Sweden

Although Sweden has 21 independent County Councils/regions in its decentralised healthcare system, there is none of the difficulty of accessing statistics that has been seen in other decentralised states, such as Belgium. In addition, for some time now, Sweden has led the field in addressing gender equity. The National Board of Health and Welfare (NBHW) was commissioned in 2002-2004 by the Ministry of Health and Social Welfare to analyse gender equity in health care, and to propose actions to diminish gender disparities.

Sweden has the highest life expectancy of the countries studied (82.7 years in 2004), and shows the highest number of women in the labour force. Births tend to be in the 25-34 year age group, with the lowest figures of all eight study countries in the age groups under 24.

Cancer is the second most common cause of death among women in Sweden, after circulatory disease. The most common cancer among women is breast cancer, which shows as one of the higher rates in the study group (although this may be attributable to the longevity of Swedish women). Other common cancers are cancer of the colon, lung cancer, uterine cancer, skin cancer (excluding melanoma) and melanoma. Sweden has one of lowest rates for cervical cancer (3.6 per 100,000 population).

Smoking in adult females dropped from 27% in 1985 to 19% in 2002/2003. Although close to the average, Sweden has one of the younger ages for girls starting smoking (12.8 years). Dieting and weight control rise from a low average in early teenage years to the third highest of the figures in the study group by the time girls are 15 year olds.

Use of condoms as contraceptive protection is reported as low by girls in Sweden (58%, compared to 89% in Spain), but this may be because other contraceptives are also in use, and considered as sufficient protection.

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Women's health

Swedish women have one of the longest life expectancies in the world: 82.4 years at birth (2003). As in the early 1990s, Swedish men still rank highest in longevity among men from the EU countries, while Swedish women now rank after women from France, Spain, and Italy. Hence, compared with the other EU countries, the life-span trend seems to have been more favourable for men than for women in Sweden.

The term ‘avoidable mortality’ refers to certain medical conditions, e.g. lung cancer, which can be influenced by national health policy measures (so-called ‘health policy indicators’), or conditions such as gall stone problems, which can be influenced by various medical interventions (so-called ‘medical care indicators’). An analysis of the health policy indicators shows that male mortality is significantly higher than female mortality, but the rate for women is increasing, while it is decreasing for men. The rise in the female mortality rate is due primarily to increasing morbidity and mortality from lung cancer. Maternal mortality in Sweden is very low, only 3-4 cases per year.

The proportion of individuals with poor self-rated health is 7 per cent among women as compared to 6 per cent among men. The proportion has increased slightly since the early 1980s, but there was a minor decrease between 2000/2001 and 2002/2003.

The proportion of individuals on a long-term sick leave (more than 60 days) has been higher among women than among men and increased dramatically in the late 1990s /early 2000s. Due to the constraints to the social security system, a more restrictive attitude towards sick leave emerged. Instead, many women were then given early retirement. The most common diagnoses causing long-term ill health among women are diseases of the musculosceletal system and psychiatric disorders. Many of the women now on long-term sick leave or disability pension have been employed by the public sector, i.e. health care, the school system etc.

As with men, there are social gradients in both morbidity and mortality among women. These differences seem not to have diminished during the last few decades.

Specific health policies for women

On the national level, the National Public Health Institute and the National Board of Health and Welfare (NBHW) monitor the health situation of both men and women. The NBHW was in 2002-04 commissioned by the Ministry of Health and Social Welfare to analyse gender equity in health care and to propose actions to diminish gender disparities (see: *Gender equity in health care in Sweden - Minor improvements since the 1990s*, Jonsson PMJ Schmidt I, Sparring V, Tomson G.; Karolinska Institutet Division of International Health (IHCAR) Health Systems and Policy (HSP) research group, 2005). However, there is no special national institution responsible for the implementation of policies to improve women’s health.

In the decentralised healthcare system of Sweden, 21 independent County Councils/regions are responsible for the financing, organisation and delivery of health services. Some of the counties

have set up specific programmes focusing on women's health. Well-established disease-specific policies targeted at women include, e.g., screening for breast cancer (see below) and cervical cancer (see below) as well as intensified prevention and treatment of circulatory diseases among women. The Swedish Federation of Counties and Local Authorities has tried to enhance gender equity in health care in a 'mainstreaming' project, but much of the focus of the federation is on gender equity among employees.

Gender-sensitive health policy design

According to The Swedish Health Care Act, good health and equal access to care for all residents of Sweden is the main goal for the health service. Generally speaking, the formulation of national policies, strategies and programmes has not distinguished the different needs, prerequisites and power of men and women, but have been gender-blind, with a few exceptions. When gender-specific approaches have been applied, e.g., in connection to the formulation of national guidelines for cardiac care, the evidence-base presented has been scarce.

Three primary issues and how they apply to women's health

- *Cancer*

Cancer is the second most common cause of death among women in Sweden, after circulatory disease. The risk of contracting cancer by the age of 75 years has been calculated to be 27 percent for women as compared to 30 percent for men in Sweden. During the period 1994-2003, the numbers of new cases of cancer increased by 0.5 percent per year in women and 1.1 percent per year in men.

The most common cancer disease among women in Sweden is breast cancer, followed by cancer of the colon, lung cancer, uterine cancer, skin cancer (excluding melanoma) and melanoma.

