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EUROPEAN SOCIAL CHARTER

12th National Report on the implementation of the European Social Charter

submitted by

THE GOVERNMENT OF SWEDEN

(Articles 3, 11, 12, 13, 14, 23 and 30 of the Charter for the period 01/01/2008 – 31/12/2011)

Report registered by the Secretariat on 30 November 2012

CYCLE 2013

REVISED EUROPEAN SOCIAL CHARTER

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(Articles 3, 11, 12, 13, 14, 23 and 30 for the period 01/01/2008 – 31/12/2011)

Twelfth report

Submitted by the Government of Sweden

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

Revised European Social Charter

Articles 3, 11, 12, 13, 14, 23 and 30 for the period of the 1st of January 2008 to the 31st of December 2011.

Article 3.4 and 12.4 has not been ratified by Sweden.

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

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

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Article 3 – The right to safe and healthy working conditions

Article 3§1 – Improving occupational safety and health

Question 1: Please describe the national policy on occupational health and safety and the consultation with employers' and workers' organizations in formulating this policy. Please specify the nature of, reasons for and extent of any reforms.

The work environment policy objective defined by the Swedish Government in its Budget Bill is formulated as a work environment which prevents ill-health and accidents, is adapted to people's different physical and mental aptitudes and is stimulating for the individual. More detailed directions for policy implementation by the Work Environment Authority are issued by the Government in the Authority's annual appropriation directions. In 2010, the Government presented a national action plan for the work environment (see En förnyad arbetsmiljöpolitik med en nationell handlingsplan Skr.2009/10:248). The Government's action plan will form the basis of measures to be taken in the area of health and safety at work in the period of 2010 to 2015. The objective of the Government's work environment policy is to improve the work environment and reduce the risk of work-related ill-health and accidents. At the same time the Government believes that a new approach is needed in the area of work environment. The work environment should not just be viewed as a source of risk, but also as an opportunity to promote both health and operations. A good work environment will also counteract exclusion from working life and increase opportunities to enter the labour market. The work is based on wide-ranging interaction and discussions with the social partners and other agencies in the field.

Questions 2 and 3: Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the national policy in consultation with employers' and workers' organisations. And, Please provide pertinent figures, statistics or any other relevant information, if appropriate.

During the period a number of initiatives were implemented as a result of the action plan. Specific initiatives have been implemented during 2009-2011 to reduce the risk of threats and violence in the workplace and a special program to improve women's work environment commenced in 2011. The informative role of the Swedish Work Environment Authority has been strengthened. The Authority has in the period of 2010-2012 conducted a pilot project in terms of screening as a regulatory method.

Measures taken to implement the national policy 2008-2010

2008:

The overall priorities for the year 2008 were ergonomics, violence and menaces, working alone and globalization. The program for 2008 gave priority to special fields of supervision:

Repetitive assembly-line work

The activities from 2007 continued with focus on assembly-line work in automotive industry and the manufacture of electro-technical equipment. More than 800 inspections were carried out during the two years.

Accidents in the engineering industry

The activities from 2007 continued with focus on the way undertakings learn from accidents and incidents with a view to identifying direct and underlying causes. The result where presented at a seminar with employers and workers organizations.

Use of trucks

The activities from 2007 continued and 2600 inspections were carried out. The activity has initiated systematic work environment management when working with trucks in many organizations.

Domiciliary care

During the year the target information to safety delegates and employers were completed. The information concerned musculoskeletal injury prevention, violence and menaces, and traffic safety. Inspections are carried out during 2009.

Young people at work - summer supervision

During the summer there are a lot of young people working, maybe for the first time. The EU-campaign 2006 “Young people in working life” is underlying this activity that SWEA carries out every summer. The focus is systematic work environment management.

Ergonomics in stores

The purpose with the activity is to reduce the risk for musculoskeletal injuries, for instance at cash work. The inspections started during the year and will continue 2009.

Safe stop

Accidents happen when temporary work inside the risk area of work equipment is performed and when it is not properly stopped. About 360 inspections were carried out and the most common deficiency was absence of instructions.

2009:

The program for 2009 gave priority to special fields of supervision:

Domiciliary care

The inspections were made and the activity was completed.

Ergonomics in stores

The inspections were completed.

Young people at work

Workplaces where young people, under 24 years of age, work has been inspected, mostly stores, restaurants and health care.

Tire workshops

About 220 inspections were carried out with focus on ergonomic risks when handling tires but also handling of technical equipment.

Planing and saw mills

During the last two years 435 planing and saw mills have been inspected. Our strategy to increase the safety in the industry has been to clarify requirement levels on the machines through information to the employers and workers organizations, through market surveillance and visits at the workplace.

Agriculture and forestry

We have started a large supervision and information activity during three years, 2009-2011, together with the industry. It should lead to that the workers themselves work for a better work environment and also is documenting it in an action plan. Change of attitude and behaviour is the goal.

EU Campaign on risk assessment

Focus for the campaign was smaller companies in construction.

2010:

The overall priorities for 2010 were ergonomics, violence and menaces, accidents at work, systematic work environment management, and wind turbines.
The program for 2010 gave priority to special fields of supervision:

Violence, menaces and equality in retail

Retail is an industry dominated of women. We have chosen to inspect stores with 1-5 persons working. Lack of knowledge in violence and menaces is common. The supervision and information was done together with the employers and workers organizations.

Risk assessment in manufacturing

We have during the inspections, around 1700, looked at risks for accidents, ergonomics and systematic work environment management.

Overcrowding in healthcare

To investigate the strategy within the healthcare sector in preventing overcrowding and also map how risk assessment are done when overcrowding occurs, we have inspected 64 hospitals.

Young people at work

The same type of supervision as in 2007 and 2008 has been done.

EU Campaign on a sustainable work life

Focus for the campaign was to look at knowledge about work environment of managers, employers and employees in all industries.

Project Screening

We shall during three years develop and try out a model for supervision called screening. Together with the employers and workers organization we have chosen to try the model on the graphic industry.

2011:

EU Campaign on a sustainable work life

Focus for the campaign was to look at knowledge about work environment of managers, employers and employees in all industries.

Project Screening

We shall during three years develop and try out a model for supervision called screening. Together with the employers and workers organization we have chosen to try the model on the graphic industry.

Violence and menaces

The inspection of retail has continued. We have also started a three year activity with inspections of violence and menaces at exercise of authorities.

Young people at work

The same type of supervision as before has been done.

Consultations with organisations of employers and employees

Reference is made to previous report. The routines for consultations with the social partners are essentially the same as before.

Article 3§2 – Safety and health regulations

Question 1: Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

The Work Environment Act (1977:1160) has been amended several times during the period 2008 – 2011. Those amendments are mentioned below.

Entering into force 1 June 2008 the Act was amended as part of the introduction of the regulation (EC) no 1907/2006 of 18 December 2006 on REACH. A reference to article 35, on information to the employees, of this regulation was introduced into the scope of the act and also a provision introducing surveillance powers to the Swedish Work Environment Authority in respect of article 35.

Entering into force 15 June 2008 amendments was made in the act for the purpose of implementing the new machinery directive (European parliaments and Councils Directive 2006/42/EC of 17 May 2006 on machinery and amending Directive 95/16/EC). A new provision was introduced on statutory powers to issue provisions on prohibitions, special conditions or restrictions for putting technical devices or chemical substances into the market and also a provision amending the provision on powers to issue warnings or decide withdrawals of products.

Entering into force 1 January 2009 several new or amended provisions were introduced to implement Council Directive 92/57/EEC of 24 June 1992 on the implementation of minimum safety and health requirements at temporary or mobile construction sites.

Entering into force 1 July 2008 The Work Environment Authority's decision in individual cases in accordance with this Act or in accordance with regulation notified with support by the Act may be appealed at the general administrative court instead of to the Government.

Also entering into force 15 June 2008 the act was amended to include in its scope work by all domestic workers working in the employer´s household. The act was also at the same time amended to include participants in employment market programs and in work placement or other professional development activities which have been assigned by the social welfare and persons seeking asylum etc. which the Swedish Migration Board grants employment.

Entering into force 1 January 2010 new provisions was introduced about participation of people in education and of safety representatives for those persons. Persons undergoing education shall be given the opportunity, by the responsible authority for the education, of taking part in safety activities at the worksite if this is reasonable in regard to the nature of the education and its duration. Pupils in compulsory education grades 7-9, special school grades 7-10 and upper secondary school as well as corresponding education are represented by *pupil safety representatives* in the working environment. Those undertaking upper secondary education and other education for adults other than special education for adults are represented by student *safety representatives* in the working environment.

Also entering into force 1 January 2010 new provisions was introduced to widen the safety representative´s powers. A safety representative's request may also refer to safety measures concerning external labour at the work place. The safety representative´s power to suspend

work involving immediate and serious danger to life or health was also expanded so that the representative also may stop work carried out by hired labour in the employer's activity.

Provisions issued by the Work Environment Authority 2008 -2011

Arbete med djur, *Work with animals* ***(AFS 2008:17)*** is an area with a lot of accidents. This new provision is a strong desire from the industry and replaces earlier Provisions about bulls.

Bly, *Lead* ***(AFS 2008:01)*** has been revised. The prohibition of the employment of pregnant workers and nursing mothers on work with lead is now incorporated in the Provision on pregnant and nursing workers.

Byggnads-och anläggningsarbete, *Building-and construction work* ***(AFS 2008:16).*** In order to implement the EC Directive about building in a correct way, some changes has been done in the Work Environment Act and also in these Provisions.

Maskiner, *Machines* ***(AFS 2008:03)*** transposes the new EC Directive on Machines. It means that the scope of application is extended and that more products are covered.

Skyltar och signaler, *Signs and signals* ***(AFS 2008:13)*** has been revised and supplemented to meet the disability perspective.

Systematiskt arbetsmiljöarbete, *Systematic Work Environment Management* ***(AFS 2008:15)*** has been revised so the requirements on yearly written summery of illness, and accidents at work repeals. This is done in order to lower the administrative burden for the employers.

Arbetsplatsens utformning, *Workplace design* ***(AFS 2009:02)*** The text in the Provisions is supplemented to clarify the scope in 1§ and of different concept in 2§. Also the ventilation demand has received a revision.

Användning av personlig skyddsutrustning, *Use of personal protective equipment* ***(AFS 2009:08)*** The list in annex 1 about Provisions containing special regulations about use of personal protective equipment has expired. The Provisions has been changed and a revised list can be found on our web.

Cytostatika, *Cytostatics* ***(AFS 2009:06)*** has been modified meaning that SWEA assesses that the pharmaceuticals MabThera should be handled in the same way as other pharmaceuticals containing monoclonal antibodies.

Artificiell optisk strålning, *Artificial optical radiation* ***(AFS 2009:07)*** transposes an EC Directive.

Maskiner, *Machines* ***(AFS 2009:05)*** has been modified according to the EC Directive
Bygg- och anläggningsarbete, *Building-and construction work* ***(AFS 2009:12)*** has been modified because the date for the education requirements has been changed.

Berg-och gruvarbete, *Rock and mining work* ***(AFS 2010:01)*** The technical and organizational development has resulted in new automated remote equipment on the market and new Provisions are necessary. The rules mean higher knowledge for machine- and vehicle drivers and increased requirements on coordination between contractors.

Tillfälliga personlyft med kranar och truckar, *Temporary hoist with cranes and trucks* ***(AFS 2010:03)*** has been modified and the new provisions permits addition of new equipment and regulate the area in a relevant way.

Dykeri, *Diving work* ***(AFS 2010:16)*** The new Provisions focus on planning, risk assessment, knowledge, staffing and the dive leaders role in the systematic work environment management. The new Provisions also require at least one Swedish professional divers certificate S30 to perform diving work.

Ändring av föreskrifterna om kemiska arbetsmiljörisker, *Changes of the Provisions on chemical work environment risks* ***(AFS 2010:04)*** The scope for the special Provisions on dangerous chemical products has been changed so the concept is consistent with the Act of chemicals.

Ändringar med anledning av Lissabonfördraget, *Changes due to the Lisbon Treaty* has been made in eleven Provisions. The change is from EG to EU, no change in substance.

Kemiska arbetsmiljörisker*, Chemical Hazards in the Working Environment* ***(AFS: 2011:19)*** has been modified. The requirements for working with systematic work environment management and risk assessment has been specified.

Hygieniska gränsvärden, *Occupational Exposure Limit Values* ***(AFS 2011:18).*** 28 new substances have been dealt with.

Innesluten användning av genetiskt modifierade mikroorganismer, *Contained Use of Genetically modified Microorganisms* ***(AFS 2011:02)*** has been modified to make the easier to understand.

Ändringar med anledning av en ny lag om ackreditering och teknisk kontroll, *Changes due to a new law on accreditation and technical control* has been made in fourteen Provisions.

Question 2: Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework in consultation with employers' and workers' organizations.

Consultations with organisations of employers and employees

No amendments. References are made to previous reports.

Information with reference to Conclusions 2009

Regarding the specific enquiry on domestic workers, both domestic workers employed by the household and domestic workers employed by companies outside the household are protected under the Swedish Work Environment Act (1977:1160), equal to other workers. This is stated in the Law on Working Time and more in Domestic Work (1970:943) § 8.

Article 3§3 – Regulation enforcement

Question 1: Please describe the enforcement of safety and health regulations. Please specify the nature of, reasons for and extent of any reforms.

Information with reference to Conclusions 2009

The Work Environment Authority´s appropriations decreased during the period of 2007-2009, resulting in a reduced number of inspections and fewer workplace visits. It has, however, been a main focus for the Work Environment Authority to increase the part of the inspectors' time spent on inspection. The number of workplace visits per inspector as well as the total number of inspections has therefore increased from 2009 and onwards. The increase in productivity is mainly due to more effective inspection methods and less administrative work.

The number of inspectors in the period of 2009-2011:

Year	Inspectors
2008	279
2009	272
2010	268
2011	273

Question 2: Please provide pertinent figures, statistics (for example Eurostat data) or any other relevant information on the number of accidents at work, including fatal accidents, in absolute figures as well as in terms of standardized accident rates per 100,000 workers; on the number of health and safety inspection visits by the labour inspectorate and the proportion of workers and companies covered by the inspections; and on the number of breaches to health and safety regulations and the nature and type of sanctions imposed.

	2008	2009	2010	2011
No. work accidents entailing sickness absence	26791	24505	26978	27580
No. fatal work accidents	67	41	54	57
No. work accidents per 100 000 employees	608	555	629	626
No. fatal work accidents per 100 000 employees	1,5	0,9	1,3	1,3
No. workplace visits	33 248	30 024	33 532	34 650
No. Inspections	22 867	20 604	22 088	21 853
No. employees inspected	4111113	3818655	4154557	4154291
No. of workplaces visited	19 216	19 226	20 374	20 755
No. inspection notices with stipulations	13 873	12 817	13 386	13 495
No. injunctions and prohibitions	914	889	944	941
No. contingent fines imposed	770	839	786	902
No. sanction charges	70	77	52	59

No. cases of corporate fines				
No. referrals for prosecution	212	259	287	351

Consultations with organisations of employers and employees

Referring to previous reports. The routines for consultations with the social partners are essentially the same.

Article 11 – The right to protection of health

Article 11§1 – Removal of causes of ill-health

Question 1: Please describe the general public health policy and legal framework. Please specify the nature of, reasons for and extent of any reforms.

Legal framework

The Health and Medical Service Act and Dental Care act - reference is made to previous report (2009).

New Patient Safety Act

A new Patient Safety Act was introduced on 1 January 2011 aimed at creating safer health care. A key aspect of the new legislation is that it should support patient empowerment. A practical example of the work to stimulate patient empowerment is the development of "My guide to safe care" that is intended to support patients in their contacts with the health care. Moreover, the new legislation emphasizes the role of the health care provider in working systematically to create an enabling environment to adequately prevent and manage adverse events. The Patient Safety Act also aims to facilitate and develop the reporting and management of adverse events. The National Board of Health and Welfare was given the main responsibility for the management of the reporting at national level.

New regulation of the national vaccination programs

In the light of new infection threats and a more innovative vaccine industry, the current regulation of the national vaccination programs is in need of review. Therefore, the Government has been working with a new regulation of the national vaccination programs, which will enter into force 1 January 2013. The new regulation implies that the decision whether a disease shall be included in the national program devolve on the Government. A contagious disease shall be included in a national vaccination program if vaccination against the disease can expect to efficiently neutralize morbidity in the society, is cost-effective from a national economically perspective and sustainable in ethical and humanitarian aspects. The programs will be carried out by the county councils and the municipalities. Vaccines that are included in the program will be free of cost for the individual.

New legislation on alcohol, narcotic drugs and tobacco

New alcohol legislation

The government appointed in 2007 a special investigator to carry out a review of the Alcohol Act (1994:1738), on the principle of a restrictive alcohol policy for the protection of public health. A new modernized Alcohol Act (2010:1622) came into force on 1 July 2010.

New narcotic drugs legislation

On 1 April 2011, a new legislation (SFS 2011:111) that concerns the destruction of certain substances of abuse dangerous to health entered into effect. The legislation aims to deal with the increased use of legal drugs of abuse that have not yet been regulated – substances that can nevertheless be assumed to be hazardous to health.

The new Act on the Destruction of Certain Substances of Abuse Dangerous to Health authorizes a public prosecutor to seize and order the destruction of certain substances. A police or customs officer finding a suspicious substance that can be assumed to fall under this legislation may confiscate the substance pending a decision by a prosecutor concerning the destruction of the substance.

The substances covered by the Act are goods/substances which:

1. have been decided by the Government to be listed as narcotics or as goods injurious to health or
2. through an international convention to which Sweden is adhering but where listing has not entered into effect or
3. can be presumed to be listed as narcotics or goods injurious to health.

In addition to this act, there are several annual classifications of new substances, either as narcotic preparations or as products endangering health.

Changes in the Tobacco Act (1993:581)

A special investigator has had the government's commission to review the efficiency of and compliance with the provision concerning an age limit for the purchase of tobacco products and other, related provisions. The overarching purpose was to, as far as possible, prevent early tobacco debuts and reduce tobacco consumption, with a view to improving public health. The more immediate purpose was to facilitate more effective compliance with the provision of the Tobacco Act prohibiting the sale or other commercial supply of tobacco products to persons aged younger than 18 years. The amendments to the Act came into force on 1 August 2010.

The re-regulation of the Swedish pharmacy market

Since 1970 the Swedish pharmacy market has been controlled by a state-owned company, Apoteket AB. On July 1, 2009, the law was changed, thereby allowing private pharmacies in Sweden.

The re-regulation of the Swedish pharmacy market was aimed at leading to an increase in the number of pharmacies and ensures better service and longer opening hours. Another expected result was price pressure resulting in lower prices on pharmaceuticals, ultimately to the benefit of consumers.

The full re-regulation procedure has consisted of four steps.

- Nicotine replacement products were allowed to be sold outside pharmacies (March 2008).
- Altered pharmaceutical provisions to hospitals (September 2008).
- Private community pharmacies were allowed on the Swedish market (July 2009).

- Specific over-the-counter medicinal products were allowed to be sold outside pharmacies (November 2009).

About 450 of the approximately 900 pharmacies formerly run by the state-owned company Apoteket AB have been sold in clusters of between 10 and 199 pharmacies to four large private companies. An additional 150 pharmacies are in the process to be sold to small business owners.

Apoteket Omstrukturering AB was the state-owned parent company in charge of the restructuring of Apoteket AB. Being responsible for planning, preparation and implementation of the process of selling pharmacies with the scope to ensure that the process is carried out in a competitively neutral, transparent and independent manner the company is also responsible for creating necessary conditions for effective competition in a re-regulated pharmacy market.

The new legislation also allows private companies to establish new pharmacies. For each pharmacy a permit from the Medical Products Agency is required. The permit guarantees compliance with the requirements regulating ownership, pharmaceutical competence, premises, staffing etc.

As of 2012, the number of pharmacies in Sweden was 1230, an increase of 300 pharmacies since the start of the re-regulation.

Inquiries in progress

A. ***Supervision of marketing of alcoholic beverages and tobacco, and supervision and age verification for e-commerce and home delivery of alcoholic beverages***

The government has appointed a Commission to

- conduct a survey on the scale and scope of alcohol and tobacco marketing in digital media – the extent, direction and forms of such marketing of alcohol beverages targeting at consumers
- identify the extent that children and adolescents are exposed to marketing of alcohol beverages and tobacco by digital media and television (including pay-tv), and identify the methods used
- analyse the conditions for conducting central supervision of existing rules and legislation for marketing of alcohol beverages and tobacco
- examine how supervision of e-commerce and home delivery of alcoholic beverages to consumers should be conducted and if age verification need to be ensured.

The Commission is to report to the Government on 1 April 2013.

B. ***Authorities in the field of infectious disease control***

The National Board of Health and Welfare (NBHW) and the Swedish Institute for Infectious Disease Control (SMI) are the authorities responsible for infectious disease control. NBHW

has the overall responsibility for the coordination, development and follow-up of disease prevention and control at national level and the SMI is responsible for the monitoring of communicable diseases in humans and also for promoting protection against such diseases. allocation of responsibilities, improve the efficiency of activities and assess the extent of public commitment. A report is to be submitted to the Government not later than 1st June 2009.

*C. **Strengthen the patients' position and influence over care***

In March 2011 the government appointed a committee of inquiry with the task of investigating how to strengthen the patients' position and influence over care and deliver a proposal for a new patients' act. First results are to be delivered in January 2013 and a final proposition no later than in June 2013. The proposal should include how to:

- provide health care on equal terms for the population;
- increase and strengthen patient choice even further;
- improve access to information and advice;
- encourage different government agencies to go about strengthening the patient's position; and
- enhance better exchange of information between the patient and the caregiver.

*D. **Review of the psychiatric compulsory***

In 2008 the Government appointed an inquiry chair to do a review of the psychiatric compulsory treatment legislation. The inquiry chair will analyse the rules of safety that should be made in the compulsory psychiatric care and forensic psychiatric care, such as searches of visitors and the general prohibition against for example mobile phones. The inquiry chary submitted its report to the government on 3 April 2012 (SOU 2012:17). The report is currently being prepared in the Government Offices.

Question 2: Please indicate the measures taken (administrative arrangements, programs, action plans, projects, etc.) to implement the public health policy and the legal framework.

During the 21st century a number of measures have been taken in order to improve availability and strengthen the position of the patient, e.g. free choice of providers and a waiting time guarantee (2010). However, there is no specific law regulating patients' rights in Sweden. Instead, different rights for patients, such as patient choice or the right to information, are incorporated in other legislation or are only formulated in policy recommendations by the Swedish association of local authorities and regions (SALAR).

Entitlement to health care

In Sweden access to health care is based on residence, not on citizenship. The individual county councils are responsible for providing health care to people residing within their geographic jurisdiction. The county councils are also obliged to provide immediate health care to persons not residing in the county council. This means that no health institution can turn away a person in need of immediate care, regardless of his or her legal status,

financial situation, religious background etc. According to Swedish law, no health institution may claim that a patient must pay the full cost in advance or be denied treatment.

