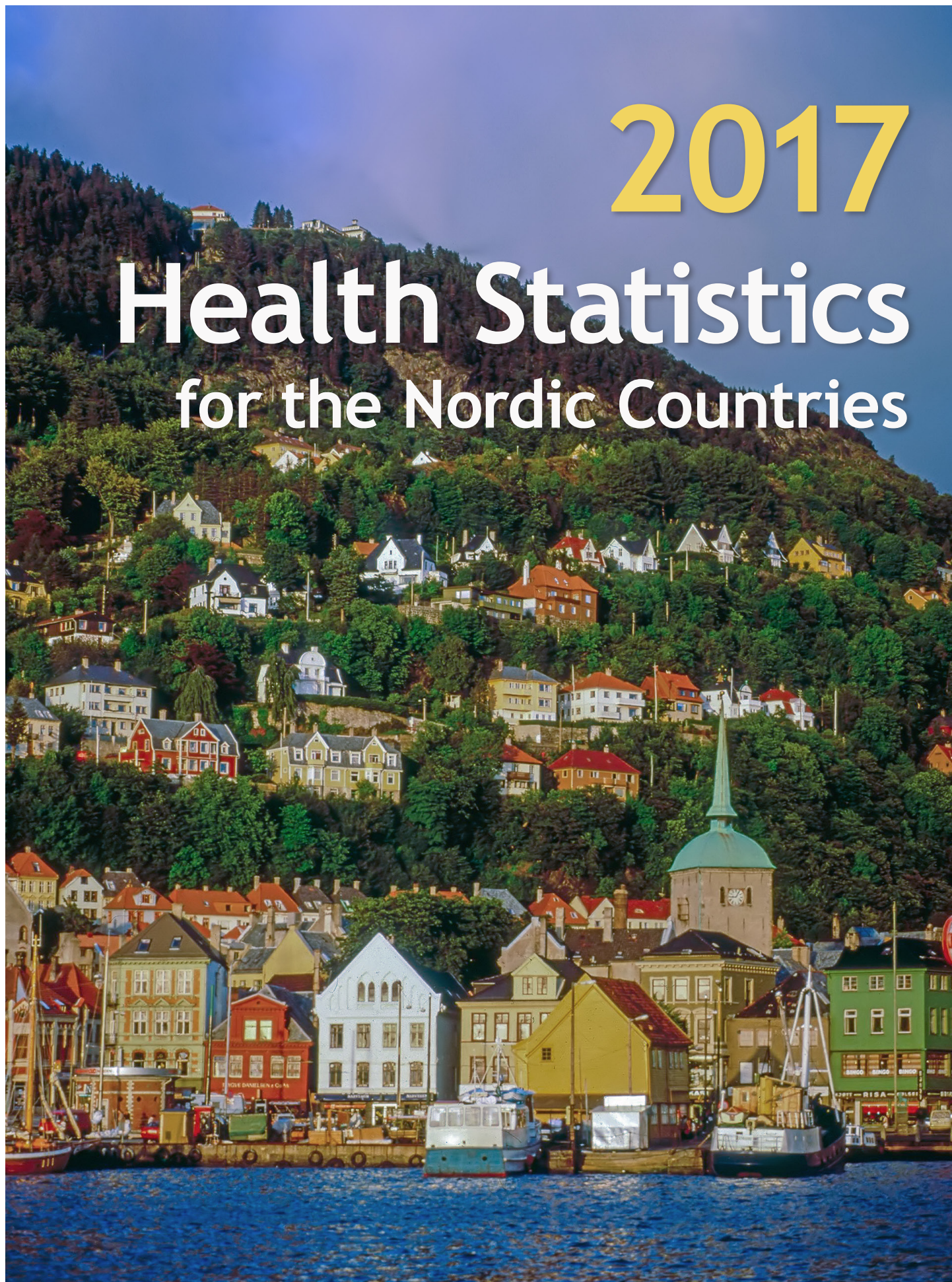


2017

Health Statistics for the Nordic Countries



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Nordic Medico-Statistical Committee 108:2017

Health Statistics for the Nordic Countries 2017

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Health Statistics for the Nordic Countries

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Copenhagen 2017

ISBN 978-87-89702-92-6

ISSN 2245-9626

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Symbols used in the tables:

Figures not available or too unreliable for use	..
Information not applicable	.
Less than half of the unit used	0.0/0
Nothing to report (value nil)	-
Five year averages are always written as 20xx-xy	
Two year averages are always written as 20xx/xy	
Data are always calculated in relation to the respective age groups	
Per cent in Tables and Figures	%

Preface

The 2017 version of NOMESCO's Health Statistics in the Nordic Countries is now available.

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

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

This version comprises the latest available data as per 1 October 2017. The latest data year may consequently be 2016 or 2015. Previous versions are available at www.nowbase.org, where our database and more specialized publications from projects carried out by NOMESCO can also be found.

Nordic Medico-Statistical Committee (NOMESCO), October 2017

Chapter 1

Organization of Health Services

Introduction

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

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

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

Specialist medical treatment is also offered outside hospitals.

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

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

1.1 Current and future changes in the health care sector

DENMARK

In 2016, a new national healthcare quality programme was launched by the government together with the regions and the municipalities. The programme established a framework for continuously improving the quality of care in the healthcare system. The programme was implemented through different initiatives. As a first step, Denmark established a set of ambitious national goals for the quality of care.

1. Better coherent patient pathways
2. Increased efforts for chronically ill and elderly patients
3. Improved survival rates and patient safety
4. High-quality care
5. Fast diagnosis and treatment
6. Increased patient involvement
7. More healthy life years
8. More effective health care systems

A number of indicators have been selected that outline the overall objectives. The indicators allow regions and municipalities to follow the goals and take the initiatives that create the desired development. The Danish Health Authority will continuously follow developments in the national objectives.

To ensure coordination and direction for the Danish collective efforts towards better and more effective healthcare the Danish Government and Danish Regions have developed a National Strategy for Personalised Medicine 2017-2020. The focus of the strategy includes, among other things, the establishment of a foundation for the development of better and more targeted health care for patients, through the use of new technologies and new knowledge.

FAROE ISLANDS

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

Since the presentation of the report and the subsequent debate in the Parliament (Løgtingið), which gave the impression that there is great political approval for the solutions stated in the report, the Ministry of Health has worked on implementing several of the new efforts. Examples of efforts that are already implemented and efforts that are in progress are:

- expansion of the offer of free dental care for children and adolescents

- establishment of local interdisciplinary health centres
- strengthening of initiatives within child and youth psychiatry
- introduction of legal rights for rehabilitation
- offers of special counselling for polymedical citizens over 75
- establishment of a Public Health Institute
- establishment of health care for diabetic and other patients with chronic diseases at local interdisciplinary health centres

In the Faroe Islands are three local hospitals. The Minister of Health and the Interior has decided to strengthen cooperation between the hospitals in order to optimize the use of resources. The Director for the main hospital will be the CEO for all three hospitals from 2018.

GREENLAND

Greenland is a large country and sparsely populated. The health system faces the challenge of serving a relatively small population close to home. Equity in health care is a guiding principle and health care as well as medication is therefore free of charge for the citizens of Greenland. The per capita health budget is approximately USD 3 000 per annum, including the coverage of primary and specialized care, part of which is provided abroad in Denmark or Iceland.

In 2012, Greenland regionalized of the health system with regional hospitals, health centres and village health stations, staffed with different medical, nursing, and paramedical staff or village health workers. The health budget is decentralized to the regions in order to enable a flexible and needs-oriented allocation of resources. We are presently in the process of conducting a five-year evaluation of this approach.

In order to make specialized care quickly available and to save transport costs and waiting time, Greenland has introduced a nation-wide telemedicine system which allows for patient consultation both between the centres in Greenland as well as with highly specialized tertiary level university hospitals in Denmark. This is presently used in radiology, ophthalmology, neurology, dermatology, haematology, and psychiatry.

In 2017, Greenland also completed the country-wide implementation of the Electronic Patient Journal “Cosmic”. This means that all Greenland’s health services are now using the same system for documenting patient’s examinations, diagnosis, treatment, and medication. This should result in a noticeable lift in quality in patient check-ups and treatment and will be the foundation for further development in clinical care and operational health services research.

The present National Health Strategy of Greenland ends in 2018 and the government is therefore in the process of developing a new National Strategy for Health for 2018-2022. The strategy will build on lessons from the previous health strategy, focusing on measurable goals and practical applicability. The strategy will aim to involve all sectors of government and society in the promotion and protection of health of its citizens. The strategy will include the respective responsibilities of other sectors in health promotion and protection and will include focus areas of concern such as the growing burden of lifestyle-related illnesses, mental health, drug and alcohol

addiction, patient safety, sexual and reproductive health, child and adolescent health, infectious diseases including tuberculosis and sexually transmitted infections and the prevention of hearing loss in children through early intervention and treatment. It will also focus on the challenge of the recruitment and retention of human resources for health.

Facing the challenge of limited resources, the new strategy for health will draw on the joint responsibility of all sectors of society and will define their respective responsibilities. Being a small country, Greenland will also rely upon the network with neighboring and other countries for joint initiatives and learning from each other, as well as supporting each other in specialized patient care. Greenland has therefore joined the Nordic working group for cooperation in highly specialized treatment and is working closely with the West Nordic countries.

FINLAND

The structure of health and social services will be reformed in Finland from 2020 onwards. The responsibility for providing public healthcare and social services will be assigned to 18 autonomous regions that are larger than municipalities. Healthcare and social services will be brought together at all levels to form customer-oriented entities, and basic public services will be strengthened. The existing multisource financing will be simplified and customers will have more freedom of choice in the services. The objective is to reduce inequalities in wellbeing and health, and to manage costs. The reform will help to bridge a large part of the sustainability gap in general government finances. Besides structural reforms, the steering and operating models in healthcare and social welfare will be thoroughly modernised. The aim is to achieve better services that are not only more customer-oriented, effective and cost-efficient than before but also better coordinated.

More information: <http://alueuudistus.fi/en/social-welfare-and-health-care-reform/about-the-reform>

ÅLAND

The on-going economic recession has also influenced Åland. The Government, with a deficit of about EUR 20 million has been forced to reduce hospital capacity, and one department for patients with dementia has been closed. Replacing services in the municipalities is also under way.

The ÅHS is struggling to update its out-dated patient information system, with a special challenge to conform with the Swedish language, but at the same time to be appropriate for Åland's health care system.

Preventing the use of tobacco and drugs has been a major topic in the Åland. A syringe exchange programme will be started in the sector of health care as a trial project.

The Government arranged a series of seminars to explore important aspects of social services and health care in Åland. Among these, a large scale digitalization of the services was considered as an attractive development, especially in the scattered Åland Islands.

ICELAND

A new reimbursement system for medicinal products, which is similar to the Danish and Swedish system, was implemented on 4th May 2013. The main goal was to increase equality between individuals, regardless of health status, and reduce the burden of high expenses for medicinal products. Co-payment is a proportion of annual expenses, and there is a step-wise increase in reimbursement by the Health Insurance up to full reimbursement. Each individual pays proportionately less as expenses increase until a subsidy limit is reached. In the first step, the individual pays the full cost, in the second step 15% of the cost, and in the third step 7.5% of the cost of the medicinal product. The self-payment then gradually decreases until annual expenses have reached the annual limit. After this, the expenses are fully covered. The annual limit is lower for elderly people and disabled people (approximately EUR 300) than for the general public (approximately EUR 400). The system will be further developed and a similar system will be adopted in other parts of the health services.

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

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

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

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

In 2017, a new formula funding financing model was implemented in primary health care in the capital area. The main goal is a transparent financing model, linked to written requirements for all primary health care centres. The funding is

based on the size and characteristics of the population and disease burden. Adjusted Clinical Group (ACG) system measures health status by grouping diagnoses into clinically cogent groups. The aim of the ACG system is to assign each individual a single, mutually exclusive ACG value, which is a relative measure of the individual's disease burden and expected or actual consumption of health services.

As of 1 May 2017 a new payment system for health care was introduced. The main goal is to increase equality between individuals, regardless of health status, and to reduce the burden of high expenses for health services through a simpler and more transparent system. The new system has a cost ceiling and will reduce user charges for patients with high health care expenditure and for families with children. The new payment system includes a references system for children aged 2 to 18 to see a specialist.

NORWAY

The Ministry of Health and Care Services has three main priorities for 2017 and onwards; to reduce waiting time for treatment, to give priority to treatment within mental health and substance abuse and to focus on quality of services and patient safety.

During the past few years efforts have been made to improve coordination between health care providers, and to pay more attention to quality of care and patient safety issues. Intersectoral cooperation has become increasingly important, especially as a means of preventing social inequalities in health. More attention has also been paid to improving allocation of resources through priority setting and increased use of modern health technology.

Patient empowerment and active involvement in decision making processes are central to the National Health and Hospital Plan 2016-2019. The website www.helsenorge.no gives patients access to information, including their medical record, providers, waiting times for treatment and a tool for hospital choice and communication solutions.

In the National Cancer Strategy (Nasjonal kreftstrategi 2013-2017) well-coordinated patient care pathways shall prevent unnecessary waiting time for examination and treatment.

A law passed in the Storting (the Norwegian Parliament) extends the choice of hospital from public hospitals (or hospitals with a tender agreement) to all public and private hospitals. All in-patient treatment is free of charge. Patients pay a user charge for out-patient treatment.

The amendment of the Patients' Rights Act, which came into force in 2015 grants all persons under the age of 67 who have a long term and great need for personal assistance the legal right to receive such help in the form of user-controlled personal assistance (UC-PA).

The level of IT use in the Norwegian health system varies and is most advanced at the level of primary care. The use of e-tools in hospitals is less common, but is improving.

In time to come the Government has stated an intention to explore various models for financing dental care, including a ceiling for deductibles. There is also an ambi-

tion to improve the adaptation of specialist services to patients' needs. In the area of mental health, community mental health care centres are to play an important role as hubs for the provision of integrated treatment in order to improve coordination, accessibility and efficiency.

SWEDEN

The Swedish Parliament decided that from 1 January 2016, medicines and products that are included in the list of pharmaceutical benefits should be free for children under the age of 18. The aim is to reduce inequalities in health between different socio-economic groups. This includes children under the age of 18, children seeking asylum, and children living in Sweden without the necessary permission.

The Swedish Parliament has decided that from 1 January 2017 persons aged 85 years or older do not have to pay a patient fee for public health care. Open care includes the dental care which the country is responsible for: necessary dental care, and medical treatment and dental care for people with severe difficulties in managing their oral hygiene. They then pay the same patient fees as for health care, and receive the same high-cost protection and free-card after they have paid SEK 1 100 for patient fees during a 12-month period.

The Government has decided how much manufacturers and importers of tobacco products must pay to the Public Health Agency of Sweden to cover the cost of the Authority's supervision of the tobacco sector. Fees are charged per product. The rules for the new charges are laid down in the Tobacco Regulation and apply from 1 August 2017.

Charges per product	Fee for new or changed product (SEK):	Annual fee (SEK)
Cigarettes	21 200	23 000
Roll Tobacco	17 200	21 500
Tobacco for use in the mouth (Snus)	13 200	900
Other tobacco products	13 600	2 700

A new system for dealing with complaints from patients and relatives has been proposed. The aim is to streamline the management of complaints, so that injuries resulting from health care can be rectified at the earliest possible stage, that patients can get their complaints dealt with more quickly, and that efforts are directed to where the need for supervision is greatest.

The Health and Social Care Inspectorate (IVO) will only investigate cases in which the patient, in connection with provision of health care, has suffered a permanent or serious illness or injury that has led to a significantly increased need for care, or which has led to the patient's death. The Government also proposes that a new law should regulate the activities of the patient advisory committees. The aim is to ensure that the boards are independent of the health authorities.

The legislative amendments are proposed to enter into force on 1 January 2018.

1.2 Organization and responsibility for the health sector

DENMARK

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

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

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

FAROE ISLANDS

The Home Government of the Faroe Islands lays down the rules concerning the tasks, benefits and administration of the health service. The organization of hospital services, specialist fields and primary health services largely follows the Danish system. The same applies to nursing homes, home nursing services, home help services and dental services. Nursing homes, home nursing services and home help services were transferred from the Home Rule Government to the municipalities on 1 January 2015.

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

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

The midwifery service is organized under the hospital services.

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

Pharmacies are run by the public authorities

GREENLAND

In Greenland all residents are covered by universal public health care inclusive of medical treatment, dental care and pharmaceutical products. Patients, who are referred for investigation, examination and/or treatment outside of Greenland, receive individual medical guidance and information on the reasons/assessment for the referral as well as the progress of the treatment outside Greenland. This very reason/assessment is made on the basis of decisions in the Visitation Committee, working out of the law and the instructions for obtaining services outside the country (for details, please see chapter 7 and 8 in <http://lovgivning.gl/lov?rid=%7b7030CA46-D861-4582-973D-01ED94FE5EF5%7d>). If persons in the need of health care do not have residence in Greenland, the rules for temporary stay in Greenland apply. Greenland is not a member of EU, has not formally joined the EU Cross-border health care directive, but joins a general treatment obligation.

FINLAND

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

The municipalities are responsible for the following:

- Guidance and preventive health care, including children's health, health education, counselling concerning contraceptive measures and health surveys and screening
- Medical treatment, including examination and care, medical rehabilitation and first aid
- General medical treatment is provided in health care centres, in-patient wards or as home nursing
- If a patient's own health centre or hospital cannot provide treatment within the given time, the patient must be offered treatment either in another municipality or at a private institution, without extra cost
- With the exception of emergency cases, patients must be examined and treated within a given period. Patients shall be able to obtain immediate contact with a health centre on weekdays within normal working hours and must have the option of visiting the health centre. If an appointment at a health centre is deemed necessary, patients shall be given an appointment within three working days from the time of contact with the health centre. Normally, treatment is provided at the health centre immediately at the first visit. Treatment that is not provided at the visit shall be started within three months. In cases where health centres provide specialized treatment, the time limits are the same as for specialized health services, i.e. six months. The need for treatment must be assessed within three weeks after referral to a hospital. If a physician has examined a patient and has established that treatment is needed, such treatment shall be started within six months
- Municipalities are also required to provide ambulance services and to ensure that occupational health services are established. Employers can either organize their own occupational health service, or they can enter into an agreement with a health centre or with others who provide occupational health services
- The municipalities must provide services for people with mental illness that can reasonably be offered in health centres
- Children and young people shall receive mental health care within three months if it is assessed to be necessary
- Dental treatment that is assessed to be necessary shall be started within a reasonable time and at the latest within six months
- Dental care includes advice and prevention, dental examination and treatment
- Dental care and treatment paid for by the health insurance scheme is provided for the entire population. Dental care is also provided for adults in health centres, particularly in rural municipalities. Most dental treatment for adults is provided by dentists in private practices. Young people under the age of 18 are entitled to dental care free of charge

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

ÅLAND

Åland is a separate region for social and health care in Finland, because it is responsible for its own legislation. Social services are the responsibility of the 16 municipalities, but health care has been centralized since 1993 into one organization, Åland's Hälso- och sjukvård (ÅHS). ÅHS is responsible for all primary and secondary care of the inhabitants. Patients who need tertiary care are referred to Sweden and Finland. Patients do not have the right to choose the hospital they wish to be referred to outside Åland. However, in accordance with the legislation on patient's right, they have the right to a second opinion. The current Finnish reform of social and health care has no direct major influence on health care in Åland.

The ÅHS runs a hospital with 121 beds and with most of the main specialities. In 2016, for the population of 28 600, there were 208 000 visits, and 25 000 patients used the services of the ÅHS. Because of its unique geographic position, the hospital provides a wide-range emergency services, which is the opposite trend according to the legislation in the Finnish mainland to centralize services to bigger hospitals. On an average there is one helicopter transport to the neighbouring countries every day. The health care in the 59 inhabited islands other than the main Åland Island is organized with the help of local health nurses. There are private sector actors in the city of Mariehamn, providing day care surgery, specialists, and general practitioner visits.

The level of health in Åland, assessed by several indicators, is the best or second best in the whole of Finland. In particular mental health, as assessed by occurrence of suicides, use of drugs for mental illness, and disability pension due to mental illness, is clearly the best in the whole of Finland. However, on average, the incidence of cancer seems to be higher than in Finland, presumably due to vigilant screening activities in the Åland Islands.

Health care in Åland is more expensive than on the mainland, about EUR 700 per inhabitant higher (EUR 3 300). This can partly be explained by the small volume of the services provided. What is important is that these health services provided on a small scale seem to be of high quality.

Recruiting competent personnel is clearly one of the greatest challenges. Moreover, the language of the islands is exclusively Swedish, which restricts the possibilities to recruit from the Finnish universities. Other challenges of providing health care in Åland are the same as elsewhere: an ageing population and economy. Due to its special geography and its autonomous position, Åland may have an opportunity to rapidly form an advanced ecosystem for digitalized health care services, especially in the Nordic context.

ICELAND

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

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

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

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

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

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

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

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

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

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

NORWAY

Public health services account for the majority of health expenditure (85 per cent). Exemptions and ceilings for out-of-pocket payments limit the financial burden of care for individuals. However, the level of subsidies is much lower for certain types of care (e.g. dental care for adults is virtually excluded from coverage). All residents are covered by the National Insurance Scheme (Folketrygden), managed by the Norwegian Economics Administration (Helseøkonomiforvaltningen, HELFO).

The Norwegian health care system can be characterized as semi-decentralized. Responsibility for specialist care lies with the state, administered by four Regional Health Authorities (RHAs). The Ministry of Health and Care Services determines national health policy, prepares and oversees legislation, decides on the allocation of funds within the health sector, and implements national health policy with the help of several subordinate institutions. The system is regulated through a large number of acts and regulations. Legislation broadly reflects the decentralized nature of the

healthcare system: specialist care organized at the level of the RHAs, primary care organized at the level of the municipalities, and dental care organized at the level of the counties.

Primary care is provided at the municipal level, mostly by self-employed physicians. General practitioners (GPs) act as gatekeepers. They constitute an important link between primary and specialized health services and refer patients to specialized care when necessary.

Healthy Life Centres (HLC) have been established in many municipalities. These provide preventive primary health services, such as measures for people who need support to change their health behaviour (e.g. exercise groups, counselling), or to cope with health problems and chronic disease.

The RHAs are responsible for providing specialized care, in somatic and mental health institutions, and other specialized medical services, such as laboratory, radiology and ambulatory services, and special care for persons with alcohol and drug addictions. Inpatient specialized care is mainly provided by hospital trusts owned by the RHAs, and some contracted private facilities. Hospitals also provide outpatient specialist care in their outpatient departments. Hospitals provide emergency care in accident and emergency departments.

Municipalities and RHAs are responsible for coordinating rehabilitation services and all RHAs and most municipalities have established designated coordination units. Rehabilitation is provided at the primary level (physiotherapy, occupational therapy, etc.) and the secondary level (specialized rehabilitation). The municipalities are responsible for regulating access to nursing homes or equivalent institutions. Care may be provided in nursing homes, sheltered accommodation or in patients' homes.

Public dental services are provided for children and adolescents. Adults receive dental care from private dentists and pay the full cost of treatment. Except for orthodontic treatment, public dental care is free of charge for children and young people aged 0-18 years. Young people aged 19-20 years pay 25 per cent of the costs. Mentally handicapped adults, elderly people and people with long-term illness, who are either living in an institution or receiving home nursing care, pay reduced fees.

SWEDEN

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

The Health and Medical Service Act (Hälso- och sjukvårdslagen, HSL) lays down the division of responsibility for health services between the county authorities and the municipal authorities. The Act gives the county authorities and the municipal authorities the task of ensuring that all inhabitants have equal access to sound and adequate services.

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

The National Board of Health and Welfare, NBHW (Socialstyrelsen) is a government agency under the Ministry of Health and Social Affairs, with many different duties within the fields of social services, health and medical services, patient safety and epidemiology. The National Board of Health and Welfare administers a number of registers to be able to analyse and monitor trends in health care and social services. The NBHW works with Regional and local comparisons and Performance Assessments to encourage the providers and management of health care to improve performance.

National guidelines indicate the benefits and risks of different interventions and support health and medical care professionals in prioritising the right interventions for those with the greatest need. The purpose of the guidelines is to ensure that people have access to good health and medical care.

The Health and Social Care Inspectorate (Inspektionen för vård och omsorg, IVO) is a government agency responsible for supervising health care, social services and activities under the Act concerning Support and Service for Persons with Certain Functional Impairments (LSS). According to the Swedish Patient Safety Act, all healthcare providers are required to register their activities with the Health and Social Care Inspectorate.

The Medical Products Agency, MPA (Läkemedelsverket) is the Swedish national authority responsible for regulation and surveillance of the development, manufacturing and marketing of drugs and other medicinal products. The Medical Products Agency also maintains supervision over all pharmacies in Sweden. The task is to ensure that both the individual patient and healthcare professionals have access to safe and effective medicinal products and that these are used in a rational and cost-effective manner. The agency is also the licensing and regulatory authority for the legal handling of narcotic drugs.

The Dental and Pharmaceutical Benefits Agency (Tandvårds- och läkemedelsförmånsverket, TLV) is a central government agency whose remit is to determine whether a pharmaceutical product, medical device or dental care procedure shall be subsidized by the state. TLV also determines retail margins for all pharmacies in Sweden, regulates the substitution of medicines at the pharmacies and supervises certain areas of the pharmaceutical market.

TLV determines whether licensed medicinal products and extemporaneous medicines (preparations that are tailor-made for a certain patient) will be included in the high-cost threshold. TLV also determines which dental care procedures will be subsidised and sets reference prices, i.e. the prices on which reimbursement is calculated.

The task of the Swedish eHealth Agency (eHälsomyndigheten) is to lead and coordinate government e-health initiatives. All pharmacies in Sweden use the eHealth data base to get the information they need to dispense a prescription.

The Public Health Agency of Sweden (Folkhälsomyndigheten) has responsibility for public health issues, and for ensuring that people have equal opportunities for good health. It does this through monitoring public health, analysing background factors, and evaluating public health initiatives. It also has responsibility for promoting health, preventing illness and aiding the control of infectious diseases through epidemiological and microbiological.

The Swedish Agency for Health Technology Assessment and Assessment of Social Services (Statens beredning för medicinsk och social utvärdering, SBU) are an independent national authority, tasked by the government with assessing health care interventions from a broad perspective, covering medical, economic, ethical and social aspects.

SBU evaluates the scientific basis for methods currently in use and new methods used in health and social services, and for activities supported by the Act on support and service for certain physically impaired people. SBU also evaluates methods used by medical and social services. SBU assessments are based on 'systematic literature reviews' of published research. The review method developed by SBU is thorough and rigorous.

1.3 Supervision of health services and health care personnel

DENMARK

Supervision of health services is carried out by the Danish Patient Safety Authority with the assistance of the Danish Patient Safety Authority, Supervision and Guidance offices North/South/East. These institutions are independent, politically and administratively, of the regional and municipal health authorities. In this way, the chief medical officers work as independent advisers and supervisors at all levels. Supervision of health care personnel and their professional activities is also carried out by the Danish Patient Safety Authority. Decisions concerning individuals can be appealed to the responsible minister and, if necessary, to the courts.

FAROE ISLANDS

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

GREENLAND

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

FINLAND

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

ÅLAND

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

ICELAND

In Iceland, the Directorate of Health carries out supervision of health institutions, health care personnel, prescription of pharmaceutical products, measures for combating substance use and control of all public health services.

The Icelandic Medicines Agency carries out advisory and supervisory tasks regarding pharmaceutical products to pharmacies, pharmaceutical companies and the public.

NORWAY

Overall supervision and monitoring of health services is provided by the National Board of Health Supervision, together with its 19 Offices of the County Medical Offices. The Norwegian Registration Authority for Health Personnel provides work authorizations/licences for health-care personnel.

The pharmaceutical sector is one of the most regulated sectors in Norway. The Norwegian Medicines Agency is in charge of granting / withdrawing marketing authorizations and market vigilance. All pharmaceutical companies must apply for a marketing authorization in order to sell their products on the Norwegian market.

SWEDEN

In Sweden, the Health and Social Care Inspectorate (IVO) is the national supervising authority for social services and for health services. The purpose of supervision is to ensure that citizens receive social care and health care, which is safe, is of good quality and is carried out in accordance with existing laws and regulations. The Inspectorate's work also includes presenting the supervised organizations with the results of supervision, to provide feedback, advice and guidance regarding the supervision and to ensure that discrepancies and irregularities are corrected.

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

1.4 Complaints about health services and health care personnel

DENMARK

The National Agency for Patients' Rights and Complaints (*Sundhedsvæsenets Disciplinærnævnet*) deals with complaints concerning authorized health care personnel. The Danish Safety Authority deals with complaints concerning the place of treatment but can handle complaints against health care personnel and place of treatment. Both the National Agency for Patients' Rights and Complaints (*Sundhedsvæsenets Disciplinærnævnet*) and the Danish Safety Authority can deal with complaints, but complaints cannot be dealt with by both these authorities at the same time.

FAROE ISLANDS

To a certain extent, the Faroese health system is covered by the regular Danish complaints system. Complaints about health services carried out by authorised health

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

Patients who have been referred by the Faroese health care system who receive treatment in the Danish hospital services, are fully covered by the Danish complaints system.

GREENLAND

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

FINLAND

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

ÅLAND

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

ICELAND

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

NORWAY

Patient rights in Norway are well-defined legal rights and can be actionable against specific parties. Every county has a Health and Social Services Ombudsman, whose purpose is to safeguard patients' rights, interests and legal rights in relation to primary and specialist health care. The ombudsman determines whether a request provides adequate grounds for investigation.

Patients can make a complaint if they think that they have not received health services to which they are entitled, or if they disagree with the assessment of their treatment needs. Complaints should be addressed to the person or body who took the disputed decision. Decisions made at the county level can be appealed at the national level (the central office of the board). The board has the powers to issue warnings to health personnel and to revoke licences / authorization. The Norwegian System for Patient Injury Compensation (NPE) handles compensation claims for patients who have sustained an injury while receiving health care. Source¹: Norwegian Knowledge Centre for the Health Services.

SWEDEN

The Health and Social Care Inspectorate (Inspektionen för vård och omsorg, IVO) is a government agency responsible for supervising health care, social services and activities under the Act concerning Support and Service for Persons with Certain Functional Impairments (LSS). IVO will only investigate cases in which the patient in connection with healthcare has had a permanent or serious illness or injury that has led to a significantly increased need for care, or which led to the patient's death.

Every county council, municipality or local authority has a Patients' Advisory Committee made up of politicians and officials. Patients can contact the Patients' Advisory Committee in the county, municipality or region where they received healthcare if they want to make a comment or complaint relating to their treatment, patient fees, diagnosis or medication. The Patients' Advisory Committee has no disciplinary powers but can provide patients with information and advice on what to do next.

Many county councils, municipalities and local authorities also offer the services of a patient ombudsman who can give advice and refer people to the correct authority.

¹ Health Systems in Transition, Vol. 15 No.8 2013: Norway. Health systems review. Norwegian Knowledge Centre for the Health Services.

Chapter 2

Population and Fertility

Introduction

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

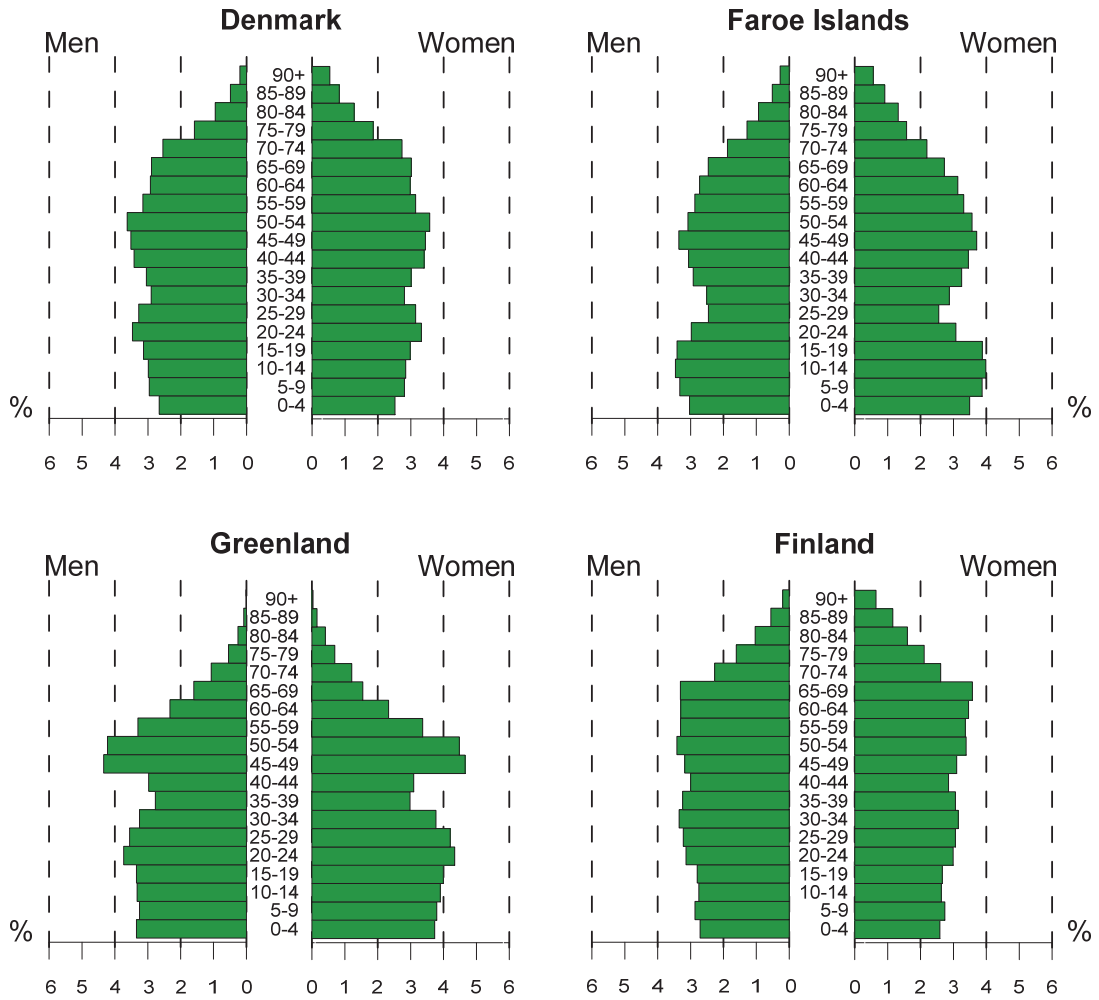
2.1 Population and population trends

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

The development in population growth varies somewhat among the Nordic countries. The natural increase has been largest in Iceland, the Faroe Islands and Greenland throughout the past decade. Denmark, Åland and Sweden have had the lowest natural increase. Åland and Finland had a negative natural population growth in 2016. In 2015, net migration contributed to population growth in all the Nordic countries with the exception of Faroe Islands and Greenland. In the Faroe Islands there is a large deficit of women of fertile age.

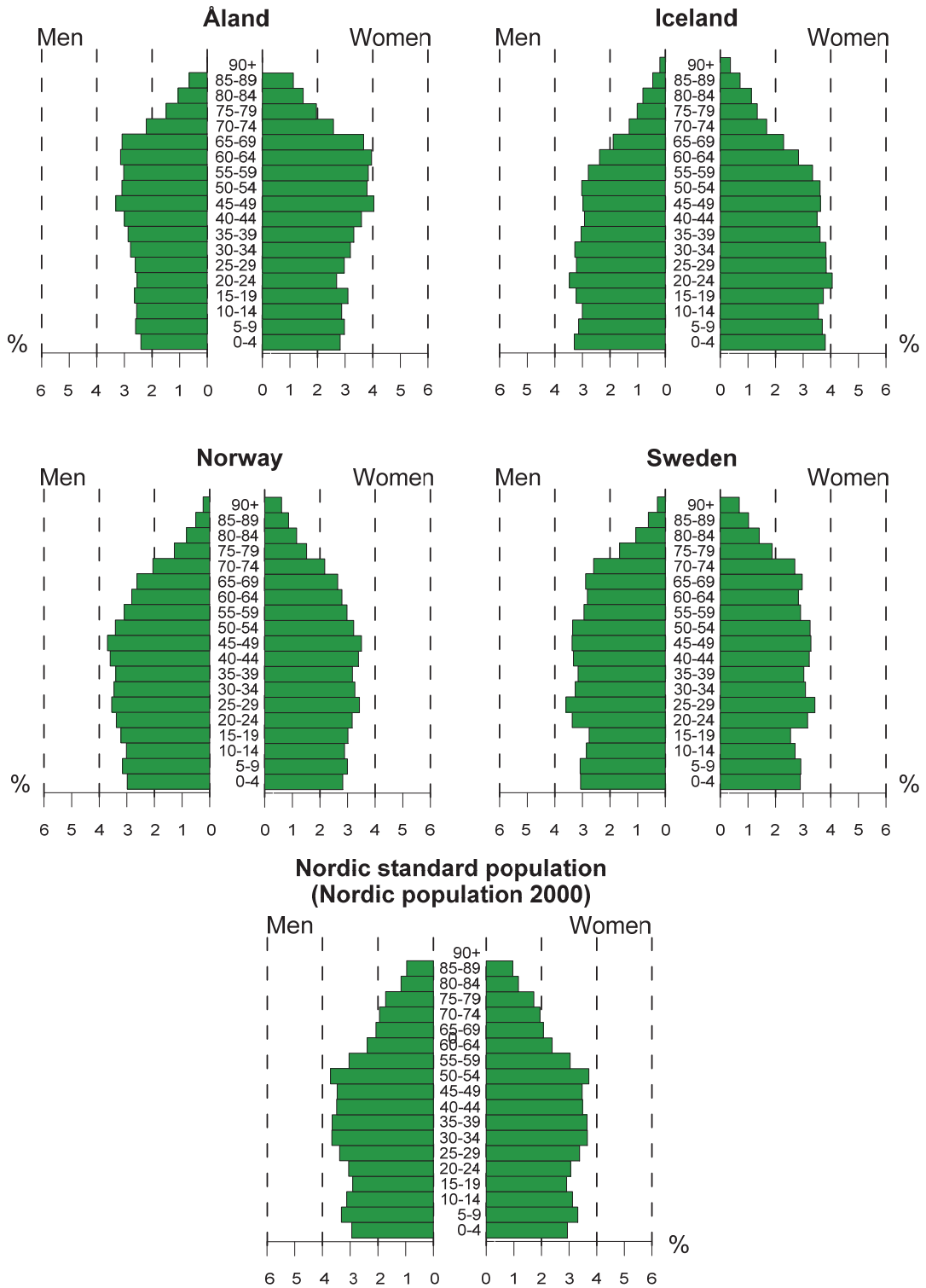
Life expectancy in the Nordic countries has increased significantly, and even though women generally live longer, the difference between the life expectancy of men and of women has been reduced.

Figure 2.1.1 Mean population by gender and age as a percentage of the total population 2016¹



Continues

Figure 2.1.1 Mean population by gender and age as a percentage of the total population 2016¹, continued



1 Faroe Islands, Greenland, Iceland and Åland: 2011-15
Source: Nordic Statistics

Table 2.1.1 Mean population 1960-2016

	Denmark	Faroe Islands	Greenland	Finland	Of which Åland	Iceland	Norway	Sweden
<i>Men</i>								
1960	2 265 000	18 000	..	2 142 263	10 254	89 000	..	3 740 119
1970	2 432 000	20 000	..	2 219 985	10 249	103 000	..	4 035 911
1980 ¹	2 529 000	22 000	27 000	2 314 843	11 274	115 000	..	4 119 822
1990	2 533 494	24 791	29 853	2 426 204	12 004	127 895	2 097 137	4 228 049
2000	2 637 878	23 665	30 002	2 529 341	12 670	140 718	2 224 221	4 386 436
2010	2 748 185	25 176	29 939	2 638 416	13 880	159 838	2 443 801	4 669 629
2015	2 811 014	25 274	29 634	2 696 677	14 466	166 228	2 611 968	4 901 603
2016	2 849 149	25 560	29 518	2 706 909	14 526	169 152	2 637 121	4 972 157
<i>Women</i>								
1960	2 301 000	17 000	..	2 303 959	10 722	87 000	..	3 757 848
1970	2 474 000	18 000	..	2 378 351	10 417	101 000	..	4 045 318
1980 ¹	2 593 000	20 000	23 000	2 472 935	11 509	113 000	..	4 198 115
1990	2 607 445	22 770	25 574	2 572 274	12 414	126 893	2 144 336	4 330 786
2000	2 699 466	22 072	26 175	2 651 774	13 072	140 436	2 266 746	4 485 674
2010	2 795 634	23 295	26 595	2 736 860	13 991	158 168	2 445 452	4 708 497
2015	2 848 701	23 639	26 480	2 782 854	14 484	164 587	2 577 926	4 897 583
2016	2 879 571	23 943	26 336	2 788 394	14 573	166 288	2 599 031	4 950 929
<i>Men and Women</i>								
1960	4 566 000	35 000	..	4 446 222	20 981	176 000	3 591 234	7 497 967
1970	4 906 000	39 000	..	4 598 336	20 666	204 000	3 874 133	8 081 229
1980 ¹	5 122 000	43 000	50 000	4 787 778	22 783	228 000	4 091 132	8 317 937
1990	5 140 939	47 560	55 426	4 998 478	24 418	254 788	4 241 473	8 558 835
2000	5 337 344	45 737	56 176	5 181 115	25 741	281 154	4 490 967	8 872 109
2010	5 543 819	48 471	56 534	5 375 276	27 871	318 006	4 889 252	9 378 126
2015	5 659 715	48 913	56 114	5 479 531	28 950	330 815	5 189 894	9 799 186
2016	5 728 720	49 503	55 854	5 495 303	29 099	335 439	5 236 151	9 923 086

1 The Faroe Islands 1977

Source: Nordic statistics

Table 2.1.2 Mean population, by age groups as a percentage, 1960-2016

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
1960								
0-17	26.3	38.4	..	35.3	30.2	39.9	30.6	27.3
18-64	63.2	53.6	..	57.4	58.6	52.1	58.5	60.9
65-79	9.1	..	..	6.4	9.4	..	..	9.9
80+	1.6	..	..	0.9	1.8	..	..	1.9
1970								
0-17	31.0	36.9	..	30.2	26.6	38.9	29.3	24.8
18-64	56.8	54.3	..	60.7	60.2	52.4	57.9	61.4
65-79	10.2	..	..	8.2	11.0	..	..	11.4
80+	2.1	..	..	1.1	2.2	..	..	2.4
1980¹								
0-17	25.8	34.9	37.9	25.1	24.3	33.7	27.0	23.8
18-64	59.9	55.4	58.4	62.9	60.2	56.4	58.3	59.8
65-79	11.6	..	3.2	10.3	12.1	..	..	13.2
80+	2.8	..	1.1	1.8	3.5	..	..	3.2
1990								
0-17	21.3	29.5	29.6	23.0	22.0	30.0	23.3	21.9
18-64	63.1	58.7	66.6	63.6	61.5	59.4	60.4	60.4
65-79	11.9	9.5	3.3	10.6	12.5	8.1	12.6	13.5
80+	3.7	2.3	0.5	2.9	4.1	2.5	3.7	4.3
2000								
0-17	21.6	27.9	31.2	21.9	22.0	27.7	23.5	21.9
18-64	63.6	58.5	63.8	63.1	61.6	60.7	61.3	60.9
65-79	10.9	10.1	4.6	11.6	11.5	8.9	10.9	12.3
80+	4.0	3.4	0.5	3.4	4.9	2.7	4.3	5.0
2010								
0-17	21.9	26.1	27.2	20.2	20.3	25.3	22.7	20.5
18-64	61.5	59.0	65.9	62.3	61.6	62.5	62.3	61.2
65-79	12.5	10.7	6.1	12.7	12.9	8.8	10.5	13.0
80+	4.1	4.1	0.8	4.8	5.2	3.4	4.5	5.3
2015								
0-17	20.6	25.3	25.2	19.6	19.7	24.1	21.7	20.5
18-64	60.7	57.8	67.0	60.2	59.7	62.2	62.0	59.8
65-79	14.4	12.5	6.8	15.1	15.4	10.0	12.0	14.6
80+	4.3	4.4	1.0	5.1	5.2	3.7	4.2	5.1
2016								
0-17	20.4	25.2	24.9	19.5	19.6	23.8	21.6	20.7
18-64	60.7	57.6	67.1	59.8	59.4	62.3	61.9	59.6
65-79	14.6	12.8	7.1	15.5	15.8	10.3	12.3	14.7
80+	4.3	4.5	1.0	5.2	5.2	3.6	4.2	5.1

1 The Faroe Islands 1977

Source: Nordic Statistiks

Table 2.1.3 Vital statistics per 1 000 inhabitants, 2000-2016

	Live births	Deaths	Natural increase	Net migration	Population increase
Denmark					
2000	12.6	10.9	1.7	1.8	3.5
2005	11.9	10.2	1.7	1.2	2.9
2010	11.5	9.8	1.6	4.0	5.7
2015	10.3	9.2	1.0	7.5	8.5
2016	10.8	9.2	1.5	5.8	7.4
Faroe Islands					
2007-11	13.1	7.7	5.4	-5.0	0.3
2012-16	13.6	7.6	6.0	8.6	14.6
Greenland					
2007-11	15.1	8.1	7.0	-5.7	1.4
2012-16	14.5	8.1	6.4	-8.8	-3.0
Finland					
2000	11.0	9.5	1.4	0.5	1.9
2005	11.0	9.1	1.9	1.7	3.6
2010	11.4	9.5	1.9	2.6	4.4
2015	10.1	9.6	0.5	2.3	2.8
2016	9.6	9.8	-0.2	3.1	2.9
Åland					
2007-11	10.3	9.1	1.2	7.7	9.4
2012-16	10.1	10.2	-0.1	6.0	7.9
Iceland					
2000	15.3	6.5	8.8	6.1	15.3
2005	14.5	6.2	8.3	13.0	21.3
2010	15.4	6.4	9.1	-6.7	2.6
2015	12.5	6.6	5.9	4.4	10.4
2016	12.0	6.9	5.1	12.1	17.4
Norway					
2000	13.2	9.8	3.4	2.2	5.6
2005	12.3	8.9	3.4	4.0	7.3
2010	12.6	8.5	4.1	8.7	12.7
2015	11.4	7.9	3.5	5.7	9.3
2016	11.3	7.8	3.5	5.0	8.3
Sweden					
2000	10.2	10.5	-0.3	2.8	2.4
2005	11.2	10.2	1.1	3.0	4.0
2010	12.3	9.6	2.7	5.3	8.0
2015	11.7	9.3	2.4	8.0	10.6
2016	11.8	9.2	2.7	11.8	14.5

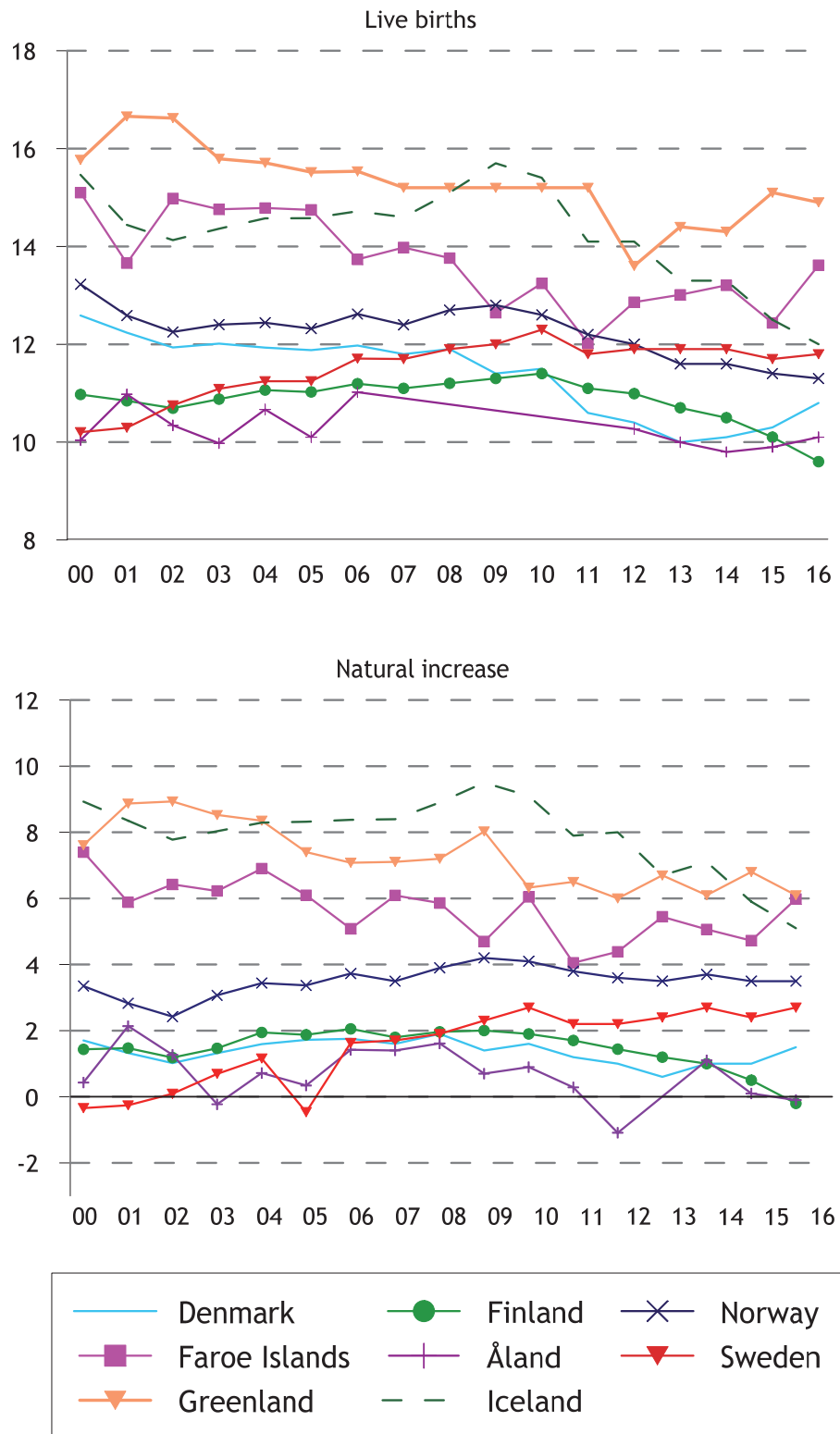
Source: DK, Statistics Denmark; FO, Statistics Faroe Islands; GL, Statistics Greenland; FI & ÅL, Statistics Finland; IS, Statistics Iceland; NO, Statistics Norway; SV, Statistics Sweden

Table 2.1.4 Average life expectancy, 2000-2016

Age	Men					Women				
	0	15	45	65	80	0	15	45	65	80
Denmark										
2000	74.3	59.9	31.4	15.0	6.7	79.0	64.4	35.3	18.1	8.5
2005	75.6	61.2	32.5	16.0	7.0	80.2	65.7	36.4	19.0	8.8
2010	77.1	62.4	33.5	16.9	7.4	81.2	66.6	37.2	19.6	9.0
2015	78.6	64.0	34.9	17.9	7.9	82.5	67.9	38.4	20.5	9.5
2016	78.8	64.2	35.1	18.1	8.0	82.8	68.2	38.7	20.7	9.5
Faroe Islands										
2002-06	..	..	..	..	..	..	..	..	..	..
2007-11	77.9	63.7	34.7	17.4	7.3	83.4	69.0	39.5	21.2	9.6
2011-12-2015-16	79.2	64.8	35.9	18.3	8.1	83.8	69.3	39.9	21.5	10.1
Greenland										
2002-06	66.1	53.4	28.3	12.1	5.2	71.7	58.3	30.3	14.2	6.7
2007-11	68.2	54.7	28.9	12.7	5.3	72.9	58.9	31.0	14.8	6.6
2012-16	..	..	..	..	..	..	..	..	..	..
Finland										
2000	74.1	59.6	31.6	15.5	6.6	81.0	66.4	37.3	19.4	8.2
2005	75.5	61.0	32.7	16.7	7.4	82.3	67.7	38.6	20.7	9.1
2010	76.7	62.0	33.7	17.3	7.6	83.2	68.5	39.2	21.2	9.4
2015	78.4	63.7	35.0	18.0	8.1	84.1	69.3	39.9	21.6	9.7
2016	78.4	63.7	35.0	18.0	8.0	84.1	69.4	40.0	21.6	9.8
Åland										
2002-06	77.6	63.5	34.7	17.4	7.4	83.9	69.5	39.8	21.3	9.5
2007-11	80.2	65.2	35.9	18.1	7.8	83.8	69.4	40.1	21.7	10.1
2012-16	79.3	64.5	35.6	18.4	8.3	84.1	69.1	39.8	21.2	9.7
Iceland										
2000	77.6	63.1	34.4	17.3	7.5	81.4	66.7	37.1	19.5	8.4
2005	79.2	64.5	35.6	18.0	7.7	83.1	68.4	39.0	20.7	9.4
2010	79.5	64.8	36.0	18.2	7.7	83.5	68.8	39.3	20.8	9.4
2015	81.0	66.3	37.4	19.4	8.4	83.6	69.1	39.7	21.3	9.7
2016	80.7	66.0	37.2	19.0	8.1	83.7	68.9	39.4	21.0	9.6
Norway										
2000	76.0	61.5	33.2	16.1	6.8	81.4	66.8	37.6	19.7	8.6
2005	77.7	63.2	34.5	17.1	7.3	82.5	67.9	38.6	20.6	9.3
2010	78.9	64.2	35.4	17.9	7.8	83.2	68.5	39.1	21.0	9.6
2015	80.4	65.7	36.6	18.8	8.2	84.1	69.4	39.9	21.5	9.9
2016	80.6	65.9	36.9	19.1	8.4	84.2	69.4	40.0	21.6	9.9
Sweden										
2000	77.4	62.8	34.0	16.7	7.1	82.0	67.4	38.0	20.1	8.9
2005	78.4	63.8	34.9	17.4	7.5	82.8	68.1	38.7	20.6	9.3
2010	79.5	64.8	35.8	18.2	7.9	83.5	68.8	39.3	21.0	9.5
2015	80.3	65.6	36.7	18.9	8.2	84.0	69.3	39.8	21.4	9.7
2016	80.6	65.9	36.9	19.0	8.3	84.1	69.4	39.9	21.5	9.8

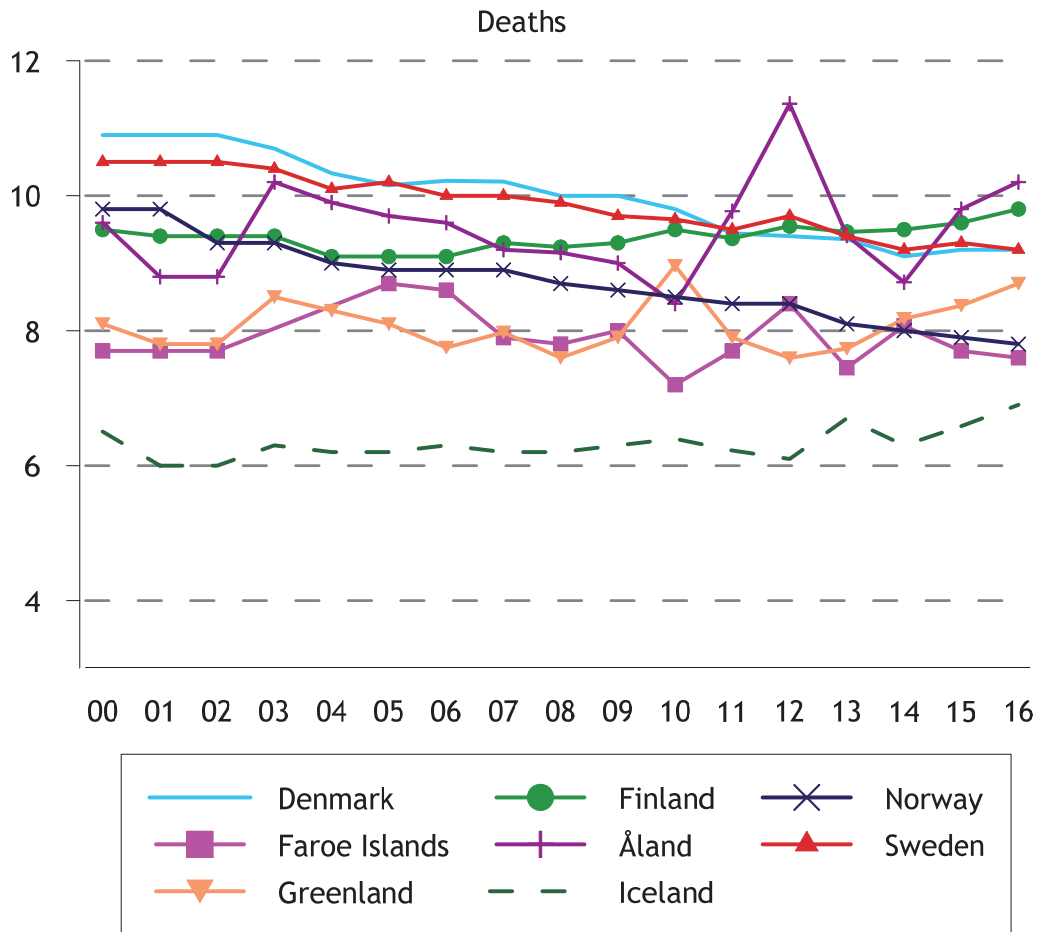
Source: DK, Statistics Denmark; FO, Statistics Faroe Islands; GL, Statistics Greenland; FI & ÅL, Statistics Finland; IS, Statistics Iceland; NO, Statistics Norway; SV, Statistics Sweden

Figure 2.1.2 Live births and natural increase per 1 000 inhabitants, 2000-2016



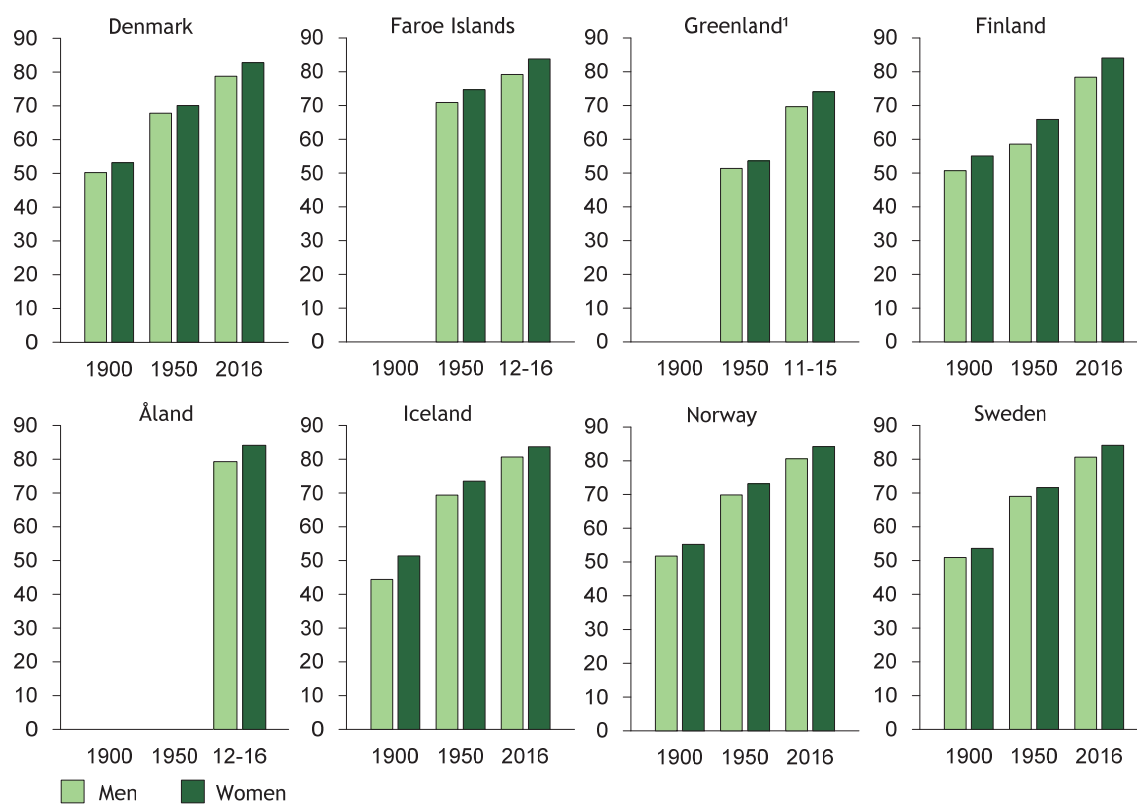
Source: DK, Statistics Denmark; FO, Statistics Faroe Islands; GL, Statistics Greenland; FI & ÅL, Statistics Finland; IS, Statistics Iceland; NO, Statistics Norway; SV, Statistics Sweden

Figure 2.1.3 Deaths per 1 000 inhabitants, 2000-2016



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

Figure 2.1.4 Life expectancy at birth 1900, 1950 and 2016



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

1 GL 1952-57

2.2 Fertility, births, infant mortality and contraception

In recent years, the overall development in fertility has resulted in Finland now having the lowest fertility rate in the Nordic countries, while the rates remain high in the Faroe Islands and Greenland, 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, even if in Iceland and Norway has higher user charges for in vitro fertilization (IVF) treatment than for other types of treatment. Denmark is the country with most IVF treatments. As shown in Table 2.2.2, more and more people receive such treatment, and a significant proportion of live births is the result of IVF. A large number of births resulting from IVF are still multiple births. The rate of multiple births among spontaneous pregnancies (non-IVF-pregnancies) are 1.0-1.5 per cent.

Internationally, the Nordic countries are characterized by having very low perinatal mortality. Greenland has the highest perinatal mortality rate among the Nordic countries. The other countries lie relatively close to each other. Changes in perinatal mortality during this period are the result of changes in the definition of gestational ages. The time limit for spontaneous abortion and stillbirth is 22 weeks in all the Nordic countries except for the Faroe Islands and Greenland, where the limit is 28 weeks. The data on stillbirths and infant deaths are presented in two ways: first according to calendar year, i.e. year of birth and death (Table 2.2.4) and second according to birth cohort, i.e. year of birth with follow-up for the first year of life (Table 2.2.5).

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

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

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

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

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

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

Abortion rates vary greatly in the Nordic countries.

Table 2.2.1 Live births and fertility rates, 2005-2016

	Number of live births	Live births per 1 000 women by age							Total fertility rate ³
		15-19 ¹	20-24	25-29	30-34	35-39	40-44	45-49 ²	
Denmark									
2005	65 194	6.7	48.8	126.1	117.9	45.5	7.2	0.3	1 756
2010	64 282	5.7	43.2	123.9	127.4	48.5	8.4	0.3	1 802
2015	57 621	3.4	34.1	109.5	125.8	57.4	11.1	0.6	1 714
2016	61 614	3.5	35.3	114.4	129.6	61.4	11.5	0.6	1 785
Faroe Islands									
2007-11	634	16.4	85.1	164.4	137.3	69.0	13.5	0.6	2 432
2012-16	633	10.4	87.9	159.2	152.5	78.7	18.3	1.5	2 542
Greenland									
2007-11	854	53.1	117.5	130.8	92.3	43.7	8.8	0.1	2 232
2012-16	819	40.4	106.3	119.2	88.3	44.7	8.1	0.4	2 037
Finland									
2005	57 745	10.3	57.4	116.3	112.9	51.5	10.7	0.6	1 803
2010	60 980	8.4	57.1	116.8	120.3	58.6	11.6	0.6	1 870
2015	55 472	6.2	46.4	98.0	109.8	57.1	12.2	0.7	1 650
2016	52 814	5.5	43.3	92.3	102.1	55.8	14.1	0.8	1 567
Åland									
2007-11	284	4.8	49.4	109.9	124.7	59.6	12.3	0.2	1 808
2012-16	286	3.5	45.1	118.0	120.3	59.4	9.7	0.7	1 792
Iceland									
2005	4 280	15.1	81.5	129.9	114.0	58.4	10.6	0.8	2 052
2010	4 907	12.9	72.9	137.7	127.5	73.7	14.6	0.2	2 197
2015	4 129	7.9	54.2	116.0	107.2	61.5	13.1	1.1	1 805
2016	4 034	6.5	48.5	109.2	108.6	59.7	14.7	1.8	1 745
Norway									
2005	56 754	8.0	58.6	124.4	118.6	48.6	8.6	0.4	1 839
2010	61 435	8.4	59.0	124.0	128.0	57.7	10.8	0.6	1 943
2015	59 048	4.6	42.4	109.7	117.6	60.1	11.1	0.8	1 760
2016	58 873	3.9	39.3	109.4	120.9	59.5	11.5	0.7	1 710
Sweden									
2005	101 346	6.2	46.6	109.5	124.9	55.9	10.3	0.5	1 769
2010	115 641	5.7	51.3	118.2	138.0	69.4	13.6	0.8	1 985
2015	114 869	4.3	42.5	112.2	128.0	67.5	14.2	0.9	1 849
2016	117 425	4.4	41.8	112.1	127.2	69.0	15.2	1.0	1 853

1 Births by women under 15 years are included

2 Births by women over 50 years are included

3 Total fertility rate: The imputed number of live births experienced by women during their fertile period, assuming that their mortality is zero during this period and that the age-specific fertility rates for the year in question are valid throughout the reproductive period

Source: DK, the Danish Health Data Authority; FO, Statistics Faroe Islands; GL, Statistics Greenland; FI & ÅL, Statistics Finland; IS, Statistics Iceland; NO, Statistics Norway; SV, Statistics Sweden

Table 2.2.2 Assisted reproduction technologies 2000-2015¹

	Denmark	Finland	Iceland	Norway	Sweden
<i>Treatments, IVF+ICSI</i>					
2000	7 077	4 323	298	4 029	6 586
2005	7 222	4 731	462	5 067	8 062
2010	11 721	4 861	618	6 557	9 593
2014	11 339	4 548	409	..	9 222
2015	11 635	4 629	428	..	..
<i>Frozen embryo transfers, FET</i>					
2000	792	2 488	83	301	1 208
2005	1 500	2 960	161	1 698	3 458
2010	2 275	3 280	257	2 046	4 948
2014	3 365	3 384	296	..	5 743
2015	4 033	3 610	324	..	..
<i>Number of live births, IVF+ ICSI + FET</i>					
2000	1 678	1 382	147	1 097	2 237
2005	1 786	1 534	167	1 521	2 874
2010	2 123	1 858	192	1 885	3 882
2014	2 978	1 658	150	..	4 071
2015	3 262	1 754	145	..	..

IVF = In vitro fertilization

ICSI = Intracytoplasmic sperm injection

FET = Frozen embryo transfer

1 Based on the year of treatment, not on the year of birth

Source: DK, the Danish Fertility Company; THL National Institute for Health and Welfare; IS, Medical Birth Registry of Iceland; NO, the Norwegian Directorate of Health; SV, National Board of Health and Welfare

Table 2.2.3 Assisted reproduction technologies, treatments per 1 000 women aged 15-49 years, 2000-2015¹

	Denmark	Finland	Iceland	Norway	Sweden
<i>IVF + ICSI</i>					
2000	..	3.5	..	..	3.3
2005	5.8	3.9	6.3	4.7	4.0
2010	9.3	4.2	8.0	5.8	4.6
2014	9.0	4.0	5.3	5.4	4.3
2015	9.2	4.0	5.5	..	..
<i>FET</i>					
2000	..	2.0	..	..	0.6
2005	1.5	2.5	2.2	1.0	1.3
2010	1.8	2.8	3.3	1.8	2.1
2014	2.7	2.9	3.8	2.6	2.7
2015	3.2	3.2	4.2	..	..
<i>Total IVF + ICSI, FET</i>					
2000	..	5.6	..	..	3.9
2005	7.8	6.6	8.5	5.7	5.3
2010	11.1	7.0	11.3	7.6	6.7
2014	11.7	6.9	9.1	8.0	7.0
2015	12.4	7.2	9.7	..	..
<i>Multiple births, % of all births after IVF²</i>					
2000	..	17.3	..	..	..
2005	20.3	11.3	28.5	24.2	6.5
2010	15.5	9.6	8.3	11.0	5.2
2014	10.2	4.8	8.6	11.1	4.7
2015	7.0	4.9	10.3	..	..
<i>Children born in multiple births, % of all children born after IVF²</i>					
2000	..	29.7	..	..	..
2005	34.1	20.5	44.3	39.2	12.2
2010	13.4	17.7	19.8	..	..
2014	18.8	9.0	15.9	20.0	..
2015	13.1	9.4	18.8	..	..
<i>IVF, ICSI and FET % of all live births²</i>					
2000	..	2.5	..	..	..
2005	3.3	2.6	3.9	2.6	2.7
2010	3.3	3.1	3.9	3.1	12.2
2014	5.1	2.9	3.5	3.4	12.9
2015	4.8	3.0	3.9	..	..

IVF = In vitro fertilization

ICSI = Intracytoplasmic sperm injection

FET = Frozen embryo transfer

1 Based on the year of treatment, not on the year of birth

Source: DK, the Danish Fertility Company; FI, THL National Institute for Health and Welfare; IS, Icelandic Medical Birth Register; NO, the Norwegian Directorate of Health; SV, National Board of Health and Welfare

Table 2.2.4 Stillbirths and infant mortality¹, 2005-2015

	Number		Per 1 000 births		Deaths per 1 000 live births			
	Still-births	Infant deaths	Still-births	Perinatal deaths ²	First 24 hours	1-6 days	7-27 days	Total under 1 year
Denmark ^{3,4,5,6}								
2005	309	285	4.8	7.5	1.7	1.1	0.6	4.4
2010	253	218	3.9	6.1	1.5	0.7	0.4	3.4
2014	235	238	4.1	6.8	1.8	1.0	0.4	4.1
2015	202	225	3.4	6.1	1.8	0.9	0.4	3.8
Faroe Islands ⁷								
2006-10	2	3	3.6	6.0	1.2	1.2	0.3	4.8
2011-15	1	3	1.3	1.1	0.6	1.0	1.0	3.9
Greenland ⁷								
2006-10	5	13	4.6	6.4	5.2	2.4	0.9	10.5
2011-15	..	..	..	..	..	..	..	..
Finland ³								
2005	182	174	3.1	4.9	1.0	0.7	0.3	3.0
2010	181	140	3.0	4.1	0.6	0.5	0.4	2.3
2014	163	124	2.8	3.9	0.6	0.5	0.4	2.2
2015	172	97	3.1	4.1	0.5	0.5	0.3	1.7
Åland ³								
2006-10	-	2	-	-	0.7	-	-	1.4
2011-15	2	-	1.4	1.4	-	-	-	-
Iceland ^{3,7}								
2005	8	10	1.9	3.3	0.7	0.7	0.2	2.3
2010	9	11	1.8	2.9	0.8	0.2	0.2	2.2
2014	11	9	2.5	3.4	0.7	0.2	0.7	2.1
2015	8	9	1.9	3.1	1.0	0.2	0.2	2.2
Norway ³								
2005	230	171	4.0	5.5	1.0	0.5	0.5	3.0
2010	246	157	3.9	5.1	0.8	0.3	0.5	2.5
2014	266	145	4.4	5.9	1.0	0.5	0.4	2.4
2015	219	136	3.7	4.8	0.7	0.5	0.3	2.3
Sweden ³								
2005	268	177	2.7	0.4	0.4	0.2	0.9	1.8
2010	278	179	2.4	0.3	0.3	0.3	0.7	1.6
2014	278	179	2.4	0.3	0.3	0.3	0.7	1.6
2015	..	..	..	..	..	..	..	..

1 Calculated according to year of death

2 Stillbirths and deaths in the first week of life

3 All registered pregnancies according to the MBRN criteria: All live born plus stillborn \geq 500 grams or \geq 22 weeks

4 The numbers are calculated according to year of birth, not year of death

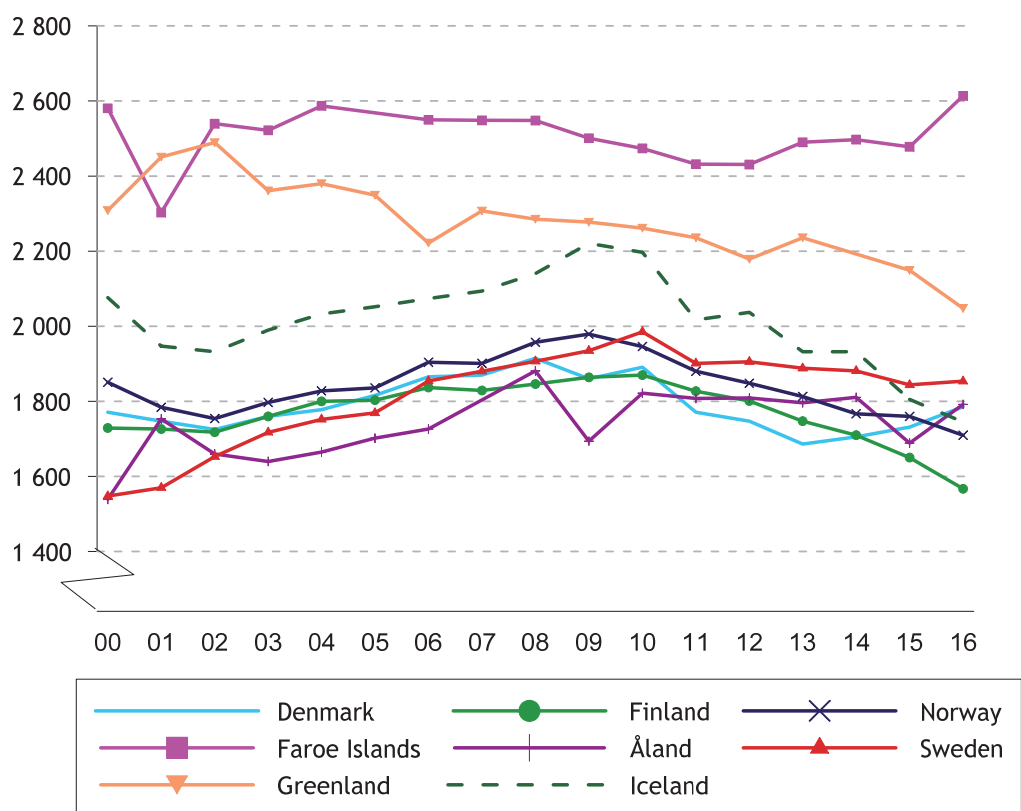
5 The numbers for 2006 are preliminary

6 Numbers regarding "First 24 hours" show the number of deaths the same day as the day of birth. Live born who die within 24 hours but at the calendar day after the birth is included in "1-6 days"

7 A child is considered stillborn at the 28th week of pregnancy or later

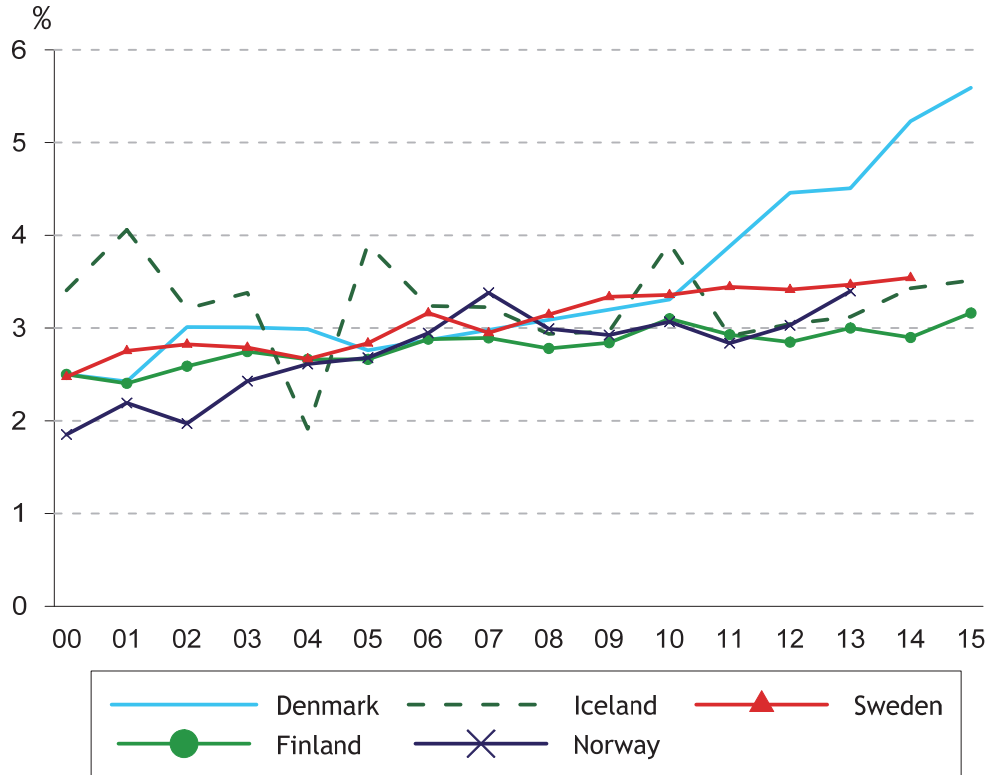
Source: DK, the Danish Health Data Authority; FO, Chief Medical Officer in the Faroe Islands; GL, Chief Medical Officer; FI & ÅL, Statistics Finland; IS, Statistics Iceland; NO, Statistics Norway; SV, Statistics Sweden

Figure 2.2.1 Total fertility rate¹ per 1 000 women aged 15-49, 2000-2016



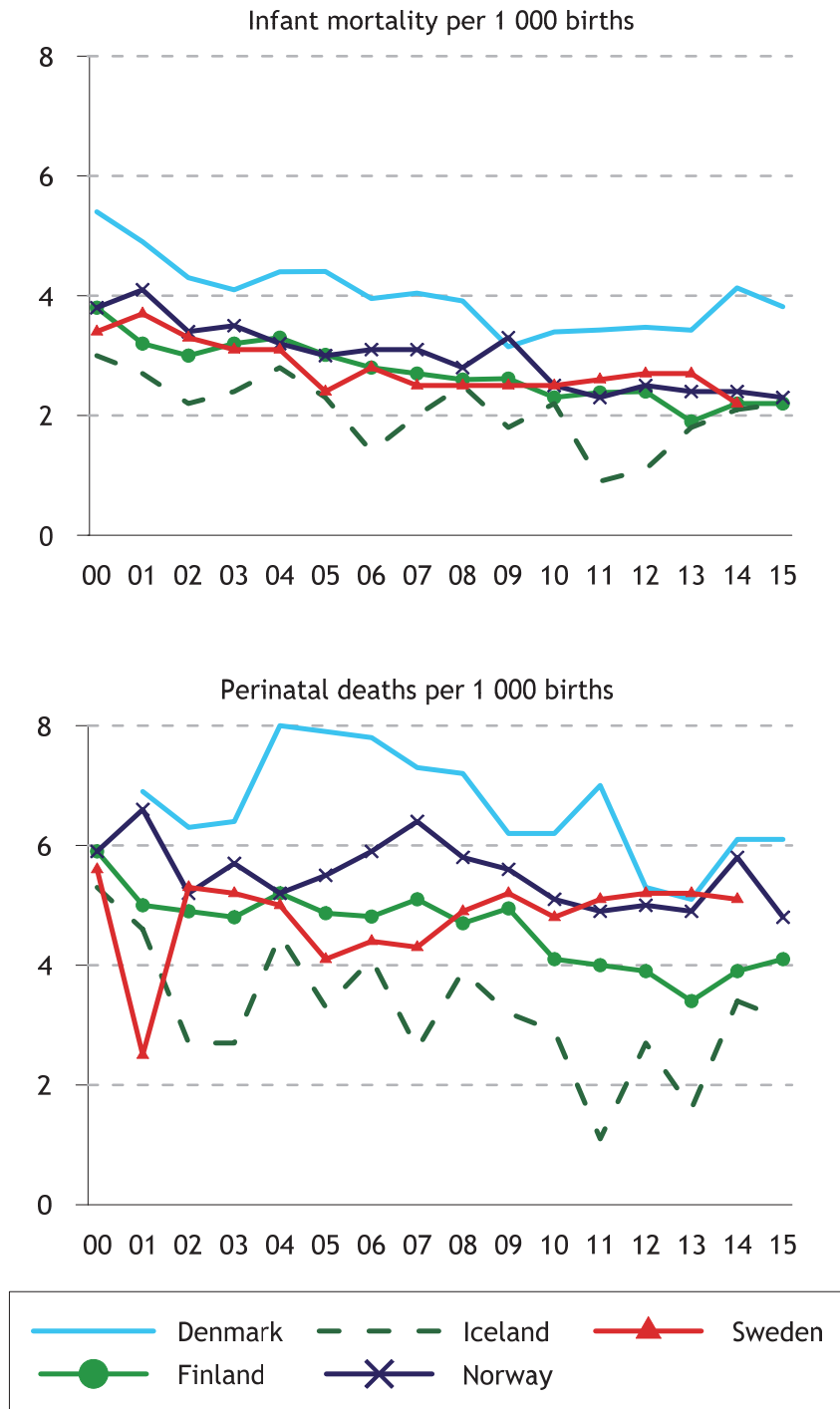
1 Total fertility rate: The imputed number of live births experienced by women during their fertile period, assuming that their mortality is zero during this period and that the age-specific fertility rates for the year in question are valid throughout the reproductive period

Figure 2.2.2 Assisted reproduction technologies, percentages of all live births 2000-2015



Source: DK, the Danish Fertility Company; FI, THL National Institute for Health and Welfare; IS, Icelandic Medical Birth Register; NO, the Norwegian Directorate of Health; SV, National Board of Health and Welfare

Figure 2.2.3 Infant deaths, and perinatal¹ deaths per 1 000 births, 2000-2015



¹ Perinatal deaths are the total number of stillbirths and deaths in the first week of life
 Source: DK, the Danish Health Data Authority; FO, Chief Medical Officer in the Faroe Islands; GL, Chief Medical Officer; FI & ÅL, Statistics Finland; IS, Statistics Iceland; NO, Statistics Norway; SV, Statistics Sweden

Table 2.2.5 Stillbirths and deaths during the first year of life per 1 000 births, with a birth weight of 1 000 grams or more, total and per 1 000 births, 2000-2015¹

	Number		Per 1 000 births	Deaths per 1 000 live births				
	Still- births	Infant deaths		Still- births	First 24 hours	1-6 days	7-27 days	28 days to 1 year
Denmark ²								
2000	183	238	2.9	0.6	1.3	0.5	1.2	3.6
2005	186	174	2.9	0.7	0.7	0.5	0.8	2.7
2010	138	97	2.2	0.3	0.4	0.3	0.7	1.6
2014	143	88	2.5	0.4	0.5	0.3	0.9	2.0
2015	115	86	2.0	0.2	0.4	0.2	0.7	1.5
Faroe Islands								
2000	-	7	-	2.7	4.1	1.3	1.3	9.7
2005	-	7	-	2.7	4.1	1.3	1.3	9.7
2010	4	2	6.1	1.5	-	-	1.5	3.1
2014	-	5	-	1.5	1.5	-	1.5	4.6
2015	1	3	1.3	1.1	0.6	1.0	1.0	3.9
Finland								
2000	149	150	2.6	0.5	0.5	0.5	1.1	2.7
2005	115	120	2.0	0.5	0.5	0.3	0.8	2.1
2010	114	97	1.9	0.3	0.4	0.3	0.7	1.6
2014	113	99	2.0	0.3	0.5	0.3	0.7	1.7
2015	105	63	1.9	0.3	0.4	0.2	0.3	1.1
Åland								
2006-10	-	2	-	-	0.7	-	0.7	-
2011-15	2	-	1.4	-	-	-	-	-
Iceland								
2000	13	5	3.0	-	0.2	0.2	0.7	1.2
2005	6	4	1.4	-	0.5	-	0.5	0.9
2010	7	9	1.4	0.2	0.2	0.2	1.2	1.9
2014	10	5	2.3	0.2	0.2	0.2	0.5	1.2
2015	8	5	2.0	0.2	0.2	0.0	0.7	1.2
Norway								
2000	195	151	3.3	0.8	0.3	0.3	1.1	2.6
2005	141	105	2.5	0.6	0.3	0.4	0.6	1.8
2010	145	112	2.3	0.5	0.2	0.4	0.8	1.8
2014	162	101	2.7	0.6	0.3	0.3	0.5	1.7
2015	129	86	2.2	0.4	0.3	0.2	0.6	1.4
Sweden								
2000	318	215	3.6	0.5	0.7	0.4	0.9	2.4
2005	263	182	2.6	0.4	0.4	0.2	0.9	1.8
2010	278	179	2.4	0.3	0.3	0.3	0.7	1.6
2014	317	161	2.8	0.3	0.3	0.1	0.6	1.4
2015	288	166	2.5	0.3	0.4	0.2	0.6	1.4

1 Calculated according to year of birth

2 Deaths first 24 hours: Death on same date as birth

Source: DK, the Danish Health Data Authority; FI, Statistics Finland & THL National Institute for Health and Welfare; IS, Medical Birth Registry of Iceland & Statistics Iceland; NO, National Institute of Public Health, (MFR); SV, the National Board of Health and Welfare

Table 2.2.6 Sales of hormonal contraceptives. ATC code G03A¹ and G02BB. DDD per 1 000 women aged 15-49 years/day, 2005-2016²

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	294	238	314	190	190	192	201	213
2010	287	232	193	201	167	204	217	207
2014	272	196	164	209	204	210	234	191
2015	265	197	148	209	202	212	236	183
2016	261	199	128	212	201	217	236	182

1 Excl. Implants (G03AC08), injections (G03AC06) and emergency contraceptives (G03AD). Intrauterine contraceptives (G02BA) are not included

2 See page 151 for more information regarding use of hormonal contraceptives

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

Table 2.2.7 Emergency contraceptives ATC code G03AD: number of packages sold per 1 000 women aged 15-49 years, 2005-2016

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	63	52	41	78	79	87	119	83
2010	81	81	53	83	84	91	140	100
2014	79	78	69	87	85	76	121	105
2015	81	75	63	87	88	83	119	115
2016	85	80	73	84	84	94	107	119

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

Table 2.2.8 Number of induced abortions, 2000-2015

	Number of abortions	Abortions per 1 000 women aged							Total abortion rate ³	Abortions per 1 000 live births
		15-19 ¹	20-24	25-29	30-34	35-39	40-44	45-49 ²		
Denmark										
2000-04	15 365	14.5	20.4	17.7	17.0	13.0	4.8	0.4	439	237
2005	15 434	16.0	21.6	17.7	16.6	13.2	5.2	0.4	454	238
2010	16 806	15.2	26.3	20.2	17.7	13.3	5.4	0.4	493	262
2014	15 608	12.2	22.9	20.7	17.0	11.7	5.1	0.4	450	271
2015	15 512	11.4	22.2	20.8	16.7	11.9	5.0	0.5	443	263
Faroe Islands										
2006-10	42	4.0	8.5	3.7	5.1	4.7	2.8	0.2	145	64
2011-15	28	1.8	5.7	3.8	3.6	3.7	1.7	0.6	105	46
Greenland										
2006-10	869	110.0	138.6	98.3	55.6	27.5	7.7	0.7	2 192	1 015
2011-15	826	95.1	117.5	92.1	57.8	30.6	10.4	0.5	2 019	1 011
Finland										
2000-04	10 869	15.3	16.4	12.6	10.7	7.7	3.1	0.2	330	192
2005	10 972	15.0	18.2	12.8	10.4	7.9	3.4	0.2	338	190
2010	10 303	12.2	17.1	13.1	9.9	7.8	3.1	0.2	317	168
2014	9 787	9.2	16.8	12.9	9.9	7.3	3.2	0.2	298	170
2015	9 441	8.4	15.4	12.6	10.3	7.2	3.3	0.3	288	170
Åland										
2006-10	67	14.3	29.5	20.2	13.6	7.0	4.1	0.2	445	235
2011-15	68	12.5	30.5	20.2	13.8	7.8	2.9	-	439	241
Iceland										
2000-04	940	21.4	23.4	17.3	13.6	9.2	4.6	0.3	449	225
2005	868	15.6	23.9	18.2	12.3	8.0	4.1	0.2	412	210
2010	978	16.0	23.0	19.2	13.4	11.4	3.5	0.5	435	199
2014	955	12.7	24.8	20.1	13.0	10.5	2.7	0.1	420	218
2015	926	12.5	18.8	19.8	14.2	10.3	5.3	0.4	407	224
Norway										
2000-04	14 008	17.3	27.1	19.4	15.1	10.6	3.8	0.3	470	246
2005	13 991	15.4	27.4	20.5	15.1	11.0	4.0	0.3	468	247
2010	15 738	14.1	29.2	23.1	16.9	11.7	4.4	0.4	500	256
2014	14 025	9.6	21.8	20.7	15.9	11.4	4.2	0.4	420	238
2015	14 008	8.3	21.1	21.1	16.4	11.3	4.2	0.5	415	237
Sweden										
2000-04	33 009	22.6	29.4	23.3	19.8	15.2	6.3	0.6	586	345
2005	34 978	23.4	31.4	24.3	19.8	16.0	7.2	0.7	614	345
2010	37 696	20.9	33.3	26.7	21.5	16.3	7.1	0.9	633	326
2014 ⁴	36 629	15.1	29.6	27.3	22.3	16.7	7.9		595	319
2015	38 071	14.4	30.6	29.9	23.7	17.0	8.2		619	331

1 Abortions for women under 15 years are included

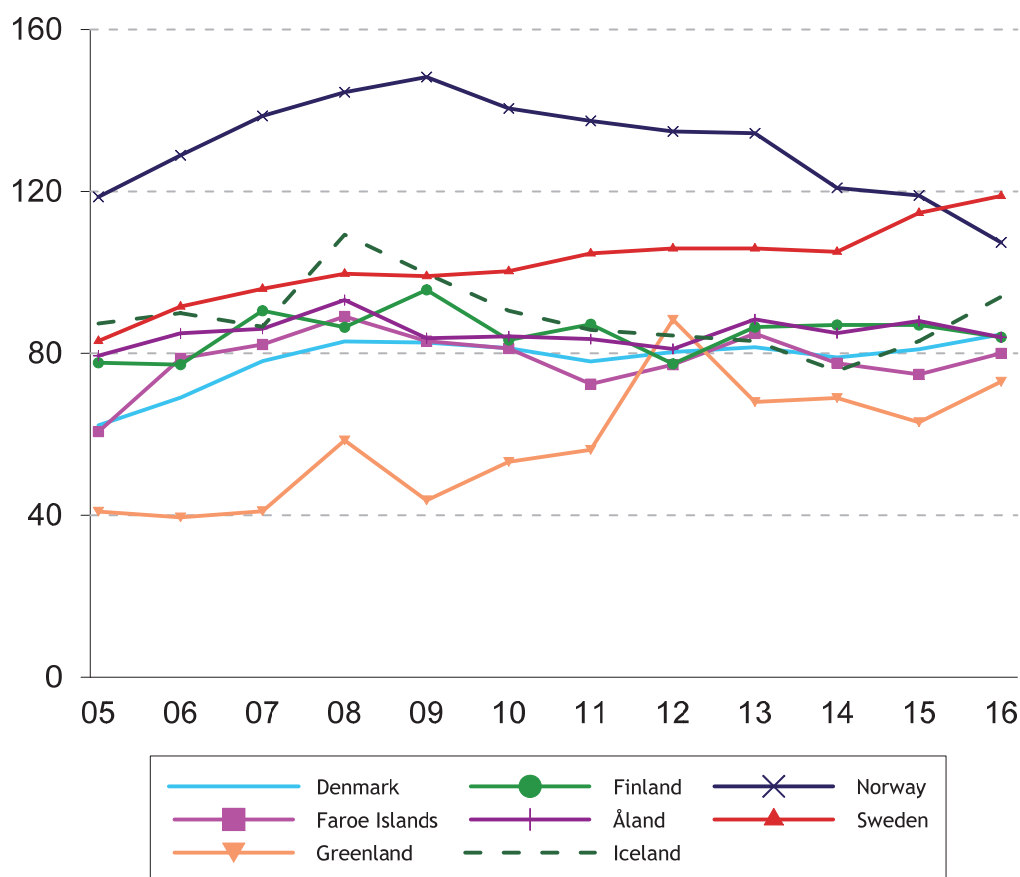
2 Abortions for women 50 years or more are included

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

4 New method for data collection from 2014. Among other changes: set age groups ≤19, 20-24, 25-29, 30-34, 35-39, 40 or more

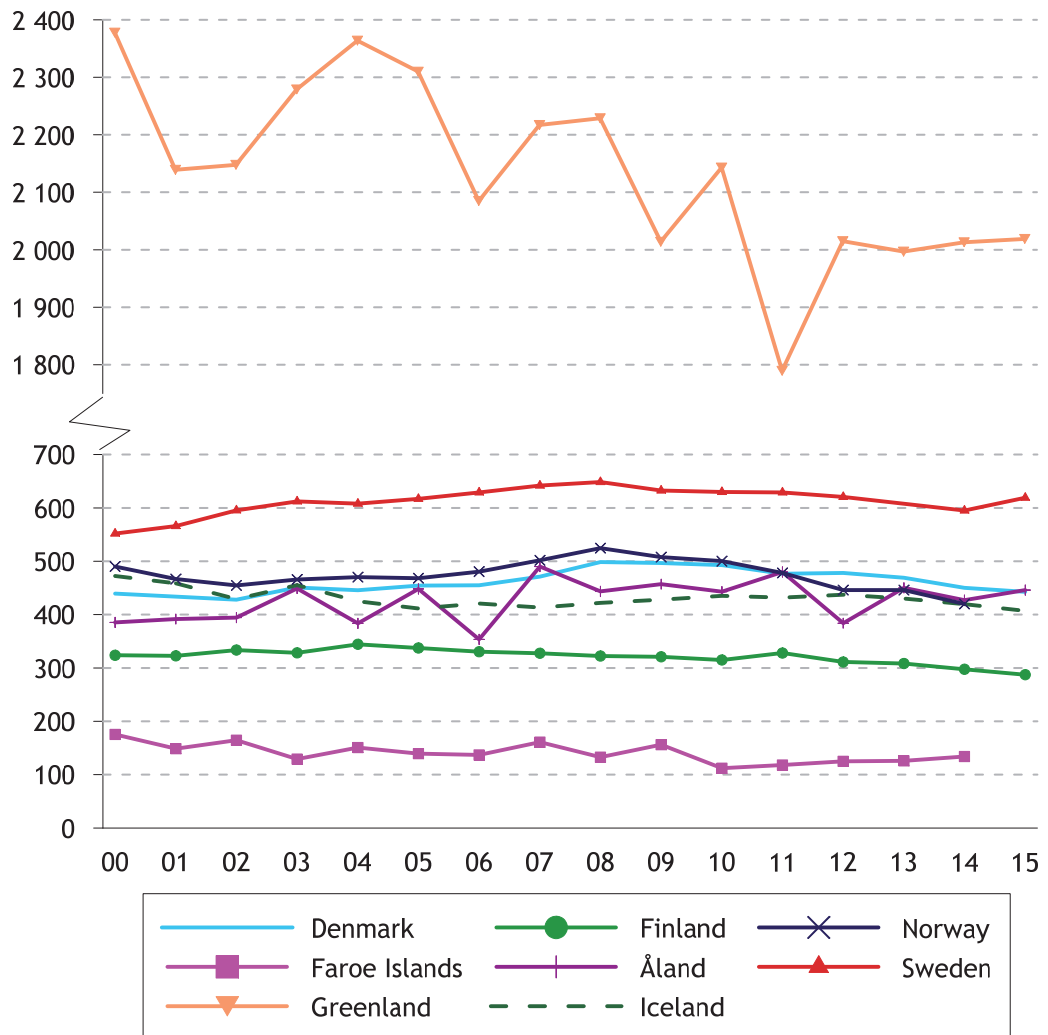
Source: The national abortion registers and THL National Institute for Health and Welfare Nordic Statistics on Induced Abortions: www.thl.fi/en/web/thlfi-en/statistics/statistics-by-topic/sexual-and-reproductive-health/abortions/induced-abortion-in-the-nordic-countries

Figure 2.2.4 Sales of emergency contraceptives per 1 000 women aged 15-49 years, 2005-2016



Source: DK, The Danish Health Data Authority; FO, Chief Pharmaceutical Officer; GL, National Pharmacy; FI & ÅL, FIMEA; IS, Icelandic Medicines Agency; NO, Norwegian Institute of Public Health; SV, Swedish eHealth Agency

Figure 2.2.5 Total abortion rate¹ per 1 000 women aged 15-49, 2000-2015



1 Total abortion rate: The imputed number of induced abortions experienced by women during their fertile period, assuming that their mortality is zero during this period and that the age-specific abortion rates for the year in question are valid throughout the reproductive period

Source: The national abortion registers

Chapter 3

Morbidity, Medical Treatment, Accidents and Pharmaceutical Products

Extra material

[Background tables Nowbase.org/Publications](#)
[The Nordic Cancer Union](#)

Introduction

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

3.1 Diseases related to lifestyle

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

The number of smokers in the Nordic countries has been decreasing during recent years, so has the differences in the number of smokers, both for men and for women as well as between countries. The incidence of lung cancer rates, as shown in Figure 3.1.1, reflects behaviour several years previously.

The proportion of people who are overweight is an increasing problem in the Nordic countries. The proportion is highest in Greenland, Finland and Iceland, and lowest in Faroe Islands, Sweden and Norway.

