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1 Executive Summary

Sweden has a relatively strong financial situation. The Swedish economy is better than most other European countries in the present financial situation. The public finances are stable and there are sufficient safety margins to guarantee a continued financial stability. The Government's commitment is to exercise a strict budgetary discipline, but at the same time also to sustain high levels of employment, good welfare and social inclusion.

The Swedish pension system was reformed more than ten years ago to include a notional defined contribution (unfunded NDC) and a mandatory funded part, in order to meet the challenges of demographic aging. It has often been regarded as a successful model of financial sustainability, through its automatic balance mechanism which insulates it from ad hoc parametric reforms and political interference. Since its introduction, the system has been subject to two major financial crisis, and in 2010 balance indexation of pensions and pension accounts (to re-balance assets and liabilities) was turned on for the first time. In 2012 the balancing is still on, and is projected to continue in the next few years. This is providing an opportunity for public debate to assess the system's performance and its possible shortcomings, e.g. in terms of adequate pensions and inter-generational fairness. In time, the effects of placing more risk and responsibility on the individual are in fact becoming more apparent: sustainability has a "price" that individuals themselves have to pay for, e.g. by working longer, if they want to preserve a given living standard. Sweden is investing a lot in information and communication campaigns meant to make people understand; it is also putting emphasis on developing policies which will make people work longer. The role of the state remains to ensure that the sustainability cost is shared equally between e.g. pensioners and workers, as well as to protect the weakest groups who can no longer adapt their labour supply. In this sense, some improvements of the system could (and possibly will) be made; recent events for instance have highlighted an in-built inequality in terms of pensioners being more penalised by balancing indexation than workers. The increase in relative poverty among the elderly, in particular women, witnessed under the past years is also pointing to the need to possibly revise the minimum guarantees in the system. In sum, we could say that the Swedish pension system remains a strong model of successful pension reform, but that it is also undergoing a process of re-assessment in the public debate; thus possibly some small re-calibration might be expected in the future.

The quality of health and long-term care in Sweden is generally high, but there are significant differences between different county councils, regions and municipalities. There are also access problems in both health and long-term care. There are long waiting lists for some surgical operations and a limited access to primary health care. Moreover, there is a lack of places in institutional long-term care, which means that there are long waiting times for people in need of such care. There have been some major initiatives to increase the access and quality of care, for example by national guarantees and by introducing open comparisons of the availability, quality and efficiency of both health care and long-term care between different county and regional councils, municipalities, hospitals and nursing homes. The government has also tried to increase the freedom of choice in the health care system by encouraging private companies to establish health centres and nursing homes for long-term care. They believe that it will lead to better access and quality of care. This strategy is, however, based more on political ideology than on scientific evidence. During the last year, there have been a number of scandals related to bad conditions in private nursing homes and an intensive public debate about the role of profit making companies in the welfare system.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2011 until February 2012)

2.1 Overarching developments

In the field of pensions, there have not been major developments or policy changes during the previous year. Yet several public enquiries have been started by the government to be able to collect better understanding of the system's performance and to shape the future pension policy agenda. One of them is the so called "Pension Age Group" (*Pensionsåldergruppen)* which aims to review patterns of work, health and retirement among elder workers, so as to inform the government position on whether a revision of the pension age(s) should be considered. The report will be available in March 2012. Overall, extending further working life is becoming the most important "message" that the policy makers want to convey and is occupying the public debate and the media. The Swedish Pension Agency for instance has changed the annual "Orange Letter" – a pension account statement sent yearly to every insured with a projection of their final pension – so as to include a cohort-based forecast of the recommended retirement age (i.e. which would preserve the same replacement rate of someone retiring at 65 today). The likely drop in adequacy of future pensions is, in other words, addressed mostly through the incitement to work longer and much less through the e.g. active promotion of complementary pension savings. The latter is in fact an area of deficit in the current public pension debate.

Another enquiry was commissioned during 2011 by the Government to the Swedish Pension Agency to review the effects of balancing and income indexation both on the system's finances and on individual outcomes. A report, with possible alternative suggestions to the current indexation system, will be available later in 2012. Overall, the question of balancing remains quite high priority. Under current projections the system's balance ratio (used to switch on and off an alternative indexation in case of financial unsustainability), despite having temporarily recovered under 2011 and 2012, is projected to go below 1 again between 2013 and 2016, due to low growth expected in the assets side. This reposes the question of how much will pensioners loose in pension (relative to balancing having been off) and for how long it will persist, since the initial idea of such balancing was to be just an occasional and temporary solution, rather than a protracted state. Another question, which has to do with income pension annuity calculation, is whether the so called "norm" (i.e. an anticipated interest rate of 1.6% which effectively front-loads the pension income stream) should be revised downwards in periods of low growth. This might partially reduce the risk of diminishing pension growth when becoming older.

There have been some major developments in the organisation of health care during the last few years. Sweden has a decentralised health care system, where county councils have been mainly responsible for the provision as well as the financing of health services. In 2007, a parliamentary committee suggested that the country should be divided into larger regional councils in order to have a stronger financial base and a more sustainable organisation of health care. The regional councils were supposed to be established voluntarily through mergers between neighbouring county councils. However, it seems that this process has not been very successful. More regional councils are being established, but not so much by mergers. Instead, some county councils are just changing their names to regional councils. This means that there will be a great number of regional councils of different size, which may have consequences for the organisation and financing of health care. It will also have consequences for the quality of care, which may be very different in the regional councils. To counteract such a development, open comparisons of the availability, quality and efficiency of health care between the different county and regional councils have been introduced. The national government has also taken an initiative to increase

the freedom of choice in primary health care, which they believe will lead to better access and quality of care. As a result, there has been a growing private sector involvement in the health care system.

There have been only few reforms in the field of long-term care during the last years. The situation has been problematic for a long time due to the increasing number of elderly people in Sweden. As a result, there is a lack of places in institutional long-term care and long waiting times for people in need of such care. Long-term care is a responsibility of the municipalities and they have been dealing with the situation in different ways, depending on their demography, resources and political majority. Many municipalities have invited private companies to establish nursing homes in addition to the municipal institutions for long-term care. The results have been mixed. There have been an increasing number of places for long-term-care, but also a number of scandals related to bad conditions observed in private nursing homes. As a result, there has been an intensive public debate about the role of profit making companies in the welfare system and the open comparisons of the availability, quality and efficiency of health care have been expanded to include also long-term care.

2.2 Pensions

2.2.1 The system's characteristics and reforms

Public Pensions

The Parliament decided in June 1994 on the principles of a new public pension system. The principles behind the pension reform were:

- A fixed contribution rate equal for all generations
- A defined contribution benefit based on life income
- Pension rights during parental or sick leave
- Flexible pension age
- Financial and political stability

The new pension scheme was introduced from 1999 on and became fully established January 2003. Those born from 1953 are covered entirely by the new system, while those born between 1938 and 1952 receive a mix of new and old (ATP) pension[1]. This means that until 2018 no pensioner in Sweden will have a pension entirely calculated from the new rules.

The new public pension system consists of three parts: *income pension*, *premium pension* and *guarantee pension*. Income and premium pension are based on the whole working life income and contributions, while the guarantee pension is a universal guaranteed minimum which is gradually withdrawn as the income pension entitlement rises above a certain threshold. The system is partly funded (the premium pension, contributions for which are invested in a freely chosen portfolio of funds) and partly PAYG (the income pension). The latter can be classified as a Notional Defined Contribution (NDC) system, where individual accounts are notional devices in which life-time contributions are "earmarked", but where no money is actually invested (as it is used to finance current pensioners).

[1] ATP was a defined benefit system based on the 15 best earnings years and 30 years of contributions for a maximum pension. The mix works in shares. That is to say, people born in 1938 receive 80% of their pension from the old ATP rules and 20% from the new system; people born in 1939, 75% from the ATP and 25% from the new system etc.

Every year, an amount corresponding to 18.5% of the insured person's pensionable income is assigned to the individual pension account. The insured pays 7% of the earnings through a pension contribution up to 8.07 income base amounts (the income base amount is SEK 54,600 in 2012).[2] Employers pay 10.21% of the total wage to the pension system regardless of the wage level. The 17.21% (7.00+10.21) of earnings corresponds to 18.5% of the pension basis[3]. From the total contributions paid, 16 percentage points goes to the income pension and 2.5 percentage points to the premium pension.

The pension basis is calculated from earned and not earned income times an adjustment factor (0.93). In addition to wage from employment and income from self-employment, benefit from sickness, disability and unemployment insurance is counted as income. Studies (with study assistance), national service (conscription) and years with children up to four years of age also confer pension entitlement. The pension basis has a ceiling of 7.5 income base amounts before tax per year. Above this threshold no pension rights are earned nor income pension are paid.

The income (and premium) pensions can be drawn at the earliest from the age of 61. A preliminary denominator (unisex annuity divisor) linked to cohort-specific life expectancy is used to calculate the pension for those drawing a pension before the age of 65. The annual pension flow is fixed once and for all when the retiree reaches the age of 65 (i.e. no further life expectancy adjustments are made after 65). There is no obligatory retirement age. Accordingly, those retiring after 65 will receive an upper adjustment in the annuity divisor based on lower remaining life expectancy. At any age after 61, an old age pension can furthermore be claimed in full (100%), or in shares (25%, 50%, 75%), facilitating those who want to combine retirement and work.

When the income pension starts to be paid, an annuity is calculated from the pension capital saved thus far, taking into consideration the predicted growth in the economy and the calculated length of life for the cohort to which the person belongs. The individual pension account balance is divided by a denominator (an annuitization factor) determined by: (i) life expectancy at retirement: if life expectancy gradually increases, later cohorts will receive a lower income pension than earlier cohorts at a given income. In order to preserve fairness between gender, unisex life expectancy tables at that age are used, updated yearly with latest mortality statistics (ii) the general income index growth[4], with a deduction for the rate of growth assumed when calculating the first annuity (this growth norm is 1.6%). In other words, when the first annuity is calculated, a yearly rate of growth of 1.6% is credited to the insured. Subsequently, the system compensates only for growth in the income index above this level. If the economy grows less than 1.6% the pension annuity will actually be reduced proportionately. (iii) inheritance gains, i.e. pension savings from people born in the same year who die during the year, and administration costs (representing a small deduction to cover for the costs of running the system).

One of the greatest innovations of the new system is the introduction of a mechanism which allows to preserve financial stability in the PAYG part vis-à-vis population changes, while

[2] EUR 1 = SEK 9 ca. in February 2012

[3] The explanation for the discrepancy is that the pension contribution of 7% is deducted from income when the pension basis is calculated. The maximum pension basis does become 0.93*8.07 income base amounts = 7.5 income base amounts.

[4] To smooth out the effect of business cycles, the index is then calculated as the average income change during the last three years (where income from earlier years is adjusted by the consumer price index in June every year). Finally, the income index is adjusted by the consumer price index for the latest (June to June) year.

keeping the contribution rate fixed. This mechanism is known as *automatic balancing* and essentially consists of reducing the pension liability by changing the way the pension accounts and the income pensions are indexed whenever the system' financing becomes unsustainable. By default, all pension benefits and the notional pension accounts are indexed to the growth rate of average income. This indexation will be interrupted whenever the automatic balancing mechanism is triggered, and an alternative indexation will kick in, at the system's internal rate of return.

The system is considered financially stable when the total pension liability does not exceed the assets in the system. The automatic balancing mechanism is triggered when the system's liabilities exceed its assets. The actuarial method of what should be counted as assets and liability is the key factor[5]. No projections are used to calculate such amounts.

The accounting of the system's assets include the so called buffer fund, which collects any surplus from the yearly contributions flow to the PAYG system and invests it in the capital markets (thus making the PAYG system effectively mixed or partly funded), through the so called First-Fourth and Sixth National Pension Funds. Since 2010 the average value of the buffer fund over the past three consecutive years is actually used to reduce the effects of the large losses experienced in 2008 over a longer period.

To see whether the system is financially sustainable, each year the Government determines a balance ratio:

(1) Balance Ratio = $\frac{ContributionAssets + BufferFund}{PensionLiability}$

If the balance ratio exceeds 1.00, there is a surplus in the system. If the balance ratio is below 1.00, there is a deficit – the pension debt exceeds the assets and the system is financially unbalanced. If this was to persist, the buffer fund would be depleted. This situation is indeed possible since liabilities and assets are likely to grow at different rates. In these cases, the income index will be multiplied by the balance ratio in order to restore the balance between assets and liabilities:

(2) Balance Index = $BalanceRatio * IncomeIndex$ [6]

Therefore, the balance index is the rate at which the pension liability must be indexed to ensure that assets and liabilities are equal, or in other words the system's internal rate of return. The system's internal rate of return is a function of (i) the growth in the contribution base (e.g. population aging would imply lower growth in the contribution base), the change in age-related income and mortality patterns, and returns to the buffer funds, all of which would affect the growth of the assets side, and of (ii) changes to the life expectancy which will affect the growth of the liability side. Unequal changes to the growth of assets against the growth of liabilities will require the balance index to work as a levelling mechanism, by lowering the liabilities so that balance will be eventually restored and income indexation resumed.

The triggering of the balance index will mean that all notional pension accounts as well as income pensions being paid out will be indexed by the system's internal rate of return rather than the rate of growth in average incomes. As the balance index is lower, the liabilities will start

[5] For more details on how assets and liabilities are calculated see e.g. Orange Report 2010 or ANR2010

[6] Recall that in the case of pension indexation (rather than pension accounts) the income index is actually calculated by withholding 1.6% from income growth. This is maintained when balancing is activated. Pension indexation this way is called *följsamhetsindexering* in Swedish.

decreasing; at some point, as the liabilities decrease and the balance ratio increases again, the balance index will reach the income index levels and normal indexing can resume.

