioterapeuter	4 920	17	12	6 600	27	405	6 723	14 694[8)]
Total								
I alt	117 311	610	509	84 400	905	5 733	155 430	262 853

1 2001.
2 For physiotherapists, only people employed in hospitals.
3 Midwives include health workers and assistants at confinements.
4 2000, only staff employed in the public sector
5 For NACE 85.31.1, 85.31.2, 85.31.4, 85.31.6, 85.31.9 and 85.32 data is not available. Dentists and Physiotherapists 2000 figures
6 Refers to those working in health institutions and old peoples homes.
7 Statistics on members of the Swedish Association of Local Authorities and Federation of County Councils.
8 Total number of authorized under 65 years.

1 2001.
2 For fysioterapeuter, kun beskæftigede på hospitaler.
3 Jordemødre er inklusiv sundhedsmedhjælpere og assistenter ved fødsler.
4 2000, kun personer ansat i den offentlige sektor.
5 Data for NACE 85.31.1, 85.31.2, 85.31.4, 85.31.6, 85.31.9 og 85.32 er ikke tilgængelige. Tallene for tandlæger og fysioterapeuter er for 2000.
6 Personer der arbejder på sundhedscentre og alderdomshjem.
7 Landstingsforbundets og Svenska kommunförbundets medlemsstatistik.
8 Totalt antal autoriserede under 65 år.

NACE *(Nomenclature generale des Activités economiques dans les Communautes Européennes)* codes covered: 85.1 and 85.3.

Source: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: STAKES; Å: Government of the
Kilde: Åland Islands; I: Directorate of Health; N: Statistics Norway; S: National Boards of Health and Welfare

Table 5.8 Active health personnel in health and social services per 100 000 inhabitants 2002
Erhvervsaktivt sundhedspersonale indenfor social- og sundhedsområdet per 100 000 indbyggere 2002

	Denmark[1)]	Faroe Islands[2)]	Greenland[3)]	Finland[4)]	Åland	Iceland[5)]	Norway	Sweden[1)]
Physicians								
Læger	292	193	148	259	233	357	342	316
Dentists								
Tandlæger	86	82	59	81	80	98	85	82
Qualified nurses								
Sygeplejersker	966	785	368	608	1 207	812	1 383	995[7)]
Qualified auxiliary nurses								
Sygehjælpere	733	170	293	526	1 795	511[6)]	1 410	1 382
Midwives								
Jordemødre	24	43	12	28	38	69	47	69
Physiotherapists								
Fysioterapeuter	92	36	20	127	103	140	148	165[8)]
Total								
I alt	2 193	1 309	899	1 629	3 456	1 987	3 414	2 955

1 2001.
2 For physiotherapists, only people employed in hospitals.
3 Midwives include health workers and assistants at confinements.
4 2000, only staff employed in the public sector.
5 For NACE 85.31.1, 85.31.2, 85.31.4, 85.31.6, 85.31.9 and 85.32 data is not available. Dentists and Physiotherapists 2000 figures.
6 Refers to those working in health institutions and old peoples homes.
7 Statistics on members of the Swedish Association of Local Authorities and Federation of County Councils.
8 Total number of authorized under 65 years.

1 2001.
2 For fysioterapeuter, kun beskæftigede på hospitaler.
3 Jordemødre er inklusiv sundhedsmedhjælpere og assistenter ved fødsler.
4 2000, kun personer ansat i den offentlige sektor.
5 Data for NACE 85.31.1, 85.31.2, 85.31.4, 85.31.6, 85.31.9 og 85.32 er ikke tilgængelige. Tallene for tandlæger og fysioterapeuter er for 2000.
6 Personer der arbejder på sundhedscentre og alderdomshjem.
7 Landstings- och Svenska kommunförbundens medlemsstatistik.
8 Totalt antal autoriserede under 65 år.

NACE codes covered: 85.1 and 85.3.

Source: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: STAKES; Å: Government of the
Kilde: Åland Islands; I: Directorate of Health; N: Statistics Norway; S: : National Boards of Health and Welfare

Table 5.9 Physicians employed in health and social services 2002
Erhvervsaktive læger beskæftiget inden for social- og sundhedsområdet 2002

	Denmark[1)]	Faroe Islands	Greenland	Finland	Åland	Iceland[2)]	Norway	Sweden
Physicians employed at hospitals								
Læger ansat ved sygehuse	10 492	63	83	7 153	41	748	8 619	..
Physicians employed elsewhere than hospitals								
Læger beskæftiget udenfor sygehusene	5 106	27	2	7 924	20	281	6 967	..
Of which:								
Heraf:								
General practitioners								
Alment praktiserede speciallæger	3 910	24	50	4 865	15	196	2 274	4 885
Physicians total								
Læger i alt	15 598	90	84	15 077	61	1 029	15 586	28 194

1 2001.
2 For NACE 85.31.1, 85.31.2, 85.31.4, 85.31.6, 85.31.9 and 85.32 data is not available.

1 2001.
2 Data for NACE 85.31.1, 85.31.2, 85.31.4, 85.31.6, 85.31.9 og 85.32 er ikke tilgængelige

NACE codes covered: 85.1 and 85.3.

Source: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: STAKES; Å: Government of the
Kilde: Åland Islands; I: Directorate of Health; N: Statistics Norway; S: : National Boards of Health and Welfare

Table 5.10 Physicians employed outside health and social services 2002
Erhvervsaktive læger beskæftiget uden for social- og sundhedsområdet 2002

	Denmark[1)]	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden[1)]
Administrativ medicin (NACE 75.1)	218	1	2	438	1	..	395	509
Medicinsk forskning, undervisning m.v. (NACE 80.3; 73.1 og 24.4)	789	1	0	1 122	-	..	934	1 393
Ikke behandlende i alt	1 007	2	2	1 560	1	..	1 329	3 063

1 2001.

NACE codes covered: 75.1, 80.3, 73.1 and 24.4.

Source: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: STAKES; Å: Government of the
Kilde: Åland Islands; N: Statistics Norway; S: National Board of Health and Welfare

Capacity and services in hospitals

For many years, there has been a trend in the Nordic countries towards fewer hospital beds. Resources have been concentrated in fewer units, often involving a division of work in the most specialized areas. Units have often been merged administratively, not necessarily leading to fewer physical units. No hospitals have been closed down in Norway during the last few years, but some of the existing hospitals have become smaller.

Another trend in the Nordic countries is that psychiatric hospitals have been closed down, however, to varying degrees.

Hospital beds are organized somewhat differently in Finland, Iceland and Greenland than in the other countries. A number of beds are attached to health centres, and these beds appear in the tables as beds in "other hospitals". Some of these beds are for care of elderly people, and they are similar to beds in nursing homes and old age 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.

The statistics in the tables about hospitals have been divided up so that developments for the different types of hospitals can be followed.

Ordinary hospitals are hospitals with several specialities that primarily provide short-term somatic treatment, and also short-term psychiatric treatment.

Kapacitet og ydelser i sygehusvæsenet

Det er et kendetegn ved de nordiske landes sygehusvæsen, at der i en årrække er blevet færre sengepladser, og ressourcerne er blevet samlet på færre enheder, og oftest med en arbejdsdeling på de mest specialiserede områder. Ofte er det tale om en organisatorisk administrativ sammenlægning, som ikke nødvendigvis behøver at medfører færre fysiske enheder. I Norge er der ikke nedlagt hospitaler de seneste år, men de eksisterende hospitaler er ofte blevet mindre.

Det er ligeledes et kendetegn, at egentlige psykiatriske hospitaler er under afvikling i de nordiske lande, dog i forskelligt tempo.

I Grønland, Finland og Island er strukturen dog lidt anderledes, idet der til sundhedscentrene er knyttet et antal sengepladser, som i tabellerne er rubriceret under andre hospitaler. En del af disse sengepladser er dog plejepladser, som i de andre lande findes ved alderdoms- og plejehjemmene. Dette medfører, især for Finland og Islands vedkommende, at man får et betydeligt større antal sengepladser i forhold til befolkningen, end i de andre lande.

I tabellerne over sygehuse er der foretaget en opdeling, således at man kan følge udviklingen i de forskellige typer sygehuse.

Almindelige sygehuse er sygehuse med flere specialer og beskæftiger sig i hovedsagen med somatisk korttidsbehandling, men inkluderer også korttidspsykiatrisk behandling.

The category 'specialized hospitals' includes hospitals that only have one speciality within somatic treatment.

Under rubrikken 'Specialsygehuse', er der opregnet sygehuse, som kun har et enkelt speciale inden for den somatiske behandling.

Psychiatric hospitals are hospitals that only provide treatment for psychiatric patients. The category 'other hospitals' includes hospitals that provide geriatric and psychiatric care and/or long-term treatment in health centres with mixed medical and surgical wards.

Psykiatriske sygehuse er sygehuse, som kun behandler psykiatriske patienter. Rubrikken 'Andre sygehuse' omfatter sygehuse med geriatrisk og psykiatrisk pleje og/eller langtidsbehandling ved helsecentrene med blandede medicinske og kirurgiske afdelinger.

Hospital beds are divided into medical, surgical, psychiatric and other beds. It is clearly indicated that, particularly for Finland and Iceland, the category 'other', includes activities that are not included in the other countries.

Sengepladserne ved sygehusene er fordelt på medicin, kirurgi, psykiatri og andet. Det fremgår klart, at det først og fremmest er Finland og Island som under rubrikken 'Andet' medregner aktiviteter, som ikke medtages af de øvrige lande.

The tables about 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.

Tabellerne over udskrivninger og gennemsnitlig liggetid omfatter indlagte patienter ved almindelige sygehuse og specialsygehuse. Denne afgrænsning er foretaget for at fremme sammenligneligheden mellem landene.

The trend is that the number of treatment places and the average length of stay has been reduced in ordinary hospitals. Within psychiatric treatment there has been a trend towards the use of more outpatient treatment, so that the number of psychiatric beds has been reduced.

Tendensen er, at antallet af behandlingspladser og den gennemsnitlige liggetid reduceres på de almindelige sygehuse. Inden for den psykiatriske behandling har der været en udvikling hen imod mere ambulante behandlingsformer, hvorfor antallet af psykiatriske sengepladser er blevet reduceret.

Table 5.11 Number of hospitals by number of beds 2002
Sygehuse efter antal sengepladser 2002

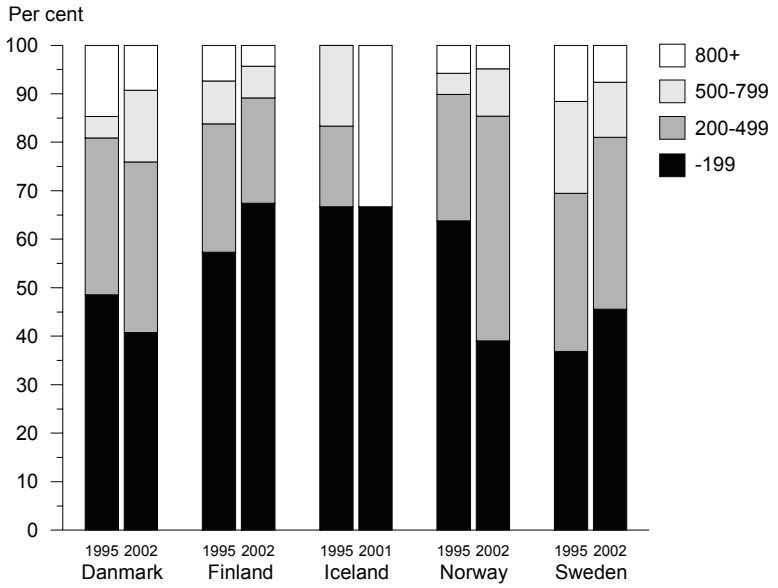
	Denmark	Faroe Islands	Greenland	Finland	of which Åland	Iceland	Norway	Sweden
Ordinary hospitals								
Almindelige sygehuse								
-199	22	2	16	62	1	2	16	36
200-499	19	1	-	20	-	-	19	28
500-799	8	-	-	6	-	-	4	9
800+	5	-	-	4	-	1	2	6
Total I alt	54	3	16	92	1	3	41	79
Specialized hospitals								
Specialsygehuse								
-199	4	-	-	9	-	-	8	1
200-499	-	-	-	-	-	-	1	-
500-799	-	-	-	-	-	-	-	-
800+	-	-	-	-	-	-	-	-
Total I alt	4	-	-	9	-	-	9	1
Psychiatric hospitals								
Psykiatriske sygehuse								
-199	7	-	-	15	1	-	11	-
200-499	3	-	-	7	-	-	-	-
500-799	-	-	-	2	-	-	-	-
800+	-	-	-	-	-	-	-	-
Total I alt	10	-	-	24	1	-	11	-
Other hospitals								
Andre sygehuse								
-199	-	-	-	258	1	20	3	-
200-499	-	-	-	8	-	-	-	-
500-799	-	-	-	1	-	-	-	-
800+	-	-	-	-	-	-	-	-
Total I alt	-	-	-	267	1	20	3	-
Hospitals, total								
Sygehuse, i alt	68	3	16	392	3	23	64	80

Note: Ordinary hospitals are hospitals that mainly provide treatment for patients with somatic diseases. Specialized hospitals are hospitals with only one speciality. Psychiatric hospitals are hospitals that only provide treatment for patients with psychiatric disorders (excl. psychiatric nursing homes). Other hospitals include hospitals providing long-term medical care as well as hospitals that cannot be categorized in the above, e.g. the Finnish health centres.

Anmærkning: Ved almindelige sygehuse forstås sygehuse, som overvejende behandler somatiske patienter. Specialsygehuse er sygehuse med kun ét speciale. Til psykiatriske sygehuse henregnes sygehuse, der udelukkende behandler psykiatriske patienter (dog ekskl. psykiatriske plejehjem). Andre sygehuse omfatter langtidsmedicinske sygehuse og sygehuse, der ikke kan kategoriseres i ovenstående, fx de finske hälsovårdscentraler.

Source: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: STAKES; Å: Government of the
Kilde: Åland Islands; I: Directorate of Health; N: Statistics Norway; S: Federation of Swedish County Councils

Figure 5.1 Number of ordinary hospitals by number of beds 1995 and 2002
Antal almindelige sygehuse fordelt efter antal senge 1995 og 2002



Source: Table 5.11
Kilde: Tabel 5.11

Table 5.12 Authorized hospital beds by speciality 2002
Normerede sengepladser ved sygehuse efter specialer 2002

	Denmark	Faroe Islands	Greenland	Finland[2)]	Åland	Iceland	Norway	Sweden[3)]
Number Antal								
Medicine Medicin	10 363	94	46	6 774	64	..	7 098	13 566
Surgery Kirurgi	7 951	95	62	5 209	47	..	6 498	8 383
Psychiatry Psykiatri	3 911	76	12	5 359	32	..	2 985	3 168
Other Andet	-	-	-[1)]	20 943	98	..	333	-
Total I alt	22 225	265	120	38 285	241	..	16 914	25 117
Beds per 100 000 inhabitants Sengepladser pr. 100 000 indbyggere								
Medicine Medicin	192	202	81	130	244	..	155	152
Surgery Kirurgi	148	204	110	100	180	..	143	94
Psychiatry Psykiatri	73	163	21	103	122	..	66	35
Other Andet	-	-	-[1)]	403	374	..	7	-
Total I alt	413	570	212	736	920	..	372	281

1 Excl. patient hotel.
2 The number of beds has been calculated by dividing the total number of bed-days by 365.
3 Average disposable beds.

1 Ekskl. patienthotel.
2 Antallet af senge er beregnet ved at dividere det totale antal sengedage med 365.
3 Gennemsnitligt disponible sengepladser.

Source: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: STAKES; Å: Government of the
Kilde: Åland Islands; I: Directorate of Health; N: Statistics Norway; S: Federation of Swedish County Councils

Table 5.13 Discharges, bed days and average length of stay in wards in ordinary hospitals and specialized hospitals 2002
Udskrivninger, sengedage og gennemsnitlig liggetid på afdelinger ved almindelige sygehuse og specialsygehuse 2002

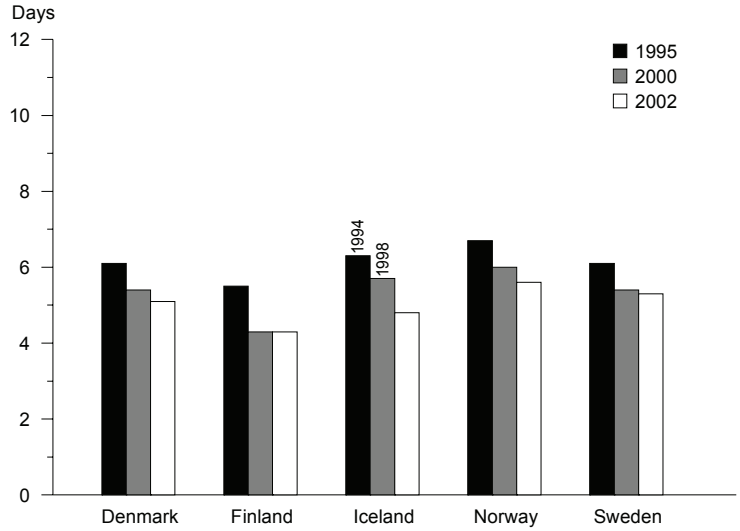
	Denmark	Faroe Islands	Greenland[1)]	Finland	Åland	Iceland[2)]	Norway	Sweden
Discharges per 1 000 inhabitants								
Udskrivninger pr. 1 000 indbyggere								
Medicine								
Medicin	101	132	24	81	103	93	78	72
Surgery								
Kirurgi	96	95	48	118	120	88	79	69
Psychiatry								
Psykiatri	8	7	5	11	19	7	5	9
Total								
I alt	205	234	77	210	242	195	162	150
Bed-days per 1 000 inhabitants								
Sengedage pr. 1 000indbyggere								
Medicine								
Medicin	593	666	175	466	663	636	462	373
Surgery								
Kirurgi	423	410	330	373	440	433	398	305
Psychiatry								
Psykiatri	247	474	88	369	393	381	219	167
Total								
I alt	1 263	1 550	593	1 208	1 496	1 786	1 079	845
Average length of stay								
Gennemsnitlig liggetid								
Medicine								
Medicin	6	5	7	6	6	7	6	5
Surgery								
Kirurgi	4	4	7	3	4	5	5	4
Psychiatry								
Psykiatri	..	64	18	34	20	52	41	19
Total								
I alt	..	7	..	6	6	9	7	6

1 Figures for average length of stay only refer to Dronning Ingrids Hospital.
2 Refers to 1995. Incl. patients who have been admitted to small hospitals for less than 90 days. The total includes rehabilitation, geriatrics and long-term care in ordinary hospitals.

1 Tallene for den gennemsnitlige liggetid omfatter kun Dronning Ingrids Hospital.
2 Vedrører 1995. Inkl. patienter, der har været indlagt ved små sygehuse i mindre end 90 dage. I sumtotalerne medregnes revalidering, geriatri og langtidspleje ved almindelige sygehuse.

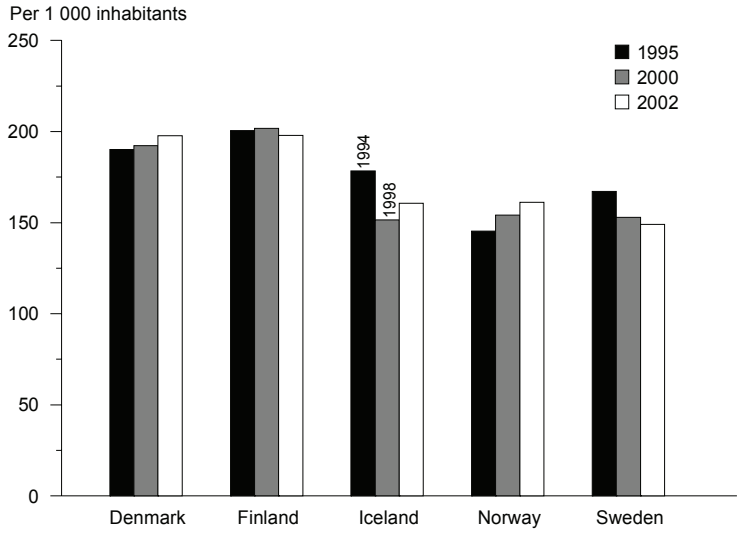
Source: D, FI, G, F, Å, I & N: The national in-patient registers
Kilde: D, FI, G, F, Å, I & N: De nationale patientregistre
S: National Board of Health and Welfare

Figure 5.2 Average length of stay in somatic wards 1995-2002
Gennemsnitlig liggetid på somatiske afdelinger 1995-2002



Source: Table 3.20
Kilde: Tabel 3.20

Figure 5.3 Number of discharges from somatic wards, per 1 000 inhabitants 1995-2002
Udskrivninger fra somatiske afdelinger pr. 1 000 indbyggere 1995-2002



Source: Table 3.19
Kilde: Tabel 3.19

Table 5.14 Discharges from hospitals* by sex and age, per 1 000 inhabitants in the age group 2002
Udskrivninger fra sygehuse* efter køn og alder, pr. 1 000 indbyggere i aldersgruppen 2002

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland[1)]	Norway	Sweden
Age Alder								
Men Mænd								
0-14	189	169	106	129	157	153	95	72
15-44	88	94	130	89	88	50	73	52
45-64	197	319		203	200	119	158	134
65-69	382	420		374	365	267	307	276
70-74	490	540	681	488	440	380	404	379
75-79	625	652		604	708	507	496	491
80+	750	747		716	899	751	643	655
Total I alt	193	218	149	180	202	131	146	135
Women Kvinder								
0-14	160	139	100	101	124	145	76	58
15-44	191	235	344	177	197	172	152	129
45-64	177	216		199	201	150	151	123
65-69	299	328		299	273	247	248	217
70-74	387	628	711	389	356	333	304	290
75-79	465	480		482	483	425	393	381
80+	597	602		546	714	592	502	525
Total I alt	225	251	298	216	241	190	176	163

1 Discharges for stays in hospital shorter than 90 days.

* Comprises somatic wards in ordinary hospitals and in specialized somatic hospitals.

