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Equity-oriented national strategy for public health in Sweden

A case study

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Equity-oriented national strategy for public health in Sweden

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In April 1997, the Swedish Government appointed a National Public Health Commission with the aim of defining national objectives of health development and strategies to achieve them (1). According to the Government, these objectives should guide society in promoting health and preventing diseases and injuries and their consequences in terms of disability and mortality. The targets and strategies should contribute to the reduction of inequalities in health among (a) socioeconomic groups, (b) women and men, (c) ethnic groups and (d) geographical regions of the country. Moreover, the proposals should be scientifically well founded and stimulate a broad democratic process on health policy issues.

The Commission consists of representatives of all seven political parties in Parliament and a number of scientific experts and advisers from national authorities, universities, trade unions and nongovernmental organizations. The seven politicians are appointed by their own parties and represent the views of those parties. Two of these representatives, one from the Social Democratic Party and one from the Conservative Party, are also Members of Parliament.³ The representatives are usually in continuing dialogue with health experts in their parties about the issues to be debated in the Commission. The Commission meets regularly and at least once a month. Each member of the Commission devotes a considerable amount of time to the process. The work of the Commission is facilitated by the Chair, who has a full-time appointment, and by a secretariat comprising four secretaries, who work full-time providing the Commission with background and discussion materials and draft resolutions.

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³ The representative of the left-wing party has recently been appointed by the Government as Director-General of the National Institute of Public Health. He still participates in the Commission, however, as an adviser.

The preliminary proposal for objectives, targets and strategies was submitted to the Government on 6 December 1999, and is currently available for public consultation (2). This is the first time since the Second World War that a proposal for a comprehensive public health policy has been made in Sweden.

A final proposal, including calculations of the costs of the recommended policies and suggestions on organizational responsibilities for implementing those policies, will be submitted to the Government in September 2000. A health policy bill will be then submitted to the Parliament in the spring of 2001. It is important to note that previous commissions and proposals related to health were predominantly health-care oriented, and that public health issues were only part of this larger context. The National Public Health Commission is the first to be set up to address for public health in its own right.

The purpose of this paper is to provide a short account of the preliminary targets and policies that have been suggested, and to describe the working process that made an ongoing dialogue with stakeholders possible and how it stimulated public discussion. We also cover the gathering of sound evidence for the targets and what that implied for the work. Before focusing on these issues, however, we explore some important circumstances that we think have contributed to the Government's decision to draw up an equity-oriented national health strategy for Sweden.

Background

In going through the different issues that we think were the most crucial for the decision to set up a National Public Health Commission and to call for a comprehensive national public health strategy, we identified the following contributing factors.

- At the beginning of the 1980s there was an increasing political and scientific interest in social inequalities in health and its causes. The major source of inspiration was the Black Report (3), showing considerable inequalities in health in the United Kingdom by occupational class, employment status, gender, area of residence, ethnic origin and housing tenure. The causes of these inequalities lay, according to the report, outside the scope of the National Health Service. Social and economic factors such as poverty, unemployment, low level of education, unhealthy housing and health-damaging lifestyles were seen as responsible for the development of health. These findings inspired other countries, including Sweden, to study more systematically inequalities in health. A cross-national comparison showed that social class inequalities in health also existed in Sweden, although they appeared to be smaller than those in the United Kingdom (4). Moreover, the explanations behind the British situation were not convincingly plausible in the Swedish context, given the universal welfare system, low level of poverty, high standard of housing and low unemployment rate. Policy-makers and the research community in

Sweden were eager to find the causes that could explain these inequalities. Such knowledge was essential in order to be able to “design” policies aimed at reducing inequalities in health. At the same time a shift in the prevailing medical philosophy had taken place, away from curative to preventive care.

- In 1988 a Public Health Group was established, primarily to develop preventive health measures from a broad public health perspective. This group of experts, active until 1991, served in an advisory capacity to the Government and to the Health and Medical Care Advisory Committee, a coordinating agency acting between the Government and the Federation of County Councils. The starting point of the Public Health Group was the general health trend in Sweden, particularly in relation to social disparities in the distribution of health, and the need for interdepartmental coordination from a health policy perspective. One of the most recognized achievements of the Group was a proposal that led to the establishment of the National Public Health Institute in 1992. Although the Group also devised a comprehensive strategy for public health, parts of which were incorporated into the bill presented by the Government during the spring of 1991 (5), it was not able to set *political* priorities. Since the experts were representing different public health disciplines and were fervently trying to preserve their own scientific “territories”, the Group was unable to handle priority-setting efficiently. It was, however, able to list proposals for things that should be done. It became obvious that there was a need for a political forum that also could handle priority-setting (which does not necessarily mean “consensus building”) and thereby provide a political platform for action within the public health field.
- The establishment of the National Public Health Institute in 1992 initiated a number of activities for health promotion and disease prevention on both the national and local levels – in county councils and municipalities. Most of the municipalities have some form of coordinating public health committee that wishes to be involved in drawing up local public health plans. According to the Health and Medical Services Act, county councils are obliged to ensure that health care is available to all members of society and to provide a high standard of general health care for everyone on equal terms. The Act requires county councils to plan the development and organization of the health care system with reference to the aggregate need of the county population. Although there was an awareness at all policy levels that social inequalities in health are a major policy issue, the lack of a long-term comprehensive strategy to reduce the health divide made the link between the vision of equity in health and the reality difficult to establish. Elements of strategies to reduce the health divide as envisaged in WHO’s European strategy for health for all existed in national and local health plans drawn up by, for example, some county councils. In reality, the social and economic policies in Sweden during the 1990s were more likely to increase rather than reduce the health gap (e.g. cuts in

social and health care expenditure, and increased unemployment due to the “downsizing” of the labour market). Stakeholders in the public health field, such as representatives of trade unions, employers, people responsible for the health of children in day-care centres and schools, and municipal public health committees, therefore expressed an urgent need for national and local guidelines for their work and called for a national strategy for equity in health.

