

Health Statistics in the Nordic Countries 2001
Helsestatistik for de nordiske lande 2001

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København 2003

Tryk: Notex - Tryk & Design

Omslag: Kjeld Brandt, Grafisk tegnestue ApS
Forsidefoto: BAM/Heine Pedersen

ISBN 87-89702-46-8

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Less than half of the unit used	Mindre end halvdelen af den anvendte enhed	0.0/0
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Preface

Forord

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

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

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

Section B, which is this year's theme section, deals with a study of day surgery.

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

*Nordic Medico-Statistical Committee
(NOMESCO)*

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

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

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

Sektion B, der er årets temasektion, omhandler dagkirurgi.

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

*Nordisk Medicinalstatistisk Komité
(NOMESKO)*

SECTION A

Health Statistics 2001
Helsestatistik 2001

CHAPTER I

Organization of health services Organiseringen af sundhedsvæsenet

Introduction

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

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

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

Specialist medical treatment is also offered outside hospitals.

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

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

Salary or cash allowances are payable to employees during illness. Self-employed

Indledning

I de nordiske lande er sundhedsvæsenet et offentligt anliggende.

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

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

Speciallægebehandling tilbydes også uden for sygehusene.

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

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

Under sygdom får lønmodtagere enten udbetalt en kontantydelse eller løn. Selv-

people have the possibility to insure themselves in case of illness.

stændige erhvervsdrivende har mulighed for at forsikre sig ved sygdom.

Current and future changes in the health services

DENMARK: In order to increase activity in the health services, and to reduce waiting time for examination and treatment, in 2002 the government granted an extra DKK 1 500 million to the health services. This shot in the arm has resulted in a marked increase in activity and in falling waiting times, for example for cataract, hip and knee operations.

In the economic agreement with the counties for 2003, DKK 510 million have been allocated to strengthen the hospital sector. The money shall be specially allocated to continued increased activity within the following areas: cancer, cardiology, medicine, postgraduate education for physicians and introduction of IT-systems in the health sector.

In order to ensure greater availability of different types of health service, and in order to increase competition between providers, on 1 July 2002, the government extended patients' rights to free choice of hospital. Patients can now apply to be treated at a private hospital or a hospital abroad that has a contract with the state, if the waiting list in the public hospitals is longer than two months. There are currently about one hundred hospitals and clinics that have such a contract. At the beginning of the year, about 5 500 citizens had chosen to use their extended right to free choice of hospital.

Igangværende og kommende ændringer i sundhedsvæsenet

DANMARK: For målrettet at øge aktiviteten i sundhedsvæsenet og nedbringe ventetiderne til undersøgelse og behandling tilførte regeringen i 2002 ekstra 1,5 mia. kr. til sundhedsvæsenet. Denne saltvandsindsprøjtning har resulteret i en markant forøgelse af aktiviteten og i fallende ventetider – bl.a. på grå stær-, hofte- og knæoperationer.

Med aftalen om amternes økonomi for 2003 er der afsat 510 mill.kr. til en forstærket generel indsats på sygehusområdet. Pengene bliver især anvendt til en fortsat styrket indsats på kræftområdet, hjerteområdet, det medicinske område, lægers videreuddannelse og indførelse af IT-systemer i sundhedsvæsenet.

For at sikre et mere varieret udbud af sundhedsydelser og øget konkurrence blandt udbydere har regeringen pr. 1. juli 2002 indført et udvidet frit valg af sygehus. Udvidelsen betyder, at patienter nu kan søge behandling på et privat sygehus eller et sygehus i udlandet, der har indgået aftale med det offentlige, når ventetiden til de offentlige sygehuse overstiger 2 måneder. På nuværende tidspunkt er der indgået aftale med omkring 100 sygehuse og klinikker. Ved årsskiftet havde 5.500 borgere valgt at benytte det udvidede frie valg.

ORGANIZATION OF HEALTH SERVICES

From April 2003, the right to free choice of medical practitioner will also be extended. Up until now it has not been possible for patients to choose a doctor further than 10 kilometres from their home. It will now be easier, for example, to keep the same doctor after moving home and to choose a doctor in the vicinity of one's workplace.

In order to ensure continued development of the services provided by the health sector, a National Strategy for Quality Development has been developed, covering the period 2002-2006. The strategy has five main themes: development of a quality culture, continuity in patients' movement through the system, measurement of, evaluation of and communication about quality, education and development of competence, and documentation and information technology. In order to follow up the strategy, draft legislation has been proposed on the establishment of a reporting system for errors and unintentional events. In addition, during 2003 and 2004, through quality declarations, systematic information about the quality of the country's hospital departments will be available to citizens.

In the autumn of 2002, the government presented the health programme "Healthy throughout life". This programme builds on earlier health policy goals for prevention, among other things by having a new focus on prevention of the following eight common diseases: maturity-onset diabetes, preventable types of cancer, cardiovascular diseases, osteoporosis, musculoskeletal diseases, allergies, mental illnesses and lung diseases caused by smoking.

Fra april 2003 vil det frie valg af praktiserende læge også blive udvidet. Hidtil har det ikke været muligt at vælge en læge, der ligger længere end 10 km. fra egen bolig. Friere lægevalg vil f.eks. gøre det nemmere at beholde sin læge ved flytning, vælge sin læge tættere på arbejdspladsen osv.

For at sikre en fortsat udvikling af de ydelser, der leveres i sundhedsvæsenet, er der udarbejdet en National Strategi for Kvalitetsudvikling, der dækker perioden 2002-2006. Strategien indeholder fem hovedtemaer: udviklingen af en kvalitetskultur, sammenhængende patientforløb, kvalitetsmåling-, vurdering og formidling, uddannelse og kompetenceudvikling og dokumentation og IT. Som opfølgning på strategien er der fremsat lovforslag om etablering af et rapporterings-system for fejl og utilsigtede hændelser. Endvidere vil borgerne i løbet af 2003 og 2004 via kvalitetsdeklarationer få adgang til systematiserede oplysninger om kvaliteten på landets sygehusafdelinger.

I efteråret 2002 fremlagde regeringen sundhedsprogrammet "Sund hele livet", der bygger videre på de tidligere sundhedspolitiske mål for forebyggelsen bl.a. med et nyt fokus på følgende 8 store folkesygdomme: aldersdiabetes, forbyggelige kræftsygdomme, hjerte-karsygdomme, knogleskørhed, muskel- og skeletlidelser, overfølsomhedssygdomme, psykiske lidelser og rygerlunger.

In order to procure the best possible evidence base, at the start of 2002, the government set up an advisory committee for the area of health. The committee, which presented its report in January 2003, has, among other things, recommended that hospitals should be given greater freedom to organize their activities, that responsibility for planning and running hospital services should be concentrated in fewer units, and that the central running of hospital services should be strengthened. Among other things, these recommendations will be followed up in 2003 with draft legislation on increased freedom for hospitals and increased use of DRG-funding (diagnosis related groups).

Finally, the government has established a Structure Commission, which shall evaluate the advantages and disadvantages of different organizational models for the public sector – including the health sector – and propose recommendations for changes that can be appropriate for many years. The committee will present its report at the turn of the year, 2003/2004.

GREENLAND: After the last election (December 2002) the health and social areas have been amalgamated under one Directorate for Social Affairs and Health, under the politically responsible leadership of a member of parliament – similar to a minister. Overall administrative leadership for clinical health services is placed in the Directorate of Health. Two units have responsibility for running the services: Dr. Ingrid's Hospital in Nuuk has responsibility for the main hospital, and the Board for the Health Districts has responsibility for the sixteen health districts.

Med henblik på at tilvejebringe det bedst mulige vidensgrundlag nedsatte regeringen i starten af 2002 et rådgivende udvalg på sundhedsområdet. Udvalget, der afgav betænkning i januar 2003, har bl.a. anbefalet, at der gives større frihedsgrader for de enkelte sygehuse i tilrettelæggelsen af arbejdet, at ansvaret for planlægning og styring af sygehusvæsenet samles hos færre enheder, og at den centrale styring af sygehusvæsenets faglige virksomhed styrkes. Anbefalingerne bliver i 2003 bl.a. fulgt op med lovforslag om øgede frihedsgrader til sygehusene og øget brug af takststyring.

Endelig har regeringen nedsat en Strukturkommission, som skal vurdere fordele og ulemper ved alternative modeller for indretninger af den offentlige sektor – herunder sundhedsvæsenet – og komme med anbefalinger til ændringer, som er holdbare over en længere årrække. Udvalget afgiver betænkning ved årsskiftet 2003/04.

GRØNLAND: Sundheds- og socialområdet er efter seneste valg (dec. 2002) lagt sammen i et sundheds- og socialdirektorat under politisk ansvarlig ledelse af et landsstyremedlem – kan sammenlignes med minister. Den overordnede administrative ledelse for det kliniske sundhedsvæsen findes i Direktoratet for Sundhed, selve driften er udskilt i 2 enheder, Dr. Ingrid's Hospital i Nuuk med drift af landshospitalet og Kystledelsen med drift af de 16 sundhedsdistrikter.

ORGANIZATION OF HEALTH SERVICES

Within the process that is currently underway for increased take-over of the health services by the Greenland Home Rule, there is a desire to revise health legislation. There is, for example, an increasing need for this in the areas of psychiatry and authorization of pharmaceutical products.

FINLAND: In order to reduce expenses on pharmaceutical products, and in order to make use of these products more homogeneous, from 1 April 2003 it is obligatory for pharmacies to dispense the cheapest alternative of prescription medicines (generic substitution). Pharmacies shall substitute pharmaceutical products with the cheapest home-produced or imported preparation.

The National Agency for Medicines has developed a list of parallel products, that is products of the same quality, containing the same active substance and that are biologically equal. If the cheapest product is not in the pharmacy's range of products, the product can be substituted by a product that is almost as cheap. The price difference between the cheapest product and the next cheapest product has been determined as EUR 2-3. However, the patient has the right to have the cheapest substitute product to be found on the market. This means that the pharmacy, in many cases, must obtain the cheapest product.

Doctors and dentists who prescribe pharmaceutical products can refuse to allow generic substitution if there are medical or therapeutic reasons for this. The patient can also refuse to accept a substitute product.

I den pågående proces mod øget overtagelse af sundhedsvæsenet indenfor hjemmestyret indgår ønsker om revision af lovgrundlaget for sundhedsvæsenet, eksempelvis er der stigende behov herfor indenfor områderne psykiatri, autorisationer og lægemidler.

FINLAND: For at reducere udgifterne til lægemidler og for at lægemiddelforbruget skal blive mere ensartet er apotekerne fra og med 1. april 2003 blevet tvunget til at udskifte ordinerede lægemidler med billigere præparater (generisk substitution). Apotekerne skal udskifte lægemidlet med det billigste indenlandske eller importerede præparat.

Läkemedelsverket har udarbejdet en liste over parallelpræparater. Det vil sige præparater af samme kvalitet, med tilsvarende aktiv substans og som biologisk set er jævnbyrdige. Hvis det billigste præparat eventuelt ikke findes i apotekets sortiment, kan præparatet udskiftes med et præparat der er næsten lige så billig. Prisforskellen mellem det billigste præparat og det der er næsten lige så billig er fastsat til 2-3 EUR. Kunden/patienten har imidlertid ret til at få det billigste, substituerbare præparat, der findes på markedet, hvilket betyder at apoteket i en række tilfælde bliver nødt til at fremskaffe præparatet.

Læger og tandlæger der ordinerer medicin kan modsætte sig at der benyttes generiske substitution hvis der findes medicinske eller terapeutiske årsager hertil. Patienten kan også modsætte sig udskiftningen.

From 1 January 2003, war veterans can be given 10 per cent discount on pharmaceutical products. The changes to the regulations on charges for pharmaceutical products came into force at the turn of the year, which means that it is obligatory for all pharmacies, with certain exceptions, to give 10 per cent discount to war veterans for all usual pharmaceutical products that are included in the reimbursement system, and for pharmaceutical products outside the health insurance scheme, including most over-the-counter medicines.

However, the right to be given a discount does not apply to purchase of pharmaceutical products over and above the annual price ceiling. It also does not apply to pharmaceutical products that, according to the Health Insurance Act, give the right to special reimbursement, or to products that are expensive. The reason for these restrictions is that, in these cases, the discount should not at all, or to any degree, reduce the maximum patient charge that is part of the health insurance.

ICELAND: From 1 July 2002 the National Economic Institute in Iceland (NEI) ceased to exist. Some of the previous responsibilities of the NEI were transferred to Statistics Iceland (e.g. national accounts - health accounts) and others to the Ministry of Finance.

A new law, the Public Health Institute Act, came into force on 1 July 2003. The new Public Health Institute shall promote and coordinate work on public health and shall have responsibility for prevention of tobacco use and alcohol and drug abuse, nutrition, accident pre-

Fra 1. januar 2003 kan krigsveteraner få 10 pct. rabat på lægemidler. Ved årsskiftet ikrafttræder ændringerne i forordninger om lægemiddeltakster, hvilket indebærer at alle apoteker er forpligtigede til, med visse undtagelser, at give 10 procents rabat til krigsveteraner på almindelige lægemidler der er omfattet refusions-systemet men også for lægemidler der er udenfor sygeforsikringsystemet, blandt andet de fleste håndkøbspræparater.

Retten til rabat gælder dog ikke de lægemiddelsindkøb som foretages efter at grænsen for den årlige selvrisikos beløb (maksimale egenbetaling) er overskredet og heller ikke for lægemidler der i følge sygeforsikringsloven er berettiget til særlig refusion eller er betydelige og dyre lægemidler. Motiveringen for denne begrænsning er at rabatten i disse tilfælde ikke i det heletaget eller i nogen grad skulle reducere selvrisikoandelen (den maksimale egenbetaling) der er indbygget i sygeforsikringen.

ISLAND: Fra og med 1. juli 2002 blev Statens Økonomiske Institut nedlagt. Nogle af de tidligere arbejdsområder overgik til Hagstofa Islands (så som nationalregnskabet, regnskabet for sundhedsøkonomi), andre arbejdsopgaver overgik til finansministeriet.

En ny lov, Loven om Institut for Folkesundhed, trådte i kraft 1. juli 2003. Folkesundhedsinstituttet skal fremme og koordinere arbejdet med folkesundhed, samt have ansvaret for det forebyggende arbejde for tobaksforbrug og alkohol- og narkotikamisbrug, ernæring, ulykkesfo-

ORGANIZATION OF HEALTH SERVICES

vention and other matters of prevention and health promotion. Its role is also to disseminate information on public health in cooperation with the Directorate of Health, among others, and to promote public health education and research in cooperation with universities and other educational institutions. The Institute shall also make recommendations to the authorities on measures to improve public health.

NORWAY: On 1 January 2002 the central government took over responsibility for all public hospitals in Norway. Delivery of specialized health care, including hospital care, is now the responsibility of five regional health authorities. Each regional health authority covers a specific part of the country. They are relatively free to organize provision of services, in conformity with legal requirements. Hospitals are now organized as health trusts, which are separate legal entities.

Also on 1 January 2002, a restructuring of central governmental bodies in the field of health was implemented. This involved the establishment of the Norwegian Directorate for Health and Social Affairs, reorganization of the National Institute of Public Health to form the Norwegian Institute of Public Health, and reorganization of the Norwegian Board of Health. The Ministry of Health and Social Affairs was divided into two ministries: the Ministry of Health and the Ministry of Social Affairs.

Many small government institutions became incorporated into larger ones, among them the following: The National Council for Tobacco and Health, the National Council on Nutrition and Physical Activity, the

rebyggelse og andre forhold vedrørende sundhedsfremmende aktiviteter. Det er også instituttets opgave at viderebringe information vedrørende sundhedsfremme i et samarbejde med bl.a. Medicinaldirektoratet samt fremme uddannelse og forskning i et samarbejde med universitetet og andre uddannelsesinstitutioner. Institutet skal også komme med anbefalinger til myndigheder om tiltag til at fremme folkesundheden.

NORGE: Fra 1. januar 2002 overtog staten ansvaret for alle offentlige sygehuse i Norge. Fem regionale sundhedsmyndigheder har nu ansvaret for den specialiserede behandling inklusiv sygehuse. Hver regional myndighed har sit eget geografiske område. De står relativt frit til å organisere behandlingen som de vil, i overensstemmelse med love og forskrifter. Sygehuse er nu organiseret som sundhedsvirksomheder, som er juridiske enheder.

Per 1. januar 2002 blev der også gennemført en reorganisering af de centrale myndigheder. Dette medførte etableringen af Sosial- og helsedirektoratet, reorganisering af Folkehelse til Nasjonalt folkehelseinstitutt samt en reorganisering af Helsetilsynet. Sosial- og helsedepartementet blev opdelt i to ministerier, Helsedepartementet og Sosialdepartementet.

Mange mindre statslige institutioner blev sammenlagt. Statens tobakkskaderåd, Statens råd for ernæring og fysisk aktivitet, Rusmiddeldirektoratet og Giftinformationscentralen blev en del af det nye

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Norwegian Directorate for the Prevention of Alcohol and Drug Problems and the National Poison Information Centre became part of the new Norwegian Directorate for Health and Social Affairs. The National Health Screening Service became part of the Norwegian Institute of Public Health.

From 1 January 2002, the Norwegian Board of Health has fewer areas of responsibility, but its role as a supervisory body has been strengthened. Responsibility for national plans of action and many administrative functions has been transferred to the Norwegian Directorate for Health and Social Affairs.

The Norwegian Registration Authority for Health Personnel was established on 1 January 2001 as a body under the Norwegian Board of Health. From 1 January 2002 it is a body under the Norwegian Directorate for Health and Social Affairs.

From 1 January 2003, the former offices of the chief county medical officers were integrated into the offices of the county governors. They are now known as the Norwegian Board of Health in the respective counties. They still come directly under the Norwegian Board of Health in matters of supervision of health services.

From 1 January 2003, the National Board of Health has been given general responsibility for supervision of social services. Supervision of these services is carried out by the county governors.

SWEDEN: On 1 January 2003, a new act on biobanks in the health sector came into force.

Sosial- og helsedirektoratet. Statens hel-seundersøkelser blev en del af det nye Nasjonalt folkehelseinstitutt.

Fra 1. januar 2002 har Helsetilsynet mindre omfattende sagsområder. Tilsynsprofilen er styrket, mens statlige handlingsplaner og mange forvaltning-soppgaver m.m. er overført til det nye Sosial- og helsedirektoratet.

Statens autorisasjonskontor for helsepersonell, der blev oprettet 1. januar 2001 som organ under Helsetilsynet, har fra 1. januar 2002 Sosial- og helsedirektoratet som overordnet.

Fra 1. januar 2003 integreres embedslæ-gerne i fylkesmannsembederne, og får betegnelsen "Helsetilsynet i Finnmark" osv. Helsetilsynet i fylkene (amterne) er fortsat direkte underlagt Helsetilsynet når det gælder tilsynssager.

Fra 1. januar 2003 fik Helsetilsynet det overordnede ansvar for tilsyn med den sociale service, der hvor tilsynet i fylkene (amterne) udføres af Fylkesmannen.

SVERIGE: Den 1. januar 2003 trådte en ny lov i kraft vedrørende biobanker indenfor sundhedsvæsenet m.v.

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In January 2003, the Committee on Genetic Integrity presented a report on legislative regulation of research with stem cells.

On January 2003, the government presented a draft legislation to the parliament concerning ethical evaluation of research on humans and human biological material.

In December 2002, a draft legislation was proposed concerning cooperation between the municipal and county authorities concerning the nursing and care sector. Through a new act, the municipal and county authorities shall have the possibility to cooperate in order to jointly carry out tasks within the nursing and care sector.

In March 2003, a final report was presented concerning fellow citizens' influence in relation to changes in ownership and organizational structure within health care. The report deals with the issue of privatization and the role of the private sector in the treatment of disease.

In a report, it is proposed that private medical practitioners and private nurses should be allowed to work in the public sector until the age of 70. The present limit is 67 years of age. The extended age-limit should also apply to dentists and dental hygienists who work to promote dental health.

In October 2002, the committee for dealing with access to public documents and the secrecy act presented a report about arrangements and care concerning public documents. A new act concerning public documents is proposed.

Komiteen vedrørende genetisk integritet har i januar 2003 overdraget en betænkning vedrørende retslig regulering af forskning i stamceller.

I januar 2003 overdrog regeringen et lovforslag til parlamentet vedrørende etisk vurdering af forskning vedrørende personer og biologisk materiale fra mennesker.

I december 2002 blev der fremsat et lovforslag vedrørende samarbejde mellem kommuner og landsting indenfor pleje – og omsorgsområdet. Kommunerne og landstingene skal gennem en ny lov have mulighed for at samarbejde i fælles nævn for sammen at gennemføre arbejdsopgaver indenfor pleje- og omsorgsområdet.

I marts 2003 kom en endelig betænkning angående medborgers indflydelse m.v. ved ændringer i ejer og driftsformer indenfor sundhedsvæsenet. I udredningen har man behandlet spørgsmålet om privatisering og hvilken rolle private fortjenester spiller i sygdomsbehandlingen.

I en udredning foreslås det privatpraktiserende læger og sygeplejersker skal kunne arbejde indenfor det offentlige indtil de fylder 70 år. Den nuværende aldersgrænse er 67 år. Den udvidede aldersgrænse bør også gælde for tandlæger og tandplejere der arbejder for forsikringen for tandpleje.

Komiteen for adgang til dokumenter i den offentlige forvaltning (Offentlighets- och sekretesskommittén) har oktober 2002 afleveret delbetænkningen *Ordning og reda bland allmänna handlinger*. Der foreslås en ny lov vedrørende den almindelige sagsbehandling.

Organization and responsibility for the health sector

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

County authorities and municipalities have the operational responsibility.

In the event of ordinary illness, the use of the health service by citizens is based on a century-long tradition of family doctors. The formal rules have been drawn up in accordance with the health insurance scheme, so that primary contact is always, in principle, with the general practitioner. One can only use the hospital service as an alternative in cases of emergency.

Likewise, consultations with dentists are made with privately practising dentists. The only public dental services are for some parts of the dental care scheme for children.

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

Child health care is linked to the health administration of the municipalities, and is provided according to the statutes for visiting nurse schemes, whereas health ex-

Organisering og ansvar for sundhedsvirksomheden

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

Driftsansvaret påhviler amter og kommuner.

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

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

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

Børnesundhedsplejen, der gives i henhold til loven om sundhedsplejerskeordninger, er knyttet til kommunernes sundhedsforvaltning, mens helbredsundersø-

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aminations of children are carried out by general practitioners according to agreement with the health insurance scheme.

Home-nursing schemes are linked to municipalities, providing treatment free of charge following referral from a physician.

Immunization programmes are laid down by the Ministry of the Interior and Health and are carried out by general practitioners, generally in connection with routine health examinations of children.

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

School and occupational health services are regulated according to statutes. Municipalities are responsible for school health services, which are provided by health visitors and physicians. Occupational health services are organized within the framework of companies and are led by committees with representatives for both employees and employers.

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

The hospital service is placed organisationally under the counties, and the county authorities are the responsible authorities. The counties own most of the

gelses af børn udføres af de alment praktiserende læger efter overenskomst med sygesikringen.

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

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

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

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

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

Sygehusvæsenet hører organisatorisk under amterne og Hovedstadens Sygehusfællesskab, og det er amtsrådene og bestyrelsen for Hovedstadens Sygehusfæl-

hospitals. The hospitals in the City of Copenhagen and Frederiksberg municipality, and Rigshospitalet have been merged into the Joint Metropolitan Hospital Service. There are a few private hospitals which have an agreement of usership with the county in which they are located, and a few small private hospitals which operate totally independently of the public hospital service.

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

Almost all practising specialist physicians work according to an agreement with the health insurance scheme and receive the majority of their patients by referral from general practitioners. There are, however, certain exceptions to this rule, such as practising eye and ear specialists.

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

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

FAROE ISLANDS: The Faroe Islands Act concerning health care came into force in 1995, and according to that Act the Faroe Islands' home rule determines

lesskab, der er den ansvarlige myndighed. Amterne ejer de fleste af sygehuse- ne. Sygehusene i København og Frederiksberg kommuner samt Rigshospitalet, er samlet i Hovedstadens Sygehusfælleskab. Der er enkelte private sygehuse, som har en fast benyttelsesaftale med det amt hvori de ligger, mens nogle få mindre, private sygehuse fungerer helt uafhængigt af det offentlige sygehusvæsen.

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

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

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

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

FÆRØERNE: Lov om sundhedsvæsenet på Færøerne blev sat i kraft i 1995 hvorefter Færøernes hjemmestyre fastsætter regler om sundhedsvæsenets op-

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the rules concerning the tasks of the health service, benefits and administration. The hospital structure and its organization, specialist fields and their organization, and the primary health service and its organization largely follow the Danish system. The same applies to nursing homes, home nurses and home helps, and dental treatment.

The Danish Act concerning central administration of health care came into force in the Faroe Islands in 1995. The Danish Act concerning medical officers etc. also applies to the Faroe Islands.

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

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

Midwifery services are organized under the hospital services.

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

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

gaver, ydelser og administration. Hospitalsstrukturen og organisationen, speciallægeordninger og deres organisation samt det primære sundhedsvæsen og dets organisation følger i alt væsentligt danske forhold. Det samme gør sig gældende for plejehjem, hjemmesygepleje og hjemmehjælp samt tandbehandling.

Den danske lov om sundhedsvæsenets centrale styrelse trådte i kraft for Færøerne i 1995. Desuden er den danske lov om embedslægeinstitutionen m.v. gældende på Færøerne.

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

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

Jordemoderordningerne er organiseret under sygehusvæsenet.

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

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

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

Health services are organized in 16 health districts, each with a health centre, where primary health services and preventive measures are provided. Other types of examination, for example blood tests and radiographs, can be carried out. Acute operations can be performed and inpatient services can be provided. If necessary, or in complicated cases, patients can be sent to Dr. Ingrid's Hospital in Nuuk or to a hospital in Denmark, or from the east coast of Greenland to Iceland.

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

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

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

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

Sundhedsvæsenet er organiseret i 16 sundhedsdistrikter, hver med et sundhedscenter, som forestår den primære og forebyggende sundhedsindsats. Der findes mulighed for supplerende undersøgelser eks blod- og røntgen. undersøgelser, der kan foretages akutte operationer og ydes døgnpleje til indlagte patienter. Ved behov og komplicerede forløb visiteres til Dr. Ingrid's Hospital i Nuuk eller til sygehus i Danmark, fra østkysten evt. til Island.

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

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

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

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

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

There are no occupational health services in Greenland.

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

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

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

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

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

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

Der er ikke indført BST – bedriftssundhedstjeneste i Grønland.

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

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

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

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

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

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

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

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

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

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

Kommunerne skal desuden tilvejebringe sygetransport og sørge for etableringen af bedriftssundhedstjenester. Arbejdsgiverne kan selv organisere bedriftssundhedstjenesten, eller de kan indgå aftale med et sundhedscenter eller andre der arbejder med bedriftssundhedstjenesten.

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

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

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

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

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

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

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

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

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

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

Det offentlige sundhedsvæsens forpligtigelser, struktur og organisation reguleres i landskabsloven om sundhedsvæsenet (Lagen om hälso- och sjukvården 1993). Loven er en rammelov, som efter behov kan suppleres med bekendtgørelser. Detaljerede bestemmelser om virksomheden beskrives hvert år i en virksomhedsplan.

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Åland legislation, or that are not regulated by separate legislation, follow Finnish legislation.	Forhold som ikke hører under ålandsk lovgivning, eller som ikke har egen lovgivning, tilpasses finsk lovgivning.
The whole public health service comes under an overall organization called Åland's Health Care Organization (ÅHS). The organization is governed by a politically elected board.	Hele det offentlige sundhedsvæsen, er underordnet en samlet organisation, Ålands hälso- och sjukvård (ÅHS). Organisationen ledes af en politisk valgt styrelse.
The Government of Åland has overall responsibility for ensuring that the population receives necessary medical care. The role of the municipalities is limited to financing certain defined types of treatment. Specialist treatment, including psychiatric treatment, is one of two sectors in the ÅHS.	Landskapsstyrelsen er hovedansvarlig og har ansvaret for at befolkningen får den nødvendige sygdomsbehandling. Kommunernes ansvar og indflydelse er begrænset til visse nærmere afgrænsede finansieringsforpligtigelser. Den specialiserede sygdomsbehandling, inkl. behandlingen af psykiatriske patienter, udgør den ene af to enheder i ÅHS.
Services that cannot be provided locally are bought from Finland and Sweden, either from private practitioners, private institutions or university hospitals.	Service som ikke kan produceres af egne enheder købes af producenter i Finland og Sverige, enten hos privatpraktiserende, private institutioner eller universitets-sygehuse.
The Åland hospitals are specialized institutions that provide both outpatient and inpatient treatment.	De ålandske sygehuse er specialiserede institutioner, der udfører såvel ambulans behandling og behandling af indlagte patienter.
Specialized treatment outside the hospitals is provided in the form of consultative support for primary health care treatment and for private general practitioners.	Speciallægevirksomheden uden for sygehuse eksisterer i form af konsultativ bistand til den offentlige primære behandling og til de privatpraktiserende læger.
Primary health care is the other sector under the ÅHS. The structure corresponds functionally as well as ideologically to the Finnish public health care system. Advice concerning contraception and counselling for mothers and infants, and school health services, function as in Finland. Immunization programmes are	Det primære sundhedsvæsen er den anden resultatenhed inden for ÅHS. Strukturen svarer ideologisk og driftsmæssigt til det finske folkesundhedsarbejde. Rådgivning vedrørende prævention, rådgivning til mødre og småbørn samt skole-sundhedspleje, fungerer som i Finland. Vaccinationsprogrammer er frivillige, og

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voluntary and the recommendations are as in Finland. Physiotherapy under the ÅHS is a shared function both for the primary health care service and the hospitals. In addition a number of private physiotherapists are used by the public sector. Occupational health services are organized in the same way as in Finland.

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

Regulations for pharmacies are the same as in Finland.

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

- The Act on the Rights of Patients
- The Social Security Act
- The Act on Patient Insurance
- The Act on Communicable Diseases
- The Act on Physicians

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

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

anbefalingerne svarer til de finske. Fysioterapien inden for ÅHS er en fællesfunktion for både primærsektoren og sygehuse. Som et supplement er der et antal private fysioterapeuter som også anvendes af det offentlige. Beriftssundhedstjenesten organiseres som i Finland.

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

Reglerne for apotekervæsenet er det samme som i Finland.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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pension scheme, as is the case for old people's homes, or through the health insurance scheme, as is the case for nursing homes.

Dental treatment is mainly provided by private dental practitioners. Dental services are also provided at some of the health centres. These health centres have dental clinics that can be used by private dental practitioners.

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

Pharmacies are privately run.

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

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

de gennem pensionsforsikringen, for plejehjemmenes vedkommende gennem sygeforsikringen.

Tandbehandlingen udføres for det meste af privatpraktiserende tandlæger. Tandplejeordning findes også ved nogle af sundhedscentrene. Her er der indrettet klinikker som kan anvendes af privatpraktiserende tandlæger.

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

Apoteker drives af private.

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

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

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

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

In Norway there is currently a National Mental Health Programme for the period 1999 to 2006. This programme aims at improving accessibility, quality and organization of mental health services and treatment on all levels. A central idea of the Mental Health Programme is to promote deinstitutionalization, with considerable emphasis on community-based psychiatry, where treatment is given closer to the pa-

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

- Sundhedsfremme og forebyggelse af sygdomme og skader, herunder at organisere og drive skolesundhedsvæsenet og sundhedscentre samt børnesundhedspleje udført af sundhedsplejersker, jordemødre og læger. Sundhedscentre skal tilbyde svangerskabsopfølgning og -kontrol samt vaccinationer efter de anbefalede vaccinationsprogrammer.
- Diagnosticering, behandling og revalidering. Dette omfatter ansvaret for den almindelige lægebehandling (inkl. lægevagtordninger), fysioterapi og sygepleje (inkl. sundhedsplejersker og jordemødre).
- Pleje og omsorg i og uden for institutionerne. Kommunerne har ansvaret for driften af sygehjemmene, hjemmesygepleje og andre ordninger (fx hjemmehjælp). Sundhedsydelse i og uden for institutionerne er i varierende grad forankret i en fælles organisatorisk enhed i form af en fælles pleje- og omsorgsafdeling i kommunen.

Der findes i øjeblikket et nationalt program for psykiatrien for perioden 1999 til 2006. Det er programmets målsætning at der gives den nødvendige adgang for psykiatrisk behandling, kvalitetssikring og udbud af behandling på alle niveauer. Det er centralt for programmet at man fremmer en deinstitutionisering af behandlingen med betydelig vægt på distriktspsykiatrien, hvor behandlingen gives i tæt kontakt til patients

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tient's local community and primary health services. These community clinics represent an all-round psychiatric practice and consist of a network of services, such as multidisciplinary treatment and teamwork, in addition to programmes for accommodation, occupation and social support.

The county authorities are responsible for providing public dental services for the following groups: children and adolescents (under 21 years of age) and intellectually disabled adults. Elderly people, disabled people, and people with chronic illnesses who live in institutions or who receive home nursing care are also entitled to treatment from the public dental service. Dental services for the rest of the population are mainly provided by private general dental practitioners, and paid for by the patients.

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

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

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

- Health Care Personnel Act
- Patients' Rights Act
- Patient Injury Act

lokale samfund og i tilknytning til den almindelige lægebehandling. Disse lokalklinikker repræsenterer en bredt funderet psykiatrisk praksis og består af et netværk af udbud såsom multidisciplinær behandling og teamwork sammen med programmer for bolig, beskæftigelse og social støtte.

Amterne (fylkene) har ansvaret for tandbehandlingen til følgende grupper; børn og unge under 21 år og mentalt handicappede voksne. Ældre, funktionshæmmede og personer med kroniske sygdomme der lever på institutioner eller modtager hjemmesygepleje er også berettiget til tandpleje fra den offentlige tandpleje. Tandbehandling for resten af befolkningen gives hovedsageligt af privatpraktiserende tandlæger og patienterne betaler selv for behandlingen.

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

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

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

- Helsepersonelloven
- Pasientrettighedsloven
- Pasientskadeloven

- Specialized Health Services Act
- Municipal Health Services Act
- Health Authorities and Health Trusts Act
- Communicable Diseases Act
- Supervision Act
- Mental Health Care Act
- Dental Health Services Act
- Tobacco Act
- Pharmacy Act
- Medicinal Products Act
- Abortion Act
- Specialisthelsetjenesteloven
- Kommunehelsetjenesteloven
- Helseforetaksloven
- Smittevernloven
- Tilsynsloven
- Psykisk helsevernloven
- Tannhelsetjenesteloven
- Tobakkskadeloven
- Apotekloven
- Legemiddeloven
- Abortloven

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

Primary health care is run by 18 county authorities and three regions. Since 1991 there has been a pilot scheme, in which some municipalities have had responsibility for primary health care services. The act allows the scheme to continue until the end of 2003. The experiment will continue in one municipality during 2003.

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

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

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

Det primære sundhedsvæsen drives af de 18 landsting og tre regioner. Siden 1991 har der været iværksat forsøg hvor nogle kommuner har været hoved ansvarlig for det primære sundhedsvæsen. Loven åbner mulighed for at fortsætte med forsøgene indtil udgangen af 2003. En kommune fortsætter forsøget i løbet af 2003.

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

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

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

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

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

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

The hospitals are run by the county and regional authorities.

The county hospitals comprise both more specialized hospitals covering the whole county and hospitals covering only part of the county. Medical treatment is

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

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

Socialstyrelsen udarbejder den almindelige vejledning for vaccination af børn.

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

Sygehusene drives af landstingene og regionerne.

Lenssygehusene omfatter såvel mere specialiserede sygehuse, der dækker hele lenet, som sygehuse, der dækker dele af lenet. Sygdomsbehandlingen foregår in-

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

Pharmacies are run by the state.

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

Supervision of health services

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

The medical officers are employed by institutions for medical officers of which there is one in every county and one in the City of Copenhagen. These institutions are state-run and thus independent, politically and administratively, of the county and municipal authorities, which have responsibility for the health service supplied to the general public. In this

den for de fleste specialer dels ved sygeafdelinger (sluten vård), dels i ambulatorier (öppen vård). Psykiatrisk behandling, som ofte er sektoropdelt, henregnes under lenssygehusvæsenet. Mere krævende og specialiseret sygdomsbehandling foregår på de regionale sygehuse. Landstingene og regionerne samarbejder i seks behandlingsregioner, hver med mindst ét regionssygehus.

Apotekerne er statslige.

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

Tilsyn med sundhedsvæsenet

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

Embedslægerne er ansat ved embedslægeinstitutionerne, som der er én af i hvert amt, samt én i Københavns Kommune. Disse institutioner er statslige og således politisk og administrativt uafhængige af amter og kommuner, der har ansvaret for sundhedsvæsenets betjening af befolkningen. Embedslægerne kan således fungere som uafhængige rådgivere og er til-

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way, the medical officers function as independent advisers and supervisors at all levels and are authorized to take necessary measures either by consultation or by handing over further treatment of a case to the central authorities. The institutions are attached to the National Board of Health, both professionally and financially.

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

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

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

FAROE ISLANDS: The rules for supervision of health service are, by and large, the same as in Denmark, both concerning

synsførende på alle niveauer. Institutionerne er bemyndiget til at foretage det fornødne, enten i form af påtale eller ved videregivelse af sagens behandling til de centrale tilsynsmyndigheder. Såvel fagligt som budgetmæssigt er embedslægeinstitutionerne knyttet til Sundhedsstyrelsen.

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

Klager over autoriseret sundhedspersonale indgives til Patientklagenævnet. Efter forbehandling af sagerne (partshøringer, faglig vurdering m.v.) hos embedslægen træffes den endelige afgørelse af Patientklagenævnet.

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

FÆRØERNE: Reglerne for tilsyn med sundhedsvæsenet er i alt væsentligt identiske med forholdene i Danmark, både

who has responsibility for supervision (the chief medical officer) and regarding in which areas supervision shall be carried out and procedures for complaints.

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

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

The most important channel for nationwide supervision of health and social services is through legislation and related statutes. In addition, the government ratifies nationwide plans for the health and social sector for the following election period (four years). Overall planning, coordination and supervision of the statutory services is

hvad angår hvem der fører tilsynet (Embedslægen/Landslægen), hvilke områder der føres tilsyn med samt vedrørende klageadgange/muligheder.

GRØNLAND: Tilsynsmyndigheden er Embedslægeinstitutionen i Grønland som er en sundhedsfagligt uafhængig institution under Grønlands Hjemmestyre. Embedslægeinstitutionen yder rådgivning og anden bistand i sundhedsfaglige spørgsmål til Landsstyret og andre myndigheder. Tilsynsområderne er sundhedsvæsenets institutioner, sundhedsfaglige personer samt kommunale og andre institutioner. Sundhedsfaglige klager rettes skriftligt til Embedslægeinstitutionen, som vurderer, forbereder og sagsfremstiller klagen, før den videresendes til Sundhedsvæsenets Patientklagenævn i København som foretager den endelige behandling, høring og afgørelse. Klager over service samt krav om erstatninger behandles af Direktoratet for Sundhed.

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

De vigtigste kanaler til den landsdækkende styring af social- og sundhedsvæsenet er lovgivning og dertil hørende forordninger. Regeringen godkender desuden de landsdækkende planer for social- og sundhedsområdet for den kommende regeringsperiode (fire år). Den generelle planlægning, styring og tilsynet med de

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the responsibility of the Ministry of Social Affairs and Health. Planning, managing and supervising services at the county level is the responsibility of the county authorities. The chief medical officers and the forensic pathologists act as medical advisers to the regional administration of the Ministry of Social Affairs and Health. In addition there are six government institutions that contribute to supervision of health services.

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

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

ÅLAND: Supervision of health personnel is carried out according to Finnish law and is administered by the Government of Åland.

Complaints concerning treatment can either be addressed, as in Finland, to the

lovpligtige ydelser påhviler Social- och hälsovårdsministeriet. Planlægning, styring og tilsyn inden for lenene påhviler länsstyrelserne. Embedslægerne og retslægerne fungerer som lægelige rådgivere for Social- och hälsovårdsministeriets regionale administration. Hertil kommer seks statslige institutioner som medvirker ved tilsynet med sundhedsvæsenet.

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

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

ÅLAND: Tilsynet med sundhedspersonalet sker efter finsk lovgivning og foretages lokalt af Landskapsstyrelsen.

Klager over behandlingen kan - som i Finland - enten indgives til de respektive

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

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

The system of district medical officers was abolished from 1 July 2002 and most of their former duties were taken over by the health centres. The State Drug Inspectorate supervises pharmacies and pharmaceutical products.

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

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

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

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

Fra og med 1. juli 2002 blev systemet med embedslæger afskaffet og de fleste af deres arbejdsopgaver blev overtaget af sundhedscentrene. Lægemedeltilsynet fører det farmaceutiske tilsyn med apoteker og lægemidler.

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

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

ORGANIZATION OF HEALTH SERVICES

These bodies are professional and independent supervision authorities, with competence in the fields of health, health legislation and government administration. Together they contribute to ensuring that:

- The needs of the population for health services are met.
- Health services are run in accordance with acceptable professional standards and current laws and regulations.
- Deficiencies in provision of health services are prevented.
- Health service resources are utilized effectively and efficiently.

In addition, they act as complaints board. The Norwegian Board of Health (centrally) and the Norwegian Board of Health in the counties process complaints against both institutions and individual health personnel. Initially, complaints are dealt with by the Norwegian Board of Health in the county. They can find that the conditions laid down in laws and regulations have not been met and can give advice on how to make improvements.

If there are grounds for more serious sanctions against an institution or health personnel, the complaint may be forwarded to the Norwegian Board of Health (centrally). If an institution is run in a way that is below acceptable standards, the Norwegian Board of Health may order changes to be made to rectify the situation.

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

Disse organer skal være faglig kompetente og uafhængige tilsynsmyndigheder hvor deres forskellige faglighed supplerer hinanden og samlet bidrager de til:

- At befolkningens behov for sundhedsydelser varetages .
- At sundhedsvæsenet drives på en faglig forsvarlig måde efter gældende lov og forordninger.
- Forebyggelse af mangler i sundhedsvæsenet.
- At ressourcerne til sundhedsvæsenet anvendes på en forsvarlig og effektiv måde.

Tilsynsmyndigheden er ligeledes patientklageinstans. Helsetilsynet (sentralt) og Helsetilsynet i amterne (fylkene) behandler klager både rettet mod institutioner/virksomheder og den enkelte sundhedsmedarbejder. I første omgang er det Helsetilsynet i amterne (fylkene) som behandler klagerne, og de kan i tilfælde af, at der konstateres afvigelser fra regelsættene rette kritik mod de aktuelle aktører.

Hvis der er et grundlag for at benytte strengere sanktioner mod virksomheden eller sundhedspersonalet oversendes klagen til Helsetilsynet (sentralt). Helsetilsynet kan, hvis virksomheden drives uforsvarligt, pålægge den at rette forholdene.

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

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

Patients can also address their complaints to the person in charge of an institution (e.g. the municipal board in the case of municipal health services), or to the Norwegian System for Compensation for Injuries to Patients, in the case of claims for compensation related to treatment in the public health service. The Patient Injury Act, that came into force on 1 January 2003, enhances patients' possibilities to complain, among other things by describing both the complaints procedure and patients' rights.

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

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

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

Efter reglerne har enhver virksomhed som udbyder sundhedsydelser pligt til at etablere et internt kontrolsystem med henblik på at sikre at virksomheden drives i overensstemmelse med love og forskrifter.

Patienterne vil også kunne klage til den ansvarlige for virksomheden (fx kommunalbestyrelsen når det gælder kommunale sundhedsydelser) eller til Norsk patientskadeerstatning, hvis der er tale om erstatning som følge af behandling i det offentlige sundhedsvæsen. Patientskadeloven, der gælder fra og med 2003, styrker patienternes klageadgang i forhold til tidligere ordninger, blandt andet ved at klageordningen beskrives og ved at forskellige rettigheder omtales.

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

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

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

ORGANIZATION OF HEALTH SERVICES

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

The agencies with overall responsibility for health services have their own impartial (patient) boards that are independent of health institutions. Patients' complaints may be addressed to these boards. The main aims of these boards are: to provide sound information and to ensure acceptable solutions for patients.

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

Financing of health services

In the Nordic countries, the health services are mainly financed by the public authorities. In Iceland, contributions are primarily made by the government, while financing in the other countries mainly consists of county and/or municipal taxes with general grants from the governments. In the Nordic countries, the governments issue block grants to the counties and/or municipalities. With the exception of Greenland, citizens in the Nordic countries contribute directly to financing, partly through insurance

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

De hovedansvarlige for sundhedsvæsenet har egne upartiske nævn (patientnævn) som er uafhængige af behandlingsstederne og hvortil man kan henvise klager fra patienterne. Hovedformålet med nævne er at de skal bidrage med god information og at sikre løsninger som patienterne er indforståede med.

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

Finansiering af sundhedsvæsenet

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

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

en finansieringsmodel for de somatiske sygehuse (fra 1. juli 1997) som kombinerer bloktilskud og stykprisfinansiering. Stykprisfinansieringen bygger på det princip, at en serviceproducent (det vil sige sygehuset) får indtægter beregnet ud fra udførte serviceopgaver. Ordningen indebærer, at staten refunderer en vis procentandel af de gennemsnitlige DRG-udgifter (Diagnose Relaterede Grupper) ved amtskommunal patientbehandling.

Charges for health care as per 1 January 2003

Egenbetaling for sundhedsydelser pr. 1. januar 2003

Consultation with a physician

Lægebesøg

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

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

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

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

- A fixed annual charge of max. EUR 22 within one year or:
- A fixed charge per visit of max. EUR 11. The charge is only made for the first three visits at the same health centre during one calendar year.
- En fast årlig betaling på højst 22 EUR inden for et år, eller:
- Et fast beløb pr. besøg, dog højst 11 EUR. Beløbet skal kun betales for de første tre besøg på et og samme sundhedscenter i løbet af samme kalenderår.

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

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

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

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

ÅLAND: For medical consultations within the primary health service at the clinic or for home visits, there is a user charge of EUR 12. Outside the opening hours the charge is EUR 23. Patients pay for a maximum of five visits during a calendar year for children under 18 years for primary health care and for hospital outpatient treatment. The maximum patient contribution for primary health care and outpatient treatment is EUR 350 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 23 per day to EUR 13 per day. The activities included in the maximum user charge have been fixed beforehand. If there is a waiting period of 45 minutes or more in connection with a scheduled visit, within opening hours, the user charge is reimbursed.

ICELAND¹: Prophylactic health care consultations for pregnant women and mothers with infants, and school health care are free of charge.

The patient charge for a consultation in a health centre or with a private general

De nævnte beløb opkræves ikke af personer under 18 år.

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

ÅLAND: Egenbetaling for lægebesøg inden for det primære sundhedsvæsen i konsultationen eller ved hjemmebesøg er 12 EUR. Uden for åbningstiden er det 23 EUR. Der betales højest for 5 besøg i løbet af et kalenderår for børn under 18 år i det primære sundhedsvæsen og ved ambulante behandling. Der er indført maksimal egenbetaling på 350 EUR for lægebesøg og ambulante behandling indenfor et kalenderår hvorefter der ikke betales den resterende del af året med undtagelse af kortvarig institutions/hospitalsophold hvor betalingen reduceres fra 23 EUR pr døgn til 13 EUR pr døgn. De aktiviteter som medregnes i den maksimale egenbetaling er fastlagt på forhånd. Hvis der er en ventetid på 45 minutter eller mere ved en aftalt besøg, indenfor åbningstiden, tilbagebetales egenbetalingen.

ISLAND¹: Lægebesøg af forebyggende karakter for gravide, nye mødre og deres børn samt skolesundhedsplejen er uden egenbetaling.

Egenbetalingen for konsultation i sundhedscentre eller ved en privat praktise-

¹ As per 15. January 2003

¹ Per 15. januar 2003

medical practitioner during normal working hours is ISK 500. The charge is ISK 250 for children under 18, pensioners, disabled people, and long-term unemployed people. The charge is ISK 150 for children who are handicapped or chronically ill. Outside normal working hours the respective charges are ISK 1 400, 600 and 400 respectively. Charges for home visits are ISK 1400, 500 and 400 during the daytime and ISK 2 000, 750 and 500 in the evenings and at night.

The charge for a consultation with a specialist is either ISK 2 100 plus 40 per cent of the remaining cost of the consultation, or ISK 700 plus one third of the remaining 40 per cent. The minimum charge for handicapped and chronically ill children is ISK 350. The maximum charge for all groups is ISK 18 000. The same patient charges apply to outpatient treatment in hospitals and casualty departments. Different charges apply to laboratory tests and X-ray examinations.

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

rende læge er i dagtimerne 500 ISK og 250 ISK for børn under 18, pensionister, handicappede og langtidсарbejdsløse. Handicappede og langtidssyge børn betaler 150 ISK. Konsultation udenfor dagtimerne er henholdsvis 1 400, 600 og 400 ISK. For hjemmebesøg er betalingen i dagtimerne 1 400, 500 og 400 ISK mens aften- og nattaksten er 2 000, 750 og 500 ISK.

Egenbetalingen for besøg hos en specialist er enten 2 100 ISK plus 40 pct. af de resterende udgifter, eller 700 ISK og en tredjedel af de resterende 40 pct. For handicappede og langtidssyge børn er egenbetalingen minimum 350 ISK. For alle grupper er maksimumbetalingen 18 000 ISK. Egenbetalingen er den samme ved behandling ved hospitalernes ambulatorier og skadestuer men en anden for laboratorieprøver og røntgenbehandling.

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

ORGANIZATION OF HEALTH SERVICES

User charges for a consultation with a physician

	Are there consistent rules for the whole country?	Size of user charge	Deviations	User charge in relation to total cost of consultation
Denmark	Yes	-	No	-
Faroe Islands	Yes	-	No	-
Greenland	Yes	-	No	-
Finland	Yes	Public EUR 0-11. EUR 15 if the visit occurs between 8 p.m. and 8. a.m. or on a Saturday, a Sunday or a public holiday. Private min. 40 per cent	No charge for children under 18 years of age	17 per cent
Åland	Yes	EUR 12 Outside opening hours EUR 23	Public, no charge for children under 18 years after 5 consultations; Free treatment after the payment of EUR 350	..
Iceland	Yes	ISK 500-2 000 in primary care, other rules for specialized care	ISK 250-750 for children under 18 years of age, pensioners, disabled and long-term unemployed. For handicapped and chronically ill children ISK 150-500	Varies
Norway	Yes	NOK 114 for primary care, NOK 200 for specialized care	No	Approx. 35 per cent
Sweden	No	SEK 100- 300		..

NORWAY: There is a user charge for medical consultations with general practitioners, specialists and outpatient treatment in hospitals. The health insurance offers full reimbursement for treatment of children under the age of seven years, treatment of industrial injuries, war injuries, pregnancy and childbirth, and, in certain other cases (e.g. treatment of dangerous contagious diseases, psychotherapy for persons under the age of 18 years, and treatment of prison inmates).

SWEDEN: Local authorities (county and regional authorities) set the charges themselves. According to the law, the maximum amount a patient shall pay for

NORGE: Der er egenbetaling for lægebesøg hos både almene læger og speciallæger, samt ambulat behandling ved sygehusene. Folketrygden yder fuld refusion ved behandling af børn under 7 år, ved behandling af arbejdsskader, krigsskader, svangerskab/fødsler og i enkelte andre tilfælde (fx behandling af farlige, smitsomme sygdomme, psykoterapeutisk behandling af personer under 18 år og behandling af indsatte i fængsler).

SVERIGE: De lokale myndigheder (landstingene og regionerne) fastsætter selv taksterne. I følge loven skal patienter højest betale 900 SEK for ambulat

Egenbetaling for lægebesøg

	Er der ensartede regler i hele landet?	Egenbetalingens størrelse	Afvigelser	Egenbetalingens andel af de samlede udgifter til lægebesøg
Danmark	Ja	-	Nej	-
Færøerne	Ja	-	Nej	-
Grønland	Ja	-	Nej	-
Finland	Ja	Offentlig 0-11 EUR. 15 EUR for besøg mellem kl 20-8.00 på hverdage, samt lørdage, søndage og helligdage Privat mindst 40 pct.	Ingen betaling for børn under 18 år	17 pct
Åland	Ja	12 EUR 23 EUR utom öppet-hållningstider	Ingen egenbetaling for børn under 18 år efter 5 besøg; Fri behandling når der er betalt 350 EUR	..
Island	Ja	500-2 000 ISK hos almen læge, andre regler for besøg hos specialist	250-750 ISK for børn under 18 år og for pensionister, handicappede og langtidsarbejdsløse. For handicappede og langtids-syge børn 150-500 ISK	Varierende
Norge	Ja	114 NOK hos almen læge. 200 NOK hos speciallæger	Nej	Ca. 35 pct.
Sverige	Nej	100-300 SEK		..

out-patient treatment is SEK 900 during a 12 month period. For medical consultations in out-patient clinics and visits to a health centre or a general medical practitioner, the user charge varies from SEK 100 to 150. The patient charge for a medical consultation with a specialist (in hospitals or in private practice) varies from SEK 180 to 300.

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

behandling for en 12 måneders periode. For ambulant behandling, besøg på helsecentre eller hos huslægen varierer egenbetalingen fra 100 til 150 SEK, mens den varierer fra 180 til 300 SEK ved lægebesøg hos specialister (ved sygehusene eller hos privatpraktiserende læger).

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

Reimbursement for pharmaceutical products

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

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

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

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

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

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

Tilskud til lægemidler

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

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

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

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

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

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

ORGANIZATION OF HEALTH SERVICES

User charges for pharmaceutical products

	Are there consistent rules for the whole country?	Size of user charge	Deviations	User charge in relation to total cost of pharmaceutical products
Denmark	Yes	Reimbursement in relation to the level of the patient's consumption of drugs	No	33,5 per cent
Faroe Islands	Yes	As in Denmark	No	..
Greenland	Yes	-	No	-
Finland	Yes	EUR 10 and 50 per cent of the cost exceeding EUR 10	For certain diseases, EUR 5 and 0/25 per cent of the cost exceeding EUR 5 is paid	47.3 per cent
Åland	Yes	As in Finland	As in Finland	-
Iceland	Yes	ISK 1700+ 65/80 per cent of the remaining cost, but max. ISK 3 400/4 950	Pensioners and disabled: ISK 600 + 50 per cent of the remaining cost, but max. ISK 1 050/1 375	Approx. 48 per cent
Norway	Yes	36 per cent maximum NOK 400 per receipt	For children below 7 years and persons who receive a minimum pension: no user charge	..
Sweden	Yes	SEK 0 - 1 800	-	..

Egenbetaling for lægemidler

	Er der ensartede regler i hele landet?	Egenbetalingens størrelse	Afvigelser	Egenbetalingens andel af de samlede udgifter til lægemidler
Danmark	Ja	Tilskud afhængig af størrelsen af den enkelte patients lægemiddelforbrug	Nej	33,5 pct.
Færøerne	Ja	Som i Danmark	Nej	..
Grønland	Ja	-	Nej	-
Finland	Ja	10 EUR og 50 pct. af det beløb som overskrider 10 EUR	Ved visse sygdomme betales 5 EUR og 0/25 pct. af det beløb som overskrider 5 EUR.	47,3 pct.
Åland	Ja	Som i Finland	Som i Finland	-
Island	Ja	1 700 ISK + 65/80 pct. af den resterende pris, dog højst 3 400/4 950 ISK	Pensionister og handicappede: 600 ISK + 50 pct. af den resterende pris, dog højst 1 050/1 375 ISK	Ca. 48 pct.
Norge	Ja	36 pct. maksimum 400 NOK pr. recept	For børn under 7 år og minstepensionister: ingen egenbetaling	..
Sverige	Ja	0 -1 800 SEK	-	..

ORGANIZATION OF HEALTH SERVICES

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

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

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.

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

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

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

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

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

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

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

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

As a main rule, the health insurance scheme reimburses expenditure on prescription pharmaceutical products exceeding EUR 601.15 in the course of one calendar year.

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

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

There is a reference price system. For generic drugs of the same type, strength and package size, the reimbursement is calculated in relation to the maximum reference price, i.e. the lowest priced generic product. The present reference price list covers about 16 per cent of registered drugs.

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

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

Som hovedregel dækker sygeforsikringen de udgifter til receptpligtige lægemidler som overskrider et beløb på 601,15 EUR i løbet af et kalenderår.

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

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

Der findes desuden et referenceprissystem. For synonympræparater med samme form, styrke og forpakning, beregnes tilskuddet i forhold til den maksimale referencepris, forstået som den laveste pris på synonympræparatet. Den nuværende referenceprisliste dækker ca. 16 pct. af de registrerede lægemidler.

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

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

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

Treatment in hospitals

As shown in the overview, there are no user charges for hospitalization in Denmark, the Faroe Islands, Greenland, Ice-

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

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

Behandlinger ved sygehuse

Som det fremgår af skemaet er der ingen brugerbetaling for sygehusophold i Danmark, på Færøerne, i Grønland, Is-

land and Norway. In Iceland and Norway, however, there is a charge for specialist out-patient treatment in hospitals, see the section on consultations with a physician.

FINLAND AND ÅLAND: Patients pay a charge for admission to hospital, psychiatric wards or health centres. For short-term treatment there is a charge of EUR 12 per day (In Åland EUR 23). The charge for rehabilitation is EUR 9 per treatment day and the maximum user charge for day surgery is EUR 72 plus EUR 26 (Åland EUR 46) if the patient has to stay overnight. A ceiling has been introduced for the maximum user charge of EUR 590 (In Åland EUR 350) during one calendar year, after which services are free of charge for the rest of the year, with the exception of short-term stays in institutions/hospitals, for which the user charge can be reduced from EUR 23 per day to EUR 13 per day.

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

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

All county and regional authorities, with the exception of four of them, have agreed that children and young people under the age of

land og Norge. Dog betales der i Island og Norge for ambulat specialistbehandling ved hospitaler, jvf. afsnittet om lægebesøg.

FINLAND OG ÅLAND: Patienterne betaler for indlæggelse på hospital, psykiatrisk afdeling eller sundhedscenter. For korttidsbehandling betales der 12 EUR pr behandlingsdag (på Åland 23 EUR). Betaling for revalidering er 9 EUR pr behandlingsdag og den maksimale betaling for dagkirurgi er 72 EUR, plus 26 EUR (Åland 46 EUR) hvis der er behov for en overnatning. Der er indført et loft på den maksimale egenbetaling på 590 EUR (på Åland 350 EUR) i løbet af et kalenderår, hvorefter ydelser er gratis resten af året, bortset fra kortvarige institutions/hospitals-ophold hvor egenbetalingen kan reduceres fra 23 EUR pr døgn til 13 EUR pr døgn.

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

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

Alle landsting og regioner på nær fire har besluttet at der skal ydes gratis sygdomsbehandling til børn og unge under 20 år

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User charges for hospitalization

	Are there consistent rules for the whole country?	Size of user charge	Deviations	User charges in relation to total cost of hospitalization
Denmark	Yes	-	No	-
Faroe Islands	Yes	-	No	-
Greenland	Yes	-	No	-
Finland	Yes	EUR 12 per day in short term care, EUR 72 for day surgery plus EUR 26 if overnight stay needed	Payment for long-term stay according to means	9.5 per cent
Åland	Yes	EUR 23 per visit and EUR 23 per day in short term care.	Payment for long-term stay according to means	9.5 per cent
Iceland	Yes	-	No	-
Norway	Yes	-	No	-
Sweden	No	SEK 0-80 per day	Early retirement pensioners under the age of 40 pay only half the cost for the first 30 days of each sickness period	..

Egenbetaling for indlæggelse på sygehus

	Er der ensartede regler i hele landet?	Egenbetalingens størrelse	Afvigelser	Egenbetalingens andel af de samlede udgifter til indlæggelse på sygehus
Danmark	Ja	-	Nej	-
Færøerne	Ja	-	Nej	-
Grønland	Ja	-	Nej	-
Finland	Ja	12 EUR pr sengedag for korttidsophold, 72 EUR for dagkirurgi plus 26 EUR hvis der er behov for overnatning	Betaling for langtidsophold efter betalingsevne	9,5 pct.
Åland	Ja	23 EUR pr besøg og 23 EUR for korttidsophold	Betaling for langtidsophold efter betalingsevne	9,5 pct.
Island	Ja	-	Nej	-
Norge	Ja	-	Nej	-
Sverige	Nej	0-80 SEK/dag	Førtidspensionister under 40 år betaler kun det halve i de første 30 dage af hver sygdomsperiode	..

20 years receive free medical treatment (three county authorities have set the age limit for free treatment to the calendar year in which young people reach 19, and one county authority has set the age limit up to and including 17 years).

(tre landsting har fastsat grænsen til det kalenderår hvor de fylder 19 og i et landsting er det gratis til og med 17 år).

Reimbursement for dental treatment

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

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

Children and young people under 18 years of age receive free municipal dental care including orthodontic treatment. Elderly people who live in a nursing home or in their own home with technical aids are offered dental care for which there is a maximum annual charge of DKK 370.95. In addition, the municipalities provide a subsidy for dentures in cases of impaired function or disfigurement resulting from damage caused by accidents.

The counties offer specialist dental treatment (county dental service) to persons, who because of psychiatric illness or mental handicap, cannot use the existing dental

Tilskud til tandbehandling

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

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

Der er vederlagsfri kommunal tandpleje, herunder tandregulering, for børn og unge under 18 år. Ældre personer, der bor på plejehjem eller i eget hjem med mange hjælpeforanstaltninger, tilbydes omsorgstandpleje, for hvilken der maksimalt opkræves 370,95 DKK pr. år. Kommunen yder derudover støtte til tandproteser i tilfælde af funktionelt ødelæggende eller vansirende følger af ulykkesbetingede skader.

Amtet tilbyder specialiseret tandpleje (amtstandpleje) til personer, der på grund af sindslidelser eller psykisk udviklingshæmning, ikke kan udnytte de eksisterende

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services for children and young people, for adults, or for people needing special care. For these services, the county, from 1 January 2003, charges the patient a maximum of DKK 1 377.82 per year.

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

In addition, the county grants a special reimbursement for dental care to cancer patients, who either due to radiation of the head and neck, or due to chemotherapy, suffer considerable documented dental problems, and to persons who due to Sjögrens syndrome suffer considerable documented dental problems. From 1. January 2003, for these services the county may charge a user payment of a maximum of DKK 1 377.82 annually. Finally, the counties provide highly specialized dental advice, examination and treatment (in dental research centres) for patients with rare diseases and handicaps, for whom the underlying condition leads to special problems with their teeth, mouth or jaws.

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

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 privately practising

tandplejetilbud i børne- og ungdomstandplejen, voksentandplejen eller i omsorgstandplejen. For disse ydelser kan amtet fra 1. januar 2003 opkræve en egenbetaling på maksimalt 1 377,82 DKK årligt.

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

Amtet yder herudover et særligt tilskud til tandpleje for kræftpatienter, der enten på grund af strålebehandling i hoved og halsregion eller på grund af kemoterapi har betydelige dokumenterede tandproblemer samt til personer, der på grund af Sjögrens Syndrom har betydelige dokumenterede tandproblemer. For disse ydelser kan amtet fra 1. januar 2003 opkræve en egenbetaling på maksimalt 1 377,82 DKK årligt. Endeligt yder amtet højt specialiseret odontologisk rådgivning, udredning og behandling (i odontologisk landsdels- og videnscenter) af patienter med sjældne sygdomme og handicap, hos hvem den tilgrundliggende tilstand giver anledning til specielle problemer i tænder, mund og kæbe.