1 Kun udskrivninger ved indlæggelsestider på mindre end 90 dage.

* Omfatter somatiske afdelinger ved almindelige sygehuse og ved somatiske specialsygehuse.

Source: The national in-patient registers
Kilde: De nationale patientregistre

Table 5.15 Bed days in hospitals* by sex and age, per 1 000 inhabitants in the age group 2002
Sengedage på sygehuse* efter køn og alder, pr. 1 000 indbyggere i aldersgruppen 2002

	Denmark	Faroe Islands	Greenland[1)]	Finland	Åland	Iceland[2)]	Norway	Sweden
Age Alder								
Men Mænd								
0-14	588	353	456	371	649	384	395	273
15-44	303	274	843	271	242	161	275	173
45-64	991	954		842	911	583	809	631
65-69	2 353	2 607		1 870	2 203	1 578	1 977	1 586
70-74	3 144	3 381	4 647	2 579	3 057	2 666	2 840	2 338
75-79	4 190	6 788		3 592	4 360	4 031	3 645	3 265
80+	5 492	7 229		5 540	6 625	6 709	4 945	4 719
Total I alt	959	957	920	786	1 021	652	808	720
Women Kvinder								
0-14	521	311	420	295	369	373	337	233
15-44	610	770	1 732	529	588	488	597	398
45-64	866	839		704	841	670	808	572
65-69	1 870	1 706		1 344	1 513	1 618	1 614	1 247
70-74	2 705	4 387	5 257	1 928	2 252	2 521	2 185	1 874
75-79	3 611	4 480		2 675	3 166	3 579	3 030	2 686
80+	5 155	7 439		3 626	5 763	6 254	4 046	4 108
Total I alt	1 141	1 274	1 577	880	1 172	887	988	856

1 Some women from villages are admitted to hospital up to one month before the expected date of delivery.
2 Bed days of discharges for stays in hospital shorter than 90 days.

1 En del kvinder fra bygderne indlægges op til en måned før termin.
2 Sengedage for udskrivninger ved indlæggelsestider på mindre end 90 dage.

* Definition, see Table 3.19
* Definition, se tabel 3.19

Source: The national in-patient registers
Kilde: De nationale patientregistre

SECTION B

Equal Access to Care
Vård på lika villkor

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Preface

Several Nordic studies have been carried out on social inequalities in morbidity and mortality, but few analyses have been carried out on differences in utilization of health services in the Nordic countries.

With this background, NOMESCO decided that the topic for this year's theme section should be social variations in utilization of health services.

However, the available data on inequalities is not without its problems. Although the Nordic countries have national register data useful for several types of studies in this

Forord

Der er foretaget flere nordiske studier vedrørende de sociale uligheder der findes i sygelighed og dødelighed, men der er kun i begrænset omfang foretaget egentlig nordiske analyser af de socioøkonomiske variationer, der måtte findes i brugen af de tilbud, der findes for behandling m.v. i de nordiske lande.

På den baggrund besluttede NOMESKO at dette års tema skulle omhandle de sociale variationer der findes i brugen af sundhedsvæsenets tilbud.

Kildegrundlaget for en sådan undersøgelse er imidlertid ikke helt enkelt. Dog har de nordiske lande nationale registre der kan anvendes for adskillige typer af studier. Det

area, a general problem is lack of information on health care need. Therefore, as a background - together with a discussion of the concept equality - analyses of differences in health are presented (Sections II and III). The analyses of socio-economic inequalities in the use of specialist treatment services is based on a literature review (Section IV), while the analysis of inequalities in use of ambulatory care is based on national household surveys (Section V).

Work on the theme section has been organized differently from in previous years. Work has been divided up in the following way. Denmark has had responsibility for the first part, Finland for the second part and Sweden for the third part. A reference group, in which Norwegian experts have also participated, has been responsible for the section as a whole.

er dog et generelt problem at der er mangel på informationer om behov for behandling. Derfor er der, som baggrund, sammen med en diskussion af konspetet om ulighed, medtaget en analyse of forskellene i sygdom (Afsnit II og III). Analysen af de socioøkonomikse forskelle i den specialiserede sygdomsbehandling er baseret på litteraturstudier (Afsnit IV mens analysen af forskellene i den ambulate behandling er baseret på nationale surveyes (Afsnit V).

I modsætning til tidligere temasektioner er temaet udarbejdet gennem en arbejdsdeling, hvor Danmark havde ansvaret for den første del, Finland for den næste og Sverige for den tredie i et samarbejde med en referencegruppe, hvor norske eksperter også deltog.

I. Introduction

By international standards, the Nordic countries are very egalitarian societies. They aspire to provide comprehensive access to health care services of a high standard. Within this common framework, however, the organization and delivery of health care services varies. Examples range from the degree of decentralization, the level of patient charges, the gate-keeping role of primary care, and the role of the private sector. These factors have the potential to increase or decrease socio-economic differences in the provision of health care services.

Socio-economic differences in health can be studied by concentrating on different aspects of health, such as mortality, morbidity, disability, self-assessed health or

I. Introduktion

Set ud fra et internationalt perspektiv, er de nordiske lande samfund med stor social lighed. Man stiler efter at give en fuldstændig adgang til et sundhedsvæsen med en høj standard. Selv med dette udgangspunkt er der imidlertid variationer i sundhedsvæsenets udbud af service. Der er for eksempel forskelle i graden af decentralisering, niveauet af patienternes egenbetaling, det primære sundhedsvæsens betydning som indgangsdøren til sundhedsvæsenet samt den private sektors rolle. Alle disse faktorer har potentiale til enten at forstærke eller formindske de socioøkonomiske forskelle i brugen af sundhedsvæsenets ydelser.

De socioøkonomiske forskelle i sundheden kan blive studeret ved at fokusere på specielle områder af sundhed, så som dødsårsager, sygdom, funktionshæmning, selv-

the use of health care services. Studies on mortality are usually based on cause-of-death registers, linked with census data or other registers, including data on socio-economic status. Similar data linkages can be used for studying use of hospital services. All the Nordic countries have national hospital registers based on hospital inpatient episodes; increasingly they include outpatient specialist care. All these registers, excluding the Norwegian one, include the personal identification number. This makes it possible to link data from these registers with data from other registers. This type of data linkage is also permitted by the national data protection authorities for statistical and scientific purposes. Hospital registers have been shown to be complete, valid, reliable and timely by international standards. However, there are some inaccuracies in the data for some diagnoses and procedures (1, 2).

oplevet sundhed eller brugen af sundhedsvæsenets tilbud. Studier af dødsårsager er normalt baseret på dødsårsagsregistrene, kombineret med spørgeskemaer eller andre registre der medtager personers socioøkonomiske placering. Tilsvarende datakoblinger kan også anvendes for at studere hospitalernes udbud af service. Alle de nordiske lande har nationale hospitalsregistre, med oplysninger om antal indlæggelsesepisoder, hvor disse registre efterhånden også omfatter den specialiserede ambulante behandling. Alle registrene, med undtagelse af det norske, indeholder personnumre, hvilket gør det muligt at kombinere disse registre med andre. Den type af samkøring er tilladt af de nationale datatilsynsmyndigheder, når det drejer sig om statistiske og videnskabelige formål. Hospitalsregistrene er komplette, valide og troværdige set i et internationalt målestok. Dog har det vist sig, at når man studerer de mere detaljerede diagnoser og procedurer, findes der visse fejl og mangler (1, 2).

Register data on morbidity is limited to some disease-specific registers. None of the Nordic countries collect diagnosis-related register information on visits to primary care physicians. Thus questionnaire surveys and health interview surveys have been used to investigate morbidity, disability, visits to primary care physicians and specialists in ambulatory care, and self-assessed health in samples of the population. This kind of data can only be used to study relatively common phenomena, such as visits to primary care physicians, common health problems etc. because of limitations in population samples. Furthermore, differences in sampling methods, response rates, wording of the questions and interpretation can make comparisons between surveys, especially internationally, difficult.

Registerdata vedrørende sygelighed er begrænset til specielle registre. Ingen af de nordiske lande har diagnoserelaterede registre om besøg hos almen læge. Spørgeskemaundersøgelser og interviewundersøgelser er blevet anvendt for at analysere sygelighed, funktionshæmning, besøg hos almenlæge og specialist samt selvoplevet helbred blandt et udvalg af befolkningen. Den type af data kan kun anvendes til at studere relative forekomster så som besøg i det primære sundhedsvæsen, udbredte sygdomsforekomster m.m. på grund af udvalgets størrelse. Desuden vil forskelligheder i indsamlingsmetoder, besvarelsesgrad, den måde der spørges på samt oversættelse, vanskeliggøre en sammenligning af resultaterne fra spørgeskemaundersøgelser, især internationalt.

II. What is understood by social inequality?

By Niels Kr. Rasmussen

The concept social inequality usually refers to systematic differences in living conditions, opportunities in life and the possession or acquisition of essential goods for different social classes in society. Such goods can be health or freedom from sickness and suffering. Social classes can be groups characterised by different education, income, occupation or relation to the labour market. They can also be different age groups, different geographical regions or different ethnic groups.

A basic characteristic of more or less all societies at a certain level of social development is that there are differences between groups or classes.

Social differences in health are not new. The first Nordic studies of social differences were carried out in the middle of the 18th century. It was, for example, shown that the plague ravaged more among those who were poor than among those who were rich (1).

English distinguishes between the term "inequalities", which refers to established descriptive differences, and the term "inequities", which refers to differences that are assessed as unjust. Other descriptive terms used in English are disparities and differences. Danish distinguishes between social differences (forskelle) in health and social inequalities (ulighed) in health. The term inequality points in the direction of injustice, of something that

II. Hvad forstår man ved social ulighed?

Af Niels Kr. Rasmussen

Med begrebet social ulighed henviser man sædvanligvis til systematiske forskelle i levevilkår, livschancer og besiddelse/erhvervelse af væsentlige goder mellem forskellige sociale klasser i samfundet. Sådanne goder kan være sundhed eller frihed for sygdom og lidelse. De sociale klasser kan være grupper karakteriseret ved forskellig uddannelse, indkomst, erhvervsstilling eller tilknytning til arbejdsmarkedet. Det kan også være forskellige aldersgrupper, forskellige geografiske regioner eller forskellige etniske grupper.

Det er et grundlæggende træk ved stort set alle samfund på et vist samfundsmæssigt udviklingsniveau, at der er sådanne forskelle mellem grupperne eller klasserne.

Sociale forskelle i besiddelsen af godet sundhed er ikke et nyt fænomen. De første nordiske studier stammer fra midten af 1700-tallet, hvor det bl.a. blev konstateret, at pesten hærgede mere blandt de dårligst stillede end blandt de bedst stillede (1).

På engelsk sondres der mellem 'inequalities', der anvendes om de deskriptivt konstaterede forskelle, og 'inequities' der anvendes om forskelle, der vurderes som værende uretfærdige. Andre engelske deskriptive betegnelser kan være: disparities og differences. På dansk kan man tilsvarende sondre mellem sociale forskelle i sundhed og social ulighed i sundhed. Begrebet ulighed peger i retning af uretfærdighed, af noget der skal fjernes eller

should be removed or changed. In other words, the evaluation contains a normative or ideological element, whereas social differences, for example between different educational groups, refer to something that is a measurable fact.

ændres. Dvs. der indgår et normativt eller ideologisk element i vurderingen, hvorimod sociale forskelle, fx mellem forskellige uddannelsesgrupper, refererer til noget faktuelt konstaterbart.

When we talk about Equal Access to Care, this can be defined as access to services according to the needs of the citizen, at the individual, organizational and social levels. In this context, need is regarded as illness or health problem. Equality should also be assessed in terms of the quality, frequency and outcomes of treatment.

Når vi taler om Vård på Lika Villkor, kan det defineres som, at der er adgang til sundhedsvæsenet og dets ydelser i forhold til borgernes behov på individuelt, organisatorisk og samfundsniveau, og i denne sammenhæng betragtes behov som sygdom eller helbredsproblem, og at der endvidere er lighed i kvalitet, hyppighed og resultat af behandling.

Social differences – causes and mechanisms

More or less all manifestations of illness are in one way or another unevenly distributed according to social group. Many different mechanisms and factors contribute to the creation of social differences, and several different models or explanatory frameworks have been developed in order to understand these mechanisms. Two groups of mechanism can be distinguished. Mechanisms belonging to the first group lead to the accumulation of illness and poor health in certain social classes. The result of the second type of mechanism is that people who are ill are unable to maintain their social position and end up in specific social classes or groups.

One particular theory stresses that a relatively low position in the class hierarchy in itself can create vulnerability in terms of health (2).

Sociale forskelle – årsager og mekanismer

Stort set alle sygdomsmanifestationer er på en eller anden måde socialt skævt fordelt. Mange forskellige mekanismer og faktorer bidrager til at skabe de sociale forskelle, og der er udviklet flere forskellige reference- eller forklaringsrammer som kan bidrage til en forståelse. En generel skelnen er mellem de mekanismer, der forårsager at sygdom og dårlig sundhed ophobes i nogle sociale klasser, og de mekanismer, der fører til at folk, der er syge, ikke kan fastholde deres sociale position, men havner i visse sociale klasser eller grupper.

En særlig teori lægger vægt på at en relativ lav placering i et klassehierarki i sig selv kan skabe sundhedsmæssig sårbarhed (2).

A causal-oriented approach stresses, for example, the inclusion of the following elements (3)

- the living conditions and living circumstances of people in different social groups or classes lead to different risks for the development of illness and health
- the lifestyle and health behaviour of people in different social groups lead to different risks
- social heritage reproduces class-specific living conditions, lifestyle etc. from one generation to the next
- different social groups are created through society's stratification or class divisions

En årsagsorienteret tilgang lægger f.eks. vægt på at følgende elementer inddrages (3)

- forskellige sociale gruppers eller klassers levekår og livsbetingelser giver forskellige risici for udvikling af sygdom og sundhed
- forskellige sociale gruppers eller klassers livsstil og sundhedsadfærd giver forskellige risici
- den sociale arv reproducerer de klassespecifikke levekår, livsstile m.m. fra en generation til en anden.
- de forskellige sociale grupper er skabt gennem samfundets lagdeling eller klasseinddeling

Another approach stresses the following levels in an overall explanation that particularly focuses on the lifetime perspective (4):

- accumulation. All kinds of factors that influence health accumulate during ones lifecourse – from parental socio-economic position, through childhood and adolescence and to the socio-economic position one attains as an adult. In addition, there is a tendency for adverse living conditions to accumulate among those who are worst off socially.
- social mobility. The socio-economic position of ones parents influences ones childhood. This also has an influence on ones position as an adult and for upward or downward social mobility, where additional health advantages or disadvantages can accumulate
- social protection. This relates to a type of self-perpetuating mechanism, in which previous socio-economic

En anden tilgang lægger vægt på følgende niveauer i en overordnet forklaring, der især fokuserer på et livsforløbsperspektiv (4):

- akkumulering. Allehånde helbredspåvirkninger ophobes gennem livsforløbet - fra forældrenes socioøkonomiske placering, gennem barndom og ungdom og til den voksne socioøkonomiske position. Desuden er der tendens til at forskelligt belastende livsomstændigheder ophobes blandt de socialt dårligst stillede
- social mobilitet. Forældrenes socioøkonomiske position har betydning for barndomslivet, der igen har betydning for placeringen i voksenlivet og for evt. opadgående eller nedadgående mobilitet, hvor yderligere sundhedsmæssige gevinster eller tab kan akkumuleres
- social beskyttelse. Her er tale om en art selvforstærkende mekanisme, hvor de tidligere socioøkonomiske betingelser –

conditions, and thus the accumulation of health advantages and disadvantages, determine the effect that new influences can have. For example, the probability that people with chronic illnesses are excluded from the labour market is greater for poor people than for rich people.

og dermed ophobningen og akkumuleringen af helbredsmæssige gevinster og tab – er bestemmende for hvilken effekt, nye påvirkninger måtte få. Eksempelvis er sandsynligheden for at kronisk syge bliver udstødt fra arbejdsmarkedet større blandt de dårligst stillede end blandt de bedst stillede .

Why should we be concerned about social differences?

There are several important reasons why we should be concerned about social differences in health and access to care, both from the point of view of research and monitoring.

First, social differences in health can mean that improvements in health status are delayed in the groups that have the poorest health status, or that improvements have taken place more quickly in the groups with the best health status. Analysis of social differences therefore provides an important contribution to the understanding of the processes that influence public health. Statistics that demonstrate social differences can also be used in determining health policy in the process of setting priorities and formulating goals. Just as comparisons of health status between countries can be used in such processes, comparisons between groups within a country can also be used.

Another important reason for identifying social differences in health and morbidity is that they often conflict with conceptions of an equitable distribution of goods. Thus the aim of reducing social

Hvorfor beskæftige sig med sociale forskelle

Der er flere grunde til at det er vigtigt at beskæftige sig med de sociale forskelle i sundhed og adgang til behandling både forskningsmæssigt og monitoreringsmæssigt.

For det første kan sociale forskelle i sundhed betyde, at udviklingen i sundhedstilstanden er forsinket i de grupper med den dårligste sundhedstilstand, eller at udviklingen har været hurtigere i grupperne med den bedste sundhedstilstand. Analyser af de sociale forskelle er derfor vigtige bidrag til i det hele taget at kunne forstå de processer, der påvirker folkesundheden. En statistik, der påviser de sociale forskelle, kan endvidere bruges som input i sundhedspolitiske prioriterings- og målsætningsprocesser. Helt på linie med at sammenligninger af hele nationers sundhedstilstand bruges i disse processer, kan sammenligninger mellem nationers sociale undergrupper anvendes.

En anden væsentlig grund til at belyse de sociale forskelle i sundhed og sygelighed, er at de ofte strider mod forestillinger om en retfærdig fordeling af forskellige goder. Derfor indgår mål om reduktion af social

inequalities is an important element in the national health programmes of the Nordic countries (5).

A particular reason for being concerned with equal access to care, is that it reflects whether health services are distributed according to needs in relation to illness and health problems, and thus whether there is a relationship between the social distribution of health services and the social distribution or accumulation of illness and health problems.

How are social differences in health and morbidity studied?

There are many different ways of studying and measuring social differences. Basically, the method involves estimating the prevalence of illness or the prevalence of health in different social classes, and then calculating the differences either between groups according to a social scale or over the whole scale.

First, the measurement will depend on the categories used to measure social class. The most usual methods of classification are according to education, income and occupation. Occupation can also be divided into economically active or not, or whether one is in the workforce or not. There is general agreement that education is the most robust measure. The most important arguments in its favour are the shortcomings of the other measures. The problem of using income is that there is a two-way causal relationship between health and income. Nor-

ulighed som vigtige elementer i de nordiske landes nationale sundhedsprogrammer (5).

Et specielt formål med at beskæftige sig med *Vård på lika villkor* er, at hermed udtrykkes hvorvidt fordelingen af sundhedsvæsenets ydelser sker i forhold til de behov i form af sygdom og helbredsproblemer, der er konstateret, og hermed om der er sammenhæng mellem den sociale fordeling af sundhedsvæsenets ydelser og den sociale fordeling eller ophobning af sygdom og sundhedsproblemer.

Hvordan undersøges sociale forskelle i sundhed og sygelighed?

Der er mange forskellige tilgange til at undersøge og beregne sociale forskelle. Basalt består metoden i at opgøre sygdomsforekomsten eller sundhedsforekomsten i de forskellige sociale klasser og derefter udregne et mål for forskellen enten mellem ydergrupperne i en social skala eller over hele skalaen.