In practice, the indexation rule for a given year is applied in January of that year with a two years lag, i.e. the index used correspond to what was calculated in December of two years earlier. Then, the average income growth over the previous three years is applied. This tends to result in a slightly counter-cyclical behaviour i.e. because of lagged indexation pensions and pension accounts tend to get indexed by a higher income growth in those years when earnings growth is in fact sluggish, and vice versa.

As of December 31, 2008, in conjunction with the financial crisis, which wiped out about 20% of the value of the buffer fund, the balance ratio went below 1 for the first time. This implied that as of January 1, 2010[7], automatic balancing was for the first time turned on in Sweden. During 2011, both pensions and pension accounts were still balance-indexed (this time according to indexes calculated from 2009 data), and the average income pension reduction hit a record high (-4,3%). In 2012, the balance ratio (calculated from 2010 data) finally returns above one (1,0024); thanks to stronger growth in incomes the average income pension has actually resumed positive growth in nominal terms (+3.5%), despite balancing being still on. The balancing enters in fact the so-called "gas" phase, i.e. a phase when balancing is still on (since the value of the balance index is still less than the income index) but the growth in the balance index (5.2%) is higher than what it would have been if the regular income indexation had been on (4,9%; see equation 2 above). This is actually a feature of the system that has become the object of some criticism (see for instance Diamond and Barr, 2011). In fact, while the balance ratio returns above 1 but balancing is still on, there is the theoretical possibility that those who contribute into the system might actually gain more with balancing on than if it had been off, while this gain is not possible for those who have already retired.

Data available for December 31, 2011 have been used in early 2012 to decide indexation holding in 2013. The balance ratio looks once again over one (1,0198), signifying still a quicker growth in the balance index than in the income index (catching up or "gas" period continues). This mainly can be explained by positive increase in the contribution flow paid in (+255 billion SEK), the performance of the buffer funds (+55 billion SEK in 2011), and limited increase in liabilities (+175 billion SEK) thanks to the negative indexation of pensions.

[7] i.e. with a two years lag, in order to have final rather than imputed income information from the tax authorities

Table 2: Assets, Liabilities and Balance Ratios (in Billions of Swedish Crowns)

	2009 (Used in 2011)	*2010 (Used in 2012)*	*2011 (Used in 2013)*
(a) Buffer Fund	811	810	865
(b)Contribution Assets	6362	6575	6828
(c)Pension Liabilities (incl. Administration costs)	7512	7367	7543
Pension Deficit ((a+b)-c)	-323	103	157
Balance Ratio	0.9549	1,0024	1,0198
Balance Index		140,45	
Income Index	142,34	149,32	

Source : Swedish Pension Authority Orange Report (2010)

Beside the contributory income pension, the new Swedish pension system also includes a universal minimum pension meant to guarantee a minimum income to all. To receive a full guarantee pension, a person must have lived in Sweden or in another EU/EES country for 40 years. Guarantee pension can be received at the earliest from the age of 65. Guarantee pension is not tested in relation to wage, agreement-based pensions or private pensions but only in relation to income pension (calculated as if they had been paid from the age of 65). It is financed by general taxation and is indexed to the Consumer Price Index.

If the income pension is low (i.e. below the equivalent of ca. 33% of the average wage) or non-existent, the guarantee pension supplements the income pension, but only up to a point. The maximum guarantee pension in 2011 was SEK 7,597 per month for an unmarried pensioner (2.13 price-related base amounts) and SEK 6,713 for a married pensioner (1.9 price-related base amounts)[8]. The maximum amount is received by those who have no contributions nor entitlement to the income pension. For those with an income pension above zero, yet below the maximum pension income threshold, more precisely up to 1.26 basic amounts (1.14 for couples), the income pension amount is withdrawn from the maximum guarantee pension amount by 100% (so in practice the total pension income of these people will be equal to the maximum

[8] This is an increase since 2010 due to 0.9% increase in the price index.

guarantee pension, albeit the composition will be split between income and guarantee pension). For those with an income pension between 1.26 and 3.07 basic amounts (1.14 and 2.72 for couples), the maximum amount of guarantee pension will be tapered away at a rate of 48% for every additional unit of income pension. Above these levels of income pension (i.e. SEK 131,500 a year) no guarantee pension is received.

It follows that any decrease in income pension due to e.g. the on setting of the automatic balancing mechanism will be partially offset by a concomitant increase in the guarantee amount (for those whose income pension falls below the upper threshold). Another effect which is produced by lowering in the indexing of the ATP/ income pension is a possible increase in the means-tested housing add-on benefit for pensioners. Overall, since the poverty risk is highly associated to having some guarantee pension and housing benefit as part of one' s retirement income, this effectively means that the poor will be affected much less by the balancing, if at all.

It is also important to remember that both in 2009 and 2010 the government had lowered income tax for pensioners (in the form of a higher tax deduction) as a way to partly compensate for the balancing effect (as well as for equity reasons with workers, see next section).

Moving on to the premium pension, the part of the pension basis set aside for the premium pension (2.5%) is invested according to the choice of the individual in at most five funds out of about 800. These funds were registered initially under the premium pension authority, PPM, and since 2010 under the Swedish Pension Agency (*Pensionsmyndigheten),* which now administers both income and premium pensions together. The amount of the premium pension is thereby affected by the change in value of the funds the individual has chosen as to invest his or her money in, as well as specific fund fees (which however are highly discounted). Individuals can trade funds freely at no costs. Individuals who do not want to make an active portfolio choice can save in the state-managed option at a very competitive fee (AP Såfa generational fund). The amount of the premium pension is affected like the income pension when the pension is drawn (at the earliest at the age of 61) and the cohort's estimated remaining lifetime.

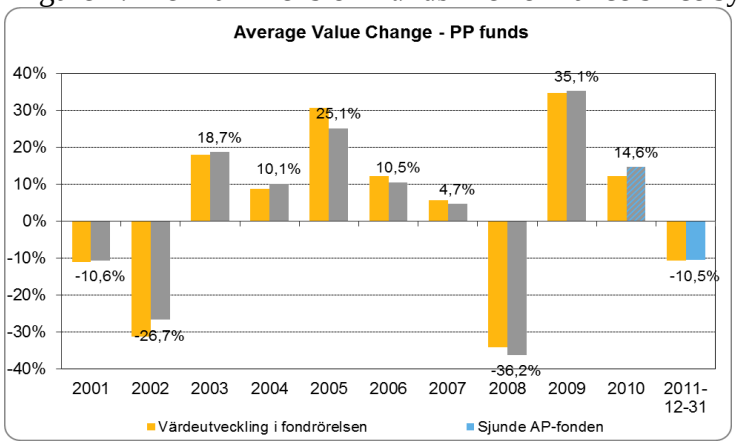
Payments for the premium pension can be shared between spouses or registered partners. Only pension entitlement earned in marriage or partnership can be transferred and this is currently done from year to year. However, in the event of transfer the amount transferred is reduced by 8% (changed from 14% from 1 December 2008). The reason for this reduction is that the transfer is mainly expected to take place from men to women since men have higher incomes than women, and since women live longer than men, the transfers would lead to a deficit for the PPM (Premiepensionsmyndigheten) system if the reduction was not made.

As of December 2011[9], premium pension assets amounted to 393 billion SEK, of which ca. 95% is placed in pension accounts belonging to working individuals and the rest to pensioners. Around 26% of the total premium pension assets were invested in the state managed fund option, APSafa.

2011 was again a bad performance year for the premium pension system, as the average premium pension fund value decreased by 10.5%, both for privately managed funds and the state option. Since its inception, the system has been subject to two major financial crises which have made returns rather volatile. Still, in 2011 94% of pension savers had an overall positive nominal return on their account (since beginning to save).

[9] Figured for 2011 are not yet released.

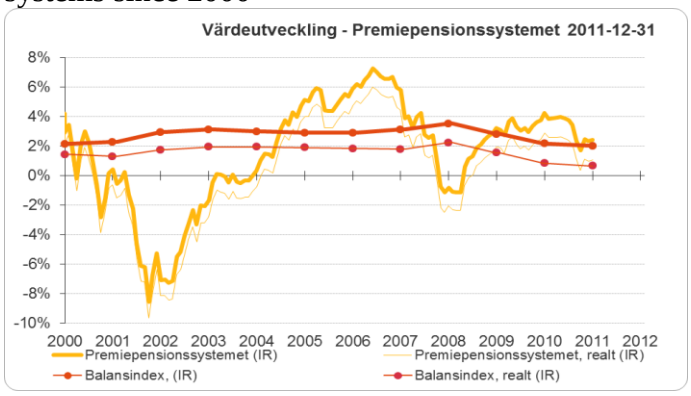
Figure 1: Premium Pension Funds' Performance since system started



Source: Swedish Pension Agency, http://www.pensionsmyndigheten.se/FondArsstatistik2011.html

A major question when assessing the performance of the premium pension is whether it can overall fulfil its original purpose to provide a way to spread risks for individuals between developments in labour and capital markets. One way to do this is to look at the so-called internal rate of return, i.e. the (capital weighted) rate of interest earned by an average premium pension account which was opened at the system's start, and compare it with the rate of return that the same savings would have earned if let to grow at the rate of income pensions (i.e. by income or balance indexing). Figure 2 below shows this.

Figure 2: Internal rate of return of the premium (yellow line) and income (orange line) pension systems since 2000



Source: Swedish Pension Agency, http://www.pensionsmyndigheten.se/FondArsstatistik2011.html

Given two major crises, we see that by 2011 the premium pension had earned a yearly net nominal return of roughly 2%, just marginally above that earned by the income pension system (1.7%). The graph however highlights how much the system's performance is subject to timing of entry and/or exit as well as the length of investment. Someone exiting the system in 2006 for instance would have had a radically different outcome from someone exiting in 2008. It is therefore important to point out that large cohort variations are embedded into such a system.

As reported by Pensionsmyndigheten (2011d), youngest cohorts are more likely to place the premium pension savings in the state run fund option compared to older ones. The state option (APSafa) invests in a generational fund that is quite skewed towards high-risk equity at the beginning of one's career, but progressively reduces risk by shifting towards fixed income products after age 55[10].

Occupational and Private Pensions

Occupational pensions are complementing the pensions from the social insurance system for most people in Sweden. More than 90% of employees are covered by occupational pensions decided on by collective agreements. The 10% who are not covered includes only very small firms, and the self-employed. One might argue that second pillar coverage is thus quasi-mandatory in Sweden.

There are four major systems for supplementary pensions: one for those employed in the state sector, one for those employed by municipalities and county councils, one for white-collar workers in the private sector and one for blue-collar workers in the private sector. All four systems have changed radically in the last fifteen years. They have changed from DB (Defined Benefit) plans to entirely or mainly DC (Defined Contribution) plans. The pension plans in the private sector are entirely DC-plans, but most white-collar workers in the private sector currently employed will get a pension according to an earlier DB plan (the transition period is very long). The pension plans for public sector employees are DC plans up to the income ceiling in the public pension system, and over that ceiling a combination of DB and DC plans (for those born before 1973) or purely DC (for those born after 1973).

All supplementary pension schemes have a flexible age for taking up the pension. The supplementary pension for state employees has 61 as the lowest age for take up and the other three 55 years. The lower the age when the pension is received, the lower the amount becomes. There is currently no upper limit for which the pension must be taken out. In all pension plans except that for the state sector a take-up of the pension before reaching the age of 65 is only allowed if the person intends to stop working. Overall all supplementary plans but that for state employees have therefore incentives to early retirement.

The supplementary pensions give especially high compensation to people with incomes higher than the ceiling in the social security old age pension system (7.5 Basic Amounts). The supplementary pension systems more or less eliminate the ceiling. In 2007, 36% of all employees had income parts over the ceiling. The supplementary pensions' part of all pension incomes for both men and women has been increasing in time. The Social Affairs Ministry has published a report on the incomes of the over 65 in 2011, and there it shows that on average, the over 66 received 15% of their income from an occupational pension and 4% from a private pension. In particular, 90% of either men or women between 66-70 years have an occupational pension income, and more women (47%) than men (42%) a private pension. Differences between men and women increase with age. 79% of the 85+ men and 65% of the women in the same age have an occupational pension, and only 9% of men and 4% of women a private one.

[10] This explaines why the state fund is chosen by 42% of all premium pension savers and yet it holds "only" 26% of the capital (as young people have lower salaries and consequently lower contributions). Conversely APSafa is chosed by only 32% of those who have already retired, who tend to prefer making an "active" portfolio choice.

Also, the share of occupational pension in a retiree's income increases among younger cohorts: from ca. 35% of those born in 1938 to ca. 40% for those born in 1940.

The agreement-based occupational pensions differ in various respects, but there are considerable similarities between the systems – mostly that they all tend to be defined contribution systems. However in the central and local government systems there are still defined benefit parts for those above the ceiling in the social insurance scheme who are older than 38. The DB parts are financed by actuarially fair fees paid by the employer.

The replacement rate is about the same level in all four supplementary pension schemes. Adding the social insurance pension, about two thirds of the income is replaced by the two pensions taken together if a person retires at the age of 65. Supplementary pensions are indexed by the consumer price index. It means that in periods with real wage growth the pensions will gradually constitute a lower share of the current wage level as the pensioner becomes older. The rights to a DC pension are not influenced by a change of employer or sector. There are however some complications regarding the DB parts when changing sector.

There are three different forms of personal pensions; traditional insurance, fund insurance and an individual pension saving in a bank (IPS). The traditional insurance gives a guaranteed yearly accrual but the pension may also be larger depending on the success of the insurance company's placement of the fees. In fund insurance the individual decides for him/herself as to which funds the fees should be placed in and there is no guarantee of a minimum growth of the assets.

A recent survey conducted by pension provider Alecta (2011) shows that most people have very bad information regarding the fees linked to their pension savings, and that management fees can vary by several hundred thousand Swedish krowns in the current pension management market. In some cases the fees can be so high that they "eat up" the entire inflow of new contributions, so that pension accounts do not grow as expected. Other important differences in the existing market refer to the life expectancy assumptions that different pension insurance companies use. More transparency and information to savers should be a priority to be pursued by the relevant financial regulation authorities.

