

異を仕事の要因で説明することは困難であることを示している。疾病手当が勤労収入に占める割合における国の順位が、先行研究が示す出自国が収入に与える影響における順位とほぼ同様であった。収入分析と健康分析における明らかな違いは、非ヨーロッパ諸国がまざりあった結果を示す一方で、南ヨーロッパが最も健康でないということが示された点である。この解釈の一つは、スウェーデンで暮らした時間の長さの違いに由来するというものである。これは、今後更に分析を予定している。また、スウェーデンに移入した時点での初期健康状態の違いを分析するには、出自国における出生時の余命、GDPなどの情報が必要になるだろう。

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## **Immigrant Consumption of Sickness Benefits in Sweden 1981 – 1996**

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## Introduction

While the income performance of immigrants is of vital importance to an understanding of their economic assimilation, another aspect sheds light on their societal assimilation. The alternative paths for adult immigrants in Sweden, as for natives themselves, consist of gainful employment in the labor market and dependence upon societal transfers, or some combination of the two.<sup>1</sup> The Swedish welfare system is a cash system in which the basic idea is that a person should be able to have a reasonable standard of living whether employed or not. An employed person who gets sick or receives an injury at work should be able to maintain almost the same standard of living as when working full time. The system of benefits has its roots in the late nineteenth century but it was in the 1950s that it got more or less its present form when public sickness insurance (1955) and ATP – a supplemental pension scheme - (1958) were introduced. The benefits are, in both cases, related to the income and should more or less fully compensate for income loss during sick leave and retirement (Hammarstedt 1998).

The labor market careers of immigrants in Sweden have been studied enough to allow us to make some generalizations. Numerous studies using various sources of Swedish data have showed that labor force attachment among immigrants has been weakening over the past three decades, as has the relative incomes earned by immigrants. Before then immigrants were doing at least as well as Swedes with the same occupations. There are indications that this shifting immigrant labor market performance is not merely a reflection of shifting quality of immigrant cohorts, but also of shifting labor market conditions which adversely affect migrants from cohorts which were fairly successful in earlier years.<sup>2</sup> Given this understanding, we turn our focus to an aspect of the social transfer system that may well be influenced by this poor labor market performance. The consumption of sickness benefits may be seen as a symptom of the problem of weak labor market attachment or unsatisfactory employment conditions. If this is true, then immigrant consumption of these benefits should exceed that of natives in the same positions.

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<sup>1</sup> Here we are assuming that the individual is not pursuing educational opportunities.

<sup>2</sup> See Scott (1999), Rosholm, Scott, & Husted (1999), Ekberg & Gustafsson (1995), Rooth (1999), Bevelander & Nielsen (1999), Bengtsson & Scott (1998).

This paper represents only the first stage in a discussion of these problems – the presentation of descriptive statistics and a discussion of the possible reasons for the current situation. As such, some of the standard components of a conference paper are left out, and we shall jump straight to a discussion of the situation as we see it after a short presentation of the data set.

### **The data**

The data used in this paper comes from the Swedish Longitudinal Immigrant Database.<sup>3</sup> This database was developed through a cooperation between the Swedish Immigrant Board and Statistics Sweden. The database consists of a sample of immigrants from sixteen European and non-European countries. This sample begins in 1968 and extends through 1993. The sample contains detailed continual information on 109,699 individuals, which implies that the database is of unprecedented size and scope.

The actual construction of the database is as follows: From the 1970 Swedish census, a random sample of 2,600 immigrants aged 0-65 from 16 nations was drawn, stratified by sex and immigration period (in five-year periods). An additional random sample of 5,200 native Swedes aged 0 - 65, stratified by sex and age (five-year groups) was drawn to serve as a control group. From the 1980 census, another random sample of native Swedes was taken, this time consisting of 400 individuals aged 0 - 10 years in an attempt to account for children born after 1970.

From the immigration register which contains information on entrances to Sweden during the period 1968 - 1996 we took a random sample of 6,760 citizens from each immigration country, again stratified by sex and immigration year.

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<sup>3</sup> For a more thorough discussion of the data, see Scott (1999).

When this sample procedure was complete, a list of names and identification numbers for individuals from 8 of the 16 countries was sent to the Swedish Immigration Board (Statens Invandrarverk) to be linked to information available from the individuals' permanent files. Here, information was linked to approximately 22,000 individuals, and then returned to Statistics Sweden for further processing.

Statistics Sweden then linked the larger sample of 110,000 individuals to a number of registers to obtain the information listed in the appendix.

We have limited the scope of the paper to the period 1981 – 1996, since the register data for sickness benefits begins in 1981. For the purpose of compiling statistics of sickness benefits we have limited the database further to males between the ages of 20 and 59, since it is those of working age which are the most interesting from a societal point of view. This leaves us with just under 300,000 yearly observations for approximately 18,000 individuals. These individuals are divided between 16 countries of birth and Sweden, with approximately 1500 individuals from Sweden per year, and about 1000 for each of the other nationalities.

The issue of interest is the consumption of sickness benefits in relation to total labor income and its determinants. First we discuss differences among different immigrant groups and Swedes after controlling for a certain number of factors including age, education, sector of employment, etc. Second we exclude short-term sickness and focus on individuals that reach a certain level of sickness benefits in relation to their total labor.

