Europe's Beating Cancer Plan – Sweden's progress

Report by the Independent Expert Committee on the Implementation of Europe's Beating Cancer Plan in Sweden, commissioned by the Swedish Cancer Society

April 2025

FOTO: EDIS POTORI

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Introduction

Europe's Beating Cancer Plan (EBCP)

In February 2021, the European Commission launched Europe's Beating Cancer Plan with the goal of reducing the number of cancer cases and deaths across Europe. The plan represents a shared commitment among EU member states and has a total budget of €4 billion, financed through programmes such as EU4Health and Horizon Europe.

Running in parallel is the Cancer Mission, which supports research projects aligned with the plan's objectives. The plan includes specific measures within four main areas: prevention, early detection, diagnosis and treatment, and quality of life. It also contains ten flagship initiatives and several supporting actions.

In Sweden, several government agencies are responsible for implementation. In June 2022, the Swedish government assigned the National Board of Health and Welfare (Socialstyrelsen) to coordinate the national implementation. The assignment is due for completion in December 2025.

The Independent Expert Committee on EBCP in Sweden

To follow and assess how EBCP is being implemented in Sweden, the Swedish Cancer Society appointed an independent expert group in June 2023: the Independent Expert Committee on the Implementation of Europe's Beating Cancer Plan in Sweden. The Committee's task is to map, monitor and assess the implementation of the plan – focusing on which measures are actually being carried out, and how Sweden is making use of the opportunities it offers, particularly in terms of funding. The Committee also proposes actions at EU level and within Sweden, both nationally and regionally, to accelerate progress.

The Committee's previous work

During 2023 and 2024, the Committee met with a wide range of stakeholders involved in EBCP in Sweden to discuss ongoing and planned activities. Dialogue has been held with authorities, researchers, healthcare professionals and civil society organisations to gain an overall picture of how the plan is being managed nationally.

The Committee has also maintained regular contact with the National Board of Health and Welfare in connection with its government mandate to coordinate the national implementation and has provided input on the roadmap's objectives and the need for clearer communication.

At an early stage, the Committee carried out a mapping of Sweden's conditions for implementing EBCP. The mapping revealed low awareness of the plan, unclear mandates, insufficient cooperation between authorities and limited support for applying for EU funding. The Committee also emphasised the importance of Swedish participation in European collaboration and that the objectives of the plan should be more clearly reflected in national policy documents such as the national cancer strategy and the annual agreements between the government and the Swedish Association of Local Authorities and Regions (SKR). The mapping formed the basis for a written submission to the government with proposals for stronger governance and coordination.

In 2025, the Committee also submitted a response to the consultation on the new national cancer strategy Better Together. The response analysed how well the strategy aligns with the objectives of EBCP and identified several areas where the Swedish strategy should be strengthened in order for Sweden to fully meet the shared EU commitment.

The Committee's report

This report presents the Committee's assessment of how well Sweden is meeting the objectives of EBCP. It is based on an analysis of selected flagship initiatives and other key actions. The purpose is to identify both progress and shortcomings in the implementation, and to highlight what is required for Sweden to achieve the goals in full.

The assessment is not comprehensive. The Committee has deliberately focused on objectives considered most relevant in a Swedish context. Some EU initiatives have not yet been fully defined, making follow-up difficult – for example, the revision of the Tobacco Products Directive and the development of the European Health Data Space. These have therefore been excluded from the assessment.

The selection has also been guided by the need to highlight areas where Sweden has potential to act and where differences in implementation, access or outcomes affect people's opportunities for prevention, early detection, equitable care and rehabilitation.

The Committee's assessments are based on public statistics, government reports, evaluations, policy documents, scientific publications and dialogue with stakeholders in Swedish cancer care and research – including authorities, researchers and patient organisations.

Summary

Prevention – Several areas require urgent attention

Preventing cancer is a cornerstone of EBCP. The Committee finds that Sweden has made progress in several areas and has strong foundations to build on – but important challenges remain before the national goals can be reached.

HPV and Hepatitis B vaccines, which protect against viruses that can cause cervical and liver cancer, are given to a large proportion of children in Sweden. However, participation in catch-up vaccination programmes for young women varies, as does access for adults in risk groups. The Committee believes these programmes should be regulated and funded by the state to ensure equitable access across the country. It also recommends a gender-neutral national target for HPV vaccination within the childhood programme.

Smoking rates have fallen, but the use of snuff tobacco and e-cigarettes has increased – especially among young women. The Committee considers this development concerning and calls for a more proactive tobacco policy. In autumn 2024, Sweden's public health objective was changed from reducing tobacco use to reducing the harm caused by tobacco and nicotine products. The Committee argues that this weakens public health policy and runs counter to the EU goal of achieving a tobacco-free generation.

Sweden has succeeded in keeping alcohol consumption low through a restrictive policy, but further measures are needed. Public awareness of the link between alcohol and cancer remains low, and the Committee highlights the need for improved health information and clear warning labels on alcoholic beverages.

In other areas linked to cancer risk – such as diet, physical activity and overweight – stronger, more coordinated efforts are required to support people in making healthy choices. Air pollution, often overlooked but an important risk factor, affects large parts of the population. The Committee calls for more proactive preventive work in this area as well.

Early detection – More screening programmes now available, but participation remains unequal

Early detection of cancer saves lives. One of the targets in EBCP is that 90 per cent of the eligible population should be offered screening for breast, cervical and colorectal cancer. Today, screening for breast and cervical cancer is fully implemented in all Swedish regions, while the rollout of colorectal cancer screening is still ongoing.

The Committee points out that the implementation of new screening programmes is slow, creating inequities in access to care. Although the National Board of Health and Welfare issues recommendations on national screening programmes, these are not binding, which contributes to variation across the country. The experience with colorectal cancer screening shows that it can take up to twelve years from recommendation to full implementation nationwide. The Committee believes that the chance of early detection should not depend on where in the country a person lives, and recommends that a national authority be given the mandate to issue binding regulations and finance the programmes.

Access alone does not determine the effectiveness of screening – participation is equally important. The Committee highlights large variations in participation between and within regions, and between different population groups.

Diagnosis and treatment – Progress made, but cohesive national action needed

EBCP emphasises the importance of equal access to high-quality diagnostics and treatment. It highlights the need for specialised cancer centres, multidisciplinary teams, innovative treatments and the development of precision medicine. A key initiative is to establish an EU network of national cancer centres for knowledge exchange and quality assurance.

The Committee notes that the quantitative goals in EBCP are vague, but that decisive action is required to achieve the vision of equitable and high-quality cancer care in Sweden. Today, there are significant regional differences in waiting times for diagnosis and treatment. The Committee stresses the need for a coordinated national approach with a clear roadmap, defined responsibilities and systematic follow-up.

Primary care, often the first point of contact in detecting cancer, needs better conditions to support early diagnosis and referral. This includes more permanent doctor–patient relationships, team-based ways of working that make full use of different professional skills, and improved methods for early detection.

The Committee also underlines the importance of ensuring equitable access to precision medicine. Legal and technical barriers that delay the sharing of diagnostic imaging between regions must be addressed. To enable collaboration and speed up diagnostics, a national infrastructure and clear legal interpretation of data sharing are essential.

Quality of life – Support for cancer patients and those close to them

EBCP stresses the importance of improving quality of life for people living with or after cancer and for their families. One goal is to implement the EU Directive 2019/1158, which aims to help families balance care and work life. The plan also raises the importance of patient-reported outcome measures to improve care based on patients' experiences and needs.

The Committee finds that Sweden has made progress in implementing the directive and in the use of patient-reported outcome measures through the Regional Cancer Centres and national quality registries. This work should continue, with stronger collaboration between patients, families and healthcare professionals. The updated national cancer strategy is expected to contribute positively to these efforts.

The Committee emphasises that improving quality of life requires a holistic approach addressing physical, psychological and social needs. It is not only about care and treatment, but also about how society and authorities can provide long-term support to people with cancer and those close to them. Continued efforts from the entire healthcare system and wider society are needed to ensure the right support in all aspects of life.

Prevention

Focus area: HPV

Selection of goals and initiatives in EBCP

Flagship initiatives

- Vaccinate at least 90 per cent of girls against HPV by 2030.
- "Significantly increase" the proportion of boys vaccinated against HPV by 2030, compared with 2021.

Other initiatives and actions

- Launch the EU Council Recommendation on cancers preventable through vaccination.

Committee's assessment

Sweden largely meets the objectives set out in the plan. However, to further strengthen protection against HPV infection and related cancers, efforts are needed to expand catch-up vaccination, especially for young men, and to set clearer national targets. The Committee considers that a gender-neutral national target should be introduced within the childhood vaccination programme, ensuring that 90 per cent of eligible children are vaccinated against HPV. Continued information efforts and equal access to vaccines across the country are essential to maintain and build on the current positive trend.

Basis for the assessment

In its assessment, the Committee has examined statistics on the proportion of girls and boys in the childhood vaccination programme who were vaccinated against HPV between 2021 and 2023, catch-up HPV vaccination among young adults, and Swedish recommendations for HPV vaccination in relation to the EU Council Recommendation on cancers preventable through vaccination.

1.1 Swedish national recommendations for HPV vaccination

In Sweden, boys and girls are offered the HPV vaccine free of charge through school health services in the fifth year of primary school, as part of the national childhood vaccination programme. This has been offered to girls since 2012 and to boys since 2020, covering all pupils regardless of where they live in Sweden or whether they have a personal identity number. Data are reported to the Public Health Agency of Sweden.

Sweden does not have formal national targets for HPV vaccination for either girls or boys, but it is considered a national priority. The country is already close to achieving the goal of having 90 per cent of girls fully vaccinated by 2030.

However, there is a national goal to eliminate cervical cancer, adopted by the Swedish Parliament in 2021 and supported by the then government[1]. In 2024, the government announced its continued commitment to eliminating cervical cancer and allocated specific funding to support the Regional Cancer Centres and the Swedish Cancer Society in promoting high and equitable HPV vaccination coverage.[2]

One of the main challenges Sweden faces in fully eliminating HPV-related cancers is the unequal participation in cervical cancer screening and catch-up vaccination programmes for young women. A national catch-up project was launched in 2020 with the aim of vaccinating 70 per cent of women born between 1994 and 1999. This age group was selected because they were not offered the HPV vaccine through the school-based programme introduced in 2012.[3]

There are also proposals for catch-up vaccination for boys and men. In 2024, the Public Health Agency of Sweden, commissioned by the government, produced a knowledge base and a health-economic analysis on catch-up HPV vaccination for boys and young men who have not yet been vaccinated. The analysis also included targeted vaccination for men who have sex with men, transgender people and individuals living with HIV. The review concluded that HPV vaccination is needed in these groups and is considered cost-effective in relation to the health benefits that can be achieved, particularly if vaccination is offered up to the age of 26. Generally, regions are responsible for specific vaccination initiatives, including decisions on organisation and funding.[4]

In June 2024, the EU Council adopted a Recommendation on cancers preventable through vaccination (C/2024/4259), which the Swedish government endorsed. The recommendation highlights the importance of maintaining high public confidence in vaccination. Confidence in HPV vaccination in Sweden – at least for children – is considered high, as parents

or guardians must provide written consent before their child is vaccinated.[5]

1.2 HPV vaccination coverage within the childhood vaccination programme

According to the latest figures from the Public Health Agency of Sweden (2023), 87 per cent of 12-year-old girls were fully vaccinated against HPV – an increase of four percentage points since 2021. Among boys of the same age, coverage reached 82 per cent, also up by four points over the same period. In Sweden, full vaccination means receiving two doses of the HPV vaccine.

Coverage among both girls and boys was already relatively high in 2021. The biggest gains were made when HPV vaccination was introduced into the national childhood vaccination programme – from 2012 for girls and from 2020 for boys. The Public Health Agency notes that data collected before 2021 were compiled using different methods and are therefore not directly comparable with more recent statistics.[6]

Girls (annual and regional statistics)

HPV vaccination coverage, girls aged 12 (two doses)	2021	2022	2023
SWEDEN (TOTAL)	83%	88%	87%
Blekinge	83%	89%	89%
Dalarna	77%	86%	85%
Gotland	79%	93%	84%
Gävleborg	87%	89%	88%
Halland	87%	91%	89%
Jämtland	80%	87%	87%
Jönköping	88%	88%	89%
Kalmar	85%	87%	89%
Kronoberg	81%	85%	85%
Norrbotten	80%	85%	84%
Skåne	83%	86%	86%
Stockholm	81%	87%	86%
Södermanland	83%	87%	89%
Uppsala	89%	89%	89%
Värmland	89%	91%	90%
Västerbotten	89%	90%	91%
Västernorrland	82%	88%	91%
Västmanland	84%	89%	87%
Västra Götaland	84%	88%	87%
Örebro	84%	89%	88%
Östergötland	85%	88%	90%

By 2023, 87 per cent of girls were fully vaccinated, and four of Sweden's 21 regions had already reached the EU target of at least 90 per cent coverage within the target group.

The rate of improvement between 2021 and 2023 varied across regions. Some saw faster progress than others. In Västernorrland, coverage among girls rose by almost ten percentage points to 91 per cent. Together with Västerbotten, the region recorded the highest coverage in Sweden. The lowest rates were found in Norrbotten and on Gotland, although coverage there also increased – from 79 per cent in 2021 to 84 per cent in 2023. The gap between the highest- and lowest-performing regions narrowed from 12 percentage points in 2021 to 7 in 2023. Overall, coverage rose in almost all regions, resulting in greater equity nationwide.

The data also show wider variation between municipalities than between regions, although this gap has narrowed considerably between 2021 and 2023. In 2021, one municipality had vaccinated all girls, while another had reached only 10 per cent. By 2023, the lowest-performing municipality had increased its rate to 41 per cent. The number of municipalities with less than 70 per cent coverage fell from 27 in 2021 to only nine in 2023, while those with at least 90 per cent coverage rose from 53 to 93 over the same period.

Boys (annual and regional statistics)

HPV vaccination coverage, boys aged 12 (two doses)	2021	2022	2023
SWEDEN (TOTAL)	78%	83%	82%
Blekinge	79%	83%	84%
Dalarna	70%	80%	80%
Gotland	81%	85%	84%
Gävleborg	81%	84%	84%
Halland	80%	86%	86%
Jämtland	76%	85%	85%
Jönköping	82%	85%	84%
Kalmar	80%	82%	84%
Kronoberg	76%	79%	78%
Norrbotten	74%	82%	79%
Skåne	77%	81%	80%
Stockholm	76%	81%	80%
Södermanland	76%	83%	83%
Uppsala	83%	85%	84%
Värmland	84%	85%	86%
Västerbotten	85%	88%	87%
Västernorrland	79%	87%	85%
Västmanland	78%	83%	84%
Västra Götaland	78%	84%	83%
Örebro	79%	84%	83%
Östergötland	80%	85%	86%

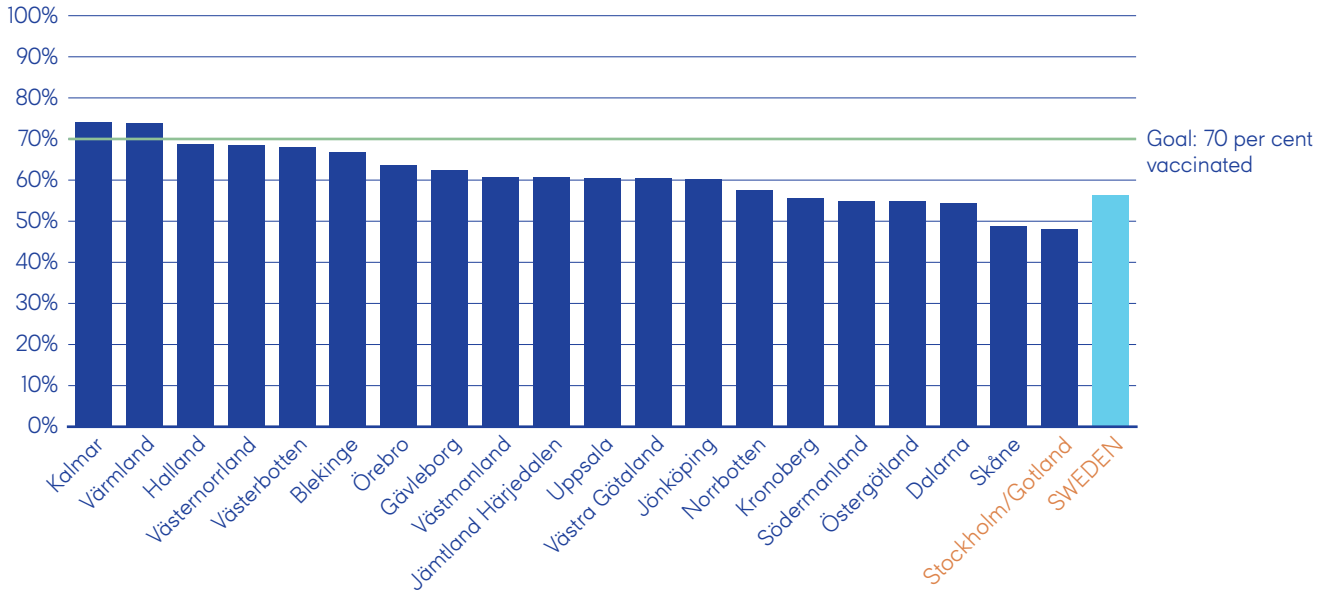
In 2023, 82 per cent of 12-year-old boys were fully vaccinated against HPV. The increase from 2021 mirrored that seen among girls – four percentage points. Some regions made faster progress than others, such as Dalarna and Jämtland, where coverage rose by ten percentage points. Västerbotten recorded the highest proportion of vaccinated boys in all three years, while Kronoberg had the lowest in both 2023 and 2022. The gap between regions also narrowed, from 15 percentage points in 2021 to 9 in 2023. Overall, vaccination coverage improved in nearly all regions, resulting in greater equity nationwide.

The data show that variation in vaccination coverage among boys is wider between municipalities than between regions, although this gap has narrowed considerably since 2021. In both 2021 and 2023 there were municipalities where all boys had been vaccinated. The lowest municipal coverage increased from 4 per cent in 2021 to 37 per cent in 2023. The number of municipalities where at least 90 per cent of boys are vaccinated has also risen, doubling since 2021 to reach 24 in 2023. At the same time, the number of municipalities with less than 70 per cent coverage has fallen sharply – from 57 in 2021 to 16 in 2023.

1.3 Catch-up vaccination

As previously mentioned, Sweden has a national catch-up programme for HPV vaccination aimed at women born between 1994 and 1999. The goal of this elimination project is for 70 per cent of this group to be vaccinated. As of April 2025, 53 per cent of women in the target group had received the vaccine, but there were significant differences both between and within regions. Two regions – Kalmar and Värmland – had already reached the goal, and several others were expected to do so during spring 2025. In the metropolitan regions, such as Stockholm and Skåne, coverage was lower – around 45 per cent – meaning these regions still had some way to go. The data also indicate that certain groups, such as people living in rural or socio-economically disadvantaged areas, are less likely to be vaccinated.[7]

HPV catch-up vaccination coverage among women born 1994–1999. Data as of 6 April 2025.