- An additional public concern during the 1990s was the recognition that public health development was not satisfactory in Sweden. Musculoskeletal diseases and psychosomatic disorders were increasing in the population, especially among poorly educated working class women. Although, in absolute terms, the population in general enjoyed excellent health compared with other Western European countries, Sweden did not perform better than the others in relative terms (6). Decade after decade, class differences in mortality and morbidity remained constant or even increased, despite a steadily increasing life expectancy for both women and men. National and local public health reports were able to demonstrate that the decline in mortality, such as from cardiovascular diseases, was considerably greater among white-collar than among blue-collar workers. Thus, health care policy in Sweden can be considered to have been successful in terms of *effectiveness*, since the average health of the population improved significantly for decades, but to have been less successful in terms of *equity*. A study of how Swedish politicians responsible for health care interpret the relationship between equity and efficiency targets in the context of public health, revealed that some two thirds were prepared to sacrifice health benefits for equity (7). Although the health development of the population was not ideal from the equity point of view, it was nevertheless better than expected considering the numerous structural changes that had taken place during the previous decade, followed by an increase in unemployment, cuts in social and health sector expenditure and so on. It became obvious that, despite the cuts made in the welfare system, social policies were still able to protect the majority of the population from negative social, economic and health consequences (8). This insight led to the recognition of the important role social policies may play in relation to public health.
- Inequalities in health became not only an issue for policy-makers but also for the research community. Social epidemiologists and medical sociologists made important contributions to research on the causes of social inequalities in health, an issue that has been largely ignored by the research community for many decades. The view of some experts has been that, since health in both the lower and higher socioeconomic groups was improving, and that in the case of lifestyles the lower groups would quickly follow the higher groups in taking up health promoting behaviours, public health was not much of a problem. This view, however, has been rejected as a result of research findings showing the paramount

importance of structural factors (such as working conditions that the individual has no power to change) behind the social inequalities in health. Research on the social etiology of health and the social mechanisms behind health inequities has, during the last couple of decades, been strongly supported by the Government and most research-funding agencies. The Council of Social Research has recently drawn up, on the request of the Government, a national programme of health equity research in collaboration with other relevant research councils (9). As a result, a national multidisciplinary research centre for health equity studies will be established in Sweden this year. The knowledge gained from research on social etiology is crucial to our understanding of the processes behind the causes of observed social differences in health, and an important requirement for policy-makers to address the health divide more effectively. However, this kind of knowledge does not always translate easily into political realities of health planning and programme implementation.

With equality in health already a national vision for health policy, as also expressed in general Swedish welfare policies aimed at the reconciliation of “efficiency in measures and equity in outcome” (5), the circumstances described above have led to the decision to draw up a comprehensive equity-oriented national public health strategy for Sweden. By appointing to this task a political/parliamentary commission consisting of both politicians and experts, the Government wanted to ensure that the national health strategy was coupled to clear priority-setting and resource allocation.

Setting national targets: a democratic process in three steps

1. Developing a framework and starting a public discussion

The work of the Commission was accomplished in three phases. During the first phase, a framework was developed that included a broad description of the health development in the country as well as the responsibilities for health of different sectors of society (10). It presented tools for the discussion on priorities and strategies, including alternatives for measuring the burden of disease and alternative dimensions for target-setting – such as diagnostic groups, determinants of diseases, target groups and arenas for action. The framework was submitted for consideration and comments to a broad range of authorities (including the National Institute of Public Health and the National Board of Health and Social Welfare), organizations and experts.

During the first phase, several short publications were also produced on scientifically and politically “controversial” issues such as causes of social inequalities in health, concepts of mental health, legislation in Swedish alcohol policy (see Part I, Appendix 1). These publications are written by well known scientists, journalists and politicians, and the editors tried to make sure that

the text was easily understandable by the general public. To ensure a wide circulation, the publications are free of charge and are also available in Braille and audio cassette. The ongoing dialogue is very important for the process, as the final proposal of the Commission must be well rooted among public health professionals, politicians and the public. In fact, although the three years placed at the Commission's disposal for completing its task may seem a long time, it is needed in order to be able to conduct the work in a transparent way, including frequent contacts with the different actors.

2. Ethical values, scientific facts and priority-setting

Since public health impinges on the highly controversial areas of economic and social policies, the proposal deliberately draws distinctions between the ethical considerations and the scientific material in order to stimulate debate on both issues; this will hopefully lead to their not being confused by the use of scientific arguments to favour certain value-driven standpoints, and vice versa. The ethical discussion is influenced by the work of Amartya Sen and John Rawls. If a central aim of a given society is to raise the level of and reduce the inequalities in the capability and freedom of people to choose their lives and pursue their vital goals (11), the aim of health policy in that society will be to reduce the level and inequality of the *consequences* of ill health, such as premature death, disability and participation. If, in accordance with Rawls (12), we accept as just only those measures against inequality that benefit the least advantaged members of society, the priorities between health determinants will have to be evaluated against their impact in at least four different dimensions:

1. on the occurrence of different diseases and injuries;
2. on the consequences in terms of mortality and morbidity;
3. on the distribution of these consequences; and
4. on the trade-off between effectiveness and equity.

Against this background, during the second step and before defining the targets, the Commission focused on a few trends in the recent health development of the country that were considered particularly important challenges for the future. Although there are no signs that Sweden is losing its lead in the increasing life expectancy in Europe, social inequalities in mortality and morbidity are persistently high. Moreover, as we look at more serious social consequences of disease, such as exclusion from the labour market, the social gradient is even steeper (Table 1).

Table 1.
Relative risk of long-standing illness in those aged 25–64 years in Sweden, with and without different consequences

Social category (professional = 1.0)	Long-standing Illness	With slightly reduced working capacity	With greatly reduced working capacity and not in the workforce
Professional	1.0	1.0	1.0
Intermediate non- manual	1.1	1.4	1.8
Routine non-manual	1.5	2.2	3.8
Skilled manual	1.7	3.3	6.0
Unskilled	1.8	3.2	6.2
Percentage of population aged 25–64 years	39.7	20.8	6.0

Source: National Public Health Commission (2).

There are indications of increasing mental and psychosomatic symptoms among children and younger adults, particularly among poorly educated women (Table 2). The labour market in Sweden, as elsewhere, is changing rapidly with increasing demands on flexibility and qualifications as well as reduced job security. There is growing evidence to show that the cohesive forces of trust, reciprocity and integration in society are crucial, and that a universal welfare state has an important role in strengthening those forces. The old structures and institutions are now facing new economic, political and ideological challenges. There is therefore a need to strike a balance between efficiency, equity and political sustainability in the welfare state. In addition, the birth rate in Sweden has recently declined sharply and there is evidence that young parents – and particularly single mothers – are facing growing constraints in terms of their financial situation and time available to spend with their children. A growing proportion of children are growing up in segregated suburbs where the allocation of resources to child care and schools is insufficient to compensate for the low opportunities their family background provides.

Table 2.**Percentages of people in Sweden aged 25–44 with mental and psychosomatic symptoms, by sex, 1980–1997**

Social category	Women			Men		
	1980/81	1988/89	1996/97	1980/81	1988/89	1996/97
Manual workers & routine non-manual workers	22.8	21.1	30,9	15.6	15.9	21.7
Professionals & intermediate non-manual workers	16.8	17.2	24.8	13.3	12.9	17.7

Source: National Public Health Commission (2).