### **The aim of the paper**

Figure 1 shows the mean sickness benefit share of total income from employment for male immigrants and Swedes. It shows that sickness benefits were a substantial share of income. It seems to follow the business cycle during the 1980s (Figure 2) quite well though the peak in sickness benefits is already in 1985 while the economic one was in 1989. Thus sickness benefits increased initially as the economy improved. Unemployment was very low during the 80s, only a few percent for Swedes though

much higher for immigrants, who despite the economic boom still had problems of getting jobs (Bevelander 1995, Scott 1999). The difference between immigrants and Swedes is striking - sickness benefits for immigrants is as much a twice the level for Swedes, although the difference becomes smaller during the 90s. The sickness benefits for immigrants are also much more volatile.

Changes in the sickness benefit system may account for decline over time, since it has become more difficult to get benefits. In the beginning of the period a persons received benefits from the first day he or she became ill, while from 1993 a qualifying period of several days without benefits was introduced. Also the high level of unemployment in the 90s made people more eager to remain at work even if they were ill, since worries about job security became greater. The employers also have had greater possibilities to hire people with good sickness records in the 90s than previously.

Why, then, is the difference between immigrants and Swedes so large? From various studies we also know that health varies with education and civil status. Higher educated and married individuals are generally healthier than the low educated and single. But immigrants to Sweden have on average about the same education and the same proportions married as Swedes. Do immigrants live in less healthy areas? Immigrants tend to be concentrated in the metropolitan areas, Stockholm, Gothenburg, and Malmoe, to a higher degree than Swedes, but health differences between metropolitan and non-metropolitan areas are not clear.

Are immigrants employed in more unhealthy jobs? Many immigrants replaced Swedes in the manufacturing industry. Immigrants dominated blue-color jobs both at textile and car factories, for example. These jobs are quite often very strenuous, and this is a possible explanation for the observed differences. Still some of the difference between immigrants and Swedes might be due to initial health differentials since the standard of living is higher and the hospital care for children as well as for adults are better than in most of the countries where the immigrants come from.<sup>4</sup>

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<sup>4</sup> For a discussion of the importance of initial conditions, see Barker (1994)

## Some preliminary results

One problem with Figure 1 is that sickness benefits are recorded as a yearly aggregate and that several short periods of illness or parental absence because of sick children might give the same benefit as longer period of leave due to a more serious health problems. We have therefore also categorized sickness benefits and separated those whose benefits are more than 20 percent of their total income of employment (including sickness benefits) from the others. This figure is rather arbitrary, but should give us an idea as to the extent of serious, long-term sick leave.

Figure 3 show the percentage of males with income of employment receiving at least 20% of their total income from sickness benefits, immigrants and Swedes. The figure is much the same as Figure 2. The gap between immigrants and Swedes increases during the first half of the 80s and then closes monotonically. When the difference is largest, in 1985, 14 percent of the immigrants and 6 percent of the Swedes received at least 20 percent of their income from sickness benefits, which is quite a considerable gap.

Figures 4a-c show the percentage of males with income of employment receiving at least 20% of their total income from sickness benefits from different immigrant countries relative to Swedes. If the curve is totally flat, then the effects of business cycles and structural changes is the same as for Swedes. But almost all immigrant groups still have an increase in sickness benefits during the 80s and a decline during the 90s. This indicates that immigrant sickness benefit consumption may be more cyclically sensitive than that of natives.

Some immigrant groups were healthier than Swedes in the beginning of the 1980s, such as the Iranians, Vietnamese, Ethiopians, Germans and North Americans. The Vietnamese, Germans and North Americans ended up approximately as healthy as Swedes in 1996 while the health of the others declined. Most immigrants groups, including Norway and Denmark, have 1.5 to 2.5 times higher sickness benefit degrees than Swedes have, while two countries are extremes, Finland and Iraq. The latter group has a development relative to Swedes that almost perfectly mirrors the vacancy/unemployment development. These groups have levels 3-4 times higher than

Swedes, and since about 6 percent of the Swedes are, on average, sick at least 20-25 percent of the time, then males from these two counties receive a substantial amount of sickness benefits. Another stringing feature of Figures 4a-c is the sharp increase for many countries in 1994 followed by a decline to next year.

Table 2 shows the OLS estimations for a simple model of sickness benefits as a share of total income of employment, and Table 3 displays the logistic estimation of a model of obtaining sickness benefits equaling 20 percent or more of total income of employment. The covariates are the same. In addition to the variables discussed above, previous sickness and waiting time until first job has been added. general health, and is defined as the number of years in which an individual received at least 20 percent of his income from sickness benefits. Waiting time is a proxy for unobserved abilities which affect the ability to get and keep a job, such as skills in the Swedish language. Waiting time has been categorized into 0 years, 1-2 years, 3-4 years, and 5 years and more until first employment. Home country may pick up some of these effects as well. Year dummies have been used instead of covariates for economic cycles and changes in economic structure, and are merely a short-term solution to facilitate the production of preliminary result. Means of the covariates are shown in Table 1.

