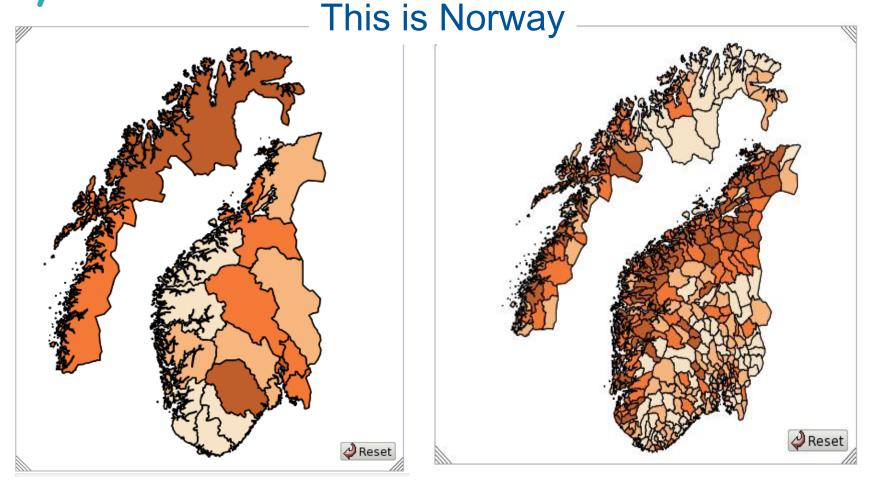


The health information systems of the NIPH

Public health profiles (compared to new Slovenian public health profiles), data banks and fact sheets

Heidi Lyshol Department of Health Statistics





19 counties, 428 municipalities, 5 million inhabitants 385,252 square kilometres

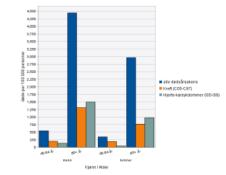


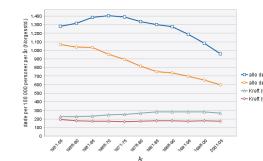
New Act on Public Health January 2012

- Norwegian counties and municipalities required to have *sufficient* overview over health conditions and influencing factors
- Data from NIPH + own sources

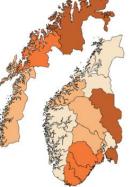


Public health profiles, databanks, fact sheets





O-alle dødsårsakene, menn → alle dødsårsakene, kvinner → Kreft (C00-C97), kvinner



You are here: <u>home</u> > <u>topics</u> > <u>satesportuis</u> > facts about oates

Osteoporosis and fractures in Norway - fact sheet

univ/reterence to this article: http://www.fni.no/artikler/7idw74450

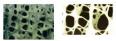
Each year, approximately 9,000 adult Norwegians fracture a hip and 15,000 fracture a wrist. Many people also experience vertebrial fractures. Oslo women have the highest nisk of hip fractures in the world. Osteoporosis is an important contributory factor to fractures in the delery.

About osteoporosis

A gradual decrease in bone mass is part of the ageing process, see pictures below. With otstoporosis, bone mass is reduced to a level below a defined threshold. Bone mass may have declanied faster than normal, or one may have had a lower than usual bone moss before the bone loss starts. Otstopprosis may also occur as a consequence of certain disease or the use of certain drugs:

Osteoporosis involves an impairment of the bone's structure so bone tissue becomes more porous. This weakness is a risk condition and gives no symptoms before a fracture occurs.

The hip, forearm and spine (vertebrae) are the most common fracture sites.



The pictures show normal bone (left) and osteoporotic bone (right). The structure is visibly thinner with larger cavities caused by osteoporosis.