2.2.2 Overview of Debates and political discourse

The overall debate over pensions in 2011 and early 2012 has more or less remained focused on the same issues already brought forward in 2010. Several events (seminars, lectures) were organised to discuss the state of pensions as part of the 100th year anniversary of the Swedish welfare state. One of the most prominent issues under scrutiny has been the adjustment of the system to increasing life expectancy and whether the pension age should be revised. However there has not been any explicit reference to a pension reform on the government agenda yet. Below we provide a list of the main issues.

Extending Working Life and the Pension Age. The Swedish pension system already accounts for changes in life expectancy by indexing the pension amount with a cohort-specific life expectancy ratio which is yearly updated. However, longer life expectancy in Sweden (SCB, 2010) will inevitably lead to a sizeable reduction in pension amounts for future cohorts if not supplemented by an increase in the time spent working. A rule of thumb for how much more one would need to work to avoid the effects of increased life expectancy on the replacement rate is two thirds of the (cohort-specific) life expectancy increase.

In Sweden there is no "legal" retirement age. However 65 represents still the "norm", since also the minimum pension can only be claimed from 65 and many other benefits stop being paid then. Increasing the effective retirement age past 65 is seen as a possible solution to maintain constant

replacement rates across generations. According to latest data from Pensionsmyndigheten (2011c) someone born in 1990 would need to work until ca. 68 and 8 months if they would want to retire with the same pension of someone born in 1930 (and retiring at 65).

Table 3. Increases in Retirement Age necessary to maintain constant pension

Cohort	**Life Expectancy at 65**	**Retirement Age to ensure same replacement rate**
1930	82 years 5 months	65
1945	84 years 4 months	65 years 9 months
1960	85 years 7 months	67 years 6 months
1975	86 years 6 months	68 years 3 months
1990	87 years 2 months	68 years 8 months

How to extend working life is becoming therefore a crucial policy issue. This concerns not only postponing exit but also anticipating entry. According to the Social Insurance Agency, the average entry age into the labour market has increased since 1985, from 19 to 21 years old today. However, the debate tends to focus mostly on increasing the retirement age so i.e. to delay exit. Older people (55-64) in Sweden have already one of the highest participation rates in Europe (70%), with one of the highest labour exit ages (63.1 on average in 2010), partly thanks to a number of reforms enacted since 1997 which have created good incentives to work longer (e.g. increasing the legal age for work guarantee to 67, introducing part-time retirement etc.). Yet, despite that the pension age is flexible and upwards adjustments to the pension benefit exist for those postponing retiring after 65, the average age for taking out the state old age pension today is still 64.7 years, showing no real change since 1998 (Pensionsmyndigheten, 2011c)[11]. All in all nearly 90% of those who are 65 today have already retired (Pensionsmyndigheten, 2011d). Retiring before 65 can mean a loss as big as 30% on the full life-long pension compared to waiting till 65[12].

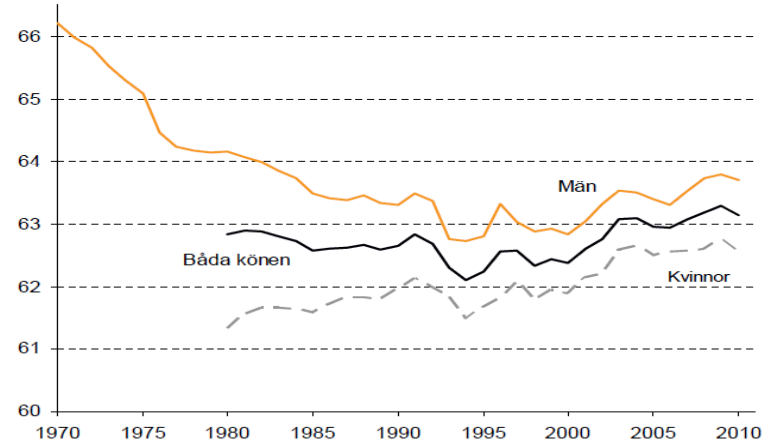
Figure 3 below shows the historical decrease in the effective average retirement age in Sweden, which is however witnessing an increasing trend again since 1998 ca. (first graph), as well as a breakdown of recipients of state pension by age for pensioners from different birth cohorts (second graph). Interestingly we see that among younger cohorts the shares of those claiming state pension early (61) is increasing, but also the share of those claiming it after 65. The key question is of course how future cohorts will behave. Generally it is shown that those who have higher education (university degree or even research specialisation) tend to retire later (65 or above). With a possible further increase of the general education level it is possible that among future cohorts the share of those retiring after 65 might increase further.

[11] There is no significant difference in the average age of receipt of a state pension between men and women. The fact that there is a lower effective retirement age (63) than the age of receipt of state pension (64) may depend on the fact that many exit the labour force with occupational pensions and wait to claim the state pension.

[12] Retiring at 61 would result in a pension which is 71% of the pension receivable if waiting till 65. At the same time postponing to 67 would mean an increase of 119% from the pension at 65.

Figure 3 - Effective Average Retirement Age, by sex (first graph) and proportion of pensioners taking out old age pension by age and birth cohort (second graph).

Diagram 1. Genomsnittlig förväntad ålder vid utträdet från arbetslivet för personer som vid 50 års ålder finns i arbetskraften (förväntad utträdesålder)



Källa: Bearbetningar av data från SCB:s arbetskraftsundersökningar (AKU).

Andel* som nybeviljats allmän pension i åldrarna 61 – 70 år, procent

Års-kull	Uttagsålder, år 61	62	63	64	65	66	67	68	69	70
1938	3,7	2,3	2,3	2,1	77,6	4,2	3,2	0,8	0,3	0,3
1939	3,9	1,9	2,1	2,4	75,8	6,5	2,3	0,8	0,3	0,3
1940	3,0	2,1	2,5	3,1	75,9	5,0	2,6	0,8	0,4	0,5
1941	2,9	2,2	3,0	3,7	73,3	6,3	2,8	0,8	0,5	
1942	3,4	2,9	3,4	3,9	71,0	6,2	3,4	1,2		
1943	4,0	3,1	3,6	5,3	66,7	7,1	4,4			
1944	4,7	3,4	4,8	6,0	63,7	7,9				
1945	5,2	4,3	5,3	6,2	62,6					
1946	6,1	4,8	5,5	6,8						
1947	6,4	4,7	6,0							
1948	6,0	4,9								
1949	5,8									

*Andelarna avser nya pensionärer i relation till möjliga pensionärer i december 2010. Åldrarna avser åldern 31 december aktuellt år som pensionären tog ut sin inkomstpension/garantipension

Source: Pensionsmyndigheten 2011d

In February 2011 the Social Minister announced that the Pension Group (a technical working group on pensions representing all major parties) would lead a new enquiry on the appropriateness to revise the pensionable age(s). Over 2011, the so called Pension Age Group has been discussing with all relevant social partners e.g. academics, civil servants, trade union representatives etc., with the aim to provide an updated picture of how the labour market for older groups works, how elderly people preferences for retirement are shaped etc., and to eventually release a completed report, including recommendations for possible policy options (e.g. raising the age beyond which employment security of older workers is protected (from 67 to 69), or the age for claiming a guarantee pension (65)).

Short of the final publication of the enquiry (results will be available in March 2012), a useful blog and website has been published with interesting updates and links on the pension age debate (www.pensionsalderutredning.se). Furthermore, several of the involved working parties have published independent reports during the year with interesting contributions on the subject.

A report published by the Swedish Pension Agency in 2011 called "Pension Age" (Pensionsåldern report, 2011d) describes recent trends in working and retirement patterns among

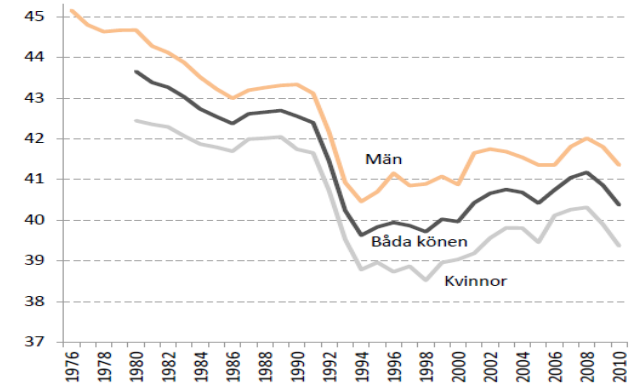
Swedish elderly and critically assess various proposals that have been put forward as part of the ongoing debate. The report for instance highlights some of the problems with raising the minimum pension age from 65 to 66 or 67. This would mostly affect low-income earners for whom the marginal benefit of working an extra year remains low (since any increase in income pension rights would be most likely be offset totally or partially by decreases in the guarantee pension), while possible repercussions on other benefit recipients (i.e. disability and sickness) need to be also factored in the costs. In fact these benefits grant certain pension rights up until age 65, after which most beneficiaries are switched to an old age or guarantee pension. The report calculates that postponing the age for claiming guarantee pension would mean paying such benefits (incl. extra pension rights) for an additional year(s) and the total costs for the state would overtake the benefits for several million crowns (see page 39 in the report). The report introduces possible solutions such as revise the lowest age for drawing the old age pension (currently 61). This could be raised in line also with rises in longevity. The problem here is rather how to integrate public pension incentives to work longer with the design of occupational pension incentives, which often work in the opposite direction, especially for the better off.

At this regard, a new paper by Hallberg (2011) shows the effects of non-wage costs (employment taxes and collective fees paid by the employer for each employee) on voluntary early retirement. Older workers cost more in terms of collective fees in Sweden (especially via premia to occupational pensions established by collective agreements) and therefore early retirement becomes a common agreed solution between employee and employer. The paper estimates that an increase of 1% in collective fees can raise retirement probability by 6%, showing that this is a crucial aspect to be reconsidered by policy as part of the debate.

As mentioned earlier the longevity issue could also be tackled not only by looking at ways to postpone retirement but rather by ways to increase the total length of working life. Another recent report by The Swedish Pension Agency (Average Pension Age and Exit Age, 2011e) illustrates the evolution in the total length of working life in Sweden, focusing also on the changes affecting the entry into working life due to increases in education participation, longer studying time and other life choices of younger people (e.g. mixing work with studies) which could explain the shortening of total working life. While we see that the average entry age into the labour market has increased over time yet only modestly (around 21-22 currently), the age of "establishment" into the labour market – i.e. the age at which at least 75% has employment - has increased much more, being 27 years in 2009. This is of course a measure that is subject to variations with the economic cycle. The total average length in working life in 2010 was 40,3 years (for men ca. one year longer and for women one year less). Seen in a historical perspective this is much lower than in 1980, when it was 43.7 years. Indeed a strong decline happened in 2010 due to a simultaneous increase in entry and decrease in exit age.

Figure 4- Length of working life for men and women from 1976 - 2010

Arbetslivets längd för kvinnor och män
År per förvärvsaktiv



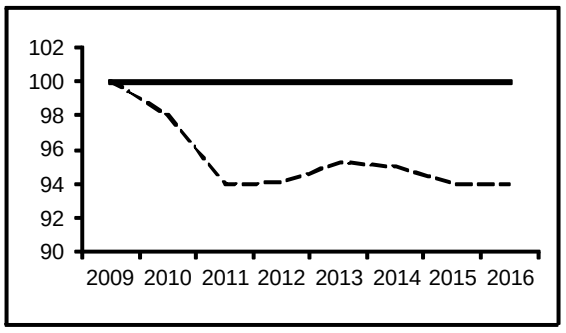
Källa: Bearbetningar av SCB:s arbetskraftsundersökningar (AKU). Arbetslivets längd är skillnaden mellan ovan redovisade utträdes- och debutåldrar, den senare beräknad för minst 20 tim/vecka och exkl. feriemånader.

This trend of a shorter average working life is of course worrisome if coupled with expected increases in life expectancy, in terms of e.g. resulting reductions in the replacement rate. It is important that the debate focuses therefore on the entire life cycle and not only on labour exit.

Indexation and Minimum Guarantees. In 2011, income pensions continued to be indexed by a negative growth (-4.3%) due to the continuing application of the "balancing" rule (with a two years lag)[13]. In 2012, thanks to positive developments in income growth, the balancing remains on but the indexation coefficient has turned positive (+3.5%). Prognosis done by the Swedish Pension Agency in January 2012 foresee balancing to remain on until 2016, which implies that growth in pensions will be much lower than growth in incomes and much lower than it is today, although still positive (3,1% in 2013, 0,8% in 2014, 1,6% in 2015 and 1,7% in 2016). Balancing is currently on an upward swing (i.e. catching up towards the value of the Income Index) but from 2014 it is forecasted to go downwards again, as the balance ratio returns below 1.

Balancing indexation implies that over time a wedge between pensions and wages will develop. For instance, a salary worth 13,000 SEK in 2009 would now be worth ca. 14,000, while a pension worth the same then would now roughly be worth 12,500 SEK. Even if / when balancing should be turned off, and normal indexation would resume, pensions and pension savings would start growing from a lower level than what it would have been otherwise. This loss is somehow fixable by people in working age, who can adjust their labour supply, while for pensioners, it will always imply a loss.

Figure 5 - Effect of the Balancing, average income pension as % of what it would have been without balancing



[13] The balance index applied in 2011 was calculated on assets and liabilities from 2009.

Source: K.J. Sherman, presentation 2011-11-11 "A pension system without contact with reality"

Some politicians as well as representatives of pensioners' organisations have deplored this development. Pension indexation remains therefore a "hot" policy question in 2011. Furthermore, besides balance indexing, there is also some questioning of the so-called indexation "norm", by which upon retirement, the income pension is yearly increased by wage growth minus 1.6%. This means that effectively in periods of low growth (below 1.6%) pensions are going to be reduced even when income growth is positive (and balancing is off). The rationale for setting the norm was to anticipate, at the time of retirement, a future interest on the remaining pension capital (while a pension is being disbursed), which should be discounted when indexing the yearly pension amount. In other words the value of the income pension in the system is guaranteed only for growth above the norm.

