

Malmö's path towards a sustainable future

Health, welfare and justice

Commission for a
Socially Sustainable Malmö



MALMÖ'S PATH TOWARDS A SUSTAINABLE FUTURE.
HEALTH, WELFARE AND JUSTICE.

Editors: Mikael Stigendal and Per-Olof Östergren

Commission for a Socially Sustainable Malmö: Sven-Olof Isacsson (Chairman), Anna Balkfors (Head Secretary) and commissioners Nihad Bunar, Eva Engquist, Ulf Gerdtham, Marie Köhler, Annelie Larsson, Christer Larsson, Kerstin Larsson, Katarina Pelin, Sven Persson, Maria Rosvall, Tapio Salonen, Mikael Stigendal, Denny Vågerö and Per-Olof Östergren

Secretariat: Anna Balkfors, Frida Leander, Eva Renhammar and Erika Pettersson

Commission for a Socially Sustainable Malmö
www.malmo.se/kommission

Third edition, December 2013.

Graphic design and illustration: Sustainable Studio
Information visualisation: Synbarligen Jörgen Abrahamsson

Photography:

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Jonas Eriksson: pages 9, 61, 93

Beatrice Bolmgren: pages 13, 54, 75

Adam Haglund: pages 16, 47, 65

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Printers: Service Point Holmbergs AB

Printed at Scandia 2000, Swan and FSC certified paper.

ISBN 978-91-87145-00-1



Preface

There is no point in existing if we are not needed for something. Therefore society must be organised so that everyone is needed. We demand to be needed!

Children's manifesto in SOPOR by Tage Danielsson

THIS REPORT is aimed at the politicians of Malmö and at everyone who is interested in sustainable development and the future of Malmö. It deals with the health inequities which have been recognised for several decades but which have not decreased. Average life expectancy differs by several years between different parts of Malmö and among socially defined groups, for example, among those with a low level of education compared with the well-educated. We live in a welfare society where the life expectancy is among the highest in the world and where the risk of social vulnerability is less than in many other countries. Numerous efforts have been made to reverse the trend of increasing inequities in Malmö. Many people work hard every day, in preschools and schools, in social services and health care, etc. in order for Malmö residents to be healthy and have good living conditions.

In spite of this, differences in health between socially defined groups are increasing throughout the country. This is worrying since good health is a prerequisite for a society to grow and develop socially, economically and ecologically.

Therefore, in 2010, the politicians of Malmö decided to appoint an independent commission with the aim of reducing health inequities by tackling the underlying causes. The Commission's objective has been to give decision-makers in Malmö a qualified basis and scientifically based proposals for strategies to reduce health inequities in Malmö.

Research clearly shows that it is not enough only to target risks by treating high cholesterol and high blood pressure, giving advice on new dietary habits, stopping smoking, drinking in moderation and increasing physical activity on an individual level if we intend to improve the health of the whole population. The health care system has a significant effect on our health, but what is most important are the factors that lie outside the field of health care.

If we really want change we have to target societal structures, both physical and social, which are the ultimate causes of the risks that give rise to illnesses, injuries and premature deaths. It is about changing attitudes and finding new ways to manage and organise in a new era where yesterday's systems are no longer adequate.

For two years we have compiled and analysed extensive scientific

information. Considerable commitment has been shown by the research community, the voluntary sector, the City of Malmö, the business sector, as well as regional and national stakeholders to the work of the Commission. Commitment that is indicative of a considerable interest in influencing Malmö's development and of the fact that the issues of social sustainability and health are pressing.

The WHO report Closing the gap in a generation (2008) has been a model for our work. Its focus is on the social factors that explain much of the health inequities throughout the world. In our work in Malmö we have considered what is possible to influence at a local level, but also what should be a national or regional responsibility. We hope that the report will make a clear contribution to increasing understanding of the need to initiate a progressive effort to combat health inequities at a national level as well.

A clear road-map, using this report as one point of departure, could strengthen Malmö as an ecological and social role-model with strong economic growth and power of attraction. And, especially, contribute to a sustainable city.

Our hope is therefore that the Commission's work and this Final Report are seen as the beginning of a long-term process that aims resolutely, and based on the best possible knowledge base, to reduce health inequities in Malmö and promote sustainable development from every perspective.

The quotation above reminds us that this is about building a society where everyone is needed. With the goal that every person who is born here or who moves here having the prerequisites to develop, believe in the future and achieve their full potential, the foundations for Malmö's future will be laid.



Sven-Olof Isacsson

Professor Emeritus, Chairman of the Commission for a Socially Sustainable Malmö

The Commission would like to thank

Hans Abrahamsson, Maria Albin, Karin Ander, Anna Angelin, Henry Ascher, Anders Beckman, Annelie Björkhagen Turesson, Laid Bouakaz, Anna Carlsson, Margareta Cederberg, Anders Djurfeldt, Marianne Dock, Henrik Ekström, Sölve Elmståhl, Maria Emmelin, Malin Eriksson, Carin Falkner, Ingrid Fioretos, Maria Fridh, Georgios Gavriilidis, Ola Ghatnekar, Marit Gisselmann, Mathias Grahm, Kristina Gustafsson, Birthe Hagström, Torbjörn Hjort, Karin Ingvarsdotter, Anna-Karin Ivert, Kristina Jakobsson, Urban Janlert, Staffan Jansson, Bertil Johansson, Gustav Kjellsson, Stefan Kling, Marcus Knutagård, Håkan Kristersson, Lennart Köhler, Petra Lindfors, Bernt Lundgren, Martin Lindström, Ann Ludvigsson, Anna Lundberg, Karl Löfgren, Lars Matsson, Christina Merker-Siesjö, Birgit Modén, Johan Molin, Fredrika Mårtensson, Ingvar Nilsson, Eva Nordström, Lars Olsson, Lars Plantin, Marianne Svensson, Susanna Toivanen and Sophia Zackrisson who all contributed to the discussion basis for the Commission's series of reports.

Our senior advisers; Michael Marmot, Tilde Björfors, Sven Bremberg, Finn Diderichsen, Lars-Erik Holm, Susanne Iwarsson, Margareta Kristenson, Johan Mackenbach, Geoff Mulgan, Per Nilsson, Joakim Palme, Tone Poulsson Torgersen, Nina Rehnqvist, Måns Rosén, Lennart Råstam and Fahrudin Zejnik, who supported the Commission during the course of its work.

Jörgen Abrahamsson, Malin Broman, Göran Cars, Göran Dahlgren, Jonas Frykman, Lars H Gustafsson, Mikaela Horn, Jan Jensen, Håkan Larsson, Birthe Müller, Lennart Svensson and Alexander Wennberg who contributed to the Commission's work in various ways.

Region Skåne, Malmö University and Lund University as well as managers and employees within the City of Malmö, who contributed with statistics, fact-checking and valuable knowledge.

Everyone who in various ways contributed to and assisted in the Commission's seminars and workshops.

Centrum för publikt entreprenörskap, Drömmarnas hus, Enighet, FC Rosengård, Hela Malmö, HUT Skåne, Lokala folkhögskolan, Imago Malmö, Malbas, Save the Children, The Red Cross, Yallatrappan, World Village of Women Sports and all other representatives from Malmö's associations, culture sector and sports associations who contributed with understanding of the impact of the voluntary sector on health.

The Delegation for Sustainable Cities, The Commission on the Future, The Swedish Association of Local Authorities and Region's "Samling för social hållbarhet – minska skillnader i hälsa" (Joint Action for Social Sustainability - reduce inequalities in Health), Svensk förening för folkhälsoarbete, Västra Götaland's "Samling för social hållbarhet" (Joint Action for Social Sustainability), UCL Institute of Health Equity, National Healthy Cities Network.

Everyone who submitted suggestions and comments on the Commission's work in other ways.

A big thank you to everyone who contributed!

Summary

THE GAP BETWEEN THOSE GROUPS that have the best health and those with the worst has increased significantly in recent decades. This applies globally, between different countries and between socially defined groups within a country and in a city like Malmö. The difference in average life expectancy is four and a half years for women and five and a half years for men, between different city districts in Malmö. The difference in remaining average life expectancy at 30 years of age between those with a low level of education (pre-upper secondary school) and the well educated (tertiary education) is 4.1 years for women and 6 years for men. The differences have increased in the last 20 years. This is despite the fact that average health in Malmö has improved considerably during the same period. When it comes to dental health, which is another indicator of social position, there are large inequities in Malmö depending on which clinic is visited, which in turn is an indicator of the area one lives in. Poor dental health is approximately six times more common among six-year-olds at clinics in areas characterised by a large proportion of adults who are outside the labour market and who have low incomes, compared with clinics situated in areas with more well-off inhabitants.

In Malmö the development of health and welfare has been followed by means of annual welfare reports. These show that Malmö residents feel better and are healthier, while differences are increasing between different living conditions. At the same time, there is a strong ambition among decision-makers to create a sustainable city, both economically and socially. When it comes to environmental matters the city has become known for turning problems into opportunities for sustainable development. Decision-makers have adopted ambitious climate objectives and they are working strategically together with other stakeholders in society to achieve these. The trend of increased social inequalities is in direct conflict with the ambition of sustainable city development. So what can the politicians in power do when they, year after year, are handed a document which shows that differences are increasing despite all the efforts made to reverse the trend?

Malmö City Executive Board decided to appoint a commission whose task was to propose actions to reduce health inequities in Malmö by making the social determinants of health more equitable. This is interpreted as being the same as turning Malmö into a socially sustainable city, which is why the Commission is named accordingly. The Commission for a Socially Sustainable Malmö started its

work at the beginning of 2011 as one of the world's first local commissions for reduced health inequities. Over the course of two years the Malmö Commission's fourteen members and Chairman and Secretariat along with many other researchers and experts established in national and international research published 31 scientific reports in which a total of more than 200 proposed actions were presented. Decision-makers and others within the City of Malmö, Region Skåne, the voluntary sector, the culture sector, sports associations, trade and industry and many others have displayed an enormous commitment and considerable interest in being involved and driving Malmö's development towards a sustainable future. In different ways, almost 2,000 people have contributed to the work and the seminars and dialogue meetings that were arranged.

The Malmö Commission's report is based on the WHO Commission's report *Closing the gap in a generation 2008*. The Commission, led by the British researcher Michael Marmot, has convincingly established the connection between the factors in society which cause ill-health and the inequitable distribution of health in the population. These factors are called the social determinants of health. The WHO report concludes that the inequitable distribution of these social determinants lies behind inequity in health. According to Marmot and his colleagues in the report, it is deeply immoral not to take immediate steps to reduce health inequities when the causes are known and can be targeted using reasonable efforts.

This ethical imperative is the first of five perspectives that have guided the Malmö Commission. Secondly, a sustainability perspective is required which can explain how the ecological, economical and social aspects of sustainability must be developed as a whole, rather like different organ systems that together constitute an individual. Thirdly, the Malmö Commission has been guided by a sociological society perspective which places importance on integration, meaning actual participation as well as a sense of participation. Fourthly, a gender perspective is required and thus a deeper understanding of women's and men's inequitable access to power, resources and influence in society which by extension affects health, well-being and the quality of life.

Fifthly, the Malmö Commission advocates a social investment perspective. This largely involves seeing social interventions and initiatives as investments, not as costs. Investments in people, particularly during childhood, lead to gains in the long term. This is demonstrated by more

people doing well at school, getting an education, working and being able to provide for themselves and having good health. Fewer end up in lengthy, both socially and economically costly, exclusion. Based on a social investment perspective, it is also important to strengthen the connection between economic growth and equal welfare, improve the quality of work and emphasise security as a value in itself.

The Malmö Commission has seen it as both possible and desirable to link these five perspectives together. The Commission has included contributors with scientific as well as experience-based knowledge. We have chosen to call this a knowledge alliance. Using a concept which is often used in international contexts the Malmö Commission has developed a transdisciplinary perspective. That is to say a perspective that integrates different kinds of knowledge, not just scientific but also experience-based knowledge.

As a basis for the objectives and actions which are presented in this report the Malmö Commission has developed its own understanding of Malmö. This is based on questioning key concepts and notions. These notions include not taking the residents of Malmö for granted. Who are the residents of Malmö? They appear to be many more than those who live in the city at any given time. During the years between 1990 and 2008 nearly half a million people have lived in the city for at least a few years. Malmö has become a transit city and this new understanding has implications for how we should see health inequities, what they are caused by and what should be done about them. In addition, an increased proportion of the population now lives on the sidelines of the established and accepted way

of living; in Malmö this group is estimated to amount to approximately 12,000 people. Another important change that is significant for how we should understand Malmö is the regionalisation of issues relating to economic growth. Welfare however has largely remained a municipal matter. This has altered the prerequisites for the relationship between economic growth and welfare.

Based on this developed understanding the Commission's Final Report contains two overarching recommendations: Firstly, it is proposed that the City of Malmö establish a social investment policy that can reduce the differences in living conditions and make societal systems more equitable. This answers the question of *what* should be done. Secondly, the Commission proposes changes to the processes that these systems are part of through the creation of knowledge alliances, co-operation on equal terms between researchers and stakeholders from, for example, the public sector, the voluntary sector and the business community, and a democratisation of management. The latter also involves the need for continuous monitoring of how inequality and segregation develop in Malmö. This answers the question of *how* the Commission intends to implement the suggested actions in practice.

The Commission's two overarching recommendations cover a total of 24 objectives and 72 actions, divided into six domains; everyday conditions during childhood and adolescence: residential environment and urban planning, education, income and work, health care as well as transformed processes for sustainable development.

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The Commission would like to thank

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0. Introduction

A SOCIETY'S DEVELOPMENT can be judged by the general level of health and the degree of inequity in the distribution of health in the population. This report describes how Malmö as a municipality can proceed to act for socially sustainable development by focusing on improving the health of the residents of Malmö and reducing health inequities between groups within the population.

Health has a crucial impact on whether a child can grow up, develop his or her full potential, live a good life and contribute to society and its systems. On the other hand, societal systems have a crucial impact on whether an individual's health is promoted or hampered.

A wealth of research is available which describes how the health of an individual or a population is determined by structural societal factors. In Malmö and in Sweden, as in many other cities and countries in the world, social differences in health between groups within the population are increasing. This is seen when differences are measured, for example, regarding average life expectancy, but also when differences in school results, household finances, access to work, participation in society and so on are looked

at. From an ethical, democratic and socio-economic point of view growing social differences are unsustainable.

The good news is that the structural societal factors that are behind health inequities can be influenced. To do this requires political will, leadership and the ability to invest in a new local agenda which has people's health and equities in health at the centre of all decisions. This involves considering social initiatives and consequences in the same way as ecological and economic ones. Ultimately it is about providing each person with the prerequisites to take control of their own lives. It is a long-term undertaking that requires efforts at every stage of life, encompasses all policy areas and requires action at local, regional, national and international levels.

The knowledge, resources and tools for change are available. Some of these are presented in this report and are corroborated by the 31 background reports which were authored as part of the work of the Commission. It is the possibility to influence, the ethical imperative to act, and the situation in Malmö which are the starting points of our work, our results and our recommendations: objectives and actions.

0.1 The assignment

Sweden's public health objectives

Public health is about everything from the individual's own choices and habits to structural factors such as external environments and democratic rights. The overarching objectives of public health are:
To create societal conditions that will ensure good health, on equal terms, for the entire population.

Groups of objectives:

1. Participation and influence
2. Economic and social prerequisites
3. Conditions during childhood and adolescence
4. Health in working life
5. Environments and products
6. Health-promoting health services
7. Protection against contagious diseases
8. Sexuality and reproductive health
9. Physical activity
10. Eating habits and food
11. Alcohol, illicit drugs, doping, tobacco and gambling

IN 2010, MALMÖ CITY EXECUTIVE BOARD DECIDED to appoint the Commission for a Socially Sustainable Malmö. It was to be a politically independent commission tasked with deepening the analysis of the causes of the growing health inequities in the population of Malmö. Part of the assignment was to work from scientifically based strategies to reduce health inequities.

The assignment is regulated in the terms of reference (Appendix 1). Malmö City Executive Board specified several reasons for appointing the Commission. Firstly, the health situation in Malmö. Within the city there are health inequities that the municipality has the ability to influence. Secondly, in Malmö there is an ambition to work towards sustainable development from all perspectives and with a greater awareness of and focus on the social dimension of sustainability. Thirdly, research shows that it is possible to reduce health inequities by focusing on the structural prerequisites of health, the so-called social determinants. The municipality has the mandate to influence many of the important determinants of the health of the residents of Malmö, such as preschools, schools, work environments, physical planning, residential environment and the conditions affecting residents' ability to support themselves.

The WHO report *Closing the gap in a generation*, was presented by the *Commission on Social Determinants of Health*, led by Professor Sir Michael Marmot, at about the same time as the City of Malmö was formulating a public health policy, a policy that was to consist of guidelines for the city's continued public health work (1). The starting point was the national public health policy and the overarching public health goal to create the prerequisites for health on equal terms and the eleven national public health objective domains. In light of what is known about the health situation in Malmö, research, the WHO report *Closing the gap in a generation* and the national public health policy, three areas have been given priority in the terms of reference of the Commission; children's and adolescents' situation, participation and influence in society as well as social and economic conditions.

When the City of Malmö came to develop its public health policy, it had already adopted 40 or so policy documents and nearly 200 objectives which, in various ways, influence the areas defined in the national public health policy's eleven objectives. However, there was no explicit strategy for reducing inequity in health. As such, there was no proper strategy for achieving the overarching goal of creating the prerequisites for equity in health. Considerable efforts have been and are being made in Malmö to influence the social prerequisites of health in areas such education, the labour market and residential environment. Despite this, the inequities have not decreased but have rather increased. In light of the political ambition for health on equitable terms as well as sustainable development in Malmö, the City Executive Board therefore decided to appoint the Commission with the task of deepening the analysis of the underlying factors behind the increased inequities and proposebased recommendations.

Since 2002, the City of Malmö has compiled an annual report on welfare and health trends in Malmö. These welfare reports describe the trends based on 50 or so indicators using information obtained from various sources. The indicators are a mixture of determinants such as level of education and employment rate, risk factors such as smoking, alcohol abuse and level of physical activity as well as health outcomes such as average life expectancy. For the majority of indicators a general improvement can be seen over time, but with clear differences between men and women and between the city districts (2-4). As part of the process of formulating the public health policy, a number of analyses were performed of the differences in health in relation to socio-economic conditions. This was done based on Region Skåne's public health survey in 2008. The differences, that is, the health inequities are striking (5).

The Commission shall:

(extract from the terms of reference)

- based on Malmö's challenges regarding social differences, injustices and inequalities analyse causes and associations and identify what can be influenced and by whom/what and how,
- using this analysis as a starting-point, the Commission should suggest progressive objectives and analyse possible conflicts between objectives,
- suggest strategies for how to reach the objectives and suggestions on how the objectives and strategies should be followed up,
- carry out health-economic analysis and weigh the cost against the benefits of realising the strategies,
- especially observe how objectives and strategies can be anchored in different decision processes,
- in the light of its work point out any need for changes in the municipal organisation and routines for co-operation and governance, with the purpose of strengthening and creating better health conditions on equitable terms for Malmö's residents,
- suggest ways to measure and monitor the development of the distribution of health. Adapt these methods to the decision-making contexts where information is used e.g. the Area programmes for a socially sustainable Malmö, the city plan, the budget process and operational planning. The existing welfare reports are an important foundation,
- calculate the economic consequences of health inequities for Malmö as well as the effects to be expected from initiatives aimed at reducing inequities in living conditions.

"The Commission's work is based on three important aspects:

- Facts, research and science about what influences the determining factors of health and the societal structures necessary to achieve equity in health as well as the health situation in Malmö today.

- Everyday Malmö i.e. the society in which changes need to be made.
- New approaches, innovative modes of working and forward-looking strategies"

"New approaches and innovative methods, which at the same time are based on facts and knowledge about what influences health, are needed. Also, the proposals coming from the Commission should take their departure from everyday life in Malmö and should be possible to implement."

"The Commission should act as an independent committee and is free to suggest strategies for the municipality to decide upon. This implies that the work should be characterised by independence and originality. The Commission can engage external experts with knowledge and experience of relevant areas who are qualified for the matter in hand. These experts can work independently in relation to the Commission to realise their task and are responsible for their own conclusions and any recommendations in their respective reports. It is then the Commission's task to make independent decisions based on the experts' analysis and conclusions.

"The Commission's assignment is limited to Malmö's challenges and requirements. The Commission's suggestions should, however, include how the City of Malmö can collaborate at a regional, national and international level. This means that forms of co-operation, contract solutions between different parties etc. can be discussed."

"Unlike a commission formed following an acute crisis the task of the Commission is to address a complex set of problems, which in themselves have major consequences, but which require long-term strategic decisions and actions."

"Processes for social change are complex and there are many challenges in Malmö. Extensive physical development such as the city tunnel and new harbour requires solid pre-planning. The Commission's work can be seen as an equivalent to pre-planning for processes for social change."

From the terms of reference from Malmö City Executive Board it can be seen that the Commission was to draw up a scientific basis for how health inequities can be reduced. Health inequities are defined in the terms of reference (exactly as by WHO) as *systematic differences in health which can be avoided by reasonable actions*. The starting points for the Commission are the structural determinants of health.

The Commission's work is regulated partly, but not in detail, in the terms of reference. Thus the Commission has been free to decide for itself how the process for achieving the Final Report was to look. A short report is given below on how the Commission has gone about its task based on the terms of reference and how we arrived at the objectives and actions. For a more detailed presentation of the working process please refer to Appendix 2.

The Commission with its fourteen commissioners has a multidisciplinary composition which covers a wide area of knowledge and experience. The aim has been, with the aid of the dynamic that arose in the meetings between different areas of expertise, to create a deeper understanding of how Malmö can become a sustainable city. The commissioners have also received support from other researchers and representatives of organisations. Specially appointed senior advisors have also contributed in various ways. It is the commissioners in conjunction with the Chairman who are behind the Commission's conclusions in this Final Report. The work has been carried out in three partially parallel processes, namely writing scientific background reports, the implementation of dialogues and the production of this Final Report.

The scientific background reports form the basis of the Final Report, and in addition each report has in itself functioned as a basis for discussion in the dialogue processes. Each author of each report bears the sole responsibility for the content of that report. The conclusions and recommendations submitted in the individual reports are therefore not necessarily shared by the Commission as a whole. There is a brief summary of the background reports in Appendix 3. There are important areas which are not covered in the reports. For some of these areas the Commission has obtained knowledge via seminars and hearings including sports associations, representatives of Malmö's culture sector, the voluntary sector and trade and industry.

The terms of reference also state that the process was expected to be transparent and that the Commission should invite stakeholders to participate. The dialogue processes have therefore been conducted in different ways. Some dialogues formed part of the work of writing the background reports while others have been carried out in the form of 30 or so seminars and hearings, to discuss the feasibility of the various proposed actions.

The Commission has also participated in meetings with representatives of the Swedish Government, the voluntary sector, the Region, research institutions, trade and industry, the culture sector and other cities in Europe which are wrestling with difficulties similar to those in Malmö. The Commission has also had dialogues with preschool teachers, university vice-chancellors, voluntary workers, ministers, local politicians, youth leaders and social workers, to name but a few. In all, about 2,000 individuals have contributed to different parts of the Commission's report.

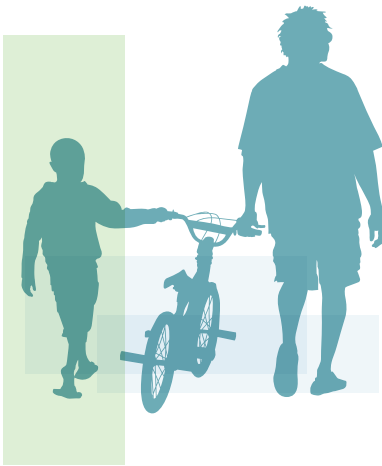
There are just over 200 suggested recommendations in the various background reports; short-term, long-term, concrete, overall, focused and general. The Final Report should not be thought of as the sum of the different background reports. These have formed an important part of the total knowledge- and experience-based material that the Commission has taken note of and considered in the final synthesis. The Commission's Final Report includes several different types of results:

- **A deepened analysis** of the scope and distribution of ill-health. As support for the analysis researchers have drawn up a number of reports explicitly focused on health aspects during different periods of life. Other reports focus on social determinants and their connection to health in Malmö.
- **An understanding of Malmö**, the historical, demographic, socio-economic, structural and geopolitical trends. It has been deemed necessary to propose recommendations.
- **Recommendations** which together are expected to enable the City of Malmö to reduce health inequities. These are based on deepened analyses of the extent of the problem and consist of objectives and actions.

This Final Report, an Interim Report and the background reports with in-depth analyses and proposals for the different areas are now available on the website where it is also possible to listen to television broadcasts of discussions with the commissioners. (6). This forms a broad basis for future development work in Malmö. It is also our hope that the new networks and relationships with researchers, trade and industry and the voluntary sector that have come about as a result of the Commission's work, will now continue their commitment to Malmö's development and that the City of Malmö will take advantage of this in the future.



0.2 What is meant by population health?



HEALTH IS OFTEN REGARDED as a characteristic of a single individual. It can be measured in many different ways, using questionnaires, interviews or questioning by a professional healthcare worker, or by using different objective investigative methods such as the analysis of body fluids, x-rays, etc. This usually leads to a diagnosis in the form of a specific disease or an overall appraisal of health. When we talk about the health of population, the situation is different. In this case we try to create an overall measure of the health of this particular population. In theory two measurements are used, where one is based on the risk of mortality among the individuals of a population (for example, average life expectancy, infant mortality, child mortality, maternal mortality, etc.) and the second is based on some kind of overall measure of health, often in the form of so-called health-related quality of life.

In the seminal report *Investing for Health* (7) a weighted measure of mortality and morbidity was presented as a measure of lost Disability Adjusted Life Years (DALY). A DALY unit means one year of life without any form of ill-health for an individual. By estimating the loss of DALY in a population an absolute measure of ill-health can be obtained for the world, a country or a city. This is called the Burden of Disease and is the total number of lost DALYs due to mortality or morbidity in the population. The DALY measure can be used to estimate the benefits of various interventions, both for the individual and for a population. This is done by calculating the economic value of a DALY unit and multiplying that by the number of DALYs which the intervention is estimated to have created. A very closely-related measure is QALY (Quality Adjusted Life Years), which has been used in a number of the health-economic calculations that were performed for three of the Commission's proposals (8).

There are thus different ways to describe the health of the population, but life expectancy is a good overall measure which is used internationally and which most people know about and understand. But the life expectancy of a country does not reflect the considerable differences that often exist within the country when geographical comparisons are made or groups are compared taking into account ethnicity, income, education, sex, age, religion, exclusion and many other variables (9).

Women in Japan have the longest life expectancy at birth in the world, 86.0 years, and for men in Iceland the corresponding figure is 80.0 years. The shortest life expectancy for men is reported from Swaziland, 36 years, and for women in Zimbabwe, 34 years. Swedish women live for 83.2 years on average and men for 79.1 years (10). The difference between Sweden's counties is small, 1.1 years for men and 1.8 years for women, but significant differences have been noted between the nation's 290 municipalities. Danderyd is at the top of the ranking for men with a life expectancy at birth of 83 years, Ljusnarsberg at the bottom with 74.6 years – a difference of a stunning 8.4 years. For women Båstad tops the list of Swedish municipalities with a life expectancy of 86 years and Arvidsjaur is at the bottom with 80.1 years. In Malmö the differences between the city districts are 5.4 years for men and 4.6 years for women

(average figures for the period 2007–2011) (4). The geographical differences in average life expectancy between countries, municipalities and city districts mirror socio-economic differences, but the larger the areas that are used for these comparisons, the greater the risk that variations within these areas will cancel each other out and result in an underestimation of health inequities. This can be the case, for example, when entire city districts are compared.

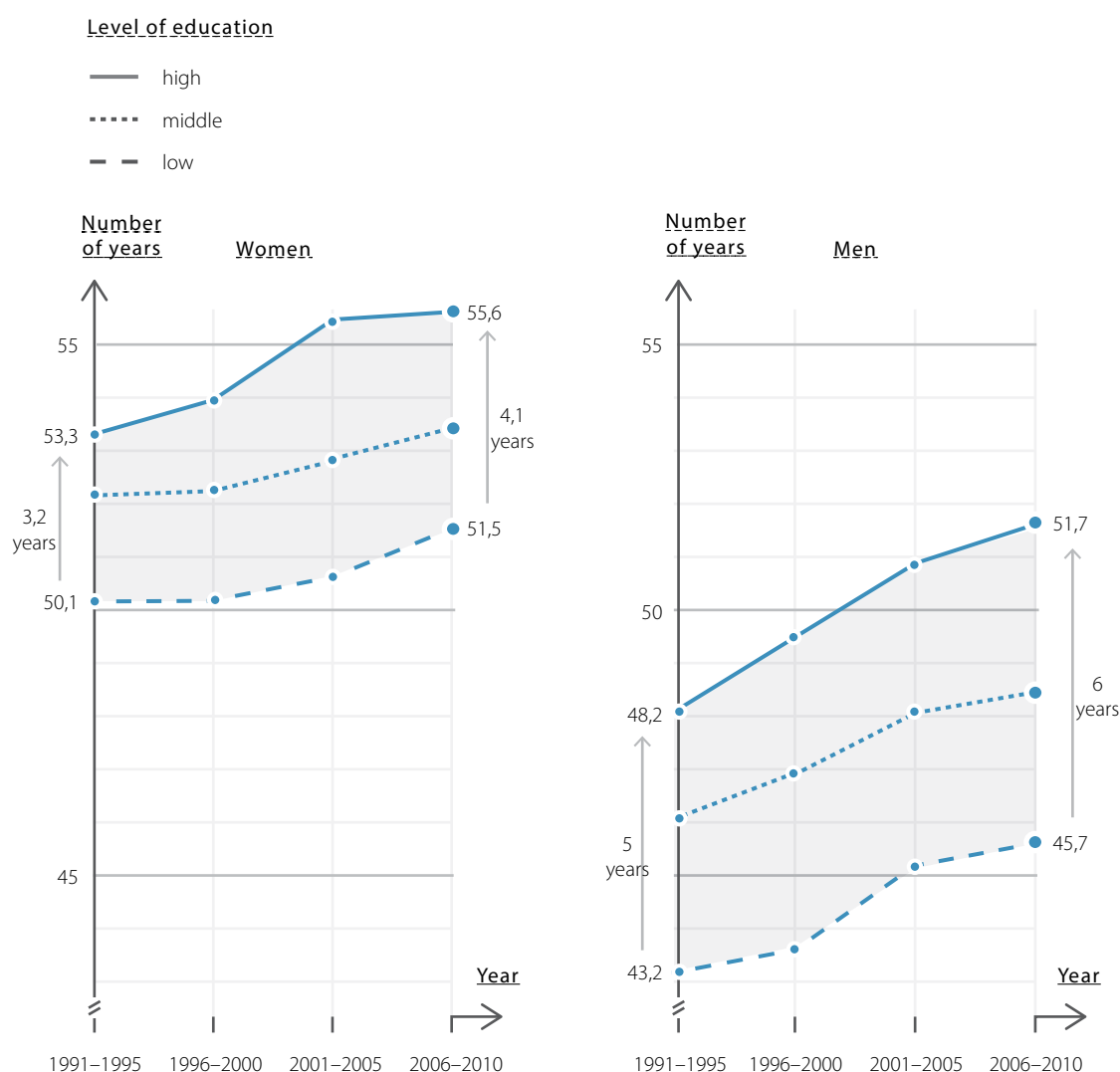
Another common measure of health is to allow individuals to rate their own health. Health is usually rated on a scale from 1-5, from very poor to very good. Self-rated health predicts mortality surprisingly well, irrespective of socio-economic status. (11, 12).

The inequities in self-rated health and average life expectancy between different groups are strongly related to the individuals' social positions, which we will return to in the chapter on the causes of health inequity. (13, 14)

The risk of dying between the age of 30 and 74 in Sweden is about twice as high for individuals who have only attended primary and lower secondary school compared to individuals with tertiary education. The difference between those who have pre-upper secondary school education (shortest) and those with tertiary education (longest) is just over five years (15, 16).

At least since 1970, inequities in average life expectancy between education groups in Sweden have increased. This can be illustrated by Figure 1 which shows how average life expectancy in Malmö has improved for all education groups, but not to the same extent for those with a low level of education as for those who are well educated. The inequities between individuals with pre-upper secondary school and those with tertiary education in 1991-1995 was five years for men but increased to six years in 2006-2010. The corresponding inequities among women in Malmö increased from three to four years during the same period.

Figure 1: Remaining average life expectancy at 30 years of age for women and men in Malmö according to educational level in 1991–2010



Source: Statistics Sweden, prepared for the Commission in 2012



The raised level of education in the population is probably the single most important explanation for the increasing average life expectancy in Sweden in recent years. Behind this is a complex pattern of causes which explain the connection between social position and health (see a model of this in Subchapter 0.6.1.) At the same time, it is likely that the almost 20 per cent of the population of Sweden which only have a pre-upper secondary school education today, comprise a socially more marginalised group than the 40 per cent with the same level of education in 1990.

The health inequities between individuals who have a high and a medium level of education, respectively, are also growing. Education is also thought to be an increasingly important determinant of health. Since education can be influenced, adequate education must be a key factor if health inequities are to be reduced. It is, however, important to distinguish between education's direct and indirect impacts on health. To the extent that, for example, the goal of the curriculum is fulfilled where it states that the pupil must be able to "make use of critical thinking and independently formulate points of view based on knowledge and ethical considerations" we can hope that education will lead to better health. But otherwise education's determination of health is presumably more indirect, primarily by leading to a better job and, for this reason, better health.

In this context it may be of interest to note that the seemingly paradoxical health inequities based on the level of education (the same pattern can also be observed even if another measurement of social position or job title is chosen) are growing while the average level of health in the population of Sweden is increasing. This is mainly because of trends in a few health-related life choices, mainly tobacco smoking. Fifty years ago, smoking was more common among individuals in higher social positions. At that time the first scientific studies were published showing that tobacco smoking is associated with a substantial risk of falling ill or dying prematurely. On the basis of this type of research, broad preventative campaigns were launched against individual health-related behaviours such as smoking. This led to a drastic reduction of smoking in the population, from over half the adult population to under 10 per cent in Canada and just above that in Sweden. At the same time, there was a significant change in the social distribution of smoking in these societies. Currently smoking is more than twice as common among individuals in low social positions, compared to those in high positions. This redistribution of individual risk factors is one of the most important factors behind the increased health inequities in our part of the world. It is simply easier to stop smoking if you have greater individual resources in the shape of knowledge, money and a socially supportive environment. In other words, the individual determinants of health are strongly linked to social determinants of health. Sometimes the latter are also called structural determinants. This is an important reason for changing public health policy from having a one-sided focus on individual factors to a broader perspective of the social determinants of health, so that the final outcomes are not further increases in health inequity. (1, 16)

0.3 Why should we work to reduce health inequity?

Reducing health inequities is an ethical imperative.

Social injustice is killing people on a grand scale

WHO Commission on Social Determinants of Health

THE MALMÖ COMMISSION WOULD LIKE TO PRESENT a number of arguments for placing health at the centre of all societal planning and working towards reducing health inequities. *Firstly*, there is the ethical imperative to do something about inequitable differences in health. *Secondly*, health inequities counteract sustainable development. *Thirdly*, reduced health inequities favour society at large. *Fourthly*, health inequity is also a matter of gender. *Fifthly*, large health inequities are very costly for society. These five arguments are included in five perspectives that we will explain in more detail. We find it important to link these five perspectives together.

0.3.1 A QUESTION OF HUMAN RIGHTS

The discussion about health inequity has been rooted in the so-called ethical imperative. Briefly, this means that out of all the components of inequity, it is the *health* aspect which is the hardest to accept. Health constitutes one of the most important prerequisites of an individual's potential for development, for example, getting an education or gainful employment, or developing social relationships. Furthermore, health is also important for the ability to participate in social life and enjoy human and political rights. Health is therefore strongly tied to a rights perspective, which is confirmed by the right to equitable conditions for good health being recognised by the UN as one of its human rights (17).

The Nobel Prize winner in Economics, Amartya Sen, develops this perspective further in his book *Development as Freedom* (18). Here, he discusses the lack of freedoms which can stop an individual from developing his or her abilities to their full potential. Poverty, lack of opportunities for political influence and poor health are three major constraints of all other freedoms. In particular, Sen points out that if these factors can be eliminated for a large number of individuals then the overall freedom of society increases by the sum of these, which demonstrates that the amount of freedom is not fixed in a society. In other words, it is not a zero-sum game, where one individual's freedom can only increase at the expense of another individual's freedom in society. Sen therefore argues that it must be in every society's interest to overcome the main constraints of freedoms mentioned above if we are seriously interested in increasing the overall freedom in society. This is an important but often overlooked aspect of the ethical imperative to take action against health inequities.

Since this means that health is a key to other human rights, and also a right in itself, every unfairly experienced inequality becomes particularly unacceptable according to the WHO Commission (1). At the same time, Marmot and many other researchers have convincingly shown that the distribution of health in a population is largely determined by social determinants (see a detailed description of this concept further on in this section). In other words, to take action against health inequity, you must take action against inequity that lies primarily in these social determinants. Marmot uses the term social justice (9) to highlight the fact that the social determinants' connection with causes of ill-health make the inequitable distribution of these social determinants just as ethically unacceptable as inequity in health itself. This perspective is also well-anchored in the UN's Convention on the Rights of



*When we see
the injustice
clearly and how
we can correct
it, the only
ethical option
is to do this.*

the Child in which each signing member state has committed itself to acknowledge the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

The ethical imperative arises when we realise the strong connection between social determinants and health, when we also have access to the necessary knowledge to make it very likely that we would be able to change the injustice that has occurred through this connection, if we simply decide to do so. When we see this injustice clearly and how we can correct it, the only ethical position is to do this. This is one of the Commission's starting points.

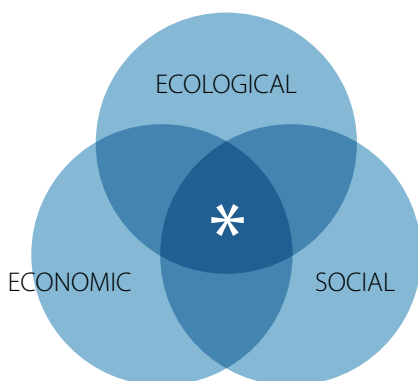
0.3.2 SUSTAINABILITY

The Commission's second perspective relates to sustainability. Sustainable development is defined as a current situation which can be prolonged over time and, based on existing knowledge, is deemed to guarantee human survival and welfare for the foreseeable future. This definition can also be applied to a limited section of humankind, for example the population of Malmö. (19). In its report in 1987, the Brundtland Commission launched a model for sustainable development which identifies three aspects of this, ecological, economic and social (20). It should also be understood that all these aspects are integrated with one other to create a whole, rather like the different organ systems that together comprise an individual. This means that none of these aspects is given higher priority than the others, all of them are needed for the whole entity to work. It also means that there must be long-term sustainability in all aspects if the whole entity is to be sustainable in the long run. It is therefore logical to speak about ecological, economic as well as social sustainability.

There is growing criticism from leading researchers from many different fields based on the fact that the measurements that for several decades have been used to steer the development of society, primarily GDP, have one-sidedly focused on the economic aspect of societal development (21). This has led to an increasingly derailed understanding of society's development and the prerequisites for this. It has been suggested that, through this one-sided focus on economy, for a long time we have overlooked the fact that the ecological aspect of development is not sustainable and that since this was realised it has not been taken seriously. The debate on global warming and the great difficulties in coming up with effective actions to halt this phenomenon, clearly demonstrate this trend.

A similar debate relates to the social aspect of sustainable development. In this case it is increasing social inequality, globally and within countries and local communities, which is in focus (22). This inequity threatens social sustainability by increasing difficulties in maintaining the social contract in society, where people have trust in each other and in societal institutions and actively participate in different contexts in which such trust is created. In other words, marginalisation of individuals and groups tends to increase, which implies societal disintegration, where the weakened social contract is demonstrated by increased crime, riots and eventually a breakdown of society as the end point of such non-sustainable social development. In line with the previous reasoning this also leads to a non-sustainable development scenario, where the conditions for economic and ecological sustainability will increasingly be undermined.

To break a socially non-sustainable development scenario, a shift in perspective is needed, from an increasingly one-dimensional focus on the economic aspects of sustainability, towards a holistic point of view, where ecological and social sustainability are given the same weight since they relate to society's willingness to correct the trend. Methods must also be developed to better determine whether efforts, such as those undertaken as part of the social aspect of sustainability, really lead to improvements. In this context the health of the population, health equity in particular, has been presented as a very relevant measure of social sustainability. This should be considered along with the argument that the significance of social determinants for health is very great (1). This has been an additional foundation for the Commission's work.



0.3.3 SOCIETAL INTEGRATION

The third perspective is the sociological society perspective. The simplest definition of sociology is "the science of the social" (23). The social means everything from global power relationships to an encounter in the street. The social includes social relationships,

structures and systems of various kinds, including those that are included in the economy. From a sociological point of view the issue of social sustainability relates to how the whole of society links together. An important concept, therefore, is social cohesion. However, the concept of integration has a deeper anchoring within sociology. It comes from the Latin word *integratio* and means to make into a whole. According to the Swedish encyclopaedia, *Nationalencyklopedin*, it is about how separate elements merge together into something greater, for example, how people form a society through relationships with each other, or how several societies unite with each other into greater entities, which is the case when we speak about European integration.

In Sweden the concept of integration soon came to deal narrowly with relationships between different ethnic groups. However, an attempt was made to broaden the meaning of the concept through the new policy that was launched in 1998 and called integration policy. A special authority, the Integration Board, was established to take responsibility for integration matters. The new integration policy aimed to “create a society for everyone” and had three overall objectives: Firstly, equal rights, obligations and opportunities for everyone irrespective of ethnic and cultural background; secondly, societal community with the diversity of society as the foundation; and thirdly, societal development characterised by a mutual respect for differences within the limits that follow from society's basic democratic values and that everyone irrespective of background should participate in and jointly be responsible for. Although the objectives and direction of the new integration policy differed markedly from previous immigration policy by not focusing on ethnicity in the same way as before, reviews and evaluations show that ethnic relationships still ended up being the focus. Other aspects of integration were not given priority in the new policy. In an evaluation in 2005, the Swedish National Audit Office criticised the Government for having an inadequate focus (24). Instead of focusing on equal rights, opportunities and obligations irrespective of ethnic and cultural background they had turned the integration policy into a matter of simply lessening inequities between immigrant groups and those who did not have a foreign background.

In the 2009 Government Budget, the previous objectives of the integration policy were replaced by one single overall goal: “equal rights, obligations and opportunities for everyone irrespective of ethnic and cultural background”, in other words, one of the three objectives from the earlier policy. In the document (25) the Swedish Government establishes the proper interpretation of the integration policy for the 2008-2010 period. It says, among other things, that the Government must give priority to work that “creates an effective system for the reception and introduction of recent immigrants”, “gets more people into work and creates more entrepreneurs”, “creates better educational outcomes and equity at school”, “creates better language skills and training opportunities for adults”, but also “creates positive development in city districts with widespread exclusion” and creates “a common set of values in a society that has increasing diversity”. In a later communication from the Government, the Government's work on a strategy for integration was reported on. This initially confirmed that the integration policy supersedes several policy areas and that the integration policy should *not* be characterised by selective efforts.

The concept of integration, however, appears to lead two lives. In the rhetoric there is much more to it than only ethnic relations. But in practice ethnic relations are still the focus, which is unfortunate since integration is one of the concepts that helps us to speak about and understand how society should function and link together.

The Malmö Commission adopts the distinction that has developed within sociology, between system integration and social integration. Someone who for example has gainful employment can be said to be system-integrated in the economic system. It could also mean that one is actually participating. It does not however necessarily mean that one has a sense of participation. The sense of participation is included in the concept of social integration. Both actual participation and sense of participation are necessary prerequisites for socially sustainable development. Opportunities must be created for all Malmö residents to be integrated in both respects. If this is successful and the two forms of integration link together the city can be described as socially cohesive. If the forms of this social cohesion are also long-term, the city can be described as socially sustainable.

0.3.4 EQUITY AND GENDER

The fourth perspective is a gender equity perspective. Gender is a concept in social sciences which is used to understand and distinguish the notions, ideas and actions that taken together shape people's gender. (27). Women and men are ascribed different tasks, roles and positions. This is called a gender system and is based on two principles, gender separation and male superiority. To overcome these systematic differences in power between women and men in society, increased gender equality is required. The Swedish Parliament and Government have defined a gender equal society as “a society where women and men have the same power to shape society and their own lives”. (28). The strategy for achieving the objectives of the gender equality policy is called gender equality integration, which must be based on gender awareness.

Gender inequities are pervasive in all societies. Gender biases in power, resources, entitlements, norms, and values and in the organisation of services are unfair. They are also ineffective and inefficient. Gender inequities damage the health of millions of girls and women. (1)

This is how the WHO Commission begins its chapter on gender equality. The lack of equity between men and women, boys and girls, has a negative impact on health through a number of factors such as discrimination, male violence against women and men, inequitable distribution of power and resources as well as through lack of influence over one's own health depending on one's sex. (1)

0.3.5 SOCIAL INVESTMENTS

The fifth perspective is what is usually called the social investment perspective. It stems from the criticism against the neo-liberalism of the 1980s, which saw social policy as a cost. Inequality was assumed to be a natural part of a market, even essential in order to motivate the economic actors. High unemployment and low economic growth were assumed to be dependent on the market not being sufficiently free. The cure was deregulation. The markets had to be made freer. And people had to be stimulated to seek work, irrespective of the quality of this work. It was also called activation. Security was less important. The state should aim to support supply and not strengthen demand, which had been characteristic of the Keynesian policy (29).

However, in the mid-1990s it became clear that this policy was not working very well. Unemployment had increased sharply and the concept of social exclusion began to be used to describe the situation in which more and more people ended up. Critics gathered around a new perspective, developed during the latter half of the 1990s and labelled the social investment perspective. It put the relationship between effectiveness and equality at the centre. It is possible to re-establish the link between effectiveness and equality, many researchers argue. This is not just desirable to reduce inequality but necessary to become internationally competitive. The advocates of the social investment perspective agree that social spending should be focused on activating people but also regard security as important. In addition, from the social investment perspective, any type of job is not sufficient, great emphasis is put on the quality of the job as well.

The social investment perspective had an impact on the European Commission during the latter half of the 1990s. It made a mark on the European Employment Strategy and laid the foundation for the Lisbon Strategy in 2000. The deepened crisis of recent years has led to renewed interest in this perspective with its requirement of uniting economic and social goals. This is demonstrated for example in the EU report *Cities of Tomorrow. Challenges, Visions, Ways Forward*. (30), which is based on a process initiated by Johannes Hahn, Commissioner of the EU Commission responsible for regional policy, and involving the participation of fifty or so experts from different European countries, researchers as well as experienced practitioners. The report was also at the centre of the URBACT Programme's annual conference in December 2012.

The Malmö Commission advocates a social investment policy based on the previous guidelines. This means that the problems of inequitable health and welfare cannot be solved separately. Inequity is linked to the type of finance-driven growth which has dominated the globe for the last 30 years. As a consequence of this special link between economic growth and welfare a major redistribution of economic wealth has taken place.

This means, among other things, that a municipality like Malmö is dependent on international investments and establishments in order to finance equitable welfare. This means that local government needs to make investment and establishment in Malmö attractive to international businesses.

However, the dependence between economic growth and welfare is mutual. Economic growth is also dependent on welfare. A trained workforce is necessary, as are conscious consumers. This implies an opportunity for managing economic growth. For example, the level and focus of education is important for the businesses that establish themselves. Therefore it is important to invest in different forms of education programmes and make it possible for people to continue their education. Those who lack formal education qualifications must be given another chance, again and again. This is a matter of equity and social cohesion but it is also about future opportunities for Malmö to assert itself in the international competition. The municipality also has a potential influence on economic growth through the procurements it makes. Therefore it is also important to improve public procurement.

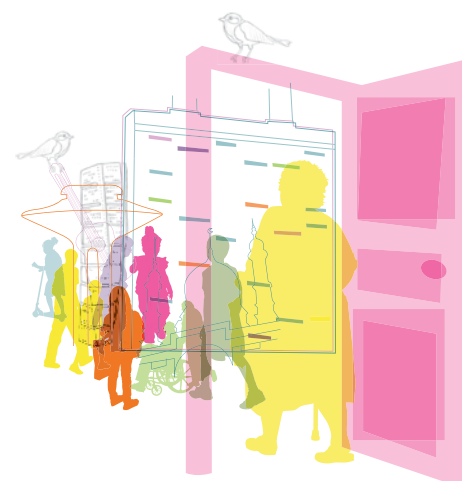
0.3.6 A TRANSDISCIPLINARY PERSPECTIVE

The Malmö Commission thinks it is both possible and desirable to link these five perspectives together. We are of the opinion that they complement each other. According to the rights perspective inequity in health must decrease in order to increase the level of freedom, not just for individuals but for society as a whole. Inequity in health is therefore not only a matter for the individual but for the whole of society. It also depends on the relationship between inequity in health and other inequities. In other words, the causes of inequitable health are social. To tackle health inequities these social determinants must therefore be changed, and this must be done based on an overarching sustainable and holistic perspective.

From a sustainability perspective the problem of increased inequity in health is due to a narrow focus on the economic aspect of sustainability. This is also how the social investment perspective describes the problem, albeit in somewhat different terms. The social investment perspective includes many important arguments for why the economic and social aspects have to be combined and what is required to achieve this. The ecological aspect must however also be embraced, which the sustainability perspective helps us to understand. None of these aspects should be given greater priority than any other. Everything is needed for the whole entity to work. In the creation of the whole entity they interact with each other, rather like the different organ systems that together form an individual.

The sustainability perspective is also consistent with the rights perspective in focusing on social inequity. While the rights perspective links this to a reduction in the total freedom in society, social inequity based on the sustainability perspective is perceived as a difficulty in maintaining the social contract. In this way, it is possible to link the sustainability perspective to a sociological society perspective with its two types of integration, which correspond to actual participation (system integration) and a sense of participation (social integration). When people's actual participation is weakened it undermines the prerequisites for the sense of participation. This can take place through marginalisation and exclusion but also through greater inequities among, for example, those who have work, in terms of salaries and working conditions.

All these perspectives require knowledge and knowledge based on all five perspectives has been represented in the Malmö Commission. Apart from scientific knowledge the Malmö Commission has also attached great importance to experience-based knowledge. The Commission has included individuals with scientific as well as experience-based knowledge. We have chosen to label this a knowledge alliance. The Malmö Commission has been such an alliance. In Section 3 we will return to the definition of the concept of a knowledge alliance. Using a concept which is often used in international contexts the Malmö Commission has developed a transdisciplinary perspective (31). That is, a perspective that integrates different types of knowledge, not just scientific but also experience-based knowledge.

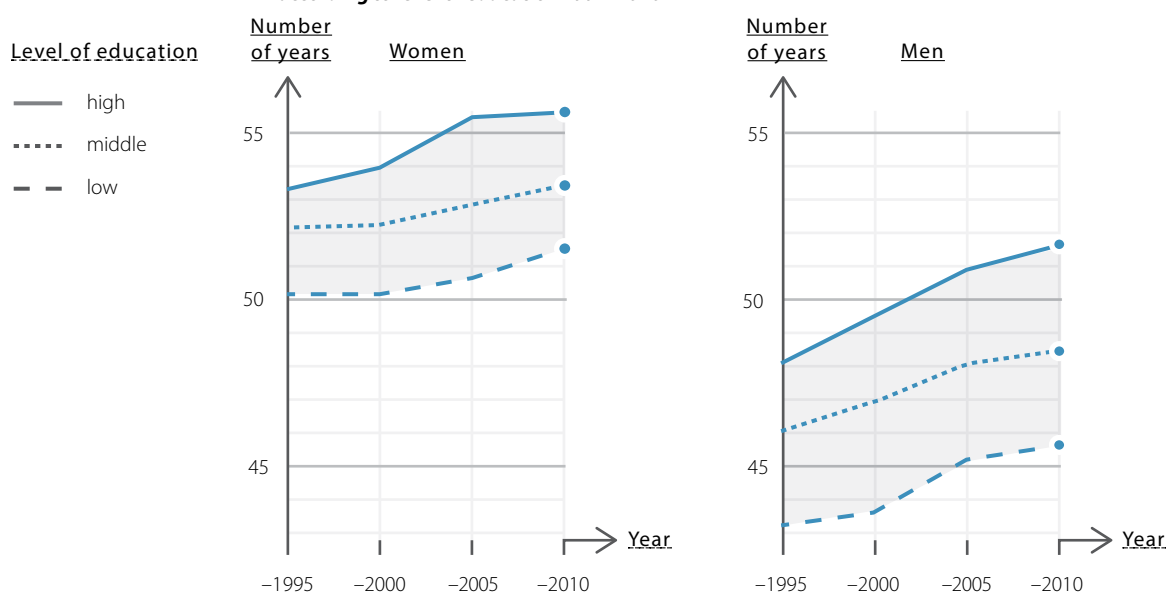


0.4 How can health inequity be measured?

THERE ARE DISTINCT health differences between different groups within Malmö's population, for example, between people with different occupations, different levels of education and different residential environment. Inequality is not limited to any specific type of disease. On the contrary, it is general and is seen in a large number of health outcomes, for example, for self-rated health measurements in surveys or average life expectancy calculated from deaths that have occurred in different age groups.

If the objective is to reduce inequality in health a way to measure this is needed which suits many different health outcomes and different types of comparisons, for example comparisons of people with different education or in different city districts. Trends need to be measured over a period of time. This could impose particular requirements on the measure used, for example if the compared groups drastically change in size. We give examples of how inequality in health can be calculated below. We start with a simple example, namely the difference in average life expectancy between three different educational groups in Malmö. A purely graphic description (Figure 2) shows that the differences may have increased,

Figure 2: Remaining average life expectancy at 30 years of age for women and men in Malmö according to level of education 1991-2010



Source: Statistics Sweden, prepared for the Commission 2012

both for men and for women. The table below provides a more detailed specification. It includes the figures behind the graph for period 1 (1991–1995) and period 4 (2006–2010). It appears, for example, that there is a difference in remaining average life expectancy of 3.2 years between women with high and low levels of education during the first period (the table's column 1, second to last row). Expressed in relative terms well educated women aged 30 could expect a 6 per cent longer life than those with a low level of education (the table's column 1, last row).

During the fourth period (2006–2010) the difference in remaining average life expectancy between women with high and low levels of education is 4.1 years. The difference has therefore increased by 0.9 years since the first period (column 3). This is an

absolute measure of the increase in inequality. In relative terms well educated women now have an 8 per cent bonus in remaining average life expectancy compared to a 6 per cent bonus the previous period (table's column 2, last row). We can draw the conclusion that inequality increased both absolutely and relatively.

The absolute comparison (Table 1) is intuitively the most understandable and interpretable. It can easily be linked to assessments of the potential effect of different actions on inequality when there is an understanding of how the measures affect health, risk of mortality and remaining average life expectancy.

Table 1: Remaining average life expectancy at 30 years of age according to level of education 1991-1995 and 2006-2010

Women	Period 1 (1991-95)	Period 4 (2006-10)	Increase P1 > P4 (number of years)
Low level of education	50,1	51,5	+1,4
Medium	52,1	53,3	+1,2
High level of education	53,3	55,6	+2,3
Difference high-low	3.2	4.1	+0.9
Ratio high/low	1.06	1.08	-

Men	Period 1 (1991-95)	Period 4 (2006-10)	Increase P1 > P4 (number of years)
Low level of education	43,2	45,7	+2,5
Medium	46,1	48,4	+2,3
High level of education	48,2	51,7	+3,5
Difference high-low	5.0	6.0	+1,0
Ratio/high low	1.12	1.13	-

Source: Statistics Sweden, prepared for the Commission 2012

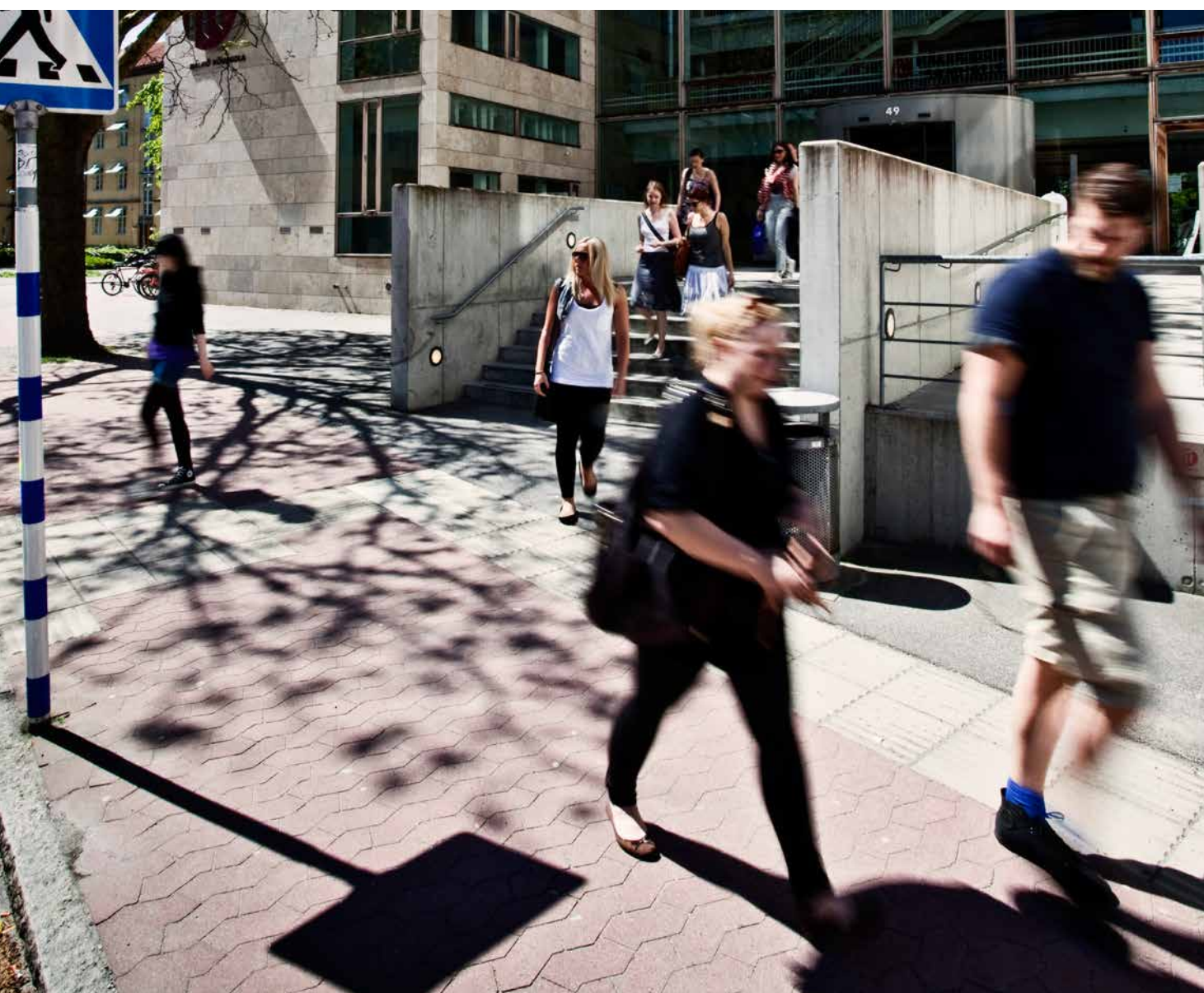
This type of simple measure of inequality is very common. They can be called minimum/maximum comparisons and entail comparing extreme groups. Although minimum/maximum comparisons are intuitively understandable and interpretable they are subject to several problems. The first is that we have not taken into consideration what is happening in the middle group. The second is that we do not take into account how large the groups are or how their size has changed over time. Both problems can be addressed by using a more sophisticated measure or index. Epidemiologists have developed a measure which (applied at mortality) is called "dispersion measure of mortality" or (generally) "average inter-group difference (AIGD)" (13, 32). We refer to the measure below as Shkolnikov's Index. Economists work with a family of measurements called the Concentration Index. Erreyger's Index is one such measure based on absolute comparisons of groups which can be ranked (33). We have used data from the previous graph to calculate both of these indexes. In this case, when we have ranked data (level of education), they give identical results and are therefore equivalent.

Below the calculations according to Shkolnikov's Method (Table 2) are reported. Briefly, the principle is that each group is compared with every other group. The middle group is therefore not ignored but is compared with both those with a high level of education and those with a low level of education. It is quite possible to increase the number of compared groups through finer divisions. To take account of the size of the groups each comparison is allowed to receive a weight, the higher the weight the bigger the compared groups are. For each comparison the compared groups' relative population proportions are multiplied and the weight is set to be proportional to the product. Finally, we balance together all comparisons into one index. There is a more detailed description in Swedish in Vågerö (34). Erreyger's Index is described in Swedish in Gerdtham and Kjellson (8).

Table 2: Index of inequality between education groups in Malmö in 1991-2010

Index of inequality (Shkolnikov's Method)	Men	Women
1991-1995	1.00	0.60
1996-2000	1.28	0.80
2001-2005	1.31	1.09
2006-2010	1.43	0.95

Source: Statistics Sweden, prepared for the Commission 2012



The index shows that for men inequality in remaining average life expectancy gradually increases during the period. For women there is a long-term increase, but with some reduction after 2005. Since the method is based on every group, not just the extreme groups, it appears to be a more reasonable way of measuring inequality.

To summarise: When it comes to comparing groups at a certain point in time absolute measurements are often best. They are easy to understand and show how the situation actually is. For example, we can compare incident cases of childhood accidents, depression, suicide, breast cancer or prostate cancer during a certain period among those with a low level of education and compare with those with medium or higher education. Or compare city districts, immigrants from various countries and the rich with the poor. We account for men and women respectively and standardise for age so that comparisons are reliable. The results can be reported as the number of affected individuals per 100,000 in the group, or as a proportion in per cent or as an average expected life expectancy, etc. The absolute difference between groups can be reported, or the ratio between these. In terms of health policy it is of great value to be able to show an effect on the absolute level of health and morbidity, and particularly to improve the absolute level of health for the groups which are most burdened.

In order to make an overall assessment of whether inequality increases or decreases, Shkolnikov's method, described previously, can be used. Shkolnikov's Index can be calculated both in comparisons of groups which can be "ranked", for example education groups, and groups which cannot be ranked, for example city districts, and provides a summarising measure of the inequality trend specified for a certain health outcome.

0.5 What does health inequity cost?

IT HAS LONG BEEN known that the costs to society for ill-health are considerable. In so-called “Cost of Illness” studies (COI) the costs of a single disease or a group of diseases are calculated in monetary terms. Both direct and indirect costs of disease and ill-health are calculated. The results describe the economic burden to society of a certain disease and can be used to describe the trend of the costs of the disease over time or to compare different countries or disease groups.

Ramsberg and Ekelund (35) calculated the total costs of disease and ill-health for Sweden in 2008 to be SEK 823 billion. This is equivalent to around SEK 90,00 per inhabitant. This cost includes the costs of medical care and pharmaceuticals, as well as loss of production as a result of sick leave and death before 65 years of age. In addition there are the municipalities' care costs for different illnesses (dementia, multiple sclerosis, osteoporosis, schizophrenia, stroke). The Royal Swedish Academy of Sciences did a similar study on the costs of psychiatric illnesses which were estimated at SEK 75 billion annually (36).

There is a limitation in the method. It attaches no monetary cost to disability or trauma that does not result in health care or loss of production. If a pensioner commits suicide or suffers a traffic accident which results in immediate death there is no loss of production or health care costs worth mentioning. The COI Method makes no attempt to quantify the loss of such human life; in practice the cost is set at zero. An alternative method, the Burden of Disease Method, is based on evaluating each living year which is lost as a result of disease or death up to the age of the expected life expectancy, that is, in Sweden up to around 80 years of age.

The calculations according to the COI Method show, not unexpectedly, that the largest part of the costs arise due to loss of production when the individual becomes disabled or dies prematurely (56 per cent of the total cost of ill-health). The fact that these costs are significant is illustrated by the authors by a comparison with the Gross Domestic Product (GDP) which this year was SEK 3,157 billion. Ill-health corresponds to around 1/4 of GDP. The high costs of ill-health form a strong argument (but not the strongest) for reducing the risks of disease and ill-health, that is, for prevention in the broad sense (37).

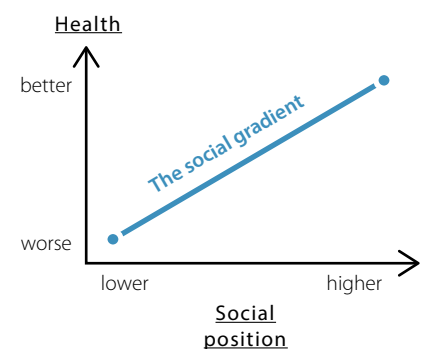
The prevalence of illness, disease and early death is unequally distributed in the population. We speak of the “social gradient” (38–40). The costs form a strong argument (but again not the strongest) for reducing the social gradient of illness and particularly for investigating how ill-health can be reduced in the social groups which have the poorest health.