Source: https://cancercentrum.se/utrotalivmoderhalscancer

Focus area: Hepatitis B

Selection of goals and initiatives in EBCP

- Launch an EU Council Recommendation on cancers preventable through vaccination, supporting the WHO target that 95 per cent of children should be vaccinated against Hepatitis B, and improving access to vaccination for adults in risk groups.

Committee's assessment

Sweden meets the target in the plan to vaccinate 95 per cent of children. However, when it comes to vaccination for adults in risk groups – such as people who inject drugs – there are regional differences in both who is offered vaccination and how many receive it. The Committee considers such differences unacceptable. It therefore recommends that vaccination programmes should be regulated and financed by the state.

Basis for the assessment

For the period 2021–2024, the Committee reviewed statistics on vaccination coverage for Hepatitis B in regional childhood vaccination programmes and on newly reported cases of the disease. The Committee also examined how many regions offer free vaccination for adults in risk groups, what measures have been taken by the government, regions and authorities to reduce new cases of Hepatitis B, and how Sweden's vaccination recommendations relate to the EU Council Recommendation on cancers preventable through vaccination.

2.1 Measures taken by the government, regions and national agencies to reduce new cases of Hepatitis B, 2021–2024

A Hepatitis B infection can become chronic and develop into liver disease, cirrhosis or liver cancer. In 2021, 30 EU and EEA countries reported 16,187 newly diagnosed Hepatitis B infections, of which a large share – 43 per cent – were classified as chronic. Despite a steady decline in the overall incidence of Hepatitis B over time, thanks to effective vaccination programmes and other preventive strategies, it is estimated that around 3.6 million people in the EU and EEA countries are living with a chronic Hepatitis B infection.[8]

In 2016, the World Health Organization (WHO) set a goal to eliminate Hepatitis B and C virus infections as major public health threats by 2030. The target includes a 90 per cent reduction in new infections (incidence) and a 65 per cent reduction in Hepatitis B- and C-related deaths compared with 2015 levels.[9]

According to the Public Health Agency of Sweden's status report from summer 2024, the number of reported cases of Hepatitis B and C has decreased in recent years. Continued work is, however, needed to achieve the WHO elimination goals, as there are still people with undiagnosed Hepatitis B and C who need to be identified. Chronic Hepatitis B occurs mainly among people infected in childhood in high-endemic countries who have later moved to Sweden, and the number of domestically acquired cases has decreased sharply between 2015 and 2023.[10]

In Sweden, the regions, through the National System for Knowledge Management and the National Programme Area (NPO) for Infectious Diseases, have identified Hepatitis as a priority area. A national working group (NAG) for Hepatitis has developed a national plan for the elimination of Hepatitis C, which was published in 2022. A similar plan for Hepatitis B was announced but has not yet been launched. As a result, the Swedish government and the relevant authorities have not yet implemented specific national measures to further reduce the number of new Hepatitis B cases.[11]

2.2 Swedish national recommendations for Hepatitis B vaccination

The Public Health Agency of Sweden last published its recommendations on Hepatitis B vaccination in 2019.[12] The following groups are covered by the recommendations:

- infants
- people who inject drugs
- men who have sex with men
- people with chronic Hepatitis C
- people living with HIV
- people with renal failure and/or receiving dialysis treatment
- sexual partners of people with Hepatitis B
- family members of people with Hepatitis B
- children up to 18 years of age originating from medium- or high-endemic countries
- parents and siblings of adopted children from medium- or high-endemic countries
- children and staff in childcare settings where a child has Hepatitis B
- individuals in care settings who come into contact with people with Hepatitis B
- Occupations that may involve an increased risk of exposure to Hepatitis B are covered by

the employer's responsibility to assess infection risks in the workplace and, where necessary, to offer and pay for vaccination in accordance with the Swedish Work Environment Authority's regulations on infection risks

In 2016, the Public Health Agency of Sweden submitted advice to the government recommending that Hepatitis B be included in the national vaccination programme. The government reviewed the proposal but decided in 2017 not to proceed. Despite this, the Agency maintained its recommendation, and from that same year all regions have introduced vaccination against Hepatitis B for children at one year of age, provided free of charge.[13, 14]

As mentioned in the section on HPV, the EU Council adopted a Recommendation in June 2024 on cancers preventable through vaccination, which the Swedish government endorsed. Regarding Hepatitis B, the Recommendation calls on Member States to strengthen their national efforts to achieve the 2030 goal of eliminating viral hepatitis – including Hepatitis B – as a public health threat within the WHO European Region. It also highlights the need to intensify efforts towards the WHO 2030 targets, including the goal that at least 95 per cent of children should receive three doses of the Hepatitis B vaccine.[15]

The Recommendation further stresses the importance of reaching adults in specific risk groups. Member States are encouraged to implement targeted actions to improve access to Hepatitis B vaccination for vulnerable populations. These include people who inject drugs, people in prison, individuals experiencing homelessness, people engaged in high-risk sexual behaviour (such as sex workers), men who have sex with men, transgender people, and migrants, asylum seekers and refugees from countries where Hepatitis B is endemic. Healthcare workers are also among the target groups.

The Recommendation states that particular attention should be given to people who inject drugs. This includes measures to provide low-threshold vaccination services and to ensure that Hepatitis B vaccination is routinely offered in connection with drug treatment, imprisonment and harm-reduction services. Vaccination should be voluntary, provided in a non-stigmatising environment, free of charge for the individual, and with access to an accelerated dosing schedule.

2.3. Regions offering Hepatitis B vaccination free of charge for adults in risk groups

All 21 regions were asked whether they offer Hepatitis B vaccination free of charge for adults in risk groups. Four regions – Kronoberg, Västmanland, Örebro and Östergötland – did not respond.

Of the 17 regions that replied, 16 reported that they offer vaccination free of charge for certain adult risk groups. Region Blekinge reported that it does not offer Hepatitis B vaccination free of charge for adults in risk groups.[16]

Region	Adult risk groups eligible for Hepatitis B vaccination free of charge
Dalarna	Regional healthcare employees whose work involves a risk of exposure to blood-borne infection are offered Hepatitis B vaccination following an occupational risk assessment.
Gotland	People who inject drugs intravenously.
Gävleborg	Individuals assessed by a physician as eligible for vaccination at the low-threshold clinic Södertull and at addiction clinics in Region Gävleborg.
Halland	– People who inject drugs – Men who have sex with men – Sexual partners of people with Hepatitis B – Family members of people with Hepatitis B
Jämtland Härjedalen	Healthcare staff, and students enrolled in healthcare education programmes within Region Jämtland Härjedalen.
Jönköping	In line with the Public Health Agency of Sweden's recommendations from 2019.
Kalmar	In line with the Public Health Agency of Sweden's recommendations from 2019, and individuals enrolled in opioid substitution treatment (LARO).
Norrbotten	In line with the Public Health Agency of Sweden's recommendations from 2019.
Skåne	– Patients with Hepatitis C or HIV – People who inject drugs – Relatives of people with Hepatitis B – Men who have sex with men
Stockholm	– People who inject drugs – Men who have sex with men – Sexual partners of people with Hepatitis B – Family members of people with Hepatitis B – Staff working in the same childcare group as young children (<6 years) with Hepatitis B
Sörmland	– Patients with significantly impaired immune function due to illness or treatment – People who inject drugs intravenously – Patients with chronic Hepatitis B or C
Uppsala	In line with the Public Health Agency of Sweden's recommendations from 2019.
Värmland	In line with the Public Health Agency of Sweden's recommendations from 2019.

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Region	Adult risk groups eligible for Hepatitis B vaccination free of charge
Västerbotten	– People who inject drugs – People with Hepatitis C or other liver diseases, and individuals awaiting liver transplantation – People living with HIV – Relatives of people with Hepatitis B – Hospital staff working in direct patient care
Västernorrland	– Men who have sex with men – People who inject drugs
Västra Götaland	– People who inject drugs intravenously – Men who have sex with men – Sexual partners of confirmed chronic carriers of the Hepatitis B virus, and household contacts of HBsAg-positive individuals – Newborn children of mothers with Hepatitis B virus infection – Dialysis and transplant patients

The table shows variation between regions in which groups are offered Hepatitis B vaccination free of charge. Only five regions – Jönköping, Kalmar, Norrbotten, Uppsala and Värmland – state that they fully follow the Public Health Agency of Sweden's 2019 recommendations. The risk group most consistently mentioned in the regional reports is people who inject drugs; this group is offered vaccination free of charge in 15 regions. Men who have sex with men (MSM) are the second most frequently mentioned group, appearing in 10 regions.

The Committee is concerned that most regions do not fully follow the Public Health Agency's recommendations on vaccination for risk groups. It is simply not acceptable that access to vaccination depends on where in the country a person lives. This situation means that people's risk of developing serious forms of cancer effectively varies from one region to another.

In light of this, the Committee believes that the state must take full responsibility for ensuring that vaccinations are offered in a consistent manner across the country. This could be achieved by giving a national authority a legal mandate to determine which risk groups should be offered vaccination. Within such a mandate, the authority would also hold national responsibility for ensuring that the recommended vaccines are available and that communication with the public is coordinated and consistent. Such a change would probably also require the state to fund vaccinations provided in line with national recommendations. Later in the report, the Committee presents a similar argument in relation to screening.

2.4 Vaccination coverage for Hepatitis B in regional childhood vaccination programmes

With a vaccination rate of 94 per cent, Sweden is very close to reaching the WHO target that 95 per cent of children should receive three doses of the Hepatitis B vaccine – several years ahead of 2030. In fact, all regions, with the exception of Stockholm and Västra Götaland, already meet the target. Vaccination rates have remained stable between 2021 and 2023. As with HPV vaccination, the largest increases were seen when vaccination free of charge was introduced, around 2016. However, complete statistics on the number of children vaccinated against Hepatitis B are not available. Separate data from investigations, press releases and media reports indicate a significant increase since at least 2011.[17, 18] At that time, 38 per cent of children had been vaccinated against Hepatitis B. At regional level, the following figures were reported for 2011:

- Norrbotten 14 per cent (when vaccination free of charge was introduced the following year, the rate rose to 70 per cent)
- Gotland 14 per cent (when vaccination free of charge was introduced the following year, the rate rose to 20 per cent)
- Dalarna 21 per cent (vaccination free of charge was introduced the same year, increasing the rate to 43 per cent within six months)
- Stockholm 43 per cent (the first year vaccination free of charge was offered)
- Jönköping 89 per cent (not free of charge during this period)
- Örebro 91 per cent (not free of charge during this period)

Statistics from the Public Health Agency of Sweden – by region, 2021–2023

Region	2021	2022	2023
SWEDEN	93%	94%	94%
Blekinge	97%	97%	96%
Dalarna	93%	96%	97%
Gotland	96%	95%	97%
Gävleborg	97%	96%	96%
Halland	91%	91%	96%
Jämtland Härjedalen	88%	96%	95%
Jönköping	95%	96%	97%
Kalmar	97%	97%	97%
Kronoberg	95%	95%	95%
Norrbotten	95%	94%	95%
Skåne	92%	94%	96%
Stockholm	91%	91%	92%

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Region	2021	2022	2023
Södermanland	96%	96%	96%
Uppsala	96%	95%	95%
Värmland	97%	95%	95%
Västerbotten	96%	95%	96%
Västernorrland	96%	96%	97%
Västmanland	96%	96%	96%
Västra Götaland	92%	94%	94%
Örebro	94%	95%	95%
Östergötland	95%	95%	97%

Several regions in Sweden have maintained a very high proportion of children receiving the Hepatitis B vaccine throughout the entire period from 2021 to 2024. In Östergötland, Kalmar and Blekinge counties, between 96 and 97 per cent of children have been vaccinated each year. At the same time, there are regions where coverage has been slightly lower. In Stockholm County, the figure has remained at 91–92 per cent throughout the period, which is below the national average. Halland was at a similar level in 2021–2022 but showed an increase from 2023 onwards.

2.5. New reported cases of hepatitis B, 2021–2024

Region	2021		2022		2023		2024	
	Number	Per 100 000	Number	Per 100 000	Number	Per 100 000	Number	Per 100 000
SWEDEN	708	7	812	8	655	6	521	5
Blekinge	17	11	8	5	2	1	2	1
Dalarna	18	6	24	8	7	2	15	5
Gotland	2	3	2	3	3	5	0	0
Gävleborg	13	5	27	9	13	5	7	2
Halland	18	5	26	8	18	5	13	4
Jämtland	7	5	8	6	0	0	1	1
Jönköping	12	3	28	8	17	5	16	4
Kalmar	6	2	16	6	10	4	6	2
Kronoberg	10	5	7	3	11	5	8	4
Norrbotten	12	5	15	6	19	8	11	4
Skåne	86	6	103	7	80	6	63	4
Stockholm	252	10	251	10	254	10	206	8
Södermanland	30	10	26	9	12	4	14	5
Uppsala	34	9	31	8	25	6	20	5
Värmland	13	5	14	5	18	6	7	2
Västerbotten	12	4	14	5	11	4	17	6
Västernorrland	7	3	11	5	7	3	6	2
Västmanland	10	4	21	7	9	3	8	3
Västra Götaland	111	6	142	8	103	6	76	4
Örebro	20	7	18	6	11	4	13	4
Östergötland	18	4	20	4	25	5	12	3

Between 2021 and 2024, Sweden has seen a decline in the number of reported cases of Hepatitis B – both in absolute numbers and per 100,000 population. At national level, the total number of reported cases fell from 708 cases (6 per 100,000) in 2021 to 521 cases (5 per 100,000) in 2024. This represents a decrease of around 26 per cent in absolute terms, corresponding to a reduction in incidence of 2 per 100,000 population. Compared with 1997, when Sweden reported 1,571 cases (18 per 100,000), the national incidence rate has almost halved.

Focus area: Tobacco

Selection of goals and initiatives in EBCP

- Achieve a tobacco-free generation
  - Less than 5 per cent of the population using tobacco by 2040.
  - A relative reduction in tobacco consumption of 30 per cent by 2025 compared with 2010.
- Incorporation of EU legislation and full implementation of the WHO Framework Convention on Tobacco Control (FCTC).
- Update the EU Council Recommendation on smoke-free environments.

Committee's assessment

Sweden does not fully meet the target of achieving a tobacco-free generation. Although smoking has continued to decline across the population, there has been a slight increase among upper secondary school students in recent years. As for tobacco use more broadly, the trend is negative due to the rise in the use of snus, particularly among young women. Research shows that all forms of tobacco use have harmful effects, and that using one type of tobacco product can lead to the use of others.

The Committee finds that the new tobacco policy goal announced by the government in the 2025 Budget Bill is not in line with the WHO and EU objective of a tobacco-free generation. The new goal focuses on reducing the harmful effects of tobacco and nicotine rather than reducing overall use. The Committee also believes that knowledge about the negative health effects of snus and e-cigarette use should be more widely communicated to the public, and that the government should consider assigning a relevant authority to lead this work.

Regarding the Framework Convention on Tobacco Control, Sweden largely meets the objective of full implementation. However, the Committee considers that rules should be in place to ensure full transparency regarding all contacts between the tobacco industry and political decision-makers.

Sweden largely complies with the EU Council Recommendation on smoke-free environments.

Basis for the assessment

For its assessment, the Committee reviewed statistics on tobacco use among children and adults between 2010 and 2024. It also examined measures taken by the government, regions and agencies between 2021 and 2024 to achieve a tobacco-free generation, as well as how the WHO Framework Convention on Tobacco Control is implemented and enforced in Sweden. Finally, the Committee compared Swedish legislation and guidelines on smoke-free environments with the EU Council Recommendation on smoke- and aerosol-free environments.

3.1 Measures taken by the government, regions and national agencies between 2021 and 2024 to achieve a tobacco-free generation

Sweden's efforts to reduce tobacco use take place at national, regional and local levels and are guided by the comprehensive ANDTS strategy. This strategy aims to reduce harm caused by alcohol, narcotics, doping and tobacco. It was introduced in the government Bill A comprehensive strategy for alcohol, narcotics, doping and tobacco policy and originally applied to the period 2011–2015.[19]

The National Board of Health and Welfare has developed national guidelines for the treatment of unhealthy lifestyle habits. These were first published in 2011, revised in 2018 and updated again in 2024, with new recommendations on the use of snus following new studies showing that it is more harmful than previously thought.[20] However, recommendations on e-cigarettes are still lacking, as knowledge about their long-term health risks and effective methods for helping users to quit remains limited.

The Public Health Agency of Sweden reports that smoking among school pupils is decreasing, but the use of snus has risen sharply. Among the population aged 16–81, the proportion of daily smokers has fallen, while the use of snus and e-cigarettes has increased significantly, especially among young people. The Agency therefore recommends that tobacco and nicotine products should be regulated in a similar way to cigarettes, to provide greater protection for children and young people.[21]

On 1 November 2024, the Swedish government increased taxes on cigarettes, cigarillos, smoking tobacco and other tobacco products by 9 per cent, while reducing the tax on snus by 20 per cent. This

adjustment, decided at national level, marks a clear shift in Sweden's tobacco tax policy. In Sweden, tobacco and nicotine taxes are generally structured according to the level of health risk, with higher taxes applied to more harmful products. The government stated that the tax on snus should be lower than that on cigarettes and smoking tobacco, as the latter are considered to pose a greater health hazard. The Swedish government justified the decision by stating that, in its view, snus entails less health risk than cigarettes and smoking tobacco.[22]

At the same time the government announced a change to its national tobacco policy goal. The previous objective – to reduce tobacco use – has been replaced with a focus on "reducing the medical and social harm caused by tobacco". This marks a move away from the long-term ambition of a tobacco-free generation and runs counter to both the EU's Beating Cancer Plan and the WHO strategy, which aim to reduce all tobacco use and improve public health.

Comparison with Nordic countries

In 2016 the government adopted the goal of a smoke-free Sweden by 2025, defined as fewer than five per cent of the population smoking. However there is no comprehensive strategy in place to achieve this, nor is there a national goal for a tobacco-free generation in line with the EU Cancer Plan.

By comparison Sweden's Nordic neighbours have set clearer and more ambitious targets. Denmark aims for a smoke-free generation by 2030 while Finland and Norway are working towards 2035 and 2040 respectively. Denmark and Norway have introduced progressive measures including plain packaging, bans on the display of cigarettes in shops and large-scale campaigns aimed at young people. Finland stands out through its Tobacco-Free Finland 2030 strategy which includes strict rules on e-cigarettes and flavoured products alongside a long-term focus on smoking cessation. Iceland has the lowest proportion of smokers among the four countries but does not have a specific target for a tobacco-free generation. It does however enforce extensive restrictions on sales and advertising as well as high tobacco taxes.