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

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

FÆRØERNE: Tandbehandlingen foregår hovedsageligt hos privatpraktiserende

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dentists. Payment is therefore partly private, but compulsory membership of the health insurance scheme gives the right to a subsidy. The subsidy amounts to about half of the total cost of dental treatment for adults.

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

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

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

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

FINLAND: The health insurance scheme reimburses 60 per cent of the treatment costs within the rates fixed by the Social Insurance Institution for one annual dental examination. Orthodontic treatment is only reimbursed if the treatment is necessary to avoid 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 also refundable, and expenses for drugs prescribed by a dentist and travelling costs to visit a dentist, under the same terms as for medical prescriptions and travelling costs to visit a physician.

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

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

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

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

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

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

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

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ÅLAND: All public dental treatment for persons under 19 years of age is free of charge. For others, the cost of a dental visit is EUR 7, with additional standard fees for items of treatment and examinations. The patient pays the actual cost of orthodontic treatment and prosthetic treatment. The same rules as in Finland apply for treatment with private dentists.

ICELAND: The health insurance scheme reimburses 75 per cent of the cost of dental treatment for children under the age of 18, except for gold and porcelain crowns and bridges, and orthodontic treatment. The cost of orthodontic treatment may be refunded by up to ISK 150 000. People with chronic illnesses, old age pensioners and disability pensioners get their costs fully or partially covered. For this group, 50, 75 or 100 per cent of the cost of dental treatment may be covered, except for gold and porcelain crowns and bridges.

For treatment (including orthodontic treatment), for congenital malformations, serious abnormalities such as cleft palate and in cases of aplasia, accidents and illness, payments are made according to special rules. Dental treatment is not subsidized for the rest of the population.

NORWAY: Adults over 20 years of age pay for their own dental treatment. Dental treatment, except for orthodontic treatment, is free of charge for young people under the age of 18 years. The same applies to certain other groups: e.g. mentally handicapped people (both those living home and those living in institutions), and elderly people, people with chronic illnesses and disabled people living in institutions.

ÅLAND: All offentlig tandbehandling for personer under 19 år er gratis. For andre koster et besøg 7 EUR med tillæg for udgifter til de enkelte foranstaltninger og undersøgelser efter særlige takster. For tandregulering og proteser betales de faktiske udgifter. For besøg hos private tandlæger gælder de samme regler som i Finland.

ISLAND: Sygeforsikringen yder refusion til tandbehandling. Bortset fra guld- og porcelænskroner, broer og tandregulering ydes der 75 pct. til tandbehandling af børn i alderen under 18 år. Tandregulering kan refunderes med op til 150 000 ISK. Langtidssyge samt alders- og invalidepensionister får ligeledes dækket deres udgifter helt eller delvist. Der kan til denne gruppe ydes 50, 75 eller 100 pct. dækning af udgifterne til tandbehandling, dog ikke for guld- og porcelænskroner eller broer.

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

NORGE: Voksne over 20 år betaler normalt selv for tandbehandling. Tandbehandling, bortset fra tandregulering, for unge under 18 år er uden egenbetaling. Det samme gælder for visse andre grupper: fx psykisk udviklingshæmmede (både dem der bor hjemme og på institutioner), ældre, kronisk syge og handicappede der bor på institution.

Adolescents 18-20 years of age receive subsidized dental care. The county authorities cover a minimum of 75 per cent of the costs of dental treatment for this group.

The National Insurance Scheme provides reimbursement for the cost of certain types of dental treatment, such as maxillo-facial surgery, orthodontic treatment, treatment of the soft tissues in the mouth and jaws, and treatment of periodontitis.

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

All persons aged 20 years or more pay part of the cost for conservative treatment. The rest of the cost is paid by the state directly to the dentist. This rule will soon no longer apply for prosthetic treatment. Dental fees are not regulated, which means that dentists decide the cost of the various types of treatment themselves. It is also possible to have a two-year contract for treatment at a fixed price. For persons 65 years or more prosthetic treatment is limited to SEK 7 700 plus the cost of materials. The dental treatment insurance pays the rest of the cost of treatment directly to the dentist.

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

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

Unge I alderen 18 – 20 år modtager tandbehandling med refusion. Amterne (fylkene) betaler mindst 75 procent af udgifterne til behandling for denne aldersgruppe.

Folketrygden giver tilskud til visse typer af behandling så som operative indgreb, købeortopædi, behandling af sygdomme i mundens og købens bløddele, samt behandling af periodontitis.

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

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

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

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

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- Surgical dental treatment carried out in hospitals
- Dental treatment that is a part of the treatment of disease over a limited period of time
- Dental treatment for certain elderly or disabled people who have difficulties maintaining their oral hygiene.
- Kirurgisk tandbehandling som udføres ved et sygehus
- Tandbehandling der er led i en sygdomsbehandling i en begrænset periode
- Tandbehandling til visse ældre og handicappede som har svært ved at klare mundhygiejne.

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

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

Maximum charges

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

FINLAND: If the total cost of pharmaceutical products exceeds EUR 615.15 per year, or if travelling costs for treatment exceed EUR 157.26 per year (151.37 for travelling costs related to rehabilitation), the Social Insurance Institution reimburses the excess costs. If a person's ability to pay taxes is reduced because of sickness, a special tax relief may be granted. The amount of the tax relief is calculated on the basis of the person's and his/her family's ability to pay taxes.

User charges for a long-term stay in an institution or a hospital cannot exceed 80 per cent of a patient's/resident's net income. The same charge is payable in all kinds of institutions within the social and

Maksimal egenbetaling

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

FINLAND: Hvis den maksimale egenbetaling for medicin udgør 615,15 EUR pr. år og hvis udgifterne til transport i forbindelse med behandling overstiger 157,26 EUR pr. år (151.37 for transport i forbindelse med revalidering), vil Folkpensionsanstalten dække det overskydende beløb. Hvis enden til at betale skat er nedsat på grund af sygdom gives der en særlig skattelettelse. Skattelettelsens størrelse beregnes i forhold til den pågældendes eller dennes families muligheder for at betale skat.

Egenbetalingen for langtidsophold på institution/hospital kan højst udgøre 80 pct. af patientens/beboerens nettoindkomst. Det er den samme betaling som opkræves på alle typer af institutioner

health care sectors. Those admitted for a long-term stay in an institution must have a disposable amount of at least EUR 80 per month for personal necessities. Persons receiving a war supplement may keep that part of the amount that is in excess of the EUR 80.

The so-called user charge ceiling of EUR 590 is applied by the municipal social and welfare sectors. Once the ceiling is exceeded, the user may generally utilize services free of charge. The ceiling applies to physician services in the primary health care sector, physiotherapy, outpatient treatment, day surgery and short-term stays in institutions in the social and health sectors. Dental care, patient transport, certificates, laboratory tests and radiological examinations requisitioned by privately practising physicians must still be paid for. Income regulated payments are not included in the maximum amount. Since 2001, the maximum amount is calculated for the calendar year. Payments made for children under 18 years of age are added to the amount paid by the person who has paid the costs.

ÅLAND: The rules for maximum user charges for medicines and transport to and from treatment are the same as in Finland. For treatment of illness, there is a maximum user charge for medical visits and outpatient treatment of no more than EUR 350 during one calendar year, after which all services are free of charge for the remaining part of the year, with the exception of short-term stays in institutions/hospitals, for which the charge is reduced from EUR 23 per day to EUR 13 per day. As part of the maximum user charge, payment for outpatient treatment and services received outside the county

indenfor social- og sundhedssektoren. De der er indskrevet til et langvarigt institutionsophold skal mindst råde over et dispositionsbeløb på 80 EUR pr måned til personlige fornødenheder. Personer der modtager krigstillæg, beholder dette beløb ud over de 80 EUR.

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

ÅLAND: Reglerne for den maksimale egenbetaling for medicin og transport til og fra behandling er den samme som i Finland. Ved sygdomsbehandling er der en maksimal egenbetaling ved lægebesøg og ambulat behandling på højst 350 EUR i løbet af et kalenderår hvorefter al service er gratis den resterende del af året med undtagelse af kortvarige institutions/hospitalsophold hvor betalingen reduceres fra 23 EUR pr døgn til 13 EUR pr døgn. Til den maksimale egenbetaling medregnes også betaling for ambulant behandling og ydelser som er modtaget uden for landskabet. Derimod medreg-

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are also included. Dental treatment, treatment in hospital departments, and x-ray and laboratory examinations are not included. User charges may be deducted from municipal tax.

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

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

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

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

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

User charges for the services that are included in the cost ceiling arrangement,

nes bl.a. tandbehandling, behandling på hospitalsafdelinger, røntgen- og laboratorieundersøgelser ikke. Egenbetalingen kan fratrækkes i kommuneskatten.

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

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

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

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

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

Egenbetalingen for de ydelser, der er omfattet af ordningen om udgiftsloft, note-

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

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

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

- Examination and treatment by a doctor or psychologist
- Necessary pharmaceutical products
- Travel costs that are paid for by the National Insurance Scheme.

The following services are included in reimbursement scheme 2:

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

Reimbursement schemes 1 and 2 are two completely separate schemes.

In 2003, the cost ceiling for reimbursement scheme 1 is NOK 1 350 and for reimbursement scheme 2 NOK 4 500

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

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

En ny refusionsordning blev indført 1. januar 2003.

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

- Undersøgelse og behandling hos læge eller psykolog
- Vigtige lægemidler
- Rejser, som Folketrygden betaler for.

Følgende ydelser indgår i egenandelsloft nr II:

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

Egenandelsloft I og II er to helt adskilte ordninger.

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

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

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

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

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

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

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

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

CHAPTER II

Population and fertility

Befolkning og fertilitet

Introduction

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

Population and population trends

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

The development in population growth varies somewhat between the Nordic countries. The natural increase has been greatest in Iceland, the Faroe Islands and Greenland throughout the period. In Sweden, the natural increase has been negative the last two years. However, in some years net migration has led to a reduction in the population in some of the countries. But in 2001, net migration contributed to population growth in all the Nordic countries.

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

Indledning

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

Befolkning og befolkningsudvikling

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

Udviklingen i befolkningstilvæksten varierer en del de nordiske lande imellem. Fødselsoverskuddet har hele perioden igennem været størst i Island, Færøerne og Grønland. I Sverige har fødselsoverskuddet de sidste to år været negativt. Nettomigrationen har dog i nogle år medført en reduktion i befolkningen i nogle af landene, men i 2001 bidrager nettomigrationen til befolkningstilvæksten i alle de nordiske lande.

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

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Figure 2.1 Mean population by sex and age as a percentage of the total population 2001

Middelfolketallet efter køn og alder i pct. af hele befolkningen 2001

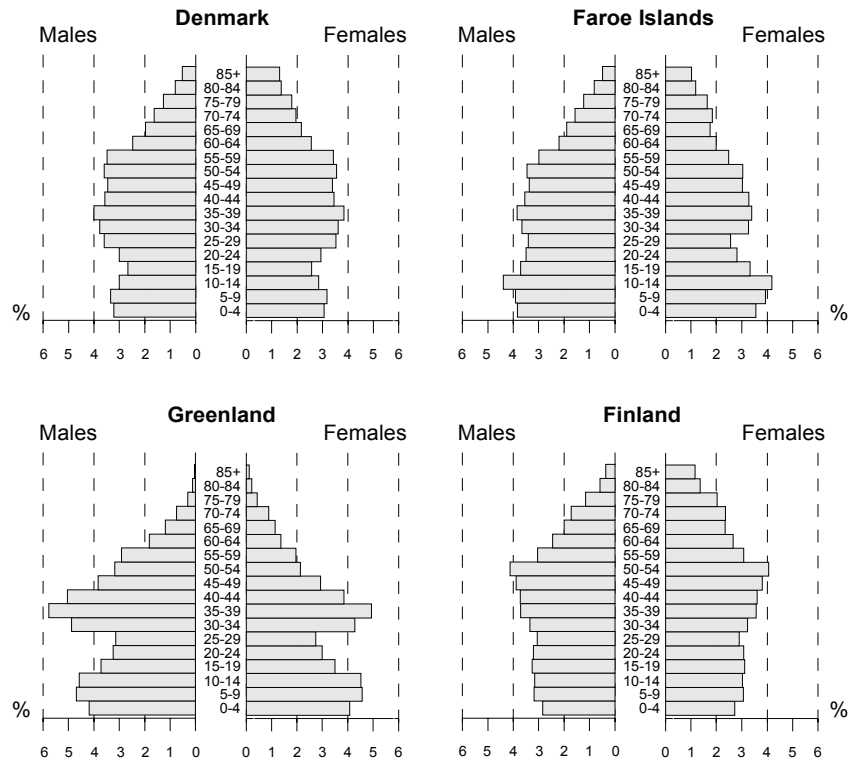
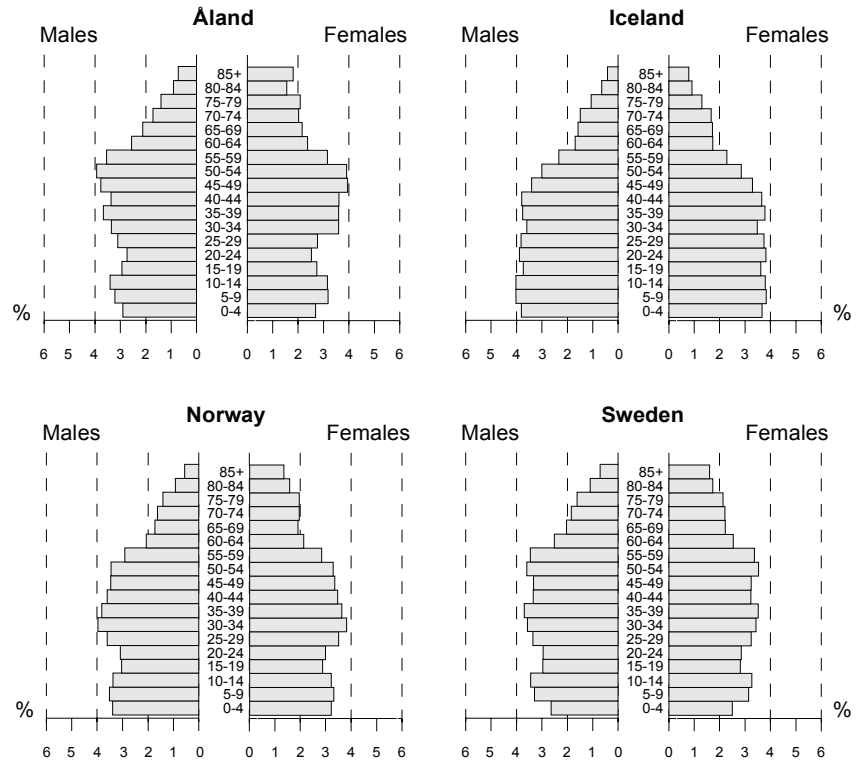


Figure 2.1 ... continued
... fortsat



POPULATION AND FERTILITY

Table 2.1 Mean population 1990-2001
Middelfolketallet 1990-2001

	Denmark	Faroe Islands	Greenland	Finland	of which Åland	Iceland	Norway	Sweden
(1 000)								
<i>Men</i>								
Mænd								
1990	2 533	25	30	2 419	12	128	2 097	4 228
1995	2 580	23	30	2 487	12	134	2 155	4 361
2000	2 639	24	30	2 526	13	141	2 224	4 386
2001	2 647	24	30	2 533	13	143	2 231	4 401
<i>Women</i>								
Kvinder								
1990	2 607	23	26	2 567	12	127	2 144	4 331
1995	2 648	21	26	2 621	13	133	2 204	4 466
2000	2 700	22	26	2 650	13	140	2 267	4 486
2001	2 708	23	26	2 655	13	142	2 272	4 495
<i>Men and women</i>								
Mænd og kvinder								
1990	5 140	48	56	4 986	24	255	4 241	8 559
1995	5 229	44	56	5 108	25	267	4 359	8 827
2000	5 340	46	56	5 176	26	281	4 491	8 872
2001	5 355	47	56	5 188	26	285	4 503	8 896

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

Table 2.2 Vital statistics per 1 000 inhabitants 1990-2001
Befolkningens bevægelser pr. 1 000 indbyggere 1990-2001

	<i>Live births</i> Levendefødte	<i>Deaths</i> Døde	<i>Natural increase</i> Fødselsoverskud	<i>Net migration</i> Nettomigration	<i>Population increase</i> Befolkningstilvækst
Denmark					
1990	12.3	11.9	0.5	1.6	2.1
1995	13.3	12.1	1.3	5.5	6.7
2000	12.6	10.9	1.7	1.8	3.5
2001	12.2	10.9	1.3	2.2	3.6
Faroe Islands					
1990	19.9	7.5	12.4	-22.3	-9.9
1995	14.7	8.3	6.4	-13.4	-7.0
2000	15.1	7.7	7.5	9.6	17.1
2001	13.5	7.7	5.8	12.0	17.2
Greenland					
1990	22.6	8.4	14.2	-10.6	3.6
1995	20.1	8.7	11.4	-8.3	3.1
2000	15.8	8.1	7.7	-3.6	4.1
2001	16.6	7.8	8.8	-3.6	5.3
Finland					
1990	13.2	10.0	3.2	1.4	4.6
1995	12.3	9.6	2.7	0.6	3.3
2000	11.0	9.5	1.4	0.5	1.9
2001	10.8	9.4	1.5	1.1	2.7
Åland					
1990	14.8	9.3	5.6	8.6	14.2
1995	13.4	10.2	3.2	-2.3	0.9
2000	10.0	9.6	0.4	2.3	2.7
2001	10.9	8.8	2.1	6.9	9.0
Iceland					
1990	18.7	6.7	12.0	-2.7	9.3
1995	16.0	7.2	8.8	-5.3	3.5
2000	15.2	6.4	8.8	6.0	14.8
2001	14.3	6.0	8.3	3.4	11.7
Norway					
1990	14.4	10.9	3.5	0.4	3.9
1995	13.8	10.4	3.5	1.5	4.9
2000	13.2	9.8	3.4	2.2	5.6
2001	12.6	9.8	2.8	1.8	4.6
Sweden					
1990	14.5	11.1	3.4	4.1	7.4
1995	11.7	10.6	1.1	1.3	2.4
2000	10.2	10.5	-0.3	2.8	2.4
2001	10.3	10.5	-0.3	3.2	3.0

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

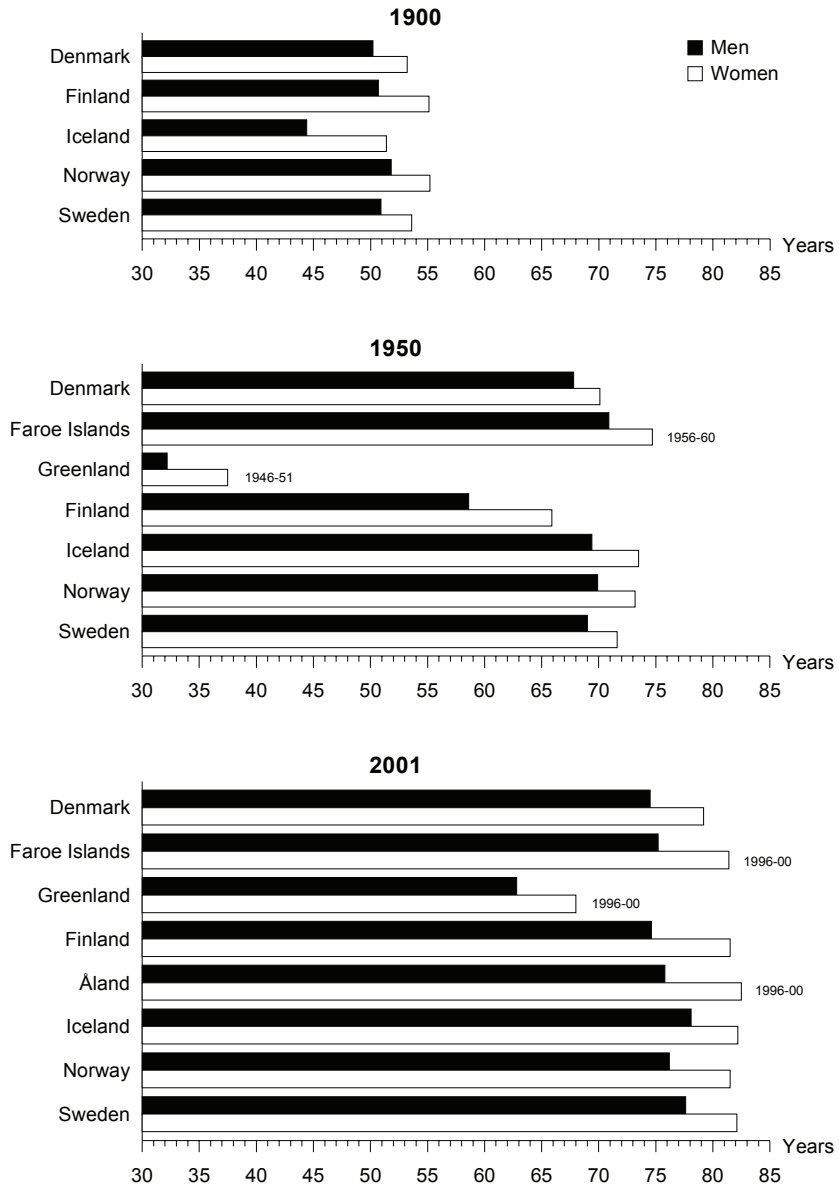
POPULATION AND FERTILITY

Table 2.3 Average life expectancy 1991-2001
Middellevetiden 1991-2001

Age	Men		Mænd			Women			Kvinder	
	0	15	45	65	80	0	15	45	65	80
Denmark										
1991-95	72.5	58.3	30.1	14.2	6.4	77.8	63.5	34.5	17.7	8.1
1996-00	73.8	59.4	31.1	14.8	6.6	78.7	64.2	35.1	18.0	8.4
2000/01	74.5	60.1	31.6	15.2	6.8	79.2	64.7	35.5	18.2	8.5
Faroe Islands										
1991-95	73.3	59.2	31.1	14.8	6.8	80.3	66.0	37.9	19.0	8.5
1996-00	75.2	60.7	32.2	15.5	7.0	81.4	66.8	37.4	19.4	8.8
Greenland										
1991-95	62.3	49.6	25.5	10.4	4.8	68.3	55.5	28.0	12.6	5.4
1996-00	62.8	50.3	26.2	11.1	5.0	68.0	55.0	27.6	12.5	5.3
Finland										
1991-95	72.1	57.7	30.0	14.2	6.3	79.7	65.2	36.1	18.2	7.7
1996-00	73.6	59.1	31.1	15.0	6.6	80.8	66.2	37.1	19.1	8.1
2001	74.6	60.0	32.0	15.7	6.8	81.5	66.8	37.7	19.7	8.5
Åland										
1991-95	78.7	64.2	35.1	17.9	8.5	84.8	70.1	40.6	21.8	9.8
1996-00	75.8	61.3	32.7	16.2	7.1	82.5	67.6	38.4	20.5	9.0
Iceland										
1991-95	76.3	61.9	33.4	16.4	7.3	80.8	66.3	37.0	19.3	8.7
1996-00	77.1	62.6	34.0	16.7	7.3	81.4	66.8	37.4	19.6	8.6
2000/01	78.1	63.5	35.2	17.6	7.9	82.2	67.5	38.1	20.3	9.2
Norway										
1991-95	74.4	60.1	31.6	15.0	6.5	80.4	66.0	36.8	19.0	8.3
1996-00	75.5	61.1	32.7	15.7	6.7	81.1	66.6	37.4	19.5	8.5
2001	76.2	61.7	33.4	16.2	6.8	81.5	66.9	37.7	19.8	8.7
Sweden										
1991-95	75.6	61.2	32.6	15.7	6.8	81.0	66.5	37.3	19.4	8.6
1996-00	76.9	62.4	33.6	16.4	7.0	81.8	67.2	37.9	19.9	8.8
2001	77.6	63.0	34.2	16.9	7.2	82.1	67.5	38.1	20.1	8.9

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

Figure 2.2 Life expectancy at birth 1900, 1950 and 2001
 Middellevetiden for nyfødte 1900, 1950 og 2001



Fertility, births, infant mortality and contraception

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

In all the Nordic countries, it is possible to obtain treatment for infertility, paid for by the public health services (in Iceland there is, however, a certain user charge). As shown in Table 2.5, more and more people are receiving such treatment, and a significant proportion of live births (between 1.9-3.4 per cent) are the result of in vitro fertilization (IVF). A large number of births resulting from IVF are still multiple births, most in Iceland and fewest in Finland.

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

Greenland also has the highest mortality rate for the first year of life. Iceland had the lowest mortality rate for the first year of life in 2000.

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

The use of sterilization as a means of birth control also varies considerably be-

Fertilitet, fødsler, spædbørnsdødelighed og prævention

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

I alle de nordiske lande er det muligt at blive behandlet for barnløshed, betalt af det offentlige (i Island er der dog en vis egenbetaling). Som det ses af tabel 2.5 modtager flere og flere behandling og en ikke ubetydelig del af de levendefødte (fra 1,9 til 3,4 pct.) er et resultat af en IVF behandling. For fødsler efter IVF behandling er der fortsat et stort antal flerbarnsfødsler, flest i Island og færrest i Finland.

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

Grønland har ligeledes den højeste dødelighed for det første leveår. Island har den laveste dødelighed i det første leveår i 2000.

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

Anvendelse af sterilisation som præventionsmiddel varierer ligeledes betydeligt

tween the Nordic countries. In most of the countries no permission for sterilization is required if the person is aged 25 or more.

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

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

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

Abortion rates vary somewhat in the Nordic countries. However, with the exception of Iceland and Åland, the total number of induced abortions has fallen.

mellem de nordiske lande. I de fleste af landene behøver man ingen tilladelse til at lade sig sterilisere efter det fyldte 25. år.

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

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

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

Der er en vis spredning mellem landene med hensyn til abortraterne. Med undtagelse af Island og Åland kan der dog spores et fald i det samlede antal provokerede aborter.

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Table 2.4 Live births and fertility rate 1991-2000
 Levendefødte og fertilitetsrate 1991-2000

	Number of live births Antal leven- defødte	Live births per 1 000 women by age Levendefødte pr. 1 000 kvinder i alderen						Total fertility rate Samlet fertilitet	
		15-19	20-24	25-29	30-34	35-39	40-44		45-49
Denmark									
1991-95	67 778	8.8	65.4	138.6	100.5	34.0	4.8	0.2	1 762
1996-00	66 951	8.0	54.7	129.7	109.3	41.3	6.0	0.2	1 746
2000	67 081	7.9	51.6	128.9	113.7	44.2	6.7	0.2	1 771
2001	65 450	7.6	51.7	126.7	113.1	44.0	6.8	0.2	1 746
Faroe Islands									
1991-95	753	28.4	126.0	164.2	117.2	51.6	10.7	0.4	2 493
1996-00	657	19.3	108.0	166.0	129.1	58.1	11.1	0.3	2 459
2001	631	14.7	118.2	145.8	116.9	56.9	9.1	0.0	2 307
Greenland									
1991-95	1 177	79.6	150.0	130.3	87.0	40.1	9.3	0.6	2 284
1996-00	994	55.9	160.9	118.4	87.7	47.6	13.5	1.4	2 426
2001	933	77.2	161.1	127.4	78.1	36.2	9.0	0.6	2 448
Finland									
1991-95	65 050	10.9	71.0	134.2	101.4	39.2	7.7	0.4	1 822
1996-00	58 295	9.5	61.4	119.8	101.6	44.7	8.8	0.5	1 735
2000	56 742	10.0	60.4	115.6	102.7	46.3	9.3	0.5	1 729
2001	56 189	10.6	59.7	114.1	101.9	47.5	9.7	0.5	1 726
Åland									
1991-95	324	8.4	61.4	133.8	104.1	44.4	6.7	0.2	1 795
1996-00	286	4.9	42.7	122.0	106.3	50.1	8.5	0.6	1 665
Iceland									
1991-95	4 497	24.8	100.7	137.7	108.4	52.1	9.9	0.2	2 169
1996-00	4 215	23.4	90.2	129.0	107.2	51.6	9.4	0.2	2 055
2000	4 315	22.5	88.4	130.4	112.4	50.6	10.5	0.4	2 076
2001	4 091	19.3	79.6	125.9	100.4	54.2	10.0	0.3	1 948
Norway									
1991-95	60 196	15.2	82.6	137.7	100.2	37.2	5.6	0.2	1 879
1996-00	59 522	12.4	70.6	130.9	107.8	43.5	6.9	0.2	1 851
2000	59 234	11.7	67.3	129.3	110.5	45.7	7.3	0.2	1 851
2001	56 696	11.0	62.7	123.6	107.9	45.6	7.0	0.3	1 784
Sweden									
1991-95	116 052	10.9	81.3	143.1	107.5	42.8	7.4	0.3	1 966
1996-00	90 688	7.1	51.7	107.9	93.4	40.3	7.3	0.3	1 540
2000	90 441	7.0	47.5	107.0	98.2	42.5	7.7	0.3	1 547
2001	91 466	6.6	46.7	104.3	102.4	45.4	8.2	0.3	1 570

Sources: The central statistical bureaus
 Kilder: De statistiske centralbureauer

Table 2.5 In vitro fertilization 1995-2000
IVF-behandling 1995-2000

	Denmark	Finland	Iceland	Norway	Sweden
<i>Treatments, IVF+ICSI</i>					
Behandlinger, IVF+ICSI					
1995	4 275	3 801	260	..	4 922
1996	4 816	4 493	266	..	5 577
1997	5 447	5 090	363	3 173	5 691
1998	6 165	4 886	364	3 323	5 893
1999	6 317	4 577	365	3 736	6 247
2000	7 002	4 323	298	4 029	6 586
<i>Frozen embryo transfers, FET</i>					
Tilbageføring af nedfrosne æg, FET					
1995	422	1 242	-	..	992
1996	726	1 924	2	..	1 135
1997	789	2 246	20	339	1 268
1998	993	2 273	55	267	1 090
1999	1 028	2 391	60	293	1 005
2000	975	2 488	83	301	1 208
<i>Number of live births, IVF+ ICSI + FET</i>					
Antal levendefødte, IVF+ ICSI + FET					
1995	1 209	958	101	..	1 435
1996	1 501	1 374	107	..	1 927
1997	1 602	1 473	150	796 ²⁾	2 021
1998	1 844	1 484	158	994 ²⁾	2 137
1999	2 001	1 451	149	1 058 ²⁾	2 278
2000	2 085	1 388	147	1 097 ²⁾	2 237
[2000]					
<i>Treatments per 1 000 women aged 15-49 years</i>					
Behandlinger pr. 1 000 kvinder i alderen 15-49 år					
IVF+ICSI	5.6	3.6	4.2	3.8	3.3
FET	0.8	2.0	1.2	0.3	0.6
Total	6.4	5.6	5.3	4.1	3.9
<i>Multiple births, total, per cent</i>					
Flerbarnsfødsler, i alt, procent					
	25.2	17.4	31.5	27.1	21.0
<i>IVF, ICSI and FET, per cent of all live births</i>					
IVF, ICSI and FET i procent af alle levendefødte					
	2.9	2.5	3.4	1.9 ²⁾	2.5

IVF = In vitro fertilisation (reagensglasbefrugtning)

ICSI = Intracytoplasmic sperm injection (mikrobehandling)

FET = Frozen embryo transfer (tilbageføring af nedfrosne æg)

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

1) Excluding FETs.

1) Eksklusiv FET.

2) For live births read all births.

2) Alle fødsler, ikke kun levendefødte.

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

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Table 2.6 Stillbirths and infant mortality¹⁾ 1991-2001
Dødfødte og dødelighed i første leveår¹⁾ 1991-2001

	Number Antal		Per 1 000 births Pr. 1 000 fødte		Deaths per 1 000 live births Døde pr. 1 000 levendefødte			Total un- der 1 year I alt under 1 år
	Stillbirths Dødfødte	Infant deaths Døde i 1. leveår	Stillbirths Dødfødte	Perinatal deaths Perinatalt døde	First 24 hours Første 24 timer	1-6 days 1-6 dage	7-27 days 7-27 dage	
Denmark								
1991-95	314	403	4.6	7.0	1.9	1.3	0.7	5.0
1996-00	308	332	4.6	7.6	1.6	1.4	0.6	5.0
2001	280	321	4.3	6.9	1.1	1.5	0.9	4.9
Faroe Islands								
1991-95	3	5	4.5	6.6	2.1	4.0	0.5	9.0
1996-00 ²⁾	3	1	4.9	6.1	..	1.2	..	1.8
2001	2	-	3.7	3.7	..	..	..	..
Greenland								
1991-95	5	33	4.0	21.9	12.1	5.8	1.2	28.5
1996-00	8	17	8.1	19.6	8.1	3.1	1.0	16.8
2001	6	15	6.4	16.0	6.4	1.1	1.1	16.1
Finland								
1991-95	190	307	2.9	5.7	1.6	1.1	0.6	4.8
1996-00	214	227	3.7	5.8	1.3	0.8	0.6	3.9
2000	231	213	4.1	5.9	1.1	0.6	0.7	3.8
2001	185	181	3.3	5.0	1.0	0.8	0.4	3.2
Åland								
1991-95	1	1	3.7	4.9	-	1.2	-	3.7
1996-00	-	1	1.4	3.5	0.7	1.4	-	3.5
Iceland								
1991-95	12	22	2.7	5.2	1.2	1.3	0.5	4.8
1996-00	15	15	3.5	5.7	1.3	0.8	0.3	3.5
2000	15	13	3.2	5.3	1.4	0.5	0.7	3.0
2001	11	11	2.7	4.6	0.7	1.2	0.0	2.7
Norway								
1991-95	257	322	4.3	7.0	1.7	1.1	0.7	5.3
1996-00	244	244	4.1	6.2	1.0	1.1	0.6	4.1
2000	225	226	3.8	5.9	1.0	1.1	0.6	3.8
2001	241	230	4.2	6.6	1.3	1.1	0.6	4.1
Sweden								
1991-95	392	583	3.4	5.8	1.1	1.3	0.7	5.0
1996-00	332	325	3.7	5.4	0.8	0.9	0.6	3.6
2000	355	309	3.9	5.6	0.7	1.0	0.7	3.4
2001	349	334	3.8	2.5	0.9	1.0	0.6	3.7

1 Computed by year of death.

2 1-6 days = 0-6 days.

1 Opgjort efter dødsår.

2 1-6 dage = 0-6 dage.

Sources: D: Statistics Denmark; FI: Chief Medical Officer in the Faroes; G: Chief Medical Officer; F & Å: Statistics Finland; I: Statistics Iceland; N: Statistics Norway ; S: Statistics Sweden

Table 2.7 Stillbirths and deaths during first year of life per 1 000 births 1990–2000, with birthweight 1 000 grams and more, total figures and rates per 1 000 births¹⁾

Dødfødte og døde i løbet af første leveår med en fødselsvægt på 1 000 gram og mere, i alt og pr. 1 000 fødte 1990–2000¹⁾

	Number Antal		Per 1 000 births Pr. 1 000 fødte		Deaths per 1 000 live births Døde pr. 1 000 levendefødte			
	Stillbirths Dødfødte	Infant deaths Døde i 1. leveår	Stillbirths Dødfødte	First 24 hours Første 24 timer	1–6 days 1–6 dage	7–27 days 7–27 dage	28 days to 1 year 28 dage til 1 år	Total un- der 1 year I alt under 1 år
Denmark								
1990	262	382	4.1	0.9	1.3	0.7	3.1	6.1
1995	282	330	4.0	1.0	1.9	0.6	1.3	4.7
1999	244	195	3.7	0.7	0.7	0.5	1.1	3.0
2000	193	238	2.9	0.6	1.3	0.5	1.2	3.6
2001	216	203	3.3	0.4	0.9	0.6	1.3	3.1
Finland								
1990	212	279	3.2	0.6	1.4	0.5	1.8	4.3
1995	189	168	3.2	0.5	0.7	0.5	1.0	2.7
1999	121	147	2.1	0.5	0.6	0.5	1.1	2.6
2000	152	152	2.7	0.5	0.5	0.5	1.2	2.7
Iceland								
1990	12	20	2.5	0.4	1.1	0.4	2.3	4.2
1995	7	13	1.6	0.9	0.7	-	1.4	3.0
1999	16	8	3.9	0.5	0.5	0.2	0.7	1.9
2000	13	5	3.0	0.0	0.2	0.2	0.7	1.2
Norway								
1990	242	276	4.0	0.9	0.6	0.3	2.6	4.5
1995	177	182	2.9	0.7	0.7	0.4	1.3	3.0
1999	205	170	3.5	0.6	0.6	0.3	1.2	2.7
2000	196	252	3.3	0.7	0.4	0.4	1.1	2.5
Sweden								
1990	391	553	3.2	0.8	1.0	0.5	2.3	4.6
1995	318	286	3.1	0.5	0.6	0.5	1.2	2.8
1999	297	203	3.5	0.6	0.5	0.3	1.0	2.4
2000	318	215	3.6	0.5	0.7	0.4	0.9	2.4

1 Computed by year of birth.

1 Opgjort efter fødselsår.

Sources: Birth and Infant Mortality in the Nordic Countries. NOMESCO; Copenhagen 1993.D: National Board of Health F: Statistics Finland & STAKES; I: Medical Birth Registry of Iceland & Statistics Iceland; N: Medical Birth Registry of Norway; S: Medical Birth Registry, National Board of Health and Welfare

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Table 2.8 Sterilizations 1990-2001
Sterilisationer 1990-2001

	Denmark ¹⁾	Faroe Islands ²⁾	Greenland	Finland	Of which Åland	Iceland ³⁾	Norway	Sweden ⁴⁾
<i>Men</i>								
<i>Mænd</i>								
1990	3 543	8	..	593	-	28	2 070	1 697
1995	5 256	3	4	792	-	87	2 697	1 507
2000	5 544	14	18	1 771	2	134	3 244	1 463
2001	5 686	9	8	1 731	-	..	3 322	..
<i>Women</i>								
<i>Kvinder</i>								
1990	5 080	46	..	12 864	8	543	6 166	6 338
1995	4 815	60	67	10 520	31	553	4 525	5 919
2000	5 101	29	127	8 700	31	641	4 512	4 931
2001	5 271	32	77	7 289	43	..	4 652	..
<i>Total</i>								
<i>I alt</i>								
1990	8 533	54	..	13 457	10	571	8 236	8 035
1995	10 071	63	71	11 312	31	640	7 222	7 426
2000	10 645	43	145	10 471	33	775	7 756	6 394
2001	10 957	41	85	9 020	43	..	7 974	..
[2001]								
<i>Per 1 000 in the age group</i>								
<i>Pr. 1 000 i alderen</i>								
<i>Men</i>								
<i>Mænd</i>								
25-34	3.6	-	0.6	1.0	-	1.4	1.8	0.3
35-44	8.8	0.6	0.7	2.7	-	4.4	6.1	1.4
45-54	2.3	-	0.3	0.7	-	0.9	1.9	0.6
<i>Women</i>								
<i>Kvinder</i>								
25-34	4.8	5.5	6.1	5.3	5.5	7.0	3.5	1.8
35-44	8.2	5.5	10.3	14.0	16.7	22.3	10.0	6.0
45-54	0.5	0.4	0.7	0.8	1.5	3.3	0.9	0.5

1 Includes sterilizations performed in hospitals. The figures for 1990 concerning men include only sterilizations performed during hospitalization.

2 Rates are for 1998.

3 2000=1997. Rates are also for 1997.

4 2000=1999. Rates are also for 1999.

1 Omfatter sterilisationer udført på sygehuse. Tallene for 1990 for mænd omfatter kun sterilisationer, der er udført under indlæggelse.

2 Raterne er for 1998.

3 2000=1997. Raterne er også for 1997.

4 2000=1999. Raterne er også for 1999.

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

**Table 2.9 Sales of oral contraceptives per 1 000 women aged 15-44 years
1990-2001. DDD per 1 000 women 15-44 years per day**
Salg af p-piller pr. 1 000 kvinder i alderen 15-44 år 1990-2001.
DDD pr. 1 000 kvinder i alderen 15-44 år pr. dag

ATC code G03A	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
1990	269	105	..	222	..	197	171	226
1995	280	214	143	201	257	226	198	258
2000	319	258	177	226	284	265	225	298
2001	331	246	162	226	275	287	236	290

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

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Table 2.10 Number of induced abortions 1991-2001

Antal fremkaldte aborter 1991-2001

	Number of abortions Antal aborter	Abortions per 1 000 women by age Aborter pr. 1 000 kvinder i alderen							Total abortion rate Samlet abortrate	Abortions per 1 000 live births Aborter pr. 1 000 levendefødte
		15-19	20-24	25-29	30-34	35-39	40-44	45-49		
<i>Denmark</i>										
1991-95	18 513	16.3	24.6	22.8	18.6	12.0	5.0	0.4	498.0	273.0
1996-00	16 877	14.5	21.2	19.7	18.5	13.0	4.8	0.5	457.3	250.6
2000	15 666	14.3	19.8	18.1	17.8	12.6	4.8	0.5	439.1	233.5
2001	15 315	14.0	19.6	18.1	17.0	13.0	4.6	0.5	433.5	239.1
<i>Faroe Islands</i>										
1991-95	57	..	..	..	..	..	..	..	..	75.9
1996-00	47	4.4	5.2	7.3	7.8	5.5	2.9	0.6	168.3	70.9
2001	38	2.6	4.5	5.8	4.0	6.8	2.6	0.0	131.3	60.2
<i>Greenland</i>										
1991-95	949	102.6	119.7	88.9	55.1	27.9	12.2	0.7	2 035.5	821.4
1996-00	881	114.6	138.7	87.7	57.8	28.0	9.2	1.1	2 185.5	888.6
2001	812	116.0	136.2	89.9	49.5	29.0	6.2	0.6	2 139.0	870.0
<i>Finland</i>										
1991-95	10 610	11.9	15.8	12.8	9.7	6.9	3.5	0.5	293.7	163.5
1996-00	10 637	12.8	15.0	13.3	10.9	7.4	2.9	0.3	312.9	183.2
2000	10 932	14.5	15.6	12.8	11.0	7.7	3.0	0.2	323.8	193.3
2001	10 700	15.2	14.8	13.0	10.6	7.5	3.2	0.2	322.8	191.8
<i>Åland</i>										
1991-95	62	18.0	15.7	11.1	10.5	10.7	5.3	0.9	360.9	192.4
1996-00	64	16.6	20.8	12.9	14.0	10.0	4.8	0.8	398.9	224.6
<i>Iceland</i>										
1991-95	762	14.7	21.4	14.3	11.0	8.3	4.5	0.4	373.0	169.7
1996-00	..	..	..	..	..	..	..	..	..	..
1999 ¹⁾	947	21.4	25.0	19.1	12.7	9.4	3.6	0.2	457.3	231.0
<i>Norway</i>										
1991-95	14 779	18.5	26.5	21.1	15.0	9.6	3.6	0.4	473.4	245.5
1996-00	14 248	18.7	26.1	19.7	15.2	9.9	3.5	0.3	471.0	239.4
2000	14 635	19.6	28.0	20.0	15.2	10.8	3.6	0.3	490.0	247.1
2001	13 888	18.5	26.3	19.2	14.8	10.2	3.7	0.3	466.5	245.0
<i>Sweden</i>										
1991-95	33 708	19.4	29.4	25.3	20.8	14.6	6.5	0.8	584.3	290.8
1996-00	31 250	18.2	27.0	23.4	20.2	15.0	5.9	0.6	551.5	344.4
2000	30 980	20.2	27.0	22.5	19.3	14.7	6.0	0.5	551.8	341.6
2001	31 772	21.5	28.1	23.1	19.6	14.6	5.7	0.6	566.0	347.4

1 Preliminary figures

Sources: The national abortion registers

Kilder: De nationale abortregistre

F & Å: STAKES

CHAPTER III

Morbidity, medical treatment, accidents and medicine

Sygelighed, sygdomsbehandling, ulykker og medicin

Introduction

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

Diseases related to lifestyle

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

Although the number of smokers in the Nordic countries has been decreasing during recent years, there continues to be large differences in the number of smok-

Indledning

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

Sygdomme relateret til livsstil

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

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

ers, both for men and for women. The number of smokers is still highest in Denmark and the Faroe Islands and lowest in Sweden, where only 19 per cent of the population are daily smokers. Among other things, this pattern of behaviour is reflected in the incidence of lung cancer, as shown in Figure 3.1.

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

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

The Hepatitis B Virus (HBV) infects only humans. The route of infection is parenteral. The transmission occurs when blood or body fluids contaminated by blood from an infected person enters the body through mucous membranes or lacerated skin, often through intravenous drug abuse and transfusion of unscreened blood products. Sexual transmission is common. Transmission from mother to child may occur in utero or, more often, during the delivery. HBV is said to be 100 times more infective than HIV.

The hepatitis B is usually self-limiting without leaving permanent harm but 5 – 10 % of the patients develop a chronic

fortsat flest tobaksbrugere i Danmark og Færøerne og de færreste i Sverige, hvor ca. 19 pct. af befolkningen i dag er daglige rygere. Dette adfærdsmønster afspejler sig blandt andet i forekomsten af nye tilfælde af lungecancer som det fremgår af figur 3.1.

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

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

Hepatit B virus (HBV) smitter kun mennesker. Hepatit B smitter gennem slimhinder, sår der bløder eller blodfyldte væsker, ofte ved intravenøs narkotikamisbrug og transfusion med blodprodukter der ikke er kontrollerede. Det er almindeligt at smitten overføres seksuelt, ligesom der kan forekomme smitte fra mor til barn, i livmoderen, men mere ofte ved fødslen. HBV anses for at være 100 gange mere smittefarlig end HIV.

I de fleste tilfælde er det ikke nødvendigt med behandling, men 5-10 pct. af patienterne udvikler dog en kronisk leverbe-

hepatitis and continue to spread the virus. Chronically infected persons may develop liver cancer. There is no specific treatment but clinical measures aimed at the symptoms. A vaccine effective against HBV is available. Vaccination is recommended for persons with a higher risk than others of exposure to the virus.

Hepatitis C is the most common type of hepatitis in most countries. It is caused by the Hepatitis C Virus (HCV). There are about 500 million carriers of hepatitis C. The route of infection is parenteral. The transmission occurs when blood or body fluids from an infected person enters the body of a person who is not infected, most often through intravenous drug abuse, but also through needle sticks or other types of injury, at work, or from an infected mother to her baby during birth. Hepatitis C was a common cause of transfusion hepatitis during the period when blood products were not screened for hepatitis C.

HCV can be sexually transmitted, but this is very rare. Hepatitis C is much less infectious than hepatitis B. There is no vaccine against hepatitis C. 80 per cent of infected persons have no signs or symptoms. 75-80 per cent of infected persons develop a chronic infection. 70 per cent of chronically infected persons develop chronic liver disease. Less than 3 per cent die from chronic liver disease. Interferon alpha and ribavirin are two drugs used for the treatment of persons with chronic hepatitis C. The disease is the most common indication for liver transplant.

Cases of hepatitis and tuberculosis are found particularly among refugees and

tændelse i kombination med at de stadig kan smitte andre. Kronisk hepatitis B giver en høj risiko for leverkræft. Der findes ingen specifik behandling, men behandling skal rettes mod patientens symptomer. Det er muligt at vaccinere mod HBV. Vaccinen gives hovedsageligt til personer der løber en større risiko end andre for at blive udsat for hepatitis B.

Hepatitis C er den mest almindeligt forekomne form for Hepatitis i de fleste lande. Forekomsten skyldes Hepatitis C virus (HCV). Der findes ca 500 millioner bærere af hepatitis C. Smitten overføres fra person til person hvor blod og kropsvæsker fra en smittet person kommer ind i kroppen på en ikke smittet person, normalt via intravenøs narkotikamisbrug, men det kan også forekomme ved stik eller andre sårskader, en arbejdsituation eller fra mor til barn under fødselen. Hepatitis C var en almindeligt forekommen årsag til transfusionshepatit førend man begyndte screening af blodprodukter for HCV.

Hepatitis C kan også overføres seksuelt men det er meget sjældent. Smittehyppigheden for hepatitis C er lavere end ved Hepatitis B. Der findes ingen vaccinationer mod Hepatitis C. 80 procent af de smittede er symptomfris. 75-80 procent af de smittede udvikler en kronisk infektion og 70 procent af disse udvikler en kronisk leversygdom hvor mindre end 3 procent dør af en kronisk leversygdom. Ved behandlingen anvendes interferon alfa og ribavirin som lægemiddel. Hepatitis C er hovedårsagen til levertransplantation.

Forekomsten af såvel hepatitis som tuberkulose findes især hos flygtninge/indvan-

immigrants in the Nordic countries. However, these diseases are also relatively common among drug abusers with poor living conditions. The number of diagnosed cases of tuberculosis is increasing in some countries and falling in others.

The spread of HIV-infection shows clear patterns. The incidence in Denmark is similar to that in other countries on the north-western European continent (Germany and Holland), while the incidence in Norway, Sweden and Iceland is lower, and shows a pattern that is strikingly similar to that in Great Britain. Finland has the lowest incidence of HIV-infection of all the countries in "old" Western Europe. However, it should be noted that the number of new cases of HIV has begun to increase again in Denmark and Sweden.

Without doubt, chlamydia infection is the most common sexually transmitted disease in the Nordic countries. It is also the most common cause of infertility among women. The disease is often without symptoms.

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

drere i de nordiske lande, men det er også sygdomme som er relativt hyppigt forekommende blandt misbrugere med dårlige levevilkår. For så vidt angår diagnosticerede tilfælde af tuberkulose spores der i nogle lande en stigning, i andre et fald.

Mønstret for udbredelse af HIV- smitte adskiller sig efter relativt klare linier. Danmark har en forekomst, der ligger på linie med andre lande på det nordvesteuropæiske kontinent (Tyskland og Holland), mens Norge, Sverige og Island har en lavere forekomst og et smitemønster, der er påfaldende ens og mere ligner det, man finder i Storbritannien. Finland har den laveste forekomst af HIV- smitte i det 'gamle' Vesteuropa. Her er det dog værd at bemærke, at der igen er en stigning i påviste nye tilfælde af HIV i Danmark og Sverige.

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

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

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.1 Percentage of daily smokers by sex 2001
Daglige rygere procentvis efter køn 2001

	Denmark ¹⁾	Faroe Islands	Finland ²⁾	Iceland ³⁾	Norway ⁴⁾	Sweden ⁵⁾
<i>Smoking men as a percentage of men 15 years and over</i>						
Mænd, rygere, i pct. af mænd 15 år og derover	31	38	29	25	30	18
<i>Smoking women as a percentage of women 15 years and over</i>						
Kvinder, rygere, i pct. af kvinder 15 år og derover	26	35	20	23	29	20

1 13+ years.

2 15-64 years.

3 15-79 years.

4 16-74 years.

5 16-84 years.

1 13+ år.

2 15-64 år.

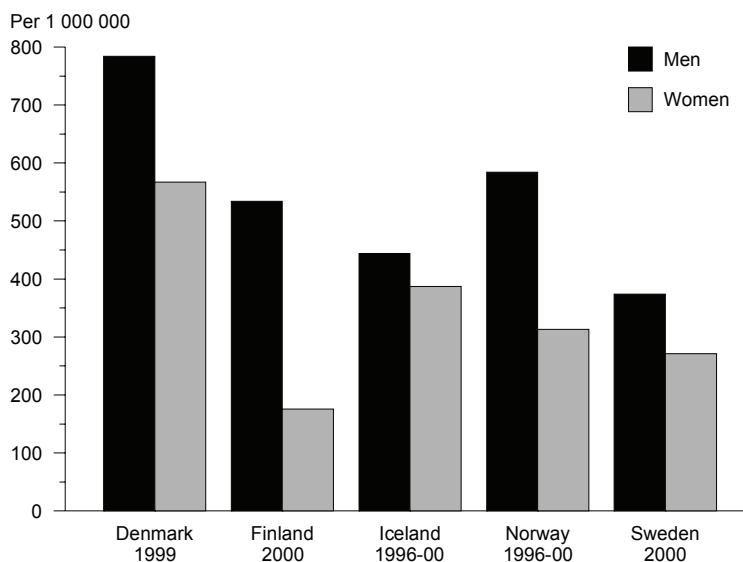
3 15-79 år.

4 16-74 år.

5 16-84 år.

Sources: D: Danish Council on Smoking and Health; FI: The national council for prevention; F: National Public Health Institute; I: Committee for Tobacco Use Prevention; N: National Council for Tobacco and Health; S: Statistics Sweden

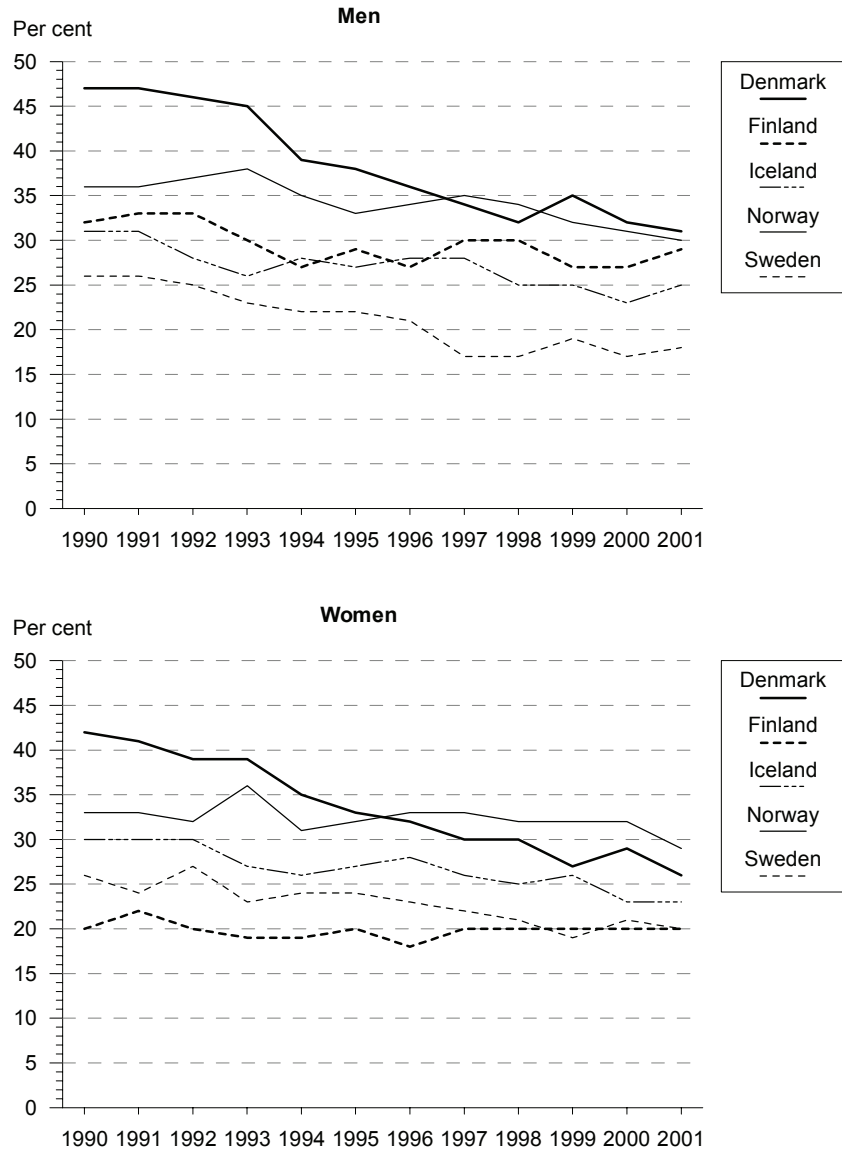
Figure 3.1 Rates for new cases of lung cancer per 1 000 000 inhabitants
Rater for nye tilfælde af lungecancer pr. 1 000 000 indbyggere



Source: Tables 3.8 and 3.9

Kilde: Tabel 3.8 og 3.9

Figure 3.2 Percentage of daily smokers by sex 1990-2001
 Daglige rygere procentvis efter køn 1990-2001



Source: OECD, for 2001 Table 3.1

Table 3.2 Alcoholic beverages in litres of 100 per cent pure alcohol per capita aged 15 years and over 1990-2001

Alkoholiske drikke i liter 100 pct. ren alkohol pr. indbygger 15 år og derover 1990-2001

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
1990	11.6	6.7	15.5	9.5	7.1	5.3	5.0	6.4
1995	12.1	6.3	12.6	8.3	5.8	4.8	4.8	6.1
2000	11.5	6.8	13.4	8.6	6.1	6.1	5.6	6.2
2001	11.6	6.9	12.5	9.0	6.3	6.3	5.5	6.5

Sources: D, FI, G, I N& S: The Central Statistical Bureaus

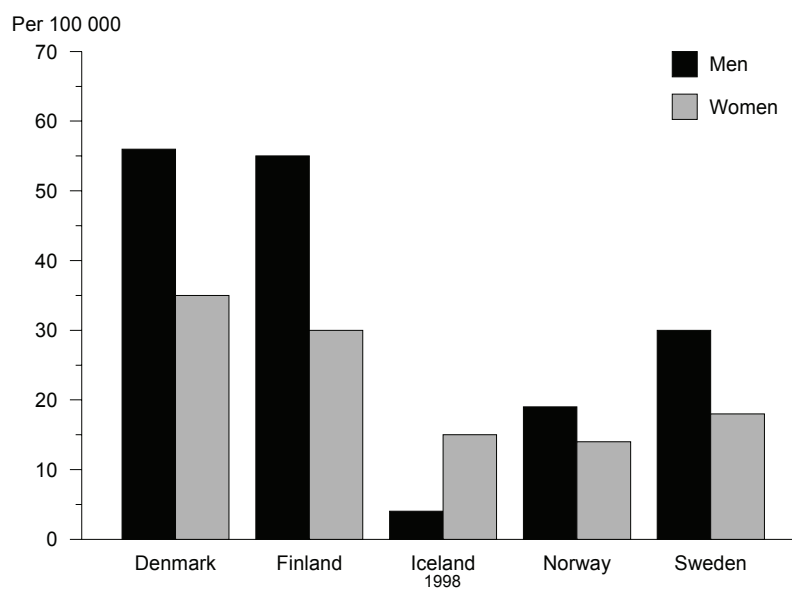
Kilder: D, FI, G, I N& S: De statistiske centralbureauer

F & Å: STAKES; S: National Board of Health and Welfare (-1993), National Institute for Public Health (1994-)

Figure 3.3 Discharges from somatic hospitals. Alcoholic liver disease per 100 000 inhabitants 2001

Udskrivninger fra somatiske sygehuse.

Alkoholisk leversygdom pr. 100 000 indbyggere 2001



Source: Table 3.30

Kilde: Tabel 3.30

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE
Table 3.3 Diagnosed cases of acute hepatitis B and C per 100 000 inhabitants by sex 1990-2001

Diagnostiserede tilfælde af akut hepatitis B og C pr. 100 000 indbyggere efter køn 1990-2001

	Denmark		Faroe Islands	Greenland	Finland ¹⁾	Åland ¹⁾	Iceland ²⁾		Norway		Sweden ⁴⁾	
	M	W	M+W	M+W	M+W	M+W	M	W	M	W	M	W
<i>Hepatitis B</i>												
1990	2.7	1.3	2.7	7.2	4.0	..	36.7	16.5	1.8	1.3	3.7	2.3
1995	2.8	1.4	2.8	3.6	2.2	3.9	1.5	5.2	3.4	1.2	4.6	2.1
2000	1.6	0.7	0.0	1.8	4.6	-	13.5	11.4	7.7	4.0	3.3	1.8
2001	1.2	0.6	0.0	1.8	2.5	3.9	16.1	12.6	6.1	2.9	3.3	1.5
<i>Hepatitis C</i>												
1990	..	..	..	..	1.2	..	10.2	2.4	..	..	7.0	3.5
1995	0.3	0.1	0.3	..	26.6	11.9	21.6	8.2	0.9	0.5	46.0	19.2
2000	0.3	0.1	0.0	1.8	2.1	-	41.2	18.5	0.5 ³⁾		31.4	13.6
2001	0.2	0.1	0.0	0.0	2.5	-	29.4	23.0	0.8 ³⁾		30.6	13.8

1 Both acute and chronic in 1995.

2 Both acute and chronic.

3 Both men and women.

4 Hepatitis C: Both acute and chronic. Hepatitis B: acute.

1 Både akutte og kroniske i 1995.

2 Både akutte og kroniske.

3 Tal for både mænd og kvinder.

4 Hepatitis C: Både akutte og kroniske. Hepatitis B: akutte.

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

Table 3.4 Diagnosed cases of tuberculosis per 100 000 inhabitants 1990-2001

Diagnostiserede tilfælde af tuberkulose pr. 100 000 indbyggere 1990-2001

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
<i>Men</i>					M+F			
Mænd								
1990	8.2	4.4	63.2	..	27.7	9.4	7.6	8.1
1995	9.8	-	94.3	14.5	7.9	4.5	6.4	6.5
2000	12.1	21.7	50.0	12.3	3.9	2.8	5.8	5.2
2001	10.2	-	156.5	10.8	7.8	5.6	7.3	4.6
<i>Women</i>								
Kvinder								
1990	5.5	-	109.8	..	.	5.5	5.7	4.9
1995	7.5	9.5	76.8	11.5	.	4.5	4.5	6.3
2000	8.5	4.5	111.0	8.5	.	6.4	4.8	5.2
2001	8.9	8.7	217.4	8.2	.	4.2	5.9	5.0

Sources: See Table 3.3

Kilder: Se tabel 3.3

I: Directorate of Health; N: National Health Screening Service

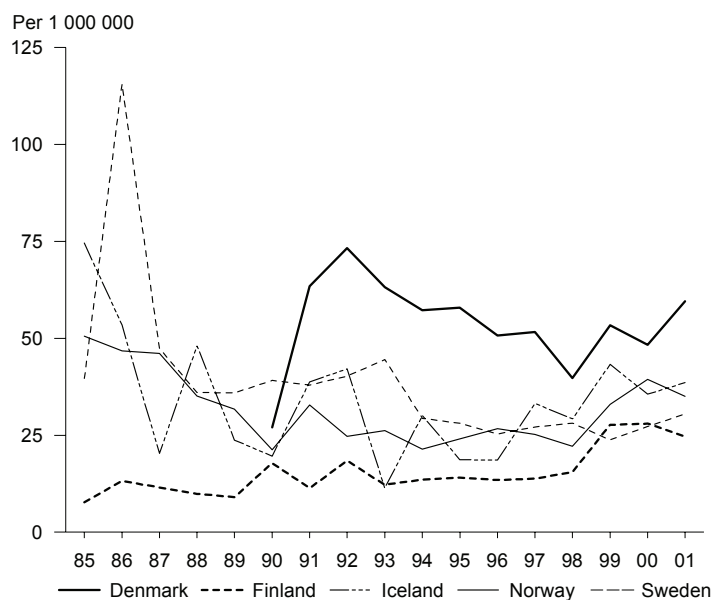
MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.5 Confirmed new cases of HIV 1991-2001
Påviste nye tilfælde af HIV 1991-2001

Five year average Femårgennemsnit	Denmark	Faroe Islands	Greenland	Finland	Of which Åland	Iceland	Norway	Sweden
<i>Men</i>								
<i>Mænd</i>								
1991-95	245	1	4	53	1	6	81	213
1996-00	180	0	6	76	0	6	81	155
2000	162	1	4	94	-	7	102	159
2001	..	-	4	95	-	9	102	169
<i>Women</i>								
<i>Kvinder</i>								
1991-95	82	-	4	18	-	2	31	102
1996-00	79	-	4	24	0	3	49	78
2000	96	-	3	51	-	3	75	83
2001	..	-	2	33	-	2	56	108
<i>Total</i>								
<i>I alt</i>								
1991-95	327	1	8	71	1	8	112	314
1996-00	259	0	9	102	0	9	130	233
2000	258	1	7	145	-	10	177	242
2001	319	-	6	128	-	11	158	271

Sources: See Table 3.3
Kilder: Se tabel 3.3

Figure 3.4 Confirmed new cases of HIV per 1 000 000 inhabitants 1985-2001



Sources: See Table 3.3
Kilder: Se tabel 3.3

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.6 Notified cases of gonorrhoea and syphilis per 100 000 inhabitants aged 15 years and over 2001

Anmeldte tilfælde af gonorré og syfilis pr. 100 000 indbyggere 15 år og derover 2001

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
<i>Gonorrhoea</i>								
Gonorré	2.9	-	1 717	5.8	-	1.4	9.1	5.9
<i>Syphilis</i>								
Syfilis	0.5	-	1.8	3.5	-	3.6	0.9	0.9

Sources: See Table 3.3
Kilder: Se tabel 3.3

Table 3.7 Diagnosed cases of chlamydia per 100 000 inhabitants 1990-2001

Diagnosticerede tilfælde af chlamydia pr. 100 000 indbyggere 1990-2001

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland ¹⁾	Norway ²⁾	Sweden
<i>Men</i>		M+W			M+W			
Mænd								
1990	..	82	..	190	374	285	..	230
1995	124	67	..	138	95	368	157	131
1999	153	95	2 532	162	198	451	297 ²⁾	169
2000	165	79	2 791	179	151	481	326 ²⁾	187
2001	167	158	3 330	183	190	541	330 ²⁾	..
<i>Women</i>								
Kvinder								
1990	..	.	..	308	.	313	..	414
1995	370	.	..	224	.	428	276	192
1999	367	.	4 414	247	.	735	. ²⁾	231
2000	384	.	4 817	271	.	793	. ²⁾	246
2001	397	.	6 173	283	.	896	. ²⁾	..