Asylum seekers that are 18 years of age and above shall be offered health and dental care that cannot be deferred, maternity care, abortion care and contraceptive advice. Care that cannot be deferred means care offered in addition to the immediate care pursuant to the Health and Medical Services Act and the Dental Care Act (1985:125), if it is deemed that such care is required to prevent serious illness. Asylum-seeking children are offered the same health care and dental care as children resident in Sweden. This is regulated in the Act (2008:344) on Health and Medical Care for Asylum Seekers and Others. The same applies to children who avoid enforcement of a decision on refusal-of-entry or expulsion. For children residing in the country without applying for a permit, there is no statutory obligation on a county council to provide care under the same conditions as for persons resident in Sweden.

Care guarantee

During its 2006-2010 term of office, the Government played a proactive role in ensuring that the health care guarantee, which stipulates the right of patients to health care within a specific period, became required by law. This is articulated in the Health and Medical Services Act (1982:763). The care guarantee has specific targets for all scheduled care. The targets are expressed as 0, 7, and 90. 90 – the maximum waiting time in days for various steps in the healthcare process. Primary care is to offer contact on the phone or in person the same day (0). If needed, a doctor’s appointment is to be offered within 7 days. An appointment with a specialized caregiver is to be offered within 90 days after a referral decision. The treatment is to be started within 90 days after being ordered by the specialist. The care guarantee also requires the county council to assist patients in obtaining care in another county council area if the waiting period for an appointment or treatment in the county council area of residence exceeds 90 days.

To shorten the time between the first contact with a care provider and the beginning of treatment, the Government has concluded a new and more stringent agreement with the Swedish Association of Local Authorities and Regions for 2012, which builds on a performance-based compensation model. The agreement is intended to encourage county councils to offer patients faster access to care in accordance with the health care guarantee and to eliminate waiting lists.

Free choice of primary care

Free choice of primary care provider for the population combined with freedom of establishment for providers accredited by local county councils became mandatory in Sweden in January 2010. This is articulated in the Health and Medical Services Act (1982:763) and in the Act on Free choice Systems (2008:962). More than 200 private primary care providers have been established in connection with or after the introduction of freedom of establishment in Swedish primary care, a 19 % increase of providers. Patients can register with any public or private provider accredited by the local county council. In all county councils, except Stockholm county council, passive registration is practised for individuals who do not make an active choice of primary care provider. Such passive registration is based on the latest visit or shortest geographical distance to a provider. The main result of the reform is an increase in accessibility to primary care. Evaluations also show an increasing overall patient satisfaction with primary care.

National eHealth - the strategy for accessible and secure information

IT use in health and medical care is today a natural part of work in these services. Nearly all medical records in Swedish health and medical care are now kept electronically, and both prescriptions and laboratory replies etc. are transmitted electronically with a nearly 100 per cent coverage. There is, however, still a great potential for improving and streamlining IT use when it comes to e.g. following the patients path through a whole care period and not just single visits.

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

The work of the Steering Group has resulted in a national IT strategy published in 2006 which is to serve as a support for local and regional development work. This strategy was partly revised in 2010. To emphasize the fact that Information and Communication Technologies were a natural part of the organizational development of Swedish healthcare and social services, there was a shift in the strategy to increase the focus on the deployment and the use and benefit of the technology instead of its development. There was also a change of the name of the National Strategy for eHealth to National eHealth - the strategy for accessible and secure information in health and social care. The National Steering group was also renamed in 2011 to the High-Level Group for National eHealth.

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

Ehealth priorities needing action have been divided into six input areas:

1. Services for accessibility and empowerment
2. Usable and accessible information
3. Knowledge management, innovation and learning
4. Technical infrastructure
5. Information structure, terminology and standards
6. Laws and regulatory frameworks

A process has been initiated by the High-Level Group for National eHealth to review the national management of the work to implement the strategy and its actions as well as introduce models for how to monitor implementation and evaluate its effects.

For many years now, the Government has also been co-operating with the SALAR to establish a nationally co-ordinated and quality-assured system of medical counselling on the Internet and by telephone, through the services Sjukvårdsrådgivningen.se and Sjukvårdsrådgivningen 1177. These services are intended to enhance patients' security by giving practical guidance prior to a medical appointment and offering advice on health and self-care. This service has been expanded to include, among other things, personal information on the individual person's own health, electronic access to excerpts from the individual person's medical record, a facility for making medical appointment, renewal of prescriptions and different "theme-sites" concerning e.g. cancer or statistics on waiting times for operations. The ultimate aim is also to be able to present target group- adapted comparative information on the quality and outcome of care from various providers. The service will then become an important tool for all citizens, both prior to a medical consultation and for choosing a care provider, and will provide greater opportunities of participation and self-determination for the individual.

The government has also initiated a project which aims to create a possibility for each citizen to open their own personal health portal where health data and information related to e.g. vaccinations or medicines is maintained by the patient as well as preventive care.

Psychiatry

The Government has invested in improvements of the psychiatric health care, especially for children and youth. A total of SEK 3.7 billion have been invested in 2007-2011. One of the initiatives focused on child and youth and the new investments focus especially on increased access and early discovers of mental illness. One major problem for children and young people affected by mental health problems is the often unacceptably long waiting times for help and healthcare. For this reason resources have being allocated to pilot schemes in various municipalities and areas to develop models for successful frontline child and adolescent psychiatry. The objective is to deal with children and young people at risk of being affected by mental health problems as successfully as possible. The Government, municipalities and county councils have since 2009 reached a yearly agreement on a reinforced care guarantee in child and adolescent psychiatry. The agreement continues on previous investments in 2007 and 2008. The reinforced child care guarantee means that the county councils by 2011 are going to offer an appointment for evaluation within 30 days and decisions on a deeper evaluation or treatment within another 30 days.

The legislation has also been changed so that health care staff since January 1st is obliged to specially observe the needs for information and support to children whose parents have for example mental illness, psychiatric disabilities or addictions to drugs or alcohol.
The National Board of Health and Welfare was in April 2009 given the assignment to intensify its efforts to improve the statistics and reporting system regarding psychiatric care and support. In December 2009 the Government and the Swedish Association of Local and Regional Municipalities made an agreement on a project to improve the institutional psychiatric care, including improvements in the reporting system and reporting of measures and treatments in compulsory psychiatric care.

Patient safety and inspection

Patient safety is a high-profile policy area of the Swedish Government. During 2011-2014, the Government is investing over SEK 2.5 billion in developing patient safety and gradually

reducing the number of injuries related to health care. The investment in patient safety yields results, as shown for example by an increased focus on central issues such as antimicrobial resistance and E-Health solutions fostering patient safety. The work relies on the efforts of various organisations, particularly the county councils that to a large extent organise health care in Sweden, as well as on the National Board of Health and Welfare and the Swedish Association of Local Authorities and Regions (SALAR).

In 2011 the Government reached a first annual performance-based agreement with SALAR in the area of patient safety. The agreement defined targets in specific key areas, such as hygiene measures, use of antimicrobials, exchange of patient information, participation in national monitoring activities, etc. County councils that met national targets received funds allocated to the respective targets, and thus the agreement provided financial incentives for county councils to improve the patient safety. A large proportion of the Government's dedicated investment in patient safety is used for the agreements with SALAR. Until at least 2014 similar annual agreements are intended to gradually raise the targets to reflect the continuous progress anticipated. Furthermore, funds allocated for patient safety have been invested in the development of other monitoring activities, the development of a national strategy, and in specific activities related to E-health, antimicrobial resistance, appropriate use of pharmaceuticals, etc.

The National Board of Health and Welfare is currently tasked with the responsibility for inspection in the realms of health care and social services. To further strengthen independent inspection and the reporting of adverse events, these tasks will be accommodated within a new government agency for inspection activities. The new agency will start operations in June 2013.

Patient safety and quality – medical hygiene/general hygiene

The Government has put in place special processes to strengthen preventive efforts against antibiotic resistance; work is devoted to medical hygiene, general hygiene and rational antibiotic treatment.

Development of public health policy

In March 2008 the government presented a proposal on a renewed public health policy, however with the same overall goal they presented in 2002, which stated that the government should create social solutions for good health on equal terms for the entire population. The government also stated that it is particularly important that the public health situation is improved for those groups that are at most risk of ill health. In the same proposition the government proposed 11 targets areas for the improvement of public health. These target areas are divided into as follows:

- Participation and influence in society,
- Economic and social security,
- Secure and favourable conditions during childhood.
- Healthier working life,
- Healthy and safe environments and products,
- A more health-promoting health,
- Protection against communicable diseases,

- Safe sexuality and good reproductive health,
- Increased physical activity,
- Good eating habits and safe food,
- Reduced use of tobacco and alcohol, a society free from drugs and doping and a reduction in the harmful effects of excessive gambling. (Bill. 2002/03:35).

In June 2012 the government presented a letter for the Parliament on the Government's policy and actions in the public health field. (Skr. 2011/12:166). No changes in the overall goal or the target-areas were presented in the letter. The letter states that public health policy should be proactive, stimulating and inspiring. People should be able to define their own health, to formulate their problems and have the opportunity to find solutions to them. There should be both tools for individuals as well as social conditions to support such a development. The individual's responsibility, supported by an effective collaboration between public, private and civil society actors, is of importance. The government states that the realization of such a policy is based on five major building blocks:

- Start - Children and young people grow up
- Support - In order to facilitate healthy choices
- Protection - An effective and safe protection against health threats
- Collaboration - The shared responsibility for good health
- Strengthened knowledge management - For a more effective public health work

The health care has been pointed out as an important arena for development

The health is an important factor in the work of promoting health and preventing diseases. Efforts have been made to stimulate a working change in the county councils so that actions of health promotion and disease prevention systematically can be integrated into the on-going care work. The National Board of Health and Welfare has produced guidelines for the preventive work on alcohol, tobacco, physical activity and eating habits. The government is now working in order to support the implementation of these guidelines. The aim of this is that the preventive work shall be integrated in the ordinary daily health care.

The National food administration has in 2012 also been tasked to support an active and evidence-based work for good eating habits in the health care. The authority shall in a practical and concrete sense support staff in the advisory work for good eating habits.
Efforts have been made to develop and disseminate the method physical activity on prescription. Among other things, during 2012, on mission of the Government, a textbook on the method has been developed with the purpose to support and facilitate the implementation of physical activity on prescription. The method have been developed and disseminated, and today every county uses and works with it. The Government's assessment is that the National Board of Health and Welfare efforts to support the implementation of national guidelines for disease preventions methods further strengthen the work of physical activity on prescription. The government is supporting the network for health promoting hospitals in order to make way for a health-oriented health care.
To further support and develop the work for children and young the National Board of Health and Welfare has been commissioned to produce and disseminate knowledge that creates conditions for, and support, an effective health promotion and disease prevention work in

maternal health, child health and school health in the areas of good eating habits and physical activity.

The government has worked in order to promote cooperation

The government is also working actively in order to make use of comparable data in order to support development on the local and regional level. The national board is for example commissioned to form indicators for open comparisons regarding the public health work in the health care.

Prevention through the cancer strategy

In 2007, the Swedish government established a "Commission of Inquiry" with a remit to present proposals for a national cancer strategy. The report: "A national cancer strategy for the future" was completed in 2009. The strategy has five overarching goals and these are to 1. reduce risk of developing cancer, 2. improve the quality of cancer patient management, 3. prolong survival time and improve quality of life after a cancer diagnosis 4. reduce regional differences in survival time after a cancer diagnosis and 5. reduce differences between population groups in morbidity and survival time. Following the strategy the government has initiated several projects during 2010-2012 designed to achieve better cancer outcomes for Sweden.

Within the framework of the national cancer strategy preventive efforts are implemented in the health care. Among other things has actions to reduce smoking been initiated. These measures will help to ensure that you in all parts of the health service have, and follows procedures to issue all patients about smoking, that smoking cessation can be offered to a sufficient extend and that there are systems to monitor and report the results of the operations.

A central part of the national cancer strategy is the creation of six Regional Cancer Centres (RCC). The aim of these centres is to achieve increased quality of care and improved health outcomes and more efficient use of health care resources. Each centre will have a role in the preventive work by designing and implementing a plan for health region's work with prevention and early detection cancer. Furthermore, the RCC should support the county councils in the effort of developing existing screening activities to include as many individuals as possible and that the activities are quality assurance. RCC will also be working with actions to reduce delayed cancer detection in the primary- and emergency care.

A cohesive strategy for alcohol, narcotic drugs, doping and tobacco (ANDT) policy

One major change since the last National Report is the Government bill A Cohesive Strategy for Alcohol, Narcotic Drugs, Doping and Tobacco Policy (En samlad strategi för alkohol-, narkotika-, dopnings- och tobakspolitiken, prop. 2010/11:47), approved by the government on 22 December 2010 and adopted by the Parliament on 30 March 2011.
The formerly separate alcohol and drugs policy goals and the general goals for tobacco policy and doping policy have now been combined into the common overall objective "A society free from illegal drugs and doping, with reduced alcohol-related medical and social harm, and reduced tobacco use". The objective entails zero tolerance towards illegal drugs and doping, measures aimed at reducing all tobacco use and deterring minors from starting to use tobacco, prevention of all harmful consumption of alcohol, e.g. by reducing consumption and harmful drinking habits. The objective reflects the Government's determination to tackle the totality of

problems caused by the use and abuse of ANDT for the individual and for society at large. A long-term perspective and increased coordination and cooperation between agencies and other parties are crucial to success. Also needed are a comprehensive, integrated approach focused on the individual/used and the family.
The strategy establishes the goals, priorities and direction of public measures for the period 2011–2015. It covers a range of areas; local preventive actions, measures designed to limit supply, the fight against drugs, care and treatment, alcohol and tobacco supervision, and EU and international efforts. In addition to the overall objective, seven long-term objectives establish the overall direction of the ANDT work. These are rolling objectives, without a set time limit, underpinned by a number of priority goals to be achieved during the strategy period. The new goal structure will also serve as a basis for the follow-up process using national indicators.

Long-term objective 1: Curtailing the supply of illegal drugs, doping substances, alcohol and tobacco

One of the most important measures for reducing the harmful effects and problems associated with the use of alcohol, narcotics, doping substances and tobacco is restricting access to and the availability of these substances.

- Effective and coordinated supervision of alcohol and tobacco
- Effective measures to combat illicit trading
- Effective measures to combat illicit sales via digital media
- Effective local and regional collaboration and coordination of ANDT prevention and crime prevention efforts

Long-term objective 2: Protecting children against the harmful effects of alcohol, narcotic drugs, doping and tobacco

Measures to protect children against their own or others harmful use of alcohol and tobacco or misuse of narcotics and doping substances form the basis of health promotion activities and preventive measures in the area of ANDT.

- Fewer children born with harmful or disabling conditions caused by exposure to alcohol, illicit drugs, doping substances or tobacco
- Appropriate support for children in families where abuse, mental illness or mental disability is present
- Better knowledge of alcohol and tobacco marketing practices via digital media, and of the effect of digital marketing on consumption

Long-term objective 3: Gradually reducing the number of children and young people who initiate the use of tobacco, illicit drugs or doping substances or begin drinking alcohol early

Effective methods to prevent people from starting to use narcotics and doping substances or who have an early alcohol or tobacco debut are to be prioritized.

- Reduced initiation of illicit drugs and doping abuse
- Development of methods for deterring children and young people from starting to use tobacco products
- Wider use of available, effective means of postponing alcohol debuts and reducing alcohol consumption
- Emphasis on health promotion in schools
- Greater participation by parents, non-governmental organisations and the business community in preventive work

Long-term objective 4: Gradually reducing the number of people who become involved in harmful use, abuse or dependence on alcohol, illicit drugs, doping substances or tobacco

To prevent people developing habits involving the harmful use or misuse of - or a dependency on - alcohol, narcotics, doping substances or tobacco, early detection and counselling within primary care is an effective method that can also contribute to positive economic, social and more health-oriented developments in society.

- Intensified efforts by the healthcare service to prevent ANDT-related ill-health (brief intervention and screening)
- Reduced risk use and less intensive alcohol consumption among students and young adults with mental health problems
- More scope for the dental care service to focus on tobacco prevention
- Improved opportunities for the early detection and prevention of ANDT problems in working life

Long-term objective 5: Improving access to good quality care and support for people with substance abuse or addiction

To enable people with abuse and addiction problems to have their care needs met and ultimately become drug-free, access to knowledge-based measures should improve and the position of the individual should be strengthened.

- Greater access to knowledge-based care and support inputs
- A clearer and more appropriate allocation of competencies among the bodies principally responsible for substance abuse and addiction care
- Reduced disparities in quality, availability and results at regional and local level

Long-term objective 6: Reducing the number of people who die or suffer injuries or damage to their health as a result of their own or others' use of alcohol, illicit drugs, doping substances or tobacco

The harmful use and abuse of alcohol, narcotics, doping substances and tobacco is responsible for a large number of early deaths and injuries in Sweden. The link between alcohol, narcotics, doping substances and tobacco on the one hand and violence and accidents on the other is well established.

Reducing the numbers of deaths and injuries caused by one's own or others' use of alcohol, narcotics, doping substances or tobacco is an obvious long-term goal.

- Fewer deaths and injuries in road accidents due to alcohol or other drugs
- Fewer deaths and injuries due to alcohol-related, drug-related or doping-related violence
- Lower mortality rate among teenagers and young adults due to alcohol poisoning or drug experimentation
- Greater awareness among the population of the health impact of ANDT use

Long-term objective 7: Promoting a public health based, restrictive approach to ANDT in the EU and internationally

Sweden is dependent on, and increasingly affected by, the rest of the world. It is crucial that ANDT policy issues are actively pursued within the EU and internationally. Sweden is also working to ensure that the strategies and conventions that it supports or has signed up to have an impact on national policy.

The long-term goal is to contribute to an EU and international approach to alcohol, narcotics, doping and tobacco that is restrictive and based on public health.
Active efforts to ensure compliance with UN conventions in the illicit drugs field

- Active efforts to ensure implementation of the EU and WHO strategies on alcohol and health
- Active efforts to ensure compliance with the WHO framework convention on tobacco control
- Active efforts to ensure compliance with UN conventions in the illicit drugs field
- More effective coordination and increased prioritisation of Nordic cooperation in the ANDT sphere

Caring services for the elderly

The Swedish Government will invest SEK 4.3 billion during the electoral period to improve health and social care for the most ill elderly people. The main objective is for the home care, elderly care, primary care and hospital care services to better work together.
For an older person with many different symptoms and diagnoses, contacts with various different authorities, services and categories of staff can be confusing.

The objectives for initiatives for elderly people in 2011-2014 are to intensify cooperation and coordination, good health, medical and social care, good and safe use of medication, good end-of-life care, good care of people with dementia, better utilise the resources and opinions of the individual and their families and develop knowledge, quality and skills.

Studies of response to homosexual, bisexual and transgender persons in health and medical services

Reference is made to previous report (2009).

Measures to create the prerequisites of good care

Reference is made to previous report (2009).

Infectious diseases

The Government has allocated 145.5 MSEK annually for the period between 2008 and 2012 for measures to combat HIV/AIDS and other infectious diseases.

More efficient structures for the control of infectious diseases

The spread of infectious diseases knows no boundaries, and accordingly the Government supports cooperation and collaboration at EU level and at international level in order to strengthen the protection of public health.

Preparedness for acute health hazard

The Government is prioritizing contingency preparedness to deal with outbreaks of serious infectious diseases. Special measures are to be taken with regard to monitoring and extent of an infection in Sweden, the effects of an infectious disease on society as a whole, ways in which non-medical measures can influence the spread of an infection, and continuing support at regional and local levels for the development of contingency preparedness to deal with epidemics. Preparedness plans are put in place and are revised continuously

Interesting non-commercial pharmaceuticals

New forms of finance and partnership between the private and public sectors are needed in order to upscale primary research findings to products, also where commercially uninteresting pharmaceuticals and products, e.g. HIV vaccines and new antibiotics, are concerned. The Swedish Government has specifically focused efforts on the issue of the need for new antibiotics.

HIV/AIDS and other sexually transmissible and blood-borne diseases

It is vital that work to combat HIV/AIDS and other sexually transmissible and blood borne diseases should be encouraged at regional and local levels. The rapid progress of the chlamydia epidemic makes it urgently necessary for clear action plans to be drawn up concerning preventive work aimed at juveniles and young adults. As mentioned above, the Government has allocated 145.5 MSEK for measures to combat HIV/aids and other infectious diseases. The greater part of this money goes to different measures taken on a local or regional level by the country councils, municipalities and non-profit organizations. Special effort is being made on measures directed to the different preventions groups such as men who have sex with men, i.v. drug users and sex sellers. The Government intends to allocate another 145.5 MSEK annually for this purpose between 2013 and 2016.

Diet and physical activity

The government has worked in order to promote cooperation

The overall public health goal focuses on that the whole of the society has a responsibility for, and has an impact on, public health. Government measures have also focused on the integration of public health policy in the general policies in the various policy areas.

The government has acted in order to promote cooperation between authorities and other stakeholders. A dialogue with the food industry has been performed; a dialogue that now will proceed in a coordinated group for health promotion that have been announced in the government letter of 2012 (see above). A forum for national cooperation regarding health promotion will be established. The forum should consist of representatives from relevant authorities, organizations, sectors, professionals and from the research community. An important and specific task for the forum should be to test the conditions for agreements between the state, the municipalities and the counties, the private business and the civil society that covers common commitments within the health promotion area.

The Swedish National Institute of Public Health has in 2010, 2011 and 2012 also been commissioned to coordinate an awareness week on diet and physical activity - "A healthier Sweden". This work is conducted as a joint project with the purpose of promoting good diet and physical activity and participation in health promotion activities. Actors from different areas have participated: other central government agencies, municipalities, county councils, the voluntary sector and private sector.

Measures within the school promotes physical activity and healthy eating habits

There is good potential for promoting health in schools, through a comprehensive student health that will work health promoting and preventive, through that primary school will endeavour to provide all students physical activity within the school day and through nutritious meals.

The new Education Act (2010:800) states that the school meals should ne nutritious. This means that meals served to the students shall contribute to good health. The Schools

Inspectorate has supervisory responsibility over the school statutes and thus even over the new provisions in the Education Act.

Health coaching for the elderly

A key objective of the national public health policy is to give people the ability to live a good life with a high quality of life in older days. In order to meet the demographic trend of an aging population, it is certainty of importance to work in order to strengthen health and prevent illness and injury among older people.

The Swedish National Institute of Public Health have a mission in collaboration with the National Board of Health and Welfare, to compile guidance to local governments to promote an active and healthy aging with health coaches, and social venues. The guidance referred launched in spring 2012 in the form of a website. The target for this work is people between 60 and 75 years with lighter morbidity. A major challenge is to find and develop forms of cooperation between county councils, municipalities and non-profit sectors.

Support for the sport and recreational sector

The government's support to the sport and recreational sector contribute to a lifetime interest for exercise and therefore promoting good health. In the budget for 2012 it is suggested that the sport should receive good, long term and stable conditions to conduct their business. The total support for sport in 2012 amounted up to 1.7 billion SEK of which approximately 6 % goes to elite sport.

Outdoor recreation contributes to both physical activity experiences and recovery and is therefore of great importance for human health and wellbeing. Outdoors life's positive health effects are of great importance for both the individual and the society at large. Through the development implemented in accordance with the bill of the Future Outdoor Activities (2009/10.238) the outdoor life's conditions is strengthened for promoting physical activity and public health.

