Introduction

The National Public Health Committee [Nationella folkhälso-kommittén] was set up in the spring of 1997 at the request of the Government and was given the task of drawing up national goals for public health. The terms of reference given to the Committee by the Government stated that the goals should act as guidance for initiatives to be taken to promote public health, prevent illness, reduce risks to health and prevent premature and avoidable disability, ill-health and death.

As outlined in Chapter 1, the Committee has comprised members of the Swedish parliament and a number of advisors and experts from public authorities, local authorities, the research world and various different organisations, representing for example immigrants, pensioners, the disabled and trade unions.

During the time it has been engaged in its task the Committee has produced two interim reports and this final report. In addition 19 scientific reports with supporting information and 10 discussion documents regarding current public health issues have been produced. The Committee has put great emphasis on ensuring that a broad democratic process took place before arriving at the final proposals for the public health goals.

Our two earlier interim reports have been circulated for comment to large sections of Swedish society – to everyone from government authorities to small interest groups. The first interim report was sent for comment to over 500 players, the second report was sent to 370 players. In order to ensure that various groups of disabled people were also able to participate and read our material, the reports and a variety of other information were produced in various versions, for example simple Swedish, Braille and talking books.

In this final version entitled Hälsa på lika villkor – nationella mål för folkhälsan [Health on Equal Terms – National Goals for Public Health] (SOU 2000:91) we present proposals for 18 national goals for public health and a number of sub-goals and indicators. 14 of the goals concern determining factors for health, connected with socio-economic conditions, environmental conditions and lifestyles, but four of the
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goals concern the quality of the infrastructure for work undertaken in the field of public health – the role of the health service, the need for a co-ordinated approach to public health initiatives, long-term investment in research, the development of new methods and education, as well as factual information about health. The goals are characterised by the fact that they concern the determining factors for ill-health, and that the measures in many cases form integrated parts of the country’s welfare policy.

This English version of the final report does not outline all the chapters, as some of them would not be of interest to international readers. The focus of the translation is the task set by the Government, and the Committee’s methods of working (Chapter 1), the Committee’s starting point and priorities for goals and action to be taken (Chapter 4), its vision and overall guidelines for good health on equal terms (Chapter 5) and national goals for public health (Chapter 6). The translation begins, however, with a short summary of all the chapters.

Chapters 2 and 3, which have not been translated, provide a review of health development, a breakdown of the health situation all over the country and our assessment of the various challenges in the way society is developing, which future health policy must concentrate on in order to minimise the negative effects of these developments.

Chapter 7, which has not been translated either, provides an economic assessment of the resources required to improve the infrastructure for public health work and health information. It is our assessment that these initiatives will cost approximately SEK 300 million per year for a period of five years. The Committee proposes that the State should provide these financial resources.

An appendix to the report, which has not been translated, outlines the indicators which the Committee believes could be used to monitor the various sub-goals, and outlines which players should have responsibility for the respective indicators.

The politician members on the Committee have determined the wording of all the texts. However, the advisors and experts on the Committee have been given the opportunity to make special remarks, if they have a different opinion. The politician members on the Committee come from the seven political parties represented in Sweden’s riksdag (Parliament). The report has the support of a very large majority. Only one reservation has been made about the report’s conclusions, and that has come from the Committee member representing the Moderates [Moderata Samlingspartiet.] The Committee member from the Liberal Party [Folkpartiet liberalerna] has made a specific comment – although not a formal reservation – expressing doubt about the need for a law requiring district councils
and county councils to draw up health plans. The member representing The Left-Wing Party [Vänsterpartiet] has made a specific comment – although again, not a formal reservation – that she believes that a reduced gap in incomes ought to have been a specific goal proposed by the Committee, rather than reduced poverty. The advisor from the Swedish Association of Local Authorities [Svenska kommunförbundet] has expressed her doubts in a special statement about the introduction of a law concerning health planning.

An appendix to the English version provides the names of the members of parliament, advisors, secretaries and experts who have formed part of the Committee. In addition, many other experts have been involved in the work producing supporting information.

The Committee presented its proposals for national goals for public health to the Minister of Health and Social Affairs on 23rd October 2000. A comprehensive appendix to the proposals has been completed during December. This shows the background information and scientific references which the Committee has based its proposals on. The Government has made it clear that it plans to circulate the proposals for national goals for public health for comment. The Government’s aim is to present proposals to the Swedish parliament regarding tobacco during the spring of 2001. It is intended that proposals regarding the remaining goals on public health will be presented to parliament during the autumn of 2001.

Stockholm in December

Margareta Persson  Bernt Lundgren
Chairman           Principal Secretary
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Summary

Chap. 1  Tasks and working method

The National Committee for Public Health has been charged with setting national goals for public health and also strategies for achieving these goals. According to the Directive these goals should be based on a scientific foundation. The proposed goals and measures are set out in this report. A number of experts and researchers within various areas have collaborated on the development of these goals. The Committee has published 19 different supporting reports with their scientific substantiation.

The Directive also states that the Committee’s task is to work in an outward looking and process-orientated manner. Two part-reports have been submitted and the Committee has sent these out for review on its own initiative to almost 500 different bodies. Ten discussion texts have been developed on topics which are important from the health point of view. Conferences and seminars have been arranged. The Committee has had discussions with politicians and civil servants at State and municipal level, with research workers, and with representatives of different organisations and trades. The Committee has further invited different players to actively monitor the work during the course of the investigation. The Committee chairman has been employed full-time and has been active in a large number of externally orientated activities at local and regional level.

Chap. 2  Health development in Sweden

This chapter reports on health development in Sweden. Life expectancy has been steadily increasing and still shows no sign of stagnation. The risk of death has declined for all age groups. Especially the decline in cardio-vascular disease and injury has contributed to increased life expectancy. Even if survival has improved, other dimensions of ill health have shown that a positive development for health cannot be taken for granted. In middle-aged and older people health has improved, but the self-estimated health of young people is
no longer good. The young are showing increasing signs of three
groups of symptoms: allergies and other oversensitivity, aching limbs,
and mental symptoms in the form of e.g. tiredness, sleep disturbance
and depression. The section offers a description of the most extensive
national illnesses. An important public health aspect is that social
differences in health still remain. People of lower education and of
working class origin run a considerably higher risk of being struck
down by illness and premature death than white-collar workers with a
higher level of education. The consequences of ill health moreover are
much more severe for the working class than for other groups. There
are also clear health differences between the sexes and between
different ethnic groups.

Chap. 3 Some important lines of development in society and the
determining factors for health

This chapter describes the determining factors for health and important
characteristics of social development which can affect it. The proposed
goals for public health are based on these determining factors. People’s
circumstances and life habits are contributory causes of illness, injury
and other forms of ill health. The focus of public health policy should
be on influencing these causes within different social sectors and, using
different methods, the incidence of ill health. The changes taking place
on the labour market, in welfare policy, the situation of families with
children, consumption patterns and access to health care are developing
tendencies which are discussed in the chapter and which can influence
health.

Chap. 4 The basis for prioritising goals and measures

When the Committee formulated its goals, the basis was a
humanitarian view of Man, which means that all people are of equal
worth and that the individual should be free to act. An important
principle for the report is a vision that all people should have an equal
chance to realise their efforts. For this to be possible it is necessary that
the major differences between the health of different groups should be
reduced. In the report the Committee has chosen not to define what
health means. Health is a subjective assessment where each individual
has his own view. The proposals submitted by the Committee aim to
prevent ill health which restricts the freedom of the individual.
Chap. 5 Vision and overarching guidelines for good health on equal terms

The vision proposed is to achieve good health on equal terms. The Committee has formulated six overarching guidelines for socio-societal development. These overarching guidelines then form the basis for the national goals of public health.

1. Strengthening the social capital
By social capital is meant the common ground between people in the near environment and the circumstances which largely promote solidarity in society, and also that large differences in income and inequality of living conditions must be countermanded.

2. Growing-up in a satisfactory environment
The foundation for health is laid during childhood. For all children and young people to have an equal start it is important for society to support parents and the social network surrounding the child.

3. Improving conditions at work
Satisfactory conditions at work are basic to health. This means that society should strive towards full employment, and a satisfactory mental and physical working environment and should combat exclusion and discrimination.

4. Creating a satisfactory physical environment
Clean water, drainage, clean air and a non-toxic environment are essential for good health. The effect of different products on health must be studied. The environment in the form of countryside and recreational facilities has an important effect on people’s opportunities for recuperation.

5. Stimulating health-promoting life habits
People’s life habits can be affected by strengthening the individual to make good choices. Society should act on environments where unhealthy habits are created. Out of solidarity with those who are particularly vulnerable, certain restrictions must be imposed as regards access to e.g. alcohol and tobacco.
6. Developing a satisfactory infrastructure for health issues
The social support system for the promotion of good health is essential. It is important for the State and also the district and municipal councils to develop health-promoting projects. Special responsibility rests with health service.

Chap. 6 National goals for public health

The National Committee for Public Health has proposed 18 health-political goals aimed at the determining factors for health and the infrastructure needed to influence health. This chapter starts with a description of how the different goals affect mental health, diseases and injuries. Each goal is set out in detail in the form of sub-goals. All goals include certain measures linked to different players and indicators which show how the various goals could be monitored.

Goal 1 A strong sense of solidarity and feeling of community in society
Health is affected by the nature of social relationships at the social level and through the social bonds binding people together. A society characterised by a common purpose between people has a high degree of financial and social cohesion and by living conditions which do not differ essentially between different social and ethnic groups. Reduced poverty, reduced segregation in housing and compensatory resources for children and young people in socially disadvantaged housing areas are urgent sub-goals for the promotion of health.

Goal 2 A supportive social environment for the individual
People’s health is formed through an interplay between individual circumstances and the surrounding social environment. Isolation, loneliness and insecurity are risk factors in health. Experiencing participation, having an opportunity to influence one’s life and having a feeling of cohesion are factors which make people less vulnerable. One important task is to promote a supportive environment in the community and give people an opportunity to participate in voluntary organisations and in educational and cultural activities.

Goal 3 Safe and equal conditions in childhood for all children
People’s physical and mental health is formed in childhood. Promoting a secure bond between child and parents has an influence on mental health. The social and financial circumstances which the parents live under influence the child’s health. Almost half the cases of ill health in
children can be put down to the family’s circumstances. For children to be given a good childhood, health-promoting nurseries and schools are important.

**Goal 4 A high level of employment**

Gainful employment is the most important source of resources for most people. Work is an important basis for people’s identity and their social life, and consequently also affects health. Unemployment affects health. The Committee therefore wishes to emphasize the significance of full employment, no discrimination against immigrants and the disabled on the labour market, and opportunities for all to experience life-long learning.

**Goal 5 A healthy working environment**

The situation at work, its location in time and place and conditions of employment are going through major changes. That all changes, for good or ill, affect people’s lives and health is obvious, but knowledge is insufficient. The rapid increase in stress-related, long-term absences from work can constitute a threat to public health in the long term. The Committee’s goal of achieving a healthy working environment concerns the adaptation of physical and mental demands of work to the circumstances of the individual, increased influence and ability to develop at work and reduced overtime. In order to acquire further knowledge about the significance of structural change at work for health, the Committee has proposed that a Commission on Working Life be appointed.

**Goal 6 Accessible green areas for recreation**

To enable people to recharge their batteries and be able to develop new thoughts and impulses, opportunities are needed for recuperation through rest and recreation. It is common knowledge today that the countryside is a great healer for various stress conditions. The Committee wishes therefore to draw attention to the need for noise-free, safe green areas near dwellings, stimulating nurseries and schools and playgrounds for children, and a satisfactory outdoor environment at special dwellings for the elderly and the disabled.

**Goal 7 A healthy in- and outdoor environment**

Factors worthy of special significance as regards the indoor environment are the occurrence of radon, damp and insufficient ventilation, and also exposure to passive smoking. As regards the outdoor environment, the Committee would stress the importance of a
well-designed environment, safety from radiation, fresh air, clean water and a non-toxic environment according to the proposals of the Environmental Targets Committee.

**Goal 8 Safe environments and products**

It is important for health to create environments which reduce the risk of injury. Injuries can result from inadvertent events such as accidents, but also from deliberate events such as violence, suicide and attempted suicide. It is first and foremost injuries due to accidents which can be prevented by means of safe environments, but also the incidence of suicide and violence can be affected to a certain extent through the design of the environment. The Committee would thus like to draw attention to the importance of a safe home environment, traffic environment and other public environments. Moreover, reduced use of products which are injurious to health and are allergenic is essential. Suicide prevention is an especially important part of public health work. With considerable effort in various social areas it should be possible to prevent suicide.

**Goal 9 More physical exercise**

The body is dependent on physical activity to be healthy. In today’s society we move too little. Our increasingly sedentary existence is a threat to health in the long term. A half-hour’s moderate physical activity daily is enough to reduce the risk of many illnesses. It is therefore of importance to increase physical activity at school and at the workplace. Society has a special responsibility to ensure the elderly can get out and that the disabled are able to move on their own terms.

**Goal 10 Healthy eating habits**

Food and our eating habits influence our health. A correctly balanced diet is of great significance for health both by promoting and preserving good health and by preventing illness. Most people today are aware of the importance of eating a varied diet, with a reduced fat and sugar intake and increased consumption of fruit and vegetables. Society has a great responsibility to ensure that food is safe, that food markings function and that there is a wide gamut of goods throughout the country. In addition, it is important for everyone to have access to impartial information about the link between eating habits and health, and also that meals served within the framework of publicly-financed activity is good and healthy.
Goal 11  Safe and confident sexuality
Sexuality is an important factor in people’s lives and is of importance for enjoyment and joie de vivre. Safe sexuality free from prejudice, discrimination, compulsion, violence and risk of disease is healthy. The Committee considers it important that negative consequences of sexuality such as sexually transmitted disease and unwanted pregnancy be counteracted and that no-one should be discriminated against due to sexual orientation.

Goal 12  Reduced tobacco consumption
Tobacco is one of the great health risks in Sweden. Every fourth smoker dies in middle-age as a result of smoking, and a large number of diseases are due to it. The negative effects of smoking also impact on people in the surrounding area. In Sweden around 500 deaths a year can be attributed to passive smoking. The Committee considers that efforts should be made to strongly reduce smoking, that everyone should enjoy a tobacco-free childhood and that no one should be forcibly exposed to smoke in his environment against his will. The Committee is therefore drafting a bill for a licensing system for tobacco retailing, and for a change in the tobacco laws so that restaurants and other catering establishments become smoke-free in common with other public areas.

Goal 13  Reduced harmful alcohol consumption
A large part of the population find it enjoyable to drink alcoholic drinks. Over-consumption of alcohol leads to medical injury however and social problems of considerable extent. Alcohol constitutes one of the major factors in violence and accidents, and also in hospital care and early retirement. EU membership has changed what used to be important parts of our alcohol policy, and Swedish society faces a major challenge in meeting the greater access to alcoholic drinks. Increased information about the injurious use of alcohol, sobriety and efforts directed at children and young people may in the long term reduce total consumption and consequent injury.

Goal 14  A drugs-free society
It is urgent that access to drugs be reduced so that fewer young people will use or try them. In order to achieve this goal preventative work must be reinforced. The Committee would stress the need for the Swedish State to combat the on-going change in attitudes jointly with other countries and increased access to drugs.
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Goal 15  A more health-orientated health service
Health-promoting and sickness-preventing efforts should be a task for the entire health service and an obvious part of all treatment. Efforts at individual, group and population level should be more efficient. Co-operation within the care sector and with other players should be stepped up. Increased efforts for non-drug treatment to combat lifestyle illnesses is needed. The Committee proposes that six regional method centres should be built up.

Goal 16  A co-ordinated effort on public health
Good health on equal terms can be achieved through many players in their respective areas working together to improve the health of the population. The section suggests a new public health law with responsibility for health planning to be assigned to district and county councils. Further, a need is stated for a report on socio-medical functions at regional level. At authority level it is important that multi-sectorial strategies be developed in order to achieve national goals. The Committee recommends that there be co-ordination within the Cabinet Office and the Ministries concerning publish health matters. A report on the health-political situation and any measures following repeated public health-political reporting should be submitted to parliament. The section gives proposals for training investment to enable national public health goals to take hold and how monitoring and assessment should be carried out.

Goal 17  Long-term investment in research, method development and education
There is a current need for increased knowledge as to how various factors affect health development and also how these factors interact. Light is shed on the role of public health research and especially on important areas recommended for research. There is also a need to develop methods for public health work. It is essential for competent public health work to be reinforced by education and further training in the science of public health.

Goal 18  Factual information on health
One condition for good health on equal terms is for everyone to have an opportunity to obtain correct, objective health information. The section describes what is needed for everyone to get factual information and society’s responsibility to ensure this. Light is shed on the various roles of district and county councils, the National
Corporation of Swedish Pharmacies [Apoteket AB], voluntary organisations and the National Institute of Public Health.

Chap. 7 Resources needed over the next few years

The socio-economic costs for ill health in Sweden are large and consist of care costs and indirect costs in the form of lost production, early retirement and sick pay. This chapter reports on the socio-economic costs of ill health and gives examples of cost-effective preventative measures. Short-term resources needed are described and proposals submitted for special financial investment which the Committee considers need to be done over the next few years.

Chap. 8 Constitutional commentary

General and specific reasons for draft bills concerning a new public health law, changes to the tobacco law with regard to smoking in restaurants, proposals for a licensing system for tobacco retailing and changes to the social service law which the Committee proposes are given here.
1 Task and working methods

1.1 Task

The National Committee for Public Health is a group composed of politicians from parties represented in the Riksdag [Swedish Parliament]. Further, experts and competent people representing various bodies and sectors in society are involved. The Directive for the National Committee for Public health was passed by the Government in December 1995. The Committee was not however finally set up until spring 1997. The Committee will be wound up following this final report. In addition to the main report it is planned to add an extensive appendix to the report. The appendix will consist of various types of documentary material with references to the scientific literature supporting various statements. The appendix is expected to be produced shortly.

The Committee’s main task according to the Directive is to work out proposals for national goals for public health and to propose strategies as to how these goals should be achieved. The national goals and strategies will be guidelines for society’s efforts to improve public health. The purpose of the work is to set out what public health problems are in the most urgent need of a solution and what aims and strategies are the most important with regard to these.

The Directive states that a national document on goals is important per se but that the actual process which leads to the goals and which should continue after the document has been developed is just as important. The goals are to serve as support and inspiration for public health work at national, regional and local level. The goal document will be one of the foundations on which pro-active, multi-sectorial public health work can be based at all levels.

Generally speaking, health developments in Sweden have been positive, but according to the Directive it is possible and desirable to achieve further improvements in health. According to the Directive there are still wide, and in some cases increasing, differences in health between different social groups. In the light of this, national goals for health are needed to draw special attention to and reduce the
differences in health between different socio-economic groups, between different ethnic groups, between different geographical areas and between men and women.

The Directive sets out seven main points which the Committee should take account of in their work. These points have been described exhaustively in a further part-report (SOU 1999:137). The points are set out below in summary form:

- The Committee will investigate and analyse existing experiences relating to goals for health development internationally and at national, regional and local level.
- The Committee will analyse and evaluate existing health problems and these may be expected to be of great significance for health development in the future.
- The Committee will assess the chances of reducing health problems through various measures. Any conflict between different goals will be analysed.
- The Committee must weigh up the costs versus the benefits of undertaking various public health initiatives.
- The Committee will submit proposals for forward-looking goals for health development, and say which of these should be prioritised.
- The Committee will propose strategies for achieving these goals.
- The Committee will submit proposals as to how these goals can be monitored and assessed.

1.2 Working methods

A process-orientated mode of working in three stages

In the light of the Directive the Committee has chosen to work in three stages in order to produce a combined national document concerning the goals of a public health policy. The purpose of the staged process has been to provide genuine conditions for the Committee, and to test, discuss and anchor each stage in detail with different players within public health before the next stage in the process towards national health goals is taken. In short, work has been carried out in the following way:

Stage 1 applied to the Committee’s work up to March 1998 when a so called orientation report was produced. The purpose of the orientation report *How can Sweden's health be improved?*, the first stage towards national public health goals (SOU 1998:43), was to set out a general orientation or framework for future work, and to provide certain guiding principles and foundations for the formulation of
national public health goals and strategies. The report was sent out for review under personal management. The views of the reviewing bodies constituted an important basis before the start of Stage 2 of the process.

Stage 2 covered the period from March 1998 to December 1999 when the part-report *Health on Equal Terms*, the second stage towards national public health goals (SOU 1999:137), was presented. This report set out proposals for a national strategy on public health based on ethical principles and criteria for prioritisation and also a vision, overarching strategies and health-political goals for improved health on equal terms.

Further, there were a large number of factual sections where goals and sub-goals were reported on, concerning what was important within the area concerned. The factual sections were in turn based on 13 reports developed by various working groups together with experts working at the Committee’s behest. These reports deal with important risk and health factors such as financial security, factors in working life, social relationships, the physical environment and various factors linked to living habits. Furthermore, mental health, skin cancer, injuries, allergies and STD were dealt with. A basis concerning target groups such as children and young people, the elderly and immigrants was also developed. In addition to these expert reports a foundation was produced for proposed goals deriving from sources such as international health-political documents concerning goals, including some from WHO, the EU and certain individual countries. New analyses of the sickness burden in Sweden were also used as a basis.

**Orientation during Stage 3**

The third and final stage of the Committee’s work has been carried out during the year 2000 with an orientation towards reporting on combined proposals and assessments concerning national goals and strategies for public health.

The review bodies’ comments on the Committee’s most recent part-report (SOU 1999:137) formed important foundation material during Stage 3. The proposals in the part-report have been revised in the light of these comments. It has become clear through the review comments which of the matters the Committee considered required especially urgent measures or more knowledge through more research. It concerned e.g. increased stress in working life and deteriorating mental health in young people in general, and in children and young people. It also applied to important determining factors for health such as people’s financial situation, segregated housing and exposure to
discrimination within working life in certain cases. It applied also to environmental matters and life habits linked to tobacco and alcohol. Also the infrastructure of public health work in the form of co-ordination, research, education and methods and also the objectivity of health information have been stated as important.

In addition to a base deriving from the comments of the review bodies, the Committee has concentrated on developing other documentary material. This has meant updating and adding to the factual sections of the previous part-report. It has meant new documentation on stress, dental health, dietary problems, educational matters, adult education, non-governmental organisations, and culture and health. It has also meant gender aspects of health and the situation of different groups, e.g. the disabled, homo- and bisexuals.

It has meant responsibility on the part of the individual and of society for health matters and also the roles and responsibilities of authorities, health and sick care, the municipalities, and organisation. It also means aspects of co-ordination and control of public health work, economic analysis of public health investment, satisfactory indicators to monitor the development of determining factors for health and also methods for measuring public health. It has also concerned the need for knowledge and research on public health policy and work, the need for scientific training in public health and also the urgency for society to guarantee objective information on health.

Amidst all this the Committee would like to mention certain documentary material:

The Committee has surveyed and analysed the activities of 32 State authorities and some other national bodies which are of direct or indirect significance for public health. The survey shows what work has been carried out within different social sectors such as life at work, financial security, the indoor and outdoor environment, recreation, food and physical activity, tobacco, alcohol, drugs, medicines, injury and allergies, and also the situation of children, the elderly and immigrants. The material shows how the authorities view the effects of their work from a health viewpoint and what responsibilities there currently are within each area. The materials provide a basis for views of roles and responsibilities at State level within public health.

Light has been shed on the possibility of setting up a more health-orientated mode of working within health service by a special working group under the Committee. The group’s report has been valuable material for taking decisions concerning health-orientated work on health care and also work in relation to other factors.

Another working group has shed light on the situation of the chronic sick and disabled and the need for health-promoting and health
preventive efforts. The report develops proposals to improve the situation of the disabled.

Problems requiring urgent research within the framework of the determining factors which the Committee have stressed have been reported on by a special working group consisting of scientific researchers in public health. The report shows that the social stratification of public health needs more research. It is also urgent for more essential research to be carried out into different methods within public health work. Another report on scientific education in public health stresses the need for such education. There is an urgent need to increase the number of people trained in the science of public health and for knowledge of public health to be improved by further training methods.

To acquire tools in public health work it is also important for skills in evolutionary methods to be improved. Health-economic competence has a role here when carrying out assessments for cost-effectiveness, etc. This is illuminated in a report.

The Committee has found inspiration in all these reports and ideas for the goals and measures presented in the report.

Process-orientated work

The Committee’s process-orientated work has taken on several different forms. One of these has been to work out texts for debates on topics which are important from the public health point of view. Another has been to organise seminars and conferences and to attend conferences organised by others. A third has been to meet and consult with politicians, civil servants and other players concerning public health matters. The Committee chairman has had a special role as regards the two latter functions.

The Committee has continually worked on specially published texts for debates shedding light on various topic areas of great importance to public health. The purpose of the texts has been to stimulate a broad and lively debate within public health. A number of knowledgeable and enthusiastic writers have been involved with the texts and have given their opinions within particular areas. The Committee has published ten such discussion documents since autumn 1997. The titles are given in an appendix to be released shortly by the Committee.
Review work etc. relating to WHO’s new, health-political goals

The Government decided in June 1997 in a special, additional directive to the Committee to monitor on-going work with a revision of health-political goals and strategies with WHO's European region, etc. The Committee worked in accordance with the directive by participating in review work on the goals, and collaborated on setting them up in September 1998. The Committee has also worked with the Ministry of Health and Social Affairs, the National Institute of Public Health, the National Board of Health and Welfare on a folder in Swedish about the new goals.

Communication concerning proposals for a national action plan against tobacco

The Government has passed an *Action Plan against Tobacco*, produced by the National Institute of Public Health, apart from the sections dealing with the EC directive concerning a ban on indirect tobacco advertising and review comments and compilations concerning the action plan.

The Committee has mainly observed the views in the action plan in its proposals as presented in this report.