1 Notified cases. Since 1997 cases verified by laboratories.

2 Figures for 1999, 2000 and 2001 are for both men and women.

1 Anmeldte tilfælde. Fra 1997 er det tilfælde der er verificeret via laboratorier.

2 Tallene for 1999, 2000 og 2001 er for både mænd og kvinder.

Sources: See Table 3.3
Kilder: Se tabel 3.3

Cancer

The Nordic countries have population-based cancer registers with centralized coding and classification.

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

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

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

The trend for cancer diseases in the Nordic countries remains analogous for most forms of cancer, but there are interesting differences. In general, the number of cases has increased with time, with a few exceptions of decreasing incidence. These exceptions are cancer of the lip, oesophagus, stomach and cervix, except for cancer of the cervix in Greenland, where the incidence has remained stable. The decrease in the incidence of cancer of the cervix in the Nordic countries is related to the public screening programmes to

Cancersygdomme

De nordiske lande har befolkningsbaserede cancerregistre med centraliseret kodning og klassifikation.

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

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

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

Udviklingen i kræftsygdommene i de nordiske lande er analog for de fleste kræftformer, men der er interessante forskelle. Generelt er antallet af kræfttilfælde gennem tiden øget, med få undtagelser hvor forekomsten er faldende. Det gælder for læbekræft, spiserørskræft, kræft i mavesækken og kræft i livmoderhalsen - for sidstnævntes vedkommende med den undtagelse, at forekomsten i Grønland er forblevet på samme niveau som tidligere. Den viste nedgang i forekomsten af livmoderhalskræft i de nordiske lande, skal

detect pre-cancerous lesions and early lesions, and the ensuing treatment. The trend in cancer of the oesophagus among Danish and Swedish men has changed to a slight increase over recent years, contrary to the other Nordic countries. For cancer of the oesophagus, both alcohol and tobacco consumption are known to be major risk factors.

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

Differences in cancer incidence between the Nordic countries and the autonomous areas the Faroe Islands, Greenland and Åland must be interpreted with caution, as the size of the population in these countries is small, such that incidence rates are unstable.

ses i sammenhæng med befolkningsbaseret screening for forstadier og tidlig kræft, og disses behandling. Udviklingen i spiserørskræft blandt danske og svenske mænd er i de seneste år, i modsætning til de øvrige nordiske lande, vendt til en svag stigning. For spiserørskræfts vedkommende er både alkohol- og tobaksforbrug erkendte større risikofaktorer.

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

Forskelle i kræftforekomst mellem de nordiske lande og de autonome områder Færøerne, Grønland og Åland må bedømmes med forsigtighed, da befolkningens størrelse i disse områder er små, hvilket fører til ustabile incidensrater.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

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

	Total* I alt*	C62 Testis Testikler	C61 Prostate Prostata	C16 Stomach Mave	C18-21 Colon and rectum Tyktarm og endetarm	C25 Pancreas Pancreas	C33-34 Lungs Lunger	C43 Melanoma of the skin Melanom i hud
Denmark								
1991-95	5 411	113	569	141	643	120	830	143
1998	5 660	108	658	116	660	130	772	150
1999	5 693	111	667	125	658	128	784	159
Faroe Islands¹⁾								
1996-00	3 586	86	405	172	474	138	465	34
1997-01	3 422	83	290	191	456	174	456	41
Greenland								
1991-95	1 920	34	34	141	162	54	586	7
Finland								
1991-95	3 745	29	787	197	353	126	687	105
1996-00	4 210	34	1 201	176	391	130	602	122
2000	4 245	36	1 325	162	384	123	534	123
Iceland								
1991-95	3 634	73	957	226	297	91	424	52
1996-00	4 019	61	1 089	201	476	71	444	99
Norway								
1991-95	4 703	90	1 074	215	667	131	591	200
1996-00	5 097	108	1 294	182	692	125	584	207
Sweden								
1991-95	4 924	52	1 295	189	592	121	407	170
1996-00	5 127	54	1 526	156	599	100	379	183
2000	5 329	56	1 735	135	598	93	374	181

Numbers refer to ICD-10.

* The total covers chapter C.
Totalen dækker kapitel C.

1 Based on 5 year average discharges from the patient register.

1 Baseret på udskrivninger for 5 års gennemsnit fra patientregisteret.

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

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE
Table 3.9 New cases of cancer per 1 000 000 inhabitants, women
 Nye tilfælde af cancer pr. 1 000 000 indbyggere, kvinder

	Total* I alt*	C50 Breast Bryst	C53 Cervix uteri Livmoder- hals	C16 Stomach Mave	C18-21 Colon and rectum Tyktarm og endetarm	C25 Pancreas Pancreas	C33-34 Lungs Lunger	C43 Melanoma of the skin Melanom i hud
Denmark								
1991-95	5 723	1 266	190	87	642	131	483	187
1998	6 078	1 373	157	81	673	145	544	177
1999	6 089	1 403	158	74	640	133	567	201
Faroe Islands¹⁾								
1996-00	3 946	922	221	101	470	175	267	37
1997-01	3 613	980	196	107	472	160	240	45
Greenland								
1991-95	2 390	388	310	78	217	78	380	0
Finland								
1991-95	3 894	1 086	58	167	394	150	165	99
1996-00	4 184	1 281	61	140	419	138	179	115
2000	4 266	1 382	62	131	405	130	176	118
Iceland								
1991-95	3 659	881	104	139	319	102	431	104
1996-00	3 883	1 076	105	104	372	83	387	174
Norway								
1991-95	4 236	939	166	140	678	138	253	218
1996-00	4 609	1 081	143	114	712	141	313	223
Sweden								
1991-95	4 694	1 246	111	115	571	132	224	168
1996-00	4 843	1 363	102	98	566	108	248	181
2000	4 929	1 415	100	99	575	100	271	183

Numbers refer to ICD-10.

 * The total covers chapter C.
 Totalen dækker kapitel C.

1 Based on 5 year average discharges from the patient register. 1 Baseret på udskrivninger for 5 års gennemsnit fra patientregisteret.

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

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

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

	Denmark	Finland	Iceland ²⁾	Norway	Sweden ³⁾
1991-95	87	53	22	45	38
1996-00	.. ¹⁾	48	34	53	41
2000	66 ¹⁾	38	..	59	34

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

Tabellen dækker numrene C91-C95 i ICD-10.

1 1999.

2 Only five year averages are presented. Figures for single years may be unstable because of low population.

3 Only covers C91 in ICD/10.

1 1999.

2 Kun femårs gennemsnit præsenteres. Tal for enkelte år kan være ustabile på grund af lav population.

3 Dækker kun C91 i ICD/10.

Sources: The cancer registers in the Nordic countries

Kilder: De nordiske cancerregistre

G: Danish Cancer Society

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

	Denmark	Faroe Islands	Greenland	Finland	Iceland	Norway	Sweden
	1999	¹⁾	2001	2000	1996-00	2000	2000
<i>Men Mænd</i>							
<i>Age Alder</i>							
0-24	2	-	-	7	4	6	4
25-44	44	61	-	29	39	59	48
45-64	683	553	198	463	550	805	580
65-84	3 659	2 374	132	2 014	3 438	4 008	2 840
85+	4 562	6 579	33	3 032	3 416	5 506	3 743
<i>Women Kvinder</i>							
<i>Age Alder</i>							
0-24	4	-	-	5	4	0	5
25-44	61	70	-	65	89	74	67
45-64	578	807	76	382	433	742	463
65-84	2 669	2 000	114	1 477	2 027	2 998	2 213
85+	3 401	1 827	-	2 378	2 272	4 307	2 384

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

Tabellen dækker numrene C18-21 i ICD-10.

1 Based on 5 year average discharges 1997-2001 from the patient register.

1 Baseret på udskrivninger for 5 års gennemsnit 1997-2001 fra patientregisteret.

Sources: The cancer registers in the Nordic countries

Kilder: De nordiske cancerregistre

G: Danish Cancer Society

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

	Denmark	Faroe Islands	Greenland	Finland	Iceland	Norway	Sweden
	1999	¹⁾	2001	2000	1996-00	2000	2000
<i>Men Mænd</i>							
<i>Age Alder</i>							
0-24	1	-	-	-	0	1	1
25-44	44	35	132	15	53	38	19
45-64	937	679	627	553	646	746	421
65-84	4 101	2 467	363	3 187	3 008	3 219	1 841
85+	2 443	457	66	3 245	1 879	2 691	944
<i>Women Kvinder</i>							
<i>Age Alder</i>							
0-24	-	-	-	1	0	-	-
25-44	47	-	-	10	59	44	21
45-64	835	443	152	216	751	551	436
65-84	2 190	1 187	38	648	1 818	1 341	913
85+	799	-	-	624	1 420	579	213

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

1 Based on 5 year average discharges 1997-2001 from the patient register. 1 Baseret på udskrivninger for 5 års gennemsnit 1997-2001 fra patientregisteret.

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

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

	Denmark	Faroe Islands	Greenland	Finland	Iceland	Norway	Sweden
	1999	¹⁾	2001	2000	1996-00	2000	2000
<i>Age Alder</i>							
0-24	10	-	-	5	8	4	2
25-44	201	210	190	95	197	173	138
45-64	212	255	-	79	137	216	119
65-84	275	667	-	88	131	191	171
85+	189	-	-	51	189	153	149

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

1 Based on 5 year average discharges 1997-2001 from the patient register. 1 Baseret på udskrivninger for 5 års gennemsnit 1997-2001 fra patientregisteret.

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

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

	Denmark	Faroe Islands	Greenland	Finland	Iceland	Norway	Sweden
	1999	¹⁾	2001	2000	1996-00	2000	2000
<i>Age Alder</i>							
0-24	48	-	-	23	11	58	25
25-44	228	214	66	71	159	257	132
45-64	90	74	-	20	45	72	35
65-84	30	-	-	21	-	20	10
85+	-	-	-	53	-	-	-

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

1 Based on 5 year average discharges 1997-2001 from the patient register. 1 Baseret på udskrivninger for 5 års gennemsnit 1997-2001 fra patientregisteret.

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

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

	Denmark	Faroe Islands	Greenland	Finland	Iceland	Norway	Sweden
	1999	¹⁾	2001	2000	1996-00	2000	2000
<i>Men Mænd</i>							
<i>Age Alder</i>							
0-24	12	-	-	6	15	6	7
25-44	90	31	-	63	82	102	82
45-64	271	74	-	191	215	351	264
65-84	412	158	-	410	246	788	573
85+	1 006	-	-	692	342	828	752
<i>Women Kvinder</i>							
<i>Age Alder</i>							
0-24	19	-	-	9	61	21	12
25-44	156	70	-	81	261	177	120
45-64	290	42	-	166	250	354	275
65-84	413	67	-	282	209	632	395
85+	683	457	-	253	95	477	433

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

1 Based on 5 year average discharges 1997-2001 from the patient register. 1 Baseret på udskrivninger for 5 års gennemsnit 1997-2001 fra patientregisteret.

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

Medical consultations and immunization schedules

In the Nordic countries, responsibility for primary health services is rooted in the public sector.

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

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

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

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

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

Lægebesøg og vaccinationsprogrammer

I de nordiske lande er ansvaret for det primære sundhedsvæsen forankret i den offentlige sektor.

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

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

Registreringspraksis for lægebesøg er meget forskellig fra land til land.

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

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

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

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

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

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

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

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

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Table 3.16 Medical consultations¹⁾ 2001
Lægekonsultationer¹⁾ 2001

	Denmark	Finland	Åland	Iceland	Sweden ²⁾
<i>Total number of consultations (millions)</i>					
Konsultationer i alt (mill.)	26.5	21.8	0.1	1.5	26.2
of which: heraf:					
<i>Consultations with a general practitioner</i>					
Besøg hos alment praktiserende læge i konsultationen	17.7	12.2	0.0	0.7	12.2
<i>Consultations with a specialist</i>					
Besøg hos specialist	8.8	9.6	0.0	0.8	14.0
<i>Consultations per capita</i>					
Besøg pr person	4.1	4.2	3.7	5.3	2.9

1 Excl. consultations by telephone, home visits by physicians. Consultations with a specialist include out-patient treatment in hospitals.

2 Incl. home visits, excl. medical consultations in day care.

1 Ekskl. telefonkonsultationer, lægebesøg i hjemmet. Besøg hos specialister omfatter også ambulante behandling på sygehuse.

2 Inkl. hjemmebesøg, ekskl. ambulante behandling.

Sources: D: National Board of Health; F & Å: STAKES; I: Directorate of Health; S: Federation of Swedish County Councils and National Board of Health and Welfare

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Table 3.17 Children under the age of two immunized according to immunization schedules (per cent) 2001

Børn under to år vaccineret i henhold til det anbefalede vaccinationsprogram (pct.) 2001

	Denmark	Faroe Islands ¹⁾	Finland ²⁾	Iceland	Norway ³⁾	Sweden
<i>BCG</i>						
Tuberkulose	..	.	99	.	..	16
<i>Pertussis</i>						
Kighoste	97	99	95	98	91	99
<i>Tetanus</i>						
Stivkrampe	97	99	95	98	91	99
<i>Diphtheria</i>						
Difteri	97	99	95	98	91	99
<i>Polio</i>						
Polio	97	99	95	98	91	99
<i>Rubella</i>						
Røde hunde	94	98	96	91	90	94
<i>Measles</i>						
Mæslinger	94	98	96	91	90	94

1 2000.

2 Figures based on 1 000 children born in 1997 selected randomly from the population register. Coverage has been calculated for the combination DTP only, not for its individual components.

3 The figures are underestimated due to low reporting in some municipalities.

1 2000.

2 Tallene er baseret på 1 000 børn født i 1997 tilfældigt udvalgt fra befolkningsregisteret. Dækningsgraden er beregnet ud fra DTP, ikke for de enkelte delkomponenter.

3 Tallene er underestimerede på grund af lav indberetning i nogle kommuner.

Source: WHO/EPI; D: Statens Seruminstitut; F: National Public Health Institute; I: Directorate of Health; N: Norwegian Board of Health; S: Swedish Institute for Infectious Disease Control

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Table 3.18 Recommended immunization schedules per 1 January, 2003

	<i>Denmark</i>	<i>Finland</i>	<i>Iceland</i>	<i>Norway</i>	<i>Sweden</i>
BCG	-	< 7 days	-	Risk groups: First week of life. Negatives: 13-14 years	Risk groups
Pertussis	3, 5 and 12 months	Children born before 1997: 3, 4, 5 and 20-24 months, Children born 1997 or later: 3, 4, 5 and 20-24 months and 6 years	3, 5, 12 months and 5 years	3, 5 and 11-12 months	3, 5 and 12 months
Tetanus	3, 5 and 12 months and 5 years	Children born before 1997: 3, 4, 5 and 20-24 months, 11-13 years; Children born 1997 or later: 3, 4, 5 and 20-24 months, 6 years and 14-16 years	3, 5, 12 months, 5 years and 14 years	3, 5 and 11-12 months, 11-12 years	3, 5 and 12 months, 10 years
Diphtheria	3, 5 and 12 months and 5 years	Children born before 1997: 3, 4, 5 and 20-24 months, 11-13 years; Children born 1997 or later: 3, 4, 5 and 20-24 months, 6 years and 14-16 years	3, 4, 12 months, 5 and 14 years	3, 5 and 11 months, 11-12 years	3, 5 and 12 months, 10 years
Polio	IPV: 3, 5 and 12 months; OPV: 2, 3 and 4 years ¹⁾	IPV: 6, 12 and 20-24 months + 6-7 years	IPV: 3, 5, 12 months and 14 years	IPV: 3, 5 and 11 months, 6-8 and 14 years	IPV: 3, 5 and 12 months, 5-6 years
Measles, Mumps, Rubella	15 months, 12 years	14-18 months and 6 years	18 months and 9 years	15 months and 12-13 years	18 months and 12 years
Rubella, only	Women of fertile age	-	Seronegative girls: 12 years	Seronegative women of fertile age	-
Measles, only	-	-	-	-	-
Haemophilus influenzae b	3, 5 and 12 months	4, 6 and 14-18 months	3, 5 and 12 months	3, 5 and 11 months	3, 5 and 12 months
Meningococcal disease gr. C			6, 8 months		

IPV = Inactivated polio vaccine
OPV = Oral polio vaccine

The Faroe Islands, Greenland and Åland have the same immunization schedules as Denmark and Finland respectively. In Greenland, however, BCG is included.

1 From 1 July 2001 children aged 2 years do not receive OPV, but an IPV-booster instead at the age of 5. Children who have received one or two OPV complete their vaccinations according to the earlier programme.

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

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Tabel 3.18 Anbefalede vaccinationsprogrammer pr. 1. januar 2003

	Danmark	Finland	Island	Norge	Sverige
Tuberkulose	-	< 7 dage	-	Risikogrupper: Første leveuge Negative: 13-14 år	Risikogrupper
Kighoste	3, 5 og 12 måneder	Børn født før 1997: 3, 4, 5 og 20-24 måneder; Født efter 1997: 3,4,5 og 20-24 måneder samt 6 år.	3, 5, 12 måneder og 5 år	3, 5 og 11-12 måneder	3, 5 og 12 måneder
Stivkrampe	3, 5 og 12 måneder og 5 år	Børn født før 1997: 3, 4, 5 og 20-24 måneder, 11-13 år; Født efter 1997: 3, 4, 5 og 20-24 måneder, 14-16 år	3, 5,12 måneder, 5 år og 14 år,	3, 5 og 11-12 måneder, samt 11-12 år	3, 5 og 12 måneder, 10 år
Difteri	3, 5 og 12 måneder og 5 år	Børn født før 1997: 3, 4, 5 og 20-24 måneder, 11-13 år; Født efter 1997: 3, 4, 5 og 20-24 måneder, 14-16 år	3, 4, 12 måneder, 5 og 14 år	3, 5 og 11 måneder samt 11-12 år	3, 5 og 12 måneder, 10 år
Polio	IPV: 3, 5 og 12 måneder OPV: 2, 3 og 4 år 1)	IPV: 6, 12 og 20-24 måneder + 6-7 år	IPV: 3, 5, 12 måneder og 14 år	IPV: 3, 5 og 11 måneder, 6-8 år og 14 år	IPV: 3, 5 og 12 måneder, 5-6 år
Mæslinger, fåresyge, røde hunde	15 måneder, 12 år	14-18 måneder og 6 år	18 måneder og 9 år	15 måneder og 12-13 år	18 måneder og 12 år
Røde hunde, alene	Kvinder i den fertile alder	-	Seronegative piger: 12 år	Seronegative kvinder i den fertile alder	-
Mæslinger, alene	-	-	-	-	-
Haemophilus influenzae b	3, 5 og 12 måneder	4, 6 og 14-18 måneder	3, 5, 12 måneder	3, 5 og 11 måneder	3, 5 og 12 måneder
Meningitis			6, 8 måneder		

IPV = Inaktiveret polio vaccine
OPV = Oral poliovaccine
Færøerne, Grønland og Åland har de samme vaccinationsprogrammer som henholdsvis Danmark og Finland. Vaccination mod tuberkulose er dog inkluderet i Grønland.

1 Fra 1.7.2001 skal børn der er fyldt 2 år ikke længere vaccineres med OPV men i stedet IPV når de er fyldt 5 år. Børn der har modtaget en eller to OPV vaccinationer skal gennemføre vaccinationsprogrammet i henhold til det tidligere program.

Kilder: WHO/EPID: Statens Seruminstitut; F: Folkhälsoinstitutet; I: Landlæknisembættið; N: Statens institutt for folkehelse; S: Socialstyrelsen

Discharges, average length of stay and surgical procedures

In this section, data on treatment in hospitals are presented, with data from selected diagnostic groups and with data on surgery according to 16 major surgical procedure groups. The statistics based on diagnosis are first presented with the total number of discharges from hospitals, the average length of stay, and the number of patients who have been treated during the year, according to the ICD-10's main chapters. Then follow tables on hospital discharges and average length of stay for 10 selected diagnostic groups. On the NOMESCO homepage at www.nom-nos.dk you will find detailed data on the total number of discharges according to the 61 groups in the Nordic abbreviated list of morbidity.

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

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

Udskrivninger, gennemsnitlig liggetid og kirurgiske indgreb

I dette afsnit gives der data for behandlingen ved sygehuse med data fra udvalgte diagnosegrupper og med data for operationer opgjort efter 16 hovedoperationsgrupper. Den diagnosebaserede statistik vises først med det samlede antal udskrivninger, den gennemsnitlig liggetid, samt patienter der er behandlet i løbet af året, fordelt efter ICD-10's hovedkapitler. Herefter kommer tabeller om udskrivninger samt den gennemsnitlige liggetid for 10 udvalgte diagnosegrupper. På NOMESCO's hjemmeside på www.nom-nos.dk findes der detaljerede data om det samlede antal udskrivninger fordelt på de 61 grupper i den nordiske forkortede morbiditetsliste.

Statistikken fra patientregistrene i de fem nordiske lande viser en del store forskelle mellem landene som ikke alene kan tilskrives forskelle i sygdomsforekomsten hvorfor NOMESCO i 2000 gennemførte et validitetsstudium af den diagnoserelaterede patientstatistik. Resultaterne derfra var medtaget som temasektion i 2000 udgaven af denne publikation. Et tilsvarende studie af procedure/operationsstatistikken blev medtaget i 2002 udgaven. I denne udgave er det medtaget et tilsvarende studie af dagkirurgi.

Det der kan konstateres ved den diagnoserelaterede statistik er, at der er en vis variation i diagnosticeringen og kodningen mellem de nordiske lande til trods for at man anvender den samme klassifikation. I validitetsstudiet blev der peget

agnostic cultures, differences in medical treatment and differences in the way in which treatment is organized.

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

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

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

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

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

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

Another important aspect is changes in the statistics in connection with the change in the classification. This is described in detail in Chapter 5 together with the causes of death. Today, all five Nordic countries use ICD-10, so that comparability is only a problem in the historic data. For example, the present tables 3.19-3.21, calculated according to the main chapters in ICD-10, are not completely comparable with the previous corresponding tables calculated according to the main chapters in ICD-9.

When evaluating the statistics it is important to note that the wrong diagnosis may have been made, or the wrong code may have been used for the correct diagnosis. Nordic studies show, however, that when it comes to the main diagnosis, validity is good.

In several countries the introduction of diagnosis related groups (DRG) has been seen to influence diagnosis in hospitals, for example more secondary diagnoses are registered and the choice of main diagnosis has changed in certain cases.

One last aspect is the different ways in which countries organize their hospital sectors, including differences in treatment practice. Differences are typically seen in the extent of out-patient versus in-patient treatment.

Tables 3.32 -3.34 include information on selected surgical procedure groups, se-

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

Et andet væsentligt aspekt er ændringer i statistikken ved klassifikationsskiftet. Dette er omfattende beskrevet i kapitel 5 sammen med dødsårsagerne. I dag anvender alle 5 nordiske lande ICD-10 hvorfor det kun er i de historiske data der kan komme brist i sammenligneligheden. De nuværende tabeller 3.19-3.21 opgjort efter ICD-10's hovedkapitler kan eksempelvis ikke helt sammenlignes med de tidligere tilsvarende tabeller opgjort efter ICD-9's hovedkapitler.

Ved vurderingen af statistikken skal man også være opmærksom på, at der kan være oplyst forkert diagnose ligesom der kan være anvendt forkert kode til korrekt oplyst diagnose. Nordiske studier viser dog, at når det gælder hoveddiagnosen er der en god validitet.

Indførslen af de diagnoserelaterede grupperinger (DRG) har i flere lande vist sig at påvirke diagnostiseringen ved sygehusene, blandt andet ved at flere bi-diagnoser registreres og valget af hoveddiagnose i visse tilfælde ændres.

Et sidste forhold der gør sig gældende er landenes forskelle i organiseringen af sygehusvæsenet og herunder også forskelle i behandlingspraksis. Her kan der typisk være forskelle med hensyn til omfanget af ambulans behandling eller om behandlingen foregår under indlæggelse.

Tabellerne 3.32-3.34 indeholder oplysninger om udvalgte operationsgrupper.

lected because of their high frequency and because the frequency of operations is influenced by differences in medical practice between the countries.

In order to present a more complete picture, Table 3.35 covers the most frequent procedures carried out as day surgery.

In order to give more detail, the 14 groups are presented by sex, and in some cases by age, in Tables 3.36-3.51. In this way, the differences between the countries appear more clearly.

Comparisons of operations between various geographic areas are however difficult, and the comparisons contain a number of potential sources of error, which in principle are the same as those mentioned for the diagnosis-related statistics.

In addition, there are differences from country to country in the way in which operations in hospitals are counted.

som er udvalgt fordi de er hyppigt forekommende og fordi operationsomfanget i forskellig grad påvirkes af forskelle i medicinsk praksis i landene.

For at få et mere fuldkomment billede er der i tabel 3.35 medtaget de mest forekommende indgreb som sker uden indlæggelse – dagkirurgisk.

For at få et mere komplet billede, er de 14 grupper medtaget fordelt på køn og i visse aldersgrupper i tabellerne 3.36-3.51. Heraf fremgår forskellene mellem landene tydeligere.

Sammenligninger af operationer mellem geografiske områder er imidlertid vanskelige og indeholder en række potentielle fejlkilder, som i princippet er de samme som er nævnt for den diagnoserelevante statistik.

Hertil kommer, at der er forskelle fra land til land i måden hvorpå operationer ved sygehuse tælles.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE
Table 3.19 Discharges from hospitals* by main diagnostic group, per 1 000 inhabitants 2001

	<i>Denmark</i>	<i>Faroe Islands¹⁾</i>	<i>Finland²⁾</i>	<i>Åland²⁾</i>
Certain infectious and parasitic diseases	5.1	5.1	4.5	6.0
Neoplasms	19.7	17.4	21.4	22.0
Diseases of the blood and blood-forming organs and certain disorders involving the immune system	2.5	3.2	1.6	1.4
Endocrine, nutritional and metabolic diseases	4.7	5.1	2.9	2.8
Mental and behavioural disorders	2.8	8.9	2.2	4.0
Diseases of the nervous system	4.6	6.0	7.9	14.2
Diseases of the eye and adnexa	1.5	3.1	8.4	3.6
Diseases of the ear and mastoid process	1.3	3.4	3.0	4.6
Diseases of the circulatory system	26.3	22.5	27.0	26.1
Diseases of the respiratory system	16.7	12.4	15.6	19.3
Diseases of the digestive system	16.0	24.7	15.6	19.1
Diseases of the skin and subcutaneous tissue	2.8	2.3	2.4	2.2
Diseases of the musculo-skeletal system and connective tissue	9.7	15.9	18.9	21.5
Diseases of the genito-urinary system	10.1	9.7	11.2	14.0
Pregnancy, childbirth and the puerperium	16.2	18.5	16.0	16.8
Certain conditions originating in the perinatal period	1.8	0.7	1.4	1.4
Congenital malformations, deformations and chromosomal abnormalities	1.8	1.4	2.1	1.8
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	13.3	10.5	12.9	12.2
Traumas and poisonings	18.7	18.7	17.4	19.5
Patients without symptoms or diseases	17.0	18.7	4.3	4.3
Total	192.4	208.5	196.8	216.6

* Comprises somatic wards in ordinary hospitals and in specialized somatic hospitals

1 Including wards in psychiatric hospitals.

2 Excluding wards in psychiatric hospitals or in non-specialized departments in health centres.

3 1998. Table 3.19-3.31: discharges with length of stay less than 90 days. Excluded are rehabilitation, geriatrics and psychiatric wards.

4 Figures are for discharges from hospitals, not for finished treatment at wards.

Sources: The national in-patient registers

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Udskrivninger fra sygehuse* efter hoveddiagnosegrupper, Tabel 3.19
pr. 1 000 indbyggere 2001

<i>Iceland³⁾</i>	<i>Norway⁴⁾</i>	<i>Sweden</i>	
3.5	3.7	4.3	Visse infektions- og parasitære sygdomme
14.6	17.6	16.3	Svulster
1.5	1.1	1.2	Sygdomme i blod og bloddannende organer og visse lidelser i forbindelse med immunsystemet
1.8	2.2	3.4	Endokrine, ernærings- og stofskiftesygdomme
2.1	1.8	1.7	Psykiske og adfærdsmæssige lidelser
5.7	5.3	4.4	Sygdomme i nervesystem
1.7	2.1	1.1	Sygdomme i øje og øjenomgivelser
0.8	0.7	0.9	Sygdomme i øre og processus mastoideus
18.9	23.6	27.4	Sygdomme i kredsløbsorganer
12.8	13.1	10.0	Sygdomme i åndedrætsorganer
12.3	11.5	12.6	Sygdomme i fordøjelsesorganer
2.7	1.7	1.2	Sygdomme i hud og underhud
10.3	11.0	8.2	Sygdomme i knogler, bevægelsessystem og bindevæv
12.9	8.3	7.5	Sygdomme i urin- og kønsorganer
22.3	15.1	12.8	Svangerskab, fødsel og barsel
1.3	2.1	1.3	Visse årsager til sygdomme i perinatalperioden
2.3	2.0	1.3	Medfødte misdannelser og kromosomanomalier
6.3	11.1	15.1	Symptomer og abnorme fund ikke klassificeret andetsteds
11.9	17.2	15.4	Traumer og forgiftninger
5.7	7.3	5.3	Patienter uden symptomer eller sygdomme
151.5	158.7	151.3	I alt

* Omfatter somatiske afdelinger ved almindelige sygehuse og ved somatiske specialsygehuse

1 Tallene inkluderer psykiatriske hospitalsafdelinger.

2 Eksklusiv psykiatriske hospitalsafdelinger eller ikke-specialiserede afdelinger på sundhedscentraler.

3 1998. Table 3.19-3.31: udskrivninger med liggetid under 90 dage. Eksklusiv revalideringsklinikker og geriatriske og psykiatriske afdelinger.

4 Opgørelsen vedrører udskrivninger fra sygehuse, ikke afsluttede behandlinger ved afdelinger.

Kilder: Landspatientregistrene

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.20 Average length of stay in hospitals* by main diagnostic group 2001

	<i>Denmark</i>	<i>Faroe Islands¹⁾</i>	<i>Finland²⁾</i>	<i>Åland²⁾</i>
Certain infectious and parasitic diseases	5.1	5.7	6.0	6.1
Neoplasms	6.4	5.3	4.8	8.1
Diseases of the blood and blood-forming organs and certain disorders involving the immune system	4.8	2.8	4.2	4.4
Endocrine, nutritional and metabolic diseases	6.6	6.0	5.5	6.0
Mental and behavioural disorders	5.1	29.1	7.9	7.0
Diseases of the nervous system	6.2	5.9	4.9	4.2
Diseases of the eye and adnexa	2.6	2.7	1.3	1.7
Diseases of the ear and mastoid process	2.6	0.7	1.7	2.0
Diseases of the circulatory system	6.6	10.7	6.0	7.8
Diseases of the respiratory system	5.2	5.3	4.2	5.1
Diseases of the digestive system	5.0	2.7	4.1	5.5
Diseases of the skin and subcutaneous tissue	5.5	5.5	5.0	4.3
Diseases of the musculo-skeletal system and connective tissue	6.8	6.3	4.1	5.7
Diseases of the genito-urinary system	4.2	3.0	3.3	3.9
Pregnancy, childbirth and the puerperium	3.4	4.9	3.5	3.7
Certain conditions originating in the perinatal period	11.2	3.3	9.9	7.9
Congenital malformations, deformations and chromosomal abnormalities	4.4	3.4	3.9	23.3
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	3.4	4.5	3.0	3.6
Traumas and poisonings	5.6	6.1	5.5	5.3
Patients without symptoms or diseases	5.3	4.4	2.9	3.6
Total	5.4	6.4	4.4	5.6

* Definition, see Table 3.19

1 Including psychiatric hospital wards.

2 Excluding wards in psychiatric hospitals or in non-specialized departments in health centres.

3 1998. Discharges with length of stay less than 90 days. Excluded are rehabilitation, geriatrics and psychiatric wards.

Sources: See Table 3.19

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Gennemsnitlig liggetid ved sygehuse* efter hoveddiagnosegrupper 2001 Tabel 3.20

<i>Iceland³⁾</i>	<i>Norway</i>	<i>Sweden</i>	
4.5	6.3	5.4	Visse infektions- og parasitære sygdomme
7.6	8.1	7.3	Svulster
4.4	5.2	5.2	Sygdomme i blod og bloddannende organer og visse lidelser i forbindelse med immunsystemet
7.6	5.5	6.3	Endokrine, ernærings- og stofskiftesygdomme
10.0	4.4	5.5	Psykiske og adfærdsmæssige lidelser
4.8	4.4	5.7	Sygdomme i nervesystem
3.8	3.8	2.9	Sygdomme i øje og øjenomgivelser
3.7	2.9	2.5	Sygdomme i øre og processus mastoideus
7.3	6.0	6.2	Sygdomme i kredsløbsorganer
6.6	5.6	5.2	Sygdomme i åndedrætsorganer
5.2	5.3	4.8	Sygdomme i fordøjelsesorganer
8.1	7.3	6.8	Sygdomme i hud og underhud
6.9	6.3	6.4	Sygdomme i knogler, bevægelsessystem og bindevæv
4.3	4.6	4.4	Sygdomme i urin- og kønsorganer
3.6	4.3	3.1	Svangerskab, fødsel og barsel
11.8	11.0	11.5	Visse årsager til sygdomme i perinatalperioden
4.9	5.2	5.2	Medfødte misdannelser og kromosomanomalier
3.9	2.6	2.6	Symptomer og abnorme fund ikke klassificeret andetsteds
5.5	5.1	5.6	Traumer og forgiftninger
3.6	9.5	7.3	Patienter uden symptomer eller sygdomme
5.7	5.7	5.4	I alt

* Definition, se tabel 3.19

1 Inklusiv psykiatriske hospitalsafdelinger.

2 Eksklusiv psykiatriske hospitalsafdelinger eller ikke-specialiserede afdelinger på sundhedscentraler.

3 1998. Udskrivninger med liggetid under 90 dage. Eksklusiv revalideringsklinikker og geriatriske og psykiatriske afdelinger.

Kilder: Se tabel 3.19

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.21 Patients treated in hospitals* during 2001 by main diagnostic group, per 1 000 inhabitants

	<i>Denmark</i>	<i>Faroe¹⁾ Islands</i>	<i>Finland²⁾</i>
Certain infectious and parasitic diseases	4.4	4.6	3.9
Neoplasms	9.6	8.1	9.7
Diseases of the blood and blood-forming organs and certain disorders involving the immune system	1.6	1.5	1.0
Endocrine, nutritional and metabolic diseases	3.6	4.1	2.3
Mental and behavioural disorders	2.1	7.1	1.8
Diseases of the nervous system	3.3	4.4	5.8
Diseases of the eye and adnexa	1.2	2.9	7.3
Diseases of the ear and mastoid process	1.2	3.3	2.7
Diseases of the circulatory system	16.6	19.1	17.6
Diseases of the respiratory system	11.8	10.3	12.3
Diseases of the digestive system	12.1	21.5	12.6
Diseases of the skin and subcutaneous tissue	2.3	2.1	1.9
Diseases of the musculo-skeletal system and connective tissue	7.9	13.7	15.2
Diseases of the genito-urinary system	8.0	8.3	9.4
Pregnancy, childbirth and the puerperium	14.4	18.0	13.5
Certain conditions originating in the perinatal period	1.5	0.6	1.3
Congenital malformations, deformations and chromosomal abnormalities	1.1	1.2	1.4
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	11.6	9.1	11.0
Traumas and poisonings	15.3	16.2	14.2
Patients without symptoms or diseases	14.5	17.4	3.7
Total	143.9	173.5	126.4

* Comprises somatic wards in ordinary hospitals and in specialized somatic hospitals

1 Including psychiatric hospital wards.

2 Excluding wards in psychiatric hospitals or in non-specialized departments in health centres.

3 The figures cover treatment at the same hospital. If a patient is transferred to another hospital, this is recorded as a new treatment period.

Sources: The national in-patient registers

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Patienter behandlet ved sygehuse* i løbet af 2001, efter hoveddiagnosegrupper, pr. 1 000 indbyggere Tabel 3.21

Åland ²⁾	Norway ³⁾	Sweden	
5.2	3.5	3.7	Visse infektions- og parasitære sygdomme
11.5	10.4	8.4	Svulster
1.2	0.8	0.9	Sygdomme i blod og bloddannende organer og visse lidelser i forbindelse med immunsystemet
2.1	1.9	2.6	Endokrine, ernærings- og stofskiftesygdomme
3.0	1.5	1.5	Psykiske og adfærdsmæssige lidelser
10.7	4.4	3.3	Sygdomme i nervesystem
2.7	1.8	0.9	Sygdomme i øje og øjenomgivelser
3.3	0.7	0.8	Sygdomme i øre og processus mastoideus
17.5	18.3	17.5	Sygdomme i kredsløbsorganer
15.3	10.7	7.6	Sygdomme i åndedrætsorganer
14.9	9.7	10.0	Sygdomme i fordøjelsesorganer
2.0	1.5	1.0	Sygdomme i hud og underhud
17.2	9.5	6.6	Sygdomme i knogler, bevægelsessystem og bindevæv
11.3	7.1	6.3	Sygdomme i urin- og kønsorganer
14.1	13.6	10.9	Svangerskab, fødsel og barsel
1.3	2.1	0.8	Visse årsager til sygdomme i perinatalperioden
1.1	1.6	0.8	Medfødte misdannelser og kromosomanomalier
10.7	10.2	13.0	Symptomer og abnorme fund ikke klassificeret andetsteds
16.2	15.5	12.7	Traumer og forgiftninger
4.1	6.4	4.6	Patienter uden symptomer eller sygdomme
139.5	131.3	114.1	I alt

* Omfatter somatiske afdelinger ved almindelige sygehuse og ved somatiske specialsygehuse

1 Inklusiv psykiatriske hospitalsafdelinger.

2 Eksklusiv psykiatriske hospitalsafdelinger eller ikke-specialiserede afdelinger på sundhedscentraler.

3 Tallene dækker behandling ved et sygehus. Hvis en patient overflyttes til et andet sygehus, er der tale om en ny behandlingsperiode.

Kilder: Landspatientregistrene

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

**Table 3.22 Discharges and average length of stay in hospitals*.
Malignant neoplasm of the breast, women 2001**
Udskrivninger og gennemsnitlig liggetid ved sygehuse*.
Kræft i bryst, kvinder 2001

	Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland ²⁾	Norway	Sweden
<i>Discharges</i>							
<i>Total</i>							
Udskrivninger I alt	9 262	128	10 529	61	367	7 340	12 557
<i>Per 100 000 women in the age group</i>							
Pr. 100 000 kvinder i alderen							
0-24							
25-44	152	34	199	120	139	142	112
45-64	714	1 731	855	1 219	666	746	559
65+	680	1 156	454	604	489	622	555
<i>Total rate</i>							
Samlet rate	342	570	397	469	267	322	392
<i>Average length of stay</i>							
Gennemsnitlig liggetid	5.4	6.9	3.8	6.7	6.8	6.5	4.7

1 Average 1997-2001.

2 1998.

1 Gennemsnit for årene 1997 til 2001.

2 1998.

The table includes ICD-9: 174-175 and ICD-10: C50.
Tabellen omfatter ICD-9: 174-175 og ICD-10: C50.

Source: * Definition, see Table 3.19
Kilde: * Definition, se tabel 3.19

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.23 Discharges and average length of stay in hospitals*.
Malignant neoplasm of the larynx, trachea, bronchus and lung 2001
 Udskrivninger og gennemsnitlig liggetid ved sygehuse*.
 Kræft i strubehoved, luftrør, bronkie og lunge 2001

		Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland ²⁾	Norway	Sweden
<i>Discharges</i> Udskrivninger								
<i>Men</i>	Mænd							
<i>Total</i>	I alt	5 907	37	5 451	35	235	4 239	5 669
<i>Per 100 000 men in the age group</i>								
Pr. 100 000 mænd i alderen								
	0-24	0	-	0	-	0	-	0
	25-44	18	-	13	-	46	11	10
	45-64	349	322	301	404	274	267	178
	65+	1 001	680	1 073	1 153	613	697	534
	<i>Total rate</i>							
	Samlet rate	223	153	215	273	170	186	129
<i>Women</i>	Kvinder							
<i>Total</i>	I alt	4 639	13	1 980	16	183	2 472	4 303
<i>Per 100 000 women in the age group</i>								
Pr. 100 000 kvinder i alderen								
	0-24	0	-	-	-	0	1	1
	25-44	29	-	11	11	15	10	12
	45-64	302	20	118	179	251	193	172
	65+	505	347	226	363	408	479	250
	<i>Total rate</i>							
	Samlet rate	171	58	75	118	133	110	96
<i>Average length of stay</i>								
Gennemsnitlig liggetid		6.9	6.0	7.4	10.9	8.0	9.9	11.0

1 Average 1997-2001.

2 1998.

1 Gennemsnit for årene 1997 til 2001.

2 1998.

The table includes ICD-9: 161-162 and ICD-10: C32-C34.
 Tabellen omfatter ICD-9: 161-162 og ICD-10: C32-C34.

Source: * Definition, see Table 3.19
 Kilde: * Definition, se tabel 3.19

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

**Table 3.24 Discharges and average length of stay in hospitals*.
Acute myocardial infarction 2001**
Udskrivninger og gennemsnitlig liggetid ved sygehuse*.
Akut hjerteinfarkt 2001

		Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland ²⁾	Norway	Sweden
<i>Discharges</i> Udskrivninger								
<i>Men</i>	Mænd							
<i>Total</i>	I alt	8 618	77	8 102	41	342	9 293	20 412
<i>Per 100 000 men in the age group</i>								
Pr. 100 000 mænd i alderen								
	0-44	26	38	18	24	10	33	18
	45-64	446	411	385	331	410	564	475
	65+	1 529	1 719	1 709	1 525	956	2 048	2 218
	<i>Total rate</i>							
	Samlet rate	326	319	320	318	248	415	463
<i>Women</i>	Kvinder							
<i>Total</i>	I alt	5 032	55	6 145	30	158	5 494	13 315
<i>Per 100 000 women in the age group</i>								
Pr. 100 000 kvinder i alderen								
	0-44	8	-	3	3	1	7	5
	45-64	130	163	97	58	157	145	147
	65+	869	1 360	1 127	1 120	426	1 173	1 310
	<i>Total rate</i>							
	Samlet rate	186	245	232	228	115	241	296
<i>Average length of stay</i>								
Gennemsnitlig liggetid		6.4	8.0	7.7	8.1	9.3	7.0	6.3

1 Average 1997-2001.

2 1998.

1 Gennemsnit for årene 1997 til 2001.

2 1998.

The table includes ICD-9: 410 and ICD-10: I21-I22.
Tabellen omfatter ICD-9: 410 og ICD-10: I21-I22.

Source: * Definition, see Table 3.19
Kilde: * Definition, se tabel 3.19

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

**Table 3.25 Discharges and average length of stay in hospitals*.
Cerebrovascular diseases 2001**
Udskrivninger og gennemsnitlig liggetid ved sygehuse*.
Karsygdomme i hjerne 2001

	Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland ²⁾	Norway	Sweden
<i>Discharges</i> Udskrivninger							
<i>Men</i> Mænd							
<i>Total</i> I alt	11 961	88	10 256	51	266	7 259	21 699
<i>Per 100 000 men in the age group</i> Pr. 100 000 mænd i alderen							
0-44	31	6	45	51	12	29	28
45-64	516	411	544	432	260	297	412
65-79	2 018	1 963	1 778	1 553	1 181	1 499	2 006
80+	3 611	3 488	2 616	2 539	1 699	3 016	3 901
<i>Total rate</i> Samlet rate	452	365	405	398	193	324	492
<i>Women</i> Kvinder							
<i>Total</i> I alt	11 876	66	9 429	49	194	7 432	20 949
<i>Per 100 000 women in the age group</i> Pr. 100 000 kvinder i alderen							
0-44	36	7	38	25	13	27	27
45-64	340	225	295	358	139	244	267
65-79	1 463	945	1 171	963	632	955	1 306
80+	3 001	3 039	2 053	2 249	1 372	2 450	3 231
<i>Total rate</i> Samlet rate	439	294	356	374	141	326	465
<i>Average length of stay</i> Gennemsnitlig liggetid	14.2	33.1	11.1	14.2	11.8	9.8	12.0

1 Average 1997-2001.

2 1998.

1 Gennemsnit for årene 1997 til 2001.

2 1998.

The table includes ICD-9: 430-434, 436-438 and ICD-10: I60-I69.

Tabellen omfatter ICD-9: 430-434 og ICD-10: I60-I69.

Source: * Definition, see Table 3.19

Kilde: * Definition, se tabel 3.19

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.26 Discharges and average length of stay in hospitals*. Asthma, bronchitis, emphysema and other chronic obstructive pulmonary disease 2001

Udskrivninger og gennemsnitlig liggetid ved sygehuse*.

Astma, bronkit, emfysem og anden obstruktiv lungesygdom 2001

		Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland ²⁾	Norway	Sweden
<i>Discharges</i>	<i>Udskrivninger</i>							
<i>Total</i>	<i>I alt</i>	31 237	164	17 218	114	824	12 934	24 521
<i>Per 100 000 in the age group</i>								
<i>Pr. 100 000 i alderen</i>								
	0-4	1 110	1 627	625	1 382	297	677	653
	5-14	205	288	116	305	65	129	11
	15-24	70	64	74	92	19	52	19
	25-64	259	169	180	153	114	126	478
	65-74	2 207	820	1 015	928	1 406	915	823
	75+	2 346	541	1 364	1 851	984	1 101	1 233
<i>Total rate</i>	<i>Samlet rate</i>	583	352	332	439	299	286	275
<i>Average length of stay</i>								
<i>Gennemsnitlig liggetid</i>								
		5.7	5.8	5.0	6.0	10.7	4.9	5.5

1 Average 1997-2001.

2 1998.

1 Gennemsnit for årene 1997 til 2001.

2 1998.

The table includes ICD-9: 490-493, 496 and ICD-10: J40-J46. Source: * Definition, see Table 3.19

Tabellen omfatter ICD-9: 490-493, 496 og ICD-10: J40-J46. Kilde: * Definition, se tabel 3.19

Table 3.27 Discharges and average length of stay in hospitals*.

Cervical and other intervertebral disc disorders 2001

Udskrivninger og gennemsnitlig liggetid ved sygehuse*.

Diskusprolaps i halsens ryghvirvler og andre ryghvirvler 2001

		Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland ²⁾	Norway	Sweden
<i>Discharges</i>	<i>Udskrivninger</i>							
<i>Total</i>	<i>I alt</i>	6 362	61	7 289	43	658	6 178	3 165
<i>Per 100 000 in the age group</i>								
<i>Pr. 100 000 i alderen</i>								
	0-24	12	12	19	29	43	13	5
	25-44	168	191	212	206	383	222	63
	45-64	195	238	232	287	448	235	58
	65+	105	160	92	141	108	75	21
<i>Total rate</i>	<i>Samlet rate</i>	119	131	140	165	239	137	37
<i>Average length of stay</i>								
<i>Gennemsnitlig liggetid</i>								
		7.0	5.2	4.3	6.6	4.9	5.3	5.9

1 Average 1997-2001.

2 1998.

1 Gennemsnit for årene 1997 til 2001.

2 1998.

The table includes ICD-9: 722 and ICD-10: M50-M51.

Tabellen omfatter ICD-9: 722 og ICD-10: M50-M51.

Source: * Definition, see Table 3.19

Kilde: * Definition, se tabel 3.19

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.28 Discharges and average length of stay in hospitals*.
Osteoporosis and osteomalacia, women 2001
 Udskrivninger og gennemsnitlig liggetid ved sygehuse*.
 Osteoporose og osteomalaci, kvinder 2001

	Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland ²⁾	Norway	Sweden
<i>Discharges</i> Udskrivninger							
<i>Women</i> Kvinder							
<i>Total</i> I alt	1 321	9	372	10	62	827	1 340
<i>Per 100 000 women in the age group</i> Pr. 100 000 kvinder i alderen							
0-44	1	14	2	-	0	0	1
45-64	16	20	5	12	26	9	4
65-74	130	60	32	185	128	77	47
75-79	290	394	82	371	392	192	144
80+	437	196	111	603	631	350	277
<i>Total rate</i> Samlet rate	49	40	14	73	45	36	30
<i>Average length of stay</i> Gennemsnitlig liggetid	12.0	13.0	10.0	8.0	11.4	8.5	10.5

1 Average 1997-2001.

2 1998.

1 Gennemsnit for årene 1997 til 2001.

2 1998.

The table includes ICD-9: 268.2, 733.0-733.1 and ICD-10: M80-M83.
 Tabellen omfatter ICD-9: 268.2, 733.0-733.1 og ICD-10: M80-M83.

Source: * Definition, see Table 3.19
 Kilde: * Definition, se tabel 3.19

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

**Table 3.29 Discharges and average length of stay in hospitals*.
Fracture of the neck of the femur 2001**
Udskrivninger og gennemsnitlig liggetid ved sygehuse*. Brud af lår 2001

	Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland ²⁾	Norway	Sweden
<i>Discharges</i> Udskrivninger							
<i>Men</i> Mænd							
<i>Total</i> I alt	3 324	23	2 462	10	78	2 806	6 319
<i>Per 100 000 men in the age group</i> Pr. 100 000 mænd i alderen							
0-44	10	6	12	3	6	9	6
45-64	79	143	69	17	44	58	54
65-74	295	432	276	162	104	325	284
75-79	841	524	665	331	422	726	797
80+	2 059	664	1 728	1 581	1 380	2 095	2 079
<i>Total rate</i> Samlet rate	126	95	97	80	57	125	143
<i>Women</i> Kvinder							
<i>Total</i> I alt	8 174	61	5 930	29	227	7 084	15 455
<i>Per 100 000 women in the age group</i> Pr. 100 000 kvinder i alderen							
0-44	3	-	6	11	2	4	3
45-64	73	61	53	23	34	72	65
65-74	524	598	350	222	447	521	446
75-79	1 452	2 756	991	741	924	1 322	1 355
80+	3 527	2 647	2 718	2 435	3 070	3 427	3 452
<i>Total rate</i> Samlet rate	302	272	224	221	165	310	343
<i>Average length of stay</i> Gennemsnitlig liggetid	13.4	17.7	9.5	10.9	10.0	10.5	11.2

1 Average 1997-2001.

2 1998.

1 Gennemsnit for årene 1997 til 2001.

2 1998.

The table includes ICD-9: 820 and ICD-10: S72.0-S72.2.
Tabellen omfatter ICD-9: 820 og ICD-10: S72.0-S72.2.

Source: * Definition, see Table 3.19
Kilde: * Definition, se tabel 3.19

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.30 Discharges and average length of stay in hospitals*.
Alcoholic liver disease 2001
 Udskrivninger og gennemsnitlig liggetid ved sygehuse*.
 Alkoholisk leversygdom 2001

		Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland ²⁾	Norway	Sweden
<i>Discharges</i> Udskrivninger								
<i>Men</i> Mænd								
<i>Total</i> I alt		1 475	9	1 398	6	6	436	1 319
<i>Per 100 000 men in the age group</i>								
Pr. 100 000 mænd i alderen								
0-44		13	-	12	5	2	4	5
45-64		141	107	134	129	7	49	65
65+		84	107	87	45	9	39	69
<i>Total rate</i>								
Samlet rate		56	37	55	45	4	19	30
<i>Women</i> Kvinder								
<i>Total</i> I alt		959	4	794	1	20	328	805
<i>Per 100 000 women in the age group</i>								
Pr. 100 000 kvinder i alderen								
0-44		11	-	11	3	0	3	3
45-64		83	-	60	17	64	37	36
65+		46	116	43	24	11	22	35
<i>Total rate</i>								
Samlet rate		35	18	30	11	15	14	18
<i>Average length of stay</i>								
Gennemsnitlig liggetid		9.8	6.3	7.8	15.0	4.6	9.0	8.9

1 Average 1997-2001.

2 1998.

1 Gennemsnit for årene 1997 til 2001.

2 1998.

The table includes ICD-9: 571.0-571.6; 571.9 and ICD-10: K70; K74.

Tabellen omfatter ICD-9: 571.0-571.6; 571.9 og ICD-10: K70; K74.

Source: * Definition, see Table 3.19

Kilde: * Definition, se tabel 3.19

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

**Table 3.31 Discharges and average length of stay in hospitals*.
Non-alcoholic liver disease 2001**
Udskrivninger og gennemsnitlig liggetid ved sygehuse*.
Ikke-alkoholisk leversygdom 2001

		Denmark	Faroe Islands ¹⁾	Finland	Åland ¹⁾	Iceland ²⁾	Norway	Sweden
<i>Discharges</i> Udskrivninger								
<i>Men</i> Mænd								
<i>Total</i> I alt		746	6	635	1	20	367	701
<i>Per 100 000 men in the age group</i>								
Pr. 100 000 mænd i alderen								
0-44		13	19	18	-	8	11	8
45-64		54	36	36	11	26	20	22
65+		49	36	36	34	22	36	36
<i>Total rate</i>								
Samlet rate		28	25	25	8	15	16	16
<i>Women</i> Kvinder								
<i>Total</i> I alt		754	10	860	2	26	489	868
<i>Per 100 000 women in the age group</i>								
Pr. 100 000 kvinder i alderen								
0-44		15	7	17	6	6	14	9
45-64		45	61	49	29	41	30	26
65+		45	174	54	8	33	36	40
<i>Total rate</i>								
Samlet rate		28	45	32	12	19	21	19
<i>Average length of stay</i>								
Gennemsnitlig liggetid		7.7	9.3	5.1	9.6	6.3	6.7	7.6

1 Average 1997-2001.

2 1998.

1 Gennemsnit for årene 1997 til 2001.

2 1998.

The table includes ICD-9: 570; 571.8; 572-573 and ICD-10: K71-K73; K75-K77.

Tabellen omfatter ICD-9: 570; 571.8; 572-573 og ICD-10: K71-K73; K75-K77

Source: * Definition, see Table 3.19

Kilde: * Definition, se tabel 3.19

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.32 Sixteen major surgical procedure groups, total numbers 2001
Seksten store operationsgrupper, i alt 2001

NCSP codes		Denmark	Faroe Islands	Finland	of which Åland ¹⁾	Iceland ²⁾	Norway	Sweden
ABC 01-26	<i>Disc operations</i>							
	Disk-operationer	2 261	19	3 608	15	451	3 269	1 917
BAA 20-60	<i>Partial and total thyroid excision</i>							
	Resektion af thyreoidea	1 621	6	1 791	5	83	1 159	2 108
CJC, CJD, CJE, CJF00, CJF10	<i>Cataract surgery</i>							
	Kataraktoperationer	23 761	..	32 746	..	710	22 905	56 972
FNA; FNB; FNC; FND; FNE	<i>Coronary anastomosis surgery</i>							
	Coronar Anastomoser	3 210	30	4 268	1	161	3 823	6 660
FNG 02; FNG 05	<i>Percutaneous expansion of the coronary artery (PTCA)</i>							
	Perkutan coronar angioplastik (PTCA)	5 155	55	3 524	1	..	7 021	10 099
HAB	<i>Partial excision of mammary gland (women)</i>							
	Resektion af mammae (kvinder)	3 070	23	3 897	17	149	2 427	3 896
HAC 10-25; HAC 99	<i>Mastectomy (women)</i>							
	Ablatio mammae (kvinder)	2 805	12	2 123	10	95	1 959	3 326
JEA	<i>Appendectomy</i>							
	Appendektomi	7 053	44	8 515	43	449	5 381	11 494 ³⁾
JKA 20-21	<i>Cholecystectomy</i>							
	Kolecystektomi	5 922	37	8 461	41	401	3 841	11 455
KAS 10-20	<i>Kidney transplant</i>							
	Nyretransplantation	158	3	181	1	-	217	308
KEC	<i>Radical prostatectomy</i>							
	Radikal prostatektomi	156	0	563	2	17	255	1 016
KED 22-72	<i>Prostatectomy, transurethral procedures</i>							
	Transurethral resektion af prostata	4 757	20	3 689	21	218	4 494	7 499
KED 00; KED 96	<i>Open prostatectomy</i>							
	Åben prostatektomi	96	0	68	1	4	203	179
LCC 10-20; LCD; LCE; LEF 13	<i>Hysterectomy (including supravaginal hysterectomy and exenteration of pelvis)</i>							
	Hysterektomi (inkl. supravaginal hysterektomi og bækkensentrering)	6 618	28	10 814	37	475	4 911	9 678
MCA	<i>Caesarean section</i>							
	Kejsersnit	11 013	88	9 226	55	639	8 391	14 058
NFB; NFC	<i>Hip replacement</i>							
	Hofteledsplastik	8 570	65	9 369	40	329	8 394	15 695

The NCSP codes refer to NOMESCO Classification of Surgical Procedures. Version 1.5. NOMESCO 59:2001.

1 Average 1998-2001.

2 1998.

3 Incl. en passant operations.

1 Gennemsnit for årene 1998 til 2001.

2 1998.

3 Inkl. en passant-operationer.

Sources: D: National Board of Health; F & Å: STAKES; N: Norwegian Patient Register; S: National Board of Health and Welfare

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.33 Sixteen major surgical procedure groups, per 100 000 inhabitants 2001
 Seksten store operationsgrupper, pr. 100 000 indbyggere 2001

NCSP codes		Denmark	Faroe Islands	Finland	of which Åland ¹⁾	Iceland ²⁾	Norway	Sweden
ABC 01-26	<i>Disc operations</i>							
	Disk-operationer	42	41	70	58	165	72	22
BAA 20-60	<i>Partial and total thyroid excision</i>							
	Resektion af thyreoidea	30	13	35	19	30	26	24
CJC, CJD, CJE, CJF00, CJF10	<i>Cataract surgery</i>							
	Kataraktoperationer	444	..	631	..	259	507	640
FNA; FNB; FNC; FND; FNE	<i>Coronary anastomosis surgery</i>							
	Coronararstamoser	60	64	82	4	59	85	75
FNG 02; FNG 05	<i>Percutaneous expansion of the coronary artery (PTCA)</i>							
	Perkutan coronar angioplastik (PTCA)	96	118	68	4	..	155	113
HAB	<i>Partial excision of mammary gland (women)³⁾</i>							
	Resektion af mammae (kvinder) ³⁾	113	102	147	129	109	106	87
HAC 10-25; HAC 99	<i>Mastectomy (women)³⁾</i>							
	Ablatio mammae (kvinder) ³⁾	104	53	80	76	69	86	74
JEA	<i>Appendectomy</i>							
	Appendektomi	132	94	164	166	164	119	129 ⁶⁾
JKA 20-21	<i>Cholecystectomy</i>							
	Kolecystektomi	111	79	163	158	146	85	129
KAS 10-20	<i>Kidney transplant</i>							
	Nyretransplantation	3	6	4	4	-	5	4
KEC	<i>Radical prostatectomy⁴⁾</i>							
	Radikal prostatektomi ⁴⁾	6	0	22	16	12	11	23
KED 22-72	<i>Prostatectomy, transurethral procedures⁴⁾</i>							
	Transurethral resektion af prostata ⁴⁾	180	83	146	165	159	201	170
KED 00; KED 96	<i>Open prostatectomy⁴⁾</i>							
	Åben prostatektomi ⁴⁾	2	0	3	9	3	9	4
LCC 10-20; LCD; LCE; LEF 13	<i>Hysterectomy (including supravaginal hystrectomy and exenteration of pelvis)³⁾</i>							
	Hysterektomi (inkl. supravaginal hysterektomi og bækkeneksentration) ³⁾	244	125	408	282	347	215	215
MCA	<i>Caesarean section⁵⁾</i>							
	Kejsersnit ⁵⁾	168	139	165	170	153	148	155
NFB; NFC	<i>Hip replacement</i>							
	Hoftedeplastik	160	139	181	155	120	186	176

The NCSP codes refer to NOMESCO Classification of Surgical Procedures. Version 1.5. NOMESCO 59:2001.

1 Average 1998-2001.

1 Gennemsnit for årene 1998 til 2001.

2 1998.

2 1998.

3 Per 100 000 women.

3 Pr. 100 000 kvinder.

4 Per 100 000 men.

4 Pr. 100 000 mænd.

5 Per 1 000 live births.

5 Pr. 1 000 levendefødte.

6 Incl. en passant operations.

6 Inkl. en passant-operationer.

Sources: D: National Board of Health; F & Å: STAKES; N: Norwegian Patient Register; S: National Board of Health and Welfare

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.34 Surgical procedures in connection with cancer diagnoses, total and per 100 000 inhabitants 2001

Operationer i forbindelse med kræftdiagnoser, i alt og pr. 100 000 indbyggere 2001

NCSF codes	Denmark	Faroe Islands ¹⁾	Finland	Åland ²⁾	Iceland ³⁾	Norway	Sweden
<i>Totalt i alt</i>							
HAB <i>Partial excision of the mammary gland (women)</i> Resektion af mammae (kvinder) (ICD-9: 174; ICD-10: C50)	1 513	6	1 730	8	69	1 190	3 020
HAC <i>Mastectomy (women)</i> 10-25; Ablatio mammae (kvinder) HAC (ICD-9: 174; ICD-10: C50)	2 503	11	1 971	9	83	1 679	3 092
KEC <i>Radical prostatectomy</i> Radikal prostatektomi (ICD-9: 185; ICD-10: C61)	149	1	555	2	12	240	1 005
KED <i>Prostatectomy, transurethral procedures</i> 22-72 Transurethral resektion af prostata (ICD-9: 185; ICD-10: C61)	790	4	389	4	48	825	1 381
LCC <i>Hysterectomy (including supravaginal hystrectomy and exenteration of pelvis)</i> LCD; Hysterektomi (inkl. supravaginal hysterektomi og bækkeneksentration) LCE; (ICD-9: 180-184; ICD-10: C51-58) LEF 13	1 227	6	859	2	29	977	1 918
<i>Per 100 000 inhabitants</i> Pr. 100 000 indbyggere							
<i>Partial excision of the mammary gland (women)⁴⁾</i> Resektion af mammae (kvinder) ⁴⁾	56	29	65	61	50	52	67
<i>Mastectomy (women)⁴⁾</i> Ablatio mammae (kvinder) ⁴⁾	92	47	74	68	61	74	69
<i>Radical prostatectomy⁵⁾</i> Radikal prostatektomi ⁵⁾	6	4	22	16	9	11	23
<i>Prostatectomy, transurethral procedures⁵⁾</i> Transurethral resektion af prostata ⁵⁾	30	17	15	31	35	37	31
<i>Hysterectomy (including supravaginal hystrectomy and exenteration of pelvis)⁴⁾</i> Hysterektomi (inkl. supravaginal hysterektomi og bækkeneksentration) ⁴⁾	45	27	32	15	21	43	43

The NCSF codes refer to NOMESCO Classification of Surgical Procedures. Version 1.5. NOMESCO 59:2001.