Community planning for an environment that enables physical activity in everyday life

A physical environment that enables healthy choices is important in the work of health promotion and disease prevention. Protected, safe, attractive and accessible pedestrian and bicycle paths, pre-school- and school playgrounds and residential areas and access to green spaces and urban hiking enables and incentive physical activity in everyday life. Among other things, The Swedish national board of Housing, Building and Planning has been commissioned to manage a collaborative project with the mission to coordinate and develop a work around community planning that enables and encourages physical activity in everyday life, including access to green areas and urban recreation areas, as well as safe, secure and attractive pedestrian and cycle paths. An important part of the mission is actively disseminating knowledge and good examples on how the planning of the physical environment can contribute to physical activity and healthy choices.

Exercise at work is a tax-exempt benefit

The state supports health promotion at the workplace since basic exercise and other wellness care is a tax-free welfare benefit. The concept includes individual dietary and exercise advice

under the circumstances that the offer is addressed to all employees and that the benefit is of lesser value. The state also supports health promotion at the workplace since the benefit of free occupational health services is tax-free for the employee and that the costs are deductible for the employer. Health examinations that are included as a part of a work environment effort and which are appropriate to the work environment risks the employees are facing in their work are considered occupational health care.

Healthy public meals

The food served in the public sector is an important part of the vision Sweden – The New Culinary Nation. The goals of public food, which is one of five focus areas of the vision Sweden, is about the food that is served within the public sector should be permeated by the quality and enjoyment of food and should be served in an environment that is appealing. It is not enough that the food is safe and healthy it must also taste good.

Effective knowledge management

And important task for the government is to promote an effective knowledge management, including developing, analysing, compiling and disseminating knowledge on effective ways to support individuals who want to change their lifestyle and to promote development of health promotion and disease prevention.

One example of this is open comparisons. Open comparisons on public health were first made in 2009 in collaboration between the Swedish Association of Local Authorities and Regions (SKL), The Institute of Public Health and the National Board of Health and Welfare. The board has been commissioned in collaboration with National Public Health Institute and SKL to suggest how the work of open comparisons within the Public Health field should be structured so that the next presentation can be made in the autumn of 2014.

Question 3: Please supply any relevant statistics or other information on the main health indicators and on health services and professions (for example WHO and/or Eurostat data).

Staffing issues

Admissions capacity for medical studies has been increased in response to growing demand for physicians. The increase was moderate between 2003 and 2007. Since 2006 however, the Government has resolved to allocate funding for a much more powerful increase of the education to become a physician. When the expansion is fully carried through 2015, the capacity to educate physicians will have increased by 26 %.

General aspects – public health situation

The health in Sweden is showing a mainly positive trend. In an international comparison, the health situation in Sweden is very good. Life expectancy continues to increase and in 2011 it was 83, 7 years for women and 79.8 years for men. The main reason for the increase in life expectancy is that mortality from cardiovascular diseases has declined sharply. Mortality cancer, accidents and suicide have also declined in the recent 20 years. The decline has been faster among men than women and gender differences in mortality have decreased, generally, the older population enjoyed the best health development.

The storm clouds exist mainly of the health differences between different socioeconomic groups where you can see clear differences in terms of lifestyle and habits, which have consequences for the health developments distribution in the population.

The proportion of adults who are overweight has not noticeably changed, but there are signs that severe obesity has become somewhat more common. Obesity is more common among men than women, and obesity is more common among people with limited education than among those with further education.

Average life expectancy expected to increase

For several years now, Sweden has had the highest average life expectancy in the world, and the figure continues to rise. In 2011 a new-born boy could be expected to live to 79.7 years and a new-born girl to 83.79 years. Forecasts by Statistics Sweden (SCB) show average life expectancy rising by 2020 to 80.8 for men and 84.2 for women. This increase can be mainly attributed to the steep decline in cardiovascular disease mortality.

Infant mortality very low

Infant mortality, i.e. the number of children dying during their first year of life, is very low in Sweden and has been steadily declining, though a certain year-on-year fluctuation is observable. Infant mortality in 2011 was 2.1 per 1,000 live births, which were down on 2010 (2.6). Most children dying in the first year of life die during the first week.

Morbidity dominated by three groups of illnesses

Reference is made in previously report.

Progressively fewer contracting and dying of cardiovascular disease

Cardiovascular diseases are the group of illnesses causing most premature deaths, while at the same time often entailing prolonged health problems and functional impairment. According to the National Board of Health and Welfare Cause of Death Register and the National Patient Register, the age standardized incidence in acute myocardial infarction (AMI) fell by 34 per cent between 1987 and 2010 and the age standardized mortality in AMI fell by more than 60 per cent during the same period. The number of cardiac infarctions fell by 1-2 % annually between 1987 and 2000. Due to new diagnosis criteria in 2001 the age standardized incidence increased and was 8 % higher in the years 2001-2003 than in year 2000. In 2004 the incidence fell to the same level as before the introduction of the new criteria. The level in 2010 was 25 % lower among both men and women compared to the year 2001. The reduced risks of cardiovascular disease are due to improved living habits, above all a reduction of smoking and to some extent better eating habits. The reduced risk of fatality among those falling ill can above all be ascribed to medical inputs. It is estimated that upwards of 3,000 more lives are saved annually than 15 years ago, thanks to improved cardiovascular care, e.g. heart surgery and preventive treatment of high blood fat levels and high blood pressure.

Some indications of improved mental wellbeing

Reference is made in previously report.

Cancer survival increasing

Cancer is the cause of half of all deaths before age 65 among women and one-third of all deaths before age 65 among men. During the last two decades the average annual increase in number of cases has been 2.0 per cent for men and 1.4 per cent for women. Upwards of half the people diagnosed with cancer today are expected to live as long as their coevals. Cancer is the second most common cause of death (22 % for women and 26 % for men). Among neoplasms, lung cancer is now the most common cause of death among women, and has increased considerably since the late eighties. Prostate cancer is the most common malignant neoplasm among men. Although the total mortality in prostate cancer has increased somewhat since 1987 there is a small decrease in men aged 15–74 years. Stomach cancer mortality is decreasing for both sexes and was about half as high in 2010 as it was twenty years ago.

Especially urgent public health problems

Suicide increasing among young women

Reference is made to previous report (2009).

New cases of HIV infection have increased in recent years

The spread of HIV infection in Sweden has been kept down to a low level by international standards. Since 1985 a total of more than 10 000 have been reported as having contracted HIV infection. Up until 2002 some 200 or 300 new cases were being reported annually, but recent years have seen an increase. Thus, averages of 440 new cases annually have been reported since 2003. In year 2011, the number of new cases reported in Sweden was 465. A heterosexual infection path accounted for 55 % (256) of the total number of cases, while 23 % (106) had been infected by sex between men and 5 % (22) were children born in a foreign country, infected by their mother at birth. 3 % (14) of the total number of new cases were infected by i.v. drug use. For 2 % (8) cases another infection path was stated. Information about the infection path is missing for the remaining 11 % (53) of the total number of new cases reported in Sweden 2011.

Disturbing increase in chlamydia infection

Chlamydia infection has shown a disturbing development since 1997. The number of new cases in 2011 was 37,000.

Less unwanted teenage pregnancies

Every year between 30,000 and 40,000 abortions are performed in Sweden. This level has remained relatively unaltered since the present Abortion Act was passed in 1975, but the number increased between 1995 and 2006, which suggests a rise in the proportion of unwanted teenage pregnancies during the same period. In year 2011, 37,693 abortions were performed in Sweden. It’s at marginal increase in the number of abortions per woman of childbearing age compared to 2009. But in the youngest age group, the statistics show a clear reduction in the number of abortions, marking the fourth year in row that teenage abortions have dropped.

HEALTH EXPENDITURE					
Health care expenditure	2006	2007	2008	2009	2010
Total expenditure on health, % gross domestic product	8,9	8,9	9,2	9,9	9,6
Total expenditure on health, /capita, US$ purchasing powe	3 195	3 431	3 656	3 711	3 758
Public expenditure on health, % total expenditure on healtl	81,1	81,4	81,5	81,5	81,0
Total expenditure on pharmaceuticals and other medical nc	13,4	13,1	12,9	12,7	12,6
Total expenditure on pharmaceuticals and other medical nc	427,9	449,0	471,7	473,0	474,4
OECD Health Data, 2012					

Health care resources	2006	2007	2008	2009	2010
Physicians, Density per 1 000 population (head counts)	3,6	3,7	3,7	3,8	..
Nurses, Density per 1 000 population (head counts)	10,9	11,0	11,0	11,0	
Medical graduates, Per 1000 practicing physicians	27,8	27,6	27,5	28,1	
Nursing graduates, Per 1000 practicing nurses	45,9	41,7	40,5	38,7	
Curative (acute) care beds, Per 1 000 population	2,1	2,1	2,1	2,0	2,0
OECD Health Data, 2012					

Avoidable mortality	2003-2006	2007-2010
Policy-related avoidable mortality per 100 000 inhabitant. Female	33,5	33,4
Policy-related avoidable mortality per 100 000 inhabitant. Male	57,3	51,2
Healthcare-related avoidable mortality per 100 000 inhabitant. Female	41,1	35,7
Healthcare-related avoidable mortality per 100 000 inhabitant. Male	58,8	51,4
Ages 1-79. Age Standardised, Source Dödsorsaksregistret, Socialstyrelsen		

Self-reported unmet needs for medical examination for reasons of barriers of access, by sex and age (%) [hlth_silc_03]

Last update 01.06.12
Extracted on 01.10.12
Source of Data Eurostat

REASON Too expensive or too far to travel or waiting list

	SEX	Males	Males	Males	Males	Males	Females	Females	Females	Females	Females
AGE	GEO/TIME	2006	2007	2008	2009	2010	2006	2007	2008	2009	2010
Total	Sweden	2,2	2,8	2,6	1,3	1,3	3,5	3,4	2,3	2,7	2,3
From 18 to 24 year	Sweden	1,8	3,3	2,2	0,7	1,1	6,3	1,4	3,4	4,8	3,8
From 25 to 44 year	Sweden	3	2,6	3,2	1,5	1,8	4,1	4,5	3	2,1	2,7
From 45 to 54 year	Sweden	2,9	3,4	3,2	1,5	1,2	3,1	3	1,9	4,4	2,8
From 55 to 64 year	Sweden	2,1	2	2,7	1,6	1,1	3,1	4,2	2,2	1,9	1,1
From 65 to 74 year	Sweden	0,8	3,8	1,6	1,1	1,5	2,6	2,4	1,9	1,7	1,7
75 years or over	Sweden	0,7	2,5	1	0,4	0,3	1,6	2,6	0,6	2,3	1,2

Special values:
0 less than half the final digit shown and greater than real zero
: not available

Waiting times and waiting lists

In 2011 9 out of 10 calls to a primary care provider were answered the same day. 92 per cent of the patients were given a doctor's appointment within a week 2011. Concerning waiting times for specialized care at outpatient clinics, the share of patients with waiting times longer

than 60 days for an appointment varied between 60 to 79 % and for a treatment between 52 to 74 %.

Re: the special question asked in Conclusions 2009 concerning counselling and screening

Sweden has a low maternal mortality, the number of mothers who die during pregnancy and delivery in Sweden has varied between 2–4 women annually, during the 2000s. This is partly due to the high medical safety during pregnancy and childbirth, with qualified management of complications.

Moreover the majority of the Swedish population are considerably healthy and the entire population has access to a general high quality health care system. Historically health risks connected with pregnancy and delivery have declined drastically in Sweden. One important reason is that women's general health has improved, but developments in health and medical care are also of great importance. Maternity health care (which reaches almost 100 % of all the pregnant women), obstetrics and neonatal care are of high quality, which contributes continuously to lower risks during delivery and to the fact that increasing numbers of children survive. Mortality due to abortion is almost non-existing since abortions are made safely in the general health care system.

During 2009 the Swedish National Institute of Public Health published the results of a survey of mental health among children and adolescents. The survey shows that a majority of students have good mental health. The level of mental ill health increases from grade 6 to grade 9 and girls report more mental ill health compared with boys. However, there are little or no differences in mental illness based on parents' country of birth or type of municipality the school is located in. In the case of well-being in school, pupils in grade 6 consistently report that they enjoy school. The same applies to the situation at home where the proportion that had a good home life is higher among students in grade 6, compared with students in grade 9. A higher proportion of boys in each grade report that they have a positive situation at home. In the case of leisure time, the proportion of pupils who feel that they can do what they want in their spare time was higher in grade 6, compared grade 9.

The group of students who consistently report significantly worse mental health was that of students who are not living with either of their parents. This group also reports the lowest satisfaction in school, at home and during their leisure time. The proportion of students who exercise/are physically active was lower in grade 9 compared to grade 6.

Statistics from the Swedish Association of Local Authorities and Regions shows that the numbers of school nurses and school social workers in 2011 have increased and that the numbers of school doctors and school psychologist have decreased compared to 2008.

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

	2008	2009	2010	2011
School doctor	93	87	84	85

School nurse	2 205	2 184	2 228	2 254
School social worker	1 484	1 462	1 481	1 525
School psychologist	612	582	569	593

Source: Swedish Association of Local Authorities and Regions

Article 11§2 – The promotion of health

Question 1: For States that have not accepted paragraph 1, please describe the general public health policy and legal framework. Please specify the nature of, reasons for and extent of any reforms.

New Education Act

In July 2011 a new Education Act came into force in Sweden. The Education Act (2010:800) stipulates that school health care and welfare services are to be offered to pupils in preschool classes, the compulsory schooling system and in upper secondary school. School health care is to comprise medical, psychological, psychosocial and special needs resources. These require access to school doctors, school nurses, school psychologists and school counsellors. Pupils are further to have access to staff qualified to meet their special needs. School health care is to be primarily health promoting and preventive.

New Discrimination Act

The Discrimination Act entered into force 1 January 2009. The act replaced seven previous acts against discrimination, inter alia the Act Prohibiting Discriminatory and Other Degrading Treatment of Children and School Students (Swedish Code of Statutes 2006:67).The prohibition against discrimination in the Discrimination Act apply to educational activities and covers any child, pupil or student participating in or applying for the activities. Further, if an education provider becomes aware that a child, pupil or student participating in or applying for the provider's activities considers that he or she has been subjected in connection with these activities to harassment or sexual harassment, the education provider is obliged to investigate the circumstances surrounding the alleged harassment and where appropriate take the measures that can reasonably be demanded to prevent harassment in the future. The Equality Ombudsman supervises compliance with the Discrimination Act.

Question 2: Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the public health policy and the legal framework.

School health care and welfare services - Government initiatives

Government has instructed the National Agency for Education to implement measures for reinforced school health care. Between 2012 and 2015, SEK 650 million are to be allocated as special state subsidies to staff reinforcements in school health care and to training programmes on, for example, schools' responsibilities for pupils with mental illnesses and

children home come to harm or are at risk of coming to harm and support teachers of physical activities to implementing the new curricula and syllabus for compulsory school.
The Government has instructed the National Agency for Education to implement measures for equality in school. As a part of this, the National Agency for Education is to offer further training in teaching about sex and relationships and honour related issues. The training is intended to provide knowledge about such complex issues as sexual abuse, sexual violence and sexual exploitation (including such exploitation as occurs in new digital media), genital mutilation and honour related violence and oppression, to be discussed with pupils from an equality and rights perspective.

The new Education Act and degrading treatment

Under the Education Act, the school and responsible authority have far-reaching responsibilities for investigating reports about degrading treatment, applying measures to ensure that the degrading treatment stops, and following up and evaluating the applied measures. Schools are further obliged to carry out preventive measures and ensure that an equal treatment plan is drawn up every year together with the pupils.

Initiatives on bullying

The Government has commissioned the National Agency for Education to offer further training for school staff in order to strengthen the school's underlying values and efforts against discrimination and degrading treatment. This training is to be based on Swedish and international research in the area and pay particular heed to the importance of a gender perspective when choosing measures against bullying and the situation for young HBT persons. Within the framework of this commission the National Agency for Education is further to compiles and spread information about tried and tested methods for prevention and remedy. The Government has earmarked SEK 40 million for the commission between 2011 and 2014. Results are to be presented no later than 20 January 2015.

Initiatives on ANDT-teaching

In 2011 the Government commissioned the National Agency for Education to produce and offer training programmes with the aim of supporting schools' ANDT teaching. The target group was head teachers and other staff at compulsory and upper secondary schools. This also includes reviewing the ANDT teaching that is being done, making an inventory of support material available in the area and when necessary produce and spread new support material to school principals. The commission is on-going between 2011 and 2014.

Question 3: Please supply any relevant statistics or other information, including on consultation and screening services in schools and for the rest of the population.

See information related to question asked in Conclusion 2009, page 33, and below.

Cost of school health care and welfare services

Type of school	2009	2010	2011
Compulsory school	2180	2330	2309

Independent compulsory school	1434	1570	1570
Upper secondary school	1710	1780	1890
Independent upper secondary school	1160	1200	1280

Source: Agency for Education

Reply to question in Conclusions 2009

Health education for the schools operation

The government commissions the Swedish National Agency for Education to provide training for teachers, and if appropriate, develop materials to support the development of physical education in the compulsory school system secondary and upper secondary. Efforts should provide support to use the new curriculum and the subject plans in terms of education and health, and to assess students' knowledge based on the proficiency requirements of the course and topic plans.

Enhanced student health

The government also commissions the Swedish National Agency for Education to implement actions for enhanced student health. The assignment includes disseminating information about the ability of school boards to apply for government grants to staff reinforcements within students' health and special education teachers. The project also includes the developing of a support material on how schools should design documentation of students' need for support when transitioning between schools and students. The Agency should also as a part of the mission propose a model for monitoring the quality of and access to student health.

Sex and relationship education in school

Under the curriculum for compulsory schooling (Lgr 11), schools' head teachers are responsible for ensuring that all pupils receive sex and relationship education. The curriculum specifies the content of teaching for a number of different subjects, including social science subjects and biology. Teaching aims to inform about and discuss issues concerning sexual health, reproduction, sexually transmitted diseases and sexuality, identity, equality, relationships and love.

According to the upper secondary school curriculum, the head teacher has a special responsibility to ensure that pupils acquire knowledge about sex and relationships. The subject programme for nature studies specifies that the education is to include natural science aspects of, reflection on and discussion about norms regarding human sexuality, lust, relationships and sexual health.

The Government has instructed the Swedish National Agency for Education to offer further training in teaching about sex and relationships and honour related issues to staff in compulsory and upper secondary education. HBT (homosexual, bisexual and transgender) issues are particularly to be considered.

Article 11§3 – Disease and accident prevention

Question 1: For States that have accepted neither paragraph 1 nor paragraph 2, please describe the general public health policy and legal framework. Please specify the nature of, reasons for and extent of any reforms.

Nothing to report.

Question 2: Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the public health policy and the legal framework.

Air

Swedish legislation on this subject is to a great extent based on the stipulations contained in the EU air quality directive (2008/50/EG). Those rules have been transposed to Swedish law in the form of provisions contained in Chap. 5 of the Environmental Code (1998:808) and in the Ordinance on Environmental Quality Standards of Ambient Air (2010:477).

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

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

Another important point of departure for Swedish efforts to improve air quality is the initiatives relating to the environmental quality objective Fresh air. A more exhaustive description of the environmental objective system can be accessed at **www.miljomal.nu**. Air quality in Sweden is good on average. Infringement of the EU air quality limits for nitrogen oxides occurs locally in a few large cities, especially on busy streets with poor air turnover. A particular problem is presented by the high concentrations of large particles, during late winter/early spring, due to the use of studded winter tyres in snow-free conditions. In small and medium-sized villages in rural areas especially, high concentrations of hydrocarbons may occur in winter, due to small-scale wood-firing.

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

Water

Reference is made to previous reports.

Noise

Reference is made to previous reports.

Nuclear

The Swedish legal framework regarding nuclear risks is well developed and the responsibility for safety is well defined. The Radiation Protection Act (Strålskyddslag, 1988:220) and the Nuclear Activities Act (Lagen om kärnteknisk verksamhet, 1984:3) also provides for public insight into the activities of the licensees. The average occupational radiation doses at the nuclear power plants as well as the releases of radioactive nuclides from the Swedish nuclear power plants are fairly low and well below regulatory limits.

In 2008 the Swedish Government merged the two former regulatory bodies into one - the Swedish Radiation Safety Authority - with a clear responsibility for radiation protection and nuclear safety. The Swedish Radiation Safety Authority, is empowered to issue regulations within its area of competence according to the Regulation on Nuclear Activities (Förordning om kärnteknisk verksamhet, 1984:14) and the Radiation Protection Regulation (Strålskyddsförordning, 1988:293).

Asbestos

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

Private persons may handle asbestos-containing material in their own houses but it's requested that they have knowledge of how to avoid health injuries and nuisance.

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

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

Preschools and schools

In 2011 a new legislation was launched from the government. The law says that the school meal is to be free and nutritious. The Swedish food agency is now defining what the school has to do to serve nutritious meals.

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

Competence centre for tax financed meals

Swedish food agency is building a centre to support target groups within the sector of tax financed meals as in school, hospitals and elderly care. The overall goal of the project is to raise the quality of all meals served in this sector.

Recommendations on food at work

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

Food recommendations for expectant and nursing mothers

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

Dietary guidelines for children 0-5 years old

Information for parents about food for infants and children 1-2 years old has been updated in 2011. A guide for health staff with more detailed information was also elaborated and published on the web site.

In April 2012 a film on infant feeding was released on the web and through a DVD that was sent to all child care centres and in October 2012 translations to English, French, Thai, Arabic, Polish, Romani, Russian, Somali and Tigrinya were published on the web site so that they can be printed out by health staff and given to parents. Training of paediatric dieticians was given when the guidelines were released and training of local child health care staff is given at a regional level.

The Keyhole

The criteria for Keyhole marking of products were revised in 2005. Among other things, stricter criteria were defined concerning the sugar content of a number of product groups. Work on introducing the Keyhole as a common marking in Norway and Denmark as well began in the autumn of 2007 and will entail a number of alterations to the criteria. The criteria's where again revised in 2009. The revision was made together with Denmark and Norway and after the revision the Keyhole was launch in both Denmark and Norway.

The Keyhole in restaurants

New restaurant criteria were drafted in 2006 and tested during 2007 in a successful pilot project, "Keyhole-certified restaurant 2007", in which 67 restaurants took part. The certification concept comprises training for all restaurant personnel and support, e.g. in the form of information material, recipe files and material for marking in the restaurant. 2009 a new organization for the certification was formed. The Keyhole Restaurant Association is a non-profit organization with seven members: the National Food Administration, the Swedish National Institute of Public Health, three trade organizations and two universities with a culinary focus. The training and tools provided should help the restaurant in all the different aspects of their work with healthy meals. One tool offered is, for example, a simplified web-based program for nutritional analysis of menus and recipes. Information and marketing material in the restaurant is also offered as well as a database with Keyhole recipes.

Riksmaten - a food dietary survey

A national food survey has been conducted of adult men and women. The results show that eating habits have improved, but they are far from good. Of particular concern is that younger eat worse than older. Most people eat too little fruit and vegetables, fish and whole grains, but too much salt and saturated fat. Not even half of the men eating fruits and vegetables daily, some drink over 4 litres of soda a week.