National goals for public health

The report provides proposals for national goals and sub-goals for public health, the intention of which is to support efficient public health work at all social levels and through many players. The goals have scientific backing which is presented more fully in the appendix to the report which the Committee intends to issue shortly. Proposals for measures, players and indicators to pursue the goals are also provided.
4 The basis for prioritising goals and measures

4.1 Improving human freedom from the consequences of ill health.

It has long been basic Swedish social and health policy to base assumptions on what is usually described as a humanist view of mankind. This has been a guiding principle for ethical viewpoints in both the Handicap Report and the Priorities Report. Humanism as an approach means that all human values are equal. Whilst Man strives to form his life in harmony with his needs he takes responsibility for the whole and for the good of others. He thus eschews a deterministic view of Man, controlled purely by fate, genetic conditions and social circumstances.

This means that everyone should have an equal opportunity to develop in important regards. A person should be able to choose for himself the means to try to satisfy his desires. The aim of social development can be described under this view as the realisation of efforts towards freedom for all to shape their own lives. This thus also implies efforts towards full participation and equality. It concerns the freedom of the individual to consciously verify and control his own circumstances, which are the decisive welfare dimension. This view of things also follows the tradition within Swedish welfare policy and research. Both effectiveness and equality within health policy should be checked against this welfare dimension.

For health policy this means that it is the significance of ill health for people’s actual ability to choose and influence their environment which is decisive. This means that it is the consequences of ill health measured in terms of premature death and handicaps which should be heeded first and foremost.

Thus, according to this view of things it is not ill health in the sense of a biological deviation or reduced subjective well-being that it is most important to remedy at the social level. The central thing is whether the interplay between people’s functions and the environment limits their actual freedom and thus creates handicaps. This approach also has important consequences for the aim of equality. Table 2.6 in Section 2 shows that inequality between social groups increases the further one moves away from self-reported ill health to the actual consequences of ill health as regards function and employment. On the other hand subjective well-being can be an important link in the psycho-social mechanisms which influence illness and injury.

Under this approach the Committee refrains from formulating its own definition of what constitutes health. Health can be described in many ways, with each individual having his own view. The main task of the Committee is to prevent ill health placing obstacles in the path of people’s freedom to determine their own lives.

The Committee has chosen to formulate aims concerning the causes of ill health and not individual illnesses. At the same time the Committee wishes to stress that the healthy and protective factors available to promote health are – as far as today’s knowledge goes – most often identical with the risk factors applying to ill health. The promotion of social fellowship, cultural experiences and green recreation areas are health factors. At the same time the absence of such factors involves long-term risk to health instead. The Committee has chosen as far as possible to express the determining factors as positive health factors.

One and the same exposure to a risk factor is often a contributory cause of several different diseases and also injury. It is thus easier to focus on the determining factors than on individual diseases. The causes chosen to be tackled can also be chosen on the basis of their significance for the distribution and consequences of ill health. It is easier to monitor the effects of determining factors since the latency period is much shorter than the time – sometimes several decades – which elapses before an illness or other affliction manifests itself. It is first and foremost a means of stressing that several social sectors “possess” the causes of illness.

Not everything can be prioritised. It must emerge from a choice of the determining factors based on principles which are as transparent and as clear as possible. The Committee will sum up its own deliberations and views here, which will be directly relevant to the prioritising of goals and measures in later chapters, in the light of our earlier reasoning and the views of the bodies to whom these matters have been sent for consideration.
4.2 Minimising ill health for the most seriously ill

The first health-political initiatives were taken 300 years ago. They derived from the State’s need to strengthen the developing European nations. Decisive factors for a nation’s survival and progress were the size and health of the population. It was important to maximise the total number of competent soldiers, farmers and workers. It was realised early on that not just fertility but also efforts to reduce infant mortality were matters of the greatest national interest. Poverty was considered to be a cause but also the result of poor health – for individuals and for nations. But human health was first and foremost for the benefit of the State, not vice versa.

The tradition of seeking to maximise total welfare in society in different ways lives on in macroeconomics, welfare policy and health policy. This principle thus takes no heed of the distribution of welfare. It is felt that welfare is equally valuable, irrespective of who possesses it. According to this view it is just as valuable to improve the health of individuals only suffering from a minor affliction as to do so for those already seriously ill. Even if it may sound just in the sense of the equality of all people, there will nevertheless be unacceptable consequences according to the Committee as regards the principle of human worth and the needs/solidarity principle which requires that the most seriously ill should receive preferential treatment.

The actual development of health has demonstrated a pattern in Sweden, as in many other countries, where the health of the nation has improved “on average” in many respects. At the same time the relative difference has increased between social groups, and between men and woman as regards certain health problems. This forces us to ponder on how to react to national health-political efforts which in practice favour many people, if it also means that the groups with the poorest health do not see any improvement. The Committee’s assessment is that the equality aspect should decide our action if efforts conflict with each other. It should be pointed out at the same time that much investment in public health does not involve any such conflict.

4.3 Efficiency and equality

Equality in health is not achieved without problems. The variation between the health of individuals is largely conditioned by genetics and age. What health differences then should be considered unjust? According to the Committee’s way of thinking, health differences are unjust if it is possible to change them and they manifestly are not the individual’s own choice. The limit to what it is possible to change moves constantly in time with scientific and social developments, and the limit to what counts as free choice is also unclear.

That adults with access to all information about risks choose to expose themselves to ill health, subsequently to suffer from it by e.g. climbing mountains, may not be considered unjust. With smoking it is worse, since it is a dependency drug and it has been observed that lone mothers with difficulties on the labour market tend to smoke more than other groups.

One could maintain that differences in health are unjust if they are the result of basic social structures which create wealth and good health for many, but poverty and ill health for some. To the extent that differences are necessary for social development to be of benefit to the less privileged, they can be regarded as just. The division of work in society, which we are all a part of, creates a dependency between people and groups. We have a mutual responsibility to prevent the "unjust" effects of this structure, by removing differences which are of no benefit to the most exposed. For these reasons we consider that responsibility for individual health is divided between the individual and society, whilst responsibility for injustice in the distribution of health between groups is first and foremost a matter for society.

Health differences between different population groups can scarcely be said to be of benefit to anyone. But some of the circumstances which create ill health and which people are marked by during their growing up period, in their work and in their dwellings, are not as easy to categorically designate as unjust. The division of labour, human freedom to participate in a market both as worker and consumer and all the inducements thereby created to increase market efficiency, give rise to differences. Different cultural and religious reasons do the same for different lifestyles.

This means that it is above all these conditions which have well-supported effects causing early death and handicaps, and which moreover especially influence those with a poor starting position which it is especially urgent to remedy. It is necessary to decide for each such determining factor whether it is possible to reduce or remove this factor...
without it jeopardising the basic conditions to ensure welfare for exposed groups.

Examples of factors which become particularly relevant in the following examination of determining factors include the financial and social situation of families with children and especially lone parents, and conditions at school which increase the risk of early exclusion amongst children and people’s ability to influence and control their working conditions. These are examples of circumstances which have proved to be of great significance for the progression of disease and which are very unevenly distributed socially amongst the population. Sometimes more intermediate factors in the causal chain are of particular significance in this connection – e.g. tobacco and alcohol consumption play a much wider role in the emergence of social divides as regards ill health.

4.4 Equality in the causes or consequences of ill health

The fact that it is the consequences of ill health in terms of “limitation on freedom” which are our ultimate criterion for the future of health policy means that it is not just the distribution of the determining factors which is important. As we mentioned (Section 3.1), the given cause of an illness is converted into illness depending on the occurrence of a number of different factors, and the consequences of a given illness for an individual are also dependent on other conditions than the illness itself.

We use the word “vulnerability” to express the situation that, as a result of genetic factors, family background, etc., individuals and groups are more sensitive to the effects of given determining factors than others. Examples abound from current health policy that we take this vulnerability into account. We know that during the first years of a child’s life a close emotional relationship with the parents is especially important for health later in life. For this reason different socio-political and health-political measures are enacted towards this group.

We know that teenagers are more sensitive to developing a dependence on alcohol and tobacco, and society has therefore imposed special restrictions on their availability to young people. We know too that people who impose very severe demands on themselves at work are particularly vulnerable to health effects due to a lack of influence and control as to how to live up to the demands imposed on them. Life is nevertheless changing within certain sectors in a direction where
demands are increasing strongly without a corresponding increase in control. This interplay between determining factors is also becoming an important criterion for choice and priorities between the determining factors and target groups.

Our deliberations in the next chapter try to take account of these, especially in the choice of target groups and in the choice of such measures where solidarity with the vulnerable imposes a special responsibility on society. These deliberations give reasons for a strong focus on children’s growth years and care for those particularly prone to damage through alcohol and tobacco.

Many determining factors have the property of not just being causes of illness but also influencing the progression and consequence of a disease. Passive smoking influences children’s risk of developing allergies. If an allergy has been developed, difficulties are considerably increased if the sufferer is exposed to tobacco smoke and other irritant substances. Ergonomic factors at the workplace influence the risk of developing backache, but they are also decisive for the extent to which people with chronic backache can stay at work. Our survey and prioritisation of various determining factors must keep these two aspects in mind.

Many determining factors are important not only to reduce the risk of healthy people becoming ill but also so that people suffering from disease and reduced functions will not have their condition exacerbated. An example raised by the handicap movement is financial stress. People with reduced function not only have greater difficulty in acquiring the necessary income but also have less chance of converting a given income into freedom to run their own lives, which is the aim, because the cost of doing so is often higher than for others.

4.5 Long-term strengthening of solidarity in health policy

In our deliberations on the role of social structure in Chapter 3 we emphasised the health-political significance of the cement that holds society together in terms of solidarity and social capital. These conditions not only have a direct impact on people’s health, they are also decisive for the extent to which the health policy we formulated in this regard can be implemented. Inasmuch as it is an integral part of broader welfare policy, it becomes at the same time dependent on, and decisive for, the long-term legitimacy of this policy.
5 Vision and overarching guidelines for good health on equal terms

5.1 Good health on equal terms – our vision

The basic principle underlying efforts in the realm of public health is equality of value for all people. This means that each individual should have the right to develop according to his own conditions. All people are unique. Some are born with severe functional handicaps, some bear a genetic vulnerability, while others become vulnerable due to an insecure childhood or their circumstances in adult life. Our health is also variable during our lifecycle.

Health and ill health, as measured today, are unevenly distributed. Our state of health is due more to different living conditions and habits than to genetic factors. The development of health is thus a socio-societal matter. For a democratic society based on a humanist view of Man it is obvious that we should try to change the conditions which basically bring about easily controllable differences in health.

Each individual should thus be allowed an opportunity to achieve the best state of health possible for him. For this to happen a socio-societal environment is needed which promotes health for all, but which also provides special support for some people and social groups.

Current Swedish society is characterised basically by a sound physical and social environment. This is reflected most clearly in increased life expectancy and very low infant mortality. On the other hand some great differences in health remain, which are not biologically conditioned. Since the differences follow very clear social patterns, the differences in health are not dependent first and foremost on the individual’s conscious choice of lifestyle. In a sound society the inhabitants should not have conditions which are so different that they result in great differences as to life expectancy or morbidity.

Since Swedish society developed during the last century into a health-promoting society in many ways, the great challenge for society as a whole is first and foremost to prioritise such effects as can even
out easily controllable differences in health. Such a society will also be better and more secure for all people to live in.

The factors which determine health are both the essential ones such as clean water, food, warmth and an unpolluted and secure environment, and also the factors which support the individual and make him strong and less vulnerable to different risks and challenges in life. People who feel needed, who experience existence as meaningful and who feel they have control over their own lives find it easier to maintain good health than those who feel lonely and without a framework.

The democratic conditions and openness to ethnic variety are therefore of great significance for people’s ability to participate and to influence their own circumstances. Strengthening the individual so as to be less vulnerable and better able to make reasoned choices is an important challenge for a health-friendly society. It is especially important for those who are more in need of help and support than others.

In the light of this we see it as an urgent task to create a society where living conditions can be changed so that all individuals have equal opportunities to develop their own health where it is controllable. People’s health will never be equal. It depends on e.g. the individual’s genetic code, different exposure to contagious diseases and accidents and also on a personal choice of living habits. On the other hand it is possible to have conditions which can be influenced in order to achieve good health.

Good health on equal terms is a vision which society should strive to achieve. A social development which has such a vision as its guiding star will develop differently than if development is characterised by some other vision.

There are a number of overarching principles and attitudes which should characterise such a social development. Decisions cannot be made about everything. Social development is far too complex and consists of so many different factors that this is impossible. There are also other reasons for social involvement than just the promotion of health. In certain respects these efforts to develop conflict with each other.
5.2 Overarching guidelines

The principles and approaches which are basic to the achievement of good health under similar conditions in current Swedish society and which ought to characterise social development involve the following six overarching guidelines.

1. Strengthening the social capital

Strong social capital is a characteristic of a society with good health for the whole population. Many important dimensions are included in the words "social capital". The concept concerns a society with strong social cohesion between its members; it concerns fellowship, solidarity, trust in both society as a whole and in other people. Social capital is promoted by participation, by the absence of wide differences in income and ownership of property, and by all inhabitants having equal access to education, economic security, health care, etc. Societies characterised by solidarity between the people, both in general and between people close at hand promote social capital. Social associations, clubs and networks also contribute to its development.

Sweden has been – and is still – rich in social capital. This is one of the reasons for our good public health. Society is changing very fast. There are elements in this social change which are tending to deplete the social capital instead of further strengthening it. All social sectors should therefore be characterised by the realisation of how important it is for the development of public health as a whole – but most obviously in order to reduce differences in health – to strengthen solidarity and cohesion. Wide differences in income should be countermanded and social security systems should function as the backbone of social cohesion, different forms of segregation should be resisted, discrimination should cease and supportive environments should be promoted.

Strengthening the social capital influences health in different ways. Since body and mind are linked, all health is promoted by good social cohesion. It is especially clear in the case of mental health, suicide risk, drinking habits, injury as a result of violence and cardio-vascular disease. Matters relating to the social capital are dealt with first and foremost under goals 1 and 2.
2. Growing-up in a satisfactory environment

The foundations of health are laid during childhood. A satisfactory mental, social and physical environment whilst growing up produces people who are secure and less vulnerable to different stresses and strains later in life. A secure relationship with parents during the early years is of particular significance for future mental health and vulnerability. A child’s health, mental and physical, is strongly related to parents’ social belonging. Good or poor health is influenced by the social heritage.

All children should be given equal opportunities as far as is possible to enjoy good health during their lives. To make this possible society needs to support parenthood in different ways and the social network surrounding each child. It is essential for parents to be secure in their nurturing role and feel that they have control over the family’s everyday circumstances. In the environment of children and young people it is important for there to be more adults than just the parents who can support the child. Investment in good nurseries, schools and leisure activities and other activities which support children and parents will serve to promote children’s and young people’s health and also influence their health as adults.

Creating good growing-up conditions for all children has a powerful influence on the state of health of the population. It also has a clearly levelling effect on social differences in health. Children’s and young people’s circumstances are dealt with especially under Goal 3, but also under most other goals.

3. Improving conditions at work

A satisfactory job is an important prerequisite for health, which means that society should constantly strive for a high level of employment and make every effort to avoid long-term unemployment, discrimination and exclusion from work on the part of different groups. Work must also be characterised by a secure and safe environment, both mental and physical. It is an important factor for a health-promoting working environment that an employee has control over his work, both how it is done and how much he can reasonably manage. Work is characterised today by too much negative stress and is insufficiently flexible to be combined with family life.

The labour market is facing great challenges. The changes taking place due to changes at work need to be balanced against people’s
ability to feel well and function throughout their working life. The working environment must be sustainable in that sense.

Developing a good job is especially important to reduce cardiovascular disease, pain and injury due to strain, mental ill health and other stress-related afflictions. Conditions at work are dealt with first and foremost under goals 4 and 5.

4. Creating a satisfactory physical environment

A satisfactory physical environment is basic to the health of a nation. Clean water, drainage, clean air and an unpolluted environment are essential to health. Therefore environmental work must always be at a high level. New products can mean risks which need to be identified and remedied, whilst at the same time people need protection against risks in the environment which have long been known.

A satisfactory environment also includes the geographical environment, which is important to people’s needs for revival and relaxation. Proximity to the countryside and parks also allows opportunities for physical exercise and interest in the great outdoors. Whether we are children or elderly, the immediate environment is of particular importance.

Linking environmental work with health work is important. Environmental work which protects plants and animals from risks is most often also healthy for us human beings.

The environment influences our health in different ways; this applies especially to infections, allergies, skin and lung cancer, injury, hearing impairment, tiredness, stress-related illnesses, mental anxiety and minor depression. Different environmental matters are dealt with under goals 6, 7 and 8.

5. Stimulating health-promoting life habits

The importance of life habits for health is all-pervading. Eating habits, physical activity, sexual relations, sunbathing, drinking, smoking, or the taking of drugs are examples of life habits which have a great influence on health.

These life habits are a combination of the environment and culture surrounding the individual and personal choice. Life habits can thus be influenced by strengthening the individual to make good choices and by influencing the environment where unhealthy life habits are created. Some restrictions are also required as regards access to e.g. alcohol,
tobacco and other drugs, out of solidarity with people who are particularly vulnerable to different risk-filled lifestyles.

Health is influenced in many ways by our life habits; this applies particularly to cardio-vascular disease, cancer, allergies, injury, sexually transmitted diseases, mental problems, brittle bones, diabetes and aching limbs. Matters dealing especially with life habits are dealt with under goals 3, 8, 9, 10, 11, 12, 13, 14, 15 and 17.

6. Developing a satisfactory infrastructure for health issues

A support system by society for the promotion of good health is essential. Health care is a factor which has only health and illness as the point of departure for its work. Therefore reorientation to a more health-promoting mode of working is central to ability to influence health development.

There are at the same time many other socio-societal players and measures which are important for the development of health. District and county councils can develop health-promotion by means of health plans and by collaboration. The training of various career categories in public health and the development of research with a cross-sector perspective are other necessary instruments for combining knowledge about health and ability to influence it.

In order for the individual to make good choices, it is a precondition for society to ensure that people are given objective information. Access to reliable information in a medium mastered by the individual is a matter of democracy. It is a responsibility to be shared by different social sectors.

A nation’s health is influenced by how social bodies and voluntary organisations plan and work together for the promotion of health. Collaboration can be of decisive significance for a reduction of social differences in health and for the promotion of health in groups which are particularly vulnerable in different respects. These matters are dealt with especially under goals 15, 16, 17 and 18.
6 National goals for public health

6.1 Introduction

In this chapter the Committee has drawn up goals for the important determining factors for good mental and physical health. As people’s general state of health and most of the illnesses which are susceptible to influence and injuries are caused by several factors working together, we have therefore chosen not to formulate goals and measures for specific symptoms of ill health. In order to prevent both mental and physical illness, all of the various sectors in society need to make a contribution; the public sector, the workplace, civic society and the individuals themselves.

Mental illness needs to be tackled along a broad front

Mental illness in the form of fatigue, distress, feelings of anxiety, depression, sleeping problems and psychosomatic pain is on the increase, according to various investigations measuring people’s own assessment of their health, but also according to the number of diagnosed cases of illness. Body and mind together form one whole, and when an individual is subjected to stress, both physical and mental health is affected. It is particularly difficult to measure mental illness over time, as people’s attitudes change. Nowadays it is easier to admit to having a mental health problem, something which was more or less taboo years ago. Medical certificates show the same pattern in part. Mental illness was often concealed behind other diagnoses in earlier times. Suicide, which is a clear measure of a person’s state of mental health, is decreasing, but it is still the commonest cause of death amongst young men. The Committee is of the opinion that irrespective of how much mental illness has increased, it is of such a magnitude that it is a serious threat to public health.

The number of people stating that they have mental health problems is increasing for all sections of the population, apart from the very oldest people in society, even though the occurrence of mental illness
is still highest in that group. But the increase is not evenly spread amongst the population. Younger women with a low level of education are showing the greatest deterioration. Gender, age, level of education and profession are important determining factors for mental health.

People’s susceptibility to psychological and physical stress in their lives varies. This susceptibility is partly genetically determined, but is primarily influenced by the circumstances of one’s childhood. The family’s situation, how well the children bond with their parents, contact with other adults, relationships with their friends, the school’s methods, education and later on starting their own families, are all important components in determining how well people are able to deal with the stress they face in life.

On the other hand people are constantly developing and are influenced all the time by the prevailing situation they find themselves in. This means that even a person who has had a very stable childhood can become extremely vulnerable if the stresses and strains of his life become too much. But it also means that a person who has had an unstable childhood right from the start can develop into a person who is mentally stable, if the circumstances in his life are favourable.

If a person is subjected to negative stress, i.e. has too much to do, but little control over his work, then this provides a hotbed for developing mental health problems. Stress reactions can also be caused by having too little to do, by not feeling needed, by feeling that one does not have control over one’s life, or feeling that one does not belong.

The causal mechanisms behind mental illness are complicated, which means that many parts of society are affected and need to be mobilised in order to try to improve people’s mental health. No sector of society can say that it is not affected in some way.

Nowadays it is a fact that people’s situation at work provides an important explanation for the increase in mental illness, as mental illness is so clearly linked to certain types of work situation. For a number of people, signs of mental illness arise in the interplay between a person’s circumstances at work and his own vulnerability.

Financial stress, an insecure financial situation, certain types of segregation, unemployment and discriminatory treatment of immigrants, disability or homosexuality for example, are all risk factors for developing a mental illness. Alcohol abuse is also a factor which has a negative effect on mental health.

Society is changing very quickly and thus makes many demands on people’s ability to deal with different relationships and different patterns of family life. Being able to get support to deal with crises and
separation is also an important aspect in reducing susceptibility to mental illness.

It is important to strengthen the feeling of community in civic society, by having a variety of supportive environments, networks and leisure activities in people’s free time, so that as individuals we can feel that we are part of a wider picture and that we know that we can get help when we need it.

People have a great need for recreation and relaxation. Nature and green surroundings have been proved to be of particular importance for how well people recover from different states of stress. Town planning, the way in which access to areas of recreation is planned, the way children’s playgrounds look and what the outdoor environment around individual housing blocks looks like, are important for mental recovery.

It is very common for elderly people to experience mental distress. Lack of social contact, loneliness and isolation form a breeding ground for mental illness. Improving the opportunities for elderly people and certain groups of the disabled to maintain social contact with others, also on a purely practical level, and to get out and about amongst other people, are important factors for mental well-being.

There is also a strong connection between mental illness and having an unhealthy lifestyle, such as smoking, alcohol abuse, drug abuse, exposure to the risk of catching sexually transmitted diseases and not taking enough exercise. Having high self-esteem and the desire to survive, not just in the short term but also in the long term, are crucial factors in a person’s choice of lifestyle. Mental health is thus an important factor in influencing a person’s way of life. In addition one’s lifestyle influences one’s mental health.

There is within the health service a large and to some extent unused potential to detect mental health problems and signs of a tendency towards suicide much earlier than is currently the case. One could also initiate a system of providing support for people who in various respects need support in crisis situations. Preventative measures against mental illness could be taken by bringing people with the same illness into contact with each other or by providing support for the relatives of those affected.

If people feel that their mental health is good, this also reduces their susceptibility to various illnesses and stress factors. Mental illness presents a big challenge to Swedish society and public health. It is the view of the Committee that mental illness is the most pressing problem within the field of public health to need addressing, partly because of the size of the problem but also because very few measures have been taken to prevent mental illness up till now.
In order to preserve and improve people’s mental health, considerable effort needs to be made in a large number of areas. Within virtually all the goals outlined in this chapter, measures are described which have a role to play in strengthening the population’s mental health.

**Severe somatic, endemic diseases which can be influenced**

The physical illnesses and diseases which people suffer from can be influenced to a varying degree by determining factors which take the environment, people’s living conditions and their lifestyles into account. Cardio-vascular disease can to some extent be influenced by a person’s way of life and by the various stress factors in his life. Some people are genetically more predisposed than others to these diseases. It is therefore even more important for the individual to look at what parts of his lifestyle are in most urgent need of being changed, in order to help prevent cardio-vascular disease. Goals 1, 2, 4, 5, 6, 9, 10, 12 and 13 cover factors which can reduce the risk of getting cardio-vascular disease.

Aches and pains and injuries caused by overburdening the limbs are a public health problem which to a great extent can be influenced by having a working environment which is better suited to the requirements of the individual. Such aches and pains are also caused by tension and negative stress. A person’s own level of physical activity also affects how susceptible his body is to stresses and strains. Goals 5, 6 and 9 are of particular importance for preventing injuries and pains in the limbs.

The number of people suffering from allergies is increasing very rapidly, and it is a major public health problem. There is still great uncertainty about the causes of the rapid increase in the incidence of allergies. It is very important that investment should continue to be made in research projects. On the other hand we now know about a range of factors which increase the risk of getting allergies or asthma, and how to defend oneself against them, these being factors like air pollution, the indoor environment, various products, ingredients in perfume, animals with fur, and when young children should begin to eat certain foods. Goals 3, 5, 7, 8, 10 and 12 are of particular importance for preventing allergies.

Certain types of cancer are directly related to known environmental risks and lifestyles. The number of cases of lung cancer can be reduced by reducing smoking, environmental tobacco smoke and the presence of radon in buildings, and the incidence of skin cancer can be reduced
by better habits regarding sunbathing. Certain types of cancer of the stomach and gut can be reduced by changing one’s eating habits etc. Goals 3, 5, 6, 7, 8, 9, 10 and 12 affect the occurrence of certain forms of cancer in a variety of ways.

Injuries are often the easiest to prevent, and the results of improved safety in our surroundings can be seen immediately in the form of fewer accidents. It is particularly important to be vigilant about what is described in goals 1, 2, 3, 5, 6, 7, 8, 9, 13 and 14 in connection with the work being done on accident prevention.