The results of the two estimations are much the same with two exceptions. The effect of sector of employment and the health of the Danish comes out differently. We will therefore only refer to Table 3, which shows the result estimations of the model of obtaining sickness benefits equaling 20 percent or more of total income of employment. The effects on health of age, previous sickness and education is much the same as one could expect. Quite interesting though is the rather large health effects of foreign versus Swedish education after controlling for all other variables including home country. Males with foreign primary education and secondary education are less healthy than Swedes with a similar education. Also people living in metropolitan areas are healthier than the rest of the population. This might seem a bit strange since the exposure to diseases should be higher in crowded cities. In historical studies one discusses the "urban mortality penalty" but today it may well pick up differences in job opportunities instead. One interesting finding is that waiting time until the first job had no influence in health. One might otherwise expect unhealthy



persons to have problems finding jobs and thus a negative association between long waiting time and poor health.

The most interesting result is that we find such large differences in obtaining sickness benefits between different immigrant groups. After controlling for human capital and workplace factors as well as changes over time (as shown in Table 3) the odds ratios and p-values for country of origin is as follows:

	Odds ratio	p-value
Germany	0.831	0.0080
USA	0.833	0.0250
Vietnam	1.025	0.7640
Italy	1.091	0.2200
Denmark	1.198	0.0070
Ethiopia	1.243	0.0040
Norway	1.315	0.0000
Chile	1.342	0.0000
Czechoslovakia	1.404	0.0000
Iran	1.612	0.0000
Poland	1.890	0.0000
Finland	1.893	0.0000
Turkey	2.092	0.0000
Yugoslavia	2.437	0.0000
Greece	2.486	0.0000
Iraq	2.697	0.0000

## Discussion

Germans and North Americans have lower benefit consumption than Swedes relative to their income of employment, or, in short, better health. Italians and Vietnamese are as healthy as Swedes are. The rest of the immigrants are less healthy. The differences could either be due to initial health differences, differences in habits (smoking, etc.), differences due to different exposures at the workplace and differences in employment opportunities between different sectors of employment. In the model we only model differences in exposure on the job as differences between the manufacturing industry and the service sector. This should be done in a more detailed way. Still, immigrants may have different jobs even within a single company. Information about occupation might therefore be used as a complement to a more

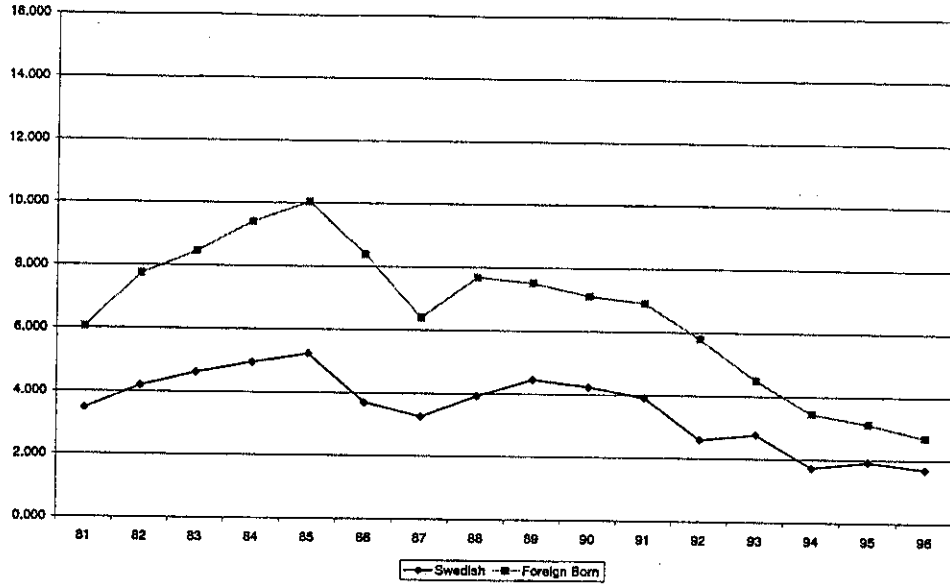
detailed sector variable. The differences between certain immigrant groups and Swedes in obtaining sickness benefits are still very large, which indicates that the entire difference will not be due to job factors. Also, the ranking of countries in the share of sickness benefits in relation to income of employment (the table above) is much the same as a ranking of effects of home country on income controlling for about the same variables (Bengtsson and Scott 1999, Scott 1999). One clear difference between the income and health analyses is that it is the Southern Europeans who seem to be the least healthy, while those from non-European countries display mixed results. One possible explanation here could be an effect of different lengths of time in Sweden, a factor which will be included in the next version. In addition to various model refinements one way to study initial health differences between persons from different countries at the time of their arrival to Sweden would be to include information about conditions in their home countries, like life expectancy, GDP, etc, back to their birth.