Food hygiene inspection

The National Food Administration is responsible at the national level for enforcing the Food Act and regulations issued under the provisions there-of. The County Administrations have responsibility for co-ordinating food control at the regional level and the municipal environment and Health Protection Committees have responsibility for food control at the local level.

The Administration supervises some 600 major food production facilities, including about 200 abattoirs. The municipalities are responsible for the supervision of nearly 90% of food

production facilities, upwards of 85 000 facilities in all. The county administrative boards are responsible for the coordination of inspection activities within their several counties. Swedish legislation in the food sector is to a very great extent harmonized with Community law. The EU regulatory instruments indicate how inspections are to be conducted and what is to be inspected. On the other hand there is considerable liberty at national level in matter of organization and funding. Food hygiene inspections in Sweden have since 2007 been financed mainly through direct charges. Each authority is duty bound to ensure that it has sufficient resources for carrying out the inspections needed. The charges paid by food manufacturing entrepreneurs must be sufficient to cover the cost of public inspection. Food hygiene inspection is governed by Community law, the Food Act and the Food Ordinance. The primary responsibility of undertakings for food safety and fir practice is clearly apparent from Community legislation. Basic requirements have to be met in order for foodstuffs to be handled for sale and in mass catering. Companies are required, for example, to carry out checks and to devise routines for self-inspection.

Traffic and injury developments

319 persons were killed on the Swedish roads in 2011 (266 in 2010 and 358 in 2009). The goal for road safety is specified in the form of the interim target that the number of fatalities is reduced by 50 % and the number of serious injuries by 25 % between 2007 and 2020.

The positive trend in Sweden can partly be explained by gradual improvements in the infrastructure and vehicle population. Both development of safe national roads and safe vehicles are improving at a sufficient rate relating to the target. Also road design in the municipal road network has long been developing towards greater safety. Developments in these areas are a good thing in themselves, but when they are combined they can optimize each other. A given level of safety in the vehicle may only have its full effect when it is combined with the right type of road design.

Road design and safety gains in the vehicle population are optimized principally when they are combined with the right vehicle speed, which is crucial to achieving the target. The assessment is that average speeds have dropped incrementally since 2006. But compliance with speed limits still remains at an unacceptably low level. Even if trends are positive in many areas, many challenges remain. Handling drink driving plays a key role in the work until 2020, as drink driving coincides with other road traffic offences. For example, for about half of all fatalities in which the person was not wearing a seat belt, he or she was also under the influence of alcohol.

Sweden, however, still has one of the world’s best ratios of fatalities to population (approximately 3.3 deaths per 100,000 inhabitants).

Measures to improve traffic safety

The interim target will be achieved by means of a long-term, efficient and systematic road safety effort. That the key organizations become involved and cooperate in the effort is of decisive importance. Measures to improve road safety for children should be given special priority.

Vision Zero has been the basis of road safety work in Sweden since it was established through a decision by the parliament in 1997. The decision has led to changes in Swedish road safety policy and in ways of working on road safety. Vision Zero is the idea of a future in which people are not killed or injured for life on the roads. Vision Zero is an ethical approach, but it is also a strategy for shaping a safe road transport system. Vision Zero establishes that it is unacceptable for road transport to claim human lives. Road safety under the principles of Vision Zero involves roads and vehicles being better adapted to people's circumstances with regard to both how we withstand impacts and the fact that we make mistakes. Another important principle is that responsibility for safety is shared between those who design road transport systems and those who use them.

Developments in the automotive industry towards increasingly safer vehicles have meant that we are now able to save 50–100 lives per year compared with 1996. The development of technology in our vehicles is an on-going process within the industry. There is therefore a major need for cooperation between the regulatory agency and the industry in the area of vehicles. Sweden is aiming at using the possibilities offered by new technology to control the sequence of events in a crash so as to limit the impact of the crash to what a human body can withstand. This concerns systems for automatic braking, keeping to one's side of the road or adapting to the speed limit, for example.

Another fundamental measure is to adapt the design of roads and speed limits to the demands posed by the vision zero. Since 2000, therefore, the Swedish Transport Administration has constructed some 200 km of segregated highway annually. The carriageway is divided into three lanes, with the two lane-part alternating between directions. At the end of 2011 there were altogether some 2,500 km of roadway of this kind, estimated to reduce the number of fatalities by about 50 per annum. This measure is very cost effective. As a result of the speed limit review that was carried out, roads have seen their speed limits reduced as well as increased. A major result is a reduction of the speed limits from 90 km/h to 80 km/h on a large part of the roads with risk of head on collisions. Work on improving the safety of verges as well as intersections has also continued. Safety improvement measures for unprotected road users are continuing primarily in the municipalities, concentrating on traffic-calming measures and the segregation of cyclists and pedestrians from motor traffic.

Although a relatively small percentage of journeys are made by drivers under the influence of alcohol, they are involved in 15 per cent of all fatal accidents in Sweden. The illegal limit for drink driving in Sweden is 0.02 % BAC. To combat drink driving coordinated and concurrent measures are the keys. That includes information and education, preventive actions, control and sanctions and co-operation between authorities as well as use of new technologies to stop drink driving. As a part of our preventive work against drunken driving Sweden wants to increase the use of alcohol interlocks (Alco locks), both to prevent drink driving offenders from relapsing and to prevent drink driving in the first place.

The Alco lock is an efficient technical device to stop drink driving. It is used to support the driver in driving sober and is also used by companies to guarantee sober transports. Sweden has implemented a system where a drink driver who wants his license back will have to drive a car with an Alco lock. The system is that all drink driving offenders can apply for an Alco lock condition to get a driving license instead of a revocation. For people in the high risk group the condition will be 2 years with Alco lock-condition. In order to get a license without condition after that they have to prove that they live a sober life. For other drink drivers the condition time will be 1 year. If a drink driver does not apply for an Alco lock conditioned

license, the driving license will be revoked for a minimum time of 1 or 2 years, same as the conditional time would have been. Compulsory rules for alcohol interlocks in vehicles used by governmental authorities have been introduced. Regional authorities are well ahead in asking for Alco locks to ensure sober school bus drivers and bus drivers etc. More than 75 000 **a**lcohol interlocks are also installed in Swedish cars on a voluntary basis. Most of them are company motor vehicles where Alco locks are installed to ensure sober drivers.

From an economic viewpoint automatic traffic surveillance control is one of the most cost effective traffic safety measures. At the end of 2011 there was 1100 traffic safety cameras nationwide estimated to reduce the number of fatalities by 15-20 per annum. Rules facilitating the expansion of automatic traffic surveillance control have been adopted, making it possible for electronic disciplinary fines to be imposed and for direct access to be gained to photographs in the driving license register. Cameras have been put up along the most accident-prone roads in Sweden, and the average speed along these stretches has fallen by 8 per cent.

To drive the development forwards, Sweden's government and industry are investing in a long-term partnership within FFI – Strategic Vehicle Research and Innovation. FFI funds R&D that focuses on climate, environment and safety. The effort is on-going and includes some €100 million per year, half of which comes from public funds through VINNOVA, the Swedish Transport Administration and the Swedish Energy Agency. An equivalent amount is invested by the five industrial partners.

Children and young persons in traffic

Sweden has had a very favourable historical development since the 1970s for children killed in road traffic. Over the past two years, about 20 children died annually. Over 60 % of those killed in road accidents in the past five years are between the ages of 15-17 years. The largest reductions in deaths of children in traffic since the 1970s are among pedestrians and cyclists.

Cycle helmets have been compulsory since 2005 for children younger than 15. This also applies to children as bicycle passengers. 40 % of the children dying on the roads are car passengers. Surveys have shown great possibilities of reducing the number of child deaths among car passengers by ensuring that the children are using the right protective equipment. New rules to this came into force on 1 January 2007. The law now requires all children shorter than 135 cm to use a special in-board safety device, i.e. a baby seat, a child seat, booster (harness) seat or booster (harness) cushion.

Question 3: Please supply any relevant statistics or other information on the percentage of smokers in the general population, trends in alcohol consumption and the rates of vaccination cover for infectious and epidemic diseases.

General aspects – public health situation (ANDT)

Alcohol consumption in 2010

Official statistics cover alcohol sales by the Swedish Alcohol Retailing Monopoly (*Systembolaget*) and restaurants plus sales by grocer's shops of 'medium-strength beer' (alcohol content 2.8–3.5 per cent by volume). To estimate total consumption, however, we must also take into account other categories ('unrecorded alcohol'): privately imported,

smuggled and home-made alcoholic beverages. Data on those categories are obtained from questionnaire surveys.

Officially recorded alcohol sales in 2009 amounted to 7.4 litres of pure alcohol per inhabitant aged 15 or older. Total consumption in 2009 is estimated at 9.3 litres. Recorded alcohol thus accounted for 78 per cent and unrecorded alcohol for 22 per cent.
In the 2000s, alcohol consumption reached a historically high level while recorded sales remained relatively unchanged. At the same time, the proportion of unrecorded alcohol doubled between 1990 and 2004. While part of this increase was due to a rising proportion of illegal alcohol, the main reason was growing volumes of private imports. Since 2004, however, total consumption has fallen by more than 10 per cent as a result of a shrinking proportion of unrecorded alcohol.

By way of an overall assessment of ninth-year pupils' alcohol consumption, it can be said that volumes increased during the 1990s but have since fallen after peaking near the turn of the millennium. This fall can be observed among both girls and boys. While boys' consumption has fallen slightly more than girls' since the peak, it should be mentioned in this context that the increase in 1995–2000 was stronger among boys. 'Intensive' alcohol consumption also increased in the 1990s. Since then, the trend for boys has gone downwards such that both sexes are now equally prone to engage in intensive consumption.

Narcotic drugs (illegal drugs) use in 2010

Studies and statistics on illegal drugs do not reflect the actual situation perfectly; findings are influenced by factors such as changes in laws and their application and changes in the focus and resources of drug-enforcement agencies, addiction services, etc.

The increase in the availability of illegal drugs which was observed in the1990s appears to have stagnated in the 2000s, judging by the slowdown of the fall in the prices of illegal drugs. At the same time, however, prices remain stable at a low level even though historically large volumes of illegal drugs are being seized by law-enforcement agencies, which could be seen as an indication that the availability of illegal drugs is good at present.
Data on occasional or less regular use of illegal drugs are obtained primarily from questionnaire surveys. Despite the methodological problems inherent in such studies, they are considered to reflect trends fairly well.

There are national self-report data on young people's use of illegal drugs going back to 1971. The proportion of young people who had ever tried illegal drugs fell during the 1980s, reaching a low level in the second half of that decade. In the 1990s, by contrast, the proportion of ninth-year pupils (aged 15–16) who had tried illegal drugs more than doubled, and similar trends were observed in other questionnaire surveys. After a slight dip in the mid-2000s, a total of 8 per cent of ninth-year pupils and twice as many among second-year pupils at upper-secondary schools (aged 17–18) claimed in 2009 that they had tried illegal drugs.

Surveys typically show that about 60–70 % of those who have tried illegal drugs have used cannabis only, while 5–10 % has used drugs other than cannabis only. Amphetamine is the second-most common drug – but if illegally used pharmaceuticals (most often benzodiazepine-type sedatives or tranquillisers) are included, they are at least as common as amphetamine.

Trends in current use (30-day prevalence) among young people have largely followed trends in lifetime prevalence. In 2010, 3 per cent of upper secondary pupils reported having used illegal drugs in the past 30 days.

Since 2004, 16–84-year-olds have been asked about their cannabis habits in postal surveys. In the 2010 survey, 12 per cent claimed to have tried cannabis at least once. This corresponds to about 900,000 people in the age range concerned. In the same survey, 2 per cent said that they had used cannabis in the past year and 1 per cent that they had done so in the past month. Recent use of cannabis was the most common among 18–29-year-olds, where 9 per cent of men and 6 per cent of women reported having used cannabis in the past year (corresponding to about 130,000 people).

Adult men are more likely than adult women to have experience of illegal drugs. It can be concluded that the differences between the sexes in their use of illegal drugs arise at upper-secondary age and that they are clearer when more frequent use alone is considered. Men in their early 20s are the most frequent cannabis users of all.

Tobacco use in 2011

According to the National Institute of Public Health’s national survey “Health on equal terms”, 10 % of the men and 12 % of the women smoked every day in 2011. A similar number, 13 % of the men and 9 % of the women smoked occasionally.

In 2011, 18 % of the men and three % of the women used “snus” every day. Compared to the beginning of the 2000s, there are fewer smokers today at age 15 in year 9. There was an increase among boys between the years 2006 and 2010, while smoking among girls has remained relatively stable at a high level last five years. In 2011, 19 % of the boys and 26 % of the girls said that they smoked (anything from daily to occasionally), 5 % were boys and 8 % girls daily. Nearly 40 % had smoked hookah at some point. Hookah smoke though more sporadically, about once a month. Only 1–2 % smoked hookah once a week.

In high school grade 2, there was an increase from 2005 to 2011 among boys, while girls who smoke has been relatively stable in recent years. In 2011, it was 32 per cent of the boys and 39 % of the girls who said they smoked (8 % corresponding 13 % daily). About 60 % had smoked hookah at some point.

Infectious diseases

Reference is made to the previous report.

Vaccination programmes

The child vaccinations offered to all children in child health care and school afford protection against 10 diseases: polio, diphtheria, tetanus, whopping cough, *Haemophilus Influenza* Type B infection (hib), measles, mumps, rubella, Pneumococcal infection and HPV. The vaccinations are free of charge for the individual.

Vaccine against Pneumococcal infection was introduced in the national vaccination program in 2009. Vaccine against HPV is offered to all girls between 10-12 years old since 2010.

Sweden does not at present have general vaccination for tuberculosis or hepatitis B. Instead these diseases are kept in check by means of targeted vaccination, i.e. vaccination offered to children at greater risk of infection.

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

General section							
Age	**Diphtheria, Tetanus, Whooping cough**	**Polio**	**Hib**	**Pneumo-cocci***	**Measles, Mumps, Rubella,**	**HPV*******	**Responsible for vaccination**
3 mths	I	I	I	I			Child health care
5 mths	II**	II**	II**	II**			
12 mths	III***	III***	III***	III***			
18 mths					I		
5–6 yrs	IV (children b. 2002 and later)	IV					
6-8 yrs					II (children b. 2002 and later)		School health care
10	IV (children born up						
yrs	to and including 2001)****						
12 yrs					II (children born up to and including 2001)		

14-16 yrs	V (children b. 2002 and later)					I+II+III	

Directed section

Age	Tuberculosis	Hepatitis B	Responsible for vaccination
Most often new-borns (depending on the risk situation)	Children at greater risk	Children at greater risk	Depending on the risk situation

Notes to tables

*Introduced on 1st January 2009
**Two months or more between injection I and injection II.
***Six months or more between injection II and injection III.
****The fourth injection was recommended in 1996 diphtheria and tetanus only. As from the 2005/2006 school year, whooping cough vaccine is also recommended for this injection.
***** Introduced 1 January 2010
The proportion of children receiving the full vaccination series under the national vaccination programme for children is approximately 98 %.

Statistics

IDB Injury Database (formerly Ehlass)

Detailed injury data are collected through IDB (2010)

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

	No. reported	Estimate
Men	3,893	55,500
Women	2,698	38,500
Total	6,591	94,000

Injuries in the home

Injury area place 10-19, home/housing area includes, e.g. kitchen, living room, bathroom,

stirs, garden, parking space and play area in the housing area.

	No. reported	Estimate
Men	8,464	120,000
Women	8,672	123,000
Total	17,136	243,000

Injuries during leisure time

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

	No. reported	Estimate
Men	17,135	243,500
Women	15,091	214,500
Total	32,226	458,000

Injuries in leisure environment, not domestic

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

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

	No.	Estimate
Men	9,034	128,500
Women	6,629	94,000
Total	15,663	222,500

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

	No.	Estimate
Men	1,560	22,000
Women	1,159	16,500
Total	2,719	38,500

Injuries during child care/school hours according to injury area
(place) Place: 40, 41, 42, i.e.
40 Day nursery, after-school centre, youth club excl. play area (43), child-minder (10-19)

41 School, university, college, excl. sports facility (50-59)
42 School playground inc. play area in school playground

	No.	Estimate
Men	1,039	15,000
Women	786	11,000
Total	1,825	26,000

Animal as causative product

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

	No.	Estimate
Men	725	10,500
Women	965	13,500
Total	1,690	24,000

Animals as causative, triggering or other product

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

	No.	Estimate
Men	1,040	15,000
Women	1,925	27,500
Total	2,965	42

Article 12 – The right to social security

Article 12§1 – Establishment or maintenance of a social security system

Article 12§2 – Minimal levels of social insurance

Article 12§3 – Increased levels of social insurance

Questions 1 and 2:

Reference is made to the previous report. Reference is also be made to the Swedish annual reports on the application of the European Code of Social Security and its Protocol by Sweden, no 41–45, attached to this report, see annex. In addition:

General

Social Security Agreements

The agreement between Sweden and Chile on social security of 13 mars 1995 has been changed by agreement of the 12 December 2005. The changes entered into force on 1 January 2007. The agreement between Sweden and Turkey on social security of 30 June 1978 has been changed by agreement of the 26 August 2004. The changes entered into force on 1 August 2012.

Social Insurance Code

A new Social Insurance Code, entered into force 1 January 2011. This Code replaced most of the existing laws in the social insurance field, except for unemployment.

Base amounts

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

Year	Base amount	Increased base amount
2008	41 000 SEK	41 800 SEK
2009	42 800 SEK	43 600 SEK
2010	42 400 SEK	43 300 SEK
2011	42 800 SEK	44 900 SEK

Income qualifying for sickness cash benefit

Reference is made to the 44st Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, page 3.

Question 3:

Administrative Changes

On 1 January 2008 the Swedish Labour Market Authority (Arbetsmarknadsverket − AMV) was reorganised to form a single body: the General Directorate of Labour (Arbetsmarknadsstyrelsen − AMS). At the same timer the 20 county employment offices were wound up and a new authority, the Public Employment Service (Arbetsförmedlingen), was created.

A comprehensive reorganisation of the Swedish Social Insurance Agency (Försäkringskassan) was made during 2008.

The Swedish Social Insurance Inspectorate (Inspektionen för socialförsäkringen) was set up 1 July 2009 and as of 1 January 2010, a new agency has been established, the Swedish Pensions Agency (Pensionsmyndigheten).

Reference is made to the 41st Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, pages 1-2.

Reference is made to the 42nd Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, page 1.

Reference is made to the 43rd Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, page 1-2.

The statistics presented in this report come from several different sources. Owing to the lack of uniform statistics, many of the figures presented must be termed approximate, not absolute. According to data from SCB (Statistics Sweden), the Swedish population at 31st of December 2011 totalled 9 482 855 persons, namely 4 726 834 men and 4 756 021women. 20.2 % of the total population were aged between 0-17 years and 18.8 % were over 65. Foreign nationals comprised 6.9 per cent of the total population and foreign-born persons 15.1 per cent. The population of Sweden in 2010 and 2009 was 9 415 570 and 9 340 682 respectively.

Some 4.5 million persons between the ages of 15 and 74 were employed in 2009, viz 2.4 million men and 2.1 million women. The figure for 2010 was 4.5 million (2.4 men and 2.1 million women) that for 2011 was 4.6 million (2.4 million men and 2.2 million women).

Medical care

Questions 1 and 2:

Dental care

A new dental insurance is in effect as of the 1 July 2008.

Reference is made to the 42nd Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, page 3.

Health care

Reference is made to the 44th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, page 2.

Question 3:

The insurance scheme includes all persons registered as residents of Sweden (9.5 million at 31st December 2011. Of these, all children up to the age of 20 qualify for free child and juvenile dental care. This group numbered 2.2 million in 2011. All adults aged 20 and over and registered as residents of Sweden qualify for dental care support.

Sickness benefit

Questions 1 and 2:

Reformation of the sickness insurance

Reference is made to the 42nd Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, pages 4 and 9.

Reference is made to the 43rd Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, under the heading III Sickness benefit, pages 4-5 and 12-18.

Reference is made to the 44th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, pages 3–5.

Question 3:

Sickness allowance and rehabilitation allowance are included in employment-based insurance. During 2011 were 4.7 million persons were insured for these benefits according to the Swedish Social Insurance Agency (SIA).

Expenditure on sickness allowances and rehabilitation allowances during 2011 totalled just under MSEK 20,000 and the sickness rate, i.e. average number of sickness allowance benefit days per insured, was 6.8 days per annum.

In its conclusions regarding Sweden (January 2010) the European Committee of Social Rights notes that employers obligation to send a rehabilitation investigation to the Swedish Social Insurance Agency (SIA) when an employee has been sick for four weeks was abolished in 2007. The Committee asks if this requirement has been replaced by another. From July 1 2008 the SIA can require that a sick person present a statement from his or her employer on the possibility of rehabilitation or repositioning at the workplace. If it is not possible for the sick to get such a statement from the employer, the SIA can demand that the employer send it directly to the SIA.

IV Unemployment benefit

Questions 1, 2 and 3:

Aside from the information given bellow reference is made to the Swedish annual reports (no 41-45) on the application of the European Code of Social Security and its Protocol by Sweden.

Questions 1 and 2:

Suitable job (training offer) and initial period during which an unemployed may refuse a job

Current regulations of IAF regarding suitable employment is attached, see annex.

The rules regarding suitable employment shall also apply if the unemployed receives a training offer.

Since the last report was submitted the Swedish parliament has decided to give the Swedish Government (the Government) a notice. This means that the government must review the regulation of the so called 100-day rule[1] and return to the Parliament with a bill on a reinstatement of the rule.

In 2010 the Government appointed a cross-party parliamentary committee on sustainable sickness and unemployment insurances to consider ways of improving both systems in the long term. The aim is to introduce obligatory universal income insurance where those who has been employed and meets the work requirement shall be entitled to income-related benefit.

Beyond the question concerning compulsory obligatory universal income insurance the committee is also considering other important questions related to the Swedish unemployment insurance. Recently the Government decided to extend the mission of the parliamentary committee. The extended missions mainly consist of issues concerning the unemployment insurance. One of the issues the committee shall look further into is the consequences of a reinstatement of the 100-day rule. Another issue is the rule which regulate the number of days for which benefit can be drawn in the event of partial unemployment. The committee shall present its final report no later than January 31, 2015.

The Government will take a position on when and how compulsory unemployment insurance can be introduced after the committee has presented its proposals. Reforms in the unemployment insurance system will continue to have the aim of improving the functioning of the labour market and combating permanently high unemployment.

The payment of the unemployed may be reduced if the person concerned rejects an offer of suitable work without acceptable reasons or without having explicitly rejected such work nevertheless through her or his conduct obviously has caused the employment not to be realised. The decision may be appealed.

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[1] Which gave the job applicant's the right, during the first 100 days, to limit his/her search area to suitable work in their profession and in the local area.

Number of reduction decisions and basis for the sanction (2009-2011).

