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NATIONAL REPORT

Submitted by the Government of Sweden

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1) Perception and policy related to the family, fertility and reproductive health

In Sweden it has become a well-established norm that couples cohabit without being married. Marriage is often postponed until after several years of cohabitation – sometimes in connection with the coming of the first child but often even after that. Around half of the children are born by unmarried parents but only 5 - 10% by single women. Divorce and separations are common and the separation rate is especially high among cohabiting partners without children. Married couples with children are much more stable. However, it is estimated that around a third of the 17 year old children are living separated from one or both of their parents. This figure is increasing but not very rapidly. Twenty-five years ago the proportion was one of four.

The individual choice of living pattern is not a concern of the Swedish Government. However, from the point of the child it is normally preferable that the parents live together. This does not mean that divorces and separations should be made difficult. Instead the Swedish Government policy is aimed at protecting the child by supporting the family economically and otherwise. One aspect of this is to ensure that fathers accept their economic responsibility for their children in case of divorce. In the majority of separation cases the parents choose to share custody after separation.

The fertility rate in Sweden has fallen quite dramatically since the beginning of the 1990's and is now around 1,5 child per woman. The Swedish Government has initiated a study concerning the factors behind this development. The study has revealed that young women with low education level have reduced childbearing to a higher extent than older, higher educated women. The development can be seen as an effect of the difficulties in the labour market during the economic crisis as the shortage of jobs has hit mainly the same groups that now show very low fertility rates. Also the rapid increase of young women in education has contributed to the fertility fall as students have a low fertility rate. Another effect of the economic crisis with consequences on fertility is the reduction of the child and housing allowances and parental insurance, which the Government has been forced to enact.

The Government has looked with concern on this development. A low fertility rate is obviously a problem in itself since studies show that most people in Sweden want to have at least two children. Low fertility is thus an indication of unfavourable societal conditions and – maybe – decreased confidence in the future. The chosen policy has been aimed at reducing unemployment and restore economic support to families with children at the rate made possible by the improving public finances. As a result of the economic recovery the child allowance has now been re-established to the level before the economic crisis and the parental insurance has been improved. The latest figures on the fertility rate show that the development now has stabilised and it is expected that the rate will start to increase.

The Swedish policy since many years has been to make it possible for couples to combine raising children and gainful employment. The policy instruments used for this purpose are mainly paid parental leave, in connection to childbirth and sickness of the child, and heavily subsidised public day-care. The parental insurance provides 360 days leave with 80% pay in connection to child birth to be shared equally between the parents. The days can be given to the other parent except for 30 days, which are exclusive for each parent. Around two-thirds of the mothers of small children work outside home. Almost all of these children have public day-care. The proportion of working mothers has dropped from 80% in 1999 as a consequence of the economic crisis. It is expected to

increase again with reduced unemployment. No special measures are planned for increasing the rate except the general fight against unemployment.

Families with children have been hit hard by the economic crisis in the beginning of the 1990's and the restoration of fiscal balance that ensued. As economic conditions in Sweden are now getting better it is expected that the economic situation of families with children also will improve. This will in itself act as a stabilising force on the family. The Swedish Government recognises the extremely important role of the family in providing for coming generations as well as caring for the ageing. However, Swedish policy also concerns the equality of women and the freedom of individual choice. The family concept has changed over time and the policy must be in keeping with that development. The rights and protection of the children deserves most concern in these aspects.

2) Perception and policy concerning mortality and health

Average length of life in Sweden has increased by 5,3 years for men and 6,6 years for women since 1960. Today men live on average 76,5 years and women 81,5 years. The increase has continued during the 1990's, but the pattern is now somewhat different. The increase is more rapid for men than for women – 1,7 years for men and 0,9 years for women in the years 1989 - 1996. Thus the difference in average length of life between the sexes is decreasing.

Infant mortality in Sweden is very low (0,40% per live births) and still falling. Mortality has in fact fallen in all age groups, including the very old, and for most causes of death – cancer being an exemption. The main reason for the preventive length-of-life development, however, is reduced mortality in cardio-vascular diseases. The reduction in mortality is greater than the morbidity reduction indicating that the medical treatment of cardio-vascular problems is getting more effective.