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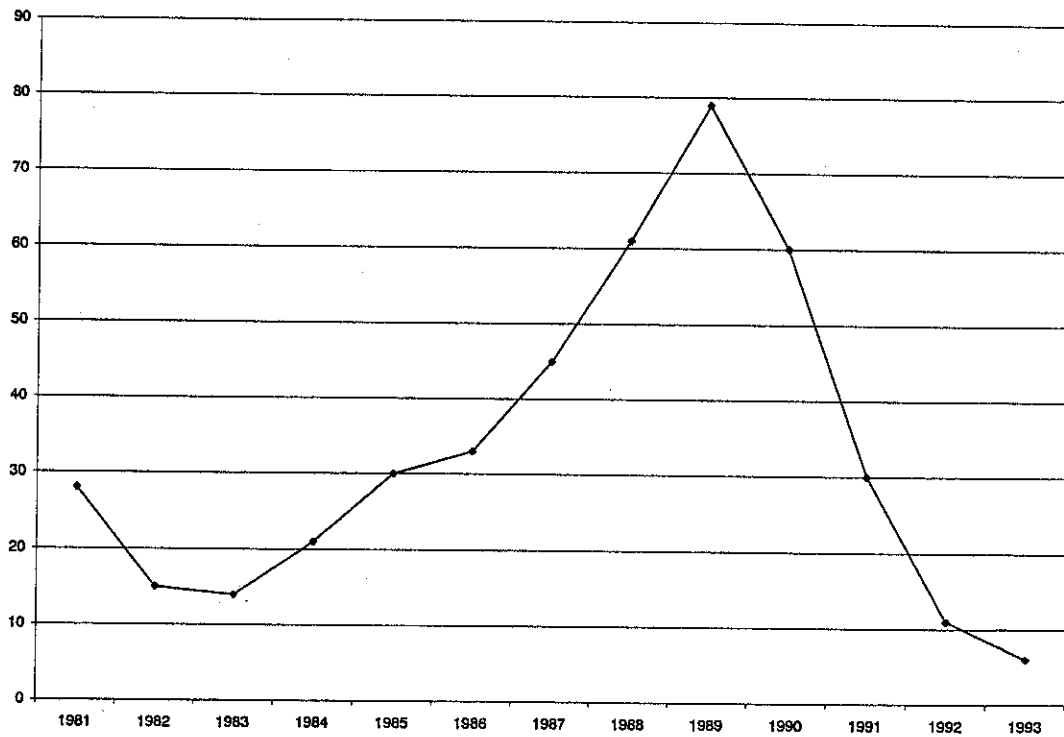
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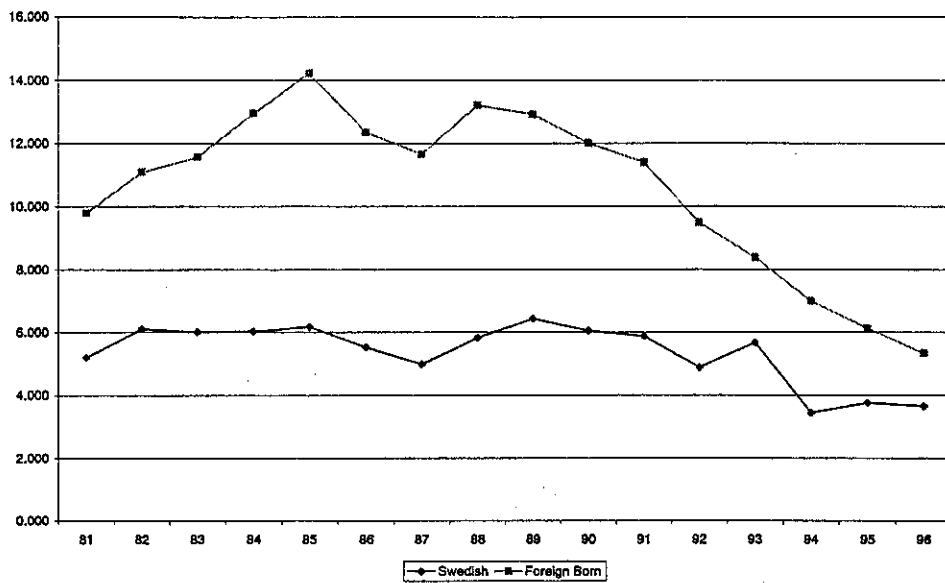
**Figure 1. Mean sickness benefit share of total income from employment**