Infectious diseases and infections have successfully been fought in our country through a combination of protection from infection, increased knowledge on the part of the general public, better living conditions and treatment with antibiotics. Society must continue to be in a state of alert as regards infectious diseases. Goals 1, 3, 6, 10, 11 and 15 are particularly important for maintaining a high level of protection from infection.

6.2 National goals, sub-goals and challenges for the players involved

The 18 goals proposed by the Committee are all-embracing in their nature and deal with the social capital of society, the conditions under which children and young people grow up, working conditions, the physical environment, different lifestyles and the infrastructures required to promote public health. The goals have been put into concrete form in the sub-goals which focus even more specifically than the main goals on elements such as risk, health and protection factors as regards public health and factors which strengthen the infrastructure for the work being done to promote public health.

For the purposes of being as clear as possible in this chapter, each goal and the sub-goals set by the Committee are presented in a panel at the beginning of each section. The text following the panel describes the significance which the determining factors relating to the goal and the sub-goals have for the state of health of the general public at large and for various groups. So as not to burden the summarised test with all the scientific references which support the Committee’s arguments, the Committee has chosen not to mention the references in this chapter. The references are instead given in the appendix section of the report, which it is intended will be issued shortly in a separate form.

Based on the respective goals and sub-goals and reasoning in the text, the Committee sets out the challenges facing the various players
involved. These are players at national level, e.g. the Government and state authorities, but also other national players such as The National Corporation of Swedish Pharmacies. There are also challenges for the players at regional and local level, such as county and district councils, as well as businesses and organisations. The challenges for the players are described very briefly, and they set out what the Committee believes to be important in terms of measures to be taken. The challenges are about both large-scale changes in the long term and about more tangible initiatives which can be undertaken in the short term. The Committee is well aware that some of the challenges have a significance which goes far beyond their political dimension as regards public health, but it is the opinion of the Committee that they are of great importance from a health perspective.

The sub-goals outlined in this chapter are linked to a large number of indicators. The aim of the indicators is to capture the most essential conditions applicable to the determining factors set out in the goals, but they are not in themselves determining factors. Percentages can be specified for the indicators, so that what ought to be achieved by a certain date is indicated as compared with the present-date situation. The Committee has chosen not to specify the indicators in this way, with the exception of how smoking ought to be reduced. In this case the percentages have been specified in the sub-goals. It is our view that it should be up to the National Institute of Public Health [Folkhälsoinstitutet] in collaboration with the other authorities to specify the percentages and also to come up with indicators for the various sub-goals. Those indicators which have been specified by the Committee are outlined in Appendix 2 of the report.

The date by which the political goals for public health ought to have been achieved is not self-evident. The Committee has arrived at the year 2010 as being a suitable point of reference for a complete evaluation. The timescale leading up to this year is short enough to be relevant in a political perspective but long enough for political initiatives on health to have had the desired effect. As the emphasis is on the determining factors for health, it will take less time to see what has been achieved than changes in the way the public’s state of health is developing, which take longer. The period of time chosen is also half as long as that applied to the European region by WHO (World Health Organisation) in its health strategy Health 21, and can thus be evaluated at the half-way stage in comparison with these goals.

Having the year 2010 as the reference point as regards monitoring and evaluating the goals for health ought not to hinder evaluation of the goals at an earlier date. On the contrary, such evaluation is desirable. The Committee proposes later in this chapter that the monitoring and
evaluation of national goals for public health should be reported to the Government every few years in the shape of two reports – a report on the political issues regarding public health and the already established Public Health Report which the National Board of Health and Welfare is responsible for producing. Based on these reports the Government should make a statement to the Swedish parliament during each period of office on the situation regarding public health, and if called for, submit proposals for revising the national goals for public health.
Goal 1

A strong sense of solidarity and feeling of community in society
- Reduced poverty
- Reduced segregation in housing
- Compensatory resources for children and young people in socially-disadvantaged housing areas

Health is influenced by what people’s social relationships are like at the social level, at the organisational level through the social ties which exist between people in general, and at the individual level in people’s relationships with their closest family. These insights and to some extent this new knowledge challenge the whole of society to see the potential in promoting health – and thus in preventing illness – through a society which is rich in positive social relationships, participation and networks.

A society characterised by fellowship between people and to a high degree by economic and social unity, and with living conditions which do not distinguish too much between different social and ethnic groups. Civic society and various social networks within it create a sense of trust between people who live close to each other. Above all, in a modern society it is not enough to have a sense of fellowship with the local community – a sense of fellowship and affinity needs to exist throughout society, so that people can have confidence in each other. Such a feeling of affinity is engendered in a democratic society where the citizens are loyal towards each other and mutually dependent on each other, e.g. state-funded and well-run schools, healthcare and a welfare system.

Poverty is the all-dominating reason for premature death in the world. In countries such as Sweden, abject poverty, with people suffering from cold or hunger, is an extremely uncommon cause of ill health. Average life expectancy in industrialised countries is more dependent upon the distribution of income in society than the absolute financial level reflected in average income. A wide distribution of income is a risk factor for health as compared to an even distribution of income.

Compared with other industrialised countries there are only small gaps in income between people in Sweden, and there is an all-embracing social security system which results in low incomes having less of a negative effect on the health of people in various groups. A
person’s state of health is, however, linked to his level of income in Sweden as well. There is a clear connection between education and career levels and health. The negative effects on a person’s health caused by unemployment have not been as great in our country as in other countries. This indicates that in general the welfare system has managed to look after people in need of help and has mitigated the economic effects of unemployment and thus checked the negative consequences for people’s health. This situation has changed during the 1990’s as a result of more people than before falling through the safety net and not being looked after by the country’s all-embracing welfare system.

Social and ethnic segregation in terms of housing has increased significantly during the past few decades. This applies both to thinly-populated areas and to the cities. It is a threat to an even improvement in health. People living in areas with social and economic problems have more difficulty in giving each other positive support. In order to be able to deal with the stresses of life it is necessary to have access to good social networks. Children are particularly vulnerable, as there are fewer adults who can provide them with positive support. The ethnic and linguistic segregation now developing makes it even more difficult for children and adults to become part of Swedish society. Discrimination and alienation are significant risk factors in ill health.

The way society is developing, with a tendency towards increased economic differences, growing segregation and a welfare system which does not adequately cover the whole of society are all factors working against improving the health of the population. This is linked to the fact that the growing gap between individuals and between different groups in society reduces the feeling of community and people’s confidence in each other. We must be vigilant regarding increased gaps in income between people, as large gaps have been seen internationally to have a negative effect on improving health. But a reduced sense of community and confidence reduces the chances of arriving at joint solutions which provide improved welfare for everyone.

Immigrants are the group who currently have the most difficulty financially and socially, living segregated from other groups and not being firmly established on the job market. The same applies to single mothers, the numbers of whom receiving long-term social benefits rose markedly during the 1990’s. The long-term unemployed, the disabled and certain elderly people with low pensions who are forced to pay high charges for services they are dependent on, are all in a vulnerable position. These groups tend to have a poorer state of health than the general public at large. Young people are also financially worse off than before. Unemployment has hit young people with a low level of
education particularly hard, and students are facing much-reduced financial circumstances. The fact that young people are finding it more difficult financially could be an explanation for the sharply declining birth rate, especially amongst those on low incomes.

Homelessness has increased in Sweden during the 1990’s, and there are now approximately 10,000 homeless people. The number of people affected is so great that homelessness constitutes a public health problem in its truest sense. Homelessness is serious in itself, but it is also an important indicator of social conditions in a society, which is why it is important that attention be paid to it. Homelessness is not just a problem associated with cities, and only a third of the homeless are believed to come from the three largest cities. Homelessness in combination with other problems also seriously aggravates the ability of the individual to get out of this situation on his own. Three out of four homeless people have addiction problems. There are also many people who are mentally impaired amongst the homeless, and people who have been turned out of their homes because of being unable to pay their rent. The number of female homeless is also increasing, and they form the majority group amongst the homeless under 30 years of age.

A high level of employment and a secure welfare system form a sort of backbone for maintaining and strengthening the social cement which has been characteristic of Swedish society, and for lessening the negative effects of certain features of how society is currently developing. It is one way of keeping people together and giving everyone access on equal terms to schools, healthcare and compensation for loss of income. An education system of high quality in all nurseries and schools is fundamental, so that all children are given the same basic opportunities to develop and receive an education. This is of particular importance, as education is an important determining factor for people’s future health.

High quality healthcare which is accessible to all is a central factor for good health. It is of manifest importance for the individual that there exists a proper system of healthcare to prevent, cure and alleviate illness. The same also applies to social services such as the care of the elderly and various services for people with disabilities. But the provision of high quality education, healthcare and social services to everyone also acts as a confidence-building factor for engendering a sense of community in the whole population. It thus contributes to maintaining the social cement which is one of the foundations of good health.

The social security and unemployment insurance systems are no longer adequate as instruments for creating security for all, in the event
of loss of income. In a situation of unemployment, level of income has considerable influence on whether the unemployment has negative social effects and negative effects on a person’s health. A growing number of people now have an income which is above the ceiling which governs what compensation is available. If people with high incomes do not feel that they are getting enough financial protection, they will look for other solutions to protect themselves. This might result in the actual system being eroded and in security for those people with lower incomes also being undermined over time. A number of people have difficulty getting into the system at all, as a result of the rules about earnings, and they are therefore not adequately protected financially. All in all this means that more and more people feel that they are not adequately protected in the face of loss of income, unemployment or illness.

Children are particularly at risk, if the family has financial difficulties. There is a clear connection between children’s health and their parents’ financial and social circumstances, even in our country where no child lives in abject poverty. Relative poverty however clearly does have an effect on children’s circumstances. Throughout the 1990’s single mothers and their children have been particularly badly affected. In comparison with international figures the differences in health between children of single mothers and other children is still relatively small in Sweden, which is probably due to the support available here. But as economic differences have grown during the past decade, there is reason for vigilance regarding the conditions single parents live in.

People’s differing financial circumstances sow the seeds for segregation, as does the attractiveness of different housing areas. The need to live together with people the same as oneself in different respects – ethnic, cultural or other – can lay the foundations for segregation. In city areas with a mixture of grants available, overall socio-economic and ethnic segregation can be extensive, but this is often balanced socially but the fact that there are many places where ‘different’ types of people can come into contact with each other, e.g. at school, in hospital, at the shops and in the town square. When we talk about segregation we usually mean the typically large-scale areas and suburbs with similar types of occupation, where many people with few economic resources live. Such residential areas can in certain cases be socially disadvantaged because the percentage of poor people is high.

To help the inhabitants, especially the children, in socially disadvantaged areas, it is important for society to give these areas more support than other areas in the form of a variety of initiatives, e.g.
schools, cultural activities, support for leisure clubs, activities for children and young people, and extended healthcare for mothers and children. It is a question of solidarity between different social groups, which primarily promotes the development of good health amongst those who are at greatest risk from developing health problems because of their living conditions. They are also acts of solidarity which will in the long-term promote the health of all groups, as the social cement and sense of community feeling will be strengthened throughout society.

In recent times many elderly and disabled people and those with long-term health problems have had to pay ever higher charges for services on which they are dependent, be they healthcare, medicine, taxis, home helps, rehabilitation training, chiropody, etc. The person responsible for setting each charge does not see the charge as placing a particular burden on people, but as it is often the same people who are dependent on several different services which are subject to charges, the total sum can be considerable. These are also charges from which other people are to some extent free.

Charges facing individual residents in certain district council areas can be so high that it can be difficult for a spouse living at home to remain living in the joint home. The combination of high charges and incomes lower than in the population as a whole makes the economic situation faced by certain groups very difficult. This can contribute to financial stress or lead the person to forego services which are in fact necessary or to forego other activities which help promote good health. The disabled cannot take out private insurance, which means that they have less economic protection than other people.

Almost ½ million people in Sweden have unregulated debts in the hands of the enforcement services. It is not uncommon for people with a permanent high level of indebtedness to have serious health problems. It is an urgent matter that the law regarding debt clearance is looked at, so that more people can get their finances on a sound basis and that the time taken to process cases is reduced.

A strong sense of community which is characterised by solidarity between people is itself the basis of good health for everyone on equal terms. Maintaining a high level of employment, so that people can support themselves by their own efforts is the basis of a welfare society. A high-quality social security system, schools, healthcare and social services on equal terms for all are the foremost structural initiatives which society can implement to promote the basic conditions needed for good health.
Specific target groups

- Single parents
- Young people
- The elderly and the disabled with many expenses
- Immigrants

Players and measures to be taken

The challenge for national players

- The State ought to develop the social security system so that more people can gain access to it. Supplementary benefit ought not to be used as a permanent method of providing financial support. Single parents and young people are important target groups as regards changes in the welfare system.
- The State ought to raise the ceiling for the various types of insurance, so that the principle of income-related compensation is maintained.
- The State ought to fix a level of protection against high charges for social services, or set limits for the maximum total amount that can be charged within the care sector, or alternatively compensate people who incur many expenses through a system of remuneration.
- The State ought to look at the law regarding debt clearance, so that more people are able to get their debts cleared.

Challenges for district councils and county councils

- Redistribute financial support to various social activities, and provide compensation to children and young people in socially-disadvantaged residential areas.
- Co-ordinate charges better and put a ceiling on them.
- Counteract the increasing residential segregation.
- Take measures against homelessness.
Challenges for insurance companies

- Make it easier for the disabled to take out personal insurance.

Challenges for property owners

- Contribute to reducing segregation in housing areas.
Goal 2

A supportive social environment for the individual

- Reduced isolation, loneliness and insecurity
- Increased participation in leisure and cultural activities

People’s health is shaped by a combination of the person’s individual circumstances and the surrounding social environment. Changes in a person’s social environment fundamentally affect the interplay which exists between the body’s various psychological systems, e.g. the mechanisms which control blood pressure, blood sugar replacement, pain sensation and the immune system.

Social relationships are influenced by what society as a whole looks like – how the conditions regarding work, financial security, accommodation and leisure are shaped. The workplace is an important arena for social contact. For the individual, a feeling of security in his social environment in the form of family, friends, work colleagues and others in his circle of acquaintance, is of great importance as regards his prospects for experiencing good health.

The concept of coping is of key importance in understanding how health at the individual level is influenced by the interplay between social relationships and stress. Coping is about the individual’s ability to deal with the situation he finds himself in, and to deal with potential threats of different kinds. One of the coping mechanisms an individual can use is to seek support from his social network. The chances of getting support depend to a large extent on what resources there are in the network, in the form of safe relationships, information or material resources. It is not the size of the individual’s network which is important, but what qualities there are in the social relationships. Not everyone has access to a positive, supportive network. The differences follow, roughly speaking, the same pattern as applies to income, education and social class. The individuals who are most in need of support from their surroundings have in many cases the least access to it.

Financial and ethnic segregation in housing has increased significantly in Sweden in the past few decades. This means that access to supportive networks is undermined for those who live in areas where many people have financial or social problems of one sort or another. This is particularly evident for those people who spend all day in the area where they live, especially children. There is one group amongst the elderly who with increasing age have very small networks and
weak social support. People on invalidity benefit and those with long-
term health problems can sometimes find themselves in the same
situation. They are more likely to live alone and they say that they keep
compagny with friends, but seldom with other people. Men living alone
tend to have poorer physical and mental health than other men and tend
to be more isolated.

The closest neighbours tend to be particularly important for people
living in isolation from others in various ways. Immigrants who live in
highly segregated areas can experience isolation from the rest of
society, and their own networks do not provide sufficient support for
them to be able to participate in Swedish society. Refugees who come
to our country must receive a respectful and warm welcome if they are
to be able to establish themselves in society and build up new social
networks.

To feel well people need to feel involved, and to have the chance to
influence their own lives and society’s development. A feeling of
coherence and seeing a meaning with life are two concepts which often
recur when trying to understand why some people are better able to
take with stress than others. An important part of being able to see
coherence and a meaning with life is having insight into oneself and the
world around one. In modern society where information and knowledge
dominate, education, knowledge and skills are essential for the
individual.

Education and learning affect people’s attitudes, their way of
understanding and thinking. Learning occurs when a person encounters
something new and unknown, which is then interpreted using the
person’s own and other people’s experiences. It is based on interaction
when talking to others and on one’s own reflections which enrich the
individual and promote a sense of community feeling. Our self-
assurance is built up in relation to others. One way of improving
people’s ability to see coherence and simultaneously gain confidence in
other people is to support people’s educational endeavours in a variety
of ways through the unique Swedish system of adult education. Adult
education can also give people power over knowledge. The individual
does not always have power over what he studies and the contents
within the traditional education system and the skills training system at
work. Therefore arenas are necessary which stimulate critical thought
and independence. Reducing the educational gap between people is one
way of promoting a sense of community in society.

Having a positive sense of commitment to something and taking
part in cultural activities helps promote good health. Encountering new
experiences, participating in creative activities, reading books, getting
social and cultural stimulus – it is all about gaining a new perspective
Cultural activities as part of direct patient care have given positive results as regards the health of the patients. The power of culture as both a creative and healing force is undervalued.

The popular movement in Sweden has been an important force in creating social cement and a sense of community, both between individuals and in society in general. Belonging to an association or society has often given the individual both a sense of involvement in something at the local level and insight into the wider picture. The popular movement’s importance for public health has been great. In addition to giving the individual a sense of belonging, many of the organisations have had a direct effect on people’s health, such as the temperance movement’s importance in reducing alcohol abuse, the organisation for safe and good food, and the trade union movement’s influence on improving working conditions.

The culture of getting involved in various societies and associations is currently undergoing a change. Old organisations have great difficulty in recruiting new members, whilst new forms of network, co-operatives and associations are being set up. Many of these associations are of great importance as regards their members’ health, often because of the sense of belonging and community feeling which being a member engenders in people. The pensioners’ movement is a prime example of this. If one feels one has been discriminated against or in some other way feels disadvantaged, meeting other people can give a person new strength and also the energy to try to change, together with others, the thing causing the problem. Associations for the disabled, immigrants, homosexual and bisexual people etc are all examples of such initiatives. Other groups such as women’s refuges and religious organisations can provide support to people in acute and difficult situations.

It is an important task for society to promote the creation of different forms of supportive environment such as those springing up under private initiative. It is also society’s responsibility to ensure that all groups in society have supportive environments. Otherwise we risk a situation where certain people, who for various reasons are isolated from society, will not be reached by the social networks engendered by the various organisations. It could be a matter of the local council ensuring that outreach work is undertaken amongst the elderly, that meeting places are set up in residential areas, that nurseries are opened, that activities for the unemployed are organised, that library services are provided, that open house facilities for women from immigrant communities are set up etc. The health sector has an important role to
play in being aware of how good health can be promoted by patients and their closest families undertaking group activities together.

Local councils and voluntary organisations are increasingly collaborating on projects nowadays, e.g. volunteers providing comfort and support to elderly people and to others in need of help. The work done by the volunteers is of a reciprocal nature. It is not just the one receiving the help who benefits. Those undertaking the voluntary work can feel that they are getting involved in the community and that they are doing something worthwhile.

Promoting supportive social environments for individuals is about breaking the isolation down, giving everyone the opportunity to be part of a community, having structures in place to help the individual in crisis situations. Taken as a whole, these measures can help promote health and prevent illness.

Specific target groups

- Children and young people in disadvantaged areas
- The elderly
- The disabled and people with long-term ill health
- Immigrants
- The long-term unemployed

Players and the measures to be taken

Challenges for district councils

- Support the establishment of supportive environments in disadvantaged areas.
- Support organised activities, networks and adult education.
- Support voluntary work.
- Promote the establishment of meeting places for various groups.
- Invest in outreach health promotion work amongst the elderly.
- Be aware of the importance of cultural activities in healthcare.

Challenges for county councils

- Support the establishment of social networks for people with certain illnesses and their families.
- Support voluntary work.
• Be aware of the importance of cultural activities in healthcare.

_Challenges for voluntary organisations_

• Develop supportive activities.
Goal 3

Safe and equal conditions in childhood for all children

- A secure bond between children and their parents
- A nursery and school system which promotes health by strengthening pupils’ self-confidence and achievements at school
- Improved mental health amongst children and young people

The foundations for people’s future mental and physical health are laid in childhood. We are all born with different backgrounds. Depending upon the environment we grow up in, we become more or less vulnerable to various stresses and health risks. Giving children the chance to grow up in the most beneficial circumstances possible is one of the most obvious ways of protecting people’s right to be treated as equals and ensuring that they all have the chance of good health on equal terms.

The social and financial circumstances faced by the parents are also those faced by the children. Differences in these circumstances and in level of education have a great impact on people’s health. Nearly half of all cases of illness amongst children are the result of the conditions in which the family lives. Social circumstances have an effect on most children, and not just those who are particularly disadvantaged. Society thus has a responsibility to even out the existing differences to as great an extent as possible. Breaking down housing segregation and creating the conditions for financial security by giving parents the chance to work and thus gain all the benefits that go with it are fundamental challenges.

It is important that society compensates for what children lack in their environment, by undertaking a variety of initiatives. The basic policy ought to be one of taking general measures aimed at all children, but with more support being provided for healthcare services for mothers and children, schools, etc in areas where there are many disadvantaged children. Poverty and relative poverty are of great significance for children’s health. The financial situation of single parents has worsened during the 1990’s, so that many are now dependent on social security payments.

The health of children and young people in Sweden is generally good. The infant mortality rate is one of the lowest in the world. Swedish school children also say that their general state of well-being is good. The principle health problems during childhood are illnesses
in the postnatal period, deformities and sudden infant death syndrome. After the period of infancy it is primarily physical illnesses, accidents, infections, asthma and allergies which worsen children’s and young people’s health.

During the 1990’s the number of cases of sudden infant death syndrome and postnatal illnesses has been reduced. The same applies for infections and accidents. But the number of cases of asthma and allergies on the other hand has increased. Certain psychological problems, primarily psychosomatic troubles, have also increased. Girls are more likely to have symptoms than boys. It is estimated that between 5 and 10% of all children have pronounced psychological or psychosomatic problems which significantly affect their daily lives.

A general welfare policy in the form of high-quality healthcare for mother and baby, high-quality, accessible medical care for sick children, financial support for families with children, good childcare, schools and leisure activities, are all ways of ensuring that no child is left without support. It is not possible to know in advance which children need the most help, even if society has a particular responsibility to concentrate more on this area, as it is a known fact that many children are disadvantaged. Having a general policy aimed at all children means that it is easier to pick up children who for various reasons need special support in their development – and these children can be found in all environments. The services provided for children ought to be of a high quality throughout.

Having a secure bond to one’s parents during one’s first years of life is an important factor in supporting a good state of physical health. Not all children have this. Having a functioning social network around one as a new parent is something which supports the parent’s ability to look after the child properly. Healthcare for mothers and children should support every family, but it is a challenge to identify the parents who are especially vulnerable and to offer them more support and information than is currently the case. Postnatal depression presents a risk to both mother and baby.

It is essential to support parents in a multi-cultural society, characterised by considerable separation and big changes on the job market. Parents need to have both the time and the energy to be able to function well as parents. Parents need to adapt their working lives better than they do today in order to meet the needs of their children. Families need to feel that they can control their own lives in a way that means that they can be the good parents they want to be.

Healthcare services for mothers and babies have an important task in actually trying to prevent illness and injury. Not smoking during pregnancy and not smoking in the home are significant ways of
preventing sudden infant death syndrome and the development of asthma. It is important to inform mothers that breast-feeding protects the child from infection and helps prevent allergies. Parents need to be provided with all the necessary information on how to prevent or reduce the effects of allergies. This is especially important for families already suffering from allergies. In order to reduce the currently rising incidence of skin cancer, both parents and those caring for children should be provided with information about how to protect children from the sun. The risk of a child being injured is clearly linked to the parents' social class. The number of accidents can be reduced by continually providing information about accident risks and taking measures to reduce the risks in a child’s surroundings.

In order for children to have a healthy psychological development it is important that they are seen and acknowledged. Many children obviously have these needs fulfilled via their families. Other children are dependent on other adults taking notice of them. The social network surrounding every child therefore has great significance for the child’s physical and social development. A child is therefore at greater risk if he grows up in an area where many adults have problems of various kinds, as there are thus fewer adults to provide support for the child. Society has a responsibility for ensuring that childcare, schools and leisure activities are of a high quality and that they contribute to ensuring that notice is taken of every child. Good childcare is of particular importance for children in vulnerable situations. It is a matter of urgency that psychological and psychosomatic difficulties amongst children and young people be spotted.

The children of immigrants need to be met with respect for their cultural inheritance and their language. A number of children, especially refugees, have been through traumatic experiences and need help in coming to terms with them. Giving every child of foreign extraction the chance to be bilingual with a double cultural identity can play an important part in strengthening his own identity. It is absolutely vital that the children learn to speak good Swedish, if they are to have the same opportunities as others in Swedish society. There is a higher incidence of ill health amongst the children of immigrants, primarily refugees. The increased risk can almost totally be explained by the low social status of the parents. Discrimination, forced segregation and isolation are all factors which can be influenced with regard to the health of the children of immigrants.

Children with various types of disability need support, so that the disability does not mark the whole of their childhood. Like other children they need the chance to play, develop and free themselves of
their parents. The parents of severely disabled children often live in very stressful circumstances. Making it easier for these parents to function in their role as parents is both a way of making the child stronger and of reducing the risk of the parents suffering ill health. Good child rehabilitation, the opportunity to play and take exercise, aids tailored to the needs of the child, a school and the healthcare system within the school which understands the needs of the disabled child are all important factors for helping the child to develop a positive identity, to be able to learn and to maintain his current state of health and improve it.

Children who have various sorts of problems regarding their ability to concentrate, or who have difficulty reading or writing, also run a considerable risk of suffering from various forms of ill health as adults. Boys often exhibit challenging behaviour, and girls can react by becoming withdrawn. It is important that the problem is noticed as early as possible and that these girls and boys get support.

