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REVISED EUROPEAN SOCIAL CHARTER

8th National Report on the implementation of
the European Social Charter (revised)

submitted by

THE GOVERNMENT OF SWEDEN

(Articles 3, 12 and 13
for the period 01/01/2005 – 31/12/2007 ;
Articles 11, 14, 23 and 30
for the period 01/01/2003 – 31/12/2007)

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CYCLE 2009

Memorandum

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Eighth Report

Submitted by the Government of Sweden

In accordance with Article 21 of the Revised European Social Charter on the measures taken to give effect to the following provisions of the

Revised European Social Charter
–Articles **3, 12**, and **13** for the period of the 1st of January 2005 to the 31st of December 2007 and
- Article **11, 14, 23** and **30** for the period of the 1st of January 2003 to the 31st of December 2007.

In accordance with Article 23 of the Revised Charter, copies of this report have been communicated to

(1) Svenskt Näringsliv (Confederation of Swedish Enterprise)
(2) Sveriges Kommuner och Landsting (The Swedish Association of Local Authorities and Regions
(3) Arbetsgivarverket (Swedish Agency for Government Employers)
(4) Landsorganisationen i Sverige (the Swedish Trade Union Confederation)
(5) Tjänstemännens Centralorganisation (the Swedish Confederation of Professional Employees)
(6) SACO, Sveriges Akademikers Centralorganisation (the Swedish Confederation of Professional Organisations)

Article 3

Article 3:1

Question 1

The work environment policy objective defined by the Swedish Government in its Budget Bill is formulated as a work environment which prevents ill-health and accidents, is adapted to people's differing physical and mental aptitudes and is developmental for the individual. More detailed directions for policy implementation by the Work Environment Authority are issued by the Government in the Authority's annual appropriation warrant. Work is currently in progress within the Ministry of Labour on the compilation of supporting documentation for the work environment policy of the future (see *Arbetsmiljön och utanförskapet – en tankeram för den framtida arbetsmiljöpolitiken*, DS 2008:16). This work is based on wide-ranging interaction and discussions with the social partners and other agencies in the field.

Questions 2 and 3

Surveillance measures during the first part of the period covered by this report were guided by the Work Environment Authority's programme of activities for 2004-2006. That programme gave priority to six areas, namely health care, mental welfare and social services, schools, construction and civil engineering, transport and the timber

goods industry. Three areas of general priority were added, namely systematic work environment management, musculoskeletal ergonomics and organisational and social aspects of the work environment.

The programme for 2007 gave priority to special fields of supervision:

- Repetitive assembly-line work

Inputs during the year were made to focus on assembly-line work in automotive industry and the manufacture of electro-technical equipment. Upwards of 600 inspections were carried out.

- Accidents in the engineering industry

Inputs focused on accidents occurring and on the way in which undertakings learn from accidents and incidents with a view to identifying direct and underlying causes.

- Violence and menaces in public transport

Inputs targeted entrepreneurs operating local and regional public transport and some 30 public transport authorities. The entrepreneurs were required to audit their operations with regard to risks of violence and menaces in the work environment.

- Renovation and enlargement of buildings

These inputs targeted heavy manhandling and strenuous work postures, as well as risks connected with exposure to vibrations, dust, asbestos and noise.

- Use of trucks

Inputs mainly targeted wholesale and transport trade. 3,800 stipulations were issued, among other things requiring an investigation and risk assessment of truck operations.

- Domiciliary care

Targeted information was issued to safety delegates and managerial staff in this field. The information concerned musculoskeletal injury prevention, violence and menaces, and traffic safety.

Information with reference to Conclusions 2007

Consultations with the social partners

Reference is made to previous reports. The routines for consultations with the social partners are essentially the same as before. The Work Environment Authority's programme of activities and programme for work relating to special fields of supervision were drawn up following consultations with the social partners.

Article 3:2

Question 1

No amendments to the Work Environment Act (1977:1160) were enacted during the period 2005 – 2007.

Provisions issued by the Work Environment Authority, 2005 – 2007

Microbiological work environment risks– infection, toxigenic effect, hypersensitivity (AFS 2005:1)
replaces earlier Provisions and transposes an EC Directive to Swedish law.

Manufacture of Certain Vessels, Piping and Installations (AFS 2005:2) is an adaptation of the product rules for vessels and tubing not covered by the EC Directive on pressure equipment to the rules transposing the Directive. In this way the rules on the subject have been made more uniform and intelligible.

Besiktning av trycksatta anordningar (AFS 2005:3) is a harmonisation with the classification categories of the manufacturing provisions based on EC Directives concerning pressure equipment, aimed at simplifying matters for manufactures and others affected by the Provisions.

Cytostatika och andra läkemedel med bestående toxisk effekt (AFS 2005:5) is a revision of earlier Provisions, following the enactment of new waste disposal legislation.

Medicinska kontroller i arbetslivet (AFS 2005:6) deals with obligatory medical screening, as well as indicating when other checks are appropriate and how they can be conducted.

Vibrationer (AFS 2005:15) refers to hand, arm and whole-body vibrations. These Provisions transpose an EC Directive and contain detailed stipulations concerning risk assessment. They also contain occupational exposure limit values.

Buller (AFS 2005:16) transposes an EC Directive and entails stricter stipulations concerning harmful noise. The instrument contains limit values.

Occupational exposure limit values and measures against air contaminants (AFS 2005:17) has been revised, with the definition of new occupational exposure limit values for 28 substances.

Thermosetting Plastics (AFS 2005:18) has been revised with a view to simplifying and clarifying the Provisions. The instrument has been made to focus clearly on allergy hazards.

Förebyggande av allvarliga kemikalieolyckor (AFS 2005:19) transposes amendments to an underlying EC Directive and achieves closer harmonisation with other Swedish rules in this field.

Hälsoundersökning av flygpersonal inom civilflyget (AFS 2005:20) transposes the Council Directive 2000/79/EC of 27 November 2000 concerning the European Agreement on the Organisation of Working Time of Mobile Workers in Civil Aviation.

Asbestos (AFS 2006:1) is a revision of the rules on asbestos, transposing the amended Council Directive on the protection of workers from the risks related to exposure to asbestos at work. Existing case law has been formalised. Certain provisions have been elucidated to ensure that the rules are complied with.

Innesluten användning av genetiskt modifierade mikroorganismer (GMM) (AFS 2006:2) entails the repeal of the requirement of charges payable for the handling and inspection of contained use of GMMs, thus reducing the administrative overheads of those engaged in GMM activity.

Use of Work Equipment (AFS 2006:4) has been further developed and elucidated. Stipulations concerning lifting devices and trucks have been transferred to instruments for the fields concerned.

Användning av truckar (AFS 2006:5) has been amended so as to give it the same structure as other Directive-based instruments, namely a sectioned part containing general stipulations and an appendix stating technical requirements. The stipulations concerning knowledge required for the conduct of such work have been made clearer.

Use of lifting devices and lifting accessories (AFS 2006:6) amounts to a modernisation of the rules on lifting devices and their bringing together in a single instrument. The earlier rules were issued by authority of different enactments and differed with regard to precision and legal status. The new rules provide an improved structure and a more uniform set of rules.

Temporary Lifting of Persons Using Cranes or Trucks (AFS 2006:7) brings together in a single instrument rules concerning temporary personnel hoists using cranes or trucks, the purpose being to simplify interpretation of the rules and avoid unnecessary duplication. The rules concerning which machines may be used as temporary personnel hoists have been made clearer.

Testing at Over or Under Pressure (AFS 2006:8) supersedes earlier rules, eliminating the gas testing permits formerly issued by the Work Environment Authority. Instead companies are accredited for gas testing by SWEDAC. The new rules are clearer and ensure that accredited companies will continue to be assessed on equal terms, added to which, companies throughout the EEA can be accredited for gas testing in Sweden.

Sprängarbete (AFS 2007:1) supersedes Provisions issued in 1986, in view of the extensive developments of technology and products which have taken place since then. The new Provisions are adapted to the present-day level of technology. Among other things, measures now have to be taken to reduce work environment hazards entailed by undetonated explosive in blasting rubble.

Hygieniska gränsvärden och åtgärder mot luftföroreningar (AFS 2007:2) contains an amendment to the list of indicative EC occupational exposure limit values, following an amendment to the EC Directive establishing a second list of indicative occupational exposure limit values.

Gravida och ammande arbetstagare (AFS 2007:5) is harmonised, with regard to its General Recommendations, to the Guidance Document on the directive on the introduction of measures to encourage improvements in the safety and health at work of pregnant workers and workers who have recently given birth or are breastfeeding. The Provisions now incorporate the prohibition, formerly included in the special Provisions on Lead, of the employment of pregnant workers and nursing mothers on work with lead.

Rök- och kemdykning (AFS 2007:6) has been revised in response to technical progress and organisational changes in the rescue services. The stipulations concerning risk assessment have been made clearer and more precise, as have the stipulations regarding manning and organisation. The clearer structuring of the contents and the increased number of informative comments are judged to have enhanced reading comprehension.

Byggnads- och anläggningsarbete (AFS 2007:11) clarifies the scope of the Provisions on Building and Civil Engineering Work. The Work Environment Authority judges phraseology improvements to have facilitated understanding and implementation of the Provisions.

Förebyggande av allvarliga kemikalieolyckor (AFS 2005:19) meets the requirements of the Convention on the Transboundary effects of Industrial Accidents as regards the limit values for methanol and oxygen.

Question 2

In connection with the issue of new Provisions by the Work Environment Authority, the social partners are consulted on at least one occasion. These occasions also include discussions concerning procedure for giving effect to the Provisions. The Work Environment Authority makes a regular practice of drawing up a communication plan for every new or revised instrument. Information measures are geared to the specific information requirement. In addition, the full texts of Provisions are accessible on the Authority's website, which also includes a search function.

Information with reference to Conclusions 2007

Asbestos

As stated in an earlier reply, there is no register of asbestos in buildings. Section 20 of the Provisions of the Work Environment Authority on Asbestos (AFS 2006:1) stipulates, however, that before work which entails or can entail exposure to asbestos-containing dust begins, every measure must be taken to identify the materials which may conceivably contain asbestos. These Provisions transpose an EC Directive on asbestos to Swedish law.

The Provisions require the person directing and the person carrying out work on the demolition of buildings etc. incorporating asbestos or asbestos-containing material to have undergone special training which has to be supplemented at least every five years.

Material containing asbestos may be handled in connection with the demolition of a building, part of a building, a technical device or part of such a device only by permission of the Work Environment Authority. A company which has obtained a permit may not commence demolition work before notification containing particulars of the demolition object have been received by the Work Environment Authority. This latter provision is designed to facilitate supervision at the worksite. A party demolishing asbestos without a permit must pay a sanction charge.

Temporary employees

A provision added to the Work Environment Act in 1994 concerns a party engaging outsourced manpower: "A person hiring rented labour to work in his activity shall take the safety measures which are needed in that work." In other words, a party engaging outsourced labour must observe the same precautions as for hired personnel.

It is the responsibility of the manpower rental firm to engage occupational health care and to ensure that the necessary medical checks are carried out. Safety delegates are appointed from among the rental firm's employees.

Self-employed persons

When the Work Environment Authority carries out special supervision projects, its aim is to scrutinise a particular field, above all through inspections, so as to gauge the deficiencies exiting and the measures which may need to be taken. In connection with projects concerning a technical device or a substance which can occasion ill-health or accidents, self-employed persons are also inspected. They are also inspected in connection with accident inquiries. many self-employed persons are active in agriculture, forestry and construction work, all three of which are particularly accident-prone sectors calling for special supervisory initiatives.

Consultations with organisations of employers and employees

As stated by way of introduction, the routines for consultations with the social partners are essentially the same as before.

Article 3:3

Question 1

Methods and routines for supervision are developing all the time. The routines are described in "Rules for inspection", which were revised in 2005. The English translation is appended to this report.

The resources of the Work Environment Authority were heavily reduced in 2007. The reduction will continue in 2008 and 2009 until it reaches a total of 20 per cent. As much of the reduction as possible has been concentrated on administrative and central personnel, with the result that inspection resources will be reduced by 24 per cent.

Question 2

	2005	2006	2007	Total
No. work accidents entailing sickness absence	31,740	32,284	28,079 (preliminary figures)	
No. fatal work accidents	68	68	75	
No. work accidents per 100 000 employees	795	789	686	
No. fatal work accidents per 100 000 employees	1.6	1.6	1.7	
No. workplace visits	38,177	39,984	36,302	
No. inspections	24,747	25,784	22,978	
No. employees inspected	379,000 approx.	385,000 approx.	344,000 approx.	
Proportion of workplaces visited	12 %	13 %	11 %	
No. inspection notices with stipulations	15,243	14,882	14,192	
No. injunctions and prohibitions	709	865	761	
No. contingent fines imposed	6	14	41	
No. sanction charges	6	3	10	
No. cases of corporate fines	2	2	1	
No. referrals for prosecution	210	222	237	

Information with reference to Conclusions 2007

Activities at the Work Environment Inspectorate

A new organisation was introduced at the Work Environment Authority with effect from 1st January 2001. By Government resolution, the formerly independent inspection districts merged with the central authority to form a single entity. The national system of inspection has not changed since 2001.

Most of the inspections (99.1 per cent) concern the work environment. Only a very small proportion (0.9 per cent) are concerned with surveillance of working time. A change occurred on 1st January 2005, when the Work Environment Authority was made responsible for surveillance under the Road Transport Working Hours Act (2005:395).

All fatal accidents reported are investigated. Serious accidents and accidents potentially of interest from a prevention viewpoint are also investigated.

Consultations with organisations of employers and employees

The routines for consultations with the social partners are essentially the same as previously reported.

Article 3:4

Article 3:4 has not been ratified by Sweden..

Annexes to Article 3 are appended.

Article 11

Article 11:1

Question 1

The fundamental principles of the Swedish healthcare system are that care should be provided on equal terms and according to need, that it should be managed democratically and financed on the basis of solidarity.

Responsibility for health and medical care in Sweden is shared between the State, county councils and municipalities. This responsibility is governed by the Health and Medical Services Act, which is designed to give county councils and municipalities considerable freedom with regard to how they organise and finance their healthcare.

The central government formulates policy and controls the system through legislation and government grants. However the central government does not run any healthcare services. It is the responsibility of the county councils and municipalities to organise, finance and run the healthcare system.

The 21 county councils have a responsibility for organising health services so that all citizens have access to adequate healthcare. The counties finance their healthcare services by taxes. County councils also receive revenue from patient charges and the sale of services.

There are 290 municipalities with responsibility for care of the elderly and support and service to those whose medical treatment has been completed and who have been discharged from hospital care. Municipalities are also responsible for housing, employment and support to people with psychiatric disabilities. The municipalities finance their care through taxes.

Although the main source of finance for the healthcare system is the taxes collected by the counties and municipalities, the state supports the system with general central government grants. The state also gives targeted grants to pharmaceutical benefits and in order to promote better access to healthcare.

Legal framework

The Health and Medical Service Act defines the responsibilities of county councils and municipalities for offering good health and medical services to all persons living or residing within their boundaries. The Act specifically states that health and medical services shall be conducted so as to meet the requirements for healthcare and in particular that the care must be of good quality and cater to the patient's need of security in care and treatment. It shall also be readily available, be founded on respect for the self-determination and privacy of the patient and promote good contacts between the patient and health and medical personnel. The Act also states that care and treatment as far as possible shall be designed and conducted in consultation with the patient and that the patients shall be given individualised information concerning their state of health and the treatment methods available; when several treatments exist which comply with science and proven experience, the county council shall give the patient the possibility of choosing the alternative which he or she prefers.

Dental care is governed by the Dental Care Act (1985:125) and the Statute on Dental Care Charges (1998:1337). The Dental Care Act makes the county councils responsible for providing necessary dental care free of charge to all citizens under the age of 19 as well as to certain groups with special needs. For other groups dental care is not free, but it is subsidised.

The use and distribution of medical products are regulated in the Medical Products Act. The purpose of the Act is to ensure the safety of patients. People using medical products should be able to rely on the product being safe, effective and of good quality.

New legislation on alcohol, drugs and tobacco

Alcohol – A Government Bill, effective from 1st July 2008, adding to the Alcohol Act a provision permitting a private person aged 20 or over to import spirituous drinks, wine or strong beer from an EEA country through commercial transport or some other independent intermediary, for the personal use of themselves or their family.

Tobacco – two Government Bills: smokeless refreshment establishments and implementation of the WHO Framework Convention on Tobacco Control. The Smokeless Refreshment Establishments Bill, effective from 1st June 2005, prohibits smoking in restaurants and other places serving refreshments except when service takes place outdoors. The ban on smoking applies to all restaurants, cafés, pubs and other refreshments serving food or drink in the course of their business activity with the option of consumption on the premises.

Narcotic drugs – several annual classifications of new substances, either as narcotic preparations or as products endangering health.

Action plans concerning alcohol and narcotic drugs

Government Bill 2005/06:30 outlines two national action plans: a national action plan for the prevention of alcohol-related damage, and a national action plan against narcotic drugs, the purpose being to indicate the direction in which public initiatives are to be reinforced between 2006 and 2010 and how they are to be followed up.

Inquiries in progress

A. Review of narcotic drugs legislation

The Government has appointed a Commission to review and analyse the existing rules on control of narcotic drugs, doping agents, narcotic precursors (i.e. substances often used in the illicit production of drugs), solvents, lighter gases and other health-endangering products used for the purpose of intoxication, and interrelation between them. The Commission is also to study the possibilities of introducing a procedure which prevents contact with a substance presumably classifiable as a narcotic drug or health-endangering product. The Commission is to report to the Government not later than 31st December 2008.

B. Review of authorities in the field of infectious disease control

A special investigator is to review the authorities engaged in activities to do with infectious disease control, in particular the National Board of Health and Welfare and the Swedish Institute for Infectious Disease Control, the purpose being to clarify the

allocation of responsibilities, improve the efficiency of activities and assess the extent of public commitment. A report is to be submitted to the Government not later than 1st June 2009.

C. Investigation of certain provisions of the Tobacco Act, with a view to protecting minors

A special investigator is to review the efficiency of and compliance with the provision concerning an age limit for the purchase of tobacco products and other, related provisions. The overarching purpose of the review is as far as possible to prevent early tobacco débuts and reduce tobacco consumption, with a view to improving public health. The more immediate purpose is to facilitate more effective compliance with the provision of the Tobacco Act (1993:581) prohibiting the sale or other commercial supply of tobacco products to persons aged under 18 years. A report is to be submitted to the Government not later than 31st December 2008.

D. Review of the Alcohol Act

A special investigator is to carry out a review of the Alcohol Act (1994:1738), on the principle of a restrictive alcohol policy for the protection of public health. A report is to be submitted to the Government not later than 28th February 2009.

Question 2

All citizens must feel secure in the knowledge that care is readily available when needed. During the 21st century a number of measures have been taken in order to improve availability and strengthen the position of the patient, e.g. the national accessibility initiative, the national action plan for the development of health and medical care, and the national care guarantee.

Care guarantee

An appointment guarantee, introduced in 1997, requires primary care to offer assistance, either by telephone or by a visit (appointment), on the same day the care agency is contacted. If medical advice is needed, the waiting period must not exceed 7 days, and a person with a confirmed referral to specialised care shall be offered an appointment of this kind within 90 days.

In 2005 the State and the Swedish Association of Local Authorities and Regions signed an agreement expanding the appointment guarantee into a care guarantee which also includes the waiting time for treatment. The care guarantee implies a pledge by the county councils to offer treatment within 90 days of a treatment decision being taken. The guarantee applies nationwide and includes all treatment within planned county council care. The care guarantee also requires the county council to assist patients in obtaining care in another county council area if the waiting period for an appointment or treatment in the county council area of residence exceeds 90 days.

Follow-ups having shown that the care guarantee is not working wholly as intended and that there are still long waiting periods for certain treatments, the ability of patients to obtain care in time and to make their own choices of care provider and care appointment needs to be further strengthened. Further development and statutory regulation of the nationals care guarantee and of the free choice of care is an important part of such an endeavour. Provisions of this kind will make the commitments of care providers to the patient clearer to both parties. In 2007, therefore, the Government appointed a Commission tasked among other things with proposing ways in which the national care guarantee and the free choice of care can be regulated by law.

Information supply and IT development – National IT strategy for health and caring services

IT use in health and medical care is today a natural part of work in these services. Nearly all medical records in Swedish health and medical care are now kept electronically, and both prescriptions and laboratory replies etc. are transmitted electronically. There is, however, a great potential for improving and streamlining IT use, mainly because Sweden, as an early user of various forms of IT support, has a number of antiquated systems which cannot communicate with each other.

This being so, the Government and the Swedish Association of Local Authorities and Regions agreed to establish close co-operation on IT development in the health and caring services sector. The *National Steering Group for IT in Health and Caring Services,* appointed in March 2005, includes representatives of the Ministry of Health and Social Affairs, the Swedish Association of Local Authorities and Regions, the National Board of Health and Welfare and The Association of Private Care Providers. Work is proceeding within the framework of the Dagmar Agreement, a State-funded agreement between the State and the Swedish Association of Local Authorities and Regions concerning special development projects for health and medical care.

The work of the Steering Group has resulted in a national IT strategy which is to serve as a support for local and regional development work. A number of measures have been initiated with the aim of achieving an IT use which will promote work in the caring sector in the best possible way. Measures have to be taken at different levels, namely county council and municipal (regional and local) levels and national level. County councils and municipalities are responsible for operative activities and thus primarily responsible for the development of IT use, while the State and several other agents are tasked with establishing the basic prerequisites of development through legislation and regulations and by means of a uniform terminology and information structure.

The work needing to be done has been divided into six input areas:

1. Harmonising laws and regulations with increased IT use.
2. Creating a common information structure.
3. Creating a common technical infrastructure.