For det første vil målingen afhænge af hvilken social klasse kategorisering, der anvendes. De oftest anvendte inddelinger er uddannelse, indkomst eller erhvervsmæssig stilling, hvor der endvidere også skelnes mellem om man er økonomisk aktiv eller ej, eller inkluderet i arbejdsstyrken eller ej. Der er generel enighed om, at uddannelse er det mest robuste mål. De væsentligste argumenter består i de andre måls mangler. Indkomst har den mangel, at der er en tovejs årsagssammenhæng mellem helbred og indkomst. Normalt vil en sammenhæng mel-

mally the interpretation of a relationship between income and health is that low income is the cause of illness or poor health and that high income is the cause of absence of illness and good health. But poor health can often lead to a reduction in income, for example if one has to take early retirement, or because one has to change occupation or job because of long-standing illness. If relatively small social differences in health are found in a community when differences are measured according to income, this can be interpreted that society redistributes income to groups with high levels of illness (sickness benefits, early-retirement pension etc.).

lem indkomst og helbred blive fortolket som om lav indkomst er årsag til sygdom eller dårlige helbredsforhold og høj indkomst årsag til sygdomsfravær og godt helbred. Men på den anden side vil dårligt helbred ofte betyde en reduceret indkomst, f.eks. hvis man bliver førtidspensionist, eller fordi man bliver nødt til at skifte erhverv eller stilling på grund af langvarig sygdom. At der i et samfund ses relativt små sociale forskelle i sundhed målt gennem indkomst kan derfor tages som udtryk for at samfundet omfordeler indkomst til de syge grupper (sygedagpenge, førtidspension m.m.).

The use of occupation as a measure of socio-economic status has the same problem. In a society in which many people are excluded from the labour market, there is a tendency for differences in health between occupational groups to be reduced, since sick people, particularly from the groups that are worst off and those with a low level of education, will have a much higher risk of being excluded than people with a high level of education.

Et tilsvarende problem gør sig gældende ved anvendelse af socioøkonomisk status eller erhvervsstilling. I en samfundsmæssig situation med høj grad af udstødelse fra arbejdsmarkedet vil der være en tendens til at helbredsforskellene mellem de erhvervsaktive grupper reduceres, idet de syge fra især de dårligst stillede grupper og de uuddannede grupper vil have en meget større risiko for at blive udstødt end personer med høj uddannelse.

Mackenbach & Kunst have reviewed the different methods of measuring social differences and evaluated the advantages and disadvantages of the different methods (6). In general, no measure can be regarded as ideal, but the different measures must be evaluated according to the specific purpose they are used for.

De forskellige måder at beregne størrelsen af de sociale forskelle er gennemgået af Mackenbach & Kunst (6), og deres fordele og ulemper vurderet. Generelt gælder, at intet mål kan betragtes som ideelt, men at de forskellige mål må vurderes ud fra det specifikke formål til hvilket de anvendes.

III. Nordic analyses of differences in health

By Niels Kr. Rasmussen

The following section presents results from analyses of social differences in mortality and health and morbidity, that have been carried out in order to compare the Nordic countries.

Social differences in mortality

In 1988 a report of analyses of differences in mortality according to occupational group in Denmark, Finland, Iceland, Norway and Sweden was published (1). Based on census data and material from Denmark, Finland, Norway and Sweden, and studies using merged register data in Iceland, social differences in mortality were identified. Mortality for employed men was highest in Finland and lowest in Sweden, and for employed women mortality was highest in Denmark and lowest in Norway. The study showed that there were significant differences in mortality between the 37 occupational groups that were included in the analyses in Denmark, Finland, Norway and Sweden. Even though there were some differences in the order of the different occupational groups with regard to mortality, the overall picture was that the same occupations had low or high mortality in the four countries.

No similar direct comparisons of the Nordic countries have been carried out since then. In some of the Nordic countries, analyses of differences in mortality according to occupational group have been carried out later.

III. Nordiske analyser af forskelle i sundhed

Af Niels Kr. Rasmussen

I det følgende vil der blive refereret resultater fra analyser af sociale forskelle m.h.t. dødelighed og helbred og sygelighed, som er foretaget så der kan foretages nordiske sammenligninger.

Sociale forskelle i dødelighed

I 1988 blev der offentliggjort en rapport med analyser af forskelle i dødelighed mellem erhvervsgrupper i Danmark, Finland, Island, Norge og Sverige (1). Med udgangspunkt i data og materialer fra folketællinger i Danmark, Finland, Norge og Sverige og i registerkoblingsstudier i Island kunne man belyse sociale dødelighedsforskelle. For erhvervsaktive mænd var dødeligheden størst i Finland og lavest i Sverige, og for erhvervsaktive kvinder var dødeligheden størst i Danmark og lavest i Norge. Undersøgelsen viste, at der var betragtelige dødelighedsforskelle mellem de 37 erhvervsgrupper, der indgik i analyserne i Danmark, Finland, Norge og Sverige. Selvom der var visse forskelle mellem landene i rangfølgen af de enkelte erhvervsgrupper m.h.t. dødelighed så var det overordnede billede at det var de samme erhverv der havde lav eller høj dødelighed i de 4 lande.

Der er ikke siden foretaget en lignende direkte sammenligning af de Nordiske lande. Der er i enkelte af de Nordiske lande senere foretaget analyser af de erhvervsmæssige forskelle i dødelighed.

Thus, in 2001 a Danish analysis of mortality in different occupational groups in the period 1981-95 was published (2). Corresponding analyses for the periods 1970-75 and 1970-80 were planned. Tables III.1 and 2 show the trend in mortalilty for men and women according to occupational group since 1970. Mortality is presented as an age-standardized index (SMR) with all men and all women in employment in 1970 as the standard. The occupational groups are characteristic of the prevailing groups in 1970-75. For men, mortality decreased in all the occupational groups during the period. The decrease was greatest for men in the following groups: other self-employed (other than agriculture), white-collar workers and skilled workers. There was also a decrease in mortaliy among non-skilled workers, but the decrease was much less than for the other groups, such that the difference between this group and the other groups has increased. There was also a decrease in mortality for women in general and for the different occupational groups, over the whole period. The decrease in mortality for women was less than for men.

Således blev der i 2001 offentliggjort en dansk analyse af dødeligheden i forskellige erhvervsgrupper i perioden 1981-95 (2). Der var tale om en opfølgning af tilsvarende analyser for perioderne 1970-75 og 1970-1980. I tabel III.1 og 2 vises hvorledes dødeligheden har udviklet sig for mænd og kvinder i erhverv siden 1970. Dødeligheden er vist som aldersstandardiserende indekstal (SMR) med alle mænd henholdsvis kvinder i erhverv i 1970 som standard. Inddelingen i erhvervsgrupper er præget af de grupper, der var fremherskende i 1970-75. For mændene er dødeligheden faldet for alle stillingsgrupper i perioden. Faldet har været størst for gruppen af selvstændige i øvrigt (uden for landbrug), for funktionærerne og for de faglærte. For de ikke-faglærte ses også et fald, men klart mindre end i de andre grupper, således at forskellen mellem de ikke-faglærte og de fleste andre grupper er øget. For kvinderne er der også sket et fald i dødeligheden generelt og i de enkelte erhvervsgrupper, når hele perioden vurderes. Faldet er mindre end hos mændene.

Table III.1 Mortality Index 1970–75, 1981–1995. Occupational Group. Men

	1970-75	1981-85	1986-90	1991-95
Employed persons, in total	100	95	89	78
Self-employed persons, in total	90	85	80	71
Self-employed persons, agriculture	67	67	63	55
Self-employed persons, other than agriculture	108	101	93	80
White-collar workers	95	85	79	70
Skilled workers	108	98	86	78
Non-skilled workers	110	112	108	97

Table III.2 Mortality Index 1970–75, 1981–1995. Occupational Group. Women

	1970-75	1981-85	1986-90	1991-95
Employed persons, in total	100	95	93	85
Self-employed persons, in total	114	105	105	96
Self-employed persons, agriculture	117	105	108	96
Assistant to spouse in total	87	77	82	72
Assistant to spouse, agriculture	74	62	69	60
Assistant to spouse, other than agriculture	100	92	97	86
White-collar workers	96	91	87	80
Skilled workers	100	100	86	88
Non-skilled workers	108	100	99	93

Several of the Nordic countries have participated in comparative European studies of social differences in mortality. One of the conclusions from these studies is that social differences in mortality in the Nordic countries are not smaller than in other European countries, and that it seems as though these differences are getting greater (3). The method that has been used to compare social differences in mortality between countries with very different mortality rates has been criticised. There is a tendency for social differences to appear to be relatively large in countries with low mortality rates (4).

Flere af de Nordiske lande har indgået i europæiske sammenlignende studier af sociale forskelle i dødelighed, hvor det bl.a. er konkluderet at størrelsen af de sociale forskelle i dødelighed i de nordiske lande ikke er mindre end i andre europæiske lande, og at der ses en tendens til øgning af de sociale forskelle i dødelighed (3). Der har været rejst en kritik af den teknik, der har været anvendt til sammenligning af de sociale forskelle i dødelighed mellem lande med et meget forskellig dødelighedsniveau. Der vil være en tendens til at de sociale forskelle vises som relativt større i de lande, hvor dødelighedsniveauet er lavt (4).

Social differences in health and morbidity

In a comparative study, social differences in self-assessed health and limiting longstanding illness were analyzed. The differences were analyzed seperately for men and women in relation to educational level, based on the data collected around 1995 (5). The pattern in the different Nordic countries is remarkably similar. In Finland, Denmark and Norway, 20-25 per cent of people with 13+ years combined school and professional education have limiting longstanding illness, whilst the proportion is 35-40 per cent among people with the shortest education. The general level is somewhat lower in Sweden, but the differences according to education are similar to the differences in the other countries. The pattern of differences in poor self-assessed health are the same for the three countries for which we have data.

An analysis of developments in social differences from the 1980s to the 1990s has been carried out, and when all the countries were analyzed together, the main conclusion was that differences according to occupational status and education were the same at the two points in time. However, in each country there were small differences between men and women with regard to social differences in health. In other words, during a period of deep economic recession and great increases in unemployment in Finland and Sweden, social differences in illness and health remained largely unchanged (6).

Sociale forskelle i helbred og sygelighed

I et nordisk sammenlignende studie blev de sociale forskelle i selvvurderet helbred og begrænsende langvarig sygdom analyseret. Forskellene blev analyseret særskilt for mænd og kvinder i forhold til uddannelsesmæssigt niveau med udgangspunkt i data indsamlet omkring 1995 (5). Det er markant så ensartet mønstret i de forskellige nordiske lande er. I Finland, Danmark og Norge er det 20-25 procent blandt dem med 13+ års kombineret skole- og erhvervsuddannelse, der har en begrænsende langvarig sygdom, medens det er 35-40 procent blandt dem med kortest uddannelse. Det generelle niveau er noget lavere i Sverige, men de uddannelsesmæssige forskelle ligner de øvrige landes forskelle. Mønstret i forskellene m.h.t. dårligt selvvurderet helbred er det samme for de tre lande, hvor der var tilgængelige data.

Der blev foretaget en analyse af udviklingen i de sociale forskelle fra 1980'erne til 1990'erne, og hovedkonklusionen var ved analyse af alle landene sammen, at forskelle m.h.t. beskæftigelsesstatus og uddannelse var den samme på de to undersøgelsestidspunkter. I de enkelte lande var der dog mindre ændringer blandt mænd og kvinder m.h.t. sociale forskelle i helbred. Det vil sige, at der i løbet af en periode med dyb økonomisk recession og stor stigning i arbejdsløsheden i Finland og Sverie, forblev de sociale forskelle i sygdom og helbred stort set uændrede (6).

IV. Socio-economic differences in use of specialist services in Nordic countries

By Alison McCallum

This chapter examines socio-economic differences in the use of specialist care in the five Nordic countries (Finland, Sweden, Denmark, Norway and Iceland). It includes socio-economic differences in investigations, specialist ambulatory and in-patient care, but excludes care by specialists in general practice. The indicators include income, education, occupation, and socio-economic status.

Findings

Studies were identified following a literature review and contact with experts in the Nordic countries. Population surveys and follow-up studies complement national and local register data. The findings are organized to reflect the movement of patients through the health care system. The chapter begins by examining socio-economic differences in specialist referrals and investigations. It then considers specialist ambulatory care, day case treatment, waiting times and in-patient care. Overall hospitalization rates, examples of common, serious conditions (ischaemic heart disease and cancer), and elective treatments (mainly surgical procedures), are examined separately. Finally, variations in treatment rates for children are considered.

IV. Socioekonomiska skillnader i användning av specialisttjänster i de nordiska länderna

Af Alison McCallum

I detta kapitel behandlas socioekonomiska skillnader i utnyttjande av specialistvård i de fem nordiska länderna (Finland, Sverige, Danmark, Norge och Island). Det omfattar också socioekonomiska skillnader när det gäller undersökning och specialiserad öppen- och institutionsvård. Däremot omfattas inte vård som ges av specialistläkare i allmän medicin. Indikatorerna inbegriper inkomst, utbildning, arbete och socioekonomisk status.

Resultat

Studier valdes ut på grundval av en litteraturöversikt och kontakter med experter i de nordiska länderna. Befolkningsundersökningar och uppföljningsstudier kompletterar nationella och lokala registerdata. Resultaten har organiserats så att de återspeglar förflyttningen av patienter i hälso- och sjukvårdssystemet. Kapitlet börjar med en granskning av de socioekonomiska skillnaderna i remitteringar till specialistläkare och i specialistundersökningar. Det omfattar specialiserad öppenvård, dagsjukvård, väntetider och institutionsvård. Övergripande intagningsfrekvenser, exempel på vanliga, allvarliga tillstånd (ischemisk hjärtsjukdom och cancer) samt elektiv vård (huvudsakligen kirurgiska behandlingar) granskas separat. I slutet av kapitlet granskas skillnader i behandlingsfrekvenser för barn.

Variations in the referral process: socio-economic differences in investigations

Few Nordic studies examine this aspect of care. One study found socio-economic differences in the follow up of 1 038 survivors (1 021 people) of out-of-hospital cardiac arrests in Gothenburg, Sweden from 1980 to 1996. Here, patients treated in the hospital that served a more disadvantaged area were less likely to receive electro physiological investigations or percutaneous transluminal coronary angioplasty (PTCA) (1).

Variationer i remitteringsprocessen: socioekonomiska skillnader i undersökning

I endast ett fåtal nordiska studier har man undersökt denna aspekt av vården. I en studie fastställdes socioekonomiska skillnader vid uppföljning av 1 038 överlevande (1 021 personer) som överlevt asystoli utanför sjukhus i Göteborg under perioden 1980–1996. Det konstaterades att det var mindre sannolikt att elektrofysiologiska undersökningar eller perkutan transluminal koronarangioplastik (PTCA)(1) gjordes på patienter som behandlades på ett sjukhus som hörde till ett mindre gynnat område.

Socio-economic differences in elective ambulatory care and day case treatment

There is no information about socio-economic differences in access to specialist ambulatory care in Iceland. Finland, Denmark, Sweden and Norway show similar patterns, but the size of the differences varies, reflecting the organization of health care.

An analysis of population surveys in several European countries, including Denmark and Finland, examined data on health service use, self-rated health and chronic conditions. Here, higher income groups made greater use of specialist ambulatory care (2). After adjusting for age, sex, self-rated health and chronic disease, Finland showed significant pro-rich bias in the use of specialist ambulatory care. In Finland, the relationship was much stronger for visits to private specialists; after

Socioekonomiska skillnader inom elektiv öppenvård och dagsjukvård

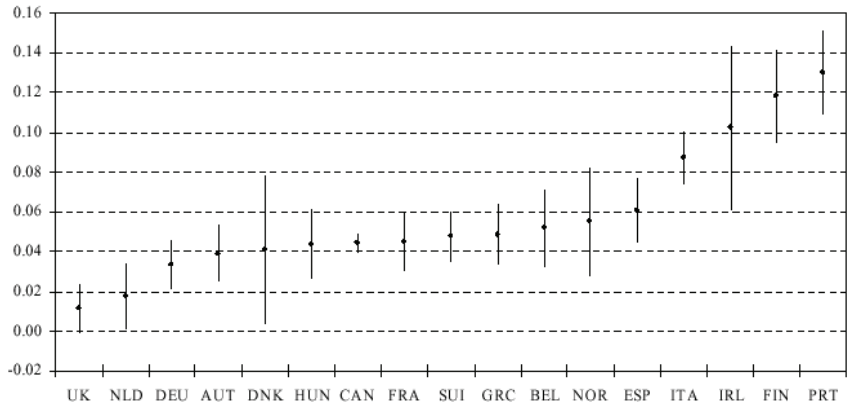
Det finns inga uppgifter om socioekonomiska skillnader i tillgång till specialiserad öppenvård på Island. I Finland, Danmark, Sverige och Norge kan man urskilja mönster som liknar varandra, men storleken på skillnaderna varierar och återspeglar organisationen av hälso- och sjukvården.

Vid analys av befolkningsundersökningar i många europeiska länder, inklusive Danmark och Finland, gick man igenom uppgifter om användning av hälso- och sjukvårdstjänster, egen bedömning av sitt eget hälsotillstånd och kroniska tillstånd. Högre inkomstgrupper utnyttjade specialiserad öppenvård mer (2). Efter korrigering för ålder, kön, egen bedömning av sitt eget hälsotillstånd och kroniska sjukdomar framgick för Finlands del att framför allt välbärgade använde specialiserad öppenvård. I

adjusting for age and chronic disease, the distribution of visits to specialists in the public sector was slightly pro-poor (3).

Finland var denna koppling mycket tydligare för besök hos privata specialister. Efter korrigering för ålder och kroniska sjukdomar var besök hos specialister inom den offentliga sektorn något vanligare bland mindre bemedlade (3).

Figure IV.1 HI indices for probability of a specialist visit, by country (with 95 per cent confidence interval)



Note: The HI measured is horizontal inequity - the concentration index of need-standardised use.
Source: Van Doorslaer, E., Masseria, C. et al. (2004), "Income-related inequality in the use of medical care in 21 OECD countries", OECD Health Working Papers No. 14. Also pub-lished as chapter 3 in OECD (2004), "Towards High-Performing Health Systems: Policy Studies", OECD Health Project series, Paris. Reprinted with permission.

Of the Nordic countries, Finland has the greatest pro-rich bias in specialist ambulatory care visits (4). Sources of these socio-economic differences include the size of co-payments, pro-rich distribution of workplace services that facilitate access to specialist care, and the large private ambulatory care sector. While the most important determinant of overall health service use among adults of working age is ill health, access to additional services increases utilization by more affluent groups. Income has a modest but detectable independent effect. Further analyses suggest pro-rich bias in access to specialist care in Denmark.

Bland de nordiska länderna är det vanligast i Finland att välbärgade besöker specialister i öppenvård (4). Orsaker till dessa socioekonomiska skillnader är storleken på patientavgifter, företagshälsovård som framför allt välbärgade har tillgång till och genom vilken det är enklare att få specialistvård, samt den stora privata öppenvårdssektorn. Medan den viktigaste bestämmande faktorn för utnyttjande av den allmänna hälso- och sjukvården bland vuxna i arbetsför ålder är ohälsa, resulterar tillgång till ytterligare tjänster i att mer välbärgade grupper börjar använda den mer. Inkomsten har en blygsam men påtaglig oberoende effekt. Noggranare analyser visar att det kan finnas bättre tillgång till specialister bland välbärgade i Danmark.

Denmark has two schemes designed to increase patient choice of providers: Group 2 insurance and the "free choice" scheme. Group 2 insurance entitles residents to an unlimited choice of general practitioner; they may also visit a specialist without referral from a general practitioner. Use of local primary care and necessary specialist services is free in Denmark, but the Group 2 scheme requires patient co-payments. "Free choice" allows patients to attend specialists or hospitals anywhere in the country but they must pay travel and associated costs. Although the proportion of the population exercising these rights is small (around 2 per cent), Group 2 insurance and "free choice" contribute to socio-economic differences in specialist care because use of these schemes is concentrated in the capital and among groups that are more affluent.

In the early 1990s, Group 2 insurance was more common among managers (35.1 per cent) than among unskilled workers (0.9 per cent) (5). Health service expenditure on specialist care among those covered by Group 2 in 1990 was higher: 167 per cent of that for the population covered by group 1. The percentage of insured persons who were in contact with a specialist during 1991 was twice as high for men (20.3 versus 10.2) and women (41.8 versus 21.3) with Group 2 compared to Group 1 insurance. There was some evidence that greater use of specialist care did not reflect morbidity; instead, those with Group 2 insurance visited specialists instead of their general practitioner. Area level analyses of the capital area also demonstrated increased use of specialist services by more affluent groups between 1988 and 1993. The incidence rate ratio

I Danmark finns det två system som syftar till att öka patientens valmöjligheter: Grupp 2-försäkringen och systemet med "fritt val". Grupp 2-försäkringen ger rätt att välja precis den allmänläkare man vill. Man kan också besöka en specialist utan remiss från en allmänläkare. Utnyttjande av lokal primärvård och nödvändiga specialisttjänster är kostnadsfritt i Danmark, men i Grupp 2-systemet krävs att patienterna betalar en del av avgifter. I systemet "fritt val" kan patienterna anlita specialister eller sjukhus i hela landet, men de måste själva betala resekostnader och motsvarande kostnader. Även om andelen av människor som utövar dessa rättigheter är liten (cirka 2 procent), bidrar Grupp 2-försäkringen och "fritt val" till socioekonomiska skillnader inom specialistvården, eftersom dessa system främst används i huvudstaden och av mer välbärgade grupper.