Prevalence of osteoporosis



Tema		Indikator	Kommune	Fylke	Norge	Enhet (*)
<u>.</u>	1	Befolkningsvekst	1,3	1,6	1,1	prosent
Befolk- ning	2	Personer som bor alene, 45 år +	22,6	22,3	25,6	prosent
a -	3	Valgdeltakelse 2015	57	61	60	prosent
	4	Vgs eller høyere utdanning, 30-39 år	80	83	83	prosent
	5	Lavinntekt (husholdninger), 0-17 år	8,9	8,1	11	prosent
kår	6	Inntektsulikhet, P90/P10	2,7	2,8	2,7	-
Levekår	7	Barn av enslige forsørgere	14	14	15	prosent
	8	Arbeidsledige, 15-29 år (ny def.)	2,5	2,3	2,7	prosent
	9	Uføretrygdede, 18-44 år	1,6	1.7	2.6	prosent (a,k*)
	10	God drikkevannsforsyning	1,0	100	92	prosent (a,k)
	11	Forsyningsgrad, drikkevann	98	94	89	prosent
Miljø				12.2	12,8	
	12	Skader, behandlet i sykehus	13,6	-		per 1000 (a,k*)
	13	Ensomhet, Ungdata	18	18	18	prosent (a,k*)
	14	Fornøyd med lokalmiljøet, Ungdata	74	72	70	prosent (a,k*)
	15	Medlem i fritidsorganisasjon, Ungdata	65	66	63	prosent (a,k*)
Skole	16	Trives på skolen, 10. klasse	88	87	85	prosent (k*)
	17	Laveste mestringsnivå i lesing, 5. kl.	21	21	25	prosent (k*)
š	18	Laveste mestringsnivå i regning, 5. kl.	22	22	26	prosent (k*)
	19	Frafall i videregående skole	18	20	24	prosent (k*)
5	20	Fysisk inaktive, Ungdata	15	12	13	prosent (a,k*)
ane	21	Overvekt inkl. fedme, 17 år	17	17	21	prosent (k*)
Levevaner	22	Alkohol, har vært beruset, Ungdata	13	15	14	prosent (a,k*)
ē	23	Røyking, kvinner	-		10	prosent (a*)
	24	Forventet levealder, menn	79,2	79,2	78,2	år
	25	Forventet levealder, kvinner	82,9	83,3	82,8	år
	26	Utdanningsforskjell i forventet levealder	5,2	5,2	4,8	år
Ę	27	Psykiske sympt./lid, primærh.tj., 15-29 år	111	132	142	per 1000 (a,k*)
Helse og sykdom	28	Psykiske lidelser, legemiddelbrukere	120	123	130	per 1000 (a,k*)
syl			235	250	262	
<mark>60</mark>	29	Muskel og skjelett, primærhelsetjenesten				per 1000 (a,k*)
se	30	Hjerte- og karsykdom, beh. i sykehus	18,0	16,2	17,3	per 1000 (a,k*)
He	31	Type 2-diabetes, legemiddelbrukere	39	32	35	per 1000 (a,k*)
	32	Lungekreft, nye tilfeller	57	53	55	per 100 000 (a,k*)
	33	Antibiotika, legemiddelbrukere	233	233	229	per 1000 (a,k*)
	34	Vaksinasjonsdekning, meslinger, 9 år	95,5	95,2	94,7	prosent

PH profiles

Municipality (etc) compared to

- <u>country</u>,
- other municipalities
- <u>spread</u> of results in county
- good, bad or neutral

2016: indicators for <u>10 best municipalities</u> marked

Tema		Indikator	Kommune	Fylke	Norge	Enhet (*)	Folkehelsebarometer for Lørenskog
÷ _	1	Befolkningsvekst	1,3	1,6	1,1	prosent	•
Befolk- ning	2	Personer som bor alene, 45 år +	22,6	22,3	25,6	prosent	o
m -	3	Valgdeltakelse 2015	57	61	60	prosent	•
	4	Vgs eller høyere utdanning, 30-39 år	80	83	83	prosent	• •
	5	Lavinntekt (husholdninger), 0-17 år	8,9	8,1	11	prosent	• •
ekåi	6	Inntektsulikhet, P90/P10	2,7	2,8	2,7	-	◆
Levekår	7	Barn av enslige forsørgere	14	14	15	prosent	
-	8	Arbeidsledige, 15-29 år (ny def.)	2,5	2,3	2,7	prosent	○ ♦
	9	Uføretrygdede, 18-44 år	1,6	1,7	2,6	prosent (a,k*)	* •