The question of the costs to society for inequality in health is not entirely easy to answer. Some calculations have been presented (37, 41) but it is highly uncertain whether they really answer the question of what inequality in health costs. Below we describe a Swedish attempt.

Calidoni et al. (42) have calculated what inequality in health costs annually for the Västra Götaland region. The calculation was done in two steps. The first step consists of an estimate of the extent of inequality, which is done by comparing the health of different education groups. The focus is on three differences, namely differences between education groups in self-reported health, risk of mortality and the number of life years lost. The second step involves calculating what these health differences are equivalent to in monetary terms. Based on these two calculations the cost to society of inequality in

Figure 3: The social gradient

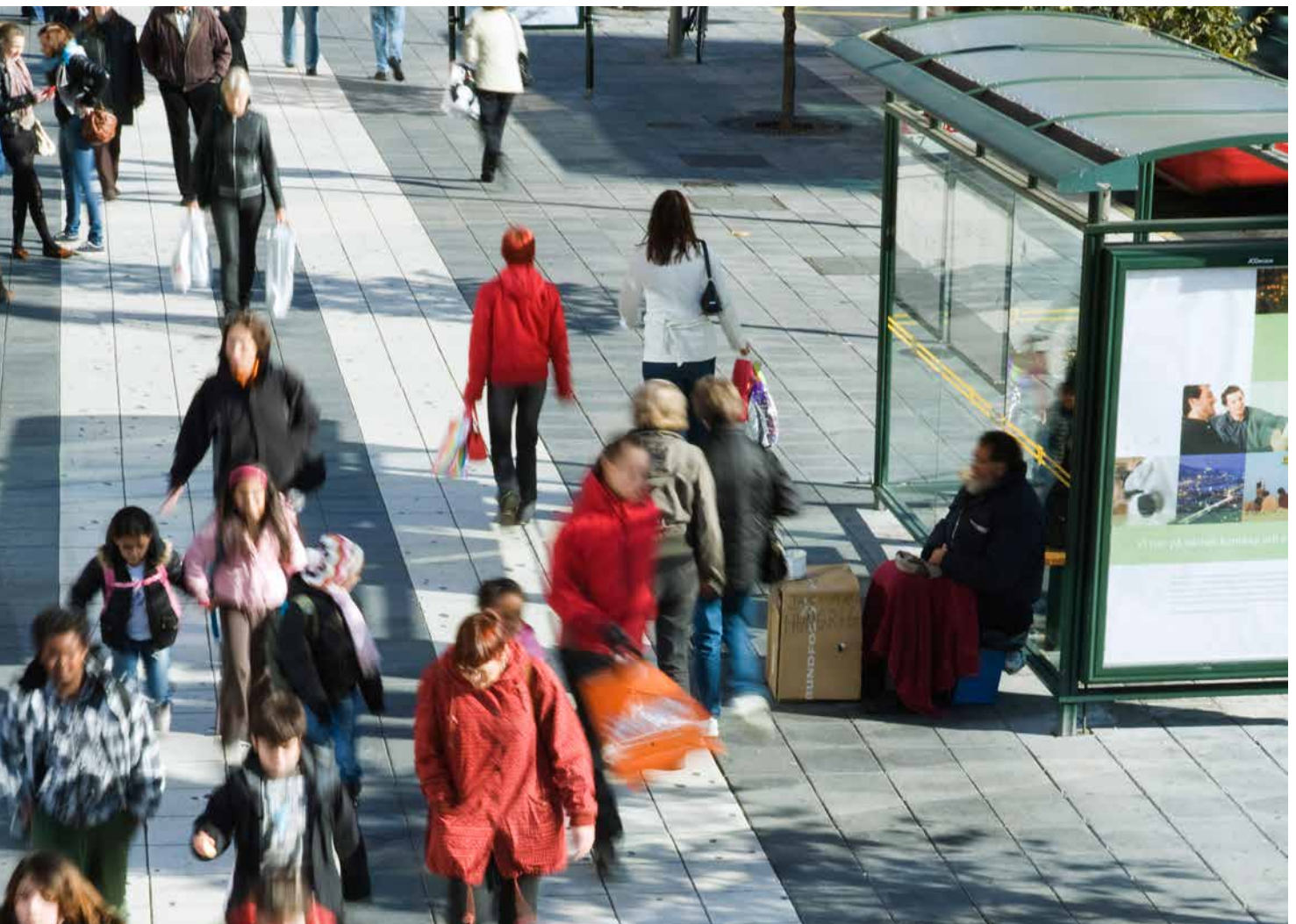
Health is unequally distributed in the population. The lower the social position, the poorer the health and vice versa. There is talk of a “social gradient” among the population.



health in Västra Götaland can be estimated at SEK 10,000 per year and inhabitant. We can assume that the same, or perhaps higher, costs apply to Malmö. Malmö residents generally have weaker health and a lower level of education than those of Västra Götaland. The total costs of inequality in health per inhabitant should therefore be greater than in Västra Götaland, but this does not automatically mean that inequality in health, or its costs, are greater. If we make a conservative assumption that they are basically the same (SEK 10,000 per individual and year) we can calculate the total cost of inequality in health in Malmö at SEK 3 billion per year.

When we calculate the costs to society of inequality in health we actually start from the premise that social inequality gives rise to health inequality. That this is mainly the case is clarified by research in social medicine and social epidemiology from the last three decades. However, the causal link between social position and ill-health is not unequivocal. Ill-health can cause withdrawal from the labour market as well as a change of occupation and downward social mobility. The most realistic model of the relationship between social position and health acknowledges their mutual impact on each other in parallel with the dominant influence of social position on health (43). The possibility that a third factor causes both social position and ill-health has also been debated (8).

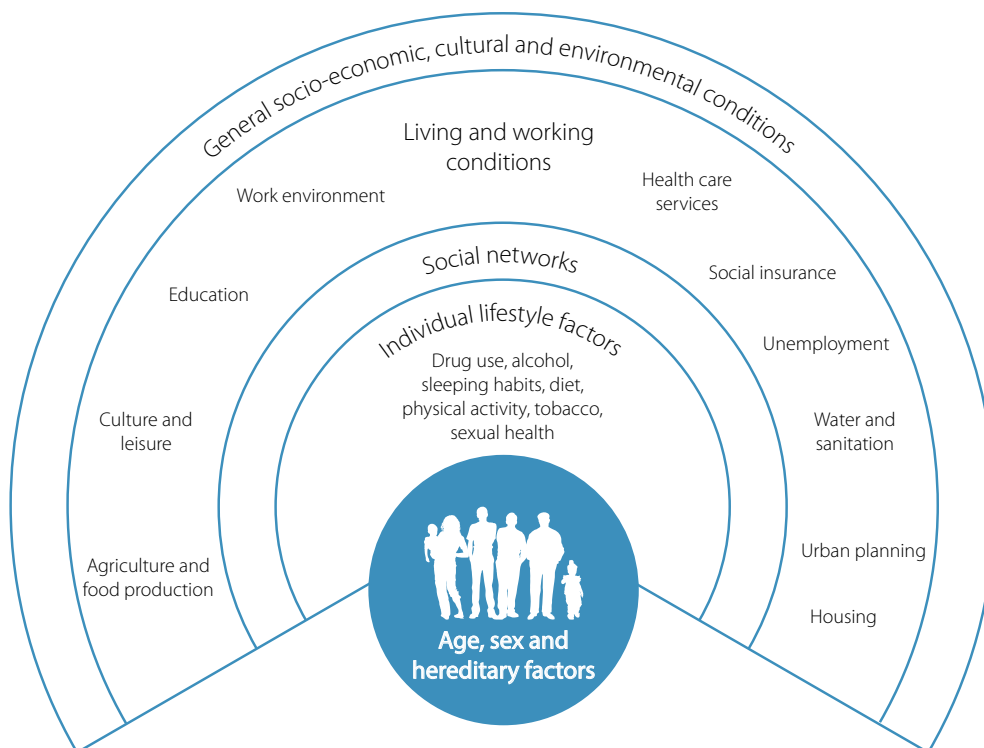
Calculations of the costs to society of social inequality are therefore by their nature difficult to perform. The calculated cost does not tell us anything about how society's scarce resources should best be used – the aim of the calculations is not to say what should be done and whether the actions are worth the sacrifice. The Malmö Commission's main task is to suggest actions in order to reduce inequality in health in Malmö and for this economic evaluations of proposed actions can instead form an important foundation.



0.6 What causes health inequity?

HEALTH INEQUITY depends on, what we in this report call, social determinants. The full term is “the social determinants of health”. This was also the official name of the WHO Commission (Commission on Social Determinants of Health), which underlines the importance of these social determinants. Those are the factors which must be identified and changed or counteracted in order for health to become more equitable. What precisely do we mean by social determinants and what are they? One of the most used models for understanding the determinant factors of health in an integrated manner was proposed by Dahlgren and Whitehead (1991):

Figure 4: Social determinants of health



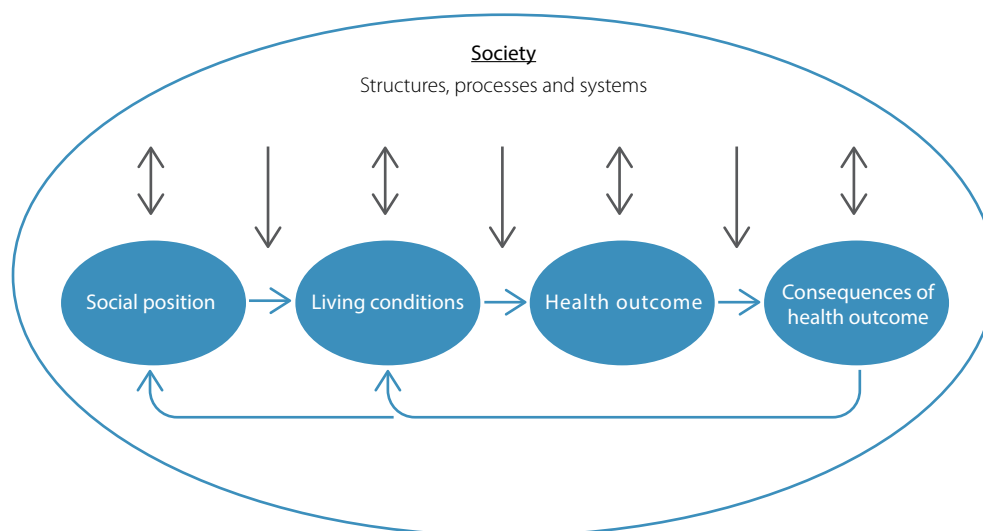
Source: Dahlgren and Whitehead 1991

This model has the advantage of encompassing all of the broad categories of determinants of health and shows that these can exist at several hierarchically ordered levels surrounding the individual. However, the model provides little guidance regarding the mechanisms that cause an inequitable distribution of ill-health in a society. In this chapter we will therefore present a developed model. We will explain our understanding of the concept of social determinants and account for the factors which we analyse in the report's three sections. In this model we divide the social determinants into six areas, which also forms the rationale for the structure of the Final Report.

0.6.1 SOCIAL POSITION AND HEALTH

Diderichsen and colleagues (44) have created a model which, among other things, formed the basis of the Danish report *Ulighed i sundhed (Inequalities in Health)* (45). The WHO report on the social determinants of health suggests a somewhat different version (1). These two models, which are based on very similar principles, have formed the basis for the model that is presented below as a framework for understanding the analyses and the disposition of this report.

Figure 5: Framework for understanding the analyses made by the Malmö Commission



Source: Revised after Diderichsen 2011 and WHO 2008

An important point of departure, which is shown elsewhere in this report, is the fact that a low social position is strongly associated with living conditions which constitute an increased risk of ill-health, compared to the living conditions associated with a high social position. Social position is a complex sociological concept, which we will not go into in depth here. It refers to a state in the structure of society, which involves assets such as income, education and housing, as well as employment. Usually these determinants of social position are linked. A higher level of education can lead to a better job which in turn can mean a higher income. But at the same time work, income and education have their own distinct connections to health (46).

The link between social position and living conditions is strong. Living conditions here include physical circumstances as well as the standard of housing and the residential area's environment, work environment/school environment, etc. and also the contribution of these environments to different behaviours which can be related to health (smoking, alcohol and drug consumption, dietary habits, exercise habits and injuries). All of this in turn affects the individual's risk of suffering ill-health. Elsewhere in this report it is clearly shown that certain living conditions entail a significantly higher risk of ill-health for an individual, and that many of these living conditions are more common among individuals with a low social position, than among those who have a higher one.

The social position is also significant when it comes to what happens when the individual falls ill and the consequences of this, which is also addressed in this report. It appears that individuals with a low social position encounter various barriers when they seek treatment for their diseases in the existing health care system. In conclusion, living conditions, disease and the consequences of disease, depend to a great extent on the individual's social position. However, the reverse relationship also exists. To a great extent, the consequences of disease have repercussions on the individual's social position. For example a deterioration in health leads to an individual being marginalised from the labour market, losing a significant part of his or her income and ending up in living conditions associated with a new and lower social position.

There has been a debate about whether this is in fact the most important causal chain behind health inequities, but Marmot has shown in the compilation of facts (47) which appeared in the WHO Commission's report on the social determinants of health as well as in the report mentioned previously (1) that this only constitutes a minor part of the contribution to health inequities. Rather it is about a mutual impact where social position is the primary

driver (43). Detrimental social determinants lead to ill-health which lead to even more detrimental social determinants. Ill-health in this way becomes a reinforcing factor in a socially determined marginalisation.

Based on his or her social position, the individual contributes to creating and maintaining and perhaps developing or phasing out society's structures, processes and systems, which is illustrated by the vertical double-pointed arrow in the figure. In other words, the individual is not a passive object in his or her social position, living conditions or in his or her interaction with the health care system, but also a subject who is involved in "making" society, though to different degrees, in different ways and based on different prerequisites. This is also the basis for the strong emphasis in this report on increasing the individual's participation and influence by means of the development of the steering processes in which the municipality is involved (see Part 3 of this report) in order to reduce the health inequities by changing their social determinants. This could for example be achieved by creating a more even distribution of income, whereby the differences between the social positions decrease and thus also the health inequities. It could also entail general improvements in residential environments, opportunities for everyone to choose housing, a working life that takes into account the beginning of ill-health, or a functioning health care system, which genuinely matches the need for care within the population. These interventions are thus aimed directly at the phenomena that are included in the causal chains described in the figure above. The interventions can therefore be assumed to be cause-orientated, that is, they aim ultimately to eliminate social inequality as a cause of ill-health.

The processes in society can also intervene to modify the different stages in the causal chain, which the figure illustrates, and which is also shown by the single-pointed vertical arrows. This can mean that the relationship between low social position and living conditions is buffered, for example, by economic transfers to families with low income, specific investments in the residential area in which many individuals in a low social position live, or directed actions to make the health care system more equitable. These interventions are thus aimed directly at the consequences of the phenomena included in the figure's causal chain. The interventions can therefore be considered to be problem-orientated, that is, they have the aim of dealing with problems which have occurred due to an existing social inequality.

The concluding recommendations, objectives and actions in this report aim to bring about both the types of changes described above. But what are these social determinants?

0.6.2 DIFFERENT TYPES OF SOCIAL DETERMINANTS – THE RATIONALE FOR THE REPORT'S STRUCTURE

These health inequities, avoidable health inequalities, arise because of the circumstances in which people grow, live, work and age. (1)

The residential environment is one of the social determinants that can explain differences in health between countries, within countries and in cities. What is a residential environment? In all simplicity it is an environment where people live. Those who live in the same residential environment have this in common, that is, they live in the same residential environment. They may not know each other and maybe do not even know about each other. Perhaps they do not have anything else in common apart from the fact that they live in the same residential environment. But that can be important enough because irrespective of whether or not they know each other the residential environment creates the same conditions for their lives. If for example there is no playground then this is to the disadvantage of all the families with children who live there. If however there is a playground it is nevertheless not certain that everyone will use it. The mere fact that people live somewhere does not mean they must be in contact with their neighbours.

This is not the case in a school. The role as pupil entails that one comes into contact with for example other pupils and with the teacher. At a school everyone forms part of a social structure and a school is also part of the greater societal system which can be called the education system. It can be said to be a system since it is governed by laws and rules. When a school is regarded as a determinant of health it is different from the residential environment. In terms of a school, it is the societal system which constitutes the determinant of health while the residential environment can be said to constitute a spatial structure, although not just any such structure. The residential environments which are of interest to the Malmö Commission are those that have been created by other societal systems, among others the one that the City Planning

Office is included in. This does not mean that people who live in the residential environment are included in the City Planning Office societal system. They should perhaps have been, but this cannot be said to have happened up to now. In the case of the residential environment it is because of the effects of the societal system that it constitutes a set of determinants of health. In the case of the educational system, health is determined by the system itself and the participation in that system.

These can be seen as two types of determinants, one relating to the effects of the societal system and the other concerning the system itself. In the first category we include, apart from the residential environment, the area which in this report is named “Everyday conditions for children and adolescents”. When a child begins his or her journey through life he or she is immediately exposed to the consequences of how different societal systems function. The effects of the different societal systems determine their health, such as, the parents' economic situation. Thus, there is a similarity between the residential environment and child poverty. The similarity consists in the fact that both are the effects of other societal systems.

In the other category we include phenomena which pertain to the societal system's way of functioning. We have already mentioned the education system. The health care system also constitutes a societal system where the roles can consist of every possible category of staff but also of patients. Its way of functioning determines the health of those who are included in it, for staff as well as patients. “Education” and “Health care” can be seen as two different social systems. What we have called “Income and work” is perhaps another case. This area cuts across others since people work within “Education” as well as within “Health care”. However, it does not concern just any type of work but specifically wage work. In principle education could be organized without wage work, which also is the case in different parts of the world where people teach without earning a wage. But the mere fact that it is performed in the form of wage work makes it a particular determinant of health. It is possible to regard the market economy as one (or more) transversal societal systems.

Thus, we hope to have justified the five areas and the classification of them into two types of determinants, one which relates to the effects of the societal systems and the other which relates to the systems in themselves, in other words, how they function.

Concerning the first type of determinants, we would argue that life in an area does not just depend on the people who live there; namely, their own individual peculiarities, strengths, weaknesses, behaviour, etc. The effects of different societal systems also constitute determinants of unequal health. Hopefully, this will make various stakeholders interested more in WHAT they do. But HOW they do it, that is, how the system functions, also constitutes a determinant, for example how the school's social structures receive recently arrived pupils or the problem within health care which forms the basis of the proposed action to “improve the intercultural competence and knowledge about the importance of social determinants for health-related behaviours, in the health care system”.

Why is a third category of actions needed, those which are presented in Section 3? What function does this category fulfil? Well, they deal with HOW things should be done INSTEAD. If the focus in Section 1 can be said to be on the effects of the societal systems, then the focus of Section 2 is on these societal systems' processes, in other words, how they function. The focus of Section 3 is on the essence of how they should function. In order for societal systems not to contribute to an increased inequity in health there is a need of knowledge alliances, new measurements of societal development, democratised management by means of, among other things, changed leadership and holistic management instruments. What is said in Section 3, is therefore not peripheral. These actions should be perceived as transversing the rest of the report, in the sense that they will permeate the actions in Sections 1 and 2.

We refer to the current distinction between government and governance. Government means the traditional forms of governing, according to the principles of representative democracy. Those forms of governing are important, but need to be complemented to a greater degree by the forms that usually are called governance. That is, network-like forms of management and organisations which arise through cross-boundary co-operation between different players. Government is characterised by hierarchically ordered forms of management and organisations with clearly defined and delineated levels of responsibility. The democratic influence is also well-defined and the form of management is public, that is, transparent. Governance means that you go outside institutions and create politics in partnership with other types of stakeholders. What we advocate is a development of governance that entails many interested parties being involved in the management of the societal systems. In other words, we advocate a deepened democracy, particularly through a democratisation of governance.

Figure 6: Malmö Commission's classification of recommendations

The first section of the report (1) deals with the social determinants that are the effects of the societal systems, that is, the living conditions in which we are born, grow up, work, live and grow old. In the second section (2) we focus directly on some of the major societal systems. The third section (3) concerns how people's participation in these societal systems could be strengthened through democratisation, particularly by the network-like forms of management and organisation which are usually called governance.

Government		
3) Governance (processes – how)	2) Social systems: Education Income and work Health care	3) Governance (processes – how)
1) Spatial and social prerequisites		

0.7 Health and health inequities in Malmö

THE HEALTH OF THE INHABITANTS OF MALMÖ does not deviate significantly from the overall health situation in the rest of Sweden even though there are some differences. Unfortunately, there is a lack of measurements which can tell us in a simple way about whether health is more inequitably distributed in Malmö, compared with the rest of the country. However, what is usually pointed out is that there are large differences in health between different residential areas in Malmö. This is confirmed by statistics from a large number of epidemiological studies which have been conducted in Malmö, where the results have been presented according to the level of education, income and occupation. These studies, briefly summarised, show that social determinants have a large impact on the distribution of health among the residents of Malmö from life in the womb to the dying breath.

During the ten-year period 2001-2010 almost 45,000 children were born in the city. Nearly all of them were born healthy thanks to the good state of health of their mothers, highly skilled maternity health care and obstetric care which Malmö residents can be proud of. The rapid population increase in Malmö in recent years is partly due to the number of births being substantially higher than the number of deaths and partly due to immigration from abroad. Immigration from the rest of Sweden to Malmö is balanced by the equivalent number moving out. In the long term Malmö's future depends on the chances the children have to develop their full potential. Although the majority of children in Malmö are in good health there are threatening storm clouds in the sky. Even during pregnancy there are already considerable social health inequities and health risks for mothers, and such differences are noted throughout the entire life cycle of Malmö residents, up to the very oldest.

With the help of researchers working at Skåne University Hospital and other experts we have attempted to create an updated picture of health inequities in Malmö seen from the perspective of social determinants during the entire life cycle (11, 48–51). The social health inequities which are seen in the oldest part of the population can often be traced back to childhood (52). Exposure to health risks during pregnancy and the very first years of life increases the vulnerability of the individual for the rest of his or her life - year after year. Much ill-health later in life can therefore be prevented if the social determinants for health are considered to a greater extent early in life.

The local knowledge base concerning health inequities in Malmö which this chapter is based on is a necessary prerequisite for us to be able to recommend actions for reducing the inequities, in addition to what is already in progress.

It is no coincidence that those who are well educated, have a good job, a good income and good living conditions are more healthy and live longer. The important question is what society can do to create the conditions for everyone to have some of these prerequisites. Research clearly shows that individuals with poorer social resources do not have the same opportunities to devote resources to health, such as by changing health-related behaviours that lead to a higher risk of illness, since they may be unemployed, be poor, or have inadequate education and have had a difficult start in life. (53, 54)

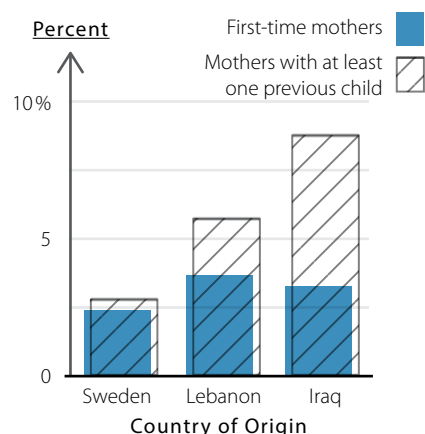
Health and health-related behaviours in Malmö during different parts of the life cycle are briefly reported below, followed by an account of the whole population.

The social differences in health which are seen in the oldest part of the population can often be traced to childhood

0.7.1 PREGNANT WOMEN IN MALMÖ

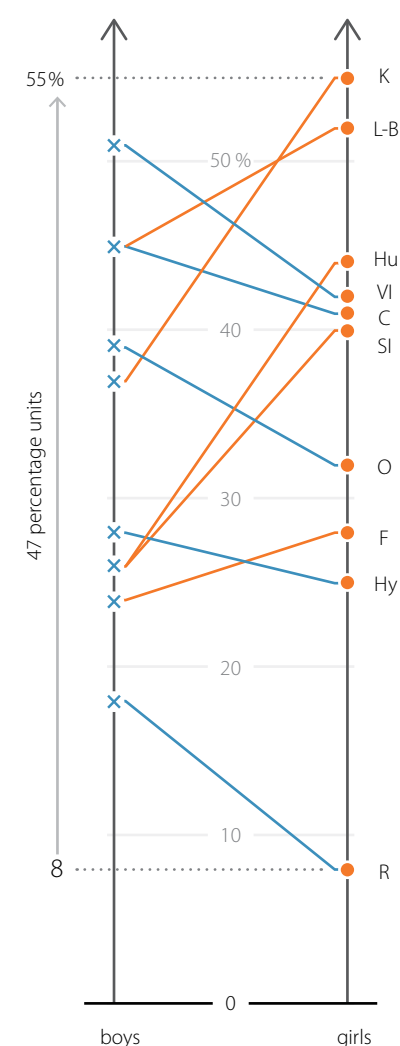
A report based on information from pregnancies from 2000 up to 2010 (in total 44,198) formed the basis for the results and conclusions that are reported here. (50)

Figure 7: Diabetes during pregnancy (per cent) among first time mothers and women residing in Malmö in 2000-2010 who have previously given birth against country of birth (Lebanon, Iraq and Sweden)



Source: Molin, 2012

Figure 8: Proportion of pupils in Year 9 who have drunk enough alcohol to feel intoxicated. Girls and boys per city district in 2008



Source: Malmö pupils' health-related behaviours, City of Malmö, 2009

Teenage pregnancies, use of tobacco, overweight, obesity and diabetes were seen to a greater extent among women with poor economic and social resources. This affects the risks of having a growth-retarded child, a stillborn child or other obstetric complications. Teenage pregnancies dominate among the unemployed and among women with a low level of education. It has been shown that immigrant mothers continue to live in the same residential area as where they gave birth to their first child, while the Swedish-born mothers largely move to more affluent areas rather than where they gave birth to their first child. This can indicate that the immigrant mothers have a greater difficulty in increasing their economic and social resources than Swedish-born women.

Obesity, which is a strong risk factor for diabetes, is also clearly linked to the family's economic and social resources and the mother's country of birth. An example that illustrates this is the fact that the risk of diabetes among mothers from Iraq is three times higher than among Swedish-born women (8.9 per cent compared with 2.8 per cent). However, this was not the case when they gave birth to the first child (Figure 7). The primary causes of obesity and thereby the risk of having diabetes is low physical activity and/or too large an energy intake. These factors occur more frequently among women with a low level of education and a weak connection to the labour market and in some immigrant groups, which from a preventative point of view represents important knowledge for maternal health care. At Skåne University Hospital research is in progress which aims to increase knowledge of this, which is essential to prevent and take action against the underlying problem.

0.7.2 THE CHILDREN OF MALMÖ

Swedish children are among the most favoured in the world from a health point of view, but this good health is not distributed in a socially equitable way. The most important thing for the health of children and young people is an environment that supports their development, in the home, in their spare time, at preschools and at school. In this environment, social relationships, the family's economy, health-related behaviors, good prerequisites to succeed at school and a good transition to work and provision are some of the most important pre-conditions for good health during childhood and the rest of the individual's life. (See also the chapter on the living conditions of children and adolescents.)

A recently published thesis presented the results of a questionnaire survey where information was gathered in connection with children's visits to child health care centres in Malmö. The unique feature about this study was that a number of health-related behaviours and health indicators were reported in relation to the mother's education, to the parents' relation to the labour market and the parents' country of birth. The study showed that lack of breastfeeding during the first 4 months, the mother smoking during pregnancy and the child being exposed to passive smoking were more common among mothers with a low level of education. In addition, mothers with a low level of education sought more out-patient as well as in-patient care for their children (55). The study also showed that there was a connection between overweight for 4-year-old children and exposure to environmental tobacco smoke (56). Furthermore, a number of social and psychosocial factors showed a clear link to higher use of antibiotics among the youngest children (57).

Every third year since 1994, the City of Malmö has conducted a survey of Malmö's pupils' health-related behaviours. Since 2012 parts of this survey have been integrated into the region-wide Public Health Report on Children and Youths which was analysed separately for Malmö (58). The results from this report showed that an increasing number of school pupils in Malmö rate their health as good or very good in a number of respects, but the proportion of school pupils with mental and somatic complaints (at least two mental or somatic complaints per week) increases with age and amounts to 28 per cent among boys and 51 per cent among girls in upper secondary school's Year Two. The same tendency is seen in the rest of Sweden. No report is available which shows a connection between these tendencies and socio-economic factors, but the proportion of pupils with such complaints varies between Malmö's city districts.

In response to the question about whether they drank alcohol until they felt intoxicated, 24-55 per cent in different city districts in Year Nine replied affirmatively, with the exception of "Rosengård" where just 8 per cent of girls and 18 per cent of boys replied affirmatively. In upper secondary school Year Two 16 per cent of girls and 25 per cent of boys used narcotics. The variation between the upper secondary schools was 1-27 per cent for girls and 15-37 per cent for boys (Figure 8).

Schools in areas with a large proportion of families in low social position showed significantly greater risk of adverse health-related behaviours than in other areas. The proportion of pupils in Year Six in Malmö who eat breakfast, a cooked lunch and a prepared dinner every day of the week was 55 per cent among boys and 49 per cent among girls. Those proportions decrease with increasing age and in the upper secondary school's Year Two the equivalent figures were 35 per cent of boys and 27 per cent of girls.

The proportion of children with overweight and obesity in Malmö has increased very sharply since the end of the 1980s, when around 4 per cent were overweight and 1 per cent was obese (49). Those increases have stalled in recent years, but according to the City of Malmö's latest welfare reports (4) a fifth of all children suffer from overweight or obesity, which is far above the national average. Since overweight and obesity are strongly related to low social position, it can be assumed that this is an important cause for the difference when Malmö is compared with the rest of the country.

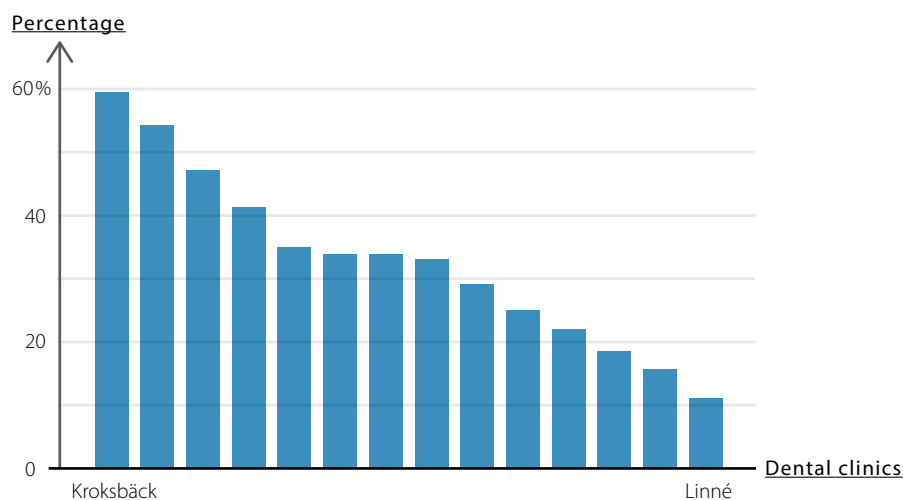
Children's dental health

Dental health is usually a good indicator of the general state of health of children and young people, since the health of teeth is strongly associated with factors that also affect other health conditions, that is, health-related behaviors, use of health care, economic conditions and knowledge of how to maintain good health.

The figure below, based on statistics from various dental clinics in Malmö, shows clear inequities in dental health among six-year-olds in Malmö depending on which clinic they have visited, which in turn is an indicator of the city district in which their family lives. Poor dental health is approximately six times more common among six-year-olds at clinics situated in areas characterised by a large proportion of adults who are outside the labour market and have low incomes, compared with clinics that are in areas whose adult inhabitants have the opposite conditions (59) (Figure 9).

The welfare reports in Malmö during the period 2005–2012 show that dental health among 12-year-olds and 19-year-olds has improved slightly, but large inequities also exist in these age groups between children from different socio-economic groups.

Figure 9: The proportion of 6-year-olds with caries in need of repair. Dental clinics in Malmö in 2010



Source: Matsson in Köhler, 2012

Children with an increased risk of ill-health

There are many factors in children's everyday conditions that can have a negative impact on their health. Weak economic and social resources increase vulnerability to social problems and mental illness. This results in a situation where children in those types of families often suffer from reduced well-being and psychological disorders. (51)

Newly arrived children and children who have taken refuge in Sweden

Newly arrived children in general, and in particular those who have taken refuge or are undocumented, are vulnerable groups which are more likely to be exposed to health risks. Being a refugee often involves previous trauma, and has usually been preceded by experiences of war and/or persecution as well as the loss of close family members. During the asylum process fam-

ilies live a life that is characterised by weak economic and social resources, often in the shape of overcrowding and exclusion. The parents' lack of well-being in turn influences their children so that their psychological problems, the effects of torture or trauma as well as concerns about the future can have serious negative effects on the child's everyday life, development and trust in the adult world. Asylum-seeking and undocumented children in Sweden have the right to the same health care as other children. Asylum-seeking children are also provided with health check-ups free of charge at the refugee health centre, Flyktinghälsan, which involves a survey of their health status, health care and check-ups for infectious diseases. Approximately 75-80 per cent of children in families undergo a check-up, while the proportion among unaccompanied children is almost 100 per cent. There is a lack of detailed information about the health of these children, but judging from their visits to health care providers, physical and mental illness and psychosomatic problems are more common than among other children. (51, 60, 61)

The number of asylum-seeking children in Malmö has increased in recent years, from 1,449 in 2008 to 3,136 children in 2011. The number of unaccompanied children was 404 and 1,157 respectively during the same years, in other words, a sharp increase. However, most of these children do not stay in Malmö for any length of time. In 2011, only 644 children stayed more than 31 days. The number of refugee children in terms of municipal receptions in accordance with the Compensation Ordinance has decreased from 429 to 174, during 2008 to 2011 (62). The exact number of undocumented children in Malmö is by definition unknown, but estimates show that there are probably around 400 undocumented children in Malmö today. (62) The everyday environment is of great significance to all children, and in particular to refugee children and those children referred to as undocumented. (61)

Children who are neglected or abused

Children who are neglected or abused in Malmö are a large heterogeneous group. In the concept "children who are exposed to different types of neglect" we usually include children who are exposed to physical and psychological violence, abuse, sexual assault or neglect. The risk of children being neglected or abused is higher in families with weak socio-economic resources, particularly when these life conditions are connected to other social problems such as substance abuse or mental illness. It is not uncommon for the same children to be exposed to psychosocial neglect in several ways, for example both neglect and violence.

In a number of reports to the Commission the authors have highlighted the situation of these children (51). In 2011, just over 6, 500 reports to social services were made concerning children and young people up to 18 years who were neglected or abused or suspected of being so. The majority of those notifications were made by the police and the most common reason was confirmed or suspected neglect. However, the number of unreported cases is assumed to be large.

Within child health care, which in theory reaches all children up to the start of school, the number of notifications and reasons for these are compiled annually. The number of notifications to the child health care centre in Malmö is very low, and consists of just three per 1,000 children. There are also large variations between different child health care centres. This is despite a statutory obligation for professionals within health care to notify social services in the case of suspicions of a child being neglected or abused. Support for staff as well as professional development and improved co-operation with social services is therefore essential in order to access unreported cases. Since there is a strong connection between the living conditions of children and young people and the risk of being neglected or abused, this is relevant for the debate about the inequitable distribution of health in Malmö. Not least considering that interventions early in life are often crucial to the individual's health for the rest of his or her life.

Homeless children

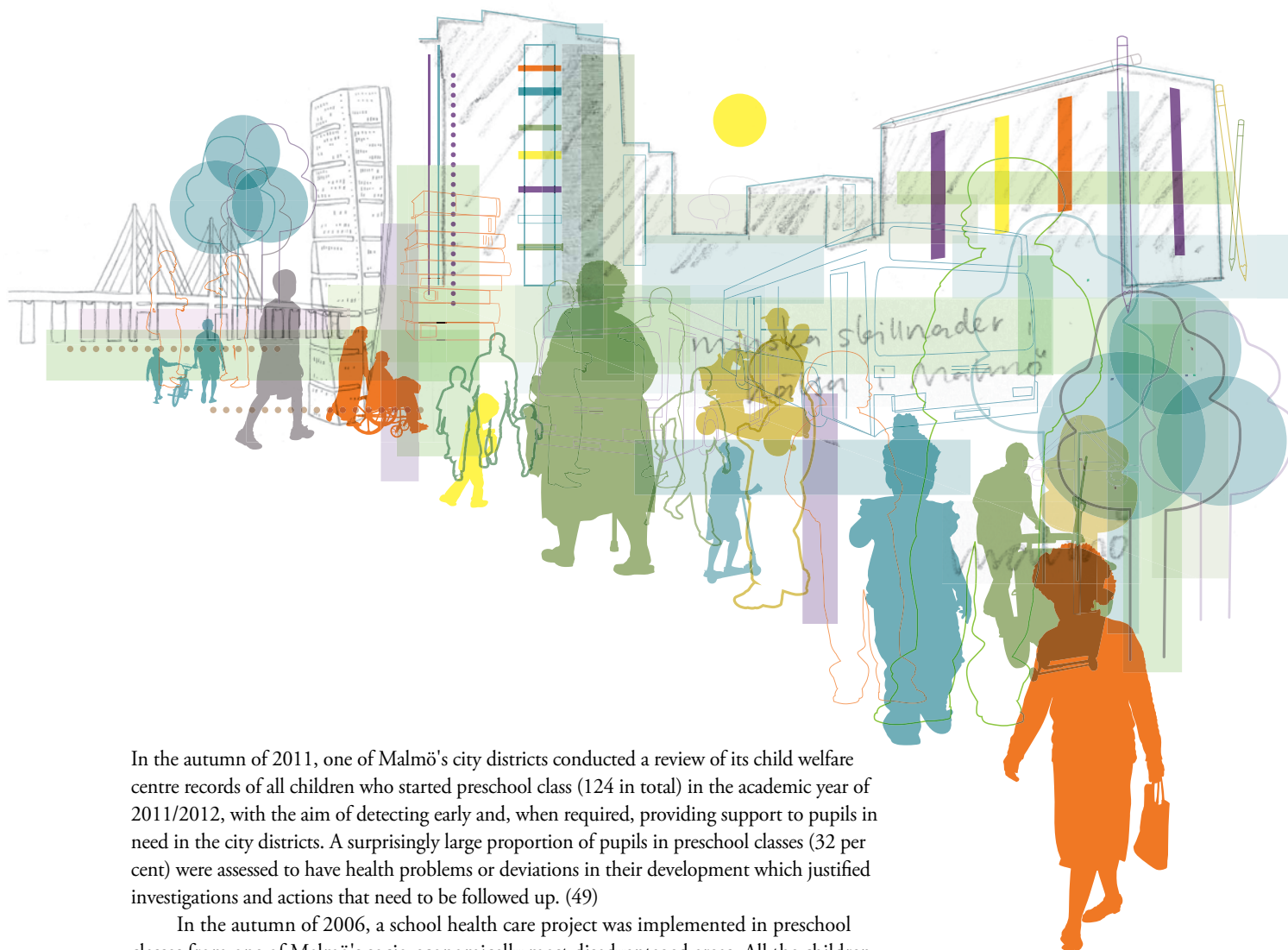
Homelessness is a consequence of weak economic and social resources. (Also see Section 1, Chapter 1) Homelessness gives rise to an increased risk of ill-health because of an unstable situation which involves being uprooted many times, having an insecure future, seeing yourself as different to other children and feeling excluded. Studies have confirmed a link between homelessness and physical and mental ill-health as well as impaired emotional, social and cognitive development in children. (49, 63)

Important to detect the risks early

If existing systems are unable to identify and support families, whose children are neglected or abused, early, the chance to prevent further negative consequences and exclusion for the rest of the individual's life is missed. Children's dental care is an existing system that in co-operation with for example children's health care should be able to increase the effectiveness of other systems.

Child neglect

Child neglect seen from the child's perspective means the failure to attend to basic physical, mental, emotional and/or social needs. Child neglect can occur sporadically or more chronically. Often a number of forms of neglect occur simultaneously. Violence and abuse can also occur at the same time. The risk of child neglect is higher in families with socio-economic deprivation and when the guardian for example has substance abuse problems, a mental illness or learning disabilities.



In the autumn of 2011, one of Malmö's city districts conducted a review of its child welfare centre records of all children who started preschool class (124 in total) in the academic year of 2011/2012, with the aim of detecting early and, when required, providing support to pupils in need in the city districts. A surprisingly large proportion of pupils in preschool classes (32 per cent) were assessed to have health problems or deviations in their development which justified investigations and actions that need to be followed up. (49)

In the autumn of 2006, a school health care project was implemented in preschool classes from one of Malmö's socio-economically most disadvantaged areas. All the children with an address in that area were invited to a health review and check-up by a school doctor and school nurse. Three quarters of the parents had a very low level of education, at most nine years of school. Eighty per cent of the assessed children were born in Sweden, but despite this half of the children had difficulty in communicating in Swedish. Fifty per cent had advanced dental caries. Twenty per cent had advanced behavioural and concentration difficulties as an indication of mental illness. Absence from school due to illness was high, a large proportion of somatic health problems were previously unknown or untreated. Actions were decided in co-operation with the child's guardians, doctor and school management. All the families were positive about the actions taken at the time of the follow-up (49). This example also shows that social systems, in this case schools, must collaborate with health care in order to contribute to more socially equitable health in Malmö. (Also see Chapter 0.6 and several other places in this report). This is entirely in line with WHO's programme called "Health in all policies", an important principle for health policy work, with health equity as an important starting point (64).

0.7.3 THE ADULT POPULATION OF MALMÖ

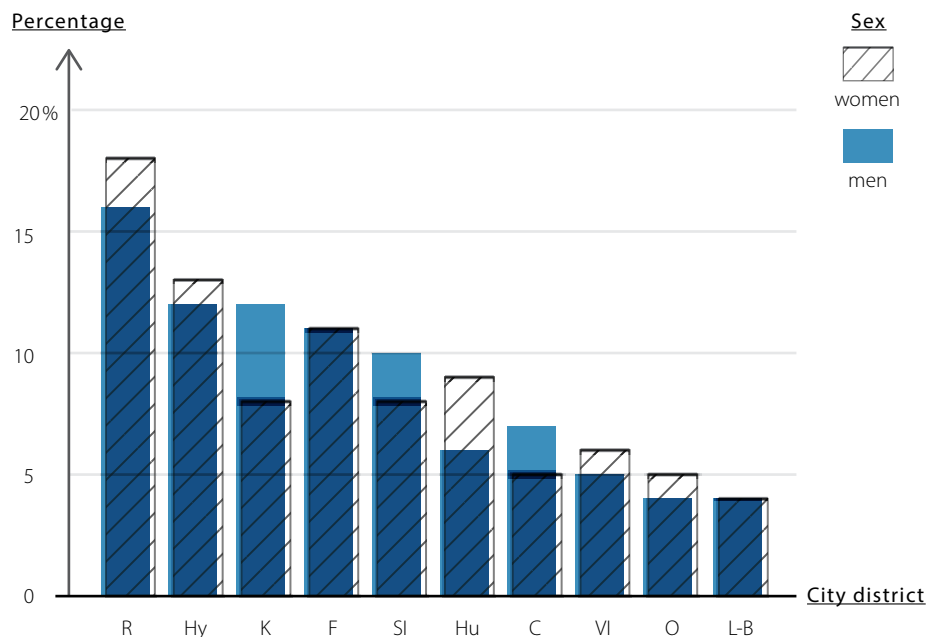
Social inequalities in health-related behaviours contribute to a significant part of health inequality in Malmö's adult population. But health-related behaviours are in turn determined by the social position and the social determinants which are associated with those.

Since 2000 Region Skåne has been conducting a public health survey every four years. It is aimed at a random selection of people in the 18-80 age range. So far four surveys have been conducted and presented in reports. Comparisons can therefore be made over time. Responses from the participants of the survey who lived in Malmö in 2008 have been analysed by Rosvall and colleagues (11). They showed that there are considerable differences in self-rated health depending on the level of education of the respondents. The proportion of poor self-rated health also varies sharply between city districts in Malmö, which is shown in Figure

City district abbreviations

R	Rosengård
Hy	Hyllie
K	Kirseberg
F	Fosie
SI	Södra Innerstaden
Hu	Husie
C	Centrum
VI	Västra Innerstaden
O	Oxie
L-B	Limhamn-Bunkeflo

Figure 10: Proportion of self-rated poor health among men and women in Malmö's city districts in 2008



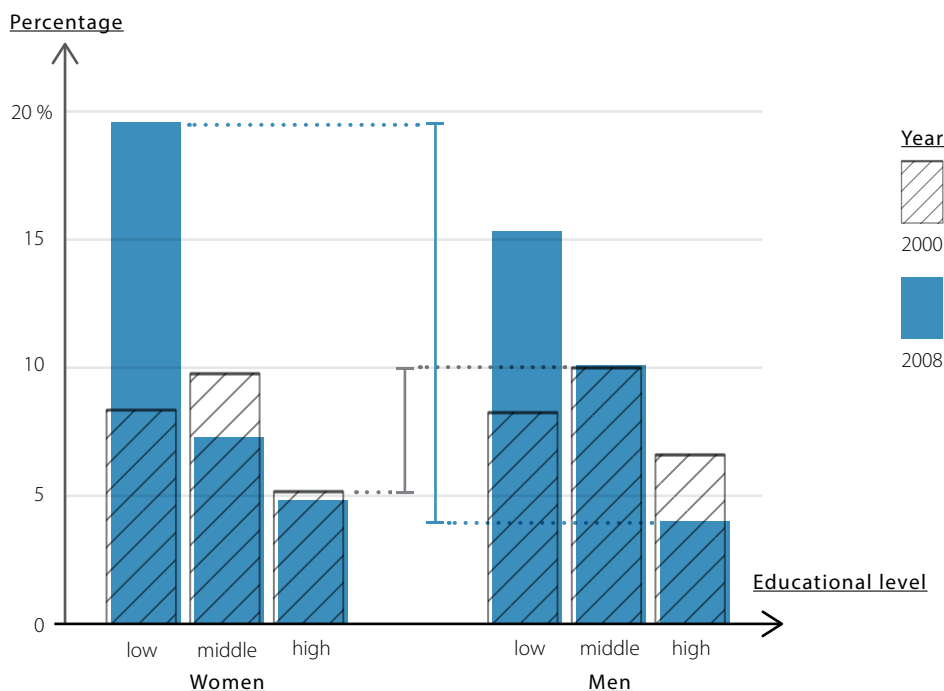
Source: Lindström et al, 2012

10. City districts should here be interpreted as a socio-economic indicator, but since there are large socio-economic differences within each city district, comparisons between different city districts by necessity are an underestimation of the actual social inequity in health.

Education is another important determinant of individuals' health. (Also see Chapter 0.4 and Section 2, Chapter 1) Self-rated health predicts the individual's remaining average life expectancy remarkably well and is therefore often used as an overall measure of health. Figure 11 demonstrates the connection between education and self-rated health, and that the difference (the gradient) has evidently increased over time. The figure also clearly illustrates that particularly women with a low level of education rate their health as low, in other words, both social position and gender have significance for health.

Figure 11: The proportion of men and women in Malmö with self-rated poor health based on education level

Pre-upper secondary school education (low), upper secondary school education (medium), tertiary education (high). Comparison years 2000 and 2008.



Source: Lindström et al, 2012

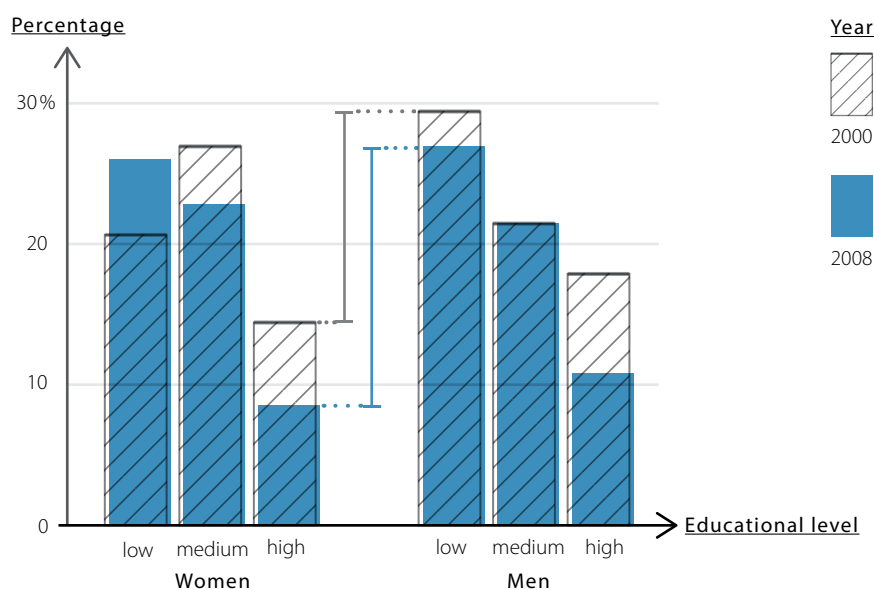
The results from the public health survey show that several other health-related factors vary in relation to your educational level, where you live and where you were born. The sense of insecurity within one's own residential area, as well as lack of trust in others and a stressful work situation, are also more common in city districts in which individuals with a low social position constitute a large proportion of the inhabitants. These factors are also more common among women, compared with men. The number of visits to the dentist also showed similar inequities between city districts.

Ill-health caused by smoking, obesity, poor dietary habits and lack of exercise are strongly related to low social position in Malmö, as in all other places in the country. Low physical activity shows similar patterns as well as dietary habits, overweight and obesity (Figure 12). In the national comparisons between the country's municipalities and counties, Malmö does not score highly when it comes to consumption of fruit and vegetables, physical activity or absence of obesity (65). Since Malmö has a relatively high proportion of individuals in low social positions, compared with the surrounding municipalities and other city municipalities, the social determinants can be assumed to be behind the observations mentioned.

In both men and women in Malmö, daily smoking is more common among individuals with a low level of education compared with those with a high level. In 2008 an average of a quarter of men with a low level of education (nine years of school) reported that they smoked daily compared to a tenth with a high level of education (at least twelve years of education). Among women with a low level of education, daily smoking increased during the period 2000–2008. Differences in daily smoking among educational groups have increased during the same period (Figure 13).

Figure 13: The proportion of men and women in Malmö who smoke daily based on educational level

Pre-upper secondary school education (low), upper secondary school education (medium), tertiary education (high). Comparison years 2000 and 2008.



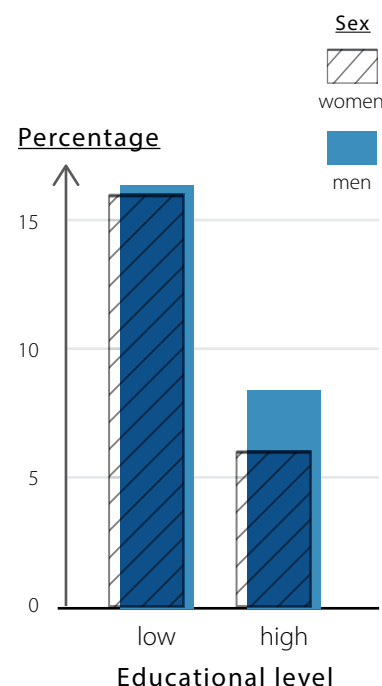
Source: Lindström et al, 2012

0.7.4 MALMÖ'S ELDERLY POPULATION

At 75 years of age, ill-health increases sharply and clear health inequities can be seen between people depending on what socio-economic position they have. (52) The project Gott Åldrande i Skåne (Good Aging in Skåne) is a part of the national aging project SNAC (Swedish National Study on Aging and Care). On behalf of the Commission Elmståhl and Ekström have analyzed information from all of the participants from Malmö in this study 2001–2004 (3,510 Malmö residents) (48).

The social gradient (that is, the lower the social position, the poorer the health) is clear for nearly all health measurements, in that group. Among elderly individuals the consequences of reduced health are greater with respect to satisfaction with life, functional capacity and activities in everyday life (ADL). The results also show that a higher level of education is related to participation in a greater number of available activities which in turn is associated with both higher satisfaction with life and a higher functional capacity.

Figure 12: Correlation between education level and sedentary leisure time for men and women in Sweden



Source: Population health in Sweden 2012, Swedish National Board for Health and Welfare



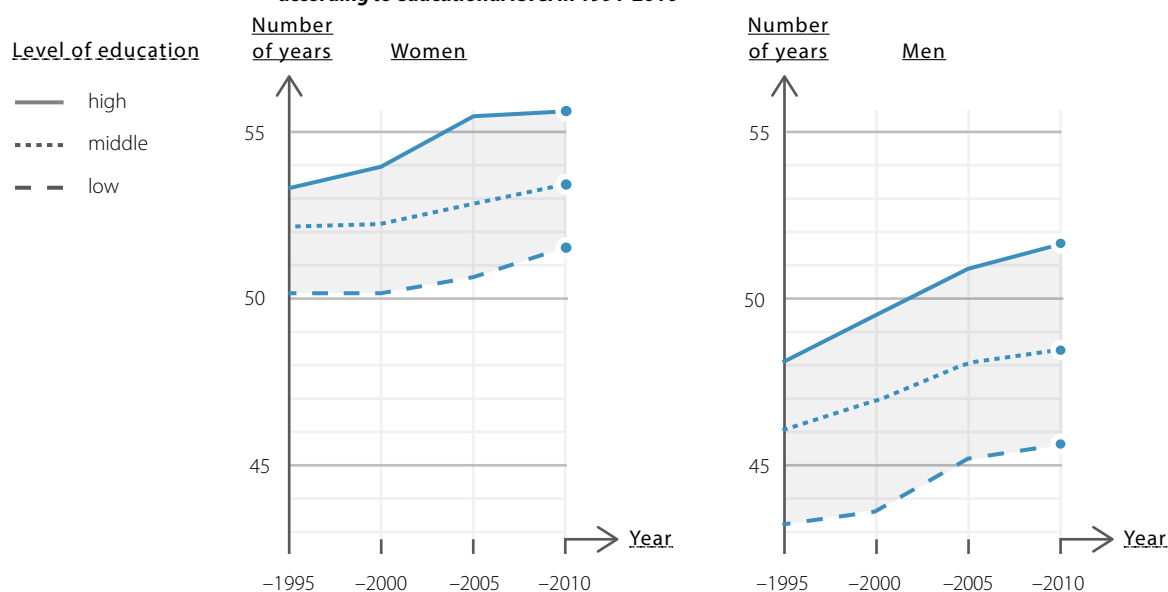
0.7.5 THE WHOLE OF MALMÖ

The inequities in average life expectancy between the city districts of Malmö is 5.4 years for men and 4.6 years for women (average figures for the period 2007–2011). Average life expectancy for women in Malmö during the period 2007–2011 was 82.8 years, and for men during the same period 78.2 years. This means that men and women in Malmö on average live one year less than men and women in the rest of the country. (4). The differences between Malmö and the rest of Sweden are explained by small differences in several different causes of death. Lung cancer and suicide are more common causes of death in Malmö than in the nation as a whole, for both men and women, which is due to factors that are strongly related to low social position. This therefore probably contributes to the widening of the differences in average life expectancy between Malmö and the nation as a whole. (66) But it is not comparisons with the nation as a whole that are at the centre of our comparisons but health inequities *within* Malmö, between different socio-economical groups and between residents of different parts of Malmö.

Level of education and life expectancy

As previously reported, education is an important social determinant of health in a population, both directly and indirectly. We have analysed how life expectancy has changed during the period 1991–2010 for Malmö residents with only nine years of education, those with twelve years of education as well as those with longer education than twelve years. Figure 14 shows that at the beginning of the period the difference between those with a short period of education and those with a long one was 5 years for men and 3.2 for women. At the end of the period it had increased to 6 years for men and 4.1 years for women. Even when the size of groups with a short and a long period of education, respectively, are adjusted for, the same trend remains. This was also discussed in Chapter 0.4.

Figure 14: Remaining average life expectancy at 30 years of age for women and men in Malmö according to educational level in 1991–2010



Source: Statistics Sweden, prepared for the Commission 2012

Injuries and accidents

Injuries are the most common cause of death among children and young people. Every year, almost 100 children in the 0–17 year age range die as a result of injuries in Sweden. Every year, 20,000 children are admitted to hospital as a result of injuries.

Mortality in adults has decreased in recent decades, but the positive trend in the number of accidental injuries and suicides has stalled. In Sweden on average more than three elderly people die every day as a result of accidents. Injuries are a social problem which cause a lot of suffering and very great costs. The relationship between social position and injuries is complex, but in general the risk of injury is greater among individuals with a low

social position. This partly relates to the fact that safe behaviour or safe equipment used in various activities requires economic resources.

Creating environments that reduce the risk of injury is therefore an important public health challenge with implications for health equity. It is mainly injuries due to accidents that can be prevented by safe environments, but even the incidences of suicide and violence can to a certain extent be influenced by the design of the environment.

Many injuries among the elderly and in children's playgrounds can be prevented, while others are more dependent on the individual's knowledge and behaviour. Many young men are injured for example through taking risks during leisure-time activities and in the traffic environment.

Malmö has a unique information base in the shape of Region Skåne's injury registration of all accidents that have led to admittance to out-patient and in-patient care, since 1993 (Also see Section 2, Chapter 3). Gender and age-related data is available regarding why patients seek health care and in what environment the injury occurred.

In Malmö approximately 6,600 men and 5,800 women sought medical care due to injuries caused by accidents in 2010. There are significant differences between city districts for both adults and children, which underlines what was said previously regarding the contribution of injuries to health inequity in Malmö. The injury register also shows the number of injuries caused by violence which during the 2006-2010 period was around 750 per year. Around 300 suicide attempts were also recorded annually. No other similar register is as comprehensive as this one. It also constitutes a unique and far too little utilized basis for preventative actions in the city. It provides additional evidence of how illness and accidents are strongly connected to different social determinants, but requires qualified analysis which is fully possible and very desirable. (67) (Also see Section 3).

Health inequities between women and men

A true understanding of the complexity of inequity between women and men requires a broadened perspective so as not to reduce a person to only his or her biological sex. A gender perspective also takes into account the fact that conditions are different for different groups of women and men, boys and girls. It is of great importance that a gender equity perspective is applied consistently, in all public health debates and interventions. (68)

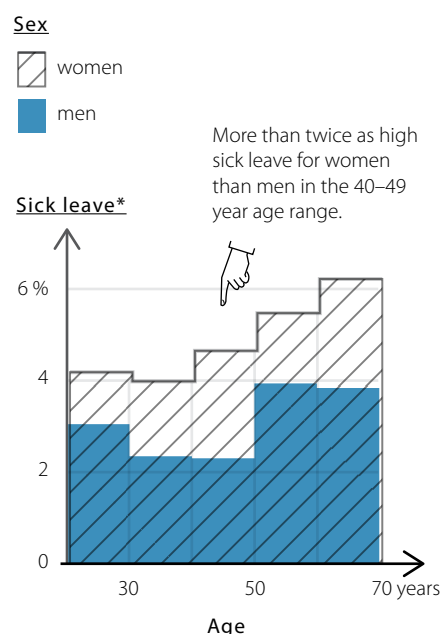
Gender-related conditions affect people's health, alongside the various determinants that are presented in this report. Women on average live longer than men do. Despite this health is often, particularly in the most socio-economically vulnerable groups, poorer among women. This demonstrates how gender and social position often work together to affect the individual's health. There are many examples of the relationship between gender and health. In Sweden women have less access to newer and more expensive medicines and medical treatment than men, and men's work injuries are more often acknowledged for compensation. It is more common for men to be granted sickness and activity compensation than women, and twice as many female as male salaried workers report muscle pain, which may be because women retain the main responsibility for the home and family even though they have the same level of education and paid workload as men. (68)

This is also clearly reflected in the social distribution of health in Malmö through substantial differences in health between women and men, girls and boys. For example, a larger proportion of women than men have reduced work capacity due to long-term sickness. (68) The women in Malmö in the age range of 20–64 had in 2010 an average of 35 sick leave days, which can be compared with an average of 27 sick leave days for men in the same age category.

In Figure 15 the volume of sick leave is reported (number of sick days, corresponding to calendar days, divided by the number of days of employment during the period, multiplied by 100) divided into male and female employees of the City of Malmö. The figures show that the municipality as an employer faces a challenge in terms of the uneven distribution of sick leave between women and men. (69) (Also see Section 2, Chapter 4).

In terms of mental illness women report a greater extent of complaints such as anxiety, tiredness and difficulty in sleeping, than men. Men's mental disorders are partly different than those of women. For example, poorer mental well-being for men is more often displayed through substance abuse, mainly increased consumption of alcohol. In Malmö nearly a fifth of the men (19 per cent) had a risk consumption of alcohol, compared to 13 per cent of women. (4). However, alcohol abuse is rarely associated with awareness of illness, which probably contributes to an underreporting of men's mental health problems. (68)

Figure 15: Volume of sick leave in 2011 in the City of Malmö. Women and men, different ages



Source: City of Malmö's staff records 2012.

* Number of sick days (calendar days) divided by the number of employment days

Health inequities between foreign-born and domestic-born people

The concept of ethnicity is often used as a social determinant for health. This concept is defined in various ways in different reports, for example by country of birth, by the language the person uses or by the culture or religion that the individual identifies with. This is problematic since completely different phenomena are behind the facts mentioned. Information on country of birth is used below which is an important indicator that the individual has gone through an immigration process. This is in many ways also connected to the individual's social position, mainly through various barriers to achieving a high social position after establishment in Sweden. Several studies show that health among foreign-born individuals and their children is poorer than for Swedish-born individuals. Sweden has changed rapidly in recent decades from a relatively homogenous society to a society with many different cultures, languages, religions and traditions. Today about one million of Sweden's inhabitants were born abroad. The people who live in Malmö come from about 175 different countries. The immigrants in Malmö are not a homogenous group, and generalising the health of foreign-born people is therefore misleading.

To reduce the inequity in health that exist between people born in Sweden and those born abroad, we need more knowledge about social determinants and the health conditions in different immigrant groups. Depending on which country one comes from there are large differences in cardiovascular diseases and cancer. The differences between Swedish-born and foreign-born individuals are clearest when it comes to mental illness. Nearly all the reported indicators of mental illness, such as care in psychiatric wards, incidence of schizophrenia and other psychoses, depression, alcohol dependency, attempted suicide and suicide, indicate that many immigrant groups have significantly poorer mental health than people born in Sweden.

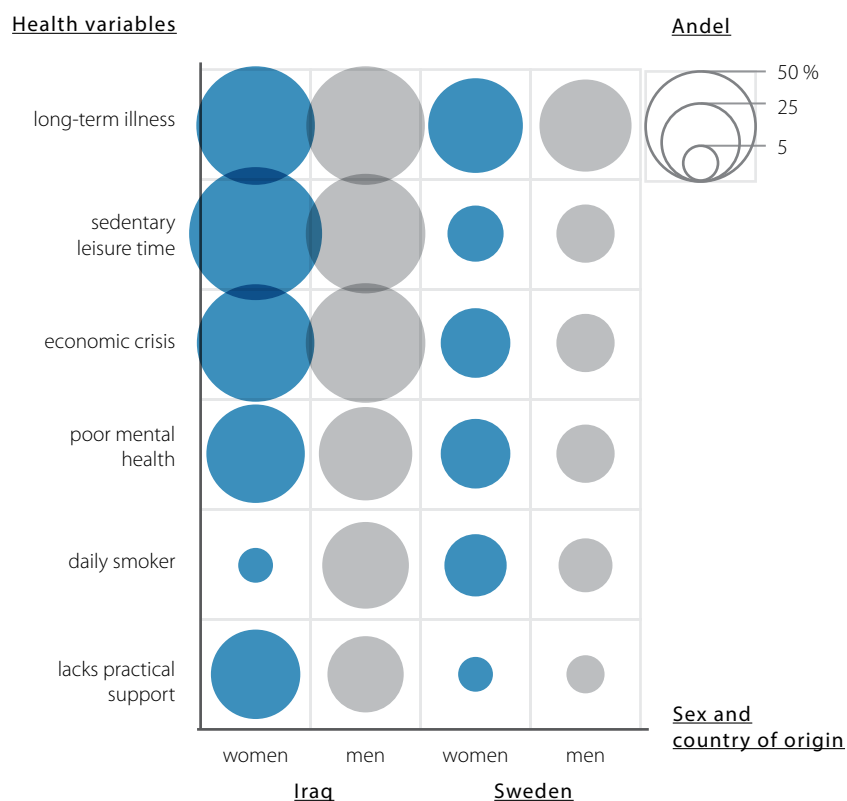
A good working environment is characterised by the fact that physical and mental work requirements are adapted to the individual's conditions. When asked, a higher proportion of individuals in all immigrant groups, except the group born in OECD countries, have physically demanding work and back pain compared with those born in Sweden.