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

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

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

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

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

Table 3.1.1 Self-reported obesity rate, population aged 15+, 2015

	Denmark	Faroe Islands	Greenland ¹	Finland	Iceland ²	Norway	Sweden
Year	2013	2014	2014	2015	2012	2015	2014
Age			18+	15-74	18-79	16+	16-84
Proportion of people with BMI \geq 30, men	14	10	26	19	17	13	12
Proportion of people with BMI \geq 30, women	14	13	29	19	16	11	12

1 Measured data from the Population survey in Greenland, 2014

2 Self-reported data from the survey: "Health and Wellbeing of Icelanders 2012". Age 19-79

Source: DK, the National Boards of Health; FO, Public Health Council; IS, Directorate of Health; FI, THL National Institute for Health and Welfare, The Regional Health and Well-being Study (ATH); SV, Statistics Sweden

Table 3.1.2 Percentage of daily smokers by gender 2015

	Denmark	Faroe Islands ¹	Finland	Iceland	Norway	Sweden
Age	15+	15+	20-74	18+	16-74	16+
Smoking men as % of men in the age group	16	20	16	11	13	10
Smoking women as % of women in the age group	17	24	12	11	13	12

1 FO 2014

Source: DK, the National Board of Health; FO, Public Health Council; FI, THL National Institute for Health and Welfare, The Regional Health and Well-being Study (ATH); IS, Directorate of Health, Annual survey on determinants of health; NO, Norwegian Directorate of Health; SV, Statistics Sweden

Table 3.1.3 Percentage of daily users of snuff by gender 2015

	Denmark ¹	Faroe Islands ²	Finland ³	Iceland ⁴	Norway	Sweden
Age	16+	15+	20-74	18-69	16-74	16-84
Men using snuff as % of men in the age group	<1	.	3	6	15	21
Women using snuff as % of women in the age group	<1	.	<1	<1	4	4

1 Estimated

2 A survey from the Council of Public Health from March 2015 showed, that 38% of pupils in 9th grade have tried using snuff, of which 15% have tried it within the previous 30 days. The survey does not cover all of the population and was not subdivided by gender

3 2016

4 Annual survey on determinants of health

Source: DK, the National Board of Health; FO, Public Health Council; FI, THL National Institute for Health and Welfare, The Regional Health and Well-being Study (ATH); IS, Directorate of Health (from regular surveys on tobacco consumption); NO, Statistics Norway; SV, Statistics Sweden

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

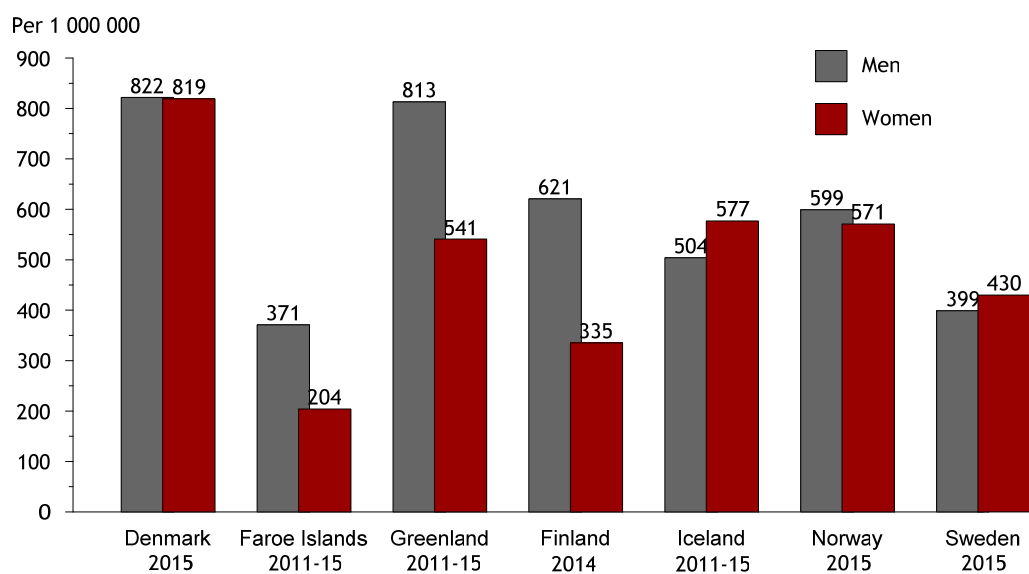
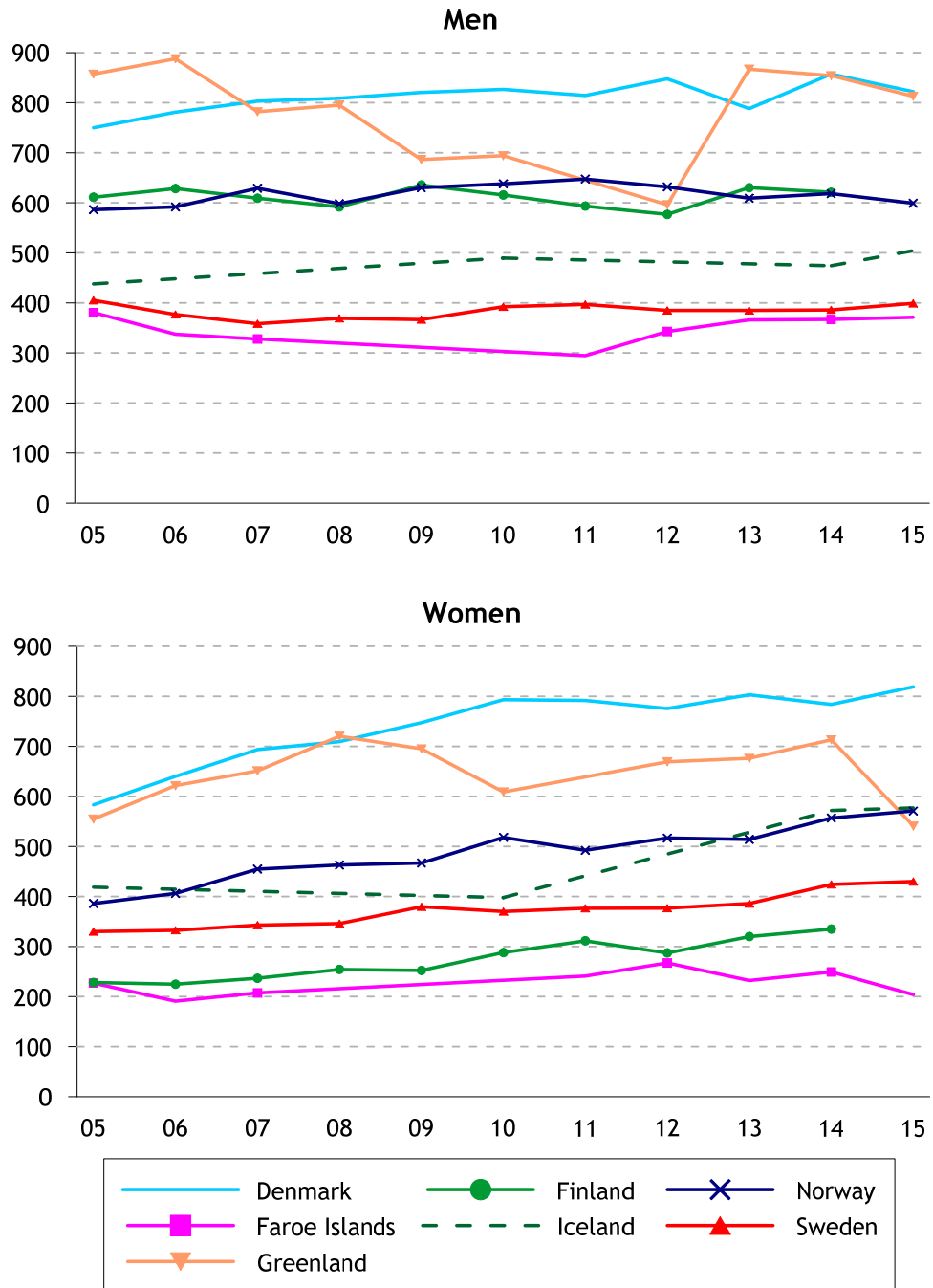


Figure 3.1.2 New cases of lung cancer per 1 000 000 inhabitants, 2005-2015¹



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

1 FO, GL, IS: 5-years average

Table 3.1.4 New cases of lung cancer per 1 000 000 inhabitants, 2000-2015

	Denmark	Faroe Islands ¹	Greenland	Finland	Iceland ¹	Norway	Sweden
Men							
2000	784	..	..	638	..	583	398
2005	750	381	857	611	438	586	399
2010	820	..	694	636	489	638	392
2014	857	367	854	621	474	618	386
2015	822	371	813	..	504	599	399
Women							
2000	522	..	..	283	..	292	232
2005	583	227	555	228	419	386	310
2010	793	..	609	288	398	518	370
2014	784	249	713	335	572	557	424
2015	819	204	541	..	577	571	430

1 2000 = 1996-00; 2005 = 2000-05; 2010 = 2006-10; 2014 = 2010-14; 2015 = 2011-15

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

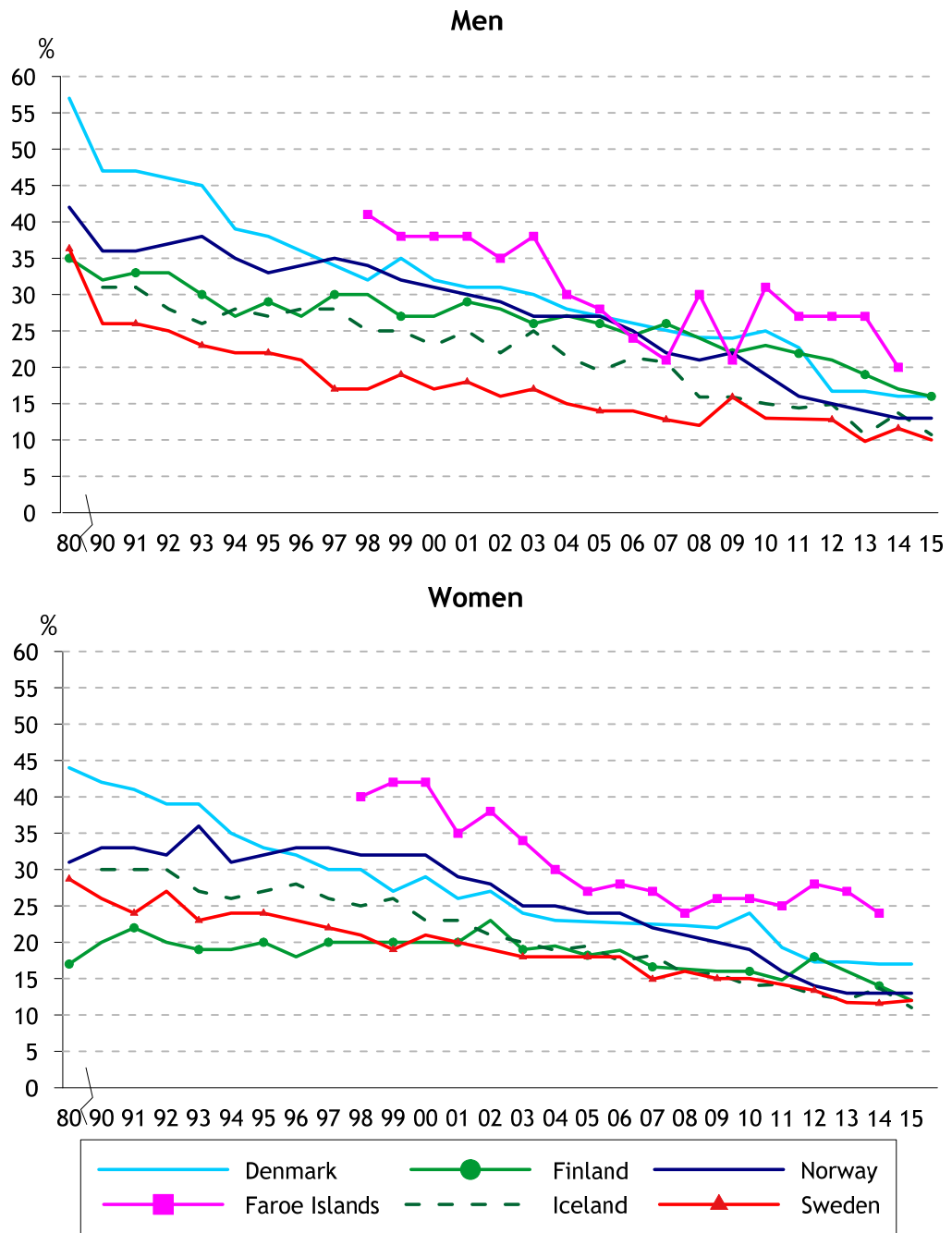
Table 3.1.5 Sales of drugs used for nicotine dependence (ATC-group N07BA), DDD/1 000 inhabitants/day, 2005-2016

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N07BA01								
Nicotine								
2005	7.6	3.7	1.7	5.3	5.6	19.4	3.7	6.7
2010	8.3	3.9	3.3	8.4	9.1	19.6	5.0	8.0
2014	8.9	4.3	1.3	10.5	10.4	22.6	6.5	8.5
2015	8.9	4.5	2.4	10.8	10.6	24.5	7.0	8.7
2016	..	5.2	5.7	11.5	11.5	24.7	7.3	8.8
N07BA03								
Varenicline¹								
2010	0.7	1.0	0.1	0.4	0.1	1.0	0.9	0.5
2014	0.2	0.4	0.1	0.2	0.2	0.8	0.5	0.4
2015	0.3	0.4	0.1	0.5	0.2	0.7	0.5	0.4
2016	0.3	0.4	0.2	0.5	0.2	0.7	0.5	0.4

1 Varenicline was introduced on the market in December 2006

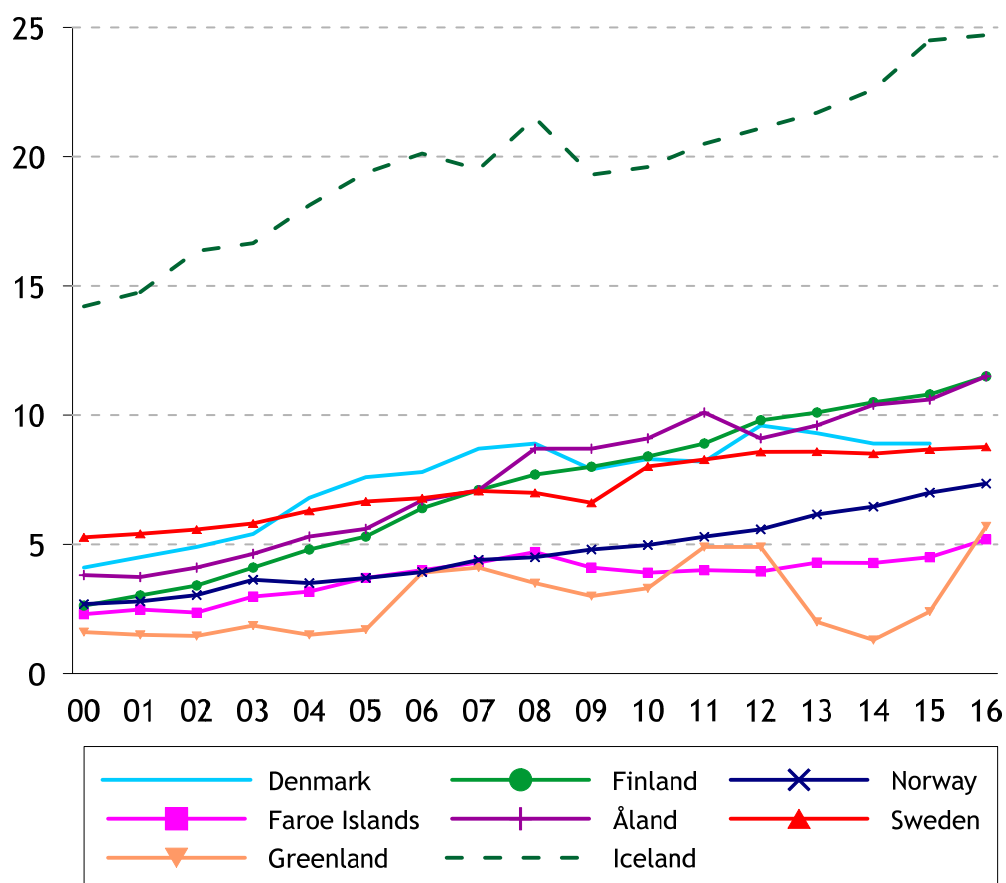
Source: DK, the Danish Health Data Authority; FO, Chief Pharmaceutical Officer; GL, Central Pharmacy in Copenhagen County; FI & ÅL, Finnish Medicines Agency; IS, Icelandic Cancer Society; NO, Norwegian Institute of Public Health; SV, Swedish eHealth Agency

Figure 3.1.3 Percentage of daily smokers by gender, 1980-2015



Source: OECD, and National Boards of Health; IS, Directorate of Health FO, Public Health Council; FI, THL National Institute for Health and Welfare; SV, Statistics Sweden

Figure 3.1.4 Sales of drugs used for nicotine dependence (ATC-group N07BA), DDD/1 000 inhabitants/day, 2000-2016



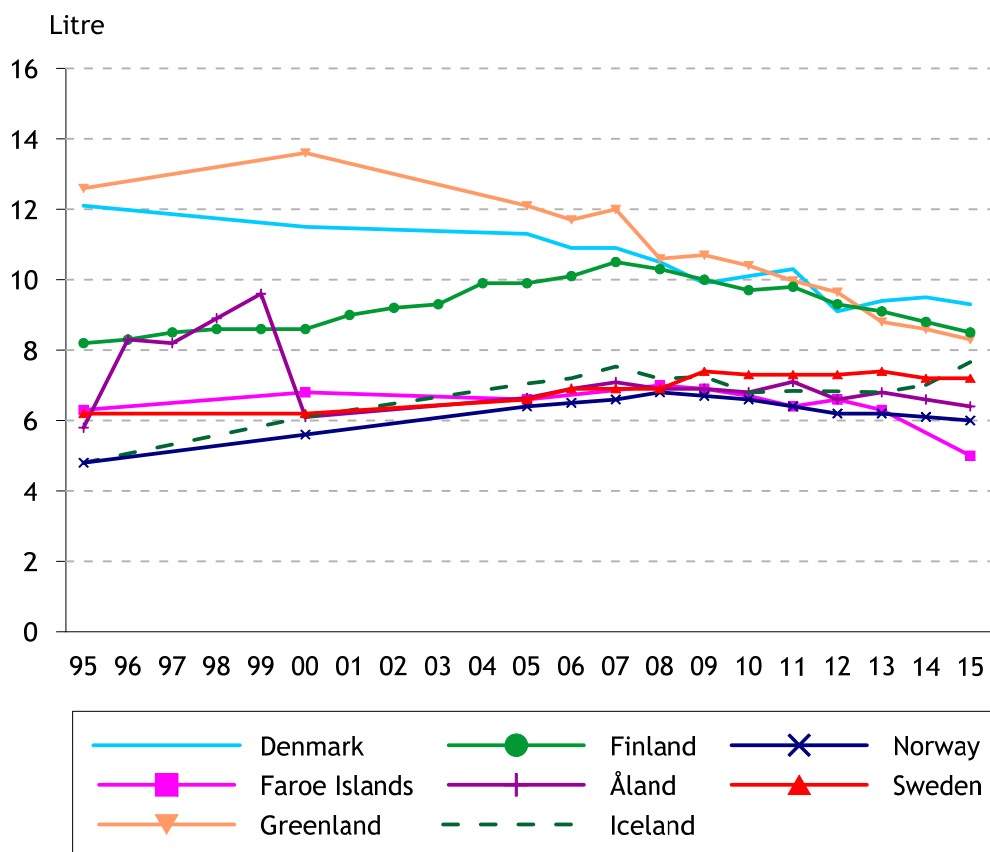
Source: DK, the Danish Health Data Authority; FO, Chief Pharmaceutical Officer; GL, Central Pharmacy in Copenhagen County; FI and ÅL, Finnish Medicines Agency; IS, Icelandic Medicines Agency; NO, Norwegian Institute of Public Health; SV, Swedish eHealth Agency and National Board of Health and Welfare

Table 3.1.6 Sales of alcoholic beverages in litres of 100 per cent pure alcohol per inhabitant aged 15 years and over, 2005-2015

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2000	11.5	6.8	13.6	8.6	6.1	6.1	5.6	6.2
2005	11.3	6.6	12.1	10.0	6.6	7.1	6.4	6.6
2010	11.3	6.7	10.4	9.7	6.8	6.8	6.6	7.3
2014	9.5	6.3	8.6	8.8	6.6	7.0	6.1	7.2
2015	9.3	5.0	8.3	8.5	6.4	7.7	6.0	7.2

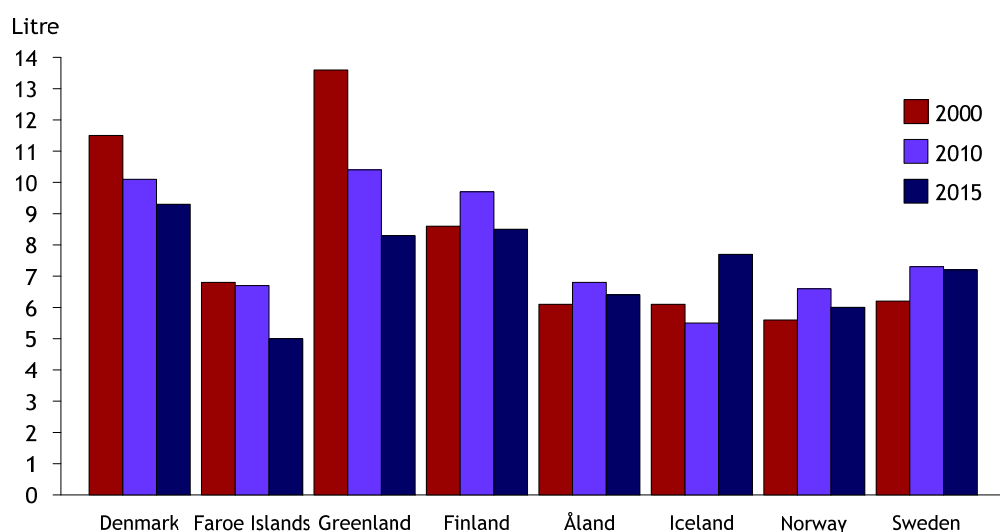
Source: DK, FO, GL, IS, NO: The central statistical bureaus; FI & ÅL: THL National Institute for Health and Welfare; SV: Public Health Agency of Sweden

Figure 3.1.5 Sales of alcoholic beverages in litres of 100 per cent pure alcohol per inhabitant aged 15 years and over, 1995-2015



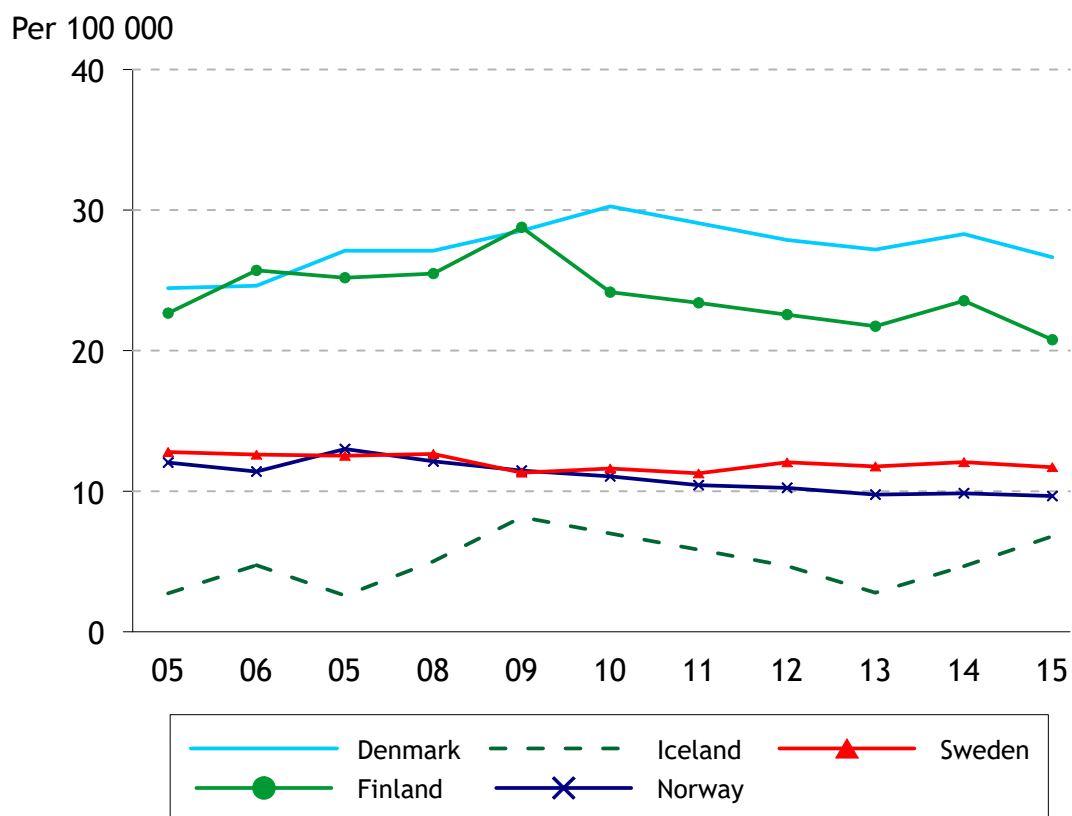
Source: DK, FO, GL, IS, NO: The central statistical bureaus; FI & ÅL: THL National Institute for Health and Welfare; SV: Public Health Agency of Sweden

Figure 3.1.6 Sales of alcoholic beverages in litres of 100 per cent pure alcohol per inhabitant aged 15 years and over, 2000, 2010 and 2015

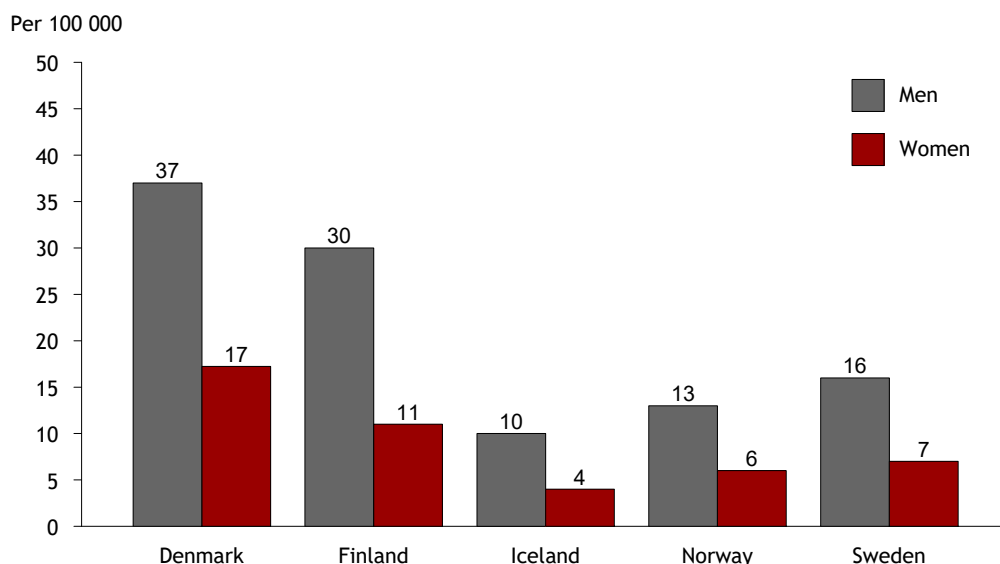


Source: DK, FO, GL, IS, NO: The central statistical bureaus; FI & ÅL: THL National Institute for Health and Welfare; SV: Public Health Agency of Sweden

Figure 3.1.7 Patients treated in somatic hospitals for alcoholic liver disease (ICD-10 K70) per 100 000 inhabitants, 2005-2015



Source: DK, the Danish Health Data Authority; FO, Ministry of Health; FI, THL National Institute for Health and Welfare; IS, Directorate of Health; NO, Norwegian Patient Register; SV, National Board of Health and Welfare

Figure 3.1.8 Patients treated in somatic hospitals for alcoholic liver disease per 100 000 inhabitants, 2015

ICD-10 K70

Source: DK, the Danish Health Data Authority; FO, Ministry of Health; FI, THL National Institute for Health and Welfare; IS, Directorate of Health; NO, Norwegian Patient Register; SV, National Board of Health and Welfare

Table 3.1.7 Diagnosed cases of tuberculosis per 100 000 inhabitants, 2000-2015

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
Men								
2000	12.1	20.8	50.0	12.4	7.9	2.8	5.8	5.2
2005	9.5	-	178.1	8.0	-	5.4	6.2	6.8
2010	7.8	-	220.5	6.9	7.2	5.0	7.4	8.0
2014	6.9	2.0	232.1	5.4	-	3.0	7.2	7.4
2015	8.8 ¹	3.9	165.8	6.2	6.9	3.0	7.3	10.0 ¹
Women								
2000	8.5	4.5	111.0	8.5	-	6.4	6.2	6.2
2005	6.2	-	165.1	5.8	7.5	2.0	6.1	6.1
2010	5.3	8.7	192.3	5.0	-	8.9	6.3	6.3
2014	4.6	-	113.1	4.2	-	2.5	5.4	6.6
2015	4.4	4.2	105.9	3.7	-	1.8	4.9	6.9

ICD-10: A15-A19

1 The increase is due to increased immigration from countries where tuberculosis remains common

Source: DK, the Danish Health Data Authority; FO, Chief Medical Officer; GL, Chief Medical Officer; FI & ÅL, THL National Institute for Health and Welfare; IS, Directorate of Health; NO, Norwegian Institute of Public Health; SV, Public Health Agency of Sweden

Table 3.1.8 Confirmed new cases of HIV/AIDS¹, 2005-2016

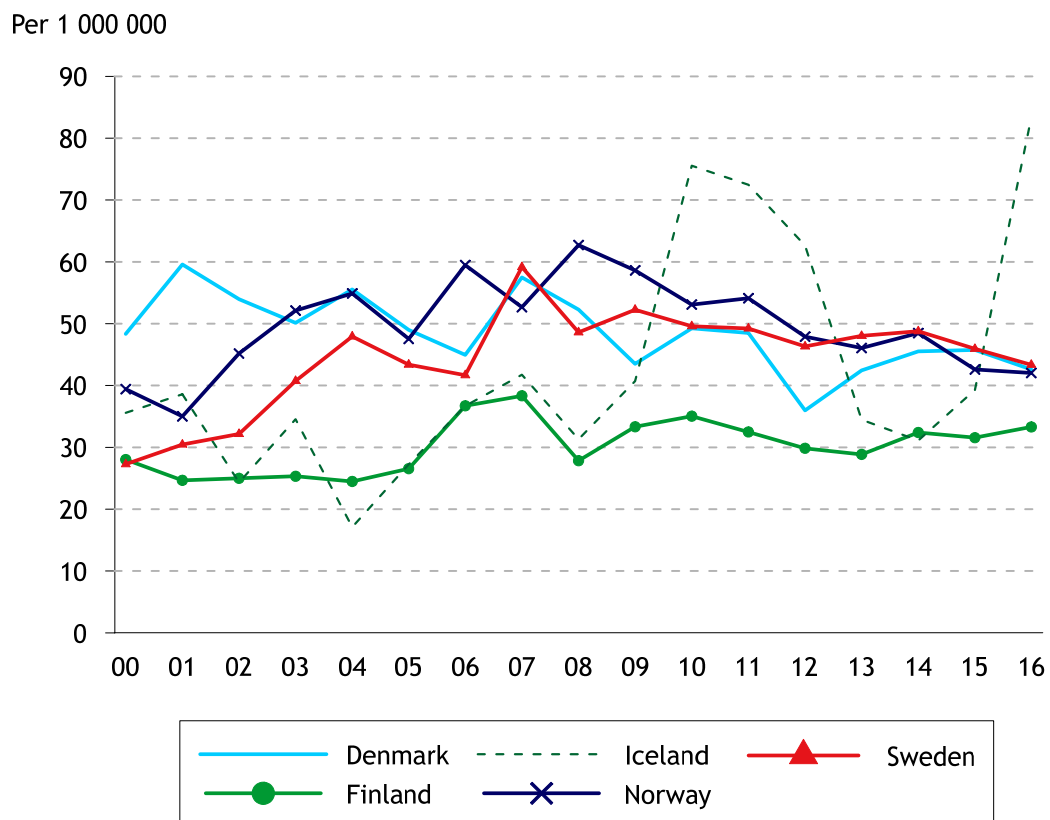
	Denmark	Faroe Islands	Greenland	Finland	Of which Åland	Iceland	Norway	Sweden ²
Men								
2005	192	-	4	96	2	5	122	228
2010	201	1	2	132	-	18	173	285
2015	194	-	3	130	-	11	145	276
2016	191	..	2	124	-	20	157	267
Women								
2005	71	-	2	35	-	3	97	164
2010	72	-	1	56	-	6	85	180
2015	66	-	2	43	-	2	76	174
2016	53	..	-	59	-	7	63	162
Total								
2005	263	-	6	131	2	8	219	392
2010	273	1	3	188	-	24	258	465
2015	260	-	5	173	-	13	221	450
2016	244	1	2	183	-	27	220	430

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

2 HIV only
ICD-10 B20

Source: DK, the Danish Health Data Authority; FO, Chief Medical Officer; GL, Chief Medical Officer; FI & ÅL, THL National Institute for Health and Welfare; IS, Directorate of Health; NO, Norwegian Institute of Public Health (MSIS); SV, Public Health Agency of Sweden

Figure 3.1.9 Confirmed new cases of HIV/AIDS per 1 000 000 inhabitants, 2000-2016



ICD-10 B20

Source: DK, the Danish Health Data Authority; FO, Chief Medical Officer; GL, Chief Medical Officer; FI & ÅL, THL National Institute for Health and Welfare; IS, Directorate of Health; NO, Norwegian Institute of Public Health; SV, Public Health Agency of Sweden

Table 3.1.9 Notified cases of gonorrhoea per 100 000 inhabitants aged 15+

	Denmark	Faroe Islands	Greenland ²	Finland	Åland	Iceland	Norway	Sweden
Men								
2005	18	4	1 535	7	8	12	12	16
2010	17	-	2 295	7	7	7	19	13
2014	54 ¹	-	3 021	8	7	20	27	21
2015	71	-	2 855	8	-	29	33	13
Women								
2005	2	-	2 124	2	-	4	3	3
2010	5	-	3 358	2	-	3	2	5
2014	29 ¹	-	3 922	3	-	9	6	7
2015	47	-	4 089	2	7	6	8	4

1 The large increase from 2013 to 2014 is due to the inclusion from 2014 of data from the Danish Microbiology Database (MiBa), which is automatically updated with test results from clinical microbiological hospital departments

2 Before 2009 gonorrhoea were reported individually to the Chief Medical Officer. Data afterwards are given from the Laboratory on Queen Ingrid's Hospital, Nuuk

Source: DK, the Danish Health Data Authority; FO, Chief Medical Officer; GL, Chief Medical Officer; FI & ÅL, THL National Institute for Health and Welfare; IS, Directorate of Health; NO, Institute of public health (MSIS); SV, Public Health Agency of Sweden

Table 3.1.10 Notified cases of syphilis per 100 000 inhabitants aged 15+

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
Men								
2005	5	-	3	3	8	3	6	2
2010	16	-	..	5	-	2	6	3
2014	17	-	136	5	-	17	8	4
2015	30	-	111	7	-	16	8	6
Women								
2005	1	-	4	2	-	1	-	-
2010	2	-	..	3	-	1	1	1
2014	2	1	92	3	-	1	1	1
2015	3	-	140	2	-	2	1	1

Source: DK, the Danish Health Data Authority; FO, Chief Medical Officer; GL, Chief Medical Officer; FI & ÅL, THL National Institute for Health and Welfare; IS, Directorate of Health; NO, Institute of public health (MSIS); SV, Public Health Agency of Sweden

Table 3.1.11 Diagnosed cases of Chlamydia per 100 000 inhabitants

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland ¹	Norway	Sweden ²
Men								
2000	165	79	2 791	180	95	479	326	187
2005	324	231	3 852	197	221	412	330	317
2010	383	286	5 277	202	196	551	351	340
2014	435	215	4 440	207	84	405	386	321
2015	446	311	3 871	211	304	469	393	332
Women								
2000	384	..	4 817	272	207	781	.	246
2005	554	..	5 797	288	499	643	524	411
2010	622	403	8 762	276	251	849	567	445
2014	659	374	8 045	280	112	626	580	424
2015	672	442	6 932	285	360	715	589	436

1 Notified cases. Cases verified by laboratories

2 Possible underrepresentation in 2005-06, due to a mutated form of chlamydia, which was diagnosable at the time

Source: DK, the Danish Health Data Authority; FO, Chief Medical Officer; GL, Chief Medical Officer; FI & ÅL, THL National Institute for Health and Welfare; IS, Directorate of Health; NO, Institute of Public Health (MSIS); SV, Public Health Agency of Sweden

3.2 Cancer

All the Nordic countries have population-based cancer registers and all the countries except Sweden have centralized coding and classification. The Danish cancer registry is the oldest and was founded in 1942. A decade later, in 1952-1954, the Norwegian, Finnish and Icelandic cancer registers were established. The Swedish cancer registry was founded in 1958.

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

The incidence of cancer increases with age. The annual number of cases of cancer is increasing in all the Nordic countries, and this trend remains after adjusting for differences in the size and age structure of the population.

The development of cancer diseases in the Nordic countries remains analogous for most forms of cancer, but there are interesting differences. In general, the number of cases has increased with time, with a few exceptions of decreasing incidence such as for cancer of the stomach. The decrease in the incidence of cancer of the cervix in the Nordic countries is related to the public screening programmes to detect pre-cancerous lesions and early lesions, and the ensuing treatment. The screening is to be done every three or five years. Denmark, Iceland and Sweden start the screening at 23 years, the Faroe Islands at 25 years, Norway at 29 years and Finland at 30 years. The upper age limit varies from 60 years in the Faroe Islands and Finland to 69 years in Norway (Table 3.2.9). In the future the HPV vaccination programmes will make the screening of cancer of the cervix less relevant for young women.

The incidence of breast cancer, cancer of the prostate and colorectal cancer is increasing in almost all countries. Dietary factors are probably significant for this development, but for cancer of the breast and prostate, hormonal factors also play an important role. All Nordic countries excluding Greenland have a breast cancer screening programme. In Denmark, the Faroe Islands, Finland and Norway, women aged 50-69 years are screened every two years. The age groups are wider in Iceland (40-69 years) and Sweden (40-74 years). The cost-effectiveness of breast cancer screening has been discussed in recent years. A meta-analysis from 2016 stated that breast cancer mortality is generally reduced with mammography screening, although estimates are not statistically significant at all ages and the size of the effects are small. Advanced cancer is reduced with screening for women aged 50 years or older¹. Denmark and Sweden have started a national screening programme for cancer of the colon and rectum, and there are similar regional pilot projects in Finland and Norway. Finland had a pilot project on prostate cancer screening, but this screening has not been included in the national screening programme.

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. None of the Nordic countries have screening programmes for lung or testicular cancer (Table 3.2.9).

¹ Nelson HD, Fu R, Cantor A, Pappas M, Daeges M, Humphrey L. Effectiveness of Breast Cancer Screening: Systematic Review and Meta-analysis to Update the 2009 U.S. Preventive Services Task Force Recommendation. *Ann Intern Med.* 2016 Feb 16;164(4):244-255.

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

	Total ¹	C62 Testis	C61 Prostate	C16 Stomach	C18-21 Colon and rectum	C25 Pancreas	C33-34 Lungs	C43 Melanoma of the skin
Denmark								
2005	6 534	99	1 597	123	918	163	818	340
2010	5 923	117	1 425	144	848	171	820	310
2014	6 293	95	1 538	118	884	157	788	327
2015	6 918	97	1 612	141	1 117	184	822	369
Faroe Islands								
2006-10	..	..	..	..	..	..	..	..
2010-14	3 827	97	1 090	121	646	194	371	81
Greenland								
2006-10	3 060	33	205	218	364	132	694	33
2011-15	3 335	41	212	226	519	157	813	48
Finland								
2005	5 282	53	2 076	152	495	165	628	160
2010	5 391	49	1 753	149	530	192	636	240
2014	5 804	65	1 886	131	582	190	630	273
2015	5 762	67	1 787	133	621	200	623	302
Åland								
2006-10	6 440	59	2 667	192	589	295	530	265
2011-15	6 817	70	2 659	140	728	140	644	336
Iceland								
2006-10	4 401	70	1 406	116	476	82	489	123
2011-15	4 454	60	1.278	102	513	125	504	108
Norway								
2005	5 574	109	1 592	127	750	124	586	249
2010	6 183	111	1 723	125	836	129	638	304
2014	6 097	132	1 893	117	828	138	609	328
2015	6 299	111	1 938	109	840	159	599	390
Sweden								
2005	5 557	63	2 207	129	635	100	405	242
2010	5 560	64	2 077	110	690	111	392	314
2014	5 798	77	2 020	117	691	126	385	354
2015	6 041	76	2 130	102	725	135	399	413

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

1 ICD-10 Chapter C, except C44 and C46.0, incl. D09-0, D32, D33, D41.4 and D43

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

	Total ¹	C62 Testis	C61 Prostate	C16 Stomach	C18-21 Colon and rectum	C25 Pancreas	C33-34 Lungs	C43 Melanoma of the skin
Denmark								
2005	5 661	103	1 249	140	845	172	856	239
2010	6 099	92	1 445	139	887	177	831	303
2014	6 293	103	1 460	139	992	161	791	339
2015	6 363	101	1 429	131	1 022	166	754	349
Faroe Islands								
2006-10	..	..	..	..	..	..	..	..
2011-15	3 811	107	1 064	125	637	194	369	84
Greenland								
2006-10	5 472	55	340	365	581	213	1 652	43
2011-15	5 201	33	380	294	986	251	1 259	51
Finland								
2005	5 842	53	2 282	178	552	186	706	170
2010	5 095	47	1 668	136	519	184	586	212
2014	5 093	68	1 502	130	552	181	562	239
2015	5 174	70	1 554	122	559	180	545	278
Åland								
2006-10	4 640	70	1 404	93	522	139	371	278
2011-15	5 722	69	2 150	117	599	116	567	289
Iceland								
2006-10	5 566	67	1 826	148	602	104	640	146
2011-15	5 018	60	1 452	116	575	144	589	120
Norway								
2005	6 336	109	1 824	161	861	139	662	276
2010	6 764	111	1 859	139	927	144	704	321
2014	6 476	122	1 933	126	907	146	654	413
2015	6 489	110	1 937	118	886	166	626	403
Sweden								
2005	5 362	64	2 101	126	618	97	391	236
2010	5 155	65	1 874	102	656	101	361	298
2014	5 281	77	1 903	94	612	116	330	359
2015	5 377	78	1 830	93	652	120	347	383

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

1 ICD-10 Chapter C, except C44 and C46.0, incl. D09-0, D32, D33, D41.4, D42 and D43

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

	Total ¹	C50 Breast	C53 Cervix uteri	C16 Stomach	C18-21 Colon and rectum	C25 Pancreas	C33-34 Lungs	C43 Melanoma of the skin
Denmark								
2006	6 788	1 507	140	75	759	158	694	293
2010	6 137	1 842	130	65	765	164	793	345
2014	6 207	1 663	145	63	886	164	784	414
2015	6 485	1 676	131	76	950	166	819	447
Faroe Islands								
2006-10	..	..	..	..	..	..	..	..
2010-14	2 738	767	92	70	415	84	204	70
Greenland								
2006-10	3 159	421	278	75	263	128	609	53
2011-15	3 103	639	197	74	516	123	541	43
Finland								
2005	4 449	1 505	47	101	452	176	225	140
2010	5 270	1 779	53	100	503	195	288	243
2014	5 386	1 795	63	97	508	216	335	239
2015	5 351	1 844	58	86	527	206	334	248
Åland								
2006-10	5 393	1 518	15	147	604	236	398	324
2011-15	4 640	1 404	70	93	522	139	371	278
Iceland								
2006-10	3 949	1 224	92	77	393	96	507	167
2011-15	4 291	1 289	99	72	460	108	577	150
Norway								
2005	4 978	1 198	126	97	736	124	386	243
2010	5 382	1 161	132	72	748	137	518	317
2014	5 655	1 301	132	73	810	147	557	387
2015	5 763	1 325	144	62	833	159	571	381
Sweden								
2005	5 213	1 529	94	74	647	97	330	228
2010	5 877	1 682	91	69	637	103	370	287
2014	6 781	2 005	113	64	636	134	424	379
2015	6 809	1 915	115	61	654	137	430	393

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

1 ICD-10 Chapter C, except C44 and C46.0, incl. D09-0, D32, D33, D41.4, D42 and D43

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

	Total ¹	C50 Breast	C53 Cervix uteri	C16 Stomach	C18-21 Colon and rectum	C25 Pancreas	C33-34 Lungs	C43 Melanoma of the skin
Denmark								
2005	4 894	1 350	148	57	628	133	619	268
2010	5 357	1 619	126	56	647	139	679	324
2014	5 329	1 461	144	53	730	132	641	384
2015	5 497	1 457	128	62	773	134	663	411
Faroe Islands								
2006-10	..	..	..	..	..	..	..	..
2010-16	2 526	705	86	59	378	80	192	75
Greenland								
2006-10	4 957	515	312	127	506	226	1 022	44
2011-15	5 254	959	259	181	939	213	1 036	53
Finland								
2005	3 864	1 347	45	86	379	146	185	127
2010	4 037	1 430	49	69	358	134	208	196
2014	4 267	1 481	61	72	378	155	244	206
2015	4 188	1 502	56	62	389	145	243	212
Åland								
2006-10	4 179	1 247	13	122	390	166	307	272
2011-15	3 754	1 163	63	69	428	107	292	253
Iceland								
2006-10	4 450	1 388	98	85	442	107	587	178
2011-15	3 709	1 118	84	59	391	93	514	128
Norway								
2005	4 661	1 173	125	85	658	108	373	235
2010	4 996	1 116	132	62	668	120	486	302
2014	4 961	1 234	134	65	727	130	507	364
2015	5 076	1 252	144	54	742	137	514	357
Sweden								
2005	4 957	1 358	90	58	518	81	281	205
2010	5 182	1 480	88	56	509	86	304	256
2014	5 829	1 660	96	51	512	99	308	310
2015	5 991	1 681	114	48	512	110	338	347

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

1 ICD-10 Chapter C, except C44 and C46.0, incl. D09-0, D32, D33, D41.4, D42 and D43

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

	Denmark	Greenland ¹	Finland	Åland ¹	Iceland ¹	Norway	Sweden
Boys				M+W			
2005	67	-	47	.	24	37	62
2010	55	109	48	-	53	37	75
2014	40	158	48	-	47	48	57
2015	24	-	52	-	35	61	47
Girls							
2005	63	-	56	.	31	32	44
2010	58	-	20	-	37	36	63
2014	38	0	55	-	37	42	45
2015	24	-	41	-	37	44	42
Total							
2005	65	-	51	42	27	34	53
2010	56	227	17	-	45	36	69
2014	39	81	51	-	42	45	51
2015	24	-	46	-	36	53	45

1 2000 = 1996-00; 2005 = 2000-05; 2010 = 2006-10; 2014 = 2010-14; 2015 = 2011-15

ICD-10 C91-95

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

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

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2015	2010-14	2011-15	2015	2011-15	2011-15	2015	2015
<i>Men, Age</i>								
0-24	8	-	-	4	-	-	9	5
25-44	64	-	-	44	56	71	84	93
45-64	1 106	686	1 015	560	401	667	806	650
65-84	4 601	3 134	2 981	2 442	3 161	2 663	3 889	2 860
85+	5 444	2 430	3 650	3 970	3 383	3 171	6 189	3 856
<i>Women, Age</i>								
0-24	12	-	-	5	-	-	6	9
25-44	85	62	115	36	104	65	103	68
45-64	923	412	931	311	370	448	741	532
65-84	3 257	1 761	3 053	1 459	1 166	2 132	3 267	2 277
85+	4 126	1 548	1 898	2 013	3 465	3 735	4 407	2 756

ICD-10 C18-21

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

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

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2015	2010-14	2011-15	2015	2011-15	2011-15	2015	2015
<i>Men, age</i>								
0-24	-	-	-	3	-	3	1	3
25-44	21	-	51	10	-	13	15	18
45-64	729	343	1 153	488	551	153	501	308
65-84	3 547	2 011	6 442	2 700	2 495	2 945	3 161	1 802
85+	4 391	486	-	3 267	3 383	3 568	3 160	1 233
<i>Women, age</i>								
0-24	-	-	-	-	-	4	1	2
25-44	30	31	23	3	52	28	17	12
45-64	842	385	843	169	123	654	588	400
65-84	3 087	636	4 071	1 100	1 431	3 177	2 495	1 711
85+	1 841	258	1 898	1 136	433	1 459	1 577	627

ICD-10 C33-34

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

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

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2015	2010-14	2011-15	2015	2011-15	2011-15	2015	2015
<i>Age</i>								
0-24	6	-	48	-	-	11	6	9
25-44	225	93	345	62	52	212	255	199
45-64	149	110	222	80	123	101	187	138
65-84	168	196	339	77	53	73	136	133
85+	178	516	-	72	-	233	207	118

ICD-10 C33-34

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

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

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2015	2010-14	2011-15	2015	2011-15	2011-15	2015	2015
<i>Age</i>								
0-24	42	-	56	28	99	38	57	34
25-44	213	-	26	184	0	116	52	186
45-64	96	62	46	34	100	50	42	50
65-84	31	59	-	14	96	23	6	21
85+	-	-	-	-	-	-	26	23

ICD-10 C62

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

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

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2015	2010-14	2011-15	2015	2011-15	2011-15	2015	2015
<i>Men, age</i>								
0-24	12	-	19	10	-	7	2	9
25-44	202	34	26	90	338	62	141	140
45-64	449	125	46	382	301	155	522	480
65-84	1 102	296	288	937	915	406	1 410	1 322
85+	1 438	-	-	1 332	677	496	1 923	2 092
<i>Women, age</i>								
0-24	45	-	32	5	-	36	21	19
25-44	398	154	69	151	104	129	220	260
45-64	626	55	44	262	535	261	563	525
65-84	821	49	-	613	335	293	898	876
85+	1 016	516	-	465	-	175	1 383	1 035

ICD-10 C43

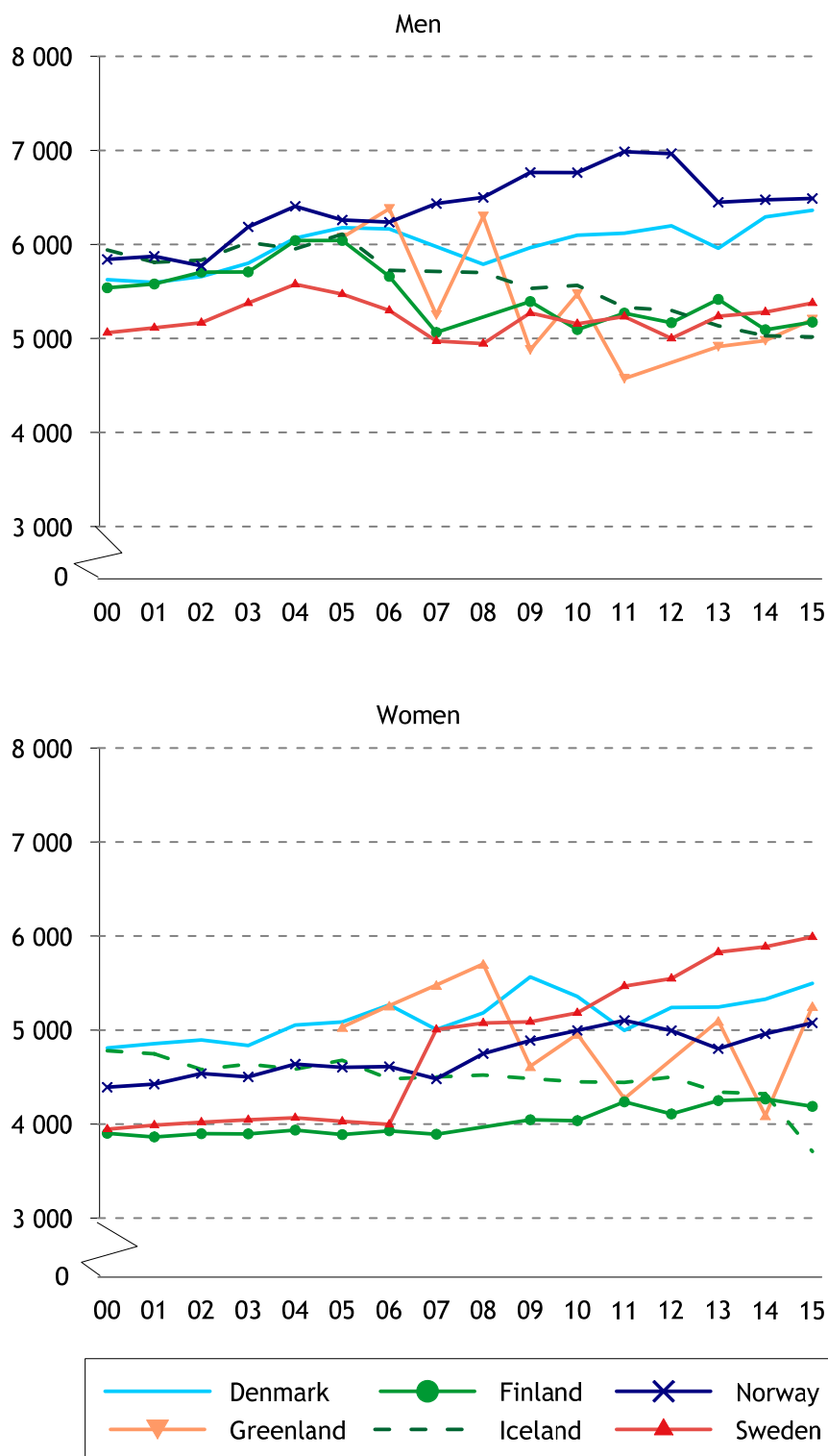
Source: The cancer registers in the Nordic countries; GL, Danish Cancer Society

Table 3.2.9 National cancer screening programmes 1 January, 2017

	Denmark	Faroe Islands	Greenland	Finland and Åland	Iceland	Norway	Sweden
Cancer of the cervix uteri, Women	Yes, 23-49 years every 3 years. 50-65 years every 5 years	Yes, 25-60 years every 3 years	Yes, 20-60 year every 3 year + 65 year if HPV is positive	Yes, 30-60 years every five years	Yes, 23-65 years, nationally, every 3 years	Yes, 29-69 years nationally	Yes, 23-64 years
Breast cancer, Women	Yes, 50-69 years every 2 years	Yes, 50-69 years every two years	No	Yes, 50-69 years every 20-26 months	Yes, 40-69 years nationally, every 2 years	Yes, 50-69 years nationally	Yes, 40-74 years
Cancer of the colon and rectum, men and women	Yes, 50-74 years, every 2. year	No	No	Pilot project (2004-) 60-69 years regionally	No	Pilot project (2012-) 50-74 years regionally	Yes, 60-74 years
Cancer of the testis, men	No	No	No	No	No	No	No
Cancer of the testicular, men	No		No	No			
Cancer of the prostate	No	No	No	Pilot project (1996-2007) for men aged 55-67 regionally			No
Lung cancer	No	No	No	No	No	No	No

Source: FO, Ministry of Health and the Interior, GL, the Agency for Health and Prevention, FI and ÅL: THL National Institute for Health and Welfare

Figure 3.2.1 New cases of cancer, age-standardized rates per 1 000 000 inhabitants, 2000-2015^{1,2,3}



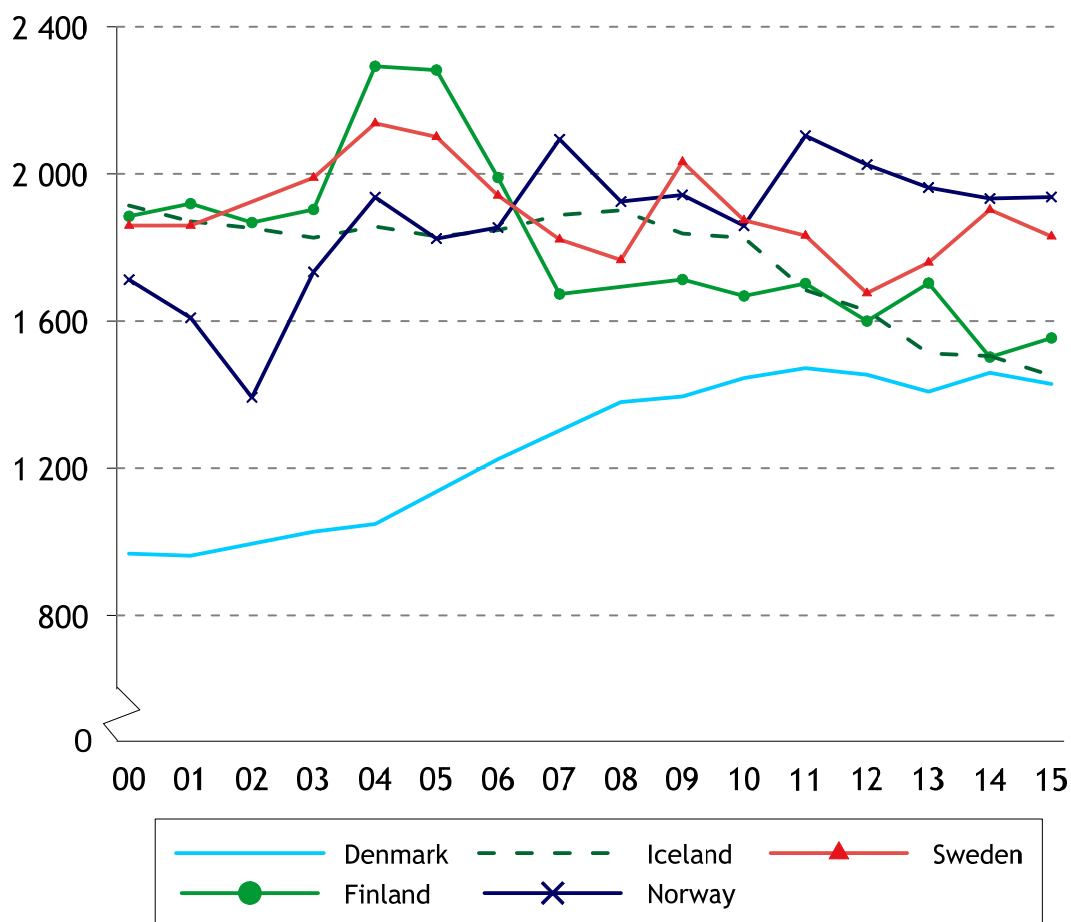
1 Age-standardized by the Nordic population 2000

2 The figures for Iceland are 5-year averages

3 ICD-10 Chapter C, except C44 and C46.0, incl. D09-0, D32, D33, D41.4, D42 and D43

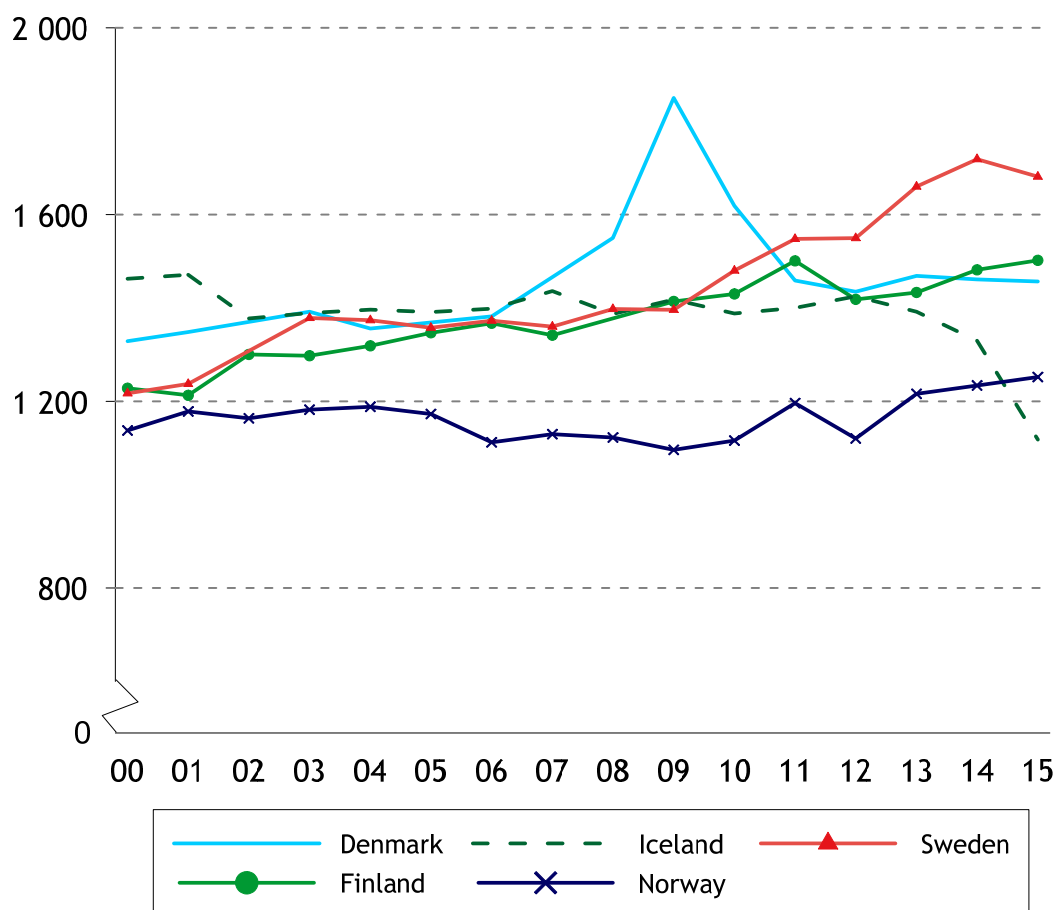
Source: The cancer registers in the Nordic countries

Figure 3.2.2 New cases of prostate cancer (men), age-standardized rates per 1 000 000 inhabitants 2000-2015^{1,2}



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

Figure 3.2.3 New cases of breast cancer (women), age-standardized rates per 1 000 000 inhabitants, 2000-2015^{1, 2}



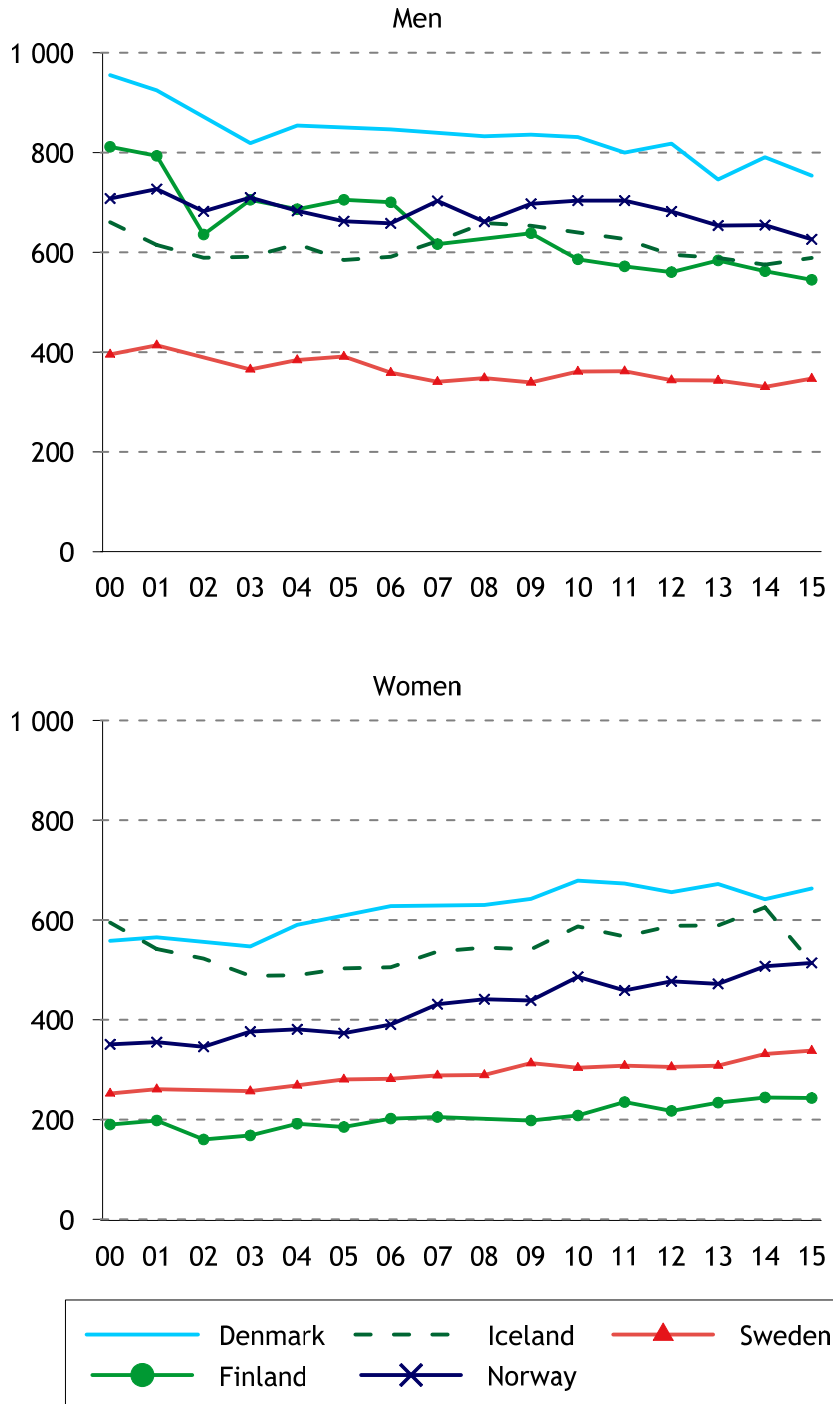
1 Age-standardized by the Nordic population 2000

2 The figures for Iceland are 5-year averages

Source: The cancer registers in the Nordic countries

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

Figure 3.2.4 New cases of lung cancer, age-standardized rates per 1 000 000 inhabitants, 2000-2015^{1,2}



1 Age-standardized by the Nordic population 2000

2 The figures for Iceland are 5-year averages

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

3.3 Immunization schedules

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

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

Table 3.3.1 Recommended immunization schedules per 1 January 2017¹

	Denmark	Greenland	Finland	Iceland	Norway	Sweden
Pneumococcus	3, 5 and 12 months	3, 5 and 12 months	3, 5 and 12 months + risk group children under 5 years	3, 5, 12 months; >60 years and risk groups	3, 5 and 12 months, 65+ years	3, 5 and 12 months
BCG	-	At birth	Only for risk group children under 7 years	-	Risk groups	Risk groups
Pertussis	3, 5 and 12 months and 5 years	3, 5 and 12 months and 5 years	3, 5 and 12 months, 4 and 14-15 years	3, 5, 12 months, 4 and 14 years	3, 5 and 12 months, 7-8 years	3, 5 and 12 months, 5-6 and 14-16 years
Tetanus	3, 5 and 12 months and 5 years	3, 5 and 12 months and 5 years	3, 5 and 12 months, 4 and 14-15 years	3, 5, 12 months, 4 and 14 years	3, 5 and 12 months, 7-8 years 15-16 years	3, 5 and 12 months, 5-6 and 14-16 years
Diphtheria	3, 5 and 12 months and 5 years	3, 5 and 12 months and 5 years	3, 5 and 12 months, 4 and 14-15 years	3, 5, 12 months, 4 and 14 years	3, 5 and 12 months, 7-8 years 15-16 years	3, 5 and 12 months, 5-6 and 14-16 years
Polio	IPV: 3, 5, 12 months and 5 years	IPV: 3, 5, 12 months and 5 years	IPV: 3, 5 and 12 months and 4 years	IPV: 3, 5, 12 months and 14 years	IPV: 3, 5 and 12 months, 7-8 years 15-16 years	IPV: 3, 5 and 12 months, 5-6 years
Measles, Mumps, Rubella	15 months, 4 years	15 months, 4 years	12-18 months and 6 years	18 months and 12 years	15 months and 11-12 years	18 months and 6-8 years
Rubella, only	Fertile women	Fertile women	-	-	Fertile women ²	
Haemophilus influenza b	3, 5 and 12 months	3, 5 and 12 months	3, 5 and 12 months	3, 5 and 12 months	3, 5 and 12 months	3, 5 and 12 months
Rotavirus	-		2, 3 and 5 months			
HPV	Girls: 12 years	Girls: 12 years	Girls: 12-13 years	Girls: 12 years	12-13 years (girls only)	3 immunizations for girls 10-12 years

Continues

Table 3.3.1 Recommended immunization schedules per 1 January 2017¹, continued

	Denmark	Greenland	Finland	Iceland	Norway	Sweden
Meningococcal disease gr. C	-	-	-	6 and 8 months	-	Risk groups
Hepatitis b	Risk groups only	At birth, 3, 5 and 12 months	Risk groups only	Risk groups only	..	Risk groups
Influenza 65+	65+ and risk groups	65+ and risk groups	6-35 months, 65+ years and risk groups	>60 years and risk groups	65+ and risk groups	65+ and risk groups

- 1 Basically, the Faroe Islands and Åland have the same immunization schedules as Denmark and Finland respectively. However, the Faroe Islands give Influenza vaccination for age groups 67+. In Åland TBE is included for children over 4 years
- 2 A vaccine for children is currently available and is offered in some counties, but is not included in the Swedish immunization schedule for children

Source: WHO/EPI, DK, DK, the Danish Health Data Authority; GL, the Chief Medical Officer; FI, THL National Institute for Health and Welfare; IS, Directorate of Health; NO, Norwegian Institute of Public Health; SV, National Board of Health and Welfare

Table 3.3.2 Children under the age of two immunized according to recommended immunization schedules and elderly people vaccinated against influenza (per cent), 2015

	Denmark ¹	Faroe Islands ²	Finland ^{3, 4}	Iceland ⁵	Norway ⁶	Sweden
Pertussis	92	90	99	92	95	98
Tetanus	92	90	99	92	95	98
Diphtheria	92	90	99	92	95	98
Polio	92	90	99	92	95	98
Rubella ⁷	86	90	95	92	96	98
Measles ⁷	86	90	95	92	96	98
Influenza 65+, in season 2015-16	10	42	43	39	25	50

- 1 Based on the immunization at 3 and 5 months
- 2 67+
- 3 Birth cohort 2014, based on National Vaccination Register (NVR). Due to data deficiencies in the register, coverage for at least one dose is reported
- 4 Rubella and measles: 12-18-month dose coverage from NVR. Based on 2015 validation study, MMR coverage in the register is currently underestimated by 3%
- 5 The number of persons vaccinated against pertussis, tetanus, diphtheria and polio is based on a birth cohort 2014, which received three doses of vaccine. The number of vaccinations against measles is based on a birth cohort 2013, which received one dose. For influenza 60+ the number is based on the number of persons vaccinated during the 4th quartile of 2015 and 1st quartile of 2016
- 6 The data is underestimated due to a low level of reporting in some municipalities
- 7 Sweden, MPR (Measles, Mumps, Rubella)

Source: WHO/EPI; DK, the Danish Health Data Authority; FO, Ministry of Health Affairs; FI, THL National Institute for Health and Welfare; IS, Directorate of Health; NO, Norwegian Institute of Public Health; SV, Public Health Agency of Sweden

3.4 Discharges, bed days, average length of stay and patients treated

Outline of this section

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

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

The presentation of the diagnosis-related statistics starts with tables of the total number of discharges (Table 3.4.1) and bed days (Table 3.4.2) per 100 000 inhabitants. Besides the tables for both genders, separate tables for men and women are now included for gender comparisons. However, age standardized tables for discharges and surgery procedures are not included (Section 3.5).

While discharge rates illustrate how common certain groups of diagnoses are as the reason for admission to hospital, bed-day rates give a better illustration of the load these diagnoses have on hospitals. The average length of stay for in-patients by diagnosis is shown in a third set of tables (Table 3.4.3). This is followed by figures that show the development over time of hospital use for three ICD-10 chapters.

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

Quality and limitations of data

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

Nordic hospital data have a high degree of coverage.

In order to make the statistics as comparable as possible, the data presented in this section are from somatic hospital departments (wards) in general hospitals and specialized somatic wards. Still, it is not possible to get completely comparable sets of hospital data. In Norway, discharges are not related to hospital departments

(wards) but only to the hospital as a whole, which means that discharge rates are slightly underestimated compared to the other countries.

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

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

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

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

Healthy new-born babies are counted differently in the Nordic countries. In the ICD-10, there is a category (Z38) and in the ISHMT list, there is a group for healthy new-born babies. In some of the countries, these babies are not registered as patients thus they are not included in the patient registers. Therefore, healthy new-born babies are excluded from the tables in this section.

Comments to the tables

The overall discharge rates (cf. Table 3.4.1.a) vary a little between the Nordic countries. Highest rates are found for Denmark and the rest of the Nordic countries are about the same level. There are marked differences, however, in hospital use between the countries for certain groups of diseases and specific diagnoses, both measured as rate of discharges and as rate of bed-days.

In all countries, there are high discharge rates for diseases of the circulatory system (ICD, Chapter IX), injuries (Chapter XIX) and neoplasms (Chapter II). In Sweden, however, pregnancy and childbirth (Chapter XV) account for the highest discharge rate, and in Denmark discharges for symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (Chapter XVIII) is the most common of all ICD chapters.

For many diagnosis groups and for specific diagnoses, there is also great similarity in average length of stay. However, there are some greater differences between the countries, such as for mental and behavioural disorders with long stays for Finland,

Denmark and Sweden. This reflects the fact that the somatic hospital data in these countries include some psychiatric patients. Long stays are also found for diseases of the nervous system in the same countries, indicating the occurrence of some long-term care cases in short-term hospitals in these countries.

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

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

The trends illustrated in Figures 3.4.1 - 3 do not show big changes in discharge rates over the years (except for Åland, due to small populations). The other countries retain their relative positions in relation to each other over the period studied.

In Tables 3.4.5 - 3.4.14, the possibilities of linking successive hospital stays for the same main diagnosis and the same person have been used, thus calculating the number of actual persons being treated, in the following called 'patients treated'. The Nordic countries are among the few countries in the world that can do this on a national level. As an example, from Table 3.4.5 on lung cancer, it shows that for all countries and for both men and women the number of patients treated is about half the number of discharges.

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

The difference in the number of discharges and the number of patients treated varies by diagnosis. The difference is largest for chronic conditions such as chronic obstructive pulmonary disease (Table 3.4.9) and alcoholic liver disease (Table 3.4.11).

In all countries, the number of patients treated amounts to about 60 per cent of the number of discharges for these two diseases. For most of the other diagnoses presented in the detailed tables, the number of patients treated corresponds to 70-80 per cent of the number of discharges.

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

ICD-10 code Main diagnosis	Denmark	Finland	Åland	Iceland ¹	Norway	Sweden
	2015	2015	2011-15	2011-15	2015	2015
I: Certain infectious and parasitic diseases (<i>A00-B99</i>)	852	580	560	170	372	489
II: Neoplasms (<i>C00-D48</i>)	1 628	1 542	1 199	1 043	1 456	1 175
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (<i>D50-D89</i>)	244	144	162	104	129	141
IV: Endocrine, nutritional and metabolic diseases (<i>E00-E90</i>)	747	290	216	204	324	338
V: Mental and behavioural disorders (<i>F00-F99</i>)	1 177	915	823	924	211	1 223
VI: Diseases of the nervous system (<i>G00-G99</i>)	645	621	508	329	603	453
VII: Diseases of the eye and adnexa (<i>H00-H59</i>)	87	135	26	60	106	86
VIII: Diseases of the ear and mastoid process (<i>H60-H95</i>)	99	72	128	44	77	86
IX: Diseases of the circulatory system (<i>I00-I99</i>)	2 494	2 381	2 171	1 149	1 973	2 185
X: Diseases of the respiratory system (<i>J00-J99</i>)	2 204	1 185	1 359	611	1 236	1 126
XI: Diseases of the digestive system (<i>K00-K93</i>)	1 973	1 235	1 499	933	1 212	1 248
XII: Diseases of the skin and subcutaneous tissue (<i>L00-L99</i>)	310	147	98	171	152	133
XIII: Diseases of the musculoskeletal system and connective tissue (<i>M00-M99</i>)	1 290	1 065	1 454	626	1 041	915
XIV: Diseases of the genitourinary system (<i>N00-N99</i>)	1 263	836	1 144	572	883	782
XV: Pregnancy, childbirth and the puerperium (<i>O00-O99</i>)	1 297	1 210	1 283	1 542	467	1 448
XVI: Certain conditions originating in the perinatal period (<i>P00-P96</i>)	185	160	139	366	168	164
XVII: Congenital malformations, deformations and chromosomal abnormalities (<i>Q00-Q99</i>)	177	130	53	139	121	99
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (<i>R00-R99</i>)	3 049	1 093	1 482	622	1 129	1 514
XIX: Injury, poisoning and certain other consequences of external causes (<i>S00-T98</i>)	2 068	1 568	1 350	849	1 520	1 543
XXI: Factors influencing health status and contact with health services (<i>Z00-Z99</i>)	2 640	249	1 003	817	1 580	616
All causes (except XX) (<i>A00-Z99</i> excluding V, W, X and Y)	24 432	15 559	16 657	11 274	14 761	15 579

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

Source: The national in-patient registers

Table 3.4.1b Discharges from hospitals per 100 000 inhabitants by main diagnosis, men

ICD-10 code Main diagnosis	Denmark	Finland	Åland	Iceland ¹	Norway	Sweden
	2015	2015	2011-15	2011-15	2015	2015
I: Certain infectious and parasitic diseases (A00-B99)	931	604	528	159	389	515
II: Neoplasms (C00-D48)	1 600	1 492	914	966	1 435	1 126
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	240	136	148	91	117	125
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	647	256	162	133	257	285
V: Mental and behavioural disorders (F00-F99)	1 230	959	714	854	240	1 343
VI: Diseases of the nervous system (G00-G99)	658	614	406	323	611	460
VII: Diseases of the eye and adnexa (H00-H59)	90	125	17	63	108	90
VIII: Diseases of the ear and mastoid process (H60-H95)	101	70	113	44	70	79
IX: Diseases of the circulatory system (I00-I99)	3 003	2 646	2 080	1 408	2 353	2 510
X: Diseases of the respiratory system (J00-J99)	2 313	1 334	1 373	600	1 268	1 144
XI: Diseases of the digestive system (K00-K93)	1 995	1 334	1 321	885	1 188	1 245
XII: Diseases of the skin and subcutaneous tissue (L00-L99)	342	163	90	179	160	136
XIII: Diseases of the musculoskeletal system and connective tissue (M00-M99)	1 171	899	1 102	522	895	803
XIV: Diseases of the genitourinary system (N00-N99)	1 106	689	623	391	904	776
XV: Pregnancy, childbirth and the puerperium (O00-O99)	.	.	.	..	.	.
XVI: Certain conditions originating in the perinatal period (P00-P96)	211	180	147	408	182	186
XVII: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	200	138	46	151	136	110
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	2 905	1 086	1 202	529	1 041	1 455
XIX: Injury, poisoning and certain other consequences of external causes (S00-T98)	2 049	1 591	1 230	789	1 479	1 486
XXI: Factors influencing health status and contact with health services (Z00-Z99)	2 518	208	712	652	728	576
All causes (except XX) (A00-Z99 excluding V, W, X and Y)	23 306	14 533	12 959	9 146	13 479	14 253

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

Source: The national in-patient registers

Table 3.4.1c Discharges from hospitals per 100 000 inhabitants by main diagnosis, women

ICD-10 code Main diagnosis	Denmark	Finland	Åland	Iceland ¹	Norway	Sweden
	2015	2015	2011-15	2011-15	2015	2015
I: Certain infectious and parasitic diseases (A00-B99)	774	556	398	181	356	463
II: Neoplasms (C00-D48)	1 656	1 590	1 031	1 120	1 476	1 224
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	248	153	118	118	140	158
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	846	322	188	277	392	392
V: Mental and behavioural disorders (F00-F99)	1 125	871	636	993	181	1 102
VI: Diseases of the nervous system (G00-G99)	633	628	421	335	595	447
VII: Diseases of the eye and adnexa (H00-H59)	83	145	24	57	104	82
VIII: Diseases of the ear and mastoid process (H60-H95)	97	75	96	44	84	93
IX: Diseases of the circulatory system (I00-I99)	1 991	2 124	1 514	887	1 588	1 858
X: Diseases of the respiratory system (J00-J99)	2 097	1 041	889	623	1 204	1 107
XI: Diseases of the digestive system (K00-K93)	1 952	1 140	1 140	982	1 236	1 251
XII: Diseases of the skin and subcutaneous tissue (L00-L99)	279	132	72	164	145	130
XIII: Diseases of the musculoskeletal system and connective tissue (M00-M99)	1 407	1 227	1 255	730	1 188	1 027
XIV: Diseases of the genitourinary system (N00-N99)	1 421	969	1 166	754	946	794
XV: Pregnancy, childbirth and the puerperium (O00-O99)	2 579	2 383	1 914	3 095	939	2 898
XVI: Certain conditions originating in the perinatal period (P00-P96)	159	140	86	324	155	142
XVII: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	155	123	41	127	107	89
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	3 191	1 099	1 213	716	1 219	1 573
XIX: Injury, poisoning and certain other consequences of external causes (S00-T98)	2 086	1 546	993	909	1 562	1 600
XXI: Factors influencing health status and contact with health services (Z00-Z99)	2 761	288	906	982	2 443	656
All causes (except XX) (A00-Z99 excluding V, W, X and Y)	25 545	16 554	14 100	13 417	16 060	16 905

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

Source: The national in-patient registers

Table 3.4.2a Bed days in hospitals per 100 000 inhabitants by main diagnosis, both genders

ICD-10 code Main diagnosis	Denmark	Finland	Åland	Iceland ¹	Norway	Sweden
	2015	2015	2011-15	2011-15	2015	2015
I: Certain infectious and parasitic diseases (<i>A00-B99</i>)	3 472	4 057	3 943	992	2 006	2 747
II: Neoplasms (<i>C00-D48</i>)	6 677	9 838	11 641	8 001	8 176	7 897
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (<i>D50-D89</i>)	678	726	1 017	587	519	609
IV: Endocrine, nutritional and metabolic diseases (<i>E00-E90</i>)	2 380	1 699	1 628	1 359	1 120	1 466
V: Mental and behavioural disorders (<i>F00-F99</i>)	16 349	21 462	11 836	10 776	585	17 259
VI: Diseases of the nervous system (<i>G00-G99</i>)	2 653	6 659	19 963	2 886	2 171	2 321
VII: Diseases of the eye and adnexa (<i>H00-H59</i>)	159	418	89	173	316	205
VIII: Diseases of the ear and mastoid process (<i>H60-H95</i>)	191	225	310	157	166	183
IX: Diseases of the circulatory system (<i>I00-I99</i>)	8 784	18 852	18 677	9 799	8 725	11 745
X: Diseases of the respiratory system (<i>J00-J99</i>)	7 743	7 484	8 428	4 507	6 777	6 009
XI: Diseases of the digestive system (<i>K00-K93</i>)	6 349	5 961	7 697	4 552	5 028	5 248
XII: Diseases of the skin and subcutaneous tissue (<i>L00-L99</i>)	969	1 036	888	1 124	890	786
XIII: Diseases of the musculoskeletal system and connective tissue (<i>M00-M99</i>)	4 017	5 628	6 549	3 858	4 203	3 921
XIV: Diseases of the genitourinary system (<i>N00-N99</i>)	3 302	4 011	5 434	2 371	3 194	3 216
XV: Pregnancy, childbirth and the puerperium (<i>O00-O99</i>)	3 168	4 802	5 915	3 069	1 695	3 403
XVI: Certain conditions originating in the perinatal period (<i>P00-P96</i>)	1 492	1 313	1 342	1 631	1 484	1 678
XVII: Congenital malformations, deformations and chromosomal abnormalities (<i>Q00-Q99</i>)	503	593	359	516	562	520
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (<i>R00-R99</i>)	5 314	4 251	5 695	2 988	2 413	3 968
XIX: Injury, poisoning and certain other consequences of external causes (<i>S00-T98</i>)	6 576	10 371	9 932	6 216	6 505	7 734
XXI: Factors influencing health status and contact with health services (<i>Z00-Z99</i>)	12 333	1 257	13 703	5 606	7 121	2 467
All causes (except XX) (<i>A00-Z99 excluding V, W, X and Y</i>)	95 067	110 643	135 045	71 171	63 656	82 680

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

Source: The national in-patient registers

Table 3.4.2b Bed days in hospitals per 100 000 inhabitants by main diagnosis, men

ICD-10 code Main diagnosis	Denmark	Finland	Åland	Iceland ¹	Norway	Sweden
	2015	2015	2011-15	2011-15	2015	2015
I: Certain infectious and parasitic diseases (A00-B99)	3 935	4 190	3 943	951	2 199	2 870
II: Neoplasms (C00-D48)	6 690	9 846	9 577	7 793	8 436	7 886
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	602	684	1 030	529	487	565
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	2 094	1 530	1 173	1 011	965	1 392
V: Mental and behavioural disorders (F00-F99)	16 339	19 746	8 946	10 030	587	18 803
VI: Diseases of the nervous system (G00-G99)	2 750	5 297	9 813	2 918	2 147	2 378
VII: Diseases of the eye and adnexa (H00-H59)	165	351	63	170	320	208
VIII: Diseases of the ear and mastoid process (H60-H95)	151	208	260	129	149	158
IX: Diseases of the circulatory system (I00-I99)	10 374	18 882	14 619	11 484	10 360	12 934
X: Diseases of the respiratory system (J00-J99)	8 347	8 197	8 786	4 162	6 923	6 019
XI: Diseases of the digestive system (K00-K93)	6 273	6 388	7 231	4 112	4 957	5 137
XII: Diseases of the skin and subcutaneous tissue (L00-L99)	961	1 067	880	1 175	908	779
XIII: Diseases of the musculoskeletal system and connective tissue (M00-M99)	3 101	4 367	4 571	2 976	3 632	3 263
XIV: Diseases of the genitourinary system (N00-N99)	2 998	3 389	3 585	1 918	3 176	3 260
XV: Pregnancy, childbirth and the puerperium (O00-O99)	.	.	.	.	.	.
XVI: Certain conditions originating in the perinatal period (P00-P96)	1 730	1 462	1 428	1 785	1 580	1 911
XVII: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	535	640	343	574	640	549
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	5 193	4 144	4 840	2 549	2 227	3 789
XIX: Injury, poisoning and certain other consequences of external causes (S00-T98)	6 105	9 676	10 200	5 331	6 418	6 829
XXI: Factors influencing health status and contact with health services (Z00-Z99)	14 244	1 204	9 672	4 912	4 700	2 475
All causes (except XX) (A00-Z99 excluding V, W, X and Y)	92 602	101 269	100 960	64 509	60 811	80 499

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

Source: The national in-patient registers

Table 3.4.2c Bed days in hospitals per 100 000 inhabitants by main diagnosis, women

ICD-10 code Main diagnosis	Denmark	Finland	Åland	Iceland ¹	Norway	Sweden
	2015	2015	2011-15	2011-15	2015	2015
I: Certain infectious and parasitic diseases (A00-B99)	3 177	3 928	2 612	1 033	1 810	2 624
II: Neoplasms (C00-D48)	6 019	9 831	9 423	8 208	7 913	7 909
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	614	766	662	644	550	654
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	2 527	1 862	1 456	1 708	1 278	1 540
V: Mental and behavioural disorders (F00-F99)	15 903	23 125	10 237	11 527	583	15 713
VI: Diseases of the nervous system (G00-G99)	2 634	7 978	21 638	2 853	2 195	2 263
VII: Diseases of the eye and adnexa (H00-H59)	148	484	80	176	313	201
VIII: Diseases of the ear and mastoid process (H60-H95)	148	241	247	185	183	208
IX: Diseases of the circulatory system (I00-I99)	6 713	18 823	15 737	8 101	7 069	10 555
X: Diseases of the respiratory system (J00-J99)	7 692	6 793	5 287	4 854	6 630	5 999
XI: Diseases of the digestive system (K00-K93)	6 079	5 546	5 485	4 996	5 099	5 360
XII: Diseases of the skin and subcutaneous tissue (L00-L99)	741	1 005	595	1 073	871	793
XIII: Diseases of the musculoskeletal system and connective tissue (M00-M99)	4 300	6 850	5 978	4 746	4 781	4 579
XIV: Diseases of the genitourinary system (N00-N99)	3 396	4 615	5 133	2 827	3 213	3 172
XV: Pregnancy, childbirth and the puerperium (O00-O99)	6 153	9 456	8 821	6 161	3 412	6 809
XVI: Certain conditions originating in the perinatal period (P00-P96)	1 381	1 169	818	1 476	1 387	1 445
XVII: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	419	548	251	458	483	491
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	5 569	4 355	4 482	3 431	2 601	4 148
XIX: Injury, poisoning and certain other consequences of external causes (S00-T98)	6 621	11 044	6 359	7 107	6 593	8 639
XXI: Factors influencing health status and contact with health services (Z00-Z99)	11 892	1 309	12 420	6 304	9 574	2 458
All causes (except XX) (A00-Z99 excluding V, W, X and Y)	92 150	119 727	117 720	77 867	66 537	84 862

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

Source: The national in-patient registers

Table 3.4.3a Average length of stay per discharge (in days) per 100 000 inhabitants by main diagnosis, both genders

ICD-10 code Main diagnosis	Denmark	Finland	Åland	Iceland ¹	Norway	Sweden
	2015	2015	2011-15	2011-15	2015	2015
I: Certain infectious and parasitic diseases (A00-B99)	4.2	7.0	7.0	5.8	5.4	5.6
II: Neoplasms (C00-D48)	3.9	6.4	9.7	7.7	5.6	6.7
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	2.5	5.0	6.3	5.6	4.0	4.3
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	3.1	5.9	7.5	6.6	3.5	4.3
V: Mental and behavioural disorders (F00-F99)	13.7	23.5	14.4	11.7	2.8	14.1
VI: Diseases of the nervous system (G00-G99)	4.2	10.7	39.3	8.8	3.6	5.1
VII: Diseases of the eye and adnexa (H00-H59)	1.8	3.1	3.5	2.9	3.0	2.4
VIII: Diseases of the ear and mastoid process (H60-H95)	1.5	3.1	2.4	3.6	2.2	2.1
IX: Diseases of the circulatory system (I00-I99)	3.4	7.9	8.6	8.5	4.4	5.4
X: Diseases of the respiratory system (J00-J99)	3.6	6.3	6.2	7.4	5.5	5.3
XI: Diseases of the digestive system (K00-K93)	3.1	4.8	5.1	4.9	4.1	4.2
XII: Diseases of the skin and subcutaneous tissue (L00-L99)	2.7	7.0	9.1	6.6	5.8	5.9
XIII: Diseases of the musculoskeletal system and connective tissue (M00-M99)	2.9	5.3	4.5	6.2	4.0	4.3
XIV: Diseases of the genitourinary system (N00-N99)	2.5	4.8	4.7	4.1	3.6	4.1
XV: Pregnancy, childbirth and the puerperium (O00-O99)	2.4	4.0	4.6	2.0	3.6	2.3
XVI: Certain conditions originating in the perinatal period (P00-P96)	8.4	8.2	9.6	4.5	8.8	10.2
XVII: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	2.7	4.6	6.8	3.7	4.6	5.2
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	1.8	3.9	3.8	4.8	2.1	2.6
XIX: Injury, poisoning and certain other consequences of external causes (S00-T98)	3.1	6.6	7.4	7.3	4.3	5.0
XXI: Factors influencing health status and contact with health services (Z00-Z99)	4.9	5.1	13.7	6.9	4.5	4.0
All causes (except XX) (A00-Z99 excluding V, W, X and Y)	3.8	7.1	8.1	6.3	4.3	5.3

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

Source: The national in-patient registers

Table 3.4.3b Average length of stay per discharge (in days) per 100 000 inhabitants by main diagnosis, men

ICD-10 code Main diagnosis	Denmark	Finland	Åland	Iceland ¹	Norway	Sweden
	2015	2015	2011-15	2011-15	2015	2015
I: Certain infectious and parasitic diseases (A00-B99)	4.2	6.9	7.5	6.0	5.7	5.6
II: Neoplasms (C00-D48)	4.2	6.6	10.5	8.1	5.9	7.0
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	2.5	5.0	6.9	5.8	4.2	4.5
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	3.2	6.0	7.2	7.6	3.8	4.9
V: Mental and behavioural disorders (F00-F99)	13.3	20.6	12.5	11.7	2.4	14.0
VI: Diseases of the nervous system (G00-G99)	4.2	8.6	24.2	9.0	3.5	5.2
VII: Diseases of the eye and adnexa (H00-H59)	1.8	2.8	3.8	2.7	3.0	2.3
VIII: Diseases of the ear and mastoid process (H60-H95)	1.5	3.0	2.3	3.0	2.1	2.0
IX: Diseases of the circulatory system (I00-I99)	3.5	7.1	7.0	8.2	4.4	5.2
X: Diseases of the respiratory system (J00-J99)	3.6	6.1	6.4	6.9	5.5	5.3
XI: Diseases of the digestive system (K00-K93)	3.1	4.8	5.5	4.6	4.2	4.1
XII: Diseases of the skin and subcutaneous tissue (L00-L99)	2.8	6.6	9.8	6.6	5.7	5.7
XIII: Diseases of the musculoskeletal system and connective tissue (M00-M99)	2.6	4.9	4.1	5.7	4.1	4.1
XIV: Diseases of the genitourinary system (N00-N99)	2.7	4.9	5.8	4.9	3.5	4.2
XV: Pregnancy, childbirth and the puerperium (O00-O99)	.	.	.	.	.	.
XVI: Certain conditions originating in the perinatal period (P00-P96)	8.2	8.1	9.7	4.4	8.7	10.3
XVII: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	2.7	4.7	7.4	3.8	4.7	5.0
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	1.8	3.8	4.0	4.8	2.1	2.6
XIX: Injury, poisoning and certain other consequences of external causes (S00-T98)	3.0	6.1	8.3	6.8	4.3	4.6
XXI: Factors influencing health status and contact with health services (Z00-Z99)	5.7	5.8	13.6	7.5	6.5	4.3
All causes (except XX) (A00-Z99 excluding V, W, X and Y)	4.0	7.0	7.8	7.1	4.5	5.6

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

Source: The national in-patient registers

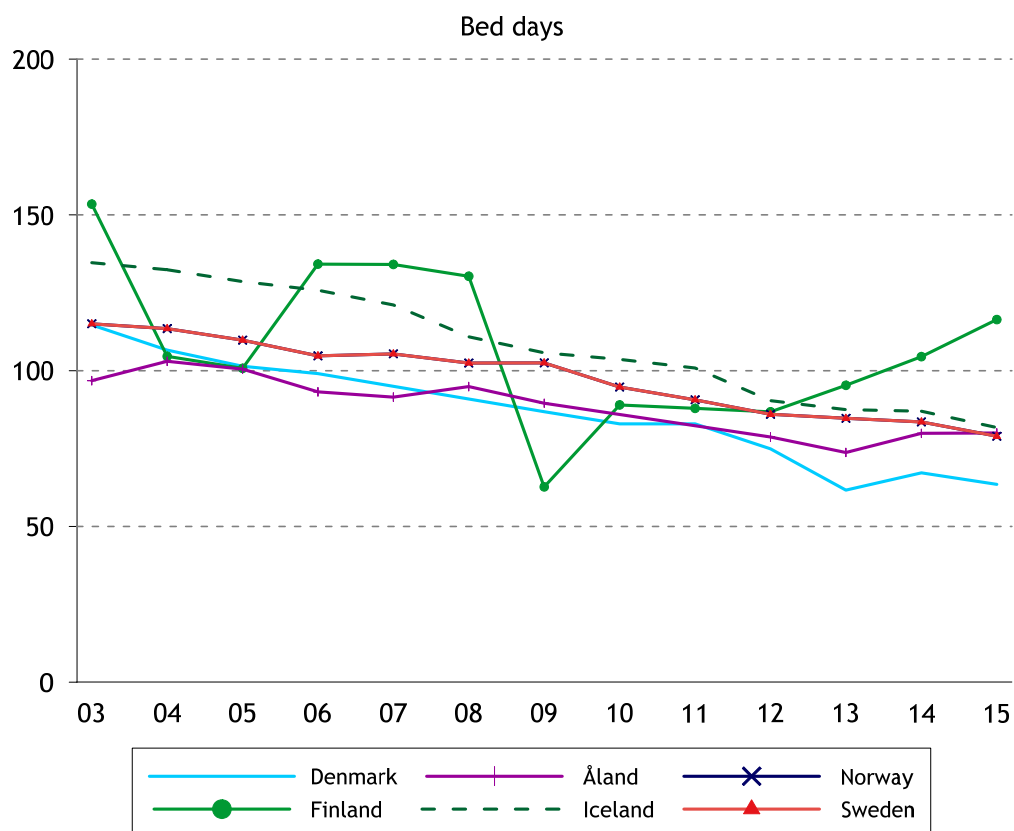
Table 3.4.3c Average length of stay per discharge (in days) per 100 000 inhabitants by main diagnosis, women

ICD-10 code Main diagnosis	Denmark	Finland	Åland	Iceland ¹	Norway	Sweden
	2015	2015	2011-15	2011-15	2015	2015
I: Certain infectious and parasitic diseases (A00-B99)	4.1	7.1	6.6	5.7	5.1	5.7
II: Neoplasms (C00-D48)	3.6	6.2	9.1	7.3	5.4	6.5
III: Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)	2.5	5.0	5.6	5.5	3.9	4.1
IV: Endocrine, nutritional and metabolic diseases (E00-E90)	3.0	5.8	7.7	6.2	3.3	3.9
V: Mental and behavioural disorders (F00-F99)	14.1	26.5	16.1	11.6	3.2	14.3
VI: Diseases of the nervous system (G00-G99)	4.2	12.7	51.4	8.5	3.7	5.1
VII: Diseases of the eye and adnexa (H00-H59)	1.8	3.3	3.3	3.1	3.0	2.4
VIII: Diseases of the ear and mastoid process (H60-H95)	1.5	3.2	2.6	4.2	2.2	2.2
IX: Diseases of the circulatory system (I00-I99)	3.4	8.9	10.4	9.1	4.5	5.7
X: Diseases of the respiratory system (J00-J99)	3.7	6.5	6.0	7.8	5.5	5.4
XI: Diseases of the digestive system (K00-K93)	3.1	4.9	4.8	5.1	4.1	4.3
XII: Diseases of the skin and subcutaneous tissue (L00-L99)	2.7	7.6	8.3	6.6	6.0	6.1
XIII: Diseases of the musculoskeletal system and connective tissue (M00-M99)	3.1	5.6	4.8	6.5	4.0	4.5
XIV: Diseases of the genitourinary system (N00-N99)	2.4	4.8	4.4	3.8	3.4	4.0
XV: Pregnancy, childbirth and the puerperium (O00-O99)	2.4	4.0	4.6	2.0	3.6	2.3
XVI: Certain conditions originating in the perinatal period (P00-P96)	8.7	8.3	9.5	4.6	9.0	10.2
XVII: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	2.7	4.5	6.2	3.6	4.5	5.5
XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	1.7	4.0	3.7	4.8	2.1	2.6
XIX: Injury, poisoning and certain other consequences of external causes (S00-T98)	3.2	7.1	6.4	7.8	4.2	5.4
XXI: Factors influencing health status and contact with health services (Z00-Z99)	4.3	4.5	13.7	6.4	3.9	3.7
All causes (except XX) (A00-Z99 excluding V, W, X and Y)	3.6	7.2	8.3	5.8	4.1	5.0

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

Source: The national in-patient registers

Figure 3.4.1 Number of bed days for cancer per 1 000 inhabitants, 2003-2015¹

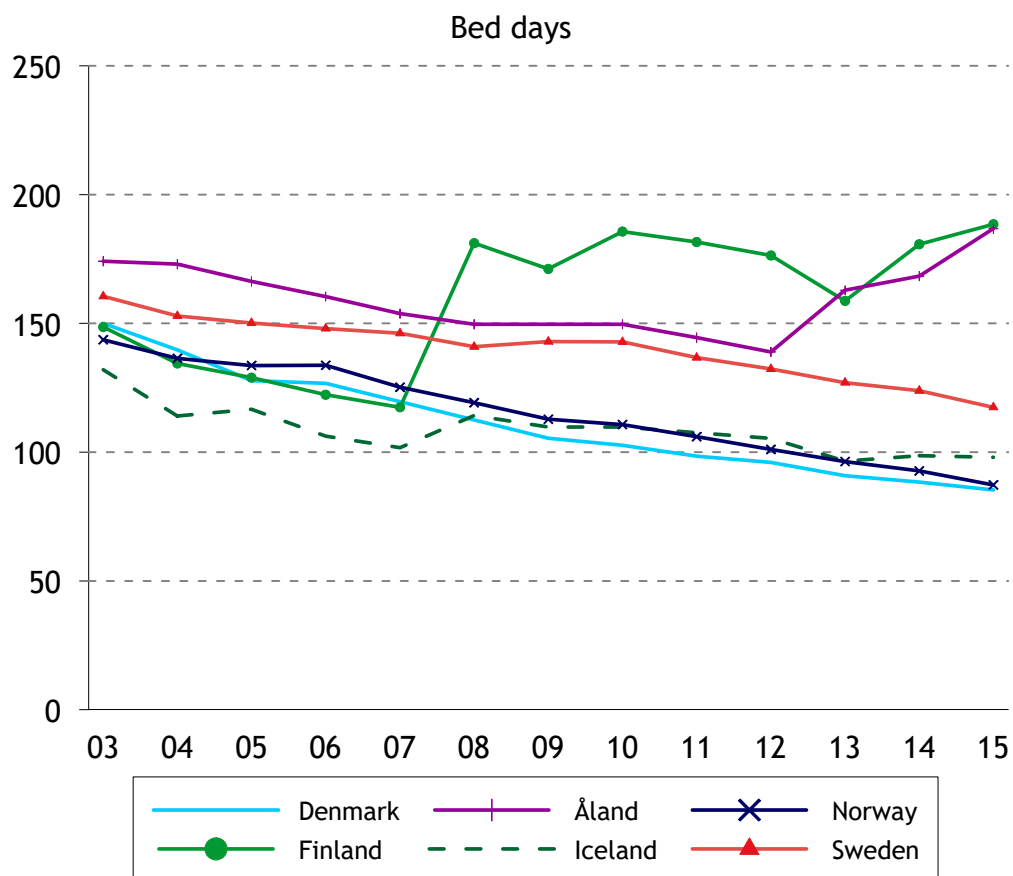


1 Iceland: Only discharges with a length of stay less than 90 days

ICD-10 C00-D48

Source: The national in-patient registers

Figure 3.4.2 Bed days during the year for diseases of the circulation organs per 1 000 inhabitants, 2003-2015¹

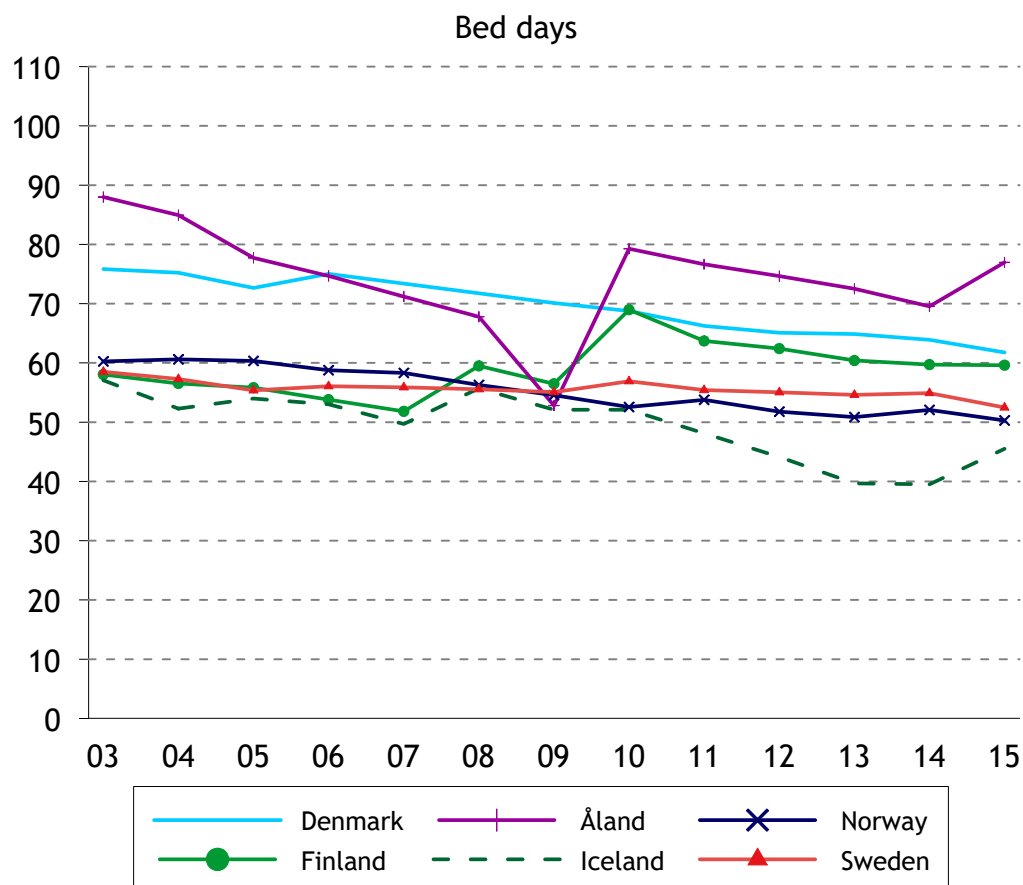


1 Iceland: Only discharges with a length of stay less than 90 days

ICD-10 I00-I99

Source: The national in-patient registers

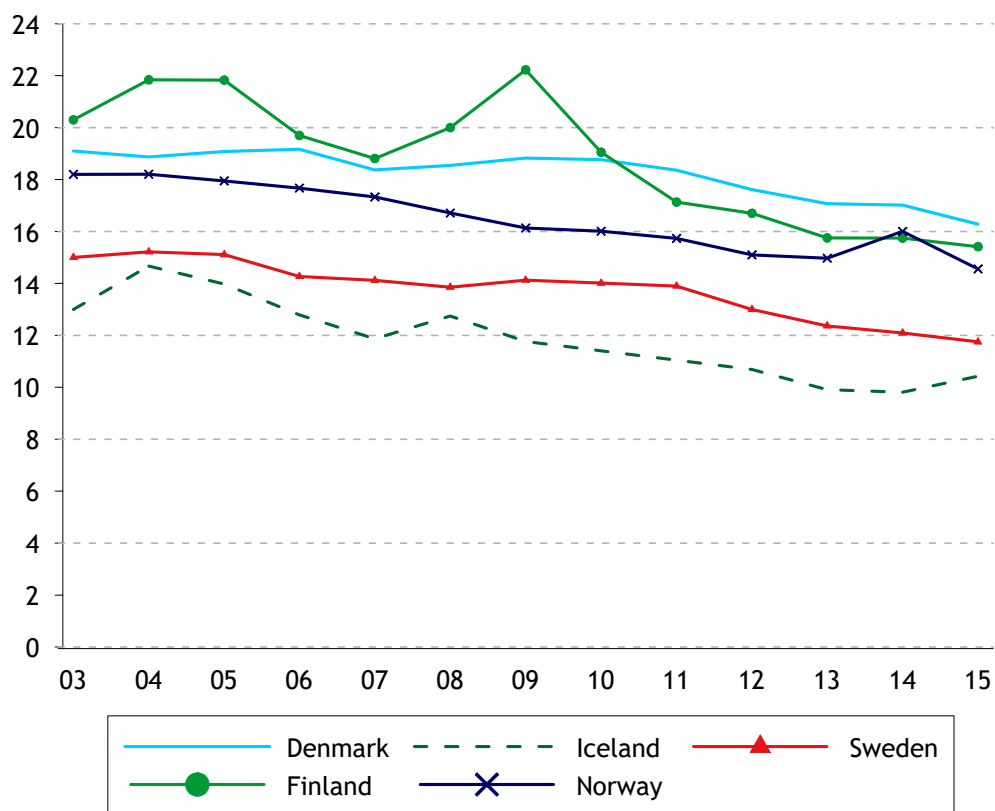
Figure 3.4.3 Bed days for diseases of the digestive system per 1 000 inhabitants 2003-2015¹



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

ICD-10 K00-K93

Source: The national in-patient registers

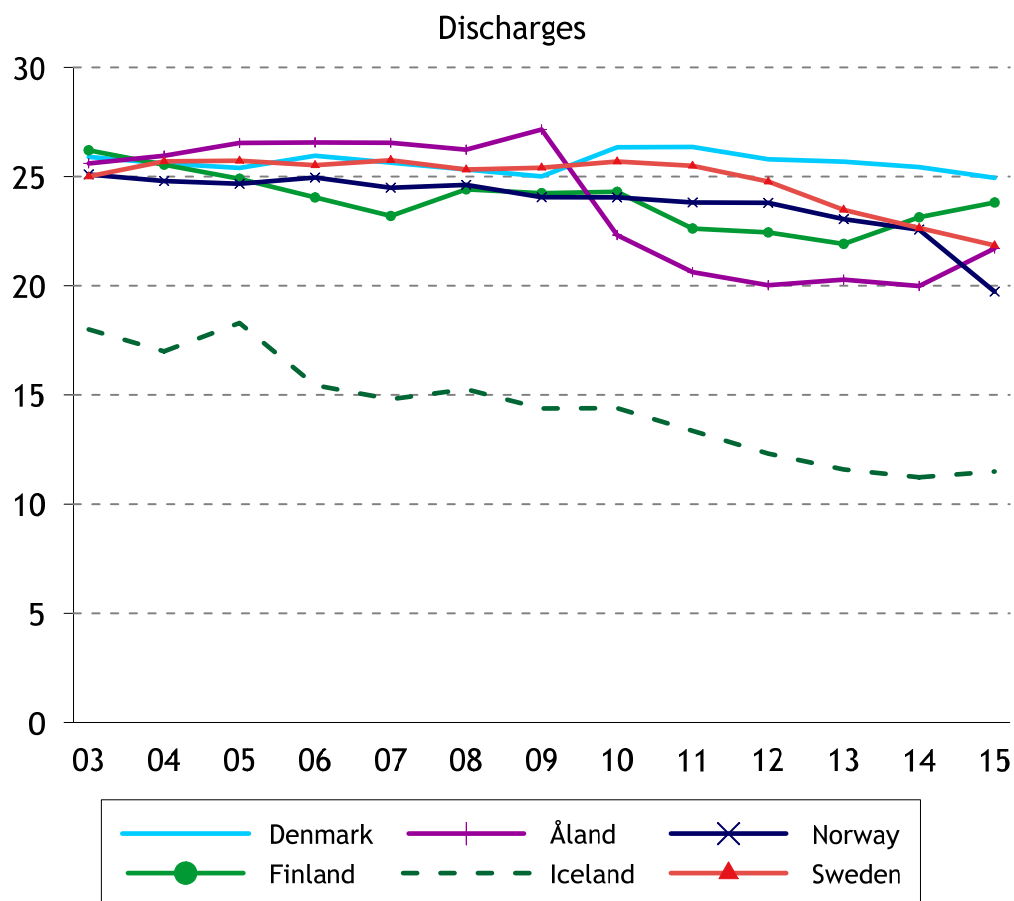
Figure 3.4.4 Discharges for cancer per 1 000 inhabitants 2000-2015¹

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

ICD-10 C00-D48

Source: The national in-patient registers

Figure 3.4.5 Discharges during the year for diseases of the circulation organs per 1 000 inhabitants, 2003-2015¹

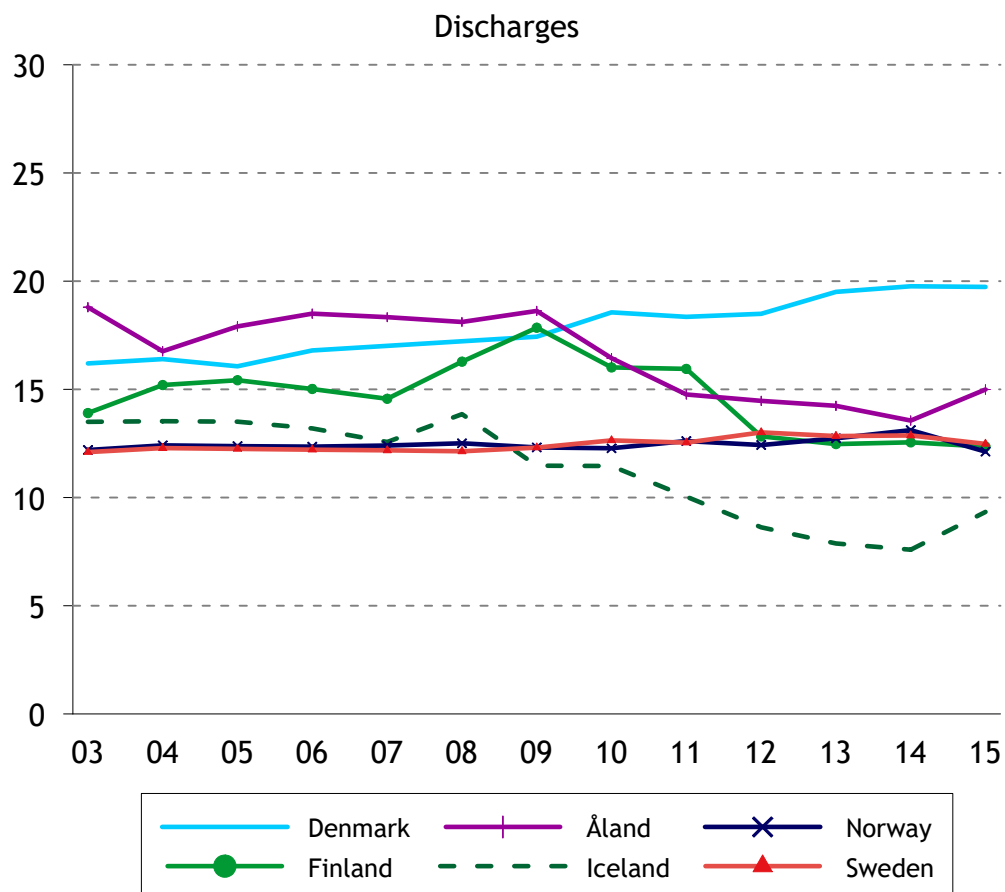


1 Iceland: Only discharges with a length of stay less than 90 days

ICD-10 I00-I99

Source: The national in-patient registers

Figure 3.4.6 Discharges for diseases of the digestive system per 1 000 inhabitants 2003-2015¹



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

ICD-10 K00-K93

Source: The national in-patient registers

Table 3.4.4 Discharges, bed days and average length of stay in wards in ordinary hospitals and special hospitals, 2015

	Denmark	Faroe Islands	Greenland ¹	Finland	Åland ²	Iceland ³	Norway ⁴	Sweden
<i>Discharges per 1 000 inhabitants</i>								
Somatic wards	244	230	296	171	173	106	152	157
Psychiatry wards	9	5	3	10	7	8	14	11
Total	253	235	299	181	180	113	166	168
<i>Bed days per 1 000 inhabitants</i>								
Somatic wards	1 016	960	1 590	1 067	722	642	762	655
Psychiatry wards	155	205	73	165	216	84	350	172
Total	1 187	1 165	1 663	1 232	938	726	1 113	827
<i>Average length of stay</i>								
Somatic wards	4	4	5	6	4	6	5	4
Psychiatry wards	15	39	23	17	32	11	26	16
Total	4	5	4	7	5	6	7	5

1 Somatic wards are throughout Greenland. Psychiatric ward is only at DIH (Dronning Ingrid's Hospital)

2 Average 2011-15

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

4 Figures for psychiatry include activity in psychiatric hospitals, psychiatric wards and community mental health care centre. Beds for adults, children and people receiving treatment for addiction are included. Figures for somatic wards include activity in somatic hospitals (not including rehabilitation).