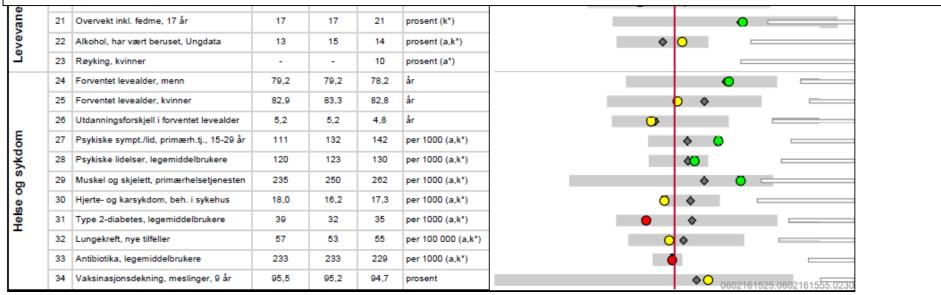
Significantly better

Significantly worse

- Not significantly different 0
- \odot Significally different
- Not tested for significance O
- County average ٠
- Country average

Variation between municipalities in county

Ten best municipalities in the country



- Green municipality is statistically significantly in better position than the average in Slovenia.
- Blue municipality is statistically significantly different from the average in Slovenia. It was not p
 - Red municipality is statistically significantly in worse position than the average in Slovenia.
- Yellow municipality is not statistically significantly different from the average in Slovenia.
 White value of chosen indicator is not reliable due to the small size of the observed population

Indicator comparison 2016 Population

Slovenia

- Municipal development
 index
- Population increase
- Older population
- Primary educated adults
- Employment rate
- Daily labour migration

Norway

- Population increase
- Population 45+ living alone
- Participation rate last election

(many others found in Municipal data bank)

Indicator comparison 2016 Risk factors/Lifestyle

Slovenia

- Physical fitness index children
- Overweight/obesity in children
- Regular/occasional smokers
- Binge drinking
- Road traffic injuries
- Road traffic accidents caused by drunk drivers

Norway

- Physical inactivity, youth
- Overweight/obesity at 17
- Ever been drunk, youth
- Smoking, women before pregnancy

(many others found in Municipal data bank)

Indicator comparison 2016 Prevention/Environment

Slovenia

- Colorectal cancer screening
- Cervical cancer screening
- Drinking water quality

Norway

- Drinking water quality
- % receiving water from controlled sources
- Injuries treated in hospital
- Loneliness (youth)
- Satisfied local environment (youth)
- Participation organised leisure activity (youth)

Indicator comparison 2016 Health status

Slovenia

- Self-assessed good health
- Sick leave, days/worker
- Asthma 0-19 years
- Alcohol-attributed diseases
- Diabetes, medication
- Hypertension, medication
- Anticoagulant, medication
- Heart attack hospitalisation
- Stroke hospitalisation
- New cancer cases
- Hip fractures 65+
- Mental disorders, medication
- Service users help at home

Norway

- Life expectancy, men
- Life expectancy, women
- Educational difference, life expectancy
- Mental disorders, primary care 15-29
- Mental disorders, medication
- Musculoskeletal disorders, primary care
- Cardiovascular disease, hospitalisation
- Diabetes 2, medication
- Lung cancer, new cases
- Antibiotics, medication
- Vaccination coverage measles, 9 years

Indicator comparison 2016 Mortality

Slovenia

- All causes mortality
- Cardiovasular mortality
- Cancer mortality
- Breast cancer mortality
- Lung cancer mortality
- Suicide mortality

Norway

(All of these found in data banks)