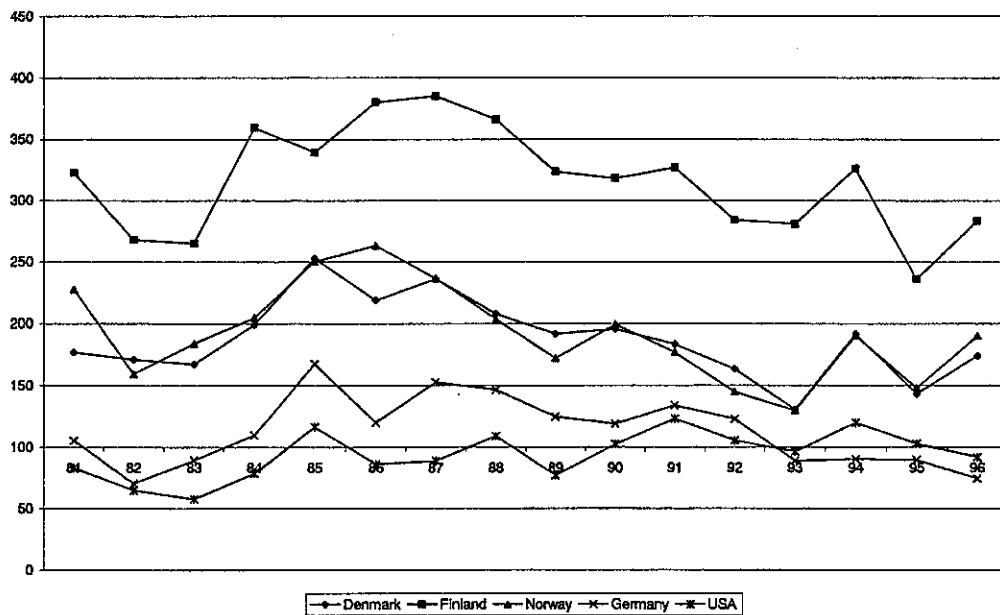
**Figure 2. Vacancy / Unemployment Ratio.**



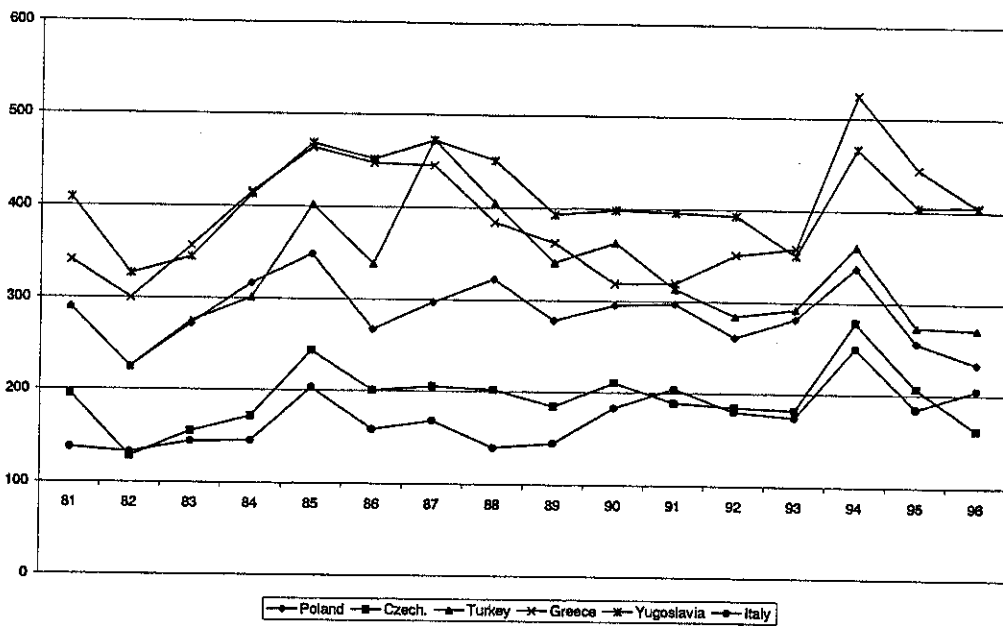
**Figure 3.** Percentage of males with income of employment receiving at least 20% of their total income from sickness benefits.



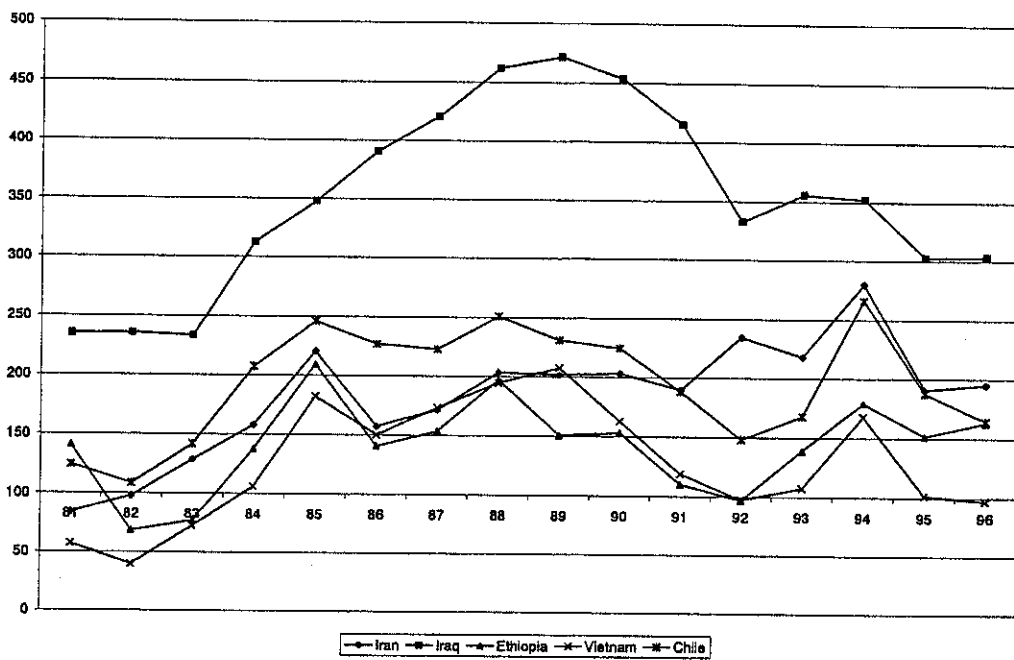
**Figure 4a.** Sickness benefit consumption of at least 20% of total income relative Swedes, per year. Swedes = 100