A patient is only counted once in somatic and/or psychiatric wards

Source: The national in-patient registers

Table 3.4.5 Discharges, patients treated and average length of stay in hospital for malignant neoplasm of trachea, bronchus and lungs, 2015

	Denmark	Finland	Åland ¹	Iceland ^{1,2}	Norway	Sweden
<i>Discharges</i>						
Men, total	2 553	2 835	12	170	3 343	3 594
Women, total	2 899	1 645	8	201	3 011	4 044
<i>Patients treated</i>						
Men, total	1 683	1 564	7	87	1 780	2 220
Women, total	1 879	888	5	101	1 628	2 468
<i>Patients treated per 100 000 men in the age group</i>						
25-44	3	2	-	7	1	2
45-64	59	51	50	40	59	33
65+	255	251	185	339	358	201
Total rate	60	58	49	53	68	45
<i>Patients treated per 100 000 women in the age group</i>						
25-44	3	1	-	2	3	2
45-64	82	32	32	73	70	44
65+	218	105	101	315	250	183
Total rate	66	32	29	63	63	50
Average length of stay per discharge	5.5	8.6	13.9	9.0	6.7	9.9

1 Average 2011-15

2 Only discharges with a length of stay less than 90 days
ICD-10 C33-C34

Source: The national in-patient registers

Table 3.4.6 Discharges, patients treated and average length of stay in hospital for malignant neoplasm of breast, women 2015

	Denmark	Finland	Åland ¹	Iceland ^{1,2}	Norway	Sweden
<i>Discharges</i>						
Total	6 227	8 121	31	378	4 468	7 207
<i>Patients treated</i>						
Total	4 744	6 361	27	296	3 351	6 374
<i>Patients treated per 100 000 women in the age group</i>						
25-44	60	63	58	48	42	44
45-64	274	399	238	349	226	193
65+	397	484	354	235	163	334
Total rate	166	229	154	183	130	130
Average length of stay per discharge	2.1	4.8	5.7	5.5	3.0	3.4

1 Average 2011-15

2 Only discharges with a length of stay less than 90 days
ICD-10 C50

Source: The national in-patient registers

Table 3.4.7 Discharges, patients treated and average length of stay in hospital for acute myocardial infarction 2015

	Denmark	Finland	Åland ¹	Iceland ^{1,2}	Norway	Sweden
<i>Discharges</i>						
Men, Total	10 794	8 323	40	338	11 227	18 536
Women, Total	4 985	5 156	28	148	5 399	10 395
<i>Patients treated</i>						
Men, Total	6 117	6 110	31	305	6 930	12 489
Women, Total	2 990	3 904	21	144	3 611	7 317
<i>Patients treated per 100 000 men in the age group</i>						
0-44	18	12	11	38	18	9
45-64	318	270	226	266	393	283
65+	712	828	785	967	1 041	986
Total rate	217	227	217	188	265	255
<i>Patients treated per 100 000 women in the age group</i>						
0-44	7	2	-	2	4	2
45-64	101	77	65	78	102	88
65+	368	529	511	492	627	594
Total rate	105	140	124	89	140	149
Average length of stay per discharge	2.9	6.0	6.2	5.9	3.6	4.1

1 Average 2011-15

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

ICD-10 I21-I22

Source: The national in-patient registers

Table 3.4.8 Discharges, patients treated and average length of stay in hospital for cerebrovascular diseases 2015

	Denmark	Finland	Åland ¹	Iceland ^{1,2}	Norway	Sweden
<i>Discharges</i>						
Men, Total	10 227	11 581	40	311	7 164	20 399
Women, Total	8 798	10 775	43	236	6 215	17 455
<i>Patients treated</i>						
Men, Total	7 703	7 804	32	226	5 950	14 475
Women, Total	6 594	7 399	33	173	5 210	12 930
<i>Patients treated per 100 000 men in the age group</i>						
0-44	25	22	16	22	15	16
45-64	295	280	165	123	206	220
65-79	864	950	722	561	839	932
80+	1 872	1 928	1 573	1 466	2 178	2 529
Total rate	273	289	227	139	228	295
<i>Patients treated per 100 000 women in the age group</i>						
0-44	22	25	2	12	17	15
45-64	195	173	117	68	135	141
65-79	574	609	435	338	537	583
80+	1 821	1 925	1 701	1 372	2 064	2 603
Total rate	231	266	189	107	202	264
Average length of stay per discharge	4.4	16.2	20.6	14.2	7.8	9.6

1 Average 2011-15

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

ICD-10 I60-I69

Source: The national in-patient registers

Table 3.4.9 Discharges, patients treated and average length of stay in hospital for chronic obstructive pulmonary disease and bronchiectasis, 2015

	Denmark	Finland	Åland ¹	Iceland ^{1,2}	Norway	Sweden
<i>Discharges</i>						
Total	21 561	6 613	59	458	11 309	19 586
<i>Patients treated</i>						
Total	12 205	4 075	31	324	7 400	11 437
<i>Per 100 000 in the age group</i>						
0-4	72	2	-	-	7	4
5-14	3	-	-	-	3	1
15-24	3	1	-	-	2	2
25-64	96	28	38	40	58	28
65-74	593	245	435	487	558	324
75+	1 303	379	654	752	843	766
<i>Total rate</i>	215	74	121	100	143	117
<i>Average length of stay</i>	3.1	7.2	7.7	9.8	6.7	5.7

1 Average 2011-15

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

ICD-10 J40-J44, J47

Source: The national in-patient registers

Table 3.4.10 Discharges, patients treated and average length of stay in hospital for asthma, 2015

	Denmark	Finland	Åland ¹	Iceland ^{1,2}	Norway	Sweden
<i>Discharges</i>						
Total	6 658	2 899	15	61	2 614	4 170
<i>Patients treated</i>						
Total	5 094	2 388	13	52	2 282	3 398
<i>Per 100 000 in the age group</i>						
0-4	457	121	325	65	200	256
5-14	137	34	42	7	53	29
15-24	79	12	21	8	21	11
25-64	59	23	25	10	28	13
65-74	51	58	28	17	51	24
75+	55	157	131	52	55	67
<i>Total rate</i>	90	44	51	16	44	35
<i>Average length of stay</i>	1.9	5.0	3.7	4.1	6.8	2.4

1 Average 2011-15

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

ICD-10 J45-J46

Source: The national in-patient registers

Table 3.4.11 Discharges, patients treated and average length of stay in hospital for alcoholic liver disease, 2015

	Denmark	Finland	Åland ¹	Iceland ^{1,2}	Norway	Sweden
<i>Discharges</i>						
Men, Total	1 866	1 400	2	15	617	1 425
Women, Total	886	557	-	8	245	551
<i>Patients treated</i>						
Men, Total	1 031	820	1	16	345	807
Women, Total	482	318	-	6	156	340
<i>Patients treated per 100 000 men in the age group</i>						
0-44	5	5	-	3	2	2
45-64	85	73	30	28	30	35
65+	68	46	7	10	31	37
Total rate	37	30	10	10	13	16
<i>Patients treated per 100 000 women in the age group</i>						
0-44	2	2	-	2	1	1
45-64	43	28	-	3	14	17
65+	26	13	6	13	11	11
Total rate	17	11	1	4	6	7
Average length of stay per discharge	6.4	7.7	15.4	12.5	7.3	7.9

1 Average 2011-15

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

ICD-10 K70

Source: The national in-patient registers

Table 3.4.12 Discharges, patients treated and average length of stay in hospital for other diseases of the liver, 2015

	Denmark	Finland	Åland ¹	Iceland ^{1,2}	Norway	Sweden
<i>Discharges</i>						
Men, Total	1 805	928	2	15	778	1 469
Women, Total	1 561	982	3	24	854	1 343
<i>Patients treated</i>						
Men, Total	1 121	603	2	5	550	1 005
Women, Total	1 056	704	3	12	617	929
<i>Patients treated per 100 000 men in the age group</i>						
0-44	13	7	8	2	8	5
45-64	70	35	20	5	34	28
65+	83	53	30	5	52	57
Total rate	40	22	14	3	21	21
<i>Patients treated per 100 000 women in the age group</i>						
0-44	14	10	7	2	9	6
45-64	58	34	12	8	34	24
65+	72	50	51	31	57	46
Total rate	37	25	17	7	24	19
Average length of stay per discharge	5.0	6.1	9.3	8.6	7.0	7.6

1 Average 2011-15

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

ICD-10 K71-77

Source: The national in-patient registers

Table 3.4.13 Discharges, patients treated and average length of stay in hospital for intervertebral disc disorders, 2015

	Denmark	Finland	Åland ¹	Iceland ^{1,2}	Norway	Sweden
<i>Discharges</i>						
Men, Total	3 384	2 495	4	61	3 119	2 240
Women, Total	3 328	2 277	5	73	2 885	2 254
<i>Patients treated</i>						
Men, Total	2 810	2 121	3	39	2 734	1 821
Women, Total	2 762	1 932	4	45	2 493	1 848
<i>Patients treated per 100 000 men in the age group</i>						
0-24	8	10	-	-	9	5
25-44	136	126	51	33	134	51
45-64	172	123	30	38	191	61
65+	98	56	7	46	102	37
Total rate	100	79	21	24	105	37
<i>Patients treated per 100 000 women in the age group</i>						
0-24	8	11	13	2	12	5
25-44	141	112	63	48	128	56
45-64	162	102	16	25	170	63
65+	86	58	11	58	91	31
Total rate	97	69	26	28	97	38
<i>Average length of stay per discharge</i>						
Men	2.3	3.8	4.1	2.9	3.1	3.5
Women	2.8	4.1	6.3	4.0	3.4	3.9

1 Average 2011-15

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

ICD-10 M50-51

Source: The national in-patient registers

Table 3.4.14 Discharges, patients treated and average length of stay in hospital for fracture of the femur, 2015

	Denmark	Finland	Åland ¹	Iceland ^{1,2}	Norway	Sweden
<i>Discharges</i>						
Men, Total	3 083	4 035	15	180	3 446	7 891
Women, Total	3 838	7 852	20	342	6 948	15 766
<i>Patients treated</i>						
Men, Total	2 409	2 823	13	165	11 294	6 118
Women, Total	2 937	5 380	19	281	8 986	12 443
<i>Patients treated per 100 000 men in the age group</i>						
0-44	76	21	13	16	330	16
45-64	99	62	65	48	471	45
65-74	94	196	136	193	574	196
75-79	95	456	351	562	780	472
80+	104	1 166	963	1 842	1 382	1 728
Total rate	85	105	94	101	432	125
<i>Patients treated per 100 000 women in the age group</i>						
0-44	47	10	7	7	169	7
45-64	134	49	28	60	259	49
65-74	196	206	157	344	496	290
75-79	193	607	292	567	890	802
80+	260	1 915	1 195	2 713	2 113	2 784
Total rate	103	193	111	174	349	254
Average length of stay per discharge	3.8	10.7	11.7	12.0	6.1	8.7

1 Average 2011-15

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

ICD-10 S72

Source: The national in-patient registers

Figure 3.4.7 Average bed days for somatic wards, 2000-2015

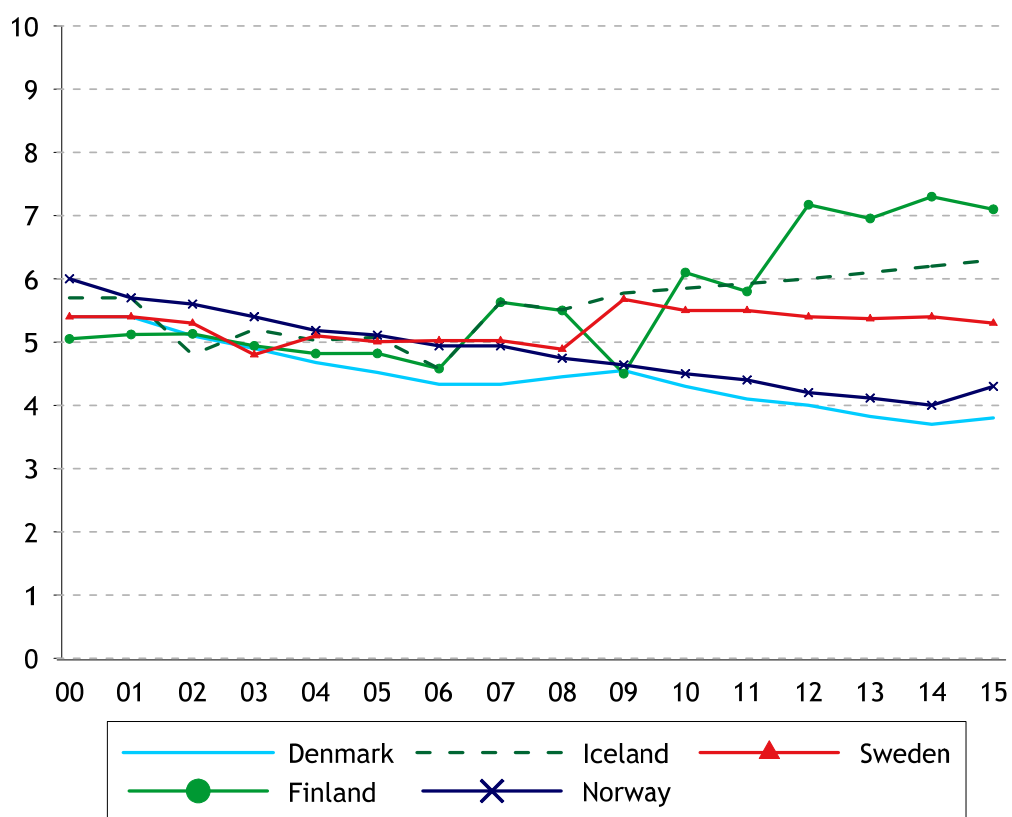


Table 3.4.15 In-patient treatment in psychiatric wards, by age and gender, 2015

	Denmark	Faroe Islands	Finland ¹	Åland ^{1, 2}	Iceland ³	Norway ⁴	Sweden ⁵
Discharges, total	51 873	260	36 919	286	2 546	70 386	107 001
Discharges per 1 000 inhabitants	9.1	5.0	6.7	9.9	7.8	13.7	10.9
Total bed days	794 293	10 036	1 184 535	4 756	27 347	2 973 458	1 682 374
Bed days per 1 000 inhabitants	139.9	140.0	216.2	164.6	84.3	578.8	171.7
Treated patients, total	25 822	164	23 498	155	1 586		52 712
Treated patients, per 1 000		3.4					5.4
<i>Men</i>							
0-14	0.4	-	2.2	0.2	1.9	..	0.2
15-29	6.0	0.6	6.1	8.4	14.5	..	7.7
30-44	6.9	0.7	5.6	7.1	10.3	..	7.4
45-64	5.8	0.9	4.3	7.1	6.4	..	7.8
65-79	3.0	0.4	2.9	3.7	2.6	..	4.7
80+	3.6	-	2.6	2.1	2.7	..	4.1
Total	4.7	2.6	4.2	5.4	7.6	..	5.8
<i>Women</i>							
0-14	0.6	-	1.7	0.3	1.1	..	0.5
15-29	7.2	1.1	7.5	10.3	14.2	..	8.4
30-44	5.4	0.5	5.0	6.0	11.5	..	6.1
45-64	4.9	0.7	4.0	6.0	7.4	..	5.8
65-79	3.4	0.2	4.0	5.0	7.1	..	4.1
80+	4.1	0.2	3.3	2.3	1.4	..	3.9
Total	4.4	2.7	4.3	5.3	8.1	..	5.1
<i>Men and women</i>							
0-14	0.5	-	1.9	0.3	1.5	..	0.3
15-29	6.6	1.7	6.8	9.3	14.3	..	8.0
30-44	6.2	1.2	5.3	6.5	10.9	..	6.8
45-64	5.3	1.6	4.1	6.6	6.9	..	6.8
65-79	3.2	0.6	3.5	4.4	4.9	..	4.4
80+	3.9	0.2	3.1	2.2	2.0	..	3.9
Total	4.5	5.3	4.3	5.4	7.8	..	5.4
Average length of stay per discharge	15.3	51.0	32.1	16.7	10.7	..	15.7

1 Figures for psychiatry include activity in psychiatric hospitals. Beds for adults and children are included. Figures for somatic wards include activity in somatic hospitals. A patient is only counted once in somatic and/or psychiatric wards

2 Average 2011-15

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

4 Figures for psychiatry include activity in psychiatric hospitals, psychiatric wards and community mental health care centre. Beds for adults, children and people receiving treatment for addiction are included. Figures for somatic wards include activity in somatic hospitals (not rehabilitation). A patient is only counted once in somatic and/or psychiatric wards

5 Figures for psychiatry include activity in psychiatric wards in ordinary and specialized hospitals

Source: The national in-patient registers

Table 3.4.16 Discharges from hospitals¹ per 1 000 inhabitants, by age and gender, 2015

Age	Denmark	Finland	Åland ²	Iceland ^{2,3}	Norway	Sweden
<i>Men</i>						
0-14	137	76	68	62	74	59
15-44	107	56	51	40	55	61
45-64	240	142	107	87	140	132
65-69	419	270	227	195	278	245
70-74	540	348	305	265	380	338
75-79	679	480	376	357	475	456
80+	975	677	646	561	686	737
Total	233	145	130	91	135	143
<i>Women</i>						
0-14	115	63	48	54	44	49
15-44	211	131	117	133	144	149
45-64	214	117	105	98	151	116
65-69	320	197	160	184	226	187
70-74	413	263	208	256	275	267
75-79	541	360	285	340	359	363
80+	781	564	537	473	321	601
Total	255	166	141	134	161	169

1 Includes somatic wards in regular hospitals and in somatic special hospitals

2 Average 2011-15

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

Source: The national in-patient registers

Table 3.4.17 Bed days for hospitals¹ per 1 000 inhabitants, by age and gender, 2015

Age	Denmark	Finland	Åland ²	Iceland ^{2,3}	Norway	Sweden
<i>Men</i>						
0-14	354	370	287	237	281	233
15-44	534	404	323	238	200	401
45-64	945	875	780	527	606	721
65-69	1 610	1 790	1 671	1 418	1 370	1 253
70-74	2 099	2 392	2 316	2 039	1 934	1 775
75-79	2 629	3 509	3 064	3 205	2 477	2 591
80+	3 891	6 317	7 086	6 073	3 529	4 566
Total	926	1 013	1 010	645	608	805
<i>Women</i>						
0-14	321	297	185	207	241	201
15-44	667	671	616	411	439	548
45-64	805	675	830	552	550	592
65-69	1 232	1 227	1 101	1 324	1 052	990
70-74	1 627	1 762	1 553	2 061	1 489	1 471
75-79	2 228	2 868	2 490	3 015	1 878	2 120
80+	3 215	6 737	7 711	5 570	2 572	3 959
Total	922	1 197	1 177	779	665	849

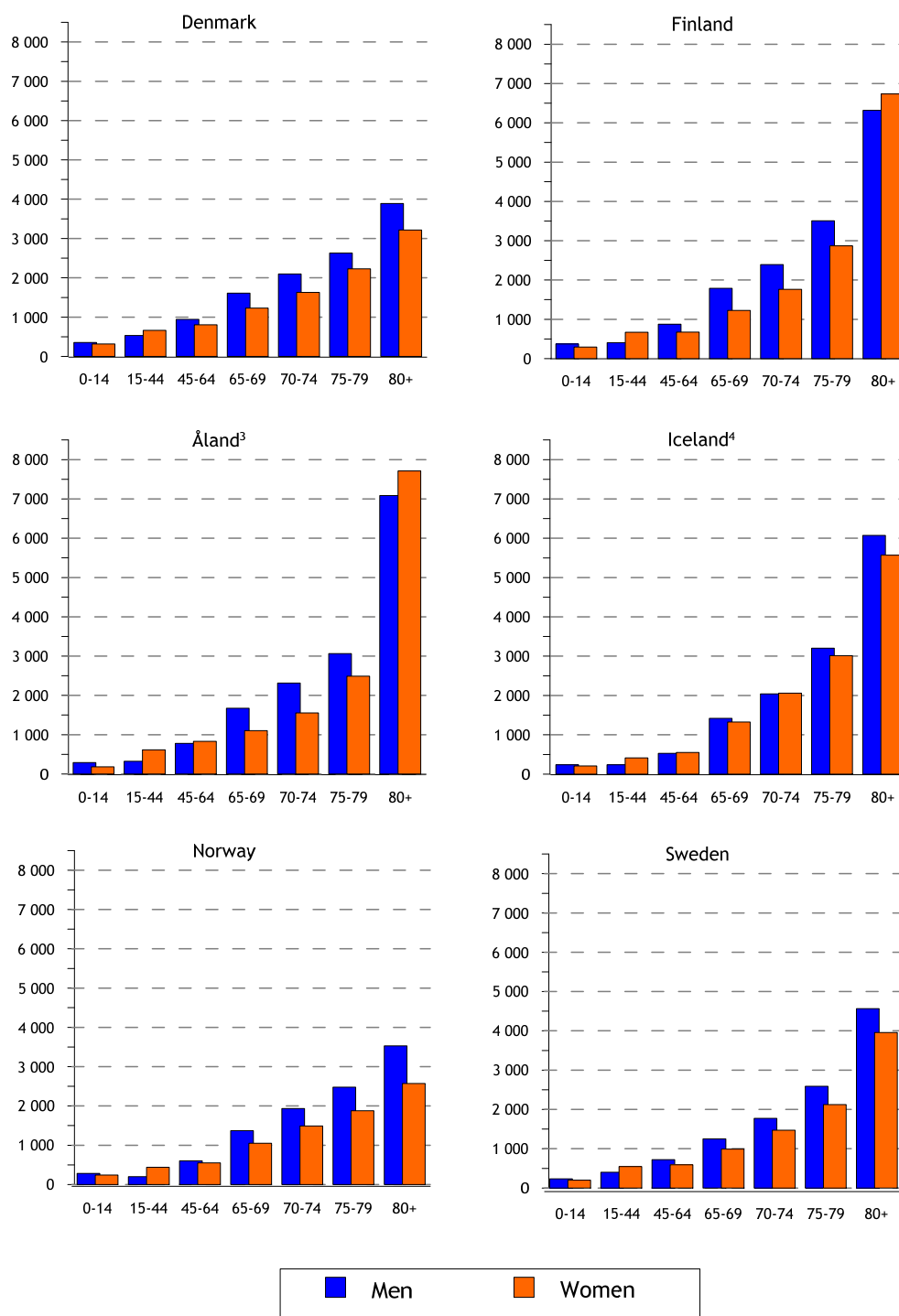
1 Includes somatic wards in regular hospitals and in somatic special hospitals

2 Average 2011-15

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

Source: The national in-patient registers

Figure 3.4.8 Bed days for hospitals¹ per 1 000 inhabitants, by age and gender, 2015



1 Includes somatic wards in regular hospitals and in somatic special hospitals

2 2013

3 Average 2010-14

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

Source: The national in-patient registers

3.5 Surgical procedures

In this section, data on selected surgical procedures performed in short-term somatic hospitals are presented. The selected list of procedures used here was developed for international comparison by the EU Hospital Data Project (HDP2).

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

Outline of this section

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

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

Quality and limitations of the data

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

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

The fact that the Nordic countries use the same procedure classification makes comparisons easier. The Nordic procedure classification, however, has not been updated since 2011. The national coding systems have started to differ from the Nordic one, which reduces the comparability. The relevant NCSP-E codes for each procedure are listed in all tables.

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

These difficulties are reflected in the Nordic statistics. Denmark has had some difficulties in separating day treatment and out-patient treatment. A further known under-reporting in the national patient registers is also caused by some private hospitals not reporting to the national registers.

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

Table 3.5.1 shows the rates per 100 000 inhabitants for men and women for all surgical procedures on the new list. However, it only covers hospitalized patients and therefore does not give a complete picture of surgical procedures that are often performed on an out-patient basis, e.g. cataract surgery, colonoscopy and hernia surgery. Several of the more common surgical procedures that are performed on in-patients, tend to show almost the same rates in all countries (with the exception of Åland, which has a small number of inhabitants and some patients are treated in Sweden and are therefore not included in the Finnish in-patient register). These are, for example, transluminal coronary angioplasty and hysterectomy. The difference between the genders are already known in all the countries, where the numbers are higher for men for heart surgery and hernia operations, and higher for women for thyroidectomy, cholecystectomy and replacement of the hip joint. The low rates for decompression of bone marrow and nerve roots in Sweden are to some degree due to lack of reporting from three private special hospitals. High rates are seen for hernia operations and transurethral prostatectomy for men in Finland and Åland and for transluminal coronary angioplasty for men in Norway. Finnish women have a high rate for transluminal coronary angioplasty, Swedish women for colectomy, and Norwegian women for hip replacement. Colonoscopy rates are high in Denmark for both men and women.

Table 3.5.1a Surgical procedures performed on in-patients per 100 000 inhabitants by list of selected procedures, men¹

Surgical procedures (NCSP-E codes in brackets)	Denmark 2015	Finland 2015	Åland 2011-15	Iceland 2011-15	Norway 2015	Sweden 2015
1: Extirpation, excision and destruction of intra-cranial lesion (AAB00-AAB20, AAB99)	21.7	18.9	16.8	15.0	19.4	16.8
2: Evacuation of subdural haematoma and intra-cranial haemorrhage (AAB30, AAD05-AAD15)	25.4	35.6	44.8	15.1	21.9	23.3
3: Discectomy (ABC)	163.8	137.4	78.4	65.6	141.0	75.5
4: Thyroidectomy (BAA20-BAA60)	20.4	15.5	7.0	12.5	12.7	12.3
5: Cataract surgery (CJC, CJD, CJE, CJF)	10.3	17.2	23.8	5.4	18.6	18.5
6: Cochlear implantation (DFE00)	4.7	3.0	1.4	1.5	1.5	3.2
7: Tonsillectomy (EMB10-EMB20)	55.6	38.8	106.4	21.5	57.2	39.7
8: Pulmectomy (GDB20-21, GDC, GDD)	16.4	11.8	5.6	14.6	13.9	8.0
9: Diagnostic bronchoscopy with or without biopsy (UGC)	82.5	51.2	18.2	79.1	102.9	39.2
10: Transluminal coronary angioplasty (FNG02, FNG05)	186.2	288.1	26.6	209.2	335.3	255.2
11: Coronary artery bypass graft (FNC, FND, FNE) ²	58.2	38.0	4.2	73.1	53.6	48.6
12: Carotid endarterectomy (PAF20-PAF22)	11.0	17.1	2.8	8.2	12.0	12.2
13: Infrarenal aortic aneurysm repair (PDG10-PDG24, PDQ10)	24.6	16.8	11.2	15.1	22.9	10.3
14: Femoropopliteal bypass (PEH)	8.6	13.7	19.6	6.0	6.4	4.9
15: Stem cell transplantation (not included ³)	9.3	5.8	-	-	-	-
16: Colonoscopy with or without biopsy (JFA15, UJF32, UJF35, UJF42, UJF45)	275.0	61.0	32.2	154.3	198.6	112.9
17: Colectomy (JFB20-JFB64, JFH)	88.2	63.9	70.0	50.2	75.9	117.1
<i>Of which:</i> 17A: Laparoscopic colectomy (JFB21, JFB31, JFB34, JFB41, JFB44, JFB47, JFB51, JFB61, JFB64, JFH01, JFH11)	42.2	23.3	2.8	14.6	30.4	10.8

Continues

Table 3.5.1a Surgical procedures performed on in-patients per 100 000 inhabitants by list of selected procedure, men, Continued¹

Surgical procedures (NCSP-E codes in brackets)	Denmark 2015	Finland 2015	Åland 2011-15	Iceland 2011-15	Norway 2015	Sweden 2015
18: Appendectomy (JEA)	102.0	127.5	149.8	148.2	130.8	123.6
<i>Of which:</i>						
18A: Laparoscopic appendectomy (JEA01)	93.0	69.4	8.4	89.5	113.6	68.8
19: Cholecystectomy (JKA20, JKA21)	56.0	87.0	99.4	72.3	53.0	80.4
<i>Of which:</i>						
19A: Laparoscopic cholecystectomy (JKA21)	44.8	70.6	74.2	64.4	46.2	63.4
20: Repair of inguinal hernia (JAB)	56.0	118.5	121.8	37.4	74.1	58.6
<i>Of which:</i>						
20: Laparoscopic repair of inguinal hernia (JAB11, JAB97)	21.5	11.1	23.8	9.2	28.3	2.5
21: Transplantation of kid- ney (KAS00-KAS20)	6.2	5.6	9.8	3.4	6.5	5.3
22: Open prostatectomy (KEC, KED00, KED96)	41.8	45.2	72.8	30.0	76.4	80.5
23: Transurethral prostatectomy (KED22, KED52-KED72, KED98)	92.9	135.6	176.4	92.9	127.9	97.2
24: Hysterectomy (LCC, LCD)	0.2	1.1	-	-	0.3	0.5
<i>Of which:</i>						
24A: Laparoscopic hysterec- tomy (LCC01, LCC11, LCC97, LCD01, LCD04, LCD11, LCD31, LCD40, LCD97)	0.2	1.1	-	-	0.2	0.4
25: Caesarean section (MCA)	..	..	..	..	..	..
26: Arthroscopic excision of meniscus of knee (NGD01, NGD11)	4.3	6.9	9.8	0.7	13.1	2.9
27: Hip replacement (NFB, NFC)	187.6	201.5	200.2	139.2	170.4	163.2
<i>Of which:</i>						
27A: Secondary hip replacement (NFC)	20.5	27.4	14.0	21.0	21.0	17.7
28: Total knee re- placement (NGB20-NGB40)	103.0	123.0	142.8	97.4	82.6	84.8
29: Partial excision of mammary gland (HAB00, HAB30, HAB40, HAB99)	0.2	1.0	-	0.4	0.2	0.2
30: Total mastectomy (HAC10-HAC25, HAC99)	4.4	2.3	1.4	3.1	3.3	1.6

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

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

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

Source: The national in-patient registers

Table 3.5.1b Surgical procedures performed on in-patients per 100 000 inhabitants by list of selected procedures, women¹

Surgical procedures (NCSP-E codes in brackets)	Denmark 2015	Finland 2015	Åland 2011-15	Iceland 2011-15	Norway 2015	Sweden 2015
1: Extirpation, excision and destruction of intra-cranial lesion (AAB00-AAB20, AAB99)	21.6	22.5	22.0	17.8	18.7	18.4
2: Evacuation of subdural haematoma and intra-cranial haemorrhage (AAB30, AAD05-AAD15)	11.7	14.9	13.9	6.7	8.2	9.3
3: Discectomy (ABC)	156.2	131.9	73.1	84.4	143.4	74.8
4: Thyroidectomy (BAA20-BAA60)	69.4	67.8	46.4	44.4	51.8	50.0
5: Cataract surgery (CJC, CJD, CJE, CJF)	9.2	20.6	27.8	2.2	15.7	17.3
6: Cochlear implantation (DFE00)	5.1	4.4	2.3	1.7	1.6	3.5
7: Tonsillectomy (EMB10-EMB20)	58.1	32.8	88.2	18.7	62.2	37.0
8: Pulmectomy (GDB20-21, GDC, GDD)	18.6	7.0	5.8	18.1	13.0	9.3
9: Diagnostic bronchoscopy with or without biopsy (UGC)	49.7	30.4	10.4	66.7	73.2	29.2
10: Transluminal coronary angioplasty (FNG02, FNG05)	63.6	124.3	5.8	65.8	105.8	93.9
11: Coronary artery bypass graft (FNC, FND, FNE) ²	11.3	11.1	1.2	16.9	11.9	11.1
12: Carotid endarterectomy (PAF20-PAF22)	6.1	7.8	2.3	3.8	5.5	5.6
13: Infraarenal aortic aneurysm repair (PDG10-PDG24, PDQ10)	4.6	2.0	5.8	2.8	6.7	2.7
14: Femoropopliteal bypass (PEH)	5.4	9.6	13.9	3.5	3.9	3.6
15: Stem cell transplantation (not included ³)	6.2	5.0	-	-	-	-
16: Colonoscopy with or without biopsy (JFA15, UJF32, UJF35, UJF42, UJF45)	245.6	60.7	29.0	171.7	209.2	123.0
17: Colectomy (JFB20-JFB64, JFH)	93.8	68.6	52.2	60.1	89.6	131.8
<i>Of which:</i>						
17A: Laparoscopic colectomy (JFB21, JFB31, JFB34, JFB41, JFB44, JFB47, JFB51, JFB61, JFB64, JFH01, JFH11)	43.4	27.5	1.2	18.3	35.8	12.8

The table continues

Table 3.5.1b Surgical procedures performed on in-patients per 100 000 inhabitants by list of selected procedures, women, Continued¹

Surgical procedures (NCSP-E codes in brackets)	Denmark	Finland	Åland	Iceland	Norway	Sweden
	2015	2015	2011-15	2011-15	2015	2015
18: Appendectomy (JEA)	108.6	125.3	106.7	131.7	131.1	129.2
<i>Of which:</i>						
18A: Laparoscopic appendectomy (JEA01)	91.8	86.0	37.1	94.4	109.4	78.2
19: Cholecystectomy (JKA20, JKA21)	91.3	119.7	165.9	151.8	105.9	129.1
<i>Of which:</i>						
19A: Laparoscopic cholecystectomy (JKA21)	81.8	107.2	148.5	145.5	100.0	113.4
20: Repair of inguinal hernia (JAB)	9.1	17.3	12.8	5.7	9.5	6.4
<i>Of which:</i>						
20: Laparoscopic repair of inguinal hernia (JAB11, JAB97)	5.4	3.3	1.2	1.2	3.1	0.5
21: Transplantation of kidney (KAS00-KAS20)	3.5	3.1	4.6	1.6	3.3	3.0
22: Open prostatectomy (KEC, KED00, KED96)	..	..	..	..	..	..
23: Transurethral prostatectomy (KED22, KED52-KED72, KED98)	..	..	..	..	..	..
24: Hysterectomy (LCC, LCD)	153.8	165.5	273.7	219.6	176.1	163.8
<i>Of which:</i>						
24A: Laparoscopic hysterectomy (LCC01, LCC11, LCC97, LCD01, LCD04, LCD11, LCD31, LCD40, LCD97)	87.9	100.2	22.0	52.8	88.0	48.8
25: Caesarean section (MCA)	424.0	310.5	412.9	413.8	362.2	380.5
26: Arthroscopic excision of meniscus of knee (NGD01, NGD11)	3.2	4.4	8.1	0.2	9.7	2.7
27: Hip replacement (NFB, NFC)	277.2	292.0	211.1	211.8	336.6	237.1
<i>Of which:</i>						
27A: Secondary hip replacement (NFC)	28.1	37.2	11.6	23.8	33.5	19.0
28: Total knee replacement (NGB20-NGB40)	143.2	219.4	177.5	127.9	123.4	118.7
29: Partial excision of mammary gland (HAB00, HAB30, HAB40, HAB99)	51.5	78.4	40.6	75.0	67.5	59.7
30: Total mastectomy (HAC10-HAC25, HAC99)	70.9	92.7	99.8	77.8	57.9	56.0

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

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

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

Source: The national in-patient registers

Table 3.5.2 Eight surgical procedures often carried out as day surgery; total rate and day surgery rate per 100 000 inhabitants and day surgery as a percentage of all procedures by gender 2015¹

	Denmark		Finland		Norway		Sweden	
	M	W	M	W	M	W	M	W
Cataract surgery (CJC, CJD, CJE, CJF)								
Total rate per 100 000 inhabitants	722	999	638	953	370	515	522	744
Of which day surgery	712	991	621	933	351	499	504	727
Day surgery % of total	98.6	99.1	97.3	97.8	95.0	96.9	96.4	97.7
Tonsillectomy (EMB10-20)								
Total rate per 100 000 inhabitants	97	116	146	162	132	167	104	100
Of which day surgery	41	58	107	129	74	104	65	63
Day surgery % of total	42.7	50.2	73.4	79.7	56.6	62.7	61.9	62.9
Diagnostic bronchoscopy with or without biopsy (UGC)								
Total rate per 100 000 inhabitants	295	233	53	32	192	149	111	95
Of which day surgery	212	184	2	1	89	75	72	66
Day surgery % of total	72.0	78.7	4.3	3.9	46.5	50.7	64.7	69.2
Colonoscopy with or without biopsy (JFA15, UJF32, UJF35, UJF42, UJF45)								
Total rate per 100 000 inhabitants	3 025	2 852	71	79	1 345	1 530	925	1 025
Of which day surgery	2 750	2 607	10	18	1 146	1 320	812	902
Day surgery % of total	90.9	91.4	14.2	23.2	85.2	86.3	87.8	88.0
Laparoscopic cholecystectomy (JKA 21)								
Total rate per 100 000 inhabitants	90	205	95	177	64	153	82	161
Of which day surgery	45	123	24	70	18	53	19	48
Day surgery % of total	50.0	60.1	25.7	39.4	27.9	34.5	23.0	29.6
Repair of inguinal hernia (JAB)								
Total rate per 100 000 inhabitants	360	41	333	40	241	28	218	17
Of which day surgery	304	32	214	23	167	18	160	11
Day surgery % of total	84.5	78.0	64.4	57.3	69.3	65.6	73.2	62.5
Arthroscopic excision of meniscus of knee (NGD01, NGD11)								
Total rate per 100 000 inhabitants	261	158	150	77	226	148	99	61
Of which day surgery	256	155	143	72	213	139	96	58
Day surgery % of total	98.4	98.0	95.4	94.3	94.2	93.5	97.1	95.5
Excision of mammary gland (HAB)								
Total per 100 000 inhabitants	2	186	3	133	2	158	2	146
Of which day surgery	2	135	2	54	1	90	2	86
Day surgery % of total	92.6	72.4	61.8	40.8	85.0	57.3	90.5	59.1

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

Source: The national in-patient registers

Of the surgical procedures shown in Table 3.5.2, cataract surgery shows the highest percentage of day surgery in all the countries (96-99 per cent). The difference in the total rates per inhabitant for cataract surgery is mainly due to lack of reporting in all the countries. There are problems with the definition of day surgery and problems with reporting from private hospitals and clinics. Tonsillectomy is performed as day surgery to various extents and with different totals per capita, which is interest-

ing in connection with clinical controversy about the indications for this type of surgery and the need for follow-up after the operation. The very low numbers per capita in Finland for bronchoscopy and colonoscopy are because these procedures do not have to be reported nationally. The number of procedures carried out as day surgery varies a great deal from country to country, with higher rates in Denmark for laparoscopic cholecystectomy and with lower rates in Finland for hernia surgery. Norway and Sweden have higher rates for day surgery for partial breast resection.

Table 3.5.3 Proportion of laparoscopic procedures and secondary hip replacements on in-patients by gender, 2015

Procedure	Denmark		Finland		Åland ¹		Iceland ¹		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W
<i>% laparoscopic</i>												
Colectomy	48	46	37	40	4	2	29	31	40	40	9	10
Appendectomy	91	85	54	69	6	35	60	72	87	83	56	61
Cholecystectomy	80	90	81	90	75	90	89	96	87	94	79	88
Repair of inguinal hernia	38	60	9	19	20	9	25	22	38	33	4	8
Hysterectomy	..	57	..	61	..	8	..	24	..	50	..	30
<i>% secondary</i>												
Hip replacement	11	10	14	13	7	5	15	11	12	10	11	8

1 Average 2011-15

Source: The national in-patient registers

The use of laparoscopic methods is shown in Table 3.5.3. Laparoscopic cholecystectomy is very common in all the countries, and more than 90% of cholecystectomies in Iceland and Norway are laparoscopic. Furthermore, Table 3.5.3 shows that the proportions for secondary hip replacement are similar for all the countries. It should be noted that the secondary hip replacements that are reported here are not secondary to the primary hip replacements performed in 2015, but mostly secondary to surgery performed several years before.

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

Table 3.5.4 Discectomy by age and gender, 2015

Age	Denmark		Finland		Åland ¹		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W
<i>Total number of procedures</i>										
<15	2	7	3	1	-	-	3	4	2	7
15-24	65	50	98	91	-	1	85	81	76	65
25-44	926	896	978	786	3	3	1 009	976	689	666
45-64	2 121	1 793	1 618	1 350	4	3	1 750	1 564	1 451	1 395
65-74	1 161	1 141	862	864	3	3	837	821	952	890
75-84	531	671	416	738	2	2	344	521	559	651
85+	78	75	45	77	-	1	41	73	65	77
Total	4 884	4 633	4 020	3 907	12	13	4 069	4 040	3 827	3 751
<i>Per 100 000 in the age group</i>										
< 15	0	1	1	0	0	0	1	1	0	1
15-24	17	14	30	29	12	32	25	25	12	11
25-44	129	127	140	119	84	82	138	141	53	54
45-64	282	239	221	183	95	61	259	242	118	115
65-74	378	351	290	261	185	178	352	335	178	161
75-84	380	384	295	367	204	148	317	376	214	202
85+	200	95	180	267	111	95	218	178	107	85
Total	173	162	149	140	81	73	156	157	78	77

1 Average 2011-15

NCSP: ABC

Source: The national in-patient registers

Table 3.5.5 Thyroidectomy by age and gender, 2015

Age	Denmark		Finland		Åland ¹		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W
<i>Total number of procedures</i>										
<15	3	3	2	3	-	-	-	3	7	14
15-24	9	47	8	77	-	-	7	49	18	129
25-44	102	529	94	520	-	3	91	419	137	805
45-54	134	532	75	363	-	2	73	338	117	553
55-64	151	399	98	398	-	1	78	265	136	418
65-74	155	371	99	371	1	1	63	201	123	396
75-84	39	144	49	184	-	-	25	73	52	172
85+	6	24	2	25	-	-	1	6	9	24
Total	599	2 049	427	1 941	1	8	338	1 354	610	2 511
<i>Per 100 000 in the age group</i>										
< 15	1	1	0	1	-	-	-	1	1	2
15-24	2	13	2	24	-	11	2	15	3	22
25-44	14	75	13	79	-	68	12	61	11	65
45-54	33	133	20	100	20	81	20	97	18	86
55-64	44	114	27	105	-	57	25	89	24	74
65-74	51	114	33	112	37	73	27	82	23	72
75-84	28	83	35	92	-	-	23	53	20	53
85+	15	30	5	26	-	35	3	8	10	14
Total	21	72	16	70	7	46	13	53	12	51

1 Average 2011-15

NCSP: BAA 20-60

Source: The national in-patient registers

Table 3.5.6 Cataract surgery by age and gender, 2015

Age	Denmark		Finland		Åland ¹		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W
<i>Total number of procedures</i>										
< 45	322	271	242	205	-	-	243	171	408	338
45-64	3 454	4 202	2 956	3 231	2	1	1 499	1 574	3 908	4 269
65-74	7 457	10 824	5 798	8 621	1	1	3 055	4 294	8 734	12 686
75-84	7 400	10 597	6 460	11 303	2	2	3 579	5 226	9 584	14 542
85+	1 747	2 657	1 754	3 166	1	2	1 292	2 012	2 959	4 605
Total	20 380	28 551	17 210	26 526	6	5	9 668	13 277	25 593	36 440
<i>Per 100 000 in the age group</i>										
< 45	20	18	16	14	-	-	16	12	15	13
45-64	459	561	403	437	45	16	222	243	317	353
65-74	2 430	3 330	1 947	2 603	74	42	1 286	1 754	1 629	2 293
75-84	5 297	6 071	4 588	5 628	281	185	3 297	3 774	3 661	4 523
85+	4 486	3 373	4 408	3 269	203	313	3 403	2 600	3 346	2 724
Total	722	1 000	638	953	41	31	370	515	522	744

1 Average 2011-15

NCSP: CJC, CJD, CJE, CJF

Source: The national in-patient registers

Table 3.5.7a Transluminal coronary angioplasty (PTCA, PCI) by age, men 2015

Age	Denmark	Finland	Iceland	Norway	Sweden
<i>Total number of procedures</i>					
<45	329	293	13	324	321
45-54	1 201	949	60	1 398	1 545
55-64	2 161	2 143	101	2 639	3 558
65-74	2 526	2 683	94	3 029	5 214
75-84	1 479	1 862	63	1 636	2 977
85+	302	410	9	357	628
Total	7 998	8 340	340	9 383	14 243
<i>Per 100 000 in the age group</i>					
<45	21	20	13	21	12
45-54	294	258	282	380	234
55-64	626	586	544	861	623
65-74	823	901	820	1 275	973
75-84	1 059	1 322	1 001	1 507	1 137
85+	776	1 030	466	940	710
Total	283	309	209	359	291

NCSP: FNG 02; FNG 05

Source: The national in-patient registers

Table 3.5.7b Transluminal coronary angioplasty (PTCA, PCI) by age, women 2015

Age	Denmark	Finland	Iceland	Norway	Sweden
<i>Total number of procedures</i>					
<45	93	88	3	53	51
45-54	271	204	11	267	311
55-64	543	562	24	547	873
65-74	811	1 083	31	959	1 690
75-84	779	1 284	26	833	1 648
85+	227	455	11	261	510
Total	2 724	3 676	106	2 920	5 083
<i>Per 100 000 in the age group</i>					
<45	6	6	3	4	2
45-54	68	56	50	77	49
55-64	156	149	131	183	154
65-74	250	327	270	392	306
75-84	446	639	348	602	513
85+	288	470	321	337	302
Total	95	132	66	113	104

NCSP: FNG 02; FNG 05

Source: The national in-patient registers

Table 3.5.8a Coronary artery bypass graft by age, men 2015

Age	Denmark	Finland	Iceland	Norway	Sweden
<i>Total number of procedures</i>					
<45	28	10	1	20	24
45-54	166	70	9	111	170
55-64	385	263	30	414	563
65-74	721	457	52	560	1 048
75-84	334	215	25	281	560
85+	10	10	1	13	20
Total	1 644	1 025	119	1 399	2 385
<i>Per 100 000 in the age group</i>					
<45	2	1	1	1	8
45-54	41	19	44	30	26
55-64	112	72	164	135	99
65-74	235	153	452	236	195
75-84	239	153	399	259	214
85+	26	25	40	34	23
Total	58	38	73	54	49

NCSP: FNC, FND, FNE

Source: The national in-patient registers

Table 3.5.8b Coronary artery bypass graft by age, women 2015

Age	Denmark	Finland	Iceland	Norway	Sweden
<i>Total number of procedures</i>					
<45	6	2	1	2	4
45-54	35	11	1	17	24
55-64	69	53	7	64	84
65-74	122	131	11	122	235
75-84	88	105	6	97	184
85+	4	7	1	9	11
Total	324	309	27	311	542
<i>Per 100 000 in the age group</i>					
<45	-	-	1	-	-
45-54	9	-	6	5	4
55-64	20	14	39	21	15
65-74	38	40	91	50	42
75-84	50	52	85	70	57
85+	5	7	29	12	7
Total	11	11	17	12	11

NCSP: FNC, FND, FNE

Source: The national in-patient registers

Table 3.5.9a Appendectomy by age, men 2015

Age	Denmark	Finland	Åland ¹	Norway	Sweden
<i>Total number of procedures</i>					
<15	645	380	3	495	1 092
15-24	746	631	5	865	735
25-44	947	1 214	6	1 088	1 954
45-64	609	821	5	650	1 095
65+	376	426	3	330	650
Total	3 323	3 472	21	3 517	6 151
<i>Per 100 000 in the age group</i>					
<15	131	83	134	104	125
15-24	199	192	302	251	120
25-44	132	174	158	149	151
45-64	81	112	120	96	89
65+	77	89	104	86	73
Total	118	129	150	135	125

1 Average 2011-15

NCSP: JEA

Source: The national in-patient registers

Table 3.5.9b Appendectomy by age, women 2015

Age	Denmark	Finland	Åland ¹	Norway	Sweden
<i>Total number of procedures</i>					
<15	458	266	3	377	757
15-24	727	660	4	831	1 301
25-44	942	1 189	6	1 101	1 952
45-64	792	930	4	752	1 500
65+	531	494	2	432	894
Total	3 450	3 539	18	3 493	6 404
<i>Per 100 000 in the age group</i>					
<15	98	61	95	83	92
15-24	204	209	226	256	226
25-44	134	180	145	159	157
45-64	106	126	73	116	124
65+	92	79	56	94	86
Total	121	127	107	135	131

1 Average 2011-15

NCSP: JEA

Source: The national in-patient registers

Table 3.5.10a Cholecystectomy by age, men 2015

Age	Denmark	Finland	Åland ¹	Norway	Sweden
<i>Total number of procedures</i>					
<25	85	50	-	59	141
25-44	672	487	3	414	1 074
45-64	1 210	1 161	5	807	2 016
65+	898	1 327	6	574	1 651
Total	2 865	3 025	14	1 854	4 882
<i>Per 100 000 in the age group</i>					
<25	10	6	10	7	9
25-44	94	70	79	57	83
45-64	161	158	130	120	164
65+	185	277	215	149	186
Total	102	112	99	71	100

1 Average 2011-15

NCSP: JKA 20-21

Source: The national in-patient registers

Table 3.5.10b Cholecystectomy by age, women 2015

Age	Denmark	Finland	Åland ¹	Norway	Sweden
<i>Total number of procedures</i>					
<25	358	241	1	277	519
25-44	2 178	1 408	9	1 489	3 012
45-64	2 412	2 211	12	1 521	3 236
65+	1 203	1 438	7	810	1 913
Total	6 151	5 298	29	4 097	8 680
<i>Per 100 000 in the age group</i>					
<25	43	32	31	35	37
25-44	310	213	208	97	242
45-64	322	299	238	235	268
65+	208	229	191	176	183
Total	215	190	166	159	177

1 Average 2011-15

NCSP: JKA 20-21

Source: The national in-patient registers

Table 3.5.11 Transplantation of the kidney by age and gender, 2015

Age	Denmark		Finland		Åland		Iceland		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W
<i>Total number of procedures</i>												
<15	3	1	4	2	-	-	-	-	5	2	4	8
15-24	9	5	2	6	-	-	-	-	9	3	13	17
25-44	58	33	31	14	-	-	1	2	44	19	66	35
45-54	44	24	45	16	-	-	2	1	27	19	56	32
55-64	34	21	36	26	-	-	1	-	47	20	67	32
65+	26	17	33	21	1	1	-	-	38	23	56	27
Total	174	101	151	85	1	1	6	3	170	86	262	151
<i>Per 100 000 in the age group</i>												
< 15	1	-	1	-	-	-	1	-	1	0	-	1
15-24	2	1	1	2	-	-	1	-	3	1	2	3
25-44	8	5	4	2	-	-	2	4	6	3	5	3
45-54	11	6	12	4	20	-	10	3	7	5	8	5
55-64	10	6	10	7	10	8	8	1	15	7	12	6
65+	5	3	7	3	30	17	2	1	10	5	6	3
Total	6	4	6	3	10	5	3	2	7	3	5	3

1 Average 2011-15

NCSP: KAS00-KAS20

Source: The national in-patient registers

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

Table 3.5.12 Open prostatectomy by age, men 2015

Age	Denmark	Finland	Åland ¹	Iceland	Norway	Sweden
<i>Total number of procedures</i>						
<45	6	5	-	1	6	11
45-64	527	566	6	26	838	1 663
65-74	629	620	4	20	1 083	2 075
75-84	28	27	-	2	80	196
85+	-	-	-	0	7	9
Total	1 190	1 218	10	49	2 014	3 954
<i>Per 100 000 in the age group</i>						
<45	-	-	-	0,8	-	-
45-64	70	77	145	65	124	135
65-74	205	208	271	177	456	387
75-84	20	19	26	28	74	75
85+	-	-	-	0	18	10
Total	42	45	73	30	77	81

1 Average 2011-15

NCSP: KEC; KED00; KED96

Source: The national in-patient registers

Table 3.5.13 Transurethral prostatectomy by age, men 2015

Age	Denmark	Finland	Åland ¹	Norway	Sweden
<i>Total number of procedures</i>					
<45	22	6	-	11	13
45-64	715	666	5	660	935
65-74	1 450	1 587	11	1 418	2 188
75-84	872	1 282	8	1 077	1 659
85+	155	307	2	301	356
Total	3 214	3 848	25	3 467	5 151
<i>Per 100 000 in the age group</i>					
<45	1	-	-	1	1
45-64	95	91	115	98	76
65-74	472	533	679	597	408
75-84	624	910	996	992	634
85+	398	771	609	793	403
Total	114	143	176	133	105

1 Average 2011-15

NCSP: KED22; KED52-KED72; KED98

Source: The national in-patient registers

Table 3.5.14 Hysterectomy by age, women 2015

Age	Denmark	Finland	Åland ¹	Iceland	Norway	Sweden
<i>Total number of procedures</i>						
<25	12	6	-	-	12	25
25-44	1 594	1 130	11	128	1 335	2 019
45-64	2 971	2 610	26	183	2 408	4 281
65+	1 260	983	10	43	957	2 225
Total	5 837	4 729	47	354	4 712	8 550
<i>Per 100 000 in the age group</i>						
<25	1	1	4	-	2	2
25-44	227	171	261	294	193	162
45-64	396	353	525	461	372	354
65+	218	156	292	191	208	213
Total	204	170	275	220	183	175

1 Average 2011-15

NCSP: LCC, LCD

Source: The national in-patient registers

Table 3.5.15 Caesarean section by age¹, women 2015

Age	Denmark	Finland	Åland ²	Norway	Sweden
<i>Total number of procedures</i>					
<15-24	1 133	1 023	31	751	1 607
25-34	7 713	5 166	210	5 639	11 225
35-44	3 374	2 421	113	2 950	5 682
45+	50	32	2	79	133
Total	12 270	8 642	356	9 419	18 647
<i>Per 1 000 deliveries³</i>					
<15-24	163	-	-	96	106
25-34	199	118	197	144	150
35-44	274	148	229	247	231
45+	407	214	368	572	436
Total	211	288	1 000	160	162

1 Total fertility rate: The imputed number of live births experienced by women during their fertile period, assuming that their mortality is zero during this period and that the age-specific fertility rates for the year in question are valid throughout the reproductive period

2 Average 2011-15

3 Sweden and Norway NCSP: MCA

Source: The national in-patient registers

Table 3.5.16a Hip replacement by age, men 2015

Age	Denmark	Finland	Åland ¹	Iceland	Norway	Sweden
<i>Total number of procedures</i>						
<25	17	11	-	1	18	15
25-44	158	139	2	9	96	162
45-64	1 488	1 643	7	69	1 063	2 221
65-74	1 966	1 816	10	64	1 461	2 645
75+	1 808	1 839	10	84	1 827	2 992
Total	5 437	5 448	29	226	4 465	8 035
<i>Per 100 000 in the age group</i>						
<25	2	1	5	1	2	1
25-44	22	20	45	21	13	12
45-64	198	224	186	172	158	180
65-74	641	610	629	559	615	493
75+	1 012	1 018	908	1 005	1 247	854
Total	193	202	204	139	171	164

1 Average 2011-15

NCSP: NFB, NFC

Source: The national in-patient registers

Table 3.5.16b Hip replacement by age, women 2015

Age	Denmark	Finland	Åland ¹	Iceland	Norway	Sweden
<i>Total number of procedures</i>						
<25	12	7	-	0	17	16
25-44	142	91	1	4	119	148
45-64	1 576	1 815	8	86	1 619	2 160
65-74	2 599	2 348	12	98	2 634	3 553
75+	3 681	3 879	16	153	4 301	5 793
Total	8 010	8 140	36	342	8 690	11 670
<i>Per 100 000 in the age group</i>						
<25	1	1	-	0	2	1
25-44	20	14	14	10	17	12
45-64	210	245	158	215	250	179
65-74	800	709	649	847	1 076	642
75+	1 453	1 303	943	1 401	1 993	1 181
Total	280	293	211	212	337	238

1 Average 2011-15

NCSP: NFB, NFC

Source: The national in-patient registers

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

Table 3.5.17a Total knee replacement by age, men 2015

Age	Denmark	Finland	Åland ¹	Norway	Sweden
<i>Total number of procedures</i>					
<25	5	1	-	1	-
25-44	29	30	-	29	27
45-64	994	1 215	6	700	1 256
65-74	1 246	1 262	9	890	1 817
75+	689	818	5	544	1 074
Total	2 963	3 326	20	2 164	4 174
<i>Per 100 000 in the age group</i>					
<25	1	-	-	-	-
25-44	4	4	-	4	2
45-64	132	166	160	104	102
65-74	406	424	580	375	339
75+	386	453	426	371	307
Total	105	123	143	83	85

1 Average 2011-15

NCSP: NGB20, NGB30, NGB40

Source: The national in-patient registers

Table 3.5.17b Total knee replacement by age, women 2015

Age	Denmark	Finland	Åland ¹	Norway	Sweden
<i>Total number of procedures</i>					
<25	3	1	-	1	-
25-44	57	27	-	33	40
45-64	1 281	1 928	11	964	1 794
65-74	1 680	2 269	11	1 215	2 291
75+	1 113	1 903	9	975	1 720
Total	4 134	6 128	31	3 188	5 845
<i>Per 100 000 in the age group</i>					
<25	-	-	-	-	-
25-44	8	4	-	5	3
45-64	171	261	218	149	148
65-74	517	685	587	496	414
75+	439	639	544	452	351
Total	145	220	180	124	119

1 Average 2011-15

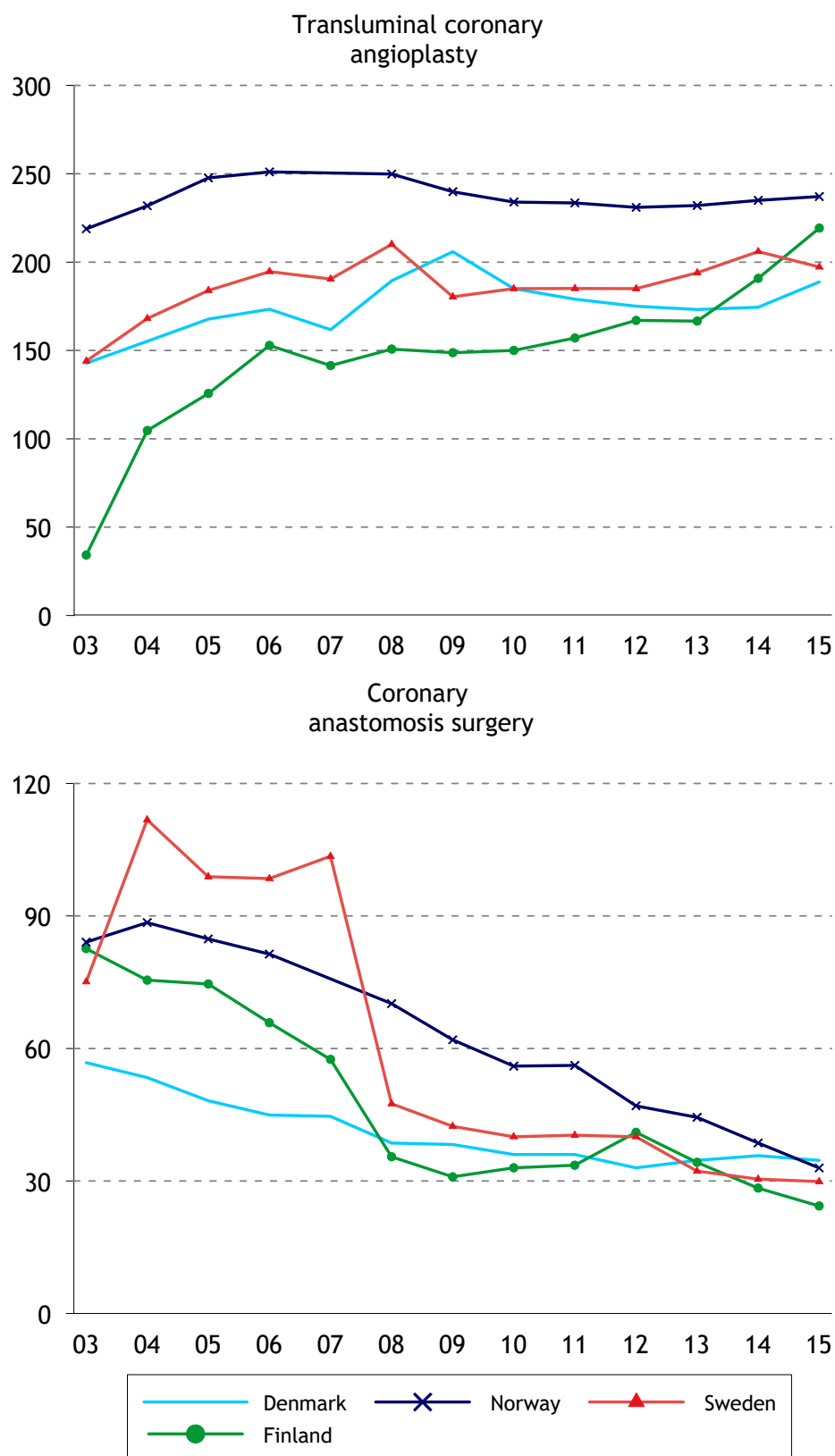
NCSP: NGB20, NGB30, NGB40

Source: The national in-patient registers

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

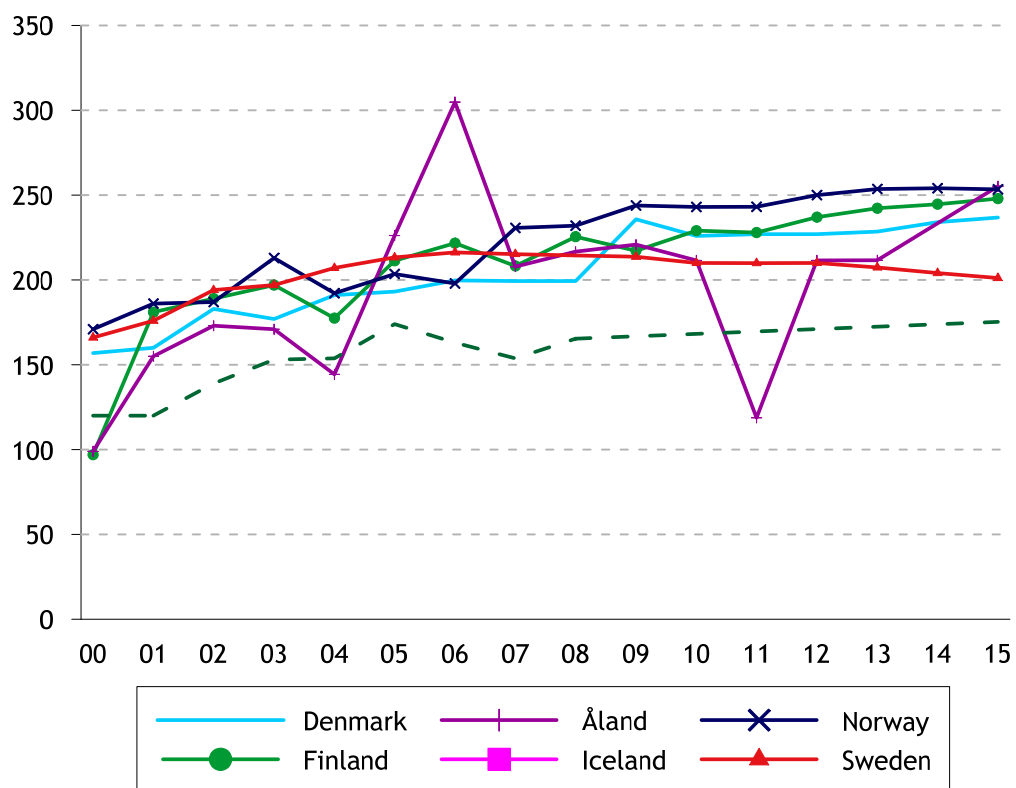
Figure 3.5.1 shows increased rates for percutaneous transluminal coronary angioplasty (PTCA) and slightly decreased rates for coronary anastomosis operations for the period 2003-2014. In general, the countries maintain their relative position over time. The HDP2 list defines coronary anastomosis operations a little less widely than in NOMESCO's earlier statistical data, but this does not explain the lower rates since 2008.

Figure 3.5.1 Transluminal coronary angioplasty and coronary anastomosis surgery, total rates per 100 000 inhabitants, 2003-2015



Source: The national in-patient registers

Figure 3.5.2 Hip replacement per 100 000 inhabitants, 2000-2015



Source: The national in-patient registers

3.6 Accidents and self-inflicted injury

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

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

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

Table 3.6.1 Discharges from hospitals after treatment for injuries per 100 000 inhabitants and by gender, 2015¹

	Denmark		Greenland		Finland		Åland ²		Iceland ²		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W	M	W
Fracture of skull and intracranial injury (S02; S06)	182	113	170	173	303	196	182	144	72	42	168	111	154	108
Fracture at wrist and hand level (S62)	57	23	82	29	63	27	50	15	12	3	30	10	16	8
Injury of lower leg (S80-S89)	172	181	221	243	405	363	250	225	89	66	139	146	105	131
Injury of hip and thigh (S70-S79)	192	353	120	205	243	430	179	191	145	221	156	291	155	291
Poisoning (T36-T65)	159	212	14	95	87	96	37	39	22	32	51	85	72	104
Burn and corrosion (T20-T32)	13	6	16	7	34	15	26	6	14	10	18	12	10	5

1 Including violence and self-inflicted injury

2 Average 2011-15

Source: The national in-patients registers

Table 3.6.2 Discharges from hospitals after treatment for injuries per 100 000 inhabitants by age and gender, 2015¹

Age	Denmark		Finland		Iceland		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W
0-14	1 396	1 027	1 053	804	265	178	787	585	895	670
15-24	1 614	1 392	1 960	1 134	505	405	1 061	821	1 140	972
25-64	1 732	1 442	2 143	1 373	575	472	1 053	846	1 214	1 029
65-79	3 286	3 466	3 308	3 264	1 610	1 991	2 193	2 497	3 430	3 228
80+	7 109	9 329	8 726	11 110	4 789	6 520	5 482	7 129	9 550	11 187
Total	2 049	2 087	2 334	2 205	719	809	1 276	1 340	1 788	1 932

1 Including violence and self-inflicted injury

Source: The national in-patients registers

3.7 Development in consumption of pharmaceutical products

All prevalence tables are based on prescription data.

Data sources in this section: Denmark: the Danish Health Data Authority; Faroe Islands: Chief Pharmaceutical Officer; Greenland: Central Pharmacy in Copenhagen County; Finland and Åland: Finnish Medicines Agency; Iceland: Icelandic Medicines Agency; Norway: Norwegian Institute of Public Health; Sweden: Swedish eHealth Agency and National Board of Health and Welfare.

Table 3.7.1 Sales of pharmaceutical products in total, DDD/1 000 inhabitants/day by ATC-group, 2016¹

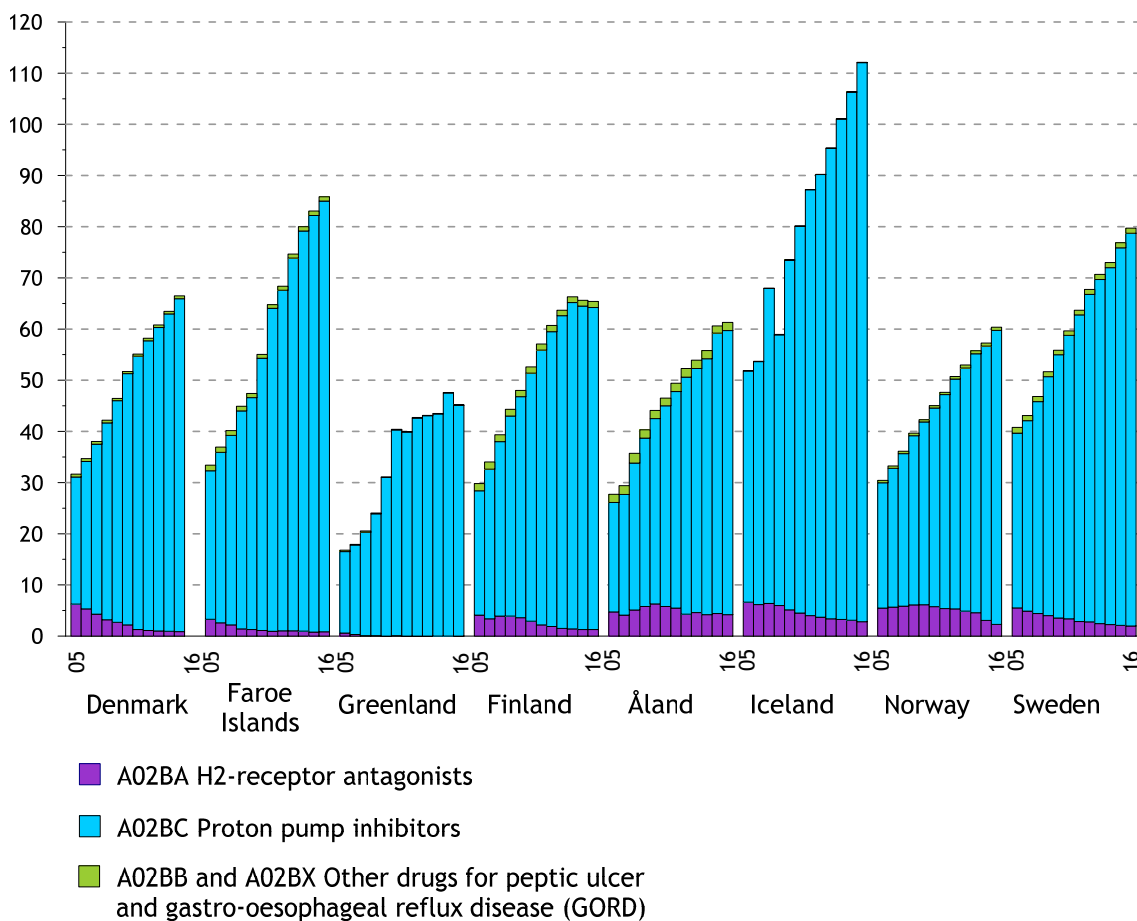
	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A Alimentary tract and metabolism	..	204	130	272	207	200	206	241
B Blood and blood-forming organs	114	130	57	138	139	163	124	256
C Cardiovascular system	549	580	284	554	411	381	415	500
G Genito-urinary system	99	80	70	133	126	110	116	104
H Systemic hormonal preparations excl. sex hormones and insulins	35	31	14	55	57	47	46	46
J Anti-infectives for systemic use	22	17	23	21	17	25	20	16
L Antineoplastic and immunomodulating agents	20	17	10	20	19	18	20	20
M Musculo-skeletal system	..	50	27	98	73	91	62	71
N Nervous system	..	213	114	257	226	392	228	299
P Antiparasitic products, insecticides and repellents	1	2	2	2	1	2	1	1
R Respiratory system	..	122	56	169	144	152	202	180
S Sensory organs	..	11	13	24	19	1	19	23

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

Table 3.7.2 Sales of drugs for acid related disorders (ATC group A02), DDD/1 000 inhabitants/day, 2005-2016

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A02								
Drugs for acid related disorders								
2005	38.9	37.6	18.9	32.7	30.5	54.2	32.5	43.1
2010	58.8	58.3	41.9	55.0	48.9	84.7	46.5	61.5
2014	70.9	83.4	45.3	68.6	58.3	106.0	57.0	75.1
2015	74.2	86.7	49.7	67.7	63.2	114.5	58.5	79.0
2016	..	89.9	47.1	67.5	63.8	121.4	61.6	81.9
A02A								
Antacids								
2005	7.3	4.2	2.1	2.8	2.7	2.4	2.1	2.6
2010	7.1	3.2	1.4	2.3	2.3	4.5	1.4	1.8
2014	7.5	3.4	1.9	2.2	2.5	7.4	1.3	2.1
2015	7.7	3.7	2.1	2.2	2.6	8.2	1.3	2.1
2016	..	4.0	1.9	2.2	2.5	9.3	1.3	2.1
A02B								
Drugs for peptic ulcer and gastro-oesophageal reflux disease								
2005	31.6	33.4	16.8	29.9	27.8	51.9	30.4	40.8
2010	51.7	55.1	40.4	52.7	46.6	80.2	45.0	59.7
2014	63.4	80.0	43.5	66.4	55.9	101.1	55.8	73.0
2015	66.5	83.1	47.6	65.5	60.6	106.3	57.3	76.9
2016	..	85.9	45.2	65.3	61.4	112.1	60.4	79.8
A02BA H2-receptor antagonists								
2005	6.3	3.3	0.6	4.1	4.7	6.6	5.5	5.5
2010	2.2	1.1	0.1	2.9	5.8	4.5	5.8	3.4
2014	0.9	1.0	-	1.4	4.2	3.2	4.6	2.2
2015	0.9	0.8	-	1.3	4.4	3.1	3.0	2.1
2016	..	0.9	-	1.3	4.2	2.8	2.3	2.0
A02BC								
Proton pump inhibitors								
2005	24.8	29.0	15.9	24.3	21.4	45.2	24.5	34.2
2010	49.1	53.2	40.2	48.5	39.2	75.6	38.8	55.4
2014	62.0	78.2	43.4	63.8	50.0	94.9	50.6	69.8
2015	65.1	81.4	47.5	63.2	54.8	103.2	53.6	73.8
2016	65.6	84.2	45.1	62.9	55.5	109.2	57.4	76.7
A02BX								
Other drugs for peptic ulcer and gastro-oesophageal reflux disease								
2005	0.5	1.1	0.3	1.4	1.6	-	0.4	1.1
2010	0.4	0.8	-	1.2	1.5	-	0.4	0.8
2014	0.5	0.9	-	1.1	1.6	-	0.6	0.9
2015	0.5	0.9	-	1.1	1.3	-	0.6	1.0
2016	..	0.9	-	1.1	1.6	-	0.6	1.0

Figure 3.7.1 Sales of drugs for treatment of peptic ulcer and gastro-oesophageal reflux disease (ATC-group A02B), DDD/1 000 inhabitants/day, 2005-2016¹



¹ Figures for Denmark 2016 are not available

Table 3.7.3 Proportion of the population per 1 000 by age and gender (one-year prevalence), receiving at least one proton pump inhibitor (ATC group A02BC) for acid related disorders, 2016

	Men	Women	Total
Denmark			
0-14	8	8	8
15-24	21	38	29
25-44	56	69	62
45-64	123	149	136
65-74	199	222	211
75+	267	294	282
Total	90	114	102
Faroe Islands			
0-14	8	6	7
15-24	20	33	26
25-44	59	68	63
45-64	129	144	137
65-74	244	294	268
75+	403	446	427
Total	100	124	112
Finland			
0-14	4	4	4
15-24	19	34	26
25-44	67	89	78
45-64	136	180	158
65-74	192	238	216
75+	264	320	299
Total	97	137	118
Iceland			
0-14	21	21	21
15-24	42	67	54
25-44	76	93	84
45-64	163	210	187
65-74	267	348	307
75+	315	361	341
Total			
Norway			
0-14	10	9	9
15-24	20	31	35
25-44	52	59	56
45-64	115	132	123
65-74	186	211	199
75+	229	239	235
Total	80	96	88
Sweden			
0-14	7	8	8
15-24	17	36	27
25-44	38	62	50
45-64	97	138	118
65-74	181	223	202
75+	265	304	288
Total	77	111	94

**Table 3.7.4 Sales of anti-obesity preparations (ATC-group A08),
DDD/1 000 inhabitants/day, 2005-2016**

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	0.7	0.4	-	0.6	0.3	1.3	2.6	2.3
2012	0.6	0.6	-	0.3	0.2	0.1	0.4	0.5
2014	0.5	0.3	-	0.2	0.2	-	0.4	0.4
2015	0.4	0.2	-	0.1	0.1	-	0.4	0.4
2016	0.3	0.2	-	0.1	0.2	-	0.3	0.3

**Table 3.7.5 Sales of drugs used in diabetes (ATC-group A10),
DDD/1 000 inhabitants/day, 2005-2016**

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A10								
Drugs used for diabetes								
2005	34.9	32.9	10.3	66.4	38.6	24.0	39.3	44.6
2010	47.6	49.6	13.2	83.4	49.3	31.7	48.3	51.9
2014	52.5	62.4	18.9	88.2	54.2	43.5	49.9	56.8
2015	53.8	62.8	20.1	90.1	54.0	46.1	51.4	58.7
2016	55.5	64.2	22.0	92.6	57.0	47.9	52.9	60.8
A10A								
Insulins and analogues for injection, long-acting								
2005	13.3	10.4	2.7	21.7	15.1	6.5	17.4	22.6
2010	17.2	14.2	3.8	30.0	19.8	9.8	19.2	26.4
2014	18.3	14.3	4.7	31.8	21.5	11.6	19.2	27.8
2015	18.6	14.7	5.1	31.7	22.0	12.4	19.4	28.1
2016	19.0	14.8	5.4	31.7	23.2	12.8	19.6	28.2
A10AB								
Insulins and analogues for injection, fast-acting								
2005	4.1	2.9	..	5.5	5.3	..	6.0	8.1
2010	5.3	4.8	0.8	8.1	5.9	4.0	7.2	9.3
2014	5.8	5.5	1.0	9.0	6.9	4.5	7.6	9.8
2015	5.9	5.9	1.0	9.3	7.7	5.0	7.9	10.0
2016	6.0	5.7	1.1	9.3	8.5	5.2	8.0	10.3
A10AC								
Insulins and analogues for injection, intermediate-acting								
2005	4.7	2.8	..	9.6	6.0	..	8.2	5.3
2010	3.6	1.0	1.7	3.8	6.2	1.3	7.0	4.6
2014	3.0	0.5	1.6	1.5	7.5	1.3	6.6	5.4
2015	2.8	0.5	2.0	1.2	7.0	1.1	6.6	5.4
2016	2.5	0.4	1.9	1.0	6.7	0.9	6.5	5.5
A10AD								
Insulins and analogues for injection, intermediate- or long-acting combined with fast-acting								
2005	3.6	4.4	..	2.8	1.7	..	2.6	5.7
2010	4.3	6.1	0.7	2.3	2.0	1.8	2.4	6.5
2014	3.4	4.5	1.5	0.9	1.3	1.3	1.6	6.1
2015	3.2	4.4	1.3	0.8	1.1	1.2	1.4	5.8
2016	2.8	4.3	1.5	0.6	1.3	1.1	1.2	5.3

The table continues

**Table 3.7.5 Sales of drugs used in diabetes (ATC-group A10),
DDD/1 000 inhabitants/day, 2005-2016, continued**

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A10AE								
Insulins and analogues for injection, long-acting for injection, long-acting								
2005	0.8	0.5	..	3.9	2.0	..	0.6	3.6
2010	4.0	2.4	0.6	15.9	5.6	2.7	2.6	6.0
2014	6.0	3.8	0.7	20.4	5.9	4.4	3.3	6.5
2015	6.7	4.0	0.7	20.4	6.2	5.1	3.5	6.8
2016	7.7	4.5	0.9	20.8	6.7	5.5	3.8	7.1
A10B								
Blood glucose lowering drugs, excl. insulins								
2005	21.6	22.5	7.6	44.7	23.5	17.5	21.9	22.0
2010	30.4	35.5	9.5	53.4	29.5	22.0	29.1	25.5
2014	34.2	48.1	14.2	56.4	32.7	32.0	30.7	29.0
2015	35.2	48.2	15.0	58.3	32.0	33.6	32.0	30.6
2016	36.5	49.4	16.7	61.0	33.9	35.1	33.3	32.6
A10BA								
Biguanides								
2005	7.9	6.7	4.3	18.5	10.1	7.7	9.7	11.8
2010	15.5	12.5	6.3	32.0	17.8	11.4	14.7	17.5
2014	19.2	23.3	10.4	31.6	19.3	14.7	14.4	19.4
2015	19.4	23.6	10.0	31.6	18.6	15.1	14.4	19.9
2016	19.6	24.0	11.6	31.7	19.5	15.5	14.6	20.4
A10BB								
Sulphonamides, urea derivatives								
2005	12.0	15.7	3.3	24.1	13.1	7.2	11.1	7.7
2010	11.1	21.0	3.0	12.2	8.5	8.1	11.5	4.7
2014	6.7	13.8	3.5	3.9	6.1	13.3	8.3	4.2
2015	6.0	12.0	4.2	3.2	5.4	13.4	7.7	4.1
2016	5.3	10.8	4.0	2.4	5.1	13.2	7.3	3.9
A10BD								
Combinations of oral blood glucose lowering								
2005	0.2	..	-	0.8	0.1	0.5	0.1	0.2
2010	1.1	-	0.1	3.0	0.3	0.3	1.1	0.4
2014	2.2	0.1	-	5.6	0.2	0.8	3.0	0.4
2015	2.5	0.2	-	5.8	0.2	1.0	3.4	0.4
2016	2.8	0.4	-	6.0	0.3	1.4	3.7	0.5
A10BG								
Thiazolidinediones								
2005	0.1	0.1	-	1.1	0.1	1.7	0.8	1.0
2010	0.1	-	-	1.8	1.9	0.7	0.6	0.6
2014	-	-	-	1.0	1.2	0.4	0.2	0.3
2015	-	-	-	0.9	1.0	0.3	0.2	0.3
2016	-	-	-	0.7	0.8	0.2	0.2	0.2

Continues

**Table 3.7.5 Sales of drugs used in diabetes (ATC-group A10),
DDD/1 000 inhabitants/day, 2005-2016, continued**

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A10BH								
Dipeptidyl peptidase 4 (DPP-4) inhibitors								
2005	-	..	-	..	..	-	-	..
2010	1.2	0.7	-	4.0	0.6	1.0	0.9	0.9
2014	2.3	4.0	-	11.8	5.4	1.6	2.5	2.3
2015	2.6	4.7	-	13.4	5.8	2.0	3.0	2.9
2016	2.8	5.0	-	14.2	6.7	2.4	3.3	3.6
A10BJ								
Glucagon-like pep- tide analogues								
2005	..	..	..	..	..	..	..	..
2010	1.1	1.2	-	..	..	-	0.1	0.2
2014	3.4	6.4	0.2	..	..	0.7	1.5	1.3
2015	3.8	6.9	0.8	..	..	1.0	1.9	1.6
2016	4.3	7.8	1.1	3.0	0.9	1.3	2.1	2.0
A10BK								
Sodium-glucose co- transporter inhibi- tors								
2005	..	..	..	..	..	..	..	..
2010		-	-	..	..	..	..	..
2014	0.4	0.5	-	..	..	0.3	0.8	0.2
2015	0.9	0.7	-	..	..	0.5	1.4	0.5
2016	1.6	1.4	-	2.8	0.3	0.8	2.0	0.9
A10BX								
Other oral blood glucose lowering drugs, excl. insulins								
2005	0.3	-	-	0.2	0.2	0.4	0.1	1.2
2010	0.2	-	-	0.5	0.5	0.3	0.1	1.1
2014	0.1	-	-	2.6	0.6	1.3	-	0.9
2015	0.1	0.1	-	2.0	1.0	1.9	-	0.9
2016	0.1	-	-	0.2	0.3	2.4	-	0.9

Figure 3.7.2 Sales of insulins and other blood glucose lowering drugs (ATC-groups A10A and A10B), DDD/1 000 inhabitants/day, 2005-2016

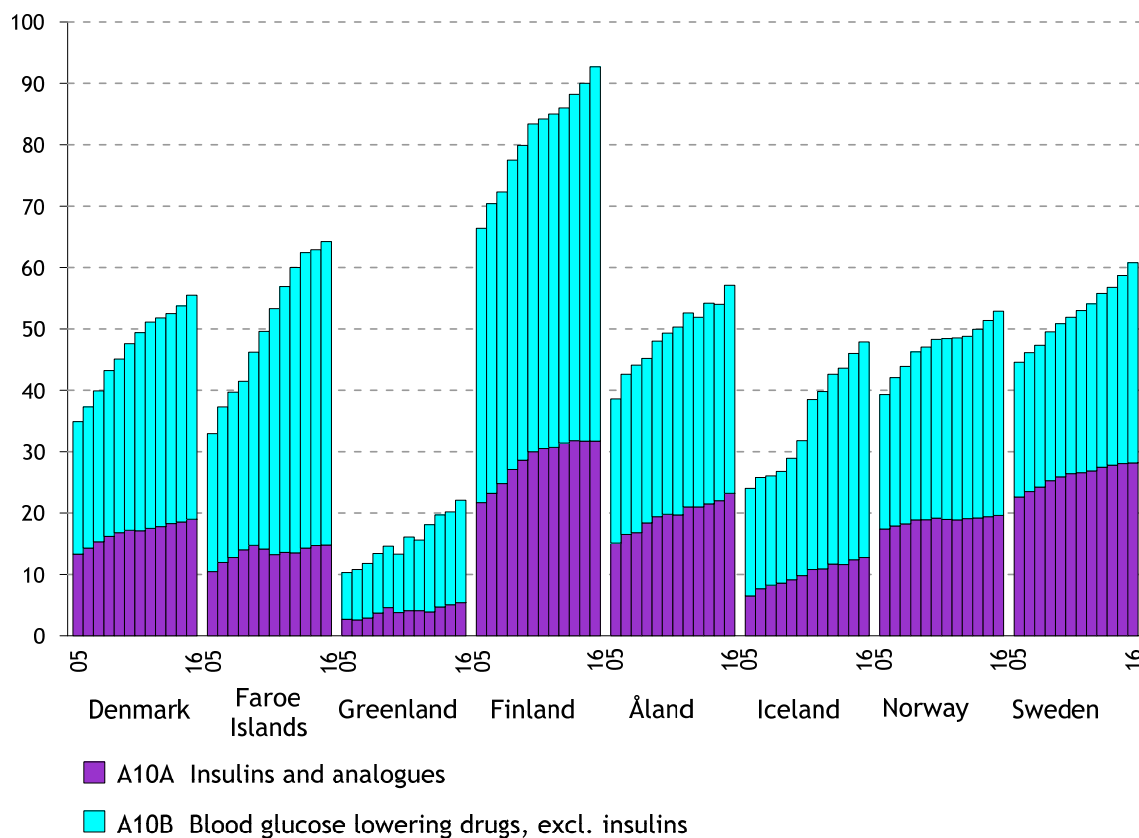


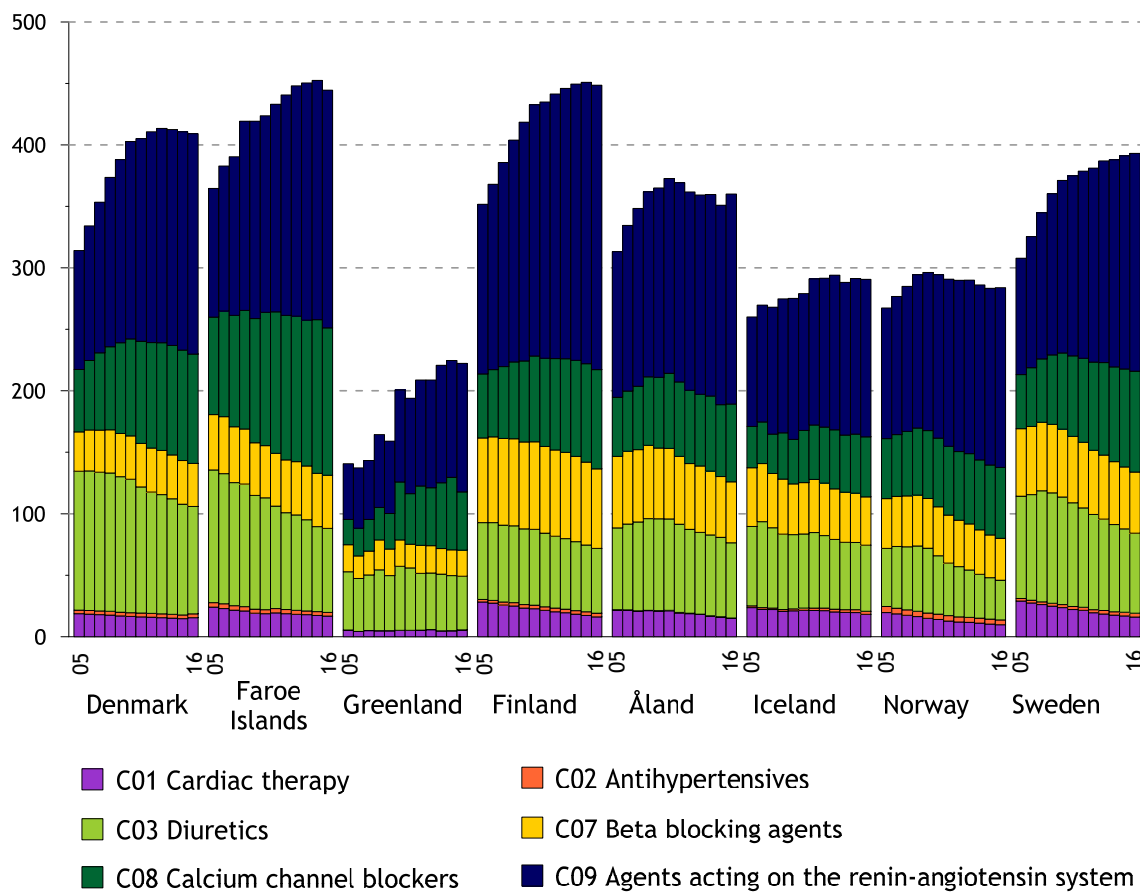
Table 3.7.6 Proportion of the population per 1 000 by age and gender (one-year prevalence) receiving at least one drug used in diabetes (ATC-group A10), 2016

	Men	Women	Total
Denmark			
0-14	9	2	2
15-24	5	7	6
25-44	15	17	16
45-64	71	48	59
65-74	141	89	114
75+	155	108	127
Total	49	38	43
Faroe Islands			
0-14	1	1	1
15-24	4	8	6
25-44	14	15	15
45-64	63	39	52
65-74	175	102	140
75+	224	124	167
Total	52	35	44
Finland			
0-14	5	4	4
15-24	11	10	11
25-44	19	18	18
45-64	100	65	83
65-74	213	141	175
75+	230	179	199
Total	74	60	67
Iceland			
0-14	1	2	1
15-24	6	10	8
25-44	11	26	19
45-64	58	42	50
65-74	120	76	99
75+	143	82	109
Total	35	30	33
Norway			
0-14	2	2	2
15-24	7	7	7
25-44	14	15	14
45-64	60	39	50
65-74	121	78	99
75+	123	85	101
Total	40	30	35
Sweden			
0-14	3	3	3
15-24	8	8	8
25-44	14	13	13
45-64	70	44	57
65-74	159	98	128
75+	180	125	148
Total	53	39	46

**Table 3.7.7 Sales of antithrombotic agents (ATC-group B01),
DDD/1 000 inhabitants/day, 2005-2016**

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
B01A								
Antithrombotic agents								
2005	85.6	52.8	..	124.7	86.0	..	80.4	85.6
2010	99.5	75.2	42.0	118.7	85.2	81.2	95.6	93.5
2014	97.1	86.7	39.7	117.9	88.7	86.9	97.4	90.5
2015	96.4	84.0	47.2	118.4	91.4	87.0	96.5	89.5
2016	94.3	82.8	40.9	114.4	86.8	89.0	98.0	88.5
B01AA								
Vitamin K antagonists								
2005	6.4	6.1	..	10.7	17.9	..	10.3	7.5
2010	8.1	7.3	3.2	13.9	14.4	8.0	11.2	9.3
2014	8.6	6.9	2.1	17.0	16.1	7.7	9.2	11.4
2015	8.5	6.3	2.3	17.6	16.5	7.2	8.0	10.6
2016	8.1	5.1	2.2	16.0	16.3	6.4	7.0	9.3
B01AB								
Heparin group								
2005	2.0	1.2	..	3.2	3.1	..	3.6	3.6
2010	2.5	1.2	0.7	5.3	5.6	2.6	5.1	5.3
2014	3.5	3.3	1.3	6.9	5.4	3.3	5.9	6.2
2015	3.5	3.1	1.1	7.3	7.1	3.6	6.0	6.2
2016	3.4	2.8	1.0	7.2	5.5	4.1	5.9	6.0
B01AC								
Platelet aggregation inhibitors excl. heparin								
2005	77.1	45.5	31.8	110.7	65.1	65.1	66.5	74.4
2010	88.8	66.5	38.1	99.3	65.2	70.7	79.3	78.8
2014	80.1	66.5	32.0	92.4	67.0	72.7	76.5	70.1
2015	77.5	63.9	39.7	90.8	67.3	70.9	74.5	67.0
2016	73.7	62.8	32.4	85.7	62.6	70.5	74.4	64.0
B01AE								
Direct thrombin inhibitors								
2005	-	..	..	-	..	0.1	-	-
2012	1.7	1.2	0.5	0.3	0.1	0.7	0.4	0.3
2014	3.6	2.1	4.2	0.7	0.2	1.6	2.0	0.9
2015	2.7	1.7	4.0	1.0	0.3	1.6	1.9	1.0
2016	2.6	1.3	5.0	1.5	0.4	1.5	1.9	1.1
B01AF								
Direct factor Xa inhibitors								
2005	..	..	..	..	..	..	..	..
2012	0.2	0.9	-	0.1	-	0.1	0.1	-
2014	2.2	8.0	-	0.7	0.1	1.6	3.7	1.9
2015	4.2	8.9	0.1	1.7	0.3	3.6	6.1	4.8
2016	6.5	10.8	0.2	3.9	2.0	6.5	8.8	8.0