- 1 Average 1996-2000.
- 2 Average 1998-2001.
- 3 1998.
- 4 Per 100 000 women.
- 5 Per 100 000 men.

- 1 Gennemsnit for årene 1996 til 2000.
- 2 Gennemsnit for årene 1998 til 2001.
- 3 1998.
- 4 Pr. 100 000 kvinder.
- 5 Pr. 100 000 mænd.

Sources: See Table 3.32
Kilder: Se tabel 3.32

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.35 Twelve surgical procedures partly carried out as day surgery in hospitals 2001

NCSF codes	<i>Carpal tunnel de- compression Dekompression og lysis af me- dianus nerve</i>	<i>Cataract surgery Katarakt- operation</i>	<i>Tonsillectomy with or without adenoidectomy Resektion på tonsiller og adenoidt væv</i>	<i>Inguinal and femoral hernia Brok-operationer</i>	<i>Chole- cystectomy laparoscopic Laparoskopisk cholecystektomi</i>	<i>Curettage and excision of the endometrium in the uterus and cervix uteri Udskrabninger</i>
	ACC51	CJC, CJD, CJE, CJF00, CJF10	EMB10, EMB20, JAB, JAC EMB30	JKA21	LCA10-16, LCB28, LCB32, LDA10	
<i>Denmark</i>						
Number of procedures	3 418	23 761	10 855	11 812	5 014	10 802
Of which day surgery	2 600	21 547	1 776	5 697	435	7 170
Day surgery (per cent)	76.1	90.7	16.4	48.2	8.7	66.4
<i>Finland</i>						
Number of procedures	5 281	32 746	19 788	11 032	5 796	6 612
Of which day surgery	4 381	27 711	10 954	4 203	190	4 117
Day surgery (per cent)	83.0	85.4	55.4	38.1	3.3	62.3
<i>Iceland¹⁾</i>						
Number of procedures	33	710	1 167	241	379	300
Of which day surgery	22	576	423	63	23	245
Day surgery (per cent)	66.7	81.1	36.2	26.1	6.1	81.7
<i>Norway</i>						
Number of procedures	4 643	22 905	13 620	8 033	3 090	5 265
Of which day surgery	4 191	19 867	5 629	4 443	439	3 282
Day surgery (per cent)	90.3	86.7	41.3	55.3	14.2	62.3
<i>Sweden²⁾</i>						
Number of procedures	8 155	70 000	14 219	17 991	9 230	18 963
Of which day surgery	7 706	67 200	6 794	12 034	935	14 444
Day surgery (per cent)	94.5	96.0	47.8	66.9	10.1	76.2

Remark: The theme section this year deals with day surgery (page 210-264). Some extra calculation has been done for this section, and for that reason some of the figures differ from the figures presented above.

1 1998.

2 The figures are estimated based on a coverage of 80 per cent.

Source: See Table 3.32

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Tolv kirurgiske indgreb, der delvist gennemføres som dagkirurgi på sygehuse 2001 **Tabel 3.35**

<i>Termination of pregnancy</i> Abort-operationer	<i>Female sterilization</i> Sterilisation af kvinder	<i>Removal of implanted devices from bone</i> Fjernelse af osteosyntese	<i>Knee arthroscopy</i> Artroskopi	<i>Arthroscopic operations on the knee meniscus</i> Artroskopisk meniskoperation	<i>Vein legation and stripping</i> Fjernelse af åreknuder	NCSP-koder
LCH	LGA	NAU, NBU, NCU, NDU, NEU, NFU, NGU, NHU	NGA11	NGD01, NGD11, NGD21, NGD91	PHB13-14, PHD	
14 081	5 271	11 184	8 047	8 978	13 318	<i>Danmark</i> Indgreb i alt
10 538	3 615	5 227	5 662	6 113	5 835	Heraf dag-kirurgi
74.8	68.6	46.7	70.4	68.1	43.8	Dag-kirurgi (pct.)
7 640	6 005	5 721	4 633	10 603	8 178	<i>Finland</i> Indgreb i alt
6 414	4 403	2 868	2 926	7 487	3 917	Heraf dag-kirurgi
84.0	73.3	50.1	63.2	70.6	47.9	Dag-kirurgi (pct.)
831	282	231	60	79	92	<i>Island</i> Indgreb i alt
810	243	105	22	65	25	Heraf dag-kirurgi
97.5	86.2	45.5	36.7	82.3	27.2	Dag-kirurgi (pct.)
13 408	5 482	7 227	5 044	10 939	6 413	<i>Norge</i> Indgreb i alt
12 886	4 504	2 430	3 675	9 043	4 803	Heraf dag-kirurgi
96.1	82.2	33.6	72.9	82.7	74.9	Dag-kirurgi (pct.)
17 788	4 695	12 917	9 476	13 690	1 881	<i>Sverige</i> Indgreb i alt
15 761	3 915	7 818	8 587	12 751	1 693	Heraf dag-kirurgi
88.6	83.4	60.5	90.6	93.1	90.0	Dag-kirurgi (pct.)

Bemærk: Dette års temasektion omhandler dagkirurgi (side 210-264). Der er i temasektionen foretaget den del ekstra beregninger, hvorfor nogle af tallene afviger fra ovenstående.

1 1998.

2 Tallene er beregnet ud fra en 80 procents dækningsgrad.

Kilde: Se tabel 3.32

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.36 Disc operations by sex and age 2001
Disk-operationer fordelt på køn og alder 2001

Age Alder	Denmark		Faroe Islands ¹⁾		Finland		Iceland ²⁾		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W
<10	-	-	0	0	-	-	-	-	-	-	-	-
10-19	9	9	0	0	30	30	3	1	17	20	10	10
20-29	118	97	1	0	238	118	30	12	176	108	108	66
30-39	342	236	2	2	607	377	81	44	527	401	299	244
40-49	348	280	2	3	630	445	84	63	557	514	297	253
50-59	275	206	2	1	425	281	49	25	383	247	221	170
60-69	111	110	2	1	159	133	24	17	119	92	96	62
70-79	48	57	0	1	53	62	8	7	47	45	37	29
80-84	6	5	0	0	5	11	2	1	8	6	4	7
85+	2	2	0	0	1	3	-	-	1	1	3	1
Total I alt	1 259	1 002	11	8	2 148	1 460	281	170	1 835	1 434	1 075	842
<i>Per 100 000</i>												
<i>in the age</i>												
<i>group</i>												
Pr. 100 000												
i alderen												
<10	-	-	0	0	-	-	-	-	-	-	-	-
10-19	3	3	7	0	9	10	14	5	6	7	2	2
20-29	33	28	52	6	73	38	146	60	59	37	19	12
30-39	82	59	77	64	166	107	385	210	149	119	46	39
40-49	92	76	78	107	160	116	438	343	174	166	50	44
50-59	73	55	106	58	114	76	375	197	131	88	35	28
60-69	47	43	120	37	69	51	251	168	69	50	23	15
70-79	40	28	30	63	36	27	120	89	34	26	12	8
80-84	14	7	0	0	16	16	126	42	19	8	4	4
85+	7	3	0	0	5	5	-	-	4	2	5	1
Total I alt	48	37	45	37	85	55	205	124	82	63	28	21

1 Average 1996-2000.

2 1998.

1 Gennemsnit for årene 1996 til 2000.

2 1998.

NCSF codes covered: ABC 01-26.

Sources: See Table 3.32

Kilder: Se tabel 3.32

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.37 Partial and total thyroid excision by sex and age 2001
 Resektion af thyreoidea, fordelt på køn og alder 2001

Age Alder	Denmark		Finland		Iceland ¹⁾		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W
<15	3	5	3	1	-	-	1	1	5	9
15-24	13	46	8	63	1	2	8	46	24	107
25-44	102	564	51	388	6	33	50	356	84	596
45-54	74	349	71	441	2	14	44	225	71	389
55-64	63	202	75	313	4	7	38	171	101	298
65-74	32	91	54	203	3	4	26	110	55	168
75-84	16	52	16	97	3	3	15	62	38	136
85+	1	8	3	4	1	-	1	5	7	20
<i>Total</i> | alt	304	1 317	281	1 510	20	63	183	976	385	1 723
<i>Per 100 000</i>										
<i>in the age</i>										
<i>group</i>										
Pr. 100 000										
i alderen										
<15	1	1	1	0	-	-	0	0	1	1
15-24	4	16	2	20	5	10	3	17	5	21
25-44	13	73	7	56	14	81	7	55	7	50
45-54	20	94	17	108	12	88	14	75	12	65
55-64	20	63	26	105	39	67	16	74	19	56
65-74	17	41	28	83	35	42	17	64	16	43
75-84	14	31	18	55	68	51	14	39	16	40
85+	4	11	16	7	85	-	4	8	11	14
<i>Total</i> | alt	12	49	11	57	15	46	8	43	9	38

1 1998.

1 1998.

NCSF codes covered: BAA 20-60.

Sources: See Table 3.32

Kilder: Se tabel 3.32

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.38 Cataract surgery by sex and age 2001
Kataraktoperationer, efter køn og alder 2001

Age Alder	Denmark		Finland		Iceland ¹⁾		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W
<50	475	349	546	408	23	4	387	327	-	-
50-54	270	267	446	439	6	2	168	139	589	631
55-64	1 013	1 154	1 368	1 669	15	38	671	814	1 977	2 549
65-74	1 925	3 398	3 056	6 376	57	98	1 722	2 801	3 963	7 091
75-84	2 837	6 553	3 971	10 750	112	227	3 605	7 756	7 429	14 958
85+	845	2 352	954	2 763	47	81	1 261	3 254	2 495	5 411
<i>Total I alt</i>	7 365	14 073	10 341	22 405	260	450	7 814	15 091	19 747	32 698
<i>Per 100 000 in the age group</i>										
<i>Pr. 100 000 i alderen</i>										
<50	26	20	32	24	22	4	25	22	-	-
50-54	140	140	208	209	77	27	109	95	187	204
55-64	317	360	479	560	145	357	289	352	365	475
65-74	997	1 536	1 580	2 616	658	1 042	1 141	1 622	1 146	1 805
75-84	2 552	3 870	4 417	6 104	2 506	3 789	3 421	4 857	3 067	4 356
85+	2 970	3 341	5 039	4 598	3 907	3 724	4 988	5 258	3 882	3 772
<i>Total I alt</i>	278	520	408	844	188	327	349	661	1 309	1 895

1 1998

1 1998

NCSF codes covered: CJC, CJD, CJE, CJF00, CJF10

Sources: See Table 3.32

Kilder: Se tabel 3.32

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.39 Coronary anastomosis surgery by sex and age 2001
Coronaranstamoser efter køn og alder 2001

Age Alder	Denmark ¹⁾		Faroe Islands		Finland		Iceland ²⁾		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W
<45	67	17	0	0	72	8	2	-	65	18	69	21
45-54	302	63	2	1	483	68	12	2	408	57	577	123
55-64	813	146	9	2	934	186	36	3	842	185	1 476	284
65-74	965	333	9	2	1254	524	65	11	1 072	347	1 907	596
75-84	344	152	2	1	410	316	23	7	504	293	1 045	527
85+	5	3	0	0	7	6	-	-	17	15	24	11
Total I alt	2 496	714	22	5	3 160	1 108	138	23	2 908	915	5 098	1 562
Per 100 000 in the age group Pr. 100 000 i alderen												
<45	4	1	1	0	5	1	2	-	5	1	3	1
45-54	80	17	69	28	116	17	72	13	131	19	94	21
55-64	255	46	364	87	327	62	350	29	363	80	272	53
65-74	500	150	531	96	648	215	752	117	711	201	551	152
75-84	505	158	210	46	456	179	525	119	478	183	431	153
85+	7	2	0	0	40	10	-	-	67	24	37	8
Total I alt	94	26	90	21	125	42	101	17	130	40	116	35

1 The age and sex distributions are estimated.
2 1998.

1 Fordelingen på køn og alder er skønnet.
2 1998.

NCSP codes covered: FNA; FNB; FNC; FND; FNE.

Source See Table 3.32
s: Se tabel 3.32
Kilder:

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.40 Percutaneous expansion of the coronary artery (PTCA) by sex and age 2001
Perkutan coronar angioplastik (PTCA) efter køn og alder 2001

Age Alder	Denmark		Faroe Islands ¹⁾		Finland		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W
<45	255	76	4	0	150	21	385	55	306	72
45-54	836	189	11	2	609	113	1 178	246	1 379	359
55-64	1 234	361	17	5	810	225	1 693	463	2 351	802
65-74	1 009	497	14	3	699	406	1 416	524	2 098	962
75-84	394	271	2	3	253	208	611	386	1 001	658
85+	16	17	-	-	15	15	28	36	67	44
<i>Total I alt</i>	3 744	1 411	47	13	2 536	988	5 311	1 710	7 202	2 897
<i>Per 100 000 in the age group</i>										
<i>Pr. 100 000 i alderen</i>										
<45	16	5	25	0	10	1	27	4	12	3
45-54	221	51	330	71	147	28	378	82	226	60
55-64	387	113	682	217	284	76	730	200	434	150
65-74	522	225	865	179	361	167	939	303	607	245
75-84	578	283	158	229	281	118	580	242	413	192
85+	22	8	-	-	79	25	111	58	104	31
<i>Total I alt</i>	141	52	193	56	100	37	237	75	163	64

1 Average 2000-2001.

1 Gennemsnit 2000-2001.

NCSF codes covered: FNG 02; FNG 05.

Sources: See Table 3.32

Kilder: Se tabel 3.32

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.41 Partial excision of mammary gland by age, women 2001
 Resektion af mammae, kvinder, fordelt på alder 2001

Age Alder	Denmark	Faroe Islands ¹⁾	Finland	Iceland ²⁾	Norway	Sweden
<20	28	-	62	3	15	3
20-29	128	2	195	4	71	32
30-39	333	2	353	17	195	160
40-49	685	3	925	46	528	579
50-59	829	2	1 178	26	807	1 302
60-69	590	3	717	38	467	1 015
70-79	295	3	357	9	186	559
80-84	73	1	60	1	56	141
85+	53	0	50	5	38	79
<i>Total</i> I alt	3 014	15	3 897	149	2 363	3 870
<i>Per 100 000 in the age group</i>						
<i>Pr. 100 000 i alderen</i>						
<20	5	-	10	7	3	0
20-29	37	64	63	20	24	6
30-39	83	71	100	81	58	26
40-49	187	96	240	250	171	101
50-59	222	70	318	205	287	211
60-69	233	161	276	377	256	238
70-79	147	173	157	115	106	146
80-84	100	70	49	42	78	90
85+	75	43	48	235	61	55
<i>Total</i> I alt	111	66	147	109	104	86

1 Average 1997-2001.

2 1998.

1 Gennemsnit for årene 1997 til 2001.

2 1998.

NCSP codes covered: HAB.

Sources: See Table 3.32

Kilder: Se tabel 3.32

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.42 Mastectomy, women, by age 2001
Ablatio mammae, kvinder, fordelt på alder 2001

Age Alder	Denmark	Faroe Islands ¹⁾	Finland	Iceland ²⁾	Norway	Sweden
<20	-	-	-	-	-	-
20-29	12	-	11	2	8	24
30-39	103	1	87	6	71	139
40-49	388	2	367	21	279	488
50-59	621	3	501	20	481	772
60-69	636	3	427	29	381	630
70-79	570	2	458	14	350	664
80-84	193	1	170	3	152	304
85+	135	-	102	-	123	201
<i>Total</i> I alt	2 658	12	2 123	95	1 845	3 222
<i>Per 100 000 in the age group</i>						
<i>Pr. 100 000 i alderen</i>						
<20	-	-	-	-	-	-
20-29	4	-	4	10	3	4
30-39	26	32	25	28	21	22
40-49	106	55	95	114	90	85
50-59	166	101	135	157	171	125
60-69	251	195	165	287	209	148
70-79	284	148	201	179	200	174
80-84	263	109	240	79	210	195
85+	192	-	170	-	199	140
<i>Total</i> I alt	98	52	80	69	81	72

1 Average 1997-2001.

2 1998.

1 Gennemsnit for årene 1997 til 2001.

2 1998.

NCSP codes covered: HAC 10-25; HAC 99.

Sources: See Table 3.32

Kilder: Se tabel 3.32

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.43 Appendectomy by sex and age 2001
 Appendektomi fordelt på køn og alder 2001

Age Alder	Denmark		Faroe Islands ¹⁾		Finland		Iceland ²⁾		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W
<10	414	355	3	4	261	238	20	33	260	217	577	481
10-19	837	799	9	7	998	945	83	79	616	566	1 766	1 369
20-29	631	661	5	3	820	883	64	49	576	529	1 144	966
30-39	493	514	2	2	719	702	33	26	483	453	967	799
40-49	298	449	2	3	557	505	16	15	291	259	584	550
50-59	259	418	2	2	435	469	10	4	212	291	465	523
60-69	144	289	2	0	265	244	8	4	128	165	300	314
70-79	119	203	1	0	155	192	2	2	112	105	224	247
80-84	39	66	0	-	25	59	-	1	33	50	75	67
85+	17	48	-	0	13	30	-	-	13	22	29	47
Total I alt	3 251	3 802	25	20	4 248	4 267	236	213	2 724	2 657	6 131	5 363
<i>Per 100 000 in the age group</i>												
<i>Pr. 100 000 i alderen</i>												
<10	118	106	78	103	83	79	88	153	84	74	111	97
10-19	275	276	228	200	300	297	383	383	211	204	305	250
20-29	178	191	143	112	252	284	312	246	193	182	205	179
30-39	119	129	57	52	196	199	157	124	137	134	149	129
40-49	79	123	68	89	141	131	83	82	91	84	98	96
50-59	68	112	73	62	117	127	77	31	73	104	74	85
60-69	60	114	94	23	115	94	84	40	74	90	73	74
70-79	77	101	46	25	104	84	30	26	82	60	73	65
80-84	91	90	106	-	35	83	-	42	79	69	75	43
85+	60	68	-	43	69	50	-	-	51	36	45	33
Total I alt	123	140	104	90	168	161	172	156	122	116	139	119

1 Average 1996-2000.
 2 1998.

1 Gennemsnit for årene 1996 til 2000.
 2 1998.

NCSF codes covered: JEA.

Sources: See Table 3.32
 Kilder: Se tabel 3.32

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.44 Cholecystectomy by sex and age 2001
Kolecystectomi fordelt på køn og alder 2001

Age Alder	Denmark		Faroe Islands ¹⁾		Finland		Iceland ²⁾		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W
<30	66	733	0	5	74	483	6	38	53	442	154	965
30-39	203	957	0	6	188	799	11	50	112	481	407	1 477
40-49	299	767	1	3	396	971	23	56	158	442	545	1 394
50-59	356	829	1	5	663	1272	19	60	234	622	823	1 760
60-69	302	644	2	4	607	1082	22	48	188	404	770	1 173
70-79	253	337	2	2	602	889	26	27	198	318	667	824
80-84	48	73	0	0	106	199	5	6	55	78	158	190
85+	19	36	0	-	36	94	2	2	18	38	56	93
Total I alt	1 546	4 376	7	25	2 672	5 789	114	287	1 016	2 825	3 580	7 876
<i>Per 100 000 in the age group</i>												
<i>Pr. 100 000 i alderen</i>												
<30	7	76	2	53	8	52	9	61	6	51	9	61
30-39	49	240	6	187	51	227	52	239	32	142	63	238
40-49	79	209	44	116	100	252	120	304	49	143	92	242
50-59	94	222	40	179	178	344	146	472	80	221	131	285
60-69	127	254	105	207	262	417	230	476	109	221	188	275
70-79	163	168	138	136	403	391	389	345	145	182	219	215
80-84	112	100	53	73	350	281	316	250	131	108	157	122
85+	67	51	89	-	190	156	170	94	71	61	87	65
Total I alt	58	162	30	111	105	218	83	210	45	124	81	175

1 Average 1996-2000.

2 1998.

1 Gennemsnit for årene 1996 til 2000.

2 1998.

NCSF codes covered: JKA 20-21.

Sources: See Table 3.32

Kilder: Se tabel 3.32

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.45 Kidney transplant by sex and age 2001

Nyretransplantationer, fordelt på køn og alder 2001

Age Alder	Denmark ¹⁾		Finland		Norway		Sweden	
	M	W	M	W	M	W	M	W
<15	5	-	4	3	4	-	2	2
15-24	12	1	4	2	4	5	11	9
25-44	48	28	38	28	40	14	64	42
45-54	23	14	39	16	32	24	48	34
55-64	16	8	22	10	26	13	43	30
65-74	1	2	8	7	25	17	17	6
75-84	-	-	-	-	6	7	-	-
85+	-	-	-	-	-	-	-	-
<i>Total</i> I alt	105	53	115	66	137	80	185	123
<i>Per 100 000 in the age group</i>								
<i>Pr. 100 000 i alderen</i>								
<15	1	-	1	1	1	-	0	0
15-24	4	0	1	2	1	2	2	2
25-44	6	4	5	4	6	2	5	4
45-54	6	4	9	4	10	8	8	6
55-64	5	3	8	3	11	6	8	6
65-74	1	1	4	3	17	10	5	2
75-84	-	-	-	-	6	4	-	-
85+	-	-	-	-	-	-	-	-
<i>Total</i> I alt	4	2	5	2	6	4	5	3

1 The age and sex distributions are partially estimated. 1 Fordelingen på køn og alder delvist skønnet.

NCSF codes covered: KAS 10-20.

Sources: See Table 3.32

Kilder: Se tabel 3.32

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.46 Prostatectomy, transurethral procedures by age, men 2001
Transurethral resektion af prostata, mænd fordelt på alder 2001

Age Alder	Denmark	Faroe Islands ¹⁾	Finland	Iceland ²⁾	Norway	Sweden
< 50	97	0	43	2	45	39
50-59	490	1	414	16	356	594
60-69	1 244	9	1 127	47	952	1 842
70-79	1 880	8	1 544	92	1 908	3 292
80-84	767	2	356	33	797	1 203
85+	279	1	205	28	436	525
Total I alt	4 757	22	3 689	218	4 494	7 495
<i>Per 100 000 in the age group</i>						
<i>Pr. 100 000 i alderen</i>						
< 50	5	1	2	2	3	1
50-59	129	27	111	123	122	94
60-69	522	471	487	492	553	450
70-79	1 209	643	1 035	1 377	1 399	1 079
80-84	1 782	582	1 174	2 086	1 896	1 198
85+	981	625	1 083	2 381	1 725	817
Total I alt	180	91	146	159	200	170

1 Average 1996-2000.

2 1998.

1 Gennemsnit for årene 1996 til 2000.

2 1998.

NCSF codes covered: KED 22-72.

Sources: See Table 3.32

Kilder: Se tabel 3.32

Table 3.47 Radical prostatectomy by age, men 2001
Radikal prostatektomi, mænd fordelt på alder 2001

Age Alder	Denmark	Finland	Iceland ¹⁾	Norway	Sweden
< 50	2	11	-	11	12
50-59	50	157	1	87	291
60-69	94	334	12	137	610
70-79	9	60	4	17	100
80-84	1	1	-	3	2
85+	-	-	-	-	-
Total I alt	156	563	17	255	1 015
<i>Per 100 000 in the age group</i>					
<i>Pr. 100 000 i alderen</i>					
< 50	0	1	-	1	0
50-59	13	42	8	30	46
60-69	39	144	126	80	149
70-79	6	40	60	12	33
80-84	2	3	-	7	2
85+	-	-	-	-	-
Total I alt	6	22	12	11	23

1 1998

1 1998.

NCSF codes covered: KEC.

Sources: See Table 3.32

Kilder: Se tabel 3.32

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.48 Open prostatectomy by age, men 2001
 Åben prostatektomi, mænd fordelt på alder 2001

Age Alder	Denmark	Finland	Iceland ¹⁾	Norway	Sweden
< 50	2	1	-	1	-
50-59	7	4	1	16	13
60-69	21	22	1	41	42
70-79	48	28	1	104	91
80-84	12	10	1	31	26
85+	4	3	-	10	7
<i>Total I alt</i>	94	68	4	203	179
<i>Per 100 000 in the age group</i>					
<i>Pr. 100 000 i alderen</i>					
< 50	0	0	-	0	-
50-59	2	1	8	5	2
60-69	9	10	10	24	10
70-79	31	19	15	76	30
80-84	28	33	63	74	26
85+	14	16	-	40	11
<i>Total I alt</i>	4	3	3	9	12

1 1998.

1 1998.

NCSF codes covered: KED 00; KED 96.

Sources: See Table 3.32

Kilder: Se tabel 3.32

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.49 Hysterectomy (including supravaginal hysterectomy and exenteration of pelvis) by age, women 2001

Hysterektomi (inkl. supravaginal hysterektomi og bækkeneksentration), kvinder fordelt på alder 2001

Age Alder	Denmark	Faroe Islands ¹⁾	Finland	Iceland ²⁾	Norway	Sweden
< 30	57	0	39	3	45	37
30-39	774	2	864	48	465	628
40-49	2 677	15	4 173	191	1 896	2 366
50-59	1 724	6	3 093	139	1 356	2 037
60-69	715	1	1 388	59	508	1 078
70-79	498	3	1 018	29	452	942
80-84	127	0	174	6	121	278
85+	46	-	65	-	68	90
Total I alt	6 618	27	10 814	475	4 911	7 456
<i>Per 100 000 in the age group</i>						
<i>Pr. 100 000 i alderen</i>						
< 30	6	2	4	5	5	2
30-39	194	71	245	229	137	101
40-49	731	512	1 084	1 039	612	411
50-59	461	234	836	1 094	483	330
60-69	282	34	535	585	278	253
70-79	248	161	447	371	259	246
80-84	173	36	246	250	167	178
85+	65	-	108	-	110	63
Total I alt	244	119	407	347	215	166

1 Average 1996-2000.

2 1998.

1 Gennemsnit for årene 1996 til 2000.

2 1998.

NCSF codes covered: LCC 10-20; LCD; LCE; LEF 13.

Sources: See Table 3.32

Kilder: Se tabel 3.32

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.50 Caesarean section, by age, women 2001
Kejsersnit, kvinder fordelt på alder 2001

Age Alder	Denmark	Faroe Islands ¹⁾	Finland	Iceland ²⁾	Norway	Sweden
< 15	1	-	-	-	1	-
15-24	1 129	17	1 371	143	989	1 426
25-34	7 547	46	5 480	353	5 449	9 118
35-44	2 318	19	2 344	142	1 933	3 489
45+	18	-	31	1	19	25
<i>Total I alt</i>	11 013	82	9 226	639	8 391	14 058
<i>Per 1 000 live births Pr. 1 000 levendefødte</i>						
< 15	0	-	-	-	22	-
15-24	123	107	122	124	100	106
25-34	164	119	161	147	143	150
35-44	225	179	223	226	225	214
45+	450	-	326	500	422	284
<i>Total I alt</i>	168	125	165	153	148	155

1 Average 1996-2000.

2 1998.

1 Gennemsnit for årene 1996 til 2000.

2 1998.

NCSP codes covered: MCA.

Sources: See Table 3.32

Kilder: Se tabel 3.32

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.51 Hip replacement by sex and age 2001
 Hoftelplastic fordelt på køn og alder 2001

Age Alder	Denmark		Faroe Islands ¹⁾		Finland		Iceland ²⁾		Norway		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W
<30	13	16	-	0	14	15	1	-	16	27	11	24
30-39	47	41	1	0	38	38	1	4	25	32	56	92
40-49	144	120	2	2	132	161	3	5	121	146	220	227
50-59	495	495	3	4	541	583	11	17	338	551	813	862
60-69	830	1 096	4	8	1 013	1 179	39	51	554	1 152	1 526	1 931
70-79	962	1 781	4	16	1 108	2 215	45	65	864	2 286	1 945	3 403
80-84	335	918	3	5	318	885	18	34	319	1 020	710	1 699
85+	253	1 024	1	4	233	896	4	31	201	742	499	1 677
Total I alt	3 079	5 491	18	40	3 397	5 972	122	207	2 438	5 956	5 780	9 915
<i>Per 100 000 in the age group</i>												
<i>Pr. 100 000 i aldermen</i>												
<30	1	2	-	4	1	2	2	-	2	3	1	2
30-39	11	10	17	13	10	11	5	19	7	9	9	15
40-49	38	33	50	55	33	42	16	27	38	47	37	39
50-59	131	133	106	164	145	158	84	134	116	196	129	140
60-69	348	433	220	459	438	454	408	505	322	631	373	453
70-79	619	887	322	976	743	974	674	831	633	1 308	637	890
80-84	778	1 251	847	873	1 049	1 249	1 138	1 418	759	1 412	707	1 089
85+	889	1 454	536	936	1 231	1 491	340	1 456	795	1 199	776	1 169
Total I alt	116	203	75	176	134	225	89	151	109	261	131	220

1 Average 1996-2000.

2 1998.

1 Gennemsnit for årene 1996 til 2000.

2 1998.

NCSP codes covered: NFB; NFC.

Sources: See Table 3.32

Kilder: Se tabel 3.32

Accidents

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

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

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

Ulykker

Patienter indlagt på grund af ulykker udnytter en væsentlig del af kapaciteten ved sygehusene.

Mens statistikken over dødsårsager er veludbygget i de nordiske lande, er registreringen af overlevende efter ulykker stadigvæk mangelfuld, og de tilgængelige data er vanskelige at sammenligne. Da kun Danmark og Island har sammenlignelig statistik for de ydre årsager ved ulykker er det ikke muligt at bringe nordisk statistik vedrørende dette.

I denne udgave er der derfor valgt at medtage statistik over udskrivninger for de mest almindelige "større" ulykker som oftest vil kræve indlæggelse. Her ser man markante forskelle, både mellem landene og mænd og kvinder.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE
Table 3.52 Patients discharged after treatment for injuries resulting from accidents per 100 000 inhabitants by sex 2001

Udskrivninger fra sygehuse efter behandling for skader pådraget ved ulykker per 100 000 indbygger og efter køn 2001

	Denmark		Faroe Islands		Finland		Åland ¹⁾		Norway ²⁾		Sweden	
	M	W	M	W	M	W	M	W	M	W	M	W
Fracture of skull and intracranial injury ICD10: S02; S06	181	114	380	148	270	138	338	123	361	185	300	182
Fracture at wrist and hand level ICD10: S62	32	12	58	22	44	15	38	15	54	15	24	9
Superficial injury of lower leg ICD10: S80-S89	148	115	466	239	510	375	438	362	261	227	162	165
Superficial injury of hip and thigh ICD10: S70-S79	114	251	146	270	234	501	169	430	225	503	200	424
Poisoning ICD10: T36-T65	17	14	67	74	101	111	92	92	145	173	433	424
Burn and corrosion ICD10: T20-T32	11	6	33	13	49	20	38	15	47	24	23	10

1 Average 1997-2001.

1 Gennemsnit for årene 1997-2001.

2 Including violence and self-inflicted injury.

2 Inklusiv vold og villet egenskade.

Table 3.53 Patients discharged after treatment for injuries resulting from accidents, per 100 000 inhabitants, by sex and age 2001

Udskrivninger fra sygehuse efter behandling for skader pådraget ved ulykker, pr. 100 000 indbyggere efter køn og alder 2001

Age Alder	Denmark		Finland		Norway ¹⁾		Sweden	
	M	W	M	W	M	W	M	W
0-14	809	543	1 046	666	645	460	1 097	705
15-24	1 122	491	2 275	866	1 492	949	1 239	625
25-64	765	432	2 120	1 258	941	628	911	553
65+	1 365	2 663	4 577	6 033	2 077	3 460	2 863	4 459
Total I alt	890	838	2 231	1 972	1 090	1 122	1 274	1 351

1 Including violence and self-inflicted injury.

1 Inklusiv vold og villet egenskade.

 Source: The Inpatient Registers of the Nordic Countries
 Kilde:

Development in consumption of medicinal products

This section presents data on consumption of medicinal products in the Nordic countries and trends in consumption within certain medicinal product groups.

Table 3.54 presents total sales of medicinal products in the Nordic countries, by ATC (Anatomical Therapeutic Chemical Classification) main group. Sales are highest in Sweden, followed by Finland and Norway, whereas sales in Denmark and Iceland are somewhat lower. Åland is in line with Finland. Sales in the Faroe Islands are somewhat lower than in Iceland, and Greenland has markedly lower sales than all the other countries.

In all the Nordic countries sales are concentrated around a few medicinal product groups: cardiovascular system (ATC group C), nervous system (ATC group N), respiratory system (ATC group R), alimentary tract and metabolism (ATC group A), and sex hormones (ATC group G).

Consumption of medicinal products in ATC group A differs greatly between the countries. Consumption in Sweden is about twice that in Iceland and Denmark. With the exception of Greenland and the Faroe Islands, consumption of medicinal products for cardiovascular diseases and consumption of sex hormones is generally at the same level in all the countries. Greenland has much

Udvikling i lægemiddelforbrug

I dette afsnit skal der ses nærmere på lægemiddelforbrugets sammensætning i de nordiske lande og udviklingen i forbruget inden for udvalgte lægemiddelgrupper.

I tabel 3.54 ses det samlede lægemiddelforbrug i de nordiske lande fordelt på ATC-hovedgrupper. Forbruget af lægemidler er højest i Sverige, dernæst kommer Finland og Norge, mens Danmark og Island har et lidt lavere forbrug. Åland er stort set på højde med Finland. Forbruget på Færøerne er lidt lavere end i Island, mens forbruget i Grønland er markant lavere end i de øvrige lande.

I alle nordiske lande er forbruget koncentreret om forholdsvis få lægemiddelgrupper. Det drejer sig om lægemidler mod sygdomme i hjerte og kredsløb (ATC-gruppe C), lægemidler til nervesystemet (ATC-gruppe N), lægemidler til åndedrætsorganerne (ATC-gruppe R), lægemidler til fordøjelse og stofskifte (ATC-gruppe A) og kønshormoner (ATC-gruppe G).

Mellem landene er der stor forskel på, hvor meget medicin til fordøjelse og stofskifte, der anvendes. I Sverige er forbruget ca. dobbelt så stort som i Island og Danmark. Ser man bort fra Grønland og Færøerne, er forbruget af lægemidler til sygdomme i hjerte og kredsløb til gengæld stort set på samme niveau i alle landene, og det samme gælder for forbruget af kønshormoner. I Grønland er

lower sales of medicinal products in both these groups, whereas the Faroe Islands have markedly higher sales of cardiovascular medicines and somewhat lower sales of sex hormones. In Denmark, Iceland and Sweden more medicinal products acting on the central nervous system are used than in the other countries, whereas Norway and Sweden take the lead for medicinal products for respiratory diseases.

These differences have many causes. Morbidity may differ between countries. Demographic differences may play a role. The proportion of elderly may differ between the countries, or there may be differences in the proportion of men and women, or in the number of people in different age groups with a high consumption of various medicines. Therapeutic traditions differ between countries, and there are geographic variations in prescribing habits within each country. Finally, the availability of medicinal products and medical care may vary. The range of medicinal products that can be bought over-the-counter can vary, and the system of reimbursement and patient charges can also have a large influence on consumption. Finally, there are different traditions in relation to doses, and these can lead to an increase in the differences.

*Drugs for acid related disorders
(ATC group A02)*

The consumption of antacids (A02A) is falling in all the Nordic countries, whereas the consumption of agents for the treatment of peptic ulcer and gastro-

forbruget i begge grupper meget lavere, mens forbruget af lægemidler til hjerte og kredsløb er markant højere på Færøerne og forbruget af kønshormoner noget lavere. I Danmark, Island og Sverige anvendes der mere medicin til nervesystemet end i de øvrige lande, mens Norge og Sverige toppe med hensyn til forbrug af lægemidler til åndedrætsorganer.

Årsagerne til forskellene i lægemiddelforbruget kan findes i flere forhold. Sygdomsforekomsten kan være forskellig landene imellem. Demografiske forskelle kan endvidere betyde, at der er en større andel ældre i ét land end i et andet, eller der kan være en større andel mænd eller kvinder eller aldersgrupper, som har et højt forbrug af en eller flere typer lægemidler. Der kan være store forskelle i de terapeutiske traditioner landene imellem, på samme måde som der kan være forskelle i lægernes ordinationsvaner mellem geografiske områder inden for de enkelte lande. Endelig kan der være forskelle i adgangen til læger og adgangen til lægemidler. Færre eller flere lægemidler kan være i håndkøb og patienternes mulighed for at få tilskud og dermed en lavere egenbetaling kan også have stor betydning for forbruget. Endelig er der forskellige traditioner for dosering som kan være med til at øge forskellene.

*Midler mod mavesyre-relaterede
forstyrrelser (ATC-gruppe A02)*

Forbruget af syreneutraliserende lægemidler (A02A) er faldende i alle nordiske lande, mens anvendelsen af midler mod mavesår og gastroøsofageal refluks

oesophageal reflux disease (GORD) (A02B) has increased rapidly during the nineties. The reason for this is that this medicinal product, to an increasing degree, is used in the treatment of heartburn. However, in Sweden consumption of agents for the treatment of peptic ulcer fell from 1996-1997, in connection with the Swedish revision of the reimbursement system. Norway had a similar fall in 1995-1996, when reimbursement for medicines for the treatment of chronic peptic ulcer was discontinued. The medicine for chronic peptic ulcer shows markedly higher sales in Sweden and Iceland than in the other Nordic countries, and the lowest sales in Finland.

Antiobesity agents (ATC-group A08)

The extent of medical treatment for obesity varies a lot between the Nordic countries. Finland and Denmark have had a certain consumption of anti-obesity agents during the nineties, especially Denmark, whereas in Iceland, Norway and Sweden consumption of these agents was first seen in 1999.

Agents used for diabetes (ATC-group A10)

Use of antidiabetics varies greatly between the countries. Finland has by far the highest consumption, followed by Sweden, Norway and Denmark. Consumption in Iceland is lower. The high consumption in Finland is explained by a higher prevalence of diabetes, which in turn may partly be explained by a higher prevalence of obesity in the population.

(A02B) har været kraftigt stigende op igennem 1990'erne. Dette skyldes at midlerne i større og større udstrækning anvendes mod halsbrand. I Sverige skete der dog et fald i forbruget af mavesårsmidler fra 1996 til 1997 i forbindelse med indførelsen af et nyt tilskudssystem. I Norge skete der tilsvarende et fald fra 1995 til 1996, da tilskud til kronisk behandling af mavesår blev fjernet. Sammen med Sverige har Island et forbrug af denne lægemiddelgruppe, som er markant højere end forbruget i de øvrige nordiske lande. Det laveste forbrug ses i Finland.

Appetitnedsættende midler (ATC-gruppe A08)

Udbredelsen af medicinsk behandling af overvægt varierer meget mellem de nordiske lande. I Finland og Danmark har man haft et vist forbrug af denne type lægemidler op igennem 1990'erne - dog mest i Danmark, mens der i Island, Norge og Sverige først ses et forbrug af lægemidler mod overvægt i 1999.

Diabetesmidler (ATC-gruppe A10)

Anvendelsen af antidiabetika varierer meget landene imellem. Finland har langt det største forbrug, derefter kommer Sverige, Norge og Danmark, mens der ses et noget lavere forbrug i Island. Forklaringen på det høje forbrug i Finland skal findes i en større forekomst af diabetes, som til dels skyldes at en større del af befolkningen - sammenlignet med

In all countries consumption is rising, and this is related to the increasing prevalence of diabetes. The percentage increase in consumption from 1995 to 2001 was greatest in Norway and least in Sweden. The incidence rises with age and is highest for men. With the increasing proportion of elderly in the population, the number of diabetics will also increase.

Drugs for cardiac therapy (ATC-group C01; C02; C03; C07; C08; C09; C10)

The total consumption of cardiovascular agents (excl. C04) is largely at the same level in all the Nordic countries, but slightly lower in Iceland. In all countries the consumption of these agents is increasing, in particular due to increased consumption of agents acting on the renin-angiotensin system (C09), used in the treatment of hypertension, and serum lipid reducing agents (C10). The largest increase in the consumption of cardiovascular agents over the past 5 years is seen in Norway.

During the period 1995-2001 the consumption of serum lipid reducing agents increased substantially in all the Nordic countries, with the steepest increase in Norway. However, the level of consumption differs between the countries. Norway has the highest consumption, followed by Sweden. Consumption in Iceland and Finland is about the same, and Denmark has the lowest consumption. The low consumption in Denmark may be due to the

de øvrige nordiske lande - her lider af overvægt. I alle landene er forbruget stigende, og dette hænger sammen med en stigende forekomst af diabetes. Den procentuelle stigning i forbruget fra 1995-2001 er størst i Norge og lavest i Sverige. Incidensen stiger med alderen og er størst for mænd. Med en stigende andel ældre i befolkningen vil antallet af diabetikere dermed også stige.

Lægemidler til hjerteterapi (ATC-gruppe C01; C02; C03; C07; C08; C09; C10)

Det samlede forbrug af lægemidler til hjerte og kredsløb (ekskl. C04) er stort set overensstemmende i de nordiske lande, dog er forbruget i Island en smule lavere end i de andre lande. I alle landene sker der en vækst i anvendelsen af denne type lægemidler, og i alle landene hænger denne stigning især sammen med et øget forbrug af midler med virkning på renin-angiotensin systemet (C09), som bl.a. anvendes i behandling af forhøjet blodtryk, og et øget forbrug af kolesterolsænkende midler (C10). Norge har i de seneste 5 år oplevet den største stigning inden for forbruget af lægemidler mod sygdomme i hjerte og kredsløb.

Forbruget af de kolesterolsænkende midler har været kraftigt øgende fra 1995-2001 i alle nordiske lande. Stigningen er størst i Norge. Der er dog stor forskel mellem landene på, hvor højt forbruget er. Norge har det største forbrug, dernæst kommer Sverige, i Island og Finland forbruges stort set den samme mængde, mens Danmark har det laveste forbrug. Det lave forbrug i Danmark kan hænge sammen med, at de kolesterolsænkende

lack of reimbursement of the serum lipid reducing agents during the nineties. Individual reimbursement was available, however, and in 1998 it was decided that the serum lipid reducing agent should be subject to general reimbursement for the indication secondary prophylaxis of ischemic heart disease. Consumption has since increased steeply. Iceland, too, does not reimburse the cost of the serum lipid reducing agents, unless certain treatment criteria are met, but in practice most patients have their costs reimbursed. The other Nordic countries fully reimburse the costs of these agents.

midler ikke har haft generelt tilskud i 1990'erne. Der har været mulighed for at søge individuelt, personligt tilskud til kolesterolsænkende midler, og i 1998 blev det besluttet, at lægemidlerne skulle have generelt, klausuleret tilskud, således at der ydes tilskud til sekundær profylakse af iskæmisk hjertesygdom. Siden da har forbruget været stærkt stigende. De kolesterolsænkende midler har heller ikke generelt tilskud i Island med mindre bestemte behandlingskriterier er fulgt. I praksis er resultatet dog, at langt de fleste får tilskud. I de øvrige nordiske lande er disse lægemidler fuldt tilskudsberettigede.

Estrogens and progestogens (ATC-group G03C and G03F)

Estrogens are increasingly being recommended for women with menopausal complaints and for the prophylaxis of osteoporosis. The marketing of formulations of estrogens and progestogens in combination has reinforced this development.

Sweden and Finland have the largest consumption of estrogens (G03C), followed by Iceland. Consumption in Norway and Denmark is lower. Consumption of estrogens and progestogens in combination (G03F) is highest in Iceland and in Norway.

Østrogener og gestagener (ATC-gruppe G03C og G03F)

Østrogener anbefales i stigende udstrækning til kvinder ved ubehag i forbindelse med overgangsalderen, samt for at mindske risikoen for osteoporose. Markedsføringen af forbedrede midler med kombinationer af østrogen og gestagen har forstærket denne udvikling.

Sverige og Finland har det største forbrug af østrogener (G03C). Derefter følger Island, mens forbruget i Norge og Danmark er mindre. Forbruget af østrogen og gestagen i kombination (G03F) er størst i Island og Norge.

Antibacterials for systemic use (ATC-Group J01)

During the last few years the consumption of antibacterials has been heavily focused upon, due to the great risk of the development of resistance with high

Antibakterielle midler til systemisk brug (ATC-gruppe J01)

I de senere år har der været stor fokus på forbruget af antibakterielle midler. Dette hænger sammen med den store risiko for resistensudvikling ved et højt forbrug,

levels of use, in particular with broad spectrum antibiotics. In all countries it is generally recommended that the use of antibacterials should be limited, and that narrow spectrum antibacterials should be the first choice of treatment.

There is little variation between the Nordic countries in total sales of antibacterials for systemic use (J01). Iceland and Finland have the largest consumption, followed by Norway and Sweden. Denmark has the lowest consumption.

Anti-inflammatory and antirheumatic products (ATC-group M01A; N02A and N02B)

The consumption of weak analgesics (N02B) and non-steroidal anti-inflammatory drugs (NSAIDs) (M01A), varies a lot between the Nordic countries.

Denmark has by far the largest consumption of weak analgesics. As the non-steroid anti-inflammatory agents are often used as analgesics, the consumption of these two groups should be considered together. When considered together, Denmark still holds the lead, although consumption of NSAIDs in Denmark is the lowest among the Nordic countries. Sweden has the second largest consumption of these two groups combined, followed by Iceland, Finland and Norway. In Sweden, weak analgesics are used more than NSAIDs, but the reverse is the case for the other countries. Finland has by far the largest consumption of NSAIDs, but the lowest consumption of paracetamol and

især af bredspektret antibiotika. I alle landene er den generelle anbefaling, at anvendelsen af antibakterielle midler begrænses, og at der som førstevalg ordineres smalspektrede antibakterielle midler.

Der er stor overensstemmelse mellem de nordiske lande i det totale forbrug af antibakterielle midler til systemisk brug (J01). Det højeste forbrug findes i Island og Finland. Dernæst kommer Norge og Sverige, og det laveste forbrug findes i Danmark.

Midler mod gigt og stærke og svagere smertestillende midler (ATC-gruppe M01A; N02A og N02B)

Størrelsen på forbruget af svage smertestillende lægemidler (N02B) og NSAID (M01A) er meget varierende mellem de nordiske lande.

Danmark har langt det største forbrug af svagere smertestillende midler. Da non-sterioide antiinflammatoriske præparater ofte anvendes som analgetika, bør forbruget af disse lægemiddelgrupper dog ses under ét. Gøres dette, ligger Danmark stadig på en førsteplads, selvom forbruget af NSAID her er det laveste i Norden. Sverige har det næsthøjeste forbrug af disse to lægemiddelgrupper, og derefter kommer Island, Finland og Norge. I Sverige anvendes der også i større udstrækning svagere smertestillende lægemidler frem for NSAID'er, mens det for de øvrige lande forholder sig omvendt. Finland har langt den højeste andel af NSAID, men den laveste andel paracetamol og opioider. I alle

opioids. In all countries there has been a small increase in the use of weak analgesics and NSAIDs.

The increased use of non-steroid anti-inflammatory agents can mainly be explained by the introduction of the new subgroup of drugs called coxibs (M01AH). These drugs are POM medicines and were introduced on the market in 2000. They are claimed to give less gastro-intestinal adverse effects than the traditional non-steroid anti-inflammatory agents.

In all the Nordic countries, weak analgesics in low strengths and small packets are sold over-the-counter. In Denmark and Sweden larger packets and, to some extent, higher strengths are also sold over-the-counter.

Antipsychotics (ATC-group N05A)

Consumption of antipsychotics is very stable in the Nordic countries. Only in Denmark has there been a minor increase.

Anxiolytics, hypnotics, and sedatives (ATC-group N05B and N05C)

The benzodiazepines (N05BA) dominate the anxiolytics in all the Nordic countries. During the period 1995-2001 consumption of anxiolytics remained unchanged or stagnating in all the Nordic countries, with the highest consumption in Denmark, Finland and Iceland.

landene er der en svag stigning i anvendelsen af de svagere smertestillende midler og NSAID.

Stigningen i non-steroid antiinflammatoriske præparater skyldes især indførelsen af en ny undergruppe af præparater kaldet cobixer (M01AH). Disse præparater er POM medicin og blev introduceret på markedet i 2000. Det er præparater der giver færre gastrointestinale problemer og har den samme effekt som de traditionelle non-steroid antiinflammatoriske præparater.

I alle nordiske lande sælges de svage smertestillende lægemidler i lave styrker og små pakninger i håndkøb. I Danmark og Sverige gør dette sig også gældende for de større pakninger og tildels de højere styrker.

Antipsykotika (ATC-gruppe N05A)

Forbruget af antipsykotika er meget stabilt i de nordiske lande. Kun i Danmark er der sket en mindre stigning i anvendelsen af disse lægemidler.

Angstdæmpende midler og sovemidler (ATC-gruppe N05B og N05C)

I alle nordiske lande er det benzodiazepinerne (N05BA), der udgør hovedparten af forbruget af neurosemidlerne. Forbruget af neurosemidler har været uændret eller stagnerende i alle nordiske lande fra 1995-2001. Forbruget af denne type lægemidler er størst i Danmark, Finland og Island.

Denmark, Norway and Iceland do not reimburse expenses on hypnotics, but Finland and Sweden do. There is no apparent correlation between consumption trends and reimbursement rules.

I Danmark, Norge og Island gives der ikke tilskud til hypnotika, mens disse lægemidler er tilskudsberettigede i Finland og Sverige. Tilsyneladende er der ingen sammenhæng mellem udviklingen i forbruget og tilskudsreglerne.

Within the group N05C, the consumption of benzodiazepine-like drugs (N05CF, zopiclone, zolpidem and zaleplon) has increased, probably because they have been claimed to be less addictive than the older benzodiazepines.

I gruppen N05C er forbruget af benzodiazepam-lignende lægemidler (N05CF, zopiclone, zolpidem og zaleplon) steget formentlig fordi de er markedsført som om de har færre bivirkninger end ældre benzodiazepin præparater.

Antidepressants (ATC-group N06A)

Consumption of antidepressants increased markedly during the nineties, mainly due to a marked increase in consumption of the new selective serotonin reuptake inhibitors (SSRIs), marketed in the late eighties. These medicinal products have fewer side effects and a better safety profile than the old antidepressants and have similar effect.

Antidepressiva (ATC-gruppe N06A)

Anvendelsen af antidepressiva er steget kraftigt op igennem 1990'erne ikke mindst takket være en kraftig vækst i forbruget af de nyere selektive serotonin genoptagelses hæmmere (SSRI'ere), som blev markedsført i slutningen af 1980'erne. Disse lægemidler har færre bivirkninger og en bedre sikkerhedsprofil end de gamle antidepressiva og ligger effektmæssigt på højde med disse.

Drugs for obstructive airway diseases (ATC-group R03)

Drugs for obstructive airway diseases are primarily used in the treatment of asthma and chronic obstructive pulmonary disease (COPD). The consumption of these drugs has risen over the past years, possibly reflecting an increasing prevalence of asthma and earlier diagnosing.

Midler til obstruktive luftvejs-sygdomme (ATC-gruppe R03)

Midler til obstruktive luftvejssygdomme bruges primært til behandling af astma og kronisk obstruktiv lungesygdom (KOL). Anvendelsen af disse midler har været stigende i de seneste år, og denne stigning kan afspejle en øget forekomst af astma, bedre og tidligere diagnosticering.

The antiasthmatics can be divided into two main groups. One group comprises

Lægemidler til behandling af astma kan inddeles i to hovedgrupper. Den ene gruppe

the bronchodilators, including the beta-2-adrenoreceptor agonists (R03AC), theophyllines (R03DA) and anticholinergics (R03BB). The other group comprises agents for the prophylaxis and treatment of lower airway inflammation, such as the corticosteroids (R03BA).

Consumption of drugs for obstructive airway diseases increased during the nineties. During the period 1995-2001 consumption levelled off in most of the countries.

Antihistamines (ATC-Group R06)

Sales of antihistamines vary a lot between the Nordic countries. Consumption in Norway is by far the highest, consumption in Iceland and in Sweden is about 2/3 of that in Norway, whereas consumption in Finland and in Denmark is only about 1/3 of that in Norway.

In some of the countries, consumption increased during the period 1995-2001.

Antihistamines in small packets are sold over-the-counter in all the Nordic countries.

pe virker bronkieudvidende. Til denne gruppe hører beta2-agonister (R03AC), teofylliner (R03DA) og antikolinergika (R03BB). Den anden gruppe anvendes til forebyggelse og behandling af inflammationen i de nedre luftveje. Til denne gruppe hører kortikosteroiderne (R03BA).

Forbruget af midler til obstruktive luftvejssygdomme har været stigende op igennem 1990'erne. Fra 1995-2001 synes denne stigning stagneret i de fleste lande.

Antihistaminer (ATC-gruppe R06)

Salget af antihistaminer varierer meget mellem de nordiske lande. Norge har langt det største forbrug af disse lægemidler, forbruget i Island og Sverige er ca. 2/3 så stort, mens forbruget i Finland og Danmark kun er ca. 1/3 så stort som forbruget i Norge.

I flere af landene er forbruget steget fra 1995-2001.

Antihistaminer i lave styrker sælges i håndkøb i alle nordiske lande.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE
Table 3.54 Sales of medicinal products in total, DDD/1 000 inhabitants/day by ATC-group, 2001

Salg af lægemidler i alt i DDD/1 000 indbyggere/døgn fordelt på ATC-grupper 2001

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A <i>Alimentary tract and metabolism</i> Fordøjelse og stofskifte	126	139	83	154	130	103	161	193
B <i>Blood and blood-forming organs</i> Blod og bloddannende organer	63	46	27	117	102	25	96	109
C <i>Cardiovascular system</i> Hjerte og kredsløb	263	383	100	320	271	259	303	312
G <i>Genito-urinary system and sex hormones</i> Kønshormoner m.m.	110	88	80	135	126	161	108	125
H <i>Systemic hormonal preparations, excl. sex hormones and insulins</i> Hormoner til systemisk brug	25	22	8	33	42	28	34	37
J <i>Anti-infectives for systemic use</i> Infektionssygdomme	16	21	28	25	22	21	17	19
L <i>Antineoplastic and immuno-modulating agents</i> Cancermidler m.m.	5	3	1	5	6	6	6	7
M <i>Musculo-skeletal system</i> Muskler, led og knogler	43	36	21	78	57	64	53	54
N <i>Nervous system</i> Nervesystemet	219	163	97	189	141	253	170	227
P <i>Antiparasitic products, insecticides and repellents</i> Parasitmidler	2	1	2	1	2	1	1	1
R <i>Respiratory system</i> Åndedrætsorganer	115	82	46	114	108	100	149	138
S <i>Sensory organs</i> Sanseorganer	8	6	12	13	13	10	16	16
<i>Total</i> I alt	994	991	507	1 185	1 019	1 030	1 117	1 237

Sources: D: Danish Medicines Agency; FI: Chief Pharmaceutical Officer; G: The Central Pharmacy in Copenhagen County; F & Å: National Agency for Medicines; I: Ministry of Health and Social Security; N: WHO Collaborating Centre for Drug Statistics Methodology; S: National Corporation of Swedish Pharmacies

Note: Sales of B05 and D are excluded from this table because of differences in the use of national DDDs. A11 is excluded because of differences in the definitions of medicinal and non-medicinal products.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.55 Sales of drugs for acid related disorders (ATC-group A02), DDD/1 000 inhabitants/day 1995-2001

Salg af midler mod mavesyre-relaterede forstyrrelser (ATC-gruppe A02), DDD/1 000 indbyggere/døgn 1995-2001

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A02								
<i>Drugs for acid related disorders</i>								
Midler mod mavesyre-relaterede forstyrrelser								
1995	21.9	17.1	..	16.2	..	24.9	19.4	26.7
1998	27.3	22.9	14.5	17.6	21.3	30.9	22.8	33.7
2000	28.2	26.3	13.0	19.3	22.2	39.0	25.3	38.4
2001	31.6	32.6	17.3	23.7	24.1	47.0	27.9	40.0
A02A								
<i>Antacids</i>								
Syreneutraliserende midler								
1995	8.7	6.6	..	3.3	..	2.9	4.9	4.7
1998	8.8	5.7	1.7	2.6	3.8	2.8	3.9	3.7
2000	8.0	5.7	2.5	2.8	3.7	2.6	3.3	3.1
2001	7.9	5.7	2.5	2.8	3.3	2.5	3.0	2.9
A02B								
<i>Drugs for peptic ulcer and gastro-oesophageal reflux disease (GORD)</i>								
Midler mod ulcus (mavesår) og gastroøsofageal reflux								
1995	12.1	9.1	..	9.6	..	22.1	11.3	21.8
1998	17.4	15.8	12.4	12.4	13.4	28.1	16.0	30.0
2000	19.9	21.9	12.2	15.9	16.7	36.4	20.9	35.3
2001	23.7	25.2	14.8	20.9	20.8	44.5	24.9	37.1
A02BA								
<i>H2-receptor antagonists</i>								
H2-receptor antagonist								
1995	7.0	4.5	..	4.6	..	14.2	6.7	7.0
1998	7.0	4.4	1.7	5.4	6.0	11.3	5.7	7.7
2000	6.5	4.0	2.5	5.1	6.2	9.6	5.9	7.1
2001	6.3	3.8	2.4	4.8	5.8	8.8	5.8	6.4
A02BC								
<i>Proton pump inhibitors</i>								
Protonpumpe-hæmmere								
1995	4.8	4.5	..	2.6	..	7.6	4.5	12.5
1998	10.3	11.3	10.7	6.0	5.8	16.6	10.2	20.5
2000	13.3	17.9	9.4	9.8	9.3	26.7	14.9	26.8
2001	16.8	21.4	12.1	14.2	12.1	35.6	18.7	29.4

The table continues ...

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE
Table 3.55, continued

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A02BX <i>Other drugs for the treatment of peptic ulcer and gastro-oesophageal reflux disease (GORD)</i> Andre midler mod mavesår og gastroøsofageal refluks								
1995	0.2	0.0	..	2.3	..	0.3	0.1	2.0
1998	0.1	0.1	0	1.0	1.7	0.2	0.0	1.5
2000	0.1	0.1	0.3	0.9	1.2	0.1	0.5	1.3
2001	0.7	0.0	0.3	1.8	2.8	0.1	0.5	1.2

Sources: See Table 3.54

Kilder: Se tabel 3.54

1 For Denmark, the figures for 1995 do not include the hospital sector.

Table 3.56 Sales of antiobesity preparations, excl. dietary products (ATC-group A08), DDD/1 000 inhabitants/day 1995-2001

Salg af appetitnedsættende midler (ATC-gruppe A08),
DDD/1 000 indbyggere/døgn 1995-2001

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A08 <i>Antiobesity preparations, excl. diet products</i> Appetitnedsættende mid- ler ekskl. slankemidler								
1995	6.2	2.9	..	0.1	..	0.0	0.0	0.0
1998	5.7	0.9	0.7	0.1	1.9	0.0	0.0	0.0
2000	4.9	3.5	0.6	0.6	0.6	1.2	0.1	4.0
2001	3.2	2.9	0.5	0.5	0.4	1.1	1.1	1.9

Sources: See Table 3.54

Kilder: Se tabel 3.54

1 For Denmark, the figures for 1995 do not include the hospital sector.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

**Table 3.57 Sales of drugs used in diabetes (ATC-group A10),
DDD/1 000 inhabitants/day 1995-2001**

Salg af diabetesmidler (ATC-gruppe A10), DDD/1 000 indbyggere/døgn 1995-2001

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A10								
<i>Drugs used in diabetes</i>								
<i>Midler mod diabetes</i>								
1995	14.6	16.0	..	30.8	..	9.9	18.0	28.8
1998	18.7	19.6	4.2	36.8	23.7	12.2	22.9	32.3
2000	22.0	24.2	6.1	42.6	25.3	15.3	27.0	36.9
2001	23.8	27.1	6.3	48.3	28.3	17.6	29.7	38.7
A10A								
<i>Insulins and analogues</i>								
<i>Insulin</i>								
1995	6.7	5.7	1.1	11.8	..	3.4	10.9	15.0
1998	8.5	6.9	1.4	13.9	11.8	4.1	13.2	17.2
2000	9.4	8.9	1.8	15.9	11.8	5.0	14.3	19.6
2001	9.7	9.5	1.9	17.4	13.0	5.4	15.5	20.4
A10B								
<i>Oral blood glucose lowering drugs</i>								
<i>Perorale midler</i>								
1995	7.9	10.3	1.7	19.0	..	6.5	7.1	13.8
1998	10.3	12.6	2.7	22.9	11.8	8.0	9.7	15.1
2000	12.6	15.6	4.3	26.7	13.5	10.3	12.7	17.3
2001	14.1	17.6	4.5	30.9	15.3	12.1	14.2	18.3
A10BA								
<i>Biguanides</i>								
<i>Biguanider</i>								
1995	1.3	1.2	..	3.1	..	2.9	0.8	2.6
1998	1.8	1.9	0.4	6.5	2.9	3.8	1.8	3.7
2000	2.8	3.3	1.0	9.3	4.2	4.7	3.7	5.5
2001	3.6	4.4	1.5	10.9	5.2	5.3	4.9	6.7
A10BB								
<i>Sulfonamides, urea derivatives</i>								
<i>Sulfonamider, urinstof-derivater</i>								
1995	6.6	9.1	..	15.8	..	3.6	6.3	11.1
1998	8.3	8.3	2.3	16.4	9.0	4.3	7.5	11.0
2000	9.4	12.4	3.2	17.4	9.2	5.4	8.6	11.2
2001	10.1	13.1	3.0	20.0	10.1	5.8	8.9	10.7
A10BG								
<i>Thiazolidinediones</i>								
<i>Thiazolindioner</i>								
2000	0.0	..	..	..	..	0.1	..	0.0
2001	0.1	0.1	0.0	0.0	0.0	0.9	0.0	0.2

The table continues ...