3.2 Full implementation of the WHO Framework Convention on Tobacco Control in Sweden

The WHO Framework Convention on Tobacco Control (FCTC) was adopted in 2003 and entered into force in 2005.[23] Tobacco products covered by the Convention are defined as "products entirely or partly made of the leaf tobacco as raw material and manufactured to be used for smoking, sucking, chewing or snuffing". Tobacco control is defined as "a range of supply, demand and harm reduction strategies that aim to improve the health of a population by eliminating or reducing tobacco consumption and exposure to tobacco smoke".

The objective of the Convention is to "protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke by providing a framework for tobacco control measures to be implemented by the Parties at national, regional and international levels in order to continuously and substantially reduce tobacco consumption and exposure to tobacco smoke". Sweden signed the Convention in 2003, which led to subsequent changes in Swedish tobacco legislation. The Convention entered into force in 2005. The countries that are Parties to the Convention submit annual reports describing their compliance with its provisions, based on seven criteria. The most recent report from Sweden was submitted in 2023. In terms of the technical aspects covered in the report, Sweden's compliance is strong. However, the country has been criticised for not having a comprehensive ban on tobacco advertising and for lacking legislation that fully prohibits smoking in public places and workplaces.[24]

Article 5.3 of the Convention emphasises the importance of protecting public health policy from the influence of commercial and other vested interests of the tobacco industry. This means that political decision-makers should minimise contact with representatives of the tobacco industry and, where such contact is necessary, ensure full transparency regarding those interactions. Furthermore, the tobacco industry's role should be limited to regulation only, without any opportunity to influence policy processes. In Sweden, implementation of Article 5.3 has been inadequate, and this area has been a particular focus of criticism. According to a report from Tobaksfakta, Sweden lacks clear guidelines and mechanisms to prevent the tobacco industry from influencing public health policy.[25]

3.3 Swedish legislation and guidelines on smoke-free environments in relation to the EU Council Recommendation on smoke- and aerosol-free environments

In the EBCP, the European Commission announced its intention to update the EU Council Recommendation on smoke-free environments. One of the Plan's tobacco-related objectives is to help create a "tobacco-free generation", defined as fewer than five per cent of the population using tobacco by 2040, compared with around 25 per cent today. The review of the Council Recommendation on smoke-free environments is an initiative intended to support this goal, aiming to strengthen protection for people in the Union from second-hand smoke from combustible tobacco products and from aerosols generated by new products, while promoting smoking cessation and the denormalisation of smoking and nicotine use.

This new Recommendation has a broader scope than Recommendation 2009/C 296/02, which it replaces. Its purpose is to better protect people in the Union from exposure to second-hand smoke and aerosols, to support the tobacco-related objectives of the EBCP, and to reduce the prevalence and social normalisation of smoking and the use of new products.[26]

The EU Council Recommendation on smoke- and aerosol-free environments was adopted in December 2024. In summary, Swedish legislation and guidelines on smoke-free environments are largely consistent with the EU Council Recommendation on smoke- and aerosol-free environments. However, to achieve full alignment, Swedish legislation will need to be reviewed – in particular with regard to recreational areas and outdoor spaces associated with healthcare facilities, not only at their entrances.

It should also be considered whether other settings – for example private vehicles carrying children, minors or vulnerable individuals – could be included in complementary measures to prevent the use of and dependence on tobacco and nicotine, and to help ensure fully smoke- and aerosol-free environments.

According to the minutes of the Parliamentary Committee on Social Affairs (2024/25:5), the government expressed general support for the proposal, and there was overall cross-party agreement with the government's position.[27] For a full comparison, see Appendix 1.

3.4 Proportion of Sweden's population using tobacco and changes in tobacco use, 2010–2024

3.4.1 Adults

In recent years Sweden has seen positive developments in relation to smoking. This progress is a good indicator of public health improvement and reflects long-term public health initiatives and increased awareness of the harmful effects of smoking.

Smoking in Sweden has declined markedly between 2010 and 2024. The proportion of people who smoke daily has halved, from 13 per cent in 2010 to 5 per cent in 2024. Occasional smoking has also fallen sharply, from 11 per cent to 6 per cent. Overall, the share of the population who smoke – daily or occasionally – has decreased from 24 per cent to 11 per cent.

- Decline across all groups: Smoking has fallen sharply in all age groups, with the greatest decrease among young people (16–29 years).
- Fewer occasional smokers: The decline in occasional smoking mirrors the fall in daily smoking, suggesting a broad shift in social attitudes.
- Age-related differences: Among older adults (65–84 years) the decline has been slower, possibly reflecting more entrenched habits in older generations.

Tobacco use in the population in 2010 and 2024, and percentage change between the periods

	Total			Women			Men		
	2010	2024		2010	2024		2010	2024	
Daily tobacco smokers	13	5	-7	13	6	-8	12	5	-7
Tobacco smokers (daily or occasional)	24	11	-13	23	11	-12	25	11	-14
Daily snus users	12	16	+4	4	10	+6	20	22	+2
Snus users (daily or occasional)	17	20	+3	7	13	+6	26	26	0
Daily tobacco users	23	16	-7	17	10	-7	30	22	-7
Tobacco users (daily or occasional)	33	22	-11	26	15	-11	39	29	-10

Proportion of smokers (daily and occasional) by age group, 2010–2013 and 2021–2024, and percentage change between the periods

	Age 16-29			Age 30-44			Age 45-64			Age 65-84		
	2010	2024		2010	2024		2010	2024		2010	2024	
Daily tobacco smokers	11	2	-8	10	5	-5	17	6	-11	11	7	-4
Occasional tobacco smokers	22	10	-13	13	6	-7	8	5	-3	2	3	0
Tobacco smokers (daily or occasional)	33	12	-21	23	11	-12	25	11	-14	13	10	-3

Tobacco use – Change 2010–2024 – Young adults (16–29 years)						
	Age 16-29			Age 65-84		
	2010	2024		2010	2024	
Daily snus users	5	18	+13	20	20	0
Occasional snus users	8	7	-1	12	9	-3
Snus users (daily or occasional)	12	24	+12	32	29	-3
Daily tobacco smokers	13	3	-10	9	2	-7
Occasional tobacco smokers	21	9	-12	23	10	-13
Tobacco smokers (daily or occasional)	34	12	-22	32	13	-20

While tobacco smoking has decreased, the use of other tobacco and non-medical nicotine products has risen — a development that is concerning and requires continued attention. This is particularly evident in the increasing use of snus among young adults (16–29 years).

Notably, this increase is almost entirely driven by young women. Among young men, snus use has remained largely unchanged between 2010 and 2024. The total proportion of snus users (either daily or occasionally) has fallen slightly from 32 to 29 per cent. This is mainly due to a decrease in occasional use. The proportion of daily snus users remains stable at 20 per cent. Among young women, however, the total proportion of snus users has doubled – from 12 to 24 per cent. Most of this increase comes from daily use, which has risen sharply from 5 to 18 per cent – a relative increase of around 260 per cent.

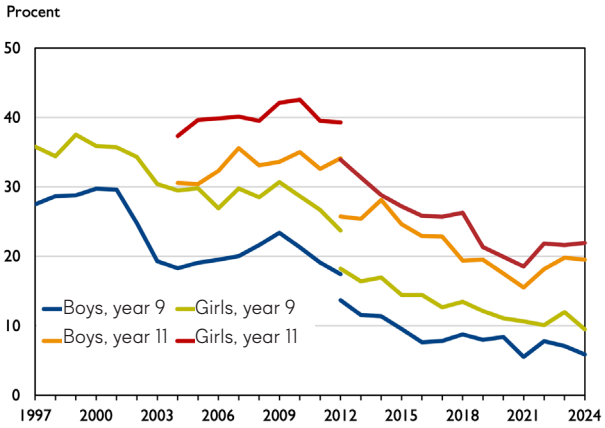
3.4.2 Children

The CAN national school survey has been conducted annually since 1971 and monitors, among other things, tobacco and nicotine use among children and young people.[28]

Cigarette smoking among Swedish school pupils peaked in the mid-1970s, when around 30 per cent of ninth-grade students smoked regularly or occasionally. Since then, smoking has declined significantly, particularly during the 2010s. In the most recent survey, 8 per cent of ninth-grade pupils reported that they smoke. Among these, occasional smoking (7 per cent) was more common than daily smoking (1 per cent). Throughout the survey period, girls have consistently smoked more than boys.

Among upper secondary school students, smoking has also decreased during the 2010s. In 2012, 30 per cent said they smoked, but by 2024 this figure had fallen to 21 per cent. However, over the past three years there has been a small but statistically significant increase,

Proportion of students who smoke (daily, almost daily or occasionally), by sex and school year, 1997–2024. **Figure from CAN National School Survey, 2024.**



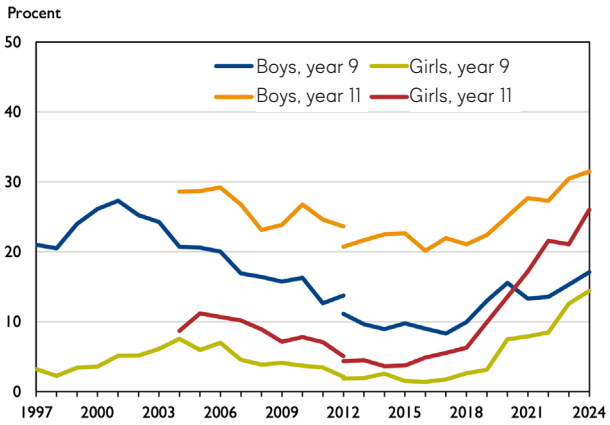
meaning that smoking levels are now similar to those observed before the COVID-19 pandemic. As among ninth-graders, occasional smoking (19 per cent) is more common than daily smoking (2 per cent). Girls have also smoked more than boys throughout the survey period.

In this section, the term snus is used as a collective term covering both traditional brown tobacco snus and white nicotine snus. The proportion of ninth-grade pupils who are snus users declined sharply during the 2000s. In the early 2010s, the decline levelled off, and from 2017 a clear increase can be observed. In the 2024 survey, 16 per cent of ninth-graders reported being snus users, compared with 5 per cent in 2017. The increase has occurred among both boys and girls, but has been particularly pronounced among girls, who now use snus at historically high levels (14 per cent). Nevertheless, snus use remains more common among boys (17 per cent), and this difference is statistically significant. Unlike cigarette smoking, ninth-graders are more likely to be daily snus users (10 per cent) than occasional users (6 per cent).

Among upper secondary school students, snus use also declined during the 2000s but has risen sharply in recent years. In 2024, 29 per cent of upper secondary students (eleventh grade) reported being snus users, compared with 13 per cent in 2012 when use was at its lowest. The largest increase has occurred among girls, whose proportion of snus users has risen from 4 to 26 per cent over the past decade. Although the increase has been most pronounced among girls, snus use remains more common among boys. In this year's survey, 31 per cent of boys reported that they are snus users, and 26 per cent of girls reported that they are snus users. As in ninth grade, upper secondary students are more likely to be frequent snus users (21 per cent) than occasional users (8 per cent).

In recent years, patterns of snus use have been strongly influenced by the introduction of white snus, which entered the Swedish market in 2016. In 2024, 25 per cent of ninth-grade students reported using only white snus, 1 per cent only traditional brown snus, and 5 per cent both types. Among upper secondary students, the corresponding figures were 40 per cent for white snus, 3 per cent for brown snus, and 9 per cent for both. Only 2–3 per cent of girls in both grades had ever used brown snus.

Proportion of students who use snus (daily, almost daily or occasionally), by sex and school year, 1997–2024. **Figure from CAN National School Survey, 2024.**



Focus area: Alcohol

Selection of goals and initiatives in EBCP

- Achieve a relative reduction of at least 10 per cent in harmful alcohol consumption by 2025.
- Introduce mandatory labelling of ingredients and nutritional information on alcoholic beverages.
- Propose health warnings on alcoholic beverages.
- Reduce young people's exposure to online marketing of alcoholic products.

Committee's assessment

Sweden partly meets the objectives set out in the plan for the alcohol area. However, the Committee considers that consumption needs to be reduced further and supports the continuation of a restrictive alcohol policy. Stronger efforts are also needed to raise public awareness of the link between alcohol and cancer risk. The Committee therefore recommends that the government consider assigning a suitable authority to carry out this task.

The Committee also proposes the introduction of health warnings and nutritional labelling on alcoholic products. It further notes that, at present, there is no general public information on safe or risk levels of alcohol consumption — something that would be reasonable, in line with information about other harmful substances published by relevant authorities.

Basis for the assessment

For its assessment, the Committee has examined statistics on the proportion of the population categorised as risky drinkers (those with harmful alcohol consumption) between 2010 and 2025, as well as measures taken by the government, regions and national agencies between 2021 and 2024 to reduce harmful alcohol consumption in Sweden.

4.1 Measures taken by the government, regions and national agencies between 2021–2024 to reduce harmful alcohol consumption in the population

There is no safe level of alcohol consumption when it comes to cancer risk. Research shows that any alcohol consumption increases the risk of certain types of cancer. When terms such as "risky drinking" or "harmful alcohol consumption" are used, they refer to levels associated with the risk of abuse and dependence. It is important to understand that even moderate alcohol consumption can increase the risk of cancer, and that there is no level of alcohol consumption that is entirely safe in this regard.

Sweden's work to reduce harmful alcohol consumption in the population takes place at national, regional and local level and, as with tobacco policy, is guided by the comprehensive ANDTS strategy. The objective of Swedish alcohol policy is to promote public health by reducing the medical and social harm caused by alcohol. This goal is to be achieved through measures that counter harmful drinking behaviour and contribute to reduced overall consumption. Swedish alcohol policy is based on the understanding that the availability of alcohol affects total consumption and the extent of alcohol-related harm. To achieve the alcohol policy objective and bring about a reduction in consumption, effective protective legislation is required. The core instruments are alcohol taxation, the retail monopoly on alcoholic beverages and restrictive regulation of alcohol marketing.[29]

Through tax provisions and the controls carried out by the Swedish Tax Agency and Swedish Customs, the availability and flow of alcoholic products into the country are largely regulated. Through the retail monopoly, society maintains control over the general availability of alcoholic beverages. The retail monopoly rests on the principle of disinterest, which means that private profit motives are excluded from the Swedish retail market in order to keep alcohol consumption down and protect public health. The retail monopoly thus serves as a tool to eliminate the incentive to increase sales, while enabling more effective control of the number of outlets, opening hours, forms of sale, age verification and marketing. Other alcohol policy instruments that affect consumption and alcohol-related harm include age limits, rules for serving alcohol, blood alcohol limits for driving, brief interventions for harmful alcohol consumption and early treatment for alcohol dependence.

Through restrictive regulation of alcohol marketing, including on the internet and social media, children and young people can be protected from exposure to such marketing. Swedish alcohol policy is designed within a national context, but some joint initiatives to reduce alcohol-related harm take place within European and international cooperation. In the alcohol area, the retail monopoly and alcohol taxation are the cornerstones for reducing availability and thereby protecting public health and children and young people. In this context, low alcohol prices in neighbouring countries as well as the possibility for consumers to purchase alcohol online from other countries under retail-like conditions pose a challenge to Sweden's restrictive alcohol policy. The National Board of Health and Welfare (Socialstyrelsen)

has developed national guidelines for how the healthcare system can work to reduce unhealthy lifestyle habits. The guidelines were first published in 2011, revised in 2018 and the Board has recently issued an updated version for 2024, introducing new thresholds for harmful alcohol consumption, as new studies show that alcohol is more harmful than previously known. The indicators for harmful alcohol consumption have also been updated to reflect the new thresholds.

Alcohol increases the risk of accidents and diseases such as stroke, cancer and liver disease, as well as the risk of premature death. Research is clear: the less alcohol consumed, the lower the risk. The National Board of Health and Welfare therefore revised the so-called risk thresholds in autumn 2023 as part of its review of the guidelines. The purpose of these thresholds is to provide guidance to healthcare professionals on when it may be relevant to offer counselling. However, the responsible clinician must always make an individual assessment, taking into account the person's specific needs, expectations and ability to absorb the information. Among those with harmful alcohol consumption there may be individuals who have already developed a dependency. Follow-up data also show that the real prices of alcoholic beverages fell during the period 2020–2023 as inflation rose, with the only exception being low-alcohol beer, whose real price increased between 2022 and 2023.

Based on the National Board of Health and Welfare's 2024 follow-up of the ANDTS strategy's goals relating to health and social care, the Board assesses, among other things, that healthcare, dental care and social services need to take a more preventive approach by increasing the use of screening tools, expanding the number of counselling sessions and structured counselling in primary care, specialist care and through the national helpline Alkohollinjen, and by continuing efforts to prevent harmful use and dependency during pregnancy. In addition, more municipalities need to have up-to-date procedures for how staff should act when there are indications of harmful use or dependency across social services. The Board also notes that participation in self-help programmes has increased and that the number of counselling sessions provided through Alkohollinjen continues to grow.[30]

The National Board of Health and Welfare considers that people with harmful use or dependency should have access to care and support of good quality, adapted to their circumstances and needs. The Board believes that healthcare, dental care and social services need to adjust their interventions accordingly. More people should have access to care and support that meet their needs, including regular and frequent basic dental check-ups. Treatment with medication for alcohol dependence should be offered to more patients. The influence of service users should be strengthened by involving them in user-led reviews as part of service development.

To further strengthen care and support for people with harmful use or dependency, the government established the Dual Diagnosis Inquiry (Samsjuklighetsutredningen) on 17 June 2020. The inquiry was tasked with proposing how coordinated interventions for care, treatment and support can be ensured for children, young people and adults with dual diagnoses, that is, individuals with both substance use disorders and other psychiatric conditions or related issues. In January 2023, the final report was presented, proposing a more integrated and person-centred system of care in which regional healthcare services would assume primary responsibility for the treatment of harmful use and dependency. The inquiry also made several proposals to improve coordination of services for people with dual diagnoses. In January 2025, the government established a Dual Diagnosis Delegation (Samsjuklighetsdelegationen) to begin implementing these proposals.[31]

The government intends to introduce farm-gate sales of small-scale and craft-produced alcoholic beverages in Sweden during the first half of 2025. All types of alcoholic drinks will be covered by the reform. For beer, cider and spirits, no cultivation of raw materials will be required to operate farm-gate sales, while wine producers will need to grow their own grapes to qualify. Sales will be permitted at a single outlet located directly adjacent to the production or cultivation site.[32]

Based on the established structure, organisation and monitoring mechanisms and with a continued restrictive alcohol policy, Sweden is considered well positioned to continue reducing harmful alcohol consumption in the population.