Indicator comparison 2016 School indicators

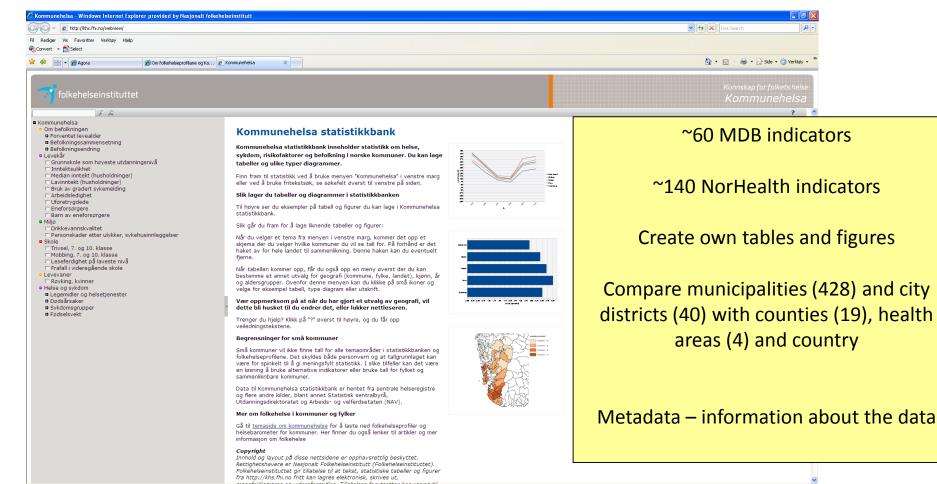
Slovenia

Norway

- Enjoy school, 10th grade
- Lowest skill level reading, 5th grade
- Lowest skill level maths, 5th grade
- High school dropout rate



Online Municipal Databank (2012) (and NorHealth (2000))



🧐 Lokalt intranett

🔍 100 % 🔹

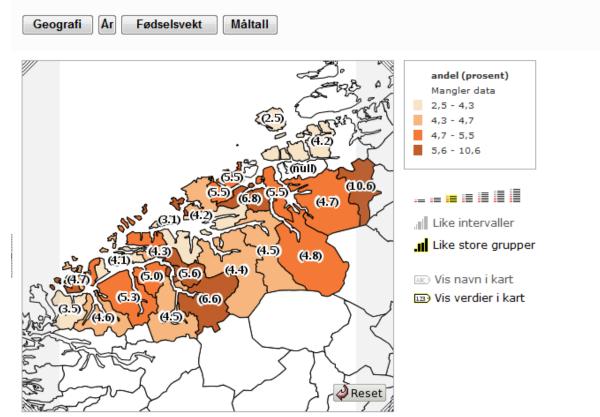


Metadata

- Indicator definition
- Population
- Units of measurement
- Data source
- Data collection
- Data quality

Percentage births over 4500 g, all municipalities in Møre og Romsdal

Høy og lav fødselsvekt – 2002-2011, høy fødselsvekt, andel (prosent)





Fact sheets

- ~100 fact sheets describing health conditions, illnesses and risk factors
- Information on:
 - incidence and/or prevalence in Norway
 - time trends
 - international comparisons
 - sources/literature
- Fact sheets use data from Norhealth where possible
- Direct linkage to data bank -> always updated figures



Example fact sheet

You are here: home > topics > mental health > suicide and suicide attempts

Suicide and suicide attempts in Norway - fact sheet

Link/reference to this article: http://www.fhi.no/artikler/?id=88579

Every year in Norway, an average of 530 suicides are registered. About 150 women and under 400 men take their own life annually. We presume that there are 10 times more suicide attempts than suicides.

Around 60 per cent of all suicides occur in the under-50 age group. Suicide is also among the most common causes of death among young adults. Suicide among children under 15 years of age is rare.

The most common suicide method is hanging, followed by poisoning, shooting and drowning. In total, these methods are used in 85 per cent of all suicides in Norway. There has been an increase in the proportion of people



who hang themselves compared to shooting and poisoning.

Unknown number concealed as accidents

Some suicides are concealed as accidents. For example, the number of registered suicides in traffic has doubled from four per year to more than eight per year after the accident analysis group at the Norwegian Public Roads Administration began to study the causes of traffic accidents in 2005. In addition to those identified by this work, there are probably many more that are not recorded as suicide in the official statistics.

Suicide may also be disguised as poisoning accidents or drowning. There is an ongoing collaborative project between the Department for Suicide Research and Prevention at the Norwegian Institute of Public Health and the Norwegian Public Roads Administration



NIPH presentation tools

- Municipal health profiles
- City district health profiles (4 largest cities)
- County health profiles
- Municipal statistics bank
- Norhealth
- Fact sheets



Congratulations to Slovenia!