Rejected an offer of suitable work:

	2009	**2010**	**2011**
25 % reduction	791	852	933
50% reduction	19	19	19

Caused the employment not to be realized

	2009	**2010**	**2011**
25 % reduction	154	184	144
50% reduction	2	0	5

Question 3:

Number of members of an unemployment insurance fund (the number varies by month) (2006-2011)

December 2006	3 785 702
December 2007	3 389 843
December 2008	3 318 926
December 2009	3 360 089
December 2010	3 370 123
December 2011	3 398 490

Average number of benefit recipients per month (2008-2011)

	Earnings-related benefit recipients	**Benefit recipients with basic amount**	**Benefit recipients with activity support**
2008	125 081	9 967	59 231
2009	148 307	11 822	97 879
2010	134 006	10 074	159 506
2011	101 283	9 537	153 107

Number of benefit recipients, distributed benefit amount (benefit in SEK) (2008-2011)

	2008	**2009**	**2010**	**2011**
<=320	54 489	62 545	52 952	48 457
321-679	172 956	159 763	144 285	113 911
680	130 624	195 558	189 281	145 162

Number of benefit recipients/Age range (2007-2011)

	2007	**2008**	**2009**	**2010**	**2011**
-24	50258	33219	41539	26693	20121
25-29	59632	44191	54069	47373	34869
30-34	55594	42788	50921	48062	37481
35-39	51621	41076	49482	47045	36586
40-44	50992	41762	48082	45411	36023
45-49	40055	34501	42007	43009	35983
50-54	34448	29364	34728	35009	29388
55-59	33222	27850	30943	31390	26119
60+	41194	32862	33010	35381	29785

Number of part time days (2009-2011)

	2009	**2010**	**2011**
Total	3 406 311	2 569 071	2 045 882

Information in respect of the Conclusions 2009

In response to the Committee's conclusion 2009 the Swedish Government would like to submit the following.

The Government believes that the Swedish social security system provides an adequate and sufficient financial support for unemployed and consequently fulfil and respects the requirements of Article 12§1 of the Charter and in this way guarantees the right to social security to workers and their dependents including the self-employed.

Based on the construction of the social security system, one individual benefit cannot be singled out and used as a sole ground for evaluation of the total support to unemployed. Different types of benefits are intertwined and should not be viewed as a number of individual benefits. The Swedish Unemployment Insurance Scheme does not for example prevent unemployed persons from getting social assistance or housing assistance combined with unemployment benefit. To the Government, the aspects which the Committee recalls and refers to indicates that the adequacy and sufficiency of a social security system firstly, should neither be evaluated nor judged only by looking at one aspect and secondly, that such a system must be reformed and adapted to the situation in each country seeking to guarantee the

best support for its citizens and the most efficient system in relation to the country's financial situation and welfare system.

As the Charter seeks to lay down minimum common standards with a view to ensure the effective exercise of the right to social security and neither imposes a common model, nor seeks to harmonize social security legislation but rather to lay down minimum common standards and thereby leaves each country free to define its own social security system, the Government believes that it is important to take into account different labour market situations and different economic conditions in each country when evaluating the sufficiency of a financial benefit. The level of unemployment benefit is a delicate balance. On the one hand, unemployment benefits may serve as automatic stabilizers in a recession: the benefit reduces the loss of income, thereby smoothing the drop in tax revenues and consumption. On the other hand, generous benefits may lead to a lack of economic incentive to find employment, thereby leading to a poverty trap where benefit dependency takes precedence over an employment. The Government believes that the unemployment benefit should reflect the average pay before the onset of unemployment, but not to the point that it serves as a disincentive to take up work.

The Swedish Unemployment Insurance Scheme is an important and integrated part of the Swedish labour market policy. The Swedish labour market policy aims to maintain a "work-for-all" strategy, i.e. work rather than allowance. Unemployed are given support to return to employment as soon as possible after being unemployed. Unemployment benefit is available when it is not possible to offer employment or when active labour market policy measures are not successful. In that sense, the rules of the unemployment insurance scheme are coherent with the goals of the Swedish labour market policy.

With regard to the above, the Government believes that the Swedish social security system provides an adequate and sufficient financial support for unemployed and consequently that the system fulfils and respects the requirements of Article 12§1 and responds to the lack of information regarding Article 12§3 of the Charter.

Regarding compulsory income related unemployment insurance reference is made to the above mentioned.

V Old age benefit

Questions 1 and 2:

Old age pension

Reference is made to the 44th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden page 9.

In its conclusions regarding Sweden (January 2010) the European Committee of Social Rights notes that in 2007, a full pension after 40 years of residence for an unmarried person amounted to SEK 85,839 (€9,264 per year or €772 per month). For each year of residence less than 40, this amount is reduced by 1/40. The Committee observes that this amount stands between 40 % and 50 % of the median equivalised income (respectively €662.4 EUR and €

828 per month in Sweden in 2007). Thus, unless combined with other supplements, it might be held inadequate. It therefore asks the Government to clarify the situation.

The Swedish Government wants to state that there are supplements to the guarantee pension as price indexed housing supplements, but as far as basic security in the national pension system is concerned, it may be assumed for several reasons that its importance will decline. Price indexing of the basic security means, in the case of unchanged rules and higher real wages that the real value of these pensions will decrease in relation to wage income and income-based pensions. But when the economy grows, fewer and fewer individuals will have an income low enough to entitle them to guarantee pension. In 2011 the total amount is around 55 per cent of the median income.

But it is important to take into account that people´s financial situation is not fully captured with the aid of information about annual income. It needs to be supplemented with a description of assets, liabilities and expenses to give a fair picture of their standard of living.

Below follows a description of basic security for pensioners in Sweden.

Guarantee pension

Those who have not earned the minimum level of an income-based pension receive a guarantee pension financed from the Central Government budget to make up the deficiency. The guarantee pension is fully taxed and amounts to 2.13 price base amounts (SEK 93 720 in 2012) for single people and 1.90 price base amounts (SEK 83 600 in 2012) for married persons. The guarantee pension is adjusted against other pensions from the Swedish old-age pension system and from comparable foreign national pensions, but is not reduced by wage income, capital income, occupational pension or private pension insurance.

Maintenance Support (Elderly Persons)

Persons residing in Sweden and aged over 65 who have a small or no old age pension are to be guaranteed a reasonable standard of living through the maintenance support. The amount of support payable depends on the beneficiary´s income and capital. The support guarantees a reasonable standard of living and a compensation for reasonable housing costs (up to 6 200 SEK a month). The Maintenance support is tax free, it´s regarded as a social insurance benefit and it´s financed through the national government revenue.

Housing supplement for pensioners

Housing supplement for pensioners is subject to means testing and is affected by housing costs, income and capital. The housing supplement amounts to 93 per cent of housing costs up to SEK 5 000 a month for single persons. Housing costs for a person who is married or cohabiting is calculated as half the couple’s joint housing costs, that is to say up to SEK 2 500 a month with an addition of SEK 340 per household. Thus, the highest housing supplement that may be disbursed is SEK 4 820 a month. Housing supplement is reduced in accordance with special rules depending on the individual’s and any partner’s capital, pension income, income from capital, earned income, etc. The amount is tax free.

Special housing supplement
If the pensioner's income after deduction for reasonable housing costs is under an acceptable level, a special housing supplement may be granted. This benefit applies mainly to those with high housing costs. A reasonable housing cost is at most SEK 6 200 a month for single persons and SEK 3 100 for a pensioner who is married or cohabiting. The established reasonable standard of living after housing costs have been paid corresponds to 1.3546 price base amounts (about SEK 60 300 in 2012) for those who are unmarried and 1.1446 price base amounts (about SEK 50 900 in 2012) for those who are married.

Other benefits

Other systems and benefits are available that contribute to the welfare of the elderly and which are of major importance when assessing what is a reasonable level for pensions. Care of the elderly is heavily subsidized and recipients of long-term care pay only a small part of the real costs. Municipalities offer transportation service for those who due to a functional disability cannot travel by public transport. Through this service, people with a functional disability can travel by taxi or specially adapted vehicles at prices equivalent to those for public transport.

Regarding health and medical care, dental care and pharmaceuticals, there is a special high-cost protection which means that the patient only pays charges or costs up to a certain sum.

Question 3:

Income based old age and survivor's pensions and widow's pension are included in employment-based insurance. According to the Swedish Social Insurance Agency, some 4.7 million persons were included in this insurance scheme in 2011.

Guarantee pension, housing supplement for pensioners and maintenance support for the elderly are residence-based benefits. According to the Swedish Social Insurance Agency, some 7.6 million persons (all residents aged over 16) are included in this insurance scheme.
1.9 million persons were in receipt of old age pensions in December 2011.

Of these, 0.8 million received guarantee pensions. The cost of income-related pensions for 2011 was just under MSEK 219,000 and guarantee expenditure pension expenditure totalled MSEK 18,500.

Housing supplements for old age pensioners were paid to some 263,000 old age pensioners at a cost of just over MSEK 7,600.

Almost 14,500 persons were in receipt of maintenance support for the elderly in December 2011, at a cost of some MSEK 500.

VI Work accident and occupational disease benefit

Questions 1 and 2:

Nothing to report

Question 3:

Work injury compensation (annuity and sickness allowance) is included in employment-based insurance. According to the Swedish Social Insurance Agency, some 4.2 million persons were included in the scheme in 2011.

Some 55,000 persons were in receipt of annuities in December 2011. Disbursements for the year totalled just under MSEK 4,200.

Family benefit

Questions 1 and 2:

Reference is made to the 45th annual report on the application of the European Code of Social Security and its Protocol by Sweden, general report – period from 1 July 2011 to 30 June 2012, under the heading Further clarifications, page 13.

In 2008 a gender equality bonus was introduced in order to promote but not enforce the equal sharing of parental leave between the parents. The bonus is constituted by a tax relief of maximum EUR 315 per month that is paid to parents who share their paid parental leave equally. The bonus will stimulate the person who normally would use the larger part of the paid parental leave to return to the labour market. In 2012 the bonus was improved, making it easier to use.

A new child raising allowance was introduced in 2008 for children between 1 to 3 years old. This allowance can offer a smoother transition between parental leave and the return to working life. The allowance provides financial support to parents so that they can take care of their children at home as a substitute to child-care services. The allowance cannot be used together with for example parental benefit and a number of other social benefits, is voluntary for municipalities to introduce and can be at most SEK 3 000 a month.

On July 1st 2010 there was a raise in the large family supplement (under the child-allowance scheme).

For the second child, there was a raise of SEK 50, for the third child SEK 100, fourth child SEK 150, fifth child and on: SEK 200.

The large family supplement is currently:
-SEK 150 a month for the second child
-SEK 454 for the third child
-SEK 1010 for the fourth child
-SEK 1250 for the fifth and up

Parent´s cash benefit is payable for a total of 480 days per child. As of the 1st of January 2012 the parents have the right to use 30 benefit days (“double days”) at the same time to take care of their child together. These 30 days can only be used during the child’s first year. The total amount of benefit days used this way is 60 days, 30 days for each parent.

Question 3:

Child allowance, extended child allowance, parental benefit at the minimum level and basic level, housing allowance, survivor's benefit for children, grants for the adoption of foreign children and maintenance support are residentially based benefits.

Parental benefit above the base level and temporary parental benefit are benefits included in the employment-based insurance.

Child allowance was disbursed for some 1,676 million children in 2011. The expenditure totalled 24.1 billion SEK.

About 227 000 households received housing allowance in 2011. Expenditure was SEK 3.3 billion.

Parental benefit in connection with childbirth was paid out to 723 000 parents in 2011. The expenditure was SEK 25 billion. Most of that amount was paid out for children aged younger than 1.5 years.

Temporary parental benefit was utilized for the children of some 786 000 parents in 2011, 52 % were women, 48 % men. Total expenditure was SEK 5 billion in 2011.

The part of temporally parental benefit paid out to care for sick children, made up 85 % of total expenditure, benefit in connection with childbirth or adoption 15 %. In 2011 on average seven days per child was used for care for sick children.

In 2011 maintenance support in some form was paid out for 238 000 children. Expenditure was SEK 2 billion.

In 2011 grants for the adoption of foreign children was paid out for 543 children. Expenditure was 22 million SEK.

VIII Maternity benefit

Questions 1 and 2.

Reference is made to the 45th annual report on the application of the European Code of Social Security and its Protocol by Sweden, general report – period from 1 July 2011 to 30 June 2012, under the heading Further clarifications, page 13.

Question 3

Pregnancy benefit is payable to women only. The benefit forms part on employment based insurance. In 2011 about 22 000 women received pregnancy benefit, expenditure was SEK 455 million. On average 39 days per women was paid out.

IX Invalidity benefit

Questions 1 and 2:

Reference is made to the 44th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, under the heading IX Invalidity benefit, page 14-16

Question 3

Income-related sickness and activity compensation, together with rehabilitation and special allowances, are included in employment-based insurance. 4.7 million persons were insured for these benefits between 2011 and according to the Swedish Social Insurance Agency.

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

Some 401,000 persons were receiving some form of sickness or activity compensation in December 2011. Approximately 225,000 of them were receiving guarantee compensation. Expenditure in 2011 totalled MSEK 44,000.

Caring allowances were awarded in December 2011 for some 47,000 children. The proportion of children in the population aged 0-19 years receiving caring allowances was approximately 2 per cent in 2011. During 2011 the Swedish Social Insurance Agency disbursed a total of MSEK 2,800.

Disability benefit in 2011 cost approximately MSEK 1,200 and was paid to 61,000 persons.

Upwards of 16,000 persons were entitled to assistance compensation in December 2011. Expenditure in 2011 totalled some MSEK 18,000. Net State expenditure, however, was somewhat less, due to a certain amount being defrayed by the municipalities.

In 2011 nearly 2,000 persons received car allowances, at a total cost of MSEK 260.

Survivor's benefit

Questions 1 and 2:

Nothing to report.

Question 3:

Income-based survivor's pension and widow's pension are included in employment based insurance. The Swedish Social Insurance Agency reports that some 7.6 million persons were included in the scheme 2011.

Guarantee pension for survivors is a residentially based benefit. The Social' reports that some 6 million persons were included in this scheme in 2009-2011.

Recipients of income-related widows' pensions constitute the largest group, numbering almost 320,000 in 2007. Guarantee pensions disbursed as window's pension numbered 13,000. Expenditure on survivors' pensions in 2007 totalled MSEK 15,200.

XI Financing

For 2011 reference is made to the 45th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden pages 11-12.

For 2010 reference is made to the 44th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden pages 18-19.

For 2009 reference is made to the 43rd Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden pages 11-12.

For 2008 reference is made to the 42nd Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden page 8.

Article 13 – The right to social and medical assistance

Article 13§1 – Granting of adequate social and medical assistance

Question 1: Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

From 1 January 2008 a new paragraph was introduced in the Social Services Act. It says that children and young persons attending school (< 21 years old) are entitled to earn ½ price base amount (=22 000 SEK in 2012) per year without reducing the family's right to social assistance.

Question 2: Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

As from 1 January 2010 the National Board of Health and Welfare is responsible for the supervision of Social Services.

Question 3: Please provide pertinent figures, statistics or any other relevant information, in particular: evidence that the level of social assistance is adequate, i.e. the assistance should enable any person to meet his/her basic needs and the level of the benefits should not fall below the poverty threshold. Information must therefore be provided on basic benefits, additional benefits and on the poverty threshold in the country, defined as 50% of the median equivalised income and calculated on the basis of the poverty risk threshold value published by Eurostat.

Social assistance payments totalled Billion SEK 11.2 in 2011. The number of recipients were approximately 418 000, which (4.4 per cent of the population) which compared to 2010 indicated a small decrease. This decrease is however, to some extent caused by a new legislation introduced in December 2010. This legislation gives refugees and their families, granted asylum after 1 Dec 2010, the right to attend an introductory scheme and to receive an introductory benefit from the state instead of social assistance from the municipality.

Single mothers, young persons and persons born abroad are groups more dependent on financial support than, for example, single fathers and cohabitants and persons born in Sweden. During 2011 23 per cent of all single mothers were receiving financial assistance, as against 37 per cent in the mid-1990s. Approximately 23 per cent of young persons, aged between 18 and 24, born abroad, received social assistance at some time during 2011 compared to 6 % of young persons born in Sweden.

		No. beneficiaries	Proportion of population (%)
1990	4,721	490,808	5.7
1991	5,642	510,205	5.9

1992	7,012	559,902	6.5
1993	8,712	641,385	7.4
1994	10,285	694,060	7.9
1995	10,786	687,951	7.8
1996	11,884	721,040	8.2
1997	12,377	716,842	8.1
1998	11,425	658,782	7.4
1999	10,465	580,934	6.6
2000	9,521	522,242	5.9
2001	8,704	469,004	5.3
2002	8,528	434,046	4.9
2003	8,274	418,395	4.7
2004	8,687	417,491	4.6
2005	8,584	406,743	4.5
2006	8,738	392,466	4.3
2007	8,899	378,552	4.1
2008	9,456	384,671	4.2
2009	11,059	422,320	4.5
2010	11,594	437,050	4.7
2011	11,248	418,039	4.4

For young persons as with persons born abroad, the need for assistance may be due to their never having gained entry to the employment sector so as to qualify for other forms of compensation, with the result that they are thrown back on social assistance for their livelihood. Many of the causes of livelihood problems are difficult for social services to address actively, coming as they do outside the social service sphere of responsibility and competence. Ever since the economic crisis of the 1990s, however, the municipalities have been assuming progressively greater responsibility for employment policy initiatives. In certain municipalities these are organised within the social services, while elsewhere they are the responsibility of special labour market units.

The level of social assistance is partly decided by the Government and partly by the municipality. The level decided by the Government (national standard) is regulated in the Social Services Act and is based on calculations on the cost of basic products and services required for a reasonable standard of living (livelihood support). It is divided into different age groups and household types. The other part of the livelihood support consists of assistance for reasonable costs for housing, home insurance, domestic electricity, travel to and from work, membership fee to trade union and unemployment insurance. These amounts are decided by the municipality.

The level of social assistance for a single person household were in 2011 approximately SEK 8500 per month (approx. Euro 900). This amount includes livelihood support plus costs covering housing, electricity and home insurance. The poverty threshold, defined as 50 % of median equivalised income and as calculated on the basis of the Eurostat at-risk-of poverty threshold value is estimated at Euro 940 in 2011.

Information in respect of conclusions in 2009

According to the Social Services Act the right to social assistance is not depending on nationality or residence for a certain length etc. Everyone staying in (or passing by) a Swedish

municipality is eligible for social assistance and is entitled to support if his or her need cannot be met in any other way. The municipality has to assess the individual need of anyone seeking help, regardless of whether he or she is a Swedish national, permanently residing in Sweden, tourist, illegal resident etc. Such an individual assessment may result in a conclusion that help is needed, but that the need can be fulfilled by for example money enough for a ticket for the applicants home, food and shelter during the journey. Municipalities cannot refuse to give emergency social assistance to a person in need if that need cannot be fulfilled in any other way.

Article 13§2 – Prevention of discrimination

Question 1: Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

The Discrimination Act

The Discrimination Act (Swedish Code of Statutes 2008:567) entered into force in Sweden on January 1, 2009. The Act replaced seven previous acts against discrimination. At the same time, the former four Ombudsmen against discrimination were merged into one Ombudsman, the Equality Ombudsman. The purpose of the Discrimination Act is to combat discrimination and in other ways promote equal rights and opportunities regardless of sex, transgender identity or expression, ethnicity, religion or other belief, disability, sexual orientation or age (read more about protection against age discrimination on page 93). The Act contains prohibitions of discrimination that apply to:

– working life
– educational activities
– labour market policy activities and employment services not under public contract
– starting or running a business
– professional recognition
– membership of certain organisations
– goods, services and housing
– meetings and public events
– health and medical care
– social services
– social insurance
– unemployment insurance
– financial support for studies
– national military service and civilian service
– public employment

Information in respect of conclusions 2009

The Committee asks whether the scope of the new law and of the work of the Anti-discrimination Ombudsman Office include also non-discrimination based on social status.
The scope of the Discrimination Act does not include social status. Accordingly, nor does the work of the Equality Ombudsman. The Ombudsman's main responsibility is to supervise compliance with the Act.

The Committee asks whether the registration with a parish was an administrative formality or was dependent on membership of a particular faith, since persons of no fixed abode can exercise their right to vote if they are registered at a parish. A parish as a civil registry-concept is the smallest geographical division in Sweden from which is made censuses by the Statistics Sweden. That means that all persons that are registered as living in Sweden are registered per municipality, and per parish in that municipality. Registration with a parish is only an administrative formality and is not dependent on membership of a particular faith.

Question 2: Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

Nothing to report.

Question 3: Please provide pertinent figures, statistics or any other relevant information, if appropriate.

Nothing to report.

Article 13§3 – Assistance in the prevention or alleviation of family want

Question 1: Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

The Social Service Act – reference is made to previous report (2006).

The Debt Relief Act – reference is made to previous report (2009).

Information in respect of conclusions made 2009

Guarantee of available information regarding social and medical assistance.

The Committee wishes to be informed on whether persons without resources are offered advice and assistance to make them fully aware of their rights to social and medical assistance and of the ways to exercise these rights. According to the Act on Public Administration (1986:223) the authorities has a service obligation. This includes providing guidance, information, advice and other such means of help on specific topics within the area of the activity of the authority as well as, if needed, an obligation to guide persons to a competent authority. This guidance and advice shall be offered to the extent which is suitable depending on the character of the issue and the individual need of assistance.

Information should be given in a way that is easy to understand and interpreting services offered for people that cannot express themselves in Swedish or have a grave hearing- or speech reduction.

Information in respect of conclusions 2009

In respect of prevention and alleviation of personal or family want.

The Swedish Consumer Agency is required to support the municipalities on their budget and debt counselling. The Swedish Consumer Agency also publishes reports concerning the state of the budget and debt counselling provided by the municipalities. Their latest publication was published in April 2012.

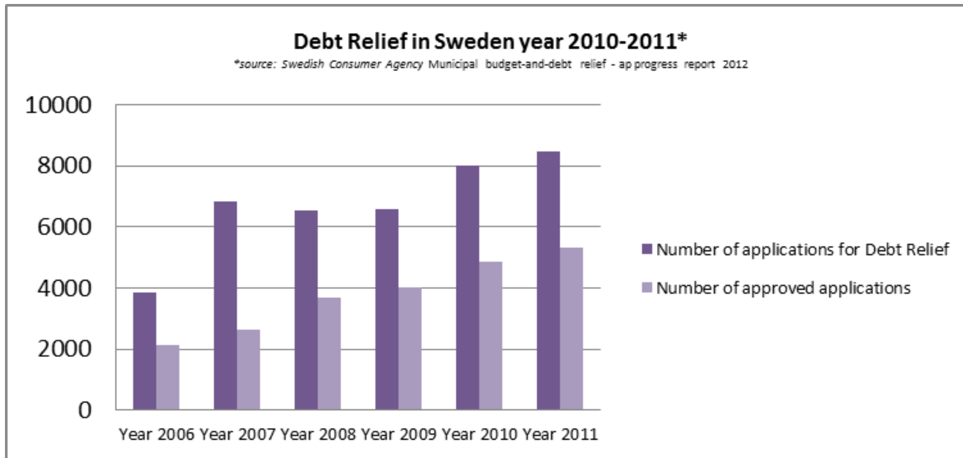
The report states that 288 out of 290 municipalities in Sweden have made budget-and-debt counselling available to the inhabitants. The two municipalities lacking budget-and-debt counselling responded that they were in progress of procure such services or that the service was not clearly defined as part of the social secretaries work. It is most common that the municipalities provide their own budget-and-debt counselling, but the municipalities are able to purchase such services from other municipalities or from consultancy agencies from the private sector. 22% of the municipalities buy their budget-and-debt counselling services, while 13% sell their services to other municipalities. 65% of the municipalities neither buys nor sells. In two out of three municipalities it is the Social Welfare Committee which administrates budget-and-debt counselling. 94 out of 290 municipalities have more than one person working full-time specifically with budget-and-debt counselling, while 194 municipalities have a single person working full-time with these issues. Municipalities with less than 5000 inhabitants offer the least amount of time for their services in comparison with the national average amount of time. Conclusions drawn from the report states that inhabitants in municipalities with a larger population, often the major cities in Sweden, have easier access to budget-and-debt counselling.