When assessing the yearly negative changes in the average income pension in 2010 and 2011, one should understand that they are the combination of both the norm, low income developments and of balancing indexation (all together known as "*följsamhetsindexering*" in Swedish). Together, they resulted in a –3% reduction in 2010 and a –4.3% reduction in 2011, bringing the total fall of income pension since 2009 to ca. 7.2%. Due to *följsamhetsindexering* the growth of pensions since 2009 thus has become less than what it would have been if they had been only indexed to prices. Furthermore, when looking further in the past, due to the crisis and its effects on indexation in 2010/2011, the total yield for pensioners since *följsamhetsindexering* was introduced has been lower (ca. 16% since 2001) compared to what it would have been under the old ATP system, which was price-indexed (ca. 19.2%).

A recent report by the Social Ministry (2011) points out how in a longer term perspective the effects of balancing get diluted, and that overall it is rather the wage development which is the crucial determinant for how pensions evolve. So long as wages grow well above prices, as it happened between 2002-2009, pensioners gain in real terms and their cumulative gain is greater than the loss incurred over a couple of bad years (the report estimates a net gain of ca. 32,000 SEK compared to what they would have had under-price indexation, see page 23). What is crucial to this argument is how long someone has been retired. Those who have retired at the beginning of the new system would have gained more than those retiring closer or in 2010, when balancing was activated. Once again this exposes differences in outcomes for different cohorts. As for the future, according to official forecasts the income pension will not reach back its 2009 levels until 2014, while over the same period incomes are expected to grow by roughly 5%. It is estimated that price indexation of the income pension from now till 2014 would in fact have resulted in less of a difference with wages than balance indexation (Pensioners Organisations Report, 2011).

The effects of *följsamhetsindexering* are important to determine the degree of inter-generational equity in the system, in relation to the growth of average incomes for working age groups.

Table 4. Growth in the average monthly wage and pension, 2001 - 2011

	2001	2011
Wages	21,300 SEK	29,400 SEK
Income Pension	9,400 SEK	10,600 SEK
Guarantee Pension (Max)	7,000 SEK	7,800 SEK

Source: PRO/RPG/SKPF/SPF/SPRF Report 2011

The table above shows that since the system started, the nominal value of the average monthly wage before tax has grown by 38%, while the average income pension has grown only by 13% over the same period. In 2001, the average income pension (before tax) was 46% of an average salary while by 2011 it is ca. 36%. At the same time, there has been no sizeable upward

adjustment of the guarantee pension (the non-contributory minimum), which is price-indexed, even after tax (in 2010, price growth was negative, resulting in negative indexation of –0.9%). Overall, these trends show that inequality between working age and retirees is therefore growing (before tax).

As mentioned in the overall introduction, the government has commissioned a study on indexation rules to the Swedish Pensions Agency, due in March 2012. This study should highlight the impact that current rules for indexation have on the system's finances and on different income groups. The study might make recommendations for possible changes to future indexation.

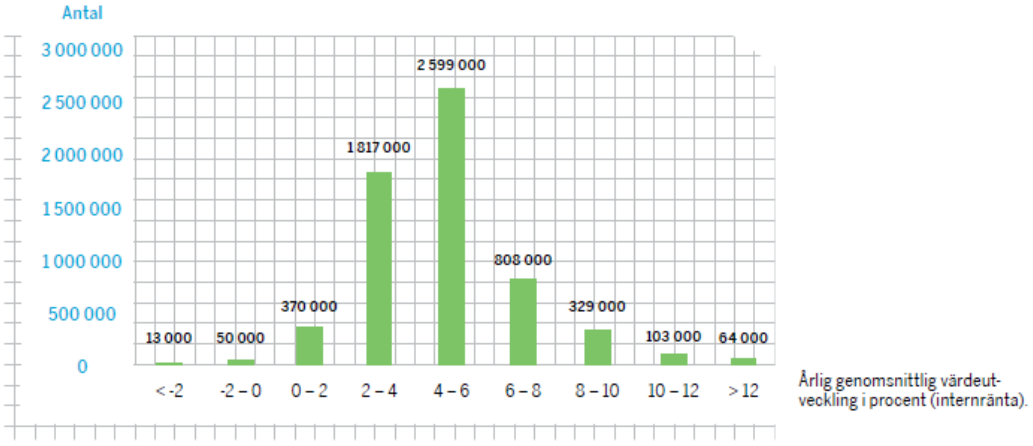
The role of Funded Pensions. Individuals and households in Sweden are today increasingly responsible for their pension outcome and fully bear the risks associated with their financial choice. The pension system has a (albeit small) mandatory funded component in the first pillar (premium pension), as well as a strong reliance on second and third pillar funded pensions. The individual, regardless of his financial literacy or education level, is therefore responsible for choosing how to allocate his capital in all the pillars. In sum, the Swedish system exposes the individual to quite a high degree of financial risks.

Several debates have been opened in 2011 on e.g. the equity and reliability of the funded component in the public system, the role of the state option, the informational challenge and the complexity hidden behind the individual choice of funds (currently ca. 800 listed in the premium pension funds market alone, to which one must add the choice of funds for the occupational pension), not to mention the role that (hidden) fees play in the final pension outcome. The overarching issue is therefore whether certain new regulatory measures should be introduced in the pension industry to reduce individual risks and protect people against unexpected turns so as to maintain a minimum level of income guarantees for their retirement.

Below, we review some of the sub-issues that pertain to this area of debate.

Equity. The 2008 financial crisis clearly revealed the vulnerability of the system to large shocks in financial markets, as differences between individual pension outcomes became more evident. Today, sizeable differences still exist between otherwise similar individuals depending on their financial choices and behaviours. The figure below shows the distribution of returns in the funded part of the public pension (premium pensions) in 2011, for all (regardless of time spent in the system).

Figure 6 - Distribution of Rate of Return in Premium Pension System, 2011

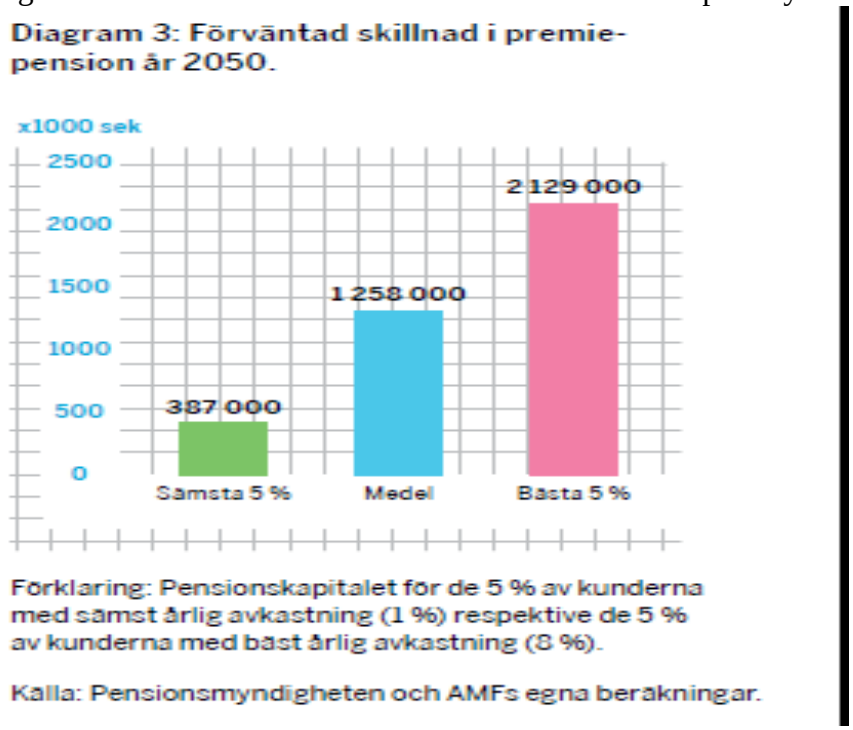


Källa: Pensionsmyndighetens hemsida, 2011.

It is of course expected that length of time spent in the system will be a source of variation. However, even individuals with the same entry year into the system have similar differences in return, regardless of the year of entry. On average it is estimated that the difference in returns between the fifth and the 95th percentile is 7.8%. It is uncertain how these differences will evolve over time. Now the system is still rather new (2000) and it is possible that with time some of the difference might smoothen out. However, differences in pension capital will possibly also grow in time as more people join the premium pension system and more and more capital is injected into the system.

The private pension insurer AMF (2011) in its latest pension report estimates for instance that by 2050 the difference in premium pension capital accumulated by the worst and the best performing 5% of all individuals will be nearly 2 million SEK.

Figure 7 - Estimated difference in Premium Pension Capital by 2050



Source: AMF(2011)

Within second and third pillar funded pensions there exist the same spread in returns but since there are many different providers it is more difficult to collect a global picture. Cumulatively these differences in investment returns across all pillars might lead to very large differences between individuals' pension outcomes, despite similar working life. This is likely to lead to further questioning of the system in the future.

Income Security. The recent European debt crisis is negatively affecting all kinds of funded pensions. As interest rates have been low and the value of equities has fallen, it becomes increasingly difficult to finance a pension promise over an ever-growing number of years (as life expectancy increases). At the same time, fewer and fewer pension insurance companies are offering so-called "traditional insurance" products, i.e. products with a guaranteed return, in favour of higher-risk funds products instead (AMF, 2011). This essentially means that uncertainty increases for pension savers.

As far as the public premium pension is concerned, some are questioning whether this mandatory part of the system, initially meant to spread risks away from labour markets performance, should be there in the first place. History shows us that between 1918-1999 the global and the Stockholm stock markets have outperformed the growth rate of average labour incomes (7,3% versus 2,5%), however since 1999 real income growth has been higher (1.8%) than that achieved by financial assets.

While it is often argued that an assessment of the performance of the funded component would require a longer time frame (the system exists only since 2000), it is also true that it has already been exposed to two major financial crisis since its inception, and the likelihood that these events will repeat themselves with greater frequency in the future is not to be underestimated.

System Complexity and Activity. In 2011, the complexity of the system as a whole has become a subject for debate, especially in the media. The system's over complexity can be reflected in a low degree of individual activity and active choice made by premium pension savers as well as by the surge in the reliance on advisory services which place premium pension contributions on behalf of the individual at very high fees.

Available statistics from 2011 (PensionsMyndigheten 2011a) show for instance that nearly 98% of new savers into the premium pension have chosen the state option in 2010. New savers tend to be young people who are new to the labour market; they therefore appear to be less inclined to make an active fund choice. Similarly, the latest pension report from AMF (2011) shows a decline in the willingness to make active choices among their clients despite the increase in financial risks faced by individuals. 49% of the clients to their occupational pensions for instance do not make any active choice of fund since the first one made upon entry.

In the last ANR we already discussed the issue of portfolio choice inertia present in the premium pension system. More than half of pension savers have made an active choice i.e. at any one point they have chosen up to 5 among 800 different funds at highly discounted rates (changing is free). Preliminary studies (Dahlqvist and Martinez, 2011) as well as data from Pensionsmyndigheten reports (Premium Pension Pensionssparande Rapport 2010, Table 6) are showing that the system is suffering from large inertia i.e. few people actually follow up their change after the first time, leading to relatively bad results as money keeps flowing into often badly performing, yet possibly expensive performing funds.

Table 5: Premium Pension Investor Activity, 2010

N. Changes since entering PM	% Net Rate of Return	% of Savers
0 (Default Option)	5,2%	42.1%
0 (First choice only)	4,1%	22.4%
1	4,5%	23.6%
2	4,5%	5.7%
3	4,8%	2.9%
6 to 9	7,1%	0.9%
10+	8,1%	0.1%

Source: Premium Pension Pensionssparande och Pensionärerna 2010

Those who have never made a choice (42% of savers, owning 26% of all premium pension invested capital) go into the so-called "default option", a state managed fund (so called AP7 fund) at a very competitive fee (0.16% a year). Historically, the default option has actually been highly competitive, producing by 2009 an internal rate of return of 5.2%/, higher than the return obtained by those who have made a moderate number of changes. Yet this might turn out considerably lower when data for 2011 is included.

Informational Challenge. According to the above-mentioned AMF report, Finansinspektionen in 2011 has carried out a survey to measure the level of financial literacy in the population and to assess how comfortable people are with making financial choices. The survey shows that only 21% of respondents answered correctly all three questions on interest rate, inflation and risk. More generally, such unpreparedness to deal with financial choices might have been underestimated, and might explain the dramatic rise in expensive financial advisory services in the premium pension (see next section as well as ANR from last year).

A great improvement in 2011 has been the introduction of the site www.minpension.se, a private public partnership whose aim is to collect at an individual level updated information about all of the person's pension accounts in one place, so that the individual can get a complete picture of what his or her retirement income is going to look like at retirement (from all pillars)[14]. Here a simulation tool is also available for people to "play" with different scenarios, for instance how alternative real return paths will affect their pension savings, alternative retirement ages etc. This tool is expected to play a very important role in allowing people to better plan their working and saving decisions. There are also discussions between all the financial actors involved in the administration of pension savings to develop a joint model for future pension forecasts. Today MinPension has ca. 1.4 million registered users and covers information on ca. 95% of all pension capital (ca. 85% of all occupational pension plans, and 56% of all private plans). Currently the website is accessible also from the major pension insurance companies' web accounts and it will be soon accessible as an Internet Banking service from the major banks.