Against this background the Commission decided to suggest health targets primarily in terms of reduced exposure to *determinants* of disease and injuries and not in terms of reduced mortality and morbidity (13). This decision is a result of the understanding that exposures can clearly be related to their causal roles for the *level* and *distribution* of different diseases and their *consequences*. Moreover, determinants make more explicit the connection between health targets and responsibilities of different sectors and policy areas, such as the labour market, social welfare, housing and schools. The determinants of health given highest priority were those that were expected, on the available scientific evidence, to have the greatest potential for reducing the overall level of *and* the social inequalities in the burden of disease.

The Commission had no difficulty in accepting targets related to determinants, but there was a debate on which determinants should be included. The decision on which determinants should be considered was affected by the comments and suggestions of those who were given the opportunity to give feedback to the Commission's proposal presented in its first report. When the "health determinants" approach had already been decided, and when there was agreement in the Commission as to which determinants the targets should be concerned with, demands were made for strong scientific evidence. Fourteen expert groups were appointed to write background papers containing sound scientific evidence on exposure areas such as employment and work conditions, economic factors and social insurance, tobacco, alcohol and drugs, and also for a few diagnostic groups including injuries, mental health and allergic conditions and target groups such as children, elderly

people and immigrants (see Part I, Appendix 2). Based on the expert groups' reports, the Commission submitted in December 1999 a preliminary proposal on a national strategy for equity in health. The proposal has recently been referred for consideration and comments to a broad range of political and nongovernmental organizations, authorities, academic institutions and other experts.

The aims and strategies presented in the report give expression to the Commission's vision of a "health-friendly" society that gives everybody an equal opportunity to influence personal and shared causes and consequences of sickness and disease. In such a society, according to the Commission, everyone should have the opportunity to manage the challenges of life and take responsibility for those aspects of health that can be influenced by the individual. Those environmental factors that cause physical and mental illness, such as inequitable living and working conditions, should be eliminated or reduced to a significant extent. A short presentation on the visions, strategic intents and health policy objectives is given in Part I, Appendix. 3.

The proposal is signed by all members of the Commission, although with the written dissent of the representative of the Conservative Party on certain issues related to the role of the welfare state as a whole. This dissent was not surprising, since the health policy suggested in the proposal is strongly linked to social policy, which is traditionally an area of political controversy. The reservations of the Conservative Party should therefore, in our opinion, strengthen rather than weaken the "status" of health and social policies, since these policies will become a more interesting subject of debate through the need for the political parties to take a stand. An insipid proposal comprising vague compromises would soon lose the interest of politicians and public alike. There is, however, always a risk that a shift in the political regime would result in a dismissal of the proposal, or parts of it, altogether.

3. Finalizing the strategies

The third phase of the Commission's work will be based on the comments received and will be completed in September 2000, when the final proposal from the Commission to the Government will be presented. According to the instructions from the Government, the Commission should also consider the *total effects* in financial terms of each specific action suggested. If a certain action would increase costs in some sectors but reduce costs in others, it would be important for the Commission to highlight this fact. A working group of experts has been appointed to assist the Commission in evaluating the costs and benefits of the different policies proposed. The final proposal will also suggest organizational arrangements for public health actions and the responsibilities of different sectors of society, including public health research and training.

So far, there is no indication from any section of society that the approach presented by the Commission will change. The big challenge after the Commissions final proposal will be to make the inter-sectorial co-operation work efficiently. Given the fact, that actors in different sectors are given the opportunity to be part of the whole process, during which their role and responsibilities are discussed and defined by the Commission, we should be optimistic about the success of their collaborative efforts for a better and more equal health of the Swedish people.

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Part I

Appendix 1

List of short publications issued by the Swedish National Public Health Commission between 1998 and 2000 with the aim of stimulating public debate

- Tobacco – the greatest enemy of public health?
Göran Boäthius, Paul Nordgren, Måns Rosén and Bengt Haglund
- Heredity and environment – how is health affected?
Marianne Rasmuson and Denny Vågerö
- The Swedish alcohol policy – well-motivated or out-of-date?
Leif Carlson, Gunnar Ågren and Sven Andréasson
- Ill-health caused by “lack of confidence” – myth or reality?
Edgar Borgenhammar and Robert Olin
- Old and healthy? – the health of the elderly.
David Gaunt, Lars Andersson, Lise-Lotte Risö Bergerlind, Gerdt Sundström and Tullia von Sydow
- Good health – a social privilege?
Olle Lundberg, Pernilla Ström and Göran Greider
- Unhealthy or healthy in the soul? – views on mental (ill)health.
Roger Qvarsell, Yvonne Forsell, Larl Grip, Töres Theorell and Danuta Wasserman
- “New diagnoses” – an explanatory model for neuro-somatic diseases
Robert Olin
- Physical activity and sport – promoting or risk factors for health?
Erwin Apitzsch, Patrik Grahn, Carina Nilsson, Tomas Gustafson, Bengt Pohjanen and Lars-Göran Rydqvist

Part I Appendix 2

List of background papers prepared by expert groups for the Swedish National Public Health Commission

- No. 1. *Working life and health*
- No. 2. *Economic provision and health*
- No. 3. *Poverty in Sweden*
- No. 4. *Social relations and health*
- No. 5. *Environmental factors and health*
- No. 6. *Life style factors: diet, physical activity, culture and leisure, sun-bathing behaviour*
- No. 7. *Life style factors: tobacco, alcohol and narcotics, abuse of pharmaceutical preparations*
- No. 8. *Injuries*
- No. 9. *Allergies*
- No. 10. *Mental health*
- No. 11. *Children and youth*
- No. 12. *Elderly*
- No. 13. *Integration and health*
- No. 14. *Demand, supply and development regarding academic public health education in Sweden*
- No. 15. *Health care for health (forthcoming)*
- No. 16. *Public health education and research (forthcoming)*

Part I Appendix 3

National Public Health Strategy for Sweden⁴ (1999 Green Paper)

Visions, strategic intents and objectives for a health-friendly society

Vision for a health-friendly society

A health-friendly society gives everyone equal opportunity to influence individual and shared causes and consequences of sickness and disease.

In such a society, everyone has the opportunity to manage the challenges of life and to take personal responsibility for those aspects of health that can be influenced by the individual.

Factors in the surrounding environment that cause physical and mental illness, such as inequitable living conditions and unsanitary environments, have been eliminated to a significant extent.