**Figure 4b.** Sickness benefit consumption of at least 20% of total income relative Swedes, per year. Swedes = 100



**Figure 4c.** Sickness benefit consumption of at least 20% of total income relative Swedes, per year. Swedes = 100



**Table 1. Means of covariates**

Variable	Mean	Min	Max	Variable	Mean	Min	Max
ind = 1	0.100	0	1	Sweden	0.081	0	1
Civil Status	0.899	0	1	Denmark	0.053	0	1
Metro Area	0.493	0	1	Finland	0.065	0	1
Previous Sickness	0.587	0	15	Norway	0.052	0	1
Sickness benefits	6.127	0	100	Germany	0.061	0	1
year	89.134	81	96	USA	0.047	0	1
Time until first employment target	1.465	0	15	Poland	0.084	0	1
Swe. Primary	0.664	0	1	Czech.	0.050	0	1
For. Primary	0.065	0	1	Turkey	0.080	0	1
Swe. Secondary	0.454	0	1	Greece	0.057	0	1
For. Secondary	0.098	0	1	Yugo	0.074	0	1
Swe. University	0.170	0	1	Italy	0.042	0	1
For. University	0.042	0	1	Iran	0.057	0	1
Unknown Edu.	0.097	0	1	Iraq	0.046	0	1
Age 20–25	0.073	0	1	Ethiopia	0.046	0	1
Age 26–35	0.141	0	1	Vietnam	0.038	0	1
Age 36–45	0.277	0	1	Chile	0.067	0	1
Age 46–55	0.271	0	1				
Age 56 +	0.232	0	1				
1981	0.078	0	1				
1982	0.047	0	1				
1983	0.049	0	1				
1984	0.051	0	1				
1985	0.054	0	1				
1986	0.056	0	1				
1987	0.058	0	1				
1988	0.060	0	1				
1989	0.062	0	1				
1990	0.065	0	1				
1991	0.069	0	1				
1992	0.071	0	1				
1993	0.073	0	1				
1994	0.074	0	1				
1995	0.073	0	1				
1996	0.073	0	1				
Manufacturing Sector	0.071	0	1				
Service Sector	0.070	0	1				
Unknown Sector	0.241	0	1				
Ethiopia	0.391	0	1				
Vietnam	0.327	0	1				
Chile	0.046	0	1				
	0.038	0	1				
	0.067	0	1				

**Table 2. OLS Estimation. Dependent variable – sickness benefits of total income of employment.**

sick	Coef.	Std. Err.	t	P> t	[95% Conf. Interval]
civil status	-0.142	0.133	-1.069	0.2850	-0.404 0.119
metro area	-0.856	0.061	-14.004	0.0000	-0.976 -0.737
For. Primary	1.531	0.147	10.383	0.0000	1.242 1.820
Swe. Secondary	-0.750	0.158	-4.739	0.0000	-1.061 -0.440
For. Secondary	0.198	0.167	1.187	0.2350	-0.129 0.525
Swe. University	-1.527	0.186	-8.192	0.0000	-1.892 -1.162
For. University	-1.216	0.180	-6.768	0.0000	-1.568 -0.864
Unknown Edu.	0.246	0.169	1.460	0.1440	-0.084 0.577
Age 26 – 35	-0.968	0.106	-9.111	0.0000	-1.176 -0.759
Age 36 – 45	-0.823	0.114	-7.248	0.0000	-1.045 -0.600
Age 46 – 55	0.760	0.118	6.449	0.0000	0.529 0.991
Age 56 +	2.289	0.150	15.300	0.0000	1.996 2.583
Previous Sickness	4.971	0.026	188.622	0.0000	4.919 5.023
1982	-0.225	0.160	-1.401	0.1610	-0.539 0.090
1983	-0.773	0.160	-4.836	0.0000	-1.086 -0.459
1984	-1.011	0.160	-6.311	0.0000	-1.325 -0.697
1985	0.090	0.164	0.549	0.5830	-0.231 0.411
1986	0.568	0.164	3.469	0.0010	0.247 0.889
1987	-0.270	0.162	-1.672	0.0940	-0.587 0.047
1988	0.744	0.161	4.632	0.0000	0.429 1.058
1989	0.359	0.159	2.252	0.0240	0.047 0.672
1990	0.252	0.164	1.536	0.1250	-0.070 0.574
1991	-1.006	0.166	-6.064	0.0000	-1.331 -0.681
1992	-3.553	0.168	-21.144	0.0000	-3.882 -3.224
1993	-3.518	0.171	-20.528	0.0000	-3.853 -3.182
1994	-2.917	0.227	-12.823	0.0000	-3.363 -2.471
1995	-3.634	0.226	-16.092	0.0000	-4.077 -3.192
1996	-4.124	0.230	-17.891	0.0000	-4.575 -3.672
Service Sector	-1.324	0.068	-19.557	0.0000	-1.457 -1.192
Unknown Sector	-0.227	0.092	-2.473	0.0130	-0.407 -0.047
1–2 Years until first employment	-0.103	0.075	-1.377	0.1690	-0.250 0.044
3–4 Years until first employment	-0.468	0.118	-3.958	0.0000	-0.700 -0.236
5+ Years until first employment	-0.825	0.180	-4.570	0.0000	-1.179 -0.471
Denmark	0.133	0.174	0.765	0.4440	-0.208 0.475
Finland	1.899	0.167	11.350	0.0000	1.571 2.227
Norway	0.356	0.177	2.012	0.0440	0.009 0.702
Germany	-0.932	0.166	-5.603	0.0000	-1.258 -0.606
USA	-0.688	0.189	-3.650	0.0000	-1.058 -0.319
Poland	1.689	0.163	10.345	0.0000	1.369 2.009
Czech.	0.502	0.180	2.793	0.0050	0.150 0.855
Turkey	2.212	0.168	13.171	0.0000	1.883 2.541
Greece	3.083	0.179	17.216	0.0000	2.732 3.434
Yugo	3.174	0.165	19.293	0.0000	2.852 3.497
Italy	-0.062	0.185	-0.338	0.7360	-0.424 0.300
Iran	1.140	0.190	5.994	0.0000	0.768 1.513
Iraq	3.085	0.208	14.806	0.0000	2.677 3.494
Ethiopia	0.483	0.196	2.471	0.0130	0.100 0.867
Vietnam	0.224	0.210	1.064	0.2870	-0.188 0.635
Chile	0.832	0.172	4.831	0.0000	0.495 1.170
Constant	4.929	0.211	23.315	0.0000	4.514 5.343