4.2 Harmful alcohol consumption in Sweden 2010–2024

4.2.1 Adults

According to the Public Health Agency of Sweden's 2024 national public health survey Health on Equal Terms (HLV), 16 per cent of the population aged 16–84 reported harmful alcohol consumption. The level has remained relatively constant since 2010. Harmful alcohol consumption refers to the proportion of the population whose self-reported alcohol intake poses a clearly increased risk of alcohol-related harm and disease. Consumption is measured using the AUDIT-C instrument, which includes questions about alcohol use over the past 12 months.[33]

The National Board of Health and Welfare updated its thresholds for harmful alcohol consumption in 2023.[34]

Prevalence of harmful alcohol consumption – whole population, change in percentage points									
	Total			Women			Men		
	2010	2024		2010	2024		2010	2024	
Percentage	17	16	-2	13	13	0	21	18	-4

Prevalence of harmful alcohol consumption – young adults (16–29 years), change in percentage points									
	Total			Women			Men		
	2010	2024		2010	2024		2010	2024	
Percentage	32	22	-10	27	24	-3	36	20	-16

Harmful use is now defined as drinking any of the following:

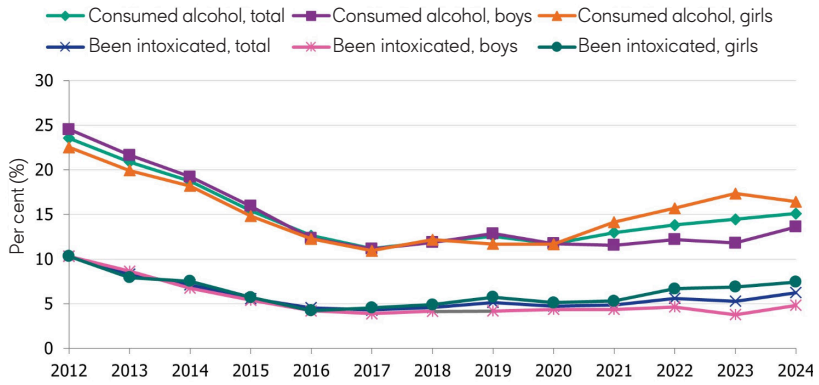
- 10 standard drinks or more per week
- 4 standard drinks or more on a single occasion once a month or more often (so called episodic heavy drinking).

Previously, the thresholds for harmful alcohol consumption among healthy adults were divided by sex as follows:

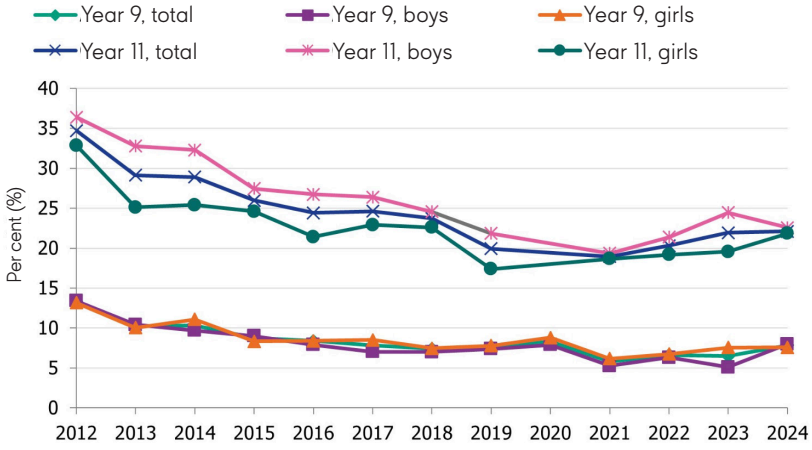
- Women: more than 9 standard drinks per week, or 4 standard drinks or more on a single occasion.
- Men: more than 14 standard drinks per week, or 5 standard drinks or more on a single occasion.

A positive trend has been observed in the 16-29 age group, which has the highest proportion of people with harmful alcohol consumption. Between 2010 and 2024, the proportion fell from 32 per cent to 22 per cent. This is mainly due to a steady annual decline among young men, from 36 per cent to 20 per cent. Among young women, the proportion was 27 per cent and fell steadily to 18 per cent in 2021, followed by a slight increase to 22 per cent in 2024.

Proportion of Year 9 students who reported having consumed alcohol and been intoxicated before the age of 14, 2012-2024. **Figure from CAN National School Survey, 2024.**



Proportion of students reporting episodic heavy drinking at least once a month during the past year, 2012-2024. **Figure from CAN National School Survey, 2024.**



According to the Public Health Agency of Sweden's 2024 report on developments within the ANDTS strategy, several follow-up indicators show progress beyond the decline in harmful alcohol consumption. For example, fewer people start drinking and becoming intoxicated at an early age, the proportion of pregnant women with harmful consumption has decreased,

Systembolaget stores show strong compliance with age restrictions in test purchases, and overall alcohol acquisition has declined since 2011.

In a longer-term perspective, alcohol consumption in Sweden began a downward trend as early as 2004. The decline is primarily driven by men, while

consumption among women has remained relatively stable. This indicates that both total consumption and harmful alcohol consumption are decreasing over time, and that alcohol use at an early age is also declining.

4.2.2 Children

Over recent decades, alcohol consumption among young people has undergone a marked shift. Studies show that fewer young people drink alcohol, and alcohol-related harm has also decreased. This trend has been tracked through several national surveys providing insight into drinking habits and patterns among young people. According to the annual National School Survey, conducted by the Swedish Council for Information on Alcohol and Other Drugs (CAN), students in Year 9 and the second year of upper secondary school are asked whether they have consumed alcohol during the past 12 months. In 2024, 35 per cent of Year 9 students reported having consumed alcohol in the previous year, compared with 69 per cent of students in the second year of upper secondary school. Over a longer period, the proportion of young people who drink alcohol has declined in both age groups, although this downward trend has levelled off in recent years.

One aspect examined in the National School Survey is the age at which young people start drinking alcohol. In 2024, 15 per cent of Year 9 students said they had drunk alcohol before turning 14. This was slightly more common among girls (16 per cent) than boys (14 per cent). After an earlier decline, this proportion has remained relatively stable in recent years. A smaller share of young people reported having been intoxicated at that age: seven per cent of girls and five per cent of boys said they had drunk enough to become drunk.

Heavy episodic drinking, which refers to consuming a large amount of alcohol on a single occasion, carries a higher risk of harm and illness. In 2024, eight per cent of Year 9 students reported engaging in heavy episodic drinking at least once a month. Among second-year upper secondary students, the corresponding proportion was 22 per cent. Since 2012, heavy episodic drinking has decreased in both groups. In the most recent survey, the difference between girls and boys was negligible.

Another survey, Health Behaviour in School-aged Children, monitors the proportion of young people who have been intoxicated. In the most recent survey, conducted in 2021/2022, one per cent of both girls and boys aged 11 reported having been drunk. Among 13-year-olds, the figures were eight per cent for girls and six per cent for boys, while 31 per cent of 15-year-old girls and 24 per cent of boys of the same age said they had been intoxicated. Compared with the 2017/2018 survey, the share of young people who had been drunk had increased among 13- and 15-year-old girls and 15-year-old boys. Despite this short-term increase, the overall long-term trend shows a steady decline in the proportion of young people who have been intoxicated.[37]

For preventive efforts, it is important to understand where young people obtain alcohol. CAN's 2024 National School Survey found that the most common source of alcohol for Year 9 students (36 per cent) and second-year upper secondary students (53 per cent) was friends, siblings or a partner. Among Year 9 students, the second most common source was a dealer, followed by those who did not know where the alcohol came from. Among students in the second year of upper secondary school, parents who had given permission were the second most common source, while dealers ranked third.

The survey also showed that 20 per cent of second-year upper secondary students had been served alcohol in a restaurant before turning 18. The figure was slightly higher among boys (21 per cent) than girls (19 per cent). Municipalities are responsible for issuing alcohol licences and carrying out inspections of licensed premises. The Public Health Agency of Sweden provides guidance on alcohol serving regulations and offers both a licensing knowledge test and training materials for the "Responsible Beverage Service" method. Comparative data from 2023 show that 21 per cent of second-year upper secondary students had been served alcohol in a restaurant before their 18th birthday, with no difference between girls and boys.

Focus area: Healthy eating habits, physical activity and prevention of overweight and obesity

Selection of goals and initiatives in EBCP

- Measures to increase the availability of healthy foods
- Update the EU Action Plan on Childhood Obesity
- Revise the EU School Fruit, Vegetable, and Milk Scheme
- Propose harmonised, mandatory front-of-pack nutrition labelling
- Support Member States and stakeholders in developing effective policies to reduce the marketing of unhealthy foods
- Explore ways to promote the production and consumption of sustainable agricultural products, moving towards a more plant-based diet with less red and processed meat and more fruit and vegetables
- Proposals for more differentiated VAT rates to make healthy and nutritious food more affordable
- Examine the feasibility of new tax rates on sugar and soft drinks

Committee's assessment

Sweden does not meet the ambition of the EBCP regarding healthy lifestyles. In recent years, an increase in obesity has been observed among both adults and children, as well as a decline in physical activity in the population. The Committee notes the absence of clear political measures in this area and emphasises that such measures need to be implemented as soon as possible. These could include differentiated VAT rates to reduce the price of healthy and nutritious food, specific taxes on sugar and soft drinks, measures to reduce the marketing of unhealthy foods, and promotion of the consumption of sustainable and healthy food products. Furthermore, a national action plan on obesity for both adults and children should be adopted.

Basis for the assessment

As a basis for its assessment, the Committee has examined statistics on the proportion of adults and children who are overweight or obese, Swedish participation in the EU School Fruit, Vegetable and Milk Scheme, and the dietary habits of adults and children in relation to the Swedish National Food Agency's dietary guidelines 2025. The Committee has also reviewed statistics on physical activity among adults and children.

5.1. Proportion of the population who are overweight or obese

5.1.1. Adults

Overweight and obesity are conditions in which the amount of body fat exceeds healthy levels and can contribute to the development of several chronic diseases. Being overweight is a well-established risk factor for developing obesity, which is recognised as a chronic and complex condition that requires long-term treatment and follow-up. Both overweight and obesity are linked to an increased risk of at least thirteen types of cancer. Together with smoking, sun exposure and diet, they represent one of the major modifiable risk factors for cancer.

Although the exact biological mechanisms are not yet fully understood, consistent research findings from large observational studies show a clear connection between higher body weight and cancer risk. One possible explanation relates to the role of adipose tissue in the body's hormonal and inflammatory processes.

Body Mass Index (BMI) is the measure used in healthcare and research to classify body weight in relation to height, and it provides the basis for statistics on overweight and obesity. Overweight is defined as a BMI of 25 to 29.9, and obesity as a BMI of 30 or higher. Obesity is further divided into three classes: Class 1 (BMI 30 to 34.9), Class 2 (35 to 39.9) and Class 3 (40 or above). Even at the levels of overweight and Class 1 obesity, the risk of cancer increases. The higher the BMI, the greater the risk. For Class 2 and Class 3 obesity, the link to cancer is even stronger, both in terms of developing the disease and having a poorer prognosis at diagnosis.

Over the past 20 years, the proportion of adults aged 16 to 84 who are overweight or obese has risen from 46 per cent in 2004 to 54 per cent in 2024. The proportion with obesity has increased from 11 to 18 per

Overweight and obesity (BMI > 25)	Percentage	
SWEDEN		
Total	54%	
Women	48%	
Men	59%	
Region with the lowest prevalence		
Total	47%	Stockholm
Women	40%	Stockholm
Men	56%	Stockholm
Region with the highest prevalence		
Total	61%	Västernorr-land
Women	55%	Västernorr-land
Men	67%	Västernorr-land

cent. Class 1 obesity has grown from 9 to 13 per cent during the same period. The proportion with Class 2 obesity has doubled, from 2 to 4 per cent, and Class 3 obesity has tripled, from 0.5 to 1.4 per cent.

This development has several underlying causes. The Public Health Agency of Sweden highlights social and structural factors such as level of education, economic conditions, access to health-promoting environments and opportunities for physical activity. It is not only individual lifestyle habits that influence the risk of overweight and obesity, but also how society is organised.

In Sweden, statistics on overweight and obesity show considerable variation by sex, age, country of birth and level of education. Obesity, for instance, is more common among individuals with only primary or lower secondary education, although prevalence has increased across all educational groups. There are also clear differences between women and men. The proportion of adults who are overweight or obese is higher among men than among women (59 per cent compared with 48 per cent). However, the proportion with obesity is the same in both groups, at 18 per cent. Women are more likely to have higher-class obesity, while men more often have Class 1 obesity.

Significant differences are also observed between regions. Levels are consistently higher among men in all regions, but regional differences are seen in both women and men. In Stockholm, 47 per cent of the adult population is overweight or obese, compared with 61 per cent in Västernorrland. Among women, the figures are 40 per cent in Stockholm and 55 per cent in Västernorrland, while among men the proportions are 56 and 67 per cent, respectively. This means that the regional difference is larger among women, at 15 percentage points, than among men, at 11 percentage points. In Västernorrland and Norrbotten, nearly a quarter of the adult population has obesity.[38]

5.1.2. Children

Overweight and obesity among children are growing public health concerns. The increase is influenced by both socioeconomic and geographical factors. The proportion of affected children has increased in recent years, and factors such as parental education and family structure play a significant role in the risk of developing overweight and obesity. Differences are also seen between age groups, sexes and different parts of the country.

The Public Health Agency of Sweden reports statistics on overweight and obesity among children aged 0 to 15 years. Data are collected in different ways. For those aged 0 to 5 years, results are based on measurements from Child Health Services (BVC). Among children aged 6 to 9 years, data come from height and weight measurements taken during school health assessments, although these are not comprehensive. For the oldest group, aged 11 to 15 years, results are self-reported through the Health Behaviour in School-aged Children survey, in which pupils in Years 5, 7 and 9 report their height and weight. Coverage and reliability are therefore lower in the older age groups.

Children aged 0-5 years

Different BMI thresholds are used to define overweight and obesity, depending on age: the WHO standards for children aged 18 months, and the International Obesity Task Force (IOTF) standards for children aged 4 years. In recent years, the proportion of children who are overweight or obese has increased, particularly among the youngest. Among 18-month-old children, the proportion rose from 7 per cent in 2016 to 9 per cent in 2020, while prevalence among 4-year-olds remained relatively stable between 2016 and 2019, before increasing by one percentage point in 2020.

Sex also plays a role in prevalence. Among 18-month-old children, boys are more likely to be overweight or obese (9 per cent) than girls (7 per cent), whereas among 4-year-olds the pattern is reversed, with a higher proportion of girls (13 per cent) than boys (12 per cent).

There are considerable regional variations in the prevalence of overweight and obesity. In Stockholm, the proportion of 4-year-olds affected is the lowest (10 per cent), while in Västernorrland it is the highest (17 per cent). Among 18-month-olds, the lowest prevalence is in Västerbotten (7 per cent) and the highest in Södermanland (10 per cent). Furthermore, overweight

Children aged 6-9 years	Overweight & obesity	Region	Overweight	Region	Obesity	Region
Sweden – both sexes	23	-	16	-	7	-
Sweden – girls		-		-		-
Sweden – boys		-		-		-
Difference in prevalence						
Both sexes	9	-	8	-	5	-
Difference in prevalence - girls	8	-	14	-	5	-
Difference in prevalence - boys	11	-	13	-	7	-
Highest region – both sexes	28	Värmland	13	Västerbotten	10	Jönköping
Highest region - girls	27	Gävleborg, Kronoberg	19	Värmland	11	Norrbotten
Highest region – boys	29	Värmland	18	Värmland	11	Värmland
Lowest region – both sexes	18	Västerbotten	5	Uppsala	5	Uppsala
Lowest region – girls	19	Västerbotten	6	Västerbotten, Uppsala	6	Uppsala, Västerbotten
Lowest region – boys	18	Västerbotten	5	Uppsala	5	Uppsala

and obesity are more common among children living in large cities or in rural municipalities than in areas close to major urban centres. Socioeconomic factors also play an important role, with children of parents who have lower levels of education or who live in single-parent households more likely to be affected by overweight or obesity. This reflects how a family's economic and social circumstances can influence children's health and lifestyle habits.[39]

Children aged 6-9 years

During the 2021/2022 school year, approximately 23 per cent of children aged 6–9 years were overweight or obese. Of these 16 per cent were overweight and 7 per cent were obese. This represents an increase of approximately 2 percentage points compared with the 2018/2019 school year, with the rise mainly attributable to a change in the prevalence of obesity, which was 6 per cent at that time.

There were clear differences related to both sex and age. Overall, girls were more likely to be overweight than boys in all age groups. However, among 9-year-olds, obesity was slightly more common among boys (13 per cent) than girls (12 per cent), while overweight remained more prevalent among girls across all ages. The prevalence of both overweight and obesity increased markedly with age.

Geographical variations in the prevalence of overweight and obesity were also evident. The proportion of children who were overweight or obese was highest in Värmland, followed by Gävleborg and Jönköping, while Västerbotten had the lowest proportion. For obesity specifically, prevalence was highest in Jönköping and Blekinge (both around 10 per cent), whereas Uppsala and Västernorrland had the lowest levels (around 5 per cent).[40]

Children aged 11-15 years

Overweight and obesity among schoolchildren aged 11–15 in Sweden have increased markedly between the 1989/90 and 2021/22 school years. The proportion of children who are overweight or obese has risen from 7 to 15 per cent, with obesity becoming four times more common during this period, increasing from 1 to 3 per cent. Since 2009/2010, the increase has been particularly pronounced, and a larger rise has been observed among boys than girls.

Between 2017/18 and 2021/22, a slight decrease in obesity is seen, but this change is not statistically significant and is likely due to underreporting. At the same time, an increase in overweight is noted, particularly among boys, although these results are also uncertain. To gain a more nuanced understanding and identify the causes of these trends, more longitudinal data following the same individuals over time are needed. It is also important to continue monitoring weight development among schoolchildren through regular surveys in order to identify and address changes effectively.

Children's weight is influenced by both biological factors and the social and physical environment. For example, boys experience an increase in muscle mass during puberty, which naturally raises their body weight. At the same time, cohort effects – where different generations of children have experienced varying conditions in their diet and physical activity environments – may play a role in the development of overweight and obesity. This means that variations between years and age groups can differ.

