# Health Statistics in the Nordic Countries 2006

*Helsestatistik for de nordiske lande 2006*

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# Preface
# *Forord*

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

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

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

Section B deals with The Health of Elderly People.

As mentioned above, this version is a more extensive version than the book version in form of a pdf. File. Additional information is also presented, including an interactive database and detailed data on hospital discharges, patients treated, procedures, new cases of cancer and causes of death.

*Nordic Medico-Statistical Committee (NOMESCO)*

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

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

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

Sektion B er et tema om ældres helse.

Denne udgave er som nævnt en udvidet bogudgave som pdf. fil og supplerende informationer, blandt andet en interaktiv database samt detaljerede data om udskrivninger, patienter behandlet, procedurer, nye tilfælde af cancer og dødsårsager.

*Nordisk Medicinalstatistisk Komité (NOMESKO)*

# SECTION A

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## Health Statistics 2006
## Helsestatistik 2006

## CHAPTER I

# Organization of health services
# Organiseringen af sundhedsvæsenet


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## Introduction

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

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

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

Specialist medical treatment is also offered outside hospitals.

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

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

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

## 1.1. Current and future changes in the health services

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

## 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 er dog en vis egenbetaling for lægemidler og i en vis udstrækning også for behandling.

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

## 1.1. Igangværende og kommende ændringer i sundhedsvæsenet

DANMARK: For målrettet at øge aktiviteten i sundhedsvæsenet og nedbringe ventetiderne til undersøgelse og behandling har regeringen i perioden 2001 til 2008

DKK 16 billion to health services in the period 2001 to 2008. Increased activity has been combined with extra choices for patients. Among other things, it is now possible for patients to receive treatment at a private hospital or a hospital abroad that has a contract with the public authorities, when waiting time for treatment at a public hospital is longer than two months. From 1 October 2007, patients have had the possibility to receive treatment at a private hospital when waiting tines exceeds one month.

afsat cirka 16 mia. DKK ekstra til det danske sundhedsvæsen. 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. Med virkning fra den 1. oktober 2007 har patienternes haft mulighed for at søge behandling på et privat sygehus hvis ventetiden overstiger 1 måned.

These measures have had a considerable effect. From 2001 to 2006, the number of people who have received treatment in somatic hospitals has increased by 419 000. During the period 2001 to 2006, the number of people who have had an operation has increased by 85 000. Waiting times have been reduced from 27 weeks to 20.6 weeks for 18 major surgical procedures from July 2002 to July 2006. During the period 1 July 2002 to the end of June 2006, 120 000 patients chose to make use of their extended right to free choice of hospital.

Indsatsen har haft en betydelig effekt. Fra 2001 til 2006 er antallet af personer, som har modtaget behandling i det somatiske syge-husvæsen, øget med 419.000. I perioden 2001 til 2006 er antallet af personer, der har fået foretaget en eller anden form for operation, øget med ca. 85.000. Ventetiderne er reduceret fra ca. 27 uger til ca. 20,6 uger for 18 vigtige operationer fra juli 2002 til juli 2006. I perioden fra den 1. juli 2002 til udgangen af 2006 har ca. 120.000 patienter valgt at benytte muligheden for udvidet frit sygehusvalg.

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

Med virkning fra den 1. januar 2007 trådte regeringens aftale om Strukturreformen i kraft. For sundhedsområdet kom den til at betyde, at amterne blev erstattet af fem nye regioner. Samtidig blev antallet af kommuner reduceret fra 271 til 98 kommuner. Kommuner og regioner forpligtes til at samarbejde om sammenhæng i behandling, træning, forebyggelse og pleje. Dette sker bl.a. ved, at kommunerne har overtaget ansvaret for forebyggelse og genoptræning. På sundheds-området bliver regionerne finansieret gennem dels et bloktilskud og et aktivitetsbaseret tilskud fra staten, dels et

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

The new, lager Danish regions from the framework for the health services. They provide better conditions under which the health sector can improve further. Focus is directed at improving the efficiency of the Danish health sector, so that more patients can be treated and waiting times can be shortened. New initiatives are continuously being implemented. The result has been significant and noticeable improvements in the Danish health sector.

The Danish Government's manifesto from November 2007 contains two overall aims for the health services. First, in the next few years, the Government will continue to strengthen the health sector. For example, there are plans to expand capacity and increase activities for the treatment of cancer. Second, increased focus will be placed on prevention. In particular, the Government wishes to protect the health of children, by focusing on the areas of smoking, diet and physical activity.

In 2007, a series of initiatives was taken to improve the treatment of cancer, both the quality of treatment and the amount of treatment provided. Patients with cancer or suspected cancer shall receive acute treatment, and they shall be given adequate information. During 2008, professional guidelines for continuity of care for each type of cancer will be developed, so that patients receive speedy and continous

kommunalt bidrag. Det kommunale bidrag består dels af et fast tilskud pr. indbygger og dels et aktivitetsafhængigt tilskud. Samlet indebærer reformen, at kommunerne tildeles en større rolle i sundhedsvæsenet.

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

Regeringsgrundlaget for VK-regeringen III fra november 2007 indeholder to overordnede målsætninger på sundhedsområdet. For det første vil regeringen i de kommende år styrke indsatsen på sundhedsområdet yderligere. Det gælder ikke mindst på kræftområdet, hvor der planlægges en væsentlig udbygning af kapaciteten og aktiviteten. For det andet vil der komme øget fokus på forebyggelse. Særligt børns heldbred ønskes beskyttet i forhold til rygning, dårlig kost og for lidt motion.

Der blev i 2007 taget en lang række initiativer til at forbedre kræftbehandlingen, både hvad angår kvaliteten i kræftbehandlingen og antallet af behandlinger. Patienter med kræft eller mistanke om kræft skal have akut behandling og klar besked. Der udarbejdes i løbet af 2008 fagligt optimale pakkeforløb for hver enkelt kræftform, så patienterne får et hurtigt og gnidningsfrit forløb uden unødig

care without unnecessary waiting time. In addition, standards for providing information to patients and for arrangements for contact persons will be developed, so that cancer patients are fully informed during all stages of their treatment.

The Danish Government will also ensure that patients with life-threatening acute heart diseases receive treatment. Services for elderly patients will also be improved. Finally, a comprehensive modernization of Danish hospital services is planned. DKK 25 billion will be invested in a new and improved hospital structure in the period 2009-2018.

In 2007, the Ministry of the Interior and Health became the Ministry of Health and Prevention. The Danish Government, with the Minister of Health at the forefront, wished to focus more on prevention in the forthcoming year. Therefore, at the beginning of 2008, a Commission for Prevention was established. At the beginning of 2009, the Commission shall put forward proposals for prevention. Based on these proposals, the Government will launch a National Action Plan for Prevention, with clear aims.

The new Psychiatry Act came into force on 1 January 2007. The aim of the legislative changes was to improve legal safeguards for people who receive mental health care in Denmark. More that 30 statutes in the Psychiatry Act have been changed. Patients' legal safeguards have been strengthened through compulsory follow-up consultations for patients after each episode of compulsory treatment, appointment of a patient adviser in the case of compulsory treatment, improved supervision by a doctor for patients for

ventetid. Desuden laves der standarder for patientinformation og forløbsbaserede kontaktpersonsordninger, så kræftpatienter får præcis besked gennem hele behandlingsforløbet.

Regeringen vil på sammen måde sikre akut behandling for patienter med livstruende hjertesygdomme. Samtidig vil indsatsen for ældre medicinske patienter bliver styrket. Endelig planlægges en omfattende modernisering af sygehusvæsenet i Danmark. Konkret vil der blive investeret 25 milliarder i perioden 2009-2018 i en ny og forbedret sygehusstruktur.

I 2007 ændrede Indenrigs- og Sundhedsministeriet navn til Ministeriet for Sundhed og Forebyggelse. Regeringen, med den nye sundhedsminister i spidsen, ønsker at sætte øget fokus på forebyggelse i de kommende år. Derfor er der i starten af 2008 nedsat en forebyggelseskommission, der primo 2009 skal komme med anbefalinger på forebyggelsesområdet. Med afsæt i kommissionens anbefalinger vil regeringen i 2009 lancere en national handlingsplan for forebyggelse med klare mål for indsatsen.

Den 1. januar 2007 blev psykiatriloven vedtaget. Formålet med lovændringen er at styrke retssikkerheden og retsstillingen for de mennesker, der behandles i den danske psykiatri. Psykiatriloven er i alt ændret på mere end 30 punkter. Patienternes retsstilling styrkes gennem obligatoriske eftersamtaler for patienterne efter ethvert tvangsindgreb, beskikkelse af patientrådgiver ved tvangsindgreb, øget lægeligt tilsyn til langvarigt bæltefikserede patienter og en ekstern lægelig efterfølgende kontrol af indgrebet. I oktober

whom long-term physical restraint is used, and follow-up control of physical restraint measures by an external doctor. In October 2006, a new psychiatry agreement was made for the period 2007-2010. This involves allocating DKK 680 billion to ensure that the positive developments in health services continue, and for developing more detailed and focused measures within mental health care.

2006 blev der indgået en ny psykiatriaftale for perioden 2007-2010. Der er med aftalen afsat 680 mio. kr. på sundhedsområdet til fastholdelse af den gode udvikling og til videreudvikling og udbygning af mere nuancerede og målrettede tilbud i psykiatrien.

In October 2006, the Ministry of Health and Prevention and the National Board of Health established a website: www.sundhedskvalitet.dk. The website provides a wide range of comparable information about the quality of services provided in public and private hospitals. The aim of the website is to help patients in their free choice of hospital, and to encourage hospital personnel to improve the quality of services. The website is currently being developed to provide information about more diseases, and to make it more user-friendly. In the future, the website will also cover other health services, including general practice and municipal health services.

Ministeriet for Sundhed og Forebyggelse og Sundhedsstyrelsen åbnede hjemmesiden www.sundhedskvalitet.dk i oktober 2006. Hjemmesiden giver adgang til en lang række sammenlignelige oplysninger om kvaliteten og servicen på de enkelte offentlige og private sygehuse. Formålet med lanceringen af hjemmesiden har været at understøtte patienternes frie sygehusvalg samt at give sygehuspersonalet en tilskyndelse til at forbedre og udvikle kvaliteten. I øjeblikket er der et arbejde i gang med bl.a. at udvide sundhedskvalitet.dk med oplysninger om flere sygdomme og gøre siden mere brugervenlig. Med tiden skal siden også omfatte det øvrige sundhedsvæsen, herunder praksissektoren og den kommunale sektor.

Productivity in the health care sector is continuously measured by the Ministry of Health and Prevention, the Ministry of Finance, the Danish Regions, and the National Board of Health. Measurement of productivity is a key instrument to ensure the optimal allocation of resources. The hospitals and regions have used the measures both internally and externally to evaluate performance and to learn from others. Nationwide, productivity in the health care sector has increased by 1.9 per cent from 2005 to 2006.

Der gennemføres løbende opgørelser af produktiviteten i sygehussektoren af Ministeriet for Sundhed og Forebyggelse, Finansministeriet, Danske Regioner og Sundhedsstyrelsen. Produktivitetsopgørelser er et centralt redskab til at sikre den bedst mulige ressourceallokering. Disse målinger er blevet anvendt aktivt både internt og eksternt på sygehusene og i regionerne til at evaluere præstationer og lære af andre. Produktiviteten er på landsplan steget med 1,9 pct. fra 2005 til 2006.

**FAROE ISLANDS:** No important changes in health care sector have taken place in the Faroe Islands during the last year.

**FÆRØERNE:** Der er ikke sket væsentlige ændringer på Færøerne det seneste år.

**GREENLAND:** During the next few years, important changes will take place in the health care sector. Changes will be made to the division of health districts, health personnel staffing of district health institutions, leadership structure in health services, and the organization of central administration. This will be described in more detail in the next publication.

**GRØNLAND:** Der vil i det/de kommende år ske væsentlige ændringer inden for Sundhedsvæsenet hvad angår opdelingen i sundhedsdistrikter, den sundhedsfaglige bemanding af de decentrale enheder, ledelsesstrukturen i sundhedsvæsenet samt organiseringen i centraladministrationen. Der vil blive redegjort mere detaljeret her om i den følgende publikation.

**FINLAND:** *The National Programme for Health and Social Policy (KASTE).*

During the present governmental period (2007-2011), the programme for health and social policy has been extended and developed. The most important reforms in the field of health and social services have been carried out as part of the National Health Project, the development project for the social sector, and the alcohol programme.

Legislation relating to countrywide management of the health and social sectors has been revised.

In January 2007, the Finnish Parliament approved a proposal from the Government to change the regulations for following up the Aims and Activity Programme that had previously been a statutory programme.

According to the law, the Government shall prepare a national health and social programme in line with the Government's programme for health and social policy. The programme outlines the most important health and social policy aims, and the central reforms, legislative projects, allocation of resources and recommendations that are required in order to implement the reform.

**FINLAND:** *Det nationale program for social- og Sundhedspolitik (KASTE).*

I den nuværende regeringsperiode (2007-2011) er statsrådets programledelse blevet udvidet og udviklet. De mest betydningsfulde reformer inden for social- og sundhedsområdet er blevet gennemført inden for rammerne af det nationale sundhedsprojekt, og udviklingsprojektet for det sociale område og alkoholprogrammet.

Lovgivningen der gælder den landsdækkende styring af social- og sundhedsområdet er ændret.

Parlamentet godkendte i januar 2007 et forslag fra regeringen om ændrede bestemmelser for opfølgningen af mål og virksomhedsprogrammet som tidligere har været et lovbestemt program.

Efter loven skal regeringen forberede et nationalt social- og sundhedsprogram som supplerer regeringens program for social og sundhedspolitik. Programmet fastsætter de vigtigste sociale og sundhedspolitiske målsætninger og de centrale reformer, lovprojekter, anvisninger og anbefalinger, der skal være med til at støtte gennemførelsen af reformen.

In addition to the development programme for the health sector, there is also a care programme, outlined in the National Budget, which focuses on municipal economy. The most important task laid down in the development programme is to specify and implement health and social policy goals that are part of the Government's programme.

The programme will be carried out with strong political management under the leadership of the Minister for Care Services. The "Strategies for Health and Social Services Policy", published by the Ministry of Health and Social Services in 2006, provide the background for the new legislation. The new system, with state funding of the development programme, which was introduced in 2003, has been useful for the programme leadership. During the period 2004-2007, the sum of EURO 180 million has been allocated to development activities in the health and social sectors.

*Reform of the structure of municipalities and services (PARAS)*

The Act relating to the reform of the structure of municipalities and services came into force on 23 February 2007. The act regulates the municipalities and areas of cooperation in such a way that health and social services are provided to a wide sector of the population (approx. 20 000 inhabitants). The municipalities have given suggestions to the minister about how service provision shall be organized from 31 August 2007. At the moment, the Ministry for Health and Social Services is analysing how the plan can be carried out.

**ÅLAND:** During 2008, new regulations will be adopted to ensure patients' rights.

Ud over udviklingsprogrammet for social- og sundhedsområdet findes der også et omsorgsprogram, som er en del af statsbudgettet, der fokusere på den kommunale økonomi mens udviklingsprogrammets vigtigste arbejdsopgave er at præcisere og gennemføre de social- og sundhedspolitiske mål der indgår i regeringsprogrammet.

Programmet vil blive gennemført med en stærk politisk styring under ledelse af omsorgsministeren. Baggrunden for den nye lovgivning er "Strategier för social- och hälsovårdspolitikken" der blev publiceret af Social och Hälsovårdsministeriet i foråret 2006. Det nye system med statstilskud til udviklingsprojektet der blev indført i 2003 har for sin del gavnet programledelsen. I perioden 2004-2007 har udviklingsvirksomheden inden for social- og sundhedsområde modtaget sammenlagt 180 millioner euro i tilskud.

*Reformen af kommune og servicestrukturen (PARAS)*

Loven om en reform af kommune og servicestrukturen, trådte i kraft den 23. februar 2007. Rammeloven styrer kommuner og samarbejdsområderne mod at social og sundhedsydelser bliver givet ud fra et bredt befolkningsgrundlag (ca. 20.000 indbyggere). Kommunerne er kommet med sine forslag til Statsrådet om hvorledes serviceydelserne skal organiseres den 31. august 2007. I øjeblikket analyserer Social- och Hälsovårdsministeriet, hvorledes planen kan gennemføres.

**ÅLAND:** I løbet af 2008 bliver der vedtaget regler der skal sikre patienternes ret-

An act is being developed during the spring regarding second opinions. Regulations relating to treatment guarantee may also be adopted.

**ICELAND:** A new government was formed in Iceland in May 2007. In order to set clearer boundaries between health and social affairs the division of tasks between the Ministry of Health and Social Security and the Ministry of Social Affairs was reorganized. Thus issues of social security and affairs of the elderly were moved from the Ministry of Health to the Ministry of Social Affairs. Health insurance and occupational injury insurance will remain within the Ministry of Health.

A new Health Service Act (No. 40/2007) came into force on 1 September 2007. The main changes brought about by the act are that now the country is now divided into seven health regions. Health care facility shall organize and provide health services in the region. The role of the Ministry to formulate health policy is strengthened. The act stipulates the status and role of the two biggest hospitals in the country, clarifies the supervisional tasks of the Directorate of Health and covers many other matters on the management of the health service in Iceland.

The new Director of Health Act came into force 1 of September 2007. One of the tasks of the Directorates is to collect and register health data. According to the Act the Directorate is required to organize and maintain countrywide registers on: births, cardiovascular diseases, neurological diseases, cancer patients, accidents, admissions to health care facilities, contacts with health care centres and contacts

tigheder. Der er en lov under udarbejdelse i foråret vedrørende andres bedømmelse, såkaldt *second opinion*, og der bliver muligvis iværksat bestemmelser vedrørende behandlingsgaranti.

**ISLAND:** I maj 2007 fik Island en ny regering. For at få klarere skillelinier mellem social og sundhed blev Sundheds- og socialforsikringsministeriets og Social ministeriets opgaver reorganiseret. Socialforsikringsdelen og ældreomsorgen blev flyttet fra Sundheds- og Socialforsikringsministeriet til socialministeriet. Sygesikringen og arbejdsskadeforsikringen vil dog forblive i sundhedsministeriet.

En ny sundhedslov (lov nr. 40/2007) trådte i kraft 1. september 2007. Hovedændringerne i loven er at landet nu er inddelt i 7 helsedistrikter, hvor der i hver distrikt er sundhedsfaciliteter der skal udbyde og tilbyde almen sundhedsservice i distriktet. Ministeriets rolle i at formulere sundhedspolitikken er styrket. Loven sætter retningslinier for de to største hospitaler i landet og præciserer Sundhedsdirektoratets tilsynspligt samt mange andre forhold der er behov for i udbudet af sundhedsydelser i Island.

En ny lov om Sundhedsdirektoratet trådte i kraft 1.september 2007 hvor en af arbejdsopgaverne er registrering og indsamling af sundhedsdata. Ifølge lovgivningen skal direktoratet organisere og vedligeholde landsdækkende registre for fødsler, cardiovaskulare sygdomme, neurologiske sygdomme, cancer patienter, ulykker, tilgang til sundhedsfaciliteter, kontakt med sundhedscentre, kontakt med privatprak-

with self-employed specialist physicians. Health care providers must provide the Directorate with the data that is necessary for the above-mentioned registers.

The Directorate can provide guidelines which health care providers are required to follow. According to the new Act, these guidelines can function as regulations when they have been approved by the Minister of Health. Thus, the acts will be easier to enforce than before. The Act in general, further enhances the Directorate´s possibilities for collecting health data.

From 1 April 2008 the authorization of health care personal was transferred from the Ministry of Health to the Directorate of Health.

**NORWAY:** During 2006 no organizational or structural changes to health services have been introduced. Some minor changes to laws and regulations related to health services have been made. Two examples are given below.

Changes have been made to the legislation related to mental health that regulates the use of coercion and restraint for clients receiving mental health care in institutions.

During the last few years, the EU has adopted several directives for standards for quality and safety in collecting, treating, storing and distributing human blood, cells and tissue. New regulations have come into force in Norway to meet these requirements.

**SWEDEN:** In 2008, the Swedish Government introduced a comprehensive reform of dental treatment for adults, that includes a dental check-up and a general

tiserende læger. Sundhedsudbydere må på skift sende data til direktoratet som er nødvendige for at vedligeholde registrene.

Sundhedsdirektoratet kan sætte forskellige retningslinier til udbyderne af sundhedsydelser som udbyderne skal følge. Ifølge den nye lov kan retningslinierne fungere som regulering, når de er godkendt af sundhedsministeren. Retningslinjerne vil således blive lettere at få indført end tidligere. Loven i almindelighed skal være med til at forbedre direktoratets muligheder for at indsamle sundhedsdata.

Fra 1. april 2008 blev autorisationen af sundhedspersonale flyttet fra Sundhedsministeriet til Sundhedsdirektoratet.

**NORGE:** Der har i løbet af 2006 ikke været organisatoriske eller strukturelle ændringer i det norske sundhedsvæsen. Der har dog været to mindre lovreguleringer i forhold til sundhedsvæsenet hvor der er givet to eksempler i det følgende.

Der har været lovændringer vedrørende mental helse, der regulerer tvang og tilbageholdelse af klienter, der bliver behandler for mentale lidelser på institutioner.

I de senere år har EU indført flere direktiver og standarder for kvalitet og sikkerhed, vedrørende behandling, opbevaring og distribution af human blod, celler og væv. I Norge er der indført reguleringer for at tilgodese disse krav.

**SVERIGE:** I 2008 gennemførte regeringen en stor reform af tandbehandlingen for voksne som indeholder en tandbehandlingskontrol og et alment tilskud til tandbe-

subsidy for dental treatment for all adults 20 years and older. The subsidy is SEK 300 per year for persons aged 30-74, and SEK 600 per year for persons aged 20-29 and 75 and older. In addition, limits have been introduced for high expenses for dental treatment. This means that expenses between SEK 3 001 and 15 000 are refunded by 50 per cent. Expenses over SEK 15 000 are refunded by 85 per cent. Expenses under SEK 3 000 for cosmetic dental treatment are not refunded. The present maximum patient contribution for persons age 65 and older has been replaced by the new regulations. Preventive dental treatment is included in the new regulations, so that patients shall avoid pain and disease. The aim is that patients shall be able to eat, chew and speak without difficulty. The reform came into force on 1 July 2008.

There is a proposal for a new act relating to patient data. Among other things, the new act will regulate the duty to keep patient records, internal security when electronic media are used in an organization, and the carrying out of tasks when the provider has direct access to data through electronic media. Also, the security of national clinical registers shall be ensured. Changes to the legislation related to data protection in the health sector are proposed. It is proposed that the legislation shall apply to everyone who provides health care, irrespective of ownership.

A proposal has been put forward to reorganize the state-owned pharmacy company Apotek AB. In order to make it easier for private pharmacies to be established, the number of state-owned pharmacies will be reduced.

handling, til alle voksne der er fyldt 20 år. Tilskuddet er på 300 SEK hvert andet år til personer i alderen 30-74 år og 600 SEK hvert andet år for personer i alderen 20-29 år og personer 75 år og over. Der er desuden indført begrænsninger i høje udgifter til tandbehandling. Ordningen indebærer for den enkelte at udgifter mellem 3.001 og 15.000 SEK gives der en refusion på 50 pct. Og for udgifter over 15.000 SEK gives der en refusion på 85 pct. af udgifterne. Udgifter der er under 3.000 SEK der er udført af kosmetiske årsager må patienten selv betale. Den nuværende maksimale egenbetaling for personer der er 65 år og ældre erstattes af de nye regler. Forebyggende tandbehandling er omfattet de nye regler for at patienterne skal undgå smerte og sygdom og som har til formål at patienterne kan spise, tygge og tale uden større besvær. Reformen trådte i kraft den 1.juli 2008.

Der er desuden fremlagt et forslag til en patientdatalov. I lovforslaget reguleres blandt andet pligten til at føre patientjournaler, intern sikkerhed når der anvendes elektroniske medier i en virksomhed, samt udførsel af opgaver og handlinger der giver direkte adgang til data ved elektroniske medier. Desuden skal de nationale kvalitetsregistre sikres og der foreslås ændringer i data beskyttelseslovgivningen på sundhedsområdet. Det foreslås at loven skal gælde alle der udbyder sundhedsydelser uanset ejerskab.

Der er desuden kommet et forslag om omstrukturering af apoteket AB. Det drejer sig om ejerskabet af Apotek-aktieselskabet (APOTEK AB). For at gøre det lettere for nye aktører på apoteker området skal antallet af statsejede apoteker reduceres.

A new cancer strategy is being developed. The report will outline recommendations for a new national cancer strategy. The strategy will focus on future needs and challenges. It will be individually based from a health perspective, and will include both primary and secondary prevention, early diagnosis, treatment and paliative care, development of knowledge, and dissemination of knowledge. Part of the mandate is the issue of a stronger patient perspective. The report shall be presented at the latest by 15 January 2009.

Der arbejdes på en ny cancerstrategi, hvor udredningen skal komme med forslag til en ny national strategi, Strategien skal have fokus på det fremtidige behov og udfordringer. Udredningen skal komme med en individbaseret strategi ud fra et helhedsperspektiv og skal omfatte såvel den primære som den sekundære prævention, tidlig diagnosticering, behandling og palativ pleje, kundskabsdannelse og kundskabsspredning. I mandatet indgår spørgsmålet om et stærkere patientperspektiv. Udredningen skal komme med sit forslag senest 15. januar 2009.

An agreement has been made between the Swedish Government and the Association of Local Authorities and Regions (SLK) to improve the treatment guarantee within mental health care for children and adolescents. This means that a young person who seeks mental health care shall be offered either a telephone contact or a place in care the same day, and a consultation with a doctor within seven days. In addition, the young person shall have a consultation with a specialist in child and adolescent psychiatry within 30 days, and shall begin treatment within 30 days after the consultation. Work with implementing the improved treatment guarantee will be carried out gradually over a three-year period beginning in the summer of 2007.

Der er indgået en aftale mellem regeringen og Sveriges Kommuner og Landsting (SKL) om at forstærke behandlingsgarantien inden for børne- og ungdomspsykiatrien. Den forstærkede behandlingsgaranti indebærer at et ungt menneske som søger hjælp inden for psykiatrien skal tilbydes kontakt via telefon eller en plads samme dag, og besøg hos en læge inden for 7 dage. Det unge menneske skal desuden træffe en specialist inden for børne- og ungdomspsykiatrien inden for 30 dage og påbegynde en behandling inden yderligere 30 dage. Arbejdet med at virkeliggøre styrkelsen af behandlingsgarantien kommer til at foregå gradvis over en tre års periode fra sommeren 2007.

The Swedish Government has given the National Board of Health and Welfare the task of developing a system for "open" comparisons of quality, cost and effectiveness of nursing and care services for elderly people. The work will be carried out in cooperation with the Association of Local Authorities and Regions (SLK), and will contribute to improved follow-up at the country level. Another aim is that the

Socialstyrelsen har fået til opgave af regeringen at udvikle et nationalt system for "Åbne" sammenligninger af kvalitet, udgifter og effektivitet inden for pleje og omsorgen af de ældre. Arbejdet skal gennemføres i et samarbejde med Sverige Kommuner og Landsting og bidrage til en bedre opfølgning på det nationale niveau. Et andet formål er at kommunerne og landsting skulle kunne tage rede på

municipalities and regions shall be able to assess which measures and methods give good results, by comparing their achievements. In the long run, comparisons of quality will also help elderly people to have increased choice of nursing and care services.

hvilke indsatser og arbejdsmetoder der giver gode resultater gennem at sammenligne sine præstationer. Kvalitetssammenligningen skal på sigt også være et hjælpemiddel for de ældre for at få øget valgfrihed inden for pleje og omsorgen.

From October 2007, new official statistics, based on personal identification number, have been introduced. These statistics involve the authorities who provide services for elderly people and handicapped people. During 2008, the range of these statistics will be more comprehensive. From 1 July 2008, the municipalities will register their activities. Information will be collected from the municipalities from 1 January 2009.

I løbet af 2007 blev der indført en ny personnummerbaseret officiel statistik der omfatter de besluttende myndigheder inden for ældre og handicapområdet fra oktober 2007. I løbet af 2008 udvides statistikken til at blive totaldækkende statistik ved at kommunerne fra og med 1. juli 2008 løbende skal registrere deres indsatser. Disse informationer samles ind fra kommunerne fra og med 1. januar 2009.

The National Board of Health and Welfare has developed a web-based tool, called "the guide for the elderly", to give elderly people the possibility to compare the quality of nursing and care services for elderly people. The web address is: http://aldreguiden.socialstyrelsen.se.

Socialstyrelsen har udviklet et WEB baseret hjælpemiddel, benævnt "Ældreguiden" for at borgere der ønsker det skal have mulighed for at sammenligne kvaliteten af plejen og omsorgen af de ældre. Adressen er følgende: http://aldreguiden.socialstyrelsen.se

Changes to the Abortion Act are proposed, so that women from other countries who have an abortion in Sweden does not need to apply for permission from the National Board of Health and Welfare. The report also recommends that work to prevent unwanted pregnancies should be expanded.

Abortloven ændres således at udenlandske kvinder der får foretaget abort i Sverige, undgår at søge om tilladelse hos Socialstyrelsen. Betænkningen foreslår også at man styrker det forebyggende arbejde mod uønskede graviditeter.

On 1 January 2008, a Social Council was established to collect information about the social sector. The Social Council consists of researchers who will advise the Government about health and social issues. It will also provide the Government with information for developing welfare

Den 1.januar 2008 blev der oprettet et social råd der skal indsamle viden inden for det sociale område. Det sociale råd består af forskere der skal rådgive regeringen i sundheds og sociale spørgsmål. Den skal også give regeringen viden til at udforme velfærdspolitikken inden for de

policy within the areas of responsibility of the Ministry of Social Affairs. The Council's mandate applies for the period 1 January 2008 to 31 December 2010. The reason why the Government has appointed a Social Council is that Sweden faces several challenges that have an impact on welfare in Sweden. The large number of people who are unemployed or on sick leave in Sweden, and the fact that people are living longer, creates an extra burden on the social security system, the health services and care for the elderly.

områder som Socialdepartementet har ansvaret for. Rådets mandat gælder for perioden 1. januar 2008 til 31. december 2010. Grunden til at regeringen har nedsat et socialt råd er at Sverige står overfor flere udfordringer som påvirker den svenske velfærd. De mange arbejdsløse og sygemeldte i Sverige ligesom befolkningen lever længere medfører et forøget tryk på socialforsikringssystemet, sygdomsbehandlingen og ældreomsorgen.

## 1.2 Organization and responsibility for the health sector

**DENMARK:** Responsibility for health services is relatively decentralized. The main principles are as follows: The State is responsible for legislation, supervision and guidelines. The regions are responsible for hospital services, health insurance and special nursing homes. The municipalities are responsible for primary health care, home nursing, nursing homes and child and school health services.

The regional authorities have operational responsibility for health services.

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

## 1.2 Organisering og ansvar for sundhedsvirksomheden

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

Driftsansvaret for sundhedsydelserne påhviler regionerne.

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

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

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

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

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

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

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.

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

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

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

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.

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

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

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

Specialsygehusene er ikke særskilt organiseret, men er under sygehusene. Der er i forbindelse med strukturreformen blevet etableret sundhedscentre 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, according to the so-called extended free choice arrangement, patients can choose to receive treatment at a private hospital or a hospital abroad that has a contract with the region in which the patient lives. Certain types of treatment are exempt from this arrangement, such as organ transplantation, sterilization and psychiatric treatment.

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

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

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,

De almindelige plejehjem drives af kommunerne, men der eksisterer et betydeligt antal private (selvejende) plejehjem,

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

der modtager beboere i henhold til aftaler indgået med beliggenhedskommunerne. Visse specialplejehjem drives af regionerne. 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' home rule determines the rules concerning the tasks of the health service, benefits and administration. The organization of hospital services, specialist fields, and primary health services largely follows the Danish system. The same applies to nursing homes, home nurses and home helps, and dental treatment.

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

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

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

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

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

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.

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.

Midwifery services are organized under the hospital services.

Jordemoderordningerne er organiseret under sygehusvæsenet.

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

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

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

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

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.

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

Health services are organized in 16 health districts, each with a health centre, where primary health services and preventive measures are provided.

Sundhedsvæsenet er organiseret i 16 sundhedsdistrikter, hver med et sundhedscenter, som forestår den primære og forebyggende sundhedsindsats.

Specialist doctors regularly visit the coastal hospitals to provide specialist out-patient care. Specialist surgeons also carry out elective surgery.

Speciallæger besøger jævnligt kystsygehusene med henblik på ambulante speciallægeundersøgelser, og for de skærende specialers vedkommende også elektive indgreb.

All obstetric services are organised under a joint obstetric leadership that has overall responsibility. With the help of patient records that are sent in, and with consultations locally, they decide which births shall be referred to special departments.

Alle fødsler er samlet under en fælles obstetrisk ledelse som har det overordnede ansvar, og som ved hjælp af udsendte manualer og visitationskonferencer beslutter hvilke fødsler der skal foregå på specialafdeling.

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.

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

There are no occupational health services in Greenland.

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

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

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

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

Der er ikke indført BST – bedriftssundhedstjeneste i Grønland.

**FINLAND:** Det er kommunerne, der har ansvaret for sundhedsvæsenet. Kommunernes ansvar for 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:

- 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.

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

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

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

- 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.

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

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

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

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

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

The municipalities must provide services for people who are mentally ill that can reasonably be offered in health centres.

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

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

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

Physicians working in health centres are usually specialists in general medical care. In the public health service system, patients need a referral for specialist

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

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

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

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

Læger, der arbejder ved sundhedscentrene, er normalt alment praktiserende specialister. Patienterne skal i det offentlige sundhedssystem have en henvisning

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.

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 nursing services, short-term and periodic stays and treatment in nursing homes, and day care in hospitals. Health services for elderly people also include primary medical care, prevention and rehabilitation. Long-term treatment and residential care for elderly people is provided in old people's homes and nursing homes.

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

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 statsligt 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, sterilisation, induced

**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

abortion, assisted reproduction, forensic medicine, and regulations for companies offering health services.

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 treatment. Primary health services and specialized health services are both part of the ÅHS.

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

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

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

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

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

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

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

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

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

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

Regulations for pharmacies are the same as in Finland.

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

- The Medical Directorate of Health Act
- Patients' Rights Act
- Social Security Act
- Patient Insurance Act
- Communicable Diseases Act
- Physicians Act

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

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

Bedriftssundhedstjenesten organiseres som i Finland.

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

Reglerne for apotekervæsenet er det samme som i Finland.

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

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

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

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.

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.

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

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

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

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

There are three types of hospitals: 1) specialized hospitals, the university hospital in Reykjavík providing highly specialised hospital service for all people in Iceland, and general care for the residents of the Capital city area, and the teaching hospital in Akureyri, 2) regional hospitals with a certain degree of specialization, and 3) local hospitals. Many local hospitals also function as old people's homes and nursing homes. Other health institutions include rehabilitation hospitals and clinics for substance abusers.

Der er tre typer sygehuse: 1) specialiserede sygehuse, hvoraf et findes i Reykjavík der udbyder højt specialiseret service for alle borgere i Island samt almen behandling til beboerne i hovedstadsområdet og et undervisningshospital 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. Physiotherapists in private practice work under a contract with the SSI.

En vis del af fysioterapien foregår gennem sundhedscentrene, men det meste af behandlingen varetages af privatpraktiserende fysioterapeuter i byområderne. Privatpraktiserende fysioterapeuter arbejder på kontrakt med Rigsforsikringen.

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

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

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

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

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

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

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

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

Pharmacies are privately run.

Apoteker drives af private.

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

**NORGE:** Udbudet af sundhedsydelser er i Norge baseret på en decentral model. Staten er ansvarlig for politiklægningen og via lovgivningen og budgetlægningen sikrer at de nødvendige ressourcer er 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).

Within the limits of legislation and available economic resources, regional health authorities and the municipalities are for-

Indenfor de begrænsninger lovgivningen og de økonomiske ressourcer sætter, er de regionale udbydere og kommunerne

mally free to plan and run public health services and social services as they like. However, in practice, their freedom to act independently is limited by available resources.

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

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

In Norway there is currently a National Mental Health Programme. The programme was originally for the period 1999 to 2006, and it has been prolonged until 2008. This programme aims at improving accessibility, quality and organization of

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.
- 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, kvali-

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.

tetssikring 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.

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

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. Tandbehandling 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
- Health Services Supervision Act
- Mental Health Care Act
- Dental Health Services Act
- Tobacco Act
- Medicinal Products Act
- Abortion Act

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

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

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

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

The purpose of the primary health service is to promote public health within a geographically defined area.

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

The county and regional authorities still have responsibility for both outpatient and inpatient psychiatric treatment.

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

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

Det primære sundhedsvæsen drives af de l8 landsting og tre regioner.

Det primære sundhedsvæsen har til opgave at arbejde for hele befolkningens sundhed inden for et afgrænset geografisk område.

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.

Landstingene og regionerne har ligesom tidligere ansvaret for den psykiatriske behandling såvel inden for som uden for

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.

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 pct. 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

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

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.

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

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

## 1.3 Supervision of health services

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

There is one office of the chief medical officer in each region. These institutions are part of the National Board of Health and are thus independent, politically and administratively, of the regional and municipal authorities, which have responsibility for health services supplied to the general public. In this way, the chief medical officers work as independent advisers and supervisors at all levels. If the National Board of Health becomes aware of breaches in the legislation or deficiencies in the health sector it informs the relevant authorities. It can also inform the public when this is necessary in the interest of the health of the Danish population.

## 1.3 Tilsyn med sundhedsvæsenet

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

Der er én embedslægeinstitution i hver region. Disse institutioner er en del af Sundhedsstyrelsen og således politisk og administrativt uafhængige af regioner og kommuner, der har ansvaret for sundhedsvæsenets betjening af befolkningen. Sundhedsstyrelsen kan således fungere som uafhængig rådgiver og er tilsynsførende på alle niveauer. Sundhedsstyrelsen kan, hvis styrelsen bliver bekendt med overtrædelser eller mangler på sundhedsområdet, orientere vedkommende myndighed i fornødent omfang samt orientere offentligheden, når særlige sundhedsmæssige forhold gør det nødvendigt.

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

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.

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

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

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

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

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

**GRØNLAND:** Tilsynsmyndigheden er Embedslægeinstitutionen i Grønland som er en sundhedsfagligt uafhængig institution under Grønlands Hjemmestyre. Embedslægeinstitutionen yder rådgiv-

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

ning og anden bistand i sundhedsfaglige spørgsmål til Landsstyret og andre myndigheder. Tilsynsområderne er sundhedsvæsenets institutioner, sundhedsfaglige personer samt kommunale og andre institutioner. Sundhedsfaglige klager rettes skriftligt til Embedslægeinstitutionen, som vurderer, forbereder og sagsfremstiller klagen, før den videresendes til Sundhedsvæsenets Patientklagenævn i København som foretager den endelige behandling, høring og afgørelse. Klager over service samt krav om erstatninger behandles af Direktoratet for Sundhed.

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

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

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

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

A nationwide body for the protection of patients rights has been established. The body may assess whether the services provided by a municipality are up to the required standards. If the body finds that the services are inadequate, and that the municipality is responsible for this, then

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

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

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

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

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

**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.

nævnet anbefale kommunen hvordan manglerne skal udbedres og inden for hvilken tidsramme det skal ske.

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

**ÅLAND:** Tilsynet med sundhedspersonalet sker efter finsk lovgivning.

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

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

The 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. Handling of a case under the provision of the Medical Directorate of Health Act may be appealed to the Minister of health.

Medicinaldirektøren modtager klager vedrørende sundhedsvæsenet og foretager de nødvendige undersøgelser og træffer afgørelserne. Håndtering af sager under loven om sundhedsdirektoratet kan appelleres til sundhedsministeren.

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

**NORGE:** Helsetilsynet (centralt) og Helsetilsynet i amterne (fylkene) fører 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 Supervisioncan 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. overordnet tilsyn 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 overordnede 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 as organizational audits: systematic appraisal of health care, to ascertain whether activities and results are in accordance with current laws and regula-

Tilsynet med sundhedsvæsenet sker ved systemrevision: Systematiske undersøgelser, for at fastslå om aktiviteter og tilhørende resultater er i overensstemmelse med de krav der fastsættes i henhold til love og for-

tions, and whether internal control systems function in practice. Every institution providing health services has a duty to establish an internal control system to ensure that the institution is run in accordance with laws and regulations.

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

The Norwegian Board of Health Supervision 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 Supervision (centrally).

If health care personnel do not comply with the regulations, the Norwegian Board of Health Supervision 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 claims for compensation related to treatment in the public health service.

**SWEDEN:** The county and regional authorities are responsible for offering high quality health care for residents in their

skrifter, samt om det interne kontrolsystem fungerer i praksis. Enhver virksomhed der udbyder sundhedsydelser har pligt til at etablere et internt kontrolsystem med henblik på at sikre at virksomheden drives i overensstemmelse med love og forskrifter.

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

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

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

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

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

**SVERIGE:** Det er landstingene og regionerne som har ansvaret for at tilbyde en god sygdomsbehandling for indbyggerne

area. They are also responsible for community dental care (primarily for children and young persons).

i deres områder. De har ligeledes ansvaret for den offentlige tandpleje (først og fremmest for børn og unge).

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

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

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

Socialstyrelsen er statens centrale tilsynsmyndighed for sundheds- og sygehusvæsenet. I følge loven om erhvervsvirksomhed inden for 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.

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

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.

The agencies with overall responsibility for health services have their own impartial (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.

De hovedansvarlige for sundhedsvæsenet har egne upartiske nævn (patientnævn) 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.

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

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

## 1.4 Financing of health services

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

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

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

## 1.4 Finansiering af sundhedsvæsenet

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

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

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

through a basic contribution from the municipalities, along with municipal and state subsidies that are dependent on activities.

grundbidrag fra kommunerne samt kommunale og statslige aktivitetsafhængige tilskud.

## 1.5 Charges for health care as per 1 January 2008

## 1.5 Egenbetaling for sundhedsydelser pr. 1. januar 2008

### *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 physician's fee. However, in most cases the actual charge is higher and thus the reimbursement is less than 40 per cent.

### *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:** For medical consultations within the primary health service at a clinic, or for home visits, there is a user charge of EUR 15 Outside the opening hours the charge for home visits is EUR 20. The fee for a visit to a specialist is EUR 20 and a casualty department is EUR 25. The maximum patient contribution for primary health care and outpatient treatment is EUR 300 within one calendar year, after which there is no charge for the remainder of the year, with the exception of short-term stays in institutions/hospitals, where the charge is reduced from EUR 20 per day to EUR 10 per day. For children and young people under the age of 18 and people over the age of 65, the maximum amount for patient fees is EUR 125 per calendar year. After this amount has been reached all treatment, for children and young people is free. The fee per day for a hospital stay for persons aged 65 years and older is reduced from EUR 20 to EUR 10. The activities included in the maximum user charge have been fixed beforehand. If there is a waiting period of 45 minutes or more in connection with a scheduled visit during normal opening hours, the user charge is reimbursed.

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

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

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

The patient charge for a consultation in a health centre or with a private general medical practitioner during normal working hours is ISK 1 000. The charge is ISK 500 for pensioners, disabled people, and long-term unemployed people. There is no charge for children under 18. Outside normal working hours the charges are ISK 2 200, 1 100. Charges for home visits

Egenbetalingen for konsultation i sundhedscentrene eller ved en privat praktiserende læge er i dagtimerne 1.000 ISK og 500 ISK for pensionister, funktionshæmmede og langtidsarbejdsløse. Der er ingen egenbetaling for børn under 18 år Konsultation udenfor dagtimerne er henholdsvis 2.200, 1.100 ISK. For hjemmebesøg er betalingen i dagtimerne 2.400,

are ISK 2 400, 1 200 and during the daytime and ISK 3 300, 1 600.

The user charge for a consultation with a specialist is either ISK 3 100 plus 40 per cent of the remaining cost of the consultation, or ISK 1 100 plus 1/3 of 40 per cent of the remaining cost for the consultation. The user charge for children under 18 years is 1/9th of the total charge with a minimum of ISK 550. There is no charge for disabled and chronically ill children. The maximum user charge for all groups is ISK 21 000. The same patient charges apply to outpatient treatment in hospitals. Different charges apply to ambulant contacts at emergency units and with other physicians, laboratory tests, X-ray and diagnostic examinations.

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

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

The user charges for a consultation with a physician and for casualty services are: primary physician: NOK 130 (day), NOK 220 (evening), specialist: NOK 160 (day), NOK 250 (evening).

The user charges for a home visit are: primary physician: NOK 180 (day) and NOK 295 (evening), specialist: NOK 210 (day) and NOK 325 (evening).

The user charge for a consultation at a hospital out-patient department is NOK 280.

1.200 ISK og ingen egenbetaling mens aften- og nattaksten er 3.300, 1.600 ISK.

Egenbetalingen for besøg hos en specialist er enten 3.100 ISK plus 40 pct. af de resterende udgifter, eller 1.100 ISK og en tredjedel af 40 pct. af de resterende udgifter. For børn under 18 år er egenbetalingen 1/9 del af de samlede udgifter minimum 500 ISK. Der er ingen egenbetaling for funktionshæmmede og langtidssyge børn. Egenbetaling for børn under 18 år er 1/9 af de samlede udgifter, med et minimum på 550 ISK. For alle grupper er maksimumbetalingen 21.000 ISK. Egenbetalingen er den samme ved behandling af specialister ved hospitalernes ambulatorier men en anden for behandling i akutmodtagelser og hos andre læger samt for laboratorieprøver, diagnostik og røntgenbehandling.

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

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

Egenbetalingen for konsultation hos en læge og hos lægevagten er følgende: Almenlæge: 130 NOK (dag) og 220 NOK (aften). Hos en specialist: 160 NOK (dag) og 250 NOK (aften).

Egenbetalingen ved sygebesøg er som følgende: Almen læge 180 NOK (dag) og 220 NOK (aften), speciallæger: 210 NOK (dag) og 325 NOK (aften).

Egenbetalingen for ambulante patienter på et hospital er 280 NOK.

The user charge for laboratory tests, histological tests and cytological tests is NOK 47.

Egenbetalingen for laboratorie-, histologiske- og cytologiske prøver er 47 NOK.

The user charge for a radiograph or an ultrasound examination is NOK 200.

Egenbetaling for røntgen- og ultralydsundersøgelser er 200 NOK.

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

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

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

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

### User charges for a consultation with a physician

| | Are there consistent rules for the whole country? | Size of user charge | Deviations | User charge in relation to total cost of consultation |
|---|---|---|---|---|
| Denmark | Yes | - | No | - |
| Faroe Islands | Yes | - | No | - |
| Greenland | Yes | - | No | - |
| Finland | Yes | Public EUR 0-11 EUR 15 if the visit occurs between 2000 and 0800 or on a Saturday, a Sunday or a public holiday. Private min. 60 per cent | No charge for children under 18 years of age | 26 per cent. |
| Åland | Yes | EUR 15 Outside opening hours for home visits, and specialist EUR 20 | Free treatment after paying EUR 300 for children below 18 and people 65 + EUR 125 | .. |
| Iceland | Yes | ISK 1 000-3 300 in primary care, other fees for specialized care | ISK 500-1 600 for pensioners, disabled and long-term unemployed. No charge for children under 18 years of age | Varies |
| Norway | Yes | Consultation with a primary physician: NOK 130 (day), NOK 220 (evening) Consultation with a specialist: NOK 160 (day) and NOK 250 (evening) | In the case of pregnancy, childbirth, treatment of industrial injuries, war injuries, for prison inmates, children under 12 years of age, in the case of psychotherapy for persons under 18 years of age and for treatment of dangerous contagious diseases | Approx 35 per cent |
| Sweden | No | SEK 100-300 | Yes | .. |

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

**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 200 SEK, mens den varierer fra 200 til 300 SEK ved lægebesøg hos specialister (ved sygehusene eller hos privatpraktiserende læger).

**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 60 pct. | Ingen betaling for børn under 18 år. | 26 pct. |
| Åland | Ja | 15 EUR. 20 EUR for hjemmebesøg udenfor åbningstiderne og besøg hos specialist. | Fri behandling når der er betalt 300 EUR og 125 EUR for børn under 18 år, samt personer 65 år og ældre. | .. |
| Island | Ja | 1.000-3.300 ISK hos almen læge, andre priser for besøg hos specialist. | 500–1.600 ISK for pensionister, handicappede og langtidsarbejdsløse. Der er ingen egenbetaling for børn under 18 år. | Varierende. |
| Norge | Ja | Hos almen læge: 130 NOK (dagtimer) 220 NOK (aften og nat) Konsultation hos en specialist: 160 NOK (dagtimer) og 250 NOK (aften og nat). | Ved svangerskab/fødsel, erhvervsskade, krigsskade, for indsatte i fængsel, børn under 12 år, ved psykoterapeutisk behandling af børn og unge under 18 år og ved farlige smitsomme sygdomme. | Ca. 35 pct. |
| Sverige | Nej | 100– 300 SEK | Ja | .. |

In most counties/regions, children and young people under the age of 20 years may attend an outpatient clinic free of charge. In some counties children and young people pay a lower user charge than adults. In the regions, the age limit for paying user charges varies from 12 years to the calendar year in which a person turns 20. In one county, user charges are lower for persons 65 years of age and older.

I de fleste landsting/regioner kan børn og unge under 20 år gå til ambulant lægebehandling uden brugerbetaling. I nogle landsting betaler børn og unge en lavere egenbetaling end voksne. I andre landsting varierer grænsen for at der ikke opkræves brugerbetaling mellem 12 år og det kalenderår hvor man fylder 20 år. I et landsting er egenbetalingen lavere for personer 65 år og ældre.

## *Reimbursement for pharmaceutical products*

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

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

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

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

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

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.

## *Tilskud til lægemidler*

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

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

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

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.

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

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.

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

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

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

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

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

**GREENLAND:** All pharmaceutical products are distributed through the health

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

Siden liberaliseringen i oktober 2001 findes der i Danmark nu mere end 1.500 godkendte forhandlere af ikke apoteksforbeholdte håndkøbslægemidler til mennesker og/eller dyr.

Fælles for de godkendte forretninger uanset sortiment af lægemidler er, at de skal respektere gældende regler vedrørende opbevaring og kvalitet samt forbud mod selvvalg og salg til børn under 15 år.

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

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

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

**GRØNLAND:** Al medicin distribueres gennem sundhedsvæsenet, bortset fra

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.

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 (42, 72 and 100 per cent) for prescription pharmaceutical products, and reimbursement is calculated separately for each purchase and for each category. However, there is a user charge of EUR 3 for pharmaceutical products with 100 per cent reimbursement.

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

Some new and expensive drugs (e.g. for dementia and multiple sclerosis), in special cases, are 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 643.14 in the course of one calendar year.

Som hovedregel dækker sygeforsikringen de udgifter til receptpligtige lægemidler som overskrider et beløb på 643,14 EUR 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 13 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. 13 pct. af de registrerede lægemidler.

**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 510 per prescription. Children under twelve 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 510 NOK pr. recept. Børn under 12 år og personer der modtager mindste pension betaler ikke for vigtige lægemidler. Andre lægemidler betales fuldt ud af patienten.

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

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

## 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 | .. per cent |
| Faroe Islands | Yes | .. | No | .. |
| Greenland | Yes | - | No | - |
| Finland | Yes | 58 per cent of the cost | For certain diseases 3 EUR or 28 per cent of the cost (disease specific) | 44 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. 34 per cent |
| Norway | Yes | 36 per cent maximum NOK 510 per prescription | For children below 12 years and persons who receive a minimum pension: no user charge | .. |
| Sweden | Yes | SEK 0-1 800 | - | .. |

## Egenbetaling for lægemidler

| | Er der ensartede regler i hele landet? | Egenbetalingens størrelse | Afvigelser | Egenbetalingens andel af de samlede udgifter til lægemidler |
|---|---|---|---|---|
| Danmark | Ja | Tilskud afhængig af størrelsen af den enkelte patients lægemiddelforbrug i primærsektoren | Nej | .. pct. |
| Færøerne | Ja | .. | Nej | .. |
| Grønland | Ja | - | Nej | - |
| Finland | Ja | 58 pct. af beløbet | Ved visse sygdomme betales 3 EUR eller 28 pct. af beløbet (sygdomsspecifikt) | 44 pct. |
| Åland | Ja | Som i Finland | Som i Finland | - |
| Island | Ja | 1.700 ISK + 65/80 pct. af den resterende pris, dog højst / ISK 3.400/4.950 | Pensionister og handicappede: ISK 600 + 50 pct. af den resterende pris, dog højst 1.050/1.375 ISK | Ca. 34 pct. |
| Norge | Ja | 36 pct. maksimum 510 NOK pr. recept | For børn under 12 år og personer som kun modtager mindste pension: ingen egenbetaling | .. |
| Sverige | Ja | 0-1.800 SEK | - | .. |

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

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

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

Rabatten udregnes efter værdien på de lægemidler som købes. Den maksimale egenbetaling er 1.800 SEK. Derefter modtager patienterne et frikort for resten af 12 måneders perioden. For indkøb op til 900 SEK i en 12 måneders periode betaler man selv det hele. På udgifter derudover ydes der rabat. For udgifter mellem 900 SEK og 1.700 SEK gives der 50 pct. rabat. Mellem 1.700 og 3.300 SEK er rabatten 75 pct. og for udgifter mellem 3.300 SEK og 4.300 SEK er rabatten 90 pct. Når der er købt lægemidler for 4.300 SEK har man nået op på egenbetalingens maksimum. Patienten har ved dette niveau selv betalt 1.800 SEK og får så tildelt et frikort for resten af 12 måneders perioden. Ordningen omfatter rabatberettigede lægemidler på recept, inkl. P-piller og brugsartikler til stomier. Insulin er gratis.

### *Treatment in hospitals*

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

**FINLAND AND ÅLAND:** Patients pay a charge for admission to hospitals and health centres: EUR 26 (Åland EUR 20), and psychiatric departments: EUR 12 (Åland 10). The charge for rehabilitation is EUR 9 per treatment day and the maximum user charge for day surgery is EUR 72 (Åland EUR 40) plus EUR 26, if the patient has to stay overnight. A series of treatment costs EUR 6 per visit (Åland EUR 5) (max. 45 times per year).

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

### *Behandlinger ved sygehuse*

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

**FINLAND OG ÅLAND:** Patienterne betaler for indlæggelse på hospital og sundhedscentre 26 EUR (Åland 20 EUR), og psykiatrisk afdeling 12 EUR (Åland 10). Betaling for revalidering er 9 EUR pr behandlingsdag og den maksimale betaling for dagkirurgi er 72 EUR (Åland 40 EUR) plus 26 EUR, hvis der er behov for en overnatning. Seriel behandling koster 6 EUR per besøg (Åland 5 EUR) (max 45 gange per år).

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

## 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 in overnight care for day surgery EUR 72 | Payment for long-term stay according to means. For children 0–17 years max. 7 days | 7 per cent. |
| Åland | Yes | EUR 20 EUR 10 for psychiatric wards EUR 10 for day surgery | Payment for long-term stay according to means | .. |
| Iceland | Yes | - | No | - |
| Norway | Yes | - | No | - |
| Sweden | No | SEK 0-80 per day | .. | .. |

## Egenbetaling for indlæggelse på sygehus

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

**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.

**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.

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.

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.

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

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

### *Reimbursement for dental treatment*

### *Tilskud til tandbehandling*

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

I alle lande bliver en del af udgifterne til tandbehandling som er nødvendige for at forebygge alvorlige komplikationer i forbindelse med infektioner i tænder og mundhuler for patienter med nedsat immunforsvar, eksempelvis patienter med leukæmi, cancer i ansigtet der venter på transplantation og patienter der har behov for benmarvs transplantation og patientgrupper der kan sammenlignes med disse, får også refunderet deres udgifter.

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

**DANMARK:** Tilskuddet til tandbehandling gives fra den offentlige sygesikring. Voksne betaler typisk 60 pct. af de overenskomstfastsatte betalingstakster. Der ydes ikke tilskud til tandprotetik.

Municipal and regional dental services are regulated by health legislation.

Kommunal og regional tandpleje gives efter reglerne i sundhedsloven.

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

Derudover er ca. 1,9 millioner danskere dækket af en privat forsikringsordning som – afhængig af dækningsgrad og forsikringspræmie – giver tilskud til egenbetaling for tandlægehjælp.

Children and young people below 18 years of age receive free municipal dental care including orthodontic treatment. Children below 16 years of age, who wish to have treatment that is not provided free of charge by the municipal council, may – by paying a user charge – choose to be treated in a private clinic of their own choice or at a public dental clinic in another municipality. Elderly people who live in a nursing home or in their own home with technical aids are offered dental care for which from 1 January 2008 there is a maximum annual charge of DKK 1 560. In addition, the municipalities provide a subsidy for dentures in cases of impaired function or disfigurement resulting from damage caused by accidents.

Der er vederlagsfri kommunal tandpleje, herunder tandregulering, for børn og unge under 18 år. Børn under 16 år, der ønsker et andet behandlingstilbud end det, kommunalbestyrelsen vederlagsfrit stiller til rådighed, kan – mod en vis grad af egenbetaling – vælge at modtage kommunal tandpleje i privat tandlægepraksis efter eget valg eller ved en anden kommunes tandklinik. Ældre personer, der bor på plejehjem eller i eget hjem med mange hjælpeforanstaltninger, tilbydes omsorgstandpleje, for hvilken der fra 1. januar 2008 maksimalt opkræves 1.560 DKK pr. år. Kommunen yder derudover støtte til tandproteser i tilfælde af funktionelt ødelæggende eller vansirende følger af ulykkesbetingede skader.

The municipality offers specialist dental treatment to persons, who because of psychiatric illness or mental handicap, cannot use the existing dental services for children and young people, for adults, or for people needing special care. For these services, the region, from 1 January 2008, charges the patient a maximum of DKK 1 560 per year.

Kommunen tilbyder specialiseret tandpleje til personer, der på grund af sindslidelser eller psykisk udviklingshæmning, ikke kan udnytte de eksisterende tandplejetilbud i børne- og ungdomstandplejen, voksentandplejen eller i omsorgstandplejen. For disse ydelser kan kommunen fra 1. januar 2008 opkræve en egenbetaling på 1.560 DKK årligt.

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

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

In addition, the region grants a special reimbursement for dental care to cancer patients, who either due to radiation of the head and neck or due to chemotherapy suffer from considerable documented dental problems and to persons who due to Sjögrens Syndrome suffer from considerable documented dental problems. From 1 January 2008, for these services the region can demand a user payment of a maximum of DKK 1 560 annually. Finally, the region provides highly specialized dental advice, examination and treatment (in dental research centres) for patients with rare diseases and handicaps, for whom the underlying disease can lead to special problems with their teeth, mouth or jaws.

Regionen 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 2008 opkræve en egenbetaling på maksimalt 1.560 DKK årligt. Endelig yder regionen højt specialiseret odontologisk rådgivning, udredning og behandling (i odontologisk landsdels- og videnscenter) af patienter med sjældne sygdomme og handicap, hos hvem den tilgrundliggende tilstand giver anledning til specielle problemer i tænder, mund og kæbe.

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

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

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 tand-behandling i henhold til den sociale lovgivning.

**FAROE ISLANDS:** Dental treatment is mainly provided by private dentists. Payment is therefore partly private, and partly subsidized by the health insurance scheme. The subsidy amounts to about half of the total cost of dental treatment for adults.

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

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

Der findes i kommunalt regi en gratis skoletandplejeordning til børn under 16 år. Denne ordning omfatter også specialtandpleje, så som tandretning.

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

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

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

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

**FINLAND:** A basic fee of EUR 7 per visit (EUR 11 for a visit to a specialist) is charged for dental treatment at a health centre. In addition to this, user fees of EUR 5-130 can be charged, dependent on the type of treatment provided.

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

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

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

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

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.

**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.

**ICELAND:** The national dental health insurance system in Iceland pays according to a public fee schedule set by the Minis-

**ISLAND:** Sygeforsikringen i Island betaler med en takst for tandbehandling som er bestemt af sundhedsministeren. Den

ter 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.

takst er sædvanligvis forskellig fra den takst som de private tandlæger bruger, fordi de har lov til at fastsætte deres egen pris.

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.

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

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.

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.

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

Der kan til denne gruppe ydes 50, 75 eller 100 pct. dækning af udgifterne til tandbehandling (af sygeforsikringens takst). Helproteser og delproteser er dækket. Guld- og porcelænskroner eller broer og implantater kan refunderes med op til 80.000 ISK per år.

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

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

The cost of dental treatment (including orthodontic treatment), for congenital malformations and serious abnormalities such as cleft palate and aplasia, and the cost of dental treatment necessary because of accidents and illness, is reimbursed according to special rules.

For behandling (inkl. ortodonti) af medfødte misdannelser, større anomalier som fx ganespalte, samt for aplasier, ulykker og sygdom betales efter særlige regler.

Dental treatment is not subsidized for the rest of the population. No private dental insurance is available either.

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 det 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 pct. 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 aged 65 years or older the cost of prosthetic treatment is limited to SEK 900 plus the cost of materials. The dental treatment insurance pays the rest of the cost of treatment directly to the dentist. Reimbursement for dental treatment from a private dentist is limited to the public fees set by the county.

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

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

- Oral surgery carried out in hospitals
- Dental treatment that is a part of the treatment of disease over a limited period of time
- Dental treatment for certain elderly or disabled people who have difficulties maintaining their oral hygiene.

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

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 900 SEK plus udgifter til materialer. Forsikringen for tandbehandling betaler det resterende beløb direkte til tandlægen. For privatpraktiserende er tilskuddet begrænset til det offentliges takster i lenet.

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

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

- Kirurgisk tandbehandling som udføres ved et sygehus
- Tandbehandling der er led i en sygdomsbehandling i en begrænset periode
- Tandbehandling til visse ældre og handicappede som har svært ved at klare mundhygiejne.

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

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

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

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

**FINLAND:** If the total cost of pharmaceutical products exceeds EUR 643.14 per year, or if travelling costs for treatment exceed EUR 157.25 per year, the Social Insurance Institution reimburses the excess costs. If a person's ability to pay taxes is reduced because of sickness, a special tax relief may be granted. The amount of the tax relief is calculated on the basis of the person's and his/her family's ability to pay taxes.

User charges for a long-term stay in an institution or a hospital cannot exceed 82 per cent of a patient's/resident's net income. However, a patient shall have at least EUR 90 per month for personal necessities. The same charge is payable in all kinds of institutions within the social and health care sectors.

The so-called user charge ceiling of EUR 590 is applied by the municipal social and welfare sectors. Once the ceiling for the

### *Maksimal egenbetaling*

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

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

**FINLAND:** Hvis den maksimale egenbetaling for medicin udgør 643,14 EUR pr. år og hvis udgifterne til transport i forbindelse med behandling overstiger 157,25 EUR pr. år vil Folkpensionsanstalten dække det overskydende beløb. Hvis evnen til at betale skat er nedsat på grund af sygdom gives der en særlig skattelettelse. Skattelettelsens størrelse beregnes i forhold til den pågældendes eller dennes families muligheder for at betale skat.

Egenbetalingen for langtidsophold på institution/hospital kan højest udgøre 82 pct. af patientens/beboerens nettoindkomst. Dog skal patienten have mindst 90 EUR per måned til personlige fornødenheder. Det er den samme betaling som opkræves på alle typer af institutioner inden for social- og sundhedssektoren.

Det såkaldte udgiftsloft på 590 EUR er taget i anvendelse for det kommunale social- og sundhedsvæsen. Når loftet i kalender-

present calendar year is exceeded, the user may generally utilize services free of charge. The ceiling applies to physician services in the primary health care sector, physiotherapy, outpatient treatment, day surgery and short-term stays in institutions in the social and health sectors. Dental care, patient transport, certificates, laboratory tests and radiological examinations requisitioned by private physicians must still be paid for. Income-regulated payments are not included in the maximum amount. Payments made for children under 18 years of age are added to the amount paid by the person who has paid the costs.

**ÅLAND:** The rules for maximum user charges for medicines and transport to and from treatment are the same as in Finland. For treatment of illness, there is a maximum user charge for medical visits and outpatient treatment of no more than EUR 300 during one calendar year, after which all services are free of charge for the remaining part of the year, with the exception of short-term stays in institutions/hospitals, for which the charge is reduced from EUR 20 per day to EUR 10 per day. The maximum charge for children and young people under 18 years and 65+ of age is EUR 125 per calendar year, after which all treatment included in the maximum user charge scheme is free, including hospital treatment for people under 18 years. As part of the maximum user charge, payment for outpatient treatment and services received outside the county are also included. Dental treatment, and x-ray and laboratory examinations are not included. User charges may be deducted from municipal tax.

**ICELAND:** Within the present system, user charges are reimbursed for people aged

året 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 inden for social- og sundhedsvæsenet. Der betales fortsat for tandbehandling og sygetransport, attester, laboratorieundersøgelser og radiologiske undersøgelser som udføres efter henvisning fra en privatpraktiserende læge. Indkomstregulerede betalinger medregnes ikke i maksimumsbeløbet. Betaling for børn under 18 år medregnes i maksimumsbeløbet hos den der har betalt for det.

**ÅLAND:** Reglerne for den maksimale egenbetaling for medicin og transport til og fra behandling er den samme som i Finland. Ved sygdomsbehandling er der en maksimal egenbetaling ved lægebesøg og ambulant behandling på højest 300 EUR i løbet af et kalenderår hvorefter al service er gratis den resterende del af året med undtagelse af kortvarige institutions/hospitalsophold hvor betalingen reduceres fra 20 EUR pr døgn til 10 EUR pr døgn. For børn og unge under 18 år og 65+ er den maksimale egenbetaling 125 EUR per kalenderår hvorefter al behandling der indgår under den maksimale egenbetaling er gratis, inklusiv behandling på en hospitalsafdeling for børn og unge under 18 år. Til den maksimale egenbetaling medregnes også betaling for ambulant behandling og ydelser som er modtaget uden for landskabet. Derimod medregnes bl.a. tandbehandling, røntgen- og laboratorieundersøgelser ikke. Egenbetalingen kan fratrækkes i kommuneskatten.

**ISLAND:** I det nuværende system refunderes egenbetalingen for personer i alderen

18-70 years of age, if the costs exceed ISK 21 000 during one calendar year. The same applies to children under 18 if charges exceed ISK 7 000. User charges exceeding ISK 5 200 are reimbursed for the following groups: 60-70 year-old senior citizens receiving a full basic pension, senior citizens 70 years and older, disabled persons, and persons who have been continually unemployed for 6 months or longer.

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

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

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

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

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

18-70 år, hvis den i løbet af ét kalenderår overstiger 21.000 ISK. Det samme gælder for børn under 18 år hvis egenbetalingen overstiger 7.000 ISK. For følgende grupper refunderes egenbetalingen hvis den overstiger 5.200 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.

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

There are two separate reimbursement schemes in Norway.

Der er to helt adskilte egenandelsordninger i Norge.

The following services are included in reimbursement scheme 1:

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

Følgende ydelser indgår i egenandelsloft nr. I:

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

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

Følgende ydelser indgår i egenandelsloft nr. II:

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

In 2008, the cost ceiling for reimbursement scheme 1 was NOK 1 740 and for reimbursement scheme 2 NOK 2 500.

Egen andelsloftet for 2008 for egen andelsloft I er 1.740 NOK og for egen andelsloft II 2.500 NOK.

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

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

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

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.

from charges is issued. The card is valid for the remaining part of the period.

Frikortet gælder for den resterende del af perioden.

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.

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.

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

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

## CHAPTER II

# Population and fertility
# *Befolkning og fertilitet*


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## Ekstra Materiale

Nordic tables for births and abortions

Nordiske tabeller for fødsler og aborter

## 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.

## 2.1 Population and population trends

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

The development in population growth varies somewhat between the Nordic countries. The natural increase has been greatest in Iceland, the Faroe Islands and Greenland throughout the period. Sweden and Åland have the lowest natural increase. In 2006, net migration contributed to population growth in all the Nordic countries with the exception of Greenland and the Faroes Islands. In addition, there is a large deficit of women of fertile age in the Faroe Islands. In Iceland in particular, there has been a marked increase in immigration.

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

## 2.1 Befolkning og befolkningsudvikling

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

Udviklingen i befolkningstilvæksten varierer en del de nordiske lande imellem. Fødselsoverskuddet har hele perioden igennem været størst i Island, Færøerne og Grønland. Sverige og Åland har det laveste fødselsoverskud. I 2006 bidrager nettomigrationen til en befolkningsforøgelse med undtagelse af Grønland og Færøerne. Desuden har Færøerne et meget stort underskud af kvinder i den fertile alder. Især Island har en meget markant stigning i indvandringen.

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

**Figure 2.1.0 Mean population by sex and age as a percentage of the total population 2006**
Middelfolketallet efter køn og alder i pct. af hele befolkningen 2006

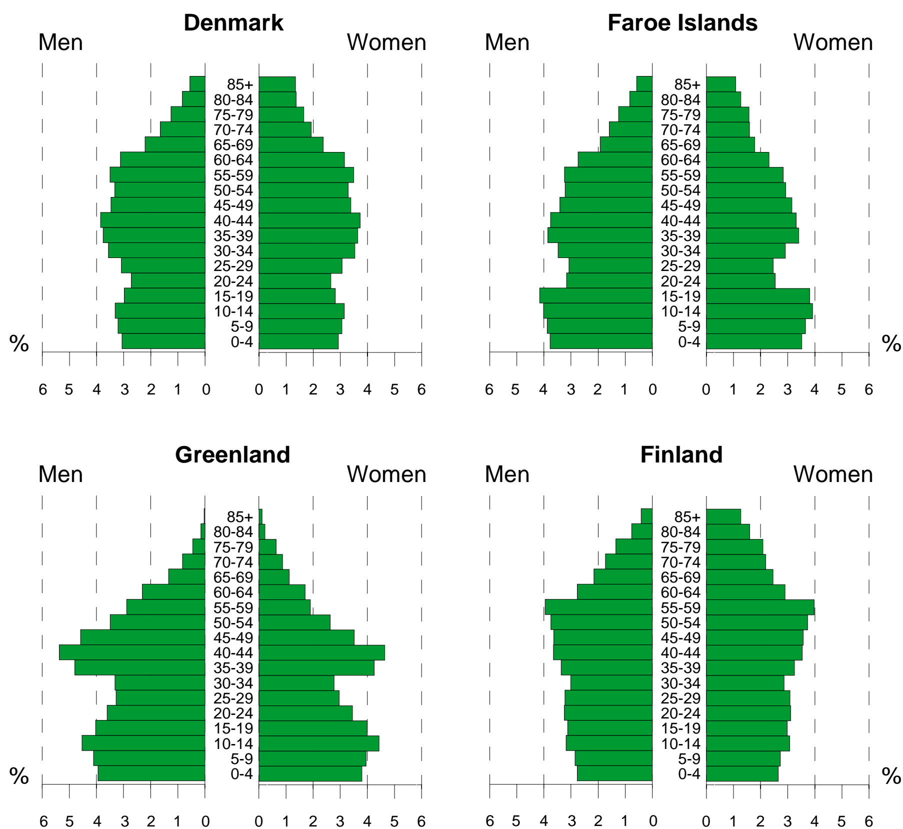

**Figure 2.1.0 ... continued**
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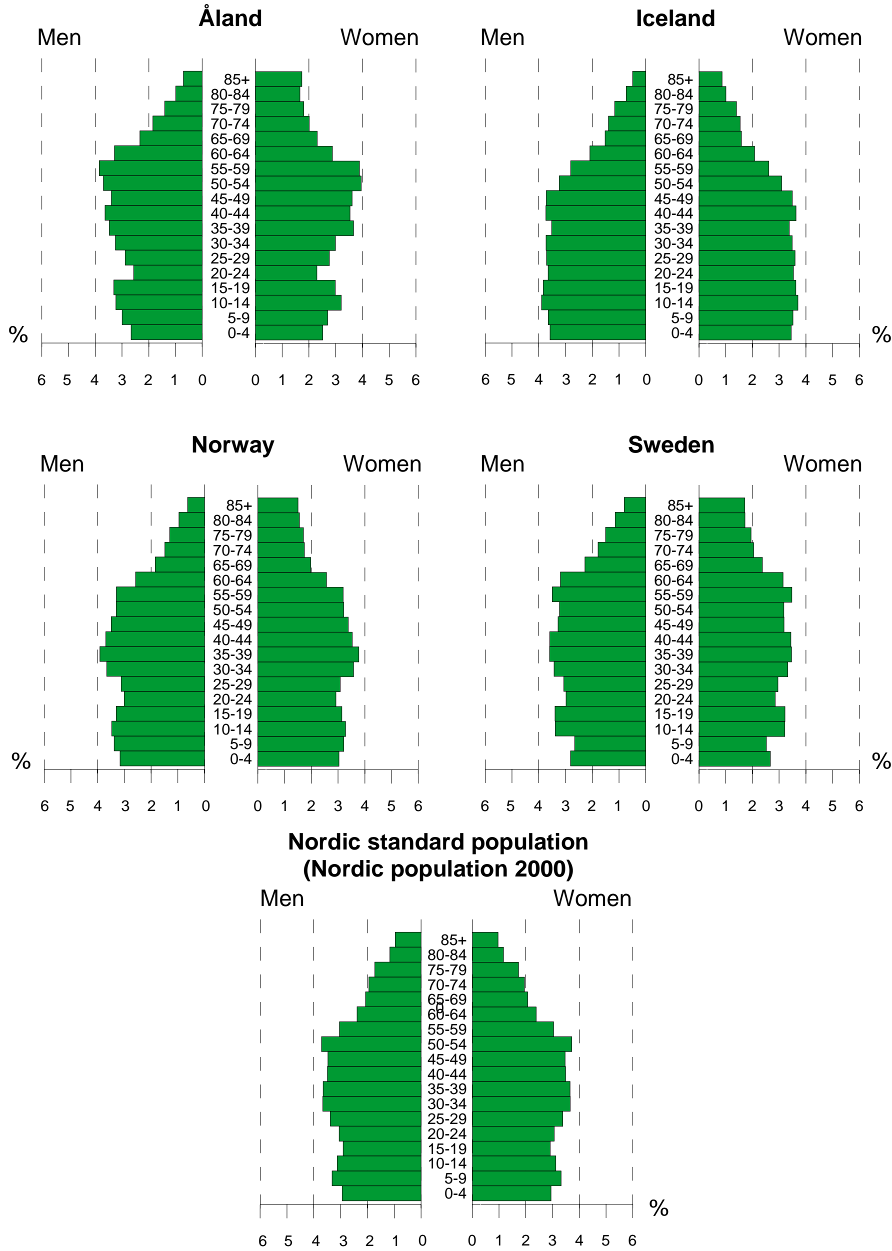


**Figure 2.1.1 Mean population by age groups 1995-2006 per cent**
Middelfolketallet fordelt på aldersgrupper 1995-2006 pct.

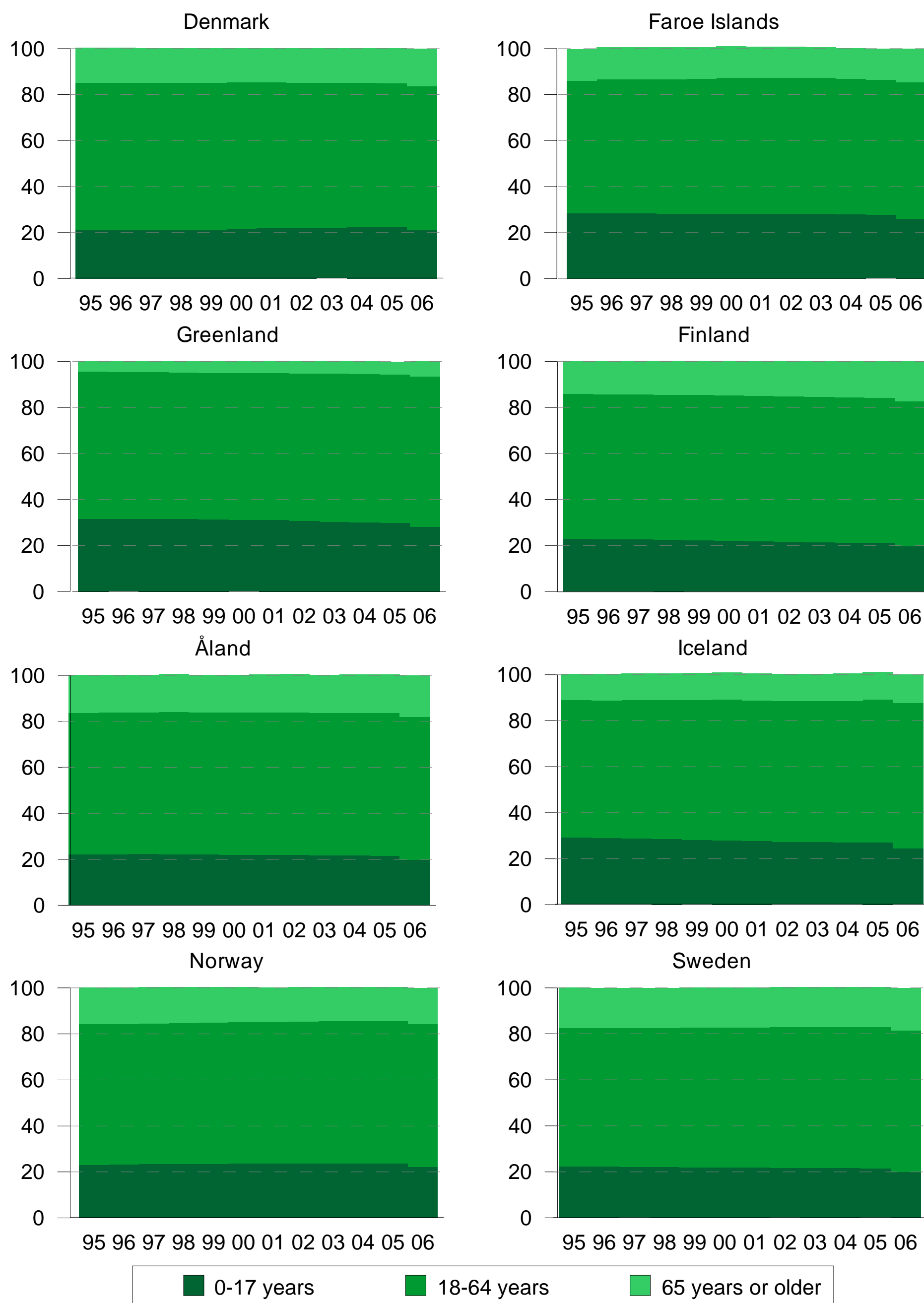


**Table 2.1.1 Mean population 1995-2006**
Middelfolketallet 1995-2006

| | 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 |
| 2005 | 2 680 | 25 | 30 | 2 567 | 13 | 148 | 2 293 | 4 487 |
| 2006 | 2 690 | 25 | 30 | 2 572 | 13 | 154 | 2 314 | 4 575 |
| *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 |
| 2005 | 2 736 | 23 | 27 | 2 679 | 13 | 147 | 2 330 | 4 561 |
| 2006 | 2 744 | 23 | 27 | 2 683 | 14 | 150 | 2 347 | 4 505 |
| *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 |
| 2005 | 5 416 | 48 | 57 | 5 246 | 27 | 296 | 4 623 | 9 048 |
| 2006 | 5 435 | 48 | 57 | 5 255 | 27 | 304 | 4 661 | 9 080 |

*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 2.1.2 Vital statistics per 1 000 inhabitants 1995-2006**
Befolkningens bevægelser pr. 1 000 indbyggere 1995-2006

| | *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 |
| 2005 | 11.9 | 10.2 | 1.7 | 1.2 | 2.9 |
| 2006 | 12.0 | 10.2 | 1.8 | 1.8 | 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 |
| 2005 | 14.8 | 8.7 | 6.1 | -8.7 | -2.6 |
| 2006 | 13.7 | 8.6 | 5.1 | -1.8 | 3.3 |
| Greenland | | | | | |
| 1995 | 20.1 | 8.7 | 11.4 | -8.3 | 3.1 |
| 2000 | 15.8 | 8.1 | 7.7 | -3.6 | 4.1 |
| 2005 | 15.5 | 8.1 | 7.4 | -7.9 | -0.5 |
| 2006 | 14.8 | 7.7 | 7.1 | -11.3 | -4.3 |
| Finland | | | | | |
| 1995 | 12.3 | 9.6 | 2.7 | 0.6 | 3.3 |
| 2000 | 11.0 | 9.5 | 1.4 | 0.5 | 1.9 |
| 2005 | 11.0 | 9.1 | 1.9 | 1.7 | 3.6 |
| 2006 | 11.2 | 9.1 | 2.1 | 2.0 | 4.1 |
| Åland | | | | | |
| 1995 | 13.4 | 10.2 | 3.2 | -3.5 | -0.3 |
| 2000 | 10.0 | 9.6 | 0.4 | -1.2 | 3.1 |
| 2005 | 10.1 | 9.7 | 0.3 | 5.6 | 5.9 |
| 2006 | 11.0 | 9.6 | 1.4 | 1.6 | 3.0 |
| Iceland | | | | | |
| 1995 | 16.0 | 7.2 | 8.8 | -5.3 | 3.7 |
| 2000 | 15.3 | 6.5 | 8.8 | 6.1 | 15.3 |
| 2005 | 14.5 | 6.2 | 8.3 | 13.0 | 21.3 |
| 2006 | 14.5 | 6.3 | 8.3 | 17.3 | 25.6 |
| Norway | | | | | |
| 1995 | 13.8 | 10.4 | 3.5 | 1.5 | 4.9 |
| 2000 | 13.2 | 9.8 | 3.4 | 2.2 | 5.6 |
| 2005 | 12.3 | 8.9 | 3.4 | 4.0 | 7.3 |
| 2006 | 12.6 | 8.9 | 3.7 | 5.1 | 8.8 |
| Sweden | | | | | |
| 1995 | 11.7 | 10.6 | 1.1 | 1.4 | 2.4 |
| 2000 | 10.2 | 10.5 | -0.3 | 2.8 | 2.4 |
| 2005 | 11.2 | 10.1 | 1.1 | 3.0 | 4.0 |
| 2006 | 11.6 | 10.0 | 1.6 | 5.6 | 7.2 |

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

**Table 2.1.3 Average life expectancy 1996-2006**
Middellevetiden 1996-2006

| | *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 |
| 2004/05 | 75.6 | 61.2 | 32.5 | 16.0 | 7.0 | 80.2 | 65.7 | 36.4 | 19.0 | 8.8 |
| 2005/06 | 75.9 | 61.4 | 32.7 | 16.2 | 7.1 | 80.4 | 65.9 | 36.5 | 19.0 | 8.8 |
| Faroe Islands | | | | | | | | | | |
| 1996-00 | 75.2 | 60.7 | 32.2 | 15.5 | 7.0 | 81.4 | 66.8 | 37.4 | 19.4 | 8.8 |
| 2001-05 | 76.9 | 62.4 | 33.7 | 16.9 | 7.7 | 81.4 | 66.6 | 37.5 | 19.5 | 8.7 |
| 2002-06 | 76.5 | 62.3 | 33.6 | 16.7 | 7.5 | 81.3 | 66.7 | 37.5 | 19.4 | 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 |
| 2002-06 | 65.7 | 52.4 | 27.5 | 11.6 | 5.1 | 71.0 | 57.2 | 29.3 | 13.5 | 6.2 |
| Finland | | | | | | | | | | |
| 1996-00 | 73.6 | 59.1 | 31.1 | 15.0 | 6.6 | 80.8 | 66.2 | 37.1 | 19.1 | 8.1 |
| 2005 | 75.5 | 61.0 | 32.7 | 16.7 | 7.4 | 82.3 | 67.7 | 38.6 | 20.7 | 9.1 |
| 2006 | 75.8 | 61.2 | 33.0 | 16.8 | 7.4 | 82.8 | 68.2 | 38.9 | 20.9 | 9.2 |
| Åland | | | | | | | | | | |
| 1996-00 | 75.8 | 61.3 | 32.7 | 16.2 | 7.1 | 82.5 | 67.6 | 38.4 | 20.5 | 9.0 |
| 2001-05 | 77.6 | 63.4 | 34.7 | 17.1 | 7.3 | 83.6 | 69.1 | 39.8 | 21.4 | 9.6 |
| 2002-06 | 78.0 | 63.8 | 34.9 | 17.3 | 7.4 | 83.5 | 69.1 | 39.4 | 21.1 | 9.4 |
| Iceland | | | | | | | | | | |
| 1996-00 | 77.1 | 62.6 | 34.0 | 16.7 | 7.3 | 81.4 | 66.8 | 37.4 | 19.6 | 8.6 |
| 2004/05 | 79.2 | 64.5 | 35.5 | 18.0 | 7.7 | 83.1 | 68.4 | 39.0 | 20.7 | 9.4 |
| 2005/06 | 79.4 | 64.7 | 35.8 | 18.3 | 7.8 | 83.0 | 68.3 | 38.8 | 20.6 | 9.4 |
| Norway | | | | | | | | | | |
| 1996-00 | 75.5 | 61.1 | 32.7 | 15.7 | 6.7 | 81.1 | 66.6 | 37.4 | 19.5 | 8.5 |
| 2005 | 77.7 | 63.2 | 34.5 | 17.1 | 7.3 | 82.5 | 67.9 | 38.6 | 20.6 | 9.3 |
| 2006 | 78.1 | 63.5 | 34.9 | 17.5 | 7.5 | 82.7 | 68.0 | 38.7 | 20.6 | 9.2 |
| Sweden | | | | | | | | | | |
| 1996-00 | 76.9 | 62.4 | 33.6 | 16.4 | 7.0 | 81.8 | 67.2 | 37.9 | 19.9 | 8.8 |
| 2005 | 78.4 | 63.8 | 34.9 | 17.4 | 7.4 | 82.8 | 68.1 | 38.7 | 20.6 | 9.3 |
| 2006 | 78.7 | 64.1 | 35.1 | 17.6 | 7.6 | 82.9 | 68.3 | 38.9 | 20.8 | 9.4 |

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

**Figure 2.1.2 Live births and natural increase per 1 000 inhabitants 1990-2006**
Levendefødte og fødselsoverskud per 1 000 indbyggere 1990-2006

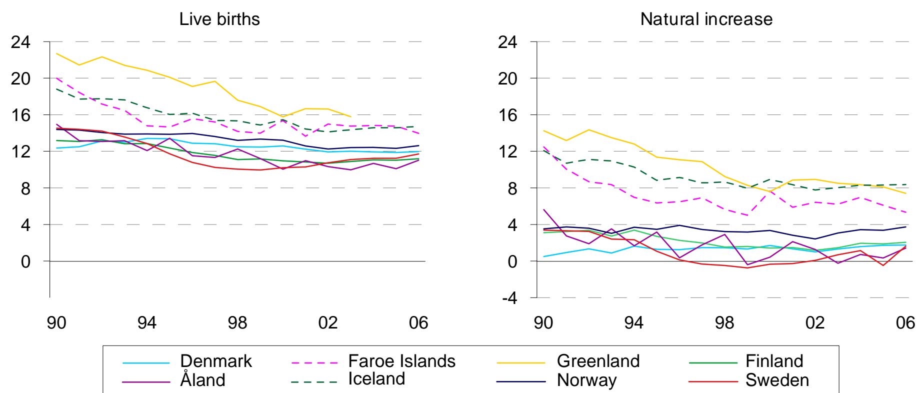
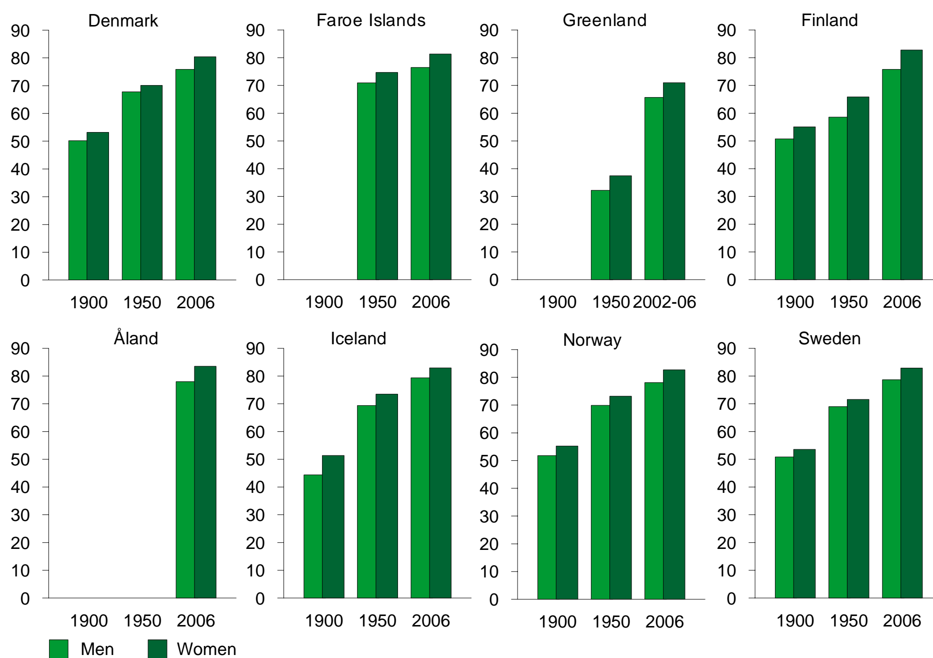



**Figure 2.1.3 Life expectancy at birth 1900, 1950 and 2006**
Middellevetiden for nyfødte 1900, 1950 og 2006



## 2.2 Fertility, births, infant mortality and contraception

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

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

Internationally, the Nordic countries are characterized by having very low perinatal mortality. Greenland has the highest among the Nordic countries. The other countries lie relatively close to each other. Changes in perinatal mortality during this period are the result of changes in the definition of gestational age. The time limit for abortion in Denmark is now 22 weeks, while it was previously 28 weeks. In Finland and Åland it was changed in 1987 from 28 weeks to 22 weeks. It is still 28 weeks in the other countries.

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 2006.

## 2.2 Fertilitet, fødsler, spædbørnsdødelighed og prævention

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

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

Internationalt er de nordiske lande kendetegnet ved at have en meget lav perinatal mortalitet. Grønland ligger højest blandt de nordiske lande. De øvrige lande ligger relativt tæt. Ændringerne i den perinitale dødelighed i perioden skyldes ændringer i definitionen på gestationsalderne. Abortgrænsen i Danmark er nu 22 mod tidligere 28 uger, Finland og Åland er ændret fra 28 til 22 uge i 1987 mens den fortsat er 28 uger i de resterende lande.

Grønland har ligeledes den højeste dødelighed for det første leveår. Island har den laveste dødelighed i det første leveår i 2006.

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

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

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

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

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

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

Use of emergency contraception is relatively widespread in the Nordic countries. Use is highest in Norway and lowest in Denmark, the Faroe Islands, and Greenland. The low use in Denmark reflects the fact that Denmark has the highest number of women who use hormonal contraceptives.

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

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

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

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 greatly in the Nordic countries.

Der er betydelige forskelle mellem landenne med hensyn til abortraterne.