I början av 1990-talet var Grupp 2-försäkringen vanligare bland personer i ledande ställning (35,1 procent) än arbetstagare utan utbildning (0,9 procent) (5). År 1990 var hälso- och sjukvårdsavgiften för specialistvård högre för dem som omfattades av Grupp 2: 167 procent av avgiften för dem som omfattades av Grupp 1. Procenttalet försäkrade personer som besökte en specialist under 1991 var dubbelt så stort för män (20,3 mot 10,2) och kvinnor (41,8 mot 21,3) i Grupp 2 jämfört med Grupp 1. Det fanns tecken på att större utnyttjande av specialistvård inte återspeglade morbiditeten. De som omfattades av Grupp 2-försäkringen besökte specialister i stället för sina allmänläkare. Analyser på regionnivå i huvudstadsområdet visade också en ökad användning av specialisttjänster bland mer välbärgade grupper mellan 1988 och 1993. Incidensrelationen för att ha konsulterat

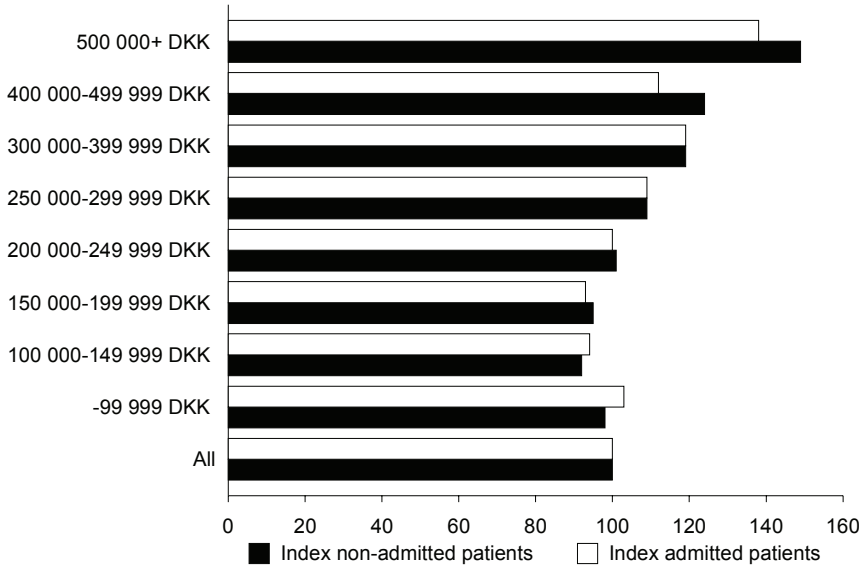
of consulting a specialist in the least affluent group of municipalities was 0.92, compared with 1.29 for general practice visits; 1.21 for somatic hospital discharges, 1.41 for stroke and 1.61 for arthroses (6).

en specialist var i de minst välbärgade kommungrupperna 0,92 jämfört med 1,29 för besök hos allmänläkare, 1,21 för utskrivningar från somatiska sjukhus, 1,41 för stroke och 1,61 för artros (6).

In 1996, utilization of the option to exercise free choice of specialist services for men and women aged 20-66 years was concentrated in the top two occupational groups, and the most educated (7).

År 1996 utnyttjades bland kvinnor och män i åldern 20–66 år möjligheten att fritt välja specialisttjänster främst av de två yrkesgrupper som förtjänade mest och av de högst utbildade (7).

Figure IV.2 Use of "free choice" for ambulatory and in-patient care among adults aged 20-66 years by income in 1996 (average =100).



The group with the highest level of education used “free choice” 33 per cent more than the general population. The gradient was even more striking for income. The threshold for use of “free choice” appeared to be an income of around DKK 250 000 per annum.

I gruppen med den högsta utbildningsnivån utnyttjades "fritt val" 33 procent mer än av befolkningen i allmänhet. Gradienten (den stigande tendensen) var ännu mer markant när man utgår från inkomstnivån. Gränsen för att utnyttja "fritt val" verkade vara en inkomst på cirka 250 000 danska kronor per år.

In Norway, 14 per cent of those with basic education, compared with 23 per cent of those with university education visited private specialists (8). In another study, the 1998 Survey of Living conditions was linked with municipal level data about health services (1999 -2000) and an index of the accessibility of specialist health care (9). The most important factors in having at least one specialist visit were poorer self-rated health and the presence of a chronic illness. However, populations with fewer general practitioners per 10 000 residents, and those with easier access to hospital physicians or private specialists, were more likely to visit a private specialist. Geographical variation in these factors is likely to contribute to pro-rich biases in accessing specialist ambulatory care by region.

Swedish data on socio-economic differences in use of outpatient services are available from analyses based on the Swedish Level of Living Survey, 1981 and 1991 (10). Socio-economic differences were modest although the same patterns emerge as in other countries. Aggregate and in-patient expenditure was greater in lower income groups but this effect was not significant by 1990. Spending on lower income groups, and their use of ambulatory care, was lower than expected in relation to need in 1980 and 1990. The authors attribute inequity in use of outpatient services to differences in the stage of disease at presentation and raise concerns about out of pocket costs.

I Norge besökte 14 procent av dem som hade grundutbildning privata specialister jämfört med 23 procent av dem som hade akademisk utbildning (8). I en annan studie kopplades undersökningen av levnadsförhållanden 1998 ihop med data på kommunnivå om hälso- och sjukvårdstjänster (1999–2000) och med ett index för tillgång till specialiserad hälso- och sjukvård (9). De viktigaste orsakerna till att ha besökt en specialist minst en gång var att man själv bedömt att hälsan försämrats samt kronisk sjukdom. Det var mer sannolikt att befolkning i områden med färre allmänläkare per 10 000 invånare och de som hade enklare att gå till sjukhusläkare eller privata specialister besökte en privat specialist. Geografisk variation i dessa faktorer bidrar sannolikt till att indelning efter region ger vid handen att främst välbärgade har tillgång till specialiserad öppenvård.

Svenska data om socioekonomiska skillander i användning av polikliniktjänster fås från analyser som grundar sig på Levnadsnivåundersökningen 1981 och 1991 (10). De socioekonomiska skillnaderna var små, även om man kan urskilja samma mönster som i andra länder. De totala kostnaderna och kostnaderna för institutionsvård var högre i lägre inkomstgrupper, men denna tendens var inte signifikant 1990. Satsningarna på lägre inkomstgrupper och de lägre inkomstgruppernas användning av öppenvård var mindre än väntat i relation till behoven 1980 och 1990. Enligt skribenterna beror ojämlikheter i användningen av polikliniktjänster på olika sjukdomsstadier vid besöket och de tar upp frågan om direkta kostnader (egenbetalning).

Variation in waiting times

A single-hospital study in Oslo in 1988 found that waiting times for elderly, disabled or unemployed people, or those with co-morbid disease, were shorter, 48 and 52 days respectively, compared with those who were employed (61- 73 days). In multivariate analyses, indicators of need and referral from another specialist, rather than from primary care, were associated with shorter waiting times. This study had a high non-response rate so its generalizeability is unclear (11).

In 1997, elective waits were generally longer for Danish women aged 20-66 years than for men. This occurred across several educational groups; women with vocational education were the exception, here there was no difference in waiting time between men and women (7). In the group with basic education, men waited longer than women did. Among men with higher levels of education – higher technical studies and university- there was a clear gradient. Those with the highest levels of education experienced the shortest waits. This is likely to reflect greater access to private specialists and membership of the Group 2 insurance category.

Skillnader i väntetider

I en studie av ett enda sjukhus i Oslo 1988 framgick det att väntetiderna för äldre, funktionshindrade eller arbetslösa personer, eller sådana som hade en komorbid sjukdom, var kortare (48 respektive 52 dagar) än för anställda (61–73 dagar). I multivariata analyser kunde man koppla både tecken på behov och remiss från en annan specialist snarare än från primärvården till kortare väntetider. Eftersom denna studie hade en låg svarsfrekvens, är dess allmängiltighet osäker (11).

År 1997 var de elektiva väntetiderna generelt längre för danska kvinnor i åldern 20–66 år än för män. Tendensen var den samma i flera utbildningsgrupper. Kvinnor med yrkesutbildning var dock ett undantag. I deras fall fanns det ingen skillnad i väntetiderna mellan kvinnor och män (7). I gruppen med grundutbildning hade män längre väntetider än kvinnor. Bland män med högre utbildning (högre teknisk och akademisk utbildning) var gradienten tydlig. De som var högst utbildade hade de kortaste väntetiderna. Detta berodde sannolikt på att de hade större tillgång till privata specialister och omfattades av Grupp 2-försäkringen.

Hospitalization rates

In most universal health care systems, hospital admission for urgent conditions occurs more frequently in lower socio-economic groups (12). In Finland, in 1988, the annual risk of hospital admission in men and women aged 25-64 was greater in lower socio-economic groups,

Intagningsfrekvens

I de flesta allmänna hälso- och sjukvårdssystem är intagning på sjukhus av akuta orsaker vanligare i lägre socioekonomiska grupper (12). År 1988 var den årliga risken bland finländska kvinnor och män i åldern 25–64 år att bli intagen på sjukhus större i lägre socioekonomiska grupper

after adjustment for age, hospital district, and education. This pattern was attenuated in those aged 60 years or over. When risk of death was added as a proxy measure of need, hospital use favoured the better off, but the absolute value of this difference was small. In Sweden, hospitalization rates during the same period - 1998/99 and 1996/97 - were compared. Here, the slight gradient in hospitalization that favoured lower income groups in 1988/89 was no longer present although the differences were not significant (13).

efter korrigering för ålder, sjukhusdistrikt och utbildning. Denna tendens minskade vid 60 år och över. När risken för dödsfall lades till som behovsorsak, gynnade användningen av sjukhustjänster de mer välbärgade. Det absoluta värdet av denna skillnad var dock litet. I Sverige jämfördes intagningsfrekvenserna under motsvarande period, nämligen 1998/99 och 1996/97. Där hade den ringa ökningen av intagningar, som fastställdes hos lägre inkomstgrupper 1988/89, försvunnit. Skillnaderna var dock osignifikanta (13).

The Norwegian Patient Register cannot be linked routinely with socio-economic data. SINTEF Helse compared use of hospital services with living conditions in Norwegian municipalities (14). Age and living conditions were associated with utilization of hospital services at municipal level. The accessibility of health services and the way they are organized reflects this variation. This suggests that publicly funded specialist services have adapted to reflect population health needs.

Det norska patientregistret kan inte rutinmässigt kopplas till socioekonomiska data. SINTEF Helse jämförde användningen av sjukhustjänster med levnadsförhållandena i norska kommuner (14). Ålder och levnadsförhållanden kopplades samman med användningen av sjukhustjänster på kommunnivå. Tillgången till hälso- och sjukvårdstjänster och det sätt på vilket de organiseras återspeglar denna variation. Detta ger vid handen att offentligt finansierade specialisttjänster har anpassats så att de svarar mot de hälsobehov befolkningen har.

In Iceland, hospitalization rates were significantly higher in those who were unemployed (16.6 per cent versus 8.7 per cent employed full-time) or in the lowest income group (14.1 per cent versus 8.4 per cent highest income group). Analysis by education showed a non-significant gradient (15).

På Island var intagningsfrekvenserna avsevärt högre bland arbetslösa (16,6 procent mot 8,7 procent för heltidsanställda) eller i de lägsta inkomstgrupperna (14,1 procent mot 8,4 procent för den högsta inkomstgruppen). Analys med utgångspunkt i utbildning visade en obetydlig gradient (15).

These studies of hospital use suggest that overall admission rates are higher among lower socio-economic groups. Urgent and elective treatments should be analyzed separately, however, to ensure that

Dessa studier av användning av sjukhustjänster ger vid handen att de övergripande intagningsfrekvenserna är högre i lägre socioekonomiska grupper. Akut eller elektiv vård bör analyseras separat

analysis of overall hospitalization rates does not mask variations in access to planned care.

Treatment for serious conditions

The next section examines socio-economic differences in treatment for two common causes of morbidity and mortality: myocardial infarction and breast cancer.

Myocardial infarction

In Denmark, the occupational gradient in admission for heart disease has widened since the early 1980s. Compared with a national level of 100, the standardized admission rate for upper white-collar workers declined from 80 to around 70. It rose slightly for skilled and unskilled workers, while for bus drivers it rose from 140 to over 180 (7). In a rural part of Sweden, the risk ratio for admission for first myocardial infarction among those aged 30-79 was lower for men born in the rural province 0.62 (0.57-0.67), self-employed farmers 0.67 (0.59-0.75) those with university education 0.67 (0.56-0.81), and increasing income (16). Similar relationships with education were found for women (although few women had university level education).

These higher rates of myocardial infarction in lower income and occupational groups do not translate into access to specialist investigation and revascularization (CABG - coronary artery bypass grafting and PTCA-percutaneous transluminal coronary angiography). All myocardial infarc-

för att säkerställa att analysen av de övergripande intagningsfrekvenserna inte döljer variationer i tillgången till planerad vård.

Behandling av allvarliga tillstånd

I detta avsnitt granskas socioekonomiska skillnader i behandling av två vanliga orsaker till morbiditet och dödlighet: hjärtinfarkt och bröstcancer.

Hjärtinfarkt

I Danmark har yrkesgradienten för intagning på grund av hjärtsjukdom ökat sedan början av 1980-talet. Jämfört med en nationell nivå på 100 har den normala intagningsfrekvensen för högre tjänstemän minskat från 80 till cirka 70. Den ökade lite för utbildade och outbildade arbetstagare, men för bussförare ökade den från 140 till över 180 (7). I ett landsbygdsområde i Sverige fastställde man att bland män i åldern 30–79 år var risken för att bli intagen för en första hjärtinfarkt lägre för män som var födda på landsbygden 0,62 (0,57–0,67), jordbrukare 0,67 (0,59–0,75), män med akademisk utbildning 0,67 (0,56–0,81) och män med stigande inkomster (16). Motsvarande kopplingar till utbildningen fanns bland kvinnor (även om få kvinnor hade akademisk utbildning).

Dessa högre frekvenser av hjärtinfarkt i grupper med lägre inkomster och lägre utbildning syns inte i tillgången till specialistundersökning och revaskularisering (CABG – kranskärlsoperation och PTCA – perkutan transluminal koronarangioplastik). Alla hjärtinfarkter hos personer i åldern

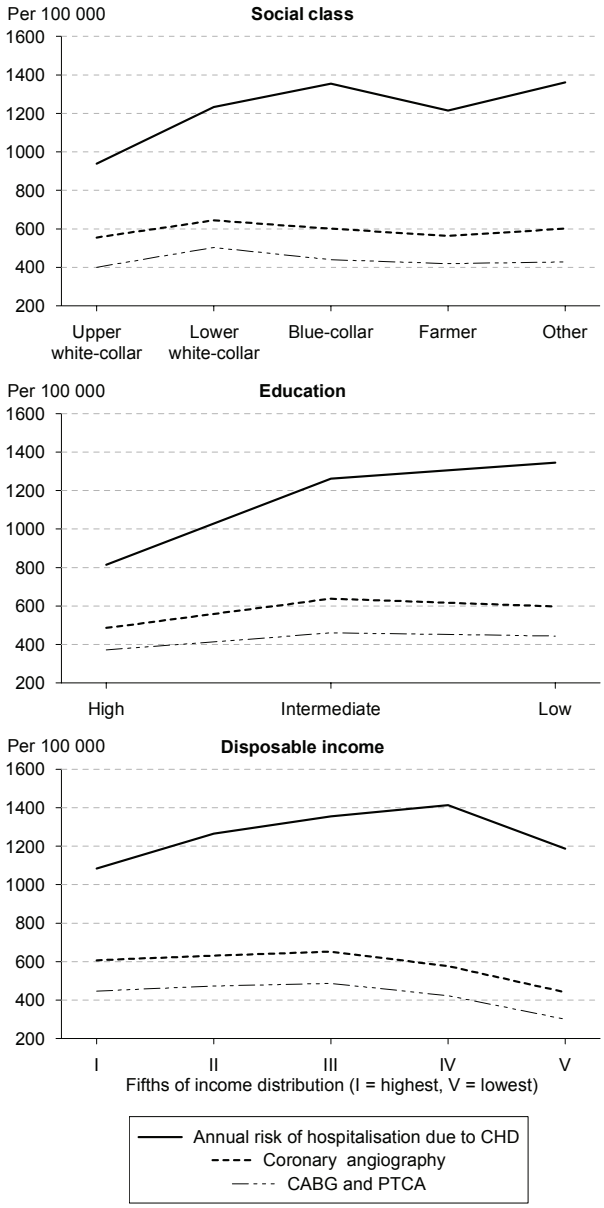
tions in people aged 35-64 years in three areas of Finland were linked with individual socio-economic data (17). Between 1988 and 1992, men from low-income groups were less likely to receive angiography within 28 days of their myocardial infarction (3.3 per cent in the low-income group versus 8.5 per cent in the high-income group) or revascularization within a year (10.2 per cent versus 20 per cent); this trend was not present for women. While men and women with low income were less likely to be treated in a specialist unit, this largely reflected urban/rural differences. Among urban residents, there were no income differences in the likelihood of treatment in a specialist unit.

National register studies confirm socioeconomic disparities in revascularization rates in men and women. Individual data on coronary procedures from the Finnish hospital discharge register in 1988 and 1996 were linked to national population censuses (18). Hospitalization and coronary heart disease mortality data provided approximate measures of need.

35–64 år i tre regioner i Finland kopplades ihop med individuella socioekonomiska data (17). Mellan 1988 och 1992 var det mindre sannolikt att män från lägre inkomstgrupper skulle få angioplastik inom 28 dagar efter sin hjärtinfarkt (3,3 procent i den lägre inkomstgruppen mot 8,5 procent i den högre inkomstgruppen) eller revaskularisering inom ett år (10,2 procent mot 20 procent). Denna tendens förkom inte bland kvinnor. Det var mindre sannolikt att kvinnor och män med låga inkomster skulle behandlas i en specialistenhet och detta återspeglade till stor del urbana och rurala skillnader. Det förekom inga inkomstskillnader mellan invånare i städer när det gäller sannolikheten för att få vård i en specialistenhet.

Nationella registerstudier bekräftar socioekonomiska skillnader i revaskuleringsfrekvenser för kvinnor och män. Individuella data om koronärbehandlingar från utskrivningsregistret i Finland 1988 och 1996 kopplades till nationella folkräkningsdata (18). Data om inskrivningar på sjukhus och om dödlighet för kranskärlssjukdom utgjorde ungefärliga mått för behovet.

Figure: IV.3 Age adjusted rates, annual risk of hospitalization due to coronary heart disease, coronary angiography, coronary artery bypass grafting (CABG) and percutaneous transluminal coronary angioplasty (PTCA) by social class, education, and disposable family income in men aged 40-69 in Finland in 1996



Source: Hetemaa T, Keskimäki I, Manderbacka K, Leyland AH, Koskinen S: How did the recent increase in the supply of coronary operations in finland affect socio-economic and gender equality in thir use? Journal of Epidemology and Community Health 2003; 57:178-185. Reprinted with permission.

Revascularization rates rose by approximately 2.5 fold between 1988 and 1996. Those in the lowest income group, however, underwent proportionately fewer procedures. In 1996, age-adjusted rates of coronary angiography and revascularization among men in the lowest income group were 441 and 301 per 100 000. This contrasts with revascularization rates of 607 and 447 per 100 000 among the highest income group. These treatment rates do not reflect mortality from coronary heart disease; this was 189 per 100 000 in the highest income group and 505 per 100 000 in the lowest.

Revaskularingseringsfrekvenserna blev uppskattningsvis 2,5 gånger större mellan 1988 och 1996. Proportionellt sett genomgick emellertid de som hörde till den lägsta inkomstgruppen färre behandlingar. År 1996 var de ålderskorrigerade frekvenserna för koronarangiografi och revaskularisering bland män i den lägsta inkomstgruppen 441 respektive 301 per 100 000. Detta står i kontrast till revaskulariseringsfrekvenser på 607 och 447 per 100 000 i den högsta inkomstgruppen. Dessa behandlingsfrekvenser visar inte dödligheten för koronär hjärtsjukdom. Denna var 189 per 100 000 i den högsta inkomstgruppen och 505 per 100 000 i den lägsta.

Breast cancer

Post-mortem only rates of cancer diagnoses are higher in lower socio-economic groups: 2.6 per cent in the highest versus 4 per cent in the lowest socio-economic group. This suggests disparities in access to care (19). In Malmö, Sweden, from 1986-1991, there were socio-economic differences in the stage that women aged over 45 years presented to breast cancer services (20). Individual-level data were limited but the ratio of more advanced: early breast cancer was higher in the four areas with lower average income and higher levels of unemployment. The relationship with education, however, was limited.