Strategic intents for a health-friendly society

1. Strengthen social cohesion and solidarity in society.
2. Increase opportunities for integration into the labour market and reduce social exclusion.
3. Increase the influence and security of people in the workplace.
4. Give priority to families with children, in economic terms and in respect of the time available for being together.
5. Give children and young people equal chances in life by reducing segregation and implementing compensatory measures.
6. Give senior citizens and people with long-term illnesses or disabilities opportunities to shape their lives according to their needs.
7. Create opportunities for sustainable enhancement of health.
8. Increase solidarity with those who are vulnerable to lifestyle risks.

⁴ *Equity in health – the second step towards national health targets*. Stockholm, National Public Health Commission, 1999 (SOU 1999:137) [in Swedish].

**The 19 health policy objectives
of the Swedish National Public Health Commission**

<i>Objective</i>	<i>Indicators of fulfilment</i>
<i>Strengthen social cohesion and solidarity in society</i>	
1. Counteraction of the wider disparities in income	Gini coefficient under 0.25 (in 1998, 0.25)
2. Reduction of relative poverty	Proportion of people living in poverty according to EU norms under 4% (at present 4.8%) Proportion of people with income below the social welfare poverty line under 7% (at present 8.9%) Proportion of households with children with long-term dependency on social assistance reduced to half
3. Elimination of long-term homelessness and dependency on social welfare benefits	Proportion of people with long-term dependency on social welfare reduced to less than 1% (at present 2.4%)
4. Reduction of political marginalization	Proportion of voters in general elections increased by 5% in districts where fewer than 60% voted in 1998; voter participation among people with foreign citizenship increased by 10%
5. Reduction in the frequency of suicide	Number of suicides reduced by 25% by 2010 (at present 21.1 per100 000)
<i>Increase opportunities for integration into the labour market and reduce social exclusion</i>	
6. Increase in employment and reduction in long-term unemployment	Increase in employment from 78% to 85%; long-term unemployment reduced from 1.4% to 0.5%
7. Favourable opportunities for continuing education, retraining and adult education	40% of the labour force over the age of 25 with access to at least five working days of education every year (at present 26%)

<i>Increase the influence and security of people in the workplace</i>	
8. Adaptation of the mental and ergonomic demands of the workplace to individual circumstances; provision of greater opportunities to influence working conditions and develop new competences; equal employment conditions for everybody regardless of the type of employment	<p>Proportion of people involved in making decisions about the form and content of their own work increased from 73% to 90%</p> <p>Proportion allowed to learn new skills and develop on the job increased from 53% to 75%</p> <p>Proportion of people engaging in heavy lifting (over 15 kg) declined from 25% to 15%</p> <p>Proportion of parents of small children working overtime reduced to 20% for both sexes and the proportion of people with flexible working hours increased to 75%</p>
<i>Give priority to families with children, in economic terms and in respect of the time available for being together</i>	
Targets 2 and 8 should be achieved, even for parents with small children	See above
<i>Give children and young people equal chances in life by reducing segregation and implementing compensatory measures</i>	
9. Reduction in economic and ethnic housing segregation and increased general compensatory measures for children and young people in vulnerable neighbourhoods	Proportion of children growing up in vulnerable neighbourhoods reduced to less than 10%; allocation of resources to pre-schools, schools, primary care, police and recreation sector complies with indicators of needs
10. The right of all children to education through to secondary level that is adapted to their needs	No child leaves compulsory school or secondary school with incomplete marks (at present 20% of compulsory school pupils lack complete final marks)

<i>Give senior citizens and people with long-term illnesses or disabilities opportunities to shape their lives according to their needs</i>	
11. Increase in opportunities for social fellowship and meaningful employment	Employment among people aged 20–64 with long-term illness and impaired capacity to work increased from 53% to 70%
12. Active outreach and health promotion programmes to all senior citizens and people with long-term illness	Increased proportion of senior citizens and people with long-term illness visited at home at least once a year by social services or health care personnel for the purpose of promoting health
<i>Create opportunities for sustainable enhancement of health</i>	
13. Elimination of problems of the indoor environment causing ill health	Nobody subjected to environmental tobacco smoke in public premises by 2010; no homes with radon levels over 400Bq/m ³ ; 75% of all homes with satisfactory ventilation
14. Reduction of injuries sustained in traffic	Disease burden for injuries sustained in traffic calculated as DALYs reduced by 5% per year
<i>Increase solidarity with those who are vulnerable to lifestyle risks</i>	
15. Reduction in tobacco smoking	Proportion of the population that smokes daily reduced by 1% per year; smoking reduced to zero among pregnant women and people under the age of 19 by 2010
16. Reduction in alcohol consumption	Total average consumption of alcohol declined by 25%, from 8 to 6 litres of 100% alcohol per person per year
17. Reduction in the fat content of food and increase in the consumption of fruit and vegetables	Fat content of the diet reduced to 30% of energy intake, with a maximum of 1/3 saturated fat; percentage of energy from carbohydrates increased to 55%; intake of fruit and vegetables increased to 600 grams per person per day
18. Increase in exercise and physical activity	Proportion of people taking exercise once a week increased from 50% to 70%
19. Decline in the proportion of overweight individuals	Proportion of adults severely overweight reduced from 8% to 5%; proportion of children under 16 moderately overweight reduced from 7% to less than 5%

Equity-oriented national strategy for public health in Sweden

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Part II – What happened next

In Part I we give an account of the ongoing work of the Swedish National Public Health Commission. We present the preliminary targets and policies suggested by the Commission for better and more equitable health for the Swedish people. We also describe the most important contributing factors behind the Swedish Government's decision to call for a comprehensive national public health strategy. Furthermore, we describe the first two steps of the democratic working process aimed at developing a framework and starting a public discussion and priority-setting based on scientific facts and ethical considerations.

On 23rd October 2000, the Commission presented its final report (1) to the Minister of Health and Social Affairs, containing a proposal for national objectives for public health and strategies to achieve them. A short version of the report is available in English, and can also be downloaded from:
<http://social.regeringen.se/inenglish/publications/index.htm>

The full report in Swedish can be downloaded from:
http://social.regeringen.se/propositionermm/sou/pdf/sou2000_91.pdf.

The final report is being circulated for comment among key actors within the public health field, such as public authorities, selected county councils, municipalities, voluntary organizations and trade unions. These comments will be considered when the Government develops its final proposal. The Government intends to present the resulting comprehensive Public Health Bill to the Swedish Parliament in December 2001.