**Table 2.2.1 Live births and fertility rate 1996-2006**
Levendefødte og fertilitetsrate 1996-2006

| | *Number of live births* | *Live births per 1 000 women by age* Levendefødte pr. 1 000 kvinder i alderen | | | | | | | *Total fertility rate* |
|---|---|---|---|---|---|---|---|---|---|
| | Antal levende fødte | 15-19[1)] | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49[2)] | Samlet fertilitet |
| *Denmark* | | | | | | | | | |
| 1996-00 | 66 951 | 8.0 | 54.7 | 129.7 | 109.3 | 41.3 | 6.0 | 0.2 | 1 746 |
| 2005 | 64 282 | 5.7 | 43.2 | 123.9 | 127.4 | 48.5 | 8.4 | 0.3 | 1 802 |
| 2006 | 65 258 | 6.0 | 44.1 | 126.5 | 130.8 | 50.9 | 8.9 | 0.3 | 1 850 |
| *Faroe Islands* | | | | | | | | | |
| 1996-00 | 657 | 19.3 | 108.0 | 166.0 | 129.1 | 58.1 | 11.1 | 0.3 | 2 459 |
| 2001-05 | 694 | 13.5 | 109.8 | 174.1 | 138.7 | 64.8 | 12.0 | 0.4 | 2 566 |
| 2002-06 | 700 | 14.7 | 97.4 | 175.0 | 142.8 | 67.0 | 12.8 | 0.5 | 2 550 |
| *Greenland* | | | | | | | | | |
| 1996-00 | 994 | 55.9 | 160.9 | 118.4 | 87.7 | 47.6 | 13.5 | 1.4 | 2 426 |
| 2005 | 884 | 66.5 | 147.2 | 118.4 | 90.6 | 38.8 | 7.3 | 1.0 | 2 349 |
| 2002-06 | 845 | 55.7 | 125.3 | 133.5 | 81.6 | 39.0 | 8.1 | 0.5 | 2 222 |
| Finland | | | | | | | | | |
| 1996-00 | 58 295 | 9.5 | 61.4 | 119.8 | 101.6 | 44.7 | 8.8 | 0.5 | 1 735 |
| 2005 | 57 745 | 10.3 | 57.4 | 116.3 | 112.9 | 51.5 | 10.7 | 0.6 | 1 803 |
| 2006 | 58 840 | 9.4 | 58.4 | 116.8 | 117.9 | 53.0 | 11.0 | 0.5 | 1 837 |
| *Åland* | | | | | | | | | |
| 1996-00 | 286 | 4.9 | 42.7 | 122.0 | 106.3 | 50.1 | 8.5 | 0.6 | 1 665 |
| 2001-05 | 273 | 4.8 | 51.9 | 103.4 | 116.5 | 52.6 | 11.5 | 0.4 | 1 702 |
| 2002-06 | 275 | 5.0 | 49.9 | 104.0 | 117.6 | 55.7 | 11.6 | 0.6 | 1 726 |
| *Iceland* | | | | | | | | | |
| 1996-00 | 4 215 | 23.4 | 90.2 | 129.0 | 107.2 | 51.6 | 9.4 | 0.2 | 2 055 |
| 2005 | 4 280 | 15.1 | 81.5 | 129.9 | 114.0 | 58.4 | 10.6 | 0.8 | 2 052 |
| 2006 | 4 415 | 14.4 | 78.8 | 128.3 | 119.4 | 62.5 | 11.2 | 0.3 | 2 074 |
| *Norway* | | | | | | | | | |
| 1996-00 | 59 522 | 12.4 | 70.6 | 130.9 | 107.8 | 43.5 | 6.9 | 0.2 | 1 851 |
| 2005 | 56 756 | 8.0 | 58.6 | 124.4 | 118.6 | 48.6 | 8.6 | 0.4 | 1 836 |
| 2006 | 58 545 | 8.7 | 60.3 | 127.2 | 122.8 | 51.9 | 8.9 | 0.4 | 1 904 |
| *Sweden* | | | | | | | | | |
| 1996-00 | 90 688 | 7.1 | 51.7 | 107.9 | 93.4 | 40.3 | 7.3 | 0.3 | 1 540 |
| 2005 | 101 346 | 6.2 | 46.6 | 109.5 | 124.9 | 55.9 | 10.3 | 0.5 | 1 769 |
| 2006 | 105 913 | 6.2 | 47.8 | 113.6 | 131.5 | 60.0 | 11.2 | 0.5 | 1 854 |

1 Women under 15 years are included
2 Women 49 + are included

1 Kvinder under 15 år er medregnet i raten
2 Kvinder over 49 år er medregnet i raten

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

## Table 2.2.2 In vitro fertilization 1995-2006[1)]
IVF-behandling 1995-2006[1)]

| | Denmark | Finland | Iceland | Norway[2)] | Sweden[3)] |
|---|---|---|---|---|---|
| *Treatments, IVF+ICSI* | | | | | |
| Behandlinger, IVF+ICSI | | | | | |
| 1995-1999 | .. | 4 569 | 324 | .. | .. |
| 2000-2004 | 7 487 | 4 448 | 301 | 4 309 | 7 447 |
| 2005 | 7 222 | 4 731 | 462 | 5 067 | 8 137 |
| 2006 | .. | 4 776 | 404 | .. | .. |
| *Frozen embryo transfers, FET* | | | | | |
| Tilbageføring af nedfrosne æg, FET | | | | | |
| 1995-1999 | .. | 2 015 | .. | .. | .. |
| 2000-2004 | 918 | 2 766 | 76 | 507 | 1 847 |
| 2005 | 1 500 | 2 960 | 161 | 1 698 | 2 636 |
| 2006 | .. | 3 063 | 170 | .. | .. |
| *Number of live births, IVF+ ICSI + FET* | | | | | |
| Antal levendefødte, IVF+ ICSI + FET | | | | | |
| 1995-1999 | .. | 1 348 | .. | .. | .. |
| 2000-2004 | 1 814 | 1 465 | 123 | 1 258 | 2 584 |
| 2005 | 1 786 | 1 534 | 167 | 1 521 | 2 690 |
| 2006 | .. | 1 694 | 143 | .. | .. |
| *Treatments in 2006 per 1 000 women aged 15-49 years* | | | | | |
| Behandlinger i 2006 pr. 1 000 kvinder i alderen 15-49 år | *2005* | | | *2005* | *2004* |
| IVF + ICSI | 5.8 | 4.0 | 5.4 | 4.7 | 4.0 |
| FET | 1.5 | 4.6 | 2.3 | 1.6 | 1.3 |
| Total | 7.8 | 6.5 | 7.7 | 6.2 | 5.3 |
| *Multiple births, per cent of all births after IVF* | | | | | |
| Flerbarnsfødsler, procent af alle fødsler efter IVF-behandling | 20.3 | 11.3 | 14.5 | 16.8 | 6.5 |
| *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 | 34.1 | 20.4 | 25.9 | 29.0 | 12.2 |
| *IVF, ICSI and FET, per cent of all live births* | | | | | |
| IVF, ICSI and FET i procent af alle levendefødte | 3.3 | 2.9 | 3.2 | 2.7 | 2.7 |

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

1 Based on the year of treatment not on the year of birth
2 Figures include the number of live births for all births in 2005
3 All figures 2004

1 Beregnet udfra behandlingsår, ikke fødselsår
2 I Norge dækker antal levendefødte over alle fødsler i 2005
3 Alle tal 2004

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

**Table 2.2.3 Stillbirths and infant mortality[1] 1996-2006**
Dødfødte og dødelighed i første leveår[1] 1996-2006

| | *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 |
| 2001-05 | 281 | 292 | 4.4 | 7.2 | 1.6 | 1.3 | 0.6 | 4.5 |
| 2006 | 349 | 254 | 5.3 | 7.8 | 1.5 | 1.0 | 0.5 | 3.9 |
| Faroe Islands | | | | | | | | |
| 1996-00 | 3.2 | 1.2 | 4.9 | 6.1 | 0.9 | 0.3 | 0.3 | 1.8 |
| 2001-05 | 1.6 | 2.2 | 2.3 | 4.0 | 0.9 | 0.9 | 0.6 | 3.2 |
| 2002-06 | 2.0 | 3.0 | 3.0 | 6.0 | 1.5 | 1.5 | 3.0 | 6.0 |
| Greenland | | | | | | | | |
| 1996-00 | 8 | 17 | 8.1 | 19.6 | 8.1 | 3.1 | 1.0 | 16.8 |
| 2001-05 | 5 | 15 | 5.4 | 14.2 | 6.0 | 2.6 | 0.4 | 16.9 |
| 2006 | 3 | 12 | 3.6 | 14.2 | 5.9 | 4.8 | .. | 14.3 |
| Finland | | | | | | | | |
| 1996-00 | 214 | 227 | 3.7 | 5.8 | 1.3 | 0.8 | 0.6 | 3.9 |
| 2001-05 | 187 | 191 | 3.2 | 5.2 | 1.1 | 0.8 | 0.5 | 3.3 |
| 2006 | 193 | 167 | 3.3 | 4.8 | 0.8 | 0.7 | 0.5 | 2.8 |
| Åland | | | | | | | | |
| 1996-00 | - | 1 | 1.5 | 3.5 | 0.7 | 1.4 | - | 3.5 |
| 2001-05 | 1 | 1 | 3.7 | 6.6 | 1.5 | 1.5 | - | 3.7 |
| 2002-06 | 1 | 1 | 2.2 | 4.4 | 1.5 | 0.7 | - | 2.9 |
| Iceland | | | | | | | | |
| 1996-00 | 15 | 15 | 3.5 | 5.7 | 1.6 | 0.5 | 0.3 | 3.5 |
| 2001-05 | 9 | 10 | 2.2 | 3.6 | 0.7 | 0.7 | 0.2 | 2.5 |
| 2006 | 15 | 6 | 3.4 | 4.1 | 0.2 | 0.5 | 0.2 | 1.4 |
| Norway[2] | | | | | | | | |
| 1996-00 | 244 | 244 | 4.1 | 6.2 | 1.0 | 1.1 | 0.6 | 4.1 |
| 2001-05 | 209 | 195 | 3.7 | 5.5 | 0.9 | 0.9 | 0.6 | 3.5 |
| 2006 | 201 | 185 | 3.4 | 5.3 | 1.0 | 0.8 | 0.7 | 3.2 |
| Sweden | | | | | | | | |
| 1996-00 | 332 | 325 | 3.7 | 5.4 | 0.8 | 0.9 | 0.6 | 3.6 |
| 2001-05 | 329 | 303 | 3.5 | 5.0 | 0.7 | 0.9 | 0.5 | 3.1 |
| 2006 | 319 | 297 | 3.0 | 4.4 | 0.7 | 0.7 | 0.4 | 2.8 |

1 Calculated according to year of death
2 Figures for infant death 2006 are preliminary figures

1 Opgjort efter dødsår
2 Spædbørnsdødelighed for Norge 2006 er foreløbige tal

*Sources:* Kilder: 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

**Figure 2.2.1 Total fertility rate 1995-2006**
Samlet fertilitetsrate 1995-2006

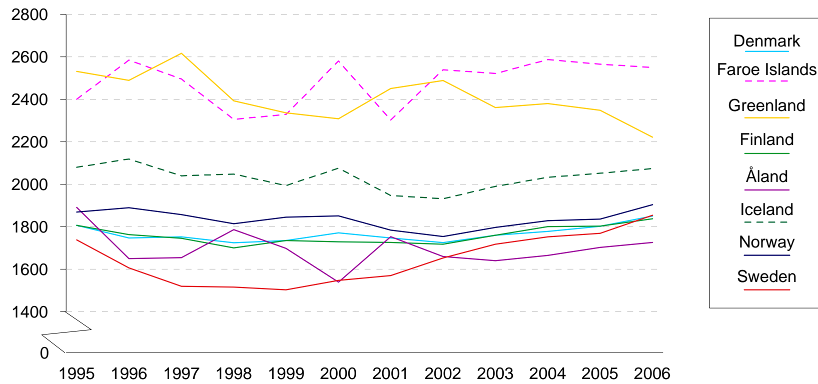
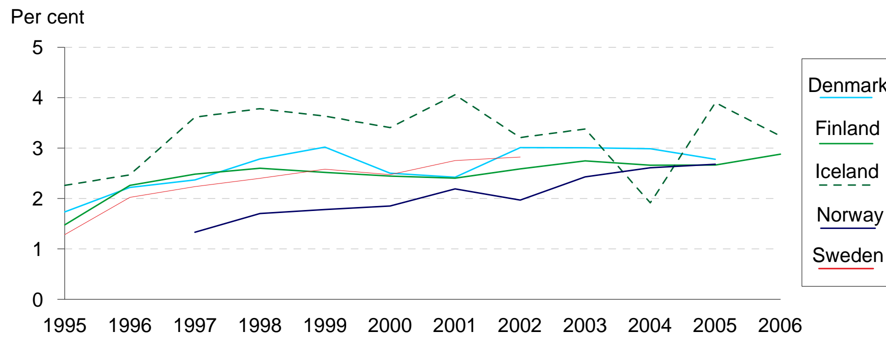



**Figure 2.2.2 IVF, ICSI and FET, percentage of all live births 1995-2006**
IVF, ICSI og FET i procent af alle levendefødte 1995-2006




*Source:* *Tables 2.2.2*
Kilde: Tabel 2.2.2

**Figure 2.2.3 Perinatal deaths and infant mortality 1996-2006**
Perinatal dødelighed og dødelighed i første leveår 1996-2006

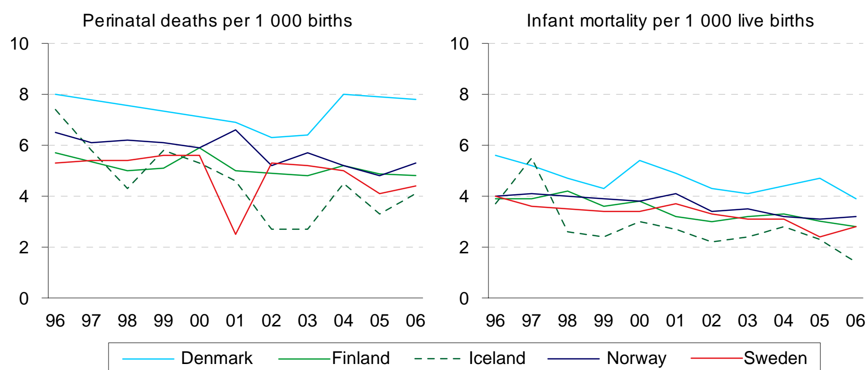


**Table 2.2.4 Stillbirths and deaths during the first year of life per 1 000 births, with birthweight 1 000 grams and more, total figures and rates per 1 000 births[1)] 1995-2006**

Dødfødte og døde i løbet af første leveår med en fødselsvægt på 1 000 gram og mere, i alt og pr. 1 000 fødte 1995-2006[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 |
| 2005 | 123 | 174 | 1.9 | 0.8 | 0.7 | 0.5 | 0.8 | 2.7 |
| 2006 | 150 | 126 | 2.3 | 0.4 | 0.5 | 0.3 | 0.7 | 2.0 |
| Finland | | | | | | | | |
| 1995 | 187 | 168 | 3.0 | 0.5 | 0.7 | 0.5 | 1.0 | 2.7 |
| 2000 | 149 | 150 | 2.6 | 0.5 | 0.5 | 0.5 | 1.1 | 2.7 |
| 2005 | 116 | 119 | 2.0 | 0.5 | 0.5 | 0.3 | 0.8 | 2.1 |
| 2006 | 124 | 101 | 2.1 | 0.3 | 0.6 | 0.3 | 0.5 | 1.7 |
| 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 |
| 2005 | 6 | 4 | 1.4 | – | 0.5 | – | 0.5 | 0.9 |
| 2006 | 12 | 4 | 2.7 | 0.2 | 0.2 | – | 0.5 | 0.9 |
| Norway | | | | | | | | |
| 1995 | 177 | 182 | 2.9 | 0.7 | 0.7 | 0.4 | 1.3 | 3.0 |
| 2000 | 195 | 149 | 3.3 | 0.6 | 0.5 | 0.3 | 1.1 | 2.5 |
| 2005 | 142 | 104 | 2.5 | 0.5 | 0.4 | 0.3 | 0.6 | 1.8 |
| Sweden | | | | | | | | |
| 1995 | 318 | 295 | 3.1 | 0.6 | 0.6 | 0.5 | 1.2 | 2.9 |
| 2000 | 318 | 215 | 3.6 | 0.5 | 0.7 | 0.4 | 0.9 | 2.4 |
| 2005 | 263 | 182 | 2.6 | 0.4 | 0.4 | 0.2 | 0.9 | 1.8 |

1 Calculated according to year of birth

1 Opgjort efter fødselsår

*Sources:* 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 2.2.5 Sterilizations 1995-2006**
Sterilisationer 1995-2006

| | *Denmark*[1)] | *Faroe Islands* | *Greenland* | *Finland* | *Of which Åland* | *Iceland* |
|---|---|---|---|---|---|---|
| *Men* | | | | | | |
| Mænd | | | | | | |
| 1995 | 5 256 | 3 | 4 | 792 | - | 87 |
| 2000 | 5 544 | 10 | 18 | 1 772 | 2 | 246 |
| 2005 | 4 974 | .. | 10 | 1 821 | - | 285 |
| 2006 | 4 990 | 22 | 7 | 1 474 | - | 313 |
| *Women* | | | | | | |
| Kvinder | | | | | | |
| 1995 | 4 815 | 60 | 67 | 10 521 | 31 | 553 |
| 2000 | 5 101 | 29 | 127 | 8 699 | 31 | 519 |
| 2005 | 4 044 | 29 | 109 | 5 102 | 48 | 274 |
| 2006 | 3 615 | 35 | 105 | 3 822 | 28 | 206 |
| *Total* | | | | | | |
| I alt | | | | | | |
| 1995 | 10 071 | 63 | 71 | 11 313 | 31 | 640 |
| 2000 | 10 645 | 39 | 145 | 10 471 | 33 | 765 |
| 2005 | 9 018 | .. | 119 | 6 923 | 48 | 559 |
| 2006 | 8 605 | 57 | 112 | 5 296 | 28 | 519 |
| [2006] | | | | | | |
| *Per 1 000 in the age group* | | | | | | |
| Pr. 1 000 i alderen | | | | | | |
| *Men* | | | | | | |
| Mænd | | | | | | |
| 25-34 | 2.7 | .. | 0.5 | 0.8 | - | 3.4 |
| 35-44 | 7.6 | .. | 0.9 | 2.4 | - | 7.7 |
| 45-54 | 2.2 | .. | 0.0 | 0.9 | - | 2.6 |
| *Women* | | | | | | |
| Kvinder | | | | | | |
| 25-34 | 3.2 | .. | 13.5 | 2.8 | 1.3 | 2.5 |
| 35-44 | 5.7 | .. | 11.1 | 7.8 | 10.9 | 6.5 |
| 45-54 | 0.5 | .. | 1.4 | 0.5 | 2.5 | 0.7 |

1 Sterilizations performed in hospitals

1 Sterilisationer udført på sygehuse

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

**Table 2.2.6 Consumption of hormonal contraceptives: consumption per 1 000 women aged 15-44 years 2000-2007. DDD per 1 000 women 15-44 years/day[1]**
Forbrug af hormonale præventionsmidler: forbrug pr. 1 000 kvinder i alderen 15-44 år 2000-2007. DDD pr. 1 000 kvinder i alderen 15-44 år/dag[1]

| ATC-code G03A, incl. patches in G03AA13 and intravaginal contraceptives (G02BB) | Denmark[2] | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| 2000 | 297 | 258 | 209 | 224 | 281 | 259 | 211 | 299 |
| 2004 | 320 | 261 | 253 | 228 | 242 | 211 | 233 | 294 |
| 2005 | 322 | 283 | 314 | 225 | 218 | 207 | 235 | 240 |
| 2006 | 321 | 286 | 195 | 234 | 217 | 210 | 252 | 236 |
| 2007 | 319 | .. | .. | 236 | 229 | 251 | 238 | 237 |

1 Excl. injections and implants
2 Only receptdata

1 Ekskl. insprøjtninger og implantater.
2 Kun data fra recepter.

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

**Table 2.2.7 Emergency contraceptives: number of 1 000 sold packages 2000-2007**
Nødprævention: antal 1 000 solgte forpakninger 2000-2007

| ATC code G03A | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| 2000 | 31.5 | 0.1 | - | 42.7 | 0.2 | 2.0 | 27.7 | 10.9 |
| 2004 | 70.9 | 0.3 | 0.4 | 91.6 | 0.5 | 5.0 | 114.2 | 165.0 |
| 2005 | 76.7 | 0.5 | 0.5 | 91.4 | 0.5 | 6.4 | 128.1 | 167.2 |
| 2006 | 85.1 | 0.7 | 0.5 | 90.6 | 0.5 | 6.7 | 140.0 | 185.7 |
| 2007 | 96.4 | 0.7 | .. | 106.0 | 0.5 | 6.6 | 151.5 | 196.5 |
| Per 1 000 women aged 15-44 | | | | | | | | |
| 2000 | 28.5 | 12.2 | - | 41.9 | 36.0 | 31.6 | 30.2 | 6.4 |
| 2004 | 67.1 | 30.1 | 29.7 | 92.1 | 94.4 | 79.0 | 123,9 | 96.0 |
| 2005 | 72.6 | 60.7 | 40.9 | 92.2 | 95.8 | 101.6 | 138.7 | 97.0 |
| 2006 | 80.8 | 78.8 | 39.5 | 91.6 | 101.4 | 104.6 | 150.6 | 106.7 |
| 2007 | 91.5 | 82.2 | .. | 107.4 | 103.2 | 101.8 | 161.9 | 111.6 |

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

## Table 2.2.8 Number of induced abortions 1996-2006
Antal fremkaldte aborter 1996-2006

| | *Number of abortions* | *Abortions per 1 000 women by age* Aborter pr. 1 000 kvinder i aldermen | | | | | | | *Total abortion rate* | *Abortions per 1 000 live births* |
|---|---|---|---|---|---|---|---|---|---|---|
| | Antal aborter | 15-19[1] | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49[2] | Samlet abortrate | Aborter pr. 1 000 levendefødte |
| *Denmark* | | | | | | | | | | |
| 1996-00 | 16 580 | 14.5 | 21.0 | 19.5 | 18.3 | 12.8 | 4.8 | 0.5 | 456.5 | 247.4 |
| 2001-05 | 15 268 | 14.9 | 20.7 | 17.6 | 16.7 | 13.1 | 4.9 | 0.4 | 440.9 | 238.0 |
| 2006 | 15 529 | 16.7 | 22.5 | 18.2 | 16.1 | 12.5 | 5.6 | 0.5 | 460.5 | 242.1 |
| *Faroe Islands* | | | | | | | | | | |
| 1996-00 | 47 | 4.4 | 5.2 | 7.3 | 7.8 | 5.5 | 2.9 | 0.6 | 168.3 | 70.9 |
| 2001-05 | 40 | 4.3 | 5.3 | 6.3 | 4.3 | 5.2 | 1.8 | 0.3 | 146.3 | 57.9 |
| 2006 | 41 | 4.3 | 5.8 | 1.7 | 5.7 | 5.0 | 4.9 | 0.0 | 137 | 61.0 |
| *Greenland* | | | | | | | | | | |
| 1996-00 | 881 | 114.6 | 138.7 | 87.7 | 57.8 | 28.0 | 9.2 | 1.1 | 2 185.5 | 888.6 |
| 2001-05 | 861 | 113.9 | 143.2 | 92.6 | 58.9 | 28.9 | 10.3 | 0.9 | 2 247.9 | 946.7 |
| 2006 | 867 | 89.0 | 139.1 | 97.3 | 50.8 | 30.6 | 8.7 | 1.5 | 2 085.0 | 1 029.7 |
| *Finland* | | | | | | | | | | |
| 1996-00 | 10 638 | 12.8 | 15.0 | 13.3 | 10.9 | 7.4 | 2.9 | 0.3 | 312.9 | 196.0 |
| 2001-05 | 10 911 | 15.5 | 17.1 | 12.7 | 10.6 | 7.8 | 3.2 | 0.2 | 335.0 | 193.0 |
| 2006 | 10 655 | 14.0 | 17.9 | 12.0 | 9.8 | 7.7 | 3.2 | 0.2 | 324.0 | 181.0 |
| *Åland* | | | | | | | | | | |
| 1996-00 | 64 | 16.6 | 20.8 | 12.9 | 14.0 | 10.0 | 4.8 | 0.8 | 398.9 | 224.6 |
| 2001-05 | 63 | 16.4 | 22.1 | 18.7 | 10.5 | 11.1 | 3.7 | 0.2 | 413.3 | 242.3 |
| 2002-06 | 62 | 14.8 | 22.8 | 18.1 | 11.3 | 10.4 | 3.6 | 0.4 | 407.4 | 226.2 |
| *Iceland* | | | | | | | | | | |
| 1996-00 | 922 | 22.6 | 24.0 | 17.4 | 11.8 | 9.4 | 3.9 | 0.3 | 447.2 | 218.8 |
| 2001-05 | 915 | 19.4 | 23.7 | 16.9 | 13.4 | 9.1 | 4.5 | 0.3 | 435.9 | 220.1 |
| 2006 | 904 | 15.7 | 23.8 | 19.5 | 12.0 | 9.2 | 3.5 | 0.5 | 420.6 | 204.8 |
| *Norway* | | | | | | | | | | |
| 1996-00 | 14 248 | 18.7 | 26.1 | 19.7 | 15.2 | 9.9 | 3.5 | 0.3 | 471.0 | 239.4 |
| 2001-05 | 13 879 | 16.4 | 26.9 | 19.5 | 15.1 | 10.6 | 3.9 | 0.3 | 465.1 | 245.8 |
| 2006 | 14 417 | 16.3 | 28.0 | 20.6 | 15.6 | 11.0 | 4.3 | 0.3 | 480.5 | 246.3 |
| *Sweden* | | | | | | | | | | |
| 1996-00 | 31 250 | 18.2 | 27.0 | 23.4 | 20.2 | 15.0 | 5.9 | 0.6 | 551.5 | 344.4 |
| 2001-05 | 33 808 | 23.3 | 30.3 | 23.6 | 19.9 | 15.5 | 6.7 | 0.6 | 599.4 | 345.9 |
| 2006 | 36 045 | 24.6 | 33.1 | 25.2 | 19.7 | 15.7 | 6.9 | 0.6 | 629.0 | 340.3 |

1 Women under 15 years are included
2 Women 49 + are included

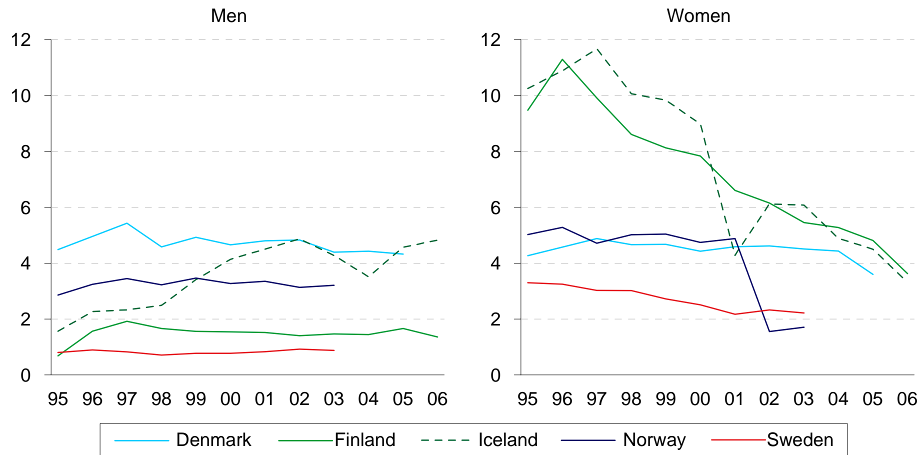
1 Kvinder under 15 år er medregnet i raten
2 Kvinder over 49 år er medregnet i raten

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

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

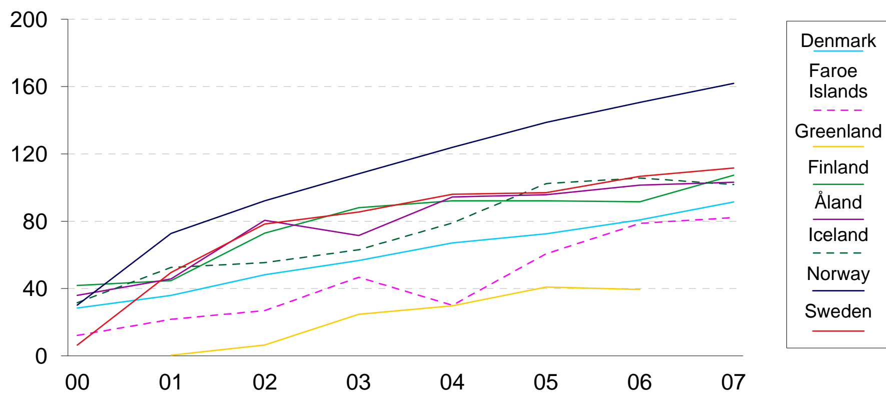
*Sources:* *The national abortion registers*
Kilder: De nationale abortregistre

**Figure 2.2.4 Sterilizations per 1 000 inhabitants aged 25-54 1995-2006**
Sterilisationer pr. 1 000 indbyggere i alderen 25-54 år 1995-2006



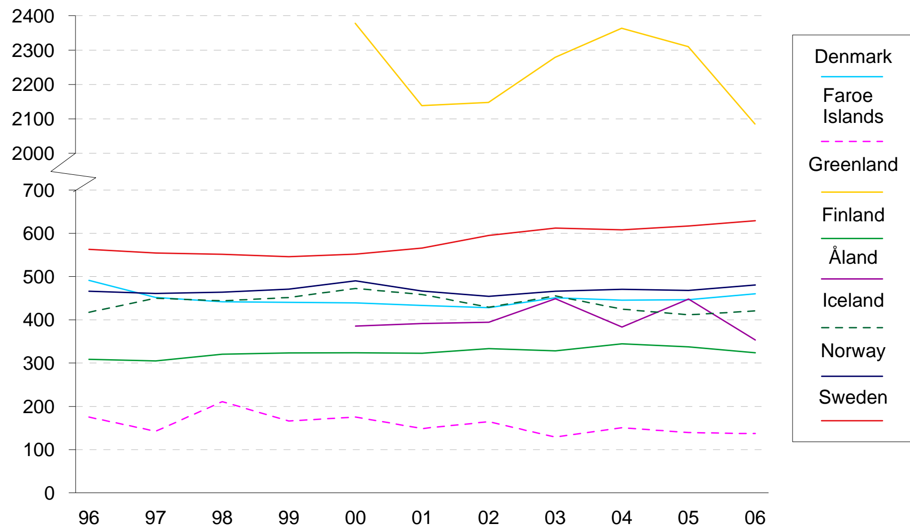

*Source:* *Table 2.2.5*
Kilde: Tabel 2.2.5

**Figure 2.2.5 Sales of emergency prevention per 1 000 women aged 15-44 years 2000-2007**
Salg af nødprævention pr. 1 000 kvinder I alderen 15-44 år 2000-2007




*Source:* *Table 2.2.7*
Kilde: Tabel 2.2.7

**Figure 2.2.6 Total abortion rate 1996-2006**
Samlet abortrate 1996-2006




*Source:* *Table 2.2.8*
Kilde: Tabel 2.2.8

# Chapter III

# Morbidity, medical treatment, accidents and medicinal products
# *Sygelighed, sygdomsbehandling, ulykker og medicin*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## Extra material / Supplerende materiale


| Extra material | Supplerende materiale |
|---|---|
| Reference group for Patient Statistics | Referencegruppe for patient statistik |
| Discharge data | Data for udskrivningerne |
| Shortlist for discharges | Kortliste for udskrivninger |
| Surgery data | Data for kirugi |
| Shortlist for surgery | Kortliste for kirugi |
| The Nordic Cancer Union | Den nordiske cancerunion |

## Introduction

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

## Indledning

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 uden for 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. Til sidst omtales medicinforbruget.

## 3.1 Diseases related to lifestyle

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

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

Table 3.1.2: Nicotine in various pharmacological formulations (N07BA01) is used to alleviate withdrawal symptoms and to help in smoking cessation. In all Nordic countries it belongs to the ten best selling substances calculated in terms of pharmacy retail prices. In Iceland the consumption is at least three times higher than in the other countries.

## 3.1 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 inden for sygehusene.

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

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

Bupropion (N07BA02), originally an antidepressant but introduced in 2000 to help smoking cessation, has a very small use in all countries.

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

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 nogenlunde er på samme niveau i de øvrige lande. Tilsvarende findes der også fleste behandlingsperioder/udskrivninger for alkoholiske leversygdomme i Danmark og Finland.

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

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

The number of diagnosed cases of tuberculosis is relatively stable in the Nordic Countries, with the exception of Greenland, where there has been a marked increase.

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

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

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

Without doubt, chlamydia infection is the most common sexually transmitted disease in the Nordic countries. It is also the most common cause of infertility

Chlamydiainfektion er helt givet den hyppigst forekommende blandt de seksuelt overførte sygdomme i de nordiske lande, og det er samtidig den almindeligste årsag

among women. There are some differences between the countries, but Greenland is radically different. The disease is often without symptoms, and is therefore probably under–reported.

til infertilitet hos kvinder. Der er en vis forskel mellem landene hvor Grønland dog skiller sig helt ud fra de øvrige lande. Sygdommen er ofte asymptomatisk, og derfor angivligt underrapporteret.

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.

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

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

**Table 3.1.1 Percentage of daily smokers by sex 2006**
Daglige rygere procentvis efter køn 2006

| | *Denmark*[1] | *Faroe Islands* | *Finland* | *Iceland* | *Norway* | *Sweden* |
|---|---|---|---|---|---|---|
| *Age* Alder | 13+ | 15+ | 15-64 | 15-79 | 16-74 | 16-84 |
| *Smoking men as a percentage of men in the age group* Mænd, rygere, i pct. af mænd i aldersgruppen | 28 | 24 | 24 | 21 | 25 | 14 |
| *Smoking women as a percentage of women in the age group* Kvinder, rygere, i pct. af kvinder i aldersgruppen | 24 | 28 | 19 | 17 | 24 | 18 |

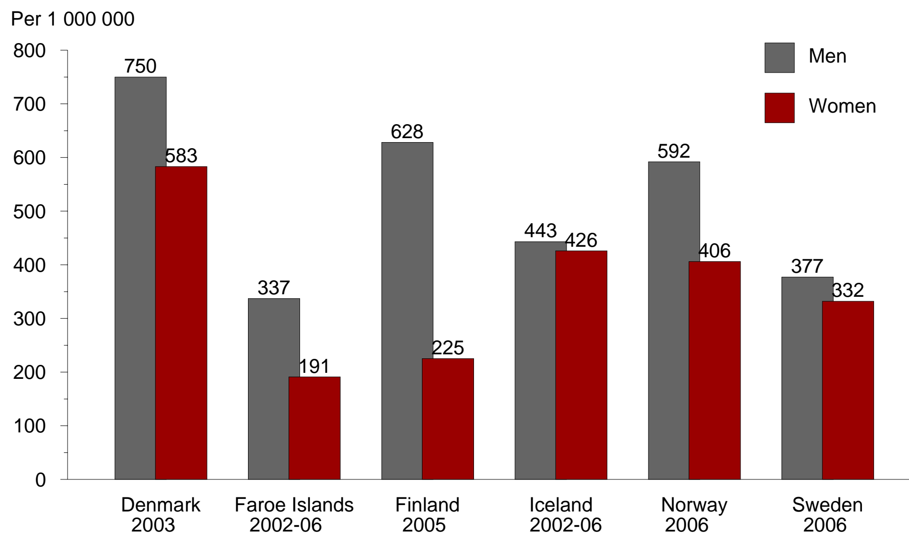
1 2006 = 2005 1 2006 = 2005

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

**Table 3.1.2 Sales of drugs used for nicotine dependence (ATC-group N07B), DDD/1 000 inhabitants/day, 1999-2007**
Salg af midler mod nikotinafhængighed (ATC-gruppe N07B), DDD/1 000 indbyggere/døgn 1999-2007

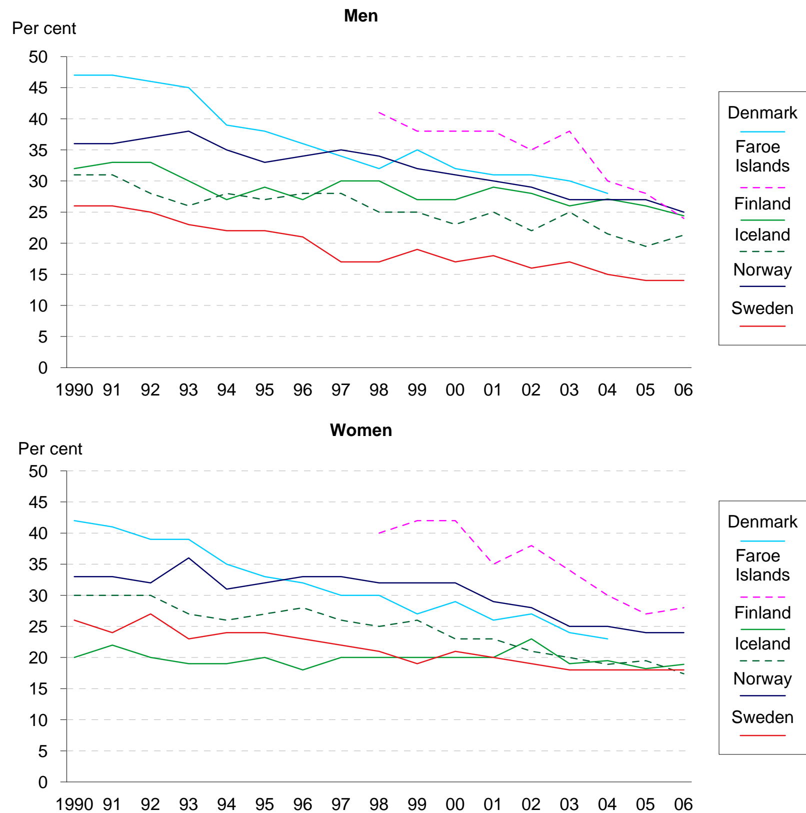
| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| N07BA01 *Nicotine* Nicotin | | | | | | | | |
| 1999 | 3.3 | 1.7 | 1.3 | 2.6 | 4.0 | 12.2 | 2.4 | 5.1 |
| 2000 | 4.1 | 2.3 | 1.6 | 2.6 | 3.8 | 14.2 | 2.7 | 5.3 |
| 2004 | 6.5 | 3.2 | 1.5 | 4.8 | 5.3 | 18.1 | 3.4 | 6.3 |
| 2005 | 6.7 | 3.8 | 1.7 | 5.7 | 5.9 | 19.4 | 3.6 | 6.7 |
| 2006 | 7.0 | 4.0 | 3.9 | 6.4 | 6.7 | 20.1 | 3.9 | 6.8 |
| 2007 | 7.2 | .. | .. | 7.1 | 7.1 | 19.5 | 4.3 | 7.1 |
| N07BA02 *Bupropion* Bupropion | | | | | | | | |
| 1999 | 0.3 | 0.0 | 0.0 | .. | .. | .. | 0.3 | 0.1 |
| 2000 | 0.3 | 0.1 | 0.0 | .. | .. | 1.1 | 0.6 | 0.2 |
| 2004 | 0.2 | 0.2 | 0.1 | 0.4 | 0.2 | 1.1 | 0.3 | 0.3 |
| 2005 | 0.3 | 0.2 | 0.1 | 0.4 | 0.3 | 1.0 | 0.2 | 0.4 |
| 2006 | 0.4 | 0.2 | 0.0 | 0.4 | 0.6 | 0.8 | 0.2 | 0.4 |
| 2007 | 0.3 | .. | .. | 0.2 | 0.3 | 1.0 | 0.2 | 0.3 |

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




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

**Figure 3.1.2 Percentage of daily smokers by sex 1990-2006**
Daglige rygere procentvis efter køn 1990-2006



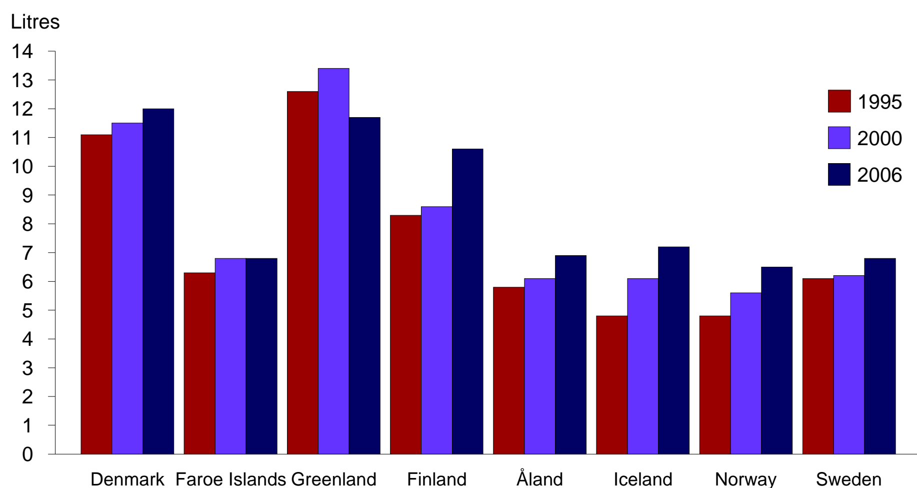

Sources: OECD, for 2001, 2002 and 2003. Other years Table 3.1.1. Faroes Islands: Statistics Faroe Islands.

**Table 3.1.3 Sales of alcoholic beverages in litres of 100 per cent pure alcohol per capita aged 15 years and over 1995-2006**
Salg af alkoholiske drikke i liter 100 pct. ren alkohol pr. indbygger 15 år og derover 1995-2006

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| 1995 | 12.1 | 6.3 | 12.6 | 8.3 | 5.8 | 4.8 | 4.8 | 6.2 |
| 2000 | 11.5 | 6.8 | 13.6 | 8.6 | 6.1 | 6.1 | 5.6 | 6.2 |
| 2005 | 11.3 | 6.6 | 12.1 | 10.0 | 6.6 | 7.1 | 6.4 | 6.6 |
| 2006 | 11.1 | 6.8 | 11.7 | 10.6 | 6.9 | 7.2 | 6.5 | 6.8 |

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

**Figure 3.1.3 Sales of alcoholic beverages in litres of 100 per cent pure alcohol per capita aged 15 years and over 1995, 2000 and 2006**
Salg af alkoholiske drikke i liter 100 pct. ren alkohol pr. indbygger 15 år og derover 1995, 2000 og 2006




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

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

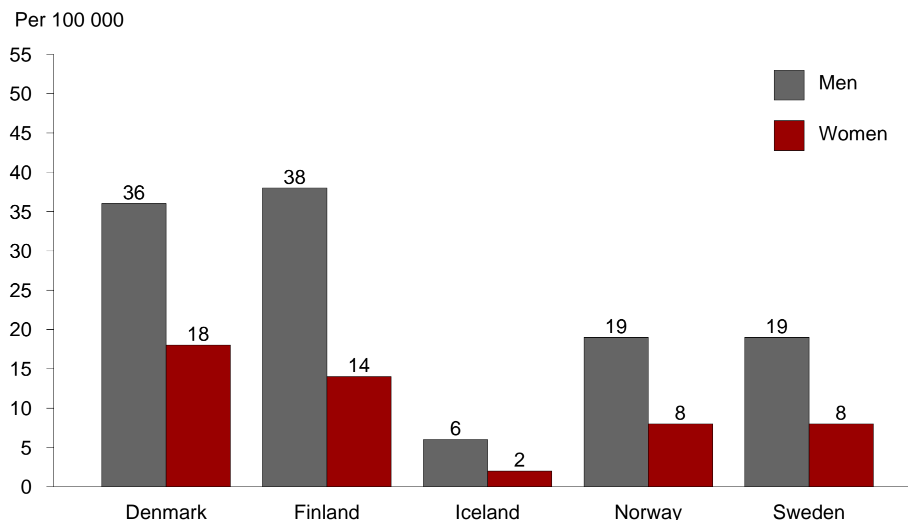
| | Denmark | Greenland | Finland[1)] | Iceland | Norway[2)] | Sweden |
|---|---|---|---|---|---|---|
| | 2005 | 2005 | 2006 | 2002 | 2005 | 2005 |
| Proportion of people with BMI > 30<br>*Andel personer med BMI > 30* | 11.4 | 23.1 | 14.3 | 12.4 | 9.0 | 10.7 |

1 Self-reported BMI from interviews
2 Self-reported heigth and weight

1 Selvrapporteret BMI i interview
2 Selvrapporteret højde og vægt

Source: Report: Quality Mapping in the Health Service. Report by the Nordic Council of Ministers' Working Group

**Figure 3.1.4 Patients treated in somatic hospitals for alcoholic liver disease per 100 000 inhabitants 2006**
Patienter behandlet på somatiske sygehuse for alkoholisk leversygdom pr. 100 000 indbyggere 2006




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

**Table 3.1.5 Diagnosed cases of tuberculosis per 100 000 inhabitants 1995-2006**
Diagnosticerede tilfælde af tuberkulose pr. 100 000 indbyggere 1995-2006

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway[1)] | Sweden[1)] |
|---|---|---|---|---|---|---|---|---|
| *Men* | | | | | M+W | | | |
| Mænd | | | | | | | | |
| 1995 | 9.8 | - | 94.3 | 13.9 | 7.9 | 3.7 | 6.4 | 6.5 |
| 2000 | 12.1 | 21.7 | 50.0 | 12.4 | 3.9 | 2.8 | 5.8 | 5.2 |
| 2005 | 9.5 | - | 178.1 | 8.0 | 3.8 | 4.0 | 6.6 | 6.8 |
| 2006 | 8.6 | 4.0 | 149.1 | 6.9 | 3.7 | 4.5 | 6.3 | 5.7 |
| *Women* | | | | | | | | |
| Kvinder | | | | | | | | |
| 1995 | 7.5 | 9.5 | 76.8 | 12.0 | . | 3.7 | 4.5 | 6.3 |
| 2000 | 8.5 | 4.5 | 111.0 | 8.5 | . | 5.7 | 4.8 | 5.2 |
| 2005 | 6.2 | - | 165.1 | 5.8 | . | 2.0 | 6.0 | 6.0 |
| 2006 | 5.7 | - | 104.8 | 4.3 | . | 4.0 | 6.3 | 5.3 |

1 Including relapses

1 Inklusive tilbagefald

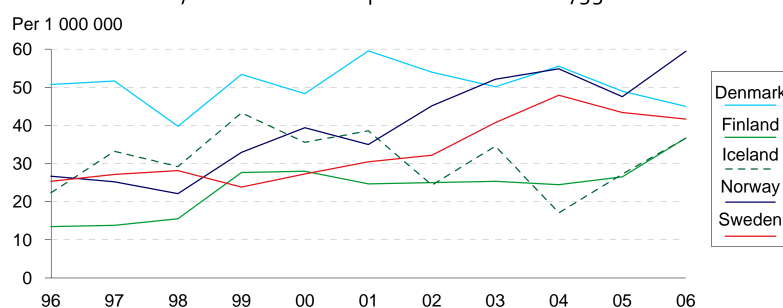
*Sources:* D: Statens Seruminstitut; FI: Chief Medical Officer; G: Chief Medical Officer; F & Å: National Public
Kilder: Health Institute; I: Directorate of Health; N: Norwegian Institute of Public Health; S: Swedish Institute for Infectious Disease Control

**Table 3.1.6 Confirmed new cases of HIV 1996-2006**
Påviste nye tilfælde af HIV 1996-2006

| | Denmark | Faroe Islands | Greenland | Finland | Of which Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| *Men* Mænd | | | | | | | | |
| 1996-00 | 180 | 0.0 | 6 | 69 | . | 6 | 81 | 155 |
| 2001-05 | 206 | 0.2 | 5 | 98 | . | 6 | 148 | 212 |
| 2006 | 174 | - | 4 | 134 | . | 8 | 179 | 230 |
| *Women* Kvinder | | | | | | | | |
| 1996-00 | 80 | - | 4 | 33 | . | 3 | 49 | 78 |
| 2001-05 | 82 | 0.4 | 2 | 41 | . | 2 | 87 | 138 |
| 2006 | 70 | - | 1 | 59 | . | 3 | 97 | 147 |
| *Total* I alt | | | | | | | | |
| 1996-00 | 260 | 0.0 | 9 | 101 | 04 | 9 | 130 | 233 |
| 2001-05 | 289 | 0.6 | 7 | 139 | 0.6 | 8 | 214 | 349 |
| 2006 | 244 | - | 5 | 193 | 1.0 | 11 | 276 | 377 |

*Sources:* *See Table 3.1.5*
Kilder: Se tabel 3.1.5

**Figure 3.1.5 Confirmed new cases of HIV per 1 000 000 inhabitants 1996-2006**
Påviste nye tilfælde af HIV per 1 000 000 indbyggere 1996-2006




*Sources:* *See Table 3.1.6*
Kilder: Se tabel 3.1.6

**Table 3.1.7 Notified cases of gonorrhoea and syphilis per 100 000 inhabitants aged 15 years and over 2006**
Anmeldte tilfælde af gonorré og syfilis pr. 100 000 indbyggere 15 år og derover 2006

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| *Gonorrhoea* Gonorré | | | | | | | | |
| Men | 16.2 | - | 1641.9 | 6.7 | - | 17.4 | 11.1 | 14.6 |
| Women | 3.3 | - | 2173.3 | 2.4 | - | 8.5 | 1.6 | 3.5 |
| Total | 9.6 | - | 1887.5 | 4.5 | - | 13.0 | 6.3 | 8.9 |
| *Syphilis* Syfilis | | | | | | | | |
| Men | 3.4 | - | - | 2.6 | - | 2.5 | 3.5 | 3.2 |
| Women | 0.2 | - | - | 2.4 | - | 1.7 | 0.1 | 1.2 |
| Total | 1.7 | - | - | 2.5 | - | 2.1 | 1.8 | 2.2 |

*Sources:* *See Table 3.1.5*
Kilder: Se table 3.1.5

**Table 3.1.8 Diagnosed cases of chlamydia per 100 000 inhabitants 1995-2006**
Diagnosticerede tilfælde af chlamydia pr. 100 000 indbyggere 1995-2006

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland[1)] | Norway | Sweden[2,3)] |
|---|---|---|---|---|---|---|---|---|
| *Men* Mænd | | | | | | | | |
| 1995 | 124 | .. | 1 509 | 115 | 48 | 368 | .. | 131 |
| 2000 | 165 | .. | 2 789 | 180 | 94 | 479 | .. | 187 |
| 2005 | 324 | .. | 3 852 | 197 | .. | 412 | 532 | 317 |
| 2006 | 343 | .. | 3 704 | 218 | .. | 420 | 559 | 311 |
| *Women* Kvinder | | | | | | | | |
| 1995 | 370 | .. | 2 500 | 203 | 140 | 428 | .. | 192 |
| 2000 | 384 | .. | 4 802 | 272 | 206 | 781 | .. | 246 |
| 2005 | 554 | .. | 5 797 | 287 | .. | 643 | 324 | 411 |
| 2006 | 571 | .. | 5 468 | 307 | .. | 682 | 349 | 402 |
| *Men and women* Mænd og kvinder | | | | | | | | |
| 1995 | 249 | 67 | 1 971 | 157 | 95 | 398 | 215 | 156 |
| 2000 | 276 | 79 | 3 727 | 226 | 152 | 647 | 326 | 217 |
| 2005 | 440 | 231 | 4 762 | 242 | 362 | 548 | 434 | 366 |
| 2006 | 458 | 232 | 4 532 | 262 | 370 | 568 | 455 | 359 |

1 Notified cases. Since 1997 cases verified by laboratories. The total includes those with missing data about gender
2 A mutant chlamydia gene, which is not detected in Abbot's test system, has been identified in the county of Halland, and has become distributed over a wide area. Cases in 2006 (and probably in 2005) are underreported in most of the counties because of problems associated with diagnosis of chlamydia. Source: Swedish Institute for Infectious Disease Control
3 For 2005, gender is not known for 45 people

1 Anmeldte tilfælde. Fra 1997 er det tilfælde der er verificeret via laboratorier. Totalen inkluderer dem med uoplyst køn
2 Et muteret klamydiagen, som ikke bliver opdaget i Abbots testsystem, er opdaget i landstinget i Halland og har formentligt større geografisk spredning. Det rapporterede antal i 2006 (og sandsynligvis også 2005) er underrapporteret i størstedelen af landstingene på grund af problemer med klamydiadiagnostikken. Kilde: Smittskyddsinstitutet
3 For 2005 er kønnet ukendt for 45 personer

*Sources:* *See Table 3.1.5*
Kilder: Se tabel 3.1.5

## 3.2 Cancer

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

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

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

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

The incidence of breast cancer, cancer of the prostate and colorectal cancer is increasing in almost all countries. Dietary factors are probably significant for this development, but for cancer of the breast

## 3.2 Cancersygdomme

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

Årsagerne til kræft er både ydre og indre faktorer, som medfører ændringer i arvemassen. Nydelsesmidler, kostfaktorer, visse 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.

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 hormo-

and prostate, hormonal factors also play an important role. The incidence of cancer of the testis is again increasing in most of the countries. The incidence of tobacco-related cancers, such as lung cancer, is high in all the countries. However, the incidence of lung cancer among men is decreasing.

nelle faktorer også en vigtig rolle. Forekomsten af testikelkræft er igen stigende i de fleste af landene. Forekomsten af tobaksrelaterede kræftformer, såsom lungecancer er høje i alle landene. Det skal dog bemærkes, at lungekræft blandt mænd er faldende.

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

| | *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 | 4 679 | 110 | 655 | 121 | 651 | 124 | 760 | 161 |
| 2003 | 4 927 | 103 | 893 | 120 | 709 | 134 | 750 | 200 |
| 2004 | 4 846 | 115 | 931 | 119 | 782 | 150 | 781 | 183 |
| *Faroe Islands*[2] | | | | | | | | |
| 1996-00 | 3 136 | 78 | 408 | 191 | 443 | 148 | 365 | 35 |
| 2002-06 | 2 941 | 104 | 538 | 161 | 514 | 121 | 337 | 32 |
| *Greenland* | | | | | | | | |
| 1996-00 | .. | 54 | 54 | 207 | 237 | 130 | 681 | 15 |
| 1999-03 | 3 061 | 66 | 46 | 193 | 345 | 120 | 857 | 20 |
| 2000-04 | 3 246 | 46 | 119 | 192 | 345 | 126 | 888 | 13 |
| *Finland* | | | | | | | | |
| 1996-00 | 4 239 | 34 | 1 201 | 176 | 391 | 130 | 602 | 122 |
| 2004 | 5 363 | 38 | 2 042 | 154 | 488 | 180 | 611 | 159 |
| 2005 | 5 282 | 53 | 2 076 | 152 | 495 | 165 | 628 | 160 |
| *Åland* | | | | | | | | |
| 2001-05 | 6 948 | 62 | 3 088 | 185 | 710 | 185 | 556 | 170 |
| *Iceland* | | | | | | | | |
| 1996-00 | 4 012 | 61 | 1 096 | 199 | 480 | 98 | 469 | 98 |
| 2002-06 | 4 249 | 60 | 1 335 | 148 | 511 | 79 | 443 | 133 |
| *Norway* | | | | | | | | |
| 1996-00 | 4 872 | 108 | 1 293 | 182 | 687 | 124 | 580 | 206 |
| 2005 | 5 574 | 109 | 1 592 | 127 | 750 | 124 | 586 | 249 |
| 2006 | 5 595 | 110 | 1 649 | 129 | 729 | 113 | 592 | 235 |
| *Sweden* | | | | | | | | |
| 1996-00 | 4 657 | 55 | 1 528 | 156 | 600 | 101 | 381 | 183 |
| 2005 | 5 557 | 63 | 2 207 | 129 | 635 | 100 | 405 | 242 |
| 2006 | 5 406 | 72 | 2 061 | 118 | 675 | 97 | 377 | 253 |

Numbers refer to ICD-10.
* *The total covers* chapter C, except C44 and C46.0. Including D09.0, D32, D33, D41.4, D42 and D43
Totalen dækker kapitel C, undtagen C44 og C46.0. Inkludere D09.0, D32, D33, D41.4, D42 og D43

1 Figures for 2003 and 2004 are preliminary
2 Based on 5 year average discharges from the patient register

1 2003 og 2004 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 3.2.1.b New cases of cancer age standardized per 1 000 000 men (Nordic population 2000)**
Nye tilfælde af cancer alderstandardiserede rater, pr. 1 000 000 mænd (Nordisk befolkning 2000)

| | *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 | 5 675 | 102 | 894 | 152 | 825 | 158 | 938 | 186 |
| 2003 | 5 468 | 100 | 1 027 | 136 | 807 | 148 | 819 | 213 |
| 2004 | 6 968 | 115 | 1 049 | 131 | 869 | 166 | 854 | 191 |
| *Faroe Islands*[2] | | | | | | | | |
| 1996-00 | 3 877 | 80 | 596 | 229 | 556 | 176 | 430 | 37 |
| 2002-06 | 3 607 | 108 | 689 | 202 | 637 | 147 | 396 | 38 |
| *Greenland* | | | | | | | | |
| 1999-03 | 6 074 | 59 | 89 | 339 | 694 | 243 | 1 987 | 28 |
| 2000-04 | 6 378 | 41 | 259 | 373 | 666 | 211 | 2 033 | 19 |
| *Finland* | | | | | | | | |
| 1996-00 | 6 091 | 34 | 1 891 | 269 | 574 | 207 | 930 | 154 |
| 2004 | 6 054 | 37 | 2 293 | 117 | 551 | 209 | 687 | 169 |
| 2005 | 5 842 | 53 | 2 282 | 178 | 552 | 186 | 706 | 170 |
| *Åland* | | | | | | | | |
| 2001-05 | 7 493 | 57 | 3 141 | 187 | 719 | 179 | 558 | 165 |
| *Iceland* | | | | | | | | |
| 1996-00 | 6 256 | 59 | 1 848 | 337 | 761 | 175 | 747 | 133 |
| 2002-06 | 5 693 | 58 | 1 847 | 213 | 712 | 108 | 591 | |
| *Norway* | | | | | | | | |
| 1996-00 | 5 959 | 97 | 1 666 | 234 | 871 | 158 | 716 | 240 |
| 2005 | 6 336 | 109 | 1 824 | 151 | 861 | 139 | 662 | 276 |
| 2006 | 6 274 | 110 | 1 854 | 151 | 833 | 127 | 658 | 255 |
| *Sweden* | | | | | | | | |
| 1996-00 | 5 073 | 52 | 1 687 | 175 | 642 | 110 | 407 | 186 |
| 2005 | 5 362 | 64 | 2 101 | 126 | 618 | 97 | 391 | 236 |
| 2006 | 5 178 | 74 | 1 941 | 114 | 653 | 92 | 359 | 246 |

Numbers refer to ICD-10.
* *The total covers* chapter C, except C44 and C46.0. Including D09.0, D32, D33, D41.4, D42 and D43
Totalen dækker kapitel C, undtagen C44 og C46.0. Inkludere D09.0, D32, D33, D41.4, D42 og D43

1 Figures for 2003 and 2004 are preliminary
2 Based on 5 year average discharges from the patient register

1 2003 og 2004 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 3.2.2.a New cases of cancer per 1 000 000 inhabitants, women**
Nye tilfælde af cancer pr. 1 000 000 indbyggere, kvinder

| | *Total** I alt* | C50 *Breast* Bryst | C53 *Cervix uteri* Livmoder-hals | C16 *Stomach* Mave | C18-21 *Colon and rectum* Tyktarm og endetarm | C25 *Pancreas* Pancreas | C33-34 *Lungs* Lunger | C43 *Melanoma of the skin* Melanom i hud |
|---|---|---|---|---|---|---|---|---|
| *Denmark*[1)] | | | | | | | | |
| 1996-00 | 4 975 | 1 381 | 160 | 73 | 641 | 131 | 537 | 197 |
| 2003 | 5 056 | 1 469 | 150 | 68 | 621 | 126 | 583 | 253 |
| 2004 | 5 137 | 1 447 | 144 | 67 | 721 | 154 | 640 | 253 |
| *Faroe Islands*[2)] | | | | | | | | |
| 1996-00 | 3 370 | 808 | 186 | 93 | 390 | 158 | 223 | 37 |
| 2002-06 | 3 324 | 816 | 113 | 113 | 469 | 200 | 191 | 52 |
| *Greenland* | | | | | | | | |
| 1996-00 | .. | 467 | 352 | 46 | 337 | 122 | 559 | 23 |
| 1999-03 | 2 928 | 441 | 243 | 68 | 434 | 190 | 555 | 8 |
| 2000-04 | 3 100 | 515 | 220 | 53 | 432 | 197 | 622 | 8 |
| *Finland* | | | | | | | | |
| 1996-00 | 4 104 | 1 281 | 61 | 140 | 419 | 138 | 179 | 115 |
| 2004 | 4 626 | 1 462 | 61 | 129 | 464 | 164 | 228 | 145 |
| 2005 | 4 449 | 1 505 | 47 | 101 | 452 | 176 | 225 | 140 |
| *Åland* | | | | | | | | |
| 2001-05 | 4 876 | 1 560 | 135 | 135 | 600 | 120 | 285 | 195 |
| *Iceland* | | | | | | | | |
| 1996-00 | 3 899 | 1 082 | 105 | 102 | 378 | 107 | 409 | 172 |
| 2002-06 | 4 060 | 1 204 | 103 | 92 | 422 | 64 | 426 | 213 |
| *Norway* | | | | | | | | |
| 1996-00 | 4 434 | 1 077 | 140 | 113 | 710 | 140 | 311 | 223 |
| 2005 | 4 978 | 1 198 | 126 | 97 | 736 | 124 | 386 | 243 |
| 2006 | 4 957 | 1 139 | 125 | 86 | 753 | 136 | 406 | 270 |
| *Sweden* | | | | | | | | |
| 1996-00 | 4 353 | 1 366 | 102 | 98 | 567 | 109 | 249 | 182 |
| 2005 | 5 602 | 1 529 | 94 | 74 | 647 | 97 | 330 | 228 |
| 2006 | 5 581 | 1 543 | 96 | 76 | 601 | 89 | 332 | 249 |

Numbers refer to ICD-10.

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

1 Figures for 2003 and 2004 are preliminary
2 Based on 5 year average discharges from the patient register

1 2003 og 2004 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 3.2.2.b New cases of cancer age standardized, per 1 000 000 women (Nordic population 2000)**
Nye tilfælde af cancer alderstandardiserede rater, pr. 1 000 000 kvinder (Nordisk befolkning 2000)

| | *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 | 4 828 | 1 312 | 158 | 70 | 620 | 129 | 538 | 195 |
| 2003 | 4 705 | 1 392 | 146 | 62 | 556 | 114 | 547 | 241 |
| 2004 | 6 096 | 1 356 | 140 | 61 | 640 | 137 | 590 | 241 |
| *Faroe Islands*[2] | | | | | | | | |
| 1996-06 | 3 593 | 889 | 197 | 90 | 407 | 151 | 239 | 41 |
| 2002-06 | 3 398 | 843 | 123 | 114 | 475 | 199 | 207 | 59 |
| *Greenland* | | | | | | | | |
| 1999-03 | 5 032 | 667 | 292 | 76 | 908 | 353 | 1 077 | 11 |
| 2000-04 | 5 259 | 746 | 254 | 65 | 847 | 343 | 1 198 | 12 |
| *Finland* | | | | | | | | |
| 1996-00 | 4 023 | 1 210 | 60 | 139 | 416 | 152 | 190 | 115 |
| 2004 | 4 037 | 1 319 | 59 | 107 | 394 | 134 | 192 | 130 |
| 2005 | 3 864 | 1 347 | 45 | 86 | 379 | 146 | 185 | 127 |
| *Åland* | | | | | | | | |
| 2001-05 | 4 142 | 1 389 | 132 | 99 | 493 | 79 | 231 | 185 |
| *Iceland* | | | | | | | | |
| 1996-00 | 4 824 | 1 345 | 116 | 138 | 494 | 155 | 557 | 201 |
| 2002-06 | 4 655 | 1 398 | 107 | 105 | 487 | 76 | 505 | 225 |
| *Norway* | | | | | | | | |
| 1996-00 | 4 380 | 1 139 | 147 | 104 | 680 | 131 | 319 | 227 |
| 2005 | 4 661 | 1 173 | 125 | 85 | 658 | 108 | 373 | 235 |
| 2006 | 4 643 | 1 112 | 124 | 77 | 671 | 120 | 391 | 263 |
| *Sweden* | | | | | | | | |
| 1996-00 | 3 985 | 1 205 | 99 | 83 | 468 | 95 | 232 | 169 |
| 2005 | 4 957 | 1 358 | 90 | 58 | 518 | 81 | 281 | 205 |
| 2006 | 4 951 | 1 373 | 93 | 60 | 481 | 75 | 282 | 222 |

Numbers refer to ICD-10.
* *The total covers* chapter C, except C44 and C46.0. Including D09.0, D32, D33, D41.4, D42 and D43
Totalen dækker kapitel C, undtagen C44 og C46.0. Inkludere D09.0, D32, D33, D41.4, D42 og D43

1 Figures for 2003 and 2004 are preliminary
2 Based on 5 year average discharges from the patient register

1 2003 og 2004er 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 3.2.3 New cases of leukemia per 1 000 000 inhabitants, 0-14 year-olds
Nye tilfælde af leukæmi pr. 1 000 000 indbyggere, 0-14-årige

| | Denmark[1)] | Finland | Iceland[2)] | Norway | Sweden |
|---|---|---|---|---|---|
| *Boys* Drenge | | | | | |
| 1996-00 | 47 | 47 | 48 | 53 | 54 |
| 2005 | 40 | 47 | 24 | 37 | 62 |
| 2006 | 69 | .. | 30 | 65 | 44 |
| *Girls* Piger | | | | | |
| 1996-00 | 43 | 50 | 25 | 51 | 49 |
| 2005 | 41 | 56 | 31 | 32 | 44 |
| 2006 | 56 | .. | 25 | 63 | 38 |
| *Total* I alt | | | | | |
| 1996-00 | 45 | 49 | 37 | 53 | 52 |
| 2005 | 40 | 51 | 27 | 34 | 53 |
| 2006 | 63 | .. | 27 | 64 | 41 |

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

1 2005 = 2003 and 2006 = 2004 are preliminary figures
2 Only five year averages are presented. 2005 = average 2001-05, 2006 = average 2002-06

Tabellen dækker numrene C91-C95 i ICD-10

1 2005 = 2003 og 2006 = 2004 er foreløbige tal
2 Kun femårs gennemsnit præsenteres. 2005 = gennemnit 2001-05, 2006 = gennemsnit 2002-06

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

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

| | Denmark[1)] | Faroe Islands | Greenland | Finland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| | 2004 | 2002-06 | 2000-04 | 2005 | 2002-06 | 2006 | 2006 |
| *Men* Mænd | | | | | | | |
| *Age* Alder | | | | | | | |
| 0-24 | 2 | - | - | 5 | - | 1 | 7 |
| 25-44 | 46 | 29 | 38 | 81 | 70 | 66 | 69 |
| 45-64 | 861 | 842 | 789 | 574 | 641 | 771 | 634 |
| 65-84 | 4 080 | 2 405 | 3 332 | 2 296 | 3 050 | 3 870 | 3 143 |
| 85+ | 4 995 | 4 612 | - | 3 634 | 5 760 | 5 852 | 3 625 |
| Women Kvinder | | | | | | | |
| Age Alder | | | | | | | |
| 0-24 | 5 | - | - | 13 | - | 6 | 6 |
| 25-44 | 52 | 34 | 159 | 65 | 76 | 76 | 66 |
| 45-64 | 703 | 532 | 1 058 | 476 | 443 | 735 | 537 |
| 65-84 | 2 964 | 2 276 | 2 866 | 1 493 | 2 212 | 3 148 | 2 194 |
| 85+ | 3 615 | 1 971 | 5 650 | 2 413 | 3 347 | 3 844 | 2 695 |

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

1 Premilinary figures

Tabellen dækker numrene C18-21 i ICD-10

1 Foreløbige tal

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

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

| | Denmark[1)] | Faroe Islands | Greenland | Finland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| | 2004 | 2002-06 | 2000-04 | 2005 | 2002-06 | 2006 | 2006 |
| *Men* Mænd | | | | | | | |
| *Age* Alder | | | | | | | |
| 0-24 | - | - | - | - | - | - | - |
| 25-44 | 25 | - | 134 | 11 | 28 | 21 | 12 |
| 45-64 | 890 | 573 | 1 842 | 643 | 528 | 761 | 400 |
| 65-84 | 4 175 | 1 729 | 9 128 | 3 371 | 3 177 | 3 194 | 1 843 |
| 85+ | 3 711 | 1 537 | 7 143 | 4 231 | 1 182 | 2 394 | 1 088 |
| Women Kvinder | | | | | | | |
| Age Alder | | | | | | | |
| 0-24 | 4 | - | - | - | - | - | 2 |
| 25-44 | 35 | 34 | 46 | 12 | 48 | 32 | 16 |
| 45-64 | 846 | 342 | 1 262 | 275 | 673 | 596 | 483 |
| 65-84 | 2 654 | 803 | 6 384 | 803 | 2 200 | 1 633 | 1 176 |
| 85+ | 968 | - | - | 635 | 1 143 | 845 | 437 |

1 Prelimilary figures

1 Foreløbige tal

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

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

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

| | Denmark[1)] | Faroe Islands | Greenland | Finland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| | 2004 | 2002-06 | 2000-04 | 2005 | 2002-06 | 2006 | 2006 |
| *Age* Alder | | | | | | | |
| 0-24 | 11 | - | 54 | 1 | 11 | 6 | 4 |
| 25-44 | 214 | 68 | 387 | 73 | 205 | 185 | 135 |
| 45-64 | 165 | 266 | 163 | 53 | 125 | 171 | 120 |
| 65-84 | 231 | 268 | 651 | 75 | 61 | 186 | 156 |
| 85+ | 142 | - | - | 64 | 327 | 155 | 120 |

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

| | Denmark[1] | Faroe Islands | Greenland | Finland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| | 2004 | 2002-06 | 2000-04 | 2005 | 2002-06 | 2006 | 2006 |
| *Age* Alder | | | | | | | |
| 0-24 | 39 | 44 | 17 | 33 | 22 | 50 | 43 |
| 25-44 | 256 | 175 | 77 | 121 | 134 | 242 | 160 |
| 45-64 | 83 | 135 | 58 | 27 | 48 | 76 | 48 |
| 65-84 | 41 | 75 | - | 16 | 14 | 38 | 13 |
| 85+ | 69 | - | - | - | - | - | 13 |

1 Premilinary figures 1 Foreløbige tal

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

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

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

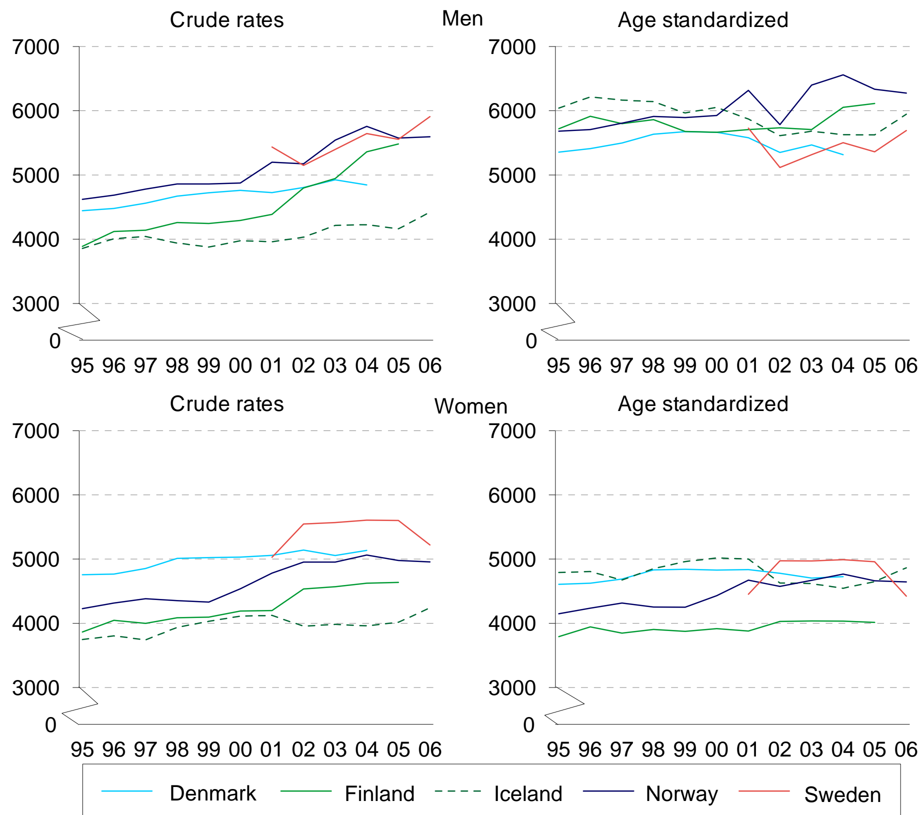
| | Denmark[1] | Faroe Islands | Finland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|
| | 2004 | 2002-06 | 2005 | 2002-06 | 2006 | 2006 |
| *Men* Mænd | | | | | | |
| *Age* Alder | | | | | | |
| 0-24 | 1 | - | 6 | 18 | 1 | 1 |
| 25-44 | 101 | - | 59 | 121 | 112 | 104 |
| 45-64 | 277 | 34 | 268 | 198 | 348 | 327 |
| 65-84 | 582 | 226 | 493 | 424 | 892 | 866 |
| 85+ | 902 | - | 747 | 591 | 964 | 1 208 |
| *Women* Kvinder | | | | | | |
| *Age* Alder | | | | | | |
| 0-24 | 32 | - | 10 | 56 | 18 | 11 |
| 25-44 | 222 | 102 | 82 | 290 | 214 | 173 |
| 45-64 | 384 | - | 201 | 293 | 417 | 335 |
| 65-84 | 457 | 201 | 311 | 330 | 592 | 573 |
| 85+ | 598 | - | 445 | 490 | 704 | 666 |

1 Premilinary figures 1 Foreløbige tal

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

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

**Figure 3.2.1 New cases of cancer crude rates and age standardized rates per 1 000 000 inhabitants 1995-2006**
Nye tilfælde af cancer summariske rater og aldersstandardiserede rater pr. 1 000 000 indbyggere 1995-2006



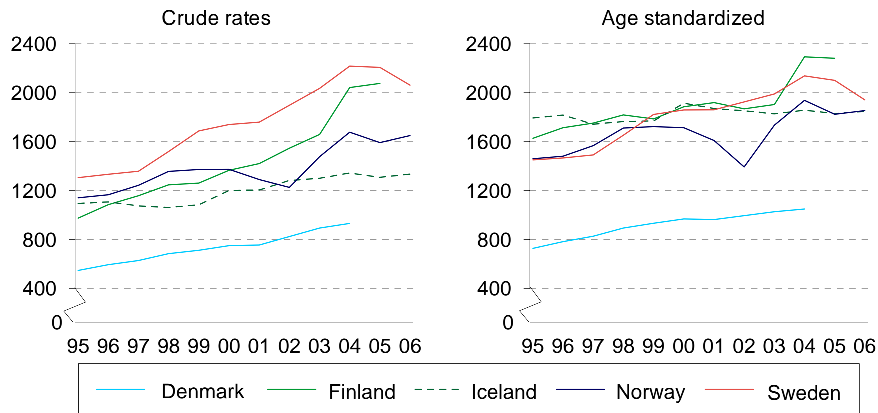

Age-standardized by the Nordic population 2000

Aldersstandardiseret med den nordiske befolkning 2000

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

*Sources:* *The Nordic Cancer Union*
Kilder: Den nordiske cancerunion

**Figure 3.2.2 New cases of prostate cancer crude rates and age standardized rates per 1 000 000 inhabitants 1995-2006**
Nye tilfælde af prostatacancer summariske rater og aldersstandardiserede rater pr. 1 000 000 indbyggere 1995-2006

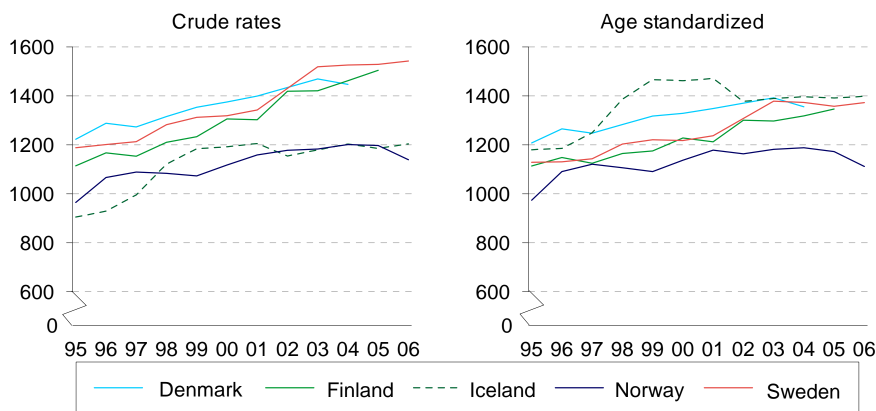



Age-standardized by the Nordic population 2000 — Aldersstandardiseret med den nordiske befolkning 2000

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

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

**Figure 3.2.3 New cases of breast cancer crude rates and age standardized rates per 1 000 000 inhabitants 1995-2006**
Nye tilfælde af brystcancer summariske rater og aldersstandardiserede rater pr. 1 000 000 indbyggere 1995-2006

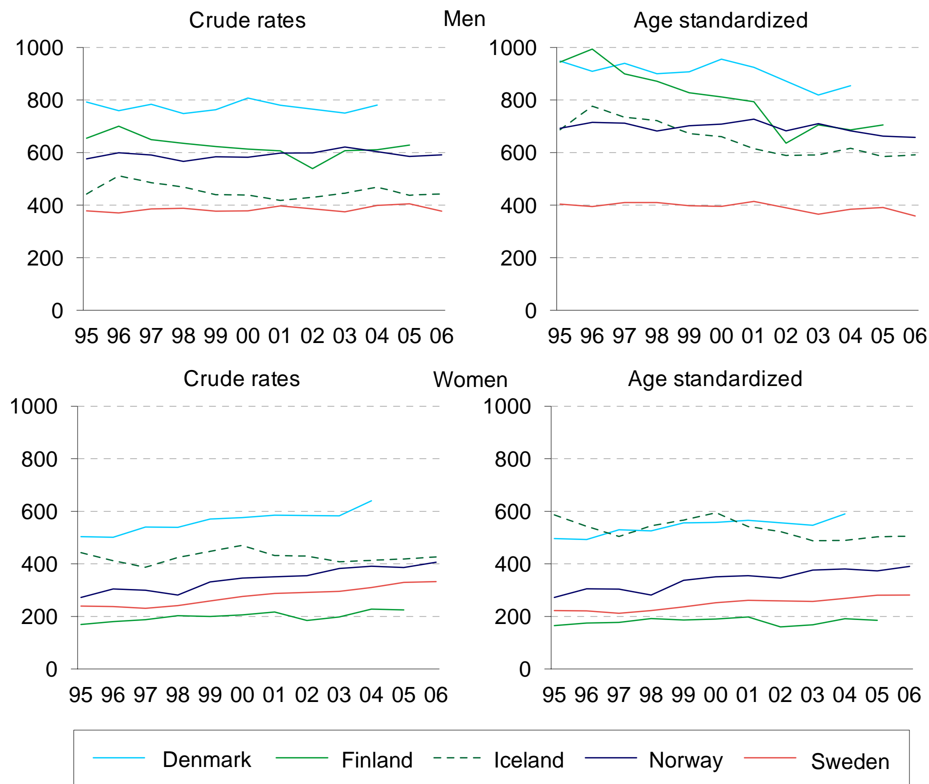



Age-standardized by the Nordic population 2000 — Aldersstandardiseret med den nordiske befolkning 2000

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

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

**Figure 3.2.4 New cases of lung cancer crude rates and age standardized rates per 1 000 000 inhabitants 1995-2006**
Nye tilfælde af lungecancer summariske rater og aldersstandardisede rater pr. 1 000 000 indbyggere 1995-2006




Age-standardized by the Nordic population 2000

Aldersstandardiseret med den nordiske befolkning 2000

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

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

## 3.3 Medical consultations and immunization schedules

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

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

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

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

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

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

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

## 3.3 Lægebesøg og vaccinationsprogrammer

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

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

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

Registreringspraksis for lægebesøg er meget forskellig fra land til land.

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

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

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

age, for general practitioners and specialists. Small children and elderly people are the largest groups

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

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

og specialist, hvor det især er mindre børn og den ældste del af befolkningen der vejer tungest.

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

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

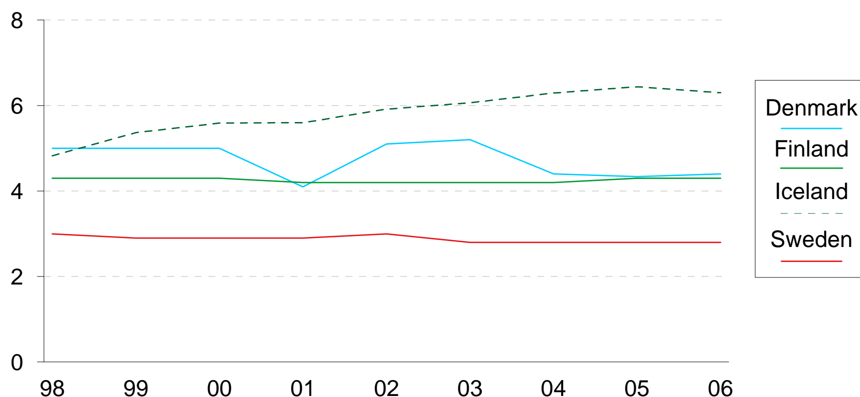
**Table 3.3.1 Number of doctors in general practice 2006**
Antal læger der arbejder i almen praktis 2006

| | Denmark | Faroe Islands | Greenland | Finland | Åland[1)] | Iceland[1)] | Norway | Sweden[1)] |
|---|---|---|---|---|---|---|---|---|
| *Number of doctors in general practice* Antal alment praktiserende læger | 3 965 | 28 | 56 | 3 850 | 16 | 228 | 5 094 | 5 051 |
| *Number of inhabitants per doctor in general practice* Antal indbyggere pr. alment praktiserende læge | 1 373 | 1 714 | 1 020 | 1 371 | 1 666 | 1 315 | 915 | 1 784 |

1 2005 1 2005

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

**Figure 3.3.1 Consultations per capita 1998-2006**
Konsultationer pr. person 1998-2006




*Sources: See Table 3.3.1*
Kilder: Se tabel 3.3.1

**Table 3.3.2 Number of consultations with doctors in general practice, estimated for the whole country, per 1000 inhabitants in age group 2006**
Konsultationer hos alment praktiserende læger, estimeret til nationalt niveau, pr 1 000 indbyggere i aldersgruppen 2006

| | Denmark | Finland | Iceland[1)] |
|---|---|---|---|
| <1 year | 4 474 | 3 056 | 7 024 |
| 1-4 year | 3 840 | 2 418 | 3 619 |
| 5-14 year | 1 979 | 1 414 | 1 565 |
| 15-24 year | 2 806 | 1 434 | 2 223 |
| 25-44 year | 3 272 | 1 434 | 2 171 |
| 45-64 year | 3 773 | 1 571 | 2 902 |
| 65-74 year | 5 266 | 2 329 | 4 500 |
| 75-84 year | 6 522 | 2 863 | 5 352 |
| 85+ | 5 088 | 2 864 | 4 344 |
| Total, per 1000 inhabitants | 3 602 | 1 719 | 2 658 |
| Total number of consultations | 19 724 565 | 9 072 828 | 826 912 |

1 Total numbers, all registered contacts with health care centres

1 Totalt antal. Alle registrede kontakter til sundheds-centre

Sources: Denmark: National Board of Health; Finland: STAKES; Iceland: Directorate of Health
*Kilder: Danmark: Sundhedsstyrelsen; Finland: STAKES; Island: Medicinaldirektoratet*

**Table 3.3.3 Number of consultations with specialists, estimated for the whole country, per 1000 inhabitants in age group 2006**
Antal konsultationer hos speciallæger, estimeret til nationalt niveau, per 1 000 indbyggere i aldersgruppen 2006

| | Denmark | Finland | Iceland[1)] |
|---|---|---|---|
| <1 year | 445 | 1 527 | .. |
| 1-4 years | 1 051 | 767 | .. |
| 5-14 years | 555 | 793 | .. |
| 15-24 years | 465 | 1 018 | .. |
| 25-44 years | 669 | 1 193 | .. |
| 45-64 years | 846 | 1 453 | .. |
| 65-74 years | 1 177 | 1 879 | .. |
| 75-84 years | 1 494 | 2 108 | .. |
| 85+ | 1 225 | 1 565 | .. |
| Total per 1 000 inhabitants | 790 | 1 309 | 1 599 |
| Total number of consultations | 4 327 487 | 6 909 208 | 486 705 |

1 Consultations with specialists in private practice for 2006. Age distributed information is not available

1 Konsultationer hos speciallæger i private praksisser 2006. Alders fordelt information er ikke tilgængelig

Sources: Denmark: National Board of Health; Finland: STAKES; Iceland: Directorate of Health
*Kilder: Danmark: Sundhedsstyrelsen; Finland: STAKES; Island: Medicinaldirektoratet*

## Table 3.3.4 Recommended immunization schedules per 1 January, 2008

| | Denmark | Greenland | Finland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|
| Pneumococcer | 3, 5 and 12 months | - | - | - | .. | .. |
| BCG | - | First week of life | Risk groups | - | Risk groups: First week of life. Negatives: 13-14 years | Risk groups |
| Pertussis | 3, 5 and 12 months and 5 years | 3, 5 and 12 months and 5 years | 3, 5 and 12 months, 4 and 14-15 years | 3, 5, 12 months, 5 years and 14 years | 3, 5 and 11-12 months | 3, 5 and 12 months, 5-6 years, 14-16 years |
| Tetanus | 3, 5 and 12 months and 5 years | 3, 5 and 12 months and 5 years | 3, 5 and 12 months, 4 and 14-15 years | 3, 5, 12 months, 5 and 14 years | 3, 5 and 11-12 months, 11-12 years | 3, 5 and 12 months, 5-6 years, 14-16 years |
| Diphtheria | 3, 5 and 12 months and 5 years | 3, 5 and 12 months and 5 years | 3, 5 and 12 months, 4 and 14-15 years | 3, 5, 12 months, 5 and 14 years | 3, 5 and 11 months, 11-12 years | 3, 5 and 12 months, 5-6 years, 14-16 years |
| Polio | IPV: 3, 5, 12 months and 5 years | IPV: 3, 5, 12 months and 5 years | IPV: 3, 5 and 12 months, and 4 years | IPV: 3, 5, 12 months and 14 years | IPV: 3, 5 and 11 months, 6-8 and 14 years | IPV: 3, 5 and 12 months, 5-6 years |
| Measles, Mumps, Rubella | 15 months. 12 years[1] | 15 months. 12 years | 14-18 months and 6 years | 18 months and 12 years | 15 months and 12-13 years | 18 months and 6-8 years |
| Rubella, only | Women of fertile age | Women of fertile age | - | - | Seronegative women of fertile age | - |
| Measles, only | - | - | - | - | - | - |
| Haemophilus influenzae b | 3, 5 and 12 months | 3, 5 and 12 months | 3, 5 and 12 months | 3, 5 and 12 months | 3, 5 and 11 months | 3, 5 and 12 months |
| HPV | - | Boys and girls at 12 years (0, 2 og 6 months) | - | - | - | - |
| Meningococcal disease gr. C | - | - | - | 6, 8 months | - | - |
| Influensa 65+ | Immunization against influenza 65+ | Immunization against influenza 65 + | Yes and for risk groups | 60+ years | .. | 65+ and also people with chronic heart disease, lung disease, impaired immune system, metabolic diseases or severe chronic diseases. |

1 From 1 April 2008 15 months and 4 years

IPV = Inactivated polio vaccine

The Faroe Islands and Greenland and Åland have the same immunization schedules as Denmark and Finland respectively. In Greenland, however, BCG is included. In Åland TBE is included for children aged 7 years in 2006-2010

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

## Tabel 3.3.4 Anbefalede vaccinationsprogrammer pr. 1. januar 2008

| | Danmark | Grønland | Finland | Island | Norge | Sverige |
|---|---|---|---|---|---|---|
| Pneumococcer | 3, 5 og 12 måneder | - | - | - | .. | .. |
| Tuberkulose | - | Første leveuge | Risikogrupper | - | Risikogrupper: Første leveuge Negative: 13-14 år | Risikogrupper |
| Kighoste | 3, 5 og 12 måneder og 5 år | 3, 5 og 12 måneder og 5 år | 3, 5 og 12 måneder, 4 og 14-15 år | 3, 5, 12 måneder, 5 og 14 år | 3, 5 og 11-12 måneder | 3, 5 og 12 måneder, 5-6 og 14-16 år |
| Stivkrampe | 3, 5 og 12 måneder og 5 år | 3, 5 og 12 måneder og 5 år | 3, 5 og 12 måneder, 4 og 14-15 år | 3, 5,12 måneder, 5 og 14 år, | 3, 5 og 11-12 måneder, samt 11-12 år | 3, 5 og 12 måneder, 5-6 og 14-16 år |
| Difteri | 3, 5 og 12 måneder og 5 år | 3, 5 og 12 måneder og 5 år | 3, 5 og 12 måneder, 4 og 14-15 år | 3, 5, 12 måneder, 5 og 14 år | 3, 5 og 11 måneder samt 11-12 år | 3, 5 og 12 måneder, 5-6 og 14-16 år |
| Polio | IPV: 3, 5, 12 måneder og 5 år | IPV: 3, 5, 12 måneder og 5 år | IPV: 3, 5 og 12 måneder + 4 år | IPV: 3, 5, 12 måneder og 14 år | IPV: 3, 5 og 11 måneder, 6-8 år og 14 år | IPV: 3, 5 og 12 måneder, 5-6 år |
| Mæslinger, fåresyge, røde hunde | 15 måneder, 12 år[1] | 15 måneder, 12 år | 14-18 måneder og 6 år | 18 måneder og 12 år | 15 måneder og 12-13 år | 18 måneder og 6-8 år |
| Røde hunde, alene | Kvinder i den fertile alder | Kvinder i den fertile alder | - | - | Seronegative kvinder i den fertile alder | - |
| Mæslinger, alene | - | - | - | - | - | - |
| Haemophilus influensae b | 3, 5 og 12 måneder | 3, 5 og 12 måneder | 3, 5 og 12 måneder | 3, 5 og 12 måneder | 3, 5 og 11 måneder | 3, 5 og 12 måneder |
| HPV | - | 3 vacc. af både piger og drenge ved det 12. år (0, 2 og 6 mdr.) | - | - | - | - |
| Meningitis | - | - | - | 6, 8 måneder | - | - |
| Influensa 65+ | Vaccination mod influenza 65 + | Vaccination mod influenza 65 + | Ja og for risikogrupper. | 60 + år | .. | 65+ inkl. personer med kronisk hjertesygdomme, lungesygdomme, meget nedsat imunforsvar, ustabil diabetes eller svære kroniske sygdomme. |

1 Fra 1. april 2008 15 måneder og 4 år

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. I Åland er TBE inkluderet for børn 7 år i 2006-2010

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

**Table 3.3.5 Children under the age of two immunized according to immunization schedules and elderly people vaccinated against influenza (per cent) 2006**
Børn under to år vaccineret i henhold til det anbefalede vaccinationsprogram samt ældre vaccineret mod influenza (pct.) 2006

| | Denmark | Faroe Islands[1)] | Greenland | Finland[2)] | Iceland | Norway[3)] | Sweden |
|---|---|---|---|---|---|---|---|
| *BCG*<br>Tuberkulose | .. | .. | 97 | 97 | – | 92 | 17 |
| *Pertussis*<br>Kighoste | 75 | 96 | 87 | 97 | 97 | 94 | 99 |
| *Tetanus*<br>Stivkrampe | 75 | 96 | 87 | 97 | 97 | 94 | 99 |
| *Diphtheria*<br>Difteri | 75 | 96 | 87 | 97 | 97 | 94 | 99 |
| *Polio*<br>Polio | 75 | 96 | 87 | 97 | 97 | 94 | 99 |
| *Rubella*<br>Røde hunde | 89 | 84 | 99 | 98 | 94 | 92 | 95 |
| *Measles*<br>*Mæslinger* | 89 | 84 | 99 | 98 | 94 | 92 | 95 |
| Influenza<br>65+ | 54 | .. | .. | 46 | .. | .. | 56 |

1 The numbers are based on all registered children born in 2004 and collected in 2006
2 Based on a random sample of 1 000 children born in 2001. Data collected in 2004
3 The figures are underestimated due to low reporting in some municipalities

1 Tallene er baseret på samtlige børn registreret med fødedato i 2004 og indsamlet i 2006
2 Baseret på en tilfældig udtrukkt stikprøve på 1 000 børn født i 2001. Data er indsamlet i 2004
3 Tallene er underestimerede på grund af lav indberetning i nogle kommuner

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

## 3.4 Discharges, patients treated and average length of stay

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

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

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

## 3.4 Udskrivninger, patienter behandlet og gennemsnitlig liggetid

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

Statistikken fra 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 på forskellige diagnostiske kulturer, forskelle i den medicinske behandling samt forskelle i den måde hvorpå behandlingen er organiseret.

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

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

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

Another important aspect is changes in the statistics in connection with the change in the classification. This is described in de-

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

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

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

Et andet væsentligt aspekt er ændringer i statistikken ved klassifikationsskiftet. Dette er omfattende beskrevet i kapitel 4

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

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

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 diagnosticeringen 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.

Finally, it must be mentioned that there are great differences in the use of Z codes for factors that have significance for health status. In particular, codes Z03 *Medical observation and evaluation for suspectes diseases and conditions* and Z50 *Care involving use of rehabilitation procedures* are used in Denmark.

Endelig skal det nævnes, at der er stor forskel på hvor meget man anvender Z-koderne for faktorer der har betydning for sundhedstilstanden hvor især Danmark anvender Z03 *Lægelig observation for og vurdering af personer mistænkt for sygdom* og Z50 *Behandling med anvendelse af genoptræningsforanstaltninger.*

**Table 3.4.1.a Patients treated in hospitals* during 2006 by main diagnostic group, per 1 000 inhabitants (crude rates)**

| | *Denmark* | *Faroe Islands[1)]* | *Finland[2)]* | *Åland[1)2)]* |
|---|---|---|---|---|
| Certain infectious and parasitic diseases | 4.9 | 4.0 | 4.4 | 5.6 |
| Neoplasms | 9.2 | 8.1 | 9.6 | 9.0 |
| Diseases of the blood and blood-forming organs and certain disorders involving the immune system | 2.0 | 2.1 | 0.9 | 0.9 |
| Endocrine, nutritional and metabolic diseases | 4.2 | 3.4 | 2.1 | 2.5 |
| Mental and behavioural disorders | 2.3 | 6.8 | 4.4 | 2.1 |
| Diseases of the nervous system | 3.6 | 4.8 | 5.8 | 5.2 |
| Diseases of the eye and adnexa | 0.9 | 2.4 | 7.8 | 1.9 |
| Diseases of the ear and mastoid process | 1.1 | 3.6 | 2.7 | 2.6 |
| Diseases of the circulatory system | 15.6 | 18.3 | 16.2 | 14.1 |
| Diseases of the respiratory system | 12.1 | 11.4 | 10.0 | 12.4 |
| Diseases of the digestive system | 12.0 | 26.2 | 12.1 | 12.8 |
| Diseases of the skin and subcutaneous tissue | 2.4 | 2.2 | 1.6 | 1.8 |
| Diseases of the musculo-skeletal system and connective tissue | 8.9 | 11.2 | 16.0 | 14.1 |
| Diseases of the genito-urinary system | 8.7 | 8.3 | 8.5 | 11.5 |
| Pregnancy, childbirth and the puerperium | 14.3 | 14.5 | 12.8 | 10.3 |
| Certain conditions originating in the perinatal period | 1.6 | 0.4 | 1.5 | 1.3 |
| Congenital malformations, deformations and chromosomal abnormalities | 1.2 | 1.2 | 1.4 | 1.0 |
| Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified | 13.9 | 11.9 | 9.4 | 11.3 |
| Injury, poisoning and certain other consequences of external causes | 16.0 | 15.4 | 14.5 | 13.9 |
| Factors influencing health status and contact with health services | 32.7 | 28.7 | 2.6 | 5.0 |
| Total | 119.6 | 188.1 | 122.9 | 87.4 |

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

1 Average 2002-2006
2 Excluding departments in psychiatric hospitals and in non-specialized departments in health centres
3 Excluding patients staying 90 days or longer
4 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period

Sources: The national in-patient registers

ICD-10 chapters.