**Figure 3.7.3 Sales of cardiovascular drugs (ATC-group C),
DDD/1 000 inhabitants/day, 2005-2016**



**Table 3.7.8 Sales of drugs for cardiac therapy (ATC-group C01),
DDD/1 000 inhabitants/day, 2005-2016**

	Den- mark	Faroe Islands	Green- land	Finland	Åland	Iceland	Norway	Sweden
C01								
Cardiac therapy								
2005	18.8	24.0	5.3	28.3	21.6	23.7	19.6	29.0
2010	16.5	18.7	5.0	22.7	21.0	21.4	14.0	22.2
2014	15.1	17.8	4.7	18.2	16.7	19.7	11.0	17.5
2015	14.6	17.3	4.7	17.3	15.9	19.6	10.3	16.9
2016	15.5	16.8	5.3	16.1	14.9	18.1	9.8	16.0
C01A								
Cardiac glycosides								
2005	6.0	3.7	1.9	6.0	5.4	3.0	4.1	5.9
2010	4.7	2.8	1.5	4.2	4.9	2.6	2.4	3.5
2014	3.9	2.4	1.2	3.2	3.8	2.5	1.5	2.6
2015	3.7	2.5	1.1	2.9	3.9	2.5	1.3	2.4
2016	3.6	2.4	0.9	2.7	3.4	2.2	1.2	2.2
C01B								
Antiarrhythmics, class I and III								
2005	1.6	1.3	..	1.7	1.9	3.4	1.4	1.1
2010	1.5	1.1	0.5	1.9	2.3	3.4	1.8	1.2
2014	1.6	1.2	0.6	2.1	2.6	4.1	2.0	1.4
2015	1.5	1.2	0.5	2.1	2.8	4.3	2.2	1.4
2016	1.5	0.9	0.6	2.1	2.9	4.4	2.2	1.5
C01D								
Vasodilators used in cardiac diseases								
2005	10.5	18.6	2.8	19.5	13.1	17.2	14.0	21.6
2010	9.4	14.3	2.5	15.5	12.8	15.2	9.5	17.1
2014	8.8	13.7	2.7	12.1	9.7	12.9	7.0	13.1
2015	8.5	13.2	2.7	11.4	8.4	12.4	6.4	12.6
2016	9.7	13.1	3.4	10.6	7.9	11.2	6.0	11.9

Table 3.7.9 Sales of cardiovascular drugs (ATC-group C02; C03; C07; C08; C09), DDD/1 000 inhabitants/day, 2005-2016

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
C02								
Antihypertensives								
2005	2.9	3.6	0.1	1.9	0.3	1.4	4.9	2.1
2010	3.0	3.3	0.1	2.9	0.4	1.8	4.3	2.5
2014	3.1	3.1	0.1	2.9	0.3	2.3	4.0	2.8
2015	3.0	3.1	0.1	2.9	0.4	2.4	4.0	3.0
2016	3.0	3.0	0.2	3.0	0.4	2.6	3.9	3.2
C03								
Diuretics								
2005	112.9	108.0	47.5	62.5	66.5	64.5	47.4	83.0
2010	108.5	91.0	52.1	61.6	74.3	60.3	47.5	84.2
2014	94.0	74.2	46.1	56.1	65.8	52.7	35.7	70.9
2015	90.1	69.2	44.8	54.3	64.5	54.6	33.7	67.9
2016	87.2	68.4	43.6	52.8	61.1	53.7	32.2	65.0
C03A								
Low-ceiling diuretics, thiazides								
2005	49.1	53.6	29.5	1.7	1.9	8.8	9.0	13.0
2010	49.2	43.9	37.5	1.9	2.3	6.3	11.8	25.2
2014	38.3	31.3	36.9	2.1	2.6	5.5	6.5	21.7
2015	35.9	28.9	33.5	6.5	7.5	5.0	5.9	20.4
2016	33.8	28.2	31.8	6.5	7.3	4.6	5.5	19.2
C03C								
High-ceiling diuretics								
2005	53.5	39.6	15.9	33.5	25.9	21.2	30.1	50.7
2010	50.9	36.8	12.8	37.8	31.7	23.7	28.4	42.8
2014	48.5	35.0	7.1	37.1	30.7	22.7	23.9	36.9
2015	47.2	32.8	9.3	36.1	31.4	23.7	22.8	35.8
2016	46.5	33.0	9.4	35.6	30.4	22.9	22.0	34.8
C03E								
Diuretics and potassium-sparing agents in combination								
2005	5.5	1.0	0.1	20.7	33.3	32.6	6.7	13.5
2010	4.1	0.6	0.2	14.1	30.6	28.0	5.9	11.6
2014	3.0	0.6	-	9.7	24.0	23.6	3.8	8.1
2015	2.8	0.5	0.1	8.9	22.4	22.8	3.4	7.4
2016	2.7	0.5	-	7.9	20.4	22.6	3.1	6.8
C07								
Beta blocking agents								
2005	32.1	44.9	22.0	68.9	58.1	47.8	40.4	55.1
2010	35.4	42.4	21.7	71.3	57.4	41.9	39.8	54.1
2014	35.7	43.9	20.8	69.4	51.9	40.7	36.1	51.1
2015	35.5	43.3	21.0	67.5	47.7	40.2	34.7	50.4
2016	35.2	43.2	21.3	64.6	49.6	39.4	34.1	49.6
C08								
Calcium channel blockers								
2005	50.7	79.3	20.5	52.2	48.1	33.6	48.9	44.0
2010	78.9	108.5	47.1	69.7	61.1	42.2	55.8	65.5
2014	89.0	118.6	53.6	78.1	61.0	46.5	56.9	77.1
2015	90.0	125.0	59.0	80.0	58.5	48.0	56.9	79.6
2016	88.9	120.0	47.3	80.7	63.2	48.8	57.8	82.2

The table continues

Table 3.7.9 Sales of cardiovascular drugs (ATC-group C02; C03; C07; C08; C09), DDD/1 000 inhabitants/day, 2005-2016, continued

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
C08C								
Selective calcium channel blockers with mainly vascular effects								
2005	43.8	75.8	19.3	47.6	46.4	27.4	43.8	39.8
2010	74.0	106.3	46.5	66.9	59.5	37.0	52.2	62.8
2014	85.4	116.7	52.7	76.1	59.7	41.9	54.4	75.2
2015	86.6	123.2	58.2	78.2	57.1	43.7	54.6	77.9
2016	85.8	118.4	46.7	79.0	62.0	44.5	55.5	80.7
C08D								
Selective calcium channel blockers with direct cardiac effects								
2005	6.8	3.5	1.2	4.6	1.7	6.2	5.1	4.1
2010	5.0	2.2	0.7	2.8	1.6	5.4	3.6	2.7
2014	3.6	1.9	0.9	2.0	1.3	4.6	2.5	1.9
2015	3.4	1.9	0.7	1.8	1.4	4.3	2.3	1.7
2016	3.1	1.6	0.7	1.7	1.3	4.3	2.3	1.6
C09								
Agents acting on the renin-angiotensin system								
2005	96.8	104.7	45.2	137.9	118.6	89.2	106.2	94.7
2010	160.5	159.8	74.8	204.5	158.4	111.3	132.9	146.4
2014	175.7	192.8	95.5	224.8	163.9	124.2	142.4	168.4
2015	177.5	194.6	95.0	228.9	162.1	126.4	143.8	173.4
2016	179.1	193.2	104.7	231.4	170.8	128.1	146.1	177.2
C09A								
ACE-inhibitors, plain								
2005	55.5	68.2	41.3	75.3	79.9	32.2	42.9	57.3
2010	90.9	104.2	64.3	104.5	86.2	38.3	45.2	83.1
2014	89.4	118.8	79.8	103.8	74.1	41.8	44.4	82.6
2015	87.8	117.3	76.8	103.5	70.9	40.6	43.9	81.4
2016	86.0	114.4	88.3	102.6	72.0	39.8	43.6	79.9
C09B								
ACE-inhibitors, combinations								
2005	6.7	5.3	0.1	14.7	4.2	7.7	7.3	3.6
2010	19.2	11.9	0.1	16.4	5.1	11.0	6.6	8.2
2014	18.3	15.3	-	13.9	5.3	6.1	5.8	8.7
2015	17.6	15.3	0.1	13.4	5.0	6.4	5.5	8.5
2016	16.9	15.7	0.1	12.6	5.1	6.0	5.2	8.3
C09C								
Angiotensin II antagonists								
2005	22.1	20.7	3.8	31.0	27.8	23.8	30.6	24.6
2010	32.1	33.4	10.2	54.7	53.1	30.6	44.1	41.2
2014	45.0	47.4	15.4	75.5	65.3	37.1	52.3	60.4
2015	48.7	49.9	18.0	80.5	67.4	39.4	54.7	66.1
2016	52.3	50.4	16.2	85.2	74.6	41.2	57.3	71.1

Continues

Table 3.7.9 Sales of cardiovascular drugs (ATC-group C02; C03; C07; C08; C09), DDD/1 000 inhabitants/day, 2005-2016, continued

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
C09D Angiotensin II antagonists, combinations								
2005	12.5	10.5	0.1	16.8	6.7	25.5	25.4	9.1
2010	17.3	9.8	0.1	28.9	14.0	31.1	36.9	14.0
2014	22.7	11.1	0.2	31.6	19.1	38.6	38.9	16.7
2015	23.2	12.0	0.2	31.5	18.7	39.9	39.7	17.4
2016	23.9	12.5	0.1	31.0	19.1	40.8	40.0	17.9

Table 3.7.10 Sales of serum lipid modifying agents (ATC-group C10), DDD/1 000 inhabitants/day, 2005-2016

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
C10 Lipid modifying agents								
2005	47.2	42.8	55.1	55.7	23.9	48.1	67.9	44.3
2010	108.4	80.4	52.3	98.8	43.3	71.5	112.7	75.6
2014	132.4	127.7	51.7	102.6	50.1	88.7	122.4	92.0
2015	141.3	134.0	58.7	105.4	49.4	89.7	127.9	99.3
2016	141.8	134.2	60.6	105.8	50.3	90.3	131.1	106.9
C10AA HMG CoA reductase inhibitors (statins)								
2005	46.5	42.3	55.0	53.9	23.1	87.3	67.2	42.0
2010	105.9	78.7	52.2	95.5	41.8	70.2	109.9	72.5
2014	129.4	126.1	51.6	98.8	48.7	87.6	118.1	88.8
2015	138.2	132.0	58.6	101.3	47.6	88.5	122.2	95.9
2016	138.4	132.3	60.4	101.3	48.6	89.0	123.8	103.0
C10AX Other lipid modifying agents								
2005	0.1	0.1	..	1.0	0.3	0.5	0.6	0.9
2010	1.5	1.0	0.1	2.5	1.2	0.5	2.7	2.1
2014	2.1	1.2	0.1	3.2	1.2	0.4	4.1	2.3
2015	2.2	1.6	0.2	3.5	1.5	0.6	4.5	2.5
2016	2.4	1.6	0.2	3.8	1.3	0.7	5.0	3.0

Table 3.7.11 Proportion of the population per 1 000 by age and gender (one-year prevalence) receiving at least one serum lipid modifying agent (ATC-group C10), 2016

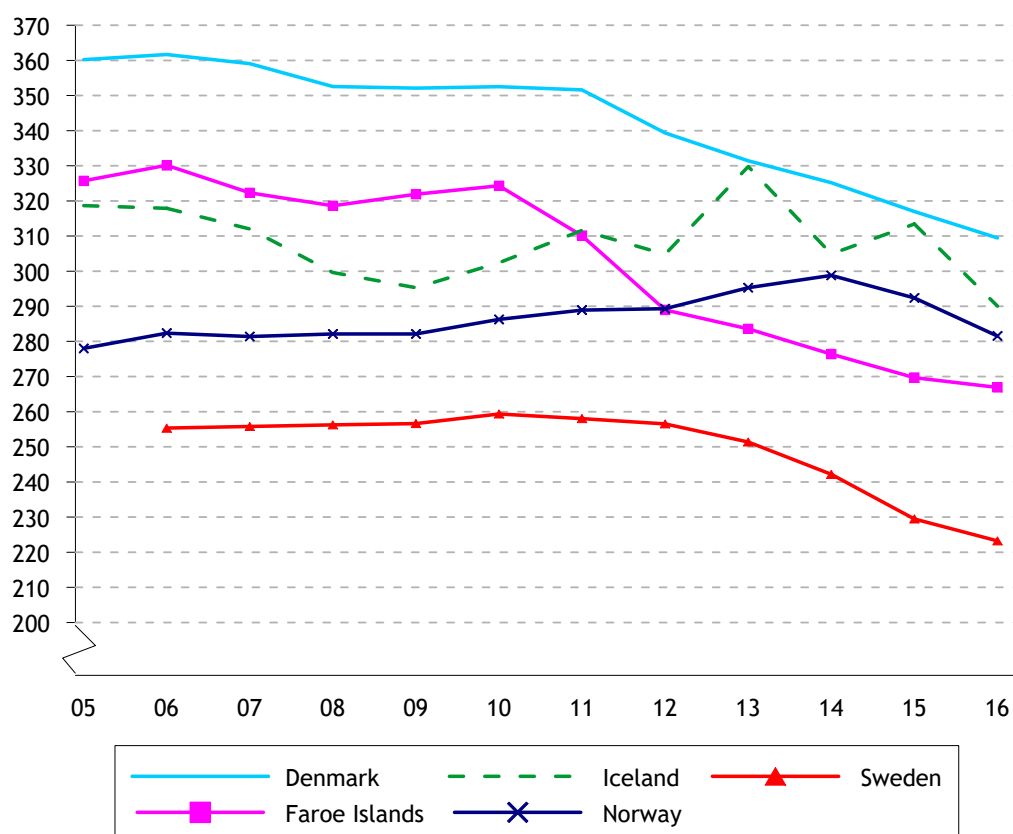
	Men	Women	Total
Denmark			
0-14	0	0	0
15-24	1	1	1
25-44	18	11	14
45-64	163	125	144
65-74	386	323	354
75+	444	360	395
Total	161	121	141
Faroe Islands			
0-14	0	0	0
15-24	1	1	1
25-44	18	11	15
45-64	166	122	145
65-74	407	336	373
75+	533	379	445
Total	120	99	110
Finland			
0-14	0	0	0
15-24	1	1	1
25-44	16	7	12
45-64	179	115	147
65-74	397	328	361
75+	484	403	434
Total	132	116	124
Iceland			
0-14	0	0	0
15-24	0	1	1
25-44	12	5	9
45-64	169	98	133
65-74	442	300	372
75+	498	340	409
Total			
Norway			
0-14	0	0	0
15-24	2	2	2
25-44	18	8	13
45-64	166	113	140
65-74	401	333	367
75+	452	353	394
Total	114	95	104
Sweden			
0-14	0	0	0
15-24	1	1	1
25-44	11	5	8
45-64	129	81	105
65-74	355	264	309
75+	448	312	369
Total	107	83	95

Table 3.7.12 Proportion of the population per 1 000 women, by age 15-49 (one year prevalence) receiving at least one type of hormonal contraceptive (ATC-groups G03A and G02BB), 2016¹

Age	Denmark	Faroe Islands	Iceland	Norway	Sweden
15-19	513	362	409	401	327
20-24	574	623	542	581	390
25-29	410	332	382	429	307
30-34	271	205	244	260	201
35-39	191	158	187	167	152
40-44	131	139	135	106	118
45-49	77	92	86	59	85

1 Excl. Implants (G03AC08), injections (G03AC06) and emergency contraceptives (G03AD). Intrauterine contraceptives (G02BA) are not included

Figure 3.7.4 Proportion of women/1 000 between 15 and 49 (one year prevalence) receiving at least one type of hormonal contraceptive and intra-vaginal contraceptive (ATC-groups G03A and G02BB), 2005-2016



1 Excl. Implants (G03AC08), injections (G03AC06) and emergency contraceptives (G03AD). Intrauterine contraceptives (G02BA) are not included

Table 3.7.13 Sales of estrogens (ATC group G03C) and progestogens and estrogens in combination (ATC-group G03F), systemic use, DDD/1 000 women/day, 2005-2016

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	27.8	29.4	..	66.2	51.3	64.9	35.9	33.0
2010	17.6	20.8	6.0	50.8	38.0	50.1	20.7	18.1
2014	14.2	19.0	4.1	42.6	38.9	42.9	21.1	15.4
2015	13.7	18.7	3.7	41.6	36.6	42.8	20.8	14.7
2016	13.8	17.8	3.5	39.0	34.4	41.9	20.8	14.4

Table 3.7.14 Sales of estrogens (ATC-group G03C), vaginal administration, DDD/1 000 women/day, 2005-2016¹

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	8.8	9.2	..	21.4	15.6	43.5	13.4	19.9
2010	11.4	10.9	4.2	29.3	29.4	35.2	13.2	20.7
2014	9.5	9.5	2.9	19.7	28.6	30.3	8.7	22.0
2015	9.0	8.6	1.8	18.3	28.5	30.0	8.9	23.5
2016	9.4	9.1	2.1	18.4	32.0	29.3	8.8	24.4

1 Vaginal tablets, vaginal gel and vaginal insert

Table 3.7.15 Sales of drugs for urinary frequency and incontinence (ATC-group G04BD), DDD/1 000 inhabitants/day, 2005-2016

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	3.0	2.1	..	3.2	3.1	3.2	4.7	3.9
2010	5.0	4.2	0.6	4.5	3.3	7.0	7.8	5.0
2014	5.8	5.1	0.5	5.5	4.9	8.0	9.4	5.7
2015	6.0	5.2	0.6	5.9	5.1	8.3	9.6	5.9
2016	6.1	5.7	0.8	6.1	5.5	8.5	9.8	6.2

Table 3.7.16 Sales of drugs used in erectile dysfunction (ATC-group G04BE), DDD/1 000 men/day, 2005-2016

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	2.2	1.2	0.7	4.0	1.4	3.0	2.6	2.4
2010	3.1	1.3	1.3	6.1	2.2	2.6	3.5	2.9
2014	5.9	2.5	2.9	12.2	4.6	4.3	4.6	3.9
2015	6.8	3.0	3.0	13.5	5.2	5.4	5.0	4.3
2016	7.6	3.2	3.2	14.7	5.9	6.2	5.4	4.7

Table 3.7.17 Sales of systemic hormonal prep, excl. sex hormones (ATC-group H), DDD/1 000 inhabitants/day

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
H02A								
Corticosteroids for system use, plain								
2005	13.4	10.4	..	16.4	19.6	10.6	15.4	14.3
2010	13.8	11.0	7.3	18.6	19.5	11.6	17.1	15.4
2014	13.9	12.2	7.9	19.4	20.2	14.5	18.1	16.0
2015	13.7	11.3	8.2	18.7	19.9	14.7	18.5	16.0
2016	13.8	12.1	7.3	19.0	19.9	16.2	18.6	16.5
H03A								
Thyroid preparations								
2005	10.1	11.4	..	19.7	25.5	18.2	20.8	22.8
2010	13.4	13.7	2.4	27.6	30.3	22.3	24.0	24.7
2014	16.3	15.1	3.1	32.6	33.4	29.0	24.7	25.8
2015	17.0	15.5	3.4	34.0	34.5	29.3	24.3	26.0
2016	17.6	15.8	3.9	34.2	35.0	29.9	25.2	26.6

**Table 3.7.18 Sales of antibacterials for systemic use (ATC-group J01),
DDD/1 000 inhabitants/day, 2005-2016**

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
J01								
Antibacterials for systemic use								
2005	16.5	18.0	20.4	21.6	22.1	23.0	18.1	16.5
2010	18.8	17.3	17.3	21.8	19.5	22.2	19.6	15.7
2014	18.2	16.5	16.0	20.7	17.4	21.5	19.2	14.1
2015	18.2	17.2	20.2	19.8	17.0	22.0	18.7	13.9
2016	18.2	16.2	20.0	19.0	15.4	23.1	18.1	13.7
J01A								
Tetracyclines								
2005	1.3	1.2	3.1	4.2	3.4	5.4	3.1	3.5
2010	1.7	1.5	1.1	4.3	3.6	5.1	3.1	3.3
2014	1.7	1.7	0.9	4.3	3.8	4.5	3.4	2.9
2015	1.6	1.5	1.0	4.1	3.5	4.8	3.3	2.7
2016	1.7	1.4	1.2	3.9	3.0	4.8	3.1	2.6
J01C								
Beta-lactam antibacterials, penicillins								
2005	10.1	11.5	11.8	6.3	7.9	11.8	7.6	7.3
2010	11.4	10.7	11.4	7.2	7.2	12.0	8.5	7.9
2014	11.7	9.4	10.4	7.0	7.6	11.4	8.1	7.2
2015	11.9	10.2	14.3	7.0	8.4	11.5	7.9	7.2
2016	11.8	9.3	14.1	7.0	7.3	12.3	7.6	7.2
J01CA								
Penicillins with extended spectrum								
2005	3.2	3.0	4.0	3.4	5.0	4.3	2.5	1.6
2010	3.8	2.9	3.9	4.1	4.5	4.2	3.2	1.7
2014	3.9	1.8	3.8	4.0	4.4	3.5	3.3	1.6
2015	4.0	1.9	5.4	4.0	5.0	3.7	3.1	1.6
2016	4.0	1.8	4.9	4.0	4.4	4.4	3.0	1.5
J01CE								
Beta-lactamase sensitive penicillins								
2005	5.7	7.2	6.9	1.7	2.2	3.0	4.5	4.1
2010	5.5	6.4	5.8	1.6	1.9	2.5	4.4	4.2
2014	4.6	5.6	4.0	1.4	1.6	2.2	3.8	3.4
2015	4.5	6.0	5.2	1.4	1.5	2.0	3.8	3.4
2016	4.4	5.0	5.8	1.3	1.3	2.2	3.7	3.4
J01CF								
Beta-lactamase resistant penicillins								
2005	1.2	1.2	0.9	0.1	0.4	1.4	0.5	1.4
2010	1.3	1.2	1.4	-	-	1.3	0.8	1.7
2014	1.6	1.4	1.5	0.1	0.8	1.2	0.8	1.9
2015	1.6	1.4	2.2	0.1	1.1	1.1	0.9	1.9
2016	1.7	1.5	1.8	0.1	1.1	1.2	0.9	1.8

The table continues

**Table 3.7.18 Sales of antibacterials for systemic use (ATC-group J01),
DDD/1 000 inhabitants/day, 2005-2016, continued**

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
J01CR								
Combinations of penicilins incl. beta-lactamase inhibitors								
2005	0.1	0.1	-	1.1	0.4	3.2	-	0.2
2010	0.8	0.2	0.3	1.5	0.8	4.0	0.0	0.3
2014	1.6	0.7	1.0	1.5	0.8	4.5	0.1	0.4
2015	1.8	0.9	1.5	1.5	0.7	4.7	0.1	0.4
2016	1.8	0.9	1.5	1.5	0.6	4.5	0.1	0.4
J01D								
Other betalactam anti-bacterials and cephalosporins								
2005	0.3	0.5	1.0	3.1	1.7	0.5	0.6	0.7
2010	0.4	0.4	0.4	3.2	1.7	0.6	0.5	0.4
2014	0.4	0.6	0.4	3.2	1.1	0.8	0.5	0.3
2015	0.4	0.7	0.4	3.0	1.0	0.8	0.4	0.3
2016	0.3	0.6	0.4	3.0	1.1	0.9	0.4	0.3
J01E								
Sulphonamides and Trimethoprim								
2005	0.9	1.0	0.6	1.9	1.0	1.9	1.1	0.9
2010	0.8	1.2	0.5	1.6	0.8	0.9	0.9	0.6
2014	0.9	1.7	0.6	1.3	0.7	0.8	0.8	0.5
2015	0.8	1.5	0.6	1.3	0.7	0.7	0.8	0.5
2016	0.8	1.4	0.5	1.2	0.6	0.6	0.8	0.4
J01F								
Macrolides, lincosamides and streptogramins								
2005	2.5	2.1	3.6	2.1	1.1	1.8	2.1	0.8
2010	2.6	1.7	2.7	1.6	1.1	1.6	2.0	0.7
2014	1.9	1.5	2.5	1.3	0.7	1.7	1.7	0.6
2015	1.9	1.7	2.6	1.2	0.7	1.9	1.5	0.6
2016	2.0	1.6	2.4	1.0	0.7	1.9	1.3	0.6
J01M								
Quinolone anti-bacterials								
2005	0.5	0.3	0.2	1.3	1.1	0.8	0.6	1.2
2010	0.8	0.5	0.5	1.2	1.1	1.0	0.7	0.9
2014	0.7	0.6	0.6	1.2	0.9	1.0	0.6	0.9
2015	0.7	0.6	0.4	1.2	0.8	1.1	0.6	0.8
2016	0.6	0.6	0.3	1.0	0.8	1.1	0.5	0.8
J01X								
Other Anti-bacterials								
2005	0.9	1.3	0.8	2.8	5.9	0.4	3.0	2.2
2010	0.9	1.1	0.5	2.7	4.1	1.0	3.8	1.7
2014	0.9	1.1	0.7	2.3	2.5	1.2	4.1	1.7
2015	0.9	1.1	0.8	2.1	1.8	1.2	4.2	1.7
2016	0.9	1.2	1.0	1.9	1.9	1.5	4.2	1.6

Figure 3.7.5 Sales of antibacterials for systemic use (ATC-group J01), DDD/1 000 inhabitants/day, 2005-2016

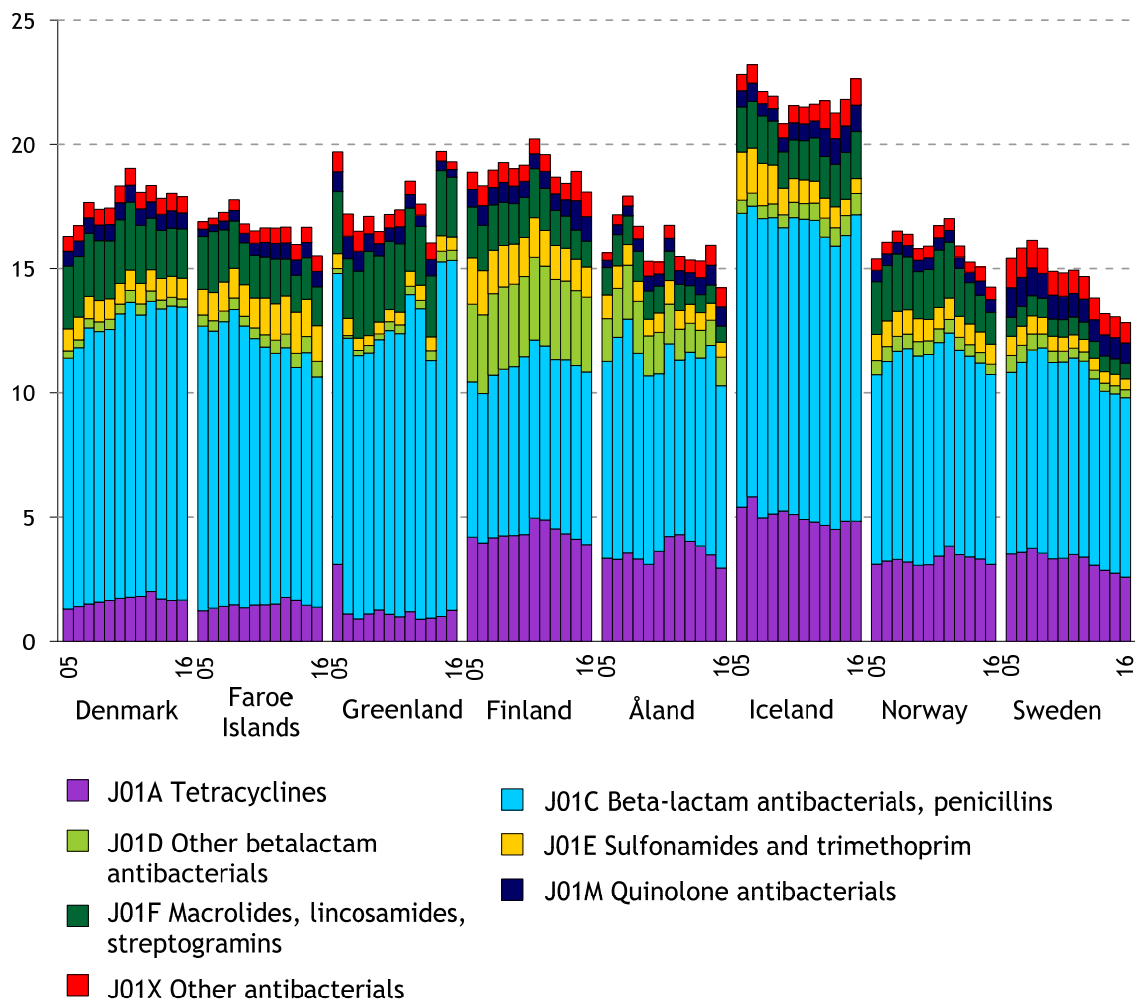


Figure 3.7.6 Sales of penicillins (ATC-group J01C), DDD/1 000 inhabitants/day, 2005-2016

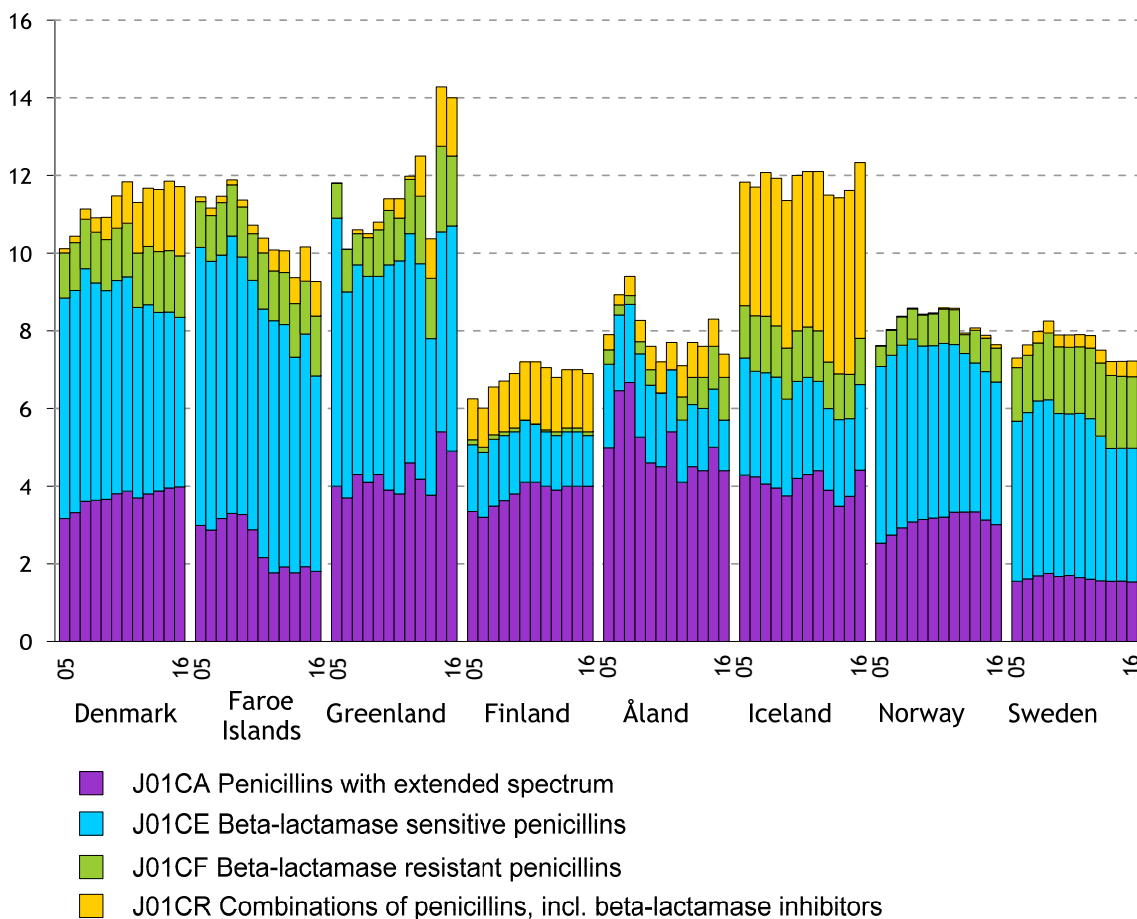


Table 3.7.19 Proportion of the population per 1 000 by age and gender (one-year prevalence) receiving at least one penicillin (ATC-group J01C), 2016

	Men	Women	Total
Denmark			
0-14	179	184	181
15-24	120	238	178
25-44	142	248	194
45-64	175	238	207
65-74	240	272	256
75+	332	369	354
Total	178	248	213
Faroe Islands			
0-14	147	151	149
15-24	140	197	166
25-44	159	246	199
45-64	170	209	189
65-74	223	259	240
75+	307	282	293
Total	172	214	193
Finland			
0-14	209	196	202
15-24	113	203	157
25-44	120	195	156
45-64	122	181	151
65-74	124	175	151
75+	148	227	196
Total	137	194	166
Iceland			
0-14	251	259	255
15-24	172	295	232
25-44	189	296	241
45-64	219	314	267
65-74	274	367	320
75+	271	326	302
Total			
Norway			
0-14	107	110	109
15-24	92	183	136
25-44	93	179	135
45-64	109	170	139
65-74	157	209	183
75+	207	249	231
Total	113	175	143
Sweden			
0-14	149	144	147
15-24	79	145	111
25-44	82	151	116
45-64	95	145	120
65-74	128	173	151
75+	176	214	198
Total	109	156	132

**Table 3.7.20 Sales of antimycotics for systemic use (ATC group J02A),
DDD/1 000 inhabitants/day, 2005-2016**

	Denmark	Faroe Islands	Green- land	Finland	Åland	Iceland	Norway	Sweden
2005	0.5	0.5	0.3	0.4	0.4	0.5	0.2	0.2
2010	0.7	0.5	-	0.4	0.3	0.7	0.2	0.3
2014	0.7	0.5	0.3	0.5	0.4	0.5	0.2	0.3
2015	0.7	0.5	0.3	0.5	0.4	0.6	0.3	0.3
2016	0.6	0.4	0.3	0.4	0.3	0.7	0.3	0.3

**Table 3.7.21 Sales of antivirals for systemic use (ATC group J05),
DDD/1 000 inhabitants/day, 2005-2016**

	Denmark	Faroe Islands	Green- land	Finland	Åland	Iceland	Norway	Sweden
2005	1.3	0.2	1.9	0.7	0.3	0.9	0.9	1.1
2010	1.7	0.4	1.6	0.9	0.3	0.9	1.1	1.4
2014	2.1	0.5	1.4	1.2	0.5	1.0	1.5	1.7
2015	2.3	0.5	1.7	1.2	0.7	1.1	1.5	1.8
2016	2.5	0.5	2.2	1.2	1.0	1.4	1.5	1.7

Table 3.7.22 Sales of immunomodulating agents (ATC-group L02, L03, L04), DDD/1 000 inhabitants/day, 2005-2016

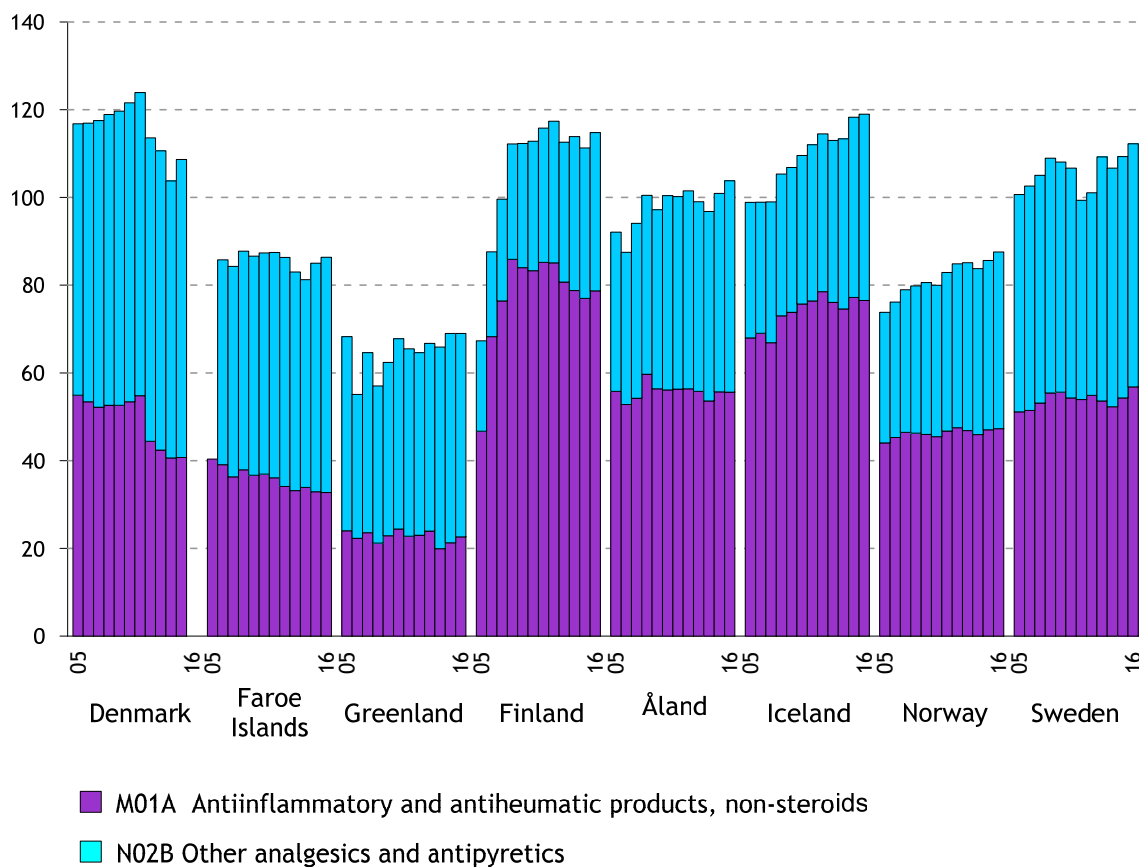
	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
L02								
Endocrine therapy								
2005	4.3	2.5	..	4.7	6.1	4.7	5.0	5.8
2010	6.0	3.7	0.9	6.3	6.8	5.4	5.9	7.1
2014	6.8	5.2	1.7	7.1	5.6	5.0	6.0	8.3
2015	7.5	5.7	1.5	7.2	5.7	5.8	6.0	8.8
2016	7.6	6.1	1.6	7.2	6.3	6.0	6.0	9.3
L03								
Immunostimulants								
2005	0.8	0.3	..	0.9	0.5	1.1	0.8	1.0
2010	1.3	1.0	0.1	1.4	0.4	0.7	1.0	1.0
2014	1.1	0.7	0.2	1.1	0.6	0.7	0.7	0.7
2015	0.9	0.8	0.1	1.1	0.6	0.5	0.6	0.5
2016	0.8	0.5	0.1	0.9	0.4	0.4	0.5	0.5
L04								
Immunosuppressants								
2005	4.7	4.0	..	5.2	7.5	4.5	5.1	4.8
2010	8.6	7.3	4.5	7.8	9.3	4.8	8.3	7.8
2014	11.7	9.8	6.8	9.8	9.7	10.2	11.4	9.4
2015	12.7	10.5	7.5	10.3	10.7	10.8	12.3	9.9
2016	13.7	10.9	7.7	11.7	12.1	11.5	13.0	10.3
L04AB								
Tumour necrosis factor alpha (TNF- α) inhibitors								
2005	0.6	0.7	..	0.6	2.5	0.7	1.3	0.9
2010	1.8	2.4	1.5	1.4	3.5	0.7	2.5	1.9
2014	2.5	4.0	2.7	2.2	3.6	3.9	3.7	2.6
2015	2.7	4.7	3.1	2.4	4.1	4.2	4.1	2.8
2016	3.1	4.7	2.8	2.7	4.3	4.7	4.6	3.0

Table 3.7.23 Sales of analgesics, including anti-inflammatory agents (ATC-groups M01A, N02A and N02B), DDD/1 000 inhabitants/day, 2005-2016

	Denmark	Faroe Islands	Greenland ¹	Finland	Åland	Iceland	Norway	Sweden
M01A								
Anti-inflammatory and antirheumatic products, non-steroids								
2005	54.9	40.3	24.0	76.7	55.8	68.0	44.0	51.4
2010	53.4	36.9	24.4	83.3	56.1	75.7	45.5	54.3
2014	40.6	33.9	19.9	78.8	53.6	74.6	45.9	52.3
2015	40.7	32.9	21.3	77.0	55.7	77.2	47.0	54.3
2016	..	32.7	22.6	78.7	55.6	76.5	47.3	56.8
N02A								
Opioids								
2005	26.6	..	4.5	15.1	9.1	17.4	19.5	20.8
2010	25.8	15.7	6.7	16.5	9.1	25.7	19.8	20.0
2014	23.3	12.5	7.3	15.9	9.8	27.5	18.9	17.7
2015	23.3	12.3	6.0	15.6	10.2	28.4	18.8	17.0
2016	..	11.9	7.5	15.0	12.2	29.0	18.8	15.9
N02B								
Other analgesics and antipyretics								
2005	61.9	..	44.3	20.6	36.3	..	29.8	49.5
2010	68.1	50.5	43.4	29.5	44.3	27.4	34.5	52.4
2014	63.2	47.3	46.0	35.1	43.2	32.0	37.9	54.4
2015	67.9	52.1	47.7	34.3	45.2	33.9	38.6	55.0
2016	..	53.6	46.4	36.1	48.2	34.8	40.3	55.4
N02BA								
Salicylic acid and derivatives								
2005	3.6	..	0.8	5.5	9.9	..	0.5	9.8
2010	3.0	3.2	-	3.6	7.7	2.9	0.3	8.0
2014	2.7	2.9	0.1	2.4	6.9	3.3	0.2	7.1
2015	2.8	3.3	0.1	2.2	6.5	3.6	0.2	7.0
2016	..	3.4	-	2.1	6.3	3.8	0.2	6.8
N02BE								
Anilides								
2005	57.7	40.3	24.6	15.1	26.4	27.4	26.0	39.7
2010	64.8	47.2	43.4	25.9	36.6	24.5	31.9	44.3
2014	60.4	44.5	46.0	32.7	36.3	27.7	36.0	47.2
2015	65.1	48.8	47.6	32.1	38.7	30.3	36.9	47.9
2016	..	50.2	46.4	34.0	42.0	31.0	38.7	48.6

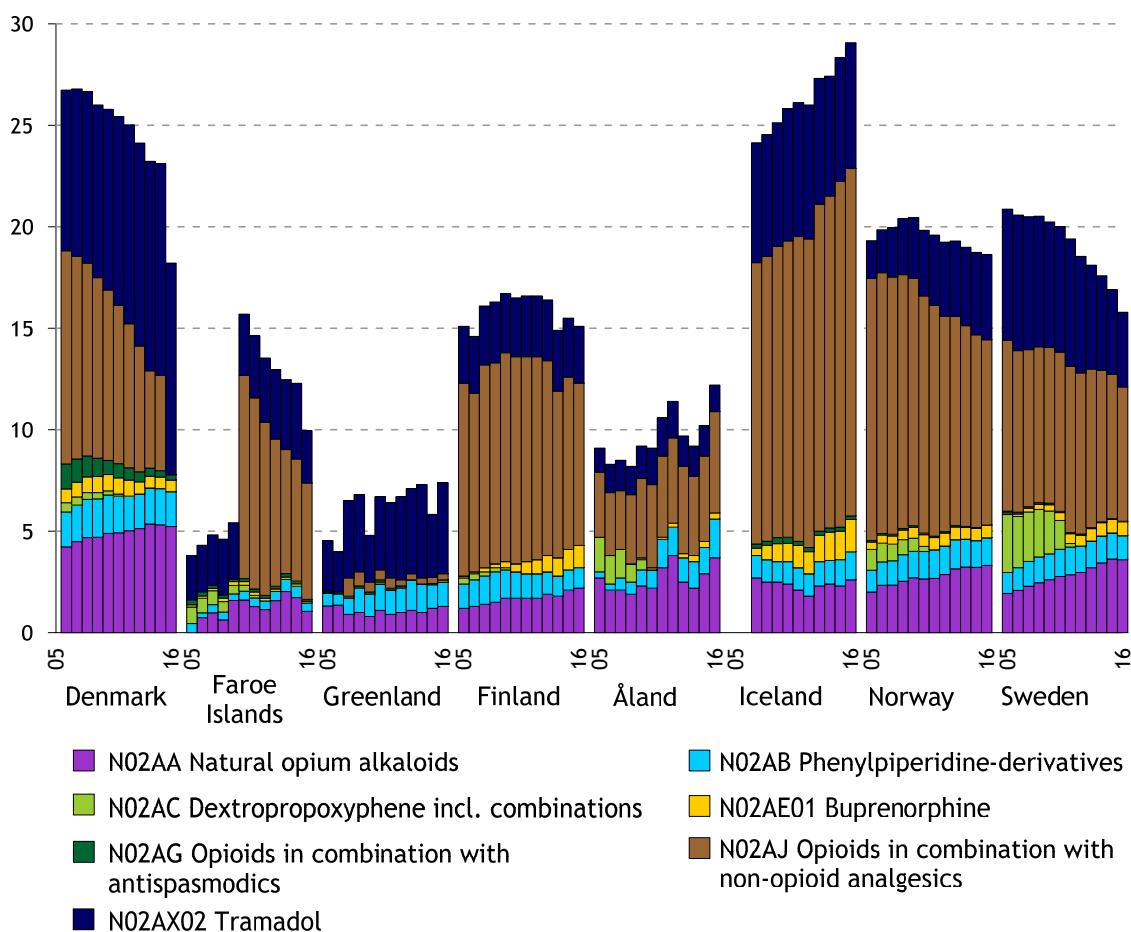
1 Sales of OTC medicines in the group N02BE for 2005 and 2006 in Greenland are not available

Figure 3.7.7 Sales of non-opioid analgesics (ATC-groups M01A and N02B). DDD/1 000 inhabitants/day, 2005-2016¹



¹ Figures for Denmark 2016 are not available

Figure 3.7.8 Sales of opioid analgesics (ATC-group N02A). DDD/1 000 inhabitants/day, 2005-2016¹



¹ N02AJ figures for Denmark 2016 are not available. Data for Iceland 2005-06 not available

Table 3.7.24 Sales of antimigraine preparations (ATC-group N02C). DDD/1 000 inhabitants/day, 2005-2016

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	2.5	2.1	..	1.1	2.0	..	3.2	3.1
2010	2.9	2.4	1.3	1.5	2.2	1.7	3.5	3.0
2014	3.1	2.3	1.5	2.0	1.9	1.8	3.8	2.9
2015	3.2	2.4	1.5	2.0	1.9	1.9	4.0	3.0
2016	3.2	2.2	1.6	2.1	2.2	1.8	4.1	2.9

Table 3.7.25 Sales of anti-epileptics (ATC-group N03). DDD/1 000 inhabitants/day, 2005-2016

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	11.6	9.0	..	12.5	8.4	11.9	10.2	9.1
2010	14.7	11.5	9.7	18.0	11.2	17.2	14.5	13.0
2014	18.0	14.5	10.9	19.9	12.5	19.6	15.7	14.4
2015	18.7	15.8	11.5	20.1	13.7	20.5	16.3	14.9
2016	19.3	16.5	11.1	20.6	14.2	21.4	16.3	15.3

Table 3.7.26 Sales of antiparkinson drugs (ATC-group N04). DDD/1 000 inhabitants/day, 2005-2016

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	3.5	5.0	..	4.5	2.9	4.1	3.0	3.8
2010	4.1	4.4	2.7	4.9	3.7	4.8	3.5	4.2
2014	4.4	4.6	3.1	5.2	3.8	4.5	3.8	4.3
2015	4.5	4.9	3.1	5.3	3.6	4.6	3.9	4.3
2016	4.5	5.0	2.9	5.2	3.7	4.5	3.9	4.3

Table 3.7.27 Sales of antipsychotics (ATC-group N05A). DDD/1 000 inhabitants/day, 2005-2016

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	13.0	10.4	14.6	17.4	9.3	11.5	10.6	9.2
2010	13.9	12.7	16.0	20.7	9.6	11.1	10.8	9.8
2014	14.1	13.0	15.4	21.8	9.6	12.6	10.9	10.4
2015	13.9	12.8	16.0	21.8	9.7	13.0	11.0	10.6
2016	13.7	12.8	16.2	21.5	9.8	13.0	10.8	10.7

Table 3.7.28 Sales of anxiolytics (ATC-group N05B). DDD/1 000 inhabitants/day, 2005-2016

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N05B								
Anxiolytics								
2005	19.9	17.1	5.3	31.2	9.9	25.8	21.3	16.4
2010	11.8	11.5	2.9	28.0	10.7	24.6	19.5	16.2
2014	9.0	10.1	2.5	23.0	11.1	22.8	15.5	15.0
2015	8.3	9.6	2.0	21.6	12.3	22.6	14.4	14.5
2016	7.7	9.6	2.1	20.0	12.6	22.0	13.5	13.8
N05BA								
Benzodiazepine derivatives								
2005	19.6	17.0	5.3	29.5	8.0	24.6	20.1	13.6
2010	11.5	11.2	2.1	26.2	8.5	23.2	18.0	12.8
2014	8.7	9.9	2.5	21.1	8.3	21.2	14.0	11.2
2015	7.9	9.3	2.0	19.8	9.5	21.0	12.9	10.6
2016	7.3	9.3	2.1	18.4	9.9	20.4	12.2	9.9

**Table 3.7.29 Sales of hypnotics and sedatives (ATC-group N05C).
DDD/1 000 inhabitants/day, 2005-2016¹**

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N05C								
Hypnotics and sedatives								
2005	31.4	30.5	8.8	54.4	34.2	66.7	41.4	51.1
2010	20.1	22.3	7.1	46.8	34.3	75.9	42.5	52.2
2014	16.3	17.5	4.6	36.1	35.0	69.9	38.1	51.8
2015	15.3	16.6	5.8	32.9	34.4	69.3	36.7	50.8
2016	14.3	15.9	4.0	31.9	37.3	68.4	35.7	49.7
N05CD								
Benzodiazepine derivates								
2005	10.5	7.1	0.5	20.9	4.3	12.1	8.5	6.7
2010	4.8	4.2	0.4	15.6	3.5	8.6	6.3	4.1
2014	2.5	2.4	0.1	10.7	3.2	5.4	3.3	2.7
2015	2.2	2.1	0.2	9.5	3.2	4.8	3.1	2.4
2016	1.9	2.0	0.1	8.3	3.3	4.5	2.9	2.1
N05CF								
Benzodiazepine-related drugs								
2005	20.9	23.4	8.3	33.1	29.3	54.5	32.8	30.4
2010	15.3	18.1	6.7	30.7	30.3	66.2	36.1	34.1
2014	13.7	15.1	4.5	25.1	31.4	61.1	34.7	36.0
2015	13.1	14.5	5.6	23.2	30.9	60.3	33.5	35.4
2016	12.4	13.9	4.0	20.8	31.6	58.5	32.7	34.5

1 Sales excluding melatonin (N05CH01)

**Figure 3.7.9 Sales of hypnotics and sedatives (ATC groups N05CD and N05CF).
DDD/1000 inhabitants/day, 2005-2016**

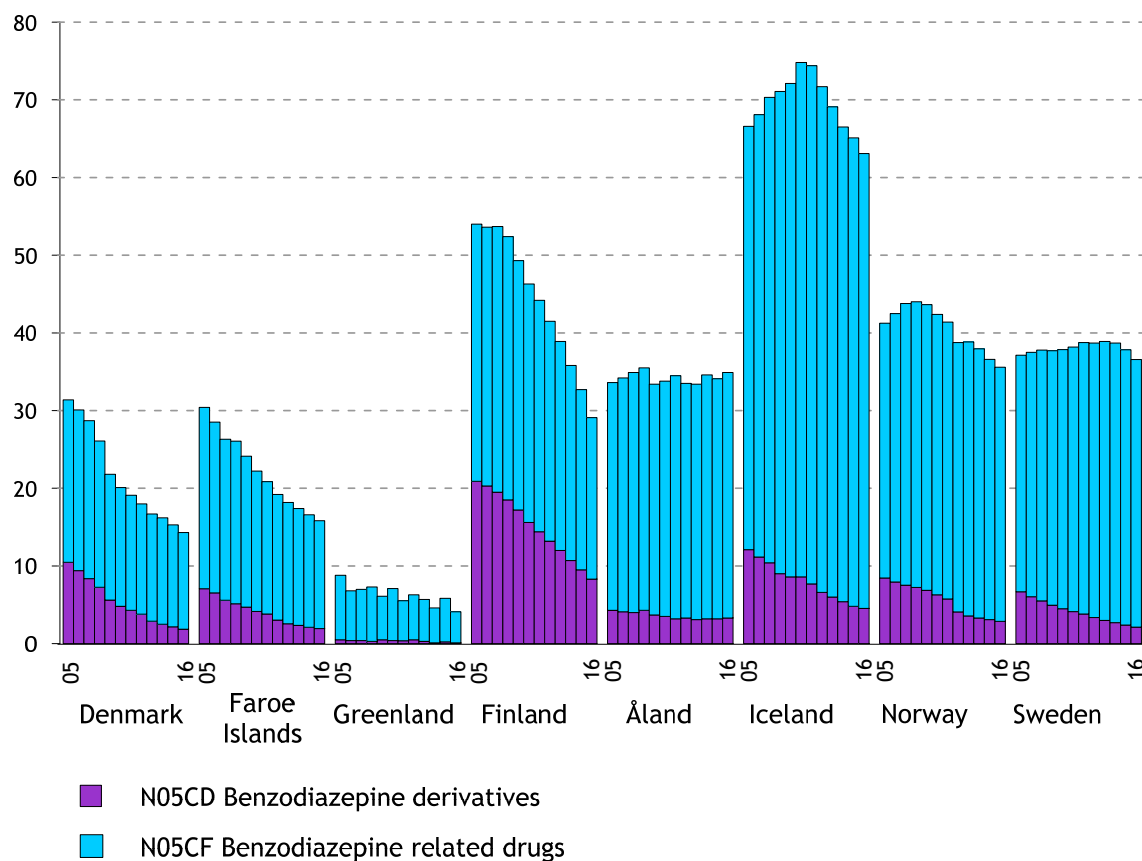


Table 3.7.30 Sales of antidepressants (ATC-group N06A). DDD/1 000 inhabitants/day, 2005-2016

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N06A								
Antidepressants								
2005	60.1	36.5	20.4	52.1	40.7	94.8	51.8	66.1
2010	84.0	57.2	24.1	69.2	50.9	100.9	56.4	75.8
2014	76.7	61.8	23.3	68.8	61.0	119.1	55.7	87.8
2015	77.0	61.5	23.0	68.2	60.2	129.6	56.5	92.5
2016	76.5	60.9	25.1	67.6	63.5	135.9	56.0	95.0
N06AA								
Non-selective monoamine reuptake inhibitors								
2005	4.3	2.1	1.1	4.2	3.2	8.1	3.8	3.8
2010	4.6	1.9	0.8	4.3	2.9	5.5	3.6	3.5
2014	4.5	1.7	1.1	4.2	3.2	5.5	3.5	3.3
2015	4.4	1.7	1.2	4.2	3.5	5.4	3.5	3.4
2016	4.2	1.8	1.6	4.2	3.8	5.4	3.4	3.4
N06AB								
Selective serotonin reuptake inhibitors								
2005	41.7	26.4	16.0	35.3	30.4	64.8	34.8	48.4
2010	56.6	40.5	16.6	44.2	36.1	72.3	37.8	53.2
2014	47.5	43.3	15.7	40.8	39.9	86.5	36.4	59.8
2015	47.7	42.8	14.1	39.8	40.8	94.2	36.9	62.5
2016	47.2	42.4	15.1	38.6	41.0	99.4	36.4	63.6
N06AX								
Other antidepressants								
2005	13.9	8.0	3.3	12.0	6.8	21.2	13.0	13.6
2010	22.7	14.8	6.6	20.2	11.5	22.6	14.8	19.0
2014	24.5	16.8	6.6	23.4	17.8	26.8	15.7	24.7
2015	24.8	17.0	7.7	23.8	15.8	29.7	15.9	26.6
2016	24.9	16.7	8.4	24.4	18.5	30.8	16.1	27.9

**Figure 3.7.10 Sales of antidepressants (ATC-group N06A).
DDD/1 000 inhabitants/day, 2005-2016**

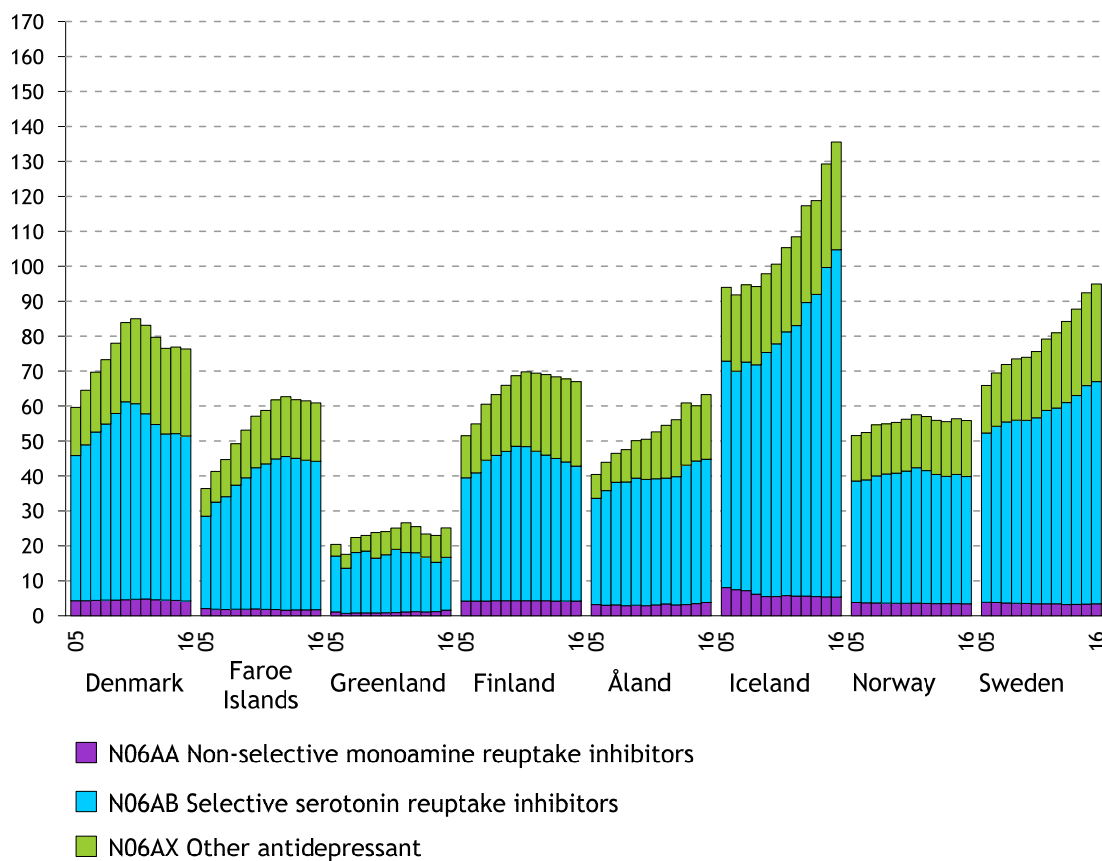


Table 3.7.31 Proportion of the population per 1 000 by age and gender (one-year prevalence) receiving at least one antidepressant (ATC-group N06A), 2016

	Men	Women	Total
Denmark			
0-14	1	1	1
15-24	19	40	29
25-44	51	88	69
45-64	73	123	98
65-74	82	128	106
75+	131	207	175
Total	53	93	73
Faroe Islands			
0-14	1	1	1
15-24	23	45	33
25-44	48	76	61
45-64	51	90	70
65-74	81	142	110
75+	159	253	213
Total	45	81	63
Finland			
0-14	2	3	2
15-24	35	73	53
25-44	67	106	86
45-64	77	126	102
65-74	70	109	91
75+	113	176	152
Total	58	99	79
Iceland			
0-14	22	19	20
15-24	86	161	123
25-44	105	190	147
45-64	115	222	169
65-74	152	268	210
75+	192	282	242
Total	96	173	134
Norway			
0-14	1	1	1
15-24	20	43	31
25-44	45	78	61
45-64	63	121	91
65-74	67	132	100
75+	84	152	124
Total	43	83	63
Sweden			
0-14	3	3	3
15-24	38	77	57
25-44	70	132	100
45-64	87	163	125
65-74	89	157	123
75+	154	251	210
Total	66	126	96

Table 3.7.32 Proportion of the population per 1 000 by age 0-39 and gender (one-year prevalence) receiving at least one drug used in the treatment of e.g. Attention Deficit Hyperactivity Disorder (ATC group N06BA¹. centrally acting sympathomimetic), 2016

	Men	Women	Total
Denmark			
0-4	0	0	0
5-9	12	4	8
10-14	34	11	23
15-19	27	17	22
20-24	16	13	15
25-29	14	11	12
30-39	11	9	10
Faroe Islands			
0-4	0	0	0
5-9	6	0	3
10-14	25	9	17
15-19	24	19	22
20-24	20	15	18
25-29	15	11	13
30-39	8	8	8
Finland			
0-4	0	0	0
5-9	21	4	13
10-14	45	9	27
15-19	19	7	13
20-24	6	4	5
25-29	4	3	4
30-39	4	3	4
Iceland			
0-4	0	0	0
5-9	58	21	23
10-14	136	53	26
15-19	89	56	35
20-24	42	39	39
25-29	40	37	39
30-39	35	18	15
Norway			
0-4		0	0
5-9	12	4	8
10-14	40	15	28
15-19	30	17	23
20-24	15	13	14
25-29	12	12	12
30-39	9	9	9
Sweden			
0-4	0	0	0
5-9	15	5	10
10-14	55	20	38
15-19	48	33	41
20-24	18	18	18
25-29	15	15	15
30-39	12	11	12

1 Excl. N06BA07

Table 3.7.33 Proportion of the population per 1 000 aged 0-39 (one-year prevalence) receiving at least one centrally acting sympathomimetic (ATC group N06BA¹)

	Men	Women	Total
Denmark			
2005	3	1	2
2010	14	6	10
2014	15	9	12
2015	16	9	13
2016	16	10	13
Faroe Islands			
2005	2	0	1
2010	6	3	5
2014	11	7	9
2015	13	7	10
2016	14	9	11
Finland			
2005	..	..	1
2010	..	..	5
2014	..	..	9
2015	..	..	10
2016	12	4	8
Iceland			
2005	..	..	10
2010	..	..	16
2014	..	..	23
2015	43	28	36
2016	54	35	44
Norway			
2005	9	3	6
2010	13	7	10
2014	14	9	12
2015	15	9	12
2016	16	10	13
Sweden			
2005	..	..	..
2010	11	6	9
2014	18	11	15
2015	20	12	16
2016	21	14	17

1 Excl. N06BA07

Table 3.7.34 Sales of anti-dementia drugs (ATC-group N06D). DDD/1 000 inhabitants/day, 2005-2016

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	2.0	1.1	0.1	6.5	2.5	2.7	3.1	3.0
2010	2.9	2.3	0.2	12.1	4.5	2.9	3.0	3.6
2014	3.7	4.9	0.4	15.6	3.8	3.8	2.9	4.5
2015	3.9	5.2	0.4	15.8	3.4	3.7	2.7	4.8
2016	4.0	5.1	0.3	16.2	3.8	3.8	2.6	4.9

Table 3.7.35 Sales of nasal preparations. Decongestants and other preparations for local use - (ATC group R01A). DDD/1 000 inhabitants/day, 2005-2016

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
R01AA								
Sympathomimetics.								
Plain								
2005	13.1	15.6	..	6.3	7.6	..	26.6	22.7
2010	13.8	15.8	2.2	9.3	13.6	16.0	30.2	27.9
2014	12.7	16.6	1.8	9.2	14.2	16.5	30.1	30.0
2015	14.1	19.6	2.0	8.9	13.0	18.7	31.5	31.4
2016	..	20.4	1.9	9.9	14.4	19.5	33.8	33.6
R01AB								
Sympathomimetics.								
combinations excl.								
corticosteroids								
2005	..	-	..	..	..	..	..	..
2010	-	-	-	..	..	..	1.9	1.7
2014	-	-	-	..	..	0.9	2.0	2.3
2015	-	-	-	..	..	0.9	2.1	2.4
2016	-	-	-	-	-	0.9	2.0	2.8
R01AC								
Antiallergic agents.								
excl.corticosteroids								
2005	0.4	0.4	..	0.4	0.5	..	1.2	0.7
2010	0.4	0.4	0.1	0.4	0.5	0.3	1.2	0.7
2014	0.5	0.7	-	0.4	0.6	0.3	1.2	0.9
2015	0.6	0.6	-	0.3	0.5	0.6	1.0	0.7
2016	..	0.7	-	0.3	0.6	0.5	1.0	0.8
R01AD								
Corticosteroids								
2005	10.4	14.3	..	14.0	7.6	..	14.4	16.5
2010	11.1	14.6	3.5	16.8	11.5	17.2	16.2	17.8
2014	12.3	15.2	3.1	19.7	13.7	18.0	18.1	21.0
2015	12.9	15.7	2.8	19.2	14.4	18.8	18.6	21.3
2016	13.6	16.7	3.5	20.0	15.5	20.7	19.0	21.8

**Table 3.7.36 Sales of drugs for obstructive airway diseases (ATC-group R03).
DDD/1 000 inhabitants/day, 2005-2016**

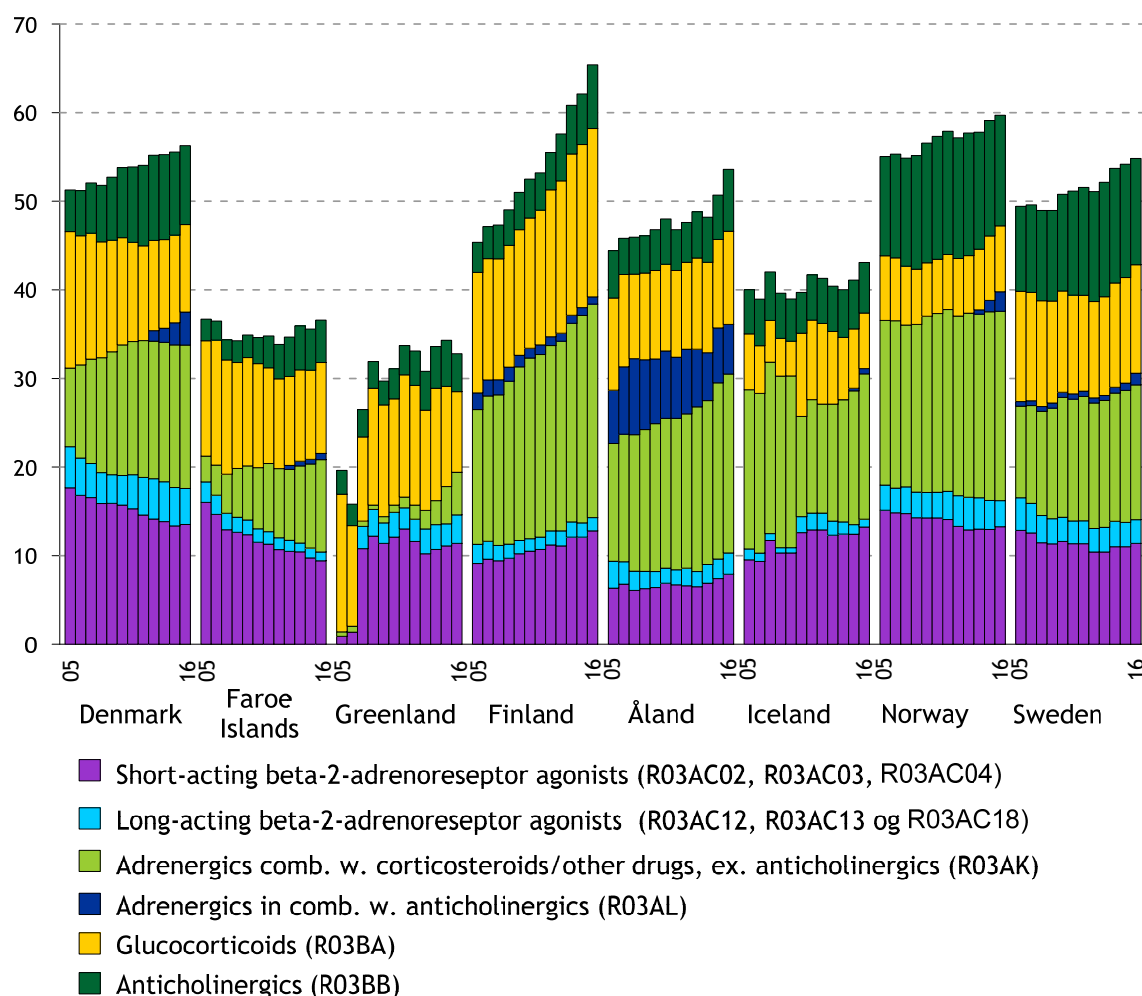
	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
R03								
Drugs for obstructive airway diseases								
2005	61.5	38.1	37.4	51.8	50.6	45.0	61.0	52.8
2010	60.5	35.9	32.2	60.6	53.3	41.3	63.4	54.2
2014	58.9	36.9	34.7	69.2	54.8	41.7	63.6	57.3
2015	59.2	36.6	35.4	70.5	57.0	42.7	64.8	57.9
2016	59.9	37.6	33.8	73.9	59.8	44.8	65.2	58.5
R03A								
Adrenergics. inhalants								
2005	36.8	21.4	17.6	28.4	28.7	31.2	36.5	27.4
2010	36.8	20.2	15.8	33.4	33.2	25.7	37.3	28.3
2014	35.8	20.7	16.3	37.1	33.6	27.6	37.7	29.0
2015	36.3	20.9	18.1	38.0	35.8	28.8	38.8	29.5
2016	37.5	21.5	19.5	39.3	36.2	31.1	39.8	30.3
R03AC								
Selective beta-2-adrenoceptor agonists								
2005	22.3	18.3	17.1	11.3	9.4	13.2	18.0	16.5
2010	19.0	13.0	14.9	11.9	8.7	14.4	17.1	13.9
2014	18.4	11.4	13.4	13.8	9.0	13.8	16.5	13.9
2015	17.8	10.9	13.6	13.8	9.7	13.5	16.2	13.8
2016	17.7	10.4	14.6	14.4	10.3	14.1	16.2	14.1
R03AK								
Adrenergics comb. w. corticosteroids/other drugs. ex. anticholinergics								
2005	8.9	2.9	0.5	15.2	13.3	18.0	18.6	22.1
2010	14.7	6.9	0.8	20.4	16.9	11.3	20.2	22.9
2014	19.7	15.3	17.4	23.9	15.6	12.4	20.7	24.7
2015	19.3	14.7	16.5	24.2	15.3	12.3	21.3	24.7
2016	18.7	15.1	13.5	24.1	20.2	12.0	21.4	24.2
R03AL								
Adrenergics in combination with anticholinergics								
2005	..	..	..	1.9	6.0	..	..	0.5
2010	..	0.4	..	1.1	7.6	..	..	0.6
2014	1.6	0.5	..	0.9	5.4	0.0	0.5	0.6
2015	2.5	0.5	..	0.9	6.2	0.3	1.3	0.8
2016	3.7	0.7	..	0.8	5.6	0.6	2.2	1.3
R03B								
Other drugs for obstructive airway diseases. inhalants								
2005	20.1	15.5	18.0	17.3	16.4	11.3	18.5	22.1
2010	19.9	14.7	15.3	19.3	15.4	14.0	20.0	22.9
2014	19.7	15.3	17.4	23.9	15.6	12.4	20.1	24.7
2015	19.3	14.7	16.5	24.2	15.3	12.3	20.3	24.7
2016	18.7	15.1	13.5	26.2	17.8	12.0	19.9	24.2

Table continues

Table 3.7.36 Sales of drugs for obstructive airway diseases (ATC-group R03). DDD/1 000 inhabitants/day, 2005-2016, continued

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
R03D Other systemic drugs for obstructive airway diseases								
2005	3.1	0.5	1.0	5.9	5.2	2.4	5.4	2.7
2010	3.2	0.7	0.8	7.5	4.5	1.5	5.8	2.7
2014	3.2	0.7	0.7	8.1	5.5	1.6	5.7	3.3
2015	3.3	0.8	0.6	8.2	5.8	1.5	5.5	3.5
2016	3.4	0.8	0.6	8.3	5.7	1.7	5.4	3.8

Figure 3.7.11 Sales of drugs for obstructive airway diseases (ATC-Group R03). DDD/1 000 inhabitants/day, 2005-2016¹



¹ R03AL figures for Greenland 2016 are not available

Table 3.7.37 Proportion of the population per 1 000 by age and gender (one-year prevalence) receiving at least one inhalant for obstructive airway diseases (ATC-groups R03A and R03B), 2016

	Men	Women	Total
Denmark			
0-14	82	58	71
15-24	40	49	44
25-44	46	55	50
45-64	73	96	84
65-74	114	138	126
75+	163	161	162
Total	74	85	79
Faroe Islands			
0-14	87	65	77
15-24	51	65	58
25-44	44	69	56
45-64	49	78	63
65-74	97	136	116
75+	114	134	126
Total	65	82	73
Finland			
0-14	108	74	91
15-24	61	83	72
25-44	68	107	87
45-64	95	146	120
65-74	122	154	139
75+	162	163	163
Total	94	121	108
Iceland			
0-14	163	132	148
15-24	59	82	70
25-44	64	102	82
45-64	105	187	146
65-74	180	292	236
75+	211	241	228
Total	110	150	130
Norway			
0-14	88	63	76
15-24	46	61	53
25-44	45	62	53
45-64	77	110	93
65-74	130	162	146
75+	145	134	138
Total	75	90	83
Sweden			
0-14	92	65	79
15-24	46	59	52
25-44	45	66	55
45-64	68	104	86
65-74	99	146	123
75+	135	151	145
Total	72	92	82

**Table 3.7.38 Sales of antihistamines (ATC-group R06A).
DDD/1 000 inhabitants/day, 2005-2016**

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
2005	20.4	20.7	7.5	31.2	24.8	30.0	54.8	30.8
2010	27.0	25.2	10.6	42.6	31.4	38.4	58.8	36.8
2014	35.8	35.4	17.7	54.0	37.6	50.4	68.2	48.1
2015	34.8	31.4	13.8	51.2	37.2	53.2	67.9	48.0
2016	..	33.4	16.0	52.2	37.4	58.8	69.6	51.4

Chapter 4

Mortality and Causes of Death

Extra material

[Nowbase.org](http://nowbase.org) - [Background tables for Health Statistics](#)

Introduction

Statistics on causes of death provide information on mortality patterns and information on developments over time. The International classification of diseases, Tenth Revision (ICD-10), is used to classify diseases and other health problems on many types of health and vital records, as well as death certificates. What is shown in the statistics is the underlying cause of death. WHO has drawn up guidelines for the choice of underlying cause of death, i.e. the disease or injury that initiated the chain of morbid events leading directly to death, or the circumstances of the accident or violence that produced the fatal injury.

Coding practice and comparability

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

The problem for comparability in some cases is that, where two or more causes of death have been recorded on the death certificate, the choice of the underlying cause of death will differ from country to country, since the ICD rules can be interpreted differently.

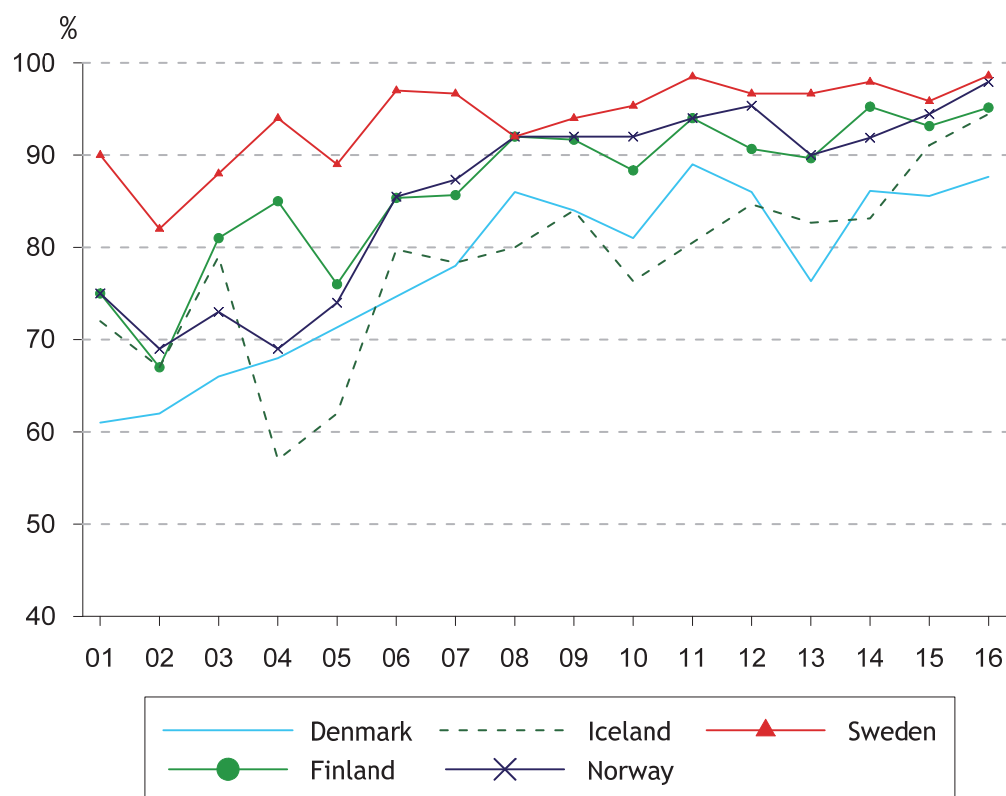
Apart from the fact that the ICD rules governing mortality coding give room for interpretation, different national traditions for the choice of underlying cause of death may also develop. An example of this is the use of the diagnostic group "insufficiently defined conditions" (codes I46.9, I95.9, I99, J96.0, J96.9, P28.50, R00-94.8 and R99). The use of these codes as underlying cause of death appears more widespread in some countries among the Nordic countries (See Table 4.1.11).

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

In order to aid the choice of underlying cause of death, the American programme ACME (Automated Classification of Medical Entities) has been developed. This system is used in most of the Nordic countries. Denmark has used ACME from the data year 2002, Iceland used ACME until 2016 but has used the program Iris since then, and Norway and Finland have used ACME from the data year 2005. Otherwise, computer-

aided coding has been used. Automatic coding does not necessarily result in a more correct picture of the pattern of causes of death than manual coding, but it does give more consistency in the coding and thus contributes to better comparability between more countries.

Figure 4.1.1 National coding compared to ACME 2001-2016



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

This comparison, and Nordic coding practice in general, is discussed at annual meetings. As seen in Figure 4.1.1, the coding in the different countries is not only getting closer to ACME's coding, but the differences in coding between the countries are also getting smaller. This indicates that the use of automatic coding and cooperation between the Nordic countries leads to a higher degree of comparability of mortality statistics.

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

jury is unclear. Such quality-control practices help to compensate for lack of information on the death certificate.

Autopsy rates

Another factor influencing the quality of the statistics on causes of death is decreasing autopsy rates (in 2015, the Danish rate was the lowest at 4 per cent, and the Finnish rate was the highest at 21 per cent). Autopsy rates have been more than halved in the Nordic countries over the last few decades. Studies have shown that in about 30 per cent of cases, the result of the autopsy has caused the underlying cause of death to be altered.

The reliability of the statistics

Considering the reservations in relation to the comparability of causes of death over time and between countries, the data presented here should be interpreted with caution. This is especially the case for the small diagnostic groups in the European short list that is used in the present publication. The picture is more stable for the large groups, such as cardiovascular diseases and cancer. This also applies to alcohol and drug-related deaths, for which it is well known that the pattern is heterogeneous. The high incidence of cancer as an underlying cause of death in Denmark is also partly the result of coding practice.

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

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

Table 4.1.1 Deaths by age and gender per 100 000 inhabitants, 2000-2015

Age	Total		Under 1 year ¹		1-14 years		15-24 years		25-64 years		65+ years	
	M	W	M	W	M	W	M	W	M	W	M	W
Denmark												
2000	1 069	1 099	607	456	17	12	79	30	448	294	6 368	5 455
2010	965	984	363	320	9	7	41	21	408	254	4 936	4 622
2014	909	919	455	348	7	6	28	16	351	216	4 239	3 280
2015	912	927	420	344	7	7	35	13	340	213	3 602	4 710
Faroe Islands												
2006-10	830	785	516	296	26	15	61	28	343	188	5 313	4 439
2011-15	801	796	497	617	24	13	34	52	313	157	4 377	4 127
Greenland												
				1								
2006-10	871	721	1 335	226	73	55	354	197	623	462	7 216	6 016
2011-15	826	717	921	628	17	25	321	178	577	362	5 913	6 367
Finland												
2000	952	954	424	324	14	14	96	34	504	222	5 545	4 606
2010	971	929	259	192	12	11	80	27	484	217	4 719	4 047
2014	963	956	236	200	11	10	57	21	402	188	4 296	3 871
2015	960	949	165	181	9	7	56	20	381	178	4 216	3 782
Åland												
2006-10	900	930	-	298	-	29	25	28	274	166	4 752	4 358
2011-15	970	998	-	-	-	-	59	39	324	164	4 313	4 342
Iceland												
2006-10	634	622	222	173	15	11	60	23	235	148	4 668	4 145
2011-15	634	640	135	196	13	9	37	22	226	155	4 163	3 946
Norway												
2000	974	985	427	329	18	15	93	33	339	201	6 052	4 965
2010	817	878	277	229	12	9	58	30	293	187	4 922	4 581
2014	772	818	264	221	11	6	42	18	256	163	4 345	4 121
2015	763	822	256	194	9	6	41	17	242	159	4 322	4 155
Sweden												
2000	1 041	1 065	399	281	15	12	59	24	305	200	5 829	4 854
2010	941	990	273	242	10	10	50	22	283	180	4 747	4 429
2014	897	940	255	179	8	8	50	21	251	165	4 233	4 024
2015	909	949	276	207	9	10	51	20	248	158	4 257	4 050

1 Per 100 000 live births

Source: the national registers for causes of death

Table 4.1.2a Death rates from malignant neoplasms (cancer) per 100 000 men by age, 2000-2015

		Denmark	Faroe Islands 1,3,4	Greenland 2,3,4	Finland	Åland ^{2,3,4}	Iceland 2,3,4	Norway	Sweden
<i>Age</i>									
0-14	2000	3	..	..	2	-	..	3	3
	2010	1	-	6	3	-	4	3	2
	2014	2	-	3	3	-	2	3	3
	2015	2	-	-	1	-	2	3	2
15-34	2000	9	..	..	6	6	..	7	8
	2010	5	7	7	6	6	8	5	5
	2014	5	6	9	7	-	6	4	5
	2015	5	3	5	6	-	6	3	6
35-44	2000	33	..	.	22	44	..	32	20
	2010	23	27	47	19	10	14	16	19
	2014	20	18	40	16	11	26	26	18
	2015	19	19	22	20	11	27	20	18
45-54	2000	148	..	..	107	170	..	120	97
	2010	110	78	133	84	42	94	77	63
	2014	87	92	157	65	111	73	70	61
	2015	89	58	131	71	100	68	65	61
55-64	2000	462	..	..	320	371	..	348	294
	2010	385	314	596	316	342	256	300	260
	2014	365	259	510	270	274	259	258	233
	2015	339	214	500	267	253	238	247	218
65-74	2000	1 189	..	..	902	1 001	..	953	826
	2010	970	928	1 868	747	940	795	850	678
	2014	890	761	1 378	706	847	733	703	633
	2015	872	593	1 209	698	876	724	717	630
75+	2000	2 440	..	..	1 947	2 081	-	2 142	1 935
	2010	2 298	2 077	3 109	1 780	1 890	1 929	2 231	1 920
	2014	2 018	2 126	2 498	1 678	1 896	1 972	2 076	1 768
	2015	2 126	1 518	2 266	1 692	1 780	1 951	2 050	1 855

1 2000 = 1996-2000

2 2010 = 2006-10

3 2014 = 2010-14

4 2015 = 2011-15

ICD-10, C00-C97

Source: the national registers for causes of death

Table 4.1.2b Death rates from malignant neoplasms (cancer) per 100 000 women, by age, 2000-2015

		Denmark	Faroe Islands 1,3,4	Greenland 2,3,4	Finland	Åland ^{2,3,4}	Iceland 2,3,4	Norway	Sweden
<i>Age</i>									
0-14	2000	2	..	..	2	-	..	4	3
	2010	1	5	3	3	18	2	1	2
	2014	1	-	3	2	9	1	2	2
	2015	1	-	3	1	-	1	1	2
15-34	2000	9	..	..	7	6	..	6	9
	2010	7	4	18	4	-	5	7	5
	2014	7	7	5	5	13	3	3	6
	2015	5	3	4	4	11	3	4	5
35-44	2000	41	..	..	36	75	..	39	21
	2010	36	-	50	30	21	32	27	24
	2014	28	13	53	24	32	31	29	26
	2015	31	11	52	14	27	31	23	20
45-54	2000	164	..	..	106	184	..	126	94
	2010	130	68	203	89	61	101	97	85
	2014	99	64	168	78	68	75	89	78
	2015	102	41	135	37	73	79	80	70
55-64	2000	425	..	..	237	275	..	319	296
	2010	342	314	644	223	249	265	286	258
	2014	310	238	547	189	200	268	239	235
	2015	301	158	402	120	194	262	234	224
65-74	2000	905	..	..	505	531	..	600	719
	2010	714	447	1 552	477	605	636	583	547
	2014	665	669	1 551	466	513	578	530	517
	2015	651	464	1 191	396	429	584	503	534
75+	2000	1 460	..	..	1 077	1 198	..	1 184	1 210
	2010	1 485	1 180	1 457	1 023	1 259	1 232	1 252	1 148
	2014	1 410	1 041	1 849	1 017	1 169	1 287	1 248	1 227
	2015	1 402	733	1 555	1 075	943	1 291	1 215	1 185

1 2000 = 1996-2000

2 2010 = 2006-10

3 2014 = 2010-14

4 2015 = 2011-15

ICD-10 C00-C97

Source: the national registers for causes of death

Table 4.1.3a Death rates from circulatory diseases per 100 000 men, by age, 2000-2015

		Denmark	Faroe Islands ^{1,3,4}	Greenland ^{2,3,4}	Finland	Åland ^{2,3,4}	Iceland ^{2,3,4}	Norway	Sweden
<i>Age</i>									
0-34	2000	3	..	6	5	7	..	3	3
	2010	2	2	5	4	-	4	2	2
	2014	1	2	3	3	-	3	2	2
	2015	2	2	4	2	-	3	3	2
35-44	2000	23	..	51	44	11	..	25	21
	2010	22	20	47	28	10	14	23	13
	2014	15	18	50	24	11	10	11	14
	2015	13	12	70	27	11	16	11	10
45-54	2000	95	..	179	184	170	..	93	104
	2010	64	47	88	117	63	66	65	63
	2014	58	75	106	91	51	50	48	54
	2015	54	70	97	89	30	48	52	54
55-64	2000	326	..	473	481	445	..	282	303
	2010	197	216	373	385	171	188	187	217
	2014	165	153	409	308	193	157	145	191
	2015	172	127	392	295	202	155	136	187
65-74	2000	1 095	..	1 049	1 378	1 105	..	1 065	1 101
	2010	557	663	1 552	897	701	643	526	592
	2014	424	513	1 219	717	719	463	417	510
	2015	442	413	1 196	714	629	444	397	534
75+	2000	4 467	..	5 058	4 766	5 051	..	4 681	4 851
	2010	2 948	3 654	4 363	3 808	3 939	3 515	3 148	3 946
	2014	2 300	2 811	3 913	3 337	3 462	3 259	2 683	3 148
	2015	2 266	1 952	3 890	3 257	3 430	3 134	2 602	3 196

1 2000 = 1996-2000

2 2010 = 2006-10

3 2014 = 2010-14

4 2015 = 2011-15

ICD-10, I00-I99

Source: the national registers for causes of death

Table 4.1.3b Death rates from circulatory diseases per 100 000 women, by age, 2000-2015

		Denmark	Faroe Islands ^{1,3,4}	Greenland ^{2,3,4}	Finland	Åland ^{2,3,4}	Iceland ^{2,3,4}	Norway	Sweden
<i>Age</i>									
0-34	2000	2	..	7	2	-	..	4	3
	2010	1	5	-	3	18	1	1	2
	2014	1	6	6	1	-	1	1	1
	2015	1	3	7	1	-	-	1	1
35-44	2000	14	..	42	17	11	..	11	11
	2010	8	-	14	9	-	6	7	6
	2014	6	-	12	8	-	8	3	2
	2015	6	-	10	5	-	9	6	2
45-54	2000	41	..	109	48	31	..	36	34
	2010	25	17	116	31	10	11	21	21
	2014	23	45	49	23	20	16	22	19
	2015	28	31	32	11	16	19	13	21
55-64	2000	41	..	271	48	97	..	36	34
	2010	76	52	262	91	80	58	61	77
	2014	68	14	225	85	48	50	48	68
	2015	68	12	148	41	40	50	51	71
65-74	2000	561	..	1 427	551	402	..	471	469
	2010	273	262	801	297	213	267	236	269
	2014	196	203	699	255	203	192	184	242
	2015	206	141	560	160	199	203	178	234
75+	2000	3 722	..	8 038	4 090	3 944	..	3 794	4 059
	2010	2 635	2 492	3 302	3 345	3 492	2 877	2 907	3 537
	2014	2 018	1 971	3 191	3 021	3 758	2 710	2 597	2 962
	2015	2 036	1 354	2 625	2 922	3 301	2 738	2 555	2 963

1 2000 = 1996-2000

2 2010 = 2006-10

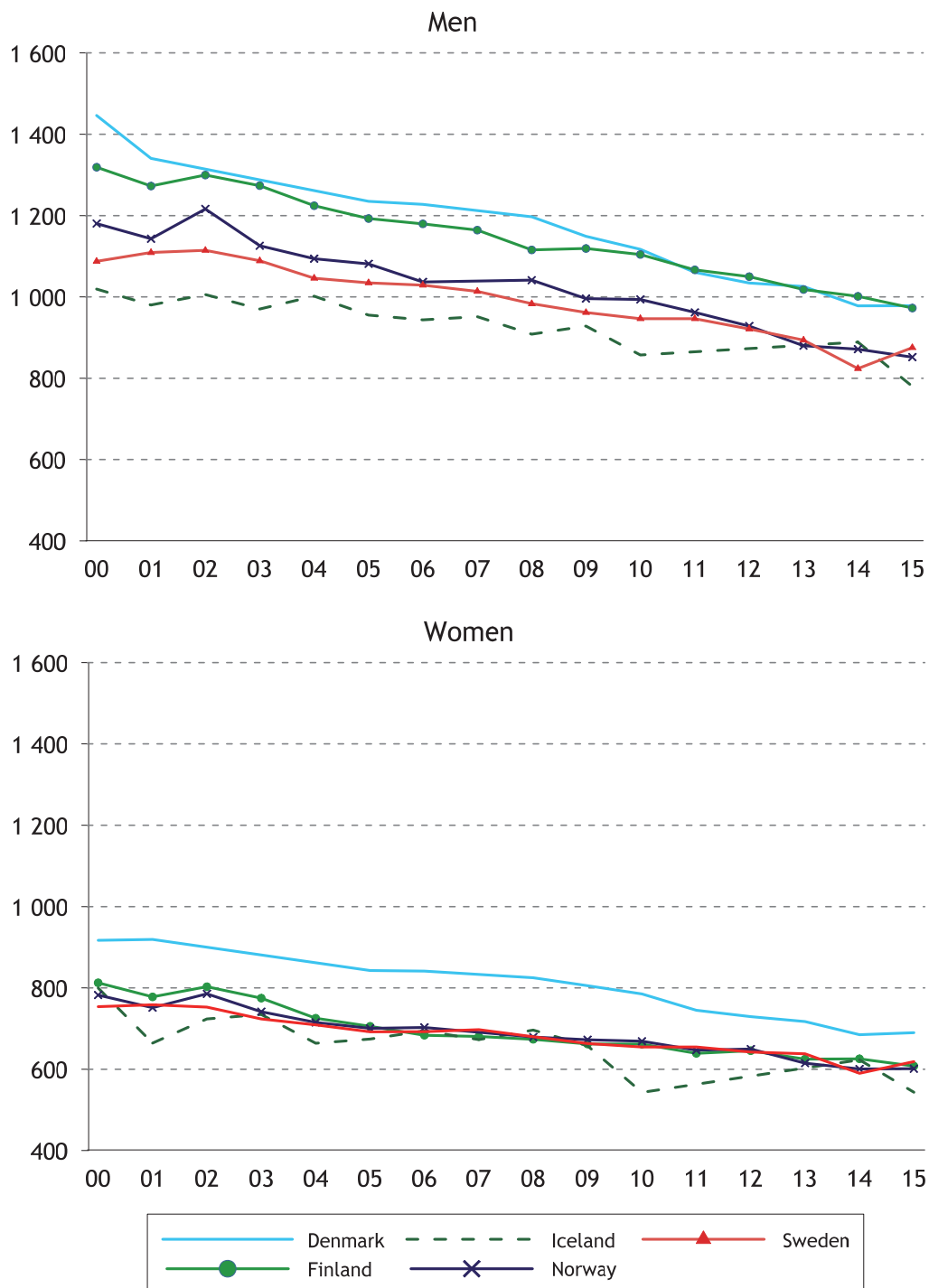
3 2014 = 2010-14

4 2015 = 2011-15

ICD-10 I00-I99

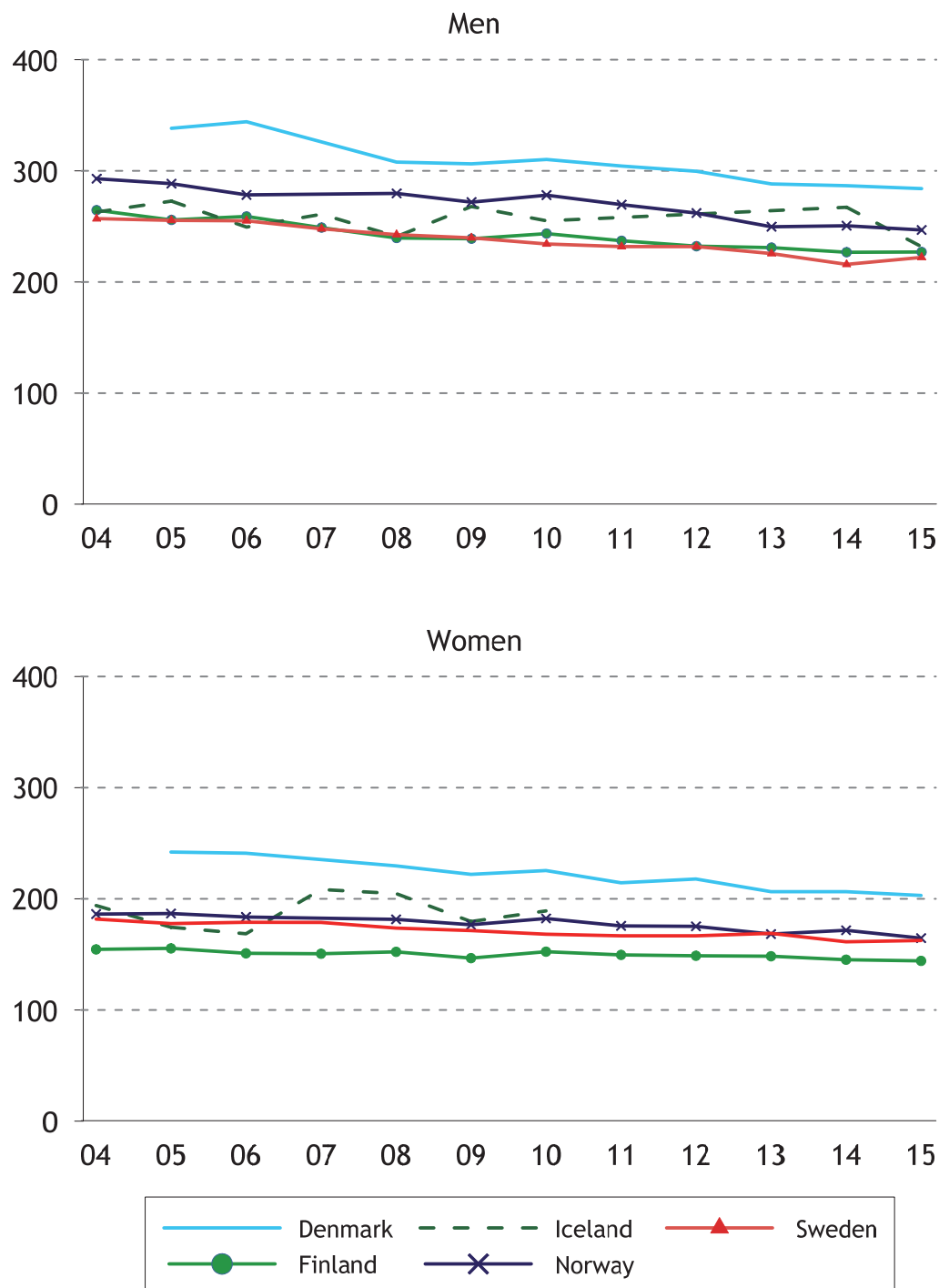
Source: the national registers for causes of death

Figure 4.1.2 Deaths per 100 000 inhabitants by gender, age standardized rates 2000-2015



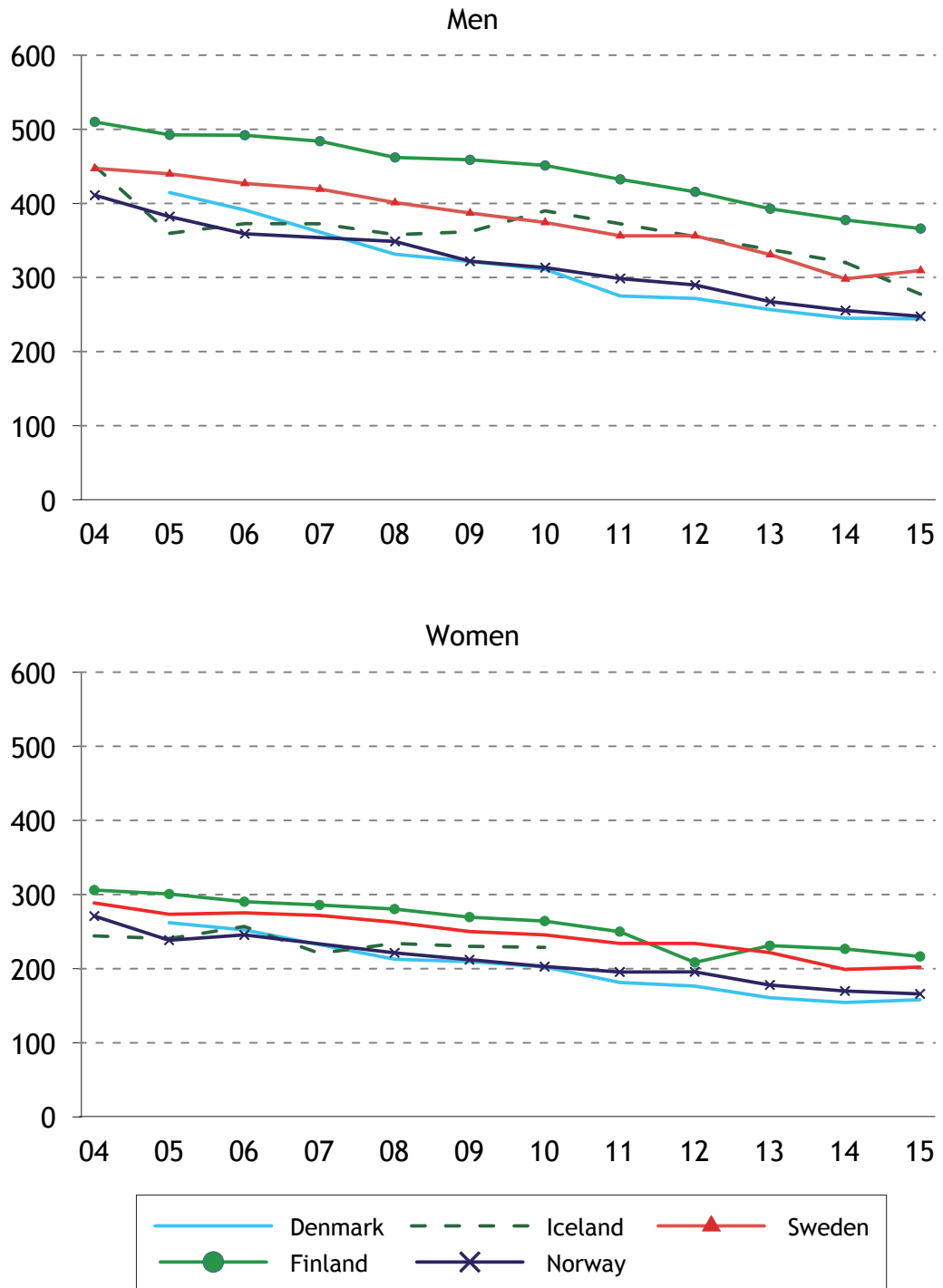
Age-standardized by the Nordic population 2000
 Source: the national registers for causes of death

Figure 4.1.3 Deaths from malignant neoplasms (cancer) per 100 000 inhabitants by gender, age standardized rates, 2004-2015



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

Figure 4.1.4 Deaths from circulatory diseases per 100 000 inhabitants by gender, age standardized rates, 2004-2015



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

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

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
ICD-10 code	2015	2011-15	2011-15	2015	2011-15	2011-15	2015	2015
Malignant neoplasm of the oesophagus (C15)	4.7	4.4	9.2	2.2	2.5	2.8	2.5	2.8
Malignant neoplasm of the trachea, bronchus and lung (C32-C34)	42.4	22.1	62.6	18.5	24.6	24.5	26.9	22.7
Malignant neoplasm of cervix uteri ¹ (C53)	2.1	3.1	6.3	1.6	-	2.1	2.3	2.4
Diabetes (E10-E14)	9.7	5.4	6.0	3.3	3.4	2.3	3.8	6.5
Cerebrovascular diseases (I60-I69)	-	7.9	37.9	12.0	13.6	8.6	9.3	11.9
Obstructive lung diseases (J40-J44)	19.9	8.4	16.7	5.9	7.6	7.1	14.0	8.6
Asthma (J45-J46)	0.6	-	0.8	0.2	0.8	-	0.2	0.3
Chronic liver disease and cirrhosis (K70; K73-K74)	10.5	2.0	3.2	17.5	6.8	1.6	3.4	5.7

1 Per 100 000 women

Source: the national central statistical bureaus

Table 4.1.5 Deaths from HIV/AIDS in total and per 100 000 inhabitants, 2000-2015

	Denmark	Faroe Islands ¹	Greenland ¹	Finland	Åland ¹	Iceland ¹	Norway	Sweden
<i>Number</i>								
2000	21	-	5	10	-	..	15	13
2010	29	-	2	7	-	1	10	11
2014	16	-	1	3	-	3	11	9
2015	13	-	1	-	-	1	9	15
<i>Per 100 000 inhabitants</i>								
2000	0.4	-	8.9	0.2	-	..	0.3	0.1
2010	0.5	0.4	3.5	0.1	-	0.2	0.2	0.1
2014	0.3	2.1	8.8	0.1	-	0.2	0.2	0.1
2015	0.2	-	2.0	-	-	0.2	0.2	0.2

1 2015 = 2011-15; 2014 = 2010-14; 2010 = 2006-10; 2000= 1996-2000

ICD-10 B20-B24

Source: the national registers for causes of death

The dramatic fall in the number of deaths from AIDS is related to new, life-prolonging medication. However, there has been a slight increase in the number of new cases in all the Nordic countries.