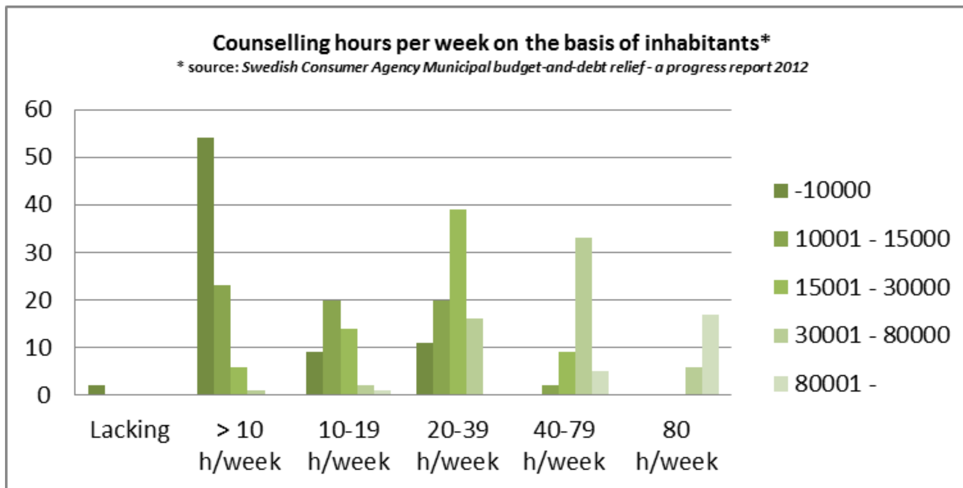
Budget-and-debt counselling work can be divided into four areas: counselling, debt relief, preventive work and administration. Budget-and-debt counselling involves work with planning a budget, giving advice, working with a debtor's individual behaviour and negotiates with creditors. It is most common that the municipalities provide their own budget-and-debt counselling. Debt relief involves work with assisting debtors during the debt clearance process with applications, reconsiderations and appeals and support throughout the debt clearance process. This is an integrated part of the municipalities work with budget-and-debt counselling. Preventive work involves everything in order to counteract indebtedness, such as working with schools, organisations, private sector and media. 110 out of 290 municipalities states that they engage in preventive work. Most of these are larger municipalities, often part of major cities in Sweden. 12 out of 290 municipalities work solely with debt relief. Administration is also seen as an integrated part of the budget-and-debt counselling work.

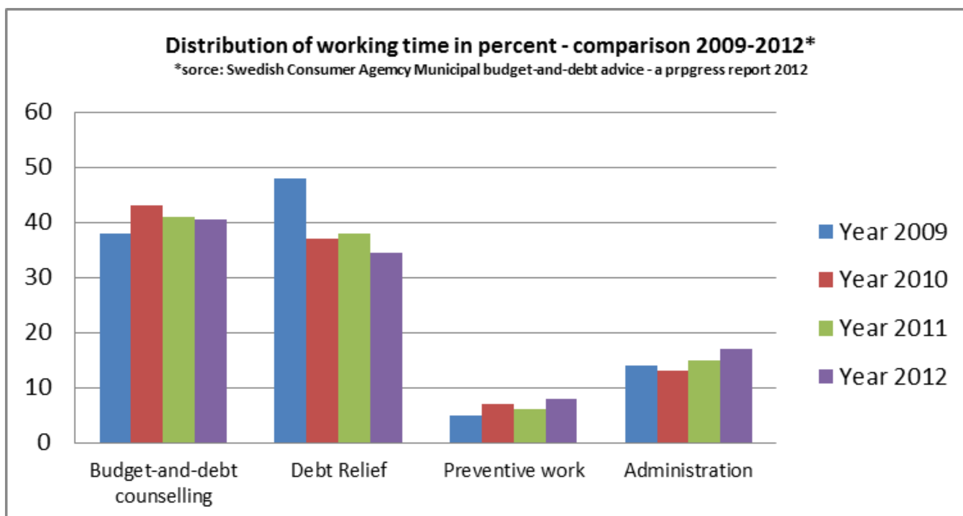
Question 2: Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

Nothing to report.

Question 3: Please provide pertinent figures, statistics or any other relevant information, if appropriate.







Article 13§4 – Social and medical assistance to nationals from other Parties

Question 1: Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

Reference is made to previous reports.

Question 2: Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

Reference is made to previous reports.

Question 3: ***Please provide pertinent figures, statistics or any other relevant information, if appropriate.***

Statistics requested are lacking for both the social and medical sector.

Information in respect of conclusions 2009

Entitlement to social assistance

See article 13§1.

Entitlement to health care

In Sweden access to health care is based on residence, not on citizenship. The individual county councils are responsible for providing health care to people residing within their geographic jurisdiction. The county councils are also obliged to provide immediate health care to persons not residing in the county council. This means that no health institution can turn away a person in need of immediate care, regardless of his or her legal status, financial situation, religious background etc. According to Swedish law, no health institution may claim that a patient must pay the full cost in advance or be denied treatment.

Asylum seekers that are 18 years of age and above shall be offered health and dental care that cannot be deferred, maternity care, abortion care and contraceptive advice. Care that cannot be deferred means care offered in addition to the immediate care pursuant to the Health and Medical Services Act and the Dental Care Act (1985:125), if it is deemed that such care is required to prevent serious illness. Asylum-seeking children are offered the same health care and dental care as children resident in Sweden. This is regulated in the Act (2008:344) on Health and Medical Care for Asylum Seekers and Others. The same applies to children who avoid enforcement of a decision on refusal-of-entry or expulsion. For children residing in the country without applying for a permit, there is no statutory obligation on a county council to provide care under the same conditions as for persons resident in Sweden.

Article 14 – The right to benefit from social welfare services

Article 14§1 – Promotion of welfare services

Question 1: Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

Reference is made to previous reports.

As mentioned above, since January 2009, a new Act against discrimination, the Discrimination Act, is in force. The purpose of the Act is to combat discrimination and in other ways promote equal rights and opportunities regardless of sex, transgender identity or expression, ethnicity, religion or other belief, disability, sexual orientation or age.

The prohibition of discrimination covers direct discrimination, indirect discrimination, harassment, sexual harassment, and instructions to discriminate. According to the Discrimination Act, a disability refers to permanent physical, mental or intellectual limitation of a person’s functional capacity that, as a consequence of injury or illness existed at birth, has arisen since then or can be expected to arise.

The protection against discrimination applies to working life, educational activities, labour market policy activities and employment services not under public contract, starting or running a business, professional recognition, membership of certain organisations, goods, services and housing, meetings and public events, health and medical care, social services, social insurance, unemployment insurance, financial support for studies, national military service and civilian service as well as public employment.

The prohibition of discrimination in working life stipulates that an employer may not, for reasons connected to e.g. disability, discriminate against a person who, with respect to the employer, is an employee, is enquiring about or applying for work, is applying for or carrying out a traineeship, or is available to perform work or is performing work as temporary or borrowed labour.

In working life, there is also a requirement to implement reasonable accommodations. The prohibition of discrimination also applies in cases where the employer, by taking reasonable support and adaptation measures, can see to it that an employee, a job applicant or a trainee with a disability is put in a comparable situation to persons without such a disability. Measures that may be considered can include those that are intended to improve physical access to the workplace and associated premises, as well as to make the premises usable for persons with disabilities. This might include technical devices and special work tools or changes to the physical working environment. This might entail stronger lighting for a person who is visually impaired, good ventilation for a person with allergies, technical devices to facilitate lifting and transport, computer support etc. Changes to work duties, working hours and working methods may also be appropriate.

Education providers may not discriminate against a child, pupil or student participating in or applying for an educational activity. The prohibition of discrimination also applies in cases where an education provider, by taking reasonable measures regarding the accessibility or usability of the premises, can arrange so that a person with a disability who is applying for or

has been accepted for education under the Higher Education Act or for education that can result in a degree in accordance with the Award of Certain Degrees Licensing Act, is put in a comparable situation to persons without such a disability. Measures that may come into question relate to improving the physical access to the university and associated premises, as well as, as far as possible, making these premises usable for persons with disabilities. This may include changes to the design of the premises, such as high thresholds, wall-to-wall carpets, the absence of lifts, the location of door openers, the design of lavatory areas etc. It may also relate to good ventilation for persons with allergies, wireless loop systems and good acoustics for individuals with impaired hearing, the need for contrast and strong lighting etc. for persons with impaired vision.

The Equality Ombudsman supervises compliance with the Discrimination Act and is entitled to bring a case to court, as a party, on behalf of an individual who consents to this. Certain non-profit organisations are also entitled to take legal action. The Equality Ombudsman shall, according to the Act concerning the Equality Ombudsman (Swedish Code of Statutes 2008:568), work to ensure that discrimination that is associated with sex, transgender identity or expression, ethnicity, religion or other belief, disability, sexual orientation or age does not occur in any areas of the life of society. The Ombudsman shall also work in other respects to promote equal rights and opportunities regardless of sex, transgender identity or expression, ethnicity, religion or other belief, disability, sexual orientation or age. The Equality Ombudsman shall provide advice and other support so as to help enable anyone who has been subjected to discrimination to claim their rights. Further, within her or his sphere of activities, the Equality Ombudsman shall inform, educate, discuss and have other contacts with government agencies, enterprises, individuals and organisations, follow international developments and have contacts with international organisations, follow research and development work, propose legislative amendments or other anti-discrimination measures to the Government, and initiate other appropriate measures.

The provisions set out in the Discrimination Act; define discrimination as both direct and indirect discrimination, harassment and sexual harassment, as well as instructions to discriminate. The concept of discrimination within the Act originates from the EU legislation on non-discrimination.

Direct discrimination consequently refers to a person being disadvantaged by being treated less favourably than someone else is treated, has been treated or would have been treated in a comparable situation, if this disadvantaging is associated with a disability (Section 1, § 4, point 1). Indirect discrimination refers to a person being disadvantaged by the application of a provision, a criterion or a procedure that appears neutral, but that may put persons of a certain disability at a particular disadvantage, unless the provision, criterion or procedure has a legitimate purpose and the means that are used are appropriate and necessary to achieve that purpose.

Harassment refers to a form of behaviour that violates a person’s dignity and that is associated with disability (Section 1, § 4, point 3). Instructions to discriminate refers to orders or instructions to discriminate against someone directly, indirectly or through harassment or sexual harassment (Section 1, § 4, point 5). The order or instruction must be given either to someone who is in a subordinate or dependent position with the person giving the orders or instructions, or to someone who has committed herself or himself to performing an assignment for that person.

New curricula and earlier grades

The Government has initiated several reforms to affirm, early on in compulsory school, the achievement requirements students need to fulfil. Making the achievement requirements clear and communicating them with the students and their guardians, is a prerequisite to identify students with difficulties at an early stage and providing them with special support. To this end, the Government in 2008 introduced achievement requirements in Swedish, Swedish as a second language and Mathematics by the end of the third school year in compulsory education. National tests have also been introduced in the third school year.

In 2010, the Parliament decided that grades were to be awarded to students from the sixth school year. This decision enters into force in 2012. Currently, grades/marks are awarded to students in the eighth and ninth year of compulsory education. Students in compulsory education are also to receive written assessments of their development throughout compulsory education.

In autumn 2011, a new curriculum with new syllabuses and knowledge requirements for compulsory schools, compulsory schools for students with intellectual impairment, special schools as well as Sami schools was introduced. The new curricula contain the fundamental values and tasks of the school, overall goals and guidelines for education and syllabuses. The fundamental values and tasks of schools and the overall goals and guidelines are the same for all types of school.

A new Education Act

In 2010, the Parliament decided on a new Education Act encompassing education from pre-school to adult education. The Act comes into force in 2011 (and in some cases in 2012). Some of the reforms decided upon in the new Education Act are reported below.

All students in the national school system for children and young persons have the right to the necessary special support they need. If it comes to the attention of the school that a student might have need of special support, the principal of the school is responsible for investigating the need. If there is such a need, the principal is responsible for drawing up an action plan for the student. This is to be done together with the student and his or her guardians. The action plan is to state the needs of the student, how these needs are to be met by the school and how the measures by the school are to be evaluated. With the new Education Act, the students' right to special support has been strengthened by a possibility for the student and his or her guardians to appeal a decision on an action plan, taken by the principal of the school.

Students with intellectual impairment can attend compulsory and upper secondary education for students with intellectual impairment. With the new Education Act, the obligation to conduct a thorough investigation before admitting a student for such education has been strengthened. The Education Act now specifies that an investigation is to be conducted consisting of a psychological, pedagogical, medical and social evaluation of the student. The right of the student to refuse an offer of education in compulsory education for students with intellectual impairment has also been incorporated in the new Education Act. If a student does not agree to receiving education in compulsory education for students with intellectual impairment, the municipality and the school are obliged to provide the student with the necessary support within mainstream compulsory education. A student can however in exceptional cases be admitted to compulsory education for students with intellectual

impairment against the wishes of the student or the guardians, if there are particular reasons for this according to the best interests of the child.

Students in compulsory education can to some extent choose what school to go to. When allocating students to different schools, the municipality shall comply with guardians' wishes in so far as this is possible without neglecting other students' justifiable claims to be placed in schools close to the home, or considerable organisational or financial difficulties being caused the municipality. In the new Education Act, there is the possibility to appeal such a decision by the municipality, thus strengthening the possibility of school choice for all students.

Special schools

There are three national and five regional special schools that are run by the State. The special schools currently encompass around 500 students. The special schools offer education corresponding to compulsory nine-year comprehensive school to students with deafness or impaired hearing, visual impairment and additional disabilities, deafness or impaired hearing combined with severe intellectual disabilities or congenital deaf-blindness, and students with severe speech and language disabilities.

In 2008, it was once again made possible for students with visual impairment and additional disabilities and students with severe speech and language disabilities to attend the special schools. Since 2001, these students had not had the possibility of attending special schools.

Reform of upper secondary education

In 2009, the Parliament decided on a new structure for upper secondary education. The reform aims at strengthening the quality of education and to reduce the number of students who drop out. The reform means a diversification between programs preparing for further studies and programs preparing for the labour market. To increase quality of the vocational programmes, greater cooperation between receivers (for instance future employers) and school governing bodies has been introduced.

Apart from the 18 national upper secondary programmes, five introductory programs have been created for students who do not meet the necessary qualifications for national programs. The introduction programs are meant to prepare the student either for continued education in a national upper secondary program or for the labour market.

The changes of upper secondary education apply as of autumn 2011.

Government agency reform

In 2008, the government agencies in the field of education were reformed. The National Agency for School Improvement was abolished and most of its tasks taken over by the National Agency for Education (www.skolverket.se). The task of inspection was removed from the National Agency for Education and a new agency was created for this purpose: the Swedish Schools Inspectorate (www.skolinspektionen.se).

A new agency was also created to coordinate government support to municipalities and schools in the area of special needs education: the National Agency for Special Needs Education and Schools (www.spsm.se). The function of the agency is to offer support to school managements in matters relating to special needs education, promote access to teaching materials, run special schools and allocate certain targeted government grants to

students with disabilities and to education providers. The new agency took over the former functions of the National Agency for Special Educational Support, the Swedish Institute for Special Needs Education and the National Agency for Special Schools for the Deaf and Hard of Hearing.

In 2009, the Swedish National Agency for Higher Vocational Education (www.yhmyndigheten.se) was established (see Higher vocational education below).

New teacher education

In its bill 'Top of the class – new teacher education programmes' the Swedish Government in February 2010 proposed that the earlier degree of Bachelor/Master of Education be replaced by four new professional degrees: a degree in pre-school education, a degree in primary school education, a degree in subject education and a degree in vocational education. The four new degrees include knowledge objectives in the subjects to be taught, and objectives concerning other key knowledge and skills of a more general nature for school and pre-school teachers. All new degrees include knowledge objectives concerning identifying and teaching students with special needs. The Swedish parliament decided to adopt the bill in April 2010 and the new teacher education programmes started in 2011.

In its bill 'Top of the class' the Swedish Government also proposed that the Postgraduate Diploma in Special Needs Training, introduced in 2008, be extended to include specialisations for deafness or hearing impairments, vision impairments, serious language impairments and intellectual impairments. The specialisations meet the need of special schools and schools catering for children with disabilities for special needs teachers with specific knowledge about the groups of students for whom these types of schools are intended. In 2011, students are admitted to the Special Needs Education programme with its new specialisations.

Higher vocational education

Higher vocational education programmes provide vocational education and training at the post-secondary level outside higher education institutions. To be included in higher vocational education, programmes must meet the needs of the labour market for qualified labour or contribute to the development or retention of qualified professional expertise in niche occupations, such as craft occupations.

The Swedish National Agency for Higher Vocational Education (www.yhmyndigheten.se) was established in 2009 to administer and to decide which programmes come within the scope of higher vocational education. Through regular supervision and quality review, the agency monitors that the programmes maintain a high standard, follow the course syllabus and meet the requirements contained in law, ordinances and other regulations. The agency is also responsible for supervision and decisions concerning government grants under the Ordinance on state support for supplementary education programmes. To ensure that the programmes organised under higher vocational education are relevant to the labour market, they are designed in collaboration with the business sector.

Question 2: Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

A reading-writing-arithmetic venture

In 2008, an extensive reading-writing-arithmetic venture was introduced. By establishing early reading, writing and arithmetic skills in grade 1–3, the Government aims at reducing the number of students leaving compulsory school without sufficient skills. The purpose is to encourage school organizers to strengthen work on students' basic skills.

Professional development for teachers

The Government has provided specific funds for the municipalities and independent schools to support professional development. In this context, it has launched the Boost for Teachers (Lärarlyftet), a comprehensive programme for in-service training of teachers with particular focus on deepening their subject knowledge and skills. For instance, the offer includes courses in special needs education. The programme runs from 2007 to 2011 and can cover 30,000 fully qualified teachers.

Inspection and quality evaluation

In 2008, the Swedish Schools Inspectorate was established to strengthen the national inspection and quality assessment of the education system in the greatly decentralised Swedish school system. The Inspectorate's work has included thematic quality assessments of the education for students with disabilities. Deficiencies have been noted by the Inspectorate, for instance lack of knowledge on how to adapt education to suit the needs of all students and failure to adapt the learning environment of the school. The Inspectorate continually follows up how schools and municipalities deal with deficiencies noted by the Inspectorate (see also the answer below to the specific question of the Committee concerning education and training for persons with disabilities).

Reform implementation

The Swedish school system has undergone considerable changes in the period since 2007. Many of the reforms, such as for instance the new Education Act and new curricula, came into force in 2011. A lot of work will be done to implement the new reforms. The National Agency for Education has been given the task by the Government to lead the implementation of the current reforms.

Students in universities and university colleges

Each university and university college must ensure that students with disabilities have access to educational support measures. These educational support measures are financed in the first instance by means of universities and university colleges setting aside 0.3 per cent of their grants for undergraduate education for this purpose. The educational centre may also apply for nationally allocated funds.

Almost all universities and university colleges have special contact persons and coordinators for students with disabilities. Some support measures that may be offered include adapted examinations, literature on adapted media, note-taking support, mentorship, additional guidance, language support and sign language interpreting. Some universities and university colleges employ interpreters to interpret lessons.

Universities' and university colleges' support measures for students with disabilities are followed up in several ways, including by the Swedish National Agency for Higher Education within the framework of the Agency's supervision activities.

Question 3: Please provide pertinent figures, statistics or any other relevant information to demonstrate effective access to education and vocational training for persons with disabilities (total number of persons with disabilities, number of persons with disabilities of 0-18 years of age, number of persons with disabilities in mainstreaming and special education and vocational training, including higher education; number of integrated classes and special education institutions, basic and in-service training for teachers).

Sweden does not keep any statistics regarding the number of children and young persons with disabilities in the education system.

The Swedish education system is based on the principle of inclusion. Most children and young persons with disabilities consequently receive their education within the framework of the regular forms of education. Only 1.7 per cent of all students within child and youth education receive their education outside of the regular forms of education, i.e. in education for students with intellectual impairment or in special schools for children with certain disabilities.

Number of students 2010/11

Mainstream education	*Number of students*
Pre-school	476,817
Pre-school class	103,529
Compulsory education	886,487
Upper secondary education	385,712

Education for students with certain disabilities

Compulsory education for students with intellectual impairment	12,115
Upper secondary education for students with intellectual impairment	9,280
Special schools	501

Educational and vocational guidance in the school system is available to all students, regardless of the type of school attended and of any functional impairment. It is the head teacher's responsibility to ensure that educational and vocational guidance activities are organised in such a way that students receive guidance preparatory to the various options offered in school and before choosing their continued education and future occupation. In the school year of 2010/11, there were a total of 1,802 full-time qualified educational and vocational guidance officers.

About six % of all young persons between 16 and 19 years of age (about 28 000 individuals) do not attend upper secondary education. Municipalities are obliged to keep track of young people who do not attend upper secondary education in order to offer them assistance. The most common form of assistance is some other form of education outside the national programmes of upper secondary education.

During 2010, a total of 1,136 education programmes were conducted within higher vocational education. A total of 43,300 students participated in this education.

In the budget year of 2010, a total of 7,200 students received special educational support at Swedish universities and university colleges. However, the statistics do not provide a complete picture of all university students who have a disability.

Misuse care

On 1st January 2010, an amendment to Chap. 2, Section 7 of the Social Services Act came into force which stipulates that the municipality together with the County council shall establish an individual plan for individuals who need services from both the social services and the health care sector. At the same time an amendment to Chap. 5, Section 8a of the Social Services Act came into force which stipulates that municipalities and county councils shall enter agreements on how to coordinate their services for persons with mental disabilities. The same amendments were also introduced in the Health Care Act. The reason behind these amendments was to strengthen the coordination of services between social services and health care.

Domestic violence

The law on investigations of deaths of children (2007:606) due to crime is amended to also include women and men who die from crime committed by a current or former family member. The new law on investigations of some deaths came into force 1 January 2012.

Personal assistance

The following amendments have been made to the Act Concerning Support and Service for Persons with Certain Functional Impairments (LSS).

On the 1st of July 2008 a reporting obligation was introduced for municipalities and county councils regarding unexecuted favourable decision (corresponding to changes made in 2006 in the Social Service Act).