**Patienter behandlet ved sygehuse* i løbet af 2006, efter hoveddiagnosegrupper, pr. 1 000 indbyggere (crude rates)** **Tabel 3.4.1.a**

| *Iceland*[3] | *Norway*[4] | *Sweden* | |
|---|---|---|---|
| 2.0 | 4.9 | 4.1 | Visse infektions- og parasitære sygdomme |
| 7.9 | 11.7 | 8.3 | Svulster |
| 0.9 | 1.1 | 1.1 | Sygdomme i blod og bloddannende organer og visse lidelser i forbindelse med immunsystemet |
| 1.7 | 2.7 | 2.5 | Endokrine, ernærings- og stofskiftesygdomme |
| 1.6 | 2.0 | 1.5 | Psykiske og adfærdsmæssige lidelser |
| 3.3 | 6.8 | 3.4 | Sygdomme i nervesystem |
| 1.3 | 1.8 | 0.9 | Sygdomme i øje og øjenomgivelser |
| 1.1 | 0.8 | 0.9 | Sygdomme i øre og processus mastoideus |
| 12.9 | 21.7 | 16.9 | Sygdomme i kredsløbsorganer |
| 7.8 | 13.0 | 7.6 | Sygdomme i åndedrætsorganer |
| 11.3 | 10.9 | 9.6 | Sygdomme i fordøjelsesorganer |
| 2.4 | 1.6 | 1.0 | Sygdomme i hud og underhud |
| 8.8 | 10.2 | 7.3 | Sygdomme i knogler, bevægelsessystem og bindevæv |
| 9.3 | 8.7 | 6.3 | Sygdomme i urin- og kønsorganer |
| 18.8 | 14.9 | 12.2 | Svangerskab, fødsel og barsel |
| 4.6 | 2.5 | 0.9 | Visse årsager til sygdomme i perinatalperioden |
| 1.4 | 1.5 | 0.8 | Medfødte misdannelser og kromosomanomalier |
| 5.8 | 11.8 | 13.2 | Symptomer og abnorme fund ikke klassificeret andetsteds |
| 9.2 | 17.7 | 13.0 | Læsioner, forgiftninger og visse andre følger af ydre påvirkninger |
| 19.2 | 6.7 | 5.3 | Faktorer af betydning for sundhedstilstand og kontakter med sundhedsvæsen |
| 129.9 | 153.1 | 95.3 | I alt |

* Omfatter somatiske afdelinger ved almindelige sygehuse og ved somatiske specialsygehuse

1 Gennemsnit for årene 2002-2006
2 Eksklusiv psykiatriske hospitalsafdelinger og ikke-specialiserede afdelinger på sundhedscentraler
3 Eksklusive patienter med liggetid på 90 dage eller mere
4 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode

Kilder: Landspatientregistrene

ICD-10 kapitler.

**Table 3.4.1.b Patients treated in hospitals* during 2006 by main diagnostic group, per 1 000 inhabitants (age standardized)**

| | *Denmark* | *Faroe Islands[1)]* | *Finland[2)]* | *Åland[1)2)]* |
|---|---|---|---|---|
| Certain infectious and parasitic diseases | 4.9 | 3.8 | 4.4 | 5.7 |
| Neoplasms | 8.9 | 8.6 | 9.2 | 8.8 |
| Diseases of the blood and blood-forming organs and certain disorders involving the immune system | 1.9 | 2.1 | 0.9 | 0.8 |
| Endocrine, nutritional and metabolic diseases | 4.1 | 3.5 | 2.0 | 2.5 |
| Mental and behavioural disorders | 2.2 | 7.0 | 4.5 | 2.2 |
| Diseases of the nervous system | 3.5 | 5.0 | 5.6 | 5.4 |
| Diseases of the eye and adnexa | 0.9 | 2.5 | 7.4 | 1.7 |
| Diseases of the ear and mastoid process | 1.1 | 3.1 | 2.9 | 2.8 |
| Diseases of the circulatory system | 15.2 | 19.6 | 15.5 | 13.6 |
| Diseases of the respiratory system | 12.0 | 10.8 | 10.1 | 13.0 |
| Diseases of the digestive system | 11.8 | 27.2 | 11.8 | 12.6 |
| Diseases of the skin and subcutaneous tissue | 2.4 | 2.2 | 1.6 | 1.9 |
| Diseases of the musculo-skeletal system and connective tissue | 8.7 | 11.9 | 15.3 | 14.3 |
| Diseases of the genito-urinary system | 8.6 | 8.7 | 8.3 | 11.4 |
| Pregnancy, childbirth and the puerperium | 15.0 | 16.0 | 13.9 | 12.8 |
| Certain conditions originating in the perinatal period | 1.6 | 0.3 | 1.6 | 1.5 |
| Congenital malformations, deformations and chromosomal abnormalities | 1.2 | 1.1 | 1.5 | 1.1 |
| Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified | 13.8 | 11.8 | 9.2 | 11.2 |
| Injury, poisoning and certain other consequences of external causes | 15.9 | 15.7 | 14.4 | 13.9 |
| Factors influencing health status and contact with health services | 32.6 | 30.2 | 2.7 | 4.9 |
| Total | 119.0 | 194.6 | 123.2 | 100.6 |

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

1 Average 2002-2006
2 Excluding departments in psychiatric hospitals and in non-specialized departments in health centres
3 Excluding patients staying 90 days or longer
4 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period

Age standardized by the Nordic population 2000

Sources: See Table 3.4.1.a

**Patienter behandlet ved sygehuse* i løbet af 2006, efter hoveddiagnosegrupper, pr. 1 000 indbyggere (alders standardiseret)** **Tabel 3.4.1.b**

| *Iceland[3]* | *Norway[4]* | *Sweden* | |
|---|---|---|---|
| 2.1 | 4.8 | 3.8 | Visse infektions- og parasitære sygdomme |
| 9.3 | 11.8 | 7.5 | Svulster |
| 1.1 | 1.1 | 1.0 | Sygdomme i blod og bloddannende organer og visse lidelser i forbindelse med immunsystemet |
| 1.9 | 2.6 | 2.4 | Endokrine, ernærings- og stofskiftesygdomme |
| 1.9 | 1.9 | 1.4 | Psykiske og adfærdsmæssige lidelser |
| 3.7 | 6.8 | 3.1 | Sygdomme i nervesystem |
| 1.5 | 1.8 | 0.8 | Sygdomme i øje og øjenomgivelser |
| 1.1 | 0.8 | 0.8 | Sygdomme i øre og processus mastoideus |
| 15.8 | 21.6 | 14.6 | Sygdomme i kredsløbsorganer |
| 8.5 | 12.9 | 7.1 | Sygdomme i åndedrætsorganer |
| 12.6 | 10.9 | 9.0 | Sygdomme i fordøjelsesorganer |
| 2.6 | 1.6 | 0.9 | Sygdomme i hud og underhud |
| 10.0 | 10.3 | 6.7 | Sygdomme i knogler, bevægelsessystem og bindevæv |
| 10.2 | 8.6 | 5.8 | Sygdomme i urin- og kønsorganer |
| 17.4 | 15.1 | 13.0 | Svangerskab, fødsel og barsel |
| 4.0 | 2.4 | 1.0 | Visse årsager til sygdomme i perinatalperioden |
| 1.3 | 1.5 | 0.8 | Medfødte misdannelser og kromosomanomalier |
| 6.5 | 11.8 | 12.2 | Symptomer og abnorme fund ikke klassificeret andetsteds |
| 10.0 | 17.5 | 12.0 | Læsioner, forgiftninger og visse andre følger af ydre påvirkninger |
| 17.7 | 6.7 | 4.9 | Faktorer af betydning for sundhedstilstand og kontakter med sundhedsvæsen |
| 137.9 | 152.5 | 89.9 | I alt |

* Omfatter somatiske afdelinger ved almindelige sygehuse og ved somatiske specialsygehuse

1 Gennemsnit for årene 2002-2006
2 Eksklusiv psykiatriske hospitalsafdelinger og ikke-specialiserede afdelinger på sundhedscentraler
3 Eksklusive patienter med liggetid på 90 dage eller mere
4 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode

Aldersstandardiseret med den nordiske befolkning 2000

Sources: See Table 3.4.1.a

**Table 3.4.2 Average length of stay in hospitals* by main diagnostic group 2006**

| | *Denmark* | *Faroe Islands*[1)] | *Finland*[2)] | *Åland*[1)2)] |
|---|---|---|---|---|
| Certain infectious and parasitic diseases | 5.0 | 5.5 | 7.9 | 5.1 |
| Neoplasms | 5.1 | 6.5 | 6.6 | 6.6 |
| Diseases of the blood and blood-forming organs and certain disorders involving the immune system | 3.7 | 5.1 | 5.9 | 5.4 |
| Endocrine, nutritional and metabolic diseases | 5.1 | 9.3 | 7.1 | 5.4 |
| Mental and behavioural disorders | 3.7 | 24.7 | 25.6 | 6.5 |
| Diseases of the nervous system | 5.0 | 5.2 | 6.2 | 4.9 |
| Diseases of the eye and adnexa | 2.2 | 0.7 | 1.9 | 1.6 |
| Diseases of the ear and mastoid process | 2.1 | 0.6 | 2.2 | 1.9 |
| Diseases of the circulatory system | 4.9 | 7.1 | 7.4 | 6.0 |
| Diseases of the respiratory system | 4.6 | 6.1 | 5.8 | 4.2 |
| Diseases of the digestive system | 4.5 | 3.3 | 5.2 | 4.0 |
| Diseases of the skin and subcutaneous tissue | 4.5 | 5.0 | 6.6 | 4.4 |
| Diseases of the musculo-skeletal system and connective tissue | 4.7 | 5.5 | 5.5 | 4.4 |
| Diseases of the genito-urinary system | 3.5 | 4.2 | 4.8 | 3.5 |
| Pregnancy, childbirth and the puerperium | 2.9 | 4.9 | 6.8 | 3.5 |
| Certain conditions originating in the perinatal period | 10.0 | 8.2 | 12.5 | 7.6 |
| Congenital malformations, deformations and chromosomal abnormalities | 3.8 | 3.5 | 5.9 | 15.8 |
| Symptoms, signs and abnormal clinical an laboratory findings, not elsewhere classified | 2.9 | 2.7 | 4.1 | 2.8 |
| Injury, poisoning and certain other consequences of external causes | 4.3 | 4.6 | 5.9 | 4.9 |
| Factors influencing health status and contact with health services | 3.9 | 0.0 | 4.5 | 3.8 |
| Total | 4.3 | 6.4 | 4.6 | 4.7 |

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

1 Average 2002-2006
2 Excluding departments in psychiatric hospitals and in non-specialized departments in health centres
3 Excluding patients staying 90 days or longer

Sources: See Table 3.4.1.a

**Gennemsnitlig liggetid ved sygehuse* efter hoveddiagnosegrupper 2006 Tabel 3.4.2**

| *Iceland[3]* | *Norway* | *Sweden* | |
|---|---|---|---|
| 5.6 | 6.3 | 5.5 | Visse infektions- og parasitære sygdomme |
| 7.3 | 7.1 | 7.3 | Svulster |
| 4.3 | 3.9 | 4.7 | Sygdomme i blod og bloddannende organer og visse lidelser i forbindelse med immunsystemet |
| 7.0 | 4.5 | 5.6 | Endokrine, ernærings- og stofskiftesygdomme |
| 15.1 | 3.7 | 6.3 | Psykiske og adfærdsmæssige lidelser |
| 5.7 | 3.5 | 5.0 | Sygdomme i nervesystem |
| 2.8 | 2.3 | 2.7 | Sygdomme i øje og øjenomgivelser |
| 1.7 | 2.6 | 2.2 | Sygdomme i øre og processus mastoideus |
| 6.9 | 5.4 | 5.8 | Sygdomme i kredsløbsorganer |
| 6.4 | 5.9 | 5.2 | Sygdomme i åndedrætsorganer |
| 4.0 | 4.8 | 4.6 | Sygdomme i fordøjelsesorganer |
| 6.6 | 6.2 | 6.4 | Sygdomme i hud og underhud |
| 6.8 | 5.0 | 5.8 | Sygdomme i knogler, bevægelsessystem og bindevæv |
| 3.6 | 4.2 | 4.1 | Sygdomme i urin- og kønsorganer |
| 2.6 | 3.6 | 2.7 | Svangerskab, fødsel og barsel |
| 5.2 | 8.9 | 10.1 | Visse årsager til sygdomme i perinatalperioden |
| 3.4 | 4.6 | 5.0 | Medfødte misdannelser og kromosomanomalier |
| 4.0 | 2.1 | 2.5 | Symptomer og abnorme fund ikke klassificeret andetsteds |
| 6.7 | 4.8 | 5.3 | Læsioner, forgiftninger og visse andre følger af ydre påvirkninger |
| 3.9 | 6.3 | 6.2 | Faktorer af betydning for sundhedstilstand og kontakter med sundhedsvæsen |
| 5.2 | 4.9 | 5.0 | I alt |

* Omfatter somatiske afdelinger ved almindelige sygehuse og ved somatiske specialsygehuse

1 Gennemsnit for årene 2002-2006
2 Eksklusiv psykiatriske hospitalsafdelinger og ikke-specialiserede afdelinger på sundhedscentraler
3 Eksklusive patienter med liggetid på 90 dage eller mere

Kilder: Se tabel 3.4.1.a

**Table 3.4.3.a Discharges from hospitals* by main diagnostic group, per 1 000 inhabitants (crude rates) 2006**

| | *Denmark* | *Faroe Islands[1)]* | *Finland[2)]* | *Åland[1)2)]* |
|---|---|---|---|---|
| Certain infectious and parasitic diseases | 5.9 | 4.4 | 5.1 | 6.5 |
| Neoplasms | 19.5 | 13.2 | 19.8 | 20.3 |
| Diseases of the blood and blood-forming organs and certain disorders involving the immune system | 3.3 | 4.2 | 1.3 | 1.1 |
| Endocrine, nutritional and metabolic diseases | 5.6 | 4.5 | 2.5 | 3.7 |
| Mental and behavioural disorders | 3.1 | 9.1 | 6.5 | 3.2 |
| Diseases of the nervous system | 5.1 | 6.7 | 7.6 | 9.0 |
| Diseases of the eye and adnexa | 1.2 | 2.7 | 9.8 | 2.3 |
| Diseases of the ear and mastoid process | 1.2 | 3.8 | 2.9 | 3.4 |
| Diseases of the circulatory system | 26.0 | 22.0 | 24.0 | 26.6 |
| Diseases of the respiratory system | 18.2 | 13.6 | 12.5 | 17.3 |
| Diseases of the digestive system | 16.8 | 30.3 | 15.0 | 18.5 |
| Diseases of the skin and subcutaneous tissue | 3.0 | 2.5 | 2.0 | 2.2 |
| Diseases of the musculo-skeletal system and connective tissue | 10.9 | 12.2 | 19.4 | 20.8 |
| Diseases of the genitor-urinary system | 11.5 | 9.1 | 10.1 | 15.9 |
| Pregnancy, childbirth and the puerperium | 17.0 | 15.0 | 14.7 | 15.5 |
| Certain conditions originating in the perinatal period | 1.9 | 0.4 | 1.7 | 1.5 |
| Congenital malformations, deformations and chromosomal abnormalities | 1.8 | 1.7 | 2.0 | 1.8 |
| Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified | 17.2 | 13.9 | 10.9 | 14.2 |
| Injury, poisoning and certain other consequences of external causes | 19.7 | 17.6 | 17.7 | 18.7 |
| Factors influencing health status and contact with health services | 39.4 | 37.6 | 3.0 | 5.8 |
| Total | 215.8 | 228.0 | 188.5 | 208.3 |

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

1 Average 2002-2006
2 Excluding departments in psychiatric hospitals and in non-specialized departments in health centres
3 Discharges with a length of stay less than 90 days
4 Figures are for discharges from hospitals, not for completed treatment in departments

Sources: See Table 3.4.1.a

**Udskrivninger fra sygehuse* efter hoveddiagnosegrupper, pr. 1 000 indbyggere (crude rates) 2006** **Tabel 3.4.3.a**

| *Iceland[3]* | *Norway[4]* | *Sweden* | |
|---|---|---|---|
| 2.1 | 5.2 | 4.7 | Visse infektions- og parasitære sygdomme |
| 12.8 | 17.7 | 14.3 | Svulster |
| 1.6 | 1.4 | 1.5 | Sygdomme i blod og bloddannende organer og visse lidelser i forbindelse med immunsystemet |
| 2.0 | 3.0 | 3.0 | Endokrine, ernærings- og stofskiftesygdomme |
| 1.9 | 2.2 | 1.8 | Psykiske og adfærdsmæssige lidelser |
| 4.5 | 8.2 | 4.3 | Sygdomme i nervesystem |
| 1.5 | 2.4 | 1.0 | Sygdomme i øje og øjenomgivelser |
| 1.2 | 0.9 | 0.9 | Sygdomme i øre og processus mastoideus |
| 15.4 | 25.0 | 25.5 | Sygdomme i kredsløbsorganer |
| 9.0 | 14.8 | 9.9 | Sygdomme i åndedrætsorganer |
| 13.2 | 12.4 | 12.2 | Sygdomme i fordøjelsesorganer |
| 2.7 | 1.8 | 1.1 | Sygdomme i hud og underhud |
| 10.1 | 11.7 | 8.7 | Sygdomme i knogler, bevægelsessystem og bindevæv |
| 10.1 | 9.8 | 7.5 | Sygdomme i urin- og kønsorganer |
| 19.7 | 15.2 | 14.3 | Svangerskab, fødsel og barsel |
| 5.3 | 2.6 | 1.6 | Visse årsager til sygdomme i perinatalperioden |
| 1.6 | 1.8 | 1.1 | Medfødte misdannelser og kromosomanomalier |
| 6.4 | 12.5 | 15.2 | Symptomer og abnorme fund ikke klassificeret andetsteds |
| 10.5 | 18.9 | 15.6 | Læsioner, forgiftninger og visse andre følger af ydre påvirkninger |
| 23.8 | 8.3 | 6.6 | Faktorer af betydning for sundhedstilstand og kontakter med sundhedsvæsen |
| 153.8 | 175.6 | 150.9 | I alt |

* Omfatter somatiske afdelinger ved almindelige sygehuse og ved somatiske specialsygehuse

1 Gennemsnit for årene 2002-2006
2 Eksklusiv psykiatriske hospitalsafdelinger og ikke-specialiserede afdelinger på sundhedscentraler
3 Udskrivninger med liggetid under 90 dage
4 Opgørelsen vedrører udskrivninger fra sygehuse, ikke afsluttede behandlinger ved afdelinger

Kilder: Se tabel 3.4.1.a

**Table 3.4.3.b Discharges from hospitals* by main diagnostic group, per 1 000 inhabitants (age standardized) 2006**

| | *Denmark* | *Faroe Islands[1)]* | *Finland[2)]* | *Åland[1)2)]* |
|---|---|---|---|---|
| Certain infectious and parasitic diseases | 5.9 | 4.2 | 5.1 | 6.4 |
| Neoplasms | 18.7 | 14.0 | 18.5 | 18.5 |
| Diseases of the blood and blood-forming organs and certain disorders involving the immune system | 3.2 | 4.3 | 1.3 | 1.0 |
| Endocrine, nutritional and metabolic diseases | 5.6 | 4.6 | 2.5 | 1.0 |
| Mental and behavioural disorders | 3.0 | 9.5 | 6.5 | 3.2 |
| Diseases of the nervous system | 5.0 | 6.9 | 7.3 | 8.6 |
| Diseases of the eye and adnexa | 1.1 | 2.8 | 9.2 | 2.1 |
| Diseases of the ear and mastoid process | 1.2 | 3.3 | 3.1 | 3.5 |
| Diseases of the circulatory system | 25.2 | 23.6 | 22.6 | 23.5 |
| Diseases of the respiratory system | 18.0 | 13.1 | 12.5 | 17.0 |
| Diseases of the digestive system | 16.5 | 31.6 | 14.5 | 17.5 |
| Diseases of the skin and subcutaneous tissue | 3.0 | 2.5 | 2.0 | 2.2 |
| Diseases of the musculo-skeletal system and connective tissue | 10.6 | 13.0 | 18.4 | 19.6 |
| Diseases of the genito-urinary system | 11.4 | 9.5 | 9.8 | 14.8 |
| Pregnancy, childbirth and the puerperium | 17.9 | 16.5 | 16.0 | 17.4 |
| Certain conditions originating in the perinatal period | 1.9 | 0.3 | 1.8 | 1.8 |
| Congenital malformations, deformations and chromosomal abnormalities | 1.8 | 1.5 | 2.1 | 2.1 |
| Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified | 17.0 | 13.8 | 10.6 | 13.4 |
| Injury, poisoning and certain other consequences of external causes | 19.6 | 18.0 | 17.4 | 17.9 |
| Factors influencing health status and contact with health services | 39.3 | 39.8 | 3.0 | 5.6 |
| Total | 213.6 | 236.4 | 184.3 | 199.3 |

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

1 Average 2002-2006
2 Excluding departments in psychiatric hospitals and in non-specialized departments in health centres
3 Discharges with a length of stay less than 90 days
4 Figures are for discharges from hospitals, not for completed treatment in departments

Age standardized by the Nordic population 2000

Sources: See Table 3.4.1.a

**Udskrivninger fra sygehuse* efter hoveddiagnosegrupper, pr. 1 000 indbyggere (alders standardiseret) 2006** **Tabel 3.4.3.b**

| *Iceland[3)]* | *Norway[4)]* | *Sweden* | |
|---|---|---|---|
| 2.3 | 5.1 | 4.4 | Visse infektions- og parasitære sygdomme |
| 14.9 | 17.8 | 13.0 | Svulster |
| 1.9 | 1.4 | 1.3 | Sygdomme i blod og bloddannende organer og visse lidelser i forbindelse med immunsystemet |
| 2.2 | 2.9 | 2.8 | Endokrine, ernærings- og stofskiftesygdomme |
| 2.2 | 2.2 | 1.6 | Psykiske og adfærdsmæssige lidelser |
| 5.0 | 8.2 | 4.1 | Sygdomme i nervesystem |
| 1.7 | 2.4 | 1.0 | Sygdomme i øje og øjenomgivelser |
| 1.2 | 0.9 | 0.9 | Sygdomme i øre og processus mastoideus |
| 18.9 | 24.8 | 22.1 | Sygdomme i kredsløbsorganer |
| 9.9 | 14.6 | 9.1 | Sygdomme i åndedrætsorganer |
| 14.6 | 12.3 | 11.4 | Sygdomme i fordøjelsesorganer |
| 2.9 | 1.8 | 1.1 | Sygdomme i hud og underhud |
| 11.6 | 11.8 | 8.0 | Sygdomme i knogler, bevægelsessystem og bindevæv |
| 11.2 | 9.8 | 6.9 | Sygdomme i urin- og kønsorganer |
| 18.2 | 15.5 | 15.2 | Svangerskab, fødsel og barsel |
| 4.6 | 2.5 | 1.8 | Visse årsager til sygdomme i perinatalperioden |
| 1.5 | 1.8 | 1.2 | Medfødte misdannelser og kromosomanomalier |
| 7.2 | 12.5 | 14.1 | Symptomer og abnorme fund ikke klassificeret andetsteds |
| 11.5 | 18.6 | 14.5 | Læsioner, forgiftninger og visse andre følger af ydre påvirkninger |
| 21.9 | 8.3 | 6.1 | Faktorer af betydning for sundhedstilstand og kontakter med sundhedsvæsen |
| 163.8 | 175.1 | 140.5 | I alt |

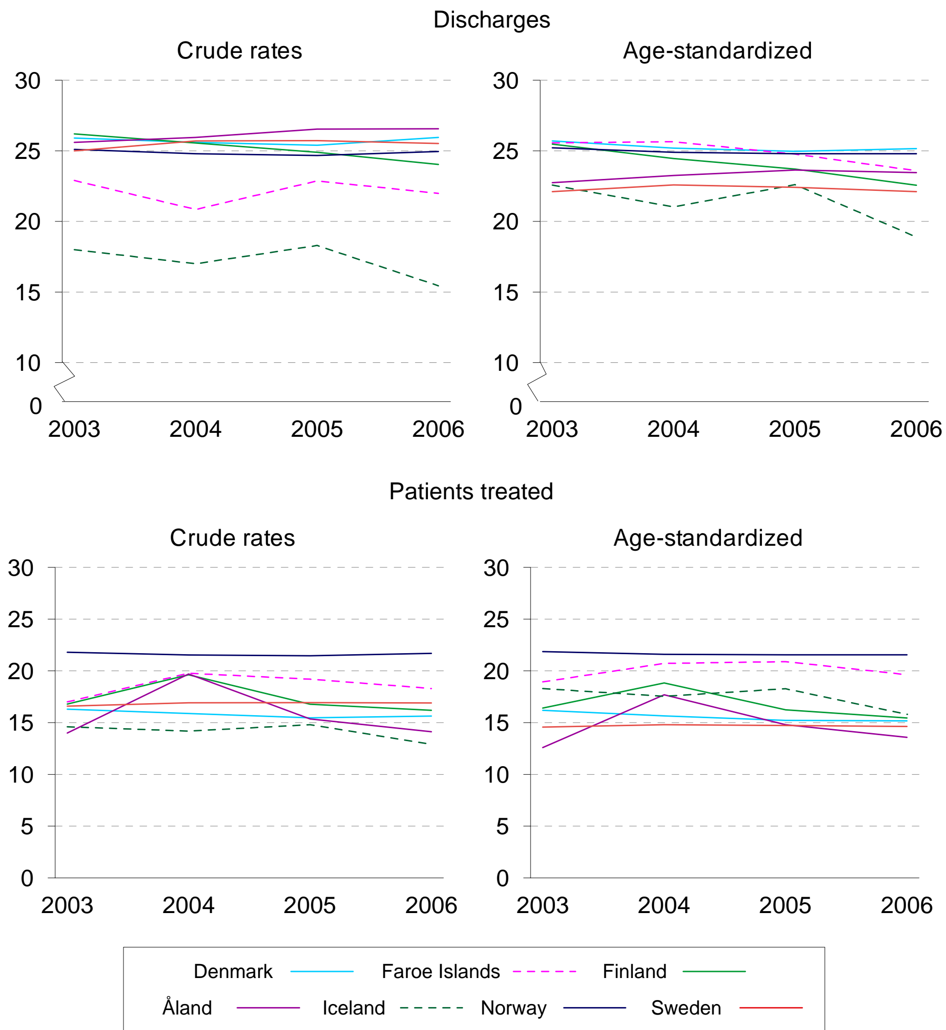
* Omfatter somatiske afdelinger ved almindelige sygehuse og ved somatiske specialsygehuse

1 Gennemsnit for årene 2002-2006
2 Eksklusiv psykiatriske hospitalsafdelinger og ikke-specialiserede afdelinger på sundhedscentraler
3 Udskrivninger med liggetid under 90 dage
4 Opgørelsen vedrører udskrivninger fra sygehuse, ikke afsluttede behandlinger ved afdelinger

Aldersstandardiseret med den nordiske befolkning 2000

Kilder: Se tabel 3.4.1.a

**Figure 3.4.1 Discharges from hospitals and treatment during the year for diseases of the circulatory system, per 1 000 inhabitants 2003-2006**
Udskrivninger og patienter behandlet i løbet af året for sygdomme i kredsløbsorganer, pr. 1 000 indbyggere 2003-2006

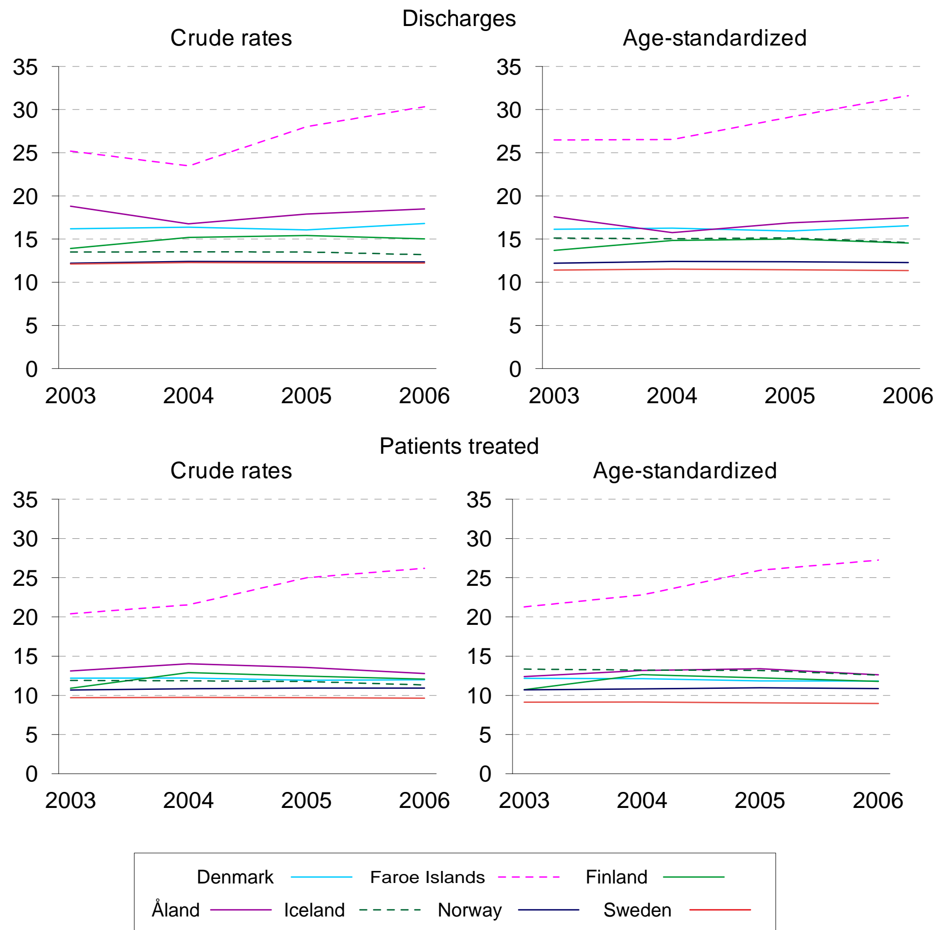



Age-standardized by the Nordic population 2000

Aldersstandardiseret efter den nordiske befolkning 2000

*Sources: See Tables 3.4.3.a and 3.4.3.b*
Kilder: Se tabel 3.4.3.a og 3.4.3.b

**Figure 3.4.2 Discharges from hospitals and treatment during the year for diseases of the digestive system, per 1 000 inhabitants 2003-2006**
Udskrivninger og patienter behandlet for sygdomme i fordøjelsessystemet, pr. 1 000 indbyggere 2003-2006

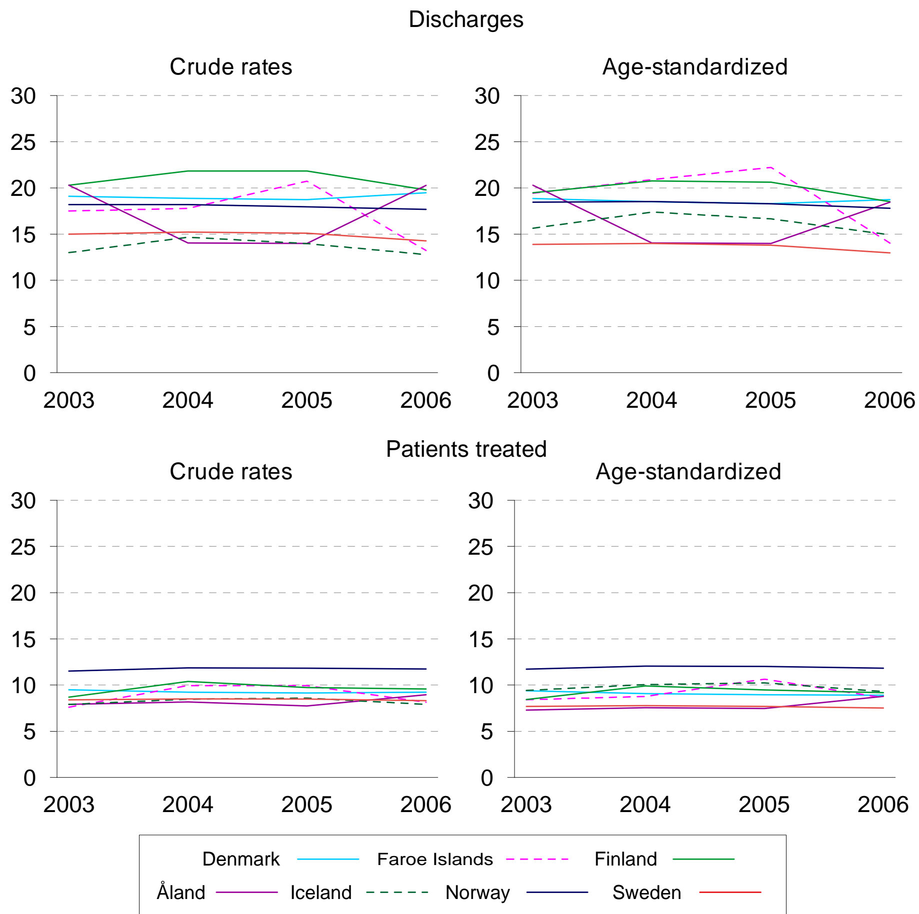



Age-standardized by the Nordic population 2000

Aldersstandardiseret efter den nordiske befolkning 2000

*Sources:* *See Tables 3.4.3.a and 3.4.3.b*
Kilder: Se tabel 3.4.3.a og 3.4.3.b

**Figure 3.4.3 Discharges from hospitals and patients treated during the year for malignant neoplasms, per 1 000 inhabitants 2003-2006**
Udskrivninger og patienter behandlet for ondartede svulster, pr. 1 000 indbyggere 2003-2006




Age-standardized by the Nordic population 2000

Aldersstandardiseret efter den nordiske befolkning 2000

*Sources:* *See Tables 3.4.3.a and 3.4.3.b*
Kilder: Se tabel 3.4.3.a og 3.4.3.b

**Table 3.4.4 Discharges, patients treated and average length of stay in hospital* for malignant neoplasm of breast, women 2006**
Udskrivninger, patienter behandlet og gennemsnitlig liggetid ved sygehuse* for kræft i bryst, kvinder 2006

| | | Denmark | Faroe Islands[1)] | Finland | Åland[1)] | Iceland | Norway[2)] | Sweden |
|---|---|---|---|---|---|---|---|---|
| *Discharges, total* | Udskrivninger, i alt | 8 028 | 24 | 9 572 | 34 | 337 | 5 691 | 10 126 |
| Patients treated, total | Patienter behandlet, i alt | 5 151 | 20 | 6 372 | 24 | 248 | 4 072 | 8 095 |
| *Patients treated per 100 000 women in the age group* Patienter behandlet pr. 100 000 kvinder i alderen | | | | | | | | |
| 25-44 | | 64 | 34 | 88 | 63 | 44 | 65 | 63 |
| 45-64 | | 351 | 165 | 485 | 318 | 376 | 351 | 331 |
| 65+ | | 450 | 255 | 447 | 400 | 518 | 410 | 386 |
| *Total rate* Samlet rate | | 188 | 86 | 237 | 178 | 165 | 174 | 177 |
| *Average length of stay per patient treated* Gennemsnitlig liggetid pr. behandlet patient | | 6.0 | 18.2 | 5.2 | 7.5 | 7.4 | 7.3 | 5.5 |
| *Average length of stay per discharge* Gennemsnitlig liggetid pr. udskrivning | | 3.9 | 15.2 | 3.5 | 5.2 | 5.5 | 5.2 | 4.4 |

1 Average 2002-2006
2 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period

1 Gennemsnit for årene 2002-2006
2 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode

*Sources: see Table 3.4.2.a*
Kilder: se tabel 3.4.2.a

** Definition, see Table 3.4.2.a*
* Definition, se tabel 3.4.2.a

*The Table includes ICD-10: C50*
Tabellen omfatter ICD-10: C50

**Table 3.4.5 Discharges, patients treated and average length of stay in hospital* for malignant neoplasm of trachea, bronchus and lung 2006**
Udskrivninger, patienter behandlet og gennemsnitlig liggetid ved sygehuse* for kræft i tracheae, bronkie og lunge 2006

| | | Denmark | Faroe Islands[1] | Finland | Åland[1] | Iceland | Norway[2] | Sweden |
|---|---|---|---|---|---|---|---|---|
| *Discharges* | Udskrivninger | | | | | | | |
| *Men, total* | Mænd, i alt | 4 615 | 32 | 4 364 | 17 | 179 | 3 707 | 4 239 |
| Women, total | Kvinder, i alt | 4 151 | 2 | 1 699 | 7 | 177 | 2 686 | 3 867 |
| *Patients trea-ted* | Patienter behandlet | | | | | | | |
| *Men, total* | Mænd, i alt | 2 197 | 10 | 1 804 | 8 | 88 | 2 293 | 2 358 |
| Women, total | Kvinder, i alt | 1 926 | 2 | 701 | 4 | 85 | 1 623 | 2 204 |
| *Patients treated per 100 000 men in the age group* Patienter behandlet pr. 100 000 mænd i alderen | | | | | | | | |
| 0-24 | | - | - | - | - | - | - | - |
| 25-44 | | 5 | - | 3 | - | - | 4 | 2 |
| 45-64 | | 110 | 66 | 82 | 84 | 71 | 130 | 57 |
| 65+ | | 378 | 200 | 359 | 257 | 388 | 513 | 240 |
| *Total rate* Samlet rate | | 82 | 40 | 70 | 60 | 57 | 99 | 52 |
| *Patients treated per 100 000 women in the age group* Patienter behandlet pr. 100 000 kvinder i alderen | | | | | | | | |
| 0-24 | | - | - | - | - | - | - | 1 |
| 25-44 | | 6 | - | 2 | - | 2 | 5 | 3 |
| 45-64 | | 108 | 37 | 37 | 68 | 90 | 107 | 68 |
| 65+ | | 232 | - | 85 | 71 | 275 | 246 | 153 |
| *Total rate* Samlet rate | | 70 | 9 | 26 | 28 | 57 | 69 | 48 |
| *Average length of stay per patient treated* Gennemsnitlig liggetid pr. behandlet patient | | 13.4 | 11.7 | 16.7 | 20.2 | 24.5 | 15.0 | 18.1 |
| *Average length of stay per discharge* Gennemsnitlig liggetid pr. udskrivning | | 6.3 | 4.1 | 6.9 | 9.8 | 11.9 | 9.2 | 10.2 |

1 Average 2002-2006
2 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period

1 Gennemsnit for årene 2002-2006
2 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode

*Sources: See Tabel 3.4.2.a*
Kilder: Se Tabel 3.4.2.a

** Definition: see Table 3.4.2.a.*
* Definition: se Tabel 3.4.2.a.

*The Table includes ICD-10: C33-C34*
Tabellen omfatter ICD-10: C33-C34

**Table 3.4.6 Discharges, patients treated and average length of stay in hospital* for acute myocardial infarction 2006**
Udskrivninger, patienter behandlet og gennemsnitlig liggetid ved sygehuse* for akut hjerteinfarkt 2006

| | | Denmark | Faroe Islands[1] | Finland | Åland[1] | Iceland | Norway[2] | Sweden |
|---|---|---|---|---|---|---|---|---|
| *Discharges* | Udskrivninger | | | | | | | |
| *Men, total* | Mænd, i alt | 9 985 | 78 | 7 449 | 48 | 330 | 12 281 | 21 346 |
| Women, total | Kvinder, i alt | 5 444 | 30 | 5 123 | 30 | 168 | 6 702 | 14 056 |
| *Patients treated* | Patienter behandlet | | | | | | | |
| *Men, total* | Mænd, i alt | 5 984 | 66 | 5 723 | 35 | 284 | 10 757 | 15 013 |
| Women, total | Kvinder, i alt | 3 439 | 26 | 4 089 | 23 | 145 | 5 924 | 10 413 |
| *Patients treated per 100 000 men in the age group* Patienter behandlet pr. 100 000 mænd i alderen | | | | | | | | |
| 0-44 | | 20 | 25 | 13 | 11 | 16 | 41 | 11 |
| 45-64 | | 314 | 360 | 250 | 268 | 308 | 726 | 352 |
| 65+ | | 940 | 1 332 | 1 096 | 1 223 | 971 | 2 015 | 1 537 |
| *Total rate* Samlet rate | | 222 | 263 | 222 | 263 | 184 | 465 | 333 |
| *Patients treated per 100 000 women in the age group* Patienter behandlet pr. 100 000 kvinder i alderen | | | | | | | | |
| 0-44 | | 6 | - | 3 | 3 | 3 | 10 | 4 |
| 45-64 | | 89 | 73 | 59 | 36 | 64 | 167 | 105 |
| 65+ | | 572 | 623 | 717 | 832 | 622 | 1 226 | 1 020 |
| *Total rate* Samlet rate | | 125 | 112 | 152 | 167 | 97 | 252 | 228 |
| *Average length of stay per patient treated* Gennemsnitlig liggetid pr. behandlet patient | | 7.7 | 8.1 | 9.8 | 9.0 | 7.6 | 5.6 | 7.1 |
| *Average length of stay per discharge* Gennemsnitlig liggetid pr. udskrivning | | 4.7 | 6.9 | 7.6 | 6.7 | 6.5 | 5.0 | 5.1 |

1 Average 2002-2006
2 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period

1 Gennemsnit for årene 2002-2006
2 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode

*Sources: See Table 3.4.2.a*
Kilder: Se Tabel 3.4.2.a

** Definition, see Table 3.4.2.a*
* Definition, se Tabel 3.4.2.a

*The Table includes ICD-10: I21-I22*
Tabellen omfatter ICD-10: I21-I22

**Table 3.4.7 Discharges, patients treated and average length of stay in hospital* for cerebrovascular diseases 2006**
Udskrivninger, patienter behandlet og gennemsnitlig liggetid ved sygehuse* for karsygdomme i hjerne 2006

| | | Denmark | Faroe Islands[1)] | Finland | Åland[1)] | Iceland | Norway[2)] | Sweden |
|---|---|---|---|---|---|---|---|---|
| *Discharges* | Udskrivninger | | | | | | | |
| *Men, total* | Mænd, i alt | 11 053 | 86 | 10 066 | 46 | 341 | 8 076 | 20 467 |
| Women, total | Kvinder, i alt | 10 005 | 52 | 8 900 | 47 | 206 | 7 983 | 19 443 |
| *Patients treated* | Patienter behandlet | | | | | | | |
| *Men, total* | Mænd, i alt | 8 164 | 74 | 7 335 | 29 | 270 | 7 499 | 15 789 |
| Women, total | Kvinder, i alt | 7 480 | 44 | 6 699 | 28 | 172 | 7 391 | 15 368 |
| *Patients treated per 100 000 men in the age group* Patienter behandlet pr. 100 000 mænd i alderen | | | | | | | | |
| 0-44 | | 25 | 31 | 25 | 16 | 21 | 29 | 17 |
| 45-64 | | 350 | 344 | 353 | 221 | 191 | 323 | 285 |
| 65-79 | | 1 187 | 990 | 1 149 | 777 | 903 | 1 331 | 1 289 |
| 80+ | | 2 430 | 1 917 | 1 477 | 1 111 | 1 263 | 1 886 | 1 877 |
| *Total rate* Samlet rate | | 303 | 295 | 285 | 216 | 175 | 324 | 350 |
| *Patients treated per 100 000 women in the age group* Patienter behandlet pr. 100 000 kvinder i alderen | | | | | | | | |
| 0-44 | | 27 | 7 | 27 | 25 | 11 | 23 | 16 |
| 45-64 | | 219 | 147 | 205 | 120 | 96 | 228 | 181 |
| 65-79 | | 795 | 842 | 696 | 586 | 477 | 896 | 862 |
| 80+ | | 1 962 | 1 269 | 1 014 | 723 | 740 | 1 358 | 1 391 |
| *Total rate* Samlet rate | | 273 | 190 | 250 | 206 | 115 | 315 | 336 |
| *Average length of stay per patient treated* Gennemsnitlig liggetid pr. behandlet patient | | 10.8 | 29.0 | 17.4 | 17.7 | 15.9 | 11.0 | 14.3 |
| *Average length of stay per discharge* Gennemsnitlig liggetid pr. udskrivning | | 8.0 | 24.8 | 12.8 | 10.8 | 12.9 | 10.2 | 11.2 |

1 Average 2002-2006
2 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period

1 Gennemsnit for årene 2002-2006
2 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode

*Sources: See Table 3.4.2.a*
Kilder: Se Tabel 3.4.2.a

** Definition, see Table 3.4.2.a*
* Definition, se Tabel 3.4.2.a

*The Table includes ICD-10: I60-I69*
Tabellen omfatter ICD-10: I60-I69

**Table 3.4.8 Discharges, patients treated and average length of stay in hospital* for chronic obstructive pulmonary disease and bronchiectasis 2006**
Udskrivninger, patienter behandlet og gennemsnitlig liggetid ved sygehuse* for bronkit, emfysem og anden obstruktiv lungesygdom 2006

| | | Denmark | Faroe Islands[1)] | Finland | Åland[1)] | Iceland | Norway[2)] | Sweden |
|---|---|---|---|---|---|---|---|---|
| *Discharges, total* | Udskrivninger, i alt | 18 909 | 89 | 6 409 | 67 | 447 | 9 276 | 16 903 |
| Patients treated, total | Patienter behandlet, i alt | 11 016 | 59 | 3 960 | 31 | 324 | 6 381 | 10 357 |
| *Per 100 000 in the age group* Pr. 100 000 i alderen | | | | | | | | |
| 0-4 | | 35 | 198 | 6 | - | - | 12 | 3 |
| 5-14 | | 3 | 27 | 1 | - | - | 7 | 1 |
| 15-24 | | 2 | - | 1 | - | - | 4 | 1 |
| 25-64 | | 89 | 41 | 36 | 45 | 44 | 68 | 39 |
| 65-74 | | 752 | 538 | 280 | 422 | 531 | 527 | 373 |
| 75+ | | 1 270 | 691 | 447 | 828 | 920 | 806 | 694 |
| *Total rate* Samlet rate | | 203 | 122 | 75 | 117 | 106 | 137 | 114 |
| *Average length of stay per patient treated* Gennemsnitlig liggetid pr. behandlet patient | | 9.2 | 13.6 | 12.2 | 12.5 | 12.7 | 9.4 | 10.1 |
| *Average length of stay per discharge* Gennemsnitlig liggetid pr. udskrivning | | 5.4 | 9.0 | 7.6 | 5.9 | 9.2 | 6.5 | 6.2 |

1 Average 2002-2006
2 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period

1 Gennemsnit for årene 2002-2006
2 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode

*Sources: See Table 3.4.2.a*
Kilder: Se Tabel 3.4.2.a

** Definition, see Table 3.4.2.a*
* Definition, se Tabel 3.4.2.a

*The Table includes ICD-10: J40-J44, J47*
Tabellen omfatter ICD-10: J40-J44, J47

**Table 3.4.9 Discharges, patients treated and average length of stay in hospital* for asthma 2006**
Udskrivninger, patienter behandlet og gennemsnitlig liggetid ved sygehuse* for astma 2006

| | | Denmark | Faroe Islands[1] | Finland | Åland[1] | Iceland | Norway[2] | Sweden |
|---|---|---|---|---|---|---|---|---|
| *Discharges, total* | Udskrivninger, i alt | 9 230 | 88 | 4 923 | 35 | 121 | 4 037 | 5 109 |
| Patients treated, total | Patienter behandlet, i alt | 6 728 | 77 | 3 820 | 23 | 110 | 3 523 | 4 276 |
| *Per 100 000 in the age group* Pr. 100 000 i alderen | | | | | | | | |
| 0-4 | | 1 034 | 1 218 | 259 | 563 | 187 | 533 | 396 |
| 5-14 | | 175 | 217 | 48 | 136 | 39 | 123 | 39 |
| 15-24 | | 56 | 75 | 19 | 40 | 11 | 30 | 14 |
| 25-64 | | 49 | 37 | 47 | 25 | 20 | 29 | 17 |
| 65-74 | | 45 | - | 113 | 97 | 28 | 42 | 38 |
| 75+ | | 47 | 126 | 212 | 234 | 64 | 51 | 78 |
| *Total rate* Samlet rate | | 124 | 160 | 73 | 86 | 36 | 76 | 47 |
| *Average length of stay per patient treated* Gennemsnitlig liggetid pr. behandlet patient | | 2.8 | 3.1 | 9.7 | 5.2 | 4.6 | 4.4 | 3.0 |
| *Average length of stay per discharge* Gennemsnitlig liggetid pr. udskrivning | | 2.0 | 2.7 | 7.5 | 3.4 | 4.2 | 3.9 | 2.6 |

1 Average 2002-2006
2 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period

1 Gennemsnit for årene 2002-2006
2 Tallene dække behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode

*Sources: See Table 3.4.2.a*
Kilder: Se Tabel 3.4.2.a

** Definition, see Table 3.4.2.a*
* Definition, se Table 3.4.2.a

*The Table includes ICD-10: J45-J46*
Tabellen omfatter ICD-10: J45-J46

**Table 3.4.10 Discharges, patients treated and average length of stay in hospital* for intervertebral disc disorders 2006**
Udskrivninger, patienter behandlet og gennemsnitlig liggetid ved sygehuse* for diskusprolaps i halsens ryghvirvler og andre ryghvirvler 2006

| | | Denmark | Faroe Islands[1)] | Finland | Åland[1)] | Iceland | Norway[2)] | Sweden |
|---|---|---|---|---|---|---|---|---|
| *Discharges, total* | Udskrivninger, i alt | 6 160 | 29 | 5 951 | 34 | 524 | 5 837 | 3 570 |
| Patients treated, total | Patienter behandlet, i alt | 4 751 | 25 | 4 991 | 23 | 478 | 5 261 | 3 066 |
| *Per 100 000 in the age group* Pr. 100 000 i alderen | | | | | | | | |
| 0-24 | | 7 | - | 10 | 13 | 22 | 10 | 4 |
| 25-44 | | 124 | 95 | 150 | 165 | 265 | 174 | 57 |
| 45-64 | | 140 | 69 | 153 | 115 | 251 | 201 | 52 |
| 65+ | | 86 | 77 | 63 | 58 | 119 | 69 | 21 |
| *Total rate* Samlet rate | | 87 | 52 | 95 | 87 | 157 | 113 | 34 |
| *Average length of stay per patient treated* Gennemsnitlig liggetid pr. behandlet patient | | 6.2 | 8.9 | 6.8 | 7.1 | 2.9 | 4.5 | 6.0 |
| *Average length of stay per discharge* Gennemsnitlig liggetid pr. udskrivning | | 4.8 | 7.7 | 5.7 | 4.8 | 2.7 | 4.1 | 5.1 |

1 Average 2002-2006
2 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period

1 Gennemsnit for årene 2002-2006
2 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode

*Sources: See Table 3.4.2.a*
Kilder: Se Tabel 3.4.2.a

** Definition, see Table 3.4.2.a*
* Definition, se Tabel 3.4.2.a

The Table includes ICD-10: M50-M51
Tabellen omfatter ICD-10: M50-M51

## Table 3.4.11 Discharges, patients treated and average length of stay in hospital* for fracture of femur 2006

Udskrivninger, patienter behandlet og gennemsnitlig liggetid ved sygehuse* for brud af lår 2006

| | | Denmark | Faroe Islands[1)] | Finland | Åland[1)] | Iceland | Norway[2)] | Sweden |
|---|---|---|---|---|---|---|---|---|
| *Discharges* | Udskrivninger | | | | | | | |
| *Men, total* | Mænd, i alt | 3 461 | 50 | 3 035 | 23 | 199 | 3 537 | 7 536 |
| Women, total | Kvinder, i alt | 8 064 | 70 | 5 801 | 38 | 360 | 7 794 | 15 976 |
| *Patients treated* | Patienter behandlet | | | | | | | |
| *Men, total* | Mænd, i alt | 3 108 | 37 | 2 481 | 15 | 154 | 3 410 | 6 288 |
| Women, total | Kvinder, i alt | 7 227 | 47 | 4 801 | 33 | 283 | 7 477 | 13 526 |
| *Patients treated per 100 000 men in the age group* Patienter behandlet pr. 100 000 mænd i alderen | | | | | | | | |
| 0-44 | | 19 | 44 | 34 | 32 | 23 | 28 | 21 |
| 45-64 | | 74 | 164 | 72 | 63 | 65 | 83 | 61 |
| 65-74 | | 248 | 291 | 194 | 215 | 287 | 313 | 239 |
| 75-79 | | 595 | 827 | 485 | 747 | 643 | 738 | 614 |
| 80+ | | 1 733 | 1 474 | 1 174 | 1 280 | 1 606 | 2 128 | 1 853 |
| *Total rate* Samlet rate | | 116 | 148 | 96 | 115 | 100 | 147 | 140 |
| *Patients treated per 100 000 women in the age group* Patienter behandlet pr. 100 000 kvinder i alderen | | | | | | | | |
| 0-44 | | 8 | - | 11 | 17 | 6 | 12 | 9 |
| 45-64 | | 92 | 37 | 54 | 63 | 58 | 88 | 68 |
| 65-74 | | 432 | 491 | 241 | 329 | 395 | 496 | 381 |
| 75-79 | | 123 | 1 471 | 675 | 745 | 1 197 | 1 183 | 1 035 |
| 80+ | | 2 938 | 2 251 | 1 941 | 2 505 | 2 982 | 3 522 | 2 937 |
| *Total rate* Samlet rate | | 263 | 203 | 179 | 244 | 189 | 319 | 296 |
| *Average length of stay per patient treated* Gennemsnitlig liggetid pr. behandlet patient | | 10.5 | 14.7 | 13.0 | 15.8 | 15.2 | 10.3 | 12.2 |
| *Average length of stay per discharge* Gennemsnitlig liggetid pr. udskrivning | | 9.5 | 10.3 | 10.7 | 12.4 | 11.9 | 9.9 | 10.3 |

1 Average 2002-2006
2 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period

1 Gennemsnit for årene 2002-2006
2 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode

*Sources: See Table 3.4.2.a*
Kilder: Se Tabel 3.4.2.a

** Definition, see Table 3.4.2.a*
* Definition, se Tabel 3.4.2.a

*The Table includes ICD-10: S72*
Tabellen omfatter ICD-10: S72

**Table 3.4.12 Discharges, patients treated and average length of stay in hospital* for alcoholic liver disease 2006**

Udskrivninger, patienter behandlet og gennemsnitlig liggetid ved sygehuse* for alkoholisk leversygdom 2006

| | | Denmark | Faroe Islands[1] | Finland | Åland[1] | Iceland | Norway[2] | Sweden |
|---|---|---|---|---|---|---|---|---|
| *Discharges* | Udskrivninger | | | | | | | |
| *Men, total* | Mænd, i alt | 1 571 | 5 | 1 589 | 3 | 12 | 633 | 1 371 |
| Women, total | Kvinder, i alt | 779 | 3 | 570 | 2 | 3 | 264 | 520 |
| *Patients treated* | Patienter behandlet | | | | | | | |
| *Men, total* | Mænd, i alt | 978 | 4 | 974 | 2 | 10 | 430 | 852 |
| Women, total | Kvinder, i alt | 495 | 3 | 378 | 2 | 3 | 179 | 348 |
| *Patients treated per 100 000 men in the age group* Patienter behandlet pr. 100 000 mænd i alderen | | | | | | | | |
| 0-44 | | 8 | - | 10 | - | 3 | 3 | 2 |
| 45-64 | | 94 | 33 | 95 | 32 | 14 | 49 | 47 |
| 65+ | | 48 | 67 | 42 | 31 | 13 | 35 | 35 |
| *Total rate* Samlet rate | | 36 | 16 | 38 | 14 | 6 | 19 | 19 |
| *Patients treated per 100 000 women in the age group* Patienter behandlet pr. 100 000 kvinder i alderen | | | | | | | | |
| 0-44 | | 3 | - | 4 | - | - | 1 | 1 |
| 45-64 | | 48 | 18 | 38 | 36 | 6 | 20 | 20 |
| 65+ | | 19 | 57 | 9 | 24 | 5 | 12 | 9 |
| *Total rate* Samlet rate | | 18 | 13 | 14 | 13 | 2 | 8 | 8 |
| *Average length of stay per patient treated* Gennemsnitlig liggetid pr. behandlet patient | | 13.0 | 7.7 | 14.6 | 13.9 | 15.9 | 12.5 | 13.6 |
| *Average length of stay per discharge* Gennemsnitlig liggetid pr. udskrivning | | 8.2 | 6.8 | 9.2 | 10.0 | 13.8 | 8.5 | 8.6 |

1 Average 2002-2006
2 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period

1 Gennemsnit for årene 2002-2006
2 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode

*Sources: See Table 3.4.2.a*
Kilder: Se Tabel 3.4.2.a

** Definition, see Table 3.4.2.a*
* Definition, se Tabel 3.4.2.a

*The Table includes ICD-10: K70*
Tabellen omfatter ICD-10: K70

**Table 3.4.13 Discharges, patients treated and average length of stay in hospital* for other diseases of liver 2006**
Udskrivninger, patienter behandlet og gennemsnitlig liggetid ved sygehuse* for ikke-alkoholisk leversygdom 2006

| | | Denmark | Faroe Islands[1] | Finland | Åland[1] | Iceland | Norway[2] | Sweden |
|---|---|---|---|---|---|---|---|---|
| *Discharges* | Udskrivninger | | | | | | | |
| *Men, total* | Mænd, i alt | 1 329 | 22 | 987 | 2 | 8 | 562 | 1 222 |
| Women, total | Kvinder, i alt | 1 318 | 10 | 1 130 | 4 | 47 | 723 | 1 203 |
| *Patients treated* | Patienter behandlet | | | | | | | |
| *Men, total* | Mænd, i alt | 869 | 7 | 615 | 1 | 7 | 477 | 868 |
| Women, total | Kvinder, i alt | 846 | 9 | 747 | 2 | 35 | 603 | 886 |
| *Patients treated per 100 000 men in the age group* Patienter behandlet pr. 100 000 mænd i alderen | | | | | | | | |
| 0-44 | | 11 | 13 | 10 | 8 | 1 | 11 | 8 |
| 45-64 | | 64 | 16 | 40 | 16 | 5 | 27 | 28 |
| 65+ | | 63 | 133 | 54 | 10 | 25 | 54 | 48 |
| *Total rate* Samlet rate | | 32 | 28 | 24 | 11 | 5 | 21 | 19 |
| *Patients treated per 100 000 women in the age group* Patienter behandlet pr. 100 000 kvinder i alderen | | | | | | | | |
| 0-44 | | 12 | 7 | 12 | 6 | 9 | 11 | 8 |
| 45-64 | | 56 | 110 | 45 | 16 | 32 | 42 | 30 |
| 65+ | | 54 | 57 | 51 | 47 | 78 | 55 | 36 |
| *Total rate* Samlet rate | | 31 | 39 | 28 | 15 | 23 | 26 | 19 |
| *Average length of stay per patient treated* Gennemsnitlig liggetid pr. behandlet patient | | 10.8 | 14.8 | 11.9 | 13.9 | 7.9 | 8.8 | 9.9 |
| *Average length of stay per discharge* Gennemsnitlig liggetid pr. udskrivning | | 7.0 | 7.4 | 7.7 | 7.6 | 6.1 | 7.4 | 7.1 |

1 Average 2002-2006
2 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period

1 Gennemsnit for årene 2002-2006
2 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode

*Sources: See Table 3.4.2.a*
Kilder: Se Tabel 3.4.2.a

** Definition, see Table 3.4.2.a*
* Definition, se Tabel 3.4.2.a

*The Table includes ICD-10: K71-K77*
Tabellen omfatter ICD-10: K71-K77

## 3.5 Surgical procedures

Tables 3.5.1-3.5.2 include information on selected surgical procedure groups, selected because of their high frequency and because the frequency of operations is influenced by differences in medical practice between the countries. Table 3.5.2b shows age standardized rates according to the Nordic Standard population.

In order to present a more complete picture, Table 3.5.3 covers the most frequent procedures carried out as day surgery.

In order to give more detail, the groups are presented by sex, and in some cases by age, in Tables 3.5.5-3.5.18. In this way, the differences between the countries appear more clearly.

Comparisons of operations between various geographic areas are however difficult, and the comparisons contain a number of potential sources of error, which in principle are the same as those mentioned for the diagnosis-related statistics.

In addition, there are differences from country to country in the way in which operations in hospitals are counted.

## 3.5 Kirurgiske indgreb

Tabellerne 3.5.1-3.5.2 indeholder oplysninger om udvalgte operationsgrupper, som er udvalgt fordi de er hyppigt forekommende og fordi operationsomfanget i forskellig grad påvirkes af forskelle i medicinsk praksis i landene. I tabel 3.5.2b vises de standardiserede rater efter den nordiske standardbefolkning.

For at få et mere fuldkomment billede er der i tabel 3.5.3 medtaget de mest forekommende indgreb som sker uden indlæggelse - dagkirurgisk.

For at få et mere komplet billede, er grupperne medtaget fordelt på køn og i visse aldersgrupper i tabellerne 3.5.5-3.5.18. Heraf fremgår forskellene mellem landene tydeligere.

Sammenligninger af operationer mellem geografiske områder er imidlertid vanskelige og indeholder en række potentielle fejlkilder, som i princippet er de samme som er nævnt for den diagnoserelaterede statistik.

Hertil kommer, at der er forskelle fra land til land i måden hvorpå operationer ved sygehuse tælles.

**Table 3.5.1 Sixteen major surgical procedure groups, total numbers 2006**
Seksten store operationsgrupper, i alt 2006

| NCSP codes | | *Denmark* | *Faroe Islands*[1)] | *Finland* | *Åland*[2)] | *Iceland* | *Norway* | *Sweden* |
|---|---|---|---|---|---|---|---|---|
| ABC 01-26 | *Disc operations* Disk-operationer | 2 571 | 21 | 3 203 | 20 | 474 | 4 053 | 2 500 |
| BAA 20-60 | *Partial and total thyroid excision* Resektion af thyreoidea | 1 721 | 6 | 1 830 | 5 | 106 | 1 259 | 2 587 |
| CJC, CJD, CJE, CJF00, CJF10 | *Cataract surgery* Kataraktoperationer | 25 706 | 112 | 38 019 | 51 | 2 261 | 20 625 | 56 541 |
| FNA; FNB; FNC; FND; FNE | *Coronary anastomosis surgery* Coronaranastomoser | 2 440 | 30 | 3 459 | 1 | 134 | 3 776 | 8 941 |
| FNG 02; FNG 05 | *Percutaneous expansion of the coronary artery (PTCA)* Perkutan coronar angioplastik (PTCA) | 9 417 | 60 | 8 033 | 2 | 610 | 11 650 | 17 677 |
| HAB | *Excision of mammary gland (women)* Resektion af mammae (kvinder) | 4 265 | 18 | 3 771 | 15 | 138 | 3 098 | 6 381 |
| HAC 10-25; HAC 99 | *Mastectomy (women)* Ablatio mammae (kvinder) | 2 234 | 12 | 2 443 | 14 | 71 | 1 467 | 3 716 |
| JEA | *Appendectomy* Appendektomi | 5 696 | 46 | 7 070 | 61 | 401 | 5 199 | 10 774 |
| JKA 20-21 | *Cholecystectomy* Kolecystektomi | 6 740 | 47 | 8 364 | 59 | 557 | 4 505 | 11 988 |
| KAS 10-20 | *Kidney transplant* Nyretransplantation | 176 | 2 | 193 | 1 | 8 | 209 | 361 |
| KEC | *Radical prostatectomy* Radikal prostatektomi | 559 | 2 | 921 | 13 | 45 | 707 | 2 487 |
| KED 22-72 | *Prostatectomy, transurethral procedures* Transurethral resektion af prostate | 4 298 | 20 | 3 588 | 75 | 219 | 4 853 | 7 437 |
| KED 00; KED 96 | *Open prostatectomy* Åben prostatektomi | 82 | 1 | 37 | - | 4 | 193 | 209 |
| LCC 10-20; LCD; LCE; LEF 13 | *Hysterectomy (including supravaginal hystrectomy and exenteration of pelvis)* Hysterektomi (inkl. supravaginal hys-terektomi og bækkeneksentration) | 6 084 | 30 | 7 534 | 50 | 441 | 4 832 | 8 771 |
| MCA | *Caesarean section* Kejsersnit | 13 499 | 88 | 9 381 | 53 | 744 | 9 388 | 18 718 |
| NFB; NFC | *Hip replacement* Hofteledsplastik | 10 854 | 73 | 11 653 | 82 | 489 | 9 186 | 19 634 |

The NCSP codes refer to NOMESCO Classification of Surgical Procedures. Version 1.10. NOMESCO 74:2005.

1 Average 2001-2005
2 Average 2002-2006

1 Gennemsnit for årene 2001-2005
2 Gennemsnit for årene 2002-2006

*Sources:* Kilder: D: National Board of Health; FI: Ministry of Health; F & Å: STAKES; I: Directorate of Health; N: Norwegian Patient Register; S: National Board of Health and Welfare

**Table 3.5.2.a Sixteen major surgical procedure groups, per 100 000 inhabitants 2006**
Seksten store operationsgrupper, pr. 100 000 indbyggere 2006

| NCSP codes | | *Denmark* | *Faroe Islands*[1)] | *Finland* | *Åland*[2)] | *Iceland* | *Norway* | *Sweden* |
|---|---|---|---|---|---|---|---|---|
| ABC 01-26 | *Disc operations*<br>Disk-operationer | 47 | 43 | 61 | 75 | 158 | 87 | 28 |
| BAA 20-60 | *Partial and total thyroid excision*<br>Resektion af thyreoidea | 32 | 12 | 35 | 20 | 35 | 27 | 28 |
| CJC, CJD, CJE, CJF00, CJF10 | *Cataract surgery*<br>Kataraktoperationer | 473 | 232 | 723 | 190 | 743 | 444 | 623 |
| FNA; FNB; FNC; FND; FNE | *Coronary anastomosis surgery*<br>Coronaranastomoser | 45 | 62 | 66 | 3 | 44 | 81 | 98 |
| FNG 02; FNG 05 | *Percutaneous expansion of the coronary artery (PTCA)*<br>Perkutan coronar angioplastik (PTCA) | 173 | 125 | 66 | 7 | 200 | 251 | 195 |
| HAB | *Excision of mammary gland (women)*[3)]<br>Resektion af mammae (kvinder)[3)] | 155 | 79 | 141 | 111 | 92 | 132 | 139 |
| HAC 10-25; HAC 99 | *Mastectomy (women)*[3)]<br>Ablatio mammae (kvinder)[3)] | 81 | 53 | 91 | 101 | 47 | 63 | 81 |
| JEA | *Appendectomy*<br>Appendektomi | 105 | 94 | 135 | 229 | 132 | 112 | 119 |
| JKA 20-21 | *Cholecystectomy*<br>Kolecystektomi | 124 | 97 | 159 | 222 | 183 | 97 | 132 |
| KAS 10-20 | *Kidney transplant*<br>Nyretransplantation | 3 | 5 | 4 | 3 | 3 | 5 | 4 |
| KEC | *Radical prostatectomy*[4)]<br>Radikal prostatektomi[4)] | 21 | 7 | 36 | 48 | 29 | 31 | 55 |
| KED 22-72 | *Prostatectomy, transurethral procedures*[4)]<br>Transurethral resektion af prostata[4)] | 160 | 81 | 139 | 282 | 142 | 211 | 165 |
| KED 00; KED 96 | *Open prostatectomy*[4)]<br>Åben prostatektomi[4)] | 3 | 3 | 1 | - | 3 | 8 | 5 |
| LCC 10-20; LCD; LCE; LEF 13 | *Hysterectomy (including supravaginal hystrectomy and exenteration of pelvis)*[3)]<br>Hysterektomi (inkl. supravaginal hysterektomi og bækkeneksentration)[3)] | 222 | 128 | 280 | 368 | 294 | 207 | 192 |
| MCA | *Caesarean section*[5)]<br>Kejsersnit[5)] | 210 | 126 | 161 | 192 | 172 | 163 | 190 |
| NFB; NFC | *Hip replacement*<br>Hofteledsplastik | 200 | 151 | 222 | 305 | 161 | 198 | 216 |

The NCSP codes refer to NOMESCO Classification of Surgical Procedures. Version 1.10. NOMESCO 74:2005.

1 Average 2001-2005
2 Average 2002-2006
3 Per 100 000 women
4 Per 100 000 men
5 Per 1 000 deliveries

1 Gennemsnit for årene 2001-2005
2 Gennemsnit for årene 2002-2006
3 Pr. 100 000 kvinder
4 Pr. 100 000 mænd
5 Pr. 1 000 fødsler

*Sources:* *See Table 3.5.1*
Kilder: Se tabel 3.5.1

**Table 3.5.2.b Sixteen major surgical procedure groups, age standardized rates per 100 000 inhabitants 2006**
Seksten store operationsgrupper, aldersstandardiseret rater pr. 100 000 indbyggere 2006

| NCSP codes | | Denmark | Faroe Islands[1] | Finland | Åland[2] | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| ABC 01-26 | *Disc operations*<br>Disk-operationer | 47 | 46 | 61 | 75 | 165 | 88 | 28 |
| BAA 20-60 | *Partial and total thyroid excision*<br>Resektion af thyreoidea | 31 | 12 | 33 | 19 | 39 | 28 | 28 |
| CJC, CJD, CJE, CJF00, CJF10 | *Cataract surgery*<br>Kataraktoperationer | 464 | 225 | 672 | 164 | .. | 434 | 534 |
| FNA; FNB; FNC; FND; FNE | *Coronary anastomosis surgery*<br>Coronaranastomoser | 43 | 69 | 60 | 2 | 55 | 84 | 89 |
| FNG 02; FNG 05 | *Percutaneous expansion of the coronary artery (PTCA)*<br>Perkutan coronar angioplastik (PTCA) | 166 | 136 | 140 | 6 | .. | 258 | 175 |
| HAB | *Excision of mammary gland (women)[3]*<br>Resektion af mammae (kvinder)[3] | 149 | 83 | 131 | 98 | 103 | 136 | 134 |
| HAC 10-25; HAC 99 | *Mastectomy (women)[3]*<br>Ablatio mammae (kvinder)[3] | 75 | 56 | 81 | 89 | 54 | 61 | 73 |
| JEA | *Appendectomy*<br>Appendektomi | 106 | 90 | 135 | 233 | 122 | 111 | 119 |
| JKA 20-21 | *Cholecystectomy*<br>Kolecystektomi | 122 | 103 | 152 | 214 | 204 | 98 | 129 |
| KAS 10-20 | *Kidney transplant*<br>Nyretransplantation | 3 | 5 | 4 | 3 | 3 | 5 | 4 |
| KEC | *Radical prostatectomy[4]*<br>Radikal prostatektomi[4] | 18 | 8 | 32 | 43 | 36 | 32 | 49 |
| KED 22-72 | *Prostatectomy, transurethral procedures[4]*<br>Transurethral resektion af prostate[4] | 171 | 100 | 153 | 278 | 204 | 241 | 158 |
| KED 00; KED 96 | *Open prostatectomy[4]*<br>Åben prostatektomi[4] | 3 | 5 | 2 | - | 3 | 10 | 5 |
| LCC 10-20; LCD; LCE; LEF 13 | *Hysterectomy (including supravaginal hystrectomy and exenteration of pelvis)[3]*<br>Hysterektomi (inkl. supravaginal hysterektomi og bækkeneksentration)[3] | 218 | 137 | 266 | 345 | 315 | 212 | 190 |
| NFB; NFC | *Hip replacement*<br>Hofteledsplastik | 193 | 165 | 207 | 274 | 203 | 197 | 187 |

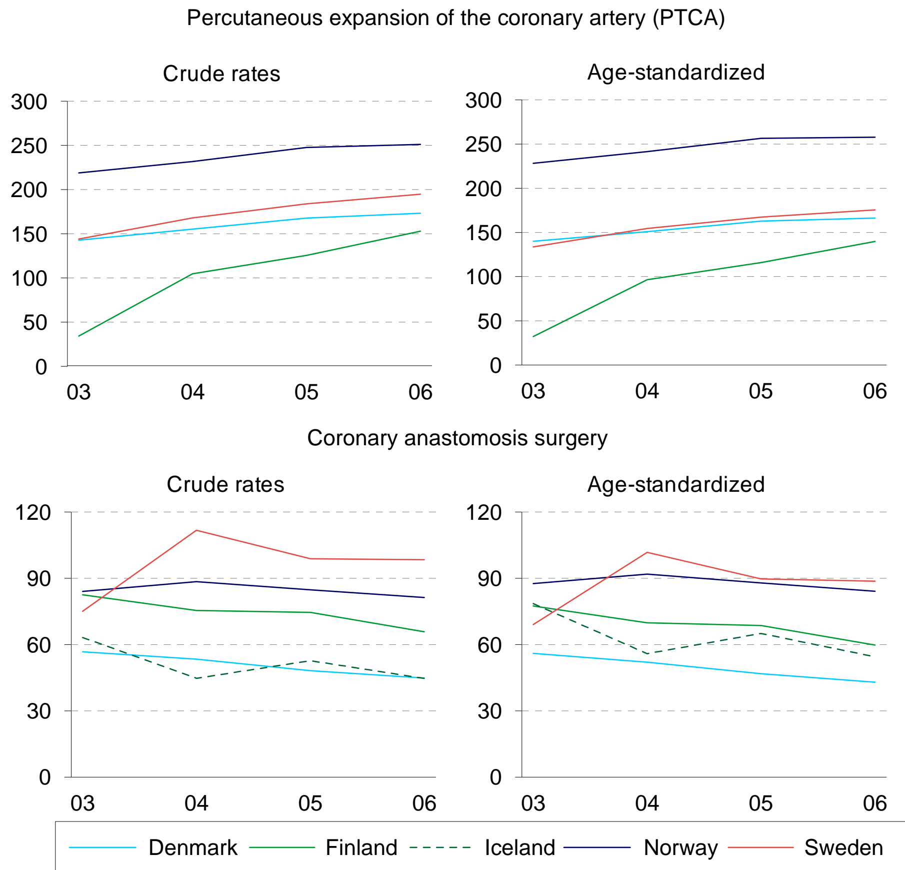
The NCSP codes refer to NOMESCO Classification of Surgical Procedures. Version 1.10. NOMESCO 74:2005.

1 Average 2001-2005
2 Average 2002-2006
3 Per 100 000 women
4 Per 100 000 men

1 Gennemsnit for årene 2001-2005
2 Gennemsnit for årene 2002-2006
3 Pr. 100 000 kvinder
4 Pr. 100 000 mænd

*Sources:* Kilder: D: National Board of Health; FI: Ministry of Health; F & Å: STAKES; I: Directorate of Health; N: Norwegian Patient Register; S: National Board of Health and Welfare

**Figure 3.5.1 PTCA and coronary anastomosis surgery, crude rates and age standardized rates per 100 000 inhabitants 2003-2006**
PTCA og Coronaranastomoser, summariske rater og alderstandardiserede rater pr. 100 000 indbyggere 2003-2006




Age standardized by the Nordic population 2000

Aldersstrandardiseret med den nordiske befolkning 2000

*Sources:* *See Tables 3.5.2a and 3.5.2b*
Kilder: Se tabel 3.5.2.a og 3.5.2.b

## Table 3.5.3 Fifteen surgical procedures partly carried out as day surgery in hospitals 2006

| | | 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*<br>Dekompression og lysis af medianus nerve | ACC51 | 4 705 | 4 168 | 88.6 | 9 066 | 7 684 | 84.8 |
| *Cataract surgery*<br>Kataraktoperation | CJC, CJD, CJE, CJF00, CJF10 | 25 706 | 24 678 | 96.0 | 37 629 | 35 433 | 94.2 |
| *Tonsillectomy and/or adenoidectomy*<br>Tonsillektomi og/eller adenoidektomi | EMB10, EMB20, EMB30 | 7 815 | 1 710 | 21.9 | 13 637 | 9 279 | 68.0 |
| *Wedge resection of mammary gland (women only)*<br>Segmentresektion af brystkirtel (kun kvinder) | HAB40 | 2 462 | 10 | 0.4 | 1 479 | 106 | 7.2 |
| *Inguinal and femoral hernia*<br>Brok-operationer | JAB, JAC | 10 887 | 6 226 | 57.2 | 11 795 | 5 919 | 50.2 |
| *Haemorrhoidectomy*<br>Haemorrhoidectomia | JHB00 | 1 672 | 900 | 53.8 | 1 549 | 651 | 42.0 |
| *Cholecystectomy, laparoscopic*<br>Laparoskopisk cholecystektomi | JKA21 | 5 816 | 987 | 17.0 | 6 711 | 1 485 | 22.1 |
| *Transurethral resection of prostate (TURP)*<br>Transurethral resektion af prostata (TURP) | KED22 | 2 860 | 24 | 0.8 | 2 901 | 42 | 1.4 |
| *Curettage and excision of endometrium in uterus and cervix uteri*<br>Abrasio af endometrium i uterus og cervix uteri | LCA10-16, LCB28, LCB32, LDA10 | 9 900 | 7 235 | 73.1 | 3 325 | 2 138 | 64.3 |
| *Termination of pregnancy*<br>Abort-operationer | LCH | 9 456 | 5 452 | 57.7 | 4 355 | 3 150 | 72.3 |
| *Female sterilization*<br>Sterilisation af kvinder | LGA | 3 615 | 2 230 | 61.7 | 3 074 | 2 489 | 81.0 |
| *Removal of implanted devices from bone*<br>Fjernelse af osteosyntese | NAU, NBU, NCU, NDU, NEU, NFU, NGU, NHU | 14 023 | 7 681 | 54.8 | 5 456 | 3 024 | 55.4 |
| *Knee arthroscopy*<br>Artroskopi af knæled | NGA11 | 7 948 | 6 135 | 77.2 | 3 835 | 2 844 | 74.2 |
| *Arthroscopic operations on meniscus of knee*<br>Artroskopisk meniskoperation på knæ | NGD01, NGD11, NGD21, NGD91 | 10 176 | 7 061 | 69.4 | 13 507 | 10 872 | 80.5 |
| *Vein ligation and stripping on leg*<br>Fjernelse af åreknuder på ben | PHB13-14, PHD | 7 572 | 6 625 | 87.5 | 6 410 | 4 208 | 65.6 |

1 The figures are estimated based on a coverage of 80 per cent. Figures for cataract surgery are data for 2006 from the Swedish cataract register with a coverage of 95 per cent, including only CJC, CJD and CJE

2 Day-surgery procedures are under-reported. The amount of missing data varies for different procedures. The amount of missing data is estimated to be on average 20 per cent, but is particulary large for cataract surgery.

Sources: See Table 3.5.1

## Femten kirurgiske indgreb, der delvist gennemføres som dagkirurgi på sygehuse 2006 — Tabel 3.5.3

| Norway | | | Sweden[1] | | |
|---|---|---|---|---|---|
| Total number of procedures | Of which day surgery | Day surgery (per cent) | Total number of procedures | Of which day surgery[2] | Day surgery (per cent) |
| 6 906 | 6 573 | 95.2 | 10 832 | 10 469 | 96.6 |
| 20 625 | 19 428 | 94.2 | 56 274 | 54 541 | 96.9 |
| 13 336 | 6 939 | 52.0 | 13 284 | 6 258 | 47.1 |
| 1 864 | 903 | 48.4 | 4 509 | 1 064 | 23.6 |
| 7 441 | 4 570 | 61.4 | 17 158 | 12 545 | 73.1 |
| 2 421 | 1 743 | 72.0 | 2 159 | 1 398 | 64.8 |
| 4 031 | 877 | 21.8 | 8 894 | 1 291 | 14.5 |
| 4 224 | 132 | 3.1 | 6 160 | 91 | 1.5 |
| 5 209 | 3 682 | 70.7 | 13 451 | 11 014 | 81.9 |
| 13 811 | 13 291 | 96.2 | 14 724 | 13 268 | 90.1 |
| 1 030 | 188 | 18.3 | 3 187 | 2 691 | 84.4 |
| 9 248 | 4 313 | 46.6 | 14 562 | 9 994 | 68.6 |
| 4 525 | 3 399 | 75.1 | 6 544 | 5 833 | 89.1 |
| 15 516 | 13 991 | 90.2 | 11 655 | 10 924 | 93.7 |
| 6 877 | 5 851 | 85.1 | 6 117 | 5 432 | 88.8 |

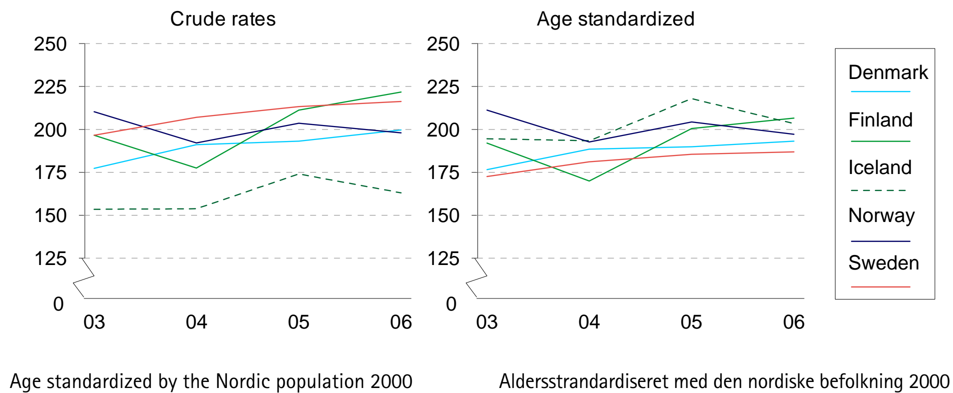
1 Tallene er beregnet udfra en 80 procents dækningsgrad. Tal for kataraktoperation er data for 2006 fra det svenske kataraktregister med 95 procent dækningsgrad. Kataraktregistret inkluderer kun CJC, CJD og CJE

2 Der findes en underapportering i antallet af dagkirurgiske indgreb. Størrelsen af dette varierer fra indgreb til indgreb, men er beregnet til ca. 20 pct. Det er især et stort bortfald af kataraktoperationer.

Kilder: Se tabel 3.5.1

## Figure 3.5.2 Hip replacement per 100 000 inhabitants 2003-2006

Hofteledsplastik, pr. 100 000 indbyggere 2003-2006



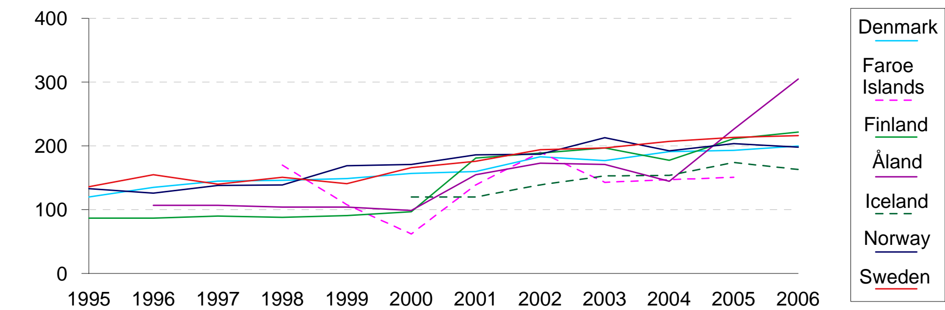

Age standardized by the Nordic population 2000

Aldersstrandardiseret med den nordiske befolkning 2000

*Sources:* *See Tables 3.5.2a and 3.5.2b*
Kilder: Se table 3.5.2.a og 3.5.2.b

## Figure 3.5.3 Hip replacement per 100 000 inhabitants 1995-2006

Hofteledsplastik, pr. 100 000 indbyggere 1995-2006




*Sources:* *See Tables 3.5.2a*
Kilder: Se tabel 3.5.2.a

**Table 3.5.4 Surgical procedures in connection with cancer diagnoses, total and per 100 000 inhabitants 2006**

Operationer i forbindelse med kræftdiagnoser, i alt og pr. 100 000 indbyggere 2006

| 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) | 2 293 | 16 | 2 717 | 14 | 72 | 1 673 | 3 628 |
| HAC 10-25; HAC 99 | *Mastectomy (women)* Ablatio mammae (kvinder) (ICD-9: 174; ICD-10: C50) | 1 981 | 12 | 2 409 | 14 | 64 | 1 273 | 3 300 |
| KEC | *Radical prostatectomy* Radikal prostatektomi (ICD-9: 185; ICD-10: C61) | 552 | 2 | 908 | 6 | 45 | 693 | 2 471 |
| KED 22-72 | *Prostatectomy, transurethral procedures* Transurethral resektion af prostata (ICD-9: 185; ICD-10: C61) | 413 | 6 | 488 | 6 | 64 | 733 | 1 249 |
| LCC 10-20; LCD; LCE; LEF 13 | *Hysterectomy (including supravaginal hysterectomy and exenteration of pelvis)* Hysterektomi (inkl. supravaginal hysterektomi og bækkeneksentration) (ICD-9: 180-184; ICD-10: C51-58) | 1 156 | 18 | 3 609 | 25 | 53 | 1 087 | 2 044 |
| | ***Per 100 000 inhabitants*** **Pr. 100 000 indbyggere** | | | | | | | |
| | *Partial excision of the mammary gland (women)*[3] Resektion af mammae (kvinder)[3] | 84 | 71 | 101 | 107 | 48 | 72 | 79 |
| | *Mastectomy (women)*[3] Ablatio mammae (kvinder)[3] | 72 | 53 | 90 | 101 | 43 | 54 | 72 |
| | *Radical prostatectomy*[4] Radikal prostatektomi[4] | 21 | 7 | 35 | 48 | 29 | 30 | 55 |
| | *Prostatectomy, transurethral procedures*[4] Transurethral resektion af prostata[4] | 15 | 22 | 19 | 45 | 42 | 32 | 28 |
| | *Hysterectomy (including supravaginal hystrectomy and exenteration of pelvis)*[4] Hysterektomi (inkl. supravaginal hysterektomi og bækkeneksentration)[4] | 42 | 77 | 135 | 186 | 35 | 46 | 45 |

The NCSP codes refer to NOMESCO Classification of Surgical Procedures. Version 1.10. NOMESCO 74:2005.

1 Average 2001-2005
2 Average 2002-2006
3 Per 100 000 women
4 Per 100 000 men

1 Gennemsnit for årene 2001-2005
2 Gennemsnit for årene 2002-2006
3 Pr. 100 000 kvinder
4 Pr. 100 000 mænd

*Sources: See Table 3.5.1*
Kilder: Se tabel 3.5.1

**Table 3.5.5 Disc operations by sex and age 2006**
Disk-operationer fordelt på køn og alder 2006

| | *Denmark* | | *Faroe Islands*[1)] | | *Finland* | | *Iceland* | | *Norway* | | *Sweden* | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Age* Alder | M | W | M | W | M | W | M | W | M | W | M | W |
| <15 | 1 | 1 | - | - | 1 | 2 | - | - | 2 | 1 | 1 | 2 |
| 15-24 | 38 | 37 | 1 | - | 72 | 69 | 17 | 8 | 74 | 68 | 65 | 35 |
| 25-44 | 559 | 534 | 4 | 4 | 950 | 576 | 115 | 109 | 1 073 | 837 | 612 | 548 |
| 45-64 | 626 | 490 | 4 | 3 | 700 | 550 | 100 | 85 | 978 | 747 | 528 | 461 |
| 65+ | 144 | 141 | 2 | 2 | 138 | 145 | 25 | 15 | 140 | 133 | 123 | 125 |
| *Total* I alt | 1 368 | 1 203 | 11 | 10 | 1 861 | 1 342 | 257 | 217 | 2 267 | 1 786 | 1 329 | 1 171 |
| *Per 100 000 in the age group* Pr. 100 000 i alderen | | | | | | | | | | | | |
| 15-24 | 12 | 12 | 23 | - | 22 | 22 | 75 | 37 | 25 | 24 | 11 | 6 |
| 25-44 | 73 | 71 | 64 | 72 | 136 | 86 | 252 | 255 | 161 | 129 | 49 | 46 |
| 45-64 | 86 | 67 | 60 | 63 | 94 | 74 | 273 | 248 | 166 | 130 | 44 | 39 |
| 65+ | 40 | 30 | 61 | 57 | 41 | 29 | 157 | 78 | 48 | 34 | 18 | 14 |
| *Total* I alt | 51 | 44 | 44 | 41 | 72 | 50 | 167 | 145 | 98 | 76 | 30 | 26 |

1 Average 2001-2005

1 Gennemsnit for årene 2001-2005

NCSP codes covered: ABC 01-26

*Sources: See Table 3.5.1*
Kilder: Se table 3.5.1

**Table 3.5.6 Partial and total thyroid excision by sex and age 2006**
Resektion af thyreoidea, fordelt på køn og alder 2006

| | *Denmark* | | *Finland* | | *Iceland* | | *Norway* | | *Sweden* | |
|---|---|---|---|---|---|---|---|---|---|---|
| *Age* Alder | M | W | M | W | M | W | M | W | M | W |
| <15 | 4 | 8 | - | 3 | - | - | - | 3 | 2 | 19 |
| 15-24 | 7 | 40 | 7 | 43 | 2 | 9 | 1 | 35 | 27 | 124 |
| 25-44 | 82 | 514 | 63 | 410 | 3 | 25 | 59 | 347 | 118 | 655 |
| 45-54 | 88 | 379 | 58 | 356 | 2 | 26 | 50 | 219 | 84 | 432 |
| 55-64 | 87 | 258 | 107 | 396 | - | 22 | 63 | 226 | 117 | 469 |
| 65-74 | 40 | 130 | 57 | 205 | 3 | 12 | 35 | 126 | 74 | 252 |
| 75-84 | 15 | 55 | 17 | 93 | - | 2 | 13 | 70 | 49 | 135 |
| 85+ | 2 | 12 | 2 | 13 | - | - | - | 12 | 3 | 27 |
| *Total* I alt | 325 | 1 396 | 311 | 1 519 | 10 | 96 | 221 | 1 038 | 474 | 2 113 |
| *Per 100 000 in the age group* Pr. 100 000 i alderen | | | | | | | | | | |
| 15-24 | 2 | 13 | 2 | 13 | 9 | 42 | - | 12 | 5 | 22 |
| 25-44 | 11 | 68 | 9 | 61 | 7 | 59 | 9 | 54 | 10 | 55 |
| 45-54 | 24 | 104 | 15 | 93 | 9 | 131 | 16 | 72 | 14 | 75 |
| 55-64 | 24 | 71 | 30 | 110 | - | 152 | 23 | 85 | 19 | 78 |
| 65-74 | 19 | 55 | 28 | 84 | 34 | 128 | 23 | 73 | 20 | 63 |
| 75-84 | 13 | 34 | 15 | 48 | - | 27 | 12 | 46 | 21 | 41 |
| 85+ | 6 | 16 | 9 | 19 | - | - | - | 17 | 4 | 17 |
| *Total* I alt | 12 | 51 | 12 | 57 | 6 | 64 | 10 | 44 | 11 | 46 |

NCSP codes covered: BAA 20-60

*Sources:* *See Table 3.5.1*
Kilder: Se tabel 3.5.1

**Table 3.5.7 Cataract surgery by sex and age 2006**
Kataraktoperationer, efter køn og alder 2006

| | *Denmark* | | *Faroe Islands*[1] | | *Finland* | | *Norway* | | *Sweden*[2] | |
|---|---|---|---|---|---|---|---|---|---|---|
| *Age* Alder | M | W | M | W | M | W | M | W | M | W |
| <45 | 295 | 173 | 2 | 1 | 308 | 245 | 214 | 196 | 402 | 351 |
| 45-64 | 2 033 | 2 247 | 12 | 9 | 2 692 | 3 152 | 1 236 | 1 408 | 3 933 | 4 387 |
| 65-74 | 2 746 | 4 279 | 15 | 17 | 3 750 | 6 935 | 1 645 | 2 801 | 5 703 | 9 165 |
| 75-84 | 3 820 | 6 797 | 14 | 31 | 5 205 | 11 898 | 3 363 | 5 957 | 8 611 | 16 046 |
| 85+ | 1 059 | 2 257 | 3 | 7 | 1 112 | 2 722 | 1 192 | 2 613 | 2 781 | 5 162 |
| *Total* I alt | 9 953 | 15 753 | 47 | 65 | 13 067 | 24 952 | 7 650 | 12 975 | 21 430 | 35 111 |
| *Per 100 000 in the age group* Pr. 100 000 i alderen | | | | | | | | | | |
| 45-64 | 278 | 309 | 198 | 160 | 363 | 423 | 210 | 246 | 328 | 372 |
| 65-74 | 1 290 | 1 822 | 907 | 1 036 | 1 837 | 2 842 | 1 064 | 1 624 | 1 536 | 2 277 |
| 75-84 | 3 354 | 4 176 | 1 444 | 2 275 | 4 692 | 6 150 | 3 209 | 3 936 | 3 617 | 4 873 |
| 85+ | 3 414 | 3 061 | 1 232 | 1 409 | 5 135 | 4 067 | 4 056 | 3 742 | 3 734 | 3 273 |
| *Total* I alt | 370 | 574 | 187 | 281 | 508 | 930 | 332 | 555 | 476 | 767 |

1 Average 2001-2005
2 2002. Data from the Swedish cataract register with a coverage of 95 per cent. Including only CJC, CJD and CJE.