Socio-economic differences in the nature and quality of treatment between patients with apparently similar levels of need have also been reported (21). The Danish Breast Cancer Co-operative Group registers data from all women with breast cancer in Denmark. Data from women

Bröstcancer

Frekvenserna för cancerdiagnoser endast efter obduktion är högre i lägre socioekonomiska grupper: 2,6 procent i den högsta mot 4 procent i den lägsta socioekonomiska gruppen. Detta tyder på skillnader i tillgång till vård (19). I Malmö förelåg 1986–1991 socioekonomiska skillnader i det stadium när kvinnor över 45 år började använda bröstcancertjänster (20). Uppgifterna om den individuella nivån var begränsade utom när det gällde andelen av mer avancerad: bröstcancer i tidigt stadium var vanligare i fyra regioner med lägre medelinkomst och högre arbetslöshet. Kopplingen till utbildning var dock begränsad.

Socioekonomiska skillnader, när det gäller typ och kvalitet av behandling, mellan patienter med till synes motsvarande behovsnivåer har också rapporterats (21). Den danska bröstcancergruppen Danish Breast Cancer Co-operative Group registrerar data om alla kvinnor med bröst-

aged less than 75 years who were diagnosed with breast cancer between 1991 and 1996 were analyzed (22). This was complemented by a questionnaire survey, including information about social class. Although social class was not associated with stage at diagnosis, women in the highest social class were more likely to undergo lumpectomy, 77 per cent compared with 50 per cent of those in the lowest social class. Auvinen also reported differences in rates of curative surgery for colon cancer in Finland, 54 per cent in the highest social class compared with 44 per cent for the lowest (23).

cancer i Danmark. Data om kvinnor under 75 år, som fått diagnosen bröstcancer mellan 1991 och 1996, analyserades (22). Analysen kompletterades med en frågeenkät, inklusive information om sociala omständligheter. Även om social ställning inte kopplades samman med stadium vid diagnosen, var det mer sannolikt att kvinnor i den högsta sociala klassen genomgick lumpektomi: 77 procent mot 50 procent av dem som hörde till den lägsta sociala klassen. Auvinen rapporterade också skillnader i frekvenserna för kurativ kirurgi för koloncancer i Finland: 54 procent i den högsta sociala klassen mot 44 procent i den lägsta (23).

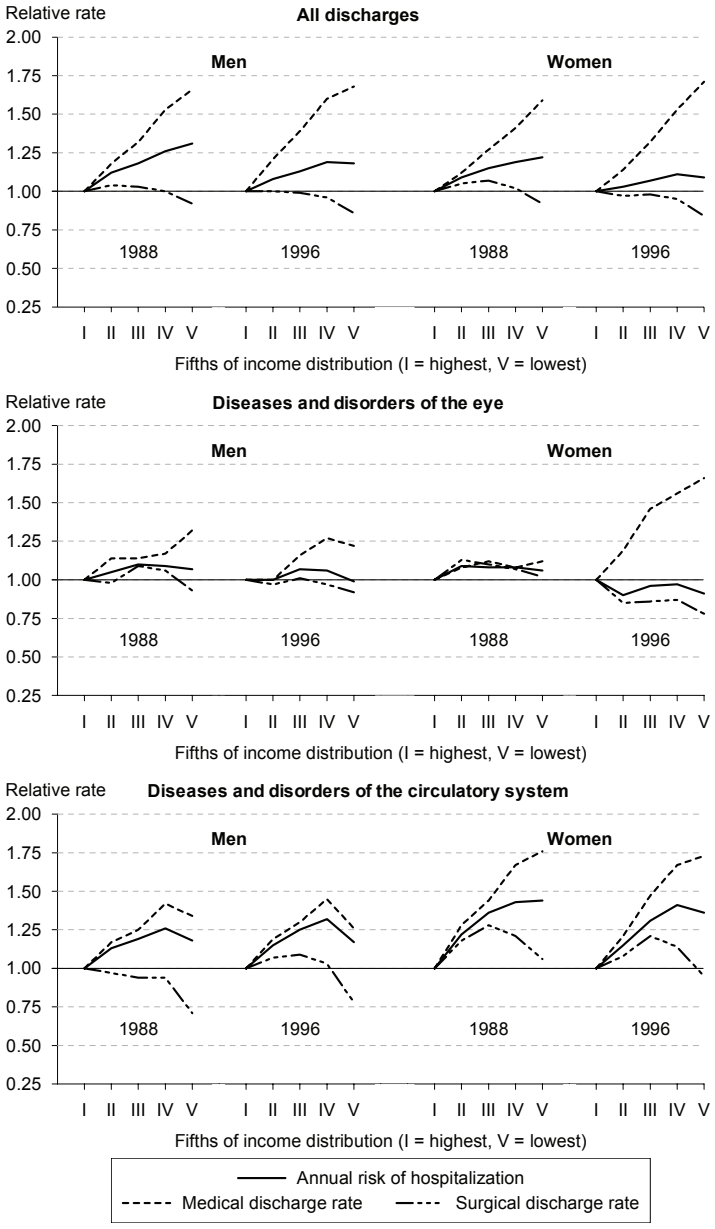
Elective surgery

Several Finnish studies that link individual data from national registers demonstrate continuing socio-economic disparities in rates of surgical treatment. Similar findings result from analyses employing complementary methods. In 1996, men and women in the lowest income group experienced surgical discharge rates that were 14 per cent and 16 per cent lower than those with the highest income were (24). In contrast, lower income groups have experienced more non-operative treatment. Examination of specific interventions indicates that income had a significant effect on rates of several surgical procedures in both sexes. These results may underestimate socio-economic differences, as they do not take account of relative need for intervention.

Elektiv kirurgi

Av många finländska studier, i vilka individuella data från nationella register kopplas samman, framgår att det fortfarande förekommer socioekonomiska skillnader i frekvenserna för kirurgisk behandling. Man har fått motsvarande resultat från analyser där kompletterande metoder använts. År 1996 var de kirurgiska utskrivningsfrekvenserna för kvinnor och män i den lägsta inkomstgruppen 16 procent respektive 14 procent lägre än för dem som hade den högsta inkomsten (24). I de lägre inkomstgrupperna fick man däremot mer icke-operativ behandling. Genomgång av särskilda ingrepp ger vid handen att inkomsten hade en betydande effekt på frekvenserna för många kirurgiska behandlingar i båda könsgrupperna. I dessa resultat underskattas eventuellt de socioekonomiska skillnaderna, eftersom det inte tas hänsyn till det relativa behovet av ingrepp.

Figure IV.4 Age-standardized relative annual risk of hospitalization and medical and surgical discharge rates for selected major diagnostic categories in the Nordic DRG system by fifths of income distribution, men and women aged 25–74 years in Finland in 1996



Source: Keskimäki I. How did Finland's economic recession in the early 1990s affect socio-economic equity in the use of hospital care? Social Science and Medicine 2003; 56: 1517-1530. Reprinted with permission.

Socio-economic differences in medical versus surgical treatments increased between 1988 and 1996. In men, this was most obvious for orthopaedic procedures, specifically second operations for hip replacement and lumbar discectomies. In women, hernia repair, cholecystectomy, hip and knee replacement were more frequent in lower income groups, although this was less marked in 1996 than 1988, suggesting that the distribution might be shifting.

De socioekonomiska skillnaderna mellan medicinska och kirurgiska behandlingar ökade mellan 1988 och 1996. Bland män var detta mest tydligt vid ortopediska behandlingar, särskilt den andra operationen i samband med höftoperation och lumbal diskektomi. Hos kvinnor var operation av bråck, kolekystektomi, höft- och knäoperationer mer vanliga i de lägre inkomstgrupperna, även om detta var mindre påfallande 1996 än 1988, vilket kanske beror på att fördelningen håller på att ändras.

Orthopaedic procedures

A complementary study examined socioeconomic and demographic determinants of public and private in-patient care for lumbar intervertebral disc disorders (LIDD) in Finland among men and women of working age (20-64 years) during 1996 (25). Individual data were linked with the 1995 census. Duration of unemployment was inversely associated with admission for LIDD (unemployed 12 months versus 0 months) rate ratio 0.66 (0.57-0.77) adjusting for age, sex, education and income. Admission for back disorders, however, was less common among the lowest than the highest income group: rate ratio 0.65 (0.57-0.77), after adjustment for education, occupation, age and sex.

Ortopediska behandlingar

I en kompletterande studie undersöktes socioekonomiska och demografiska bestämmande faktorer inom den offentliga och den privata institutionsvården vid problem med ländryggens mellankotskivor hos finländska kvinnor och män i arbetsför ålder (20–64 år) 1996 (25). Individuella data kopplades till folkräkningen 1995. Varaktigheten av arbetslöshet kopplades omvänt ihop med frekvensrelationen för vårdtillfällen av problem med ländryggens mellankotskivor (arbetslös 12 månader mot 0 månader), dvs. 0,66 (0,57–0,77) efter korrigering för ålder, kön, utbildning och inkomst. Vårdtillfällen av ryggproblem var dock mindre vanliga i den lägsta inkomstgruppen än i den högsta inkomstgruppen: frekvensrelation 0,65 (0,57–0,77), efter korrigering för utbildning, yrke, ålder och kön.

Gynaecological surgery

Finnish women have experienced high hysterectomy rates compared to the other Nordic countries; socio-economic patterning of treatment may be one ex-

Gynekologisk kirurgi

De finländska kvinnorna har haft höga hysterektomifrekvenser jämfört med kvinnorna i de andra nordiska länderna. Den socioekonomiska fördelningen av

planation. Socio-economic differences in hysterectomy rates in women aged 35 years and over were identified from analysis of the 1988 hospital discharge register and linked to individual census data on socio-economic status (26).

Hysterectomy rates rose with increasing income (from 19.4 to 37.6 per 100 000 for myoma) although there was no clear pattern by occupational group or education. Indications for hysterectomy varied by occupational group: prolapse and menstrual disorders were more common in farmers and manual workers while myoma was recorded more frequently among upper white-collar workers. The gradient in treatment rates was steeper when the proportion of operations provided in private hospitals and pay beds was examined; this group comprised 1 per cent and 18 per cent of operations respectively.

behandlingen kan vara en förklaring. De socioekonomiska skillnaderna i hysterektomifrekvenser för kvinnor i åldern 35 år och över fastställdes genom analys av utskrivningsregisteruppgifter från 1988 och kopplades till individuella folkräkningsdata om socioekonomisk ställning (26).

Hysterektomifrekvenserna ökade parallellt med stigande inkomster (från 19,4 till 37,6 per 100 000 for myoma), även om det inte fanns något tydligt mönster med hänsyn till yrkesgrupp eller utbildning. Indikationer på hysterektomi varierade mellan yrkesgrupperna: prolaps och menstruationsrubbningar var vanliga hos jordbrukare och kvinnor med fysiskt arbete, medan myom diagnostiserades oftare hos högre tjänstemän. Gradienten för behandlingsfrekvenser var större när andelen av operationer på privata sjukhus och sjukhussängar för privatpatienter vid offentliga sjukhus granskades. Denna grupp omfattade 1 procent respektive 18 procent av operationerna.

Maternal and children's care

The universal and comprehensive provision of maternal and children's services in the Nordic countries suggest that socio-economic differences in health care for these groups should be minimal. However, the pattern of specialist visits and hospitalization mirrors that of adults. A random sample of parents in Denmark, Finland, Iceland, Norway, and Sweden was mailed questionnaires on their children's use of health services in 1996 (29). Socio-economic status was classified by disposable income and parental educational level. Overall, use of specialist services (adjusted for age, sex, urbanization, health status and other socio-economic indicators) varied in-

Mödra- och barnavård

Man skulle tro att de socioekonomiska skillnaderna inom hälso- och sjukvård för mammor och barn skulle vara små till följd av det allmänna och övergripande tillhandahållandet av mödra- och barnavårdstjänster i de nordiska länderna. Mönstret för besök hos specialister och för intagning på sjukhus återspeglar emellertid de vuxnas. Till slumpmässigt utvalda föräldrar i Danmark, Finland, Island, Norge och Sverige sändes ett formulär med frågor om deras barns användning av hälso- och sjukvårdstjänster 1996 (29). Den socioekonomiska ställningen klassificerades efter disponibel inkomst och föräldrarnas utbildningsnivå. Allmänt sett varierade användningen av specialisttjänster (efter korriger-

versely with maternal education. The odds of using specialist services were 0.68 for children whose mothers had primary school education versus those with university education. For fathers with primary school education differences the picture across the countries was mixed and no longer significant after adjustment for other socio-economic factors. Similarly, the odds ratio for use of specialist services was 0.77 for those in the lowesr quartile of disposable income compared with the highest. This relationship was attenuated after adjustment for other measures of socio-economic status, 0R 0.85; although the gradient remains, the difference between income groups is no longer significant.

When the countries were examined individually, the variation in specialist service use by maternal education was greatest in Finland (0.34) although it was also significant for Denmark and Norway. Finland was the only country in which the odds of using specialist services were significantly lower in the lowest income group (0.56).

There are several Swedish studies of socio-economic disparities in children's use of specialist services for specific conditions such as infections, respiratory disease and accidents. In Stockholm County, socio-economic status was measured at area level and relative inequality indices were constructed for 1989 to 1998. The values varied from year to year but, overall, days in hospital per 1000 children were higher in the lowest socio-economic group compared with the highest: 1.13 to 2.14 for infections, 0.76 to 2.24 for asthma and allergic disorders, and 1.20 to 1.63 for accidents (28). Other studies confirm socio-economic differing för ålder, kön, urbanisering, hälsotillstånd och andra socioekonomiska indikatorer) omvänt i relation till moderns utbildning. Oddsen för att använda specialisttjänster var 0,68 för barn vars mödrar hade en primärskoleutbildning jämfört med dem som hade en akademisk utbildning. För fäder var skillnader mellan länder blandade och osignifikanta efter korrigering för socioekonomiska faktorer. Skillnaden när det gäller inkomster gick enligt samma mönster. Oddsen var 0,77 för dem i den lägsta kvartilen av disponibel inkomst jämfört med den högsta. Denna relation avmattades efter att andra dimensioner av socioekonomisk ställning togs i beaktande (OR 0,85). Även om grandienten kvarstod, var skillnader mellan inkomstgrupper inte länge signifikanta.

När länderna granskades vart och ett för sig, var variationen i användning av specialisttjänster efter mammans utbildning störst i Finland (0,34), även om den också var betydande i Danmark och Norge. Finland var enda landet där oddsen för att använda specialisttjänster var betydligt lägre i den lägsta inkomstgruppen (0,56).

Det har gjorts många svenska studier om socioekonomiska skillnader när det gäller barns användning av specialisttjänster vid t.ex. infektioner, luftvägssjukdomar och olycksfall. I Stockholms län mättes den socioekonomiska statusen på regionnivå och index för relativ ojämlikhet skapades för 1989–1998. Värdena varierade från år till år, men totalt sett var antalet sjukhusdagar per 1 000 barn högre i den lägsta socioekonomiska gruppen än i den högsta: 1,13–2,14 för infektioner, 0,76–2,24 för astma och allergier samt 1,20–1,63 för olycksfall (28). I andra studier bekräftas de socioekonomiska skillnaderna när det gäller intag-

ferences in hospitalization rates associated with injuries (29) and respiratory disorders (30), particularly asthma, where children whose mothers were receiving social welfare were more likely to be admitted, even after adjusting for maternal smoking and other socio-demographic factors (31).

Summary of findings

Nordic countries seem to provide urgent care to all population sub-groups. For publicly organized services, the most important factors affecting health service use are chronic disease and disability. The timeliness and appropriateness of this care, particularly hospitalization, is unclear. The socio-economic distribution of hospital admission may reflect the more limited opportunities to obtain specialist ambulatory care that some sections of the population experience.

It is clear, however, that variation in investigation and treatment rates for elective conditions reflects socio-economic status, particularly income, rather than need. This differential is a consequence of the interaction between differences in the ability of some groups to have their problems understood by doctors in primary care, variation in the availability of services, reflecting their concentration in specific geographical areas, and the ability of some groups to access additional services through workplace care, private insurance or specific schemes.

The positive relationship between increasing income and planned specialist care is particularly obvious in Finland and Den-

ningsfrekvenser i samband med skador (29) och luftvägsproblem (30). Detta gällde särskilt astma där sannolikheten för att barn vars mödrar får utkomststöd tas in på sjukhus var större även efter korrigering för att mammorna röker och andra sociodemografiska faktorer (31).

Sammanfattning av resultaten

I de nordiska länderna verkar man ge akut vård till alla subgrupper i befolkningen. När det gäller offentliga tjänster, är de viktigaste faktorerna som påverkar användningen av hälso- och sjukvårdstjänster kronisk sjukdom och funktionshinder. Det är oklart om denna vård, särskilt intagning på sjukhus, är lämplig och ges i rätt tid. Den socioekonomiska distributionen av intagning på sjukhus kan återspegla de mer begränsade möjligheterna för vissa befolkningsgrupper att få specialiserad öppenvård.

Däremot är det helt klart att variationen i undersöknings- och behandlingsfrekvenser för elektiva förhållanden återspeglar socioekonomisk status, särskilt inkomst, snarare än behov. Denna differens är en följd av interaktion mellan skillnaderna i vissa gruppers förmåga att få läkarna inom primärvården att förstå deras problem; i variationen i tillgång på tjänster, som återspeglar dess koncentration till specifika geografiska områden, och i vissa gruppers möjlighet att få tillgång till ytterligare service genom företagshälsovård, privat försäkring eller särskilda system.

Den positiva kopplingen mellan stigande inkomster och planerad specialistvård är särskilt tydlig i Finland och Danmark.

mark. Both of these countries have arrangements that facilitate direct access to specialists; in practice, utilization is concentrated among those in the highest socio-economic groups. This appears to reflect increased opportunities for investigation and treatment experienced when some parts of the population can access private, additional or more rapid care at less than full cost. The importance of income means that additional information steering is unlikely to change the pattern of health service use among those with lower levels of education: measures that are more proactive are necessary.

To determine the most appropriate responses in the various Nordic countries, detailed assessment of the underlying reasons for this phenomenon is required. This should include analysis of the variations in the patterns seen across the Nordic countries, and the contribution of the organization of the health care system.

Båda dessa länder har lösningar som underlättar direkt tillgång till specialister. I praktiken är användningen störst bland dem som hör till de högsta socioekonomiska grupperna. Detta verkar återspegla bättre möjligheter till undersökning och behandling, eftersom en del av befolkningen har tillgång till privat, kompletterande eller snabbare vård till lägre än fullt pris. Vikten av inkomster innebär att mer information sannolikt inte skulle ändra mönstret för användningen av hälso- och sjukvårdstjänster bland dem som har lägre utbildning. Det skulle krävas mer aktiva åtgärder.

För att slå fast vad som skulle vara den mest lämpliga responsen i de olika nordiska länderna, krävs en detaljerad utvärdering av de underliggande orsakerna till detta fenomen. Denna bör omfatta analys av variationer i de mönster som kan ses i hela Norden samt av det som ett organiserat hälso- och sjukvårdssystem medför.

V. Social differences in utilization of ambulatory care

By Bengt Haglund

The issue of whether ambulatory care is equally accessible is particularly important, since for most people ambulatory care is their primary contact with health services. If health services as a whole are to be equally accessible for the whole population, then primary contact with health services must of course be equally accessible to everyone.

A necessary prerequisite in order to be able to study health care from the perspective of equality is that data is available on need for treatment, utilization of services and social status. Access to data on ambulatory care

V. Sociala skillnader i utnyttjandet av öppen vård

Av Bengt Haglund

Frågan om den öppna vården är tillgänglig på lika villkor är särskilt viktig, eftersom öppenvården i de allra flesta fall är den primära kontakten med sjukvården. Om sjukvården som helhet skall kunna ha en möjlighet att verka på lika villkor för hela befolkningen, så måste naturligtvis den primära kontakten kunna ske på ett jämlikt sätt.

En viktig förutsättning för att kunna studera vården ur ett jämlikhetsperspektiv är att data finns om såväl vårdbehov som vårdutnyttjande och social ställning. Tillgången till hälsodataregister med uppgifter

from health data registers is inadequate in the Nordic countries. However, data from interview studies is available, that makes it possible to study utilization of ambulatory care. Interview studies in this area also have the advantage that they generally, in addition to the issue of utilization, include other issues relevant to whether health care is equally accessible.

However, a limitation of interview studies is that the need for health care has to be estimated on the basis of the interviewees' reported health, illness and handicap. Data for some medically defined diagnoses are not available.

Several possible indicators of social status are to be found in the Nordic interview studies on health and living conditions. The indicator that seems to be most appropriate for comparing the Nordic countries is education.