There is no comprehensive picture of the health situation of people who were born in different countries and reside in Malmö, but the Malmö section of the Public Health Survey in Skåne shows significant inequities in self-rated health between people born in Sweden and foreign-born individuals. This may be linked to the social determinants of health in such a way that access to work, a good income and good accommodation is lacking to a greater extent among foreign-born individuals in Malmö. There is, in other words, a strong connection between being foreign-born and ending up in a low social position, which was mentioned in the introduction.

In-patient utilisation of health care provides a good picture of non-trivial illnesses that require hospitalization. There are substantial geographical differences and inequities between those who have high incomes and those who have low incomes in the whole of Malmö which also partly reflect the effects of immigration.

One study has been conducted where health among immigrants from Iraq (the largest group of immigrants in Malmö, nearly 10,000) was compared, concerning health, with a random sample of Swedish-born people in Malmö. See Figure 16. (70)

Figure 16: Comparison between Malmö residents born in Iraq and Malmö residents born in Sweden (per cent)



Source: Daryani et al, 2012

Of men and women born in Iraq, only 10 per cent were employed. Forty per cent however had an educational level above twelve years of education, which reflects the difficulties for a migrant to conquer a social position that corresponds to their level of education in their new country. The level of physical activity during leisure time was very low and a large proportion of the men were daily smokers. Being unemployed, lacking a cash margin, having a low level of education and having a monotonous job, result in living conditions with an increased likelihood of unhealthy behaviour and poor health.

Another study was conducted in 2010 in an area where 3,300 adults from Iraq lived. A survey of 158 men and women was compared with gender and age-matched individuals born in Sweden within the same area, concerning the incidence of type 2 diabetes or a clear sign of this disease. Type 2 diabetes is strongly linked to obesity. The incidence of obesity (BMI > 30) was twice as high among individuals born in Iraq (44.8 per cent) compared to those born in Sweden (26.6 per cent). The Iraq-born participants in the study also had a prevalence of diabetes of 20 per cent. (71) The authors' conclusions are that the living conditions associated with a segregated environment characterised by exclusion, via lack of physical activity and other lifestyle factors, explains this extreme rate of diabetes which in turn increases the risks of cardiovascular diseases, musculoskeletal disorders and an increased need of health care for the rest of the individual's life.



0.8 Understanding Malmö

FOR A LONG TIME the understanding of Malmö largely rested on facts in the shape of figures. The rate of gainful employment has functioned as a thermometer. The higher the rate of gainful employment, the better the welfare. This was for example the case when the City of Malmö's major initiative "Welfare for all" was assessed. And it was because the rate of gainful employment did not increase that it was assumed to have been a failure. Understanding is however much more than just facts. It is another type of knowledge than factual knowledge. Both types of knowledge are needed, but there has been a great deal of emphasis on factual knowledge. The concepts and what we measure have been taken for granted. This is something we have not done in the Malmö Commission. Of course factual knowledge has been very important, but the developed understanding of Malmö that we want to contribute is also based on us questioning central concepts and notions.

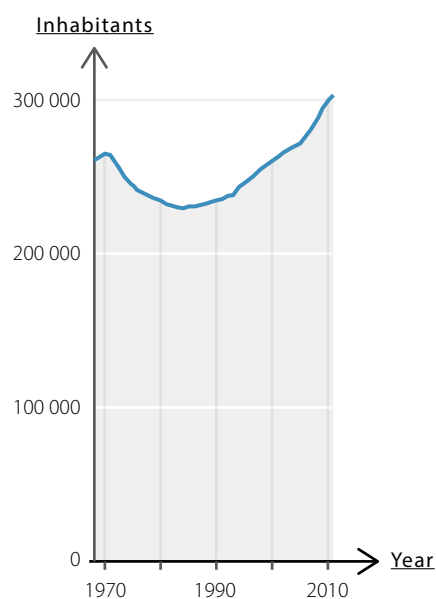
We have therefore not taken the Malmö resident for granted. Who is the Malmö resident really? There appear to be many more residents than those who live in the city at any particular time. During the years between 1990 and 2008 nearly half a million people have lived in the city for at least a few years. Malmö has become a transit city and this new understanding has consequences for how we should see the differences in ill-health, what they are caused by and what should be done about them. In addition, an increased proportion of the population now lives on the sidelines of an established and recognised way of living; in Malmö this group is estimated to amount to approximately 12, 000 people. Another important change which is significant for how we should understand Malmö is the regionalisation of issues to do with economic growth. Welfare issues have however largely remained within the remits of the municipality. This has changed the prerequisites for the relationship between economic growth and welfare. At the same time it has become increasingly urgent to change this relationship, which the WHO Report (1) sees as crucial in order to reduce health inequities.

The requirement of participation in society has been enhanced. Society has developed into a state of social inclusion which explains the emergence of social exclusion. It has also led to a form of segregation which coincides with the difference between inclusion and exclusion. A question we have asked ourselves is why the large differences in ill-health have not had greater consequences. One of the answers to the question may be the culture sector. This has contributed to counteracting the effects of the fundamental causes of ill-health, as has the voluntary sector.

0.8.1 THE HIDDEN MALMÖ

A special set of problems in Malmö's population structure is what the Commission chose to call *the hidden Malmö* – all those individuals who for various reasons are not counted or are rendered invisible in the statistics. An increased proportion of the population now lives on the sidelines of established and recognised ways of living; in Malmö this group is estimated to amount to approximately 12, 000 people. This may concern people who are quite simply not registered in different established arenas such as the official labour market, study system or actions for the unemployed and the sick. In addition, there are people living in the city illegally, often referred to as undocumented. Here there are obvious gaps in knowledge both in the authorities' gathering of statistics and functionality and in the research community's unanswered questions concerning the increased proportion of people who are living on the sidelines of established systems (72).

Figure 17: Malmö's population development 1970-2010



Source: Salonen, 2012

0.8.2 MALMÖ AS A TRANSIT CITY

In one of the Commission's background reports an analysis of the city's population development was presented (72). The analysis illustrates a city in rapid change in terms of population movements, people's relationships to arenas for livelihood provision and residential structures as centres for social cohesion. Malmö is one of Europe's fastest growing cities. The city is populated by approximately 300,000 inhabitants but seen over time – between 1990 and 2008 – almost half a million people have lived in the city for a year or more. Only a quarter, 23 per cent, lived in Malmö for the whole of this period. The city functions as an arrival area and temporary transit place for some, as a student city for others, and for a number of people the city constitutes a space for future generations. Young people are drawn to the city as a place to become established and educated while other regional and transnational movement streams are in effect. Commuting over the border, across the strait to Denmark, creates new everyday conditions for an increasing number of people, while social systems have difficulty adapting to the cross-border commuting pattern. Migration streams from distant countries find their destination in Malmö's residential areas where close relatives and friends already live. It illustrates the city's demographic dynamic.

0.8.3 THE RELATIONSHIP BETWEEN HEALTH AND A CHANGED MODEL FOR ECONOMIC GROWTH

In another background report the increasing inequality is linked to the changed model for economic growth of recent decades (73). The model for economic growth that dominated during the first decades of the post-War period was industry-driven. It included increased real wages so that the producers would be able to become well-to-do consumers. A completely new sphere emerged alongside working life. It came to be called welfare, and encompassed mass consumption and a developed public sector. The financing of welfare occurred with earned money. And it was in everyone's interest. It was in industry's interest that real wages increased and the public sector developed because then demand increased as well. With its large factories, strong ownership and well-organised labour movements Malmö was a showpiece of industrial society. Malmö was therefore also hit hard by the crisis during the 1980s and 90s.

To cope with the crisis of the 1980s and 90s Malmö became a part of the new global order that emerged during the 1980s, dominated by a relationship between finance-driven growth and an increasingly unequal welfare. This was done through a new type of politics, described as entrepreneurial city politics, which is more regional than municipal, governed through networks more than parliamentary assemblies and often involves the business community and technical/hard administrations. In this way issues related to economic growth became regional while welfare matters have largely remained a municipal responsibility. This has made it more difficult to influence the relationship between economic growth and welfare. A striking illustration of this is the 60,000 people who commute daily to their work in Malmö but who pay tax and contribute to welfare in other municipalities. The changes led to Malmö being put on the map as a successful node in the global economic development but at the same time deepened the earlier inequities.

The poorest households have become poorer, in the absolute sense, while the most financially well-positioned households have become substantially better off since the beginning of the 1990s. The richest tenth have gone from being six times richer than the poorest tenth in 1990 to being twelve times as rich in 2008. This is despite excluding all those with zero incomes. Income inequality is largely explained by the household's relation to the labour market. Income poverty, measured according to the EU's definition, has increased and currently includes three out of ten Malmö residents. This in turn explains the high proportion of households that live on municipal social assistance, where more and more receive support for longer periods. When it comes to child poverty (see Section 1, Chapter 1) Malmö is at the very bottom, at 290th place out of all the municipalities in Sweden. What is also noteworthy is the large difference between foreign-born and Swedish-born people in terms of employment rate. The employment rate in Malmö was only 62 per cent in 2011, compared with 74 per cent in the nation as a whole. The difference between foreign-born and Swedish-born people in Malmö is almost 25 per cent.(72)

0.8.4 INCREASED SEGREGATION – BETWEEN INCLUSION AND EXCLUSION

As a result of harsher conditions in the labour market, increased income differences and more stringent requirements generally society has evolved into a state of social inclusion. Stigendal describes this in his report in terms of new societal boundaries arising between those who live inside and outside society, respectively. In this way the difference between inclusion and exclusion coincides with segregation. (73)

People tend to live in increasingly socio-economically homogenous areas. There are few resource-strong areas in Malmö, based on analyses of income, accommodation, family status, occupation and education. Large parts of Malmö are characterised by areas with a high proportion of inhabitants with low incomes as well as a high proportion of inhabitants born outside the Nordic countries and Western Europe. Social position and ethnicity often overlap and determine where you live in Malmö. The majority of Malmö's population therefore lives in resource-poor areas. A marked increase of these areas has taken place since 1990. In Malmö only two per cent of the population live in resource-strong areas compared with 15 per cent of the country's cities on average. This is largely explained by the affluent areas in the Malmö area mainly being located outside the border of Malmö's municipality, in peripheral municipalities such as Vellinge, Lomma, Svedala and Staffanstorp. The results show that nothing has changed in this pattern since 1990. The differences in purchasing power measured as the household's disposable income are therefore significant between Malmö and the rest of the country as well as within Malmö. In order for Malmö to reach the national level 20,000 households would be required to move from the half with lowest incomes to the half with highest incomes. (72)

The image of Malmö also contributes to strengthening the segregation between inclusion and exclusion. Malmö has been described as being divided into two parts and becoming increasingly more polarised. The bright image presents Malmö as a party city which can be likened to Berlin or New York with innovative, cultural values that attract entrepreneurs, young and creative people. The success story often includes Malmö's bold investments in the Öresund bridge, Turning Torso, the City Tunnel and the establishment of a university. Malmö often appears to be more continental and cosmopolitan than other Swedish metropolitan cities. The dark image includes tales of poverty, alienation and growing tensions between groups. At worst streets and certain residential areas are described as a lawless territories where the authorities have lost control. This dark image of Malmö only reflects a small part of the reality, but since it is so often generalised this contributes to stigmatising "the other" Malmö and thereby worsens the problem.

0.8.5 THE CULTURE AND VOLUNTARY SECTORS

Given the large differences in people's living conditions we can wonder why the contrasts have not become even greater. Why is it not worse? We have asked ourselves this question in the Malmö Commission. The answer may partly be Malmö's culture sector but also the voluntary sector with all its associations and voluntary organisations. The culture sector and voluntary sector act as bonding cement – bonding the city together and affecting people's health, participation and sense of cohesion. These activities contribute to what Emmelin and Eriksson in their background report call social capital (74). In his background report, Stigendal refers in to it as social integration and sense of participation, unlike system integration and actual participation, which means it encompasses for example having a job, being a citizen or going to school. Central to both these perspectives is the concept of trust. Strengthened trust is a sure way to achieve increased security, health and well-being in a society. Often there is a lack of meeting places and contact interfaces between different population groups which means that delusions about the other thrive, with associated feelings of alienation and insecurity (75).

The Commission sides with the broadened concept of culture, which involves individual creativity, artistic expression, nature and the environment (76). Culture in this sense thus means not only participation in traditional cultural events but also artistic self-expression in various forms; culture concerns participation, involvement, security and trust.

Malmö has a strong culture sector consisting of both public and independent cultural players. Some are well-organised, other are more ad hoc. Some are resource-strong while some survive through voluntary efforts. The Commission's conviction is that Malmö's culture sector forms a vital part of the city's social integration and cohe-



sion. Not least for children culture acts as a strengthening force. Culture in learning and in schools can serve as a tool for different kinds of learning and modes of expression. Culture can for example serve as a resource for improved reading and writing skills. It is therefore important to also see schools as cultural platforms.

The voluntary sector has a high potential to make Malmö socially sustainable. Many important efforts have already been made throughout the city. The voluntary sector is of course not a homogeneous group, but comprises everything from small, local groups to large, international organisations. The voluntary sector fulfils many different important functions. Many, such as the non-profit organisations, target another party that needs extra help and support, such as homework help or information. Others, particular associations, primarily target their own members. Both functions are very important to people's health and well-being, and they often contribute to greater cohesion in the city. Malmö ideella föreningars paraplyorganisation (Malmö's umbrella organisation of voluntary organisations) conducted a study on learning and personal development in the voluntary sector between 2003 and 2006. The survey shows that the voluntary sector contributes to creating understanding of democratic principles and respect for the opinions and values of others. Improved self-confidence, increased trust and better understanding of others' backgrounds and living conditions are also a result of active participation in voluntary work (77).

In many situations the voluntary sector fulfils a role that the municipality or any other public body is unable to. Voluntary organisations often reach people who never come into contact with the municipality's decision-makers and/or administrations. This may, for example, involve refugees and undocumented immigrants who for various reasons simply do not dare or want to contact a public institution. The voluntary sector also often has a capacity for social innovation that the municipality due to its lack of suitable structures cannot always take advantage of. The voluntary sector should therefore be considered in the preparation of many of the political decisions that aim to make the city socially sustainable. Just as when it comes to culture the municipality should use the voluntary sector as a resource in the development of health-promoting and cohesive actions. What is needed is an infrastructure within the municipality which can take advantage of the voluntary sector's innovative capacity and knowledge.



0.9 Two overarching recommendations

THE WHO REPORT *Closing the gap in a generation* contains three sections of overall recommendations; improve daily living conditions, tackle the inequitable distribution of power, money and resources, and measure and understand the problem and assess the impact of action. The Malmö Commission's Final Report also consists of three sections, besides this introductory section, and two overarching recommendations. The first overarching recommendation involves the establishment of a social investment policy and is the overarching recommendation for the first two sections. The second is about how processes in general must be changed in order to reduce inequality in health. It is an overarching recommendation for Section 3.

0.9.1 ESTABLISH A SOCIAL INVESTMENT POLICY THAT CAN REDUCE INEQUITIES IN LIVING CONDITIONS AND MAKE SOCIETAL SYSTEMS MORE EQUITABLE

The debate on sustainable development implies a distinct shift in perspective in how growth and development are viewed. It has become increasingly clear that it is people's own survival, that is, their health and well-being, which must be the focus of the development we need from a sustainability point of view. A senior international politician called this a revolution in thinking on a par with the one Copernicus started when he pointed out that the Earth is not the centre of our planetary system but the sun (78). The politician asserted that today it is an equally great revolution in our thinking to realise that growth in the economy is not the most important thing, but our health and welfare and the ecological challenges. This understanding is essential to steer towards sustainable development that permits human survival in the long term, he said.

We already have ways of thinking to help us understand what such a worldview might look like. The so-called Brundtland Commission launched a model of sustainable development in which three aspects are intimately linked without any being superior to any other; ecologically, economically and socially (20). This means that we cannot assess the sustainability of a country or a city like Malmö by only looking at one aspect of development, which we have traditionally done by using the GDP measure. We must have measurements of all three aspects in order to assess whether development really is sustainable. Leading economists have already suggested such panels of development measurements. From this it follows that purely economic investments are not enough. Ecological and social investments are also required, that is, investments that favour ecological as well as social sustainability. Malmö has been praised internationally for its ecological investments, but the same thinking has not been developed in terms of social sustainability. The appointment of the Malmö Commission must be interpreted as a first step in this direction.

One obstacle to thinking in terms of social investments is that the current governance systems for the municipality reflect a world view with economic growth at its centre and economic sustainability as the only interesting factor. This does not allow space for thinking about social investments. Since economic growth has such an exalted position all expenses in the social sphere, such as schools and health care, are defined as costs that “divert” resources from economic growth. This is the case despite the fact that hardly

anyone would dispute that the health and education of the population are important factors in the development of a society. Neither legislative or financial planning instruments therefore define the resources allocated to these areas as investments, but as costs which have to be covered by equivalent incomes from a short-term perspective. This is different from investments in for example the Öresund bridge or the City Tunnel, where the costs can be written off over a much longer period of time because they are considered to be investments and not expenses. To put the insight into practice that the three aspects of sustainability are equivalent and in balance with each other, these impeding thought models and control systems must be changed. The implementation of such an important social innovation requires courage, as do all innovations. But sitting on the fence is not a cautious alternative. In fact, it will take great courage to say no to or to delay the start of such an innovation, as this could lead to a markedly negative development scenario for Malmö in the future. Accountability will therefore be demanded, whatever the decision is. The Malmö Commission's recommendation is therefore urgently to initiate a social investment policy which is based on a social investment perspective and, among other things, includes social investment funds corresponding to major infrastructure investments of a material nature.

How much should be put into social investments? How large should for example a social investment fund be? In this respect, it might be interesting to take note of the health of the population as a key indicator of sustainable development. If the health of the population deteriorates, this means in theory that the development scenario is not sustainable in the long term. The end point in such a trend is of course zero health, which is the same as the extinction of mankind. Inversely, if health improves, it is a good sign of sustainable development, which in turn has its theoretical extreme in all individuals having full health. There is much to suggest that a society benefits from trying to optimise the health of its population since the prevention of ill-health costs considerably less than dealing with the consequences once they have arisen. This is to say that there are very good reasons for investing in preventative efforts in order to improve the health of the population. This further underlines the wisdom of accepting investments outside the narrow framework that today's models and systems allow.

There is also considerable scientific support for investments early in life, during the individual's childhood and upbringing, having the biggest effect on the individual's health for the rest of his or her life. This is a third argument for a broadened approach to investment.

It has been calculated that the total burden of illness (a total measure of reduced quality of life due to illness and premature death) in Sweden costs approximately 25 per cent of our total GDP in terms of the costs of taking care of individuals with reduced health and the loss of production due to illness and premature death (see Chapter 0.5). By comparing the health of individuals in different social positions, we can gain an understanding of how much of the burden of illness could be prevented if the structural factors that give individuals different prerequisites for optimal health were removed. It has been calculated that the burden of illness would decrease by between a quarter and a fifth, in other words, approximately by the equivalent of 5-6 per cent of GDP. This perhaps gives an idea of the order of magnitude that would be justified for the social investment funds.

In 2011 Sweden's GDP was SEK 3,500 billion. According to the calculation above, the burden of illness would cost Swedish society around SEK 858 billion and health inequity just over SEK 200 billion. Malmö's share of this, based on its proportion of the country's population being a thirtieth, would then be of the order of magnitude of SEK 7 billion. We have previously shown that with the aid of the method that we applied in Västra Götaland the costs could be estimated at SEK 3 billion. There is thus great uncertainty in the estimation, but it is still obvious that inequitable health represents a significant social cost of the order of magnitude of between SEK 3-7 billion annually in Malmö. If it is feasible that investments for preventing all ill-health due to inequity can be made, then this is a possible ceiling for a fund with this specific purpose. As in other contexts, it is likely that the phenomenon of diminishing marginal costs must be taken into account in these types of investments, so the figure is probably a maximum amount, but still gives an indication of what order of magnitude can be justified for such a fund. The health-economic calculations that the Commission made for three of the measures

in the chapter on education, show that two of these are cost-effective, that is, give back at least what they cost to implement.

It is important to point out that there are different approaches to the calculations of costs of health inequities (see Chapter 0.4). There is currently a lack of methods for estimating the costs that a society incurs through the effects of inequity at a social level. Wilkinson's research has showed that a more equitable society is thought to function better than an inequitable one, even if the average income level is the same and one takes into account other possible factors (19).

Health-economic calculation

Economic evaluations are about weighing the costs and outcomes of one action against another (79). An action is defined as being cost effective if the value of the action's additional benefit or advantage in relation to the additional cost is assessed as reasonable. A cost effective action does not necessarily mean that the action results in a saving. It tells you how much more the action is expected to cost in relation to the additional outcome that the action can lead to. A cost effective allocation of resources means that health in a society is maximised, given the society's limited resources. Cost effectiveness can be changed by increased resources and new technologies/actions. Economic evaluations should therefore be seen as an important basis among others for decisions on priorities. (80) So far health-economic evaluations have not been used as a basis for decisions on priorities in municipal operations, but it is possible to discern an increased interest in providing health-economic evaluations as part of the decision process. The Commission's Terms of Reference state that health-economic analyses of strategies should be performed. It has not been possible to implement every single recommendation due

to the nature of the recommendations and the limitations of the methods, and for time reasons. However, the Swedish Institute for Health Economics (IHE) has done health-economic analyses of a number of the Commission's proposed actions; Make Ungdomsuppföljningen (Monitoring of Young People) permanent (action 2.1.1.1), daily physical education and health in schools (action 2.1.1.6) and reduce the size of groups of young children in preschools (action 2.1.1.2). The report also discusses how urban planning actions can be evaluated with the aid of new economic models and how social investment funds can apply health-economic evaluation principles in order to give a better basis for decisions. (80) The reported analyses should be seen as illustrative examples of how the City of Malmö could develop methods for health-economic analyses as well as socio-economic calculations in order to consider different options and obtain a basis for decisions that as far as possible result in reducing health inequities.

The analyses are presented under each respective action in Section 2, Chapter 1.

0.9.2 CHANGE PROCESSES BY CREATING KNOWLEDGE ALLIANCES AND DEMOCRATISED MANAGEMENT

In the third overarching recommendation the WHO report urges us (1) to “measure and understand the problem and assess the impact of action”. Knowledge is described as “the backbone of action”.

Action on the social determinants of health will be more effective if basic data systems, including vital registration and routine monitoring of health inequity and the social determinants of health, are in place and there are mechanisms to ensure that the data are understood and applied to develop more effective interventions.

Facts are not enough, argues the WHO report. What is also required is a better understanding, particularly of the underlying causes of health inequities. Research must be both cross-disciplinary and multi-disciplinary. Both qualitative and quantitative data are important. How the problem is defined is also crucial. In addition, knowledge of the context is required and the WHO report mentions examples such as history, the political environment and the strengths of the voluntary sector.

The WHO report advocates a broad definition of evidence. Actions to tackle the causes of health inequities must be based on a rich and diverse evidence base. “This should include evidence from multiple disciplines and methodological traditions, as well as systematic collection of knowledge and experience from key stakeholders involved, especially from practitioners and the planned beneficiaries of the interventions.” This is said to be particularly important since the evidence is often context dependent. Therefore knowledge about the context is very important. The WHO report does not wish to favour any single form of evidence.

What counts as legitimate evidence should be determined on the basis of ‘fitness for purpose’ rather than on a single hierarchy of evidence (which traditionally puts randomized controlled trials and laboratory experiments at the top).

In all of the respects mentioned above the Malmö Commission wishes to build further on the WHO report. We should not however limit ourselves to regarding knowledge solely as a “backbone of action” and thus as the precondition for the solutions. We do not consider that knowledge should be fully formed before it is converted into actions. The actions should not just be about applying pre-existing knowledge. Instead we would like to make the creation and development of knowledge a part of the solutions. Thus we aim to shift the focus from prerequisites to processes. We believe this is in line with what the WHO report states in the quotation above about taking advantage of knowledge and experiences from various kinds of stakeholders. The same applies to learning. This should not just take place in advance but the processes must be designed in such a way as to enable continuing learning.

The Malmö Commission advocates a change of processes in order to solve and prevent the problems of inequitable health and welfare. These processes should not just be based on knowledge but also be centred on knowledge and learning. Various stakeholders must be involved in these processes. Knowledge and learning should thereby be linked to the questions of management, involvement and influence, what is usually called governance.

The processes themselves should not just be about solving specific problems but also contribute to changes in the development of society in which investments in equitable welfare to a greater extent are made based on a wider perspective of sustainable development and are not viewed as a cost. The new type of processes that we advocate should therefore not constitute a sideline, as has been the case until now, but be given a central place and be viewed as part of the creation of the social innovations that are needed for development towards social sustainability. In this way these processes will also contribute to a changed relationship between economic growth and welfare.

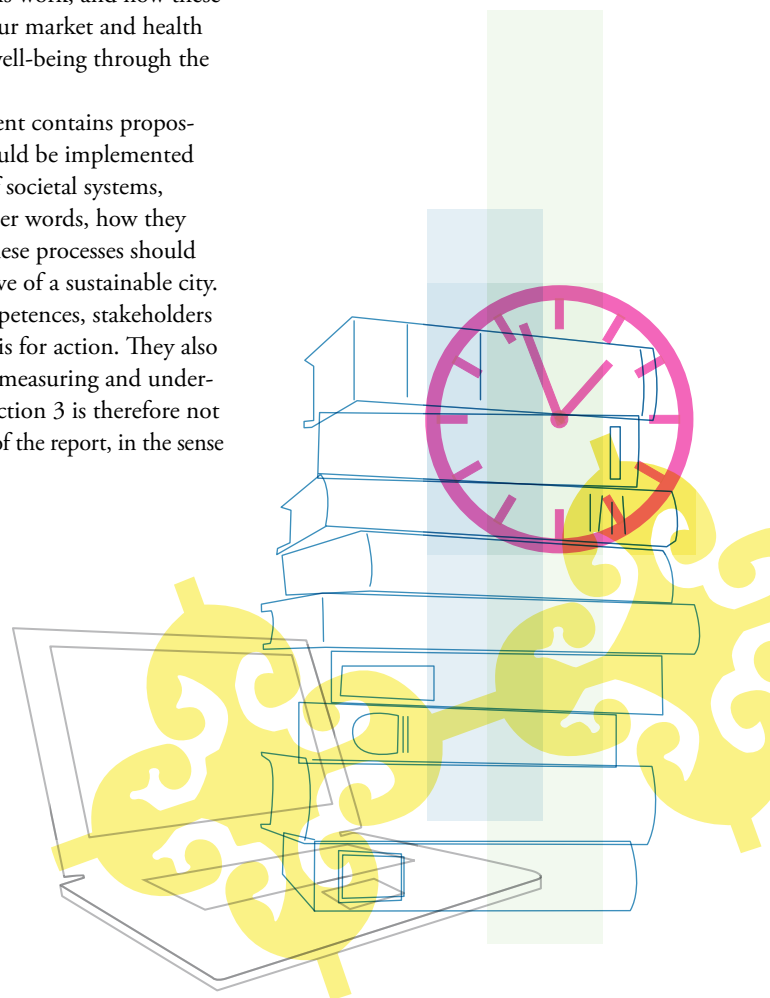
0.10 The report's continued structure

THE MALMÖ COMMISSION HAS divided its recommendations; objectives and actions into three sections with subsections. The municipality has the ability to influence all these areas. Sometimes the main responsibility lies on a different political-administrative level, but the municipal room for manoeuvre is never non-existent. There are not always absolute boundaries between the different areas and there are a lot of interconnections between different sections and areas.

Section 1 deals with people's everyday conditions. These conditions can to a great extent be viewed as the consequences of social systems. The economic situation of families with children and child poverty are seen as examples in this report as one of the important everyday conditions for children and young people. At the same time the economic situation is a result of societal systems such as the labour market and social security systems. In the same way residential environments are essentially the result of various urban planning processes, but are viewed here as an everyday condition since people do not need to be included in, or excluded from, particular societal systems in order to be affected by their immediate environment.

Section 2 on societal systems is about the way societal systems work, and how these systems in themselves affect health inequities. Education, the labour market and health care constitute all such systems, which affect people's health and well-being through the way they are organised and function.

Section 3 on a new type of process for sustainable development contains proposals on how the recommendations in the two previous sections should be implemented suitably. If the focus in Section 1 is on the consequences/results of societal systems, then the focus in Section 2 is on societal systems' processes, in other words, how they function. The focus in Section 3, then, is on the essence of how these processes should function, how they can be changed in order to achieve the objective of a sustainable city. This includes knowledge alliances bringing together different competences, stakeholders and levels of responsibility to develop knowledge together as a basis for action. They also include other initiatives, such as changed leadership, new ways of measuring and understanding as well as holistic control instruments. The content of Section 3 is therefore not peripheral. These actions should be perceived as transversing the rest of the report, in the sense that they will permeate the actions in Sections 1 and 2.



A photograph of two children playing in a park. The child on the left is wearing a blue jacket and is looking down. The child on the right is wearing a dark jacket and checkered gloves, looking towards the camera. In the background, there are trees and a building with a clock tower.

1. A social investment policy that can reduce inequities in living conditions

WHAT NEEDS TO BE DONE? That is the question that forms the basis of this section of the report. To be specific, in this section we will focus on people's spatial and social conditions. Section 1 consists of two chapters which correspond to the two areas of social determinants. We label the first "Everyday conditions of children and young people" and the second "Residential environment and urban planning". The similarity between these two areas is that they both concern the results of societal systems. Thus, it is not the societal systems' internal way of functioning that we want to touch

upon in this section but their results, which in public health are referred to as "down-stream determinants".

As the following chapters show, we have identified large inequities in living conditions. We can also show strong relationships between these inequities and health inequities. Our overall recommendation is that these inequities must be reduced by means of a social investment policy. By that we mean a way of thinking and acting which sees social interventions as investments and not as expenses, according to the social investment perspective.

1.1 Everyday conditions of children and young people

A GOOD START IN LIFE is one of the most important factors for a long life of good health and well-being (1). Good health during the early years of life means that the individual can interact with his or her environment in a positive way, by for example creating good social relationships and benefitting from education. This may be crucial to being able to make optimal use of life chances as an adult. This in turn determines the chances of attaining emotional and social well-being, optimal cognitive development, a successful professional career and a good income. All of these are important social determinants for good health. Good health during the start of life also appears to be one of the most important determinants of good health later in life, from a biological point of view.

The rights perspective is particularly obvious when it comes to young individuals, since they cannot influence the factors that are important to their health development, through their own choices. The so-called ethical imperative for creating equitable conditions for good health at the start of life therefore becomes very clear and unavoidable in a society that is serious about acknowledging that the right to the best possible prerequisites for good health is a human right. The UN Convention on the Rights of the Child takes a similar approach including the right to life and development, non-discrimination, the principle of the best interests of the child and the right to be heard and have influence.

However, during the course of the Commission's work it has emerged that it is largely not possible to use social determinants to systematically describe the equity situation in Malmö concerning children and young people's health in the way that has been done for many years for adults. The very first step in successful actions towards health equity, is therefore to develop adequate measuring instruments and apply these to evaluate whether actions that have already been implemented actually work. So far there has been a considerable lack of such instruments in Malmö. What has been available since 1994 is a survey of Malmö pupils' health-related behaviours, which is conducted every third year among pupils in Years 6 and 9 as well as Year 2 of upper secondary school. During the spring of 2012, Region Skåne conducted an equivalent regional public health survey aimed at school pupils, in which the results are also available at the municipal level with the possibility to analyse social differences in self-rated health and living conditions. There is also a regional public health survey in progress aimed at young children and their parents and the results from this survey will be reported in 2014. These results will also be reported at the municipal level. The other option is to describe health inequalities among children and young people between different child health care centres, dental care clinics, schools and residential areas. The data which is compiled in this way serves as a good estimation of social inequities due to the pronounced residential segregation in Malmö. This instrument however provides poor prerequisites for follow-up interventions to reduce these inequities, because of many pupils changing schools and a high tendency to move between different residential areas, among other things.

Despite these limitations, the information which is currently available shows the existence of clear social inequities in the health of children and young people in Malmö

today. The limitations also mean that it is highly likely that this picture is a significant underestimation of the actual situation, since there are also great inequities between residential areas *within* the various city districts. A detailed report of the health of children and young people is available in Chapter 0.7.

The systematic health inequities among children and young people that were confirmed in Malmö are associated with the social determinants that comprise their everyday conditions. For example, social relationships and opportunities for emotional and cognitive stimuli, the quality of the home and the residential area and access to a secure and stimulating environment at preschool, school and during leisure time. In this chapter equity aspects based on children's direct experiences of these factors in their everyday environment will be considered. The opportunities to increase equality in terms of important social determinants of health among children and young people through interventions in the societal systems which consist of preschool, school and after-school services, are discussed in the following chapters, as well as what can be done to increase equity through the planning of physical environments.

1.1.1 THE INFLUENCE AND PARTICIPATION OF CHILDREN AND YOUNG PEOPLE

There are clear connections between children's participation, influence and health. When individuals and groups perceive that they lack the opportunity to influence their own living conditions and the development of society at large, a sense of social exclusion and powerlessness arises. These factors in turn contribute to negative health outcomes. Children's and young people's opportunities to influence and participate mainly take place in their everyday lives. Having influence and being a participant is about being able to affect the environment you find yourself in and about being able to influence your own life, who you are and how you choose to express yourself. Being discriminated against often entails being deprived of power, which is why intensive work against discrimination among children and young people is of great importance in order to ensure their participation and influence. The survey Malmö pupils' health-related behaviours which is reported in the City of Malmö's welfare reports shows that the older Malmö pupils become, the less they consider themselves to have influence. (3)

Both the City of Malmö and Region Skåne have conducted surveys in recent years where they measure children's and young people's sense of participation, influence, trust and security. It is of great importance that these surveys are conducted and used to improve the everyday environments children and young people find themselves in, since this is where the greatest potential to create participation and influence exists. To measure, monitor and assure the quality of the development of this work requires municipal structures. Some municipalities in Sweden have for example appointed a child ombudsman with the task of securing the children's rights perspective in the services provided. It would be advantageous to appoint a similar body in Malmö.

O OBJECTIVE 1.1.1

Strengthen all children's and young people's opportunities for influence and participation.

A ACTION 1.1.1.1

Develop actions to ensure that the children's rights perspective pervades all political decisions.

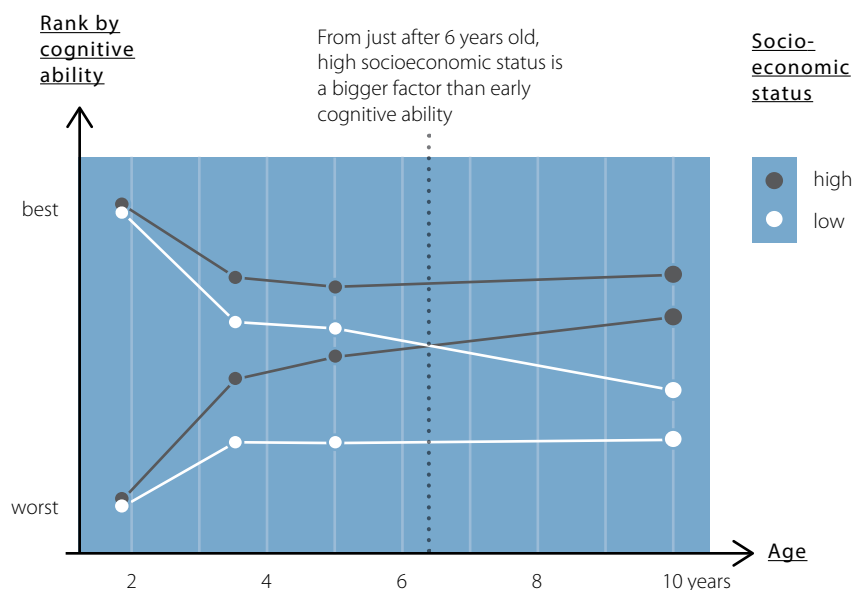
Ensuring that the children's rights perspective pervades all political decisions implies a process of continuous development with clear management where the influence and participation of children and young people is brought into the municipality's long-term planning and into everyday decisions that affect children and young people. This may for example be achieved through the appointment of a municipal children's ombudsman with the specific task of focusing on children's and young people's opportunities to participate and influence, conducting child impact analyses regarding the budget process, municipal decisions and services and actively working against discrimination of children and young people.



1.1.2 ECONOMIC CONDITIONS OF FAMILIES WITH CHILDREN IN MALMÖ

The economic situation of children and their family constitutes a fundamental determinant for good childhood conditions. The relationship between the economy of families with children and a number of key aspects such as children's health, educational opportunities and prospects is clear and points to a general need to raise families with children to the lowest necessary economic standard.(81). Parents who live under stressful socio-economic conditions can find it harder to develop good relationships with their children (82), and an upbringing with a strained economic situation can have negative consequences in terms of housing conditions and opportunities to participate in leisure activities (83). Research also shows that children's cognitive abilities are developed in different directions depending on what socio-economic group they belong to (9). See Figure 18.

Figure 18: Inequities in cognitive development of children



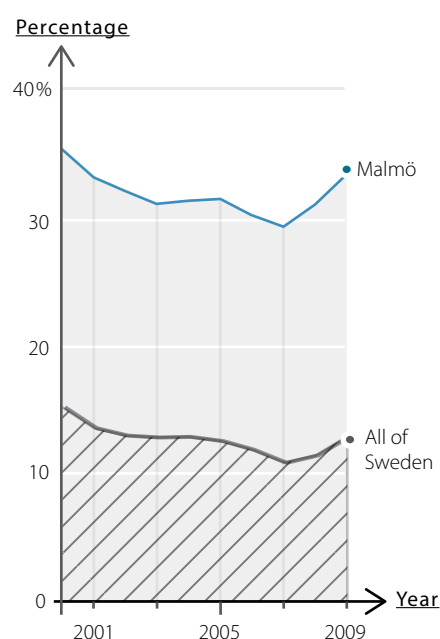
Source: Fig. 6, *Fair Society Healthy Lives, The Marmot Review. Inequality in early cognitive development of children in the 1970 British Cohort Study*

A third of the children in Malmö grow up in poverty for parts, or all, of their childhood. Malmö is the city in Sweden with the highest number of children who live in economically vulnerable families, and this has been the case since Save the Children started its assessments in 1991. Figure 19 shows child poverty in Malmö and the nation respectively (81). The differences within the city are also great; the proportion of children in economic vulnerability differs by up to five times between two city districts. In two of Malmö's city districts poor children are in the majority. (3) The high proportion of children in economic vulnerability in Malmö has no single explanation. Population-wise Malmö can be said to have an over-representation of families with children who in general have a weaker economic situation, among them single parents and parents born abroad. But there is also an increased economic vulnerability generally among families with children in Malmö, which cannot be linked to strict demographic factors but must be seen in relation to the specific historical and structural conversion the city has undergone since the decline of the industrial epoch. (81)

The Commission shares Save the Children's definition of child poverty, which means that children who live in households with either a low income standard or on social assistance are counted as poor. *Low income standard* is a measure developed by Statistics Sweden, and means that a household's disposable income falls below a necessary level of expenditure. This composite definition encapsulates the economic vulnerability of children and their families in a relevant way, since it covers the children's household income capacity to cope with necessary household expenses at the same time as it includes all of the households with children that are granted income support. (81)

Children who grow up in economic vulnerability often as adults have poorer health, a lower level of education, greater need of social assistance and are often far from the labour

Figure 19: Child poverty in Malmö and the nation as a whole in 2000-2009. Proportion of all children



Source: Angelin and Salonen, 2012

market. Especially for children who have grown up in households with long periods of social assistance, there is a high risk of unfavourable living conditions later in life. Children in families with lengthy social assistance also have significantly worse outcomes related to health problems such as alcohol and drug abuse, suicide attempts and mortality. (81)

Children's own view of economic hardship has been highlighted in several reports. Among other things, Children's Rights in Society in Sweden (BRIS) has recently published a report; *When there isn't enough money* (84), where children have given their own views on living under economically inadequate conditions. The report clearly shows that children in economic vulnerability can worry about their family's economy, that the parents will not be able to pay the bills. There is an awareness that unpaid bills lead to letters of demand from the Swedish Enforcement Authority and that this in turn leads to eviction. The report makes it clear that children who live in economically weak households are forced to grow up quickly and lose their right to be a child early.

When I was twelve years old I could cope by myself. /.../ I am damn good at being stingy when it comes to food but it is really boring. Mum often does not manage to pay the bills so me and my sister usually have to work extra in order to make ends meet. (84)

The children describe their anger about being poor, anger that is directed against the state and their own parents. They describe how being poor means that they have to go to poor schools, where for example there is a lack of access to computers and the Internet, even though the school work requires access to these. At the same time hope and optimism is reflected in the experiences they acquire.

You cope with a lot of crap. If you have a difficult experience and it happens again you become a stronger person. /.../ Sometimes you think you do not have the strength to deal with difficult things. You think you will get weaker but actually you get much stronger. It happens automatically. (84)

Save the Children's report, Ung Röst (Young Voice) 2011 reported children's responses to questions based on the criticisms that the UN's Committee on the Rights of the Child directed at Sweden. In Malmö it was revealed that 24 per cent were worried that the family's money would not be enough for what is needed. Five per cent said they have been forced to abandon an activity at school because it cost money. (85)

Every day I feel I want to do things that the others do, but I can not afford it. I keep quiet about it. I always say that I do not want to go when friends do things that cost money. (85)

The key to a secure upbringing for children is in the parents' situation. It is by combatting parental unemployment, health problems, lack of social insurance protection and participation in society that long-term sustainable improvements for vulnerable children can be created. (81, 86)

Knowing that poverty reduction is in some respects mainly a matter for the state, such as through labour market policies, cannot be used as an excuse at the municipal level for being passive or hesitant. The municipality has a significant role to play in this vital aspect of welfare policy, primarily when it comes to actions of an alleviating nature. This is particularly true in a rapidly changing city such as Malmö, where issues of social integration and long-term social sustainability are shared challenges for the entire city. (81)

The national economic family policy is increasingly less capable of reducing the growing income inequalities among families with children and demonstrates an increasingly weaker ability to reduce poverty. Without family policy initiatives approximately 25 per cent of Swedish families with children would have been poor according to the EU's definition of poverty (60 per cent of the median income). The poverty-reducing effect of family policy has declined significantly over time, and a major contributory factor is the decreased effect of governmental aid to families in reducing economic vulnerability among families with children. (87)

There are a variety of things a municipality can do to combat child poverty. The purely statutory obligations such as responsibility for social assistance and schools are a given, but the extent to which these relate to improvements aimed at economically

vulnerable children varies considerably. In addition to statutory investments, municipalities can also undertake a self-imposed extended municipal responsibility for social interventions (88).

Investments can be designed to *mitigate* the obvious negative consequences of families' economic vulnerability and *reduce* the incidence of economic vulnerability themselves. Strategies should therefore include both reactive, dealing with acute problems, and proactive steps to prevent economic vulnerability among families with children. Poverty-reducing strategies can consist of targeted as well as general actions. The concept of proportional universalism, which means that society's activities are offered to all who need them, without explicitly stating that some groups have a greater need, where the public health care system is a good example, can serve as a guiding principle. The application of this principle, the introduction of general elements within a range of policy areas, in practice works by distributing and securing an acceptable minimum level regarding for example the provision of leisure and cultural activities.

Proportional universalism means that actions should be universal, but be adapted, both in extent and design, to the greatest need



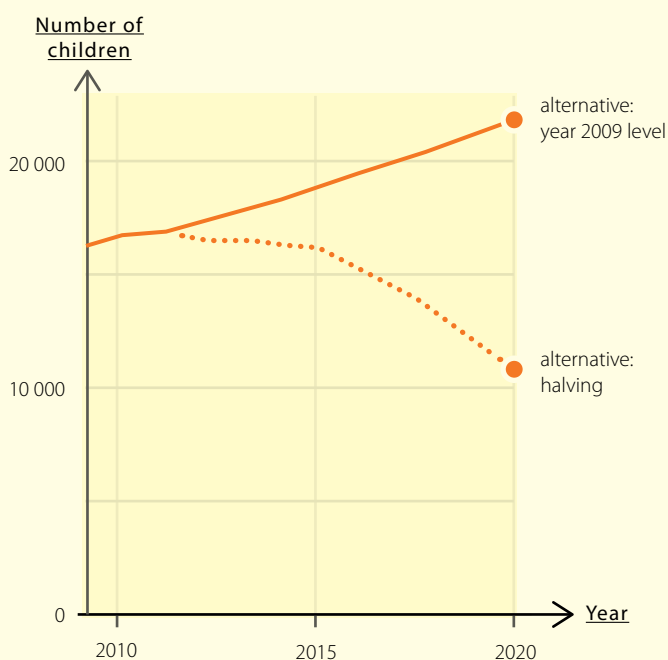
OBJECTIVE 1.1.2

Halve child poverty by 2020 and in the long term eliminate it completely.

Halving child poverty in Malmö by 2020 can be seen as a clear objective towards reducing and in the long-term eliminating child poverty, tentatively by 2050. Halving child poverty by 2020 would mean a significant reversal in the trend for the city of Malmö which has consistently reported levels of more than 30 per cent since the early 1990s. Meanwhile, the level of economic vulnerability among children and their families in Malmö would probably still be above the national level, which must be seen as reasonable based on the municipality's demographic and socio-economic profile. (81)

In the diagram below the stated objective is compared with an unchanged level of child poverty in Malmö. What would it mean if the level remained at around 30 per cent in the years ahead with the expected population growth? If the child poverty level remains unchanged, the number of children in economically vulnerable families will gradually increase in the municipality for the rest of the 2010s. (81)

Figure 20: The number of children in economically disadvantaged households in Malmö based on unchanged or halved level, respectively, up until 2020.



Source: Angelin and Salonen, 2012

During the course of its work the Commission has focussed on a number of possible actions that alone and combined with actions within other areas in this report should contribute to achieving the objective of halving child poverty by 2010. Interventions to reduce economic vulnerability among children and their families in Malmö and mitigate its effects can be seen as a central strategic element of the social investment policy that Malmö should strive for in the long term. According to the UN Convention on the Rights of the Child's reducing economic vulnerability among children would contribute to reaching the objectives of a safe and inclusive childhood, by creating long-term health-promoting and society-building value for both the individual and the local community at large.

A ACTION 1.1.2.1

Develop and implement a municipal action plan to reduce child poverty.

The City of Malmö lacks a municipal strategic plan for combating child poverty. Such a strategy exists in several other municipalities throughout the country, though only in a clear minority of cases at present. In view of the large group of economically vulnerable children in Malmö, the Commission sees it as appropriate to develop and implement a comprehensive action plan for continued attention and focus on these children's living conditions. (81)

A municipal action plan to reduce economical vulnerability among families with children has far-reaching consequences for the whole city's development and in theory involves every municipal service. The municipality can contribute with substantial grants to both alleviate and reduce child poverty. Both these aims should receive attention and action be taken. Likewise, it is strategically important that the municipal level identifies and mediates shortcomings and vulnerability in the economic conditions of families with children which can be related to the national child and family policy.

A ACTION 1.1.2.2

Establish municipal family support.

A high and stable proportion of families with children in Malmö have incomes below the required minimum levels, including both the national norm for social assistance and various conventional poverty thresholds. One way to raise many families to a minimum decent standard of living would be to set up specific municipal family support, which would be paid after consideration of families' incomes and relieve the municipal social assistance system.

A committee should be appointed to examine the consequences and clarify to what degree this type of family support could compensate for other municipal costs, primarily social assistance.

A ACTION 1.1.2.3

Raise the municipal social assistance for families with children with long-term social assistance.

The number of households receiving long-term social assistance is substantial in Malmö, especially among families with children. This means that economic vulnerability cannot usually be viewed as a short-term or transitory life situation for this group. Seventy per cent of the costs of social assistance in Malmö go to this group. (81) At the same time the standard level of municipal social assistance has a number of built-in problems which mean that a decent standard of living cannot be guaranteed for the beneficiaries. The national norm for social assistance cannot therefore be considered to be a guarantee for achieving a reasonable standard of living, especially not for households with a long-term dependence on support. Therefore the commission suggests that municipal social assistance, independent of the national norm, should be raised for those families with children who receive it on a long-term basis. (81, 89)

A thorough investigation should be conducted to enable differentiated social assistance to be introduced urgently. The overall aim is to ensure that all households receiving financial assistance have a reasonable standard of living in accordance with the applicable social policy legislation.

A ACTION 1.1.2.4

Introduce a norm of a standardized addition on an annual basis for households with children with long-term social assistance, intended for children's leisure and cultural activities.

Children in economically vulnerable families in Malmö may not have sufficient access to recreational activities. The proposed addition should therefore not be something to apply for in addition to the norm, but a standardized addition on an annual basis for all households with children with long-term social assistance. It is of great importance that such a leisure norm reaches all children and not just those in families with the knowledge and resources to make additional applications. The norm could also be used to carry out an activity together within the family. (81)

A ACTION 1.1.2.5

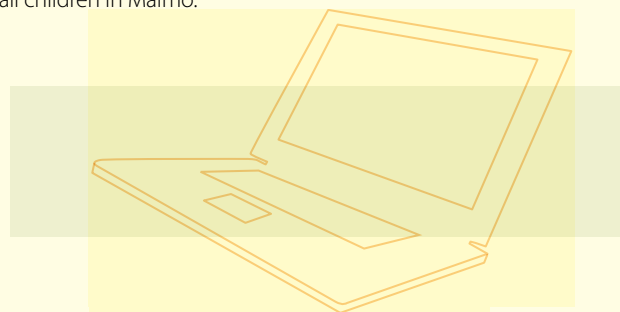
Provide all children in Malmö with free access to public transport within the city.

One aspect of access to participation and communication for children relates to having the whole of Malmö as their everyday arena. This is highlighted as significant when meetings and integration are discussed. Accessibility is an important tool and a prerequisite for participation beyond the current national norm, which is why the Commission considers children's access to free public transport within the city to be urgent. (89) This initiative would also contribute to the increased use of public transport which promotes ecologically sustainable development in Malmö. (88) (90)

A ACTION 1.1.2.6

Increase access to computers and Internet in the home for families with children in Malmö.

One of Malmö's problems is the lack of participation among the population, primarily in terms of groups who are usually outside the labour market and receive social assistance. During the last 10-20 years, in line with the growth of the digital society, the ambition to create strengthened citizenship with the aid of ICT has been apparent. At the same time access to the Internet and to computers has also become increasingly important for social communication, not least among children and young people. (89) The Swedish National Institute of Public Health for example uses access to the Internet at home as an indicator of participation. For most people this is taken for granted, while for groups in receipt of social assistance it is not, at least not in relation to the national norm. Through an addition to the standard social assistance for families with children the municipality would be able to ensure access to computers and the Internet at home for all children in Malmö.



Homelessness

According to the Swedish National Board of Health and Welfare's definition from 1999 a homeless person is a person who lacks his or her own or rented accommodation and who does not live in long-term lodgings or sublet accommodation, but is dependant on temporary accommodation.

"Mosippan"

For several years children's health care has, in co-operation with school health care and dental care, observed children in Mosippan, a residential area on the outskirts of Malmö which functions as a municipal-wide transitional residence for homeless families with children. In 2010 the project "Barnen på Mosippan" (Children at Mosippan) was implemented, largely funded by the County Administration Board, Region Skåne and the City of Malmö in co-operation, with a focus on children's health. The results which were presented in a report are clear-cut. Among the approximately 70 children up to 18 years of age who lived there, there were many health problems, and many of these had not been attended to. The children had not taken part in general offers of for example health check-ups and vaccinations as expected (48).

1.1.3 CHILDREN'S AND YOUNG PEOPLE'S HOUSING CONDITIONS AND ENVIRONMENT

Children and young people who are homeless

Homelessness is a serious social problem which clearly affects families with children and thereby the children's living conditions and health. A national survey of homelessness was done in 2005 and thereafter the National Board of Health and Welfare, commissioned by the Swedish Government, did a survey of homelessness, including homelessness among families with children, using a measure of the number of homeless people during one week in May 2011 (91). Comparisons with the previous survey were complicated by the fact that different definitions of homelessness were used, and therefore non-comparable estimations were arrived at. All in all, an increase in the number of homeless people can be seen, mainly consisting of women and foreign-born persons. The number of children under 18 years of age who live in homelessness is, despite these surveys, incompletely known.

In line with the increase in homelessness in Malmö in general, the number of homeless children has increased and in 2011 a calculation showed that 240 children were homeless (63). Compared with 2003 the number is five times as high. The difference between city districts is great and 101 of the 204 homeless children in Malmö are in "Rosengård". The number of homeless children in "Rosengård" has thus doubled since 2010. Housing is solved in various ways: the municipal residence "Mosippan", hostels such as Bulls specialisten, hotels, etc. Homelessness impacts on children's social life in many ways, for example, through frequent change of addresses and broken networks of contacts that make a good everyday life in terms of things like participation in school and leisure activities difficult. A sense of shame and dejection is also common among homeless children and young people. Homelessness is usually linked to other problems in the family such as poverty, mental illness, abuse and violence. (63)

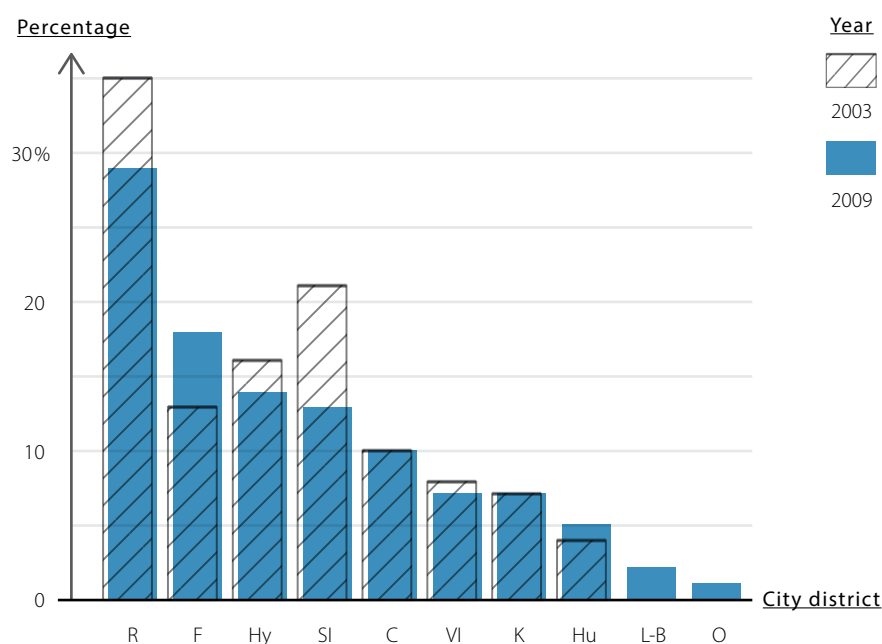
Overcrowding among children and young people in Malmö

Overcrowding is also associated with physical and mental health problems (2). Mental stress, disturbed sleep and lack of hygiene can be some of the consequences of overcrowding. Children's performance at school is very much linked to the ability to do homework in peace and quiet. Overcrowding means that children have less time for homework (92). In Sweden overcrowding is in general low compared with other countries, but the rate varies greatly depending on socio-economic factors such as income, ethnic background and the housing's type of tenure. Among single parents there is a clear increase in overcrowding of 10 per cent during the last ten years, generally in Sweden. Since the post-WWII period, Swedish research has not focussed on the effects of overcrowding among children, or on the effectiveness of strategies to counteract it and possible initiatives to reduce its impact on children.

Overcrowding is usually defined as the number of residents per room in the dwelling, kitchen and living room excluded, exceeding two. Therefore up to four people can live in a normal two bedroom flat, without being overcrowded. In Malmö there are marked differences in overcrowding between the different city districts. On average 4 per cent of Malmö residents are overcrowded while this proportion is 17 per cent in "Rosengård" and 9 per cent in "Södra Innerstaden". In "Husie" and "Limhamn-Bunkeflo" only 1 per cent are classified as overcrowded. (93)

An even clearer difference between city districts can be observed concerning overcrowding among children (Figure 21). The pattern in relation to city districts is however the same as among adults. The extremes are represented by "Oxie", where 1 per cent of 4-year-olds are overcrowded, and "Rosengård" where the corresponding figure is around 30 per cent. The estimation of overcrowding calculated based on population registration information does not however always match the actual situation. Within the framework of a study of housing conditions and ill-health, which was conducted in 2010–2011 by the Division of Occupational and Environmental Medicine at Lund University, the homes of 133 families with children were visited in the areas "Herrgården" (private landlords) and "Törnrosen" (the City of Malmö's housing company), both in the "Rosengård" city district. Among the visited families in "Herrgården" 74 per cent of all children and young people (0–18 years of age) were overcrowded, while the corresponding proportion in "Törnrosen" was somewhat lower, 59 per cent (93). The distribution of housing and overcrowding for families and children is shown

Figure 21: The proportion of 4-year-olds in the city districts of Malmö living in overcrowded households. Change 2003-2009



Source: Albin et al, 2012. Note that the number of children in the survey in 2009 was 20% fewer than 2008, which may distort the results slightly.

in Table 3. It is clear that the accommodation which has been available for large families with small resources does not correspond to their needs, despite the fact that the social welfare service pays a substantial part of the rent. Albin et al have also calculated the ideal number of flats of different sizes that would be needed for none of the visited families to be overcrowded. A significant number of flats with 3-4 bedrooms would be needed, as well as a few additional 5 bedroom flats. (93)

Table 3: Overcrowdedness among 133 families in "Rosengård" in 2010-2011

	Num-ber of fami-lies	Number of chil-dren	Family size	Proportion of over-crowded families	Proportion of over-crowded children (%)	Ideal flat stock without over-crowding
Herrgård						
One bedroom apartment	6	14	3,5 (2-7)	67%	86%	3
Two bedroom apartment	34	125	5 (2-9)	71%	83%	13
Three bedroom apartment	10	41	6,5 (3-10)	50%	68%	21
Four bedroom apartment	2	7	5,5 (5-6)	0%	0%	11
Five bedroom apartment	1	4	7	0%	0%	5
Törnrosen						
One bedroom apartment	7	13	3,6 (3-5)	100%	100%	1
Two bedroom apartment	44	122	5 (3-7)	59%	73%	28
Three bedroom apartment	24	85	6 (3-9)	33%	45%	40
Four bedroom apartment	5	16	5 (4-6)	0%	0%	10
Five bedroom apartment	-	-	-	-	-	1

Source: Albin et al, 2012

Damage because of damp

Children spend a lot of time indoors and in the home environment and are therefore particularly exposed to the health risks that are associated with damp and mould, but for adults it is also a problem. Indoor mould is a problem which appears to increase the risk of developing allergies in children and make them more sensitive to infections. Poor ventilation markedly increases the risk of asthma. A Swedish study of asthma among children has shown that wall-to-wall carpets, smoking and damp stains in the home during the child's first two years of life are risk factors for the development of asthma (94). For a general review of the knowledge in Swedish, see Socialstyrelsens Miljöhälsorapport (The Swedish National Board of Health and Welfare's Environmental Report) (94).

During the period 2003–2004, 6 per cent of parents with children who were 8 months old stated that they lived in environments which they knew or suspected were affected by damp or mould. The problem was reported to be greatest in “Kirseberg” and in “Rosengård” where 12 per cent of the households were assumed to be affected by damp and mould in the residential environment. “Oxie”, “Limhamn” and “Västra Innerstaden” are among the city districts where the lowest proportion of children were reported to be exposed to damp and mould in the home (11).

There are also differences related to the parents' country of birth. For children with at least one parent born in Sweden, 5 per cent report that there is a damp and mould problem in the home. Of those who were born abroad, 9 per cent report such a situation (11). The same pattern is repeated in terms of the parents' economic circumstances and educational level. Unemployed parents, parents with a low level of education and parents with problems paying the bills are more exposed to damp and mould in the home, according to the child health care centre's survey.

Many families live in residential areas that were built as part of the Swedish One Million Dwellings Programme, that took place during 1965–75 on the basis of a decision taken by the Social Democratic government in 1965, and which are now so old that the need of renovation is beginning to become obvious. In Malmö there is some housing where maintenance has been considerably neglected, and many flats are damaged by damp and mould. In the area of “Herrgården” in “Rosengård”, the City of Malmö's Environment Department has been forced to issue fines for non-compliance concerning the renovation of more than 700 kitchens and as many bathrooms. The impression of the problem of damp and mould in homes being very limited, which is given by the child health care service's survey, may thus be considerably underestimated.

Exposure to environmental tobacco smoke

For a general account of the state of knowledge in terms of the effects of environmental tobacco smoke on the health of children and adults refer to Miljöhälsorapporterna (the Environmental Health Reports) from 2003 and 2008 (96, 97). In terms of smoking habits and consequential exposure to environmental tobacco smoke, there is a strong connection to socio-economic conditions, for example, level of education. Available information on adults' smoking habits shows great differences in the prevalence of smoking, and thus children's exposure to environmental tobacco smoke, between city districts. Parents' smoking habits may not always have an immediate significant impact on children's health, but they are also strong determinants for children's own future smoking habits.

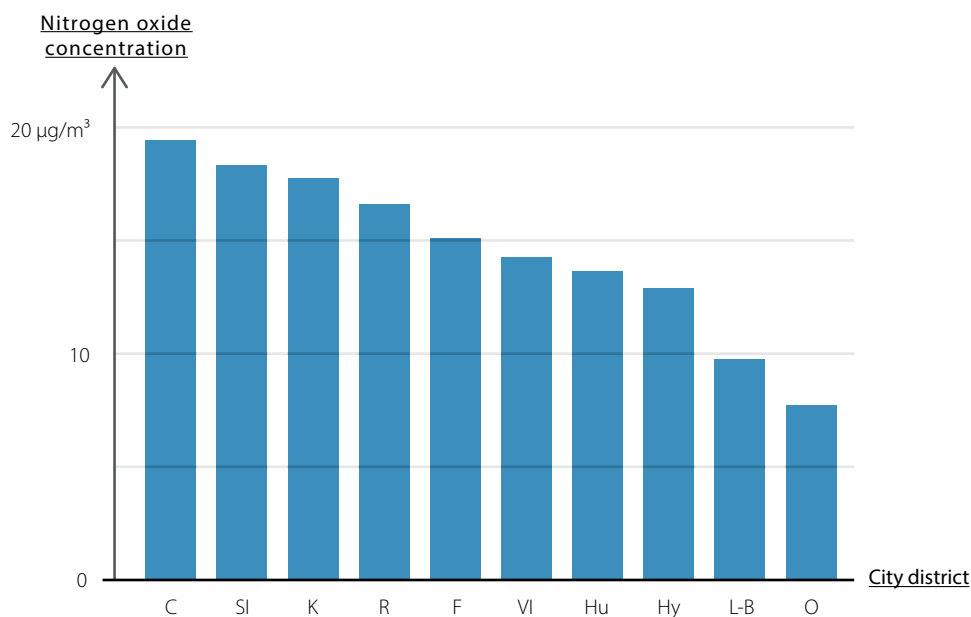
There are great differences in terms of women's smoking habits in Malmö. Information in the Medicinska födelseregistret (Medical Birth Register) from all pregnancies between 2005–2009 in Malmö can be broken down to the parish level. The greatest proportion of women who smoked during pregnancy was found in the parishes of “Oxie”, “Fosie” and “Hyllie” while “Kirseberg”, “Möllevången-Sofielund” (roughly the same areas as the city district “Södra Innerstaden”) and “Västra Skävinge” (roughly the same area as the city district “Rosengård”) are close behind. The parishes of “S:t Petri”, “Slottstaden”, “Limhamn” and “Bunkeflo” are those with the least proportion of women smoking during pregnancy. Children's exposure to environmental tobacco smoke per city district, which is documented through the child health care centre survey, also highlights the clear inequities that exist within Malmö. Children whose parents have difficulties in paying the bills, that is, experience financial stress, who live in a rented flat, rather than owning a detached house or living in a tenant-owned flat, and/or are unemployed are also more exposed to environmental tobacco smoke. (93)

Air pollution at preschools and schools

Children's exposure to air pollutants in the home and at school depends very much on where in Malmö they live, which in turn depends on the family's socio-economic position (98). If a child lives in a building in which the residents generally have lower income levels, the risk is greater that the child is more exposed to air pollutants than a child in a building with residents with higher average incomes. The same patterns are apparent when it comes to the school which the children attend.

Half of the total exposure air pollutants (measured as NO₂) are higher at schools that children with lower socio-economic status attend, than at schools which children with generally high socio-economic status attend. (98). Models of nitrogen oxides at preschools and compulsory schools in Malmö show that the highest concentrations are found in "Centrum", "Kirseberg", "Södra Innerstaden" and "Rosengård" (Figure 22). The lowest levels were recorded in "Oxie", "Limhamn-Bunkeflo" and "Hyllie". (93)

Figure 22: Average concentrations (average annual value) of nitrogen oxide at preschools and schools in Malmö's different city districts, 2008.



Source: Albin et al, 2012

Noise

Noise disturbance at schools and preschools does not only result from the children's own activities, but also from the surrounding environment, especially from traffic. The largest proportion of schools and preschools with noise levels exceeding the recommended benchmark of 55 decibels (dB (A); daily average at facade) were noted in the city districts "Södra Innerstaden", "Rosengård", "Husie" and "Fosie". The city districts with the largest proportion of schools and preschools where the benchmark was not exceeded were "Hyllie", "Västra Innerstaden" and "Oxie". (91) (93)



O OBJECTIVE 1.1.3

Reduce homelessness, overcrowding, poor housing conditions and poor outdoor environments for children and young people in Malmö.