HEALTH IN THE MUNICIPALITY 2016

MOZIRJE



Health in the municipality 2015 is an overview of key health indicators that show how the mu-nicipality compares to the regional and Slove-nian average Living and working environment has an important impact on local people's health. By demon-strating the local health status, we wish to help and encourage stakeholders at local level, par-

ticularly decision-makers, to implement their ac-tivities on health promotion and health preven-tion of their population. For additional data visit: http://podatki.nijz.si

Suicide mortality rate was 20 per 100,000 population while it was 22 in Slovenia.

Pisk factors and prevention
 Physical fitness index of children was close to Slovenian

average. The share of smokers was 19%, whereas it was 24% in

Road traffic injuries hospital admission rate was 1.0 per

Hoad traine injuries nospital admission rate was 10 per 1,000 population; in Slovenia, it was 1.8.
 The share of traffic accidents caused by drunk drivers

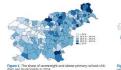
Inicidate or traffic accidents caused by drunk onlytes was higher than Sloverian average.
 Response rate in colorectal cancer screening programme – Svit was 60.9%, while it was 60.4% on the national level.
 Participation rate in central cancer screening programme – ZORA was 75.2%, while it was 71.3% on the national level.

NITZ National institute of Public Health

SOME MUNICIPAL HEALTH FEATURES

Health status and mortality

 The share of the municipal population with good The share of the municipal population with good and reported healthy was higher than Sharemin samples. All populations was higher than Sharemin and population days per person, which was the same on Sharemin healthy blood pressure was higher than Sharemin a wang, while healthy the same of the same of the same of the modulation for details.
 Healt datak heaptal administra make was 2.9 per 1000 population, ang 6.5 Myeas, while in Sharemin was 31 per 1000, while this low was Ghard to the same charts.



by: National Institute of Public Health 2, SI-1000 Ljubljana, Slovenia infoarijesi by SOKol, http://hfp-el.elonet.europe.eu/ackol/

HEALTH IN THE MUNICIPALITY 2016

Determinants of health

The usefulness of health information

Information on population's health, healthcare and rement, so are cycling networks, which are used by peo-ple for leisure or travel. Creating such possibilities in residential areas encourages healthy choices. If such lated factors are important for decision-making on all areas of life and functioning of the community. We use them for the assessment of the situation, planning possibilities do not exist, individuals tend to make unof health system infrastructure and care, monitoring of healthy decisions more often. societal, political, social and other impacts on health status and healthcare system. Health and disease indi-cators, in the environment where people live, demon-People's health directly affects the economy. Healthy

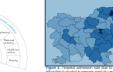
individual is active and creative: is employed, guickly recovers from acute diseases and thus benefits the trate solid starting point and help in finding suitable solutions for improvements. society. Inequalities in health

The data on population's health status in smaller ar-eas can substantially differ from general, national data, which represent average values. Some health data in Stovenia are available on municipal level. By fol-lowing data on population's health, municipalities and these deaders meahers are not una which are water are represented by the substance on populations of the memory and the substantial data on populations of the memory and the substantial data on populations are also been and the memory and the substantial data on the substantial data data are substantial and the substantial data are substantial are substantial and the substantial data are substantial and the substantial data are substantial and the substantial are substantial and the substantial are substantial are substantial are substantial are substantial are substantially substantial are substantially substantially substantial are substantially substantial are substantially substantial are substantially substantial are substantial a

Inequalities in health Lifestyle if often associated with education and in-come. People with higher education and higher in-comes usually have healthier lifestyle habits and con-sequently botter health, and vice versa – people with lower education and lower incomes live less healthy their decision-makers can plan activities and propose measures for improving health of the population. and get ill more often. Socio-economic status is one of the main reasons for the occurrence of inequalities in health, which are unfair and can be prevented. ALCOHOL +

Health of an individual is changeable and related to numerous factors, called determinants of health (Figure