4. Creating the prerequisites for interactive and activity-supporting IT systems.
5. Facilitating access to information across organisational boundaries.
6. Making information and services readily available to citizens.

The results of this work are being presented in annual situation reports, the latest of which, presented in May 2008, shows that work is progressing more rapidly than expected, many of the initiatives proposed in the IT strategy now being fully developed or in the process of introduction. The county councils too have strengthened their national co-ordination so as to be able to deliver the new national services, through the establishment of a common ordering function within the Swedish Association of Local Authorities and Regions.

One stage in the implementation of this strategy involves harmonising laws and regulatory instruments. The Patient Data Act, which entered into force on 1st July this year, is aimed at strengthening patient security by facilitating the interchange of information within health and medical services, and at strengthening the patient's influence as to who shall have access to his or her medical records.

The Patient Data Act applies to all care providers, regardless of mandatorship and among other things regulates the ability of care providers to exchange data electronically across organisational boundaries. The previous prohibition of direct electronic access between care providers is being removed, and a possibility introduced for care providers, subject to the patient's consent, to create a coherent picture of the patient's previous care history. At the same time the patient's ability to check the use made of information in his or her own medical records is being strengthened through the introduction of a new system of consent. As a confidence-building measure, a stipulation is also being introduced whereby the patient will be able to study a log showing which members of the nursing or medical staff have read the record.

For many years now, the Government has also been co-operating with the Swedish Association of Local Authorities and Regions to establish a nationally co-ordinated and quality-assured system of medical counselling on the Internet and by telephone, through the services Sjukvårdsrådgivningen.se and Sjukvårdsrådgivningen 1177. These services are intended to enhance patients' security by giving practical guidance prior to a medical appointment and offering advice on health and self-care. During 2009 this service will be expanded so as also to include, among other things, personal information on the individual person's own health, electronic access to excerpts from the individual person's medical record, and a facility for making medical appointments and renewing prescriptions. The ultimate aim is also to be able to present target-group-adapted comparative information on the quality and outcome of care from various providers. The service will then become an important tool for all citizens, both prior to a medical consultation and for choosing a care provider, and will provide greater opportunities of participation and self-determination for the individual.

Psychiatry
On 23rd October 2003 the Government resolved to appoint a national psychiatry co-ordinator to review issues concerning working procedures, co-operation, co-ordination, resources, personnel and competence in nursing, social welfare and rehabilitation for the mentally ill and persons with mental functional impairment. The national psychiatry coordinator was also commissioned, together with municipalities, county councils and the national authorities concerned, to formulate strategies for quality development and to co-ordinate and strengthen development work. A final report was submitted on 30th November 2006.

In the final report the psychiatry co-ordinator proposed, among other things, measures to be taken in the contexts of housing, occupation, rehabilitation, user influence, national control, research and development and manpower supply

In 2007 the Government inaugurated initiatives in the field of psychiatry, based on the co-ordinator's final report. One of the initiatives focused on child and youth psychiatry, deficiencies having emerged in the availability of mental heath care and nursing, above all where child and youth psychiatry was concerned. In many places, waiting periods for psychiatry for children and young persons exceed 90 days, which is the maximum limit on waiting periods under the care guarantee. With reinforced front-line health and medical care for children and young person suffering from mental illness, many of those waiting for help could obtain help earlier in the care chain than in specialist psychiatry. The care guarantee for child and youth psychiatry has also been reinforced, namely as follows: appointments with specialist child and youth psychiatry must be available within 30 days instead of the 90 days indicated in the general care guarantee. Furthermore, treatment must be on offer within 30 days of a treatment decision being made (as against 90 days under the general care guarantee).

In addition to measures to improve availability, initiatives have also been taken with regard to training and general qualitative improvements, e.g. the setting up of national competence centres for children and young persons. Every such centre will be tasked with gathering, coordinating and disseminating knowledge and science concerning identification, prevention and treatment for children and young persons in danger of contracting severe mental illness.

Patient safety and supervision
Patient safety is a priority issue with the Swedish Government. A national Commission was appointed in the spring of 2007, tasked among other things with reviewing the legislation in a patient safety perspective. The Commission is due to report to the Government not later than 31st December 2008.

The National Board of Health and Welfare, which is the supervisory authority for health and medical care and the competent authority in the field of patient safety, has on its own initiative inaugurated a medical injuries assay resembling the surveys carried out earlier, e.g. in Denmark and the UK. At least rough comparisons will be possible between Sweden and other countries concerning the occurrence of iatrogenic injuries. The report, presented in June 2008, shows that 8.6% of patients incur some

form of harm in connection with medical care, the total numbers being approximately 100,000 iatrogenic injuries and 630,000 extra care days. Part of the Government's bid to minimise the risk of iatrogenic injuries is to ensure that necessary information concerning a patient can be available to the medical personnel treating the patient, if the patient has consented thereto. The Government's work together with medical mandators and authorities within the framework of the national IT strategy for health care and caring services constitutes the foundation of this work, since it establishes a common agenda for the key players in the sector to follow in their efforts to eliminate legal, semantic and technical impediments to safe and efficient information supply in all health care and other caring services.

The county councils, which are responsible for health care and medical activities, are also working intensively to address matters of patient safety. In 2007 the Swedish Association of Local Authorities and Regions (SKL), which is an interest organisation, launched a national initiative for patient safety, aimed at halving the incident of iatrogenic infections by the end of 2009, compared with 2006.

Since 2003 the National Board of Health and Welfare, SKL and several other organisations have arranged three national patient safety conferences, and a fourth is planned for September 2008.

The National Board of Health and Welfare is also responsible for supervision of health and medical care services and their personnel, the main purpose of this supervision being to strengthen patient safety and improve the quality of care by preventing injuries and eliminating risks in the caring sector. Furthermore, it is the duty of care providers to notify the National Board of Health and Welfare if a patient incurs, or is exposed to the risk of incurring, serious injury or disease in connection with medical care. The National Board of Health and Welfare compiles and feeds back information concerning serious incidents in the caring sector and issues binding prescriptions for the health and medical services on matters relating to patient safety and quality.

Staffing issues

Admissions capacity for medical studies has been increased in response to growing demand for physicians. The increase was moderate between 2003 and 2007, but in this year's Budget Bill the Government has resolved to allocate funding for 110 new medical student equivalents.

Measures taken to implement public health policy

To intensify and reinforce work in particular important fields of public health policy, the Government intends allocating an additional MSEK 115 annually to the Public Health policy field between 2008 and 2010, in accordance with the proposal presented in the Budget Bill for 2008. This funding will above all be applied to strengthening and developing support for parents in their parenting, intensifying suicide prevention work, promoting good eating habits and physical activity, and reducing tobacco consumption.

Government Bill 2007/08:110 A new public health policy, indicates eleven target areas:

1. Participation and influence in the community
2. Economic and social preconditions
3. Formative conditions of children and young persons
4. Health in working life
5. Environments and products
6. Health-promoting health care and nursing
7. Protection against the spread of infection
8. Sexuality and reproductive health
9. Physical activity
10. Eating habits and foodstuffs
11. Tobacco, alcohol, narcotic drugs, doping and gambling.

A brief account will now be given of initiatives in target areas 6,7,8,9,10 and 11.

Health and medical care
More health-promoting health and medical care
For several years now, development work has been in progress in this area, on a voluntary basis, through the Health-Promoting Hospitals network, to which upwards of 30 Swedish hospitals are now affiliated. This internal development work in health and medical care plays a strategically important role in the integration of the disease-prevention and health-promotion perspective in health and medical care.

Studies of response to homosexual, bisexual and transgender persons in health and medical services
According to the Swedish National Institute of Public Health (FHI), discrimination is an important cause of ill-health among homosexuals, bisexuals and transgender persons (HBT persons). Homosexual and bisexual women in particular show inferior self-reported health compared to the rest of the population. The Government intends devoting special attention to the question of how HBT persons are treated by health care and medical services.

Measures to create the prerequisites of good care
In addition to the components which have now been mentioned, the Government's strategy for good care also includes initiatives to give the individual more freedom of choice, e.g. through a wider range of options, and to develop compensatory systems. Improved information supply will among other things improve the prospects of recording data which reflect measures of prevention and health promotion.

Psychiatry initiatives
The Government has made a number of policy decisions concerning psychiatry, aimed at achieving more readily available care and a development towards proactive measures.

Infectious diseases
The Government intends allocating some MSEK 145 annually for the period between 2008 and 2010 for measures to combat HIV/AIDS and other infectious diseases.

More efficient structures for the control of infectious diseases
The spread of infectious diseases knows no boundaries, and accordingly the Government wishes to bank on deeper and efficient EU co-operation and on international cooperation, so that aggregate resources will be put to optimum use.

Preparedness for acute health hazards

During 2009 and 2010 the Government intends continuing to allocate MSEK 10 annually for contingency preparedness to deal with outbreaks of serious infectious diseases. Special measures are to be taken with regard to monitoring and extent of an infection in Sweden, the effects of an infectious disease on society as a whole, ways in which non-medical measures can influence the spread of an infection, and continuing support at regional and local levels for the development of contingency preparedness to deal with epidemics.

Interesting non-commercial pharmaceuticals
New forms of finance and partnership between the private and public sectors are needed in order to upscale primary research findings to products, also where commercially uninteresting pharmaceuticals and products, e.g. HIV vaccines and new antibiotics, are concerned.

Patient safety and quality – medical hygiene/general hygiene
To prevent serious developments and strengthen preventive efforts against antibiotic resistance, more work needs to be devoted to medical hygiene, general hygiene and rational antibiotic treatment.

Review of the national vaccination programmes
In the light of new infection threats and a more innovative vaccine industry, the current regulation of the national vaccination programmes is in need of review.

HIV/AIDS and other sexually transmissible and blood-borne diseases
It is vital that work to combat HIV/AIDS and other sexually transmissible and blood-borne diseases should be encouraged at regional and local levels. The rapid progress of the chlamydia epidemic makes it urgently necessary for clear action plans to be drawn up concerning preventive work aimed at juveniles and young adults.

Diet and physical activity

Supporting data for an action plan for good eating habits and increased physical activity

Under a remit from the previous Government, the National Food Administration and the National Institute for Public Health (FHI) have drafted an action plan for good eating habits and increased physical activity among the population. The action plan proposes 79 initiatives. These impinge on many different policy fields in the community: labour market, public health, health and medical care, sport, consumer, food, environment, taxation, transport, education, disability and elderly policy.

Dialogue with the industry, expertise, the voluntary sector and other key players

In the Government's view, in order for the negative development of overweight and obesity to be reversed, all major players in the sectors concerned must work together.

Interaction group

The Government sees a need for national co-ordination between public authorities in order to improve the prospects of monitoring and evaluating initiatives for good eating habits and the promotion of physical activity. A national interaction group for eating habits and physical activity should therefore be set up, consisting of experts from FHI and the National Food Administration as well as other authorities.

Sustainable eating habits

Good eating habits are defined as those which are good both for health and for the environment. Eat SMART is a body of documentation compiled jointly by the Stockholm County Council and a number of national authorities which is now being followed by a large number of municipalities and county councils. The need for a change to good eating habits is especially great among socioeconomically disadvantaged groups.

National evaluation of physical activity on prescription (FaR)

The aim of a national evaluation of FaR must be to ascertain whether the FaR method is well known and is being used, whether it is well established and thus included on the agenda at workplace get-togethers, whether county councils and municipalities have steering documents for the method and whether a cogent strategy for preventive activities such as FaR exists at regional level.

National implementation of Physical activity in the prevention and treatment of disease

In the spring of 2008 FHI will be publishing recommendations on physical activity with reference to a large number of common illnesses. The recommendations are to constitute both a general knowledge bank containing information on the latest

research findings in the subject field and a support for nursing personnel, enabling them to prescribe FaR more adequately than before.

Basic/in-service training in motivating interview methodology and physical activity on prescription

Basic and in-service training concerning interview methodology in health and medical care are of great importance. The motivating interview is aimed at increasing the motivation of the individual for a change of behaviour. There is evidence today that various forms of short-term counselling and motivating interview methodology for the prevention of alcohol addiction actually work and produce effects. Similar effects have been demonstrated where physical activity is concerned.

Improving quality of life for older persons through activity programmes and meeting points in the neighbourhood

Amenities including various leisure activities, such as intellectual, social and physical activities, are of great importance to older persons, and action early on in people's lives plays an important part in promoting health and preventing illness. The EU Healthy Ageing project, under Swedish direction, made people aged 50 and over the starting point of its systematic planning of health promotion measures. This means initiatives for older persons at an early point in the age cycle.

Development of the governmental remit on the built environment and physical activity

Simple, practical tools are needed at local level to facilitate the work of agencies concerned with creating built environments conducive to physical activity. More health-promoting urban planning could bring about an increase in everyday exercise. Best urban planning practices for promoting physical activity can take the form of a safe, attractive footpath and cycle path, the preservation and development of parks and green spaces, greater emphasis on safe routes for children to and from school, measures to facilitate recreation and exercise, and so forth.

Question 3

General aspects – public health situation

Health developments in Sweden are predominantly positive. The storm clouds existing previously concerned mental health, increasing overweight and obesity and rising alcohol consumption, especially among young people. Mental wellbeing, however, appears to have improved among both adults and the majority of schoolchildren since the beginning of the 21st century, except that mental disorders among 15-year-old girls are still increasing. The increase in overweight and obesity has come to a standstill among adults and possibly among children as well. Alcohol consumption is no longer rising and has declined among the school population, especially in the past two years.

Average life expectancy expected to increase

For several years now, Sweden has had the highest average life expectancy in the world, and the figure continues to rise. In 2006 a newborn boy could be expected to live to 78.7 years and a newborn girl to 82.9 years. Forecasts by Statistics Sweden (SCB) show average life expectancy rising by 2020 to 80.8 for men and 84.2 for women. This increase can be mainly attributed to the steep decline in cardiovascular disease mortality.

Infant mortality very low

Infant mortality, i.e. the number of children dying during their first year of life, is very low in Sweden and has been steadily declining, though a certain year-on-year fluctuation is observable. Infant mortality in 2007 was 2.5 per 1,000 live births, which was down on 2006 (2.8). Most children dying in the first year of life die during the first week.

Morbidity dominated by three groups of illnesses

Morbidity in Sweden is dominated by three groups of illnesses: cardiovascular diseases, neuropsychiatric illnesses and cancer (malignant tumours). Together these three categories account for over 60 per cent of Sweden's total morbidity.

Progressively fewer contracting and dying of cardiovascular disease

Cardiovascular diseases are the group of illnesses causing most premature deaths, while at the same time often entailing prolonged health problems and functional impairment. According to the National Board of Health and Welfare cause of death register, the risk of contracting cardiac infarction fell by 19 per cent between 1987 and 2005 and the risk of dying of cardiac infarction fell by 47 per cent during the same period. The reduced risks of cardiovascular disease are due to improved living habits, above all a reduction of smoking and to some extent better eating habits. The reduced risk of fatality among those falling ill can above all be ascribed to medical inputs. It is estimated that upwards of 3,000 more lives are saved annually than 15 years ago, thanks to improved cardiovascular care, e.g. heart surgery and preventive treatment of high blood fat levels and high blood pressure.

Some indications of improved mental wellbeing

According to the ULF (living conditions) survey, the proportion of the population stating that they experienced anxiety, unease or anxiety rose throughout the 1990s following a decline in the 1980s. According to the latest figures, for the period 2004-2005, the figures have fallen to 24 and 14 per cent respectively, except for young women between the ages of 16 and 24, for whom the percentages are still increasing. A similar improvement can be seen concerning severe discomfort from anxiety, unease or anxiety, and for sleep disturbances, recurrent headache and constant tiredness. The fact of several indicators pointing in the same direction underscores the impression of some improvement in the mental wellbeing of the population as a whole during the

past three years. On the other hand, the negative development among young women gives cause for concern.

Cancer survival increasing

Cancer is the cause of half of all deaths before age 65 among women and one-third of all deaths before age 65 among men. The number of new cancer cases (allowing for the increased proportion of older persons in the population) rose between 1997 and 2006 by 0.8 per cent annually for women and 1.5 per cent annually for men, while the corresponding mortality remained constant. Upwards of half the people diagnosed with cancer today are expected to live as long as their coevals. The two commonest forms of cancer – lung cancer among women and prostate cancer among men – make up a third of all cases. One cancer case in three is put down to tobacco, eating habits and sunbathing habits.

Specially urgent public health problems

Suicide increasing among young women

The number of suicides has declined considerably in all over-25 age groups since 1980. In the 15-24 age group, however, no improvement has occurred since the beginning of the 1990s. The National Board of Health and Welfare's preliminary statistics for 2006 show suicides in total figures to have declined for the country as a whole, at the same time as they have distinctly increased among young women aged between 15 and 24.

Resistance to antibiotics increasing

Care, quality and safety depend on good medical hygiene to prevent the spread of infection and the occurrence of iatrogenic infections. This also includes antibiotic-resistant bacteria, which pose an increasing problem. During 2007 the number of cases of multiresistant staphylococci (MRSA) rose by 8 per cent compared with the same period in 2006.

New cases of HIV infection have increased in recent years

The spread of HIV infection in Sweden has been kept down to a low level by international standards. Since 1985 a total of 5,617 men and 2,397 women (8,014 persons in all) have been reported as having contracted HIV infection. Up until 2002 some 200 or 300 new case were being reported annually, but recent years have seen an increase. Thus 541 new cases, the highest number on record for any single year since 1986, were reported in 2007. A heterosexual infection path accounted for just under half the total number of cases (228), while one quarter (130 cases) had been infected by sex between men and upwards of 10 per cent (61 cases) by i.v. drug use.

Disturbing increase in chlamydia infection

Chlamydia infection has shown a disturbing development since 1997. The number of new cases in 2007, at 47,127, was considerably higher (45 per cent) than in 2006. There is, however, an unknown dark figure involved, due to a mutation of the Chlamydia bacterium having appeared which is not detectable by conventional test methods.

Growth in the proportion of unwanted teenage pregnancies

Every year between 30,000 and 40,000 abortions are performed in Sweden. This level has remained relatively unaltered since the present Abortion Act was passed in 1975, but the number increased between 1995 and 2006, which suggests a rise in the proportion of unwanted teenage pregnancies during the same period.

Growth of excess weight and obesity

According to SCB (Statistics Sweden), more than half of all men and upwards of one-third of women aged between 16 and 7 are overweight or obese, and just under 10 per cent of both sexes are obese. The proportion of persons with excess weight or obesity increased during the 1990s, but this increase appears to have been halted between 2000-2001 and 2004-2005. Data concerning children's weight and height in various studies have shown between 15 and 20 per cent of children to be overweight and between 2 and 8 per cent of these to be obese.

Slight drop in drug abuse

According to the Federation of Alcohol and Drug Awareness (CAN), drug use among pupils in the ninth year of compulsory school rose steadily during the second half of the 1990s and the beginning of the 2000s. It peaked in 2001, when 10 per cent of the boys and 9 per cent of the girls reported having used drugs. A decline then followed, and the figures in 2007 were 7 per cent for boys and 5 per cent for girls. There are also signs of abuse of doping preparations by non-athletes, especially as regards young men's use of anabolic-androgenic steroids. One per cent of the boys and fewer than 0.5 per cent of the girls stated that they had used anabolic steroids at one time or other. The number of 18-year-old conscripts who had tried narcotic drugs declined in 2004 for the first time in 15 years. That year 15 per cent had tried drugs, as against 18 per cent in 2002. By 2006 the proportion had fallen to 13 per cent. Various surveys have shown roughly one per cent of adult men to have used anabolic steroids on one or other occasion. The available data indicate a total of about 26,000 persons with heavy drug abuse problems. Certain studies indicate that 80 or 90 per cent of i.v. drug abusers are carriers of Hepatitis C virus. Hepatitis B is less widespread than Hepatitis C. In the past 5 years the number of reported HIV carriers among persons intravenously infected has averaged 30 per annum. Up until the mid-1970s the number of drug-related deaths remained at a low and relatively constant level, roughly 35 cases annually. Since then the number has risen, with something in the region of 400 deaths annually recorded since 2000.

Concerning alcohol and tobacco, reference is made to the reply to question 11§3.