Table 4.1.6 Deaths from suicide per 100 000 inhabitants by age and gender 1990-2015

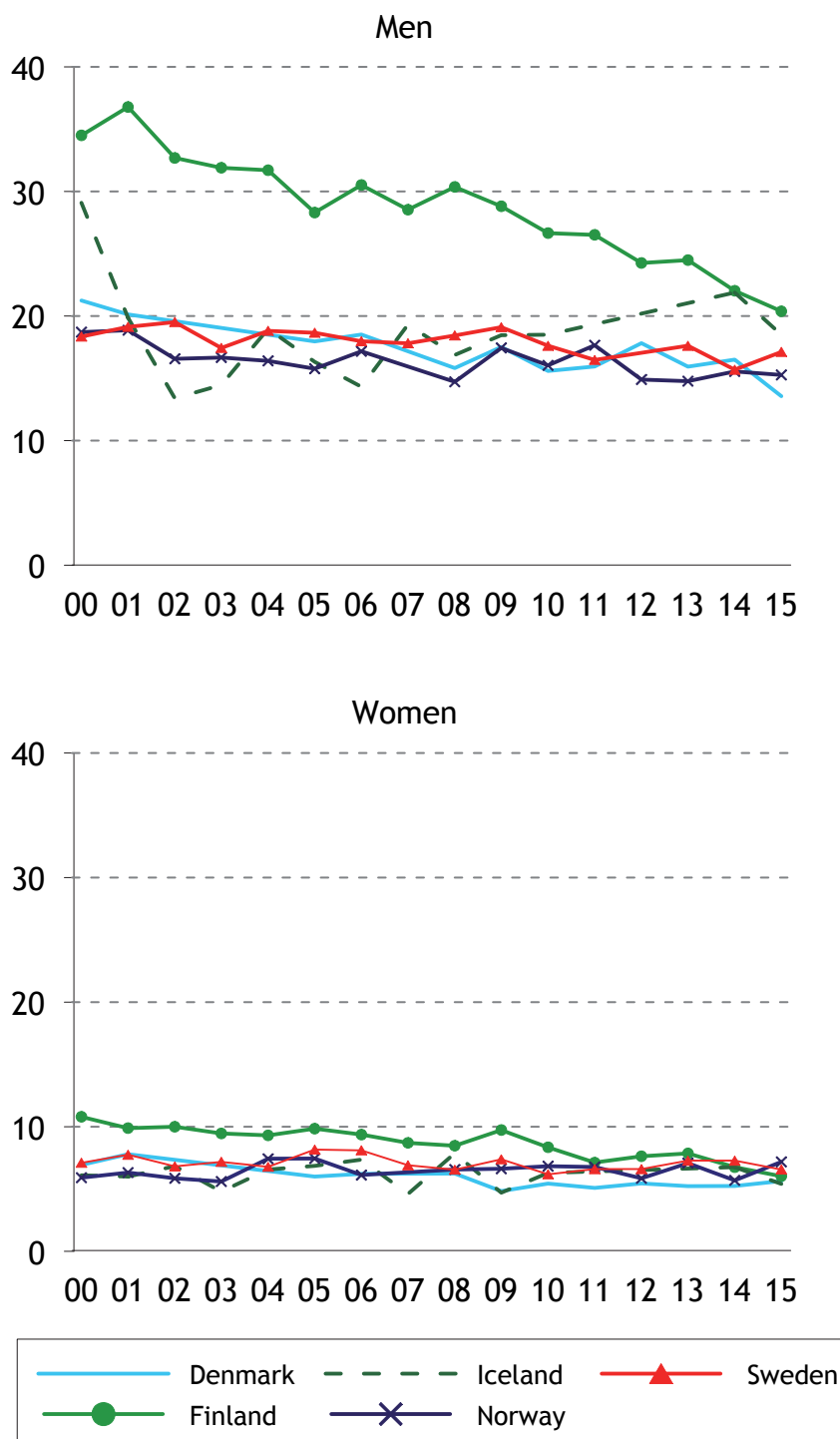
	Men						Women					
	Total	10-19	20-24	25-64	65-79 ¹	80+	Total	10-19	20-24	25-64	65-79 ¹	80+
Denmark												
1990	32.2	4.8	19.8	41.3	58.9	100.7	16.4	1.2	5.6	19.8	31.0	30.0
2000	20.2	4.4	16.0	23.8	34.2	70.1	7.2	2.5	1.2	8.1	10.6	23.3
2010	14.7	3.4	3.0	18.5	25.4	38.1	5.7	1.2	3.7	6.8	10.4	7.5
2014	16.7	4.5	8.4	21.5	9.1	36.2	5.6	0.9	2.7	6.6	9.2	15.3
2015	13.8	1.1	7.2	17.8	7.4	34.0	6.1	1.2	2.7	7.2	9.2	19.0
Faroe Islands												
2006-10	5.2	-	15.7	13.6	8.5	..	1.1	-	-	-	7.1	..
2011-15	4.8	-	-	8.2	5.3	..	0.7	4.8	-	-	-	..
Greenland												
2006-10	112.4	128.5	360.4	118.4	13.2	..	50.4	127.1	85.4	40.6	12.1	..
2011-15	99.8	127.7	267.4	101.9	37.5	..	35.6	60.3	103.2	30.5	16.2	..
Finland												
1990	49.4	20.6	60.3	63.9	58.0	91.5	12.5	2.6	15.8	16.7	15.2	8.6
2000	34.6	7.3	41.8	46.6	34.2	50.7	10.9	4.1	9.4	15.3	11.4	7.1
2010	27.2	9.6	44.9	33.8	24.4	37.8	8.6	2.9	13.2	11.2	8.4	7.5
2014	22.2	6.8	24.6	28.3	24.7	36.9	6.8	3.1	8.4	9.1	6.9	2.7
2015	20.6	6.6	25.3	26.6	21.4	30.4	6.2	0.7	6.0	8.4	7.0	7.2
Åland												
2006-10	10.3	-	-	5.4	46.9	..	13.1	-	65.6	13.4	15.3	..
2011-15	16.8	-	24.6	23.9	14.8	..	2.3	-	-	4.4	-	..
Iceland												
2006-10	18.1	8.5	27.6	24.3	16.7	..	5.8	-	3.6	9.5	5.8	..
2011-15	18.0	8.9	19.1	23.1	25.4	29.3	6.4	1.9	5.0	8.6	9.4	11.7
Norway												
1990	..	..	..	33.0	33.0	..	..	..	..	10.3	11.1	..
2000	18.4	11.3	29.9	22.5	21.0	28.0	5.8	3.0	4.4	8.0	7.8	3.1
2010	15.8	6.1	25.7	18.9	24.0	20.6	6.7	1.3	6.0	10.1	6.0	4.9
2014	15.5	1.8	19.3	20.6	18.9	24.6	5.8	2.6	6.0	7.9	6.2	1.3
2015	15.3	4.0	18.7	19.9	16.9	28.1	7.4	1.9	7.8	9.5	9.7	9.0
Sweden												
1990	24.1	5.0	20.9	28.8	45.7	..	10.4	2.5	6.1	13.7	14.5	..
2000	18.3	4.0	15.9	21.2	33.1	45.5	7.3	3.2	3.9	9.2	9.8	3.1
2010	17.9	5.6	17.7	21.9	23.1	39.9	6.4	2.6	6.3	7.9	9.3	6.7
2014	16.2	5.0	18.4	19.1	20.8	36.2	7.5	3.7	6.5	9.5	8.5	10.5
2015	17.3	4.2	14.1	21.8	22.2	37.0	6.8	3.7	7.4	8.1	8.5	8.9

For Faroe Islands, Greenland and Åland 65-80+

ICD-10 X60-X84

Source: the national registers for causes of death

Figure 4.1.5 Deaths from suicide per 100 000 inhabitants by gender, age standardized rates, 2000-2015



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

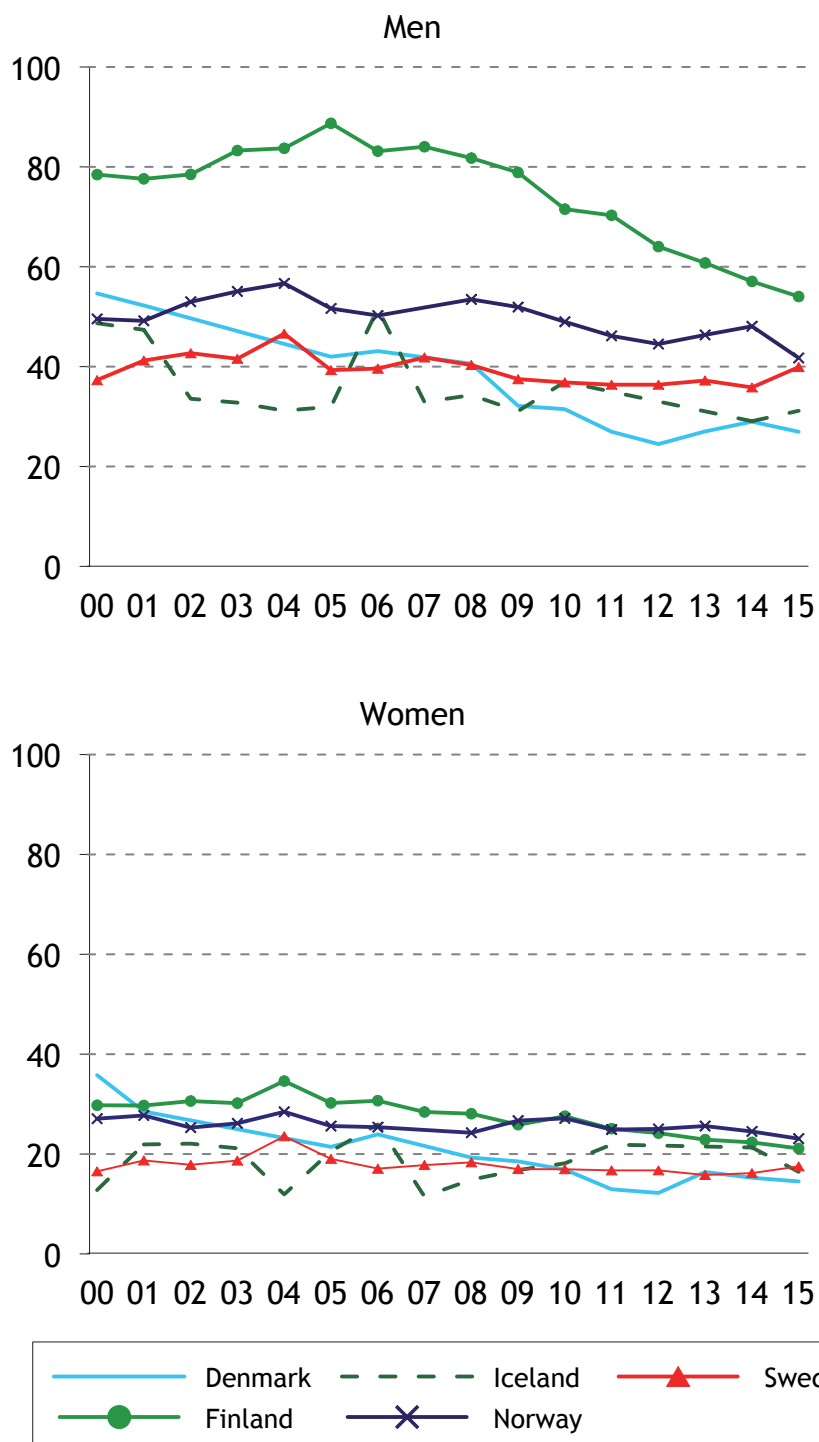
Table 4.1.7 Deaths from accidents per 100 000 inhabitants by age and gender, 2000-2015

	Men						Women					
	Total	0-14	15-24	25-64	65-79	80+	Total	0-14	15-24	25-64	65-79	80+
Denmark												
2000	45.3	6.3	37.7	30.2	80.2	544.7	43.6	2.9	10.3	11.3	64.2	525.9
2010	27.8	2.5	18.6	24.9	31.2	264.0	21.0	1.6	3.9	7.0	31.3	238.5
2014	26.1	1.4	9.1	21.4	34.4	277.0	20.3	0.6	4.8	5.2	23.9	256.2
2015	24.9	1.4	14.2	18.8	36.0	244.3	19.3	0.6	3.9	5.7	21.3	239.5
Faroe Islands												
2007-10	48.9	13.2	7.1	50.4	120.7	298.5	24.8	4.6	8.2	11.2	42.0	266.5
2011-15	29.9	3.8	11.6	29.3	62.1	156.5	9.9	-	16.1	2.9	5.9	107.6
Greenland												
2006-10	66.1	19.1	57.1	70.8	241.1	595.2	34.6	5.6	34.8	29.0	109.5	916.5
2011-15	54.0	6.5	40.3	44.9	259.8	570.3	30.3	2.5	3.8	12.0	39.1	256.8
Finland												
2000	70.8	6.0	30.8	75.6	137.1	471.2	34.4	3.0	9.3	18.9	53.2	310.8
2010	68.9	2.6	28.5	68.6	131.1	387.3	35.5	2.3	5.9	18.5	52.7	279.6
2014	56.8	2.4	20.7	48.0	110.7	378.4	31.5	1.6	6.3	13.0	40.7	267.3
2015	55.0	3.1	24.6	46.1	107.1	334.0	30.4	2.5	3.8	12.0	39.6	258.4
Åland												
2006-10	56.0	-	25.2	34.9	169.8	371.0	24.7	-	-	2.7	23.6	301.5
2011-15	53.2	-	24.2	50.4	96.3	224.7	29.0	-	-	4.4	55.4	308.3
Iceland												
2006-10	29.1	2.4	17.8	25.5	46.9	341.3	17.6	0.6	11.6	6.2	30.0	251.0
2011-15	27.8	2.9	11.6	25.3	42.8	284.7	20.2	3.1	8.7	9.6	24.2	258.2
Norway												
2000	43.9	4.8	35.4	31.8	81.0	442.9	34.2	5.0	9.4	8.1	44.6	381.3
2010	43.1	1.7	23.7	34.8	64.1	450.8	35.1	1.1	10.5	11.6	43.3	389.1
2014	42.6	2.3	16.0	30.5	66.4	514.5	33.4	1.3	5.5	8.6	33.0	439.9
2015	37.3	1.3	14.2	26.3	54.9	468.3	31.3	0.4	6.2	9.0	31.4	406.6
Sweden												
2000	36.2	3.1	27.1	25.5	66.9	310.0	22.7	1.6	6.4	6.5	28.4	227.4
2010	36.3	1.6	15.3	22.1	60.3	375.7	25.4	4.1	4.6	6.0	29.8	266.2
2014	37.7	1.4	16.8	24.0	54.1	363.4	25.5	1.3	5.0	6.2	22.7	270.6
2015	40.4	2.4	16.5	25.8	58.7	415.0	26.4	0.7	4.2	7.1	26.0	289.9

ICD-10, V01-X59

Source: the national registers for causes of death

Figure 4.1.6 Deaths from accidents per 100 000 inhabitants by gender, age standardized rates, 2004-2015



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

Table 4.1.8 Deaths from land transport accidents per 100 000 inhabitants by age and gender, 2000-2015

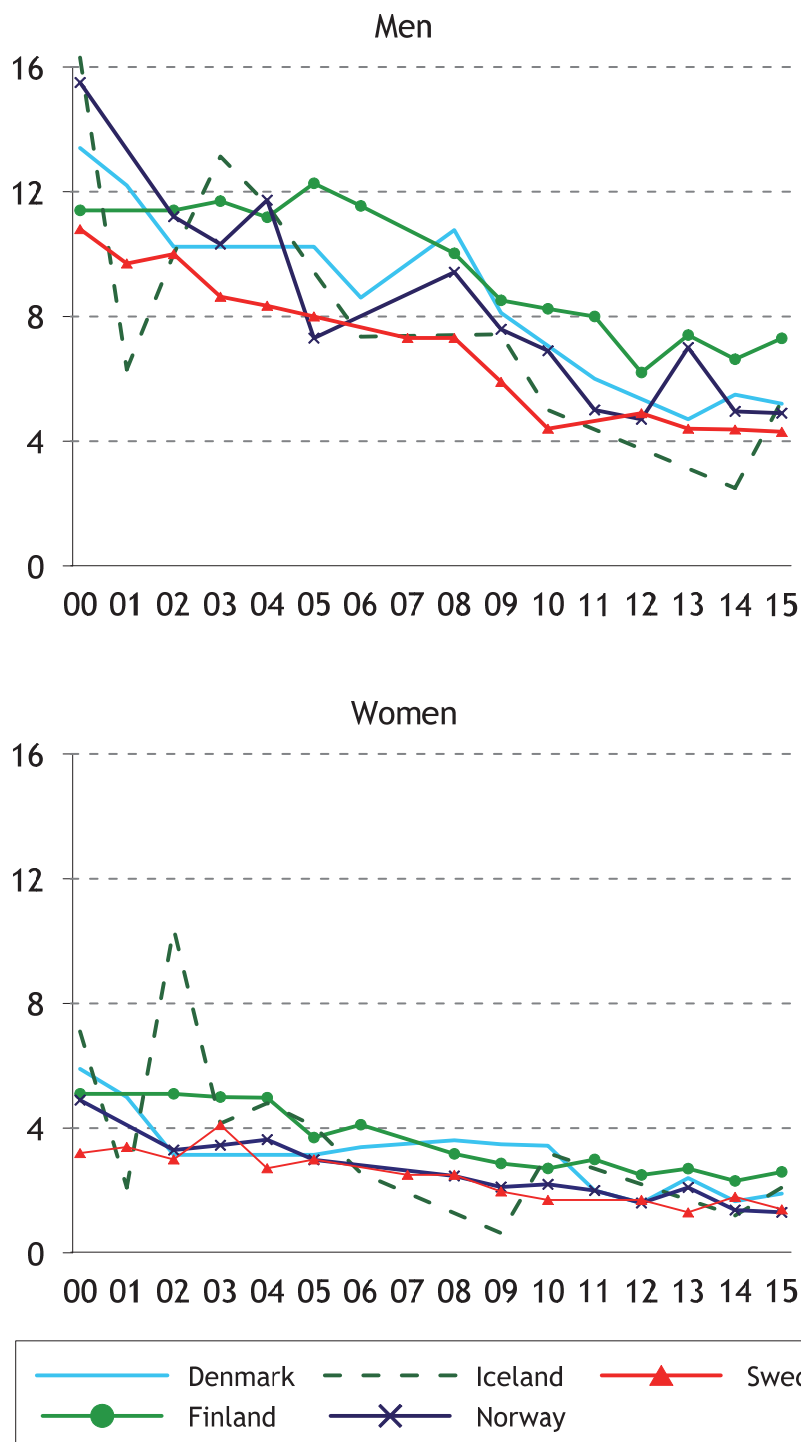
	Men						Women					
	Total	0-14	15-24	25-64	65-79 ¹	80+	Total	0-14	15-24	25-64	65-79 ¹	80+
Denmark												
2000	13.4	3.8	28.0	11.7	20.7	28.6	5.9	1.2	9.3	4.6	9.4	19.7
2010	7.1	1.4	10.9	7.2	6.7	24.6	3.4	1.2	3.0	2.4	7.1	12.9
2014	5.5	0.8	4.8	5.9	7.0	20.4	1.7	0.4	1.7	1.1	3.8	4.7
2015	5.2	0.6	8.6	5.1	5.3	18.6	1.9	0.4	2.2	1.5	3.0	6.7
Faroe Islands												
2006-10	7.0	-	7.1	7.8	17.0	..	4.3	-	8.2	2.2	14.2	..
2011-15	7.3	-	5.8	9.8	13.8	..	2.1	-	16.1	-	-	..
Greenland												
2006-10	19.2	13.7	19.0	20.9	26.5	..	6.0	2.8	19.9	2.9	12.1	..
2011-15	1.4	-	-	-	20.8	..	0.6	-	-	-	8.1	..
Finland												
2000	11.3	2.3	13.3	11.4	22.1	54.9	5.1	2.2	5.6	4.1	9.4	14.1
2010	8.2	0.7	14.0	7.8	13.1	16.4	2.7	1.4	2.8	2.2	5.1	4.6
2014	6.6	0.9	9.3	6.3	10.6	14.1	2.3	1.1	2.8	1.8	3.0	6.0
2015	7.1	1.7	11.8	6.2	11.0	15.7	2.6	1.6	2.9	1.9	4.7	5.4
Åland												
2006-10	8.8	-	12.6	2.7	48.5	-	2.9	-	-	-	11.8	21.5
2011-15	9.8	-	24.2	13.3	-	-	4.6	-	-	2.2	23.8	-
Iceland												
2006-10	8.0	0.6	10.2	8.4	17.9	..	2.7	0.6	6.2	2.0	5.0	..
2011-15	5.3	1.8	7.4	5.2	6.7	16.7	2.1	3.1	4.4	0.5	3.8	5.8
Norway												
2000	14.5	2.6	27.8	15.0	16.0	28.0	4.9	2.5	8.7	3.6	9.3	7.0
2010	6.9	0.4	11.2	6.8	9.7	20.6	2.2	0.2	4.6	1.9	2.6	4.9
2014	5.0	0.8	4.6	4.7	9.3	19.7	1.4	0.4	2.2	1.2	1.9	2.9
2015	4.9	0.4	7.2	5.0	8.3	7.3	1.3	-	3.4	1.0	1.6	2.9
Sweden												
2000	10.8	1.4	19.1	10.7	15.4	20.5	3.2	1.0	4.2	2.6	5.7	14.6
2010	4.4	0.9	6.6	4.5	4.8	8.7	1.7	0.5	2.5	1.3	2.8	3.5
2014	4.4	0.6	3.9	4.1	7.8	13.4	1.8	0.6	1.9	1.5	1.9	5.9
2015	4.3	0.3	5.4	4.5	6.3	8.9	1.4	0.4	1.9	1.0	2.2	4.5

1 For Faroe Islands and Greenland 65-80+

ICD-10, V01-V89

Source: the national registers for causes of death

Figure 4.1.7 Deaths from land transport accidents per 100 000 inhabitants by gender, 2000-2015



Source: the national registers for causes of death

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

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2015	2011-15	2011-15	2015	2011-15	2011-15	2015	2015
Men								
0-34	0.4	-	-	1.4	-	0.5	0.1	0.1
35-44	9.9	61.9	27.0	19.2	-	1.9	1.6	2.5
45-64	76.8	93.6	173.0	103.9	45.1	13.5	18.8	21.0
65-74	92.9	179.7	747.6	107.1	61.7	17.5	36.2	37.5
75+	59.9	127.6	188.8	50.4	18.5	14.4	25.3	23.4
Total	35.9	56.5	99.1	46.5	21.0	5.8	9.8	11.4
Women								
0-34	-	-	-	0.7	-	-	0.1	0.1
35-44	3.0	-	-	5.8	-	3.8	0.9	1.0
45-64	22.0	-	77.6	28.1	12.1	5.0	7.3	7.7
65-74	34.8	78.6	178.7	41.7	20.9	12.1	8.2	13.0
75+	13.8	43.1	-	15.7	-	5.5	5.6	5.3
Total	11.3	9.1	30.7	13.4	5.8	3.0	3.2	4.1
M+W								
0-34	0.2	-	-	1.0	-	0.3	0.1	0.1
35-44	6.4	35.2	15.6	11.5	-	2.8	1.3	1.7
45-64	49.4	53.2	149.7	71.1	33.0	9.3	13.2	14.4
65-74	63.0	154.7	545.9	123.5	49.2	14.8	22.0	25.1
75+	32.9	98.0	96.3	87.8	9.3	9.3	13.5	12.8
Total	23.5	38.9	76.1	29.7	15.6	4.4	6.6	7.7

Source: the national registers for causes of death

ICD-10: E244, F10.0-F10.9, G312, G621, G721, I426, K292, K70.0-70.9, K860, O354, P043, Q860, Y15, X45

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

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2015	2011-15	2011-15	2015	2011-15	2011-15	2015	2015
Men								
0-34	3.2	-	20.3	2.8	-	2.0	6.7	5.8
35-44	14.1	-	81.1	4.4	-	5.6	18.4	11.4
45-64	15.9	31.2	69.2	2.6	-	3.5	19.3	7.6
65-74	6.5	44.9	-	0.7	-	5.3	9.3	1.7
75+	9.5	-	-	0.6	-	2.4	5.5	1.1
Total	8.8	12.1	41.0	2.6	-	3.1	11.8	6.2
Women								
0-34	1.1	-	-	0.9	-	1.8	4.0	1.7
35-44	4.3	-	-	-	-	4.8	8.7	3.6
45-64	9.6	-	55.4	1.4	-	3.0	11.0	4.6
65-74	7.7	-	59.6	1.2	-	1.7	8.6	2.0
75+	5.1	-	-	1.6	-	-	7.4	1.2
Total	4.9	-	18.4	1.0	-	2.4	7.1	2.6
M+W								
0-34	2.2	-	11.4	1.8	-	1.9	5.4	3.8
35-44	9.2	-	46.8	2.1	-	5.2	13.7	7.6
45-64	12.8	111.1	74.8	2.2	-	3.3	15.2	6.1
65-74	7.1	210.8	36.4	1.5	-	3.5	8.9	1.8
75+	6.9	-	-	2.9	-	1.0	6.6	1.2
Total	6.8	6.9	35.1	1.8	-	2.7	9.4	4.4

Source: the national registers for causes of death

ICD-10: F11-F16, F18-F19, O35.5, P04.4 OR (X40-X49, X60-X69, Y10-Y19) coupled with (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 by age and gender

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
	2015	2011-15	2011-15	2015	2011-15	2011-15	2015	2015
<i>Men</i>								
0-44	3.2	-	5.4	0.7	-	1.6	0.1	2.3
45-64	25.9	46.8	276.8	2.9	-	12.0	2.7	10.3
65-74	101.3	89.9	1 308.2	4.0	-	21.0	11.4	26.9
75+	606.3	2 423.8	9 063.4	5.0	-	43.2	106.5	165.6
Total	58.1	173.6	321.2	1.9	-	7.6	7.7	18.7
No death certificate	0	0	0	209	3	0	490	418
<i>Women</i>								
0-44	2.6	12.3	9.5	0.1	-	0.6	-	0.9
45-64	15.2	27.5	33.3	0.5	-	7.0	0.9	3.6
65-74	63.1	39.3	297.8	1.2	-	10.3	2.9	15.7
75+	731.1	3 364.7	9 046.9	6.4	36.3	85.8	201.1	280.7
Total	77.4	292.1	248.8	1.0	3.5	8.7	17.3	31.3
No death certificate	0	0	0	147	2	0	309	418
<i>M+W</i>								
0-44	2.9	7.8	9.2	0.4	-	1.1	-	1.7
45-64	20.6	44.4	183.7	1.7	-	9.5	1.8	7.0
65-74	81.7	77.4	946.2	2.5	-	15.6	7.0	21.2
75+	679.5	3 790.1	11 455.5	5.9	28.0	67.4	162.8	232.7
Total	67.8	288.3	341.6	1.5	2.3	8.1	12.5	25.0
No death certificate	0	0	0	356	5	0	799	836

Source: the national registers for causes of death

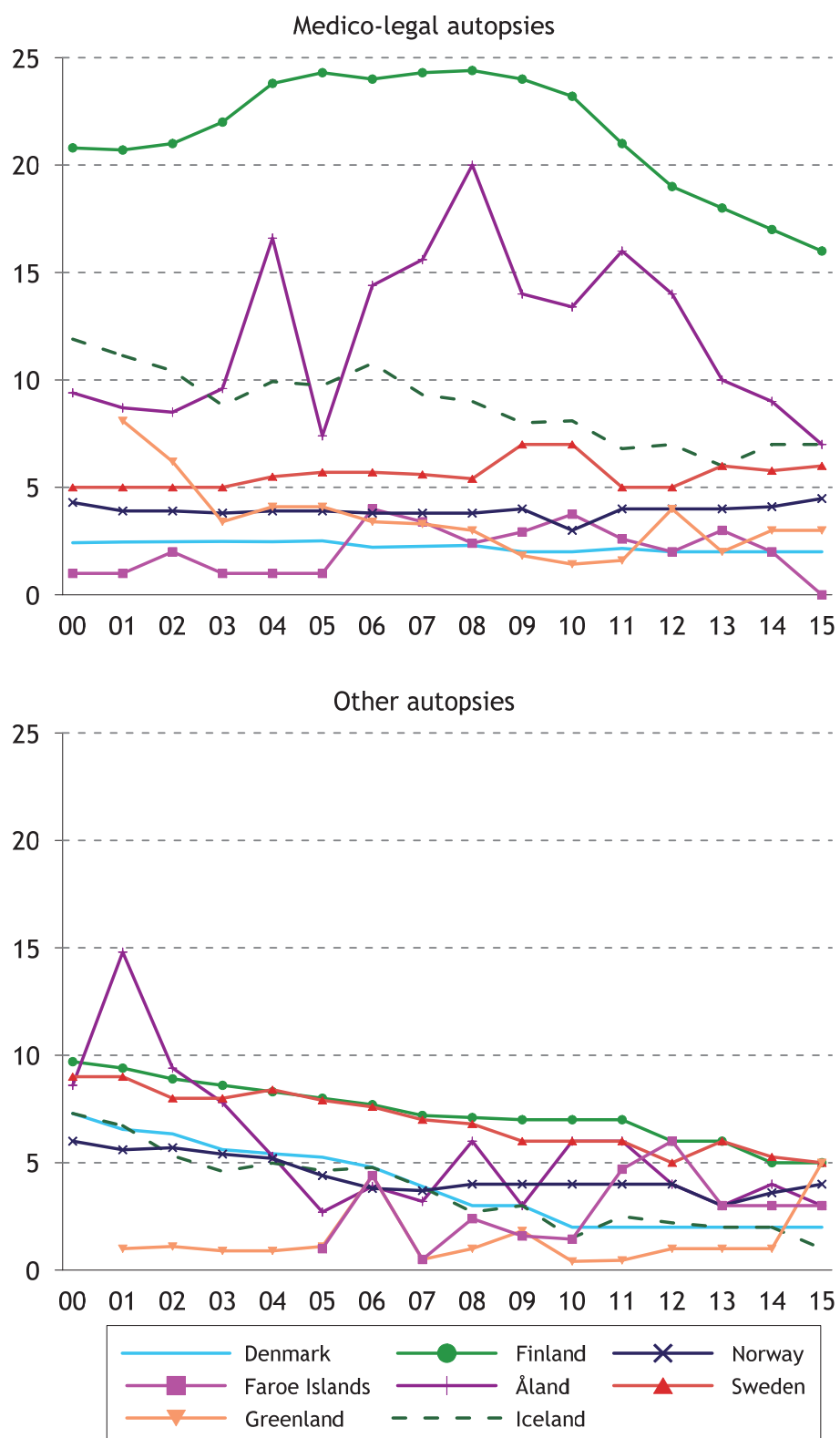
ICD-10: I46.9. I95. I99. J960. J969. P28.50. R00-R94.8. R99

Table 4.1.12 Autopsy rates as a percentage of all deaths. 2000-2015

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
<i>Medico-legal autopsies</i>								
2000	2	1	..	21	9	12	4	5
2005	3	1	4	24	7	10	4	6
2010	2	3	1	23	13	8	3	7
2014	2	1	2	17	9	7	4	6
2015	2	-	3	16	7	7	4	6
<i>Other autopsies</i>								
2000	7	..	..	10	9	7	6	9
2005	5	1	1	8	3	5	4	8
2010	2	1	-	7	6	2	4	6
2014	2	3	1	5	4	2	4	5
2015	2	3	5	5	3	1	4	5

Source: the national registers for causes of death

Figure 4.1.8 Autopsy rates as a percentage of all deaths. 2000-2015



Source: the national registers for causes of death

Chapter 5

Diagnosis-related morbidity and mortality

In this section, diagnosis-related data is presented, based on the respective registers in the Nordic countries for cancer, patients, prescribed drugs and causes of death (see below). The information concerns several diseases and disease groups that are common among old people. They are presented in ten sections.

- 5.1 Cardiovascular diseases
- 5.2 Cancer diseases
- 5.3 Diseases of the digestive system and the urinary system
- 5.4 Endocrine diseases
- 5.5 COPD and asthma
- 5.6 Pneumonia
- 5.7 Dementia and Alzheimer's disease
- 5.8 Mental illness
- 5.9 Muscular and skeletal diseases
- 5.10 Falls and hip fractures

For all disease groups, data is presented on *patients admitted to hospital* and *mortality*. For treatment, data is presented on *prescribed and collected medicines* for most of the disease groups and, for some groups, *surgical measures*. Cancer data concerns newly detected tumours during the year.

Patients register data show the number of patients who were discharged after hospital treatment during the year in question. Every unique individual was only counted once per year, on discharge from the first treatment period with the diagnosis in question as the main diagnosis, i.e. the main reason for the treatment occasion. The information shows how common a certain diagnosis or diagnosis group is as a cause of hospitalisation, which is not necessarily a measure of illness.

Many of the differences in the tables and figures are caused by organisational differences in health care systems, and in differences in registration practices and coding of diagnoses. This applies, for example, to the information about the number of patients treated in hospital for fibrillation and for hypertension.

Data from the Norwegian Patient Register also includes patients who have been treated in open care, which means that these are not comparable with data from the other Nordic Countries.

Cancer register data show the incidence of cancer, i.e. the number of newly detected cancer cases/tumours in the year in question. All Nordic countries except Sweden have centralised coding and classification. The Swedish cancer register does not follow up cancer cases in the Cause of Death Register to find any cancer cases that were not reported to the register, unlike the other Nordic cancer registers. This can mean that Sweden may report too low incidence figures, particularly for old people and for diseases with short survival and high mortality. Swedish survival data shown in the section on quality indicators may also be overestimated. Lung cancer is an example of a cancer disease where Swedish incidence and survival data may not be directly comparable with the data from the other Nordic countries. However, mortality is more comparable.

Prescription register data show prescribed and collected medicines. However, it does not include over-the-counter medicines, nor orders to nursing homes or medicines consumed in hospitals. Differences in how orders versus prescriptions are managed in old people's homes in the different countries can affect comparisons of medicine data. In Norway, for example, medicines are distributed within the municipal nursing homes from a central medicines store, and are therefore not included in the prescription register. In Sweden, on the other hand, medicines are prescribed to people who live in elderly care homes primarily individually via primary care doctors, and so are recorded in the Swedish register.

Consequently, when interpreting data presented in this report, it is important to bear in mind that conditions relating to collection of data to the registers can differ from country to country. For example, differences in health care structure mean that data for the exact same patient groups are not collected and reported, or that there are certain differences in classification and coding practices.

Also, it is important to remember that the way of presenting data with age-standardisation has both advantages and limitations. The diseases shown in this report are usually strongly age-dependent. The advantage of age standardisation is that it allows comparisons between countries and over time, regardless of differences in age composition. In this way, it can be excluded that the differences shown depend on differences in age structure.

We have chosen to age-standardise the data, using the 2014 Nordic population. One disadvantage of age standardisation is that, for example, the number of cancer cases shown for each country and time are not the actual figures; they are converted to the number that would have applied if the population in question had the same age composition as the Nordic region as a whole in 2014. The information presented only gives a relative picture of cancer-related illness in the Nordic region, not an exact picture in the individual country.

It is also important to remember that the number of cases per 100 000 inhabitants shown in the tables and figures does not describe the actual numbers treated. For example, 1 290 cases of acute myocardial infarction per 100 000 men aged 80 and older in Iceland in 2014 gives the impression of a major load on health care. But since there are only just over 4 800 men in that age group, the actual figure was only just over 60 cases of acute myocardial infarction treated in Icelandic hospitals.

Registers used in the report

Denmark

<i>Cancer:</i>	The Danish Cancer Registry (The Danish Health Data Authority)
<i>Patients:</i>	The Danish National Patient Register (The Danish Health Data Authority)
<i>Prescriptions:</i>	The Danish National Prescription Database (The Danish Health Data Authority)
<i>Cause of death:</i>	Danish Cause of Death Register (The Danish Health Data Authority)

Finland

<i>Cancer:</i>	The Finnish Cancer Registry (Institute for Statistical and Epidemiological Cancer Research / National Institute for Health and Welfare)
<i>Patients:</i>	Finnish Hospital Discharge Register (National Institute for Health and Welfare)
<i>Prescriptions:</i>	The Finnish Prescription Register (The Social Insurance Institution of Finland)
<i>Cause of death:</i>	Finnish Cause of Death Register (Statistics Finland)

Iceland

<i>Cancer:</i>	Icelandic Cancer Registry (the Icelandic Cancer Society)
<i>Patients:</i>	National Patient Register (Directorate of Health in Iceland)
<i>Prescriptions:</i>	Prescription Drugs Database (Directorate of Health in Iceland)
<i>Cause of death:</i>	Causes of Death Register (Directorate of Health in Iceland)

Norway

<i>Cancer:</i>	The Cancer Registry of Norway (Institute of Population based Cancer Research)
<i>Patients:</i>	The Norwegian Patient Registry (the Norwegian Directorate of Health)
<i>Prescriptions:</i>	Norwegian Prescription Database (Norwegian Institute of Public Health)
<i>Cause of death:</i>	Norwegian Cause of Death Registry (Norwegian Institute of Public Health)

Sweden

<i>Cancer:</i>	The Swedish Cancer Register (National Board of Health and Welfare)
<i>Patients:</i>	The Swedish National Patient Register (National Board of Health and Welfare)
<i>Prescriptions:</i>	The Swedish Prescribed Drug Register (National Board of Health and Welfare)
<i>Cause of death:</i>	Swedish Cause of Death Register (National Board of Health and Welfare)

5.1 Cardiovascular diseases

Cardiovascular diseases are the most common cause of hospital care and fatalities among old people. Myocardial infarction is caused by acute lack of oxygen due to clot formation in the heart's coronary artery. Stroke is the generic name for myocardial infarction, cerebral haemorrhage and cerebral membrane bleeding. Myocardial infarction, also called ischaemic stroke, is the most common form of stroke. Atrial fibrillation is a cardiac dysrhythmia that increases the risk of blood clotting and myocardial infarction. Heart failure has several causes, the most common being coronary artery disease and high blood pressure.

The risk of contracting cardiovascular diseases is correlated to gender, but above all to age. People who die from cardiovascular diseases are generally older than 65. Known risk factors for cardiovascular diseases include hereditary factors, smoking, high blood pressure, dyslipidaemia, diabetes, physical inactivity, and alcohol. The more risk factors, the greater the risk of developing cardiovascular diseases.

Apart from the consequences shown below in the form of hospitalisation and death, cardiovascular diseases also cause disabilities among old people. Stroke can lead to permanent disability. Heart failure may not only affect the heart; it can also affect the functions of the brain and skeletal musculature, resulting in increased tiredness and poorer quality of life.

Hospitalisation

Cardiovascular diseases are very common causes of hospitalisation among old people. Stroke is the somatic disease responsible for the most days of hospital care among old people.

Men are more likely than women to suffer myocardial infarction and stroke, and women are generally considerably older when they become ill (Figure 5.1.1). However, because there are more women in older age groups, the difference in the actual numbers that develop cardiovascular diseases is not great.

The number of people contracting myocardial infarction and stroke has fallen in all age groups, but somewhat less in younger than older ages (Figure 5.1.1). Norway and Sweden have the largest number of cases of illness, but the differences between the Nordic countries have decreased, and mainly in the very oldest age groups.

High blood pressure is one of the most common causes of cardiac diseases. How blood pressure is recorded on admission to hospital varies from country to country, so data from the patient registers does not necessarily reflect differences in illness. Norway reports the clearly highest proportion of older patients treated for high blood pressure and for fibrillations (Figure 5.1.1). While the proportion treated for high blood pressure has fallen, the proportion treated for fibrillation increased between 2006 and 2014 (Figure 5.1.1). In other countries, the proportions have remained largely unchanged. This also applies for heart failure (Figure 5.1.1)

Pharmaceutical treatment

Even if admission to hospital is common, a large proportion of old people with cardiovascular diseases are treated with pharmaceuticals and the most common are shown below. However, these pharmaceuticals are also prescribed for other diseases, for example renal failure.

Diuretics (C03), which increase the amount of salt and water expelled from the body, are used to reduce the water content of the blood, which helps to reduce the

pressure in the blood vessels. Diuretics are prescribed more often to women than to men, and are used most frequently in Denmark and Iceland. They are prescribed least in Norway, and prescription of these drugs is generally decreasing throughout the Nordic region (Figure 5.1.2).

Betablockers (C07) protect the heart by reducing the pulse and dampening stress symptoms, and are used to treat high blood pressure and heart failure. Betablockers are used most in Finland and Iceland, and least in Denmark (Figure 5.1.2). Prescription of betablockers is increasing somewhat, primarily among the oldest age groups.

Calcium antagonists (C08) widen the arteries by reducing the potassium content in the artery muscles, which has a sedating effect and reduces pressure. Norway uses least of these drugs and Denmark most. Consumption has increased, but by different amounts, which means a greater variation in the prescription patterns between the Nordic countries (Figure 5.1.2).

Pharmaceuticals that affect the renin-angiotensin system (C09) are used to improve the long-term prognosis in heart failure and myocardial infarction, and are used mainly in Finland and in other countries at approximately the same, slightly lower, level (Figure 5.1.2). Use is increasing generally.

Lipid-lowering drugs (C10) reduce the new formation of cholesterol in the body, and help to increase the good cholesterol (HDL) and reduce the bad cholesterol (LDL) and the triglycerides, which reduce the risk of heart disease and premature death (Figure 5.1.2).

Surgical treatment

Myocardial infarction is caused by clots forming in the heart's coronary artery. Figure 5.1.3 show the frequency of two important treatment forms that work by opening the passage in the coronary artery, PCI treatment (Percutaneous Coronary Intervention) and CABG treatment (coronary artery bypass grafting, sometimes just called a bypass). Figure 5.1.3 also show that surgical intervention is most common in the 75-84 age group, and that Norway has a somewhat higher treatment frequency than other Nordic countries, particularly for PCI.

PCI is more common than bypass. The differences are greatest among women and are generally highest in Sweden. Gender differences can be seen in both treatments. In the 65-74 age group, PTCA is performed three times more often among men than women. In the 75-84 age group, the frequency is twice as high. For bypass operations, the difference is four times for younger age groups and three times for older age groups.

Mortality

Mortality due to cardiovascular diseases is considerably higher in older than younger age groups, and is higher among men than women. Mortality in myocardial infarction is highest in Finland and lowest in Norway (Figure 5.1.3). Mortality in stroke is highest in Denmark and lowest in Iceland (Figure 5.1.3).

Mortality due to cardiovascular diseases has fallen considerably throughout the Nordic region for both men and women, and has helped to increase average life expectancy. Despite the noticeable decrease in recent decades, cardiovascular diseases are still the most common cause of death among old people.

The decreasing mortality is due to a decreased level of illness through improved lifestyle habits, such as reduced smoking, and improved survival among those who become ill, for example through better treatment methods. In the chapter on quality indicators, mortality 30 days after illness is compared.

Statistics - Cardiovascular diseases

The figures show information for 2014 divided into gender and the 65+ and 80+ age groups. For the period 2006-2014, information is reported for the 65+ and 75+ age groups. The statistics show:

Patients discharged from hospital

- Acute myocardial infarction
- Hypertensions
- Stroke
- Heart failure
- Atrial fibrillation and flutter

Pharmaceutical treatment

- Agents acting on the renin-angiotensin system
- Beta-blocking agents
- Calcium channel blockers
- Diuretics
- Lipid modifying agents

Surgical measures

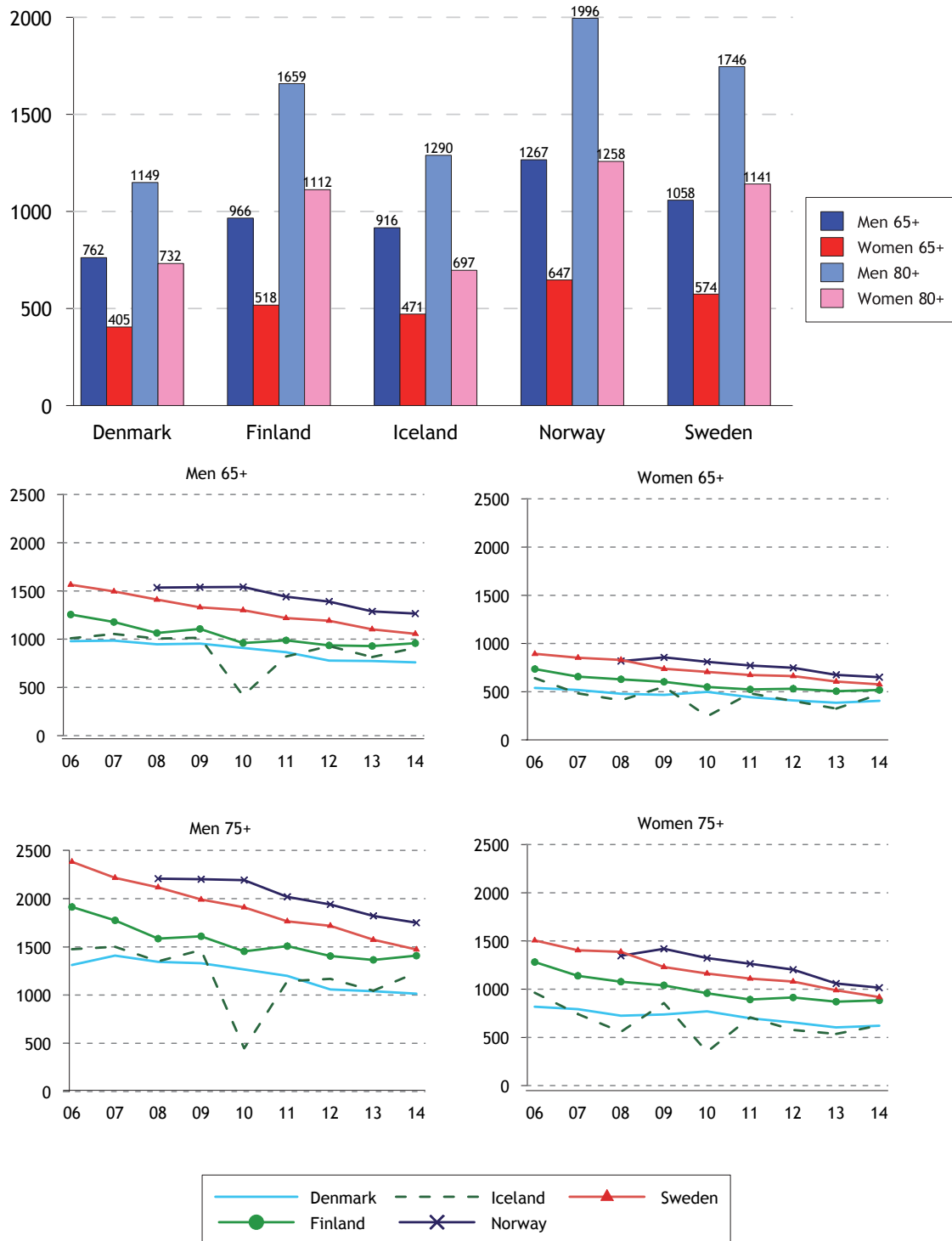
- Transluminal coronary angioplasty (PTCA, PCI)
- Coronary artery bypass grafting

Death

- Ischaemic heart disease
- Stroke

Patients discharged from hospital

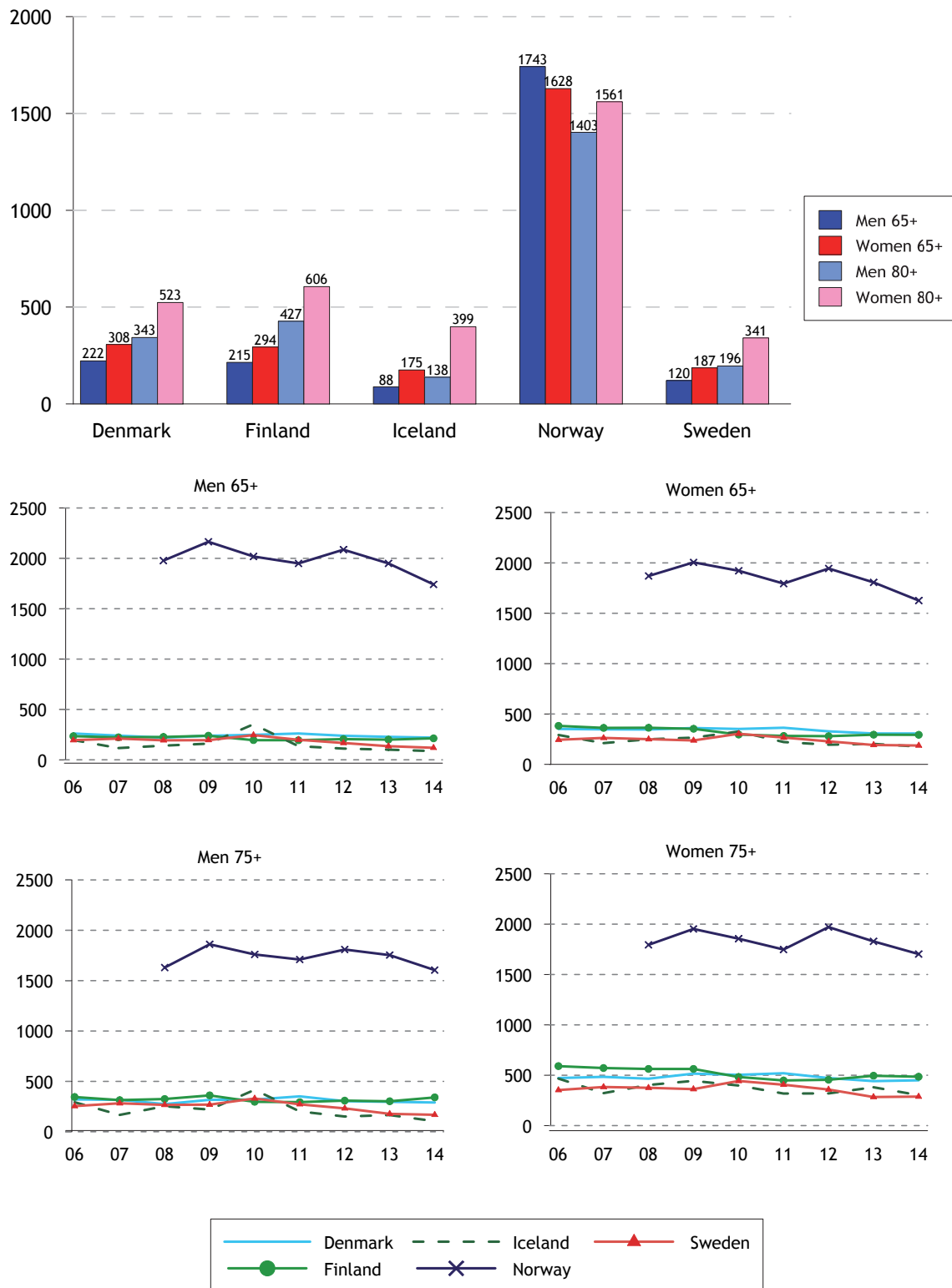
Figure 5.1.1 Patients treated in somatic hospitals for acute myocardial infarction, ICD-10: I21-I22, age-standardised number of patients per 100 000 population, 2014 and time series 2006-2014¹



1 Data from the Norwegian Patient Register also includes patients who have been treated in open care, which means that these are not comparable with data from the other Nordic Countries

Source: The National inpatient registers

Figure 5.1.2 Patients treated in somatic hospitals for hypertension, ICD-10: I10-I15, age-standardised number of patients per 100 000 population, 2014 and time series 2006-2014¹

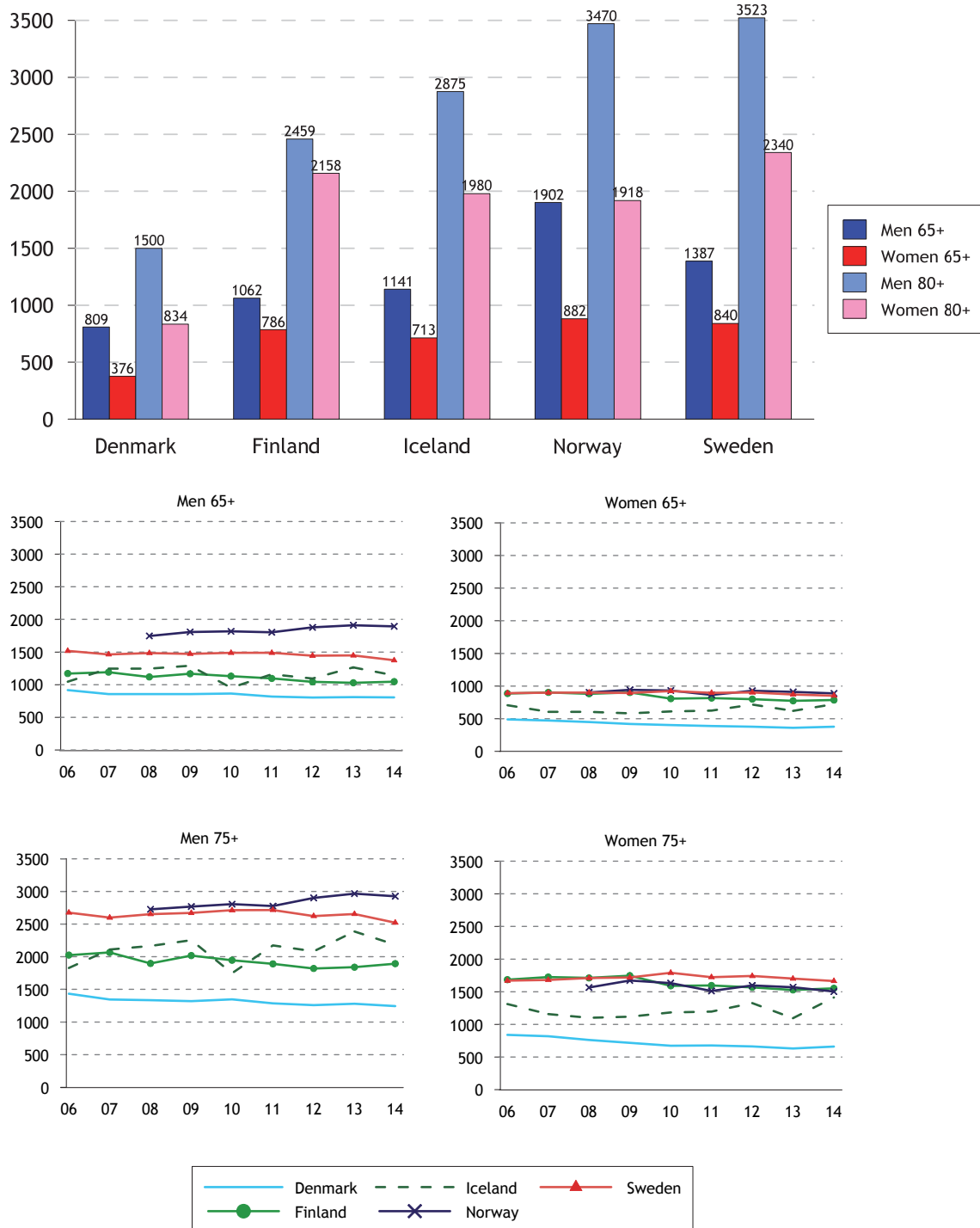


¹ Data from the Norwegian Patient Register also includes patients who have been treated in open care, which means that these are not comparable with data from the other Nordic Countries

Source: The National inpatient registers

Heart failure

Figure 5.1.3 Patients treated in somatic hospitals for heart failure. ICD-10: I50. Age-standardised number of patients per 100 000 population, 2014 and time series 2006-2014¹

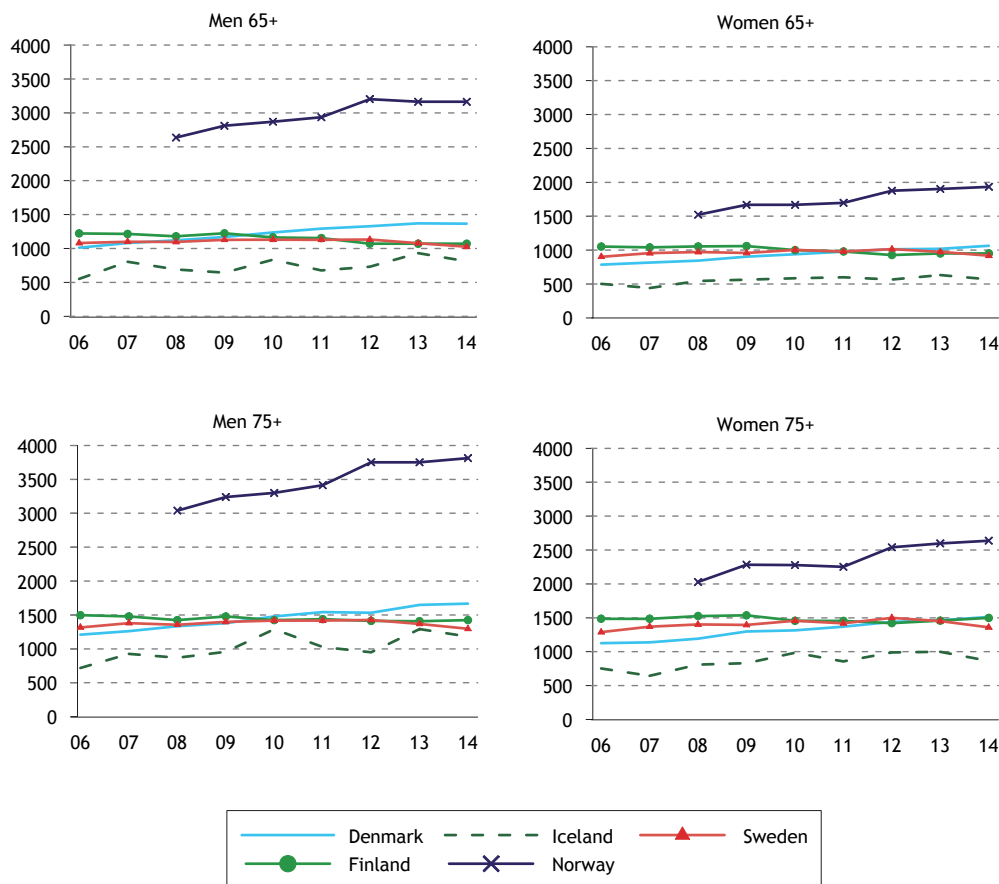
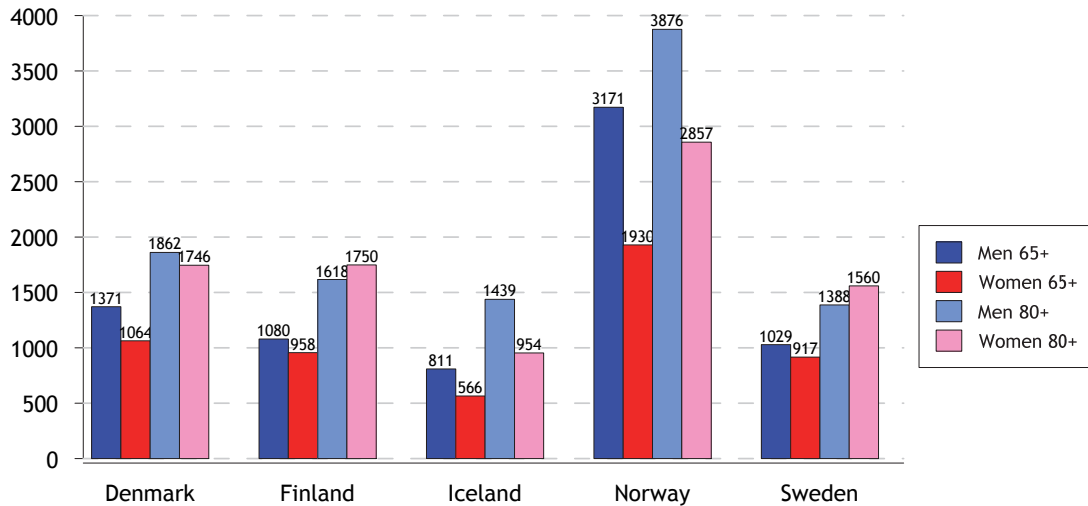


1 Data from the Norwegian Patient Register also includes patients who have been treated in open care, which means that these are not comparable with data from the other Nordic Countries

Source: The National inpatient registers

Atrial fibrillation and flutter

Figure 5.1.4 Patients treated in somatic hospitals for atrial fibrillation and flutter, ICD-10: I48, age-standardised number of patients per 100 000 population, 2014 and time series 2006-2014¹

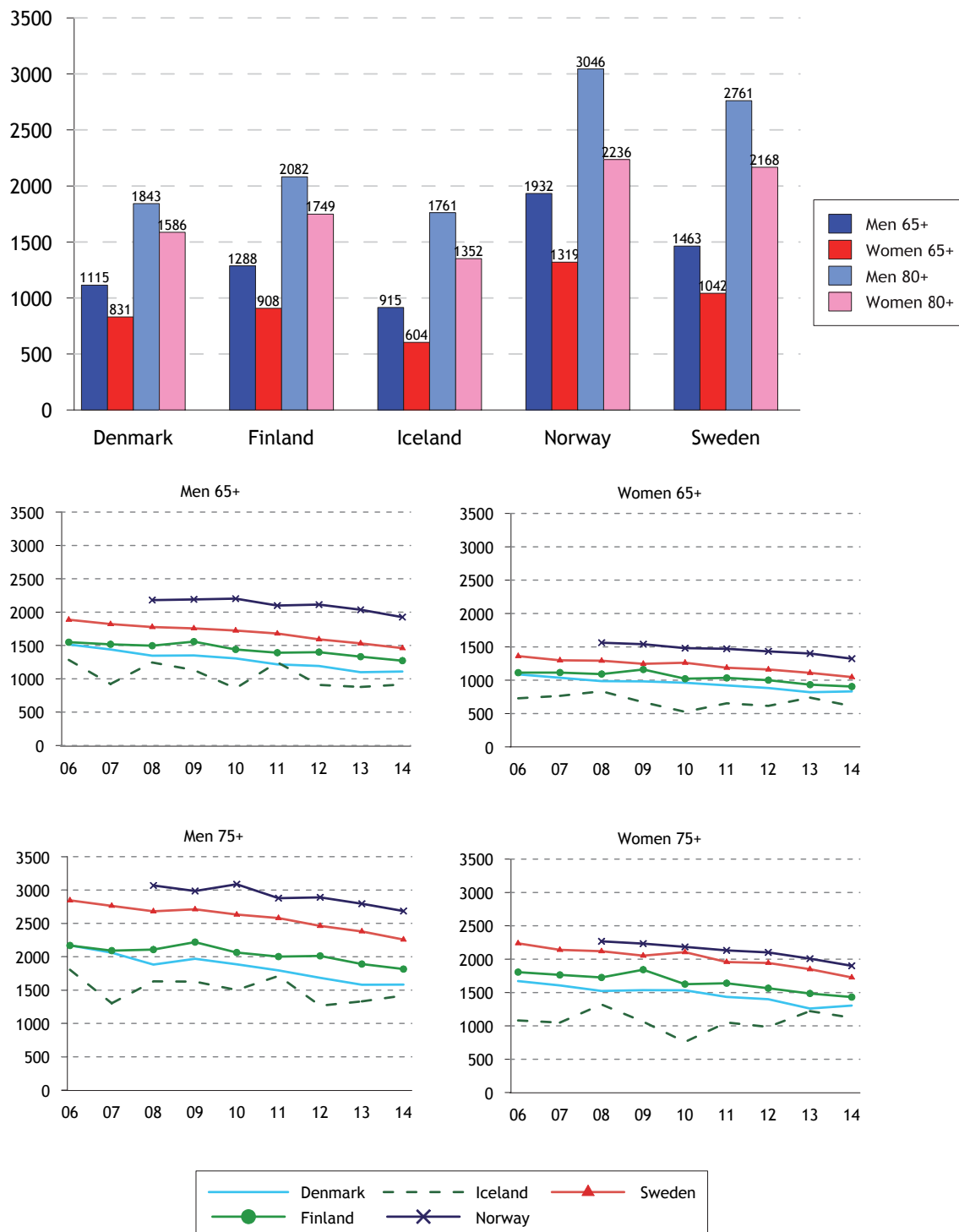


1 Data from the Norwegian Patient Register also includes patients who have been treated in open care, which means that these are not comparable with data from the other Nordic Countries

Source: The National inpatient registers

Stroke

Figure 5.1.5 Patients treated in somatic hospitals for cerebrovascular diseases (stroke), ICD-10: I60-I169 age-standardised number of patients per 100 000 population, 2014 and time series 2006-2014¹

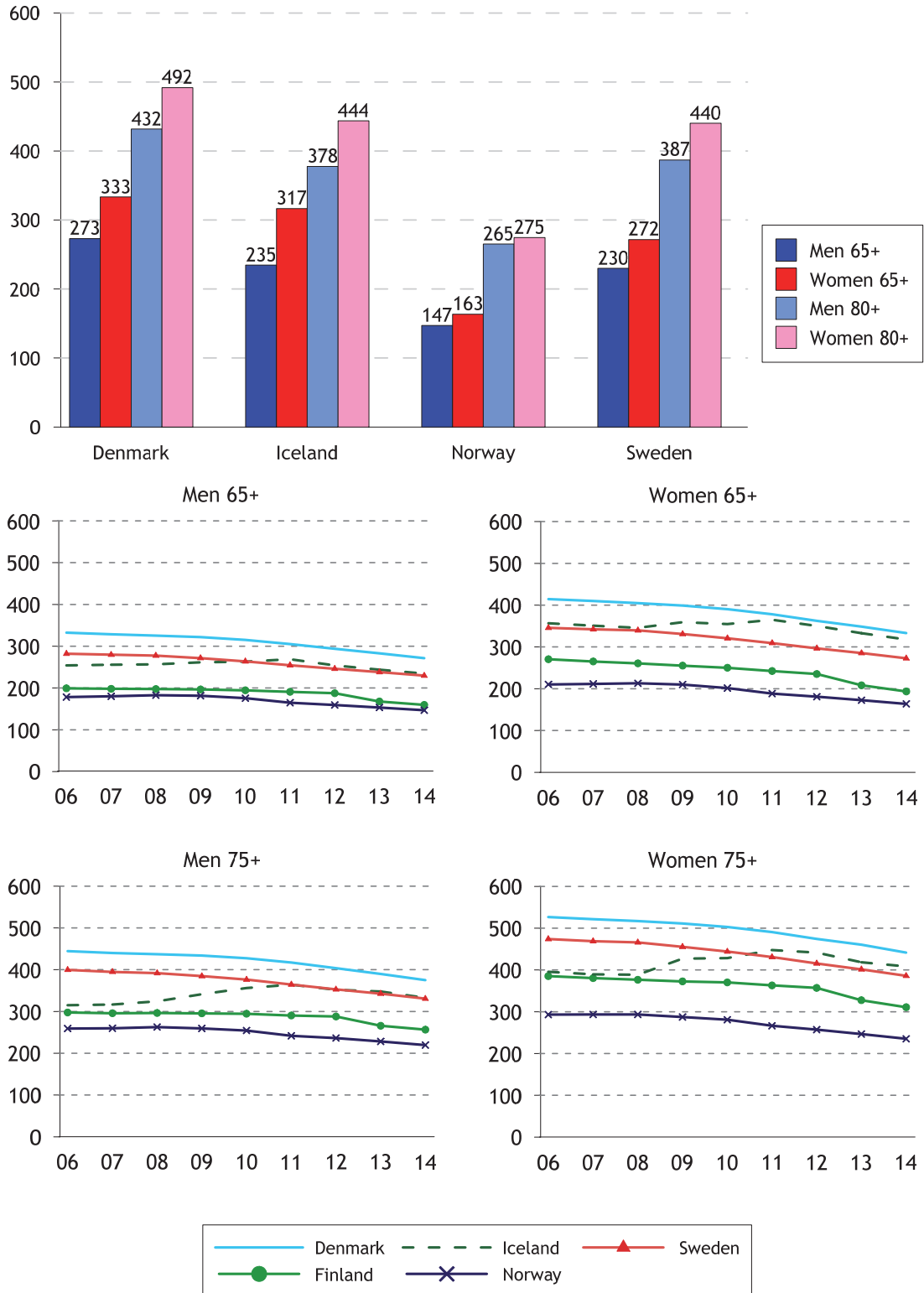


1 Data from the Norwegian Patient Register also includes patients who have been treated in open care, which means that these are not comparable with data from the other Nordic Countries

Source: The National inpatient registers

Pharmaceutical treatment

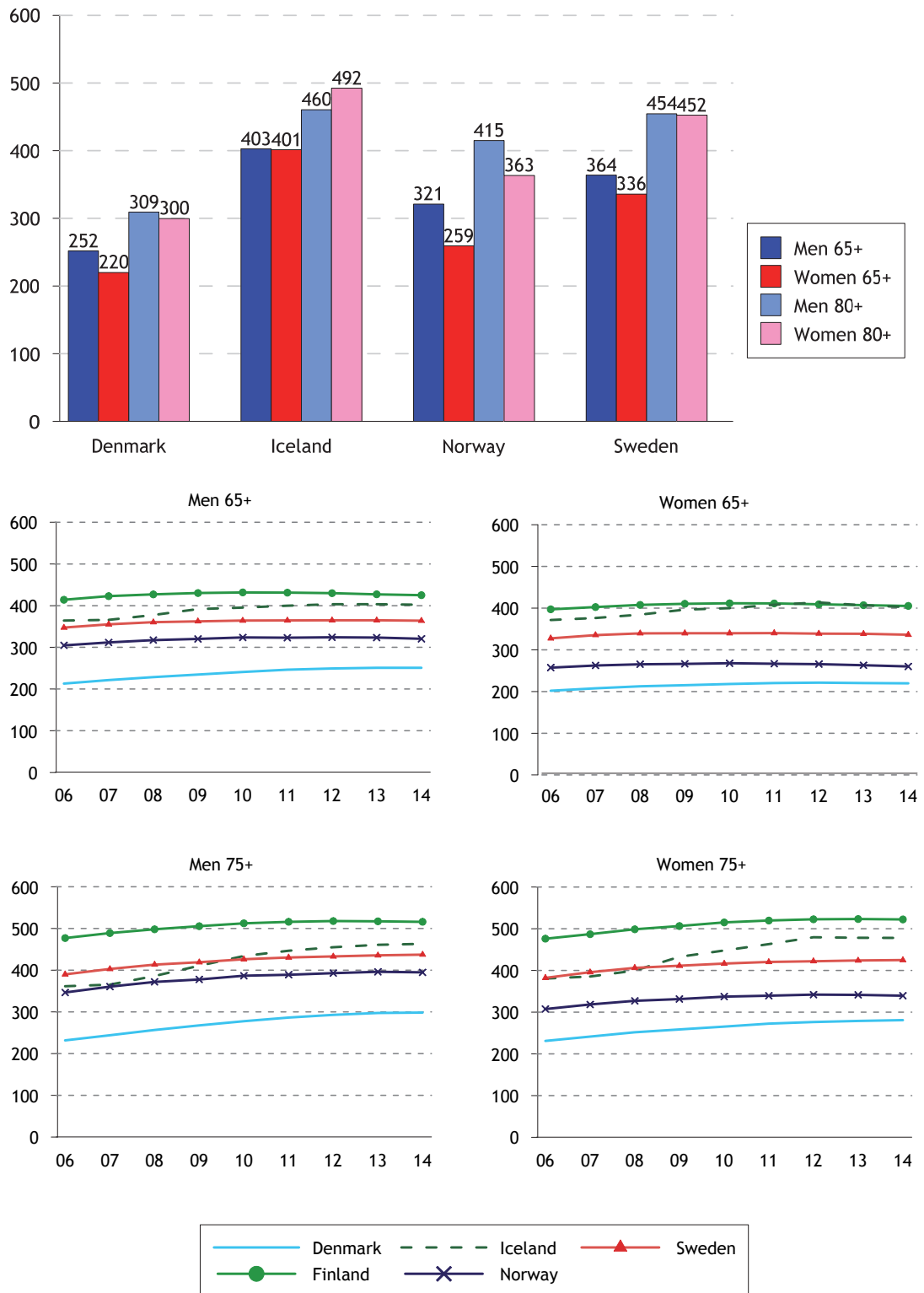
Figure 5.1.6 Prescription of diuretics, ATC: C03, age-standardised one-year prevalence per 100 000 population, 2014 and time series 2006-2014



Source: The national prescription databases

Beta-blocking agents

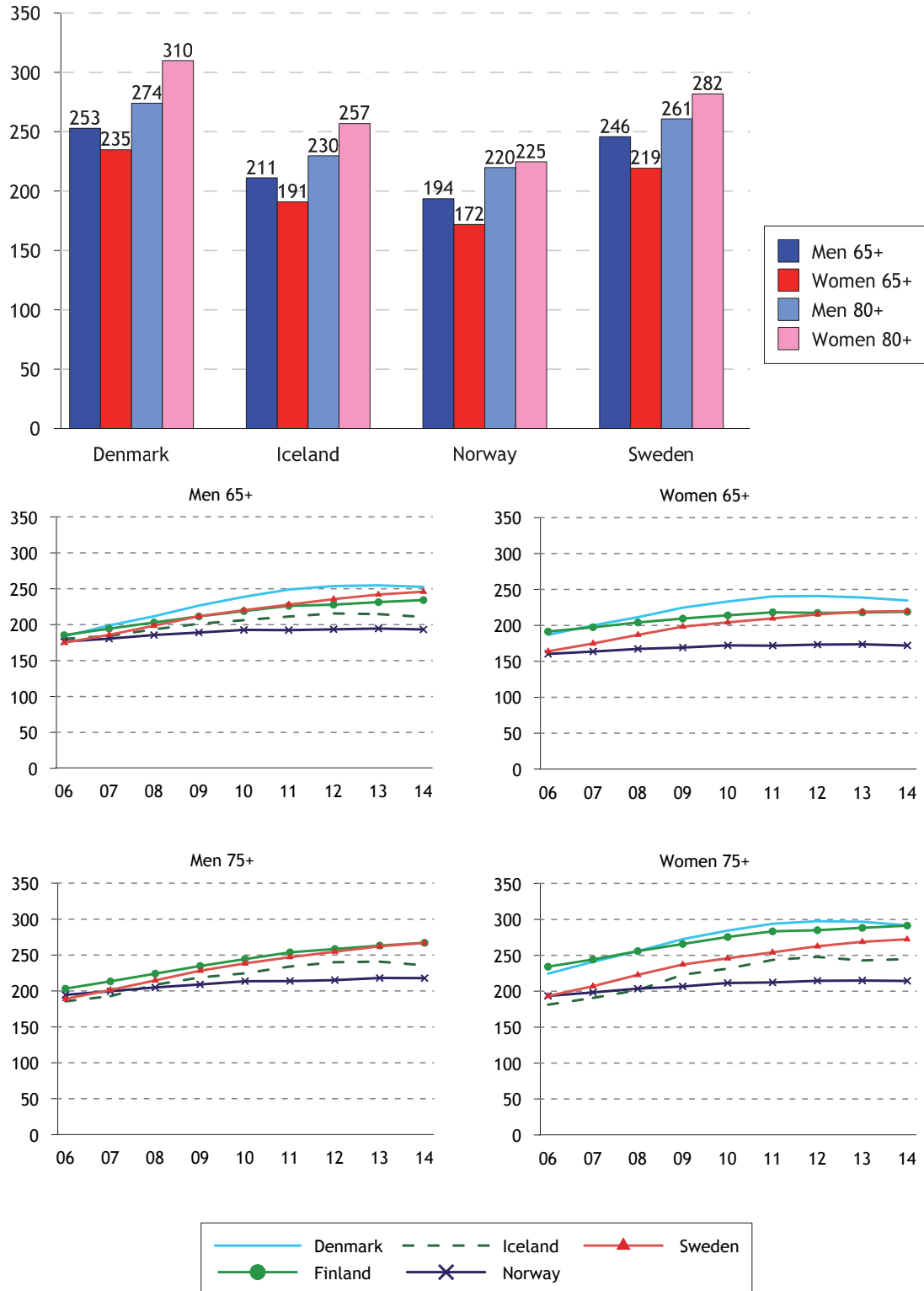
Figure 5.1.7 Prescription of beta-blocking agents, ATC: C07, age-standardised one-year prevalence per 100 000 population, 2014 and time series 2006-2014



Source: The national prescription databases

Calcium channel blockers

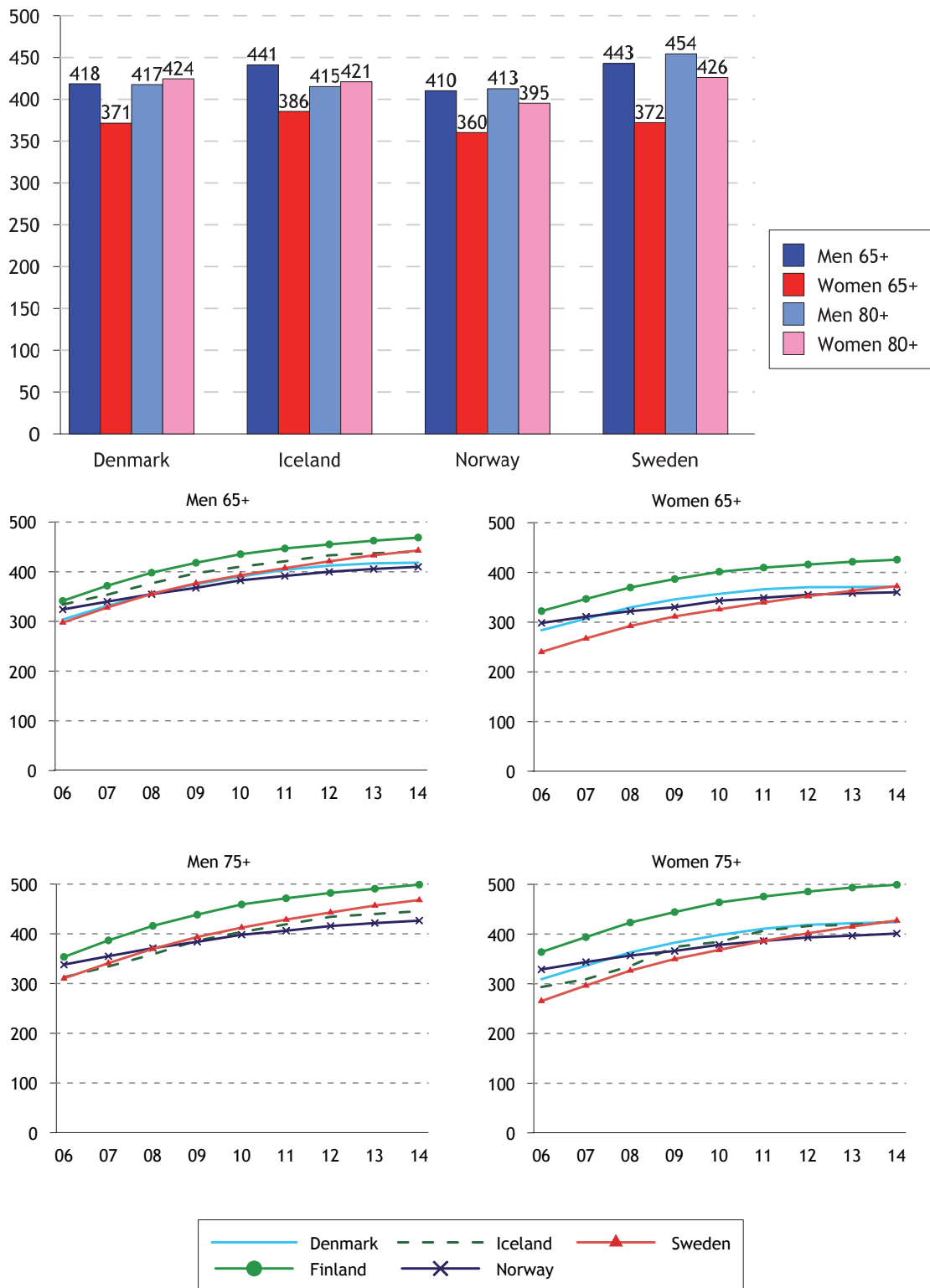
Figure 5.1.8 Prescription of calcium channel blockers, ATC: C08, age-standardised one-year prevalence per 100 000 population, 2014 and time series 2006-2014



Source: The national prescription databases

Agents acting on the renin-angiotensin system

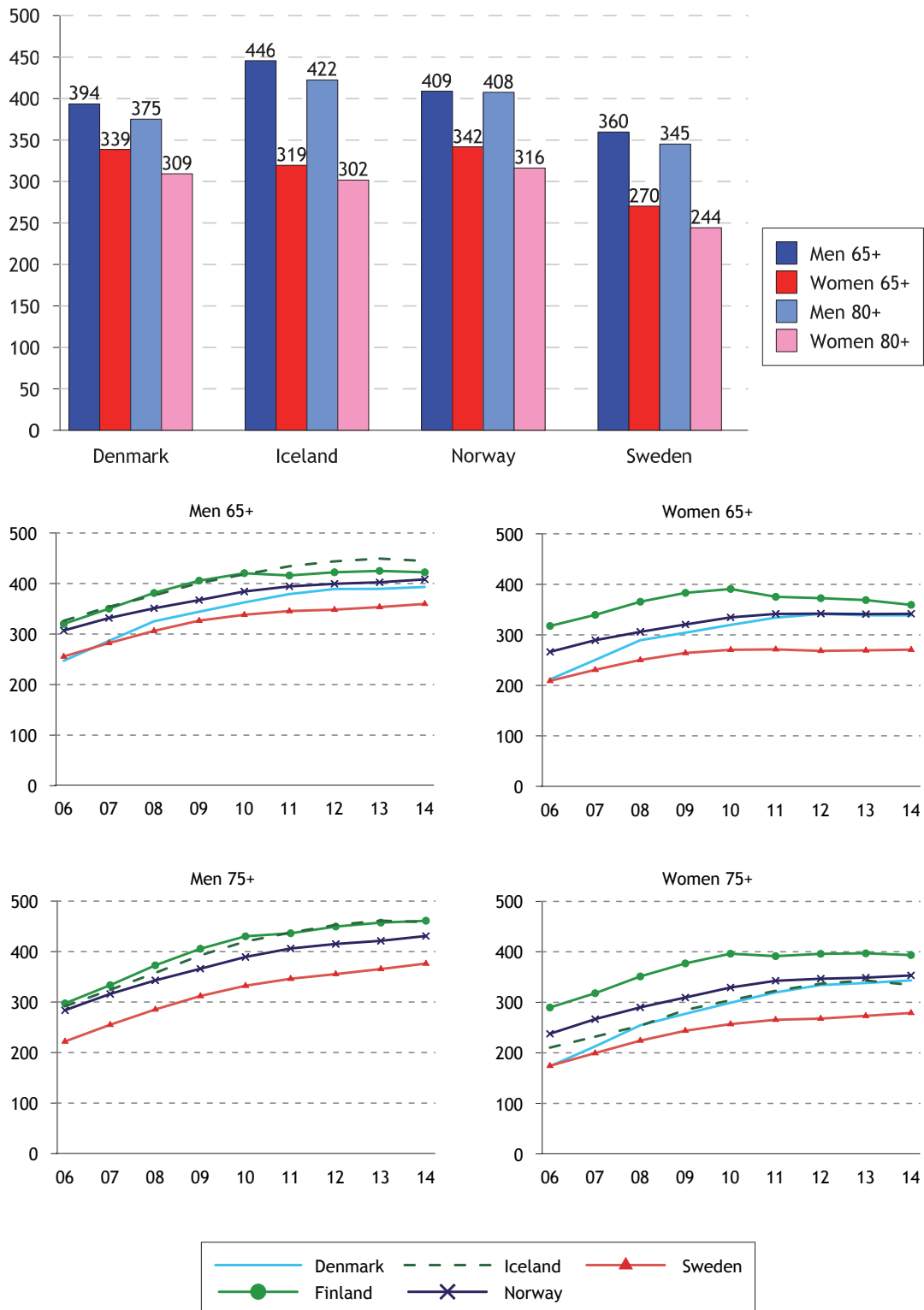
Figure 5.1.9 Prescription of agents acting on the renin-angiotensin system, ATC: C09, age-standardised one-year prevalence per 100 000 population, 2014 and time series 2006-2014



Source: The national prescription databases

Lipid modifying agents

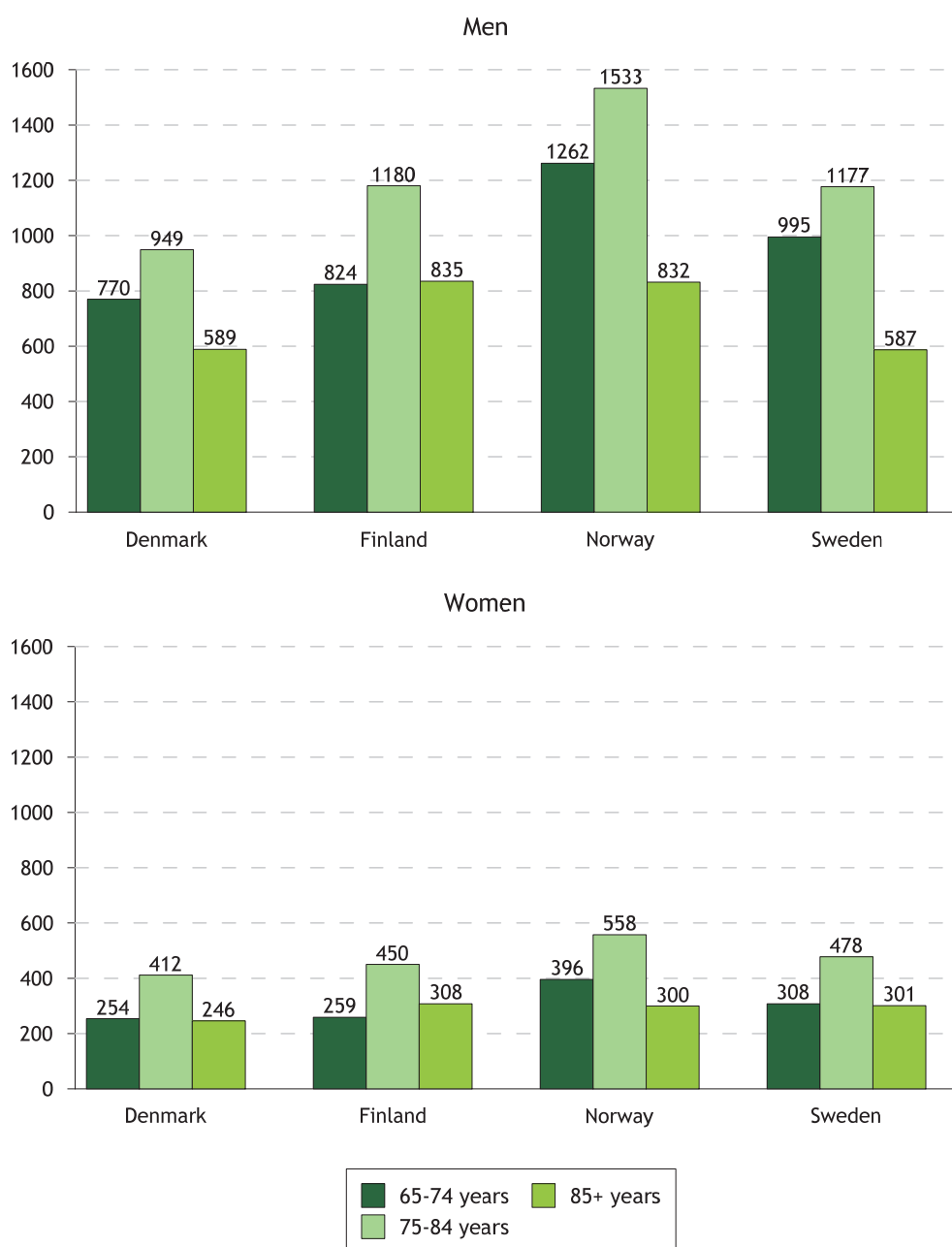
Figure 5.1.10 Prescription of lipid modifying agents, ATC: C10, age-standardised one-year prevalence per 100 000 population, 2014 and time series 2006-2014



Source: The national prescription databases

Surgical measures

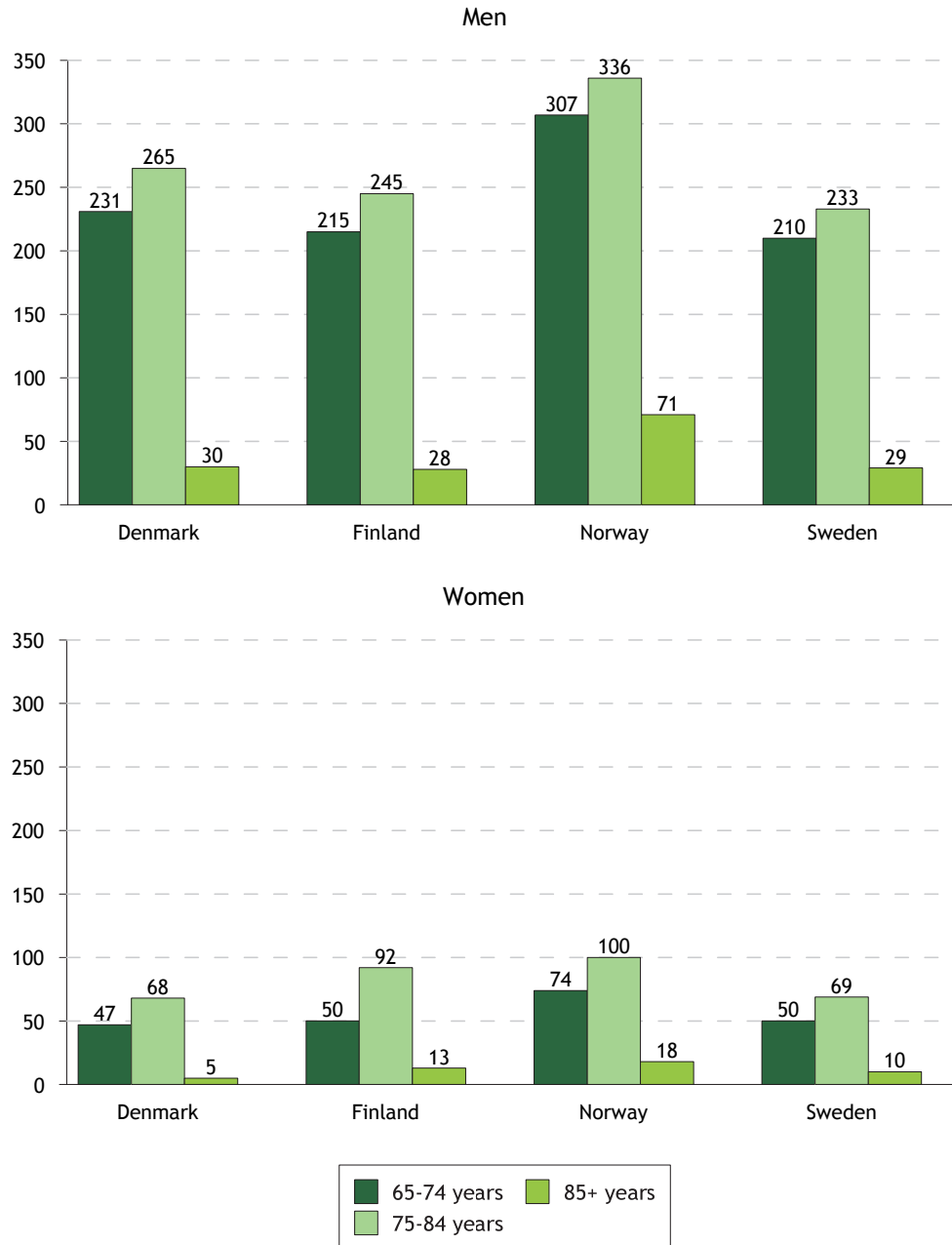
Figure 5.1.11 Transluminal coronary angioplasty (PTCA/PCI)
 NCSP: FNG 02; FNG 05, total numbers of procedures per 100 000
 in the age group, 2013



Source: NOMESCO: Health Statistics in the Nordic Countries 2016

Bypass/CABG

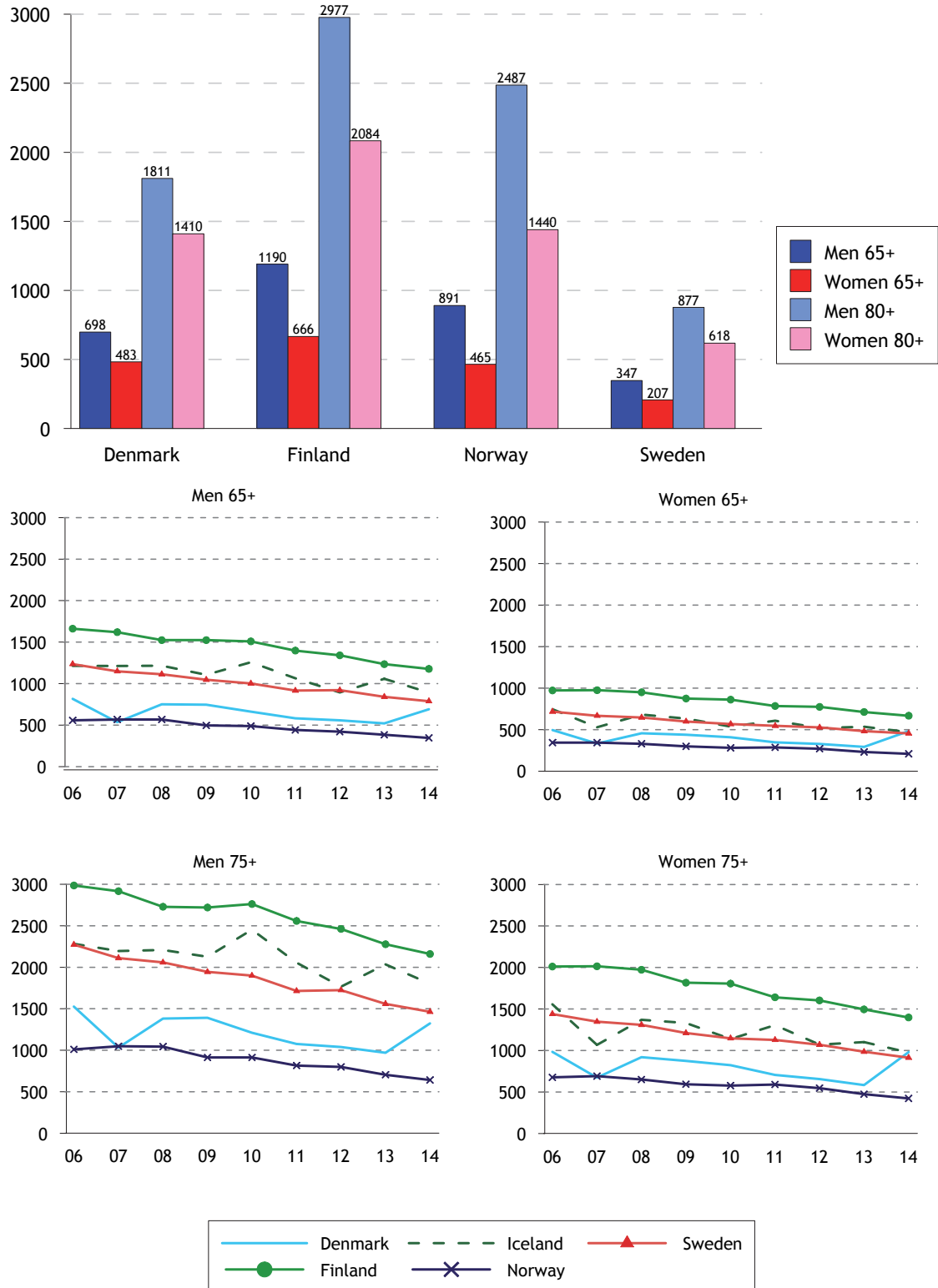
Figure 5.1.12 Coronary artery bypass graft. NCSP: FNC. FND. FNE, total numbers of procedures per 100 000 in the age group, 2013



Source: NOMESCO: Health Statistics in the Nordic Countries 2016

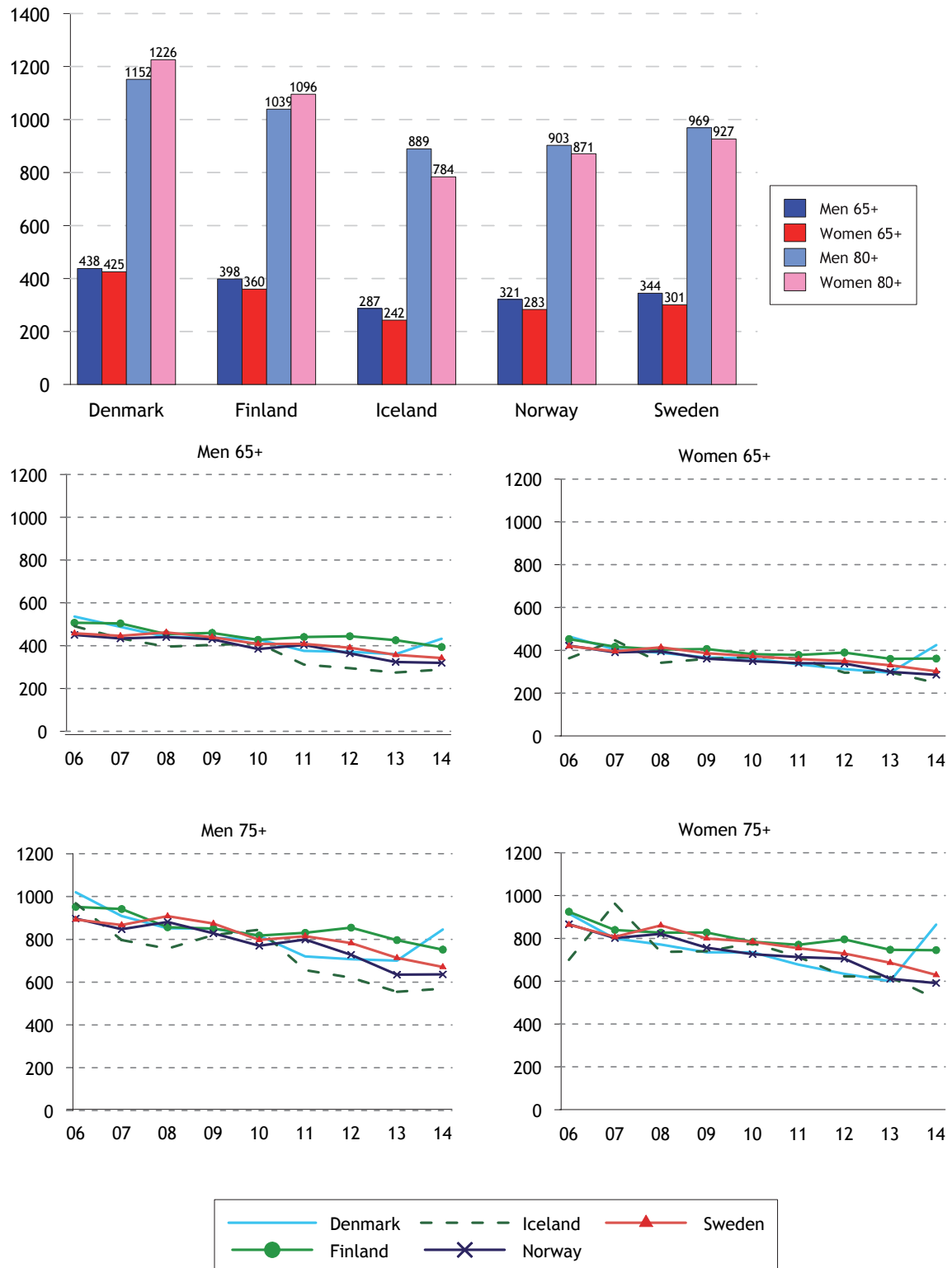
Death

Figure 5.1.13 Deaths from ischaemic heart disease, ICD-10: I20-I25, age-standardised deaths per 100 000 population, 2014 and time series 2006-2014



Source: The national registers for causes of death

Figure 5.1.14 Deaths from stroke, ICD-10: I60-I69, age-standardised deaths per 100 000 population, 2014 and time series 2006-2014



Source: The national registers for causes of death

5.2 Cancer diseases

Cancer is one of our most common diseases and the risk of contracting cancer increases with age. Cancer is more common among older men than older women, mainly because prostate cancer is relatively common among older men. Cancer is the second most common cause of death among old people after cardiovascular diseases, regardless of gender.