Approximately 30 percent of all the cancer cases in women are breast cancer, which has increased during the last decade by 1.5 percent per year. Mortality in breast cancer, however, is not increasing, which can be explained by early and improved diagnostics. A general screening programme with mammography was started in some counties in the mid-1980s and in the last of the counties in 1997. In all parts of the country, mammography screening is now offered to women in the age groups 50-69 years and most of the counties also invite other age groups for screenings in the interval between 40 and 74 years.

During the last decade, lung cancer among women has increased by 2.6 percent a year, while the trend for men has been a decrease by 0.8 percent a year. This is explained by the delayed effect of trends in gender-specific smoking habits. The relative 5-year survival rate in lung cancer is

somewhat better in women than men, 15 percent as compared to 10 percent. The risk of contracting lung cancer varies between socio-economic groups and is lowest among the highest social classes. This applies for both women and men. Certain occupations, e.g. female journalists, run a higher risk of lung cancer.

While breast cancer, lung cancer, skin cancer and melanoma are increasing in women, other forms of cancer are decreasing. Cervix cancer has decreased due to the general screening programme, which has made it possible to treat pre-cancerous stadiums of the disease. Also, cancer of the ventricle is becoming less common, probably partly due to improved treatment of Helicobacter pylori.

- *Sexually transmitted infections*

In Sweden, the classic STIs gonorrhea and syphilis are today uncommon. Gonorrhea is more often found in men than women and in most cases imported from Asia. The number of new cases in 2003 was approximately 600, which can be compared to nearly 40.000 annual cases in the early 1970s. The number of new cases of syphilis in 2003 was 180, three out of four cases appearing in men.

In contrast, clamydia has become a major STI challenge with approximately 27.000 new cases reported in 2003 and with a clear upward trend in incidence. Of all the new cases, 50 percent were in women, regardless of age group. Clamydia is most common among young women, 75 percent of the new cases occurring in the age groups 15-24 years. The increase in the numbers of new cases may be explained by changing sexual behaviour among young people. Especially individuals having sexual debut under the age of 15 have been found to be at high risk for both STI and unwanted pregnancy.

Of all the 7.300 cases of HIV reported in Sweden, 29 percent have been women. Today, more than 3.200 HIV-infected persons live in the country. Of the newly reported cases, approximately 40 percent are women, among infected heterosexual persons 60 percent. Extremely few pregnant women are carriers of HIV. All pregnant women are offered HIV-testing, and if found to be infected, medication is started to prevent infection of the foetus.

- *Reproductive health*

In 2003, Swedish women gave birth to 1.71 children per woman. There has been a slight upward trend, which has been interpreted as a consequence of current female cohorts having waited for

giving birth later than was the norm with previous cohorts. The average age of the mother at first delivery was 28.6 years.

There were 93.000 deliveries in 2002, corresponding to 5.5 percent of all women aged 15-44 years. In 1.400 deliveries twins were born. Very close to 100 percent of all the pregnant women in Sweden pay regular visits to maternal care centres. Except for routine monitoring of the pregnancy, the centres give psychological support, enhance breast feeding and try to prevent alcohol and tobacco use during pregnancy. During the last two decades the proportion of smokers in early pregnancy has decreased from 31 to 11 percent. Of other risk factor overweight has become more common among the mothers. As alcohol consumption has increased in the general population, it has become more important to inform about the tentative negative effects of alcohol during pregnancy. Abstaining from alcohol use during pregnancy is one of the prioritised public health goals set up by the Swedish Parliament in 2003.

As mentioned before, the maternal mortality rate in Sweden is very low, as is the perinatal mortality rate, 5/10.000. Of all the deliveries in 2002, 74 percent were uncomplicated vaginal deliveries. Yet, serious perineal ruptures are fairly common, occurring in approximately 4 percent of all vaginal deliveries. In some counties the corresponding figure is more than 5 percent. The Caesarean section rate has increased from 11 percent in 1990 to 17 percent in 2004. The rate varies between counties from 13 to 21 percent of the deliveries.

Despite easy access to birth control, the abortion rate in Sweden is 18-20/1000 women aged 15-44 years. The relationship between the number of abortions and deliveries is close to one abortion per three live-born babies. The abortion rate has been relatively constant since 1975, when the current legislation on abortions and birth control was introduced. The introduction of prescription-free acute P-pills in 2001 does not seem to have had any major impact on abortions. Teen-age abortions are relatively common, 24/1000 women aged 15-19 years. According to a population survey from the 1990s, there is no social gradient in the occurrence of abortions.

Specific healthcare policies for young girls

Many of the national policies dealing with reproductive health implicitly focus on young girls' problems, like smoking cessation during pregnancy. The legislation against female genital mutilation was sharpened in 1999 to protect young girls from cultural minorities where this tradition has been applied. Areas where at least local (county) policies have been implemented include prevention of alcohol and drug abuse, prevention of teen-age pregnancies, protection against STI, prevention of overweight, and suicide prevention.

An example of 'best practice' in women's health

The establishment of the Centre for Gender-specific Medicine at the Karolinska Institutet exemplifies the fact that only through systematic research can the evidence-base for gender-sensitive health care be created. For details, see **www.ki.se/cfg** .

Further gender influences on patterns of health

See: *Gender equity in health care in Sweden - Minor improvements since the 1990s*, Jonsson PMJ Schmidt I, Sparring V, Tomson G.; Karolinska Institutet Division of International Health (IHCAR) Health Systems and Policy (HSP) research group, 2005

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