Health expenditure	2002	2003	2004	2005	2006
Total expenditure on health, % of gross domestic	9.3	9.4	9.2	9.2	9.2
Total health expenditure per capita, US$ PPP	2707	2841	2964	3012	3202
Public expenditure on health, % total expenditure on health	82.1	82.5	81.8	81.7	81.7
Pharmaceutical expenditure, % total expenditure on health	14.0	13.7	13.8	13.7	13.3
Pharmaceutical expenditure per capita, US$ PPP	379	389	410	412	426

Source: OECD Health data 2008

Health care resources	2002	2003	2004	2005	2006
Practising physicians, density per 1 000 population	3.3	3.4	3.4	3.5	n/a
Practising nurses, density per 1 000 population	10.3	10.4	10.6	10.7	n/a
Medical graduates, density per 1 000 practising physicians	26.5	27.8	25.9	25.5	n/a
Nursing graduates, density per 1 000 practising nurses	35.3	36.8	40.3	47.0	n/a
Acute care beds, density per 1 000 population	2.3	2.2	2.2	2.2	2.2

Source: OECD Health data 2008

Avoidable mortality	2000-2003	2001-2004
Policy-related avoidable mortality per 100 000 inhabitants. Female	26,6	27,2
Policy-related avoidable mortality per 100 000 inhabitants.Male	46,2	46
Healthcare-related avoidable mortality per 100 000 inhabitants. Female	26,5	25,7
Healthcare-related avoidable mortality per 100 000 inhabitants.Male	37,7	36,8

Ages 1–74. Age standardised. Source: Centre for Epidemiology / The National Board of Health and Welfare

Questions following the previous report, conclusions from 2005

Mortality

Life expectancy

Source: Statistics Sweden

Year	Life expectancy in years					
	Male			Female		
	At birth	At 50	At 65	At birth	At 50	At 65
1951-1960	70.89	25.54	13.85	74.1	27.47	15.00
1961-1970	71.73	25.7	13.93	76.13	28.87	16.05
1971-1980	72.26	25.82	14.1	78.1	30.41	17.47
1981-1985	73.55	26.46	14.6	79.53	31.45	18.39
1986-1990	74.37	27.17	15.09	80.22	32.06	18.91
1991-1995	75.6	28.03	15.7	80.98	32.59	19.42
1996-2000	76.89	28.95	16.35	81.83	33.19	19.93
2001-2005	77.99	29.89	17.11	82.41	33.64	20.3
1983	73.62	26.51	14.65	79.61	31.59	18.49
1984	73.84	26.73	14.81	79.89	31.72	18.65
1985	73.79	26.6	14.66	79.68	31.59	18.5
1986	73.97	26.83	14.8	79.99	31.84	18.69
1987	74.16	26.99	14.99	80.15	31.99	18.9
1988	74.15	26.99	14.95	79.96	31.85	18.7
1989	74.79	27.56	15.4	80.57	32.37	19.17
1990	74.81	27.5	15.3	80.41	32.2	19.04
1991	74.94	27.6	15.42	80.54	32.34	19.21
1992	75.35	27.82	15.55	80.79	32.42	19.27
1993	75.49	27.91	15.56	80.79	32.4	19.19
1994	76.08	28.43	16.03	81.38	32.92	19.75
1995	76.17	28.42	15.97	81.45	32.9	19.7
1996	76.51	28.61	16.1	81.53	32.95	19.73
1997	76.7	28.77	16.25	81.82	33.2	19.92
1998	76.87	28.94	16.34	81.94	33.3	20.03
1999	77.06	29.11	16.45	81.91	33.23	19.92
2000	77.38	29.41	16.69	82.03	33.3	20.08
2001	77.55	29.6	16.88	82.07	33.36	20.06
2002	77.73	29.64	16.9	82.11	33.37	20.01
2003	77.91	29.83	17.01	82.43	33.67	20.32
2004	78.35	30.19	17.39	82.68	33.92	20.56
2005	78.42	30.21	17.36	82.78	33.93	20.61
2006	78.7	30.45	17.6	82.94	34.13	20.75
2007	78.94	30.7	17.84	82.99	34.14	20.67

Principal causes of death, relative share (%) of deaths in nine categories based on the ICD-10 classification, 1996-2006

Causes of death	Sex	Year									
		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Diseases of the circulatory system	Male	47.6	47.2	46.2	45.7	45.0	43.9	43.5	42.1	41.8	41.3
	Female	48.8	48.9	47.5	46.9	46.6	46.1	43.6	42.9	42.4	42.9
Neoplasms	Male	24.7	24.8	24.7	25.0	25.3	24.9	26.1	26.4	26.4	26.8
	Female	22.5	22.1	21.6	22.2	23.0	22.3	21.7	22.9	23.1	23.3
Diseases of the respiratory system	Male	7.4	7.0	7.4	7.3	6.7	7.1	6.9	6.4	6.7	6.3
	Female	7.5	6.7	7.2	7.1	6.4	6.8	6.4	6.1	6.8	6.1
External causes of morbidity and mortality	Male	6.0	5.9	5.7	5.9	6.5	6.6	6.3	7.2	6.5	6.6
	Female	3.4	3.4	3.4	3.3	3.6	3.5	3.6	4.1	4.0	3.7
Mental and behavioural disorders	Male	2.6	3.1	3.4	3.5	3.4	3.7	3.2	3.7	3.7	3.8
	Female	3.7	4.5	5.4	5.3	5.7	6.4	5.3	6.1	6.5	6.4
Diseases of the digestive system	Male	3.0	3.0	3.1	3.0	3.1	3.3	3.3	3.1	3.3	3.4
	Female	3.0	3.2	3.1	3.2	3.2	3.4	3.3	3.3	3.0	3.2
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	Male	1.6	1.9	1.8	1.9	1.9	1.9	1.9	2.1	2.3	1.0
	Female	2.8	3.1	3.1	3.4	3.3	3.8	3.4	3.5	4.0	2.7
Certain conditions originating in the perinatal period	Male	0.2	0.2	0.2	0.1	0.2	0.2	0.2	0.2	0.1	0.2
	Female	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Other	Male	6.9	6.9	7.6	7.6	8.0	8.3	8.4	8.8	9.1	10.8
	Female	8.0	7.9	8.7	8.5	9.2	9.5	9.4	9.4	10.2	11.5

Source: The Swedish National Board of Health and Welfare

Number of deaths per 100,000 inhabitants with an alcohol diagnoses mentioned in the death certificate.

Sex	Year									
	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Male	35.33	34.8	34.95	33.99	36.84	35.12	36.88	37.74	37.35	36.34
Female	7.89	9.18	8.57	8.96	8.74	8.99	9.34	9.63	10.37	9.79
Both sexes	21.44	21.84	21.61	21.34	22.64	21.93	22.98	23.56	23.74	22.96

Source: The Swedish National Board of Health and Welfare

Maternal and infant mortality

Year	Infant mortality Deaths per 1 000 live births	Maternal mortality Deaths per 100 000 live births
1995	4.1	3.9
1996	4.0	5.3
1997	3.6	3.3
1998	3.6	7.9
1999	3.4	1.1
2000	3.4	4.4
2001	3.7	3.3
2002	3.3	4.2
2003	3.1	2.0
2004	3.1	2.0
2005	2.4	n/a
2006	2.8	n/a

Source: OECD HEALTH DATA 2007, July 07

Follow-up of the national action plan

The national action plan for the development of health and medical care (2001-2004) was intended to develop the basic structure ad focus of health and medical care services. The main focus of attention was on primary care, caring services for the elderly, mental illness and diversity of care providers. Among other things the evaluation revealed the following.

Primary care: The number of GPs has increased, though to a lesser extent than was aimed for (a shortfall of 200). Possibilities of recruiting GPs have improved during the past year. Statistics from the Swedish Association of Local Authorities and Regions also point to an increase in the number of specialist physicians receiving their specialist training in general medicine.

Availability: The population find that getting through to the health centre on the phone has grown easier, even though measurement by the National Board of Health and Welfare shows no real change to have occurred. The perceived improvement is probably due to the introduction of telephone-monitoring systems and to the Internet, in addition to which, phone-in medical advisory services have been heavily expanded during the past year. Internet services have also improved, and the National Board of Health and Welfare's population questionnaires indicate a larger proportion of the population now using the Internet for information on how to get in touch with health care services.

It is being increasingly used to facilitate information supply between different care levels.

Caring services for the elderly: Graduate staff numbers have increased, and so too has the proportion of staff with basic nursing education. Two-thirds of the

municipalities have offered their nurses further training to deepen their medical competence.

Several municipalities have expanded their rehabilitation activities. Above all, they have reinforced rehabilitation in short-term care following discharge from hospital, other short-term care and domiciliary rehabilitation. The municipalities appear to be assuming progressively greater responsibility for rehabilitation of the elderly.

Mental illness: efforts have been mainly devoted to children and young persons. All county councils have invested heavily in measures for offering early support to children and young persons at risk. Work has begun in some parts of the country to co-ordinate child and youth psychiatry inputs with adult psychiatry inputs.

Diversity of care providers: Up to and including 2001 there was a relatively heavy increase in the number of private care providers in county council primary care, but more recently this growth has been halted. During the years in which the action plan was operational, the proportion of older persons in the municipalities receiving their home-case services from private providers rose from about 7 to 9 per cent. In special housing accommodation the corresponding figures were, respectively, upwards of 11 and 13 per cent.

Free choice of care from 2003
A recommendation by the Swedish Association of Local Authorities and Regions (the interest organisation representing all municipalities and county councils in Sweden). It is recommended that a patient should be entitled to seek care everywhere in Sweden and not only in the county council area of residence. No figures are available concerning the outcome, i.e. the number of persons actually availing themselves of this possibility.

Health and medical care for all, a human right.

Availability in time not amenable to breakdown by ethnicity

People with unmet needs for medical examination by sex and age (%), due to problems of access (could not afford it, waiting list, too far to travel).

Age		Males			Females	
18-44	2.3	2.9	2.6	3.9	2.7	4.5
45-54	1.6	2.9	3	1.7	2.6	3.4
55-64	1.7	2.7	1.9	2.9	2.4	3
65-74	0.7	1.7	1.4	2.5	3.8	2.7
75+	1.1	1.8	n/a	2.8	1.1	1.5

Source: Eurostat 2008, EU-SILC

Waiting times and waiting lists
Any waiting lists are managed by the medical care providers. Waiting times are regulated through the healthcare guarantee introduced in 2005.

In 2005 a healthcare guarantee, which articulates a clear national policy with specific targets for all scheduled care, was introduced in the Swedish health care system. The targets are expressed as 0, 7, 90, 90 – the maximum waiting time in days for various steps in the healthcare process. Primary care is to offer contact on the phone or in person the same day (0). If needed, a doctor's appointment is to be offered within 7 days. An appointment with a specialised caregiver is to be offered within 90 days after a referral decision. The treatment is to be started within 90 days after being ordered by the specialist.

The nationwide result in terms of the proportion of patients who were given a doctor's appointment the same day has since March 2007 varied between 68 to 81 per cent, with better results later on. The same tendency can be seen for the proportion of patients who were given a doctor's appointment within a week, where the nationwide result varied from 87 to 91 per cent. Concerning waiting times for specialised care at outpatient clinics, the share of patients with waiting times longer than 90 days for an appointment has a yearly average about 25 per cent, in the measurement period from April 2006 to June 2008. The yearly average for the share of patients with waiting times longer than 90 days for a specialist meeting and treatment is instead about 30 per cent. Taken together, the results indicate that the Swedish health care system is still far from complying with the healthcare guarantee.

In the last follow-up of Sweden's attainment of the goals of the Social Charter, the Government stated that more general practitioners were needed in the new system (the National Action Plan). The Committee has now requested a situation report showing whether the number of GPs has been sufficient to offset the shortcomings then perceived in medical care.

According to the latest annual report of the National Board of Health and Welfare, National Planning Support, NPS, 2008, the supply of general medical specialists rose by about 25% between 1995 and 2005. However, the Board forecasts a reduction of supply by 15% between 2005 and 2023.

The Government is now planning a number of measures to improve the diversity and availability of health care. To strengthen patients' freedom of choice, the Government wishes to introduce a choice-of-care system whereby the power of choosing "performer" is transferred from the county council to the patient Since the supply of specialists in general medicine is still falling short of needs, the Government is now planning to abolish the requirement of the permanent medical contact being a specialist in general medicine. A change of this kind would enable other specialist categories to serve as permanent medical contact, thus improving the chances of the

county councils measuring up the requirements of the Health and Medical Services Act concerning the provision of good, efficient primary care to the population.

Article 11:2

Question 2

Responsibility for schools in Sweden has been extensively delegated to municipalities and independent mandators. The Government defines national targets and frames, The municipalities and schools are responsible for teaching and have extensive liberty to organise their work with the given frames as their starting point. Inspection of schools is the responsibility of the National Agency for Education.

School health care
The Education Act lays down that school health care must be provided for pupils in the preschool class, compulsory school, upper secondary school, compulsory school for pupils with learning disabilities, schools for pupils with special needs, and Sami schools. The task of school health care is to observe the pupils' development, preserve and improve their mental and physical health and promote health living habits. School health care is intended above all to work proactively. It must include health screening and basic nursing. A school doctor and school nurse must be available to staff the service. In addition to school health care there are pupil welfare services. Pupil welfare comprises both general and individualised measures, its task being to promote the pupil's development and prevent the occurrence of problems in school. The curriculum make clear that all staff are involved in school pupil welfare work and that ultimate responsibility rests with the head teacher or principal.

The curricula and syllabi stress the duty of schools to observe matters relating to health and lifestyle. The pupils must leave compulsory school with a basic knowledge of the prerequisites of good health and an understanding of the importance of their own lifestyle for health and the environment. Similar wordings apply to the independent schools.

Health-related work in schools also includes sex education and instruction concerning interpersonal relations, as well as instruction concerning alcohol, drugs and tobacco. The Swedish curriculum makes the head teacher specially responsible for the teaching of these subjects.

Government initiatives
During the period covered by this report, several initiatives have been mounted for the promotion of health-related work in schools. New legislation prohibiting discrimination and victimisation of children and pupils came into force on 1st April 2006. This legislation applies to preschools, out-of-school centres, compulsory school, upper secondary school and municipal adult education (Komvux). The legislation is designed to protect children and pupils and to ensure that everyone receives equal treatment wherever the Education Act applies. Schools and staff must clearly indicate

how they are working to protect children and pupils from discrimination. All schools must draw up a plan describing what they are doing to prevent discrimination. A special commissioner, the Children's and Pupils' Ombudsman (BEO), has been appointed to ensure that children's rights are respected. The National Agency for Education has been commissioned to monitor implementation of the legislation in schools. A report on the remit is due on 1st March 2009.

Several measures have been taken to support the health-related work of schools. The Agency for education has been tasked with deepening the knowledge possessed by municipalities and schools concerning the connections between learning, basic values and health. The Agency for Educational Development, acting on Government instructions, has convened several conferences to disseminate knowledge on the same theme. In addition, during 2003, *eleven regionally appointed experts* worked to promote co-operation with county councils, municipalities, universities and colleges to support the development of school health care and pupil welfare.

Sex education and instruction concerning interpersonal relations

In 2005 the Agency for Educational Development was instructed to mark the fiftieth anniversary of sex education and instruction on interpersonal relations becoming obligatory in Swedish schools and to encourage a growth of quality thinking on this instruction, as well as organising four regional conferences for school staff.

During the period covered by this report, the Agency for Education was instructed to review the goals of the various syllabi relating to sex education and interpersonal relations instruction in compulsory and upper secondary school and to consider ways in which this field of knowledge could be further highlighted in the documents concerned.

Physical education and health

The National Centre for Child Health Promotion (NCFF) was formed, on the Government's initiative, in 2004, tasked with extensively supporting health promotion work in schools. The Centre is to disseminate experience of instructive examples and research and development projects, and promote greater co-operation between higher education establishments, municipalities and other educational mandators and authorities, interest organisations and local NGOs.

Physical activity is an important part of health-related work in schools. To encourage physical activity among pupils, the Government amended the curriculum for compulsory schools in 2003 in such a way that schools are required to offer pupils daily physical activity during school hours.

Co-operation concerning children neglected or at risk

Co-operation between preschool activities, school child care, schools and social services, the police and psychiatric services for children and young persons is essential in order for support and assistance to be given to children who are neglected or

otherwise at risk. In 2007 the Government allocated MSEK 50 for joint projects at local level conducted by the authorities concerned.

Question 3

During the period under consideration, the mental health of children and young persons has formed the subject of a succession of reports. As part of a WHO project, a cross-sectional survey of children aged 11, 13 and 15 has been conducted and presented in a report (in Swedish) entitled "Swedish schoolchildren's health habits. [1] That report shows that children in Sweden are happy on the whole. Living habits, social relations and perceptions of the school environment change, however, between different ages and often differ as between boys and girls. At age 11 children as a rule are happier, live more healthily and take a more positive view of school than in the higher age groups. Both self-assessed health, somatic and mental disorders and general wellbeing deteriorate with advancing age, at the same tie as the difference between boys and girls increases. Mental disorders have increased with the passing of time. In all age groups, girls are less happy with their lives than boys.

(7) At the same time as mental illness among children and young persons has increased, statistics from the Swedish Association of Local Authorities and Regions point to a growth of pupil welfare personnel strength in municipal schools over the past ten-year period and a year-by-year reduction of the number of pupils each member of staff (school nurse, school doctor, school welfare officer and school psychologist) is responsible for.

Pupils health care staff in municipal compulsory and upper secondary schools, including compulsory schools for pupils with learning difficulties, annual personnel equivalents

Position	**2004**	**2005**	**2006**	**2007**
School doctor	82	88	88	85
School nurse	2,078	2,135	2,158	2,200
School social worker	1,342	13,69	1,450	1,490
School psychologist	645	631	621	644

Source: Swedish Association of Local Authorities and Regions

[1] *Svenska skolbarns hälsovanor* 2005/06, Grundrapport Folkhälsoinstitutet

Cost of pupil welfare per pupil

Type of school	2004	2005	2006
Compulsory school	1,510	1,340	1,780
Independent compulsory school	1,100	1,010	1,170
Upper secondary school	1,610	1,390	1,420
Independent upper secondary school	1,140	1,070	1,160

Source: Agency for Education

Reply to question in Conclusions 2005

Encouragement of individual responsibility, Health education in schools, Publicity campaigns on harmful life styles aimed specifically at young people

On instructions from the Government, the Agency for Education, together with the National Institute for Public Health and the Swedish Association of Local Authorities (now the Association of Local Authorities and Regions) has analysed and devised initiatives capable of strengthening alcohol prevention work in schools. A report in the remit was presented in September 2003. Within the scope of the remit, four cornerstones were evolved for alcohol and drug prevention work, based on a broad educational development perspective in which attention is above all made to focus on the school climate and relations between pupils and adults.

During the period under consideration, the Agency for Educational Development collaborated with the National Institute for Public Health on the "Proactive School" project to support schools in their preventive work regarding alcohol, narcotic drugs and tobacco..

Article 11:3

Question 2

Air

Swedish legislation on this subject is to a great extent based on the stipulations contained in the EU air quality directive (1999/62/EC) and its daughter directives. Those rules have been transposed to Swedish law in the form of provisions contained in Chap. 5 of the Environmental Code(1998:808) and in the Ordinance on Environmental Quality Standards of Ambient Air (2001:527). A new air quality directive (2008/50/EC) was adopted recently. The Swedish environmental Protection Agency has been tasked with proposing a way of transposing this directive to Swedish law.

It is incumbent on the municipalities, in keeping with the requirements of the air quality directives, to monitor the quality of the ambient air locally in order to decide whether there is any danger of the environmental quality limits being exceeded. In case where an environmental quality limit value for air quality is exceeded, a remediation programme must be drawn up, aimed at improving air quality in the long term so that the limit can be contained. The county administrative boards are responsible for devising and adopting remedial programmes, while the municipalities are principally responsible for the implementation of locally effective measures. To date, remediation programmes have been drawn up for eight municipalities.

The State is involved in more general measures impacting on air quality. The main issue pertaining to air quality concerns the use of studded winter tyres. The State also decides on incentives influencing vehicle exhaust emissions. The introduction of a congestion tax in Stockholm is one such example.

Another important point of departure for Swedish efforts to improve air quality is the initiatives relating to the environmental quality target *Fresh* air. A more exhaustive description of the environmental target system can be accessed at www.miljomal.nu.

Air quality in Sweden is good on average. Infringement of the EU air quality limits for nitrogen oxides occurs locally in a few big cities, especially on busy streets with poor air turnover. A particular problem is presented by the high concentrations of particles during late winter/early spring, due to the use of studded winter tyres in snow-free conditions. In forest communities especially, high concentrations of hydrocarbons occur in winter, due to small-scale wood-firing.

Viewed in a long perspective, concentrations of the majority of health-endangering air contaminants have declined substantially, but this trend ahs been inflected in the case of nitrogen oxides and larger particles, PM_{10}, concentrations of which are no longer declining.

Water
Where water is concerned, the building regulations include temperature stipulations for hot water, e.g. for the avoidance of legionella. EU regulatory systems exist concerning building products which come into contact with drinking water.

Noise
The building regulations contain rules on noise in the form of noise classes. The Government has resolved to task the National Board of Housing, Building and Planning with compiling input data for new interim targets and policy measures for the indoor environment with regard to noise, damp and mould and, if possible, to illuminate connections between deficiencies of the indoor environment and perceived ill-health.

Nuclear
The Swedish legal framework regarding nuclear risks is well developed and the responsibility for safety is well defined. The Radiation Protection Act (Strålskyddslag, 1988:220) and the Nuclear Activities Act (Lagen om kärnteknisk verksamhet, 1984:3) also provides for public insight into the activities of the licensees. There have been several minor reviews of the applicable legislation in recent years.

The average occupational radiation doses at the nuclear power plants as well as the releases of radioactive nuclides from the Swedish nuclear power plants are fairly low and well below regulatory limits.

The Swedish Government recently merged the two former regulatory bodies into one with a clear responsibility for radiation protection and nuclear safety. The new regulatory body, the Swedish Radiation Safety Authority, is empowered to issue regulations within its area of competence. Förordning (1984:14) om kärnteknisk verksamhet, Strålskyddsförordning (1988:293).

Asbestos
New *Asbestos* Provisions (AFS 2006:1) came into force on 15th April 2006 and have been revised and adapted to the latest EU directive in the field of occupational safety and health.
All handling of asbestos in working life must comply with Provisions issued by the Work Environment Authority. Under the new, stricter rules, the county administrative board is empowered to impose a sanction charge is asbestos is demolished without a permit. Another new requirement is for supervisory personnel also to be trained in the handling of asbestos. The rules concerning demolition workers have also been tightened up. They are now required to update their skills every five years. A succession of training and information measures have been taken as routine measures in connection with implementation of the Provisions AFS 2006:1. Apart from its own initiative, Sweden also took part in the European asbestos campaign mounted in 2006 by the EU Senior Labour Inspectors' Committee (SLIC).

Private persons may handle asbestos-containing material in their own houses but must have a knowledge of how to avoid health injuries and nuisance.

Asbestos is classed as hazardous waste under the Waste Ordinance (SFS 2001:1063) and must be transported without dust emission.