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The purpose of this update is to give an account of the working process involved in the third and final phase resulting in the Commission's final proposal for public health targets and strategies.

Review of comments on the Green Paper presenting the preliminary health policy objectives

The third and final phase of the Commission's work took place during 2000. The most important starting point for this phase comprised the comments and suggestions provided by a broad range of stakeholders, such as political and non-governmental organizations, county councils, municipalities, trade unions and academic institutions, in response to the Commission's Green Paper (2) presenting the preliminary public health goals and strategies. Those proposals that were supported by strong scientific evidence and that were seen by the Commission as areas of political priority were taken into consideration, and the Commission decided to revise to a certain extent the proposals presented in the Green Paper.

The basic structure of the proposal, with its broad cross-sectoral approach and all targets framed in terms of determinants rather than health outcomes, was broadly supported. A number of stakeholders, mainly representing different public health fields in the scientific community, wanted certain issues to be given higher priority. These included the increasing levels of absenteeism at work and indications of deterioration in mental health among young people observed during the last decade. The Commission was urged to pay greater attention to certain determinants of health, such as increased levels of job strain, the increased economic stress among single mothers and young people, and increasing residential segregation along ethnic and economic lines. The stakeholders, mainly representing those with responsibilities for coordinating and implementing public health measures (such as the National Institute of Public Health, county councils and municipalities) emphasized the importance of an infrastructure for public health work in terms of coordination, research, education and the development of methodological tools for health impact assessment and economic appraisal of public health interventions, as well as indicators for monitoring the targets. Greater attention to the gender perspective in public health research and policies was also recommended.

Updating the knowledge base

In addition to considering the comments and recommendations from stakeholders, the Commission has updated and complemented the knowledge base underlying the proposals. New data and documents have been produced concerning stress, oral health, eating disorders, cultural activities and health, as well as comprehensive overviews of the future need for public health training and research. Further discussion documents address the responsibilities of individuals versus society, and the role and

responsibilities of sectoral authorities (including the health care sector), municipalities and organizations in relation to public health.

One important survey conducted for the Commission has, for example, mapped out 32 national authorities covering a broad range of sectors (e.g. Swedish Work Environment Authority, National Agency for Education, Swedish Environmental Protection Agency, National Food Administration, Swedish Labour Market Administration, Swedish National Road Administration) regarding the direct and indirect effects of their activities on public health. The survey describes activities performed within different sectors of society concerning, for example, working life, economic security, indoor and outdoor environment, recreation, nutrition and physical activity, tobacco, alcohol, narcotics, pharmaceuticals, injuries and allergies, and the situation for children, the elderly and immigrants.

Representatives of the authorities participating in the survey were interviewed about how the activities of their organization may have an impact on public health. The survey highlighted the current role and responsibility of each authority, and provided valuable information as to how the roles and responsibilities of the respective authorities should be shared and coordinated in the future. The Commission has thus paid serious attention to the crucial role of many different sectors, but there is no doubt that the mechanisms for coordinating the contributions from different sectors is still one of the weak points when it comes to implementing the new policy. This insight has led the Commission to emphasize the important role of the National Institute of Public Health in monitoring multisectoral cooperation and in developing tools for health impact assessment, including health inequality impact assessment of policy actions in different subgroups of the population. However, the National Institute of Public Health does not have ultimate responsibility for coordinating the different sectors. There is thus still a need for a political structure at the ministerial level for coordinating multisectoral public health action. The Government may initiate such a political structure in the Public Health Bill that will be presented to Parliament in December 2001.

Possibilities for health promotion within the health care sector were analysed by an expert group appointed by the Commission. In addition to concrete suggestions on what could be done within the sector itself, the experts described various ways by which the health care sector might cooperate with other sectors. Previous proposals as to how the health care sector might carry out health promotion activities had tended to be too narrow, mainly focusing on action at the individual level such as screening and immunization. The present investigation initiated by the Commission had the mandate of proposing promotional activities in a much broader sense.

Another expert group provided the Commission with information on the situation of chronically ill and handicapped people, and their need for health promotion and disease prevention efforts.

Additional discussion documents on public health education and research were also produced by a group of experts. Important areas for public health research were identified; these included the mechanisms that produce and maintain socioeconomic inequalities in health and the development of methods such as health impact assessment and evaluation of experimental and non-experimental interventions and policies.

Another report to the Commission is arguing for increased efforts in the field of public health training. The demand for better-skilled staff in the health care sector, including the skills needed for needs assessment and management, as planned markets are expanding coincides partly with the need for better public health skills among those responsible for the broader health policy. Public health education in Sweden is not considered adequate to accommodate these growing needs. Efforts should be made not only to increase the number of people with competence in public health sciences – particularly in the interface between epidemiology and economy – but also to strengthen and improve the public health aspect in other types of education.

The final proposal of national goals and subgoals

In its final report, the National Public Health Commission proposes 18 health policy objectives grouped into six categories called “overarching guidelines”, which express the strategic intents of the Commission (see Part II, Appendix 1). To each objective a number of more specific targets are linked, together with various indicators for follow-up. The Commission also defines specific target groups for each objective and identifies the actors to be responsible for implementation. The health objectives address determinants of health mainly at the societal level. Eight of the objectives deal with underlying determinants, six with lifestyle factors and four with public health infrastructure. It is important to note that most of the strategies concerning lifestyle factors emphasize *collective* rather than *individual* responsibility and, consequently, most measures proposed to diminish lifestyle-related health risks need to be implemented at the societal level, without the direct involvement of individuals.

It is proposed that, in principle, responsibility for implementation be integrated into the remit of national agencies. The commission recommends a new public health law, according to which county councils and municipalities would have the responsibility to draw up, in co-operation with each other, a public health plan for their populations. Strong co-ordination of public health within the Cabinet is also proposed. For regional and local authorities, as well as commerce and the voluntary sector, a number of different actions are defined as “challenges”. The Commission has also drafted a bill for licensing tobacco retailing, and for a change in the law so that restaurants and other catering establishments become smoke-free like other public areas.

According to an economic assessment of the initiatives proposed, including the resources required to improve the infrastructure for public health work and

health information, the costs involved will be approximately SEK 300 million per year for a period of five years. The Commission proposes that the Government provide the necessary financial resources.

The final proposal is supported by a large majority of the political representatives. A reservation in writing has been made about the conclusions of the report by the representative of the Conservative Party. The representative of the Liberal Party has made a written comment –though not a formal reservation – expressing doubt about the need for a public health law requiring municipalities and county councils to draw up health plans. The member of the Left-Wing Party has also made a specific comment (not a reservation), expressing her disappointment that the preliminary target on reducing income inequalities has been replaced with a target on reducing poverty. The reason for not including a target on reducing income was the lack of convincing scientific evidence that an additional reduction in Sweden's already relatively low income inequalities would actually result in better health of the population in general and fewer health inequalities in particular.