A pending issue that has received much media attention in 2011 is the lack of transparency around fund fees and their long-term meaning (especially when summed up across all pillars). In the premium pension market fees are subsidised by the state but in the occupational and private markets it is common for fees to be above 1%. Yearly in the long run this can have a real impact on the size of the pot. ALECTA, a pension provider, claims in its report (Adolphson 2011) that fees can make a substantial difference in the final pension capital outcome, sometimes eating up the entire gains from market returns (hence resulting in no growth).

Regulatory Measures. The most important measure taken in 2011 has been to put a stop to so called "Mass Fund Changes" operated by so called advisory services**.** In the last ANR for Sweden (2010-11) we already discussed the problem of mass fund changes in the Premium Pension**.** These "advisors" (both independent actors as well as established banks and pension insurance companies) had begun operating in a regulatory vacuum, often charging between 500 and 1400 SEK a year (regardless of fund performance) for getting access to individual account details which they would use to make random portfolio changes (i.e. not tailored to individual characteristics such as age or risk preference) simultaneously for a large number of clients. An estimated 60% of all active fund changes in 2010 were made by such actors, on behalf of ca. 700,000 pension savers (10%). Only in January 2011 the pension agency had recorded 3.5

[14] Within the public pillar, every individual already receives a yearly letter, known as the „Orange Envelop" with information about the pension insurance contributions and returns accumulated during the year and in total, as well as a forecast of the expected pension amount receivable at alternative pension ages.

million orders for fund changes. These unforeseen attacks have generated enormous strain on the administration of the system and have raised transaction costs. Fund companies could not cope with such large volumes of transactions (i.e. fund shares to be sold and bought) and some of them as a result have pulled out of the system all together; others were forced to increase their fees to meet increases in administration costs. In December 2010 the government gave the Swedish Pension Agency the remit to investigate and propose solutions. In March 2011 the Agency produced a report essentially proposing two types of solution, one soft i.e. to introduce the possibility for funds to request payment of a fee vis a vis mass fund changes, so as to sharing costs generated by these services between those who use them and one hard i.e. to outlaw these services altogether unless they operate within the "*fondtorget*" (the premium pension investment platform) as registered fund companies which trade in their own funds or in funds of funds. Based on this report in April 2011 the Government opted for the hard option and outlawed these services in their current shape. Since then we have witnessed a large number of fund changes/selling off as these firms are re-orienting their customers' portfolios towards their own funds-of-funds. From December 1, 2011 the Swedish Pension Agency has furthermore introduced a new IT measure to hopefully stop robot-generated mass fund changes, i.e. a password capture solution which involves typing a code appearing on the screen in order to access the premium pension account. Each premium fund change executed on-line will therefore require manual access, thus preventing access through computer-generated algorithms used by advisory services. First statistics show a small decrease in mass fund changes since this measure was introduced.

2.2.3 Impact of EU social policies on the national level

Generally, the OMC has not generated particular policy responses at the national level in the field of pensions, since the Swedish pension system reflects already quite closely the generally agreed principles of sustainability and adequacy highlighted e.g. in the Green Paper on Pensions , being often used as a reference or a "model" by other member states. The system is also considered transparent and credible in light of its automatic stabilisation features, which entail less risk for *ad hoc* policy measures.

Pensions are consequently not an area of intervention in the national strategy for meeting EU2020 targets. Labour market policy rather is. The Swedish NRP puts in fact great emphasis on the goal to reduce poverty and social exclusion through greater labour market participation, particularly for youth and non-EU immigrants. The social inclusion target makes no explicit reference to the elderly (over 64), and does not go into depth on the question of how to realistically increase labour market participation for older workers, in particular women, who currently have a risk of poverty in old age well above EU average (ca. 30%).

Related to pension adequacy is however the strong government commitment to promote longer working lives. Fiscal policies have been implemented to reward work in general (in-work tax credits, as well as raising the threshold for state tax eligibility, only paid by the better off). The flexible pension age in particular is a feature of the pension system which, since its introduction, has proven to contribute somewhat to the rise of the effective retirement age for older workers. At the same time there have been no explicit interventions on the front of disincentives early exit through occupational pension schemes.

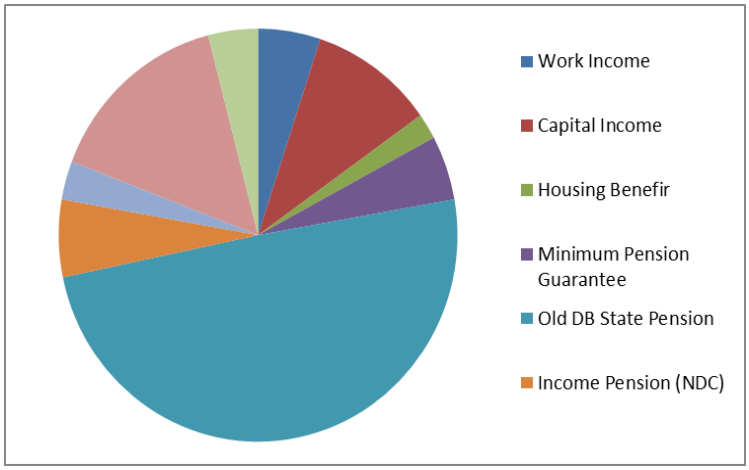
The Country Specific Recommendations Issued by the Commission have not directly addressed nor impacted the pension agenda. The government still intends to implement the planned tax cuts for the over 65.

2.2.4 Impact assessment

This section aims to provide an update to the previous report, which had already extensively reviewed the impact of the current Swedish pension system, particularly in terms of pension levels and replacement rate offered to its current (and projected) retirees. Other adequacy indicators will also be presented here, measuring the impact of the system on gender inequality and on poverty.

To begin with, it might be useful to provide a general description of how Swedish pensioners' incomes look like today, and the role that pensions play in the total. The figure below shows a breakdown of income sources according to a recent report by the Social Ministry (65 – Not Just Pension, page. 33).

Figure 8 - Different sources of Incomes for 66+



Overall, the public pension (still including a mixed of old DB and new NDC benefits for current retirees, as well as guarantee pension) amounts to ca. 70% of the total average income of a Swedish retiree, while 15% comes from occupational pensions and the rest from other incomes. Women have on average 69% of a retired male income, and a much higher proportion of income coming from the minimum guarantee pension and the means-tested housing benefit for pensioners (12% as opposed to 2%). Men instead tend to have a higher proportion of income-related pensions (both public and occupational), as well as a higher share of earned income even past the age of 66.

Indeed, the share of elderly with labour income has grown considerably since 1997, as a result of the pension reform, from 19% to 36% in 2009 (41% if including self-employed). Usually labour income complements some partial take-out of pension, which is possible in Sweden (a pension can be claimed in full or in shares of 25%, 50% or 75%). Overall, given the relatively high and increasing share of over 66 who combine work with retirement, we can therefore conclude that the new Swedish pension system might have contributed positively to promote active ageing.

Moving on to measuring current and projected adequacy of the system the most updated sources come from EUROSTAT[15] (relative poverty or material deprivation) and OECD[16] (replacement

[15] http://epp.eurostat.ec.europa.eu/portal/page/portal/income_social_inclusion_living_conditions/data/database

rates). The Indicators Sub-Group (ISG) provides also projections for future adequacy (theoretical replacement rates) for member countries (forthcoming).

The risk of relative poverty for the 65+ in Sweden is at first sight quite in line with the European average (15.5% against 15.9%). However, we see a significant rise in poverty rates among those 75+, well above the EU average (23.5% against 18%), and a more marked difference between genders (7.8% for men against 21.6% for women, while in the EU27 it is 12.9% for men and 18% for women). A closer look shows that relative poverty in Sweden is thus concentrated among women, even more than in other European countries, despite Sweden' s historically high female labour market participation rates. Furthermore, this gender difference grows with age: 31.5% of Swedish women above 75 are regarded as poor, well above a European average of 20%. On the contrary elderly men (both 65+ and 75+) have poverty rates actually below EU27 averages. [17]

Relative poverty outcomes in Sweden are consistent with how the median income of the over 65 relative to those 0-64 group looks (79%), with elderly women in particular having a rather lower relative median income than other European women (73% of the 0-64 incomes, instead of 86% as in the rest of the EU27). One way to understand this is to look at how closely public pension benefits replace and follow wages in Sweden. Income pensions (as well as the old DB "Tilläggspension", still received in parts or in full from older cohorts) are only partially indexed to wage developments due to "norm"indexation, which covers only income growth above 1.6%. This means that pension incomes will always grow more slowly than labour incomes. At the same time, those who receive a guarantee pension (63% of retired women against only 15% of men) have only price indexation. Altogether this can explain why many public pension incomes, especially those of single women, are subject to falling behind over time relative to working households and why there is a wedge between the two medians. Furthermore, relatively fewer women would be able to rely on an occupational pension to compensate for this gap.

When we look at indicators of material deprivation however, we see an opposite trend, whereby deprivation remains much lower than European levels (around 8%) and actually slightly improves with age (0.2% for the over 75 against 0.7% for the 65+); furthermore women do better than men when it comes to material deprivation. Such low levels of material deprivation might be explained by the fact that Sweden has a need-based economic safety net for the elderly (*Äldreförsörjningsstöd*) that can be claimed on top of a pension and housing allowance, should they not be sufficient to cover costs for essential needs.

The adequacy of the system can also be measured in terms of how much continuity it can guarantee relative to previous economic standards. Replacement rates are meant to assess this degree of continuity, although different calculation methodologies exist in the literature (e.g. in terms of which income profile is assumed, or how many years of earnings are included), which can lead to rather different results. The OECD calculates the Swedish replacement rate (from both public and occupational pensions) for instance as the pension of a "representative" individual at age 65 (born 1988) relative to the salary earned at age 64, before tax and other benefits are applied. The result is 54%. The Swedish Pension Agency has released an official response to the OECD figure[18], showing a slightly higher value (62.5%), correcting the OECD

[16] Pensions at a Glance, 2011

[17] When looking at the EU2020 poverty and social exclusion indicators for Sweden, we see no significant difference from the monetary risk-of-poverty indicators.

[18] Pensionsmyndigheten, Comments to OECD's evaluation of future replacement rates in Sweden.

calculation[19]. When looking at how the replacement rate varies with additional work, the OECD[20] estimates an increase of 5-6% in pension for an additional year in work. The same calculations done by the Swedish Pension Agency show that an average pension would grow by 8.3%, or by 5.8% in relation to last salary[21]. Overall, the replacement rate would increase from 62.5% (if retiring at 65) to 75.5% if the same person was retiring at 68 years and 3 months instead (incl. occupational pension). The increase in replacement rate can be attributed to extra pension rights earned (at least in the public pension part), lower annuity coefficients used to convert capital when retiring at an older age, additional survival bonuses, and longer period of pension capital growth.

Another interesting measure to assess future pension adequacy comes from the projections made by ISG on the so called Theoretical Replacement Rate (TRR). These TRR allow to assess the change in replacement rates over time (i.e. compare the replacement ratio of someone retiring today with that of someone retiring in 2050), as well as showing the sensitivity of the measure to different sets of alternative assumptions, e.g. the effect of periods of unemployment or parental leave on the final outcome, different income profiles etc.

Due to increases in longevity, TRR for future Swedish retirees who will have worked 40 years at average earnings show, expectedly, a reduction of ca. -7.3% net and -9% gross between 2010 (net TRR 60.3%, gross TRR 63.4%) and 2050 (net TRR 53%, gross TRR 54.6%). This is a slightly lower drop in TRR than what was forecasted in the last EPC-IPC Joint Report.

Low income earners with 40 years contributions however will witness in time a much more dramatic drop in both net and gross TRR compared to their current TRR (82.9% net TRR and 72.4% gross TRR in 2010), amounting to -29.7% net TRR and -17.8% gross TRR by 2050. This drop will effectively bring the TRR of low income workers to roughly the same level as average and high income workers, instead of being much higher as it is today, indicating that the new system is less redistributive.

At the same time working longer (42 years) will raise the net TRR more by 2050 than it does today, especially for low income earners: 2 years of extra work will in fact rise it by nearly 10% for these workers, while in 2010 it would only rise it by 3.8%. In other words working longer will pay off most for this group in the future, in terms of adequacy gains. At the same time the gain in (net) TRR from working 2 years longer for high income workers will remain what it is today, i.e. ca. 8%.

Working less (38 years) instead shows an average reduction in net TRR by 2050 of ca. 5% , which is roughly the same "price" that both middle and high income workers have to pay for working two years less today. However, for low income workers working two years less will cost much less in terms of TRR loss compared to what it does today (-25% in 2010). Overall, it appears difficult to generalise on the system' s future adequacy, since it is subject to large variations depending on which income group one looks at; moreover this makes the total effects of TRR changes on elderly labour supply and future retirement choice difficult to predict.

All absences from the labour market will "cost" more in terms of TRR than they do today. Three years of unemployment will reduce the TRR by ca. 9% more in 2050 than they would in 2010,

[19] Among the criticism there is that of not having included the right pension indexation coefficient in the calculation

[20] E. Whitehouse, OECD Social, Employemtn and Migration Working Papers n. 109 (2010), table A1

[21] This difference is also explained by the fact that OECD disregarded the gain of new pension rights past age 65 in its calculation, which is however the case in Sweden.

while three years of maternity leave will reduce it by ca. 7.8% more. Longer absences from the labour market e.g. 10 years will lower the TRR in 2050 by 16.7%. All in all, these decreases are much more substantial than in other comparable EU member states (e.g. NL, FI, DK, DE).

2.2.5 Critical assessment of reforms, discussions and research carried out

The Swedish pension system continues to be regarded as an international "model" for its ability to combine rather well several objectives: sustainability, adequacy, transparency, credibility. The recent financial crisis however (2008) and its (at least temporary) effects on pensions have created a natural opportunity to re-assess the system's ability to live up to its expectations.