On the 1st of January 2010 were the supervisory and authorization activities according to the Social Services Act and the Act Concerning Support and Service for Persons with Certain Functional transferred from the County Administrative Boards of Sweden to the National Board of Health and Welfare and coordinated with the health- and medical supervision. The supervisory responsibility was defined. At the same time, extended powers of the supervisory authority were introduced in the form of injunctions, prohibitions, withdrawal of authorization and inspections. (Proposition 2008/09:160).

On the 1st of January, authorization and obligation to report for activities with personal assistance according to the Act Concerning Support and Service for Persons with Certain Functional Impairments was introduced (23 § LSS), in order to strengthen the supervision of the activities.

On the 1st of July 2011 the so-called “Lex Sarah”-regulation was changed in the Social Services Act and the Act Concerning Support and Service for Persons with Certain Functional Impairments when the notification procedure was strengthened.

On the 1st of May 2011, new regulations in the Social Services Act and the Act Concerning Support and Service for Persons with Certain Functional was introduced regarding which municipality that carries the responsibility of efforts according to respective law in different situations, in order to ensuring that no case falls between the responsibility of two municipalities. The purpose was, among other things, to ensure that cases of people affected of homelessness or persons of no fixed abode, would not be transmitted between municipalities without anyone taking responsibility.

Introduction to newly arrived immigrants

A new system for the introduction of newly arrived immigrants entered into force on 1 December 2010. The key responsibility for the introduction process for adults, moved from the municipalities to the central government. The purpose of the reform is to speed up the introduction into working and community life. The Swedish Public Employment Service has a coordinating responsibility for adult introduction activities. This underlines the work-first principle.

The target group covered by the Introduction Act (SFS 2010:197) is refugees, other people in need of protection who have a residence permit and their close relatives who have applied for a residence permit within two years. The target group is adults between 20 and 64 years. Newly arrived immigrants without parents in Sweden aged 18-19, are also included.

Question 2: Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

This section deals with measures not referable to any other article. Everything to do with financial assistance is dealt with under article 12 and 13 and everything to do social protection of elderly persons under article 23 and issues regarding public health is dealt with under article 11.

Reference is made to previous reports.

Misuse care

The evaluation of the three-year State initiative (2005-2007) to reinforce care for persons with substance abuse indicated that the state support have promoted quality of services and the use of evidence based methods as well as integrated services where social services and health care cooperate.

In 2008 the Government initiated support for implementation of the national guidelines for the care of substance abusers and addicts, published by the National Board of Health and Welfare, in collaboration with the Swedish Association for Local Authorities and Regions. This implementation project has been running since then and includes, education and training for professionals, “hands on” implementation support at regional level, coordination on decision making level between municipalities and county councils and support to improved user involvement in the development of the services and care provided. The Government has

also initiated a strengthened supervision of the misuse care and services provided by both municipalities and county councils to ensure access and equality in services provided during 2008 and 2010. Finally, the Government appointed an investigation to make an overview of the misuse care and services and give proposals for improvements. The investigation presented a final report in 2011. All these initiatives are included in a cohesive strategy for alcohol, narcotic drugs, doping and tobacco policy which run from 2010 to the end of 2015.

Domestic violence

The government continue to make efforts in order to combat domestic violence and strengthening the support to women exposed to violence and their children. The action plan to combat men's violence against women, violence and oppression in the name of honour and violence in same-sex relations is followed up by new measures during the period of 2011-2014. This includes development work, continued education measures and quality assurance of working methods. The objective is new working methods and approaches to be integrated into regular activities to support and protect women subjected to violence and children who witness violence. In April 2012 the Government appointed a Swedish Domestic Violence Coordinator. The Coordinator´s tasks include bringing together and supporting the relevant authorities, municipalities, county councils and organisations to increase the effectiveness, quality and sustainability of the work against violence in close relationships. The Coordinator will also consider ways of improving protection and support to victims. A final report is to be presented by 30 June 2014. Initiatives directed at violent abusers are an important part of the work to combat and prevent crime, including the abuse of women, children and other close relations. The National Board of Health and Welfare has been tasked with developing methods to deal with violent abusers who are not subject to correctional treatment measures. Furthermore the National Board of Health and Welfare has been tasked to conducting an overall analysis of the sheltered housing initiative for people under threat, as well as producing a guidance document for the target groups concerned.

Personal assistance

In 2010 the Swedish government presented a government bill with proposals on strengthened monitoring of personal assistance performed by private/non-public performers. Another proposal in the bill prescribed that private and non/public performers should be bound to have a certain permission in order to perform personal assistance financed by government funds. The legislation came into force the 1 January 2011.

Homelessness

In January 2012, the Swedish Government appointed a Homelessness Coordinator with a two-year (2012–2013) commission to support the local authorities in creating long-term, sustainable working methods and routines regarding homelessness and exclusion from the housing market. The Homelessness Coordinator aims to establish a dialogue with the municipalities to stress their responsibility to provide housing for all of their inhabitants. The Homelessness Coordinator’s aim is also to implement up-to-date-knowledge and provide the local authorities with research results. The Homelessness Coordinator also gathers information on good examples and on what needs and challenges the municipalities meet. A special focus lies on the prevention of evictions, especially concerning families with children.

A governmental assignment, the most recent national mapping of homelessness and exclusion from the housing market in Sweden was carried out in 2011 by the National Board of Health and Welfare. The mapping was based on data from municipalities, other local authorities, institutions and NGO's. The mapping showed that approximately 34 000 people were reported homeless or excluded from the regular housing market during the measurement week. This included people living under very different conditions, with many different needs for support from the community. 4 500 people were in acute homelessness, of which almost 300 were sleeping rough. 5 600 people received institutional care or lived in different forms of category housing. 13 900 people lived in long-term housing solutions (training flats, apartments with sublet contracts) provided by the social services in the municipalities. 6 800 persons lived in short-term housing solutions, for instance with friends, relatives, acquaintances.

Although the mapping is not completely comparable to previous mappings due to changes in the definition of homelessness, the result shows an increase of people in all the homelessness situations mentioned above. The proportion of females in the group of homeless people has increased, as well as the proportion of people born outside of Sweden. Further on, the mapping shows that very few of the homeless people had an income from an employment salary. Many people were dependent on social assistance. About 40 % had some kind of addiction problem or a psychiatric disorder. One third of the homeless population had children younger than 18 years of age.

Information in respect of conclusions 2009

Introduction to newly arrived immigrants

The Committee wished to be informed of the conclusion from the special investigator concerning the reception of new arrivals. A newly arrived immigrant is entitled to an introduction plan within one year of registration in the Swedish population register. The plan is drawn up together by the Swedish Public Employment Service and the newly arrived immigrant. The introduction plan is to be designed based on an individual mapping of the educational background, previous work experience and need for training and other initiatives. As a general rule, the activities contained in the introduction plan should correspond to a full-time programme and contain, at a minimum, Swedish for immigrants, civic orientation and employment preparation activities. Newly arrived immigrants who take part in activities according to an introduction plan, are entitled to an introduction benefit. The benefit is individual and the same for everyone regardless of where in the country one lives. Absence for reasons other than illness, care of children or other acceptable reason, result in the introduction benefit being reduced. The introduction benefit is a central government benefit and decisions concerning the benefit are taken by the Swedish Employment Service.

A newly arrived immigrant with an introduction plan is entitled to choose an introduction guide. The guide is an independent actor working for the Swedish Public Employment Service to support newly arrived immigrants in their search for work.

Question 3: Please provide pertinent figures, statistics or any other relevant information to demonstrate the effective access to social services (beneficiaries in total and per category of social welfare services, number and geographical distribution of services, staff number and qualifications).

Misuse care

Alcohol-related mortality among men and women aged 25-64 has decreased since 1980's. But in contrast has the alcohol-related morbidity continued to increase, especially among women and an increased number of elderly are treated for alcohol-related conditions. There is an increase in the number of persons treated for drug-related diagnoses. The total number of inputs from the social services for persons with addictive problems has increased during the last five year period. The development shows that outpatient measures are increasing and institutional care is constantly decreasing. The strengthened supervision of the misuse care made by the National Board of Health and Welfare indicates that the accessibility to misuse treatment is good. But still a large group of persons hesitate to seek treatment for harmful use of alcohol and drugs.

Personal assistance

The number of persons/beneficiaries that receives the assistance benefit have increased from 11 600 in 2002 to 16 000 in 2011. The average amount of assistance hours per week received by the beneficiary has increased from 92 hours in 2002, to 116 hours in 2011. The total cost for the assistance benefit has increased from 9 8 billion SEK in 2002, to 24.3 billion SEK in 2011.

Information in respect of conclusions made 2009

Certain services free of charge or services requiring financial contribution

The Committee request information regarding to what extent some social services are free of charge or requires financial contribution. Provisions according financial contributions are stipulated in chapter 8 in the Social Services Act. Some social services are free of charge, but in most cases the municipalities can determine a reasonable financial contribution required for a given service. They are not allowed to charge a fee that is higher than the municipality's prime cost and not allowed to charge a fee that is higher than what an individual is able to pay without inflicting on the individual's ability to sustain sufficient means of living. This means that fees vary between municipalities, services and individuals, making it is therefore difficult to state the average fee for certain social services in Sweden. Regarding some services, such as home care and day care services the fee charged may never exceed a certain sum (for home care and day care1/12 * 0,48 of the price base per month).

Measures that are given according to the Act Concerning Support and Service for Persons with Certain Functional Impairments are mostly free of charge.

When a person is eligible to personal assistance she or he gets the benefit in cash and can thereby buy the assistance from the municipality or a private performer. Another possible way of acquiring the assistance is to become the employer of the assistant and pay him or her with the assistance benefit.

Article 14§2 – Participation of individuals or organizations in the welfare services

Question 1: Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

Reference is made to previous reports.

Question 2: Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

Reference is made to previous reports.

Information in respect of conclusions 2009

As a result of a dialogue on how to develop the relationships between the state and the non-profit sector the Government signed an agreement t in October 2008 that was jointly formulated by the parties to the dialogue. The Swedish Association of Local Authorities and Regions and some fifty idea-based organisations have so far entered into the agreement. The agreement – which is a joint declaration of intent – contains common principles and commitments, as well as measures that each party is to implement. A secretariat has been set up for the joint monitoring activities.

Regarding the possibility of voluntary organisations negotiating contract with municipalities to provide specific service – see Article 23:1 The Act of system of Choice in the Public Sector.

There is no statistics regarding the total numbers of volunteers providing social services.

Question 3: Please provide pertinent figures, statistics or any other relevant information to demonstrate the participation of the voluntary sector to the provision of social services, as well as the effective access of individuals to these services.

Nothing to report.

Article 23 – The right of elderly persons to social protection

***Question 1**: Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.*

The Health and Medical Services Act (1982:763) stipulates that health care has to be available to all members of society, thus ensuring a high standard of general health and care for everyone on equal terms. Under the Health and Medical Services Act every municipality is obliged to provide good health and medical care (except physicians) to individuals living in special housing or individuals taking part in daytime activities. The county councils are responsible for providing home health services, but can transfer this responsibility to the municipalities.

The Social Services Act (2001:453) is a framework law that emphasises the right of the individual to receive municipal services. The services provided by the social services are based on assessment of the individual´s needs of service and care. A person who is not satisfied with the decision can appeal against it to an administrative court. Charges for the care of the elderly are levied under the Social Services Act. The national rules are designed to protect the individual against high costs.

It is stipulated in the Social Services Act as well as in the Health and Medical Services Act that measures within social services and health care shall be of good quality. Suitably trained and experienced personnel shall be available to perform the tasks of the social welfare committee (comprised of elected politicians) in the municipality. The quality of activities shall be systematically and continuously developed and monitored.

A special regulation in the Social Services Act stipulates that every person active in caring services for older persons or persons with functional disabilities shall verify that these persons receive good care and have secure living conditions (Ch. 14, 2 §). Whoever observes or becomes apprised of abuse or a real risk of abuse in the care of any individual shall report the matter immediately to the social welfare committee. This also applies to professional private activity of a similar kind. From 1 July 2011 the regulation comprise all activities of the social services. It is obvious that it is an integrated part of the municipalities' systematic work with quality which is a duty for the municipalities.

Until 2008 a special regulation in the Social Services Act stipulated that the social welfare committee should assist, through support relief services, persons caring for next-of-kin who are suffering from long-term illness, are elderly or have functional impairments. From 1 July 2009 the regulation was sharpened and stipulates that the social welfare committee shall offer support to facilitate people who are suffering from long-term illness, are elderly or have functional impairments. Municipalities have been compensated by MSEK 300 per year from the state for the sharpened provision. The Government stipulates that the regulation is not to force any family carer to do more but to clarify that the municipalities are responsible to offer individual support for family carers. The preventive work is crucial to prevent family carers becoming physically or mentally worn out. A crucial point is to give family carers a credit for the work done. Family carers can also apply for help for themselves by a needs assessor under the Social Services Act.

Since 1 January 2011 there is a provision in the Social Services Act on core values for the elderly. Care of the elderly should focus on older people can live in dignity and to feel well-being. Core values reinforce a view that older people will be able to live after their identity and personality even if they need extensive care. The aim is to highlight certain ethical principles that must permeate all elderly care, by both public and private providers. These principles include respect for privacy and physical integrity, autonomy, individualised services and participation, quality services and treating the elderly person in a respectful way.

The Act of system of Choice in the Public Sector

In order to promote freedom of choice for the individual and to stimulate a greater variety of providers and increase the quality in services for elderly the Government launched a new law in 2009, The Act of system of Choice in the Public Sector. The aim of the legislation is to make it easier for different actors to enter the commercial market of providing service and care for the elderly. The Law is expected to function as a volunteer tool for those municipalities who wants to expose the service and care actors in the public sector to competition and thereby let the elderly choose the supplier. The law is an alternative to the Swedish Public Procurement Act (2007:1091) and may be applied on elderly care, support to individuals with disabilities as well as health and medical service. It is mandatory within the health care system. The act is constructed to ensure equal opportunities for all providers and to facilitate for small companies and non-profit organisations to be providers of social services and health care. The competition is based on quality and not price.

The Maintenance Support (Elderly Persons) Act (2001:853) – see 8th National Report.

No. pensioners with full guarantee pension
Upwards of 150 000 persons (some 130 000 of them women) in December 2006 received full guarantee pension. The corresponding figure for December 2007 was nearly 140 000 and for 2011 nearly 104 000.

No. pensioners with maintenance support for the elderly
Almost 10 500 persons (just over half of them women) were receiving maintenance support for the elderly in December 2006. The figure for December 2007 was close on 11 000 and for December 2011 nearly 14 600.

The Care and Nursing (Joint Committees) Act (2003:192) – see 8th National Report.

The Services to the Elderly (Municipal Authority to Provide) Act (2006:492) – see 8th National Report.
This Act has been repealed and provisions are now placed in **Certain Municipal Powers Act (2009:47)**.

The Social Services Ordinance – see 8th National Report

The Health and Medical Services Act – agreement concerning physician staffing – see 8th National Report.

Question 2: Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

Knowledge

The National Board of Health and Welfare has developed official recommendations for the basic level of competence among staff working in social services for elderly people [SOSFS 2011:12(S)]. Among those recommendations, for example it is important to have skills about communication, regulations, geriatric and gerontology, social care and nourishing.

The Swedish Government is financing a four-year training initiative, called Omvårdnadslyftet, to improve the competence among staff working in long time care without any formal education. The initiative will cover about 1 billion SEK. The aim is both to raise the basic level of competence and to meet the demand for more specialized skills. Municipalities can apply for state support to procure education courses corresponding to upper–secondary-school level. The National Board of Health and Welfare has set criteria for the components that need to be covered in the courses. In order to motivate the municipalities to boost competence levels among their staff, a bonus will be paid at the end of the period to those municipalities that have raised competence levels to a certain extent. From 2012, specialized level will also be included in the proposed courses. During 2011, more than 200 of 290 municipalities applied for contribution from the Omvårdnadslyftet.

The Government has also commissioned the National Board for Health and Social Services as well as the to conduct national training on how to improve the identification, monitoring and evaluation of efficient quality indicators in procurements within the social service sector. The numbers of private actors implementing social services through contracts with municipalities is increasing continuously. This requires a sometimes new and different competency within the field of social services.

The Swedish Dementia Centre and the Swedish Family Care Competence Centre for relatives are non-profit organisations which are financed by the government. Their commission is for example to develop more practically orientated knowledge, facilitate translation of research and implementation of new knowledge into nursing and care, interventions and social policy, be a link between research, practice and decision makers and be the hub of a national network for research and development units.

The Government is devoting MSEK 35 per annum to elderly research, MSEK 14 annually to the build-up of long-term population-based research databases (SNAC – Swedish National Study on Ageing and Care). 135 MSEK annually is devoted to stimulate systematic improvement of social services, based on knowledge, and to increase the use of e-Health in social services.

Quality of care and nursing

In 2009 – 2011 the Government continued to allocate annually incentive grants to municipalities and county councils to raise the quality of care and nursing for elderly people. The Government has allocated totally just under SEK 5 billion in the period 2007 – 2011. Seven priority fields have been designated: physician availability, medication reviews, preventive work, dementia care, rehabilitation, diet and nutrition and social content. 70 per cent of the funding has been paid to municipalities, 30 per cent to county councils.

This funding has enabled the mandators to hire personnel with competence which has been partly or wholly lacking. The funding has also made it possible to provide basic staff with training.

The principal´s own assessments the incentive grants has promoted better cooperation between principals.

The Government has appointed a senior coordinator to submit proposals on how the Government can strengthen incentives and opportunities for local governments to better coordinate care of the most ill elderly people. Another objective is to streamline the use of resources so that health and social care is based to a greater extent on the needs of elderly people with the most serious diseases, and a more efficient organization. The Government is striving to reward results, so that local solutions tailored to the conditions in each county and municipality can emerge.

A major project has begun to encourage health care and social services for the most fragile elderly people – in the form of home care, elderly care, primary care and hospital care – to better work together. New ways of concentrating efforts on the elderly to provide better care need to be developed.

For an older person with many different symptoms and diagnoses, contacts with various different authorities, businesses and categories of staff can be confusing. Therefore, there is now a special focus on streamlining the use of resources so that health care and social services can be based to a greater extent on the needs of patients and on more efficient organization.

The aim is to use economic incentives and place the needs of elderly people with the most serious diseases in focus in order to encourage, strengthen and intensify cooperation between social services and health care. The initiative aims to reward results, so that local solutions tailored to the conditions in each county and municipality can emerge.

Over the next few years, performance bonuses will be paid to the heads that meet the set requirements. Intensive efforts are currently under way to develop indicators and systems for performance compensation.

Approximately total of SEK 4.3 billion is available for development during the period 2011–2014.

Care for people with dementia

The National guidelines for care in cases of dementia briefly point out that health and medical care services should carry out a basic investigation into dementia, and all nursing care for persons with dementia should be based on an individual-centred approach and multi-professional team-based work and training. Health and medical care and social services should follow up, at least once a year, medication, treatment, cognition, functional capacity, general state of health and behaviour, and they should support the inputs agreed upon, medicinal treatment for cognitive impairment in the event of Alzheimer’s disease and evaluation of medicines.

Social services should offer persons with dementia daily activities that are specifically adapted to group needs. Younger persons should be offered a place in adult day-care specifically adapted to their needs.

Persons with dementia should be offered a place in small-scale sheltered housing schemes specifically adapted to their needs. The atmosphere should be home-like and the residential environment should be designed with the individual in mind. People who need to be outside for certain periods should be able to do this.

The National Board of Health and Welfare, in cooperation with the Swedish Association of Local Authorities and Regions, has been tasked with allocating MSEK 25 to those municipalities that, in partnership with local authorities, develop and try models for implementing the guidelines in the years 2012–2014.

The Swedish Dementia Centre has together with the National Board on Health and Welfare has developed web training for the guidelines. More than 33 650 persons have until 1 December 2011 participated in the training.

Core values

The National Board of Health and Welfare has been appointed to support the professionals in implementing the core values in their daily work by offering training and guidelines. The Government has allocated totally MSEK 280 in the period 2009 – 2012 for implementing the core values. The Government wants to encourage municipalities to make it clear to older people, relatives and local residents what they can expect from care of the elderly. Performance compensation is paid with MSEK 100 per year from 2011 to 2014 for those municipalities who produce local dignity guarantees.

Family carers

The National Board and Welfare has been commissioned by the Government to develop a guide, monitor and evaluate the impact of the amended provision about support for family carers.

The Swedish Family Care Competence Centre for relatives works with blended learning networks such as working relatives and relatives to persons in special housing accommodation. The Centre has commissioned a three-year mission to develop support for working families.

System of choice

The National Board of Health and Welfare is mandated to allocate stimulus grant to municipalities to prepare and develop the system of choice for the elderly and disabled. It also monitors how the municipalities have chosen to prepare, adopt and adapt the free choice system. The Swedish Association of Local Authorities and Regions has received funds to support the municipalities that are considering or has decided to introduce the system of free choice.

The Government (The Ministry of Health and social Affairs) follows the development through various agencies which are missioned with the task to evaluate the reform. The

National Board of Health and Welfare focuses on the individual's perspective, a competition viewpoint is provided by The Swedish Competition Authority and The Swedish Agency for Economic and Regional Growth contributes with aspects crucial for entrepreneurs involved in the system of choice in the public sector.

In September 2012 the Government decided to launch an inquiry to analyse the effects of The Act of System of Choice in the Public Sector. The evaluation shall focus on the impact on the users and also describe the development from the provider's point of view and from a competition viewpoint. The evaluation shall also address questions concerning quality, costs and efficiency. The work is due to be reported before the 15th of January 2014.

Healthy ageing

The Swedish Government has decided on an initiative for active and healthy ageing. The Swedish National Institute of Public Health will produce a guidance document to inspire local authorities to work together with NGOs in order to create health promotion activities, such as cultural events, cooking, dancing, etc. The initiative also includes health coaches to help individuals with minor health problems to lead a healthier lifestyle.

Housing

Elderly people can apply for housing adaptation allowances from the municipality to improve accessibility in their homes. The most common measures are the removal of doorsteps and adjustments in the bathroom. In 2008, around 75 000 cases for housing adaptation were granted at a total cost of SEK 959 million.

Still, many middle-aged and elderly people have difficulties in finding themselves a home that is more suitable to their expectations. In many older houses, steps to the entrance or a laundry room located in the basement make daily tasks difficult. A key area is to promote the possibilities for elderly people to stay living in an ordinary home, where they feel secure and independent, by introducing 'intelligent' and user-friendly technical support. Over a period of six years, the Swedish Government has been supporting the development of products and services that can assist elderly people and their relatives in their everyday lives. The Technology for the Elderly programme is coordinated by the Swedish Institute of Assistive Technology. One hundred projects received support from Technology for the Elderly in the period 2007–2010. This initiative will continue until 2012.

In 2007, a tax credit was introduced for household services. With this credit the customer pays only 50 per cent of the price. This reform has become quite popular and has made services available to new groups. During the first six months of 2011, more than 11 000 companies performed services for 257 000 people. The population group with most users is women aged 85 years or older.

An aid scheme to support construction of special housing for elderly people has been operational since 2007. Beneficiaries as property owners and owners to leasehold right can obtain SEK 2,600 per square meters for new construction and SEK 2, 200 per square meters for rebuilding. The aid has a maximum fixed frame of SEK 2.5 billion. The aid scheme was prolonged in 2012 and the duration of the aid scheme is now set to 2014. The National Board of Housing, Building and Planning are responsible for the aid scheme and pay-outs.