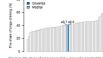
The population's drinking babits attitudes towards We cannot influence some factors, such as gen 31. We cannot influence some factors, such as gen-dor; age and genotics, but can influence many others. Lifestyle, as one of the important determinants, can promote batter health, on the other hand it can lead to illness. Lifestyle includes what and how much we have, such as smoking and drinking alcohol, etc. Our way of thinking and functioning as well as our way of coping with stress are also important for our health. Our exclusion Interpolations difficult additional additionadditional additionadditionadditionadditionadditionaddi to alcohol consumption and binge drinking. Each day in Slovenia, 10 persons are admitted to hospitals ex-clusively due to alcohol. More than 800 people die per year due to diseases and conditions directly al-tributable to alcohol. Additional 75 persons die each year due to traffic accidents caused by drunk drivers. Our education, employment possibilities and financial status influence our lifestyle.



(Dahlgreen and Whitehead, 2006). Many people have their first alcohol drink in adoles-

It is important for health of people not to be isola individuals, but to have the possibility to join differ ent social networks, which represent opportunities for social help and support.

Lifestyle is not exclusively formed by personal choices Lifestyle is not exclusively tormed by personal choices because there are many factors we cannot influence ourselves. Environment and society, in which we live, work, play, low, age, otc. have an important rolo. We more readly make healthy choices, if our envi-ronment onabilies and oncourage their motion's abilities, playgrounds, which encourage their motion's abilities, are a groat example of a health-portmoting environ-



ure 5: The share of persons aged 15- years, who reported binge sking in the past year; Mozinje Administrative Unit, of which rine municipality is part. 2014.

Alcohol-related costs

The estimated sum of alcohol-related health and other costs (such as traffic accidents, domestic violence, alcohol-related crime), is high – in 2011 the costs amounted to EUR 242 million in Slovenia. In co the excise duties generated only EUR 90 mil national treasury.

Working together in reducing alcohol-rela Family, friends, social networks, local com kindergartens, schools, working environn

other institutions, policymakers and decision on all levels, as well as experts, media and o ety in whole must work together to achieve m effects in reducing alcohol related harm.

In Slovenia as well as in most other Europe tries, overweight and obesity are increasing. T lem affects the length and the quality of life as it contributes to various chronic dis is more prevalent in lower educated and w

children and adolescents is worrisome. In th ncreased from 5.5 % to 127 %, while in girl same age period, it increased from 3.3 % to



Sedentary lifestyle Adults, as well as children and adolescents, are es posed to numerous risk factors for the occurrence o various diseases due to sedentary lifestyle and lack of physical activity.

HEALTH IN THE MUNICIPALITY 2016

Recommended daily physical activity for adults and older adults is at least 30 minutes daily, while we rec-ommend at least 60 minutes of physical activity daily for children and adolescents

In Slovenia, 18.2% adolescents aged 11, 13 and 15 years spend their leisure time seated more than 4 hours per day during school week. The share of children who are mainly seated during their leisure time is increasing with age; thus, 8.2% 11-year-olds spend their leisure time in this way, as well as 18% of 13-year-olds and 28.4% of 15-year-olds 12.9

€ 30

HEALTH IN THE MUNICIPALITY 2016

Health indicators in the municipality: Mozirje

Set of health indicators in the table show how the municipality compares with administrative unit (ULI) statistical region and national average. Comparison municipal and national levels are graphically deplayed. The indicators are teated for statistical significance. Higher variations of indicator values are support between particular years in marillar municipalities due to arrait number of versits. Definitions, additional data and applicat are valued ball at NLZ web page -

A structure of the second s

2010 B. Followski A. B. D. B. Kolowski and Service was an occurrence or an environment of products - the meaning of colours and space of methods: a Colours - municipality is statistically applicatly in bater position than the average in Sources (a Service - municipality is statistically applicatly response) and the service of the source of the distribution of the service of the distribution of the service of the distribution of the service of th cossible to determine the favourable direction of the indicate