The number of overweight children and young people is on the increase. It is calculated that approximately 5% of all young people, primarily girls, suffer from some form of eating disorder. There are a variety of reasons for the increase in the number of overweight children. Important factors are lack of exercise combined with poor eating habits. When providing information on the importance of healthy eating, it is important that the message does not come across that all fat is dangerous. This can then be counter-productive and instead lead to eating disorders.

Nurseries and schools have a totally pivotal role to play in how children and young people develop, not least from a health point of view. It is the one area of activity in society which has the greatest chance of levelling out socially-determined ill health. The importance of all young people having the chance to finish senior school is considerable. Schools are Sweden's largest workplace, and schools are an arena where there are both children and many adults. It is important for the future health of children and young people that schools and nurseries are involved in health promotion.

Ability to learn increases if the pupil feels well, both mentally and physically. Children who are happy at school find it easier to learn. As the gap in health between adults with a high level of education and those with only a low level of education is large, it is therefore important from the point of view of future health to encourage pupils who currently have difficulty achieving the academic goals set by the schools to learn. A school system which promotes good health and one which encourages learning are interdependent. Encouraging learning and counteracting mental health problems amongst children and young
people is basically about creating supportive structures in school. Bullying and other offensive behaviour must not be allowed to take place. Increasing the influence children and young people have over their own situation is important for building up their self-belief.

Healthcare within schools and care of pupils in various forms undertaken by a variety of professionals have a considerable impact on pupils’ mental and physical health. It is particularly important that staff in schools look out for signs of mental health problems amongst children and young people. The children of parents with substance-abuse problems or parents with mental health problems may need help, so that they do not develop problems themselves. The suicide rate has reduced in all age groups except amongst children and young people. The number of girls attempting suicide has increased. Being aware of the early signs in a young person considering suicide and giving that person support in good time can prevent suicide.

There are a number of risk factors when growing up which can lead to ill health as adults. Smoking is not on the decrease. More girls than boys smoke. Alcohol consumption seems to be rising. The number of young people trying drugs has also increased. Health education in schools is treated as an academic subject on the syllabus, and this does not adequately create the conditions for developing attitudes which promote good health and healthy lifestyles. Health education does not function properly at the moment.

Sexuality and matters concerning personal relationships, as well as the risks associated with alcohol, tobacco and drugs, are not just a question of knowledge, but just as much a question of feelings and points of view which need to be discussed. Having a reflective conversation is one way of meeting children and young people from different ethnic groups, religions, with different sexual preferences and with different forms of disability on their own terms and with respect. Youth clubs are an important complementary aspect to schools, especially in the area of providing young people with support in matters concerning sex and personal relationships. The work now being undertaken in schools on the question of basic values ought to be supported.

It is a challenge to schools to supply pupils with good and healthy food and with knowledge about the importance of food for a person’s health, energy level and sense of well-being. Children who do not eat much of the food provided at school are often also the same children who do not eat enough for lunch. Pupils who do not eat enough become tired and are not able to do their schoolwork as well as they otherwise would be. Schools’ responsibility to give pupils basically good eating
habits thus also has a direct effect on the learning process for the children whom schools nowadays have the most difficulty in reaching.

The games children play and their spontaneous sports activities have changed. Free play is a central part of a child’s development which must be stimulated and must not be impeded by too many organised or controlled activities. Physical movement is an important factor for promoting good health. Children’s and young people’s level of physical activity has fallen over the past few decades. But on the other hand sport is the most supremely popular organised leisure activity. Approximately half of all children and young people are active members of sports clubs. But the number of children and young people who do not dedicate any time to regular sporting activity has increased. There are large social, regional, ethnic and gender-related differences in participation in sport. Fewer children can swim nowadays than formerly.

The attitude schools have to the importance of taking exercise is becoming particularly significant, because the social differences in children’s level of physical activity are so great. There is not enough room for play, movement, sport and outdoor activities in schools nowadays. Taking exercise also affects children’s ability to learn. Increased physical activity encourages learning. As there is much to be said for the fact that daily, repeated activity gives the best protection, children ought to have access to nearby park areas, safe cycle paths and well-built playgrounds. More and more research supports the fact that learning is improved by participation in various artistic and cultural forms of expression.

Schools have a considerable role to play in promoting both the mental and the physical health of their pupils. There is currently nothing written generally about health in the legislation on schools, except in areas which are the direct responsibility of the health services in schools. The report on pupil care (SOU 2000:19) has proposed certain improvements in connection with pupils’ health. It is the opinion of the Committee that The Standing Committee on the School Law (U 1999:01) ought to be given the task of looking at how the promotion of good health can be regulated within the remit of the law on schools. It is a matter of urgency that schools look at the health question, not least based on the fact that other laws, e.g. the laws on the working environment, and planning and building and the code for the environment now cover this question.

A wide range of initiatives which have significance for the health of children and young people have been covered in this chapter. Certain important measures are not, however, described in connection with the
goals and sub-goals presented here, but are instead set out under other goals where they are more pertinent.

**Specific target groups**

- Children in disadvantaged housing areas
- Children with various forms of disability, concentration problems, and difficulties with reading and writing.
- Children of immigrants
- Children of parents with substance abuse problems or psychological problems
- Parents with young children

**Players and measures to be taken**

*Challenges for national players*

- The State ought to act to make health promotion a responsibility of schools and to include this in the law on schools.
- The State ought to act to ensure that methods for promoting the physical and mental health of pupils are included in teacher-training courses.

*Challenges for district councils*

- Create the necessary conditions for a supportive environment for children and parents, and a nursery and school system which promotes health.

*Challenges for county councils*

- Create the necessary conditions for a healthcare service for mothers and babies which functions well; youth clubs in collaboration with district councils, mental healthcare for children and young people, and psychiatric clinics for children and young people; and support for children of parents with substance-abuse or psychological problems.
Goal 4

A high level of employment

- Opportunities for life-long learning
- Low unemployment
- No discrimination against immigrants or the disabled on the job market

For the majority of people paid employment is the most important source of financial support. It also has great significance for our chances of being active members of society and forming relationships with other people. Work is an important foundation for people’s identities and social life. It therefore also has an effect on our health.

Unemployment affects health in a variety of ways. People’s mental sense of well-being worsens, people make more use of public health services and take more prescribed medication. Young men increase their consumption of alcohol, and young women smoke more. Long periods of unemployment are a serious risk factor for mental health problems and cardio-vascular disease. The negative effects of unemployment also affect the unemployed person’s family and thus contribute to social disparity as regards health.

The situation on the jobs market has improved over the past few years. More women than men have gained employment. Unemployment is still very widespread amongst many immigrant groups and amongst certain groups of disabled people. Youth unemployment which was very high in the 1990’s is on the decrease. There are manifest differences in job opportunities available in various parts of Sweden. Unemployment has primarily fallen amongst people with a high level of education, whilst unemployment continues to be high amongst those with only a low level of education.

Extensive changes in the job market are currently taking place, and these changes are making great demands on people to adapt. Many work places have reduced the number of permanent posts and have instead increased the number of project-related posts and temporary contracts. It is more common to use temporary contracts within the health sector and for certain types of seasonal service production. From a health point of view temporary contracts in particular are a worse form of employment than other forms. But on the other hand they can give people who previously were totally outside the job market the chance to work. A change in the law from 1st January 2000 gave
approximately 50,000 temporary employees within district and county councils permanent contracts.

Countries which industrially and financially speaking are similar to Sweden have very different views on the system of using fixed-term contracts. There is no simple mechanism which leads organisations to invoke this type of employment contract. It depends on the cultural tradition of the country and its views on employment law. In the majority of countries permanent employment is given a high priority. Young people also seem to prefer permanent positions. Uncertainty for those on fixed-term contracts affects their health. People become stressed if they face financial or social uncertainty. There is little research to support this, but research done shows that people employed on temporary contracts have more health problems and less developmental opportunities than others. Women are heavily over-represented amongst those employed on temporary contracts. Being employed to undertake project work is another form of employment, which a number of people find to be free and flexible, but on the other hand little is known about how this type of work affects people’s health in the long term.

The number of people of working age is expected to fall in the future. This development will result in shortages of labour within many sectors and professions. It will have consequences for future policy regarding the job market and working conditions. The ability of employers to retain and recruit employees with the desired skills will become more and more important.

If the jobs market of the future to a greater extent comes to be characterised by temporary appointments, the threshold for the good jobs and companies’ own training will be raised. This could thus lead to difficulties for those groups who only have a weak connection with the jobs market in maintaining the necessary level of skills.

Education and training of various types will thus become even more important than before as regards a person’s chances of gaining a firm foothold on the job market. Health, illness and death are linked to a large degree to people’s position at work. A person’s position at work in turn has a clear connection with his level of education, i.e. people in white-collar jobs tend to have a higher level of education than people in blue-collar jobs. The connection between health and social status and education applies throughout a person’s life.

There is a long-term need for education and training for adults, as the number of jobs for unskilled workers is declining. The skills required in every industry are changing.

There are still many people in employment who do not have a full secondary school education. They can thus be in danger of facing
unemployment, despite the shortages of employees, and they will need to undertake additional training. This applies primarily to people with disabilities, immigrants of non-Nordic extraction with a low level of education, people with a low level of education in jobs which are in decline, and young people who have not completed a secondary school education.

[Kunskapslyftskommittén] The Committee for Raising the Standards of Education and Training (SOU 2000: 28) has proposed that the individual’s right to adult education provided by the State be extended and that the State guarantee the individual the right to gain a level of competency equivalent to a secondary school education. It is further proposed that the individual should not need to get into debt to receive an elementary education. The whole system of grants ought to be made up of contributions based on the level of study. The Committee proposes that people with developmental problems be guaranteed a basic adult education course like other adults. District councils ought also to be obliged to give students in need of special help the right to a more in-depth individual study plan. The right of disabled people to support in connection with adult education must be safeguarded. The proposals are important for the future health of these groups, as unemployment is an increasing risk factor for ill health.

A number of immigrants have little education. It is therefore urgent for adult education to be structured in such a way that immigrants have more chance of supplementing their education. All immigrants with both low and high levels of education need to be given the chance to learn Swedish, so that they have a chance of establishing themselves on the job market. The teaching of Swedish as a foreign language must be made more effective. Immigrants with disabilities have particular difficulty in gaining access to education and training initiatives.

To design secondary school education in such a way that no pupil leaves without completing his studies is an important challenge. Investing in communal adult education, skills development and lifelong learning, by supporting education, are also of primary importance. Discrimination on the jobs market against people of non-Nordic extraction, homosexuals and people with disabilities often originates from lack of knowledge and must be actively fought. Companies and council departments ought to draw up diversity plans.

Public and private employers have the main responsibility for training within their respective organisations. Nowadays the resources for staff training are often distributed in such a way that employees with the most qualified jobs receive the most training. On the other hand it is also important that resources be set aside for training employees within all professional groups. The resources are also
unevenly distributed between the sexes. Women receive less training than men.

Employers have primary responsibility for rehabilitating employees who have been absent from work for long periods of time due to illness. More needs to be done within the area of rehabilitation, also by the social insurance offices. More people are on certified sick leave for long periods nowadays, and at the same time active efforts at rehabilitating employees begin later or not at all. This can in turn lead to longer, certified sick leave and to early retirement on grounds of invalidity, which could have been avoided. Not enough rehabilitation is provided, and it is not evenly distributed, either between different groups of patients or between regions.

If action is taken earlier it can make it easier for the employee to take up his former duties again. In addition, there can be a need for rehabilitative measures for people with health problems or a work-related handicap who are still in employment. If it is not possible to resume one’s former duties, rehabilitation also involves offering training of some sort, so that the employee can undertake new duties for example. More and more people needing rehabilitation will be somewhat older, which makes special demands on the system. The type of training which work-orientated rehabilitation involves is very important. It can prevent long-term unemployment and exclusion from working life. Just as important for employment is the way work is organised and designing work tasks which take differences in people’s capacity during their life into account. This idea is developed under Goal 5.

People with different types of disability and who cannot find employment on the open job market must be offered sheltered employment, where the State makes contributions to the salary paid, or within Samhall. Giving invalidity pensions to people who both can and want to work is an obvious risk to their health. Neither is there any financial motive for society to do this.

Specific target groups

- Young people
- People with a low level of education
- Immigrants
- Disabled people and those on long-term certified sick leave
Players and measures to be taken

Challenges for national players

- The State ought to improve opportunities for adult education, in accordance with the proposals of the Committee for Raising the Standards of Education and Training.
- The State ought to improve what is done for the long-term unemployed to get them into jobs.
- The State ought to improve opportunities for special forms of employment within Samhall\(^1\) or by making salary contributions.
- The State ought to improve the social insurance offices’ rehabilitation activities.
- The Swedish Labour Market Administration ought to work to help immigrants gain increased access to the job market.
- The National Agency for Education should review the quality of the teaching of Swedish as a foreign language.
- The Swedish National Board of Student Aid rules should be reviewed, so that the system of dispensation regarding longer periods of study for the disabled functions properly.

Challenges for district councils

- No young person should leave secondary school without taking his exams.
- Invest in adult education via the Municipal Adult Education Service.
- The teaching of Swedish as a foreign language should be made more effective.

Challenges for private and public employers

- Counteract discrimination in recruitment.
- Give employees the opportunity to raise their level of skills.
- Encourage permanent contracts.
- Draw up diversity plans.

\(^1\) Samhall is a state-owned company. Samhall’s operating concept is to create meaningful and developing employment for people with occupational disabilities.
Goal 5

A healthy working environment

- Adaptation of the physical and mental demands of work to meet the requirements of the individual
- Increased influence and opportunities for development at work
- Reduced overtime

Working life is undergoing many changes. The international economy and technical developments are playing a major role in the structural changes in progress. Information Technology is altering the conditions of working life in many ways. Unpredictability has become a basic fact of life on the job market. All of this has direct effects on the work situation of employees.

The consequences of on-going developments from the point of view of the working environment are the extensive dismantling of previously fixed structures. This is leading to profound changes in working conditions, such as the relocation of work in terms of times and places and forms of employment. Being freed from these traditional structures means that the individual has to take control and set boundaries himself. Little is known about the consequences of this for people’s health.

The public sector is undergoing major changes. This is partly due to having to adapt to the new world situation. But an important reason is also the need that existed during the 1990’s to make considerable financial savings. This has resulted for example in a large amount of restructuring, large-scale redundancies and expansion of areas of work within healthcare, social services and schools. Many employees with only a low level of education have been forced to leave their jobs, which has placed much pressure on the remaining employees. At the same time certain of the tasks at work have been taken over by more qualified staff, who thus have new additional tasks to add to their existing ones.

The health sector could not initially observe any deterioration in people’s state of health during the 1990’s resulting from these changes, but by the end of the decade, many people were facing increasing problems with “burn-out” and similar psychological symptoms. People in the health sector do not feel that they have much opportunity to influence their situation at work, which can have a considerable impact on people’s health. Many people have had a blind faith in the ability of reorganisation to solve all the problems. But reorganisation can also
cause problems. Research has not been alert enough about this. Managers need more skills in the psycho-social aspects of work, both in the public sector and in private industry.

One pronounced development has been that companies and councils have been slimmed down more and more, so that they can concentrate on the organisation’s core business. This has led to an increase in the number of fixed-term contracts. There is a large amount of difference in forms of employment as regards job security and opportunities for development, and this can have an effect on health. People employed on projects are employed for a set period of time, working on a specific project. They have considerable influence on the work they do and more opportunity for learning and developing than temporary employees. Temporary employees, who are employed when the employer has a temporary need for staff, manifestly have more health problems than people who are permanently employed. These people also have fewer opportunities for development in their work. Women are heavily over-represented in this form of insecure employment.

It has become ever more common for swings in demand to be managed by hiring temporary staff, and in situations where permanent posts cannot be filled, primarily within the public sector. Employment agencies are growing quickly. A number of employees receive a higher salary than before in this way and experience a larger amount of freedom. But it is unclear how health is affected in the long term, by moving from workplace to workplace on a frequent basis and by not forming relationships with one’s colleagues at work. In addition, the situation of employees is affected when shortages of employees are dealt with by the use of temporary appointments.

There are currently approximately 400,000 one-man businesses. A number of them are people who are no longer directly employed by a company but continue with the same organisation as external contractors, and in many cases compete by working longer hours. Conditions for these one-man businesses vary considerably. Little research has been done into what happens to people’s health in these types of employment.

The on-going development of working life makes the job market and the work force more and more differentiated. Work-related ill health has increased. The number of people on certified sick leave and the number of reported workplace injuries increased dramatically at the end of the 1990’s. It is primarily long-term certified sick leave which has increased. The increase is greatest for professions within the health sector, education, the police and other public services. Women are over-represented in the statistics concerning the extent of certified sick leave and workplace injuries.
The percentage of long-term certified sick leave has risen significantly in the past few years, having fallen in the middle of the 1990’s. It is not really possible to compare the statistics from different years, as the regulations have changed, as has the situation on the job market. As highlighted in the introduction to this chapter, different people are vulnerable to different types of risk. Care ought therefore to be taken when interpreting figures on work-related mental health problems. Current willingness to be honest about the extent of mental illness resulting from a change in attitudes in society can also affect the diagnoses made. The number of certified sickness absences where mental health problems are cited as being the cause has increased, but it still only constitutes a small number, compared with problems with limbs. Overall, neck and shoulder pain, lower back pain, and diseases of the limbs dominate as the reasons for sickness absence. A number of these pains are stress-related.

After declining for several years, the number of workplace injuries is increasing again. Physical strain injuries and psychological problems are the most commonly reported workplace injuries. The highest rate of increase has been that for psychological problems. Work-related illnesses caused by organisational or social factors have increased the most in relation to all illnesses. The majority of them are related to stress and a high level of pressure at work. As regards physical strain injuries, which form the largest group of reported workplace injuries, there has been a significant increase in injuries connected with stress and pressure of work. Bullying is the most common cause of mental health problems after stress and work pressure.

The working environment and the work people do has a crucial effect on their health. If unskilled workers of working age were to have the same low mortality rate as more qualified professionals of the same age, mortality amongst blue-collar workers of working age would have to be reduced by over 40 % for men and 20 % for women. Women with a blue-collar background have seen the least positive improvement in their health. The area which divides the various socio-economic groups the most is the physical working environment. It is much more common for blue-collar workers to have to lift heavy objects every day, stand in unsuitable working positions or carry out repetitive monotonous movements, than it is for professional white-collar staff. The same is true of exposure to dangerous substances and noise.

Negative stress is a combination of a high level of pressure to perform one’s job and few opportunities for influencing how and when the work is done. Work with strict demands and little influence is on the increase. This applies primarily to female workers. This type of work is more extensive within the public sector.
It is particularly urgent for employees to be given more influence over their working conditions, hours of work, skills development and working environment. Influence can be seen as the individual’s way of having the energy to cope throughout his working life. It is in the light of this that the view has emerged that the workplace should be made into an area where health-promotion and illness-prevention work is undertaken. The Committee believes that the idea of the workplace promoting health is worth supporting. There are many factors involved in working to change unsuitable working environments and undertaking other initiatives which promote employees’ health. The people involved are employers with their responsibility for the working environment, the authorities, the employees, the safety representatives and the occupational health services. The health service and social insurance offices also have an incentive to contribute with measures to increase the number of workplaces which actively promote health.

It is of vital importance for the regional safety representatives to be given continued support, particularly in relation to their part in drawing up action plans for the working environment etc of small companies where there is no local safety representative. It is important to continue supporting training courses concerned with the working environment.

Occupational health services are an important resource, with their combined skill and knowledge within the field of the working environment and rehabilitation, and within the field of health care. Since the 1990s organisations have no longer received subsidies from the State to support their occupational health services. Many larger organisations have maintained the level of their occupational health services, but many smaller companies have withdrawn from occupational health work in the traditional sense. The Committee believes that for reasons of health all workplaces should have access to occupational health services.

Over the past few years the level of overtime being undertaken has been very high, despite the high level of unemployment. It tends to be people aged 30–49, both men and women, who do the most overtime, at an age where many have young children. Family life is affected in a variety of ways when there is a long working day. Several studies have shown that in addition to registered overtime, an extensive amount of unpaid overtime is also undertaken. The majority of professions characterised by a high level of unpaid overtime are dominated by men.

A central factor for health is recuperation. Pressure of work and the length of one’s working day have increased in several sectors, which means that the ability to recuperate has reduced. Research has not shown up any simple link between long working hours and health. The factors playing a role are whether the an employee receives a direct
order from his employer to work overtime, whether the work to be done requires a high level of concentration, or whether there is a risk of accidents occurring with an extended working day. Measures aimed against overtime must be based on increased knowledge of the specific conditions prevailing in different types of work. One complication is that in modern working life it can be hard to see the boundaries between work and home. More research is needed into the effects of long working hours on health and the way the working day is structured in various types of job.

The changes currently taking place in the way we work can have an effect on health. These changes can give a number of employees a conducive and advanced working environment which is adapted to meet the needs of the individual. On the other hand these changes can lead to a worsening of the working environment for some groups, with associated negative consequences for health. The rapid increase in stress-related, long-term certified sick leave implies that the changes in the job market could present a risk to public health in the long term.

The low birth rate combined with the large number of people who will soon be retiring can be expected to lead to shortages of labour in many sectors and professions. This will put pressure on the State and employers to invest more resources in prevention as regards the working environment and in timely work-related rehabilitation. The shortage of labour could turn into a risk to people’s welfare, but it ought also to be a positive force for the prevention work being undertaken as regards the working environment and for developing the way work is organised in a wider sense.

The National Committee for Public Health is of the opinion – in spite of the various investigations currently being undertaken – that a Commission on Working Life ought to be set up. A very broad overview of the complicated and multi-faceted issues regarding working life is needed. It is obvious that changes on the job market for good and ill influence people’s lives and their health, but we do not know enough about how the new model of working life will influence health. The internationalisation of companies, compliance with the EU, new types of employment contract which in some cases reduce job security, the new forms of information technology, migration, increased demands on employees to improve their skills and level of knowledge, a faster pace of work, reductions in staffing levels in the public sector and fewer collective agreements between unions and employers are all changes which could have an effect on people’s health.

The trend in health problems at work has been very worrying, and work-related illness is very unevenly distributed in the population. A
Commission on Working Life needs to have a wide membership and must include representatives from the union movement and employers’ organisations. It ought to analyse health trends in relation to actual and future changes in patterns of work and also draw up supporting material and proposals for a policy on work which promotes health. For example, the following problems urgently need looking at:

- Preventing and reducing the number of people excluded from the job market, so that the real average pensionable age is raised to nearer 65.
- Integrating immigrants more quickly as regards getting jobs.
- Raising employees’ level of skill and knowledge at work.
- Mapping out the requirements as regards knowledge and research into health matters in connection with working life in the future.

Whilst waiting for such a Commission on Working Life to gain a firm overall grasp of the key issues regarding working life, it is urgent that the work being done on improving the working environment continues. It is in this connection that the Committee is calling attention to the importance of adapting the physical and psychological demands of work to meet the needs of the individual, that the chance of having influence and developing one’s skills is increased, both on an individual level and for all employees collectively, and that overtime is reduced at work as well.

**Specific target groups**

- Employees within the care sector, primarily women
- Employees in nurseries and schools
- Employees in the retail, hotel and catering industries
- Employees in the police force and transport sector
Players and measures to be taken

Challenges for national players

- In collaboration with unions and employers the State ought to set up a Commission on Working Life, with the task of proposing measures for a policy on health promotion at work.
- The Swedish National Board of Occupational Safety and Health ought to intensify their work regarding stress at work.

Challenges for private as well as public employers

- Adapt the physical and psychological working environment to meet the needs of individual employees.
- Promote the use of permanent contracts of employment.
- Introduce measures for increasing the amount of influence employees have over their work, both individually and collectively.
- Strengthen occupational health services.
- Increase opportunities for flexible working hours to suit the needs of employees.
- Draw up descriptions of the consequences of health policies at work.
Goal 6

Accessible green areas for recreation

- Quiet and safe green areas near residential housing
- Stimulating playgrounds at nurseries and schools
- Good outdoor facilities near sheltered housing for the elderly and disabled

People have a great need to recover from the demands of work and family. We know today that nature has a particular healing power as regards various conditions caused by stress. We need first to recover through rest and relaxation in order to recharge our batteries, have new ideas and gain new impetus. Recovery takes a longer period of time than the time needed to gain new impressions. As spending time enjoying nature in parks and green areas is an important way of relaxing, it is urgent for everyone to have access to such surroundings.

Greenery also purifies the air of dust and exhaust fumes and therefore affects the environment in a positive way from a health point of view.

It is particularly important to maintain and protect the Swedish right of common access. The right of common access to the vast countryside in our country gives people the chance to get out into nature, regardless of social class. Our natural surroundings are at risk from many sides nowadays, e.g. by beach protection being undermined in many places, for example in city areas.

Outdoor life, going for walks and on trips without having to make any effort or compete with anyone is something which has great significance for the quality of life and the health of many people. The value of outdoor life for health ranks significantly higher for women than for men. Going for a walk or rambling in the woods and fields is a popular leisure pursuit which increases in popularity with advancing age. It has also become more common for women who have taken early retirement through ill health and the long-term unemployed to spend time in woods and fields. There are significant regional differences as regards such activity, and it is more popular in the country’s northern regions. The percentage of men and women going for walks is increasing for all groups in society, also amongst people of foreign extraction. Outdoor life has great potential for becoming a health factor of increasing importance. Many people however do not take advantage of the right of common access. This could be because people feel it takes too long to reach the countryside. There is a clear connection
between people’s use of green areas for recreation in general and access to a green area in the residential area where they live.