1 Gennemsnit for årene 2001-2005
2 2002. Data fra det svenske kataraktregister med 95 procent dækningsgrad. Inkluderer kun CJC, CJD og CJE

NCSP codes covered: CJC, CJD, CJE, CJF00, CJF10

*Sources: See Table 3.5.1*
Kilder: Se table 3.5.1

**Table 3.5.8 Coronary anastomosis surgery by sex and age 2006**
Coronaranastomoser efter køn og alder 2006

| | *Denmark* | | *Faroe Island*[1)] | | *Finland* | | *Iceland* | | *Norway* | | *Sweden* | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Age* Alder | M | W | M | W | M | W | M | W | M | W | M | W |
| <45 | 41 | 13 | - | - | 35 | 8 | 2 | - | 38 | 14 | 86 | 20 |
| 45-54 | 173 | 24 | 2 | - | 285 | 28 | 14 | - | 317 | 45 | 608 | 93 |
| 55-64 | 555 | 102 | 8 | 1 | 797 | 128 | 50 | 3 | 919 | 130 | 2 158 | 373 |
| 65-74 | 728 | 224 | 10 | 3 | 1 034 | 357 | 33 | 7 | 999 | 321 | 2 563 | 728 |
| 75-84 | 386 | 163 | 3 | 1 | 476 | 287 | 17 | 8 | 615 | 320 | 1 559 | 660 |
| 85+ | 19 | 12 | - | - | 14 | 10 | - | - | 42 | 16 | 62 | 31 |
| *Total* I alt | 1 902 | 538 | 6 | 6 | 2 641 | 818 | 116 | 18 | 2 930 | 846 | 7 036 | 1 905 |
| *Per 100 000 in the age group* Pr. 100 000 i alderen | | | | | | | | | | | | |
| 45-54 | 47 | 7 | 68 | 14 | 73 | 7 | 65 | - | 101 | 15 | 103 | 16 |
| 55-64 | 153 | 28 | 268 | 57 | 226 | 35 | 331 | 21 | 337 | 49 | 355 | 62 |
| 65-74 | 342 | 95 | 613 | 173 | 506 | 146 | 379 | 75 | 646 | 186 | 690 | 181 |
| 75-84 | 339 | 100 | 346 | 102 | 429 | 148 | 301 | 110 | 587 | 211 | 655 | 200 |
| 85+ | 61 | 16 | - | - | 65 | 15 | - | - | 143 | 23 | 83 | 20 |
| *Total* I alt | 71 | 20 | 96 | 26 | 103 | 30 | 75 | 12 | 127 | 36 | 156 | 42 |

1 Average 2001-2005

1 Gennemsnit for årene 2001-2005

NCSP codes covered: FNA; FNB; FNC; FND; FNE

*Sources: See Table 3.5.1*
Kilder: Se tabel 3.5.1

**Table 3.5.9 Percutaneous expansion of the coronary artery (PTCA) by sex and age 2006**
Perkutan coronar angiplastik (PTCA) efter køn og alder 2006

| | *Denmark* | | *Faroe Islands*[1)] | | *Finland* | | *Norway* | | *Sweden*[2)] | |
|---|---|---|---|---|---|---|---|---|---|---|
| *Age* Alder | M | W | M | W | M | W | M | W | M | W |
| <45 | 354 | 99 | 3 | - | 230 | 44 | 453 | 92 | 375 | 103 |
| 45-54 | 1 131 | 263 | 9 | 2 | 897 | 174 | 1 536 | 277 | 1 588 | 412 |
| 55-64 | 2 190 | 539 | 16 | 4 | 1 711 | 444 | 2 860 | 669 | 4 071 | 1 042 |
| 65-74 | 1 957 | 760 | 13 | 6 | 1 752 | 855 | 2 211 | 882 | 3 888 | 1 490 |
| 75-84 | 1 059 | 721 | 3 | 4 | 893 | 846 | 1 424 | 899 | 2 544 | 1 563 |
| 85+ | 162 | 182 | - | - | 84 | 103 | 185 | 162 | 288 | 313 |
| *Total* I alt | 6 853 | 2 564 | 44 | 16 | 5 567 | 2 466 | 8 669 | 2 981 | 12 754 | 4 923 |
| *Per 100 000 in the age group* Pr. 100 000 i alderen | | | | | | | | | | |
| 45-54 | 306 | 72 | 274 | 54 | 231 | 45 | 487 | 91 | 269 | 72 |
| 55-64 | 605 | 148 | 563 | 172 | 484 | 123 | 1.049 | 250 | 669 | 173 |
| 65-74 | 920 | 324 | 742 | 370 | 858 | 350 | 1.430 | 511 | 1.047 | 370 |
| 75-84 | 930 | 443 | 346 | 292 | 805 | 437 | 1.359 | 594 | 1.069 | 475 |
| 85+ | 522 | 247 | 145 | 39 | 388 | 154 | 629 | 232 | 387 | 198 |
| *Total* I alt | 255 | 93 | 176 | 69 | 216 | 92 | 377 | 127 | 283 | 108 |

1 Average 2001-2005
2 NCSP: F00-F06

1 Gennemsnit for årene 2001-2005
2 NCSP: F00-F06

NCSP codes covered: FNG 02; FNG 05

*Sources: See Table 3.5.1*
Kilder: Se tabel 3.5.1

**Table 3.5.10 Excision of mammary gland by age, women 2006**
Resektion af mammae, kvinder, fordelt på alder 2006

| *Age* Alder | *Denmark* | *Faroe Islands*[1] | *Finland* | *Iceland* | *Norway* | *Sweden* |
|---|---|---|---|---|---|---|
| <15 | 6 | - | 4 | - | 1 | 2 |
| 15-24 | 137 | 1 | 145 | 4 | 91 | 211 |
| 25-44 | 846 | 4 | 605 | 27 | 495 | 1 154 |
| 45-64 | 2 207 | 7 | 2 160 | 75 | 1 753 | 3 344 |
| 65-74 | 731 | 3 | 570 | 15 | 506 | 1 190 |
| 75-84 | 274 | 2 | 233 | 16 | 191 | 386 |
| 85+ | 64 | 1 | 54 | 1 | 61 | 94 |
| *Total* I alt | 4 265 | 18 | 3 771 | 138 | 3 098 | 6 381 |
| *Per 100 000 in the age group* Pr. 100 000 i alderen | | | | | | |
| 15-24 | 46 | 46 | 45 | 18 | 32 | 38 |
| 25-44 | 112 | 75 | 90 | 63 | 76 | 97 |
| 45-64 | 304 | 134 | 290 | 219 | 306 | 284 |
| 65-74 | 311 | 160 | 234 | 160 | 293 | 296 |
| 75-84 | 168 | 117 | 120 | 220 | 126 | 117 |
| 85+ | 87 | 196 | 81 | 38 | 87 | 60 |
| *Total* I alt | 155 | 79 | 141 | 92 | 132 | 139 |

1 Average 2001-2005

1 Gennemsnit for årene 2001-2005

NCSP codes covered: HAB

*Sources:* *See Table 3.5.1*
Kilder: Se tabel 3.5.1

**Table 3.5.11 Mastectomy, women, by age 2006**
Ablatio mammae, kvinder, fordelt på alder 2006

| *Age* Alder | *Denmark* | *Faroe Islands*[1)] | *Finland* | *Iceland* | *Norway* | *Sweden* |
|---|---|---|---|---|---|---|
| <15 | - | - | - | - | - | - |
| 15-24 | - | - | 3 | - | 7 | 17 |
| 25-44 | 248 | 1 | 223 | 9 | 185 | 441 |
| 45-64 | 960 | 5 | 1 140 | 33 | 686 | 1 561 |
| 65-74 | 507 | 4 | 498 | 13 | 212 | 733 |
| 75-84 | 406 | 2 | 441 | 13 | 256 | 691 |
| 85+ | 113 | 1 | 138 | 3 | 121 | 273 |
| *Total* I alt | 2 234 | 12 | 2 443 | 71 | 1 467 | 3 716 |
| *Per 100 000 in the age group* Pr. 100 000 i alderen | | | | | | |
| 15-24 | - | - | 1 | - | 2 | 3 |
| 25-44 | 33 | 10 | 33 | 21 | 29 | 37 |
| 45-64 | 132 | 93 | 153 | 96 | 120 | 133 |
| 65-74 | 216 | 222 | 204 | 139 | 123 | 182 |
| 75-84 | 249 | 175 | 228 | 178 | 169 | 210 |
| 85+ | 153 | 157 | 206 | 114 | 173 | 173 |
| *Total* I alt | 81 | 53 | 91 | 47 | 63 | 81 |

1 Average 2001-2005

1 Gennemsnit for årene 2001-2005

NCSP codes covered: HAC 10-25; HAC 99

*Sources:* *See Table 3.5.1*
Kilder: Se tabel 3.5.1

## Table 3.5.12 Appendectomy by sex and age 2006
Appendektomi fordelt på køn og alder 2006

| | *Denmark* | | *Faroe Islands*[1] | | *Finland* | | *Iceland* | | *Norway* | | *Sweden* | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Age* Alder | M | W | M | W | M | W | M | W | M | W | M | W |
| <15 | 671 | 594 | 7 | 6 | 500 | 430 | 198 | 187 | 434 | 358 | 1 121 | 866 |
| 15-24 | 611 | 542 | 6 | 6 | 779 | 815 | 329 | 218 | 690 | 630 | 1 369 | 1 197 |
| 25-44 | 761 | 731 | 6 | 5 | 1114 | 1.106 | 112 | 103 | 883 | 808 | 1 709 | 1 416 |
| 45-64 | 499 | 616 | 4 | 3 | 799 | 865 | 65 | 67 | 451 | 496 | 875 | 1 136 |
| 65+ | 271 | 400 | 2 | 1 | 309 | 353 | 31 | 31 | 208 | 241 | 503 | 582 |
| *Total* I alt | 2 813 | 2 883 | 26 | 20 | 3.501 | 3.569 | 143 | 120 | 2 666 | 2 533 | 5 577 | 5 197 |
| *Per 100 000 in the age group* Pr. 100 000 i alderen | | | | | | | | | | | | |
| <15 | 129 | 120 | 116 | 104 | 108 | 97 | 198 | 187 | 93 | 81 | 141 | 114 |
| 15-24 | 196 | 182 | 181 | 183 | 233 | 255 | 329 | 217 | 235 | 224 | 234 | 215 |
| 25-44 | 99 | 97 | 93 | 85 | 160 | 165 | 112 | 103 | 132 | 125 | 138 | 119 |
| 45-64 | 68 | 85 | 69 | 52 | 108 | 116 | 65 | 67 | 77 | 87 | 73 | 96 |
| 65+ | 76 | 85 | 74 | 23 | 92 | 70 | 31 | 31 | 72 | 61 | 74 | 65 |
| *Total* I alt | 105 | 105 | 103 | 85 | 136 | 133 | 143 | 120 | 116 | 108 | 124 | 114 |

1 Average 2001-2005

1 Gennemsnit for årene 2001-2005

NCSP codes covered: JEA

*Sources:* *See Table 3.5.1*
Kilder: Se tabel 3.5.1

## Table 3.5.13 Cholesystectomy by sex and age 2006
Kolecystectomi fordelt på køn og alder 2006

| | *Denmark* | | *Faroe Islands*[1] | | *Finland* | | *Iceland* | | *Norway* | | *Sweden* | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Age* Alder | M | W | M | W | M | W | M | W | M | W | M | W |
| <25 | 48 | 303 | - | 3 | 39 | 229 | 5 | 27 | 30 | 224 | 86 | 509 |
| 25-44 | 503 | 1 976 | 3 | 16 | 467 | 1 629 | 29 | 144 | 303 | 1 259 | 933 | 2 853 |
| 45-64 | 840 | 1 719 | 5 | 13 | 1 162 | 2 325 | 64 | 174 | 569 | 1 149 | 1 634 | 3 155 |
| 65+ | 498 | 853 | 2 | 4 | 1 081 | 1 432 | 47 | 67 | 382 | 589 | 1 222 | 1 596 |
| *Total* I alt | 1 889 | 4 851 | 11 | 36 | 2 749 | 5 615 | 145 | 412 | 1 284 | 3 221 | 3 875 | 8 113 |
| *Per 100 000 in the age group* Pr. 100 000 i alderen | | | | | | | | | | | | |
| <25 | 6 | 38 | 4 | 38 | 5 | 30 | 9 | 50 | 4 | 31 | 6 | 39 |
| 25-44 | 65 | 262 | 44 | 266 | 67 | 243 | 64 | 337 | 45 | 194 | 75 | 239 |
| 45-64 | 115 | 237 | 83 | 242 | 157 | 312 | 174 | 507 | 97 | 201 | 136 | 268 |
| 65+ | 139 | 181 | 81 | 114 | 321 | 284 | 294 | 347 | 132 | 150 | 179 | 179 |
| *Total* I alt | 70 | 177 | 43 | 154 | 107 | 209 | 94 | 275 | 56 | 138 | 86 | 177 |

1 Average 2001-2005

1 Gennemsnit for årene 2001-2005

NCSP codes covered: JKA 20-21

*Sources:* *See Table 3.5.1*
Kilder: Se tabel 3.5.1

**Table 3.5.14 Kidney transplants by sex and age 2006**
Nyretransplantationer, fordelt på køn og alder 2006

| | *Denmark* | | *Finland* | | *Iceland* | | *Norway* | | *Sweden* | |
|---|---|---|---|---|---|---|---|---|---|---|
| *Age* Alder | M | W | M | W | M | W | M | W | M | W |
| <15 | 4 | 8 | 8 | 3 | - | - | 4 | 1 | 4 | 7 |
| 15-24 | 8 | 3 | 7 | 3 | - | - | 9 | 2 | 11 | 5 |
| 25-44 | 36 | 30 | 30 | 23 | 4 | 3 | 37 | 20 | 64 | 34 |
| 45-54 | 32 | 9 | 37 | 16 | - | - | 29 | 13 | 62 | 28 |
| 55-64 | 28 | 13 | 31 | 18 | - | 1 | 29 | 14 | 68 | 42 |
| 65+ | 3 | 2 | 12 | 5 | - | - | 37 | 14 | 27 | 9 |
| *Total* I alt | 111 | 65 | 125 | 68 | 4 | 4 | 145 | 64 | 236 | 125 |
| *Per 100 000 in the age group* Pr. 100 000 i alderen | | | | | | | | | | |
| 15-24 | 3 | 1 | 2 | 1 | - | - | 3 | 1 | 2 | 1 |
| 25-44 | 5 | 4 | 4 | 3 | 9 | 7 | 6 | 3 | 5 | 3 |
| 45-54 | 9 | 2 | 10 | 4 | - | - | 9 | 4 | 11 | 5 |
| 55-64 | 8 | 4 | 9 | 5 | - | 7 | 11 | 5 | 11 | 7 |
| 65+ | 1 | 0 | 4 | 1 | - | - | 13 | 4 | 4 | 1 |
| *Total* I alt | 4 | 2 | 5 | 3 | 3 | 3 | 6 | 3 | 5 | 3 |

NCSP codes covered: KAS 10-20

*Sources:* *See Table 3.5.1*
Kilder: Se tabel 3.5.1

**Table 3.5.15 Prostatectomy, transurethral procedures and open prostatectomy men by age 2006**
Transurethral resektion af prostata og åben prostatektomi, mænd fordelt på alder 2006

| *Age* Alder | *Denmark* | *Faroe Islands*[1] | *Finland* | *Iceland* | *Norway* | *Sweden* |
|---|---|---|---|---|---|---|
| <45 | 24 | - | 23 | 2 | 17 | 37 |
| 45-64 | 1 413 | 4 | 1 525 | 69 | 1 489 | 3 151 |
| 65+ | 3 502 | 19 | 2 993 | 197 | 4 247 | 6 945 |
| *Total* I alt | 4 939 | 23 | 4 541 | 268 | 5 753 | 10 133 |
| *Per 100 000 in the age group* Pr. 100 000 i alderen | | | | | | |
| 45-64 | 193 | 63 | 206 | 188 | 253 | 263 |
| 65+ | 979 | 643 | 889 | 1 234 | 1 471 | 1 016 |
| *Total* I alt | 184 | 91 | 177 | 174 | 250 | 225 |

1 Average 2001-2005

1 Gennemsnit for årene 2001-2005

NCSP codes covered: KEC, KED 00, KED 22-72, KED 96

*Sources:* *See Table 3.5.1*
Kilder: Se tabel 3.5.1

### Table 3.5.16 Hysterectomy (including supravaginal hysterectomy and exenteration of pelvis) women by age 2006

Hysterektomi (inkl. supravaginal hysterektomi og bækkeneksentration), kvinder fordelt på alder 2006

| *Age* Alder | *Denmark* | *Faroe Islands*[1)] | *Finland* | *Iceland* | *Norway* | *Sweden* |
|---|---|---|---|---|---|---|
| <25 | 10 | - | 5 | 1 | 8 | 18 |
| 25-44 | 1 953 | 2 | 1 670 | 163 | 1 334 | 2 083 |
| 45-64 | 3 078 | 17 | 4 280 | 230 | 2 604 | 4 479 |
| 65+ | 1 043 | 5 | 1 563 | 47 | 886 | 2 191 |
| *Total* I alt | 6 084 | 30 | 7 518 | 441 | 4 832 | 8 771 |
| *Per 100 000 in the age group* Pr. 100 000 i alderen | | | | | | |
| 25-44 | 259 | 137 | 250 | 381 | 206 | 175 |
| 45-64 | 424 | 316 | 574 | 671 | 454 | 380 |
| 65+ | 221 | 131 | 310 | 244 | 225 | 246 |
| *Total* I alt | 222 | 128 | 280 | 294 | 207 | 192 |

1 Average 2001-2005

1 Gennemsnit for årene 2001-2005

NCSP codes covered: LCC 10-20; LCD; LCE; LEF 13

*Sources: See Table 3.5.1*
Kilder: Se table 3.5.1

### Table 3.5.17 Caesarean section, by age, women 2006

Kejsersnit, kvinder fordelt på alder 2006

| *Age* Alder | *Denmark* | *Faroe Islands*[1)] | *Finland* | *Iceland* | *Norway* | *Sweden* |
|---|---|---|---|---|---|---|
| <15 | - | - | - | - | - | 1 |
| 15-24 | 1 148 | 17 | 1 325 | 132 | 1 033 | 1 690 |
| 25-34 | 9 159 | 53 | 5 690 | 456 | 5 693 | 11 610 |
| 35-44 | 3 173 | 17 | 2 345 | 156 | 2 628 | 5 357 |
| 45+ | 19 | - | 21 | - | 34 | 60 |
| *Total* I alt | 13 499 | 88 | 9 381 | 744 | 9 388 | 18 718 |
| *Per 1 000 deliveries* Pr. 1 000 fødsler | | | | | | |
| 15-24 | 159 | 105 | 121 | 135 | 110 | 124 |
| 25-34 | 202 | 131 | 157 | 174 | 151 | 179 |
| 35-44 | 273 | 137 | 218 | 215 | 253 | 268 |
| 45+ | 365 | 333 | 250 | - | 586 | .. |
| *Total* I alt | 210 | 126 | 161 | 172 | 163 | 190 |

1 Average 2001-2005

1 Gennemsnit for årene 2001-2005

NCSP codes covered: MCA

*Sources: See Table 3.5.1*
Kilder: Se tabel 3.5.1

**Table 3.5.18 Hip replacement by sex and age 2006**
Hofteledplastik fordelt på køn og alder 2006

| | *Denmark* | | *Faroe Islands*[1)] | | *Finland* | | *Iceland* | | *Norway* | | *Sweden* | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Age* Alder | M | W | M | W | M | W | M | W | M | W | M | W |
| <25 | 15 | 16 | - | - | 7 | 14 | - | - | 16 | 7 | 3 | 15 |
| 25-44 | 146 | 115 | 1 | 1 | 148 | 137 | 7 | 2 | 115 | 91 | 199 | 201 |
| 45-64 | 1 368 | 1 393 | 8 | 11 | 1 601 | 1 642 | 62 | 73 | 761 | 1 209 | 2 168 | 2 372 |
| 65-74 | 1 254 | 1 940 | 7 | 14 | 1 463 | 2 008 | 44 | 86 | 812 | 1 609 | 2 202 | 3 243 |
| 75+ | 1 317 | 3 290 | 8 | 24 | 1 253 | 3 380 | 68 | 147 | 1 215 | 3 351 | 2 958 | 6 273 |
| *Total* I alt | 4 100 | 6 754 | 23 | 50 | 4 472 | 7 181 | 181 | 308 | 2 919 | 6 267 | 7 530 | 12 104 |
| *Per 100 000 in the age group* Pr. 100 000 i alderen | | | | | | | | | | | | |
| 25-44 | 19 | 15 | 17 | 17 | 21 | 20 | 15 | 5 | 17 | 14 | 16 | 17 |
| 45-64 | 187 | 192 | 126 | 201 | 216 | 220 | 169 | 213 | 129 | 211 | 181 | 201 |
| 65-74 | 589 | 826 | 389 | 717 | 716 | 823 | 505 | 918 | 525 | 933 | 593 | 806 |
| 75+ | 909 | 1 391 | 603 | 1 003 | 945 | 1 298 | 938 | 1 481 | 905 | 1 515 | 946 | 1 288 |
| *Total* I alt | 152 | 246 | 92 | 169 | 174 | 268 | 117 | 205 | 127 | 268 | 167 | 265 |

1 Average 2001-2005

1 Gennemsnit for årene 2001-2005

NCSP codes covered: NFB; NFC

*Sources:* *See Table 3.5.1*
Kilder: Se tabel 3.*5.1*

## 3.6 Accidents and self-inflicted injury

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

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

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

## 3.6 Ulykker og villet egenskade

Patienter indlagt på grund af ulykker udnytter en væsentlig del af kapaciteten ved sygehusene.

Mens statistikken over dødsårsager er veludbygget i de nordiske lande, er registreringen af overlevende efter ulykker stadigvæk mangelfuld, og de tilgængelige data er vanskelige at sammenligne. Da kun Danmark og Island har sammenlignelig statistik for de ydre årsager ved ulykker er det ikke muligt at bringe nordisk statistik vedrørende dette.

Det er derfor valgt at medtage statistik over udskrivninger for de mest almindelige "større" ulykker som oftest vil kræve indlæggelse. Her ser man markante forskelle, både mellem landene og mænd og kvinder.

**Table 3.6.1 Discharges from hospitals after treatment for injuries per 100 000 inhabitants by sex 2006[1)]**
Udskrivninger fra indlæggelser fra sygehuse efter behandling for skader per 100 000 indbygger og efter køn 2006[1)]

| | *Denmark* | | *Faroe Islands[2)]* | | *Greenland* | | *Finland* | | *Åland[2)]* | | *Iceland* | | *Norway* | | *Sweden* | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M | W | M | W | M | W | M | W | M | W | M | W | M | W | M | W |
| *Fracture of skull and intracranial injury* Kraniebrud og intrakraniel læsion ICD10: S02; S06 | 249 | 148 | 323 | 142 | 82 | 160 | 190 | 110 | 251 | 160 | 79 | 43 | 292 | 165 | 234 | 159 |
| *Fracture at wrist and hand level* Brud i handled og hand ICD10: S62 | 66 | 24 | 88 | 30 | 15 | 18 | 48 | 16 | 29 | 19 | 11 | 3 | 57 | 19 | 22 | 8 |
| *Injury of lower leg* Læsion af knæ og underben ICD10: S80-S89 | 243 | 206 | 443 | 211 | 145 | 128 | 452 | 317 | 314 | 234 | 110 | 94 | 220 | 192 | 147 | 157 |
| *Injury of hip and thigh* Læsion af hofte og lår ICD10: S70-S79 | 157 | 332 | 175 | 229 | 71 | 43 | 142 | 251 | 162 | 289 | 97 | 171 | 191 | 382 | 195 | 388 |
| *Poisoning* Forgiftning ICD10: T36-T65 | 196 | 261 | 76 | 82 | 71 | 46 | 83 | 95 | 58 | 60 | 18 | 32 | 106 | 162 | 89 | 150 |
| *Burn and corrosion* Forbrænding og ætsning ICD10: T20-T32 | 19 | 8 | 44 | 17 | 10 | 10 | 28 | 13 | 31 | 4 | 16 | 5 | 36 | 16 | 21 | 8 |

1 Including violence and self-inflicted injury
2 Average 2002-2006

1 Inklusiv vold og villet egenskade
2 Gennemsnit for årene 2002-2006

*Source: The Inpatient Registers of the Nordic Countries*
Kilde: Patientregistrene i de nordiske lande

**Table 3.6.2 Discharges from hospitals after treatment for injuries, per 100 000 inhabitants, by sex and age 2006[1]**
Udskrivninger fra indlæggelse på sygehuse efter behandling for skader, pr. 100 000 indbyggere efter køn og alder 2006[1]

| | *Denmark* | | *Faroe Islands[2]* | | *Finland* | | *Iceland* | | *Norway* | | *Sweden* | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Age* Alder | M | W | M | W | M | W | M | W | M | W | M | W |
| 0-14 | 647 | 466 | 705 | 502 | 877 | 620 | 624 | 493 | 1 134 | 805 | 1 188 | 817 |
| 15-24 | 934 | 383 | 1 343 | 1 074 | 1 804 | 865 | 1 120 | 619 | 2 244 | 1 466 | 1 346 | 770 |
| 25-64 | 653 | 405 | 1 217 | 391 | 1 920 | 1 167 | 936 | 654 | 1 711 | 1 209 | 1 201 | 914 |
| 65+ | 1 135 | 2 126 | 1 532 | 1 784 | 2 807 | 3 636 | 2 581 | 3 882 | 3 719 | 5 373 | 4 354 | 5 554 |
| *Total* I alt | 749 | 709 | 1 165 | 722 | 1 834 | 1 509 | 1 066 | 1 030 | 1 915 | 1 863 | 1 696 | 1 782 |

1 Including violence and self-inflicted injury
2 Average 2002-2006

1 Inklusiv vold og villet egenskade
2 Gennemsnit 2002-2006

*Sources: The Inpatient Registers of the Nordic Countries*
Kilde: Patientregistrene i de nordiske lande

ICD-10: S00-T98

## 3.7 Consumption of medicinal products in the Nordic countries

Table 3.7.1 presents total sales of medicinal products in the Nordic countries, by ATC main group. Sales of medicinal products are highest in Sweden, followed by Finland and Norway, while Iceland, Åland and Denmark have slightly lower sales.

## 3.7 Legemidelforbruket i Norden

I tabel 3.7.1 vises totalt salg av legemidler i de nordiske land fordelt på ATC hovedgrupper. I Sverige, etterfulgt av Finland og Norge er salget størst, mens Island, Åland and Denmark har et noe lavere salg.

### *Drugs for acid-related disorders*

Table 3.7.2: For many years, the sale of drugs in the ATC group A02 has been steadily increasing. The reason for this is an ever-increasing consumption of proton pump inhibitors (A02BC). Approved indications for the proton pump inhibitors are gastroesophageal reflux diseases and gastric ulcer.

The consumption varies greatly between the Nordic countries. Iceland has more than twice the consumption of Norway.

Sales are stable for other drugs in the group, antacids and H2-reseptor antagonists.

### *Midler mot syrerelaterte lidelser*

Tabell 3.7.2: Salget av legemidler i ATC gruppe A02 har i mange år vært jevnt økende. Årsaken til dette er et stadig økende forbruk av protonpumpehemmere (A02BC). Godkjente bruksområder for protonpumpe-hemmere er spiserørbetennelse og magesår.

Forbruket varierer sterkt mellom de nordiske landene. Island har mer enn dobbelt så høyt forbruk som Norge.

For andre legemidler i gruppen, antacida og H2-reseptorantagonister, holder salget seg på et stabilt nivå.

### *Anti-obesity preparations*

Table 3.7.3: Three new medicinal products for the treatment of obesity have been put on the market during the latest few years: Orlistat (A08AB01) that prevents fat absorption from the gut, centrally acting sibutramine (A08AA10), and rimonabant (A08AX01) which is

### *Midler mot fedme*

Tabel 3.7.3: Flere nye legemidler til behandling av fedme er blitt introdusert de siste årene: Orlistat (A08AB01), som hindrer fettopptak fra tarmen, sentraltvirkende sibutramine (A08AA10) og rimonabant (A08AX01) som både har en lokal og sentral virkningsmekanisme. Sal-

both locally and centrally acting. Sales of these agents are low in all the Nordic countries.

get av disse midlene er lite i alle de nordiske land.

### *Drugs used in diabetes*

Table 3.7.4: The prevalence of type 1 and type 2 diabetes is growing. The increase in the prevalence is explained by the fact that patients are living longer, and that there is an increase in the number of new cases reported. In Western countries the prevalence of diabetes is 2-4 per cent of the population. The incidence rises with age; in Norway every eighth person over 70 years old has diabetes.

Type 2 diabetes patients have a reduced sensitivity to insulin in their tissues, and the disease is associated with obesity. The increasing incidence of type 2 diabetes is probably connected with the increase in the prevalence of obesity in the population.

Type 1 diabetes patients are treated with insulin (A10A), while type 2 diabetes patients are treated with oral blood glucose lowering agents (A10B), insulin and tablets in combination or insulin alone. A lot of patients diagnosed with type 2 diabetes are treated with diet, physical activity and weight reduction.

In the Nordic countries, the sale of drugs to treat diabetes mellitus, in terms of defined daily doses, has more than doubled over the last decade. Increased incidence of type 2 diabetes, which is most prevalent, and more intensive treatment are the main reasons for the growth. Finland has the highest consumption of antidiabetic drugs, while Iceland has the lowest

### *Midler til diabetesbehandling*

Tabel 3.7.4: Antallet personer med type 1 og type 2 diabetes er stigende. Økningen i prevalens forklares ut fra at pasientene lever lenger, og at det stadig blir flere nye tilfeller. I de vestlige land er prevalensen av diabetes 2-4 prosent av befolkningen. Insidensen stiger med alderen; i Norge har hver åttende person over 70 år diabetes.

Personer med type 2 diabetes har nedsatt insulinfølsomhet i vevene, og sykdommen er forbundet med fedme. Den stigende insidensen av type 2 diabetes, har med stor sannsynlighet sammenheng med det voksende problemet overvekt i befolkningen representerer.

Type 1 diabetes behandles med insulin (A10A), mens type 2 diabetes behandles med orale antidiabetika (A10B), en kombinasjon av insulin og tabletter eller insulin alene. I tillegg må nevnes at mange med type 2 diabetes reguleres kun med kosthold, fysisk aktivitet og vektreduksjon.

I de nordiske land er salget av legemidler til behandling av diabetes, målt i definerte døgndoser, mer enn doblet i løpet av siste tiårsperiode. Økt insidens av type 2 diabetes, som er mest utbredt, og intensivert behandling er hovedårsakene til veksten. Finland har det høyeste forbruket av antidiabetika, mens Island har det laveste, Sammenliknet med Norge og

consumption. In Finland the use of oral antidiabetic drugs is twice as high as in Norway and Sweden, The consumption of insulin, on the other hand, is similar in Sweden and Finland.

Sverige, brukes det i Finland dobbelt så mye orale antidiabetika, mens forbruket av insulin er det samme i Sverige og Finland.

### *Inhibitors of platelet aggregation*

Table 3.7.5: The sale of platelet aggregation inhibitors (ATC group B01AC) has steadily increased in all Nordic countries. The dominant drug in this group is low-dose acetylsalicylic acid that is used in the prophylaxis of thrombosis, in order to reduce the risk of stroke and myocardial infarction. The consumption of platelet aggregation inhibitors is highest in Finland.

Sales of other drugs used for thrombosis prevention (warfarin (B01AA) and heparins (B01AB) are not included in Table 3.7.5.

### *Hemmere av blodplateaggregasjon*

Tabell 3.7.5: Salg av hemmere av blodplateaggregasjon (ATC gruppe B01AC) har økt jevnt i alle nordiske land. Det dominerende legemiddel i denne gruppe er lavdose acetylsalicylsyre til forebygging av blodpropp. Forebygging av blodpropp er viktig for å redusere risikoen for slag og hjerteinfarkt. Finland har høyest forbruk av disse midlene i Norden.

Salg av andre legemidler som brukes til forebygging av blodpropp, warfarin (B01AA) og heépariner (B01AB) er ikke tatt med i tabell 3.7.5.

### *Cardiovascular medicines*

Tables 3.7.6, 3.7.7. and 3.7.8: In all the Nordic countries the consumption of cardiovascular drugs (ATC group C) is increasing, in particular due to increased consumption of agents acting on the renin-angiotensin system (C09) and lipid modifying agents (C10).

Cardiovascular drugs are used in the treatment of hypertension, ischemic heart disease and hypercholesterolemia. Prophylactic treatment is also important in the population with the highest risk of developing cardiovascular diseases.

### *Midler mot sykdommer i hjerte og kretsløp*

Tabell 3.7.6, 3.7.7 og 3.7.8: I alle nordiske land er forbruket av hjerte/karmidler (ATC gr. C) økende, dette gjelder særlig for midler med virkning på renin-angiotensin systemet (C09) og de lipidmodifiserende midler (C10).

Legemidler innenfor denne gruppen brukes blant annet til behandling av høyt blodtrykk, angina, hjertesvikt og høyt kolesterol. Forebyggende behandling er også viktig i den populasjonen som har høyest risiko for å få hjerte/karsykdom.

Sweden and Finland have the highest use of cardiovascular drugs (table 3.7.1).

Sverige og Finland har det høyeste forbruket av hjerte/karmidler (tabell 3.7.1).

The use of digitalis glycosides (C01A) and nitrates (C01D) has gradually declined in all Nordic countries.

Forbruket av digitalisglykosider (C01A) og nitrater (C01D) har blitt gradvis redusert i hele Norden.

The ACE inhibitors/angoitensin II antagonist (C09) and the calcium channel blockers (C08) have gradually replaced the use of other agents in the group (C02, C03 and C07). Part of the increase in the use of cardiovascular drugs could be explained by the more frequent use of combined treatment with different cardiovascular drugs.

ACE-hemmere/angiotensin II antagonister (C09) og calsiumantagonister (C08) har overtatt mer og mer av forbruket sett i forhold til andre midler i gruppen (C02, C03, C07). Noe av økningen i forbruket av hjerte/karmidler kan forklares med at samtidig bruk av flere hjerte/karmidler blir stadig mer vanlig.

The use of angiotensin II antagonists in combination with diuretics (C09D) has increased in all Nordic countries from 2000 to 2007. The highest consumption of these combinations is seen in Iceland and Norway.

Bruk av angiotensin II antagonister i kombinasjon med diuretika (C09D) har økt kraftig i alle de nordiske land fra 2000 til 2007. Island og Norge har det høyeste forbruket.

The sale of the lipid modifying agents (C10) has increased in all the Nordic countries and Norway has the highest use. In all the Nordic countries the statin group (C10AA) dominates. Use of cholesterol reducing agents is important in patients with established coronary heart disease or in the group of individuals in the high risk population (for example in individuals with diabetes and/or hypertension).

Salg av lipidmodifiserende legemidler (C10) har økt kraftig i hele Norden og Norge har det høyeste forbruket. Statiner (C10AA) er den dominerende gruppen i alle land. Behandling med kolesterolsenkende midler er viktig hos pasienter som har etablert hjerte/karsykdom eller har høy risiko for å få hjerte/karsykdom (f eks personer diabetes og/eller høyt blodtrykk).

## *Oestrogens and progestogens*

Table 3.7.9: The use of oestrogens for the treatment of menopausal complaints in women has been reduced in all countries since 2002. The use of these agents increased during the 1990s, but in 2002

## *Østrogen og gestagen*

Tabell 3.7.9: Forbruket av hormoner til behandling av plager i forbindelse med overgangsalderen hos kvinner har blitt redusert i alle nordiske land siden 2002. Etter at forbruket hadde økt gradvis i 1990

the use of oestrogens came into focus due to new information regarding the benefit/risk of oestrogens for long-term use in e.g. the prevention of osteoporosis.

The highest reduction in use is observed in the group of products used for systemic treatment (oestradiol or tibolone tablets). There has been less reduction in the use of oestrogens used for local treatment (for example creams/vagitories containing e.g. estriol).

The use of oestrogens is highest in Finland and the level is nearly twice the level in Denmark, Norway and Sweden.

årene, ble det i 2002 publisert nye studier som satte søkelyset på nytte/risiko forhold ved langtidsbruk av østrogener (for eksempel for å forebygge osteoporose).

Størst reduksjon i forbruket ses i gruppen av produkter som brukes til systemisk behandling (tabletter som inneholder østradiol eller tibolon). For østrogener som brukes til lokal behandling (for eksempel krem/vagitorier som inneholder østriol), ses en mindre reduksjon.

Forbruket av østrogener er høyest i Finland og nivået er her nesten dobbelt så høyt som i Danmark, Norge og Sverige.

### *Medicines used for the treatment of erectile dysfunction*

Table 3.7.10: The sale of drugs for the treatment of erectile dysfunction (G04BE) is slightly increasing. There is reason to believe that these drugs are also sold via the Internet, so that the statistics are too low.

### *Midler ved erektil dysfunksjon*

Tabell 3.7.10: Salget av legemidler til behandling av ereksjonsforstyrrelser (G04BE) er svakt økende. Det er grunn til å tro at det i tillegg omsettes slike midler via internett og at tallene i statistikken derfor er for lave.

### *Antibacterial medicines*

Table 3.7.11: The sales of antibacterials for systemic use (ATC gruppe J01) vary among the Nordic countries. Iceland and Finland have the highest use, while Sweden and Denmark have the lowest use. The total use of antibacterials in the Nordic countries is increasing. Since 1999 there has been an increase in the sales of antibacterials in Denmark, Iceland and Norway, while the sales have been relatively stable in Finland and Sweden.
The pattern of therapy varies from coun-

### *Antibakterielle midler*

Tabell 3.7.11: Salg av antibakterielle midler for systemisk bruk (ATC gruppe J01) varierer mellom de nordiske land. Island og Finland bruker mest, mens Sverige og Danmark bruker minst. Generelt ser vi et økende antibiotikaforbruk i Norden. Siden 1999 har det vært en økning i salget i Danmark, Island og Norge, mens det har vært relativt stabilt i Finland og Sverige.

Terapimønsteret varierer fra land til

try to country. In 2007 Denmark had the highest share of penicillins (J01C) (62 per cent of the total use in Denmark) but Norway and Sweden had the highest use of narrow spectrum penicillins (J01CE) if we look at the total use of penicillins. Denmark has also the relatively highest proportion of macrolides (J01F), 15 per cent of the total use of antibacterials in Denmark. Finland has the relatively highest use of cephalosporins (J01D), 15 per cent of the total use of antibacterials in Finland, as opposed to 2-4 per cent in the other countries. Norway has the highest sales of group J01X, other antibacterials. This group consists mainly of methenamin, an antiseptic agent for the urinary tract. Methenamin constitutes 14 per cent of the total use of antibacterials in Norway.

## *Medicines for the treatment of pain*

Table 3.7.12: The most widely used drugs for the treatment of pain are paracetamol and NSAID, particularly ibuprofen (anti-inflammatory and anti-rheumatic drugs, M01A). In addition, opioids are indicated for more severe pain.

The consumption of analgesics is increasing, but thedrug utilization profile in the Nordic countries is different. Finland has the highest consumption of NSAID (M01A), particularly ibuprofen, and the lowest consumption of opioids. Denmark has the highest consumption of paracetamol. The consumption of opioids is relatively similar in Denmark, Iceland, Norway and Sweden.

land. For 2007 finner vi følgende: Danmark har høyest andel av penicilliner (J01C) (62 prosent av dansk totalforbruk). Det er imidlertid Norge og Sverige som benytter forholdsvis mest smalspektret penicillin (J01CE), om vi ser på penicillinene (J01C) under ett. Danmark bruker også forholdsmessig mest makrolider (J01F), 15 prosent av totalbruken i Danmark. Finland bruker forholdsmessig mest cefalosporiner (J01D), 15 prosent av total antibiotikabruk i Finland i motsetning til 2-4 prosent i de andre landene. Norge har størst salg av Andre antibiotika (ATC gruppe J01X). I hovedsak består denne gruppen av metenamin, et urinveisantiseptikum. Metenamin står for 14 prosent av alt antibiotikasalg i Norge.

## *Smertestillende midler*

Tabell 3.7.12: De mest brukte legemidler mot smerter er paracetamol og NSAID, spesielt ibuprofen (antiinflammatoriske og antirevmatiske midler, M01A). I tillegg brukes opioider ved sterke smerter.

Forbruket av smertestillende midler er økende, men forbruksprofilene i de nordiske landene er forskjellig. Finland har det høyeste forbruket av NSAID (M01A), spesielt ibuprofen, og det laveste forbruk av opioider. Danmark har høyeste forbruket av paracetamol. Forbruket av opioider er relativt like i Danmark, Island, Norge og Sverige.

### *Antipsychotic medicines*

Table 3.7.13: The consumption of antipsychotics (N05A) has been relatively stable in the period 2000 to 2007. Finland had the highest consumption in 2007, twice as high as Sweden.

### *Antipsykotika*

Tabell 3.7.13: Forbruket av antipsykotiske legemidler (N05A) har vært relativt stabilt i perioden 2000 til 2007. Finland hadde høyest forbruk i 2007, dobbelt så høyt som Sverige.

### *Anxiolytics, hypnotics, and sedatives*

Tables 3.7.14 and 3.7.15: In all the Nordic countries benzodiazepines (N05BA) account for most of the consumption of anxiolytics (N05B) and the benzodiazepine related drugs (the so-called z-hypnotika, N05CF) account for most of the consumption of hypnotics and sedatives.

Denmark has had a marked decrease in the use of anxiolytics since 1995. In the other countries consumption has been relatively stable.

During the period 1995 to 2007, the z-hypnotics (N05BA) took over as the dominating hypnotic in all the Nordic countries, with the exception of Finland, where consumption of benzodiazepines continues to be substantial. Consumption of hypnotics in Iceland is more than twice as high as in Denmark, where consumption is the lowest. The z-hypnotics were marketed as drugs with less adverse effects and addictive potential, but are now considered to be very similar to benzodiazepines.

### *Midler mot angst, sovemidler og beroligende midler*

Tabellene 3.7.14 og 3.7.15: I alle de nordiske land utgjør benzodiazepiner (N05BA) hoveddelen av forbruket av angstdempende midler og benzodiazepinlignende legemidler (såkalte z-hypnotika, N05CF) hoveddelen av forbruket av sovemidler og beroligende midler (N05C).

Danmark har hatt en markant nedgang i bruk av angstdempende legemidler siden 1995. I de andre landene har forbruket vært relativt stabilt.

Z-hypnotika (N05BA) har i perioden 1995 til 2007 overtatt som dominerende sovemiddel i alle nordiske land med unntak av Finland som fortsatt har et betydelig bruk av benzodiazepiner. Island har mer enn dobbelt så høyt forbruk av sovemidler som Danmark, som ligger lavest i statistikken. Z-hypnotika ble markedsført som midler med mindre bivirkninger og avhengighetsskapende potensiale, mens de nå anses for å være svært like benzodiazepinene.

### *Antidepressants*

Table 3.7.16: The launching of the selective serotonin reuptake inhibitors (SSRI) in the late 1990s led to a strong increase in sales of antidepressants.

After a period of steady increase, consumption seems to have stabilised and the increase is smaller.

Consumption varies greatly between the Nordic countries: Iceland has the highest consumption, almost double the consumption in Norway, while Denmark, Finland and Sweden have an intermediate consumption.

Antidepressants are also to some extent used in panic disorder, bulimia, obsessive-compulsive neurosis and the treatment of pain.

### *Antidepressiva*

Tabell 3.7.16: Markedsføringen av selektive serotonin reopptakshemmerer (SSRI) på slutten av 1990-tallet førte til en sterk økning i salget av antidepressiva.

Etter en periode med jevn økning, ser nå forbruket av antidepressiva ut til å ha stabilisert seg og økningen er liten.

Forbruket varierer sterkt mellom de nordiske landene, Island har det høyeste forbruket, nesten det dobbelte av forbruket i Norge, mens Danmark, Finland og Sverige kommer i en mellomposisjon.

Antidepressiva brukes også i en viss utstrekning ved panikklidelser, bulemi tvangslidelse, angst og i smertebehandling.

### *Anti-dementia drugs*

Table 3.7.17: Drugs for the treatment of dementia were marketed in the late 1990s. The effect of these drugs is now considered to be moderate. Since there is no alternative treatment, consumption has grown slowly in all the Nordic countries, except in Norway, where there was a decline in use in 2007. Consumption is highest in Finland and lowest in Denmark.

### *Midler mot demens*

Tabell 3.7.17: Legemidler mot demens ble markedsført i slutten av 1990-tallet. Effekten ansees nå å være moderat. Siden det ikke finnes alternative behandlingsformer, har bruken steget langsomt i alle de nordiske land, unntatt Norge, hvor det i 2007 var en nedgang i bruk. Forbruket er høyest i Finland og lavest i Danmark.

### *Medicines for the treatment of asthma and chronic obstructive pulmonary disease*

Table 3.7.18: Medicines for obstructive airway diseases (R03) – asthma and chronic obstructive pulmonary disease

### *Midler mot astma og kronisk obstruktiv lungesykdom*

Tabel 3.7.19: Legemidler mot obstruktiv lungesykdom (R03), dvs. astma og kronisk obstruktiv lungesygdom (KOLS), er

(COPD) – are divided into two main groups. Glucocorticoids (R03BA) are the basic treatment for management of the lower airway inflammation that is present in obstructive pulmonary diseases. The other group acts as bronchodilators, and is used especially in the treatment of acute asthma attacks, but also to prevent bronchoconstriction in asthma and COPD. This group includes beta-2-agonists (R03AC), anticholinergics (R03BB) and theophyllines (R03DA).

From 2000 to 2005 there was a steep increase in consumption of combinations of adrenergics and other drugs for obstructive airway diseases (R03AK) in all the Nordic countries. However, during the last three years, the increase has been levelling off. These agents should be used only for patients who have a constant need for both corticosteroids and bronchodilating medication. Sweden has the lowest consumption of these combinations, while the use in the other countries is relatively similar.

### *Antihistamines*

Table 3.7.19: Sales of antihistamines (R06A) vary a lot among the Nordic countries. Norway has by far the highest sales, Denmark the lowest. Both in Finland, Denmark og Norway the use of antihistamines has doubled since 1995. However, there has been a modest increase in antihistamine consumption in all the Nordic countries during the last 3 years.

inndelt i to hovedgrupper. Glucokortikoider (R03BA) er grunnbehandlingen for å kontrollere inflammasjonen som er tilstede i de nedre luftveiene ved kronisk ostruktiv lungesykdom. Den andre gruppen virker bronkieutvidende og brukes spesielt i behandling av akutte astmaanfall, men også til å forhindre bronkokonstriksjon ved astma og KOLS. Denne gruppe inkluderer beta-2-agonister (R03AC), antikolinergika (R03BB) og teofyllin (R03DA).

Fra 2000 til 2005 var det en kraftig økning i forbruket av kombinasjoner med adrenergika og andre midler ved obstruktiv lungesykdom (R03AK) i alle nordiske land. De tre siste årene har forbruket imidlertid kun vist en svak stigning. Disse midlene skal bare brukes til pasienter som har et konstant behov for både cortikosteroider og bronkieutvidende medisin. Sverige har det laveste forbruket av disse midlene, mens de andre landene ligger relativt likt.

### *Antihistaminer*

Tabell 3.7.19: Salget av antihistaminer (R06A) varierer i stor grad mellom de nordiske land. Norge har et mye høyere forbruk enn de andre landene, mens Danmark ligger lavest. Både i Finland, Danmark og Norge er forbruket doblet fra nivået i 1995. De tre siste årene har det vært en svak, men jevn økning av forbruket i alle de nordiske landene.

**Table 3.7.1 Sales of medicinal products in total, DDD/1 000 inhabitants/day by ATC-group, 2007**
Salg av legemidler i alt i DDD/1 000 innbyggere/døgn fordelt på ATC-grupper, 2007

| | *Denmark* | *Faroe Islands*[1)] | *Greenland*[1)] | *Finland* | *Åland* | *Iceland* | *Norway* | *Sweden* |
|---|---|---|---|---|---|---|---|---|
| A *Alimentary tract and metabolism* Fordøyelse og stoffskifte | 145 | 122 | 56 | 211 | 174 | 119 | 202 | 220 |
| B *Blood and blood-forming organs* Blod og bloddannende organer | 102 | 73 | 34 | 136 | 147 | 90 | 117 | 320 |
| C *Cardiovascular system* Hjerte og kretsløp | 497 | 449 | 196 | 517 | 412 | 382 | 454 | 453 |
| G *Genito-urinary system and sex hormones* Kjønnshormoner m.m. | 102 | 85 | 69 | 130 | 105 | 134 | 95 | 102 |
| H *Systemic hormonal preparations, excl. sex hormones and insulins* Hormoner til systemisk bruk | 29 | 26 | 9 | 42 | 51 | 33 | 41 | 41 |
| J *Anti-infectives for systemic use* Midler mot infeksjoner | 20 | 19 | 23 | 23 | 26 | 25 | 21 | 19 |
| L *Antineoplastic and immunomodulating agents* Antineoplastiske og im-munmodulerende midler | 11 | 7 | 9 | 13 | 16 | 11 | 13 | 11 |
| M *Musculo-skeletal system* Muskler og skjelett | 66 | 40 | 28 | 98 | 67 | 77 | 61 | 66 |
| N *Nervous system* Nervesystemet | 260 | 182 | 100 | 248 | 179 | 311 | 217 | 2571 |
| P *Antiparasitic products, insecticides and repellents* Parasitmidler, insekticider og insektmidler | 1 | 1 | 3 | 2 | 2 | 1 | 1 | 1 |
| R *Respiratory system* Åndedrettsorganer | 118 | 91 | 53 | 129 | 118 | 113 | 179 | 149 |
| S *Sensory organs* Sanseorganer | 9 | 8 | 13 | 16 | 16 | 11 | 17 | 18 |

1 2006 1 2006

*Sources:* Kilder: D: Danish Medicines Agency; FI: Chief Pharmaceutical Officer; G: The Central Pharmacy in Copenhagen County; F & Å: National Agency for Medicines; I: Ministry of Health and Social Security; N: Norwegian Intitute of Public Helath; S: National Corporation of Swedish Pharmacies

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

**Figure 3.7.1 Sales of cardiovascular drugs (ATC-group C), DDD/1 000 inhabitants/day, 2003-2007**

Salg av legemidler til hjerte og kretsløp (ATC-gruppe C), DDD/1 000 innbyggere/døgn, 2003-2007

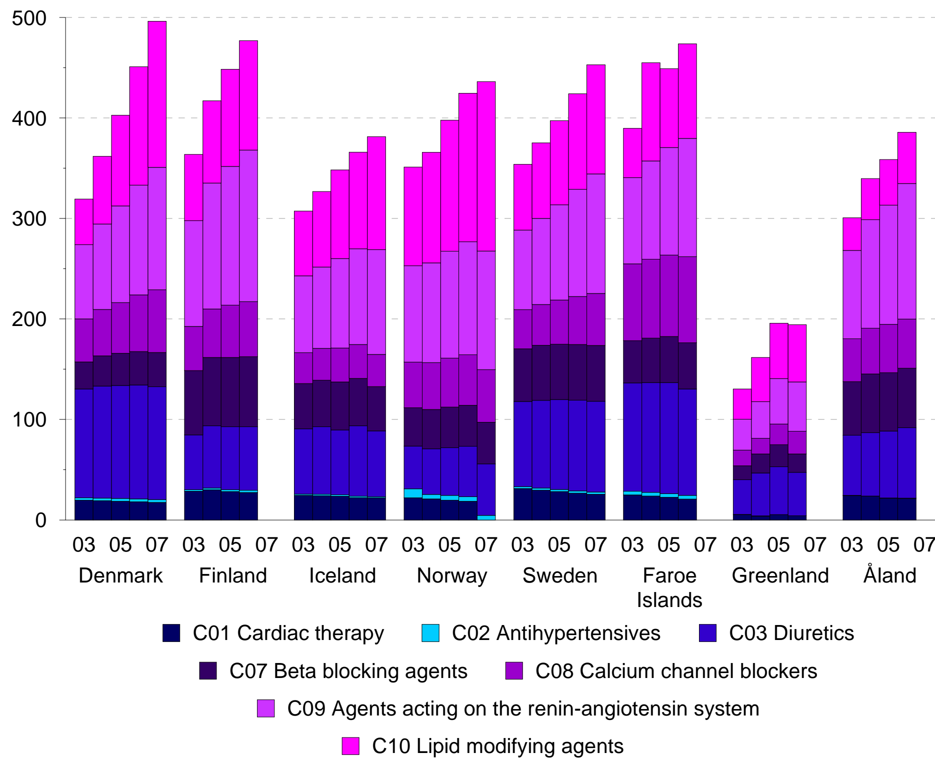


**Figure 3.7.2 Sales of antidepressants (ATC-Group N06A), DDD/1 000 inhabitants/day 2003-2007**
Salg av antidepressiver (ATC-gruppe N06A), DDD/1 000 innbyggere/døgn 2003-2007

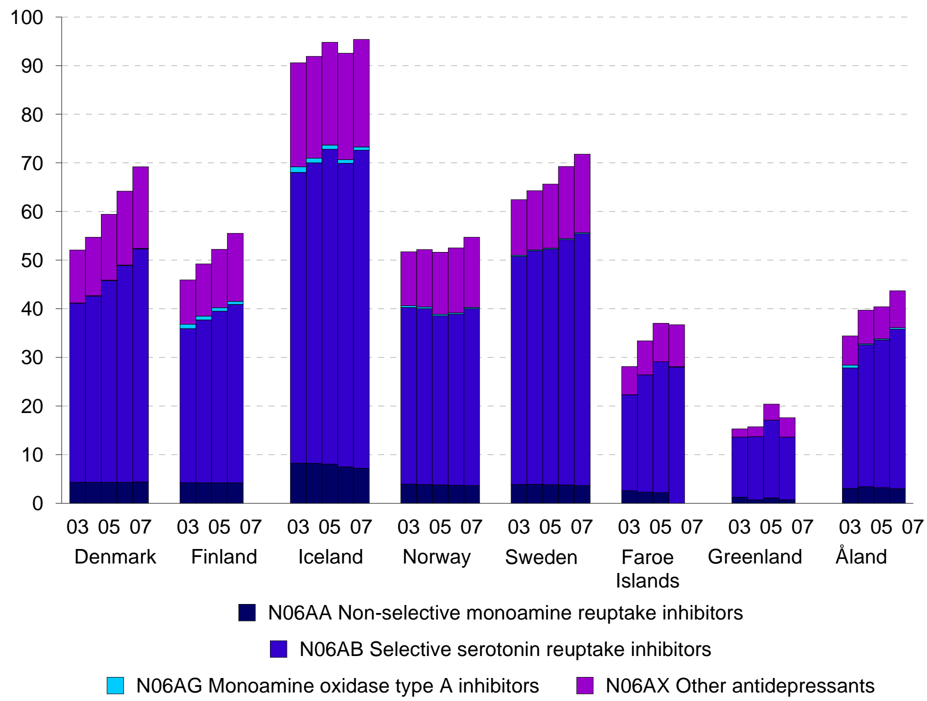


**Table 3.7.2 Sales of drugs for acid-related disorders (ATC-group A02), DDD/1 000 inhabitants/day 1995-2007**
Salg av midler mot syre-relaterte lidelser (ATC-gruppe A02), DDD/ 1 000 innbyggere/døgn 1995-2007

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| A02<br>*Drugs for acid related disorders*<br>Midler mod syre-relaterte lidelser | | | | | | | | |
| 1995 | 29.1 | 17.1 | .. | 16.2 | .. | 24.9 | 19.4 | 26.7 |
| 2000 | 28.1 | 27.4 | 14.8 | 19.7 | 22.1 | 39.0 | 24.5 | 38.4 |
| 2005 | 38.4 | 38.3 | 18.9 | 32.7 | 30.5 | 54.2 | 32.5 | 43.1 |
| 2006 | 41.7 | 40.7 | 19.8 | 36.5 | 32.1 | 56.7 | 35.2 | 45.6 |
| 2007 | 44.7 | .. | .. | 41.8 | 38.0 | 59.9 | 38.0 | 49.1 |
| A02A<br>*Antacids*<br>Syrenøytraliserende midler | | | | | | | | |
| 1995 | 8.7 | 6.6 | .. | 3.3 | .. | 2.9 | 4.9 | 4.7 |
| 2000 | 7.5 | 5.4 | 1.7 | 2.8 | 3.7 | 2.6 | 3.3 | 3.1 |
| 2005 | 7.0 | 4.2 | 2.1 | 2.8 | 2.7 | 2.4 | 2.1 | 2.6 |
| 2006 | 7.3 | 4.0 | 1.9 | 2.5 | 2.7 | 3.0 | 2.0 | 2.5 |
| 2007 | 7.0 | .. | .. | 2.5 | 2.3 | 2.3 | 1.9 | 2.3 |
| A02B<br>*Drugs for peptic ulcer and gastro-oesophageal reflux disease (GORD)*<br>Midler mot ulcus og gastroøsofageal reflukssyk-dom (GORD) | | | | | | | | |
| 1995 | 12.1 | 9.1 | .. | 9.6 | .. | 22.1 | 11.3 | 21.8 |
| 2000 | 20.6 | 22.0 | 12.3 | 17.0 | 18.5 | 36.4 | 21.2 | 35.3 |
| 2005 | 31.4 | 34.1 | 16.8 | 29.9 | 27.8 | 51.9 | 30.4 | 40.5 |
| 2006 | 34.5 | 36.7 | 17.9 | 34.1 | 29.4 | 53.7 | 33.2 | 43.2 |
| 2007 | 37.7 | .. | .. | 39.3 | 35.7 | 57.5 | 36.1 | 46.9 |
| A02BA<br>*H2-receptor antagonists*<br>H2-reseptor antagonister | | | | | | | | |
| 1995 | 7.0 | 4.5 | .. | 4.6 | .. | 14.2 | 6.7 | 7.0 |
| 2000 | 6.5 | 3.8 | 2.5 | 5.1 | 6.2 | 9.6 | 5.9 | 7.1 |
| 2005 | 6.3 | 3.4 | 0.6 | 4.1 | 4.7 | 6.6 | 5.5 | 5.2 |
| 2006 | 5.3 | 2.6 | 0.3 | 3.4 | 4.1 | 6.2 | 5.7 | 4.9 |
| 2007 | 4.2 | | | 3.9 | 5.1 | 6.4 | 5.8 | 4.4 |
| A02BC<br>*Proton pump inhibitors*<br>Protonpumpehemmere | | | | | | | | |
| 1995 | 4.8 | 4.5 | .. | 2.6 | .. | 7.6 | 4.5 | 12.5 |
| 2000 | 13.4 | 16.9 | 9.5 | 9.8 | 9.3 | 26.6 | 14.7 | 26.8 |
| 2005 | 24.6 | 29.6 | 15.9 | 24.3 | 21.4 | 45.2 | 24.5 | 34.2 |
| 2006 | 28.6 | 33.2 | 17.5 | 29.2 | 23.6 | 47.5 | 27.1 | 37.2 |
| 2007 | 33.0 | .. | .. | 1.3 | 1.9 | 51.2 | 29.8 | 41.4 |

**The table continues ...**

**Table 3.7.2 continued**

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| A02BX<br>*Other drugs for peptic ulcer and gastro-oesophageal reflux disease (GORD)*<br>Andre midler mot ulcus og gastroøsofageal reflukssyk-dom (GORD) | | | | | | | | |
| 1995 | 0.2 | 0.2 | .. | 2.3 | .. | 0.3 | 0.1 | 2.0 |
| 2000 | 0.7 | 1.3 | 0.3 | 1.9 | 2.9 | 0.1 | 0.5 | 1.3 |
| 2005 | 0.5 | 1.1 | 0.3 | 1.4 | 1.6 | 0.0 | 0.4 | 1.1 |
| 2006 | 0.5 | 1.0 | 0.1 | 1.4 | 1.7 | 0.0 | 0.4 | 1.0 |
| 2007 | 0.4 | .. | .. | 1.3 | 1.9 | 0.0 | 0.5 | 1.0 |

**Table 3.7.3 Sales of antiobesity preparations, excl. dietary products (ATC-group A08), DDD/1 000 inhabitants/day 1995-2007**
Salg av midler mot fedme (ATC-gruppe A08), DDD/1 000 innbyggere/døgn 1995-2007

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| A08<br>*Antiobesity preparations, excl. dietary products*<br>Midler mot fedme, ekskl. diettpreparater | | | | | | | | |
| 1995 | 6.2 | 2.9 | .. | 0.1 | .. | 0.0 | 0.0 | 0.0 |
| 2000 | 4.9 | 3.3 | 0.6 | 0.6 | 0.6 | 1.2 | 1.1 | 4.0 |
| 2005 | 0.6 | 0.4 | 0.0 | 0.6 | 0.3 | 1.3 | 2.6 | 2.3 |
| 2006 | 0.7 | 0.5 | 0.0 | 0.8 | 0.3 | 1.2 | 2.4 | 2.6 |
| 2007 | 1.2 | .. | .. | 1.1 | 0.4 | 1.1 | 2.8 | 3.3 |

**Table 3.7.4 Sales of drugs used in diabetes (ATC-group A10), DDD/1 000 inhabitants/day 1995-2007**

Salg av diabetesmidler (ATC-gruppe A10), DDD/1 000 innbyggere/døgn 1995-2007

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| A10 | | | | | | | | |
| *Drugs used in diabetes* | | | | | | | | |
| Midler ved diabetes | | | | | | | | |
| 1995 | 14.6 | 16.0 | .. | 30.8 | .. | 9.9 | 18.0 | 28.8 |
| 2000 | 22.0 | 23.0 | 6.1 | 42.6 | 25.3 | 15.3 | 27.0 | 37.0 |
| 2005 | 33.8 | 26.1 | 10.3 | 65.5 | 38.5 | 24.0 | 39.3 | 44.6 |
| 2006 | 36.4 | 27.3 | 10.8 | 70.4 | 42.6 | 25.8 | 42.1 | 46.1 |
| 2007 | 38.7 | .. | .. | 72.2 | 44.1 | 26.9 | 43.9 | 47.3 |
| A10A | | | | | | | | |
| *Insulins and analogues* | | | | | | | | |
| Insulin | | | | | | | | |
| 1995 | 6.7 | 5.7 | 1.1 | 11.8 | .. | 3.4 | 10.9 | 15.0 |
| 2000 | 9.4 | 8.1 | 1.8 | 15.9 | 11.8 | 5.0 | 14.3 | 19.6 |
| 2005 | 13.2 | 10.6 | 2.7 | 21.7 | 15.1 | 6.5 | 17.4 | 22.6 |
| 2006 | 14.3 | 11.9 | 2.6 | 23.2 | 16.5 | 7.7 | 17.9 | 23.5 |
| 2007 | 15.2 | .. | .. | 24.8 | 16.8 | 8.2 | 18.2 | 24.2 |
| A10B | | | | | | | | |
| *Blood glucose lowering drugs* | | | | | | | | |
| Blodglukosesenkende midler, ekskl. insuliner | | | | | | | | |
| 1995 | 7.9 | 10.3 | 1.7 | 19.0 | .. | 6.5 | 7.1 | 13.8 |
| 2000 | 12.6 | 14.8 | 4.3 | 26.7 | 13.5 | 10.3 | 12.7 | 17.5 |
| 2005 | 20.6 | 15.4 | 7.6 | 43.8 | 23.4 | 17.5 | 21.9 | 22.0 |
| 2006 | 22.2 | 15.5 | 8.2 | 47.2 | 26.1 | 18.1 | 24.2 | 22.6 |
| 2007 | 23.6 | .. | .. | 47.5 | 27.3 | 18.5 | 25.7 | 23.1 |
| A10BA | | | | | | | | |
| *Biguanides* | | | | | | | | |
| Biguanider | | | | | | | | |
| 1995 | 1.3 | 1.2 | .. | 3.1 | .. | 2.9 | 0.8 | 2.6 |
| 2000 | 2.8 | 3.1 | 1.0 | 9.3 | 4.2 | 4.7 | 3.7 | 5.5 |
| 2005 | 7.9 | 6.9 | 4.3 | 18.5 | 10.1 | 7.7 | 9.7 | 11.8 |
| 2006 | 9.2 | 7.7 | 5.3 | 20.4 | 12.4 | 8.2 | 10.7 | 12.9 |
| 2007 | 10.5 | .. | .. | 22.5 | 14.1 | 8.8 | 12.0 | 13.9 |
| A10BB | | | | | | | | |
| *Sulfonamides, urea derivatives* | | | | | | | | |
| Sulfonamider, derivater av urea | | | | | | | | |
| 1999 | 8.9 | 11.2 | 2.5 | 18.3 | 8.4 | 4.6 | 8.2 | 11.2 |
| 2000 | 9.4 | 11.7 | 3.2 | 17.4 | 9.2 | 5.4 | 8.6 | 11.2 |
| 2005 | 12.0 | 8.5 | 3.3 | 24.1 | 13.1 | 7.2 | 11.1 | 7.7 |
| 2006 | 12.1 | 7.7 | 2.9 | 23.3 | 13.2 | 6.4 | 11.7 | 6.9 |
| 2007 | 12.1 | .. | .. | 20.8 | 12.2 | 6.3 | 11.8 | 6.2 |

**The table continues ...**

**Table 3.7.4 continued**

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| A10BD *Combinations of oral blood glucose lowering drugs* Kombinasjoner av blodglukosesenkende midler til oralt bruk | | | | | | | | |
| 2005 | 0.20 | 0.00 | 0.00 | 0.83 | 0.07 | 0.48 | 0.05 | 0.20 |
| 2006 | 0.40 | 0.00 | 0.00 | 1.52 | 0.07 | 1.42 | 0.35 | 0.35 |
| 2007 | 0.50 | .. | .. | 2.01 | 0.09 | 0.66 | 0.52 | 0.43 |
| A10BG *Thiazolinediones* Tiazolindioner | | | | | | | | |
| 1999 | .. | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | .. | 0.0 |
| 2000 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | .. | 0.0 |
| 2005 | 0.1 | 0.1 | 0.0 | 1.1 | 0.1 | 1.7 | 0.8 | 1.0 |
| 2006 | 0.2 | 0.1 | 0.0 | 1.7 | 0.3 | 1.7 | 1.1 | 1.1 |
| 2007 | 0.2 | .. | .. | 1.9 | 0.7 | 1.7 | 1.1 | 1.1 |
| A10BX *Other blood glucose lowering drugs excl. insulins* Andre blodglukose-senkende midler, ekskl. insuliner | | | | | | | | |
| 1999 | 0.2 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.2 |
| 2000 | 0.3 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.5 |
| 2005 | 0.3 | 0.0 | 0.0 | 0.2 | 0.2 | 0.4 | 0.1 | 1.2 |
| 2006 | 0.3 | 0.0 | 0.0 | 0.2 | 0.2 | 0.3 | 0.1 | 1.2 |
| 2007 | 0.3 | .. | .. | 0.3 | 0.2 | 0.4 | 0.1 | 1.3 |

**Tabel 3.7.5 Sales of platelet aggregation inhibitors excl. heparin (ATC/group B01AC), DDD/1 000 inhabitans/day, 1995-2007**
Salg av blodplate-aggregations-hemmere ekskl. heparin (ATC-gruppe B01AC), DDD/1 000 innbyggere/døgn 1995-2007

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| 1995 | 40.6 | 9.5 | 0.2 | 75.6 | 39.2 | 42.2 | 45.4 | 56.0 |
| 2000 | 42.3 | 14.3 | 4.9 | 80.6 | 43.6 | 46.0 | 48.7 | 58.9 |
| 2005 | 60.6 | 46.4 | 31.8 | 110.7 | 65.1 | 60.3 | 66.5 | 74.4 |
| 2006 | 69.5 | 49.8 | 29.8 | 89.4 | 67.1 | 68.1 | 69.4 | 77.1 |
| 2007 | 73.2 | .. | .. | 101.0 | 69.6 | 61.6 | 72.9 | 78.7 |

**Table 3.7.6 Sales of drugs for cardiac therapy (ATC group C01), DDD/1 000 inhabitants/day, 1995-2007**
Salg av legemidler til hjerteterapi (ATC-gruppe C01), DDD/1 000 innbyggere/døgn 1995-2007

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| C01 | | | | | | | | |
| *Cardiac therapy* | | | | | | | | |
| Hjerteterapi | | | | | | | | |
| 1995 | 20.7 | 38.3 | .. | 45.5 | .. | 22.5 | 29.3 | 38.8 |
| 2000 | 21.1 | 34.8 | 5.4 | 35.0 | 33.0 | 22.2 | 25.9 | 35.8 |
| 2005 | 18.6 | 22.5 | 5.3 | 28.3 | 21.6 | 23.7 | 19.6 | 28.3 |
| 2006 | 18.1 | 20.7 | 4.2 | 27.3 | 21.5 | 22.3 | 18.6 | 26.7 |
| 2007 | 17.4 | .. | .. | 25.8 | 20.7 | 22.1 | 17.4 | 25.5 |
| C01A | | | | | | | | |
| *Cardiac glycosides* | | | | | | | | |
| Hjerteglykosider | | | | | | | | |
| 1995 | 9.0 | 13.2 | 2.6 | 15.7 | .. | 5.8 | 8.3 | 13.0 |
| 2000 | 7.9 | 8.8 | 3.2 | 9.7 | 10.2 | 2.0 | 5.8 | 9.3 |
| 2005 | 6.0 | 1.9 | 1.9 | 6.0 | 5.4 | 3.0 | 4.1 | 5.9 |
| 2006 | 5.7 | 1.7 | 1.3 | 5.6 | 5.0 | 2.8 | 3.9 | 5.3 |
| 2007 | 5.4 | .. | .. | 5.1 | 4.7 | 2.7 | 3.6 | 4.7 |
| C01D | | | | | | | | |
| Vasodilators used in cardiac diseases | | | | | | | | |
| Kardilaterende midler ved hjertesykdommer | | | | | | | | |
| 1995 | 10.5 | 24.1 | 1.8 | 26.3 | .. | 14.5 | 20.1 | 23.7 |
| 2000 | 11.3 | 25.1 | 1.7 | 21.9 | 18.1 | 17.5 | 18.9 | 24.4 |
| 2005 | 10.4 | 19.0 | 2.8 | 19.5 | 13.1 | 17.2 | 14.0 | 20.9 |
| 2006 | 10.2 | 17.6 | 2.4 | 18.8 | 13.0 | 16.1 | 13.1 | 20.0 |
| 2007 | 10.1 | .. | .. | 17.8 | 12.6 | 16.0 | 12.1 | 19.2 |

**Table 3.7.7 Sales of cardiovascular drugs (ATC-group C02, C03, C07, C08, C09), DDD/1 000 inhabitants/day, 1995-2007**
Salg av kardiovaskulære legemidler (ATC-gruppe C02, C03, C07, C08, C09), DDD/1 000 innbyggere/døgn 1995-2007

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| C02 | | | | | | | | |
| *Antihypertensives* | | | | | | | | |
| Antihypertensiva | | | | | | | | |
| 1995 | 1.1 | 2.4 | .. | 2.2 | .. | 0.6 | 6.4 | 0.9 |
| 2000 | 1.8 | 3.2 | 0.2 | 1.1 | 0.4 | 1.4 | 9.3 | 1.2 |
| 2005 | 2.9 | 3.7 | 0.1 | 1.9 | 0.3 | 1.4 | 4.9 | 2.1 |
| 2006 | 2.9 | 3.8 | 0.1 | 2.2 | 0.3 | 1.4 | 4.6 | 2.2 |
| 2007 | 2.9 | .. | .. | 2.4 | 0.3 | 1.1 | 4.5 | 2.3 |
| C03 | | | | | | | | |
| *Diuretics* | | | | | | | | |
| Diuretika | | | | | | | | |
| 1995 | 102.0 | 88.8 | 27.4 | 62.6 | .. | 56.8 | 41.9 | 86.5 |
| 2000 | 103.9 | 108.4 | 31.7 | 60.5 | 53.6 | 58.9 | 41.2 | 82.5 |
| 2005 | 112.4 | 110.4 | 47.5 | 62.5 | 66.5 | 64.5 | 47.4 | 89.4 |
| 2006 | 113.3 | 105.7 | 43.1 | 63.3 | 69.8 | 70.0 | 50.2 | 90.4 |
| 2007 | 112.2 | .. | .. | 62.6 | 72.2 | 65.5 | 51.3 | 90.2 |
| C03A | | | | | | | | |
| *Low-ceiling diuretics, thiazides* | | | | | | | | |
| Tiazider | | | | | | | | |
| 1995 | 36.8 | 37.6 | .. | 3.9 | .. | 7.9 | 2.9 | 9.0 |
| 2000 | 38.6 | 50.7 | 14.3 | 4.1 | 1.2 | 6.9 | 3.1 | 9.9 |
| 2005 | 48.8 | 54.8 | 29.5 | 5.6 | 4.4 | 8.8 | 9.0 | 19.4 |
| 2006 | 50.5 | 53.0 | 28.2 | 6.1 | 5.4 | 8.4 | 11.4 | 21.5 |
| 2007 | 50.1 | .. | .. | 6.3 | 7.0 | 8.3 | 13.3 | 23.1 |
| C03C | | | | | | | | |
| *High-ceiling diuretics* | | | | | | | | |
| High-ceiling -diuretika | | | | | | | | |
| 1995 | 50.5 | 40.9 | .. | 21.4 | .. | 20.5 | 29.6 | 57.4 |
| 2000 | 53.2 | 44.1 | 15.7 | 27.1 | 17.1 | 21.9 | 30.8 | 54.9 |
| 2005 | 53.3 | 40.5 | 15.9 | 33.5 | 25.9 | 21.2 | 30.1 | 50.7 |
| 2006 | 53.3 | 39.0 | 13.6 | 34.9 | 28.8 | 27.5 | 30.3 | 49.6 |
| 2007 | 52.7 | .. | .. | 35.4 | 29.0 | 23.5 | 29.9 | 48.0 |
| C03E | | | | | | | | |
| *Diuretics and potassium-sparing agents in combination* | | | | | | | | |
| Diuretika i komb. med kaliumssparende midler | | | | | | | | |
| 1995 | 10.0 | 2.1 | .. | 34.1 | .. | 26.7 | 7.3 | 10.5 |
| 2000 | 7.7 | 1.7 | 0.6 | 26.7 | 33.3 | 27.9 | 6.0 | 10.7 |
| 2005 | 5.5 | 1.0 | 0.1 | 20.7 | 33.3 | 32.6 | 6.7 | 13.5 |
| 2006 | 5.1 | 0.8 | 0.2 | 19.5 | 32.7 | 32.0 | 6.8 | 13.6 |
| 2007 | 4.9 | .. | .. | 17.9 | 33.3 | 31.6 | 6.5 | 13.6 |

**The table continues ...**

**Table 3.7.7 continued**

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| C07<br>*Beta blocking agents*<br>Beta-blokkere | | | | | | | | |
| 1995 | 15.5 | 31.2 | 7.5 | 43.3 | .. | 34.3 | 25.6 | 36.7 |
| 2000 | 20.3 | 37.1 | 11.3 | 57.2 | 45.8 | 40.2 | 33.2 | 45.0 |
| 2005 | 31.9 | 45.9 | 22.0 | 68.9 | 58.1 | 47.8 | 40.4 | 55.1 |
| 2006 | 33.2 | 46.2 | 18.4 | 69.7 | 59.2 | 47.2 | 40.7 | 55.4 |
| 2007 | 34.1 | .. | .. | 70.5 | 58.9 | 44.1 | 41.3 | 55.7 |
| C07A<br>*Beta blocking agents, plain*<br>Beta-blokkere, usammen-satte | | | | | | | | |
| 1995 | 14.3 | 30.4 | .. | 42.8 | .. | 34.3 | 25.6 | 36.0 |
| 2000 | 19.3 | 36.4 | 11.3 | 51.9 | 44.8 | 39.9 | 33.2 | 43.3 |
| 2005 | 30.4 | 45.5 | 22.0 | 59.9 | 56.6 | 47.2 | 39.7 | 53.6 |
| 2006 | 31.7 | 45.8 | 18.4 | 60.5 | 57.4 | 46.7 | 39.8 | 53.9 |
| 2007 | 32.7 | .. | .. | 61.4 | 56.9 | 43.7 | 40.2 | 54.4 |
| C08<br>*Calcium channel blockers*<br>Calciumantagonister | | | | | | | | |
| 1995 | 28.2 | 38.2 | 0.0 | 31.0 | .. | 21.3 | 33.8 | 32.5 |
| 2000 | 37.2 | 71.0 | 7.8 | 36.7 | 35.9 | 26.7 | 41.5 | 34.9 |
| 2005 | 50.4 | 81.0 | 20.5 | 52.2 | 48.1 | 33.6 | 48.9 | 44.0 |
| 2006 | 56.4 | 85.6 | 22.4 | 54.7 | 48.9 | 33.7 | 50.3 | 47.7 |
| 2007 | 62.4 | .. | .. | 58.5 | 51.7 | 31.9 | 52.6 | 51.7 |
| C08C<br>*Selective calcium channel blockers with mainly vascular effects*<br>Selektive kalsiumantago-nister med primært vasku-lær effekt | | | | | | | | |
| 1995 | 18.2 | 30.8 | .. | 17.7 | .. | 14.0 | 26.6 | 23.4 |
| 2000 | 28.8 | 65.3 | 5.9 | 28.5 | 33.3 | 20.5 | 34.9 | 28.6 |
| 2005 | 43.6 | 77.4 | 19.3 | 47.6 | 46.4 | 27.4 | 43.8 | 39.8 |
| 2006 | 49.8 | 82.4 | 21.5 | 50.4 | 47.1 | 27.8 | 45.5 | 43.9 |
| 2007 | 56.3 | .. | .. | 54.7 | 49.9 | 26.1 | 48.1 | 48.3 |
| C08D<br>*Selective calcium channel blockers with direct cardiac effects*<br>Selektive kalsiumantago-nister med direkte virkning på hjertet | | | | | | | | |
| 1995 | 10.0 | 7.5 | .. | 13.3 | .. | 7.2 | 7.2 | 9.1 |
| 2000 | 8.4 | 5.7 | 1.9 | 8.2 | 2.7 | 6.2 | 6.6 | 6.3 |
| 2005 | 6.8 | 3.6 | 1.2 | 4.6 | 1.7 | 6.2 | 5.1 | 4.1 |
| 2006 | 6.5 | 3.2 | 1.0 | 4.3 | 1.8 | 5.9 | 4.8 | 3.8 |
| 2007 | 6.2 | .. | .. | 3.9 | 1.8 | 5.9 | 4.5 | 3.5 |

**The table continues ...**

**Table 3.7.7 continued**

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| C09<br>*Agents acting on the renin-angiotensin system*<br>Midler med virkning på renin-angiotensin systemet | | | | | | | | |
| 1995 | 22.3 | 21.8 | .. | 40.6 | .. | 27.8 | 35.8 | 31.2 |
| 2000 | 45.4 | 59.2 | 19.8 | 65.7 | 55.0 | 51.4 | 65.1 | 56.2 |
| 2005 | 96.3 | 107.0 | 45.2 | 137.9 | 118.6 | 89.2 | 106.2 | 94.7 |
| 2006 | 109.2 | 117.6 | 49.1 | 150.8 | 134.8 | 95.2 | 112.3 | 106.6 |
| 2007 | 121.7 | .. | .. | 166.0 | 144.5 | 104.3 | 117.9 | 118.8 |
| C09A<br>*ACE-inhibitors, plain*<br>ACE-hemmere, usammen-satte | | | | | | | | |
| 1995 | 20.2 | 21.6 | .. | 35.6 | .. | 26.5 | 33.8 | 29.7 |
| 2000 | 29.4 | 52.5 | 19.4 | 42.8 | 46.2 | 29.6 | 35.2 | 42.3 |
| 2005 | 55.1 | 69.8 | 41.3 | 75.3 | 79.9 | 32.2 | 42.9 | 57.3 |
| 2006 | 62.0 | 72.8 | 44.6 | 78.9 | 87.6 | 31.1 | 43.4 | 63.1 |
| 2007 | 67.4 | .. | .. | 86.2 | 89 | 32.3 | 43.9 | 68.6 |
| C09B<br>*ACE-inhibitors, combinations*<br>ACE-hemmere, kombinas-joner | | | | | | | | |
| 1995 | 0.7 | 0.0 | .. | 5.0 | .. | 0.4 | 0.2 | 0.7 |
| 2000 | 1.8 | 0.1 | 0.0 | 11.6 | 1.8 | 4.2 | 6.6 | 2.1 |
| 2005 | 6.7 | 5.4 | 0.1 | 14.7 | 4.2 | 7.7 | 7.3 | 3.6 |
| 2006 | 8.4 | 8.2 | 0.1 | 14.4 | 4.3 | 8.3 | 7.1 | 4.4 |
| 2007 | 10.6 | .. | .. | 15 | 4.6 | 8.1 | 7.0 | 5.3 |
| C09C<br>*Angiotensin II antagonists*<br>Angiotensin II antagonister ekskl. kombinasjoner | | | | | | | | |
| 1995 | 1.4 | 0.1 | .. | .. | .. | 1.0 | 1.8 | 0.8 |
| 2000 | 10.6 | 5.9 | 0.5 | 8.2 | 6.0 | 12.9 | 15.6 | 9.8 |
| 2005 | 22.0 | 21.2 | 3.8 | 31.0 | 27.8 | 23.8 | 30.6 | 24.6 |
| 2006 | 24.6 | 25.3 | 4.3 | 37.5 | 35.2 | 26.1 | 33.6 | 28.5 |
| 2007 | 27.6 | .. | .. | 42.6 | 42.6 | 29.9 | 36.4 | 32.7 |
| C09D<br>*Angiotensin II antagonists, combinations*<br>Angiotensin II antagonister, kombinasjoner | | | | | | | | |
| 1995 | 0.0 | .. | .. | .. | .. | 0.0 | .. | 0.0 |
| 2000 | 3.6 | 0.7 | 0.0 | 3.1 | 1.0 | 4.7 | 7.7 | 2.0 |
| 2005 | 12.5 | 10.7 | 0.1 | 16.8 | 6.7 | 25.5 | 25.4 | 9.1 |
| 2006 | 14.1 | 11.3 | 0.1 | 20 | 7.7 | 29.7 | 28.2 | 10.6 |
| 2007 | 16.0 | .. | .. | 22.2 | 9.3 | 34.0 | 30.6 | 12.1 |

**Table 3.7.8 Sales of lipid modifying agents (ATC-group C10A), DDD/1 000 inhabitants/day, 1995-2007**
Salg av lipidmodifiserende midler (ATC-gruppe C10A), DDD/1 000 innbyggere/døgn 1995-2007

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| C10A | | | | | | | | |
| *Lipid modifying aghents* | | | | | | | | |
| Lipidmodifiserende midler | | | | | | | | |
| 1995 | 3.1 | 0.9 | .. | 5.7 | .. | 6.2 | 11.1 | 8.0 |
| 2000 | 16.2 | 19.3 | 3.2 | 32.1 | 14.1 | 34.2 | 59.6 | 36.7 |
| 2005 | 90.2 | 78.5 | 55.1 | 96.7 | 45.4 | 88.1 | 130.3 | 83.9 |
| 2006 | 117.9 | 94.1 | 57.1 | 108.9 | 51.0 | 96.2 | 147.7 | 95.2 |
| 2007 | 145.5 | .. | .. | 130.5 | 60.6 | 112.4 | 168.6 | 108.7 |
| C10AA | | | | | | | | |
| *HMG CoA reductase inhibitors (statins)* | | | | | | | | |
| HMG CoA reduktase-hemmere | | | | | | | | |
| 1995 | 2.4 | 0.8 | .. | 4.6 | .. | 6.2 | 10.8 | 5.8 |
| 2000 | 15.6 | 19.2 | 3.1 | 31.2 | 13.9 | 34.0 | 59.3 | 34.9 |
| 2005 | 89.6 | 78.0 | 55.0 | 94.9 | 44.6 | 87.3 | 129.6 | 81.6 |
| 2006 | 117.1 | 93.4 | 57 | 106.8 | 49.9 | 95.3 | 147.7 | 92.6 |
| 2007 | 144.4 | .. | .. | 128.2 | 59.1 | 111.4 | 167.3 | 105.6 |

**Table 3.7.9 Sales of oestrogens and oestrogens in combination with progestogens (ATC group G03C and G03F), DDD/1 000 inhabitants/day 1995-2007**
Salg av østrogener og kombinationer av østrogener og progestogener (ATC-gruppe G03C og G03F), DDD/1 000 innbyggere/døgn 1995-2007

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| G03C | | | | | | | | |
| *Oestrogens* | | | | | | | | |
| Østrogener | | | | | | | | |
| 1995 | 13.5 | 10.5 | .. | 23.9 | .. | 20.3 | 15.0 | .. |
| 2000 | 15.1 | 11.7 | 2.7 | 34.7 | 30.8 | 34.7 | 20.7 | 28.6 |
| 2005 | 11.3 | 10.0 | 3.8 | 29.7 | 26.7 | 23.8 | 14.6 | 16.1 |
| 2006 | 11.0 | 9.9 | 2.9 | 29.9 | 26.4 | 22.7 | 13.8 | 14.9 |
| 2007 | 10.2 | .. | .. | 28.7 | 26.7 | 21.2 | 13.3 | 14.4 |
| G03F | | | | | | | | |
| *Progestogens and oestrogens in combination* | | | | | | | | |
| Progestogener og østrogener i kombinasjon | | | | | | | | |
| 1995 | 14.8 | 9.9 | .. | 13.3 | .. | 23.4 | 19.9 | 16.8 |
| 2000 | 15.6 | 13.6 | 5.0 | 20.7 | 19.3 | 27.0 | 25.9 | 22.6 |
| 2005 | 7.0 | 8.9 | 2.0 | 15.0 | 7.1 | 10.5 | 10.2 | 7.6 |
| 2006 | 6.3 | 7.9 | 2.2 | 14.5 | 5.6 | 9.4 | 8.9 | 6.4 |
| 2007 | 5.6 | .. | .. | 13.3 | 5.1 | 8.8 | 7.9 | 5.8 |

**Table 3.7.10 Sales of drugs used in erectile dysfunction (ATC group G04BE), DDD/1 000 men/day 1999-2007**
Salg av midler mot erektil dysfunksjon (ATC-gruppe G04BE), DDD/1 000 menn/døgn 1999-2007

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| 1999 | 0.6 | 0.1 | 0.2 | 1.4 | 0.6 | 0.6 | 0.9 | 2.1 |
| 2000 | 0.7 | 0.2 | 0.2 | 1.7 | 0.8 | 1.2 | 1.1 | 2.5 |
| 2005 | 2.1 | 0.7 | 0.7 | 4.0 | 1.4 | 3.0 | 2.6 | 2,3 |
| 2006 | 2.4 | 1.5 | 1.4 | 4.7 | 1.7 | 3.3 | 2.8 | 2.4 |
| 2007 | 2.5 | .. | .. | 4.5 | 1.9 | 3.4 | 3.1 | 2.5 |

**Table 3.7.11 Sales of antibacterials for systemic use (ATC-group J01), DDD/1 000 inhabitants/day, 1995-2007**
Salg av antibakterielle midler til systemisk bruk (ATC-gruppe J01), DDD/1 000 innbyggere/døgn 1995-2007

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| J01<br>*Antibacterials for systemic use*<br>Antibakterielle midler til systemisk bruk | | | | | | | | |
| 1995 | 13.4 | 15.7 | 18.4 | 24.7 | .. | 21.9 | 17.3 | 18.8 |
| 2000 | 13.6 | 17.4 | 20.9 | 22.6 | 21.0 | 20.3 | 16.3 | 17.2 |
| 2005 | 16.2 | 18.6 | 20.4 | 21.6 | 22.1 | 23.0 | 18.2 | 16.6 |
| 2006 | 16.8 | 17.8 | 16.6 | 20.8 | 23.6 | 23.4 | 19.0 | 17.1 |
| 2007 | 17.8 | .. | .. | 21.5 | 25.4 | 23.2 | 19.6 | 17.4 |
| J01A<br>*Tetracyclines*<br>Tetracykliner | | | | | | | | |
| 1995 | 0.9 | 1.2 | 3.1 | 5.6 | .. | 5.2 | 4.1 | 3.8 |
| 2000 | 1.0 | 1.1 | 5.9 | 4.9 | 3.0 | 4.7 | 3.2 | 3.5 |
| 2005 | 1.3 | 1.3 | 3.1 | 4.2 | 3.4 | 5.4 | 3.1 | 3.5 |
| 2006 | 1.4 | 1.3 | 1.1 | 4.0 | 3.3 | 5.8 | 3.2 | 3.6 |
| 2007 | 1.5 | .. | .. | 4.2 | 3.6 | 5.0 | 3.3 | 3.7 |
| J01C<br>*Beta-lactam antibacterials, penicillins*<br>Penicilliner | | | | | | | | |
| 1995 | 7.7 | 10.5 | 10.5 | 7.0 | .. | 10.4 | 7.3 | 8.8 |
| 2000 | 8.3 | 10.7 | 9.8 | 6.1 | 8.0 | 10.3 | 7.0 | 8.0 |
| 2005 | 10.0 | 11.7 | 11.8 | 6.3 | 7.9 | 11.8 | 7.6 | 7.3 |
| 2006 | 10.4 | 11.1 | 10.1 | 6.0 | 8.9 | 11.7 | 8.0 | 7.6 |
| 2007 | 11.0 | .. | .. | 6.6 | 9.4 | 12.3 | 8.4 | 8.0 |

**The table continues ...**

**Table 3.7.11 continued**

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| J01CA<br>*Penicillins with extended spectrum*<br>Penicilliner med utvidet spektrum | | | | | | | | |
| 1995 | 2.8 | 3.3 | 4.2 | 3.4 | .. | 4.8 | 1.7 | 1.4 |
| 2000 | 2.6 | 3.0 | 3.8 | 3.2 | 4.2 | 4.2 | 2.0 | 1.4 |
| 2005 | 3.1 | 3.1 | 4.0 | 3.4 | 5.0 | 4.3 | 2.5 | 1.6 |
| 2006 | 3.3 | 2.8 | 3.7 | 3.2 | 6.5 | 4.2 | 2.7 | 1.6 |
| 2007 | 3.5 | .. | .. | 3.5 | 6.7 | 4.1 | 2.9 | 1.7 |
| J01CE<br>*Beta-lactamase sensitive penicillins*<br>Beta-lactamase følsomme penicilliner | | | | | | | | |
| 1995 | 4.6 | 6.8 | 5.7 | 3.3 | .. | 3.7 | 5.4 | 5.9 |
| 2000 | 5.0 | 6.7 | 5.5 | 2.3 | 3.3 | 3.1 | 4.7 | 5.0 |
| 2005 | 5.6 | 7.3 | 6.9 | 1.7 | 2.2 | 3.0 | 4.5 | 4.1 |
| 2006 | 5.7 | 6.9 | 5.3 | 1.7 | 2.0 | 2.7 | 4.6 | 4.3 |
| 2007 | 5.9 | .. | .. | 1.7 | 2.0 | 2.9 | 4.7 | 4.5 |
| J01CF<br>*Beta-lactamase resistant penicillins*<br>Beta-lactamase resistente penicilliner | | | | | | | | |
| 1995 | 0.3 | 0.4 | 0.6 | 0.1 | .. | 1.2 | 0.2 | 1.3 |
| 2000 | 0.7 | 0.9 | 0.5 | 0.1 | 0.2 | 1.3 | 0.4 | 1.3 |
| 2005 | 1.2 | 1.2 | 0.9 | 0.1 | 0.4 | 1.4 | 0.5 | 1.4 |
| 2006 | 1.2 | 1.2 | 1.1 | 0.1 | 0.3 | 1.4 | 0.6 | 1.5 |
| 2007 | 1.3 | .. | .. | 0.1 | 0.2 | 1.5 | 0.7 | 1.5 |
| J01CR<br>*Combinations of penicillins, incl. beta-lactamase inhibitors*<br>Komb. av penicilliner, inkl. bata-lactamase hemmere | | | | | | | | |
| 1995 | 0.0 | 0.0 | .. | 0.2 | .. | 0.7 | 0.0 | 0.2 |
| 2000 | 0.0 | 0.1 | 0.0 | 0.5 | 0.3 | 1.8 | 0.0 | 0.2 |
| 2005 | 0.1 | 0.1 | 0.0 | 1.1 | 0.4 | 3.2 | 0.0 | 0.2 |
| 2006 | 0.1 | 0.2 | 0.0 | 1.0 | 0.3 | 3.3 | 0.0 | 0.3 |
| 2007 | 0.3 | .. | .. | 1.2 | 0.5 | 3.9 | 0.0 | 0.3 |
| J01D<br>*Other beta-lactam antibacterials, cephalosporins, monobacts and carbapenems*<br>Andre beta-laktamantibak-terielle midler: cefalosporiner, monobaktamer og carbap-enemer | | | | | | | | |
| 1995 | 0.0 | 0.2 | .. | 3.5 | .. | 0.5 | 0.5 | 1.1 |
| 2000 | 0.2 | 0.3 | 0.1 | 3.0 | 1.6 | 0.6 | 0.5 | 0.8 |
| 2005 | 0.3 | 0.5 | 0.2 | 3.1 | 1.7 | 0.5 | 0.6 | 0.7 |
| 2006 | 0.3 | 0.4 | 0.1 | 3.2 | 2.0 | 0.5 | 0.6 | 0.7 |
| 2007 | 0.3 | .. | .. | 3.3 | 2.2 | 0.5 | 0.6 | 0.6 |