As the Nordic population ages, the number of people with a cancer diagnosis has increased. However, if we remove the effect of ageing, the pattern is slightly different. Changes in the total cancer frequency in the most recent tenyear period are small, and have been both positive and negative. Certain cancer types are increasing, such as breast cancer and lung cancer among women, while other types, such as stomach cancer and prostate cancer among men in the oldest age group, 75+, are decreasing.

On a more fundamental level, the number of new cancer cases and mortality in cancer are also affected by various risk factors. Smoking is a clear example that not only affects the risk of developing lung cancer, but also other cancer types. Lung cancer frequency among old people today can be said to reflect smoking habits of the older age group around two decades ago. Ultraviolet radiation from the sun is another significant risk factor in development of, for example, malignant melanoma, which is linked to changes in sunbathing habits, travel patterns, etc. Other risk factors for cancer include eating habits, alcohol consumption and degree of physical activity.

Since mortality in cardiovascular diseases has decreased, cancer has increased in relative importance as a cause of death. However, mortality in cancer has also fallen over time. One reason is that cancer is now often being diagnosed earlier, resulting in better treatment and survival prognosis. Another reason is that treatment methods are improving. (See data on 5-year survival in the section on quality indicators.)

Mortality differs greatly between cancer types. More women over 65 die from lung cancer and colorectal cancer than, for example, breast cancer. Consequently, the prognosis for breast cancer patients is better than for the two somewhat less frequent cancer types. Among men over 65, prostate cancer is the most common cancer type, both in terms of illness and mortality.

The following section describes some of the most common cancer types that affect old people.

Prostate cancer is the most common cancer type in men, and occurs most frequently in ages over 65 (Figure 5.2.2). Prostate cancer develops slowly, and the number of diagnosed cases is therefore dependent on the effectiveness of diagnostic procedures (e.g. screening using PSA test via blood test). The male sex hormone, testosterone, is significant in the development of prostate cancer. Fatness and obesity increase the risk of developing a more aggressive prostate cancer.

Norway and Sweden report most cases per 100 000 older men, both in terms of illness and mortality. Illness has remained at approximately the same level in all Nordic countries in the past decade among men aged 65+, but it has fallen somewhat for the older group (75+). Mortality is decreasing in both groups (Figure 5.2.2). However, the trend in Iceland is not as positive.

Stomach cancer has decreased in recent decades, and continues to decrease, both in terms of new cases and mortality (Figures 5.2.3 and 5.2.9). Better eating habits, with more fruit and vegetables, are thought to reduce the risk of developing stomach cancer. There is also probably an association with the decline in infections caused by the *Helicobacter pylori* bacteria. Stomach cancer is more common among men. The differences between genders is smallest in Finland.

Colorectal cancer is one of the more common cancer types among older people. In 2014 the highest number of cases per 100 000 older people were diagnosed in Norway and the smallest number in Finland. In the past decade, there has been a slight increase in the number of diagnosed cases in the oldest group (75+), while mortality has fallen slightly. Iceland is an exception, and the oldest people in Sweden are more difficult to assess (Figures 5.2.4 and 5.2.10).

Lung cancer (including bronchus and trachea) is one of the cancer diseases with the worst prognosis, and mostly affects men. Tobacco smoking is the clearly dominant cause of lung cancer. In 2014, most lung cancer cases occurred among Danish men and women (Figure 5.2.5). Sweden had the smallest number of cases, and least differences between the genders. The fact that Sweden records the lowest incidence figures may be an effect of the Swedish cancer register not following up cancer cases in the Cause of Death Register to find any cancer cases that were not reported to the registry, unlike the other cancer registers in the Nordic region. Among men, illness has not changed significantly in the past ten years, while an increasing proportion of women have developed lung cancer in the same period.

Incidence of lung cancer has fallen in the Nordic region, except in Iceland. Figure 5.2.5 show the incidence, and Figure 5.2.11 show mortality in lung cancer.

Breast cancer is the most common type of cancer among women, and the incidence is highest in Finland and Sweden (Figure 5.2.13). The incidence in the Nordic region has increased in the past ten years (Figure 5.2.6), but the trend for mortality is not as clear. Except for Iceland, mortality has decreased somewhat, particularly in Denmark. For the 75+ age group, the trend is not as clear (Figure 5.2.12). However, an increasing number of women are now surviving breast cancer. Mortality is highest in Denmark and Iceland, and lowest in Finland.

The number of new cases of breast cancer, and mortality, is affected by screening. The Nordic countries have had screening for breast cancer to varying extents and for different lengths of time, which affects both illness and mortality.

Some forms of breast cancer are hereditary, and the risk of contracting breast cancer increases if the family history includes the disease. There is an association between breast cancer and obesity, where the fat protects the woman before the menopause but increases the risk of contracting the disease after the menopause. Giving birth to many children, and at a young age, has a protective effect. In view of the low birth rate today in many of the Nordic countries, together with the increasing age of mothers having their first children, it is possible that breast cancer will continue to increase.

Cancer of the uterus and ovary is an unusual type of cancer that occurs before the menopause, and mainly affects older women. Women who have not had children, women who started to menstruate early, and women entering the menopause late are at increased risk. Heredity is also important in the risk of developing this type of

cancer. Obesity and fatness are other known risk factors. The prognosis for cancer of the uterus and ovary is relatively good. The mortality pattern is similar in the Nordic region, but Figure 5.2.53 shows that mortality is highest in Denmark and lowest in Iceland.

Statistics - Cancer diseases

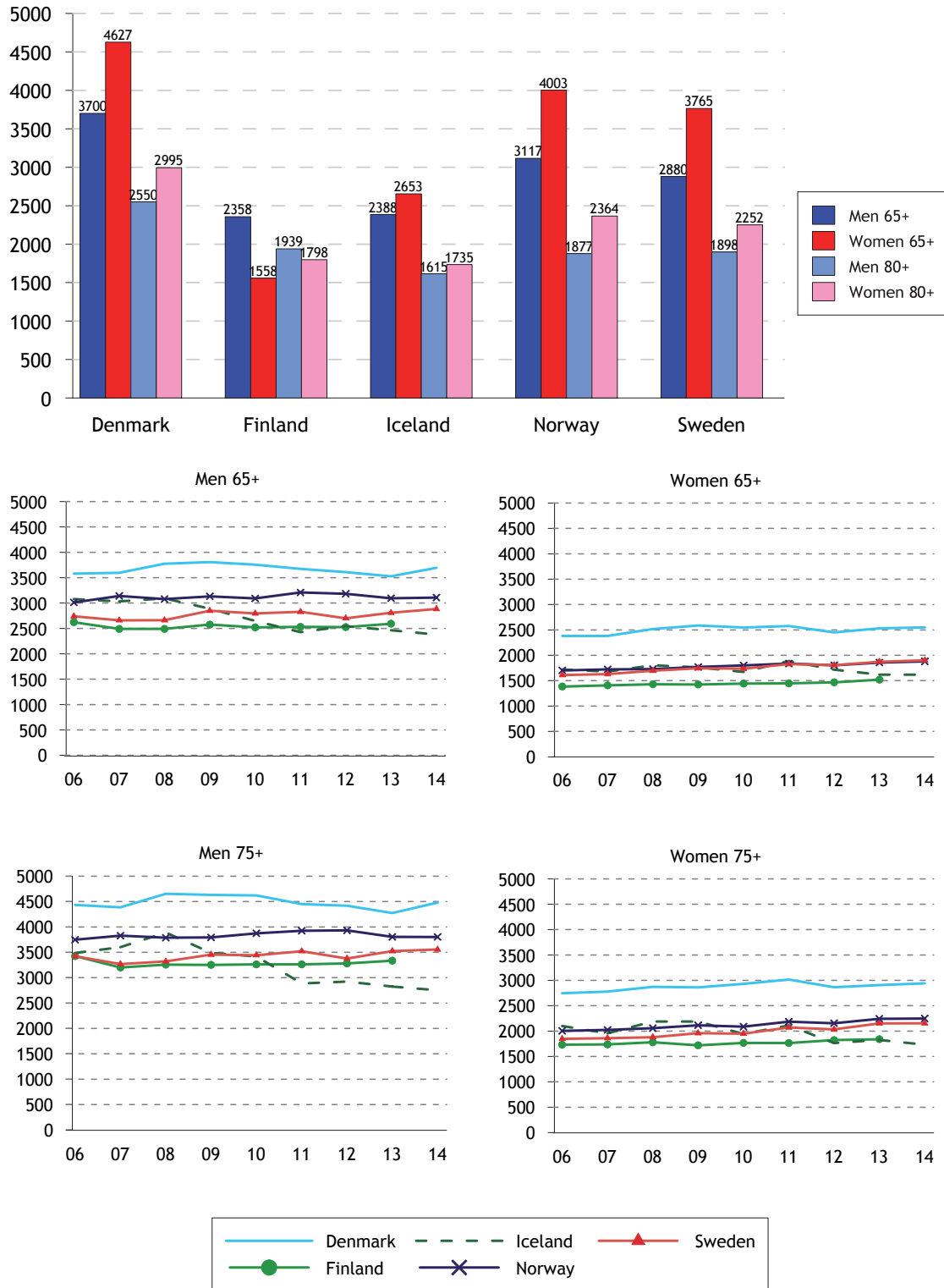
The figures show information for 2014 divided into gender and the 65+ and 80+ age groups. For the period 2006-2014, information is reported for the 65+ and 75+ age groups. Statistics are shown for the following forms of cancer:

New cases and mortality for

- Cancer all sites
- Prostate
- Stomach
- Colon and rectum
- Lung, bronchus and trachea
- Breast
- Uterus and ovary

New cancer cases

Figure 5.2.1 New cases of cancer¹, all sites, age-standardised cases per 100 000 population, 2014 and time series 2006-2014

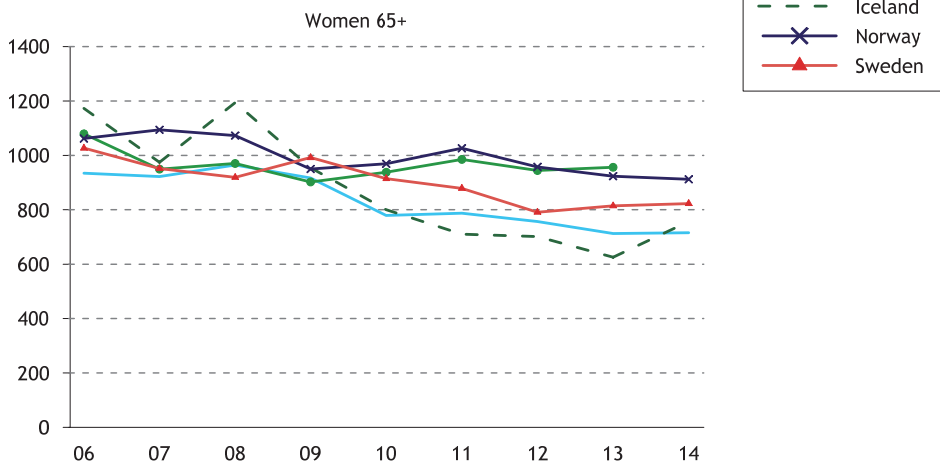
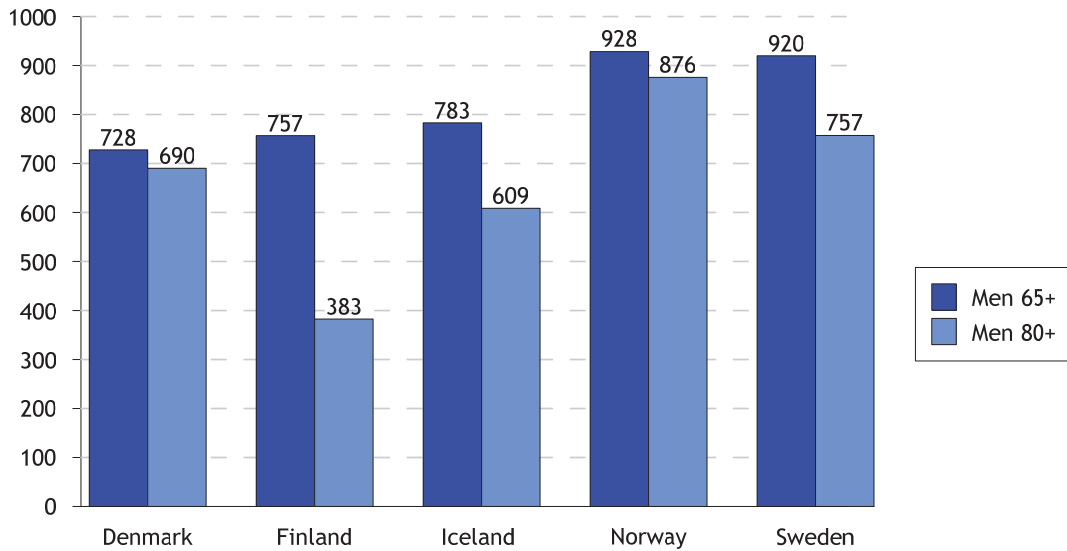


1 ICD-10: C00-C97

Source: The cancer registers in the Nordic countries

Prostate cancer

Figure 5.2.2 New cases of prostate cancer¹, age-standardised cases per 100 000 population, 2014 and time series 2006-2014

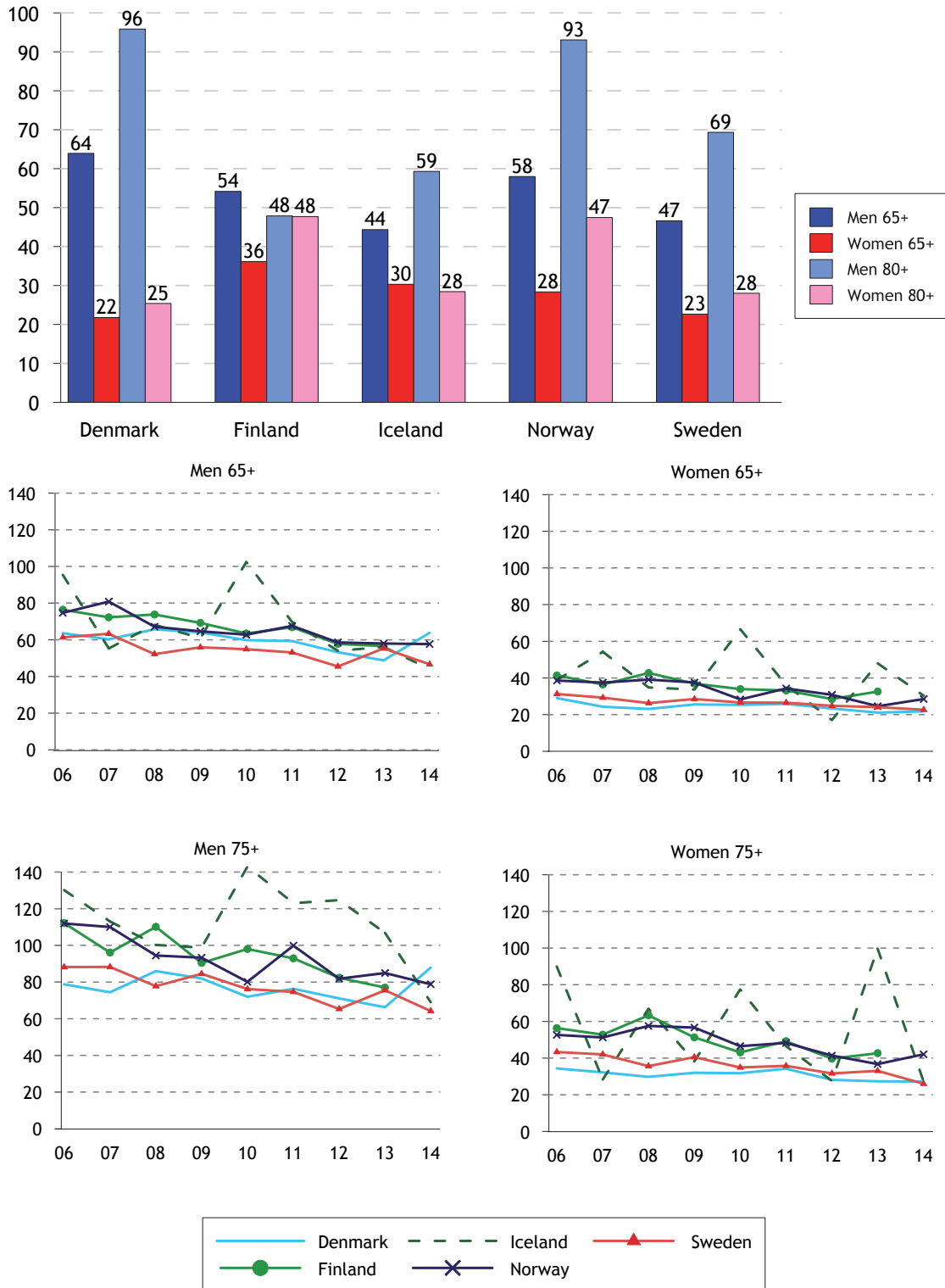


1 ICD-10: C61

Source: The cancer registers in the Nordic countries

Stomach cancer

Figure 5.2.3 New cases of stomach cancer¹, age-standardised cases per 100 000 population, 2014 and time series 2006-2014

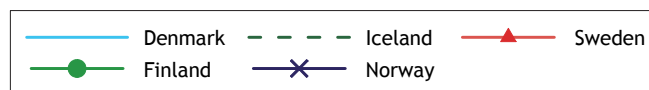
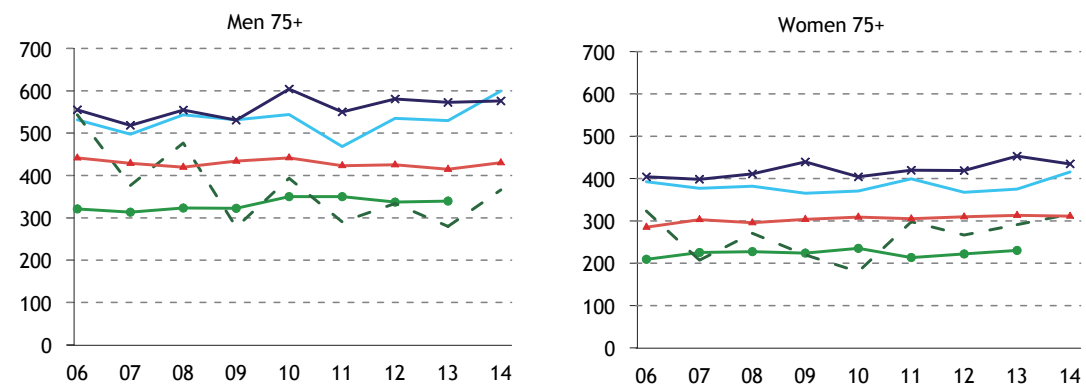
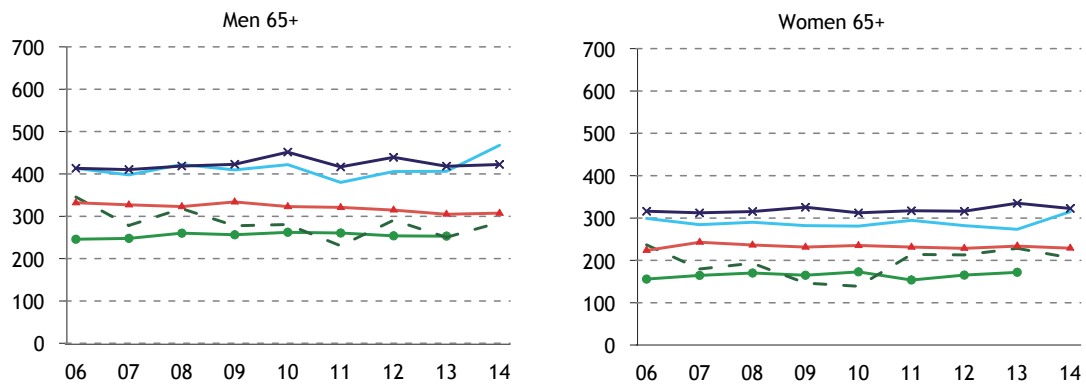
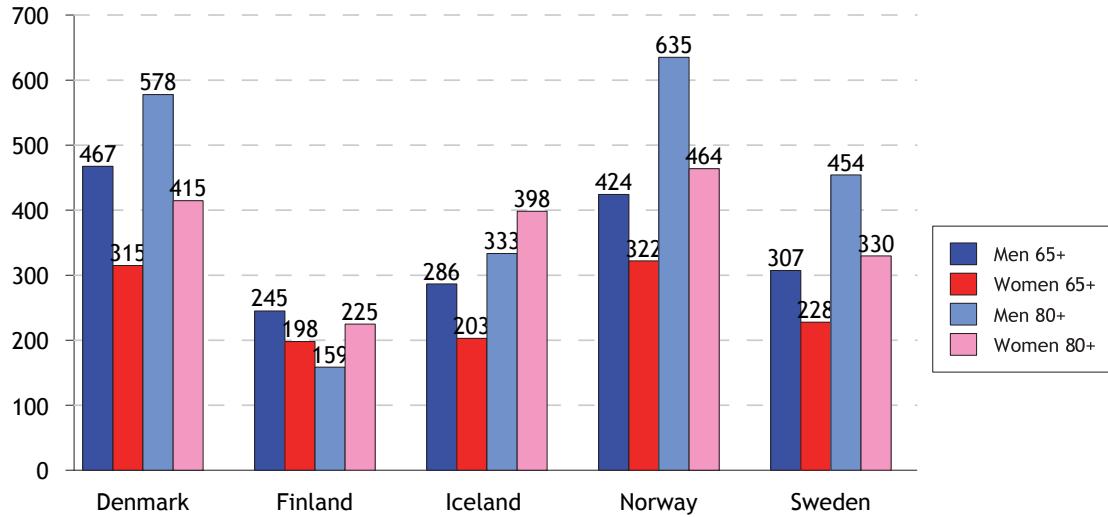


1 ICD-10: C16

Source: The cancer registers in the Nordic countries

Colorectal cancer

Figure 5.2.4 New cases of colorectal cancer¹, age-standardised cases per 100 000 population, 2014 and time series 2006-2014

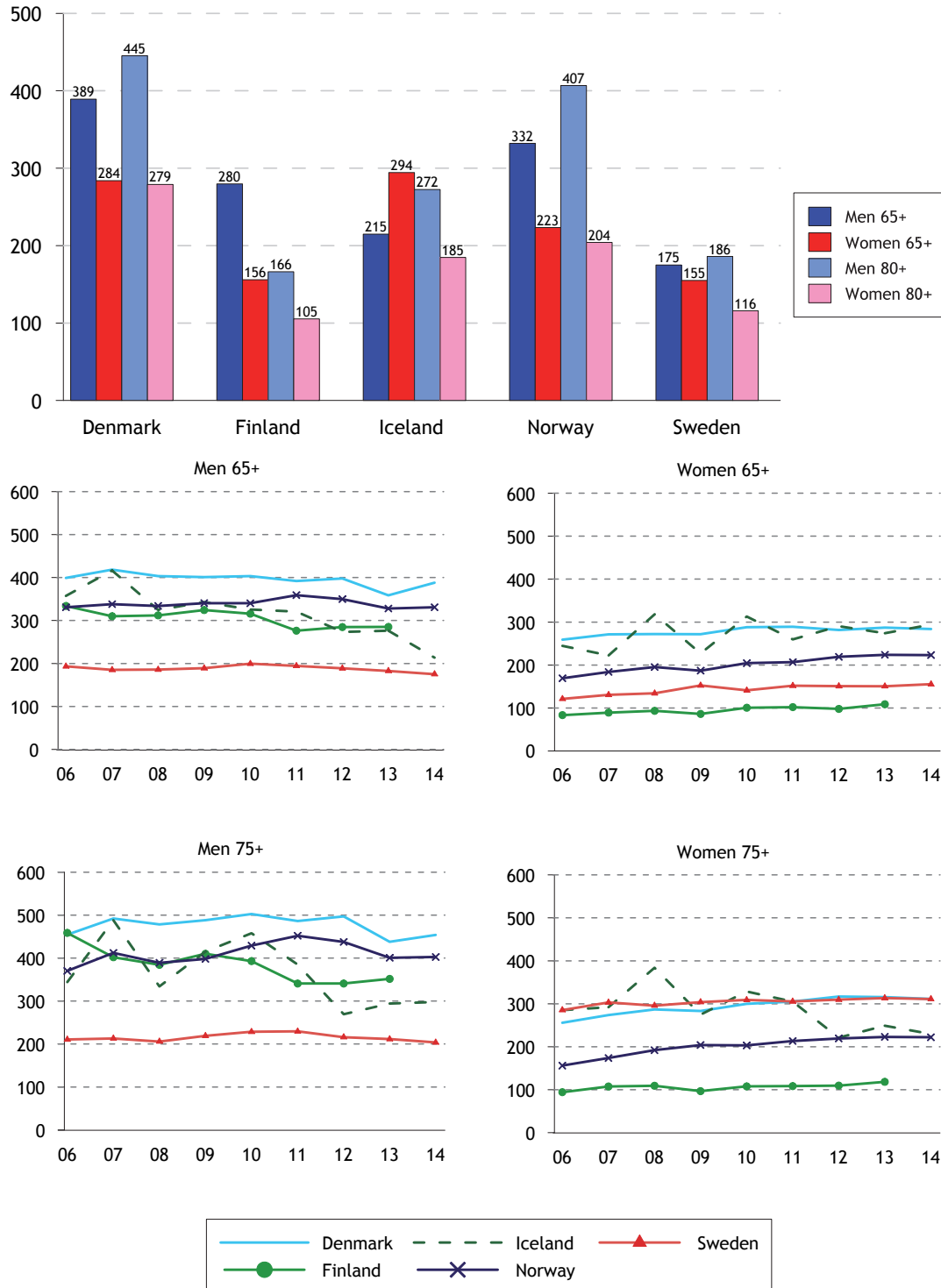


1 ICD-10: C18-C21

Source: The cancer registers in the Nordic countries

Cancer of the lung, bronchus and trachea

Figure 5.2.5 New cases of cancer¹ of the lung, bronchus and trachea, age-standardised cases per 100 000 population, 2014 and time series 2006-2014

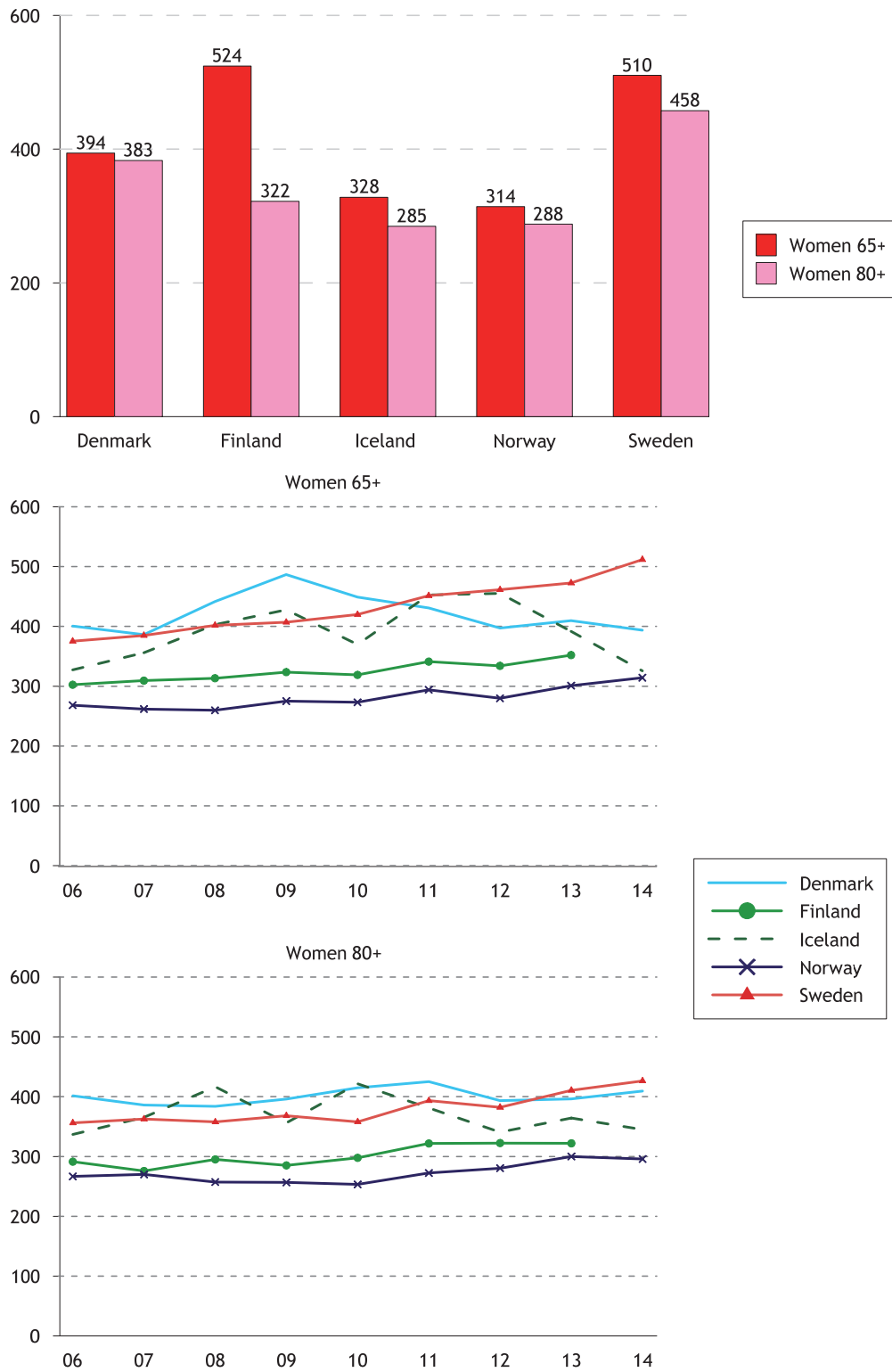


1 ICD-10: C33-C34

Source: The cancer registers in the Nordic countries

Breast cancer

Figure 5.2.6 New cases of breast cancer¹, age-standardised cases per 100 000 population, 2014 and time series 2006-2014

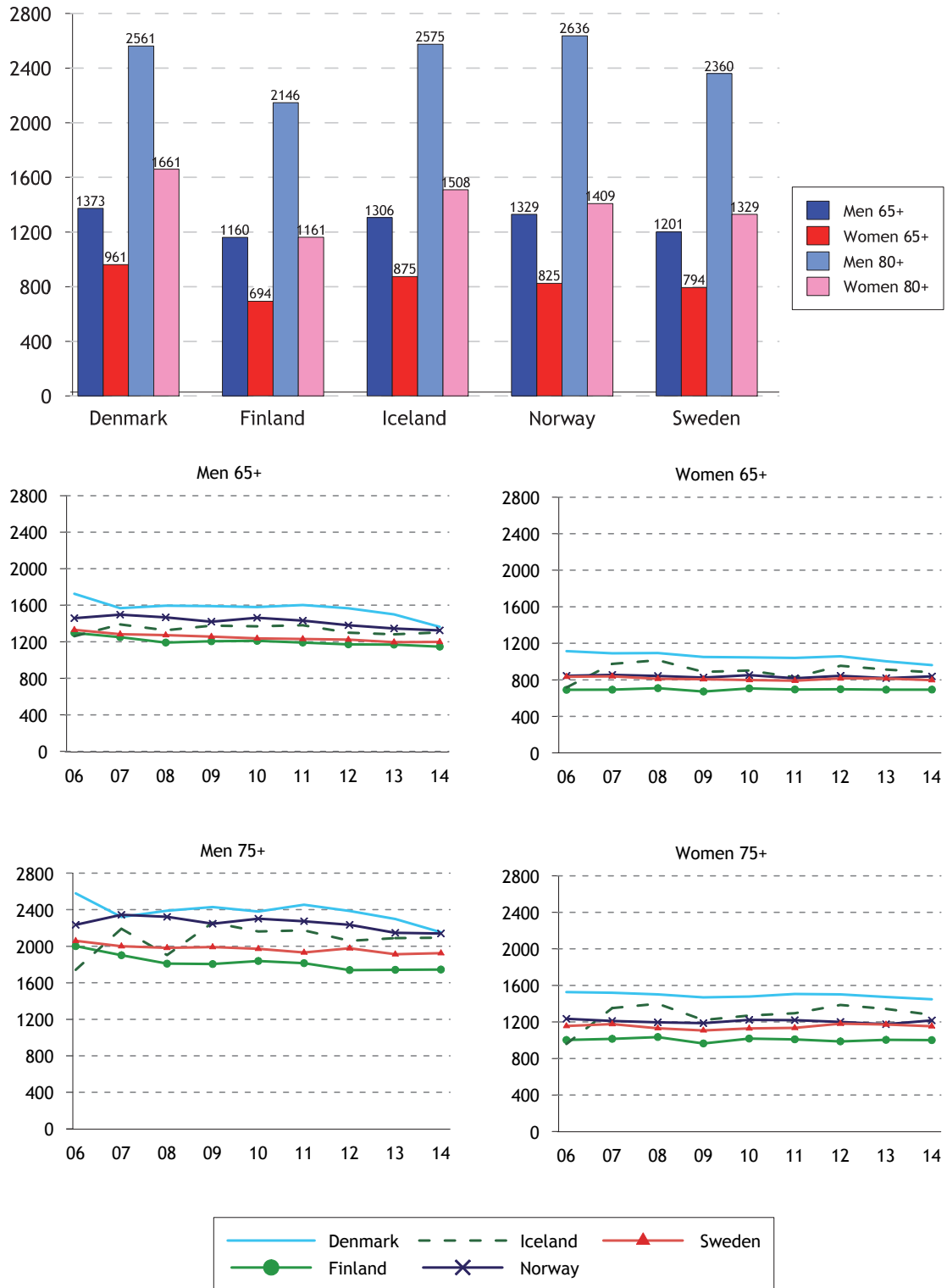


1 ICD-10: C50

Source: The cancer registers in the Nordic countries

Mortality in cancer

Figure 5.2.7 Deaths from all cases of cancer¹, age-standardised cases per 100 000 population, 2014 and time series 2006-2014

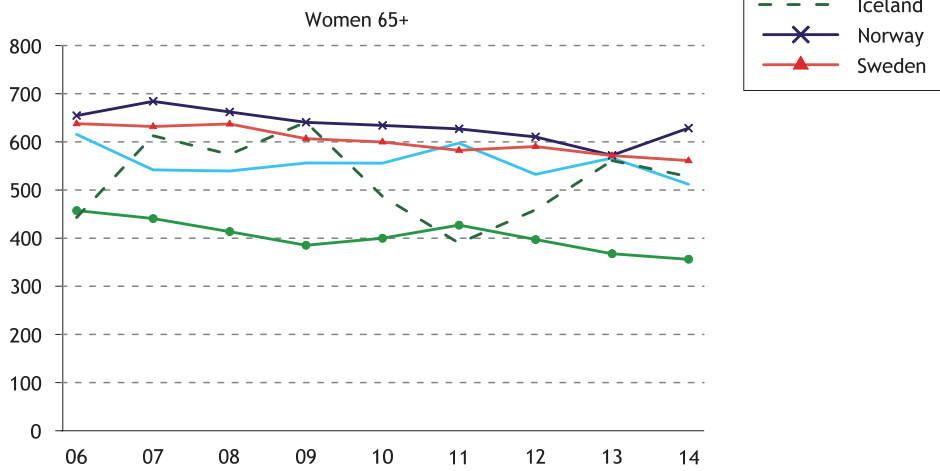
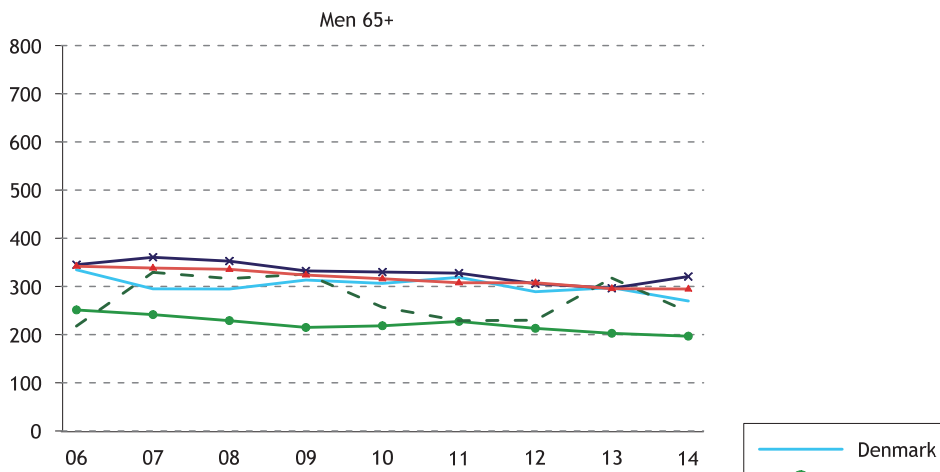
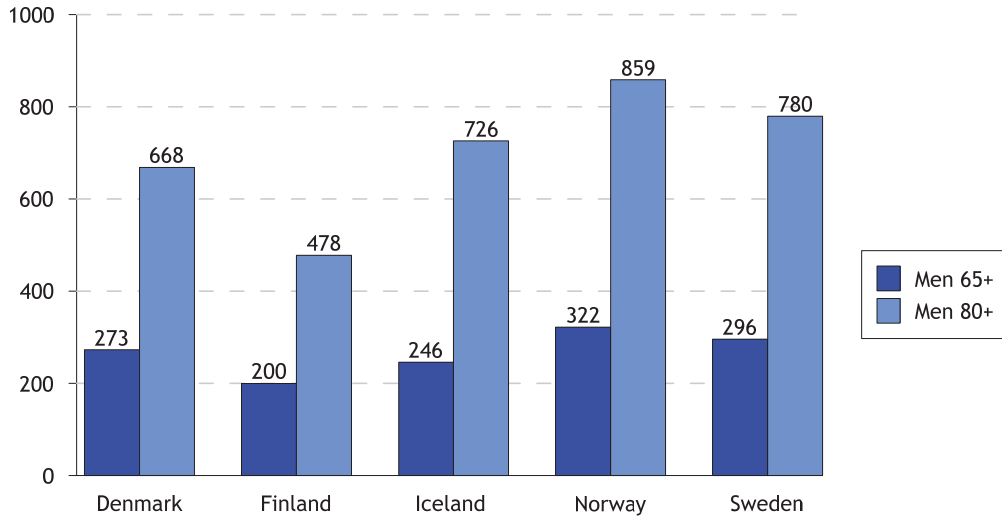


1 ICD-10: C00-C97

Source: The cancer registers in the Nordic countries

Prostate cancer

Figure 5.2.8 Deaths from prostate cancer¹, age-standardised cases per 100 000 population, 2014 and time series 2006-2014

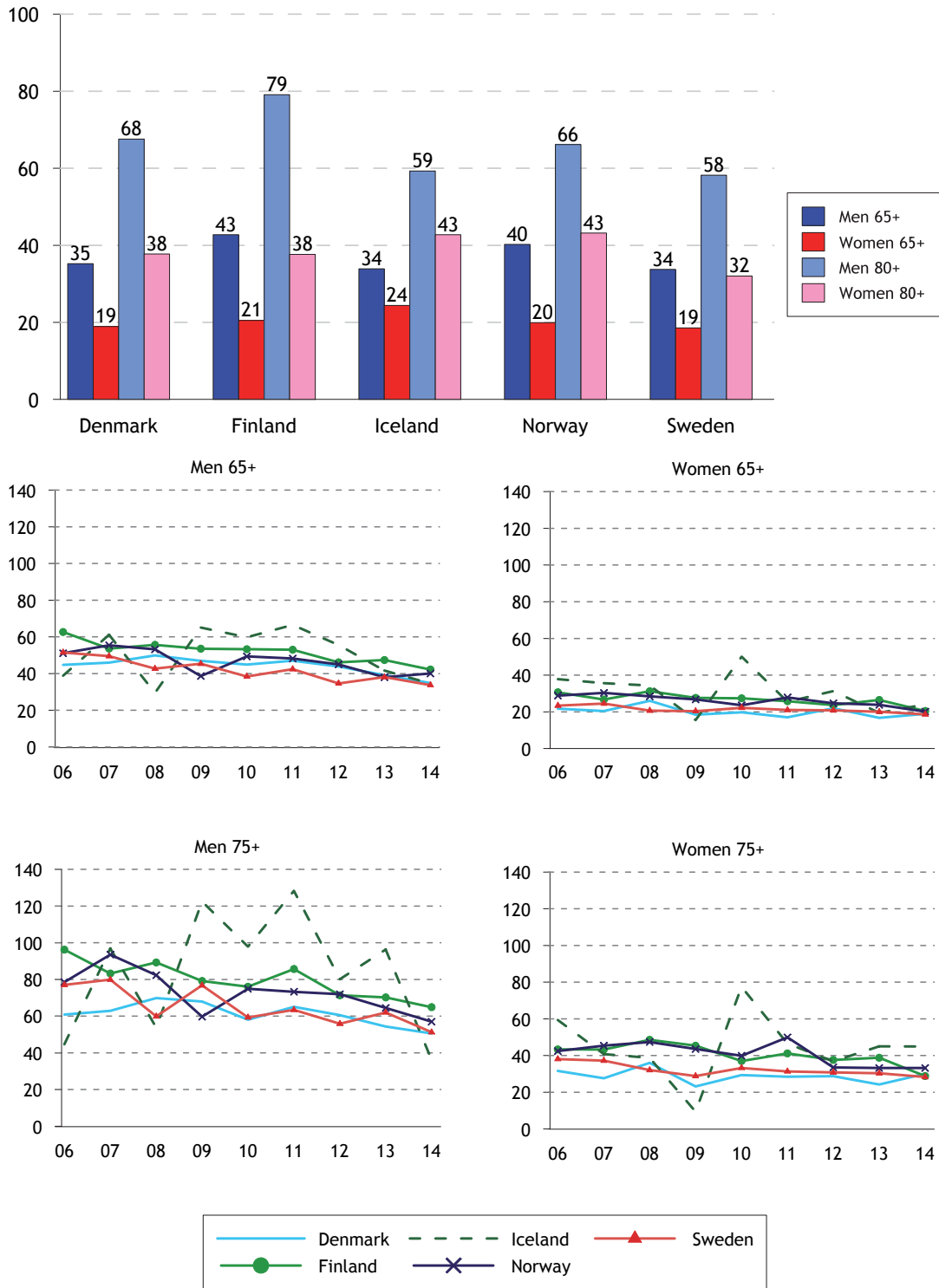


1 ICD-10: C61

Source: The cancer registers in the Nordic countries

Stomach cancer

Figure 5.2.9 Deaths from stomach cancer¹, age-standardised cases per 100 000 population, 2014 and time series 2006-2014

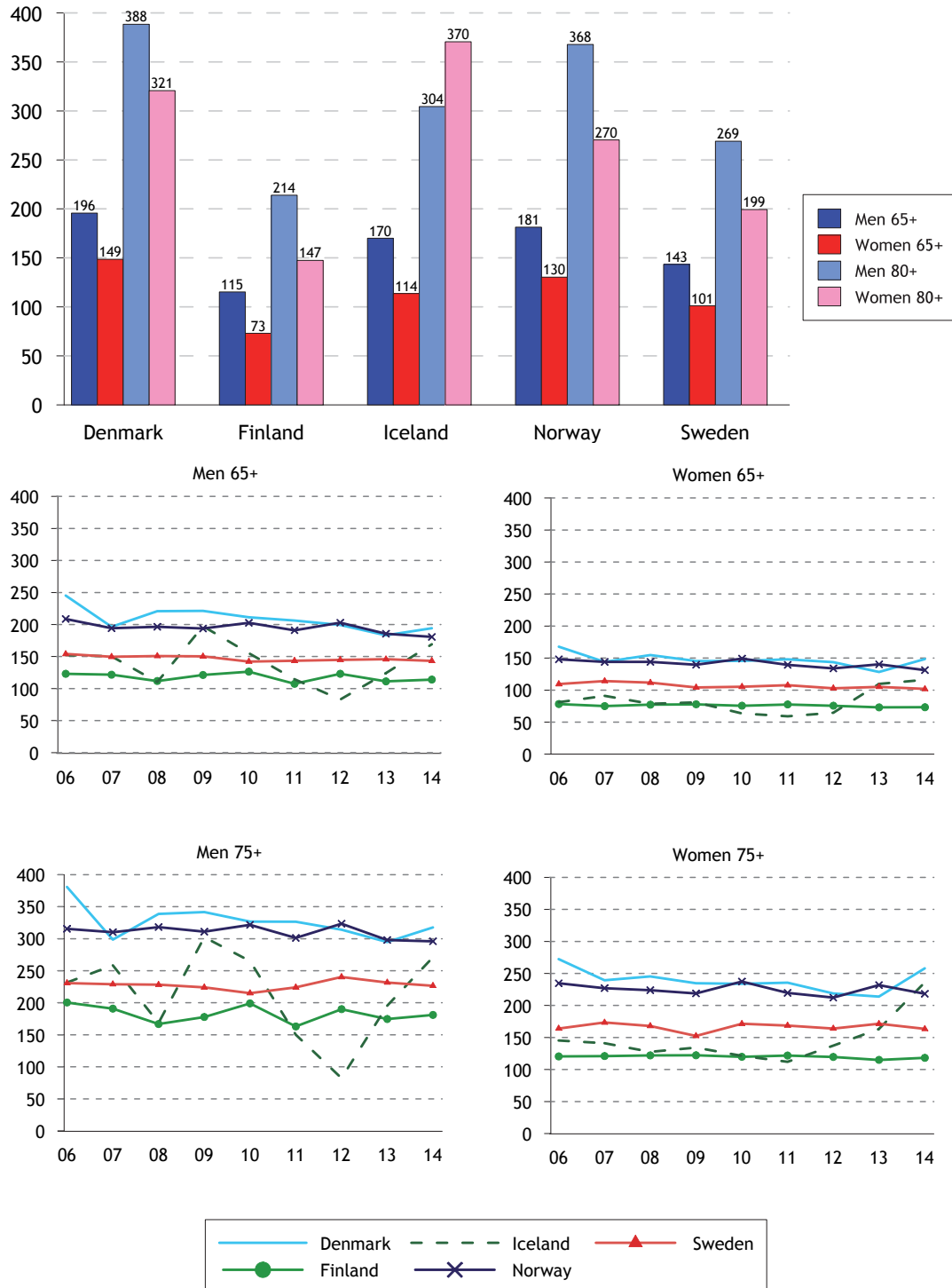


1 ICD-10: C16

Source: The cancer registers in the Nordic countries

Colorectal cancer

Figure 5.2.10 Deaths from colorectal cancer¹, age-standardised cases per 100 000 population, 2014 and time series 2006-2014

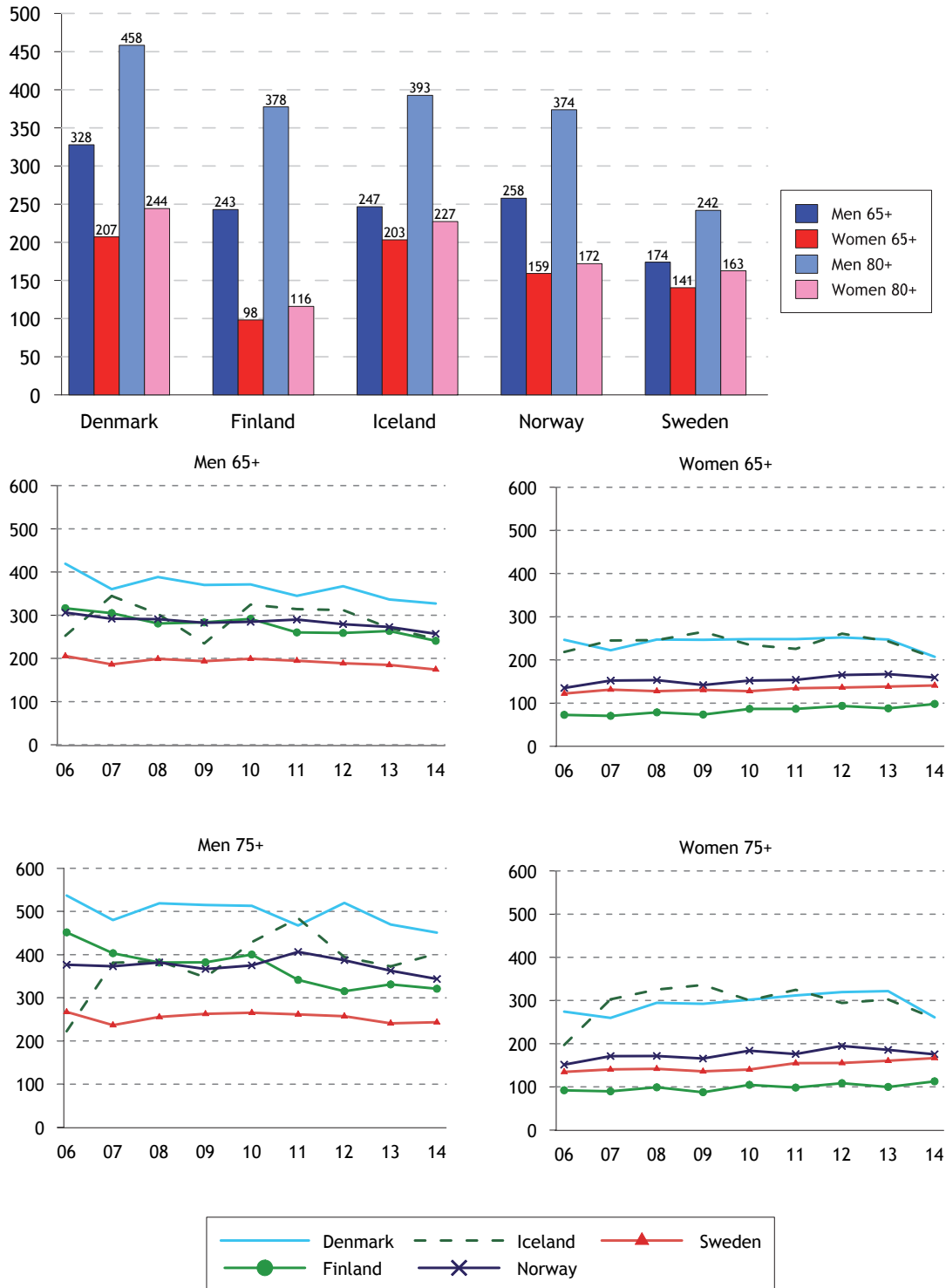


1 ICD-10: C18-C21

Source: The cancer registers in the Nordic countries

Cancer of the lung, bronchus and trachea

Figure 5.2.11 Deaths from cancer¹ of the lung, bronchus and trachea, age-standardised cases per 100 000 population, 2014 and time series 2006-2014

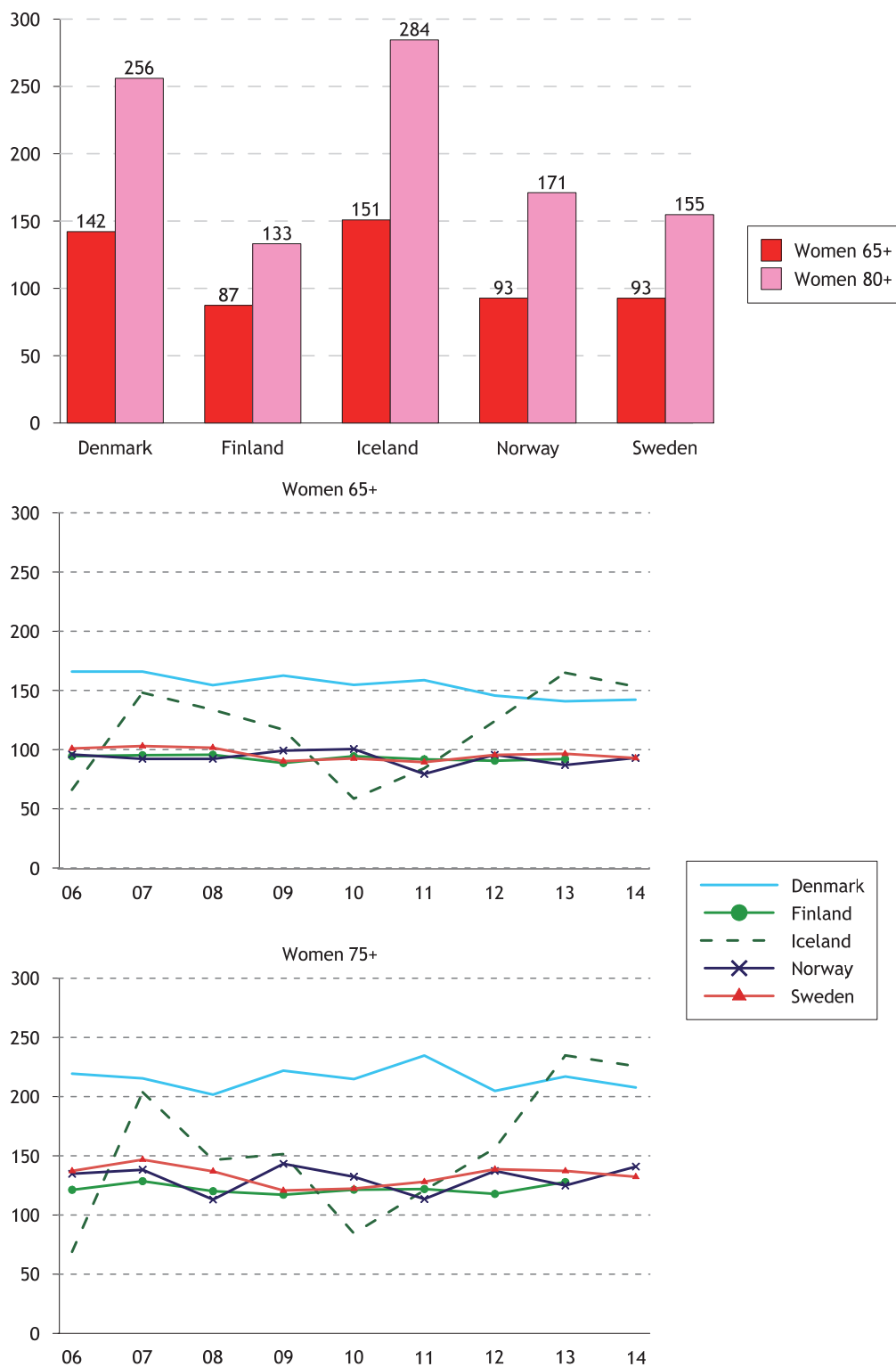


1 ICD-10: C33-C34

Source: The cancer registers in the Nordic countries

Breast cancer

Figure 5.2.12 Deaths from breast cancer¹, age-standardised cases per 100 000 population, 2014 and time series 2006-2014

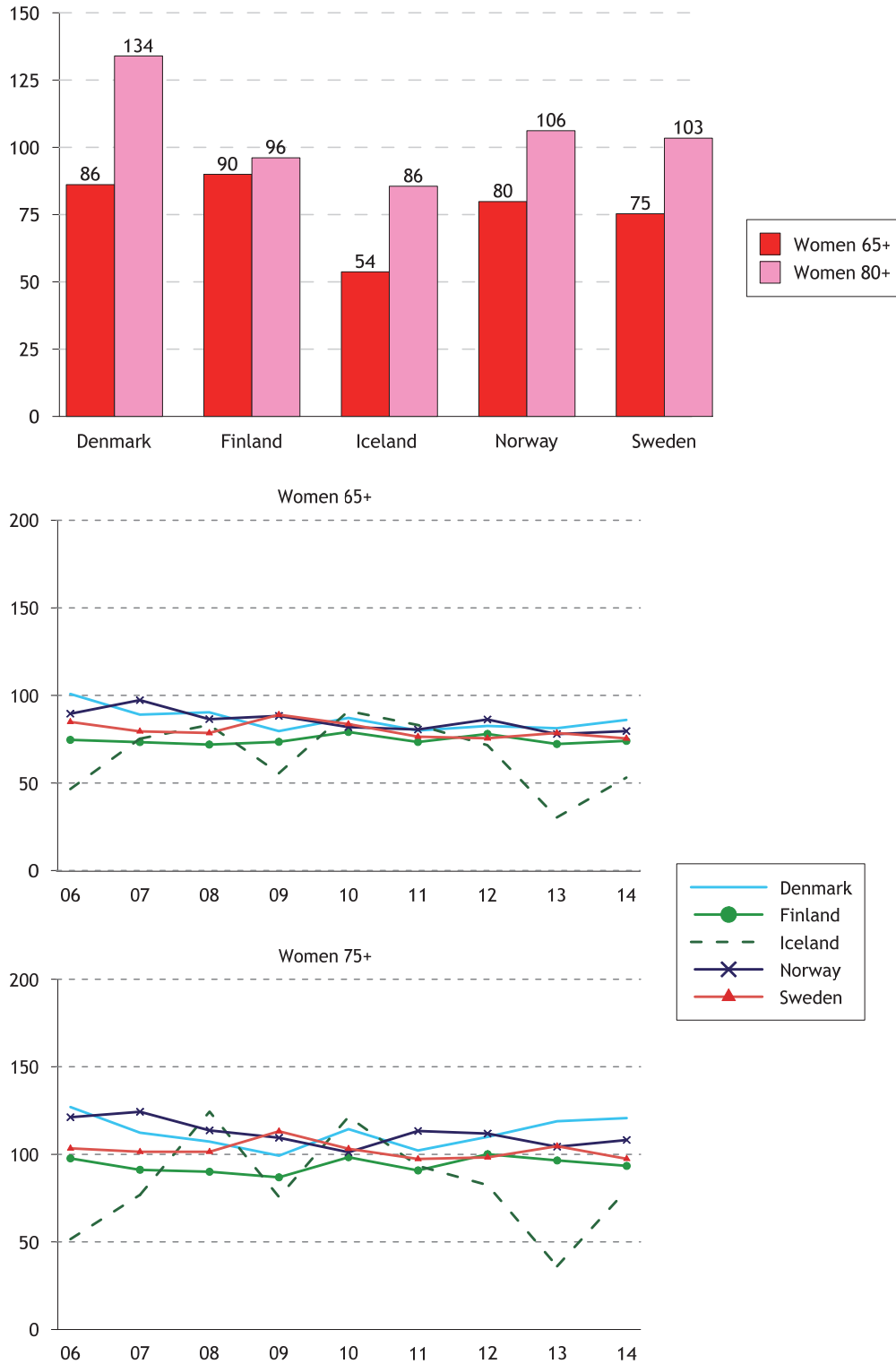


1 ICD-10: C50

Source: The cancer registers in the Nordic countries

Cancer of the uterus and ovary

Figure 5.2.13 Deaths from cancer¹ of the uterus and ovary, age-standardised cases per 100 000 population, 2014 and time series 2006-2014



ICD-10: C53-C56

Source: The cancer registers in the Nordic countries

5.3 Diseases of the digestive system and the urinary system

Problems associated with eating and digestion is common among old people, but it is less common that these disorders are treated in hospital. Information from the Nordic patient registers presented in Figure 5.3.1 therefore does not reflect differences in the occurrence of the disease as much as differences in health care structure and admissions policy.

Norway and Denmark report the largest number of stomach ulcer patients. However, the number has fallen in recent years, in line with the rest of the Nordic region (Figure 5.3.1).

Consumption of drugs for stomach ulcers and reflux diseases has generally increased, and is highest in Iceland (Figure 5.3.1). Consumption increases with age, and is more common among women than men. Norway and Denmark show lowest consumption of drugs.

Inguinal hernia is a much more common cause of admission to hospital among men than women. Most people are treated in hospital in Norway and fewest in Iceland (Figure 5.3.1).

The number of patients treated for cholelithiasis disorders increases with age, and the treatment pattern does not differ significantly between the countries (Figure 5.3.1). Norway has most people under treatment, while Finland has the highest number of patients who have undergone surgery (Figure 5.3.2). In Finland, more women than men undergo surgery, unlike the rest of the Nordic region.

For renal failure, all countries except Norway show similar admission patterns. Norway reports more patients treated in hospital and, unlike other countries, the number of admissions is increasing (Figure 5.3.2). Norway also shows the highest frequency of transplants, but does not differ from the other countries in terms of mortality from diseases in the kidneys and the urinary tract (Figure 5.3.2). Generally, men are more often treated for these diseases, undergo more transplants, and have higher mortality.

Statistics - Diseases of the digestive system and the urinary system

The figures show information for 2014 divided into gender and the 65+ and 80+ age groups. For the period 2006-2014, information is reported for the 65+ and 75+ age groups. The statistics show:

Patients discharged from hospital

- Gastric ulcer
- Inguinal hernia
- Cholelithiasis
- Renal failure

Drugs for peptic ulcer and gastro-oesophageal reflux

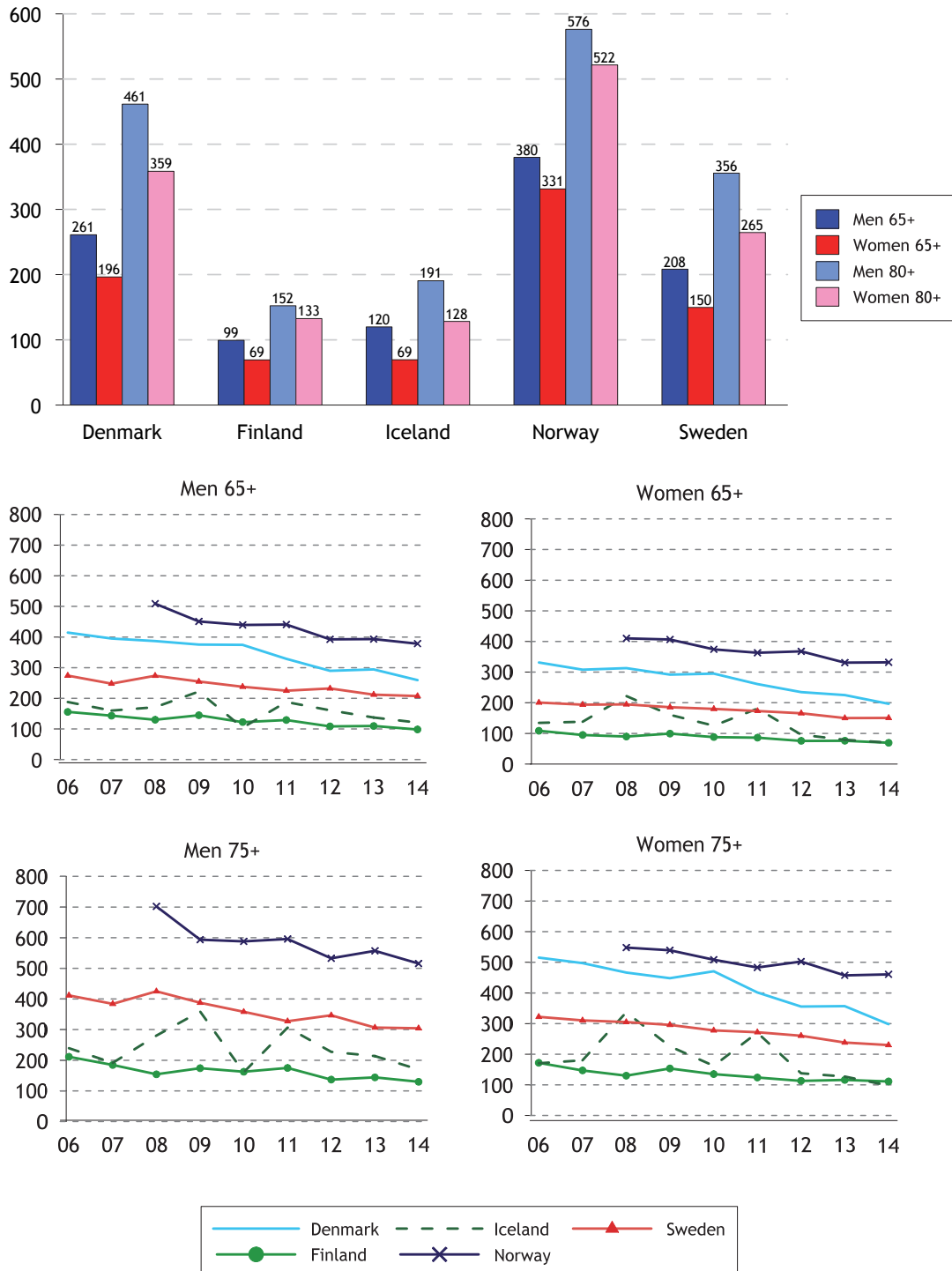
Surgical treatment

- Cholecystectomy
- Transplantation of kidney

Deaths caused by kidney and ureter disorders

Patients discharged from hospital

Figure 5.3.1 Patients treated for gastric ulcer, ICD-10: K25-K28, age-standardised number of patients per 100 000 population, 2014 and time series 2006-2014¹

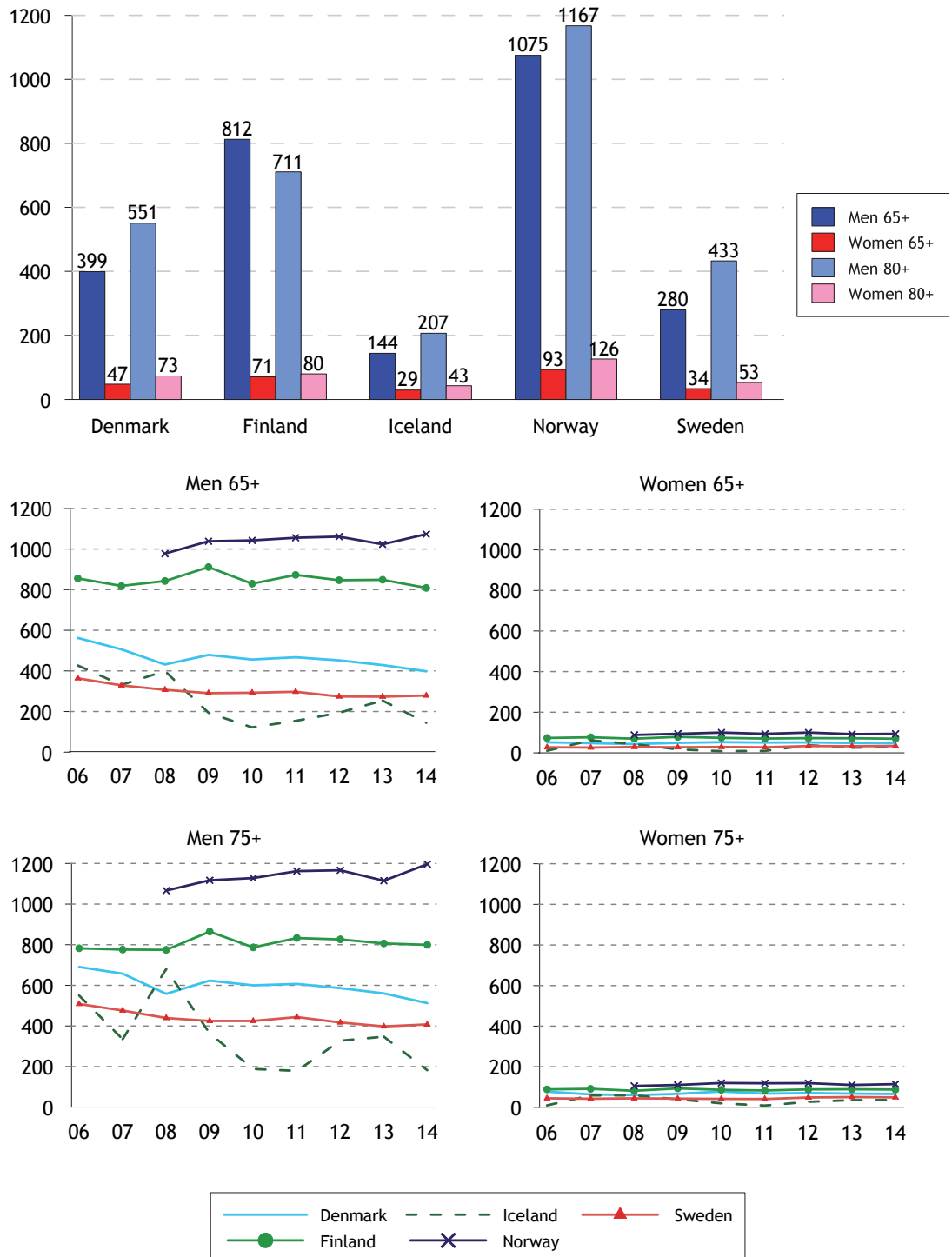


1 Data from the Norwegian Patient Register also includes patients who have been treated in open care, which means that these are not comparable with data from the other Nordic Countries

Source: The national inpatient registers

Inguinal hernia

Figure 5.3.2 Patients treated for inguinal hernia, ICD-10: K40, age-standardised number of patients per 100 000 population, 2014 and time series 2006-2014¹

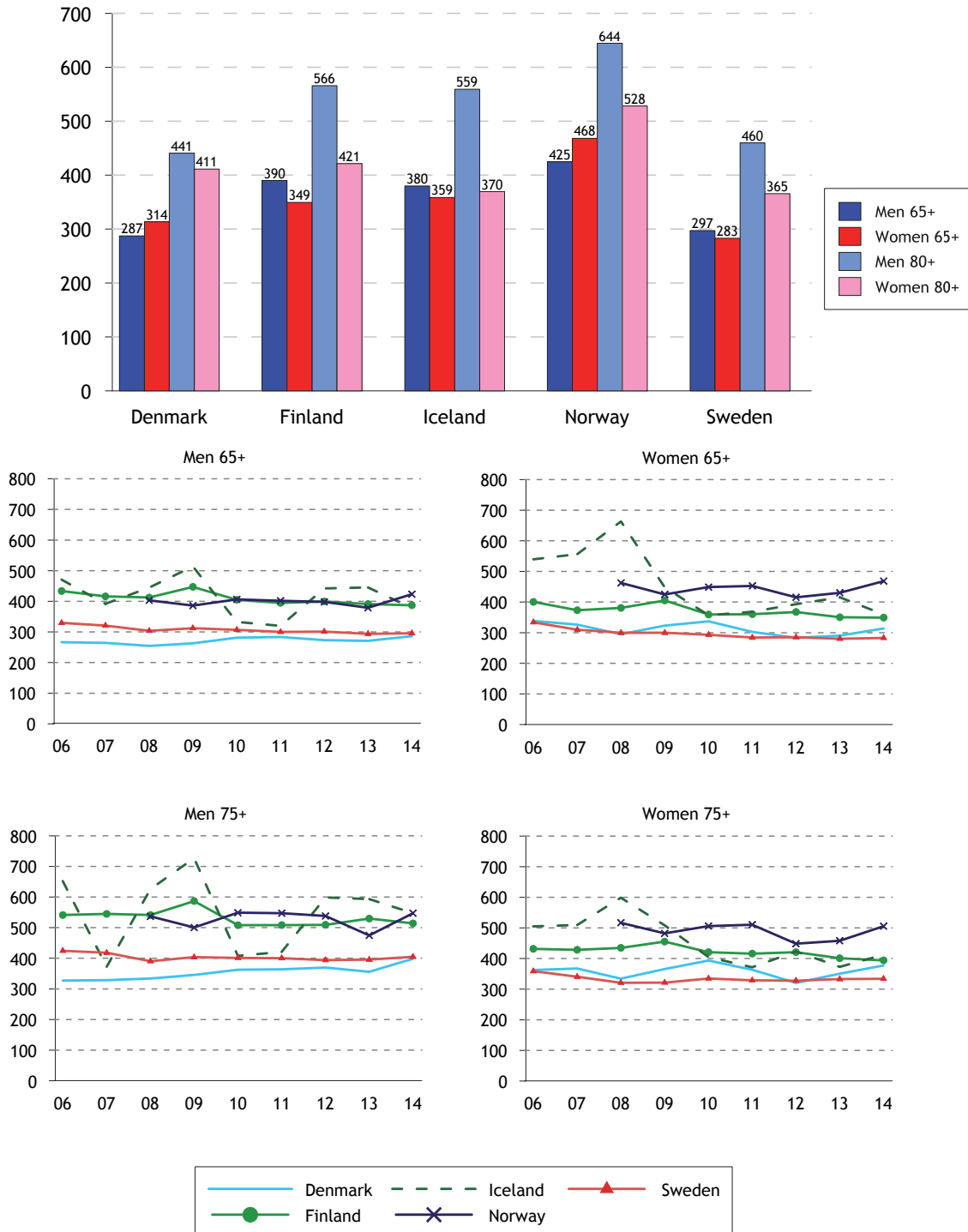


1 Data from the Norwegian Patient Register also includes patients who have been treated in open care, which means that these are not comparable with data from the other Nordic Countries

Source: The national inpatient registers

Cholelithiasis

Figure 5.3.3 Patients treated for cholelithiasis, ICD-10: K80, age-standardised number of patients per 100 000 population, 2014 and time series 2006-2014¹

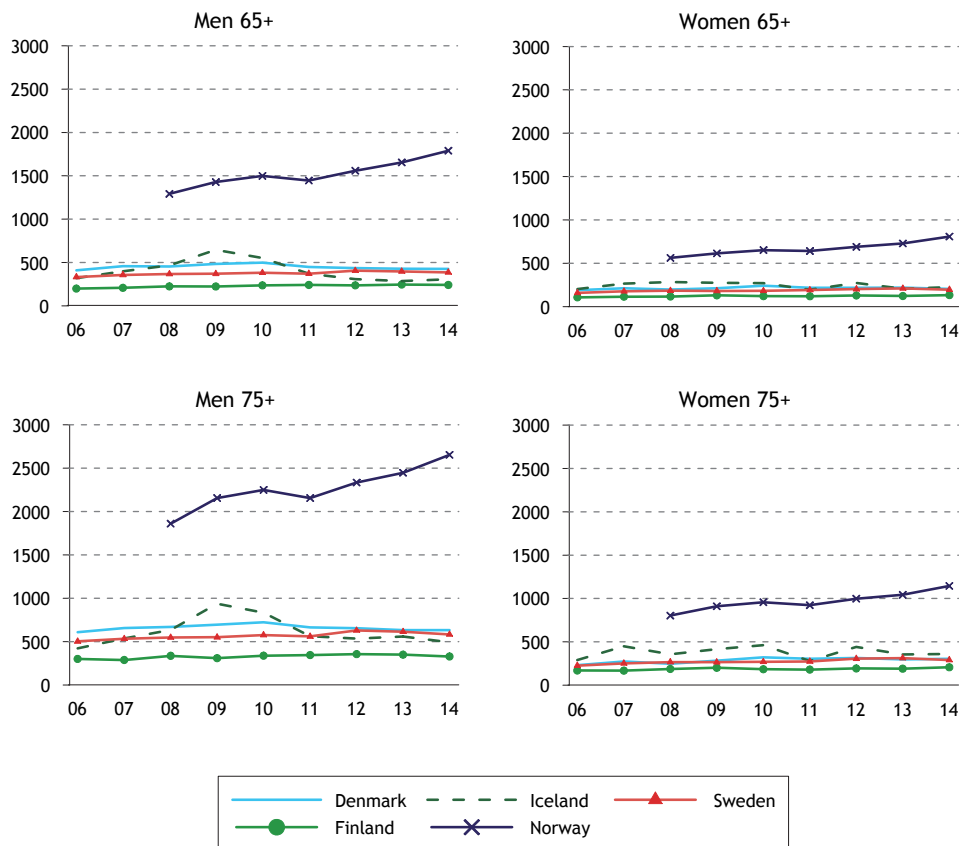
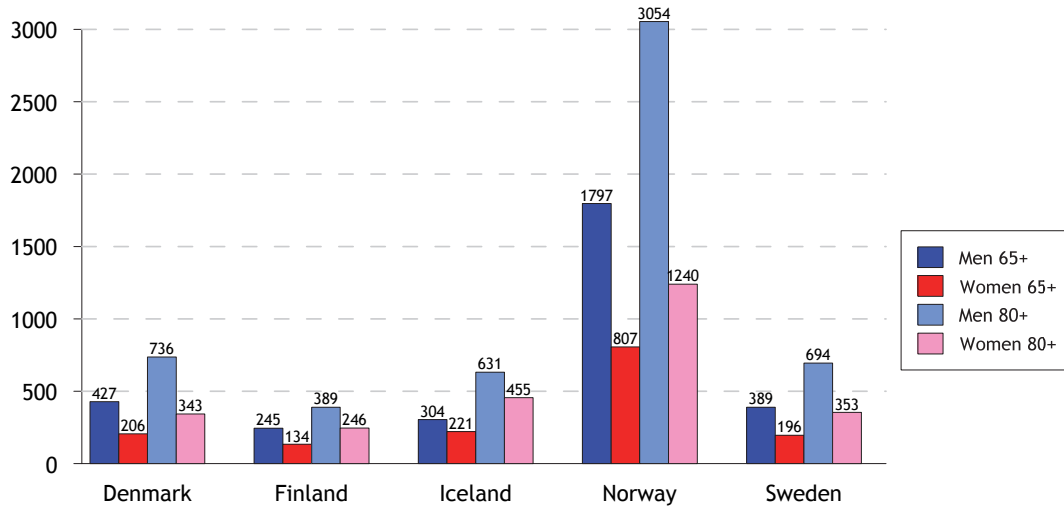


¹ Data from the Norwegian Patient Register also includes patients who have been treated in open care, which means that these are not comparable with data from the other Nordic Countries

Source: The national inpatient registers

Renal failure

Figure 5.3.4 Patients treated for renal failure, ICD-10: N17-N19, age-standardised number of patients per 100 000 population, 2014 and time series 2006-2014¹

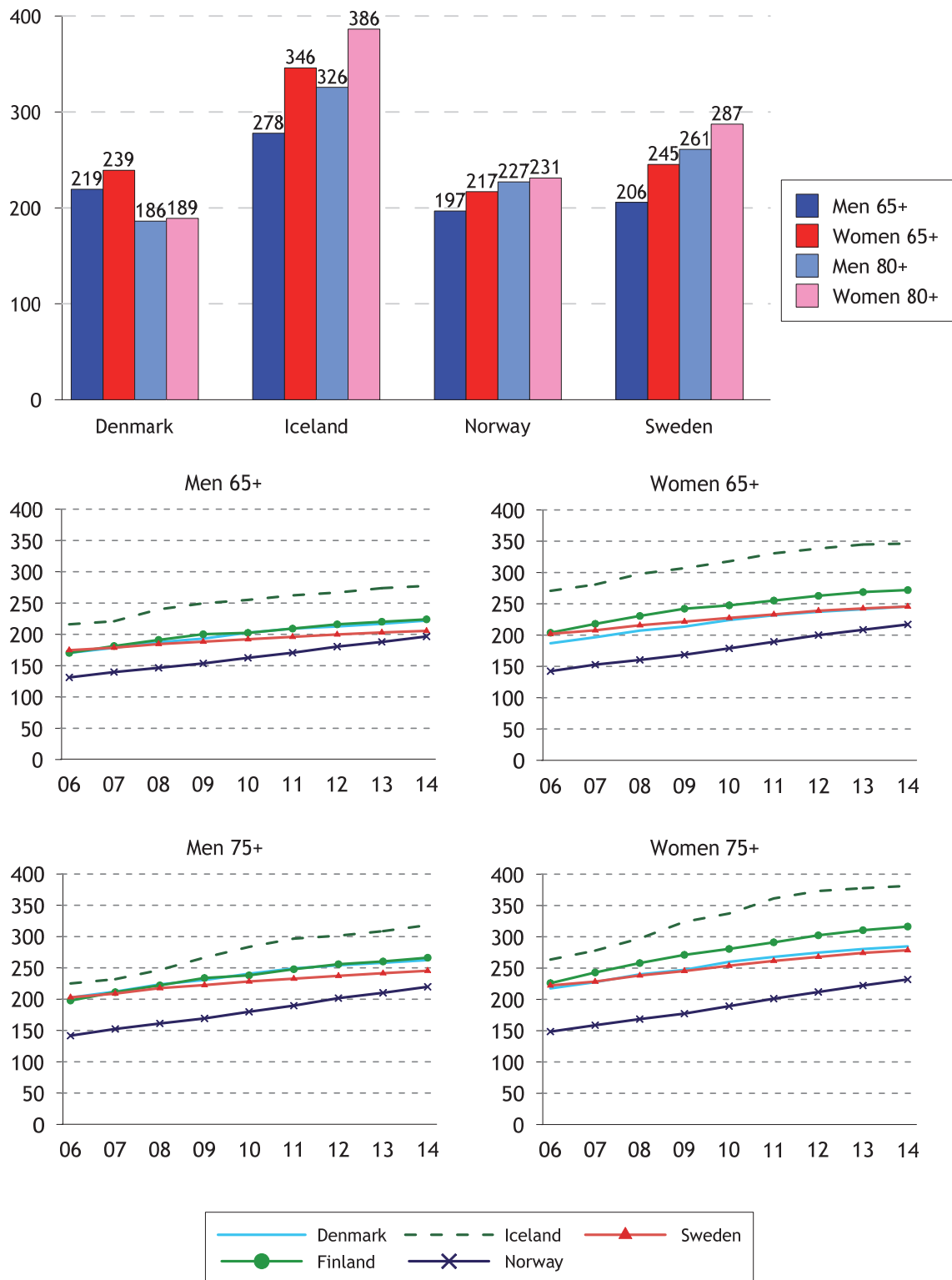


1 Data from the Norwegian Patient Register also includes patients who have been treated in open care, which means that these are not comparable with data from the other Nordic Countries

Source: The national inpatient registers

Prescription of drugs

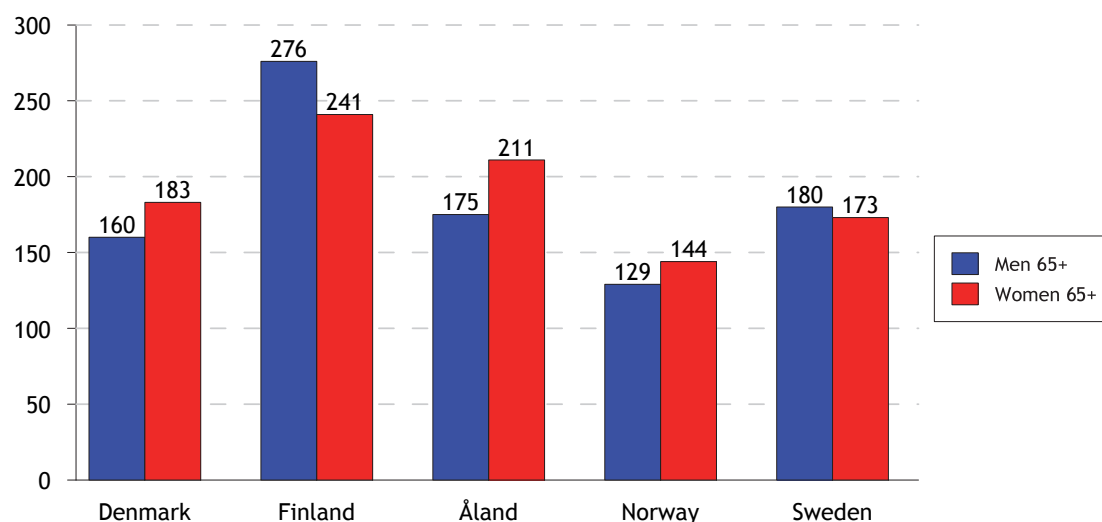
Figure 5.3.5 Prescription of drugs for peptic ulcer and gastro-oesophageal reflux, ATC: A02B, age-standardised one-year prevalence per 1 000 population, 2014 and time series 2006-2014



Source: The national prescription databases

Surgical treatment

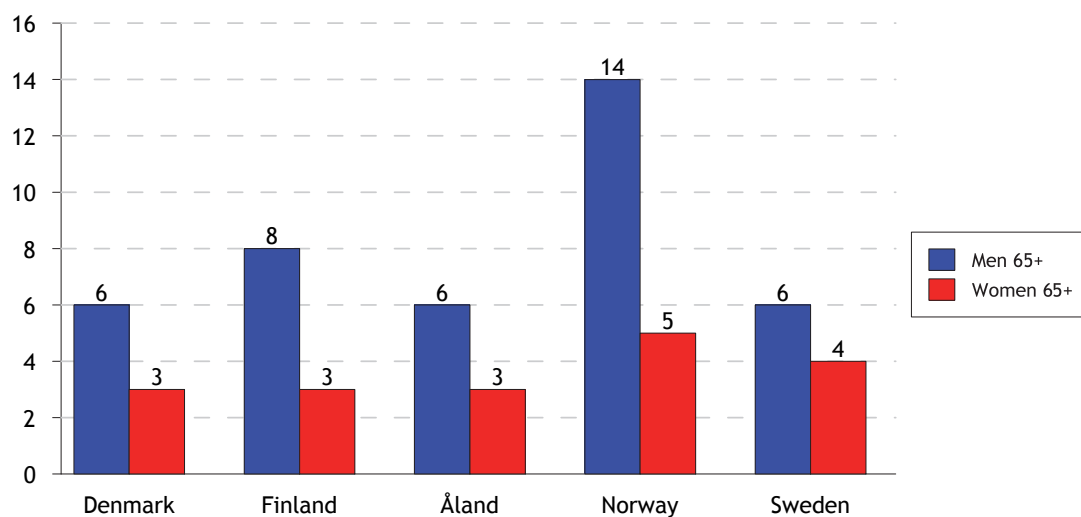
Figure 5.3.6 Cholecystectomy in the age of 65+, NCSP: JKA 20-21, total numbers of procedures per 100 000 in the age group, 2013



1 Åland average 2009-13

Source: NOMESCO: Health Statistics in the Nordic Countries 2015

Figure 5.3.7 Transplantation of kidney in the age of 65+, NCSP: KAS00-20, total numbers of procedures per 100 000 in the age group, 2013

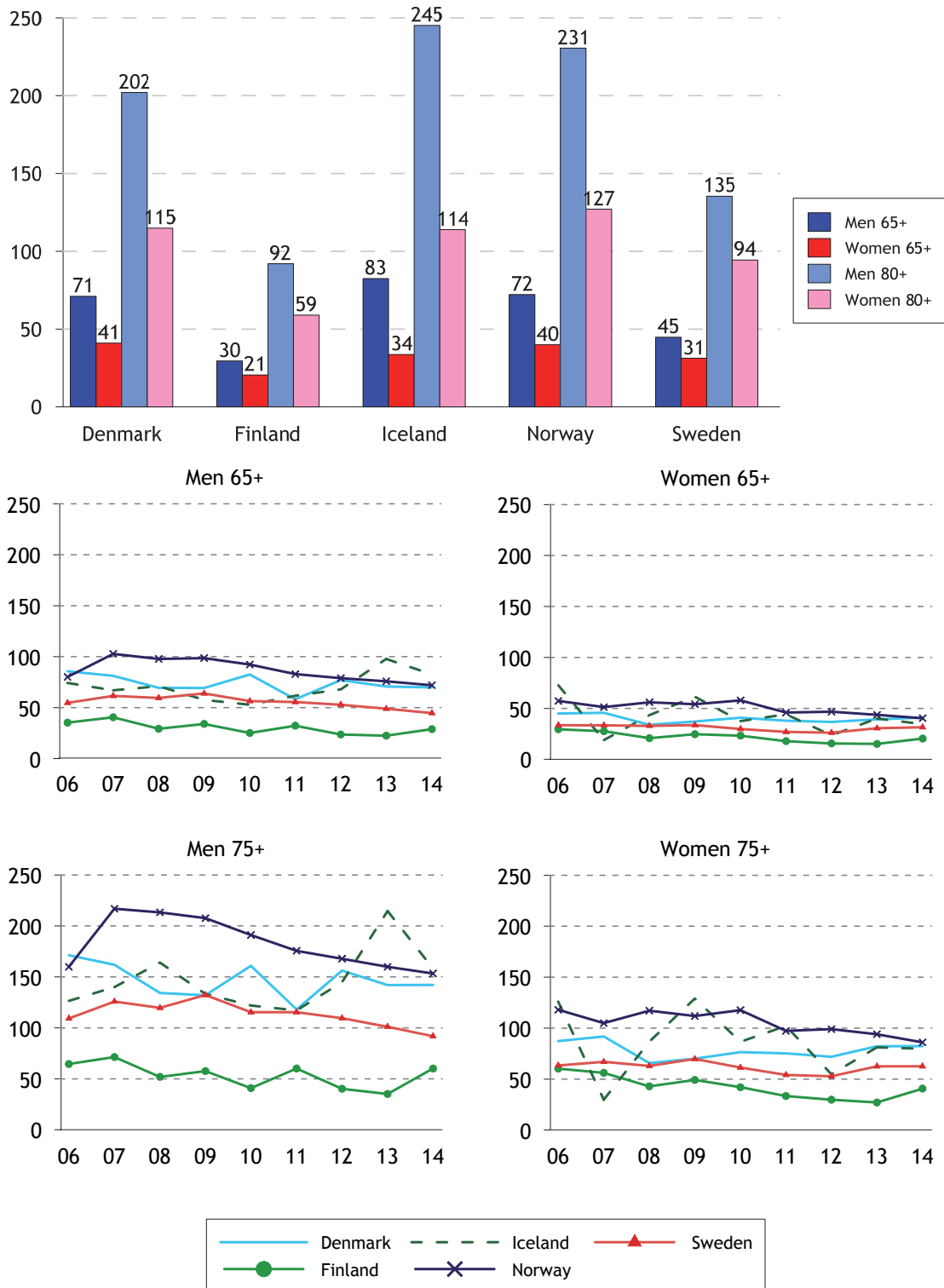


1 Åland average 2009-13

Source: NOMESCO: Health Statistics in the Nordic Countries 2015

Deaths

Figure 5.3.8 Deaths from diseases of the kidney and ureter, ICD-10: N00-N29, age-standardised deaths per 100 000 population, 2014 and time series 2006-2014



Source: The national registers for causes of death

5.4 Endocrine diseases

Diabetes is a chronic disease that increases the risk of developing other diseases, known as diabetes complications. For example, diabetes patients are at higher risk of contracting and dying from cardiovascular diseases such as myocardial infarction, angina, ischaemic stroke, high blood pressure, and narrowing of arteries in the legs. Similarly, there is greater risk of eye diseases, such as retinopathy, i.e. vascular damage in the retina.

Hospitalisation of diabetes patients can be avoided if factors such as blood sugar, blood pressure, living habits, and eye ground are monitored in primary care or outpatient specialist care. (See text on avoidable hospitalisation in the section on quality indicators.) Because there is no register information from primary care in most Nordic countries, diabetes sickness among old people is described in this report using pharmaceutical data, i.e. the diabetes population treated with drugs.

Iceland has the highest rate of prescription of diabetes drugs (Figure 5.4.1). In Iceland, prescription is higher to women, but it is higher in men in the rest of the Nordic region. Prescription has increased throughout the Nordic region, with the highest increase being in Iceland and Finland (Figure 5.4.1).

The thyroid gland produces hormones that steer metabolism and affect many of the body's functions. Insufficient production of the thyroid gland hormone leads to hypothyroidism and low metabolism, which can also cause weight increase.

Hypothyroidism is treated with thyroid hormones. Treatment with thyroid hormones is considerably more common among women, and increases with age. The prescription pattern corresponds reasonably well in the Nordic countries, except Denmark (both men and women), where consumption is lower than people in other countries (Figure 5.4.2).

Prescription is increasing in all Nordic countries, particularly among women. Prescription has increased fastest in Finland (Figure 5.4.2).

Thyroidectomy, i.e. removal of the thyroid gland, is more common among younger old people (65-74) and is more common among women than men (Figure 5.4.3). The reason for the removal is often hyperthyroidism, which means overproduction of the thyroid hormones, i.e. the opposite of hypothyroidism.

Statistics - Endocrine diseases

The figures show information for 2014 divided into gender and the 65+ and 80+ age groups. For the period 2006-2014, information are reported for the 65+ and 75+ age groups. Data for surgical interventions apply to 2013. The statistics show:

Prescriptions

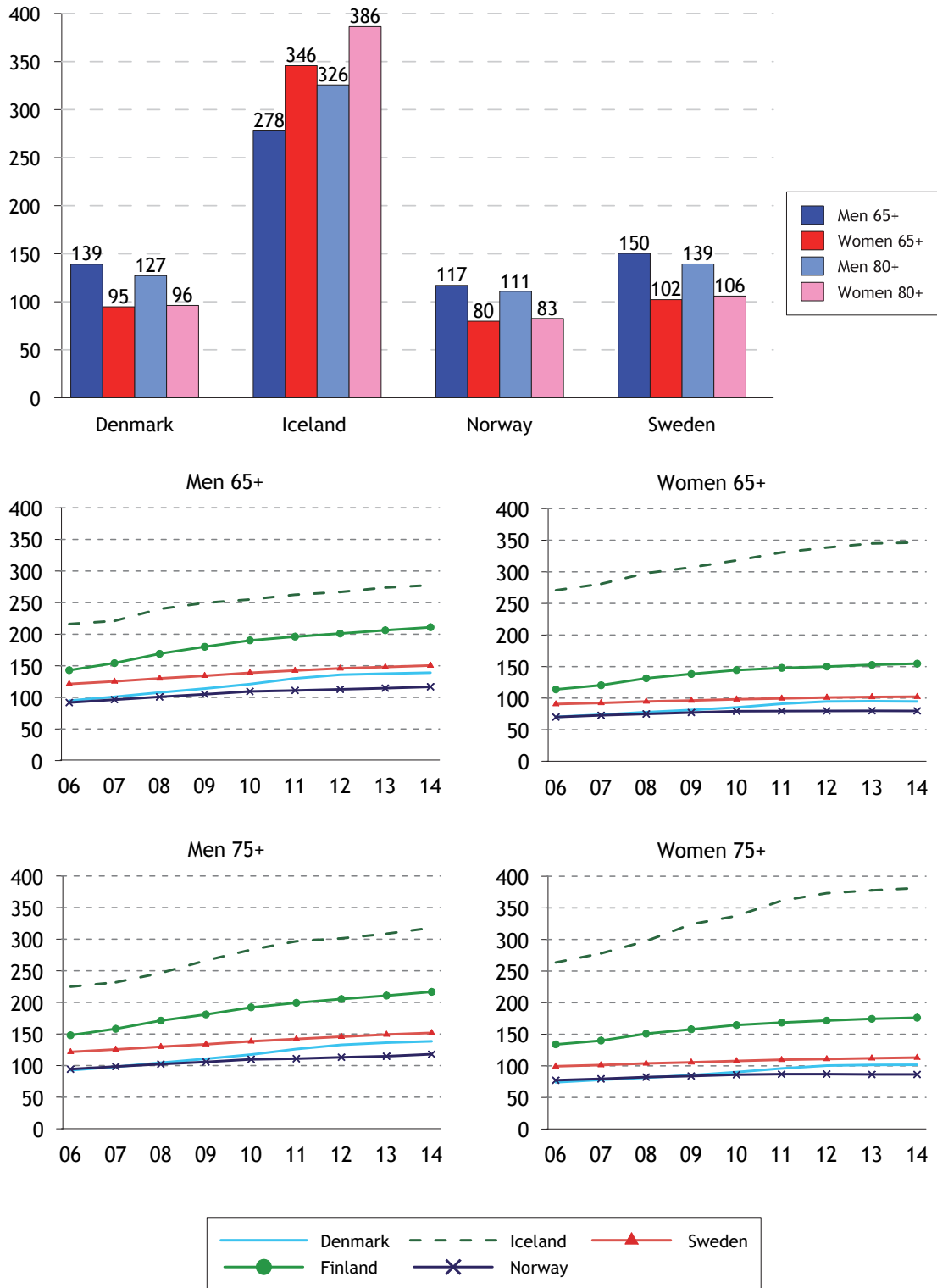
- For diabetes
- For disorders of the thyroid gland

Surgical interventions

- Thyroidectomy

Pharmaceutical treatment

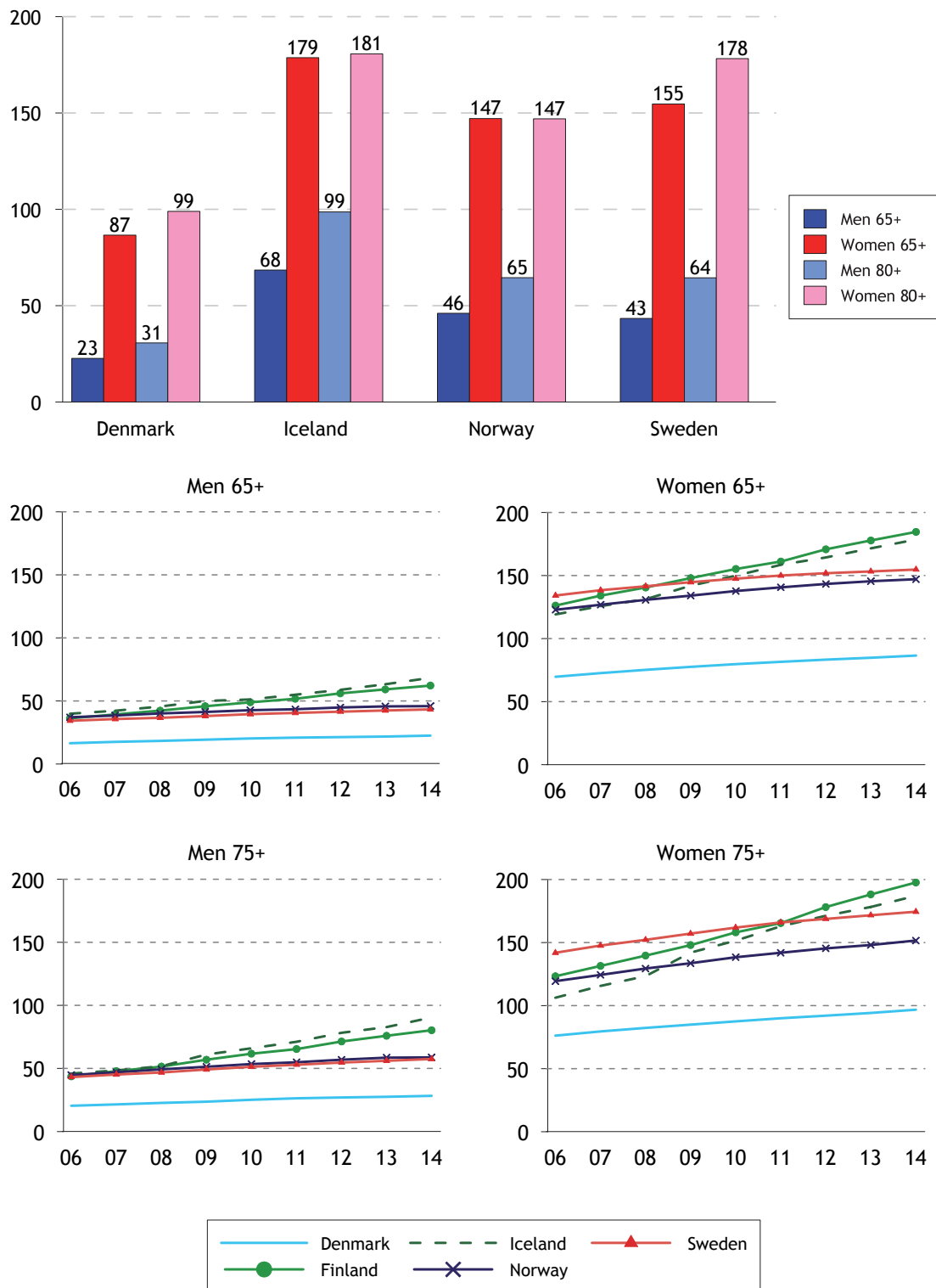
Figure 5.4.1 Prescription of drugs for diabetes, age-standardised one-year prevalence per 1 000 population, 2014 and time series 2006-2014



1 ATC: A10

Source: The national prescription databases

Figure 5.4.2 Prescription of drugs for disorders of the thyroid gland, age-standardised one-year prevalence per 1 000 population, 2014 and time series 2006-2014

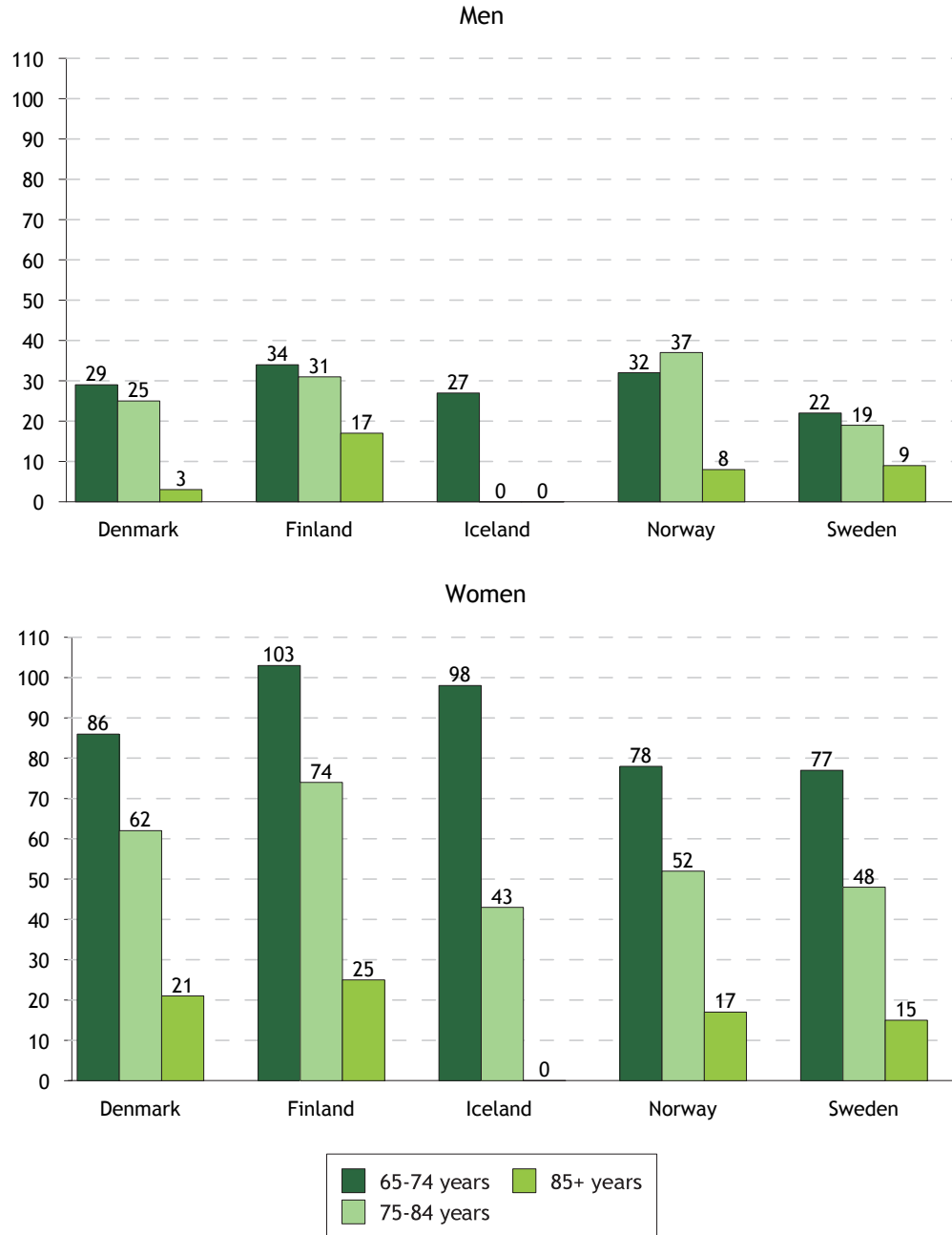


1 ATC: H33AA

Source: The national prescription databases

Surgical interventions

Figure 5.4.3 Thyroidectomy, total numbers of procedures per 100 000 in the age group, 2013



1 NCSP: BAA 20-60

2 Åland Average 2009-13

Source: NomESCO, Health Statistics in the Nordic Countries 2015

5.5 COPD and asthma

Asthma and chronic obstructive pulmonary disease (COPD) are common disorders, causing much suffering and high socioeconomic costs. Both are chronic diseases in the lower respiratory tract, and are regarded as obstructive lung diseases because they reduce air flow in the airways. While asthma is common in both children and adults, COPD mainly affects older people. COPD causes considerably more deaths than asthma.