What makes the Swedish public health strategy unique?

In the following final section we list a number of factors that make the Swedish public health strategy unique in comparison with national health strategies in other countries.

Politicians and experts working together

The common practice in many countries is to appoint a group of experts and/or civil servants from research institutions and ministries of health to develop a national health strategy. As we point out in Part I, such a group of experts is seldom capable of setting priorities efficiently. Proposals for a health strategy produced by expert groups are not political documents and need to go through a process of political negotiation, which often result in substantial revisions of the original document or rejection of the proposals altogether. For example, the "Healthy people" programme in the United States, developed by thousands of experts since the beginning of the 1980s, has an unclear political base and the prerequisites for implementation of the proposed strategies are weak. Another example is the Black Report,⁽³⁾ published in 1980 by experts in the Working Group on Inequalities in Health, which contained thirty-seven recommendations for a better and more equal health for the population of the United Kingdom. The document received a frosty reception by the Conservative administration and the proposals were dismissed. A third example is the public health strategy ⁽⁴⁾ developed in Sweden at the end of the 1980s by the Public Health Group, which consisted of experts (see Part I). The strategy has not been implemented because of its lack of clear priority-setting.

Learning from these experiences, the Swedish Government appointed to the Commission both experts and politicians from all political parties represented in Parliament. The experts ensured that the proposals were scientifically well founded and that there were prerequisites in place for the implementation of strategies. The politicians, on the other hand, were able to continuously discuss and negotiate during the working process and thereby agree on priority-setting. Cooperation between the two groups turned out to be very successful – the initial uncertainty and even “mistrust” between the groups turned to mutual sincerity and respect during the working process. The final report developed by the Commission is a *political* document based on *scientific* evidence.

The broad political support for the final proposal within the Commission is remarkable and probably unique for Sweden, since the proposals are strongly linked to social policy, which used to be an area of political controversy.

Focus on determinants of health and multisectoral implementation

As emphasized in Part I, the most striking developments in the Swedish strategy are that the Commission suggested health targets that primarily address the actual determinants of disease and injury at the societal level.

The objectives deal with issues related to poverty and economic disparity, social welfare, unemployment, homelessness, job strain, segregation, education, childhood conditions and care of the elderly. For each of the objectives, the Commission suggested quantifiable indicators for their attainment. These determinants were given high priority as, based on the available evidence, they were considered to have a great potential for reducing the overall level of and particularly the social inequalities in the burden of disease. The rationale behind this approach was that determinants make it easier for different sectors to identify their role, and that the relationship between action and effect is less blurred by time-lag and confounders compared to effects in terms of health outcome. The determinant approach makes the role of the health sector less obvious; accordingly, the proposed Swedish strategy requires implementation in a number of policy areas and sectors, where the health care sector is “only” one of the actors.

Sweden is not the only country striving for greater equality in health and improved overall health for the population. In fact, health strategies outlined in many other countries have the same objective. In contrast to Sweden, however, most of these countries have formulated health targets in terms of reduced levels and inequalities in *mortality* and *morbidity*. Thus these objectives mainly (and traditionally) address different types of disease and injury. Such an approach makes the role of the health care sector more obvious, but tends to restrict areas of intervention to individual behavioural risk factors and neglects factors of greater importance for health equity.

Such a “disease” approach is found, for example, in *Healthy people 2001* (5). Although the overall goals include eliminating health inequalities and improving the quality of life by broad societal changes and determinants of health, 23 of the 28 objectives deal with specific diseases and types of risk behaviour. The indicators of fulfilment entail reductions in specific mortality or prevalence estimates (6). Another example is The New Zealand Health Strategy, released in December 2000 by the Ministry of Health, which “aims to ensure that health services are directed at those areas that will ensure the highest benefits for our population, focusing in particular on tackling inequalities in health” (7). Seven of the 13 priority population health objectives deal with behavioural factors (smoking, nutrition, obesity, physical activity, suicide, alcohol consumption and violence), five address specific diseases (cancer, cardiovascular disease, diabetes, oral health and severe mental illness) and the remaining objective deals with child and family health care services and immunization.

Demands for strong scientific evidence

The Government’s demand for scientific evidence behind the various proposals has mobilized the research community. Over a hundred scientists, representing different fields of public health research, have published 19 reports (see Part II, Appendix 2) to support the working process. The research groups were instructed to draw policy-relevant conclusions from the scientific evidence presented in their state-of-the-art reports. Even if the epidemiological evidence for the causal role of the chosen determinants were considered sufficient, the knowledge base on how interventions and policy changes influence the levels and distribution of determinants is comparatively weak. The Commission therefore suggests that the National Institute of Public Health should give high priority in its research policy to research on the health effects of interventions.

Strong emphasis on the democratic process behind the development of the strategy

The success of any public health strategy depends greatly on the process by which it has been developed. The process that leads to national goals is just as important as the goals themselves. It is crucial for the strategy to be formed through a democratic process, involving a continuous dialogue with those who will be subject to the strategy as well as those who will have responsibility for its implementation. In Part I we describe how the democratic and interactive process between the Commission and the public was ensured. The process-orientated work involved the publishing of ten short discussion documents (see Part II, Appendix 3) for debate on scientifically and politically controversial issues within the public health field. Seminars and conferences in various regions of the country were arranged by the Commission itself or in collaboration with others. Most importantly, the Commission, prior to the final proposal, produced two preliminary consultation documents, which were submitted for consideration to a broad range of political and nongovernmental organizations, authorities, academic institutions and other experts. Such a

working process is, of course, time-consuming. It took more than three years to undertake the work involved in the development of the new Swedish public health strategy. Our hope is that the time and effort invested in the process will pay off in due course in terms of better and more equal health for the Swedish population.

References

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Part II Appendix 1

Health on equal terms – national goals for public health in Sweden⁷ (Final proposal October 2000)

Vision, overarching guidelines and objectives

Vision

Good health on equal terms.

Overarching guidelines

9. Strengthening the social capital
10. Growing up in a satisfactory environment
11. Improving conditions at work
12. Creating a satisfactory physical environment
13. Stimulating health-promoting life habits
14. Developing a satisfactory infrastructure for health

⁷ *Health on equal terms – national goals for public health. Final report.* Stockholm, National Public Health Commission, 2000 (SOU 2000:19) [English version].