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE
Table 3.57 continued

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
A10BX <i>Other oral blood glucose lowering drugs</i> Andre perorale antidiabetika								
2000	0.2	..	..	0.0	0.0	0.0	0.1	0.3
2001	0.2	0.0	-	..	..	0.2	0.1	0.4

Sources: See Table 3.54

Kilder: Se tabel 3.54

1 For Denmark, the figures for 1995 do not include the hospital sector.

**Table 3.58 Sales of drugs for cardiac therapy (ATC-group C01),
DDD/1 000 inhabitants/day 1995-2001**
Salg af lægemidler til hjerteterapi (ATC-gruppe C01),
DDD/1 000 indbyggere/døgn 1995-2001

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
C01 <i>Cardiac therapy</i> Hjerteterapi								
1995	20.7	38.3	..	45.5	..	22.5	29.3	38.8
1998	22.0	38.5	5.0	39.5	42.4	25.2	28.4	38.1
2000	21.0	35.9	5.4	35.0	33.0	22.2	25.9	35.8
2001	20.7	33.9	6.1	34.9	31.4	20.8	25.0	35.0
C01A <i>Cardiac glycosides</i> Hjerteglykosider								
1995	9.0	13.2	2.6	15.7	..	5.8	8.3	13.0
1998	8.7	10.2	3.0	11.6	14.3	5.4	6.8	10.6
2000	7.8	8.3	3.2	9.7	10.2	1.2	5.8	9.3
2001	7.3	7.1	3.3	8.8	9.8	3.1	5.4	8.6
C01D <i>Vasodilators used in car- diac diseases</i> Midler mod angina pectoris (hjertekrampe)								
1995	10.5	24.1	1.8	26.3	..	14.5	20.1	23.7
1998	11.6	27.0	1.5	24.5	22.7	17.0	20.5	25.4
2000	11.3	26.5	1.7	21.9	18.1	17.5	18.8	24.4
2001	11.2	25.5	2.1	22.6	17.3	14.9	18.3	24.4

Sources: See Table 3.54

Kilder: Se tabel 3.54

1 For Denmark, the figures for 1995 do not include the hospital sector.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.59 Sales of antihypertensives, diuretics, beta-blocking agents, calcium channel blockers and ACE inhibitors (ATC-group C02, C03, C07, C08, C09), DDD/1 000 inhabitants/day 1995-2001

Salg af midler mod forhøjet blodtryk, diuretika, beta-receptorblokerende midler, calciumantagonister og ACE-hæmmere (ATC-gruppe C02, C03, C07, C08, C09), DDD/1 000 indbyggere/døgn 1995-2001

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
C02								
<i>Antihypertensives</i>								
Midler mod forhøjet blodtryk								
1995	1.1	2.4	..	2.2	..	0.6	6.4	0.9
1998	1.3	1.7	0.2	1.3	0.6	1.2	8.5	0.8
2000	1.8	3.4	0.2	1.1	0.4	1.4	9.3	1.2
2001	2.0	4.1	0.1	1.2	0.4	1.3	9.1	1.4
C03								
<i>Diuretics</i>								
Vanddrivende midler (diuretika)								
1995	102.0	88.8	27.4	62.6	..	56.8	41.9	86.5
1998	104.0	103.3	33.0	59.9	54.9	61.9	40.5	82.3
2000	104.0	114.4	31.6	60.5	53.6	58.9	41.2	82.4
2001	105.2	118.0	37.2	61.9	55.2	61.3	41.7	82.1
C03A								
<i>Low-ceiling diuretics, thiazides</i>								
Thiazider								
1995	36.8	37.6	..	3.9	..	7.9	2.9	9.0
1998	37.2	49.4	17.9	3.8	0.9	8.3	2.5	9.1
2000	38.6	53.5	14.3	4.1	1.2	6.9	3.0	9.9
2001	39.9	56.1	18.2	4.3	1.6	8.3	3.4	10.1
C03C								
<i>High-ceiling diuretics</i>								
Loop-diuretika								
1995	50.5	40.9	..	21.4	..	20.5	29.6	57.4
1998	53.9	43.4	13.6	24.6	18.3	23.9	29.9	55.3
2000	53.2	45.5	15.7	27.1	17.1	21.9	30.7	54.9
2001	53.7	46.4	16.9	29.1	18.3	22.3	30.7	54.0
C03E								
<i>Diuretics and potassium-sparing agents in combination</i>								
Kaliumsbesparende midler i komb med andre diuretika								
1995	10.0	2.1	..	34.1	..	26.7	7.3	10.5
1998	8.9	2.2	0.8	28.9	34.4	27.9	6.4	10.5
2000	7.7	1.8	0.6	26.7	33.3	27.9	6.0	10.6
2001	7.0	1.7	0.7	25.8	33.0	28.6	6.1	11.0
C07								
<i>Beta-blocking agents</i>								
Beta-receptorblokerende midler								
1995	15.5	31.2	7.5	43.3	..	34.3	25.6	36.7
1998	17.8	35.3	7.9	51.1	41.6	36.8	29.6	40.0
2000	20.4	39.7	11.3	57.2	45.8	40.2	33.2	45.1
2001	22.0	41.9	15.0	61.4	48.8	42.8	35.5	48.0

The table continues ...

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE
Table 3.59, continued ...

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
C07A								
<i>Beta-blocking agents</i>								
Beta-receptor-blokerende midler uden kombination								
1995	14.3	30.4	..	42.8	..	34.3	25.6	36.0
1998	16.5	34.5	7.9	48.2	41.1	36.8	29.6	38.7
2000	19.2	38.9	11.3	52.0	44.8	39.9	33.2	43.3
2001	21.3	41.5	15.0	55.0	47.5	42.4	35.7	46.1
C08								
<i>Calcium channel blockers</i>								
Calciumantagonister (midler mod forhøjet blodtryk m.m.)								
1995	28.2	38.2	0.0	31.0	..	21.3	33.8	32.5
1998	34.1	55.4	5.7	32.3	30.2	25.4	37.8	31.2
2000	37.2	48.0	7.8	36.7	35.9	26.7	41.5	34.9
2001	39.1	81.9	12.8	39.3	40.3	28.4	43.8	35.9
C08C								
<i>Selective calcium channel blockers with mainly vascular effect</i>								
Selektive med effekt på karrene								
1995	18.2	30.8	..	17.7	..	14.0	26.6	23.4
1998	25.0	48.7	4.2	22.3	27.1	18.8	30.9	24.2
2000	28.7	69.0	5.8	28.5	33.3	20.5	34.9	28.6
2001	31.1	76.3	11.6	31.9	38.0	21.9	37.4	30.1
C08D								
<i>Selective calcium channel blockers with direct cardiac effect</i>								
Selektive med effekt på hjertet								
1995	10.0	7.5	..	13.3	..	7.2	7.2	9.1
1998	9.1	6.7	1.5	10.0	3.1	6.6	6.9	7.1
2000	8.3	6.0	1.9	8.2	2.7	6.2	6.6	6.3
2001	8.0	5.6	1.3	7.5	2.4	6.5	6.4	5.8
C09								
<i>Agents acting on the renin-angiotensin system</i>								
Midler med virkning på renin-angiotensin systemet (midler mod forhøjet blodtryk m.m.)								
1995	22.3	21.8	..	40.6	..	27.8	35.8	31.2
1998	34.8	43.6	12.1	53.7	43.0	35.9	48.9	43.4
2000	45.5	62.5	19.8	65.7	55.0	51.4	65.1	56.2
2001	52.7	72.4	22.0	76.5	64.0	59.7	76.0	63.8

The table continues ...

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.59, continued ...

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
C09A								
<i>ACE-inhibitors, plain</i>								
ACE-hæmmere ekskl. kombinationer								
1995	20.2	21.6	..	35.6	..	26.5	33.8	29.7
1998	25.6	42.1	11.9	41.0	38.7	26.0	34.6	36.8
2000	29.5	55.5	19.3	42.8	46.2	29.6	35.2	42.3
2001	33.3	60.5	20.9	46.8	52.3	31.0	38.3	45.8
C09B								
<i>ACE-inhibitors, combinations</i>								
ACE-hæmmere i kombination med diuretika								
1995	0.7	0.0	..	5.0	..	0.4	0.2	0.7
1998	1.3	0.1	0.1	9.0	1.1	2.8	5.0	1.7
2000	1.8	0.1	0.0	11.7	1.8	4.2	6.6	2.1
2001	2.1	0.3	0.0	12.9	2.0	4.9	7.2	2.3
C09C								
<i>Angiotensin II antagonists, plain</i>								
Angiotensin II antagonisters ekskl. kombinationer								
1995	1.4	0.1	..	..	..	1.0	1.8	0.8
1998	6.3	1.2	0.2	2.9	2.9	5.8	6.7	4.3
2000	10.6	6.2	0.5	8.2	6.0	12.9	15.6	9.8
2001	12.2	9.2	1.0	11.4	8.1	15.9	18.8	12.5
C09D								
<i>Angiotensin II antagonists, combinations</i>								
Angiotensin II antagonisters i kombination								
1995	0.0	..	..	..	..	0.0	..	0.0
1998	1.7	..	..	0.8	0.3	1.3	2.7	0.6
2000	3.7	..	..	3.1	1.0	4.7	7.7	2.0
2001	5.2	2.4	-	5.4	1.6	7.9	11.6	3.2

Sources: See Table 3.54

Kilder: Se tabel 3.54

1 For Denmark, the figures for 1995 do not include the hospital sector.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.60 Sales of cholesterol and triglyceride reducers (ATC-group C10A), DDD/1 000 inhabitants/day 1995–2001
 Salg af lipidsænkende midler (ATC-gruppe C10A), DDD/1 000 indbyggere/døgn 1995–2001

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
C10A								
<i>Cholesterol and triglyceride reducers</i>								
Lipidsænkende midler								
1995	3.1	0.9	..	5.7	..	6.2	11.1	8.0
1998	8.5	7.9	1.8	15.8	8.4	17.2	37.8	19.6
2000	16.2	20.9	3.2	32.1	14.1	34.2	59.6	36.7
2001	21.2	30.9	5.8	43.3	18.3	44.5	71.7	45.6
C10AA								
<i>HMG CoA reductase inhibitors</i>								
HMG CoA reductase-hæmmere								
1995	2.4	0.8	..	4.6	..	6.2	10.8	5.8
1998	7.9	7.8	1.7	14.8	8.2	17.0	37.5	17.5
2000	15.7	20.8	3.1	31.3	13.9	34.0	59.3	34.9
2001	20.6	30.6	5.8	42.5	18.0	44.2	71.3	43.9

Sources: See Table 3.54

Kilder: Se tabel 3.54

1 For Denmark, the figures for 1995 do not include the hospital sector.

Table 3.61 Sales of estrogens and progestogens and estrogens in combination (ATC-groups G03C and G03F), DDD/1 000 inhabitants/day 1995–2001
 Salg af østrogener og gestagener og østrogener i kombination (ATC-gruppe G03C og G03F), DDD/1 000 indbyggere/døgn 1995–2001

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
G03C								
<i>Estrogens</i>								
Østrogener								
1995	12.8	9.8	..	23.9	..	20.3	15.0	28.2
1998	13.9	10.5	2.4	31.7	27.7	29.6	19.5	31.5
2000	13.8	11.3	2.7	33.9	30.1	28.4	18.4	26.9
2001	13.8	11.3	3.2	33.8	28.8	27.7	17.9	24.3
G03F								
<i>Progestogens and estrogens in combination</i>								
Gestagener og østrogener i kombination								
1995	14.8	9.9	..	13.3	..	23.4	19.9	16.8
1998	15.3	12.7	5.1	16.4	17.5	26.7	26.2	21.8
2000	15.6	14.3	5.0	20.4	19.2	27.0	25.9	21.9
2001	15.9	14.6	5.0	22.2	18.5	27.8	25.6	20.2

Sources: See Table 3.54

Kilder: Se tabel 3.54

1 For Denmark, the figures for 1995 do not include the hospital sector.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

**Table 3.62 Sales of antibacterials for systemic use (ATC-group J01),
DDD/1 000 inhabitants/day 1995–2001**
Salg af antibakterielle midler til systemisk brug (ATC-gruppe J01),
DDD/1 000 indbyggere/døgn 1995–2001

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
J01								
<i>Antibacterials for systemic use</i>								
<i>Antibakterielle midler til systemisk brug</i>								
1995	13.5	15.7	18.4	24.7	..	21.9	17.3	18.8
1998	14.0	15.9	16.4	22.1	21.3	23.0	16.6	18.0
2000	13.5	17.3	16.2	22.8	21.1	20.4	16.3	17.2
2001	14.2	19.9	18.3	23.6	20.9	19.9	16.8	17.4
J01A								
<i>Tetracyclines</i>								
<i>Tetracykliner</i>								
1995	1.6	1.2	3.1	5.6	..	5.2	4.1	3.8
1998	1.0	1.2	2.0	4.9	3.8	5.4	3.4	3.6
2000	1.0	1.2	1.2	4.9	3.0	4.7	3.2	3.5
2001	1.0	1.1	2.5	4.8	3.3	4.6	3.1	3.5
J01C								
<i>Beta-lactam antibacterials, penicillins</i>								
<i>Penicilliner</i>								
1995	7.7	10.5	10.5	7.0	..	10.4	7.3	8.8
1998	8.4	10.6	9.0	6.0	7.9	11.1	7.3	8.5
2000	8.3	11.3	9.8	6.1	8.1	10.4	7.0	8.0
2001	8.9	12.3	10.4	6.6	7.4	10.1	7.2	8.1
J01CA								
<i>Penicillins with extended spectrum</i>								
<i>Penicilliner med udvidet spectrum</i>								
1995	2.8	3.3	4.2	3.4	..	4.8	1.7	1.4
1998	2.7	2.9	3.4	3.0	3.8	4.6	1.9	1.4
2000	2.6	3.2	3.8	3.2	4.2	4.2	2.0	1.4
2001	2.8	3.6	3.7	3.5	3.7	3.9	2.1	1.5
J01CE								
<i>Beta-lactamase sensitive penicillins</i>								
<i>Beta-lactamase føl-somme penicilliner</i>								
1995	4.6	6.8	5.7	3.3	..	3.7	5.4	5.9
1998	5.1	7.0	5.0	2.6	3.6	4.0	5.1	5.5
2000	5.0	7.0	5.5	2.3	3.4	3.1	4.7	5.0
2001	5.2	7.7	6.0	2.2	3.0	2.9	4.7	5.0

The table continues ...

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE
Table 3.62, continued

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
J01CF								
<i>Beta-lactamase resistant penicillins</i>								
Beta-lactamase resistente penicilliner								
1995	0.3	0.4	0.6	0.1	..	1.2	0.2	1.3
1998	0.5	0.6	0.6	0.1	0.3	1.3	0.3	1.3
2000	0.7	0.9	0.5	0.1	0.2	1.3	0.4	1.3
2001	0.8	0.9	0.7	0.1	0.3	1.3	0.4	1.4
J01CR								
<i>Combinations of penicillins, incl. beta-lactamase inhibitors</i>								
Komb. af penicilliner, inkl. beta-lactamase hæm.								
1995	0.0	0.0	..	0.2	..	0.7	0.0	0.2
1998	0.0	0.1	0.0	0.3	0.2	1.3	0.0	0.3
2000	0.0	0.1	0.0	0.4	0.3	1.8	0.0	0.2
2001	0.0	0.1	-	0.8	0.4	2.0	0.0	0.2
J01D								
<i>Other beta-lactam antibacterials</i>								
Cefalosporiner								
1995	0.0	0.2	..	3.5	..	0.5	0.5	1.1
1998	0.2	0.2	0.1	2.9	1.3	0.6	0.4	0.9
2000	0.2	0.4	0.1	3.1	1.6	0.6	0.5	0.8
2001	0.2	0.5	0.1	3.1	1.6	0.5	0.6	0.8
J01E								
<i>Sulfonamides and trimethoprim</i>								
Sulfonamider og trimethoprim								
1995	0.8	1.4	..	2.9	..	2.7	1.8	0.9
1998	0.9	1.4	0.6	2.4	1.8	2.5	1.4	0.9
2000	0.8	1.3	0.6	2.3	1.4	2.2	1.2	0.8
2001	0.8	1.2	0.6	2.2	1.4	2.1	1.2	0.8
J01F								
<i>Macrolides, lincosamides and streptogramins</i>								
Makrolider, lincosamider og streptograminer'								
1995	2.1	2.1	2.2	2.0	..	1.6	1.6	1.4
1998	2.3	2.2	3.7	2.1	1.1	1.9	1.6	1.1
2000	2.1	2.9	3.8	2.3	0.8	1.6	1.6	1.0
2001	2.2	3.2	3.8	2.5	1.2	1.5	1.8	1.1
J01M								
<i>Quinolone antibiotics</i>								
Quinoloner								
1995	0.3	0.1	..	0.9	..	0.4	0.3	1.5
1998	0.3	0.1	0.2	1.0	0.8	0.5	0.3	1.3
2000	0.3	0.1	0.1	1.2	1.3	0.6	0.3	1.3
2001	0.3	0.1	0.2	1.5	1.7	0.7	0.4	1.3

Sources: See Table 3.54

Kilder: Se tabel 3.54

1 For Denmark, the figures for 1995 do not include the hospital sector.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.63 Sales of anti-inflammatory and antirheumatic products, non-steroids, opioids and other analgesics and antipyretics (ATC-groups M01A, N02A and N02B), DDD/1 000 inhabitants/day 1995-2001

Salg af midler mod gigt og stærke og svagere smertestillende midler (ATC-gruppe M01A, N02A og N02B), DDD/1 000 indbyggere/døgn 1995-2001

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
M01A								
<i>Anti-inflammatory and antirheumatic products, non-steroids</i>								
Midler mod gigt (NSAID)								
1995	29.7	28.8	17.1	52.7	..	36.7	24.6	33.6
1998	30.6	24.2	12.3	53.5	39.7	43.8	29.6	33.6
2000	32.3	23.7	15.4	61.3	46.0	53.2	34.5	43.0
2001	37.1	29.9	17.8	65.0	46.7	59.1	43.6	45.3
M01AH								
<i>Coxibs</i>								
Coxibs								
1998	0.0	..	..	..	..	0.0	..	0.0
2000	2.9	..	..	1.0	0.5	7.9	2.6	6.3
2001	7.8	4.9	2.9	4.7	3.0	14.6	13.2	7.8
N02A								
<i>Opioids</i>								
Stærke smertestillende midler (opioider)								
1995	9.6	3.2	..	5.7	..	6.9	14.6	26.9
1998	12.6	3.9	1.8	7.8	5.6	12.1	16.6	27.7
2000	14.6	4.3	2.7	10.4	6.6	16.2	17.4	26.5
2001	15.0	4.2	3.4	12.2	9.1	17.6	18.2	25.5
N02B								
<i>Other analgesics and antipyretics</i>								
Svagere smertestillende midler								
1995	61.7	38.7	30.7	18.7	..	31.5	25.6	43.0
1998	69.7	38.5	33.3	15.0	27.9	32.2	25.8	46.8
2000	70.2	..	..	13.3	27.9	31.5	26.3	45.5
2001	70.4	53.6	34.9	14.3	27.9	31.4	26.3	46.5
N02BA								
<i>Salicylic acid and derivatives</i>								
Salicylsyre-derivater								
1995	22.0	20.9	..	14.6	..	9.2	3.2	16.3
1998	20.2	18.6	10.7	10.3	14.7	7.9	1.9	14.3
2000	18.0	19.4	9.9	7.3	12.4	6.7	1.3	12.5
2001	16.8	18.7	8.0	7.0	10.0	6.2	1.1	11.8

The table continues ...

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE
Table 3.63 continued

	Denmark ¹⁾	Faroe Is-lands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N02BB								
<i>Pyrazolones</i>								
<i>Pyrazoloner</i>								
1995	2.6	0.3	..	0.4	..	0.7	5.9	0.3
1998	2.1	0.3	0.0	0.1	0.2	0.5	4.6	0.3
2000	1.8	0.1	0.0	0.0	0.0	0.4	4.2	0.1
2001	1.6	0.1	-	..	..	0.1	4.0	0.1
N02BE								
<i>Anilides</i>								
<i>Anilider</i>								
1995	37.1	17.4	..	3.4	..	21.6	16.5	26.4
1998	47.4	19.6	22.6	4.6	13.1	23.7	19.3	32.3
2000	50.5	25.6	27.5	6.0	15.5	24.4	20.8	32.9
2001	52.0	34.8	26.8	7.3	17.8	25.1	21.2	34.6

Sources: See Table 3.54

Kilder: Se tabel 3.54

- 1 For Denmark, the figures for 1995 do not include the hospital sector.
For the year 1995, the Danish recording of over-the-counter sales was incomplete.

Table 3.64 Sales of antipsychotics (ATC-group N05A), DDD/1 000 inhabitants/day 1995-2001

Salg af antipsykotiske midler (ATC-gruppe N05A), DDD/1 000 indbyggere/døgn 1995-2001

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N05A								
<i>Antipsychotics</i>								
<i>Antipsykotiske midler</i>								
1995	6.6	7.7	9.4	15.2	..	8.4	8.7	8.8
1998	9.1	8.8	10.0	14.7	9.0	8.8	8.5	8.3
2000	9.7	8.9	11.6	15.3	8.7	9.5	9.0	8.6
2001	10.8	9.5	11.0	15.6	8.9	9.7	9.1	8.5

Sources: See Table 3.54

Kilder: Se tabel 3.54

- 1 For Denmark, the figures for 1995 do not include the hospital sector.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

**Table 3.65 Sales of anxiolytics (ATC-group N05B), DDD/1 000 inhabitants/day
1995-2001**

Salg af angstdæmpende (ATC-gruppe N05B), DDD/1 000 indbyggere/døgn 1995-2001

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N05B								
<i>Anxiolytics</i>								
Angstdæmpende midler								
1995	26.6	19.5	5.2	28.9	..	23.0	18.9	17.2
1998	24.3	17.7	3.1	28.9	10.0	24.2	18.5	16.4
2000	22.8	17.3	5.1	30.1	10.6	24.6	19.0	17.1
2001	22.5	16.7	4.9	31.0	10.2	24.8	19.4	17.0
N05BA								
<i>Benzodiazepine derivatives</i>								
Benzodiazepin-derivater								
1995	26.5	..	..	27.5	..	22.4	18.3	15.1
1998	24.1	..	..	27.2	8.1	23.2	17.7	14.4
2000	22.5	..	..	28.3	8.9	23.6	18.0	14.9
2001	22.3	16.6	4.9	29.2	8.4	23.8	18.3	14.7

Sources: See Table 3.54

Kilder: Se tabel 3.54

1 For Denmark, the figures for 1995 do not include the hospital sector.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.66 Sales of hypnotics and sedatives (ATC-group N05C), DDD/1 000 inhabitants/day 1995–2001

Salg af sovemidler og beroligende midler (ATC-gruppe N05C), DDD/1 000 indbyggere/døgn 1995–2001

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N05C								
<i>Hypnotics and sedatives</i>								
Sovemidler og beroligende midler								
1995	44.4	43.1	5.1	39.5	..	41.2	25.9	40.7
1998	34.8	34.6	3.0	43.7	33.2	50.4	29.4	44.3
2000	32.6	35.2	5.3	49.0	35.2	55.4	31.8	47.2
2001	32.6	34.6	6.1	51.6	37.8	55.4	34.0	48.5
N05CD								
<i>Benzodiazepine derivatives</i>								
Benzodiazepin-derivater								
1995	32.6	..	..	20.1	..	38.3	21.7	22.8
1998	18.9	..	..	20.2	6.7	37.5	17.0	15.8
2000	15.7	..	..	21.0	7.0	28.9	13.7	13.3
2001	14.9	13.0	0.9	21.5	6.8	20.8	13.1	11.7
N05CF								
<i>Benzodiazepine related drugs</i>								
Cyclopyrroloner								
1995	11.9	..	..	17.7	..	2.3	4.2	7.1
1998	15.9	..	..	22.5	25.2	12.9	12.4	17.0
2000	16.8	..	..	27.4	27.2	26.5	18.0	21.6
2001	17.7	21.6	5.3	29.5	30.0	34.5	20.9	24.3

Sources: See Table 3.54

Kilder: Se tabel 3.54

1 For Denmark, the figures for 1995 do not include the hospital sector.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

**Table 3.67 Sales of antidepressants (ATC-group N06A),
DDD/1 000 inhabitants/day 1995-2001**

Salg af antidepressive midler (ATC-gruppe N06A), DDD/1 000 indbyggere/døgn
1995-2001

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
N06A								
<i>Antidepressants</i>								
<i>Antidepressive midler</i>								
1995	18.3	10.6	3.9	20.3	..	33.0	22.5	27.8
1998	28.9	15.3	5.8	27.4	19.4	53.1	31.7	37.5
2000	34.8	19.6	10.1	35.5	23.8	70.5	41.4	48.8
2001	41.5	23.8	13.3	39.4	28.1	78.3	44.2	55.7
N06AA								
<i>Non selective monoamine reuptake inhibitors</i>								
<i>Non-selektive monoamin genoptagelseshæmmere</i>								
1995	5.3	4.1	..	5.0	..	9.7	6.3	5.4
1998	4.8	3.1	0.8	4.5	3.9	9.5	4.9	4.3
2000	4.6	2.9	1.6	4.4	3.4	8.6	4.5	4.0
2001	4.6	2.9	1.2	4.3	3.1	8.7	4.2	4.0
N06AB								
<i>Selective serotonin reuptake inhibitors</i>								
<i>Selektive serotoninin gen- optagelseshæmmere</i>								
1995	11.9	5.7	..	12.1	..	18.9	11.2	21.0
1998	20.7	10.0	4.8	18.3	12.7	35.9	21.9	28.4
2000	23.9	13.2	8.1	24.2	16.8	49.2	29.9	37.1
2001	28.8	16.3	11.1	26.9	19.6	53.2	32.0	42.2
N06AG								
<i>Monoamine oxidase A inhibitors</i>								
<i>Monoamin-oxidase type A hæmmere</i>								
1995	0.3	0.1	..	1.6	..	2.0	1.9	0.7
1998	0.2	0.0	0.0	1.5	0.4	2.1	0.9	0.5
2000	0.1	0.0	0.0	1.3	0.3	2.0	0.6	0.4
2001	0.1	0.0	0.0	1.1	0.3	1.7	0.5	0.3
N06AX								
<i>Other antidepressants</i>								
<i>Andre antidepressiva</i>								
1995	0.6	0.6	..	0.2	..	2.4	3.0	0.7
1998	3.0	2.0	0.3	3.1	2.4	5.6	4.1	4.3
2000	6.0	3.4	0.4	5.6	3.3	10.7	6.4	7.3
2001	7.8	4.4	1.0	7.1	5.0	14.7	7.5	9.2

Sources: See Table 3.54

Kilder: Se tabel 3.54

1 For Denmark, the figures for 1995 do not include the hospital sector.

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE
**Table 3.68 Sales of drugs for obstructive airway diseases (ATC-group R03),
DDD/1 000 inhabitants/day 1995-2001**

 Salg af midler til obstruktive luftvejssygdomme (ATC-gruppe R03),
DDD/1 000 indbyggere/døgn 1995-2001

	Denmark ¹⁾	Faroels- lands	Greenland	Finland	Åland	Iceland	Norway	Sweden
R03								
<i>Drugs for obstructive airway diseases</i>								
Midler til obstruktive luftvejssygdomme								
1995	59.2	27.1	..	42.9	..	43.8	57.2	64.7
1998	62.5	35.2	21.7	48.2	46.9	47.6	63.1	55.0
2000	59.0	38.1	31.6	49.9	47.9	48.2	61.5	56.4
2001	63.8	39.1	26.3	49.9	49.9	45.8	62.2	54.9
R03A								
<i>Adrenergics, inhalants</i>								
Adrenergene til inhalation								
1995	27.2	14.4	10.0	15.6	..	20.4	26.2	29.2
1998	28.8	18.0	11.8	17.7	16.6	21.7	28.6	23.8
2000	27.9	19.3	16.8	15.3	19.3	20.6	30.1	22.7
2001	24.9	19.5	12.2	14.2	13.0	18.0	22.5	21.2
R03AC								
<i>Selective beta-2-adrenoceptor agonists</i>								
Selektive beta-2-adrenoceptor agonister								
1995	2.2	..	..	0.8	..	0.0	..	0.0
1998	5.5	..	..	2.1	1.3	0.0	..	0.0
2000	7.8	..	..	4.9	5.2	1.5	5.8	2.8
2001	9.1	0.2	0.1	7.4	7.6	5.7	9.0	4.9
R03AK								
<i>Adrenergics and other drugs for obstructive airway diseases</i>								
Adrenergika og andre lægemiddelstoffer til obstruktive luftvejssygdomme								
1995	28.3	..	..	15.6	..	20.4	26.2	29.4
1998	32.6	..	..	17.7	16.6	21.7	28.5	23.8
2000	32.8	..	..	20.2	19.3	22.1	30.1	25.6
2001	33.9	19.7	12.3	21.5	20.6	23.7	31.6	26.0
R03B								
<i>Other drugs for obstructive airway diseases, inhalants</i>								
Andre midler til obstruktive luftvejssygdomme til inhalation								
1995	19.6	8.3	5.8	20.7	..	18.6	23.6	29.1
1998	24.1	14.5	6.5	24.7	24.3	22.2	29.2	26.3
2000	22.7	16.5	11.6	23.7	21.1	22.3	26.2	25.9
2001	22.2	17.3	10.7	22.4	21.2	18.9	25.1	24.4

The table continues ...

MORBIDITY, MEDICAL TREATMENT, ACCIDENTS AND MEDICINE

Table 3.68 continued

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
R03C								
<i>Adrenergics for systemic use</i>								
Adrenergene midler til systemisk brug								
1995	5.2	1.6	..	0.9	..	0.6	2.1	2.5
1998	4.0	1.2	1.2	0.7	0.8	0.3	1.3	1.6
2000	3.1	0.9	1.2	0.6	0.8	0.2	1.0	1.3
2001	2.8	0.9	1.4	0.5	0.8	0.2	0.8	1.2
R03D								
<i>Other systemic drugs for obstructive airway diseases</i>								
Andre midler til obstruktive luftvejssygdomme til systemisk brug								
1995	7.3	2.7	..	5.7	..	4.3	5.3	3.8
1998	5.6	1.5	2.3	5.1	5.2	3.3	4.1	3.3
2000	5.3	1.4	2.0	5.5	6.8	3.6	4.4	3.7
2001	4.9	1.2	1.9	5.5	7.4	3.1	4.5	3.4

Sources: See Table 3.54

Kilder: Se tabel 3.54

1 For Denmark, the figures for 1995 do not include the hospital sector.

Table 3.69 Sales of antihistamines for systemic use (ATC-group R06A), DDD/1 000 inhabitants/day 1995-2001

Salg af antihistaminer til systemisk brug (ATC-gruppe R06A), DDD/1 000 indbyggere/døgn 1995-2001

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
R06A								
<i>Antihistamines for systemic use</i>								
Antihistaminer til systemisk brug								
1995	10.7	10.9	..	12.5	..	19.4	32.9	20.3
1998	12.9	12.4	2.5	17.4	18.4	21.9	37.2	22.6
2000	14.1	14.6	3.0	21.0	21.9	24.9	39.4	25.5
2001	15.1	16.0	4.5	23.0	22.4	26.4	42.1	24.9

Sources: See Table 3.54

Kilder: Se tabel 3.54

1 For Denmark, the figures for 1995 do not include the hospital sector.

For the year 1995, the Danish recording of over-the-counter sales was incomplete.

CHAPTER IV

Mortality and causes of death

Dødelighed og dødsårsager

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

Revisions of the classification make statistical comparisons of countries over time difficult, when different versions of ICD are used at the same time. It is therefore important to have an understanding of the possible sources of error that a change in classification introduces in the morbidity and mortality statistics, and how to handle these problems. The most recent revision has above all meant an increase in the level of detail in ICD. Many new diagno-

Den internationale sygdomsklassifikation (ICD), som udarbejdes af Verdenssundhedsorganisationen (WHO), har som sin vigtigste anvendelse at være instrument for statistiske beskrivelser af sygelighed og dødelighed. Det er et system som på meningsfuld måde grupperer sygdomme og dødsårsager, så der kan gives overskuelige statistiske opstillinger og analyser, som for eksempel sammenligninger mellem forskellige lande over en tidsperiode. ICD's historie er over 100 år, og klassifikationen er blevet revideret ca. hvert tiende år for at den kan afspejle den medicinske udvikling. Den seneste, tiende revision (ICD-10) blev godkendt af WHO i 1990, men blev først taget i brug i de fleste lande adskillige år senere. I de nordiske lande blev ICD-10 taget i brug til dødsårsagsregistrering i 1994 i Danmark, i Finland, Island og Norge i 1996, og i Sverige i 1997.

Revision af klassifikationen vanskeliggør statistiske sammenligninger over tid mellem lande, når de på samme tid anvender forskellige versioner af ICD. Det er derfor vigtigt at forsøge at forstå hvilke fejlkilder et klassifikationsskifte kan medføre for analysen af morbiditets- og mortalitetsstatistikken samt hvorledes problemet kan håndteres. Det seneste klassifikationsskifte har frem for alt medført en større detaljeringsgrad i ICD. Der er medtaget et stort

ses have been added as a result of developments in medicine. Also, certain diseases or groups of diseases have been transferred to other chapters in order to reflect new medical knowledge.

Statistical analyses are carried out on aggregated data, for example at the level of the chapter. There are 21 chapters in ICD-10. With the change to ICD-10 the number of chapters increased from 17 to 21 due to the splitting up of certain chapters. The basic structure of ICD has generally remained the same through the revisions and most chapters have the same name. However, it is important to realize that even if the name of a chapter is the same in ICD-10 as in ICD-9 differences in content may exist due to the transfer of diagnostic codes from one chapter to another. For example, HIV and AIDS were originally placed among diseases of the immune system in ICD-9 but were moved to the chapter for infectious diseases in ICD-10. Another example is the transfer of transitory ischemic attacks from the chapter for circulatory diseases in ICD-9 to the chapter for nervous system diseases in ICD-10. Certain symptoms have also been moved from the chapter for symptoms to so-called organ chapters.

Another potential source of error is that certain rules and guidelines for the use of ICD have been changed in connection with the new revision. With reference to mortality statistics, certain rules for the selection of underlying cause of death have been altered, which may, for example, affect the frequency of pneumonia as a cause of death. For morbidity statistics, new rules for dual coding of manifestation (asterisk code) and etiology (dagger code) may also have an effect on the statistics. Beside

antal nye diagnoser som følge af den medicinske udvikling. Samtidig er enkelte sygdomme og sygdomsgrupperinger flyttet til andre kapitler for at det bedre kan afspejle det medicinske vidensniveau.

Statistiske analyser foretages på et aggregeret niveau. Dette niveau kan være kapitelinndelingen i ICD-10, som i alt består af 21 kapitler. Ved overgangen fra ICD-9 til ICD-10 steg antallet af kapitler fra 17 til 21 ved at visse kapitler blev opdelt. Grundstrukturen i ICD er dog i det store og hele blevet bevaret uforandret igennem de forskellige revisioner og de fleste kapitler har beholdt det samme navn. Det er imidlertid vigtigt at indse, at selvom et kapitel hedder det samme i ICD-10 som i ICD-9, kan der findes forskelle ved at diagnoser er flyttet fra et kapitel til et andet. Et eksempel er HIV og AIDS som præliminært blev placeret blandt immunsygdommene i ICD-9 men blev placeret under infektionssygdomme i ICD-10. Et andet eksempel er flytningen af cerebral transitorisk iskæmi fra cirkulationssystemets sygdomme i ICD-9 til nervesystemets sygdomme i ICD-10. Visse symptomer er også blevet flyttet mellem symptomkapitlet og de såkaldte organkapitler.

En anden fejlkilde er at visse regler og anvisninger for brugen af ICD er ændret i forbindelse med klassifikationsskiftet. Indenfor dødsårsagsstatistikken er for eksempel visse regler for valg af den underliggende dødsårsag blevet ændret, hvilket for eksempel kan påvirke frekvensen af pneumoni som dødsårsag. For sygdomsstatistikken kan de nye regler om dobbeltkodning af både manifestation (asteriskkode) og ætiologi (daggerkoder) ligeledes påvirke statistikken. Ved siden af de inter-

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changes in the international rules, national rules for applying the classification may also be modified in connection with a classification change, which will affect both comparisons over time within a country and comparisons between countries.

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

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

nationale regelændringer kan de nationale tilpasninger ændres i forbindelse med et klassifikationsskifte, hvilket både påvirker sammenligningerne over tid i det samme land og sammenligninger mellem flere lande.

Det er ikke usædvanligt at tro, at en automatisk oversættelse af koderne i forskellige ICD versioner kan løse problemerne ved et klassifikationsskifte. Dette er imidlertid ikke en nemt fremkommelig vej. Kun for en tredjedel af koderne i ICD-9 og ICD-10 er der en direkte og entydig oversættelse mellem koderne. I stedet for bør man stræbe efter, at de aggregerede grupper man anvender til statistiske sammenligninger konstrueres så det er muligt at eliminere nogle af de problemer, klassifikationsændringerne har skabt. De såkaldte kortlister som anvendes i denne publikation for mortalitet og morbiditet er defineret både i relation til ICD-9 og ICD-10 ud fra tanken om sammenlignelighed.

Man må imidlertid altid være klar over at en observeret forskel over tid eller mellem lande kan være effekten af et klassifikationsskifte samt andre metodologiske problemstillinger. En måde hvorpå man kan kvantificere betydningen af et klassifikationsskifte er den såkaldte "bridge kodning." Dette indebærer at man koder samme materiale, så som dødsattester og sygehusjournaler, to gange, uafhængig af hinanden, først efter den tidligere klassifikation og derefter efter den nye. De forskelle som fremkommer når man sidenhen sammenligner de statistiske grupperinger baseret på de to kodninger, giver en opfattelse af hvor meget en vis sygdomsgruppe (eksempelvis ICD-kapitlet om cirkulationsorganernes sygdomme) stiger eller falder som en direkte følge af klassifikationsskiftet. Denne type

and only a few, limited bridge-coding studies have been carried out on the change from ICD-9 to ICD-10.

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

In order to support the choice of the underlying cause of death, a number of automatic coding systems have been developed. The most widely used system is the American programme, ACME (Automated Classification of Medical Entities). This system is used in Sweden. The other Nordic countries use computer-aided coding. Automatic coding does not necessarily result in a more correct picture of the pattern of causes of death than does manual coding, but it does give more consistency in the coding and thus contributes to better comparability between more countries. However, several other factors also influence comparability, such as the type of information the statistics producer has access to and the quality of that material (death certificates, etc.).

studier er dog ressourcekrævende og der er kun gennemført et fåtal begrænsede bridge-kodnings-studier i forbindelse med overgangen fra ICD-9 til ICD-10.

Et andet forhold af stor betydning for sammenligneligheden af dødsårsagerne mellem flere lande, er den kodningspraksis, der er etableret i de enkelte lande. Det som vises i statistikken er den underliggende dødsårsag, hvor WHO har udarbejdet retningslinier for valget af den underliggende dødsårsag, hvilket vil sige den sygdom eller skade som starter rækken af sygelige tilstande der leder direkte til døden, eller ydre omstændigheder ved en ulykke eller voldshandling som var årsag til den dødelige skade. Det problematiske for sammenligneligheden er, at i nogle tilfælde, hvor der er opført to eller flere dødsårsager på dødsattesten, bliver valget af den underliggende dødsårsag forskellig fra land til land, fordi reglerne giver mulighed for forskellig fortolkning.

For at støtte valget af den underliggende dødsårsag, er der udviklet flere automatiske kodningssystemer. Det mest anvendte er det amerikanske program ACME (Automated Classification of Medical Entities). Blandt de nordiske lande anvendes systemet af Sverige. I de andre nordiske lande anvender man edb-støttet kodning. Automatisk kodning giver ikke nødvendigvis et mere korrekt billede af dødsårsagsmønsteret end manuel kodning. Derimod vil automatisk kodning give en bedre stabilitet i kodningen og dermed bidrage til en bedre sammenlignelighed mellem flere lande. Men der er også flere andre forhold der påvirker sammenligneligheden, blandt andet hvilken type af information statistikproducenten har tilgang til, herunder kvaliteten på dette materiale (dødsattester og andre oplysninger).

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Apart from the fact that the ICD rules governing mortality coding give room for interpretation, different national traditions for the choice of underlying cause of death may also develop. An example of this is the use of the diagnostic group "insufficiently defined conditions" (codes I469, I959, I99; J960, J969; P285.0; R000-R948; R99). The use of these codes as underlying causes of death is more widespread in Denmark than in the other Nordic countries, in situations where more specific causes of death are also recorded on the death certificate.

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

Another factor influencing the quality of the statistics on causes of death is the decreasing autopsy rate. The autopsy rate has been more than halved in the Nordic countries over the last few decades. Studies have shown that in about 30 per cent of cases, the result of the autopsy has caused the underlying cause of death to be altered.

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

Udover at ICD's regler for mortalitetskodning giver plads for fortolkning kan der også være tale om udvikling af nationale traditioner for valget af den underliggende dødsårsag. Som eksempel kan nævnes brugen af diagnosegruppen "mangelfuldt definerede tilstande" (koderne I469, I959, I99; J960, J969; P285.0; R000-R948; R99). Anvendelsen af disse koder som underliggende dødsårsag er mere udbredt i Danmark end i de andre nordiske lande i situationer hvor der også er oplyst mere specifikke dødsårsager på dødsattesten.

Kulturelle forskelle i rapporteringen af bestemte tilstande kan også påvirke sammenligneligheden. Hvis læger i et land er langt mere tilbageholdende med at anvende for eksempel selvmord på dødsattesten, end læger i andre lande, kan det vanskeliggøre sammenligneligheden. I flere af de nordiske lande findes der imidlertid rutiner for at kontakte lægen eller sygehuset i de tilfælde hvor de ydre årsager til skaden er uklare. Sådanne kvalitetssikringsrutiner er med til at kompensere for de manglende informationer på dødsattesten.

En yderligere faktor der spiller ind på dødsårsagsstatistikens kvalitet er de faldende rater for obduktion. Anvendelsen af obduktion ved dødsfald er mere end halveret i de nordiske lande over de seneste årtier. Studier har vist, at i ca. 30 pct. af tilfældene med obduktion, har obduktionen medført at den underliggende dødsårsag er blevet ændret.

Det er klart, at med de forbehold der er taget her over for sammenligneligheden af dødsårsagerne over tid og mellem landene, må de præsenterede data fortolkes

caution. This is especially the case for small diagnostic groups in the European short list that is used in the present publication. The picture is more stable for the large groups, such as cardiovascular diseases and cancer.

Detailed data on causes of death according to the European short list are to be found on the NOMESCO homepage at www.nom-nos.dk.

med forsigtighed. Det vil især dreje sig om mindre diagnosegrupper i den europæiske forkortede liste, der anvendes i denne publikation. Når det drejer sig om de helt store grupper, hjerte-karsygdomme for sig og cancer for sig, tegner der sig dog et noget mere stabilt billede.

På NOMESKO's hjemmeside på www.nom-nos.dk findes der detaljerede data om dødsårsager opgjort efter den europæiske forkortede liste.

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Table 4.1 Deaths by sex and age per 100 000 inhabitants 1990-2001
Døde efter køn og alder pr. 100 000 indbyggere 1990-2001

Age Alder	Total I alt		Under 1 year ¹⁾ Under 1 år ¹⁾		1-14 years 1-14 år		15-24 years 15-24 år		25-64 years 25-64 år		65+ years 65+ år	
	M	W	M	W	M	W	M	W	M	W	M	W
Denmark												
1990	1 230	1 141	852	633	34	22	74	34	539	349	6 985	5 242
1995	1 212	1 203	557	452	25	17	79	33	506	338	7 114	5 724
2000	1 069	1 099	607	456	17	12	79	30	444	294	6 368	5 455
2001	1 073	1 105	480	484	20	17	63	22	447	291	6 387	5 504
Faroe Islands												
1992	905	747	484	683	36	19	53	-	399	143	6 427	4 636
2000	772	769	275	-	-	39	60	35	328	208	5 054	4 203
2001	795	752	576	312	19	-	41	-	357	196	5 013	4 255
Greenland												
1991	889	675	3 056	2 467	146	61	701	167	781	510	7 875	6 403
1995	942	795	1 805	3 610	111	100	493	240	814	430	9 746	8 188
2000	853	772	2 138	1 659	110	14	446	169	720	529	7 547	7 552
2001	893	766	2 174	3 007	83	14	436	332	792	566	7 547	6 383
Finland												
1990	1 035	976	567	581	27	17	135	51	615	237	6 731	4 979
1995	977	955	431	355	21	16	93	26	530	218	6 263	4 752
2000	952	954	424	324	14	14	96	34	504	222	5 545	4 606
2001	938	932	415	226	16	10	91	28	487	217	5 412	4 484
Åland												
1990	941	894	-	-	-	-	294	62	344	113	5 368	4 211
1995	929	1 125	649	1 242	88	-	64	-	415	196	5 012	5 299
2000	852	1 063	-	885	-	-	137	-	457	202	4 255	5 035
2001	925	845	694	-	-	-	68	-	298	172	5 367	3 989
Iceland												
1990	712	625	548	554	36	17	114	28	374	179	5 769	4 757
1995	733	705	717	488	38	47	85	29	298	203	5 493	4 702
2000	644	653	456	141	13	10	120	43	272	187	4 591	4 317
2001	647	563	239	301	16	13	111	28	240	161	4 817	3 690
Norway												
1990	1 139	1 034	840	583	32	22	87	25	430	224	6 472	4 875
1995	1 068	1 006	491	314	22	16	86	30	361	200	6 393	4 858
2000	974	985	427	329	18	15	93	33	339	201	6 052	4 965
2001	967	982	434	350	16	10	97	34	331	201	6 078	4 984
Sweden												
1990	1 160	1 064	663	526	30	22	71	29	378	218	5 930	4 553
1995	1 088	1 042	453	349	15	11	52	26	347	208	5 942	4 631
2000	1 041	1 065	337	251	15	12	59	24	305	200	5 829	4 854
2001	1 032	1 075	354	280	14	14	58	22	310	194	5 751	4 938

1 Per 100 000 live births.

1 Pr. 100 000 levendefødte.

Source: The national central statistical bureaus.
Kilde: De nationale centrale statistikbureauer.

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Table 4.2 Death rates from malignant neoplasms per 100 000 by age 1991-2000
 Dødeligheden af ondartede svulster pr. 100 000 efter alder 1991-2000

		Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland ¹⁾	Norway	Sweden
Men	Mænd								
Age	Alder								
0-14	1991-95	4	8	-	3	-	-	3	3
	1999	3	-	-	4	-	-	3	2
	2000	..	..	..	2	-	-	3	3
15-34	1991-95	8	11	15	7	-	7	8	8
	1999	8	-	13	8	-	7	7	6
	2000	..	..	..	6	32	-	7	8
35-44	1991-95	37	35	41	28	52	29	30	27
	1999	25	62	22	24	56	39	31	23
	2000	..	..	..	22	-	24	32	20
45-54	1991-95	146	120	203	110	104	105	120	99
	1999	150	32	191	101	98	125	117	97
	2000	..	..	..	105	197	84	127	92
55-64	1991-95	514	297	682	393	279	345	405	339
	1999	469	391	1 346	363	214	441	351	296
	2000	..	..	..	320	472	340	348	294
65-74	1991-95	1 285	993	1 993	1 025	1 015	948	1 006	888
	1999	1 190	941	1 573	951	1 445	1 260	1 019	865
	2000	..	..	..	902	204	856	953	826
75+	1991-95	2 451	1 810	3 277	2 151	1 697	1 935	2 184	1 872
	1999	2 443	3 017	3 318	1 983	2 410	1 987	2 226	1 953
	2000	..	..	..	1 947	1 846	2 267	2 142	1 935
Women	Kvinder								
Age	Alder								
0-14	1991-95	4	7	-	3	8	1	3	3
	1999	3	-	-	2	-	10	2	3
	2000	..	..	..	2	-	3	4	3
15-34	1991-95	8	6	4	7	5	7	7	7
	1999	10	-	14	7	32	10	5	6
	2000	..	..	..	7	-	10	6	4
35-44	1991-95	57	67	89	37	42	43	49	40
	1999	48	-	172	31	55	25	41	36
	2000	..	..	..	36	-	39	39	34
45-54	1991-95	189	93	263	114	109	182	138	126
	1999	178	185	352	106	196	190	133	118
	2000	..	..	..	106	341	101	126	126
55-64	1991-95	477	315	845	253	271	390	320	308
	1999	445	251	926	228	394	390	316	285
	2000	..	..	..	237	150	315	319	301
65-74	1991-95	873	576	1 448	525	426	647	597	595
	1999	900	1 057	1 305	489	937	596	601	586
	2000	..	..	..	505	558	658	600	577
75+	1991-95	1 411	1 275	1 616	1 106	1 105	1 226	1 122	1 064
	1999	1 571	1 565	2 206	1 068	1 649	1 246	1 113	1 076
	2000	..	..	..	1 078	1 369	1 496	1 184	1 085

1 1999=1997, 2000=1998.

ICD 9 140-208 and ICD-10 C00-D09.

Source: *The National Registers for Causes of Death*

Kilde: De nationale dødsårsagsregistre

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Table 4.3 Death rates from cardiovascular diseases per 100 000 by age 1991–2000
Dødeligheden af hjerte-karsygdomme pr. 100 000 efter alder 1991–2000

		Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland ¹⁾	Norway	Sweden
Men	Mænd								
Age	Alder								
0-34	1991-95	3	12	10	5	3	3	3	4
	1999	4	-	6	4	14	1	3	3
	2000	..	..	..	6	-	-	3	3
35-44	1991-95	32	47	58	63	26	21	33	30
	1999	31	-	88	50	-	29	24	30
	2000	..	..	..	44	-	19	25	21
45-54	1991-95	127	149	181	210	189	126	134	115
	1999	111	161	191	173	245	81	116	99
	2000	..	..	..	184	98	42	93	104
55-64	1991-95	523	445	641	709	528	432	518	467
	1999	343	217	1 053	514	356	341	319	321
	2000	..	..	..	481	539	311	281	303
65-74	1991-95	1 610	1 776	1 683	1 926	1 388	1 322	1 602	1 485
	1999	1 203	1 568	2 697	1 481	1 342	1 143	1 182	1 168
	2000	..	..	..	1 378	510	971	1 062	1 101
75+	1991-95	5 603	6 597	8 680	5 893	4 120	5 224	5 281	5 637
	1999	4 654	4 170	6 161	5 049	4 685	4 619	4 890	5 031
	2000	..	..	..	4 767	3 823	4 695	4 665	4 851
Women	Kvinder								
Age	Alder								
0-34	1991-95	3	9	6	3	-	2	2	2
	1999	3	-	7	2	-	3	2	2
	2000	..	..	..	3	-	-	2	1
35-44	1991-95	16	13	61	16	25	9	9	11
	1999	24	-	49	13	-	5	9	12
	2000	..	..	..	17	-	10	10	11
45-54	1991-95	45	18	82	46	22	31	35	38
	1999	74	37	176	39	49	20	30	34
	2000	..	..	..	48	-	13	36	34
55-64	1991-95	208	110	410	179	90	121	157	150
	1999	242	-	309	124	315	137	110	117
	2000	..	..	..	129	75	105	102	112
65-74	1991-95	774	641	1 358	845	455	571	684	630
	1999	890	235	1 398	571	187	426	506	496
	2000	..	..	..	551	465	382	467	469
75+	1991-95	4 569	4 407	6 233	4 912	3 855	4 044	4 131	4 464
	1999	4 152	4 000	5 147	4 117	5 018	3 826	3 982	4 159
	2000	..	..	..	4 091	3 603	3 766	3 776	4 058

1 1999=1997, 2000=1998.

ICD-9: 390-398;401-405;410-438;440-459 and ICD-10: I00.0-I199; G45.0-G46.8; M30.0-M31.9.

Source: *The National Registers for Causes of Death*

Kilde: De nationale dødsårsagsregistre

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Table 4.4 Avoidable deaths per 100 000 inhabitants
Undgåelige dødsfald pr. 100 000 indbyggere

ICD10 codes	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden	
	1999	1999	1999	2001	2000	1998	2000	2000	
	Age								
	Alder								
C53	1-74	<i>Cancer in the cervix uteri¹⁾</i> Kræft i livmoderhalsen ¹⁾							
		5.6	2.2	3.6	1.8	-	4.7	3.4	2.4
C81	"	<i>Hodgkin's disease</i> Hodgkins sygdom							
		1.2	-	-	0.3	-	0.8	0.2	0.3
I05- I09	"	<i>Chronic rheumatic heart disease</i> Kronisk reumatisk hjertesygdom							
		0.1	-	1.8	0.5	-	0.8	0.7	0.5
E10- E14	"	<i>Diabetes mellitus</i> Sukkersyge							
		11.8	4.4	1.8	4.8	-	3.5	4.9	6.3
J00- J99	1-14	<i>Diseases of the respiratory system</i> Sygdomme i ånde- drætsorganer							
		0.3	1.1	-	1.6	1.0	0.4
J45- J46	"	<i>Asthma</i> Astma							
		0.0	..	..	-	-	0.1	0.0
K35- K37	1-74	<i>Appendicitis</i> Blindtarms- betændelse							
		0.2	-	-	0.2	-	0.1	0.1	
K40- K46	"	<i>Hernia</i> Brok							
		0.3	-	-	0.4	-	0.1	0.2	
I10- I15	"	<i>Hypertensive disease</i> Hypertensionssygdom							
		4.7	-	42.8	1.9	-	1.6	2.5	1.3
I60- I69	"	<i>Cerebrovascular disease</i> Sygdom i hjernen							
		25.9	19.9	58.8	26.9	8.5	15.2	17.9	21.5
C33- C34	"	<i>Malignant neoplasm of the trachea, bronchus and lung</i> Kræft i luftrør, bronkie og lunge							
		45.7	8.9	41.0	23.9	21.3	25.8	27.3	23.0
C15	"	<i>Malignant neoplasm of the oesophagus</i> Kræft i spiserør							
		4.9	-	3.6	2.4	-	0.8	2.0	2.4
K70- K71; K73- K74	"	<i>Chronic liver disease and cirrhosis</i> Kronisk leversygdom og skrumpelever							
		15.9	-	-	13.4	8.5	2.0	4.8	5.1
V01- V79; V892	"	<i>Motor vehicle traffic accidents</i> Motortrafikulykker							
		8.5	7.9	4.3	9.8	7.0	5.7

1 Per 100 000 women.

1 Pr. 100 000 kvinder.

Source: The National Registers for Causes of Death
Kilde: De nationale dødsårsagsregistre

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Table 4.5 Deaths caused by HIV/AIDS, in total and per 100 000 inhabitants 1991-2001
Dødsfald som følge af HIV/AIDS, i alt og pr. 100 000 indbyggere 1991-2001

<i>Five year average Femårsgen- emsnit</i>	Denmark	Faroe Islands	Greenland	Finland ¹⁾	Åland	Iceland	Norway	Sweden
<i>Number</i>								
<i>Antal</i>								
1991-95	217	1	2	25	1	4	56	512
1996-00	265	1	4	12	-	1	24	195
2000	20	-	5	10	-	1	17	13
2001	16	-	4	5	-	1	11	20
<i>Per 100 000 inhabitants Pr. 100 000 indbyggere</i>								
1991-95	4.2	0.4	3.6	0.5	2.4	1.5	1.3	1.5
1996-00	5.0	0.4	7.1	0.2	-	0.3	0.5	0.4
2000	0.4	-	8.9	0.2	-	0.4	0.4	0.1
2001	0.3	-	7.1	0.1	-	0.4	0.2	0.2

1 Excluding foreigners.

1 Eksklusive udlændinge.

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

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Table 4.6 Suicides per 100 000 inhabitants by sex and age 1990-2001
Selvmord pr. 100 000 indbyggere efter køn og alder 1990-2001

	Men					Women				
	Total I alt	10-19	20-24	25-64	65+	Total I alt	10-19	20-24	25-64	65+
Denmark										
1990	36.3	4.9	20.2	41.3	58.9	18.2	1.2	5.7	19.8	31.0
1995	27.7	5.3	16.7	29.1	48.9	12.7	0.7	3.3	12.5	24.6
1998	24.1	6.1	10.0	26.4	37.2	9.2	1.4	2.9	10.2	13.2
1999	24.7	5.4	15.2	25.7	42.4	8.4	0.4	3.5	8.5	14.9
Faroe Islands										
1991-95	12.6	5.0	-	18.7	22.8	4.8	1.8	-	3.9	0.0
1996-00 ¹⁾	4.0	..	..	..	..	..	..	..	..	..
Greenland										
1991-95	130.7	206.0	351.6	124.9	102.0	31.8	58.9	66.0	34.5	-
1996-00	171.6	199.4	427.1	146.8	68.1	53.7	41.7	47.5	47.4	34.0
Finland										
1990	49.3	20.6	60.3	63.9	64.2	12.4	2.6	15.8	16.7	13.7
1995	43.4	13.1	48.9	58.5	53.3	11.8	1.9	13.5	16.7	11.3
2000	34.6	10.5	41.8	46.6	36.8	11.0	4.1	9.4	15.5	10.3
2001	36.8	9.3	39.6	50.8	38.0	10.2	3.5	7.5	14.4	9.8
Åland										
1991-95	40.7	13.1	70.3	42.1	86.0	9.4	-	21.3	12.3	8.1
1996-00	30.4	12.8	26.9	37.8	47.1	12.3	-	-	14.7	24.4
Iceland										
1990	27.4	23.2	47.1	33.9	33.1	3.9	4.9	-	6.7	-
1995	16.4	9.3	18.9	24.3	14.8	3.7	-	-	4.7	12.1
1997	19.1	9.4	9.4	28.4	28.6	5.2	4.9	9.8	7.6	0.0
1998	16.8	9.2	29.0	20.5	28.2	5.1	4.8	-	7.5	5.7
Norway										
1990	23.2	10.4	27.1	29.6	33.0	8.0	4.6	4.3	10.3	11.1
1995	19.1	12.9	24.6	22.4	28.8	6.2	3.9	5.1	8.1	7.4
1999	19.5	10.1	36.4	23.4	25.6	6.8	6.4	5.8	8.6	7.5
2000	18.4	11.3	29.9	22.5	22.6	5.8	3.0	4.4	7.9	6.3
Sweden										
1990	24.1	5.0	20.9	28.8	45.7	10.4	2.5	6.1	13.7	14.5
1995	21.5	5.8	16.2	27.4	35.1	9.3	2.0	6.6	11.5	14.2
1999	19.7	5.9	18.3	23.5	35.0	8.0	2.5	7.4	10.3	10.3
2000	18.3	4.0	15.9	21.2	36.0	7.3	3.2	3.9	9.2	10.1

1 The total number comprises both men and women.

1 Totalen omfatter både mænd og kvinder.

Source: *The national registers for causes of death*

Kilde: De nationale dødsårsagsregistre

G: Chief Medical Officer

ICD-9: E950-E959 and ICD-10: X600-X849

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Table 4.7 Deaths from accidents per 100 000 inhabitants by sex and age 1990–2001
Dødsfald i ulykker pr. 100 000 indbyggere efter køn og alder 1990–2001

	Men					Women				
	Total I alt	0-14	15-24	25-64	65+	Total I alt	0-14	15-24	25-64	65+
Denmark										
1990	48.7	10.7	34.5	32.6	183.1	41.0	6.3	11.0	11.5	177.9
1995	51.2	7.3	42.7	33.2	200.0	43.3	3.4	8.5	12.8	196.9
1998	45.7	5.9	30.8	30.9	186.3	42.2	2.4	7.6	9.9	206.2
1999	48.8	7.9	36.4	30.8	203.6	43.8	3.6	6.7	11.5	210.4
Faroe Islands										
1991-95	51.2	7.0	46.1	54.7	138.3	21.7	7.6	5.4	11.7	93.8
1996-00 ¹⁾	31.1	..	..	..	..	..	..	..	..	..
Greenland										
1991-95	99.4	50.3	93.4	111.2	282.3	46.5	40.7	37.2	37.5	199.8
1996-00	94.3	51.3	71.9	105.2	289.2	29.9	13.2	35.6	27.7	122.5
Finland										
1990	78.9	11.2	53.9	86.7	210.1	35.3	5.7	18.5	18.2	133.3
1995	72.6	7.0	33.2	81.7	199.4	32.0	3.6	7.4	16.3	125.5
2000	70.8	6.0	30.8	75.6	200.4	34.4	3.0	9.3	18.9	127.7
2001	70.5	5.5	38.4	73.2	199.1	34.8	2.4	9.3	19.2	128.1
Åland										
1991-95	48.8	-	24.7	60.1	98.6	17.3	-	-	6.2	72.7
1996-00	59.6	4.1	19.2	62.1	168.4	21.0	-	7.0	10.5	77.0
Iceland										
1990	47.7	24.6	60.6	48.5	82.7	18.9	3.2	14.5	11.6	86.6
1995	51.5	26.9	47.0	56.3	96.4	35.2	34.6	14.6	31.1	78.5
1997	32.4	15.1	13.8	34.3	92.8	14.8	3.2	14.5	6.1	69.9
1998	41.6	3.0	36.9	41.0	140.8	21.2	3.2	19.3	17.9	68.0
Norway										
1990	54.4	12.1	43.4	42.2	172.5	37.9	8.7	10.0	13.6	150.1
1995	44.7	7.3	38.3	30.9	161.9	31.8	3.6	9.7	7.9	140.3
1999	44.4	7.0	37.3	26.8	195.6	33.2	4.2	7.8	8.2	175.2
2000	43.9	4.8	35.4	31.8	167.1	34.2	5.0	9.4	8.1	159.6
Sweden										
1990	41.2	5.7	35.1	31.2	124.3	26.5	4.3	12.4	8.4	99.4
1995	33.0	4.8	21.0	24.3	110.5	22.2	3.4	6.0	6.7	87.0
1999	33.1	4.5	17.1	23.1	119.5	23.5	3.0	6.0	6.1	97.3
2000	36.2	3.1	27.1	25.5	125.4	22.7	1.6	6.4	6.5	93.5

1 The total number comprises both men and women.

1 Totalen omfatter både mænd og kvinder.

Source: *The national registers for causes of death*
Kilde: De nationale dødsårsagsregistre
G: Chief Medical Officer

ICD-9: E800-E949 and ICD-10: V01-V99; W00-W99;
X00-X59; Y40.0-Y89.9

CHAPTER V

Resources

Ressourcer

Introduction

This chapter deals with resources and use of resources in the health sector. It begins with an overview of total health care expenditure, then a detailed description of expenditure on medicinal products, followed by a description of health personnel, capacity and services in hospitals.

Indledning

I dette kapitel gives der en samlet belysning af ressourcer og ressourceforbruget inden for sundhedsvæsenet. Først omtales de samlede sundhedsudgifter, med særlig omtale af udgifter til medicin, efterfulgt af sundhedspersonalet, kapacitet og ydelser i sygehusvæsenet.

Health care expenditure

Development of health care expenditure

Measured in relation to gross domestic product, since 1990 there has been a fall or a stagnation in expenditure on health services. One of the reasons for this is that, in recent years, the health services have undergone processes to rationalize the services and to improve efficiency, and new methods of treatment have come into use.

However, there are a number of problems when making international comparisons of health care expenditure. When comparisons are made in relation to GDP, the differences cover both differences in GDP and differences in health care expenditure. In addition, there are fluctuations in the exchange rates. Finally, there are structural differences in the health ser-

Sundhedsudgifter

Udviklingen i sundhedsudgifterne

Målt i forhold til BNP har der siden 1990 været et fald/stagnation i udgifterne til sundhedsvæsenet. Dette skyldes blandt andet at sundhedsvæsenet de senere år har gennemgået rationaliserings- og effektiviseringsprocesser, samtidig med at der er taget nye behandlingsformer i brug.