Children's housing conditions and residential environment are a determinant of their health which is probably underestimated to a substantial degree. This is due in large part to a lack of awareness of the conditions mentioned previously, which in turn also explains a lack of information that can quantify the extent of the problems and the ability to analyse the health effects of these. The reason for poor housing conditions is largely poor economic resources of families who are referred to the cheapest homes on the market. But much can also be done by ensuring that these homes meet the stipulated standards and requirements for a reasonable living environment, and that such housing is made available to all families regardless of income. In this context the identified need for an extensive renovation of homes in the One Million Dwellings Programme areas is of course of great interest.

A ACTION 1.1.3.1

Develop an action programme to increase the availability of housing of good quality that families can afford.

A significant proportion of children in Malmö live in homes that are too small for their family. This affects the ability of the children to do their homework and recuperate, and also represents a heavy domestic workload for the parents. The risk of damp increases, which in turn is a risk factor for asthma in young children. In all age groups an increase in symptoms among those who have asthma have been noted. A social policy for housing that provides all families with access to good, healthy housing is an important prerequisite to ensure that housing conditions do not aggravate the income-related health inequities and replicate them from one generation to the next.

There is a need for renovation of the existing housing stock, increased supervision of suspected neglect of maintenance and for increasing the availability of housing that does not require purchase or investment, especially larger apartments (3 bedrooms and upwards).

The problem needs to be tackled from several angles, with a combination of more deliberate use of the municipality's ability to control the design of the housing stock and incentives towards more efficient and innovative solutions to the social problems of housing. Since it is difficult to predict what the need will be in the future, it is essential that the solutions allow for adaptation to fluctuations in the composition of the population. The action programme should be developed speedily but in wide consultation with property owners, users, their organisations and the construction industry. It should include measurable milestones. The following starting points are suggested:

1) The rate of new construction is generally too low. This makes overcrowding worse, for example, because young adults have difficulties in finding their own accommodation.

2) The municipality's ability to control the forms of tenure and size of dwellings in new constructions (for example towards more large apartments for rent, with tenancy rights as the initial form of tenure) on both municipal and non-municipal land should be reviewed in this context. This especially applies to areas of land with good access to public transportation.

3) For housing stock with substantial technical or social problems, it should be possible for the property owner to obtain financial and organisational support to develop the stock to better functionality, in consultation with the residents. Making apartments larger is an option, but significantly increased access to common areas for socialising, doing homework, hobbies, more extensive cooking, etc., can also strengthen social community and reduce the congestion in one's own apartment. A focus on the participation of the residents in the management of their own dwellings should be considered.

4) Devoting a few centrally situated municipally-owned plots of land should be considered for projects where, together with interested potential residents, new housing is developed which is suitable for multi-generational housing/extended families.

A ACTION 1.1.3.2

Develop an action programme to address deficiencies in the environment for children and young people in Malmö.

The action programme should consider the following:

1. The city's physical planning and the particular impacts on children and young people's immediate environment in terms of residency, urban environment, school and preschool should be considered.

2. Planning for new schools and preschools should be taken into account early when major new constructions or renovations are planned, so that a safe and sound environment for the children, both indoors and outdoors, makes it safe and attractive to go to school/preschool by foot or bicycle.

3. The City of Malmö's Environmental Department's efforts when environmental problems (damp, mould, pests) are suspected should be strengthened.

4. When considering the cost of interventions to reduce children's and young people's exposure to air pollution and traffic noise, it should be considered that such interventions will benefit the whole population, and also that they will reduce social health inequities because of the socially differentially impact of environmental burdens in the city.

5. Green areas (including beaches) of good quality close (within 300 m) to the home are probably important for well-being and daily exercise, which is particularly important for those who do not have their own garden. (97) (99)

1.2 Residential environment and urban planning

A CITY'S DESIGN and residential environments affect well-being, health and their social distribution in many respects (1). Some physical characteristics of the city environment such as access to green spaces, lack of physical barriers to walking and cycling, safe and inviting outdoor environments, are directly connected to well-being and health and are often socially inequitably distributed. Since the physical environment also provides a framework for all the social interactions that occur in a city, the city's design is a fundamental prerequisite for the health of the residents from this point of view as well. Social contacts, social control and trust can be achieved or hindered depending on the residential area's design (9). The term health-promoting urban planning encompasses all of these aspects.

Health inequities largely coincide with the geographic separation of different social groups, what is called segregation. Malmö is a highly segregated city. There are large differences between different city districts when it comes to access to green spaces, inviting outdoor environments, trust and well-being, and problems with overcrowding, homelessness and housing supply.

In this chapter we will observe the way in which the physical environment relates to health inequities, and present suggestions on how urban planning as a tool can contribute to sustainable urban development and lead to a better integrated city and decreased health inequities. Another form of segregation is school segregation, and we devote a special subchapter in this report to this. To reduce segregation requires both spatial and social actions.

Since it was introduced in 1947, the municipal planning monopoly has been one of the most important prerequisites of municipal self-governance in Sweden. This means that the municipality decides how land should be used which provides unique opportunities to remove spatial barriers between segregated areas, localise key functions where they give the best advantages and create mobility in the city. Urban planning as a tool therefore provides the opportunity to transform the physical barriers that separate residential environments into more linking areas, change infrastructure for improved access, transform roads into city streets and reinforce routes through mixed functions.

The attractiveness of a city does not just depend on a mix of features such as homes, workplaces and public environments. A number of basic conditions must be met if a city is to be health-promoting, perceived as attractive and attract residents and businesses. It is about the kind of physical properties mentioned previously, good schools and job opportunities, safe environments, good housing conditions and clean air, prerequisites for positive health-related behaviours, and not least communications to, from and within the city.

The residential environment itself affects health in several respects; directly through the building's physical structure, design, indoor environment (damp, mould, cold), noise and physical deterioration, but also in the shape of factors such as overcrowding, homelessness and housing discrimination. The design and accessibility of the outdoor environment are also important factors. Not least because children are dependent on an outdoor environment that offers physical play and movement. A green environment is very important for both mental and physical health and for the climate change issue. Sustainable urban development that promotes health and reduces health inequities, must go hand in hand with adaptation to climate change and environmentally-friendly actions (9). Sustainable urban development also requires a gender perspective in which women and men have equal access to public spaces. The municipality can influence all these factors.





The Commission's recommendations related to residential environment and urban planning include actions that will contribute to a sustainable, mixed and inclusive city. The recommendations are divided into three subareas; housing and housing provision, residential segregation and trust. Actions for the three subareas overlap each other in such a way that the actions for example for increased trust can also lead to reduced segregation and vice versa.

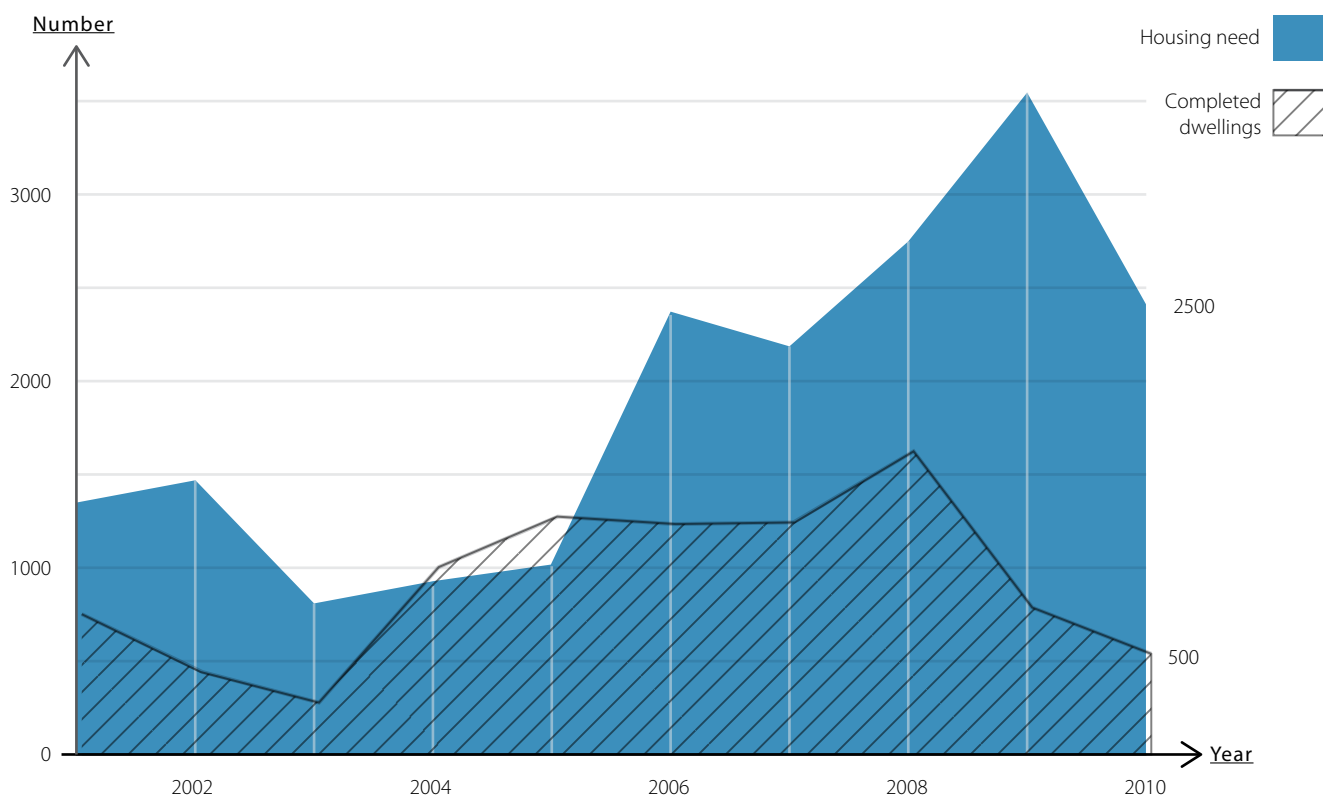
1.2.1 HOUSING AND HOUSING PROVISION

Malmö has experienced a sharp growth in population during the last 20 years, an outcome of diverse factors, such as the construction of the Öresund Bridge, the establishment of Malmö University and immigration from foreign countries (72). This development places great demands on urban planning related to housing provision and the establishment of important social functions that influence the social determinants of health, such as preschools, schools and workplaces.

The residential environment influences our health and our well-being in a number of respects. The primary one is to have a home. Involuntarily lack of permanent anchoring in the housing market influences the prerequisites for good health. Recommendations relating to homelessness and overcrowding of families with children have been highlighted in previous chapters. Homelessness has often been associated with single, substance-abusing men, but in recent years other groups have also attracted attention: women, immigrants, refugees and families with children. Structurally induced homelessness may be due to a shortage of housing, poor economic opportunities to request a home and difficulties in entering the housing market. Homelessness in Malmö has decreased slightly between 2011 and 2012, but has almost doubled since 2003 from 531 to 997 people (4).

The municipality is responsible for the provision of housing and for appropriate actions for housing provision being prepared and implemented (100). In accordance with the Swedish Social Services Act, the municipality must act so that the elderly and individuals with physical, mental or other impairments inducing difficulties in their life should be able to live in a way that is adapted to their needs. The municipality possesses various instruments to promote the supply of housing and can influence the provision of housing development through the planning monopoly, land policy and public housing companies as well as strategic purchases and sales of land. Through exploitation agreements the municipality can set up terms and conditions for additional housing, such as the design of buildings, allocation of costs or to secure the right to apartments for the

Figure 23: Completed housing relative to housing need in Malmö in 2001-2010



Source: City of Malmö, 2010

needs of the social services and assure the municipality intermediary rights in future housing development or influence the structure of flats and type of tenure. The municipality can also clear the way for construction companies and developers by itself investing in improvements related to for example infrastructure and green structures in less attractive areas.

The public housing company MKB is a tool for the municipality to fulfil its responsibility for housing provision. Through the ownership directive the municipality-owned housing company's operations can be managed so that they contribute to the provision of good housing in the municipality. Through the ownership directive new construction can be encouraged, the municipal housing authority's principles for allocation can be established or obligations for household groups with particular needs can be prescribed.

The discrepancy between the need for dwellings in Malmö and the proportion of dwellings built is great. In 2010, a need for 2,500 new dwellings was defined, but only 500 dwellings were completed, in spite of high planning preparedness (Figure 23). The economic downturn partially accounts for this. Housing policy is complex with many state and private actors and the regulations also influence the situation.

O OBJECTIVE 1.2.1

The city should ensure that all Malmö residents have the prerequisites for suitable accommodation and a good residential environment.

To promote a functioning housing market and thereby also secure the right to housing, the Swedish Government and Parliament are responsible for ensuring that there is functional funding for housing and appropriate legislation. The supply and shortage of housing is a complex matter which cannot be solved solely within the municipality's decision latitude. It is worth noting that the construction of housing has not matched the existing demand for a long time.

A ACTION 1.2.1.1

Reduce the housing shortage.

It is proposed that the City of Malmö initiates a process geared to increase co-operation between different departments within the city administration, the research community and private stakeholders on how housing can be produced at a reasonable cost to remedy overcrowding, homelessness and adopt a holistic approach to housing in relation to social sustainability. Within three years 300 apartments should be ear-marked and set aside for the homeless. Evaluations and solutions in other countries and municipalities should be assessed. (See the action below).

A ACTION 1.2.1.2

Establish a new municipal contractor organisation for assignment-based housing development.

To secure housing supply, a new contractor organisation is suggested. It should be given a mandate, resources and expertise from social, economic, environmental and physical areas. Either MKB can be given new ownership directives or a new municipal company can be established. The organisation should have a cross-sector structure, manage housing and statutory issues at the national level and have a particular focus on those groups who currently have difficulties finding housing. The experiences of working with the project UngBo (YoungLiving) and the method of identifying need and demand in

order to design and build suitable dwellings can be applied.

The organisation should work actively on densification and utilise complementary building to increase the variation and services in areas with a uniform housing stock. The organisation can concentrate on taking an overall approach to major areas, for example, by using methods from the Förtättningsstudie längs Eriksfältsgatan i Malmö (Densification Study along "Eriksfältsgatan", a major street in Malmö) (101). The assignment should also include ensuring that new dwellings also contribute to physical connections, increase security by increasing street life, streamline land use by pooling functional areas and increase the quality of outdoor spaces and parks. The organisation can also actively manage the democratic and participatory aspect of the urban planning process.

In the creation of this new function, the consequences of changed conditions for public housing companies must be considered, most recently as a result of the new Swedish Public Municipal Housing Companies Act (2010:879) that came into force on 1 January, 2011 (102). Under this law it is possible for municipalities to carry forward almost the entire previous year's surplus from their municipal public housing company if the surplus is used for actions aimed at increasing integration and social cohesion. What these actions may be, however, has not been defined in the Act. The flexibility for the public housing company to manage actions to promote integration and social cohesion itself has, at the same time, been restricted since these actions must now be commercially profitable if they are to be implemented. Now it is primarily municipalities that will pay for social actions, using any surplus in the housing company as an additional resource to complement and further develop the municipality's existing work on integration and social cohesion in residential areas.

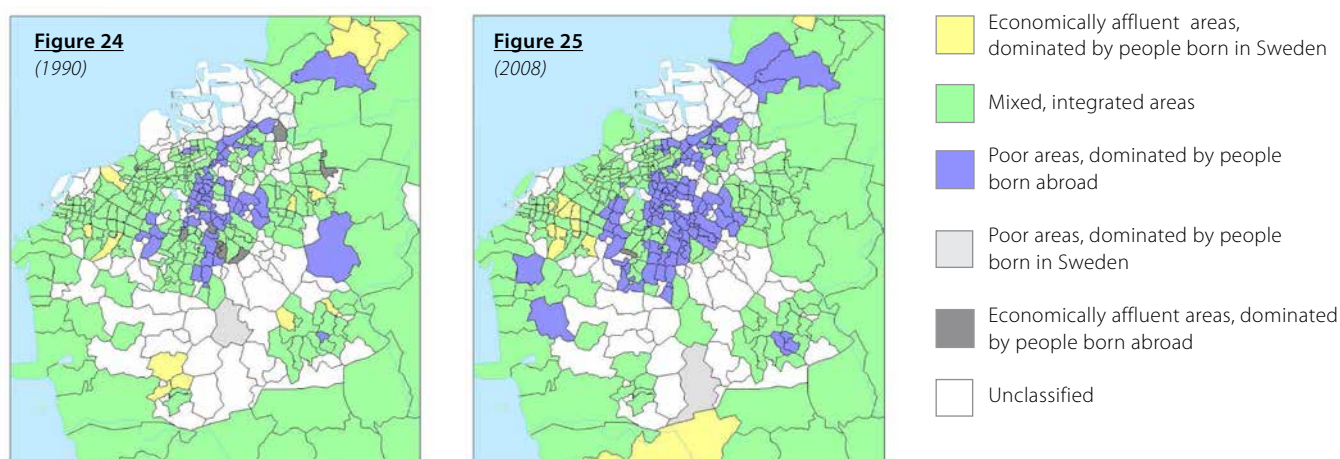
Housing policy changes since the 1970s, linked to Swedish politics and EU legislation on state aid, coupled with increasing segregation in metropolitan cities have made it both more difficult and more important for the public housing sector to work with social issues. The Swedish public housing sector has been gradually eroded and Sweden is currently the only country in Europe that does not have a subsidised housing sector. As a result of the new law, specific knowledge and expertise in this sector is also in danger of being lost. It is the Commission's view that a strong public housing sector according to a general model is important to municipal housing provision.

1.2.2 RESIDENTIAL SEGREGATION

Segregation is a Latin word which means to separate or divide. In the Swedish National Encyclopaedia segregation has been translated as “the spatial separation of population groups. Segregation can take place on the basis of socio-economic status, skin colour, religion or ethnic origin. It can be involuntary or voluntary” (our translation). This definition corresponds to the predominant approach in research. This is also how it is defined in the background reports to the Commission which deal with segregation. It is however not always used in this way in the general debate. Often people focus on the “losers”, which only however constitutes one side of segregation. Based on the definition that is presented by for example the Swedish National Encyclopaedia, segregation constitutes a relationship. Only focusing on one side of this relationship risks blaming the victims and making the problem worse.

Segregation consists of relationships between geographic areas which in social and economic respects form each another's opposite poles, which can be called segregation poles. A segregation pole can be measured by the proportion of inhabitants with a low or a high income, respectively. Salonen (72) has worked out a composite segregation index based on income and ethnicity. This is illustrated in a colour scale where the green area is the mixed area, the yellow area has a concentration of resource-rich and Swedish-born inhabitants while the blue area is dominated by resource-poor and foreign-born inhabitants.

Figure 24 and 25: Segregation patterns based on income (proportion of low and high income) and ethnicity (proportion of people born outside the Nordic region and Western Europe and the proportion of people born in Sweden) 1990 (Figure 24) and 2008 (Figure 25)



Source: Salonen, 2012

The analysis shows a clear correlation between socio-economic and ethnic distribution in housing in Malmö. Simply put, class and ethnicity increasingly coincide with residential area in Malmö. Individuals tend to a great extent to live with people who are similar to themselves. The proportion of the population who lived in mixed areas (green) was in the majority in Malmö in 1990. Nearly two thirds lived in green areas. By 2008, this proportion had been reduced to half of the population. Instead there has been a marked increase in population in blue areas, dominated by economically resource-poor people and a high concentration of people born outside Western Europe. The majority of Malmö's population lives in such areas today. (72). Research also shows that people who have immigrated have a poorer income development if they live for a long time in areas with a high proportion of people from their own minority group, in relation to those who do not live in ethnically homogenous areas. (103). In comparisons with other Swedish cities Malmö stands out. The economically resource-strong areas are relatively few, which among other things is explained by the fact that such areas are to be found in municipalities surrounding Malmö (72).

It is important to point out that segregation does not necessarily need to be a problem, for example, if elderly people live in one part of the city and young people live in another or if people with different backgrounds themselves choose to reside in

different areas. It does however become a problem if the differences relate to prerequisites for participation in society, contribute to health inequity and if people do not have the opportunity to choose for themselves. Stigendal (73) links this difference to the relationship between social inclusion and social exclusion and argues that it is because society has developed into a state of social inclusion with stringent conditions for participation that social exclusion has arisen. Social exclusion is characterised by a lack of participation. If people with a high or low degree of participation in society live in different parts of the city, segregation coincides with the difference between social inclusion and social exclusion.

Abrahamsson (75) refers to research on how perceived exclusion can bring about strong frustration which can be expressed in different ways. Frustration arises when the gap between people's expectations and needs, and what they can actually achieve, creates feelings of unfairness. Sometimes this frustration can contribute to something constructive and assists people in improving their situation. Research has observed that similar frustration gaps can be transformed into individual guilt and suppressed feelings of shame in cases of low social mobility or when prospects are lacking for other reasons. This guilt, and its associated feelings of shame, increases when people are exposed to different types of discrimination. Sometimes, this frustration is expressed violently.



O OBJECTIVE 1.2.2

Urban planning should contribute to reducing residential segregation.

In order to reduce segregation, strategies are required which target both social differences and spatial separation. According to Salonen's analysis it is the overall income inequality that has been driving residential segregation. This means that area-focused interventions are not enough. Actions that are able to affect income inequality in general are also required. It is improved economic conditions which lay the foundation for people to be able to choose for themselves where they settle and enable them to have control over their own lives. Factors influencing income inequality are presented in Section 2, Chapter 2. The fact that housing construction in Malmö for a long time has failed to meet the increased demand for housing as a result of the growing population, may have further exacerbated the situation.

A ACTION 1.2.2.1

Introduce social impact assessments which should precede any decision concerning physical investments.

Decisions concerning physical and spatial investments (buildings, facilities, public services and meeting places) will help to reduce segregation, enhance cohesion and promote a positive health trend, contribute to reducing environmental impacts and also create the conditions for economic growth. Impact analysis, from the Commission's perspective, should have a particular focus on health inequities and include both social determinants and opportunities for a healthy lifestyle.

A ACTION 1.2.2.2

Develop and intensify the successful work on mixing different forms of tenure, types of housing, workplaces and services.

By means of urban planning the municipality could contribute to the development of different types of housing, tenures, public environments, workplaces and services which are currently lacking and which can provide more mixed uses and population groups in each city district. Mixed tenures have been a guiding principle of urban planning during much of the post-War period. This has largely been successful and turned Malmö into one of the most diverse cities in Europe in terms of types of tenure. This is also based on the existence of public housing and cooperative housing associations, two types of tenure which are relatively unique to Sweden. The mixture of these has helped to counter segregation. In cities where entire city districts consist of a single type of tenure, such as social housing (a type of tenure that had not existed in Sweden up until now), segregation is significantly worse (103).

The Commission suggests that the municipality work actively with densification and complementary building to increase the variation and services in areas of uniform building stock and to develop small scale and diversity, especially in large-scale neighbourhoods.

A ACTION 1.2.2.3

Transform barriers into linking areas.

Barriers and structures that separate residential areas should be removed. This mainly involves reducing the barrier effects which were created by traditional planning models. Coherent and distinct routes can contribute to bridging barriers of this kind and turning traffic routes into city streets can give such routes active functions. Densification should contribute to connecting the areas better to each other, increasing security and services through increased street life and higher quality outdoor environments and parks. Pedestrian and bicycle traffic and public transportation should at the same time be given better prerequisites to connect the city areas.

A ACTION 1.2.2.4

Invest in two major city improvement projects – “Amiralsstaden” and “Bygga om Dialogen” (Rebuild Dialogue).

Integrated and sustainable physical improvement and development of residential environments should help to reduce residential segregation. For this two model projects are suggested where the Commission's recommendations can be put into practice using new innovative approaches and structures. The projects' level of ambition should correspond to the intervention before the international housing exposition in Malmö in 2001 (Bo01), and the conversion of the harbour area, when creating the new city area “Västra hamnen” (The Western Harbour). The planned physical interventions should be health-promoting, bridge barriers, improve access, increase safety and trust, increase participation, increase attraction and become a tool for local mobilisation and the creation of local jobs. This requires a mandate from national and regional stakeholders so that the City of Malmö is able to test new economic models based on a long-term social investment perspective. A major driving force should also be to make solutions climate-friendly. The proposal includes “Amiralsstaden” and “Bygga om Dialogen” in “Lindängen”. (See Appendix 4)

Near the Continental railway line and the street “Amiralsgatan”, the “Amiralsstaden” project could improve the city areas of “Annelund”, “Östra Sorgenfri”, “Emilstorp” and “Rosengård”. “Amiralsgatan” is one of the barriers that needs to be converted from a traffic route to a city street, on a scale that better suits people's need for experiences and proximity.

“Bygga om Dialogen” is also linked to the principle of long-term social investments with a very clear participatory perspective, that is, where the implementation is an example of a governance process involving the relevant private property companies and the City Planning Office as well as the residents themselves of the homes that are to be rebuilt. The project is also an example of a holistic perspective where the rebuilding meets stringent environmental requirements and a significant part of the necessary workforce is recruited from the population in the area and, if required, undergoes training for this type of work. Thus, the project has economic as well as ecological and social sustainability in mind, in an integrated perspective.

This action includes approaching the state in order to give the City a mandate to try out new models. This may involve investigating “affordable housing”, drawing up a renewed contact with the Construction Cost Delegation, facilitating legislation and changing the directives for credit institutions.

1.2.3 TRUST

Emmelin and Eriksson have written a background report on social capital. According to the authors social capital includes “our social networks, our social support, our opportunities to participate in social life and the degree of social belonging in our local environment, something that has great importance for our perceived and mental health, both at an individual and a societal level (our translation) (74). The report describes social capital, both as an individual asset and a collective resource at the area level. The question that the background report seeks to answer, based on a review of various scientific work, is whether social capital can be “built into” the residential area to improve and increase health equity.

The concept of social capital, as well as the various definitions of this that have been suggested, has been subject to a lively debate among different researchers. In the international scientific literature that relates to studies of the link between social capital and health, the concept has most frequently been operationalised as generalised trust or social participation, according to Robert Putman's model. In this, trust is seen as the central concept that arises through social participation which generates trust between the participants, which in turn creates shared values. The connection between the built environment and trust is mainly assumed to lie in the opportunities to stimulate social participation by creating meeting places of both a spontaneous and a planned nature (for example through clubs and societies, public and commercial services, etc.). There are many definitions of social capital other than Putnam's, but these are less used with regard to studies of the effects on health.

Whatever concept is chosen, the Commission completely agrees that networks, support, participation in society and belonging are of great importance to health. The Malmö Commission is aware of the criticism, but has still chosen to make use of the term social capital. Much research has been carried out starting from the concept of social capital, which is reported in one of the background reports (74). The authors draw five conclusions about how social capital can be promoted.

Firstly, social interaction in the area must be facilitated, for example by establishing places where residents of the area can meet naturally. The need for meeting places, such as playgrounds, however differs for different groups and over time which is why mapping the local needs is recommended.

Secondly, investments must be made in attractive green and recreation areas. In addition to the fact that green areas can provide relaxation and reduce stress, access to parks has proved to increase the chances of informal encounters and thereby the development of social support and social capital. The residential area being “walk-friendly” can also invoke a sense of neighbourhood and of trust in the ability affect the residential environment together. Shared responsibility for the outdoor environment, through for example joint “cleaning evenings” of courtyards and playgrounds, may also increase the sense of neighbourhood.

Thirdly, it is important to satisfy the need for security. Security and trust are important for health and the likelihood of encounters between people increases when the inhabitants feel secure about moving freely in their residential area. Implementing “security walks” to identify unsafe locations and discuss solutions can be a way to increase security and trust between people and thus strengthen the social capital of the residential area.

Fourthly, the reputation of marginalized areas must be improved. An area with a good reputation gives a sense of status and strengthens the sense of belonging among the residents, that is, what is called social integration. Improving an area's reputation can be challenging and requires both political will and co-operation with the local media. Refurbishment of housing and public facilities as well as the establishment of attractive community services can certainly contribute to an improved reputation for particularly marginalized areas.

Fifthly, the authors advocate a balance between so-called bonding and bridging social capital. Bonding social capital mainly comprises the strong ties within a network that strengthen a common identity and which contribute to support within the group or network. Bridging social capital refers to the weaker ties that bring people together from different networks and thereby, among other things, contributes to the exchange of information. Actions for solely strengthening bonding social capital can lead to social exclusion and mistrust between people. It is necessary to create inclusive environments in which cohesion between different types of individuals and groups is encouraged. Here the established local voluntary associations are of considerable importance for providing individuals with the opportunity to meet in a context of common interest and thereby also promote bridging social capital.

Maria Rosvall and her colleagues subscribe to the concept of social capital in Region Skåne's assessment of trust. The authors define trust as the cognitive aspect of the concept of

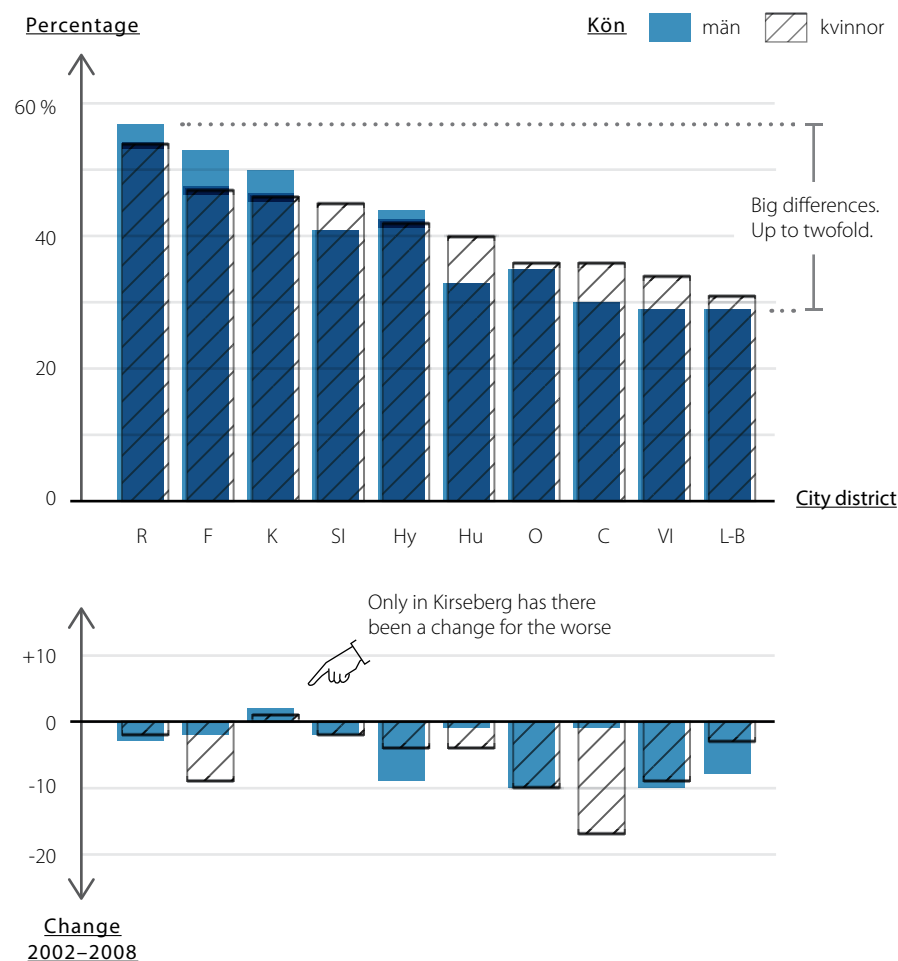


social capital while social participation in different social activities in the community and belonging to a social network are defined as the structural aspects of social capital. "A community with a lot of social capital, that is, high trust, mutual support and a high degree of participation in everyday life, is often a community that is characterised by more co-operation, stronger societal institutions, stronger economic development and better public health" (11).

In the public health survey in Skåne in 2008 which is conducted every fourth year a positive link between social capital and good health emerges. Despite a reduction in the latest assessment, around 40 per cent of the adult participants in the survey who lived in Malmö still reported low trust towards other people. In the nation as a whole the proportion with low trust was 26 per cent (among both men and women). In more than half of Malmö's ten city districts the proportion with low trust has decreased among both men and women during the period 2000–2008. The differences between city districts are large and range between 29 per cent and 57 per cent for men with low trust. A similar pattern can be seen among women where the proportion with low trust was 31 per cent in one city district compared with 54 per cent in the one with the highest proportion of individuals reporting low trust. Low trust is more common among younger than older individuals in Malmö. The proportion with low trust towards others has generally decreased among individuals in the workforce but increased in groups without work. Among men with a low level of education the proportion with low trust instead increased from 41 per cent to 53 per cent and among women from 50 per cent to 54 per cent. Among people born in Sweden the proportion with low trust was lower than among people born abroad. However, in the group born outside Europe the proportion with low trust has decreased among men from 65 per cent to 54 per cent and among women from 59 per cent to 49 per cent (11). See Figure 26.

The information in the figure can be compared with the results of Levnadsundersökningen i Fösie 2006 (the Survey of Living Conditions made in the area of "Fösie" 2006). Although it did not contain any question about trust explicitly, the statement "I feel like

Figure 26: Proportion (per cent) of the population in Malmö's city districts of 18-80 years of age with low trust in other people 2008, and changes 2002-2008.



Source: Public health survey Skåne 2002 and 2008, Region Skåne

a participant in Swedish society” was included which those interviewed had taken a position on. Twenty-two per cent of the residents (18-74 years) disagreed and thus did not have a sense of participation in Swedish society. Seventeen per cent were indifferent, while 40 per cent more or less had a sense of participation. There were large differences between the subareas. In the subarea “Eriksfält” which almost solely consists of owner-occupier accommodation, 12 per cent did not have a sense of participation in Swedish society, while the corresponding proportion for subarea “Hermödsdal”, which consists entirely of tenancies, of which 95 per cent are owned by private landlords, amounted to 30 per cent. “Eriksfält” and “Hermödsdal” may be said to comprise two opposite segregation poles in the city district of “Fosie” in the measurement of the sense of participation in Swedish society. (104)

O OBJECTIVE 1.2.3

Urban planning should contribute to strengthening trust and promoting good and accessible environments and meeting places that invite participation.

There is a great deal the municipality can do to build social capital into the residential areas and the city (74). This can be in terms of places that facilitate meetings in the residential area (bonding social capital) but also places that generate meetings between different groups from different parts of the city (bridging social capital).

The needs in relation to the demographic situation should be identified and compared so that deficiencies can be corrected. Refurbishment of housing and public facilities as well as the establishment of attractive community services can certainly contribute to an improved reputation for particularly vulnerable areas. The City of Malmö is planning to build 20 new schools and preschools. We propose that the location of these and the surrounding environment around the preschools and schools be carefully evaluated in order to promote health and strengthen the social capital in an area. The same applies to investments in infrastructure and conditions for the localisation of workplaces.

A ACTION 1.2.3.1

Create more accessible meeting places, especially in areas with great overcrowding.

We should strive to build in/enhance the social capital in residential areas by facilitating social interaction in which the residents can meet naturally on the stairs, around the courtyard, in the residential block and in the area. To add new attractions in a residential area, such as a swimming pool, a theme park or a new concert hall, can provide incentives for the city's residents to visit and stay in all parts of the city. The locations of such attractions should be mainly in places where communications are good and where the meeting place can function as a bridge between city districts. The city can take inspiration from for example Idea Stores in London and Toy Library in Italy (101).

Sports, culture, and voluntary associations have a great potential to promote “bridging social capital”. Therefore city planners should form knowledge alliances with representatives of the culture sector and voluntary associations as well as with the research community, in order to offer Malmö residents the opportunities of the currently lively cultural and voluntary sectors which create both actual participation and a sense of participation. Voluntary associations include those focusing on sports but also other types of activities.

Security and trust can be strengthened through a deliberate urban design that gathers street life and movement to active thoroughfares instead of spreading it to many thoroughfares. An active thoroughfare means that there are a lot of entrances and windows that cater to different types of functions along the edges. Within residential areas a small scale and clear boundaries of responsibility can help the residents to find “their” place, which they can defend and be proud about.

Safe residential areas have an ordered structure in which it is easy to orientate oneself and understand where the limits of responsibility are. Many post-War areas lack such structures and also are on a scale which functions as a clear marking of differences in status between areas. These areas do not just need facades and courtyards to be renovated, but also changes to the existing infrastructure with regard to pedestrian, cycle and vehicle routes, in order to improve connections and access. Many of these areas also lack clarity about what is private, semi-private, semi-public and public. Planning actions that clarify the boundaries strengthen the perception of trust, safety and security, and are mainly needed in the city districts where safety is today perceived as low.

A ACTION 1.2.3.2

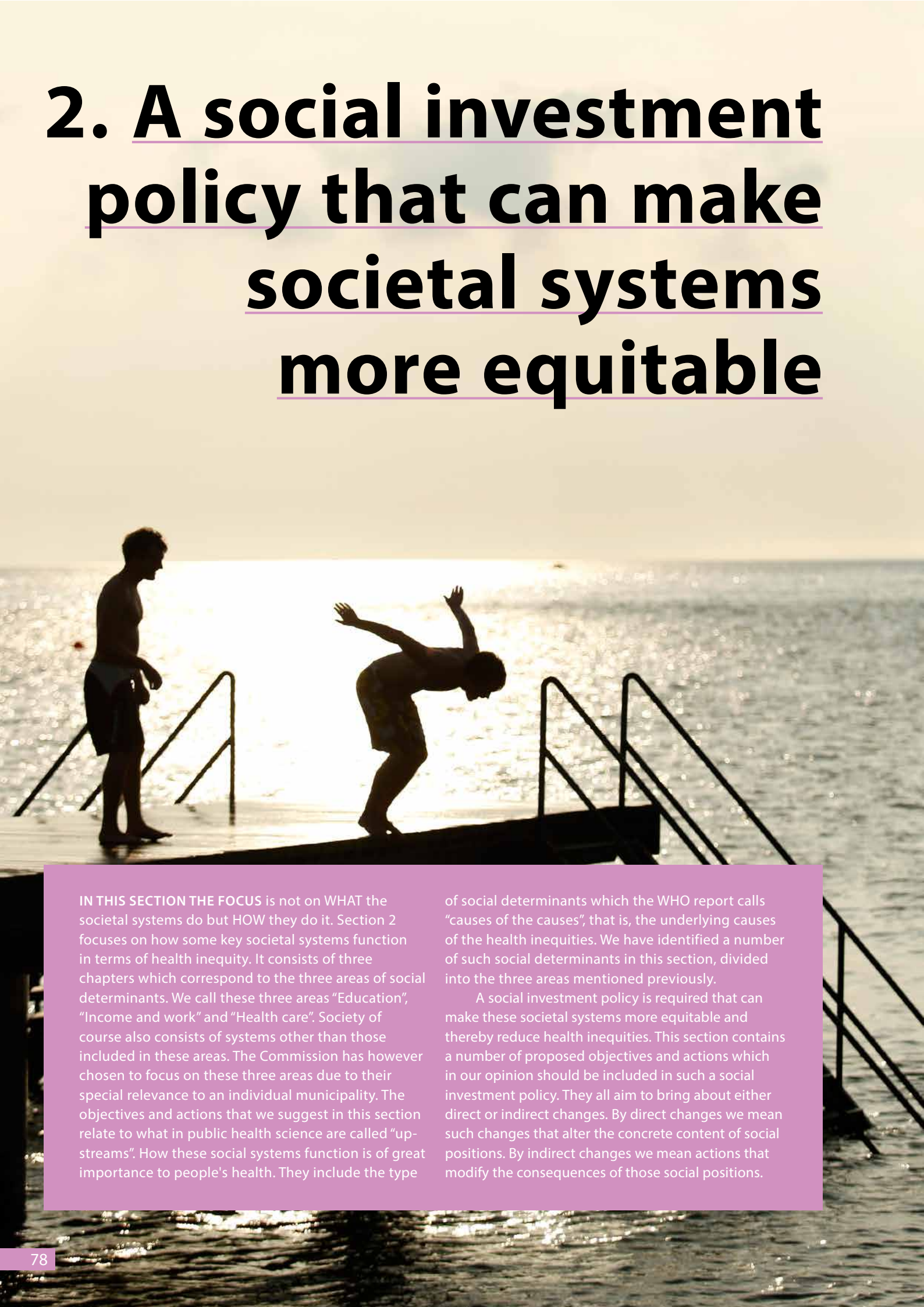
Urban planning should contribute to strengthening the inhabitants' participation and influence.

Urban planning processes have the potential to engage residents to bring about more purposefully designed physical environments and to improve participation and the ability to influence. A residential area that has involved residents in decisions and maintenance can show stability with less vandalism and an increased sense of security.

It is suggested that the municipality develop dialogue models when physical plans are drawn up and to a greater extent try planning methods in which residents can have more influence over the final physical results. This entails increased preparedness from the authorities when residents wish to influence their surroundings.

The City of Malmö should increase equity in the public environment by involving girls and boys, women and men in the assessment of needs and the design process of new places in the city. A focussed and continuous participatory process directed towards the target group is needed to meet the wants and needs of places for meetings, physical activity and feeling free to use the urban space. This should take place early in a planning process and include gender analysis of the space's present use and an assessment of needs in the area. Participation should continue once the place is brought into use, in order to establish and maintain equity in its use.

2. A social investment policy that can make societal systems more equitable



IN THIS SECTION THE FOCUS is not on WHAT the societal systems do but HOW they do it. Section 2 focuses on how some key societal systems function in terms of health inequity. It consists of three chapters which correspond to the three areas of social determinants. We call these three areas “Education”, “Income and work” and “Health care”. Society of course also consists of systems other than those included in these areas. The Commission has however chosen to focus on these three areas due to their special relevance to an individual municipality. The objectives and actions that we suggest in this section relate to what in public health science are called “up-streams”. How these social systems function is of great importance to people's health. They include the type

of social determinants which the WHO report calls “causes of the causes”, that is, the underlying causes of the health inequities. We have identified a number of such social determinants in this section, divided into the three areas mentioned previously.

A social investment policy is required that can make these societal systems more equitable and thereby reduce health inequities. This section contains a number of proposed objectives and actions which in our opinion should be included in such a social investment policy. They all aim to bring about either direct or indirect changes. By direct changes we mean such changes that alter the concrete content of social positions. By indirect changes we mean actions that modify the consequences of those social positions.

2.1 Education

EDUCATION IS THE societal structure which has the greatest potential to equip children and young people with the capacity to exceed the family background's social limitations and develop good health. Marmot puts it this way: "There is strong evidence that educational achievement leads to a range of positive outcomes, including good health".

(9) And while research, evaluations, inspection reports and statistics show that a lot has happened in terms of the quality of teaching – with new teaching methods, facilities and better trained teachers – the same sources nevertheless show that in Sweden we are currently moving in the opposite direction in relation to the objective of an equitable school where all pupils are given the conditions to finish school based on their capacities (105). Why is this? What are the limiting and restricting factors? What is the current situation in Malmö's educational institutions? And not least, what can be done, who will do it, how and with what resources in order to overcome the factors that create and sustain the performance gap between children and young people in different parts of Malmö?

To sum up, overall Malmö's educational institutions face four major challenges.

The first relates to differences in socio-economic conditions at an individual, group and residential area level. The unequal distribution of social and economic conditions among Malmö's population is clearly shown in the other chapters in this Final Report. Educational research is unanimous that the pupils' socio-economic background is the most important factor for achievement of grades and for pupils in general to achieve final grades or complete upper secondary school studies. A continued uneven distribution of living conditions will lead to continued significant differences in school performance between pupils and between schools in Malmö.

The second is the untapped potential in Malmö's educational institutions and the challenge is to unlock this potential. Compulsory school and the voluntary forms of education can be developed by raising the quality of educational programmes and by a conscious effort to increase equity in all types of education. Quality-raising actions include both structural environmental factors and how teaching processes can be developed.

The third is that the city of Malmö receives relatively many newly arrived pupils, pupils who have immigrated to Sweden after the normal start of school. For an initial period these pupils are in need of special support in order to catch up with their Swedish-born classmates language-wise and subject-wise. We know that newly arrived pupils are a very heterogeneous group and that they are unevenly distributed across Malmö's schools. This means that the educational institutions face the task of providing thought-out, purposeful and flexible organisational, educational and social conditions adapted to the pupils' needs that can lead to the attainment of educational objectives.

The fourth is that Malmö's educational institutions share much the same challenges as many other municipalities in Sweden in terms of distribution of resources, skills development, differences between boys' and girls' school performances, upper secondary school drop-outs, the role and function of after-school centres, the introduction of new educational models and the development of existing ones and relationships between different stakeholders in and around the school. Malmö's socio-economic situation and multi-cultural composition however further accentuate these conditions and their management in everyday political and educational practices.

In order to more closely study what the four general challenges mean in practice and how they have so far been managed in Malmö's educational institutions (and with what consequences, including health), the Commission has drawn up ten or so background reports anchored in Swedish and international research. We have reported research that highlights the importance of early interventions in preschool, the socio-economic background's importance to pupils' school performances, arrival in Sweden



after the normal start of school and residential segregation. We have also touched upon educational policy reforms, such as freedom of choice, preschools' and schools' potential and local organisation, dropping out from upper secondary school, the challenges faced by after-school centres, alternative forms of schooling, co-operation with parents and the quality of educational models for work with children who do not have Swedish as their native language. In this chapter we summarise sections of the report's findings and related analyses.

2.1.1 EQUITY AND HIGH QUALITY

Pupils' performance differences at school are reflected in health disparities between groups, schools and city districts. Reducing differences by increasing the most vulnerable groups' opportunities for equitable education, higher grades, well-being and cultural recognition has a direct connection to pupils' physical and mental health. That a pupil's socio-economic background has important implications for school results has been confirmed in every study which has analysed the connection between a pupil's background and results. But, there are also significant differences in the results between pupils with a Swedish background and pupils with a foreign background, even after adjusting for the pupils' socio-economic background. These differences in grades have however decreased over time with regard to pupils born in Sweden with a foreign background but increased in terms of foreign-born pupils. School segregation based on foreign background has increased during the whole of the 00s and especially in the metropolitan cities. (105)

From an international and historical point of view, Sweden has had relatively small differences in results between schools. Sweden's position has however gradually deteriorated and in the latest PISA survey Sweden looks like a fairly average country in terms of aspects of equity (105). The assessment is based on the fact that the variation in schools' average results has increased sharply and that the composition of pupils in schools is of increasing importance to the pupils' results. Differences between schools are greatest in the metropolitan cities, Stockholm, Gothenburg and Malmö. Peer effects and teacher expectations likely play a role and possibly also increase differences in quality between schools. All this means that which school a pupil goes to has become more significant. Freedom of choice and decentralisation reforms in the beginning of the 1990s have most likely contributed to this development even though other factors may also have played a role. In the light of this, investments which strengthen the socially most vulnerable pupil groups through education appear to be an overriding task for education policy. From this point of view, the educational institutions' lack of equity and the increasing differences between schools are becoming a key problem to draw attention to.

An important question is what the educational institutions can do to increase equity and generally raise the quality of teaching. The most important factors in the school's internal work that contribute to pupils' achievement of objectives are, according to Hattie (106), teachers' professionalism and the quality of interaction between teachers and pupils. Engaged, active and pupil-focused teachers get pupils to do better at school. The teacher's relational skills are crucially important to pupils' success at school. The ability to provide feedback to the pupil is vital in this respect. The ongoing individualisation in Swedish schools, in the sense that pupils are increasingly busy with their own work, has however no support in research about what promotes pupils' performance. Another aspect of teachers' competence is what researchers call management skills in the classroom. Teachers' diverse organisation of teaching, a clear delegation of responsibilities and a measure of order and structure favour pupils' learning. The teaching should be characterised by feedback to previous teaching and contextual progression and focus on the curriculum's key principles and essential content, rather than on details.

All in all, the teacher appears to be the single most important factor for pupils' results at school. It is the teacher who can make a difference and thus the teacher is important as a counterforce to the structural factors, parents' educational background, pupils' gender and immigration after the normal start of school, which most strongly influence the pupils' ability to succeed at school. Teacher competence is a matter of, in co-operation with colleagues and parents, meeting pupils based on an understanding of their social, cultural and individual prerequisites, but without this leading to lower expectations or demands.

In addition to what happens in the meeting between teacher and child/pupil, the meeting with parents is an important factor. Laid Bouakaz was commissioned to write a

Equitable education

Equitable education is a fundamental part of Swedish society. Equitable education is about everyone's opportunities irrespective of background and where in the country they live. Equity in education does not mean that education should be uniform or the same for everyone. Equity can be seen as being based on three aspects: equal access to education, equal quality of education and that the education should compensate for social inequities. All pupils should be given the chance to achieve good study results. The pupils' social background should not matter to his or her study results and it shouldn't matter which school a pupil goes to. (105)

report on parental participation in multi-cultural environments that particularly describes the importance and potentials of so-called complementary schools (107). The question of the school's co-operation with parents is important and needs to be developed and studied further.

In the introduction we pointed out that there are four major challenges for Malmö's educational institutions to respond to. The Commission supports the eight objectives and accompanying actions associated with them and which jointly respond to these four challenges. The first objective and associated actions cut across all educational levels that affect children and young people, objectives two to six are school- and age-specific while objectives seven and eight have to do with Malmö's specific population composition.

O OBJECTIVE 2.1.1

All children and young people in the city of Malmö should have access to equitable preschools/after-school centres/schools of high quality.

A ACTION 2.1.1.1

Conduct a thorough survey of resource needs in the city's educational institutions accompanied by a financial plan.

The City of Malmö's Education Department should be given the task of making an survey of resource needs and drawing up a plan with suggestions on how the needs can be met. The plan should contain additional resources in the short and long term, and extra funds that for a limited period should go to the educational institutions with the greatest needs which are defined based on a number of criteria; socio-economic background, the number of pupils with a native language other than Swedish, achievement of objectives, etc.

A ACTION 2.1.1.2

The knowledge-supporting structures in the city must be strengthened.

Each type of school should use a reliable and scientifically proven instrument for systematic quality work/quality development. The City of Malmö should work from scientifically based success criteria for Malmö's schools as a complement to grade results. The criteria can be used to highlight the schools' strengths and weaknesses at different levels. It is a priority that the municipality has support structures to ensure this. Based on the present structure it is suggested that FoU Malmö-utbildning (R&D Malmö-Education) is merged with CPI, Centrum för Pedagogisk Inspiration (Centre for Educational Inspiration) and thereby continues to develop Malmö into a research-based school development municipality.

A ACTION 2.1.1.3

Staff who work in the City's educational institutions must have a high level of knowledge and opportunities for professional development. Continue to invest in professional development, what is called Skolsatsning 2012 (School Investment 2012), for increased competence among teachers at all levels in order to manage the transfer to the new Education Act, curricula and syllabi.

FoU Malmö – Utbildning and CPI

FoU Malmö-utbildning (R & D Malmö- Education) started in 2005, at that time as Resurscentrum för mångfaldens skola (Resource centre for a diverse school). Since 2008 the unit belongs to the City Office's department for children and young people, and is a part of the co-operation between the City of Malmö and Malmö University. The unit's mission is to support various forms of research-based school development. Examples include postgraduate educators responsible for different areas of development, educators in postgraduate education, research circles and seminars that present current educational research.

CPI - Centrum för pedagogisk inspiration (Centre for Pedagogical Inspiration) is the City of Malmö's central resource for pedagogic inspiration and development. The unit works in conjunction with staff in preschool, compulsory school and adult education. CPI offers inspirational activities, skills development, advanced training, advice and support. In addition CPI develops and manages both the media system SELMA and the inspiration website Pedagog Malmö (Educator Malmö).

Special interventions should be made to recruit and retain university-trained staff in socially vulnerable areas. This can be done by offering favourable work and development opportunities which are designed in agreement with the relevant unions. In co-operation with Malmö University investments should also be made to provide further training to child minders at preschools, with the highest priority for those who work in socially vulnerable areas. In connection with this and in co-operation with Malmö University, the City of Malmö should pursue the question of increasing the number of places in preschool teacher training in order to provide for the need of university-trained staff. Efforts should also be made to recruit university-trained after-school teachers.

Skolsatsning 2012

Skolsatsning 2012 (School investment 2012) is a long-term language development initiative within educational services in the City of Malmö. The initiative was decided on by Malmö City Executive Board and is being implemented by FoU Malmö-utbildning (R & D Malmö-education).

The intervention covers all educational institutions: preschool, after-school centres, compulsory school, upper secondary school and adult education, and has three clear focuses:

- *Content-based language development*
Work on the pupil's language development is integrated into all subject teaching.
- *Multi-lingual subject teaching*
Strengthening multi-lingual pupils in their native language and in the Swedish language in parallel.
- *Formative assessment or assessment of learning*
Ongoing feedback regarding where the pupil is in relation to the objective.

A ACTION 2.1.1.4

The results of each type of school's systematic quality work should form the basis for how the staff's continuing professional education and further training is prioritised.

Continuing professional education and further training are among the most effective actions for raising quality. Further training should take its starting point in the staff's own practice, take place over a long period of time and have continuity. Special attention should be directed towards after-school centre staff. Intensified professional development in terms of the after-school centre's educational task should be provided to after-school centre staff.

A ACTION 2.1.1.5

The influence of children and youths on everyday activities at preschool, after-school centres and school, based on the prevailing conditions at every school level, should be strengthened by actively including them in systematic quality work. This also applies to parental influence.

School's democratic objective is about contributing to: creating independent and knowledgeable/competent citizens who are prepared for active citizenship; defend and develop democratic institutions; defend and develop respect for human rights; defend and develop respect for differences. The democratic objective is also about the school's way of working being characterised by equity and striving to level out social differences and reduce health inequities. The influence of pupils over forms of management and types of work and teaching through different formal arenas (class councils, pupil councils and advisory bodies) as well as informal ones (deliberative democracy) leads to the development of the pupils' competence as citizens and a more favourable learning climate (108-111). Developed parental support

and collaboration can contribute to reduced social inequality, provided that the service is designed so that all parents are given the opportunity to be participants.

A ACTION 2.1.1.6

Educational institutions should actively work with health-related issues through strengthening the subject of Physical education and Health given to all pupils in the City of Malmö's schools.

Opportunities for children and young people to exercise, play and engage in sports increase physical and mental health. Studies done in Malmö also show that increased investment in Physical education and Health leads to improved school performances. The so-called Bunkeflo Model, which is also reported on in Section 2, Chapter 3, could in this context serve as a model for increased investments in Physical education and Health.

Health-economic calculations of action 2.1.5.1

This action has undergone a health-economic analysis which shows that the introduction of daily physical education and health in all of Malmö's compulsory schools would increase the potential production value by SEK 59 million during the 10-year period after leaving primary and secondary school. The higher levels of education which it is demonstrated that the action would lead to would in addition help reduce morbidity costs by almost as much; SEK 56 million (the increase occurs in comparison with scheduled physical education and health remaining the same as today). These values exceed the approximately SEK 16 million that costs of staff and premises to carry out the investment amount to. The result per pupil in the age group corresponds to an investment cost of SEK 4,600 for all nine years of compulsory school with expected productivity gains and reduced morbidity costs of SEK 38,000 over the 10 years after the end of primary and secondary school. (75) (80)

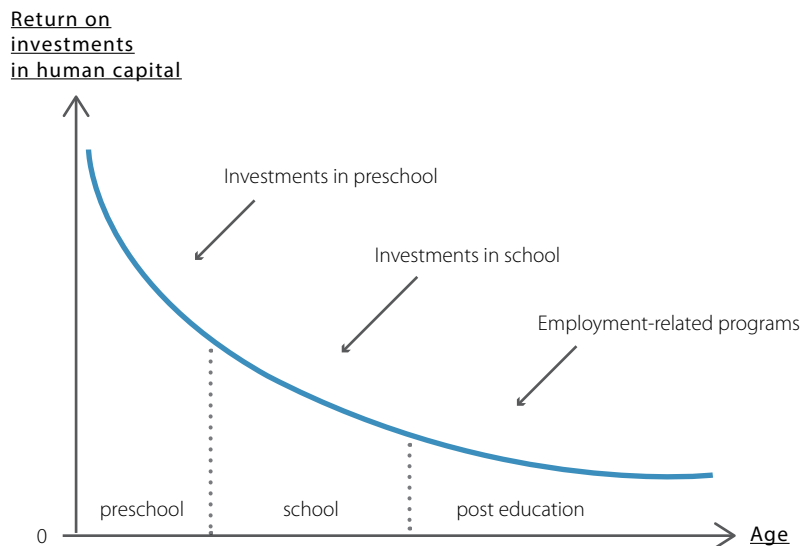
The Bunkeflo Model

The Bunkeflo project started in the autumn of 1999 as a co-operation project between schools, sports associations and researchers. The project has been evaluated on a scientific basis and has shown to produce positive effects on both immediate health and the pupils' school performance. The Bunkeflo project was launched at "Ängslättskolan" school in "Bunkeflostrand", and the local sports association helped make it possible by providing children in Years 1 and 2 one hour of physical activity a day – every day. All new children starting Year 1 have physical activity as a daily, compulsory subject. (112)

2.1.2 THE IMPORTANCE OF PRESCHOOL IN CHILDREN'S DEVELOPMENT, LEARNING AND HEALTH

There is convincing research evidence that preschool has long-term positive effects on children's learning and development and that these effects tend to be stable for a long period (113–121). Early investments in preschool are socio-economically profitable and have great importance in promoting the health of the population.

Figure 27: Calculation of return on investment in human capital for children from resource-poor conditions from a life perspective



Source: Heckman 2006 in Persson, 2012

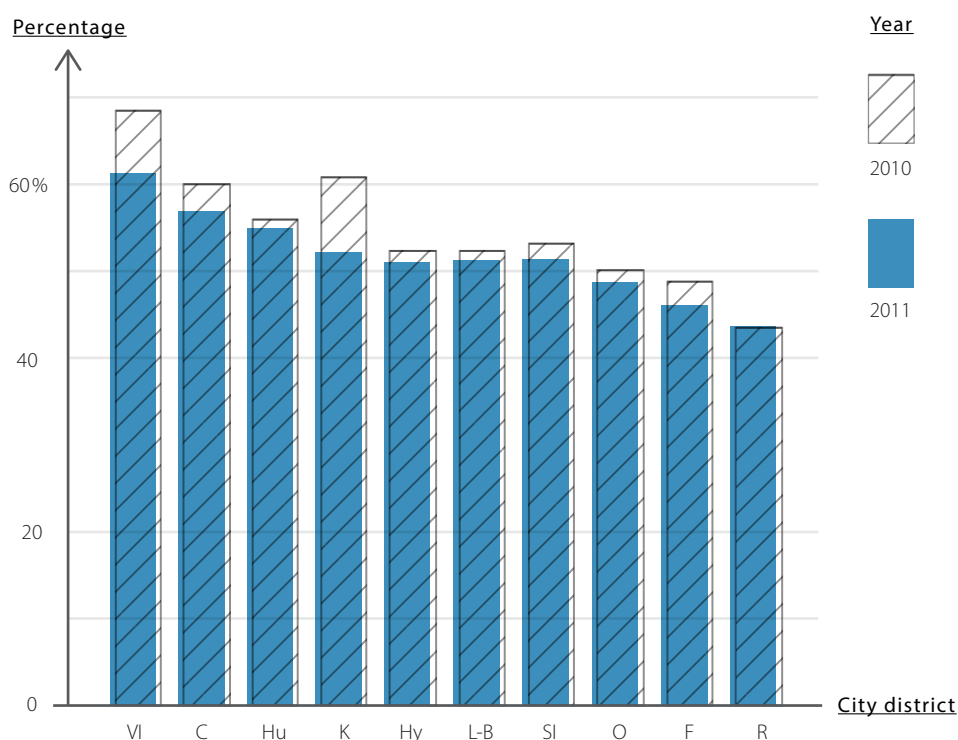
Figure 27 shows that early investments in preschool are what from a life expectancy point of view give the greatest dividends. This is calculated on the return on invested human capital for children from resource-poor conditions, divided into types of school.

Research shows that preschool is most important to children whose parents have limited socio-economic conditions and for children at risk (122). Health risks for children are linked to the family's social status and socio-economic conditions, and research indicates that a preschool of good quality promotes social equality. Children from vulnerable socio-economic conditions and children at risk are therefore those who benefit the most from attending a preschool of high quality with professional teachers and by being in groups of children from different socio-economic backgrounds. Staff training and competence are crucial for these effects to be achieved. Statistics from Malmö however show that children in areas with few socio-economic resources usually have teachers with lower levels of education.

Secure relationships at preschool

In Malmö the cooperative group ALMA implemented a preschool project for complementary attachment persons at preschool, which was evaluated by Birthe Hagström (2010). The project was targeted at children in vulnerable living environments. Based on the project, preschools in Kirseberg have developed their work concerning young children in vulnerable living situations. The aim of the project "Young children" is that children in exposed living environments from an early age should develop abilities such as responsiveness, communication, emotion management, empathy and co-operation by giving them the opportunity to attach to a person outside the home.

Figure 28: The proportion of staff with higher education training per city district 2010 and 2011



Source: City Office, 2011b in Persson, 2012

Figure 28 shows that preschools with children from areas where parents have poorer social and economic resources have staff with a lower level of education than children in areas where families have better social and economic conditions. To some extent, these differences between city districts are most likely explained by efforts made in these districts to find staff with the right linguistic backgrounds. There may also be difficulties in recruiting university-trained staff for some city districts. The variation is also large within city districts, this applies especially to the most economically vulnerable city districts.

The child's ability to cope with and adapt to adverse life events varies greatly from child to child, but it is possible to discern some of the most significant factors. The children that fare best in difficult circumstances are those who have at least one secure relationship with adults outside the family, get help to work through their painful experiences and to manage their current situation as well as possible and experience consistency and continuity in their lives. Preschool staff can in other words serve as complementary attachment persons.

The single most important quality aspect is the pedagogical relationship between preschool staff and children. Common to those studies that show that preschool has positive effects on children's learning and development is that *every child* is seen as, and allowed to be, active, engaged and co-creating. Preschool has great potential as an arena for integration. The diversity and mobility of modern childhood combined with preschools' increased educational responsibility, places great demands on the development of inclusive teaching methods and subject didactics at preschool. Preschool staff have to relate to and use this diversity of languages, cultural expressions, semiotic mediations and differences in childhood conditions to create inclusive learning environments. Diversity therefore provides content and meaning in concrete learning and care situations which preschool staff have to act in.

The child's perspective and influence is also an important aspect of quality. In preschools characterised by high quality pedagogical relationships there is a negotiating climate between preschool staff and children where agreements are made about the theme and activities to work on. From an early age, children gain an understanding of what health and well-being mean. Children's views on health are consistent with an approach where health is viewed from several different dimensions, that is, physical symptoms, social aspects (such as participation and activity) and factors in the local environment.

Children mainly say they feel good when they are engaged in different activities and situations that occur in day-to-day life at preschool (122). The extent to which children are engaged in their own development and their everyday lives can thus be said to constitute a measure of physical health.

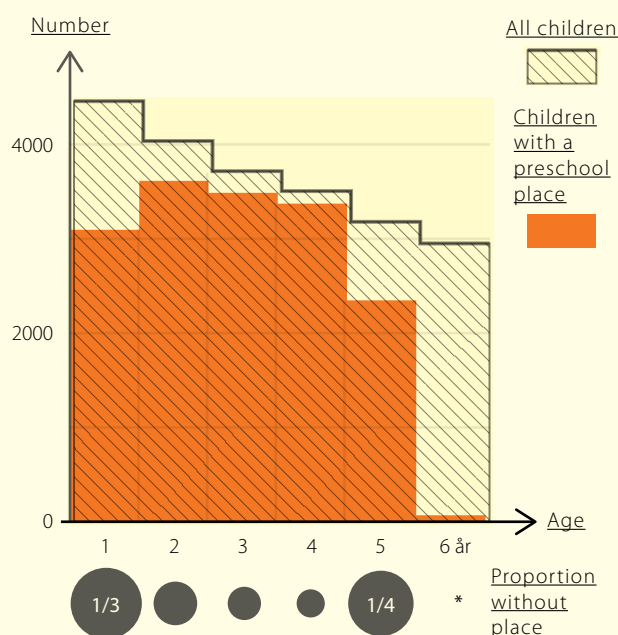
Based on these conclusions and analysis of the situation in Malmö, the Commission has formulated some objectives and suggests a number of actions to ensure that these objectives are attained. Those that specifically apply to preschool are as follows:

O OBJECTIVE 2.1.2

All children of preschool age in Malmö should attend a preschool of good quality at least 20 hours a week by 2015.

The diagram below shows the number of children in various age groups who had a place at a preschool in Malmö in October 2010.

Figure 29: The number of children with a preschool place, divided according to age



Source: Persson, 2012 *Nearly all 6-year-olds attend a preschool class

A OBJECTIVE 2.1.2.1

Map out which children are outside preschool followed by active outreach work and adapted information to parents who do not have their children in preschool.