The mandatory funded part of the system (premium pension), albeit still small, has received criticisms on the basis of the emerging inequality in rates of returns between people with otherwise similar incomes. This inequality can be partly explained as the result of a system which is complex and requires one to be rather active in order to make the most; this might be effectively discriminating against those e.g. who are less financially literate and not as active. As a matter of principle, it is questionable whether this should be the case in a public system (even if the state default alternative should somehow provide to partially correct this bias). So far, the argument of using the funded component as a way to differentiate risks between capital and labour market developments has proven also weak: rate of returns since the system inception have been rather similar (i.e. the funded part has not really outperformed the unfunded). One possible policy development in the future could therefore be to abolish the premium pension system altogether and transfer the mandatory 2.5% contribution currently destined to it to the income pension instead. This way, by raising the contribution flow into the PAYG part of the system[22], the balance sheet of the income pension system would also get more consolidated, making it less vulnerable to future striking of the automatic balance mechanism, and stronger vis-à-vis future demographic changes.

This leads to another weakness highlighted by the recent crisis, namely the indirect exposure of the unfunded NDC part to financial markets, through the so called buffer funds (which in 2008 lost ca. 25% of their value). The buffer funds are the system' "reserves", which collect any contribution surplus after paying current pensioners' pensions and invest it mostly in equity (so called AP-fonder). When a crisis strikes, individuals now risk losing on both the premium pension (through negative returns) and on the income pension (through more likely on-setting of balance indexation). A possible policy proposal could be to remove these funds from the calculation of the balance ratio, whereas today they are normally counted as assets of the system.

Another reflection concerns the low adequacy of the system in terms of current poverty rates. The levels of relative poverty among Swedish elderly, particularly women, is very high compared to the EU average. Of course, this will partly fix itself as in the future women retirees will have worked more than current ones. However, it is also important to acknowledge and recognise those features of the system which might be contributing to such an outcome. The design of annuitisation and indexation factors reflects first and foremost the ambition of the Swedish system to be financially sustainable. The amount of pension paid out during retirement is in fact decided on the basis of remaining life expectancy (expected) at retirement and an imputed annual interest rate of 1.6%. Consequently this amount is updated annually with a growth factor which reflects income developments minus 1.6% (the "norm"). This method essentially amounts to "frontloading" the pension annuity, i.e. crediting a 1.6% interest rate to the person upon retirement (when future growth is not yet known) and then withdrawing it in

[22] The NDC part, which would therefore receive 18.5% instead of just 16% contributions as it does now

subsequent years. In case of low growth, this might effectively entail a declining pension income profile, which might, among other things, entail a higher risk of relative poverty in older ages. Furthermore this problem might be exacerbated every time that balance indexation is activated (further reducing pensions growth relative to incomes). Future developments of the system might want to reconsider lowering the norm, especially if periods of low economic growth are expected. Another solution might entail linking the norm to the economic cycle, or in any case making it subject to regular revision.

Another aspect which might lie behind the growing inadequacy of pensions with age is the design of many occupational pension schemes, which are also front-loaded. The majority of these plans pay annuities not for the expected remaining life but only for a few years into retirement (normally five). This entails a sudden drop in pension income only a few years into retirement, coinciding with a period of increasing health or assistance costs, and often even with the loss of one's spouse (which reduces household income due to the lack of survival provisions). It would be recommendable that pension policies addressed this issue in the context of preserving adequacy.

Aside from these suggested improvements, the expected reductions in future replacement rates cannot really be avoided as this is "the price" for higher life expectancy, if financial sustainability is to be preserved. Financial sustainability is essentially achieved by placing more of the responsibility for adequacy on individuals, through the one variable that individuals can control, namely the length of working life and their retirement age. The Swedish government is operating a strong campaign to sensitise people to the need to work longer, if pensions are to remain on a similar level with those of older generations. As of 2011, the annual letter to the entire collective of insured (so called Orange Letter) includes individual-specific projections of pension to be earned at different retirement ages, and indicates the "optimal" retirement age for that individual given increases in life expectancy. Individuals can also make more complete projections online (www.minpension.se) which include updated details on their occupational and any private pension. These efforts in communicating with the public should be taken as a promising step for succeeding to make people work longer and also make complementary savings.

2.3 Health Care

2.3.1 The system's characteristics and reforms

It is important to understand that the political as well as the financial power in the Swedish health care system rests mainly on the regional and to some extent also on the local level of the society, while the national level is less important. Both the county councils and the municipalities are quite independent of the national government, since most of their activities are financed through county and municipal taxes. This means that they are free to set their own priorities and organise their health services according to local needs and conditions. In 2007 the county councils were financing 71% and the municipalities 8% of the total health care expenditures. The households were financing 16% of the health care expenditures, while the national government contributed only 2% of the expenditures in the form of state grants that were earmarked for special purposes.[23]

[23] National Board of Health and Welfare, *Health Care Report 2009* (in Swedish). Stockholm: Socialstyrelsen, 2009, page 48.

During the last four years, the state grants have increased but the county councils still have a dominant and independent position in the Swedish health care system. This means that the characteristics and reforms of the system have to be described and discussed mainly from a regional point of view. This is a complex task, since there are many different developments in the different county councils. These developments are reflecting financial as well as social and demographic differences between the county councils. They are also reflecting different political majorities in the different county councils.

Health care organisation

There are presently 16 county councils and four regional councils in Sweden. The county councils are of different geographical size and the populations are ranging between 126,691 (Jämtland) and 429,642 (Östergötland). Stockholm county council is an exception with a population of 2.054 million. The regional councils in Skåne and Västra Götaland have populations of 1.243 and 1.580 million respectively.[24] These councils were created in 1997 and 1999 through mergers of previous county councils. One of the main reasons behind these mergers was to strengthen the financial base for health care and regional development, and also to make it possible to organise health services in a more rational way across the borders of the previous county councils.

A parliamentary committee on the division of responsibilities between different levels of the society, the so-called Responsibility Committee, suggested in 2007 that the country should be divided into 6-9 regional councils in order to provide a stronger financial base and a more sustainable organisation on the regional level. The regional councils were supposed to be established through voluntary mergers between neighbouring county councils.[25] However, in 2011 regional councils were established in Halland and on the island of Gotland. Halland was previously one of the smaller county councils with a population of 299,484 and Gotland was a municipality with a population of only 57,269.[26] More regional councils are in the process of being established, but not so much by mergers. Instead it seems that some county councils are just changing their names to regional councils.

On the national level, the government through the Ministry of Health and Social Affairs is responsible for the overall health policy of the country. The Parliament is responsible for the health legislation. The most important law is the Health and Medical Services Act from 1982, where the responsibilities of the county and regional councils as well as the municipalities are established.[27] The law also confirms the independent position of the county and regional councils and the municipalities regarding the organisation of health services. In spite of their independence, however, the National Board of Health and Welfare, which is a government agency under the Ministry of Health and Social Affairs, is responsible for supervising the quality and safety of all health care provided.

Due to different local conditions, the county and regional councils have chosen different organisational structures.[28] The organisation of health services is usually divided into a number of district health authorities. Some of the county and regional councils have also separate

[24] Statistics Sweden, Population database 2010, http://www.scb.se.
[25] SOU 2007:10, "Sustainable organisation of society with development power. Final report of the Responsibility Committee" (in Swedish). Stockholm: Finansdepartementet, 2007.
[26] Statistics Sweden, Population database 2010, http://www.scb.se.
[27] SFS 1982:763, "Health and Medical Services Act" (in Swedish). Stockholm: Socialdepartementet, 1982.
[28] The organisation of the different county and regional councils is shown on their respective homepages. There are also links to all the county and regional councils on the homepage of the Swedish Association for Local Communities and Regions, http://www.skl.se.

organisations for primary health care and specialised medical care. Primary health care is provided mainly in health centres, while specialised medical care is provided in hospitals. There are presently around 70 hospitals and more than a thousand health centres in Sweden. Most of the hospitals are local hospitals with limited specialisation or county hospitals with a wider range of medical specialties. There are also groups of several smaller hospitals under a common administration. Eight hospitals are highly specialised regional hospitals and they are at the same time also university hospitals. [29]

Health care financing

Because of the division of responsibilities between different levels of the society, it is difficult to get reliable data on health care expenditures in Sweden. When the care of the elderly and disabled was decentralised from the county councils to the municipalities in 1992 it was for a period classified as social service. However, the quality of the data has improved during the 2000s. In 2010 about 82% of the total expenditures of the county and regional councils, and 30% of the total municipal expenditures, were related to health care.[30] As a percentage of the GDP, the total health care expenditures in Sweden were on an average level (9.2%) compared with other EU countries in 2008. They used to be on a higher level in the beginning of the 1990s, but were reduced and stabilised during the last two decades, mainly as a result of cost containment measures taken by the county councils and regions.[31] In 2009 the health care expenditures have increased again and they are now over 10% of the GDP.[32] Therefore, most county councils and regions have been forced to take new measures to contain their costs, for example closing down wards and reducing health care personnel.

Although health care in Sweden is financed predominantly from public sources, there is a growing private sector involvement in the health care system. There is an increasing number of private providers, mainly in primary health care, who are contracted and financed by the county and regional councils. There are also a few hospitals that are run by private companies but financed by the county or regional councils. In 2005, the contracting of private providers accounted for almost 10% of the total health care expenditures of the county and regional councils.[33] In 2008 the Law on System of Choice was introduced with the aim to facilitate the contracting of private providers and to encourage competition in the public sector.[34] As a result, the number of private providers who are financed by the county and regional councils has increased to 15.7% in 2009.[35] The number of private providers varies between the different county and regional councils, depending on the concentration of the population, but also on the political majority. In general, there are more private providers in the big cities and also in county and regional councils with a liberal or conservative majority.

In addition to the private providers who are financed from public sources, there are also private practitioners who are financed by private out-of-pocket payments or private health insurance.

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29 Government Offices of Sweden, "Health and medical care in Sweden". Stockholm: Regeringskansliet. Available at http://www.regeringen.se

30 Swedish Association of Local Communities and Regions, "Costs and revenues 2010" (in Swedish), http://www.skl.se.

31 European Observatory on Health Systems and Policies, *Health Systems in Transition: Sweden*. Copenhagen: World Health Organization, 2005. Available at http://www.euro.who.int.

32 OECD Health Data 2010, http://stats.oecd.org (accessed in January 2012).

33 Government Offices of Sweden, "Health and medical care in Sweden", Stockholm: Socialdepartementet, 2007. Available at http://www.sweden.gov.se.

34 SFS 2008:962, "Law on System of Choice" (in Swedish). Stockholm: Socialdepartementet, 2008.

35 National Board of Health and Welfare, *Annual Report on Health Care and Social Services 2011* (in Swedish). Stockholm: Socialstyrelsen, 2011.

Most of these practitioners are providing specialised somatic or psychiatric care, but there are also physiotherapists and other health related therapists with private practice. Many of these practitioners have their own offices, but there are also group offices. In 2008, the private expenditures on health care amounted to 16.8% of the total expenditures on health care, but that figure also included patient fees to the county and regional councils.[36] In Sweden there is a co-payment system, which means that all patients are paying a nominal fee in connection with visits to the public hospitals and health centres. The fee varies between the different county and regional councils, and also between different treatments, but it amounts to around 3% of their total revenues.[37]

Health care management

During the last years, there have been a number of structural developments within the Swedish county councils and regions. Inspired by the ideas of New Public Management and developments in the UK, about half of the county councils introduced internal markets in the form of a purchaser-provider split in the beginning of the 1990s. As mentioned before, the county and regional councils are free to organise the health services according to local conditions, which means that they may choose different organisational models. However, the internal markets have proved to be a costly experience. The administrative costs of the county and regional councils with purchaser-provider split have been rising and these costs have not been compensated by an increased efficiency.[38] During the last few years, more and more county councils have therefore abandoned their market models and there is now only one county council (Stockholm) and one regional council (Västra Götaland) left with a purchaser-provider split. The others have modified their internal market models or returned to a more traditional administrative organisation.[39]

Another development that has been inspired by New Public Management but also by political considerations is the increasing number of private providers of health care, which was described in the previous section. This development is expected to be accelerating with a new system of free choice for patients in primary health care ("vårdval"), which was proposed by a parliamentary committee in 2008 and has been introduced in most county and regional councils during 2010.[40] The rights of the patients to choose their providers of primary health care have also been added to the Health and Medical Services Act, but according to this legislation the county and regional councils may have their own models for accreditation of private providers and for reimbursement of public as well as private providers. As a result, more than 200 new health centres have been established during the last two years. Most of them have been established in big cities.[41]

In some of the county and regional councils hospitals have been privatised, which means that they have been taken over by private companies. These hospitals have in many cases been

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[36] WHO Statistical Information System (WHOSIS), World Health Statistics 2011, http://www.who.int (accessed in January 2012).

[37] Swedish Association for Local Communities and Regions, Costs and Revenues 2010 (in Swedish), http://www.skl.se.

[38] Hallin, B. & Siverbo, S., *Control and Organising in Health Care* (in Swedish). Lund: Studentlitteratur, 2003.

[39] See the homepages of the different county and regional councils, which can be reached on the homepage of the Swedish Association for Local Communities and Regions, http://www.skl.se.

[40] SOU 2008:37, "Free patient choice of health care in Sweden. Report from the Committee on Patient Rights" (in Swedish). Stockholm: Socialdepartementet, 2008.