Det er dog forbundet med en række vanskeligheder at foretage internationale sammenligninger af sundhedsudgifterne. Når sammenligningen foretages i relation til BNP, dækker forskellene såvel over forskellene i BNP som i sundhedsudgifterne. Dertil kommer fluktuationer i landenes valutaer. Endelig er der strukturelle forskelle på de enkelte landes sundhedsvæse-

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vices of the individual countries, which, among other things, affect what is included as health care expenditure.

ner, hvilket blandt andet indebærer forskelle i, hvad der medregnes som sundhedsudgifter.

Change in the recording of health care expenditure

In order to improve the comparability of international data on the health sector, the OECD has performed a thorough revision of what should be included as health care expenditure. The most important change is that expenditure on social services for elderly people and disabled people is now included as health care expenditure. Consequently, the data differ considerably from the data presented in previous issues of this publication. It should also be noted that the OECD data differ considerably from the information on health care expenditure published by EUROSTAT according to the ESSPROS system.

For some of the countries, the OECD data also differ from what is nationally defined as health care expenditure, but as the OECD is often used as the source of data for international comparisons, NOMESCO has chosen to use the same data as OECD, in order to avoid creating even more estimations of health care expenditure.

Ændring af opgørelsesmetoden for sundhedsudgifterne

For at få mere sammenlignelige internationale data på sundhedsområdet, har OECD foretaget en gennemgribende revision af det som medtages som sundhedsudgifter, hvor den væsentligste ændring er, at den sociale service til ældre og handicappede medregnes som udgifter under sundhedsvæsenet. Derfor adskiller de medtagne data sig væsentlig i forhold til de tidligere udgivelser af denne publikation. Ligeledes skal det bemærkes at OECD's data adskiller sig væsentlig fra de oplysninger om sundhedsudgifter der publiceres af EUROSTAT efter ESSPROS systemet.

OECD's data adskiller sig også for nogle af landene, fra det som nationalt defineres som sundhedsudgifter, men da OECD oftest anvendes som kilde for internationale sammenligninger, har NOMESCO valgt at anvende samme data som OECD for ikke at skabe endnu flere opgørelsesmetoder af sundhedsudgifterne.

Developments in expenditure on medicinal products

Table 5.4 shows the total sales of medicinal products according to ATC group for each of the Nordic countries. In order to have a better basis for comparison, ex-

Udvikling i lægemiddeludgifter

I tabel 5.4. ses de samlede udgifter til lægemidler i de enkelte nordiske lande fordelt på ATC-hovedgruppe. For at få et bedre sammenligningsgrundlag er udgif-

penditure in Table 5.5 is presented in EUR per capita.	terne i tabel 5.5 omregnet til EUR per capita.
The medicinal products for which expenditure is high are largely the same in all the Nordic countries.	I alle landene er det i stor udstrækning de samme lægemidler, som vejer tungt i udgifterne.
It is difficult to compare expenditure on medicinal products in the hospital sector between countries, since hospitals pay very different prices for the same medicines, and prices are very different from prices in pharmacies in the primary health sector.	Det er dog generelt set svært at sammenligne udgifterne i denne sektor mellem landene, da sygehusene erhverver sig lægemidler til vidt forskellige priser og til helt andre priser end apotekerne i den primære sektor.
Measured in EUR per capita, expenditure on medicinal products is considerably higher in Iceland than in the other countries. The greatest difference in expenditure on medicinal products is for ATC group N.	Målt i EUR per capita har Island betydeligt større udgifter til lægemidler end de øvrige lande hvor den mest markante forskel findes i udgifterne til gruppe N.

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Table 5.1 Health care expenditure (million KR/EUR) 2000
Udgifter til sundheds- og sygepleje (mio. KR/EUR) 2000

	Denmark	Faroe Islands	Greenland	Finland ¹⁾	Iceland	Norway	Sweden
	DKK	DKK	DKK	EUR	ISK	NOK	SEK
<i>Public consumption</i> Offentligt konsum	88125	572	792	6 538	51 016	94 868	156 791
<i>Private consumption</i> Privat konsum	18 665	62	-	2 172	10 711	16 502	27 607
<i>Total health care expenditure</i> Samlede udgifter til sundheds- og sygepleje	106 790	634	792	8 710	61 727	111 370	184 398

1 Finnish figures include Åland.

1 Finske tal inkluderer Åland.

Source: OECD HEALTH DATA 2001

Kilde: FI: Statistics Faroe Islands; G: Directorate for Health; I: Statistics Iceland

Table 5.2 Health care expenditure (EUR/capita) 2000
Udgifter til sundheds- og sygepleje (EUR/capita) 2000

	Denmark	Faroe Islands	Greenland	Finland ¹⁾	Iceland	Norway	Sweden
<i>Public consumption</i> Offentligt konsum	2 215	1 669	1 903	1 262	2 498	2 605	1 908
<i>Private consumption</i> Privatkonsum	469	181	-	419	525	453	336
<i>Total health care expenditure</i> Samlede udgifter til sundheds- og sygepleje	2 684	1 850	1 903	1 681	3 015	3 058	2 234

1 Finnish figures include Åland.

1 Finske tal inkluderer Åland.

Source: OECD HEALTH DATA 2001

Kilde: FI: Statistics Faroe Islands; G: Directorate for Health; I: Statistics Iceland

Table 5.3 Health care expenditure per capita and as a percentage of GDP 1990–2000
 Udgifter til sundheds- og sygepleje pr. indbygger og i pct. af BNP 1990–2000

	Denmark	Faroe Islands	Greenland	Finland ¹⁾	Iceland	Norway	Sweden
<i>Total expenditure per capita</i>							
<i>KR/EUR 2000</i>							
Samlede udgifter pr. indbygger KR/EUR 2000	20 009	14 200	14 139	1 681	219 549	24 799	20 784
<i>GDP (million KR/EUR) 2000</i>							
BNP (mio. KR/EUR) 2000	1 296 136	8 339	8 633	131 229	658 284	1 465 096	2 196 764
<i>Expenditure in 2000–prices (million KR/EUR)</i>							
Udgifter i 2000–priser (mio. KR/EUR)							
1990	85 007	..	..	8 312	48 352	76 509	149 105
1995	91 339	532	660	7 726	50 825	90 512	141 930
1999	105 202	610	726	8 580	61 576	110 431	175 275
2000	106 790	634	792	8 710	61 727	111 370	184 398
<i>Expenditure as a percentage of GDP</i>							
Udgifter i pct. af BNP							
1990	8.5	8.2	8.8	7.9	7.8	7.8	8.2
1995	8.2	10.4	9.4	7.5	8.2	7.9	8.1
1999	8.5	8.4	9.9	6.9	9.5	8.5	8.4
2000	8.2	7.8	9.2	6.6	9.4	7.6	8.4

1 Finnish figures include Åland.

1 Finske tal inkluderer Åland.

Source: OECD HEALTH DATA 2001/2003

Kilde: FI: Statistics Faroe Islands; G: Directorate for Health; I: Statistics Iceland

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Table 5.4 Sales of medicinal products by ATC-group, calculated in pharmacy retail prices (million euro), 2001

Salg af lægemidler fordelt på ATC-grupper, apotekernes salgspris (mio. euro) 2001

	Denmark	Faroe Islands	Greenland ¹⁾	Finland ²⁾	of which Åland ²⁾	Iceland	Norway	Sweden
<i>A Alimentary tract and metabolism</i>								
Fordøjelse og stofskifte	176.8	1.6	0.3	236	1.1	17.7	193	415.8
<i>B Blood and blood-forming organs</i>								
Blod og bloddannende organer	99.9	1.1	0.2	81	0.6	8.0	81	242.8
<i>C Cardiovascular system</i>								
Hjerte og kredsløb	236.2	2.9	0.4	358	1.4	20.1	336	420.6
<i>D Dermatologicals</i>								
Hudmidler	42.4	0.3	0.3	57	0.2	4.8	45	92.8
<i>G Genito-urinary system and sex hormones</i>								
Kønshormoner m.m.	96.0	0.5	0.3	135	0.5	11.3	87	161.8
<i>H Systemic hormonal preparations, excl. sex hormones and inulins</i>								
Hormoner til systemisk brug	29.4	0.2	0.1	37	0.2	3.0	38	80.7
<i>J Anti-infectives for systemic use</i>								
Infektionssygdomme	139.6	1.2	0.7	143	0.6	11.2	87	204.4
<i>L Antineoplastic and immunomodulating agents</i>								
Cancermidler m.m.	77.9	0.4	0.1	109	0.8	9.8	103	206.3
<i>M Musculo-skeletal system</i>								
Muskler, led og knogler	65.1	0.4	0.1	130	0.6	8.5	91	118.9
<i>N Nervous system</i>								
Nervesystemet	433.3	2.4	1.1	325	1.3	43.2	330	586.8
<i>P Antiparasitic products, insecticides and repellents</i>								
Parasitmidler	9.3	0.1	0.0	5	0	0.5	4	7.4
<i>R Respiratory system</i>								
Åndedrætsorganer	176.3	1.1	0.3	175	0.9	13.0	194	229.3
<i>S Sensory organs</i>								
Sanseorganer	28.5	0.2	0.1	34	0.1	3.2	39	55.4
<i>V Various</i>								
Diverse	16.9	0.1	0.5	16	0.1	2.1	22	37.3
Total I alt	1 627.9	12.5	4.4	1 840	8.3	156.2	1 649	2 860.3
<i>Of which user charges</i>	561.6	1.6	.	819	3.6	66.9	..	576.3

Sources: D: Danish Medicines Agency; FI: Chief Pharmaceutical Officer; G: The Central Pharmacy in Copenhagen County; F & Å: National Agency for Medicines; I: Ministry of Health and Social Security; N: WHO Collaborating Centre for Drug Statistics Methodology; S: National Corporation of Swedish Pharmacies

1 Calculated on the basis of the purchase prices paid to the Hospital Pharmacy in the County of Copenhagen by Greenland's health service.

2 For Finland, sales in the primary health sector are calculated in PRP (pharmacy retail prices) and in the hospital sector in PPP (pharmacy purchase prices).

Table 5.5 Sales of medicinal products by ATC-group, EUR/capita 2001 - based on pharmacy retail prices

Salg af lægemidler fordelt på ATC-grupper, EUR/capita 2001 - baseret på apotekernes salgspris

	Denmark	Faroe Islands	Greenland	Finland	Åland	Iceland	Norway	Sweden
<i>A Alimentary tract and metabolism</i>								
Fordøjelse og stofskifte	33	35	5	45	42	62	43	47
<i>B Blood and blood-forming organs</i>								
Blod og bloddannende organer	19	24	3	16	21	28	18	27
<i>C Cardiovascular system</i>								
Hjerte og kredsløb	44	62	7	69	53	70	74	47
<i>D Dermatologicals</i>								
Hudmidler	8	6	5	11	8	17	10	10
<i>G Genito-urinary system and sex hormones</i>								
Kønshormoner m.m.	18	12	6	26	20	39	19	18
<i>H Systemic hormonal preparations, excl. sex hormones and inulins</i>								
Hormoner til systemisk brug	5	4	2	7	8	10	8	9
<i>J Anti-infectives for systemic use</i>								
Infektionssygdomme	26	26	12	27	24	39	19	23
<i>L Antineoplastic and immunomodulating agents</i>								
Cancermidler m.m.	15	8	1	21	29	34	23	23
<i>M Musculo-skeletal system</i>								
Muskler, led og knogler	12	9	2	25	21	30	20	13
<i>N Nervous system</i>								
Nervesystemet	81	52	20	63	51	151	73	66
<i>P Antiparasitic products, insecticides and repellents</i>								
Parasitmidler	2	1	0	1	1	2	1	1
<i>R Respiratory system</i>								
Åndedrætsorganer	33	24	5	34	33	45	43	26
<i>S Sensory organs</i>								
Sanseorganer	5	4	2	7	6	11	9	6
<i>V Various</i>								
Diverse	3	3	9	3	3	7	5	4
<i>Total I alt</i>	304	269	78	354	319	546	365	322
<i>Of which user charges</i>	105	35	.	158	138	234	..	65

Sources: See Table 5.4

Kilder: Se tabel 5.4

Health personnel

Statistics on health personnel in the health services are very incomplete, and it is therefore difficult to compare the situation in the Nordic countries. For some countries, the statistics include information about the number of people employed, whereas in other countries they include information about the number of people trained for each category of health personnel.

In order to give a more accurate picture of health personnel in the health services, the number of physicians, state registered nurses, state enrolled nurses, midwives and physiotherapists has been converted into 'man-years', where possible. The figures show the total number of 'man-years' and the number of 'man-years' for hospital employees.

There are large differences in the use of health personnel in different countries, both in total and for the different categories of health personnel.

Sundhedspersonale

De statistiske oplysninger om personaleforbruget i sundhedsvæsenet er yderst mangelfulde, og det kan derfor være vanskeligt at give et sammenligneligt billede af forholdene i de nordiske lande. I nogle lande indgår således oplysninger om antallet af erhvervsaktive i statistikken, og i andre lande indeholder tallene også oplysninger om antallet af uddannede inden for de respektive personalekategorier.

For at give et mere præcist billede af personaleforbruget til sundhedsydelser, er der, i det omfang det har været muligt, foretaget en omregning af antal læger, sygeplejersker, sygehjælpere, jordemødre og fysioterapeuter til årsværk. Beregningen viser dels årsværk i alt, dels antal årsværk for ansatte ved sygehuse.

Der er betydelige forskelle i personaleforbruget, både totalt set og inden for de enkelte personalekategorier mellem landene.

Table 5.6 Active health personnel in total calculated as full time equivalents 2001
Erhvervsaktivt sundhedspersonale i alt omregnet til årsværk 2001

	Denmark ¹⁾	Faroe ²⁾ Islands	Greenland	Finland ⁵⁾	of which Åland	Iceland ⁶⁾	Norway ⁷⁾	Sweden ⁸⁾
<i>Physicians</i>								
Læger	19 600	90	85	16 110	62	938	13 059	25 382
<i>Dentists</i>								
Tandlæger	4 834	38	34	4 731	20	278	3 666	7 111
<i>Qualified nurses</i>								
Sygeplejersker	51 990	366	222	73 260	286	1 674	44 405	83 423
<i>Qualified auxiliary nurses</i>								
Sygehjælpere	38 709	79	174 ³⁾	29 275	247	1 106	38 545	92 468
<i>Midwives</i>								
Jordemødre	1 399	20	8 ⁴⁾	3 980	10	142	1 450	⁹⁾
<i>Physiotherapists</i>								
Fysioterapeuter	7 059	17	12	10 386	25	288	5 178	8 243
Total I alt	123 591	610	535	137 742	650	4 426	106 303	216 627

1 All figures are head-counts for 2002, except the number for qualified auxiliary nurses, which is full-time equivalents/'man-years' for 2000.

2 Only physiotherapists employed in hospitals.

3 Qualified auxiliary nurses are health workers with independent skills.

4 In addition to midwives, health workers and birth assistants assist at births.

5 The Finnish data are for health workers of working age, not for health workers actually in employment. This leads to a large overestimation, particularly for nurses.

6 1999.

7 Figures cover the municipal and county health care services with the exception of dentists.

8 2000.

9 Midwives incl. under qualified nurses.

1 Alle tal er uddannede personer for 2002, undtagen sygehjælpere, der er årsværk for 2000.

2 Fysioterapeuter omfatter kun hospitalsansatte.

3 Sygehjælpere er sundhedsmedhjælpere med selvstændig kompetence.

4 Ud over jordemødre varetager sundhedsmedhjælpere og fødselsmedhjælpere fødsler.

5 De finske data er registrerede i den erhvervsaktive alder, ikke erhvervsaktive, hvilket især for sygeplejersker giver en stor overestimation.

6 1999.

7 Tallene dækker den kommunale og amtskommunale sundhedsservice med undtagelse af tandlægerne.

8 2000.

9 Jordemødre er inkluderet under sygeplejersker.

Source: D: National Board of Health; FI: Hospital Board; G: Personaledirektoratet; F: STAKES; Å: Government of the Åland Islands; I: Directorate of Health; N: Statistics Norway and Norwegian Board of Health; S: Federation of Swedish County Councils, Swedish Association of Local Authorities, Statens Arbejdsgivarverk and Privattandlækarna

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Table 5.7 Active health personnel employed in hospitals calculated as full time equivalents 2001

Erhvervsaktivt sundhedspersonale ansat ved sygehuse omregnet til årsværk 2001

	Denmark ¹⁾	Faroe ²⁾ Islands	Greenland ³⁾	Finland ⁴⁾	of which Åland	Iceland ⁵⁾	Norway ⁶⁾	Sweden
<i>Physicians</i>								
Læger	10 722	63	83	7 300	42	575	8 206	..
<i>Dentists</i>								
Tandlæger	48	1	1	55	-	..	..	..
<i>Qualified nurses</i>								
Sygeplejersker	30 069	271	222	..	204	1 158	24 836	..
<i>Qualified auxiliary nurses</i>								
Sygehjælpere	10 850	51	174	..	135	676	7 760	..
<i>Midwives</i>								
Jordemødre	733	20	8	..	10	110	1 172	..
<i>Physiotherapists</i>								
Fysioterapeuter	2 696	17	12	..	13	88	1 066	..
<i>Total</i>								
I alt	55 118	424	500	..	404	2 607	43 040	..

1 The number for physiotherapists also include some ergotherapists (occupational therapists).

2 See Table 5.6.

3 See Table 5.6.

4 See Table 5.6.

5 See Table 5.6.

6 See Table 5.6.

1 Tallet for fysioterapeuter inkluderer nogle ergoterapeuter (erhvervs terapeuter).

2 Se tabel 5.6.

3 Se tabel 5.6.

4 Se tabel 5.6.

5 Se tabel 5.6.

6 Se tabel 5.6.

Source: See Table 5.6

Kilde: Se tabel 5.6

F: Finnish Medical Association and Finnish Dental Association

Table 5.8 Active health personnel in total per 100 000 inhabitants calculated as full time equivalents 2001

Erhvervsaktivt sundhedspersonale i alt pr. 100 000 indbyggere omregnet til årsværk 2001

	Denmark ¹⁾	Faroe Islands	Greenland ²⁾	Finland ³⁾	Åland	Iceland ⁴⁾	Norway ⁵⁾	Sweden ⁶⁾
<i>Physicians</i>								
Læger	365	193	151	310	239	336	289	286
<i>Dentists</i>								
Tandlæger	90	82	60	91	77	100	81	80
<i>Qualified nurses</i>								
Sygeplejersker	967	785	394	1 410	1 105	600	984	939
<i>Qualified auxiliary nurses</i>								
Sygehjælpere	725	170	309	563	954	396	854	1 041
<i>Midwives</i>								
Jordemødre	26	43	15	76	39	51	32	⁷⁾
<i>Physiotherapists</i>								
Fysioterapeuter	131	36	22	199	97	103	115	93
<i>Total</i>								
I alt	2 304	1 309	951	2 651	2 511	1 586	2 355	2 439

1 See notes in Table 5.6.

2 See notes in Table 5.6.

3 See notes in Table 5.6.

4 See notes in Table 5.6.

5 See notes in Table 5.6.

6 See notes in Table 5.6.

7 See notes in Table 5.6.

1 Se noter til tabel 5.6.

2 Se noter til tabel 5.6.

3 Se noter til tabel 5.6.

4 Se noter til tabel 5.6.

5 Se noter til tabel 5.6.

6 Se noter til tabel 5.6.

7 Se noter til tabel 5.6.

Source: See Table 5.6

Kilde: Se tabel 5.6

RESOURCES

Table 5.9 Active health personnel employed in hospitals per 100 000 inhabitants calculated as full time equivalents 2001

Erhvervsaktivt sundhedspersonale ansat ved sygehuse pr. 100 000 indbyggere omregnet til årsværk 2001

	Denmark ¹⁾	Faroe Islands	Greenland ²⁾	Finland ³⁾	Åland	Iceland ⁴⁾	Norway ⁵⁾	Sweden
<i>Physicians</i>								
Læger	200	135	148	140	162	206	182	..
<i>Dentists</i>								
Tandlæger	1	2	2	..	-	..		..
<i>Qualified nurses</i>								
Sygeplejersker	562	582	394	..	788	415	550	..
<i>Qualified auxiliary nurses</i>								
Sygehjælpere	203	109	309	..	521	242	172	..
<i>Midwives</i>								
Jordemødre	14	43	15	..	39	39	26	..
<i>Physiotherapists</i>								
Fysioterapeuter	50	36	22	..	50	31	24	..
<i>Total</i>								
I alt	1 030	910	889	..	1 560	934	954	..

1 See notes in Table 5.6.

2 See notes in Table 5.6.

3 See notes in Table 5.6.

4 See notes in Table 5.6.

5 See notes in Table 5.6.

1 Se noter til tabel 5.6.

2 Se noter til tabel 5.6.

3 Se noter til tabel 5.6.

4 Se noter til tabel 5.6.

5 Se noter til tabel 5.6.

Source: See Table 5.7

Kilde: Se tabel 5.7

F: Finnish Medical Association and Finnish Dental Association

Table 5.10 Working physicians by specialist group 2001
Erhvervsaktive læger efter beskæftigelsesområde 2001

	Denmark ¹⁾	Faroe Islands	Greenland	Finland	of which Åland	Iceland ²⁾	Norway ⁴⁾	Sweden ⁶⁾
<i>Physicians, total</i> Læger i alt	18 330	90	85	15 150	62	938	16 828	27 500
<i>of which:</i> heraf:								
<i>Hospital health service</i> Sygehuse	10 933	63	83	7 300	42	..	9 111	18 000
<i>Non-hospital health service</i> Sundhedsvæsen uden for sygehuse	7 397	27	2	7 850	20	..	6 402	9 500
<i>of which:</i> heraf:								
<i>General practitioners</i> Alment praktiserende læger	3 541	24	-	4 370	15	184	4 327	5 000
<i>Practising specialists</i> Praktiserende speciallæger	1 310	1	-	1 320	4	52 ³⁾	861	2 000
<i>Administrative medicine</i> Administrativ medicin		1	2	400	1	..	282	-
<i>Medical research, education, etc.</i> Medicinsk forskning, undervisning m.m.		1	-	1 210	-	..	638	2 000
<i>Other medical work</i> Andet medicinsk arbejde	2 546	-	-	550	-	..	1 609 ⁵⁾	500

1 For hospitals the Wage and Employment register, for other employed information from the union.

2 1999.

3 Only practising specialists who are not employed at a hospital.

4 Includes 294 occupational physicians and 169 physicians without a stated occupation.

5 As per 10.12.2002.

6 2000. Members of the Swedish Medical Association.

1 For hospitalsansatte Løn- og beskæftigelsesregisteret, øvrige tal fagforeningen.

2 1999.

3 Kun praktiserende speciallæger der ikke er ansat ved sygehus.

4 Omfatter 294 virksomhedslæger og 169 læger med uoplyst erhverv.

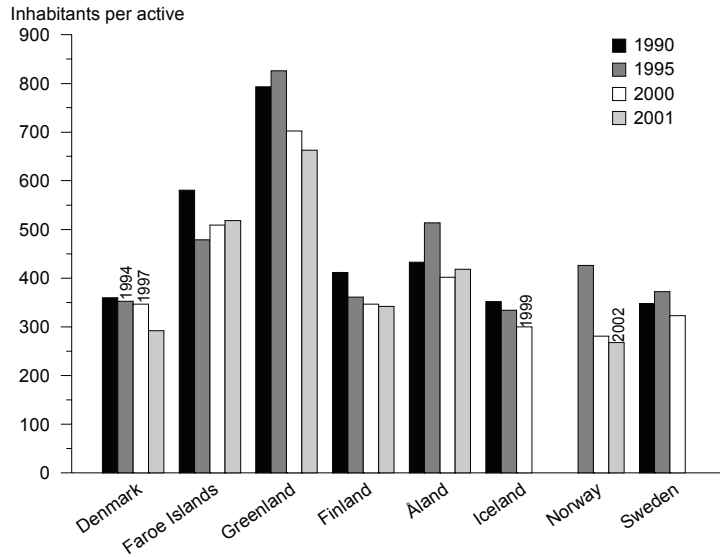
5 Per 10.12.2002.

6 2000. Medlemmer af Sveriges Läkareförbund.

Source: D: National Board of Health; FI: Chief Medical Officer; G: Directorate for Health; F: Finnish Medical Association; Å: Landskapsstyrelsen; I: Directorate of Health; N: Norwegian Medical Association; S: Swedish Medical Association

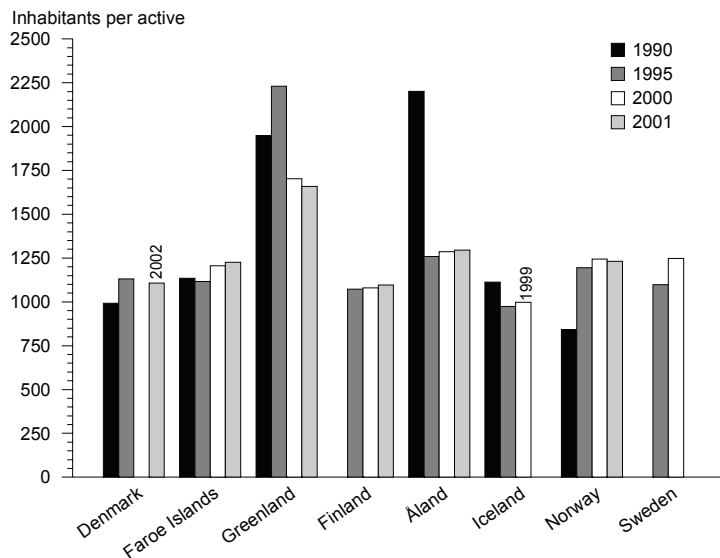
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Figure 5.1 Inhabitants per working physician 1990-2001
 Indbyggere pr. erhvervsaktiv læge 1990-2001



Source: Table 5.10
 Kilde: Tabel 5.10

Figure 5.2 Inhabitants per working dentist 1990-2001
 Indbyggere pr. erhvervsaktiv tandlæge 1990-2001



Source: Table 5.6
 Kilde: Tabel 5.6

Capacity and services in hospitals

For many years, there has been a trend in the Nordic countries to close down small hospitals. Resources have been concentrated in fewer units, often involving a division of work in the most specialized areas. Units have often been merged administratively, not necessarily leading to fewer physical units. No hospitals have been closed down in Norway during the last few years, but some of the existing hospitals have become smaller.

Another trend in the Nordic countries is that psychiatric hospitals have been closed down, however, to varying degrees.

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

The statistics in the tables about hospitals have been divided up so that developments for the different types of hospitals can be followed.

Ordinary hospitals are hospitals with several specialities that primarily provide short-term somatic treatment, and also short-term psychiatric treatment.

Kapacitet og ydelser i sygehusvæsenet

Det er et kendetegn ved de nordiske landes sygehusvæsen, at man i en årrække har nedlagt sygehuse, og ressourcerne er blevet samlet på færre enheder, og oftest med en arbejdsdeling på de mest specialiserede områder. Ofte er det tale om en organisatorisk administrativ sammenlægning, som ikke nødvendigvis behøver at medfører færre fysiske enheder. I Norge er der ikke nedlagt hospitaler de seneste år, men de eksisterende hospitaler er ofte blevet mindre.

Det er ligeledes et kendetegn, at egentlige psykiatriske hospitaler er under afvikling i de nordiske lande, dog i forskelligt tempo.

I Grønland, Finland og Island er strukturen dog lidt anderledes, idet der til sundhedscentrene er knyttet et antal sengepladser, som i tabellerne er rubriceret under andre hospitaler. En del af disse sengepladser er dog plejepladser, som i de andre lande findes ved alders- og plejehjemmene. Dette medfører, især for Finland og Islands vedkommende, at man får et betydeligt større antal sengepladser i forhold til befolkningen, end i de andre lande.

I tabellerne over sygehuse er der foretaget en opdeling, således at man kan følge udviklingen i de forskellige typer sygehuse.

Almindelige sygehuse er sygehuse med flere specialer og beskæftiger sig i hovedsagen med somatisk korttidsbehandling, men inkluderer også korttidspsykiatrisk behandling.

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The category 'specialized hospitals' includes hospitals that only have one speciality within somatic treatment.	Under rubrikken 'Specialsygehuse', er der opregnet sygehuse, som kun har et enkelt speciale inden for den somatiske behandling.
Psychiatric hospitals are hospitals that only provide treatment for psychiatric patients. The category 'other hospitals' includes hospitals that provide geriatric and psychiatric care and/or long-term treatment in health centres with mixed medical and surgical wards.	Psykiatriske sygehuse er sygehuse, som kun behandler psykiatriske patienter. Rubrikken 'Andre sygehuse' omfatter sygehuse med geriatrisk og psykiatrisk pleje og/eller langtidsbehandling ved helsecentre med blandede medicinske og kirurgiske afdelinger.
Hospital beds are divided into medical, surgical, psychiatric and other beds. It is clearly indicated that, particularly for Finland and Iceland, the category 'other', includes activities that are not included in the other countries.	Sengepladserne ved sygehusene er fordelt på medicin, kirurgi, psykiatri og andet. Det fremgår klart, at det først og fremmest er Finland og Island som under rubrikken 'Andet' medregner aktiviteter, som ikke medtages af de øvrige lande.
The tables about hospital discharges and average length of stay apply to patients admitted to ordinary hospitals and specialized hospitals. This limitation has been done in order to improve comparability between the countries.	Tabellerne over udskrivninger og gennemsnitlig liggetid omfatter indlagte patienter ved almindelige sygehuse og specialsygehuse. Denne afgrænsning er foretaget for at fremme sammenligneligheden mellem landene.
The trend is that the number of treatment places and the average length of stay has been reduced in ordinary hospitals. Within psychiatric treatment there has been a trend towards the use of more out-patient treatment, so that the number of psychiatric beds has been reduced.	Tendensen er, at antallet af behandlingspladser og den gennemsnitlige liggetid reduceres på de almindelige sygehuse. Inden for den psykiatriske behandling har der været en udvikling hen imod mere ambulante behandlingsformer, hvorfor antallet af psykiatriske sengepladser er blevet reduceret.

Table 5.11 Number of hospitals by number of beds 2001
 Sygehuse efter antal sengepladser 2001

	Denmark	Faroe Islands	Greenland	Finland	of which Åland	Iceland	Norway	Sweden
<i>Ordinary hospitals</i>								
<i>Almindelige sygehuse</i>								
-199	21	2	16	49	1	2	40	32
200-499	19	1	-	17	-	-	16	29
500-799	6	-	-	5	-	-	4	9
800+	8	-	-	3	-	1	2	6
<i>Total I alt</i>	54	3	16	74	1	3	62	76
<i>Specialized hospitals</i>								
<i>Specialsygehuse</i>								
-199	6	-	-	8	-	-	7	-
200-499	-	-	-	-	-	-	1	-
500-799	-	-	-	-	-	-	-	-
800+	-	-	-	-	-	-	-	-
<i>Total I alt</i>	6	-	-	8	-	-	8	-
<i>Psychiatric hospitals</i>								
<i>Psykiatriske sygehuse</i>								
-199	6	-	-	18	1	-	12	-
200-499	3	-	-	4	-	-	-	-
500-799	-	-	-	1	-	-	-	-
800+	-	-	-	1	-	-	-	-
<i>Total I alt</i>	9	-	-	24	1	-	12	-
<i>Other hospitals</i>								
<i>Andre sygehuse</i>								
-199	-	-	-	269	1	20	33	-
200-499	-	-	-	11	-	-	-	-
500-799	-	-	-	2	-	-	-	-
800+	-	-	-	1	-	-	-	-
<i>Total I alt</i>	-	-	-	283	1	20	33	-
<i>Hospitals, total</i>								
<i>Sygehuse, i alt</i>	69	3	16	389	3	23	115	76

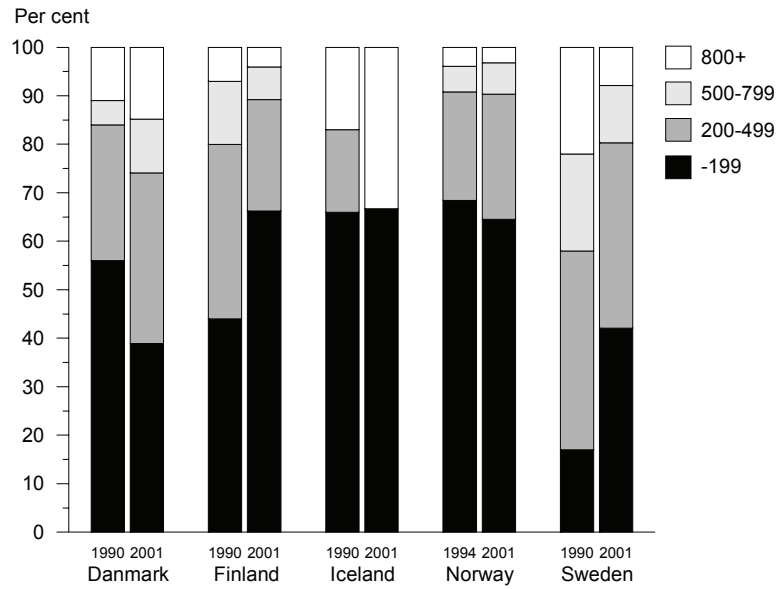
Note: Ordinary hospitals are hospitals that mainly provide treatment for patients with somatic diseases. Specialized hospitals are hospitals with only one speciality. Psychiatric hospitals are hospitals that only provide treatment for patients with psychiatric disorders (excl. psychiatric nursing homes). Other hospitals include hospitals providing long-term medical care as well as hospitals that cannot be categorized in the above, e.g. the Finnish health centres.

Anmærkning: Ved almindelige sygehuse forstås sygehuse, som overvejende behandler somatiske patienter. Specialsygehuse er sygehuse med kun ét speciale. Til psykiatriske sygehuse henregnes sygehuse, der udelukkende behandler psykiatriske patienter (dog ekskl. psykiatriske plejehjem). Andre sygehuse omfatter langtidsmedicinske sygehuse og sygehuse, der ikke kan kategoriseres i ovenstående, fx de finske helsevårdscentraler.

Source: D: National Board of Health; FI: Hospital Board; G: Directorate for Health; F: STAKES; Å: Government of the Åland Islands; I: Ministry of Health and Social Security; N: Statistics Norway; S: Federation of Swedish County Councils

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Figure 5.3 Number of ordinary hospitals by number of beds 1990 and 2001
 Antal almindelige sygehuse fordelt efter antal senge 1990 og 2001



Source: Table 5.11
 Kilde: Tabel 5.11

Table 5.12 Authorized hospital beds by speciality 2001
Normerede sengepladser ved sygehuse efter specialer 2001

	Denmark	Faroe Islands	Greenland	Finland ²⁾	of which Åland	Iceland ³⁾	Norway	Sweden ⁴⁾
<i>Number</i>								
<i>Antal</i>								
<i>Medicine</i>								
Medicin	10.565	94	46	7 025	62	586	6 597	13 958
<i>Surgery</i>								
Kirurgi	8.008	95	54	5 208	45	417	6 472	8 756
<i>Psychiatry</i>								
Psykiatri	4.031	76	18	5 077	32	315	2 905	3 368
<i>Other</i>								
Andet	-	-	286 ¹⁾	20 914	98	1 114	1 034	-
<i>Total</i>								
I alt	22.604	265	404	38 224	237	2 432	17 008	26 082
<i>Beds per 100 000 inhabitants</i>								
<i>Sengepladser pr. 100 000 indbyggere</i>								
<i>Medicine</i>								
Medicin	197	202	82	135	239	157	147	157
<i>Surgery</i>								
Kirurgi	149	204	96	100	174	156	144	98
<i>Psychiatry</i>								
Psykiatri	75	163	32	98	124	118	65	38
<i>Other</i>								
Andet	-	-	510 ¹⁾	403	378	479	23	-
<i>Total</i>								
I alt	421	570	720	737	915	910	378	293

1 Excl. patient hotel.

2 The number of beds has been calculated by dividing the total number of bed-days by 365.

3 Refers to 1995. Calculated from bed-days and a 90 per cent bed occupancy rate. Beds in mixed medical and surgical wards in small hospitals are included under "Medicine". "Other" includes beds in geriatric wards, for rehabilitation, and long-term care in hospitals (incl. ordinary hospitals).

4 Average disposable beds.

1 Ekskl. patienthotel.

2 Antallet af senge er beregnet ved at dividere det totale antal sengedage med 365.

3 Vedrører 1995. Beregnet på basis af sengedage og en belægningsprocent på 90. Under "Medicin" medregnes senge i blandede medicinske og kirurgiske afdelinger ved de små sygehuse. "Andet" omfatter sengepladser i geriatri, genoptræning og langtidspleje på hospitaler (inkl. almindelige hospitaler).

4 Gennemsnitligt disponible sengepladser.

Source: D, FI, G, F, Å, I & N: See Table 5.11

Kilde: D, FI, G, F, Å, I & N: Se tabel 5.11

Å: Government of the Åland Islands; S: National Board of Health and Welfare & Federation of Swedish County Councils

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Table 5.13 Discharges, bed days and average length of stay in wards in ordinary hospitals and specialized hospitals 2001

Udskrivninger, sengedage og gennemsnitlig liggetid på afdelinger ved almindelige sygehuse og specialsygehuse 2001

	Denmark	Faroe Islands	Greenland ¹⁾	Finland	Åland ²⁾	Iceland ³⁾	Norway	Sweden
<i>Discharges per 1 000 inhabitants</i>								
Udskrivninger pr. 1 000 indbyggere								
<i>Medicine</i>								
Medicin	99	127	27	84	109	93	76	74
<i>Surgery</i>								
Kirurgi	93	131	52	111	118	88	78	70
<i>Psychiatry</i>								
Psykiatri	8	7	3	10	10	7	6	8
<i>Total</i>								
I alt	200	265	82	205	237	195	161	152
<i>Bed-days per 1 000 inhabitants</i>								
Sengedage pr. 1 000 indbyggere								
<i>Medicine</i>								
Medicin	615	606	208	487	654	636	468	386
<i>Surgery</i>								
Kirurgi	420	693	346	365	447	433	407	314
<i>Psychiatry</i>								
Psykiatri	256	469	45	366	367	381	237	159
<i>Total</i>								
I alt	1.291	1 768	599	1 219	1 468	1 786	1 113	974
<i>Average length of stay</i>								
Gennemsnitlig liggetid								
<i>Medicine</i>								
Medicin	6	5	8	6	6	7	6	5
<i>Surgery</i>								
Kirurgi	7	5	7	3	4	5	5	4
<i>Psychiatry</i>								
Psykiatri	..	67	18	40	36	52	41	20
<i>Total</i>								
I alt	..	7	7.0	6	6	9	7	6

1 Figures for average length of stay only refer to Dronning Ingrid's Hospital.

2 2000.

3 Refers to 1995. Incl. patients who have been admitted to small hospitals for less than 90 days. The total includes rehabilitation, geriatrics and long-term care in ordinary hospitals.

1 Tallene for den gennemsnitlige liggetid omfatter kun Dronning Ingrid's Hospital.

2 2000.

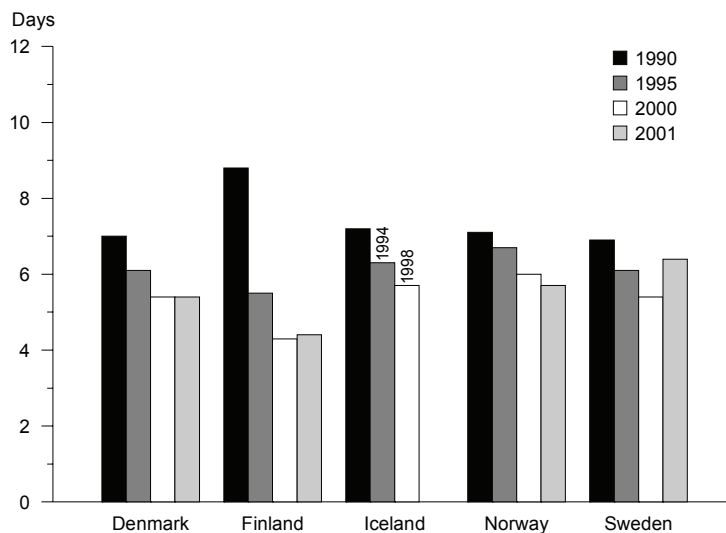
3 Vedrører 1995. Inkl. patienter, der har været indlagt ved små sygehuse i mindre end 90 dage. I sumtotalerne medregnes revalidering, geriatri og langtidspleje ved almindelige sygehuse.

Source: D, FI, G, F, Å, I & N: See Table 3.19.

Kilde: D, FI, G, F, Å, I & N: Se tabel 3.19.

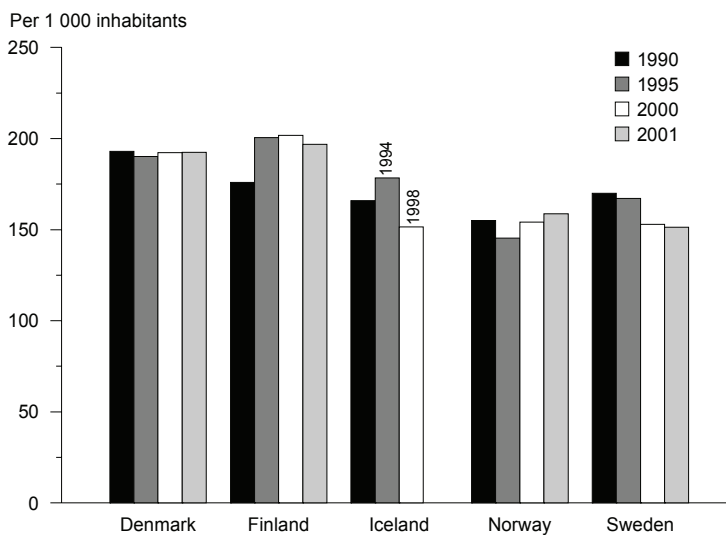
S: National Board of Health and Welfare

Figure 5.4 Average length of stay in somatic wards 1990–2001
Gennemsnitlig liggetid på somatiske afdelinger 1990–2001



Source: Table 3.20
Kilde: Tabel 3.20

Figure 5.5 Number of discharges from somatic wards, per 1 000 inhabitants 1990–2001
Udskrivninger fra somatiske afdelinger pr. 1 000 indbyggere 1990–2001



Source: Table 3.19
Kilde: Tabel 3.19

RESOURCES

Table 5.14 Discharges from hospitals* by sex and age, per 1 000 inhabitants in the age group 2001

Udskrivninger fra sygehuse* efter køn og alder, pr. 1 000 indbyggere i aldersgruppen 2001

	Denmark	Faroe Islands ¹⁾	Greenland	Finland	Åland	Iceland ²⁾	Norway	Sweden
<i>Age</i> Alder								
<i>Men</i>								
Mænd								
0-14	128	169	128	134	158	91	104	71
15-44	82	91	} 141	88	77	54	87	63
45-64	186	289		202	186	138	204	148
65-69	367	495	} 756	374	406	346	429	294
70-74	475	522		491	459	431	523	399
75-79	596	813		633	603	544	674	520
80+	718	626		730	781	643	755	671
<i>Total</i>								
I alt	173	214	165	180	188	122	182	146
<i>Women</i>								
Kvinder								
0-14	95	115	115	105	122	83	82	58
15-44	185	216	} 373	178	201	187	167	138
45-64	170	197		196	189	162	183	134
65-69	296	592	} 788	301	258	269	291	229
70-74	373	491		385	322	311	378	306
75-79	451	416		489	458	404	447	406
80+	569	486		549	619	494	540	544
<i>Total</i>								
I alt	206	230	324	216	229	181	200	172

1 Including psychiatric wards.

2 1998. Wards in specialized hospitals excl. psychiatry, rehabilitation, geriatrics and nursing wards, though only discharges for stays in hospital shorter than 90 days.

1 Inklusiv psykiatriske afsnit.

2 1998. Afdelinger ved specialiserede sygehuse ekskl. psykiatri, genoptræning, geriatri og sygepleje. Dog kun udskrivninger ved indlæggelsestider på mindre end 90 dage.

* Comprises somatic wards in ordinary hospitals and in specialized somatic hospitals.

* Omfatter somatiske afdelinger ved almindelige sygehuse og ved somatiske specialsygehuse.

Source: D, FI, G, F, I & N: See Table 3.19

Kilde: D, FI, G, F, I & N: Se tabel 3.19

Å: STAKES; S: National Board of Health and Welfare

Table 5.15 Bed days in hospitals* by sex and age, per 1 000 inhabitants in the age group 2001
 Sengedage på sygehuse* efter køn og alder, pr. 1 000 indbyggere i aldersgruppen 2001

	Denmark	Faroe Islands ¹⁾	Greenland ²⁾	Finland	Åland	Iceland ³⁾	Norway	Sweden
<i>Age</i> Alder								
<i>Men</i>								
Mænd								
0-14	419	359	521	376	500	393	381	278
15-44	293	343	} 844	281	192	207	267	394
45-64	968	1 325		867	804	737	792	837
65-69	2 247	2 426	} 6 321	1 917	2 333	2 306	1 990	1 752
70-74	3 143	2 950		2 679	3 575	3 366	2 758	2 584
75-79	4 295	4 589		4 046	4 424	4 605	3 644	3 669
80+	5 498	6 710		6 027	6 596	6 574	4 787	4 964
<i>Total</i>								
I alt	912	991	1 004	813	962	739	790	900
<i>Women</i>								
Kvinder								
0-14	345	311	437	308	315	339	308	240
15-44	616	740	} 1 721	545	715	651	609	593
45-64	872	974		719	815	823	804	770
65-69	1 972	2 346	} 6 827	1 397	1 413	1 891	1 634	1 456
70-74	2 751	3 973		2 007	2 238	2 748	2 193	2 083
75-79	3 726	3 875		2 800	4 237	3 860	2 891	3 085
80+	5 228	5 388		3 764	6 557	5 727	3 932	4 406
<i>Total</i>								
I alt	1 128	1 186	1 658	905	1 288	977	978	1 035

1 Including psychiatric wards.

2 Some women from villages are admitted to hospital up to one month before the expected date of delivery.

3 1998. Wards in specialized hospitals excl. psychiatry, rehabilitation, geriatrics and nursing wards, though only discharges for stays in hospital shorter than 90 days.

1 Inklusiv psykiatriske afsnit.

2 En del kvinder fra bygderne indlægges op til en måned før termin.

3 1998. Afdelinger ved specialiserede sygehuse ekskl. psykiatri, genoptræning, geriatri og sygepleje. Dog kun udskrivninger ved indlæggelsestider på mindre end 90 dage.

* Definition, see Table 3.19

* Definition, se tabel 3.19

Source: D, FI, G, F, I & N: See Table 3.19

Kilde: D, FI, G, F, I & N: Se tabel 3.19

Å: STAKES; S: National Board of Health and Welfare

THEME SECTION

SECTION B

BJÖRN SMEDBY

Validity and comparability of Nordic day surgery statistics

Validitet och jämförbarhet i NOMESKO:s dagkirurgistatistik

Background

For the past five years, NOMESCO, in its yearly report "Health Statistics in the Nordic Countries", has presented statistics that illustrate how, to an increasing degree, there has been a trend away from carrying out traditional surgical procedures on in-patients in hospitals, towards carrying out surgical procedures on an out-patient basis. The driving force behind this trend in surgical practice has not only been to save health care resources, but also to reduce the time that patients are sick, and to facilitate their recovery. An important prerequisite for this trend has been the development of less invasive surgical techniques, such as laparoscopy and endoscopy. Organizational changes have also been important for making it possible to carry out so-called day care or day surgery, where the patient only stays in hospital for a few hours in connection with the surgery. New methods have been developed for pre-operative assessment of patients, for care of patients in connection with the actual operation, and for after-care of patients in their home.

Up until now, no attempt has been made in NOMESCO's statistics to reflect day surgery activity as a whole. Instead, sta-

Bakgrund

NOMESKO har de senaste fem åren i sin årliga rapport "Helsestatistik for de nordiske lande" också redovisat vissa uppgifter vars främsta syfte har varit att belysa hur man i ökande utsträckning gått över från traditionell operation av patienter som varit intagna på sjukhus till polikliniskt utförda operationer. Drivkraften för denna poliklinisering av den kirurgiska verksamheten har varit inte bara en strävan att spara sjukvårdsresurser utan också en önskan att förkorta patienternas sjukdomstid och underlätta deras tillfrisknande. Viktiga förutsättningar har varit kirurgins utveckling mot mindre omfattande ingrepp, till exempel genom laparoskopiska och endoskopiska metoder. Viktiga är också de organisatoriska förändringar som möjliggjort så kallad dagvård eller dagkirurgi, där patienten endast stannar på sjukhuset några timmar i samband med ingreppet. Nya former har utvecklats för den preoperativa utredningen av patienterna, för omhändertagandet i samband med själva operationen och för eftervården i hemmet.

NOMESKO:s hittillsvarande statistik har inte försökt spegla den dagkirurgiska verksamheten som helhet, utan man har

tistics for twelve selected common surgical procedures or surgical procedure groups have been presented. These can be regarded as indicators of the general trend. The selected surgical procedure groups are among those that are carried out both as day surgery and as in-patient surgery. The central result variable is the proportion of all surgical procedures of that type performed in the health services that are performed as day surgery.

It has proved to be very difficult to compile statistics of surgical procedures carried out as day surgery for the different countries. In 1997 and 1998, which were the first two years with available statistics, only Denmark and Finland could provide statistics. In 1999, statistics became available for Norway. It was not until 2001, however, that statistics became available for all the five Nordic countries. With this background in mind, it is interesting to look at the experience gained and the difficulties encountered in compiling and interpreting the statistics on day surgery in the Nordic countries.

Special theme

At the plenary meeting of NOMESCO in Mariehamn in June 2002, it was decided that the special theme for the current edition of *Health Statistics in the Nordic Countries* should be day surgery. This was a natural follow-up of the previous year's theme, which was validity and comparability of the statistics of surgical procedures in Nordic hospitals [1]. The report indicated the need for a more thorough study of day surgery and other out-patient surgery, in order to improve

valt att redovisa förekomsten av tolv särskilt utvalda, vanliga operationer eller operationsgrupper. Dessa kan ses som indikatorer på en mer allmänt förekommande poliklinisering. De valda operationsgrupperna är sådana som utförs både som dagkirurgi och som operationer på intagna patienter. Den centrala resultatvariabeln är andelen operationer som utförts som dagkirurgi av samtliga i sjukvården utförda operationer av samma slag.

Det har funnits stora svårigheter att på nationell nivå få till stånd en redovisning av dagkirurgiskt utförda operationer. För 1997 och 1998, som var de första två åren för vilka dagkirurgisk verksamhet redovisades, kunde endast Danmark och Finland lämna uppgifter. År 1999 tillkom uppgifter från Norge men först med denna redovisning som avser år 2001 föreligger uppgifter från samtliga fem nordiska länder. Mot denna bakgrund är det av intresse att söka belysa erfarenheter och svårigheter när det gäller att ta fram och tolka statistiken över dagkirurgisk verksamhet i de nordiska länderna.

Uppdraget

Vid NOMESCO:s plenarmöte i Mariehamn i juni 2002 beslutades att temasektionen för innevarande års hälsostatistiska årsbok skulle gälla dagkirurgi. Det skulle bli en naturlig uppföljning av föregående års tema som var validitet och jämförbarhet av statistiken över kirurgiska ingrepp vid nordiska sjukhus [1]. Den genomgången visade på behovet av att mer ingående studera dagkirurgi och annan poliklinisk kirurgi för att bättre förstå de skillnader som finns mellan de nordis-

our understanding of the differences between the Nordic countries with regard to in-patients and surgical treatment in general.

The mandate for this year's theme section was to aim to create a clear and unequivocal definition of the concept of day surgery, and to describe day surgery services and their development over time. The list of twelve surgical procedure groups was to be assessed to see whether it should be revised or extended. It was also intended that the report should aim to describe the amount of day surgery carried out in private health institutions that is not included in the current statistics. One question is whether the payment systems for day surgery in the different countries could be used for collecting additional statistics on this activity.

The aim was thus to make proposals for improving the statistics that NOMESCO collects on day-surgery.

Professor Björn Smedby, former head of the Nordic Centre for Classifications in Health Care, has been responsible for the report. However, important contributions to the report have been made by several statistical and clinical specialists from the Nordic countries, who have functioned as contact persons. Statistics from the different countries have primarily been discussed with Jakob Lyng Sandegaard, Denmark, Oleg Nikiforov and Hannu Rintanen, Finland, Gudrun Gudfinnsdottir, Iceland, Ola Kindseth and Leena Kiviluoto, Norway, and Leif Forsberg and Curt-Lennart Spetz, Sweden. Other specialists who have made valuable contributions are Glen Thorsen, Norway,

ka länderna när det gäller inlagda patienter och den kirurgiska verksamheten som helhet.

I kommissoriet för årets temasektion angavs att man skulle söka skapa en klar och entydig definition av begreppet dagkirurgi samt söka belysa omfattningen av den dagkirurgiska verksamheten och dess utveckling över tiden. Den aktuella listan över tolv operationsgrupper skulle granskas med avseende på om det är aktuellt att revidera den och eventuellt utöka den. Temarapporten skulle också söka belysa storleksordningen på den dagkirurgiska verksamhet som sker utanför den offentliga sjukvården och som inte kommer med i den nuvarande redovisningen. En fråga är i vad mån olika nationella betalningssystem för dagkirurgi kan användas för att insamla kompletterande uppgifter om denna verksamhet.

Syftet är sålunda att lägga fram förslag som kan förbättra den av NOMESCO redovisade statistiken över så kallad dagkirurgi.

För rapporten svarar professor Björn Smedby, tidigare föreståndare vid Nordiskt center för klassifikationer inom hälso- och sjukvården i Uppsala. Väsentliga bidrag till rapporten har emellertid lämnats av en rad medicinalstatistiska och kliniska specialister från de nordiska länderna som fungerat som kontaktpersoner. Uppgifter om de nationella registreringarna har främst diskuterats med Jakob Lyng Sandegaard för Danmark, Oleg Nikiforov och Hannu Rintanen för Finland, Gudrun Gudfinnsdottir för Island, Ola Kindseth och Leena Kiviluoto för Norge samt Leif Forsberg och Curt-Lennart Spetz för Sverige. Andra specialister som givit värdefulla bidrag är Glen

Mats Fernström and Mats Lundström, Sverige, and – with regard to DRG-related issues – Lennart Green, Rikard Lindqvist and Martti Virtanen.

Thorsen, Norge, Mats Fernström och Mats Lundström, Sverige, samt - när det gäller DRG-relaterade frågor - Lennart Green, Rikard Lindqvist och Martti Virtanen.

The basic statistics have been produced by NOMESCO's secretariat, based on material from patient registers in the Nordic countries. For this report, these data have been supplemented with data from special studies of certain issues, in which statistics from one or several countries have been obtained with the help of the contact persons.

De grundläggande statistiska uppgifterna har tagits fram av NOMESKO:s sekretariat och bygger på redovisning av material från patientregistren i de nordiska länderna. Dessa data har för den aktuella rapporten kompletterats med specialstudier av vissa frågor, där uppgifter från enbart ett eller ett par länder tagits fram med hjälp av kontaktpersonerna.

A basic and important condition for comparability of studies of surgical services is that all the Nordic countries use NOMESCO's Classification of Surgical Procedures (NCSP) in their patient registers. The small differences between the national versions of NCSP are not judged to have any appreciable importance at the level of aggregation of NOMESCO's statistics. A more detailed description of the registers of surgical statistics is to be found in last year's report [1].

En grundläggande och viktig förutsättning för jämförande studier av kirurgisk vård är att alla de nordiska länderna använder NOMESCO Classification of Surgical Procedures (NCSP) i sina patientregister. De små skillnader som finns mellan de nationella versionerna av NCSP bedöms inte ha någon nämnvärd betydelse på den aggregeringsnivå som NOMESKO:s statistik avser. En mer ingående beskrivning av de kirurgiska registeruppgifterna finns i förra årets rapport [1].

How are day care and day surgery defined?

One would expect to find formal definitions of the terms day care and day surgery primarily in the regulations governing the duty of the health care services to provide statistics to the central authorities and to the patient registers, and in the health care payment system at the national and regional levels. However, the definitions to be found in the Nordic

Vilka definitioner finns beträffande dagvård och dagkirurgi?

Formella definitioner av begreppen dagvård och dagkirurgi kan man förvänta sig finna främst i de bestämmelser som reglerar sjukvårdens uppgiftsskyldighet till de centrala myndigheternas statistik och patientregister samt i de system för ersättning till sjukvårdshuvudmännen som utvecklats nationellt och regionalt. Det visar sig dock att de definitioner som finns i de nordiska

countries are often relatively imprecise, and differ between countries.

Denmark: No official definition of day care or day surgery is to be found for registration in the National Patient Register of the National Board of Health. In 2001, the National Board of Health published a report on surgical activity in publicly owned somatic hospitals in Denmark, for the years 1996-1999 [2]. However, although in-patients were distinguished in this report from day-patients and out-patients, no precise definitions of the different types of care were given. This classification is no longer used, and the term day care is now obsolete.

A Danish case-mix system was introduced in 2002. This system regulates payment to the health care producers. The system is divided into two groups: one group for somatic in-patients and one group for somatic out-patients. The definitions of types of care that this system uses have not yet been incorporated into the reporting system to the National Patient Register. In the payment system for out-patients, there are several so-called grey zone groups, that are characterized by including patients who can be treated either as in-patients or out-patients. In other words, these groups contain exactly the types of patients that NOMESCO's statistics on day surgery are directed at. The system is designed in such a way that in the future it can be expected to influence the type of care that hospitals choose, since out-patient treatment is advantageous from a payment perspective.

Finland: Day surgery is defined as planned surgical procedures that are carried out in a hospital, where the patient

länderna ofta är relativt oprecisa. De överensstämmer inte heller mellan länderna.

Danmark: För Sundhedsstyrelsens registrering i Landspatientregistret existerar inte någon officiell definition av dagvård eller dagkirurgi. Sundhedsstyrelsen publicerade 2001 en redogörelse för operationsaktiviteten vid offentligt ägda somatiska sjukhusavdelningar i Danmark under åren 1996-1999 [2]. Där särredovisades dock patienter i heldygnsvård från sådana i deldygnsvård eller ambulansvård, men rapporten ger inga exakta definitioner av de olika vårdformerna. Uppdelningen har inte bibehållits och begreppet deldygnsvård har nu utgått.

Från år 2002 har Dansk Casemix-system tagits i bruk som reglerar ersättningen till sjukvårdsproducenterna. Systemet består av två grupperingssystem, ett för intagna ("stationära") somatiska patienter och ett för ambulanta somatiska patienter. De definitioner av vårdformer som detta system förutsätter har ännu inte integrerats i rapporteringen till Landspatientregistret. I ersättningssystemet för ambulanta patienter finns ett antal så kallade gråzonsgrupper som karakteriseras av att de avser patienter som kan behandlas antingen som intagna eller ambulanta patienter, det vill säga just den typ av patienter som NOMESKO:s statistik över dagkirurgi är inriktad på. Systemet är så utformat att det i framtiden kan förväntas få klara effekter på vilken vårdform sjukhusen väljer, eftersom det gynnar ambulanta ingrepp från ersättningssynpunkt.

Finland: Dagkirurgi definieras som planerade kirurgiska ingrepp som görs vid sjukhus och där patienten inte stannar

does not stay for more than twelve hours. All patients who are admitted and discharged on the same day, and who do not die in hospital, are included. Statistics on day surgery are based on reports from public and private hospitals and from wards and hospitals in health centres. A special list of procedures that can be carried out as day surgery has been compiled by experts, and represents what can be regarded as established practice. The list of day surgery procedures includes about 150 surgical procedure codes. It has been published by STAKES in a report on regional variations in surgical and day surgical care 1998 [3]. The report includes a discussion of the difficulties of producing standardized national statistics for day surgery and the possibilities for improving the reported statistics. A similar report for 2001 has just been published [4]. The annual statistics published by STAKES are limited to the same twelve indicator surgical procedures as those that are included in NOMESCO's statistics.

Iceland: No clear definition of day surgery has been available earlier, but the Directorate of Health has issued a directive for national reporting, that came into force in 1999. In this directive, day care wards are defined as separate wards with permanent resources for care of day patients, with separate personnel and with the possibility to care for patients for up to 16 hours a day. Reporting to NOMESCO in this publication relates to 1998, however. For this reporting a similar definition was used, such that the figures reported to NOMESCO include surgical procedures that were carried out in day care wards without an over-night stay.

mer än 12 timmar. Häri innefattas även intagna patienter om de skrivs in och ut samma dag och inte dör på sjukhuset. Statistiken för dagkirurgi grundar sig på vårdanmälan från offentliga och privata sjukhus samt hälsocentralernas vårdavdelningar och sjukhus. En särskild lista över åtgärder som lämpar sig för dagkirurgi har tagits fram av sakkunniga och avses spegla vad som kan betecknas som etablerad praxis. Listan över dagkirurgiska åtgärder omfattar cirka 150 operationskoder. Den publicerades av STAKES i en rapport om regionala variationer i kirurgisk och dagkirurgisk vård år 1998 [3]. I rapporten diskuteras även svårigheterna att få fram en enhetlig nationell statistik över dagkirurgi och möjligheterna att förbättra rapporteringen. En motsvarande rapport avseende 2001 har nyligen publicerats [4]. Den av STAKES publicerade årliga statistiken har dock begränsats till samma tolv indikatoroperationer som NOMESCO:s statistik omfattar.

Island: Någon klar definition av dagkirurgi har inte funnits tidigare men Medicinaldirektoratet har utfärdat direktiv för nationell rapportering som trädde i kraft 1999. Där definierade man dagvårdsavdelningar som separata avdelningar med permanenta resurser för vård av dagpatienter, med särskild personal och med möjlighet att ta hand om patienter upp till 16 timmar av dygnet. Rapporteringen till NOMESCO i denna publikation avser dock dagkirurgi år 1998. För den rapporteringen användes en motsvarande definition, vilket innebär att man rapporterat de av NOMESCO angivna kirurgiska ingreppen som utförts vid på motsvarande sätt definierade dagvårdsavdelningar utan övernattnig.

Norway: No official definition of day surgery exists for hospital reporting to the Norwegian Patient Register. However, in the activity-based financing system (ISF), day surgery is defined as surgical procedures without admission to hospital, classified according to about one hundred specific diagnosis-related groups (DRG), for which there is a DRG payment in ISF [5]. Only procedures that require an operating theatre are included in the list. All admitted patients who are admitted and discharged on the same day (with null days-of-stay) are included, and payment is made as day surgery on the condition that the patient is discharged alive and is not classified as an acute case ("need for emergency care").

Sweden: A previous regulation (1993:1057) gave responsibility to health care providers, among other things, to provide statistics to the National Board of Health and Welfare about patients – besides in-patients – who "have received out-patient care, if this was previously usually reported as in-patient care". This referred to day surgery care, but this formulation does not constitute a proper definition. In the new regulation on patient register (SFS 2001:707) and in the regulations of the National Board of Health and Welfare (SOSF 2002:1) relating to responsibility for providing statistics to the patient register, responsibility for providing statistics on "in-patient care and that part of out-patient care that is not primary care", including, among other things, statistics on surgical procedures, is referred to. This is thus the legal basis for collecting statistics on so-called day surgery from hospital out-patient clinics and other specialist clinics in Sweden.