There are also clear sex- and age-related differences in the prevalence of overweight and obesity. In general, overweight and obesity are more common among boys than girls. Among boys, the proportion who are overweight gradually increases with age, while it remains relatively stable among girls. Regarding obesity, prevalence is fairly consistent across different age groups among boys, whereas girls tend to have a lower proportion of obesity as they get older, particularly at age 15. According to the Public Health Agency of Sweden's analysis, this may partly be explained by prevailing thinness ideals, which can influence older girls to try to maintain their weight, or lead them to report a lower weight than their actual weight.[41]

5.2. Swedish participation in the EU School Fruit, Vegetable and Milk Scheme

Under the School Milk Scheme, municipal and independent schools in Sweden can apply for support to purchase milk. In 2023, the Swedish Board of Agriculture, on behalf of the government, conducted an investigation to explore the possibility of extending EU support to the distribution of fruit in schools. The purpose of the investigation was to analyse how such support could be designed and implemented effectively in Sweden. The investigation concluded that the administrative costs of introducing and managing the support would be high relative to the budget for school fruit.

An evaluation of the School Milk Scheme for 2017–2023 found that the objectives of increasing milk consumption and improving children's knowledge of healthy eating habits had not been achieved to the desired extent. The programme has contributed to the continued provision of milk in schools, but it is unclear whether this has led to an actual increase in milk intake. According to the evaluation, most school authorities believe they would continue serving milk even without support from the programme, calling its relevance into question. However, the support contributes to an increased budget for schools, allowing other activities to be financed. Even though there is no direct need for school milk, school authorities view the support as beneficial for the overall budget. The programme has also been criticised for its inefficient administration, which imposes a heavy workload on both school authorities and the Swedish Board of Agriculture. Many schools refrain from applying for support due to the extensive administrative work and limited reimbursement.[42]

The Swedish Board of Agriculture concluded that experiences from the School Milk Scheme indicate that support for fruit distribution would not be an effective measure for municipalities and schoolchildren. Nevertheless, in March 2024, the government decided to proceed with the issue and tasked the Board with preparatory measures to enable support from the European Agricultural Guarantee Fund (EAGF) for the distribution of fruit, vegetables, and bananas in schools from the 2025/2026 school year onwards. The assignment also includes a review of the existing school milk support to ensure effective and appropriate implementation of the EU School Scheme as a whole.[43]

5.3. The Swedish population's diet in relation to the Swedish National Food Agency's dietary guidelines

New dietary guidelines from the Swedish National Food Agency are expected to be published in April 2025. The current guidelines date from 2012 and state, among other things:

- Eat at least 500 g of fruit and vegetables per day, which corresponds, for example, to two generous handfuls of vegetables, root vegetables, and legumes, and two pieces of fruit.
- Fish two to three times per week.
- Dairy – 2-5 dl of fermented milk products, yoghurt, or milk per day.
- Red meat and processed meat – less than 500 g per week.
- Sugar – less than 10 per cent of energy intake should come from free sugars.

5.3.1. Adults

The Public Health Agency of Sweden monitors the population's dietary habits using four indicators in the survey Health on Equal Terms. These are the consumption of vegetables and root vegetables, fruit and berries, fish and seafood, and sugary drinks. For the period 2016–2022, the following is observed:[45]

Dietary habits, adults aged 16-84	Total	Women	Men
Consume vegetables and root vegetables at least twice a day	34%	42%	26%
Consume fruit and berries at least twice a day	25%	32%	18%
Consume fish and seafood at least twice a week	26%	27%	25%
Consume sugary drinks at least twice a week	31%	25%	36%

Statistics show that a relatively small proportion of the Swedish population consumes fruit and vegetables to the recommended extent. Around one third of the population report eating vegetables and root vegetables at least twice a day, while just under one quarter report the same frequency for fruit. Women consume both vegetables and fruit more often than men. Among women, it is almost twice as common to eat vegetables daily compared with men, and a similar difference is seen for fruit.

Fish and seafood are also consumed less frequently than recommended. Only one quarter of the population eat fish at least twice a week, with only a marginal difference between men and women.

Regarding sugary drinks, one third of the population report consuming them at least twice a week. This consumption is more common among men than women, with men consuming almost twice as much as women.

In summary, the statistics indicate that two thirds of the population do not meet the recommendations for fruit, vegetables, and fish. At the same time, consumption of sugary drinks is high, particularly among men. This suggests clear sex differences in dietary habits, with men being less likely than women to follow the Swedish National Food Agency's dietary guidelines.

5.3.2. Children

In 2018, the Swedish National Food Agency conducted a comprehensive survey of dietary habits among students in Year 5 and Year 7 of primary school, as well as Year 2 of upper secondary school.[46] In summary, most young people eat too little fruit and vegetables. Girls consume more fruit and vegetables than boys, but fruit intake remains low, even though vegetable consumption has increased slightly. At the same time, adolescents eat too much red and processed meat, which is associated with health risks such as cardiovascular disease and diabetes. Although the proportion of calories from sweets, cakes, snacks, and soft drinks has decreased since 2003, these foods still contribute a large share of adolescents' energy intake. This is a concern, as it can lead to the displacement of other important nutrients.

Overweight and obesity are a growing problem, with around one in five adolescents affected. This is concerning because overweight and obesity can lead to serious long-term health problems. A particularly vulnerable group is adolescents with parents who have low education and income. Young people from these families generally have poorer dietary habits, consuming fewer vegetables and fish while drinking more soda.

Another vulnerable group is adolescents who do not attend upper secondary school, among whom almost one quarter have obesity, compared with 6 per cent of upper secondary students. Many in this group also report poor wellbeing, further highlighting the importance of education for health. These results should, however, be interpreted with caution, as they are based on a smaller sample.

To reduce social inequalities in society and improve adolescents' dietary habits, long-term interventions involving various societal actors are needed. These efforts should focus on supporting young people from socioeconomically disadvantaged groups in order to prevent overweight and obesity and improve t heir health.

Detailed results are provided in Appendix 2.

5.4. Physical activity

5.4.1. Adults

The Public Health Agency of Sweden compiles statistics on physical activity based on self-reports in the National Public Health Survey. For the period 2021–2024, a majority of both women and men report being physically active for at least 150 minutes per week, in line with the recommendations for physical activity.

The region with the highest proportion of physically active adults is Blekinge, where 71 per cent of the adult population report being active for at least 150 minutes per week. At the other end of the scale is Värmland, where only 61 per cent of adults reach this level, representing a gap of 10 percentage points between the highest and lowest proportions.

Physically active for at least 150 minutes per week, adults aged 16-84			
	Total	Women	Men
SWEDEN	66%	65%	68%
Blekinge	71%	72%	70%
Dalarna	70%	67%	73%
Gotland	68%	68%	69%
Gävleborg	63%	62%	63%
Halland	68%	63%	73%
Jämtland	66%	65%	68%
Jönköping	63%	63%	64%
Kalmar	67%	65%	69%
Kronoberg	65%	69%	62%
Norrbotten	65%	63%	66%
Skåne	66%	64%	68%
Stockholm	68%	66%	70%
Södermanland	62%	58%	65%
Uppsala	71%	71%	71%
Värmland	61%	59%	64%
Västerbotten	67%	65%	68%
Västernorrland	62%	61%	64%
Västmanland	65%	64%	66%
Västra Götaland	64%	63%	66%
Örebro	63%	63%	63%
Östergötland	67%	66%	68%

Men are generally somewhat more active than women, which applies to all regions except Kronoberg, where women are slightly more active than men. The largest difference between the sex is observed in Halland, where 73 per cent of men are physically active for at least 150 minutes per week, compared with only 63 per cent of women, resulting in a difference of 10 percentage points. On average, 68 per cent of men are active, while the corresponding proportion for women is slightly lower, at 65 per cent. For women, the highest proportion of physically active individuals is found in Blekinge, where 72 per cent reach at least 150 minutes of activity per week. The lowest proportion is in Värmland, where 59 per cent of women are active, giving a gap of 13 percentage points between the most and least active regions for women. For men, the highest proportion of active individuals is in Halland, where 73 per cent are physically active for at least 150 minutes per week. The lowest proportion among men is in Jönköping, where 64 per cent report being sufficiently active, resulting in a 9-percentage-point gap between the most and least active regions for men.

In its analyses, the Public Health Agency of Sweden has highlighted that there are differences between population groups. The most active are the age groups 16–44 years, and individuals with post-secondary education are more physically active compared with those with upper secondary or pre-upper secondary education, amnong both women and men. Based on statistics by region, no clear trends related to population size, geographic location, or average income can be identified to explain differences in physical activity. Regarding geographic location, there does not appear to be a consistent difference between the north and south of the country. For example, Blekinge, located in the south, has the highest proportion of physically active adults, while Värmland, situated more centrally, has the lowest proportion. Nor can it be concluded that regions with higher or lower income generally have higher or lower levels of physical activity based on the data presented.

5.4.2. Children

In 2018, the Swedish National Food Agency conducted a comprehensive survey of physical activity among children in Year 5 and Year 7 of primary school, as well as upper secondary school students. The results showed that a large proportion of children and adolescents in Sweden are insufficiently active, which may have long-term health consequences. According to the survey, as many as seven out of ten young people do not achieve the recommended 60 minutes of moderate-to-vigorous physical activity per day. The proportion of physically active individuals is lowest among older adolescents, and there are also clear differences between the sexes, with more boys being active than girls. Overall, 43 per cent of boys reach the activity target, compared with only 23 per cent of girls.

The survey also showed that physical activity levels are linked to parents' educational attainment. Children of parents with higher education tend to be more active, a difference that is most pronounced among girls. For these adolescents, greater parental involvement often translates into higher activity levels. Sedentary behaviour is another concern, as both boys and girls spend on average over 10 hours per day being sedentary, corresponding to approximately 75–77 per cent of the day. This sedentary time also increases with age, meaning that older adolescents spend even more time in front of screens and engaged in passive activities.

To improve these figures and encourage young people to be more active, interventions are required from multiple actors, with particular focus on older adolescents. Physical activity provides substantial health benefits in both the short and long term, and it is crucial to increase activity levels to prevent future health problems.

5.5. A Swedish action plan to promote health and prevent childhood obesity

The EU Cancer Plan highlights the need for evaluation and follow-up of the European Commission's EU Action Plan on Childhood Obesity 2014–2020. In Sweden, the need for a national action plan to address obesity in adults, as well as a specific plan for children with obesity, has long been discussed. Such plans do not currently exist.

Focus area: Air quality

Selection of goals and initiatives in the EU's Cancer Plan

- Align EU air quality standards more closely with WHO guidelines.

Committee's assessment

Sweden largely complies with the EU's air quality limit values but not with those set by the WHO. The EU has also not yet adjusted its standards to the WHO's guidelines, although this remains a long-term objective. To ensure improved air quality, the committee considers that action is needed for more sustainable transport, reduced industrial emissions, more sustainable heating, decreased use of studded tyres, and other suitable measures to meet the applicable emission limit values.

Basis for assessment

As the basis for its assessment, the committee has reviewed statistics on Swedish air quality in relation to EU air quality standards and WHO air quality guidelines, as well as the incorporation of EU legislation and the implementation of WHO's air quality guidelines in Sweden.

6.1. Air quality and cancer

PM10 and PM2.5 are both small airborne particles that can affect the respiratory system and health, but they come from different sources and impact the body in different ways. The World Health Organization (WHO) classifies both as significant health risks. PM10, the larger particles (up to 10 micrometres), mainly originate from traffic, construction work, industrial processes and fuel combustion. These particles can irritate the airways and worsen symptoms in people with asthma or other lung diseases. Long-term exposure to PM10 has also been linked to an increased risk of lung cancer. PM2.5, which is even smaller (up to 2.5 micrometres), often comes from diesel engines, the burning of fossil fuels and forest fires. Because they are so small, they can penetrate deep into the lungs and even enter the bloodstream, making them more dangerous. PM2.5 has been linked to serious health problems such as heart and lung disease, stroke, and an increased risk of lung cancer. Both PM10 and PM2.5 carry harmful substances that can cause cell damage, but PM2.5 particles are particularly hazardous because of their ability to penetrate deeper into the body.[48]

Data from the Air Quality Life Index show that if the world permanently reduced fine particle pollution to

Compound [permitted exceedances]	New EU limit value (directive 2024)	Current EU limit value (directive 2004+2008)	Limit value in Sweden	WHO guidelines limit value
PM10	20 µg/m³ (år) 45 µg/m³ (dygn) [18 dygn]	40 µg/m³ (år) 50 µg/m³ (dygn) [35 dygn]	15 µg/m³ (år) 30 µg/m³ (dygn) [35 dygn]	15 µg/m³ (år) 45 µg/v (dygn) [3-4 dygn]
PM2,5	10 µg/m³ (år) 25 µg/m³ (dygn) [18 dygn]	25 µg/m³ (år) -	10 µg/m³ (år) 25 µg/m³ (dygn) [3 dygn]	5 µg/m³ (år) 15 µg/m³ (dygn) [3-4 dygn]
Nitrogen dioxide	20 µg/m³ (år) 50 µg/m³ (dygn) [18 dygn] 200 µg/m³ (timme) [3 timmar]	40 µg/m³ (år) 60 µg/m³ (dygn) [7 dygn] 200 µg/m³ (timme) [18 timmar] 90 µg/m³ (timme) [175 timmar]	20 µg/m³ (år) - 60 µg/m³ (timme) [175 timmar]	10 µg/m³ (år) 25 µg/m³ (dygn) [3-4 dygn] 200 µg/m³ (timme)
Benzo(a)pyrene	1,0 ng/m³ (år)	1 ng/m³ (år)	0,1 ng/m³ (år)	0,12 ng/m³ (a) (år) 0,012 ng/m³ (b) (år)
Carbon monoxide	10 mg/m³ (8-timmarsmedel) 4 mg/m³ (dygn) [18 dygn]	10 mg/m³ (8-timmarsmedel)	-	10 mg/m³ (8-timmarsmedel) 4 mg/m³ (dygn) [3-4 dygn]

meet WHO guidelines, the average life expectancy would increase by 2.3 years per person. In total, this would result in 17.8 billion life-years gained globally.[49] Nordic studies indicate that mortality related to PM2.5 and ozone was highest in Denmark and lowest in Iceland. In 2015, the number of deaths per million ranged from 8,500 to 11,400 for PM2.5 and from 230 to 260 for ozone across the five Nordic countries.[50]

Nitrogen dioxide (NO2) is an air pollutant that affects both the respiratory system and the heart. Long-term exposure has been linked to an increased risk of lung diseases, as well as a higher risk of lung cancer. Nitrogen dioxide can contribute to inflammation in lung tissue and weaken the body's defenses against harmful substances. It also interacts with other air pollutants, which may promote cancer-causing processes. In addition, nitrogen dioxide can contribute to the formation of secondary particles, such as PM2.5, which are strongly associated with lung cancer. The World Health Organization (WHO) has classified nitrogen dioxide as a cancer risk factor. According to the Karolinska Institute, there is no direct evidence that nitrogen dioxide is carcinogenic, but exposure has been linked to toxic effects on the lungs and airways.[51]

6.2. Swedish air quality in relation to EU air quality standard

The new EU directive introduces stricter limit values for several air pollutants and requires increased efforts to reduce PM10 and other harmful particles. Sweden is required to report in accordance with the new rules by 2026 and may, if necessary, apply for extended deadlines until 2035 or 2050.

Sweden generally meets the current EU air quality standards, but there are exceptions. Regarding the new limit values, the greatest challenge for Sweden is likely to be meeting the PM10 limits, which may require new action plans in several municipalities.

The main issue is the use of studded tires and road dust. The previous limits allowed a maximum of 35 days per year with PM10 concentrations above 50 µg/m³, but this has been tightened to 18 days per year under the new directive. For certain areas, such as Visby and Östersund, these new requirements have created additional challenges. In 2022, an unfavorable year with high particle levels demonstrated that efforts to reduce air pollution need to be intensified.

Regarding the EU's new PM2.5 limits, these are already being met in Sweden. However, WHO guideline values are exceeded at several monitoring stations.

6.3. Swedish air quality in relation to WHO guidelines

Although Sweden has good air quality compared with many other countries, WHO's stricter guidelines are exceeded in several locations, particularly in cities such as Uppsala, Borås, and along major traffic corridors. The most hazardous particles, PM2.5, remain a concern, even though levels have decreased significantly over the past 20 years. A study examining exposure to PM2.5, PM10, and nitrogen oxides (NOx, NO2) in Swedish metropolitan areas between 2000 and 2018 showed a substantial reduction in air pollution exposure, from a population-weighted average of 12.2 µg/m³ for PM2.5 in 2000 to 5.4 µg/m³ in 2018. This reduction in exposure was estimated to be associated with an annual decrease of 2,719 premature deaths. Despite these improvements, the study found that a significant proportion of the population in the modeled areas – 65 per cent for PM2.5, 8 per cent for PM10, and 42 per cent for NO2 – was still exposed to levels exceeding WHO guidelines for annual average exposure.

Furthermore, research indicates that the relationship between air pollution and mortality becomes stronger per unit at lower concentrations. In other words, a small reduction in air pollution levels in countries like Sweden, where air quality is already relatively good, can yield greater relative health benefits than an equivalent reduction in countries with much higher pollution levels. This means that even modest efforts to reduce pollution in areas where levels are already low, such as in Sweden, can have a substantial positive impact on public health.

6.4. Incorporation of EU legislation and Implementation of WHO guidelines in Sweden

The Swedish government has recently begun efforts to align national legislation with the new EU directive. An investigation is underway to identify necessary regulatory changes, with the final report expected in November 2025. WHO guidelines are not yet legally binding in Sweden, but the new EU directive adopts a strategy that is closer to WHO's stepwise approach. Fully implementing WHO guidelines would require significant efforts in areas such as traffic, industry, and residential wood burning. For example, reduced use of studded tires and continued electrification of the transport sector could lead to substantial improvements.

Effective cross-border cooperation is also crucial, as air pollutants can travel long distances. Initiatives such as FLEACE, in which municipalities near limit values develop preventive strategies, can play an important role. Municipalities also have a responsibility to improve public information and address local emission sources, such as traffic and wood burning. Considering the well-documented links between air pollution and health problems, including lung cancer, it is clear that further action is needed to protect public health. Sweden has a unique opportunity to take a leading role in implementing stricter standards and advanced health modeling to prevent premature deaths and chronic diseases.

Early detection

Focus area: Screening

Selection of goals and initiatives in EBCP

Flagship initiatives

- Ninety per cent of the target population is offered screening for breast cancer, cervical cancer, and colorectal cancer.

Other initiatives

- Update the EU Council's recommendation on cancer screening.

Committee's assessment

Sweden meets the target of offering 90 per cent of the population screening for breast and cervical cancer and is on track to achieve this for colorectal cancer as well. This is very positive. However, the introduction of colorectal cancer screening has proceeded at very different rates across the regions. There is a gap of more than twelve years between the region that implemented the programme first and the region planning to do so last, in 2026. The Committee considers it unreasonable that early cancer detection should depend on where a person lives and therefore recommends that the state authorise a national authority to issue binding regulations and finance the screening programmes.