In spite of this generally positive picture some areas of concern still remain. The health of the young has not developed in the same positive way as for the middle-aged and elderly. Women show worse health development than men, and differences in health between socio-economic groups are increasing. Also allergic problems tend to become more and more common. In response to these problems, which were pointed out in the National Public Report of 1997, a special parliamentary committee has been appointed and given the task to analyse health problems, evaluate alternative actions, formulate health goals and propose strategies for achieving those goals. In this work special attention should be given to reducing health differences between socio-economic and ethnic groups, geographical areas and with respect to gender.

The economic crisis during the 1990's has led to increased economic and social stress in connection to steeply increased unemployment. However, the effect on the health of the population have – until now at least – not been as severe as was feared. One reason for this might be that the social protection systems have functioned as intended. Also the Swedish system with a very high proportion of two-income families has cushioned the effects of unemployment on the household economy.

The increase of certain health problems – anxiety, sleeplessness etc. – during the 1990's, has undoubtedly a connection to the difficult economic times. Suicide rates have fallen since 1980, but the last year reported (1995) shows a slight increase. It is not clear, however, whether this

represents a broken trend.

Cigarette smoking still stands out as the most important among determinants of health. The prevalence of smoking is decreasing among both men and women though more rapidly among men. Also fewer young people smoke, but again the situation for women is less favourable than for men. There are also socio-economic differences in smoking. The proportion of daily smokers is higher among blue-collar workers than white-collar – for men as well as women. As a consequence of past smoking habits lung cancer rate is still higher among men than women, but the trends are opposite. Other heath risks of concern in Sweden are alcohol and drugs, inactivity and obesity. The Governmental Public Heath Institute, instated in 1992, works actively with health promotion and disease prevention in order to reduce health risks and increase awareness of the importance of a healthy life-style. Much public health work is also done locally by county councils, municipalities and non-governmental organisations.

The Swedish health care system is regarded to be on a very high international standard. Health care is the responsibility of the public county councils, who also organise most of the health services. The small private sector is mostly financed through the public budget. During the 1990's the health care organisations in the county councils have undergone wide-ranging structural reform aiming at increased efficiency and cost reduction in response to decreasing available funding. In-patient care has been reduced in favour of out-patient care and day-surgery. The responsibility for long-term care was transferred to the municipalities in the big 1992 Ädel-reform. Some county councils have introduced internal markets for purchasing and production of health services. Others have restored to co-operation between hospitals as a means of adjusting to the reduced demand of hospital beds. Much effort is involved in securing the quality of care despite reductions and a much reduced length of stay in hospitals. As a consequence the expenditures for health care in Sweden have fallen in fixed prices since 1992 without serious problems of quality or accessibility. However, the cost development of drugs continues to present a problem.

Current problems in the health services concern mostly waiting times. The Government and The Federation of County Councils have agreed upon a guarantee of care, that ensures access to health care within certain specific time limits depending on the situation. The Government will follow access to care closely through a new system for monitoring waiting times and access to different forms of care. Another important reform concerns the rights of the patient to be informed about and influence care and treatment. This involves among others the right to a second opinion in difficult cases.

Maternal mortality is extremely low in Sweden (7 per 100 000). The use of contraception is legal and abortion depends on the decision of the mother. The number of abortions amounts to around 30 000 per year compared to 90 000 live births. The frequency has remained fairly stable since 1975 after the legislation on abortion was reformed. Teen-age abortions is not a big problem in Sweden. The proportion of abortions among women under 20 years has decreased rapidly since 1990 and only a few percent of live births involve teen-age mothers. It should also be noted that the number of teen-age mothers has not increased in spite of the high unemployment among young, low-educated women in the 1990's. One reason for this might be the system of parental leave in Sweden, which gives a pronounced incentive for women to complete education and gain a foothold in the labour market before they bear children.

3) Perception and policy related to population ageing including change in population age structure

Sweden has the highest proportion of elderly persons in the world. In 1997 slightly more than 17% of the population were 65 years or older and almost 5% were over 80 years. The increase of the latter category has been extremely rapid the last 25 years with a constant yearly growth of 3 - 4 %. The number of younger elderly on the other hand has been fairly stable since the middle of the 1980's.

In the coming decades the proportion of younger elderly will start to grow very rapidly, when the "baby-boomers" born in the 1940's begin to get old. After 2020 this group will cause a rapid increase in the number of 80-years old. The rapid increase in the number of elderly is connected to falling mortality in all age-groups. Forecasts have consistently underrated this development resulting in repeated upward adjustments in the projected number.