[41] National Board of Health and Welfare, *Annual Report on Health Care and Social Services 2011* (in Swedish). Stockholm: Socialstyrelsen, 2011.

hospitals with financial or other problems, so privatisation has been regarded as an alternative to closing them down.[42] It is a difficult decision for politicians in a county or regional council to privatise a hospital, since this means a loss of control, but it is even more difficult to close down a hospital. There have also been other alternatives to closing down hospitals in some of the county and regional councils. In recent years there have been a number of mergers of hospitals or creation of "hospital groups" under a joint management. In spite of bad experiences, related to the size and complexity of the new organisations, these developments have continued and spread to more and more county and regional councils.[43]

Another alternative to closing down hospitals has been to integrate them into an organisation of local health care ("närsjukvård"). There are different models of local health care, but the basic idea is an integration of a local hospital with primary health care and municipal health services. In this way, local health care should provide integrated and accessible health services for the basic needs of the local population.[44] There are also other developments of integration in the Swedish health care system. In many hospitals there is a development of integrated care pathways, which is linked to a general process orientation. Moreover, there is an increasing integration of services from the county and regional councils and the municipalities in the care of the elderly and open psychiatric care. In vocational rehabilitation, there is also collaboration between the health sector, the social sector, the employment service and the social insurance system. During the last ten years, there have been a number of experiments with different models of intersectoral collaboration.[45]

Provisions of the system

The Swedish health care system is providing a wide range of health services for the whole population on an equal basis. Primary health care is provided at health centres or surgeries, which are run either by the county and regional councils or by private providers and practitioners. However, in spite of official declarations that primary health care is the basis of the health system, the main part of the resources available for health services are still allocated to provision of specialised medical care at the hospitals. There are local hospitals as well as county hospitals for specialised care. The county hospitals have a wider range of medical specialties than the local hospitals. The most complicated diseases and injuries are treated in the eight highly specialised regional hospitals, which are also university hospitals. In these hospitals there is a lot of research, teaching and training going on, but they are still belonging to county or regional councils.

In international comparisons, the performance and quality of the Swedish health care system is usually placed very high. The health status of the Swedish population is one of the best in the world and the life expectancy one of the longest.[46] However, there are also problems in the Swedish system. There are long waiting lists for some surgical operations like hip joint replacements and cataract surgery. National comparisons have also shown significant regional differences, both in the quality of care and in the length of the waiting lists. The national

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42 Kullén Engström, A. & Axelsson, R., "The double spiral of change – Experiences of privatisation in a Swedish hospital". *International Journal of Health Planning and Management*, 2010, vol. 38(2), pp. 156-168.

43 Ahgren, B., "Is it better to be big? The reconfiguration of 21st century hospitals: Responses to a hospital merger in Sweden. *Health Policy*, 2008, vol. 87(1), pp. 92-99.

44 Edgren, L. & Stenberg, G., *The Faces of Local Health Care* (in Swedish). Lund: Studentlitteratur, 2006.

45 Ahgren, B. & Axelsson, R., "A decade of integration and collaboration: The development of integrated care in Sweden 2000-2010". *International Journal of Integrated Care*, vol. 11, 2011. Available at http://www.ijic.org.

46 WHO Statistical Information System (WHOSIS), World Health Statistics 2011, http://www.who.int (accessed in January 2012).

government has taken several initiatives to deal with these problems, for example by issuing national guarantees for care and rehabilitation within a certain period of time, by allocating resources for reduction of waiting lists and sick leave, by introducing a national cancer strategy and by offering patients a free choice of hospitals and other health care providers.[47] These initiatives have been taken to reduce the regional differences, maybe also to increase the national control of the health care system, but they have not been very successful so far.

A more successful strategy has been to initiate open comparisons of the availability, quality and efficiency of health care in the different county and regional councils. The quality of care is measured by general indicators like health status, mortality, health promotion and patient satisfaction, but also by a number of more specific indicators for different specialties. The availability is measured by waiting times and access to different specialties, while the efficiency is measured by the costs of different treatments. The comparisons have shown significant differences between different county and regional councils, but also between different hospitals. The results are published annually by the Swedish Association for Local Communities and Regions together with the National Board of Health and Medical Care.[48] These open comparisons have stimulated a development of evidence based medicine in the county councils. They have also led to national recommendations in different fields of health care issued by the National Board of Health and Medical Care.[49]

The access problems in the Swedish health care system are not limited to the hospitals. Because of the dominance of specialised health services, it has been difficult to recruit general physicians to primary health care, particularly in the rural areas of the country. The lack of general physicians has caused problems of access to the health centres and many patients are instead going to the emergency departments of the hospitals. Another consequence of the dominance of specialised health services is that there are fewer resources available for health promotion and rehabilitation. In recent years, however, there has been an increasing interest in vocational rehabilitation as a strategy to reduce sick leave. There have been a number of experiments with different models of collaboration between the health sector and other sectors involved in vocational rehabilitation, for example the social and employment services and the social insurance system.[50] These experiments have resulted in a Law on Financial Co-ordination of Rehabilitation Measures, which is an important part of the same strategy.[51]

2.3.2 Overview of debates and political discourse

Health care has always been an important topic in the public debate and the newspapers are usually filled with articles reporting and discussing all sorts of problems in health care. Although the Swedish health care system has a good international reputation, the general public is not equally impressed by the performance of the system, judging from the reports and discussions in

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47 SOU 2008:127, "The patient's right. Some proposals to strengthen the position of the patient" (in Swedish). Stockholm: Socialdepartementet; National Board of Health and Welfare, *Annual Report on Health Care and Social Services 2011* (in Swedish). Stockholm: Socialstyrelsen, 2011.

48 Swedish Association of Local Communities and Regions & National Board of Health and Welfare, *Open Comparisons of the Quality and Efficiency of Health Care – Comparisons between County Councils 2011* (in Swedish). Stockholm: Sveriges Kommuner och Landsting och Socialstyrelsen, 2011.

49 National Board of Health and Welfare, *Annual Report on Health Care and Social Services 2011* (in Swedish). Stockholm: Socialstyrelsen, 2011.

50 Andersson, J. et al, "Organizational approaches to collaboration in vocational rehabilitation – An international literature review". *International Journal of Integrated Care*, vol. 11, 2011. Available at http://www.ijic.org.

51 SFS 2003:1210, "Law on Financial Co-ordination of Rehabilitation Measures" (in Swedish). Stockholm: Ministry of Labour, 2003.

the mass media. There is also a fear among the general public that the measures taken to contain the health care costs will have negative effects on the quality and safety of care. However, the political debate on health care has not been as intensive as the public debate. This may be due to the Swedish political tradition of compromise and consensus, but it may also be due to the fact that the health care issues have not been so controversial for the politicians. In fact, many of them are deeply involved in the governance of the health care system on the regional and local level. Health policy is also discussed mainly in the local community and regional parliaments.

The recent public and political discussions on health care have been focused on the reforms described in the previous sections, but the most controversial issue during the last few years has been a reform which is only indirectly related to health care. When the present liberal-conservative coalition government came to power in 2006, they introduced new rules for sickness insurance in order to reduce sick leave and increase employment. As a result, there has been a reduction of sick leave, which the government has described as a "decline in ill-health".[52] Studies have shown, however, that many sick-listed people have been forced out on the labour market although they are not fit to work and should therefore have stayed on sick leave. There have been many reports in the mass media of people who are seriously ill, but have been denied sick leave and forced to apply for jobs. These reports have forced the government to reconsider parts of the reform, but it is still a controversial issue.[53]

Another issue, which has been discussed a lot during the last years, is the suggestion from the Responsibility Committee that the country should be divided into 6-9 regional councils in order to have a more sustainable organisation for health care and regional development. As mentioned before, two new regional councils have been established in 2011, but they have not been created through mergers of county councils. Some of the county councils have started negotiations to merge into new regional councils, while others have been more doubtful. Some county councils have stubbornly refused to enter into negotiations with other county councils. Their refusal has seems to be based on local patriotism rather than political arguments. Among the political parties, only the conservative party has expressed some doubts concerning the suggested regional structure.[54]

An issue, which has also been discussed for some time, is the increasing privatisation of health services. Privatisation of public services has always been a very controversial and a highly ideological issue in Sweden, separating the socialist parties from the liberal and conservative parties. In 2004 the previous social democratic government introduced a regulation in the Health and Medical Services Act, the so-called stop law, in order to prevent profit making private companies from running hospitals.[55] When the present liberal-conservative coalition government came to power in 2006 this regulation was immediately abolished.[56] The discussion on privatisation in health care has continued and it is still one of the most controversial issues. Surprisingly, all the political parties have largely agreed on the new system of free choice of

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52 Government Offices of Sweden, "Swedish National Reform Programme 2011". Stockholm: Regeringskansliet, 2011.

53 Ministry of Health and Social Affairs, "Proposals to improve the sickness insurance" (in Swedish). Memorandum, April 2011.

54 SOU 2007:10, "Sustainable organisation of society with development power. Final report of the Responsibility Committee" (in Swedish). Stockholm: Finansdepartementet, 2007.

55 Prop. 2004/05:145, "Forms of management of publicly financed hospitals" (in Swedish). Stockholm: Socialdepartementet, 2005.

56 Prop. 2006/07:52, "Forms of management of hospitals" (in Swedish). Stockholm: Socialdepartementet, 2007.

providers for patients in primary health care, although this system is expected to increase the number of private providers.[57]

During the last year, there have also been discussions about the open comparisons showing great differences in the availability, quality and efficiency of health care between different county and regional councils and between different hospitals. These comparisons have been supported by the national government and they have given valuable inputs to improvements in the county and regional councils concerned. The comparisons have also been reported and discussed a lot in the mass media, and many people have been upset by the great differences between county and regional councils as well as between hospitals. Some people have questioned the decentralised Swedish system and suggested that the national government should take over the responsibility for health care from the county and regional councils in the same way as it has happened in Norway.[58] Others have argued for a European health market where the Swedish patients can choose the best possible health care.[59]

2.3.3 Impact of EU social policies on the national level

Because of the decentralised character of the Swedish health care system, there is not a great impact of EU social policies on the national level but rather on the regional and local levels of the society. According to the Swedish Association of Local Authorities and Regions, about 50% of the items on a county or regional council agenda are related to the EU in one way or another. The EU influences the county and regional councils in different ways, but most of all through the structural funds that provide resources for different development projects. The EU also influences the county and regional councils through promoting an exchange of ideas and best practice between the different Member States.[60]

The exchange of ideas has taken a more structured form through the Open Method of Coordination (OMC), where the Member States are asked to produce three-year national reform programmes for how to achieve a set of common EU goals. They are also asked to produce ten-year programmes that can contribute to Europe 2020, the EU strategy for smart, sustainable and inclusive growth. Since the strategic development of the Swedish health care system is a responsibility mainly for the county and regional councils, the Swedish national reform programme (NRP) of 2011 has instead been focusing on other fields of development such as employment, education, poverty reduction and pensions.

As mentioned before, there have been discussions about the open comparisons of availability, quality and efficiency in the Swedish health care system, but very few discussions about the OMC on the European level. There seems to be hardly any impact of the Europe 2020 strategy on the Swedish debate on health care reforms, and there is also very little written about health policy in the Swedish NRP. This may be due to the fact that the national government is not so directly involved in health care. The policy making in this field takes place mainly in the county and regional councils on the regional level. Concerning the access and quality problems in health

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[57] SOU 2008:37, "Free patient choice. Report from the Committee on Patient Rights" (in Swedish). Stockholm: Socialdepartementet, 2008.

[58] European Observatory on Health Systems and Policies, *Health Systems in Transition: Norway*. Copenhagen: World Health Organization, 2006. Available at http://www.euro.who.int.

[59] *The Barometer of Care* (in Swedish) is a recurrent study of public opinion on health care and health related issues, which is commissioned by the Swedish Association of Local Communities and Regions. The latest report from 2010 is available at http://www.vardbarometern.nu.

[60] Nyberg, L., "EU in local politics – A study of agendas from municipalities, county councils and regions" (in Swedish). Stockholm: SKL, 2010.

and long-term care, the NRP is referring to "major initiatives" to increase accessibility and quality of care. The national government believes that increasing the freedom of choice through competition and privatisation will lead to better access and better quality of care.[61] This belief is however based on the political ideology of the government rather than on scientific evidence.

2.3.4 Impact assessment

The financial developments in the Swedish health care system are followed closely by the different county and regional councils and also by the different municipalities. The Swedish Association of Local Communities and Regions is also collecting and compiling financial data from all the county and regional councils and all the municipalities. In addition, the association is forecasting the tax revenues as well as the total expenditures of the county and regional councils and the municipalities. According to the latest prognosis, the tax revenues are increasing more than previously expected due to a strong recovery in the economy and the labour market. At the same time, however, the health care expenditures are also expected to rise as a result of the ageing population, so it may be difficult to balance the budgets of the county and regional councils and the municipalities.[62]

Health data are collected mainly by the county councils and the regional councils. These data include statistical information on morbidity and mortality, visits to health care, different diagnoses, treatments, operations etc. They are compiled by the Swedish Association of Local Communities and reported to the National Board of Health and Welfare.[63] The open comparisons of the availability, quality and efficiency of health care in the different county and regional councils and in different hospitals are based on the same health data, but they are published separately in order to have more impact on the development and improvement of health care.[64] As mentioned before, these comparisons have shown significant differences in the availability as well as the quality and the efficiency of health care between different county and regional councils and also between different hospitals.

Beside these statistical sources, there are also studies commissioned by the National Board of Health and Welfare on different aspects of health care, for example the access to health services in terms of waiting times and waiting lists, patient safety, quality of care, social inequities in health, and efficiency of health services.[65] The National Institute of Public Health is also publishing reviews of different initiatives in public health policy.[66] In addition, there are regular assessments of medical methods carried out by the Swedish Council on Technology Assessment in Health Care. This council is assessing the evidence base of different medical methods and technologies. In 2009 and 2010 there have been assessments of methods for treatment of diabetes, migraine, chronic wounds, abdominal aortic aneurysm, inflammatory bowel disease

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61 Government Offices of Sweden, "Swedish National Reform Programme 2011". Stockholm: Regeringskansliet, 2011. Available at http://sweden.gov.se.

62 Swedish Association of Local Communities and Regions, "Tax revenues greater than expected" (in Swedish), 2011, http://www.skl.se/press/nyheter_2/skatteintakterna_blir_storre_an_forvantat.