What is of interest is not only which children have a preschool place, it is also important to analyse which children are outside preschool. Figure 29 shows that nearly all 6-year-olds are in preschool, and that about 3,100 of 4,442 1-year-olds have a preschool place. It is worth noting that about 800 of 5-year-olds do not attend preschool, and the reasons for this need to be further analysed. Malmö lacks data on those who do not request a place.

A ACTION 2.1.2.2

The size of groups of children in Malmö's preschools should decrease. A first objective is that groups of children in the age range of 0-3 should not exceed 15.

There are research studies that indicate that staff/child ratio and the size of groups of children are most significant for the youngest ages groups and for children at risk. Children who live in social and economic vulnerability have greater needs. Data from the Swedish National Agency for Education which indicates that the size of groups of children are increasing while the staff/child ratio is decreasing in Swedish preschools is therefore of concern (123). It is especially serious that conditions are becoming worse for the very youngest preschool children. One in three groups in preschool are groups of young children who are 0-3 years of age. Since 2003, the number of groups of young children consisting of 17 or more children tripled.

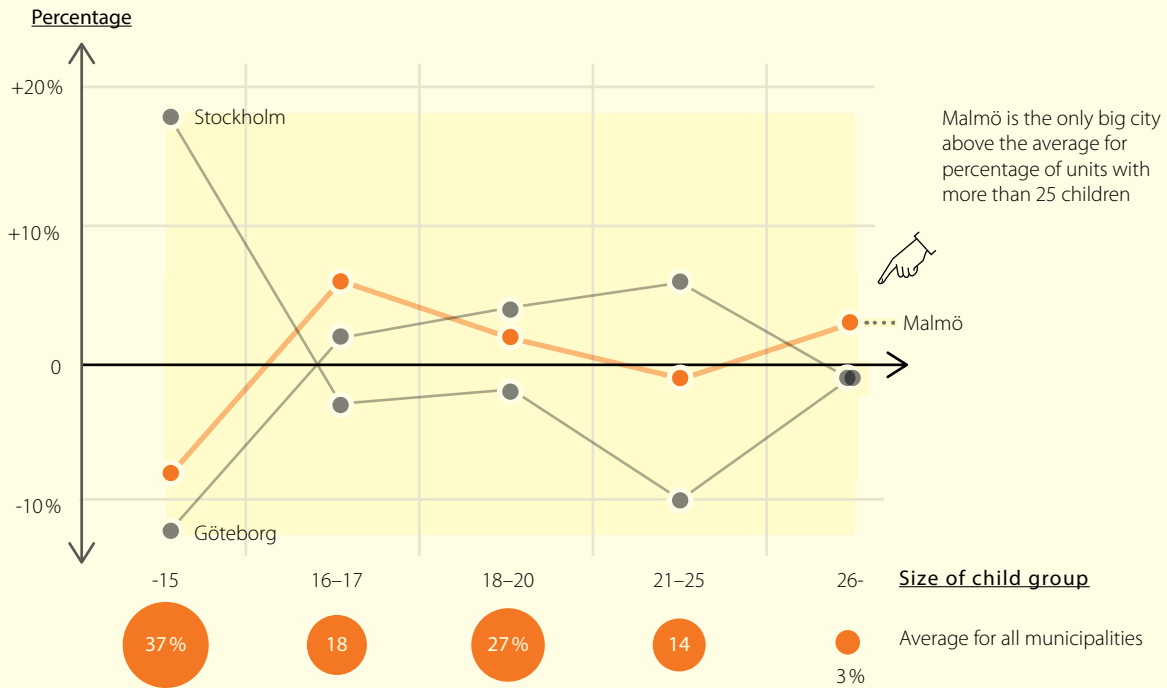
Figures 30 and 31 (next page) show that 25 per cent of young children units (0-3 years of age) in Malmö have 17 children or more, nearly ¾ of young children units have 14 children or more. The proportion of groups with 17 or fewer children is increasing because the proportion of children aged one to two is increasing. A result of this is that the groups size for 4-5 year olds is also increasing, with groups of 21 or more children (124). Provide resources for the preschool service that enable a reduction of the size of groups of children for the youngest and most vulnerable children.

Health-economic calculations of action 2.1.5.1

The health-economic analysis of the proposed action has found that there are no economic gains from the initiative. However, cost estimates have been made, which show that a reduction in the size of young groups of children (all enrolled children under 3 years of age) to a maximum of 15 children/group would mean an additional cost of SEK 124 million, or about 41 million per age group. It is however important to note that considerations other than economic factors should be taken into account. (80)

Figure 30: The proportion of units by size of groups of children

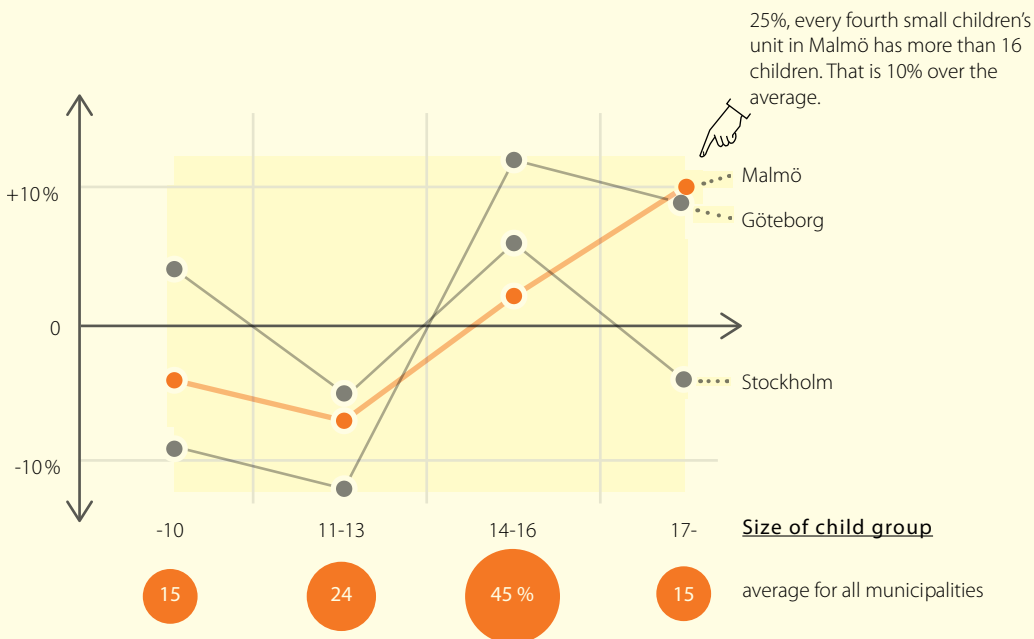
Malmö, Gothenburg and Stockholm in relation to average value for all municipalities



Source: The Swedish National Agency for Education 2010b in Persson, 2012

Figure 31: The proportion of young children units and size of groups

Malmö, Gothenburg and Stockholm in relation to average value for all municipalities



Source: The Swedish National Agency for Education 2010b in Persson, 2012





Professional development in multilingualism in “Rosengård”

Extensive professional development in the field of multilingualism and learning has been in progress in “Rosengård’s” pre-schools and schools since 2004. The project has been carried out in co-operation with Malmö University among others. The professional development has focussed on all levels in the organisation. One example is “Processtöd-jarutbildning” (Process support training) with a focus on multilingualism and learning which The National Centre for Swedish as a Second Language at Stockholm University implemented and is implementing. The target group has been educators and teachers at preschool and compulsory school. As a basis for the professional development, observations in preschool and compulsory school have been carried out based on a version of the SIOP model (Sheltered Instruction Observation Protocol). (122)

2.1.3 COMPULSORY SCHOOL – AN EQUITABLE SCHOOL?

As a globalised knowledge economy leads to increased competition between national school systems, demands on children’s performance at school are increasing worldwide. Schools strive to achieve set learning goals in the most efficient manner possible in order to become competitive. This discourse of knowledge effective schools is presented as education’s ultimate goal and function. Proponents of market solutions in education emphasise that values such as competition, individuality, freedom of choice and producer-consumer relationships in the school system ensure that the school will be knowledge effective.

Teachers and politicians at different levels are of course not unaware of the internal problems in a school that strives to be knowledge effective. Teachers want pupils to be successful at school. They also know that there are pupils who cannot live up to the requirements, and they are concerned about what will happen to them. Several of these teachers are looking for alternatives to a school that only rewards measurable skills. The answer for many lies in what Aspelin and Persson call a socially-oriented school. This is a school that puts social relationships, group processes and teachers’ knowledge about individual pupils at the centre of education (106). In the socially-oriented school pupils’ influence and participation are important elements. There is also an effort to understand the pupils based on their circumstances and social situation. The problem however is that the socially-oriented school tends to prioritise the pupils’ identity formation. Who you are in the socially-oriented school is more important than what you will be. The heterogeneity and diversity that pupils represent may in educational practice become normalising and standardising. It is therefore a great challenge to formulate alternatives that are beyond the knowledge effective and the socially-oriented school (122).

The knowledge-effective school with its emphasis on competition, rivalry and freedom of choice in combination with reduced equity has had a number of negative effects on pupils’ average school performance. Increased individualisation has led to emphasis being placed on the pupils’ own responsibility for their acquisition of knowledge. Pupils’ own work has been given prominence and teachers have toned down their own role. For several years the differences between schools have increased, which has strengthened peer influence and the importance of parents’ educational background for the pupils’ results. Overall, Swedish schools have evolved to become less equitable (105). This becomes particularly clear in a city like Malmö, where the differences between schools are reinforced by residential segregation and increased inequities between population groups. Despite this, we can detect a faint but noticeable improvement in pupil performance.

The Swedish Agency for Public Management report “Obligatoriska skolan vårterminen 2012” (Compulsory School Spring Term 2012) (170) includes the following:

Still few, but more pupils than previously passed all tests in Year 3: Compared to 2011, the proportion of pupils who passed all tests in both Swedish and Mathematics has increased. In Swedish from 54.5 per cent to 57.2 per cent and in Mathematics from 54.3 per cent to 59 per cent.

Malmö’s schools must get better at helping weak pupils at an early age: By comparing Year 9 pupils’ national test scores in Swedish, English and Mathematics with the national test scores of pupils in Year 5 it can be confirmed that there is a strong correlation between weak national test scores in Year 5 and weak national test results in Year 9 (for pupils in municipal schools).

There are pupils in Year 3 who do not have an action programme, despite the fact that they are not achieving learning objectives: Monitoring of learning outcomes in Year 3 shows that 90-95 per cent of pupils achieve learning objectives in most subjects. The proportion is lower in Mathematics (84 per cent), Swedish (85 per cent) and Swedish as a second language (61 per cent). Most pupils who do not achieve learning objectives have action programmes but there are also pupils at many schools who do not have an action programme despite the fact that they are failing to achieve the learning objectives.

The results of subject tests in Year 9 have improved: The results of the national tests in English and Swedish in Year 9 have improved by 1.1 and 2.4 percentage points respectively compared with 2011, to 85.2 per cent and 85.5 per cent in 2012. In Mathematics there has been an increase of over 6 percentage points from 62.1 per cent to 68.5 per cent. This may be due to the proportion of pupils who did not do the tests in Mathematics falling from 14 per cent to 9 per cent. At the same time, the differences between city districts with the highest and lowest results respectively decreased in all three subjects.

In Malmö there are large differences between the city districts, schools, and types of school in terms of entrance qualifications for upper secondary studies in national programmes. These differences, with some variations, correspond very well to the socio-economic differences between the city districts in Malmö regarding the residents' education, the proportion of gainfully employed people, disposable income and the proportion who receive social assistance.

O OBJECTIVE 2.1.3

All children in Malmö who complete compulsory school should qualify for continued studies at upper secondary school or vocational programmes.

Early intervention at preschool and school so that all children can read and write has been shown to be of great importance to cognitive development and how they cope with school and later working life. The Royal Swedish Academy of Science's systematic research review emphasises, among other things, that early difficulties at school and especially difficulties in reading and writing causes internalised and externalised mental problems. (126)

A ACTION 2.1.3.1

Early and regular monitoring of children's language development followed by early interventions when needed. This applies to both the Swedish language and other native languages.

The Swedish Research Council's Results Dialogue in 2012 highlighted research which considers language to be the human tool of all tools. Language is a visible indicator of identity and with its support people are able to access and navigate in their social and physical world. Language creates affiliation(s) and different positions. In other words, language has both a communicative and a symbolic value for individuals and communities of practice. This means that language use is essential to consider when it comes to identity positions such as gender, ethnicity and disability. (127)

A ACTION 2.1.3.2

Targeted professional development investments in preschools and schools with many children from multilingual environments and especially in Year 1-3 schools with low attainment of objectives. All teaching staff must have skills in the reading and writing process as well as increased awareness of deficiencies in children's language and communication abilities. Where these skills are lacking, professional development should be made mandatory.

Within the context of the preschool/school, according to the Education Act, children with a native language other than Swedish are to be given the opportunity to develop this language and

the Swedish language. This places great demands on the staff's knowledge of the internal and external factors of language learning and skills in how to develop good language environments for these children and young people. Professional development has proven to be the most effective action for this.

A ACTION 2.1.3.3

Early and continuous monitoring of learning outcomes which when needed are followed up with adequate interventions.

Research shows that interventions need to be made early, be continuous throughout the pupil's time at school and that they should be based on solid knowledge about what supporting measures the pupil needs. Today there is an arsenal of instruments to identify pupils' problems but less knowledge about what actions are the most effective.

A ACTION 2.1.3.4

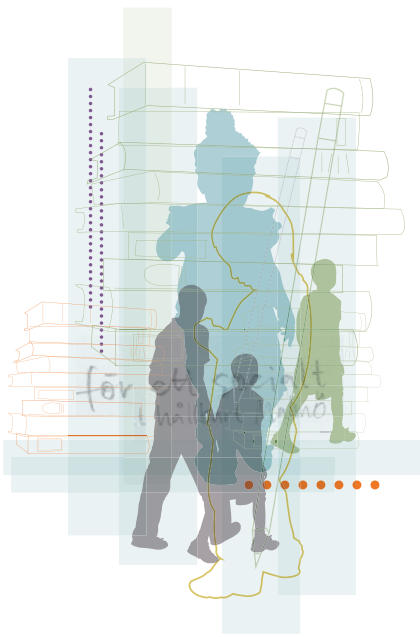
All pupils with a foreign background should have access to and be offered study instruction in their native language.

Deficiencies in this respect have been mentioned in numerous school inspections, despite the requirements of the Education Act. Research indicates that pupils with a native language other than Swedish need to receive study instruction in their native language and at the same time need support in making connections to Swedish terms to increase their understanding of the teaching.

Study instruction in the native language

A pupil should according to the Education Act receive study instruction in his or her native language if the pupil needs it. A pupil who is entitled to teaching in his or her native language and who before his or her arrival in Sweden has been taught in a language other than the native language, may be given study instruction in that language instead of the native language, if there are special reasons.

2.1.4 THE AFTER-SCHOOL CENTRE'S PREREQUISITES FOR DEVELOPING HEALTH AND LEARNING



The after-school centre is a voluntary educational group service for school children up to the age of twelve. There is no curriculum or any detailed objectives about what skills the pupils should attain. The Education Act and the Curriculum Lgr 11 (Curriculum for compulsory schools, preschool classes and after-school centres 2011) regulate the activities of the after-school centre. The after-school centre is described as a borderland in the Swedish education landscape, between preschool, preschool class and compulsory school. This position means that the after-school centre has to live up to various expectations and varying conditions for its assignment.

Based on research on after-school centres the following conclusions can be drawn. Firstly, there is limited scientific knowledge about the service. Secondly, the most researched area is the integration between the after-school centre and the compulsory part of schooling. Overall, research shows that there are cultural differences in the co-operation between the after-school centre and compulsory school in terms of views of learning, knowledge, attitudes towards the pupils and organisation of work.

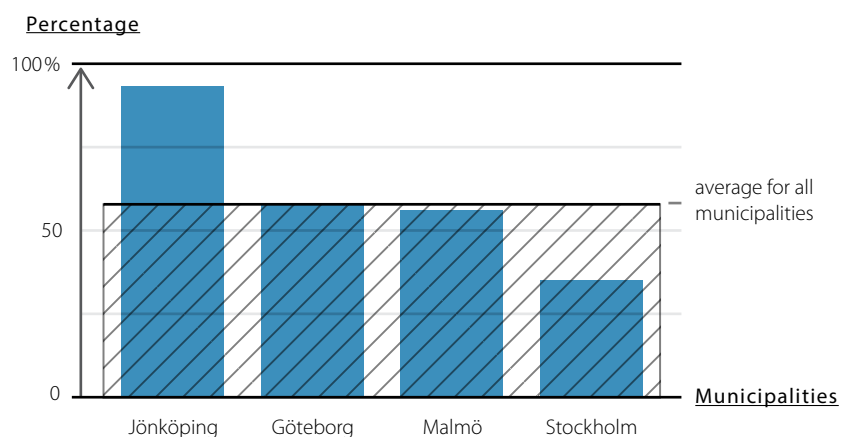
The third conclusion relates to the conditions for the pupils' learning at the after-school centres. At after-school centres the educational activities are often characterised by starting from spontaneous situations and being based on the pupil's interests and ideas. This is however not enough for a good educational service. After-school centre staff should – based on their knowledge of the child's experiences at school and at leisure – be able to plan and offer the child stimulating and creative activities to promote their learning and social abilities. To do this the prerequisites for the after-school centre's educational activities must be strengthened in several respects such as the size of the groups of children, staff/child ratio and staff competence.

The fourth conclusion is that it is of great importance that after-school centre teachers are observant and able to read and interpret the pupils' interactions so as to be able to make educational interventions towards strengthening the pupils in forming relationships with their peers and in their positioning in the group/class. (128)

In 2010 10,873 children in the 6-12 year age range were registered at an after-school centre in Malmö. In 2010 Malmö was slightly lower than the national average in terms of the total number of children who were registered at an after-school centre in the age range of 6-9. For children aged 10-12 twice as many were registered at an after-school centre compared with the national total. In the municipal after-school centres in Malmö there were 37.8 children per after-school centre unit and in after-school centres under private management the figure was 56.7.

Figure 32 shows that Malmö is slightly above the national average in terms of the number of children per unit. The number of children per unit is however high if it is combined with the proportion of yearly employees with teacher training at university level (see Figure 34).

Figure 34: Full-time employee equivalents in after-school centres with a university teaching degree 2010

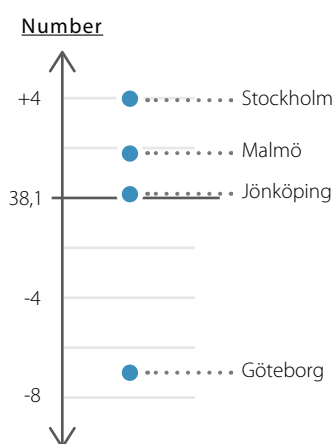


Source: The Swedish National Agency for Education 2010:b in Ludvigsson and Falkner, 2012.

Figure 34 shows that 56 per cent of the staff in Malmö's after-school centres have had teacher training at university level. It is interesting to compare this with the municipality of Jönköping where 95 per cent of the staff in the municipal after-school centres have completed teacher training at university level. The picture becomes more complete if the number of children per full-time person equivalent is brought into the calculation (see Figure 33).

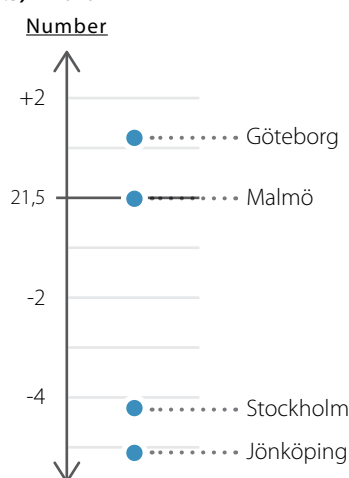
Overall research and evaluations point out that after-school centres have an important, most often unutilised educational potential. At the same time an alarming trend can be seen in the nation as a whole with regard to the large increase in the size of groups of children. The ability of after-school centres to provide a high-quality service in Malmö depends on the material prerequisites and the staff's training and competence. After-school centres in Jönköping can in this respect serve as a model for quality development. Jönköping has systematically invested in highly trained staff and local coordination of after-school centres.

Figure 32: Children per unit in after-school centres in relation to average for all municipalities (38.1 children)



Source: The Swedish National Agency for Education 2010:b in Ludvigsson and Falkner, 2012.

Figure 33: Number of children per full-time employee equivalent in after-school centres in relation to average for all municipalities (21.5) in 2010



Source: The Swedish National Agency for Education 2010:b in Ludvigsson and Falkner, 2012.

O OBJECTIVE 2.1.4

All children of 6–12 years of age should have access to a place at an after-school centre of good quality.

A ACTION 2.1.4.1

The size of groups of children in Malmö's after-school centres should be decreased. As a first step groups should not exceed 30 children/unit.

The size of groups is approximately 40 children per unit in Malmö's after-school centres, with a staff ratio of scarcely two members of staff per unit. In light of the reported research results the prerequisites for running a high-quality service are very much limited.

A ACTION 2.1.4.2

The proportion of university-trained staff should be increased in Malmö's after-school centres. A first objective should be that 75 per cent of after-school centre staff have university training and in the long term all staff.

The figure above on yearly employees with university training shows that 56 per cent of the staff in Malmö's after-school centres have university training. This can be compared with the municipality of Jönköping where 95 per cent of the staff at the municipal after-school centres are university trained. Research shows that the staff's competence and training is one of the most important quality factors.

A ACTION 2.1.4.3

Establish at least one full-time position responsible for after-school centres in the new administration for compulsory education.

Jönköping's administration for schools and child care has set up a development strategist position for its after-school centres, who is responsible for various issues relating to compulsory school and the after-school centre service. Along with a development coordinator the strategist has a particular responsibility for the development of the after-school centre service in the municipality. Experiences of this strategy work emphasise that it leads to a rise in quality, which is demonstrated by the high proportion of university trained staff among other things.

2.1.5 UPPER SECONDARY SCHOOL – NOT FOR EVERYONE?

The Swedish National Institute of Public Health (2010) states in its report about the health of children and young people that Swedish children under 15 years of age are among the best favoured in the world, from a health point of view, and the development in this age group has only been positive in the last 20 years. However, the picture changes if we look at young Swedish people in the age range of 15-24 whose mental health had become markedly poorer. Several surveys show that some symptoms have doubled or increased even more, such as anxiety, depression and difficulties sleeping. This increase also applies to hospital care for the treatment of depression or self-harming behaviour. The increase is particularly clear from the mid-1990s onwards (106). Research shows that a low level of education is associated with a number of health problems or social problems in adulthood, which means suffering for individuals and costs for society. Therefore, it is a large health problem that a large proportion of young people drop out of upper secondary school and do not complete their studies.

The proportion of drop-outs from what was previously called the Individual Programme (IV) has been particularly large. Out of the pupils who started their upper secondary school studies on IV only 20 per cent had attained their final grades after five years. The drop-out rate from the National Programme (NP) was almost 25 per cent during the corresponding period. After four years of National Programme studies approximately 70 per cent of pupils achieved final grades qualifying them for entry to further studies at college and university (the statistics refer to the national level in 2008). Three types of reasons for dropping out can be identified; structural; the parents' educational background, socio-economic background and foreign background – interpreted as late immigration, individual; school fatigue and health as well as factors which have to do with the school's internal work; incidence of bullying, relationships and support and educational quality. It is important to emphasise however that many of these factors tend to occur together and that it can be difficult to draw a clear line of distinction between for example school fatigue and lack of educational quality. (129)

In terms of structural factors the parents' level of education interacts with dropping out and final grades that do not qualify for entry to higher education. If the parents have low levels of education, this can mean that the family is poor, since this leads to an increased risk of low-paid work or a weak connection to the labour market and possible need of social assistance from social services. Children who grow up in families who receive social assistance, generally leave school with much lower grades than other children. The Swedish National Agency for Education's statistics from 2008 show that a large number of pupils of foreign background discontinue their studies. Pupils with a foreign background are however a heterogeneous group with large differences in school results. Upper secondary school pupils who arrived in Sweden after the start of compulsory school are also strongly underrepresented among those with final grades. (129)

What is the situation in Malmö? Of those who started their upper secondary school studies in the academic year of 2008/2009 approximately one third dropped out of their studies after two years. The majority of drop-outs are from the IV programme. Approximately 1,300 pupils have in the past year dropped out of their upper secondary school studies. In the 2010 spring term only 66 per cent of Malmö's upper secondary school pupils had qualified for higher education entry after four years of studies (130). Qualification for higher education entry means that the pupil has passed or attained a higher grade in at least 90 per cent of the subjects in their final grade.

The differences in results between programmes are very large. There are apprenticeship programmes where approximately 30-50 per cent of pupils have qualified for higher education entry and preparatory study programmes where approximately 90 per cent of pupils qualify. Furthermore, a very large group of pupils who started the IV programme in the academic year of 2008/2009 discontinued their studies. They have therefore not attained a formal level of education higher than compulsory school.

Although schools are improving their support for pupils enrolled in the National Programmes and municipalities are working to better satisfy pupils' choices, there is a risk that a large number of young people in spite of this will discontinue their studies or wait for the next intake. These pupils will then only in exceptional cases be offered studies on an introduction programme in the new system. The Swedish National Agency for Education therefore proposes that the municipality's responsibility for information should be given political priority with a clear allocation of responsibilities within the municipality and that resources must be set aside for this. Even if a municipality has several different services for young people an overall picture is needed to ensure that no young people slip through the net. (131)



O OBJECTIVE 2.1.5

All pupils who have started upper secondary school studies should have completed their studies within a five-year period.

A ACTION 2.1.5.1

Make the Ungdomsuppföljningen (Youth Monitoring Service) at the Vägledningscentrum (Guidance Center) permanent and provide resources for monitoring, informing and motivating young people to study and/or take up work experience.

The municipal responsibility for information is enshrined in the Education Act and covers all young people under 20 years of age who are no longer required to attend school and gives municipalities a clear responsibility to continuously keep abreast of what these young people are doing. Malmö has chosen the name Ungdomsuppföljningen. Ungdomsuppföljningen in its current form started in 2010 as a project. From 2011 onwards the service at Vägledningscentrum has not however been permanent. In the 2011/12 academic year Ungdomsuppföljningen had contact with approximately 1,300 young people who at the time were not enrolled in upper secondary school. By the end of 2012 Ungdomsuppföljningen had reached 100 per cent of the pupils who were not enrolled in upper secondary school.

The Ungdomsuppföljningen service is vital for monitoring, providing information and offering these young people with the chance to continue their studies. To facilitate the initiative, we suggest that reports on drop-out from all upper secondary schools are coordinated by Ungdomsuppföljningen.

Health-economic calculations of action 2.1.5.1

According to the health-economic calculation which was done to determine whether the intervention is cost-effective the outcomes of the follow-up are put in proportion to what the impacts would otherwise have been. Based on the scenario that young people who received support from Ungdomsuppföljningen were unemployed for the first two years after which they found work the economic consequences of Ungdomsuppföljningen would be in total SEK 8.1 million in reduced costs over a ten-year period (in terms of production gains and reduced sickness). This was placed in proportion to the cost of Ungdomsuppföljningen's interventions, which were estimated at SEK 2 million. (80)

A ACTION 2.1.5.2

Make major efforts to expand and reinforce medical, psychological, special education and socially trained staff within the Elevhälsan (School Health Service), at the municipal secondary schools.

Pupils' health problems are one of the main reasons for dropping out from upper secondary school education. Preventive and monitoring health work among Malmö's upper secondary school pupils could therefore reduce dropping out and help more pupils complete their studies.

2.1.6 NEWLY ARRIVED AND LATE ARRIVED CHILDREN AND YOUNG PEOPLE

Newly arrived and late arrived pupils are the most vulnerable group in the education system both socially and performance-wise. But at the same time Bunar in his background report (132) states that they are the group whose education has generated the least interest from researchers and decision-makers, the least development in recent decades and is characterised by the most clumsy, confused, non-scientific experiments and actual incompetence. The right of newly arrived pupils to an equitable education has so far not been satisfied. What has also come up in the research and in evaluations is that this group of pupils has been surrounded, within the framework of more or less segregated preparatory classes, by teachers (usually teachers with Swedish as a second language) who have unreservedly displayed a large amount of commitment to “their” pupils. The problem does not therefore lie in the level of interest of the immediately concerned teacher, but in how the rest of the school acts towards these pupils, in how their reception is organised and in how and what subjects are taught. The reception system is crucial to the effective educational and social integration of these pupils, in the school's and the surrounding society's structures.

In the light of previous research (132) we can identify a number of dilemmas which have encompassed the newly-arrived pupil's school integration. They have mainly related to preparatory classes' “to be or not to be”, how the mapping and evaluation of the pupils' school experiences has been done, what subjects the pupils should study during the introductory period, and when and in what subjects they will first be integrated into in a regular class. Furthermore, it has to do with how teaching in the native language and study instructions in the pupils' native language are arranged and to what extent, how and when the transfer will take place, who determines the transfer and on the basis of what considerations and finally how much the parents are involved in the whole process.

Malmö is a big receiver of newly arrived pupils and every dilemma mentioned above has also characterised the reception here. A new system in the shape of a reception school has been created to bypass the organisational failings and thus also some of the educational ones. However this approach runs counter to the development in most other municipalities as well as the criticism (133) that newly arrived pupils are unnecessarily isolated from regular classes. It also goes against the results highlighted in international and Swedish research related to similar models. Malmö's new model has not been created on scientific grounds, which the Education Act stipulates. Furthermore, one risk of a central reception school is that, by the competence being pooled there, development will stop at other schools and the newly arrived pupils will thereby be made invisible.

The transfer from preparatory class to ordinary classes has in the research been identified as a critical point even if the pupils are under the same roof. The transfer from a school which is situated in another part of the city will further complicate this process.

For late arrived youths who belong in upper secondary school there is the Startskolan (Start School) which belongs to Värnhemsskolan (formerly the Frans Suell and Jörgen Kock schools). In the 2011/12 academic year there were about 400 Malmö pupils enrolled in Startskolan which offers Language Introduction Programmes for pupils with a length of stay of less than 3 years and an individual option for pupils with a longer length of stay, but who are expected to make slow progress in their studies. These approaches have replaced what was formerly called IVIK and are part of the new upper secondary school organisation which was introduced on 1 July 2011. It is still too early to tell what impact the new eligibility rules for admission to secondary school will mean for this group of pupils. But an imminent risk is that a large proportion of them will never be able to be eligible for entry before 20 years of age, especially considering that many of the late arrivals have little or no educational background in their country of origin.

The term “newly arrived”

By newly arrived we refer to those who:

- have immigrated to Sweden, irrespective of the reason for immigrating (refugees, relatives, children of working immigrants)
- lack basic skills in the Swedish language, irrespective of educational background
- enroll in compulsory school or upper secondary school just before they are old enough to start school or at any point after that.

O OBJECTIVE 2.1.6

Late arrived children in Malmö should be given access to or rapidly be transferred to studies within an ordinary compulsory school or upper secondary school.

A OBJECTIVE 2.1.6.1

Reform the system for the reception of newly arrived pupils.

Phase out the Mosaik reception school. Newly arrived pupils should go to the nearest school or another school their guardians choose in accordance with their right to choose schools. For each newly arrived pupil previous knowledge should be properly mapped. An action plan should be prepared from the first day at school that consists of a strategy for how the pupil will be supported in order to achieve the most success possible. Newly arrived pupils in compulsory school, placed in special teaching groups, should receive teaching in all subjects by the regular subject teacher, access to the regular class teaching in the sub-

jects the pupil is assessed to be able to follow as well as access to other activities (class council, school council, etc.) on the same terms as other pupils. New forms of special study support are to replace special teaching groups and their teaching methods after one year. The teaching of newly arrived pupils should always be based on the pupil's individual prerequisites and scientifically anchored assessments of the pupil's individual needs.

A ACTION 2.1.6.2

For each newly arrived pupil of upper secondary school age previous knowledge should be properly mapped and an action plan drawn up from the first day at school that consists of a strategy for how the pupil will be supported in order to achieve the most success possible.

An evaluation of the new language introduction programme's impact on late arriving pupils should be done after three years, that is, in 2014. Otherwise all the same basic prerequisites apply as for newly arrived pupils in compulsory school.

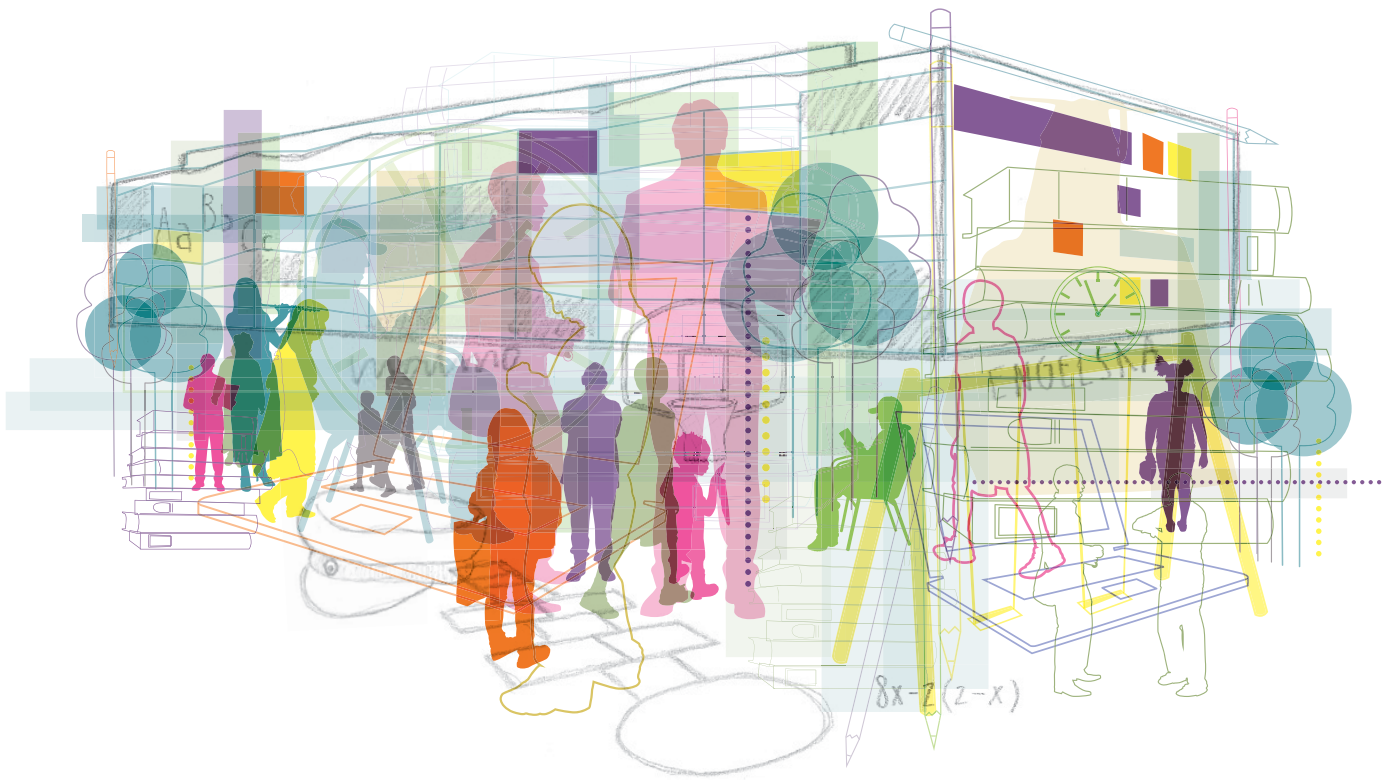
2.1.7 SCHOOL SEGREGATION

In the chapter on residential environment the Commission has defined the term segregation. Segregation arises when social differences coincide with geographical separation, that is, when different groups and/or categories of the population live, work and/or live separated geographically. Residential segregation means that different social groups and/or categories live in different parts of the city. In a corresponding way different social groups and/or categories can go to school in different parts of the city. Then we can speak about school segregation.

A few conclusions which can be drawn from earlier research (132) related to school segregation are as follows. Firstly, residential segregation has its own dynamic which can scarcely be altered just by setting aside more funds for the different areas and their activities. That is not to say that the municipality and the state should terminate additional investments in the most vulnerable areas but the problem of segregation must primarily be tackled through systematic and long-term work on strengthening local institutions, such as the preschool and school, adult education and labour market initiatives, health centres, leisure activities, social services, police, etc. in the most vulnerable areas. The objective should thus be to ensure that the inhabitants are strengthened socially and that the local institutions' quality of service is improved.

Secondly, the social composition of pupils in a school is important for the individual pupil. Therefore it must also be a prioritised political objective to bring about more mixing between different pupil groups (defined based on their socio-economic background) from different parts of the city. There are few areas where decision-makers have such a powerful instrument, with such large impacts, at their disposal to bypass the negative effects of how other areas of society are configured, as in the field of education.

Thirdly, the freedom to choose has brought about some segregation between schools, or in other words, it has to some extent aggravated the already considerable social and ethnic segregation that exists between the schools in Malmö. But at the same time the freedom to choose has the support of parents and is part of the city's attraction. We also know that the freedom to choose in many cases has provided a structure for the creation of physical integration between children and young people, with different social and ethnic backgrounds, from different areas of the city. The previous deadlock in the segregated urban space has eased up.



O OBJECTIVE 2.1.7

The composition of pupils in Malmö's schools should be integrated with reference to socio-economic, ethnic, gender and performance categories.

A ACTION 2.1.7.1

Establish, finance and locate attractive profiles for schools in the most vulnerable areas to attract pupils from the whole city.

At least in the short term the issue of socioethnic diversity should first be played out at the educational and not the political level. What makes a school attractive to parents, irrespective of where they live, should be the quality and the opportunity for development and not a political vision of the "your child will contribute to integration" message, this does not work.

A ACTION 2.1.7.2

Review the impacts of the localisation of planned schools and consider a new structure for the organisation of compulsory schools in Malmö.

When new schools are to be built, an analysis of the pupils' composition must be done (based on the catchment area) and factored into the decision in accordance with the integration principle. This should especially be observed in the organisation of the 20 new schools which are planned in the city of Malmö.

The local effects of the freedom of choice should be studied more closely. Such a study should result in concrete recommendations on how municipal educational institutions should act to position themselves in the emerging education market. One suggestion to start with is that all compulsory schools be either preschool to Year 5 or Year 6-9 schools. An

unrestricted proximity principle and the right to choose would continue to apply to pupils in preschool to Year 5. However, the present division of catchment areas for Years 6-9 should be dissolved. Malmö should be divided into a number of large catchment areas comprising of a couple of schools. The division should be organised based on ease of communication so that pupils can travel between home and school as smoothly as possible but the 6-9 schools should also be strategically placed in relation to the catchment area so that they include addresses with a socio-economically mixed population. All pupils should actively choose schools before Year 6, something which has already been done in some municipalities. The choice should be offered as three options:

Option 1: The municipal school pupils would most prefer to go to, in the whole of Malmö.

Option 2: The municipal school located within the framework of the designated catchment area, calculated according to the pupil's residential address.

Option 3: The nearest school. According to the Education Act all pupils must be guaranteed the right to a place at the school which is geographically closest to their home. The point is however that the family and the pupil in the end, and having weighed up the different options, should be "forced to choose" their school and not just be assigned one. (132)

A ACTION 2.1.7.3

Find new ways of disseminating information about the educational institutions' activities and development to the public in order to prevent stigmatisation.

Arrange regular education evenings at different schools at which politicians, officials, principals, teachers, the media, parents and pupils are invited to discuss relevant issues concerning Malmö's educational institutions.

2.2 Income and work

IN THE 2008 REPORT FROM THE WHO on Social Determinants of Health, the opportunities for gainful employment and reasonable employment conditions were brought up as some of the most important factors for good health, both for those who work and for other family members who depend on the income that such work generates (1). They state that despite the fact that the right to the opportunity to support oneself through employment has been recognised as a human right in most countries, a large proportion of the world's individuals of a productive age lack such opportunities, completely or partially. With increasing demands for competitiveness and productivity in the global context; that is, the pursuit of producing a unit at the lowest possible cost, the global labour market has changed fundamentally.

A growing proportion of individuals in the global labour market rely on the informal sector where their legal rights to job security, to organize themselves in a union or to a healthy and safe working environment, are lacking. In our part of world, where the labour market and working conditions are regulated by laws and regulations, the majority of individuals in the labour market have this protection. The exception are the so-called undocumented migrants who in many high-income countries, Sweden and Malmö not excepted, constitute a growing share of those who are gainfully employed. These individuals are often under conditions which are just as bad as those for workers in low income countries. But conditions have changed in recent years even for other gainfully employed individuals.

A growing number of leading economists have also addressed the question of how one should view and evaluate unpaid work (1, 21, 131). Therein lies a huge potential to better understand how work is related to health, and how this is linked to social determinants of inequity. Existing knowledge about this is currently relatively sparse, but we foresee a rapidly expanding field of research on these issues. There is a trend whereby a reduction of the public provision of services, for example in the health and social care sector, has led a situation in which this work is now often performed as unpaid work primarily by women, especially in lower social positions. At the same time, we see the opposite tendency where society subsidises domestic services so that some of the previously produced unpaid work in the household, can now be purchased on the expanding market of household services, with the support of for example “RUT-avdrag” (tax deduction for cleaning, maintenance and laundry work) in an expanding market. There is also a tendency to employ relatives for the care of one's own family members, where new research shows that the responsibility for employment conditions and work environments aspects are unclear, and it therefore also becomes unclear how workloads such as long working hours, and physically and mentally demanding aspects of this work should be handled (136).

The discussion of the voluntary sector's contribution to the economy is also strongly linked to the issue of unpaid work. The debate on subsidising or not subsidising homework help offered by a voluntary organisation in Stockholm (137), clearly demonstrates this. On the one hand, the voluntary sector's contributions are often praised as something that is necessary for modern society to function. On the other hand, this comes into conflict with the ambition that as much work as possible should be offered through market solutions, since this increases society's income in the calculation methods that dominate today. This shows the great importance of developing a valid method for evaluating the total amount of work being performed in a society. The criticisms against the GDP measure and the discussion about what can supplement or replace this tool are therefore an important part of such a development which is intimately associated with the issue of development which is sustainable both socially and overall. The link to the social determinants of health is also made evident by the examples mentioned, where both social position and gender appear to be important aspects of equity.





Research on the health consequences of unemployment is nearly as old as unemployment itself as a historical phenomenon. In almost all such studies there is a clear positive correlation between unemployment and premature death, even when attempts have been made to take into account factors such as health-related selection, the fact that illness precedes unemployment rather than the reverse, and that risk behaviour, such as high alcohol consumption, would occur even before people became unemployed. A negative effect of unemployment on mental health is evident in countries with unequal income distribution and a comparatively poor safety net for the unemployed, worse unemployment benefits and fewer labour market policy initiatives for the unemployed. (86)

2.2.1 INCOME AND LIVELIHOOD

There is overwhelming evidence of a strong correlation between low income and poor health, in terms of individuals as well as groups and countries (1). In the case of individuals, the focus from a global perspective has been on those who live in what is defined as absolute poverty, that is, not having an income sufficient for the bare necessities of life such as adequate food for the day, or a roof over one's head. In these countries, low income and ill-health are linked by malnutrition, poor hygiene and insufficient protection from the climate and weather conditions.

Even in some so-called high income countries, poor health and death has this direct connection to low income, for example through households with very low incomes not being able to afford to heat their poorly insulated homes enough during the cold part of the year. In Sweden, however, nearly all such effects of low income are non-existent, but still one can note significant health differences between individuals with different income levels.

There are several factors that mediate the relationship between income and health. These are often divided into individual and structural determinants of health. The individual factors include both the individual's immediate living conditions and living habits, which are sometimes called health-related behaviours. Some of these have particular relevance to health, such as eating habits, exercise habits, consumption of different substances for example through smoking and alcohol intake or sexual risk behaviour. The structural determinants refer to societal systems of importance for an individual's living conditions and health-related behaviours, such as educational system, labour market, work organisation/environment, social security system, income and tax policy, etc. These structural factors explain to a considerable extent systematic inequalities in health between groups of different individuals in a society. (Also see Chapter 0.6)

Traditionally, efforts to improve population health in countries like Sweden have almost exclusively focused on individual factors, especially the so-called health-related behaviors. This has in many ways been very successful. For example, the sharp decline in tobacco smoking is one of the single most important factors in the substantial increase in average life expectancy observed in Sweden during recent decades. However, a growing problem with this strategy is that success has been greatest among individuals with the highest incomes and significantly less among individuals with low incomes. This is due to the structural factors being more important as determinants of health-related behaviors among individuals with low incomes. An unintended outcome of the individual-focused strategy to improve population health in a country is therefore increased inequity in terms of the distribution of health in the country's population.

Since health is a major resource for the individual's opportunities to realise his or her life chances, poor health risks contributing to inequity, also in terms of other aspects of the individual's living conditions. This would be a very undesirable outcome of an individual-based public health policy. This was expressed by Marmot and many others as an important argument for shifting the focus to the structural determinants of health, that is, what the WHO report called "Social Determinants of Health" or "the causes of causes". This subchapter refers to the structural approaches to the relationship between income and health, and the recommendations and actions suggested should be interpreted as efforts to mitigate the structural causes of unequal income distribution as a cause of health inequity in Malmö's population.

Health inequity due to income can be noted between *all* income groups. In other words, a particular threshold cannot be found beyond which health cannot continue to improve with increasing income. Since income is often regarded as an indicator of socio-

economic position which is also associated with social status, Marmot explains this in terms of the status position, itself being an important determinant of health (40). A high income does not only indicate better economic resources to make healthy choices when it comes to nutrition and exercise activities, being able to recover in a good way, getting optimal information about health and access to care options, etc. but a high income is also linked to high status that minimises the stress and the frustration of being subordinated in the status hierarchy. This should also be seen in light of income inequality having increased significantly in the vast majority of the world's countries, including Sweden.

The association between the average income of a country and overall measures of population health such as life expectancy at birth (what we call average life expectancy), is as expected very strong in the poorest countries and in countries which are called middle income countries. However, this link also exists in countries that are called high income countries, to which Sweden belongs. In the case of these countries, recent research has shown that it is rather the income gap between the group with the lowest income and the group with a high income, that is, poverty in a relative sense, which is of importance for the average level of health in the country (138).

That is, when comparing two countries with the same average level of income the population's health is better in countries with the smallest income gap between low income and high income earners. The Scandinavian countries and Japan are examples of such countries, where the health of the population is better than would be expected based on average income, while the opposite is true for the USA and the United Kingdom for example (see Figure 35).

Research shows that more equal societies with a more even distribution of income generally have a stronger social cohesion, sometimes called the "social glue" (19). This factor can affect health in a variety of ways, such as, through generally better access to purely material conditions, such as greater opportunities to borrow money, or through a more effective communication of adequate information that is relevant to health, since individuals in a context with high social capital tend to trust the sender of such information and allow themselves to be influenced by the message. In societies with a high level of social cohesion, general stress is also lower, because of higher expectations of being able to cope with the demands of everyday life. Other researchers argue that this is the same thing as saying that better social capital, which means that people have more trust in each other and in the institutions of the society they live in, is associated with better health for *everyone* in this society. (19)

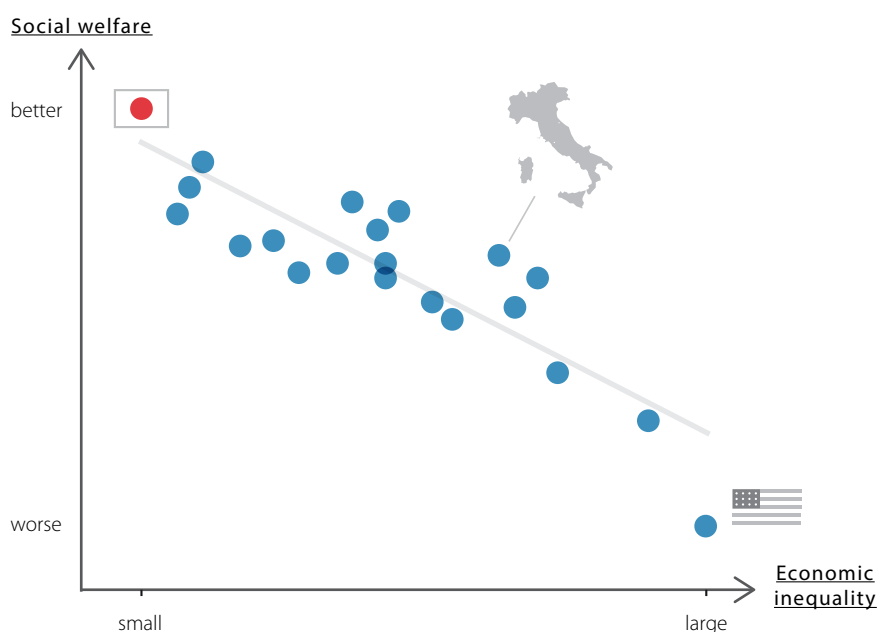
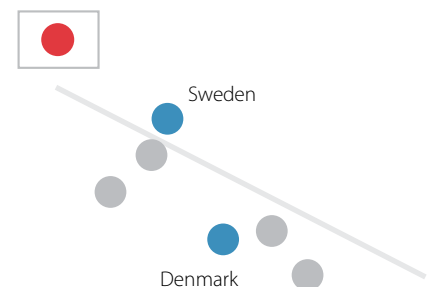


Figure 35: The relationship between social welfare and economic inequality



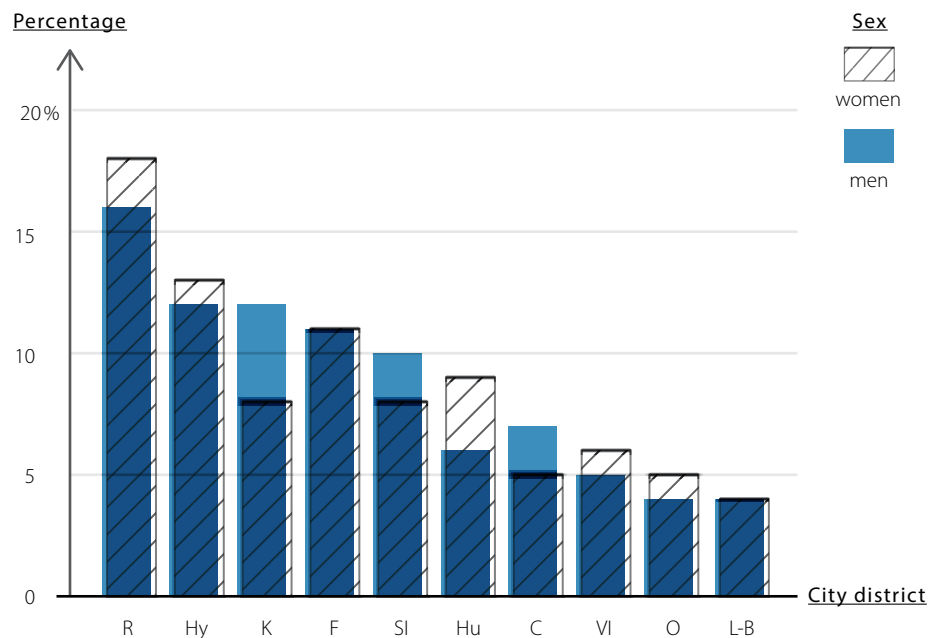
Source: Wilkinson and Pickett, 2009

Income and health in Malmö

Self-rated health is a measure based on the individual's own assessment of his or her health, both physical and mental. Studies that have followed individuals who reported good or poor self-rated health in surveys, have shown that those who report good self-rated health often live longer than people who say they are in poor health. (11)

In connection with Folkhälsoenkät Skåne (FHS) 2008 (Scania Public Health Survey 2008), participants were asked to rate their own health by answering the question "How would you rate your general health?" Five choices were given, ranging from "very poor" to "very good" health. On average 9 per cent of women and men respectively in Malmö reported that their self-rated health was poor or very poor. In the whole of Skåne, 7 per cent of men and 6 per cent of women reported poor self-rated health in the same survey. Compared with the results from the national public health survey "Hälsa på lika villkor" (Health on equal terms), the proportion who reported poor self-rated health was slightly higher in Malmö than in the nation as a whole (women about 7 per cent; men about 6 per cent). However, the variation between city districts was considerable, see Figure 36. (11)

Figure 36: Proportion of individuals with self-rated poor health among men and women in Malmö's city districts in 2008



Source: Lindström et al, 2012

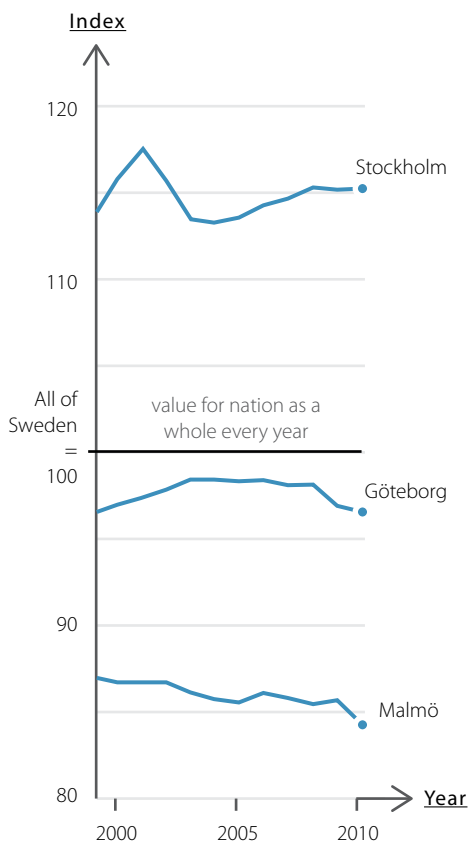
The same question was asked in Levnadsundersökningen 2006 (The Survey of Living conditions) in the city district "Fosie". The responses also relate to the individuals' economic situation. Of all the respondents in the 18-74 age range, 44 per cent classified themselves as either poor or low income earners. Twenty per cent of these rated their physical health as poor or very poor. Among those who considered themselves to have a better economic situation only 8 per cent rated their physical health as poor or very poor. (104)

Malmö is a relatively poor municipality with average incomes that are significantly lower than the national average. This is shown in Figure 37.

Income inequality (measured by Gini) has increased by nearly 60 per cent in Malmö between 1990-2008, Figure 38. That is 12 percentage points more than the national average. The difference between the national average and Malmö is therefore pronounced. There are several reasons for this. The economic gap is growing steadily between households that are worse-off and those that are well-off in relation to households with an average income. The very poorest households have not entirely benefitted from the economic recovery and the poorest tenth were worse off in real terms in 2008, compared with the situation in 2000 (72). This can be illustrated by the change in disposable income distribution between 1991 and 2010, Figure 39.

Figure 37: Average income* for people aged 20-64 in the nation's metropolitan cities in relation to the nation as a whole in 1999-2010

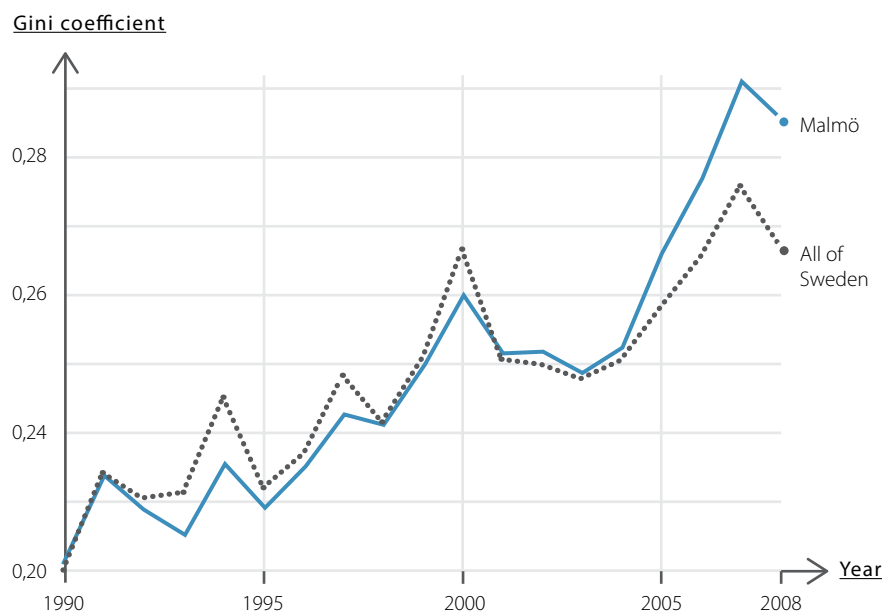
Index 100 = average national income per year



Source: Salonen, 2012

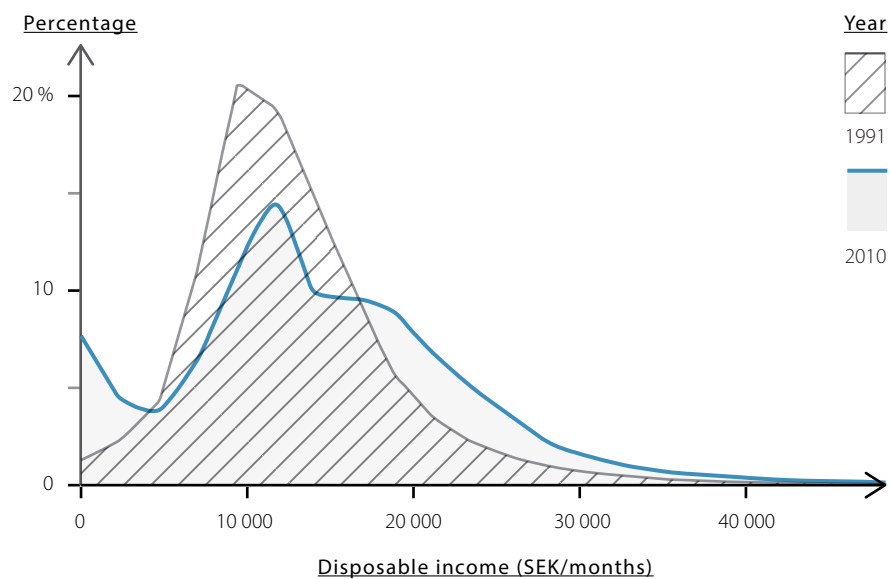
* Income before tax incl. business income and taxable transfers.

Figure 38: Income inequality. Gini coefficient.



Source: Salonen 2012

Figure 39: Change in income distribution in Malmö in 1991-2010



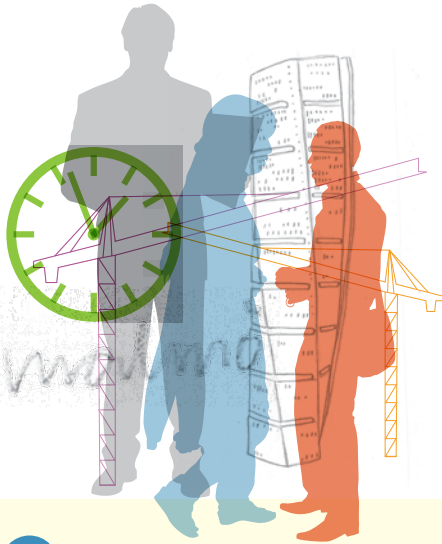
Source: www.svtpejl.se

In order to affect income inequality, national labour market and distribution policy interventions at different levels are required. How can the City of Malmö respond to growing patterns of inequity? On a more concrete and direct level, various actions at the local level can mitigate or compensate for the impacts of increased inequities in the economic living conditions of households. The prerequisites for being able to tackle the underlying causes of those are largely outside the remit of a municipality. A social investment policy at the local level can prevent the effects of increased differences in economic conditions between households being amplified and also reduce marginalisation and discrimination through government efforts.

The Commission is well aware that household livelihood conditions are affected by various factors at the structural, organisational and individual level. Moreover, that fundamental livelihood conditions for households are affected by changes at a global, international, national, regional and local level. In the Swedish welfare model which was

developed during the post-War period, the main responsibility for ensuring citizens' livelihood and security has been at a national level. In the transition to a post-industrial society, the effect of this has become weaker and the initial success of this model has become less evident, in terms of including the entire population in the current social security system, when it comes to, for example, childbirth, unemployment and sickness. This is particularly devastating in a city like Malmö where a higher proportion of the population of working age is completely or partly outside working life. In the meantime, while the national level is implementing interventions for a more inclusive investment policy the local level must act responsibly to tackle the underlying problems of unemployment, poverty and social exclusion.

The Commission therefore recommends the following objectives and actions that 1) mitigate the impact of increased income inequality, economic poverty, unemployment and deficiencies in the existing support systems and 2) affect the underlying causes of unemployment and poverty. Actions are required in many areas that focus on inclusion and cohesion, and strengthening actual participation and thus improving the preconditions for the sense of participation, without stigmatizing the ones who are the most needy. In other words, initiatives are required that affect the whole social gradient in terms of income inequality. Some actions may by their nature decrease inequality in health without being stigmatizing or artificial.



O OBJECTIVE 2.2.1

The City of Malmö should actively seek to enable an economically reasonable standard of living for everyone and reduce economic inequities between households.

There is a value in all residents being given decent/reasonable economic conditions; it benefits not only the individual but the entire local community. Based on the starting points of human capital theory one can argue that, apart from the ethical imperative, it is also economically profitable to provide people with reasonably secure conditions especially when they are exposed or vulnerable in some way, such as in the case of illness, unemployment or impaired health of children. A society that invests in people by offering a reasonable basic standard of living is perhaps the most obvious example of an inclusive society and such a social investment policy benefits the entire local community, in terms of cohesion and trust to which people jointly contribute. (68, 137) (72, 139)

A ACTION 2.2.1.1

The municipality monitors the effects of redistributive policies in the city and takes steps to reduce and mitigate their adverse effects.

The municipal level can act in a compensatory manner in relation to the national distribution policy. This can be done across the board through inclusive municipal services in many policy arenas, such as preschool, school, culture, leisure, and health. Through the principle of proportional universalism municipally-run services can act in a redistributive manner without being seen as special arrangements or being stigmatizing. The objective of such elements of a social investment policy is for the quality and attractiveness of these local

services to be perceived as satisfactory by the general population.

Ultimately, the national policy implementors are responsible for making the development of welfare inclusive, not least considering their responsibility for the implementation of labour market policies. At the local level, it is essential to document and analyse the actual effects of these policies. The city of Malmö with its specific role as a transit city into Sweden and Northern Europe for many newly arrived individuals and families, should have a particular focus on the integration process in close dialogue with responsible stakeholders at the national level. The consequences of deficiencies in individual government social security systems in particular should be analysed and communicated to the national level. Examples of this are the need for reinforced economic protection against unemployment and ill-health.

A ACTION 2.2.1.2

Initiate a discussion at the national level to raise the national minimum level for national social assistance.

The Commission has identified clear deficiencies in the current national minimum level for social assistance that Parliament on the recommendation of the Swedish National Board for Health and Welfare decides on annually, in particular for households with long-term assistance needs. The municipality should take responsibility for adjusting these levels based on detailed calculations of what is required in order for the objectives of the social legislation on a "reasonable standard of living" to be met. The level of the adjustment should result from impact assessments where social and economic aspects are observed. In addition, the municipality should act to ensure that the national minimum level is adjusted accordingly. (Also see Section 1, Chapter 1)

2.2.2 LABOUR MARKET

The traditional form of employment based on collective bargaining and organisation in unions represents a declining proportion of the jobs in the labour market. Particularly among young individuals, or among individuals who have lost their footing in the labour market through the loss of secure employment, or have migrated from another country, trainee employment without pay has become increasingly common as well as project employment/internships, forced self-employment and indirect employment through a staffing company where the employment rate can never be guaranteed because of the frequent stand-by situations. This leads to increasing stress about the lack of opportunities to plan one's time and finances. A large number of international studies, including some carried out in the Nordic countries, show that this has a negative impact on health for the affected individuals, both mentally and physically. (1)

Young individuals are particularly affected, because it is taking increasingly longer for them to establish themselves in working life. This means that young people in general are becoming more vulnerable from a livelihood point of view. At the same time there are some groups of young people who have greater problems establishing themselves than others. They are young people with incomplete upper secondary education and young people with a foreign background. These groups are affected by longer periods of unemployment and are more dependent on social assistance. Municipalities are required to keep themselves informed about youth employment and should also, if necessary, provide appropriate interventions.

Municipalities have traditionally been an important actor in terms of labour market policy. They have focused primarily on interventions for unemployed young people. However, the terms of such interventions are under review. A desire has been expressed to strengthen the role of the state and to give Arbetsförmedlingen (the Swedish Public Employment Service) primary responsibility for the large group of unemployed people who are currently provided for through economic assistance. The government commission Långtidsutredningen (The Long-term Survey) from last year (140), for example, presented proposals to change unemployment insurance and make it possible for the unemployed to qualify for the basic compensation (SEK 320/day), after a shorter time. Fundamentally, the municipal responsibility for young people as well as for other age groups is regulated by the Social Services Act. The municipality is to support the individual's right to work and education, in this context.

The fourth chapter of the Social Services Act regulates the individual's right to income support, social assistance. Such support is conditional and the obligations of young people are particularly highlighted. The Social Service may request that people under the age of 25 and who receive social assistance for a certain period of time participate in designated "training or other skill-enhancing activities". Municipalities are required to set up an organisation to manage their labour market policy commitments. Today, the vast majority of municipalities have such special labour market units. For 2013, the City of Malmö has a budget of SEK 389 million set aside for labour market activities, of which SEK 173 million is earmarked for JobbMalmö (141).