The baby-boom generation already contributes to an increase in the average age of the labour force. This effect has been augmented by the reduced entrance of younger persons due to prolonged studies and unemployment. As a consequence a large proportion of the labour force will retire in the next decade and problems with recruiting enough staff in certain key areas as health services and education are foreseen. The Government has started to investigate these questions and propose action to remediate expected staff shortage problems.

Early retirement is also an important problem, which the Government needs to give high priority in the coming decade. Even if average retirement age still is higher in Sweden than in most European countries, there has been a serious tendency to decrease in the 1990's in connection with the unemployment problems. Since the financial support of the Swedish welfare system presumes a high labour force participation it is important that trend is broken and replaced by an increasing effective retirement age.

As a consequence of the rapid increasing number of very old persons the pressure on the system of the long-term care to adjust to this development has been very high. Sweden has a very comprehensive public system of long-term care for elderly organised by the municipalities. The care policy emphasises a reduction of institutional care and increased possibilities for the elderly persons to remain and receive care in her or his home.

The demographic pressure in combination with tightened economic resources during the 1990's has resulted in a reduction of the proportion of elderly persons that receive care and services. The care services have been concentrated on the most dependent elderly. Following the Ädel-reform (cf above) some problems have arisen concerning the medical care of the elderly. More emphasis is now put on the need for closer co-operation between the medical and the social services for the elderly.

In June 1998 the Swedish Parliament approved a national action plan on policy for the elderly developed by the Government. In this plan national policy objectives for the elderly have been formulated and a number of measures in order to improve the quality of life and care of elderly have been postponed. The government plans to use the United Nations Year of the Elderly 1999 as a starting point for a long-term effort to adopt the Swedish society to a changed demographic structure.

One consequence of the increasing number of elderly persons is a mounting pressure on the pension systems. Sweden has engaged in a thorough-going reform of its public pension system in order to make the system more robust against economic strain and more adaptive to changed demographic or economic developments. Among others this means that pension levels will be based on lifetime earnings and contributions and adjusted to economic growth. Retiring age can be decided individually from the age of 61 years with pension levels calculated on an actuarial basis. The new pension system will be successively implemented during 20 years from the year 2000 and onwards. Private pensions and occupational pensions schemes exist in Sweden, but are not involved in the pension system reform. Their supplementary role is expected to remain the same in the future.

4) Perception and policy concerning international migration

Since 1968 Sweden has had a controlled immigration of foreign citizens seeking permanent residence. A substantial inflow of non-Swedes in search of temporary employment from the late 1950´s has lost much of its significance in the mid-1970´s. A comparatively generous stance with regard to refugee reception and family reunification has been one of the main characteristics of Sweden's immigration policy since the early 1980s. Another important element has been the open Nordic labour market.

The main concern of Swedish migration policy is with the immigration and emigration of non-Nordic nationals. The migration for Nordic nationals under the open Nordic labour market attracts little attention. Immigration to Sweden in 1993 numbered 62,000 people, of which every fifth immigrant was a national of Sweden or a Nordic country. Due to the large influx of displaced persons from the conflicts in former Yugoslavia, the number of immigrants in 1994 rose to 83,600. Between 1995 and 1997, about 40-45,000 persons per year immigrated to Sweden, and the same figure is expected for 1998. Roughly a third of all immigrants during the past five-year period have been non-Europeans.

Annual emigration from Sweden has increased in the period between 1993 and 1997 by 30% , or from about 30,000 to 38,500. In 1997 there was a net migration of 6,300 people. About 60% of all emigrants registered in 1997 were Swedish nationals, which is an increase from 50% in 1993.

Like many other Western European countries Sweden is experiencing an influx of asylum seekers. The number of refugees and asylum-seekers is mainly influenced by developments in other countries. Since the influx resulting from the conflicts in former Yugoslavia decreased substantially, the number of asylum-seekers in Sweden decreased notably after 1994. There is, however, no reason to believe that the numbers will decrease substantially from the current level over the near future. In 1997 about 9,600 people sought asylum in Sweden. 1,275 were recognised as Geneva Convention refugees, about 6,650 were given leave to stay due to humanitarian reasons or as persons in need of protection, and 3,400 were permitted to stay as family members to refugees. Of the other 21,500 residence permits issued in 1997, two thirds were given to family members, a tenth to guest students, and one fifth to migrants in the framework of the EEA-agreement. Residence permits issued for adopted children and for labour market reasons were only marginal in comparison.