Norge: Någon officiell definition av dagkirurgi finns inte för sjukhusens inrapportering till Norsk patientregister. I det särskilda ersättningssystemet för insatsstyrd finansiering (ISF) definieras dock dagkirurgi som kirurgiska ingrepp utan intagning på sjukhus som kan hänföras till ett drygt hundratal specificerade DRG-grupper, vilka utlöser DRG-ersättning i ISF [5]. Endast ingrepp som kräver operationssal finns med på listan. Även intagna patienter som skrivs in och ut samma dag (med noll vård dagar) räknas och ersätts som dagkirurgi under förutsättning att patienten skrivs ut levande och inte klassificerats som akutfall ("behov av ögonblicklig hjälp").

Sverige: En tidigare förordning (1993:1057) angav skyldighet för den som bedriver sjukvård att bland annat lämna uppgifter till Socialstyrelsen om patienter - förutom de i den slutna vården - som "har vårdats i öppen vård om vården tidigare vanligen meddelades i den slutna vården". Med detta syftade man på den dagkirurgiska verksamheten, men denna formulering utgör ingen egentlig definition. I den nya förordningen om patientregister (SFS 2001:707) och i Socialstyrelsen föreskrifter (SOSF 2002:1) om uppgiftsskyldighet till patientregistret talas om sådan skyldighet inom "den slutna vården och den del av den öppna vården som inte är primärvård", innefattande bland annat uppgift om utförda operationer. Detta är sålunda den legala grunden för insamling av uppgifter om så kallad dagkirurgi vid sjukhusens öppna mottagningar och andra specialistmottagningar i Sverige.

Formally, day care is defined as out-patient care that involves more extensive care and/or that requires more resources than a normal visit. Day surgery is defined as day care involving a surgical procedure that normally requires that the patient receives anaesthesia and a period of post-operative supervision [6]. To what degree these generally accepted definitions apply, and how responsibility for reporting is interpreted by the county authorities, is unclear. With regard to statistics on out-patient care, the patient register of the National Board of Health and Welfare is in the process of being built up and the completeness of the statistics on out-patient care reported by the county councils varies.

Within the payment systems that have been developed by the Swedish county councils, different operational definitions have been formulated for what is reimbursed as day surgery. In some cases there are regulations for how many hours a patient shall have stayed in hospital, or what type of anaesthesia shall have been administered, in order for a case of health care to be considered as and reimbursed as day surgery. It is unclear to what degree such local definitions of day surgery have influenced reporting to the National Board of Health and Welfare, and thus to NOMESCO.

OECD's definitions: The Organisation for Economic Cooperation and Development (OECD) has developed a method for carrying out studies of health services. During the 1990s, several studies of the introduction of day surgery in the member countries were carried out with the cooperation of the organization [e.g., reference 7]. Later, OECD has developed a System of Health Accounts, which is an international system for de-

Formellt definieras dagsjukvård som öppen vård som innebär mer omfattande och/eller resurskrävande insatser än vad ett besök normalt kräver och dagkirurgi som dagsjukvård där den kirurgiska åtgärden normalt kräver att patienten får anestesi och en period av postoperativ övervakning [6]. I vilken utsträckning dessa allmänt hållna definitioner tillämpats och hur rapporteringsskyldigheten har uppfattats av olika landsting är oklart. Socialstyrelsens patientregister är när det gäller åtgärder i öppen vård under uppbyggnad och klara olikheter föreligger i registreringens fullständighet avseende olika landsting.

Inom de ersättningssystem som utvecklats inom svenska landsting har olika operationella definitioner utformats för vad som ersätts som dagkirurgi. I vissa fall finns regler för hur många timmar patienten skall ha stannat på sjukhuset eller vilken anestesiform som skall ha använts för att vårdtillfället skall räknas och ersättas som dagkirurgi. Det är oklart i vilken utsträckning sådana lokala definitioner av dagkirurgi påverkat rapporteringen till Socialstyrelsen och därmed till NOMESCO.

OECD:s definitioner: Organisation for Economic Cooperation and Development (OECD) har utvecklat metoder för jämförande studier av hälso- och sjukvården. Under 1990-talet gjordes med organisationens medverkan flera studier av införandet av dagkirurgi i medlemsländerna [se t.ex. referens 7]. Senare har OECD utvecklat ett System of Health Accounts såsom ett internationellt beskrivningssystem för hälso- och sjukvård

scribing health services, that has achieved wide acceptance in OECD's approximately thirty member states [8]. The system includes activities, personnel and financing. In this system, detailed definitions of various functions within the health services, including in-patient care, day care and out-patient care are to be found.

EU Hospital Data Project: A project financed by the EU has recently produced guidelines for collecting and analysing hospital statistics, that can improve comparability between the European countries. In this EU Hospital Data Project [9] an attempt has been made, on the basis of a careful assessment of the conditions in the different European countries, to produce comparable statistics for describing hospital activity. The definitions presented in the report are very similar to those developed by the OECD for its System of Health Accounts, with regard to care of in-patients and day care (including day surgery). The definitions, in a somewhat shortened form, are as follows:

In-patient care: An in-patient is a patient who is formally admitted to a hospital for treatment or care, and is expected to stay at least one night. Such patients, who for some reason do not stay overnight (e.g. because they die) should be recorded as in-patients. Patients admitted with the intention of discharge on the same day, but who subsequently stay in hospital overnight, should be recorded as in-patients.

Day care: Day care comprises medical or paramedical services delivered to patients that are formally admitted for diagnosis,

som fått bred acceptans i OECD:s trettio-tal medlemsländer [8]. Systemet avser aktiviteter, personal och finansiering. I detta system finns detaljerade definitioner av olika funktioner inom hälso- och sjukvården såsom sluten vård (in-patient care), dagvård (day care) och öppen vård (out-patient care).

EU Hospital Data Project: Ett EU-finansierat projekt har nyligen tagit fram riktlinjer för insamling och bearbetning av sjukhusstatistik som kan underlätta jämförbarheten mellan länder inom Europa. I detta EU Hospital Data Project [9] har man sökt att på basen av en noggrann genomgång av förhållandena i olika europeiska länder ta fram jämförbara statistiska uppgifter som kan beskriva sjukhusens verksamhet. I sin rapport har man presenterat definitioner som mycket nära anknyter till dem som OECD utarbetat för sitt System of Health Accounts när det gäller vård av inlaggande patienter och dagvård (och därmed också dagkirurgi). Definitionerna är i något förkortad form följande:

Sluten vård: En slutenvårdspatient (in-patient) är en patient som är formellt inskriven vid ett sjukhus för behandling eller vård och som avses stanna minst en natt. Sådana patienter som av någon orsak inte stannar över natten (t.ex. på grund av att de dör) skall ändå räknas som vårdade i sluten vård. Patienter som intas med avsikt att skrivas ut samma dag men som senare stannar på sjukhuset över natten skall registreras som slutenvårdspatienter.

Dagvård: Dagvård omfattar medicinska eller paramedicinska tjänster till patienter som är formellt inskrivna för diagnos,

treatment or other type of health care with the intention of discharging the patient on the same day.

Day surgery is thus indirectly defined as day care when a surgical procedure is carried out. What should be regarded as a surgical procedure remains to be defined. Both OECD and the Hospital Data Project get round this problem by having a special list of certain defined surgical procedures that should be reported and thus possible to compare. Neither OECD or the Hospital Data Project has a definition that includes all activities that could be described as day surgery. This corresponds with NOMESCO's list of twelve chosen surgical procedure groups. However, the groups that have been chosen are not the same. OECD's list includes about 25 surgical procedures, whilst the Hospital Data Project has a provisional list of 18 surgical procedures that includes both inpatient procedures and day surgery. However, the lists are similar to a certain degree. Most of the surgical procedures on NOMESCO's list are to be found on one or both of the other two lists.

Which definitions have the countries used when reporting to NOMESCO?

NOMESCO has not given any clear, written instructions about the definitions to be used for day surgery. Reporting to NOMESCO has probably therefore been based on the discussions that have taken place in the publication committee and the verbal consensus that has been

behandling eller annan typ av vård med avsikten att patienten skall skrivas ut samma dag.

Dagkirurgi blir därmed indirekt definierad som dagvård under vilken ett kirurgiskt ingrepp gjorts. Vad som skall räknas som ett kirurgiskt ingrepp återstår då att precisera. Såväl OECD som Hospital Data Project kommer runt detta problem genom att ange en särskild lista för vissa definierade kirurgiska ingrepp som blir föremål för rapportering och som sålunda kan jämföras. Någon definition som omfattar alla aktiviteter som skulle kunna beskrivas som dagkirurgi har varken OECD eller Hospital Data Project. Detta överensstämmer sålunda med NOME-SKO:s ansats med tolv utvalda operationsgrupper. De valda grupperna av ingrepp är dock inte desamma. OECD anger en lista på cirka 25 operationer, medan Hospital Data Project presenterar en preliminär lista med 18 operationer som omfattar både slutenvårdsoperationer och dagkirurgi. Det finns dock en viss överensstämmelse mellan listorna. Flertalet av ingreppen på NOME-SKO:s lista återfinns i någon av eller båda de andra listorna.

Vilka definitioner har länderna tillämpat vid rapportering till NOME-SKO?

NOME-SKO har inte givit några klara, skriftliga instruktioner för vilken definition som skall tillämpas beträffande dagkirurgi. Rapporteringen till NOME-SKO torde därför bygga på de diskussioner som förts inom publikationskommittén och den muntliga konsensus som upp-

reached. However, a kind of pragmatic limitation takes place through NOMESCO's list of the surgical procedures for which statistics are collected.

Patients who are formally admitted as in-patients, but who are discharged on the same day, are probably not always recorded as day surgery patients in the statistics reported to NOMESCO. For Denmark, new statistics have been compiled for 2001 for the number of patients admitted and discharged on the same day for the twelve surgical procedure groups that are included in NOMESCO's statistics. The number corresponds to an under-reporting of day surgery of on average 9 per cent in relation to the amount of day surgery according to the international definition mentioned above. For Sweden also, patients admitted and discharged on the same day have not been reported to NOMESCO as day surgery cases. A more detailed analysis of the Swedish figures for 2001 shows that this represents an under-reporting to NOMESCO of about 2 per cent of day surgery cases in Sweden. The difference varies for the different surgical procedure groups.

Both for Denmark and Finland, the national patient registers include both out-patients and in-patients. With regard to out-patients, there is no clear division between day surgery and other out-patient care in hospitals or special clinics. This means that all surgical procedures in the chosen surgical procedure groups that are performed on out-patients are included in the statistics, whether or not they are formally regarded as day surgery.

There are special problems for Sweden, since the reporting of statistics on out-

nåts där. Ett slags pragmatisk avgränsning sker dock genom NOMESKO:s val av vilka operationer som skall ingå i redovisningen.

Sådana patienter som formellt skrivits in som intagna för sluten vård men som skrivits ut samma dag torde inte alltid ha räknats som dagkirurgiska patienter i rapporteringen till NOMESKO. Från dansk sida har man tagit fram uppgifter om hur många inlagda patienter som år 2001 togs in och skrevs ut samma dag för de tolv operationsgrupper som ingår i NOMESKO:s statistik. Antalet motsvarar en underrapportering av dagkirurgi med i genomsnitt 9 procent i förhållande till den nyss citerade internationella definitionen som räknar sådana fall som dagkirurgiska. Inte heller i Sverige har patienter in- och utskrivna samma dag rapporterats som dagkirurgifall vid rapporteringen till NOMESKO. En närmare analys av de svenska siffrorna för 2001 visar att detta inneburit en underrapportering med cirka 2 procent av svenska dagkirurgifall i NOMESKO:s statistik. Skillnaden växlar för de olika operationsgrupperna.

Både för Danmark och Finland gäller att de nationella patientregistren omfattar både sluten och öppen vård och när det gäller den öppna vården finns det inte en klar avgränsning mellan dagkirurgi och annan poliklinisk vård vid sjukhus eller specialistmottagningar. Det betyder att alla polikliniskt utförda operationer inom de utvalda operationsgrupperna kommer att redovisas, oavsett om de formellt betraktats som dagkirurgi eller ej.

För Sverige finns särskilda problem, eftersom redovisningen av ambulanta in-

patients to the National Board of Health and Welfare is in the process of being built up. Some county councils have not reported statistics on out-patients to the National Board of Health and Welfare for 2001. The figures have been estimated for the county councils that have not reported (about 20 per cent). The estimations have been made on the basis of the figures from the counties that are assumed to have provided complete figures on day surgery and the estimated frequency of these surgical procedures in that population. These figures have then been extrapolated to the whole population. These estimates have been made separately for each type of surgical procedure.

In this connection, the rule for counting procedures when reporting to NOMESCO should be mentioned. This rule states that only one recording within any one of the twelve day surgery procedure groups is allowed. If two procedure codes belonging to the same NOMESCO group are recorded for the same hospital stay, they are counted as one. (The same rule applies for all the 14 surgical procedure groups in NOMESCO's statistics on in-patients.) After a closer inspection of the data, it has been found that this rule has not been applied by Denmark when reporting to NOMESCO. The Danish figures have therefore been recalculated, applying this rule, in order to avoid duplicate recording. This means that the total number of cases in the twelve surgical procedure groups has been reduced by about 13 per cent. However, in certain groups, the reduction is considerably greater. This is explained in more detail below.

grepp till Socialstyrelsen fortfarande är under uppbyggnad. Några landsting har sålunda inte redovisat ambulanta ingrepp till Socialstyrelsen för år 2001. Bortfallet av rapportering från vissa landsting (cirka 20 procent) har "räknats upp". Uppräkningen har skett genom att man utgått från de landsting som antas lämna en fullständig redovisning av dagkirurgi och beräknat operationsfrekvensen i befolkningen för dessa och sedan tillämpat denna på hela rikets befolkning. Uppräkningen har skett för varje operationstyp för sig.

Det bör i detta sammanhang också nämnas att det för rapporteringen till NOMESCO finns en beräkningsregel som innebär att bara *ett* fall räknas om mer än en operationskod finns registrerad av de olika koder som ingår i en och samma operationsgrupp. (Samma regel gäller de 14 operationsgrupperna i NOMESCO:s statistik över inlagda patienter.) Vid närmare granskning av primäruppgifterna har det visats sig att denna regel inte tillämpats av Danmark vid rapporteringen till NOMESCO. De danska siffrorna har därför räknats om med tillämpning av denna regel för att undvika dubbelräkning, vilket innebär en minskning med cirka 13 procent av det totala antalet fall i de tolv operationsgrupperna. Inom vissa grupper blev dock minskningen avsevärt större, vilket närmare redovisas nedan.

Day surgery in privately owned health institutions

Privately owned health institutions represent a special problem for statistics on day surgery. The Nordic countries vary in relation to the extent to which such day surgery is included in the reporting to NOMESCO. However, in most cases, this service is publicly funded through health insurance contracts or other reimbursement systems. It should therefore be possible to obtain figures on the approximate size of this service. One problem, however, is that reporting is not the same as for other surgical services. Specific surgical procedures or surgical procedure groups cannot therefore always be identified in the same way as those used for reporting to NOMESCO.

In Denmark, the National Patient Register of the National Board of Health only includes statistics from publicly owned somatic hospitals. The Public Health Insurance Negotiating Committee has determined fees that regulate reimbursement to privately owned hospitals and specialist clinics. Figures on reimbursement are presented in the Health Insurance Register. For Denmark, it has thus been possible to produce some statistics which show how many surgical procedures are reimbursed in this way, for five of the twelve surgical procedure groups included in NOMESCO's statistics. Comparisons show that the degree of coverage of the National Patient Register varies a great deal for these five surgical procedures, and in certain cases under-reporting can be

Dagkirurgisk verksamhet vid icke offentligt ägda sjukvårdsinrättningar

Ett särskilt problem för statistiken utgör redovisningen av dagkirurgi vid icke offentligt ägda sjukvårdsinrättningar. De nordiska länderna skiljer sig med avseende på i vilken utsträckning sådan dagkirurgi omfattas av den redovisning som sker till NOMESCO. I flertalet fall är det dock så att denna verksamhet blir föremål för betalning från det allmänna genom sjukförsäkringsavtal eller andra ersättningssystem. Det borde därför vara möjligt att ta fram uppgifter om storleksordningen av denna verksamhet. Ett problem är emellertid att den inte redovisas på samma sätt som annan kirurgisk verksamhet. Enskilda operationer eller operationsgrupper kan därför inte alltid avgränsas på samma sätt som gäller för NOMESCO:s redovisning.

I Danmark omfattar Sundhedsstyrelsens Landspatientregister endast uppgifter från offentligt ägda somatiska sjukhusavdelningar. Den offentliga Sygesikringens Forhandlingsudvalg har fastställt taxor som reglerar ersättningen till privata sjukhus och specialistläkarmottagningar och i Sykesikringsregistret sammanställs uppgifter om den ersättning som utbetalas. Det har därför varit möjligt att för Danmarks del ta fram vissa uppgifter som visar hur många ingrepp som ersatts på detta sätt inom fem av de tolv operationsgrupper som NOMESCO:s redovisning omfattar. Det framgår av jämförelsen att Landspatientregistrets täckningsgrad är mycket olika för dessa fem ingrepp och bortfallet kan i vissa fall vara avsevärt. Uppgifterna re-

considerable. The statistics are presented below in connection with a discussion of the problems related to the different surgical procedure groups.

In Finland, statistics are reported to STAKES, including statistics from privately owned health institutions. It is therefore assumed that most of the treatment provided by privately owned hospitals is also included in the statistics that are reported to NOMESCO. However, statistics for a small number of surgical procedures carried out in independent private specialist clinics can be missing.

In Iceland the social insurance authority reimburses day surgery care in hospitals and privately-run specialist clinics. However, the way in which statistics on this type of care are produced is different, and the surgical groups are different, from those for in-patient care. It is therefore difficult to gain an impression of the amount of surgical procedures carried out for the different groups.

In Norway, privately-run hospitals also report statistics to the Norwegian Patient Register, so that these statistics are included in the reporting to NOMESCO. However, in 2001 many surgical procedures carried out in private clinics and specialist clinics were not registered, even though such treatment was reimbursed by the National Insurance Administration according to a special fee schedule. From 2002, the health authorities receive reimbursements according to the activity-based financing system (ISF), as well as for day surgery treatment from private specialists with a contract and from private, publicly approved hospitals. Therefore, from this

do visas nedan i anslutning till en problemgenomgång av de olika operationsgrupperna.

I Finland förekommer redovisning till STAKES även när det gäller verksamheten vid icke offentligt ägda sjukvårdsinrättningar. Man räknar därför med att det allra mesta av vården vid privat drivna sjukhus också kommer med i redovisningen till NOMESCO. Ett litet antal ingrepp som gjorts vid fristående privata specialistmottagningar kan dock saknas i redovisningen.

I Island ersätter socialförsäkringsmyndigheten viss dagkirurgisk vård vid sjukhus och privat drivna specialistmottagningar. Redovisningen av denna vård sker dock efter andra principer och med andra grupperingar än när det gäller den slutna vården. Det är därför inte enkelt att få någon uppfattning om storleksordningen av sådan vård i de aktuella grupperna.

För Norges del gäller att slutenvårdstillfällena vid privat drivna sjukhus också skall rapporteras till Norsk patientregister och de kommer sålunda med i redovisningen till NOMESCO. Beträffande dagkirurgiska ingrepp blev dock år 2001 en hel del ingrepp vid privata kliniker och specialistmottagningar inte registrerade, även om en del sådan vård blev föremål för ersättning från Rikstrygdeverket enligt särskild taxa. Från år 2002 får de regionala hälsoföretagen ersättning enligt systemet för insatsstyrd finansiering även för dagkirurgisk behandling hos privatpraktiserande avtalsspecialister och vid icke-statliga, offentligt godkända sjukhus. Från detta år kan man därför

year, the statistics on day surgery should be more complete.

In Sweden, the situation varies in the different counties. Most of the treatment of in-patients and out-patients carried out in privately owned health institutions is reimbursed by the county councils according to special health care contracts. However, the way in which this treatment is reported to the county authorities varies. Thus the level of further reporting to the National Board of Health and Welfare's patient register, especially with regard to day surgery, also varies. In some cases, the reports have lacked the specific information that is necessary in order to register the surgical procedures in NOMESCO's surgical procedure groups. In 2001, there were some cases in the county of Stockholm, where the private health providers only reported statistics on diagnosis-related groups (DRG's), but not diagnosis or surgical procedure to the health care register of the county council. Thus, statistics for these surgical procedures were not included in the statistics reported to NOMESCO. However, the rules for reporting have recently been tightened up, so that from 2003, reporting in the county council for Stockholm should be almost complete and detailed, for private health care provided under a health care contract. Thus, incomplete statistics from privately-run health institutions was a problem for 2001, but it is difficult to assess the extent of this. However, incomplete statistics on surgical procedures carried out in private health institutions can be estimated in some cases by comparing with other, independent registration, such as registration in the national quality registers. Such a comparison with the cataract register is reported below.

räkna med en fullständigare redovisning av dagkirurgiska aktiviteter.

När det gäller Sverige växlar förhållandena i de olika landstingen. Merparten av vård av inneliggande och ambulanta patienter utförda vid icke offentligt ägda sjukvårdsinrättningar ersätts av landstingen genom särskilda vårdavtal. Formerna för hur sådan vård redovisas till landstingen varierar dock liksom i vilken utsträckning den sedan redovisats till Socialstyrelsens patientregister, särskilt när det gäller dagkirurgisk verksamhet. I vissa fall har redovisningen skett utan så preciserad information om de utförda operationerna som krävs för att en utsökning till de av NOME-SKO definierade grupperna skall kunna ske. År 2001 förekom till exempel i Stockholms läns landsting att de privata vårdgivarna endast redovisade DRG-grupp men inte diagnos eller operation till landstingets vårdregister. Sådana ingrepp kom därför inte med i redovisningen till NOME-SKO. Dock har nyligen en skärpning skett av rapporteringsprinciperna i Stockholms läns landsting, så att man från år 2003 räknar med att få en i det närmaste fullständig och detaljerad redovisning av sådan privat vård som omfattas av vårdavtal. Problem med bortfall av icke offentligt driven verksamhet fanns sålunda för det aktuella året 2001, men det är svårt att få någon uppfattning om storleksordningen av det. Bortfall av privat utförda operationer kan dock i något fall belysas genom jämförelse med annan, oberoende registrering såsom den som sker i nationella kvalitetsregister. En sådan jämförelse med kataraktregistret återges nedan.

NOMESCO's current statistics on day surgery

NOMESCO's statistics on the twelve surgical procedures that are partly carried out as day surgery for 2001 are presented in Table 1. The table corresponds to Table 3.35 in the main section of Health Statistics in the Nordic Countries 2001. However, Table 1 is presented in a somewhat different way, in order to facilitate comparison between the countries. In addition, the table presents the number of surgical procedures per 100 000 of the population, calculated from the total number of surgical procedures of each type that are carried out. The figures per 100 000 of the population are not standardized according to age.

Table 2 gives the definitions of the twelve surgical procedure groups and the corresponding codes in NOMESCO's Classification of Surgical Procedures (NCSP) [10].

NOMESKO:s nuvarande dagkirurgiredovisning

NOMESKO:s statistik över de tolv kirurgiska ingrepp som delvis genomförs som dagkirurgi under år 2001 presenteras i Tabell 1. Tabellen motsvarar Tabell 3.35 i huvudavsnittet av Health Statistics in the Nordic Countries 2001. Tabell 1 är dock något annorlunda uppställd för att underlätta jämförelser mellan länderna. Dessutom innehåller den befolkningsrelaterade tal för frekvensen av de aktuella ingreppen, beräknad på totalantalet utförda operationer av samma slag. De befolkningsrelaterade talen är inte åldersstandardiserade.

Hur de tolv operationsgrupperna definierats framgår av Tabell 2 som redovisar de relevanta koderna i NOMESCO Classification of Surgical Procedures (NCSP) [10].

VALIDITY AND COMPARABILITY OF NORDIC DAY SURGERY STATISTICS

Table 1 Reported statistics on twelve day surgery procedures in the Nordic countries in 2001

Procedure group	Denmark	Finland	Iceland ¹⁾	Norway	Sweden
1 Decompression of median nerve					
Number of procedures	3 418	5 281	33	4 643	8 155
Per 100 000	64	102	12	103	92
Of which day surgery	2 600	4 381	22	4 191	7 706
Day surgery, per cent	76	83	67	90	95
2 Cataract surgery					
Number of procedures	23 761	32 746	710	22 905	56 972
Per 100 000	444	631	259	507	640
Of which day surgery	21 547	27 711	576	19 867	54 162
Day surgery, per cent	91	85	81	87	95
3 Tonsillectomy and/or adenoidectomy					
Number of procedures	12 585	19 788	1 167	13 620	14 219
Per 100 000	235	381	426	302	160
Of which day surgery	2 278	10 954	423	5 629	6 794
Day surgery, per cent	18	55	36	41	48
4 Repair of hernia					
Number of procedures	11 812	11 032	241	8 033	17 991
Per 100 000	221	213	88	178	202
Of which day surgery	5 697	4 203	63	4 443	12 034
Day surgery, per cent	48	38	26	55	67
5 Laparoscopic cholecystectomy					
Number of procedures	5 014	5 796	379	3 090	9 230
Per 100 000	94	112	138	68	104
Of which day surgery	435	190	23	439	935
Day surgery, per cent	9	3	6	14	10
6 Curettage and excision of endometrium					
Number of procedures	10 802	6 612	300	5 265	18 963
Per 100 000 kvinnor	399	248	219	231	422
Of which day surgery	7 170	4 117	245	3 282	14 444
Day surgery, per cent	66	62	82	62	76
7 Termination of pregnancy					
Number of procedures	14 081	7 640	831	13 408	17 788
Per 100 000 women	520	286	608	589	396
Of which day surgery	10 538	6 414	810	12 886	15 761
Day surgery, per cent	75	84	98	96	87
8 Female sterilization					
Number of procedures	5 271	6 005	282	5 482	4 695
Per 100 000 women	195	225	206	241	104
Of which day surgery	3 615	4 403	243	4 504	3 915
Day surgery, per cent	69	73	86	82	83

The table continues ...

VALIDITY AND COMPARABILITY OF NORDIC DAY SURGERY STATISTICS

Table 1 (continued)

Procedure group	Denmark	Finland	Iceland ¹⁾	Norway	Sweden
9 <i>Removal of implanted devices from bone</i>					
Number of procedures	11 184	5 721	231	7 227	12 917
Per 100 000	209	110	84	160	145
Of which day surgery	5 662	2 868	105	2 430	7 818
Day surgery, per cent	47	50	46	34	61
10 <i>Knee arthroscopy</i>					
Number of procedures	8 047	4 633	60	5 044	9 476
Per 100 000	150	89	22	112	107
Of which day surgery	5 662	2 926	22	3 675	8 587
Day surgery, per cent	70	63	37	73	91
11 <i>Arthroscopic operation on the knee meniscus</i>					
Number of procedures	8 978	10 603	79	10 939	13 690
Per 100 000	168	204	29	242	154
Of which day surgery	6 113	7 487	65	9 043	12 751
Day surgery, per cent	68	71	82	83	93
12 <i>Ligature and resection of veins of leg</i>					
Number of procedures	13 318	8 178	92	6 413	1 881
Per 100 000	249	158	34	142	21
Of which day surgery	5 835	3 917	25	4 803	1 693
Day surgery, per cent	44	48	27	75	90

1 1998.

Table 2 Definitions of NOMESCO's twelve day surgery groups by selection of codes

Group	Group title	NCSF codes included
1	Decompression and freeing of adhesions of median nerve	ACC51
2	Cataract surgery	CJC, CJD, CJE, CJF00, CJF10
3	Tonsillectomy and/or adenoidectomy	EMB10, EMB20, EMB30
4	Repair of inguinal and femoral hernia	JAB, JAC
5	Laparoscopic cholecystectomy	JKA21
6	Curettage and excision of the endometrium in uterus and cervix uteri	LCA10-16, LCB28, LCB32, LDA10
7	Termination of pregnancy	LCH
8	Female sterilization	LGA
9	Removal of implanted devices from bone	NAU, NBU, NCU, NDU, NEU, NFU, NGU, NHU
10	Arthroscopic exploration of knee joint	NGA11
11	Arthroscopic operations on the knee meniscus	NGD01, NGD11, NGD21, NGD91
12	Ligature and resection of veins of leg	PHB13-14, PHD

Note: The group titles have sometimes been slightly modified (abbreviated) in the text and in other tables.

As shown in Table 1, the differences between the countries are relatively large for the central result variable "number of surgical procedures carried out as day surgery". The proportion carried out as day surgery has the least variation for cataract surgery (range 81-95 per cent), decompression and freeing of adhesions of median nerve (76-95 per cent), curettage and excision of the endometrium in uterus and cervix uteri (62-82 per cent), termination of pregnancy (75-98 per cent) and arthroscopic operation on the knee meniscus (68-93 per cent). In some cases, the variation between the countries is remarkably great, such as for ligation and resection of veins of leg (27-90 per cent), knee arthroscopy (37-91 per cent), repair of inguinal and femoral hernia (26-67 per cent) and tonsillectomy and/or adenoidectomy (18-55 per cent).

The observed differences can, of course, reflect real differences in the way in which surgical practice is organized in the different countries. However, the differences can also be explained by differences in reporting, for example the way in which the actual surgical procedures are described, and the definition of day surgery, as discussed above. It is also possible that selection bias in reporting can have influenced the estimated proportion of day surgery.

A comparison of the frequency of surgical procedures in the different countries can give us an indication about this. Great differences in the frequency of surgical procedures in relation to the population should make one aware of the possibility of missing data or other errors in the reports. The figures per 100 000 of the population in Table 1 show great differences between the countries. For

Som framgår av Tabell 1 är skillnaderna mellan länderna relativt stora för den centrala resultatvariabeln "andel ingrepp som utförts som dagkirurgi". Mest likartad är andelen dagkirurgi när det gäller kataraktoperationer (variationsbredd från 81 till 95 procent), kvinnlig sterilisering (69-86 procent), karpaltunnelingrepp för dekompression av medianusnerv (76-95 procent), uteruskrampning (62-82 procent), legala abortingrepp (75-98 procent) och artroskopisk meniskoperation (68-93 procent). I några fall är variationen mellan länderna anmärkningsvärt stor som för åderbråcksoperation (27-90 procent), knäartroskopi (37-91 procent), bråckoperation (26-67 procent) samt tonsillektomi och/eller adenoidektomi (18-55 procent).

De observerade skillnaderna kan naturligtvis avspegla verkliga skillnader i sättet att organisera den kirurgiska verksamheten i de olika länderna. Skillnaderna kan emellertid också förklaras av olikheter i rapporteringen, till exempel hur man har avgränsat de aktuella ingreppen och hur man definierat begreppet dagkirurgi såsom tidigare har nämnts. Det är också mycket möjligt att selektiva bortfall i rapporteringen kan ha påverkat den beräknade andelen dagkirurgi.

En jämförelse av förekomsten av de aktuella operationerna i de olika länderna kan ge viss ledning härvidlag. Om man finner mycket stora skillnader i de populationsrelaterade frekvenserna har man anledning att vara särskilt uppmärksam på möjligheten av bortfall eller andra felaktigheter i rapporteringen. De populationsrelaterade talen i Tabell 1 uppvisar i vissa fall mycket stora skillnader mellan

most of the types of surgical procedures, the highest frequency is between two and three times greater than the corresponding lowest frequency. However, in some cases the highest frequency is about ten times greater than the lowest frequency, for example for ligation and resection of veins of leg (12 times), decompression of median nerve (9 times), arthroscopic operation on the knee meniscus (9 times) and knee arthroscopy (7 times).

These simple comparisons show that there is reason to check the reliability of the reported figures, and to examine possible errors in the reporting. One conclusion of this examination of the figures is that there is reason to suspect great methodological problems in the reporting. We shall come back to some of the large differences later.

There are some general differences between the countries. Denmark reports the highest frequencies in relation to the population for four of the surgical procedure groups, Iceland and Norway for three and Sweden for two, while Finland has no highest frequency. In relation to the central result variable "proportion of surgical procedures carried out as day surgery", Sweden has the greatest number of highest frequencies, that is for seven of the twelve surgical procedures, whilst Iceland has three and Finland and Norway one each. A contributing factor for the high frequencies in Sweden can be the upward adjustment procedure that has been carried out on the Swedish figures, as described above. A known under-reporting of day surgery procedures was compensated for through this process.

länderna. För flertalet operationstyper är den högsta frekvensen mellan två och tre gånger så stor som motsvarande lägsta frekvens. Det finns emellertid exempel på att den högsta frekvensen är omkring tio gånger så stor som den lägsta. Det gäller till exempel åderbråcksoperation (12 gånger), karpaltunneloperation (9 gånger), artroskopisk meniskoperation (9 gånger) och knäartroskopi (7 gånger).

Dessa enkla jämförelser visar alltså att det finns anledning att granska de rapporterade uppgifternas tillförlitlighet och undersöka tänkbara felkällor i rapporteringen. En konklusion av denna översiktliga genomgång är sålunda att man har anledning att misstänka stora metodproblem i redovisningen. Till några av de stora skillnaderna skall vi därför återkomma i det följande.

Det finns vissa övergripande skillnader mellan länderna. Danmark uppvisar den högsta befolkningsrelaterade förekomsten inom fyra operationsgrupper, Island och Norge inom tre och Sverige inom två, medan Finland inte har någon högstanotering. När det gäller den centrala resultatvariabeln "andelen operationer som dagkirurgi" uppvisar Sverige det största antalet högstanoteringar, nämligen för sju av de tolv ingreppen, medan Island har tre och Finland och Norge vardera en. Bidragande till de höga siffrorna för Sveriges del kan dock vara det uppräkningsförfarande man tillämpat för de svenska siffrorna som beskrivits ovan. Härigenom kompenseras ett känt bortfall i rapporteringen av just dagkirurgioperationer.

Trends in day surgery

Table 3 presents the figures published by NOMESCO for surgical procedures that are carried out as day surgery for 1997-2001. Trends can only be studied for Denmark and Finland, for which figures are available for five years, and to a certain extent for Norway, for which figures are available for three years. For Iceland and Sweden, figures are only available for 2001. The figures for Iceland are actually for 1998.

Utvecklingen över tiden av dagkirurgi

De uppgifter som NOMESCO publicerat över kirurgiska ingrepp som genomförts som dagkirurgi under åren 1997-2001 har sammanställts i Tabell 3.

Trender kan egentligen bara studeras för Danmark och Finland som redovisat uppgifter för fem år och i viss mån för Norge från vilket uppgifter finns för tre år. För Island och Sverige är det först till innevarande års rapport som några uppgifter finns. När det gäller Island avser uppgifterna dock 1998.

Table 3 Proportion of twelve surgical procedure groups performed as day surgery 1997-2001, per cent

Procedure group	Denmark	Finland	Iceland	Norway	Sweden
1 <i>Decompression of median nerve</i>					
1997	70	75	..	..	..
1998	72	78	67	..	..
1999	70	82	..	93	..
2000	72	85	..	92	..
2001	76	83	..	90	95
2 <i>Cataract surgery</i>					
1997	77	59	..	..	..
1998	80	67	81	..	..
1999	85	75	..	86	..
2000	88	82	..	87	..
2001	91	85	..	87	95
3 <i>Tonsillectomy and/or adenoidectomy</i>					
1997	10	55	..	..	..
1998	11	11	36	..	..
1999	14	11	..	45	..
2000	20	13	..	44	..
2001	18	55	..	41	48
4 <i>Repair of hernia</i>					
1997	35	30
1998	40	32	26
1999	38	34	..	48	..
2000	42	38	..	54	..
2001	48	38	..	55	67

The table continues ...

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Table 3 (continued)

Procedure group	Denmark	Finland	Iceland	Norway	Sweden
5 <i>Laparoscopic cholecystectomy</i>					
1997	2	0	..	..	..
1998	2	1	6	..	..
1999	6	3	..	7	..
2000	7	3	..	13	..
2001	9	3	..	14	10
6 <i>Curettage and excision of endometrium</i>					
1997	50	59	..	..	..
1998	55	60	82	..	..
1999	60	63	..	59	..
2000	65	67	..	61	..
2001	66	62	..	62	76
7 <i>Termination of pregnancy</i>					
1997	14	83	..	..	..
1998	11	85	98	..	..
1999	71	89	..	96	..
2000	71	91	..	96	..
2001	75	84	..	96	87
8 <i>Female sterilization</i>					
1997	48	60	..	..	..
1998	54	64	86	..	..
1999	59	68	..	80	..
2000	66	74	..	82	..
2001	69	73	..	82	83
9 <i>Removal of implanted devices from bone</i>					
1997	41	48	..	..	..
1998	43	51	46	..	..
1999	44	57	..	28	..
2000	43	57	..	35	..
2001	47	50	..	34	61
10 <i>Knee arthroscopy</i>					
1997	65	51	..	..	..
1998	68	56	37	..	..
1999	62	65	..	73	..
2000	64	70	..	72	..
2001	70	63	..	73	91
11 <i>Arthroscopic operation on the knee meniscus</i>					
1997	61	60	..	..	..
1998	64	63	82	..	..
1999	62	72	..	78	..
2000	62	75	..	80	..
2001	68	71	..	83	93
12 <i>Ligature and resection of veins of leg</i>					
1997	39	39	..	..	..
1998	37	41	27	..	..
1999	31	46	..	71	..
2000	36	49	..	72	..
2001	44	48	..	75	90

Most of the surgical procedures show a clear trend of an increase in the proportion of procedures carried out as day surgery. In several cases, this increasing trend is apparent for the three countries. This is the case for cataract surgery, repair of hernia, laparoscopic cholecystectomy and curettage and excision of endometrium. In other cases there are certain exceptions from a generally increasing trend. For 2001 for Finland, some of the figures are lower than for previous years, which break an increasing trend in no less than eight of the twelve groups. The explanation for this is that there was a doctors' strike in Finland in 2001, which affected surgical services. Among other things, there was an increase in the number of non-planned admissions, while the number of planned admissions decreased, including the number day surgery cases.

The very low proportion of day surgery for termination of pregnancy in Denmark 1997-1998 and for tonsillectomy and/or adenoidectomy in Finland 1998-2000 is certainly the result of technical reporting factors and does not reflect real differences in relation to surgical procedures carried out as day surgery.

Problems regarding NOMESCO's day surgery statistics

The following presents a discussion of some of the problems that deserve attention for the surgical procedure groups that are included in NOMESCO's current statistics. The problems relate both to the definitions of the different groups and to different types of missing data.

För flertalet ingrepp finns en klar tendens till ökning av andelen operationer som utförts som dagkirurgi. I flera fall är den ökande trenden tydlig för alla de tre länderna. Det gäller kataraktoperation, bräckoperation, laparoskopisk kolecystektomi och livmoderskrapning. I andra fall finns vissa avvikelser från en i stort sett ökande trend. Finland visar för år 2001 något lägre siffror än tidigare år som bryter en stigande trend i inte mindre än åtta av de tolv grupperna. Förklaringen till detta är att man i Finland år 2001 hade en läkarstrejk som hade effekter också på den kirurgiska verksamheten. Bland annat ökade antalet intagna patienter som börjat som jourfall medan de planerade intagningarna minskade, däribland också dagkirurgifallen.

De mycket låga dagkirurgiandelarna för abortingrepp i Danmark 1997-1998 och för tonsillektomier i Finland 1998-2000 har säkert redovisningstekniska orsaker och motsvaras inte av verkliga skillnader när det gäller dagkirurgiskt utförda ingrepp.

Problem beträffande NOMESCO:s dagkirurgiredovisning

Här följer en genomgång av några av de problem som uppmärksammats för de operationsgrupper som ingår i NOMESCO:s nuvarande redovisning. Problemen gäller både definitionerna av de olika grupperna och olika typer av bortfallsproblem.

Before the different surgical procedure groups are examined more closely, the consequences of the following shall be discussed: In the original reports from Denmark, some of the patients who are admitted and discharged on the same day are not recorded as day surgery patients, and some surgical procedure groups are recorded more than once, if more than one surgical procedure code in a group is registered for the same hospital stay. The aim is to demonstrate the effect of such deviations from the principles for recording that to some extent also occur in the reporting from the other countries, but are most apparent in the case of Denmark. Table 4 shows the change in the Danish statistics after correcting for the definition of day surgery and correcting for double counting. The four surgical procedure groups for which the effects are the greatest are presented in the table.

Innan de enskilda operationsgrupperna granskas närmare, skall konsekvenserna först redovisas av att man i den ursprungliga redovisningen från Danmark dels inte räknade patienter som skrivits in och ut samma dag som dagkirurgi, dels dubbelräknat fall om mer än en operationskod inom gruppen registrerats vid ett och samma vårdtillfälle. Syftet är att demonstrera effekter av sådana avvikelser i redovisningsprinciperna som i viss utsträckning förekommer även i andra länders redovisning men som är tydligast för Danmarks del. Tabell 4 visar förändringarna i de danska siffrorna efter korrigering av dagkirurgidefinitionen och korrigering av dubbelräkningen. Endast de fyra operationsgrupper redovisas för vilka effekterna är starkast.

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Table 4 Changes in certain procedure groups after correction of the day surgery definition and of double counting within groups, Denmark 2001

Procedure group	Originally reported data	After correction for patients in and out same day	Changes in relation to original data, per cent	After further correction for double counting of cases	Changes in relation to original data, per cent
<i>1. Decompression of median nerve</i>					
Number of procedures	3 418	3 418	±0	3 234	-5.4
Per 100 000	64	64	±0	60	-6.3
Of which day surgery	2 600	2 977	+14.5	2 427	-6.7
Day surgery, per cent	76.1	87.1	+11.0	75.0	-1.1
<i>2. Cataract surgery</i>					
Number of procedures	23 761	23 761	±0	21 438	-9.8
Per 100 000	444	444	±0	400	-9.9
Of which day surgery	21 547	21 699	+0.7	19 248	-10.7
Day surgery, per cent	90.7	91.3	+0.6	89.8	-0.9
<i>3. Tonsillectomy and/or adenoidectomy</i>					
Number of procedures	12 585	12 585	±0	8 006	-36.4
Per 100 000	235	235	±0	150	-36.2
Of which day surgery	2 278	3 332	+46.3	1 506	-33.9
Day surgery, per cent	18.1	26.5	+8.4	18.8	+0.7
<i>12. Ligature and resection of veins of leg</i>					
Number of procedures	13 318	13 318	±0	6 010	-54.9
Per 100 000	249	249	±0	112	-55.0
Of which day surgery	5 835	7 704	+32.0	2 770	-52.5
Day surgery, per cent	43.8	57.8	+14.0	46.1	+2.3

As shown in the table, correction of admission and discharge on the same day from in-patient surgery to day surgery increases the number of cases of day surgery for decompression of the median nerve by almost 15 per cent, for tonsillectomy and/or adenoidectomy by almost 50 per cent, and for ligature and resection of veins of leg by over 30 per cent. This means that the percentage of cases operated on as day surgery for these three surgical procedure groups increases by 11, 8 and 14 percentage points respectively.

However, the total number of cases in the surgical groups remains unchanged.

Det framgår av tabellen att omräkningen av in- och utskrivna samma dag från slutten vård till dagkirurgi ökar antalet dagkirurgifall för dekompression av medianusnerv med knappt 15 procent, för tonsillektomi och/eller adenoidektomi med nästan hälften och för åderbräcksoperation med en tredjedel. Det innebär att procenttalen för andelen fall som opererats som dagkirurgi ökar med 11, 8 respektive 14 procentenheter. Det totala antalet fall i grupperna blir dock oförändrat.

After correcting for double counting, the total number of cases in the surgical groups is reduced, in two cases considerably. The reduction is 55 per cent for ligation and resection of veins of leg, 36 per cent for tonsillectomy and/or adenoidectomy and 10 per cent for cataract surgery. However, the two types of correction cancel each other out. The combined effect on the key variable "percentage of cases performed as day surgery" is therefore insignificant, when the originally reported figures are compared with the adjusted figures. The differences are in the order of 1-2 percentage points.

Decompression of the median nerve:

This group is defined as surgical procedures with NCSP code ACC51, which includes decompression and freeing of adhesions of the median nerve, a surgical procedure that is carried out for carpal tunnel syndrome. However, it appears that for this diagnosis, not only this surgical procedure is carried out, but also several other surgical procedures with their own codes. Therefore not all surgical procedures for carpal tunnel syndrome are included in the statistics.

A special examination of the Swedish data for 2001 shows that patients with the diagnosis G56.0 Carpal tunnel syndrome, who have been operated on, are registered with several different surgical procedure codes. ACC51 was the most usual code, which was used for 77 per cent of cases with a surgical procedure. Other usual surgical procedure codes were ACC52 (corresponding surgery of the radial nerve) and ACC53 (ulnar nerve), plus several codes from the chapter for surgical procedures on the mus-

Korrigeringen för dubbelräknade fall innebär att totalantalet fall minskar i grupperna, i ett par fall i avsevärd grad.

Minskning är 55 procent för åderbråcksoperation, 36 procent för tonsillektomi och/eller adenoidektomi och 10 procent för kataraktoperation. De båda typerna av korrigerings motverkar emellertid varandra. Den samlade effekten på nyckelvariabeln "andelen fall som utförts som dagkirurgi" blir därför obetydlig, när man jämför med de ursprungligen rapporterade uppgifterna. Skillnaderna ligger här i storleksordningen 1-2 procentenheter.

Dekompression av medianusnerv:

Denna grupp definieras som operationer med NCSP-kod ACC51 som avser dekompression och adheranslösning av medianusnerven, ett ingrepp som görs vid diagnosen karpaltunnelsyndrom. Det visar sig emellertid att vid denna diagnos görs inte bara detta ingrepp utan också ett flertal andra operationer med egna koder. Alla ingrepp vid karpaltunnelsyndrom ingår därför inte i redovisningen.

En särskild genomgång av svenska data från 2001 visar att patienter med diagnosen G56.0 Karpaltunnelsyndrom, som blivit föremål för operation, registrerats på ett antal olika operationskoder. ACC51 var den vanligaste koden som förekom i 77 procent av de opererade fallen. Andra vanliga operationskoder var ACC52 (avseende motsvarande operation på radialisnerven) och ACC53 (ulnarisnerven) samt ett flertal koder från kapitlet för operationer på muskuloskeletala systemet, såsom NDE12 (avskärning

culo-skeletal system, such as NDE12 (cutting of ligament in the wrist), NDM09 (fasciotomy of wrist or hand) and NDM49 (discission of sheath of tendon of wrist or hand). A corresponding analysis of the Norwegian data confirms that many different surgical procedures are carried out for carpal tunnel syndrome. The term “carpal tunnel decompression”, which is used in the English version of NOMESCO’s report, can therefore be misunderstood, and should be changed to “decompression of median nerve”.

In the Finnish version of NCSP, there is no code ACC51, but this surgical procedure is included in the code ACC59 Neurolysis of peripheral nerve. Other surgical procedures for decompression in the wrist are also included and, in addition, also neurolysis of the brachial plexus, lumbar plexus and nerves of the lower extremities. Finland has therefore chosen only to report to NOMESCO patients with surgical procedure code ACC59 if at the same time they have the main diagnosis G56.0 Carpal tunnel syndrome. If the same conditions prevail in Finland that have just been shown to prevail in Sweden, then there is a certain degree of over-reporting in relation to the formal definition, since surgical procedures for compression of the radial nerve and the ulnar nerve are also included. One possibility for improving the comparability of this group of surgical procedures between the countries, would be to define this surgical procedure group as also including the codes ACC52 (radial nerve) and ACC53 (ulnar nerve) for the other countries. But this deviation is probably of little practical importance and is hardly sufficient reason to change the definition.

av ligament i handleden), NDM09 (fasciotomi i handleden) och NDM49 (delning av senskida i handleden). En motsvarande analys av norska data styrker att många olika operationer utförs vid karpaltunnelsyndrom. Beteckningen “Carpal tunnel decompression” som används i den engelska versionen av NOME-SKO:s redovisning kan därför missförstås och bör ändras till “Decompression of median nerve”.

I den finska versionen av NCSP finns inte koden ACC51 utan detta ingrepp innefattas i koden ACC59 Neurolysis av perifer nerv. Här ingår sålunda både andra dekompressionsoperationer i handleden och dessutom neurolysis av brakialplexus, lumbalplexus och av nerv på nedre extremiteten. Finland har därför valt att till NOME-SKO redovisa endast patienter med operationskoden ACC59 som samtidigt haft huvuddiagnosen G56.0 Karpaltunnelsyndrom. Om samma förhållanden råder i Finland som nyss visades gälla för Sverige, innebär detta dock en viss överrapportering i förhållande till den formella definitionen, eftersom dekompressionsoperationer på radialis- och ulnarisnerven då också ingår. En möjlighet att öka jämförbarheten mellan länderna vore att i definitionen av denna operationsgrupp inbegripa koderna ACC52 (radialisnerven) och ACC53 (ulnarisnerven) för de övriga länderna, men denna avvikelse torde vara av mindre praktisk betydelse och motiverar knappast en ändring av definitionen.

A greater problem is probably the many other types of surgical procedures that are registered for carpal tunnel syndrome. Whether this is primarily an expression of varying coding practice or whether this reflects real differences in surgical methods, is difficult to judge. As shown by comparing the figures in Tables 1 and 3, Finland is not particularly different from the other countries with regard to this group of surgical procedures, whereas Iceland has a noticeably low figure. This may possibly be explained by a different coding practice in Iceland for surgical procedures for carpal tunnel syndrome.

Cataract surgery:

In the case of Denmark, as previously mentioned, double counting of cases occurs for cataract surgery. Several codes in the group cataract surgery can thus occur for the same hospital stay, for example in the case of bilateral operations. This has led to an over-estimation of the number of cases of about 10 per cent for 2001, as shown in Table 4. The same method of calculation is reported to have been used in previous years, which means that figures for the frequency of this surgical procedure are comparable over time for Denmark, but not among countries. However, since the same method of calculation has been used for both in-patient surgery and day surgery, the percentage of surgical procedures carried out as day surgery is not influenced to any appreciable degree.

With regard to cataract surgery, probably the greatest problem has to do with the fact that this is a surgical procedure that is widely carried out in private health institutions. Comparison with the Health

Ett större problem torde vara de många andra operationstyper som registreras vid karpaltunnelsyndrom. Huruvida detta främst är ett uttryck för varierande kodningspraxis eller motsvarar verkliga skillnader i operationsmetod är svårt att bedöma. Som framgått av jämförelserna i Tabell 1 och Tabell 3 skiljer sig Finland inte markant från de övriga stora länderna när det gäller denna operationsgrupp, medan däremot Island har en anmärkningsvärt låg siffra för förekomsten, vilket möjligen skulle kunna förklaras av annan kodningspraxis i Island beträffande ingreppen vid karpaltunnelsyndrom.

Kataraktoperation:

För Danmarks del förekommer som tidigare nämnts en dubbelräkning av kataraktoperationer. Flera koder inom gruppen kataraktoperationer kan sålunda förekomma vid samma vårdtillfälle, bland annat vid dubbelsidiga operationer. Detta har lett till en överskattning av antalet fall med cirka 10 procent år 2001, vilket framgick av Tabell 4. Samma beräkningssätt uppges ha gällt under tidigare år, vilket gör siffrorna för förekomsten av dessa ingrepp jämförbara över tid för Danmark men inte helt mellan länderna. Eftersom samma beräkningssätt tillämpats för både slutna vård och dagkirurgi påverkas emellertid inte den beräknade procentandelen operationer som utförts som dagkirurgi i nämnvärd grad.

När det gäller kataraktkirurgin torde de största problemen ha att göra med att detta är ett ingrepp som i stor utsträckning utförs i privata vårdformer. Jämförelsen med Sygesikringsregistret i Dan-

Insurance Register in Denmark shows that only about three-quarters of all surgical procedures for cataract surgery are carried out in publicly driven institutions, and are thus reported to NOMESCO. It is more difficult to make a more exact estimation due to double counting in the Danish figures. Double counting can also occur in the Health Insurance Register.

Cataract operations can be delimited in different ways. NOMESCO's grouping of this surgical procedure does not correspond exactly with that used by the Swedish National Cataract Register, which is based on separate reporting, and is organized by the Swedish Ophthalmological Society [11]. However, the differences in definitions are small. The independent data collection of the national cataract register therefore provides the possibility for checking the number of surgical procedures carried out. This is of particular interest, since the cataract register also includes most of the operations carried out in private health institutions (the coverage of both private and public health care is reported to be about 95 per cent). The number of surgical procedures reported to the cataract register in 2001 was about 70 000, while according to the National Board of Health and Welfare's patient register for the same year, there were about 57 000, after recalculating the figures, taking into account the missing data from some counties, as described above. This means that the figures from the National Board of Health and Welfare, and therefore also NOMESCO's figures, constitute about 80 per cent of those in the cataract register. The difference is probably largely related to surgical procedures carried out privately, but it has not been possible to investigate this further.

mark visar att endast omkring tre fjärdedelar av samtliga operationer utförs inom den offentligt drivna vården och sålunda rapporterats till NOMESCO. En mer exakt uppskattning är svår att göra med hänsyn till den dubbelrapportering som finns i de danska siffrorna och som också kan förekomma i Sykesikringsregistret.

Kataraktoperationerna kan avgränsas på något olika sätt. NOMESCO:s gruppering av ingreppen överensstämmer inte helt med den som används i det nationella svenska kataraktregistret, vilket bygger på en separat inrapportering, organiserad av ögonläkarföreningen [11]. Definitionsskillnaderna är emellertid små. Den oberoende datainsamlingen till det nationella kataraktregistret ger därför en möjlighet till avstämning av antalet utförda operationer. Detta är av särskilt intresse, eftersom kataraktregistret även omfattar de allra flesta i privat vård utförda kataraktoperationerna (täckningsgraden uppges beträffande både privat och offentlig vård vara cirka 95 procent). Antalet till kataraktregistret år 2001 inrapporterade operationer var cirka 70 000, medan det enligt Socialstyrelsens patientregister samma år var knappt 57 000 efter den nämnda uppräknningen för bortfallet av uppgifter från vissa landsting. Det innebär att Socialstyrelsens och därmed NOMESCO:s siffror endast utgör omkring 80 procent av kataraktregistrets. Det är sannolikt att skillnaden till stor del hänförs till privat utförda operationer men detta har inte kunnat studeras närmare.

Thus, for both Denmark and Sweden there is a significant amount of missing data for cataract operations. The situation in the other countries is unclear. Comparison of the number of cataract surgery procedures in relation to the population indicates that the amount of missing data may be particularly large for Iceland, which has the lowest frequency of these surgical procedures (see Table 1).

Tonsillectomy and/or adenoidectomy: The name of this group in NOMESCO's report is misleading. Here, the group is called "tonsillectomy with or without adenoidectomy". However, NCSP code EMB30 is included, which is adenoidectomy without tonsillectomy. The correct name of the group is therefore "tonsillectomy and/or adenoidectomy".

In the report, it would probably have been better to record a group consisting of tonsillectomy with or without adenoidectomy, in other words the sum of cases with NCSP code EMB10 for tonsillectomy (alone) and cases with code EMB20 for tonsillectomy with adenoidectomy. Adenoidectomy alone with code EMB30 is carried out much more often on an out-patient basis. Inclusion of this surgical procedure therefore has a "dilution" effect, and makes the group less suitable as an indicator of the trend in day surgery in this area. Whether tonsillectomies should be carried out on an in-patient or out-patient basis is a topic for discussion within the profession, with regard to the risk of complications such as post-operative bleeding. This makes the statistics on how tonsillectomies are carried out in the Nordic countries (irrespective of whether adenoidectomy is performed at the same time or not) particularly interesting.

Både för Danmark och Sverige gäller alltså att ett inte obetydligt bortfall förekommer när det gäller kataraktoperationerna. Det är något oklart hur situationen är i de övriga länderna. En jämförelse av de befolkningsrelaterade siffrorna för kataraktkirurgi antyder att bortfallet kan vara särskilt stort i Island som visar den lägsta förekomsten av sådana operationer (se Tabell 1).

Tonsillektomi och/eller adenoidektomi : Den i NOMESKO:s redovisning använda rubriken är missvisande. Där kallas gruppen "Tonsillectomy with or without adenoidectomy". Här ingår emellertid även NCSP-koden EMB30 som avser adenoidektomi utan samtidig tonsillektomi. En korrekt benämning av gruppen är därför "Tonsillectomy and/or adenoidectomy".

I själva verket torde det dock vara bättre att redovisa en grupp bestående av tonsillektomi med eller utan adenoidektomi, det vill säga summan av fall med NCSP-koden EMB10 för tonsillektomi (enbart) och fall med koden EMB20 för tonsillektomi med samtidig adenoidektomi. Den rena adenoidektomin ("polypsrapning") med koden EMB30 utförs i mycket stor utsträckning i öppna vårdformer. Att inkludera den i statistiken innebär därför en utspädningseffekt och gör gruppen mindre lämplig som indikator på polikliniseringen inom detta område. Huruvida tonsillektomier bör utföras i slutna eller öppna vård diskuteras däremot i fackkretsar med hänsyn till den risk för komplicerande efterblödning som finns. Statistik som kan belysa hur man gör i de nordiska länderna med tonsillektomier (oavsett om de utförs tillsammans med adenoidektomi eller ej) är därför klart intressant.

A calculation done on the Swedish data for 2001 has shown that the number of adenoidectomies alone, reported to the NOMESCO surgical group tonsillectomy and/or adenoidectomy, amounted to 35 per cent. Of these, 89 per cent were carried out as day surgery. If surgical group EMB30 is excluded, the proportion of surgical procedures carried out as day surgery falls from 40 per cent to 15 per cent (estimation from raw figures).

Surgical procedures carried out in private health institutions are a particular problem for this surgical procedure group.

For Denmark, a comparison can be made with the statistics in the Health Insurance Register, where approximately 10 000 tonsillectomies and adenoidectomies were performed in private health institutions in 2001. It has been shown that these surgical procedures were mainly adenoidectomies. A considerable degree of double counting has taken place in the figures reported to NOMESCO in this surgical group (and a certain amount of double counting is also assumed to have occurred in the reporting to the Health Insurance Register). After correcting for double counting, the total number of cases in the National Patient register is about 8 000 (see Table 4), of which about 20 per cent are performed as day surgery. These figures also indicate that the reporting should be limited to tonsillectomy with or without adenoidectomy. Since adenoidectomies alone are performed to a large extent in private health institutions, and are therefore more difficult to obtain statistics on, the problem of under-reporting is reduced and the quality of the statistics is improved, if adenoidectomies alone are excluded from this surgical group.

En beräkning gjord på svenska data för år 2001 visar att antalet rena adenoidektomier i den till NOMESCO redovisade gruppen utgjorde 35 procent. Av de rena adenoidektomierna (EMB30) var 89 procent ambulantly behandlade. Om EMB30 exkluderas sjunker andelen dagkirurgiskt behandlade fall från 40 procent till 15 procent (beräkningen gjord på ej uppräknade tal).

Operationer utförda i privata vårdformer är ett särskilt problem för denna operationsgrupp.

För Danmark kan en jämförelse göras med Sykesikringsregistret, i vilket fanns cirka 10 000 resektioner av tonsiller och adenoider utförda i privata vårdformer 2001. Det visar sig att dessa till övervägande del är rena adenoidoperationer. En avsevärd dubbelräkning visade sig ju förekomma i de danska uppgifterna till NOMESCO inom denna grupp (och en viss dubbelräkning antas förekomma även i Sykesikringsregistret). Efter korrektion för dubbelräkning uppgår totalantalet fall i Landspatientregistret till cirka 8000 (se Tabell 4), varav knappt 20 procent utfördes som dagkirurgi. Även dessa siffror talar därför för att man begränsar statistiken till tonsillektomi med eller utan adenoidektomi. Eftersom de rena adenoidektomierna i stor utsträckning utförs i privata vårdformer och därför kommer att vara svårare att få uppgift om, minskar man också problemet med underrapporteringen och höjer kvaliteten på statistiken, om man begränsar gruppens omfattning.

VALIDITY AND COMPARABILITY OF NORDIC DAY SURGERY STATISTICS

New statistics have therefore been collected from all the Nordic countries for a revised surgical group, including only tonsillectomy with or without adenoidectomy (only codes EMB10 and EMB20). These figures are presented in Table 5.

Nya uppgifter har därför samlats in från samtliga länder för en reviderad grupp endast omfattande tonsillektomi med eller utan adenoidektomi (enbart koderna EMB10 och EMB20). Uppgifterna redovisas i Tabell 5.

Table 5 Tonsillectomy with or without adenoidectomy 2001 with the new definition including NCSP codes EMB10 and EMB20 only

	Denmark	Finland	Iceland ¹⁾	Norway	Sweden
Number of procedures	7 183	9 001	1 051	9 625	7 561
Per 100 000	134	173	384	213	85
Of which day surgery	1 674	1 598	314	1 968	1 038
Day surgery, per cent	23	18	30	20	14

1 1998.

A comparison of the statistics in Tables 1 and 5 shows that the effect of the new definition is that the number of tonsillectomies carried out as day surgery becomes considerably lower in all the Nordic countries except Denmark. The differences between the countries may reflect differences in practice with regard to the trend from in-patient to out-patient surgery for this surgical procedure. It is also noticeable that the number of surgical procedures per 100 000 of the population vary greatly, with a relatively low frequency in Sweden. This may also reflect differences in treatment practice.

Surgical procedures for repair of hernia:

The group of surgical procedures for inguinal hernia and femoral hernia are well defined. No special problems have been noted with these surgical procedures. An increasing number of hernias are repaired with laparoscopy, but this method is included in the definitions.

Double counting of surgical procedures in this group in Denmark is a very limited

Det framgår av en jämförelse mellan tabellerna 1 och 5 att renodlingen inneburit att andelen tonsillektomier som utförts som dagkirurgi nu är avsevärt lägre i samtliga länder utom Danmark. De skillnader som finns mellan länderna kan spegla skillnader i praxis när det gäller poliklinisering av detta ingrepp. Det bör också observeras att de befolkningsrelaterade talen för detta ingrepp skiljer sig väsentligt med förhållandevis låg förekomst i Sverige, vilket också kan vara en fråga om olikheter i behandlingspraxis.

Operationer för ljumskbråck och femoralbråck:

Gruppen operationer för inguinal- och femoralbråck är väl definierad. Inga särskilda problem har noterats med dessa ingrepp. Ett ökande antal ljumskbråcksoperationer utförs med laparoskopisk teknik men denna metod innefattas i de angivna definitionerna.

Dubbelräkning av operationer inom denna grupp i Danmark är ett mycket be-

problem. Correction for this, and correction for the definition of day surgery, reduces the total number of cases by only 2 per cent.

Surgical procedures for hernia are performed to some extent in private health institutions, and may therefore not be included in reporting to NOMESCO. Comparison with the Health Insurance Register shows that about one fifth of all hernia operations in Denmark are not included in the reporting, since they are carried out in private health institutions.

As shown in Table 1, the numbers of surgical procedures for repair of hernia per 100 000 of the population are similar for the Nordic countries. Only Iceland lies considerably below the level of the other countries.

Laparoscopic cholecystectomy:

Laparoscopic cholecystectomy is a well-defined surgical procedure. So far, it is only carried out to a limited degree as day surgery, but the proportion is increasing, as shown in Table 3. There is good reason to continue studying this trend.

Curettage and excision of the endometrium:

This group includes two different types of operations. The largest type includes simple curettage of the cervix and uterus, which is most often performed for the purpose of diagnosis (NCSP codes LCA10, LCA13, and LCA16 and LCD10). The other sub-group includes two hysteroscopic procedures, primarily hysteroscopic excision of endometrium (TCR-E) (NCSP code LCB28) and a similar procedure, hysteroscopic destruction

gränsat problem; korrektion för detta och dagkirurgidefinitionen minskar totalantalet fall med endast 2 procent.