Labour market and health in Malmö

An individual's foothold in the labour market is crucial for health. There is extensive research on the relationship between unemployment and health which can be summarised as follows:

- Unemployment, particularly long-term unemployment, increases mortality, both total mortality and mortality from suicide and cardiovascular disease
- Unemployment increases mental health problems, and to some extent also increases somatic ill-health
- There is a link between unemployment and the abuse of alcohol and drugs
- Duration of unemployment and health impact; the longer the unemployment, the greater risk of adverse health effects

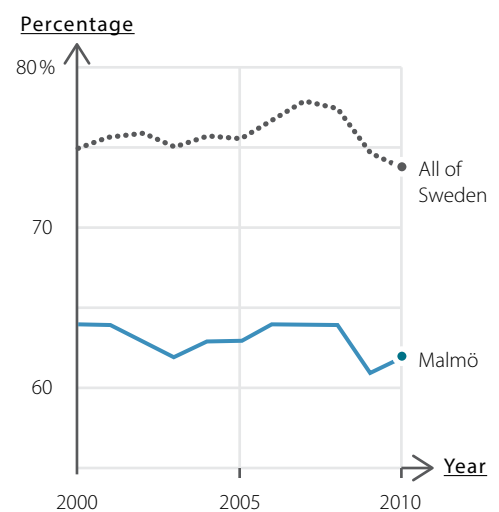
In most cases, the relationship goes in both directions. Employment and a good work environment promote health. Similarly, unemployment contributes to poorer health. Unemployment means for examples a greater risk of substance abuse, but substance abuse also increases the risk of becoming unemployed (86).

What is the trend in the labour market in Malmö in recent years? The employment rate has fallen since the early 1990s and has sharply deviated from the national level since then. Figure 40 shows the proportion of gainfully employed individuals in Malmö and the nation as a whole since the start of the millennium. Malmö's employment rate has constantly been 11-14 percentage points lower than the national average, but follows the national

JobbMalmö

JobbMalmö is a service for labour market policy interventions, including mapping, assessment of work abilities and work experience.
www.malmo.se/jobbmalmö

Figure 40: The proportion (per cent) of gainfully employed 20-64-year-olds in Malmö and the nation as a whole in 2000-2010



Source: Salonen, 2012

trend over time. Malmö's employment rate has consistently been among the country's lowest and the difference from the national average corresponds numerically to approximately 20-25,000 fewer people of working age who are gainfully employed in Malmö.

Between 1990 and 2008, the proportion of individuals of working age who were not working or studying increased from 14 per cent to 23 per cent. The largest proportion of income in this group has been in the form of national social insurance, usually combined with municipal social assistance. (81)

There are several possible explanations for the lower employment rate in Malmö. For example, foreign-born individuals' establishment patterns, regional commuting, as well as young individuals' studies and patterns of living. (72)

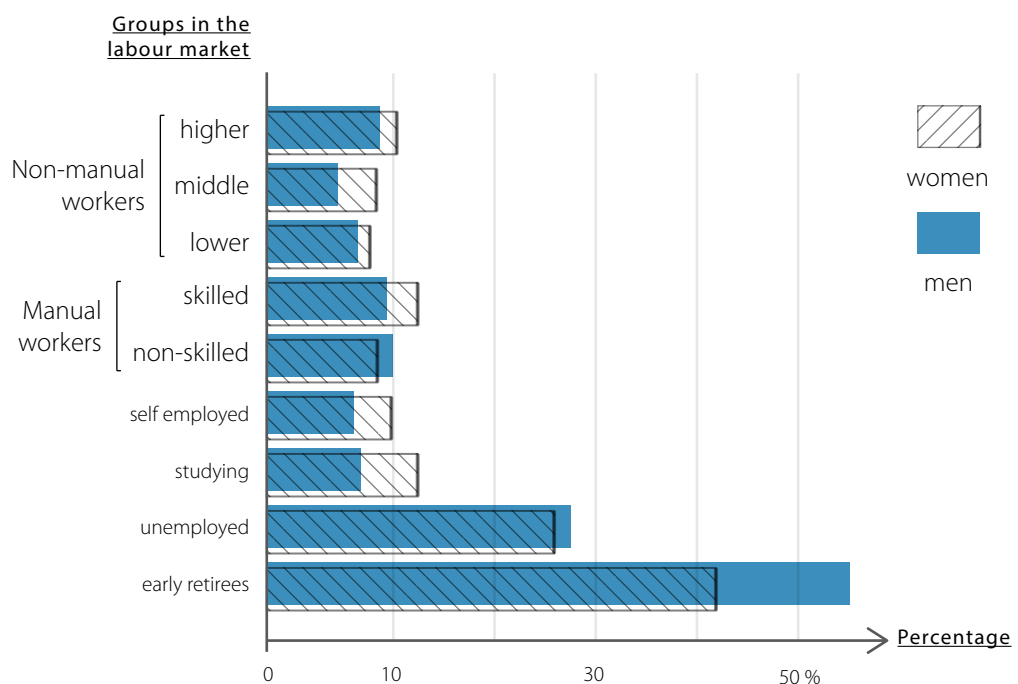
Foreign-born individuals run a greater risk of becoming unemployed than Swedish-born individuals. National statistics show that in the third quarter of 2011 the proportion of foreign-born people in long-term unemployment was 43 per cent while the corresponding figure for Swedish-born individuals was 13 per cent. Foreign-born individuals are, as mentioned earlier, not a homogeneous group, but generally migrants have poorer health than native-born individuals. This may partly be due to the barriers to social mobility in this group which mean that a greater proportion remain in a low social position throughout their adult life. Unemployment has proven to be one of the biggest causes of health inequities between foreign-born and Swedish-born individuals (86).

The aggregate number of unemployed Malmö residents registered with the Arbetsförmedlingen (the Swedish Public Employment Service) – openly unemployed and individuals in programmes with activity support, 16-64 years of age, in November 2012 amounted to 19,626 people, or 14.2 per cent of the workforce in Malmö. The number of unemployed young people, 18-24 years of age, according to the previous definition, in November amounted to 3,679 people, or 23.3 per cent of the workforce in that age-bracket. For foreign-born people, 16-64 years of age, the unemployment rate was 27.6 per cent in November, compared to the overall figure of 14.2 per cent in Malmö. For foreign-born people, 18-24 years of age, the unemployment rate was 37.3 per cent in November, compared with the overall figure of 23.3 per cent. (142)

Health inequities between different groups in the labour market, especially between those who are gainfully employed and those who have a weaker foothold in the labour market or are unemployed, are significant. This is illustrated below by four indicators, self-rated health, poor mental health, sleep disorders and dental health.

Individuals with a disability pension and unemployed individuals report significantly poorer self-rated health than those who work or study, Figure 41.

Figure 41: The proportion of those with self-rated poor health by occupational group

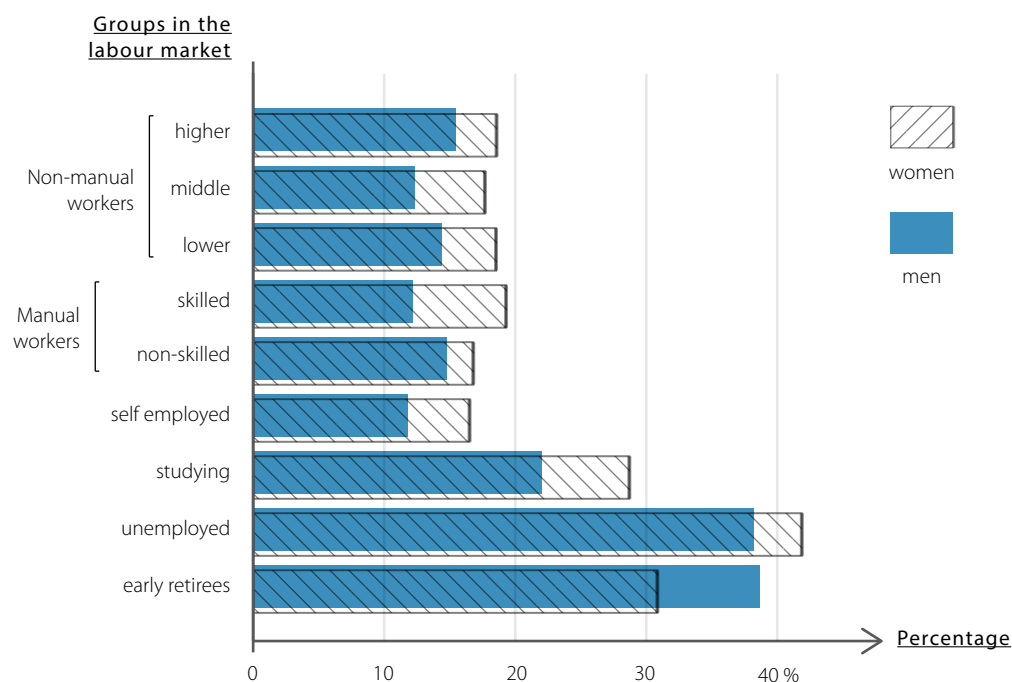


Source: Hälsöförhållanden i Skåne, Folkhälsoenkät Skåne 2008 (Health Conditions in Skåne, Public Health Survey 2008), Region Skåne



The same patterns can be seen for poor mental health. It is significantly more common among people who lack gainful employment compared with people who work, Figure 42.

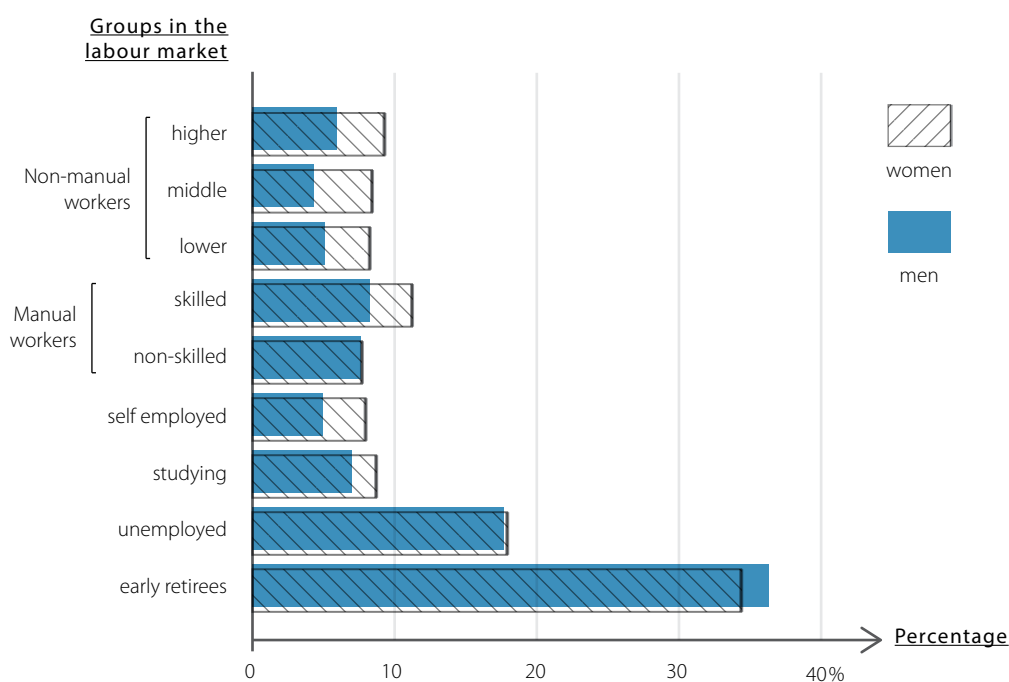
Figure 42: The proportion of those with poor self-rated mental health by occupational group



Source: Hälsöförhållanden i Skåne, Folkhälsoenkät Skåne 2008 (Health Conditions in Skåne, Public Health Survey 2008), Region Skåne

Regarding inequities in sleeping disorders between individuals in different socio-economic groups, the highest proportion was found among individuals with a disability pension and unemployed individuals of both genders, Figure 43.

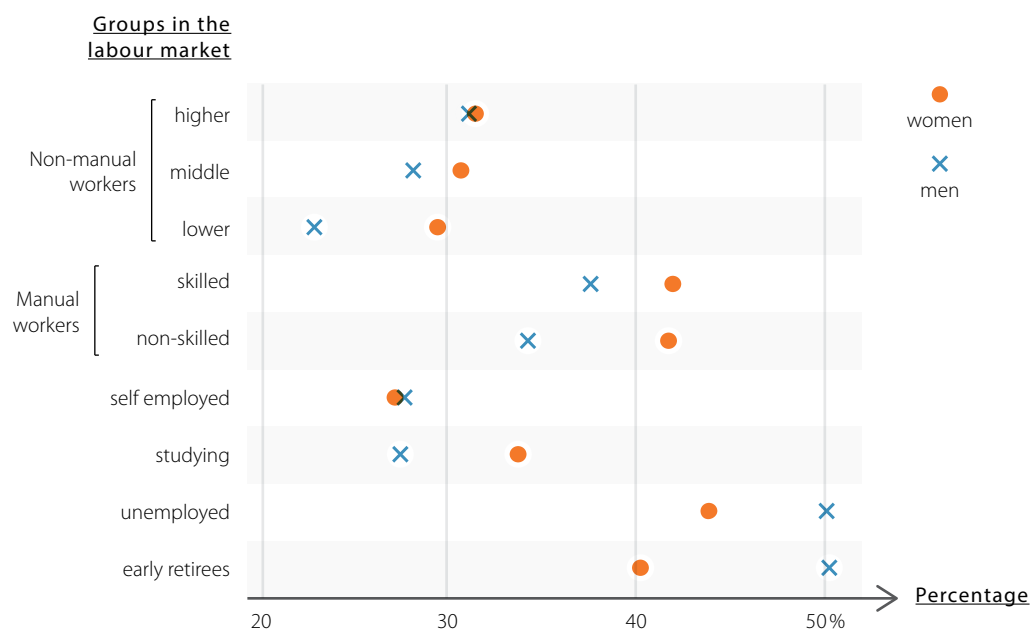
Figure 43: The proportion of those with sleep disorders by occupational group



Source: Hälsöförhållanden i Skåne, Folkhälsoenkät Skåne 2008 (Health Conditions in Skåne, Public Health Survey 2008), Region Skåne

The proportion of individuals with tooth decay is also highest in the groups of individuals with a disability pension and unemployed individuals, both among men and women. Among men, the lowest proportion of individuals with tooth decay can be seen among high level non-manual employees. Among women who are economically active, there is a higher proportion of those with dental decay among manual workers than among non-manual employees and the self-employed/farmers. Since the previous survey an increase in poor dental health among men with a disability pension and the unemployed can be seen, while among women there is a reduction among students, Figure 44.

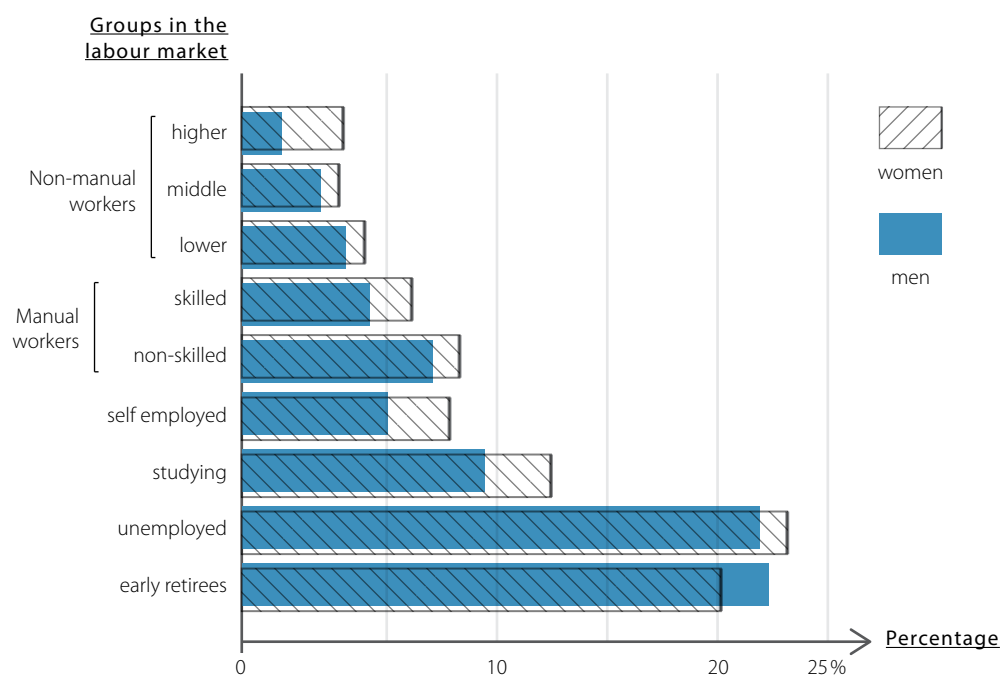
Figure 44: The proportion of those with tooth decay by occupational group



Source: *Hälsöförhållanden i Skåne, Folkhälsoenkät Skåne 2008 (Health Conditions in Skåne, Public Health Survey 2008)*

The socio-economic differences in experienced financial stress, defined as difficulties in paying the bills for ongoing household expenses for most of the months of the year are very large (Figure 45). Among men, a lower proportion experience financial stress among high level non-manual employees, compared with men in all other socio-economic groups. Among men who have a disability pension or are unemployed, the proportion experiencing financial stress is more than ten times greater compared to high level non-manual employees. Women who are high level non-manual employees experience financial stress to a lesser extent than women who are skilled manual workers, unskilled manual workers, women with a disability pension, unemployed or students. Among women, the proportion experiencing financial stress is five times as high among those who have a disability pension or are unemployed, compared with women who are high level non-manual employees.

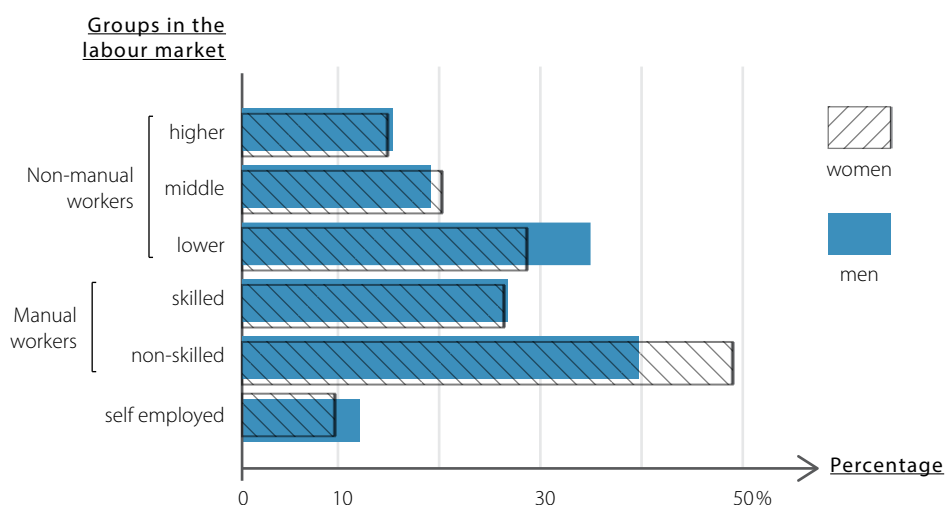
Figure 45: Proportion of those considered to be under financial stress by occupational group



Source: Hälsöförhållanden i Skåne, Folkhälsoenkät Skåne 2008 (Health Conditions in Skåne, Public Health Survey 2008), Region Skåne

The need for mobility and matching in the labour market is dealt with in more detail elsewhere in this report and is an important mechanism for the adaptation between the individual and his or her working duties that has a significant effect on an individual's health and especially on opportunities for individuals with a limited work capacity to avoid exclusion from working life. Being locked into an undesirable job situation is therefore a negative determinant of an individual's health. (143) Analysis of the responses to the Folkhälsoenkät Skåne 2008 (Scania Public Health Survey 2008) showed that the lowest proportion who desire a career change was noted among non-manual employees and the self-employed, among both men and women, while the proportion was greater among unskilled manual workers, 39 per cent and 49 per cent respectively, Figure 46.

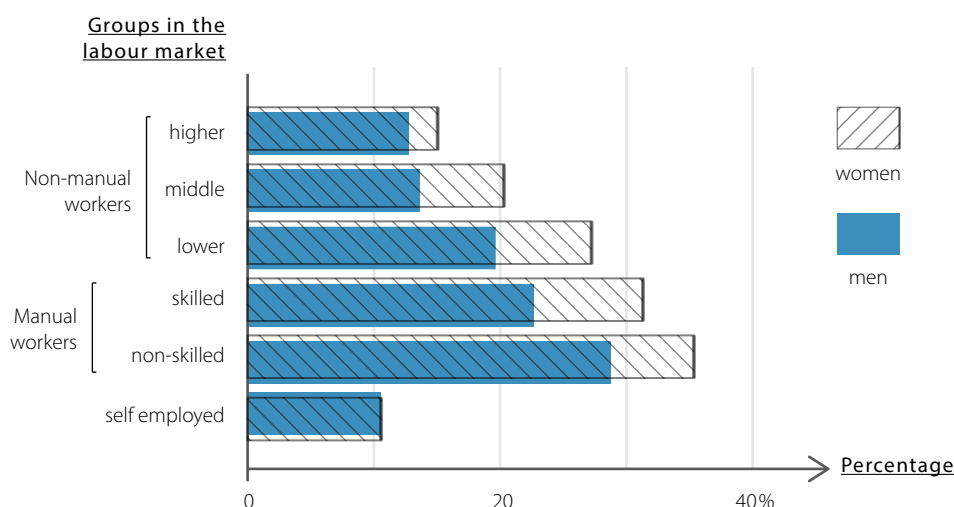
Figure 46: The proportion who wish to change occupation by occupational group



Source: Hälsöförhållanden i Skåne, Folkhälsoenkät Skåne 2008 (Health Conditions in Skåne, Public Health Survey 2008), Region Skåne

There is also a clear socio-economic gradient in terms of the presence of job strain, that is, exposure to work-related stress, Figure 47. The lowest prevalence was found among the self-employed and high level non-manual employees and the highest among unskilled manual workers. A general tendency towards a decrease in the prevalence was noted in all socio-economic groups except among self-employed women.

Figure 47: The proportion of those with a stressful job situation by occupational group



Source: Hälsöförhållanden i Skåne, Folkhälsoenkät Skåne 2008 (Health Conditions in Skåne, Public Health Survey 2008), Region Skåne

Since the crisis during the first half of the 1990s, Swedish labour market policy has gradually changed from a mainly nationally organised operation into an increasingly dual responsibility between the state and the municipalities. This division also reflects a growing division between established and unestablished individuals in the Swedish labour market. The established individuals are characterised by previous experience of employment, membership of trade unions and acquired rights-based insurance for such things as unemployment. The unestablished individuals lack these characteristics and over the past two decades, they have been referred to the municipalities' labour initiatives. The latter group is dominated by young people, individuals who have arrived in Sweden in recent years and single women. The divided labour market policy is characterised by a clear boundary between a national rights-driven labour market policy and a local unemployment policy for those who fall outside the national security systems.

OBJECTIVE 2.2.2

The City of Malmö should actively explore new ways to stimulate the development of the labour market and the emergence of new jobs.

The paradox is that a person who is unemployed is at risk of becoming ill to a greater extent, with the cost being higher for the individual and for society than labour market initiatives. It is therefore in the long-term more cost effective to create opportunities for work, so that individuals can provide for themselves, than to take the costs of health care. The problem is that different authorities pay for the impacts of unemployment and illness (139). A new social investment policy is required to address this.

ACTION 2.2.2.1

Develop an integrated approach to employment and welfare issues with national (Försäkringskassan, The Swedish Social Insurance Agency, Arbetsförmedlingen, The Swedish Public Employment Service, Migrationsverket, The Swedish Migration Board) and local agencies (Social Services etc.).

A strategy for a socially sustainable Malmö which is sustainable in the long-term requires an ambitious reform policy that is able to renew existing welfare systems towards shared welfare objectives. Poverty and exclusion are addressed most effectively by changing the fundamental institutional and systemic prerequisites in different areas of society such as health, housing, employment and security. It was this type of policies that attracted international attention to the Swedish or Nordic welfare model until the 1970s and 1980s and the recipe for success has been called the welfare or redistribution paradox (144). This entails not just looking blindly at the conditions of the poor and vulnerable alone but paying attention to and addressing the underlying conditions that create inequities. This is a historical lesson which with a renewed interpretation and meaning can form the basis of a social investment or sustainability strategy for a city like Malmö during the 2010s. In the international research on welfare there is a discussion on the increasing need for a shift in perspective in policy formulation at a time when economic and social disparities are once again increasing in many countries (29, 145). In the "new" social policy thinking in a post-industrial society, there is a need for policy development that is preventative rather than regulating social problems and conflicts which already exist. In such a social investment

policy, people – human capital – must take centre stage.

The Commission proposes a social investment policy with an integrated model for employment and welfare issues. The City of Malmö should investigate an integrated approach with national (Försäkringskassan, The Swedish Social Insurance Agency, Arbetsförmedlingen, The Swedish Public Employment Service, Migrationsverket, The Swedish Migration Board) and local agencies (Social Services etc.). This model should result from mapping and evaluation of the existing structure. The already established co-operation through FINSAM should be reviewed and investigated to see whether it is possible to develop such structures further. Evaluations of previous integrated models such as Arbets- och utvecklingscentra (Work and Development Centres) should be studied and the results of these evaluations should be taken into account. Social investment funds can be used in efforts to strengthen co-operation through for example the FINSAM model.

A ACTION 2.2.2.2

Use investments in the physical environment as an engine for local employment and urban development.

Local procurement rules should be designed so that they can promote local employment and urban development through co-operation between residents, housing and construction companies. The municipality is proposed to design a number of pilot projects and should encourage stakeholders to develop new financing models, based on a social investment perspective. The Commission proposes two projects; “Amiralsstaden” and “Bygga om Dialogen” which can serve as pilot projects for the development of a social investment perspective with the ability to solve many problems; social, economic as well as ecological. The initiatives require careful impact assessments and monitoring. (See Appendix 4)

A ACTION 2.2.2.3

Decentralise labour market policy initiatives to places where people feel at home.

The sociologist Loïs Wacquant, in the book “Urban outcasts”, compares what it means to be an outcast and why this happens in Chicago and Paris. In Chicago, public institutions and authorities withdrew from areas characterised by social exclusion. In Paris, efforts are still made but usually based on an approach which can be called problem-oriented, that is, initiatives are carried out based on a top-down perspective and contribute to a view of problems being individual. (146)

The initiative which in Malmö has been called Områdesarbetet (the Area Project), which was part of the EU project SÖM Fosite, has demonstrated great success in reaching out to people where they are and feel at home. (147) It has reduced the psychological gap between life in the residential area and the authorities and the world of work and has facilitated communication between citizens and authorities. It has made the exercise of authority more responsive. Other authorities and administrations should also be able to learn from Områdesarbetet and move out to places where people can feel involved. It requires networking and the creation of meeting places that people actually visit and where they can feel at home. The Malmö Commission considers it important, by means of knowledge alliances, to take advantage of the experience and knowledge that field workers acquire and to create forums for the processing of this into knowledge, where it can also be passed on to change social structures.

SEF Unga

SEF Unga operates as a staffing company within the City of Malmö and offers young people aged 18-24 years employment for 6 months within the municipality's city districts and administrations. www.malmo.se

A ACTION 2.2.2.4

Continue to strengthen municipal labour market training initiatives and thereby prevent the emergence of a low-wage sector.

Trade unions and employers' organizations must be encouraged to reach collective agreements that open up apprenticeships and introduction places for young people. A less strict work requirement for the right to unemployment insurance and an expansion of the programmes called Jobbgarantin (the Job Guarantee) and Jobb- och utvecklingsgarantin (the Job and Development Guarantee), respectively, in the Arbetsförmedlingen, The Swedish Public Employment Service, are not enough to solve the basic problems connected to incomplete professional training and high thresholds to employment. The collective agreements that have been concluded in parts of the labour market on so-called work introduction and labour market introduction should be noted. The municipalities have signed a similar outline agreement. Municipalities can set a good example and expand the service with youth jobs for unemployed young people, youth jobs that also include quality-assured elements of training. SEF Unga in Malmö provides a platform for such initiatives and closer co-operation with labour market stakeholders.

The concept of becoming locked-in to an employment contract or particular occupations has been launched by Professor Gunnar Aronsson of Stockholm University and means that an individual either has a job or an occupation that he/she does not want, in the worst case both (143). This has proved to be negative for the individual, both because health is negatively affected and because individuals with impaired health cannot find a work situation which is adapted to this and therefore there is a risk of them becoming completely marginalised from the labour market. The latter also results in considerable costs for society through the social insurance that has to be utilized when the individual can no longer support him-/herself through his/her own employment. The state of being locked-in is a phenomenon that is very much socially inequitable in terms of distribution and therefore contributes to the inequitable distribution of work-related ill-health. Mechanisms that can increase opportunities for individuals to work, that is reduce the proportion of individuals who are locked-in, have a significant potential to reduce work-related ill-health and at the same time reduce the inequitable distribution of health problems in society. (143)

In the long-term, demographic changes are expected to lead to labour shortages. These shortages are expected to apply in particular to skilled manual workers, both in the private and public sectors. The simultaneous segmentation of the labour market into normal and insecure/impoverished conditions, respectively, threatens to increase the health inequities related to the labour market. A shortage of individuals with appropriate skills is also an obstacle to economic development. It is therefore important to increase the individual's ability to qualify for a good job, both from the individual's perspective and to increase Malmö's attractiveness to different businesses.

In the long run the most important step is probably to provide good opportunities for more and further education for groups which are currently neglected. Investments in education affect both the individual's opportunities to choose work and therefore also their working environment, and businesses and job opportunities in the municipality. For most work, education up to upper secondary school level is required, and sometimes even higher education. Overcoming barriers to reaching upper secondary school qualifications, even in adulthood, is a municipal task, while access to higher education is a state issue. Those who lack the right skills for permanent employment are employed as substitutes when there is a lack of staff. In the welfare sector particularly staff shortages are expected to increase. Therefore solutions should be considered whereby substitutes who are suitable for the work, in co-operation between employers and authorities, are given the opportunity to acquire the required competence while retaining their income. In these situations skills which have been acquired during the period of employment should be considered.

It is also important that municipalities contribute to addressing the matching problem which characterises the Swedish labour market. Despite high unemployment, businesses and the public sector have large recruitment problems. This is basically due to the fact that vocational education in upper secondary schools has a low status and attractiveness, in the eyes of the employers. The generational shift in the labour market makes these problems more acute. In Malmö, as in many other municipalities, startlingly few individuals apply for the industrial technology programme and health care programme compared with the number of those applying for the aesthetic programme. This is not a sustainable pattern and it contributes to reinforcing the problem of parallel unemployment and labour shortages. The municipality can assist in mitigating this problem by marketing vocational training more intensively and by strengthening the resources for career counselling and guidance in secondary school. To develop the variety of paths that is necessary to address these concerns co-operation with the voluntary sector and folk high-schools needs to be developed.

A ACTION 2.2.2.5

Conduct periodic surveys on living conditions to map hidden competences and other potentials in the local society.

The public debate surrounding social exclusion, integration and multiculturalism tends to be rather stigmatizing and risks creating and maintaining inequities, by selecting individuals according to families' need for economic assistance, children's problems at school and adults' lack of connection to the labour market. A shift in perspective is required, which involves recognizing all Malmö residents as resources instead of seeing them as problems that must be dealt with. In other words, the problem-oriented approach must be replaced by a potential and cause-oriented approach. One reason for this is that we will all be better off if everyone is given the opportunity to contribute. Another reason is that we live in a globalised world. The contacts and exchanges with the world around us require language skills, ethnic and cultural competence and networks. The population of Malmö provides a fantastic opportunity in this respect, since the individuals residing in Malmö speak virtually every country's languages, have knowledge and experience from virtually all countries and are involved in networks which have their base across the globe. The City of Malmö, Region Skåne, and companies and individuals in Malmö should benefit from these circumstances.

This could be done by introducing surveys of living conditions where people of different backgrounds and roles collaborate to identify hidden competences and other potentials in the local community. Levnadsundersökningen 2006 (The Survey of Living Conditions 2006) contained a question about the highest level of education completed in another country. Responses to this question were then compared with the responses to a question about the highest completed and certified training in Sweden. Thirty-five per cent of all immigrants aged 20-64 said they had completed education in another country which was higher than they had completed in Sweden. This reveals considerable hidden potential competence. Another hidden potential competence is one that many residents in multicultural areas have. This can be called intercultural competence and because it is not graded, it is not recognised. Surveys and improved validation of existing competence would make it easier for employers/companies, while its value would be confirmed for the individual and increase the prospects for him/her to make use of it. The gathering of a broad collection of experiences and expertise involving the participation of all groups in Malmö could create a dynamic process, and provide impulses for improvements to welfare systems. (147)

A ACTION 2.2.2.6

Extend the municipal information responsibility to 25 years of age.

It is doubtful whether the suggestion of the government commission on Sweden's long term development, Långtidsutredningen, (140) regarding a decreased municipal responsibility for unemployed young people is the right solution. Instead, closer coordination between municipal and government initiatives is required. A first step should be to strengthen and expand the municipal responsibility for information regarding young people who have not completed upper-secondary school. Young people with a low educational level are overrepresented among the unemployed and those dependent on social assistance. Municipalities should be obliged to monitor these young people up to and including 25 years of age (rather than 20 years of age which is the limit today). Co-operation structures should be further developed between municipalities and placement services regarding unemployed adolescents' and young adults' opportunities for additional vocational training and practical work experience.

In Malmö, the follow-up of young people related to the work with young people outside of school aged under 20 and the creation of specific youth jobs for young people aged up to 25 (SEF-unga), are examples of constructive and long-term oriented initiatives. These efforts need to be strengthened and coordinated between JobbMalmö, the Education Department (municipal adult education, the monitoring of young people) and the youth initiatives of job placement services. It is both to do with providing opportunities to complete interrupted studies and meeting the need of work experience and personalised social support. (Also see this section, Chapter 1)

The aim is to provide coordinated initiatives for young people who are unemployed, poorly educated, or receive social assistance. One main task of the joint efforts should be to offer guidance, training, work experience and social support to young people aged up to 25. The municipal information responsibility regarding young people should be linked to this co-operation. Close co-operation should be developed with private enterprises and stakeholder organisations with the purpose of collective agreements concerning youth jobs and introduction places to provide job and learning opportunities for young people in the city of Malmö.



2.2.3 WORK ENVIRONMENT AND WORK ORGANISATION

In high-income countries many hazardous work environments have disappeared as in the global economy this kind of work has shifted to countries with lower labour costs. This applies particularly to work in agriculture and horticulture and industrial production, while the service sector has proved to be less geographically mobile. In these types of jobs the most common problems in the work environment tend to be strenuous work postures/lifting and psychosocial stress. Because of this, work-related ill-health in Sweden has gradually shifted towards musculoskeletal disorders and mental illness.



OBJECTIVE 2.2.3

The City of Malmö should be a role-model in terms of uniting a high quality of welfare services with good working conditions.

The work environment is an important determinant of health for the adult population. As previously mentioned in this report, the work environment in Sweden has in many respects improved significantly, particularly when it comes to exposure to hazardous chemicals and risks of physical injury. This does not mean that no challenges remain or that new risks do not arise in the work environment. These are often distributed in a socially inequitable way. A functional system for monitoring the work environment and persuading employers to comply with the relevant regulations is therefore of great importance. In this regard a particular challenge arises from the change in employment conditions described previously, where the proportion of permanently employed individuals is diminishing while other forms of employment are increasing, such as trainee positions, work through staffing agencies or in the black market. This has led to unclear, sometimes non-existent, terms of liability with regard to the work environment, which is a growing challenge for the application of work environment legislation, and probably more prominent in Malmö than in any other place in the country.



ACTION 2.2.3.1

Coordinated inspections with regard to the work environment,

Arbetsmiljöverket (The Swedish Work Environment Authority) is responsible for supervising the work environment. The need to strengthen the resources for inspections has been called for at a national level. The impact on the work environment has been shown to be stronger if the Swedish Work Environment Authority carries out an inspection of the workplace, rather than just sending out written information about the duties of an employer. The municipality is responsible for supervision with regard to the external environmental impact of most businesses. Coordinated inspections with regard to both environmental impacts and the work environment have proven to be effective, for example within the recycling industry, and directed joint efforts, possibly with other authorities, may be one way to reach many small businesses while offering a coordinated advice service. Some parts of the service sector, such as the hotel and restaurant industry, have an inadequate infrastructure for work environment services, for example, poor access to health care and little connection to labour market organisations. Here it is important that supervision is effective, but the need for supporting structures should also be mapped.

Vocational courses should focus on teaching safe practices and how individual protective equipment is used correctly. A review of any deficiencies and needs should be carried out in co-operation with the Swedish Work Environment Authority and the relevant regional safety representatives.

It is the ambition of the The Swedish Work Environment Authority to disseminate information about work environment issues through new channels, video clips, Twitter, an app about noise, etc., but a major breakthrough is required. Insecure forms of employment, mainly for young people and newly arrived immigrants, are making the commitment to work environment obligations more difficult in large sectors.

One way to reach these sectors could be to engage young people in knowledge alliances in order to describe and discuss their work environment while giving good examples, bringing about contacts, etc. The possibilities of a joint commitment to this involving the municipality (through for example folk high-schools), companies in the ICT sector and the Swedish Work Environment Authority, in consultation with labour market organisations, should be considered.



ACTION 2.2.3.2

Develop and implement strategies that promote good working conditions in the City of Malmö's own operations as well as services that are procured.

The municipality itself, is a major employer, especially for women. Working conditions in education, health and social care are strained for large groups of employees in the whole country, which is reflected in surveys to employees and in inspections carried out by the Swedish Work Environment Authority. This may take the shape of excessive workloads, lack of support and a low decision latitude, heavy lifting and night work. Meanwhile, there is a looming staff shortage in several of these areas, which means that it is important to create conditions so that those who have the right skills can continue to work for their whole professional career. It is equally important to formulate and implement strategies that combine good quality welfare services with good working conditions. Long-term planning is needed for employees in relation to job requirements, skills development, physiological aging and their own conditions and preferences, so-called "age management". Corporate health care is an important resource in terms of work adaptation and rehabilitation efforts to retain older employees. Better co-operation between the relevant authorities and corporate health care with a long-term perspective is needed for this.

The City of Malmö is also a major stakeholder when it comes to procurement. Public procurement has been criticized for not considering the opportunity to impact on the work environment, in

the procurement process. The Swedish Work Environment Authority has recently clarified its opinion on this (93). Stronger monitoring of the quality of procured welfare services would probably also benefit the working environment of employees.

A ACTION 2.2.3.3

Introduce peer review as a method for developing new forms of organisations characterised by discretionary learning.

Work organisations characterised by discretionary learning are one aspect of what is advocated within the social investment perspective. Discretionary learning is the name of a particular type of work organisation that differs from "Lean production," "Taylorist organisation" and "Traditional organisation." (148) The differences between these four organisations of labour mainly concern the elements of problem solving and learning as part of the job, as well as the employees' degree of freedom in organising their work. Discretionary learning is the type of work organisation which contains the most problem-solving, learning and freedom. This is the type of work organization that dominates in the Nordic countries. "Lean production" dominates in the United Kingdom, Ireland and Spain. The differences in Europe are described by Bengt-Åke Lundvall and Edward Lorenz as quite dramatic and "... the dramatic differences within Europe in how people learn at the workplace reflect differences in domestic institutional

settings in relation to education and labour markets." (148)

The authors show that it is work organisations designed according to discretionary learning that are the most successful in the global competition; "... innovation thrives in countries where a large proportion of the employees are engaged in work activities involving problem solving and learning". For people to be able to solve problems and be interested in learning a developed welfare system is required, according to the authors. In this way economic growth and welfare are linked. Countries with large inequities in welfare, such as the United Kingdom and Portugal, are also those with the least emphasis on problem solving and learning at work. These countries therefore have the poorest prerequisites for surviving in international competition, because "... growing income inequality reduces the willingness of workers to take an active part in processes of organisational learning." (148)

The Commission proposes that peer review becomes a regularly recurring and general method for organisational development. It can be used to allow colleagues working on similar issues to meet and evaluate each other's activities. Even pupils at different schools could evaluate each other's schools by using this method. We regard it as important that the research community is also represented in the peer reviews that are carried out, through the participation of researchers or postgraduates. In this way peer review will also contribute to the long term development of knowledge about working life. The action is explained in detail in Section 3.

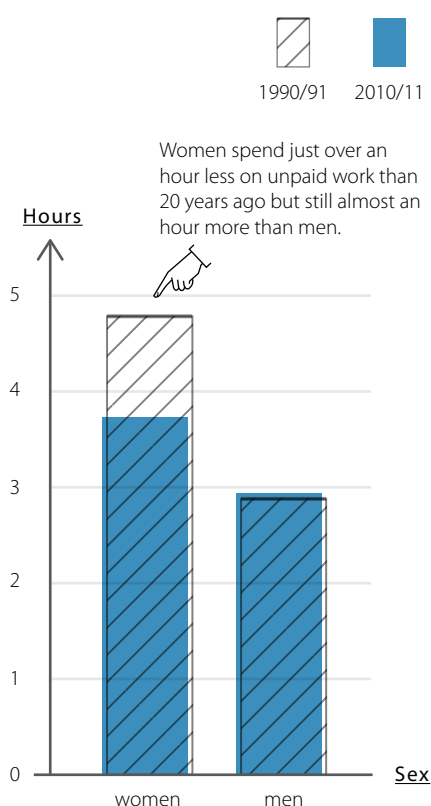


Figure 48

The number of hours of unpaid work per day, for women and men in Sweden. Change from 1990/91 to 2010/11. Source: Statistics Sweden, 2010

2.2.4 UNPAID WORK

Work is not just a job, as it is expressed in Statistics Sweden's recently published time use survey "Nu för tiden. En undersökning om svenska folkets tidsanvändning år 2010/11" (Living Conditions, Report 123; Swedish Time Use Survey 2010/11). (149) Similar studies have been carried out in 1990/91 and 2000/01. Many unpaid activities must also be categorised as work, it is declared in the report, and this unpaid work is extensive in contemporary society. It is performed to a greater extent by women than men. Of women's total work 46 per cent is unpaid, which is a decrease from 55 per cent in the previous survey in 1990/91, see Figure 48. For men unpaid work amounts to 36 per cent of the total work. It has, however, increased by about three percentage points. The gender difference has thus decreased.

The WHO Commission on social determinants of health also considers it important to broaden the view of work and make unpaid work visible. Housework, social care and voluntary work must be included in the national accounts, the WHO Commission claims and refers to Canada as a good example. As Susanna Toivanen et al write in a report to the Malmö Commission, more remains to be done:

Of the 6 recommendations to improve the health of women which were made in the WHO report there is only one which Sweden has not already addressed in the legislation: Upgrade unpaid work (housework, care in the home and voluntary work) and also factor it into national accounts such as GDP (our translation). (68)

Failures in the welfare sector particularly impair women's ability to provide for themselves and their families through gainful employment. Access to child care, including outside office hours, after-school places and adequately dimensioned and well-functioning care for the elderly are therefore important issues. Surveys conducted by care researchers and unions suggest that a significant portion of primarily women with low levels of education, involuntarily reduce their working hours to ensure that the care needs of elderly parents are not neglected. This accentuates the income inequities between socio-economic groups in society. (132).

OBJECTIVE 2.2.4

The unpaid work which contributes to a socially sustainable development of Malmö must be made visible, supported and undergo gender equity integration.

One of the Swedish researchers who has done the most research on the importance of work is Lars Ingelstam. In his book *Ekonomi på plats* (*Economy in Place*) he defines work using three criteria. The first defines work as an "activity which is performed or could in theory be performed for monetary payment." (135) An example of this is the assembly (e.g. assembling IKEA furniture in the home by oneself, etc.) that nowadays are expected of us in the home. This is also called self-service and basically concerns the conversion from paid work to unpaid work. We now have to carry out the work ourselves that the furniture manufacturers used to do for us. It is exactly the same when we scan our groceries at the supermarket. This is still work, but nowadays it is not paid and therefore does not count as gainful employment. If all of this self-service work was reconverted to paid employment the employment rate would probably increase substantially.

Secondly, Ingelstam includes in his definition "such activity which unambiguously within our culture and our society is defined as (productive) work", and thirdly, "such activity that constitutes a prerequisite for work in the monetary economy and paid work ... to function." (our translation) (135) An example of the third category is activities that are carried out in households and associations. Ingelstam's view of work forms the basis of his division of the economy into four sectors: Yellow (largely the private sector), blue (the public sector), white (groupings other than private or public ones) and black (illegal activities of any kind). Ingelstam divides the white sector into two main types of organisation; households and what he calls the co-operation sector. The latter consists of, e.g., voluntary associations.

The head secretary of the government commission Demokratiutredningen (the Democracy Survey), Erik Amnå, was one of those responsible for the survey of voluntary associations which was published in 2003, *Föreningslivet i Sverige* (*Associations in Sweden*) (150). It showed that 44 per cent of individuals in the age range of 16-84 are active in at least one voluntary association. In *Levnadsundersökningen 1995-97* (The Survey of Living Conditions 1995-97) 33 per cent of all Malmö residents aged 18-74 were active in voluntary associations, that is, a significantly lower proportion than Statistics Sweden's figures for the whole of Sweden. However, Statistics Sweden's figures apply to the age range of 16-84. Of all the city districts in Malmö the highest proportion of individuals who were active in associations was recorded in "Södra Innerstaden" (44 per cent) and the lowest in "Rosengård" (11 per cent). In 1996, "Fosie" had the second lowest proportion of individuals who were active in voluntary associations. Twenty-five per cent of all those in the age range of 18-74 were active in at least one association. Ten years later, this proportion had increased to 28 per cent. (73)

However, the value for society of the work carried out by the voluntary sector is not usually recognized. Its importance to social sustainability and reduced inequity in health is therefore not made visible at all. According to Vogel and Amnå, voluntary associations contribute to welfare by providing social contacts, giving information, creating identity, creating a sense of belonging, providing an arena for creativity and supporting the interests of their members.

People learn to collaborate around a common goal, to be faced with different life experiences and values, to prepare

and jointly make decisions, and to (partially) organise everyday life in collective forms. From such experiences of interacting human activities, people together build mutual trust, social capital of broad significance beyond the associations, in market relationships and in the greater democracy. In this way the social capital weaves a sort of undergrowth of social trust which is conducive to democratic development (our translation). (150)

It can be added that the voluntary sector through its mix of paid and unpaid work has important implications for social cohesion in the city. This is by creating alternative forms of actual participation, which make it possible for people to gain a sense of participation in society, even if there is a lack of employment and the economic resources otherwise required for someone to be "inside".

A ACTION 2.2.4.1

Strengthen the co-operation with the voluntary sector and take advantage of its potential to create social innovations.

A number of innovative environments have been created in the voluntary sector in recent decades. Characteristic of these environments is the interest in new ideas and opportunities to test them. They consist of contexts where different commitments can be linked to each other. In this way chains of commitment have arisen and the emergence of such chains in recent decades is an important explanation for the relatively strong position of voluntary sector.

These innovative environments also usually comprise organisations characterised by discretionary learning, which people in research tend to emphasise as a prerequisite for the development of social innovations and decisive benefits in global competition. The voluntary sector's innovative environments are mainly characterised by three elements; namely (a) the methodical commitment and drive to find new ways to capture the intuitive knowledge in everyday life where traditional bureaucracy fails, (b) the development of new institutional game rules and re-negotiations of normative obligations between a multiplicity of actors with a variety of goals, and (c) enunciating consensus and mobilisation around sustainable, universal, indivisible, and solidarity values which cannot be negotiated and reduced to pure matters of interest.

The importance of unpaid work has recently attracted the attention of the Stiglitz Commission. They want to broaden the economic concepts to make the activity that takes place outside the market visible.

For example, many of the services people received from other family members in the past are now purchased on the market. This shift translates into a rise in income as measured in the national accounts and may give a false impression of a change in living standards, while it merely reflects a shift from non-market to market provision of services. Many services that households produce for themselves are not recognized in official income and production measures, yet they constitute an important aspect of economic activity. (21)

The Stiglitz Commission's proposal to change this can be interpreted as a radical shift in the view of work. In recent decades

work has come to be synonymous with gainful employment. Work is only considered as being what you get paid for. The Stiglitz Commission is laying the foundations for important discussions about what is really meant by work and the importance of the contribution of various types of work to societal development.

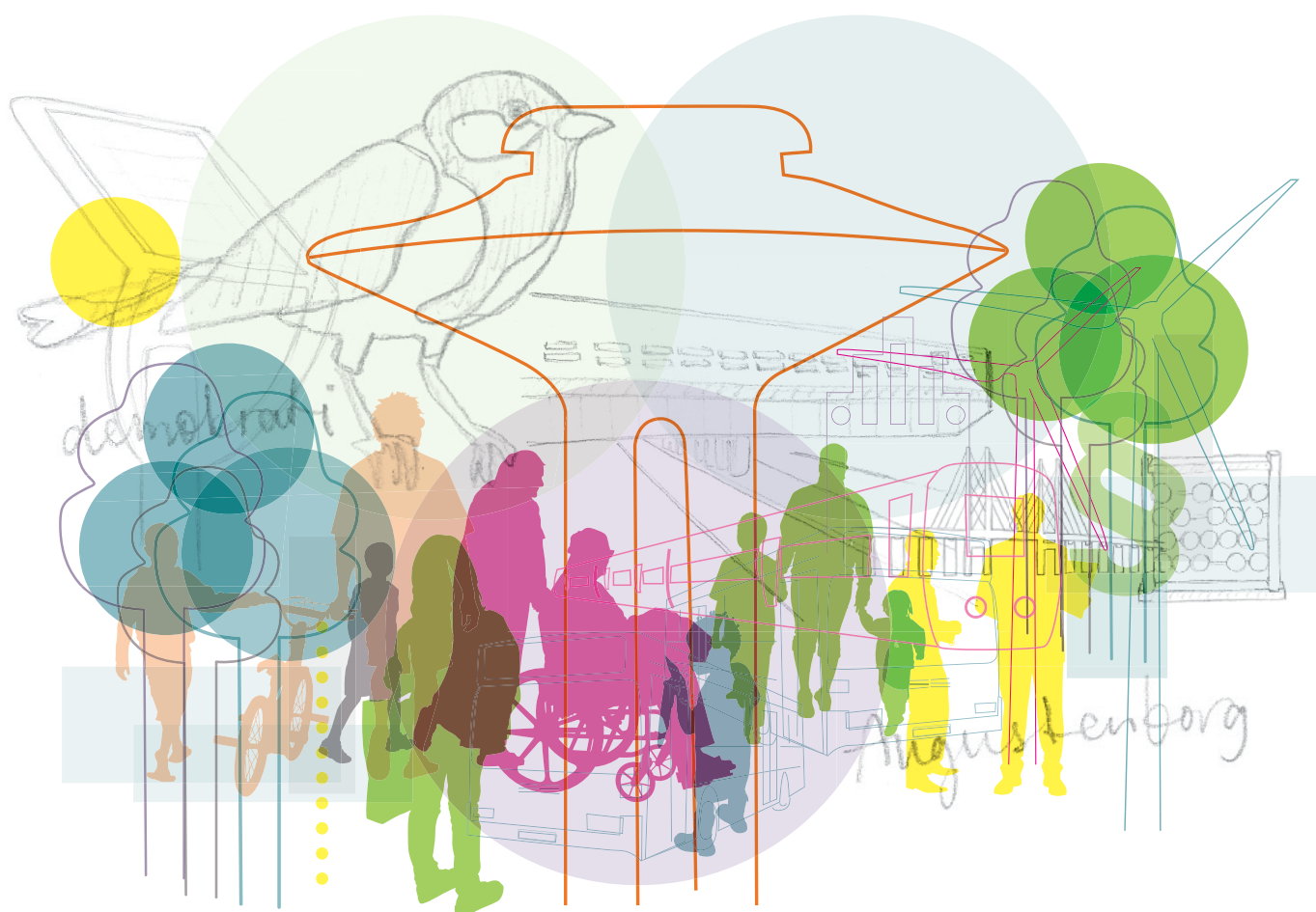
Education can also be considered as a type of work, but in measurements of the employment rate, those who study end up on the wrong side of the line. They are among those who are not working, that is, the non-employed, and therefore appear in the statistics as a problem rather than as part of the solution to future societal development (73). The employment rate will therefore drop if more people choose to enter into education. Conversely, an increase in the employment rate could be due to fewer people going into education. The solution to this obvious problem does not consist of regarding education as gainful employment. But what

should it be considered as? The reason why the problem arises is the definition of work. Equating work with paid employment means that all other activities apart from paid work are insignificant. This also applies to education.

A ACTION 2.2.4.2

Conduct recurrent surveys of living conditions to identify the extent of unpaid work.

The Commission proposes that surveys of living conditions be conducted as a recurrent method of identifying the extent of unpaid work. Surveys on living conditions also help to increase people's participation in the development of knowledge which could be important to them as well as to the entire society. The action is explained in detail in Section 3.



2.3 Health care

HEALTH CARE can contribute to reducing health inequities if its initiatives are developed so that they occur in an equitable manner based on the needs that exist among the population. The most important public health work is without doubt outside the area of responsibility of health care, but in this chapter the focus is on the important contribution health care can make as one of many actors working to improve public health and reducing health inequities.

Health-promoting initiatives to support individuals' confidence in their own ability and efforts to prevent illness in the form of support in changing bad living habits are particularly important for individuals with poor socio-economic resources. This requires the development of effective methods and improvement of knowledge about how to influence health-related behaviours even where there are social or linguistic obstacles. Otherwise the risk is that those who have good resources will benefit the most. The same is true of the efforts of health care to contribute to the knowledge about causes of disease and actively participate in multidisciplinary initiatives in order to improve the working environment for their own employees as well as from the population perspective. This approach has strong support among both politicians and employees, but more must be done to develop methods and control systems that make this approach possible (148).

Until 1983, health care services have had a relatively limited mission "to provide health care." With the new Swedish Health and Medical Services Act of 1983 health care received a broader mission. This has been clarified in the national public health objectives, in their sixth domain, "A more health-promoting Health Care Service", which was adopted by the Swedish government in 2003 (152). This approach has a clear analogy with the WHO's concept of Health Promoting Hospitals and Health Services, which is based on the Ottawa Charter, which aims at reorienting health care so that it can respond to the needs of society (153).

In Skåne and Malmö, Region Skåne is responsible for most of the health care services. The municipality is responsible for home health care, care for people in institutions run by the municipality and school health services. Although health care is primarily a regional responsibility the Commission has examined the current situation regarding the prerequisites for equitable health care. A number of areas have been identified that show deficiencies in the present approaches and suggestions are given as to how improvements can be made. As one of the Commission's priority areas is living conditions during childhood and adolescence, we particularly analysed some of the most important functions within the health care services related to children and young people, such as maternal health care, child health care and school health services. We have also conducted an analysis of health care use in Malmö to evaluate whether the care is equitably used.

2.3.1 EQUITY IN HEALTH CARE AND PREVENTATIVE SERVICES

The Health and Medical Services Act places great emphasis on contributing to health equity and equitable health care which is provided by needs:

The goal of health care is good health and health care on equal terms for the entire population. Care should be provided with respect for the equal value of all people and for human dignity. Those who have the greatest need of health care should be given priority in health care.

In 2010, the Audit Office in Region Skåne conducted an examination regarding equality and equitable health care in the region (154). Interesting information was obtained from

various documents, in-depth interviews with key persons, focus groups and an online survey to employees within the region.

In brief, it was found that the availability and accessibility of health care were not equitable in the region. Socially vulnerable groups have greater difficulties in their contacts with health care services, often because of communication problems. The consensus was striking that there are language barriers, a shortage of interpreters, barriers to accessing information because patients have a low level of education or a foreign background, that many patients for various reasons find it hard to make their voice heard, partly because of cultural differences and partly depending on conflicting value systems vis-a-vis the staff. Notable deficiencies were also found in employees' understanding of the actual rules and regulations that govern health care services and negative attitudes towards patients with a foreign background.

Clear shortcomings in knowledge about the Health and Medical Services Act's implications were demonstrated when it came to understanding how employees' own knowledge, skills and attitudes about equity in health may affect their work. The employer rarely, if ever, provides information on equity issues and there is no difference between public and privately run services. Furthermore, it was revealed in the interviews that many felt that health care cannot prioritise problems concerning equitable and fair treatment because "*Region Skåne (the regional health authority has bigger problems to deal with)*". The basis of the report also included a scientific study of equitable care with regard to cardiovascular diseases, mental illness and the utilisation of children's health care (155). It showed that the quality of treatment is worse for the elderly compared to younger people and that individuals with low incomes often are given cheaper drugs than those with higher incomes.

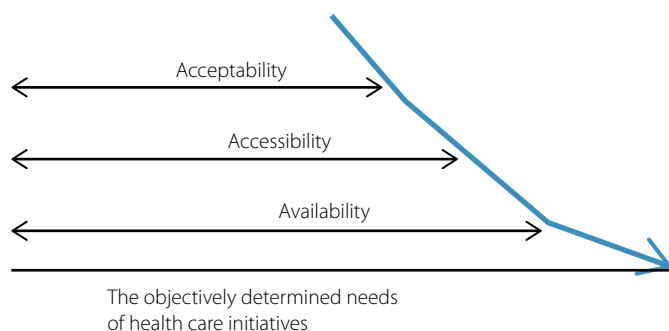
Wachtler reports in her thesis on the importance of the intercultural competence of doctors. Medical students in Lund and Malmö are not taught and assessed in a consistent manner in terms of competence in dealing with cultural differences. Teaching about such topics is perceived as peripheral and of lower status than medical knowledge (156).

Intercultural competence in health care is inadequate and the interest in prioritising this area in basic and advanced training is often low or non-existent. The same applies to gender issues. Interviews even showed that many felt that these issues should not be given priority and that other issues were more important.

It is reasonable to assume that what is reported for the whole of Skåne is also of relevance to Malmö. The results are in line with and provide further support to the results obtained in the report on utilisation of health care in Malmö which was published on behalf of the Commission (157).

The following model (Figure 49) shows how inequities in the utilisation of health care may arise from barriers at different levels.

Figure 49: Barriers in the health care system



Source: Adapted from Tanahashi 1978

This model can be used for all levels of health care services to improve health for individuals and groups, regarding preventative services, treatment of disease and rehabilitation after overcoming an illness.

At the bottom of the model the objectively determined needs for health care interventions in a population are illustrated. The next step illustrates whether a specific needs-based intervention even exists, that is, availability. Even here social inequalities may manifest themselves. It ought to be just as easy to make investments in those unhealthy

conditions which are most common among individuals with a low social position as it is for those that are most common among those with a higher social position. Almost invariably this is not the case. The British doctor Tudor Hart coined the term “the inverse care law” (158) to describe this phenomenon. The figure illustrates that some of the complete needs coverage in a population is already lost here.

The next step in the figure concerns the accessibility of health care services. This depends on a variety of factors, including costs, opening times and geographic location, that is, factors that are often associated with social status. In the debate that followed the health care choice reform in Sweden, it has been argued that health centres tend to close down in resource-poor areas, while the number of health care providers increases in central parts of the city. This often results in reduced accessibility for individuals in lower social positions.

Finally, social inequalities can arise through acceptance of the types and content of the provided service being lower for individuals in low social positions. It can be because health care providers use a language which is not understood by an individual in a low socio-economic position, or that the offered services are perceived as being insulting or stigmatising. For a long time, this has been identified as a general problem and for this reason the clause concerning the individual's participation and influence in his or her own health care process was included in the Health and Medical Services Act Main Article, in 1983. The factors discussed below, can be understood based on this classification of barriers to the use of the range of services provided by the health care system.

2.3.2 USE OF HEALTH CARE IN MALMÖ

On behalf of the Commission the relationship between utilisation of health care, such as visits to the doctor in out-patient care, visits to nurses, physiotherapists, psychologists and use of in-patient care in relation to the socio-economic position of families with children as well as adult men and women of all ages in Malmö, was studied (157). In Malmö in 2010 around 870, 000 visits to the doctor were made equivalent to 2.9 visits per inhabitant (Skåne 2.8, Sweden 2.5). Almost half of all visits in Malmö were in primary care. The elderly's share of the number of visits to the doctor is clearly shown in Figure 50. Irrespective of where one seeks health care in the city information about the individual and his or her address is recorded.

There is no difference in the number of visits to the doctor in out-patient care per inhabitant between the city districts despite their differences in income. But the majority of indicators clearly show that there are significant health inequities between city districts which are related to the individuals' income and education. One would therefore expect a higher utilisation of health care in some city districts if this truly reflected the needs, which is why this can be interpreted as an inequitable situation.

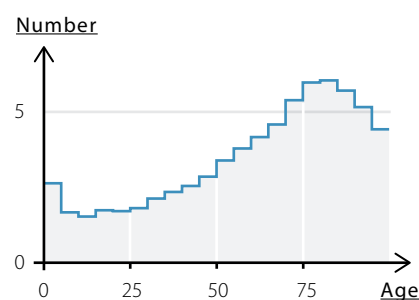
Those with the lowest income and the lowest levels of education mostly use in-patient care which corresponds to their morbidity being greater. Studies of the utilisation of in-patient care and its relation to self-rated health recorded in the Scania Public Health Surveys, show significant differences in the pattern between the city districts. This is also shown in the studies reported in the passage on the health inequity between Swedish-born and foreign-born individuals, where health for example among immigrants from Iraq, the largest group of immigrants in Malmö, is far poorer than among Swedish-born people. The previous reporting of maternal health care and child health care points in the same direction. All this indicates inequity regarding out-patient care in Malmö's population.

The following briefly outlines a basis for improving preventative work and making health care more equitable in Malmö.

2.3.3 PREVENTATIVE SERVICES IN REGION SKÅNE AND IN MALMÖ

The question about how to handle issues of health-related behaviours in primary care and specialised care is a hot topic in Skåne and Malmö. On 9 March 2012 the region's health care committee decided on accreditation and contracts for health care units in Skåne applying in 2012 (159). In this respect, reference is made to the Health and Medical Services Act's requirement that those most in need of care should be given priority. The key words were availability, continuity and security, encountering the right skills, being seen and having a sense of trust and participation.

Figure 50: The number of visits to the doctor in 2010 per resident and year in Malmö, age stratified



Source: Beckman, 2012

The caregiver should at the individual level of working with health-promoting and illness-preventing efforts, both primary and secondary prevention, give advice on self-care and early detection of risk behaviour. Systematic work should be done regarding discussions concerning health and the health-related behaviours in terms of use of tobacco, use of alcohol, physical activity and dietary habits.

Furthermore, it was made clear that an interpreter should be provided when the patient does not understand Swedish and as a service for the deaf, deaf-blind and severely hearing impaired. An extensive literature review of 30,000 articles form the basis of the recommendations, but the knowledge of how to reach out to individuals in low socio-economic positions is inadequate (160).

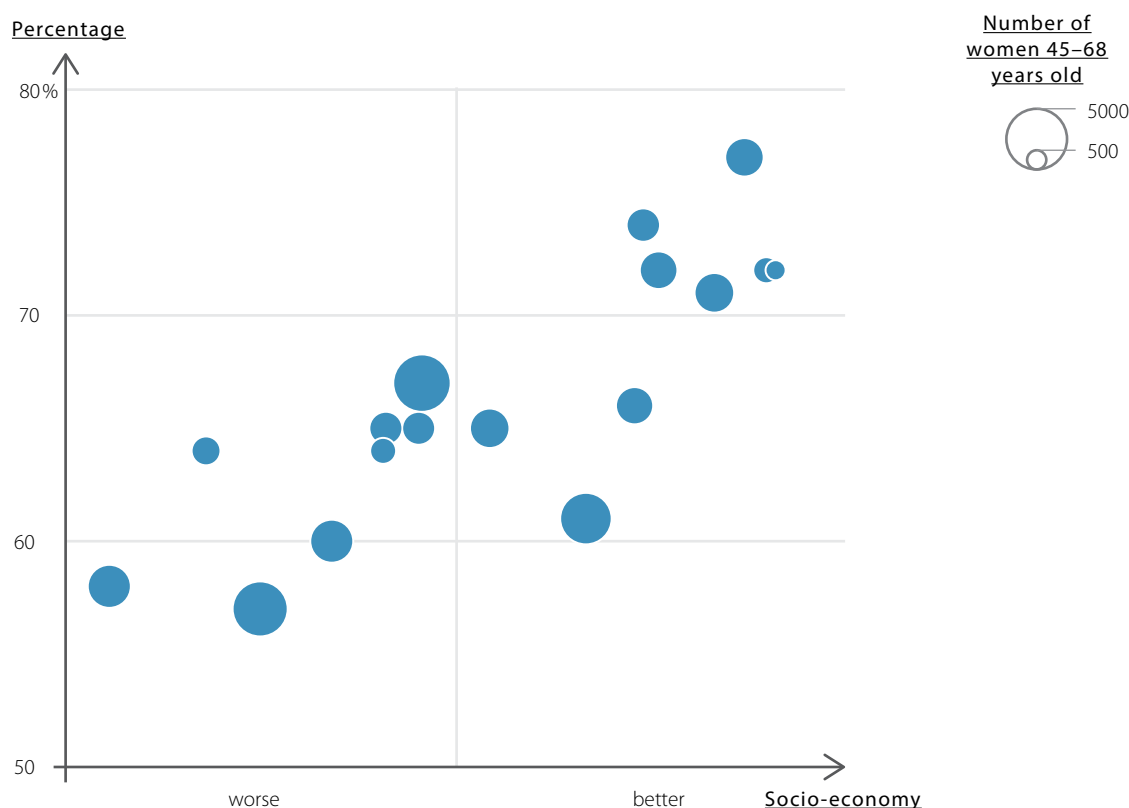
Skåne University Hospital and the other Skåne hospitals are included in the national network Health-promoting Health Care. Membership (WHO-dictated) requires that the hospital will work in a health-focused manner based on three perspectives: patients, employees and the population. According to a statement the Commission received from the person responsible at Skåne University Hospital, patients can be referred to the Skåne University Hospital Health Unit for physical activity and smoking cessation. There are also specific health promoters. The patient forum at Skåne University Hospital is aimed at the public with lectures on various themes. The current focus is the Swedish National Board for Health and Welfare's new guidelines on health-related behaviours. It is important to make this work integrated into health care so that it does not become a parallel track of services. The importance of knowledge about how to communicate these issues based on social and cultural conditions has not received sufficient attention. There is considerable potential for improvement here.