People who have an inviting garden spend more time outdoors than those who do not have such a place to go to. People who have a nice garden also spend more time in parks or in green areas further afield. This makes great demands on town planning. We can increase people’s use of parks and green areas if they are within easy walking distance. Access to green surroundings in residential areas in towns has decreased during the past few decades. District councils could actively plan for providing access to green areas close to residential areas and in towns as a whole by producing a programme as part of the overall plan dealing with the provision of green areas. It is important that green areas are quiet and safe. By quiet is meant that the noise level in the area is not intrusive.

Children spend their time in the area near where they live, whether they are at home, nursery or school. Having access to green areas near nurseries and schools is important with regards to children’s development and health. There is a connection between how much time children at nursery spend outdoors and the number of infections and stress-related infections they suffer from. Children’s motor skills and ability to concentrate are also affected by spending time outdoors. There is much to suggest that there is also a connection between the reduced occurrence of allergies amongst children and the time spent outdoors; there is in the same way a connection between spending time outdoors and children’s ability to deal with conflict. There are currently no clear guidelines for children’s public playgrounds nor for how much time they should spend outdoors when they are at nursery or school.

Access to a good and easily accessible courtyard is important for the health of elderly people who have difficulty walking and for certain groups of disabled people. Many people who currently live in various types of sheltered accommodation rarely go outdoors. The chance to go out depends on whether there actually is somewhere green and easily accessible nearby and whether there are people available to provide help and support with getting outside. Elderly people are more reliant than young people on daylight as a source of vitamins, so that their bones do not suffer calcium deficiency. Natural daylight affects people’s psychological and physiological health. It affects people’s circadian rhythms, regulates various hormones, and has an effect on certain forms of depression.

When planning gardens and green areas it is important to bear in mind that they should be accessible for people with various types of disability and that seating be provided so that people can rest. Elderly
people often refrain from going out for fear of not being able to find a park bench. Many people, especially women, are worried about being molested or attacked on footpaths or exercise routes. This fear can prevent them from going to these recreational areas. Measures must be taken to make these places safer. It could for example be a question of improving the lighting or designing footpaths so that it is easy for people to survey the surrounding area.

There is much interest to be found in tending one’s own garden or an allotment. Gardening is one of the most common leisure pursuits and is the most popular form of leisure activity after walking. There are currently 2 million gardens in Sweden, and as well as doing the actual gardening, people are also outdoors and taking exercise in a way which they probably otherwise would not do to the same extent. Having access to an allotment for people who live in blocks of flats can also create a sense of community spirit in the neighbourhood. The chance to do some gardening is also of particular importance for those groups of people who do not have access to a summerhouse.

Specific target groups

- Children
- The elderly
- The disabled

Players and measures to be taken

Challenges for national players

- The National Board of Housing, Building and Planning and the Children’s Ombudsman should be given the task of drawing up guidelines on the various types of play environment.

Challenges for district councils

- Protect the right of common access
- Draw up programmes for the provision of green areas.
- Create accessible and safe green areas
- Create stimulating playgrounds outside nurseries, schools and sheltered accommodation.
- Increase opportunities for people to do gardening.
- Improve supervision of play areas
Challenge for property owners

- Create the necessary conditions for improved supervision of play areas.
Goal 7

**A healthy in- and outdoor environment**

- Reduce exposure to passive smoking
- Well-ventilated indoor environment
- A high standard of building, protection from radiation, fresh air and a non-toxic environment in accordance with the proposals of The Environmental Targets Committee

Swedish residential accommodation is generally of a high standard, although in some cases there are problems with the indoor environment and the air quality. The areas where particular attention needs to be paid are the occurrence of radon, damp and insufficient ventilation and also exposure to passive smoking.

The illness and problems caused by exposure to these factors are primarily asthma and other respiratory problems caused by tobacco smoke, damp and poor ventilation, lung cancer caused by exposure to radon and passive smoking, and cardio-vascular disease caused by smoking. In addition to these afflictions come general symptoms resulting from a poor indoor environment. Approximately 400,000 to 500,000 Swedes are so affected by the poor indoor environment that they experience symptoms as a result. One explanation for so-called ‘hospital symptoms’ can be the increased levels of certain chemical elements in the air in hospitals, as well as damp and poorly-ventilated buildings. The symptoms suffered by those affected are irritation of the eyes, nose, throat and the respiratory tract, skin reactions, oversensitivity, fatigue, headaches, feeling ill and giddiness.

Access to drinking water in Sweden is good, but there are still problems with the quality of the water. There is a certain amount of microbial pollution of drinking water, causing stomach and intestinal problems. Other examples of risks to health are increased levels of nitrate in agricultural districts and radon in boreholes. Our drinking water can also be a carrier of various chemical substances. Around one million people living in thinly populated areas and just as many people living in summerhouses get their drinking water from separate springs. It is estimated that the water quality is unsatisfactory in roughly 25 % of individual springs in thinly populated areas.

Access to fresh air is an essential natural resource which is of great importance for public health. The two biggest global risks to our environment are the emission of carbon dioxide from the burning of fossil fuels and the emission in particular of freon. They give rise to the
greenhouse effect and accelerate destruction of the protective ozone layer. The health hazards caused by air pollution are largely a problem for densely-populated areas with many local sources of pollution such as traffic, the provision of energy, heating and industrial activity. Burning wood is another important source of pollution in the air which is hazardous for health. The most important risk factors as regards effects on the respiratory system are nitrogen dioxide, ozone and particles. Nitrogen dioxide is of great significance from a health point of view. The worst affected group are those living in densely-populated areas, especially cities. People suffering from allergic asthma run an increased risk of suffering health problems in densely populated areas and in traffic as compared with those living in areas with cleaner air. Air pollution in the country’s densely-populated areas is estimated to cause approximately 100 cases of lung cancer per year.

Noise is perhaps the environmental factor which affects the largest number of people. The major sources of noise are traffic, noisy neighbours and noise from various technical installations in buildings such as fan motors and ventilation systems for example. The Swedish Environmental Protection Agency (Naturvårdsverket) has calculated that approximately 1.5 million people in Sweden are exposed to noise levels of over 55 dBA from traffic outside their homes, which is the long-term target for the highest level of noise outdoors. Studies into the problems caused by noise estimate that approximately 5–10 % of the country’s population are badly affected by traffic, and approximately 2–6 % have considerable problems with noisy neighbours. Noise from restaurants and night clubs, and noise from workshops, industrial sites and building sites are causes of significant disturbance. Continuous low-frequency sound from businesses outside people’s homes can also present a risk to their living environment. The high levels of noise which people going to concerts and discos are exposed to can lead to damaged hearing. Tinnitus is one such form of damage which cannot be cured. Children are particularly at risk because their auditory canals are shorter and narrower. Noise is also a major issue in the working environment. Studies of levels of noise which people are exposed to in the course of their work show that noise can be a risk factor in high blood pressure.

The deposits of non-biodegradable substances in the environment and in the human body are a potential risk to health, for example by affecting the immune system and the hormone system, damaging the reproductive organs, causing kidney damage, damage to the nervous system and cancer. The substances in question are heavy metals like cadmium and quicksilver as well as various organic substances.
Cadmium levels in Swedish samples are high and are close to the level where there can be a negative effect on health.

Methyl quicksilver contents in fatty East-coast fish and in fresh water fish, primarily pike, pikeperch, turbot, perch and eel are so high that pregnant women, breast-feeding women and women planning to conceive should refrain from eating these species of fish. The situation has become worse because of the on-going acidification. The Report on Environmental Health [Miljöhälsoutredning] (SOU 1996:124) estimated that nearly 5% of the country’s population eats fresh water fish once a week or more. If the quicksilver levels in the fish eaten by this group are high, then the safety margins are small as regards foetal abnormalities.

Despite the fact that the hazards to the environment and to health caused by chlorine and bromide compounds are well-known, bromide compounds are now being manufactured and used to an ever greater extent as a flame-retarding agent in textiles and electronic equipment for example. It is increasingly the case that bromide flame-retardant agents are being found in increasing amounts in breast milk, which is extremely serious. No obvious effects on the health of the Swedish people as a result of exposure to these substances has yet been seen in practice, but we are much closer to the levels where it is feared that health could be endangered, and the potential effects are extremely serious.

The majority of the work being done to prevent and remove environmental health risks is being undertaken primarily on the basis of the Environmental Code, work on setting environmental targets and the work on chemicals. The active parties operationally are district councils, county administrative boards, the central supervisory agencies, sector authorities and companies involved in work covered by the Environmental Code and environmental targets. In the light of this it is important that matters concerning the environment and health are co-ordinated with the work on environmental targets.

The priorities and proposals which the Committee described earlier (SOU 1999:137) are in total accord with the priorities set out in the work on environmental targets in the Environmental Targets Committee’s report The Environment of the Future – Everyone’s Responsibility [Framtidens miljö – allas vårt ansvar] (SOU 2000:52) and the report by the Chemicals Commission [Kemikalieutredning] Products without hazards – Proposals for the implementation of new guidelines on chemicals policy [Varor utan faror – förslag till genomförande av nya riktlinjer inom kemikaliepolitiken] (SOU 2000:53). In the report by the Environmental Targets Committee the national goals on environmental quality which Parliament had agreed
at an earlier date have been specified in detail and are intended to be met within a generation. The Committee has also produced proposals regarding strategies for action, instruments of control and the delegation of responsibility concerning implementation and monitoring, etc. In the report from the Chemicals Commission it is proposed for example that knowledge of the properties of chemical substances which have an effect on health be increased and that there should be no bio-accumulative substances in chemical products.

Based on the fact that issues concerning the environment and health are well-integrated in the Environmental Code and the work on setting environmental targets, we are of the opinion that there are no grounds for setting up parallel activities within the environmental and health area using goals and strategies which the Committee might draw up specially. It is instead a matter of urgency that action be taken based on the proposals which The Environmental Targets Committee has presented and which are directed towards a series of goals which aim stage by stage to meet the goals on environmental quality for high quality buildings, safe levels of radiation, fresh air and a non-toxic environment. Within the framework of these proposals and taking the Chemicals Commission’s proposals on for example the phasing-out of bio-accumulative organic substances into account, we still would like to emphasise certain points.

The National Committee for Public Health attaches great importance to increasing the number of healthy houses by laying down requirements for function and emissions, and to reducing the number of houses where radon is present. We are further of the opinion that it is a matter of urgency that residential areas receive a environmental and health declaration, and that nurseries, schools, workplaces and other places to which the general public have access are made more allergy-proof. As regards the outdoor environment we would like to stress the importance of reducing ozone, air pollution and noise.

As regards the continued preparation of the Environmental Targets Committee’s proposals the Committee believes that the time scales for reaching the intermediate goals should be looked at in certain cases. It is a pressing matter that the time scale for meeting the goals which affect people’s health can be monitored in the year 2010, which is the reference point for the national public health area. Monitoring certain goals before or after this date presents no problem in this connection.

The Environmental Targets Committee has not presented any proposals of its own on passive smoking, because the National Committee for Public Health is dealing with this issue. The goal of reducing exposure to passive smoking occupies a special position, as this issue is not dealt with in the work done on setting environmental
targets, nor is it covered in the Environmental Code or the laws on planning and building. Our aim based on this fact is to reduce passive smoking by proposing a new law prohibiting smoking in restaurants, cafés and other places serving food to which the general public has access. The general and specific reasoning behind our draft law is described in Chapter 8. The issue of smoke-free restaurants and other places serving food is dealt with under Goal 12 – Reduced tobacco consumption – together with other issues on tobacco.

Our conclusion is moreover that environmental health work could be improved if local and regional work on public health and Agenda 21 work were integrated together. This would provide greater opportunities for arousing public opinion and maintaining a high level of ambition in this area.

The properties in products which are damaging to health and the public health goal in relation to this are covered under Goal 8 – Safe Environments and Products.

Specific target groups

- Children and young people
- People with allergies and other forms of hypersensitivity
- People who live in areas with a high level of exposure to ozone, air pollution and noise

Players and measures to be taken

Challenges for national players

- The State ought to revise the law on tobacco so that restaurants and other places serving food are made smoke-free.
- The State ought to introduce initiatives for increasing the number of healthy houses, by stating the function and emission requirements for buildings and building materials.
- The State ought to help ensure that action is taken over poor ventilation, damp buildings and high levels of radon.
- The State ought to help ensure that knowledge about defects in the indoor environment is increased by a process of education, information, opinion forming and research.
- The State ought to adopt rules for giving residential buildings an environmental and health declaration.
- The State ought to adopt the Environmental Targets Committee’s series of goals for meeting the environmental quality goals passed
by the Swedish Parliament regarding high-quality buildings, safety from radiation, fresh air and a non-toxic environment.

Challenges for building companies and property owners

- Attend to houses with a presence of radon and houses which cause allergy problems and other forms of hypersensitivity.

Challenges for companies, county administrative boards and district councils

- Take action over air pollution and noise through initiatives which above all deal with road traffic.

Challenges for district councils

- Link the work being done on Agenda 21 with measures for good health.
Goal 8

Safe environments and products

- A safe home environment, a safe traffic environment and safety in other public places
- Reduced use of products hazardous to health and those causing allergies

It is an important matter for health that environments be created which reduce the risk of injury. Injuries can be the result of unintentional events such as accidents, and intentional action such as violence, suicide and attempted suicide. It is primarily injuries caused by accidents which can be prevented by having a safer environment, but the number of suicides and incidences of violence can also be influenced to a certain extent by the way the environment is designed.

Work on preventing injuries has been very successful in Sweden. Many deaths and injuries have been prevented by changing the environment, not least the working environment, and by providing information on certain risks. It is public health work which achieves quick results in terms of reduced human suffering. The number of fatal accidents amongst children for example has been reduced from approximately 400 children per year in the 1950s to approximately 80 fatal accidents per year now. Injury is still, however, the most common cause of death amongst children, young people and young adults.

Risk of injury is present in every environment, but the majority of accidents occur in the home, at school, whilst spending time outdoors, taking exercise or taking part in sporting activities. The issue of accidents at work is discussed at the end of Goal 5 in connection with having a good working environment.

Events which lead to injuries do not happen at random in society. They occur to a large extent in relation to exposure to risks in various environments. The risk of being injured depends primarily on age, gender and socio-economic group. For a society which wishes to attain a high and even level of health, it is therefore important to create a safe environment. Children from different social backgrounds do not come to harm to the same extent. The children of white-collar workers have a considerably lower fatality rate as a result of accidents than the children of blue-collar workers or farm workers. Men suffer more injuries than women – a difference which applies to all age groups. Many injuries can be prevented by having safer environments, for
example elderly people falling and hurting themselves, accidents in play areas, fire prevention and good traffic planning. Other injuries are more dependent upon the abilities and behaviour of the individual. Many young men come to harm by taking risks whilst pursuing their hobbies and in traffic. There is good cause to direct specific initiatives at young men. Other initiatives to provide information to specific groups include information to cyclists about the important of wearing cycle helmets, and information to parents with young children about risks in the home. Making homes and play areas safe for children can be achieved by a combination of providing parents and nursery staff with information, and by taking action regarding the physical environment.

The road traffic environment needs to be made safer, primarily for unprotected road-users. The so-called ‘zero vision’ which implies that no one dies or is seriously injured in traffic is a vision which the Swedish Parliament has laid down. There is a target linked to this vision that the number of people killed in traffic should be a maximum of 270 by the year 2007, which would mean halving the current number of deaths over a 10-year period. As regards cycling accidents, 40–50 deaths each year occur because the cyclists were not wearing cycle helmets. In addition, many accidents occur which cause head injuries. Initiatives have been undertaken to increase the use of cycle helmets, but the work of providing information and influencing people needs to be intensified. Accidents currently occur within taxi services for the disabled which are often not even reported, as they did not involve a collision, e.g. wheelchairs are not fixed in place properly, and safety belts do not work correctly.

Products must be safe for the user. This demands action both by the manufacturers and the authorities, so that the risk of injury is reduced. It is especially important that toys and other products which children come into contact with are safe. From the point of view of allergies the standard of various products is of vital importance. Nearly 20% of the population suffer from various forms of contact allergy. It is decidedly more common for women than men to have contact allergies. Women are for example 10 times more likely to have an allergy to nickel than men are. One group particularly at risk are the people who risk developing allergies or a worsening of existing allergies in connection with their work. New products appear constantly, such as chemical products, cosmetics, hygiene items and building materials. There are currently 3,700 different substances which are described as contact allergens. The production of food has also changed radically over the past few decades. There is a great need for consultation between trade and industry, scientists, the authorities and allergy organisations.
Almost 40,000 new cases of cancer are registered every year in Sweden, 10% of which are skin cancer. Skin cancer has increased considerably over the past few decades. There is a clear connection between people’s sunbathing habits and the risk of skin cancer. Factors such as package holidays, other leisure and recreational activities on offer, the clothing we wear and the fashion for being brown have all contributed to the increase. If a person uses a solarium regularly, the risk of getting skin cancer is greater. Sun creams can also contribute, as they protect the skin from burning caused by ultra-violet rays, but not against contracting cancer. The use of sun creams can therefore give people a false sense of security and lead them to expose themselves to the sun for longer periods. It is vital that information is provided on the various causes of skin cancer and that sun creams have a product declaration.

Taking action to prevent suicide is a particularly important part of public health work. Even though the number of cases of suicide has fallen, suicide is still the most common cause of death for men, and the second most common one for women aged 15–45. Taking action in various areas of society can help prevent suicide. It could be a question of looking at the conditions under which children grow up, health care resources in schools, the working environment, how qualified the health service is to notice when someone is at risk of trying to commit suicide. But it is also a question of reducing risks in the physical environment. Preventing suicide is therefore a question of various authorities working together.

Women and children face a significant risk of coming to harm through violence and being attacked in their own homes. It is important to support parents in various ways so that they are able to cope with their role in bringing up their children, in order to avoid child abuse. The Government act concerning women’s freedom from molestation, which was passed by the Swedish Parliament in 1998, stated that violence against women was a large-scale public health problem. The bill stated that 7% of all girls had been subjected to sexual abuse before the age of 18. Almost every 10 days a woman in Sweden is killed by a close male relative. Compared with other studies these figures are somewhat low. The initiatives which the Swedish Parliament passed in connection with the women’s molestation act are to form the basis for action against violence towards women.

Violence between men is the most common type of violent crime. Preventing this type of crime is a matter of looking at the conditions in which the young people grow up and living conditions in general, but it is also a question of men’s role in society which needs to be changed.
The work on increasing equality between men and women is one way of taking action against violence.

Violence as an expression of discrimination against a particular group is a serious matter. The groups subjected to this are primarily homosexuals and immigrants, particularly those from non-European countries.

Anyone can accidentally come to form part of a group at risk of injury by being in a particular environment. Entertainment and going to restaurants is often associated with alcohol consumption. Arguments and violence can occur now and then. This makes great demands on the organisers of the events and publicans to prevent this occurring, but effective supervision is also important.

Sweden took much successful action during the 1900s to prevent injury, and this has resulted in a dramatic reduction in the number of fatalities caused by injury. In recent years local programmes for preventing injury, based on the model for ‘a safe and secure district council’ have easily reduced the number of accidents by up to 30% for some councils. The model is based on the fact that there are many players involved in collaborating on accident prevention work.

The Centre for Epidemiology at the National Board of Health and Welfare (Socialstyrelsens Epidemiologiska Centrum, EpC) is undertaking development work to set up a national register of injuries. The aim is to set up a register in two parts, one part holding general, national data, and one part holding data from a representative selection of health care providers. The register will include all types of injury, both those which occur intentionally and those caused by accidents.

A national injury register will form the foundation for preventative measures and for the evaluation of these measures. It must therefore meet the needs of the district councils for providing information in order to reduce the risk of injury. It should also be used to provide epidemiological information for planning within the health sector to improve treatment and for research. It must also meet the needs of the National Institute of Public Health (Folkhälsoinstitutet) for data for monitoring and for evaluating national public health targets. It is particularly important to be able to gain information on injuries from a perspective of equality and from a socio-economic perspective. It is urgent that this national injury register be set up and that the Government draws up a decree for a health data register.

The so-called 'sector principle' which gives various authorities sectors of responsibility for separate issues ought also to include responsibility for ensuring that the environments within different areas are safe.
Specific target groups

Injuries

- The whole population as regards injuries, but different groups require different forms of information and action.

Products hazardous to health

- Children and young people
- People suffering from allergies

Players and measures to be taken

Challenges for national players

- All players, both public and private, should be responsible for implementing measures and covering the costs of creating safe environments within their area of responsibility.
- A national injury register should be set up as soon as possible by the National Board of Health and Welfare. A decree for a health data register ought to be drawn up, to make this possible.
- The Swedish National Road Administration’s work to reduce traffic injuries ought to be completed. The Administration ought to have responsibility for intensifying the information campaign for increasing the use of cycle helmets.
- The Swedish Consumer Agency ought to be given the chance to improve control of the safety of products, especially toys.
- The Medical Products Agency (Läkemedelsverket) ought to work to ensure that sun creams have a product declaration.

Challenges for district councils

- Develop safe environments, based on the model ‘a safe and secure community’.
- Reduce the risk of accidents in the homes of elderly people, e.g. by preventing accidents where the elderly fall.
- Improve supervision of play areas and make plain that it is the responsibility of property owners to ensure the environment is safe.
- Schools ought to make sure that all children can swim.
• District councils and the providers of taxi services for the disabled ought to set exacting standards for safety when transporting disabled people.
• Attention ought to be paid to the properties of products purchases which can cause allergies and are hazardous to health.
• Provide affected occupational groups and the general public with information on allergies.

Challenges for county councils

• Develop information within the health sector on the risks of injury through the health services provided for mothers and children.
• Improve co-ordination between health services and district councils regarding safe environments.
• Record injuries.
• Attention ought to be paid to the properties which can cause allergies and which are hazardous to health in the products purchased.
• Provide affected occupational groups and the general public with information on allergies.
Goal 9

**More physical exercise**

- More physical exercise at school and in connection with work
- More physical exercise in people’s leisure time

In peasant society physical work was a necessary part of life, but in today’s society there is less and less demand for physical activity. In order to get the exercise which our bodies need, we must, in contrast to earlier times, take the initiative ourselves in our spare time and take exercise. That is also why there are great differences between people as to their physical activity.

In general we take much too little exercise to feel the positive effects of it. The increasingly sedentary lifestyle we lead is a risk to the health of many people in the long term. Physical activity is becoming more and more a question of social class. Physical activity – as with many other habits in life – follows a clearly defined social pattern and is linked to people’s way of life and their living conditions in general terms. People with the highest level of education take the most exercise, and those with the lowest level of education take the least. People who are physically active eat more healthily and smoke less than other people.

There is a very clear connection between the extent of people’s physical activity and their state of health. Half an hour of moderate physical exercise every day can reduce the risk of cardiovascular disease, non-insulin-dependent diabetes, accidents caused by falling, brittle bones in the long term, certain forms of cancer and less severe forms of depression. One of the causes of the increasing number of overweight people in society is that people do not take enough exercise. For many people it is also a question of eating habits. It has been calculated that approximately 45% of the population are overweight or obese.

Many people still work in jobs involving hard physical effort. This is especially the case for women in the care sector. But it is a mistake to believe that such people can get enough physical exercise through their work. In fact the opposite is the case. If a person works in an occupation where an uneven burden is placed on the body and with monotonous movements, it can be even more important to take exercise to prevent strain injuries and pain. It ought to be obvious that no one should come to harm at work, and this should also be the case for those exposed to chemicals. Physical activity to help prevent injuries ought
to form a natural part of the working day in all workplaces where people work in sedentary positions or where the work places an uneven physical burden on the body.

Games and spontaneous sporting activities have changed, which means that children and young people do not take enough exercise. However, sport is the most popular organised leisure activity amongst children and young people. Boys are more actively involved than girls. There is also a noticeable social imbalance in the groups of people involved in sporting activities. Swedish schools have fewer games lessons when compared with many other countries in Europe. Outdoor life has a much too remote place in school life. Nurseries and schools ought to encourage children to undertake physical activity. Children with various forms of disability must be given the opportunity to take part in activities which have been adapted to take account of their abilities, and this ought also to apply to overweight children. Many children nowadays have never learnt to swim. This is most commonly the case for children of non-Swedish extraction.

With regard to elderly people, physical activity and the chance to get out are very important for maintaining and improving their state of health. However, many remain sitting in their homes or in sheltered accommodation because they are not given the help and support they need to get out. Certain disabled people do not get anything like the amount of physical exercise they require to maintain their level of physical ability. The support required, so that the disabled person can perform the various important exercises specifically adapted to his situation, is often lacking.

The vast majority of those devoting time to exercise do it as a form of recreation and to relax. Taking more exercise on a daily basis is one of the health factors where we as individuals can directly influence ourselves. It is, however, also a social issue. It has to be made possible on a practical level for everyone to take exercise. It is society’s responsibility to stimulate children to undertake physical activity and see that roads to schools and school playgrounds encourage children to cycle and take part in spontaneous physical activity. Similarly it is society’s responsibility to ensure that the elderly and the disabled are actively provided with opportunities to take exercise or to train on their own terms. Employers have a corresponding responsibility to ensure that employees are offered opportunities for physical activity in connection with work. The sports movement, including sports for the disabled, is of great importance for stimulating broad-based sport. The way councils plan towns affects the possibility of quickly and simply being able to reach recreational areas and sports facilities. Councils via
schools also have a responsibility to ensure that all children are given the chance to learn to swim.

**Specific target groups**

- Children and young people
- The elderly
- Immigrants
- Certain disabled people and people with long-term health problems
- People working in occupations which are highly strenuous physically or which place an uneven strain on the body.

**Players and measures to be taken**

**Challenges for national players**

- The State ought to encourage the taking of exercise and broad-based sport in all its forms.
- The National Corporation of Swedish Pharmacies ought to inform its customers of the connection between physical activity and health.