Sweden has two companies which, in keeping with current exceptions, still have asbestos diaphragms in service at their facilities.

Work relating to good eating habits
Our work for the promotion of good eating habits has three main components:

1) NNR and SNR, the Nordic and Swedish Nutrition Recommendations respectively, which were last updated in 2004; a new update is planned to start in 2009.
2) The Foodstuffs Database, which is updated continuously and for which international co-operation is becoming more and more important.
3) Surveys of eating habits; a survey of children was conducted in 2003 and work on a survey of adults began in 2007 and will be completed in 2009.

Food recommendations for preschool and schools
New food recommendations for preschool and schools were presented in the spring of 2007. Schools and preschools have unique opportunities for promoting, in a positive and natural manner, a healthy lifestyle and good eating habits among our children. The basic responsibility rests with the home and family, but with the majority of children eating many of their meals away from home, children's eating habits are also influenced by other adults. The recommendations are intended as support for everyone actively concerned, one way or another, with food arrangements in preschools or schools, and also for parents, regarding the promotion of good eating habits among children and young persons. The recommendations address both good eating habits and food safety.

Recommendations on food at work
Recommendations on food arrangements in the workplace were presented in September 2007, their purpose being to indicate the possibilities open to various groups – employers, trade unions, safety delegates, occupational health services and also the individual person – for influencing food in the workplace. The recommendations were drawn up in close co-operation with the social partners, and a major seminar on the subject was organised while they were in preparation.

Food recommendations for expectant and nursing mothers
The new recommendations for expectant and nursing mothers were presented in June 2008, one innovation in this edition being that the information is now divided into two brochures – one for expectant and the other for nursing mothers. Great interest has been aroused and the information is readily available at maternity and child health centres. As a further simplification the National Food Administration has produced a "wallet card" containing the most important information about fish and cheese. This card, which can be printed out from the website, fits easily into a wallet or handbag and simplifies the process of choosing in the shops. A scheme is also in progress for supporting dieticians and midwives in their role as information officers.

The Keyhole
The criteria for Keyhole marking of products were revised in 2005. Among other things, stricter criteria were defined concerning the sugar content of a number of product groups.

Work on introducing the Keyhole as a common marking in Norway and Denmark as well began in the autumn of 2007 and will entail a number of alterations to the criteria.

The Keyhole in restaurants

New restaurant criteria were drafted in 2006 and tested during 2007 in a successful pilot project, "Keyhole-certified restaurant 2007", in which 67 restaurants took part. The certification concept comprises training for all restaurant personnel and support, e.g. in the form of information material, recipe files and material for marking in the restaurant. A new organisation for ongoing certification work will be launched in 2008.

Food hygiene inspection

Public inspection means ensuring that companies themselves assume responsibility for complying with the requirements of food legislation. Responsibility for food hygiene inspection in Sweden is at present divided between the State and the municipalities. The National Food Administration is the central inspection authority, responsible for the direction and co-ordination of food hygiene inspection activities. The Government has given the Administration extensive powers of directing and co-ordinating municipal inspection activities.

The Administration supervises some 600 major food production facilities, including about 130 abattoirs. The municipalities are responsible for the supervision of nearly 90% of food production facilities, upwards of 52,000 facilities in all. The county administrative boards are responsible for the coordination of inspection activities within their several counties. Swedish legislation in the food sector is to a very great extent harmonised with Community law. The EU regulatory instruments indicate how inspections are to be conducted and what is to be inspected. On the other hand there is considerable liberty at national level in matter of organisation and funding. Food hygiene inspections in Sweden have since 2007 been financed mainly through direct charges. Each authority is duty bound to ensure that it has sufficient resources for carrying out the inspections needed. The charges paid by food manufacturing entrepreneurs must be sufficient to cover the cost of public inspection.

Food hygiene inspection is governed by Community law, the Food Act and the Food Ordinance. The primary responsibility of undertakings for food safety and fir practice is clearly apparent from Community legislation. Basic requirements have to be met in order for foodstuffs to be handled for sale and in mass catering. Companies are required, for example, to carry out checks and to devise routines for self-inspection.

Initiatives relating to alcohol, narcotic drugs and tobacco

An expanded hazardous use project

Binge drinking is widespread in Sweden and the proportion of heavy consumers has grown parallel to the growth of total alcohol consumption. In 2004 the proportion of consumers at risk was 17 per cent among men aged between 18 and 84. The

corresponding figure for women the same year was 9 per cent. The hazardous use project is aimed at strengthening the role of health and medical care in the work of alcohol prevention by encouraging methods detecting patients with a dangerously high level of alcohol consumption and supporting them in the alteration of their habits. During the year all county councils carried out further initiatives relating to hazardous use in primary care, e.g. maternity health care and occupational health care.

Special initiatives for pregnant women who are substance abusers

One of the aims of alcohol policy is that children should not be born with injuries due to the mother's intake of alcohol or drugs during her pregnancy. Through prevention, alcohol and drug-related injuries can be fully averted. This makes it important to secure the continuity of information work targeting the whole population on the subject of the hazards of alcohol and drugs during pregnancy. Maternity health care services come into contact with virtually all pregnant women and are therefore in a unique position to catch women at risk and offer them the support they need for a pregnancy free from alcohol and drugs.

The schools project

Consumption of alcohol and drugs rose steeply among young persons in the ninth and final year of compulsory school during the second half of the 1990s. The curve took a downward turn in the 21st century, and there has been a pronounced decline over the past two years. During this period the proportion not consuming alcohol has risen from 20 to 340 per cent. To consolidate and reinforce this positive trend among young persons and break the negative trend among older persons, continuing efforts must be devoted to drug prevention work in schools.

Swedish and international prevention research has shown that traditional, informative instruction about alcohol, drugs and tobacco does not have the effects on pupils' risk behaviour it was previously thought to have. Other, research-based methods are known today which, moreover, go hand in hand with the essential teaching mission of schools. The National Institute for Public Health (FHI) has been commissioned by the Government to disseminate knowledge concerning effective methods of prevention in schools during the period between 2005 and 2007. "The schools project" is aimed at developing broad proactive initiatives and protective factors for children and young persons which, in addition to colloquies on alcohol and drugs, also include such things as parental participation, leadership in the classroom, development of social and emotional competence and good pupil health.

The co-ordinating function at the Government Offices

Responsibility for implementing the national alcohol and drug action plans is vested, as from January 2008, in the national authorities concerned. Co-ordination of initiatives at national level for implementing the national alcohol and drug prevention plans, including attainment of the intermediate targets for tobacco, is managed within the Government Offices. A special co-ordinating function has been set up within the Government Offices, consisting, firstly, of an interdepartmental working party for the co-ordination of alcohol, drugs, doping and tobacco policy, and secondly, of a secretariat.

The Government has also resolved on the setting up of a council on alcohol, drug, doping and tobacco issues. The council is to advise the Government on alcohol, drug, doping and tobacco issues and keep it information, for example, of research and survey findings relevant to the framing of policy in these fields.

County co-ordinators
Local and regional work is a cornerstone of health promotion and proactive work. The municipal and county coordinators who have been active nationwide have helped to develop a viable structure for this work. The county co-ordinators also serve as a link between national and local levels. Evaluations have shown the county co-ordinators to have greatly contributed towards the development of proactive work in the municipalities. Support from national level enables them to disseminate experience and knowledge concerning the conduct of evidence-based initiatives and in this way to support the process of change in the municipalities in their several counties. It is also desirable that the co-ordinators should develop co-operation with NGOs and the voluntary sector.

Developments within the European Union and international co-operation
Public health in Sweden is being affected by the growth of transboundary tendencies where alcohol, drugs, tobacco, doping and gambling are concerned. In order to maintain a high level of public health protection, Sweden must play an active part in EU co-operation and in other international contexts, e.g. WHO in the tobacco and alcohol sector, and UN co-operation against drugs. The Government is working to achieve a more restrictive view of alcohol within the EU, the aim being to consolidate and further develop the Union's work for the prevention of alcohol-related harm. Alcohol will also be a priority issue during the Swedish chairmanship in 2009.

Traffic and injury developments
471 persons were killed on the roads in 2007 (445 in 2006 and 440 in 2005). This is far in excess of the target set in 1998, which would have meant half as many, or at most 270, deaths in 2007. There are three main fields where a deterioration or no improvement has occurred, namely: two-wheeled motor vehicles, alcohol and speed. More successful areas concerning the reduced number of fatalities among pedestrians and cyclists and among children and, above all, elderly persons. All things considered, traffic safety measures have not proceeded rapidly enough to offset the growing volume of traffic and the additional risk groups resulting from the high level of economic activity during the period under consideration. Sweden, however, still has one of the world's best ratios of fatalities to population (approximately 5.1 deaths per 100,000 inhabitants).

Measures to improve traffic safety
One important measure is to adapt the design of roads and speed limits to the demands posed by the zero vision. Since 2000, therefore, the National Road Administration has constructed some 200 km of segregated highway annually. The carriageway is divided into thee lanes, with the two lane-part alternating between directions. At the end of 2007 there were altogether some 1,750 km of roadway of this kind, estimated to reduce the number of fatalities by about 40 per annum and the

number of persons severely injured by about 100 per annum. This measure is very cost effective. About 2,500 km of road have also been provided with centre-line rumble strips. Work on improving the safety of verges as well as intersections has also continued. Safety improvement measures for unprotected road users are continuing primarily in the municipalities, concentrating on traffic-calming measures and the segregation of cyclists and pedestrians from motor traffic.

In 2007 the Riksdag (parliament) passed a Government Bill for additions to the present system of speed limit, so that limits of 40, 60, 80, 100 and 120 km/h can also be introduced. In this way speed limits can be used at all intervals of 10 in between 30 and 120 km/h. Analyses have shown that a greater number of speed limits can help to reduce the number of fatalities, contribute towards a reduction of carbon dioxide emissions and, moreover, be economically effective.

Successive measures have been taken to increase the use of alcohol locks. In 2007 the Government appointed a Commission to propose a system whereby alcohol locks would be a prerequisite for convicted drink drivers being allowed to drive again. Also in 2007, work began aimed at stipulating alcohol locks for the transport operations of national authorities. Sweden is also working to make alcohol locks obligatory for new buses and HGVs in commercial traffic within the EU. Sweden is also working actively in relation to other Member States, EU institutions and the UN to inform them of its work with alcohol locks and of ways in which together we can proceed further with the use of supportive technology for greater sobriety on the roads. Measures including support for research and market conditioning have been taken to make new technology detecting and alerting to drivers under the influence of alcohol, drugs, fatigue or illness being made standard features of all new vehicles. The National Road Administration is continuing its efforts to encourage quality assurance among enterprises which among other things promote the voluntary use of alcohol locks in their own vehicles and in outsourced transport. At the end of 2007 there were some 33,000 alcohol locks fitted to various vehicles on our roads.

From an economic viewpoint automatic traffic surveillance control is one of the most cost effective traffic safety measures. At the end of 2007 there were 880 traffic safety cameras covering 142 stretches and about 2,400 km of roads nationwide. Rules facilitating the expansion of automatic traffic surveillance control have been adopted, making it possible for electronic disciplinary fines to be imposed and for direct access to be gained to photographs in the driving licence register. Cameras have been put up along the most accident-prone roads in Sweden, and the average speed along these stretches has fallen by 8 per cent.

In 2006 the police adopted a national strategy and action plan for traffic safety work in road traffic and off-road, the aim being to reduce the number of accidents by proactive methods and more intensive controls. In addition, traffic safety duties will now be performed by all police officers on outside duty and not, as previously, by traffic police only.

As from 1st January 2006, only a person who has completed introductory training together with his or her pupil can be approved as an instructor for private car-driving lessons. The purpose of the introductory training is for pupil and instructor together to be helped in organising the practical side of practice driving, to be informed concerning driving licence instruction as such and to acquire vital knowledge of road safety..

In 2006 the Attorney-General heavily increased the fines imposed for traffic offences entailing a high accident risk. Fines for exceeding the speed limit, for example, have been raised from SEK 800-2,000 to SEK 2,000-4,000, those for disregarding red lights from SEK 1,200 to SEK 3,000 and fines for offences concerning driving times and hours of rest from SEK 1,200 to SEK 3,000.

The State has contributed funding towards IVSS (Intelligent Vehicle Safety System), a research programme aimed at developing safer vehicles. IVSS is a joint venture by the State, industry and higher education establishments, with a budget of MSEK 640 for 2003-2008.

Children and young persons in traffic
Cycle helmets have been compulsory since 2005 for children aged under 15. This also applies to children as bicycle passengers. The person carrying a child on a bicycle is liable under criminal law to ensure that the child is wearing a helmet.

40 % of the children dying on the roads are car passengers. Surveys have shown great possibilities of reducing the number of child deaths among car passengers by ensuring that the children are using the right protective equipment. New rules to this end came into force on 1st January 2007. The law now requires all children under 135 cm tall to use a special in-board safety device, i.e. a baby seat, a child seat, booster (harness) seat or booster (harness) cushion.

In December the Government promulgated a new Ordinance establishing an experimental scheme of speed limits for passing a vehicle in regular service, e.g. a bus or a school transport vehicle, which has stopped in order for a passenger or passengers to board or alight. Under this scheme, the National Road Administration is empowered to issue prescriptions requiring vehicles not to exceed 30 km/h when passing a vehicle in regular service or a school transport vehicle, which has stopped in order for a passenger or passengers to board or alight.

Question 3

Concerning infectious diseases, reference is made to the previous report.

Concerning vaccination programmes and statistics, the following addition is offered to the latest report.

The child vaccinations offered to all children in child health care and school afford protection against 8 diseases: polio, diphtheria, tetanus, whopping cough, caused by *Haemophilus influenzae* type B, measles, mumps and rubella. As from 1st January 2009, 9 diseases will be covered, following the addition to the programme of vaccination for serious diseases caused by pneumococci. Sweden doe not at present have general vaccination for tuberculosis or hepatitis B. Instead these diseases are kept in check by means of targeted vaccination, i.e. vaccination offered to children at greater risk of infection.

The timing of the different vaccinations conforms to a recently revised timetable for children born in 2002 and subsequently. Children born up to and including 2001 are vaccinated according to the earlier timetable.

HPV vaccine will be included in the programme as from 1st January 2010 and will be given to girls aged 10-12.

The vaccines are administered as per the following tables:

Allmän del						
Age	**Diphtheria, Tetanus, Whooping cough**	**Polio**	**Hib**	**Pneumo-cocci***	**Measles Mumps Rubella**	**Responsible for vaccination**
3 mths	I	I	I	I		Child health care
5 mths	II**	II**	II**	II**		
12 mths	III***	III***	III***	III***		
18 mths					I	
5–6 yrs	IV (children b. 2002 and later)	IV				
6-8 yrs					II (children b. 2002 and later)	School health care

10 yrs	IV (children born up to and including 2001)****					
12 yrs					II (children born up to and including 2001)	
14-16 yrs	V (children b. 2002 and later)					

Targeted portion			
Age	**Tuberculosis**	**Hepatitis B**	**Responsible for vaccination**
Most often newborns (depending on the risk situation)	Children at greater risk	Children at greater risk	Depending on the risk situation

Notes to tables

*To be introduced on 1st January 2009

**Two months or more between injection I and injection II.

***Six months or more between injection II and injection III.

****The fourth injection was recommended in 1996 diphtheria and tetanus only. As from the 2005/2006 school year, whooping cough vaccine is also recommended for this injection.

The proportion of children receiving the full vaccination series under the national vaccination programme for children is approximately 95 % .

Fewer smokers, but more snuff-takers

Smoking has been declining among men and women in all socio-economic groups since the beginning of the 1980s. It has declined faster among men than among women, though it is a good deal more prevalent among foreign-born men than Swedish-born. The number of daily smokers among men in Sweden is low by international standards, with men and boys smoking least compared with the rest of Europe. Between 2004 and 2005, 14 per cent of men and 18 per cent of women aged between 16 and 84 were smokers. This marks an ongoing decline compared with the period 2002-2003. The downward trend shows signs of continuing, and in FHI's national public health questionnaire survey 12 per cent of men and 16 per cent of women reported smoking every day in 2007. Social differences remain considerable,

however, and have grown still more conspicuous in recent years. The largest proportion of smokers is found among persons on sickness allowance and activity compensation and among long-term unemployed, almost one-third of whom are smokers.

Snuff consumption has increased since the beginning of the 1970s, and in the 1990s the proportion of snuff-takers increased among both sexes. Over 23 per cent of men and 3 per cent of women are snuff-takers. According to the FHI national public health questionnaire survey in 2007, snuff-taking is commonest in the 16-29 age group, with 22 per cent of men and 5 per cent of women stating that they take snuff.

More alcohol consumers at risk, especially young persons

Alcohol consumption rose by nearly 30 per cent between 1996 and 2004. Since the peak year of 2004, with more than 10 litres of pure alcohol per annum, consumption has fallen off to 9.8 litres in 2006. Consumption in 2007 remained constant. The increase for the period ending in 2004 was mainly due to a growth of travellers' imports and smuggling. The subsequent decline has been due above all to a drop in travellers' imports.

Alcohol consumption is very unevenly distributed. The one-tenth of consumers drinking most account for roughly half of all consumption and only 30 per cent drink more than the average. During the past ten-year period the proportion of consumers at risk has grown and binge drinking has increased among young persons. There is special cause for concern at the large number of consumers at risk among young women and men. In the 18-29 age group, 38 per cent of men and 25 per cent of women have harmful or dangerous drinking habits. Generally speaking, drug habit surveys in the ninth grade of compulsory school point to a declining trend in consumption by young persons, boys especially.

Total alcohol-related mortality has declined by one-third since the beginning of the 1980s, due probably in part to a change in the pattern of drinking, with les consumption of spirits. For the period as a whole, however, alcohol-related mortality has increased among women, especially those aged between 45 and 65, and among men aged over 65.

Re: the special questions asked in Conclusions 2005 concerning article 11: 3, pp. 10 – 11.

Reduction of environmental risks

The following text concerns work by the National Food Administration with reference to drinking water. According to the Swedish report in 2002, nothing has previously been reported for this field. The National Food Administration is responsible for the framing of Swedish rules on drinking water and on natural mineral water and spring water. The Administration has transposed the EU drinking water directive (98/83/EC) through its Provisions (SLVS 2001:30) on drinking water. A new drinking water directive is currently in preparation. The Administration is taking part in this work by compiling supporting documentation for the Ministry and serving with working

parties. It is also engaged in drafting national prescriptions on measures to prevent sabotage and other damage to drinking water facilities. The Administration is responsible by law for the approval of chemicals of use in the preparation of drinking water. It also approves aquifers for the extracting of natural mineral water in Sweden.

The National Food Administration is responsible for supervision (inspection, support and information) in the drinking water sector, the main target group here being municipal inspection authorities. The Administration provides support in the form of guides, checklists and training programmes, partly under its own auspices but also as a participant in the activities of others. The most comprehensive support is provided through day-to-day contact with all recipients by letter, telephone and e-mail. The provision of effective support, e.g. in the form of qualified supporting documentation for measures of risk management, is facilitated by the Administration's organisation covering the entire chain of risk analysis, i.e. risk evaluators, risk managers and risk communicators.

The National Food Administration carries out some 20 standardised inspections of municipal inspection authorities annually, the purpose being to evaluate the efficacy of public inspection in the drinking water sector. The municipal inspection authorities report the outcomes of public drinking water inspections annually, through web-based systems, to the National Food Administration, which in turn publishes a digest of the data in an annual national report.

For some 15 years now, the National Food Administration has been operating a separate programme of support for inspection authorities and operators in the field of crisis preparedness. Among other things, this support has comprised administration of financial support for emergency power supply at waterworks, resources in the form of national capacity for emergency water supply (with funding from Civil Preparedness Authority, later the Emergency Management Agency), practical assistance with planning and exercises, documentation, training programmes, seminars and recurrent in-service days. The National Food Administration heads a joint group of representatives of water supply and water quality authorities (SAMVA) as well as a national water emergency group for supporting and assisting with municipal drinking water supply in times of crisis (VAKA).

The National Food Administration is operating an accredited programme for qualification testing of methods of microbiological analysis, with participants mainly from Nordic laboratories, and also manufactures and sells microbiological reference material. Experts from the Administration are participating in the methods standardisation work of SIS, CEN and ISO.

Food safety

Four new EU Regulations on hygiene and inspection in the food sector came into force within the Community on 1st January 2006, namely two addressed to enterprise, Regulations (EC) no. 852/2004 and (EC) no. 853/2004, and two on the subject of inspection, addressed to inspection authorities, namely Regulation (EC) no. 882/2004 and Regulation (EC) no. 854/2004.

The hygiene and inspection regulations build on the foundations laid in the Regulation (EC) No 178/2002 of the European Parliament and of the Council of 28 January 2002 laying down the general principles and requirements of food law. That Regulation defines the basic requirements for all food activity: food must be safe and should be presented in a way which does not mislead consumers. Food business operators are duty bound to ensure that they meet the requirements of food legislation, to have a system for tracing their products and of their own accord to inform consumers and withdraw products when a food is not safe.

Food legislation is to a high degree harmonised. The new hygiene and inspection regulations are directly applicable in all Member States. At the same time as these regulations began to be applied in 2006, many national provisions were repealed which contained both rules for business undertakings and rules addressed to the inspection authorities. Those provisions too, however, were already based on a number of EU directives applying previous to 1st January 2006.

A new national Food Act and Food Ordinance, as well as certain new national prescriptions, have been promulgated since 2006. This national legislation is mainly intended to supplement with EC regulations, e.g. with rules on responsibility for public inspection and penal provisions.

The new hygiene and inspection regulations focus on the targets to be achieved and accordingly allow business undertakings to choose different paths in pursuit of the goals. In certain cases the new rules are flexible and can be adapted to local conditions, e.g. continued use of traditional methods.