**The table continues ...**

**Table 3.7.11 continued**

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| J01E<br>*Sulfanamides and trimethoprim*<br>Sulfonamider og trimetoprim | | | | | | | | |
| 1995 | 0.8 | 1.4 | .. | 2.9 | .. | 2.7 | 1.8 | 0.9 |
| 2000 | 0.8 | 1.2 | 0.6 | 2.3 | 1.4 | 2.2 | 1.2 | 0.8 |
| 2005 | 0.9 | 1.0 | 0.6 | 1.9 | 1.0 | 1.9 | 1.1 | 0.8 |
| 2006 | 0.9 | 1.1 | 0.7 | 1.8 | 0.9 | 1.8 | 1.0 | 0.8 |
| 2007 | 0.8 | .. | .. | 1.8 | 0.8 | 1.7 | 1.0 | 0.7 |
| J01F<br>*Macrolides, lincos-amides and streptogramins*<br>Makrolider, lincosamider og streptograminer | | | | | | | | |
| 1995 | 2.1 | 2.1 | 2.2 | 2.0 | .. | 1.6 | 1.6 | 1.4 |
| 2000 | 2.1 | 2.8 | 3.8 | 2.3 | 0.8 | 1.6 | 1.6 | 1.0 |
| 2005 | 2.5 | 2.5 | 3.6 | 2.1 | 1.1 | 1.8 | 2.1 | 0.9 |
| 2006 | 2.5 | 2.4 | 3.2 | 1.8 | 1.3 | 1.9 | 2.2 | 1.0 |
| 2007 | 2.6 | .. | .. | 1.8 | .. | 1.9 | 2.3 | 1.0 |
| J01M<br>*Quinolone antibacterials*<br>Quinoloner | | | | | | | | |
| 1995 | 0.3 | 0.1 | .. | 0.9 | .. | 0.4 | 0.3 | 1.5 |
| 2000 | 0.2 | 0.1 | 0.1 | 1.0 | 1.1 | 0.6 | 0.3 | 1.2 |
| 2005 | 0.5 | 0.3 | 0.2 | 1.3 | 1.1 | 0.8 | 0.6 | 1.2 |
| 2006 | 0.6 | 0.3 | 0.3 | 1.2 | 1.2 | 0.9 | 0.6 | 1.2 |
| 2007 | 0.6 | .. | .. | 1.3 | 1.3 | 0.9 | 0.7 | 1.1 |
| J01X<br>*Other antibacterials*<br>Andre antibakterielle midler | | | | | | | | |
| 1999 | 0.9 | 1.2 | 0.6 | 2.8 | 4.9 | 1.0 | 2.3 | 1.8 |
| 2000 | 0.9 | 1.1 | 0.5 | 3.0 | 4.9 | 0.3 | 2.4 | 1.8 |
| 2005 | 0.9 | 1.3 | 0.8 | 2.8 | 5.9 | 0.7 | 3.0 | 2.2 |
| 2006 | 0.9 | 1.2 | 0.9 | 2.8 | 5.9 | 0.7 | 3.2 | 2.2 |
| 2007 | 0.9 | .. | .. | 2.6 | 7.0 | 0.8 | 3.3 | 2.2 |

**Table 3.7.12 Sales of non-steroid anti-inflammatory and antirheumatic products (NSAID) and other analgesics (ATC-group, M01A, N02A and N02B) DDD/1 000 inhabitants/day, 1995-2007**

Salg av NSAID og andre smertestillende midler (ATC-gruppe, M01A, N02A og N02B), DDD/1 000 innbyggere/døgn 1995-2007

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| M01A<br>*Anti-inflammatory and antirheumatic products, non-steroids*<br>NSAID | | | | | | | | |
| 1995 | 29.7 | 28.8 | 17.1 | 52.7 | .. | 36.7 | 24.6 | 33.6 |
| 2000 | 31.0 | 22.3 | 15.4 | 60.6 | 45.5 | 51.3 | 33.8 | 40.9 |
| 2005 | 53.2 | 32.2 | 24.0 | 76.7 | 55.8 | 68.0 | 43.9 | 51.4 |
| 2006 | 52.0 | 27.9 | 22.3 | 68.2 | 52.8 | 69.0 | 45.3 | 51.7 |
| 2007 | 50.6 | .. | .. | 76.4 | 54.2 | 65.9 | 46.4 | 53.4 |
| M01AH<br>*Coxibs*<br>Coxibs | | | | | | | | |
| 1999 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | .. | 0.3 |
| 2000 | 1.6 | 0.6 | 0.0 | 0.7 | 0.3 | 4.0 | 1.8 | 4.1 |
| 2005 | 0.6 | 1.5 | 0.0 | 6.3 | 2.0 | 4.0 | 3.8 | 2.0 |
| 2006 | 0.3 | 0.7 | 0.0 | 6.1 | 1.6 | 3.9 | 1.4 | 1.7 |
| 2007 | 0.3 | .. | .. | 6.7 | 1.5 | 4.8 | 1.5 | 2.0 |
| N02A<br>Opioids<br>Sterke smertestillende midler (opioider) | | | | | | | | |
| 1995 | 9.6 | 3.2 | .. | 5.7 | .. | 6.9 | 14.6 | 26.9 |
| 2000 | 14.9 | 3.9 | 2.7 | 10.4 | 6.6 | 14.8 | 16.7 | 26.4 |
| 2005 | 18.5 | 6.9 | 4.5 | 15.4 | 9.2 | 17.4 | 19.5 | 20.8 |
| 2006 | 19.2 | 6.7 | 4.0 | 14.6 | 8.3 | 17.6 | 19.8 | 20.4 |
| 2007 | 19.6 | .. | .. | 16.1 | 8.5 | 19.7 | 19.9 | 20.2 |
| N02B<br>*Other analgesics*<br>Andre smertestillende midler | | | | | | | | |
| 1995 | 61.7 | 38.7 | 30.7 | 18.7 | .. | 31.5 | 25.6 | 43.0 |
| 2000 | 69.1 | 44.0 | 37.5 | 13.3 | 27.9 | 29.2 | 26.4 | 45.5 |
| 2005 | 71.6 | 55.8 | 44.3 | 20.6 | 36.3 | 30.9 | 29.5 | 49.5 |
| 2006 | 72.4 | 55.9 | 32.8 | 19.3 | 34.7 | 29.9 | 30.9 | 51.1 |
| 2007 | 73.1 | .. | .. | 23.2 | 39.9 | 32.1 | 32.5 | 51.9 |
| N02BA<br>Salicylic acid and derivatives<br>Salicylsyre-derivater | | | | | | | | |
| 1995 | 22.0 | 20.9 | .. | 14.6 | .. | 9.2 | 3.2 | 16.3 |
| 2000 | 18.0 | 19.5 | 9.9 | 7.3 | 12.4 | 4.4 | 1.3 | 12.5 |
| 2005 | 13.4 | 14.5 | 7.4 | 5.5 | 9.9 | 3.5 | 0.5 | 9.8 |
| 2006 | 12.4 | 13.4 | 0.3 | 4.2 | 7.7 | 3.5 | 0.5 | 9.6 |
| 2007 | 11.7 | .. | .. | 5.0 | 8.5 | 3.5 | 0.4 | 9.3 |

*The table continues ...*

**Table 3.7.12 continued**

| | Denmark | Faroe Islans | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| N02BB | | | | | | | | |
| *Pyrazolones* | | | | | | | | |
| Pyrazoloner | | | | | | | | |
| 1995 | 2.6 | 0.3 | .. | 0.4 | .. | 0.7 | 5.9 | 0.3 |
| 2000 | 1.8 | 0.1 | 0.0 | 0.0 | 0.0 | 0.4 | 4.2 | 0.1 |
| 2005 | 0.8 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 3.2 | 0.1 |
| 2006 | 0.6 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 3.0 | 0.1 |
| 2007 | 0.6 | .. | .. | .. | .. | 0.0 | 2.8 | 0.1 |
| N02BE | | | | | | | | |
| *Anilides* | | | | | | | | |
| Anilider | | | | | | | | |
| 1995 | 37.1 | 17.4 | .. | 3.4 | .. | 21.6 | 16.5 | 26.4 |
| 2000 | 49.4 | 24.3 | 27.5 | 6.0 | 15.5 | 24.4 | 20.8 | 32.8 |
| 2005 | 57.4 | 41.2 | 36.9 | 15.1 | 26.4 | 27.4 | 25.8 | 39.7 |
| 2006 | 59.3 | 42.4 | 32.5 | 15.1 | 27 | 26.4 | 27.5 | 41.4 |
| 2007 | 60.8 | .. | .. | 18.3 | 31.4 | 28.6 | 29.3 | 42.5 |

**Table 3.7.13 Sales of antipsychotics (ATC-group N05A), DDD/1 000 inhabitants/day, 1995-2007**
Salg av antipsykotiske midler (ATC-gruppe N05A), DDD/1 000 innbyggere/døgn 1995-2007

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| 1995 | 6.6 | 7.7 | 9.4 | 15.2 | .. | 8.4 | 8.7 | 8.8 |
| 2000 | 10.0 | 8.5 | 11.8 | 15.3 | 8.7 | 9.5 | 9.0 | 8.6 |
| 2005 | 13.0 | 10.6 | 14.6 | 17.4 | 9.3 | 11.5 | 10.6 | 9.2 |
| 2006 | 13.0 | 12.0 | 12.8 | 18.7 | 9.0 | 11.5 | 10.8 | 9.6 |
| 2007 | 13.1 | .. | .. | 19.1 | 9.0 | 11.5 | 11.0 | 9.4 |

**Table 3.7.14 Sales of anxiolytics (ATC-group N05B), DDD/1 000 inhabitants/day, 1995-2007**
Salg av angstdempende midler (ATC-gruppe N05B), DDD/1 000 innbyggere/døgn 1995-2007

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| N05B | | | | | | | | |
| *Anxiolytics* | | | | | | | | |
| Angstdempende midler | | | | | | | | |
| 1995 | 26.6 | 19.6 | 5.2 | 28.9 | .. | 23.0 | 18.9 | 17.2 |
| 2000 | 22.8 | 16.2 | 5.1 | 30.1 | 10.6 | 24.6 | 19.0 | 17.1 |
| 2005 | 19.7 | 16.0 | 5.3 | 31.2 | 9.9 | 25.8 | 21.3 | 16.4 |
| 2006 | 18.3 | 14.2 | 3.7 | 30.9 | 9.6 | 25.0 | 21.0 | 16.4 |
| 2007 | 17.2 | .. | .. | 30.9 | 10.7 | 25.8 | 20.9 | 16.5 |
| N05BA | | | | | | | | |
| *Benzodiazepine derivatives* | | | | | | | | |
| Benzodiazepin-derivater | | | | | | | | |
| 1995 | 26.5 | .. | .. | 27.5 | .. | 22.4 | 18.3 | 15.1 |
| 2000 | 22.5 | 16.1 | 5.1 | 28.3 | 8.9 | 23.6 | 18.0 | 14.9 |
| 2005 | 19.4 | 15.8 | 5.3 | 29.5 | 8.0 | 24.6 | 20.1 | 13.6 |
| 2006 | 18.1 | 14.0 | 3.6 | 29.1 | 7.8 | 23.8 | 19.7 | 13.5 |
| 2007 | 17.0 | .. | .. | 29.1 | 8.9 | 24.6 | 19.4 | 13.4 |

**Table 3.7.15 Sales of hypnotics and sedatives (ATC-group N05C). DDD/1 000 inhabitants/day. 1995-2007**
Salg av sovemidler og beroligende midler (ATC-gruppe N05). DDD/1 000 innbyggere/døgn 1995-2007

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| N05C<br>*Hypnotics and sedatives*<br>Sovemidler og beroligende midler | | | | | | | | |
| 1995 | 44.4 | 43.1 | 5.1 | 39.5 | .. | 41.2 | 25.9 | 40.7 |
| 2000 | 32.5 | 33.3 | 5.4 | 49.0 | 35.2 | 55.4 | 31.8 | 47.2 |
| 2005 | 31.2 | 31.0 | 8.8 | 54.4 | 34.2 | 66.7 | 41.4 | 51.6 |
| 2006 | 30.0 | 28.2 | 6.8 | 53.8 | 34.5 | 68.3 | 42.6 | 52.1 |
| 2007 | 28.5 | .. | .. | 53.8 | 34.9 | 70.5 | 43.9 | 53.0 |
| N05CD<br>*Benzodiazepine derivatives*<br>Benzodiazepin-derivater | | | | | | | | |
| 1995 | 32.6 | .. | .. | 20.1 | .. | 38.3 | 21.7 | 22.8 |
| 2000 | 15.6 | 13.3 | 0.9 | 21.0 | 7.0 | 28.8 | 13.6 | 13.3 |
| 2005 | 10.5 | 7.1 | 0.5 | 20.9 | 4.3 | 12.1 | 8.5 | 6.7 |
| 2006 | 9.4 | 6.3 | 0.4 | 20.3 | 4.1 | 11.2 | 7.9 | 6.0 |
| 2007 | 8.3 | .. | .. | 19.5 | 4.0 | 10.4 | 7.5 | 5.5 |
| N05CF<br>*Benzodiazepine related drugs*<br>Benzodiapine lignende midler | | | | | | | | |
| 1995 | 11.9 | .. | .. | 17.7 | .. | 2.3 | 4.2 | 7.1 |
| 2000 | 16.8 | 20.0 | 4.5 | 27.4 | 27.2 | 26.5 | 18.1 | 21.6 |
| 2005 | 20.7 | 23.8 | 8.3 | 33.1 | 29.3 | 54.5 | 32.8 | 30.4 |
| 2006 | 20.7 | 21.9 | 6.4 | 33.3 | 30.1 | 56.9 | 34.4 | 31.5 |
| 2007 | 20.2 | .. | .. | 34.2 | 30.9 | 59.9 | 36.3 | 32.3 |

**Table 3.7.16 Sales of antidepressants (ATC-group N06A). DDD/1 000 inhabitants/day. 1995-2007**
Salg av antidepressive midler (ATC-gruppe N06A). DDD/1 000 innbyggere/døgn 1995-2007

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| N06A<br>*Antidepressants*<br>Antidepressive midler | | | | | | | | |
| 1995 | 18.3 | 10.6 | 3.9 | 20.3 | .. | 33.0 | 22.5 | 27.8 |
| 2000 | 34.7 | 18.2 | 10.1 | 35.5 | 23.8 | 70.5 | 41.0 | 48.8 |
| 2005 | 59.5 | 37.1 | 20.4 | 52.1 | 40.4 | 94.8 | 51.6 | 65.7 |
| 2006 | 64.3 | .. | 17.7 | 55.5 | 43.7 | 92.6 | 52.5 | 69.3 |
| 2007 | 69.3 | .. | .. | 61.1 | 46.3 | 95.4 | 54.7 | 71.8 |

**The table continues ...**

**Table 3.7.16 continued**

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| N06AA<br>*Non-selective monoamine reuptake inhibitors*<br>Ikke-seltektive monoamin reopptakshemmere | | | | | | | | |
| 1995 | 5.3 | 4.1 | .. | 5.0 | .. | 9.7 | 6.3 | 5.4 |
| 2000 | 4.6 | 2.8 | 1.6 | 4.4 | 3.4 | 8.6 | 4.5 | 4.0 |
| 2005 | 4.3 | 2.2 | 1.1 | 4.2 | 3.2 | 8.1 | 3.8 | 3.8 |
| 2006 | 4.3 | .. | 0.7 | 4.2 | 3.0 | 7.5 | 3.7 | 3.8 |
| 2007 | 4.4 | .. | .. | 4.2 | 3.1 | 7.2 | 3.7 | 3.7 |
| N06AB<br>*Selective serotonin reuptake inhibitors*<br>Selektive serotonin reopptakshemmere | | | | | | | | |
| 1995 | 11.9 | 5.7 | .. | 12.1 | .. | 18.9 | 11.2 | 21.0 |
| 2000 | 23.9 | 12.1 | 8.2 | 24.2 | 16.8 | 49.2 | 29.9 | 37.1 |
| 2005 | 41.5 | 26.9 | 16.0 | 35.3 | 30.4 | 64.8 | 34.8 | 48.4 |
| 2006 | 44.6 | 28.0 | 12.9 | 36.7 | 32.8 | 62.5 | 35.2 | 50.5 |
| 2007 | 47.9 | .. | .. | 40.3 | 35.1 | 65.4 | 36.4 | 51.8 |
| N06AG<br>*Monoamine oxidase type A inhibitors*<br>MAO-hemmere, type A | | | | | | | | |
| 1995 | 0.3 | 0.1 | .. | 1.6 | .. | 2.0 | 1.9 | 0.7 |
| 2000 | 0.1 | 0.0 | 0.0 | 1.3 | 0.3 | 2.0 | 0.6 | 0.4 |
| 2005 | 0.1 | 0.0 | 0.0 | 0.7 | 0.2 | 0.8 | 0.3 | 0.2 |
| 2006 | 0.1 | 0.1 | 0.0 | 0.6 | 0.3 | 0.7 | 0.3 | 0.2 |
| 2007 | 0.1 | .. | .. | 0.6 | 0.2 | 0.7 | 0.2 | 0.2 |
| N06AX<br>*Other antidepressants*<br>Andre antidepressiver | | | | | | | | |
| 1995 | 0.6 | 0.6 | .. | 0.2 | .. | 2.4 | 3.0 | 0.7 |
| 2000 | 6.0 | 3.3 | 0.4 | 5.6 | 3.3 | 10.7 | 6.1 | 7.3 |
| 2005 | 13.5 | 7.9 | 3.3 | 12.0 | 6.6 | 21.2 | 12.8 | 13.1 |
| 2006 | 15.3 | 8.6 | 4.0 | 14.0 | 7.6 | 21.9 | 13.3 | 14.8 |
| 2007 | 16.8 | .. | .. | 16.0 | 6.0 | 22.1 | 14.4 | 16.2 |

**Table 3.7.17 Sales of anti-dementia drugs (ATC-group N06D). DDD/1 000 inhabitants/day. 1999-2007**
Salg av midler mot demens (ATC-gruppe N06D). DDD/1 000 innbyggere/dag. 1999-2007

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| 1999 | 0.30 | 0.15 | 0.02 | 0.63 | 0.41 | 0.95 | 0.34 | 0.86 |
| 2000 | 0.46 | 0.32 | 0.01 | 1.12 | 0.42 | 1.37 | 0.73 | 1.20 |
| 2005 | 2.00 | 1.12 | 0.10 | 6.50 | 2.50 | 2.75 | 3.10 | 3.02 |
| 2006 | 2.20 | 1.35 | 0.10 | 7.80 | 3.10 | 2.74 | 3.26 | 3.18 |
| 2007 | 2.30 | .. | .. | 9.00 | 3.80 | 2.78 | 2.99 | 3.33 |

**Table 3.7.18 Sales of drugs for obstructive airway diseases (ATC-group R03). DDD/1 000 inhabitants/day. 1995-2007**
Salg av midler ved obstruktiv lungesykdom (ATC-gruppe R03). DDD/1 000 innbyggere/døgn 1995-2007

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| R03<br>*Drugs for obstructive airway diseases*<br>Midler ved obstruktiv lungesykdom | | | | | | | | |
| 1995 | 59.2 | 27.1 | .. | 42.9 | .. | 43.8 | 57.2 | 64.7 |
| 2000 | 64.0 | 35.9 | 31.7 | 49.9 | 47.9 | 48.2 | 62.1 | 56.4 |
| 2005 | 60.5 | 38.6 | 37.4 | 51.8 | 50.6 | 45.0 | 61.0 | 50.4 |
| 2006 | 60.5 | 37.7 | 29.7 | 54.0 | 51.5 | 43.5 | 61.4 | 50.2 |
| 2007 | 60.2 | .. | .. | 54.4 | 51.5 | 43.9 | 61.0 | 49.1 |
| R03A<br>*Adrenergics. inhalants*<br>Adrenergika til inhalasjon | | | | | | | | |
| 1995 | 28.3 | .. | .. | 15.6 | .. | 20.4 | 26.2 | 29.4 |
| 2000 | 32.8 | 18.3 | 16.8 | 20.2 | 19.3 | 22.1 | 30.7 | 25.6 |
| 2005 | 35.9 | 21.7 | 17.6 | 28.4 | 28.7 | 31.2 | 36.5 | 27.4 |
| 2006 | 36.6 | 20.5 | 14.2 | 29.8 | 31.3 | 30.5 | 36.5 | 27.5 |
| 2007 | 36.5 | .. | .. | 29.8 | 32,3 | 31.5 | 36.0 | 26.8 |
| R03AC<br>*Selective beta-2-adrenoceptor agonists*<br>Selektive beta-2-agonister | | | | | | | | |
| 1995 | 27.2 | 14.4 | 10.0 | 15.6 | .. | 20.4 | 26.2 | 29.2 |
| 2000 | 25.0 | 18.3 | 16.7 | 15.3 | 14.1 | 20.6 | 24.9 | 22.7 |
| 2005 | 21.5 | 18.5 | 17.1 | 11.3 | 9.4 | 13.2 | 18.0 | 16.5 |
| 2006 | 20.9 | 16.8 | 13.5 | 11.6 | 9.3 | 12.5 | 17.6 | 15.9 |
| 2007 | 20.3 | .. | .. | 11.1 | 8.2 | 12.2 | 17.8 | 14.5 |
| R03AK<br>*Adrenergics and other drugs for obstructive airway diseases*<br>Adrenergika og andre midler ved obstruktiv lungesykdom | | | | | | | | |
| 1995 | 2.2 | .. | .. | 0.8 | .. | 0.0 | .. | 0.0 |
| 2000 | 7.8 | 0.1 | 0.2 | 4.9 | 5.2 | 1.5 | 5.8 | 2.8 |
| 2005 | 14.4 | 3.2 | 0.5 | 17.1 | 19.3 | 18.0 | 18.6 | 10.9 |
| 2006 | 15.6 | 3.7 | 0.7 | 18.2 | 22.0 | 18.0 | 18.9 | 11.6 |
| 2007 | 16.2 | .. | .. | 18.7 | 24.1 | 19.3 | 18.3 | 12.3 |
| R03B<br>Other drugs for obstructive airway diseases. inhalants<br>Andre midler ved obstruktiv lungesykdom, til inhalasjon | | | | | | | | |
| 1995 | 19.6 | 8.3 | 5.8 | 20.7 | .. | 18.6 | 23.6 | 29.1 |
| 2000 | 22.7 | 15.4 | 11.7 | 23.7 | 21.1 | 22.3 | 26.2 | 25.9 |
| 2005 | 19.9 | 15.8 | 18.0 | 17.2 | 16.4 | 11.3 | 18.5 | 19.6 |
| 2006 | 19.7 | 16.2 | 13.8 | 17.5 | 15.1 | 10.6 | 18.9 | 19.4 |
| 2007 | 19.7 | .. | .. | 17.7 | 14.2 | 10.2 | 18.9 | 19.1 |

**The table continues ...**

**Table 3.7.18 continued**

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| R03C *Adrenergics for systemic use* Adrenergika, midler til systemisk bruk | | | | | | | | |
| 1995 | 5.2 | 1.6 | .. | 0.9 | .. | 0.6 | 2.1 | 2.5 |
| 2000 | 3.1 | 0.8 | 1.2 | 0.6 | 0.8 | 0.2 | 0.8 | 1.3 |
| 2005 | 1.5 | 0.6 | 0.9 | 0.3 | 0.4 | 0.1 | 0.5 | 0.7 |
| 2006 | 1.3 | 0.5 | 0.5 | 0.3 | 0.3 | 0.1 | 0.5 | 0.6 |
| 2007 | 1.0 | .. | .. | 0.2 | 0.3 | 0.1 | 0.5 | 0.6 |
| R03D *Other systemic drugs for obstructive airway diseases* Andre systemiske midler ved obstruktiv lungesykdom | | | | | | | | |
| 1995 | 7.3 | 2.7 | .. | 5.7 | .. | 4.3 | 5.3 | 3.8 |
| 2000 | 5.3 | 1.3 | 2.0 | 5.5 | 6.8 | 3.6 | 4.4 | 3.7 |
| 2005 | 3.1 | 0.5 | 1.0 | 5.9 | 5.2 | 2.4 | 5.4 | 2.7 |
| 2006 | 3.0 | 0.5 | 1.3 | 6.4 | 4.8 | 2.2 | 5.6 | 2.7 |
| 2007 | 2.9 | .. | .. | 6.7 | 4.7 | 2.2 | 5.6 | 2.7 |

**Table 3.7.19 Sales of antihistamines for systemic use (ATC-group R06A). DDD/1 000 inhabitants/day. 1995-2007**

Salg av antihistaminer til systemisk bruk (ATC-gruppe R06A). DDD/1 000 innbyggere/døgn 1995-2007

| | Denmark | Faroe Islands | Greenland | Finland | Aland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| 1995 | 10.7 | 10.9 | .. | 12.5 | .. | 19.4 | 32.9 | 20.3 |
| 2000 | 14.1 | 13.8 | 2.8 | 21.0 | 21.9 | 24.9 | 39.3 | 25.5 |
| 2005 | 20.1 | 19.5 | 7.5 | 27.7 | 23.5 | 30.0 | 54.8 | 30.8 |
| 2006 | 22.2 | 21.1 | 7.4 | 31.6 | 27.3 | 30.4 | 57.2 | 33.1 |
| 2007 | 23.7 | .. | .. | 33.8 | 27.6 | 33.3 | 59.7 | 34.4 |

## CHAPTER IV

# Mortality and causes of death
# *Dødelighed og dødsårsager*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## Extra material / Supplerende materiale

European short list for causes of death — Den forkortede europæiske dødsårsagsliste

Data from the European short list for causes of death — Data fra den europæiske forkortede dødsårsagsliste

EUROSTAT:

www.eurostat.eu

## *The International Classification of Diseases (ICD)*

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

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

## *Den internationale sygdomsklassifikation (ICD)*

Den internationale sygdomsklassifikation (ICD), som udarbejdes af Verdenssundhedsorganisationen (WHO), har som sin vigtigste anvendelse at være instrument for statistiske beskrivelser af sygelighed og dødelighed. Det er et system som på meningsfuld måde grupperer sygdomme og dødsårsager, så der kan gives overskuelige statistiske opstillinger og analyser, som for eksempel sammenligninger mellem forskellige lande over en tidsperiode. ICD´s historie er over 100 år, og klassifikationen er blevet revideret ca. hvert tiende år for at den kan afspejle den medicinske udvikling. Den seneste, tiende revision (ICD-10) blev godkendt af WHO i 1990, men blev først taget i brug i de fleste lande adskillige år senere. I de nordiske lande blev ICD-10 taget i brug til dødsårsagsregistrering i 1994 i Danmark, i Finland, Island og Norge i 1996, og i Sverige i 1997. Der foretages en fortløbende revision af ICD-10, via WHO´s opdateringsprocedurer, og en revideret version af ICD-10 blev udgivet i 2004.

Revision af klassifikationen vanskeliggør statistiske sammenligninger over tid mellem lande, når de på samme tid anvender forskellige versioner af ICD. Det er derfor vigtigt at forsøge at forstå hvilke fejlkilder et klassifikationsskifte kan medføre for analysen af morbiditets- og mortalitetsstatistikken samt hvorledes problemet kan håndteres. Det seneste klassifikationsskifte har frem for alt medført en større detaljeringsgrad i ICD. Der er medtaget et stort antal nye diagnoser som følge af den medicinske udvikling. Samtidig er enkelte sygdomme og sygdomsgrupperinger flyttet til andre kapitler for at det bedre kan afspejle det medicinske vidensniveau.

### *Sources of error*

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

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

It is commonly believed that a direct translation of codes in different versions of ICD can solve the problem of changes in classification. However, this is not so

### *Fejlkilder*

Statistiske analyser foretages på et aggregeret niveau. Dette niveau kan være kapitelinddelingen i ICD-10, som i alt består af 21 kapitler. Grundstrukturen i ICD er dog i det store og hele blevet bevaret uforandret igennem de forskellige revisioner og de fleste kapitler har beholdt det samme navn. Det er imidlertid vigtigt at indse, at selvom et kapitel hedder det samme i ICD-10 som i ICD-9, kan der findes forskelle ved at diagnoser er flyttet fra et kapitel til et andet. Et eksempel i nogle lande er HIV og AIDS som præliminært blev placeret blandt immunsygdommene i ICD-9 men blev placeret under infektionssygdomme i ICD-10. Et andet eksempel er flytningen af cerebral transitorisk 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. Inden for dødsårsagsstatistikken er for eksempel visse regler for valg af den underliggende dødsårsag blevet ændret, hvilket for eksempel kan påvirke frekvensen af pneumoni som dødsårsag. Ved siden af de internationale regelændringer kan de nationale tilpasninger ændres i forbindelse med et klassifikationsskifte, hvilket både påvirker sammenligningerne over tid i det samme land og sammenligninger mellem flere lande.

Det er ikke usædvanligt at tro, at en automatisk oversættelse af koderne i forskellige ICD versioner kan løse problemerne ved et klassifikationsskifte. Dette er imidlertid ikke

simple. A direct, unambiguous translation is possible only for about one third of the codes in ICD-9 and ICD-10. Instead, an attempt must be made to make the aggregated groups of codes used for statistical presentations as comparable as possible, so as to eliminate some of the effects of the changes in classification. The so-called short lists used in this publication for mortality statistics have been defined both according to ICD-9 and ICD-10 with comparability in mind.

en nemt fremkommelig vej. Kun for en tredjedel af koderne i ICD-9 og ICD-10 er der en direkte og entydig oversættelse mellem koderne. I stedet for bør man stræbe efter, at de aggregerede grupper man anvender til statistiske sammenligninger konstrueres så det er muligt at eliminere nogle af de problemer, klassifikationsændringerne har skabt. De såkaldte kortlister som anvendes i denne publikation for mortalitet er defineret både i relation til ICD-9 og ICD-10 ud fra tanken om sammenlignelighed.

### *Change in classification*

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

### *Klassifikationsskifte*

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 siden hen sammenligner de statistiske grupperinger baseret på de to kodninger, giver en opfattelse af hvor meget en vis sygdomsgruppe (eksempelvis ICD-kapitlet om cirkulationsorganernes sygdomme) stiger eller falder som en direkte følge af klassifikationsskiftet. Denne type studier er dog ressourcekrævende og der er kun gennemført et fåtal begrænsede bridgekodnings-studier i forbindelse med overgangen fra ICD-9 til ICD-10.

### *Coding practice*

Differences in the national coding practises is another factor of importance to the

### *Kodningspraksis*

Et andet forhold af stor betydning for sammenligneligheden af dødsårsagerne mellem

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

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

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

In order to support the choice of the underlying cause of death, the American programme, ACME (Automated Classification of Medical Entities) has been developed. This system is used in most of the Nordic countries, Denmark has used

flere lande, er den kodningspraksis, der er etableret i de enkelte lande. Det som vises i statistikken er den underliggende dødsårsag, hvor WHO har udarbejdet retningslinier for valget af den underliggende dødsårsag, hvilket vil sige den sygdom eller skade som starter rækken af sygelige tilstande der leder direkte til døden, eller ydre omstændigheder ved en ulykke eller voldshandling som var årsag til den dødelige skade. Det problematiske for sammenligneligheden er, at i nogle tilfælde, hvor der er opført to eller flere dødsårsager på dødsattesten, bliver valget af den underliggende dødsårsag forskellig fra land til land, fordi reglerne giver mulighed for forskellig fortolkning.

Udover at ICD´s regler for mortalitetskodning giver plads for fortolkning kan der også være tale om udvikling af nationale traditioner for valget af den underliggende dødsårsag. Som eksempel kan nævnes brugen af diagnosegruppen "mangelfuldt definerede tilstande" (koderne I469, I959, I99; J960, J969; P285.0; R000-R948; R96-99). Anvendelsen af disse koder som underliggende dødsårsag er mere udbredt i Danmark end i de andre nordiske lande i situationer hvor der også er oplyst mere specifikke dødsårsager på dødsattesten (Jfr. tabel 4.1.11).

Men der er også flere andre forhold der påvirker sammenligneligheden, blandt andet hvilken type af information statistikproducenten har tilgang til, herunder kvaliteten på dette materiale (dødsattester og andre oplysninger).

For at støtte valget af den underliggende dødsårsag, er der udviklet et amerikansk program ACME (Automated Classification of Medical Entities). Blandt de nordiske lande anvendes systemet af de fleste af de nordiske lande, Danmark med data fra

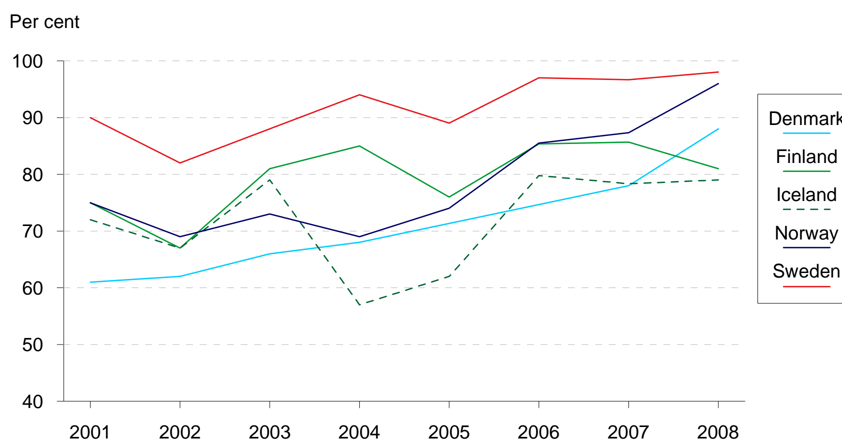
data from 2002, Iceland has used ACME for a few years to check manual coding, and Norway and Finland have used ACME with data for 2005. Otherwise, computer-aided coding has been used. Automatic coding does not necessarily result in a more correct picture of the pattern of causes of death than does manual coding, but it does give more consistency in the coding and thus contributes to better comparability between more countries.

2002, Island har anvendt ACME til kontrol med manuel kodning i nogle år og Norge og Finland har anvendt ACME med data fra 2005. Indtil da anvendes edb-støttet kodning. Automatisk kodning giver ikke nødvendigvis et mere korrekt billede af dødsårsagsmønsteret end manuel kodning. Derimod vil automatisk kodning give en bedre stabilitet i kodningen og dermed bidrage til en bedre sammenligneligheld mellem flere lande.

Since 2001, the Nordic Classification Centre has carried out annual comparisons of how the countries classify a sample of causes of death. The sample is relatively small (200-250 death certificates per year), but the results still give an indication of how comparable the statistics are (see Figure 4.1). When making comparisons, the ACME classification system is used as the standard.

Siden 2001 har det nordiske klassifikationscenter foretaget årlige sammenligninger af hvorledes landene klassificerer et udvalg af dødsårsager. Udvalget er relativt lille (200-250 dødsattester per år) men resultatet giver dog et fingerpeg af hvorledes sammenligningen er (jfr. nedenstående figur). Ved sammenligningen er det den klassificering som ACME systemet giver, der anvendes som standard.

**Figure 4.1.1 National coding compared to ACME 2001-2008**
National kodning sammenlignet med ACME 2001-2008




Cultural differences in the reporting of certain conditions may also influence comparability. For example, if doctors in one country are far more reluctant to reg-

Kulturelle forskelle i rapporteringen af bestemte tilstande kan også påvirke sammenligneligheden. Hvis læger i et land er langt mere tilbageholdende med at an-

ister 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.

vende for eksempel selvmord på dødsattesten, end læger i andre lande, kan det vanskeliggøre sammenligneligheden. I flere af de nordiske lande findes der imidlertid rutiner for at kontakte lægen eller sygehuset i de tilfælde hvor de ydre årsager til skaden er uklar. Sådanne kvalitetssikringsrutiner er med til at kompensere for de manglende informationer på dødsattesten.

### *Autopsy rate*

Another factor influencing the quality of the statistics on causes of death is the decreasing autopsy rate (in 2006 7 per cent in Denmark as the lowest and 32 per cent in Finland as the highest). The autopsy rate has been more than halved in the Nordic countries over the last few decades. Studies have shown that in about 30 per cent of cases, the result of the autopsy has caused the underlying cause of death to be altered.

### *Obduktioner*

En yderligere faktor der spiller ind på dødsårsagsstatistikkens kvalitet er de faldende rater for obduktion (i 2006 7 pct. i Danmark som det laveste og 32 pct. i Finland som det højeste). Anvendelsen af obduktion ved dødsfald er mere end halveret i de nordiske lande over de seneste årtier. Studier har vist, at i ca. 30 pct. af tilfældene med obduktion, har obduktionen medført at den underliggende dødsårsag er blevet ændret.

### *The reliability of the statistics*

Considering the reservations in relation to the comparability of causes of death over time and between countries, the data presented here should be interpreted with caution. This is especially the case for small diagnostic groups in the European short list that is used in the present publication. The picture is more stable for the large groups, such as cardiovascular diseases and cancer. This also applies to alcohol and drug-related deaths, for which it is well known that the pattern is heterogeneous. The dramatic fall in the number of deaths from AIDS is related to new, life-prolonging medication. However,

### *Statistikkens pålidelighed*

Det er klart, at med de forbehold der er taget her over for sammenligneligheden af dødsårsagerne over tid og mellem landene, må de præsenterede data fortolkes med forsigtighed. Det vil især dreje sig om mindre diagnosegrupper i den europæiske forkortede liste, der anvendes i denne publikation. Når det drejer sig om de helt store grupper, hjerte-karsygdomme for sig og cancer for sig, tegner der sig dog et noget mere stabilt billede. Tilsvarende gælder også de alkohol og narkotikarelaterede dødsårsager hvor der er et velkendt uensartet mønster. For dødsfald ad AIDS skyldes de dramatiske fald ny livsforlængende medi-

there has been a slight increase in the number of new cases in all the Nordic countries. The high incidence of cancer as an underlying cause of death in Denmark, is also partly the result of coding practice.

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

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

cin, hvor der til gengæld er en svag stigning af nye tilfælde i alle de nordiske lande. De større forekomster af cancer som underliggende dødsårsag i Danmark skyldes dog også til en vis grad kodningspraksis.

En anden forekomst er faldulykker der i langt højere grad kodes i Danmark end i Sverige og derfor er med til at gøre sammenligningen dødsårsagsstatistikken vedrørende ulykker ringe. Når det gælder alle ulykker er forekomsten størst i Finland.

For de mangelfuldt definerede tilstande er det især Finland og Island der adskiller sig fra de øvrige nordiske lande, fordi der kun er få tilfælde af mangelfulgt definerede tilstande.

## Table 4.1.1 Deaths by sex and age per 100 000 inhabitants 1995-2006
Døde efter køn og alder pr. 100 000 indbyggere 1995-2006

| *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 |
| 2005 | 1 001 | 1 030 | 509 | 359 | 14 | 9 | 58 | 19 | 425 | 275 | 5 761 | 5 131 |
| 2006 | 1 006 | 1 029 | 380 | 304 | 14 | 9 | 58 | 20 | 446 | 273 | 5 633 | 5 109 |
| *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 |
| 2005 | 835 | 824 | 1 337 | 1 180 | - | 40 | 113 | - | 340 | 196 | 5 784 | 4 852 |
| 2006 | 854 | 852 | 562 | 543 | 41 | 20 | 74 | 27 | 349 | 192 | 5 519 | 4 703 |
| *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 |
| 2005 | 848 | 784 | 1 235 | 1 020 | 58 | 150 | 464 | 97 | 730 | 528 | 6 809 | 7 173 |
| 2006 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| *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 |
| 2005 | 934 | 888 | 333 | 286 | 18 | 13 | 69 | 29 | 517 | 229 | 4 838 | 4 045 |
| 2006 | 944 | 884 | 323 | 246 | 13 | 11 | 95 | 25 | 498 | 217 | 4 857 | 4 012 |
| *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 |
| 2001-05 | 945 | 963 | 567 | 152 | 35 | 37 | 53 | - | 315 | 163 | 5 294 | 4 614 |
| 2002-06 | 945 | 992 | 417 | 153 | 35 | 37 | 39 | - | 318 | 155 | 5 228 | 4 789 |
| *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 |
| 2005 | 636 | 606 | 275 | 191 | 6 | 10 | 77 | 19 | 241 | 150 | 4 659 | 4 051 |
| 2006 | 622 | 629 | 133 | 139 | 16 | 13 | 75 | 42 | 252 | 165 | 4 554 | 4 151 |
| *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 |
| 2005 | 877 | 906 | 329 | 283 | 18 | 11 | 73 | 31 | 307 | 198 | 5 533 | 4 846 |
| 2006 | 848 | 921 | 370 | 256 | 13 | 10 | 67 | 26 | 310 | 195 | 5 285 | 4 835 |
| *Sweden* | | | | | | | | | | | | |
| 1995 | 1 091 | 1 038 | 470 | 357 | 15 | 11 | 52 | 26 | 347 | 208 | 5 942 | 4 631 |
| 2000 | 1 041 | 1 065 | 399 | 281 | 15 | 12 | 59 | 24 | 305 | 200 | 5 829 | 4 854 |
| 2005 | 996 | 1 026 | 215 | 206 | 17 | 13 | 48 | 21 | 298 | 195 | 5 420 | 4 725 |
| 2006 | 970 | 1 024 | 313 | 265 | 13 | 9 | 53 | 26 | 293 | 195 | 5 259 | 4 706 |

1 Per 100 000 live births

1 Pr. 100 000 levendefødte

*Source: The national central statistical bureaus*
Kilde: De nationale centrale statistikbureauer

**Table 4.1.2 Death rates from malignant neoplasms per 100 000 by age 1996-2006**
Dødeligheden af ondartede svulster pr. 100 000 efter alder 1996-2006

| | | Denmark | Faroe Islands[1] | Greenland | Finland | Åland[1] | Iceland | Norway[2] | Sweden[2] |
|---|---|---|---|---|---|---|---|---|---|
| *Men* Mænd | | | | | | | | | |
| *Age* | | | | | | | | | |
| Alder | | | | | | | | | |
| 0-14 | 1996-00 | 4 | - | 3 | 3 | - | 4 | 3 | 3 |
| | 2000 | 3 | - | - | 2 | - | 3 | 3 | 3 |
| | 2006 | 1 | 7 | 14 | 2 | - | - | 3 | 4 |
| 15-34 | 1996-00 | 9 | 6 | 9 | 7 | 6 | 8 | 7 | 7 |
| | 2000 | 9 | - | 11 | 6 | 32 | 7 | 7 | 8 |
| | 2006 | 8 | - | 12 | 5 | - | 13 | 5 | 5 |
| 35-44 | 1996-00 | 34 | - | 47 | 26 | 44 | 31 | 29 | 23 |
| | 2000 | 33 | - | 51 | 22 | - | 38 | 32 | 20 |
| | 2006 | 28 | 22 | 50 | 21 | - | 9 | 20 | 20 |
| 45-54 | 1996-00 | 148 | 39 | 136 | 107 | 170 | 100 | 120 | 97 |
| | 2000 | 145 | 32 | 230 | 105 | 196 | 102 | 127 | 91 |
| | 2006 | 129 | 93 | 267 | 81 | 53 | 120 | 94 | 77 |
| 55-64 | 1996-00 | 471 | 303 | 801 | 348 | 371 | 362 | 365 | 305 |
| | 2000 | 462 | 214 | 985 | 320 | 471 | 227 | 348 | 294 |
| | 2006 | 432 | 367 | 617 | 308 | 469 | 298 | 324 | 281 |
| 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 |
| | 2006 | 1 092 | 866 | 1 715 | 774 | 698 | 895 | 861 | 811 |
| 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 |
| | 2006 | 2 483 | 1 894 | 6 627 | 1 914 | 1 553 | 1 573 | 2 239 | 1 973 |
| *Women* Kvinder | | | | | | | | | |
| *Age* | | | | | | | | | |
| Alder | | | | | | | | | |
| 0-14 | 1996-00 | 3 | - | 5 | 3 | - | 4 | 3 | 3 |
| | 2000 | 2 | - | - | 2 | - | 3 | 4 | 3 |
| | 2006 | 2 | 7 | 14 | 3 | - | - | 1 | 2 |
| 15-34 | 1996-00 | 9 | 11 | 12 | 6 | 6 | 9 | 7 | 7 |
| | 2000 | 9 | - | 13 | 7 | - | 2 | 6 | 9 |
| | 2006 | 7 | 11 | 14 | 5 | - | 9 | 4 | 5 |
| 35-44 | 1996-00 | 48 | 14 | 113 | 34 | 75 | 30 | 45 | 24 |
| | 2000 | 41 | - | 104 | 36 | - | 19 | 39 | 21 |
| | 2006 | 42 | 37 | 77 | 29 | - | 28 | 35 | 30 |
| 45-54 | 1996-00 | 175 | 113 | 312 | 108 | 184 | 124 | 141 | 99 |
| | 2000 | 164 | 36 | 109 | 106 | 340 | 113 | 126 | 94 |
| | 2006 | 137 | 75 | 177 | 90 | - | 126 | 120 | 105 |
| 55-64 | 1996-00 | 440 | 306 | 811 | 235 | 275 | 350 | 325 | 303 |
| | 2000 | 425 | 297 | 542 | 237 | 150 | 396 | 319 | 296 |
| | 2006 | 372 | 333 | 710 | 217 | 378 | 305 | 300 | 291 |
| 65-74 | 1996-00 | 895 | 698 | 1 355 | 511 | 531 | 727 | 605 | 743 |
| | 2000 | 905 | 589 | 1 427 | 505 | 557 | 775 | 600 | 719 |
| | 2006 | 809 | 762 | 1 695 | 460 | 433 | 534 | 569 | 586 |
| 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 |
| | 2006 | 1 530 | 1 167 | 2 863 | 995 | 1 722 | 937 | 1 214 | 1 296 |

1 2006=2002-2006
2 2006=2005

1 2006=2002-2006
2 2006=2005

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

*Source- The national registers for causes of death*
Kilde: De nationale dødsårsagsregistre

**Table 4.1.3 Death rates from circulatory diseases per 100 000 by age 1996-2006**
Dødeligheden af kredsløbssygdomme pr. 100 000 efter alder 1996-2006

| | | Denmark | Faroe Islands[1] | Greenland | Finland | Åland[1] | Iceland | Norway[2] | Sweden[2] |
|---|---|---|---|---|---|---|---|---|---|
| Men Mænd | | | | | | | | | |
| *Age* Alder | | | | | | | | | |
| 0-34 | 1996-00 | 3 | - | 13 | 4 | 7 | 2 | 3 | 3 |
| | 2000 | 3 | - | 6 | 5 | - | 3 | 3 | 3 |
| | 2006 | 2 | 6 | - | 4 | - | 4 | 3 | 3 |
| 35-44 | 1996-00 | 22 | 6 | 50 | 50 | 11 | 23 | 27 | 25 |
| | 2000 | 23 | - | 51 | 44 | - | 38 | 25 | 21 |
| | 2006 | 27 | 44 | 33 | 34 | - | 9 | 25 | 18 |
| 45-54 | 1996-00 | 76 | 104 | 168 | 181 | 170 | 80 | 112 | 105 |
| | 2000 | 95 | 96 | 179 | 184 | 98 | 113 | 93 | 104 |
| | 2006 | 91 | 75 | 134 | 141 | 106 | 51 | 77 | 79 |
| 55-64 | 1996-00 | 274 | 367 | 491 | 529 | 445 | 329 | 343 | 341 |
| | 2000 | 326 | 299 | 473 | 481 | 538 | 209 | 282 | 303 |
| | 2006 | 256 | 301 | 274 | 384 | 156 | 232 | 211 | 243 |
| 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 |
| | 2006 | 734 | 819 | 1 544 | 1 007 | 873 | 700 | 706 | 794 |
| 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 |
| | 2006 | 3 619 | 4 614 | 6 627 | 3 988 | 4 779 | 3 422 | 3 653 | 4 397 |
| Women Kvinder | | | | | | | | | |
| *Age* Alder | | | | | | | | | |
| 0-34 | 1996-00 | 2 | 9 | 8 | 2 | - | 1 | 2 | 2 |
| | 2000 | 2 | 18 | 7 | 3 | - | 1 | 2 | 1 |
| | 2006 | 1 | 9 | 7 | 2 | - | 1 | 1 | 1 |
| 35-44 | 1996-00 | 20 | 7 | 41 | 16 | 11 | 8 | 10 | 11 |
| | 2000 | 14 | 33 | 42 | 17 | - | 10 | 11 | 11 |
| | 2006 | 12 | 6 | 58 | 11 | - | - | 9 | 6 |
| 45-54 | 1996-00 | 68 | 23 | 91 | 42 | 31 | 28 | 33 | 34 |
| | 2000 | 41 | - | 109 | 48 | - | 24 | 36 | 34 |
| | 2006 | 36 | 21 | 266 | 41 | - | 15 | 23 | 28 |
| 55-64 | 1996-00 | 225 | 74 | 274 | 132 | 97 | 136 | 107 | 117 |
| | 2000 | 131 | 198 | 271 | 129 | 75 | 198 | 102 | 112 |
| | 2006 | 101 | 102 | 304 | 93 | - | 83 | 69 | 84 |
| 65-74 | 1996-00 | 770 | 309 | 1 412 | 624 | 402 | 427 | 525 | 522 |
| | 2000 | 561 | 118 | 1 427 | 551 | 464 | 419 | 471 | 469 |
| | 2006 | 407 | 455 | 1 427 | 353 | 346 | 320 | 311 | 346 |
| 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 |
| | 2006 | 3 099 | 3 373 | 3 550 | 3 412 | 4 089 | 3 113 | 3 085 | 3 693 |

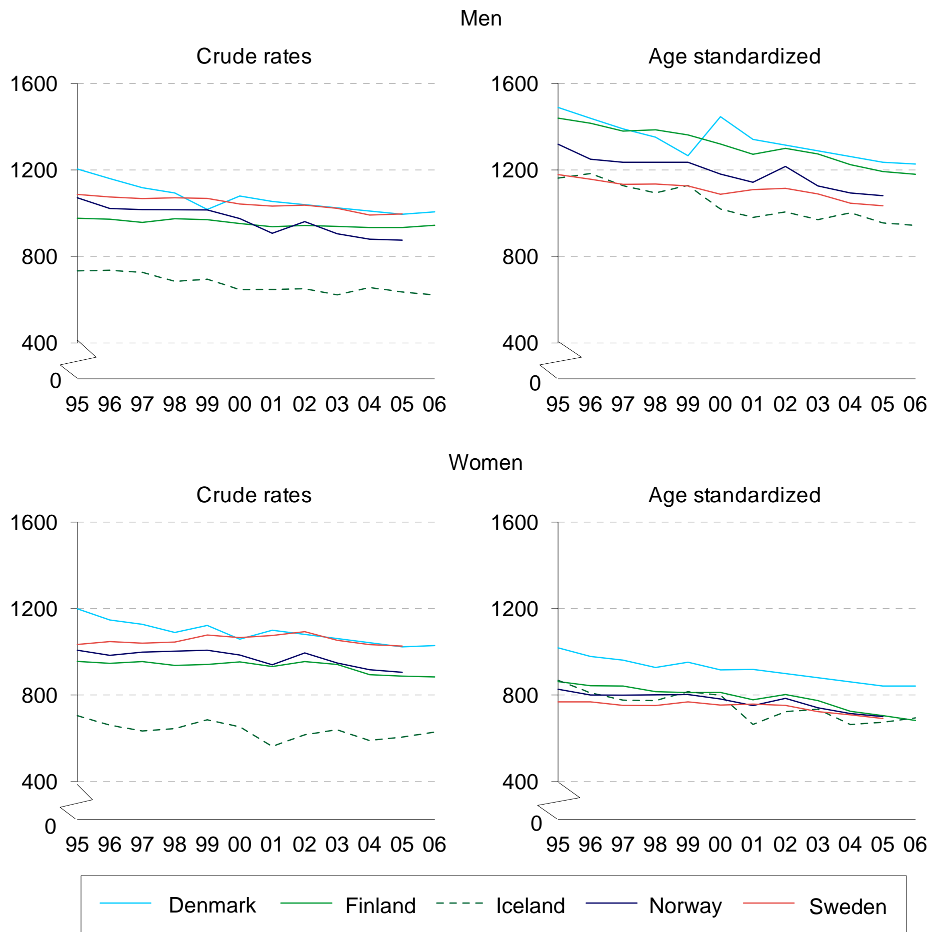
1 2006=2002-2006 | 1 2006=2002-2006

2 2006=2005 | 2 2006=2005

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

*Source: The national registers for causes of death*
Kilde: De nationale dødsårsagsregistre

**Figure 4.1.2 Deaths per 100 000 inhabitants by sex 1995-2006**
Døde pr. 100 000 indbyggere efter køn 1995-2006

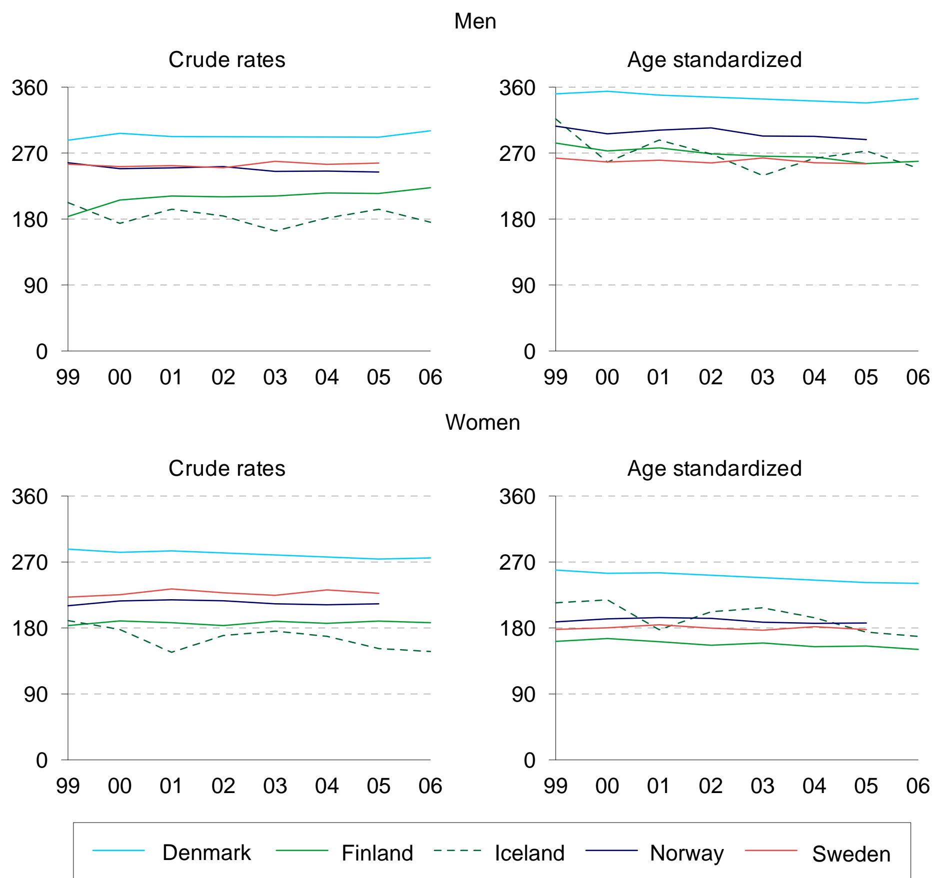



Age-standardized by the Nordic population 2000

Aldersstandardiseret med den nordiske befolkning 2000

*Source:* *Table 4.4.1*
Kilde: Tabel 4.4.1

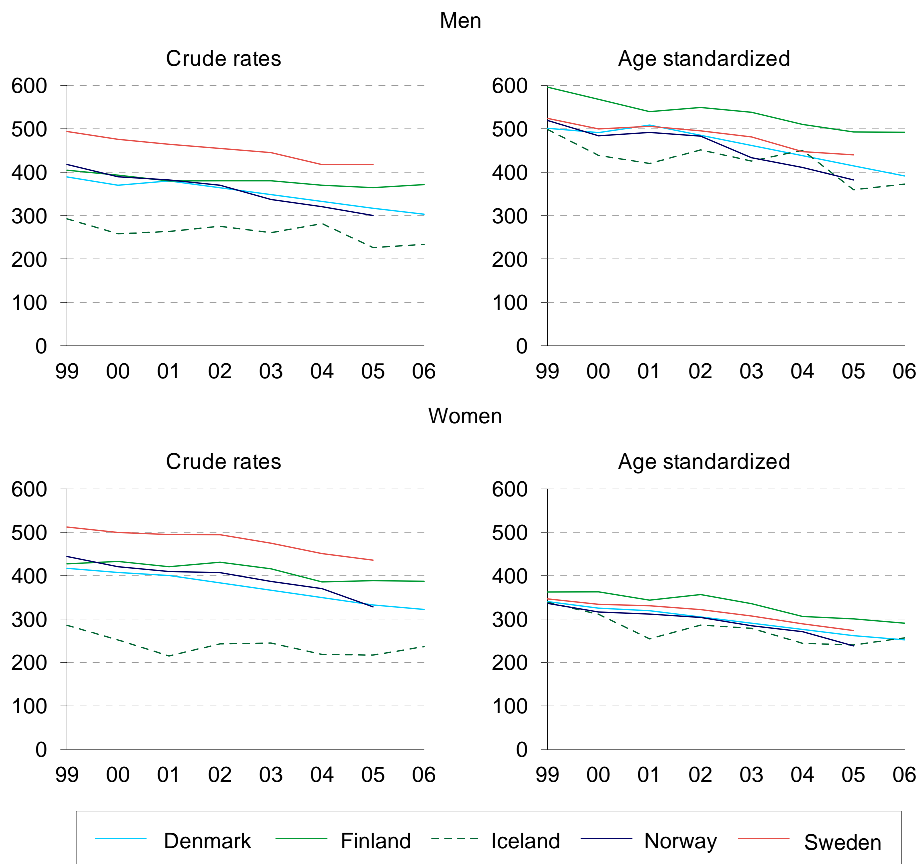
**Figure 4.1.3 Deaths from malignant neoplasms per 100 000 inhabitants by sex 1999-2006**
Døde som følge af ondartede svulster pr. 100 000 indbyggere efter køn 1999-2006




Age-standardized by the Nordic population 2000

Aldersstandardiseret med den nordiske befolkning 2000

**Figure 4.1.4 Deaths from circulatory diseases per 100 000 inhabitants by sex 1999-2006**
Døde som følge af kredsløbsygdomme pr. 100 000 indbyggere efter køn 1999-2006




Age-standardized by the Nordic population 2000 Aldersstandardiseret med den nordiske befolkning 2000

**Table 4.1.4 Deaths from avoidable causes per 100 000 inhabitants**
Undgåelige dødsfald pr. 100 000 indbyggere

| *ICD10 codes* | | | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | 2005 | 2002-06 | 2005 | 2006 | 2002-06 | 2006 | 2005 | 2005 |
| | *Age* Alder | | | | | | | | | |
| C15 | 0-74 | *Malignant neoplasm of the oesophagus* Kræft i spiserør | 5.0 | 3.6 | 7.1 | 2.2 | 0.0 | 3.1 | 2.5 | 2.6 |
| C32-C34 | 0-74 | *Malignant neoplasm of the trachea, bronchus and lung* Kræft i luftrør, bronkie og lunge | 48.3 | 20.1 | 58.8 | 24.0 | 40.6 | 29.3 | 27.2 | 25.8 |
| C53 | 0-74 | *Malignant neoplasm of cervix uteri*[1] Kræft i livmoderhalsen[1] | 2.6 | 1.9 | 7.7 | 1.3 | 0.0 | 1.4 | 2.2 | 2.1 |
| E10-E14 | 0-74 | *Diabetes mellitus* Sukkersyge | 11.0 | 7.1 | 7.1 | 5.0 | 0.0 | 2.1 | 5.2 | 6.8 |
| I60-I69 | 0-74 | *Cerebrovascular diseases* Sygdom i hjernen | 22.3 | 20.1 | 53.5 | 22.6 | 4.1 | 12.2 | 13.4 | 16.4 |
| J40-J44 | 0-74 | *Obstructive lung diseases* Rygerlunger | 20.4 | 8.5 | 28.5 | 8.0 | 4.1 | 7.7 | 11.1 | 9.1 |
| J45-J46 | 0-14 | *Asthma* Astma | 0.0 | 0.0 | 0.0 | 0.1 | 0.0 | 0.0 | 0.0 | 0.0 |
| K70; K73-K74 | 0-74 | *Chronic liver disease and cirrhosis* Kronisk leversygdom og skrumpelever | 16.3 | 4.0 | 1.8 | 20.5 | 12.2 | 2.1 | 3.3 | 6.1 |

1 Per 100 000 women

1 Pr. 100 000 kvinder

*Source: The national registers for causes of death*
Kilde: De nationale dødsårsagsregistre

**Table 4.1.5 Deaths from HIV/AIDS, in total and per 100 000 inhabitants 1996-2006**
Dødsfald som følge af HIV/AIDS, i alt og pr. 100 000 indbyggere 1996-2006

| | Denmark | Faroe Islands[1] | Greenland | Finland | Åland[1] | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| *Number* | | | | | | | | |
| Antal | | | | | | | | |
| 1996-00 | 63 | - | 4 | 12 | - | 1 | 25 | 39 |
| 2000 | 21 | - | 5 | 10 | - | 1 | 15 | 13 |
| 2005 | 39 | - | 3 | 9 | - | - | 24 | 31 |
| 2006 | 27 | - | .. | 9 | - | 1 | .. | .. |
| *Per 100 000 inhabitants* | | | | | | | | |
| Pr. 100 000 indbyggere | | | | | | | | |
| 1996-00 | 1.0 | - | 7.1 | 0.2 | - | 0.3 | 0.6 | 0.4 |
| 2000 | 0.4 | - | 8.9 | 0.2 | - | 0.4 | 0.3 | 0.1 |
| 2005 | 0.7 | - | 5.3 | 0.2 | - | - | 0.5 | 0.3 |
| 2006 | 0.5 | - | .. | 0.2 | - | 0.3 | .. | .. |

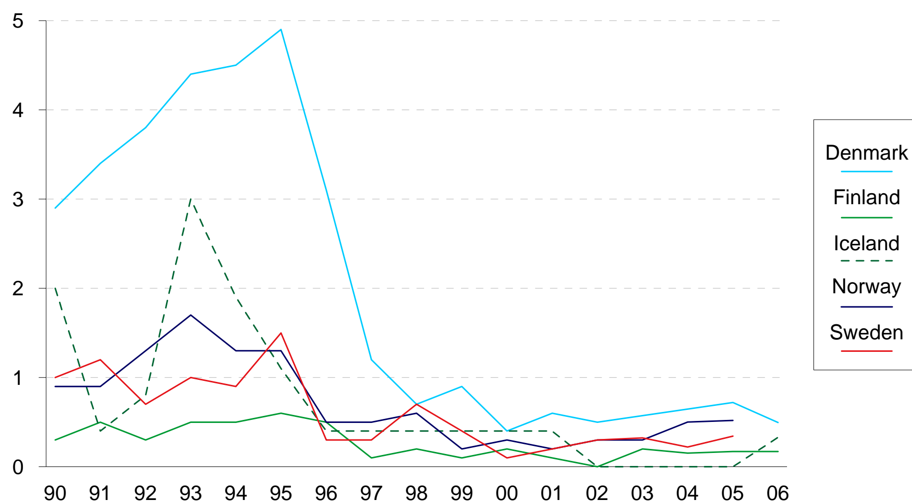
ICD-10: B20-B24

1 Average 2002-2006

1 Gennemsnit for årene 2002-2006

*Sources:* *The national registers for causes of death*
Kilder: De nationale dødsårsagsregistre

**Figure 4.1.5 Deaths from HIV/AIDS per 100 000 inhabitants 1990-2006**
Døde som følge af HIV/AIDS pr. 100 000 indbyggere 1990-2006




*Source:* *Table 4.1.5*
Kilde: Tabel 4.1.5

**Table 4.1.6 Deaths from suicide per 100 000 inhabitants by sex and age 1995-2006**
Selvmord pr. 100 000 indbyggere efter køn og alder 1995-2006

| | Men | | Mænd | | | *Women* | | | 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 |
| 2000 | 23.3 | 4.4 | 16.0 | 23.8 | 41.8 | 8.3 | 2.5 | 1.2 | 8.2 | 15.0 |
| 2005 | 16.9 | 3.3 | 8.8 | 18.9 | 41.8 | 6.3 | 0.6 | 3.5 | 6.8 | 14.2 |
| 2006 | 17.5 | 2.0 | 12.2 | 19.4 | 43.5 | 6.5 | 1.5 | 3.5 | 7.4 | 12.4 |
| Faroe Islands | | | | | | | | | | |
| 1996-00 | 5.2 | 11.3 | - | 6.8 | - | 2.8 | - | - | 5.9 | - |
| 2001-05 | 11.5 | 5.3 | 12.3 | 17.6 | 7.1 | 0.9 | - | - | 1.8 | - |
| 2002-06 | 1.6 | - | - | 3.1 | - | 0.9 | - | - | 1.8 | - |
| Greenland | | | | | | | | | | |
| 1996-00 | 171.6 | 199.4 | 427.1 | 146.8 | 68.1 | 53.7 | 41.7 | 47.5 | 47.4 | 34.0 |
| 2005 | 89.1 | 61.33 | 438.2 | 86.9 | - | 86.3 | 62.4 | 307.6 | 79.6 | 121.6 |
| 2006 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Finland | | | | | | | | | | |
| 1995 | 43.4 | 13.1 | 48.9 | 58.5 | 53.3 | 11.8 | 1.9 | 13.5 | 16.7 | 17.5 |
| 2000 | 34.6 | 10.5 | 41.8 | 46.6 | 36.8 | 11.0 | 4.1 | 9.4 | 15.5 | 17.5 |
| 2005 | 28.1 | 4.8 | 30.5 | 36.5 | 39.0 | 10.0 | 4.7 | 12.3 | 13.5 | 8.6 |
| 2006 | 31.1 | 12.7 | 40.5 | 38.5 | 39.8 | 9.6 | 2.8 | 6.8 | 13.2 | 10.2 |
| Åland | | | | | | | | | | |
| 1996-00 | 30.4 | 12.8 | 26.9 | 37.8 | 47.1 | 12.3 | - | - | 14.7 | 24.4 |
| 2001-05 | 23.2 | 11.9 | 27.9 | 33.5 | 10.9 | 4.5 | - | - | 2.8 | 15.9 |
| 2002-06 | 15.0 | - | - | - | 100.9 | 14.8 | - | - | 13.6 | 39.2 |
| Iceland | | | | | | | | | | |
| 1995 | 16.4 | 9.3 | 18.9 | 24.3 | 14.8 | 3.7 | - | - | 4.7 | 12.1 |
| 2000 | 29.8 | 22.9 | 73.4 | 38.1 | 13.6 | 5.7 | - | 9.4 | 8.6 | 5.6 |
| 2005 | 16.2 | 8.7 | 9.2 | 27.2 | - | 6.1 | - | - | 12.0 | - |
| 2006 | 14.3 | 8.6 | 36.2 | 18.2 | 6.3 | 6.7 | - | - | 11.7 | 5.2 |
| Norway | | | | | | | | | | |
| 1995 | 19.1 | 12.9 | 24.6 | 22.4 | 28.8 | 6.2 | 3.9 | 5.1 | 8.1 | 7.4 |
| 2000 | 18.4 | 11.3 | 29.9 | 22.5 | 22.6 | 5.8 | 3.0 | 4.4 | 7.9 | 6.3 |
| 2004 | 15.8 | 6.9 | 24.7 | 18.6 | 16.9 | 7.3 | 4.3 | 7.2 | 9.8 | 5.4 |
| 2005 | 15.7 | 7.1 | 23.0 | 20.8 | 16.0 | 7.4 | 2.4 | 10.4 | 10.4 | 6.4 |
| Sweden | | | | | | | | | | |
| 1995 | 21.5 | 5.8 | 16.2 | 27.4 | 35.1 | 9.3 | 2.0 | 6.6 | 11.5 | 14.2 |
| 2000 | 18.3 | 4.0 | 15.9 | 21.2 | 36.0 | 7.3 | 3.2 | 3.9 | 9.2 | 10.1 |
| 2004 | 18.7 | 5.1 | 23.3 | 22.1 | 30.9 | 7.1 | 3.5 | 6.3 | 8.6 | 9.3 |
| 2005 | 18.6 | 3.8 | 18.2 | 22.3 | 32.3 | 8.4 | 3.1 | 8.5 | 10.4 | 11.2 |

*Source: The national registers for causes of death* ICD-9: E950-E959 and ICD-10: X60-X84
Kilde: De nationale dødsårsagsregistre
G: Chief Medical Officer

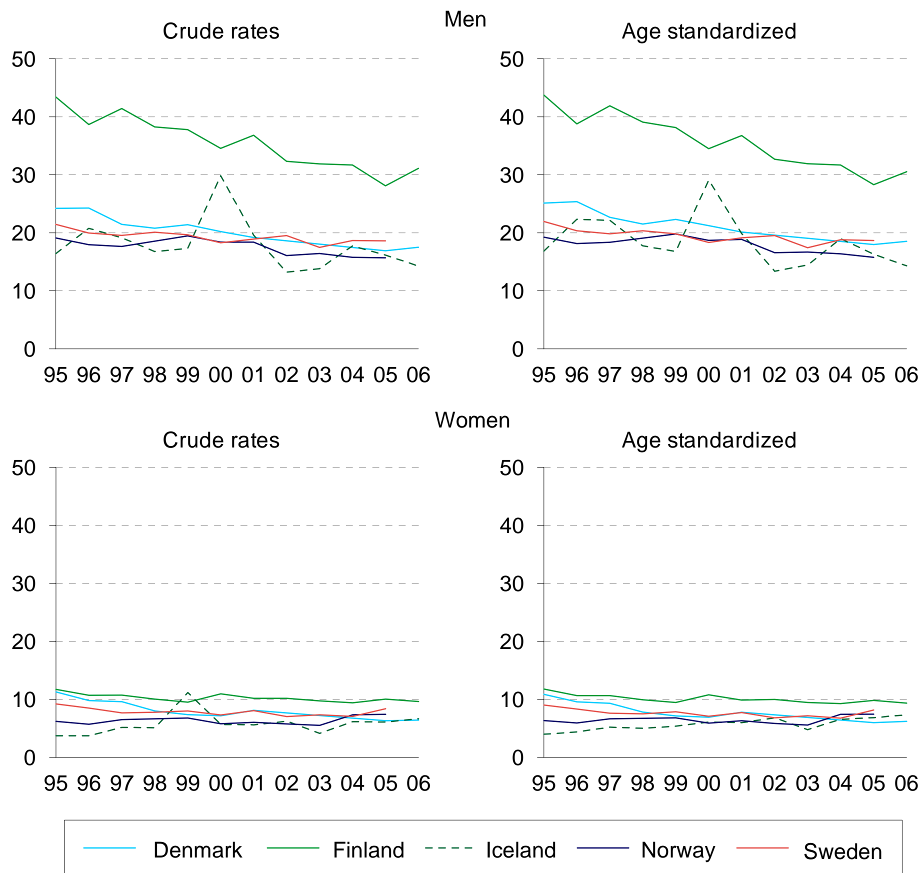
**Table 4.1.7 Deaths from accidents per 100 000 inhabitants by sex and age 1995–2006**
Dødsfald som følge af ulykker pr. 100 000 indbyggere efter køn og alder 1995–2006

| | *Men* | | | Mænd | | | *Women* | | | Kvinder | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Total* I alt | 0-14 | 15-24 | 25-64 | 65-79 | 80+ | *Total* I alt | 0-14 | 15-24 | 25-64 | 65-79 | 80+ |
| Denmark | | | | | | | | | | | | |
| 1995 | 51.2 | 7.3 | 42.7 | 33.2 | 102.6 | 578.0 | 43.3 | 3.4 | 8.5 | 12.8 | 42.0 | 327.9 |
| 2000 | 45.3 | 6.3 | 37.7 | 30.2 | 80.2 | 544.7 | 43.6 | 2.9 | 10.3 | 11.3 | 64.2 | 525.9 |
| 2005 | 35.4 | 3.4 | 28.6 | 28.0 | 52.4 | 373.0 | 26.7 | 2.2 | 4.4 | 8.2 | 32.3 | 328.7 |
| 2006 | 36.5 | 3.1 | 32.3 | 27.5 | 57.9 | 383.2 | 29.7 | 3.4 | 7.1 | 7.5 | 44.7 | 353.4 |
| Faroe Islands | | | | | | | | | | | | |
| 1997-01 | 44.0 | 7.4 | 72.1 | 29.1 | 64.4 | 479.4 | 25.8 | 7.7 | 7.2 | 3.9 | 88.4 | 257.7 |
| 2001-05 | 36.8 | 7.0 | 70.4 | 27.2 | 63.2 | 225.8 | 19.4 | 3.7 | 6.9 | 11.0 | 33.1 | 191.0 |
| 2002-06 | 45.0 | 21.1 | 458 | 34.4 | 88.3 | 305.3 | 20.8 | 3.7 | 6.6 | 12.6 | 33.5 | 198.8 |
| Greenland | | | | | | | | | | | | |
| 1996-00 | 94.3 | 51.3 | 71.9 | 105.2 | .. | .. | 29.9 | 13.2 | 35.6 | 27.7 | .. | .. |
| 2005 | 82.5 | 55.1 | 46.4 | 75.3 | 356.1 | 1 063.8 | 52.5 | 28.3 | 24.3 | 79.6 | - | - |
| 2006 | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Finland | | | | | | | | | | | | |
| 1995 | 72.6 | 7.0 | 33.2 | 81.7 | 155.6 | 386.6 | 32.0 | 3.6 | 7.4 | 16.3 | 33.9 | 235.5 |
| 2000 | 70.8 | 6.0 | 30.8 | 75.6 | 137.1 | 471.2 | 34.4 | 3.0 | 9.3 | 18.9 | 53.2 | 310.8 |
| 2005 | 80.9 | 7.7 | 27.8 | 87.3 | 153.0 | 464.7 | 35.8 | 2.7 | 6.6 | 22.7 | 51.7 | 285.7 |
| 2006 | 78.4 | 2.8 | 42.3 | 84.1 | 147.6 | 384.3 | 37.0 | 2.3 | 6.5 | 22.9 | 53.1 | 293.0 |
| Åland | | | | | | | | | | | | |
| 1996-00 | 59.6 | 4.1 | 19.2 | 62.1 | .. | .. | 21.0 | - | 7.0 | 10.5 | .. | .. |
| 2001-05 | 43.2 | 24.6 | 13.2 | 44.7 | 56.7 | 186.3 | 16.5 | 8.6 | - | 5.6 | 12.4 | 156.8 |
| 2002-06 | 67.7 | 0.0 | 0.0 | 40.7 | 394.0 | 0.0 | 29.5 | 0.0 | 0.0 | 0.0 | 0.0 | 436.2 |
| Iceland | | | | | | | | | | | | |
| 1995 | 51.5 | 26.9 | 47.0 | 56.3 | 74.0 | 186.1 | 35.2 | 34.6 | 14.6 | 31.1 | 65.4 | 115.5 |
| 2000 | 38.4 | 3.0 | 46.0 | 36.7 | 76.6 | 274.6 | 12.8 | - | 23.7 | 10.1 | 30.2 | 21.5 |
| 2005 | 25.6 | - | 36.2 | 14.2 | 82.1 | 253.0 | 17.6 | - | 4.7 | 13.3 | 44.5 | 163.9 |
| 2006 | 40.8 | 3.0 | 35.1 | 34.0 | 65.1 | 490.1 | 24.7 | 3.1 | 32.3 | 6.5 | 36.7 | 335.3 |
| Norway | | | | | | | | | | | | |
| 1995 | 44.7 | 7.3 | 38.3 | 30.9 | 82.1 | 478.5 | 31.8 | 3.6 | 9.7 | 7.9 | 48.0 | 368.0 |
| 2000 | 43.9 | 4.8 | 35.4 | 31.8 | 81.0 | 442.9 | 34.2 | 5.0 | 9.4 | 8.1 | 44.6 | 381.3 |
| 2004 | 49.9 | 6.2 | 42.1 | 42.5 | 80.5 | 403.9 | 34.5 | 4.7 | 12.4 | 17.4 | 38.8 | 311.6 |
| 2005 | 45.0 | 3.7 | 34.8 | 37.4 | 65.9 | 418.4 | 33.0 | 2.0 | 11.1 | 11.7 | 32.2 | 357.9 |
| Sweden | | | | | | | | | | | | |
| 1995 | 33.0 | 4.8 | 21.0 | 24.3 | 58.5 | 295.0 | 22.2 | 3.4 | 6.0 | 6.7 | 16.1 | 143.9 |
| 2000 | 36.2 | 3.1 | 27.1 | 25.5 | 66.9 | 310.0 | 22.7 | 1.6 | 6.4 | 6.5 | 28.4 | 227.4 |
| 2004 | 44.5 | 9.8 | 26.8 | 32.0 | 68.3 | 371.2 | 31.0 | 8.1 | 9.3 | 14.0 | 35.8 | 247.4 |
| 2005 | 38.1 | 2.4 | 21.2 | 25.6 | 67.3 | 345.1 | 27.6 | 4.3 | 5.3 | 8.4 | 34.0 | 265.0 |

*Source: The national registers for causes of death*
Kilde: De nationale dødsårsagsregistre
G: Chief Medical Officer

ICD-9: E800-E929 and ICD-10: V01-X59

**Figure 4.1.6 Deaths from suicide per 100 000 inhabitants by sex 1995-2006**
Døde som følge af selvmord pr. 100 000 indbyggere efter køn 1995-2006

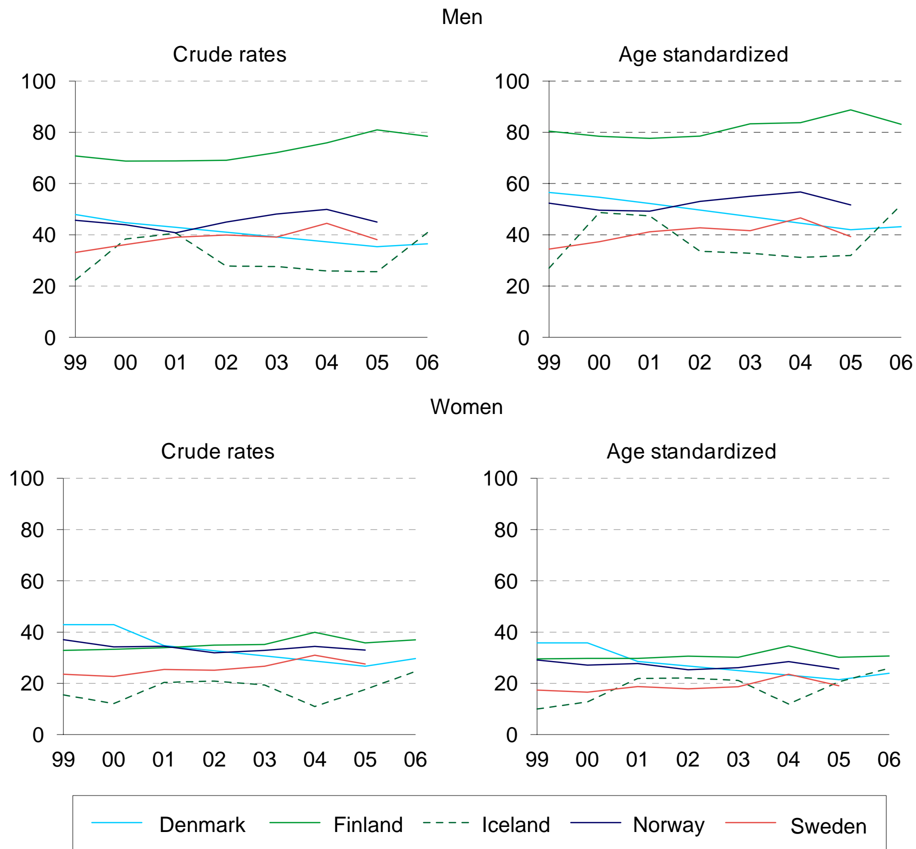



Age-standardized by the Nordic population 2000

Aldersstandardiseret med den nordiske befolkning 2000

*Source:* *Table 4.1.6*
Kilde: Tabel 4.1.6

**Figure 4.1.7 Deaths from accidents per 100 000 inhabitants by sex 1999-2006**
Døde som følge af ulykker pr. 100 000 indbyggere efter køn 1999-2006




Age-standardized by the Nordic population 2000

Aldersstandardiseret med den nordiske befolkning 2000

*Source:* *Table 4.1.7*
Kilde: Tabel 4.1.7

**Table 4.1.8 Deaths from land transport accidents per 100 000 inhabitants by sex and age**

Dødsfald i landtransportulykker pr. 100 000 indbyggere efter køn og alder

| | *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 | | | | | | | | | | |
| 2001 | 12.2 | 2.7 | 24.1 | 11.2 | 20.5 | 4.5 | 1.7 | 6.7 | 3.6 | 9.1 |
| 2005 | 10.2 | 1.3 | 21.0 | 9.7 | 16.4 | 3.1 | 1.8 | 2.7 | 2.5 | 6.9 |
| 2006 | 8.6 | 0.6 | 20.4 | 7.7 | 13.8 | 3.4 | 1.8 | 6.4 | 2.2 | 6.8 |
| Faroe Islands | | | | | | | | | | |
| 2001-05 | 10.6 | 3.5 | 58.7 | 3.2 | - | 2.6 | 3.7 | - | 3.7 | - |
| 2002-06 | 10.4 | 7.0 | 34.3 | 6.3 | 6.8 | 3.5 | 3.7 | - | 3.6 | 5.7 |
| Finland | | | | | | | | | | |
| 2000 | 11.3 | 2.3 | 13.3 | 11.4 | 24.0 | 5.1 | 2.2 | 5.6 | 4.1 | 10.7 |
| 2005 | 12.3 | 4.1 | 14.7 | 11.9 | 22.8 | 3.7 | 1.3 | 4.4 | 3.2 | 6.8 |
| 2006 | 10.3 | 1.1 | 20.0 | 9.3 | 17.7 | 3.6 | 0.9 | 4.4 | 3.2 | 6.8 |
| Åland | | | | | | | | | | |
| 2001-05 | 13.9 | 8.2 | 13.2 | 19.5 | - | 3.0 | - | - | 2.8 | 8.0 |
| 2002-06 | 15.0 | - | - | - | 100.9 | - | - | - | - | - |
| Iceland | | | | | | | | | | |
| 2000 | 16.3 | - | 32.2 | 16.9 | 27.3 | 7.1 | - | 19.0 | 5.8 | 11.2 |
| 2005 | 9.4 | - | 31.7 | 6.5 | 12.7 | 4.1 | - | 4.7 | 5.3 | 5.3 |
| 2006 | 17.5 | - | 22.0 | 19.5 | 37.6 | 8.0 | 3.1 | 27.7 | 3.9 | 10.4 |
| Norway | | | | | | | | | | |
| 2000 | 12.5 | 2.6 | 26.4 | 12.2 | 16.3 | 4.6 | 2.5 | 7.9 | 3.4 | 8.3 |
| 2004 | 11.7 | 2.9 | 20.9 | 10.8 | 14.6 | 3.6 | 2.1 | 5.2 | 2.9 | 5.6 |
| 2005 | 7.4 | 1.1 | 15.9 | 7.0 | 10.4 | 3.3 | 0.7 | 6.1 | 3.1 | 4.6 |
| Sweden | | | | | | | | | | |
| 2000 | 10.8 | 1.4 | 19.1 | 10.7 | 16.6 | 3.2 | 1.0 | 4.2 | 2.6 | 6.1 |
| 2004 | 8.3 | 1.8 | 14.6 | 7.4 | 14.6 | 2.7 | 0.3 | 3.8 | 2.0 | 6.0 |
| 2005 | 8.2 | 0.7 | 12.8 | 8.4 | 12.2 | 2.8 | 0.4 | 3.6 | 2.6 | 4.7 |

*Source:* *The national registers for causes of death* ICD9: E800-E829; ICD-10: V01-V89
Kilde: De nationale dødsårsagsregistre
G: Chief Medical Officer

**Table 4.1.9 Deaths from alcohol-related causes per 100 000 inhabitants**
Alkoholrelaterede dødsårsager per 100 000 indbyggere

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| | 2006 | 2002-06 | 2005 | 2006 | 2002-06 | 2006 | 2005 | 2005 |
| *Men* | | | | | | | | |
| Mænd | | | | | | | | |
| 0-34 | 1.2 | - | - | 3.8 | 17.9 | - | 0.3 | 0.3 |
| 35-44 | 27.6 | 10.9 | 33.0 | 41.8 | - | - | 4.0 | 4.9 |
| 45-64 | 110.9 | 19.7 | 67.5 | 147.0 | - | 16.4 | 30.0 | 21.1 |
| 65-74 | 117.2 | 23.6 | 171.5 | 110.7 | 89.4 | 57.4 | 32.8 | 23.9 |
| 75+ | 49.3 | - | 301.2 | 46.0 | - | 13.8 | 21.8 | 10.3 |
| Total | 46.7 | 8.0 | 33.0 | 61.2 | 15.1 | 7.8 | 11.8 | 9.1 |
| *Women* | | | | | | | | |
| Kvinder | | | | | | | | |
| 0-34 | 0.6 | - | - | 0.4 | - | - | 0.1 | 0.1 |
| 35-44 | 9.8 | - | 19.2 | 10.1 | - | - | 0.6 | 1.6 |
| 45-64 | 37.9 | - | 37.4 | 41.7 | - | - | 8.9 | 8.0 |
| 65-74 | 29.7 | 12.3 | 178.4 | 25.0 | 173.2 | - | 10.5 | 8.3 |
| 75+ | 18.2 | - | 190.8 | 6.5 | - | - | 3.2 | 1.6 |
| Total | 15.8 | 0.9 | 22.5 | 16.0 | 14.8 | - | 3.4 | 3.2 |
| *M+W* | | | | | | | | |
| M+K | | | | | | | | |
| 0-34 | 0.9 | - | - | 2.1 | 9.3 | - | 0.2 | 0.2 |
| 35-44 | 18.8 | 5.8 | 26.7 | 26.2 | - | - | 2.3 | 3.3 |
| 45-64 | 74.5 | 10.5 | 54.8 | 94.2 | - | 8.5 | 19.5 | 14.6 |
| 65-74 | 71.2 | 18.1 | 174.9 | 64.0 | 132.0 | 27.6 | 21.0 | 15.7 |
| 75+ | 30.0 | - | 233.6 | 19.8 | - | 5.8 | 10.2 | 5.0 |
| Total | 31.0 | 4.6 | 28.1 | 38.1 | 14.9 | 3.9 | 7.5 | 6.1 |

*Source: The national registers for causes of death*
Kilde: De nationale dødsårsagsregistre

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

**Table 4.1.10 Deaths from drug-related causes per 100 000 inhabitants**
Misbrugsrelaterede dødsfald per 100 000 indbyggere

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| | 2006 | 2002-06 | 2005 | 2006 | 2002-06 | 2006 | 2005 | 2005 |
| *Men* | | | | | | | | |
| Mænd | | | | | | | | |
| 0-34 | 5.2 | 6.5 | 26.0 | 2.9 | - | 1.3 | 10.9 | 6.3 |
| 35-44 | 12.8 | 10.9 | - | 5.7 | - | - | 25.5 | 15.2 |
| 45-64 | 8.4 | 6.6 | - | 1.6 | - | - | 17.8 | 18.4 |
| 65-74 | 1.4 | 23.6 | - | 2.0 | - | - | 6.6 | 13.6 |
| 75+ | 0.0 | 15.6 | - | 0.8 | - | - | 5.3 | 7.7 |
| Total | 6.7 | 8.8 | 13.2 | 2.8 | - | 0.6 | 14.3 | 11.5 |
| *Women* | | | | | | | | |
| Kvinder | | | | | | | | |
| 0-34 | 1.3 | 3.6 | 13.8 | 0.6 | - | - | 4.2 | 2.3 |
| 35-44 | 2.8 | 6.2 | - | 1.1 | - | - | 10.7 | 7.7 |
| 45-64 | 2.9 | 0.0 | 18.7 | 0.8 | - | - | 11.0 | 11.2 |
| 65-74 | 2.2 | 0.0 | 89.2 | 1.2 | - | - | 2.9 | 9.3 |
| 75+ | 3.4 | 0.0 | - | 1.2 | - | - | 6.3 | 6.4 |
| Total | 2.2 | 2.6 | 15.0 | 0.8 | - | - | 6.9 | 6.4 |
| *M+W* | | | | | | | | |
| M+K | | | | | | | | |
| 0-34 | 3.3 | 5.2 | 20.1 | 1.8 | - | 0.6 | 7.6 | 4.4 |
| 35-44 | 7.9 | 8.7 | - | 3.4 | - | - | 18.3 | 11.5 |
| 45-64 | 5.6 | 3.5 | 7.8 | 1.2 | - | - | 14.5 | 14.8 |
| 65-74 | 1.8 | 12.0 | 43.7 | 1.6 | - | - | 4.6 | 11.4 |
| 75+ | 2.1 | 6.3 | - | 1.0 | - | - | 5.9 | 6.9 |
| Total | 4.4 | 5.8 | 14.0 | 1.8 | - | 0.3 | 10.6 | 8.9 |

*Source: The national registers for causes of death*
Kilde: De nationale dødsårsagsregistre

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

**Table 4.1.11 Deaths from incompletely defined causes on the death certificate per 100 000 inhabitants**

Dødsfald af personer med dødsattester der har mangelfuldt definerede tilstande per 100 000 indbyggere

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| | 2006 | 2002-06 | 2005 | 2006 | 2002-06 | 2006 | 2005 | 2005 |
| *Men* Mænd | | | | | | | | |
| 0-44 | 0.3 | 1.3 | - | - | - | 1.0 | 0.2 | 2.8 |
| 45-64 | 7.3 | - | 27.0 | - | - | 13.6 | 2.9 | 10.9 |
| 65-74 | 30.0 | 35.4 | - | - | - | - | 9.2 | 41.9 |
| 75+ | 200.7 | 171.7 | 903.6 | 2.3 | - | 55.2 | 116.6 | 225.9 |
| Total | 15.3 | 12.0 | 16.5 | 0.1 | - | 6.5 | 8.3 | 23.6 |
| *No death certificate, number* Uden dødsattest, antal | 352 | 0.6 | .. | 87 | 3 | 3 | 290 | .. |
| *Women* Kvinder | | | | | | | | |
| 0-44 | - | 1.4 | - | 0.1 | - | 1.0 | 0.3 | 1.2 |
| 45-64 | 3.2 | - | - | - | - | 2.9 | 0.9 | 6.4 |
| 65-74 | 14.2 | - | 89.2 | - | - | 21.3 | 4.7 | 22.7 |
| 75+ | 297.9 | 275.0 | 954.2 | 3.5 | - | 30.2 | 187.9 | 360.7 |
| Total | 27.8 | 23.3 | 22.5 | 0.4 | - | 4.7 | 18.6 | 42.9 |
| *No death certificate, number* Uden dødsattest, antal | 366 | 1 | .. | 48 | 1 | - | 167 | .. |
| *M+W* M+K | | | | | | | | |
| 0-44 | 0.2 | 1.3 | - | - | - | 1.0 | 0.3 | 2.0 |
| 45-64 | 5.2 | - | 15.7 | - | - | 8.5 | 1.9 | 8.7 |
| 65-74 | 21.7 | 18.1 | 43.7 | - | - | 11.1 | 6.8 | 31.8 |
| 75+ | 261.1 | 233.3 | 934.6 | 3.1 | - | 40.8 | 161.1 | 308.2 |
| Total | 21.6 | 17.4 | 19.3 | 0.2 | - | 5.6 | 13.5 | 33.3 |
| *No death certificate, number* Uden dødsattest, antal | 718 | 1.6 | .. | 135 | 4 | 3 | 457 | .. |

*Source: The national registers for causes of death*
Kilde: De nationale dødsårsagsregistre

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

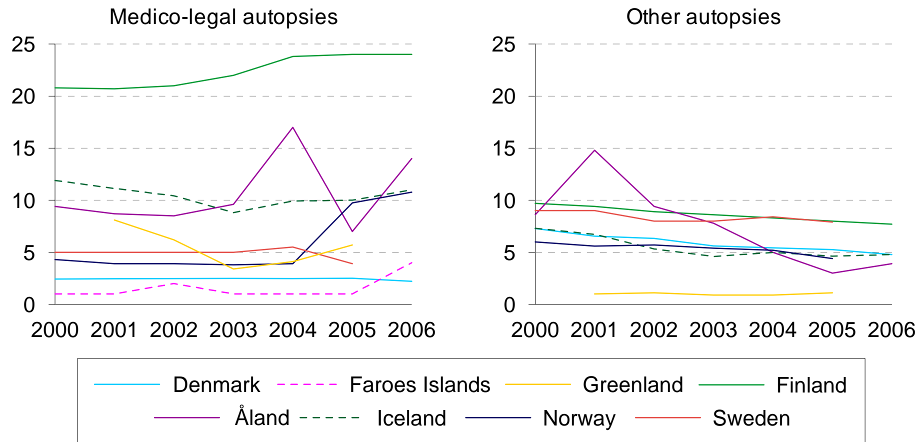
**Table 4.1.12 Autopsy rates as a percentage of all deaths 1995-2006**

Obduktionsrater i procent af alle døde 1995-2006

| | Denmark | Faroe Islands | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| *Medico- legal autopsies* Retsmedicinske obduktioner | | | | | | | |
| 1995 | 2 | 2 | 19 | 10 | .. | .. | 5 |
| 2000 | 2 | 1 | 21 | 9 | 12 | 4 | 5 |
| 2004 | 2 | 1 | 24 | 17 | 10 | 4 | 6 |
| 2005 | 3 | 1 | 24 | 7 | 10 | 4 | 6 |
| 2006 | 2 | 4 | 24 | 14 | 11 | .. | .. |
| *Other autopsies* Andre obduktioner | | | | | | | |
| 1995 | 10 | .. | 12 | 9 | .. | .. | 13 |
| 2000 | 7 | .. | 10 | 9 | 7 | 6 | 9 |
| 2004 | 5 | .. | 8 | 5 | 5 | 5 | 8 |
| 2005 | 5 | .. | 8 | 3 | 5 | 4 | 8 |
| 2006 | 5 | 4 | 8 | 4 | 5 | .. | .. |

*Source: The national registers for causes of death*
Kilde: De nationale dødsårsagsregistre

**Figure 4.1.8 Autopsy rates as a percentage of all deaths 2000-2006**
Obduktionsrater i pct. af alle døde 2000-2006



# CHAPTER V

# Resources
*Ressourcer*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## Extra material

## Supplerende materiale

OECD:

www.oecd.org

# Introduction

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

# Indledning

I dette kapitel gives der en samlet belysning af ressourcer og ressourceforbruget inden for sundhedsvæsenet. Først omtales de samlede sundhedsudgifter, med særlig omtale af udgifter til medicin, efterfulgt af sundhedspersonalet, kapacitet og ydelser i sygehusvæsenet.