**Challenges for district councils**

- Take action to ensure that schools and nurseries encourage children to undertake physical activity.
- Create the conditions necessary so that all children can learn to swim.
- Create the conditions necessary so that the elderly can get out every day.
- Support non-profit-making organisations which are involved in various physical activities.

**Challenges for county councils**

- The health sector ought to encourage patients to take exercise.
- Ensure that the disabled are offered training and exercises adapted to meet their individual needs.
Challenges for sporting organisations

• Recruit new groups of people to take part in organised sport.

Challenges for employers and unions

• The work place ought to be a supportive environment for promoting health through physical exercise.

Other players and measures are outlined under goals 6 and 8.
Goal 10

**Healthy eating habits**

- Increased consumption of fruit and vegetables and reduced consumption of fat and sugar
- Reduced number of overweight people in society
- Increased number of women breast-feeding

Food and our eating habits affect our health, but also function as bearers of culture, a meeting place and a source of enjoyment. A well-balanced diet is of great importance for our health, both by promoting and maintaining good health and by preventing illness. Our eating habits are a part of our cultural and social class. Changes in eating habits amongst the population depend on a combination of price, marketing, new fashions, altered family patterns, working conditions and information on health.

Eating habits vary between people with different cultural and social backgrounds, between the sexes, between young and old people, and between different regions in Sweden. Knowledge and awareness of the importance of food for health is somewhat lower amongst people with a low level of education as compared with people with a higher level of education. Women eat more healthily than men and are more willing to change their eating habits. Young people eat low-fat dairy products but less fruit and vegetables than adults. Children and young people eat more sweets and ice-cream and drink more fizzy drinks than adults. Healthy elderly people generally eat a balanced diet, but poor nourishment or malnutrition sometimes occur within certain types of residential accommodation and amongst some people living alone.

Everyone ought to have access to both safe and healthy food. Sweden has long been spared major food disasters. Legislation and control of the quality of food products and drinking water, the marking of food products, their shelf-life and information about their country of origin are all key issues for people’s health. Increased vigilance is now required in the face of the internationalisation and harmonisation of legislation within the EU.

Nowadays most consumers are aware of the importance for good health of eating a varied diet, reducing their intake of fat and sugar and increasing their consumption of fruit and vegetables. The consumption of fruit and vegetables has increased dramatically, but on average we still eat too few vegetables, too little fibre and too much sugar and fat, which is not good for our health in the long term.
The primary reasons people give for not eating healthily are lack of time, not wishing to refrain from eating food which they enjoy eating and lack of practical knowledge or opportunity to prepare and store food. Groups with a low social status state that price is one of the factors which has greatest significance for their choice of food.

Oversensitivity to food stuffs occurs more often amongst children than amongst adults. Approximately 10% of children under the age of 6, teenagers and young adults are oversensitive or allergic to certain food stuffs. In families with a high risk of allergies children should refrain from eating foodstuffs known to cause allergies such as fish and eggs, until they are over a year old. A safe and all-embracing system of marking food products is of the greatest importance for people with food allergies or oversensitivity.

Being overweight or obese is a rapidly increasing health problem. This problem is more common amongst manual workers than amongst white-collar professionals. Nearly half of the adult population is overweight or obese. Being overweight to such an extent that it can be expected to shorten life expectancy has become so common that it is estimated that 10% of all adults belong to this category. It is particularly worthy of note that the percentage of young people who are overweight or obese is also rising. The number of people being taken ill with age-related diabetes has increased. One of the reasons is probably the considerable increase in body weight. Different types of eating disorder are a problem amongst young people, particularly girls. It is estimated that approximately 5% of women between the ages of 13 and 40 suffer from some form of eating disorder. It is estimated that between 30 and 40% of people who are severely overweight suffer from compulsive eating (bulimia).

The number of women breast-feeding has increased considerably since the 1970s, as has the length of time they continue breast-feeding. Breast-feeding and breast milk are very good for the child. All of the country’s maternity clinics now encourage breast-feeding. There are still great regional differences in how many mothers breast-feed and for how long. Young women with a low level of education breast-feed the least.

Eating habits are strongly associated with social class. Senior school pupils who come from homes with manual occupations do not eat lunch as often as the other pupils. Pupils who eat lunch at school are fitter than those who seldom eat lunch.

It is important to provide a supportive environment to help improve eating habits amongst those who are in most need of help, such as having a good selection of dishes in restaurants, at school and within various care services. The public sector has a particular responsibility
for ensuring that the food served in all the various public institutions and schools is both good and healthy, and that the eating environment helps promote enjoyable mealtimes. It is important that teaching on health and food at school is integrated with other forms of health education, as unhealthy eating habits are often associated with other forms of unhealthy lifestyle. The information provided should promote a positive attitude to food and to one’s own body. The methods used in health education should be developed.

Elderly people who can no longer cook their own meals are often dependent on the delivery of ready-cooked meals. One’s desire to eat can be reduced when one is no longer involved in cooking the food nor in cooking the food one likes. Eating alone can also reduce one’s appetite. It ought therefore be possible for the elderly to have their meals cooked at home in certain cases, in the same way as the severely disabled nowadays can get help in the shape of personal carers.

People with learning difficulties and a number of people with mental disabilities may need help and support to develop healthy eating habits. It is common for people with learning difficulties or mental disabilities to eat both unhealthy food and lead inactive lives, resulting in weight problems and poor health. For people with mental disabilities weight gain is a common side-effect of neuroleptic drugs, primarily because the medicine increases feelings of hunger. Certain chronic illnesses can lead to a need for special diets and nourishing drinks as supplements or as sufferers’ actual food. Special diets are often expensive, and the level of economic support available varies all over the country.

Industry and so-called professional cooks can end up taking over to an ever increasing degree the role of being the home’s producer of meals. People are increasingly eating so-called functional foods, which are normal foods which have been modified so they are healthier. It is still unknown how increased use of such food products will affect eating habits in general. At the moment it is not an issue of significance from a public health point of view.

Eating habits are affected by politics in general. There is an agreed national action plan on nutrition, which it is important to support. Important policy decisions on agriculture and food are now made at EU level. To some extent the current policy takes other factors into consideration than what is good for the health of the population. It is a matter of urgency for Sweden to take an active part in the international work being done on nutrition.

Society has a great responsibility for ensuring that food products are safe, that the system of marking food products works well, that there is a choice of products all over the country, that everyone has access to
objective information about the connection between eating habits and health, and that meals provided by the public sector as part of their services are good and healthy and served in a stimulating environment.

**Specific target groups**

- Children and young people
- The elderly
- People with foodstuffs allergies
- Certain groups of disabled people
- Immigrants

**Players and measures to be taken**

*Challenges for national players*

- Based on its sectorial responsibility for food, the National Food Administration (Livsmedelsverket) ought to develop the information it provides to the public on the connection between diet and health.
- The National Food Administration, The National Institute of Public Health (Folkhälsoinstitutet), The Swedish Consumer Agency (Konsumentverket), The National Board of Health and Welfare (Socialstyrelsen), The National Agency for Education (Skolverket), The Swedish Environmental Protection Agency (Naturvårdsverket) and the National Integration Office (Integrationsverket) ought to continue their work and further develop the strategy document *Nationella mål och strategier för nutrition 1999–2004* [National Goals and Strategies for Nutrition 1991–2004].
- The Swedish Consumer Agency ought to take action to ensure satisfactory access to everyday commodities all over the country.
- The State, and district and county councils ought to ensure that all political decisions affecting eating habits and food safety are subject to a review of the consequences for health, both nationally and within the EU.
- The National Corporation of Swedish Pharmacies ought to inform its customers about the importance of eating habits as regards preventing various illnesses.
Challenges for county councils

- Take action to ensure good and healthy food is provided within the health and care sector.
- The health and care sector ought to provide information to a greater extent concerning the connection between diet and health and give individuals advice.
- Promote, protect and support breast-feeding.
- Provide support for those requiring a special diet.

Challenges for district councils

- Schools ought to support the development of healthy eating habits by making pupils into conscious consumers, improving school meals and making more use of domestic science and consumer studies.
- The elderly and people with disabilities who cannot make their own food should have access to a good and healthy diet in their homes and in sheltered accommodation.
- Councils should take action to ensure that the food served in publicly-financed organisations is good, stimulating and nutritional.

Challenges for the food industry

- Promote the development and marketing of healthy food.
- Improve the marking of food products.

Challenges for the hotel and catering industry

- The choice of dishes ought to be such that first and foremost daily meals provided at work promote good health.
Goal 11

Safe and confident sexuality

- Reduced spread of sexually transmitted diseases
- Reduced number of unwanted pregnancies
- No one should be discriminated because of their sexual orientation

Sexuality is an important aspect of people’s lives and has importance for their disposition and their enjoyment of life. People’s view of sexuality is formed in their interplay with other people and the community where people grow up and live. Our view of sexuality in society is influenced by biological, emotional, social and religious factors. These factors change in importance at different stages in an individual’s life, in different groups and in society over time.

Enjoyable and secure sexuality, free from prejudice, discrimination, coercion and violence is healthy. The view of sexuality held by society as a whole is therefore important. This view determines for example where people who are homosexual or bisexual are subjected to prejudice and discrimination – with ill health as a result. A degraded view of women’s sexuality leads to sexual coercion and violence and thus also to ill health.

Sexuality is often associated with sexually transmitted diseases and unwanted pregnancies. It does not have to be like that. A prerequisite for ensuring that people’s outlook is not dominated by mainly the negative effects of sexuality is for there to exist a basically positive and open attitude to sexuality in society. With open attitudes it is easier to venture to use protection in sexual encounters. An approach like this is an important explanation for the fact that Swedish society has managed so far to prevent a dramatic rise in HIV.

The work being done against HIV and other sexually transmitted diseases must continue however. The number of sexually active young people being infected with chlamydia is currently increasing. Gonorrhoea is increasing amongst men who have sex with men. This points to changes in sexual behaviour and is causing concern that the spread of HIV could also increase. Measures need to be taken to prevent a possible increase. Part of this work involves effective measures for protecting people from infection. Continued action must also be taken to support the work being done against HIV in countries where the number of cases of HIV infection is high in the resident population. The extremely fast infection rate in many places in the
world today, for example in parts of Russia, may become a threat to Sweden as well. The international sex trade which exists in Europe, and which is increasing, also holds the threat of increased infection, and also preserves a degrading view of women from a sexual point of view.

The number of abortions fell during the 1990s amongst teenagers. The highest abortion rate is now amongst women aged between 20 and 30. During the past few years the number of abortions has, however, risen amongst girls in their early teens. The rate of abortion is highest amongst women living in socially and economically disadvantaged areas. Increased access to the so-called morning-after pill will reduce the ability to monitor the progress of interrupted pregnancies from now on. Abortions can have consequences for health, and contraceptive advice should thus be easily accessible and free of charge. When advice on abortion is given, it ought to be offered to both the woman and the man.

The increasing number of cases of sexually transmitted diseases and abortions amongst people in their early teens is a warning signal that sexual behaviour can lead to ill health. Early detection of sexually transmitted diseases is important, as they otherwise can have serious consequences such as infertility, ectopic pregnancy and cervical cancer. Feelings of guilt over an abortion are unusual nowadays, but an abortion can cause stress, particularly psychological stress.

Preventing the health risks associated with sexual behaviour is primarily a matter of strengthening the individual’s own identity and self-esteem. It is also a matter of sexual abuse. People who abuse other people suffer from low self-esteem and identity. Being secure in oneself is an important general factor promoting health, and in connection with how one deals with one’s sexuality this sense of self-esteem is paramount.

Sexual messages are supplied to a great extent by commercial channels nowadays. Schools and youth clubs have a significant role to play in giving young people the chance to reflect on and talk about sexuality, ethics and co-existence. Schools and youth clubs need to meet all the pupils, regardless of sexual orientation, ethnic background, moral or religious beliefs on equal terms and show them respect. The starting point for sex education ought to be the reflective discussion. It is extremely important that young people from different cultures are able to play an active part.

Sexuality as a source of enjoyment in life continues to be important right up to people’s later years in life. People’s knowledge about sexuality as a factor which can promote health, both from a gender and an age perspective, ought to be increased. It is discriminatory to
associate sexuality with youth and beauty. Attitudes in society need to change so that elderly people’s needs are also recognised. The situation for certain disabled people is even more difficult, as they often meet the attitude that they do not have sexual needs when they are in rehabilitation or receiving care. This is a discriminatory attitude.

Specific target groups

• Young people

In connection with reducing the transmission of infection

• Men who have sex with men
• People who have spent time or plan to spend time in regions with a high rate of sexually transmitted diseases and HIV
• People infected with HIV and their partners

Players and measures to be taken

Challenges for national players

• The National Institute of Public Health ought to follow the progress of sexually transmitted diseases and HIV in collaboration with the National Board of Health and Welfare and the Swedish Institute for Infectious Disease Control (Smittskyddsinstitutet)
• The National Institute of Public Health ought to monitor developments within the area of sex and life together.
• The Integration Department ought to improve the information it provides on sexually transmitted diseases to people newly arrived in Sweden.
• The National Agency for Education ought to take action to improve sex education in schools.
• The Prison and Probation Service (Kriminalvårdsverket) ought to improve the advice it gives on sexuality and infection to inmates.
• The Military High Command (Försvarshögkvarteret) ought to intensify efforts to provide conscripts with information and discussions about sexuality and sexually transmitted diseases and HIV.
• The National Corporation of Swedish Pharmacies ought to provide information on sexually transmitted diseases, the transmission of infection and contraception to its customers.
• The National Agency for Higher Education (Högskoleverket) ought to improve its teaching on matters regarding sexuality and sexually transmitted diseases in its teacher-training programmes.

**Challenges for district and county councils**

• Develop sex education in schools.
• Develop youth clubs and individual support in schools.
• Invite voluntary organisations to get more involved in preventative work on sexually transmitted diseases and HIV.
• Increase access to contraceptive advice and ensure it remains free of charge.
• Take action to increase the use of condoms to reduce the transference of infection by targeted measures aimed at groups where infection is primarily spread.
• Abortion advice ought to be offered to both the woman and the man.

**Challenges for the tourist industry**

• Provide information about the prevalence of sexually transmitted diseases and HIV in different countries.
Goal 12

**Reduced tobacco consumption**

- A tobacco-free start in life from the year 2010.
- A halving up to the year 2010 of the number of young people under the age of 18 who take up smoking or who use moist snuff.
- A halving up to the year 2010 of the number of smokers amongst those groups in society who smoke the most.
- No one should be subjected against his will to smoking by those around him.

Tobacco is the single biggest risk to health in Sweden. One in four smokers die in middle age as a result of smoking. The most common medical effects of smoking are respiratory problems, chronic obstructive lung disease, lung cancer, other forms of cancer, cardiovascular disease, allergies, loose teeth, impotence, etc. Lung cancer is the most common cause of cancer deaths in the world. Smoking tobacco is the primary cause of this.

The negative effects of smoking also kill people around smokers. People subjected to passive smoking suffer the same sorts of health problems as smokers themselves. The risk is determined by the concentration of smoke in the air and the length of exposure. Approximately 8,000 people die every year in Sweden because of smoking. In addition, 500 deaths per year can be ascribed to passive smoking. One effect of smoking is an increase in the risk of sudden infant death syndrome (cot death).

There has been a marked decline in the consumption of tobacco. Nearly 20% of the population currently smoke, but there are big differences between different groups and between men and women. Amongst young and middle-aged people more women than men smoke. Young girls smoke significantly more than boys. There are big differences between people with high and low incomes, occupational groups, ethnic groups and different forms of marital status. For example, approximately 10% of men in senior professional positions smoke, whilst approximately 50% of single mothers smoke. In certain ethnic groups half of the men smoke but very few of the women.

New evidence shows that consumption of tobacco is not the result of freedom of choice as regards consumption, but rather it is a drug which quickly becomes addictive. Nearly everyone who smokes took up the habit before they reached adulthood. Tobacco consumption ought therefore to be viewed from a narcotic perspective and not just as
a mere consumer habit. This means that tobacco must be fought more actively than has been the case up until now.

The use of moist snuff (placing moist tobacco under the upper lip) is increasing amongst both men and women. Mixed usage of cigarettes and moist snuff is widespread. The health effects of long-term use of moist snuff have not been adequately researched. It is necessary to study the effects primarily on the cardio-vascular system, diabetes and during pregnancy and when breast-feeding. The issue of moist snuff has become a topical one in the EU, and Sweden has a responsibility to evaluate the health effects of this habit.

Work against tobacco must, however, be integrated with all other work on public health, as the big differences in consumption of tobacco in different groups in society show that the reasons why people smoke are complex. It is a question of lifestyle patterns which have their foundations in social conditions and is only partly a question of information about the health risks associated with smoking. The fact that the people who currently smoke most are those with the most difficult financial situation, the lowest level of education, who live in stressful circumstances, underlines the importance of a co-ordinated approach to public health. There are many different risks to health affecting certain groups of the population, of which smoking is an important one.

Every child ought to experience a start in life which is free from smoke, as it is known that nicotine and other substances from tobacco can be transferred to the foetus. This means that health care provided to mothers, part of which involves informing and supporting pregnant women who smoke, is particularly important. Every child has the right to grow up in a smoke-free environment, as passive smoking is dangerous. Society has a specific responsibility to protect children from the damage caused by smoking. It is a matter of urgency to reach parents with young children, particularly via health services for children, so that no child is subjected to smoke.

The role of schools as providers of information about various dangerous habits, such as smoking, is important. This process of providing information to pupils does not function properly at the moment. If the information is provided in the wrong way, it can be counterproductive. It is a challenge for schools to find a means of engaging with young people’s attitudes and situation in life in a respectful way, whilst simultaneously having to provide information about the dangers of tobacco.

The smoking habits of people around them and their attitude to smoking generally have considerable importance for children and young people’s tendency to take up smoking. This concerns attitudes at
home, at school, in clubs and associations and the public arena as a whole. If smoking is seen as an obvious and accepted feature of adult
life, the risk of children and young people taking up smoking increases.
Rooms provided as meeting places for children and young people and
community halls of various kinds are smoke-free nowadays, as a result
of legislation. Cafes, restaurants and other places serving food are now
the only places where smoking is permitted. These places are also some
of the few where tobacco advertisements are frequently seen. It is
important that a supportive environment is set up which contributes to
reducing smoking amongst young people. Having a smoke-free
environment within the care sector and at school is an important signal
to children, young people and those who are ill. Initiatives must be
taken on a local basis to create more and more completely smoke-free
environments.

Looking at smoking as a narcotic issue means that society has a
responsibility for helping people who wish to give up smoking. Various
types of support for stopping smoking must be supported. The health
service must become better at helping those who wish to stop. School
health services and youth clubs can help support young people wishing
to give up smoking in a variety of ways. Employers can take action so
that employees are provided with help if they wish to try to give up.
There are many different ways of giving up smoking. People can for
example take part in stop-smoking clubs, or can be provided with
subsidised nicotine substitutes.

The damaging effects of tobacco can be reduced by taking action of
various kinds. It is a question of providing information and support to
various groups, but also of having legislation and restrictions in place
which prevent access to tobacco and protect young people and
employees from exposure to risk.

A rather rapid change has taken place in public attitudes towards
tobacco at the same rate as knowledge about the extensive, injurious
effects of tobacco has grown. Nowadays it is generally accepted – in
contrast to a few years ago – that public places and work places should
be smoke-free.

On an international level more and more co-ordinated action is
being taken against tobacco. This is taking the form of increased
information to citizens, various forms of restriction and prohibition, but
also by taking up the fight against the tobacco companies. There is no
other issue which is of such great importance for the public’s health as
smoking, where such powerful interests exist, which for reason of
profit are working against the public health work being undertaken. The
tobacco companies are now trying to get people in the third world to
take up smoking. Tobacco has become one of the greatest threats to
health in the world. WHO has begun working on the introduction of an international convention on tobacco. More and more countries are investing large sums of money in extensive information campaigns about the damaging effects of tobacco at the same time as introducing restrictions on access. Work is underway in the EU on a directive concerning product control and the marking of tobacco products. The Swedish Government ought to operate a restrictive tobacco policy together with the EU.

Taxation has been used in Sweden as a way of restricting tobacco consumption. There is a very clear connection between tax levels and consumption. However, there is also a large illegal market which cannot be ignored, when taxes are used as a tool for reducing consumption. New import regulations regarding tobacco have been passed by the EU and these will mean that it will become easier to get cheap tobacco products in Sweden. This means that traditional instruments such as taxation and import regulations will no longer have the same significance as ways of reducing consumption.

The tobacco law has been successively tightened up. It is for example prohibited to sell tobacco to minors. But selling tobacco to minors still takes place anyway nowadays. Unscrupulous shopkeepers also sell smuggled cigarettes. The Committee is of the opinion that a licensing system needs to be introduced so that it becomes easier for councils to check that tobacco sales take place in accordance with the law. Only shops or other establishments which the council believe will abide by the law should be given a licence to sell tobacco. It has been proposed that The National Institute of Public Health and the district councils be made the supervisory authorities. The Committee proposes that this statutory order should be included in the tobacco law. More detailed reasons for this are outlined in Chapter 8.

Smoking in public places is prohibited under the tobacco law. Employers are also responsible for ensuring that no employee is forced to breathe in smoke against his will. The tobacco law has made an exception for cafes and restaurants. It is also in these environments that people are most troubled by smoke. The tobacco law ought to be tightened up on this point, and the Committee has presented proposals on this matter. There is no reason – with the knowledge which now exists about the damage caused by passive smoking – to accept the presence of smoke in places where the general public gather. Employees in restaurants are exposed to toxic substances in tobacco smoke which are totally forbidden in other work places, one of the reasons being that they cause cancer. Many people with asthma or other respiratory problems have great difficulty or have to refrain from
visiting smoky places. It is discriminatory if public places are not accessible to the whole population.

Decisive action is required by society because of tobacco’s serious threat to health, as it is one of the main reasons for differences in health between different groups in the population and because there are strong vested interests in maintaining and increasing the level of tobacco consumption. It is therefore a matter of urgency that the tobacco law be tightened up. The reasons for this are described in more detail in Chapter 8. New methods need to be developed for how to take preventative action in the best possible way. A continued effort regarding education and information is also required, not least in connection with tightening up the tobacco law. In addition to its supervisory role in connection with the tobacco law the National Institute of Public Health ought be given the task by the Government of providing information as widely as possible and co-ordinating national initiatives at a local level.

**Specific target groups**

- Pregnant women and parents with young children
- Children and young people
- Women with a low level of education
- Male immigrants

**Challenges for national players**

- The tobacco law ought to be tightened up, so that the exceptions made for restaurants and cafes are removed.
- The tobacco law ought to be tightened up by introducing a licensing system for the sale of tobacco.
- The National Institute of Public Health ought to become the national supervisory authority, and district councils ought to become the local supervisory authority.
- The National Institute of Public Health ought to be given the specific task by the Government of providing information to the general public about the damaging effects of tobacco and co-ordinating national and local initiatives on smoking.
- Taxation ought to be used as an instrument for restricting sales of tobacco.
- Smuggling of cigarettes ought to be fought.
• The National Board of Health and Welfare or the National Institute of Public Health ought to have specific funds available to support organisations who undertake tobacco prevention work.
• The National Agency for Education ought to take action to improve ANT-teaching (Alcohol, Narcotics and Tobacco) in schools.
• The National Corporation of Swedish Pharmacies ought to be given the task of supplying its customers with information on the dangerous effects of smoking.

Challenges for county councils

• Increased efforts on the part of health services for mothers and children as regards providing information about the damaging effects of smoking.
• Health services to be given greater responsibility for supporting people who wish to give up smoking.
• Ensure that smoking is prohibited in all areas of the health service.
• Integrate anti-smoking work with other public health initiatives.

Challenges for district councils

• Improve the information provided about tobacco in schools, and improve teaching of the subject.
• Ensure that all services for children, young people and the sick are completely smoke-free.

Challenges for unions, immigrant associations, etc

• Invest in activities to help members give up smoking.

Challenges for employers

• Offer employees various types of help and support in giving up smoking.
Goal 13

<table>
<thead>
<tr>
<th>Reduced harmful alcohol consumption</th>
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<tr>
<td>Reduced total consumption</td>
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<tr>
<td>Total abstinence in connection with pregnancy, driving and sailing, at work and when undertaking sporting activity.</td>
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<tr>
<td>Reduced occurrence of drinking to a state of inebriation</td>
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A large part of the population find drinking alcohol enjoyable. For many people drinking is associated with festive or relaxed company and good food. Drinking habits are very different in different cultures. In Sweden it has been common for people to drink themselves into a state of inebriation, with low or no consumption of alcohol between the heavy drinking sessions. In the early twentieth century alcohol abuse was very widespread. The temperance movement’s work and ever more stringent regulations led to a major reduction in the abuse of alcohol during the first half of the twentieth century.

The drinking habits of the Swedish people are changing concurrently with increased internationalisation. More moderate drinking in everyday situations has increased. However, the percentage of the population who regularly become inebriated has more than doubled since the 1960s. Women have considerably increased their consumption of alcohol during the past few decades. In the same period young people have increased their consumption of alcohol to a certain extent. Sweden has the lowest registered sales of alcohol within the EU. The damage caused by alcohol is also low compared with other EU countries. Even when unregistered consumption is included, Sweden has a very low level of consumption of alcohol compared with other countries.

Alcohol causes major public health problems. Over-consumption leads to medical problems and social problems of considerable proportions. Alcohol is one of the main factors behind violence, accidents, taking sick leave, hospital treatment and early retirement on grounds of ill health. The number of deaths which are directly related to alcohol is between 5,000 and 6,000 people per year. In addition, many deaths on the roads are in turn alcohol-related. Alcohol also has a role to play in suicides, injuries and a number of diseases, not least of which is cardiovascular disease. Approximately 10 % of in-patients in hospitals suffer from alcohol-related diseases. Alcohol is closely connected with crimes of violence. Approximately 70 % of all perpetrators of crime and approximately 40 % of all victims of violence
reported to the police were under the influence of alcohol. The drinking habits of adults have a direct effect on the lives of children. It is calculated that more than 100,000 children grow up in homes where at least one of the parents has a problem with alcohol. It is estimated that between 100 and 200 children are born every year with health problems caused by the mother’s drinking problem.