The available information shows that Region Skåne is now facing new procedures in health care where health-promoting and preventative services will be more prominent. At the same time public medical care has changed: It is reducing in scope and new ways of collaborating have been developed between the private and public sectors. There is a global health care market with health care employees and health care providers who work across national boundaries, where large multi-national pharmaceutical companies and health care companies increasingly play a role. The Commission has noted the major changes which are in progress, within for example maternal health care, child health care and primary care. (161) There is a risk that globalisation and privatisation of health care services could lead to less resources being allocated for disease prevention within health care. Effective systems for monitoring the interventions made by the health care services, regarding preventative and health-promoting aspects, irrespective of the patients' background, must therefore be developed as a high priority in the future in Malmö as well as in the rest of the country. Management, monitoring, targeted resources, expansion of the reimbursement system, the mission of primary health care and its development, as well as the profession's approach to disease prevention, are of great importance for equitable health care based on the needs of the population.

The profession's basic and advance training is of great importance for being able to achieve equitable health care. More health-oriented health care services, place higher demands on a broader professional training of employees with the aim of achieving a synergy among different professions. It can lead to a change in the professions' own attitudes to their daily clinical work with health-promoting and disease prevention interventions.

A concrete example of how social factors affect the participation rate in preventative services is the Malmö mammography study in which more than 34,000 women aged 50-69 were invited to participate. Comparisons between the 134 subareas of Malmö showed a non-participation rate which varied between 18 per cent and 63 per cent. Areas with the lowest participation were among those with the highest proportion of individuals in low socio-economic positions (162), see Figure 51. Researchers at Skåne University Hospital have analysed possible causes of this inequity. A fee is charged for participating in the mammography programme and the invitations are written in Swedish, which may be part of the explanation.

Figure 51: Association between the proportion of those who attended mammography screening in Malmö and socio-economic status



Source: Zackrisson, 2012

Health care services have recently begun to apply new recommendations on how issues related to smoking, diet, exercise, and alcohol should be handled in the context of a patient's visit. The importance of intercultural competence and knowledge of how to effectively reach patients from different social backgrounds is not being identified in the new accreditation agreements that exist within the region. Basic training courses and further professional training of all staff working in health care must be improved to meet society's need for intercultural competence and the importance of social factors for patient's health-related behaviours.

2.3.4 ACTIONS DURING MALMÖ RESIDENTS' LIFECYCLE

Based on the scientific evidence that formed the basis of the passage on the health of Malmö residents, the Commission has identified a number of actions that individually or together could help to reduce health inequities during the entire life cycle.

As early as during pregnancy better use of opportunities to create greater chances for a good life for the expected child through increased psychosocial and social initiatives should be made (163). The demands placed on the quality of the handling of those issues within maternal health care are currently not the same as for the management of purely medical checks, and therefore largely depend on the individual midwife's knowledge, insight and commitment to these aspects of care (50). Training of midwives in motivational interview techniques, and regarding psychosocial issues and the development of models of parental preparation that focus on confident parenting are important aspects of those services. As noted previously, it is necessary to develop effective methods to reach mothers regardless of their social position or other factors, such as language skills. The opportunities to make health care more equitable are counteracted by other forces such as limitations due to costs, e.g. regarding the use of ultra-sound, longer doctor appointments, longer midwife appointments and recurrent health appointments (164).

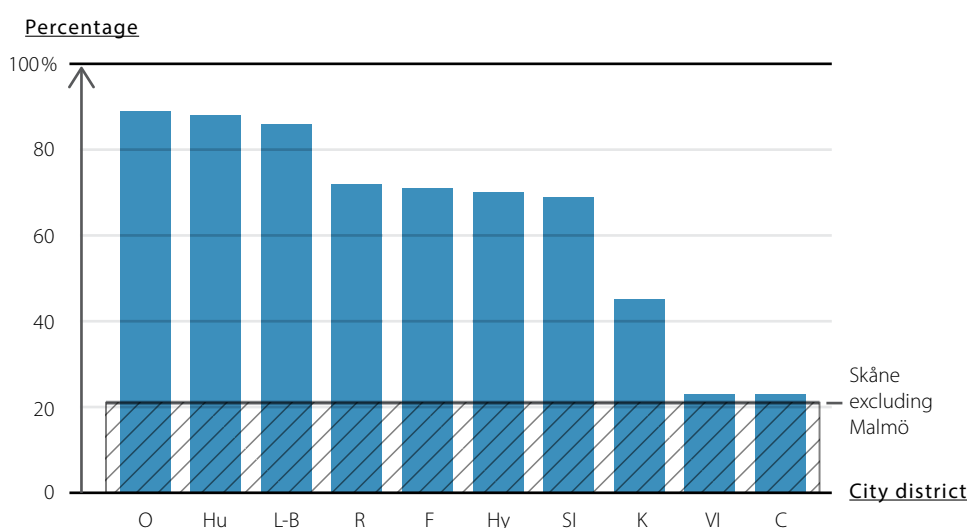
Children who are 0-5 years old are enrolled in the child health care services. When they start attending preschool classes, usually at six years of age, the responsibility for pupil health is usually transferred to the municipality. Children who do not attend preschool continue to



be registered with the child health care service. In 2011, there were 23 child health care centres in Malmö which provided services for 27,000 children. During that year, approximately 15,000 children were born in the region, of which 5,000 were born in Malmö.

The task of the child health care services, is to promote the child's physical and mental health, prevent illness and identify children in need of health interventions or treatment, that is, to pay attention to the actual needs. The child health care service offers health programmes to all children including health visits and other interventions. The programme includes support for parents, vaccinations, health examinations and interventions when needed. A few important components are home visits, parent support in groups and screening of new mothers for depression. Statistics show that the differences between the city districts in terms of the implementation of these services are great, for example in the case of home visits (Figure 52). No analysis has been done regarding the causes of these differences. The parents' social situation may be one explanation, the child health care service's working practices another. Home visits are considered to be a particularly important measure from a preventative perspective and it is important that these reach the parents with the greatest need.

Figure 52: The proportion of first-child families who have received a home visit in 2010 in the different city districts, sorted in descending order. Striped bars show the average for Skåne County rather than Malmö



Source: Köhler, 2012

Staff in health care have a legal obligation to inform social services about a child who has been abused or is suspected to have been abused. Child abuse is often related to the families' living conditions and it is therefore important from an equity perspective to note these needs and offer the required services. The number of notifications that come from child health care are however very low, just under 3 per thousand children, which means that most children who are abused are not detected. The differences in reporting rates between different areas/child health care centre units are great. There are indications that the organisational form of family centres have a better capacity to both motivate families to seek assistance from social services and to identify children who are abused. The family centres contain several services under one roof – open preschool, child health care, maternal health care and supportive social services – and have both the region and municipality as principals (51).

School health care includes medical health care and has psychological, psychosocial, social and special educational competencies. The passage on education in this report describes how poor health is behind a significant part of all school failures and school drop-outs. This shows the great potential importance that school health has to both prevent and deal with health problems that are strongly connected to the pupils' health-related behaviours and their families' socio-economic position (see Section 1, Chapter 1).

Only medical school health care is discussed here. Medical school health care, unlike maternal health care and child health care which has Region Skåne as its principal, is a purely municipal service. The Commission has not been able to obtain a clear picture of the school health care's organisation, management, content and quality in Malmö. Health care in mu-

Folkhälsoundersökning 2013 (Public Health Survey 2013)

In 2013, The Department for Public Health and Social Sustainability, Region Skåne, in co-operation with Kunska-pscentrum för Barnhälsovård (The Knowledge centre for Child health care) will conduct a public health survey aimed at children of 8 months and 4 years of age and their parents in Skåne. This survey will map health, health-related behaviours and living conditions among young children and their parents. It will also be possible to break down the results at municipality level. The results are estimated to be ready for presentation in autumn 2014.

municipal compulsory schools and upper secondary schools in Malmö have, unlike in Stockholm and Gothenburg, different management organisations. The medical school health care in the municipal compulsory schools is coordinated by a school doctor and is served by eight part-time doctors with different expertise as well as eighty nurses. Operational managers of services for children and young people within each city district are responsible for municipal school health. The City of Malmö's Education Department in charge of the municipal upper secondary schools has their own organisation with a responsible school doctor and school nurses attached to each upper secondary school. How the private schools organise health care services is unclear. Within the context of the pupil funds that follow each pupil it is up to the management to determine what resources will be allocated to school health care. Private schools, as a rule, have health care services linked to each company. The municipal primary schools and upper secondary schools use the same digital record system; how this works in private schools is unclear.

The City of Malmö is currently reorganising the school system. In connection with this, it is of the utmost importance that school health is seen as a resource for ensuring children's equitable conditions for good health and their ability to benefit from their education. In order to bring this about a resource overview is required that ensures every pupil's entitlement to school health care of high quality and continuity. Co-operation is needed between the child health care services and school health care services, so that the records follow each pupil. This is an important issue if one is to obtain an overall picture of Malmö pupils' right to equitable health during the important years of school. The Swedish National Board for Health and Welfare has drawn up guidelines concerning how maternal health care records should be taken into account in child health care and then passed on to the school health services (165). Legally, this is somewhat complicated but not impossible (166). This is particularly urgent regarding children at risk of being abused and those who are homeless, asylum seekers and foster children. Systematic monitoring of pupils' health is needed based on information from the medical records system from both municipal and private schools.

The recurrent surveys regarding health-related behaviours in compulsory school Years 6, 9, and upper secondary Year 2 in Malmö's schools should also be an important source of inspiration for a holistic approach to the health of the children in Malmö and its social distribution. Comparisons can be made with the whole of Region Skåne and partly also with the whole of Sweden. However, the picture is fragmented in terms of how the survey responses are used. No monitoring attempts have been performed to assess whether the results of the surveys were used as an integral part of the school's work on health and preventative services.

The careful monitoring and follow-up available within both maternal health care and child health care does not exist in the school health services in Malmö. Nor is there any information on how children are performing at school, which is important knowledge about children who are abused and not least for effective prevention. It is of particular importance that a well-functioning school health service collaborates closely with both school and parents. Within compulsory school the focus has so far mainly been on physical and mental health problems which have not been put into a social and educational context, a shortcoming that has become increasingly evident. (49)

Newly arrived children are an important group in terms of health equity. As suggested by the Swedish Paediatric Society and The Swedish National Medical Society, all newly arrived individuals have the right to free health examinations, that is, asylum seekers, migrant relatives, quota refugees and undocumented individuals. This currently only works partially in Malmö (112, 167).

The so-called Bunkeflo Model in Malmö has attracted international attention. The project included, among other things, increased physical activity during the school day. This model is a good example of how schools, parents, pupils, sports associations and the research community together can lay the foundations for a change in approach that leads to both better health and better school performances. This model is one example of the knowledge alliance project which is discussed in several places in this report. It also aims to ensure increased participation and influence for the target group. The project works in accordance with WHO's concept of "Health-promoting schools". It means that everyday life at school should provide a supporting and health-promoting environment for physical, social and mental health and learning. Health is at the centre. The scientific evaluation after nine years showed that both girls and boys improved their physical activity and their learning performance also became significantly better, with nearly ten per cent more pupils being eligible for upper secondary school in the group with increased teaching in physical education and

health, compared with a control group. (112) The Commission has conducted a health-economic evaluation of the project which shows that the investment was clearly profitable for the municipality (80). (The calculation is reported in Section 2, Chapter 1).

There is significant knowledge about the health of the adult population in Malmö. But no-one in Malmö is responsible for providing a complete picture of morbidity, disability, self-rated health, mortality, remaining average life expectancy for various ages, health-related behaviours, differences in health related to age, gender, ethnicity and social position. Nor is there any continuous analysis of existing health-related records, such as the comprehensive injury registry or results from the mammography programme and gynaecological check-ups.

The scientific evidence gathered by the Commission clearly shows that the health inequities are significant and that they have increased in recent years. The municipality must take responsibility for continuously monitoring and analysing health trends in the city. This of course applies to the entire life cycle, from pregnancy to the last breath. A continuous epidemiological monitoring system is needed linked to analysis and suggestions for effective actions to reduce health inequities and for improving the health of all of the residents of Malmö. The epidemiological monitoring system should be coordinated with the corresponding analysis of other social determinants of health which are collected and presented in this report.

As for the health of older Malmö residents, a trial should be initiated in Malmö with socially and medically focused health checks/health visits to older people in the same way as was done in Denmark and in recent years by a number of health clinics in Gothenburg. A study of 75-80 year olds in Malmö showed that significant socially-determined needs were identified in every seventh person and that many of these could be addressed by the municipality. In every third person the need for medical and psychological measures was identified. Every fourth person was in need of contact with medical care. In a follow-up a year later, a dramatic effect was demonstrated with a halving of the need for medical and social interventions (165). The economic, medical and social impacts of these results must be analysed. Since a large number of elderly people make many visits to primary care services each year this initiative could be integrated in a cost-effective manner throughout the municipality in co-operation with Region Skåne.

O OBJECTIVE 2.3.4.1

The City of Malmö city in co-operation with Region Skåne prepares an action plan to better achieve more equitable health and health care on equal terms for the entire population of Malmö.

A ACTION 2.3.4.1.1

Ensure that maternal health care has the prerequisites to offer care on equal terms.

Maternal health care has a key role in providing early childhood conditions for a good start in life. Due to the fact that the health choice reform is being introduced in maternal care attention needs to be paid to assuring quality and that good maternal health care reaches all expectant mothers in Malmö. Continued public health monitoring and quality assurance are important to achieving preventative efforts as well as co-operation with child health care and municipal activities, and others.

A ACTION 2.3.4.1.2

Ensure that child health care has the prerequisites to offer care on equal terms.

Increased expertise in mental health and improved co-operation on children at risk of ill-health or vulnerable living conditions is needed

regarding guidelines for action. The general initiatives that can be done such as home visits should be provided to all families in Malmö with new-born babies. An in-depth analysis of why the frequency of notifications to social services of children who are at risk of being abused is so low in child health care is needed, as well as actions taken.

A ACTION 2.3.4.1.3

Improve the conditions for socially equitable mammography screening.

Differences in participation rates in mammography screening are largely explained by socio-economic factors. Mammography screening in Malmö should be free of charge, as it is in many other parts of the country. Invitations must be in several different languages, and not only in Swedish, and contain relevant information to encourage participation.

A ACTION 2.3.4.1.4

Conduct an analysis of visits to the doctor in out-patient care in Malmö's city districts.

The reason for the discrepancy between visits to the doctor in out-patient care in Malmö's city districts and the actual morbidity in those districts, needs to be investigated to provide a basis for reducing social inequities in the availability, accessibility and acceptance of this type of care.

A ACTION 2.3.4.1.5

Offer health checks to everyone aged 80 and above

Attempts should be made in Malmö, in co-operation with Region Skåne, to offer everyone aged 80 and above a free medically and socially oriented health check.

A ACTION 2.3.4.1.6

Improve intercultural competence and knowledge about the importance of social determinants for health-related behaviours within health care.

Basic training courses in the health care sector should be strengthened with regard to intercultural competence and the importance of social determinants of health-related behaviours. Furthermore, health care services should provide their staff with continuous training. Within the city of Malmö there is extensive experience of various types of training both regarding attitudes and intercultural competence. Possibly training courses could be coordinated with the range of training opportunities available within the City of Malmö.

O OBJECTIVE 2.3.4.2

All children in Malmö should have equitable access to health care as well as health-promoting and preventative efforts until they leave school.

A ACTION 2.3.4.2.1

Strengthen the focus on the social determinants of health in maternal health care, child health care and municipal school health care.

A concentrated effort should be made in co-operation with the region and universities to reform the basic training and advanced training of staff in maternal health care, child health care and municipal school health care with regard to social determinants of health, gender issues and intercultural competence. The existing quality registers in the health care services should be clear on these issues. The social determinants must be included in health discussions.

A ACTION 2.3.4.2.2

Conduct a review of collaborative efforts relating to children's health.

Real conditions must be created for an interdisciplinary and intersectoral collaboration on children's health and living conditions, health and health inequity, by establishing a system to monitor the health trends and exposure to health risks for all children in Malmö, from pregnancy through the first years in child health care and school health care. This issue must be made a high priority if all children are to have an optimal chance of a good and healthy life. The relevant structures already exist but collaboration and alternative types of work must be reviewed. This could for example involve setting up a children's unit in the city of Malmö in co-operation with relevant stakeholders.

A ACTION 2.3.4.2.3

Make preventative actions against violence, neglect and sexual abuse of children a priority.

Increase the identification of children who have been abused. Strengthen the co-operation between authorities and services that work on behalf of such children. Increase support for families with children, who have social problems.

A ACTION 2.3.4.2.4

Evaluate the Family Centres.

Set up an evaluation of the Family Centres' ability to promote children's health and prevent ill-health and based on the outcome of this consider establishing more Family Centres. This could be included in the assignment of a possible Children's Centre (see also chapter 1.1).

O OBJECTIVE 2.3.4.3

School health care in Malmö should guarantee equity and high quality in both municipal and private schools.

A ACTION 2.3.4.3.1

Establish a common management structure for school health care.

Ensure a joint management structure for school health care which is responsible for providing municipal as well as private schools with competent staff. Guarantee relevant advanced training for all staff, regarding medical and social issues, irrespective of the type of school. The quality requirements regarding school health care should be on the same level as in child health care. The municipality and region should jointly apply to the Swedish National Board for Health and Welfare to coordinate the patient records systems of maternal health care, child health care and school health care. Malmö could showcase such a model for the rest of the country by this initiative.

The collaboration between medical and other school health care, social services and other stakeholders needs to be improved, especially with regard to pupils who need special support.

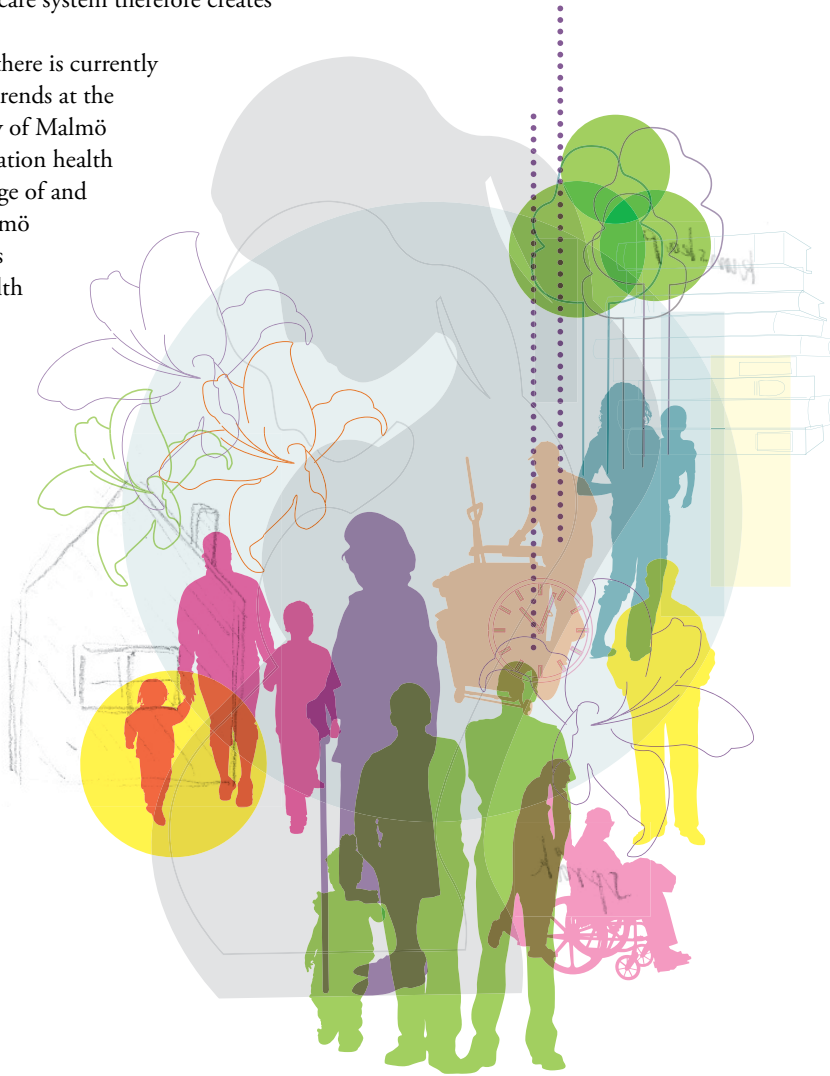
The City of Malmö is currently reorganising its school system. In connection with this it is of the utmost importance to ensure good health care in all schools. The municipality should consider the possibility of coordinated health care services in compulsory schools and upper secondary schools.

Furthermore, systematic monitoring of pupils' health is needed both by municipal and private schools, at the same time as enhanced collaboration with the university to follow health indicators, medical as well as social ones, over time to be able to implement the initiatives mentioned. The knowledge that exists about Malmö pupils' living conditions and health-related behaviours, is an important basis in this work and needs to be made available with the aim of systematically putting it into practice.

2.3.5 THE NEED FOR A PERMANENT COLLABORATIVE BODY

Health care often gets a unique insight into individuals' lives and the consequences for their health. A population-focussed approach in the health care system therefore creates opportunities to influence the basic causes of ill-health.

The Commission has called attention to the fact that there is currently no key role in society for professionally monitoring health trends at the municipal level. The public health reports made by the City of Malmö highlight the need for a high level of competence for population health surveillance at the municipal level. In order to take advantage of and use the knowledge that exists within the universities in Malmö and the unique expertise available in the health care services to report on illness, injuries, mortality, determinants of health and to perform health-economic analyses, the municipality must create a permanent collaborative structure. Health care services, including primary health care, no longer have a clear responsibility for population-oriented work that specifically address the needs of the population in Malmö. Adequate local competence in epidemiological and public health science is also necessary if health inequities are to be reduced and overall population health improved. Such expertise already exists in Malmö, but must be better utilized for the preventative and health-promoting work to become more effective.



O OBJECTIVE 2.3.5

The knowledge about the population's health in Malmö should be improved and the results should be analysed and used in the municipality's and region's preventative work.

A ACTION 2.3.5.1

Establish a qualified epidemiological surveillance system of the entire population of the city.

With the unique and considerable competence at Lund University and especially the Malmö part of the Faculty of Medicine at Malmö University, within Region Skåne and within the municipality, the City of Malmö should ensure a solid base for epidemiological surveillance, analysis and monitoring of the health of Malmö residents. As an example, the Public Health Surveys in Region Skåne should be analysed together with other types of health information (morbidity, mortality, health care consumption, social determinants of health) and lead to discussions on how the results should be interpreted

and applied at the local level. In the collection of this information, scientists, epidemiologists, representatives of health care, the City of Malmö and the wider society should be included.

Knowledge of cultural differences and the reasons for immigration must be improved so that ill-health can be prevented among immigrants. This applies within health care services as well as within schools and other societal systems.

A ACTION 2.3.5.2

Use analyses from the injury registry in Malmö to continuously convert the results into practical preventive work in all areas.

The partially unique and high-quality injury registration in Malmö must be used to the fullest extent to reduce injuries in different environments and help reduce inequity regarding injuries. It is unacceptable for valuable information to be gathered and not used far more in a comprehensive approach to the preventative work. This could be included in the assignment that is suggested in Section 3.

3. Transformed processes for socially sustainable development through knowledge alliances and democratised management

THIS SECTION OF THE FINAL REPORT starts with the question of HOW the changes should be made, that is, the changes which are required to reduce the inequity in health. Another starting point is the overall recommendation which we formulated in the introductory section, namely, “change processes by creating knowledge alliances and democratised management”. This means that we would like to make the creation and development of knowledge part of the solutions. This could also be described as a changed focus: From a one-sided emphasis on prerequisites and results to also including knowledge and learning processes. The processes must be designed in a way that makes continuous learning possible.

The change we seek is to not identify and solve one problem at a time, but to contribute to a changed development of society where action always starts from a holistic perspective and helps to solve several problems at once. It requires impact assessments for the sustainable development of all strategic decisions, more transparent processes where the starting point/problem is identified

and described in broader terms than is traditionally done. In this way, a direction is established but the final objective is not defined precisely out of respect for the process and the freedom to develop new knowledge and find new solutions.

Learning and the creation of knowledge are keywords in this fundamental change in the processes. Other keywords are actual participation, sense of participation and democracy. It is therefore about changing existing systems, which also means creating new social structures that make improved participation possible where types of actual participation also benefit a sense of participation. We regard it as desirable to increase citizens' influence and participation at all levels to increase the sense of participation and as an extension of this, experience increased control over one's own life. Some of this obviously applies to democracy and governance but our proposal is considerably more extensive. Figuratively speaking, it does not only concern City Hall and politics but the municipal processes in general.

In recent decades a new type of management has emerged, which is usually called governance. This means a type of management and organising closely associated with the concept of networks and with different forms of cross-boundary co-operation between public and private stakeholders. Governance is usually contrasted with government, which is the traditional form of management and organising, hierarchically ordered with clearly defined and delineated levels of responsibility. Government involves policies being made, decided on and taking place in formal institutions. Governance means going outside the institutions and making politics in partnership. Government can be characterised as a vertical form of management compared with governance which is horizontal. It does not mean that governance is neutral and less political than government. These are two different ways of doing politics and politics in recent decades has become increasingly characterised by governance. Since often only the business sector is involved in governance, not associations or representatives of the people in city districts with low voter turnout, this raises questions about the development of democracy.

It is this development and the risk of an increased lack of democracy that the Malmö Commission wishes to counteract through the development of participation and the creation of new forms of it. We have a fundamentally positive view of governance but are of the opinion that it must be democratised. The governance processes are being debated with regard to matters such as accountability and the principles of representative democracy (169). Who and what should be represented in the networks that governance often results in is not always a given. Despite the fact that governance processes can be regarded as having in-built democratic problems (mainly in the shape of the previously-mentioned accountability and representation), from a democratic perspective, they can also embody great advantages, primarily through flexibility, a focus on solutions and the loosening-up of more hierarchical types of decisions.

Sustainable development requires a critical approach to the traditional management of societal problems. Today we know that objectives can be achieved more quickly and resources saved through cross-sectorial or transdisciplinary co-operation within the municipality, between administrative levels and between public institutions, the business community and the voluntary sector. With this insight it is no longer acceptable to act based on perspectives or the use of methods with inherent limitations in the shape of silo-type thinking. The term "health in all politics" has been used to emphasise that all political decisions can have impacts on health. The representative democracy's public exercise of power through elected assemblies (government) must be developed, for example, through increased public transparency and accountability. It is important to safeguard the principle of public access and freedom of information. This vertical management of society according to the principle of government must also be complemented with network-based and horizontal management (governance). It requires a developed combination of government and governance using new methods for participation and influence that function better in order to solve complex problems in a complex world.

Participation and influence in society is one of public health's most fundamental prerequisites, and also constitute the first of the eleven national public health objective domains. A democratic society requires that the citizens feel that they are participants and are given real opportunities to affect their own lives. As described in Section 1, Chapter 2, if people do not feel that they are participants in a society there is a great risk of losing trust in their surrounding environment (75), which must be considered a considerable democratic risk. A sustainable society, in terms of the three aspects of sustainability, is in turn not possible without a stable and democratic base. When individuals and groups perceive that they lack the opportunity to influence their own conditions and the development of society at large, a sense of alienation and powerlessness develops. These factors in turn contribute to negative health outcomes. There is also a relationship between low democratic participation and poor self-rated health. Participation in the form of social and practical support through close and positive social relationships has great significance for health – the lack of such relationships has proved to be able to affect blood pressure and blood sugar levels and ultimately also leads to early death. (170) As mentioned in the introduction participation must build on a recognition of people's experiences and knowledge. It requires that the view of and approach to knowledge be developed.

The Malmö Commission is of the opinion that an approach that focuses on an integrated view of knowledge, in line with what the curriculum for compulsory school, Lgr 11, advocates, provides the potential for increased participation. To these forms of knowledge

can be added the importance of integrating, discussing and problematising experience-based and scientifically produced knowledge about social conditions and their relationship to health. Malmö residents can also be made more participative in the interpretation and use of scientific results, respond to these based on their experiences and become participants in knowledge processes which concern the improvement of their situation and social conditions. There are great opportunities to create such contexts through so-called knowledge alliances (see below).

One of the conclusions the Malmö Commission draws from the city initiatives of recent decades is that social issues have not become strategic. By this we mean that they have not been linked to economic and environmental issues and treated with equal importance. Inequitable health and welfare cannot however be solved separately as the dependence between economic growth and welfare is mutual. Economic growth cannot remain the overriding indicator of societal development. Instead it must be sustainability. The expanded forms of network management (governance) which are advocated by the Commission should be related to sustainability. It is in such an overall perspective that the relationship between economic growth and welfare should be placed.

One of today's major challenges is the management and definition of problems; how we identify what is desirable and set objectives, how we identify and solve challenges, how we make budgets and finance, how we lead, how we measure and monitor and how we integrate experiences and new knowledge. A problem is rarely separated from the larger context but rather its impacts comprise a multidimensional spectrum of small and large changes, which in turn may extend deep into the different parts of society. Actions to remedy these problems are characterised by similar complexity: partly, in the sense that the actions affect the consequences of the problem in various parts of society, but also in the sense that the actions have their own spectrum of impacts alongside the problem they are intended to remedy.

To be able to manage this also requires knowledge and competences other than those which are formalised through for example qualifications. One example could be the knowledge that many young people and adults in multi-cultural areas acquire. This can be called intercultural competence. The Malmö Commission regards it as very important to recognise and take advantage of this competence. The recognition and utilisation of the intercultural competence of many Malmö residents would mean using potentials and resources which are not recognised today and at the same time could give people a sense of participation in society.

In this section we will begin with suggested objectives and actions in a subchapter which we call knowledge alliances. This is because we see the utilisation of people's knowledge as fundamental to the democratisation of governance that we advocate. Increased participation should not only build on the democratic principle of one person – one vote. It should also be based on the knowledge that people have. It is on this basis that participation should be enabled although not only in decisions but also in a learning and a shared development of knowledge. Participation in decisions and management are part of the broader participation that the Malmö Commission advocates. It requires a new kind of leadership and holistic management principles.

3.1.1 KNOWLEDGE ALLIANCES

The EU's overall strategy Europe 2020 advocates efforts for knowledge alliances. Europe 2020 contains three priorities, all of which have to do with economic growth. Economic growth should be smart, sustainable and inclusive. These three priorities form the basis for five objectives and seven so-called flagship initiatives. One of the seven flagship initiatives is called "Innovative Union" and this includes the focus on knowledge alliances. The definition, however, tends to be too narrowly limited to alliances between "education and business."

O OBJECTIVE 3.1.1

Promote the development of learning and knowledge-developing organisations with a potential- and cause-oriented approach that takes advantage of experience and informal knowledge, such as intercultural competence.

We suggest efforts for knowledge alliances in Malmö, but from a broader definition than the one in Europe 2020. By knowledge alliances, we mean equal partnerships between researchers and stakeholders such as the public sector, the voluntary sector, trade and industry, focused on combining excellence and relevance. Allow these knowledge alliances to deal with sustainable development and welfare, with particular focus on the connection between economic growth and health. The EU report *Cities of tomorrow* advocates efforts for knowledge alliances, also in a broader sense than the flagship initiative "Innovative Union" expresses (30). We are of the opinion that knowledge alliances can be created in many different contexts and therefore we would like to emphasize this as a suggestion in its own right but below we also suggest four particular types of knowledge alliances.

The participants in a knowledge alliance have different experiences and knowledge, the one is not necessarily better or worse than the other. The collaboration in a knowledge alliance should meet requirements of relevance, but not only this. On the part of research it must also result in excellence. The requirement of high scientific quality should be met and therefore it cannot be called action research. It has to be interactive research using the meaning of the concept that has evolved in recent years. The ambition is that all the various parties' interests should be satisfied. It should concern innovative societal development just as much as research and also education. Participation will involve mutual learning and the development of new knowledge. It is not just a matter of applying existing knowledge but it is also about developing new knowledge.

A ACTION 3.1.1.1

Include regular surveys on living conditions in processes.

More knowledge is needed about people's living conditions. This is highlighted in several background reports. The question is how to acquire this knowledge. All methods have their advantages and disadvantages. We suggest efforts for the particular type of knowledge alliance called surveys on living conditions to develop knowledge, in

terms of both quantity and quality, about people's living conditions that is not available in public registers, take advantage of the experience and experience-based knowledge among practitioners, enable the processing of experience into knowledge, enable shared learning among practitioners and mobilise practitioners into change processes in collaboration with researchers. Those who conduct interviews with Malmö residents in a survey on living conditions, could for example be employees from different departments within the city administration who then also get to know each other and each other's work. In this way a survey on living conditions contributes to boundary crossing between different parts of the municipal organization. The boundary crossing becomes even more fundamental if, for example, representatives of the voluntary sector are also involved in doing interviews. Surveys of living conditions, for example, could be used to identify the extent, content and conditions of unpaid work. They could also be used to learn more about the skills available in the population, which have not been formalised in grades. Moreover, they could be used to develop knowledge about a residential area's problems and potentials. Surveys of living conditions have previously been carried out in Malmö with good results (147).

Young people in research (Ung i forskning)

A special form of survey of living conditions is the Young people in research (Ung i forskning). For one summer month, ten young people aged 15-18 have worked with surveys that contribute to current research on both opportunities and problems in areas characterised by social exclusion. The work has built heavily on young people's own experiences and knowledge but they have also had to learn what is needed for them to contribute to the research. The contribution to current research is the first aim of Ung i Forskning. The second aim has been to contribute to the development and the structural changes required for young people not to be considered as a problem but rather as a resource. Ung i Forskning was organised for three summers, 2009-2011, each time in the city district of "Fosie" and mainly financed by the initiative called Young people in summer (Ung i sommar). This meant that young people were paid for their participation and it has therefore been regarded as work.

A ACTION 3.1.1.2

Use peer review to make work organisations more learning and in the long-term to develop knowledge about working life.

Peer review is a method that has spread more and more in Europe. The method has long been used by academics. Before an article is published in a journal one or more researchers are engaged who examine, comment on and perhaps advise against publication. The EU Commission turned this method into a part of the Lisbon Process' *Open Method of Coordination* (OMC) and thereby extended its area of application. In the beginning it was only used in national comparisons but the areas of application have been extended gradually. Thanks to Eurocities and others it has spread widely. The method involves colleagues who work with similar issues meeting and evaluating each other's efforts. In this way they learn not just from others but also better understand what they themselves are doing. There are good experiences of this in the City of Malmö and in the co-operation with Malmö University.

We propose efforts for the specific type of knowledge alliance known as peer review, not just of projects but also of other activities, in order to develop knowledge about working life, to strengthen learning about working life (discretionary learning) and to allow people from different areas to meet and exchange experiences together with researchers. Peer review could also be important in developing familiarity and tacit knowledge, that is, knowledge that is required in order to make assessments of what is good and less good. Peer review could be feasible for example between schools by teachers but also by pupils.

A ACTION 3.1.1.3

Use on-going evaluation in both projects and ordinary activities to develop knowledge of problems, solutions, concepts and contexts.

Ahead of the EU programme period 2007-13 there was a shift from traditional evaluation to that which is called "on-going

evaluation". In Sweden, the National agency for Economic and Regional Growth (Tillväxtverket) chose to translate it into 'följeforskning'. In the publication *Nytta med följeforskning* (Benefits of on-going evaluation) from 2008 (171) the Swedish Agency for Economic and Regional Growth specified four guidelines. On-going evaluation should firstly contribute process support, secondly document experiences and knowledge with the aim of creating learning and retrieving knowledge, thirdly evaluate how well a project achieves its objectives in order to enable strategic changes and fourthly place the results in a broader societal context. We suggest efforts for the type of knowledge alliance called on-going evaluation, not only in projects but also in ordinary activities. On-going evaluation is needed in order to develop knowledge about problems, solutions and how they will be assessed, but also to develop knowledge about concepts, perspectives and contexts as well becoming better at problematising and comparing.

A ACTION 3.1.1.4

Use research circles for the production of knowledge and operational development based on the participants' own formulations of problems.

A problem which is constantly discussed is the issue of how to link operational development with relevant and current research in the field. As part of building knowledge alliances research circles have proved to be a usable method and model. The basic idea of the research circle is that it involves an organised search for knowledge and the development of knowledge in co-operation with all participants. The purpose of the research circle is to contribute to knowledge development through professionals seeking knowledge about a problem that they themselves formulate. Research circles are led by researchers from universities. In research circles the participants make empirical investigations which are interpreted and discussed by everyone in the circle in order to reach deeper knowledge about the problem area which the researchers regard as important for operational development.

3.1.2 LEADERSHIP AND HOLISTIC INSTRUMENTS OF GOVERNANCE

O OBJECTIVE 3.1.2

Promote the democratic development of governance and enable participation in various forms through inclusive management.

A ACTION 3.1.2.1

Develop leadership that enables sustainable development.

Modern and courageous leadership is required at all levels to create good prerequisites for all Malmö residents. Leadership that understands the meaning of promoting the work for a sustainable city for everyone who lives in the city. Leadership that contributes to visions and development goals, which perceives the city with all its opportunities and challenges as a whole, which regards

itself and its activities as a tool to use in conjunction with others. Furthermore, leadership which is value-based and therefore goal-orientated, brave and diligent. In order to create this, long-term development work on leadership is required. This entails a joint development programme for existing leaders which takes as a starting point change work and team spirit. Recruitment processes that systematically contribute to creating a team. The Commission suggests that the City of Malmö in wide co-operation with researchers and other experts on leadership, initiates a continuous development programme for leaders at all levels. The development programme should be value-based, build on the understanding and meaning of sustainability and holistic solutions and contribute to developing leaders who take Malmö to the next phase of development. The Commission also suggests that the recruitment processes for leaders be developed with the same purpose.

A ACTION 3.1.2.2

Develop holistic instruments of management.

The development of holistic instruments of management, such as impact assessments of planned actions and investments, budget systems and systems for annual accounts/monitoring, is necessary in order to get past the well-known but difficult to influence “silo phenomenon”. In other words, a saving (or an investment; just as important!) does not only have an effect on the “silo”, defined as an operation with the budget, administration and monitoring, which it is implemented in, but perhaps has still greater effects in another, or many other, “silos”. For example, it has been clearly demonstrated that savings in de-icing measures in the city's traffic environment lead to an increased number of injuries due to skid accidents, in this way much greater costs result in terms of medical care and elderly care. It is well-documented that this in the long-term leads to multiplying costs to society in the form of social security fees (reporting sick), care interventions (home medical care, other care initiatives, transportation, etc.), and an increased need for interventions from the health care services.

“The silo phenomenon” is a particular problem in a situation in which each administration has as its most important task sticking to the budget and reducing costs. They then risk the opposite effect, that is, a substantial deficit in the overall/holistic economy. It becomes obvious from the holistic perspective that existing resources could be used to very significantly increase the overall efficiency of the public service without increasing the overall costs. It is therefore of the utmost importance to create good management tools for such development. This has a huge potential impact on equity, perhaps particularly health equity, as it is the socio-economically weaker groups in a society who are most dependent on the compensating effects of public services.

A ACTION 3.1.2.3

Develop new and complementary measures of societal development which relate to overall sustainability.

In the Sarkozy Commission's Final Report the authors presented an analysis of existing measures of societal development and the problems with these. They state that the overall problem is that the GDP measure has for far too long been allowed to dominate overall measures of development. (21) This brings about a number of serious problems, which are described in more detail in Subchapter 0.03. We must therefore work with a number of different measures of development, a “dashboard” of old as well as new measures, which at the same time capture the various important aspects of societal development, economic, environmental and social, so that the balance between them provides an idea of society's overall sustainability. Some of these must be general so

that a place or situation can be compared with others, but some measures need to be adapted to local needs and contexts. This is in order to fit into processes with increased democratic governance, where different knowledge alliances jointly define concepts, challenges and solutions. This could also mean that these processes have the potential not only to generate locally usable information but also to contribute to the general development of concepts and measures relating to sustainable development in all its aspects. Relevance can, in other words, be combined with excellence in this process. The Malmö Commission elsewhere in its Final Report points at the interesting possibility of the monitoring of its proposals creating structures in Malmö for such a development, which could become of international interest since the preparedness to adopt the challenge of sustainability is increasing in similar cities around the world. The work should bear in mind the international debate which is in progress and seek collaboration with the cities and organisations that together with researchers are working on equivalent assignments and objectives.

An important measure of societal development concerns the health of the population in Malmö and also its social distribution. This is based on the view that health and its distribution in the population is a good indicator of the sustainability of society's development. Equity in health is a specific indicator of social sustainability through its strong link to the social determinants. An in-depth discussion on how the measures of health and its social distribution can be developed, will be found elsewhere in this Final Report (Chapter 0.4).

A developed and coherent information system with knowledge alliances linked to each stage of the planning/implementation cycle, must be established: Choice of measure, data collection, analysis of measured values, how they can be related to the implementation of the activity and finally how the effects of this implementation are evaluated. We regard the previously mentioned four types of knowledge alliances as central to the development of new measures of societal development.

Another key instrument that we would like to highlight is the Policy Empowerment Index. On behalf of the Commission, Gavriilidis and Östergren have developed a Policy Empowerment Index (PEI), which is intended to serve as a monitoring tool with which to measure the degree of civic participation in the municipal policy process (172). By continuously using PEI as an evaluation methodology the policy process in itself contributes to the increased participation of citizens, and by extension also becomes a means for improving the health of the residents of Malmö.

Such a coherent information system is a necessary function to support the priorities of a social investment perspective and in the democratized governance processes, which constitute the two overarching strategies that the Commission proposes in this Final Report.

3.1.3 INFRASTRUCTURE OF KNOWLEDGE ALLIANCES

O OBJECTIVE 3.1.3

Create new forms of collaboration between the private and public sectors as well as the voluntary sector based on knowledge alliances, which can contribute to changing the relationship between economic growth and welfare.

A ACTION 1.1.3.1

Further develop an infrastructure for social innovation and urban integration.

We propose the creation of an infrastructure of knowledge alliances that can contribute to the development of better and more equitable health in Malmö. This infrastructure should aim to develop social innovations and strengthen urban integration based on a social sustainability perspective. It should also build on and take advantage of the successful co-operation between different disciplines and stakeholders that was established in connection with the Commission's two-year project. The connection between social innovations, urban integration and public health work, is especially important because it concerns changing the relationship between economic growth and welfare. This infrastructure should be established through existing services and interventions within the municipality, the voluntary sector, the business community, the university, authorities and educational establishments being invited to participate. Existing co-operation platforms between the City of Malmö and Malmö University can suitably be integrated into a new infrastructure.

Stakeholders who want to help to influence the social determinants of health by creating social innovations and at the same time strengthen urban integration, should be invited to participate. This also requires that development efforts be based on knowledge alliances according to the previous definition. The players will create nodes in this infrastructure and the plans developed in the City of Malmö's feasibility study on the Innovation Forum can be a source of inspiration for how these nodes could work. For example, the Area Programme could be invited to participate and thereby become a local Innovation Forum for structural and transdisciplinary public health work such as through urban planning and co-operation-driven development within education, health care and social care. Cornerstones in the voluntary sector such as Glokala folkhögskolan, Yallatrappan and Drömmarnas hus (the Glocal folk high-school, the women's co-operative Yallatrappan and the multi-purpose childrens' and youth centre Drömmarnas hus) are important sources of inspiration for how social innovations can be created, in order to strengthen urban integration. We regard it as very important that the voluntary sector's organisations are offered participation and influence on the same terms as other stakeholders.

The infrastructure with its nodes and other features, should through regular conferences and a continuous exchange of knowledge contribute to increased knowledge and inspiration for social innovation and social entrepreneurship. It can also contribute to increased urban integration for the benefit of the City

of Malmö and its citizens, in line with and as a continuation of the Malmö Commission's intentions regarding social sustainability and reduced health inequities. The forms of this infrastructure should preferably be developed in co-operation between representatives of the voluntary sector, the research community and the business community which the City of Malmö should invite. It is important that the infrastructure benefit from the fact that Malmö University has been appointed by the Swedish Government to become a national meeting place for social innovations with the task of coordinating knowledge and communication in the field of social innovations and social entrepreneurship. This meeting place is directly involved in the group of experts in the EU that is developing new methods to measure the results of social investments. Similarly, the meeting place has close educational co-operation with British organisations such as NESTA and Young Foundation which are deeply involved in developing new assessment methods. A coordinating body is required that supports and inspires the infrastructure's actors and maintains a continuous relationship between them but also stays open to and encourages other stakeholders to participate. At this point in time, we have no opinion on the specifics of this coordination process but it must be developed as a part of the next action.

A ACTION 3.1.3.2

Ensure that members of the Malmö Commission, together with the City of Malmö, Region Skåne and interested institutions create a joint agency for implementing and monitoring the Malmö Commission's proposals.

The implementation of all or parts of the Malmö Commission's proposals, will require commitment from many stakeholders. Elsewhere in this Final Report it is shown that a large part of the information which is primarily needed to describe, analyse and monitor health development, especially development related to the social distribution of health, takes place through Region Skåne's activities. Earlier there was a unit at Skåne University Hospital in Malmö, whose primary task was to collect this type of information, analyse it and in various ways disseminate it to stakeholders in the field of public health and outside health care. The most important of these stakeholders were Skåne's municipalities. The coordination of this co-operation was done by the public health strategists who were employed at the five former hospital districts. When the hospital districts were phased out the extent of this co-operation decreased considerably, while Region Skåne invested more in the health-promoting measures within its own area of responsibility, such as primary health care, and the concept of health-promoting health care, which is described elsewhere in this Final Report. The collection of information has however continued unabated which, as is also pointed out in the chapter on health care, means a considerable and currently vastly underutilised potential for Skåne municipalities' work on influencing the social determinants of health and promoting equity in health.

An important prerequisite for being able to utilise this information efficiently, is that the methods for data collection, analysis

and dissemination of results, are continuously quality assured. This has so far been done through Region Skåne's co-operation with researchers at the Faculty of Medicine in Lund University. Several of these have participated in the Commission's work, either as commissioners or as authors of the Commission's background reports, or both. Thus many important ingredients are already in place for establishing a joint agency to support the implementation and monitoring of the Malmö Commission's work. The Commission's work has also clearly shown the considerable potential of handling the mentioned type of information, that is concerning the health of Malmö residents and its social distribution, in a transdisciplinary forum. It is only natural to recommend that the City of Malmö builds further on this experience.

Therefore a new body of the proposed type should be based on interested researchers who represent a broad transdisciplinary knowledge base. Such an agency has proved to be necessary to handle the issue of the social determinants of health

in a holistic manner. Furthermore, this breadth should also be reflected among the representatives of the City of Malmö who should be invited to the formation of this agency. In order to mirror the Commission's perspective regarding deepened democratic governance for the handling of the social determinants of health representatives of the voluntary sector, the business community and relevant stakeholders in Malmö's population should also be given the opportunity right from the outset to participate in the starting up of this agency. As most of the material and human resources needed to get started with the activities already exist, it is mainly about initially injecting resources for coordinating these.

Key tasks for this body are also to promote the development of new measures for sustainability and health equity and methods of data collection, analysis, prioritisation, implementation support and evaluation of public health policy from a holistic sustainability perspective.

OECD Territorial Review of Skåne

With the objective of changing the relationship between economic growth and welfare, the previous actions should, for example, be linked to the initiative of a "Healthy Region" which the OECD proposes in its recently conducted Territorial Review of Skåne. The OECD highlights Skåne's culinary traditions as a special strength. The food industry's multicultural character should be turned into a distinctive characteristic of Skåne. The OECD states that the promotion of cycling could contribute to the "healthy region" identity and brand. It would also help to prevent overweight and thereby link a development of cycle tourism with public health work. We see this as an interesting example of a new relationship between economic growth and welfare.

It would be even more interesting if the concept "Healthy Region" was broadened to include what the Malmö Commission has been dealing with, that is, reduced inequities in health and welfare. This is in line with what the OECD report also proposes, for example, to engage public health specialists in urban planning in a more systematic way. The OECD report also points

out that Region Skåne has committed itself to work towards establishing a stronger link between public health and regional development in its future development programme. The health aspect needs to be highlighted as a bridging principle which connects the other key aspects in a sustainable development of the region. For example, a healthy workforce is one of the most important assets for the region's competitiveness, which is worth the equivalent investment.

Finally, the OECD makes the point that the on-going development work to promote regional growth would benefit from Region Skåne's public health work. An important step forward has been taken by Skåne's international innovation strategy 2012–2020, which focuses on health and sustainable cities/municipalities as key innovation areas. As the Malmö Commission sees it, a further important step could be to make reduced health inequities a part of the identity as a "healthy region". (145)

4. Compilation of objectives and actions



EVERYDAY CONDITIONS OF CHILDREN AND YOUNG PEOPLE

With the objective of strengthening all children's and young people's opportunities to influence and participate in society, the following actions are recommended:

- Develop the work on ensuring the children's rights perspective in the municipality, for example by appointing a children's ombudsman with the specific task of focusing on children's and young people's opportunities to participate and influence their living conditions, conducting child impact assessments of municipal decisions and actively working against discrimination of children and young people.

With the objective of halving child poverty by 2020 with a view to eliminating it completely, the following actions are recommended:

- Develop and implement a municipal action plan to reduce child poverty, establish municipal family support, increase access to computers and the Internet in the homes of families with children in Malmö, raise the municipal social assistance and introduce a standardized addition for children's leisure and cultural activities for households with children with long-term social assistance as well as provide all children in Malmö with access to free public transport in the city.

With the objective of reducing homelessness, overcrowding, poor housing conditions and poor outdoor environments for children and young people in Malmö, the following actions are recommended:

- Develop an action programme to increase the availability of housing of good quality that families can afford.
- Develop an action programme to address deficiencies in the environment for children and young people in Malmö. Consider the specific impacts on the local environment of children and young people in the city's physical planning and in new constructions and renovations of preschools and schools. Strengthen the efforts of the Environment Department in order to detect suspected problems of damp, mould and pests.

RESIDENTIAL ENVIRONMENT AND URBAN PLANNING

With the objective of ensuring that all Malmö residents have suitable accommodation and a good residential environment the following actions are recommended:

- Reduce the housing shortage. Initiate development work between different departments within the city administration, the research community and private stakeholders on how housing can be produced at reasonable cost. Within three years, 300 apartments should be ear-marked and set aside for the homeless.
- Establish a new municipal contractor organisation for assignment-based housing development with the aim of securing the provision of housing for all Malmö residents. Either MKB can be given new ownership directives or a new municipal company can be established.

With the objective that urban planning should contribute to reducing residential segregation the following actions are recommended:

- Introduce social impact assessments which should precede any decision concerning physical investments.
- Develop and intensify the successful work on mixing different forms of tenures, types of housing, workplaces and services. Transform barriers and structures which separate residential area into linking areas.
- Invest heavily in the model projects "Bygga om Dialogen" in "Lindängen" and "Amiralsstaden". The projects' level of ambition should correspond to the intervention before the international housing exhibition in Malmö in 2001 (Bo01), and the conversion of the harbour area, "Västra hamnen" (The Western Harbour), and contribute to the implementation of the Commission's recommendations. Long-term social investments should be linked to the principle of actual participation, whereby private property companies as well as the City Planning Office involve the residents in the area. The mentioned projects build on an integrated perspective where both social, economic and ecological objectives should be achieved. Therefore, renovation and reconstruction projects should take place so that stringent environmental requirements are met and a significant part of the workforce which is needed, should be recruited from the area and if required undergo training.

With the objective that urban planning should contribute to strengthening trust and promoting environments that invite participation, the following actions are recommended:

- Create more easily accessible meeting places, especially in areas with great overcrowding.
- Strengthen the participation and influence of residents in the urban planning processes and increase equity in the public environment by developing dialogue models and initiating planning methods where the citizen's participation increases.

EDUCATION

With the objective that all children and young people in the city of Malmö should have access to equitable preschools, schools and after-school centres, the following actions are recommended:

- Conduct a thorough survey of resource needs in the city's educational institutions accompanied by a financial plan.
- Strengthen knowledge-supporting structures and use scientifically validated instruments for quality development within each type of school.
- Continue investing in professional development through the language development initiative, School Investment 2012.
- Design professional education and advanced training of staff so that they follow the results of each type of school's systematic quality work.
- Strengthen the influence of children, young people and parents in everyday activities in preschools, after-school centres and schools, by actively including them in the systematic quality work.
- Strengthen the subject of Physical education and Health for all pupils in the City of Malmö's schools.

With the objective that all children of preschool age in Malmö should attend a preschool of good quality at least 20 hours a week by 2015, the following actions are recommended:

- Map children who are outside preschool, followed by active outreach and information.
- Reduce the number of pupils in the teaching groups in Malmö's preschools. As a first objective the groups for young children (0-3 years of age) should not exceed 15.

With the objective that all children and young people in the city of Malmö who complete compulsory school should qualify for further studies at upper secondary school, the following actions are recommended:

- Early and regular monitoring of children's language development followed by early interventions, when needed.
- Professional development initiatives aimed at teaching skills regarding reading and writing and increased awareness of deficiencies in children's language and communication abilities in preschools and schools, especially those with many children from multi-lingual environments.
- Give all pupils with a foreign background access to study instruction in their native language.
- Early and continuous monitoring of pupils' learning outcomes, accompanied by interventions, when required.

With the objective that all children of 6 – 12 years of age should have access to an after-school centre of good quality, the following actions are recommended:

- Reduce the number of pupils in the groups in Malmö's after-school centres up to a maximum of 30 children per unit as a first step.
- Increase the proportion of university-trained staff in Malmö's after-school centres. A first objective should be that 75 per cent of after-school centre staff should have university training.
- Establish at least one full-time position with the responsibility for after-school centres in the new administration for compulsory education.

With the objective that all pupils who have started upper secondary school education should have completed their studies within a five-year period, the following actions are recommended:

- Make the Ungdomsuppföljningen (Youth Monitoring Service) at the Vägledningssentrum (Guidance Centre) permanent and provide resources for monitoring, informing and motivating young people to study and/or take up work experience.

- Make major efforts to expand and reinforce medical, psychological, special education and socially trained staff within the Elevhälsan (School Health Service), at the municipal secondary schools.

With the objective that late arrived children in Malmö should urgently be given access to or rapid transfer to studies within an ordinary compulsory school or upper secondary school service, the following actions are recommended:

- Reform the system for the reception of newly arrived pupils. These pupils should attend the nearest school or another school which their guardian chooses. The existing Mosaik reception school, where presently all newly arrived children are concentrated, should be phased out.
- Perform a proper mapping of existing knowledge and develop an action plan from the first day, with a strategy on how the pupil should be supported in order to achieve the most success possible at school.

With the objective that the composition of pupils in Malmö's schools should be integrated with reference to socio-economic, ethnic, gender and school performance categories, the following actions are recommended:

- Establish, finance and locate attractive profiles for schools in the most vulnerable areas, in order to attract pupils from the whole city.
- Review the impacts of the localisation of planned schools and consider a new structure for the organisation of compulsory schools in Malmö.
- Find new ways of disseminating information about the educational institutions' activities and development, in order to prevent stigmatisation.

INCOME AND WORK

With the objective of actively enabling an economically reasonable standard of living for everyone and reduce economic inequities between households in Malmö, the following measures are recommended:

- Monitor the effects of redistributive policies in the city and take steps to reduce and mitigate adverse effects of inequity. Considering that Malmö is a “transit city”, the integration process of newly arrived individuals should be in focus in close dialogue with responsible stakeholders at the national level. Specific deficiencies in individual government social security systems should be analysed and communicated to the national level, for example, the need for increased economic protection against unemployment and ill-health.
- Initiate a discussion at the national level to raise the national minimum level for social assistance.

With the objective to explore new ways to stimulate the development of the labour market and the emergence of new jobs, the following actions are recommended:

- Develop an integrated approach to employment and welfare issues with national and local initiatives, like for example Försäkringskassan (The Swedish Social Insurance Agency), Arbetsförmedlingen, (The Swedish Public Employment Service), and Migrationsverket (The Swedish Migration Board).
- Review and investigate opportunities to further develop existing structures.
- Use physical investments as engines for local employment and urban development (see the previous proposal on “Bygga om Dialogen” and “Amiralsstaden”), decentralize labour market policy initiatives to places where people feel at home and strengthen the investments in municipal labour market training. It is also important that municipalities contribute to addressing the matching problem, which characterises the Swedish labour market.
- Conduct surveys on living conditions in order to map hidden competences and other potentials among Malmö's population.
- Expand the municipal information responsibility to 25 years of age in order to coordinate interventions for young people who are unemployed, poorly educated or have social assistance.

With the objective that the City of Malmö should be an example of uniting a high quality of welfare services with good working conditions the following actions are recommended:

- The municipality, Arbetsförmedlingen (The Swedish Public Employment Service), and Arbetsmiljöverket (The Work Environment Authority), should coordinate inspections of the public environment and work environment.
- Develop and implement strategies to promote good working conditions in the City of Malmö's own operations as well as services that are procured.

With the objective for unpaid work, which contributes to socially sustainable development in Malmö, to be made visible, be supported and undergo gender equity integration, the following actions are recommended:

- Strengthen the co-operation with the voluntary sector and take advantage of its potential to create social innovations.
- Conduct recurrent surveys of living conditions to identify the extent of unpaid work.

HEALTH CARE

With the objective to achieve equity in health and health care for the entire population of Malmö, the following actions are recommended:

- The City of Malmö and Region Skåne are encouraged to develop a joint action plan. It should include ensuring that maternal health care and child health care have the adequate resources to offer health care on equal terms, to create equitable mammography screening services, to conduct an analysis of visits to the doctor in out-patient care in Malmö, to offer health checks free of charge for everyone aged 80, and to improve intercultural competence and knowledge regarding the social determinants of health-related behaviours among staff in health care.

With the objective that all children in Malmö should have equitable access to health care as well as to health-promoting and preventative services until they leave school, the following actions are recommended:

- Strengthen the focus on social determinants of health in maternal health care and child health care as well as school health care with the aim of providing all children in Malmö with equitable access to health care until they leave school.
- Prioritise preventative actions against violence, neglect and sexual abuse of children. Strengthen the collaboration between authorities and services that work on behalf of neglected children.
- Conduct a review of collaborative efforts relating to children's health with the aim of establishing information systems to monitor health trends in all children in Malmö. There is a particular need for increased collaboration and improved co-operation concerning children at high risk of ill-health and children who have been abused. This could for example be achieved by setting up a children's unit in the City of Malmö.

With the objective that school health care in Malmö should guarantee equity and high quality in both municipal and private schools, the following actions are recommended:

- Establish a joint management structure for school health care. The municipality and the Region should jointly apply to the National Board for Health and Welfare to coordinate the patient records systems of maternal health care, child health care and school health care. The Commission also underlines the importance for the municipality, when reorganising the schools, to regard school health as a resource for ensuring children's prerequisites for equitable health and education.

With the objective that information about the health of the population in Malmö should be improved and the results analysed and used in the preventative work of the municipality and the Region, the following actions are recommended:

- Create a permanent body for epidemiological surveillance, analysis and monitoring of the health of the population in Malmö. The partially unique competence that already exists at Region Skåne, Lund University, Malmö University and the municipality should be included in such a body. By collaboration between researchers, representatives of health care, the City of Malmö and the voluntary sector, information derived from the Scania Public Health Surveys, and from other sources should be analyzed and lead to proposals on how the results should be applied at the local level. The task should include information from the partially unique injury register in Malmö.

CHANGED PROCESSES FOR SOCIALLY SUSTAINABLE DEVELOPMENT

With the objective to promote the development of learning and knowledge-developing organisations with a potential- and cause-oriented approach that takes advantage of experience and informal knowledge, the following actions are recommended:

- Perform recurrent qualitative surveys of living conditions with the aim of developing knowledge, both quantitatively and qualitatively, about people's living conditions which is not available in public registers, take advantage of experience and experience-based knowledge among practitioners and mobilise practitioners into change processes.
- Use methods such peer review, on-going evaluation and research circles, in order to develop knowledge about problems, solutions and how the results of interventions should be assessed.

With the objective to promote the democratic development of governance and enable participation in various forms through inclusive management the following actions are recommended:

- In a broad collaboration between researchers and other experts, initiate a continuous development programme that builds on the understanding and the meaning of sustainability and holistic solutions, which can take Malmö into the next phase of development.
- Develop holistic steering mechanisms, using tools such as impact assessments, budget systems for annual accounts and monitoring. The purpose being that existing resources should be used to raise the overall effectiveness of municipal services, without an increase of the total costs. The so called "silo-effect" is a particular problem in a situation in which each department within the city administration regards keeping the budget as its most important goal and must be avoided. The "silo-effect" has a deficit in the overall/holistic financial resources of the municipality as an unintended effect.
- Introduce development work in order to produce new measures of societal progress, which relate to overall sustainability, economic, ecological as well as social. Important measures of this kind are health and health equity in Malmö's population, which could be regarded as good indicators of general progress and social sustainability, respectively, of a society. Work with knowledge alliances should be developed, keeping in mind the current international debate in this area.

With the objective to create new forms of collaboration, by means of knowledge alliances between the private and public sector as well as the voluntary sector, which can contribute to changing the relationship between economic growth and welfare, the following actions are recommended:

- Further develop an infrastructure for social innovation and urban integration through existing services and interventions within the municipality, the voluntary sector, the business community, universities, authorities and educational institutions. Stakeholders who wish to help to influence the social determinants of health through social innovations and urban integration should be invited to participate. A coordinating body should be created and recurring conferences and knowledge exchange be initiated.
- Ensure that members of the Commission, the City of Malmö, Region Skåne and interested institutions create a joint body for implementing and monitoring the suggestions of the Malmö Commission. Invite representatives of the voluntary sector, the business community and relevant stakeholders in Malmö, to participate from the outset. Key tasks for this body should be to drive development further when it comes to initiating the development of new measures of progress and methods of data collection, analysis, prioritisation, implementation support and evaluation of public health from a holistic sustainability perspective.

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Appendix 1

Terms of reference

Commission for a Socially Sustainable Malmö

2010-10-06

The Commission's assignment

A commission has been appointed with the aim of drafting a plan including objectives and strategies on how the City of Malmö should reduce inequality in health. Inequality in health here refers to systematic differences in health which can be avoided through reasonable efforts. The plan should guide the City of Malmö's efforts to reduce inequalities in health between groups in the population. The starting point is the overall national public health objective "creating social conditions for good health on equal terms" with the focus on influencing the structural prerequisites for health.

The Commission's aim is to provide the City of Malmö with a foundation and some tools for controlling, prioritising and realising efforts which affect all Malmö citizens' prerequisites for health and decrease health inequality.

The Commission shall:

- based on Malmö's challenges regarding social differences, injustices and inequalities analyse causes and associations and identify what can be influenced and by whom/what and how,
- using this analysis as a starting-point, the Commission should suggest progressive objectives and analyse possible conflicts between objectives,
- suggest strategies for how to reach the objectives and suggestions on how the objectives and strategies should be followed up,
- carry out health-economic analysis and weigh the cost against the benefits of realising the strategies,
- especially observe how objectives and strategies can be anchored in different decision processes,
- in the light of its work point out any need for changes in the municipal organisation, and routines for co-operation and governance, with the purpose of strengthening and creating better health conditions on equal terms for Malmö citizens,
- suggest ways to measure and monitor the development of the distribution of health. Adapt these methods to the decision-making contexts where information is used e.g. the Area programmes for a socially sustainable Malmö, the city plan, the budget process and operational planning. The existing welfare reports are an important basis,
- calculate the economic consequences of health inequalities

for Malmö as well as the effects to be expected from initiatives aimed at reducing inequalities in living conditions.