# 5.1. Health care expenditure

## Development of health care expenditure

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

In the Nordic countries, between 75 and 85 per cent of health care expenditure is publicly financed. In 2006, the level of public financing was lowest in Finland.

# 5.1. Sundhedsudgifter

## Udviklingen i sundhedsudgifterne

Sundhed angår folks hverdag og har en central placering i folks bevidsthed. Dermed bliver temaet til genstand for debat og sundhedsspørgsmål får en mere dominerende plads i pressen. Der sættes især fokus på det stigende pres på forbruget af sundhedsydelser. Der stilles spørgsmål om sundhedsvæsenet er tilstrækkelig og i forlængelse af dette stilles der spørgsmål om hvad sundhedsvæsenet koster det offentlige og den enkelte. Stigende sundhedsudgifter er årsag til bekymring i mange lande. I følge OECD er årsagen til dette at det offentlige finansierer største delen af udgifterne. Stigende sundhedsudgifter bliver derved en ekstra byrde på de offentlige budgetter og vil, hvis der ikke foretages en omprioritering i budgetterne, medføre at skattetrykket for både borgere og virksomheder stiger.

I de nordiske lande finansierer det offentlige mellem 75 og 85 procent af sundhedsudgifterne. I 2006 var det offentliges andel lavest i Finland.

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

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. Sundhedsudgifternes andel af BNP er mellem ca. 8 og 9 procent.

Table 5.1.3 shows health care expenditure per inhabitant, which was highest in Norway and lowest in Greenland.

Tabel 5.1.3. viser sundhedsudgifterne per indbygger, som var højest i Norge og lavest på Grønland.

## Changes in the recording of health care expenditure

Health care expenditure includes all expenditure, both private and public, on consumption or investment in health services etc. Expenditure can be financed both privately and publicly, including by households. Examples of health care expenditure by households are the cost of spectacles, orthopaedic items, medicinal products, dental treatment, medical treatment, physiotherapy services and other health services. Other types of expenditure include national insurance or private insurance reimbursements for use of health services, and public expenditure (net) on hospitals and primary health services.

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

Health care expenditure also includes part of the expenditure on nursing and care for elderly people and people with disabilities. According to international guidelines, this applies to the part of expendi-

## Ændring af opgørelsesmetoden for sundhedsudgifterne

Udgifterne til sundhedsformål omfatter alle udgifter, både private og offentlige, der går til forbrug eller investeringer i sundhedsvæsenet m.v. Udgifterne kan finansieres både af offentlige og private kilder, inklusiv husholdningerne. Som sundhedsudgifter regnes eksempelvis husholdningernes køb af briller og ortopædisk udstyr, lægemidler, tandbehandling, lægebehandling, forbrug af fysioterapi og andre sundhedsydelser, samt det offentliges, eller forsikringernes refusion for brugen af sundhedsydelserne samt det offentliges udgifter (netto) til drift af sygehuse og det primære sundhedsvæsen m.v.

Det offentliges udgifter til forbyggende foranstaltninger samt administration af sundhedsvæsenet er ligeledes inkluderet. Det samme gælder udgifter til drift af private sygehuse m.v. som ligger uden for de offentlige budgetter.

Sundhedsudgifterne omfatter også dele af udgifterne til pleje og omsorg for ældre og funktionshæmmede. Ifølge internationale retningslinier gælder dette den del af pleje og omsorgsudgifterne der kan specificeres

ture on nursing and care that can be specified as expenditure related to health. Services for elderly people and people with disabilities are often integrated, and it can be difficult to draw a clear demarcation between what should be defined as expenditure on health services and what should be defined as expenditure on social services. What is included as expenditure on health services can vary for the different countries.

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.

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.

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.

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.

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

Alle de nordiske lande har eller er i færd med at indføre OECD´s system for sundhedsregnskab, og tallene i denne publikation baserer sig på dette system. Alle landene er ikke kommet lige langt i implementeringen af systemet, men på det ag-

system, but at the aggregated level on which the data are presented here, the data are assessed as being comparable. However, the unsolved problems faced by the countries and the different solutions they have found, must be taken into account when interpreting the data. For example, the reason that per capita health care expenditure in Finland is 30 per cent lower than in the other countries, may be because the demarcation of what is included as health care expenditure on care of the elderly may be different from in the other countries. At the same time, Table 5.1.3 shows that health care expenditure per capita in Norway is substantially higher than in the other countries. It is important to be aware of the fact that OECD's system of health accounts and EUROSTAT's ESSPROS system are very different. Thus data on health care expenditure from these two sources are very different. EUROSTAT data are published by NOSOSCO in the publication *Social Protection in the Nordic Countries.*

ESSPROS includes all social arrangements, both public and private. The statistics include pension schemes, insurance schemes, humanitarian organizations and other charitable organizations. Insurance schemes are included if they are collective. This means that expenditure on health also includes sickness benefits (or salary paid during sickness) including sickness benefits paid by employers. These cash payments are not included in OECD's system, in which only expenditure on actual health services is included.

gregerede niveau som data præsenteres her, vurderes de at være sammenlignelige. Man må alligevel tage forbehold over for de vanskeligheder der står tilbage, og som landene måske har løst forskelligt. Der er blandt grund til at stille spørgsmålstegn ved om der er forskellige afgrænsninger af ældreområdet der gør at Finland har sundhedsudgifter per indbygger der rundt regnet er 30 pct. lavere end gennemsnittet i de andre nordiske lande. Samtidig ser man i tabel 5.1.3 at Norge har udgifter per indbygger som ligger væsentlig højere end i de andre lande. Det er vigtigt at være klar over at OECD´s sundhedsregnskabssystem og dermed data om sundhedsudgifter adskiller sig væsentlig fra sundhedsudgifter der publiceres af EUROSTAT efter ESSPROS - systemet og som også publiceres af NOSOSKO i publikationen *Social tryghed i de nordiske lande.*

ESSPROS omfatter alle sociale ordninger, enten de drives af offentlige eller private. Statistikken omfatter også pensionskasser og fonde, forsikringer, humanitære organisationer og andre velgørende organisationer. Forsikringsordningerne er medtaget hvis de er kollektive. Det betyder at udgifter til sygdom også vil omfatte sygedagpenge (sygedagpenge eller løn under sygdom) herunder sygedagpenge betalt af arbejdsgiveren. Dette er 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 5.1.4 shows the total sales of medicinal products according to ATC group for each of the Nordic countries 2007. In order to have a better basis for comparison, expenditure in Table 5.1.5 is presented in EUR per capita.

The medicinal products for which expenditure is high are largely the same in all the Nordic countries.

It is difficult to compare expenditure on medicinal products in the hospital sector between countries, since hospitals pay very different prices for the same medicines, and prices are very different from prices in pharmacies in the primary health sector.

Measured in EUR per capita, expenditure on medicinal products is considerably higher in Iceland and is lower in Greenland than in the other countries. The greatest difference in expenditure on medicinal products is for ATC group N.

## Udvikling i lægemiddeludgifter

I tabel 5.1.4 ses de samlede udgifter til lægemidler i de enkelte nordiske lande fordelt på ATC-hovedgrupper 2007. For at få et bedre sammenligningsgrundlag er udgifterne i tabel 5.1.5 omregnet til EUR per capita.

I alle landene er det i stor udstrækning de samme lægemidler, som vejer tungt i udgifterne.

Det er dog generelt set svært at sammenligne udgifterne i denne sektor mellem landene, da sygehusene erhverver sig lægemidler til vidt forskellige priser og til helt andre priser end apotekerne i den primære sektor.

Målt i EUR per capita har Island betydeligt større udgifter til lægemidler og Grønland det mindste i forhold til de øvrige lande hvor den mest markante forskel for Islands vedkommende findes i udgifterne til gruppe N.

**Table 5.1.1 Health care expenditure (million KR/EUR) 2006**
Udgifter til sundheds- og sygepleje (mio. KR/EUR) 2006

| | Denmark[1)] | Faroe Islands | Greenland | Finland[2)] | Iceland | Norway | Sweden[1,3)] |
|---|---|---|---|---|---|---|---|
| | DKK | DKK | DKK | EUR | ISK | NOK | SEK |
| *Public financing* Offentlig finansiering | 118 945 | 862 | 934 | 10 344 | 87 431 | 156 003 | 217 487 |
| *Private financing* Privat finansiering | 22 486 | .. | 4 | 3 272 | 19 252 | 30 393 | 48 742 |
| *Total health care expenditure* Samlede udgifter til sundheds- og sygepleje | 141 432 | .. | 938 | 13 616 | 106 683 | 186 396 | 266 229 |

1 Preliminary figures
2 Finnish figures include Åland
3 Health Related functions are not included (HC.R.)

1 Foreløbige tal
2 Finske tal inkluderer Åland
3 Sundhedsrelateret funktioner er ikke inkluderet (H.C.R.)

*Source: OECD HEALTH DATA 2006*
Kilde: FI: Statistics Faroe Islands; G: Directorate of Health

**Table 5.1.2 Health care expenditure (EUR/capita) 2006**
Udgifter til sundheds- og sygepleje (EUR/capita) 2006

| | Denmark[1)] | Faroe Islands | Greenland | Finland[2)] | Iceland | Norway | Sweden[1,3)] |
|---|---|---|---|---|---|---|---|
| *Public financing* Offentlig finansiering | 2 944 | 2402 | 2 210 | 1 964 | 3 275 | 4 184 | 2 597 |
| *Private financing* Privat finansiering | 557 | .. | 9 | 621 | 721 | 815 | 582 |
| *Total health care expenditure* Samlede udgifter til sundheds- og sygepleje | 3 501 | .. | 2 210 | 2 586 | 3 996 | 4 999 | 3 179 |

1 Preliminary figures
2 Finnish figures include Åland
3 Health Related functions are not included (HC.R.)

1 Foreløbige tal
2 Finske tal inkluderer Åland
3 Sundhedsrelateret funktioner er ikke inkluderet (H.C.R.)

*Source: OECD HEALTH DATA 2006*
Kilde: FI: Statistics Faroe Islands; G: Directorate of Health

**Table 5.1.3 GDP and health care expenditure in total and per capita 1995-2006**
BNP og udgifter til sundheds- og sygepleje i alt og pr. indbygger 1995-2006

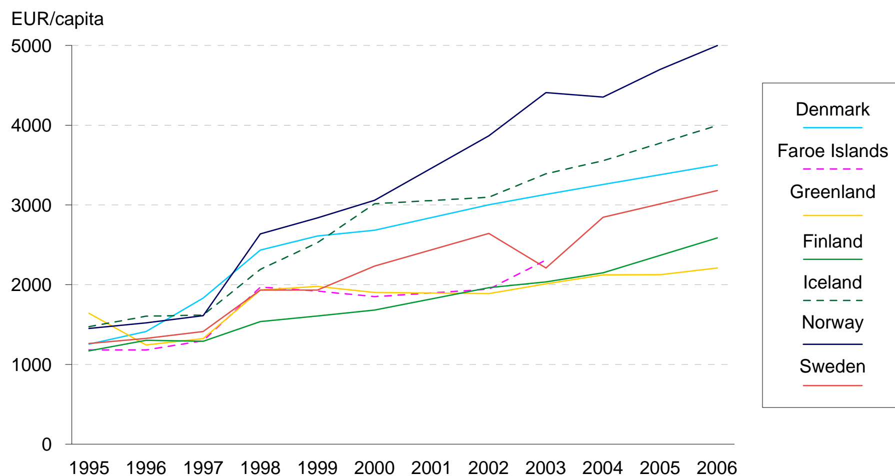
| | Denmark[1)4)] | Faroe Islands[2)] | Greenland | Finland[3)] | Iceland | Norway[4)] | Sweden[1,4)] |
|---|---|---|---|---|---|---|---|
| | DKK | DKK | DKK | EUR | ISK | NOK | SEK |
| *Total expenditure per capita 2006* Samlede udgifter pr. indbygger 2006 | 26 059 | 17 874 | 16 414 | 2 586 | 350 547 | 39 993 | 266 229 |
| *GDP (million) 2006* BNP (mio.) 2006 | 1 641 520 | 9 699 | 10 210 | 167 041 | 1 162 930 | 2 147 986 | 2 899 653 |
| *Expenditure in 2006-prices (million)* Udgifter i 2006-priser (mio.) | | | | | | | |
| 1995 | 125 685 | .. | 1 151 | 9 513 | 73 911 | .. | 183 888 |
| 2000 | 127 391 | 611 | 1 087 | 10 682 | 93 160 | 139 098 | 222 060 |
| 2005 | .. | 849 | 961 | 13 307 | 104 326 | 168 181 | 254 851 |
| 2006 | 141 432 | 862 | 938 | 13 616 | 106 683 | 171 205 | 266 229 |
| *Expenditure as a percentage of GPD* Udgifter i pct. af BNP | | | | | | | |
| 1995 | 7.7 | 7.0 | 11.3 | 7.7 | 8.3 | . | 6.3 |
| 2000 | 7.8 | 8.5 | 10.6 | 7.0 | 9.5 | 6.5 | 7.7 |
| 2005 | .. | 8.7 | 9.4 | 8.3 | 9.5 | 7.8 | 8.8 |
| 2006 | 8.6 | 8.9 | 9.2 | 8.2 | 9.2 | 8.0 | 9.2 |

1 Preliminary estimates
2 Expenditures 2003 in 2006 prises
3 Finnish figures include Åland
4 Changes in method of calculation from 2003 for Denmark, from 2000 for Norway and from 2001 for Sweden

1 Foreløbige tal
2 Udgifter 2003 i 2006 priser
3 Finske tal inkluderer Åland
4 Ændringer i opgørelsesmetode fra 2003 for Danmark, for Norge fra 2000 og fra 2001 fra Sverige

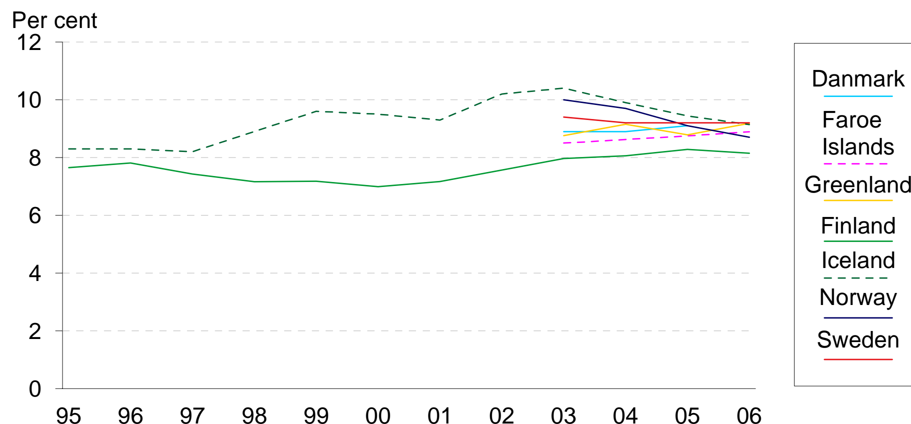
*Source: OECD HEALTH DATA 2006*
Kilde: FO: Statistics Faroe Islands; G: Directorate of Health; I: Statistic Iceland

**Figure 5.1.1 Total health care expenditure (EUR/capita) 1995-2006**
Samlede udgifter til sundheds- og sygepleje (EUR/capita) 1995-2006




*Sources:* *Table 5.1.3*
Kilder: Tabel 5.1.3

**Figure 5.1.2 Health care expenditure as a percentage of GDP 1995-2006**
Udgifter til sundheds- og sygepleje i pct. af BNP 1995-2006




*Sources:* *OECD HEALTH DATA 2006*
Kilder: FO: Statistics Faroe Islands; G: Directorate of Health

## Table 5.1.4 Sales of medicinal products by ATC-group, measured in pharmacy retail prices (million EUR), 2007

Salg af lægemidler fordelt på ATC-grupper, apotekernes salgspris (mio. EUR) 2007

| | Denmark[1] | Faroe Islands[2] | Greenland [2,3] | Finland[4] | of which Åland[4] | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| A *Alimentary tract and metabolism* Fordøjelse og stofskifte | 233 | 2.2 | 0.3 | 292 | 1.1 | 20 | 228 | 407 |
| B *Blood and blood-forming organs* Blod og bloddannende organer | 170 | 1.3 | 0.2 | 135 | 0.5 | 10 | 134 | 316 |
| C *Cardiovascular system* Hjerte og kredsløb | 295 | 3.3 | 0.4 | 352 | 1.3 | 24 | 266 | 367 |
| D *Dermatologicals* Hudmidler | 39 | 0.3 | 0.3 | .. | .. | 3 | 49 | 99 |
| G *Genito-urinary system and sex hormones* Kønshormoner m.m. | 130 | 8.3 | 0.3 | 166 | 0.6 | 11 | 109 | 182 |
| H *Systemic hormonal preparations, excl. sex hormones and insulins* Hormoner til systemisk brug | 55 | 3.6 | 0.1 | 45 | 0.4 | 3 | 50 | 89 |
| wJ *Anti-infectives for systemic use* Infektionssygdomme | 232 | 1.2 | 1.0 | 174 | 1.0 | 17 | 152 | 241 |
| L *Antineoplastic and immunomodulating agents* Cancermidler m.m. | 379 | 1.7 | 0.8 | 318 | 2.1 | 22 | 328 | 527 |
| M *Musculo-skeletal system* Muskler, led og knogler | 85 | 4.8 | 0.2 | 153 | 0.7 | 9 | 76 | 142 |
| N *Nervous system* Nervesystemet | 556 | 3.4 | 1.6 | 514 | 1.7 | 45 | 443 | 693 |
| P *Antiparasitic products, insecticides and repellents* Parasitmidler | 11 | 0.0 | 0.0 | 9 | 0.1 | - | 7 | 10 |
| R *Respiratory system* Åndedrætsorganer | 231 | 1.4 | 0.3 | 215 | 1.0 | 13 | 224 | 293 |
| S *Sensory organs* Sanseorganer | 48 | 2.9 | 0.1 | 52 | 0.3 | 4 | 48 | 75 |
| V *Various* Diverse | 68 | 1.8 | 0.4 | 13 | 0.1 | 2 | 20 | 59 |
| *Total* I alt | 2 533 | 36.2 | 6.2 | 2438 | 11 | 183 | 2 135 | 3 500 |
| *Of which user charges* | - | - | - | - | - | 41 | 643 | 666 |

*Sources:* Kilder: D: Danish Medicines Agency; FI: Chief Pharmaceutical Officer; G: The Central Pharmacy in Copenhagen County; F & Å: National Agency for Medicines; I: Ministry of Health and Social Security; N: Norwegian Institute of Public Health; S: National Corporation of Swedish Pharmacies

1 Both for hospitals and pharmacies. Prices are calculated using different methods
2 2007 = 2006
3 Calculated on the basis of the purchase prices paid to the Hospital Pharmacy in the County of Copenhagen by Greenland's health service. 2005 refers to 2004.
4 For Finland and Åland, sales in the primary health sector are calculated in PRP (pharmacy retail prices) and in the hospital sector in PPP (pharmacy purchase prices)

1 Sammenlagt for hospitaler og apoteker. Der er forskellig opgørelses metoder
2 2007 = 2006
3 Beregnet på grundlag af indkøbsprisen fra amtshospitalet i København til Grønlands Sundhedsvæsen 2005 tal er 2004.
4 I Finland og Åland er salget i den primære sektor beregnet som apotekernes detail salg (Apotekernes salgspriser) og i hospitalssektoren som hospitalernes indkøbspriser

**Table 5.1.5 Sales of medical products by ATC-group, EUR/capita 2007 - based on pharmacy retail prices**
Salg af lægemidler fordelt på ATC-grupper, EUR/capita 2007 - baseret på apotekernes salgspris

| | Denmark[1] | Faroe Islands[2] | Greenland [2] | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| A *Alimentary tract and metabolism* Fordøjelse og stofskifte | 31 | 46 | 6 | 55 | 41 | 65 | 49 | 45 |
| B *Blood and blood-forming organs* Blod og bloddannende organer | 23 | 27 | 4 | 25 | 19 | 32 | 29 | 35 |
| C *Cardiovascular system* Hjerte og kredsløb | 40 | 69 | 7 | 66 | 47 | 79 | 57 | 40 |
| D *Dermatologicals* Hudmidler | 5 | 6 | 5 | .. | .. | 11 | 11 | 11 |
| G *Genito-urinary system and sex hormones* Kønshormoner m.m. | 17 | 17 | 5 | 31 | 24 | 36 | 23 | 20 |
| H *Systemic hormonal preparations, excl. sex hormones and insulins* Hormoner til systemisk brug | 7 | 7 | 2 | 9 | 14 | 11 | 11 | 10 |
| J *Anti-infectives for systemic use* Infektionssygdomme | 31 | 26 | 18 | 33 | 37 | 56 | 32 | 26 |
| L *Antineoplastic and immunomodulating agents* Cancermidler m.m. | 51 | 36 | 14 | 60 | 79 | 74 | 70 | 58 |
| M *Musculo-skeletal system* Muskler, led og knogler | 11 | 10 | 3 | 29 | 25 | 28 | 16 | 16 |
| N *Nervous system* Nervesystemet | 74 | 71 | 29 | 97 | 64 | 149 | 95 | 76 |
| P *Antiparasitic products, insecticides and repellents* Parasitmidler | 1 | 1 | 1 | 2 | 2 | 1 | 1 | 1 |
| R *Respiratory system* Åndedrætsorganer | 31 | 29 | 5 | 41 | 37 | 43 | 48 | 32 |
| S *Sensory organs* Sanseorganer | 6 | 6 | 3 | 10 | 9 | 12 | 10 | 8 |
| V *Various* Diverse | 9 | 4 | 7 | 2 | 3 | 5 | 4 | 6 |
| *Total* I alt | 340 | 355 | 108 | 460 | 401 | 610 | 456 | 384 |
| *Of which user charges* | - | - | - | 55 | 41 | 131 | 137 | 73 |

1 Total for hospitals and pharmacies. The methods for producing the statistics are different.
2 2007 = 2006

1 Sammenlagt for hospitaler og apoteker. Der er forskellig opgørelses metoder
2 2007 = 2006

*Sources:* *See Table 5.1.4*
Kilder: Se tabel 5.1.4

## 5.2 Health care personnel

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

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

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

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

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

## 5.2 Sundhedspersonale

Det har i mange år været vanskeligt at fremskaffe sammenlignelige data om sundhedspersonale for de nordiske lande, især fordi kildegrundlaget har været meget forskelligt.

Derfor nedsatte NOMESKO i 2003 en arbejdsgruppe, med henblik på at skaffe data med mere ensartet kildegrundlag, samt definere sundhedspersonalet med samme afgrænsning som findes for sundhedsøkonomien i OECD`s A System for Health Accounts.

Til det brug har man fundet det mest hensigtsmæssigt at anvende erhvervsklassifikationen (NACE´s) definitioner og afgrænsninger, sammenkoblet med de personer der findes i autorisationsregistrene, hvorved man har fundet mere sammenlignelige data, selvom der stadigvæk findes fejl og mangler.

Med de nye definitioner og afgrænsninger er oplysningerne om sundhedspersonale fra tidligere år (før 2004) ikke sammenlignelige med de nuværende oplysninger, ligesom der er medtaget data for nye personalegrupper.

Her skal det bemærkes at gruppen *qualified auxiliary nurses*, tidligere benævnt sygehjælpere på dansk, nu er opdelt i gruppen sygeplejerskeassistenter for de der har en uddannelse på mindst 18 måneder og de der har en uddannelse på under 18 måneder er medtaget i gruppen andet plejepersonale. Da Sverige kun har data for ansat i det offentlige er der ikke medtaget data for disse personalekategorier. Andet sundhedspersonale med en højere uddannelse er defineret som personale med en universitetsuddannelse så som ernærings-

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

fysiologer og farmaceuter. Endvidere er der for læger, medtaget en gruppe som ikke arbejder inden for social og sundhedssektoren, herunder ikke med deres fag.

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

De medtagne data er desuden en opgørelse på et givet tidspunkt i året.

Note that the Finnish figures only cover the public sector. Figures from Åland both cover the public and the private sector.

Desuden skal det bemærkes at de finske data kun gælder den offentlige sektor. De ålandske data gælder både den offentlige og den private sektor.

**Table 5.2.1 Employed health care personnel in health and social services 2006 (NACE 85.1 and 85.3)**
Erhvervsaktivt sundhedspersonale inden for sundheds- og socialområdet 2006 (NACE 85.1og 85.3)

| | Denmark[1] | Faroe Islands[2] | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| *Physicians* Læger | 17 350 | 90 | 92 | 12 177 | 67 | 1 120 | 17 585 | 30 966 |
| *Dentists* Tandlæger | 4 634 | 40 | 28 | 2 360 | 26 | 286 | 4 131 | 7 438 |
| *Dental hygienists* Tandplejere | 1 189 | .. | - | 3 833 | 31 | 19 | 825 | 3 245 |
| *Dental surgery assistants* Tandlægeassistenter | 3 948 | 44 | 75 | .. | .. | 297 | 3 309 | .. |
| *Psychologists* Psykologer | 2 917 | 5 | 4 | 1 939 | 8 | .. | 3 736 | 4 819 |
| *Qualified nurses* Sygeplejersker | 52 843 | 354 | 235 | 49 581 | 304 | 2 567[3] | 73 507 | 92 320 |
| *Radiographers* Radiografer | 1 125 | 5 | - | 1 934 | 7 | 88 | 2 218 | 430[4] |
| *Qualified auxiliary nurses* Sygeplejerskeassistenter | 27 072 | 118 | - | 36 880 | 469 | 1 600[3] | 75 114 | .. |
| *Other health care personnel* Andet plejepersonale | 55 821 | .. | - | 20 677 | 81 | .. | .. | .. |
| *Midwives* Jordemødre | 1 304 | 19 | 15 | 1 778 | 12 | .. | 2 372 | 6 378 |
| *Physiotherapists* Fysioterapeuter | 6 480 | 17 | 7 | 2 617 | 21 | 425 | 8 386 | 10 626 |
| *Occupational therapists* Ergoterapeuter | 4 763 | 10 | 2 | 699 | 7 | 165 | 2 638 | 7 346 |
| *Hospital laboratory technicians* Hospitalslaboranter | 5 416 | 35 | 10 | 3 915 | 21 | 300 | 4 586 | .. |
| *Other health care personnel with a higher education* Andet sundhedspersonale med en højere uddannelse | 564 | .. | .. | 8 810 | 15 | .. | 3 520 | .. |

1 Refers to 2005
2 Refers to 2003
3 Estimate
4 Includes only radiographers who have obtained a license after 2000. The majority of radiographers do not have a license and are included in the group qualified nurses

1 Refererer til 2005
2 Refererer til 2003
3 Estimeret
4 Indeholder kun radiografer der har opnået deres licens siden 2000. Størstedelen af radiograferne har ingen licens og er medregnet som sygeplejersker

*Source:* Kilde: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: STAKES; Å: Government of the Åland Islands; I: Directorate of Health; N: Statistics Norway; S: National Board of Health and Welfare

**Table 5.2.2 Employed health care personnel in health and social services 2006 per 100 000 inhabitants (NACE 85.1 and 85.3)**
Erhvervsaktivt sundhedspersonale inden for sundheds- og socialområdet per 100 000 indbyggere 2006 (NACE 85.1 og 85.3)

| | Denmark[1] | Faroe Islands[2] | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| *Physicians* Læger | 321 | 188 | 162 | 231 | 250 | 364 | 379 | 342 |
| *Dentists* Tandlæger | 86 | 83 | 49 | 45 | 97 | 93 | 89 | 82 |
| *Dental hygienists* Tandplejere | 22 | .. | - | 73 | 116 | 6 | 18 | 36 |
| *Dental surgery assistants* Tandlægeassistenter | 73 | 92 | 131 | .. | .. | 97 | 71 | .. |
| *Psychologists* Psykologer | 54 | 10 | 7 | 37 | 30 | .. | 81 | 53 |
| *Qualified nurses* Sygeplejersker | 977 | 738 | 412 | 941 | 1 136 | 834[3] | 1 584 | 1 021 |
| *Radiographers* Radiografer | 21 | 10 | - | 37 | 26 | 29 | 48 | 5[4] |
| *Qualified auxiliary nurses* Sygeplejerskeassistenter | 500 | 246 | - | 700 | 1 752 | 520[3] | 1 619 | .. |
| *Other health care personnel* Andet plejepersonale | 1 032 | .. | - | 393 | 303 | .. | .. | .. |
| *Midwives* Jordemødre | 24 | 40 | 26 | 34 | 45 | .. | 51 | 71 |
| *Physiotherapists* Fysioterapeuter | 120 | 35 | 12 | 50 | 78 | 138 | 181 | 118 |
| *Occupational therapists* Ergoterapeuter | 88 | 21 | 4 | 13 | 26 | 54 | 57 | 81 |
| *Hospital laboratory technicians* Hospitalslaboranter | 100 | 73 | 18 | 74 | 78 | 98 | 99 | .. |
| *Other health care personnel with a higher education* Andet sundhedspersonale med en højere uddannelse | 10 | .. | .. | 167 | 56 | .. | 76 | .. |

1 Refers to 2005
2 Refers to 2003
3 Estimate
4 Includes only radiographers who have obtained a license after 2000. The majority of radiographers do not have a license and are included in the group qualified nurses

1 Refererer til 2005
2 Refererer til 2003
3 Estimat
4 Indeholder kun radiografer der har opnået deres licens siden 2000. Størstedelen af radiograferne har ingen licens og er medtaget som sygeplejersker

*Source:* Kilde: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: STAKES; Å: Government of the Åland Islands; I: Directorate of Health; N: Statistics Norway; S: National Board of Health and Welfare

**Table 5.2.3 Employed physicians by specialty in health and social services 2006 (NACE 85.1 and 85.3)**

Erhvervsaktive læger fordelt på specialer inden for social - og sundhedsområdet 2006 (NACE 85.1 og 85.3)

| | Denmark[1)] | Faroe Islands[2)] | Greenland | Finland | Åland | Iceland[3)] | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| *General practice* Almen medicin (alment praktiserende læger) | 4 156 | 27 | 56 | 2 254 | 9 | 183 | 2 203 | 5 172 |
| *Internal medicine* Intern medicin | 1 272 | .. | 3 | 2 080 | 11 | 155 | 1 349 | 1 200 |
| *Paediatrics* Pædiatri | 323 | .. | 1 | 760 | 5 | 54 | 432 | 856 |
| *Surgery* Kirurgi | 767 | .. | 3 | 1 928 | 5 | 74 | 719 | 1 206 |
| *Plastic surgery* Plastik kirurgi | 74 | .. | - | 47 | .. | 8 | 71 | 123 |
| *Gynaecology and obstetrics* Gynækologi og obstetric | 484 | .. | 3 | 755 | 3 | 37 | 509 | 1 196 |
| *Orthopaedic surgery, incl. hand surgery* Ortopædisk kirurgi, inkl. Hånd-kirurgi | 566 | .. | 3 | 160 | 2 | 37 | 353 | 999 |
| *Ophthalmology* Øjensygdomme | 287 | .. | - | 422 | 3 | 30 | 325 | 642 |
| Ear, nose and throat Øre næse hals | 322 | .. | 1 | 358 | .. | 18 | 262 | 508 |
| *Psychiatry* Psykiatri | 859 | 3 | 2 | 1 502 | 7 | 80 | 1 124 | 1 505 |
| *Skin and sexually transmitted diseases* Hud og kønssygdomme | 147 | .. | - | 208 | .. | 16 | 131 | 324 |
| *Neurology* Neurologi | 198 | .. | - | 379 | .. | 17 | 234 | 287 |
| *Oncology* Onkologi | 84 | .. | - | 141 | 1 | 16 | 124 | 282 |
| *Anaesthetics* Anæsteisologi | 816 | .. | 2 | 734 | 3 | 59 | 605 | 1 277 |
| *Radiology* Radiologi | 438 | .. | 2 | 651 | 1 | 37 | 486 | 929 |
| Clinical laboratory specialities incl. pathology Kliniske/laboratoriespecialer, inkl patologi | 476 | .. | - | 612 | .. | 47 | 402 | 742 |
| *Other specialities* Andre specialer | 136 | 35 | - | 2 745 | 6 | 24 | 572 | 4 925 |
| *Specialists in total* Specialister i alt | 11 405 | 65 | 76 | 15 736 | 56 | 892 | 9 901 | 22 173 |
| *Physicians without specialist authorization* Læger uden specialistgodkendelse | 5 945 | 25 | 16 | .. | 14 | 228 | 7 684 | 8 793 |
| *Physicians in total within NACE 85.1 and 85.3* Læger i alt indenfor NACE 85.1 og 85.3 | 17 350 | 90 | 92 | .. | 70 | 1 120 | 17 585 | 30 966 |

1 2005
2 2003
3 Data based on the register of physicians at the Directorate of Health. The most recent specialty is chosen for those with more than one specialty

1 2005
2 2003
3 Data er baseret på Helsedirektoratets register. Den nyeste specialisering er valgt, hvor der er flere end en specialisering

*Source:* Kilde: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: STAKES; Å: Government of the Åland Islands; I: Directorate of Health; N: Statistics Norway; S: National Board of Health and Welfare

## Table 5.2.4 Employed physicians by specialty in health and social services per 100 000 inhabitants 2006 (NACE 85.1 and 85.3)
Erhvervsaktive læger fordelt på specialer inden for social - og sundhedsområdet per 100 000 indbyggere 2006 (NACE 85.1 og 85.3)

| | Denmark[1] | Faroe Islands[2] | Greenland | Finland | Åland | Iceland[3] | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| *General practice* Almen medicin (alment praktiserende læger) | 77 | 56 | 98 | 43 | 34 | 60 | 47 | 57 |
| *Internal medicine* Intern medicin | 24 | .. | 5 | 39 | 41 | 51 | 29 | 13 |
| *Paediatrics* Pædiatri | 6 | .. | 2 | 14 | 19 | 18 | 9 | 9 |
| *Surgery* *Kirurgi* | 14 | .. | 5 | 37 | 19 | 24 | 15 | 13 |
| *Platic surgery* *Plastik kirurgi* | 1 | .. | - | 1 | .. | 3 | 2 | 1 |
| *Gynaecology and obstetrics* Gynækologi og obstetrik | 9 | .. | 5 | 14 | 11 | 12 | 11 | 13 |
| *Orthopaedic surgery incl. hand surgery* Ortopædisk kirurgi, inkl håndkirurgi | 10 | .. | 5 | 3 | 7 | 12 | 8 | 11 |
| *Ophthalmplogy* Øjensygdomme | 5 | .. | - | 8 | 11 | 10 | 7 | 7 |
| *Ear, nose and throat* Øre næse hals | 6 | .. | 2 | 7 | .. | 6 | 6 | 6 |
| *Psychiatry* Psykiatri | 16 | 6 | 4 | 29 | 26 | 26 | 24 | 17 |
| *Skin and sexually transmitted diseases* Hud og kønssygdomme | 3 | .. | - | 4 | .. | 5 | 3 | 4 |
| *Neurology* Neurologi | 4 | .. | - | 7 | .. | 6 | 5 | 3 |
| *Oncology* Onkologi | 2 | .. | - | 3 | 4 | 5 | 3 | 3 |
| *Anaesthetics* Anæsteisologi | 15 | .. | 4 | 14 | 11 | 19 | 13 | 14 |
| *Radiology* Radiologi | 8 | .. | 4 | 12 | 4 | 12 | 10 | 10 |
| *Clinical laboratory specialities incl. pathology* Kliniske/laboratoriespecialer, inkl patologi | 9 | .. | - | 12 | .. | 15 | 9 | 8 |
| *Other specialities* Andre specialer | 3 | 73 | - | 52 | 22 | 8 | 12 | 54 |
| *Specialists in total* Specialister i alt | 211 | 136 | 133 | 299 | 209 | 293 | 213 | 245 |
| *Physicians without specialist authorization* Læger uden specialistgodkendelse | 110 | 52 | 29 | .. | 52 | 75 | 166 | 97 |
| *Physicians in total within NACE 85.1 and 85.3* Læger i alt indenfor NACE 85.1 og 85.3 | 321 | 188 | 162 | .. | 262 | 368 | 379 | 342 |

1 2005
2 2003
3 Data based on the register of physicians at the Directorate of Health. The most recent specialty is chosen for those with more than one specialty

1 2005
2 2003
3 Data er baseret på Helsedirektoratets lægeregister. Den nyeste specialisering er valgt, hvor der er flere end en specialisering

*Source:* Kilde: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: STAKES; Å: Government of the Åland Islands; I: Directorate of Health; N: Statistics Norway; S: National Board of Health and Welfare

## Table 5.2.5 Employed physicians 2006
Erhvervsaktive læger 2006

| | Denmark[1)] | Faroe Islands[2)] | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| *Physicians employed in hospitals (NACE 85.1 and 85.3)* Læger beskæftiget på hospitaler (NACE 85.1 og 85.3) | 11 755 | 63 | 92 | 8 200 | 44 | 829 | 10 422 | .. |
| *General practitioners (NACE 85.1 and 85.3)* Læger der arbejder som alment praktiserende læger (NACE 85.1 og 85.3) | 4 203 | 27 | .. | 3 850 | 16 | 228[4)] | 5 094 | 5 172 |
| *Of which those without specialist authorization* Heraf uden specialistgodkendelse | | | | | | | | |
| *Other physicians employed outside hospitals (mainly privately practising specialists) (NACE 85.1 and 85.3)* Andre læger der arbejder udenfor hospitaler (hovedsageligt privat praktiserende speciallæger) (NACE 85.1 og 85.3) | 1 392 | - | .. | 2 960[3)] | 7 | .. | 2 083 | .. |
| *Physicians employed in administrative medicine (NACE 75.1)* Læger beskæftiget med administrativ medicin (NACE 75.1) | 186 | 1 | 2 | .. | 3 | .. | 316 | 724 |
| *Physicians employed in medical research, teaching etc. (NACE 80.3, 73.1 and 24.4)* Læger beskæftiget med medicinsk forskning, undervisning m.v. (NACE 80.3, 73.1 og 24.4) | 747 | - | .. | .. | .. | .. | 820 | 1 381 |
| *Physicians employed within all other NACE codes* Læger beskæftiget på alle andre NACE-koder | 1 037 | - | .. | .. | .. | .. | 1 029 | 1 654 |

1 2005
2 2003
3 Includes only physicians who have general practice as their main employment. The others are placed under "Other physicians employed outside hospitals (mainly privately practising specialists) (NACE 85.1 and 85.3)"
4 Estimate

1 2005
2 2003
3 Omfatter kun læger som har almen praksis som sin hovedbeskæftigelse. De øvrige vil være placeret under "Andre læger der arbejder udenfor hospitaler (hovedsageligt privat praktiserende speciallæger) (NACE 85.1 og 3)"
4 Estimat

*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

## 5.3 Capacity and services in hospitals

For many years, there has been a trend in the Nordic countries towards fewer hospital beds. Resources have been concentrated in fewer units, often involving a division of work in the most specialized areas. Units have often been merged administratively, not necessarily leading to fewer physical units. No hospitals have been closed down in Norway during the last few years, but some of the existing hospitals have become smaller.

Another trend in the Nordic countries is that psychiatric hospitals have been closed down, however, to varying degrees.

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

Hospital beds are divided into medical, surgical, psychiatric and other beds. It is clearly indicated that, particularly for Finland and Iceland, the category 'other', includes activities that are not included in the other countries.

The tables about hospital discharges and average length of stay apply to patients admitted to ordinary hospitals and specialized hospitals. This limitation has been done in order to improve comparability between the countries.

## 5.3 Kapacitet og ydelser i sygehusvæsenet

Det er et kendetegn ved de nordiske landes sygehusvæsen, at der i en årrække er blevet færre sengepladser, og ressourcerne er blevet samlet på færre enheder, og oftest med en arbejdsdeling på de mest specialiserede områder. Ofte er det tale om en organisatorisk administrativ sammenlægning, som ikke nødvendigvis behøver at medfører færre fysiske enheder. I Norge er der ikke nedlagt hospitaler de seneste år, men de eksisterende hospitaler er ofte blevet mindre.

Det er ligeledes et kendetegn, at egentlige psykiatriske hospitaler er under afvikling i de nordiske lande, dog i forskelligt tempo.

I Grønland, Finland og Island er strukturen dog lidt anderledes, idet der til sundhedscentrene er knyttet et antal sengepladser, som i tabellerne er rubriceret under andre hospitaler. En del af disse sengepladser er dog plejepladser, som i de andre lande findes ved alderdoms- og plejehjemmene. Dette medfører, især for Finland og Islands vedkommende, at man får et betydeligt større antal sengepladser i forhold til befolkningen, end i de andre lande.

Sengepladserne ved sygehusene er fordelt på medicin, kirurgi, psykiatri og andet. Det fremgår klart, at det først og fremmest er Finland og Island som under rubrikken 'Andet' medregner aktiviteter, som ikke medtages af de øvrige lande.

Tabellerne over udskrivninger og gennemsnitlig liggetid omfatter indlagte patienter ved almindelige sygehuse og specialsygehuse. Denne afgrænsning er foretaget for at fremme sammenligneligheden mellem landene.

The trend is that the number of treatment places and the average length of stay have been reduced in ordinary hospitals. Within psychiatric treatment there has been a trend towards the use of more outpatient treatment, so that the number of psychiatric beds has been reduced.

Tendensen er, at antallet af behandlingspladser og den gennemsnitlige liggetid reduceres på de almindelige sygehuse. Inden for den psykiatriske behandling har der været en udvikling hen imod mere ambulante behandlingsformer, hvorfor antallet af psykiatriske sengepladser er blevet reduceret.

**Table 5.3.1 Available hospital beds by speciality 2006**
Disponible sengepladser ved sygehuse efter specialer 2006

| | Denmark | Faroe Islands[1] | Greenland[2] | Finland | Åland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| *Number*<br>Antal | | | | | | | |
| *Medicine*<br>Medicin | 7 096 | 88 | 40 | 6 289 | 59 | 6 911 | 14 089 |
| *Surgery*<br>Kirurgi | 6 255 | 76 | 72 | 4 940 | 47 | 5 938 | 7 938 |
| *Medicine and surgery in total*<br>Medicin og kirurgi ialt | 13 351 | 148 | 112 | 11 229 | 106 | 12 849 | 22 027 |
| *Psychiatry*<br>Psykiatri | 2 859 | 60 | 12 | 4 854 | 32 | 2 831 | 4 325 |
| *Other*<br>Andet | - | - | 286 | 20 574 | 97 | 366 | - |
| *Total*<br>I alt | 16 210 | 224 | 410 | 36 657 | 235 | 16 046 | 26 352 |
| *Beds per 100 000 inhabitants*<br>Sengepladser pr. 100 000 indbyggere | | | | | | | |
| *Medicine*<br>Medicin | 131 | 182 | 70 | 119 | 220 | 148 | 155 |
| *Surgery*<br>Kirurgi | 115 | 157 | 127 | 94 | 175 | 127 | 87 |
| *Psychiatry*<br>Psykiatri | 53 | 124 | 21 | 92 | 119 | 60 | 47 |
| *Other*<br>Andet | - | - | 503 | 391 | 362 | 8 | - |
| *Total*<br>I alt | 298 | 464 | 721 | 696 | 887 | 343 | 289 |

1 Prescribed number of hospital beds
2 Other is excl. patient hotel, numbers refers to 2005

1 Normerede sengepladser
2 Andet er ekskl. Patienthotel, tal refererer til 2005

*Source:* D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: STAKES; Å: Government of the Åland Islands; N: Statistics Norway; S: Swedish Association of Local Authorities and Regions
Kilde:

**Table 5.3.2 Discharges, bed days and average length of stay in wards in ordinary hospitals and specialized hospitals 2006**
Udskrivninger, sengedage og gennemsnitlig liggetid på afdelinger ved almindelige sygehuse og specialsygehuse 2006

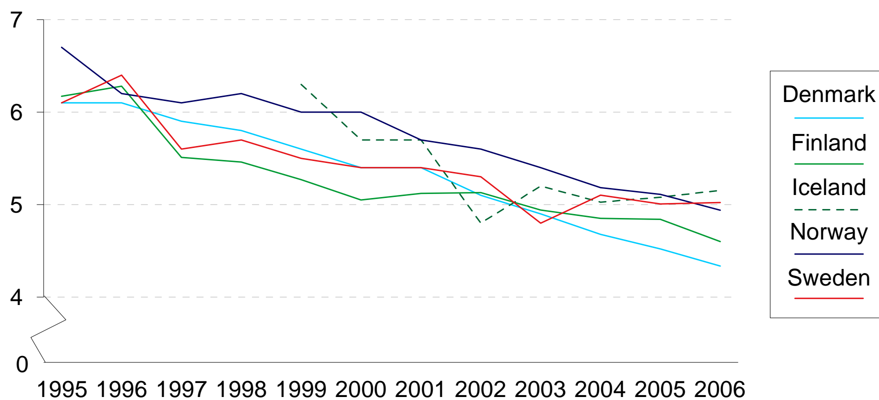
| | Denmark[1)] | Faroe Islands | Greenland[2)] | Finland | Åland | Iceland | Norway | Sweden[3)] |
|---|---|---|---|---|---|---|---|---|
| *Discharges per 1 000 inhabitants* Udskrivninger pr. 1 000 indbyggere | | | | | | | | |
| *Medicine* Medicin | 108 | 99 | 29 | 73 | 93 | 61 | 91 | 74 |
| *Surgery* Kirurgi | 95 | 122 | 72 | 110 | 103 | 95 | 85 | 69 |
| *Psychiatry* Psykiatri | 7 | 7 | 5 | 8 | 23 | 6 | 6 | 9 |
| *Total* I alt | 210 | 228 | 106 | 191 | 219 | 162 | 182 | 152 |
| *Bed days per 1 000 inhabitants* Sengedage pr. 1 000 indbyggere | | | | | | | | |
| *Medicine* Medicin | 548 | 585 | 255 | 373 | 533 | 495 | 514 | 366 |
| *Surgery* Kirurgi | 370 | 463 | 487 | 320 | 364 | 300 | 372 | 282 |
| *Psychiatry* Psykiatri | 310 | 403 | 116 | 304 | 375 | 85 | 203 | 171 |
| *Total* I alt | 1 128 | 1 451 | 858 | 998 | 1 272 | 880 | 1 088 | 818 |
| *Average length of stay* Gennemsnitlig liggetid | | | | | | | | |
| *Medicine* Medicin | 5 | 6 | 9 | 5 | 6 | 8 | 6 | 5 |
| *Surgery* Kirurgi | 4 | 4 | 7 | 3 | 4 | 3 | 4 | 4 |
| *Psychiatry* Psykiatri | .. | 56 | 23 | 36 | 16 | 14 | 33 | 19 |
| *Total* I alt | 9 | 6 | 8 | 5 | 6 | 5 | 6 | 5 |

1 2005
2 Figures for average length of stay only refer to Dronning Ingrids Hospital. Tal fra 2005
3 2004

1 2005
2 Tallene for den gennemsnitlige liggetid omfatter kun Dronning Ingrids Hospital. Tal fra 2005
3 2004

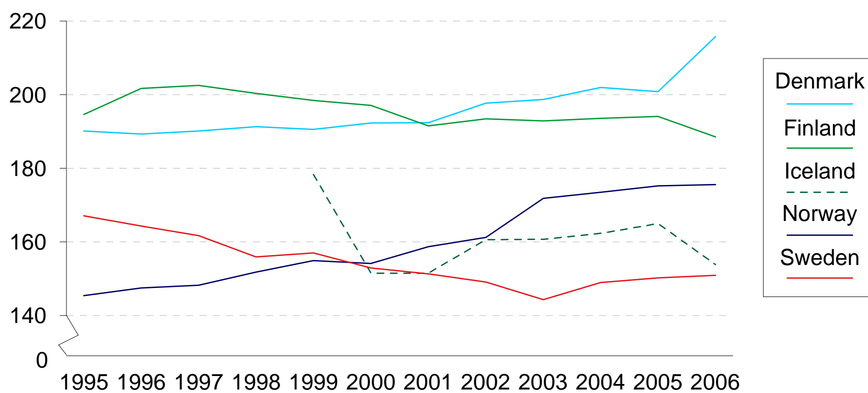
*Source: The national in-patient registers*
Kilde: De nationale patientregistre

**Figure 5.3.1 Average length of stay in somatic wards 1995-2006**
Gennemsnitlig liggetid på somatiske afdelinger 1995-2006




*Source: Table 3.4.2*
Kilde: Tabel 3.4.2

**Figure 5.3.2 Number of discharges from somatic wards, per 1 000 inhabitants 1995-2006**
Udskrivninger fra somatiske afdelinger pr. 1 000 indbyggere 1995-2006




*Source: Table 3.4.3*
Kilde: Tabel 3.4.3

**Table 5.3.3 Hospital treatment in psychiatric units by age and sex, 2006**
Hospitalsbehandlinger på psykiatriske afdelinger efter alder og køn, 2006

| | Denmark[1] | Faroe Islands[2] | Finland | Åland[2] | Iceland[3] | Norway[4] | Sweden |
|---|---|---|---|---|---|---|---|
| Discharges | 38 563 | 347 | 47 828 | 612 | 1 751 | 29 886 | 82 937 |
| Discharges per 1 000, Total | 7.2 | 7.2 | 9.1 | 23.1 | 5.8 | 6.4 | 9.1 |
| Bed-days | 1 119 776 | 19 458 | 1 698 910 | 9 939 | 25 986 | 874 354 | 1 549 705 |
| Bed-days per 1 000, Total | 206.8 | 403 | 322.6 | 375.4 | 85.4 | 188.4 | 170.7 |
| Patients treated | 24 711 | 230 | 29 608 | 98 | 1 345 | 23 322 | 45 496 |
| *Patients treated per 1 000* | | | | | | | |
| Men | | | | | | | |
| 0-14 | 0.3 | - | 2.3 | 0.1 | 0.1 | 0.4 | 0.3 |
| 15-29 | 4.8 | 2.8 | 6.2 | 3.8 | 8.0 | 6.9 | 5.3 |
| 30-44 | 6.8 | 5.4 | 7.5 | 5.4 | 8.7 | 7.2 | 6.6 |
| 45-64 | 5.5 | 8.5 | 6.7 | 4.7 | 7.1 | 5.2 | 7.8 |
| 65-79 | 3.5 | 6.5 | 4.6 | 6.5 | 4.6 | 3.5 | 4.5 |
| 80+ | 4.8 | - | 5.1 | 5.9 | 1.4 | 5.7 | 4.2 |
| Total | 4.4 | 4.4 | 5.7 | 3.9 | 5.8 | 4.8 | 5.2 |
| Women | | | | | | | |
| 0-14 | 0.5 | 0.4 | 1.4 | - | - | 0.3 | 0.6 |
| 15-29 | 5.9 | 7.3 | 7.4 | 4.1 | 7.0 | 8.0 | 6.6 |
| 30-44 | 5.8 | 4.1 | 6.5 | 3.5 | 7.7 | 6.9 | 5.8 |
| 45-64 | 5.6 | 8.3 | 6.5 | 4.0 | 7.7 | 5.6 | 5.7 |
| 65-79 | 5.1 | 6.7 | 5.6 | 5.4 | 6.5 | 4.7 | 4.6 |
| 80+ | 5.4 | 6.1 | 5.0 | 8.4 | 4.4 | 5.1 | 4.3 |
| Total | 4.7 | 5.2 | 5.6 | 3.5 | 5.7 | 5.2 | 4.8 |
| M + W | | | | | | | |
| 0-14 | 0.4 | 0.2 | 1.9 | - | 0.1 | 0.4 | 0.4 |
| 15-29 | 5.3 | 4.8 | 6.8 | 3.9 | 7.6 | 7.4 | 6.0 |
| 30-44 | 6.3 | 4.8 | 7.0 | 4.4 | 8.2 | 7.0 | 6.2 |
| 45-64 | 5.6 | 8.4 | 6.6 | 4.3 | 7.4 | 5.4 | 6.8 |
| 65-79 | 4.4 | 6.6 | 5.2 | 5.9 | 5.6 | 4.2 | 4.6 |
| 80+ | 5.2 | 3.8 | 5.0 | 7.6 | 3.2 | 5.3 | 4.2 |
| Total | 4.6 | 4.8 | 5.6 | 3.7 | 5.8 | 5.0 | 5.0 |
| Average length of stay per discharge | 29.0 | 56.0 | 35.5 | 16.2 | 13.9 | 29.0 | 18.7 |

1 2006 = 2005
2 2002–2006
3 2004–2006
4 Data are incomplete (about 98 per cent coverage for discharges and 80 per cent coverage for bed-days and diagnoses)

1 2006 = 2005
2 2002–2006
3 2004–2006
4 Data er ikke fuldstændigt (omkring 98 procent af udskrivninger og 80 procent af sengedage og diagnoser er inkluderet)

Source: National Hospital Registers

**Table 5.3.4 Discharges from hospitals* by sex and age, per 1 000 inhabitants in the age group 2006**
Udskrivninger fra sygehuse* efter køn og alder, pr. 1 000 indbyggere i aldersgruppen 2006

| | Denmark | Faroe Islands | Finland | Åland | Iceland[1)] | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| *Age* Alder | | | | | | | |
| *Men* Mænd | | | | | | | |
| 0-14 | 139 | 165 | 121 | 145 | 141 | 98 | 73 |
| 15-44 | 94 | 98 | 85 | 83 | 46 | 79 | 50 |
| 45-64 | 217 | 236 | 195 | 173 | 117 | 182 | 136 |
| 65-69 | 395 | 419 | 343 | 325 | 268 | 344 | 281 |
| 70-74 | 527 | 501 | 424 | 450 | 357 | 435 | 367 |
| 75-79 | 648 | 675 | 532 | 629 | 456 | 541 | 485 |
| 80+ | 830 | 799 | 677 | 838 | 653 | 724 | 672 |
| *Total* I alt | 199 | 204 | 173 | 186 | 122 | 163 | 137 |
| *Women* Kvinder | | | | | | | |
| 0-14 | 115 | 139 | 95 | 116 | 125 | 82 | 60 |
| 15-44 | 210 | 280 | 170 | 195 | 179 | 161 | 133 |
| 45-64 | 193 | 205 | 186 | 187 | 143 | 164 | 124 |
| 65-69 | 316 | 304 | 277 | 272 | 255 | 267 | 224 |
| 70-74 | 405 | 342 | 348 | 315 | 328 | 326 | 289 |
| 75-79 | 495 | 534 | 433 | 469 | 396 | 417 | 377 |
| 80+ | 635 | 563 | 492 | 676 | 537 | 565 | 538 |
| *Total* I alt | 233 | 255 | 203 | 230 | 186 | 190 | 166 |

1 Discharges for stays in hospital shorter than 90 days

1 Kun udskrivninger ved indlæggelsestider på mindre end 90 dage

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

* Omfatter somatiske afdelinger ved almindelige sygehuse og ved somatiske specialsygehuse

*Source: The national in-patient registers*
Kilde: De nationale patientregistre

**Table 5.3.5 Bed days in hospitals* by sex and age, per 1 000 inhabitants in the age group 2006**
Sengedage på sygehuse* efter køn og alder, pr. 1 000 indbyggere i aldersgruppen 2006

| | Denmark | Faroe Islands | Finland | Åland | Iceland[1)] | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| *Age* Alder | | | | | | | |
| *Men* Mænd | | | | | | | |
| 0-14 | 395 | 370 | 327 | 595 | 407 | 379 | 278 |
| 15-44 | 281 | 554 | 649 | 280 | 167 | 264 | 160 |
| 45-64 | 941 | 1 582 | 767 | 780 | 613 | 821 | 628 |
| 65-69 | 1 998 | 2 972 | 1 347 | 1 673 | 1 713 | 1 949 | 1 523 |
| 70-74 | 2 879 | 5 240 | 2 107 | 2 781 | 2 564 | 2 707 | 2 147 |
| 75-79 | 3 755 | 5 312 | 3 273 | 3 666 | 3 984 | 3 502 | 3 039 |
| 80+ | 5 110 | 7 113 | 6 453 | 5 781 | 6 738 | 5 041 | 4 672 |
| *Total* I alt | 870 | 1 288 | 919 | 923 | 680 | 803 | 703 |
| *Women* Kvinder | | | | | | | |
| 0-14 | 349 | 375 | 822 | 349 | 355 | 333 | 237 |
| 15-44 | 587 | 1 129 | 1 102 | 606 | 479 | 548 | 375 |
| 45-64 | 791 | 1 613 | 1 664 | 788 | 694 | 765 | 554 |
| 65-69 | 1 620 | 2 387 | 2 595 | 1 387 | 1 658 | 1 526 | 1 196 |
| 70-74 | 2 343 | 3 122 | 3 350 | 1 667 | 2 380 | 2 046 | 1 722 |
| 75-79 | 3 131 | 5 844 | 3 874 | 2 835 | 3 484 | 2 744 | 2 455 |
| 80+ | 4 417 | 7 195 | 4 598 | 4 627 | 6 471 | 4 055 | 3 975 |
| *Total* I alt | 1 001 | 1 632 | 1 690 | 1 043 | 909 | 938 | 817 |

1 Bed days of discharges for stays in hospital shorter than 90 days

1 Sengedage for udskrivninger ved indlæggelsestider på mindre end 90 dage

* Definition, see Table 3.4.2
* Definition, se tabel 3.4.2

*Source: The national in-patient registers*
Kilde: De nationale patientregistre

# SECTION B

# The Health of Elderly People

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## Preface

The Nordic countries have some of the oldest populations in the world. During the last decade increasing attention has been focused on the health of elderly people, since the proportion of elderly people in the population has increased and the number of people in the oldest group of elderly people is expected to increase during the next decade.

At the plenary meeting of NOMESCO in June 2006, it was decided that the theme in the 2008 edition of *Health Statistics in the Nordic Countries* should be the health of elderly people aged 65 and over in the Nordic countries, with the focus on people aged over 80. This is the first NOMESCO report about the health of elderly people in the Nordic countries. During the course of the work there have been five working meetings.

The purpose of this theme section is to present a general but comprehensive statistical description of the health of elderly people aged 65 years and older, with a focus on the age group 80 years and older. The report is partly based on available Nordic statistics that are collected continually by NOMESCO, and partly on statistics that have been collected specially for this purpose. Research results, reports and articles on the health and living conditions of elderly poeple have also been used as references. The theme section also aims to develop and improve NOMESCO's annual statistics, and recommendations are made for improving the statistics.

As a supplement to NOMESCO's regular statistics, we have used a sample

## Förord

Norden har en av världens äldsta befolkningar och under de senaste decennierna så har de äldres hälsa uppmärksammats mer och mer med anledningen av att andelen äldre i befolkningen blir allt fler och att de allra äldsta förväntas öka under de kommande decennierna.

Vid plenarmötet i juni 2006 så beslöt Nomesko att 2008 års tema i Helsestatistik for de nordiske lande skulle behandla de äldres hälsa i Norden från 65 års ålder med fokus på åldersgruppen över 80 år. Inom ramen för Nomesko är detta den första rapport som berör de äldres hälsa i Norden. Under arbetets gång har sammanlagt fem arbetsmöten hållits.

Syftet med detta tema är att ge en översiktlig men fördjupad statistisk beskrivning av de äldres hälsa från 65 års ålder med fokus på gruppen 80 år och äldre. Rapporten grundar sig dels på tillgänglig nordisk statistik som samlas in kontinuerligt av Nomesko, dels på statistik som samlats in speciellt för detta tillfälle men även på forskning, rapporter och artiklar som beskriver äldres levnadsförhållanden och hälsa. Temat syftar också till att utveckla och förbättra Nomeskos årliga statistik och föreslå förändringar av statistiken där så är önskvärt.

Som komplement till Nomeskos ordinarie statistik har vi tagit fram ett urval

of statistics from the national registers of patient statistics, cancer, pharmaceutical products and causes of death. The statistics present morbidity, prescribing of pharmaceutical products and mortality for different age groups over 65 and for men and women in the Nordic countries. The data is mainly for 2006, as in the rest of this publication. The statistics are also to be found on the NOMESCO web site.

Statistics from various national interview surveys are also important for following trends in the health of the population over time, and can be regarded as a supplement to the available register data.

This theme section includes short descriptions of legislation, the organization of health and care services for elderly people, the demography of the elderly population, factors that influence ageing, the health of elderly people, and care of elderly people in the Nordic countries.

There are regional and socio-economic differences in the health status of elderly people. There are also differences in the health status of different groups of immigrants. These issues are important when analysing health status, but because of the limited scope of this theme section, it has not been possible to deal with them.

av statistik från de nationella patient-, cancer-, läkemedels- och dödsorsaksregistren. Statistiken visar på sjukdomsförekomst, läkemedelsförskrivning och dödlighet mellan olika åldersgrupper över 65 år och mellan kvinnor och män i de nordiska länderna. Huvudsakligen redovisas data från år 2006 i likhet med den övriga statistiken i publikationen. Statistik finns även tillgänglig på Nomeskos webbplats.

Uppgifter från olika nationella intervjuundersökningar är av betydelse för att kunna följa hälsoutvecklingen över tid i befolkningen och kan ses som ett komplement till de registerdata som finns tillgängliga.

Temat beskriver kort lagar och organisation inom vården och omsorgen om äldre, den äldre befolkningen ur ett demografiskt perspektiv, vad styr åldrandet, äldres hälsa och äldreomsorgen i Norden.

När det gäller de äldres hälsa finns regionala och socioekonomiska skillnader i hälsoutfall. De finns även skillnader i hälsa i olika invandrargrupper i de nordiska länderna. Detta är betydelsefullt för analys av hälsoutfall men på grund av det begränsade utrymmet i temaavsnittet så är det inte möjligt att även belysa dessa frågor.

## Organization and legislation

There are clear similarities in care of elderly people in the Nordic countries, where such services are provided as

## Organisation och lagstiftning

Den nordiska äldreomsorgen har haft och har påtagliga likheter mellan länderna där den varit och är en del av

part of the general welfare systems. The trend in the Nordic countries is towards more needs tested care of elderly people, apart from in Denmark, where these services include all elderly people.

det generella välfärdsystemet. Utvecklingen i de nordiska länderna går mot alltmer behovsprövad äldreomsorg utom i Danmark där omfattar äldreomsorgen alla äldre.

**DENMARK:** The act governing social services for elderly people is the Social Services Act. This Act provides the legislative basis for advice, support and a series of services – including preventive measures – to persons who have reduced short-term or long-term physical or mental functional abilities or who have social problems.

The main aims of care are to enable individuals to care for themselves, to make daily living problem-free, and to improve quality of life. The Act ensures the provision of a series of services for elderly people. The most important services are municipal home help services, home nursing services, physiotherapy, provision of aids for handicapped people, chiropody, meals-on-wheels, provision of support persons and transport services. The level of service provision can vary, as this is determined by the individual municipality.

According to the Health Act, the muncipalities are required to provide health-promoting conditions for elderly people, as for other citizens, and to provide preventive and health-promoting services. In the Health Act there are also provisions for health contracts between the region and the municipalities, for example within the following compulsory areas: discharge for frail elderly patients and training. These contracts shall, for example, ensure that treatment services and preventive measures in the region and in the municipalities are harmonized and coordinated.

**DANMARK:** Lovgrundlaget for den sociale service, der ydes til ældre, er Lov om social service (Serviceloven). Formålet med Serviceloven er at tilbyde rådgivning og støtte samt en række serviceydelser - der også kan have et forebyggende sigte - til personer, der midlertidigt eller varigt har nedsat fysisk og psykisk funktionsevne eller sociale problemer.

Hovedsigten for hjælpen er, at den enkelte skal kunne klare sig selv, at lette den daglige livsførelse og at forbedre livskvaliteten. Her sikrer loven en række serviceforanstaltninger til de ældre, hvor de vigtigste er den kommunale hjemmehjælp og hjemmesygepleje, fysio- og ergoterapi, fodpleje, madudbringning, ledsageordninger, kørselsordninger samt en række andre serviceydelser. Kvalitetsstandarderne kan variere, idet de fastlægges af den enkelte kommune.

I følge Sundhedsloven er kommunen forpligtet til at skabe sunde rammer og forebyggende og sundhedsfremmende tilbud til ældre såvel som andre borgere. I sundhedsloven er der også fastsat regler om sundhedsaftaler mellem region og kommuner bl.a. med følgende obligatoriske områder: udskrivningsforløb for svage ældre patienter og træningsområdet. Aftalerne skal bl.a sikre at behandling og forebyggelse i region og kommune er sammenhængende og koordineret.

In accordance with the Act Relating to Preventive Home Visits, the municipalities have a duty to offer elderly people over 75 years of age annual home visits, but they can choose not to include elderly people who receive personal and practical help.

I henhold til Lov om forebyggende hjemmebesøg er kommunen forpligtet til at tilbyde, ældre der er fyldt 75 år to årlige hjemmebesøg, men kan vælge at undtage ældre der får personlig og praktisk hjælp.

Residences for elderly people are built either as independent residences, nursing homes (including temporary accommodation and accommodation for respite care), or communal housing. This is in accordance with the Act Relating to Public Housing. The provision relating to nursing homes and sheltered accommodation is a transitional provision in the Services Act, as the municipalities can no longer build these types of accommodation in accordance with this Act.

Ældreboliger bygges enten som selvstændige boliger, plejeboliger (herunder midlertidige boliger/aflastningsboliger) eller bofællesskaber. Det sker i henhold til Lov om almene boliger. Bestemmelsen om plejehjem og beskyttede boliger er en overgangsbestemmelse i Serviceloven, da kommuner ikke længere kan bygge disse i henhold til denne lov.

The municipalities (98 in total) have overall responsibility for providing services for elderly people and other people who have reduced short-term or long-term physical or mental functional abilities or who have social problems.

Det er kommunerne (98 i alt) der har det overordnede ansvar for ydelser til ældre og andre, der midlertidigt eller varigt har nedsat fysisk og psykisk funktionsevne eller sociale problemer.

Home help services and home nursing services are the responsibility of the municipalities. For example, nursing care can be provided after referal from a doctor. Sheltered housing and nursing homes are run and owned by the municipalities or by private organizations. Private homes often have a contract with the municipality to be inspected.

Hjemmehjælp og hjemmesygeplejen er et kommunalt anliggende. Sygepleje kan bl.a. gives efter lægens anvisning. Beskyttede boliger og plejeboliger drives og ejes af kommuner eller private virksomheder, der ofte indgår aftale med de pågældende kommuner om visitering til disse ældreboliger.

According to the regulations, elderly people have free choice, both regarding accommodation and home help services, which can be provided either by the municipality or a private provider.

Der er regler om frit valg, der gælder både bolig og hjemmehjælp, som enten kan ydes af kommunen eller private leverandører.

A few nursing homes (for example psychiatric nursing homes) are run by the regions.

Nogle få plejehjem (eksempelvis for psykiatri) drives af regionerne.

Services provided to citizens in accordance with the Services Act are free of charge. Apart from that, there are several services, for example temporary home help services, that clients have to pay a fee for. The cost of food and delivery of meals is met in total or in part by client fees.

Ydelser til borgerne efter serviceloven er gratis. Derudover er der en række brugerbetalingsordninger fx midlertidig hjemmehjælp, som betales af borgeren, og udgifter til mad og levering af denne kan brugerbetales delvist eller fuldt ud.

The regions have responsibility for running hospitals and for contracts with general practitioners and specialists. Pharmacies have a monopoly over sale of prescription medicines.

Regionerne har ansvar for sygehusdriften og overenskomster med de alment praktiserende læger og speciallæger. Apotekervæsenet har monopol på salg af receptpligtig medicin til borgerne.

Residents in nursing homes receive a full pension and pay for all the services they receive, including rent, the cost of medicines, food, washing and other personal needs.

Beboere i plejeboliger får udbetalt den fulde pension og betaler for alle de ydelser de modtager, herunder husleje, udgifter til medicin, mad, vask og andre personlige fornødenheder.

**FAROE ISLANDS:** Health and social policy in the Faroe Islands is based on Danish legislation in this area, and has therefore many similarities with Danish policy. The greatest difference is in the organization, since service provision is the responsibility of the Home Government (nearly all residences for elderly people are built by the municipalities, with grants from the Home Government). The legislative basis for social services for elderly people is primarily the Welfare Act. The aim of the Welfare Act is to provide advice, support and a series of services – that can also be preventive measures – to persons who have reduced short-term or long-term physical or mental functional abilities or who have social problems.

**FÄRÖARNA:** Den færøske sosial og sundhedspolitik er udsprunget af den danske lovgivning på området, og har derfor mange lighedstræk. Den største forskel er organisatorisk, da serviceydelser altovervejende er et anliggende for landsstyret (på nær bygning af ældreboliger, der med tilskud fra landsstyret hovedsagligt bliver bygget af kommunerne). Lovgrundlaget for den sociale hjælp, der ydes til ældre, er primært lov om offentlig forsorg (Forsorgloven). Formålet med Forsorgloven er at tilbyde rådgivning og støtte samt en række serviceydelser - der også kan have et forebyggende sigte - til personer, der midlertidigt eller varigt har nedsat fysisk og psykisk funktionsevne eller sociale problemer.

The main aims of care are to enable individuals to care for themselves, to make daily living problem-free, and to improve quality of life. The legislation ensures the provision of a series of services for elderly people. The most important of these services are home help services, communal residences and nursing homes. Support for social activities, transport services and meals-on-wheels are provided in accordance with the Act Relating to Care Services. There are separate acts for home nursing services and grants for aids for handicapped people.

Hovedsigtet med hjælpen er, at den enkelte skal kunne klare sig selv, at lette den daglige livsførelse og at forbedre livskvaliteten. Her sikrer loven en række serviceforanstaltninger til de ældre, hvor de vigtigste er hjemmehjælp, bofællesskaber og plejehjem. Støtte til sociale aktiviteter, kørselsordninger og madudbringning bliver givet med hjemmel i lov om omsorgsarbejde, og hjemmesygeplejen og pasningstilskud har og også hjemmel i selvstændig lov.

Residences for elderly people are built either as communal residences or nursing homes. These are provided in accordance with the Act Relating to Grants for Building Residences for the Elderly. In accordance with this Act, the Home Government can give grants to the municipalities and independent institutions for building communal residences and nursing homes.

Ældreboliger bygges enten som bofællesskaber eller plejehjem. Det sker i henhold til lov om støtte til bygning af ældreboliger, hvorefter landsstyret kann yde kommunerne og selvejende institutioner tilskud til bygning af bofællesskaber og plejehjem.

Services provided to citizens in accordance with the Services Act are free of charge. Apart from that, there several services, for example temporary home help services, for which clients have to pay a fee. The cost of food and delivery of meals is met in total or in part by client fees.

Ydelser til borgerne efter forsorgloven er gratis. Derudover er der en række brugerbetalingsordninger fx midlertidig hjemmehjælp, som betales af borgeren, og udgifter til mad og levering af denne kan brugerbetales delvist eller fuldt ud.

The Home Goverment has responsibility for running hospitals. Contracts with general practitioners and specialists are the responsibility of the sickness benefits system. Pharmacies have a monopoly over sale of prescription medicines.

Landsstyret har ansvar for sygehusdriften hvorimod overenskomster med de alment praktiserende læger og speciallæger er et anliggende for sygekasserne. Apotekervæsenet har monopol på salg af receptpligtig medicin til borgerne.

Residents in communal residences receive a full pension and pay for all the services they receive, including rent, the cost of medicines, food, washing and other personal needs.

Beboere i bofællesskaber får udbetalt den fulde pension og betaler for alle de ydelser de modtager, herunder husleje, udgifter til medicin, mad, vask og andre personlige fornødenheder.

**GREENLAND:** In the 2006 autumn session of parliament, improvement in the living conditions of elderly people was debated.

Elderly people have the possibility to apply for a home help, and to receive help with practical tasks in the home and in everyday life. Client fees for a home help are dependent on the pensioners' household income.

If elderly people need more support to manage on their own, or if they can no longer manage to live in their own home, they can apply for sheltered accommodation or a place in a communal residence. They can also apply for a place in an old people's home or a nursing home. There are old people's homes and other types of residence for elderly people in all the towns in Greenland. The types of residence that are available in villages vary.

**FINLAND:** The aim of Finland's old-age policy is to promote elderly people's functional capacity and independent living, with the aim that as many elderly people as possible can continue to live in their own homes and their familiar environment. While the provision of health and social services is the responsibility of the municipalities, the services can be provided in many alternative ways. A municipality can provide the services alone or in cooperation with other municipalities. It can also purchase services from private business enterprises, non-profit organizations, other municipalities or joint municipal boards. From the beginning of 2004, municipalities have had the option of organising services by granting the client a service voucher. [1, 2]

**GRÖNLAND:** Landstinget drøftede på Efterårssamling 2006 forbedring af de ældres levevilkår.

Ældre har mulighed for at søge hjemmehjælp til at klare praktiske gøremål i hjemmet og i hverdagen. Betaling for hjemmehjælp er afhængig af pensionistens husstandsindkomst.

Såfremt ældre har brug for mere støtte til at klare sig i hverdagen og ikke længere kan bo i eget hjem, er der mulighed for at søge om en beskyttet bolig, eller der kan søges om at bo i et bokollektiv. Endvidere kan søges om en plads på alderdomshjemmet, evt. på en plejeafdeling. Der er alderdomshjem og eventuelt øvrige botilbud i alle Grønlands byer; i bygderne varierer botilbuddet.

**FINLAND:** Syftet med Finlands äldrepolitik är att hjälpa de äldre upprätthålla sin funktionsförmåga och leva ett självständigt liv. Målet är att så många äldre som möjligt skall kunna bo kvar och leva självständigt i sitt hem och i sin invanda boendemiljö. Kommunerna ansvarar för anordnandet av social service och hälso- och sjukvård, men det kan ske på många olika sätt. En kommun kan producera tjänster självständigt eller i samarbete med andra kommuner. Kommunen kan också köpa tjänster av privata företagare med affärsekonomiska principer, av sammanslutningar som inte bedriver vinstbringande verksamhet eller av andra kommuner eller samkommuner. Från och med början av 2004 har kommunerna kunnat ge klienten en servicecheck. [1, 2]

In February 2008, the Ministry of Health and Social Affairs and Finland's Association of Local Authorities produced new recommendations for services for elderly people. These recommendations provide guidelines for municipalities and their partners when they, together with other sectors, private service providers, clients, clients' relatives and other residents in the muncipality, develop services for elderly people, based on local needs and resources. The recommendations provide national quantitative goals for the most important services for elderly people. Based on these goals, the municipalities and their partners can develop their own goals. The recommendations focus on promotion of welfare and health and the importance of preventive measures. Elderly people should receive support to live in their own homes, and should have a detailed assessment of their individual service needs. [1, 2]

I februari 2008 gav social- och hälsovårdsministeriet och Finlands Kommunförbund ut en ny kvalitetsrekommendation om tjänster för äldre. Kvalitetsrekommendationen är ett stöd för kommunerna och samarbetsområdena när de tillsammans med den tredje sektorn, privata vårdgivare, klienter, klienternas anhöriga och andra kommuninvånare utvecklar tjänster för äldre med utgångspunkt i lokala behov och resurser. Rekommendationen sätter upp nationella kvantitativa mål för de viktigaste tjänsterna för äldre, och utgående från dem kan kommunerna och samarbetsområdena sätta upp egna mål. Rekommendationen betonar främjande av välfärd och hälsa, stöd för förebyggande verksamhet och hemmaboende samt en utförlig bedömning av det individuella servicebehovet. [1, 2]

Institutional care and non-institutional services for elderly people are provided by both health and social services, and in many municipalities, jointly by these services. Institutional care for elderly people is mostly provided in residential homes and health centre inpatient wards. Day-hospital services are provided by health centres and hospitals. Day centre activities, in turn, are usually provided by social services, and by sheltered housing and support services. Services provided in the person's home are provided by social services (home help service units) or health services (home nursing units) either jointly or separately. [1, 2]

Institutionsvård och öppenvård för äldre produceras såväl inom socialvården som inom hälso- och sjukvården, och i många kommuner också som ett samarbete mellan dessa. Inom äldreomsorgen ges institutionsvård främst på ålderdomshem och hälsovårdscentralernas vårdavdelningar. Dagsjukvård anordnas på hälsovårdscentraler och sjukhus, medan dagcentralverksamhet i regel hör till socialvården. Vanligen ansvarar socialvården också för serviceboende och stödtjänster. Tjänster som ges hemma produceras av socialvården (hemhjälp) och hälso- och sjukvården (hemsjukvård) antingen gemensamt eller separat. [1, 2]

There is no separate legislation concern-

Det finns ingen separat lagstiftning om

ing services for elderly people. Key legislative acts on the provision of health and social services include the Social Welfare Act (710/1982), the Primary Health Care Act (66/1972) and the Act Relating to Specialized Medical Care (1062/1989). These are complemented by specific legislation in the areas of social welfare and health care. [1, 2]

**ÅLAND:** In Åland, care of elderly people is the responsibility of the municipalities, and the legislation and organization are the same as in Finland. One difference between Finland and Åland with regard to health and social services for elderly people, is that all public health and social services in Åland come under a joint organization, Åland's Health and Social Services, with the Home Government of Åland as the responsible body.

In all the municipalities in Åland, the inhabitants can receive home help services. In most of the municipalities there are service housing. Institutional care is provided by the municipality, alone or in cooperation with other municipalities.

**ICELAND:** The aim of care of elderly people in Iceland is that as many elderly people as possible should be able to live in their own homes. The new aim of the Ministry of Social Affairs and Social Security is that 98.5 per cent of people aged 67-74 years, 95.5 per cent of people aged 75-79 years and 80 per cent of people aged 80 and older shall manage to live in their own homes, with appropriate support.

In order to achieve this aim, health and wellbeing are promoted by focussing on personal help in the home (in accor-

äldreomsorg. De viktigaste lagarna om organisation av social service och hälso- och sjukvård är socialvårdslagen (710/1982), folkhälsolagen (66/1972) och lagen om specialiserad sjukvård (1062/1989). De kompletteras av speciallagar om socialvård och hälso- och sjukvård. [1, 2]

**ÅLAND:** På Åland handhas äldreomsorgen av kommunerna och lagstiftning och organisation är samma som i Finland. När det gäller hälso- och sjukvård för äldre skiljer det sig organisatoriskt från övriga Finland eftersom hela den offentliga hälso- och sjukvården är underordnad en samlad organisation, Ålands hälso- och sjukvård, med Ålands landskapsregering som huvudansvarig.

I alla åländska kommuner har invånarna tillgång till hemhjälp och i de flesta kommuner finns serviceboende. Instituinsvården anordnas antingen av den enskilda kommunen eller genom samarbete mellan flera kommuner.

**ISLAND:** Äldreomsorgen på Island syftar till att så många äldre som möjligt skall kunna bo kvar i sina hem. Social- och försäkringsministeriets nya målsättning utgår från att 98,5 procent av de äldre i åldersgruppen 67-74 år, 95,5 procent av åldersgruppen 75-79 år och 80 procent av all 80-åringar och äldre klarar av att bo hemma, med lämpligt stöd.

För att uppnå dessa mål prioriteras främjande av hälsa och välbefinnande genom att fokusera på personlig hjälp i

dance with the Municipal Services Act), home nursing services, outpatient services, short-term care and nursing homes.

In Iceland there is a statutory social security system for all inhabitants, and a statutory pension scheme for all employed people (the Social Security Act).

People in Iceland who do not manage to live independently because of chronic illness, despite being provided with home help services, shall be offered a place in a nursing home.

Nursing homes are owned by non-government organizations, voluntary organizations, or municipalities, but the state provides grants for developing these nursing homes, and finances the organizations, mainly through reimbursement per day of stay.

The Act Relating to Care of Elderly people lays down the services that are provided for elderly people. Elderly people cannot be admitted to a nursing home before they have had a special assesssment carried out by an assessment board.

Icelandic health care and medical services are organized and run by the state, in accordance with the Health Service Act. Health care and medical services are financed primarily by taxes and are divided between primary health services, home nursing and hospitals.

Iceland has special legislation for elderly people – the Act Relating to Care for El-

hemmet enligt lagen om Kommunal service (nummer 40/1991) hemsjukvård, dagsjukvård, korttidsvård, och sjukhem.

På Island finns dels ett lagstadgat socialförsäkringssystem för alla innevånare dels ett lagstadgat pensionssystem för alla på arbetsmarknaden (Socialförsäkringslagen nummer 100/2007).

Personer på Island som inte klarar av att bo på egen hand på grund av kronisk sjukdom, trots erbjuden hemhjälp, ska erbjudas en plats på sjukhem.

Sjukhemmen ägs av icke statliga organisationer, frivilligorganisationer, eller kommunerna, men staten ger bidrag till utveckling av dessa sjukhem och finansierar verksamheten huvudsakligen genom ersättning per vårddag.

Lagen om Äldreomsorg (nummer 125/1999) anger vilka tjänster som tillhandahålls för de äldre. Äldre personer kan inte skrivas in på sjukhem utan att först ha genomgått en särskild bedömning som utförs av lagstadgade bedömningsnämnder/organ.

Den isländska hälso- och sjukvården är organiserad och styrs av staten med utgångspunkt från lagen om Hälso- och sjukvård (nummer 40/2007). Hälso- och sjukvården finansieras främst via skattemedel och fördelas jämt mellan primärhälsovården, sjukvårdshemmen och sjukhusen.

Island har en särskild lagstiftning för de äldre, lagen om Äldreomsorg, med

derly People. The aim of the Act is to protect elderly people and to give them statutory rights to receive treatment and care.

avsikt att värna om de äldre och ge de äldre lagstadgade rättigheter till vård och omsorg.

Legislation for elderly people was regarded as essential when it was introduced in 1982. The legislation has contributed to directing attention to this issue and has stimulated debate. This has resulted in improved rights and conditions for elderly people.

Lagstiftningen för de äldre ansågs nödvändig då den infördes 1982 och har onekligen bidragit till att denna fråga uppmärksammats och sporrat till debatter, vilket har resulterat i bättre rättigheter och omständigheter för de äldre.

This issue has been debated, and several people mean that instead of having special legislation for elderly people, services should be provided on the basis of individual needs, independent of age.

Denna fråga har debatterats och fler anser att istället för en speciell lagstiftning för de äldre bör man istället utgå från individuellt inriktad service vid behov och oavsett ålder.

**NORWAY:** In Norway, responsibility for providing care is mainly decentralized to the municipalities. The local health care services supplement specialized health care services in many areas. Primary health services and social services, to varying degrees, have been coordinated at the level of the municipality. The reform of municipal health services took place in accordance with the Municipal Health Services Act from 1984. With the reform, the municipalities were given responsibility for primary health services, and health and social services were coordinated. With the reform of nursing home services, responsibility was transferred from the county authorities to the municipal authorities in 1988.

**NORGE:** I Norge er ansvaret for å yte pleie og omsorg i utstrakt grad desentralisert til kommunene, og den lokale omsorgs-tjenesten avhjelper spesialisthelsetjenesten for mange oppgaver. Primærhelsetjenesten og sosialtjenesten har i noe ulikt tempo blitt samordnet på kommunenivå. Kommunehelsereformen ble gjennomført med lov om helsetjenesten i kommunene fra 1984. Reformen førte til at kommunene fikk det samlede ansvaret for all primærhelsetjeneste og ble samordnet med sosialtjenesten. Sykehjemsreformen overførte ansvaret for sykehjemmene fra fylkeskommunalt til kommunalt nivå i 1988.

During the last few years, the municipalities in Norway have given more priority to specially adapted housing and home-based services. Home-based services have become more tailor-made, in particular for people with comprehensive needs for

I de senere år har kommunene i Norge valgt å satse mer på tilrettelagte boliger og hjemmetjenester. Hjemmetjenestene har over tid utviklet seg til å bli stadig mer skreddersydde og konsentrert om mennesker med store hjelpebehov.

care. Alternative types of ownership and different ways of running care services through exposure to competition and client-managed arrangements are relatively new, and are still not so widespread within care services in Norway.

Alternative eier- og driftsformer ved konkurranseutsetting eller brukerstyrte ordninger av omsorgstjenesten er relativt nytt og fortsatt ganske lite utbredt i omsorgssektoren i Norge.

Today, the state regulates municipal financing of care services through two different sets of legislation, one for home-based services and one for institutional care. All people who do not live in an institution cover their own living expenses and pay a user fee for health services (consultation with a doctor or psychologist, pharmaceutical products on a "blue prescription", and travelling expenses associated with treatment, up to a maximum annual amount.

Staten regulerer i dag kommunenes adgang til å ta betalt for omsorgstjenester gjennom to ulike regelverk, ett for hjemmetjenester og ett for tilbud i institusjon. Alle som ikke bor i institusjon dekker egne boutgifter og betaler egenandeler for helsetjenester (legehjelp, psykologhjelp, legemidler på blå resept og reiser i forbindelse med behandling) inntil frikortgrensen.

There are no user fees for home nursing services, personal practical help, contact person services and respite care. The municipality can demand a fee for practical help such as cleaning, shopping and preparing food. The municipality can decide on the level of user fees. However, user fees must not be higher than the cost of producing the service. The cost to the client must be at such a level that the client has adequate means to meet personal needs and to support their family.

For kommunale tjenester er hjemmesykepleie og personrettet praktisk bistand fritatt for egenandeler, det samme er støttekontakt og avlastningstiltak. Kommunen kan kreve betaling for praktisk bistand, som f.eks. rengjøring, innkjøp og matlaging. Kommunen står i utgangspunktet fritt til å fastsette nivået på egenandelene. Egenandelene må imidlertid ikke være høyere enn det tjenesten koster å produsere (selvkost). Vederlaget kan ikke settes høyere enn at vedkommende beholder tilstrekkelig midler til å dekke personlige behov og bære sitt ansvar som forsørger, jf. forskriften § 8-3.

**SWEDEN:** The aim of the government's policy for elderly people is that elderly people should be able to live an active life, should have an influence over society and over their everyday life, should be able to grow older with security while maintaining their independence, sho-

**SVERIGE:** Målet för regeringens äldrepolitik är att äldre ska kunna leva ett aktivt liv och ha inflytande i samhället och över sin vardag, kunna åldras i trygghet och med bibehållet oberoende, bemötas med respekt och ha tillgång till god vård och omsorg. Särskilt

uld be met with respect and should have access to adequate treatment and care. Special focus is directed at the most frail individuals, such as people with dementia, people whose native language is not Swedish, and people with several different diseases. [3]

fokus ligger på de sköraste individerna som t.ex. personer med demenssjukdom, personer med annat modersmål än svenska och personer med flera sjukdomar samtidigt. [3]

The Health and Medical Services Act gives people the right to receive treatment in hospitals and health centres, and lays down the division of responsibility between the county councils and the municipalities. The Social Services Act gives people the right to receive help in their home. People also have the right to a place in a residence for elderly people or a day centre if they are unable to meet their needs themselves or if their needs cannot be met in another way.

Hälso- och sjukvårdslagen ger rätt till behandling på sjukhus och vårdcentraler och styr ansvarsfördelningen mellan landsting och kommun. Socialtjänstlagen ger rätt till hjälp i hemmet, äldreboende, dagverksamhet om personen inte själv kan tillgodose sina behov eller få dem tillgodosedda på annat sätt.

Different forms of maximum user charge are available for health care and treatment services, pharmaceutical products and municipal treatment and care services. The county councils offer free dental treatment for elderly people who, because of severe disability, cannot manage to maintain their oral health.

Olika former av högkostnadsskydd finns för hälso- och sjukvård, läkemedel och kommunal vård och omsorg. Landstingen erbjuder fri tandvård för äldre som på grund av omfattande funktionshinder inte själva klarar av att sköta sin tandvård.

For people who need help in the home, a place in a residence for elderly people, taxi services for disabled people, or other services for elderly people, the muncipalies carry out an assessment of the type and amount of care the client needs. [4] The municipality has responsiblity for health and care services, up to the level of services provided by nurses in special residences, and for services and care for elderly people with special needs. This responsibility includes health care for people of all ages who live in residences for disabled people. These people may have physical,

Vid behov av hjälp i hemmet, plats i äldreboende, färdtjänst eller annan äldreomsorg så gör kommunen en bedömning av hjälpbehovet och beslutar även om hjälpens omfattning. [4] Kommunen ansvarar för hälso- och sjukvård upp till och med sjuksköterskenivå i särskilda boendeformer för service och omvårdnad för äldre personer med behov av särskilt stöd. Ansvaret innefattar också hälso- och sjukvård i bostäder med särskild service för funktionshindrade i alla åldrar som av fysiska, psykiska eller andra skäl möter betydande svårigheter i sin livs-

mental or other types of disability that influence their daily life. This division of responsiblity is regulated by the Ädel Reform 1992.

föring. Denna ansvarsfördelning reglerades genom ÄDEL-reformen 1992.

As a result of the reform, the municipalities have taken over responsibility for providing care for patients when they are discharged from the following services: acute somatic treatment, geriatric treatment and mental health care, provided as inpatient care by the county councils. When these patients are ready to be discharged, a treatment plan has to be drawn up. A patient is ready to be discharged if he or she has been assessed by a doctor to no longer require inpatient treatment.

Genom Ädelreformen övertog kommunerna betalningsansvaret från landstingen för patienter vid enheter för somatisk akutsjukvård, geriatrisk vård eller psykiatrisk vård inom landstingets slutna hälso- och sjukvård som är utskrivningsklara och för vilka en vårdplan bör finnas upprättad. En patient är utskrivningsklar om han eller hon av den behandlande läkaren inte längre bedöms behöva vård vid en enhet inom landstingets slutna hälso- och sjukvård (10§ Lag (2003:193).

In April 2008, the National Board of Health and Welfare launched its web site: *Guide for Elderly People*, to make it easier for elderly people and their relatives to compare the quality of treatment and care services provided by different residential homes and by different municpalities.

I april 2008 lanserade Socialstyrelsen webbplatsen *Äldreguiden* för att underlätta för äldre och anhöriga att jämföra kvaliteten inom vården och omsorgen mellan olika äldreboenden och mellan olika kommuner.

In June 2008, the Swedish municipalities and county councils launched their web site Gateway for Elderly People – a meeting place for muncipalities and county councils to share their experiences and to describe measures that have led to improved quality of services for elderly people.

I juni 2008 presenterade Sveriges kommuner och landsting webbplatsen *Äldreportalen* – en mötesplats för kommuner och landsting för att sprida och förmedla erfarenheter om utvecklingsarbete och goda exempel för att bidra till ökad kvalitet inom äldreomsorgen.

## What influences ageing?

## Vad styr människans åldrande?

Elderly people do not make up one homogenous group in relation to health and living conditions, and there is obviously large individual variation. Most

Gruppen äldre är ingen homogen grupp när det gäller hälsa och olika livsbetingelser och det finns självklart stora individuella variationer. Det sto-

elderly people have good health when they become a pensioner, and they can live a long time, maintain their health and function well. With increasing age, the prevalence of disease and disability increases.

In the report *The Genetics of Ageing*, a number of researchers attempt to answer the questions: What influences ageing? Why do we age so differently? [5]

According to the researcher Andrus Viidik, our genes (genetic makeup) are of great importance, and they influence, among other things, our resistance to diseases and injury and our disposition to be affected by age-related conditions. These genetic factors can both accelerate and slow down ageing.

But environmental factors such as lifestyle, our habits and the external environment, can also have an influence on ageing. Physical activity and a balanced diet counteract ageing. Overweight, inactivity, smoking and high alcohol consumption hasten ageing. All these factors play a role in a complex interaction between heredity and the environment.

With time, age changes occur in all organs. This means that the organs' function deteriorates, at a different rate for different individuals and also for different organs in the same individual. [5]

According to the researcher Nancy Pedersen, genetic factors explain about 65 per cent of the variation in different cognative abilities. But she also stresses that, in relation to ageing, as with various diseases, there is a complex interaction between heredity and the environ-

ra flertalet av de äldre som går i ålderspension har en god hälsa och kan leva länge med bibehållen hälsa och god funktionsförmåga. Med stigande ålder så ökar förekomsten av sjukdomar och funktionsnedsättningar.