Quality registers

Quality registers are an important tool for following up outcomes. Through registers, knowledge of health care performance is visible and it is thus possible to benchmark operational results over time, but also compare with other operations. The results from greater participation in quality registers are primarily useful for improvement efforts, but they can also be used for open comparisons and policy priorities, and they also constitute a valuable source of data for research purposes.

In recent years, quality registers that are adapted to elderly care have been developed. The Swedish Palliative Register and Senior Alert are two quality registers that are included in a performance-based support system.

The registers contain data on quality indicators on fall injuries, care-related infections, malnutrition, patients' experiences of pain, etc. The registers build on modern IT solutions and give care providers the opportunity to monitor results over time and compare their own results with those of others. In order to motivate care providers to register, the Government has introduced a performance-based grant system. This has increased the input to the registers dramatically, and the coverage and quality of data have improved. The next step is to promote the use of the registers for local improvements in quality by strengthening analysis capacity at local level.

Two quality registers under development are the Swedish Dementia Register (SveDem), which is a national quality register for dementia, and the Swedish Register for the Behavioural and Psychological Symptoms of Dementia (BPSD). The purpose of SveDem is to improve the quality of dementia care and the goal is equivalent, optimised management of patients with dementia. There are currently too few local governments registering data, so a development process will be implemented. The register will be developed and areas that are crucial to monitor will be identified, as well as which indicators are relevant and possible in order to make it a good tool for municipal elderly care as well.

Open comparisons

To improve efficiency, there is a need to create a better basis for comparing and following up outcomes. In 2007, the Government commissioned the National Board of Health and Welfare to develop a system for open comparisons in care of older people consisting of a set of national quality indicators and the result of national user surveys. The aim of the system for open comparisons is to make it possible for everybody to compare the quality, costs and efficiency of the services provided to older people. Potential users, users, families, care personnel, managers, private and public providers and local and national politicians should all have easy access to comparative data about service and care. This could be the base for the older person's choice of provider, support improvement efforts and form a basis for local and national monitoring, follow up and evaluation of services and care. Transparent reporting and comparisons has had a great impact and is increasingly being used as a basis for the work of improving health and social care. Today, there is a national website with comparable data from all municipalities and providers of home care and special housing, both public and private.

Open comparisons in home help services cover participation, staffing, skills and leadership. Open comparisons in special housing cover participation, staffing, skills, continuity, independence, food and leadership.

Question 3: Please provide pertinent figures, statistics or any other relevant information on measures taken to ensure that elderly persons have access to adequate benefits in cash or in kind; on the level of public expenditure for social protection and services for the elderly; on the accessibility of measures and the number of elderly people benefiting from them; on the number of places available in institutions for elderly persons; on the number of elderly living in such institutions, and on whether a shortage of places is reported.

Municipal care of the elderly

Table 1. Home-help services and special housing accommodation for men and women respectively aged 65 and over, 2009-2011. By numbers and percentages

	Home-help services		Special housing accomodation	
Year	Women	Men	Women	Men
2 008	104 200 (11,4)	48 700 (6,7)	66 100 (7,2)	28 000 (3,9)
2 009	*)			
2 010	107 300 (11,2)	51 500 (6,6)	63 200 (6,6)	27 600 (3,5)
2 011	109 200 (11,2)	53 100 (6,6)	62 400 (6,4)	27 400 (3,4)

* No figures available for 2009

Statistics for 2008 refer to the situation on June 30, 2010 on November 1 and 2011 on October 1.

As from 2007 the statistics also covers persons with help only with snow clearance, food distribution or security alarm.

Source: National Board of Health and Welfare

The number of persons over 65 receiving elderly care in the form of special housing accommodation or home-help services totalled approximately 250,000 per annum between 2008 and 2011. In October 2011 approximately 252,000 persons were either receiving home-help assistance or living in special housing accommodation.

The trend towards a growing proportion of elderly care to be provided in people’s own homes in the form of home-help service continues. Between 2008 and 2011 the proportion of persons receiving home-help rose by about 6 per cent, from 152,900 to 162,300. During the same period the number living in special housing accommodation fell from 94,200 to 89,800, i.e. by 5 per cent. In 2011 upwards of 14 per cent of the population aged 65 and over was receiving home-help or living in special housing accommodation. In October 2011 approximately 189,700 persons aged over 80 were receiving home-help or living in special housing accommodation, which is 38 per cent of all persons in this age group. The proportion of persons aged 80 and over receiving home-help or living in special housing accommodation has not changed since 2002. The higher average life expectancy of women and the fact of

elderly women more often living alone than elderly men means that a majority of the persons receiving assistance through municipal caring services for the elderly are women. Women make up approximately 68 per cent of those receiving home-help or living in special housing accommodation.

Table 2. No. persons aged 65 or over awarded certain inputs under the Social Services Act, and the number of persons aged 65 and over receiving municipal health care under HSL. 2008, 2010 and 2011.
No figures available for 2009

			2008			2010			2011
Input	Women	Men	Total	Women	Men	Total	Women	Men	Total
Security alarm in ordinary housing *	109 000	39 900	148 900	114 600	43 300	157 800	115 900	44 500	160 400
Daytime activity	7 200	4 300	11 500	7 200	4 300	11 500	7 100	4 400	11 500
Short-term care/accommodation	6 200	5 800	12 000	6 200	6 000	12 100	5 700	5 600	11 300
Contact person/family	500	300	800	400	200	600	550	350	900
Municipal health care **	105 100	52 200	157 300	111 200	57 100	168 300	112 100	58 000	170 100

Source: National Board of Health and Welfare

*) Assistance not included in home health care.

**) According to the Health and Medical Services Act the municipalities is obliged to provide health and medical care (except physicians) in special housing and daytime activities. In addition the municipality may take over the responsibility for health and medical care (except physicians) in ordinary housing. More than half of the municipalities have this responsibility.

The statistics according to the Social Services Act refers to 30 June 2008, 1 November 2010 and 1 October 2011. The statistics according to the Health and Medical Services Act concerns June 2008, November 2010 and October 2011.

Security alarms for elderly persons in ordinary housing are a commonly occurring arrangement, and some 170,100 persons had been awarded financial assistance for security alarms at 1st October 2011. The number of persons receiving short-term care fell by 6 per cent between 2008 and 2011.

Decisions concerning daytime activity for elderly persons under the Social Services Act has been constant, 11 500, since 2008. At the same time, daytime activities are also provided on a drop-in basis with no award being necessary, and the extent of these activities is not known.

Altogether some 170,100 persons aged 65 and over received municipal health care some time during October 2011, and 66 per cent of them were women.

The proportion of inputs in elderly care performed by private care providers raised from 17 per cent in 2009 to 20 per cent in 2011. It is as common for special housing to be operated under private auspices as for home-help services.

Free choice

248 municipalities out of 290 in total have applied for and being granted stimulus grant until the end of 2011. A free choice system has been implemented in particular elderly care and in the care for persons with disabilities. In August 2012 all in all 123 municipalities had implemented the system and another 47 had decided to implement the system. Another 57 municipalities were at this point investigating the possibilities to implement it.

The reform has led to a higher degree of diversity among the providers. More than 900 are now active within the system. Some of them offer services in different languages, other has special knowledge of specific treatments or diets and some providers offer cultural or religious competence. Evaluations suggest that most users appreciate the reform. At the same time it is important to be aware of that some people find it difficult to choose and that they need support from the local municipality in order to be able to benefit from the system.

Family caretaker

No statistic is available.

An aid scheme to support construction of special housing for elderly people

The National Board of Housing, Building and Planning reports that during the period of current interest (1 of January 2009--31 of December 2011) altogether 5 714 special housing for elderly people i.e. flat, was built whereas 2 203 flats still was under construction. The total amount of pay-outs was approximately MSEK 660. Statistics from The Board show that the proportion of Swedish Municipalities estimating their need for special housing for elderly people covered the coming next two year increased by two to five per cent during the current period.

Page 87 in the 8th National Report
Updating of the system of user charges in caring services for the elderly - see 8th National Report.

User charges cover 2011 approximately 3.8 per cent of the total cost of municipal care and nursing for the elderly (Source: SCB).

In 2011 the maximum permissible charge for home-help services, day-care and municipal health care was SEK 1 712 per month.

Maximum cost thresholds for home-help services and calculations of the same - see 8th National Report.
The minimum mount for 2011 is SEK 4 832 per month for a single person and SEK 4 083 per month and per person for couples.

Page 88 in the 8th National Report
No. of employees (SKL 2011)

The number of employed assistant nurses was 99 068 of which 94.7 per cent are women. The number of actual full-time equivalents are 72 374 of which 68 298 are women. The number of employed are 91 758 of which 94.5 per cent are women.

The number of employed care assistants for the elderly are 54 975 of which 89.5 per cent are women. The number of actual full-time equivalents are 32 904 of which 29 404 are women. The number of employed are 51 732 of which 89.2 per cent are women.

Data refer in municipal elderly care. No data exist on the number of staff run by private performers of the elderly.

Foreign-born persons

In 2011 there were 209 731 persons born abroad which was more than 39 000 up on the figure for 2005.

Information in respect of conclusions 2009 - Legislation against age-related discrimination

The Discrimination Act entered into force 1st January 2009. Prohibition of discrimination on the ground of age was introduced in the Act in the area of working life and education. The protection against age discrimination does not cover all of the areas of society included in the Discrimination Act. In a Government Bill, submitted to the Swedish Parliament in June 2012, the Government proposes to extend the protection against age discrimination to apply to the areas of goods, services and housing, public meetings and events, health and medical care, social services, social insurance, unemployment insurance, financial support for studies and assistance to the public with information, guidance, advice or other similar help, or in other types of contacts with the public when these activities are carried out in the line of duty by someone who is fully or partly covered by the Public Employment Act (1994:260). The Parliament will vote on the Bill in the autumn 2012.

Article 30 – The right to protection against poverty and social exclusion

Question 1: Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

Reference is made to the 8th Swedish annual report on the application of the European Code of Social Security and its Protocol by Sweden, under the heading Article 30, page 89 concerning the general legal framework, the approach to combating poverty and social exclusion, priorities and general measures.

As a weak foothold in the labour market is the main reason for financial vulnerability, an increase in employment leads to an increase in people able to support themselves and a reduction in the number of financially vulnerable people. In addition, the Swedish welfare system covers the entire population and is aimed at creating equal opportunities for everyone and equality between women and men. It covers health and medical care, social welfare and financial security in case of sickness, disability or old age. It is a general system that redistributes and equalizes economic resources and living conditions between people and over different stages in life. The Government's ambitions of reaching high distribution targets and well-functioning welfare systems available to all make it important to nurture and develop the public welfare systems. The ambition should be to minimize the risk of people getting trapped in permanent poverty without the ability to support themselves. The value of work, which provides freedom, community, security, and opportunities, cannot be emphasised enough. Therefore, the Government works continuously to improve the labour market's functioning through additional measures that increase available labour supply, prevent long periods of unemployment and strengthen the demand for groups with a weak position in the labour market, and improve matching of job-seekers with available jobs. A more effective integration policy, reducing the time from arrival to entry on the labour market, is an important step in polies aimed at reducing poverty and social exclusion.

Reform

The Swedish welfare system has not changed during the period to which this report refers. The specific changes made to various enactments are described with reference to the relevant articles. See, e.g., the reply concerning article 12. Two specific amendments that have an important impact on poverty reduction are mentioned below.

Raise of large family supplement

What can be mentioned as a reform aimed at raising income in large families is that in July 2010 the large family supplement within the child allowance program was raised. Child allowance is given as 1 050 SEK/child. For families with 2 children, SEK 150 of large family supplement is given, for three families, SEK 604, for four children SEK 1 614, for five children SEK 2 864.

Introduction activities reform

On December 1st 2010 there was a new law on introduction activities for certain newly-arrived immigrants. The aim is to give better help for establishment on the labour market for

this group. Introduction activities are activities that will support in learning Swedish and getting to work. Which activities it deals with is indicated in the introduction plan, which is developed by the Swedish Public Employment Service. Which activities the plan will contain depends on individual needs, but it will consist at least of Swedish for Immigrants, employment preparation efforts (for example an internship, validation of training and occupational experience), and social orientation, which will aim at giving basic knowledge of Swedish society. The starting point is that the activities in the introduction plan will occupy the person eligible full-time, which means 40 hours a week. An introduction plan can cover a maximum of 24 months. A new benefit was introduced and is paid out when participating in activities.

The Public Employment Service has since December 1, 2010, received 8,000 people in conjunction with the introduction program assignment. It is still too early to say anything about the results of the reforms. But the Government can conclude that today the Public Employment Service meets the target group for the introduction assignment much earlier than in the last assignment. Most of the newly arrived people have received an introduction plan. Of those who received an introduction plan, 95 per cent have participated in some form of labour market program or labour preparation activities, 79 per cent participated in Swedish for Immigrants (SFI), and 39 per cent took part in civic orientation activities. One of the biggest integration and gender challenges today is helping more foreign-born women support themselves. The newly implemented Introduction Act reform has a clear focus on gender equality. An individual social benefit that is not affected by other household members' incomes creates stronger incentives for both spouses in a family to participate in activities which will prepare them for work.

Question 2: Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

The legal framework is implemented through the Swedish Social Insurance Agency concerning social insurance, The Swedish Pensions Agency regarding pensions and through municipalities concerning financial assistance. Boosting employment has been the Swedish Government's top priority for a long period and the main strategy for inclusion and fighting poverty. The law on introduction activities is one important reform in this regard.
There have been measures taken within the framework of the Strategy of Homelessness during the years 2007-2009. Supporting local development of practice, for example in preventing evictions is one important measure.
For people in a vulnerable situation, there are often complex problems that require coordinated rehabilitation measures from the social services, the health and medical care system, the Swedish Social Insurance Administration and the Public Employment Service. In a little more than two-thirds of Sweden's municipalities these agencies have implemented such initiatives through coordinating organizations.

Question 3: Please provide pertinent figures, statistics or any other relevant information: on the nature and extent of poverty and social exclusion, including the number of persons or households who are socially excluded or live in poverty; and on the methodology followed or criteria used to measure poverty and social exclusion, bearing in mind that the Eurostat at-risk-of-poverty rate before and after social transfers is used as a comparative value to assess national situations.

Different poverty measures

In 2010 was the proportion of low economic standard, according to the relative 60-percent measure, 14 %. In international comparisons was the proportion of low economic standard, according to the relative 60-percent measure, 13 % in Sweden. The calculations of the Eurostat and the Government Offices of Sweden are not completely comparable due to differences in data and choice of method. Between the years 2006 and 2009, the proportion of people working or studying increased, while the proportion of people in economic risk among children, senior citizens and people neither working nor studying continued to increase. Between 2009 and 2010 the number of people living with low economic standard in different groups remained generally unaltered. The increase in the number of people in low economic standard is explained by an increasing proportion of both people born in Sweden and people born outside of Sweden living in low economic standard. The increase was higher in the proportion of people born outside of Sweden.

The proportion of young people, aged 20-24 years old, living in low economic standard was high, about 28 % in 2010. In 1991 was the proportion only 11 %. A major cause to this development is the increase of the proportion of people attending universities and colleges, which has increased the age-level of entering the labour market for young people. Among young people aged 20-24 and among older, a larger proportion of women than men is living in low economic standard.

Long-lasting low economic standard is in this section defines as at least four years following each other with low economic standard in relative or absolute measurements. With regard to the relative measurement have the proportion of people living in low economic standard increased continuously since 1998. During the last years has the increase been significantly higher than during previous years. The proportion of households that long-lasting has had a disposable income under 60 % of the median income increased from 4.3 % in 2009 to 5.5 % in 2010. With an absolute low income limit (60 % of the median income in 1991) a different picture of the development is presented. The proportion with long-lasting low economic standard in absolute measurement has continuously decreased since the end of 1990.

EU-measurements:

In 2010 in Sweden were about 1.4 million Swedish citizens, or about every seventh swede, exposed of the risk of poverty or social exclusion. Of these belonged about 1.2 million or 13 % groups that live under the risk of poverty (relative measure above). 418 000 swedes in the ages of 0-59 years old, 6 %, was living in households with low work intensity (households where those at working age were working less than 20 % of possible working time). When it comes to people in the group of severe material deprivation (that cannot afford a certain standard of living, see note below) they accounted for about 125 000 people or roughly about 1 % of the population.

Severe material deprivation: Is defined as not having the ability to afford a certain standard of living. This is measured by examining if people can afford to pay unexpected expenses, can afford one week of vacation per year, can afford one meal of meat, chicken or fish every other day, can afford domestic heating, can afford capital goods such as a colour-TV,

washing machine, telephone or a car and is able to pay debts (mortgage loan, bills, hire-purchase or re-pay a loan). In the Europe 2020-strategy, severe material deprivation is defines as the inability to pay at least for of the posts mentioned above. The indicator distinguishes between individuals that cannot afford a certain service or good, and individuals who do not own this service or good due to the fact that they don't want to own it or doesn't feel the necessity to own it.

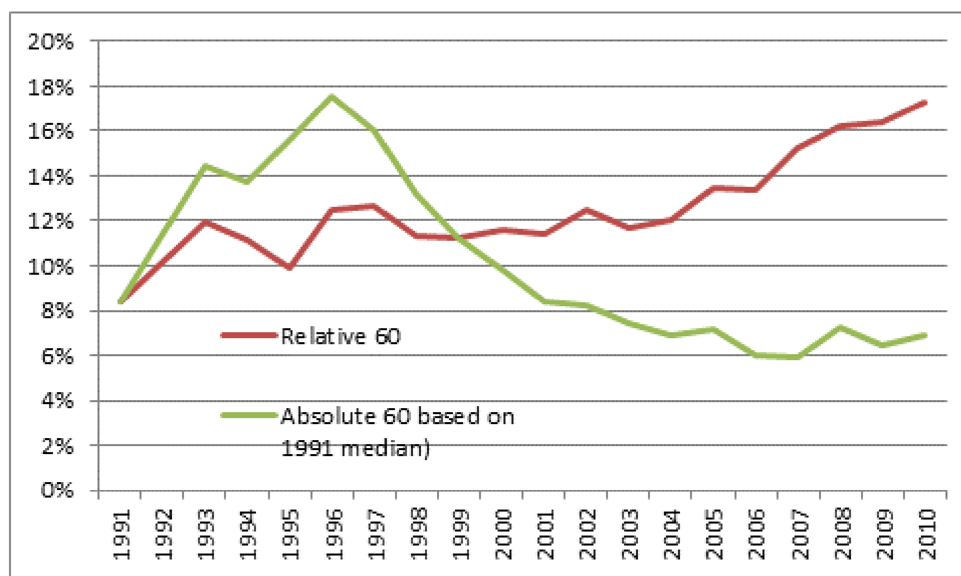
Low work intensity: Reports the number of persons living in households with low work intensity. That means households where household members of working age worked less than 20 % of the possible working time. A person of working age is in this context between 18-59 years and they have excluded students between 18 and 24 years.

Impact of transfers and child poverty

Transfers in Sweden have a large redistributive effects, due above all to the comparatively large benefits paid to households with children. In 2011 the cost of financial family policy was 72 billion SEK.

Children´s living standards vary considerably according to the type of family they belong to. Poverty is greatest among children where both parents are foreign-born. Children in single-parent families are worse off financially than children whose parents are living together, regardless of whether the parent is Swedish or foreign-born.

Diagram: Two measures of the living standards of individuals 0-19 years 1991-2010



Source: Statistics Sweden and the Government Offices own calculations.

There are different ways to measure low living standards. The portion of children living in households with an income lower than the 1991 relative limit, adjusted for inflation (in the

diagram called the absolute measure), has gone down significantly compared with the high levels in the 1990s, and during the past years has been at about 7 per cent. At the same time, the portion of children living in households with income under 60 per cent of the median income (a relative measure) has gone up to about 17 per cent in 2010. The difference between the measures can be explained by the fact that even those with low income have had an increase in earnings that surpasses inflation, and thus a real rise in income. At the same time, the income in child households with low income has not risen as fast as the median income in society as a whole, which means the share of households with income lower than 60 per cent of the median income has gone up. The main determinant of children's financial vulnerability is generally that their parents lack work or education. Measures in these areas are therefore of great importance in trying to prevent children from living in financially vulnerable circumstances. Child households of foreign background generally have a lower economic standard compared with child households with a Swedish background. Income support for families strengthens single- parent households more than it benefits two-parent households. At the same time, the fact that benefits and allowances are either fixed sums or follows the price development instead of the income development, and that the disposable income for single-parent households – in which the income to a higher degree is based on income support to families – lags behind the real income development.

Financial family policy decreased the number of households with children living in poverty significantly. For all households with children, the share having a low living standard (absolute measure) was 11 % in 2011, without family policy the share would have been 19 %.

For single households the decrease was larger, without family policy about 30 % would be considered having a low income standard (absolute measure) in 2011, the actual percentage was 19. The means-tested benefits, such as housing allowance, had particular importance for single households.

Financial assistance

Recipients of financial assistance was 418 000 in 2011 (4.4% of the population). This was a decrease from the year before. The decrease can in part be explained by a reform for newly arrived refugees, (Introduction reform) who since December 1st 2010 have the possibility of receiving an Introduction plan at the Employment Agency, and getting Introduction benefit paid out instead of financial assistance from the municipality. The number of children living in households with financial assistance 2011 was 137 000, a decrease by eight % compared to 2010 and constituted seven % of all children in Sweden. Financial assistance is most common among single mothers. In the middle of the 90s 37 % of these households had financial assistance, about ten years later this share had decreased by 19 %. One explanation is the decrease in unemployment. IN 2008, this share started to increase again, as a result of the financial crisis. In 2011 23 % of all households with single mothers received financial assistance.

Access to health care, participation, homelessness

Adequate access to high quality health care contributes to good health and active participation in society. Most Swedes feel they have access to the health care they need. Still, there is a need for targeted measures to achieve further improvements. Transparent comparisons of results, quality and efficiency are important tools for the Government, in cooperation with among others the National Board of Health and Welfare and the Swedish Association of

Local Authorities and Regions, to achieve systematic improvement and improve equality. The Government will continue to invest in systems that give individuals more opportunity to choose healthcare providers and to reduce the waiting time for health care. Examples of initiatives to reduce waiting time are the regulated “health care guarantee” and extra financial stimulus measures. These initiatives are supplemented by special initiatives in certain areas such as psychiatry. The patient's position is an important aspect of creating improved opportunities for participation, choice and the power to influence one’s own care.

The National Board of Health and Welfare's latest survey on homelessness, its extent and character, shows that very few of the homeless people have wage labour, and social assistance is a regular source of income. Almost half of the roughly 34,000 people who have been reported to be homeless or excluded from the regular housing market in 2011 live in relatively long-term living situations, such as trial apartments and apartments rented by Social Services. Of the reported homeless people, there were about 3,400 in urgent homeless situations. Of these, 280 sleep outside in public spaces. The municipalities are responsible for housing and support to people with a variety of social problems. The Government has appointed a homelessness coordinator to support the municipalities' work, especially to prevent eviction. Improved eviction statistics and support to municipalities' housing planning are other initiatives to prevent homelessness.