The Committee does, however, consider that it is not sufficient for a large proportion of the population to be offered screening. What matters in practice is the number of people who actually participate in screening. The Committee has therefore chosen to compile data on actual participation in screening as a complement to the indicators in the cancer plan. The figures show that differences in participation in screening programmes are very large, both between and within regions, as well as between different socio-economic groups. Certain groups also participate to a lesser extent. This applies, for example, to women born abroad and women with mental disabilities, who participate in breast cancer screening less than others. A clearer authorisation for a national authority to issue binding regulations, as proposed by the Committee, would enable more uniform methods and approaches to reach groups that participate in screening less than others. However, this would not be a complete solution; greater attention to these disparities and cooperation between public and private actors will always be required to reach all groups.

Basis for the assessment

As a basis for its assessment, the Committee has examined the proportion of the population invited to screening for cervical cancer, breast cancer, and colorectal cancer, as well as participation in these screening programmes. The Committee has also analysed access to colorectal cancer screening based on the number of regions that have fully implemented the programme and reviewed the coverage in the mammography register.

7.1. Participation in breast cancer screening programmes

In the Cancerfonden screening report from autumn 2024, participation in mammography, HPV testing, and colorectal cancer screening is presented at the regional level. For mammography and colorectal cancer screening, differences within the regions are also shown by reporting statistics for the municipalities with the highest and lowest participation.[52]

During the period 2022–2023, approximately four out of five women in Sweden participated in mammography screening. At the national level, participation was 78 per cent, but there was considerable variation between municipalities. The municipality with the lowest participation had 63 per cent, while the one with the highest had 91 per cent, a difference of 28 percentage points.

Differences were also observed at the regional level. Regions such as Blekinge, Halland, Jämtland Härjedalen, Jönköping, Västerbotten, and Västernorrland generally had high average levels, with the proportion of women participating in screening often around 85 per cent. In Blekinge and Halland, the differences between municipalities were small, only four percentage points. Similar patterns were seen in Västerbotten and Västernorrland, where participation was evenly distributed between municipalities. In some regions,

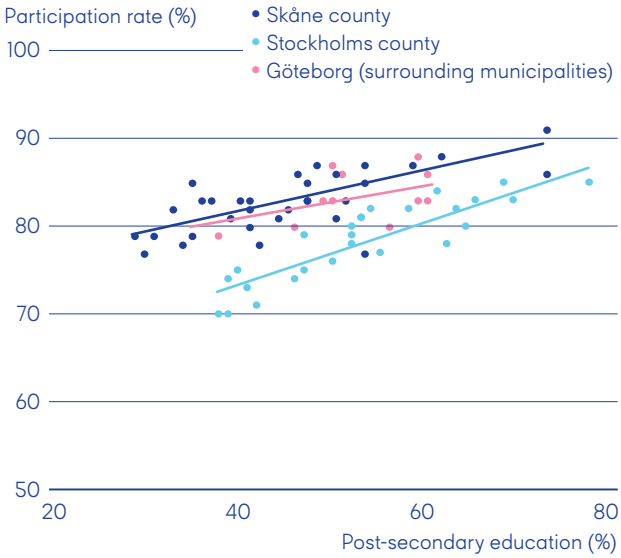
	Total participation 2022–2023	Lowest municipality	Highest municipality	Difference
SWEDEN	78%	63%	91%	28
Blekinge	87%	86%	90%	4
Dalarna	80%	76%	84%	8
Gotland	85%	-	-	-
Gävleborg	82%	77%	87%	10
Halland	86%	86%	89%	4
Jämtland Härjedalen	84%	80%	86%	6
Jönköping	85%	84%	88%	4
Kalmar	82%	73%	85%	12
Kronoberg	80%	69%	83%	13
Norrbotten	82%	70%	86%	16
Skåne	82%	77%	91%	14
Stockholm	78%	70%	85%	16
Södermanland	78%	69%	81%	13
Uppsala	82%	63%	85%	22
Värmland	83%	77%	89%	13
Västerbotten	85%	82%	87%	6
Västernorrland	85%	83%	87%	3
Västmanland	80%	75%	82%	7
Västra Götaland	84%	76%	91%	15
Örebro	81%	67%	83%	16
Östergötland	82%	70%	84%	14

however, the differences between municipalities were more pronounced. In Uppsala, participation ranged from 63 per cent in the municipality with the lowest rate to 85 per cent in the municipality with the highest, a difference of 22 percentage points. In Stockholm and Örebro, the variation was also notable, with differences of 16 percentage points between the municipalities with the lowest and highest participation. This demonstrates that participation can vary considerably within a single region.

The larger regions of Skåne and Västra Götaland were close to the national average, with average participation rates between 82 and 84 per cent. However, differences between municipalities within these regions were notable; in Skåne, participation in the most engaged municipality was 14 percentage points higher than in the municipality with the lowest participation. Västra Götaland showed a similar spread, with a difference of 15 percentage points.

Kalmar and Kronoberg are further examples of regions where variation between municipalities was noticeable. In Kalmar, participation was 73 per cent in the municipality with the lowest rate, compared with 85 per cent in the municipality with the highest, a difference of 12 percentage points. Kronoberg showed a similar spread, with a difference of 13 percentage points between municipalities.

Differences in mammography participation in 2022/2023 between municipalities in metropolitan regions, based on education level. Image from Cancerfonden's report Nationell styrning för ökad jämlikhet.



One observation is that regions with similar average participation can have different levels of internal variation. For example, Västerbotten and Västra Götaland both have average participation rates of around 84 per cent, but the difference between municipalities is considerably smaller in Västerbotten (6 percentage points) compared with Västra Götaland (15 percentage points). This may indicate that organisational factors or local initiatives play a role.

In addition to uneven participation between regions, differences are also observed within regions for all screening programmes. Income and education levels, as well as country of birth, are among the factors influencing participation. These differences have remained consistent since 2019. Socioeconomically based disparities are particularly evident, for example in mammography participation in Stockholm, where overall participation has increased. Similar disparities are also seen in colorectal cancer screening.

Another aspect of inequality that should be considered is participation in mammography among women with disabilities. According to the National Board of Health and Welfare's report "Measures and Support for People with Disabilities", breast cancer mortality is higher in this group. The risk of death is five times higher among breast cancer patients receiving support under the LSS Act (primarily intellectual disabilities and autism) and more than six times higher among those receiving support under the Social Services Act (SoL) (primarily mental disabilities). Furthermore, women receiving support under LSS or SoL are more likely to be diagnosed with breast cancer at stage 3 or 4. This is likely a contributing factor to the higher breast cancer mortality in these groups.

In a previous assignment, representatives of mammography services indicated that individuals with mental, intellectual, or neuropsychiatric disabilities are generally difficult to reach, and that it is a challenge for the services that invitations are sent to women based on the population register without knowledge of the woman and her health status. The representatives also stated that the target group may lack motivation and, in some cases, may not fully understand the importance of the examination. At the same time, the National Board of Health and Welfare points out that many individuals receiving support under SoL and LSS live in special housing, where staff could assist with mammography examinations. Patient and user organisations emphasise the need for adapted information for people with, for example, intellectual disabilities, such as easy-to-read material about both mammography and breast cancer treatment.[53]

7.2. Participation in cervical cancer screening programmes

The figures for HPV testing refer to coverage rather than participation. In other words, the data do not indicate whether the women actually attended their invitation; instead, the figure shows the proportion of women in the target group who have taken an HPV test within the recommended time frame.

HPV test, 2023	
Region	Proportion (%)
SWEDEN	78
Blekinge	77
Dalarna	86
Gotland	78
Gävleborg	66
Halland	84
Jämtland	64
Jönköping	83
Kalmar	82
Kronoberg	62
Norrbotten	65
Skåne	83
Stockholm	79
Södermanland	71
Uppsala	69
Värmland	89
Västerbotten	65
Västernorrland	71
Västmanland	85
Västra Götaland	76
Örebro	89
Östergötland	75

Coverage of cervical cancer screening with HPV testing varies considerably between regions. The national average is just under eight out of ten women. Several regions, however, achieve significantly higher levels than the average. For example, both Örebro and Värmland have the highest coverage, with nearly nine out of ten women tested, closely followed by Dalarna and Västmanland, where coverage is very similar. Regions such as Halland, Skåne, Jönköping, and Kalmar also have high coverage, with more than four out of five women having completed the test.

In contrast, some regions show significantly lower coverage. Jämtland and Kronoberg have the lowest coverage, with the proportion of women tested close to six out of ten. Västerbotten, Norrbotten, and Gävleborg are slightly above these levels, with approximately two-thirds of women tested. Coverage in Uppsala is also below the national average. There is thus a difference

of 27 percentage points between the region with the highest and the lowest coverage.

Another factor affecting participation in cervical cancer screening is women with mental illness or disabilities. As with other types of cancer-related screening programmes, participation among these women is lower than in the general population.

Studies and government reports have shown that individuals with mental illness (such as bipolar disorder, schizophrenia, and other psychotic conditions) or neuropsychiatric disabilities often have lower participation in screening programmes and experience higher mortality.[54] A recently published study from the Karolinska Institute, funded by Cancerfonden, found that women diagnosed within specialised care with mental illness, neuropsychiatric disabilities, or substance abuse participate less frequently in gynaecological cytology screening and have more than double the risk of developing the disease.[55]

Several regions have introduced medical guidelines to offer annual health consultations and somatic check-ups for patients with long-term mental illness, which among other things relate to participation in screening programmes. Complete statistics on the number of cancer cases detected through these health consultations are not yet available, but several national and regional knowledge supports indicate that this approach can help reduce premature mortality from cancer and other diseases in this patient group. Västra Götaland County was the first to implement this guideline in 2016, and similar guidelines now exist in, among others, Skåne and Stockholm.

7.3. Participation in colorectal cancer screening programmes

As all regions have now begun implementing colorectal cancer screening, the total number of people participating in screening has increased between 2019 and 2023. At the same time, the proportion of those invited who actually participate has decreased. Of the individuals invited to screening, approximately two out of three participated nationwide. Clear geographical differences in participation were also observed. When comparing regions as a whole, the proportion of participants ranged from 59 per cent in Norrbotten to 73 per cent in Gotland—a difference of 14 percentage points. Differences were even greater between individual municipalities, where participation ranged from 47 per cent in the municipality with the lowest rate to 73 per cent in the one with the highest, representing a difference of 26 percentage points.

Participation, both sexes, 2023, by region and municipality

Region	Total participation	Lowest municipality	Highest municipality	Difference highest-lowest
SWEDEN	64%	47%	73%	26
Blekinge	63%	62%	63%	1
Dalarna	68%	64%	73%	9
Gotland	73%	-	-	
Gävleborg	65%	57%	69%	12
Halland	62%	59%	65%	6
Jämtland Härjedalen	62%	52%	67%	15
Jönköping	63%	61%	63%	2
Kalmar	61%	56%	63%	7
Kronoberg	61%	47%	63%	16
Norrbotten	59%	49%	63%	14
Skåne	61%	54%	66%	12
Stockholm	68%	61%	73%	12
Södermanland	64%	61%	66%	5
Uppsala	60%	54%	63%	9
Värmland	62%	54%	67%	13
Västerbotten	63%	55%	66%	11
Västernorrland	61%	54%	64%	10
Västmanland	61%	53%	62%	9
Västra Götaland	64%	57%	65%	8
Örebro	62%	51%	64%	13
Östergötland	64%	58%	71%	13

Participation by sex			
Region	Women's participation, 2023	Men's participation, 2023	Difference men-women
SWEDEN	68%	61%	7%
Blekinge	67%	59%	8%
Dalarna	72%	64%	8%
Gotland	74%	71%	3%
Gävleborg	69%	62%	7%
Halland	66%	58%	8%
Jämtland Härjedalen	68%	56%	12%
Jönköping	67%	60%	7%
Kalmar	65%	57%	8%
Kronoberg	65%	57%	8%
Norrbotten	62%	55%	7%
Skåne	63%	58%	5%
Stockholm	70%	65%	5%
Södermanland	68%	61%	7%
Uppsala	63%	57%	6%
Värmland	67%	58%	9%
Västerbotten	67%	59%	8%
Västernorrland	67%	56%	11%
Västmanland	64%	57%	7%
Västra Götaland	68%	60%	8%
Örebro	65%	59%	6%
Östergötland	68%	61%	7%

In Stockholm, the average participation was 68 per cent. Between municipalities in the region, participation ranged from 61 to 73 per cent – a difference of 12 percentage points. Clear differences between municipalities were also observed in other regions. In Östergötland, the average participation was 64 per cent, while participation in individual municipalities ranged from 57 to 71 per cent. This means that the municipality with the highest participation had almost a quarter higher rate than the municipality with the lowest. In Kronoberg, the variation was even greater, with 47 per cent in the municipality with the lowest participation and 63 per cent in the one with the highest – a difference of 16 percentage points, the largest of all reported regions. This was followed by Jämtland Härjedalen, with a difference of 15 percentage points between the municipalities with the lowest and highest participation.

In other regions, such as Blekinge, Västmanland, and Jönköping, the difference between municipalities was very small, often only 1–2 percentage points. This indicates that participation is more evenly distributed in these areas, which may be the result of local efforts to engage and encourage participation.

In general, a larger proportion of women than men participated in the screening programme, but the differences between the sexes varied by region. At the national level, participation among women was 68 per cent, while among men it was slightly lower, at 61 per cent. This means that women generally participated to a greater extent than men in the screening programme. The largest gender differences were observed in regions such as Västernorrland, Jämtland, and Västerbotten, where participation among women was around 10 per cent higher than among men. For example, 67 per cent of women participated in Västerbotten, while only 59 per cent of men participated. Similar differences are seen in Västernorrland, where 67 per cent of women participated compared with only 56 per cent of men. There are also regions where the gender differences are less pronounced. In Östergötland and Jönköping, the difference between women and men was relatively small, at only 6–7 percentage points. In these regions, participation among women was 68 per cent, while men participated at 61–62 per cent.

The regions with the highest participation among women were Gotland and Dalarna, where 74 per cent and 72 per cent of women, respectively, took part in the screening programme. For men, Gotland was also among the regions with the highest participation, with 71 per cent participating, representing one of the largest gender differences. Here, women were slightly

Implementation plan for colorectal cancer screening, version 2023-09-25				
2026	Start	Number of cohorts	Birth years	Planned year of full implementation
Stockholm + Gotland	2008/2009	8 /60–74	1952, 1954, 1956, 1958, 1960, 1962, 1964, 1966	2025
Dalarna	2021	8 /60–74	1952, 1954, 1956, 1958, 1960, 1962, 1964, 1966	2025
Skåne	2021	8 /60–74	1952, 1954, 1956, 1958, 1960, 1962, 1964, 1966	2025
Örebro	2021	8 /60–74	1952, 1954, 1956, 1958, 1960, 1962, 1964, 1966	2025
Östergötland	2021	8 /60–74	1952, 1954, 1956, 1958, 1960, 1962, 1964, 1966	2025
Västra Götaland	2022	8 /60–74	1952, 1954, 1956, 1958, 1960, 1962, 1964, 1966	2025
Norrbotten	2022	8/60–74	1952, 1954, 1956, 1958, 1960, 1962, 1964, 1966	2026
Värmland	2022	8/60–74	1952, 1954, 1956, 1958, 1960, 1962, 1964, 1966	2024
Jönköping	2022	8 /60–74	1952, 1954, 1956, 1958, 1960, 1962, 1964, 1966	2026
Gävleborg	2022	8 /60–74	1952, 1954, 1956, 1958, 1960, 1962, 1964, 1966	2025
Sörmland	2022	8 /60–74	1952, 1954, 1956, 1958, 1960, 1962, 1964, 1966	2024
Västernorrland	2022	8 /60–74	1952, 1954, 1956, 1958, 1960, 1962, 1964, 1966	2026
Blekinge	2022	8 /60–74	1952, 1954, 1956, 1958, 1960, 1962, 1964, 1966	2025
Västmanland	2022	8 /60–74	1952, 1954, 1956, 1958, 1960, 1962, 1964, 1966	2026
Västerbotten	2022	8 /60–74	1952, 1954, 1956, 1958, 1960, 1962, 1964, 1966	2025
Jämtland/Härjedalen	2022	8/60–74	1952, 1954, 1956, 1958, 1960, 1962, 1964, 1966	2026
Uppsala	2022	8 /60–74	1952, 1954, 1956, 1958, 1960, 1962, 1964, 1966	2026
Kalmar	2022	8 /60–74	1952, 1954, 1956, 1958, 1960, 1962, 1964, 1966	2025
Kronoberg	2022	8 /60–74	1952, 1954, 1956, 1958, 1960, 1962, 1964, 1966	2026
Halland	2022	8 /60–74	1952, 1954, 1956, 1958, 1960, 1962, 1964, 1966	2026

overrepresented, with only a marginal difference between the sexes. On the other hand, Norrbotten was the region with the lowest participation among women, with only 62 per cent participating. Participation among men in Norrbotten was even lower, at just 55 per cent, the lowest rate for both women and men in the entire country.

7.4. Access to colorectal cancer screening programmes

in healthcare. The National Board of Health and Welfare is responsible for providing recommendations on national screening programmes to promote equitable care, but these are not legally binding. By law, the regions are required to offer free screening for cervical and breast cancer, but not for colorectal cancer, which results in variation in implementation between regions.

Differences between regions become particularly evident with the introduction of new screening programmes. The example of colorectal cancer screening shows that it can take up to twelve years from the National Board of Health and Welfare's recommendation in 2014 until the programme is fully implemented nationwide in 2026. Stockholm and Gotland regions introduced colorectal cancer screening as early as 2008, while other regions only began in 2021 or 2022. Västra Götaland County is expected to be the last to fully implement the programme in 2026. According to the 2023 implementation plan (see table above), this was originally planned for 2025. Due to the size of the region, Sweden is unlikely to achieve the EBCP target of offering colorectal cancer screening to 90 per cent of the population by 2025.

7.5. Coverage of the mammography register

The national quality register for mammography screening (NKM) was established in 2020. The quality register includes women aged 40–74 who are invited to mammography screening and contains breast radiology data for the entire process – from invitation and participation to screening results and further investigation if needed. In total, 2.1 million women are included in the target group, and to manage the large volume of data, a solution has been developed that allows automatic transfer of information from the mammography units' medical record systems to the register. This eliminates the need for manual data entry. Registration in the register occurs at the regional level, which means that for a participating region, coverage is almost 100 per cent.