The present study aims to investigate whether utilization of ambulatory care is primarily governed by need, or whether patients' educational level influences their utilization of physician services. Another aim is to study the differences between men and women in relation to utilization of ambulatory care.

Material

In the Nordic countries – Denmark, Finland, Norway and Sweden – national interview surveys are carried out, that include questions on social conditions, health and utilization of health services. The organization and size of the surveys varies in the different countries, but they are similar enough to be suitable for a comparative Nordic study.

från den öppna vården är bristfällig i Norden. Däremot finns det intervjustudier som gör det möjligt att studera utnyttjade av öppen vård. Intervjustudier inom detta område har dessutom fördelen att de i allmänhet inte bara tar upp frågor om vårdutnyttjande, utan omfattar även andra frågor som är nödvändiga för att bedöma om vården sker på lika villkor.

En begränsning som vidlåder intervjustudier är dock att behovet av vård måste skattas utifrån intervjupersonens egna uppgifter om hälsa, sjukdomar och handikapp. Några medicinskt definierade diagnoser finns inte att tillgå.

Flera tänkbara indikatorer på social ställning finns i de nordiska intervjustudierna om hälsa och levnadsförhållanden. Den som förefaller vara mest lämpad för nordisk jämförelse är utbildningsnivå.

Föreliggande studie syftar till att undersöka om utnyttjandet av den öppna vården främst styrs av behov eller om även patientens utbildningsnivå påverkar möjligheterna till läkarvård. Ytterligare ett syfte är att studera skillnaderna mellan mäns och kvinnors utnyttjande av den öppna vården.

Material

I de nordiska länderna – Danmark, Finland, Norge och Sverige – genomförs nationella intervjustudier som bl a omfattar frågor om sociala förhållanden, hälsa och vårdutnyttjande. Studierna har olika uppläggningar och omfattningar, men är tillräckligt likartade för att lämpa sig för en jämförande nordisk studie.

The material is limited to people 25-74 years of age for whom data is available on use of health services, education and health.

Materialet begränsas till personer i åldrarna 25-74 år för vilka det finns uppgifter om vårdutnyttjande, utbildning och hälsa.

Denmark

The survey of health and diseases 2000 is the third general survey of health and disease carried out by the Danish National Institute of Public Health. The aim of the survey is, among other things, to describe the distribution of health and disease in the population and to provide a basis for research in this area.

The sample in the survey carried out in 2000 was considerably larger than in previous years, and comprised over 22 000 people, of which about 13 000 are in the age group included in this study. About 74 per cent of the people in the sample completed all or part of the interview.

Danmark

Sundheds- og sygelighedsundersøgelsen 2000 är den tredje generella undersökningen av hälsa och sjuklighet som Statens Institut for Folkesundhed genomför. Undersökningens syfte är bl a att beskriva hälsan och sjuklighetens fördelning i befolkningen samt att utgöra ett underlag för forskning inom detta område.

Urvalsstorleken var i 2000 års undersökning betydligt större än tidigare år och uppgick till totalt något mer än 22 000 personer, varav drygt 13 000 i de åldrar som denna studie omfattar. Drygt 74 procent av personerna i urvalet genomförde helt eller delvis intervjun.

Finland

Health 2000 was a survey that was carried out from the autumn of 2000 to the spring of 2001 in the whole of Finland. The Finnish National Public Health Institute had overall responsibility for the survey, but other organizations from the health and social sectors also took part. The people who were invited to participate in the survey were first interviewed at home. Six weeks later they had a comprehensive health examination.

The sample size was about 10 000 people. Complete or partial response was obtained from over 90 per cent. There are about 6 800 people in the relevant age groups for this study, with completed or partially completed interviews.

Finland

Hälsa 2000 var en undersökning, som genomfördes från hösten 2000 till våren 2001 i hela Finland. Folkhälsoinstitutet var huvudansvarigt för undersökningen, men också andra organisationer från social- och hälsosektorn deltog. De som inbjöds till undersökningen intervjuades först hemma. Efter en till sex veckor deltog de i en grundlig hälsoundersökning.

Urvalet omfattade närmare 10 000 personer. Helt eller delvis fick man svar från mer än 90 procent. I de aktuella åldersgrupperna för denna studie ingår drygt 6 800 personer med helt eller delvis kompletta intervjuer.

Norway

Statistics Norway carry out a survey of health and living conditions every few years. The last survey was in 2002. The sample included 10 000 people aged 16 years and older. The response rate was about 70 per cent, so that about 6 800 interviews were carried out in the relevant age groups.

Norge

I Norge genomför Statistisk sentralbyrå en Helse- og levekårsundersøkelse med några års mellanrum, senast under 2002. Urvalsstorleken var totalt 10 000 personer, 16 år och äldre. Cirka 70 procent deltog i studien. Materialet i de aktuella åldersgrupperna uppgår till cirka 6 800 intervjuer.

Sweden

Statistics Sweden carry out annual surveys of living conditions. The surveys have a schedule of recurring themes, of which health is one theme. However, certain central questions are included every year. The basic questions on health and utilization of health services are included in each survey.

The sample includes about 7 000 people each year. In order to have a large enough sample, this study has used data from 2000 and 2001. By doing this the number of people in the relevant age groups is nearly 9 000. For these years the response rate was about 80 per cent.

Sverige

I Sverige genomför Statistiska centralbyrån årliga undersökningar av levnadsförhållanden. Undersökningen har ett rullande schema med återkommande teman, varav hälsa är ett. Emellertid ställs vissa centrala frågor från varje tema alltid. De basala frågorna om hälsa och vårdutnyttjande tillhör de frågor som alltid förekommer.

Urvalet omfattar cirka 7 000 personer årligen. För att få tillräckligt stort material används i denna studie data från åren 2000 och 2001. Därmed uppgår materialet i de aktuella åldersgrupperna till närmare 9 000. Under de aktuella åren uppgick deltagandet till drygt 80 procent.

Method

In this study, utilization of health services is defined as whether one has recently visited the doctor because of one's own illness or injury. Unfortunately, different time periods are used in the Nordic surveys. In Finland and Norway, the question is whether one has visited the doctor during the last twelve months, in Denmark and Sweden the last three months.

Metod

Med vårdutnyttjande menas i denna studie att man besökt läkare för egen sjukdom eller skada under den senaste tiden. Dessvärre används olika tidsperioder i de nordiska undersökningarna. I Finland och Norge gäller frågan läkarbesök under de senaste tolv månaderna, medan man i Danmark och Sverige frågar om läkarbesök under de senaste tre månaderna.

Another important difference in methodology in the Nordic surveys is that in Denmark the question on utilization is about "contact with the doctor", whereas in the other countries the question is about a visit to the doctor. Contact with the doctor includes telephone consultations. Telephone consultations are so frequent that inclusion of them can influence the estimation of the proportion of the population that has had contact with the doctor during the last three months. Unfortunately, it is not possible with the available data to identify contact with the doctor that has only been by telephone.

En annan viktig skillnad mellan metoderna i de nordiska länderna är att man i Danmark efterfrågar "kontakt med läkare", medan övriga länder ställer frågor om läkarbesök. I läkarkontakt ingår bl a även telefonkonsultationer. Telefonkonsultationer är så vanliga att dessa kan komma att påverka beräkningen av hur stor andel av befolkningen som haft läkarkontakt under de senaste tre månaderna. Dessvärre är det inte möjligt att i tillgängliga data särskilja vilka som enbart har haft läkarkontakt via telefon.

In this study, education is classified into three groups according to the length of education: less than ten years education, 10-12 years education and 13 years education or more. Since compulsory schooling in Norway is 10 years, and pupils start school at the age of six, the categories for Norway are: less than eleven years education, 11-13 years education and 14 years education or more.

Utbildningen klassificeras i denna studie med hänsyn till utbildningens längd och sammanförs till tre grupper: mindre än 10 års utbildning, 10-12 års utbildning respektive 13 års utbildning eller mer. Eftersom den norska grundskolan omfattar tio år och eleverna börjar i sex års ålder så används i det norska materialet gränserna mindre än 11 års utbildning, 11-13 år respektive 14 år eller mera.

In order to assess whether differences in utilization of health services in the different educational groups reflect inequalities, the variables gender, age and health status are controlled for in the analyses. As a measure of health status, the answer to the following questions are used: 1) assessment of one's own health – very good, good, medium, poor, very poor, 2) presence of long-standing illness, and 3) whether ones ability to work or ones daily activities are reduced because of illness. Data from these three questions are summarized to give a measure of health. People with very good or good self-reported health and no long-standing illness are classified as having good health. People

För att kunna bedöma om skillnader i vårdutnyttjande mellan olika utbildningsgrupper är tecken på ojämlikhet innefattar analyserna även kön, ålder och hälsotillstånd. Som mått på hälsotillstånd används dels svaret på frågan hur man själv uppfattar sin hälsa – mycket god, god, någorlunda, dålig, mycket dålig – dels förekomsten av långvariga sjukdomar och om arbetsförmågan eller den dagliga aktiviteten är nedsatt på grund av sjukdom. I ett sammanfattande mått på hälsa bedöms personer med mycket god eller god hälsa och inga långvariga sjukdomar ha god hälsa. Personer som uppger att de har dålig eller mycket dålig hälsa, eller har minst tre långvariga sjuk-

with poor or very poor self-reported health, or at least three long-standing illnesses, or an illness that to a large degree influences their ability to work, are classified as having poor health. People who do not fall into these two categories are classified as having moderately reduced health.

Table V.1 presents data for the whole country for each of the Nordic countries, without standardization. The data used for Figure V.1 is age-adjusted and the data used for Figure V.2 is adjusted for gender and age with the population of Sweden as the standard. The multivariate anlayses used for Table V.2 and Figure V.3 are logistic regression analyses. Apart from education and gender, the following variables are possible confounders in the models: age, self-reported health, reduced ability to work and number of chronic illnesses.

domar, eller har en sjukdom som i hög grad påverkar arbetsförmågan bedöms däremot ha i hög grad nedsatt hälsa. De som inte tillhör någon av dessa två kategorier karakteriseras som personer med måttligt nedsatt hälsa.

I tabell V.1 presenteras riksrepresentativa data för respektive land, utan någon standardisering. Dataunderlaget till figur V.1 är åldersstandardiserad och till figur V.2 köns- och åldersstandardiserad med Sveriges befolkning år 2000 som standard. De multivariata analyserna som ligger till grund för tabell V.2 och figur V.3 är logistiska regressionsanalyser. Förutom utbildning och kön ingår ålder, självskattad hälsa, nedsatt arbetsförmåga och antal långvariga sjukdom som möjliga confounders i modellerna.

Table V.1 Percentage of the population who have visited the doctor at least once during the last twelve months (Finland and Norway) or during the last three months (Denmark and Sweden)

	Denmark		Sweden		Finland		Norway	
	Men (N=6 393)	Women (N=6 523)	Men (N=4 302)	Women (N=4 535)	Men (N=3 239)	Women (N=3 622)	Men (N=2736)	Women (N=2 671)
Age								
25-34 years	35.7	48.4	29.1	39.6	64.4	80.5	67.9	73.5
35-44 years	33.7	45.3	28.9	37.8	61.7	76.2	65.5	72.8
45-54 years	37.7	50.6	35.4	40.6	64.2	81.4	70.5	81.2
55-64 years	44.9	52.1	39.1	47.1	70.2	78.3	79.0	82.9
65-74 years	53.9	58.1	47.1	50.5	76.0	82.7	81.1	83.8
Education								
<10 years education	42.9	53.7	37.6	46.5	67.3	78.6	78.9	82.7
10-12 years education	40.6	53.1	35.6	42.6	66.6	80.6	72.3	77.6
13 years education or more	38.1	47.6	31.8	40.1	64.0	80.0	67.5	76.9
Health								
Good health	28.4	37.8	20.7	25.8	56.6	72.6	62.1	69.5
Moderately reduced health	46.9	58.2	41.9	49.8	68.4	81.5	82.3	85.1
Poor health	71.6	79.5	65.9	68.3	82.1	90.6	92.0	96.3
Total	39.7	50.1	34.8	42.5	66.1	79.7	71.5	78.0

Results

In all the countries, women visited the doctor more than men. In addition, as expected, there was a clear relationship between health and utilization of health services. Apart from in the youngest age group, utilization of health services increased with increasing age for both men and women. Another common feature is that utilization of health services decreased with increasing educational level, with the exception of Finnish women (Table V.1).

There are also some differences between the countries. The most obvious difference is that the proportion of the population that has visited the doctor at least once is significantly greater in Finland and Norway than in Sweden and Denmark. However, this reflects the fact that the data for Finland and Norway are for a twelve-month period, while the data for Denmark and Sweden cover a three-month period. The comparable data for a visit to the doctor during the last three months show that it is more common to visit the doctor in Denmark than in Sweden. The corresponding figures for a twelve-month period show that the proportion in Norway is higher than in Finland.

The somewhat higher utilization among people with low education compared to high education may reflect differences in morbidity. Many studies have shown that health varies according to social conditions (1-3). The data that have been analyzed in this study show a similar relationship (Figure V.1). Those with low education reported poorer health than

Resultat

För alla länder gäller att kvinnorna besökte läkare i större utsträckning än män. Vidare finns – vad man rimligen kan förvänta sig – ett tydligt samband mellan hälsa och vårdutnyttjande. Bortsett från den yngsta åldersgruppen så ökar hela tiden vårdutnyttjandet med stigande ålder, för såväl män som kvinnor. Ett gemensamt drag är även att vårdutnyttjandet minskar med ökande utbildningsnivå. Det senare gäller dock inte de finska kvinnorna (Tabell V.1).

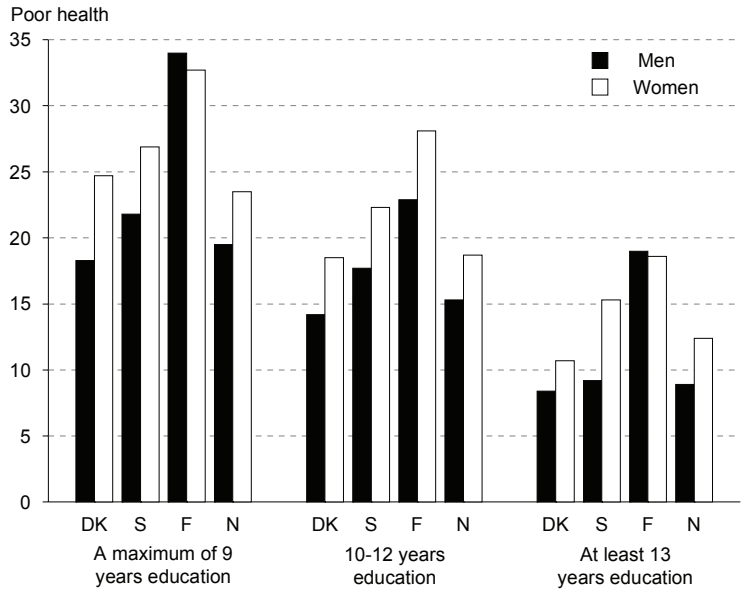
Det finns även vissa skillnader mellan länderna. Det mest iögonenfallande är att andelen i befolkningen med minst ett läkarbesök var betydligt större i Finland och Norge än i Danmark och Sverige, vilket alltså beror på att de finska och norska uppgifterna gäller en tolvmånadersperiod medan man i Danmark och Sverige frågar efter läkarbesök under en tremånadersperiod. De jämförbara siffrorna för läkarbesök inom en tremånadersperiod visar att det är vanligare att besöka läkare i Danmark än i Sverige. Motsvarande jämförelse för tolvmånadersperiod ger de högst värdena för Norge jämfört med Finland.

Det något högre vårdutnyttjandet bland personer med låg utbildning i jämförelse med högutbildade kan bero på skillnader i sjuklighet. Att hälsan varierar med sociala förhållanden har visats i många sammanhang (1-3). Även i de data som här analyseras finns motsvarande samband (Figur V.1). De med låg utbildning rapporterar sämre hälsa än de med hög ut-

those with high education. A similar ranking is to be found in the different countries for the three educational groups. The highest proportion of people who report poor health is in Finland, Sweden comes next in line, and Norway and Denmark have the lowest proportion that reports poor health. Women report poorer health than men, with the exception of in Finland. There are really no gender differences in self-reported health for people with high education and low education in Finland.

bildning. En likartad rangordning mellan länderna finns i de tre utbildningsgrupperna: Sämst hälsa rapporteras från Finland och därefter kommer Sverige, medan Norge och Danmark har den lägsta andelen som uppger dålig hälsa. Kvinnorna rapporterar sämre hälsa än männen, dock utgör Finland även här ett undantag. För lågutbildade och högutbildade i Finland finns det strängt taget ingen skillnad mellan män och kvinnor i rapporterad ohälsa.

Figure V.1 Percentage of people with poor health, according to education, country and gender



Since there is a relationship between high education and better health, the data presented here indicate that health services are equally accessible in the Nordic countries. However, behind the pattern of increasing utilization of health services with poorer health, inequalities may be hidden. The

Eftersom hög utbildning är förenad med bättre hälsa så talar de hittills presenterade uppgifterna för att de nordiska länderna har en vård på lika villkor. Bakom mönstret med stigande vårdutnyttjande med försämrad hälsa kan det dock döljas ojämlikheter. En första stratifierad analys

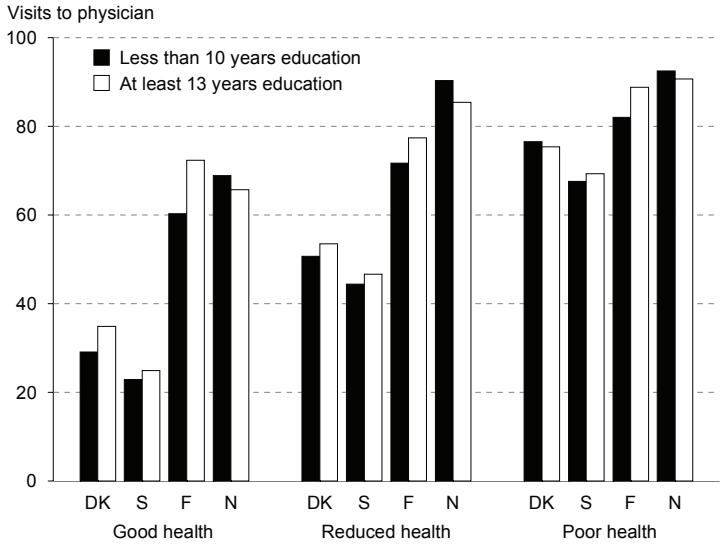
first stratified analysis carried out indicates that the differences in Norway are very small, and the small differences that have been found indicate a slightly higher utilization rate among people with low education. In the other three countries the proportion of those who have visited the doctor is almost always higher for those with low education independent of health status (Figure V.2). The opposite situation is only to be found among those with poor self-reported health in Denmark. In addition, the figure shows that the importance of whether the question about visiting the doctor refers to the last three months or the last twelve months gets less with poorer health.

In order to demonstrate clearly a possible relationship between education, health and utilization of health services, the stratified analysis was limited to two educational levels, standardized for gender and age. Regression analysis of the material confirms the impression gained from the stratified analysis. There is no evidence for inequality in utilization of health services in Norway, while the situation for people with low education compared to people with high education is slightly unfavourable in the other three countries, for both men and women (Table V. 2). Also, the middle group, that is those with 10-12 years education, lie between the low and high education groups with regard to utilization of ambulatory care. However, compared to those with high education, this difference in most cases is not statistically significant. Finnish women differ somewhat from this pattern. Finnish women in the two highest educational groups have the same level of utilization of health services.

visar att i Norge är skillnaderna mycket små och de små skillnader som finns tyder på ett något högre vårdutnyttjande bland de lågutbildade. För övriga tre länder så gäller att bland de högutbildade så har nästan genomgående en större andel än lågutbildade besökt läkare oberoende av hälsotillstånd (Figur V.2). Endast bland dem som rapporterar dålig hälsa i Danmark finns det omvända förhållandet. Av figuren framgår vidare att betydelsen av huruvida frågan om läkarbesök gäller tre eller tolv månader minskar med försämrat hälsotillstånd.

För att överskådligt visa på möjliga samband mellan utbildning, hälsa och vårdutnyttjande begränsades den stratifierade analysen till två utbildningsnivåer med köns- och åldersstandardiserade uppgifter. Regressionsanalysen av materialet bekräftar intrycket från den stratifierade analysen. Det finns inga belägg för ojämlikt vårdutnyttjande i Norge, medan lågutbildade missgynnas något i övriga tre länder i förhållande till högutbildade, både bland män och kvinnor (Tabell V.2). Mellangruppen, de med 10 – 12 års utbildning, ligger mellan låg- och högutbildade även när det gäller utnyttjande av den öppna vården. I jämförelse med de högutbildade är dock denna skillnad i de flesta fall inte statistiskt säkerställd. Finska kvinnor avviker något från mönstret genom att de två högre utbildningsnivåerna har samma vårdutnyttjande.