Given the changed focus of the new regulations, only a limited need has been found for retaining previous detailed regulations or creating entirely new national rules. It is also the intention for guidelines to be laid down and distributed by trade organisations. Industrial guidelines are the industry's own description of how business operators can meet the requirements of food legislation.

In April 2004 the EU acquired new legislation on genetically modified organisms, GMOs, in both food and feed. The new regulations contain stricter requirements on the marking of GMOs, the intention being for clear marking to enable consumers to make a deliberate choice between products consisting of, containing or produced with GMOs and conventional products.

The new regulations applying to GMOs are Regulation (EC) No 1829/2003 of the European Parliament and of the Council of 22 September 2003 on genetically modified food and feed and Regulation (EC) No 1830/2003 of the European Parliament and of the Council of 22 September 2003 concerning the traceability and labelling of genetically modified organisms and the traceability of food and feed products produced from genetically modified organisms.

The incidence of salmonella in Swedish livestock is extremely low in Sweden, less than 1%. Inspection programmes for combating salmonella have been in place here for a long time. Samples are systematically collected, e.g. from abattoirs, butchering plants, hatcheries and farms. Cases of salmonella (whether in livestock or foodstuffs) are notifiable and livestock are slaughtered when a farm is decontaminated in the vent of discovery. All positive samples have to be sent to the National Veterinary Institute (SVA).

The World Organisation for Animal Health (OIE) has classified Sweden as free from BSE. OIE notes that the risk of BSE in Sweden is so slight as to be negligible, and it places Sweden, as one of only ten countries, in the lowest risk category. Sweden had one case of BSE in March 2006. That was a spontaneous case and not due to the feed the animal had been given.

Measures to combat smoking

Implementation of interim targets for national tobacco policy

The Government's tobacco policy initiatives are guided by the national interim targets for the tobacco sector. A successful tobacco policy also requires regional and local agencies to act efficiently and NGOs and other agents to be active. The Government will be focusing on four priority areas of tobacco policy: support for local work and national co-ordination of the tobacco issue, smoking cessation, improved supervision, and support for NGOs. National activities are also to include a special initiative concerning children and young persons. The Government has observed a lag in health promotion work regarding tobacco in schools and other environments frequented by children and juveniles. Child and juvenile health is a priority field. Accordingly, information and education initiatives in schools and other environments for children and young persons need to be reinforced, but efforts must also be made to ensure that instructional material is produced for relevant post-secondary education programmes.

Concerning infectious diseases, reference is made to the previous report.

Concerning vaccination programmes and statistics, the following addition is offered to the latest report.

The child vaccinations offered to all children in child health care and school afford protection against 8 diseases: polio, diphtheria, tetanus, whopping cough, caused by *Haemophilus influenzae* type B, measles, mumps and rubella. As from 1st January 2009, 9 diseases will be covered, following the addition to the programme of vaccination for serious diseases caused by pneumococci. Sweden doe not at present have general vaccination for tuberculosis or hepatitis B. Instead these diseases are kept in check by means of targeted vaccination, i.e. vaccination offered to children at greater risk of infection.
The timing of the different vaccinations conforms to a recently revised timetable for children born in 2002 and subsequently. Children born up to and including 2001 are vaccinated according to the earlier timetable.
HPV vaccine will be included in the programme as from 1st January 2010 and will be given to girls aged 10-12.

The vaccines are administered as per the following tables:

Allmän del						
Age	**Diphtheria, Tetanus, Whooping cough**	**Polio**	**Hib**	**Pneumo-cocci***	**Measles Mumps Rubella**	**Responsible for vaccination**
3 mths	I	I	I	I		Child health care
5 mths	II**	II**	II**	II**		
12 mths	III***	III***	III***	III***		
18 mths					I	
5–6 yrs	IV (children b. 2002 and later)	IV				
6-8 yrs					II (children b. 2002 and later)	School health care
10	IV (children born up					

yrs	to and including 2001)****					
12 yrs					II (children born up to and including 2001)	
14-16 yrs	V (children b. 2002 and later)					

Targeted portion			
Age	**Tuberculosis**	**Hepatitis B**	**Responsible for vaccination**
Most often newborns (depending on the risk situation)	Children at greater risk	Children at greater risk	Depending on the risk situation

Notes to tables

*To be introduced on 1st January 2009

**Two months or more between injection I and injection II.

***Six months or more between injection II and injection III.

****The fourth injection was recommended in 1996 diphtheria and tetanus only. As from the 2005/2006 school year, whooping cough vaccine is also recommended for this injection.

The proportion of children receiving the full vaccination series under the national vaccination programme for children is approximately 95 % .

Statistics

IDB Injury Database (formerly Ehlass)

Detailed injury data are collected through IDB.

The figures presented here are taken from IDB 2007. Data were entered in casualty wards and emergency centres. Data collection in 2007 covered the four hospitals in the former County of Skaraborg in Västra (West) Götaland (Skövde, Lidköping, Mariestad, Falköping), the three hospitals i the County of Värmland (Karlstad, Arvika, Torsby) and the Norrland University Hospital in Umeå. These catchment areas account for some 7 per cent of Sweden's population. The number of injuries in the country as a whole is estimated with the aid of demographic data. The Epidemiological Centre at the National Board of Health and Welfare, however, has estimated that the system should cover about 15 per cent of the national population in order to be reasonably representative of

the country as a whole. Apart from accidents in the home and leisure-related accidents, injuries in other sectors of society are also included, as well as deliberate self-destructive injuries and injuries resulting from acts of violence.
Further information about IDB is available on http://www.socialstyrelsen.se/Statistik/statistik_amne/skador/EHLASS.htm

The estimates compiled here are rounded to the nearest 500. The only conditions applied to the production of data are those mentioned in the table. Otherwise, accordingly, the injuries can be of any and every kind.

Children injured outdoors
Ages: 0-17 years
Indoors and out: 2, Outdoors

	No. reported	Estimate
Men	4,259	62,000
Women	2,905	42,500
Total	7,164	104,500

Injuries in the home
Injury area place 10-19, home/housing area includes, e.g. kitchen, living room, bathroom, stirs, garden, parking space and play area in the housing area.

	No. reported	Estimate
Men	8,423	119,500
Women	8,733	124,000
Total	17,156	243,500

Injuries during leisure time
Situation: 1, i.e. private time
road accident not 1, i.e. not road traffic accident, activity not 00, i.e. not gainful employment

	No. reported	Estimate
Men	18,525	263,000
Women	15,770	224,000
Total	34,295	487,000

Injuries in leisure environment, not domestic
Situation: 1, leisure/private time
road accident not 1, i.e. not road traffic accident, activity not 00, i.e. not gainful employment

Place not 10-19, i.e. not the housing area

	No.	Estimate
Men	10,350	147,000
Women	7,170	102,000
Total	17,520	249,000

Injuries during child care/school hours

Situation: 2 or 3, i.e. school hours/education time or child care time

	No.	Estimate
Men	1,670	23,500
Women	1,152	16,500
Total	2,822	40,000

Injuries during child care/school hours according to injury area (place)

Place: 40, 41, 42, i.e.

40 Day nursery, after-school centre, youth club excl. play area(43), childminder (10-19)

41 School, university, college, excl. sports facility (50-59)

42 School playground inc. play area in school playground

	No.	Estimate
Men	999	14,000
Women	773	11,000
Total	1,772	25,000

Animal as causative product

product5: S03-S09, domestic animals-pets, reptiles-batrachians, birds, fish-marine animals, insects, game, other animal

	No.	Estimate
Men	617	9,000
Women	970	14,000
Total	1,587	22,500

Animals as causative, triggering or other product

causative product5, triggering product5, other product5: S03-S09, domestic animals-pets, reptiles-batrachians, birds, fish-marine animals, insects, game, other animal

	No.	Estimate
Men	862	12,000
Women	1,848	26,000

Total	2,710	38,500

Triggering product: the product which triggered the accident, i.e. triggered the series of events leading to the injury.

Causative product: the product causing the actual bodily injury.

Other product: other product involved

Example *A person under the influence of alcohol walking the dog was pulled over by the dog and fell, striking the kerb*. The dog is the triggering product, the kerb the causative product and the alcohol another product.

Kicked by a horse. The horse is a causative product.

As regards accidents involving horses, it can be noted that horses and riding are a leisure activity causing many accidents to children. Statistics for the period 2001-2005 show a total of some 13,000 injuries annually, 90% of the victims being girls or women. Of these, 55% of the injured are under 20 years old. Horse accidents are often serious: 16% of those injured in horse accidents are hospitalised for at least one night. A special information campaign, partly targeting children and young persons, has therefore been mounted for the promotion of safety.

Article 12

12:1-3

Reference is made to the previous report. Reference might also be made to the Swedish annual reports on the application of the European Code of Social Security and its Protocol by Sweden, no 38-41, attached to this report. In addition:

I GENERAL

Question 1-2

Social Security Agreements

The social security agreement of 27th May 1995 between Sweden and the United States of America has been changed by an agreement of 22nd June 2004. The changes entered into force on 21st November 2007.

The social security agreement of 13th March 1995 between Sweden and Chile has been changed by an agreement of 12th December 2005. The changes entered into force on 1st January 2007.

Base amounts
During the period to which this report refers, the base amount, by which several benefits under the Swedish social security system are calculated, was raised as follows:

Year	Base amount	Increased base amount
2005	39,400 SEK	40,300 SEK
2006	39,700 SEK	40,500 SEK
2007	40,300 SEK	41,100 SEK

Reference is also made to the 40th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, page 2 under the heading Base Amount.

Income qualifying for sickness cash benefit
Reference is made to the 41st Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, page 2 under the heading Income qualifying for sickness cash benefit.

Question 3

The statistics presented in this report come from several different sources. Owing to the lack of uniform statistics, many of the figures presented must be termed approximate, not absolute.

According to data from SCB (Statistics Sweden), the Swedish population at 31st December 2007 totalled 9,182,927 persons, namely 4,563,921 men and 4,619,006 women. 21 per cent of the total population were aged between 0-17 years and 17.5 per cent were over 65. Foreign nationals comprised 5.7 per cent of the total population and foreign-born persons 13.4 per cent. The population of Sweden in 2006 and 2005 was 9,113,257 and 9,047,752 respectively.

Some 4,440,000 members of the population aged between 16 and 64 were employed in 2007 (approximately 2.3 million men and 2.1 million women). 290,000 persons were unemployed. The corresponding figures for 2005 and 2006 were 4,300,000 persons employed and, respectively, 360,000 and 330,000 unemployed. Some 4.3 million persons between the ages of 15 and 74 were employed in 2005, viz 2.3 million men and 2.1 million women. The figure for 2006 was 4.4 million (2.3 men and 2.1 million women) that for 2007 was 4.5 million (2.4 million men and 2.2 million women).

II MEDICAL CARE

Question 1-2

<u>Dental care</u>
Nothing to report.

Health care
Nothing to report.

Question 3

The insurance scheme includes all persons registered as residents of Sweden (9.2 million at 31st December 2007. Of these, all children up to the age of 20 qualify for free child and juvenile dental care. This group numbered 2.2 million in 2007. All adults aged 20 and over and registered as residents of Sweden qualify for dental care support.

III SICKNESS BENEFIT

Question 1-2

Reference is made to the 40th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, under the heading III Sickness benefit, pages 4-5.

Reference is made to the 39th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, under the heading III Sickness benefit, pages 2-3.

Reference is made to the 38th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, under the heading III Sickness benefit, pages 3-4.

Question 3

Sickness allowance and rehabilitation allowance are included in employment-based insurance. Between 2005 and 2007, 4.2 million persons were insured for these benefits according to the Swedish Social Insurance Agency.

Expenditure on sickness allowances and rehabilitation allowances during 2007 totalled just under MSEK 30,000 and the sickness rate, i.e. average number of sickness allowance benefit days per insured, was 12.3 days per annum.

IV UNEMPLOYMENT BENEFIT

Question 1-2

Reference is made to the 41st Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, under the heading IV Unemployment benefit, pages 5-6.

Reference is made to the 40th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, under the heading IV Unemployment benefit, pages 6-7.

Reference is made to the 39th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, under the heading IV Unemployment benefit, pages 4-7.

Question 3

Unemployment insurance is employment-based. Between 2005 and 2007 the scheme included some 4.3 million persons.

The number of persons entitled to unemployment compensation in 2005 is estimated at 3,800,000 persons with income-related compensation and 520,000 with basic insurance coverage. The number of persons entitled to unemployment compensation in 2006 is estimated at 3,800,000 with income-related compensation and 470,000 with basic insurance coverage. The number of persons entitled to unemployment compensation in 2007 is estimated at 3,700,000 persons with income-related compensation and 715,000 with basic insurance coverage.
The number of persons who are esteemed to be covered by the loss of income insurance is based on the average number of members in all unemployment insurance funds for each year. The number of persons who are covered by the universal basic insurance is based on a estimation of reason based on the total number of persons who are deemed to comply with the demands in the unemployment insurance, adjusted for the number of persons who are covered by the loss of income insurance.

V OLD AGE BENEFIT

Question 1-2

Old age pension
Reference is made to the 40th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, under the heading V Old age pension, page 8.

Reference is made to the 38th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, under the heading V Old age pension, page 4.

Housing supplements for Pensioners
Reference is made to the 40th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, under the heading V Old age pension, page 8.

Financial support for the elderly

Maintenance support for the elderly (Act 2001:853) is payable to persons over 65 with little or no guarantee pension, its purpose being to assure the persons qualifying for it of a reasonable standard of leaving and the wherewithal to cover reasonable housing costs. The reasonable standard of living corresponds to 1,294 and 1,084 times the price-referenced base amount for, respectively, unmarried and married persons. as from 2007, a housing cost of up to SEK 6,200 and 3,100 monthly for, respectively, unmarried and married persons is to be considered a reasonable housing cost.

Question 3

Income based old age and survivor's pensions and widow's pension are included in employment-based insurance. According to the Social Insurance Agency, some 4.2 million persons were included in this insurance scheme in 2005-2006.

Guarantee pension, housing supplement for pensioners and maintenance support for the elderly are housing-based benefits. According to the Social Insurance Agency, some 7.3 million persons (all residents aged over 16) are included in this insurance scheme.

Upwards of 1.7 million persons were in receipt of old age pensions in December 2007. Of these, 0.87 million received guarantee pensions. The cost of income-related pensions for 2007 was just under MSEK 190,000 and guarantee expenditure pension expenditure totalled MSEK 20,400.

Housing supplements for old age pensioners were paid to some 280,000 old age pensioners at a cost of just over MSEK 7,200.

Almost 11,000 persons were in receipt of maintenance support for the elderly in December 2007, at a cost of some MSEK 400.

VI WORK ACCIDENT AND OCCUPATIONAL DISEASE BENEFIT

Question 1-2

Reference is made to the 40th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, under the heading VI Work accident and occupational disease benefit, page 9.

Question 3

Work injury compensation (annuity and sickness allowance) is included in employment-based insurance. According to the Social Insurance Agency, some 4.2 million persons were included in the scheme in 2005-2007.

Some 60,000 persons were in receipt of annuities in December 2007. Disbursements for the year totalled just under MSEK 3,900.

VII FAMILY BENEFIT

Question 1-2

Reference is made to the 40th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, under the heading VII Family benefit, pages 9-10.

Reference is made to the 39th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, under the heading VII Family benefit, page 9.

Reference is made to the 38th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, under the heading VII Family benefit, page 5 and under the heading VIII Maternity benefit, page 6.

Question 3

Child allowance, extended child allowance, parental benefit at the minimum level and guarantee level, housing allowance, survivor's benefit for children, grants for the adoption of foreign children and maintenance support are residentially based benefits. According to the Social Insurance Agency, 7.4 million persons annually were included in this scheme between 2005 and 2007.

Parental benefit above the guarantee level and temporary parental benefit are benefits included in employment-based insurance. Some 4.2 million persons were included in this scheme between 2005 and 2007 according to the Social Insurance Agency.

Child allowances were disbursed in May 2007 for some 1.7 million children (all children domiciled in Sweden). There were 989,000 allowance recipients. Expenditure under this head totalled some MSEK 1,800.

Some 250,000 households in 2007 received housing allowances, at a cost of MSEK 3,400.

Parental benefit in connection with childbirth was disbursed to 631,000 parents in 2007. The Social Insurance Agency disbursed MSEK 20,600 to the parents concerned. Most of this money went to parents of children aged under 1.5 years.

Temporary parental benefit was utilised for the children of some 750,000 parents in 2006. Most of these parents refrained from work in order to stay at home and look after a sick child. The Social Insurance Agency paid a total of some MSEK 4,300 to

these parents in 2006. On average, during 2006, temporary parental benefit for care of children was utilised for a total of seven days per child by the parents insured.

Some 280,000 children received some form of maintenance support in 2007, at a net cost to the Social Insurance Agency of MSEK 2,100.

Adoption grants were disbursed in 2007 for upwards of 700 children. Disbursements totalled MSEK 28.

VIII MATERNITY BENEFIT

Question 1-2

Reference is made to the 40th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, under the heading VIII Maternity benefit, page 11.

Question 3

Pregnancy benefit is payable to women only. The benefit forms part of employment-based insurance. According to the Social Insurance Agency some 2 million persons (women) were included in the scheme between 2005 and 2007.

Upwards of 24,000 women received pregnancy benefit in 2007, at a cost of just over MSEK 400.

IX INVALIDITY BENEFIT

Question 1-2

Reference is made to the 41st Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, under the heading IX Invalidity benefit, page 8.

Reference is made to the 40th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, under the heading IX Invalidity benefit, page 13.

Question 3

Income-related sickness and activity compensation, together with rehabilitation and special allowances, are included in employment-based insurance. 4.2 million persons were insured for these benefits between 2005 and according to the Social Insurance Agency.

Sickness and activity compensation in the form of guarantee benefit, caring allowance, disability benefit, vehicle support for persons with functional impairment and assistance allowance are included in residentially based insurance. Accordingly, this insurance includes everyone deemed domiciled in Sweden. These forms of support are available to certain categories only, e.g. parents of persons with functional impairment in the case of the caring allowance.

Some 550,000 persons were receiving some form of sickness or activity compensation in December 2007. Approximately 290,000 of them were receiving guarantee compensation. Expenditure in 2007 totalled MSEK 57,000.

Caring allowances were awarded in August 2007 for some 43,000 children. The proportion of children in the population aged 0-19 years receiving caring allowances was approximately 2 per cent in 2006. During 2007 the Social Insurance Agency disbursed a total of MSEK 2,600.

Disability benefit in 2007 cost approximately MSEK 1,200 and was paid to 61,000 persons

Upwards of 15,000 persons were entitled to assistance compensation in December 2007. Expenditure in 2007 totalled some MSEK 18,000. Net State expenditure, however, was somewhat less, due to a certain amount being defrayed by the municipalities.

Just under 2,000 persons received car allowances, at a total cost of MSEK 245.

X SURVIVORS' BENEFIT

Question 1-2

Nothing to report.

Question 3

Income-based survivor's pension and widow's pension are included in employment-based insurance. The Social Insurance Agency reports that some 7.3 million persons were included in the scheme during 2005-2007.

Guarantee pension for survivors is a residentially based benefit. The Social' reports that some 4.2 persons were included in this scheme in 2005-2007.

Recipients of income-related widows' pensions constitute the largest group, numbering almost 360,000 in 2007. Guarantee pensions disbursed as window's pension in 27,500 numbered 27,500. Just under 7,000 persons received survivor's pension in the form of adjustment pension, and only 18 per cent of these had income-related adjustment pensions. Expenditure on survivors' pensions in 2007 totalled MSEK 15,700.

XI FINANCING

For 2007 reference is made to the 40th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, under the heading XI Financing, page 15.

For 2006 reference is made to the 39th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, under the heading XI Financing, page 13.

For 2005 the following rates for the statutory *employer's contributions* apply. The contributions are calculated by the gross wage cost.

Old age pension	10.21 %
Survivor's pension	1.70 %
Sickness insurance	10.21 %
Parental insurance	2.20 %
Work injury	0.68 %
Labour market	4.45 %
General salary contribution	3.70 %
Total	*33.09 %*

The following rates for the statutory *contributions for self-employed persons* apply for 2005. The contributions are calculated by gross income.

Old age pension	10.21 %
Survivor's pension	1.70 %
Sickness insurance	11.12 %
Parental insurance	2.20 %
Work injury	0.68 %
Labour market	1.91 %
General salary contribution	3.70 %
Total	*31.52 %*

The *general pension contribution* amounts to 7 percent of the income up to 7,5 times the income base amount.

Information in respect of the Conclusions 2006

Statistics

Reference is made to point 3 in the report on measures taken to give effect to article 12.

Complements to the basic unemployment benefits

The structure of unemployment insurance impacts on the labour market. The Government takes the view that unemployment insurance must be an adjustment insurance. Generous unemployment insurance for unemployment of brief duration can in the Government's opinion increase the flexibility of the labour market. Persons who are able to receive financial compensation during temporary periods of unemployment will feel secure and ready to try new jobs. excessively generous unemployment insurance, on the other hand, is liable to counteract people's determination when unemployed to find new work. The economic driving forces for overcoming unemployment are important. The Government takes the view that work must always pay better than unemployment.

The basic unemployment insurance is SEK 320 per day (five days per week) and is paid to a person who, is not a member of an unemployment fund or a person who is a member of an unemployment fund but does not satisfy the condition applicable for the entitlement to the income loss insurance. The amount per day is proportionately lower if the person has not worked full-time during the period the compensation is based on. The basic insurance is paid at the earliest on the date the unemployed person reaches the age of 20.

In addition to income-related benefits, the Swedish model also includes various general and needs-tested forms of support. The social insurance system includes child allowance, housing allowance and maintenance support, which can supplement the income-related unemployment benefits. In addition, financial assistance is available, as an ultimate safeguard, to persons with temporary livelihood problems; for a more detailed account on this point, see articles 13 and 20.