According to RCC's website for registers, only three regions – Västmanland, Värmland, and Västernorrland – are currently connected, but several regions are actively working to join the register. In an interview with the register manager Eric Arelöf on Sveriges Radio in November 2024, he stated that regions not yet connected cited partly technical, but also financial reasons. Furthermore, he estimated that approximately half of the regions were expected to be connected to the register by the turn of the year 2024/2025.[61]

Diagnosis and treatment

Selection of goals and initiatives in EBCP

The EBCP emphasises the importance of equitable access to high-quality diagnostics and treatment in cancer care. It highlights the need for specialised cancer centres, multidisciplinary care teams, and access to innovative treatments. A central initiative is the establishment of an EU network connecting national cancer centres to promote knowledge exchange and quality assurance. The plan also underscores the importance of education and skills development for healthcare professionals, the advancement of precision medicine, and improved access to cancer medicines. Through collaboration in research and digital technology, the EU aims to strengthen diagnostics, treatment, and personalised care for cancer patients.

Committee's assessment

The Committee notes that the quantitative targets in the EU Cancer Plan are vague, but that strong measures are required to achieve the overarching vision of equitable and high-quality cancer care in Sweden. Currently, there are significant regional differences in waiting times for diagnosis and treatment.

A coordinated national effort is needed, in line with the recently submitted proposal for an updated national cancer strategy. The Committee emphasises that such a strategy must be complemented by a clear roadmap, well-defined responsibilities for the various actors, and a time-bound follow-up.

It is also important that primary care, which often detects cancer, is provided with the right conditions and that accessibility is improved. This includes, among other things, creating the possibility for more residents to have a regular doctor, developing team-based approaches that make use of the expertise of different professionals, and ensuring access to improved methods for early detection.

The Committee considers that follow-up of nationally highly specialised care will be important in the future from an equity perspective. However, the Committee notes that there is currently no basis for such an assessment. Finally, the Committee concludes that a solution is needed for the legal and technical barriers that currently delay the sharing of imaging diagnostics between regions. To facilitate collaboration and consultations across borders and to accelerate diagnostic processes, a common national infrastructure and a clear legal interpretation of data sharing are required.

Basis for the assessment

As a basis for its assessment, the Committee has reviewed the national initiative on genome-based precision diagnostics and precision medicine, Genomic Medicine Sweden (GMS), as well as guidelines and statistics on physician availability in primary care and healthcare providers' ability to share patient data.

8. Reference values for physicians in primary care

Primary care plays an important role in detecting cancer. It is therefore essential that these services have the right conditions. The National Board of Health and Welfare has set a reference value of 1,100 registered patients per primary care physician, but few regions meet this standard. Only one in four Swedes has a regular doctor. Several regions have, however, introduced patient registration limits and measures to achieve this, and this work must continue. It is also important to develop team-based approaches that utilise the expertise of different professionals within primary care. This requires a continued transition towards high-quality, accessible, and patient-centred care. Additionally, there must be easily accessible channels for consultation between primary care and other specialist services relevant to the diagnosis and treatment of cancer.

9. Access to nationally highly specialised care

Equitable access to the most complex cancer care is an important quality parameter. Since 2018, the National Board of Health and Welfare has been tasked with deciding which areas should constitute nationally highly specialised care and where it should be provided. The Committee has reviewed the follow-up conducted to date but notes that an assessment of equity is not yet possible, as these involve rare diagnoses with few cases. The Committee has also reviewed the Regional Cancer Centres' reporting on care that was nationally level-structured prior to the National Board of Health and Welfare's mandate, but has concluded that the

data are not usable for assessment in conjunction with the Board's current follow-up.

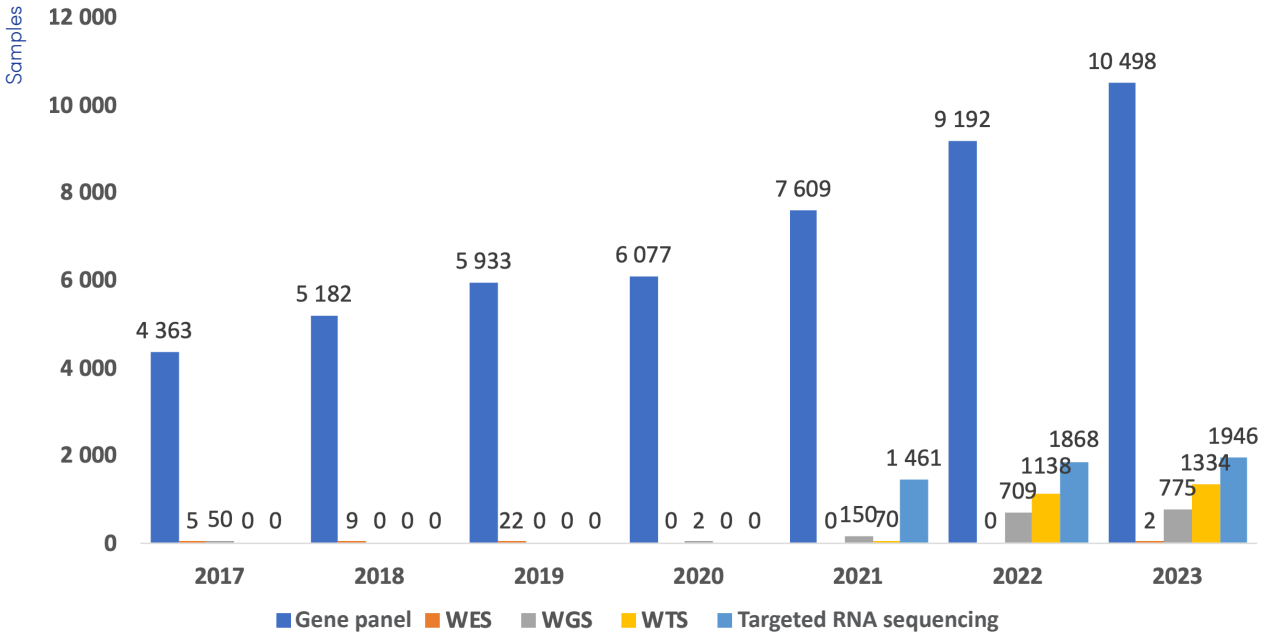
10. Number of cancer patients nationally diagnosed using genome sequencing/ precision medicine techniques

The EBCP highlights genome sequencing, also known as NGS (next generation sequencing), as a key component in the development of precision medicine and personalised care for cancer patients. The plan emphasises the importance of improving access to advanced diagnostics and innovative treatment methods across the EU in order to reduce inequalities in cancer care between member states. Against this background, it is increasingly important to analyse how genome sequencing is used in Sweden, the opportunities and challenges it presents, and how its implementation can be ensured in a way that benefits both patients and healthcare services.

Genomic Medicine Sweden (GMS) is a national initiative in Sweden focusing on genome-based precision diagnostics and precision medicine. The initiative began in 2017 and involves collaboration between the seven universities with medical faculties and the seven regions responsible for university hospital care. Sweden aims to be a leader in implementing precision medicine within healthcare, and to support this development there is a need to monitor and follow up on the large-scale sequencing analyses carried out in the country. These analyses include various methods based on so-called NGS technology (next generation sequencing). The goal is to obtain a consolidated overview of the annual number of NGS analyses performed on clinical samples in Sweden. The information collected enables healthcare providers to monitor developments, anticipate needs and capacity, and plan the implementation of new genomic analyses developed by GMS in collaboration with the Clinical Genomics platform at SciLifeLab. Most NGS analyses on clinical samples are carried out at university hospital laboratories, often in close collaboration with the SciLifeLab Clinical Genomics platform and the regional Genomic Medicine Centers (GMC) established by GMS. Analyses are also conducted at other hospital laboratories, university-affiliated laboratories, and by private operators.[64]

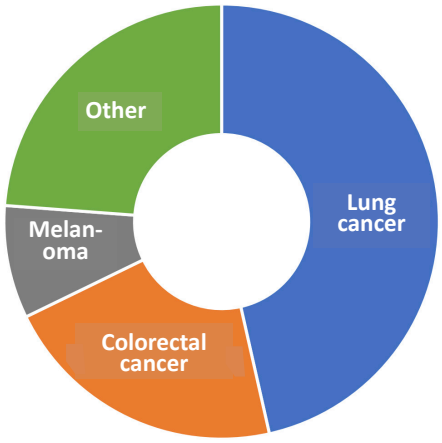
In its annual reports, GMS presents statistics at the national level. Ahead of preparing this compilation, the review committee requested statistics broken down by region. However, the GMS steering and management group has chosen not to release this information. According to GMS, this is because the data were not initially collected with the intention of regional disaggregation, and there are a number of factors that may affect the reliability of the data. For example, the analyses are not always linked to the patient's place of residence, and some analyses have been sent abroad from certain centres. GMS further states that the goal is to generate more accurate and representative data by using NGP (Next Generation Pathology) and linking the analyses to the INCA registries. This is an ongoing project, and GMS hopes it will be able to provide more detailed data from next year.

Number of samples for rare diagnoses, solid tumours, and haematology analysed using gene panels, targeted RNA sequencing, WTS, WES, and WGS during 2017–2023. **Figure from Genomic Medicine Sweden's report Inventory of NGS-based Analyses in Sweden 2023.**



The 2023 annual report from GMS indicates that a total of 90,874 patient samples were analysed using NGS-based methods to support diagnosis in areas such as rare diseases, cancer, haematology, microbiology, SARS-CoV-2, and NIPT (a prenatal test used to detect certain chromosomal abnormalities in the fetus). The analytical methods applied included gene panels (targeted sequencing of specific regions of DNA), whole genome sequencing (WGS), where the entire DNA sequence of a sample is analysed, and RNA sequencing, which provides information on gene expression within cells.

Distribution of the number of cancer samples for lung cancer, colorectal cancer, malignant melanoma, and other cancer types analysed using gene panels in 2023. **Image from Genomic Medicine Sweden's report Inventory of NGS-based analyses in Sweden 2023.**

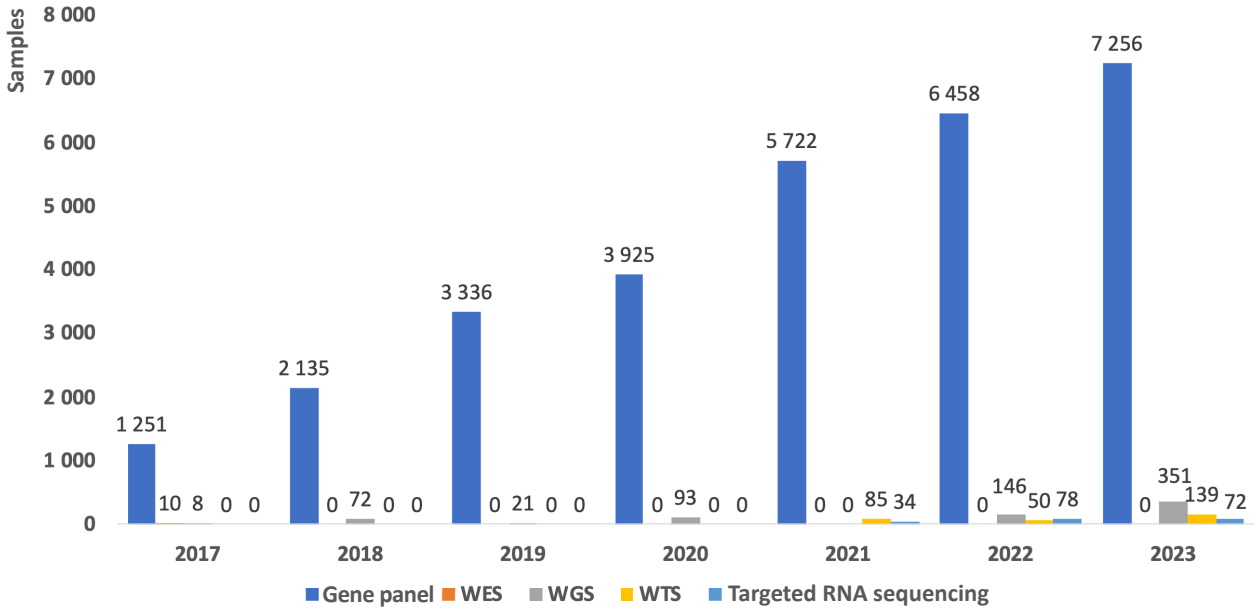


A total of 10,498 cancer samples were analysed during the year using gene panels, representing a 14 per cent increase compared to the previous year. A new gene panel for solid tumours, GMS560, was introduced in 2023 and was used for 508 samples. During the same period, targeted RNA sequencing was performed on 1,946 samples, and whole genome sequencing was conducted on 775 samples, both showing an increase from the previous year. In addition, 1,334 samples were analysed using whole transcriptome sequencing (WTS), an approach that increased by 17 per cent compared to 2022. For haematological diseases, 7,256 samples were analysed using gene panels, which represented a 12 per cent increase from the previous year. Of these, 4,586 samples were analysed using a specific gene panel for myeloid disorders (blood cancer).

11. Legal conditions and regional differences regarding the sharing of medical imaging

The EBCP includes a range of initiatives aimed at improving cancer care across Europe, including enhanced access to and use of medical imaging. One of the plan's objectives is to create a European infrastructure for sharing and managing cancer-related imaging, which is intended to support better diagnosis, faster treatment, and more effective cancer care. A concrete example of this is the "Cancer Image Europe" platform, which aims to establish a shared infrastructure for exchanging cancer imaging data between countries and regions in Europe. This platform is intended to make it easier for healthcare providers and researchers to access and utilise high-quality medical imaging in real time, which in turn is expected to improve the accuracy

Number of haematology samples analysed using gene panels, WES, WGS, WTS, and targeted RNA sequencing during 2017–2023. **Image from Genomic Medicine Sweden's report Inventory of NGS-Based Analyses in Sweden 2023.**



of diagnosis and treatment. In the Swedish context, it is important to consider the legal conditions for sharing imaging diagnostics between regions.

In Sweden, each region is responsible for managing and storing patient data, including imaging diagnostics, and there is some variation in how this is done. Imaging diagnostics can be stored in different systems and platforms depending on the region, which means there may be differences in how data is shared across regions.

Within the framework of the 2024 national cancer agreement, which aims to improve equality and efficiency in cancer care, 60 million SEK has been allocated to development projects covering pathology as well as imaging and functional medicine. These areas are crucial for meeting the national lead time targets for SVF (standardised care pathways). Imaging and functional medicine, which is a central part of almost all SVF, has faced challenges that hinder rapid and efficient diagnosis, a direct consequence of obstacles in sharing digital images and other diagnostics between regions.

According to a review of pathology by the Regional Cancer Centres (RCC), facilitating consultation and collaboration across regional borders requires both legal and technical solutions to enable the sharing of digital images. A national legal interpretation needs to be clarified to overcome the current barriers, and common technical solutions for digital image sharing must be implemented. Achieving this requires collaboration among multiple actors, including the Swedish eHealth Agency, the National Board of Health and Welfare, and RCC, to create a unified infrastructure and ensure that all regions have access to and can share relevant imaging diagnostics in real time. This would contribute to faster diagnoses and more equitable cancer care across Sweden, in line with the goals of the EBCP and the national cancer agreement.

In discussions with personnel working in these types of services, the Committee has received testimonies consistent with RCC's review. It was reported that there are extensive issues because regional legal advisors make different assessments regarding how data sharing may occur. Currently, some regions only allow images to be sent by post, causing delays in analysis, which in turn affects the ability to meet SVF lead time targets.

Quality of life

Selection of goals and initiatives in EBCP

The goal in the EBCP regarding quality of life for people who have or have had cancer, as well as their relatives, includes, among other things, that Member States should begin preparations for the implementation of EU Directive 2019/1158 on work-life balance for parents and carers (also known as the Work-Life Balance Directive). The EBCP also emphasises the importance of using patient-reported measures such as PROM (Patient Reported Outcome Measure) and PREM (Patient Reported Experience Measure) to improve cancer care.

Committee's assessment

Sweden is already assessed to largely comply with the Work-Life Balance Directive. Regarding the use of patient-related measures, there is ongoing work within the Regional Cancer Centres (RCC) and the national quality registers. The Committee believes this work must continue. In addition, patient and relative involvement, both in individual care and at the group level, needs to be strengthened. The focus on this in the proposed updated national cancer strategy is expected to contribute to a positive development. The Committee emphasises the importance of examining and improving the quality of life for people living with cancer from a holistic perspective. This includes aspects such as financial security, opportunities for family life, survival, and a range of physical and mental health issues arising from the cancer. People's experiences of cancer are not only about the disease and care but also more broadly about living conditions and the support provided by various authorities, as well as how society is structured for those living with cancer.

Basis for the assessment

The Committee has examined the Work-Life Balance Directive in relation to Swedish legislation, as well as data from the RCC regarding the use of patient-reported measures in quality registers. Furthermore, the Committee has held a dialogue meeting with a number of cancer patient associations.

12. EU Directive on work-life balance for parents and carers

The EBCP emphasises the importance of enabling the families of cancer patients to balance their work life with the support and care that cancer treatment often requires. Directive 2019/1158 supports this objective by granting the right to more flexible working hours, particularly for those who are informal caregivers. It is underlined that all EU countries should implement the directive in a way that strengthens working conditions for these groups, which in turn can contribute to better quality of life and support for both cancer patients and their relatives.

The directive was adopted in June 2019, and by August 2027 at the latest, Member States must submit all information on the implementation of this directive to the Commission, as needed for the Commission to prepare a report. The information should include available aggregated data on how men and women have made use of the various types of leave and flexible working arrangements under this directive, in order to enable proper monitoring and evaluation, particularly from a gender equality perspective, of how the directive has been implemented.[66]

Consequently, there is currently no reporting on the measures Sweden has taken to ensure the implementation of the directive. However, a government inquiry has been carried out, which was followed by legislative changes.

In 2019, the government commissioned an inquiry to analyse and assess whether Swedish law is compatible with the directive.[67] The inquiry was reported in 2020 and concluded that Swedish legislation is largely already in line with the directive, although some changes were necessary.[68] In 2022, the government bill 2021/22:175 on the implementation of the work-life balance directive was considered by the Parliament. The bill was largely consistent with the inquiry's recommendations. The legislative changes resulting from the bill were proposed to take effect in August 2022, with one exception: an amendment to the Act on Leave for Family Care was proposed to take effect in October of the same year.[69]

A complete description of the content of the Work-Life Balance Directive, as well as a comparison of the inquiry's proposals in relation to the government bill considered by the Parliament's Committee on Labour, can be found in Appendix 3.

13. Patient-reported measures

The EBCP emphasises the importance of integrating patient-reported measures (PROM and PREM) to improve cancer care across Europe. These measures provide insights into patients' own experiences and outcomes, which is crucial for developing more person-centred and effective care. The plan includes several initiatives aimed at strengthening the collection and use of such data to improve the quality of life for cancer patients and survivors. By collecting and analysing patient-reported measures, healthcare providers can better understand patients' needs and preferences, leading to improved treatment outcomes and increased patient satisfaction.

In Sweden, the Regional Cancer Centres (RCC) work to increase patient involvement in cancer care by collecting and using PROM and PREM.[70] This work aligns with the goals of the EBCP to improve the quality of life for people living with or having had cancer.