I konferensrapporten *Åldrandets genetik* försöker ett antal forskare besvara frågorna: Vad styr människans åldrande? Varför åldras vi så olika? [5]

Enligt forskaren Andrus Viidik så har våra gener (arvsanlag) stor betydelse och påverkar bland annat vår motståndskraft mot sjukdomar och skador samt vår benägenhet att drabbas av åldersrelaterade tillstånd. Dessa genetiska faktorer kan både påskynda och bromsa åldrandet.

Men miljöfaktorer som vår livsstil, våra levnadsvanor samt den yttre miljön påverkar också åldrandet. Fysisk aktivitet, balanserad kost motverkar åldrandet medan övervikt, inaktivitet, tobaksrökning och hög alkoholkonsumtion påskyndar åldrandet. Allt sker i ett komplext samspel mellan arv och miljö.

Med tiden sker åldersförändringar i alla organ, vilket medför att organens funktioner försämras men olika för olika individer och även olika för olika organ hos en och samma individ. [5]

Enligt forskaren Nancy Pedersen förklarar genetiska faktorer cirka 65 procent av variationen i olika kognitiva förmågor men betonar också att när det gäller såväl åldrande som olika sjukdomar är det fråga om ett komplext samspel mellan arv och miljö.

ment. The importance of genetic factors also tends to diminish with increasing age. It is therefore possible, through a sensible life-style, to prevent different diseases. [5]

Betydelsen av genetiska faktorer tenderar även att avta med ökad ålder och därför är det möjligt att genom en vettig livsstil försöka förebygga olika sjukdomar. [5]

## The elderly population in the Nordic Countries

Table 1 shows the number of people in the population according to age and gender, in order to give a picture of the elderly population in the Nordic countries. Table 2 shows the distribution of different age groups in relation to the total population.

The number of people aged 65 years and over has markedly increased over the last decade, and all forecasts predict that this increase will continue. Of all the Nordic countries, Sweden has the highest percentage of people aged 65 years and over – 17.3 per cent – and also the highest proportion of people aged 80 and over – 5.3 per cent (Table 2). The most dramatic population increase during the next decade will be in the age group 80 years and over.

Average life expectancy at birth has increased over many years and is expected to continue to increase (Table 3). Average life expectancy is the number of years a person can expect to live, calculated on the basis of the risk of death in each age group. Since calculation of average life expectancy began, women have always had longer life expectancy than men. Average life expectancy is now increasing slightly more for men than for women, so that the difference is decreasing.

## Den äldre befolkningen i de nordiska länderna

I den första tabellen redovisas antal personer fördelat på kön och ålder för att ge en bild av den äldre befolkningen i de nordiska länderna. I tabell 2 redovisas fördelningen mellan olika åldersgruppper i förhållande till totalbefolkningen.

Andelen personer i åldrarna över 65 år i de nordiska länderna har ökat markant de senaste decennierna och alla prognoser pekar på att denna ökning fortsätter framöver. Av de nordiska länderna har Sverige högst andel över 65 år och äldre med 17,3 procent och även högst andel 80 år och äldre med 5,3 procent (se tabell 2). De mest dramatiska befolknings-ökningarna kommer de närmaste decennierna att ske i åldrarna 80 år och över.

Återstående medellivslängd räknat från födelsen har ökat i många år och förväntas fortsätta att öka (se tabell 3). Med återstående medellivslängd det genomsnittliga antal år som en person förväntas leva beräknat utifrån dödsrisken i varje åldersgrupp. Ända sedan man började beräkna medellivslängd har kvinnor haft längre medellivslängd än män. Nu ökar medellivslängden något mer för män än för kvinnor vilket bidrar till att könsskillnaderna minskat något.

During the first half of the 20th Century, the decrease in mortality from infectious diseases, particularly for young people, contributed to an increase in average life expectancy. During the second half of the 20th Century, primarily the decrease in mortality from cardiovascular diseases contributed to increased average life expectancy. This, in combination with reduced fertility, has resulted in an increase in the proportion of elderly people in the population.

Under första hälften av 1900-talet bidrog den minskande dödligheten i infektionssjukdomar, framför allt bland de yngre, till en ökad av medellivslängd. Under den andra hälften av 1900-talet är det först och främst den minskade dödligheten i hjärt-kärlsjukdom som bidragit till en ökad medellivslängd. Tillsammans med minskad fruktsamhet har det resulterat i en ökad andel äldre i befolkningen.

Between 1960 and 2006, average life expectancy at birth for Finnish men and women increased by 10 years, while average life expectancy for Danish men increased by 5.5 years, and for Danish women by 6 years.

Mellan 1960 och 2006 så ökade finländska mäns och kvinnors återstående medellivslängd från födelsen med drygt 10 år medan en dansk mans medellivslängd ökade 5,5 år och en dansk kvinnas medellivslängd ökade 6 år.

In 2006, a Danish woman lived on average 2.6 years less than an Icelandic woman.

År 2006 så lever en dansk kvinna i genomsnitt 2,6 år kortare än en isländsk kvinna.

The differences are greater for men. An Icelandic man can expect to live on average 3.6 years longer than a Finnish man.

Skillnaderna är dock större mellan de nordiska männen, där en isländsk man kan förväntas leva i genomsnitt 3,6 år längre än en finländsk man.

**Table 1 Mean population in the Nordic countries 2006**
**Number of men and women in different age groups**

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| *Men* | | | | | | | | |
| 0-19 | 683 001 | 7 635 | 9 455 | 626 935 | 3 263 | 45 017 | 620 156 | 1 110 192 |
| 20-64 | 1 649 421 | 14 437 | 19 140 | 1 608 647 | 8 036 | 93 307 | 1 403 443 | 2 710 984 |
| 65-69 | 121 592 | 944 | 762 | 113 204 | 624 | 4 586 | 86 616 | 208 994 |
| 70-74 | 91 237 | 776 | 469 | 90 986 | 494 | 4 129 | 68 903 | 162 301 |
| 75-79 | 68 411 | 605 | 255 | 70 909 | 375 | 3 575 | 60 180 | 135 478 |
| 80-84 | 45 495 | 394 | 83 | 40 013 | 265 | 2 195 | 44 510 | 102 611 |
| 85-89 | 22 402 | 208 | 14 | 15 887 | 128 | 1 087 | 22 361 | 54 681 |
| 90+ | 8 620 | 77 | 4 | 5 769 | 60 | 391 | 7 716 | 19 797 |
| Total | 2 690 179 | 25 076 | 30 182 | 2 572 350 | 13 245 | 154 287 | 2 313 885 | 4 505 037 |
| *Women* | | | | | | | | |
| 0-19 | 649 360 | 7 172 | 9 204 | 600 911 | 3 052 | 43 077 | 589 938 | 1 054 041 |
| 20-64 | 1 623 712 | 12 472 | 15 832 | 1 577 922 | 7 921 | 87 674 | 1 363 108 | 2 631 882 |
| 65-69 | 129 499 | 870 | 637 | 129 230 | 617 | 4 761 | 92 450 | 217 414 |
| 70-74 | 105 345 | 759 | 495 | 114 778 | 538 | 4 608 | 80 403 | 185 104 |
| 75-79 | 89 076 | 748 | 360 | 109 611 | 483 | 4 260 | 78 461 | 175 409 |
| 80-84 | 73 669 | 621 | 126 | 83 845 | 445 | 3 026 | 71 412 | 153 906 |
| 85-89 | 47 071 | 352 | 47 | 44 605 | 279 | 1 749 | 47 409 | 102 680 |
| 90+ | 26 656 | 182 | 18 | 22 328 | 186 | 892 | 23 611 | 55 035 |
| Total | 2 744 388 | 23 176 | 26 179 | 2 683 230 | 13 521 | 150 047 | 2 346 792 | 4 575 468 |
| *Men and women* | | | | | | | | |
| 0-19 | 1 332 361 | 14 806 | 18 659 | 1 227 846 | 6 315 | 88 094 | 1 210 094 | 2 164 233 |
| 20-64 | 3 273 133 | 24 160 | 34 972 | 3 186 569 | 15 957 | 180 981 | 2 766 550 | 5 342 865 |
| 65-69 | 251 091 | 1 814 | 1 399 | 242 434 | 1 241 | 9 347 | 179 067 | 426 408 |
| 70-74 | 196 582 | 1 535 | 964 | 205 764 | 1 032 | 8 737 | 149 306 | 347 405 |
| 75-79 | 157 487 | 1 353 | 615 | 180 520 | 858 | 7 835 | 138 641 | 310 887 |
| 80-84 | 119 164 | 1 015 | 209 | 123 858 | 710 | 5 221 | 115 921 | 256 516 |
| 85-89 | 69 473 | 560 | 61 | 60 492 | 407 | 2 836 | 69 770 | 157 361 |
| 90+ | 35 276 | 259 | 22 | 28 097 | 246 | 1 283 | 31 328 | 74 832 |
| Total | 5 434 567 | 48 252 | 56 901 | 5 255 580 | 26 766 | 304 334 | 4 660 677 | 9 080 505 |
| Men and women 65+ | 829 073 | 6 536 | 3 270 | 841 165 | 4 494 | 35 259 | 684 033 | 1 573 409 |
| Men and women 80+ | 223 913 | 1 834 | 292 | 212 447 | 1 363 | 9 340 | 217 019 | 488 709 |

Source: The central statistical bureaus

**Table 2 Mean population by sex and age as a percentage of the total population in the Nordic population, 2006**

| | Denmark | Faroe Islands | Greenland | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|---|
| *Men* | | | | | | | | |
| 0-19 | 12.6 | 15.8 | 16.6 | 11.9 | 12.2 | 14.8 | 13.3 | 12.2 |
| 20-64 | 30.4 | 29.9 | 33.6 | 30.6 | 30.0 | 30.7 | 30.1 | 29.9 |
| 65-69 | 2.2 | 2.0 | 1.3 | 2.2 | 2.3 | 1.5 | 1.9 | 2.3 |
| 70-74 | 1.7 | 1.6 | 0.8 | 1.7 | 1.8 | 1.4 | 1.5 | 1.8 |
| 75-79 | 1.3 | 1.3 | 0.4 | 1.3 | 1.4 | 1.2 | 1.3 | 1.5 |
| 80-84 | 0.8 | 0.8 | 0.1 | 0.8 | 1.0 | 0.7 | 1.0 | 1.1 |
| 85-89 | 0.4 | 0.4 | 0.0 | 0.3 | 0.5 | 0.4 | 0.5 | 0.6 |
| 90+ | 0.2 | 0.2 | 0.0 | 0.1 | 0.2 | 0.1 | 0.2 | 0.2 |
| Total | 49.5 | 52.0 | 53.0 | 48.9 | 49.5 | 50.7 | 49.6 | 49.6 |
| *Women* | | | | | | | | |
| 0-19 | 11.9 | 14.9 | 16.2 | 11.4 | 11.4 | 14.2 | 12.7 | 11.6 |
| 20-64 | 29.9 | 25.8 | 27.8 | 30.0 | 29.6 | 28.8 | 29.2 | 29.0 |
| 65-69 | 2.4 | 1.8 | 1.1 | 2.5 | 2.3 | 1.6 | 2.0 | 2.4 |
| 70-74 | 1.9 | 1.6 | 0.9 | 2.2 | 2.0 | 1.5 | 1.7 | 2.0 |
| 75-79 | 1.6 | 1.6 | 0.6 | 2.1 | 1.8 | 1.4 | 1.7 | 1.9 |
| 80-84 | 1.4 | 1.3 | 0.2 | 1.6 | 1.7 | 1.0 | 1.5 | 1.7 |
| 85-89 | 0.9 | 0.7 | 0.1 | 0.8 | 1.0 | 0.6 | 1.0 | 1.1 |
| 90+ | 0.5 | 0.4 | 0.0 | 0.4 | 0.7 | 0.3 | 0.5 | 0.6 |
| Total | 50.5 | 48.0 | 47.0 | 51.1 | 50.5 | 49.3 | 50.4 | 50.4 |
| *Men and women* | | | | | | | | |
| 0-19 | 24.5 | 30.7 | 32.8 | 23.4 | 23.6 | 28.9 | 26.0 | 23.8 |
| 20-64 | 60.2 | 50.1 | 61.5 | 60.6 | 59.6 | 59.5 | 59.4 | 58.8 |
| 65-69 | 4.6 | 3.8 | 2.5 | 4.6 | 4.6 | 3.1 | 3.8 | 4.7 |
| 70-74 | 3.6 | 3.2 | 1.7 | 3.9 | 3.9 | 2.9 | 3.2 | 3.8 |
| 75-79 | 2.9 | 2.8 | 1.1 | 3.4 | 3.2 | 2.6 | 3.0 | 3.4 |
| 80-84 | 2.2 | 2.1 | 0.4 | 2.4 | 2.7 | 1.7 | 2.5 | 2.8 |
| 85-89 | 1.3 | 1.2 | 0.1 | 1.2 | 1.5 | 0.9 | 1.5 | 1.7 |
| 90+ | 0.6 | 0.5 | 0.0 | 0.5 | 0.9 | 0.4 | 0.7 | 0.8 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Men and women 65+ | 15.3 | 13.7 | 13.7 | 16 | 16.7 | 11.7 | 14.8 | 17.3 |
| Men and women 80+ | 4.2 | 3.8 | 3.8 | 4 | 5.1 | 3.1 | 4.7 | 5.3 |

Source: The central statistical bureaus

**Table 3 Average life expectancy at birth, at 65 years and at 80 years for men and women for the years 1960[1] and 2006[1] and projections for the years 2025-30[2] and 2045-50[2]**

| | Denmark | Finland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|
| *At birth* | | | | | |
| *Men* | | | | | |
| 1960 | 70.4 | 65.5 | 70.7 | 71.3 | 71.2 |
| 2006 | 75.9 | 75.8 | 79.4 | 78.1 | 78.7 |
| 2025-30 | 77.9 | 79.4 | 82.2 | 80.5 | 81.2 |
| 2045-50 | 80.0 | 82.1 | 84.3 | 82.7 | 83.4 |
| *Women* | | | | | |
| 1960 | 74.4 | 72.5 | 75.0 | 75.8 | 74.9 |
| 2006 | 80.4 | 82.8 | 83.0 | 82.7 | 82.9 |
| 2025-30 | 82.5 | 84.9 | 85.6 | 85.0 | 85.4 |
| 2045-50 | 84.6 | 87.1 | 87.8 | 87.2 | 87.6 |
| *At 65* | | | | | |
| *Men* | | | | | |
| 1960 | 13.7 | 11.5 | 15.0 | 14.5 | 13.7 |
| 2006 | 16.2 | 16.8 | 18.3 | 17.5 | 17.6 |
| 2025-30 | 17.0 | 18.0 | 19.8 | 18.7 | 19.0 |
| 2045-50 | 18.3 | 19.8 | 21.3 | 20.1 | 20.6 |
| *Women* | | | | | |
| 1960 | 15.3 | 13.7 | 16.9 | 16.0 | 15.3 |
| 2006 | 19.0 | 20.9 | 20.6 | 20.6 | 20.8 |
| 2025-30 | 20.6 | 22.1 | 22.7 | 22.3 | 22.5 |
| 2045-50 | 22.1 | 23.9 | 24.5 | 24.0 | 24.3 |
| *At 80* | | | | | |
| *Men* | | | | | |
| 1960 | 5.8 | 5.0 | 6.2 | 6.2 | 5.7 |
| 2006 | 7.1 | 7.4 | 7.8 | 7.5 | 7.6 |
| 2025-30 | 7.8 | 8.3 | 9.3 | 8.4 | 8.7 |
| 2045-50 | 8.6 | 9.4 | 10.3 | 9.4 | 9.7 |
| *Women* | | | | | |
| 1960 | 6.1 | 5.5 | 7.1 | 6.7 | 6.2 |
| 2006 | 8.8 | 9.2 | 9.4 | 9.2 | 9.4 |
| 2025-30 | 10.0 | 10.5 | 11.0 | 10.6 | 10.8 |
| 2045-50 | 10.9 | 11.9 | 12.3 | 12.0 | 12.2 |

1 Statistical bureaus for 1960 and for 2006
2 United Nations Department of Economic and Social Affairs, World Population Ageing 2007, projections for the years 2025-2030 and 2045-2050

## Health of the elderly

In the latest Swedish Public Health Report, it is asserted that a clear definition of health is lacking, and the concept of health is often used without clearly defining what it means. Health is also associated with values and cultural patterns,

## Äldres hälsa

I den senaste svenska *Folkhälsorapporten* konstateras att det saknas ett entydigt hälsobegrepp och att begreppet hälsa ofta används utan att det närmare preciseras vad som avses. Hälsa hör även ihop med värderingar, kulturmönster och är förän-

and changes over time. There are several different approaches and theories about what health is, and the concept of health is often used as a goal to achieve without defining it more clearly. [6]

From an epidemiological view, which is used here, in which health or disease are studied over time in a specific population, these concepts are often seen as opposites. This is largely because health data that describe use of inpatient services, consumption of pharmaceutical products etc., or interview surveys in which questions are asked about sickness and disability, are used.

Ageing is the result of complex biological, psychological and social processes that occur slowly and successively without clear limits and with great variation in different individuals.

Lifestyle factors such as unhealthy eating and drinking habits, low level of physical activity, smoking influence the body and can result in poor health and disablility. Changes in the health status of elderly people can also be influenced by factors that have their basis in a long period earlier in life.

The proportion of people in the population with one or more health problems at the same time increases with increasing age. The need for treatment and care also increases as morbidity increases and as physical and mental functioning decreases.

Reliable statistics on causes of death, the incidence of cancer, consumption of pharmaceutical products and hospital admissions are available for all countries. Data on outpatient treatment in hospitals

derlig över tid. Det finns flera olika synsätt och teorier på vad hälsa är och ofta används begreppet hälsa som ett mål att sträva mot utan närmare definition. [6]

Med ett epidemiologiskt synsätt, som används här, där man studerar hälsa eller sjukdom över tid i en bestämd population, ses ofta dessa begrepp som varandras motsatser. Det beror till stor del på att man utgår från de hälsodata som beskriver slutenvårdskonsumtion, läkemedelförskrivning och så vidare eller intervjuundersökningar där man ställer frågor om sjukdom och funktionsnedsättning.

Åldrandet utgörs av komplexa biologiska, psykologiska och sociala processer, vilka sker långsamt och successivt utan bestämda gränser och med stor variation mellan olika individer.

Livsstilsfaktorer såsom osunda mat- och dryckesvanor, låg fysisk aktivitet, rökning påverkar kroppen och kan leda till sämre hälsa och funktionsnedsättning. Hälsoförändringar för de äldre kan även bero på faktorer som grundlagts under en mycket lång period tidigare i livet.

Med stigande ålder så ökar andelen i befolkningen med ett eller flera hälsoproblem samtidigt. Även beroendet av vård och omsorg ökar då sjukligheten ökar och/eller fysisk och psykisk funktionsförmåga avtar.

För alla länder finns tillförlitlig statistik för dödsorsaker, cancerincidens, läkemedelsuttag och sjukhusinläggningar. Data för öppenvård vid sjukhus och primärvård är inte helt jämförbart mel-

and for primary health services are not completely comparable for the Nordic countries, so the working group has chosen not to include statistics for these areas.

lan de nordiska länderna och därför har arbetsgruppen valt att inte redovisa dessa.

The statistics on pharmaceutical products do not include statistics on non-prescription drugs, drugs requisitioned by residential homes for elderly people and drugs used by inpatients in hospitals. Differences in use of prescription drugs and requisitioned drugs in residential homes can vary in the different Nordic countries, and can affect the comparability of statistics on pharmaceutical products.

Läkemedelsstatistiken innehåller inte receptfria läkemedel, inte heller rekvisitioner till äldreboenden eller de läkemedel som konsumeras inom den slutna vården. Skillnader i hur rekvisition kontra recept hanteras på äldreboenden i de olika länderna kan påverka jämförelsen av läkemedelsdata.

In this section, some of the common reasons for admission to hospital, consumption of pharmaceutical products and mortality among elderly people are presented. For inpatient treatment, the proportion of patients in different diagnostic groups is presented. For pharmaceutical products, the number of defined daily doses (DDD) per 1 000 inhabitants is presented. For mortality, the number of deaths for different diagnostic groups is presented.

I detta avsnitt redovisas några av de vanligare orsakerna till inläggning i slutenvård, läkemedelskonsumtion och dödlighet bland de äldre. För slutenvård redovisas andel patienter för olika valda diagnosgrupper, för läkemedel redovisas antal dygnsdoser (DDD) per 1 000 invånare och för dödlighet redovisas andel avlidna för vissa diagnosgrupper.

Elderly people who receive inpatient care or outpatient care, or who live in residential homes often have many different chronic diseases at the same time, or disability as a result of accidents. These patients often receive several different types of treatment at the same time. In the report *Evidence Based Treatment for Elderly People*, the Swedish Council on Technology Assessment in Health Care, after a review of the statistics on inpatient care, has found that statistics on diagnoses do not give a full picture of morbidity among elderly people. This is because diagnoses are often based on different

Äldre personer som vårdas i öppen eller sluten vård eller bor på äldreboenden har ofta många olika kroniska sjukdomar samtidigt eller funktionsnedsättning efter skador. Dessa patienter är ofta föremål för flera typer av behandlingar samtidigt. Statens beredning för medicinsk utvärdering har i rapporten, *Evidensbaserad äldrevård*, efter genomgång av diagnossättningen i slutenvård konstaterat att detta inte ger en fullständig bild av de äldres sjuklighet. Det beror på att diagnossättningen ofta baseras på olika akuta sjukdomstillstånd och att underliggan-

acute illnesses, and underlying chronic conditions are less often reported. This is important to take into account when analysing morbidity among elderly people. [7]

de kroniska tillstånd mer sällan rapporteras. Detta är viktigt att beakta när man analyserar äldres sjuklighet. [7]

For several decades, the Nordic countries have developed their own surveys of living conditions, that have been adapted to national conditions. This has led to certain differences between the countries in survey methodology and response rate, which in some cases has led to reduced comparability of statistics between the countries over time. Hopefully, European cooperation in the field of health statistics will lead to improved comparability between the European countries, including the Nordic countries.

De nordiska länderna har under flera decennier utvecklat egna levnadsnivåundersökningar som anpassats efter nationella förhållanden. Det har medfört vissa skillnader mellan länderna i undersökningsmetodik och täckningsgrad vilket i vissa fall minskat jämförbarheten mellan länderna och över tid. Det europeiska samarbetet inom hälsostatistiken kommer förhoppningsvis att leda till bättre jämförelser mellan länder, vilket även kan nyttjas av de nordiska länderna och Nomesko.

In this theme section, statistics on self-reported health are presented, from the European survey: *Statistics on Income and Living Conditions* (EU-SILC) for the Nordic countries.

I temat redovisas uppgifter om självskattad hälsa från den europeiska undersökningen *Statistics on Income and Living Conditions* (EU-SILC) för de nordiska länderna.

## Lifestyle

Lifestyle is of importance for public health. Unhealthy lifestyle can lead to disease and disability, and can result in reduced quality of life.

Risk factors such as smoking, alcohol, overweight and obesity, low level of physical activity and unhealthy eating habits have a large influence on our health. In several of the Nordic countries, alcohol consumption, and the incidence of overweight and obesity, are increasing. This can lead to increased morbidity and increased need for treatment services. At

## Levnadsvanor

Levnadsvanorna är av väsentlig betydelse för folkhälsan. Osund livsstil kan medföra besvär och sjukdom med eventuell funktionsnedsättning och minskad livskvalitet som följd.

Riskfaktorer som rökning, alkohol, övervikt och fetma, fysisk inaktivitet samt dåliga kostvanor har en stor inverkan på vår hälsa. I flera av de nordiska länderna ökar alkoholkonsumtionen och även övervikt och fetma, vilket på sikt kan leda till ökad sjuklighet och ökat behov av vård. Samtidigt så konsumeras, enligt *OECD:s hälsodatabas 2008*, mer av frukt

the same time, according to OECD Health Data 2008, the consumption of fruit and vegetables is increasing, which is positive in terms of health. The Nordic country in which most fruit and vegetables are consumed is Denmark. [8]

och grönsaker, vilket är positivt ur hälsosynpunkt. Av de nordiska länderna konsumeras mest frukt och grönsaker i Danmark. [8]

Smoking greatly increases the risk for different types of cancer, heart diseases and respiratory diseases.

Rökning mångdubblerar risken för framför allt olika cancersjukdomar, hjärt- kärlsjukdomar och sjukdomar i andningsorganen.

Smoking is a risk factor that has a great influence on morbidity and mortality. But for elderly people who have smoked for many years, stopping smoking can be of substantial benefit.

Rökning är en riskfaktor som har stor inverkan på sjukdom och dödlighet. Även för de äldre som rökt i många år så kan ett rökstopp ge betydande hälsovinster.

The proportion of smokers among elderly people varies between the Nordic countries and between men and women. Finnish women and Swedish men smoke the least (Table 4). As shown in the table, there are different age groups in the Nordic health surveys, so the figures are not directly comparable.

Andelen rökare bland de äldre varierar mellan de nordiska länderna och mellan män och kvinnor. I Norden röker finländska kvinnor respektive svenska män minst (se tabell 4). Som framgår av tabellen så redovisar de nordiska intervjuundersökningar olika åldersgrupper, vilket inte gör det helt jämförbart mellan de nordiska länderna.

**Table 4 Percentage of daily smokers by sex and age in the Nordic countries**

| | Denmark | Finland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|
| | 2005 | 2006 | 2006 | 2005 | 2004-05 |
| *Men* | | | | | |
| 60-69 | . | . | 16.3 | . | . |
| 65-74 | . | 20.5 | . | . | 11.2 |
| 65-79 | 30.0 | . | . | . | . |
| 70-79 | . | . | 13.2 | . | . |
| 75-84 | . | 10.7 | . | . | 7.9 |
| 80-89 | . | . | 0.0 | . | . |
| 65+ | 28.5 | 16.1 | . | . | . |
| 67+ | . | . | . | 16 | . |
| 75+ | . | . | . | . | . |
| 80+ | 23.0 | . | . | . | . |
| 85+ | . | 10.8 | . | . | 4.2 |
| *Women* | | | | | |
| 60-69 | . | . | 19.5 | . | . |
| 65-74 | . | 6.5 | . | . | 15.7 |
| 65-79 | 25.0 | . | . | . | . |
| 70-79 | . | . | 14.7 | . | . |
| 75-84 | . | 3.0 | . | . | 9.0 |
| 80-89 | . | . | 6.3 | . | . |
| 65+ | 21.7 | 5.0 | . | . | . |
| 67+ | . | . | . | 13 | . |
| 75+ | . | . | . | . | . |
| 80+ | 14.0 | . | . | . | . |
| 85+ | . | 2.2 | . | . | 4.6 |

Source: National Surveys in the Nordic countries, see Table 3.1.1 Section A

## Self-reported health among elderly people

Self-reported health is an important indicator of long-term health, disability and mortality. Reliable and comparable statistics of self-reported health for the oldest group of elderly people are more difficult to obtain than for adults in general. Reasons for this can be that reduced sight and hearing, and reduced cognitive function, are more common among the oldest group of elderly people. Also, there are few epidemiological surveys or interview surveys that include inpatients, or people who live in residential homes or institutions. This can influence the results, as the

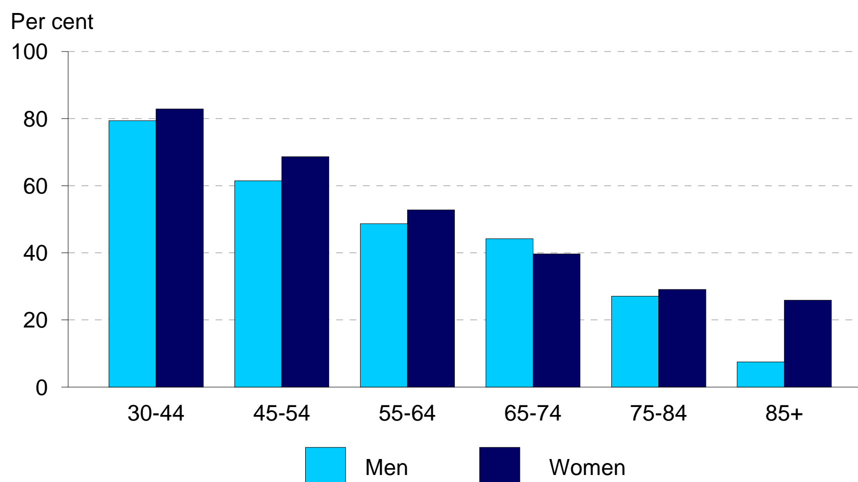
## Självskattad hälsa hos äldre

Självskattad hälsa är en viktig indikator för långvarig sjukdom, funktionsnedsättning och dödlighet. Tillförlitliga och jämförbara data av de allra äldstas självskattade hälsa är svårare att få fram än bland vuxna i övrigt. Det kan bero på att syn- och hörselnedsättningar, kognitiva funktionsnedsättningar är mer vanligt förekommande bland de allra äldsta. Vidare är det få epidemiologiska studier eller intervjundersökningar som inkluderar patienter i slutenvård eller de som bor på äldreboende eller på institution. Det kan få effekt på resultatet genom att

most healthy people in the oldest group of elderly people are over-represented in surveys. This must be taken into consideration when using the results of such surveys. An exception in this respect is the Finnish survey *Health 2000* [9]. This survey has a low drop-out rate, and different methods were used to reach the group of elderly people that can be difficult to reach, or who are excluded from other surveys. Figure 1 shows results from the Finnish survey of self-reported health in the population. Only 7.5 per cent of men but 25.9 per cent of women over 85 years of age reported that their health was good or very good. For the age group 65-74 years, a higher proportion of men than women reported that their health was good or very good. For the age group 75-84, the proportion for men and women was about the same. For the oldest age group, those over 85 years of age, the proportion was much lower for men.

det blir de friskaste bland de allra äldsta som finns representerade i studien eller intervjuundersökningen. Detta måste man ta i beaktande då man använder sig av dessa resultat. Ett undantag i detta fall är den finska studien *Hälsa 2000* [9] som dels har ett litet bortfall dels använder olika metoder för att nå grupper bland de äldre som annars kan vara svåra att nå eller är exkluderade i andra studier. I figur 1 visas resultaten från den finska studien om självskattad hälsa i befolkningen, där bara 7,5 procent av männen medan 25,9 procent av kvinnorna över 85 år skattade sin hälsa som god eller mycket god. Endast i åldersgruppen 65-74 år rapporterar männen en högre andel god eller mycket god självskattad hälsa än kvinnorna. I åldersgruppen 75-84 är det relativt jämt mellan könen men bland de allra äldsta männen över 85 år så har detta minskat till en mycket låg nivå.

**Figure 1 Prevalence of good or very good self-reported health among Finnish men and women**




Source: National Public Health Institute. Health and functional capacity in Finland, Baseline Results of the Health 2000 Examination Survey (2004)

Table 5 presents statistics for self-reported health, from the European survey *European Union Statistics on Income and Living Conditions (EU-SILC),* according to age-group in the Nordic countries.

I tabell 5 redovisas uppgifter om självskattad hälsa från den europeiska undersökningen *the European Union Statistics on Income and Living Conditions (EU-SILC)*, fördelade på åldersgrupper i de nordiska länderna.

This survey shows that, to a large extent, elderly people in the Nordic countries assess their health as good or very good, with the exception of Finland. [10]

Denna undersökning visar att de äldre i de nordiska länderna i hög grad uppfattar sig ha en god eller mycket god hälsa med undantag av Finland. [10]

**Table 5 Health status: Self-perceived health by age group (percentage) in 2005**

| | Denmark | Finland | Iceland[2)] | Norway | Sweden |
|---|---|---|---|---|---|
| *Age 65-74* | | | | | |
| Very good | 31.7 | 16.8 | 24.6 | 12.8 | 24.1 |
| Good | 31.8 | 28.4 | 22.1 | 45.5 | 39.3 |
| Fair | 29.6 | 36.3 | 35.4 | 25.9 | 26.8 |
| Bad | 6.0 | 13.3 | 11.3 | 13.7 | 6.8 |
| Very bad | 0.9 | 5.2 | 6.6 | 2.0 | 3.1 |
| *Age 75-84* | | | | | |
| Very good | 15.8 | 7.9 | 22.3 | 9.4 | 14.7 |
| Good | 31.2 | 21.3 | 24.4 | 42.7 | 32.0 |
| Fair | 34.0 | 38.8 | 36.1 | 28.4 | 39.2 |
| Bad | 15.5 | 22.6 | 10.5 | 15.1 | 10.3 |
| Very bad | 3.5 | 9.3 | 6.7 | 4.0 | 3.6 |
| *Age 85+* | | | | | |
| Very good | 12.5 | 10.5 | 19.2 | 8.5 | 10.4 |
| Good | 35.6 | 13.9 | 33.6 | 34.9 | 29.8 |
| Fair | 28.0 | 39.6 | 25.7 | 26.9 | 42.2 |
| Bad | 16.2 | 21.5 | 11.9 | 26.5 | 12.0 |
| Very bad | 7.7 | 14.5 | 9.7 | 3.2 | 4.6 |

Source: Eurostat[1)]

1 European Commission, DG SANCO, the European Union Statistics on Income and Living Conditions (EU-SILC) based on the national surveys in the Nordic countries
2 Uncertain data for the age group 85+

## Consumption of medication

During the last decade, many new types of medication have been developed, both improvements in already available medication and completely new medication. Consumption of medication is increasing in all the Nordic countries, and elderly people account for a large proportion of consumption. The increase in costs, to a large extent, is due to a switch from older, cheaper medication to new and more expensive medication. Generic substitution, in which the pharmacist substitutes the prescribed medication with a cheaper alternative, is used in all the Nordic countries as a method of reducing costs.

The groups of medication that have the highest consumption are medication for cardiovascular diseases (ATC Group C) and medication for treatment of pain and mental disorders (ATC Group N).

Ageing leads to changes both in consumption of medication and in the body's sensitivity to medication. Consequently, many medicines have a different and stronger effect for elderly people. Elderly people often suffer from several diseases, and this means that they are treated with several different types of medication at the same time. When prescribing medication for elderly people, it is important to take account of their weight and whether they have impaired kidney funtion. Inappropriate use of medication is a common cause of hospital admission of elderly people, and this should be avoided.

## Äldres läkemedelskonsumtion

Under de senaste decennierna har det utvecklats många nya mediciner, både förbättringar av redan befintliga läkemedel och helt nya läkemedel. Förbrukningen av läkemedel ökar i alla de nordiska länderna och de äldre står för en stor andel av läkemedelskonsumtionen. De ökade kostnaderna beror till stor del på en växling från äldre billiga läkemedel till nya och dyrare läkemedel. Generiskt utbyte, där farmaceuten ersätter den förskrivna medicinen med ett billigare alternativ, används i alla de nordiska länderna som ett sätt att minska kostnaderna.

De läkemedelsgrupper som konsumeras mest är medel mot hjärt-kärlsjukdom (ATC-grupp C) samt medel för behandling av smärta och psykiska störningar (ATC-grupp N).

Åldrandet leder till förändringar i såväl läkemedelsomsättning som kroppens känslighet för läkemedel. Detta leder till att många läkemedel har en annorlunda och kraftigare verkan hos äldre. Äldre lider oftare av flera sjukdomar, vilket leder till att de samtidigt behandlas med flera olika läkemedel. Vid läkemedelsförskrivning till äldre är det viktigt att bland annat ta hänsyn till de äldres vikt och försämrade njurfunktion. Olämplig läkemedelsanvändning är en vanlig orsak till sjukhusinläggningar hos äldre och borde kunna undvikas.

The results from the Swedish register of pharmaceutical products, presented in the report *Comparison of the Quality and Effectiveness of Health Services*, show that 16.4 per cent of all Swedish people aged 80 and over treated in primary health services are treated with more than 10 different drugs, 6.4 per cent are treated with 3 or more psychoactive drugs, and 4.4 per cent are treated with inappropriate combinations of drugs. This increases the risk of side effects and serious drug interactions. [11]

Resultat från det svenska läkemedelsregistret, vilka redovisas i rapporten *Öppna jämförelser av hälso- och sjukvårdens kvalitet och effektivitet*, visar att i öppen vård behandlas 16,4 procent av alla svenskar, 80 år och äldre, med fler än 10 olika läkemedel. 6,4 procent behandlas med tre eller fler psykofarmaka och 4,4 procent behandlas med olämpliga kombinationer av läkemedel. Detta ökar risken för biverkningar och allvarliga läkemedelsinteraktioner. [11]

## Cardiovascular diseases

Cardiovascular diseases (diseases of the heart and blood vessels) include myocardial infarction (heart attack), vascular spasm, stroke and other conditions that involve calcification of the blood vessels, which can lead to lack of oxygen and serious damage to the heart and brain.

Stroke is a collective name for cerebral infarction, cerebral haemorrhage and meningeal haemorrhage.

Myocardial infarction and stroke are more common in Sweden and Norway than in the other Nordic countries. (See Table 6)

Known risk factors include genetic disposition, smoking, high blood pressure, high serum lipids, diabetes, physical inactivity, and alcohol. The more risk factors one has, the greater the risk of cardiovascular disease.

Cardiovascular diseases are more common among men than women, and women are, on average, 10-15 years older when they suffer from heart diseases.

## Hjärt-kärlsjukdom

Hjärt-kärlsjukdomarna (sjukdomar i hjärtat och blodkärlen) omfattar hjärtinfarkt, kärlkramp, stroke med flera sjukdomstillstånd och beror främst på förkalkningar i blodkärlen som i sin tur kan leda till syrebrist med allvarliga skador på hjärta och hjärna som följd.

Stroke är samlingsnamnet för hjärninfarkt, hjärnblödning och hjärnhinneblödning.

Insjuknande i hjärtinfarkt och stroke (se tabell 6) är vanligare i Sverige och Norge än i de övriga nordiska länderna.

Kända riskfaktorer är till exempel ärftlig belastning, rökning, högt blodtryck, höga blodfetter, diabetes, fysisk inaktivitet, alkohol och så vidare. Ju fler riskfaktorer man har desto större är risken att drabbas av hjärt-kärlsjukdom.

Hjärt-kärlsjukdom är vanligare bland män än bland kvinnor och kvinnorna är i genomsnitt 10-15 år äldre när det blir sjuka.

For 70-year-olds, cardiovascular diseases account for about one third of all deaths, and for 85-year-olds for about one half of all deaths. The number of deaths from cardiovascular diseases has decreased a lot for both men and women in all the Nordic countries. This has resulted in an increase in average life expectancy. But even though the incidence of cardiovascular diseases and the number of deaths from heart diseases have decreased during the last decade (see Table 7), these diseases are still the most common causes of death for both men and women.

The reduced mortality is partly the result of decreased incidence of the disease (through improved lifestyle) and partly because of improved survival among those with the disease (among other things, as a result of improved methods of treatment).

In Sweden, mortality within 28 days of a heart attack (lethality) has reduced from 41 per cent (1995) to 31 per cent (2005) for men, and from 45 per cent til 32 per cent for women during the same period. [12]

Myocardial infarction, heart failure, vascular spasm, stroke, and atrial fibrilation and flutter are very common causes for hospital admission for elderly people.

The incidence of heart failure, high blood pressure and coronary arrhythmias increases with increasing age. Although admission to hospital is common for these diseases, many elderly people are treated with medication. Consumption of these types of medication is highest in Sweden and Finland.

Hos 70-åringar står hjärt-kärlsjukdom för drygt en tredjedel av alla dödsfall medan den hos 85-åringar står för mer än hälften av alla dödsfall. Dödligheten i hjärt-kärlsjukdom har minskat kraftigt i hela Norden för både män och kvinnor och har bidragit till en ökning av medellivslängden. Men trots att insjuknande i hjärt-kärlsjukdom och dödligheten ischemiska hjärtsjukdomar (se tabell 7) har minskat de senaste årtionderna så är det fortfarande den vanligaste dödsorsaken bland både kvinnor och män.

Den minskande dödligheten beror dels på en minskad insjuknandegrad (genom förbättrade levnadsvanor som till exempel minskad rökning), dels på en förbättrad överlevnad bland dem som insjuknar (bland annat genom bättre behandlingsmetoder).

I Sverige har dödligheten inom 28 dagar efter en hjärtinfarkt (letaliteten) minskat från 41 procent (1995) till 31 procent (2005) för männen och för kvinnorna från 45 procent till 32 procent under motsvarande tid. [12]

Hjärtinfarkt, hjärtsvikt, kärlkramp, stroke och retledningsrubbningar är mycket vanliga orsaker till inläggning i sluten vård bland äldre.

Hjärtsvikt, högt blodtryck och hjärtrytmrubbningar ökar med stigande ålder. Även om inläggning på sjukhus är vanligt för dessa sjukdomar behandlas en stor andel av de äldre med läkemedel. Störst konsumtion av dessa läkemedel har Sverige och Finland.

Diuretics (CO3) cause an increase in passing of water and salts and are used to reduce the content of water in the blood. This reduces blood pressure. Diuretics are used most in Denmark and Sweden (see Table 8).

Beta blocking agents (CO7) protect the heart by reducing the pulse and suppressing stress symptoms. They are used in the treatment of high blood pressure and heart failure. Beta blocking agents are used most in Finland and Sweden (see Table 8).

Calcium channel blockers (CO8) enlarge the blood vessels by decreasing the calcium content in the muscles in the wall of the blood vessels. This causes relaxation and reduces the pressure in the blood vessels. These drugs are used the least in Island. Consumption in the other Nordic countries is fairly similar (see Table 8).

Agents acting on the renin-angiotensin system (CO9) are used to improve the long-term prognosis for heart failure and myocardial infarction. They are used most in Finland and Norway (see Table 8).

Lipid modifying agents (C10) reduce the formation of cholesterol in the body and help to increase the level of "good" cholesterol (HDL) and reduce the level of "bad" cholesterol (LDL) and triglycerides. This reduces the risk of heart disease and premature death (see Table 8).

Diuretika (C03) verkar salt- och vätskedrivande och används för att minska blodets innehåll av vatten, vilket bidrar till att minska trycket i blodkärlen. Diuretika används främst i Danmark och Sverige (se tabell 8).

Betablockerare (C07) skyddar hjärtat genom att sänka pulsen och dämpa stressymptom och används för behandling av högt blodtryck samt för behandling av hjärtsvikt. Betablockerare används mest i Finland och Sverige (se tabell 8).

Kalciumantagonister (C08) vidgar blodkärlen genom att minska kaliumhalten i blodkärlets muskler vilket verkar avslappnande och minskar trycket i blodkärlen. Island förbrukar minst av dessa läkemedel medan förbrukningen i de övriga nordiska länderna är relativt lika (se tabell 8).

Läkemedel som påverkar renin-angiotensinsystemet (C09) används för att långsiktigt förbättra prognosen vid hjärtsvikt och hjärtinfarkt och används främst i Finland och Norge (se tabell 8).

Lipidsänkande läkemedel (C10) minskar nybildningen av kolesterol i kroppen och bidrar till att öka det goda kolesterolet (HDL) och minska det onda kolesterolet (LDL) och triglyceriderna vilket minskar risken för hjärtsjukdom och för tidig död (se tabell 8).

**Table 6 Patients treated in somatic hospitals for cardiovascular diseases per 100 000 inhabitants 2006**

| | Denmark | Faroe Islands[1)] | Finland | Åland[1)] | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| *Acute myocardial infarction ICD-10: I20-I21* | | | | | | | |
| *Men* | | | | | | | |
| 0-64 | 112 | 118 | 92 | 97 | 93 | 242 | 118 |
| 65-69 | 623 | 530 | 614 | 577 | 436 | 1 327 | 818 |
| 70-74 | 856 | 1 289 | 905 | 1 174 | 823 | 1 672 | 1 086 |
| 75-79 | 979 | 1 489 | 1 251 | 1 227 | 1 315 | 2 044 | 1 580 |
| 80-84 | 1 396 | 1 779 | 1 797 | 1 962 | 1 367 | 2 579 | 2 311 |
| 85+ | 1 673 | 3 158 | 2 618 | 2 447 | 1 624 | 3 893 | 3 392 |
| *Women* | | | | | | | |
| 0-64 | 33 | 20 | 22 | 15 | 19 | 56 | 36 |
| 65-69 | 264 | 460 | 231 | 227 | 252 | 509 | 319 |
| 70-74 | 402 | - | 396 | 335 | 521 | 710 | 542 |
| 75-79 | 622 | 1 070 | 640 | 373 | 634 | 1 114 | 877 |
| 80-84 | 821 | 322 | 1 203 | 1 393 | 859 | 1 563 | 1 470 |
| 85+ | 1 048 | 1 498 | 1 727 | 2 151 | 1 174 | 2 527 | 2 264 |
| *Hypertension ICD-10: I10-I15* | | | | | | | |
| *Men* | | | | | | | |
| 0-64 | 53 | 63 | 30 | 57 | 17 | 48 | 34 |
| 65-69 | 191 | 212 | 113 | 160 | 87 | 179 | 132 |
| 70-74 | 252 | 645 | 151 | 445 | 97 | 225 | 163 |
| 75-79 | 260 | 662 | 172 | 480 | 84 | 238 | 210 |
| 80-84 | 352 | 254 | 300 | 604 | 364 | 225 | 241 |
| 85+ | 367 | - | 379 | 532 | 271 | 263 | 277 |
| *Women* | | | | | | | |
| 0-64 | 57 | 46 | 27 | 46 | 14 | 39 | 25 |
| 65-69 | 226 | 460 | 150 | 194 | 126 | 185 | 139 |
| 70-74 | 307 | 922 | 240 | 409 | 152 | 234 | 199 |
| 75-79 | 383 | 1 203 | 354 | 704 | 211 | 271 | 278 |
| 80-84 | 502 | 805 | 444 | 854 | 198 | 339 | 344 |
| 85+ | 547 | 1 124 | 421 | 860 | 871 | 438 | 375 |
| *Heart failure ICD-10: I50* | | | | | | | |
| *Men* | | | | | | | |
| 0-64 | 48 | 27 | 29 | 28 | 14 | 39 | 41 |
| 65-69 | 424 | 106 | 338 | 449 | 262 | 388 | 474 |
| 70-74 | 639 | 387 | 613 | 769 | 533 | 765 | 829 |
| 75-79 | 972 | 1 323 | 1 028 | 1 813 | 727 | 1 087 | 1 522 |
| 80-84 | 1 449 | 1 525 | 1 582 | 3 396 | 1 276 | 1 660 | 2 533 |
| 85+ | 2 018 | 702 | 2 577 | 4 894 | 3 045 | 2 706 | 4 117 |
| Women | | | | | | | |
| 0-64 | 17 | 10 | 12 | 18 | 6 | 13 | 17 |
| 65-69 | 149 | 115 | 157 | 130 | 168 | 147 | 187 |
| 70-74 | 304 | 132 | 332 | 446 | 347 | 291 | 427 |
| 75-79 | 493 | 267 | 669 | 745 | 704 | 556 | 780 |
| 80-84 | 842 | 483 | 1 263 | 2 742 | 958 | 1 088 | 1 455 |
| 85+ | 1 268 | 936 | 2 086 | 3 140 | 2 045 | 2 192 | 2 770 |

**The table continues...**

**Table 6 Continued**

| | Denmark | Faroe Islands[1)] | Finland | Åland[1)] | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| *Atrial fibrillation and flutter ICD-10: I48* | | | | | | | |
| *Men* | | | | | | | |
| 0-64 | .. | 145 | 138 | 90 | 54 | 113 | 130 |
| 65-69 | .. | 1 271 | 834 | 833 | 327 | 772 | 810 |
| 70-74 | .. | 1 934 | 994 | 688 | 581 | 894 | 1 032 |
| 75-79 | .. | 2 151 | 1 182 | 1 227 | 559 | 1 012 | 1 200 |
| 80-84 | .. | 2 795 | 1 257 | 1 811 | 866 | 1 108 | 1 412 |
| 85+ | .. | 2 105 | 1 547 | 2 766 | 1 286 | 1 164 | 1 344 |
| *Women* | | | | | | | |
| 0-64 | .. | 20 | 43 | 24 | 16 | 33 | 48 |
| 65-69 | .. | 230 | 501 | 648 | 294 | 333 | 488 |
| 70-74 | .. | 1 449 | 764 | 818 | 391 | 521 | 758 |
| 75-79 | .. | 1 203 | 1 077 | 1 201 | 775 | 751 | 1 120 |
| 80-84 | .. | 1 771 | 1 286 | 1 888 | 1 024 | 1 022 | 1 333 |
| 85+ | .. | 2 060 | 1 346 | 2 022 | 492 | 1 240 | 1 425 |
| *Stroke ICD-10: I60-I69* | | | | | | | |
| *Men* | | | | | | | |
| 0-64 | 127 | 118 | 134 | 85 | 66 | 115 | 101 |
| 65-69 | 856 | 847 | 862 | 481 | 480 | 914 | 868 |
| 70-74 | 1 225 | 645 | 1 180 | 688 | 1 090 | 1 289 | 1 315 |
| 75-79 | 1 723 | 1 654 | 1 567 | 1 387 | 1 231 | 1 979 | 1 907 |
| 80-84 | 2 249 | 4 828 | 1 992 | 1 509 | 1 640 | 2 685 | 2 726 |
| 85+ | 2 695 | 2 105 | 2 059 | 2 553 | 2 165 | 3 677 | 3 504 |
| *Women* | | | | | | | |
| 0-64 | 89 | 46 | 88 | 58 | 34 | 84 | 69 |
| 65-69 | 518 | 230 | 410 | 454 | 273 | 565 | 488 |
| 70-74 | 791 | 659 | 685 | 372 | 521 | 811 | 831 |
| 75-79 | 1 201 | 1 738 | 1 045 | 994 | 657 | 1 375 | 1 360 |
| 80-84 | 1 674 | 1 449 | 1 423 | 854 | 1 190 | 1 956 | 2 100 |
| 85+ | 2 250 | 1 124 | 1 761 | 1 935 | 1 022 | 2 961 | 2 933 |

1 Average 2002-06

Source: The national inpatient registers

**Table 7 Deaths from cardiovascular diseases per 100 000 inhabitants**

| | Denmark | Faroe Islands | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| | 2006 | 2002-06 | 2006 | 2002-06 | 2002-06 | 2005 | 2005 |
| *Ischaemic heart disease ICD-10: I20-I25* | | | | | | | |
| *Men* | | | | | | | |
| 0-64 | 25 | 36 | 56 | 29 | 26 | 28 | 34 |
| 65-69 | 217 | 241 | 508 | 375 | 371 | 262 | 358 |
| 70-74 | 405 | 596 | 871 | 671 | 562 | 484 | 620 |
| 75-79 | 793 | 1 758 | 1 466 | 996 | 1 158 | 822 | 1 135 |
| 80-84 | 1 324 | 1 874 | 2 649 | 2 134 | 1 962 | 1 677 | 1 982 |
| 85+ | 3 023 | 4 228 | 5 755 | 4 315 | 5 036 | 3 289 | 4 223 |
| *Women* | | | | | | | |
| 0-64 | 7 | 8 | 8 | 4 | 6 | 7 | 9 |
| 65-69 | 100 | 73 | 121 | 33 | 105 | 81 | 113 |
| 70-74 | 187 | 325 | 256 | 389 | 195 | 155 | 219 |
| 75-79 | 397 | 473 | 610 | 356 | 500 | 378 | 469 |
| 80-84 | 777 | 1 134 | 1 581 | 904 | 1 057 | 849 | 1 074 |
| 85+ | 2 141 | 3 114 | 4 394 | 3 856 | 3 184 | 2 227 | 2 941 |
| *Stroke ICD-10: I60-I69* | | | | | | | |
| *Men* | | | | | | | |
| 0-64 | 13 | 9 | 14 | 9 | 5 | 6 | 8 |
| 65-69 | 118 | 88 | 118 | 34 | 49 | 115 | 96 |
| 70-74 | 237 | 311 | 241 | 84 | 179 | 192 | 194 |
| 75-79 | 515 | 414 | 492 | 262 | 358 | 430 | 422 |
| 80-84 | 874 | 1 114 | 926 | 791 | 876 | 851 | 858 |
| 85+ | 1 890 | 2 229 | 1 727 | 2 265 | 1 772 | 1 829 | 1 767 |
| *Women* | | | | | | | |
| 0-64 | 9 | 6 | 9 | - | 4 | 4 | 5 |
| 65-69 | 100 | 24 | 62 | 33 | 34 | 49 | 56 |
| 70-74 | 147 | 300 | 129 | 78 | 127 | 129 | 128 |
| 75-79 | 377 | 342 | 293 | 316 | 300 | 299 | 288 |
| 80-84 | 741 | 834 | 764 | 678 | 744 | 660 | 672 |
| 85+ | 1 780 | 1 774 | 1 966 | 1 343 | 1 804 | 1 808 | 1 764 |

Source: The national registers for causes of death

**Table 8 Consumption of medication for cardiovascular diseases, DDD/1000 inhabitants/day 2006**

| | Denmark | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|
| *Diuretics (C03)* | | | | | | |
| *Men* | | | | | | |
| 0-64 | 35.9 | 12.7 | 17.1 | 14.1 | 14.2 | 23.3 |
| 65-69 | 258.0 | 100.1 | 129.5 | 152.6 | 102.2 | 181.9 |
| 70-74 | 361.9 | 157.9 | 169.8 | 201.2 | 148.6 | 260.1 |
| 75-79 | 480.4 | 224.3 | 263.5 | 266.8 | 185.2 | 358.0 |
| 80-84 | 615.4 | 322.4 | 353.4 | 277.4 | 286.3 | 477.2 |
| 85+ | 756.2 | 440.1 | 484.9 | 289.6 | 397.8 | 706.3 |
| *Women* | | | | | | |
| 0-64 | 55.1 | 20.2 | 29.0 | 33.7 | 17.5 | 30.1 |
| 65-69 | 314.7 | 128.4 | 140.8 | 231.3 | 114.2 | 206.1 |
| 70-74 | 428.3 | 198.5 | 201.7 | 281.0 | 164.8 | 291.2 |
| 75-79 | 543.6 | 285.3 | 266.2 | 329.7 | 217.5 | 390.5 |
| 80-84 | 665.1 | 406.2 | 365.0 | 348.6 | 291.2 | 511.0 |
| 85+ | 834.7 | 553.0 | 414.3 | 278.8 | 392.4 | 754.9 |
| *Beta blocking agents (C07)* | | | | | | |
| *Men* | | | | | | |
| 0-64 | 18.8 | 34.8 | 28.8 | 21.6 | 20.8 | 26.7 |
| 65-69 | 104.2 | 197.4 | 151.9 | 174.9 | 153.7 | 173.1 |
| 70-74 | 126.1 | 238.8 | 227.8 | 203.6 | 185.0 | 204.4 |
| 75-79 | 130.7 | 257.3 | 234.3 | 200.6 | 181.1 | 224.1 |
| 80-84 | 123.2 | 255.2 | 236.4 | 180.3 | 204.5 | 222.4 |
| 85+ | 87.9 | 210.8 | 221.6 | 109.7 | 172.4 | 199.3 |
| *Women* | | | | | | |
| 0-64 | 17.8 | 31.2 | 25.0 | 23.7 | 16.2 | 24.0 |
| 65-69 | 94.8 | 170.0 | 150.6 | 175.9 | 117.4 | 145.9 |
| 70-74 | 116.3 | 225.8 | 172.0 | 210.9 | 151.4 | 181.0 |
| 75-79 | 130.3 | 264.0 | 190.9 | 221.8 | 179.5 | 211.7 |
| 80-84 | 132.1 | 275.3 | 255.2 | 215.0 | 186.3 | 223.9 |
| 85+ | 100.3 | 229.8 | 209.6 | 125.3 | 158.1 | 204.6 |
| Calcium channel blockers (C08) | | | | | | |
| *Men* | | | | | | |
| 0-64 | 33.0 | 30.5 | 26.4 | 17.4 | 28.0 | 24.5 |
| 65-69 | 191.8 | 170.2 | 150.0 | 175.9 | 201.4 | 168.2 |
| 70-74 | 226.6 | 199.6 | 193.5 | 193.0 | 237.9 | 198.3 |
| 75-79 | 237.4 | 210.2 | 217.3 | 189.9 | 228.7 | 213.6 |
| 80-84 | 228.6 | 199.0 | 240.8 | 196.1 | 249.2 | 206.2 |
| 85+ | 178.6 | 156.6 | 130.7 | 132.2 | 215.8 | 173.4 |
| *Women* | | | | | | |
| 0-64 | 24.4 | 19.9 | 17.4 | 11.2 | 17.2 | 16.7 |
| 65-69 | 151.6 | 129.0 | 103.0 | 110.7 | 142.0 | 121.2 |
| 70-74 | 200.0 | 179.1 | 185.1 | 154.6 | 185.5 | 154.9 |
| 75-79 | 231.5 | 211.8 | 131.3 | 158.9 | 220.5 | 180.2 |
| 80-84 | 248.4 | 225.4 | 215.1 | 190.9 | 232.3 | 189.4 |
| 85+ | 212.9 | 196.5 | 149.2 | 126.1 | 208.1 | 178.6 |

**The table continues...**

**Table 8 Continued**

| | Denmark | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|
| *Agents acting on the renin-angiotensin system (C09)* | | | | | | |
| *Men* | | | | | | |
| 0-64 | 71.7 | 96.1 | 70.8 | 61.3 | 68.3 | 63.0 |
| 65-69 | 384.4 | 443.1 | 394.2 | 432.6 | 425.0 | 399.1 |
| 70-74 | 434.6 | 497.8 | 563.5 | 478.1 | 486.0 | 454.0 |
| 75-79 | 418.6 | 502.4 | 641.8 | 427.1 | 443.5 | 488.6 |
| 80-84 | 388.5 | 458.8 | 722.6 | 370.5 | 493.2 | 472.1 |
| 85+ | 262.7 | 347.7 | 788.6 | 216.7 | 417.9 | 393.5 |
| *Women* | | | | | | |
| 0-64 | 53.1 | 70.2 | 44.4 | 43.2 | 48.6 | 38.2 |
| 65-69 | 295.2 | 329.6 | 201.5 | 336.7 | 322.5 | 249.4 |
| 70-74 | 362.4 | 410.6 | 327.5 | 369.2 | 381.1 | 306.4 |
| 75-79 | 396.1 | 467.5 | 409.4 | 394.5 | 432.2 | 347.6 |
| 80-84 | 384.1 | 476.4 | 540.0 | 336.7 | 434.1 | 352.8 |
| 85+ | 286.9 | 402.2 | 460.9 | 215.1 | 372.7 | 311.8 |
| *Lipid modifying agents (C10)* | | | | | | |
| *Men* | | | | | | |
| 0-64 | 83.0 | 70.2 | 34.5 | 65.3 | 109.2 | 61.3 |
| 65-69 | 469.8 | 367.0 | 160.5 | 585.1 | 653.2 | 397.4 |
| 70-74 | 508.8 | 392.4 | 211.7 | 690.9 | 690.3 | 432.3 |
| 75-79 | 467.5 | 375.8 | 190.4 | 604.3 | 586.6 | 425.5 |
| 80-84 | 348.0 | 306.9 | 199.2 | 482.6 | 528.4 | 331.2 |
| 85+ | 154.6 | 161.9 | 92.6 | 188.5 | 283.3 | 176.5 |
| *Women* | | | | | | |
| 0-64 | 57.4 | 45.3 | 17.1 | 28.1 | 61.5 | 35.7 |
| 65-69 | 375.7 | 317.0 | 135.8 | 341.7 | 491.0 | 277.6 |
| 70-74 | 416.3 | 370.0 | 165.8 | 427.4 | 564.2 | 327.9 |
| 75-79 | 387.8 | 370.9 | 161.2 | 431.1 | 553.3 | 324.3 |
| 80-84 | 280.2 | 290.2 | 170.9 | 343.5 | 418.0 | 244.1 |
| 85+ | 114.0 | 137.2 | 40.7 | 104.6 | 188.3 | 108.7 |

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

## Cancer

Cancer is one of the most common types of illness. About two-thirds of people are over 65 years of age when cancer is diagnosed (see Table 9). Each year, about 120 000 men and women in the Nordic countries are afflicted with cancer. Cancer of the colon and rectum, cancer of the prostate, breast cancer and lung cancer

## Cancersjukdomar

Cancer är en av våra vanligaste sjukdomar och cirka två tredjedelar är över 65 år när diagnosens ställs (se tabell 9). I Norden drabbas ungefär 120 000 män och kvinnor varje år av någon cancersjukdom. Cancer i tjock- och ändtarm, prostatacancer, bröstcancer och lungcancer är vanliga

are common forms of cancer that affect elderly people. For men, the incidences of cancer of the prostate and of the skin are increasing and the incidence of lung cancer is decreasing. For women, the incidences of breast cancer, lung cancer and skin cancer are increasing. Statistics that show the trends for several types of cancer are presented in Chapter 3.2, Section A.

cancerformer hos äldre. Prostata- och hudcancer ökar bland män, medan lungcancer minskar. Bland kvinnor ökar bröst-, lung- samt hudcancer. I kapitel 3.2, i sektion A i denna publikation, finns bland annat redovisade trender för flera cancersjukdomar.

Cancer is the next most common cause of death (see Table 10) after cardiovascular diseases for both men and women. For 70-year-olds, cancer accounts for about 40 per cent of all deaths, while for 85-year-olds, it accounts for less than 20 per cent of all deaths. About half of all people who are diagnosed with cancer today, can expect to live as long as other people of the same age.

Cancer är den näst vanligaste dödsorsaken (se tabell 10) efter hjärt-kärlsjukdom för både kvinnor och män. Hos 70-åringar står cancer för ca 40 procent av alla dödsfall medan den hos 85-åringar står för mindre än 20 procent av alla dödsfall. Drygt hälften av alla som får en cancerdiagnos i dag förväntas i de flesta fall leva lika länge som sina jämnåriga.

For Swedish women, since 2005, the number of deaths from lung cancer has been higher than the number of deaths from breast cancer.

Sedan 2005 så är den totala dödligheten i lungcancer högre för kvinnor i Sverige än den totala dödligheten i bröstcancer.

The incidence of breast cancer (the number of new cases during a specified period of time) and mortality from breast cancer are fairly similar in the Nordic countries. Morbidity and mortality from cancer of the stomach and colon are also fairly similar. Morbidity in relation to mortality for lung cancer is lowest in Sweden and highest in Denmark. This probably reflects differences in smoking.

Incidensen (antalet nya fall under en avgränsad period) och dödligheten i bröstcancer är relativt lika i de nordiska länderna. Även insjuknandet och dödligheten i magsäcks- och tjocktarmscancer är relativt lika. Insjuknande respektive dödlighet i lungcancer är lägst i Sverige och högst i Danmark vilket troligen avspeglar skillnader i rökvanor.

Below, some of the most common forms of cancer that affect elderly people are presented. [13, 14, 15]

Nedan redovisas några av de vanligaste cancerformerna som drabbar äldre. [13, 14, 15]

Cancer of the prostate is the most common type of cancer among men, and each year about 17 000 men in the Nor-

Prostatacancer är den vanligaste cancerformen hos män och årligen insjuknar cirka 17000 män i Norden.

dic countries get this disease. The risk of getting the disease increases with increasing age, and cancer of the prostate is most common among men aged 65 years and older (see Tables 9 and 10). Cancer of the prostate develops slowly, and therefore the number of cases detected each year depends on diagnostic activity (eg. screening with the PSA test using a blood sample). The male hormone testosterone plays a large part in the development of cancer of the prostate. Obesity and overweight increase the risk for the development of a more agressive cancer of the prostate.

Risken att insjukna ökar med åldern och prostatacancer är vanligast i åldrarna över 65 år (se tabell 9 och 10). Prostatacancer utvecklas långsamt och antalet diagnostiserade fall är därför beroende av hur aktivt det diagnostiska arbetet bedrivs (t.ex. screening med hjälp av PSA-test via blodprov). Det manliga könshormonet testosteron spelar stor roll för uppkomst av prostatacancer. Fetma och övervikt ökar risken för att utveckla en mer aggressiv prostatacancer.

The incidence of stomach cancer has decreased during the last decade, but the risk increases with age. About 75 per cent of people are over 65 years of age when they get stomach cancer, and this cancer is more common among men than women. Inproved eating habits with more fruit and vegetables is believed to reduce the risk of stomach cancer. Each year, about 1 750 men and about 1 200 women in the Nordic countries get cancer of the stomach. Both morbidity and mortality from this disease are decreasing (see Tables 9 and 10).

Magsäckscancer har minskat de senaste decennierna men risken att insjukna ökar med åldern. Cirka 75 procent är över 65 år när de insjuknar och magsäckscancer är vanligare bland män. Bättre kostvanor med mer frukt- och grönsaker, anses minska risken för magsäckscancer. Årligen drabbas cirka 1 750 män och cirka 1 200 kvinnor i Norden av magsäckscancer. Både insjuknande och dödlighet (se tabell 9 och 10) minskar.

Cancer of the colon and rectum is one of the most common types of cancer among elderly people. Each year about 4 250 men and about 4 750 women in the Nordic countries get this cancer. During the last decade the number of diagnosed cases has increased for both men and women, but mortality has decreased for both men and women during the same period (see Tables 9 and 10).

Tjock- och ändtarmacancer är en av de vanligare cancerformerna bland äldre. Årligen insjuknar cirka 4 250 män och cirka 4 750 kvinnor i Norden. Under det senaste årtiondet har det skett en ökning av antalet diagnostiserade fall både bland män och kvinnor, men däremot har dödligheten minskat för båda könen under samma tidsperiod (se tabell 9 och 10).

Cancer of the lung (including cancer of the bronchus and trachea) is the third

Lungcancer (inklusive luftstrupe och luftrör) är den tredje vanligaste can-

most common type of cancer in the Nordic countries, and is one of the types of cancer with the worst prognosis. Smoking is the clear dominant cause of lung cancer. The number of cases in the Nordic countries each year is about 11 500, of which about 60 per cent are men. Danish men and women are affected most with lung cancer. Although more men than women get lung cancer, during the last decade, the number of men in the Nordic countries with lung cancer has reduced by 1.2 per cent each year. But for women, the number of cases has increased each year by 2 per cent during the same period, with the exception of Iceland, where there has been a decrease. The incidence of the disease is shown in Table 9, and mortality from lung cancer is shown in Table 10.

cersjukdomen i Norden och är en av de cancersjukdomar som har sämst prognos. Tobaksrökning är den helt dominerande orsaken till lungcancer. Årligen insjuknar i Norden cirka 11 500 personer i lungcancer varav cirka 60 procent är män. Främst drabbas danska män och kvinnor av lungcancer. Även om flest män insjuknar i lungcancer så har det under de senaste 10 åren skett en genomsnittlig årlig minskning bland män i Norden med 1,2 procent. För kvinnor i Norden har det däremot skett en genomsnittlig årlig ökning med 2 procent för motsvarande tidsperiod, undantaget Island där det faktiskt skett en minskning. Tabell 9 visar incidensen och tabell 10 visar dödligheten i lungcancer.

Up until now, breast cancer has been the most common type of cancer among women, and each year about 16 100 women in the Nordic countries get this disease. The incidence of breast cancer in the Nordic countries has increased since 1960, from about 40 cases per 100 000 inhabitants to about 80 cases per 100 000 inhabitants in 2003. During the last decade, the incidence of breast cancer has increased on average by 1.9 per cent each year in the Nordic countries. During the same period, mortality has decreased by about 2.2 per cent each year. This means that more women with breast cancer survive.

Bröstcancer har hitintills varit den vanligaste cancerformen bland kvinnor och varje år insjuknar cirka 16 100 kvinnor i Norden. Förekomsten av bröstcancer i Norden har ökat från 1960 då cirka 40 per 100 000 personer insjuknade i bröstcancer till cirka 80 per 100 000 år 2003. De senaste 10 åren har bröstcancer haft en genomsnittlig årlig ökning på 1,9 procent i Norden. Under samma tidsperiod har dödligheten minskat med ungefär 2,2 procent årligen, vilket innebär att alltfler kvinnor överlever sin bröstcancer.

The number of new cases of breast cancer is influenced by screening. There has been screening for breast cancer in the Nordic countries to a varying extent and for varying lengths of time. This has influenced both mortality (Table 9) and

Antalet nya fall av bröstcancer påverkas av screening. De nordiska länderna har haft screening för bröstcancer i olika omfattning och olika länge, vilket påverkar både sjuklighet (se tabell 9) och dödlighet (se tabell 10). Dödligheten är

morbidity (Table 10). Mortality is highest in Denmark and lowest in Finland.

högst i Danmark och lägst i Finland.

The risk of getting breast cancer increases if there are other people who have had the disease in the same family. There is an association between breast cancer and obesity. Obesity reduces the risk for pre-menopausal women but increases the risk for post-menopausal women. Having many children and having children at a young age reduces the risk of breast cancer. Taking into account the low fertility rates today in several of the Nordic countries, in combination with the increasing age of women when they have their first child, it is possible that the incidence of breast cancer will increase in the future. Health policy goals should therefore be directed at improving survival rates, for example through mammography screening.

Risken att få bröstcancer ökar om man har sjukdomen i släkten. Samband finns mellan bröstcancer och fetma, där fetma skyddar premenopausala kvinnor, men ökar risken hos postmenopausala kvinnor. Att föda många barn och föda barn i ung ålder är skyddande. Med tanke på de låga nativitetstal som råder i dag i flera av de nordiska länderna, tillsammans med den ökande åldern hos förstföderskor, är det möjligt att insjuknandet kommer att öka framöver. Hälsopolitiska mål bör därmed inriktas på att förbättra överlevnaden, bland annat genom mammografiscreening.

Cancer of the uterus is uncommon before the menopause, and affects mainly older women. Women who have never had children, women who began to menstruate at an early age, and women who have a late menopause, have an increased risk of cancer of the uterus. Heredity is also a factor for this type of cancer. Overweight and obesity are other risk factors. In the Nordic countries, about 3 200 women get this disease each year. The prognosis for cancer of the uterus is relatively good. The five-year survival rate is 82 per cent and the ten-year survival rate is 78 per cent. Table 10 presents mortality for cancer of the uterus in the Nordic countries.

Livmoderkroppscancer är en ovanlig cancerform före klimakteriet och drabbar framför allt äldre kvinnor. Kvinnor som inte fött barn, kvinnor som tidigt får sin menstruation och kvinnor som kommer sent in i klimakteriet löper ökad risk och ärftlighet har betydelse för att utveckla denna typ av cancer. Övervikt och fetma är andra kända riskfaktorer. I Norden insjuknar cirka 3 200 kvinnor per år. Prognosen vid livmoderkroppscancer är förhållandevis god med en femårsöverlevnad på 82 procent och en tioårsöverlevnad på 78 procent. I tabell 10 redovisas dödligheten i livmoderkroppscancer i de nordiska länderna.

## Table 9 New cases of cancer per 100 000 inhabitants

| | Denmark | Faroe Islands | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| | 2004 | 2002-06 | 2006 | 2001-05 | 2002-06 | 2006 | 2006 |
| *All cases of cancer ICD-10: C00-C97* | | | | | | | |
| *Men* | | | | | | | |
| 0-64 | 208 | 134 | 232 | 250 | 167 | 227 | 234 |
| 65-69 | 1 623 | 1 073 | 1 814 | 2 367 | 1 942 | 2 045 | 1 898 |
| 70-74 | 2 386 | 1 450 | 2 585 | 3 433 | 2 947 | 2 765 | 2 465 |
| 75-79 | 2 839 | 1 999 | 3 234 | 4 433 | 3 068 | 3 360 | 2 924 |
| 80-84 | 3 051 | 2 837 | 3 666 | 4 816 | 3 514 | 3 500 | 3 274 |
| 85+ | 2 910 | 2 383 | 3 699 | 5 000 | 3 249 | 3 249 | 3 228 |
| *Women* | | | | | | | |
| 0-64 | 283 | 154 | 254 | 270 | 244 | 264 | 271 |
| 65-69 | 1 392 | 943 | 1 029 | 1 122 | 1 403 | 1 292 | 1 256 |
| 70-74 | 1 601 | 1 374 | 1 171 | 1 451 | 1 549 | 1 509 | 1 505 |
| 75-79 | 1 830 | 1 367 | 1 440 | 1 197 | 1 715 | 1 691 | 1 648 |
| 80-84 | 1 900 | 1 601 | 1 647 | 2 315 | 1 961 | 1 903 | 1 762 |
| 85+ | 1 596 | 1 380 | 1 914 | 2 082 | 1 804 | 1 804 | 1 756 |
| *Prostate cancer ICD-10: C61* | | | | | | | |
| *Men* | | | | | | | |
| 0-64 | 25 | 6 | 74 | 90 | 34 | 55 | 78 |
| 65-69 | 377 | 241 | 846 | 1 060 | 755 | 787 | 822 |
| 70-74 | 532 | 285 | 1 139 | 1 330 | 1 063 | 949 | 964 |
| 75-79 | 665 | 448 | 1 307 | 2 111 | 1 073 | 1 020 | 1 008 |
| 80-84 | 788 | 962 | 1 357 | 2 612 | 1 209 | 1 051 | 1 000 |
| 85+ | 680 | 461 | 1 110 | 1 848 | 916 | 1 287 | 859 |
| *Stomach cancer ICD-10: C16* | | | | | | | |
| *Men* | | | | | | | |
| 0-64 | 5 | 7 | 6 | 7 | 4 | 4 | 4 |
| 65-69 | 41 | 22 | 39 | 71 | 75 | 29 | 35 |
| 70-74 | 62 | 78 | 68 | 86 | 47 | 65 | 43 |
| 75-79 | 61 | 34 | 95 | 106 | 115 | 83 | 59 |
| 80-84 | 71 | 203 | 149 | 82 | 171 | 88 | 92 |
| 85+ | 83 | 231 | 148 | 109 | 236 | 223 | 91 |
| *Women* | | | | | | | |
| 0-64 | 3 | 2 | 4 | 2 | 3 | 2 | 2 |
| 65-69 | 24 | 73 | 17 | 34 | 17 | 16 | 16 |
| 70-74 | 27 | 75 | 42 | 39 | 34 | 37 | 21 |
| 75-79 | 19 | - | 36 | 39 | 75 | 45 | 34 |
| 80-84 | 40 | 100 | 43 | 139 | 63 | 48 | 42 |
| 85+ | 31 | 79 | 62 | 87 | 114 | 56 | 39 |

**The table continues...**

**Table 9 Continued**

| | Denmark | Faroe Islands | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| | 2004 | 2002-06 | 2006 | 2001-05 | 2002-06 | 2006 | 2006 |
| *Cancer of the colon and rectum ICD-10: C18-C21* | | | | | | | |
| *Men* | | | | | | | |
| 0-64 | 28 | 24 | 22 | 31 | 18 | 25 | 22 |
| 65-69 | 283 | 175 | 154 | 177 | 168 | 210 | 207 |
| 70-74 | 427 | 129 | 220 | 300 | 331 | 398 | 297 |
| 75-79 | 487 | 345 | 299 | 475 | 370 | 492 | 380 |
| 80-84 | 570 | 456 | 334 | 327 | 448 | 573 | 474 |
| 85+ | 499 | 461 | 349 | 435 | 576 | 787 | 363 |
| *Women* | | | | | | | |
| 0-64 | 24 | 15 | 19 | 18 | 14 | 24 | 20 |
| 65-69 | 201 | 169 | 102 | 136 | 121 | 213 | 149 |
| 70-74 | 276 | 200 | 133 | 275 | 212 | 276 | 206 |
| 75-79 | 358 | 342 | 172 | 232 | 265 | 328 | 263 |
| 80-84 | 405 | 200 | 215 | 370 | 341 | 476 | 285 |
| 85+ | 362 | 197 | 234 | 217 | 334 | 384 | 269 |
| *Cancer of the lung, bronchus and trachea ICD-10: C33-C34* | | | | | | | |
| *Men* | | | | | | | |
| 0-64 | 28 | 15 | 21 | 22 | 14 | 23 | 13 |
| 65-69 | 305 | 175 | 212 | 177 | 216 | 242 | 149 |
| 70-74 | 462 | 104 | 348 | 343 | 349 | 335 | 184 |
| 75-79 | 515 | 241 | 463 | 317 | 394 | 392 | 213 |
| 80-84 | 470 | 203 | 432 | 163 | 352 | 346 | 217 |
| 85+ | 371 | 154 | 407 | 326 | 118 | 222 | 109 |
| *Women* | | | | | | | |
| 0-64 | 28 | 10 | 10 | 22 | 19 | 19 | 16 |
| 65-69 | 252 | 73 | 51 | - | 218 | 143 | 104 |
| 70-74 | 299 | 150 | 66 | 39 | 233 | 199 | 132 |
| 75-79 | 283 | 26 | 94 | - | 215 | 182 | 127 |
| 80-84 | 221 | 67 | 129 | 46 | 209 | 129 | 109 |
| 85+ | 97 | - | 62 | 217 | 114 | 84 | 44 |
| *Breast cancer ICD-10: C50* | | | | | | | |
| *Women* | | | | | | | |
| 0-64 | 101 | 49 | 112 | 100 | 85 | 84 | 106 |
| 65-69 | 373 | 193 | 366 | 544 | 448 | 314 | 380 |
| 70-74 | 346 | 275 | 293 | 471 | 289 | 203 | 359 |
| 75-79 | 388 | 158 | 306 | 193 | 370 | 223 | 320 |
| 80-84 | 362 | 400 | 291 | 417 | 375 | 273 | 343 |
| 85+ | 316 | 355 | 311 | 347 | 302 | 289 | 358 |

Source: *The cancer registers in the Nordic countries*

## Table 10 Deaths from cancer per 100 000 inhabitants

| | Denmark | Faroe Islands | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| | 2006 | 2002-06 | 2006 | 2002-06 | 2002-06 | 2006 | 2006 |
| *All cases of cancer ICD-10: C00-C97* | | | | | | | |
| *Men* | | | | | | | |
| 0-64 | 94 | 65 | 69 | 73 | 48 | 64 | 62 |
| 65-69 | 875 | 810 | 619 | 580 | 600 | 682 | 663 |
| 70-74 | 1 381 | 932 | 974 | 1 552 | 1 058 | 1 076 | 1 000 |
| 75-79 | 1 959 | 1 344 | 1 545 | 1 572 | 1 407 | 1 757 | 1 501 |
| 80-84 | 2 576 | 2 229 | 2 117 | 1 897 | 2 200 | 2 291 | 2 031 |
| 85+ | 3 523 | 2 614 | 2 730 | 4 854 | 2 762 | 3 180 | 2 770 |
| *Women* | | | | | | | |
| 0-64 | 90 | 62 | 59 | 68 | 56 | 67 | 71 |
| 65-69 | 676 | 484 | 402 | 334 | 565 | 495 | 498 |
| 70-74 | 973 | 1 049 | 528 | 506 | 700 | 650 | 687 |
| 75-79 | 1 273 | 815 | 747 | 870 | 840 | 913 | 925 |
| 80-84 | 1 463 | 1 234 | 999 | 1 356 | 1 182 | 1 160 | 1 142 |
| 85+ | 1 914 | 1 616 | 1 386 | 1 343 | 1 608 | 1 625 | 1 296 |
| *Prostate cancer ICD-10: C61* | | | | | | | |
| *Men* | | | | | | | |
| 0-64 | 4 | 5 | 3 | 4 | 4 | 3 | 4 |
| 65-69 | 80 | 131 | 53 | 34 | 62 | 72 | 95 |
| 70-74 | 178 | 155 | 152 | 84 | 146 | 184 | 195 |
| 75-79 | 366 | 172 | 267 | 105 | 261 | 343 | 350 |
| 80-84 | 592 | 507 | 445 | 316 | 628 | 600 | 613 |
| 85+ | 1 008 | 461 | 783 | 863 | 930 | 1 141 | 930 |
| *Stomach cancer ICD-10: C16* | | | | | | | |
| *Men* | | | | | | | |
| 0-64 | 3 | 2 | 5 | - | 3 | 3 | 3 |
| 65-69 | 30 | 44 | 25 | - | 40 | 24 | 34 |
| 70-74 | 37 | 52 | 55 | 42 | 38 | 47 | 35 |
| 75-79 | 34 | 69 | 79 | - | 67 | 73 | 55 |
| 80-84 | 60 | 152 | 109 | 79 | 114 | 96 | 83 |
| 85+ | 102 | 231 | 116 | - | 192 | 147 | 117 |
| *Women* | | | | | | | |
| 0-64 | 2 | 3 | 2 | 4 | 1 | 2 | 2 |
| 65-69 | 14 | - | 13 | - | 13 | 14 | 9 |
| 70-74 | 15 | 75 | 30 | - | 13 | 31 | 19 |
| 75-79 | 21 | - | 41 | 40 | 45 | 39 | 29 |
| 80-84 | 39 | 67 | 32 | 90 | 63 | 52 | 33 |
| 85+ | 37 | 197 | 60 | 43 | 180 | 76 | 43 |
| *Cancer of the colon and rectum ICD-10: C18* | | | | | | | |
| *Men* | | | | | | | |
| 0-64 | 6 | 8 | 3 | 7 | 4 | 9 | 7 |
| 65-69 | 67 | 66 | 24 | 68 | 57 | 91 | 77 |
| 70-74 | 129 | 78 | 53 | - | 132 | 145 | 115 |
| 75-79 | 177 | 103 | 92 | 210 | 139 | 232 | 185 |
| 80-84 | 254 | 304 | 146 | 79 | 209 | 262 | 212 |
| 85+ | 392 | 231 | 152 | 324 | 251 | 379 | 334 |

**The table continues...**

## Table 10 Continued

| | Denmark | Faroe Islands | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| | 2006 | 2002-06 | 2006 | 2002-06 | 2002-06 | 2006 | 2006 |
| *Cancer of the colon and rectum ICD-10: C18* | | | | | | | |
| *Women* | | | | | | | |
| 0-64 | 6 | 5 | 3 | 2 | 3 | 8 | 5 |
| 65-69 | 57 | 48 | 23 | - | 21 | 59 | 55 |
| 70-74 | 78 | 100 | 34 | 39 | 72 | 89 | 84 |
| 75-79 | 137 | 210 | 50 | - | 95 | 133 | 121 |
| 80-84 | 193 | 67 | 60 | - | 118 | 192 | 159 |
| 85+ | 289 | 158 | 131 | 87 | 180 | 342 | 188 |
| *Cancer of the lung, bronchus and trachea ICD-10: C32-C34* | | | | | | | |
| *Men* | | | | | | | |
| 0-64 | 27 | 12 | 18 | 5 | 12 | 16 | 14 |
| 65-69 | 281 | 131 | 187 | 102 | 185 | 211 | 140 |
| 70-74 | 430 | 129 | 269 | 168 | 302 | 255 | 213 |
| 75-79 | 552 | 310 | 413 | 210 | 358 | 422 | 265 |
| 80-84 | 569 | 253 | 542 | 79 | 390 | 443 | 278 |
| 85+ | 553 | 231 | 497 | 324 | 222 | 362 | 265 |
| *Women* | | | | | | | |
| 0-64 | 24 | 10 | 7 | 4 | 15 | 13 | 14 |
| 65-69 | 197 | 97 | 52 | 33 | 218 | 125 | 106 |
| 70-74 | 273 | 175 | 69 | 39 | 187 | 151 | 123 |
| 75-79 | 321 | 53 | 81 | 79 | 215 | 166 | 144 |
| 80-84 | 287 | 67 | 127 | 181 | 223 | 143 | 140 |
| 85+ | 207 | 39 | 77 | 260 | 212 | 104 | 80 |
| *Breast cancer ICD-10: C50* | | | | | | | |
| *Women* | | | | | | | |
| 0-64 | 19 | 13 | 16 | 4 | 13 | 13 | 16 |
| 65-69 | 112 | 97 | 72 | 33 | 80 | 76 | 60 |
| 70-74 | 144 | 125 | 79 | 39 | 72 | 72 | 89 |
| 75-79 | 153 | 26 | 100 | - | 100 | 104 | 103 |
| 80-84 | 175 | 167 | 103 | 181 | 111 | 121 | 125 |
| 85+ | 352 | 79 | 173 | 43 | 155 | 222 | 189 |
| *Cancer of the uterus and ovary ICD-10: C53-C56* | | | | | | | |
| *Women* | | | | | | | |
| 0-64 | 10 | 10 | 7 | 9 | 7 | 9 | 9 |
| 65-69 | 74 | 97 | 42 | 0 | 29 | 49 | 55 |
| 70-74 | 91 | 75 | 59 | 39 | 68 | 69 | 70 |
| 75-79 | 114 | 105 | 77 | 119 | 75 | 87 | 98 |
| 80-84 | 148 | 167 | 104 | 271 | 139 | 100 | 128 |
| 85+ | 121 | 39 | 122 | 43 | 155 | 135 | 82 |

Source: *The national registers for causes of death*

## COPD and asthma

Chronic obstructive pulmonary disease (COPD) is common among elderly people. COPD is characterized by a gradual deterioration in lung function, that often begins with chronic bronchitis and that develops over time into emphysema. The clear dominant cause of COPD is smoking. The gradual increase in the incidence of COPD reflects smoking habits over the last 30-50 years. During the last 20 years, mortality from COPD has almost doubled. The increase is particularly seen for women. Among smokers who live to be old, about half of them have developed COPD. In cases of malignant COPD, medication gives only limited relief, but stopping smoking gives increased survival.

Asthma is a chronic inflammatory disease of the trachea, that causes periods of reduced flow of air and respiratory distress. Serious chronic asthma can develop into COPD. With the help of new types of medication most people today can live an almost normal life. Nowadays, admission to hospital and death from asthma are unusual.

Men between 75 and 85 years old in the Nordic countries are the group of people who consume most medication for asthma and COPD, though this varies somewhat in the different countries. For women, the highest consumption is to be found in a slightly younger age group – 70-80 year-olds. This may reflect the time when men and women began to smoke.

The incidence of COPD is expected to continue to increase, and particularly among women. Smoking has become

## KOL och astma

Kronisk obstruktiv lungsjukdom (KOL) är vanligt bland äldre. KOL kännetecknas av en gradvis försämrad lungfunktion som oftast börjar med kronisk bronkit och med tiden utvecklas även emfysem. Den helt dominerande orsaken till KOL är tobaksrökning och den gradvisa ökningen speglar rökvanorna de senaste 30-50 åren. Under de senaste 20 åren har det skett nästan en fördubbling av dödligheten i KOL och ökningen ses främst bland kvinnor. Bland rökare som uppnår hög ålder har nästan hälften utvecklat KOL. Vid svårartad KOL ger läkemedel endast begränsad lindring men rökstopp ger förlängd överlevnad.

Astma är en kronisk inflammatorisk sjukdom i luftrören som leder till perioder av nedsatt luftflöde och andnöd. Svår kronisk astma kan övergå till KOL. Med hjälp av de nya medicinerna kan de flesta idag leva ett nästan normalt liv. Inläggning på sjukhus och dödlighet i astma är numera ovanligt.

Äldre män mellan 75 och 85 år i Norden är de som konsumerar mest läkemedel mot astma och KOL, även om det varierar något mellan länderna. För kvinnorna återfinns den största konsumtionen i lite yngre åldrar, 70-80 år, vilket kan spegla skillnaden i tid när män och kvinnor började röka.

Framöver väntas en fortsatt ökning av KOL i befolkningen och då framför allt hos kvinnor. Rökning har blivit

more common among women, and a reduction in smoking among women has not taken place to the same extent as among men. This means that more women in the future will develop COPD.

vanligare hos kvinnorna och kvinnorna har inte heller i samma utsträckning som männen slutat röka, vilket medför att fler kvinnor framöver kommer att utveckla KOL.

**Table 11 Patients treated in somatic hospitals for chronic obstructive pulmonary disease per 100 000 inhabitants 2006**

| | Denmark | Faroe Islands[1)] | Finland | Åland[1)] | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| *Men* | | | | | | | |
| 0-64 | 54 | 54 | 29 | 28 | 17 | 39 | 21 |
| 65-69 | 510 | 212 | 328 | 513 | 218 | 442 | 247 |
| 70-74 | 939 | 516 | 556 | 810 | 581 | 684 | 444 |
| 75-79 | 1 425 | 662 | 822 | 800 | 727 | 992 | 720 |
| 80-84 | 1 723 | 762 | 1 117 | 1 283 | 1 230 | 1 171 | 942 |
| 85+ | 1 463 | 1 754 | 914 | 1 809 | 1 353 | 1 091 | 959 |
| *Women* | | | | | | | |
| 0-64 | 68 | 36 | 19 | 31 | 36 | 51 | 31 |
| 65-69 | 605 | 575 | 135 | 227 | 609 | 440 | 334 |
| 70-74 | 1 050 | 922 | 176 | 186 | 716 | 585 | 500 |
| 75-79 | 1 317 | 1 070 | 255 | 704 | 915 | 718 | 621 |
| 80-84 | 1 218 | 161 | 199 | 674 | 760 | 679 | 661 |
| 85+ | 760 | 187 | 124 | 473 | 871 | 527 | 497 |

1 Average 2002-06

Source: The national inpatient registers ICD-10: J40-J44, J47

**Table 12 Deaths from chronic obstructive pulmonary disease and asthma per 100 000 inhabitants**

| | Denmark | Faroe Islands | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| | 2006 | 2002-06 | 2006 | 2002-06 | 2002-06 | 2006 | 2006 |
| *Men* | | | | | | | |
| 0-64 | 6 | 4 | 5 | 9 | 2 | 3 | 3 |
| 65-69 | 92 | 44 | 64 | 102 | 35 | 84 | 46 |
| 70-74 | 222 | 52 | 125 | 42 | 123 | 189 | 99 |
| 75-79 | 457 | 207 | 270 | 157 | 261 | 324 | 195 |
| 80-84 | 755 | 355 | 501 | 949 | 381 | 607 | 359 |
| 85+ | 971 | 769 | 716 | 1 294 | 990 | 920 | 535 |
| *Women* | | | | | | | |
| 0-64 | 7 | 3 | 2 | 4 | 1 | 4 | 4 |
| 65-69 | 107 | 48 | 22 | 167 | 88 | 68 | 58 |
| 70-74 | 268 | 175 | 33 | 78 | 76 | 122 | 95 |
| 75-79 | 389 | 158 | 69 | 40 | 180 | 170 | 150 |
| 80-84 | 485 | 234 | 94 | 136 | 382 | 258 | 207 |
| 85+ | 446 | 434 | 144 | 173 | 563 | 348 | 264 |

Source The national registers for causes of death ICD-10: J40-J47

**Table 13 Consumption of medication for chronic obstructive pulmonary disease, DDD/1000 inhabitants/day 2006**

| | Denmark | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|
| *Adrenergic inhalants (R03A)* | | | | | | |
| *Men* | | | | | | |
| 0-64 | 23.2 | 17.3 | 18.5 | 17.8 | 25.7 | 17.7 |
| 65-69 | 74.0 | 50.8 | 67.3 | 64.7 | 77.8 | 45.7 |
| 70-74 | 109.1 | 65.7 | 100.7 | 80.1 | 97.4 | 55.4 |
| 75-79 | 128.2 | 79.2 | 81.1 | 83.3 | 96.0 | 65.1 |
| 80-84 | 115.0 | 87.3 | 94.2 | 71.8 | 103.4 | 64.0 |
| 85+ | 71.9 | 66.7 | 63.8 | 44.7 | 73.6 | 59.2 |
| *Women* | | | | | | |
| 0-64 | 26.8 | 22.4 | 22.3 | 24.5 | 31.5 | 23.3 |
| 65-69 | 92.9 | 56.4 | 66.2 | 90.7 | 90.6 | 64.7 |
| 70-74 | 117.2 | 61.9 | 81.6 | 100.7 | 95.1 | 66.7 |
| 75-79 | 110.9 | 63.7 | 74.4 | 92.7 | 91.1 | 64.1 |
| 80-84 | 77.1 | 55.6 | 89.9 | 64.0 | 70.0 | 55.3 |
| 85+ | 41.4 | 39.4 | 30.2 | 45.4 | 44.0 | 42.6 |
| Consumption of other drugs for chronic obstructive pulmonary disease (R03B) | | | | | | |
| Men | | | | | | |
| 0-64 | 11.8 | 9.1 | 9.2 | 4.8 | 9.4 | 9.5 |
| 65-69 | 39.7 | 31.0 | 21.2 | 21.1 | 50.0 | 37.9 |
| 70-74 | 56.6 | 41.6 | 55.5 | 34.2 | 71.0 | 49.9 |
| 75-79 | 69.0 | 49.8 | 32.2 | 38.1 | 76.7 | 60.5 |
| 80-84 | 63.6 | 53.4 | 46.7 | 39.2 | 90.3 | 64.4 |
| 85+ | 41.0 | 44.9 | 58.1 | 28.0 | 69.8 | 64.6 |
| Women | | | | | | |
| 0-64 | 14.8 | 13.1 | 8.6 | 6.6 | 11.5 | 14.0 |
| 65-69 | 53.7 | 36.7 | 24.4 | 40.7 | 52.2 | 54.9 |
| 70-74 | 66.3 | 39.5 | 35.1 | 43.6 | 63.6 | 61.3 |
| 75-79 | 64.3 | 40.0 | 46.9 | 38.4 | 66.6 | 59.2 |
| 80-84 | 47.2 | 36.2 | 43.1 | 25.5 | 56.8 | 53.6 |
| 85+ | 25.5 | 24.9 | 10.9 | 18.5 | 36.8 | 41.0 |

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

## Pneumonia and the use of antibiotics

The widespread use of antibiotics has been strongly criticised because of the increased risk of the development of resistance. In all countries, it is recommended

## Lunginflammation och antibiotikaanvändning

Den omfattande användningen av antibiotika har kritiserats starkt på grund av den ökande risken för resistensutveckling. I alla länder rekommenderar man

that use of antibiotics should be limited, and that narrow spectrum antibiotics should be the first choice. Compared to the rest of Europe, consumption of antibiotics in the Nordic countries is low. Elderly people consume three times as much penicillin as children aged 0-14 years.

att användningen av antibiotika begränsas och att smalspektrumantibiotika borde användas i första hand. Jämfört med övriga Europa så är konsumtionen av antibiotika i de nordiska länderna låg. Äldre använder tre gånger så mycket penicillin jämfört med barn 0-14 år.