Child allowance is payable for all children domiciled in Sweden, up to and including the quarter in which they are 16 (SEK 1,050 monthly). Children who, after their 16th birthday, are still attending compulsory school are entitled to extended child allowance. Large family supplement is paid automatically to persons receiving child allowance for two or more children. Child allowances and large family supplements are tax free.

Families with children and persons aged 18-28 but without children may be entitled to housing allowance. Families with children may receive a contribution towards housing costs and allowances for the children living at home or sometimes live at home. Persons of the age of 18 to 28 without children can receive the housing contribution. The amount payable depends partly on the size of the household, the income, the housing costs and the size of the accommodation.

Maintenance allowance is the amount payable by a parent not living with their child towards the child's upkeep. If the parent not living with the child does not pay maintenance allowance or pays less than SEK 1,273 per month, the Social Insurance Agency can pay maintenance support of up to SEK 1,273 to the parent living with the child. Maintenance support is also payable when a child is adopted by one person only.

Article 12:4

Article 12:4 has not been ratified by Sweden.

Article 13

Article 13:1

Question 1

Reference is made to previous reports.

Question 2

Social services are supervised by the county administrative board and the National Board of Health and Welfare. The National Board of Health and Welfare supervises social services nationwide and is responsible for their monitoring and further development. As guidance on implementation of the relevant enactments, the Board issues directions, partly in the form of General Recommendations. The county administrative board supervises the social services for which the municipalities in the county are responsible, its task being to monitor implementation of the law by municipal social welfare committees, to inform and advise the general public on matters relating to social services, to advise the municipal social welfare committees in connection with their activities, etc.

Question 3

The number of persons in receipt of assistance has been practically halved since it peaked in the mid-1990s. On the other hand the average duration of assistance (6 months in 2007) and the average amount disbursed (approximately SEK 41,000 in 2007) have increased over the past ten-year period. Long-term receipt of assistance (at least 10 months during one calendar year) has remained practically unaltered during the same period.

Financial assistance payments in 2007 (including introduction benefit for refugees and certain other aliens) totalled MSEK 8,900, which was practically the same as in 2006. The number of beneficiaries, at 379,000, equalled some 4 per cent of the population. Single mothers, young persons and persons born abroad are groups more dependent on financial support than, for example, single fathers and cohabitants. Developments have nonetheless taken a positive turn for single mothers and for young persons born abroad. During 2007, for example, 20 per cent of all single mothers were receiving financial assistance, as against 123 per cent in 2002. Some 4 per cent of young persons aged between 18 and 24 and born abroad received financial assistance at some time during 2007, which was considerably fewer than the 32 per cent recorded for 2002.

Year	Disbursements, MSEK	No. beneficiaries	Proportion of population (%)
1990	4,721	490,808	5.7
1991	5,642	510,205	5.9
1992	7,012	559,902	6.5
1993	8,712	641,385	7.4
1994	10,285	694,060	7.9
1995	10,786	687,951	7.8
1996	11,884	721040	8.2
1997	12,377	716,842	8.1
1998	11,425	658,782	7.4
1999	10,465	580,934	6.6
2000	9,521	522,242	5.9
2001	8,704	469,004	5.3
2002	8,528	434,046	4.9
2003	8,274	418,395	4.7
2004	8,687	417,491	4.6
2005	8,584	406,743	4.5
2006	8,738	392,466	4.3
2007	8,899	378,552	4.1

For young persons as with persons born abroad, the need for assistance may be due tot heir never having gained entry to the employment sector so as to qualify for other forms of compensation, with the result that they are thrown back on financial assistance for their livelihood. Many of the causes of livelihood problems are difficult

for social services to address actively, coming as they do outside the social service sphere of responsibility and competence. Ever since the economic crisis of the 1990s, however, the municipalities have been assuming progressively greater responsibility for employment policy initiatives. In certain municipalities these are organised within the social services, while elsewhere they are the responsibility of special labour market units.

Statistics concerning financial assistance are published by the National Board of Health and Welfare. Work on developing statistics concerning financial assistance is in progress at the Board, with a view to facilitating better analysis of the underlying causes of the need for financial assistance and the purposes for which it is disbursed. The aim is for the first collection of data to be possible in 2010.

Information in respect of conclusions 2006

Reduced social allowance and the proportion of assistance payments constituting reduced payments

There are no data available at national level to show whether it is common for municipalities to reduce assistance, e.g. if it is only to be paid temporarily. Presentation of such data may become possible when the statistical development reported under point 3 has been completed.

Average monthly amount per beneficiary

The national standard (personal and household expenses) in 2008 for a single person with no children is SEK 3,550 monthly. Over and above this amount, assistance is obtainable towards housing costs, domestic electricity, household insurance, travel to and from work, membership of an unemployment insurance fund and trade union membership dues. These amounts vary according to actual expenditure. Entitlement to compensation for housing costs should be on a level with what a low income earner can afford. The amount to which a single and childless beneficiary would be entitled to in 2008 is estimated at approximately SEK 8,200 per month.

Proportion of assistance beneficiaries regularly receiving assistance towards housing costs

See reply under "Reduced social allowance…"

Article 13:2

Anti-discrimination legislation

Health and medical services and social services have safeguards against discrimination on grounds of ethnic identity, religion or other creed and sexual orientation.

A new, unitary anti-discrimination law enters into force on 1st January 2009. A new Anti-discrimination Ombudsman Office is being set up. Safeguards against

discrimination in health and medical services and social services will cover the grounds of gender, transsexual identity or expression, ethnic identity, religion or other creed, functional impairment or sexual orientation.

The new Discrimination Act also includes stronger safeguards for the individual in the context of public activity. Public servants are subject to the ban on discrimination in their contacts with the general public.

Guardian/receiver

If, by reason of illness, mental disturbance, impaired health or suchlike, a person needs help in asserting their rights, managing their property or taking care of themselves, the court can appoint a guardian or receiver. The provisions on guardians and receivers are contained in the Code of Parenthood and Guardianship (1949:381). A guardian must, to the extent indicated by the terms of his appointment, safeguard the rights of the individual, manage his property and/or make arrangements for his personal care.

Article 13:3

Question 1

The Social Services Act – reference is made to previous reports.

A new Debt Clearance Act which came into force on 1st January 2007 has made debt clearance procedure simpler and more efficient. It is still the duty of the municipality to provide indebted persons with advice and directions in matters of budgeting and debt, but it has been made clear that this obligation also includes provision of advice and directions during the debt clearance process and thereafter. The municipality was made expressly responsible for supporting debtors all the way, both previous to a debt clearance application and throughout the process.

The Enforcement Service is now the first instance deciding whether debt clearance is to be granted or not. Its decision can be appealed in a district court. Municipal responsibilities have been clarified. Rehabilitation and advisory activities are placed at the centre of attention and viewed as a precondition for indebted persons achieving freedom from debt.

One new development is that a debtor wishing to apply for debt clearance need no longer try to reach a voluntary agreement with the creditors first. The Enforcement Service is empowered to decide a debt clearance case even if one or more creditors object to debt clearance. (Previously decisions of this kind could only be made by a district court.)

The Swedish Consumer Agency is required to support and furnish guidance on the budget and debt counselling for which the municipalities have been made responsible (Section 2 of the Debt Clearance Act) before and throughout the debt clearance process.

Question 2

Nothing to report.

Question 3

No national statistics are available concerning this advisory aspect of social service activities.

Through its HEPSYSTEM computer program the Swedish Consumer Agency has collected case statistics from municipal budget and debt counselling activities in 137 municipalities in different parts of Sweden. The cases number 13,806 in all, 8,487 of them being new for the year. The statistics refer to budget and debt counselling in 2007.

Types of case:

• **Assistance prior to debt clearance.** 29 per cent of applicants for budget and debt counselling were given assistance prior to debt clearance. 6 per cent received help following a debt clearance decision, e.g. help in connection with appeals and reviews.

• **Budget and debt counselling.** Just over half received budget counselling and 69 per cent received debt counselling.

• **Voluntary settlement with creditors.** 17 per cent of the cases were concluded following some form of voluntary settlement with creditors.

The entry into force of the new Act was followed by a distinct rise in the number of debt clearance applications to the Enforcement Service. The number of applications received in 2007, at 6,800, was 80 per cent up on 2006. A large part of the increase involved persons applying on their own initiative

Year-on-year comparison of debt clearance application figures for the whole of Sweden

Year	No. debt clearance applications
2007	6,831
2006	3,830
2005	4,178

Year-on-year comparison of no. debt clearance decisions in Sweden as a whole

Year	No. debt clearance decisions

2007	2,452
2006	1,538
2005	1,516

In addition to the above, court orders for debt clearance numbered 176 in 2007, 575 in 2006 and 796 in 2005.

Information in respect of conclusions 2006

Proportion of "social services" expenditure devoted to counselling and personal support

No statistics are available.

Article 13.4

Question 1

Reference is made to previous reports.

Question 2

Reference is made to previous reports.

Question 3

There are no data showing how common it is for social services to receive applications for assistance from persons who are hidden asylum-seekers or illegal immigrants.

The statistics requested are lacking for both the medical and the social sector.

Information in respect of conclusions 2006

Entitlement to social assistance

Under the Social Services Act, ultimate responsibility for persons living in the municipality devolves on the social services. This means that an illegal resident or a hidden asylum-seeker is entitled to have their application examined. Assistance is the right of a person who cannot provide for their own needs or whose needs cannot be provided for in any other way. The social welfare committee in the municipality of residence assesses the need of assistance and the way in which it is to be provided for, e.g. through the grant of assistance or through repatriation.

Entitlement to health care

In Sweden access to health care is based on residence, not on citizenship. The individual county councils are responsible for providing health care to people residing within their geographic jurisdiction. The county councils are also obliged to provide immediate health care to persons not residing in the county council. This means that

no health institution can turn away a person in need of immediate care, regardless of his or her legal status, financial situation, religious background etc. According to Swedish law, no health institution may claim that a patient must pay the full cost in advance or be denied treatment.

Article 14

Article 14:1

Question 1

Reference is made to previous reports.

Under new provisions of the Social Services Act effective from 1st July 2006, it is the duty of municipalities to report to the county administrative board, the municipal auditors and the municipal council all favourable decisions under the Social Services Act (2001_453) which have not been effectuated within three months of the decision date. A sanction charge has been introduced as an ultimate recourse for obtaining effectuation of a favourable decision within a reasonable time. The provisions on notifiability and the sanction charge are expected to improve the prospects of internal and external monitoring of measures decided on. This can among other things help to counteract the shortage of special housing accommodation for older persons and persons with functional impairment.

On 1st July 2007, for example, an amendment to Chap. 5, Section 11 of the Social Services Act came into force which elucidates the responsibilities of the social welfare committee towards women exposed to violence. In particular, the amendment implies that the social welfare committee *shall*, and not as previously *should*, take into account that women exposed to violence and children witnessing violence may be in need of support and assistance

Question 2

This section deals only with measures not referable to any other article. Everything to do with financial assistance is dealt with under article 13 and everything to do with social protection of older persons under article 23.

Support for women exposed to violence
By reason of, and as an adjunct to, the statutory amendment elucidating the responsibility of the municipal social welfare committee for women exposed to violence, several remits were issued during 2007 to various agents for the purpose of establishing a more comprehensive structure round and strengthening support to women exposed to violence and their children. Most of the remits are now in progress and have been gathered in the action plan presented by the Government in November 2007, Action plan for combating men's violence to women, honour-related violence and oppression and violence in same-sex relations (skr. 2007/08:39). The action plan

has resulted from the holistic approach which the Government has adopted to these problems.

In 2006 and 2007 The county administrative boards were commissioned to distribute "development funding" to the municipalities for the purpose of reinforcing women's refuge activities and improving the quality of support to women exposed to violence and their children at local level. In 2007 MSEK 109 were available for the initiative and a further MSEK 109 have been reserved for 2008. By then some MSEK 153 out of the total allocation of MSEK 216.5 had been allocated. A total of 264 out of Sweden's 290 municipalities had applied, figured as co-applicants or been referred to as partners in another municipality's application. The corresponding initiative in 2006 involved MSEK 77.5, and 36 of the applications in that connection came from municipalities, plus 37 from municipalities and women's refuges jointly.

Support for substance abusers
A three-year State initiative to reinforce care for person with heavy substance abuse was operated between 2005 and 2007, with the county administrative boards distributing funding to the municipalities. A final report on the initiative will be presented on 31st December 2009.

In 2007 the National Board of Health and Welfare published national guidelines for the care of substance abusers and addicts. These guidelines refer to both municipal and county council activities, and also to the substance abuser care provided by other mandators, e.g. in the prison and probation system .

Question 3

Only measures not referable to any other article are dealt with in this section. everything to do with financial assistance is presented with reference to article 13, and most aspects of social safeguards for older persons are presented with reference to article 23 (with the exception of certain issues relating to Conclusions 2005).

Care of substance abusers and addicts
Municipal responsibilities for ensuring that substance abusers receive the help or support they need are defined in the Social Services Act and the Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents Act (LMV). At 1st November 2007 upwards of 20,000 persons were the subjects of some form of initiative in municipal care of substance abusers and addicts.

No. women and men with programmes for substance abuse at 1st November 2007

	2003	now 2006 (2007)	% change 2003-(2007)
Housing assistance	6,300	5,980	-5
whereof women	1,500	1,370	-9
men	4,800	4,620	-4
Individual needs-tested outpatient care	11,200	12,000	7
whereof women	3,400	3,570	5
men	7,800	8,440	8
Whole-day care	3,600	3,250	-10
whereof women	900	820	-9
men	2,700	2,430	-10
- *whereof compulsory institutional care*	220	200	27
whereof women	70	100	43
men	150	180	20
Total no. persons with programmes	21,100	21,240	1
whereof women	5,800	5,760	-1
men	15,300	15,480	1

Source: National Board of Health and Welfare

A comparison between 2003 and 2007 shows the total number of inputs for persons with substance abuse problems to be virtually unchanged. On the other hand a change has occurred in the breakdown between different types of input. During the period under consideration, outpatient measures have increased at the same time as whole-day care and housing-related assistance have diminished. Although the number of outpatient inputs for 2007 is greater than for 2003, it has successively declined after peaking in 2005. As regards compulsory institutional care, fewer women were admitted in 2007 than in 2003, while the number of men remained more or less constant. Thus the increase in LVM care observable between 2005 and 2006 appear to have been broken.

Support to women exposed to violence
No statistics are available concerning municipal inputs.

Unenforced decisions and judgements and sanction charges

In 2007 the National Board of Health and Welfare and the county administrative boards jointly reported that the municipalities had some 2,900 decisions under LSS (the Support and Services (Certain Functionally Impaired Categories) Act) and approximately 5,000 under the Social Services Act which had not been effectuated by 31st December 2006. This implies an increase of about 20 per cent for LSS and 63 per cent for orders under the Social Services Act.

The numbers of judgements remaining unenforced at the same date were 34 for LSS and 75 for the Social Services Act, indicating a total reduction of 38 per cent since 2004. During 2007 the county administrative boards handled more than 10,000 reports concerning favourable decisions on assistance-related measures. Of the 2,500 or 2,750 decisions reported every quarter, 600 or 700 were carried over from the preceding quarter. Upwards of 100 decisions were still included in reporting after one year.

A provisions came into force on 1st July 2006 imposing a special charge for decisions not effectuated by the municipalities within a reasonable length of time. In 2007 the county administrative boards filed 731 applications of this kind with the county administrative courts.

During 2006 the county administrative boards applied for a special charge to be imposed for unenforced judgements under LSS in 23 cases and in 2007 in 10 cases. In 2006 there were only two applications concerning judgements under the Social Services Act, and in 2007 there were three. The joint report by the National Board of Health and Welfare and the county administrative boards notes that the statutory amendment making it possible for a special charge to be imposed has helped to reduce the number of unenforced judgements.

Information in respect of conclusions 2005

The staffing shortage in social services

The figures in the 4th report were supplied by the supervisory authorities responsible, namely the National Board of Health and Welfare and the county administrative boards. In subsequent reports from the same agencies, staffing shortages are not remarked on as a major and general problem in the social services. Staffing remains an issue in caring services for the elderly.

The following measures have now been taken and have a bearing on the issue:

Invest Now

In the summer of 2002 the National Labour Market Board, the Work Environment Authority, the Swedish Integration Board, the National Agency for Higher Education, the Migration Board, the Swedish Agency for Advanced Vocational education, the National Social Insurance Board, the National Agency for Education and the National Board of Health and Welfare were jointly tasked with drawing up a plan of competence supply in municipal caring services for the elderly and persons with functional impairment. A final report on the remit was submitted in May 2004.

Competence steps

Reference is made to the reply concerning article 23.

Vocational requirements in caring services for the elderly
Reference is made to the reply concerning article 23.

Incentive grants to the municipalities in 2006, 2007 and 2008
Reference is made to the reply concerning article 23.

Shortage of special housing for older persons and persons with functional impairment
Concerning older persons, reference is made to the reply concerning article 23.

As regards persons with functional impairment, the latest report from the National Board of Health and Welfare concerning unenforced decisions and judgements shows the number of unenforced decisions concerning housing for adults to have doubled between 2002 and 2006, despite the number of accommodation units for adults having risen during the same period according to official statistics of the National Board of Health and Welfare.

In view of the failure by municipalities to effectuate favourable decisions, new legislation effective from 1st July 2008 requires municipalities and county councils to report unenforced decisions concerning inputs under the Support and Services (Certain Functionally Impaired Categories) Act (LSS). The decision-making committee is to report all favourable decisions not effectuated within three months of the decision date to the county administrative board, the municipal auditors and the municipal council. A sanction charge has been introduced as an ultimate resort. Corresponding provisions were added to the Social Services Act with effect from 1st July 2006; see the reply under point 1 of this article.

Difficulties in accommodating the needs of certain immigrant categories
A special investigator was appointed in April 2007 to consider
• a suitable allocation between national authorities, municipalities and other agencies of responsibility for refugee reception and other measures for new arrivals,
• changes to national compensation for refugee reception and how the compensation is to be regulated,
• the individual person's livelihood during the initial period and whether or not this should be made a national government responsibility.
The remit also underlined that new arrivals must as far as possible be included within the scope of general policy, that the National Labour Market Board together with other employment organisations should have a more prominent role and clearer responsibility, and that "new arrivals must in the normal instance not be provided for through maintenance support under the Social Services Act." A final report was submitted on 2nd June 2008.

A Commission was appointed in December 2007 to review the reception of asylum-seekers. The review takes as its starting point that reception must be designed so as to contribute towards an efficient and humane asylum process under the rule of law, with short handling times, help to promote the asylum-seekers' opportunities of employment and self-sufficiency both while their applications are pending and in the

event of their being granted residence permits, and be designed so as to facilitate rapid return after a refusal-of-entry or expulsion order has acquired force of law, with the shortest possible length of stay in the asylum system.

The investigator is to consider and submit proposals on topics which include housing, organised employment, co-operation between the Migration Board, municipalities, NGOs and other relevant agencies, settlement and repatriation, financial support, asylum-seekers with special needs, national compensation to municipalities and county councils, and reception conditions for persons with fixed-term residence permits. A report on the remit is due not later than 27th February 2009.

Updated information on the structure of social services

Municipal responsibilities for social service inputs are defined by the Social Services Act, Chap. 2, Section 2 of which makes the municipality ultimately responsible for persons living within its boundaries receiving the support and assistance they need. Thus a single public agency, the municipality, is made responsible for the individual receiving the support and assistance which he or she is in need of. The purpose of the provision concerning ultimate municipal responsibility is not for the municipality to enter into another mandator's stead, but situations can arise where for a limited time the municipality has to take charge of necessary measures, pending intervention by another mandator.

Chap. 3 of the Social Services Act contains a general description of the duties of the municipal social welfare committee. Its provisions require the committee to supply information concerning social services in the municipality and among other things to take charge of caring and other services, information, counselling, support and care for families and individuals in need of the same. The municipalities must also support individual persons in their efforts to lead as normal a life as possible, e.g. by enabling them as far as possible to continue living in their accustomed home surroundings.

The entitlement of the individual to assistance is governed by Chap. 4, Section 1 of the Social Services Act; see art 13. I

The Social Services Act is based on the voluntary principle, and measures can only be granted if the individual wants them. An adult person unable to manage their own affairs, e.g. applying for assistance under the Social Services Act, can in certain cases be allotted a guardian or receiver. Chap. 5, Section 3 of the Social Services Act requires the municipal social welfare committee to notify the Chief Guardian if in its opinion a guardian or receiver should be appointed for an individual person. The provisions on proxies – guardians and receivers – are contained in Chap. 11 of the Code of Parenthood and Guardianship. Guardianship and receivership orders are made by a common court of law.

Chap. 3, Section 3 of the Social Services Act lays down that social service measures must be of good quality and that there must be suitably trained and experienced staff to discharge the duties of the municipal social welfare committee. The stipulation of good quality applies to both private and public social service activities and to the exercise of authority as well as other inputs. Quality must be systematically and

continuously developed and secured. The National Board of Health and Welfare has issued Provisions and General recommendations on quality management systems for activities under the Social Services Act, LVU, LVM and LSS, the aim being to articulate the statutory requirements for quality, to support authorities responsible for supervision and to support municipalities outsourcing activities under the Social Services Act and LSS, The Provisions of the National Board of Health and welfare are to be implemented, for example, by the committees discharging municipal social service duties. A social welfare committee outsourcing services for the discharge of its duties under the Social Services Act is duty bound to ascertain that quality management and development is conducted in the activity concerned.