COPD is characterised by a gradually worsening lung function. The disorder often starts with chronic bronchitis and, over time, emphysema also develops. Comorbidity is common among COPD patients, who also often suffer from, for example, depression, cardiovascular disease, metabolic syndrome, diabetes, and osteoporosis. Comorbidity further reduces quality of life, and increases mortality.

COPD is an underdiagnosed disease. In Sweden, it is estimated that half a million people suffer from COPD, of which 400 000 or 80 per cent are thought to have the disorder without knowing it. Under diagnosis is more common among young people. This is because the diagnosis is not made until the disease has advanced to a moderate or severe stage.

By far the most dominant cause of COPD is tobacco smoking, and today's prevalence can be assumed to reflect smoking habits in the previous 30-50 years. Among smokers who have attained a high age, nearly half have developed COPD. With severe COPD, drugs only provide limited relief, while stopping smoking extends survival. For a long time, a greater proportion of men than women have contracted and died from COPD in the Nordic region. However, as smoking habits have changed, the pattern has also changed in recent years. This applies primarily to younger old people in Iceland and Sweden.

Asthma is a chronic inflammatory disease in the airways that lead to periods of reduced air flow and respiratory distress. Severe asthma can develop into COPD. Drugs enable most people to lead an almost normal life, and hospitalisation and mortality in asthma is now unusual.

Hospitalised patients

Data from hospital care is not a good measure of the prevalence of COPD. As shown by data presented on avoidable hospital care in the section on quality indicators, the general ambition is to treat these patients in primary or outpatient care. Norway reports the highest proportion of old people treated in hospitals for COPD and other chronic pneumonia diseases in the lower airways, and Finland the lowest (Figure 5.5.1). The differences between the countries reflect differences in health care structure rather than in disease prevalence.

Prescription of drugs

Even if the differences are not great, most medicines for COPD and asthma and other obstructive pulmonary diseases are prescribed to women aged 65 and older, particularly in Iceland (Figures 5.5.2 and 5.5.3). The oldest group of men, aged 80+, has high levels of prescription in, for example, Denmark and Norway. Regardless of the type of medicine and age group, prescription has increased noticeably in all Nordic countries (Figures 5.6.2 and 5.6.3).

Mortality

Mortality in asthma and other chronic diseases in the lower airways has been reasonably stable in the past decade, with mostly small movements downwards, but also some small movements upwards in, for example, women aged 75 and older in Sweden and Norway. Denmark has the highest mortality (Figures 5.6.4).

Statistics - Chronic obstructive pulmonary disease and asthma

The figures show information for 2014 divided into gender and the 65+ and 80+ age groups. For the period 2006-2014, information is reported for the 65+ and 75+ age groups. The statistics show:

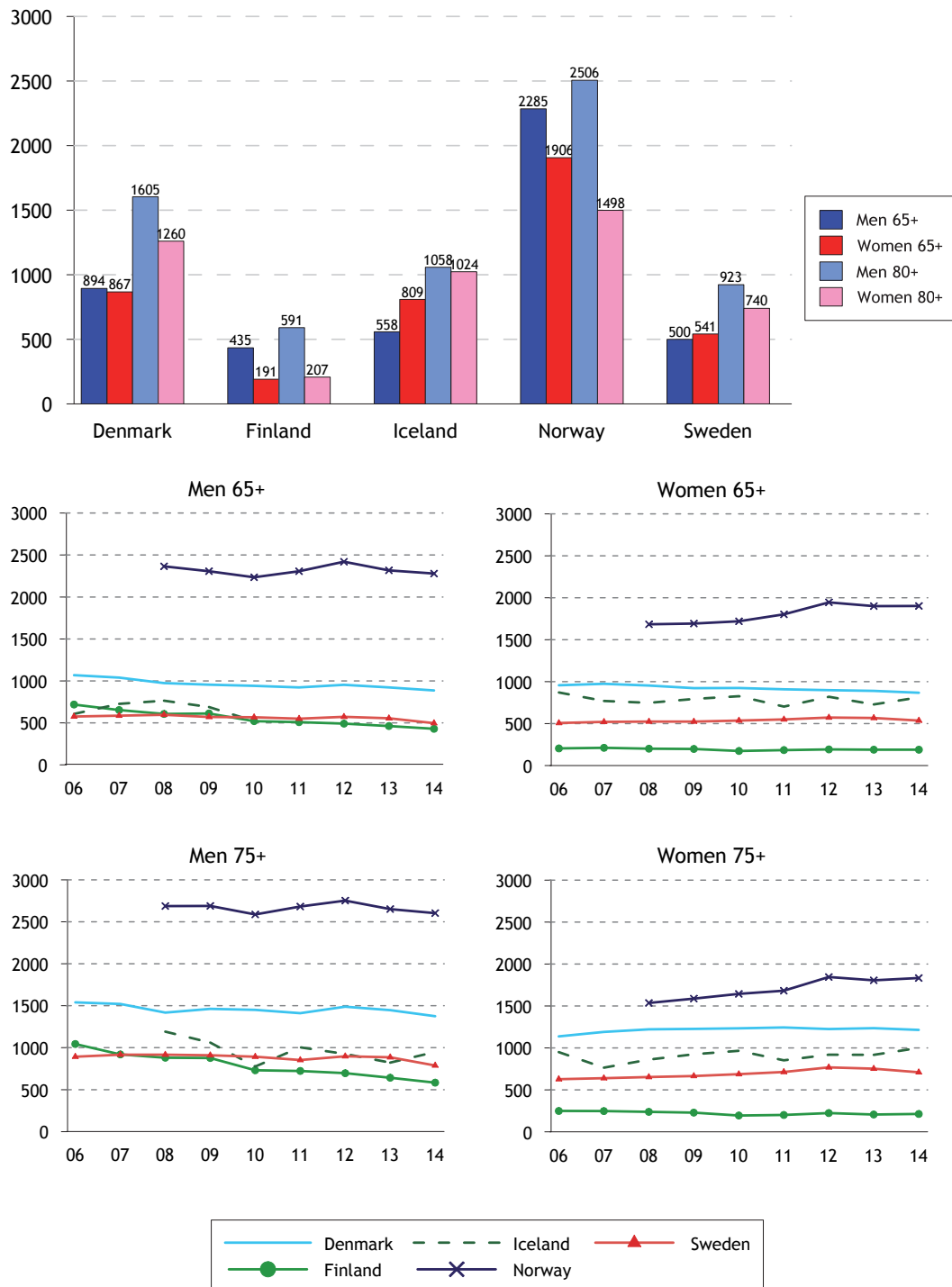
Patients discharged after hospital treatment for COPD**Prescriptions**

- Adrenergic inhalants
- Other drugs for chronic obstructive pulmonary disease

Mortality from chronic obstructive pulmonary disease and asthma

Patients in hospitals, Chronic obstructive pulmonary disease

Figure 5.5.1 Patients treated in somatic hospitals for chronic lower respiratory diseases¹ excl. asthma, age-standardised number of patients per 100 000 population, 2014 and time series 2006-2014²



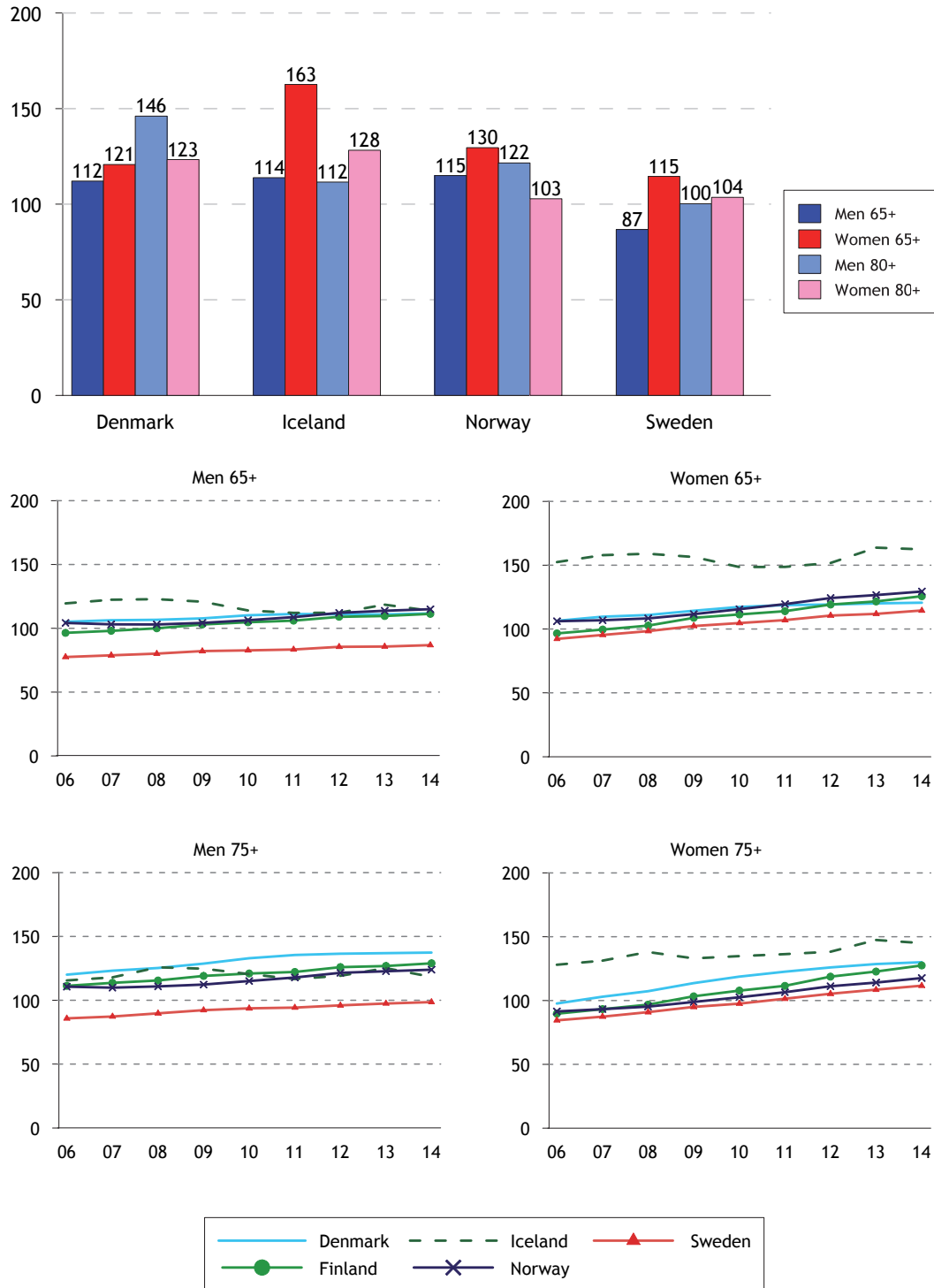
1 ICD10: J40-J44, J47

2 Data from the Norwegian Patient Register also includes patients who have been treated in open care, which means that these are not comparable with data from the other Nordic Countries

Source: The national inpatient registers

Prescription of medications, adrenergic inhalants

Figure 5.5.2 Prescription of adrenergic inhalants, age-standardised one-year prevalence per 1 000 population, 2014 and time series 2006-2014

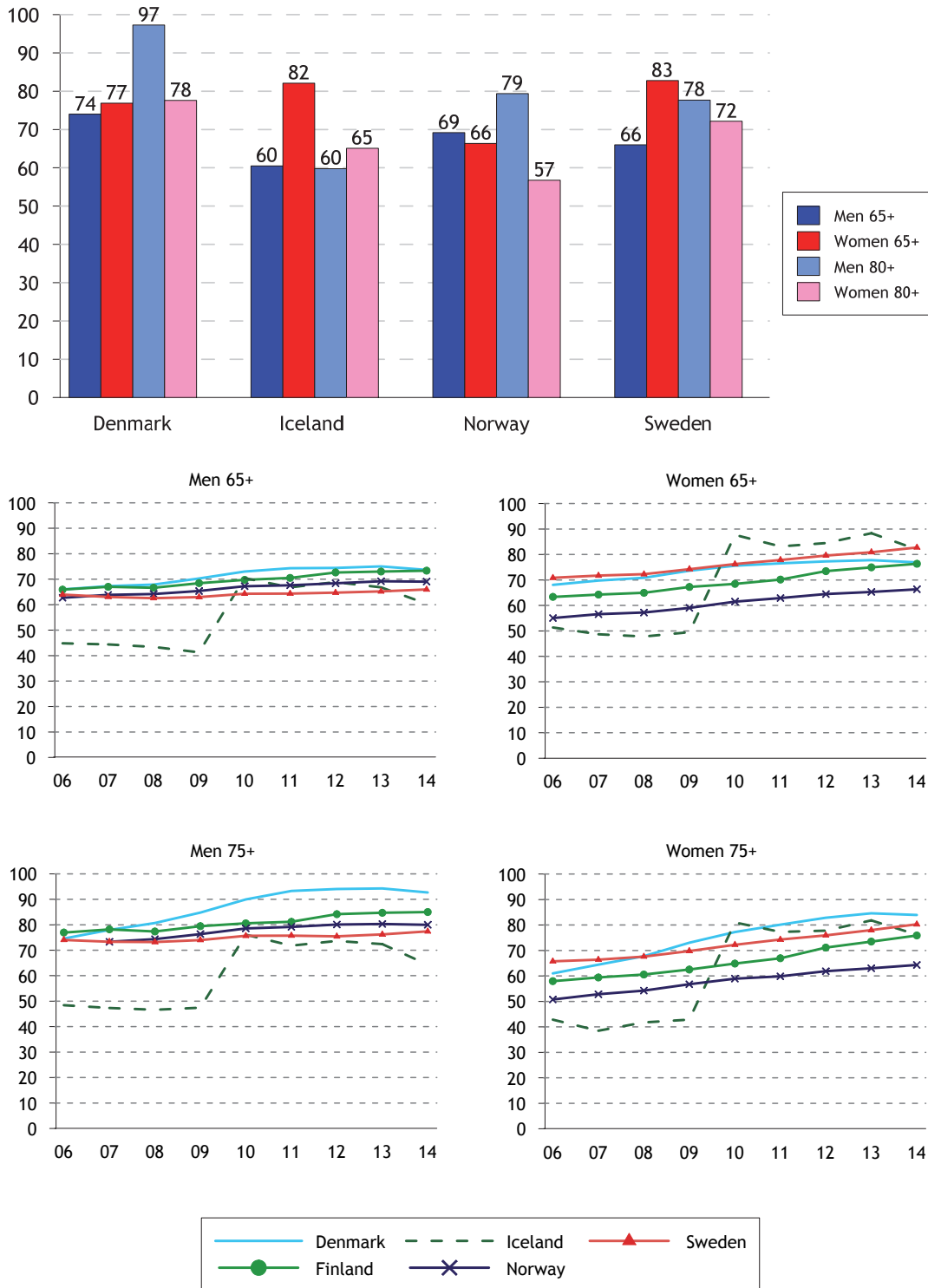


1 ATC: R03A

Source: The national prescription databases

Other drugs for chronic obstructive pulmonary disease (and asthma)

Figure 5.5.3 Prescription of other drugs for chronic lower respiratory diseases, age-standardised one-year prevalence per 1 000 population, 2014 and time series 2006-2014

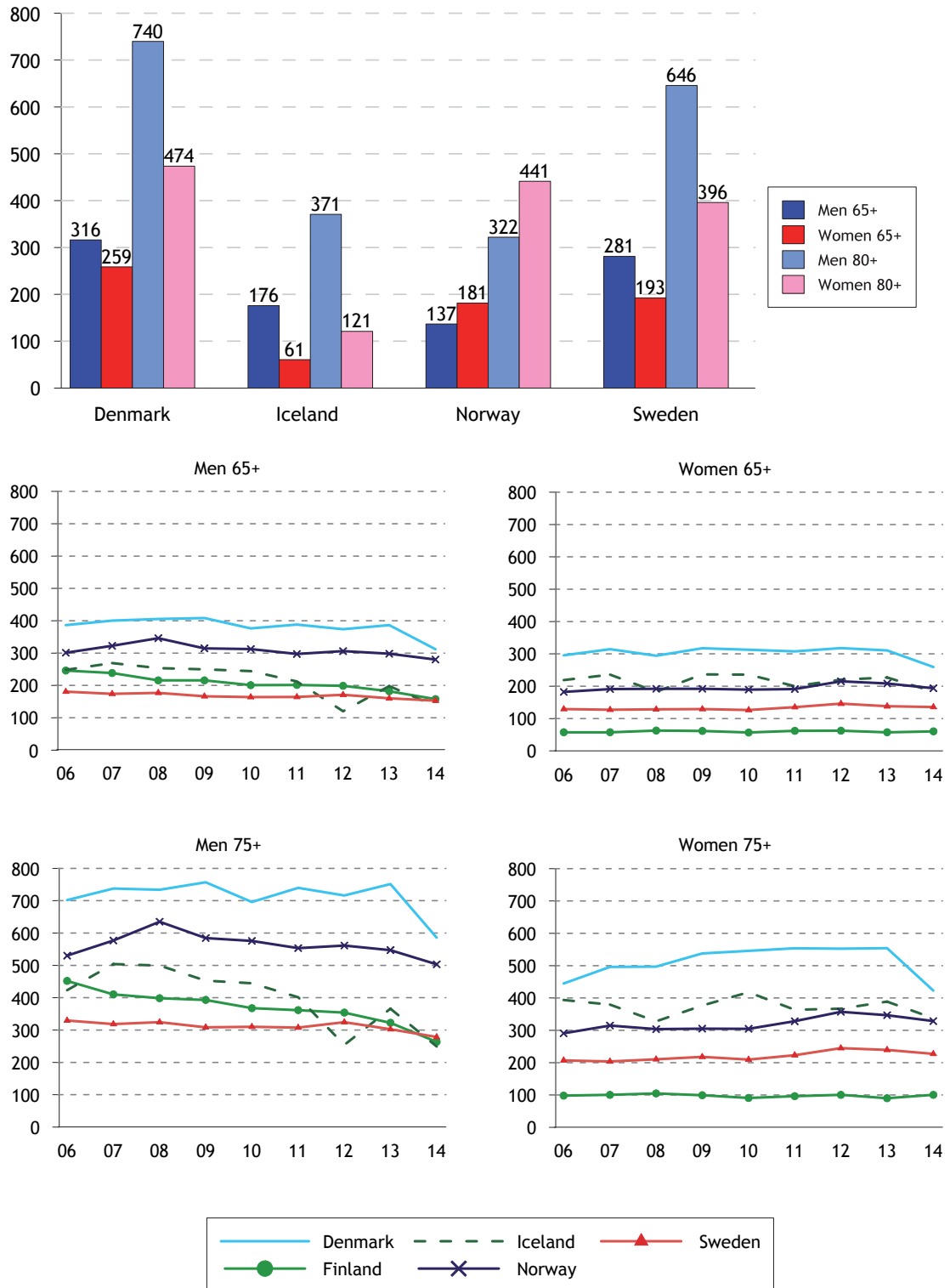


1 ATC: R03B

Source: The national prescription databases

Deaths

Figure 5.5.4 Deaths from chronic lower respiratory diseases, age-standardised deaths per 100 000 population, 2014 and time series 2006-2014



1 ICD-10: J40-J47

Source: The national registers for causes of death

5.6 Pneumonia

Pneumonia is a common cause of hospitalisation (Figure 5.6.1) of older people in all the Nordic countries. Iceland reports the lowest proportion of hospitalised patients, and Denmark the highest. Frail older people are hit considerably harder by pneumonia than younger people, and a fatal course is not uncommon. Among the oldest, those over 85, pneumonia is therefore a common cause of death. However, the differences between the Nordic countries and differences over time reflect differences/similarities in coding practice in the cause of death registers.

Both admission patterns and mortality patterns (Figure 5.6.1) are largely the same throughout the Nordic region. Pneumonia is considerably more common among the older group of elderly than the younger group. Men are affected more often than women, and it is among the oldest men that difference is greatest between the Nordic countries.

While the number of patients per 100 000 old people has remained relatively constant (Figure 5.6.1), mortality has fallen in the past ten-year period (Figure 5.6.1). Finland shows considerably lower mortality in pneumonia than other Nordic countries.

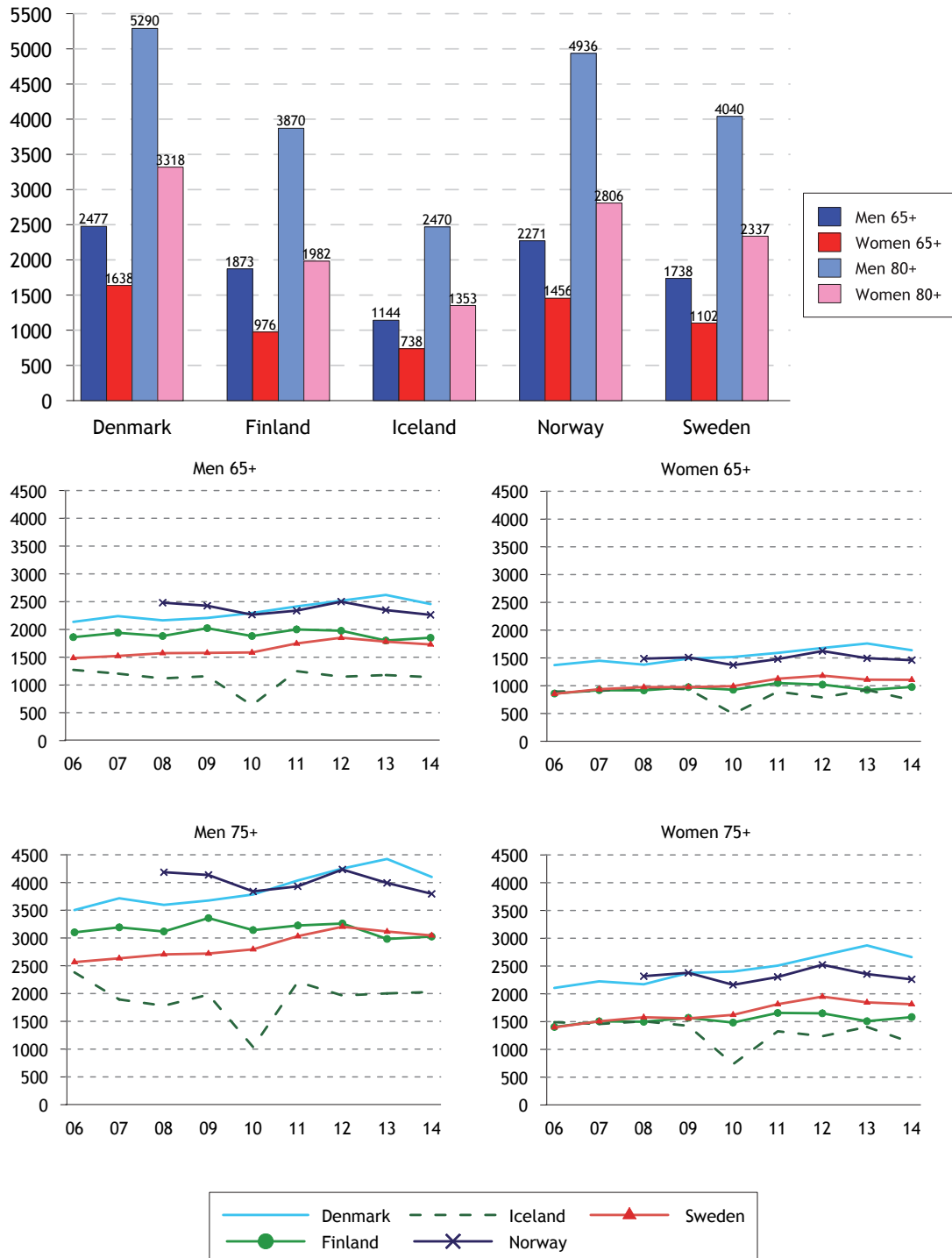
Statistics - Pneumonia

The figures show information for 2014 divided into gender and the 65+ and 80+ age groups. For the period 2006-2014, information is reported for the 65+ and 75+ age groups. The statistics show:

Patients discharged from hospital after treatment for pneumonia
Deaths caused by pneumonia

Hospitalised patients

Figure 5.6.1 Patients treated in somatic hospitals for pneumonia, ICD-10: J12-J18, age-standardised number of patients per 100 000 population, 2014 and time series 2006-2014¹

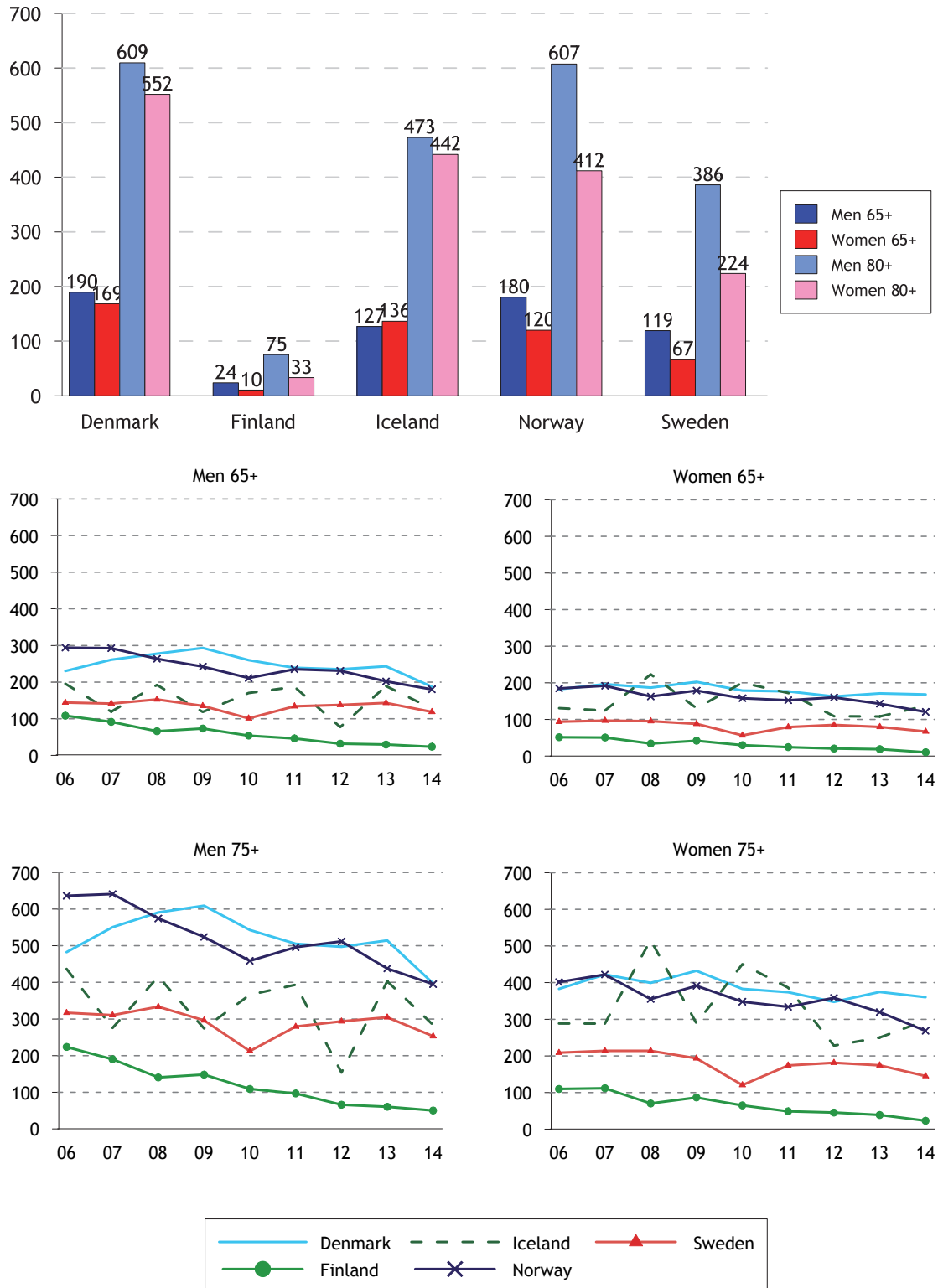


1 Data from the Norwegian Patient Register also includes patients who have been treated in open care, which means that these are not comparable with data from the other Nordic Countries

Source: The national inpatient registers

Deaths

Figure 5.6.2 Deaths from pneumonia, ICD-10: J12-J18, age-standardised deaths per 100 000 population, 2014 and time series 2006-2014



Source: The national registers for cause of death

5.7 Dementia and Alzheimer's disease

Dementia is caused by damage in the brain, and gives a number of different symptoms depending on which parts of the brain are affected. Usually, memory deteriorates, and the ability to plan and carry out everyday activities diminishes. Language, perception of time, and orientation ability are other cognitive abilities that can be affected. The pattern of disease also includes worry, depression, and behavioural changes. The symptoms often result in people with dementia, over time, finding it hard to cope with their everyday lives.

Alzheimer's disease is the most common form of dementia, and accounts for approximately 60-70 per cent of all cases. The next most common dementia disease is vascular dementia, which accounts for approximately 20 per cent. Other related disorders are frontal lobe dementia, dementia in Parkinson's disease, and alcohol dementia.

The preventive strategies for dementia include preventing cardiovascular diseases, by reducing the risk of diabetes, high blood pressure, overweight, smoking and alcohol mis use. Genetic factors are also important in Alzheimer's disease. The lifetime risk is estimated to be doubled if a parent or sibling has had the disease (Swedish Gene Technology Advisory Board, *Åldrandets genetik*, 2006).

Dementia is not part of natural ageing, even though the number of people with dementia diseases increases with age. There are no indications that the risk of contracting dementia diseases has increased in recent years. However, the number of people with dementia has probably increased in line with the ageing population, which presents a future challenge for the Nordic welfare systems, not so much for health care, but for the municipal care services.

It is hard to get an exact impression of the number of people with dementia diseases. The number has previously been estimated by assuming that the proportion of dementia patients comprises a growing percentage in different age intervals in the older population. However, according to an article published in the journal *Lancet Neurology*, dementia is falling in percentage terms among people over 80. The study is based on five epidemiological studies carried out in Sweden, the Netherlands, UK and Spain. The reason for the reduction is assumed to be higher levels of education and better living conditions, but also prevention and treatment of cardiovascular diseases has become better, which reduces the risk of dementia (World Alzheimers Report 2015. *The Global Impact of Dementia*. London; 2015).

Hospitalised patients

Figures 5.7.1 show that Norway and Iceland have most dementia patients treated in hospital, while Sweden and Denmark have the lowest proportions. However, the differences reflect differences in care policy and health care structure rather than differences in occurrence of dementia.

Prescription of drugs

When a person is diagnosed with dementia, treatment often starts with a dementia drug, but there is no scientific support for treating all forms of dementia with drugs. However, for Alzheimer's disease, there is support for drug therapy. Alzheimer's disease cannot be cured, but dementia drugs can help to, for a period, maintain cognitive functional abilities and thereby improve quality of life.

There are two types of drug used to treat Alzheimer's disease, cholinesterase inhibitors and memantine. The latter is classified as the only named drug in what Figure 5.7.3 are shown as 'other anti-dementia drugs'. Cholinesterase inhibitors are mainly used for treating mild or moderate Alzheimer's disease, while memantine is used for moderate to severe Alzheimer's disease.

As Figure 5.7.2 show, prescription of cholinesterase inhibitors has remained relatively constant in the Nordic region since 2006, except for Finland where prescriptions have increased, primarily in the oldest age group (75+). However, prescription of other anti-dementia drugs, e.g. memantine, has increased in all countries. Here too, prescription is highest in Finland.

Mortality

The number of deaths where a dementia diagnosis is given as the cause of death has increased slightly in all Nordic countries, with the highest figures in Finland (Figure 5.7.3). Part of the increase can probably be ascribed to the greater attention in recent decades to dementia, and thereby an increased tendency to give dementia as the underlying cause of death.

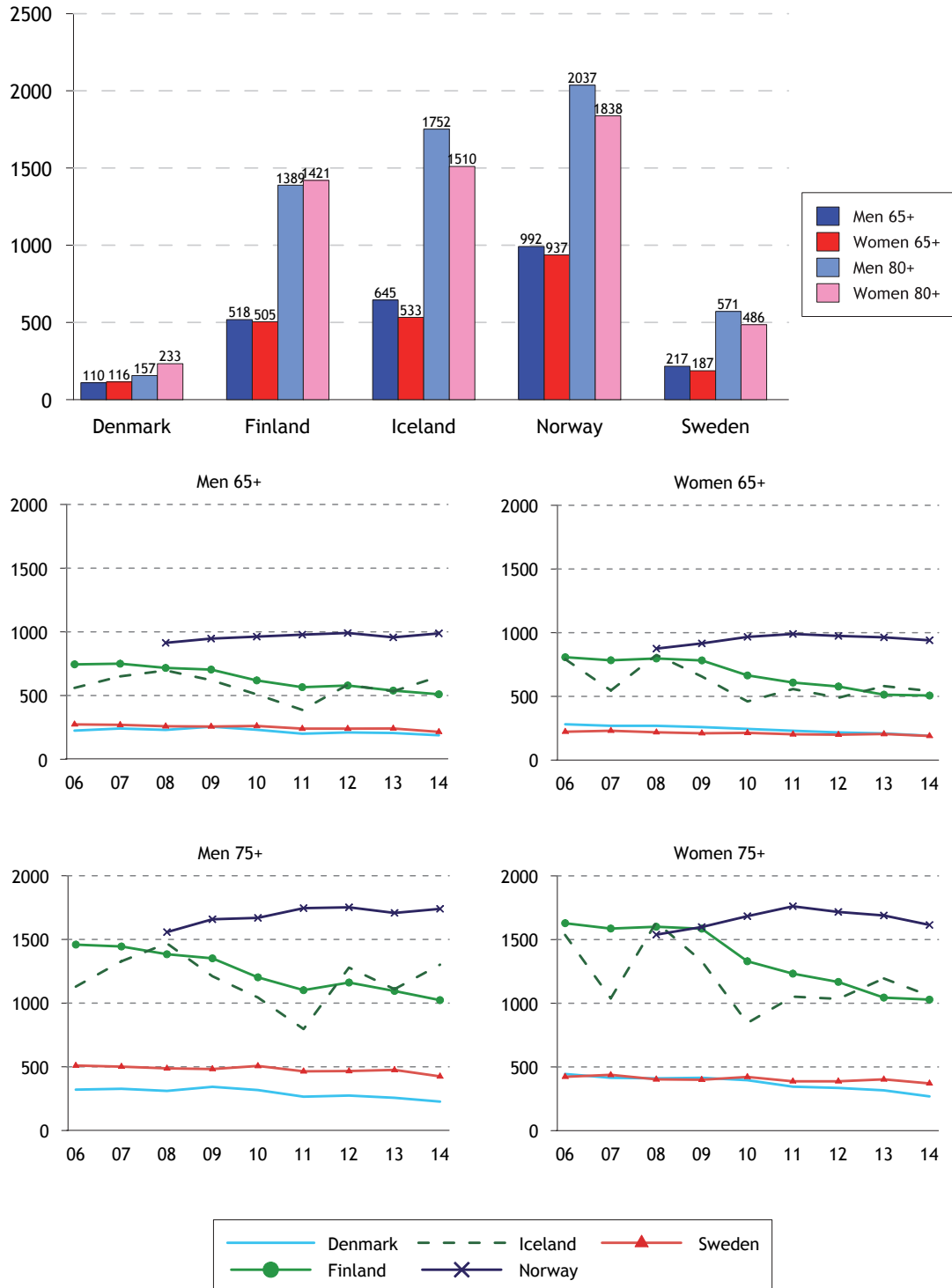
Statistics - Dementia diseases

The figures show information for 2014 divided into gender and the 65+ and 80+ age groups. For the period 2006-2014, information is reported for the 65+ and 75+ age groups. The statistics show:

- **Patients discharged from hospital**
- **Prescription of medicines**
 - Anticholinesterases
 - Other anti-dementia drugs
- **Deaths**

Patients discharged from hospital after treatment for dementia

Figure 5.7.1 Patients treated for dementia¹, age-standardised number of patients per 100 000 population, 2014 and time series 2006-2014²



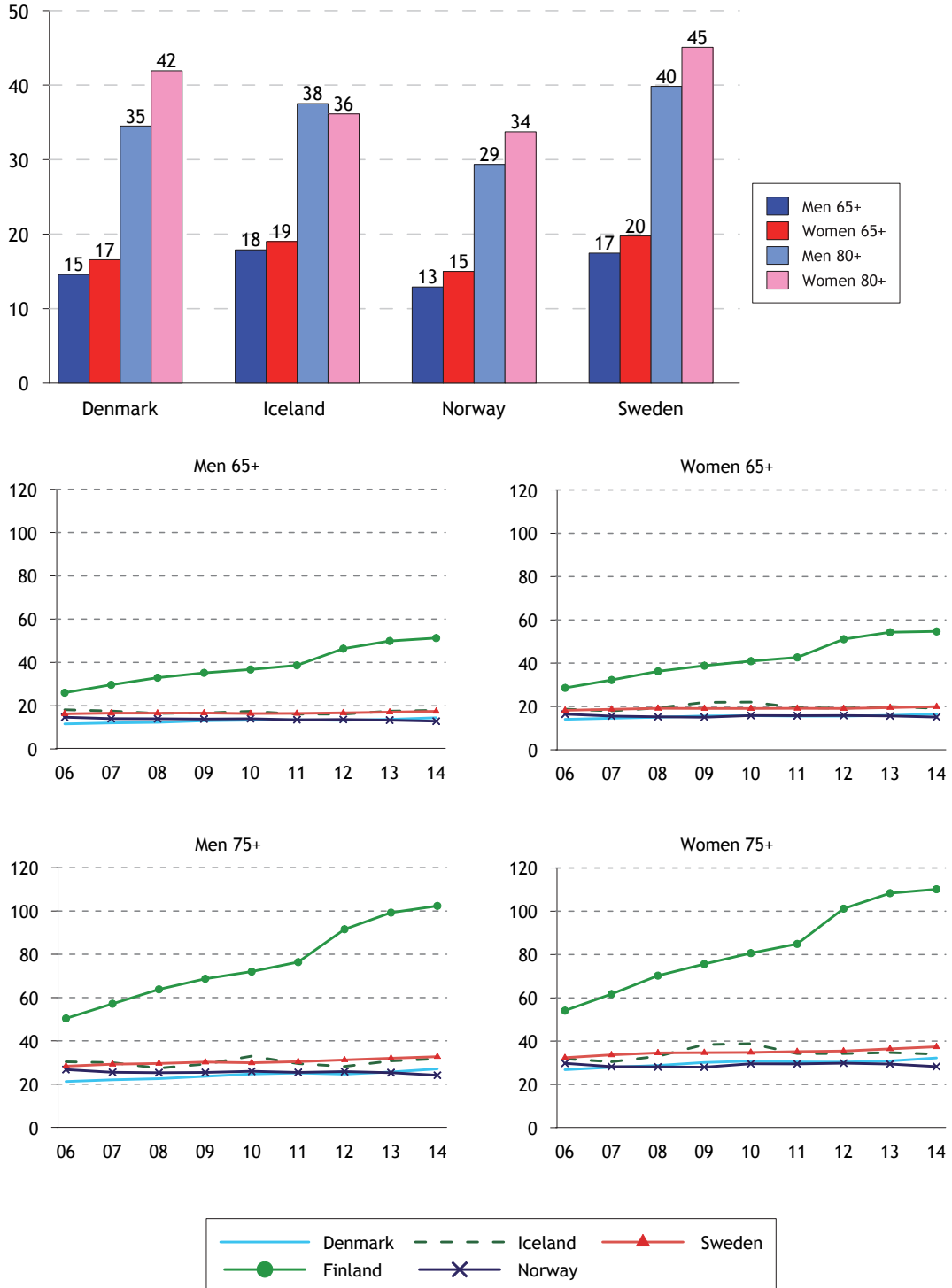
1 ICD-10: F00-F03 G30-G31

2 Data from the Norwegian Patient Register also includes patients who have been treated in open care, which means that these are not comparable with data from the other Nordic Countries

Source: The national inpatient registers

Prescription of anti-dementia drugs

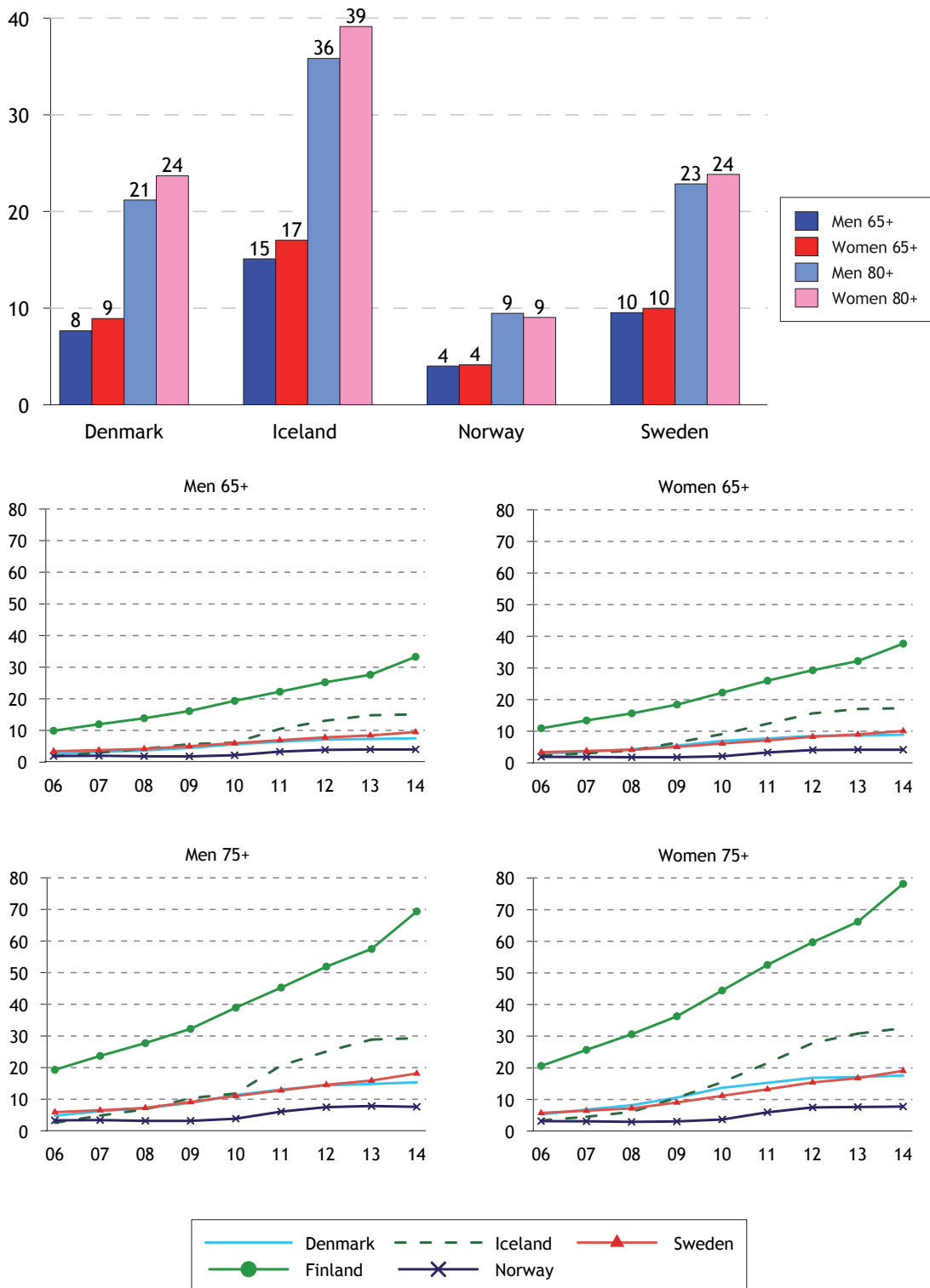
Figure 5.7.2 Prescription of anticholinesterases, age-standardised one-year prevalence per 1 000 population, 2014 and time series 2006-2014



1 ATC: N06DA

Source: The national prescription databases

Figure 5.7.3 Prescription of other anti-dementia drugs^{1, 2}, age-standardised one-year prevalence per 1 000 population, 2014 and time series 2006-2014



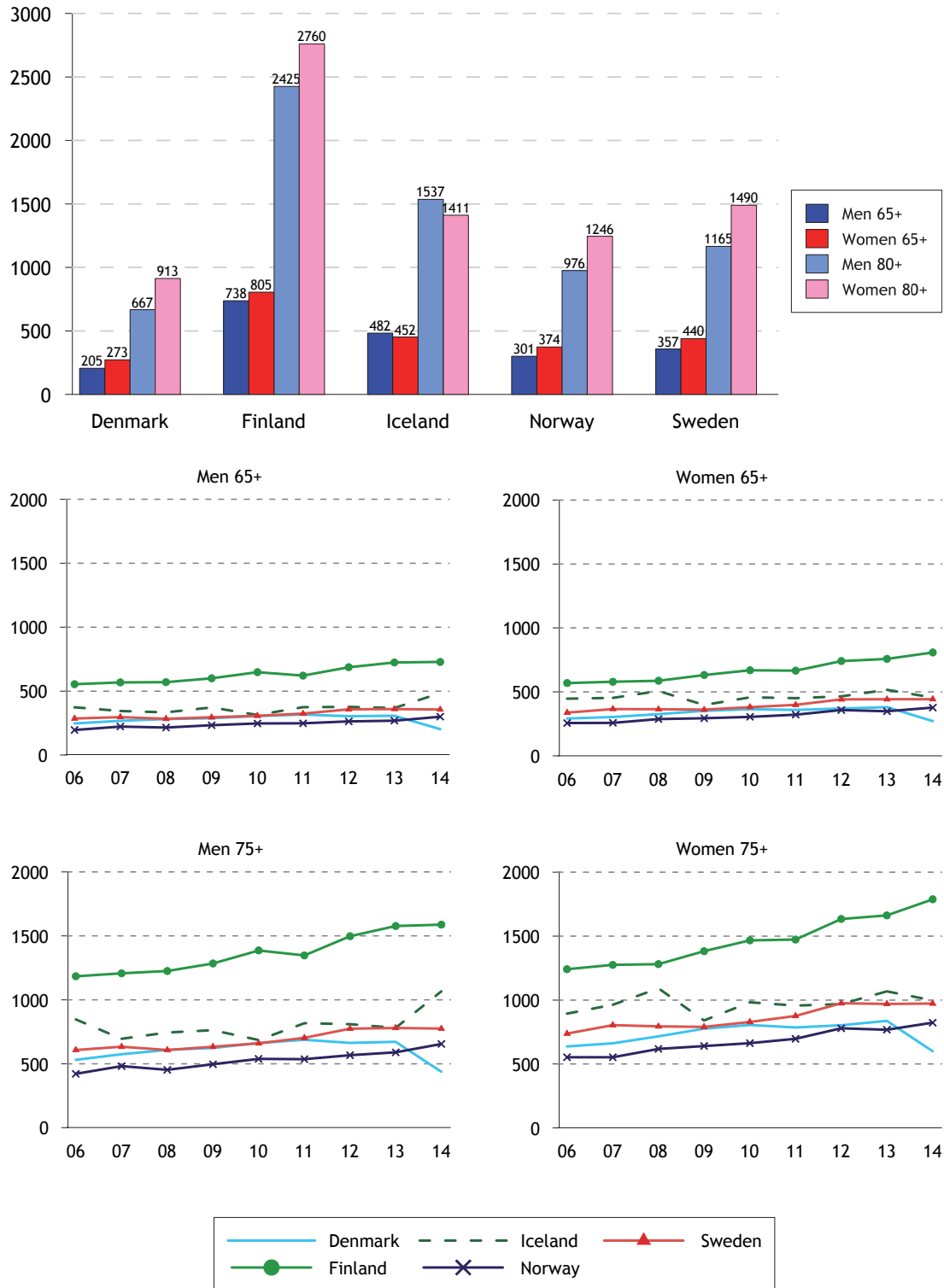
1 ATC: N06DX

2 Other drugs mainly comprise Memantine

Source: The national prescription databases

Deaths caused by dementia

Figure 5.7.4 Deaths from dementia¹, age-standardised deaths per 100 000 population, 2014 and time series 2006-2014



1 ICD-10: F00-F03 G30-G31

Source: The national registers for cause of death

5.8 Mental illness

Anxiety, worry, angst, and insomnia are common among old people, but this does not mean that mental illness is a natural part of ageing. However, loss of social identity after retirement, loss of bodily abilities and greater illness are examples of factors that can affect the mental balance and a sense of wellbeing.

Mental ill-health is often measured through questionnaires and interview surveys. In the 2014 living conditions survey (ULF/SILC) in Sweden, 12 per cent of men and nearly 26 per cent of women aged 75-84 reported that they experienced problems of anxiety, worry and angst. In addition, over one per cent of the men and nearly six per cent of the women reported that they had severe problems. Approximately 30 per cent of the men in this age group and more than 40 per cent of the women reporting sleeping difficulties, ranging from mild to severe.

Depression is the most common cause of mental ill-health among old people. Angst diseases are also common. Old people with this type of mental ill-health have, more than other old people, comorbidity with severe somatic illnesses, such as heart diseases and chronic respiratory diseases. There is also a complex relationship between dementia and depression.

Figure 5.8.1 show the number of old people per thousand in the population who were admitted and treated at psychiatric clinics in 2013. In most age groups, more women were treated than men, more in young ages (65-79) than in older (80+). In total, most men were treated in Norway and Sweden. Iceland reported the lowest number of people treated.

Pharmaceutical treatment

Data on hospitalised patients gives an incomplete and less comparable picture of mental ill-health and psychiatric disorders among old people. This is partly because psychiatric care is largely run in outpatient care forms and is organised in so many different ways. In this section, prescription of psycho-tropics is used as an indicator of mental illness and disorders, and provide more information.

The pattern is the same for all four pharmaceutical groups presented below. Prescription increases with patient age, and more prescriptions are issued for women than for men.

In 2014, prescription of *antipsychotics* was highest in Norway and lowest in Iceland. Prescription has decreased in Denmark, Norway, and Sweden, and increased in Finland and Iceland. The pattern is the same for all age groups (Figure 5.8.2).

Prescription of *anxiolytics* was highest in Iceland and lowest in Denmark, with a slight decrease in all countries except Iceland (Figure 5.8.3).

Prescription of *hypnotics and sedatives* was also highest in Iceland and lowest in Denmark, with a general decline in all countries (Figure 5.8.4).

Prescription of *antidepressants* was highest in Iceland and lowest in Norway. The prescription pattern has not changed significantly, except in Iceland where prescriptions have increased, particularly in the oldest age group (Figure 5.8.5).

Prescriptions to old people have attracted increasing attention in recent years. The question has been raised as to whether old people are being prescribed unreasonably many drugs and in excessively high doses. The risk of overmedication is particularly great in treatment with psychotropics, because depression and anxiety states among old people are so common and difficult to diagnose, and expertise in

geriatric psychiatry is limited. Prescription of drugs to old people is considered in a special section of this report, 'Pharmaceutical treatment of old people', and in the section on quality indicators (prescription of long-acting benzodiazepines and long-term prescription of benzodiazepines).

Suicide attempts and suicide among old people

In many cases, depression is a significant risk factor for suicidal actions. Swedish studies have shown that 70-75 per cent of the investigated suicides were triggered by depression diseases (Beskow 1979). Depression among old people is not uncommon and, like for young people, often has multifactorial causes. One problem among old people is that depression is more often not diagnosed and treated, unlike among young people.

Figures 5.8.6 and 5.8.7 show the number of old people treated for intentional self-harm and for events of undetermined intent, i.e. what is generally called suicide attempt (even though this includes other injuries where the intent was not to take the life). Sweden and Finland report clearly most treatment for suicide attempt, which not only reflects differences in occurrence but also differences in diagnostics and classification.

The pattern is different for completed suicide (Figure 5.8.8). Iceland and Denmark report most cases, Sweden least. A common pattern is that more twice as many men than women take their lives, and more older elderly men than younger elderly. It is virtually only Sweden and Finland that report deaths with undetermined intent, and Sweden's relatively low number of completed suicides should probably be seen in relation to the number of cases reported with unclear intent (Figures 5.8.9).

Statistics - Mental illness

The figures show information for 2013 and 2014, divided into gender and the 65+ and 80+ age groups. For the period 2006-2014, information is reported for the 65+ and 75+ age groups. The statistics show:

Hospitalised patients at psychiatric clinics

Pharmaceutical treatment

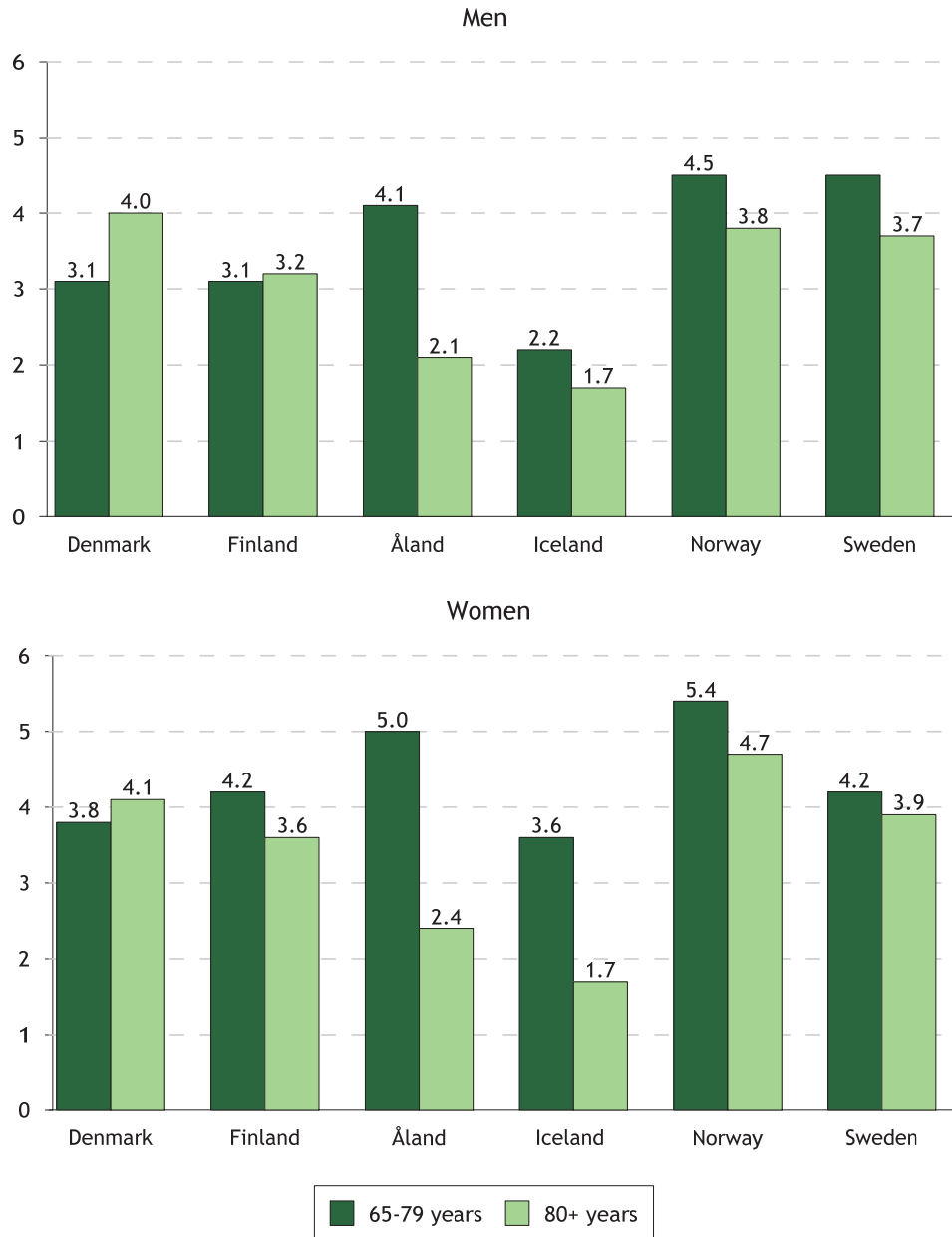
- Antipsychotics
- Anxiolytics
- Hypnotics and sedatives
- Antidepressants

Suicide and suicide attempt

- Hospitalised patients, intentional self-harm
- Hospitalised patients, undetermined intent
- Deaths, intentional self-harm
- Deaths, undetermined intent

Treated at psychiatric clinics in hospitals

Figure 5.8.1 In-patient treatments at psychiatric wards, treated patients per 1 000 population, 2013¹

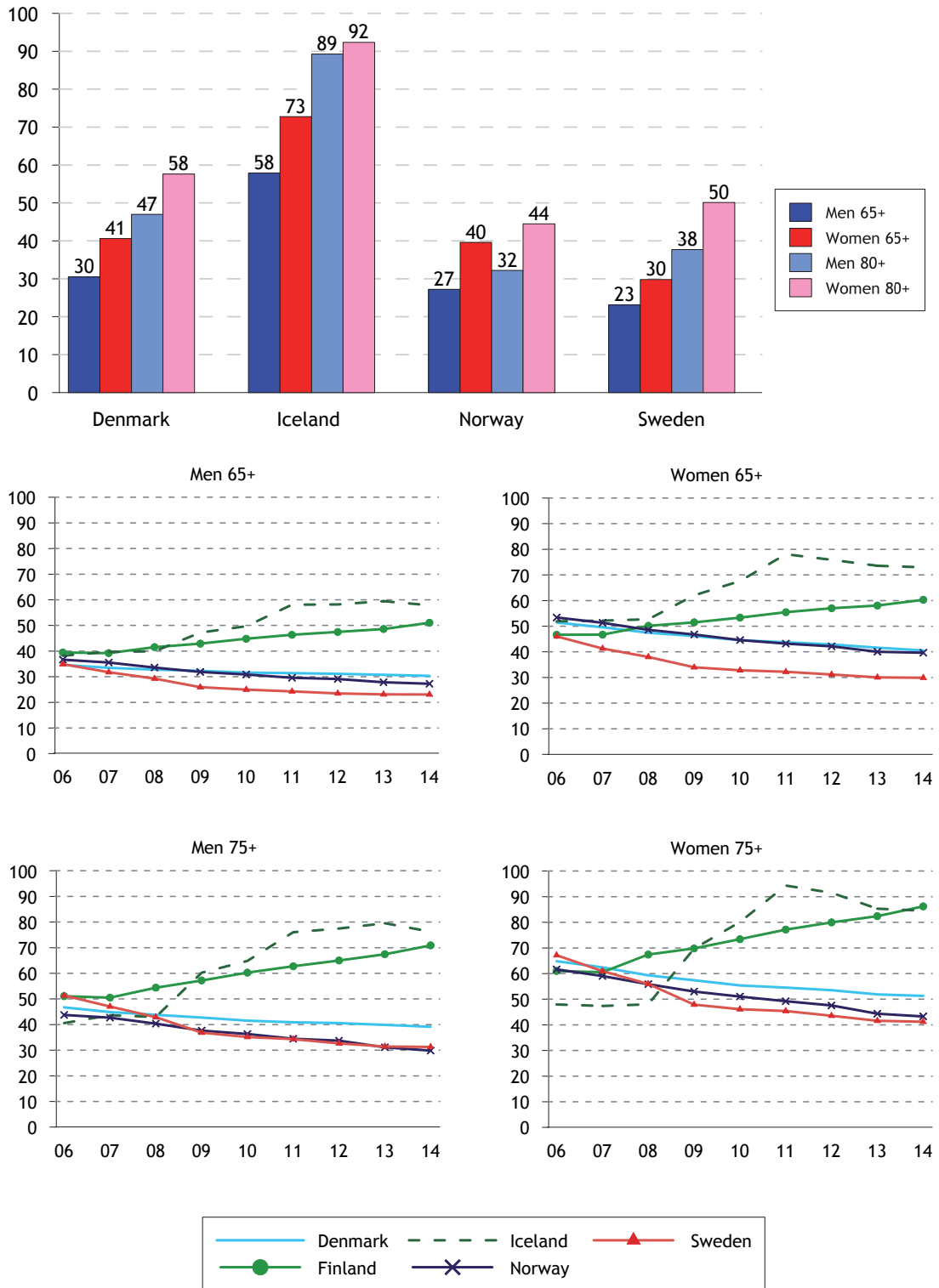


1 Data from the Norwegian Patient Register also includes patients who have been treated in open care, which means that these are not comparable with data from the other Nordic Countries

Source: The national in-patient registers

Pharmaceutical treatment

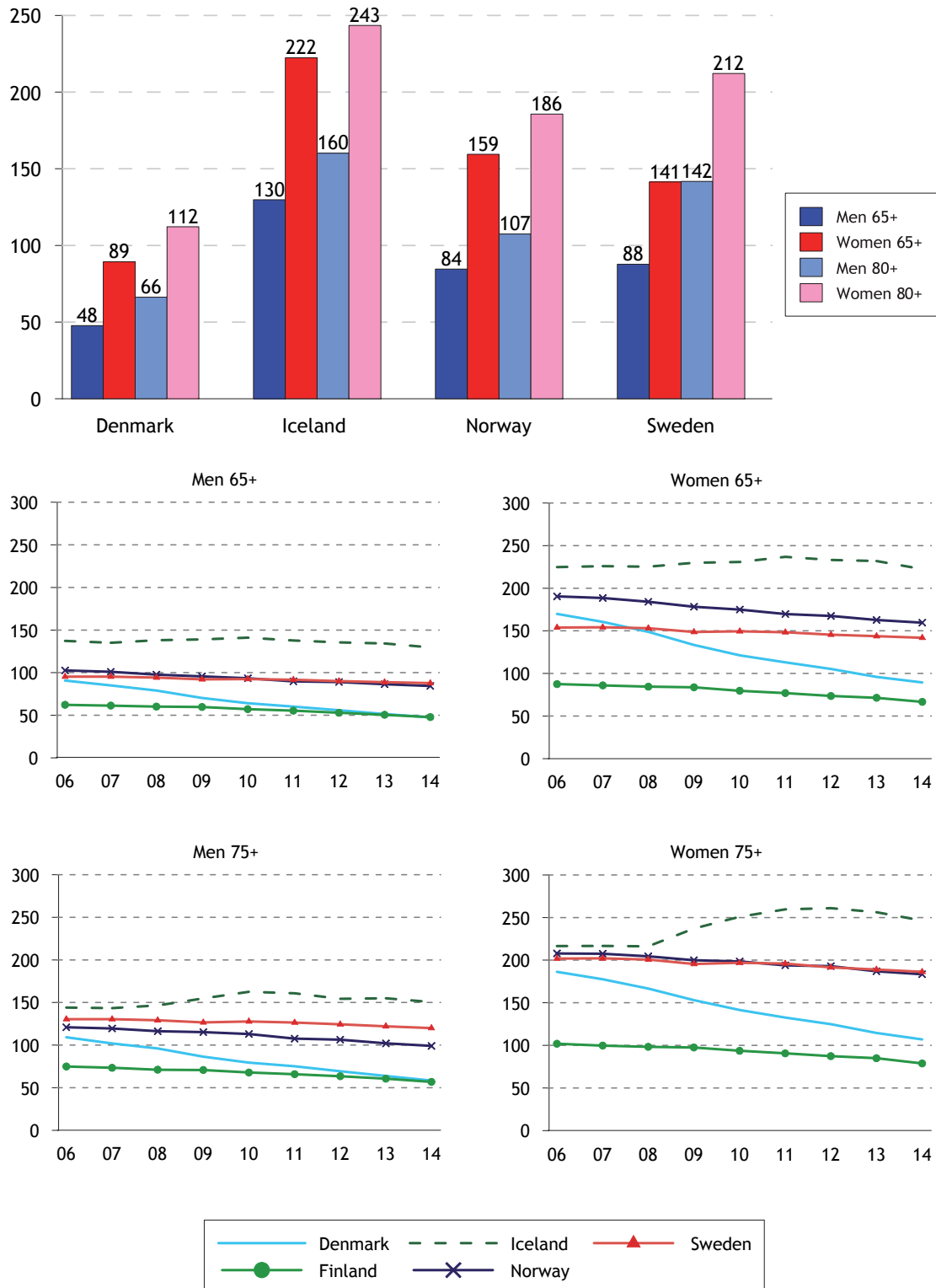
Figure 5.8.2 Prescription of antipsychotics¹, age-standardised one-year prevalence per 1 000 population, 2014 and time series 2006-2014



1 ATC: N05A

Source: The national prescription databases

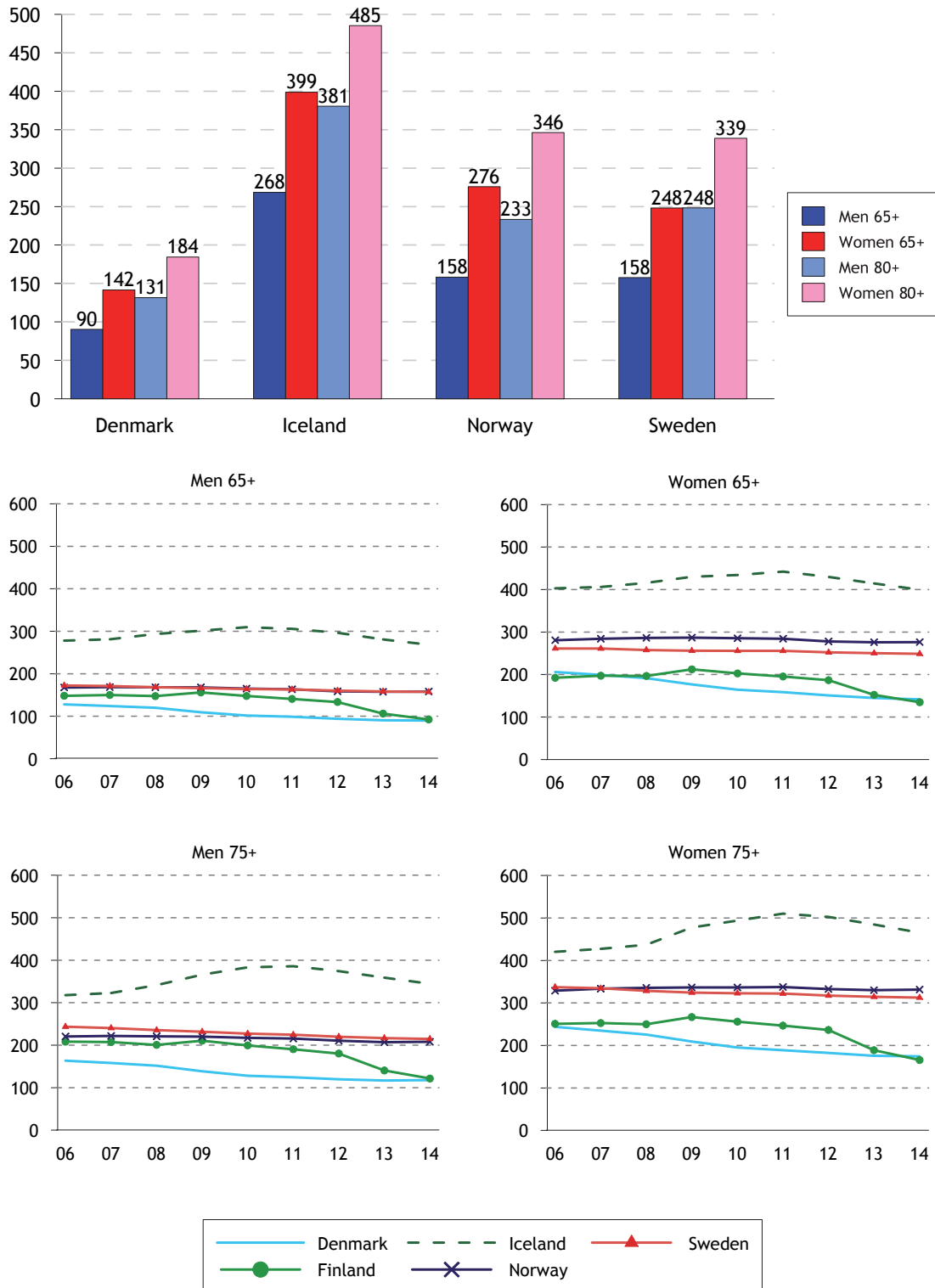
Figure 5.8.3 Prescription of anxiolytics, age-standardised one-year prevalence per 1 000 population, 2014 and time series 2006-2014



1 ATC: N05B

Source: The national prescription databases

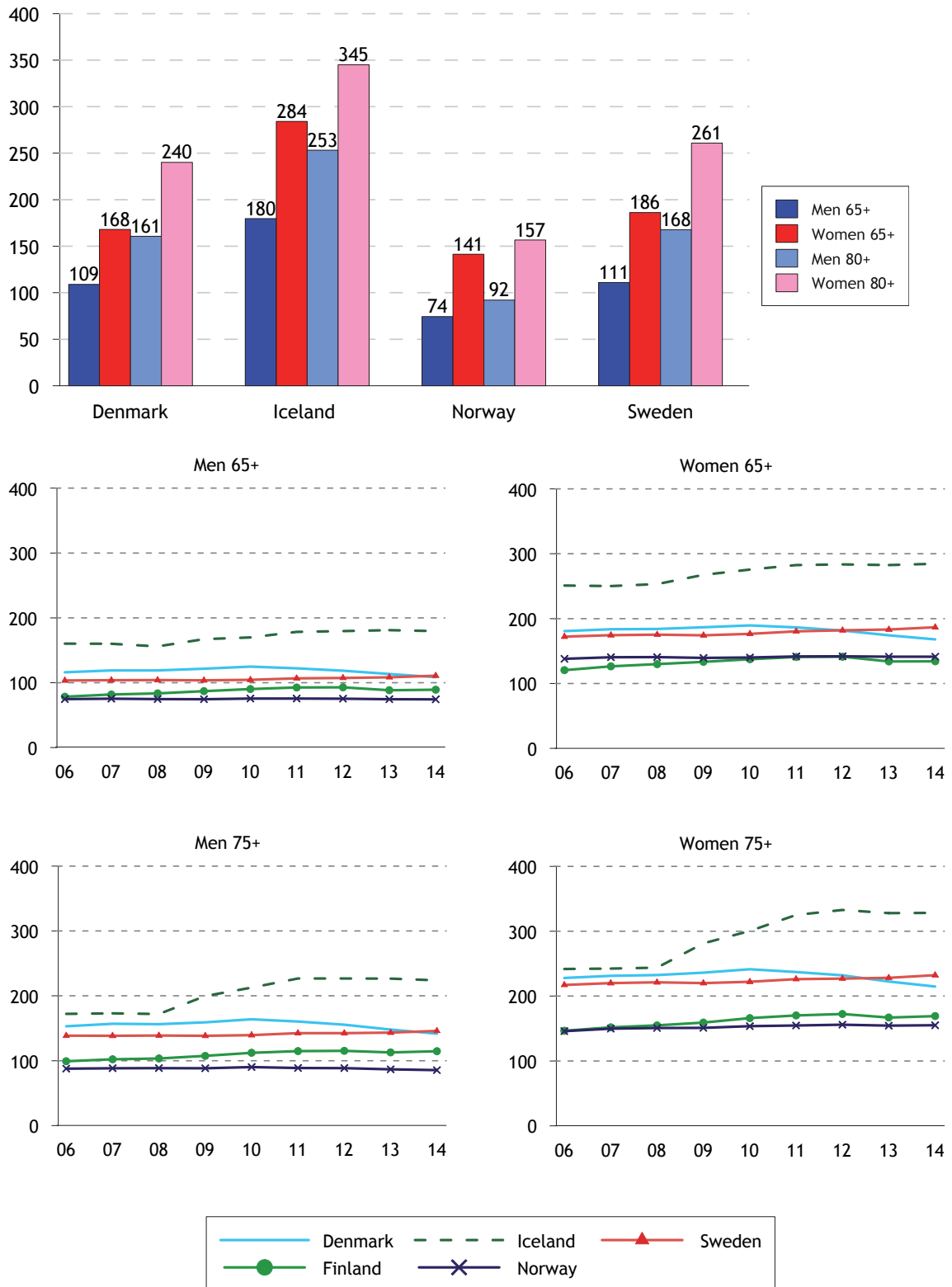
Figure 5.8.4 Prescription of hypnotics and sedatives, age-standardised one-year prevalence per 1 000 population, 2014 and time series 2006-2014



1 ATC: N05C

Source: The national prescription databases

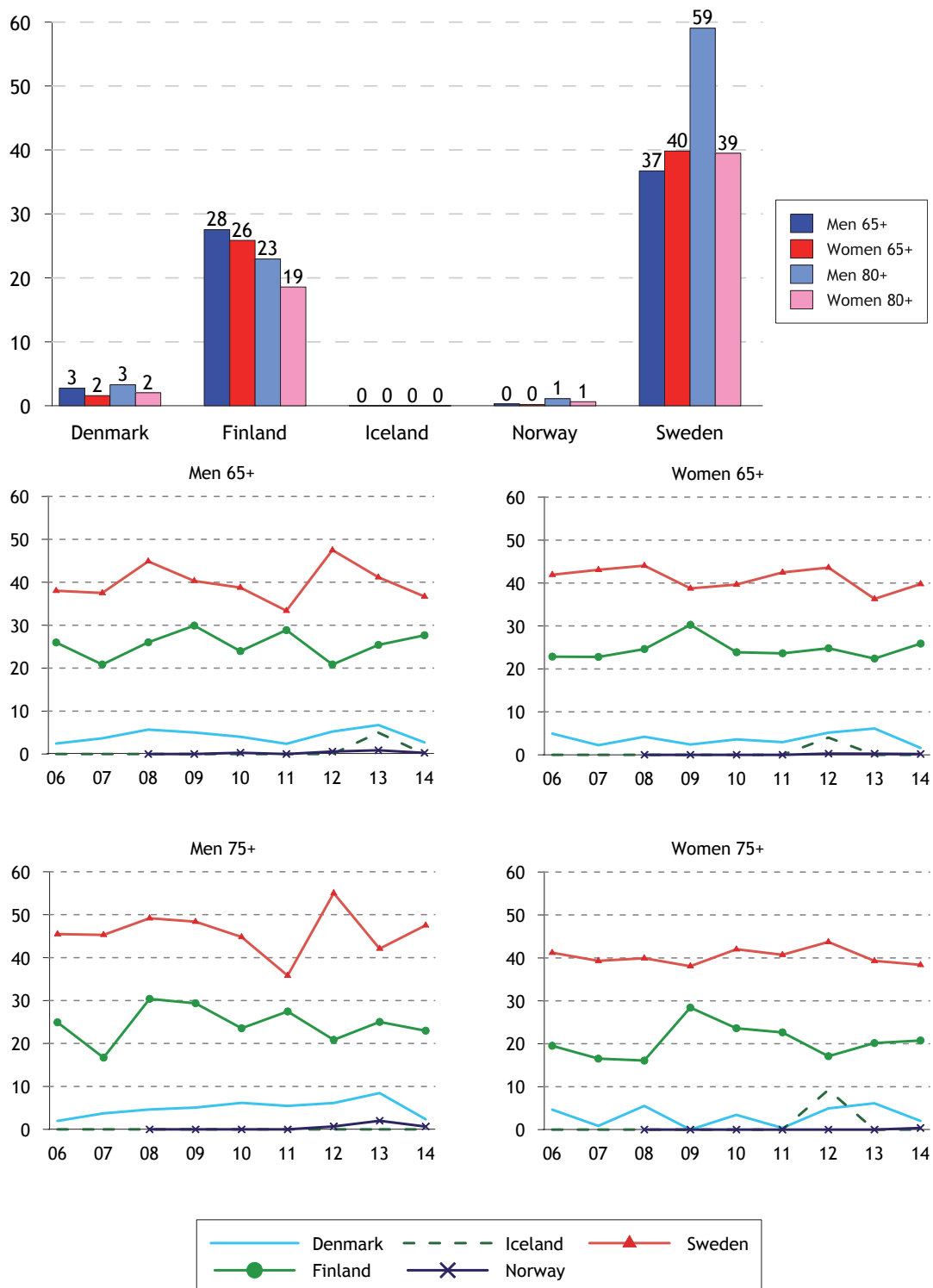
Figure 5.8.5 Prescription of antidepressants, age-standardised one-year prevalence per 1 000 population, 2014 and time series 2006-2014



1 ATC: N05C

Source: The national prescription databases

Figure 5.8.6 Patients treated for intentional self-harm¹, age-standardised number of patients per 100 000 population, 2014 and time series 2006-2014²

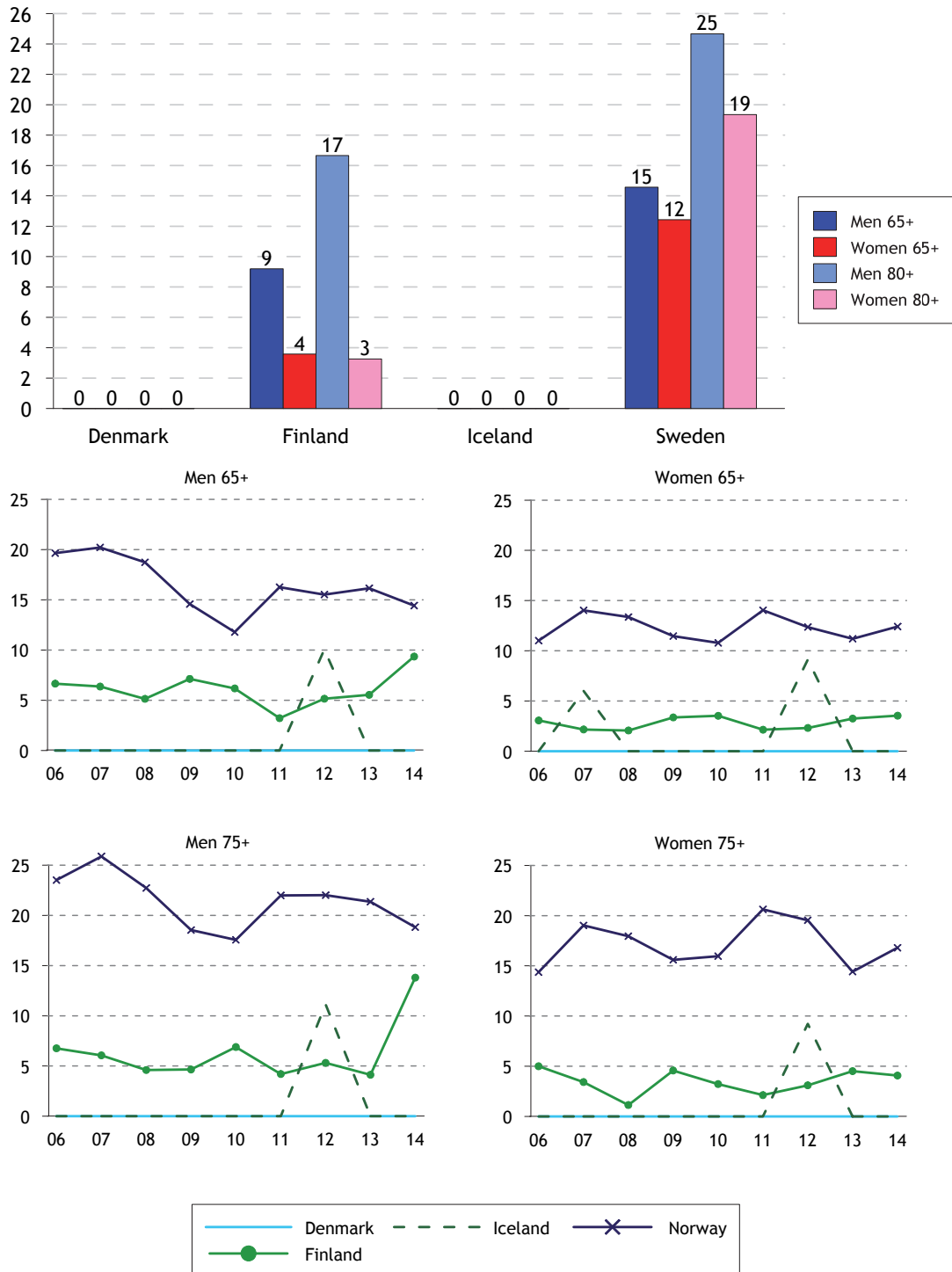


1 ICD-10: X60-X84

2 Data from the Norwegian Patient Register also includes patients who have been treated in open care, which means that these are not comparable with data from the other Nordic Countries

Source: The national inpatient registers

Figure 5.8.7 Patients treated for event of undetermined intent¹, age-standardised number of patients per 100 000 population, 2014 and time series 2006-2014²



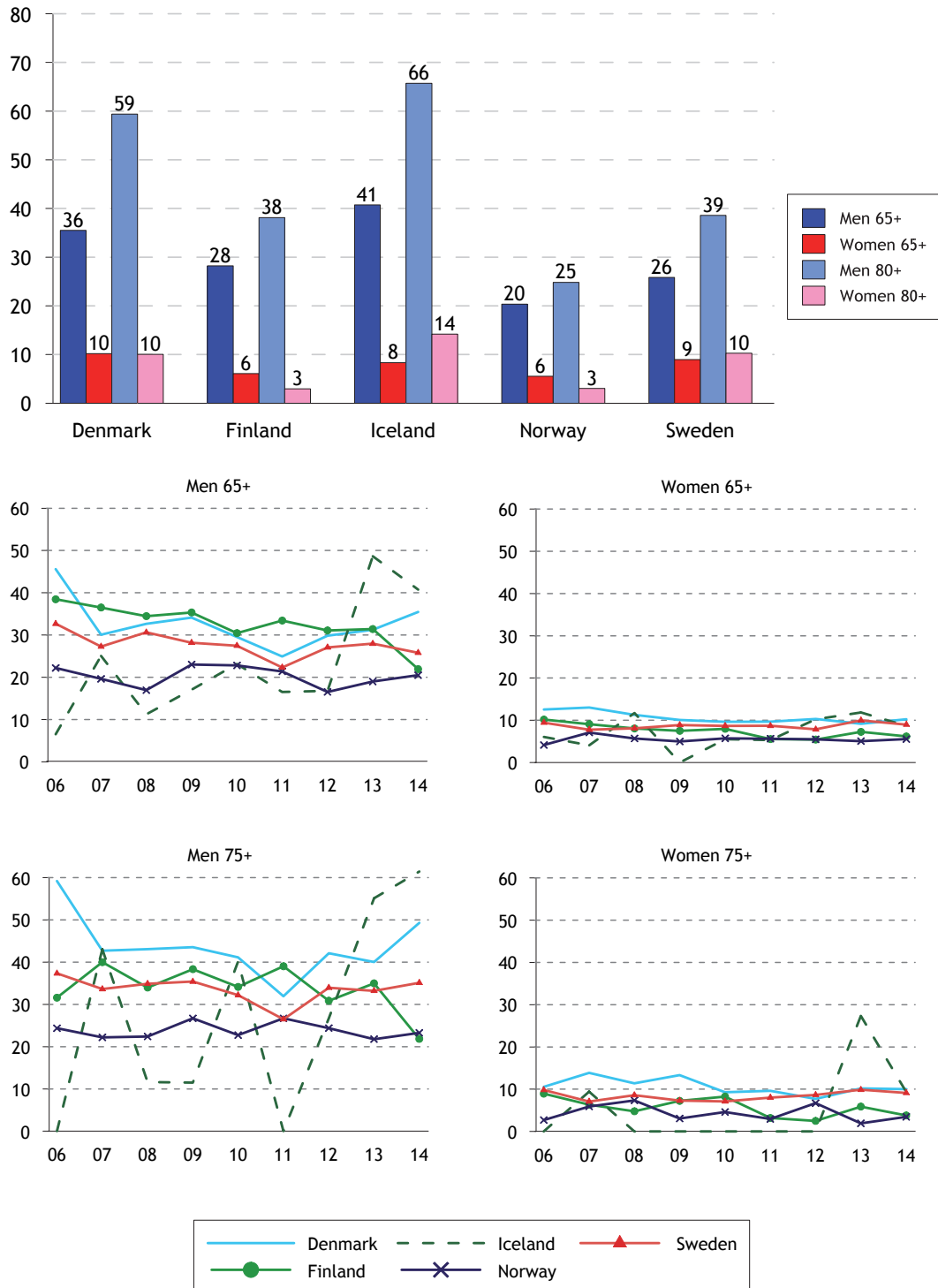
1 ICD-10: Y10-Y34

2 Data from the Norwegian Patient Register also includes patients who have been treated in open care, which means that these are not comparable with data from the other Nordic Countries

Source: The national inpatient registers

Deaths

Figure 5.8.8 Deaths due to intentional self-harm¹, age-standardised number of deaths per 100 000 population, 2014 and time series 2006-2014²

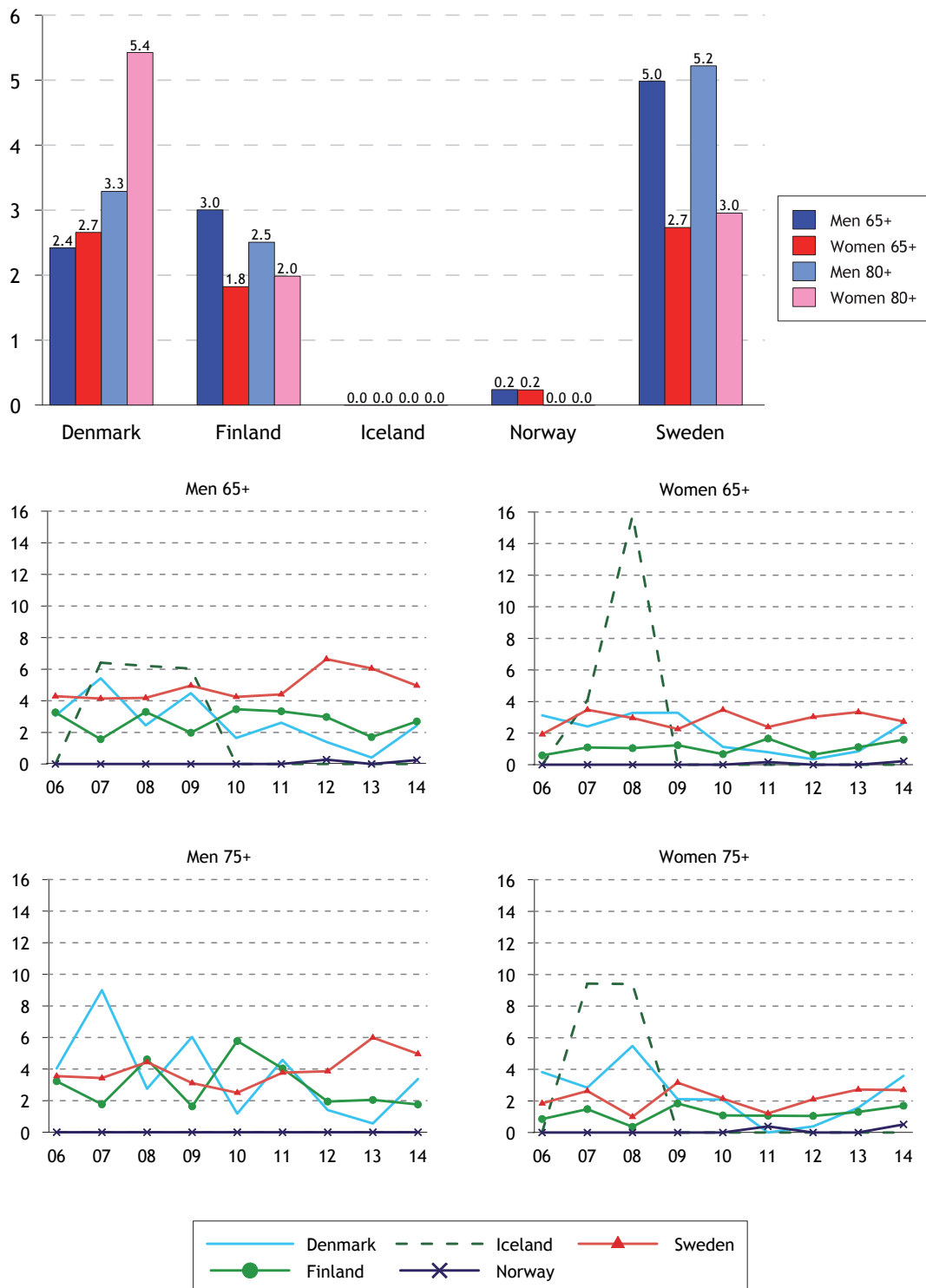


1 ICD-10: X60-X84

2 Data from the Norwegian Patient Register also includes patients who have been treated in open care, which means that these are not comparable with data from the other Nordic Countries

Source: The national registers for cause of death

Figure 5.8.9 Death due to event of undetermined intent¹, age-standardised number of deaths per 100 000 population, 2014 and time series 2006-2014²



1 ICD-10: Y10-Y34
 2 Data from the Norwegian Patient Register also includes patients who have been treated in open care, which means that these are not comparable with data from the other Nordic Countries

Source: The national registers for cause of death

5.9 Muscular and skeletal diseases

Even if many old people manage on their own up to a high age, the risk of musculoskeletal diseases with subsequent disability increases markedly with age. When the OECD in 'Health at a Glance 2015' presents the data provided by the Nordic countries about limitations in everyday activities, as shown in Table 1, some clear differences can be seen. The overall differences between countries are relatively small, but the differences between countries are much more significant when the categories 'limited to some extent' and 'greatly limited' are considered separately. Denmark and Sweden are the countries that show the highest proportions of old people with limitations in ability to perform everyday activities.

Table 5.9.1 Limitations in ability to perform daily activities in adults aged 65 years and over, 2013

	Limited to some extent	Greatly limited	Total
Denmark	27.7	7.7	35.4
Finland ¹	..	15.0	..
Iceland	9.3	15.3	24.6
Norway	13.2	10.1	23.4
Sweden	20.8	11.1	31.9

1 2012 data

Table 5.9.2 Great limitations in daily activities in adults aged 65 years and over, 2013

	Men	Women	Total
Denmark	7.5	8.0	7.7
Finland ¹	14.6	15.3	15.0
Iceland	13.9	16.7	15.3
Norway	8.4	11.9	10.1
Sweden	9.8	12.2	11.1

1 2012 data

A slightly higher proportion of women than men report they have a high level of disability (Table 5.9.2).

In Finland in 2013, nearly 14 per cent of men and over 21 per cent of women over 65 reported that only with difficulty could they walk upstairs without help.

In the Norwegian Health Study from 2012, over 13 per cent of the 65-64 age group, and over 26 per cent of the 75-84 age group reported difficulties in walking up and down stairs or walking for 5 minutes at a reasonably fast speed.

The tables relating to gonarthrosis and coxarthrosis (Figure 5.9.2) show that hospitalisation because of these is more common among women than among men, and that it is somewhat less common in the oldest age group (75+) than in the 65+ age group. The differences between the Nordic countries are small, except that Norway reports considerably more hospital treatment than other countries. Norway has also reported an increasing number of admissions for gonarthrosis in recent

years, unlike other countries which report a constant or declining trend. For coxarthrosis, there has been no change in admission frequency.

In 2013, knee replacement was generally more common for women than for men. It was also slightly more common among younger elderly (65-74 years) than in the older age group (75+). The highest number of knee replacement operations per 100 000 were carried out in Finland (Figure 5.9.3).

In 2013, the highest number of hip replacement operations per 100 000 were carried out in Norway. In all countries, the number of operations increases with age (Figure 5.9.3).

Statistics - Muscular and skeletal diseases

The figures show information for 2014 divided into gender and the 65+ and 80+ age groups. For the period 2006-2014, information is reported for the 65+ and 75+ age groups. Data for surgical interventions applies to 2013. The statistics show:

Patients discharged from hospital

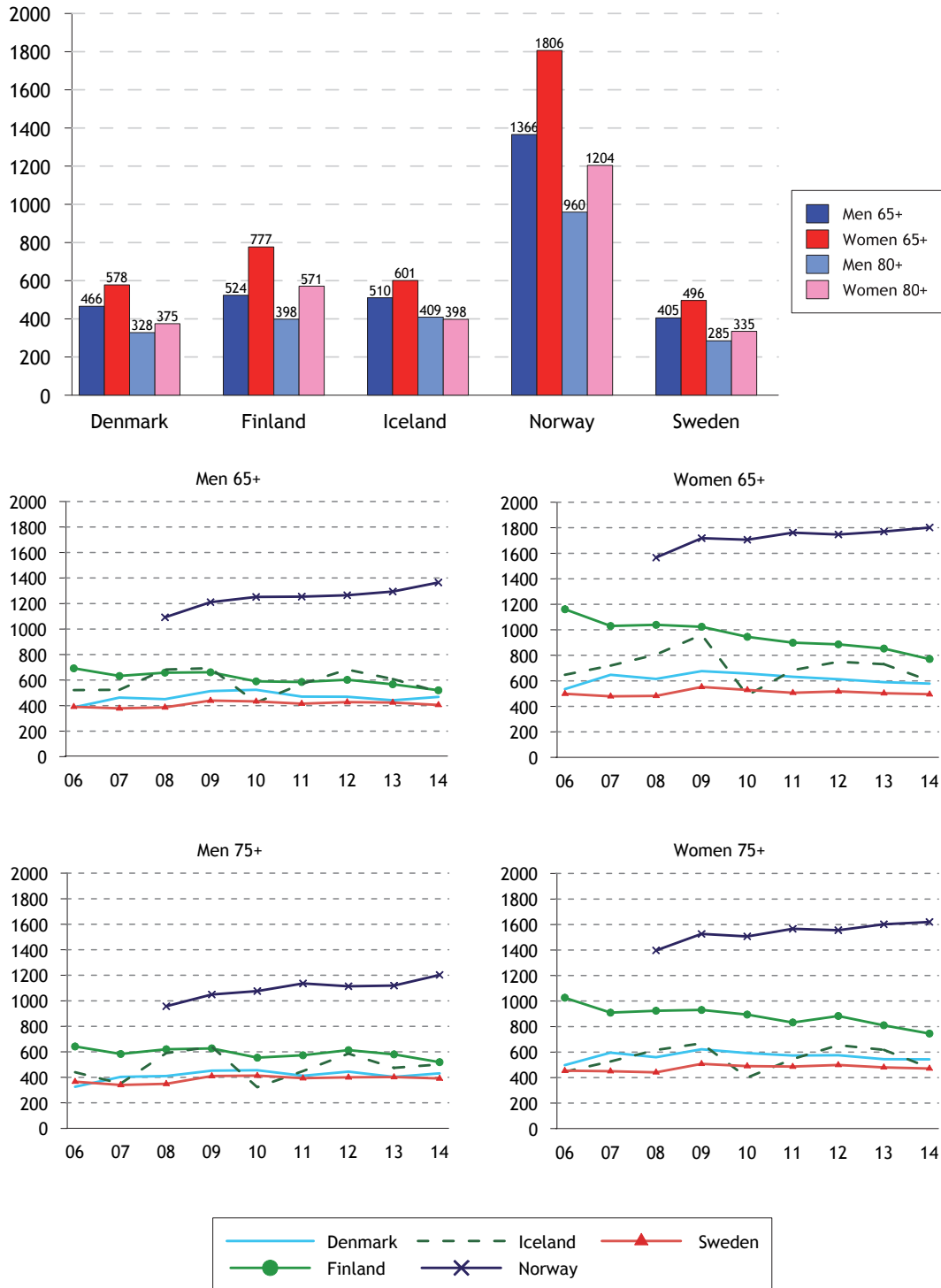
- Gonarthrosis
- Coxarthrosis

Surgical interventions

- Knee replacement
- Hip replacement

Patients discharged from hospital

Figure 5.9.1 Patients treated for gonarthrosis¹, age-standardised number of patients per 100 000 population, 2014 and time series 2006-2014²

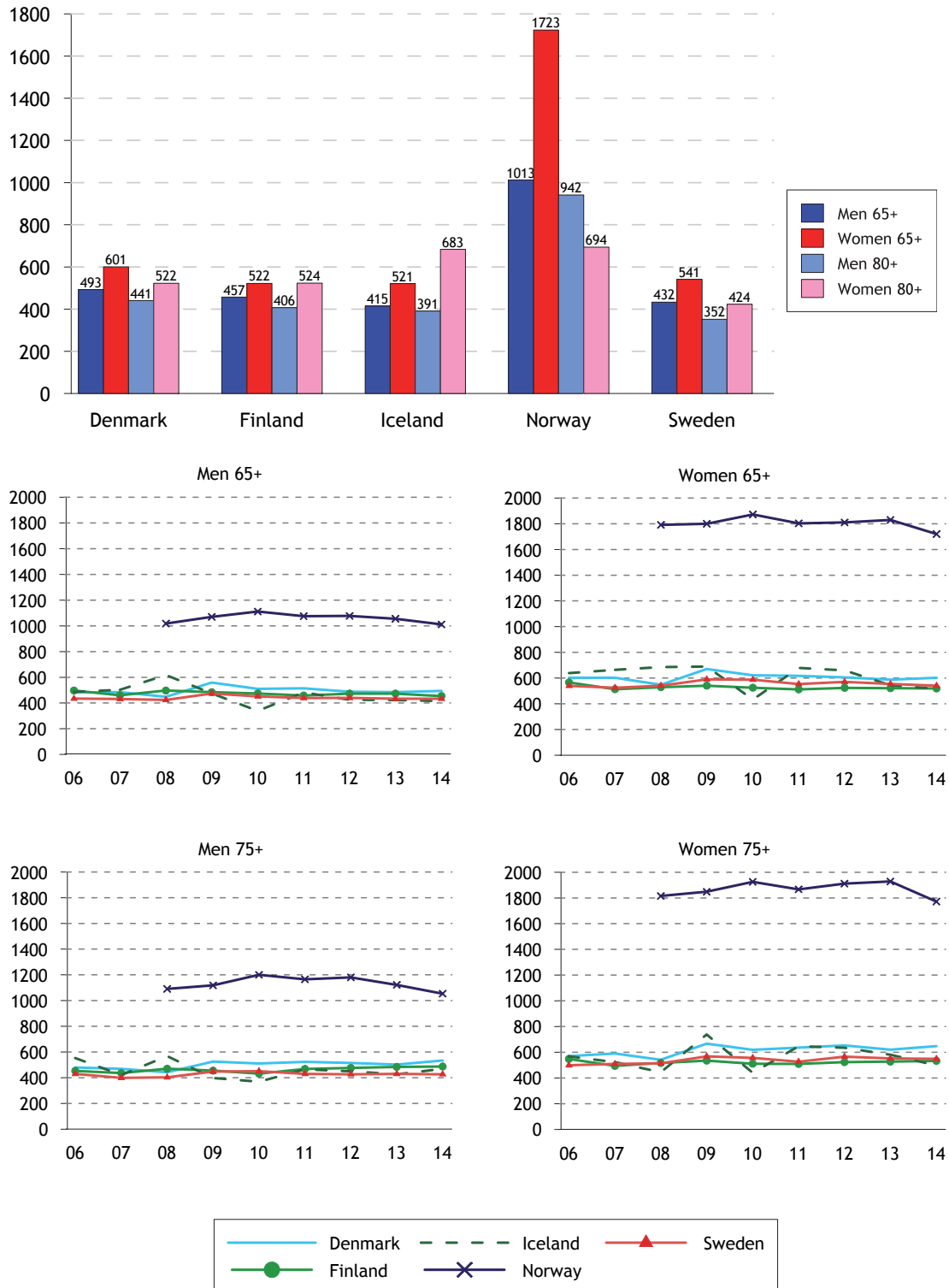


1 ICD-10: M17

2 Data from the Norwegian Patient Register also includes patients who have been treated in open care, which means that these are not comparable with data from the other Nordic Countries

Source: The national inpatient registers

Figure 5.9.2 Patients treated for coxarthrosis¹, age-standardised number of patients per 100 000 population, 2014 and time series 2006-2014²



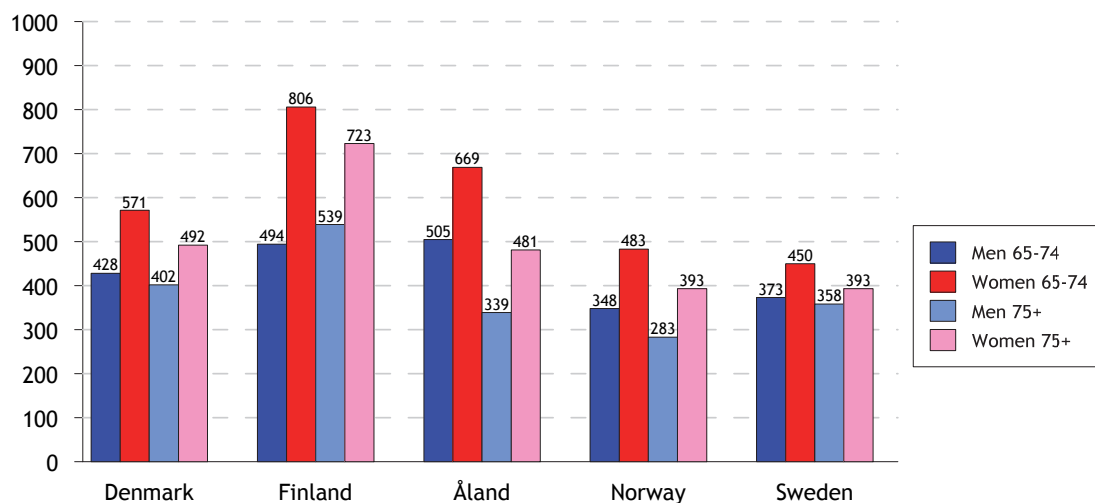
1 ICD-10: M16

2 Data from the Norwegian Patient Register also includes patients who have been treated in open care, which means that these are not comparable with data from the other Nordic Countries

Source: The national inpatient registers

Surgical interventions

Figure 5.9.3 Total knee replacement¹ by age, total numbers of procedures per 100 000 in the age group, 2013

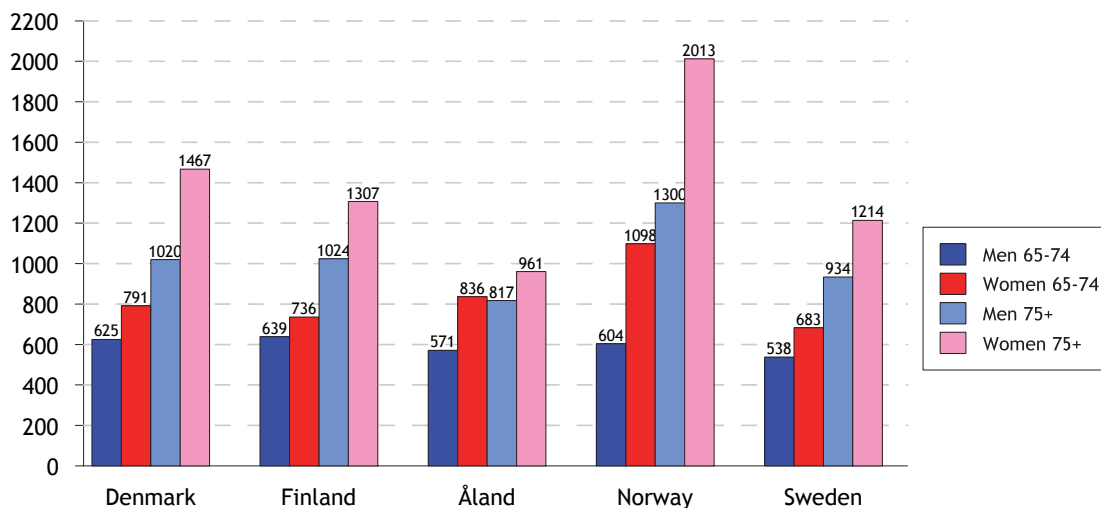


1 NCSP: NGB 20; NGB 30; NGB 40

2 Åland average 2009-13

Source: NOMESCO, Health Statistics in the Nordic Countries 2015

Figure 5.9.4 Hip replacement¹ by age, total numbers of procedures per 100 000 in the age group, 2013



1 NCSP: NFB, NFC

2 Åland average 2009-13

Source: NOMESCO, Health Statistics in the Nordic Countries 2015

5.10 Falls and hip fractures

Injuries caused by falling are the most common cause of injury among old people. Falls often result in a hip fracture which, apart from being painful, can lead to isolation and increased dependence on others. Apart from consequences in the form of lower quality of life for the individual, it can also entail major costs for society, as many old people never retain their earlier functional ability and become dependent on home-help services.