The 18 health policy objectives of the Swedish National Public Health Commission

<i>Health policy objectives</i>	<i>Specific targets</i>	<i>Indicators of achievement*</i>
Strengthening the social capital		
1. A strong sense of solidarity and feeling of community in society	Reduced poverty	For example: distribution of material and economic resources (gini coefficient); proportion of households with disposable income below 50% of the median; proportion of people with long-term dependence on social assistance (dependence for 10 months per year); possibility of obtaining SEK 14 000 for unexpected expenses within one week; proportion of people with illness and those unemployed with the lowest level of economic compensation from the health insurance and occupational injury insurance system
	Reduced segregation in housing	For example: ratio of people with high and low income in residential areas (segregation index); ratio of people born in Sweden and elsewhere at parish level; number of homeless; number of municipalities with action plans to counteract homelessness
	Compensatory resources for children and young people in socially disadvantaged housing areas	For example: number of children in socially disadvantaged housing areas; allocation of resources to nursery schools, schools, primary care, police and recreation sectors in relation to need
2. A supportive social environment for the individual	Reduced isolation, loneliness and insecurity	For example: proportion of people with regular contact with relatives and/or close friends; proportion of people with fear of or being subject to violence; proportion of adults reporting psychological problems and psychosomatic symptoms
	Increased participation in leisure and cultural activities	For example: number of visits per 1000 inhabitants to library and sports establishments; number of boards/committees in municipalities per 1000 inhabitants, where inhabitants have a direct influence on activities, such as schools, care for the elderly; proportion of voters in general elections by district and citizenship

* The Commission proposed that the National Institute of Public Health be given the main responsibility to overview, suggest and develop previous and new indicators for achievement of the various public health objectives. The indicators listed here are just examples that should be refined and further developed.

<i>Growing up in a satisfactory environment</i>		
3. Safe and equal conditions in childhood for all children	<p>A secure bond between children and their parents</p> <p>A nursery and school system that promotes health by strengthening pupils' self-confidence and achievements at school</p> <p>Improved mental health among children and young people</p>	<p>Indicators to be developed by, for example, the National Institute of Public Health</p> <p>For example: proportion of pupils with complete final marks in compulsory and secondary schools; proportion of pupils subjected to bullying; proportion of pupils absent without permission; proportion of pupils having lunch provided by schools at least four times a week</p> <p>For example: proportion of children with self-reported mental illness and psychosomatic problems; number of suicides or attempted suicides among children 10–18 years of age by residential area</p>
Improving conditions at work		
4. A high level of employment	<p>Opportunities for life-long learning</p> <p>Low unemployment</p> <p>No discrimination against immigrants or the disabled in the job market</p>	<p>For example: possibility of education within employment at least five days a year; educational opportunities for people with long-term dependence on social welfare; educational possibilities for people with reduced working capacity; proportion of young people leaving high school without a final examination</p> <p>For example: proportion of people in employment by sex and age; proportion of long-term unemployed (more than six months)</p> <p>For example: proportion of people in the labour market by nationality; proportion of disabled in the labour market; number of people with reduced working capacity who are waiting for an employment opportunity</p>
5. A healthy working environment	<p>Adaptation of the physical and mental demands of work to meet the requirements of the individual</p> <p>Increased influence and opportunities for development at work</p> <p>Reduced overtime</p>	<p>For example: proportion of workers with high mental demands at work; proportion of workers exposed to noise, heavy lifting, uncomfortable working postures; statistics on work-related injuries and diseases; the pattern of absenteeism due to illness in different occupations</p> <p>For example: proportion of workers with little influence on the form and content of their own work; proportion of workers with no possibility of learning new skills and developing at work</p> <p>For example: proportion of parents of small children with overtime work versus flexible working hours; proportion of workers with paid and unpaid overtime work.</p>

Creating a satisfactory physical environment		
6. Accessible green areas for recreation	Quiet and safe green areas near residential housing	For example: availability of recreational area within 5–10 minutes walk from residence; number of municipalities with planning strategies for green areas
	Stimulating playgrounds at nurseries and schools	For example: presence of playgrounds at nursery schools and school that satisfy children's need for play, movement, stimulation and relaxation
	Good outdoor facilities near sheltered housing for the elderly and disabled	For example: presence of stimulating open-air places near residential areas for the elderly and disabled people
7. Healthy indoor and outdoor environment	Reduced exposure to passive smoking	For example: follow-up of supervision exercised by municipalities of the tobacco law concerning smoke-free environments; surveys of the prevalence of exposure and attitude to tobacco smoke in different environments
	Well ventilated indoor environment	For example: proportion and number of indoor environments that do not fulfil the requirements for adequate ventilation or are damaged by mould or damp; prevalence of ailments and symptoms that can be related to inadequate indoor environments
	A high standard of building, protection from radiation, fresh air and a non-toxic environment in accordance with the proposals of the Environmental Targets Committee	For example: see indicators suggested by the Environmental Targets Committee
8. Safe environments and products	A safe home environment, a safe traffic environment and safety in other public places	For example: proportion of children and elderly people injured at home; proportion of children injured in nursery schools, schools, traffic and during leisure; proportion of children at age 12 who can swim; number of reported injuries due to accidents, violence and suicide in different environments per 1000 inhabitants; number seriously injured or killed in road accidents; proportion of reported head injuries caused by cycling in different age categories; number of registered violations against speed limits per 1000 road users per year; proportion of municipalities working according to the model for "safe communities"
	Reduced use of products hazardous to health and those causing allergies	For example: number of injuries caused by products; number of products in various consumer categories that contain a declaration for allergic consumers

Stimulating health-promoting life habits		
9. More physical exercise	More physical exercise at school and in connection with work	For example: hours devoted to sports and health in schools; extent of physical exercise in schools; proportion of children at age 12 who can swim; proportion of employers in public and private sectors that offers possibility to employees for exercise during working hours
	More physical exercise in people's leisure time	For example: proportion of children and adults exercising at least 30 minutes per day; resources for leisure provided by municipalities to girls and boys up to the age of 13 and in age group 13–18 in relation to total municipal resources available for leisure; number of municipalities that guarantee daily outings for elderly people cared for by municipalities; proportion of disabled people offered the possibility to exercise according to their own needs
10. Healthy eating habits	Increased consumption of fruit and vegetables and reduced consumption of fat and sugar	For example: proportion of population consuming ½ kg fruit and vegetables daily; number of health-promoting schools working actively on promoting healthy eating habits and integrating the subject into different educational areas; number of municipalities that guarantee healthy food according to recommendations by the National Food Administration to elderly and disabled people in sheltered residential areas
	Reduced number of overweight people in society	For example: proportion of the population with normal body weight (body mass index (BMI) <25); proportion of the population substantially overweight (BMI ≥ 30); proportion of children below 16 who are moderately overweight
	Increased number of women breastfeeding	For example: proportion of children being breastfed at the age of four months
11. Safe and confident sexuality	Reduced spread of sexually transmitted diseases	For example: prevalence of HIV infection and other sexually transmitted diseases by sex and age
	Reduced number of unwanted pregnancies	
	No one should be discriminated because of their sexual orientation	For example: survey of the attitudes towards and treatment of homosexuals and bisexuals in school, at work and in residential areas