Municipal social service duties are performed by the committee or committees appointed by the municipal council; in the statutory text these are referred to as "the social welfare committee". It is for the social welfare committee to ensure that activities are conducted in accordance with the goals and guidelines resolved on by the municipal council and that the prescriptions applying to the activity are complied with. The social welfare committee must also see to it that there is an effective system of internal control and that activities are conducted in a satisfactory manner in all other respects. The purpose of internal control is to ensure administrative efficiency and to avert the commission of serious errors. The municipal auditors are among other things tasked with examining the adequacy of controls within the municipality. Since overriding responsibility for social services rests with the municipality as mandator, the duties of inspection and control continue to devolve on the social welfare committee, even if certain social service tasks have been entrusted to another provider. To establish beyond any doubt that the operational responsibilities of the municipal committees also include outsourced activities, an addition to this effect has been made to Chap. 6, Section 7 of the Local Government Act.

Quality control of social service activities is also effected through surveillance. The social welfare committee is responsible for the day-to-day surveillance of all private activities for which permits are required. Under the Social Services Act this applies to nursing or sheltered accommodation, special forms of served accommodation for older persons, specially serviced housing for persons with functional impairment, homes for certain other whole-day care and homes or non-residential activities providing care for a limited part of the day. Surveillance is the responsibility of the social welfare committee in the municipality where the activities are carried on. Thus the municipality has a local supervisory responsibility for private activities for which permits are required, and the social welfare committee is entitled to inspect those activities. A social welfare committee must notify the county administrative board of any abuses in private activity which come to its knowledge.

In order for improvement and development of social services to be possible and to facilitate a systematic investigation of compliance, activities need to be adequately documented. The social welfare committee therefore has a duty of documentation under Chap. 11, Section 5 of the Social Services Act, to the effect that the handling of matters relating to individual persons and the implementation of decisions concerning supportive measures, care and treatment must be documented. This documentation

has an important bearing on the legal security of the individual, on the social welfare committee's own follow-up, evaluation and quality assurance of activities, on the ability of State to observe the development of activities in relation to national targets, on the production of statistics and as input data for social services research. It is also needed for close knowledge of outcomes for individual persons etc.

The duties of the social welfare committee include one of information concerning social services in the municipality. This information must cater both to the general public and to individuals. A person contacting the social services in order to apply for assistance must be given comprehensive, intelligible and concrete information. In order for individuals to be able to exercise their rights, the social welfare committee must assist them with information, counselling and support. This can mean explaining the preconditions of entitlement to assistance, explaining how to draw up an application, and helping people to fill in forms. It can also concern matters of co-determination and complaints procedures. If there are several alternative types of assistance, information must be supplied which will enable the individual to decide between them. As regards legal security, it is important for the individual to be informed of such matters as the right to inspect investigation material and personal records, the right to legal representation, the possibility of being assigned an interpreter and of being accompanied by a facilitator, and the possibility of appealing decisions. The committee must also explain the obligations of the individual, e.g. the duty of furnishing correct and adequate particulars in connection with the investigation. It is also the duty of a municipality to ensure that the general public have access to information concerning the conduct of municipal affairs. A municipality entrusting the conduct of a municipal matter to another agency must therefore, under Chap. 3, Section 19 a of the Local Government Act, include in the contrast a provision assuring the general public of insight. More immediate responsibility for assuring the general public of information devolves on the municipal body engaging the contractor. In the procurement process, the tendering documentation should include particulars of transparency arrangements, but transparency provisions must not be framed in such a way as to distort competition between the agents concerned. When signing contracts, therefore, a balance should be struck between the interest of the general public to know how the activity is conducted and, on the other hand, the contractor's interest in not having to divulge certain information which may be detrimental to his business operation and distort competition.

Article 14:2

Question 1

Reference is made to previous reports.

Question 2

In September 2007 the Government invited NGOs active in the social sphere to join in a dialogue which could form the basis of an agreement on ways of developing relations between the State and the voluntary sector, and a draft agreement of this kind was presented in the spring of 2008. The basic reason for this initiative is that an independent voluntary sector is an important guarantee of democracy and diversity.

The Government wishes to clarify the role of non-profit enterprises in the social sphere and enable them to compete on equal terms with other agents active in this context. The Government also wishes to support the emergence of a far greater diversity of performers and providers, e.g. in health care and mental welfare.

Question 3

No national statistics are available concerning social services as a whole. Mandatorship data are presented for certain types of input; see below.

Table C. Children and young persons with ongoing whole-day inputs at 1st November 2007. Numbers by type of input and form of placement. Percentages and absolute numbers, rounded figures.

Form of placement	**Type of input**				
	SoL care	**LVU care**	**Immediate care order**	**All children/young persons in care**	
	Per cent	**Per cent**	**Per cent**	**Per cent**	**N**
Family home (foster care)	77	66	44	73	11,100
Nursing or residential home run by a municipality or county council	5	3	6	4	650
Nursing or residential home run privately	16	14	15	15	2,300
Home with special supervision	0	10	32	4	570
Own home	-	6	-	2	270
Other placement	2	1	4	2	250
Total percentage	100	100	100	100	-
Total no. children and young persons	10,300	4,600	200	-	15,100

The proportion of elderly care inputs from private care providers rose from 9.5 in 2000 to 12 per cent in 2006. The figure for 2007 was also 12 per cent. Rather more special accommodation (13 per cent) than domiciliary care (11 per cent) is provided under private auspices.

Roughly 72 per cent of all persons with functional impairment living in special housing accommodation under the Social Services Act (SoL) at 1st October 2007 were living in accommodation run by their own municipality. 27 per cent were living in homes run privately and 1 per cent in homes run by the county council or another municipality.

70 per cent of all care days in substance abuser care during 2007 had private/individual providers. Public care providers accounted for 25 per cent, and private and public providers together for the remaining 5 per cent. Outpatient care presents a different picture. The survey conducted by the National Board of Health and Welfare in 2007 showed 88 per cent of support units to be under public mandatorship. The IKB survey for 2007 showed 84 per cent of treatment units operating under municipal/county council auspices.

Information in respect of conclusions 2005

Availability and efficiency of services with non-public providers

An individual person applying for "social services" addresses the application to the municipal social services, regardless of which agency then provides the service. Either the municipality provides the service under its own auspices, or else it signs an agreement with another provider. Thus the availability of services has to do with the municipality's agreements with external providers. The same quality requirements apply to private producers as to in-house activities, and outsourced activities come under the same continuous, regional and national surveillance.

Co-ordination of services from the non-public sector with public sector activities

The decision-making body is always responsible for the individual actually receiving the assistance granted in the form of social services, no matter which agency – the decision-making body itself, another committee or a private operator – effectuates the decision. As mandator the municipality decides the goals and focus of activities, follow-up evaluation, charges etc. If for some reason an external provider is forced to cease operating or otherwise fails to discharge his commitments under the agreement with the municipality, it is the municipality's duty to ensure that the users affected still receive the services which they have been awarded.

Article 23

Question 1

The Maintenance Support (Elderly Persons) Act (2001:853), effective from 1st January 2003, supplements the provisions of the Social Services Act on financial assistance, the intention being for long-term maintenance support needed by certain elderly persons with little or no old age pension to be provided as maintenance support for the elderly instead of as financial assistance under the Social Services Act. Through this support, persons residing in Sweden and aged 65 or over are to be guaranteed a reasonable standard of living and the wherewithal to defray reasonable housing costs. The amount of support payable depends on the beneficiary's income. The support is regarded as a social insurance benefit, it is tax free and is financed out of national government revenue. See further the report on measures taken to give effect to article 12.

The Care and Nursing (Joint Committees) Act (2003:192), effective from 1st July 2003, enables a single committee to discharge the duties of municipality and county council

in the care and nursing sector. Among other things this change requires joint planning of care in connection with the discharge of patients from institutional care in order for the municipality's liability for payment to become operative.

The Services to the Elderly (Municipal Authority to Provide) Act (2006:492) enables municipalities to provide such services to elderly persons without any individual assessment of needs. This, however, applies to services for the prevention of injuries, accidents or ill-health to persons aged 67 or over. The Act came into force on 1st July 2006.

A "pair-living guarantee" was introduced with effect from 1st June 2006 through an amendment to the Social Services Ordinance (2001:937), to the effect that, in the event of a married couple, two cohabitants or registered partners being awarded special housing accommodation for the elderly, reasonable living conditions for the purposes of the Social Services Act shall be understood to include providing both persons with places in the same accommodation if they so request.

As from 1st January 2007, under the Health and Medical Services Act, county councils are to make agreements with municipalities concerning physician staffing of special housing accommodation and in ordinary accommodation in municipalities responsible for health care. If the county council fails to discharge its duties under the agreement of providing physicians, the municipality is entitled to engage them itself and to obtain reimbursement from the county council for the expenditure thus entailed. The county council and the municipality are to co-operate in such a way that an individual person whose health care is the municipality's responsibility also receives such other care and treatment, assistive devices and disposable articles as his or her condition requires.

Question 2

The Competence Steps, a national government initiative for developing the competence of staff employed in the care and nursing of elderly persons, was operated in most municipalities between 2004 and 2007, with national government funding support totalling MSEK 1,050 and at least the same amount of municipal funding.

To encourage the construction of more special housing units for the elderly, a national investment subsidy totalling MSEK 500 per annum has existed since 2007. The municipalities can apply for up to SEK 2,200 per square metre for housing added through conversion to special accommodation. Support is obtainable for up to 50 sq. m. per dwelling unit, comprising 35 sq. m. dwelling space and 15 sq. m. communal facilities.

In 2007 and 2008 the Government allocated just under MSEK 1,400 annually for incentive grants to municipalities and county councils to raise the quality of care and nursing for elderly persons. Seven priority fields have been designated: physician availability, medication reviews, preventive work, dementia care, rehabilitation, diet

and nutrition and social content. 70 per cent of the funding has been paid to municipalities, 30 per cent to county councils.

This funding has enabled the mandators to hire personnel with competence which has been partly or wholly lacking, primarily dieticians and rehabilitation staff. The funding has also made it possible to provide basic staff with training, e.g. concerning diet, pharmaceuticals and rehabilitation working methods. The report on incentive grants for 2007 shows rehabilitation, medication reviews and dementia care to be the three fields in which both municipalities and county councils deploy most funding.

As from 2007 the Government is devoting MSEK 30 per annum to elderly research (fro the period 2008-2010 this has been augmented by MSEK 5 per annum), MSEK 14 annually to the build-up of long-term population-based research databases and MSEK annually to support for local and regional centres for R&D at practitioner level.

In addition, the Government has for the past 10 years been providing funds to encourage the development of support for next-of-kin. The State rant for next-of-kin support was augmented by a further MSEK 25 in 2005 and for 2006-2007 totalled MSEK 125 per annum. Reports from the National Board of Health and Welfare show that in 2007 95 per cent of the municipalities were working to develop next-of-kin support, the highest proportion since 2002. The most widespread form of next-of-kin support is relief, which exists in nearly all municipalities, with relief in the home free of charge becoming increasingly common. The biggest increase in forms of next-of-kin support concerns training of next-of-kin, feel-well activities and centres or meeting points for next-of-kin. There are one or more such centres or meeting points in 177 of Sweden's municipalities and sub-municipal districts, and 58 of these have been started with the aid of the incentive grants. Outreach activities, serving among other things to inform people of the availability of next-of-kin support, exist in 65 per cent of municipalities.

Between 2003 and 2006, together with the Swedish Association of Local Authorities and the Federation of County Councils, the Ministry of Health and Social Affairs operated a dementia care development project. The Dementia Association has produced and distributed information material which is available in printed, video and sound-recorded form and has been translated into seven languages. At the National Board of Health and Welfare, work is in progress on national guidelines and other guidance concerning nursing and care of dementia patients. Knowledge of dementia issues, and also of next-of-kin issues, needs to be gathered at national level and distributed to nursing and caring staff, decision-makers, elderly persons and next-of-kin. To this end, two national competence centres were formed in the autumn of 2007. These centres are to collect knowledge concerning dementia issues and next-of-kin issues and disseminate it to caring and nursing staff, decision-makers and elderly persons.

A number of Commissions were appointed between 2003 and 2007 in order among other things to strengthen safeguards for the elderly. In August 2008 a Commission

appointed by the Government in 2007 presented draft legislation aimed at clarifying the legal position and making it easier for municipalities and county councils to provide greater freedom of choice in their social welfare activities. The document referred to the Council on Legislation recommends the introduction of new legislation, a Freedom of Choice Systems Act (LOV). A special investigator was appointed in May 2007 to draw up proposals for a dignity guarantee concerning the nursing and care of elderly women and men. The purpose of the dignity guarantee will be to make clear to all concerned what caring services for the elderly must offer and what elderly persons and their next-of-kin are entitled to expect when they find themselves in need of elderly care. The investigator's report was submitted on 31st May 2008. In 2006 a special delegation was appointed to observe and analyse the need for and development of housing for the elderly. The delegation is to propose measures capable of influencing and encouraging the development of housing and accommodation adapted to the needs of the elderly, both in the ordinary housing market and in special forms of housing accommodation. Finally, a special investigator (remit: Professional requirements in the care of the elderly) is to put forward, not later than 30th November 2008, a draft national strategy for competence supply in municipally funded caring and nursing services for elderly women and men.

Question 3

Municipal care of the elderly

Table 1. Home-help services and special housing accommodation for men and women respectively aged 65 and over, 2003-2007. By numbers and percentages of population in the same age group.

	Home-help services		Special housing accommodation	
Year	Women	Men	Women	Men
2003	89,700 (10.1%)	38,300 (5.7%)	78,000,(8.8%)	32,900 (4.9%)
2004	92,400 (10.4%)	39,900 (5.9%)	73,800 (8.3%)	31,000 (4.6%)
2005	93,900 (10.5%)	41,100,(6%)	70,600 (7.9%)	29,800 (4.4%)
2006	97,100 (10.8%)	43,200,(6.2%)	69,400 (7.7%)	29,300 (4.2%)
2007	105,400 (11.6%)	47,900,(6.7%)	66,800 (7.4%)	28,100 (4%)

* As from 2007, also including persons with meals on wheels and/or snow clearance.

Source. National Board of Health and Welfare.

The number of persons over 65 receiving elderly care in the form of special housing accommodation or home-help services totalled approximately 240,000 per annum between 2003 and 2006. In October 2007 approximately 249,000 persons were either receiving home-help assistance or living in special housing accommodation. A new procedure for collecting statistics in the elderly sector was introduced in 2007, which accounts for much of the change between 2006 and 2007.

The trend towards a growing proportion of elderly care to be provided in people's own homes in the form of home-help service continues. Between 2002 and 2007 the proportion of persons receiving home-help rose by about 23 per cent, from 125,200 o 153,700. During the same period the number living in special housing accommodation

fell from 115,500 to 95,200, i.e. by 18 per cent. In 2007 upwards of 15 per cent of the population aged 65 and over was receiving home-help or living in special housing accommodation. In October 2007 approximately 203,500 persons aged over 80 were receiving home-help or living in special housing accommodation, which is 38 per cent of all persons in this age group. The proportion of persons aged 80 and over receiving home-help or living in special housing accommodation has not changed since 2002. The higher average life expectancy of women and the fact of elderly women more often living alone than elderly men means that a majority of the persons receiving assistance through municipal caring services for the elderly are women. Women make up approximately 70 per cent of those receiving home-help or living in special housing accommodation, and have done so for the past five years.

Table 2. No. persons aged 65 or over at 1st October 2007 awarded certain inputs under the Social Services Act, and the number of persons aged 65 and over receiving municipal health care under HSL in September 2007

Input	Women	Men	Total*
Security alarm in ordinary housing	106,000	38,600	145,000
Daytime activity	6,800	3,800	10,600
Short-term care/accommodation	5,700	5,300	11,000
Contact person/family	450	250	700
Municipal health care	98,200	47,600	146,900

* Totals also include persons whose full national registration numbers are lacking and who, consequently, cannot be assigned by gender.

Source: National Board of Health and Welfare

Security alarms for elderly persons in ordinary housing are a commonly occurring arrangement, and some 145,000 persons had been awarded financial assistance for security alarms at 1st October 2007. The number of persons receiving short-term care has been relatively constant since 2000, but between October 2003 and October 2007 the number of residence days in short-term care rose by about 12 per cent. This means that fewer persons are staying for progressively longer periods in short-term care. Decisions concerning daytime activity for elderly persons under the Social Services Act fell from just under 15,500 in 2000 to just over 10,600 in 2007. At the same time, daytime activities are also provided on a drop-in basis with no award being necessary, and the extent of these activities is not known. Altogether some 146,900 persons aged 65 and over received municipal health care some time during September 2007, and 67 per cent of them were women.

The proportion of inputs in elderly care performed by private care providers rose from 9.5 per cent in 2000 to 12 per cent in 2006. The figure for 2007 was also 12 per cent. It is slightly more common for special housing (14 per cent) to be operated under private auspices than home-help services (11 per cent).

Next-of-kin support

Very limited data are at present available concerning various measures of direct or indirect support to next-of-kin. The data which have long been available in the official

statistics concerning the numbers of persons awarded short-term housing accommodation, daytime activities and next-of-kin grants, plus numbers of next-of-kin employees. The data collection procedure for national statistics in the social service sector has been greatly changed during the year. As from 2007, individually related data (i.e. data based on national registration numbers) are being collected, which will make possible new and wider analyses of social service statistics. The change also implies certain possibilities of shedding light on support to next-of-kin, limited to persons warded assistance in the form of homehelp and referring to "relief of next-of-kin in the home".

This represents a substantial improvement as regards particulars concerning the number of persons obtaining relief in the home. The following table shows numbers of persons awarded daytime activity and short-term housing accommodation, but it is unclear to what extent the inputs refer to relief of next-of-kin.

Table 20. No. elderly persons awarded, respectively, daytime activity and short-term housing accommodation at 1st October, 2000-2007

	2000	2001	2002	2003	2004	2005	2006	2007
Daytime activity	15,843	14,314	12,965	12,677	12,505	12,191	12,752	10,515
Short-term accommodation	8,398	8,503	9,082	8,889	9,039	8,662	8,963	9,695

Source: National Board of Health and Welfare. Vård och omsorg om äldre. Socialtjänststatistik för åren 2000-2007 (8, 9)

The number of persons awarded short-term housing accommodation shows a slight year-on-year increase (8 per cent approx.). On the other hand the number of persons awarded daytime activity declined considerably between 2006 and 2007. This decline coincides with the reorganisation of the procedure for gathering statistics. It is unclear in what way, or indeed whether, the change of procedure accounts for the difference. Between 2002 and 2006 the number of persons awarded daytime activity remained fairly constant, declining in 2007 by upwards of 2,200 or nearly 1§8 per cent. Developments over the seven-year period can serve as a starting point for discussing how availability is changing. Where short-term accommodation is found, an increase appears starting in 2005, peaking in 2007 at the highest level since the millennium shift. Other changes in care and nursing of the elderly, e.g. fewer places in special housing accommodation, are liable, however, to reduce the possibilities of relief in short-term housing, because many of the available places are occupied by elderly persons waiting for a place in special housing accommodation
Social service statistics also show the number of persons receiving next-of-kin grants and the number of next-of-kin employed as in-family carers.

Table 21. No. persons and no. municipalities with next-of-kin hiring and next-of-kin grants at 1st October, 2000-2007

	2000	2001	2002	2003	2004	2005	2006	2007
Persons hired as next-of-kin	2,375	2,139	2,081	2,002	1,856	1,764	1,881	X**
Municipalities with next-of-kin employees	-*	216	212	208	196	194	189	X**
Persons with next-of-kin grants	4,619	4,978	5,513	5,547	5,280	5,279	5,162	5,246
Municipalities with next-of-kin grants	-*	150	150	153	143	140	131	120

** No figure available for 2000. ** No data on next-of-kin hiring collected in 2007.*
Source: National Board of Health and Welfare. Vård och omsorg om äldre. Socialtjänststatistik för åren 2000-2007 (8, 9)

The numbers of next-of-kin employees, insofar as they are traceable, diminished year by year until the terminal year, 2006, when the number again rose slightly (by about 7 per cent). Between 2000 and 2007 the total number of persons with next-of-kin grants rose by just over 600 persons or nearly 14 per cent.
In the case of persons awarded home help, the municipalities are required to particularise the nature of assistance for each recipient. Just over 3,400 persons out of all those awarded home help in ordinary housing were awarded relief of a family member in the home (solely or else combined with some other type of input).

Services
No statistics are available at national level.
Investment support
The National Board of Housing, Building and Planning reports that up to and including 24th August 2008 there had been 127 applications for investment support, of which 83 had been granted while a further 44 cases were pending. The cases decided involved 258 dwelling units and a total award of MSEK 290. The cases pending involve 1,425 dwelling units and a total of MSEK 168 applied for. Altogether, then, the sum total of applications decided and pending is 3,953 dwelling units and MSEK 458 in investment support.
Incentive grants to the municipalities in 2006, 2007 and 2008
The report of the National Board of Health and Welfare for 2007 shows 70 per cent of the funding to have been paid to municipalities and 30 per cent to county councils. This funding has enabled the mandators to hire personnel with competence which has been partly or wholly lacking, primarily dieticians and rehabilitation staff. The funding has also made it possible to provide basic staff with training, e.g. concerning diet,

pharmaceuticals and rehabilitation working methods. The report on incentive grants for 2007 shows rehabilitation, medication reviews and dementia care to be the three fields in which both municipalities and county councils deploy most funding.

The Competence Steps

The final report from the Competence Steps shows the scheme to have communicated new skills to a large proportion of employees through workplace-related learning. Some 118,000 persons employed in the care and nursing of the elderly have, one way or another, taken part in the Competence Steps. This is 62 per cent of total personnel strength. About 11,000 participants were women and 7,000 men. Roughly 101,000 of the participants work as nursing assistants or assistant nurses. The commonest forms of development and learning have been tutoring, reflective interviews, quality development, and competence for change and development. Validation and basic training are also being conducted on a considerable scale.