It is not just people with a high level of consumption who die of alcohol-related damage, even though this group runs a high individual risk. People who on average do not drink enough alcohol to cause medical damage to their bodies can still get killed or cause injury to other people by being inebriated or by drinking on occasions where sober behaviour is required. Damage caused by alcohol is therefore not just associated with a small group of people with severe alcohol problems. The mortality rate from alcohol-related diseases for men is higher amongst manual workers than amongst professionals, despite the fact that professionals consume slightly more alcohol. Death from cirrhosis of the liver amongst women is higher amongst professionals than amongst manual workers. On the other hand, alcoholism, alcoholic psychosis and alcohol poisoning are higher amongst women in manual occupations. This shows that it is not just the average level of consumption which is decisive for the amount of damage caused by alcohol. It is also a question of drinking habits and the social situation which people find themselves in. There are large regional differences in alcohol-related mortality.

Sweden’s policy on alcohol is characterised by measures directed at the population with the aim of limiting access to and demand for alcohol. Membership of the EU means for example that import quotas for beers, wines and spirits will increase considerably over the next few years. The big differences in the levels of taxation in the EU countries close to Sweden mean increased legal and illegal importation of alcohol. In addition, a harmonisation of taxes is required, so that production of alcohol in people’s homes is not encouraged. The changes also include an increase in “black liquor” i.e. both illicitly distilled spirits and illegal imports.

Membership of the EU has changed important parts of Sweden’s policy on alcohol. The process which Sweden is undergoing in order to bring itself into line with the EU is not without its problems. Our low level of alcohol consumption compared with other countries has its background in our history and our people-orientated policy. Different EU countries are now successfully trying to reduce alcohol consumption in their own countries and are looking with interest at the Swedish policy. At the same time, Sweden is adapting to new rules.
There is a connection between the total level of consumption in society and the level of damage. If consumption is changed, the level of damage and criminality will also change in a predictable way. There is therefore good reason for having misgivings that alcohol-related damage will increase because total consumption will probably increase over the next few years.

Sweden must now use new methods to try and reduce the damage caused by alcohol. An important part of the work being done to provide various groups with information is to ensure that information is correct and scientifically based. Interest in and understanding of the idea of total abstinence or of just drinking on the odd occasion has declined. Attitudes to alcohol are different nowadays from what they have been before. Certain research findings point to the fact that a very moderate consumption of alcohol, without drinking to the level of inebriation, does not have any negative medical effect on health. The information provided and the measures taken to shape attitudes must be based on this changed background. The information must be based on the actual risks and the risk situations connected with alcohol. The preventative work done by schools is particularly important and must be improved.

Drinking to a state of inebriation is dangerous for many reasons. Total sobriety must be maintained in a variety of situations, such as pregnancy, when driving or sailing, at work and when undertaking sporting activities. On average, women cannot tolerate as much alcohol as men. Children should not consume alcohol whilst growing up. As well as increasing the risk of damage to their health, other problems and social problems can arise when young people consume alcohol. A high level of supervision of age restrictions is required, as is regulation in restaurants, out-reach work in risk environments and reduced access to bootlegged liquor. Councils have an important role to play in this work. The county administrative boards also have an important task through their supervision of issues concerning alcohol. Together with the county councils they take part in county consultative committees on alcohol prevention and drug prevention work.

Health care services for mothers and primary health care are important factors in alcohol-prevention work. Many opportunities within the health and care services exist to talk to patients in good time about dangerous alcohol consumption and the damage it can do to health in a variety of ways. The health service has a role to play in providing the general public with information, and not just patients seeking help. Voluntary organisations can provide support to people with alcohol problems who wish to stop drinking – they can make an important contribution by helping relatives and also by providing information about alcohol consumption.
Swedish society is facing a great challenge in dealing with the greater access to alcoholic beverages. Greater efforts must be made to provide information about the damaging effects of alcohol, and about what constitutes a dangerous level of alcohol consumption.

**Specific target groups**

- Young people
- Pregnant women
- Relatives of abusers of alcohol

**Players and measures to be taken**

*Challenges to national players*

- The State ought to continue to have a high level of control over the sale of alcohol, through taxes, the continued monopoly of the state-controlled company for the sales of wines and spirits (Systembolaget) and by influencing the EU.
- The State ought to tighten its control of the sale of bootlegged liquor.
- County administrative boards ought to develop their collaborative work on prevention aimed at alcohol and drugs.
- The National Agency for Education ought to take action to improve ANT-education, (Alcohol, Narcotics and Tobacco.)
- The National Institute of Public Health ought to provide basic information on alcohol for use by various players when providing information to the public in general and to specific risk groups.
- The National Corporation of Swedish Pharmacies ought to inform its customers of the effects of alcohol on various illness and on medication.

*Challenges for county councils*

- Improve information about the damaging effects of alcohol provided by health care services for mothers and children, youth clubs and the health service.
Challenges for district councils

- Improved information about alcohol in schools.
- Increased supervision of environments which young people frequent where drinking to a state of inebriation occurs.
- Improved supervision of age restrictions regarding the serving and the purchase of alcohol.
- Support associations for abusers of alcohol who wish to help each other lead a sober life, and associations for relatives.
- Provide support for children who have parents who abuse alcohol.
Goal 14

A drugs-free society

- Reduced access to drugs
- Reduced number of young people trying and using drugs

An increase in drug misuse has been seen during the 1990s. Access to drugs has probably never been greater than it is today. This increase is not unique to Sweden, but is part of an international trend towards a more liberal view of drugs and increased movement across international borders. Swedish drug abuse is limited in comparison with other European countries.

In comparison with the public health problems caused by alcohol abuse, problems with drugs are on a much lower level. However, drug abuse has serious consequences for the individual person and is increasing to such an extent that it must be seen as a public health issue and not just from a criminal or social perspective. Drug abusers suffer significantly more illness and a higher mortality rate than the rest of the population.

Men dominate the group of people with experience of drugs. However, there are no manifest differences between boys and girls in Year 9 at school. People with early and pronounced social problems are over-represented amongst people with severe drug abuse. A larger proportion of school pupils who use drugs say that they are not happy at school than other pupils, and that they play truant more often than others. Investigations which have been carried out show that young people with an immigrant background try drugs more often. Young people whose level of education does not go beyond senior school have significantly more experience of drugs than others. Young people with an advanced level of drug use are much more likely than other young people to suffer from psycho-social problems. Established abuse occurs most commonly in the three largest cities in Sweden.

Drug use has tripled amongst people enlisting in the armed forces during the 1990s. A marked increase in the number of pupils trying drugs has also been seen amongst school pupils in Year 9. A significant increase has taken place in drug-related fatalities since the 1980s.

The youth culture with its liberal attitude to drugs which prevailed during the 1990s is a significant factor in increased drug abuse amongst young people. This youth culture implies a questioning of the picture painted by adults of drugs as a threat. The poor state of the national economy in the 1990s, with increased youth unemployment and
reduced access to supportive environments for young people has also contributed to an increase in drug abuse.

The drug which is perhaps most associated with the liberal drug culture amongst young people is Ecstasy. Ecstasy and other similar synthetic drugs are primarily found amongst young people from relatively well-off backgrounds. An increase has also been reported in the abuse of smoked heroin amongst groups with social and financial problems living in disadvantaged residential areas. Above all, the increase in the use of drugs amongst young people from disadvantaged backgrounds can lead to an increase in the number of people who will be excluded from society in the future.

A new worrying trend is the abuse of GHB, a cheap drug which received a drug classification in February 2000. It is very dangerous and becomes even more dangerous when combined with alcohol or other substances. GHB is an example of the development in drugs using other products than have been used earlier. It is a development which we must keep a sharp eye on.

The Swedish policy on drugs has been directed at limiting access to drugs and reducing demand. This has involved introducing political measures in the field of drug prevention focussing on control measures, international collaboration, preventative measures and care. This work must continue.

The preventative work being undertaken must be improved in order to reduce drug abuse amongst young people. It is extremely important that methods be found which give young people insight into the dangers of drug abuse. The Board of Education’s study of ANT-teaching has shown that it has many flaws. It is a matter of importance that this teaching is improved.

The work on limiting access to drugs has to be undertaken in various arenas. International collaboration on fighting drugs has intensified through the EU. The liberal attitude to drugs which exists today amongst young people is internationally influenced. This shows that it is very difficult to fight drugs with national measures alone. It is therefore a matter of urgency for the Swedish State to work in collaboration with other countries to fight the on-going shift in attitude towards drugs and access to them.

The Committee concurs with proposals (SOU 2000:57) for giving the National Institute of Public Health a comprehensive supervisory role with regard to legislation on preventative measures against drugs. An important part of this role should also include a clear responsibility to provide information and responsibility for developing methods to prevent the use of drugs amongst young people.
A well-developed collaborative effort and teamwork between the various sectors, levels and players in society is required in order to limit access to drugs in an effective way. The Drugs Commission (Dir. 1998:18) will be presenting proposals about this before the end of year 2000.

Specific target groups

- Young people

Players and measures to be taken

Challenges for national players

- The State ought to intensify its efforts to fight drug abuse within the framework of EU collaboration.
- The National Institute of Public Health ought to be given the task of managing the factual information which applies to the damaging effects of various drug preparations.
- The National Institute of Public Health ought to develop methods for preventing the abuse of drugs.
- The National Agency for Education ought to take action to improve ANT-teaching (Alcohol, Narcotics and Tobacco) in schools.

Challenges for district councils

- Improve and develop teaching about drugs in schools.

Challenges for voluntary organisations

- Fight the liberal attitude towards drugs.
Goal 15

<table>
<thead>
<tr>
<th>A more health-orientated health service</th>
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<tr>
<td>− More effective measures for the prevention of ill health and for health promotion on an individual, group and community level.</td>
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<tr>
<td>− Increased co-ordination to ensure equal development of health in the population.</td>
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<tr>
<td>− Advanced methods and strategies for work on preventing illness and promoting health.</td>
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The work of the health service as regards public health comes from the perspective of treatment, the prevention of ill health, and health promotion, and this work forms part of an overall picture. Action to promote health and prevent ill health ought to be a task for the whole health service and also an obvious part of all treatments.

Changes in the patterns of illness, treatments available and demands for cost efficiency have imposed new demands on the health service. In order to be at the forefront of developments the health service must look at the whole person and his circumstances, and not just at various illnesses. Both the person-orientated and the population-orientated aspects need to be looked at, and the new conditions which an ever larger part of the private and public care services represent need to be integrated into the health service. This requirement is accentuated by the way society is developing, with more and more difference in people’s living conditions.

Historically speaking, great gains in health have been made by the co-ordination of medical knowledge aimed at general health care and medical care, and developments in the level of welfare in society as a whole. Our country’s low levels of mother and infant mortality, the low level of mortality from children’s accidents and reduced mortality from cardiovascular disease have not come about by accident. Conscious preventative measures in collaboration with other players and a decentralised health service which everyone has benefited from are important factors which have contributed to the positive developments made.

The health service has great importance as regards the long-term development of health through its professional competence, its strong influence on the development of knowledge, its wide base of contact with the general public and its nearness in daily life to the local community.
The health service’s primary task is to meet the needs of patients in terms of medical care. If this task cannot be discharged satisfactorily, then the health service also loses its credibility and legitimacy regarding its work on prevention. From a public health perspective there is no contradiction between treatment and prevention. In every case of medical care an approach to the person and a health-orientated attitude must be applied which help the person who is already ill to maintain and strengthen his physical, mental and social well-being and to strengthen what is healthy about the person.

Through its wide contact base the health service has the chance to reach groups who are particularly vulnerable as regards their health. This can happen through care which is locally provided, open to everyone on equal terms, and which can – via its structure – “reach every individual.” It has a unique basis for meeting the individual at different periods of his life and can contribute to the promotion of e.g. good health via youth clubs, health care services for mothers and children, the school health service or by inviting people to have a discussion about their general state of health, vaccinations or discussions about specific health problems which are partly caused by people’s way of life. The health service can also prevent people becoming ill with widespread diseases such as cardio-vascular disease and certain forms of cancer by early detection. From the point of view of public health, improving primary health care in particular is a matter of urgency.

In order to understand the significance of the health service’s means of promoting health in the population at large – and not just amongst its patients – it is important to have an understanding of the paradox of prevention. People who are particularly at risk of cardio-vascular disease for example are those who have the highest blood pressure. People with high blood pressure often make use of the health service and receive treatment. If the health service only directs its efforts at talking about the importance of changing habits of life with these patients, then the vast majority of people who later suffer from cardio-vascular disease will be overlooked. The reason is that there are many more people who only have moderately high blood pressure than have high blood pressure, and the vast numbers of patients come from this larger group. From the point of view of the general population it is not enough if the health service only provides advice on ways of preventing illness with the group actively seeking help as patients. This preventative paradox clearly points to the potential which exist in health prevention work within the framework of the health service.

The opportunities available to conduct preventative work are currently not being adequately utilised. The health service can use its
authority, its skills and its wide contact base to a greater extent in promoting health when it comes into contact with patients, relatives and the general public. This could take the form for example of more active information about risks caused by people’s lifestyles which can lead to illness, or taking part in debates in society or registering injuries, so that something can more easily be done about dangerous environments.

There is uncertainty and a lack of knowledge within the health service about what preventative methods can be used to deal with diseases caused by people’s way of life. An important explanation for this is that the development of new preventative models and drugs-free methods has been neglected for a long time by the scientific community. This imbalance in the development of new methods might partly explain why the cost of drugs is rising so quickly.

The primary health care sector, as with the more specialised hospital services, could identify patients with psychological problems much earlier than is currently the case if it were more alert to the problem. In order for suicide prevention to work properly, various groups of staff within the health service must become more alert to the early signals. The knowledge which now exists about the connection between body and mind and about how various states of illness can affect these ought to have a much greater role to play in the work being done within the health service than is the case today.

The provision of information about health by the health service requires a shift in outlook about what skills are required. People in the health sector need to improve their level of knowledge and skill regarding the complex connections in people’s own experiences in relation to their health. If people’s own experiences in relation to their health is improved this will contribute to less illness. It is a matter of positive synergy effects. This knowledge is of particular importance in understanding the connection between mental and physical ill health. Knowledge about the importance of social networks in being able to stay healthy or to recover after illness is now supported by scientific research. If the health service were better able to support relatives and put patients into contact with other similar patients or groups than is the case today, this would have a positive effect on health.

From an international perspective infectious diseases and infections are a serious threat to people’s health. Health development in our country has meant that there is a high level of control as regards infectious diseases. Vaccinations have been introduced, and infections can be successfully treated with drugs. The work done on HIV in Sweden over the past few decades has been successful. There is, however, every reason to continue to be vigilant towards the risks
which infectious diseases impose, not least because of the fact that the spread of HIV and tuberculosis in countries close to our own is much more extensive than in Sweden. The ability to fight infections is also dependent on bacteria not becoming resistant to antibiotics. A successful high level of protection from infection implies a society where people have good living conditions and have a general understanding of how infection can be avoided. The work being done to protect people from infection must be conducted in collaboration with various parts of society. The health service has a big role to play in this case promoting health and preventing illness.

Dental services are one part of the Swedish health care system which have been very successful in their work on prevention. The health of people’s teeth has improved significantly since the 1970s. There have been some distinct trends in the development of better dental health. Differences in the state of people’s teeth are more and more a question of level of education, unemployment, receipt of supplementary benefits and ethnic origin. This means that a poor state of dental health follows the same pattern as ill health in general. The other trend is that more and more elderly people require extensive dental care, as they keep their own teeth to a greater extent. Smokers are much more likely to suffer the loss of their teeth. The medication taken in connection with some illnesses can have a negative effect on dental health. A number of disabled people and certain elderly people have practical problems in looking after their teeth. A good state of dental health also affects the body’s other functions. Dental services and their high level of skill as regards prevention are an important part of the work of the health service.

Attention ought to be paid to the prescribing of medication within the health service in relation to the work on health promotion. A number of patients abuse medication. They have become dependent on various forms of psychoactive drugs and would be healthier if they could stop taking certain types of medication. In addition, another form of abuse of medication takes place, which elderly people in particular are subjected to. In some cases they are prescribed several different drugs which all in all have a negative effect on their health. Clearer information from the health service could provide people with the knowledge necessary to ensure that incorrect prescriptions are avoided, and that other measures are taken instead. The need for a drugs register based on people’s social security number ought to be examined. It ought to make it easier to evaluate the effectiveness and safety of drugs and the risks in connection with their regular prescription.

For people with various types of disability contact with the health service can be difficult because the staff lack the knowledge and skill
to treat people with disabilities. There is a risk that the health service’s unfamiliarity with interpreting people with learning disabilities, mental disabilities, autism, speech problems, reduced hearing or deafness can mean that illnesses are not detected in time. Certain disabilities also affect other medical afflictions, which means that symptoms can manifest themselves in different ways than would normally be the case. The health service’s role in promoting health and preventing illness amongst various groups of disabled people requires a better level of knowledge and skill amongst the staff, and that staff should listen to what the patients have to say based on their experience and knowledge. It is also a question of ensuring that people can physically gain access to buildings in order to be examined.

The reception people receive when they come into contact with the health service is important, so that they feel secure and feel they are being listened to. It is important to be aware of the fact that some people do not speak very good Swedish or have a different cultural background. Homosexuals and bisexuals sometimes feel vulnerable in various ways. Lesbian women can find it difficult to attend gynaecological clinics. It is a crucial matter for the health service in terms of being able to conduct health promotion work that people are met on their own terms.

A large part of the health service is run by the district councils. A health promotion way of working ought to be encouraged in collaboration with other local government players. There are both human and financial gains to be made by working in this way.

Various forms of purchaser and provider models are applied within the health service. Regardless of the model for purchasing and for decision-making, senior managers in the health service need to develop methods for how health promotion work should be purchased and also evaluated. It will be a challenge for the health service in the future to facilitate and reward a method of working which promotes health and which is available on equal terms to everyone, regardless of who is managing it.

The tasks found in the WHO’s Health 21 can actively support a reorientation of the health service, in exactly the same way as the health-promoting hospitals initiated by the WHO. The aim of the health-promoting hospitals is that preventative measures, treatment of illness and rehabilitation should be seen from a health perspective. There are currently 15 such hospitals in Sweden.

The health service must support health promotion and preventative measures on an individual, group and national level. This means that the health service must treat illness effectively, rehabilitate people after their illness, but also support the chronically sick so that they have the
chance to live a good life. Preventative measures must of course be integrated into the care chain. It is important that the health service supports individuals and groups with a high level of vulnerability to illness and poor health, i.e. people who are at risk of suffering ill health or who are lacking in psycho-social resources. Similarly, it is a matter of urgency that the health service should take part in the work directed at the general population on reducing health risks and providing support in the form of information etc to other players.

The health service must support an even development in health amongst the population. This means that the sectors must contribute with knowledge about diseases and the factors which determine health, how these factors are apportioned and how they can be influenced, as well as actively participating in the initiatives taken in the local community, in the region or on a national level to influence the fundamental causes of illness and poor health.

The health service must develop methods and strategies in order to work in a way which prevents disease and promotes health. Working in a target-orientated way will provide the conditions necessary for prioritising, co-ordinating and becoming more effective. As an employer the health service must promote the positive development of health amongst its own staff. This is important in itself but also for the legitimacy of the health service in relation to patients and relatives.

Regional centres ought to be set up to promote the development of new methods regarding the prevention of disease and health promotion work. Many millions are invested on an annual basis in the Western world in developing new drugs to affect health problems related to our lifestyle. Measures for treating people without drugs and modern method development for dealing with diseases caused by our lifestyles are very modest in comparison with the developmental work being undertaken regarding other forms of treatment. One of the reasons for this is that there is a high level of commercial potential in relation to this work, but there is no similar driving force in the area of prevention. This has an effect on the costs of running the health service.

As things stand at present the lack of development of new methods as regards alternative forms of treatment of problems related to our lifestyles other than drugs means that the preventative potential which exists practically speaking in every meeting between patients and the health service is under-utilised. Concurrent with the increase in our knowledge about the effect of our genes on our susceptibility to various diseases and various lifestyles, the health service will be faced with totally new challenges to act in a preventative way when coming into contact with each individual patient.
Nowadays, patients’ rights give them the right to choose between different forms of treatment when they are actually ill, but a person can seldom choose an alternative which prevents him from becoming ill. A more health-based health service ought to increase the chances of this. Health insurance provides various opportunities for paying compensation when preventative measures are taken. In the present situation the social insurance office can pay sickness benefit for preventative measures, but cannot buy treatment, for example treatment to help people give up smoking, for weight loss or therapy. Improving the opportunities for using health insurance to pay for preventative measures would contribute to preventing illness.

It is in the interest of many different parties to contribute to a renewal and development of the treatment of ill health related to our lifestyle without drugs. It is our view that six regional centres are needed to develop new methods. They ought to be closely connected with everyday health care, the medical institutes and university departments concerned with public health matters, and the practical work being done on public health. The staffing of the respective centres should be divided between the senior managers of the health service and the research institutions involved. Every centre ought to focus on a specific area and ought to form part of a collective national resource.

The law on the health service contains regulations which state that the health service has responsibility for preventing disease and injury and for taking action to improve the health of the population. The regulations are often interpreted as meaning that the health service has a responsibility for health promotion measures aimed at individual people but not to such a great extent for health promotion and illness prevention in a wider perspective. The Committee cannot find any grounds for such an interpretation of the law and is thus of the opinion that the law does not need to be changed.

**Specific target groups**

- Children and young people
- The elderly
- Individuals and groups with an increased level of susceptibility to illness and poor health.
Players and measures to be taken

Challenges for national players

- The National Board of Health and Welfare (Socialstyrelsen) ought to include preventative work in its monitoring.
- The National Institute of Public Health ought to cover development of new methods as regards prevention and collecting knowledge.
- Greater opportunities ought to be provided for health insurance to be spent on preventative measures.

Challenges for the state and county councils

- Set up six regional centres for developing treatment methods which do not use drugs.
- The question of a drug register based on social security numbers ought to be examined.

Challenges for county councils and district councils

- Develop methods for measuring health gains.
- Identify the health effects of lack of equal treatment and pass on this information to society in general.
- Undertake specific initiatives for improving mental health.
- Encourage the more active provision of information about risks caused by our lifestyle which can lead to ill health and about alternatives to the use of drugs.
- Be alert to the need to support various patient groups and relatives.
- Improve the way certain patient groups are received and treated.
- Monitor the health service’s work with regard to preventative measures and how well orientated it is towards health promotion.
- Work to promote health in the role as an employer.

Challenges for employers

- Support occupational health services in dealing with work-related ill health.
Goal 16

A co-ordinated effort on public health

- Responsibility for health planning in the hands of district councils and county councils.
- Development of co-ordinated sector strategies within the field of public health on a national level by the responsible authorities.
- A co-ordination of public health issues in the Cabinet Office and the Ministries.
- A regular up-date regarding national policy for public health presented to the Swedish Parliament in the form of a report on public health policy.

The national goals on public health are indeed intended to be goals for the whole nation. A good state of health on equal terms can be achieved by the many players in their respective areas and by working collaboratively to improve public health. For this to happen the right conditions need to be in place in the form of a co-ordinated strategy. Roles and responsibility must be made plain. The level of skills and knowledge needs to be raised. The way the work is to be managed and co-ordinated needs to be specified, and goals and methods must be monitored and evaluated so that the initiatives can be successively improved.

Responsibility for health planning in the hands of district councils and county councils

The services provided by district councils on a local level: environmental and health protection, planning and building, traffic, culture and leisure, education, social services and health care – are of great importance for public health. It is important that the public health aspects of the services provided by local authorities are emphasised and that the work on public health continues to develop both in the individual council areas and in collaboration with county councils, national authorities, trade and industry and voluntary organisations. Health issues in relation to all council services and to their strategic development need to be made plain, for example by conducting reviews of the effects on health and local balance of accounts as regards welfare. Furthermore, the work on Agenda 21 ought to go hand in hand with the work for health-orientated local politics. Future work
should aim to ensure clear political responsibility for the work on public health and a higher level of professional competence.

Similarly it is important that county council and regional representatives develop the responsibilities and tasks of the health service within the framework of a co-ordinated public health policy. As with local councils it is a matter of urgency for clear political and administrative responsibility for public health matters, a high level of competence and collaboration with other public agencies, organisations, etc to be developed. To give a concrete example, it is important for the point of view of public health policy that community medicine functions are developed and that a health-orientated method of working is developed in the health service in general. The Committee’s proposals as regards the health service are outlined in detail under Goal 15.

The National Committee for Public Health is proposing a special law on public health which will give district and county councils responsibility for drawing up health plans and working collaboratively, as a way of drawing attention to the importance and political legitimacy of public health issues in district councils and county councils, and also to encourage the continuous development of work on public health. Danish law demands similar plans, where district and county councils have to work in collaboration to prevent ill health.

Health planning involves drawing up and adopting goals, programmes and measures to influence the conditions necessary for a good state of health on equal terms within the spheres of activities of the authorities involved. Reviews of the consequences for health, drawing up a balance of accounts as regards welfare, health budgets, etc. The draft law proposes that district and county councils should collaborate together and with others when drawing up the plans and that the public authority designated by the Government should be given the task of discharging the tasks in accordance with the law.

In an earlier sub-report (SOU 1998:48) the Committee stressed the importance of health planning being conducted by district councils and county councils and saw an opportunity in this for models for the work on public health to be designed in collaboration with the various parties, and without any of these parties having a specific leading role. Having such plans in place and actively working on public health issues locally, which are also integrated into the county’s and the region’s work, which is desirable in the long term, will increase the chances of a variety of effective models for public health work being developed and being more effective. Attempting to design health plans in this way will also improve the chances of being able to improve and
render more effective the support and the other initiatives which the authorities and national agencies have at their disposal.