The quality registers help healthcare providers identify what works well and what can be improved. They are also used to monitor the quality of care in different parts of the country and contribute to more equitable and safe care for all patients. Patient-reported measures are used to capture patients' own experiences of their health, illness, treatment, and healthcare interactions. They provide healthcare professionals with valuable information about how patients feel and how they perceive the care they receive.

The measures are divided into two categories:

- PROM (Patient Reported Outcome Measure) measures how patients perceive their health and any changes following treatment or other interventions. This can include symptoms, physical and mental functioning, and overall quality of life. In Sweden, PROM is used in many disease-specific quality registers, with cancer registers being an example. These registers collect patients' experiences of their health and treatment, enabling the follow-up of treatment outcomes and quality of life from the patient's perspective. By combining PROM with medical data, healthcare providers gain a more complete picture of the patient's condition, which can lead to more personalised and effective care.
- PREM (Patient Reported Experience Measure) focuses on the patient's experiences of healthcare, such as staff attitude, information provided, participation, and accessibility. Its purpose is to understand how care is perceived and to identify areas for improvement. Unlike PROM, this information is always collected anonymously to ensure that patients can freely express their opinions. PREM data is gathered, among other sources, through 1177 Vårdguiden's national patient survey, providing insight into patients' experiences of the entire care process.

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Annex 1: Swedish legislation and guidelines on smoke-free environments in relation to the Council Recommendation on smoke- and aerosol-free environments

Recommendation 1

Provide effective protection against exposure to tobacco smoke in indoor workplaces, indoor public places, and public transport in accordance with Article 8 of the WHO Framework Convention on Tobacco Control and based on the guidelines for protection against tobacco smoke adopted at the second session of the Conference of the Parties to the Convention.

Assessment

Fulfilled under Swedish legislation on smoke-free environments (Chapter 6, Sections 2 and 10).

Recommendation 2

Provide effective protection in indoor workplaces, indoor public places, and public transport against exposure to secondhand emissions from the use of new products that emit smoke or aerosols, such as heated tobacco products, electronic cigarettes – whether containing nicotine or nicotine-free – tobacco substitutes, and any other products that emit smoke and/or aerosols, such as herbal smoking products (hereinafter, together with exposure to tobacco smoke, referred to as exposure to secondhand smoke and aerosols).

Assessment

Fulfilled under Swedish legislation on smoke-free environments (Chapter 6, Sections 2 and 10).

Recommendation 3

Provide effective protection against exposure to secondhand smoke and aerosols in designated outdoor recreational areas, especially where children, adolescents, and vulnerable individuals are likely to be present. These areas should include public playgrounds, amusement parks, swimming pools, beaches, zoos, and other similar outdoor environments.

Assessment

Smoke-free outdoor environments in designated recreational areas under Swedish law include public playgrounds and enclosed outdoor areas primarily intended for sports activities, according to Chapter 6, Section 2, points 8 and 9.

Note

Property owners and others in control of premises/areas/land can implement smoke-free environments beyond those required by law.

Recommendation 4

Provide effective protection against secondhand smoke and aerosols in outdoor or partially outdoor areas belonging to service establishments (e.g., partially covered, fenced, enclosed, or otherwise delineated areas adjacent to or near an establishment, including rooftop terraces, balconies, verandas, or patios). These should include outdoor areas associated with restaurants, bars, and cafés, as well as outdoor areas belonging to other similar premises.

Assessment

Fulfilled under Swedish legislation on smoke-free environments (Chapter 6, Section 2, point 5).

Recommendation 5

Provide effective protection against secondhand smoke and aerosols in outdoor or partially outdoor areas associated with public transport, including bus, tram, and train stops, as well as at airports.

Assessment

Fulfilled under Swedish legislation on smoke-free environments (Chapter 6, Section 2, point 4).

Recommendation 6

Provide effective protection against secondhand smoke and aerosols in outdoor areas associated with a workplace.

Assessment

Fulfilled under Swedish legislation on smoke-free environments (Chapter 6, Sections 2, 3, and 10). In addition to the workplaces specifically mentioned in Sections 2 and 3, the employer is responsible for ensuring that employees are not exposed to passive smoking at their workplace, in accordance with Section 10.

Recommendation 7

Provide effective protection against secondhand smoke and aerosols in all outdoor areas associated with healthcare facilities. Such facilities should include hospitals, clinics, health centres, care homes, and other similar premises.

Assessment

Partially fulfilled under Swedish legislation on smoke-free environments (Chapter 6, Section 2, point 10). Entrances to premises intended for healthcare, as well as residential and service or care facilities, are covered by the smoking ban.

Recommendation 8

Provide effective protection against secondhand smoke and aerosols in outdoor areas associated with facilities providing education for children and adolescents. Such facilities should include preschools, primary schools, secondary schools, vocational schools, universities, youth centres, and other similar premises.

Assessment

Fulfilled under Swedish legislation on smoke-free environments (Chapter 6, Section 2, point 1).

Recommendation 9

Consider including other outdoor environments where the general public is likely to be present, including children, minors, or vulnerable individuals, in complementary measures to prevent tobacco and nicotine use and dependence, and to contribute to comprehensive smoke- and aerosol-free environments. Such environments may include outdoor areas where events are held, stands and spectator areas at public events, as well as areas associated with buildings open to the public where many pedestrians are likely to be present (e.g., entrances to shopping centres, courtyards belonging to buildings open to the public).

Assessment

Fulfilled under Swedish legislation on smoke-free environments (Chapter 6, Section 2, point 1).

Recommendation 10

Consider including other environments, such as private cars where children, minors, or vulnerable individuals are present, in complementary measures to prevent tobacco and nicotine use and dependence, and to contribute to comprehensive smoke- and aerosol-free environments.

Assessment

Not included in Swedish legislation.

Recommendation 11

- Develop and/or strengthen policies for smoke- and aerosol-free environments by:
- Developing national strategies and programmes to ensure effective protection against exposure to secondhand smoke and aerosols.
- Implementing and/or developing preventive campaigns, as well as smoking cessation and awareness campaigns, such as education, outreach activities, and information campaigns to ensure compliance with measures for smoke- and aerosol-free environments. Such campaigns may also be part of initiatives to reduce dependence and can build on and/or complement preventive initiatives included in Europe's Cancer Plan.
- Ensuring that appropriate structures and mechanisms exist to promote compliance and to implement and/or develop best practices that can improve the implementation and enforcement of measures for smoke- and aerosol-free environments.

Assessment

- 11a and 11b: Not regulated under Swedish legislation.
- 11c: Supervision of smoke-free environments is regulated in Chapter 7. Supervision under the Tobacco and Similar Products Act (2018:2088), Sections 3 and 7.

Annex 2: Survey of the eating habits of children in Year 5 and Year 7 of compulsory school, and year 2 of upper secondary school

Fruits and Vegetables

The majority of adolescents consumed fruits and vegetables daily (Tables 9 and 10). Among all participants, the average intake was 233 ± 178 grams per day. Girls consumed significantly more fruits and vegetables across all year groups, and the intake was lowest in Year 5. Only 7.5 per cent of all participants consumed 500 grams or more of fruits and vegetables (5 per cent in Year 5, 8 per cent in Year 10, and 10 per cent in Year 2 of upper secondary school).

Fish and Seafood

It is difficult to measure fish and seafood intake accurately using a two-day method. Just under 50 per cent had recorded fish and seafood, whereas the survey showed that the majority of participants ate fish at least occasionally (approximately 90 per cent). On average, participants reported consuming fish 1.6 times per week, with small variations between year groups and sexes (Table 40).

Low-fat dairy products

Among participants in Riksmaten Ungdom 2016-17, it was most common to drink semi-skimmed milk and to eat regular-fat hard cheese (28-31 per cent fat content). Overall, 75 per cent of Year 5 participants drank milk, while the proportion was lower in Year 8 (71 per cent) and Year 11 of upper secondary school (61 per cent). Among those who drank milk, 74 per cent drank semi-skimmed milk, 31 per cent skimmed milk, and 15 per cent whole milk, and approximately 20 per cent of milk drinkers had consumed multiple types of milk. Fewer than 100 participants reported eating low-fat hard cheese. Choosing low- or medium-fat fermented milk and yoghurt products was uncommon. The selection of plant-based alternatives to milk, fermented milk, and yoghurt was rare, and among girls in Year 11 of upper secondary school, 7 per cent had done so.

Red Meat and Processed Meat

Just over 8 out of 10 participants consumed red meat and processed meat (Table 9). Among all participants, the average intake was 95 ± 78 grams per day. Boys consumed significantly more red and processed meat overall and across all year groups. Girls consumed the most red and processed meat in Year 5, while boys consumed the most in Year 11 of upper secondary school.

Figure from the Swedish National Food Agency report Riksmaten Ungdom 2016-17 - Part 1: Food Consumption.

	Boys		Girls	
	n	Average times per week	n	Average times per week
Year 5	490	200 (151)	559	247 (150)
Year 8	476	231 (201)	574	247 (167)
Year 11	423	237 (187)	577	267 (200)
Total	1389	221(181)	1710	243(176)

Average consumption of fish and seafood (grams/day) over two days, by sex and school year.

	Boys		Girls	
	n	Average times per week	n	Average times per week
Year 5	490	1,6 (1,4)	559	1,7 (1,8)
Year 8	476	1,6 (1,4)	574	1,6 (1,2)
Year 11	423	1,5 (1,5)	577	1,4 (1,1)
Total	1389	1,6 (1,3)	1710	1,6 (1,4)

Average consumption of red and processed meat (grams/day) over two days, by sex and school year.

	Boys		Girls	
	N	Average times per week	n	Average times per week
Year 5	490	106 (80)	559	81 (60)
Year 8	476	117 (89)	574	72 (58)
Year 11	423	140 (100)	577	71 (59)
Total	1389	120 (90)	1710	74 (59)

Images from the Swedish Food Agency's report Riksmaten Ungdom 2016–17 – Part 1: Food Consumption.

Annex 3: Limit values for PM2.5 and PM10 – examples from Swedish monitoring stations

PM10 limit values – examples from monitoring stations				
Year	Station	Average PM10 µg/m³ (MKN = 40, EU 2030 = 20, Environmental Target = 15)	Number of days PM10 > 50 µg/m³ (MKN = 35)	Number of days PM10 > 45 µg/m³ (EU 2030 = 18)
2023	Visby Österväg 17	23,46	46	53
2023	Östersund Rådhusgatan	26,32	41	47
2023	Västerås Stora Gatan 78	20,95	31	39
2023	Sundsvall Bergsgatan	17,4	23	37
2023	Skellefteå Kv Pantern	23,26	28	36
2023	Sundsvall Köpmangatan	17,77	28	35
2023	Hedemora Gussarvsgatan	15,81	28	33
2023	Härnösand Storgatan	16,66	30	33
2023	Gävle Staketgatan 22	17,54	29	31
2023	Piteå Hamnplan	18,49	28	31
2023	Umeå Västra Esplanaden	17,85	21	31
2023	Stockholm Hornsgatan 108 Gata	19,43	29	30
2023	Piteå Prästgårdsgatan	18,06	22	27
2023	Göteborg Gårda	22,21	21	26
2023	Stockholm E4/E20 Lilla Essingen	21,07	20	26
2023	Örnsköldsvik Centralesplanaden - Nygatan 24	14,54	22	24
2023	Linköping Hamngatan 10	16,46	21	23
2023	Luleå Sandviksgatan	17,32	20	22
2023	Södertälje Birkakorset	16,62	16	20
2023	Södertälje Turingegatan 26	17,2	16	20
2023	Karlstad Jungmansgatan 8	15	16	20
2023	Norrköping Kungsgatan 32	13,83	16	18
2023	Jönköping Kungsgatan 2A	17,1	10	16
2023	Sundbyberg Tulegatan 9	12,87	12	16
2023	Danderyd Mörbyskolan	19,68	12	15
2023	Stockholm E4 Skonertvägen	14,2	10	15
2023	Uppsala Kungsgatan 67	14,46	11	15
2023	Borås Kungsgatan	19,15	7	12
2023	Stockholm St Eriksgatan 83	13,58	10	12
2023	Stockholm Sveavägen 59 Gata	15,87	9	12
2023	Danderyd Gymnasiet	13,76	10	11
2023	Sollentuna E4 Häggvik	12,92	9	11

PM2.5 limit values – examples from monitoring stations			
Year	Station	Average PM2.5 µg/m³ (MKN = 25, environmental target = 10, EU 2030 = 10)	Number of days > 25 µg/m³ (Environmental Target = 3, EU 2030 = 18)
2023	Visby Österväg 17	6,92	4
2023	Helsingborg Drottninggatan	6,87	4
2023	Råö	6,77	1
2023	Malmö Rådhuset	6,59	3
2023	Växjö Liedbergsgatan 11	6,52	2
2023	Kalmar Södra Vägen	6,29	3
2023	Västerås Stora Gatan 78	6,25	1
2023	Stockholm Hornsgatan 108 Gata	5,72	0
2023	Gävle Staketgatan 22	5,66	2
2023	Hyltemossa Chatka	5,61	3
2023	Göteborg Femman	5,37	1
2023	Östersund Rådhusgatan	5,29	5
2023	Hedemora Gussarvsgatan	5,23	0
2023	Sundsvall Köpmangatan	5,2	1
2023	Burlöv Församlingshemmet	5,15	1
2023	Stockholm St Eriksgatan 83	5,01	0
2023	Stockholm Olaus Petri	4,91	0
2023	Norrköping Kungsgatan 32	4,85	0
2023	Linköping Hamngatan 10	4,78	0
2023	Sundsvall Bergsgatan	4,77	0
2023	Umeå Västra Esplanaden	4,7	0
2023	Visby Brömsebroväg 8	4,68	0
2023	Sollentuna E4 Häggvik	4,66	0
2023	Sundbyberg Tulegatan 9	4,65	0
2023	Solna Råsundavägen 107	4,54	0
2023	Sollentuna Danderydsvägen	4,53	0
2023	Sollentuna Sollentunavägen 192	4,49	0
2023	Härnösand Storgatan	4,47	0
2023	Stockholm Torkel Knutssongatan	4,46	0
2023	Uppsala Kungsgatan 67	4,24	0
2023	Sollentuna Ekmans Väg 11	4,06	0
2023	Norrköping Trädgårdsgatan 21	3,72	0

Annex 4: The EU Work-Life Balance Directive

EU Directive 2019/1158 on Work-Life Balance for Parents and Carers, aimed at creating a better balance between professional life and family responsibilities.

The main provisions of the directive are:

- **Parental leave:** The directive establishes that each parent is entitled to a minimum of four months of parental leave, of which two months are non-transferable between parents and must be taken within a specified period following the child's birth or adoption. This aims to give parents greater opportunity to be present for their children during critical periods in their lives.
- **Paternity leave:** The directive grants fathers a right to at least ten days of paid paternity leave in connection with the birth of a child, aimed at enabling fathers to take a more active role in the care of their newborn.
- **Carer's leave:** Employees who provide care for a seriously ill or dependent relative are entitled to at least five days of leave per year. This leave is an important measure to support those caring for family members who are seriously ill or have long-term health conditions.
- **Flexible working arrangements:** Workers who are parents or carers have the right to request flexible working arrangements, such as altered working hours or the possibility to work from home. This provides parents and carers with greater ability to balance work with their care responsibilities.
- **Protection against discrimination:** The directive ensures strong protection against discrimination for workers exercising their rights under the directive, including protection against dismissal or unfavourable treatment during leave. It also strengthens protections for those taking parental or carer's leave.

Comparison of the Swedish inquiry's proposal for implementation of the Work-Life Balance Directive and the government bill being considered by the Committee on Labour.

1. **Parental leave**
   The inquiry's proposal states that parents cannot transfer days of basic parental benefit to the other parent, and that parental benefit at sickness benefit level should be treated in the same way.
   The government bill proposes an amendment to the Social Insurance Code, stipulating that 90 days of basic parental benefit shall be reserved for one parent. These days cannot be transferred to the other parent, regardless of the level of parental benefit.
   Comparison: The government bill specifies that exactly 90 days of basic parental benefit are to be reserved for one parent, which is a clearer formulation than the inquiry's proposal.

2. **Flexible working arrangements**
   The inquiry proposes that rules for flexible working arrangements be introduced into the laws on parental leave and caring for a relative, so that parents or persons caring for a relative can request flexible working arrangements, such as part-time work or remote work.
   The government bill proposes that parents and persons caring for a relative should be able to request flexible working arrangements, such as working from home or having flexible working hours. The employer must respond to the request within a reasonable time, and if it is refused, the employer must provide a justification. This right applies to parents with children under eight years old and to those caring for a relative.
   Comparison: The government bill specifies a timeframe for when the employer must respond to requests for flexible working arrangements, which is not included in the inquiry's proposal.

3. **Protection against dismissal**
   The inquiry proposes that if someone is dismissed because they have taken parental leave or caring leave, the employer should be obliged to justify the dismissal.
   The government bill proposes that an employee must not be dismissed or terminated if it is linked to taking parental leave or caring for a relative. If a dismissal is suspected to be for this reason, the employer must explain why the dismissal is taking place.
   Comparison: The government bill strengthens protection against dismissal by clarifying that employees cannot be dismissed due to taking leave for parental or caring responsibilities.

4. **Right of action for the Equality Ombudsman (DO)**
   The inquiry proposes that DO should have the right to represent employees who have been subjected to discrimination due to parental leave or caring responsibilities.
   The government bill proposes that DO should have an extended right to represent individual employees in disputes concerning unfavourable treatment

due to parental leave or caring responsibilities.
Comparison: The government bill confirms and expands the inquiry's proposal by specifying DO's right to act in such cases.

5. Prohibition of retaliation

The inquiry proposes introducing a prohibition of retaliation, so that employers cannot penalise employees for exercising their rights, for example by reducing their working hours or treating them unfavourably.
The government bill proposes a prohibition of retaliation and specifies that employees who report a violation of the laws on parental leave or caring responsibilities shall be protected from unfavourable treatment or reprisals.
Comparison: The government bill and the inquiry are aligned in introducing a prohibition of retaliation, but the bill clarifies protection against unfavourable treatment and reprisals when reporting violations of the laws.

6. Return to work

The inquiry proposes that an employee who has been on leave to care for a relative should have the right to return to the same or an equivalent position.
The government bill proposes that employees who have been on parental leave or caring leave for a relative should be able to return to their previous or an equivalent job, and that they should also benefit from improvements that have occurred in the workplace during their leave.
Comparison: The government bill and the inquiry agree on the right to return to the same or an equivalent position, but the bill goes further by specifying that employees should also be able to benefit from workplace improvements made during their absence.

The Independent Expert Committee on the Implementation of Europe's Beating Cancer Plan in Sweden, commissioned by the Swedish Cancer Society.

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