**Table 3. Logistic Estimation. Dependent variable – obtaining sickness benefits equaling 20% or more of total income of employment.**

Number of obs = 161469      Pseudo R2 = 0.2127  
 LR chi2(49) = 23764.13      Log likelihood = -43988.69  
 Prob > chi2 = 0.0000

ind	Odds Ratio	Std. Err.	z	P> z	[95% Conf. Interval]
civil status	1.012	0.046	0.258	0.7960	0.926 1.105
metro area	0.812	0.016	-10.605	0.0000	0.782 0.844
For. Primary	1.353	0.071	5.760	0.0000	1.221 1.500
Swe. Secondary	0.770	0.044	-4.558	0.0000	0.688 0.862
For. Secondary	1.012	0.058	0.214	0.8300	0.905 1.133
Swe. University	0.383	0.035	-10.400	0.0000	0.320 0.459
For. University	0.590	0.039	-7.921	0.0000	0.518 0.673
Unknown Edu.	1.071	0.062	1.176	0.2400	0.955 1.201
Age 26 – 35	0.805	0.028	-6.162	0.0000	0.751 0.862
Age 36 – 45	0.876	0.033	-3.540	0.0000	0.814 0.943
Age 46 – 55	1.400	0.052	9.005	0.0000	1.301 1.507
Age 56 +	2.059	0.090	16.469	0.0000	1.889 2.244
Previous Sickness	2.132	0.015	108.275	0.0000	2.103 2.162
1982	0.899	0.044	-2.202	0.0280	0.817 0.988
1983	0.769	0.038	-5.337	0.0000	0.699 0.847
1984	0.693	0.035	-7.346	0.0000	0.629 0.764
1985	0.942	0.046	-1.214	0.2250	0.855 1.037
1986	0.960	0.047	-0.845	0.3980	0.872 1.056
1987	0.931	0.045	-1.478	0.1390	0.847 1.024
1988	1.051	0.049	1.062	0.2880	0.959 1.153
1989	0.931	0.044	-1.506	0.1320	0.849 1.022
1990	0.904	0.045	-2.040	0.0410	0.820 0.996
1991	0.660	0.034	-7.981	0.0000	0.596 0.731
1992	0.391	0.022	-16.395	0.0000	0.350 0.438
1993	0.399	0.023	-15.700	0.0000	0.356 0.448
1994	0.552	0.041	-8.042	0.0000	0.478 0.638
1995	0.420	0.033	-11.080	0.0000	0.360 0.490
1996	0.338	0.028	-12.947	0.0000	0.287 0.398
Service Sector	0.774	0.017	-11.992	0.0000	0.743 0.807
Unknown Sector	1.067	0.030	2.303	0.0210	1.010 1.127
1–2 Years until first employment	1.032	0.024	1.318	0.1880	0.985 1.080
3–4 Years until first employment	0.967	0.035	-0.933	0.3510	0.901 1.038
5+ Years until first employment	0.933	0.051	-1.270	0.2040	0.838 1.039
Denmark	1.198	0.080	2.704	0.0070	1.051 1.366
Finland	1.893	0.115	10.544	0.0000	1.682 2.132
Norway	1.315	0.087	4.138	0.0000	1.155 1.497
Germany	0.831	0.058	-2.667	0.0080	0.726 0.952
USA	0.833	0.068	-2.249	0.0250	0.711 0.977
Poland	1.890	0.115	10.458	0.0000	1.677 2.130
Czech.	1.404	0.096	4.952	0.0000	1.227 1.606
Turkey	2.092	0.127	12.195	0.0000	1.858 2.355
Greece	2.486	0.155	14.580	0.0000	2.200 2.810
Yugo	2.437	0.145	14.976	0.0000	2.169 2.738
Italy	1.091	0.078	1.226	0.2200	0.949 1.255
Iran	1.612	0.115	6.705	0.0000	1.402 1.854
Iraq	2.697	0.185	14.486	0.0000	2.358 3.085
Ethiopia	1.243	0.095	2.854	0.0040	1.070 1.443
Vietnam	1.025	0.083	0.300	0.7640	0.874 1.201
Chile	1.342	0.087	4.536	0.0000	1.182 1.524