12. Reduced tobacco consumption	<p>A tobacco-free start in life from the year 2010</p> <p>A halving up to the year 2010 in the number of young people under the age of 18 who take up smoking or who use moist snuff</p> <p>A halving up to the year 2010 in the number of smokers among those groups in society who smoke the most</p> <p>No one should be subjected against his/her will to smoke by those around him/her</p>	For example: proportion of people smoking and taking snuff in the population, among women and men in different age categories, among people with high and low levels of education, among different ethnic groups, among single mothers, etc.
13. Reduced harmful alcohol consumption	<p>Reduced total consumption</p> <p>Total abstinence in connection with pregnancy, driving and sailing, at work and during sporting activities</p> <p>Reduced occurrence of drinking to a state of inebriation</p>	<p>For example: total average consumption of alcohol, including unregistered consumption; alcohol-related mortality and morbidity</p> <p>For example: surveys of alcohol drinking habits among pregnant women; surveys on alcohol consumption at work; proportion of drivers affected by alcohol</p> <p>For example: occurrence of alcohol consumption to the state of inebriation in the population; proportion of conscripts with alcohol consumption to the state of inebriation; number of work- and traffic-related accidents caused by alcohol</p>
14. A drug-free society	<p>Reduced access to drugs</p> <p>Reduced number of young people trying and using drugs</p>	<p>For example: mortality caused by drugs</p> <p>For example: proportion of 16-year-olds who have tried drugs; proportion of conscripts who have tried drugs</p>
<i>Developing a satisfactory infrastructure for health</i>		
15. A more health-orientated health service	<p>More effective measures for the prevention of ill health and for health promotion on an individual, group and community level</p> <p>Increased coordination to ensure equal development of health in the population</p> <p>Advanced methods and strategies for work on preventing illness and promoting health</p>	For example: number of county councils that have established health budgets for planning their health-promoting and health care oriented objectives and strategies; number of hospitals participating in the WHO Healthy Hospitals Project; number of county councils and municipalities providing education about methods for health promotion and disease prevention; number of county councils and municipalities that have adapted models for purchasing health-promoting efforts; annual follow-up of protective efforts to halt infectious diseases; annual follow-up of resistance to antibiotics; number of county councils with programmes directed towards the public on how to avoid infections

16. A co-ordinated effort on public health	<p>Responsibility for health planning in the hands of district councils and county councils</p> <p>Development of coordinated sector strategies within the field of public health on a national level by responsible authorities</p> <p>Coordination of public health issues in the Cabinet Office and Ministries</p> <p>A regular update on national policy for public health presented to the Swedish Parliament in the form of a report on public health policy</p>	Indicators to be developed by the National Institute of Public Health
17. Long-term investment in research, method development and education	<p>Intensified research into value, costs and effects of various interventions</p> <p>Improved methods for managing work on public health</p> <p>Increased investment in education in the discipline of public health</p>	<p>For example: the magnitude of financial support to research within the field of intervention research, health economics and research on health determinants</p> <p>For example: number of scientifically evaluated methods within different health research fields</p> <p>For example: number of examinations within public health science programmes and number of courses in public health-related issues within other educational programmes</p>
18. Factual information on health	Access to factual and objective information on health for everyone	

Part II

Appendix 2

Background papers prepared by expert groups for the Swedish National Public Health Commission

- No. 1. Working life and health
- No. 2. Economic provision and health
- No. 3. Poverty in Sweden
- No. 4. Social relations and health
- No. 5. Environmental factors and health
- No. 6. Lifestyle factors: diet, physical activity, culture and leisure, sunbathing behaviour
- No. 7. Lifestyle factors: tobacco, alcohol and narcotics, abuse of pharmaceutical preparations
- No. 8. Injuries
- No. 9. Allergies
- No. 10. Mental health
- No. 11. Children and youth
- No. 12. Elderly
- No. 13. Integration and health
- No. 14. Demand, supply and development regarding academic public health education in Sweden
- No. 15. Health care for health
- No. 16. An economic analysis of public health efforts – an anthology on frameworks, evaluation methods, etc.
- No. 17. The need for knowledge and research for public health policy and public health work
- No. 18. Health and handicap
- No. 19. Responsibilities of public health authorities

Part II

Appendix 3

Short publications issued by the Swedish National Public Health Commission between 1998 and 2000 with the aim of stimulating public debate

- Tobacco – the greatest enemy of public health? – by *Göran Boäthius, Paul Nordgren, Måns Rosén and Bengt Haglund*
- Heredity and environment – how is health affected? – by *Marianne Rasmuson and Denny Vågerö*
- The Swedish alcohol policy – well motivated or out-of-date? – by *Leif Carlson, Gunnar Ågren and Sven Andréasson*
- Ill health caused by “lack of confidence” – myth or reality? – by *Edgar Borgenhammar and Robert Olin*
- Old and healthy? – the health of the elderly – by *David Gaunt, Lars Andersson, Lise-Lotte Risö Bergerlind, Gerdt Sundström and Tullia von Sydow*
- Good health – a social privilege? – by *Olle Lundberg, Pernilla Ström and Göran Greider*
- Unhealthy or healthy in the soul? – views on mental (ill) health – by *Roger Qvarsell, Yvonne Forsell, Larl Grip, Töres Theorell and Danuta Wasserman*
- “New diagnoses” – an explanatory model for neuro-somatic diseases – by *Robert Olin*
- Physical activity and sport – promoting or risk factors for health? – by *Erwin Apitzsch, Patrik Grahn, Carina Nilsson, Tomas Gustafson, Bengt Pohjanen and Lars-Göran Rydqvist*
- With joint effort. The importance of organisations for public health – by *Olof Björlin, Sven-Olov Edvinsson, Eva Fried, Staffan Hallin, Ulla Inezdotter, Kjell E Johansson, Ann Jönsson, Anna Mohr, Kerstin von Plato and a member of Alcoholics Anonymous*