Open comparisons

In 2007 the Government instructed the National Board of Health and Welfare, acting in collaboration with the Swedish Association of Local Authorities and Regions, to develop a national system for open comparisons of quality, expenditure and efficiency in municipal care and nursing of elderly persons and in county council home nursing. The aim is to arrive at a national picture of the care and nursing of elderly persons, for the findings to be fed back into the improvement of operations, and for them to serve as input data for the national control of care and nursing of the elderly. The comparisons are also to serve as a basis for users' free choice of providers of elderly care. The National Board of Health and Welfare has also been instructed to carry out national user surveys of the care and nursing of the elderly, the purpose being to monitor, in a user perspective, the quality and availability of care and nursing for elderly women and men at national level. The results constitute an important foundation for ongoing development initiatives at both local and national levels.

Information in respect of conclusions 2005

Legislation against age-related discrimination

A new Discrimination Act enters into force on 1st January 2009. The ban on discrimination contained in the new Act covers a large part of the life of the community, and also many situations to which at present no prohibition applies. Two new grounds for discrimination – transgender identity or expression and age – are being introduced.

A review has been completed of the rules concerning proxies, e.g. for adults in need of assistance. In 2004 the Commission on Guardians, Trustees and Receivers presented its final report, entitled (in Swedish), Issues concerning guardians and proxies for adults (SOU 2004:12). The proposals contained in the report are currently being processed at the Government Offices.

No. pensioners with full guarantee pension
Upwards of 150,0000 persons (some 130,000 of them women) in December 2006 received full guarantee pension. The corresponding figure for December 2007 was nearly 140,000.

No. pensioners with maintenance support for the elderly
Almost 10,500 persons (just over half of them women) were receiving maintenance support for the elderly in December 2006. The figure for December 2007 was close on 11,000.

Updating of the system of user charges in caring services for the elderly
Municipal systems concerning charges for nursing and care of the elderly and persons with functional impairment have grown more uniform following the introduction of new provisions in 2002. There are data suggesting that availability in this perspective has improved for elderly women and men with low incomes. The purpose of the new provisions was to reduce the great differences between municipalities, to strengthen safeguard for the individual against unreasonably heavy charges and low reserve amounts, and to achieve a more uniform computation of charge-related incomes, as well as strengthening legal safeguards for the individual. According to the evaluation presented by the National Board of Health and Welfare in the spring of 2007, the purpose has to a great extent been achieved. The provisions on income computation, charge capping and reserved amounts are being complied with. User charges cover approximately 4 per cent of the total cost of municipal care and nursing for the elderly. In 2006 the maximum permissible charge for home-help services was SEK 1,588 per month. The proportion of women stating that they refrain from applying for home-help services because of the charge was halved between 2003 and 2005, falling from 23 to 11 per cent. The corresponding figure for men did not change and was 9 per cent on both occasions. Taking both sexes together, the proportion fell from 21 to 10 per cent. According to the National Board of Health and Welfare, the reduction is probably due to the municipalities having grown more proficient at informing people about the system of charges and to care recipients having become better informed, e.g. about the reserve amount as a safeguard against excessive charges. More people were paying charges for their home-help services in 2007 than three years previously, due probably to rising incomes. In 2004 one out of every three recipients of home-help services was exempted from charges. By 2007 that proportion had fallen to one in five.

Maximum cost thresholds for home-help services and calculations of the same
Individual persons are entitled to retain from their income the wherewithal for actual housing costs and a minimum amount for other reasonable living expenses. The minimum amounts are geared to the price-related base amount and are adjusted annually. The current (which year) minimum mount is SEK 4,421 per month for single persons and SEK 3,704 per month for husband and wife together. A higher minimum amount can be fixed for the individual as a consequence of additional expenses. Of the moneys then remaining to the individual, the municipality may levy a charge for home help. The charge for 2008 may not exceed SEK 1,640 per month. About 20 per cent of home-help recipients do not have sufficient income to pay the charge.

Statistics concerning the number of forms of special housing accommodation, no. employees in relation to no. applications.
Reference is made to previous reports.
There are no statistics at national level of the number of institutions and their staff on the availability of places in relation to the number of applications.

Work is currently in progress at the National Board of Health and Welfare to develop the statistics concerning measures for children and young persons, and the intention is for statistics also to begin to be compiled in that field concerning the number of applications and reports. In the elderly sector, the question of compiling statistics concerning the number of applications has not been at the centre of attention, but it is possible that the ongoing development work in child and youth statistics can also influence other statistical fields within the social services.

Consequence of the Commission on unenforced decisions and judgements pursuant to the Social Services Act
The legislation was tightened up with effect from 1st July 2006 in order to intensify stipulations for the effectuation within a reasonable time of favourable decisions under the Social Services Act, with a view to enhancing legal security. The statutory amendment makes it the duty of the municipalities to report to the county administrative board, the municipal auditors and the municipal council the favourable decisions which have not been effectuated within three months. The municipal auditors have been given wider powers of examination. In addition, a sanction charge has been introduced, as an ultimate recourse for bringing pressure to bear to secure the effectuation of a favourable decision within a reasonable time. Reference is also made to the reply concerning article 14.

Guidelines on medication with tranquillisers in special housing accommodation
There are no guidelines at national level.

Foreign-born persons in special housing accommodation in need of ethnically adapted inputs
The only statistics available are population statistics broken down by age and country of birth. One assumption is that the number of elderly persons in need of ethnically adapted inputs will increase as the number of elderly persons born abroad increases. Altogether in 2005 there were 166,000 persons born abroad, which was more than 30,000 up on the figure for 1998.

In 2006 the National Board of Health and Welfare together with the Swedish Association of Local Authorities and Regions carried out a questionnaire survey of elderly persons belonging to ethnic minorities. Among other things they were asked whether the municipality had, or expected to have, users in need of ethnically adapted inputs. Just over half the country's municipalities replies that there existed, and another 8 per cent that there would exist within a three-year period, users with special

needs due to ethnic identity. In the survey the municipalities were asked to state the extent to which they could accommodate these needs. As regards accommodating the need for staff who can speak the user's language and have cultural competence, only about one municipality in three can accommodate the need. In a questionnaire survey in 2006 concerning municipal catering activities for the elderly, 80 per cent of municipalities in Sweden stated that they could offer diet adapted according to religion and culture in ordinary housing, and 86 per cent that they could do so in special housing.

Provided that the extent of needs among elderly persons born abroad does not clearly differ from the needs of elderly persons born in Sweden, there is no clear indication of elderly persons born abroad being under-represented as users of public inputs. If there is a high level of consensus between the way in which the municipalities asses the situation and the way in which the users perceive the inputs, however, there is a manifest risk of many elderly persons belonging to ethnic minorities receiving inputs, but inputs of poor quality, e.g. in the sense of people having difficulty in communicating with the provider of the inputs and of the provider not having specific cultural competence.

Next-of-kin hiring and next-of-kin grants are nationwide the most widespread measures for responding to users in need of ethnically adapted inputs. According to a study in 2006, the number of next-of-kin employees supporting close relatives in need of ethnically adapted inputs was nearly 1,300 persons, i.e. over 70 per cent of all next-of-kin employees in Sweden caring for elderly persons. This finding highlights the need for more knowledge concerning the situation for these next-of-kin.

Results of the prioritisation of health care for elderly persons in the national health care action plan adopted in October 2000
See subsequent question with reference to article 11.1.

New action plans focusing on health care for the elderly
No new action plan exists.

Article 30

Supporting documentation from S ST concerning 1, 2 and 3.

Question 1

The Swedish welfare system comprises universal health care, supportive measures within the social services,. social insurance affording financial security in the event of illness, functional impairment and old age and for young families. There is also a basic supplementary safeguard in the form of financial assistance.

The Swedish welfare system is general and includes the entire population. It is funded by means of obligatory charges and taxation. In this way everyone helps to finance welfare and everyone participates in it, not only the persons whose need is greatest. A

general system has large redistributive elements which equalise economic resources and living conditions. It effects redistribution between different groups in society, and it helps to equalise individual incomes between different stages of life. General welfare also includes support for the most disadvantaged groups in society.

The work strategy is an important principle of general welfare policy. Labour market policy is based on measures to promote the work and competence strategy and to achieve a more flexible labour market by increasing the employability of those who are without work, at the same time creating security for readjustment. The Equal Opportunities Act requires employers to facilitate the combination of gainful employment and parenthood by both male and female employees.

Social insurance provides income-related compensatory benefits for loss of earnings, e.g. benefit paid to parents when they stay at home from work in order to look after very young children (parental benefit), compensation to those prevented from working by illness (sickness benefit), compensation for permanently reduced work capacity (sickness compensation/activity compensation), compensation to persons injured or contracting illness in the workplace (work injury compensation) and old age pension. Several of these benefits also have a guarantee level for insurees with little or no income. The social insurance system also includes grants for various situations, e.g. child allowance and housing allowance. A general insurance system with income-related benefits has been chosen in preference to a system of low, minimum-based benefit levels. General systems afford the security of being able to retain a standard-pegged income during temporary interruptions of gainful activity due to illness, unemployment etc. , and in cases where a person has ceased working due to disability or old age. A general welfare system is not only less expensive to administer than a system of needs-tested benefits but, in the long term, also offers good distributive effects and a high level of legitimacy.

Responsibility for municipal residents receiving the help and support they need rests ultimately with the municipal social services. Financial support is the ultimate recourse for persons with temporary livelihood problems. Entitlement to financial assistance is examined on the merits of each individual case and the decision, in common with several other decisions under the Social Services Act, can be appealed in an administrative court.

Question 2

The Swedish welfare system has not changed during the period to which this report refers. The specific changes made to various enactments are described with reference to the relevant articles. See, e.g., the reply concerning article 12.

Question 3

The development of relative and absolute poverty furnishes information on the practical workings of the welfare system and on groups not receiving the financial security which the system is designed to give.

Relative poverty in Sweden has developed differently from absolute poverty. It has increased since 1994, due to a growth of income differentials, i.e. due to earnings rising more swiftly in middle and high than in low income brackets. Relative poverty in 2006 was nearly 11 per cent. In contrast to relative poverty, the proportion of persons with incomes below the absolute poverty line has been diminishing since the mid-1990s and in 2006 stood at 4.5 per cent. The proportion of persons receiving financial assistance has also declined, namely by over 44 per cent in the past ten years, and assistance receipts are lower today than they were at the beginning of the 90s. Young people's long-term dependence on financial assistance, however has remained virtually unaltered.

Both relative and absolute poverty vary from one group of the population to another. In 2006 the proportion of poor people was roughly three times as great among foreign-born residents as among persons born in Sweden, and this relation has been constant so far throughout the 21st century, as regards both relative and absolute poverty. Parallel, however, to an improvement in the employment situation for foreign-born residents, the proportion of poor people is declining. Large groups in an economically vulnerable situation are also to be found among persons with functional impairment, one reason being that many of them have never had the opportunity of entering the employment sector but are consigned to lifelong dependence on the social security systems.

Transfers in Sweden have a large redistributive effects, due above all to the comparatively large benefits paid to households with children. Just over 6 per cent or, in absolute figures, 130,000 of all children in Sweden in 2006 belonged to families whose available income was below the absolute poverty line, as against 18 per cent in the mid-90s. The proportion of children in households receiving financial assistance has also declined substantially. Only 6 per cent of all children live in households receiving financial assistance, which is half the figure for the beginning of the 90s. Relative child poverty, on the other hand, has developed differently. Some 15 per cent of all children in 2006 were living in families which can be termed relatively poor, and this proportion has grown in recent decades.

Children's living standards vary considerably according to the type of family they belong to. Poverty is greatest among children both of whose parents are foreign-born, but this poverty has been halved since the beginning of 2000. Children in single-parent families are considerably worse off financially than children whose parents are living together, regardless of whether the parent is Swedish or foreign-born. Relative poverty among single persons with children rose from 11 per cent at the beginning of the 90s to over 20 per cent in 2006.

Year	Absolute poverty[2]	Relative poverty 60% of available income (after social transfers)[3]	Financial assistance	Relative poverty 60% of available income **(before** social transfers)[4]
1991	5.5	6.8	6.9	
92	6.4	6.3	7.5	
93	7.4	5.9	8.1	
94	7.2	5.3	8.2	
95	9.8	6.4	8.8	
96	11.1	7.7	9.1	
97	10.8	7.8 (8)	8.8	
98	9.9	7.6	8.2	
99	7.9	7.6 (8)	7.1	
00	7.6	8.7	6.4	
01	6.4	9.4 (9)	5.8	17
02	7.1	10.2 (11)	5.4	29
03	5.8	9.1	5.1	-
04	6.0	9.5 (11)	5.3	30
2005	5.9	9.5 (9)	5.1	29
2006	4.7	10.6 (12)	4.4	29

Source: SCB, National Board of Health and Welfare and Eurostat.

[2] Defined as a threshold value for the income level which can be deemed minimal for keeping a family in food, housing, clothing, necessary medication etc. The definition is based on recommended norms for decisions concerning financial assistance. It is adjusted upwards so that the sum total will equal the same purchasing power over time, i.e. allowing for inflation. The threshold value also coincides on the whole with the level of financial assistance intended to secure a reasonable standard of living. Amounts vary from one municipality to another, since there can be differences in the level of costs.

[3] The indicator is defined as the share of persons with an equivalised disposable income below the risk-of-poverty threshold, which is set at 60 % of the national median equivalised disposable income (after social transfers).

[4] Share of persons with an equivalised disposable income below the at-risk-of-poverty threshold, which is set at 60% of the national median equivalised disposable income. This indicator is calculated before social transfers (original income including pensions but excluding all other social transfers) and after social transfers (total income).

Information in respect of conclusions 2005

Resources allocated for achieving the goals set in the national action plan against poverty and social exclusion in 2003

This account indicates the funding, over and above ordinary finance, which the Government has allocated for the implementation of reforms resolved on. The measures taken at local and regional level which are part of the responsibilities of the municipalities and county councils, and which have a vital bearing on many people's welfare, are not included in this account. The account is based on a review of Sweden's action plan against poverty and social exclusion in 2003-2005 and on the implementation and update report on measures taken which the Member States compiled in the spring of 2005.

A recruitment delegation was appointed during the period 2002-2004 to broaden recruitment for higher education and reach out to new target groups. During the period the delegation distributed MSEK 120 to nearly 100 recruitment projects. During the same period the Government allocated MSEK 10 to encourage universities and colleges to organise special education for immigrants with foreign postgraduate qualifications.

The main cause of child poverty is parental unemployment. Boosting employment has therefore been the Swedish Government's top priority for a long period. As from 2006 the Government has devoted MSEK 1,000 to increased maintenance support, child supplement for students and improvements to the proportion of the housing allowance constituting a special allowance for households with children.

Between 2005 and 2007 the Government operated a special scheme for improving the care and treatment of substance abusers. A total of MSEK 820 was allocated for the three-year period. Persons with mental functional impairment are another group which has received attention. To improve the possibilities of access to necessary care and support and to encourage the development of activities of various kinds., the Government allotted MSEK 500 in 2005 and a further MSEK 200 in 2006.

During the period 2003-2007 the Government focused attention on the situation of young persons subjected to pressure, threats and violence by next-of-kin with reference to the honour of the family. Altogether the Government allotted MSEK 180 for measures to ease the situation of these young persons.

As regards measures to combat homelessness, during the period 2002-2004 the Government allotted MSEK 30 to encourage and support the work of municipalities and NGOs. The National Board of Health and Welfare has since continued this work and for the period 2005-2007 the Government allotted a further MSEK 50.

Outcomes of efforts under the national action plan for health care (2001-2004) to improve health care for socially disadvantaged groups

See follow-up question with reference to article 11.1.

Special support for pupils with special needs

Pupils with functional impairment are mainly to be found in ordinary compulsory and upper secondary schools. Responsibility for schools in Sweden is to a great extent delegated to municipalities and independent mandators. These are responsible for all pupils being given the support they need in order to achieve the national goals. Pupils who, owing to certain kinds of functional impairment, are not capable of achieving the goals within the ordinary education system are, however. offered education in compulsory school for pupils with learning disabilities or in special school. The Government has initiated several reforms to strengthen the educational achievement of those pupils who have most difficulty in achieving the goals of education. The measures taken include clearer objectives, better follow-up of pupils' achievement and improved teacher education.

Adults with functional impairment can strengthen their position in the community and working life by studying, e.g. in municipal adult education (Komvux) or popular education. A new structure of authority for the school sector is being implemented so as o optimise goal achievement in the activities concerned.

A number of changes have been made concerning support for pupils with special needs. The National Agency for Special Needs Education and Schools was established on 1st July. The National Agency for Special Schools and the Swedish Institute for Special Needs Education were abolished at the same time and their activities transferred to the new authority, as were the activities of the National Agency for Special Educational Support (SISUS) at the National Board of Health and Welfare.

A single authority enhances the prospects of co-operation experience interchange between the various staff categories concerned. The quality of supportive activity will also benefit from its amalgamation with education activities in special schools. Since the Government took office, an Education Drafting Committee has been working on the draft version of a new Education Act. The intention is for a departmental memorandum to be circulated in a wide-ranging consultation process as a basis for the Bill which the Government plans to put before the Riksdag in 2009. This is a further important possibility of ensuring quality and availability for pupils with functional impairment.

State support to local activities for children and young persons in sport totalled MSEK 674 in 2005. In addition the State gave a total of MSEK 1,000 to the sports movement during the period 2003-2006 during the *Handshake* special initiative to reach new groups of children and young persons by restraining charges so that no child will be excluded by high costs.

Wider preschool entitlement for children of unemployed persons and immigrants

Since 2002 it has been the duty of the municipalities to offer preschool activities for at least 3 hours daily or 15 hours per week to children whose parents are unemployed or on parental lave in order to look after another child. As from January 2003, all children must be offered public preschool from the autumn term in which they are 4 years old. Public preschool is free of charge and must comprise 525 hours per annum. The number of children enrolled in preschool has risen during the period under consideration. The importance of various background factors (e.g. municipality of residence, parental employment and foreign background) influencing preschool attendance has diminished. Availability has above all improved for children whose parents are on parental leave with younger siblings and for children whose parents are unemployed.

Improved access to culture for all

Cultural aspects of the implementation of article 30 i

General legal framework

Cultural policy initiatives in Sweden are not regulated by statute, but there are cultural policy aims, seven in number, which have been defined by the Government and Riksdag. These policy aims are not operationalised in the sense of definite outcomes being discernible in statistical terms or suchlike. Instead the policy aims serve as overarching guidelines. Relevant aims in this connection is the aim of safeguarding freedom of expressions and creating genuine opportunities for everyone to exercise it, and the aim of enabling everyone to have the opportunity of taking part in cultural life and cultural experiences and themselves engaging in creative activity.

Measures taken

Between 2003 and 2007, in order to guarantee broad and universally available cultural amenities for everyone in Sweden, the State continued supporting both permanent infrastructure and free agents in many cultural spheres by means of funding allocations and grants. The main responsibility for the regional infrastructure to which the State pays grants devolves on the regions.

Through grants from the Swedish Arts Council the State supports a wide range of music, theatre, dance, literature and periodicals. One important purpose here is to support freedom of expression and democracy. The measures taken are mainly of a general nature, i.e. not focusing on particularly disadvantaged groups. On the other hand high priority is given to measures having children as their target group. A considerable proportion of the support given to free agents, e.g. drama groups, refers to performances for children. In this way children in disadvantaged families are also reached.

During 2007 the Government drafted proposals for a general long-term initiative entitled Creative School, which is presented in September 2007 in its Budget Bill. The Riksdag has voted MSEK 55 for 2008. The Creative School project refers to pupils in grades 7-9 and is intended to facilitate improved interaction between culture and

schools for the benefit of all pupils. The project is administered by the Swedish Arts Council.

Functional impairment can augment the risk of social exclusion. The Swedish Arts Council is tasked with promoting the availability of cultural amenities, e.g. physically, to all comes within the cultural sector. During the autumn of 2007 preparations were made for a Nordic seminar on accessibility to the performing arts. (*The seminar took place on 14th-15th February 2008 and resulted in the Hallunda Declaration, calling on all performing arts managers in the Nordic area to hasten the process of accessibility improvement.)*

Gender equality issues, mainly in the performing arts, were also highlighted by the Government in 2007 and a number of pilot projects are in progress.

Presentation of findings

Sweden does not at present have any good statistics on participation in cultural amenities by persons living in a position or social exclusion or poverty, or in danger of so doing, and their families. Utilisation of cultural amenities by a number of disadvantaged groups can, however, be roughly measured and compared with participation by other groups through various surveys of cultural habits. Disadvantaged groups can, for example, include those subjectively experiencing poor health, persons who have taken early retirement or are long-term unemployed, and persons who were born in another country.

Persons in poor health are defined as a group in the national SOM survey which was carried out in 2007 by the University of Göteborg (Gothenburg). The findings show persons considering themselves to be in poor health to have visited public libraries or participated in study circle/cultural activities to the same extent as those professing to be in good health. On the other hand those in poor health have participated far less than those in good health in cultural amenities in the form of the cinema, museum visits, theatre visits, art exhibitions, concerts or dance performances. (A report on the SOM survey can be accessed on the Swedish Arts Council website.)

The group comprising "permanent disability pensioners and persons who have been long-term unemployed" is described in the so-called ULF survey which was carried out by SCB (Statistics Sweden) in 2006-2007. Figures, as yet unpublished, show for example that this group went to the theatre or concerts about half as often as the population on average. This relation has been fairly stable ever since 1982/93.

The ULF survey shows the cultural habits of persons born in other countries to be much the same as the average of the whole survey.