Many individual factors relating to living habits affect the risk of falling and subsequent injuries. Diet, smoking and alcohol consumption are risk factors that can lead to fall injuries, as well as blood pressure drops, underlying illnesses, low body weight and various types of medicines. Osteoporosis is a risk factor particularly relevant to women. However, physical activity reduces the risk of injury.

Apart from preventive measures directed towards these risk factors, such as physical activity, balance training, treatment of osteoporosis and medicinal review, measures such as adaptation of the surroundings, snow clearance, sanding of ice, and improved lighting have proved successful in protecting individuals from falling and injuring themselves.

The patterns are the same throughout the Nordic region in terms of gender and age. The number of people treated in hospital for hip fractures increases sharply with age, and more women than men injure their hips, regardless of age (Figure 5.10.1). Norway has the highest number of people treated for hip fractures, regardless of gender and age. The number treated per 100 000 in each population group is generally falling slowly. The changes are smallest among men in the younger age group, 65 and older (Figure 5.10.1).

Mortality through fall-related injuries does not show the same gender pattern as the number of people treated in hospital. Above all, it is in the oldest age group, 80+, that a larger proportion of men than women die. In Denmark and Iceland, there is no or very little difference between the genders. Finland generally reports most deaths resulting from fall-related injuries, and Denmark least (Figure 5.10.2). In Norway and Sweden, the number of deaths resulting from fall-related injuries has increased in the past decade, while the trend for the rest of the Nordic region is difficult to interpret (Figure 5.10.2).

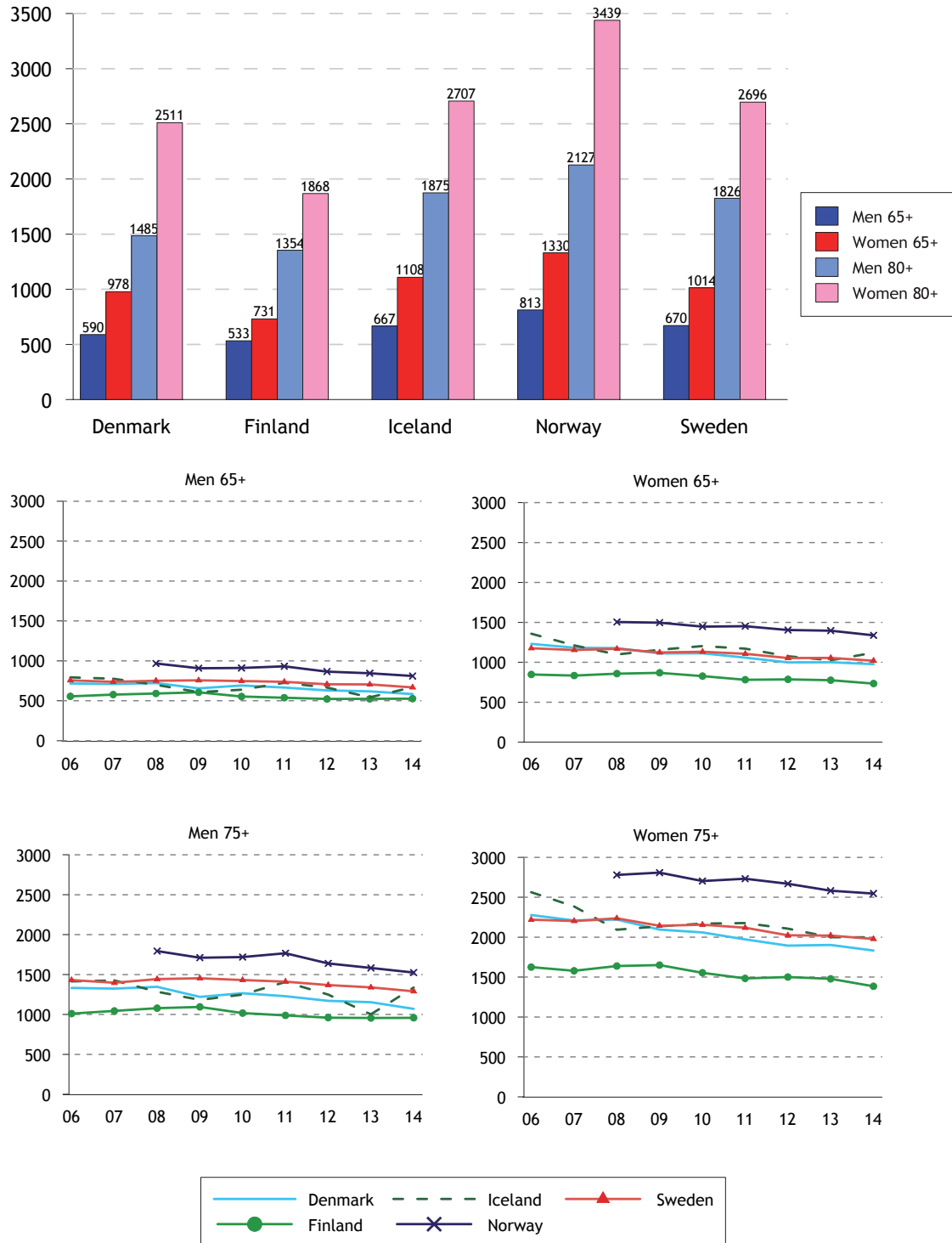
Statistics presented - Falls and hip fractures

The figures show information for 2014 divided into gender and the 65+ and 80+ age groups. For the period 2006-2014, information is reported for the 65+ and 75+ age groups. The statistics show:

- Patients discharged from hospital after hip fracture
- Deaths caused by fall-related injuries

Patients discharged from hospital

Figure 5.10.1 Patients treated for hip fracture¹, age-standardised number of patients per 100 000 population, 2014 and time series 2006-2014²



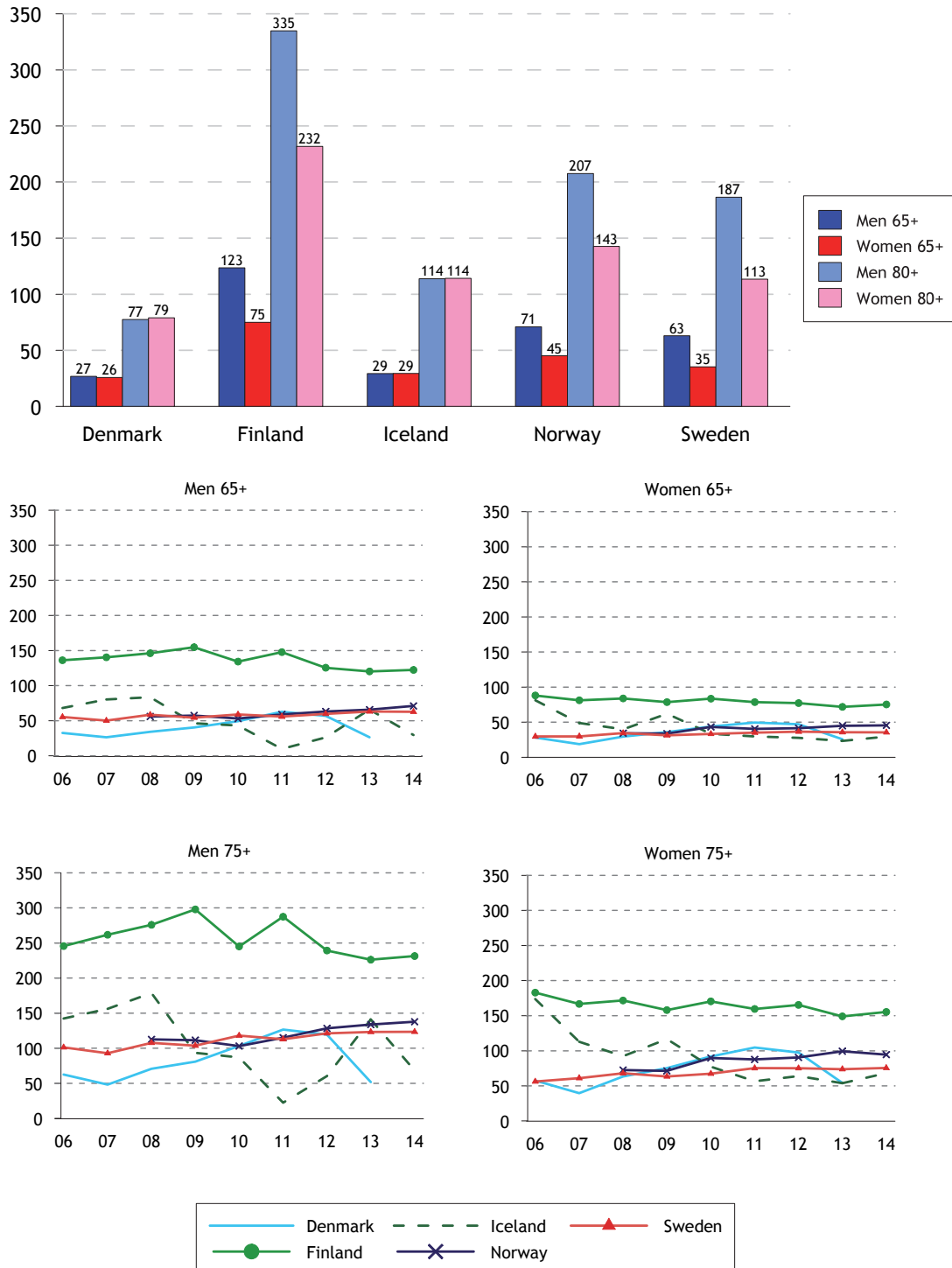
1 ICD-10: S72

2 Data from the Norwegian Patient Register also includes patients who have been treated in open care, which means that these are not comparable with data from the other Nordic Countries

Source: The national inpatient registers

Deaths

Figure 5.10.2 Deaths due to falls¹, age-standardised number of deaths per 100 000 population, 2014 and time series 2006-2014²



1 ICD-10: S72

2 Data from the Norwegian Patient Register also includes patients who have been treated in open care, which means that these are not comparable with data from the other Nordic Countries

Source: The national inpatient registers

Appendix 1

Method

This appendix begins with a detailed description of the methods used in this report, followed by a description of calculations with regard to life situations, including equivalence calculations, the purpose of compensation rates, and an outline of the recipient groups concerned.

It also describes the calculation of the income distribution used in Chapter 2, as well as the purchasing power parity used to compare social benefits throughout the publication.

Definitions

The statistics used in previous editions of *Social Protection in the Nordic Countries*, as well as in ESSPROS, primarily reflect public-transfer incomes and service measures aimed at insuring citizens in certain specific situations, including against the consequences of certain life events. The statistics also cover schemes that are compulsory for large groups of people under collective bargaining agreements or other kinds of agreements.

The focus is on current running costs. As a rule, investment spending and tax relief is not included.

Financing

Incoming funds or contributions to the financing of social expenditure are presented by source, i.e. public authorities, employers and insured individuals or households. In some cases, financing are also used to establish funds with the purpose of guaranteeing future payments. Where necessary, and depending on the rules laid down, such funds may also cover ongoing payments.

Return on investment as a form of funding mainly relates to pension funds. Where transfers to funds are made, and where money from funds has been used to finance ongoing expenditure, the net amounts are listed in the expenditure statistics.

Benefits from public authorities that are payable only to their own employees are considered benefits payable by an employer. Certain benefits payable by employers to their employees (e.g. benefits for part of a period of sickness absence) are regarded as being financed by the employer, even though in other contexts such benefits would be considered part of an employee's salary.

The social expenditure tables do not include user charges for healthcare and social services. According to the ESSPROS method of calculation, return on property investments is considered part of the financing.

Administration costs

The report treats administration costs as a single entry. In principle, only expenditure on the direct administration of social expenditure is included. However, it is not always possible to separate administration costs from other payroll or running costs.

Calculation of fixed prices

The Nordic Statistics database's consumer price index is used to calculate fixed prices.

Life situations

This publication uses the term "life situation" to describe events that affect individuals or households, e.g. childbirth, unemployment or retirement, which often entail changes to status and income.

The calculations used for life situations are designed to make country-specific data as comparable as possible. The calculations reflect the income levels for people receiving transfer incomes ("Life situations I-VII"), compared with incomes from work ("Life situation 0") in the Nordic countries. On this basis, compensation rates are calculated for different income levels, from 50 per cent up to 125 per cent of the wages of an average worker, as defined by the OECD term "AW".

A special workgroup is responsible for the calculations concerning life situations and for comparing the income distribution.

When calculating disposable income, housing benefits and payments for the day-care of children are taken into consideration. Both amounts are dependent on household income, which therefore plays a substantial role when calculating the compensation rate following a change in life situation.

With regard to social assistance, the disposable income is calculated following the deduction of rent.

The calculations on the most recent rules and legislation. For this reason, the 2016 code of practice was used for this report. However, the OECD AW is only available for 2015. As such, all of the countries, with the exception of the Faroe Islands, have used national wage indexes to update the OECD 2015 AWs to 2016 prices, cf. the table below:

Calculation of an AW for 2016

		AW 2015	Wage index 2016	Estimated AW 2016
Denmark	DKK	403 600	1.017	410 614
Faroe Islands ¹	DKK	341 751	1.021	348 995
Finland	EURO	43 382	1.012	43 901
Iceland	ISK	7 416 000	1.150	8 496 000
Norway	NOK	557 800	1.015	566 200
Sweden	SEK	414 105	1.024	424 044

1 The source for the Faroe Islands is Statistics Faroe Islands, which calculates AW figures on an annual basis

A description follows of the most important factors in calculating life situations.

Employer costs

In order to present a clear picture of overall taxation in the Nordic countries in terms of income tax and social contributions, the calculation includes employer costs, i.e. gross wages plus statutory social contributions (the assumption is that the individual concerned works in the private sector). As a result, two accounts of net income (i.e. gross wages minus income tax and social contributions payable by the employee) have been prepared: net income in relation to employer costs; and net income in relation to gross wages. In addition, the net income after payment of rent has been included in order to calculate the life situation with regard to social assistance.

For Denmark, employers' statutory social contributions cannot be calculated. However, it is estimated that for an employee with a salary that corresponds to an AW, the contributions constitute approx. 1.5 per cent of the salary. This estimate is only used in calculations of "Life situation 0" for single people earning wages corresponding to that of an AW. The calculations of lowest AW values do not include social assistance, even though people with such an income would be entitled to it.

Tax payment

The calculation uses average national rates of taxation, i.e. average local authority rates of taxation, including average church tax percentages, as well as the state tax.

Gross income

Gross income consists of income from work, and excludes, e.g. child allowance and housing benefit.

Disposable income

Disposable income is calculated as gross income plus child allowance and housing benefit, minus income tax, social security contributions payable by employees and charges payable for day-care institutions. For Denmark, Finland and Sweden, the social security contributions payable by employees include contributions to the voluntary unemployment insurance scheme, in the form of membership fees paid to unemployment funds. The calculations do not, include union contributions.

Disposable incomes are calculated on a yearly basis, both for people in work and for those receiving various social benefits. The calculations are based on the assumption that those concerned receive social benefits throughout the year, even where this is not the case (e.g. parental benefit). The listed incomes per month are the annual amounts divided by 12.

Equivalent disposable income

In order to enable comparisons between households of different sizes, a household's disposable income is usually divided by an equivalent weight. In this publication, the modified OECD scale (also used in EU-SILC) is applied.

On this scale, the first adult in the household is assigned a weight of 1. Any other adults are assigned a weight of 0.5. Children between 0-13 years are weighted at 0.3, whereas older children are weighted at 0.5.

Therefore, for a couple with two young children, the equivalent weight is $1+0.5+0.3+0.3 = 2.1$.

If the annual disposable income of a household is DKK 500 000, the equivalent disposable will be: $500\ 000/2.1 \approx \text{DKK } 238\ 000$.

Compensation rate

The compensation rate calculates the remaining income following the change in life situation (e.g. in the event of unemployment, income in the form of unemployment benefits), in relation to the income one would have earned from work had the change not occurred. This gives the equivalent disposable income and the compensation rate is given in per cent.

Compensation rate = $100 * \text{equivalent disposable income after the incident} / \text{equivalent disposable income before the social event}$.

Children's ages and use of day-care

Child allowances and charges payable for day-care are calculated based on the following family types:

- A single parent with an infant of 0 years, i.e. childbirth as a life event
- A single parent with a child attending day-care. The age of the child is five years old
- A couple with two children aged five and eight, i.e. a child attending daycare and a child attending school but in need of after-school care

For Denmark and Sweden, charges payable for day-care are calculated based on average charges and the national rules governing payments. For the Faroe Islands, calculations are based on the rates that apply in Torshavn. In Finland, it is assumed that other children of preschool age also make use of daycare facilities, albeit on a part-time basis only. For Iceland, calculations are based on the rates that apply in Reykjavík; for Norway, the rates that apply in Oslo.

In all of the calculations of life situations, with the exception of “Life situation I”, it is assumed that the children are attending day-care. For child allowances, the calculation includes child maintenance to single parents (corresponding to the amount of the contributions payable in advance by the public authorities), in addition to the actual child allowance to single parents and couples with children (see Chapter 3).

Housing costs and housing benefits

In all cases, it is assumed that the families live in rented accommodation. The amount of the housing costs/rent depends solely on family type, and is independent of the income level. Housing costs include rent payments. For the life situation involving social assistance, heating costs are also included.

It has not been possible to determine the amount of rent for the individual family types in a manner that is consistent across all of the countries. In some countries, the rent is based on an estimate of the amount spent on rented accommodation per family type, as well as the national average rent per square metre. In others, it is based on survey data of rents for various family types in certain local authorities.

With the exception of the life situation involving social assistance, the rent for the individual family types is merely used to calculate the amount of any housing benefit - the rent itself is not included in the calculation of the disposable income.

The rents in Iceland are based on data that applies only to Reykjavik. For Norway, the rents are based on the data for Oslo in the first quarter of the relevant year. In this case, the assumption is that the rent depends on the size of the family. Furthermore, housing benefits are estimated by means of Husbanken's housing benefit calculator. It also uses the Oslo rates.

Outline of life situations, 2016

The table below describes the various life situations used in this publication.

	Single parent with one child	Single person with no children	Couples with two children	Couples with no children
Life situations 0 Income and tax in life situations for an AW	Single parent with one child. AW 50%, AW 75%, AW 100% and AW 125%	Single person with no children. AW 50%, AW 75%, AW 100% and AW 125%	Couple with two children. AW 50/75%, AW 75/100% and AW 100/125%	Couple with no children. AW 50/75%, AW 75/100% and AW 100/125%
Life situation I Compensation rate concerning childbirth	Single parent with a new-born child drawing daily cash benefits, in relation to a single childless person in work. AW 50%, AW 75%, AW 100% and AW 125%		Couple with two children (aged 5 and 8) other than the newborn, where the person earning the lowest income draws daily cash benefits, in relation to a couple with two children (aged 5 and 8), where both adults are in work. AW 50/75%, AW 75/100% and AW 100/125%	Couple with a new-born child where the person earning the lowest income draws daily cash benefits, in relation to a childless couple where both work. AW 50/75%, AW 75/100% and AW 100/125%
Life situation II Compensation rate in life situation concerning unemployment for insured individuals	Single parent with one child drawing unemployment benefits, in relation to a single parent in work with one child. AW 50%, AW 75%, AW 100% and AW 125%	Single childless person drawing unemployment benefits, in relation to a single childless person in work. AW 50%, AW 75%, AW 100% and AW 125%	Couple with two children (aged 5 and 8) where the person earning the lowest income draws unemployment benefits, in relation to a couple with two children (5 and 8 years), where both adults work. AW 50/75%, AW 75/100% and AW 100/125%	Childless couple where the person earning the lowest income draws unemployment benefits, in relation to a childless couple where both adults work. AW 50/75%, AW 75/100% and AW 100/125%
Life situation III Compensation rate in life situation concerning unemployment for uninsured individuals		Single childless person drawing social assistance, in relation to a single childless person in work. AW 50%, AW 75%, AW 100% and AW 125%. It is assumed that the person is at least 30 years of age		

Continues

continued

	Single parent with one child	Single person with no children	Couples with two children	Couples with no children
Life situation IV Compensation rate in life situation concerning sickness	.	Single childless person drawing sickness benefits, in relation to a single childless person in work	.	.
Life situation V Compensation rate in life situation concerning retirement pension	.	Single childless person receiving retirement pension, in relation to a single childless person in work. AW 0 (assuming that the person in question has never been in work), AW 50%, AW 75%, AW 100% and AW 125% (assuming that the person in question has been in work for 40 years)	.	.
Life situation VI Compensation rate in life situation concerning disability pension	.	Single childless person receiving disability pension (pensionable age 50 years), in relation to a single childless person in work. AW 0 (assuming that the person in question has never been in work), AW 50%, AW 75%, AW 100% and AW 125% (assuming that the person in question has been in work for 25 years)	.	.
Life situation VII Compensation rate in life situation concerning social assistance	Single parent with one child drawing social assistance, in relation to a single parent in work with one child. AW 0%	Single childless person drawing social assistance, in relation to a single childless person in work. AW 0%	Couple with two children (aged 5 and 8), where the person earning the lowest income draws social assistance, in relation to a couple with two children (aged 5 and 8), where both adults work. AW 0%. It is assumed that neither adult has paid work or any other income-substituting benefits	Childless couple where the person earning the lowest income draws social assistance, in relation to a childless couple where both adults work. AW 0%. The partners have neither any income from work nor any other income-related benefits

Calculations of income distribution

The basis of the calculations in the tables on income distribution and poverty is detailed below.

EU-SILC's definitions

The first EU-SILC survey appeared in 2004, with income data for 2003. Data is now available from 2010-2015, covering income from the years 2010-2014.

Surveys are used to gather data relating to people aged 16 and over living in private households.

People at risk of poverty are defined as the percentage share of the population with an equivalent disposable income that is less than 60 per cent of the corresponding median income.

For each person, the equivalent disposable income is defined as his/her disposable household income, divided by the equivalent weight of the household.

The total disposable household income is calculated by adding together all of the household members' personal incomes, plus any other income at household level. The disposable household income is divided by members' equivalent weight in order to arrive at a standard financial measure that makes households with different compositions of adults and children more comparable.

The disposable income consists of a household's total income after tax, including social cash benefits. According to EUROSTAT's definitions, the disposable income does not include capital yield.

Other income, such as interest and dividends, is included. Capital income, e.g. due to the sale of stocks and shares, is not included. Social cash benefits cover disability, old-age and survivor's pensions and other family allowances, child allowances, parental benefits, maintenance advances, housing benefits and other social benefits. Interest income from housing was not included until 2007 for the financial year 2006. However, earlier years were included for Denmark.

Statistics Faroe Islands calculated the income distribution in the Faroe Islands according to the method described here.

Households

A household consists of individuals living together and sharing the household economy. EU-SILC does not include people living in institutions/nursing homes, prisons, etc. A household may also consist of other family types.

Single people

One-person households consist of one adult (aged over 17) and any children living at the same address, irrespective of the children's ages.

Cohabiting couples

Cohabiting couples consist of 2 adults (over 17 years) and any children living at the same address, irrespective of the children's ages. This group also includes households with more than two adults.

Children

The age limit for dependent children has been fixed at 16 years (0-16). People aged 17-24 who are financially inactive and who live in the same household as at least one parent also count as dependent children

Purchasing power

The definition of *Purchasing power parities* (PPP) is the currency-conversion factor corresponding to the purchasing power of the individual currencies. They are used to calculate figures expressed in *purchasing power standards* (PPS¹). In other words, a certain amount, converted from different currencies by means of PPP¹ factors, will buy the same amount of goods and services in all of the countries. Following conversion, figures are expressed in PPS¹.

PPS¹ calculations are used to compare social expenditure and compensation rates for life situations, as described above.

Purchasing power parities (PPP) for the Nordic countries, 2015 and 2016

	PPP 2015	PPP 2016
Denmark	9.84	9.89
Faroe Islands	9.84	9.89
Finland	1.22	1.24
Iceland	186.59	192.73
Norway	12.86	13.71
Sweden	11.99	12.28

Source: OECD

The PPS calculations in this report are in PPS (EU27=1) with regard to private consumption (based on 2015 estimates). An independent PPS has not been calculated for the Faroe Islands. For this reason, this publication uses Danish PPS, as both countries use the same currency.

Comparing the Nordic countries with other countries

The introduction to each chapter includes a table of relevant social expenditure in relation to GDP.

When comparing social expenditure in the Nordic countries with that of other EU member states, it must be noted that social cash benefits are often subject to tax in the Nordic countries, whereas parts of these benefits are exempt from tax in the

other EU countries. In addition, several countries offer tax relief (tax reductions) for families with children, but this is not identified as social expenditure.

It should also be noted that the boundaries between the social and the education sectors vary from country to country. For example, in some European countries children start school at an earlier age, which makes it difficult to compare expenditure on the minding of preschool children.

The OECD and EUROSTAT are in the process of developing models for the calculation of net social expenditure after tax (see Figure 9.2).

Note also that the OECD calculations of expenditure in the healthcare sector differ considerably from the calculations in the ESSPROS system and in this report. In ESSPROS, efforts are made to obtain the most precise data possible on expenditure on social services to the elderly and the disabled. However, in the OECD statements in *A System of Health Accounts*, these figures come under health expenditure. In addition, expenditure in ESSPROS is based on net calculations, while the OECD statements are based on gross expenditure (i.e. including investments, user charges, etc.).

Other factors

Norway started using the national accounts as the basis for calculations of social expenditure in 2002, Iceland in 2007. This means that social expenditure from 2001 (Norway) and 2006 (Iceland) and earlier cannot be accurately compared with the data for later years. See the 2004 report for a detailed description of the earlier situation in Norway.

Appendix 2

Annual adjustment of social benefits

Rules for adjustment of transfer incomes

Faroe Islands

There are three different systems for the adjustment of transfer income in the Faroe Islands. Adjustments to the level of pay are agreed by the private sector, and consist of setting the level of payments in the event of unemployment and sick leave. Payments in the event of social assistance and rehabilitation are also derived from this. Payments from the solidary pension scheme to the elderly are adjusted by the overall level of payment. Other social security transfers are adjusted in accordance with current legislation. At present, the level of adjustment is zero. The maximum payment in the event of parental leave or unemployment, as well as the tax-free part of the basic old-age pension, is not adjusted.

Finland

In Finland, benefits are broadly protected by indices. Practically all basic social security benefits, with the exception of housing supplements for students, are linked to the national pension index. Benefits are adjusted each January by the national pension index, which reflects the price level of the previous year. The national pension index follows the cost-of-living index, which is calculated by Statistics Finland on the basis of the prices of essential goods. Most benefits linked to the national pension index are adjusted at the beginning of the year by an index-point figure set by the Social Insurance Institution.

All earnings-related pensions in payment are adjusted annually in line with the earnings-related pension index, in which wage-earners' income level is weighted at 20 per cent, while the change in price level is weighted at 80 per cent. When calculating a new employment pension, the previous earnings are adjusted to the level of the year of retirement by means of a wage factor - wage changes are weighted at 80 per cent, while price increases are weighted at 20 per cent.

Norway

The old-age pension payable by the Social Insurance Scheme is calculated on the basis of the basic amount. In 2011, as part of the pension reform, new adjustment rules were introduced that apply both to the basic amount and to the pension payable by the Social Insurance Scheme. The basic amount is fixed by Parliament and adjusted annually from 1 May to reflect the wages of those in active employment. As of 1 May 2015, the basic amount was NOK 90 068; as of 1 May 2016, it was NOK 92 576. The

rules are based on predicted wages in the adjustment year, adjusted for any deviation between the predicted and actual wages in the previous two years. The adjustment basis is agreed between the national government and pensioners', disabled people's and professional organisations. Old-age pensions are first adjusted by the income development (basic amount), from which 0.75 per cent is then deducted when the pension amount reaches a certain point above the minimum level. The lowest pension levels are adjusted to reflect prevailing income trends, and then adjusted based on current life expectancy for 67-year-olds.

Disability pension is calculated on the basis of any previous pensionable income and the basic amount of the Social Insurance Scheme.

The temporary Social Insurance Scheme benefit, *arbeidsavklaringspenger* (work-clarification benefit), is calculated on the basis of a recipient's previous pensionable income. The benefit is adjusted annually in line with the changes in the basic amount from the Social Insurance Scheme.

Sickness benefits are not adjusted during a period of sickness absence. Consequently, they are not adjusted in the event of changes to an ill person's wage/salary level or the basic amount during his/her sickness benefit period.

The income basis used to set daily cash benefits in the event of unemployment is fixed for the entire period at the transition to unemployment benefits, and is not affected by changes in the general income level in society.

Financial social assistance is a means-tested benefit that is calculated both specifically and individually. Government guidelines for the calculation of support for maintenance (financial social assistance) are provided to adults and children in different age groups. The Ministry evaluates and revises the guidelines on an annual basis.

Appendix 3

Further information

Further information on Nordic social security systems and statistics in the Nordic countries is available from the following bodies in the respective countries:

DENMARK

Danmarks Statistik (Statistics Denmark)
www.dst.dk

Arbejdsmarkedets Tillægspension (The Labour Market Supplementary Pension Scheme)
www.atp.dk

Sundhedsstyrelsen (The Danish Health and Medicines Authority)
www.sst.dk

Social- og Indenrigsministeriet (The Ministry of Social Affairs and the Interior)
www.sim.dk

SFI - Det Nationale Forskningscenter for Velfærd (The Danish National Centre for Social Research)
www.sfi.dk

Ankestyrelsen (The National Social Appeals Board)
www.ast.dk

Beskæftigelsesministeriet (The Ministry of Employment)
www.bm.dk

Styrelsen for Arbejdsmarked og Rekruttering (The Danish Agency for Labour Market and Recruitment)
www.star.dk

Udbetaling Danmark (Payments Denmark)
www.udbetalingdanmark.dk

THE FAROE ISLANDS

Almannamálaráðið
(Ministry of Social Affairs)
www.amr.fo

Hagstova Føroya (Statistics Faroe Islands)
www.hagstova.fo

FINLAND

Folkpensionsanstalten (The Social Insurance Institution of Finland)
www.kela.fi

Social och hälsovårdsministeriet (The Ministry of Social Affairs and Health)
www.stm.fi

THL - National Institute for Health and Welfare
www.thl.fi

Statistikcentralen (Statistics Finland)
www.stat.fi

Pensionsskyddscentralen (Finnish Centre for Pensions)
www.etk.fi

Arbets- och näringsministeriet (Ministry of Employment and the Economy)
www.tem.fi

ICELAND

Hagstofa Íslands (Statistics Iceland)
www.statice.is

Vinnumálastofnun (Directorate of Labour)
www.vinnumalastofnun.is

Landssamtök Lífeyrissjóða (Icelandic Pension Funds Association)
www.ll.is

Tryggingastofnun Ríkisins (Social Insurance Administration)
www.tr.is

Velferðarráðuneytið (Ministry of Welfare)
www.velferdarraduneyti.is

NORWAY

Statistisk sentralbyrå (Statistics Norway)
www.ssb.no

Arbejds- og sosialdepartementet (Ministry of Labour and Social Affairs)
www.regjeringen.no/asd

Arbeids- og velferdsdirektoratet (Norwegian Labour and Welfare Administration)
www.nav.no

SWEDEN

Socialdepartementet (Ministry of Health and Social Affairs)
www.regeringen.se

Socialstyrelsen (The National Board of Health and Welfare)
www.sos.se

Försäkringskassan
www.forsakringskassan.se

Statistiska centralbyrån (Statistics Sweden)
www.scb.se

Inspektionen för arbetslöshetsförsäkringen, IAF (The Swedish Unemployment Insurance Board)
www.iaf.se

Skolverket (The Swedish National Agency for Education)
www.skolverket.se

Pensionsmyndigheten (The Swedish Pensions Agency)
www.pensionsmyndigheten.se

NOSOSCO publications since 2000

Recurrent publications

Every year, NOSOSCO publishes *Social Protection in the Nordic Countries*.

Theme publications

Microsimulation in Nordic Social Policy Analysis

Nordic Social-Statistical Committee no. 61:16. Copenhagen 2016

Sickness absence in the Nordic countries

Nordic Social-Statistical Committee no. 59:15. Copenhagen 2015

Challenges to the Nordic Welfare State. Comparable Indicators.

Nordic Social-Statistical Committee no. 54:13. Copenhagen 2013

Udfordringer for den nordiske velferdsstaten. Comparable indicators. 2nd edition

Nordisk Socialstatistisk Komité nr. 52:13. København 2013

Youth Unemployment in the Nordic Countries - A Study on the Rights of and Measures for Young Jobseekers'.

Nordic Social-Statistical Committee no. 50:11. Copenhagen 2011

Ungdomsarbejdsledighed i Norden - En studie av rettigheter og tiltak for unge arbeidssøkere'.

Nordisk Socialstatistisk Komité nr. 47:11. København 2011

Challenges to the Nordic Welfare State. Comparable Indicators.

Nordic Social-Statistical Committee no. 42:10. Copenhagen 2010

Udfordringer for den nordiske velferdsstaten. Sammenlignbare indikatorer

Nordisk Socialstatistisk Komité nr. 41:10. København 2009

Do the Nordic Welfare Systems Encourage the 60-74-Year-Olds to Work?

Nordic Social-Statistical Committee no. 39:10. Copenhagen 2010

Opmuntrer de nordiske systemer 60-74-årige til at arbejde?

Nordisk Socialstatistisk Komité nr. 38:09. København 2009

Old-age Pension Systems in the Nordic Countries.

Nordic Social-Statistical Committee no. 35:09. Copenhagen 2009

Ålderspensionssystem i Norden.

Nordisk Socialstatistisk Komité nr. 34:08. København 2008

Sustainable Social and Health Development in the Nordic Countries. Seminar 6th April 2006, Oslo.

Nordic Social-Statistical Committee no. 29:06. Copenhagen 2006

Sustainable Social and Health Development in the Nordic Countries. Seminar 27th May 2003, Stockholm.

Nordic Social-Statistical Committee no. 22:03. Copenhagen 2003

Nordic/Baltic Social Protection Statistics 2000

Nordic Social-Statistical Committee no 19:03. Copenhagen 2003

Chapter 5

Resources

Extra material

OECD: www.oecd.org/els/health-systems/health-data.htm

Introduction

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

5.1 Financing of health services

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

DENMARK

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

THE FAROE ISLANDS

The health care system is mainly based on publically provided and financed services, as the private part of health services is limited to e.g. dental care and physiotherapy.

A fixed duty and an income related duty is imposed on citizens.

The municipalities are responsible for providing and financing practitioners' facilities.

FINLAND

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

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

ÅLAND

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

ICELAND

The Icelandic health care system is mainly financed by the Central Government and by social security funds. Primary care and hospital care are mainly provided by public institutions financed through the state budget and relatively low user charges. Services provided by privately practicing medical specialists are based on fee-for-service schemes financed by the Icelandic Health Insurance and user charges.

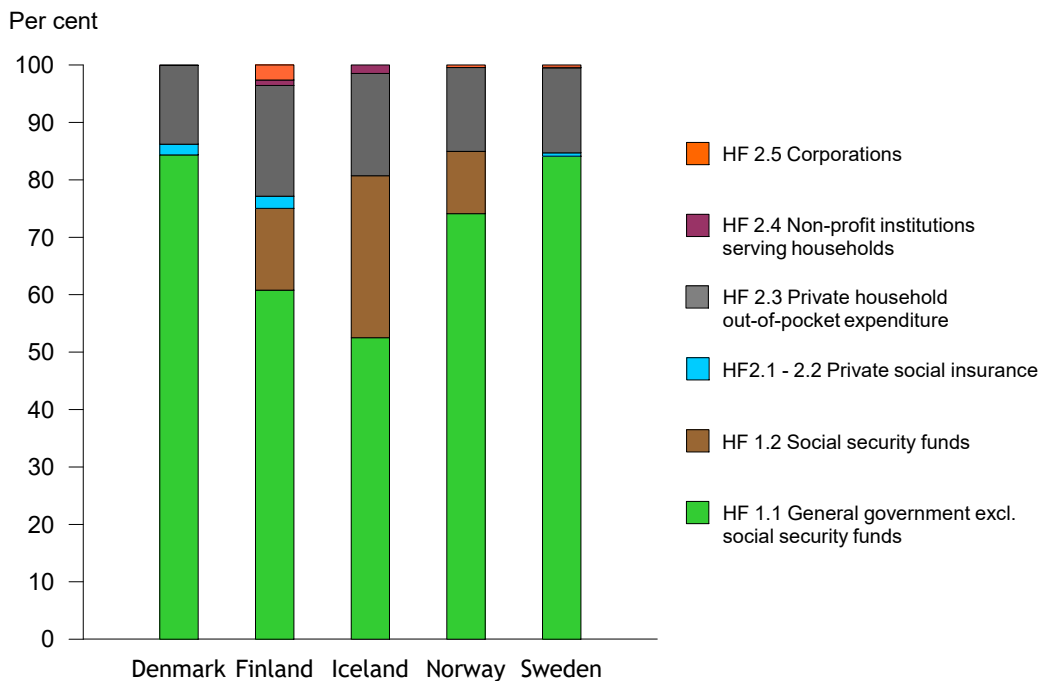
NORWAY

The Norwegian somatic hospital sector is based on a financing model that combines block grants and fee-for-service financing. Fee-for-service financing is based on the principle that a service provider (i.e. the hospital) is paid on the basis of services rendered. The state reimburses a percentage of the average DRG expenses (Diagnosis Related Groups) in connection with treatment of patients.

SWEDEN

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

Figure 5.1.1 Distribution of health expenses after funding, percentage of total expenses, 2013



Source: OECD Health Statistics

5.2 Charges for health care services per 1 January 2017

Medical visits

DENMARK, FAROE ISLANDS and GREENLAND

No user charges are payable in Denmark, the Faroe Islands and Greenland.

FINLAND

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

- A fixed annual user charge of no more than EUR 41.70 in a year, or
- A fixed user charge per visit of no more than EUR 20.90. The user charge is payable for the first three visits to the same health centre in the same calendar year only

A user charge of EUR 28.70 is payable for visits to health centres on working days between 8 pm and 8 am and for visits on Saturdays, Sundays and public holidays.

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

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

ÅLAND

For medical consultations within the primary health service at a clinic, at specialized health centres and for home visits, there is a user charge of EUR 27. The user charge for a visit to a casualty department is EUR 40. Children and young people under the age of 18 pay half of the user charge. If there is a waiting period of 45 minutes or more in connection with a scheduled visit, the user charge is reimbursed.

ICELAND

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

The user charge for a consultation with a specialist is ISK 5 700 plus 40 per cent of the remaining cost of the consultation, ISK 4 400 plus 13.3 per cent of the remaining cost of the consultation for 67-69-year-olds who do not have a pension or who have a reduced pension, ISK 2 100 plus 13.3 per cent of the remaining cost of the consultation for other pensioners, disabled people and long-term unemployed people. The user charge for children under 18 years is one ninth of the total charge with a minimum of ISK 890. There is no user charge for disabled and chronically ill children.

The maximum charge is ISK 35 200 in all cases. The same user charges apply for out-patient treatment in hospitals (with the exception of children, for whom there is no user charge). Different user charges apply for treatment in emergency units and with other physicians, and for laboratory tests, radiographs and diagnostic examinations. User charges for persons who have been continuously unemployed for a period of 6 months or longer are the same as for pensioners.

As of 1 May 2017 a new payment system for health care was introduced. The new system has a cost ceiling and will reduce user charges for patients with high health care expenditure and for families with children. The new payment system includes a references system for children aged 2 to 18 to see specialists. With these changes most patients will never pay more than ISK 24 600 in a single month and children, pensioners and disabled patients ISK 16 400 a month. With a discount system in place regular patients will never pay more than ISK 69 700 in a 12 month period and others a maximum of ISK 46 467.

NORWAY

Patients only pay a fixed part of the cost for public health services. This applies to medical treatment, medicines on a refundable prescription (a so-called blue prescription), physiotherapy, consultations at a psychologist and travel expenses to consultations/treatment. When the ceiling for user charges is reached, patients are eligible for an exemption card valid for the rest of the calendar year. The ceiling or the upper limit is set annually by the Norwegian Parliament. There are two types of ex-

emption cards. The exemption card for user charge group 1 covers approved user charges paid to doctors, psychologists and out-patient clinics, and for x-rays, patient travel and blue prescription medicine and equipment. The exemption card for user charge group 2 covers approved user charges for physiotherapy, certain dental diseases, treatment in approved rehabilitation institutions and travel for treatment abroad organized by Oslo University Hospital HF - Rikshospitalet.

There are no user charges in connection with check-ups during pregnancy, examinations and treatment for children under the age of 16, psychotherapy for children and young people under the age of 18 and treatment of infectious diseases that are a danger to public health or suspicion of such diseases.

User charges apply to consultations with general practitioners and specialists, out-patient treatment at hospitals, and treatment from a doctor on call. User charges for consultation with general practitioners: NOK 152 (day) and NOK 257 (evening/night). User charges for consultations with a specialist are NOK 345.

SWEDEN

Health care in Sweden is largely financed by county councils and municipal taxes and county councils can decide the level of user charges for different types of visit and treatment. In 1981, the cost ceiling system was introduced in the health care services. The cost ceiling is regulated in the Act on health care (HSL) services and applies to all counties. The following applies to public health care and private healthcare providers who have an agreement with a county council.

According to current patient fees for 2017, a patient pays a maximum of 1 100 SEK for open health care for a twelve-month period. Nearly all county councils have decided that children and adolescents under the age of 20 are exempt from paying user charges for out-patient treatment. Visits for maternity and child health centres (MVC and BVC) are free of charge throughout the country. Mammography screening in the age group 40-74 years is free of charge throughout the country.

For persons aged 85 and over, open health care is free from 1 January 2017.

User charges for primary health care vary from SEK 0 to SEK 300 per visit. An extra charge of between SEK 0-110 is payable for home visits, and of SEK 0-150 for telephone prescriptions.

User charges for out-patient consultations with a specialist vary from SEK 200-400 per visit. If the patient has a referral from the primary health service, the user charge is between SEK 0-400 per visit.

User charges for visits to an emergency unit vary from SEK 200-400

Table 5.2.1 User charges for a consultation with a physician

	Are there consistent rules for the whole country?	Amount of user charge	Deviations
Denmark	Yes	-	No
Faroe Islands	Yes	-	No
Greenland	Yes	-	No
Finland	Yes	Public: EUR 0-20.90. EUR 28.70 for visits between 8 pm and 8 am on weekdays or on Saturdays, Sundays or public holidays. Private: min. 60%	No charge for children under the age of 18 years
Åland	Yes	EUR 27. Children and young people under the age of 18 years pay half the price	Free treatment after paying EUR 375. Free treatment for children under 18 and people 65+ and disability pensioners and persons receiving full-time rehabilitation benefits after paying EUR 120
Iceland	Yes	ISK 1 200-4 500 in primary care, other fees for specialized care	Half the amount of ISK 600-2 200 for pensioners, disabled and long-term unemployed people. ISK 960-3 800 for 67-69-year-olds with no or a reduced pension. No charge for children under the age of 18 years
Norway	Yes	Consultation with: a general practitioner: NOK 152 (day), NOK 257 (evening/night), with a specialist: NOK 345	No charge for children under 16 years
Sweden	No	Primary health services, general practitioners 0-300 SEK, specialists 200-400 SEK	Yes. Nearly all counties have decided that children and young people under the age of 20 do not pay user charges for outpatient treatment

Source: SV, the Swedish Association of Local Authorities and Regions, SALAR

Pharmaceutical products

DENMARK

Reimbursement of pharmaceutical products in Denmark depends on the accumulated amount for reimbursable pharmaceutical products purchased by the individual person. There are five reimbursement categories. Reimbursement starts at DKK 950, for children <18 yrs. at DKK 0. The percentage of reimbursement increases proportionally with the patient's costs. Maximum payment within a 12-month period is DKK 3 955.

Reimbursable pharmaceutical products are products with a documented and valuable therapeutic effect. The price of the pharmaceutical product must be reasonable in relation to its therapeutic value.

For pharmaceutical products that are not subject to a general subsidy an individual subsidy can be granted. This requires an application to the Danish Medicines Agency by one's own doctor.

The Danish Medicines Agency determines a reference price for each group of pharmaceutical products covered by the reference price system. The reference price forms the basis for the calculation of the subsidy. The reference price system includes prescription-only products and over the counter products that are allowed for pharmacy-only sales.

The aim of the system is that the pharmacy sells the cheapest product on the market. In special cases, the physician or dentist can mark the prescription thus there will be no substitution.

Since October 2001, some over-the-counter pharmaceutical products are allowed to be sold outside pharmacies (liberalization of the pharmaceutical market). By now approx. 3 500 shops are authorized. Authorized shops shall offer a basic selection of pharmaceutical products, determined by legislation, and must follow the current regulations e.g. relating to storage, the quality of pharmaceutical products and monthly report of sales to the authorities. A list of pharmaceutical products that are allowed for sale outside pharmacies is available on the Danish Medicines Agency's website.

FAROE ISLANDS

Pharmaceuticals prescribed by GPs are subjected to co-insurance whose level depends on the pharmaceuticals cost sustained in a 12-month period (reimbursement year). The National Health Insurance reimburses the costs for pharmaceuticals included in the Health Insurance scheme included in the cost ceiling arrangement. Pharmacies are obliged to substitute pharmaceuticals with cheaper generic alternatives as stipulated by the reference price system.

The costs incurred by the user aged 18-67 as of 2017 are as follows:

Price bracket of Pharmaceuticals DKK	National Health %	User charges DKK	National Health Insurance DKK
0-509	0	509	0
509-1017	40	304.80	203.20
1017-2034	60	406.80	610.20
2034-5391	75	839.25	2 517.75
5391-	100		
		Total: 2 059.85	

For users aged 67 and older, the percentages are the same. However, the maximum payment for this aged group is set at DKK 1 317.35. For users aged 0-18, the users charges are DKK 0.

GREENLAND

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

FINLAND AND ÅLAND

There are three payment categories (40, 65 and 100 per cent) for prescription pharmaceutical products, and reimbursement is calculated separately for each purchase after an annual initial deductible of EUR 50.00 for all adults. However, there is a user charge of EUR 4.50 for pharmaceutical products with 100 per cent reimbursement.

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

Some new and expensive drugs (e.g. for dementia and multiple sclerosis) are paid for by the hospital or municipality in special cases. New drugs are not automatically covered by the reimbursement scheme, and many drugs are marketed without any reimbursement.

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

As a main rule, the health insurance scheme reimburses expenditure on prescription pharmaceutical products exceeding EUR 605.13 in the course of one calendar year (excluding user charges of EUR 2.50 per product per purchase).

ICELAND

The subsidy system for pharmaceutical products in Iceland is similar to the other Scandinavian countries (Denmark, Faroe Islands, Norway and Sweden). The system builds on payment contribution steps, where the individual pays proportionally less as the costs for pharmaceutical products increase during a 12-month period. The individual pays all expenses for pharmaceutical products up to a certain limit (the subsidy limit). Then his or her payment gradually decreases until annual expenses have reached a maximum amount (the annual limit). After this the expenses are fully covered.

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

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

NORWAY

General reimbursement prescriptions (“Blue Prescriptions”):

Reimbursement according to of drugs listed will always be reimbursed when prescribed for the diagnoses (indicated by the ICPC and ICD codes) specified in the reimbursement list. The Norwegian Medicines Agency decides which medicines are included in the list and which diagnostic codes/conditions should be subject to reimbursement prescribing. User charges for pharmaceutical products on blue prescription are 39 per cent of the prescription cost, up to a maximum of NOK 520 per prescription up to a quantity corresponding to 3 months' use. Free card for further expenditures is granted at NOK 2 205 (2017).

Individual reimbursement: The Health Economics Administration (HELFO) will make decisions regarding individual reimbursement for drugs not included in the general reimbursement list. Individual reimbursement requires either that the indication for use of the drug is covered by a diagnostic code in the reimbursement list or the drug will be used to treat a rare or serious chronic disease not listed in the reimbursement list. Decisions are made for each patient on the basis of application from the treating physician.

Drugs used for communicable diseases: Fully reimbursed according to a specified disease list. The reimbursement is granted for anti-infectives, immunostimulants and vaccines. This support is provided to all who live in Norway, regardless of citizenship.

Health Trust financed prescriptions: The regional health trusts provide dedicated funding for certain expensive drugs. This applies to defined drugs used in the treatment of rheumatic disorders, multiple sclerosis, various cancer types, skin diseases, hepatitis C, kidney failure and gastrointestinal diseases.

SWEDEN

Most medicines that are prescribed are subsidised and the cost ceiling system is regulated in the Act on Pharmaceutical Benefits. This means that part of the cost of the pharmaceutical product is refunded by the state through taxation. The Dental and Pharmaceutical Benefits Agency (TLV) is a state authority whose remit is to determine which pharmaceutical products, disposable items and dental treatment shall be included in the cost ceiling arrangement. Different types of pharmaceutical products are included in the cost ceiling arrangement, including disposable items and contraceptives. Some non-prescription pharmaceutical products are also included in the cost ceiling arrangement.

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

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

- the whole cost up to SEK 1 100
- 50 per cent of the cost in the range SEK 1 100 - 2 100
- 25 per cent of the cost in the range SEK 2 101 - 3 900
- 10 per cent of the cost in the range SEK 3 901 - 5 400

When a patient has paid a total of SEK 2 200 in a 12-month-period, the patient receives pharmaceutical products and disposable items free of charge for the rest of the period.

Pharmaceutical products included in the cost ceiling arrangement are free of charge for children under 18 years of age.

Table 5.2.2 User charges for pharmaceutical products

	Are there consistent rules for the whole country?	Amount of user charge	Deviations
Denmark	Yes	Reimbursement is dependent on the level of the users accumulated costs for reimbursed drugs in the primary sector. The maximum cost for a person for prescription medicines is DKK 3 955 during a 12-month period (2017)	Children <18 years have different limits compared to adults and generally pay less. The maximum cost is the same as for adults of DKK 3 955
Faroe Islands	Yes	Reimbursement dependent on the level of the patient's consumption of drugs in the primary sector	Reimbursement is higher for persons over the age of 67 years or under the age of 18 years
Greenland	Yes	-	No
Finland	Yes	60% of the cost after the annual costs exceed EUR 50	For certain diseases EUR 4.50 or 35% of the cost are paid (disease-specific)
Åland	Yes	As in Finland	As in Finland
Iceland	Yes	Reimbursement dependent on the level of the patient's consumption of drugs in the primary sector	Pensioners, children (under 18 years), young people (18-22 years old) and disabled people pay two thirds of the costs
Norway	Yes	39% of the cost, maximum NOK 520 per prescription	No user charge for children under 16 years
Sweden	Yes	The maximum cost for a patient for prescription medicines in the high cost threshold system is 2 200 SEK during a 12-month period.	From January 1st 2017, contraceptives in the reimbursement system are free for people under the age of 21

Treatment in hospitals

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

FINLAND

Patients pay a charge for admission to hospitals and health centres: EUR 41.70 for an out-patient visit and EUR 49.50 for overnight care in somatic department and EUR 22.80 in psychiatric departments. The charge for rehabilitation is EUR 17.10 per treatment day, and the maximum user charge for day surgery is EUR 136.80 plus EUR 49.50, if the patient has to stay overnight. A series of treatment costs EUR 11.50 per visit (max. 45 times per year).

ÅLAND

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

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

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

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

NORWAY

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

SWEDEN

The county authorities and the municipalities can largely decide themselves about user charges for a visit to the doctor and for other health services. For a hospital stay, there is a user charge per day of a maximum of SEK 100. The amount varies in different counties from SEK 0 to 100, depending on the patient's income, age and length of stay.

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

There are private hospitals in most of the Nordic countries, which provide all or some of their services to the public health service, but according to somewhat different regulations in the different counties.

Table 5.2.3 User charges for hospitalization

	Are there consistent rules for the whole country?	Amount of user charge	Deviations	User charges as % of the total cost of hospitalization
Denmark	Yes	-	No	-
Faroe Islands	Yes	-	No	-
Greenland	Yes	-	No	-
Finland	Yes	EUR 49.50 per day for overnight care EUR 136.80 for day surgery	For children 0-17 years max. for 7 days. Payment for long-term stay according to means	4.7
Åland	Yes	EUR 33; EUR 18 for people under the age of 18 years EUR 66 for day surgery	Payment for long-term stay according to means	..
Iceland	Yes	-	No	0.6 ¹
Norway	Yes	-	No	2.3 ¹
Sweden	No	SEK 0-100/day	County councils and regions decide charges	1.9 ¹

1 2013

Source: OECD HEALTH STATISTICS; GL, Chief Medical Officer

Dental treatment

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

DENMARK

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

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

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

Children and young people under 18 years of age receive free municipal dental care including orthodontic treatment. Children under 16 years of age who wish to have treatment that is not provided free of charge by the municipal council, may - by paying a user charge - choose to be treated in a private clinic of their own choice or at a public dental clinic in another municipality. From 1 January 2016, elderly people who live in a nursing home or in their own home with technical aids are offered den-

tal care for which there is a maximum annual charge of DKK 490. In addition, the municipalities provide a subsidy for dentures in cases of impaired function or disfigurement resulting from damage caused by accidents.

The municipality offers specialist dental treatment to persons who because of psychiatric illness or mental health disorders cannot use the existing dental services for children and young people, for adults, or for people needing special care. For these services, the region, from 1 January 2016, charges the patient a maximum of DKK 1 815 per year.

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

In addition, the region grants a special reimbursement for dental care for cancer patients, who either due to radiation of the head and neck or due to chemotherapy suffers from considerable documented dental problems, and to persons who due to Sjögren's syndrome suffer from considerable documented dental problems. From 1 January 2016, the region can demand a user payment of a maximum of DKK 1 815 annually for these services. Finally, the region provides highly specialized dental advice, examination and treatment (in dental research centres) for patients with rare diseases and disabilities, for whom the underlying disease can lead to special problems with their teeth, mouth or jaws.

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

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

FAROE ISLANDS

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

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

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

GREENLAND

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

FINLAND

There is a basic user charge of EUR 10.30 per visit for dental treatment at a health centre, EUR 13.30 per visit to a dentist, and EUR 19.40 for a visit to a specialist. In addition to this, user charges of EUR 8.50-225.50 can be charged, dependent on the type of treatment provided.

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

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

ÅLAND

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

ICELAND

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

In April 2013, a new contract for dental treatment for children under the age of 18 was signed. According to the agreement parents register their child with a family dentist, who is then responsible for providing the necessary dental care of the child and is fully paid by the national health insurance except for a low annual appointment charge of ISK 2500 that the parents pay. The agreement is being implemented in seven stages until all children from 0-18 years-old will be covered on 1 of January 2018. Until then other children receive a 75 per cent subsidy for dental treatment (according to health insurance rates), with the exception of gold and porcelain crowns, dental bridges and orthodontic treatment. A special grant will be given to children in need who are not yet covered by the agreement if they cannot afford the necessary dental treatment. Orthodontic treatment is not covered by the agreement. Subsidies for orthodontic treatment can reach ISK 150 000 according to special rules.

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

People suffering from chronic illnesses, pensioners and disability pensioners are also eligible to receive a partial subsidy for their costs.

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

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

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

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

NORWAY

Adults over 20 years of age normally pay all costs for dental treatment.

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

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

Adolescents 19-20 years of age receive subsidized dental care. The county authorities cover a minimum of 75 per cent of the cost of dental treatment for this group and the cost is eligible for user charge card 2

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

SWEDEN

The dental care benefits system comprises a general and a specific dental care grant in addition to a high-cost protection scheme. According to the Act relating to dental services, children and young people have the right to regular and comprehensive dental care until and including the calendar year in which they reach 19 years of age. Comprehensive dental care means that young people under 20 years of age shall receive general dental care and specialist dental care.

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

The system consists of:

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

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

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

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

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

Adults with specific illnesses, elderly people and people with functional disabilities, have the right to receive reimbursements for dental treatment from the county authorities. This includes reimbursement for preventive care, necessary treatment, dental treatment that is part of the treatment of a disease, and dental aids.

Apart from providing free dental treatment for children and young people, the county authorities and the regions have responsibility for: oral surgery in hospitals, dental treatment that is part of the treatment of a disease, and dental treatment for people who have difficulty in maintaining their own oral health. Special regulations for reimbursement of dental expenses apply for these groups.

Maximum user charges

DENMARK

There are no rules in Denmark for maximum user charges, with the exception of pharmaceutical products and dental treatment (cf. the section on reimbursement for dental treatment).

FAROE ISLANDS

For subsidized medicine, there is a maximum user charge of DKK 2 090 annually (no charges for children under 18 years and DKK 1 340 for pensioners). There is no maximum user charge for dental treatment. Apart from pharmaceutical products and dental care, there are no user charges in the Faroe Islands (cf. the sections on reimbursement for pharmaceutical products and reimbursement for dental treatment).

GREENLAND

There are no user charges in Greenland with the exception of non-prescription medicines and some types of dental treatment (cf. the sections on reimbursement for pharmaceutical products and reimbursement for dental treatment). There are no maximum user charges.

FINLAND

If the total cost of pharmaceutical products exceeds EUR 605.13 per year, or if travelling costs for treatment exceed EUR 300 per year, the Social Insurance Institution reimburses the excess costs.

If a person's ability to pay taxes is reduced because of sickness, a special tax relief may be granted. The amount of the tax relief is calculated on the basis of the person's and his/her family's ability to pay taxes.

User charges for a long-term stay in an institution or a hospital cannot exceed 85 per cent of a patient's/resident's net income per month. If the spouse with the highest income is hospitalized, the user charge for the hospitalization cannot exceed 42.5 per cent of the spouse's joint net income per month. A patient must have at least EUR 107 per month for personal necessities. The same user charge is payable in all kinds of institutions within the social and health care sectors.

A user charge ceiling of EUR 691 is applied by the municipal social and welfare sectors. Once the ceiling for the present calendar year is exceeded, the user may generally utilize services free of charge. The ceiling applies to physician services in the primary health care sector, physiotherapy, out-patient treatment, day surgery and short-term stays in institutions in the social and health sectors. Dental care, patient transport, certificates, laboratory tests and radiological examinations requisitioned by private physicians must still be paid for. Income-regulated payments are not included in the maximum amount.

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

ÅLAND

The rules for maximum user charges for pharmaceutical products and transport to and from treatment are the same as in Finland.

The maximum user charge for health care and out-patient treatment is EUR 375 within one calendar year, after which there is no charge for the remainder of the year, with the exception of short-term stays in institutions/hospitals, where the charge is reduced from EUR 33 per day to EUR 15 per day.

For children and young people under the age of 18 and people over the age of 65, the maximum amount for user charges is EUR 120 per calendar year. After this amount has been reached, all treatment for children and young people is free. The user charge per day for a hospital stay for persons aged 65 years and older is reduced from EUR 33 to EUR 15.

As part of the maximum user charge, payment for out-patient treatment and services received outside the county are also included. Dental treatment and x-ray and laboratory examinations are not included. User charges may be deducted from municipal tax.

ICELAND

User charges for people aged 18-70 years and for unemployed people are reimbursed if the costs exceed ISK 35 200 during one calendar year.

The same applies to children under 18 if user charges exceed ISK 10 700.

User charges exceeding ISK 28 200 are reimbursed for people aged 67-69 who have either no pension or reduced pension.

User charges exceeding ISK 8 900 are reimbursed for the following groups: people aged 60-70 who receive a full basic pension, pensioners aged 70 years or older, and disabled people.

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

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

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

NORWAY: When a patient has paid user charges up to a certain amount, he or she receives an exemption card. All further treatment is then free for the rest of the year.

There are two exemption schemes in Norway, exemption scheme 1 and exemption scheme 2. They cover different health services.

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

- treatment from a medical practitioner
- psychologist
- out-patient treatment
- x-ray examination
- travel costs, and
- pharmaceutical products (blue prescription)

User charges for the following services are included in exemption scheme 2:

- examination and treatment by a physiotherapist
- certain types of dental treatment
- treatment in approved rehabilitation institutions
- travel abroad for treatment under the auspices of Oslo University Hospital HF Rikshospitalet

The cost ceiling is NOK 2 205 for exemption scheme 1 and NOK 1 990 for exemption scheme 2 in 2017.

SWEDEN

Special regulations apply for the cost ceiling arrangement for pharmaceutical products and health care.

5.3 Health care expenditure

Development of health care expenditure

Health plays a central role in peoples' everyday lives and is an issue that people are concerned about. Thus, health is often a topic for debate, and health issues receive much attention in the press. Attention is particularly focussed on production of health services. Questions are asked about whether health services are adequate and about what health care costs society and individuals. The increasing cost of health care is an issue of concern in many countries. According to the OECD, the reason for this concern is that health services are mainly publicly financed and so increasing health care expenditure is an extra burden on public budgets. If priorities are not changed, this will lead to higher taxes for both citizens and companies.

In the Nordic countries, between 75 and 85 per cent of health care expenditure is publicly financed. In 2015, the level of public financing was lowest in Finland.

Measured in relation to gross domestic product (GDP), health care expenditure has been relatively stable or has shown a slight increase in the second half of the 1990s and the beginning of this century. Health care expenditure represents between 8 and 9 per cent of GDP.

Table 5.3.3 shows health care expenditure per inhabitant, which was highest in Norway and lowest in Greenland.

Changes in the recording of health care expenditure

Health care expenditure includes all expenditure, both private and public, on consumption or investment in health services, etc. The expenditure can be financed by both private and public sources, including by households. Examples of health care expenditure by households are the cost of spectacles, orthopaedic items, pharmaceutical products, dental treatment, medical treatment, physiotherapy services and other health services. Other types of expenditure include national insurance or private insurance reimbursements for use of health services, and public expenditure (net) on hospitals and primary health services.

Public expenditure on preventive measures and administration of health services is included. Expenditure on running private hospitals that are not included in the public budget is also included.

Health care expenditure also includes part of the expenditure on nursing and care for elderly people and people with disabilities. According to international guidelines, this applies to the part of expenditure on nursing and care that can be specified as expenditure related to health. Services for elderly people and people with disabilities are often integrated, and it can be difficult to draw clear boundaries between what should be defined as expenditure on health services and what should be defined as expenditure on social services. What is included as expenditure on health services can vary for the different countries.

There will always be such problems when one compares statistics from several countries. This does not mean that comparisons are worthless, but one must be

aware that some of the observed differences can be the result of different definitions and boundaries.

In order to ensure the best possible comparability of statistics, international organizations such as the OECD, the UN and EUROSTAT work on producing classifications, standards and definitions. For example, the OECD has developed "A System of Health Accounts". This accounting system has been developed in order to meet the political needs for data, and also the needs of researchers in this area. The common framework that the system is built on will ensure that the comparability of data between countries and over time is as good as possible. The system has also been developed to provide comparable statistics, independently of how health services are organized in the countries.

All the Nordic countries have implemented, or are in the process of implementing, OECD's system of health accounts, and the figures presented in this publication are based on this system. Not all the countries have come equally far in implementing the system, and it is not certain at the moment how comparable the various national health accounts are. Therefore, the unsolved problems faced by the countries, and the different solutions they have found, must be taken into account when interpreting the data. For example, the reason that per capita health care expenditure in Finland is 30 per cent lower than in the other countries, may be because the boundary for what is included as health care expenditure on care of the elderly may be different from that in the other countries. At the same time, Table 5.3.3 shows that health care expenditure per capita in Norway is substantially higher than in the other countries. It is important to be aware of the fact that OECD's system of health accounts and EUROSTAT's ESSPROS system are very different. Thus data on health care expenditure from these two sources are very different. EUROSTAT data are published by NOSOSCO in the publication *Social Protection in the Nordic Countries*.

ESSPROS includes all social arrangements, both public and private. The statistics include pension schemes, insurance schemes, humanitarian organizations and other charitable organizations. Insurance schemes are included if they are collective. This means that expenditure on health also includes sickness benefits (or salary paid during sickness) including sickness benefits paid by employers. These cash payments are not included in OECD's system, in which only expenditure on actual health services is included.

Table 5.3.1 Total health care expenditure (million national currency) 2015

	Denmark	Faroe Islands	Greenland	Finland ¹	Iceland	Norway	Sweden
	DKK	DKK	DKK	EUR	ISK	NOK	SEK
Public financing	176 925	..	1 306	15 089	157 086	265 179	384 992
Private financing	33 291	..	..	4 888	34 861	45 915	75 001
Total health care expenditure	210 216	..	1 306	19 977	191 946	311 094	459 993

1 Finnish data include Åland

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

Table 5.3.2 Total health care expenditure (EUR/capita) 2015

	Denmark	Faroe Islands	Greenland	Finland ¹	Iceland	Norway	Sweden
Public financing	4 177	..	3 121	2 754	3 245	5 707	4 199
Private financing	786	..	..	892	720	988	818
Total health care expenditure	4 963	..	3 121	3 646	3 966	6 695	5 017

1 Finnish data include Åland

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

Table 5.3.3 Gross domestic product (GDP) and health care expenditure in total and per capita, 2000-2015

	Denmark ¹	Faroe Islands ²	Greenland	Finland ³	Iceland	Norway	Sweden ¹
	DKK	DKK	DKK	EUR	ISK	NOK	SEK
Total expenditure per capita 2015	36 831	..	23 279	3 612	576 186	59 920	46 986
GDP (million) 2015	2 027 171	..	14 939	209 581	4 181 103	3 117 433	2 214 086
Expenditure in 2015 prices (million)							
2000	143 964	..		9 353	124 073	194 463	176 433
2010	196 172	1 048	1 133	16 618	154 321	260 273	298 721
2014	205 131	..	1 285	19 528	176 209	291 925	438 130
2015	210 216	..	1 306	19 977	191 946	310 981	459 993
Expenditure as a percentage of GDP							
2000	8.1	8.5	8.9	6.7	9.0	7.7	7.4
2010	10.4	7.8	9.2	8.9	8.8	8.9	11.1
2015	10.6	..	8.7	9.6	8.8	10.0	11.1

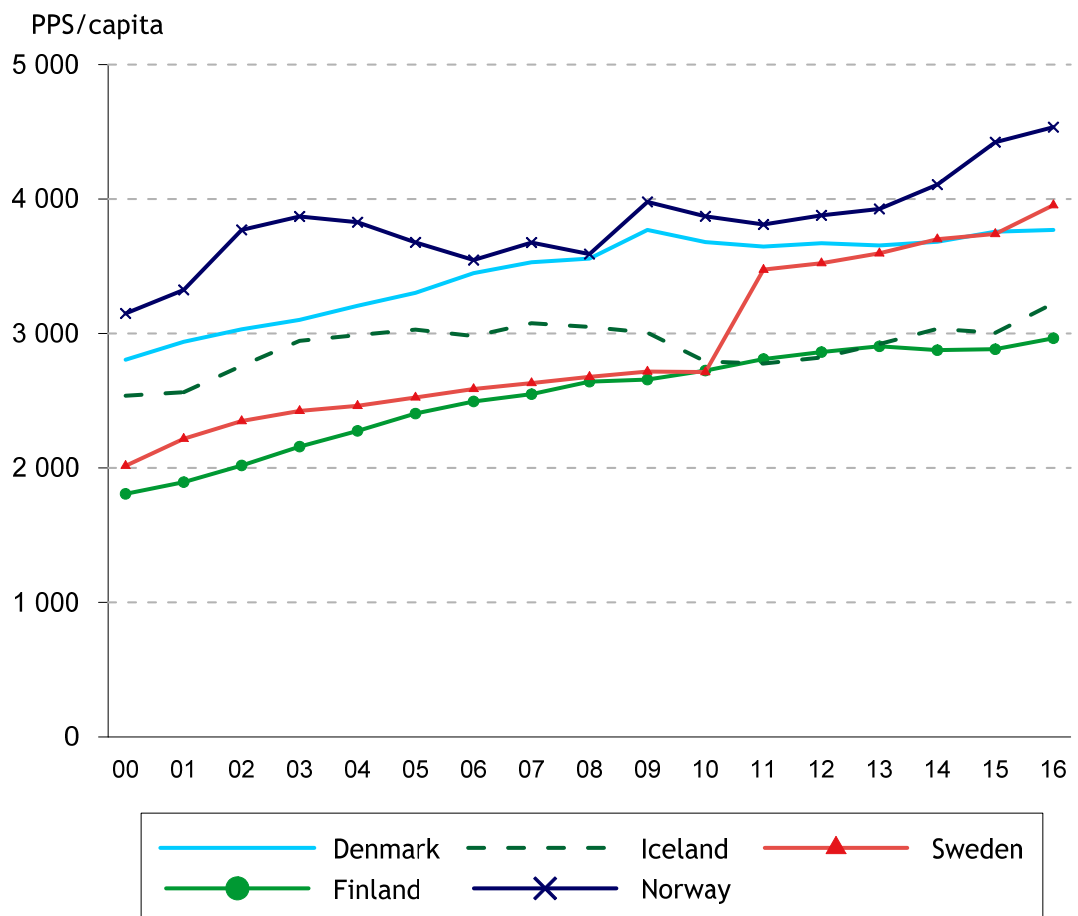
1 Changes in method of calculation from 2003 for Denmark, from 2000 for Finland and Norway and from 2001 for Sweden

2 Only public health expenditure

3 Finnish data include Åland

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

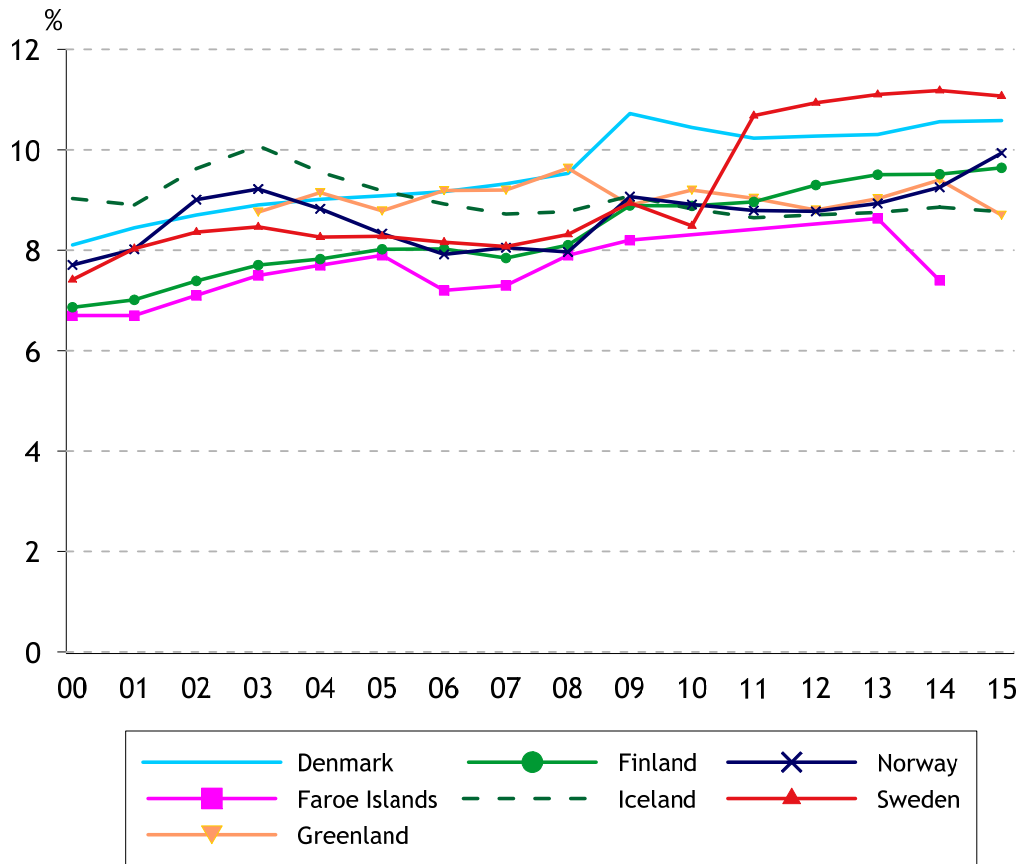
Figure 5.3.1 Total health care expenditure (PPS/capita) in 2016 prices ¹



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

Source: OECD HEALTH STATISTICS

Figure 5.3.2 Health care expenditure as a percentage of GDP 2000-2015



Source: OECD HEALTH STATISTICS; FO, Statistics Faroe Islands; GL, Directorate of Health

5.4 Health care personnel

For many years, it has been difficult to obtain comparable data about health care personnel in the Nordic countries, because the sources for the data have been very different.

Therefore, in 2003, NOMESCO appointed a working group to obtain more comparable data, and to define health care personnel in the way that it is done for health economy in OECD's "A System for Health Accounts".

For this purpose, it has been found to be most appropriate to use NACE's classification of occupations, linked to the registers of authorization for health care personnel. These registers are more comparable, though the data are still incomplete and there are some inaccuracies.

With the new definitions and groups, data on health care personnel for previous years (before 2004) are not comparable with more recent data, since data for new groups of health care personnel are included.

It should be noted that the group 'qualified auxiliary nurses' is now subdivided. Those with an education of at least 18 months remain in this group, while those with an education of less than 18 months are included in the group 'other health care personnel'. Since Sweden only has data for employees in the public service, data for these categories are not included. 'Other health care personnel with a higher education' is defined as personnel with a university degree, such as dieticians and pharmacists. Furthermore, for physicians a group is included with physicians who do not work in the social and health care sectors, and not with medicine.

Besides, the included data are registered at a given time of the year.

Table 5.4.1 Employed health care personnel in health and social services, 2015 (Q86)

	Denmark ¹	Faroe Islands	Greenland ²	Finland ³	Åland	Iceland ⁴	Norway ⁵	Sweden ^{1,6}
Physicians	20 637	128	104	16 859	88	1 249	23 431	39 514
Dentists	4 300	46	32	3 990	26	278	4 434	7 767
Dental hygienists	1 741	25	50	1 585	6	13	1 079	4 157
Dental surgery assistants	4 424	77	23	..	21	315	3 355	-
Psychologists	5 581	26	4	3 373	12	-	5 325	6 377
Qualified nurses	58 897	368	280	61 309	340	3 090	89 966	102 747
Radiographers	1 814	5	..	2 774	9	141	3 006	1 572
Qualified auxiliary nurses	41 568	65	174	77 012	570	2 022	..	-
Other health care personnel	52 951	84	185	..	33	-	93 404	-
Midwives	1 955	21	24	..	18	275	2 914	7 038
Physiotherapists	10 024	19	19	8 389	27	548	9 453	12 457
Occupational therapists	6 904	10	2	..	15	286	3 127	8 481
Hospital laboratory technicians	5 647	39	20	5 438	22	301	5 022	-
Other health care personnel with a higher education	674	..	..	..	34	..	33 302	33 711

1 2014

2 "Other health care personnel" includes "medicine custodians", "health workers" and "porters"

3 2013

4 Physicians licensed to practice up to 70 years old at end of year, with permanent residence and registered domicile in Iceland

5 Active health personnel in health and social services

6 The data apply to November

Source: DK, the Danish Health Data Authority; FO, Ministry of Health Affairs; GL, Agency for Health and Prevention; FI, THL National Institute for Health and Welfare; ÅL, The Åland Government; IS, Directorate of Health; NO, Statistics Norway; SV, National Board of Health and Welfare

Table 5.4.2 Employed health care personnel in health and social services per 100 000 inhabitants, 2015 (Q86)

	Denmark ¹	Faroe Islands	Greenland ²	Finland ³	Åland	Iceland ⁴	Norway ⁵	Sweden ^{1,6,7}
Physicians	398	262	185	310	304	378	451	396
Dentists	83	94	57	73	90	84	85	80
Dental hygienists	34	51	90	29	21	4	21	42
Dental surgery assistants	85	157	41	..	72	95	65	-
Psychologists	108	53	8	62	41	-	103	63
Qualified nurses	1 135	752	498	1 127	1 173	934	1 733	1 056
Radiographers	35	10	-	51	31	43	58	15
Qualified auxiliary nurses	801	133	310	1 416	1 967	611	0	-
Other health care personnel	1 020	172	330	..	114	-	1 800	-
Midwives	38	43	43	..	62	83	56	72
Physiotherapists	193	39	33	154	93	166	182	125
Occupational therapists	133	20	4	..	52	86	60	85
Hospital laboratory technicians	109	80	36	100	76	91	97	82
Other health care personnel with a higher education	13	..	-	..	117	-	642	373

1 2014

2 "Other health care personnel" includes "medicine custodians", "health workers" and "porters"

3 2013

4 Physicians licensed to practice up to 70 years old at end of year, with permanent residence and registered domicile in Iceland

5 Active health personnel in health and social services

6 The data apply to November 2014

7 An additional 2 207 qualified nurses are specialized and employed as radiographers

Source: DK, the Danish Health Data Authority; FO, Ministry of Health Affairs; GL, Agency for Health and Prevention; FI, THL National Institute for Health and Welfare; ÅL, The Åland Government; IS, Directorate of Health; NO, Statistics Norway; SV, National Board of Health and Welfare

Table 5.4.3 Number of general practitioners 2015

	Denmark ¹	Faroe Islands	Greenland ²	Finland ³	Iceland	Norway ⁴	Sweden ⁴
Number of general practitioners	3 509	30	51	5 950	191	6 463	5 952
Number of inhabitants per general practitioner	1 618	1 629	1 098	924	1 732	795	1 636

1 The capacity of doctors in general practice (each doctor working full time = 1 capacity)

2 County practitioners

3 2016. Includes GPs in health centres and occupational health services

4 2013

Source: DK, the Danish Health Data Authority; FO, Ministry of Health Affairs; GL, Agency for Health and Prevention; FI, Finnish Medical Association; ÅL, The Åland Government; IS, Directorate of Health; NO, Statistics Norway; SV, National Board of Health and Welfare

Table 5.4.4 Employed physicians by specialty in health and social services, 2015 (Q86)

	Denmark ¹	Faroe Islands	Greenland ²	Finland ³	Åland	Iceland ^{4,5}	Norway	Sweden ^{1,6}
General practice	4 436	32	53	1 748	19	191	2 812	5 952
Internal medicine	1 725	12	5	425	14	161	1 690	1 352
Paediatrics	421	3	2	598	3	56	514	966
Surgery	968	6	4	544	4	85	808	1 346
Plastic surgery	116	-	-	108		10	112	153
Gynaecology and obstetrics	545	2	3	674	6	46	574	1 365
Orthopaedic surgery, incl. hand surgery	724	5	3	551	5	42	532	1 392
Ophthalmology	345	3	-	425	2	32	370	714
Ear, nose and throat	350	-	2	336	1	21	306	593
Psychiatry	991	1	3	1 388	6	78	1 553	1 701
Skin and sexually transmitted diseases	180	1	-	196		18	166	381
Neurology	318	1	-	422		15	318	413
Oncology	169	3	-	188	1	13	218	449
Anaesthetics	1 021	6	4	839	4	57	873	1 640
Radiology	526	5	3	630	2	34	704	1 135
Clinical laboratory specialties incl. pathology	549	1	-	374		31	477	932
Other specialties	143	1	-	2 887	4	26	563	6 442
Specialists in total	13 527	81	82	12 333	71	916	12 590	26 926
Physicians without specialist authorization	7 110	49	22	8 637	18	333	10 841	12 588
Physicians in total within Q86	20 637	130	104	20 970	88	1 249	23 431	39 514

1 2014

2 Physicians working as general practitioners, but some of them might have other specialities. A few (6) have surgical skills to be able to perform a Caesarean section

3 2016 according to the most recent speciality

4 Data based on the register of physicians at the Directorate of Health. The most recent speciality is chosen for those with more than one speciality

5 Physicians licensed to practice in Iceland, up to the age of 70 years at the end of the year, with permanent residence and registered domicile in Iceland

6 The data apply to November

Source: DK, the Danish Health Data Authority; FO, Ministry of Health Affairs; GL, Agency for Health and Prevention; FI, Finnish Medical Association; ÅL, The Åland Government; IS, Directorate of Health; NO, Statistics Norway; SV, National Board of Health and Welfare

Table 5.4.5 Number of employed physicians by specialty in health and social services per 100 000 inhabitants, 2015 (Q86)

	Denmark ¹	Faroe Islands ²	Greenland ³	Finland ⁴	Åland	Iceland ^{5,6}	Norway	Sweden ^{1,7}
General practice	85	65	94	32	66	58	54	61
Internal medicine	33	25	9	8	48	49	33	14
Paediatrics	8	6	4	11	10	17	10	10
Surgery	19	12	7	10	14	26	16	14
Plastic surgery	2	0	0	2	-	3	2	2
Gynaecology and obstetrics	11	5	5	12	21	14	11	14
Orthopaedic surgery, incl. hand surgery	14	9	5	10	17	13	10	14
Ophthalmology	7	6	0	8	7	10	7	7
Ear, nose and throat	7	0	4	6	3	6	6	6
Psychiatry	19	3	5	25	21	24	30	17
Skin and sexually transmitted diseases	3	2	0	4	-	5	3	4
Neurology	6	1	0	8	-	5	6	4
Oncology	3	5	0	3	3	4	4	4
Anaesthetics	20	11	7	15	14	17	17	17
Radiology	10	10	5	11	7	10	14	11
Clinical laboratory specialties incl. pathology	11	2	0	7	0	9	9	10
Other specialties	3	2	0	52	14	8	11	65
Specialists in total	261	166	146	224	245	277	243	273
Physicians without specialist authorization	137	100	39	156	62	101	209	123
Physicians in total within Q86	398	266	185	381	304	378	451	396

1 2014

2 Full-time equivalents, of which 11 specialists had full-time positions as consultants. The figure for 2013 is not comparable with the figure for 2012. The number of specialist consultants was too low in the last report. The number of physicians without specialization (specifically general practice trainee) was 6 full-time equivalents too low last year

3 Physicians working as general practitioners, but some of them might have other specialties. A few (6) have surgical skills to be able to perform a Caesarean section

4 2016 according to the most recent speciality

5 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

6 Physicians licensed to practice in Iceland, up to the age of 70 years at the end of the year, with permanent residence and registered domicile in Iceland

7 The data apply to November

Source: DK, the Danish Health Data Authority; FO, Ministry of Health Affairs; GL, Agency for Health and Prevention; FI, Finnish Medical Association; ÅL, The Åland Government; IS, Directorate of Health; NO, Statistics Norway; SV, National Board of Health and Welfare

Table 5.4.6 Employed physicians 2015

	Denmark ¹	Faroe Islands	Greenland ²	Finland ⁴	Åland ¹	Iceland	Norway	Sweden ¹
Physicians employed in hospitals (Q86)	14 689	97	104	8 050	59	936	12 711	-
General practitioners (Q86)	4 250	32 ³	.	5 950	15		6 463	5 992
- of whom working without specialist authorization	121	0	.	3 588	..	..	3 103	0
Other physicians working outside hospitals (mainly privately practising specialists) (Q86)	1 698	0	.	..	15	..	903	-
Physicians employed in administrative medicine (NACE 75.1)	235	1	.	..	2		413	1 147
Physicians employed in medical research, teaching etc. (NACE 80.3, 73.1 and 24.4)	1 014	1	.	..	..	..	1 144	1 396
Physicians employed within all other NACE codes	938	-	.	..	..	..	4 981	2 306

1 2014

2 The general practitioners outside Nuuk also treat inpatients at the health centres and regional hospitals. Thus all are reported here

3 Time rated

4 2016

Source: DK, the Danish Health Data Authority; FO, Ministry of Health Affairs; GL, Agency for Health and Prevention; FI, Finnish Medical Association; ÅL, The Åland Government; IS, Directorate of Health; NO, Statistics Norway; SV, National Board of Health and Welfare

Table 5.4.7 Foreign-trained physicians and nurses - Stock and in per cent

	Denmark	Finland	Norway	Sweden
Foreign-trained physicians - Stock				
2000	681	..	..	3 827
2005	1 092	..	..	5 866
2010	1 158	3 528	6 766	8 552
2014	1 087	..	8 447	..
2015	..	..	..	..
% of foreign-trained physicians				
2000	4.4	..	..	..
2005	6.1	..	..	..
2010	5.9	20.9	33.8	23.5
2014	5.3	..	37.3	27.1
2015	..	..	38.1	..
Foreign-trained nurses - Stock				
2000	889	..	..	2 358
2005	817	..	..	2 796
2010	751	910	5 940	2 858
2014	672	..	7 640	..
2015	..	..	..	..
% of foreign-trained nurses				
2000	1.8	..	..	2.7
2005	1.6	..	..	2.9
2010	1.4	1.3	7.9	2.8
2014	1.2	..	9.1	2.8
2015	..	..	9.1	..

Source: OECD HEALTH STATISTICS

5.5 Capacity and services in the hospital sector

For many years, there has been a trend in the Nordic countries towards fewer hospital beds. Resources have been concentrated in fewer units, often involving a division of work in the most specialized areas. Units have often been merged administratively, not necessarily leading to fewer physical units. No hospitals have been closed down in Norway during the last few years, but some of the existing hospitals have become smaller.

Another trend in the Nordic countries is that psychiatric hospitals are being closed down, but to a varying degree.

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

Hospital beds are divided into medical, surgical, psychiatric and other beds. Particularly for Finland and Iceland, the category 'other', includes activities that are not included in the other countries.

The tables on hospital discharges and average length of stay apply to patients admitted to ordinary hospitals and specialized hospitals. This limitation has been done in order to improve comparability between the countries.

The trend is that the number of treatment places and the average length of stay have been reduced in ordinary hospitals. Within mental health care treatment, there has been a trend towards the use of more out-patient treatment, for which reason the number of psychiatric beds has been reduced.

Table 5.5.1 Available hospital beds by speciality, 2015

	Denmark	Faroe Islands	Greenland ¹	Finland	Åland	Iceland	Norway	Sweden
<i>Number</i>								
Curative (acute) care beds	12 202	-	..	16 732	73	752	17 433	22 152
Rehabilitative care beds	168	-	..	413	10	42	2 086	..
Long-term care beds	242	-	..	6 552	50	113		1 637
Other hospital beds		-	..	157	-	155		96
Psychiatric care beds	2 275	26	..	3 408	18	145	5 898	4 341
Total hospital beds	14 871	204	464	23 854	151	1 052	19 519	..
Beds in publicly owned hospitals	13 922	178	..	22 552	..	1 052	14 956	..
Beds in not-for-profit privately owned hospitals	632	-	..	-	..	-	..	..
Beds in for-profit privately owned hospitals	317	-	..	1 302	..	-	..	23 885
<i>Beds per 100 000 inhabitants</i>								
Curative (acute) care beds	213	-	..	305	251	226	339	226
Rehabilitative care beds	3	-	..	8	34	14	41	..
Long-term care beds	4	-	..	120	172	37		17
Other hospital beds	0	-	..	3	-	50		1
Psychiatric care beds	40	53	..	62	62	47	115	44
Total hospital beds	260	412	821	435	519	342	380	..
Beds in publicly owned hospitals	243	360	..	412	..	342	291	..
Beds in not-for-profit privately owned hospitals	11	-	..	-	..	-	..	..
Beds in for-profit privately owned hospitals	6	-	..	24	..	-	..	244

1 Greenland does not divide beds in categories and there are only public beds. Number of beds indicated in totals

Source: DK, the Danish Health Data Authority; FO, Ministry of Health Affairs; GL, Chief Medical Officer; FI, THL National Institute for Health and Welfare; ÅL, The Åland Government; IS, Directorate of Health; NO, Statistics Norway; SV, National Board of Health and Welfare

Appendix

Further Information on the Bodies Responsible for Statistics in the Nordic Countries

The following bodies responsible for statistics in the Nordic countries can be contacted for further information concerning the statistics in this publication.

Denmark

Statistics Denmark
www.dst.dk

Responsible for:

- Population statistics
- Statistics on alcohol consumption
- Statistics on health care economy

The Danish Health Data Authority
www.sundhedsdatastyrelsen.dk

Responsible for:

- Statistics on births
- Statistics on induced abortions
- Statistics on congenital anomalies
- Statistics on causes of death
- Statistics on hospital services
- Statistics on health care personnel
- Statistics on pharmaceutical products

Statens Serum Institut
www.sst.dk

Responsible for:

- Statistics on infectious diseases
- Statistics and information on vaccinations

National Board of Health
www.sst.dk

Responsible for:

- Statistics on the use of tobacco

Faroe Islands

Statistics Faroe Islands
www.hagstova.fo

Responsible for:

- Population and vital statistics

Chief Medical Officer
www.landslaeknin.fo

Responsible for:

- Statistics on infectious diseases
- Statistics on forensics
- Statistics on births
- Statistics on causes of death

Chief Pharmaceutical Officer
www.apotek.fo

Responsible for:

- Statistics on pharmaceutical products

Ministry of Health and the Interior
www.himr.fo

Responsible for:

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

The Danish Health Data Authority
www.sundhedsdatastyrelsen.dk

Responsible for:

- Statistics on causes of death
- Statistics on health care economy

Greenland

Statistics Greenland

www.stat.gl

National Board of Health

www.nun.gl

E-mail: nun@nanoq.gl

The Danish Health Data Authority

www.sundhedsdatastyrelsen.dk

Chief Pharmaceutical Officer

www.peqqik.gl

E-mail: apotek@peqqik.gl

The Department of Health and Infrastructure

Responsible for:

- Population and vital statistics

Responsible for:

- Statistics on births
- Statistics on induced abortions
- Statistics on infectious diseases

Responsible for:

- Statistics on causes of death
- Statistics on cancer

Responsible for:

- Statistics on pharmaceutical products

Responsible for:

- Statistics on hospital services
- Statistics on health care economy
- Statistics on health care personnel

Finland

Statistics Finland

www.stat.fi

National Institute for Health and Welfare

www.thl.fi

Responsible for:

- Population and vital statistics
- Statistics on causes of death
- Statistics on road traffic accidents
- Statistics on income and living conditions (EU-SILC)

Responsible for:

- Statistics on institutional care
- Statistics on births
- Statistics on congenital anomalies
- Statistics on induced abortions
- Statistics on health care personnel
- Statistics on public health care
- Statistics on private health care
- Statistics on labour force in health care
- Statistics on the use of alcohol and drugs
- Statistics on the use of tobacco
- Statistics on health care expenditure
- Definitions and classifications in health care
- Statistics on primary health care
- Statistics on hospital care and surgery

National Agency for Medicines (FIMEA)
www.fimea.fi

- Statistics on infectious diseases
- Statistics and information on vaccinations
- Health interview and examination surveys
- Public Health Report

Social Insurance Institution of Finland (FPA)
www.kela.fi

Responsible for:

- Registration of pharmaceutical products and sales licences
- Statistics on adverse drug reactions
- Statistics on pharmacies

The Cancer Register
www.cancer.fi

Responsible for:

- Sickness insurance benefits and allowances, reimbursements for medicine expenses for pharmaceutical products, and disability pensions

Åland

The Åland Government
www.regeringen.ax

Responsible for:

- Statistics on cancer and cancer screening

Statistics Finland
National Institute for Health and Welfare
National Agency for Medicines
Finnish Cancer Registry
Social Insurance Institution of Finland
Finnish Centre for Pensions

Responsible for:

- Statistics on health care personnel
- Statistics on hospital services, such as capacity (number of beds)
- Statistics on health care economy - user charges for health care

See Finland

Iceland

Statistics Iceland
www.statice.is

Responsible for:

- Population and vital statistics
- Statistics on alcohol consumption
- Statistics on health care expenditure
- National accounts

Directorate of Health
www.landlaeknir.is

Responsible for:

- Medical statistics on births
- Statistics on induced abortions
- Statistics on sterilizations
- Statistics on primary health care
- Statistics on hospital services
- Statistics on infectious diseases
- Statistics on vaccinations
- Statistics on health care personnel
- Statistics on causes of death
- Statistics on use of tobacco

Icelandic Medicines Agency
www.imca.is

Responsible for:

- Statistics on pharmaceutical products

Icelandic Cancer Society
www.krabb.is

Responsible for:

- Statistics on cancer

Norway

Statistics Norway
www.ssb.no

Responsible for:

- Population and vital statistics
- Statistics on health and social conditions
- Statistics on health and social services
- Statistics on health care personnel
- Statistics on alcohol consumption
- Statistics on health care economy
- Statistics on use of tobacco

Norwegian Institute of Public Health
www.fhi.no

Responsible for:

- Statistics on sexually transmitted diseases and infectious
- Statistics on tuberculosis
- Statistics on immunization
- Statistics on sale of pharmaceutical products
- Statistics on prescription drugs
- Statistics on births and infant deaths
- Statistics on induced abortions
- Statistics on causes of death

Norwegian Directorate of Health
www.helsedirektoratet.no

Responsible for:

- Statistics on hospital services

Cancer Registry of Norway
www.kreftregisteret.no

Ministry of Health and Care Services
www.regjeringen.no/en/dep/hod

Sweden

Statistics Sweden
www.scb.se

National Board of Health and Welfare
www.socialstyrelsen.se

Public Health Agency of Sweden
www.folkhalsomyndigheten.se

Swedish Association of Local Authorities and Regions
www.skl.se

Responsible for:

- Statistics on cancer

Responsible for:

- Statistics on in vitro fertilization

Responsible for:

- Population and vital statistics
- Statistics on health care expenditure
- Survey on Living Conditions (ULF/SILC)

Responsible for:

- Statistics on births
- Statistics on induced abortions
- Statistics on in-patients and accidents
- Statistics on surgery
- Statistics on cancer
- Statistics on causes of death
- Statistics on prescription drugs
- Statistics on authorized health personnel
- Definitions and classifications in health care

Responsible for:

- Statistics on infectious diseases
- Statistics and information on vaccinations
- Statistics on alcohol consumption

Responsible for:

- Statistics on hospital capacity
- Statistics on health economics - user charges for health care

NOMESCO's Publications since 2000

Recurring Publications

Each year, NOMESCO publishes *Health Statistics in the Nordic Countries*. Up until and including 2011, this was a bi-lingual publication in Danish (Nordic languages) and English.

In cooperation with the Nordic Centre for Classification of Health Services (Nordclass), NOMESCO publishes NOMESCO Classification of Surgical Procedures. The publication was updated annually until 2011 the most recent version is 1.16.

In cooperation with the Baltic countries, the publication Nordic/Baltic Health Statistics has been published four times, the latest version with data from 2006.

Moreover, a number of theme publications have been published. These are shown below with their number in NOMESCO's publication list.

107. Statistics on Patient Mobility in the Nordic Countries, 2017
106. Health and health care of the elderly in the Nordic Countries - From a statistical perspective, 2017
105. Social Inequality in Mortality in the Nordic Countries - The impact of smoking and alcohol, 2017
99. Financing of Health Care in the Nordic Countries, 2013
92. NOMESCO Report on Mortality Statistics - Theme section 2010, NOMESCO, Copenhagen 2010
90. Temasektion vedrørende kvalitetsindikatorer, NOMESCO's Health Statistics in the Nordic Countries 2009, NOMESCO, Copenhagen 2010
88. Medicines Consumption in the Nordic Countries 2004-2008. NOMESCO, Copenhagen 2010
82. Ældres Helse, Temasektion, Health Statistics in the Nordic Countries 2006
80. Mental Helse, Temasektion, Health Statistics in the Nordic Countries 2005
79. NOMESCO Classification of External Causes of Injuries. Fourth revised edition. NOMESCO, Copenhagen 2007
78. Sustainable Social and Health Development in the Nordic Countries. Seminar, 6th April 2006, Oslo. Seminar Report. NOMESCO, Copenhagen 2006
76. Smedby, Björn and Schiøler Gunner: Health Classifications in the Nordic Countries. Historic development in a national and international perspective 2006. NOMESCO, Copenhagen 2006
72. Medicines Consumption in the Nordic Countries 1999-2003. NOMESCO, Copenhagen 2004