Sweden has never regarded immigration in the light of population policies and has therefore not established any desirable levels or trends of immigration or emigration. Sweden has, however, a policy of regulated immigration whereby levels of immigration may be affected by some of the policy measures. The public debate has sometimes centred on the desirability of adapting immigration to the needs of the labour market. Some opinions have also been voiced to the effect that Sweden should be prepared for considerable future levels of immigration.

As a result of Sweden's membership of the European Union, it now plays a full part in promoting the free movement of persons, both regarding the elements covered by Community legislation and those that come under the third pillar, i.e. justice and home affairs. When Sweden became an EU member state, it also undertook to enter into certain conventions in the field of migration. The Dublin Convention e.g., regulating the EU member state responsibility to process an asylum application, has been in force since 1 October 1997 in Sweden. Community legislation covering visas for third country nationals when crossing the EU external frontiers, and EU-resolutions and measures such as uniform residence permits and measures to combat illegal immigration have also had effects on Swedish policy. With the Amsterdam Treaty, migration matters such as external border control, free movement of persons, asylum and immigration, shall be covered by Community legislation. The Schengen co-operation shall also become an integrated part of the EU.

In December 1996 Sweden signed the Schengen Agreement. Sweden participates in the decision-making, but has still to fulfil some conditions in order to become an operative member, as expected in the year 2000. Such conditions concern the abolishing of passport controls at internal borders and applying Schengen rules to controls at the external frontiers, visas and the principle of first country of asylum.

Notwithstanding the EU-membership, Sweden still takes part in the free Nordic labour market. Sweden as well as the other Nordic countries have been active in co-operating with the Baltic states, Estonia, Latvia and Lithuania, with the main objective to approximate these countries' refugee and migration policies to those of Western Europe so that they are consistent with the basic international principles in this area.

In recent years Sweden has signed a number of re-admission agreements, with the Baltic states in May 1997, Romania in 1994 and with the Federal Republic of Yugoslavia in 1998. The latter has, however, not yet been implemented. Sweden is planning to enter into re-admission agreements with a number of additional states in the near future.

Return migration has become a more important feature of Sweden's comprehensive approach to migration matters. Financial aid for return is granted both to persons who have received protection and a right to residence in Sweden, as well as to persons who have been refused residence permits in Sweden. In the first half year of 1998 about 500 people received grants in order to facilitate their return.

5) Perception and policy of the Government related to population growth

The Swedish population has grown from 8,1 millions 1960 to 8,9 millions 1997. It is expected to continue to grow until the year 2030, when the expected level will be 9,6 millions. Population growth as such is no concern of the Swedish Government. The increase of the Swedish population, that has taken place in the past decades, is due mainly to the high immigration rate. Around 900 000 of the persons living in Sweden at present are born outside the country. The future development of the immigration rate is very dependent on international factors and difficult to forecast.

The increase in life expectancy and the resulting increase in the number of older persons is seen as a positive sign of improved living conditions. On the other hand, if the very low fertility should continue in the next decade concerns will arise with regard to the balance between generations and future dependency ratios. At present the low fertility rate is interpreted predominately as a postponement of childbearing, since it mainly affects younger women. It is too early to say whether this will result in a lower total number of children per woman. The present Governmental policy is to observe the development closely and try to stabilise the conditions.

6) Perception of the Government regarding the need for policy-related collection of data and research

Policy-making in the field of population development needs a firm basis of facts and analysis concerning demographic and social development. At present Statistics Sweden is responsible for collecting and analysing statistical information regarding this field. The National Board of Health and Welfare is responsible for statistics in the area of public health and social services. Among others the Board maintains registers concerning causes of death and abortions.

The arrangements for collection of data is considered to be adequate, but there is a lack of resources for analyses of data. Also there is a need for more longitudinal data to support analysis of cause-effect relationships in determining the effects of policy.

Data for regional country comparisons are provided by among others the EU statistical office (Eurostat), WHO/Europe and the OECD.
Also results from the ECE programme on population are of great importance in this context. Current arrangements seem to be adequate but the importance of co-operation between these agencies in order to enhance efficiency and avoid unnecessary duplication of work should be emphasised. Since many of the problems mentioned in this report are shared by several countries in the region closer co-operation seems highly motivated.

7) Perception and policies of the Government concerning other aspects of population change

Large variations in the number of children cause planning problems in the short run in day-care and schools with shortages or surplus of premises and staff. These pertuberations propagate through the years to the higher levels of education, the labour market and the pension systems. However, the variations are difficult to influence and the Swedish Government has at present no enacted policy for handling these problems.