	Indicator	Municip.	AU	Tegen	SLO	Unit	Lower than average	e Higher than average
Aun	11 Municipal development index	11	1	1	10	index		0
	12 Population increase	-8.0	-73	-0.8	0.9	%.o		
9 200	13 Older population (aged 80+ years)	2.9	5.2	43	4.7	×		
Po publicenan	14 Primary educated adults (primary school or lass)	30.2	31.8	276	25.7	*		•
	15 Employment rate	59.4	50.1	581	57.2	x		Δ
	16 L6 Daily Labour migration	64	88	96	101	%		
Γ	21 Physical fitness index of children	49.9	49.8	49.5	50.0	index		¢
	22 Overweight and obesity in children	31.0	28.4	25.8	24.6	x		•
factors	2.3 Regular and occasional smokers	19 ^m	21	24	24	×	A	
Risk fi	24 Binge drinking	40 ^m	41	42	41	*		4
	2.5 Road traffic injuries	10	11	18	18	5.o	0	
	2.6 Road traffic accidents caused by drunk drivers	17.5	167	81	8.7	%		•
8	3.1 Response rate in colorectal cancer screening	60.9	63.3	60.3	60.4	%		0
Pawant	3.2 Participation rate in cervical cancer screening	75.2	73.9	746	713	×		A
	3.3 Drinking water good microbiological quality	1.1	1	1.	1.	%		
	41 Self-assessed good health	76"	77	63	66	×		▲
	42 Sick leave days per worker	13.7	13.9	15.0	13.7	daya		
	4.3 Asthma in children and adolescents (aged 0-19 years)	12	07	0.8	12	ASR/2000		0
	4.4 Diseases, directly attributable to alcohol ((5+ years)	23	22	2.0	2.0	A58/3000		0
	45 Persons, receiving medications for diabetes	4.9	43	5.6	5.1	ASR/100		c
status	4.6 Persons, receiving medications for high blood pressure	25.7	24.3	25.1	23.7	AS9/100		•
	47 Persons, receiving anticoagulant medications	11.3	11.9	12.6	11.8	A59/100		0
Health	4.8 Heart attack hospital admission rate (35-74 years)	2.8	2.6	25	19	ASR/1000		0
	4.9 Stroke hospital admission rate (35-84 years)	23	30	32	2.6	A58/3000		C
	410 New cancer cases	6.3	5.1	5.3	5.6	A59/1000		0
	4.11 Hip fracture in older people (aged 65+ years)	31	45	42	6.4	ASR/1000	0	
	4.12 People, receiving medications for mental disorders	17.9	175	16.3	15.5	A524/100		•
	413 Help at home service users	1.5	0.8	21	16	×		c
Mortality	5.1 All causes mortality	945	1139	1062	980	A5R/100.000		d
	5.2 Cardiovascular mortality rate (0-74 years)	117	124	98	89	A50/100.000		0
	5.3 Cancer mortality rate ID-74 years	137	144	169	169	ASR/100.000	0	
	5.4 Colon cancer mortality rate/D-74 years)	11	8	- 14	11	A58/100.000		¢
	5.5 Breast cancer mortality rate (0-74 years)	16	19	21	20	A59/100.000		C
	5.6 Lung cancer mortality rate ID-74 years	42	29	35	41	ASR/100.000		0
	5.7 Suicide mortality rate	20	26	28	22	A50/100.000		

Logond: / indicator is not analytic on this administrative level ASP age standardised rate per

Parallel and elements 1.1 pp. 2014. Up. pp. 2014. Exp. 2014. Exp.

cence In comparison with international average, Slovene adolescents drink more alcohol and more frequently. Chil dren and adolescents are more vulnerable to alcohol related harm because of their development, mainly unfinished brain maturation (which lasts at least until 25th year of age). The younger the person is when he starts drinking alcohol, the higher is the risk he will have alcohol-related problems later in life. Tolerance nave atconot-rotated problems later in tite. Ioterance to adolescent alcohol consumption, or even worse, enabling it, is therefore not acceptable. In Slovenia, this is too often still the case, e.g. celebrating the end of primary or high school education.

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PHYSICAL ACTIVITY, OBESITY >

population and is associated with different r habits in different social classes. The trend of increasing overweight and obe years, the share of overweight boys aged 7-1



Questions?