## APPENDIX

List of variables based on information from the Immigration Board Archives and from various computerized registers about immigrants from Norway, Denmark, Finland, *Germany, USA, Poland, Czechoslovakia, Italy, Greece, Turkey, Yugoslavia, Iran, Iraq, Ethiopia, Chile, Vietnam*. (Countries in italics also have information from the Immigration Board - marked with an asterisk in list).

identification number	(*) country of occupational education
year of event	(*) highest education (education in Sweden 1970, 1985-)
week of event	1970, 1985-)
type of event	degree of employment code 1 (1985)
sex	degree of employment code 2 (1970, 1975, 1980, 1990)
civil status	degree of employment (1986-)
sex of latest born child	sector of employment, 4-digit level
birth order of latest born child	sector of employment 5-digit level (1980-)
cause of death	sector of employment (1986-)
birth place	occupation 3-digit level
birth country	occupation 5-digit level (1985-)
citizenship country	total income of employment and self-employment
emigration country	socio-economic code 1 (1970)
immigration country	socio-economic code 2 (1980)
municipality of residence in Sweden	occupation in home country
municipality of previous residence in Sweden	years of employment in home country
* place of departure	General Unemployment
* country of departure	Unemployment Insurance
* reason for immigration	Pension / Early retirement
* date for first application of residence	Taxable Income
* date for decision about residence	Housing Subsidies
* time of previous travel into Sweden	Disposable Income
* time of previous travel out of Sweden	Sick Leave
* length of stay in previous travel to Sweden	Parental Leave
* 1st language at arrival	Wages
* 2nd language at arrival	Income of Employment
* 3rd language at arrival	Income of Capital
* 4th language at arrival	Property Tax
(*) general education	Welfare Payments
(*) country of general education (Sweden, other)	Student Loans / Support
(*) occupational education	

## 第4章 南欧諸国

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## 南欧諸国平成 11 年度研究成果の概要

西岡八郎

### (1) 研究課題と初年度結果の概要

世界で出生率が最も低い国々のなかには、イタリア、スペイン、ポルトガルなど多くの南欧諸国が含まれている。これらの地中海沿岸諸国では合計特殊出生率が 1.2-1.4 程度と超低出生率状態にある。これらの国々が、他の欧米先進諸国に比較して出生率の低下が遅れて始まっていること、女性の社会進出が比較的新しいこと、伝統的な家族観をもっていることなど、日本との共通点も多く、日本の将来の低出生率を見通すうえでも、重要な比較研究の対象国となろう。

現在、日本をはじめ多くの国で、「少子化」というきわめてダイナミックな社会変動が生じており重要な課題とされている。先進国においてすでに進行し、今後わが国においても進行する可能性の高い社会現象のひとつは、女性の地位の向上にともなう家族形成パターンの変化である。これは、就業行動と出生行動が密接に関連すると考えられるためである。日本と比較的似たような人口動態の状況や社会的背景をもつ南欧の国々で、女性の就業行動に対しどのような支援的な施策、たとえば家族政策や労働政策が実施され、出生行動にどのような有効性をもつのか、などの研究を進めることは、日本の場合と比較、参考にするうえで意義のある研究課題である。

しかし、地中海沿岸の南欧諸国に関しては、分析に必要な基礎的な情報やデータが決定的に不足している。そのため、初年度は出生率などの人口動態、世帯・家族に関する推移・動向、女性の地位指標や家族政策、労働政策の基本的な動向に関する基礎資料の収集と整理に重点を置いた。また、入手した資料から可能な範囲で南欧圏諸国間の同質性や異質性、あるいは各国内の地域性(差)の検討を行い、次年度以降の研究を方向づける作業を行った。

今年度は、上記のイタリア、スペイン、ポルトガルについてデータの収集や整理を行ったが、とくにスペインに重点を置いて、1970 年代半ば以降の出生動向の分析を行い、南欧諸国の出生行動の特徴を明らかにするとともに、その他の欧米先進諸国とは異なる傾向を示している非嫡出子比率、同棲率、未婚者の居住状態(離家遅れ)、離婚率などの動向についても検討を行った。

南欧諸国に共通してみられる現象を 2、3 紹介しておく。(1)合計出生率 1.3-1.4 前後か