Figure V.2 Percentage of people who have visited the doctor, according to health, country and education



Women's higher utilization of health services is demonstrated even more clearly with the regression analysis. The odds for women having visited the doctor are 1.3 to 2 times higher than the odds for men (Table V.2). According to this analysis, the greatest difference between men and women in utilization of ambulatory care is to be found in Finland. The odds ratio is often interpreted as relative risk, but one must be aware that such an interpretation cannot be made in this context, since the proportion of men who have visited the doctor ranges from 0.35 (Sweden) to 0.72 (Norway). A calculation of relative risk requires that one can compare women's utilization of health services with a common hypothetical level for men. Thus according to the analysis presented in Table V.2, we can calculate that the probability for a woman having visited the doctor is 1.3 (Denmark), 1.2 (Sweden) or 1.5 (Finland) times greater than men, if the probability for a man visiting the doctor is assumed to be 0.35.

Kvinnors högre vårdutnyttjande framgår även tydligt av regressionsanalysen med odds för att ha gjort ett läkarbesök som är 1,3 till 2 gånger högre än männens odds (Tabell V.2). Största skillnaden mellan män och kvinnor i utnyttjandet av den öppna vården finns enligt denna analys i Finland. Oddskvoter tolkas ofta som relativa risker, men man bör vara medveten om att en sådan tolkning inte låter sig göras i detta sammanhang, eftersom andelen som besökt läkare bland männen varierar totalt sett mellan 0,35 (Sverige) och 0,72 (Norge). En omräkning till relativa risker kräver att man jämför kvinnornas vårdutnyttjande med en gemensam hypotetisk nivå för männen. Vi kan således enligt den analys som framgår av tabell V.2 beräkna att sannolikheten för att en kvinna gjort ett läkarbesök är 1,3 (Danmark), 1,2 (Sverige) respektive 1,5 (Finland) gånger större än män, om sannolikheten för att män skall besöka läkare antas vara 0,35.

Table V.2 Relative utilization of health care expressed as odds ratio with 95 per cent confidence interval

	Men		Women	
	OR	95 per cent CI	OR	95 per cent CI
Denmark				
<10 years education	0.83	0.71 – 0.97	0.72	0.62 – 0.83
10-12 years education	0.85	0.75 – 0.96	0.95	0.84 – 1.08
13 years education or more	1.00		1.00	
Gender	1.00		1.48	1.36 – 1.61
Sweden				
<10 years education	0.81	0.66 – 0.99	0.80	0.66 – 0.97
10-12 years education	0.95	0.81 – 1.11	0.95	0.82 – 1.09
13 years education or more	1.00		1.00	
Gender	1.00		1.30	1.18 – 1.44
Finland				
<10 years education	0.81	0.64 – 1.01	0.67	0.53 – 0.93
10-12 years education	0.94	0.76 – 1.16	1.02	0.81 – 1.28
13 years education or more	1.00		1.00	
Gender	1.00		2.06	1.82 – 2.33
Norway				
<10 years education	1.20	0.89 – 1.64	0.81	0.58 – 1.12
10-12 years education	1.12	0.93 – 1.35	0.85	0.69 – 1.05
13 years education or more	1.00		1.00	
Gender	1.00		1.26	1.08 – 1.47

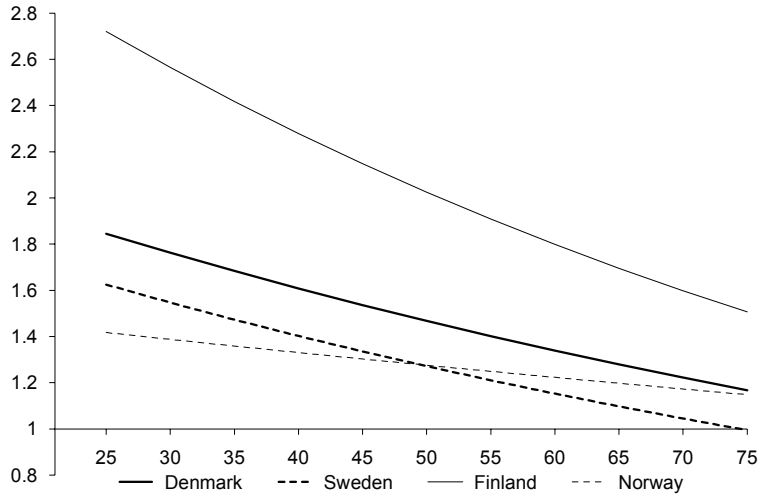
The analyses that form the basis for Table V.2 are based on the assumption that the odds ratio for a visit to the doctor for women and men is the same, irrespective of, for example, education, health status and age. For both men and women the illness panorama changes with increasing age. In addition, it is reasonable to suppose that people's inclination to seek health care also changes with age.

The differences in utilization between men and women decrease with increasing age in all countries. The curves for Denmark and Sweden are almost parallel, while the curve for Finland is steeper and the curve for Norway is less steep.

De analyser som ligger till grund för tabell V.2 bygger på antagande att kvoten mellan oddset för läkarbesök för kvinnor respektive män är lika oavsett exempelvis utbildning, hälsotillstånd och ålder. För såväl män som kvinnor förändras sjukdomspanoramat med stigande ålder. Vidare är det rimligt att tänka sig att benägenheten att söka vård även förändras med ålder.

I alla länderna så minskar skillnaden i vårdutnyttjande mellan män och kvinnor med stigande ålder. Kurvorna avseende Danmark och Sverige är i det närmaste helt parallella, medan den finska kurvan går brantare och norska flackare.

Figure V.3 Utilization of health care for women in relation to men (OR), according to age and country



Discussion

The comparability of the data from interview surveys of health and living conditions in the Nordic countries is assessed as being adequate for the purpose of compiling the results in a common study. However, it should be noted that differences in the formulation of the questions may influence the results. In addition, there are certainly differences between the Nordic countries in how individuals assess their own health and their ability to work. This may also influence the results of this study.

The most important difference between the Nordic studies relates to the question about visiting the doctor. In Finland and Norway the question refers to the last year, while in Denmark and Sweden it refers to the last three months. This dif-

Diskussion

De nordiska ländernas intervjuundersökningar om hälsa och levnadsförhållanden bedöms vara tillräckligt likartade för att resultaten skall kunna sammanställas i en gemensam studie. Det bör dock observeras att det naturligtvis förekommer skillnader i frågeformulärens utformning som kan påverka resultaten. Vidare finns säkerligen skillnader mellan de nordiska länderna i hur individer bedömer sin hälsa och arbetsförmåga, vilket också kan påverka resultatet av denna studie.

Den vikigaste skillnaden mellan de nordiska studierna gäller frågan om läkarbesök, där man i Finland och Norge frågar om besök under det senaste året, medan frågan i Danmark och Sverige gäller de senaste tre månaderna. Denna skill-

ference obviously makes it impossible to compare correctly how often people visit the doctor in the different countries. However, for the purpose of this study, it is more important that this difference does not influence the interpetation of the question about whether there are social inequalities in access to health care.

nad gör det självfallet omöjligt att på ett rättvisande sätt jämföra hur vanligt det är att besöka läkare i de olika länderna. För denna studie är det dock viktigare att denna skillnad inte påverkar bedömningen av frågan om det finns sociala skillnader i vårdutnyttjandet.

During a twelve-month period, a large proportion of the population visit the doctor at least once. In the Finnish and Norwegian material, three-quarters of the population had visited the doctor on average. The differences in utilization of health services are most clearly observed across a short time period, since relatively small proportions of the population are likely to visit the doctor. A true comparison should therefore be limited to countries in which the formulation of the question is identical. Thus in a twelve-month perspective this study provides no evidence for inequalities in utilization of health services in Norway, but it does provide evidence for inequalities in Finland. However, this study cannot provide the answer to the question of whether utilization of health services is more equitable in Norway than in Sweden and Denmark.

Under en tolvmånadersperiod kommer en stor del av befolkningen att ha gjort minst ett läkarbesök. I genomsnitt i det norska och finska materialet hade tre fjärdedelar besökt läkare. Skillnader i vårdutnyttjande framträder tydligast under en relativt kort observationsperiod eftersom en relativt liten andel av befolkningen sökt läkarvård. En rättvisande jämförelse bör således begränsas till länder där frågan om läkarbesök är lika formulerad. Man kan således konstatera att i ett tolvmånadersperspektiv så ger denna studie inga belägg för ojämlikhet i vårdutnyttjande i Norge, men väl i Finland. Frågan om vården är mer jämlik i Norge än i Sverige och Danmark kan dock denna studie inte besvara.

The Danish data include telephone consultations as a form of contact with the doctor. In order to obtain better comparability with the other countries, the analysis should have been confined to visits to the doctor. This was not possible using the existing data. If it is more usual for people with higher education than people with lower education to contact the doctor by telephone – which is a reasonable assumption – then inequalities in utilization of health services for Denmark have been slightly overestimated in this analysis.

I danska data ingår telefonkonsultationer som en möjlig form av läkarkontakt. För att få en bättre jämförbarhet med övriga länder så borde analysen begränsas till läkarbesök, vilket dock inte är möjligt med tillgängliga data. Om det är vanligare att enbart ha konsulterat läkare via telefon bland högutbildade än bland lågutbildade – vilket är ett rimligt antagande – så är den danska ojämlikheten i vårdutnyttjandet något överskattad i denna analys.

In all four countries, women utilize health services more than men. This difference is still present when differences in health between men and women are controlled for. This difference is not unique for the Nordic countries, and many different explanations have been suggested, including biological, social and cultural differences between men and women. From a health political point of view – as concluded by Gissler (4) based on a review of gender differences in health – it is important to be aware that mortality and the level of social problems is higher among men and that morbidity and the level of poor self-reported health is higher among women. Perhaps the most likely explanation for higher levels of utilization among women is related to health care for women in connection with pregnancy and child-birth. But even gender-specific diseases contribute to women seeking more health care than men. A Dutch study (5) has shown that the proportion of diagnoses in ambulatory care for men that is gender-specific is 2 per cent, while for women aged 15-24 the proportion is almost 12 per cent, decreasing with increasing age. Thus, the reduction in the differences in utilization of health services between women and men with increasing age may be dependent on an increasingly lower contribution from gender-specific diseases. Another possible explanation is that the risk of serious illness increases with increasing age, which in turn may reduce any differences in people's inclination to seek health care (6).

In Finland studies have just recently been started on utilization of ambulatory care, so no publications are available yet which can be used to compare the results of this study. A recently published Norwegian study, based on data other than that which has been used in this study, concluded

I alla fyra länderna utnyttjar kvinnorna vården i högre grad än männen. Denna skillnad kvarstår trots att analysen tar hänsyn till skillnader i hälsa mellan män och kvinnor. Detta är inte unikt för Norden och en rad olika förklaringar har framförts som innefattar både biologiska, sociala och kulturella skillnader mellan män och kvinnor. Ur hälsopolitisk synvinkel – konkluderar Gissler (4) utifrån en översikt över könsskillnader i hälsa – är det viktigt att uppmärksamma högre mortalitet och mer sociala problem bland män och mer sjuklighet och sämre självrapporterad hälsa bland kvinnor. Den kanske mest närliggande förklaringen till högre vårdutnyttjande bland kvinnor utgår från kvinnors vård i samband med graviditet och förlossning, men även könsspecifika sjukdomar medverkar till att kvinnor söker mer vård än män. En holländsk studie (5) har visat att cirka två procent av diagnoserna i öppen vård bland män är könsspecifika, medan kvinnornas andel i åldern 15 – 24 år är närmare 12 procent och minskar sedan med stigande ålder. De minskande skillnaderna i vårdutnyttjande mellan män och kvinnor med stigande ålder skulle således kunna bero på ett allt mindre inslag av könsspecifika sjukdomar. En annan tänkbar förklaring är att med stigande ålder ökar risken för svår sjukdom, vilket i sin tur rimligen borde minska eventuella skillnader i benägenhet att söka vård (6).

I Finland har man nyligen påbörjat studier av den öppna vårdens utnyttjande, varför det för närvarande inte finns några publikationer att jämföra denna studies resultat med. En nyligen publicerad norsk studie, baserad på andra data än föreliggande studie, kommer fram till en

that access to health care is more or less equal, and need, measured as self-reported health, is the primary factor that determines utilization of health services (7).

The three surveys of health and disease that have been carried out in Denmark since 1987 together mainly conclude that access to health care is equal. This applies primarily to women. Among men with poor health, men with higher education utilize health services somewhat more that men with lower education (8).

In Sweden the issue of equal access to care has been been given attention for several years. During the 1980s there were no significant indications of inequalities (9), but from the beginning of the 1990s, there have been several indications of inequalities that have been given attention (10-12). By the end of the 1990s, it seemed that inequalities had become fewer (13), but the present study shows, at least in relation to utilization of health services among people with different levels of education, that some inequalities still remain.

The reasons for the social differences in utilization of ambulatory care are certainly numerous and their significance varies in the different Nordic countries. Health care services are traditionally public services in the Nordic countries, but the contribution of private health care has increased during the last few years. It is reasonable to suppose that private health services are utilized to a greater extent by people with higher education than by people with lower education. This may lead to differences in access to health care, and may thus contribute to the inequalities that we have found.

bild av tämligen jämlik vård, där behoven, mätt som självskattad hälsa, är den faktor som främst styr utnyttjandet av hälsovård (7).

De tre undersökningarna om hälsa och sjuklighet som genomförts i Danmark sedan 1987 ger sammantaget huvudsakligen en bild av jämlik vård. Detta gäller främst kvinnorna. För män med dålig hälsa har de högutbildade något större vårdutnyttjande än de med lägre utbildning (8).

I Sverige har frågan om vård på lika villkor följts under flera år. Under 1980-talet fanns det inga betydande tecken på ojämlikhet (9), men från början av 1990-talet har flera tecken på bristande jämlikhet uppmärksammats (10-12). Det fanns vid slutet av 1990-talet vissa tecken på förbättrad jämlikhet (13), men föreliggande studie visar att åtminstone när det gäller vårdutnyttjande bland personer med olika utbildning så kvarstår viss ojämlikhet.

Orsakerna till de funna sociala skillnaderna i utnyttjande av den öppna vården är säkert många och skiftar i betydelse mellan de nordiska länderna. Traditionellt är hälso- och sjukvården i Norden en offentlig angelägenhet, men inslaget av privat vård har ökat under senare år. Det är rimligt att tänka sig att den privata vården i högre grad utnyttjas av högutbildade än lågutbildade, vilket kan bidra till skillnader i vårdens tillgänglighet och därmed medverka till den ojämlikhet som vi funnit.

In Denmark there are no patient charges for ambulatory care, but there are patient charges in the other Nordic countries. Patient charges vary for primary care and specialist care, and for health insurance. For primary care, the patient charges amounted to €11 – €14 in 2000. Since people with lower education usually have lower income than people with higher education, patient charges may be a significant factor in terms of the inequalities that this study has identified. Certainly it can be difficult using the data used in this study to demonstrate that people with low income do not utilize ambulatory health care according to self-reported need (10). However, other studies that have specifically investigated the importance of patient charges for utilization of health services have concluded that some people with low income do not utilize health services that they consider that they need (14, 15).

The high cost of health services and the subsequent requirement for rational utilization of resources leads to continual changes in the supply of health services. Adaptation to change always takes time and involves the risk of inequality in access to health services. Thus there is good reason to continue to follow the question of equality of access, both using national studies and comparative Nordic studies.

VI. Summary

In Section III it is pointed out that earlier studies have shown marked differences in mortality between occupational groups, with the highest mortality among Finnish men and the lowest mortality among Swedish men. For women, the highest

I Danmark förekommer inga patientavgifter i öppen vård, men övriga nordiska länder har avgifter. Olika avgifter för primärvård respektive specialiserad vård förekommer, liksom olika typer av högkostnadsskydd. För primärvård uppgick avgifterna till 11€ – 14€ år 2000. Eftersom lågutbildade vanligen har sämre ekonomiska förutsättningar än högutbildade kan även patientavgifter ha betydelse för den ojämlikhet som denna studie visar. Visserligen kan det vara svårt att påvisa med hjälp av uppgifter motsvarande de data som använts i föreliggande studie att personer med små ekonomiska tillgångar inte utnyttjar den öppna vården i enlighet med självrapporterade behov (10). Andra studier som varit särskilt inriktade på att studera patientavgifternas betydelse för vårdutnyttjandet har emellertid kommit till slutsatsen att personer med låga inkomster avstår från vård som de anser sig behöva (14, 15).

Sjukvårdens höga kostnader och därmed sammanhängande krav på rationell resursanvändning leder till ständiga förändringar i sjukvårdens utbud. Anpassningen till förändringar tar alltid viss tid och innebär risker för orättvisor i tillgången till sjukvård. Det finns således all anledning att även fortsättningsvis följa frågan om vård på lika villkor, såväl genom nationella studier som nordiska jämförande studier.

VI. Sammenfatning

I afsnit III blev der påvist at tidligere studier har vist markante forskelle i dødelighed mellem erhvervsgrupper med den største dødelighed hos finske mænd og den laveste for svenske mænd. For kvindernes vedkommende var der den største

mortality is for Danish women, and the lowest for Norwegian women. Altogether, the differences between occupational groups are greater than the differences between men and women.

dødelighed i Danmark og den laveste i Norge. Samlet set var forskellen dog større blandt erhvervene end blandt kønnene og landene.

With regard to socio-economic differences in self-assessed health in relation to educational background, the pattern was very similar for the Nordic countries that have available data.

Når det gælder socioøkonomiske forskelle i selvrapporteret helbred set i relation til den uddannelsesmæssige baggrund var mønsteret meget ensartet blandt de nordiske lande hvorfra der findes tilgængelige data.

Another study over a period of ten years in which health was measured in relation to education and occupational status shows the same pattern with just small differences according to gender and between countries.

Et andet studie for en 10 års periode hvor helbred blev målt i forhold til uddannelse og beskæftigelsesstatus viser det samme mønster med kun mindre ændringer mellem kønnene og landene.

Section IV illustrates socio-economic differences in the use of specialist health services in all of the Nordic countries, with people in the highest socioeconomic groups having the best access to these services in relation to levels of need. In Denmark people in the highest income groups also have the shortest waiting time for treatment.

Afsnit IV illustrerer socioøkonomiske forskelle i brugen af specialisthelsetjenester i alle de nordiske lande, hvor de højeste indkomstgrupper har den bedste adgang til denne service i relation til behov. I Danmark har de højeste indkomstgrupper også den korteste ventetid for at komme i behandling.

A more detailed Finnish study of visits to the doctor and elective treatment also showed that higher socio-economic groups have higher treatment rates. When the results are adjusted for relative need, they are even more striking.

Et mere detaljeret finsk studie af lægebesøg og planlagt behandling viste også at de højere socioøkonomiske grupper havde højere behandlingsrater, når disse blev justeret for det relative behov, hvor resultatet dog var mere slående.

In Section V, the study of socio-economic differences for ambulatory care indicates that there are inequalities in utilization of ambulatory care between people with different levels of education in the Nordic countries, with the exception of Norway, where no evidence is found for inequalities according to education. In addition, in all the Nordic

I afsnit V, studiet vedrørende de socioøkonomiske forskelle der findes i den ambulante behandling, viste resultatet af studiet forskelle mellem personer med forskellige uddannelsesniveauer i benyttelsen af den ambulante behandling i de nordiske lande, med undtagelse af Norge, hvor der ikke findes belæg for at lavt uddannede har en mindre benyttelses-

countries, utilization of ambulatory care is higher for women than for men. However, this difference between women and men becomes less with increasing age.

Altogether, the studies presented in this report demonstrate that in the Nordic countries all population groups have access to urgent care on relatively equal terms. However, there are a lot of examples of inequalities in access to elective procedures, specialist care and ambulatory care. Those with the lowest socio-economic status have the greatest needs, whilst those with the highest status and position have the best access.

VII. Recommendations

The routines for data collection are somewhat different in the different countries. However, several sets of data are collected routinely, and these could be used more. In addition, several of the countries have register data that could be used to demonstrate socio-economic differences by linking data from different registers.

The socio-economic differences that have been identified in the studies must be regarded as important in the debate on health policy, since they are associated both with differences in need and differences in use. It should also be mentioned that the similarities between the Nordic countries provide the basis for comparative studies, while interesting differences are also to be found.

NOMESCO should therefore address these aspects regularly in its special studies.

grad. Desuden gælder det for samtlige af de nordiske lande at kvinderne benytter den ambulante behandling mere end mænd. Denne forskel mellem mænd og kvinder aftager dog med alderen.

Sammenfattende indikerer studiet at i de nordiske lande har alle befolkningsgrupper adgang til den nødvendige behandling på relativt lige vilkår, men der er en lang række eksempler på uligheder i adgangen til den specialiserede og ambulante behandling hvor de der har den laveste socioøkonomiske status har det største behov mens de der har den højeste status og placering har den letteste adgang

VII. Anbefalinger

De indsamlingsrutiner der findes mellem landene er noget forskellig, men der findes dog en del rutinemæssige indsamlinger der i højere grad kan benyttes end i øjeblikket. Ligeledes har flere af landene mulighed for at benytte registerbaserede data via sammenkobling af registre, som kan belyse de socioøkonomiske forskelle.