The focus is on the structural determinants of health. In light of the health situation in Malmö, the three areas of research, the WHO report Closing the gap in a generation and the national public health policy have been prioritised:

1. **Conditions during childhood and adolescence.** Conditions during childhood and adolescence are of great importance for both mental and physical health for the rest of one's life. Malmö has a young population and the prerequisites for the living conditions of children and adolescents are crucial to Malmö's development.
2. **Participation and influence in society** is one of the most fundamental conditions for public health. A lack of influence and the opportunity to affect one's living conditions has a strong connection with health. If individuals or groups feel that they cannot influence their own living conditions and the development in society there is a feeling of powerlessness.
3. **Economic and social conditions.** There is a connection between good public health and a community characterised by economic and social security, equal living conditions, equality and justice. Financial stress and social insecurity cause ill-health, especially mental ill-health and lead to increased inequality in health.

In 2008, WHO published one of the most important documents written in the field of health in recent decades. This report, Closing the gap in a generation, and its conclusions is a key source of inspiration for shaping strategies for Malmö's current unequal distribution of preconditions for health. In the report it is established that "systematic differences in health which can be avoided with reasonable efforts are simply unjust and it is an ethical imperative to balance health inequalities. Social injustice is literally a question of life and death". According to the report there is enough knowledge about what needs to be done to achieve change, but there is a need for efficient decisions to put it into practice. Three general recommendations are presented in the report:

1. Improve daily living conditions.
2. Tackle the inequitable distribution of power, money and resources – globally, nationally and locally.
3. Develop and use methods to measure and monitor inequality in health, educate people who are trained to find the social determinants of health and develop people's awareness of these.

The report gives an account of some 60 concrete strategies and urges all governments to take the initiative for actions which can influence the social determinants of health, with the aim of achieving equality in health within one generation. It is not possible to directly apply the proposals of strategies/actions which have been defined globally. There is a need for a Swedish perspective and not least a local one where the City of Malmö's requirements for achieving equality in health are defined with concrete objectives and strategies. In the United Kingdom an independent commission has processed the report based on British conditions and suggested actions to be taken. Shortly, a European commission is expected to start work on a revision of Closing the Gap in a generation for WHO Europe. It goes under the name of The European Review of Social Determinants and the Health Divide. The Swedish government has given the National Institute of Public Health an assignment which involves testing to what extent the commission's conclusions are relevant to Swedish conditions. This report will also be considered, as well as WHO Europe's work.

The Commission should acquire experience of how other cities have handled inequalities in living conditions, which can then be compared to Malmö. Development work with a focus on decreasing health inequalities is in progress in some regions, for instance Västra Götaland and Region Skåne.

At its meeting on 23 August 2010 the City Executive Board decided that the City of Malmö should take part in a preliminary study regarding socio-economic analysis. The work will be carried out in co-operation with five Swedish cities within the framework of the Swedish network of Healthy cities. This work will constitute an important basis for the Commission's work.

A natural connection for putting it into practice is the on-going work in the Area programmes for a socially sustainable Malmö. The Malmö City Executive Board has decided to prioritise four areas; "Herrgården", "Holma-Kroksbäck", "Lindängen" and "Seved". The city's total resources should be mobilised for the development of these areas. Through co-operation with a number of different stakeholders such as citizens, associations, property owners, entrepreneurs and other authorities solutions to social problems should be realised and the areas transformed from problem areas to innovation areas.

From words to action – a working commission

The Commission's work is based on three important factors:

- Facts, research and science about what influences the determining factors of health and social structures to achieve equality in health as well as the health situation in Malmö today.
- Everyday Malmö i.e. the community in which changes needs to be made.
- New approaches, innovative modes of working and forward-looking strategies

New approaches and innovative methods, which at the same time

are based on facts and knowledge about what influences health, are needed. Also, the suggestions from the Commission should take their departure from everyday life in Malmö and should be possible to implement.

The Commission consists of a Chairman, a Head Secretary and the necessary number of commissioners. The City Office is in charge of coordinating the work and setting up the necessary civil servant support.

The Public Health Council is Malmö City Executive Board's preparatory body for public health issues and should prepare the suggestions and strategies devised by the Commission. It is the Chairman and Head Secretary who are in charge of finding methods for this. The Public Health Council's chairman is co-opted into the Commission and thus guarantees feedback to the Public Health Council.

It is an independent commission whose work should be transparent. The Commission should actively invite organisations and Malmö residents who can share their experiences to take part in the analysis and the shaping of strategies. It is important that the Commission's work is made accessible and that it is communicated both internally and externally. For instance, this can be done through different types of meetings, hearings/lectures to and with different stakeholders such as Malmö residents, professionals, the private sector, interest groups and different educational institutes. Material produced by the Commission can be made available on a website where it is also possible to submit suggestions to the Commission and ask questions or raise issues which the Commission should shed light on.

The Commission should be linked to different reference groups of experts depending on which areas the Commission will be prioritising. For instance, that includes contact with Region Skåne's newly-established council for health, the County Administrative Board in Skåne County, the Swedish National Institute of Public Health and WHO Europe.

In Malmö some 100,000 encounters between employees of the City of Malmö and citizens take place every day at, for instance, preschool, school and in different health care establishments. All these encounters bring experience and knowledge. It is important that the Commission devises working methods which make it possible for employees to contribute to the work. It is part of the Commission's assignment to find ways of including competences from different areas and being open to those who in various ways show interest in contributing to the Commission's work. The methods for this are left to the Commission to organise.

An independent Commission

The Commission should act as an independent committee and has the opportunity to suggest strategies for the municipality to decide upon. This implies that the work should be characterised by independence and originality. The Commission can engage external experts with knowledge and experience of relevant areas who are qualified for the matter at hand. These experts can work independently in relation to the Commission to realise their task and are responsible for their own conclusions and any recommendations in their respective reports. It is then the Commission's task to independently make decisions based on the experts' analysis and conclusions.

The Commission is an official committee and has to be objective and impartial and exercise equality in accordance with the law. Furthermore, its activities must be carried out in accordance

with applicable laws for municipal services. The Commission's modus operandi should be characterised by an open way of working and a clear citizen's perspective.

Limitation of the assignment

The Commission's assignment is limited to Malmö's challenges and requirements. The Commission's suggestions should, however, include how the City of Malmö can collaborate at a regional, national and international level. This can mean that forms of co-operation, contract solutions between different parties etc. can be discussed.

Time frame

In addition to reports at hearings, the Commission should deliver a Final Report with suggestions of objectives and strategies. The Final Report should be submitted to Malmö City Executive Board in November 2012. The Commission will deliver an Interim Report in March 2012 to synchronise with the budget process and the new city plan for Malmö.

Appendix 1 to the Terms of reference

Background

A commission is usually appointed in a crisis situation when there is a need to find answers to questions through a deepened analysis based on obtaining guidelines on how to continue further. Unlike a commission that is formed following an acute crisis, the task of the Commission is to address a complex set of problems, which in themselves have major consequences, but which require long-term strategic decisions and actions.

The Commission was appointed in light of the differences in health (morbidity, mortality, self-rated health) and welfare between different groups of the population and between different areas in Malmö being so great that it is both unjust and unethical, but also that it affects Malmö's development and conditions for sound economic growth and a sustainable city.

Malmö has undergone a major transformation from an industrial to a knowledge city and has become known for its work on ecologically sustainable development and for having created new innovative solutions in this area. The city's work now needs to be directed towards a city which is sustainable from all points of view. Environmental, economic and social sustainability need to be integrated to mutually strengthen one another, which requires increased focus on social sustainability, where the Commission and the *Area programme for a socially sustainable Malmö* are two important tools.

Relatively many Malmö residents lack the most important prerequisites for health such as education, work, housing, economic and social resources to manage everyday life. Malmö stands out in comparison with national statistics related to problems such as a low level of education, high child poverty, a low employment rate and the large proportion of people with a need for social assistance. As early as 1991 a public health report about Malmö was presented. The report showed that there was a difference of 8 years in average life expectancy between the areas in the city that have the lowest and highest average life expectancy, respectively. The difference 20 years later is still 8 years. Since 2002 the City Office

has prepared an annual welfare report in which the development in terms of welfare is described based on 40 or so indicators. The level of health has generally improved with for example a greater choice of leisure opportunities, better education and longer average life expectancy. However, the distribution of good health has not improved but rather the differences have increased.

The welfare reports show that the differences between men and women, between low and high levels of education and between people born abroad and those who were born in Sweden are great. A division of socio-economic factors shows that if you are unemployed or have a disability pension you are more and more often ill, have poorer mental health, have poorer self-rated health, smoke to a greater extent, are more likely to be overweight or obese, you are less physically active, are more vulnerable to violence, have lower trust in social institutions, have less anchoring in the residential area, have a lower level of social participation and perceive that you cannot influence your own health development to as great an extent.

The difference between men's/boys' and women's/girls' health is evident. Women have for example poorer health in working life, experience greater insecurity in residential areas, are less physically active, smoke more and have poorer physical health than men. However, when it comes to using snus, alcohol consumption, abuse of narcotics, dietary habits and overweight men have a worse trend than women.

The City of Malmö's new public health policy

It is partly against the background of work on designing proposals for the City of Malmö's public health policy that the need for a commission has been identified. The overarching objective of the policy is the national overarching public health objective adopted by the Swedish Parliament "to create societal conditions for health on equal terms". A national objective that has spanned over two legislatures. To accomplish this, 11 national objective domains for public health were formulated:

Participation and influence, Economic and social prerequisites, Conditions during childhood and adolescence, Health in working life, Environments and products, Health-promoting health services, Protection against contagious diseases, Sexual and reproductive health, Physical activity, Dietary habits and food, Tobacco, alcohol, narcotics, drug abuse and gambling.

These objective domains are also the starting point of Malmö's public health policy. During the preparation of proposals for the public health policy for Malmö all of the existing objectives and policy documents adopted by Malmö City Executive Board and/or City Council that are affected by the 11 national public health policy domains have been surveyed. The surveying identifies 40 programmes, action plans, strategies and policies that aim at improving conditions for Malmö citizens' health directly or indirectly. In addition to these the City of Malmö's budget specifies 17 objectives that concern public health areas.

Despite the stated ambitions of the policy documents the difference between the Malmö residents who have the prerequisites for good health and those who do not is great. One conclu-

sion of the review is that the existing structure is not sufficient to create the change that is required. The Commission's assignment is to investigate and suggest what the municipality can do but also what is required of interacting stakeholders as well as opportunities at other levels.

The City of Malmö's work on sustainable development

The City's work now needs to be directed towards a sustainable city from all points of view. Environmental, economic and social sustainability need to be integrated to mutually reinforce each other, which requires an increased focus on social sustainability, where the Commission and with the Area Programme for a socially sustainable Malmö will pave the way for new approaches, new thinking and new methods for social sustainability. Processes for social change are complex and there are many challenges in Malmö. Extensive physical development such as the city tunnel and new harbour requires solid pre-planning. The Commission's work can be seen as an equivalent to pre-planning for processes for social change.

Appendix 2

How has the Commission operated?

About the Commission's working procedures – from Terms of reference to Final Report

Malmö City Executive Board decided in May 2010 to appoint the Commission for a Socially Sustainable Malmö and in November 2010 Terms of reference were established that specified the assignment. At the same time Sven-Olof Isacson, Professor Emeritus of Social Medicine, was appointed Chairman. This appendix is intended to broadly outline the Commission's work process.

The starting point for how the Commission was put together and how the work has been designed is the Terms of reference. Initially 14 commissioners were appointed to respond to the assignment. This involves deepening the analysis about what causes inequality in health and understanding what can be influenced and transformed in practice. Therefore the Commission comprises both researchers and practitioners working in the City of Malmö. All the areas that the Commission has to consider are not however represented by an expert in the Commission and therefore various other researchers and stakeholders have been consulted. A number of senior advisers have also been linked to the Commission. They have contributed in different ways, including critical reviews of background reports.

A secretariat consisting of the Chairman, Head Secretary, Communications Secretary and Project Secretary have led and coordinated the work. The Commission's work is partially regulated, but not in detail, in the Terms of reference. How

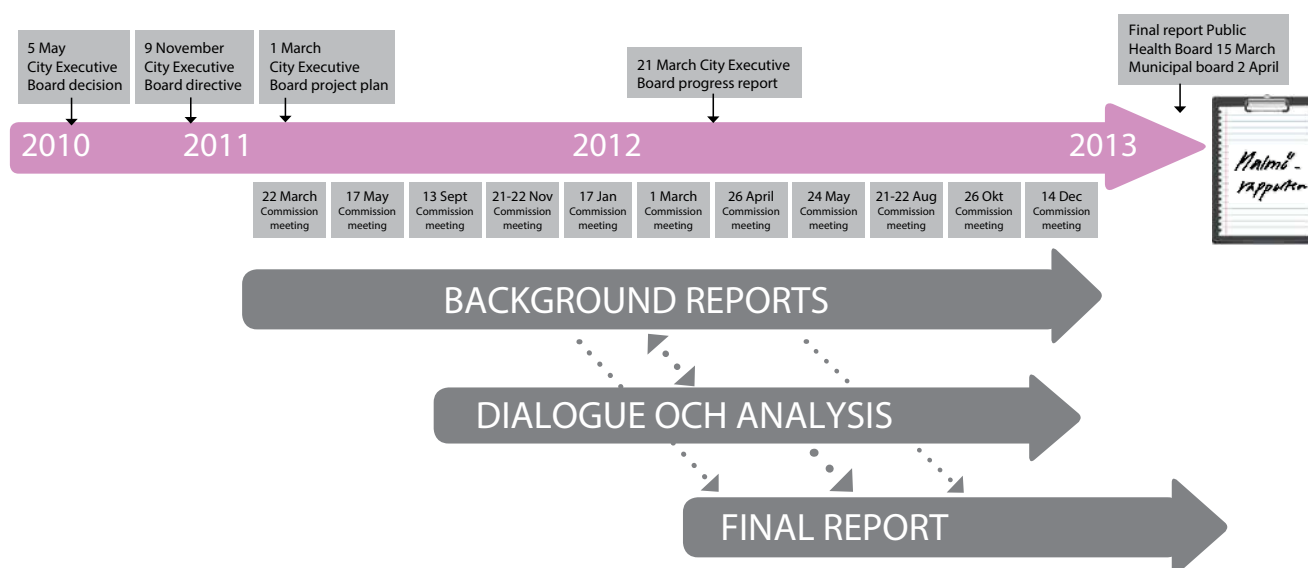
the Commission chose to design its work is illustrated in the picture below.

The Commission's work process can be described as three parallel processes; compilation of scientific background reports, dialogue and analysis and the production of an Interim Report and Final Report. As the picture below shows, the processes have in many respects been linked together. The background reports have for example been a prerequisite for large parts of the dialogue and analysis. In the same way conclusions in some background reports have been developed in dialogue. The Final Report builds on considerations based on background reports, dialogues, other literature and the analyses carried out within the Commission.

Alongside the overall processes eleven meetings of the entire Commission have taken place. On these occasions questions about evidence, views of knowledge, prioritised areas and different causal explanations were processed. The commissioners represent different fields of research and areas of expertise and have not always been unanimous. This has not been considered as a problem, but rather as evidence that the issues that the Commission works on are interesting and complex.

Background reports

Since the Commission's work is based on the extensive research that exists on the determinants of health these factors



have formed the basis of the recommendations and the areas that were subjected to a deepened analysis. To create scientifically based knowledge about the situation in Malmö regarding both health in itself and its social determinants scientific background reports have been drawn up by the commissioners and external researchers. Altogether this has resulted in 31 reports that address the following areas;

- Conditions during childhood and adolescence
- The distribution of health during the course of life from maternal health care to old age (six different reports)
- Education by preschools, compulsory schools, upper secondary schools, after-school centres, complementary schools and factors that influence educational structures
- Work and work environment
- Unemployment and health
- The physical environment's importance to health
- Social capital, cohesion
- Understanding of the relationship between health and sustainable development, economic growth and welfare and participation
- Gender and health
- Organisation and governance, implementation

The reports largely cover the social determinants and are produced to function in a Malmö context. For the majority of these the disposition includes a description of the research position, the situation in Malmö and a conclusion containing suggested actions. Altogether the authors of the background reports have contributed more than 200 recommendations. These are briefly summarised in one report¹.

The background reports fulfil two purposes. The first is that the series of reports comprises a solid and scientific basis for the Final Report. The second is that each background report acts as a discussion document that can contribute to the development of knowledge and raises questions about social inequities in health, determinants of health and the structural changes that must be brought about for health to become more equally distributed.

It is important to point out that despite the breadth and depth of the series of reports, it does not include all of the areas that need to be covered and discussed for a complete understanding of the social determinants of health. To fill in some of the gaps in knowledge that occurred, the Commission has chosen to enter into dialogues on for example the significance of the culture sector, the business sector and the voluntary sector in reducing the social inequalities in health.

Dialogue and analysis

The Terms of reference expressed expectations of transparency and a participative approach.

It is an independent Commission whose work should be transparent. The Commission should actively invite organisations and Malmö residents who can share their experiences to take part in the analysis and the shaping of strategies. It is important that the Commission's work is made accessible and that it is communicated both internally and externally. For instance, this can be done through different types of meetings, hear-

ings/lectures to and with different stakeholders such as Malmö residents, professionals, the private sector, interest groups and different educational institutes.

It is part of the Commission's task to find ways of including competences from different areas and being open to those who in various ways show an interest in contributing to the Commission's work. [...] The Commission's modus operandi should be characterised by an open way of working and a clear citizen's perspective.

(From the Terms of reference)

Many of the approximately 30 seminars and workshops organised by the Commission have been based on a specific background report. Some have been open to the public, while some have been directed towards a few, specially invited participants. The aim has primarily been to obtain knowledge, deepen the analysis, discuss recommendations and to disseminate knowledge. By discussing with the stakeholders affected by the issues and recommendations the conditions for a better implementation are created. The dialogue has also been about gaining an understanding about what is already being done or has been done in the municipality and what is feasible. In all, about 2,000 people participated in these forums for discussion.

The commissioners have in various ways spread and anchored the discussions that were conducted locally, regionally, nationally and internationally. The Commission has also participated in meetings with representatives of the Swedish Government, associations, the region, research institutes, trade and industry, the culture sector and to some extent other cities in Europe which are wrestling with difficulties similar to those in Malmö.

The Chairman of the Public Health Committee, who is also co-opted to the Commission, has been continuously updated on the Commission's work, and politicians have been invited to participate in seminars. Background reports and the Commission's work have been discussed regularly at the Public Health Committee which is a preparatory body for Malmö City Executive Board, and on two occasions, the Commission has had half-day seminars with the City Executive Board.

Expectations of a transparent approach have led to carefully prepared communication and the Commission has as far as possible made background reports and activities available through www.malmo.se/kommission and communicated through various channels such as a blog and newsletter. Media interest in the Commission's questions and work is represented by some 90 published articles or features directly connected with the Commission.

Final Report

The path towards the Final Report can be described by the work on background reports, dialogue and analysis. The Final Report should not be considered as the sum total of the various background reports, but as an overall analysis of all the processes described previously. Other literature in the field, both Swedish and international, has been considered and various groupings within the Commission have processed recommendations for the different areas.

¹ Compilation of recommendations in the background reports for the Commission for a Socially Sustainable Malmö

A number of aspects have been discussed and factored into the evaluation of recommendations. These can be illustrated in Figure 1 and are described briefly below:

Figure 1: Outline of aspects considered in the evaluation of different strategies, from the Commission for a Socially Sustainable Malmö, Interim Report 2012)



Evidence

The Commission's proposals should affect health inequalities and the fundamental science base concerns knowledge on what causes health inequalities. The relationship between socio-economic factors and health is well-documented and is thought to exist over time despite medical and economic development, irrespective of what measure of health is used. The starting point for the Malmö Commission's recommendations is the extensive research which, among other things, forms the basis of previous reports with the focus on inequalities in health.^{2, 3, 4}

The disciplines which incorporate the social determinants of health are multidisciplinary. These different scientific disciplines assess science and evidence differently, which has meant that the Commission, due to its interdisciplinary composition, has neither been capable of nor endeavoured to find a specific way to evaluate the concepts of evidence and scientific precision.

The Commission's assessments of the recommendations have been made in relation to the research available, but also to experience-based knowledge in the field. Most of the Commission's recommendations are based on Swedish and international research. Other more innovative recommendations are by definition not scientifically proven, yet have been deemed to affect health inequalities by the Commission as a whole.

Effect of inequality in health

The recommendations should have an effect on the structural factors that affect inequality in health. Knowledge about the importance of determinants for the distribution of health is extensive. There is also an on-going discussion within the

research on causality, that is, knowledge about what causes what. Is it, for example, ill-health that make anchoring in the labour market more difficult or is it unemployment that causes ill-health? Research shows that the connection often goes in both directions.

Research on effective interventions and policies for reducing inequality in health is relatively limited.⁵ Since the WHO Report was released in 2008, a growing knowledge network has been established including countries and cities that work purposefully on policies to reduce inequality in health.^{6, 7}

General or focused interventions

To decrease health inequities action is required towards reducing the social gradient. Only targeting the most vulnerable will not adequately reduce inequality in health. To reduce the social gradient actions must be universal, but with a scope and strength that is proportional to the degree of vulnerability, so-called proportional universalism.⁸ In the range of recommendations the Commission has considered both general initiatives and targeted interventions with a particular focus on certain groups/areas.

Stakeholders and remits

The areas discussed by the Commission are not exclusively municipal matters. Several of the overall problems in Malmö require efforts from the municipality, region and state. Considering its geographical position, Malmö should also be seen from an Öresund perspective. Through support from other non-governmental stakeholders such as the voluntary and business sectors the suggested interventions can be facilitated more efficiently. The Commission has conducted an overall review of which stakeholders are responsible as well as the legal possibilities to do what is connected to the social determinants. Also see the Commission's memo about *The remits of the municipality and social determinants*.⁹

Cost and cost effectiveness

The Commission should according to the Terms of reference calculate the economic consequences of inequality in health for Malmö and what effects can be expected from work which aims to reduce inequality in health. The Commission should also make health-economic impact assessments of strategies. These challenges have been processed in different ways and discussed in a number of background reports: both how to measure inequality in health from a health-economic perspective¹⁰ and a social economical perspective with a social investment perspective as the starting point¹¹. Output from existing

² WHO, Commission on Social Determinants of Health. Closing the gap in a generation – health equity through action on the social determinants of health; 2008

³ The Marmot Review, Marmot M, Fair Society, Healthy lives:2010

⁴ Diderichsen F, Andersen I, Manuel C. Ulighed i sundhed – årsager og indsatser, 2011 (Inequality in health – some actions and impacts, 2011)

⁵ Chandra Amitabh, Vogl S.Tom (Rising up with shoe leather? A comment on fair society, Health Lives (The Marmot Review), Social Science & Medicine 71 (2010) 227-1230

⁶ UCL, Institute of Health Equity:
<http://www.instituteofhealthequity.org/>

⁷ http://www.skl.se/vi_arbetar_med/halsaochvard/folkhalsa_1/social-hallbarhet

⁸ The Marmot Review, Marmot M, Fair Society, Healthy lives:2010

⁹ Kommunens rådtrum och sociala bestämningsfaktorer (The remits of the municipality and social determinants, Commission for a Socially Sustainable Malmö, 2013).

¹⁰ Gerdtham U och Kjellson G, Mätning och analys av ojämlikhet i hälsa: Mätning och analys av ojämlikhet i hälsa: Om konsten att mäta något utan att veta vad och hur. (Measurement and analysis of inequality in health: The art of measuring something without knowing what and how). Commission for a Socially Sustainable Malmö, 2012.

¹¹ Nilsson I. Den ojämlika hälsan i Malmö ur ett socioekonomiskt

calculations from other studies about the costs of inequality in health have been roughly converted to Malmö conditions and presented in the Final Report.

It has not been possible to make health-economic assessments of every single recommendation, however, the Swedish Institute for Health Economics (IHE) has made health-economic analyses of a number of the Commission's suggested actions, which are presented in a supporting document.¹² The reported analyses should be seen as examples of how the City of Malmö could develop methods for health-economic analyses along with socio-economic calculations in order to consider different options and obtain a basis for decisions that as far as possible result in reducing inequality in health.

Follow-up

The Commission has organised a number of workshops together with the City of Malmö to review and analyse the existing monitoring structure in the City of Malmö's welfare reports. The aim has been to review the way the growth and development of welfare today is monitored and make comparisons with the available research in the field.

Furthermore, three commissioners from social medicine and health-economics research have drawn up proposals for how the municipality can measure inequality in health and annually monitor the inequality in health. The proposal advocated is that follow-ups are done in absolute measures where health outcomes,

determinants and risk factors are reported based on socio-economic indicators: income and education and that the reporting is supplemented by an index. The results are presented in the Final Report.

One aim has been to propose indicators for following up the objectives and actions presented in the Final Report. The Commission has begun such work, but has no finished structure. Depending on the design of future political decisions, indicators need to be linked to each proposal as well as a calculation of the resource consumption. Here the methods that the Commission tested to calculate cost effectiveness can be used. During the course of the work the need for new structures for monitoring emerged where all dimensions of sustainability need to be included. Other measures are needed to measure social development, which places different requirements on indicators and monitoring.

In conclusion, what the Commission is submitting to Malmö City Executive Board is this Final Report as well as solid scientific material in the form of background reports. It is likely that the background reports on specific areas have a particular value for specific target groups and hopefully the new networks and co-operation that were established between researchers, practitioners and other stakeholders can, as an outcome of the Commission, support the City of Malmö's continued development work towards a sustainable city.

perspektiv. (The unequal health in Malmö from a socio-economic perspective) Commission for a Socially Sustainable Malmö, 2012.

12 Gerdtham U, Ghatnekar O, Svensson M. Hälsoekonomiska utvärderingar (Health-economic evaluations), Commission for a Socially Sustainable Malmö, 2013

Appendix 3

Background reports for the Commission for a Socially Sustainable Malmö

CONDITIONS DURING CHILDHOOD AND ADOLESCENCE

1. Gravida kvinnor och deras barn i Malmö år 2000-2010. Några uppgifter om boende, härkomst och komplikationsrisker (Pregnant women and their children in Malmö in 2000-2010. Some data on housing, origin and risk of complications)

Author: Johan Molin, senior physician, Women's Health Clinic, Skåne University Hospital

Maternal health care services come into contact with all expectant parents and have an important preventative function. The report is based on a study and analysis of all pregnancies in Malmö for 10 years. Risk factors such as teenage pregnancies, tobacco use, overweight and diabetes are predominantly seen in the economically vulnerable part of the population. As a consequence this affects the risk of growth-retarded babies, dead babies and other obstetric complications. There is reason for concern about the rising proportion of mothers affected by overweight and obesity. Another concern is the development of mental illness and its effects on the unborn child and the childbirth situation. The report gives several recommendations.

2. Skolbarnens hälsa i Malmö (School children's health in Malmö)

Author: Stefan Kling, Coordinating school physician for compulsory schools, The City of Malmö

The report provides an analysis of the function of school healthcare and school children's health in Malmö. The clear social inequities in health which are well-documented in the literature on physical and mental health problems are evidently present as soon as one begins to investigate the incidence of these problems. Knowledge about children's health needs to be put into a social context. The author points out that there is a lack of systematic, comprehensive and continuous reporting of school children's health and monitoring over time in Malmö, which is a prerequisite for providing school health care on equal terms.

3. Barn i Malmö – skilda livsvillkor ger ojämlik hälsa (Children in Malmö – different living conditions give unequal health)

Responsible author: Marie Köhler, commissioner and senior consultant, Child Health Care in Region Skåne, Editor: Anders Djurfeldt, Master of Political Science

This anthology is based on a number of contributions by researchers and those responsible for various services relating to children. The report describes the situation of children in Malmö from different perspectives and starts from the Commission's questions. Different measures of children's health are presented as well as research on,

among other things, children who are maltreated, newly arrived children, homeless children, children of parents with mental illness, children of detained parents and the link between health and residential area. The report points out that health for the majority of children in Malmö is good, but the differences in health are large. An increased focus on children's health in terms of service development, measurement, monitoring and evaluation and inequities in health are needed. Each author gives recommendations within his or her own field of research and operational area. The report concludes with overall recommendations for more children to experience better health, get a good start in life and to reduce inequities in health.

4. Nyanlända barn i Malmö – en kartläggning av demografi och organisation av mottagande (Newly arrived children in Malmö – a survey of demographics and organisation of reception)

Author: Karin Ander, Bachelor of Arts in Human Rights

The report is a survey of the situation for newly arrived children in Malmö. The survey covers the period 2008-2011 and describes newly arrived children from a demographic perspective in Malmö. The concept "newly arrived children" in the survey includes nationally registered immigrant children, asylum-seeking children and undocumented children. The authors set out a number of recommendations. It is stated in the report that it is difficult to get an overall picture of demographics, reception and knowledge about the health of newly arrived children, and therefore a deepened study is required.

5. Lokala handlingsstrategier mot barnfattigdom (Local action strategies against child poverty)

Authors: Tapio Salonen, commissioner and Professor of Social Work, Malmö University and Anna Angelin, Doctor of Social Work, Lund University

The aim of the report is to deepen the understanding of the economic vulnerability of families with children in Malmö. This is particularly challenging given that the city has a level of child poverty that deviates from the country at large and other large cities. Based on the current state of knowledge, elements of an overall action strategy are presented for halving child poverty by 2020 with the objective of eliminating child poverty in Malmö by 2050.

EDUCATION

6. Förskolans betydelse för barns utveckling, lärande och hälsa (The importance of preschool in children's development, learning and health)

Author: Sven Persson, commissioner and Professor of Pedagogy at Malmö University

The report provides a scientific overview of the importance of preschool in children's development, learning and health. The early years at preschool are important, mainly through children having access to trained staff and learning environments in which they learn to be active, engaged and creative together with other children. Most important are the educational relationships between preschool staff and children and that opportunities and a structure are created that support preschool staff in using their knowledge and skills. This is especially important for children in socio-economically resource-poor environments. The report describes the situation in Malmö and gives recommendations.

7. Skolan och elevers utveckling, lärande och hälsa – några nedslag (Compulsory school and pupils' development, learning and health – some examples)

Author: Sven Persson, commissioner and Professor of Pedagogy at Malmö University

The starting point is that health is associated with the level of education and that actions that contribute to raising the level of education are health-promoting. One of the most important actions is to create good learning environments in compulsory education. The background report discusses some of the most important strategies for ensuring good learning environments in compulsory education.

8. Skolan och staden – forskningsperspektiv på integration och skolrelaterade klyftor i den moderna staden (The school and the city – research perspectives concerning integration and school-related disparities in the modern city)

Author: Nihad Bunar, commissioner and Professor of Child and Youth Studies, University of Stockholm

The report builds on the reasoning within sociology of education on social disparities and injustices as well as in some of the main external factors which affect pupils' school results. External factors include the time of entry in the Swedish school, background factors (class, gender, ethnicity) and the effects of residential segregation and freedom of school choice. Finally, concrete recommendations are presented to those responsible in the municipality, schools and families on what should be done to provide a stronger structure of opportunities for children and young people who do not live up to the school's objectives.

9. God kvalitet i fritidshem – grund för elevers lärande, utveckling och hälsa (Good quality in after-school centres – basis for pupils' learning, development and health)

Authors: Carin Falkner, Associate Professor of Education and Ann Ludvigsson, Senior Lecturer in Pedagogy, The School of Education and Communication, Jönköping University

The report describes the growth in the after-school centre service during the last twenty years as a very turbulent time. The service has more than doubled in terms of the number of enrolled children while large cut-backs have affected the centres. In the report data for Malmö and comparisons with other municipalities are presented. The after-school centre is a service which in many contexts is made invisible, but which could have the potential to make a difference in terms of children's learning, development and health, state the authors who set out various recommendations.

10. Gymnasieskolan – inte en skola för alla? En forskningssammanställning om låg utbildning och hälsa (Upper secondary school – not a school for everyone? A compilation of research on low level of education and health)

Author: Margareta Cederberg, PhD in Pedagogy, Lecturer, Malmö University

The report is an overview of research on the group of pupils who do not complete upper secondary school within three years with a particular focus on health consequences. Why do young people drop out of upper secondary school and what are the social and health consequences? What can the City of Malmö do for more pupils to start and complete upper secondary school? In the report the author gives suggestions of investments with the objective that 90 per cent of young people will have achieved approved final grades from an upper secondary school programme or an equivalent upper secondary school level within adult education services such as KOMVUX (municipal adult education) or folk high-school no later than 24 years of age by 2020.

11. "Att behålla mitt och lära mig något nytt" – föräldraengagemang i mångkulturella miljöer ("Retaining me and learning something new" – parental participation in multi-cultural environments)

Author: Laid Bouakaz, PhD in Educational Sciences, Lecturer, Malmö University

The report discusses a type of school that is partially hidden from researchers, teachers, politicians and decision-makers. These "complementary forms of teaching" take the form of assistance with homework, native language teaching, cultural and religious teaching, and are organised by voluntary leaders after the end of normal school days or at weekends. Many parents in multi-cultural environments have managed to mobilise themselves outside the school's regular activities and combat pupils' poor school results. The report finally sets out suggestions on increasing the co-operation between complementary and municipal schools and carrying out a survey of these schools to obtain greater knowledge about the child's everyday life outside school.

MALMÖ RESIDENTS' HEALTH, Health care

12. Livsvillkor, levnadsvanor och hälsa i Malmö (Living conditions, lifestyle and health in Malmö)

Authors: Maria Rosvall, commissioner and Senior Lecturer, Lund University and the Department of Public Health and Social Sustainability, Region Skåne, Martin Lindström, Professor, Centre for Primary Health Care Research, Lund University, Birgit Modén, Researcher, accidents, Department of Public Health and Social Sustainability, Region Skåne, Mathias Grahm, Statistician, Department of Public Health and Social Sustainability, Region Skåne and Maria Fridh, qualified doctor, Skåne University Hospital, Malmö, Region Skåne

The report is based on an analysis of the health of Malmö residents, mainly carried out based on Region Skåne's public health surveys directed at the adult population in 2000, 2004 and 2008. It clearly shows that there are geographical and social differences in living conditions, lifestyles and health in Malmö's population. A large part of the geographical differences which were found are socially based, state the authors. Recommendations include continued gathering of epidemiological data and strengthening children's and youth's childhood conditions, reducing unemployment and invest-

ments to create supportive environments for a good physical and mental environment in the residential area.

13. Sjukvårdskonsumtion i Malmö 2010 (Health care consumption in Malmö in 2010)

Author: Anders Beckman, General Practitioner, specialist in public medicine in Malmö and PhD, Lund University

The report is based on analysis and health care consumption in Malmö during 2010. Equal and fair health care consumption is discussed based on consumption, need, demand and access. In the report an account is given of health care consumption in Malmö in out-patient and in-patient care based on socio-economic variables such as education, income, age and gender. Individuals with lower levels of income and education consume more health care, but a deepened analysis is required in order to know if this is sufficient for reducing health inequities, states the author. The increase in average health care time for the elderly is three times greater in Malmö than for Skåne, which should also be investigated further.

14. Kvinnors deltagande i mammografiscreening i Malmö och kopplingen till sociala determinanter (Women's participation in mammography screening in Malmö and the connection to social determinants)

Author: Sophia Zackrisson, specialist doctor in Radiology at Skåne University Hospital

Among women breast cancer is the most common type of cancer and early detection improves the possibility of curing the disease. Mammography screening is recommended for women in Sweden aged between 40-74 with an interval of 1.5-2 years and in Malmö general mammography screening was introduced in 1990. The report is based on analysis of the importance of socio-economic status upon whether women choose to participate in mammography screening. The inequities are great. Low income and whether they live in an area with high unemployment and a high rate of immigration influence participation. Patient data and the fact that the invitation is sent in Swedish via the post could be significant. The author gives recommendations and suggests, among other things, a dialogue between the region and the municipality regarding use of health care and preventative services to reduce the inequities.

15. Hur mår Malmö's äldre? (How do Malmö's elderly feel?) Prediktorer för livstillfredsställelse, funktionsförmåga och aktiviteter i det dagliga livet (Predictors of satisfaction with life, functional ability and activities of daily living)

Authors: Sölve Elmståhl, Professor and Head of Clinic at the Faculty of Medicine, Lund university and Henrik Ekström, Researcher in Geriatrics, Skåne University Hospital

The report is based on the extensive longitudinal study "Gott åldrande Skåne" (Good Aging in Skåne), which is based on studies of Malmö residents in the 60-93 age range. The results show that a lower age, higher level of education and number of available activities give higher satisfaction with life, better mobility and better ADL (Activities of Daily Living). Furthermore, factors such as being born in Sweden, having a good economy, being a cohabiting partner and good social contacts and social anchoring are important for higher satisfaction with life. Recommendations include improved availability of leisure activities or voluntary work to strengthen the individual's physical, mental and social health.

WORK AND INCOME / SOCIAL ASSISTANCE

16. Skälig levnadsnivå i Malmö (Reasonable living standards in Malmö)

Author: Torbjörn Hjort, Senior Lecturer in Social Work, Lund University

The report is an empirical study that examines how the City of Malmö both in policies and in practice deals with matters of reasonable living standards in relation to financial support. Particular attention is given to how the need for social assistance is assessed for families with children. The empirism is based on interviews with managers and officials in social services. The conclusions are linked to general societal development and the welfare state's attitude to and management of poverty.

17. Arbetslöshet och hälsa – en kunskapsöversikt (Unemployment and health – a knowledge overview)

Author: Urban Janlert, Professor of Public Health and Clinical Medicine at Umeå University

The report describes the national trend in unemployment in recent years and demonstrates the effects on health as well as the variation between men and women. Research demonstrates a relationship between unemployment and increased mortality. Unemployment is also related to increased mental illness, and to some extent even increased somatic ill-health and abuse of alcohol and drugs. A central aspect for Malmö is the consequences of high youth unemployment, which is also emphasised in the report. The function of work is also described here which, according to research, fulfils important health-promoting functions other than simply being a source of income.

18. Kön, genus och hälsa; socioekonomiska skillnader i hälsa bland kvinnor och män (Sex, gender and health; socio-economic differences in health between women and men)

Author: Susanna Toivanen, Senior Lecturer in Sociology, Marit Gisselmann, PhD in Sociology at CHESS, Stockholm University and Petra Lindfors, Senior Lecturer in Psychology and university lecturer, Stockholm University

The report provides a broad knowledge overview and describes how socio-economic differences in health between women and men arise, are reinforced throughout life and how society can influence them. The differences are seen not least in the segregated labour market where women and men to a large extent have different professions and work in different sectors of the labour market. Generally childhood is a good time to influencing health differences, the authors write. We need to influence the entire chain and start with support to parents so that families offer the same opportunities to girls and boys, we need to work with gender-aware teaching in preschool and school and continue into working life.

19. Befolkningsrörelser, försörjningsvillkor och bostadssegregation (Population movements, conditions for livelihood provision and residential segregation)

Author: Tapio Salonen, commissioner and Professor of Social Work, Malmö University

The report is based on three linked aspects which, taken together, illustrate Malmö's rapid change; population changes in the last twenty years, income distribution among Malmö's residents and its importance for inequality in health and income equality and residential segregation. Population analysis shows that almost half a million people have lived in Malmö between 1990 and 2008,

which is almost twice as many as the population at any given time. Malmö acts as a portal or node in globalisation for both near and long-distance migratory flows. The population profile has gone from an aged to a young population where the proportion of foreign-born people or people with a foreign background is over 40 per cent. Almost a third of the working population are neither working nor studying. There has also been a sharply increased income inequality between households in Malmö, at the same time as residential segregation has increased in recent decades. The report concludes by identifying problems and general elements of change strategies that could break the inequality patterns which accelerated during the first years of the 2000s.

20. Malmö – de två kunskapsstäderna (del 1) (Malmö – the two knowledge cities – Part 1)

Author: Mikael Stigendal, Professor of Sociology, Malmö University

The report analyses causes and associations of social inequity in health and particularly highlights the link between economic growth and welfare. The understanding has been made more difficult by the approach to knowledge which forms the basis of the view of Malmö as a knowledge city, the author states. It is an approach to knowledge that equates knowledge with facts and makes knowledge an issue of quantification, which means that Malmö has become a quantity knowledge city. In order to solve the problems of large inequities in health and welfare, Malmö must become more of a quality knowledge city, the author writes and explains what this could entail.

21. Malmö – från kvantitets- till kvalitetskunskapsstad (del 2) (Malmö – from quantity to quality knowledge city – Part 2)

Author: Mikael Stigendal, Professor of Sociology, Malmö University

In this second report the author goes through suggestions of possible solutions, which are based on lessons learned from the particular metropolitan measures taken in recent decades in Malmö to solve the problem of increased social inequities. Among other things this concerns the URBAN programme, Storstadssatsningen (Metropolitan Policy), Välfärd för alla (Welfare for All) and SÖM (South-East Malmö). After a review and analysis conclusions are drawn about how the relationship between economic growth and welfare can be changed through changing the view of work, participation and knowledge.

THE SUSTAINABLE CITY

22. Hur hänger en socialt hållbar utveckling och hälsans jämlikhet ihop? (How are socially sustainable development and equity in health related?)

Author: commissioner Per-Olof Östergren, Professor of Social Medicine and Global Health, Lund University

The report describes and discusses the relationship between health and sustainable development based on a system theoretical perspective. The aim is to lay the foundation for a common reference framework for how the concepts of public health, equity, social sustainability and sustainability development relate to each other. Emphasis is placed on the importance of equity in a community for socially sustainable development and how the health of a population can be influenced by this. One of the conclusions is that equity in health can be seen as a measure of socially sustainable development.

23. Städer som nav för en globalt hållbar utveckling eller slagfält för sociala konflikter (Cities as nodes for globally sustainable development or battlefields for social conflicts)

Author: Hans Abrahamsson, Senior Lecturer, Peace and Development Research, University of Gothenburg, Guest Professor Global Political Studies, Malmö University

The city's role in the network society and the "glocalised" political economy are dealt with in the report which aims to discuss the conditions of socially sustainable development, the challenges many medium-sized cities face and the political room for manoeuvre which exists to handle the problem. Globalisation, urbanisation and immigration are discussed, as well as various forms of social governance.

24. Kan socialt kapital "byggas in" i våra bostadsområden och därmed förbättra invånarnas upplevda och mentala hälsa? (Can social capital be "built into" our residential areas and thereby improve the residents' perceived and mental health?)

Authors: Maria Emmelin, Professor of Global Health, Lund University and Malin Eriksson, University Lecturer in Public Health and Clinical Medicine, Umeå University

Social capital includes our social networks, our social support, our opportunities to participate in society and the degree of social belonging in our surroundings, something that has great importance for our perceived and mental health, both at an individual and a societal level.

The report provides an overview of how residential environments influence health and gives suggestions on scientifically based actions to promote social capital with the aim of improving health among inhabitants in a residential area.

25. Stadens rumsliga påverkan på hälsa (The city's spatial influence on health)

Authors: Marianne Dock, Programme Architect, Bertil Johansson, City Planner, senior adviser and Håkan Kristersson, Head of IT/GIT Department, the City Planning Office, City of Malmö. Commissioned by Eva Engquist, commissioner and Vice Chancellor, Malmö University, Christer Larsson, commissioner and Head of the City Planning Office, City of Malmö and Katarina Pelin, commissioner and Director of the Environment Department, City of Malmö

The report describes the spatial factors that affect health and the ability of city planning to influence this. City planning can be used as an engine and help an area become better integrated, increase physical activity, trust and social control and not least ensure that the city has healthy and green environments. The report suggests several actions. Barriers can be transformed into linking areas by turning traffic routes into city streets and providing better conditions for pedestrians, cycles and public transport. The area can be complemented with housing and services that contribute to a more mixed city. Construction companies and property developers can be rewarded when they take social responsibility and promote local participation. A specific major investment in the form of a densification project with social ambitions is suggested in Malmö.

26. Miljöns betydelse för sociala skillnader i hälsa (The importance of the environment for social differences in health)

Authors: Maria Albin, Kristina Jakobsson, Associate Professors at the Division for Occupational and Environmental Medicine, Lund University, and Senior Consultants at the Division for Occupational and Environmental Medicine, Labmedicin Skåne and Anders Djurfeldt, M.Pol.Sc.

The report presents and discusses data mainly from studies in Malmö which show the connection between health and the environment at home and in the area surrounding it, as well as between work environment and health. Health risks in and around the home are distributed in such a way that they are likely to make a significant contribution to inequities in health between social groups in Malmö. One aspect is overcrowding, which is an evident problem in parts of Malmö, particularly among children. Actions against overcrowding and to mitigate its consequences appear to be urgent. Conclusions and recommendations are also presented for the work environment with a focus on the municipality as an important employer, particularly for women, and as a large purchaser of services.

ORGANISATION AND GOVERNANCE

27. Den ojämlika välfärden i Malmö ur ett socioekonomiskt perspektiv (Inequitable welfare in Malmö from a socio-economic perspective)

Author: Ingvar Nilsson, economist, SEEAB, Institute for SocioEcological Economics

The report highlights the costs, in principle, of alienation from a socio-economic perspective. Example calculations have also been carried out for a city district in Malmö and at an individual level. Mechanisms that lead to and/or reinforce this alienation are discussed and linked to the concept of efficiency. This is followed by recommendations for social investments which include suggested methods for socio-economic analysis, social investment funds, the need to reassess compensation systems and procurement, a socio-economic shadow budget and arguments for reassessing the organisational structure for investments in children and young people to obtain a long term and holistic view of preventative work.

28. Mätning och analys av ojämlikhet i hälsa – om konsten att mäta något utan att veta vad och hur (Measurement and analysis of inequality in health – on the art of measuring something without knowing what and how)

Authors: Ulf Gerdtham, commissioner and Professor of Health Economics and Gustav Kjellson, PhD student in Economics, Lund University

An ambitious political objective for health is that health should be equitably distributed, that is, health should not be systematically correlated with various socio-economic factors such as income and education. The link between socio-economic factors and health is well-documented and is thought to endure over time despite medical and economic development, irrespective of what measure of health is used. The purpose of the report is to survey the debate on economists' analysis of inequality in health and discuss various interpretations and problems with different inequality measures, as well as what relevance this has for the Commission's assignment.

29. Hälsoekonomiska utvärderingar (Health-economic evaluations)

Authors: Ulf Gerdtham, commissioner and Professor of Health Economics, Ola Ghatnekar, M.A. and Marianne Svensson, B.A., IHE, The Swedish Institute for Health Economics

The report accounts for how health-economic analysis methods can be used as the basis for prioritisations when resources are limited. The models are tested with the aid of some examples that show that

the same analysis methods which are used within other sectors can also be used for social interventions in schools, child care, etc. The aim of the examples is also to describe what type of data would be desirable to estimate the costs and benefits of these actions. Furthermore, social investment funds are discussed as well as how city planning actions can be evaluated using economic models. The authors suggest that health-economic analysis together with socio-economic analysis could be used in the prioritisation of future investments in Malmö that aim to reduce inequality in health.

30. Policy Empowerment Index: Evaluation of the Development Plan for Gender Equity Integration, City of Malmö, 2011.

Authors: commissioner Per-Olof Östergren, Professor of Social Medicine and Global Health, Lund University and Georgios Gavriilidis MD, PhD, MPH, Lund University

The report describes the tool Policy Empowerment Index (PEI) which can be used to measure the degree of participation in a policy process. The authors have reviewed and analysed an existing policy in the City of Malmö "Hållbar jämställdhet – utvecklingsplan för hållbar jämställdhet" (Sustainable gender equity integration – a development plan for gender equity integration) based on the principles in PEI. The authors draw the conclusion that the tool can be used to affect participation and influence in the development of municipal policies and to better ensure conditions for implementation.

31. Implementeringsforskning – en kunskapsöversikt (Implementation research – a knowledge review)

Author: Karl Löfgren, PhD and Associate Professor in Public Administration and Management at Roskilde University

The report describes the historical development of implementation research, where we stand today and how the research can be applied to the implementation of decisions brought about by the Commission's work. The research area is relatively undeveloped, but the author gives a number of pieces of advice; for example, the importance of not seeing the public sector as a company in terms of implementation work and thereby applying models and theories from the private sector to the public sector. Having clearly formulated objectives also facilitates implementation. The implementation and idea of the perfect realisation of political decisions is a myth, states the author. Modern political governance usually takes place through self-regulated networks and this should be considered in political decisions and the implementation of these.

32. Samlade rekommendationer från underlagsrapporter till Kommission för ett socialt hållbart Malmö (Overall presentation of recommendations from background reports for the Commission for a Socially Sustainable Malmö)

The Commission's Secretariat has compiled all the recommendations found in the 31 background reports produced for the Commission. The summary is very brief and specifies references to the background report in question.

Appendix 4

“Bygga om Dialogen” (Rebuild Dialogue) and “Amiralsstaden” – two projects for achieving social, economic and environmental objectives

In order to implement a number of the recommendations that are presented in the Final Report the Commission suggests that the municipality starts and strengthens two major social development projects in Malmö. The project's level of ambition should correspond to the investment before Bo01 and the conversion of the harbour area in “Västra hamnen” (The Western Harbour). The ambition is to achieve social, environmental and economic objectives through physical investments.

The suggestions include objectives and actions in the Commission's Final Report which span across several municipal operational areas and call for partnership at levels other than the municipal level. The prerequisites are that national actors provide the City of Malmö with the room for manoeuvre and possibility to test and evaluate new financial models based on a social investment perspective.

Action suggestion 1: “Bygga om Dialogen”

The City of Malmö is on the way to developing a project which aims to develop and strengthen the social investment funds established in Malmö. The purpose of the dialogue is to progressively develop a place-based social and environmental investment fund. In addition to physical changes that contribute to better connections in order to break segregation, the ambition of “Bygga om Dialogen” is to factor in necessary environmental investments

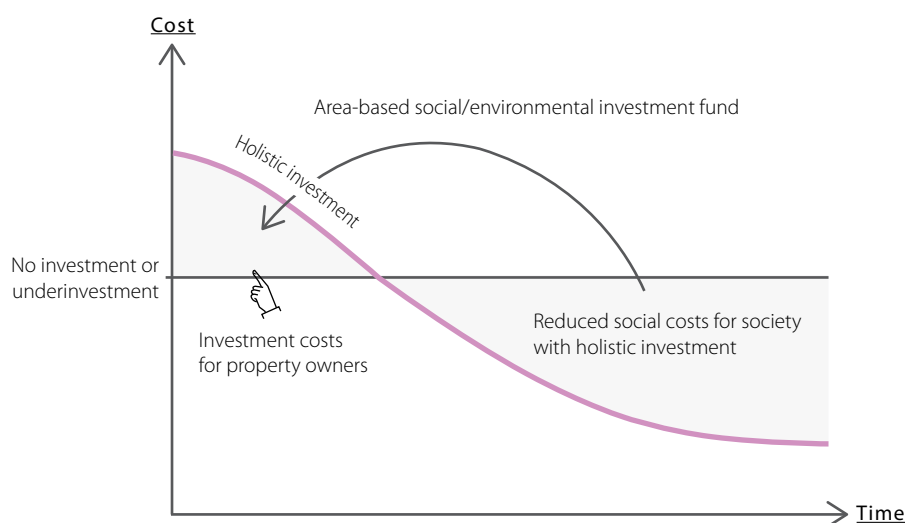
needed for the city to achieve its environmental objectives by 2030 (a 50 per cent reduction of energy use, 100 per cent renewable energy in the city system). Physical changes, environmental investments and local environmental work also become a tool for social and economic change through a strong focus on local job creation and social mobilisation.

The basic idea behind the social investment funds is to make investments today that will lead to both a better future for vulnerable groups and future savings in the public transfer systems. “Bygga om Dialogen” aims to develop a model where future savings for both private and public stakeholders can be used today to finance the investments which makes these savings possible.

What is needed is a model that, firstly, can calculate future savings as a result of an “integrated” investment with a focus on local job creation and mobilisation and secondly can describe how these savings can be converted into investment capital today. The problem, described in Ingvar Nilsson's report to the Commission as an investment hump, can be illustrated as in Figure 1 below.

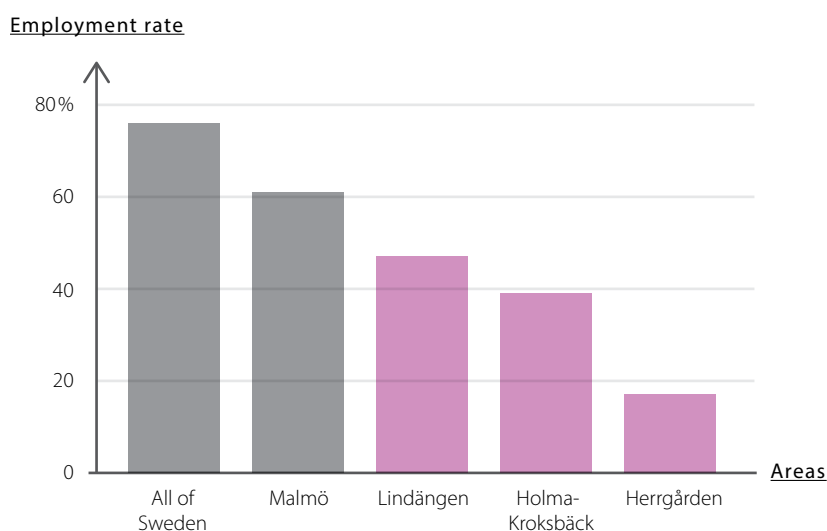
The illustration gives a schematic picture of how the investment costs for property owners in the long run can generate reduced social costs for other stakeholders. Today, there are no developed methods for converting investments in physical improvements into local jobs and making this a part of a broad social mobilisation. The various stakeholders who would need to

Figure 1. Investment costs of property owners render reduced social costs for other stakeholders in the long term



Source: Adapted from Ingvar Nilsson (2012), *Den ojämlika välfärden i Malmö ur ett socioekonomiskt perspektiv* (The unequal health in Malmö from a socio-economic perspective)

Figure 2. Employment rates in some of the city's One Million Dwellings Programme areas



Source: Statistics Sweden, 2009

interact and the different “purses” that would need to be added together are separated today into different function-oriented “silos” (Nilsson, 2012). The situation is the same across the entire country.

What is lacking are models and methods that broaden the investment calculation to include all the costs and potential new revenues which should be part of an “integrated” or “holistic” investment in the large scale One Million Dwellings Programme areas from the 1960’s and 1970’s. Finding these methods and models requires that the city builds up the capacity for goal-oriented development work around the system changes and social innovations which are needed to create successful comprehensive strategies.

Tapio Salonen’s report “Befolkningsrörelser, försörjningsvillkor och bostadssegregation” (Population movements, conditions for livelihood provision and housing segregation) describes how neighbourhoods in Malmö with low income and a high proportion of population of foreign origin between 1990 and 2008 increased both in number and area (Salonen 2012). Of Sweden’s more than 650,000 apartments in One Million Dwellings Programme areas 30,000 are in Malmö. Figure 2 above shows the employment rate (2009) in some of the city’s One Million Dwellings Programme areas.

Several of the One Million Dwellings Programme areas are characterised simultaneously by substantially neglected maintenance, which manifests itself in, for example, dilapidated and sometimes hazardous environments and in high energy costs¹. In the neighbourhood “Brogården” in the city of Alingsås the municipal housing company invested SEK 1 million/apartment in order to attain a modern standard and 50 per cent energy savings². This is also the level several private property owners in different places in the country calculate is needed. If we were to cautiously count on SEK 500,000/apartment in Malmö’s One Million Dwellings Programme areas, we would be talking about a total investment need of SEK 15 billion. According to calcula-

tions from the construction industry, this provides a basis for 7,500 one-year jobs in the construction industry in Malmö. Such a large potential economic activity can be utilised and developed using new and innovative methods to provide maximum benefit in terms of social, environmental and economic sustainability in the areas where investment is needed. Used properly, the physical improvements can be the lever for real social change, not least in terms of local job creation, which Malmö and so many of Sweden’s and Europe’s cities need.

Today, there are a host of problems and obstacles that stand in the way of such sustainable development. One is that the property owners cannot recoup the investments needed without sharply increased rents, often in the order of magnitude of 40-50 per cent, which would have unacceptable social consequences. In the media there are a number of articles on how both municipal and privately-owned One Million Dwellings Programme areas were offered for sale³, precisely because it was not possible to finance the improvement.

The prospect is that the City of Malmö, through concrete development work, will be able to release unused societal resources for a radical and effective continued transformation of the city. Models developed in Malmö could be used elsewhere in the country and in Europe. “Bygga om Dialogen” is currently underway and being led by the Environment Department in co-operation with the City Planning Office, with funding from among others the Delegation for Sustainable Cities and Malmö City Executive Board. The feasibility study will culminate in a estimate of the property and socio-economic benefits that can occur for both private and public stakeholders if renovation is done from a social and environmental investment perspective.

The project is proceeding in co-operation with three major property owners in “Lindängen” (Stena Property, Willhem and Trianon). Altogether they own 1,700 rented apartments grouped around the center of the neighbourhood. In “Lindängen” as a whole, the employment rate is 47 per cent (2009), which means that many of the tenants earn their living through public stakeholders, as the City of Malmö, Försäkringskassan (the Swedish Social Insurance Agency) and Arbetsförmedlingen (the Swedish

¹ Energimyndigheten (The Swedish Energy Agency) (2012): Energiläget (The Energy Situation) and Boverket (The Swedish National Board of Housing, Building and Planning) (2010): Socialt hållbar stadsutveckling - en kunskapsöversikt (Socially Sustainable Urban development - A Knowledge Overview)

² Alingsås municipality, Byggnytt.se, August 2011.

³ <http://www.di.se/artiklar/2012/8/8/miljonprogrammen-en-tickande-ekonomisk-bomb/>

Public Employment Service). The report “Den ojämlika välfärden i Malmö ur ett socioekonomiskt perspektiv” (The unequal welfare in Malmö from a socio-economic perspective) by Ingvar Nilsson in 2012 also shows that regional health care bears significant costs caused by the low employment rate and the exclusion in “Lindängen”. The report also shows that public stakeholders’ costs grow rapidly the longer exclusion lasts. The housing stock in “Lindängen” is characterised to some extent by long-term lack of maintenance, overcrowding and high energy use. The majority of the children at the local school (where 46 per cent of pupils in Year 9 in 2010/2011 graduated with a pass in all subjects, compared with 68 per cent nine years earlier); live in rented apartments around the center of “Lindängen”⁴.

With a successful renovation of existing buildings the image which characterises “Lindängen” today can be changed. This can also change the calculations that need to form the basis for the desification of new construction in “Lindängen”. Several of the property owners in “Lindängen” have plans for new buildings, plans that currently cannot be profitable because property values in the area are too low.

The feasibility study “Bygga om Dialogen” will continue until 2013 and will subsequently require a political decision on implementation.

Action suggestion 2: “Amiralsstaden”

The Commission's assembled recommendations, among other things, point out how physical interventions in the urban environment can be a tool to create health-promoting environments, reduce segregation, bridge barriers, improve accessibility, increase safety and trust, increase participation, enhance attraction and not least serve as a clear signal that a change is afoot.

Through a city improvement project near the street “Amiralsgatan” and the Continental train line a number of the reported actions can be integrated. Physical investments and new connections can be utilised as a motor for improving the social factors above and improving the area's identity and status. By vitalising and connecting the surrounding neighbourhoods with the aid of new functions, new buildings, new housing and new infrastructure including a new railway station, the social conditions will be affected.

Today barriers, in the shape of roads and railways, cement the differences between residential areas. With the Continen-

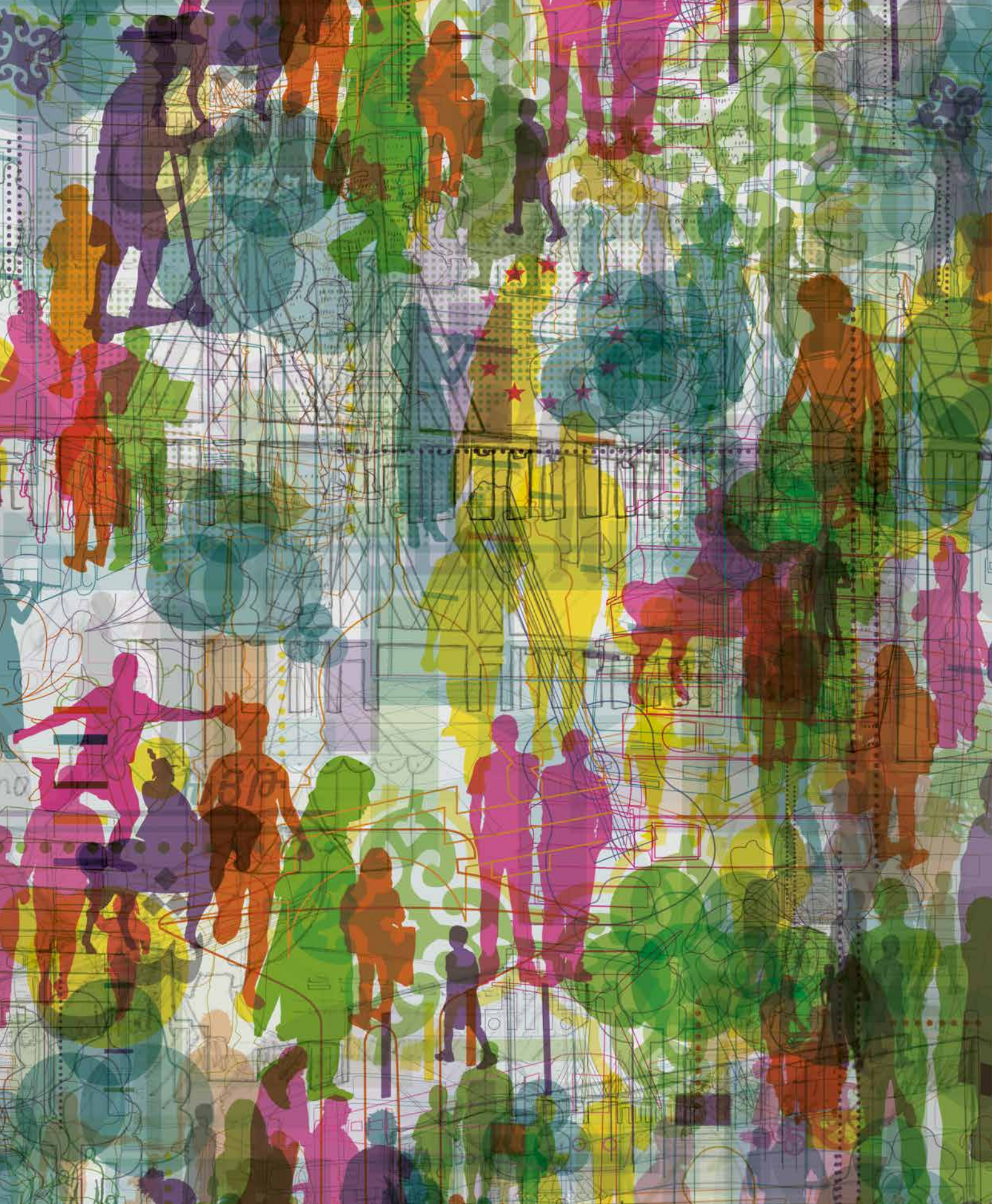
tal train line and the rebuilding of the main street, the “Amiralsstaden” project could improve “Annelund”, “Östra Sorgenfri”, “Emilstorp” and “Rosengård”. The main street, “Amiralsgatan” is one of the barriers that needs to be converted from a traffic route to a city street on a scale that better suits people's need for experiences and proximity. The Continental train line is another clear barrier than can be bridged by the new station. With a holistic approach these actions can give new momentum and energy to the area.

“Amiralsstaden's” level of ambition will require its own organisation with its own political leadership and a combination of skills from all of the City's administrations to guarantee a cross-sectoral approach. Property owners, trade and industry, associations and others should be involved. Urban basics, that is, good schools, good health, good communications and safe environments are also of interest to the city's businesses. New forms of co-operation with trade and industry may thus be a way forward. People living and working in the area should be invited to participate in the process.

The ambition is to achieve social, environmental and economic objectives through physical investments. This means that the project should not only include new spatial changes, but also explore new ways of working, new organisational structures with new partners and new economic models. The same method/model should of course be used to mobilise citizens, bridge barriers and level out differences in other areas in Malmö, for example in “Holma-Kroksbäck”.

Initially feasibility studies should be conducted that generate project plans and financing. Today there is a lack of the broad and weighted business and socio-economic calculations that may form the basis for sustainable financing of an actual project. Calculations corresponding to those mentioned in the “Förtätningssstudie längs Eriksfältsgatan i Malmö” (Densification study along “Eriksfältsgatan” in Malmö) and “Bygga om Dialogen” can form the basis for bringing together more stakeholder with a long-term interest in a sustainable transformation of the area where the work on “Amiralsstaden” also becomes a tool for local mobilisation and local job creation. The goal should be that the proposals drawn up lead to real positive change for as many Malmö residents as possible in their everyday lives.

⁴ http://pejl.svt.se/skola/skane/malmo/fosie/1280083_lindangeskolan/



The Commission for a Socially Sustainable Malmö is an independent commission appointed by the City of Malmö to suggest objectives and actions to reduce inequities in health. This is the Final Report. Read more at www.malmo.se/kommission