The Committee is aware of the fact that legislation is only one of several ways of bringing about the desired health planning by the authorities involved and collaboration between them. An alternative way of doing so would be to develop the public health aspects of the services provided on a continuous basis, within the framework of the agreements between the authorities involved. The reason why the Committee is presenting a draft law as a primary alternative at all is that we are of the opinion that legal regulation is required to stress the importance of public health issues. The Committee accepts that within the framework of the public health law these issues will also be developed on a continuous basis.

Additions to the Social Services Act regarding health matters

The Committee proposes an addition to Paragraph 5 Social Services Act which would mean that promoting conditions for good health would become the task of the Social Welfare Board. This task is similar to the task which the Social Welfare Board already has – to promote conditions for a good quality of life.

Having regard for both health and good living conditions are naturally an integral part of the role of the Social Welfare Board. Many factors influencing health can be affected and observed through the work of the social services. This applies for example to people’s economic circumstances, the effects of living segregated from other groups and the existence of social networks and social support in the environments where different groups live.

The Committee stresses the urgency of having access to green areas near residential areas for purposes of recreation. Social services can also contribute through their participation in community planning. Social services can also help ensure that the elderly and the disabled who receive services and care from social services get out of the house every day, so they can enjoy daylight and fresh air. This improves their health. Another example of initiatives to promote health by social services is encouraging good food. For certain elderly people it is a pressing matter from a health point of view that they have their meals prepared at home.

Other health-promotion measures by social services are identifying and taking action in environments where obvious risk factors are present, such as environments where alcohol, tobacco or other drugs can be found amongst children and young people.
Investigation of social medicine functions at regional level

Collaboration between district councils and county councils is also important for reasons of competency. The majority of district councils do not have the means to establish local scientific competency in public health matters with the breadth and analytical capacity required. Their knowledge concerning the connection between exposure to health risks and the outcome for a person’s health as well as the effectiveness of various methods is often of a general nature. To be effective, public health work must often tackle several causes and links in the causal chain simultaneously.

Many county councils have amassed this type of skill and competency in social medicine units. The current mapping of the manning and competency of these organisations indicates that the majority of county councils do not currently have a sufficiently broad or deep level of competency in this area. The design of this social medicine organisation varies considerably. It has primarily been possible to establish a more solid organisation with the broad aim and direction required at a regional level and in connection with university institutes which undertake work on public health. A coherent social medicine function is completely lacking in some county council areas.

The issue of county councils’ social medicine functions has further been brought to the fore at the same time as health care reforms using various purchaser/provider models are being tried. It makes it even more important for purchasers of health care to be able to analyse the needs for health care in the population they have responsibility for, in a qualified way. The skills and knowledge required for this are largely the same as those required to manage a qualified public health function. Co-ordinating these functions could therefore be a rational idea. This issue is also touched upon under Goal 15. As the demand for qualified expertise in the field of epidemiology and health economics far exceeds the supply and will continue to do so for a number of years in the future, there is good reason for considering whether co-ordinating the work of the six health regions would not be preferable. The Committee proposes that regional co-ordination of the social medicine function be discussed by the State and the health service, and that a special report be issued on the matter.
Sector strategies at authority level for national goals

The Organisational Committee of the The National Institute of Public Health has recently presented proposals for collaboration and responsibility at national level (SOU 2000:57). It is of the opinion that the Institute’s main task should be to have responsibility for the overall monitoring of the sectors and the evaluation of initiatives concerning public health based on the national goals for public health, as well as being a national centre of excellence regarding methods and strategies within the public health area. The National Institute of Public Health’s main users ought to be the Government, other public authorities, district councils and county councils. The National Committee for Public Health supports the proposals for the aim and direction of the work of the National Institute of Public Health.

Comprehensive monitoring and evaluation of the sectors proceeds from the fact that the public authorities have to an adequate degree of sector responsibility for tasks specified by the National Committee for Public Health. It is our opinion that the primary orientation of the national goals for public health towards the determining factors for public health creates the conditions for a clear sector responsibility for all levels of society, in the same way as the national environmental goals. The Committee has asked 32 authorities about their role and responsibility as regards public health issues (Report 19 provides supporting information). The study shows that a large number of authorities have direct or indirect involvement with public health issues, but that the link between the responsibilities of the authority and the health effects of the services it provides needs to be the subject of more focus and in many cases needs to be further developed.

In the light of this it is a matter of urgency that strategies be developed within the respective sectors, aimed at the determining factors. To state the current position as regards exactly which authority has responsibility for what matter is meaningless until such strategies have been developed. Instead, continuous investigation should take place of the issues, in the light of the delegation of responsibility which currently occurs, complemented by the Organisational Committee’s proposals regarding which authority has responsibility for alcohol, tobacco and drug prevention. The authorities which the National Committee for Public Health has specified as suitable players for carrying out the goals have been emphasised in the light of the current delegation of responsibility which is taking place.

In the continued examination of the delegation of responsibility it is a matter of urgency that the ability of both the national authorities and the regional and local authorities to promote health and prevent illness...
are taken into account. At a regional level for example there is the County Administrative Board which has responsibility for supervision within the area of environmental health protection and social issues including alcohol abuse. At a regional and local level for example there is the Social Insurance Office, the Employment Office, the police and the National Highways Agency, who are all important players as regards public health in their own organisations and also in their interplay with district councils and county councils etc at local and regional level.

Management and Co-ordination

It is important that public health issues are effectively co-ordinated politically at a national level. Since 1997 Great Britain for example has had a specific Minister of Public Health. Public health issues cover all sectors, and there are many similarities with the “horizontal nature” of environmental issues. There is therefore reason for having the Cabinet Office and the Ministries co-ordinate the work on public health issues, so that political management of the work takes place across all sectors.

It is necessary for state authorities to work effectively in partnership with each other. In this instance the Director-General Group for Public Health Issues which already exists and is led by the National Institute of Public Health provides a reason for further developing collaboration at management level and for compiling sector strategies aimed at meeting the various goals set by the Committee.

The Organisational Committee for reorganising the National Institute of Public Health proposes that a sort of counterpart to the Director-General Group be set up between the Institute and representatives from district and county councils. Such a group could have a strategically vital role in helping the national public health goals make an impact on county councils and district councils – and conversely in articulating the regional and local representatives’ need in a collective way for support in terms of strategies, knowledge and methods. The National Committee for Public Health supports such a solution.

As regards various types of support for voluntary organisations it is important to uphold the integrity of clubs and associations by not allowing public institutions to steer their activities in a particular direction. The idealistic activities run by voluntary organisations have a value in themselves and form the basis of the social cement holding society together. In certain circumstances it can, however, be a very effective way of reaching agreement with voluntary organisations.
which wish to undertake work directed at public health. It is important that these two points of view are not placed in opposition to each other. The trend has been to continually reduce general grants to organisations and increase the use of voluntary organisations as ‘entrepreneurs’ through the use of various forms of support for projects. In the long term such a development could lead to a undermining of independent clubs and associations and to their social importance disappearing. When implementing the national goals on public health it is important that this balance be taken into account in the future collaboration between public institutions and independent clubs and associations.

**Education and Training**

In order for the national public health strategy to have an impact it is crucial for the level of competency of the professionals involved to be increased. There is reason to invest extensively in education and training over a three to five year period. The Committee is of the opinion that approximately 3,500 people in government departments, public authorities, county councils, regions and district councils ought to receive basic training in public health, corresponding to 5–10 university points.

The content of this training ought to be tailor-made and be based on national public health goals, together with the current level of knowledge as regards implementation, methods, measurement of public health, monitoring, etc. The providers of this training ought primarily to be the institutes involved in research into public health which have the capacity to place public health issues in a sector-wide context.

**Resources**

In connection with putting the national public health goals into practice, the State ought to arrive at a special agreement with district and county councils in order to facilitate work on health planning and to place resources at their disposal to undertake the work.

**Monitoring and Evaluation**

The monitoring and evaluation of the national public health goals ought to be reported to the Government every few years in the form of two reports: a report on public health policy and the already established
Public Health Report, which the National Board of Health and Welfare is responsible for. It shows how health is developing in the population. The National Institute of Public Health ought to be responsible for the report on public health policy which should show how the determining factors for health are developing and how the national goals for public health are being monitored. Both authorities ought to collaborate in the production of the two reports. The Government ought to present a report to the Swedish Parliament during every term of office about the public health situation and if necessary present proposals for adjusting the national public health goals.

Conditions for monitoring and evaluation can in principle be divided between State and other players and must be solved “on their own terms”. The National Institute of Public Health has an important role here in relation to both types of player.

The proposals of the National Committee for Public Health regarding indicators need to be further developed, partly so that they can give a more immediate picture of progress made, and partly so that they are highly relevant in reflecting – and preferably evaluating – different types of action. This ought to become one of the tasks for the reorganised National Institute of Public Health.

**Players and measures to be taken**

*Challenges for national players*

- The Government ought to co-ordinate the work on public health issues within the Cabinet Office.
- The National Institute of Public Health ought to be given the task by the Government of taking the initiative to develop sector strategies for public health issues in collaboration with the other authorities.
- The National Institute of Public Health ought to be given the task by the Government of presenting proposals on sector responsibility for public health issues with regard to the authorities affected by this.
- The National Institute of Public Health ought to take the initiative for the setting up of a collaborative group between the Institute and representatives of district and county councils.
- The National Institute of Public Health ought in collaboration with the National Board of Health and Welfare to report on the results of their sector-wide monitoring and evaluation in a regular report on public health. This should include proposals for the further development of the national goals and indicators.
• The National Institute of Public Health ought in collaboration with the National Board of Health and Welfare to present future reports on public health in such a way that changes can be understood in relation to the national goals and indicators.
• The Government ought to present a report to the Swedish Parliament during every term of office, setting out the public health situation and if necessary suggesting revisions to the national public health goals.

Challenges for the state, county councils and district councils
• Investigate the issue of co-ordination between the six health regions of social medicine forms and functions in order to widen and improve competence.
• Formulate training needs for the professions involved and stipulate the need for financial support for district and county councils for training over a three to five year period.
• Reach an agreement on setting up structures for the new responsibility for health planning and establish the need for resources to do this.

Challenges for district councils and councils
• Develop health plans and specific public health initiatives in collaboration with the responsible authorities.
• Take part in a collaborative group of representatives from district and county councils and the National Institute of Public Health.
Goal 17

Long-term investment in research, method development and education

- Intensified research into the value, costs and effects of various interventions.
- Improve methods for managing work on public health.
- Increased investment in education in the discipline of public health.

The discipline of public health is by its very nature inter-disciplinary. This is a result of the fact that the determining factors of health are multi-faceted. The core areas of research in the discipline of public health are held to be social medicine, environmental medicine, research into the working environment, epidemiology, research into health care, medical sociology, health economics and medical ethics.

Public health research has in certain respects a relatively strong position in Sweden as compared with other countries. Examples of this can be found in the fields of epidemiological research and research into the working environment. There are, however, areas within public health research which are clearly neglected. One comprehensive public health issue which needs further research is the social layering of health. This is not primarily a question of a need for more descriptive knowledge about health gaps, but above all the need for new knowledge about the mechanisms at a structural level and in people’s everyday lives. This would provide greater understanding of the context and form the basis of measures for more equal conditions in terms of health.

To gain a better knowledge base regarding structurally directed public health initiatives, it is a matter of urgency that knowledge about what significance social relationships, social capital and economic security have for developments in health be further developed. Community-related and epidemiological public health research ought to be supported so that this knowledge can be developed.

Working in a preventative way within the field of health has often been a matter of influencing risk factors and taking measures which are known to promote health. We see more and more evidence and gain more and more knowledge showing that factors such as attitudes to life, having close friends, having access to culture and being able to go out into the countryside have an impact on people’s ability to deal with the
challenges in their lives and maintain a good state of health. Research into this area needs to be developed.

More research is needed into how different factors and products in our environment and the connections between them influence developments in health. Furthermore research needs to be done in the area of environments which prevent injury and appropriate measures. A national register of injuries is one way of increasing our level of knowledge, which could lead to injuries being prevented.

There is also a need for further information about how people’s eating habits develop and how these changes affect health. Therefore regular studies on eating habits, which both cover the whole of the country and are aimed at specific groups, are required. The level of knowledge regarding people’s exercise habits is relatively high. However, information on people’s individual level of physical activity is lacking. Furthermore, studies are needed on how much physical activity is necessary to maintain a good state of health for children, adults and the elderly. Research concerning eating habits and physical activity which sheds light on why different groups in society develop such different attitudes to their lifestyles would be of particular interest.

The negative effects on public health of tobacco, alcohol and drugs are well mapped out. There is, however, a lack of satisfactory information about the connection between tobacco, alcohol and drug addiction. Furthermore information is lacking about the extent of the misuse of prescribed drugs in the population.

One major public health issue is mental illness. More information is needed in this area about how mental illness changes over time. Knowledge ought also to be developed on how different psycho-social factors work together in cases of mental illness. This knowledge is required in order to find better preventative measures.

Medical research has traditionally been undertaken on men. Nowadays we know that symptoms of illness are not always the same for women and men. Methods of treatment may also need to be partially different in order to be effective. Public health research conducted has in general a more advanced gender perspective than that conducted by medical research, but not to a sufficient extent. In research there is reason to be alert to the fact that health and risk factors for health and illness can be different for women and men.

The determining factors for health can also vary between elderly and younger people. The elderly react for example differently in many cases to drugs than younger people. There is therefore a need for specific research into preventative measures aimed at the elderly.
Research is also needed to gain more knowledge of the health situation of specific groups. Examples of groups whose health situation requires more illumination are homosexuals and bisexuals, immigrants and various groups of ethnic minorities, for example Laplanders and Romanies. There are grounds for admitting that the health of these groups is worse than for the population as a whole. It is however not clear how important various determining factors are for the health of these groups.

In terms of all the research needs mentioned above, it is a matter of urgency that the differences in health developments between different groups, between both women and men, and between groups with different levels of education, be analysed, and that measures be proposed for reducing these differences.

There is a great need generally for research into measures to influence health developments in different groups of society. This concerns both people’s social and financial circumstances but also their behaviour.

Such research is particularly urgent, as it is an important basis for bringing about systematic methods within the area of public health, first and foremost those intended to affect the determining factors for health but also those which can be used to evaluate initiatives. In this connection it is important that health-economic research be given increased scope.

Health economics can make a vital contribution to explaining why individuals and also organisations take decisions in the way they do. Health economists stress the significance of impetus. Cost-efficiency reviews of measures aimed at influencing the health of the population for example also form a part of the research. Such reviews, together with epidemiological information, can have great significance by forming the foundation for decisions about priorities within the field of public health.

It is of particular importance to gain knowledge about methods which can reach people who are at greatest risk from a health point of view. This is particularly important, as there is evidence that traditional health information primarily benefits favoured groups who are more motivated to look after their health.

Practical work on public health is best supported if it is undertaken from a local perspective. Through measures being anchored in the local democracy, personal motivation can be strengthened and the effects will have greater impact. On the other hand, local projects can in certain cases be much too limited to shed comprehensive light on the effects of the health intervention when they are evaluated. Therefore it can be necessary to co-ordinate evaluations at regional level. Under
Goal 16 on co-ordinated work on medical health the need on the part of regional social medical organisations for qualified guidance in conducting local work on public health was also discussed. Such functions ought to be developed in collaboration with university institutes.

There is currently a lack of skill and knowledge as regards public health in Sweden. This concerns both the number of people holding a qualification in the discipline of public health and people within other professions where the discipline of public health is a pressing complementary aspect. It is therefore necessary that more people become qualified by undertaking basic training in the discipline of public health, and that the discipline of public health be given more weight in other subjects. Examples of types of training where public health ought to form part of the course are in the education and training of nurses, care workers, dentists, doctors, nursery nurses and school teachers. In order to meet the great needs for increased competency within the field of public health in the short term, it is also necessary to provide training for people currently employed in the above-mentioned professional areas over the next 3 to 5 years. This issue is specifically dealt with under Goal 16.

Medical practitioners need to have a clear public health perspective in their everyday work. Current medical training almost totally lacks this perspective. As doctors traditionally have considerable influence over the health sector agenda, it is a matter of urgency that medical training provides a view of knowledge which is scientific but also covers the clinical as well as the public health aspects.

As the determining factors for health are linked to a number of different factors, the development of skills and knowledge by professionals will also be vital in the future within certain professional categories, where training in public health does not form part of the schedule. Examples of such categories are administrators in social insurance offices and insurance companies, staff development managers, environmental experts working for county administrative boards and district councils.

The Organisational Committee’s report (SOU 2000: 57) on the new role of the National Institute of Public Health in the work on public health proposes that the National Institute of Public Health becomes a national centre of excellence for methods and strategies in the field of public health. Part of the task will involve conveying information on methods and strategies to local and regional players. The National Institute of Public Health must also monitor international and Swedish public health research. The general responsibility which it is proposed the National Institute of Public Health should have for monitoring and
evaluating the national goals on public health, involves the National Institute of Public Health being given specific responsibility for keeping track of studies on the determining factors on health. It is proposed that the National Institute of Public Health should also finance certain commissioned research and develop its current partnership agreements with research institutions. The National Committee for Public Health agrees to the proposals on the future role of the National Institute of Public Health.

**Specific target groups**

- Researchers and professionals with the field of public health
- Decision-makers
- Officials in various purchaser functions.

**Players and measures to be taken**

*Challenges for national players*

- The National Institute of Public Health ought to provide specific support for research into methods of intervention and reviews of the consequences for health of measures within various social areas.
- The National Institute of Public Health ought to convey information to district and county councils about satisfactory methods and strategies for work on public health.
- The National Agency for Higher Education ought to take action to ensure that more people qualify within the public health discipline. The discipline of public health ought to a greater extent to become an integrated part of many other training courses.

*Challenges for the research council*

- Give a higher priority to research within the fields of research into interventions, health economics, and studies which aim to explain how different determining factors affect public health.

*Challenges for county councils and district councils*

- Develop and evaluate methods for undertaking public health work.
Challenges for the state, county and district councils

- Investigate the issue of a regional collaboration of social medical functions and forms, in order to widen and improve the level of competence, (the same as under Goal 16).
Goal 18

Factual information on health

- Access to factual and objective information on health for everyone.

One of the requirements for good health on equal terms is that everyone should have an opportunity to receive correct and factual information on health. In a society characterised by an ever increasing amount of available information provided by a range of commercial players, it is particularly important for people to have access to objective information on health.

In order for the general public to be able to benefit from factual information on health, access to information is required. This means that the information must not be too difficult to get hold of, must not cost money or only be available on the Internet for example. Health information must be adapted to the different needs of the people as regards its content and design.

Disabled people need to receive information in a manner and through a medium they can use. This could mean people with reading and writing difficulties, learning disabilities, visual impairment, hearing impairment and the deaf. In today’s multi-cultural society people with little knowledge of the Swedish language or with another ethnic background need access to information which is adapted to meet their linguistic and cultural needs.

Health information can have several different aims. It can aim to prevent dangerous behaviour amongst the population, arouse opinion on an issue or get people to examine themselves for certain symptoms in time, for example changes in the breast or on the surface of the skin. In the US campaigns on depression have made people aware of how normal it is to suffer from depression, what the symptoms are and where one can get help to deal with the problem.

Sweden has traditionally had a high level of objectivity in the health information provided by public authorities, information which is scientifically-based. It is very important that this attitude should continue. One problem with health information, precisely as with other social information, is that it primarily reaches the better-off and those who take more interest in their health. This can therefore mean that health gaps increase further. To counteract this, efforts must be made to ensure that objective health information actually reaches disadvantaged groups.
The National Institute of Public Health was earlier responsible for health information aimed at the general public. Under the new way of working the Institute will primarily provide facts for the Government, the sector authorities and county and district councils, and not to the general public. The National Institute of Public Health ought, however, to have a more pronounced responsibility for information concerning alcohol, tobacco and drugs, as it is the supervisory authority in these matters, and in other matters where the Government has entrusted the Institute with specific tasks. The Government must also be able to give the Institute the task of providing specific information in particular cases. The new way of working will mean that the sector authorities must have a clear responsibility for providing health information to the general public on the matters they deal with. District and county councils will also have a greater responsibility for providing information to the people living in their catchment areas.

Important health information is provided via pharmacies nowadays, which in principle should reach the whole population. This task is not, however, regulated in the contract the State has signed with The National Corporation of Swedish Pharmacies and is carried out on a voluntary basis. It ought to be regulated in the contract between the State and The National Corporation of Swedish Pharmacies that the pharmacy’s work includes certain tasks to perform regarding the provision of factual, objective health information to its customers. The contract with the State ought also to require The National Corporation of Swedish Pharmacies to provide its information in collaboration with the authorities involved, and that the information must be linguistically and practically accessible to different groups in society.

Voluntary organisations are often better able to provide groups at risk with information than public authorities. In most cases it is also not suitable for a public authority to actively propagate certain lifestyles. Health information which is provided by social players must be factual. Public authorities ought to provide support for voluntary organisations financially in the various types of health information they provide for their target groups. This must be entirely a voluntary matter for the organisations, with no compulsion whatsoever. Support for their general work should not be influenced by this.

Specific target groups

- Children and young people
- The disabled
- Immigrants
Players and measures to be taken

Challenges for national players

- The National Institute of Public Health ought to be given responsibility for the general provision of information which supports health information.
- Every authority ought via its sector responsibility to have responsibility for providing health information in its area to the general public and to various different target groups.
- The contract between the State and The National Corporation of Swedish Pharmacies ought to assign to the pharmacy the task of providing objective, factual and accessible health information to its customers.
- Voluntary organisations ought to be supported to take more measures as regards the provision of health information.

Challenges for district councils and county councils

- Improve general health information and adapt it so that it reaches various target groups, e.g. different ethnic groups.
Appendix

Composition of the National Public Health Committee

Chairman
Margareta Persson, former member of the Swedish parliament, a member of the Committee with effect from (w.e.f.) 9th December 1996.

Members
Appointed to the Committee w.e.f. 24th March 1997, unless otherwise stated:
Agneta Börjesson (Miljöpartiet) [The Environment Party], Transport Engineer
Leif Carlson (Moderaterna) [The Moderates], member of the Swedish parliament
Cecilia Carpelan (Folkpartiet) [The People’s Party], Research Secretary
Eva Lannerö (Kristdemokraterna) [The Christian Democrats], Consultant
Lars Weinehall (Centern) [The Centre Party], District Medical Officer
Conny Öhman (Socialdemokraterna) [The Social Democrats], member of the Swedish parliament
Gunnar Ågren (Vänsterpartiet) [The Left-Wing Party], County Commissioner, until 30th October 1999.
Carina Åström (Vänsterpartiet) [The Left-Wing Party], Regional Commissioner, w.e.f. 1st February 2000
Representatives from National Authorities

Kerstin Blom Boklidén, Environment and Health Analyst at the Swedish Association of Local Authorities [Svenska Kommunförbundet], w.e.f. 10th August 1998.

Maria Enggren, Principal Administrative Officer at the Ministry for Health and Social Affairs [Socialdepartementet], w.e.f. 1st March 1998.

Måns Rosén, Professor and Head of the Center for Epidemiology at the Swedish National Board of Health and Welfare [Socialstyrelsen], w.e.f. 1st June 198.

Douglas Skalin, Head of Research at the Swedish Association of County Councils [Landstingsförbundet], w.e.f. 1st July 1998.

Gunnar Ågren, Director-General of the National Institute of Public Health [Folkhälsoinstitutet], w.e.f. 1st November 1999.

Experts

Olof Björlin, Research Secretary at Sweden’s Association of Pensioners [Sveriges Pensionärsförbund], w.e.f. 1st October 1999.

Finn Diderichsen, Professor at Karolinska institutet, w.e.f. 23rd April 1997.

Kerstin Hildingsson, Company Lawyer at SACO, [Sveriges akademikers centralorganisation] the Swedish Confederation of Professional Associations w.e.f. 23rd April 1997.

Christer Hogstedt, Professor at the National Institute for Working Life [Arbetslivsinstitutet], w.e.f. 15th August 1997.

Pelle Johansson, Project Manager at the National Association for Sufferers of Heart and Lung Disease [Hjärt- og Lungsjukas Riksförbund], w.e.f. 23rd April 1997.

Helena Kivisaari, Company Lawyer at the Swedish-Finnish National Association [Sverigefinska Riksförbundet], w.e.f. 25th April 1997.

Carin Lyckéus, Researcher at the Care Association [Vårdförbundet], w.e.f. 23rd April 1997.

Carina Nilsson, Researcher at the Swedish Trade Union Confederation [Landsorganisationen], w.e.f. 23rd April 1997.

Kjell Nilsson, Director of Public Health for the Västra Götaland region, w.e.f. 24th October 1997.

Britt-Inger Stoltz, member of the Education Committee at the Board of Education [Skolverket], w.e.f. 1st November 1999.

Leif Svanström, Professor at Karolinska institutet, w.e.f. 24th October 1997.
Töres Theorell, Professor at the Institute of Psycho-Social Medicine [Institutet för psykosocial medicin] and Karolinska institutet, w.e.f. 15th August 1997.

Principal Secretary

Bernt Lundgren, graduate from a School of Social Studies and Economic Historian, Secretary from 1st March 1997 to 30th September 1999, Principal Secretary w.e.f. 1st October 1999.

Secretaries

Lillemor Cedergren, graduate from a School of Social Studies and MPH, w.e.f. 17th May 1999.
Isak Reichel, fil. mag, w.e.f. 1st March 2000.
Malena Sjöberg, journalist, from 1st January 2000 to 30th September 2000.
Susanne Öhrling, M.A, w.e.f. 1st March 2000.