De socioøkonomiske forskelle, der her er påvist, må anses for at være vigtige i den sundhedspolitiske debat idet de både peger på forskelle i behov og forskelle i brug. I den sammenhæng bør det nævnes at de nordiske lande på den ene side er tilstrækkelig ensartede til at danne rammer for sammenlignelige studier, og på den anden side findes der interessante forskelle mellem landene.

NOMESKO bør derfor også med mellemrum behandle disse aspekter i sine specialstudier.

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SECTION C

Appendices
Bilag

Appendix 1

Additional information at www.nom-nos.dk

On NOMISCO's homepage, the following additional information can be found:

- Obstetric definitions
- Hospital definitions
- Overview of medical, surgical and psychiatric specialities that are included in the statistics in this publication
- Short list and statistics on causes of death
- Short list and statistics on discharges from somatic hospitals
- Short list and statistics on surgical procedures

The detailed statistics on the homepage are presented according to gender and 5-year age groups.

In addition, an interactive database is to be found, with the most important data that is available, presented graphically and in maps. The database can be found under the icon *Social and Health Indicators*.

Supplerende oplysninger på www.nom-nos.dk

På NOMESKO´s hjemmeside findes følgende supplerende oplysninger:

- Obstetriske definitioner
- Sygehusdefinitioner
- Oversigt over medicinske, kirurgiske og psykiatriske specialer som indgår i statistikken i denne publikation
- Kortliste samt statistik over dødsårsager
- Kortliste samt statistik over udskrivninger ved somatiske sygehusafdelinger
- Kortliste samt statistik over kirurgiske procedurer

Den detaljerede statistik på hjemmesiden er fordelt på køn og 5-års-aldersgrupper

Desuden findes der en interaktiv database med de vigtigste data hvor det er muligt med såvel grafisk præsentation samt præsentation ved brug af kort. Databasen findes under ikonet *Social and Health Indicators*.

Further information
Yderligere oplysninger

The following offices responsible for statistics can be contacted for further information concerning the statistics in this publication.

Denne oversigt over statistikansvarlige i de nordiske lande kan bruges til at søge yderligere oplysninger vedrørende statistikken i denne bog.

Denmark

Statistics Denmark
Sejrøgade 11
DK-2100 Copenhagen Ø
Phone: +45 39 17 39 17
Fax: +45 39 17 39 99
E-mail: dst@dst.dk
Website: www2.dst.dk

Have responsibility for:
- Population statistics
- Statistics on alcohol consumption
- Statistics on health care economy
- Statistics on alcohol consumption

National Board of Health
Islands Brygge 67
P.O. Box 1881
DK-2300 Copenhagen S
Phone: 72 22 74 00
Fax: 72 22 74 11
E- mail: sst@sst.dk
Website: www.sst.dk

Have responsibility for:
- Statistics on births
- Statistics on abortions
- Statistics on malformations
- Statistics on causes of death
- Statistics on hospital services
- Statistics on health personnel
- Statistics on the use of tobacco

Statens Seruminstitut
Artillerivej 5
DK-2300 Copenhagen S
Phone: +45 32 68 32 68
Fax: +45 32 68 38 68
E- mail: serum@ssi.dk
Website: www.serum.dk/dk

Have responsibility for:
- Statistics on infectious diseases
- Statistics and information on vaccinations

Danish Medicines Agency
Frederikssundsvej 378
DK-2700 Brønshøj
Phone: +45 44 88 91 11
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E mail: dkma@dkma.dk
Website: www.dkma.dk

Have responsibility for:
- Statistics on medicinal products

Faroe Islands

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FO-165 Argir
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Have responsibility for:
- Population and vital statistics
- Statistics on health care economy

Chief Medical Officer
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Have responsibility for:
- Statistics on infectious diseases

Chief Pharmaceutical Officer
P.O. Box 187
FR-110 Tórshavn
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Fax: +298 35 01 51

Have responsibility for:
- Statistics on medicinal products

National Board of Health in Denmark
Islands Brygge 67
P.O. Box 1881
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E-mail: sst@sst.dk
Website: www.sst.dk

Have responsibility for:
- Statistics on causes of death

Ministry of Social and Health Affairs
Eiragardur 2
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E-mail: hmr@hmr.fo
Website: www.ahs.fo

Have responsibility for:
- Statistics on health personnel
- Statistics on hospital services
- Statistics on abortions
- Statistics and information on vaccinations

Greenland

Statistics Greenland
P.O. Box 1025
DK-3900 Nuuk
Phone: +299 34 50 00
Fax: +299 32 29 54
E-mail: stat@gs.gh.gl
Website: www.statgreen.gl

Have responsibility for:
- Population and vital statistics
- Statistics on health personnel
- Statistics on hospital services
- Statistics on health care economy

Chief Medical Officer
P.O. Box 120
DK-3900 Nuuk
Phone: +299 34 5192
Fax: +299 32 51 30
E-mail: eli@gh.gl

Have responsibility for:
- Statistics on births
- Statistics on abortions
- Statistics on malformations
- Statistics on infectious diseases
- Statistics and information on vaccinations

National Board of Health in Denmark
Islands Brygge 67
P.O. Box 1881
DK-2300 Copenhagen S
Phone: 72 22 74 00
Fax: 72 22 74 11
E-mail: sst@sst.dk
Website: www.sst.dk

Have responsibility for:
- Statistics on causes of death

The Central Pharmacy in Copenhagen County
Marielundsvej 25
DK-2730 Herlev
Phone: +45 44 57 77 00
Fax: +45 44 57 77 09

Have responsibility for:
- Statistics on medicinal products

The Directorate for Health
P.O. Box 1160
DK-3900 Nuuk
Phone: +299 34 50 00
Fax: +299 32 55 05

Have responsibility for:
- Statistics on hospital services
- Statistics on health care economy
- Statistics on health personnel

Finland

Statistics Finland
Työpajankatu 13
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Phone: +358 9 173 41
Fax: +358 9 173 42 750
Website: www.stat.fi

Have responsibility for:
- Population and vital statistics
- Statistics on causes of death
- Statistics on the use of tobacco
- Statistics on road traffic accidents

STAKES (National Research and Development Centre for Welfare and Health)
P.O. Box 220
FIN-00531 Helsinki
Phone: +358 9 396 71
Fax: +358 9 761 307
Website: www.stakes.fi

Have responsibility for:
- Register of Institutional Care
- Medical Birth Register and IVF statistics
- Register of Abortions and Sterilizations
- Statistics on Health Care Personnel
- Statistics on public health care
- Statistics on private health care
- Statistics on labour force in health care
- Statistics on the use of alcohol and drugs
- Statistics on health care expenditure
- Definitions and classifications in health care
- Statistics on primary health care

Finnish National Public Health Institute
Mannerheimintie 166
FIN-00300 Helsinki
Phone: +358 9 474 41
Fax: +358 9 474 48 408
Website: www.ktl.fi

Have responsibility for:
- Register of Infectious Diseases
- Register of Coronary Heart Disease and Stroke
- Statistics and information on vaccinations
- Survey on health behaviour among adults and elderly
- Public Health Report

National Agency for Medicines
Mannerheimintie 166
P.O. Box 55
FIN-00301 Helsinki
Phone: +358 9 473 341
Fax: +358 9 714 469
Website: www.nam.fi

Have responsibility for:
- Registration of medicinal products and sales licences
- Register on Adverse Drug Reactions
- Statistics on pharmacies

Social Insurance Institution of Finland
Nordenskiöldinkatu 12
FIN-00250 Helsinki
Phone: +358 20 434 11
Fax: +358 20 434 50 58
Website: www.kela.fi

Have responsibility for:
- Sickness insurance benefits and allowances, reimbursements for medicine expenses, and disability pensions

Finnish Cancer Registry
Liisankatu 21B
FIN-00170 Helsinki
Phone: +358 9 135 331
Fax: +358 9 135 1093
Website: www.cancer.fi

Have responsibility for:
- Statistics on cancer

Finish Centre for Pensions
Fin-00065 Eläketurvakeskus
Phone: +358 9 107511
Fax: + 358 9 14 81172
Website: www.etk.fi

Have responsibility for:
- Pensions due to reduced capacity to work

Åland

The Åland Government
P.O. Box 1060
Ax-22111 Mariehamn
Phone: +358 18 250 00
Fax: +358 18 191 55

Have responsibility for:
- Statistics on infectious diseases
- Statistics on health personnel
- Statistics on hospital services
- Statistics on health care economy

Social Insurance Institution of Finland
Statistics Finland
STAKES
National Agency for Medicines
Finnish National Public Health Institute
Finnish Cancer Registry

See Finland

Iceland

Statistics Iceland
Borgartún 21a
IS-150 Reykjavík
Phone: +354 528 1000
Fax: +354 528 1199
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Website: www.statice.is

Have responsibility for:
- Population and vital statistics
- Statistics on causes of death
- Statistics on alcohol consumption
- Statistics on health care expenditure
- National accounts

Directorate of Health
Austurströnd 5
IS-170 Seltjarnarnes
Phone: +354 510 1900
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E mail: postur@landlaeknir.is
Website: www.landlaeknir.is

Have responsibility for:
- Medical statistics on births
- Statistics on abortions
- Statistics on sterilizations
- Statistics on primary health care
- Statistics on hospital services
- Statistics on infectious diseases
- Statistics on vaccinations
- Statistics on health personnel

Icelandic Ministry of Health and Social Security
Vegmúla 3
IS-150 Reykjavík
Phone: +354 545 8700
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Website: www.stjr.is

Have responsibility for:
- Statistics on pharmaceutical products

Committee for Tobacco Use Prevention
Skógarhlíð 8
IS-105 Reykjavík
Phone: +354 561 2555
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Website: www.reyklaus.is

Have responsibility for:
- Statistics on the use of tobacco

Icelandic Cancer Register
Skógarhlíð 8
IS-105 Reykjavík
Phone: +354 540 1900
Fax: +354 540 1910
E mail: jongl@krabb.is; laufeyt@krabb.is;
Website: www.krabb.is

Have responsibility for:
- Statistics on cancer

Norway

Statistics Norway
P.O. Box 8131 Dep.
N-0033 Oslo
Phone: +47 21 09 00 00
Fax: +47 21 09 49 73
E- mail: ssb@ssb.no
Website:www.ssb.no

Have responsibility for:
- Population and vital statistics
- Statistics on causes of death
- Statistics on health and social conditions
- Statistics on health and social services
- Statistics on health personnel
- Statistics on hospital services
- Statistics on sterilizations
- Statistics on induced abortions
- Statistics on alcohol consumption
- Statistics on health care economy

Norwegian Institute of Public Health
P.O. Box 4404 Nydalen
N-0403 Oslo
Phone: +47 22 04 22 00
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E- mail: folkehelseinstituttet@fhi.no
Website: www.whocc.no

Have responsibility for:
- Statistics on sexually transmitted diseases
- Statistics on tuberculosis
- Statistics on immunization
- Statistics on sale of medicinal products

Norwegian Institute of Public Health
Department of Medical Birth Registry
Kalfarveien 31
N-5018 Bergen
Phone: +47 22 04 27 00
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Website: www.fhi.no

Have responsibility for:
- Statistics on births and infant deaths

SINTEF-Unimed
Norwegian Patient Register
Olav Kyrresgate 3
N-7465 Trondheim
Phone: +47 73 59 25 90
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E- mail: npr@sintef.no
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Have responsibility for:
- Statistics on hospital services

National Directorate for Health and Social Welfare
P.O. Box 8054 Dep.
N-0031 Oslo
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E- mail: postmottak@shdir.no
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Have responsibility for:
- Statistics on use of tobacco

Cancer Registry of Norway
Institute of population-based cancer research
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Phone: +47 22 45 13 00
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Website: www.kreftregisteret.no

Have responsibility for:
- Statistics on cancer

Ministry of Health
P.O. Box 8011 Dep.
N-0030 Oslo
Phone: + 47 22 24 90 90
E- mail: postmottak@hd.dep.no
Website: www.hd.dep.no

- Statistics on in vitro fertilization

Sweden

Statistics Sweden
P.O. Box 24 300
SE-104 51 Stockholm
Phone: +46 8 506 940 00
Fax: +46 8 661 52 61
E-mail: scb@scb.se
Website: www.scb.se

Have responsibility for:
- Population and vital statistics
- Statistics on health care economy

National Board of Health and Welfare
SE-106 30 Stockholm
Phone: +46 8 55 55 30 00
Fax: +46 8 55 55 33 27
E-mail: socialstyrelsen@sos.se
Website: www.sos.se

Have responsibility for:
- Statistics on births
- Statistics on abortions
- Statistics on sterilizations
- Statistics on in-patients
- Statistics on cancer
- Statistics on causes of deaths

Swedish Institute for Infectious Disease Control
SE-171 82 Solna
Phone: +46 8 457 23 00
Fax: +46 8 32 83 30
E- mail: smittskyddsinstitutet@smi.ki.se
Website:www.smittskyddsinstitutet.se

Have responsibility for:
- Statistics on infectious diseases
- Statistics and information on vaccinations

National Corporation of Swedish Pharmacies
SE-131 88 Stockholm
Phone: +46 8 466 10 00
Fax: +46 8 466 15 15
Website: www.apoteket.se

Have responsibility for:
- Statistics on drug sales and drug prescribing

Federation of Swedish County Councils
SE-118 82 Stockholm
Phone: +46 8 452 72 00
Fax: +46 8 452 72 10
E- mail: landstingsforbundet@lf.se
Website: www.lf.svekom.se

Have responsibility for:
- Statistics on health personnel
- Statistics on hospital capacity
- Statistics on health care economy

Swedish Association of Local Authorities
SE-118 82 Stockholm
Phone: +46 8 452 71 00
Fax: +46 8 641 15 35
E- mail: sk@svekom.se
Website: www.lf.svekom.se

Have responsibility for:
- Statistics on health personnel

Swedish Agency for Government Employers
P.O. Box 3267
SE-103 65 Stockholm
Phone: +46 8 700 13 00
Fax: +46 8 700 13 40
E-mail: agv@arbetsgivarverket.se
Website:www.arbetsgivarverket.se

Have responsibility for:
- Statistics on health personnel

NOMESCO Publications

1. Medisinsk fødselsregistrering. Forslag fra en arbeidsgruppe opprettet av NOMESKO. NOMESKO, Bergen 1971.

2. Planning Information Services for Health/Administration. Decision - Simulation - Approach. Recommendations submitted by a Working Party within NOMESCO. NOMESCO, Stockholm 1973.

3. Computer-based Patient Statistics. Part I. Hospital In-patients. Recommendations submitted by a Working Party within NOMESCO. NOMESCO, Stockholm 1974.

4. Databaseorienteret patientstatistik. 1. Del. Indlagte patienter. Förslag från en arbetsgrupp inom NOMESKO. NOMESKO, Stockholm 1974.

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6. Databaseorienteret patientstatistik. 2. del. Statistik om lægebesøg. Förslag från en arbetsgrupp inom NOMESKO. NOMESKO, Stockholm 1978.

7. Översyn av ICD-8. 1. del. Jämförelse mellan de nordiska versionerna av klassifikationen adapterad för sjukhusbruk. Förslag från en arbetsgrupp inom NOMESKO, Stockholm 1978.

8. Översyn av ICD-8. Andra delen:1. ICD-8 och de nordiska versionerna jämförda med ICD-9. Tabellarisk del. NOMESKO, Stockholm 1978.

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10. Computer-based Patient Statistics. Part II. Statistics on Doctor-visits. Recommendations submitted by NOMESCO/APAT-group. NOMESCO, Copenhagen 1979.

11. Health Statistics in the Nordic Countries. 1978. NOMESCO, Stockholm 1980.

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15. Health Statistics in the Nordic Countries 1980. NOMESCO, Copenhagen 1982.

16. Rapport fra Nordisk konference om Besöksorsaker inom primärvården. NOMESKO, København 1982.

17. Fødsler i Norden. Medicinsk fødselsregistrering 1979. (Births in the Nordic Countries. Registration of the Outcome of Pregnancy 1979). NOMESCO, Reykjavík 1982.

18. Health Statistics in the Nordic Countries 1981. NOMESCO, Copenhagen 1983.

19. Health Statistics in the Nordic Countries 1982. NOMESCO, Copenhagen 1984.

20. Nordisk klassifikation til brug i ulykkesregistrering. NOMESKO, København 1984.

21. Nordisk dødsårsagsstatistik. Analyse af kodepraksis. NOMESKO, København 1985.

22. Health Statistics in the Nordic Countries 1983. NOMESCO, Copenhagen 1985.

23. Datorstödda informationssystem inom primärvården i Norden. NOMESKO, Helsinki 1985.

24. Health Statistics in the Nordic Countries 1984. NOMESCO, Copenhagen 1986.

25. Fødsler i Norden. Medicinsk fødselsregistrering 1979-1983. (Births in the Nordic Countries. Registration of the Outcome of Pregnancy 1979-1983). NOMESCO, Reykjavík 1987.

26. Health Statistics in the Nordic Countries 1985. NOMESCO, Copenhagen 1987.

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31. Health Statistics in the Nordic Countries 1988. NOMESCO, Copenhagen 1990.

32. Trender i hälsoutvecklingen i de nordiska länderna. Annus Medicus 1990, Helsingfors 1990.

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39. Births and Infant Mortality in the Nordic Countries. NOMESCO, Copenhagen 1993.

40. Health Statistics in the Nordic Countries 1991. NOMESCO, Copenhagen 1993.

41. Primary Health Care in the Nordic Countries in the early 1990s. NOMESCO, Copenhagen 1994.

42. Health Statistics in the Nordic Countries 1992. NOMESCO, Copenhagen 1994.

43. Rates of Surgery in the Nordic Countries. Variation between and within nations. NOMESCO, Copenhagen 1995.

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52. Nordic and Baltic Health Statistics 1996. NOMESCO, Copenhagen 1998.

53. Health Statistic Indicators for the Barents Region. NOMESCO, Copenhagen 1998.

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55. Sygehusregistrering i de nordiske lande, 2. reviderede udgave, Købehavn 1999

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CANCEL PAGE TO CHAPTER III

Unfortunately the figures for Norway and Sweden in the book were total numbers and not rates in the following three tables. The correct figures appear below.

Table 3.26 Discharges and average length of stay in hospitals*. Asthma, bronchitis, emphysema and other chronic obstructive pulmonary disease 2002

	Denmark	Faroe Islands	Finland	Åland	Iceland	Norway	Sweden
Discharges							
Total	28 636	189	15 270	111	794	11 898	23 396
Per 100 000 in the age group							
0-4	1 043	1 794	247	1 160	559	**572**	**562**
5-14	187	350	43	351	115	**103**	**33**
15-24	61	68	38	63	52	**45**	**18**
25-64	243	171	80	133	113	**126**	**100**
65-74	1 914	858	447	826	969	**809**	**802**
75+	2 192	1 043	617	2 080	1 721	**1 648**	**1 208**
Total rate	533	411	147	431	276	**261**	**262**
Average length of stay	5.4	6.2	5.3	6.1	8.2	..	5.6

Table 3.30 Discharges and average length of stay in hospitals*. Alcoholic liver disease 2002

	Denmark	Faroe Islands	Finland	Åland	Iceland	Norway	Sweden
Discharges							
Men							
Total	1 684	6	1 341	6	15	573	1 564
Per 100 000 men in the age group							
0-44	16	1	12	3	7	**6**	**4**
45-64	160	88	132	132	23	**69**	**82**
65+	89	43	72	69	7	**39**	**79**
Total rate	63	26	53	47	10	**25**	**35**
Women							
Total	800	1	630	2	-	309	740
Per 100 000 women in the age group							
0-44	8	0	7	6	-	**2**	**3**
45-64	74	17	52	35	-	**35**	**35**
65+	34	12	32	32	-	**24**	**31**
Total rate	29	5	24	18	-	**13**	**16**
Average length of stay	8.5	7.1	8.4	15.3	5.1	8.7	8.3

Table 3.31 Discharges and average length of stay in hospitals*. Non-alcoholic liver disease 2002

	Denmark	Faroe Islands	Finland	Åland	Iceland	Norway	Sweden
Discharges							
Men							
Total	840	7	631	1	9	403	821
Per 100 000 men in the age group							
0-44	14	19	17	-	6	**11**	**9**
45-64	60	47	38	7	10	**27**	**28**
65+	55	36	34	29	0	**33**	**40**
Total rate	32	28	25	6	6	**18**	**19**
Women							
Total	882	10	858	2	33	519	993
Per 100 000 women in the age group							
0-44	14	9	14	3	10	**12**	**11**
45-64	54	75	51	29	33	**34**	**30**
65+	61	163	50	20	71	**45**	**44**
Total rate	32	47	32	13	23	**23**	**22**
Average length of stay	7.6	7.5	4.9	6.5	6.9	7.3	7.6