Pneumonia is a very common cause for admission to hospital for elderly people in all the Nordic countries (see Table 14). Mortality from pneumonia is common and the number of deaths increases markedly for people aged over 85 years, though this partly reflects practice with regard to coding causes of death.

Lunginflammation är en mycket vanlig orsak till inläggning på sjukhus (se tabell 14) för de äldre i alla de nordiska länderna. Även dödlighet (se tabell 15) i lunginflammation är vanligt och dödstalen stiger kraftigt för äldre över 85 år. Dock avspeglar det delvis kodningspraxis i dödsorsaksregistren.

**Table 14 Patients treated in somatic hospitals for pneumonia per 100 000 inhabitants 2006**

| | Denmark | Faroe Islands[1)] | Finland | Åland[1)] | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| *Men* | | | | | | | |
| 0-64 | 243 | 136 | 172 | 145 | 85 | 207 | 125 |
| 65-69 | 835 | 318 | 633 | 609 | 262 | 999 | 477 |
| 70-74 | 1 417 | 903 | 939 | 1 134 | 581 | 1 596 | 813 |
| 75-79 | 2 236 | 993 | 1 512 | 1 920 | 1 315 | 2 657 | 1 343 |
| 80-84 | 3 422 | 3 304 | 2 359 | 2 717 | 2 278 | 4 195 | 2 253 |
| 85+ | 5 290 | 3 509 | 3 653 | 4 362 | 3 451 | 6 962 | 3 829 |
| *Women* | | | | | | | |
| 0-64 | 201 | 249 | 132 | 115 | 76 | 183 | 111 |
| 65-69 | 639 | 575 | 308 | 324 | 315 | 699 | 346 |
| 70-74 | 1 019 | 791 | 438 | 446 | 543 | 968 | 496 |
| 75-79 | 1 430 | 401 | 645 | 497 | 845 | 1 421 | 758 |
| 80-84 | 2 047 | 966 | 934 | 1 393 | 1 421 | 2 172 | 1 192 |
| 85+ | 2 991 | 936 | 1 406 | 2 237 | 2 537 | 3 644 | 2 009 |

1 Average 2002-06

Source: The national inpatient registers ICD-10: J12-J18

**Table 15 Deaths from pneumonia per 100 000 inhabitants**

| | Denmark | Faroe Islands | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| | 2006 | 2002-06 | 2006 | 2002-06 | 2002-06 | 2006 | 2006 |
| *Men* | | | | | | | |
| 0-64 | 3 | 1 | 3 | 4 | 1 | 1 | 2 |
| 65-69 | 22 | - | 20 | 68 | 13 | 17 | 12 |
| 70-74 | 61 | 52 | 21 | 0 | 9 | 55 | 20 |
| 75-79 | 120 | 138 | 49 | 105 | 61 | 172 | 87 |
| 80-84 | 307 | 507 | 122 | 553 | 143 | 414 | 231 |
| 85+ | 1 176 | 1 614 | 586 | 1 726 | 990 | 1 576 | 852 |
| *Women* | | | | | | | |
| 0-64 | 1 | 2 | 1 | 2 | - | 1 | 1 |
| 65-69 | 20 | 24 | 4 | 0 | 4 | 11 | 5 |
| 70-74 | 43 | 25 | 10 | 0 | 13 | 38 | 9 |
| 75-79 | 89 | 237 | 28 | 158 | 55 | 93 | 41 |
| 80-84 | 220 | 267 | 53 | 316 | 167 | 246 | 151 |
| 85+ | 928 | 1 498 | 279 | 2 210 | 971 | 1 112 | 597 |

Source: The national registers for causes of death ICD-10: J12-J18

## Diseases of the digestive system and the urinary system

Disorders with eating and digestion are common among elderly people. It is difficult to obtain statistics about this, as most of these disorders do not require admission to hospital. However, consumption of medication for peptic ulcer and gastro-oesophageal reflux increases with increasing age. The number of hospital admissions for peptic ulcer also increases with increasing age. Consumption of medication and admission to hospital for peptic ulcer are lower in Finland than in the other Nordic countries (see Tables 16 and 17). Danish men and women have the highest level of hospital admissions for these disorders.

The incidence of inguinal hernia for men increases with increasing age. The incidence of gallstones also increases with increasing age, for both men and women (see Table 16).

## Sjukdomar i magtarmkanalen och urinvägarna

Besvär med födointag och matsmältning är vanligt bland äldre. Det är svårt att få några uppgifter om detta då de flesta besvär inte kräver sjukhusinläggning. Vi ser dock att konsumtionen av mediciner mot magsår och refluxsjukdom stiger med ökande ålder. Sjukhusinläggning för magsår ökar också med stigande ålder. Finland har både lägre konsumtion av läkemedel och inläggningar på grund av magsår (se tabell 16 och 17). Danska män och kvinnor har den högsta andelen vårdade i sluten vård.

Ljumskbråck hos män ökar med stigande ålder, liksom gallsten (se tabell 16) hos både män och kvinnor.

The incidence of renal failure increases with increasing age and varies greatly for the different countries (see Table 18). To a large degree, this probably reflects differences in diagnosis rather than morbidity.

Njursvikt ökar med stigande ålder (se tabell 18) och visar stora skillnader mellan länderna. Detta avspeglar troligen i högre grad skillnader i diagnossättning än i sjuklighet.

**Table 16 Patients treated for diseases of the digestive system per 100 000 inhabitants 2006**

| | Denmark | Faroe Islands[1)] | Finland | Åland[1)] | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| *Gastric ulcer ICD-10: K25-K28* | | | | | | | |
| *Men* | | | | | | | |
| 0-64 | 42 | 59 | 24 | 27 | 21 | 28 | 27 |
| 65-69 | 206 | 636 | 107 | 160 | 131 | 142 | 154 |
| 70-74 | 338 | 1 161 | 121 | 81 | 194 | 244 | 184 |
| 75-79 | 478 | 165 | 159 | 107 | 140 | 326 | 296 |
| 80-84 | 657 | - | 190 | 151 | 410 | 492 | 404 |
| 85+ | 758 | 351 | 277 | 638 | 271 | 648 | 530 |
| *Women* | | | | | | | |
| 0-64 | 29 | 31 | 10 | 20 | 14 | 18 | 16 |
| 65-69 | 171 | 345 | 48 | - | 84 | 111 | 84 |
| 70-74 | 211 | 132 | 66 | 112 | 130 | 185 | 132 |
| 75-79 | 368 | 802 | 134 | 83 | 188 | 266 | 206 |
| 80-84 | 516 | 483 | 177 | 90 | 264 | 417 | 357 |
| 85+ | 699 | 1 124 | 185 | 387 | 114 | 641 | 399 |
| *Inguinal hernia ICD-10: K40* | | | | | | | |
| *Men* | | | | | | | |
| 0-64 | 113 | 240 | 291 | 255 | 79 | 69 | 42 |
| 65-69 | 396 | 742 | 777 | 897 | 458 | 260 | 210 |
| 70-74 | 515 | 774 | 903 | 1 012 | 509 | 340 | 306 |
| 75-79 | 649 | 496 | 747 | 800 | 755 | 452 | 461 |
| 80-84 | 765 | 1 017 | 770 | 1 132 | 820 | 584 | 569 |
| 85+ | 622 | 1 053 | 614 | 426 | 474 | 628 | 508 |
| *Women* | | | | | | | |
| 0-64 | 11 | 56 | 33 | 27 | 10 | 8 | 5 |
| 65-69 | 29 | - | 45 | 65 | 21 | 13 | 12 |
| 70-74 | 33 | - | 66 | 149 | - | 19 | 19 |
| 75-79 | 67 | 134 | 77 | 166 | - | 48 | 36 |
| 80-84 | 68 | - | 95 | 135 | 33 | 52 | 50 |
| 85+ | 95 | 187 | 67 | - | - | 61 | 47 |

**The table continues ...**

**Table 16 Continued**

| | Denmark | Faroe Islands1) | Finland | Åland1) | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| *Cholelithiasis ICD-10: K80* | | | | | | | |
| *Men* | | | | | | | |
| 0-64 | 66 | 32 | 73 | 101 | 72 | 59 | 72 |
| 65-69 | 191 | 106 | 310 | 160 | 283 | 242 | 245 |
| 70-74 | 250 | 645 | 390 | 486 | 291 | 266 | 273 |
| 75-79 | 265 | 331 | 515 | 587 | 503 | 387 | 346 |
| 80-84 | 358 | - | 547 | 679 | 547 | 472 | 399 |
| 85+ | 371 | 702 | 550 | 638 | 609 | 632 | 544 |
| *Women* | | | | | | | |
| 0-64 | 183 | 224 | 183 | 273 | 259 | 148 | 172 |
| 65-69 | 315 | 345 | 358 | 486 | 525 | 267 | 317 |
| 70-74 | 315 | 264 | 354 | 297 | 499 | 307 | 315 |
| 75-79 | 364 | 134 | 355 | 373 | 493 | 371 | 321 |
| 80-84 | 326 | 644 | 402 | 539 | 364 | 392 | 354 |
| 85+ | 382 | 187 | 490 | 559 | 454 | 501 | 408 |

1 Average 2002-06

Source: National registers

**Table 17 Consumption of drugs for peptic ulcer and gastro-oesophageal reflux, DDD/1000 inhabitants/day 2006**

| ATC-code A02B | Denmark | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|
| *Men* | | | | | | |
| 0-64 | 17.7 | 15.0 | 14.0 | 35.9 | 20.2 | 19.0 |
| 65-69 | 66.9 | 49.6 | 45.0 | 146.4 | 73.0 | 78.8 |
| 70-74 | 82.8 | 58.4 | 60.9 | 175.6 | 84.1 | 90.7 |
| 75-79 | 94.7 | 68.6 | 59.5 | 182.2 | 82.8 | 106.3 |
| 80-84 | 111.9 | 83.0 | 78.2 | 168.1 | 94.5 | 119.1 |
| 85+ | 125.7 | 96.7 | 96.2 | 123.0 | 96.1 | 147.3 |
| *Women* | | | | | | |
| 0-64 | 20.0 | 17.7 | 13.7 | 46.4 | 18.7 | 24.3 |
| 65-69 | 75.7 | 58.3 | 51.1 | 210.1 | 78.0 | 91.9 |
| 70-74 | 92.8 | 72.5 | 59.0 | 234.6 | 88.8 | 104.2 |
| 75-79 | 105.6 | 84.1 | 79.7 | 223.5 | 100.6 | 116.1 |
| 80-84 | 123.9 | 95.0 | 79.6 | 214.9 | 98.7 | 126.9 |
| 85+ | 146.5 | 104.3 | 79.1 | 137.3 | 90.9 | 155.6 |

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

**Table 18 Patients treated for renal failure per 100 000 inhabitants 2006**

| | Denmark | Faroe Islands[1)] | Finland | Åland[1)] | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| *Men* | | | | | | | |
| 0-64 | 41 | 9 | 17 | 14 | 19 | 45 | 29 |
| 65-69 | 202 | - | 104 | 160 | 196 | 270 | 167 |
| 70-74 | 324 | - | 131 | 81 | 242 | 446 | 229 |
| 75-79 | 528 | 331 | 227 | 267 | 308 | 675 | 357 |
| 80-84 | 648 | 254 | 292 | 377 | 364 | 964 | 486 |
| 85+ | 632 | 702 | 296 | 851 | 406 | 1430 | 584 |
| *Women* | | | | | | | |
| 0-64 | 25 | 5 | 9 | 7 | 11 | 27 | 17 |
| 65-69 | 131 | - | 50 | 65 | 168 | 120 | 81 |
| 70-74 | 187 | 132 | 70 | 149 | 87 | 218 | 126 |
| 75-79 | 214 | - | 114 | 83 | 188 | 331 | 169 |
| 80-84 | 267 | 644 | 155 | 315 | 231 | 471 | 229 |
| 85+ | 203 | - | 152 | 172 | 303 | 742 | 229 |

1 Average 2002-06

Source: The national inpatient registers ICD-10: N17-N19

**Table 19 Deaths from diseases of the kidney and ureter per 100 000 inhabitants**

| | Denmark | Faroe Islands | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| | 2006 | 2002-06 | 2006 | 2002-06 | 2002-06 | 2006 | 2006 |
| *Men* | | | | | | | |
| 0-64 | 2 | 1 | 1 | - | 1 | 1 | 1 |
| 65-69 | 13 | 22 | 3 | - | 13 | 13 | 9 |
| 70-74 | 31 | 26 | 12 | - | 24 | 24 | 19 |
| 75-79 | 75 | 69 | 32 | - | 24 | 63 | 44 |
| 80-84 | 174 | 203 | 46 | - | 105 | 155 | 84 |
| 85+ | 310 | 231 | 219 | 108 | 295 | 414 | 253 |
| *Women* | | | | | | | |
| 0-64 | 1 | 2 | - | - | - | - | - |
| 65-69 | 7 | 73 | 4 | - | 17 | 7 | 5 |
| 70-74 | 20 | - | 9 | 39 | 17 | 11 | 14 |
| 75-79 | 39 | - | 29 | - | 25 | 38 | 29 |
| 80-84 | 69 | 133 | 62 | 226 | 70 | 64 | 40 |
| 85+ | 166 | 118 | 196 | 130 | 204 | 212 | 107 |

Source: The national registers for causes of death ICD-10: N00-N29

## Endocrine diseases

Type 2 diabetes and disorders of the thyroid gland are common among elderly people. About 10 per cent of both men and women over 80 years of age

## Endokrina sjukdomar

Diabetes (typ 2) och sköldkörtelsjukdom är vanlig förekommande bland de äldre. Ungefär 10 procent av både män och kvinnor över 80 år behandlas med

are treated with medication for diabetes. In addition, a few per cent are treated just with diet. Finland and Sweden are the countries with the highest prevalence of diabetes in the world.

Overweight increases the risk for developing diabetes. Overweight is more common in Finland, and this is reflected in the consumption of medication for diabetes, which is much higher in Finland than in the other Nordic countries.

Treatment with thyroid hormones is much more common for women than for men. About 15 per cent of women in Sweden aged over 80 years receive some form of treatment for disorders of the thyroid gland, but only 5 per cent of men. Consumption of thyroid hormones seems to be fairly similar in the Nordic countries, though Danish men and women have a lower consumption than men and women in the other Nordic countries.

läkemedel mot sin diabetes. Utöver dessa kan ytterligare några procentenheter antas få enbart kostbehandling. Finland och Sverige är de länder i världen med högst förekomst av diabetes.

Övervikt ökar risken för att utveckla diabetes. Övervikt är vanligare i Finland och detta avspeglas också i den finska konsumtionen av läkemedel mot diabetes som är betydligt högre än i de övriga nordiska länderna.

Behandling med tyreoideahormoner är betydligt vanligare bland kvinnor. Ungefär 15 procent av alla kvinnor i Sverige över 80 år får någon form av sköldkörtelhormonbehandling, medan endast cirka 5 procent hos männen behandlas. Konsumtionen av tyreoideahormoner tycks vara relativt lika i de nordiska länderna, dock har danska män och kvinnor en lägre konsumtion än övriga nordiska män och kvinnor.

**Table 20 Consumption of drugs for diabetes DDD/1000 inhabitants/day 2006**

| ATC code A10 | Denmark | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|
| *Men* | | | | | | |
| 0-64 | 29.4 | 47.2 | 30.7 | 18 | 33.8 | 33.6 |
| 65-69 | 123.5 | 222.3 | 117.2 | 113 | 143.9 | 160.4 |
| 70-74 | 130.4 | 255.6 | 168.2 | 119 | 153.9 | 175.9 |
| 75-79 | 119.3 | 248.7 | 165.7 | 120 | 132.1 | 167.4 |
| 80-84 | 100.5 | 221.1 | 131.3 | 103 | 126.5 | 139.1 |
| 85+ | 70.8 | 167.6 | 81.5 | 42 | 101.8 | 106.8 |
| *Women* | | | | | | |
| 0-64 | 19.7 | 28.3 | 17.6 | 11 | 22.1 | 21.3 |
| 65-69 | 81.7 | 138.3 | 66.3 | 60 | 93.2 | 100.9 |
| 70-74 | 95.3 | 182.8 | 111.4 | 84 | 111.9 | 122.4 |
| 75-79 | 92.7 | 206.7 | 84.6 | 83 | 115.1 | 122.7 |
| 80-84 | 80.9 | 207.5 | 129.6 | 45 | 102.3 | 112.2 |
| 85+ | 59.5 | 158.3 | 80.4 | 21 | 77.1 | 87.7 |

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

**Table 21 Consumption of drugs for disorders of the thyroid gland DDD/1000 inhabitants/day 2006**

| ATC code H03AA | Denmark | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|
| *Men* | | | | | | |
| 0-64 | 2.5 | 4.7 | 6.0 | 4.3 | 5.1 | 4.5 |
| 65-69 | 8.8 | 16.8 | 22.9 | 20.5 | 19.5 | 17.1 |
| 70-74 | 9.7 | 20.4 | 25.5 | 24.2 | 22.0 | 19.3 |
| 75-79 | 11.5 | 21.3 | 24.5 | 24.4 | 21.6 | 22.7 |
| 80-84 | 11.5 | 22.6 | 24.7 | 22.4 | 25.4 | 25.9 |
| 85+ | 12.4 | 23.2 | 47.4 | 23.5 | 27.4 | 28.1 |
| *Women* | | | | | | |
| 0-64 | 12.5 | 23.1 | 30.4 | 21.8 | 24.7 | 23.3 |
| 65-69 | 38.4 | 69.8 | 89.1 | 76.0 | 75.5 | 75.4 |
| 70-74 | 41.2 | 70.6 | 105.0 | 81.5 | 73.3 | 80.4 |
| 75-79 | 43.5 | 67.1 | 104.7 | 73.3 | 70.7 | 81.4 |
| 80-84 | 43.2 | 60.1 | 79.0 | 59.7 | 63.3 | 79.0 |
| 85+ | 36.9 | 48.7 | 71.4 | 27.3 | 52.1 | 75.4 |

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

## Disorders of the musculoskeletal system

Results from the Finnish report *Health 2000* shows that 44 per cent of men and 35 per cent of women aged over 84 years have arthritis of the knee (gonarthrosis). Arthritis is also common in other joints. For example, 40 per cent of men and 25 per cent of women aged over 84 years have arthritis of the hip (coxarthrosis). [9]

The results for the other Nordic countries also show that back pain and neck pain are common among elderly people.

The Finnish study [16] shows that the prevalence of disorders of muscles and joints has not reduced much among elderly people during the last 20 years. This may indicate that preventive measures have not had an effect for elderly people. The results for Denmark also show that back pain and neck pain are common among elderly people. [17]

## Muskel- och skelettsjukdomar

Resultat från den finska rapporten *Hälsa 2000* visar att 44 procent av männen och 35 procent av kvinnorna, äldre än 84 år, har knäartros. Atros i andra leder är också vanligt förekommande. Till exempel har 40 procent av männen och 25 procent av kvinnorna, äldre än 84 år, höftartros. [9]

Resultat från de övriga nordiska länderna visar också att värk i nacke och rygg är vanligt i de äldre åldersgrupperna.

Den finska studien [16] visar att besvär i muskler och leder inte minskat speciellt mycket bland de äldre under de senaste tjugo åren, vilket kan tyda på att preventiva åtgärder inte har nått de äldre. Resultat från Danmark visar också att ryggvärk och värk i nacken är vanligt bland äldre. [17]

The results of the Swedish study of living conditions (ULF), show that the proportion of people with severe pain in the neck, shoulder, back and joints has generally remained unchanged in the age groups 65-74 and 75-84 during the period 1980/81-2005. However, in the age group 85 years and older, there has been a fairly large increase in prevalence during the period 2002/02-2005. The drop-out rate is fairly high for this age group, so the results must be interpreted with caution. [18]

I den svenska undersökningen om levnadsförhållanden (ULF), så visar resultaten att andelen med svår värk i nacke, axlar, skuldror, rygg och leder är i stort sett oförändrat i åldersgrupperna 65-74 och 75-84 år mellan åren 1980/81 och 2005. I åldersgruppen 85 år och äldre visar däremot en ganska stor ökning mellan åren 2002/03 och 2005, men bortfallet är ganska stort i den åldersgruppen så resultaten bör användas med viss försiktighet. [18]

Table 22 shows that the number of admissions to hospital for arthritis of the hip and knee increases with increasing age, and is more common for women that for men. The differences between the countries are small.

Tabellerna över höftleds- och knäledsartros (tabell 22) visar att inläggning på grund av dessa besvär stiger med ökande ålder och är vanligare bland kvinnor än bland män. Dock är skillnaderna mellan länderna små.

**Table 22 Patients treated for diseases of the musculoskeletal system and connective tissue per 100 000 inhabitants 2006**

| | Denmark | Faroe Islands[1)] | Finland | Åland[1)] | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| *Coxarthrosis ICD-10: M16* | | | | | | | |
| *Men* | | | | | | | |
| 0-64 | 53 | 32 | 60 | 53 | 37 | 40 | 49 |
| 65-69 | 408 | 318 | 468 | 545 | 392 | 350 | 389 |
| 70-74 | 512 | 258 | 564 | 729 | 436 | 470 | 492 |
| 75-79 | 591 | 496 | 544 | 1 120 | 755 | 494 | 557 |
| 80-84 | 418 | - | 422 | 453 | 501 | 420 | 410 |
| 85+ | 322 | - | 249 | 0532 | 271 | 369 | 269 |
| *Women* | | | | | | | |
| 0-64 | 49 | 61 | 59 | 64 | 50 | 59 | 53 |
| 65-69 | 498 | 690 | 451 | 681 | 588 | 606 | 503 |
| 70-74 | 709 | 395 | 681 | 1 004 | 738 | 837 | 635 |
| 75-79 | 702 | 535 | 672 | 621 | 469 | 905 | 643 |
| 80-84 | 576 | 322 | 543 | 674 | 727 | 781 | 525 |
| 85+ | 317 | 562 | 226 | 387 | 417 | 397 | 269 |

**The table continues ...**

**Table 22 Continues**

| | Denmark | Faroe Islands[1)] | Finland | Åland[1)] | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| *Gonarthrosis ICD-10: M17* | | | | | | | |
| *Men* | | | | | | | |
| 0-64 | 59 | 168 | 141 | 108 | 43 | 36 | 40 |
| 65-69 | 372 | 742 | 648 | 449 | 502 | 247 | 346 |
| 70-74 | 437 | 903 | 722 | 243 | 654 | 327 | 481 |
| 75-79 | 374 | 1 323 | 784 | 480 | 755 | 374 | 493 |
| 80-84 | 341 | 508 | 655 | 75 | 319 | 254 | 383 |
| 85+ | 174 | 702 | 282 | - | 135 | 103 | 171 |
| *Women* | | | | | | | |
| 0-64 | 74 | 153 | 191 | 117 | 54 | 45 | 51 |
| 65-69 | 467 | 1 035 | 1 004 | 389 | 630 | 375 | 450 |
| 70-74 | 590 | 922 | 1 326 | 595 | 825 | 526 | 621 |
| 75-79 | 628 | 802 | 1 358 | 497 | 681 | 561 | 663 |
| 80-84 | 502 | 805 | 960 | 629 | 397 | 412 | 454 |
| 85+ | 232 | 375 | 327 | 387 | 151 | 170 | 181 |

1 Average 2002-06

Source: National inpatient registers

## Vision and hearing

Vision and hearing deteriorate with increasing age, which can cause serious difficulties for elderly people to carry out daily tasks and manage their daily life. Information on visual acuity and the prevalence of visual impairment and blindness in the Nordic countries is incomplete, and the available data is not completely comparable. Particularly in extreme old age, the proportion of the population with good vision and hearing is reduced.

The proportion of elderly people with visual impairment (visual acuity < 0.3 based on the criteria of WHO) has varied from 3 per cent in *the Copenhagen City Eye study* for people aged 65-80 years, and 4 per cent in the Finnish study for people aged 65-79 years. [19, 20, 21] Based on earlier Finnish studies, 19-27 per cent of the population aged

## Syn och hörsel

Syn och hörsel försämras med stigande ålder vilket avsevärt kan försvåra för de äldres att utföra dagliga sysslor och klara av det dagliga livet. Informationen om visuell skärpa och prevalensen för nedsatt synförmåga och blindhet i de nordiska länderna är otillräcklig och resultaten är inte helt och hållet jämförbara. Vid hög ålder minskar i synnerhet den andel av befolkningen som har god visuell skärpa och andelen med nedsatt hörsel ökar.

Andelen äldre med nedsatt syn (visuell skärpa < 0,3 baserat på WHO:s kriterier) har varierat från 3 procent i *The Copenhagen City Eye Study* på personer mellan 65-80 år och 4 procent i den finska på personer i åldern 65-79 år. [19, 20, 21] Baserat på tidigare finska studier så har så många som 19-27 procent av befolkningen över 80 år

over 80 years have visual impairment. [21, 22] The proportion of elderly people who are blind (visual acuity <0.05) varies between 2-5 per cent. [19, 20, 21]

Visual impairment among elderly people is often the result of age-related eye diseases such as age-related macular degeneration (AMD) (age changes in the yellow spot), cataract and glaucoma. According to Danish and Finnish studies, 45-56 per cent of cases of reduced vision in the age group over 70 years are cases of AMD (with or without cataract), 11-27 per cent are cases of cataract only, and 12-18 per cent are cases of glaucoma (with or without cataract). [19, 20, 22]

Visual impairment due to uncorrected refraction also increase with age, and especially for people aged 80 and over. [23, 24] Early detection and treatment of age-related eye diseases can considerably reduce the number of cases of visual impairment and handicap among elderly people. Permanent visual impairment because of cataract can usually be prevented using modern surgery (cataract surgery). In cases of visual impairment that are incurable, different types of aids and rehabilitation can help to reduce the effect of the visual impairment on function, can postpone admission to an institution and can improve quality of life. Table 3.5.7 (Section A in this publication) presents statistics on cataract operations, according to age and gender. Most cataract operations (per 100 000 inhabitants) are carried out in Finland, a large number for people aged over 75 years.

The prevalence of reduced hearing increases after the age of 50. [25, 26] According to a Swedish study (based on

nedsatt synförmåga. [21, 22] Andelen med en blindhet (visuell skärpa <0,05) har varierat mellan 2-5 procent bland de äldre. [19, 20, 21]

Nedsatt synförmåga hos de äldre beror oftast på åldersrelaterade ögonsjukdomar som makuladegeneration (åldersförändringar i gula fläcken), grå och grön starr. Enligt danska och finska studier orsakas nedsatt synförmåga i åldersgruppen över 70 år i 45-56 procent av fallen av makuladegeneration (med eller utan grå starr), 11-27 procent av fallen endast av grå starr och 12-18 procent av fallen av grön starr (med eller utan grå starr). [19, 20, 22]

Nedsatt synförmåga på grund av okorrigerade brytningsfel ökar också med åldern och speciellt i åldrarna 80 och över. [23, 24] Tidig upptäckt och behandling av åldersrelaterade ögonsjukdomar kan väsentligt reducera antalet fall av nedsatt synförmåga och visuella handikapp hos de äldre. Permanent nedsatt synförmåga på grund av gråstarr kan vanligtvis förhindras med modern kirurgi (kataraktkirurgi). I de obotliga fallen med nedsatt synförmåga kan olika hjälpmedel och rehabilitering hjälpa till att reducera effekten av den nedsatta synförmågan på funktion, skjuta upp inläggning på institution och höja livskvaliteten. I tabell 3.5.7 (i sektion A i denna publikation) redovisas kataraktoperationer fördelat på ålder och kön. Flest kataraktoperationer, redovisat per 100 000 innevånare, utförs i Finland och ett stort antal i åldrarna över 75 år.

Nedsatt hörsel börjar öka efter 50 år. [25, 26] Enligt en svensk studie (baserad på självrapporterad hälsa) och en

self-reported health) and a Finnish study (based on WHO's criteria), the proportion of people with reduced hearing is estimated to be 30 per cent in the age group 75-84 years and 33 per cent for people aged 75 years. [25, 26] According to the Finnish study *Health 2000*, over 50 per cent of people aged 75-84, and over 90 per cent of people aged over 85 have at least a mild form of reduced hearing (based on the criteria of WHO). [27] It has been estimated that about 30-50 per cent of people who suffer from reduced hearing are in need of hearing rehabilitation.

finsk studie (baserad på WHO:s kriterier) så varierar andelen med nedsatt hörsel från 30 procent i åldrarna 75-84 år till 33 procent i kring 75 år. [25, 26] Enligt den finska undersökningen *Hälsa 2000* har (baserat på WHO:s kriterier) över 50 procent i åldrarna 75-84 och mer än 90 procent över 85 år åtminstone en lättare form av nedsatt hörsel. [27] Det har uppskattats att ungefär 30-50 procent av de som lider av nedsatt hörsel är i behov av hörselrehabilitering.

## Mental illness

Depression is the most common cause of mental ill health among elderly people. Elderly people suffer more often than young people from anxiety and psychotic disorders. Physical illness and dementia among elderly people increase the risk of mental illness. It is difficult to obtain a picture of how many elderly people suffer from mental illness, and the relationship between dementia and depression is complex. The Finnish study *Health 2000* [27], which was carried out between September 2000 and July 2001, showed that about 15-20 per cent of Finnish people had been diagnosed with a mental illness. Anxiety, depression and alcohol-related disorders were also common. We refer to the theme section in last year's publication [28]: mental health.

Consumption of psykoactive drugs provides an indicator of mental illness and psychiatric disorders.

## Psykisk sjukdom

Depression är den vanligaste orsaken till psykisk ohälsa bland äldre. Äldre drabbas oftare av ångestsjukdomar och psykotiska tillstånd. Äldres kroppsliga sjukdomar och demens ökar risken för psykisk ohälsa. Det är svårt att få en uppfattning om hur många som lider av psykisk ohälsa bland de äldre och det finns komplexa samband mellan demens och depression. Den finländska studien *Hälsa 2000* [27], som genomfördes mellan september 2000 och juli 2001, visade att omkring 15-20 procent av finländarna fått en psykisk sjukdom diagnostiserad. Ångest, depression och alkoholrelaterade sjukdomar var också vanligst i den finska studien. Förra årets tema [28] handlade om psykisk hälsa och där finns det mer att läsa.

Användningen av psykofarmaka redovisas som en indikator på psykiatrisk sjukdom och psykiatriska besvär.

Analysis of consumption of medication in Sweden shows that about 20 per cent of elderly women use antidepressants, and about 15 per cent of men. Almost one-third of elderly people, at some time during the year, have taken sedative medication or sleeping pills. Women use more antidepressants than men in all the Nordic countries. Consumption of both antidepressants and sedatives is highest among the oldest elderly people – those aged 85 years and older. In Norway and Finland, consumption of antidepressants among the oldest elderly people is lower than in the other Nordic countries. However, in Finland the consumption of antipsychotic medication is slightly higher.

Suicide is common among elderly people, particularly among elderly men, and more elderly men than young men commit suicide. Table 4.1.6 in Section A in this publication presents statistics on suicide according to age and gender.

Analys av läkemedelsuttag i Sverige visar att ungefär 20 procent av de äldre kvinnorna använder antidepressiva läkemedel och cirka 15 procent av männen. Närmare en tredjedel har någon gång under året tagit lugnande tabletter eller sömntabletter. Kvinnor använder mer antidepressiva än män i alla de nordiska länderna. Konsumtionen av både antidepressiva medel och lugnande medel är som störst bland de allra äldsta, 85 år och äldre. I Norge och Finland är konsumtionen av antidepressiva bland de äldre lägre än i de andra nordiska länderna. I Finland har man istället en lite högre konsumtion av antipsykotiska medel.

Självmord är vanligt bland de äldre, speciellt bland äldre män och fler äldre män begår självmord än yngre män. I tabell 4.1.6, i sektion A, i denna publikation, redovisas självmord fördelat på kön och ålder.

**Table 23 Consumption of antidepressants N06A, DDD/1000 inhabitants/day 2006**

| | Denmark | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|
| *Antidepressants (N06A)* | | | | | | |
| *Men* | | | | | | |
| 0-64 | 36.2 | 34.8 | 20.4 | 47.5 | 30.5 | 39.8 |
| 65-69 | 69.1 | 42.0 | 19.3 | 119.1 | 52.4 | 61.9 |
| 70-74 | 79.5 | 42.7 | 49.2 | 124.3 | 54.1 | 68.7 |
| 75-79 | 99.3 | 48.5 | 39.1 | 133.7 | 55.2 | 86.7 |
| 80-84 | 126.7 | 56.9 | 75.5 | 124.1 | 63.4 | 107.3 |
| 85+ | 140.4 | 64.9 | 104.5 | 98.7 | 69.3 | 142.3 |
| *Women* | | | | | | |
| 0-64 | 65.7 | 56.6 | 39.1 | 96.8 | 55.1 | 74.4 |
| 65-69 | 122.9 | 66.7 | 72.6 | 189.4 | 106.8 | 114.5 |
| 70-74 | 135.0 | 65.3 | 72.4 | 204.4 | 103.5 | 116.5 |
| 75-79 | 162.0 | 76.1 | 81.5 | 193.6 | 110.1 | 139.5 |
| 80-84 | 199.4 | 87.9 | 99.5 | 174.7 | 111.8 | 170.3 |
| 85+ | 226.4 | 93.2 | 115.0 | 117.4 | 102.6 | 219.0 |

**The table continues ...**

**Table 23 Continued**

| | Denmark | Finland | Åland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|
| *Anxiolytics (N05B)* | | | | | | |
| *Men* | | | | | | |
| 0-64 | 10.9 | 22.7 | 3.4 | 10.8 | 13.5 | 10.3 |
| 65-69 | 25.1 | 28.9 | 3.5 | 46.0 | 29.3 | 22.2 |
| 70-74 | 26.2 | 29.3 | 12.0 | 46.1 | 30.1 | 22.8 |
| 75-79 | 27.3 | 30.0 | 5.2 | 41.5 | 26.7 | 25.1 |
| 80-84 | 26.8 | 33.1 | 15.0 | 35.4 | 31.9 | 28.8 |
| 85+ | 24.3 | 30.6 | 15.0 | 24.1 | 30.4 | 37.1 |
| *Women* | | | | | | |
| 0-64 | 15.4 | 18.2 | 4.5 | 17.2 | 8.2 | 12.9 |
| 65-69 | 54.8 | 35.3 | 4.4 | 71.6 | 26.4 | 33.0 |
| 70-74 | 59.7 | 36.7 | 14.5 | 78.1 | 29.5 | 33.9 |
| 75-79 | 59.6 | 41.1 | 15.7 | 66.2 | 32.5 | 39.0 |
| 80-84 | 55.1 | 38.2 | 19.3 | 53.6 | 34.5 | 44.7 |
| 85+ | 45.8 | 35.0 | 13.6 | 31.2 | 34.9 | 56.8 |
| *Hypnotics and sedatives (N05C)* | | | | | | |
| *Men* | | | | | | |
| 0-64 | 12.7 | 18.8 | 6.2 | 20.4 | 16.6 | 22.2 |
| 65-69 | 49.6 | 70.2 | 28.5 | 124.0 | 62.9 | 73.5 |
| 70-74 | 62.6 | 91.1 | 52.0 | 150.6 | 80.2 | 90.7 |
| 75-79 | 76.0 | 123.3 | 78.4 | 177.5 | 90.9 | 118.9 |
| 80-84 | 96.0 | 167.4 | 93.2 | 198.9 | 135.8 | 158.1 |
| 85+ | 115.3 | 212.8 | 210.4 | 168.2 | 172.8 | 239.3 |
| *Women* | | | | | | |
| 0-64 | 18.9 | 22.7 | 8.2 | 39.2 | 27.9 | 35.5 |
| 65-69 | 88.8 | 87.4 | 45.0 | 196.7 | 115.6 | 116.7 |
| 70-74 | 107.1 | 112.9 | 65.3 | 234.3 | 137.0 | 136.1 |
| 75-79 | 130.0 | 151.4 | 100.3 | 258.3 | 170.3 | 170.6 |
| 80-84 | 150.8 | 188.9 | 144.3 | 245.5 | 204.5 | 212.2 |
| 85+ | 174.7 | 212.4 | 185.8 | 164.2 | 228.6 | 293.9 |
| *Antipsychotics (N05A)* | | | | | | |
| *Men* | | | | | | |
| 0-64 | 12.5 | 16.4 | 7.3 | 9.7 | 9.2 | 8.6 |
| 65-69 | 11.3 | 17.1 | 5.6 | 10.1 | 11.4 | 11.4 |
| 70-74 | 8.8 | 13.2 | 9.8 | 7.0 | 8.5 | 9.6 |
| 75-79 | 7.9 | 9.6 | 2.7 | 6.2 | 6.0 | 8.7 |
| 80-84 | 7.3 | 8.4 | 14.9 | 4.2 | 5.5 | 8.6 |
| 85+ | 8.3 | 7.7 | 6.7 | 1.9 | 4.5 | 9.6 |
| *Women* | | | | | | |
| 0-64 | 10.5 | 13.7 | 5.8 | 8.2 | 4.1 | 7.5 |
| 65-69 | 15.1 | 19.3 | 13.7 | 11.5 | 7.1 | 13.3 |
| 70-74 | 13.6 | 15.9 | 11.0 | 12.5 | 6.0 | 11.9 |
| 75-79 | 12.6 | 13.0 | 8.5 | 6.1 | 5.4 | 10.8 |
| 80-84 | 12.5 | 11.2 | 13.7 | 5.2 | 5.0 | 11.3 |
| 85+ | 12.9 | 9.9 | 7.9 | 3.0 | 4.4 | 14.4 |

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

## Dementia and Alzheimer's disease

Dementia is described as a loss of intellectual and emotional ability with loss of memory and changes in personality and behaviour. It often leads to difficulties in managing by oneself in daily life.

Alzheimer's disease is the most common type of dementia, and accounts for about 60-70 per cent of all cases of dementia.

According to the researcher Carolin Graff [5], Alzheimer's disease begins with loss of memory, and often leads to death within ten years. There is no cure, only medication that can slow down the progression of the illness. Genetic factors play a major role in Alzheimer's disease, and the life-time risk is calculated to be about 10 per cent, increasing to about 20 per cent for people with a parent or sibling with the disorder.

The next most common type of dementia is vascular dementia, which accounts for about 20 per cent of cases. Other forms of dementia are frontotemporal dementia, dementia associated with Parkinson's disease and alcohol-related dementia.
The number of people with dementia increases with increasing age.

Research is currently being carried out to identify risk factors for dementia. Risk factors include old age, genetic factors, diabetes, alcohol abuse, smoking, high blood pressure and high cholesterol level.

## Demens och Alzheimers sjukdom

Demens beskrivs som en förlust av intellektuella och emotionella förmågor med minnesstörningar, personlighets- och beteendeförändringar och leder ofta till att man får svårt att klara sig själv i det dagliga livet.

Alzheimers är den vanligaste demenssjukdomen och svarar för cirka 60-70 procent av alla sjukdomsfall.

Enligt forskaren Carolin Graff [5] så börjar Alzheimers sjukdom med minnesstörningar och leder oftast till döden inom tio år. Ännu så finns ingen botande behandling utan endast läkemedel som kan bromsa upp sjukdomsförloppet. Genetiska faktorer har stor betydelse vid Alzheimers sjukdom och livstidsrisken beräknas till cirka 10 procent men ökar till cirka 20 procent om man har en förälder eller syskon som drabbats.

Den näst vanligaste demenssjukdomen är vaskulär demens som svarar för cirka 20 procent. Utöver dessa förekommer frontallobsdemens, demens vid Parkinsons sjukdom och alkoholdemens.

Antalet personer med demenssjukdomar ökar med stigande ålder.

Forskning pågår för att identifiera riskfaktorer för demens. Det finns ett flertal riskfaktorer som till exempel hög ålder, genetiska faktorer, diabetes, alkoholmissbruk, rökning, högt blodtryck och höga kolesterolvärden.

Dementia accounts for the highest single diagnostic group for treatment and care. A survey in Norway in 2006 showed that about 80 per cent of residents in nursing homes suffered from some form of dementia. [29]

Table 24 shows the number of elderly people with dementia in the Nordic countries. The number is estimated based on an earlier estimate in 2002 carried out as a Nordic cooperation project. [30]

The statistics presented here on the prevalence of dementia for people over 65 years of age are based on estimates of prevalence from a study carried out in 1995. In this study, the prevalence of dementia was estimated to be approximately 1 per cent for people aged 65-69, 2 per cent for people aged 70-74, 6 per cent for people aged 75-79, 18 per cent for people aged 80-84, 30 per cent for people aged 85-89, and 40 per cent for people aged over 90. These figures are only esteimates, and must therefore be interpreted with caution. [31]

Table 24 shows statistics on the number of persons with dementia in the Nordic countries. Because women live longer than men, more women than men get dementia. The large differences between the Nordic countries in the number of people with dementia reflect differences in the number of people aged over 65.

Table 25 shows the number of people who received inpatient treatment per 100 000 inhabitants in 2006. The figures show that Iceland has the highest rate for dementia.

Demens utgör den största enskilda diagnosgruppen inom vård och omsorg. Vid en undersökelse i Norge år 2006 visade det sig att drygt 80 procent av de boende på sjukhem hade en demenssjukdom. [29]

Tabell 24 redovisar uppskattat antal personer med demens i de nordiska länderna fördelat på de äldsta åldersgrupperna. Antalet är beräknat utifrån en tidigare utförd skattning år 2002 i ett nordisk samarbetsprojekt. [30]

Prevalensen av demens hos personer äldre än 65 år som redovisas här utgår från den beräkning av prevalensen som gjordes i en studie utförd 1995. I den studien så utgick man från följande uppskattning när man beräknade prevalensen, mellan 65 och 69 år är cirka 1 procent dementa, mellan 70 och 74 år cirka 2 procent, mellan 75 och 79 år cirka 6 procent, mellan 80 och 84 år närmare 18 procent, mellan 85-89 har denna andel ökat till 30 procent och över 90 år har ungefär 40 procent en demenssjukdom. Beräkningarna är endast uppskattningar och bör därför tolkas med försiktighet. [31]

Tabell 24 visar en uppskattning av antalet personer med demens i de nordiska länderna. På grund av att kvinnor lever längre så kommer fler kvinnor än män att drabbas av demens. De stora skillnaderna i antal dementa mellan de nordiska länderna speglar skillnaderna i antal personer över 65.

Tabell 25 visar enbart antal behandlade patienter inom den slutna vården per 100 000 innevånare år 2006. Som framgår av tabellen har Island den högsta andelen patienter vårdade i slutenvård för demens.

Table 26 shows that the number of deaths per 100 000 inhabitants from Alzheimer's disease and dementia varies somewhat for the Nordic countries. This may reflect different practice with regard to registration, and under-reporting.

Tabell 26 visar att antal dödsfall per 100 000 innevånare till följd av Alzheimer och demens varierar något mellan de nordiska länderna. Detta kan bero på olika praxis vid registrering och underrapportering.

In Sweden and Denmark, consumption of medication for dementia is slightly higher than in Norway (see Table 27).

Sverige och Danmark har något högre förbrukning av läkemedel mot demens än Norge (se tabell 27).

Since people will live longer in the future, the number of people with demential will increase.

Då fler kommer att leva längre så kommer även antalet med demens att öka.

**Table 24 Expected number of persons with dementia by country and age group 2007**

| | Denmark | Finland | Iceland[1] | Norway | Sweden |
|---|---|---|---|---|---|
| 65-69 | 2 300 | 2 300 | 100 | 1 600 | 4 100 |
| 70-74 | 4 200 | 4 400 | 200 | 3 100 | 7 500 |
| 75-79 | 9 600 | 11 200 | 500 | 8 400 | 19 000 |
| 80-84 | 20 900 | 23 000 | 900 | 20 300 | 44 600 |
| 85-89 | 22 300 | 21 600 | 900 | 22 500 | 52 900 |
| 90+ | 14 400 | 12 300 | 600 | 13 000 | 32 700 |
| Total | 73 700 | 74 800 | 3 200 | 69 000 | 161 000 |

1 2007 = 2006

Source: Prevalence of Alzheimer's disease and vascular dementia: association with education. The Rotterdam Study, Ott et al, BMJ 1995; 310: 970-973

**Table 25 Patients treated for dementia per 100 000 inhabitants 2006**

| | Denmark | Faroe Islands[1] | Finland | Åland[1] | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| *Men* | | | | | | | |
| 0-64 | 2 | - | 2 | - | 2 | 1 | 1 |
| 65-69 | 26 | - | 41 | - | 44 | 22 | 36 |
| 70-74 | 54 | - | 104 | - | 97 | 65 | 84 |
| 75-79 | 127 | 331 | 189 | 107 | 308 | 135 | 198 |
| 80-84 | 266 | 508 | 400 | 226 | 911 | 252 | 371 |
| 85+ | 461 | 0 | 610 | 319 | 947 | 459 | 499 |
| *Women* | | | | | | | |
| 0-64 | 1 | 10 | 2 | - | 1 | 1 | 1 |
| 65-69 | 18 | - | 26 | - | 84 | 15 | 28 |
| 70-74 | 48 | - | 78 | 37 | 195 | 47 | 60 |
| 75-79 | 138 | 668 | 142 | 41 | 376 | 131 | 148 |
| 80-84 | 235 | 322 | 265 | 180 | 1 024 | 209 | 318 |
| 85+ | 423 | 187 | 336 | 301 | 1 174 | 386 | 414 |

1 Average 2002-06

Source: National inpatient registers ICD-10: F00-F03

**Table 26 Deaths from dementia per 100 000 inhabitants**

| | Denmark | Faroe Islands | Finland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|
| | 2006 | 2002-06 | 2006 | 2002-06 | 2006 | 2006 |
| *Men* | | | | | | |
| 0-64 | 1 | 1 | 2 | - | 1 | 1 |
| 65-69 | 15 | 22 | 36 | 13 | 19 | 18 |
| 70-74 | 55 | 52 | 124 | 71 | 60 | 68 |
| 75-79 | 146 | 103 | 366 | 291 | 136 | 178 |
| 80-84 | 424 | 152 | 916 | 543 | 354 | 486 |
| 85+ | 1 189 | 461 | 2 716 | 1 580 | 878 | 1 222 |
| *Women* | | | | | | |
| 0-64 | 0 | 2 | 1 | - | 1 | 1 |
| 65-69 | 19 | - | 27 | 17 | 19 | 22 |
| 70-74 | 44 | 25 | 91 | 115 | 58 | 57 |
| 75-79 | 161 | 53 | 267 | 195 | 158 | 183 |
| 80-84 | 453 | 200 | 828 | 563 | 338 | 503 |
| 85+ | 1 437 | 631 | 3 011 | 1 902 | 1 243 | 1 641 |

Source: The national registers for causes of death ICD-10: F00-F09 G30-G31

**Table 27 Consumption of anti-dementia drugs, DDD/1000 inhabitants/day 2006**

| ATC code N06D | Denmark | Finland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|
| *Men* | | | | | |
| 0-64 | 0.1 | 0.2 | 0.1 | 0.1 | 0.2 |
| 65-69 | 2.4 | 4.3 | 4.1 | 3.0 | 3.4 |
| 70-74 | 6.4 | 13.8 | 12.2 | 7.2 | 9.2 |
| 75-79 | 13.1 | 35.8 | 23.4 | 14.7 | 18.9 |
| 80-84 | 25.1 | 62.3 | 26.2 | 26.1 | 29.3 |
| 85+ | 28.1 | 78.1 | 26.5 | 30.5 | 32.5 |
| *Women* | | | | | |
| 0-64 | 0.1 | 0.2 | 0.2 | 0.0 | 0.2 |
| 65-69 | 2.4 | 5.0 | 4.1 | 1.6 | 3.4 |
| 70-74 | 6.7 | 16.4 | 9.3 | 4.4 | 9.4 |
| 75-79 | 17.7 | 40.0 | 23.3 | 9.9 | 20.2 |
| 80-84 | 30.7 | 70.1 | 27.3 | 17.4 | 32.4 |
| 85+ | 34.1 | 72.4 | 19.2 | 21.1 | 34.6 |

Sources D: Danish Medicines Agency; FI: Chief Pharmaceutical Officer; G: Medical Officer; F & Å: National Agency for Medicines; I: Icelandic Medicines Control Agency; N: WHO Collaborating Centre for Drug

## Oral health

Oral health has a great influence on general health and people's quality of life. Being able to chew, taste, talk and laugh with other people is dependent on good oral health and adequate functioning. The risk of malnutrition and dehydration

## Tandhälsa

Tandhälsan har en stor inverkan på den allmänna hälsan och människors livskvalitet. Möjligheten att tugga, smaka, prata och le mot andra människor är beroende av en god tandhälsa med god funktion. Risken för undernäring och

among elderly people is associated with poor oral health. Therefore, it is important to monitor the oral health of elderly people.

uttorkning bland äldre hänger ihop med dålig tandhälsa. Därför så är det viktigt att följa de äldres tandhälsa.

The proportion of elderly people who are edentulous (no natural teeth) has decreased in all the Nordic countries over the last decade. This proportion is higher for women in all the Nordic countries, but the differences between men and women seem to be getting smaller in the younger age groups. More and more people will retain their own teeth into old age in the future (see Table 28). [32, 33]

Andelen som helt saknar egna tänder har minskat bland de äldre i alla de nordiska länderna de senaste decennierna. Andelen som helt saknar tänder är högre bland kvinnor i alla de nordiska länderna men skillnaderna mellan män och kvinnor ser ut att minska i de yngre åldersgrupperna. Allt fler kommer i framtiden att få behålla sina tänder i högre åldrar (se tabell 28). [32, 33]

According to a Norwegian survey from 2005 [34], 6 per cent of people in the age groups 60-69 and 70-79 are edentulous. The proportion is as high as 14 per cent for people aged 80 and over.

Enligt en norsk undersökning [34] från 2005 så beräknas 6 procent i åldrarna 60-69 år respektive 70-79 år vara utan tänder men i åldrarna 80 år och äldre så ökar det till cirka 14 procent.

**Table 28 Prevalence of total edentulism (no natural teeth in both jaws) among people aged 65 years and older in the Nordic countries in per cent**

| | Denmark | Finland | Iceland | Sweden[2)] |
|---|---|---|---|---|
| | 2005 | 2000 | 2000 | 2004-05 |
| Men | 20.9 | 38.0 | 44.3 | 9.6 |
| Women | 31.3 | 48.0 | 64.4 | 9.9 |
| Men and women | 26.5 | 44.0 | 54.6 | 9.8 |

Sources: F: The National Public Health Institute, KTL, Hälsa 2000, D: Folkesundheds-rapporten Danmark 2007, I: Guðjón Axelsson and Sigrún Helgadóttir. Tannlækningastofnun Háskóla Íslands. Háskólaútgáfa, 2004 S: SCB, Undersökningarna av levnadsförhållanden (ULF)65-84 år

## Injuries and accidents

The risk of falls increases with increasing age. The most common type of injury for older people in the Nordic countries is fracture of bones as a result of a fall. Women are affected more than men, and

## Skador och olyckor

Risken för fallskador ökar med stigande ålder. Frakturer till följd av fallskador är den vanligaste orsaken till skada bland äldre personer i de nordiska länderna. Kvinnor drabbas oftare av fall-

most falls happen in the home. [6] The number of deaths as a result of falls increases with increasing age, and this increase has occurred, for example, in Sweden since the 1990s for both men and women. This can partly be explained by the increasing proportion of elderly. The number of deaths from road traffic accidents also increases with increasing age (see Figure 2).

With osteoporosis, the amount of bone tissue is reduced, and changes occur in the structure of the bone tissue. The bone becomes more brittle and there is greater risk of fracture. Osteoporosis mainly affects elderly women in Scandinavia. This can partly be explained by the fact that women have lighter bones than men, and that women loose more bone tissue after the menopause. Risk factors for osteoporosis are age, low body weight, genetic disposition for fracture, and smoking. Low body weight is also a risk factor for fracture of the hip. Physical activity and adequate nutrition have been shown to reduce the risk of fracture.

The Danish Public Health Report [17] shows that half of all days of stay in hospitals because of injuries are for persons aged over 64 years. Falls are also the most common reason for attending outpatient clinics or for admission to hospital for people aged 85 and over. Table 29 shows the number of fractures of the hip, for men and women.

skador än män och de flesta fallolyckor sker i hemmen. [6] Dödsfall till följd av fallskador ökar med åldern och har ökat ibland annat i Sverige sedan 1990-talet för både män och kvinnor. Till viss del kan detta förklaras av den ökande andelen äldre. Även dödsfall till följd av trafikolyckor ökar med stigande ålder (se figur 2).

Benskörhet (osteoporos) karaktäriseras av minskad benvävnad och förändringar i benvävnadens struktur, vilket leder till reducerad hållfasthet av skelettet och ökad risk för frakturer. Benskörhet drabbar främst äldre kvinnor i Skandinavien, vilket delvis kan förklaras av att kvinnor har ett tunnare skelett än män och att kvinnor snabbare förlorar benvävnad efter klimakteriet. Benskörhet är relaterat till riskfaktorer som ålder, låg vikt, ärftlighet för frakturer och rökning. Låg vikt är även en riskfaktor för höftfraktur. Fysisk aktivitet och en bra kost har visat sig minska risken för frakturer.

Den danska folkhälsorapporten [17] visar att hälften av vårddagarna i sluten vård av skador gäller personer äldre än 64 år. Fallolyckor är också vanligaste anledningen till besök i öppenvård eller slutenvård för 85 år och äldre. Tabell 29 visar höftfrakturer fördelat på män och kvinnor.

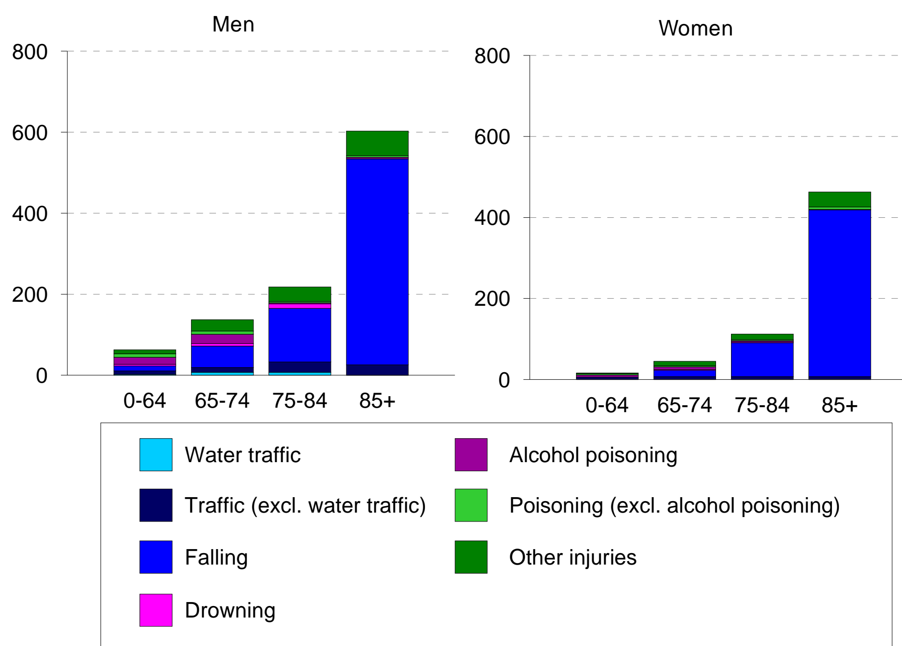
**Table 29 Hip fracture. Number of patients treated per 100 000 inhabitants 2006**

| | Denmark | Faroe Islands[1)] | Finland | Åland[1)] | Iceland | Norway | Sweden |
|---|---|---|---|---|---|---|---|
| *Men* | | | | | | | |
| 0-64 | 36 | 77 | 46 | 42 | 34 | 44 | 34 |
| 65-69 | 183 | 212 | 165 | 192 | 240 | 230 | 181 |
| 70-74 | 333 | 387 | 230 | 243 | 339 | 417 | 314 |
| 75-79 | 595 | 827 | 485 | 747 | 643 | 738 | 614 |
| 80-84 | 1 279 | 1 271 | 882 | 1 057 | 1 048 | 1 499 | 1 316 |
| 85+ | 2 398 | 1 754 | 1 713 | 1 596 | 2 436 | 3 059 | 2 594 |
| *Women* | | | | | | | |
| 0-64 | 35 | 10 | 26 | 33 | 20 | 35 | 28 |
| 65-69 | 303 | 460 | 168 | 162 | 210 | 366 | 244 |
| 70-74 | 589 | 527 | 322 | 520 | 586 | 647 | 541 |
| 75-79 | 1 229 | 1 471 | 675 | 745 | 1 197 | 1 183 | 1 035 |
| 80-84 | 2 033 | 1 610 | 1 368 | 2 022 | 1 884 | 2 463 | 2 005 |
| 85+ | 3 843 | 2 996 | 2 658 | 2 968 | 4 241 | 4 587 | 3 847 |

1 Average 2002-06

Source: The national inpatient registers ICD-10: S72

**Figure 2 Death due to injury per 100 000 inhabitants. Finland 2006 for men and women**




Source: National Public Health Institute. Health and functional capacity in Finland, Baseline Results of the Health 2000 Examination Survey (2004)

## Care for elderly people in the Nordic countries

Today, elderly people are much healthier than in the past, but since the proportion of elderly people aged over 80 is increasing, the need for treatment and care and the cost of providing these services for elderly people are also increasing.

In the Nordic welfare systems, treatment and care services for elderly people are mainly public services that are publically funded. This has been one of the cornerstones of the Nordic welfare model for a long time. The well-developed services for children and elderly people in the Nordic countries has made it possible for relatives, and primarily daughters, to work outside the home. This is one of the reasons why Nordic women have a high income.

The latest statistics published by NOSOS-CO [35], show that the proportion of elderly people who live in institutions (old people's homes, nursing homes) or other residences for people aged 65/67 and over, is highest in Norway: 11.7 per cent. The proportion in Finland is only 6.9 per cent.

Almost 25 per cent of people aged 80 and older live in institutions in Norway and Iceland, but only 16.5 per cent in Sweden.

In Sweden, home help services were introduced as early as in the 1950s, but they are available in all the Nordic countries now. The amount of service provided is based on individual needs, and varies from a few hours per month to

## Äldreomsorgen i de nordiska länderna

De äldre är idag betydligt friskare än tidigare, men i och med att andelen äldre över 80 år ökar så ökar kraven på och kostnaderna för vård och omsorg.

I de nordiska välfärdssystemen så har vården och omsorgen om de äldre, med en offentligt finansierad och till stor del offentligt producerad äldreomsorg utgjort en av hörnstenarna i den nordiska välfärdsmodellen under lång tid. Den väl utbyggda barn- och äldreomsorgen i de nordiska länderna har möjliggjort för anhöriga och då framför allt för döttrarna att arbeta utanför hemmet vilket starkt bidragit till de nordiska kvinnornas höga förvärvsfrekvens.

I Nososkos [35]senaste publicerade statistik visas att boende på institution (åldersdomshem, sjukhem) eller annat äldreboende för åldersgrupperna 65/67 år och äldre är vanligast i Norge med 11,7 procent, medan i Finland endast 6,9 procent bor på institution.

När det gäller gruppen 80 år och äldre bor nära 25 procent på institution både i Norge och på Island men endast 16,5 procent i Sverige.

I Sverige infördes hemhjälp redan på 1950-talet, men det förekommer nu i alla de nordiska länderna. Omfattningen bestäms utifrån individuella behov och varierar från några timmar i månaden till flera timmar per dag. Målet

several hours per day. The aim is that as many people as possible should be able to live in their own home. The proportion of people aged over 65/67 years who receive home help services is highest in Denmark (21.7 per cent) and Iceland (21.0 per cent). The highest proportion is for people aged over 80. In Denmark half of people aged over 80 years receive home help services, according to NOSOSCO's statistics. The statistics are not directly comparable for the different countries, because of different criteria for selection and content (see NOSOSCO's web site). However, the statistics give an estimation of the distribution of home help services for different age groups, but not for the distribution according to gender.

During the last decade, care for elderly people in the Nordic countries has undergone great changes. These services are still largely publicly financed, but different types of client contribution have been introduced in the Nordic countries, with the exception of Denmark, where the services are still free of charge.

### *Care of the elderly in the future*

Because of reduced fertility, reduced mortality and increased life expectancy, the age distribution of the population in the Nordic countries has changed.

The populations in the Nordic countries have become older. This means that there are fewer people of employable age to provide for more people over 65/67 years of age, depending on the pensionable age.

med detta är att så många som möjligt ska kunna bo kvar hemma. Hemhjälp är nu vanligast i Danmark och på Island med 21,7 respektive 21,0 procent i åldersgruppen över 65/67 år. Det är främst i åldersgrupperna över 80 år som hemhjälp beviljats och i Danmark så får hälften av alla över 80 år hemhjälp enligt statistik från Nososko. Statistiken är inte helt jämförbar mellan länderna på grund av olika kriterier för uttag och innehåll (se Nososkos webbplats). Den ger dock en grov uppskattning av fördelningen av hemhjälp mellan olika åldersgrupper men inte hur den fördelar sig mellan könen.

Äldreomsorgen i Norden har under de senaste decennierna genomgått stora förändringar. Ännu är äldreomsorgen till stor del offentligt finansierad men olika typer av avgifter har införts i de nordiska länderna förutom Danmark där den ännu är avgiftsfri.

### *Morgondagens äldreomsorg*

Minskad fruktsamhet och minskad dödlighet tillsammans med en ökad livslängd har medfört att ålderssammansättningen i befolkningen i de nordiska länderna har förändrats.

Befolkningen i de nordiska länderna blir allt äldre, vilket innebär att allt färre personer i yrkesverksam ålder skall försörja allt fler personer över 65 respektive 67 år, beroende på när pensionsåldern inträder.

Table 30 shows old-age dependency ratios. This ratio is the number of people over 65 years of age divided by the number of people of employable age 15-64 for 1980 and later, and with projections up to 2050.

Tabell 30 över äldreförsörjningskvoten visar antalet över 65 år dividerat med antalet i arbetsför ålder 15-64 år sedan 1980 och framåt med prognoser fram till 2050.

Projections for old-age dependency ratios describe the possible demographic development, based on how fertility, mortality, emigration and immigration develop over time. The old-age dependency ratio is expected to increase up to the year 2050.

Prognosen över äldreförsörjningskvoten beskriver en möjlig demografisk utveckling utifrån hur fertiliteten, dödligheten samt hur in- och utvandring utvecklas över tid. Äldreförsörjningskvoten beräknas öka stort fram till år 2050.

The proportion of elderly people aged 65 years and older is increasing greatly in relation to the proportion of people of employable age. This partly explains the increase in the old-age dependency ratio. The increasing proportion of people who cease to work early because of illness also contributes to an increasing burden on people of employable age.

Andelen äldre över 65 år ökar kraftigt i förhållande till andelen i yrkesverksamma befolkningen ålder, vilket är en del av förklaringen till den ökande äldreförsörjningskvoten. Andelen som lämnar arbetet i förtid på grund av sjukdom och ohälsa bidrar också till att den totala försörjningsbördan på den yrkesverksamma befolkningen ökar.

These factors combined will lead to greater demands on treatment and care services in the future.

Detta kommer sammantaget att ställa stora krav på vård och omsorg framöver.

**Table 30 Old-age dependency ratio and projections for the years 2020, 2030, 2040 and 2050. Population aged 65 and over as a percentage of the population aged 15-64**

| | Denmark | Finland | Iceland | Norway | Sweden |
|---|---|---|---|---|---|
| *Years* | | | | | |
| 1980 | 22.2 | 17.7 | 16.1 | 23.4 | 25.4 |
| 1990 | 23.2 | 19.9 | 16.5 | 25.2 | 27.7 |
| 2000 | 22.5 | 22.3 | 17.9 | 23.7 | 27.1 |
| 2006 | 23.6 | 24.1 | 18.1 | 23.2 | 27.6 |
| 2020 | 32.5 | 36.8 | 24.4 | 30.8 | 37.1 |
| 2030 | 39.0 | 44.1 | 32.2 | 38.5 | 42.8 |
| 2040 | 44.6 | 44.7 | 36.9 | 45.2 | 47.2 |
| 2050 | 41.7 | 45.5 | 40.4 | 44.4 | 46.8 |

Source: OECD, Society at a Glance 2005

The Nordic countries face a great challenge with the increasing proportion of elderly people in the population. It is also expected that there will be an increased need for elderly people to be able to live in their own homes. The Nordic countries cooperate with various development projects, financed, for example, by the Nordic Development Centre for Rehabilitation Technology NUH [36], in order to take advantage of all the knowledge available in the Nordic countries.

De nordiska länderna står inför en stor demografisk utmaning med en ökande andel äldre i befolkningen med ett förväntat ökat behov av för att äldre ska kunna bo kvar hemma. De nordiska länderna samarbetar kring olika utvecklingsprojekt, finansierade av bland annat Nordiska centret för utveckling av rehabiliteringsteknologi [36], för att utnyttja den samlade kunskapen i de nordiska länderna.

Dementia also represents one of the great challenges for the future. Through cooperation with NUH, different ways of making the situation easier for people with dementia and their relatives are being sought.

Demenssjukdomarna är en av framtidens stora utmaningar där man inom NUH-samarbetet söker olika lösningar för att underlätta för pesoner med demens och deras vårdare.

One possibility for helping elderly people to live in their own homes is the “Smart Home Technology”. The Nordic "Smart House" project provides information about possibilities for the future, and disseminates information between the countries.

En möjlighet att stödja de äldre att bo kvar hemma är att utnyttja så kallade “smarta-hem-teknologi”. Det nordiska smarta-hus-projektet ger kunskap och vad som kan bli möjligt i framtiden samt sprida kunskapen mellan länderna.

## *Technical aids*

Technical aids help elderly people to live independent, active lives in their own homes when their level of functioning is reduced because of age or disease. The need for technical aids increases when the proportion of elderly people increases, and when new technology is developed that can make everyday life easier.

## *Tekniska hjälpmedel*

Tekniska hjälpmedel stödjer och ger möjlighet att leva ett oberoende, aktivt liv hemma när funktionsförmågan avtar på grund av ålder eller sjukdom. Behovet av tekniska hjälpmedel ökar med ökande andel äldre och ny teknologi som kan underlätta vardagen. I tabell 31 redovisas fördelningen av användandet av olika tekniska hjälpmedel.

**Table 31 Use of technical aids according to age and gender (per cent) in Finland 1997, 2001 and 2005**

| | Year | | | Age Group | | | |
|---|---|---|---|---|---|---|---|
| | 1997 | 2001 | 2005 | 65-69 | 70-74 | 75-79 | 80-84 |
| *Men* | | | | | | | |
| Hearing aid | 10.0 | 8.8 | 8.6 | 4.3 | 4.0 | 13.9 | 20.2 |
| Walking stick | 14.8 | 11.8 | 9.4 | 1.6 | 7.5 | 13.5 | 26.9 |
| Rollator (indoor use) | 1.9 | 2.5 | 2.4 | 0.5 | 0.5 | 4.3 | 7.7 |
| Rollator (outdoor use) | 2.9 | 2.4 | 2.4 | 0.5 | 1.5 | 2.9 | 8.2 |
| Pill dispenser | 18.0 | 22.4 | 23.0 | 14.4 | 23.6 | 26.4 | 38.5 |
| Anti-slip on shoes | 5.8 | 9.4 | 13.8 | 11.2 | 15.1 | 13.0 | 19.7 |
| No technical aid | 61.4 | 58.6 | 56.3 | 68.6 | 58.8 | 48.1 | 33.2 |
| *Women* | | | | | | | |
| Hearing aid | 6.9 | 5.9 | 6.9 | 4.8 | 6.6 | 5.4 | 12.4 |
| Walking stick | 14.3 | 12.6 | 9.2 | 0.9 | 4.4 | 14.1 | 21.5 |
| Rollator (indoor use) | 3.7 | 5.0 | 5.0 | 1.3 | 2.7 | 4.9 | 13.9 |
| Rollator (outdoor use) | 7.5 | 9.4 | 10.1 | 2.6 | 4.0 | 14.1 | 24.4 |
| Pill dispenser | 21.1 | 22.3 | 24.6 | 15.4 | 20.8 | 27.3 | 39.7 |
| Anti-slip on shoes | 12.3 | 14.4 | 30.0 | 25.1 | 31.4 | 35.6 | 28.2 |
| No technical aid | 55.0 | 52.6 | 40.0 | 56.8 | 43.8 | 30.2 | 20.1 |

Source: Health Behaviour and Health among Finnish Elderly, Spring 2005, with trends 1993–2005. Sulander T, Helakorpi S, Nissinen A, Uutela A. Publications of the National Public Health Institute 1/2006

# Conclusions and recommendations

## *Summary*

Many elderly people manage very well, and better than they did several decades ago. Many of them live a long life with good health after becoming a pensioner.

Mortality from cardiovascular diseases has decreased markedly in all the Nordic countries.

Average life expectancy has increased for both men and women, and will continue to increase in the Nordic countries. There are fairly large differences between the countries, and it would be interesting to analyse these differences in more depth. The proportion of people aged over 80 will increase dramatically in the future, and will make different demands on treatment and care services.

# Sammanfattning och förslag

## *Sammanfattning*

Många äldre mår mycket bra och bättre än för flera decennier sedan och har många år av god hälsa efter pensioneringen.

Dödligheten i hjärt-kärlsjukdomar har minskat kraftigt i alla de nordiska länderna.

Medellivslängden har ökat för både män och kvinnor och fortsätter att öka i de nordiska länderna. Det finns delvis stora skillnader mellan länderna vilket vore intressant att djupare analysera. Andelen av personer över 80 år kommer att öka dramatiskt framöver och kommer att ställa andra krav på morgondagens vård och omsorg.

Although many good and bad habits are formed at an early age, it is important to work with health prevention and promotion among young and middle-aged people. Encouraging them to have a healthy lifestyle helps them to have improved health when they are old.

Då många vanor och ovanor grundläggs tidigt i livet är det viktigt att arbeta förebyggande och hälsofrämjande bland yngre och medelålders för att medverka till en sund livsstil och bättre hälsa bland de äldre.

## *Recommendations*

*The age groups in the tables are too broad to analyse the health of elderly people*

It is desirable to have tables in NOMESCO's publications with narrower age groups, in order to make it possible to carry out more detailed analyses of the health status of elderly people. Narrower age groups are particularly interesting for the illnesses and types of treatment that are common among elderly people. It is desirable to have two-year intervals for these tables.

*Primary Health Care data*

Elderly people with one or more chronic illnesses are frequent users of primary health services. These people rarely participate in interview surveys and we know little about their health and lifestyle.

Statistics about primary health services would provide a more comprehensive picture of morbidity among these people, and give us the possibility to estimate their needs for treatment and care over time.

*International Classification of Functioning, Disability and Health (ICF)*

The International Statistical Classification of Diseases and Related Health

## *Förslag*

*Åldersindelning av tabeller är för grov för att analysera de äldres hälsa*

Mer finfördelade tabeller i Nomeskos publikation vore önskvärt då de äldre åldersgrupperna är för stora för att möjliggöra en mer finfördelad analys av de äldres hälsoutfall. Speciellt är en mer finfördelad ålderindelning intressant för de sjukdomar, operationer etc som är vanligast bland de äldre. Indelning i tioårsintervaller vore för dessa tabeller önskvärt.

*Uppgifter från primärvård*

Äldre personer med en eller flera kroniska sjukdomar besöker ofta primärvården. Dessa personer medverkar sällan i intervjuundersökningar och kunskapen om deras hälsa och livsvillkor liten.

Uppgifter från primärvården skulle i dessa fall ge en något mer fullständig bild över dessa personers sjuklighet samt möjlighet att uppskatta vårdbehovet över tid.

*Klassifikation av funktionstillstånd, funktionshinder och hälsa (ICF)*

Den internationella klassifikationen om Sjukdomar och hälsoproblem (ICD)

Problems (ICD) can be used to describe the prevalence of illness in the population, but cannot be used to describe the consequences of illness, or how diseases or injuries influence daily life.

kan användas för att beskriva sjukdomsförekomst i befolkningen men kan inte användas för att beskriva konsekvenser av sjukdom och vilken påverkan sjukdomen eller skadan har på det dagliga livet.

WHO's International Classification of Functioning, Disability and Health (ICF) provides the possibility to describe bodily functions, bodily structures, activity, participation and environmental factors. Examples from this chapter are memory, experience of pain, the ability to manage household tasks, the ability to participate in social activities, and the way in which one's surroundings are organized, for example access to accommodation and society. Both these classifications can be used together to describe health and functioning, in order to give a better description of how illness influences important areas of life.

I WHO:s Klassifikation av funktionstillstånd, funktionshinder och hälsa (ICF) finns möjlighet att beskriva kroppsfunktioner, kroppsstrukturer, aktivitet och delaktighet samt omgivningsfaktorer. Exempel från dessa kapitel är minnesfunktioner, smärtupplevelser, förmåga att klara hushållsarbete, delta i sociala aktiviteter, och omgivningens utformning t.ex. tillgänglighet i bostad och samhälle. Om båda dessa klassifikationer används tillsammans för att beskriva hälsa och funktionstillstånd ges en bättre beskrivning av hur sjukdomar påverkar viktiga livsområden.

*Classification of accidents and injuries*

*Klassificering av olyckor och skador*

The Nordic classification contains more detailed statistics. These statistics can provide more information about, for example, falls, and can also be used to plan measures to prevent accidents and injuries among elderly people.

Den nordiska skadeklassifikationen innehåller mer detaljerade uppgifter, vilket skulle ge en bättre information om bland annat fallolyckor och även ge ett bättre underlag till det skadeförebyggande arbetet hos äldre.

*Reports about pharmaceutical products and quality indicators*

*Redovisning av läkemedelsuppgifter och kvalitetsindikatorer*

When developing quality indicators for elderly people's consumption of pharmaceutical products, it would be interesting in the future to be able to compare people with high consumption (more than ten types of medication) in the Nordic countries, and elderly people who have been prescribed 3-4 different psychoactive drugs.

I arbetet med kvalitetsindikatorer där äldres läkemedelskonsumtion analyseras vore det intressant att framöver kunna göra nordiska jämförelser av storkonsumenter av läkemedel (fler än 10 läkemedel) och äldre med mer än 3-4 psykofarmaka utskrivna.

According to studies carried out in Sweden, drug interactions are not uncommon among elderly people. This causes discomfort for patients and is also a reason for admission to hospital. It would be interesting to compare this in a Nordic perspective.

Läkemedelsinteraktioner är inte ovanligt bland äldre enligt de studier som gjorts i Sverige. Detta förorsakar besvär för patienterna och är även en orsak till inläggning på sjukhus, vilket vore intressant att jämföra ur ett nordiskt perspektiv.

Statistics on pharmaceutical products do not include over-the-counter drugs. They also do not always include drugs requisitioned by residences for elderly people, or drugs used in hospitals. These drugs should also be included in the statistics, in order to obtain a comprehensive picture of elderly people's consumption of drugs. If this is not possible, at least an estimate should be made about which drugs these are and the amount that is used (defined daily doses - DDD).

Läkemedelsstatistiken innehåller inte receptfria läkemedel, så kallade ”over-the-counter drugs” (OTC), oftast heller inte rekvisitioner till äldreboenden eller läkemedel som konsumeras inom den slutna vården. Dessa läkemedel borde också redovisas för att få en fullständig bild av äldres läkemedelskonsumtion. Om det inte är möjligt så borde åtminstone en uppskattning göras av vilka läkemedel det är och hur många dygnsdoser (DDD) det handlar om.

*Use of data from interview surveys*

*Användning av data från intervjuundersökningar*

In this theme section, statistics on self-reported health are presented from the European survey: *the European Union Statistics on Income and Living Conditions* (EU-SILC). Through cooperation between the European countries, a more detailed survey of health, *the European Health Interview Survey* (EHIS) is being carried out, along with other health-related studies. Data from national surveys, and from these European surveys, can be used in the future to compare the Nordic countries.

I temat redovisas uppgifter om självskattad hälsa från den europeiska undersökningen *The European Union Statistics on Income and Living Conditions* (EU-SILC). I det europeiska samarbetet pågår även en utveckling av en mer detaljerad undersökning om hälsa, den s.k. *European Health Interview Survey* (EHIS) men även andra undersökningar relaterade till hälsan. Dessa europeiska undersökningar kan, tillsammans med de nationella, fram över eventuellt även användas för nordiska jämförelser.

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32 Guðjón Axelsson and Sigrún Helgadóttir. Tannlækningastofnun Háskóla Íslands. Háskólaútgáfa, 2004. University of Iceland 2004.

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# SECTION C

## Appendices
## Bilag

# Appendix 1

## Additional information at www.nom-nos.dk

On NOMESCO's homepage, the following additional information can be found:

- Obstetric definitions
- Hospital definitions
- Overview of medical, surgical and psychiatric specialities that are included in the statistics in this publication
- Short list and statistics on causes of death
- Short list and statistics on discharges from somatic hospitals
- Short list and statistics on surgical procedures

The detailed statistics on the homepage are presented according to gender and 5-year age groups.

In addition, an interactive database is to be found, with the most important data that is available, presented graphically and in maps. The database can be found under the icon *Social and Health Indicators*.

## Supplerende oplysninger på www.nom-nos.dk

På 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 om de statistikansvarlige i de nordiske lande*

The following offices responsible for statistics can be contacted for further information concerning the statistics in this publication.

Denne oversigt over statistikansvarlige i de nordiske lande kan bruges til at søge yderligere oplysninger vedrørende statistikken i denne bog.

### *Denmark*

Statistics Denmark
Sejrøgade 11
DK-2100 Copenhagen Ø
Phone: +45 39 17 39 17
Fax: +45 39 17 39 99
E-mail: dst@dst.dk
Website: www2.dst.dk

Have responsibility for:
- Population statistics
- Statistics on alcohol consumption
- Statistics on health care economy
- Statistics on alcohol consumption

National Board of Health
Islands Brygge 67
DK-2300 Copenhagen S
Phone: 72 22 74 00
Fax: 72 22 74 11
E- mail: sst@sst.dk
Website: www.sst.dk

Have responsibility for:
- Statistics on births
- Statistics on abortions
- Statistics on malformations
- Statistics on causes of death
- Statistics on hospital services
- Statistics on health personnel
- Statistics on the use of tobacco

Statens Seruminstitut
Artillerivej 5
DK-2300 Copenhagen S
Phone: +45 32 68 32 68
Fax: +45 32 68 38 68
E- mail: serum@ssi.dk
Website: www.serum.dk/dk

Have responsibility for:
- Statistics on infectious diseases
- Statistics and information on vaccinations

Danish Medicines Agency
Axel Heides Gade 1
DK-2300 København S
Phone: +45 44 88 95 95
Fax: +45 44 88 95 99
E-mail: dkma@dkma.dk
Website: www.dkma.dk

Have responsibility for:
- Statistics on medicinal products

## *Faroe Islands*

Statistics Faroe Islands
P.O. Box 2068
FO-165 Argir
Phone: +298 35 28 00
Fax: +298 35 28 01
E-mail: hagstova@hagstova.fo
Website: www.hagstova.fo

Have responsibility for:
- Population and vital statistics
- Statistics on health care economy

Chief Medical Officer
P.O. Box 9
FO-110 Tórshavn
Phone: +298 31 18 32
Fax: +298 31 76 60
E-mail: hdj@sst.dk
www.landslaeknin.fo

Have responsibility for:
- Statistics on infectious diseases
- Statistics on forensics
- Statistics on births
- Statistics on causes of death

Chief Pharmaceutical Officer
P.O. Box 187
FR-110 Tórshavn
Phone: +298 35 01 50
Fax: +298 35 01 51
www.apotek.fo

Have responsibility for:
- Statistics on medicinal products

Ministry of Social and Health Affairs
Eiragardur 2
FO-100 Tórshavn
Phone: +298 30 40 50
Fax: +298 5 40 48
E-mail: ahr@ahr.fo
Website: www.ahs.fo

Have responsibility for:
- Statistics on health personnel
- Statistics on hospital services
- Statistics on abortions
- Statistics and information on vaccinations

## Greenland

Statistics Greenland
P.O. Box 1025
DK-3900 Nuuk
Phone: +299 34 50 00
Fax: +299 32 29 54
E-mail: stat@gs.gh.gl
Website: www.statgreen.gl

Have responsibility for:

- Population and vital statistics
- Statistics on health personnel
- Statistics on hospital services
- Statistics on health care economy

Chief Medical Officer
P.O. Box 120
DK-3900 Nuuk
Phone: +299 34 5192
Fax: +299 32 51 30
E-mail: eli@gh.gl

Have responsibility for:

- Statistics on births
- Statistics on abortions
- Statistics on malformations
- Statistics on infectious diseases
- Statistics and information on vaccinations

National Board of Health in Denmark
Islands Brygge 67
P.O. Box 1881
DK-2300 Copenhagen S
Phone: 72 22 74 00
Fax: 72 22 74 11
E-mail: sst@sst.dk
Website: www.sst.dk

Have responsibility for:

- Statistics on causes of death

The Central Pharmacy in Copenhagen County
Marielundsvej 25
DK-2730 Herlev
Phone: +45 44 57 77 00
Fax: +45 44 57 77 09

Have responsibility for:

- Statistics on medicinal products

The Directorate for Health
P.O. Box 1160
DK-3900 Nuuk
Phone: +299 34 50 00
Fax: +299 32 55 05

Have responsibility for:

- Statistics on hospital services
- Statistics on health care economy
- Statistics on health personnel

## *Finland*

Statistics Finland
Työpajankatu 13
FIN-00022 Tilastokeskus
Phone: +358 9 173 41
Fax: +358 9 173 42 750
Website: www.stat.fi

Have responsibility for:

- Population and vital statistics
- Statistics on causes of death
- Statistics on the use of tobacco
- Statistics on road traffic accidents

STAKES (National Research and Development Centre for Welfare and Health)
P.O. Box 220
FIN-00531 Helsinki
Phone: +358 9 396 71
Fax: +358 9 761 307
Website: www.stakes.fi

Have responsibility for:

- Register of Institutional Care
- Medical Birth Register and IVF statistics
- Register of Abortions and Sterilizations
- Statistics on Health Care Personnel
- Statistics on public health care
- Statistics on private health care
- Statistics on labour force in health care
- Statistics on the use of alcohol and drugs
- Statistics on health care expenditure
- Definitions and classifications in health care
- Statistics on primary health care

Finnish National Public Health Institute
Mannerheimintie 166
FIN-00300 Helsinki
Phone: +358 9 474 41
Fax: +358 9 474 48 408
Website: www.ktl.fi

Have responsibility for:

- Register of Infectious Diseases
- Register of Coronary Heart Disease and Stroke
- Statistics and information on vaccinations
- Survey on health behaviour among adults and elderly
- Public Health Report

National Agency for Medicines
Mannerheimintie 103b
P.O. Box 55
FIN-00301 Helsinki
Phone: +358 9 473 341
Fax: +358 9 714 469
Website: www.nam.fi

Have responsibility for:

- Registration of medicinal products and sales licences
- Register on Adverse Drug Reactions
- Statistics on pharmacies

Social Insurance Institution of Finland
Nordenskiöldinkatu 12
FIN-00250 Helsinki
Phone: +358 20 634 11
Fax: +358 20 634 50 58
Website: www.kela.fi

Have responsibility for:
- Sickness insurance benefits and allowances, reimbursements for medicine expenses, and disability pensions

Finnish Cancer Registry
Liisankatu 21B
FIN-00170 Helsinki
Phone: +358 9 135 331
Fax: +358 9 135 1093
Website: www.cancer.fi

Have responsibility for:
- Statistics on cancer

Finnish Centre for Pensions
Fin-00065 Eläketurvakeskus
Phone: +358 9 107511
Fax: + 358 9 14 81172
Website: www.etk.fi

Have responsibility for:
- Pensions due to reduced capacity to work

## *Åland*

The Åland Government
P.O. Box 1060
Ax-22111 Mariehamn
Phone: +358 18 250 00
Fax: +358 18 191 55

Have responsibility for:
- Statistics on infectious diseases
- Statistics on health personnel
- Statistics on hospital services
- Statistics on health care economy

Social Insurance Institution of Finland
Statistics Finland
STAKES
National Agency for Medicines
Finnish National Public Health Institute
Finnish Cancer Registry

See Finland

## *Iceland*

Statistics Iceland
Borgartún 21a
IS-150 Reykjavík
Phone: +354 528 1000
Fax: +354 528 1199
E-mail: hagstofa@hagstofa.is
Website: www.statice.is

Have responsibility for:
- Population and vital statistics
- Statistics on causes of death
- Statistics on alcohol consumption
- Statistics on health care expenditure
- National accounts

Directorate of Health
Austurströnd 5
IS-170 Seltjarnarnes
Phone: +354 510 1900
Fax: +354 510 1919
E-mail: postur@landlaeknir.is
Website: www.landlaeknir.is

Have responsibility for:
- Medical statistics on births
- Statistics on abortions
- Statistics on sterilizations
- Statistics on primary health care
- Statistics on hospital services
- Statistics on infectious diseases
- Statistics on vaccinations
- Statistics on health personnel

Icelandic Medicines Control Agency
Eiðistorg 13-15
172 Seltjarnarnes
Phone: +354 520 2100
Fax: +354 561 2170
E-mail: imca@imca.is
Website: www.imca.is

Have responsibility for:
- Statistics on pharmaceutical products

Public Health Institute of Iceland
Laugarvegur 116
IS-105 Reykjavík
Phone: +354 5 800 900
Fax: +354 5 800 901
E-mail: lydheilsustod@lydheilsustod.is
Website: www.lydheilsustod.is

Have responsibility for:
- Statistics on the use of tobacco

Icelandic Cancer Register
Skógarhlíð 8
IS-105 Reykjavík
Phone: +354 540 1900
Fax: +354 540 1910
E-mail: jongl@krabb.is; laufeyt@krabb.is;
Website: www.krabb.is

Have responsibility for:
- Statistics on cancer

## *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 alcohol consumption
- Statistics on health care economy

Norwegian Institute of Public Health
P.O. Box 4404 Nydalen
N-0403 Oslo
Phone: +47 22 04 22 00
Fax: +47 23 40 81 46
E-mail: folkehelseinstituttet@fhi.no
Website: www.fhi.no

Have responsibility for:
- Statistics on sexually transmitted diseases and infectious diseases
- Statistics on tuberculosis
- Statistics on immunization
- Statistics on sale of medicinal products
- Statistics on drug prescribing

Norwegian Institute of Public Health
Department of Medical Birth Registry
Kalfarveien 31
N-5018 Bergen
Phone: +47 21 07 70 00
Fax: +47 22 35 36 05
E-mail: mfr@uib.no
Website: www.uib.no/mfr

Have responsibility for:
- Statistics on births and infant deaths
- Statistics on induced abortions

National Directorate for Health
P.O.Box. 7000 St Olavs plass
N-0130 Oslo
Phone: +47 810 200 50
Fax: +47 24 16 30 01
E-mail: postmottak@shdir.no
Website: www.shdir.no

Have responsibility for:
- Statistics on use of tobacco
- Statistics on hospital services

Cancer Registry of Norway
Institute of population-based cancer research
Montebello
N-0310 Oslo
Phone: +47 22 45 13 00
Fax: +47 22 45 13 70
E-mail: kreftregisteret@kreftregisteret.no
Website: www.kreftregisteret.no

Have responsibility for:
- Statistics on cancer

Ministry of Health and Care Services
P.O. Box 8011 Dep.
N-0030 Oslo
Phone: + 47 22 24 90 90
E-mail: postmottak@hod.dep.no
Website: www.hod.no

Have responsibility for:
- Statistics on in vitro fertilization

## *Sweden*

Statistics Sweden
P.O. Box 24 300
SE-104 51 Stockholm
Phone: +46 8 506 940 00
Fax: +46 8 661 52 61
E-mail: scb@scb.se
Website: www.scb.se

Have responsibility for:
- Population and vital statistics
- Statistics on health care economy

National Board of Health and Welfare
SE-106 30 Stockholm
Phone: +46 75 247 30 00
Fax: +46 75 247 33 27
E-mail: socialstyrelsen@socialstyrelsen.se
Website: www.socialstyrelsen.se

Have responsibility for:
- Statistics on births
- Statistics on abortions
- Statistics on in-patients
- Statistics on cancer
- Statistics on causes of deaths
- Statistics of prescribed drugs

Swedish Institute for Infectious Disease Control
SE-171 82 Solna
Phone: +46 8 457 23 00
Fax: +46 8 32 83 30
E-mail: smittskyddsinstitutet@smi.ki.se
Website:www.smittskyddsinstitutet.se

Have responsibility for:
- Statistics on infectious diseases
- Statistics and information on vaccinations

National Corporation of Swedish Pharmacies
SE-131 88 Stockholm
Phone: +46 8 466 10 00
Fax: +46 8 466 15 15
Website: www.apoteket.se

Have responsibility for:
- Statistics on drug sales and drug prescribing

Swedish Association of Local Authorities and Regions
SE-118 82 Stockholm
Phone: +46 8 452 70 00
Fax: +46 8 452 70 50
E-mail: info@skl.se
Website: www.skl.se

Have responsibility for:
- Statistics on health personnel
- Statistics on hospital capacity
- Statistics on health care economy

# NOMESCO Publications from 1995

43. Rates of Surgery in the Nordic Countries. Variation between and within nations. NOMESCO, Copenhagen 1995.

44. Health Statistics in the Nordic Countries 1993. NOMESCO, Copenhagen 1995.

45. Sygehusregistrering i de nordiske lande. NOMESKO, København 1995.

46. Classification of Surgical Procedures. NOMESCO, Copenhagen 1996.

47. Health Statistics in the Nordic Countries 1994. NOMESCO, Copenhagen 1996.

48. NOMESCO Classification of External Causes of Injuries. 3rd revised edition. NOMESCO, Copenhagen 1997.

49. Health Statistics in the Nordic Countries 1995. NOMESCO, Copenhagen 1997.

50. Health Statistics in the Nordic Countries 1996. NOMESCO, Copenhagen 1998.

51. Samordning av dödsorsaksstatistiken i de nordiska länderna. Förutsättningar och förslag. NOMESKO, Köpenhamn 1998.

52. Nordic and Baltic Health Statistics 1996. NOMESCO, Copenhagen 1998.

53. Health Statistic Indicators for the Barents Region. NOMESCO, Copenhagen 1998.

54. NOMESCO Classification of Surgical Procedures, Version 1.3. Copenhagen 1999

55. Sygehusregistrering i de nordiske lande, 2. reviderede udgave, Købehavn 1999

56. Health Statistics in the Nordic Countries 1997. NOMESCO, Copenhagen 1999.

57. NOMESCO Classification of Surgical Procedures, Version 1.4. Copenhagen 2000

58. Nordiske læger og sygeplejersker med autorisation i et andet nordisk land. København 2000.

59 NOMESCO Classification of Surgical Procedures, Version 1.5. Copenhagen 2001.

60. Health Statistics in the Nordic Countries 1998. NOMESCO, Copenhagen 2000.

61. Health Statistics in the Nordic Countries 1999. NOMESCO, Copenhagen 2001.

62. Nordic/Baltic Health Statistics 1999. NOMESCO, Copenhagen 2001.

63. NOMESCO Classification of Surgical Procedures, Version 1.6. Copenhagen 2002

64. Health Statistics in the Nordic Countries 2000. NOMESCO, Copenhagen 2002.

65. NOMESCO Classification of Surgical Procedures, Version 1.7. Copenhagen 2003

66. Health Statistics in the Nordic Countries 2001. NOMESCO, Copenhagen 2003

67. Sustainable Social and Health Development in the Nordic Countries. Seminar 27th May 2003, Stockholm. NOMESCO, Copenhagen 2003

68. NOMESCO Classification of Surgical Procedures, Version 1.8. Copenhagen 2004

69. Health Statistics in the Nordic Countries 2002. NOMESCO, Copenhagen 2004

70. NOMESCO Classification of Surgical Procedures, Version 1.9:2005. Copenhagen 2004

71. Nordic/Baltic Health Statistics 2002. NOMESCO, Copenhagen 2004.

72. Medicines Consumption in the Nordic Countries 1999-2003. NOMESCO, Copenhagen 2004.

73. Health Statistics in the Nordic Countries 2003. NOMESCO, Copenhagen 2005.

74. NOMESCO Classification of Surgical Procedures, Version 1.10:2006. Copenhagen 2005

75. Health Statistics in the Nordic Countries 2004. NOMESCO, Copenhagen 2006.

76. Smedby, Björn and Schiøler Gunner: Health Classifications in the Nordic Countries. Historic development in a national and international perspective 2006. NOMESCO, Copenhagen 2006

77. NOMESCO Classification of Surgical Procedures, Version 1.11:2007 Copenhagen 2006

78. Sustainable Social and Health Development in the Nordic Countries. Seminar, 6th April 2006, Oslo. Seminar Report. NOMESCO, Copenhagen 2006

79. NOMESCO Classification of External Causes of Injuries. Fourth revised edition. NOMESCO, Copenhagen 2007

80. Health Statistics in the Nordic Countries 2005. NOMESCO, Copenhagen 2007.

81. NOMESCO Classification of Surgical Procedures, Version 1.12:2008 Copenhagen 2007