Operationer för ljumskbräck företas i viss utsträckning utanför den offentligt drivna sjukvården och riskerar därför att hamna utanför NOMESCO:s redovisning. Av jämförelse med Sygesikringsregistret framgår att drygt en femtedel av alla bräckoperationer i Danmark torde falla utanför redovisningen, eftersom de utförs i privata vårdformer.

Som framgått av Tabell 1 är den befolkningsrelaterade förekomsten av bräckoperationer av samma storleksordning i de nordiska länderna. Endast Island ligger avsevärt under de andra ländernas nivå.

Laparoskopisk kolecystektomi:

Laparoskopisk kolecystektomi är ett väl definierat ingrepp. Det utförs ännu endast i begränsad omfattning som dagkirurgi men andelen är stigande som framgått av Tabell 3 ovan. Det finns mycket goda skäl att i den nordiska statistiken fortsätta att följa denna utveckling.

Skrapningar och excision av endometriet:

Denna grupp innehåller två olika operationstyper. Den största delen utgörs av enkla skrapningar av cervix och uterus, vilka oftast görs i diagnostiskt syfte (NCSP-koderna LCA10, LCA13 och LCA16 samt LCD10). En annan delgrupp är två hysteroskopiska operationer, främst transcervikal resektion av endometriet (TCR-E) (NCSP-kod LCB28) samt ett liknande ingrepp (LCB32). Den båda senare är mer omfattande och görs

of endometrium (LCB32). These two surgical procedures are more extensive, and are carried out primarily for polyp resection or myoma resection, and for endometriosis of the type adenomyosis. Simple curettage is carried out more and more often as day surgery and is less demanding of resources than the hysteroscopic surgical procedures. Gynaecologists have therefore recommended that these two sub-groups should be separated.

A closer analysis of the Swedish data for 2001 confirms that the two groups vary with regard to the proportion of surgical procedures carried out as day surgery. Sixty-nine per cent of curettage of uterus (LCA10-16) and 91 per cent of curettage of cervix uteri (LDA10) are carried out as day surgery, whilst 63 per cent of the two hysteroscopic surgical procedures are carried out as day surgery. However, it has been shown that the two hysteroscopic surgical procedures only amount to 2 per cent of all the surgical procedures in the NOMESCO group, and are thus too small a group for special reporting. In addition, the number of TCR-E for endometriosis has become less during the last few years, due to new methods of treatment with insertion of coils with gestagen progesterone.

A possible way of altering this surgical procedure group would be to make it include only curettage of uterus and cervix uteri. However, the difference between this and the present definition has little practical importance.

However, the biggest problem is missing data for surgical procedures carried out in private health institutions. This missing data most probably comprises mainly

främst för polyp- eller myomresektion och vid endometriosis av typen adenomyos. De enkla skrapningarna genomförs i högre utsträckning som polikliniska ingrepp och är mindre resurskrävande än de hysteroskopiska ingreppen. Från gynekologiskt håll har därför påpekats att dessa båda delgrupper borde skiljas upp.

En närmare analys av svenska data från 2001 bekräftar att de båda grupperna skiljer sig något i graden av poliklinisering. Av uterus-skrapningarna (LCA10-16) gjordes 69 procent och av cervix-skrapningarna (LDA10) 91 procent polikliniskt, medan 63 procent av de båda hysteroskopiska ingreppen var polikliniska. Det visar sig emellertid att de två hysteroskopiska ingreppen endast utgör 2 procent av samtliga ingrepp i den aktuella NOMESCO-gruppen och således är en alldeles för liten grupp för särredovisning. Därtill kommer att antalet TCR-E-operationer för endometriosis under senare år har minskat på grund av nya behandlingsmöjligheter genom inläggning av spiral med gestagen progesteron.

En eventuell modifiering för att renodla denna operationsgrupp är att låta den enbart omfatta uterus- och cervixskrapning. Skillnaden mot nuvarande definition är dock från praktisk synpunkt betydelslös.

Det stora problemet är emellertid bortfallet av operationer utanför den offentligt drivna sjukvården. Detta bortfall utgörs med stor sannolikhet till största delen av

procedures carried out as day surgery. The effect of this is that the proportion of surgical procedures carried out as day surgery is probably much higher than shown in NOMESCO's data.

NOMESCO's statistics for Denmark, after correction, include 10 000 cases in this group, a reduction of 8 per cent from the originally reported data. In the Health Insurance Register, 27 000 of these surgical procedures are registered. After closer inspection, it has been shown that a considerable amount of double counting of surgical procedure codes has probably occurred in this reporting, and it is therefore difficult to estimate the number of surgical procedures that are carried out in private health institutions in Denmark. However, it is likely that there are more unreported surgical procedures carried out privately than those that have been reported and included in NOMESCO's statistics for 2001. Despite this, the Danish figure per 100 000 of the population is high, as is the Swedish figure (Table 1).

For this group, it is probable that, in several of the Nordic countries, many surgical procedures carried out in private institutions have not been reported.

However, there are also other reasons to question the suitability of this surgical group as an indicator for trends in day surgery. A comparison of curettage of the uterus carried out as day surgery with the same procedure carried out as in-patient surgery is not really meaningful, since it partly concerns different patient groups. Curettage carried out as day surgery is often only diagnostic and is the only surgical procedure carried out on the patient in question, whilst curettage carried out as in-patient surgery is of-

polikliniskt utförda operationer, vilket påverkar den beräknade polikliniseringsgraden som i verkligheten torde vara betydligt högre än vad NOMESKO:s statistik visar.

NOMESKO-statistiken för Danmark omfattar efter korrigeringar 10 000 fall i denna grupp, en minskning med 8 procent av den ursprungligen redovisade siffran. I Sygesikringsregistret redovisades samtidigt över 27 000 motsvarande ingrepp. Det visar sig vid närmare granskning att en avsevärd dubbelräkning av operationskoder torde förekomma i denna redovisning, och det är därför svårt att få någon uppskattning av antalet ingrepp som utförts i privat vård i Danmark. Det är dock sannolikt att de oredovisade privata ingreppen är fler än de ingrepp som kom med i NOMESKO:s statistik 2001. Trots detta ligger den danska befolkningsrelaterade förekomsten i denna statistik högt tillsammans med den svenska siffran (Tabell 1).

Det är sannolikt att vi inom denna grupp har ett stort antal i statistiken oredovisade, i privat vård utförda ingrepp i flera nordiska länder.

Man kan emellertid även av andra skäl ifrågasätta den aktuella operationsgruppens lämplighet som indikatoroperation för dagkirurgiutvecklingen. En jämförelse mellan uteruskrapningar som utförs i öppen vård med sådana som görs i slutenvård är nämligen inte riktigt meningsfull, eftersom den avser delvis olika patientgrupper. Skrapningar i öppen vård är ofta bara diagnostiska och utgör det enda ingreppet på patienten i fråga, medan skrapningar som görs i slutenvård ofta är

ten a preliminary procedure, followed by a more extensive surgical procedure such as hysterectomy or investigation for malignancy. In the Swedish material, about one-third of the in-patients had another larger operation in addition to curettage during the same admission.

Termination of pregnancy:

Surgical procedures for termination of pregnancy include different techniques for evacuation of the uterus. These surgical procedures are to a large extent carried out as day surgery.

The main problem for the statistics is that termination of pregnancy to an increasing degree is carried out as so-called medical abortion, using hormonal therapy without any surgical procedure. These procedures are not registered as surgical procedures with an NCSP code, but can be identified with the diagnosis code O04 Termination of pregnancy (at the same time without a surgical procedure code). The question of to what degree legal termination of pregnancy is carried out as medical abortions is clearly interesting, but it cannot be illuminated with the help of the NCSP code alone, which is of course the basis for the present NOMESCO statistics. The national abortion registers are a better source for studying changes in practice with regard to termination of pregnancy.

The publication *Induced Abortions in the Nordic Countries*, published by STAKES, has recently been updated, based on the official statistics in each country [12]. In 2001 16 per cent of abortions in Finland and 38 per cent in Sweden were drug-induced. The proportion in Denmark was 18 per cent in 2000. No data were available for Nor-

ett inledande ingrepp som efterföljs av en mer omfattande operation såsom hysterektomi eller malignitetsutredning. I det svenska materialet hade ungefär en tredjedel av de inlagda patienterna en annan större operation utöver uteruskrapningen vid samma vårdtillfälle.

Legal abortingrepp:

Operationer för avbrytande av graviditet omfattar olika kirurgiska tekniker för utrymning av uterus. Dessa ingrepp utförs i stor utsträckning polikliniskt.

Det främsta problemet för statistiken är här att abortingreppen i växande utsträckning görs som så kallade medicinska aborter genom hormonell terapi och utan något kirurgiskt ingrepp. De kommer alltså inte att registreras som kirurgiska ingrepp med NCSP-kod men kan identifieras med diagnoskoden O04 Legal abort (och samtidig avsaknad av operationskod). Frågan om i vilken utsträckning legala graviditetsavbrytanden görs som medicinska aborter är klart intressant, men den kan alltså inte belysas med hjälp av NCSP-kod enbart, vilket ju är grunden för den nuvarande NOMESCO-statistiken. De nationella abortregistren är en bättre källa för studier av förändrad praxis när det gäller de legala abortingreppen.

Den av STAKES utgivna publikationen *Aborter i Norden* har nyligen uppdaterats med siffror från den officiella statistiken i respektive land [12]. Därav framgår att år 2001 utgjorde de så kallade farmakologiska aborterna 16 procent av alla aborter i Finland och 38 procent av alla aborter i Sverige. Motsvarande tal för Danmark var år 2000 18 procent. För Norges del saknas

way and in Iceland drug-induced abortions were not available.

A closer analysis of NOMESCO's statistics for 1999-2001 shows a small reduction in the number of surgical abortions for the three countries that have reported: a reduction of 7 per cent for Denmark, 2 per cent for Finland and 4 per cent for Norway.

The increasing number of medical abortions, which must be carried out early in pregnancy, involves a selection of late abortions for surgical treatment and therefore the need for more extensive surgical procedures. This should lead to a smaller proportion of surgical abortions carried out as day surgery. However, such a trend is not apparent in NOMESCO's statistics (see Table 3).

The problem of missing data due to surgical procedures carried out in private health institutions should not occur in this case, since abortion legislation in all the countries requires termination of pregnancy to be carried out by the public health services.

For the sake of clarity, NOMESCO from now on should call this group "surgical termination of pregnancy"

Female sterilization:

Surgical procedures for female sterilization is a well-defined group, which is coded with about ten codes in the NCSP group LGA. Most of the methods are laparoscopic, which probably accounts for the increasing proportion of surgical procedures carried out as day surgery. No problems have been identified with this group, apart from the uncertainty of

uppgifter och i Island var läkemedelsinducerad abort inte möjlig.

En närmare analys av siffrorna från åren 1999-2001 i NOMESKO:s statistik visar en viss nedgång av antalet kirurgiskt utförda aborter för de tre länder som rapporterat uppgifter, nämligen en minskning med för Danmark 7 procent, för Finland 2 procent och för Norge 4 procent.

Den ökande andelen medicinska aborter, vilka ju måste utföras tidigt under graviditeten, innebär en selektion av sena fall till kirurgisk behandling och därmed behov av större ingrepp. Detta skulle kunna leda till en minskande andel polikliniskt utförda, kirurgiska aborter. Någon sådan tendens kan emellertid ännu inte utläsas i NOMESKO:s statistik (se Tabell 3).

Något problem med bortfall genom att ingrepp utförs utanför den offentligt drivna sjukvården bör inte finnas i detta fall, eftersom abortlagstiftningen i samtliga länder torde förutsätta att legala abortingrepp görs i den offentliga sjukvården.

För tydlighetens skull bör NOMESKO i fortsättningen kalla den aktuella operationsgruppen "Kirurgiska legala abortingrepp".

Kvinnlig sterilisering:

Ingrepp för kvinnlig sterilisering är en väl definierad grupp som kodas med ett tiotal koder inom NCSP-gruppen LGA. Här ingår laparoskopiska metoder som en väsentlig del, vilket torde förklara den växande andelen polikliniskt utförda ingrepp. Några problem med denna grupp har inte noterats utöver oklarheten om i vilken utsträckning dessa ingrepp under-

the degree of under-reporting of these procedures to NOMESCO, as a consequence of the fact that they may also be carried out in private health institutions.

The figures for the number of female sterilizations per 100 000 of the population show that Sweden lies at a lower level than the other countries. Whether this is an indication of missing data, or whether it reflects a difference in treatment practice, is difficult to say.

Removal of implanted devices from bone:

Removal of implanted devices from bone is a very mixed group, which includes surgical procedures on all parts of the body. The different surgical procedures differ in extent and level of complexity. This relatively large group should probably be defined better. However, no closer analysis of the group has been carried out.

Knee arthroscopy:

Explorative or diagnostic arthroscopy of the knee joint (NCSP code NGA11) is a well-defined surgical procedure. However, it is possible that uncertainty can sometimes occur with regard to coding of simpler therapeutic procedures in connection with explorative arthroscopy, such as removal of a small foreign body in the joint. In the DRG grouping, diagnostic arthroscopy is grouped together with such minor therapeutic procedures, since the use of resources for this surgery is similar.

Explorative knee arthroscopy has to a certain degree been replaced by other diagnostic methods, primarily investigation with magnetic resonance tomogra-

graferas i NOMESKO:s statistik som följd av att de också torde utföras i privata vårdformer.

De befolkningsrelaterade talen för förekomst av kvinnlig sterilisering visar att Sverige ligger på en lägre nivå än de övriga länderna. Huruvida detta indikerar ett bortfallsproblem eller avspeglar en annan behandlingspraxis är svårt att säga.

Avlägsnande av osteosyntesmaterial:

Borttagande av osteosyntesmaterial är en mycket blandad grupp som innefattar ingrepp på alla delar av kroppen. De enskilda ingreppen varierar i omfattning och svårighetsgrad. Möjligen skulle gruppen som är förhållandevis stor kunna renodlas bättre. Någon närmare analys härav har dock inte gjorts.

Knäledsartroskopi:

Explorativ eller diagnostisk artroskopi av knäled (NCSP-kod NGA11) är i och för sig ett väldefinierat ingrepp. Det är dock möjligt att oklarhet ibland råder beträffande hur kodningen skall ske av enklare terapeutiska ingrepp i samband med explorativ artroskopi, såsom extraktion av en mindre fri kropp i leden. Vid DRG-gruppering sammanförs den diagnostiska artroskopin med sådana mindre terapeutiska ingrepp på basen av den likartade resursåtgången vid ingreppen.

Den explorativa knäledsartroskopin har i viss utsträckning ersatts av andra diagnostiska metoder, framför allt undersökning med magnetkamera (MRT).

phy (MRT). The decreasing number of investigations is clearly shown in NOMESCO's statistics. The statistics from previous years show that, for Denmark, the number of surgical procedures in this group decreased by 23 per cent from 1997-2001. The corresponding reduction for Finland was 36 per cent. However, for Norway, the number of surgical procedures increased from 1999 to 2001 by 12 per cent.

It is probable that there is missing data for this group, due to surgical procedures carried out in sports medicine centres and other private health clinics. For this reason one can question whether it is meaningful to keep purely diagnostic knee arthroscopy as a separate group. However, it is considered to be of interest to follow the trend, so no changes to the statistics for this surgical procedure group are recommended.

Arthroscopic operation on the knee meniscus:

This group includes arthroscopic knee operations, such as total and partial excision of meniscus of knee, and reinsertion of meniscus of knee. It is a well-defined group of surgical procedures that to a large extent are carried out as day surgery. No special problems have been found with the statistics for this group. However, it is probable that these surgical procedures are sometimes carried out in sports medicine centres or other private health clinics, which are not included in NOMESCO's statistics. It has not been possible to estimate the extent of this private day surgery activity.

As shown in Table 1, the number of surgical procedures in this group per

Det minskande antalet undersökningar framgår också tydligt i NOMESCO:s statistik. En sammanställning av uppgifter från tidigare år visar att för Danmark minskade antalet ingrepp i denna grupp kontinuerligt från 1997 till 2001, en sammanlagd minskning med 23 procent. För Finlands del var motsvarande minskning 36 procent. För Norge ökade dock ingreppens antal från 1999 till 2001 med 12 procent.

Det är sannolikt att man också har ett bortfall som utgörs av ingrepp utförda vid idrottsmedicinska och andra privata mottagningar. På dessa olika grunder kan man ifrågasätta om det är meningsfullt att bibehålla den rent diagnostiska knäledsartroskopi som en egen grupp. Det har dock ansetts vara av intresse att följa den vidare utvecklingen, varför någon förändring av statistiken inte föreslås avseende denna grupp.

Artroskopisk operation av knäleds-menisk:

Denna grupp omfattar artroskopiska knäledoperationer, nämligen total respektive partiell excision av menisk i knä samt återinsättning av menisk i knä. Den torde vara en väl definierad grupp som i relativt hög grad blir föremål för poliklinisk behandling. Några särskilda problem med statistiken har inte framkommit. Det är dock sannolikt att dessa ingrepp ibland görs vid idrottsmedicinska specialmottagningar eller andra privata mottagningar som inte omfattas av NOMESCO-statistiken. Ingen möjlighet har funnits att få uppfattning om storleksordningen av sådan dagkirurgisk verksamhet.

De befolkningsrelaterade talen i Tabell 1 visar en anmärkningsvärt låg siffra för Is-

100 000 of the population is notably low for Iceland. The reason for this is unclear. However, for Iceland, the figures reported to NOMESCO are low for all orthopaedic surgical procedures.

Ligature and resection of veins of leg:

Ligature of perforating veins and resection of veins of the lower extremities are included in this group. The group does not however include the simplest surgical procedures for varicose veins, such as injection of sclerotic fluid.

There are great differences between the Nordic countries in the statistics reported to NOMESCO for this group. The original figures reported by Denmark were much too high, and were reduced to less than half after correction (see Table 4). The figures per 100 000 of the population are very low for Sweden and Iceland.

The significance of these large differences between the countries is unclear. There is reason to believe that there is much missing data in this group. The group needs to be further investigated and reconsidered with regard to continued registration.

Should NOMESCO'S day surgery statistics include other surgical procedure groups?

In order to form the basis for a possible increase in the number of surgical procedure groups for NOMESCO's statistics of day surgery, an assessment of the hundred most common NCSP codes re-

land, vilkens innebörd är oklar. Det kan noteras att Island redovisar låga förekomster för samtliga ortopedkirurgiska ingrepp i NOMESKO-statistiken.

Operation av åderbråck:

Underbindning av perforantvener och resection av vener på nedre extremiteten ingår i denna grupp. Den omfattar däremot inte de enklaste ingreppen vid åderbråck såsom injektion av skleroserande medel.

Stora skillnader i rapporteringen förekommer mellan de nordiska länderna när det gäller denna grupp i NOMESKO-statistiken. Den ursprungligen rapporterade mycket höga frekvensen i Danmark visade sig ju reduceras till mindre än hälften efter korrektionerna (se Tabell 4). I de befolkningsrelaterade talen finner man mycket låg frekvens i Sverige och i Island.

Innebörden av dessa stora skillnader mellan länderna är oklar. Det finns anledning att tro att stora bortfallsproblem kan föreligga inom denna grupp, vilket bör bli föremål för vidare utredning och överväganden när det gäller den fortsatta registreringen.

Bör NOMESKO:s dagkirurgi omfatta flera ingrepp?

För att få underlag för förslag till en tänkbar utvidgning av antalet ingrepp för NOMESKO:s statistik över dagkirurgi gjordes en genomgång av de 100 vanligast förekommande NCSP-koderna

ported to the Swedish National Board of Health and Welfare, that were carried out both as in-patient surgery and day surgery in 2001 was carried out. It should be noted that ranking the surgical procedure codes in order of frequency is not an ideal point of departure, since choosing a combination of several codes in the same group can be more appropriate than choosing a single code.

A number of surgical procedure groups have been assessed with regard to the proportion of surgical procedures carried out as day surgery and possible coding problems. The results have been discussed with Finnish, Norwegian and Swedish experts (Martti Virtanen, Glen Thorsen, Leena Kiviluoto and Mats Fernström).

For some of the surgical procedure groups, the proportion of surgical procedures carried out as day surgery is so high that they are not suitable candidates for the statistics, since the main purpose is to study an expected continuing increase in the proportion of surgical procedures carried out as day surgery. One example of such a surgical procedure is shock-wave lithotripsy ("kidney stone crushing") of which 91 per cent of cases are carried out as day-surgery.

One type of surgical procedure that has been widely discussed is endoscopy (via natural body openings), which can be either purely diagnostic or else therapeutic, in other words associated with surgical procedures. Several types of endoscopy are carried out very frequently, such as gastroscopy, colonoscopy and cystoscopy. Thus they constitute a large proportion of total out-patient activity in the health services, but often without be-

bland till den svenska Socialstyrelsen inrapporterade ingrepp som utförts i öppen respektive sluten vård 2001. Det bör dock noteras att en rangordning efter frekvensen av enskilda koder inte är en idealisk utgångspunkt, eftersom en kombination av flera koder i samma grupp kan vara mera rimlig än att välja enskilda koder.

Ett antal grupper har granskats med avseende på aktuell polikliniseringsgrad och eventuella kodningsproblem. Resultatet har diskuterats med finska, norska och svenska experter (Martti Virtanen, Glen Thorsen, Leena Kiviluoto och Mats Fernström).

För ett antal ingrepp är polikliniseringsgraden redan så hög att de inte utgör lämpliga kandidater för en statistik, vars främsta syfte är att spegla en förväntat fortsatt ökning av ingrepp i öppen vård. Exempel på ett sådant ingrepp är stötvågslitotripsi ("njurstenskrossning") med 91 procent polikliniskt utförda ingrepp.

En typ av ingrepp som diskuterats ingående är de endoskopiska ingreppen (genom naturliga kroppsöppningar) som kan vara rent diagnostiska eller terapeutiska, det vill säga förenade med kirurgiska ingrepp. Flera endoskopier är mycket frekventa såsom bronkoskopi, gastroskopi, koloskopi och cystoskopi. De utgör därigenom en stor del av den samlade polikliniska aktiviteten i sjukvården, ofta inte ens karakteriserad som dagkirurgi.

ing classified as day surgery. However, comparison of endoscopic procedures that are carried out as day surgery with those carried out as in-patient surgery is not really meaningful, since they often concern totally different groups of patients. Out-patient endoscopy is most often diagnostic and is carried out on relatively healthy patients, while in-patient endoscopy is most often carried out on patients who are in hospital for reasons other than the endoscopic procedure. Examples are follow-up of earlier surgery and evaluation of the result of treatment of more or less seriously ill patients. Thus it was agreed not to propose that endoscopic procedures should be included in the statistics of day surgery.

In other cases, there are potential problems with differences in registration and coding practice, such that some common surgical procedures were not assessed as suitable candidates for comparable Nordic day surgery statistics. Surgery for hallux valgus is a common surgical procedure. The appropriate surgical procedures are denoted angulation, rotation or displacement osteotomy of ankle or foot (the usual codes are NHK57 and NHK59). A closer examination has shown that this section in the national versions of NCSP has been formulated differently. This has probably influenced coding practice and led to relatively low precision in coding in Sweden. Similarly, varying precision in coding of surgical procedures for Dupuytren's contracture has been found. The appropriate code for this condition should be NDM19 Partial or total excision of fascia of wrist or hand.

After further discussions with experts in surgery and registration, the following

En jämförelse mellan endoskopiska ingrepp som gjorts i öppen vård med sådana som gjorts i sluten vård ter sig emellertid inte riktigt meningsfull, eftersom de i många avseenden avser helt olika patientgrupper. Öppenvårdsendoskopierna är oftast diagnostiska och utförs på relativt friska personer, medan de som utförs i sluten vård oftast görs på patienter som av andra orsaker än endoskopiingreppet vårdas på sjukhus. Det kan här vara fråga om uppföljning av tidigare kirurgi och värdering av behandlingsresultat hos mer eller mindre allvarligt sjuka patienter. Man enades därför om att inte lägga fram förslag om att ta med endoskopiska ingrepp i dagkirurgistatistiken.

I andra fall är det befarade problem med olika registrerings- och kodningspraxis som gör att i och för sig vanliga ingrepp inte bedömts vara goda kandidater för jämförande nordisk dagkirurgistatistik. Operationer för hallux valgus är ett vanligt ingrepp. De aktuella operationerna betecknas som vinklings-, rotations- eller förskjutningsosteotomi på fot eller fotled (vanliga koder är NHK57 och NHK59). En närmare granskning visar att de nationella versionerna av NCSP tidigare har varit olika utformade inom detta avsnitt, vilket torde ha inverkat på kodningspraxis och lett till en relativt låg precision i kodningen i Sverige. På liknande sätt kan man befara varierande precision i kodningen av operation för Dupuytren's kontraktur, där den adekvata koden torde vara NDM19 Partiell eller total excision av fascia i hand eller handled.

Efter ytterligare diskussioner med kirurgisk och registreringskunnig expertis

three surgical procedures were proposed as the best candidates for an extension of NOMESCO's day surgery statistics.

Partial excision of mammary gland:

The trend in treatment of breast cancer and other diseases of the mammary glands is towards less invasive surgery, which can therefore be carried out as day surgery to an increasing degree.

There are six different codes in the NCSP section HAB Partial excision of mammary gland. The two most common are:

HAB00 Excision of lesion of mammary gland (1712 procedures in Sweden in 2001, of which 79 per cent as day surgery)

HAB40 Wedge excision of mammary gland (4598 procedures, 24 per cent as day surgery).

Since HAB40 is both the most common surgical procedure and the procedure with the greatest potential for being carried out as day surgery, it is proposed as the main candidate. Choosing a single code causes the fewest coding and registration problems. An alternative is to choose HAB00 and HAB40 as a combined group, though this combination is less specific.

In NOMESCO's statistics of in-patient care, the whole group HAB Partial resection of mammary gland is included. The reason for including this more broadly-defined group of surgical procedures is that it is the group that it is natural to compare with mastectomy (group HAC). Group HAC is also included in the statistics on in-patient care. For statistics that shall primarily be used to measure the in-

framstår följande tre operationer som de starkaste kandidaterna för en utvidgning av NOMESKO:s dagkirurgiredovisning.

Partiell mammarresektion:

Behandlingen av bröstcancer och andra bröstkörtelsjukdomar har utvecklats mot mindre stympande ingrepp, vilka bland annat därför i ökande grad kunnat utföras polikliniskt.

Sex olika koder finns i NCSP inom avsnittet HAB Resektion av bröstkörtel. De två vanligaste är:

HAB00 Exstirpation av förändring i bröstkörtel (1712 ingrepp i Sverige 2001, varav 79 procent i öppen vård)

HAB40 Partiell mastektomi (kilresektion) (4598 ingrepp, 24 procent i öppen vård).

Med hänsyn till att HAB40 är den vanligaste operationen och är det ingrepp som har störst potential för poliklinisering föreslås den i första hand som kandidat. Att välja en enda kod vållar minst kodnings- och registreringsproblem. Ett alternativ är den kombinerade gruppen HAB00 och HAB40 som dock är mindre renodlad.

I NOMESKO:s slutenvårdstatistik ingår kodgruppen HAB Resektion av bröstkörtel som helhet. Denna bredare definierade grupp av ingrepp motiveras av att den är den naturliga jämförelsegruppen i förhållande till mastektomi (kodgruppen HAC), som också ingår i slutenvårdsstatistiken. För en statistik som främst skall tjäna som mått på processen mot ökad användning av ingrepp i

crease in the proportion of surgical procedures carried out as day surgery, there is reason to choose a more narrowly-defined surgical procedure group as an indicator (HAB40), as proposed.

Surgical procedures for haemorrhoids:
The section JHB Procedures for haemorrhoids and prolapse of mucosa, contains six codes. The commonest are:

JHB00 Haemorrhoidectomy (2107 procedures in Sweden in 2001, of which 50 per cent as day surgery)

JHB20 Sclerotherapy of haemorrhoids (1079 procedures, 94 per cent as day surgery)

JHB30 Rubber band ligation of haemorrhoids or prolapse of mucosa (2382 procedures, 97 per cent as day surgery)

The recently introduced code JHB40 Resection and stapled suture of haemorrhoids or prolapse of mucosa was not registered at all in Sweden in 2001.

It is fairly clear that JHB00 is the most suitable candidate, perhaps in combination with JHB40 when it starts to be used.

Surgical procedures on the prostate:
There are eight codes in the section KED Partial excision of prostate, of which the three most common are:

KED22 Transurethral resection of prostate (TURP) (7295 procedures in Sweden in 2001, of which 4 per cent as day surgery)

KED32 Transurethral incision of prostate (616 procedures, 14 per cent as day surgery).

öppen vård kan det dock vara motiverat att välja en snävare definierad indikatoroperation (HAB40) såsom här föreslås.

Hemorroidoperationer:

Sex koder finns inom avsnittet JHB Behandling av hemorrojder och analprolaps. De vanligaste är:

JHB00 Hemorrojdektomi (2107 ingrepp i Sverige 2001, varav 50 procent i öppen vård)

JHB20 Injektionsbehandling av hemorrojder (1079 ingrepp, 94 procent i öppen vård)

JHB30 Gummibandsligatur av hemorrojder (2382 ingrepp, 97 procent i öppen vård)

Den nyligen införda koden JHB40 Resektion och staplad sutur av anal mukosa registrerades inte alls i Sverige år 2001.

Det är ganska klart att JHB00 är den lämpligaste kandidaten, eventuellt i kombination med JHB40 när den börjar användas.

Prostataoperationer:

Åtta koder finns inom avsnittet KED Resektion och andra avflödesfrämjande ingrepp vid prostatism, varav de tre vanligaste är:

KED22 Transuretral resection av prostata (TURP) (7295 ingrepp i Sverige 2001, varav 4 procent i öppen vård)

KED32 Transuretral incision av prostata (616 ingrepp, 14 procent i öppen vård)

KED72 Transurethral microwave therapy of prostate (TUMT) (404 procedures, 99 per cent as day surgery)

The primary candidates here are KED22, and perhaps KED22 plus KED32. KED22 is by far the dominant group in terms of number of procedures carried out. There is probably potential for an increased proportion of procedures carried out as day surgery, even though until now this procedure has been carried out to a very limited degree as day surgery. It is an advantage to have only one code in the group. This makes KED22 the strongest candidate.

NOMESCO's statistics on in-patient care includes the group of codes KED22-KED72 Transurethral surgery of prostate (previously wrongly called TURP). The reason for including this more broadly-defined group of transurethral surgical procedures is that it is the group that it is natural to compare with Transvesical prostatectomy (KED00) and Total excision of prostate and seminal vesicles (group KEC00-KEC20), which are also included in the in-patient statistics. As just pointed out, for statistics that shall primarily be used to measure the increase in the proportion of surgical procedures carried out as day surgery, there is reason to choose a more narrowly-defined surgical procedure group as an indicator (KED22).

Recommendations for new groups

The three additional groups proposed for NOMESCO's statistics on day surgery are as follows:

KED72 Transuretral mikrovågsterapi (TUMT) (404 ingrepp, 99 procent i öppen vård)

Kandidater är här i första hand KED22, eventuellt KED22+KED32. KED22 är den storleksmässigt helt dominerande. Det finns sannolikt en potential för poliklinisering av detta ingrepp, även om det ännu görs i mycket begränsad utsträckning i öppen vård. Det är en fördel att arbeta med bara en kod i gruppen. Detta gör KED22 till den starkaste kandidaten.

I NOMESKO:s slutenvårdstatistik ingår gruppen KED22-KED72 Transuretrala resektionsingrepp på prostata (tidigare felaktigt benämnd TURP). Denna bredare definierade grupp av transuretrala ingrepp motiveras av att den är den naturliga jämförelsegruppen i förhållande till öppen prostatektomi (KED00) och radikal prostaektomi (gruppen KEC00-KEC20), som också ingår i slutenvårdsstatistiken. För en statistik som främst skall tjäna som mått på processen mot ökad poliklinisering kan det dock - som nyss påpekats - vara motiverat att välja en snävare definierad indikatoroperation (KED22).

Förslag beträffande nya grupper

De tre ytterligare grupper som här föreslås för NOMESKO:s dagkirurgiedövning är följande:

VALIDITY AND COMPARABILITY OF NORDIC DAY SURGERY STATISTICS

HAB40 Wedge resection of mammary gland (women only)

HAB40 Partiell mastektomi (kilresektion) (avser endast kvinnor)

JHB00 Haemorrhoidectomy

JHB00 Hemorrojdektomi

KED22 Transurethral resection of prostate (TURP)

KED22 Transuretral resektion av prostata (TURP)

Statistics on these three surgical procedures have been collected from the Nordic countries. The statistics are for 2001, and the definition of day surgery includes cases of in-patient care with admission and discharge on the same day. (This is one of the reasons why the above-quoted figures for Sweden, which have been obtained from working material, are not quite the same as the figures in the table.)

Statistiska uppgifter har hämtats in från de nordiska länderna beträffande dessa tre operationer. Uppgifterna avser år 2001 och definitionen av dagkirurgi innefattar slutenvårdsfall med in- och utskrivning samma dag. (Detta är en av sakerna till att de ovan citerade siffrorna för Sverige, som hämtats från ett arbetsmaterial, inte helt överensstämmer med dem i tabellen.)

Table 6 Data from 2001 on the suggested three new surgical procedures for NOMESCO's day surgery statistics

Procedure	Denmark	Finland	Iceland ¹⁾	Norway	Sweden
<i>Wedge excision of mammary gland (HAB40)</i>					
Number of procedures	1 524	1 385	108	1 237	4 647
Per 100 000 women	56	52	79	54	103
Of which day surgery	214	91	12	579	1 243
Day surgery, per cent	14	7	11	47	27
<i>Haemorrhoidectomy (JHB00)</i>					
Number of procedures	1 986	1 710	23	1 910	2 184
Per 100 000	37	33	8	42	25
Of which day surgery	863	320	6	945	1 167
Day surgery, per cent	43	19	26	49	53
<i>Transurethral resection of prostate (TURP) (KED22)</i>					
Number of procedures	4 193	3 088	214	4 109	7 083
Per 100 000 men	158	121	156	184	161
Of which day surgery	20	10	2	29	93
Day surgery, per cent	0	0	1	1	1

1 1998.

As shown in Table 6, the proportion of surgical procedures carried out as day surgery varies in the different countries.

Det framgår av tabellen att andelen ingrepp som dagkirurgi varierar mellan länderna och med avseende på ingrepp.

The range for wedge excision of mammary gland is 7-47 per cent and for haemorrhoidectomy 19-53 per cent. The percentage of TURP carried out as day surgery is 1 per cent or less for all the countries.

The frequency of surgical procedures in relation to the population is highest in Sweden for wedge excision of mammary gland, and highest in Norway for haemorrhoidectomy and TURP.

Variationsbredden är för partiell mastektomi 7-47 procent och för hemorrojdektomi 19-53 procent. Procentandelen dagkirurgi är särskilt låg för TURP där inget land ännu når över 1 procent.

Den befolkningsrelaterade förekomsten för partiell mastektomi är högst i Sverige och för hemorrojdektomi och TURP högst i Norge.

Future possibilities for using DRG groups in the statistics

Together with Leena Kiviluoto and Martti Virtanen, some work has been done to show how certain DRG groups could be used to describe the trend in day surgery, instead of using – or using in combination with – groups defined solely with NCSP codes. One advantage of this type of classification is that one can combine information about diagnosis and surgical procedure in the definitions. This means that the definitions of the groups are improved and more meaningful from a medical point of view, and the groups are more homogeneous. In addition, small differences in coding practice become less significant. For example, the differences in coding that occur with the present grouping for decompression of median nerve would be eliminated. However, in other cases, the corresponding DRG group is less appropriate than the NCSP group as an indicator for the proportion of surgical procedures carried out as day surgery, because the DRG group combines procedures with different proportions of day surgery.

Möjligheten att i framtiden använda DRG-grupper i redovisningen

Tillsammans med Leena Kiviluoto och Martti Virtanen har visst arbete lagts ned på att visa hur ett antal DRG-grupper skulle kunna användas för att beskriva dagkirurgiutvecklingen i stället för – eller snarare som komplement till – grupper definierade enbart med NCSP-koder. En fördel med denna typ av gruppering är att man kan kombinera diagnos- och operationsinformation i definitionerna, vilket gör att grupperna blir medicinskt mer väldefinierade och meningsfulla samt att man får resursmässigt mer homogena grupper. Samtidigt minskar betydelsen av mindre olikheter i kodningspraxis. De kodningsolikheter som föreligger med nuvarande gruppering när det gäller dekompression av medianusnerv skulle till exempel undvikas. I andra fall är dock motsvarande DRG-grupp mindre lämplig som indikator på poliklinisering än den NCSP-definierade gruppen, därför att ingrepp med olika grad av öppenvårdspraxis kombineras.

If one wishes to shift the focus of the statistics on day surgery from the present focus – primarily the proportion of surgical procedures carried out as day surgery – to a focus aimed at a broader description of all surgical procedures carried out on out-patients, and the extent of this treatment in relation to in-patient treatment, a change-over to a DRG-based system would almost be a prerequisite. This also makes it possible to compare the weighted volume of in-patient and out-patient surgery. This can be done by using DRG points as weights for the statistics.

The out-patient version of NordDRG, that has been developed by a Nordic working-group, and that will be tested out in Sweden in 2003, creates new conditions for developments in this direction. In addition, earlier experience with the Finnish version of NordDRG for day surgery, the recently introduced Danish case-mix system and the Norwegian activity-based financing system, contribute valuable experience. It remains to be seen whether the out-patient version of NordDRG will be accepted and developed, and how soon and to what degree it can become a common basis for the Nordic countries.

It is worth noting here that the common Nordic out-patient version that was recently adopted (NordDRG-O version 2004) will define cases involving patients who are admitted and discharged on the same day as day surgery cases, on the condition that they are discharged alive. In this way any differences in administrative practice, with regard to cases with very short length of stay in a health institution, will automatically be corrected.

Om man vill förskjuta statistiken över dagkirurgi från det nuvarande syftet som huvudsakligen är inriktad på polikliniseringsgraden till en bredare beskrivning av alla ambulantly utförda kirurgiska ingrepp och deras omfattning i relation till slutenvårdskirurgin, är en övergång till ett DRG-baserat system däremot närmast en förutsättning. Detta ger nämligen också möjlighet att jämföra och väga samman den olika tyngd som karakteriserar slutenvårdskirurgin och öppenvårdskirurgin, vilket kan ske med användning av DRG-poäng som vikter.

Den öppenvårdsversion av NordDRG som tagits fram av en nordisk arbetsgrupp och som under 2003 prövas i Sverige skapar nya förutsättningar för en utveckling i denna riktning. Även tidigare erfarenheter av finska tillämpningar av NordDRG på dagkirurgiska fall, av det nyligen införda danska casemix-systemet och det norska systemet för insatsstyrd finansiering bidrar med värdefulla erfarenheter. Det återstår att se hur öppenvårdsversionen av NordDRG kommer att accepteras och vidareutvecklas och hur snart och i vilken utsträckning den kan bli en gemensam bas för de nordiska länderna.

Det kan här noteras att den gemensamma nordiska öppenvårdsversion som nyligen fastställts (NordDRG-O version 2004) kommer att hantera vårdtillfällen med samma in- och utskrivningsdatum som om de vore dagkirurgiska fall under förutsättning att patienten skrivs ut levande. Härigenom får man en automatisk korrigering av eventuella olikheter i administrativ praxis när det gäller vårdtillfällen med mycket kort vårdtid.

Recommendations for further statistics on day surgery

From now on, NOMESCO should clearly indicate which definition should be used for day surgery. NOMESCO should use the definition of day care/day surgery recently recommended by the EU Hospital Data Project. In this definition, day surgery includes not only surgical procedures carried out on out-patients, but also surgery carried out on patients who are admitted and discharged on the same day, as long as they have not died. In this way, the effect of differences in registration practice are reduced.

It is not meaningful to try to maintain a distinction between what is defined as day surgery on the basis of administrative or reimbursement-based definitions and what is defined as other types of out-patient care, with regard to the chosen groups. Through the choice of appropriately qualified surgical groups for day surgery statistics, one gains a pragmatic boundary between other surgical activity in hospitals or health institutions.

It is important to check whether the existing principles for reporting and the counting procedures are abided by. These principles should be formulated in writing and sent out each year to all the people who are responsible for reporting, bearing in mind the fact that there can be changes in the people who report from the various national authorities.

With regard to the fact that probably more and more surgical procedures in the future will be carried out in private health institutions, it is important to investigate sec-

Rekommendationer för fortsatt redovisning av dagkirurgi

NOMESKO bör i fortsättningen tydligt ange vilken definition man avser när det gäller dagkirurgi. NOMESKO bör därvid följa den definition av dagvård/dagkirurgi som EU:s Hospital Data Project nyligen har föreslagit. Det innebär att till dagkirurgi räknas inte bara ingrepp som utförts på ambulanta patienter utan även på inlagda patienter som skrivits in och ut samma dag, såvida de inte har utskrivits döda. På detta sätt frigör man sig från vissa administrativt betingade skillnader i avgränsningen.

Det är inte meningsfullt att försöka upprätthålla någon gräns mellan vad som betecknas som dagkirurgi utifrån administrativa eller ersättningsbaserade definitioner och vad som är annan poliklinisk vård när det gäller de valda grupperna. Genom valet av tillräckligt kvalificerade operationsgrupper för dagkirurgiredovisningen får man en pragmatisk gräns mot annan kirurgisk verksamhet vid sjukhus eller specialistmottagningar.

Det är viktigt att man kontrollerar efterlevnaden av de redovisningsprinciper och beräkningsregler som skall gälla. Principerna bör utformas skriftligt och sändas ut till alla berörda uppgiftslämnare varje år med tanke på de personförändringar som sker hos de ansvariga nationella myndigheterna.

Med hänsyn till att allt fler operationer i framtiden torde komma att utföras i icke offentligt drivna vårdformer är det viktigt att ytterligare studera omfattningen av

tors of the health services that presently are not included in the reporting. It is particularly unsatisfactory that, in several of the Nordic countries, statistics on day surgery carried out privately are so incomplete, despite the fact that most of it is paid for by public funds.

To a certain extent, statistics can be collected from the various reimbursement systems that are used in the Nordic countries for these sectors. For 2001, there were great difficulties in obtaining statistics from private health institutions in a form that allows direct comparison with NOMESCO's statistics and surgical procedure groups. Reimbursement contracts should be formulated with definitions that include NCSP codes, even if this is not easy to achieve, bearing in mind the fact that many different reimbursement systems exist at the national and regional levels in the Nordic countries. A minimum condition must be to attempt to estimate the magnitude of missing data for the surgical procedure groups for which the problem is greatest.

Several Nordic countries have recently introduced reforms for payment of health service producers, which present greater possibilities than previously to obtain comparable statistics both on day surgery and other out-patient activities that are provided in privately-run health care institutions. Examples of these are the Danish case-mix system, the Norwegian activity-based financing system and the Swedish pilot project with the out-patient version of NordDRG. The conditions for improving the quality of NOMESCO's statistics to an appreciable extent within this area should therefore be favourable within the next few years.

den vård som nu inte kommer med i redovisningen. Det är synnerligen otillfredsställande att man i flera av de nordiska länderna har så ofullständiga uppgifter om dagkirurgi som bedrivs i privat regi, trots att den till största delen bekostas med offentliga medel.

Uppgifter kan i viss utsträckning hämtas från de olika ersättningssystem som finns för sådan vård. Stora svårigheter har dock förelegat att för år 2001 få privat driven vård redovisad på sätt som gör den direkt jämförbar med NOMESCO:s statistik och operationsgrupper. Ersättningsavtal borde utformades med definitioner som innefattar NCSP-koder, även om detta inte är enkelt att uppnå med tanke på de många olika ersättningssystem som finns nationellt och regionalt i Norden. Ett minimikrav är att man ändå söker uppskatta och redovisa bortfallets storlek inom de operationsgrupper där bortfallsproblemet är störst.

Inom flera av länderna har nyligen genomförts reformer för betalningen till sjukvårdsproducenter som innebär större möjligheter än tidigare att få jämförbara uppgifter även om sådan dagkirurgisk eller annan poliklinisk verksamhet som sker utanför den offentliga sjukvården. Det gäller utvecklingen av det danska case-mix-systemet, det norska systemet för insatsstyrd finansiering och den svenska försöksverksamheten med DRG-system inom den öppna vården. Förutsättningarna för en avsevärd kvalitetshöjning av NOMESCO:s statistik inom detta område torde därför vara goda på ett par års sikt.

Some of the terms and definitions used for the surgical procedure groups that have been used up to now, should be changed. It should be clearly specified that the carpal tunnel surgical procedure that has been chosen only includes decompression of median nerve. Tonsillectomy with or without adenoidectomy is an incorrect term for the statistics that have been reported up to now. However, in the future, this group should be confined to tonsillectomy with or without adenoidectomy, and statistics on adenoidectomy alone (without tonsillectomy) should be removed from this group. In this way, the term can be retained, even if the definition is changed. The change in definition must be clearly pointed out in the report. The term for the surgical procedure group termination of pregnancy should be more precise and should be changed to surgical termination of pregnancy.

It is recommended that three new surgical procedure groups should be included in the day surgery statistics: wedge excision of mammary gland (HAB40), haemorrhoidectomy (JHB00) and transurethral resection of the prostate (TURP) (KED22).

NOMESCO should publish population-related frequencies for the groups of surgical procedures that are studied, in addition to statistics on the proportion of surgical procedures carried out as day surgery. It is of interest to compare frequency per 100 000 of the population for the surgical procedure groups included in the statistics. In this way it is also easier to detect missing data in the material. Under-reporting can be suspected primarily for day surgery activity.

Benämning och avgränsning av de hittills använda operationsgrupperna bör i ett par fall ändras. Det bör tydliggöras att den valda karpaltunneloperationen endast avser dekompression av medianus-nerv. Tonsillektomi med eller utan adenoidektomi är en felaktig benämning på vad man hittills har redovisat. Man bör emellertid i fortsättningen begränsa denna grupp till just dessa ingrepp och ta bort den rena adenoidektomin från gruppen. Då kan benämningen behållas även om definitionen ändras. Detta kräver att definitionsändringen tydligt påpekas i redovisningarna. Benämningen på gruppen legala abortingrepp bör förtydligas och ändras till kirurgiska legala abortingrepp.

Tre nya operationer föreslås tas med i dagkirurgiredovisningen, nämligen partiell mastektomi (kilexcision) (HAB40), hemorrojdektomi (JHB00) och transuretral resektion av prostata (TURP) (KED22).

NOMESKO bör publicera befolkningsrelaterade frekvenser av de studerade operationstyperna vid sidan av uppgiften om polikliniseringsgrad. Det är i sig av intresse att jämföra den befolkningsrelaterade förekomsten av de operationsgrupper som ingår i redovisningen. Därtill kommer att man på så sätt lättare kan upptäcka bortfall i materialet. Underrapportering kan misstänkas i första hand drabba den dagkirurgiska verksamheten.

In the future NOMESCO should consider the advantages of DRG-based statistics to complement the existing statistics on day surgery. However, a prerequisite for this is that the present pilot projects with the out-patient version of NordDRG becomes more widely used in the Nordic countries. DRG-based statistics make it possible to describe all day surgery activity more comprehensively. The limited aims of the current statistics limit the possibilities for such a comprehensive description.

NOMESKO bör i framtiden överväga de fördelar en DRG-baserad statistik har som komplement till nuvarande redovisning av dagkirurgi. En förutsättning är emellertid att den nuvarande försöksverksamheten med en öppenvårdsversion av NordDRG leder till mer allmän användning i de nordiska länderna. Med en DRG-baserad redovisning får man möjlighet att på ett bredare sätt beskriva all dagkirurgisk verksamhet än vad den nuvarande statistiken med sitt begränsade syfte tillåter.

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2. Jørgensen J., Lyng Sandegaard J., Schiøler G. Operationer 1996-1999. Nye tal fra Sundhedsstyrelsen. Årgång 5, nr 4, 2001. (Rapporten är tillgänglig på Sundhedsstyrelsens hemsida http://www.sst.dk/nyheder/tidsskrifter/nyetal/pdf/01_05_04.pdf).
3. Nenonen M., Rasilainen J. Kirurgian ja päiväkirurgian aluevaihtelut Suomessa 1998 (Regionala variationer i kirurgi och dagkirurgi i Finland 1998). STAKES Rapport 12.5.2001. (Rapporten är tillgänglig på STAKES' hemsida <http://www.stakes.info/files/pdf/tiedonantajapalautteet/palaute3.pdf>).

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| 8. OECD. A System of Health Accounts. OECD 2000. | 8. OECD. A System of Health Accounts. OECD 2000. |
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SECTION C

Appendices
Bilag

Appendix 1

Additional information at www.nom-nos.dk

On NOMISCO's homepage, the following additional information can be found:

- Obstetric definitions
- Hospital definitions
- Overview of medical, surgical and psychiatric specialities that are included in the statistics in this publication
- Short list and statistics on causes of death
- Short list and statistics on discharges from somatic hospitals
- Short list and statistics on surgical procedures

The detailed statistics on the homepage are presented according to gender and 5-year age groups.

In addition, an interactive database is to be found, with the most important data that is available, presented graphically and in maps. The database can be found under the icon *Social and Health Indicators*.

Supplerende oplysninger på www.nom-nos.dk

På Nomesko's hjemmeside findes følgende supplerende oplysninger:

- Obstetriske definitioner
- Sygehusdefinitioner
- Oversigt over medicinske, kirurgiske og psykiatriske specialer som indgår i statistikken i denne publikation
- Kortliste samt statistik over dødsårsager
- Kortliste samt statistik over udskrivninger ved somatiske sygehusafdelinger
- Kortliste samt statistik over kirurgiske procedurer

Den detaljerede statistik på hjemmesiden er fordelt på køn og 5-års-aldersgrupper

Desuden findes der en interaktiv database med de vigtigste data hvor det er muligt med såvel grafisk præsentation samt præsentation ved brug af kort. Databasen findes under ikonet *Social and Health Indicators*.

Further information

Yderligere oplysninger

The following offices responsible for statistics can be contacted for further information concerning the statistics in this publication.

Denne oversigt over statistikansvarlige i de nordiske lande kan bruges til at søge yderligere oplysninger vedrørende statistikken i denne bog.

Denmark

Statistics Denmark
Sejrøgade 11
DK-2100 Copenhagen Ø
Phone: +45 39 17 39 17
Fax: +45 39 17 39 99
E-mail: dst@dst.dk
Website: www2.dst.dk

Have responsibility for:

- Population statistics
- Statistics on alcohol consumption
- Statistics on health care economy
- Statistics on alcohol consumption

National Board of Health
Islands Brygge 67
P.O. Box 1881
DK-2300 Copenhagen S
Phone: 72 22 74 00
Fax: 72 22 74 11
E-mail: sst@sst.dk
Website: www.sst.dk

Have responsibility for:

- Statistics on births
- Statistics on abortions
- Statistics on malformations
- Statistics on causes of death
- Statistics on hospital services
- Statistics on health personnel
- Statistics on the use of tobacco

Statens Seruminstitut
Artillerivej 5
DK-2300 Copenhagen S
Phone: +45 32 68 32 68
Fax: +45 32 68 38 68
E-mail: serum@ssi.dk
Website: www.serum.dk/dk

Have responsibility for:

- Statistics on infectious diseases
- Statistics and information on vaccinations

FURTHER INFORMATION

Danish Medicines Agency
Frederikssundsvej 378
DK-2700 Brønshøj
Phone: +45 44 88 91 11
Fax: +45 44 91 73 73
E mail: dkma@dkma.dk
Website: www.dkma.dk

Have responsibility for:

- Statistics on medicinal products

Faroe Islands

Statistics Faroe Islands
P.O. Box 2068
FO-165 Argir
Phone: +298 35 28 00
Fax: +298 35 28 01
E- mail: hagstova@hagstova.fo
Website: www.hagstova.fo

Have responsibility for:

- Population and vital statistics
- Statistics on health care economy

Chief Medical Officer
P.O. Box 9
FO-110 Tórshavn
Phone: +298 31 18 32
Fax: +298 31 76 60

Have responsibility for:

- Statistics on abortions
- Statistics on infectious diseases
- Statistics and information on vaccinations

Chief Pharmaceutical Officer
P.O. Box 187
FR-110 Tórshavn
Phone: +298 35 01 50
Fax: +298 35 01 51

Have responsibility for:

- Statistics on medicinal products

National Board of Health in Denmark
Islands Brygge 67
P.O. Box 1881
DK-2300 Copenhagen S
Phone: 72 22 74 00
Fax: 72 22 74 11
E-mail: sst@sst.dk
Website: www.sst.dk

Have responsibility for:

- Statistics on causes of death

FURTHER INFORMATION

Ministry of Family and Health
Eiragardur 2
FO-100 Tórshavn
Phone: +298 30 40 50
Fax: +298 5 40 48
E-mail: hmr@hmr.fo
Website: www.ahs.fo

Have responsibility for:

- Statistics on health personnel
- Statistics on hospital services

Greenland

Statistics Greenland
P.O. Box 1025
DK-3900 Nuuk
Phone: +299 34 50 00
Fax: +299 32 29 54
E-mail: stat@gs.gh.gl
Website: www.statgreen.gl

Have responsibility for:

- Population and vital statistics
- Statistics on health personnel
- Statistics on hospital services
- Statistics on health care economy

Chief Medical Officer
P.O. Box 120
DK-3900 Nuuk
Phone: +299 34 5192
Fax: +299 32 51 30
E-mail: eli@gh.gl

Have responsibility for:

- Statistics on births
- Statistics on abortions
- Statistics on malformations
- Statistics on infectious diseases
- Statistics and information on vaccinations

National Board of Health in Denmark
Islands Brygge 67
P.O. Box 1881
DK-2300 Copenhagen S
Phone: 72 22 74 00
Fax: 72 22 74 11
E-mail: sst@sst.dk
Website: www.sst.dk

Have responsibility for:

- Statistics on causes of death

The Central Pharmacy in Copenhagen
County
Marielundsvej 25
DK-2730 Herlev
Phone: +45 44 57 77 00
Fax: +45 44 57 77 09

Have responsibility for:

- Statistics on medicinal products

FURTHER INFORMATION

The Directorate for Health
P.O. Box 1160
DK-3900 Nuuk
Phone: +299 34 50 00
Fax: +299 32 55 05

Have responsibility for:

- Statistics on hospital services
- Statistics on health care economy
- Statistics on health personnel

Finland

Statistics Finland
Työpajankatu 13
FIN-00022 Tilastokeskus
Phone: +358 9 173 41
Fax: +358 9 173 42 750
Website: www.stat.fi

Have responsibility for:

- Population and vital statistics
- Statistics on causes of death
- Statistics on the use of tobacco
- Statistics on road traffic accidents

STAKES (National Research and Development Centre for Welfare and Health)
P.O. Box 220
FIN-00531 Helsinki
Phone: +358 9 396 71
Fax: +358 9 761 307
Website: www.stakes.fi

Have responsibility for:

- Register of Institutional Care
- Medical Birth Register and IVF statistics
- Register of Abortions and Sterilizations
- Statistics on Health Care Personnel
- Statistics on public health care
- Statistics on private health care
- Statistics on labour force in health care
- Statistics on the use of alcohol and drugs
- Statistics on health care expenditure
- Definitions and classifications in health care

Finnish National Public Health Institute
Mannerheimintie 166
FIN-00300 Helsinki
Phone: +358 9 474 41
Fax: +358 9 474 48 408
Website: www.ktl.fi

Have responsibility for:

- Register of Infectious Diseases
- Register of Coronary Heart Disease and Stroke
- Statistics and information on vaccinations
- Survey on health behaviour among adults and elderly
- Public Health Report

FURTHER INFORMATION

National Agency for Medicines
Mannerheimintie 166
P.O. Box 55
FIN-00301 Helsinki
Phone: +358 9 473 341
Fax: +358 9 714 469
Website: www.nam.fi

Have responsibility for:

- Registration of medicinal products and sales licences
- Register on Adverse Drug Reactions
- Statistics on pharmacies

Social Insurance Institution of Finland
Nordenskiöldinkatu 12
FIN-00250 Helsinki
Phone: +358 20 434 11
Fax: +358 20 434 50 58
Website: www.kela.fi

Have responsibility for:

- Sickness insurance benefits and allowances, reimbursements for medicine expenses, and disability pensions

Finnish Cancer Registry
Liisankatu 21B
FIN-00170 Helsinki
Phone: +358 9 135 331
Fax: +358 9 135 1093
Website: www.cancer.fi

Have responsibility for:

- Statistics on cancer

Åland

Government of the Åland Islands
P.O. Box 60
FIN-22101 Mariehamn
Phone: +358 18 250 00
Fax: +358 18 191 55

Have responsibility for:

- Statistics on infectious diseases
- Statistics on health personnel
- Statistics on hospital services
- Statistics on health care economy

Social Insurance Institution of Finland
Statistics Finland
STAKES
National Agency for Medicines
Finnish National Public Health Institute
Finnish Cancer Registry

See Finland

FURTHER INFORMATION

Iceland

Statistics Iceland
Borgartún 21a
IS-150 Reykjavík
Phone: +354 528 1000
Fax: +354 528 1199
E-mail: hagstofa@hagstofa.is
Website: www.statice.is

Have responsibility for:

- Population and vital statistics
- Statistics on causes of death
- Statistics on alcohol consumption
- Statistics on health care expenditure
- National accounts

Directorate of Health
Austurströnd 5
IS-170 Seltjarnarnes
Phone: +354 510 1900
Fax: +354 510 1919
E mail: postur@landlaeknir.is
Website: www.landlaeknir.is

Have responsibility for:

- Medical statistics on births
- Statistics on abortions
- Statistics on sterilizations
- Statistics on primary health care
- Statistics on hospital services
- Statistics on infectious diseases
- Statistics on vaccinations
- Statistics on health personnel

Icelandic Ministry of Health and Social Security
Laugavegi 116
IS-150 Reykjavík
Phone: +354 545 8700
Fax: +354 551 9165
E mail: postur@htr.stjr.is
Website: www.stjr.is

Have responsibility for:

- Statistics on pharmaceutical products

Committee for Tobacco Use Prevention
Skógarhlíð 8
IS-105 Reykjavík
Phone: +354 561 2555
Fax: +354 561 2563
E mail: reyklaus@reyklaus.is
Website: www.reyklaus.is

Have responsibility for:

- Statistics on the use of tobacco

Icelandic Cancer Register
Skógarhlíð 8
IS-105 Reykjavík
Phone: +354 540 1900
Fax: +354 540 1910
E mail: jongl@krabb.is; laufeyt@krabb.is;
Website: www.krabb.is

Have responsibility for:

- Statistics on cancer

Norway

Statistics Norway
 P.O. Box 8131 Dep.
 N-0033 Oslo
 Phone: +47 21 09 00 00
 Fax: +47 21 09 49 73
 E- mail: ssb@ssb.no
 Website: www.ssb.no

Have responsibility for:

- Population and vital statistics
- Statistics on causes of death
- Statistics on health and social conditions
- Statistics on health and social services
- Statistics on health personnel
- Statistics on hospital services
- Statistics on sterilizations
- Statistics on induced abortions
- Statistics on alcohol consumption
- Statistics on health care economy

Norwegian Institute of Public Health
 P.O. Box 4404 Nydalen
 N-0403 Oslo
 Phone: +47 22 04 22 00
 Fax: +47 23 40 81 46
 E- mail: folkehelseinstituttet@fhi.no
 Website: www.whocc.no

Have responsibility for:

- Statistics on sexually transmitted diseases
- Statistics on tuberculosis
- Statistics on immunization
- Statistics on sale of medicinal products

Norwegian Institute of Public Health
 Department of Medical Birth Registry
 Kalfarveien 31
 N-5018 Bergen
 Phone: +47 22 04 27 00
 Fax: +47 22 04 27 01
 E- mail: mfr@uib.no
 Website: www.fhi.no

Have responsibility for:

- Statistics on births and infant deaths

SINTEF-Unimed
 Norwegian Patient Register
 Olav Kyrresgate 3
 N-7465 Trondheim
 Phone: +47 73 59 25 90
 Fax: +47 73 59 63 61
 E- mail: npr@sintef.no
 Website: www.npr.no

Have responsibility for:

- Statistics on hospital services

FURTHER INFORMATION

National Directorate for Health and
Social Welfare
P.O. Box 8054 Dep.
N-0031 Oslo
Phone: +47 24 16 30 00
Fax: +47 24 16 30 01
E-mail: postmottak@shdir.no
Website: www.shdir.no

Have responsibility for:

- Statistics on dentists
- Statistics on use of tobacco

Cancer Registry of Norway
Institute of population-based cancer
research
Montebello
N-0310 Oslo
Phone: +47 22 45 13 00
Fax: +47 22 45 13 70
E-mail: kreftregisteret@kreftregisteret.no
Website: www.kreftregisteret.no

Have responsibility for:

- Statistics on cancer

Norwegian Medical Association
P.O. Box 1152 Sentrum
N-0107 Oslo
Phone: +47 23 10 90 00
Fax: +47 23 91 10
Website: www.legeforeningen.no

Have responsibility for:

- Statistics on physicians

Ministry of Health
P.O. Box 8011 Dep.
N-0030 Oslo
Phone: + 47 22 24 90 90
E-mail: postmottak@hd.dep.no
Website: www.hd.dep.no

Have responsibility for:

- Statistic on in vitro fertilization

Sweden

Statistics Sweden
P.O. Box 24 300
SE-104 51 Stockholm
Phone: +46 8 506 940 00
Fax: +46 8 661 52 61
E-mail: scb@scb.se
Website: www.scb.se

Have responsibility for:

- Population and vital statistics
- Statistics on health care economy

FURTHER INFORMATION

National Board of Health and Welfare
SE-106 30 Stockholm
Phone: +46 8 55 55 30 00
Fax: +46 8 55 55 33 27
E- mail: sosialstyrelsen@sos.se
Website: www.sos.se

Have responsibility for:

- Statistics on births
- Statistics on abortions
- Statistics on sterilizations
- Statistics on in-patients
- Statistics on cancer
- Statistics on causes of deaths

Swedish Institute for Infectious Disease
Control
Nobels väg 18
SE-171 82 Solna
Phone: +46 8 457 23 00
Fax: +46 8 32 83 30
E- mail: smittskyddsinstitutet@smi.ki.se
Website: www.smittskyddsinstitutet.se

Have responsibility for:

- Statistics on infectious diseases
- Statistics and information on vaccinations

National Corporation of Swedish
Pharmacies
SE-131 88 Stockholm
Phone: +46 8 466 10 00
Fax: +46 8 466 15 15
Website: www.apoteket.se

Have responsibility for:

- Statistics on drug sales and drug prescribing

Swedish Federation of County Councils
SE-118 82 Stockholm
Phone: +46 8 452 72 00
Fax: +46 8 452 72 10
E- mail: landstingsforbundet@lf.se
Website: www.lf.se

Have responsibility for:

- Statistics on health personnel
- Statistics on hospital capacity
- Statistics on health care economy

Swedish Association of Local Authorities
SE-118 82 Stockholm
Phone: +46 8 452 71 00
Fax: +46 8 641 15 35
E- mail: sk@svekom.se
Website: www.svekom.se

Have responsibility for:

- Statistics on health personnel

FURTHER INFORMATION

Swedish Agency for Government
Employers
P.O. Box 3267
SE-103 65 Stockholm
Phone: +46 8 700 13 00
Fax: +46 8 700 13 40
E-mail: agv@arbetsgivarverket.se
Website: www.arbetsgivarverket.se

Have responsibility for:

- Statistics on health personnel

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