63 Swedish Association of Local Communities and Regions, Municipal and county council database, http://www.kolada.se.

64 Swedish Association of Local Communities and Regions & National Board of Health and Welfare, *Open Comparisons of the Quality and Efficiency of Health Care – Comparisons between County Councils 2011* (in Swedish). Stockholm: Sveriges Kommuner och Landsting och Socialstyrelsen, 2011.

65 National Board of Health and Welfare, *Annual Report on Health Care and Social Services 2011* (in Swedish). Stockholm: Socialstyrelsen, 2011.

66 National Institute of Public Health, *Public Health Policy Report 2010* (in Swedish). Östersund: Statens Folkhälsoinstitut, 2010.

etc.[67] In addition, there is a lot of research on the Swedish health care system going on, not only in medical schools and departments of public health but also in faculties of social science and even in business schools. Reviews and evaluations are important parts of this research. Different parts of the health system have been evaluated, for example local health care and intersectoral collaboration in vocational rehabilitation.[68] There have also been studies of the increasing number of private providers of health care, evaluating the possible effects of this privatisation. The results of these studies have been contradictory, however, depending on their scientific perspectives and points of departure.[69]

Unfortunately, there have been very few evaluations of the internal markets in the Swedish county and regional councils.[70] Since about half of the county councils introduced a purchaser-provider split in the 1990s, while the others kept their traditional administrative organisation, there was a good opportunity for comparative research, almost like a natural experiment. However, as mentioned before, most of the county councils have now abandoned their market models and there is only one county council and one regional council left with a purchaser-provider split, so there will probably not be any more evaluation of the internal markets in Swedish health care. Nevertheless, the fact that so many county councils have abandoned the purchaser-provider model can be regarded as an evaluation in itself.

2.3.5 Critical assessment of reforms, discussions and research carried out

The Swedish health care system can be described as a system with high performance and quality. As mentioned before, the health status of the Swedish population is one of the best in the world. It is a decentralised system where the county councils, the regional councils and the municipalities have the main responsibility for the financing, administration and provision of health services, while the national government has only a limited role and responsibility. The system is predominantly a public system, with a small percentage of private financing and provision of health services, although the number of publicly financed private providers is increasing, particularly in primary health care.

There are advantages as well as disadvantages with the decentralised nature of the Swedish health care system. The advantages are that the county and regional councils and the municipalities can make their own priorities and organise their health services according to the needs of the local population. The disadvantages are that there are great regional differences both in the resources available and in the quality and efficiency of the health services provided. Moreover, there are also regional differences in the access to health care.

The **access** to health services is a problem in the Swedish health care system. There are long waiting lists for some surgical operations and there are also access problems in primary health care due to a lack of general physicians. The government has taken several initiatives to deal with this problem, for example by issuing national guarantees for care and rehabilitation within a certain period of time. The new system of free choice for patients in primary health care is also

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67 Swedish Council on Technology Assessment in Health Care, http://www.sbu.se.

68 Ahgren, B. & Axelsson, R., "Evaluating integrated health care: A model for measurement". *International Journal of Integrated Care*, vol 5, 2005; Ahgren, B. et al, "Evaluating intersectoral collaboration: A model for assessment by service users". *International Journal of Integrated Care*, vol. 9, 2009. Both of the articles available at http://www.ijic.org.

69 Anell, A., "Health services under private management". In: Hartman, L. (ed), *Consequences of Competition. What is Happening with Swedish Welfare?* (in Swedish). Stockholm: SNS Förlag, pp. 181-214.

70 Hallin, B. & Siverbo, S., *Control and Organising in Health Care* (in Swedish). Lund: Studentlitteratur, 2003; Berlin, J., *Purchaser Control of Health Services* (in Swedish). Göteborg: Förvaltningshögskolan, 2006.

expected to improve the access to health services by increasing the number of private providers. A great number of private health centres have already been established, but it seems that most of them have been established in the big cities, which has increased the relative disadvantage of the rural areas.

The **quality** of health care in the Swedish system is generally high, but there are significant differences between different county and regional councils, and also between different hospitals. The creation of larger regional councils may help to reduce these differences, at least within the councils, and so may also the open comparisons of the quality of health care, which are published annually by the Swedish Association of Local Communities and Regions and the National Board of Health and Welfare. The government is supporting these open comparisons as a strategy to reduce the regional differences, but maybe also to increase the national control of the health care system.[71] The question is if this strategy will be enough to calm down the public dissatisfaction with the differences in health care. The question is also whether a reduction of the regional differences will lead to an improvement in the quality of health care, or just an adaption to an average quality level.

The **sustainability** of the health care system is related both to the financing and the organisation of the system. The total health care expenditures in Sweden are on an average level compared with other EU countries. The expenditures have been reduced and stabilised during the past two decades, mainly as a result of cost containment measures taken by the county and regional councils. There are expectations that the health care costs may rise in the future because of the ageing population, but not so much as to threaten the sustainability of the system.[72] A process to create larger regional councils has been initiated in order to provide a better financial base and a more sustainable organisation of health care. However, it seems that this process is not very successful. Instead of merging county councils into regional councils, some county councils are just changing their names to regional councils.

2.4 Long-term Care

2.4.1 Overview of the system's characteristics and reforms

Long-term care operates at the boundaries between health care and social services. It is provided to frail elderly and to persons with physical or mental disabilities who need support in their daily life activities. In Sweden the municipalities are responsible for long-term care, including both health care and social services. As mentioned before, the responsibility for care of the elderly was decentralised in 1992 from the county councils to the municipalities in order to improve integration with the municipal social services. In 1996 the responsibility for care of the disabled and long-term psychiatric care was also decentralised from the county councils to the municipalities for the same reason. As a result of these developments and others related to the financial situation of the municipalities, there has been a restructuring of long-term care during the last fifteen years. Places in institutions and special accommodation have been reduced and more people are now receiving care and services in their homes.

There are presently 290 municipalities in Sweden. They provide a number of services for their inhabitants, from child care and school education to technical services, social services and care

[71] European Commission, National strategy reports on social protection and social inclusion 2008-2010: Sweden, http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/nap/sweden_en.pdf.

[72] European Commission, Joint reports on social protection and social inclusion 2009: Sweden, http://ec.europa.eu/employment_social/spsi/joint_reports_en.htm.

of the elderly. Since the municipalities are financing most of their services through municipal taxes, they are like the county and municipal councils quite independent of the national government. This means that they are free to make their own priorities and organise their services according to the needs of the local population. The municipalities are however very different, with different geographical size and populations ranging between 2,460 (Bjurholm) and 847,073 (Stockholm).[73] This means that there are financial as well as social and demographic differences. In addition, there are also different political majorities among the municipalities. As a result, they may have different priorities and choose different strategies to provide services for their inhabitants.

On the national level, the Government through the Ministry of Health and Social Affairs and the Parliament are responsible for legislation and guidelines concerning long-term care. The most important law is the revised Social Service Act, which has been in force since 2001.[74] This law gives the right to the individual to receive municipal services, but at the same time it also confirms the independence of the municipalities regarding the organisation and provision of these services. However, the National Board of Health and Welfare is supervising the quality of the long-term care provided by the municipalities.

Like most European countries, Sweden has an ageing population, but the Swedish population is ageing more than most other countries because of the long life expectancy.[75] In 2010, 18% of the population was aged over 65 while 5.3% was aged over 80 and the number of elderly people is steadily increasing.[76] This is a financial and organisational challenge first of all for the Swedish municipalities but in a longer perspective also for the whole society. In 2009, about 29% of the total municipal expenditures in Sweden were related to long-term care: 19% were related to care of the elderly and 10% were related to care of the physically and mentally disabled.[77] There is now a concern that the increasing number of elderly people will require alternative sources of financing. Already in 2008, Sweden spent 3.6% of the GDP on long-term care, which was more than any other OECD country.[78]

The municipalities are responsible for the provision of health care and social services to the elderly and the disabled, while the county and regional councils are responsible for the provision of medical care to these groups of patients. A parliamentary committee has pointed out that this division of responsibilities is not very clear. Therefore, the committee recommended increasing collaboration between the municipal health care and the primary and secondary care of the county and regional councils in order to develop a more integrated system of long-term care.[79] An obligation for the municipalities to work together with the county and regional councils in the provision of long-term care has also been introduced in an addition to the Health and Medical Services Act in 2007.

There is a growing private sector involvement in long-term care, particularly in the care of the elderly, which has been supported by the national government. In 2007, nearly 14% of the frail elderly were living in private nursing homes and most of these nursing homes were contracted

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73 Statistics Sweden, Population database 2010, http://www.scb.se.
74 SFS 2001:453, "Social Service Act" (in Swedish). Stockholm: Socialdepartementet, 2001.
75 WHO Statistical Information System (WHOSIS), World Health Statistics 2011, http://www.who.int (accessed in January 2012).
76 Colombo et al, *Help Wanted? Providing and Paying for Long-Term Care*. Paris: OECD, 2011.
77 Swedish Association of Local Communities and Regions, "Costs and revenues 2010" (in Swedish), http://www.skl.se.
78 Colombo et al, *Help Wanted? Providing and Paying for Long-Term Care*. Paris: OECD, 2011.
79 SOU 2004:68, "Integrated home care" (in Swedish). Stockholm: Socialdepartementet, 2004.

and financed by the municipalities. Moreover, nearly 11% of the home services granted to elderly people in 2007 were provided by private companies.[80] In addition, many elderly are renting flats in houses specially designed for old people and run by private companies, who are also offering different services to their tenants. This means that the privatisation of services has gone further in long-term care than in health care. It has also been encouraged by the Law on System of Choice from 2008, which came into force in 2009.[81] During the last two years, the number of private providers has increased even more and is now about 15-20% of the total number of providers of long-term care.[82]

Another form of private involvement in long-term care is the increasing number of informal carers who are taking care of elderly or disabled family members.[83] According to an addition to the Social Services Act, there is now an obligation for the municipalities to provide financial support to informal and family carers. It is still up to the municipalities to decide on the level and form of support, which means that the support may vary depending on the financial situation of the municipalities and the needs of their inhabitants.[84]

2.4.2 Overview of debates and political discourse

The care of the elderly has for a long time been an increasingly important topic in the political as well as the public debates and discussions in Sweden, while the care of people with physical or mental disabilities has not received equal attention. This focus on the care of the elderly is natural since everyone is getting old, but only a smaller part of the population has physical or mental disabilities. Moreover, with the present demographic development, there will be an increasing number of elderly people in Sweden with a longer life expectancy. This means an ageing population where more people will be in need of care, service and support from the society.

The public and political discussions on the care of the elderly have been focused on the development and the reforms described in the previous section. One issue, which has been discussed for some time, is the reduction of places in institutional care and special accommodation that has taken place in most municipalities. This reduction has become more controversial as the number of frail elderly with multiple chronic diseases has been steadily increasing. Many elderly people and their relatives have been complaining about unreasonable waiting times for institutional care. The political parties have the same view of the problems but their solutions differ. The social democratic opposition would like to give more money to the municipalities for provision of home care and special accommodation, while the liberal-conservative government would like to increase the number of private services and nursing homes, which in their view would give the elderly people and their relatives a wider choice of services and accommodation.[85]

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80 European Commission, National strategy reports on social protection and social inclusion 2008-2010: Sweden, http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/nap/sweden_en.pdf

81 SFS 2008:962, "Law on System of Choice" (in Swedish). Stockholm: Socialdepartementet, 2008.

82 National Board of Health and Welfare, *Annual Report on Health Care and Social Services 2011* (in Swedish). Stockholm: Socialstyrelsen, 2011.

83 Ds 2008:18, "Support to relatives who take care of family members" (in Swedish). Stockholm: Socialdepartementet, 2008.

84 SFS 2009:549, "Law on Amendment in the Social Service Act". Stockholm: Socialdepartementet, 2009.

85 European Commission, National strategy reports on social protection and social inclusion 2008-2010: Sweden, http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/nap/sweden_en.pdf.

The increasing number of private nursing homes and private service providers in the care of the elderly has become another controversial issue, not only for the political parties on the national and the local level but also for the general public.[86] During the last years and particularly during 2011, there have been many reports in the mass media of old people who have been treated badly in nursing homes due to cost containment measures to improve the profits of the private companies involved, or due to insufficiently trained personnel employed by the private providers. As a result of these "care scandals", there has been an intensive public debate about the role of profit making companies in the welfare system.[87] The reports from the private nursing homes have upset many people and the political opposition has also taken advantage of the situation, while the government has argued for better contracting and control of the private providers.[88] Thus, the care of the elderly remains one of the most important topics in the political debate in Sweden.

2.4.3 Impact of EU social policies on the national level

In the Swedish system of long-term care, the impact of EU social policies is felt mainly on the local level of the society. According to the Swedish Association of Local Authorities and Regions, about 60% of the items on a municipal council agenda are influenced by the EU. The main influences are through the structural funds that provide resources for different development projects in the municipalities, but there is also some influence from the exchange of ideas and best practice that is taking place within the EU.[89]

As mentioned above, there have been some discussions in the municipalities as well as on the national level about the quality of long-term care in different institutions, but there have been very few discussions about the Open Method of Coordination on the EU level. In the same way as in the health care system, there seems to be hardly any impact of the Europe 2020 strategy on the Swedish debate and there is very little written about long-term care in the Swedish National Reform Programme of 2011. The reform programme is only referring to initiatives to increase the freedom of choice in elderly care, for example through incentive funds for municipalities that want to introduce free choice systems.[90] The government is convinced that increasing the freedom of choice through competition and privatisation will lead to better access and quality of care.

2.4.4 Impact assessment

The financial developments regarding long-term care are followed closely by the different municipalities and compiled by the Swedish Association for Local Communities and Regions. The expenditures have been steadily rising as a result of the ageing population, and this development is expected to continue.[91] The National Board of Health and Welfare is following

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86 Meagher, G. & Szebehely, M., "Private financing of elder care in Sweden. Arguments for and against". Stockholm: Institute for Future Studies, 2010. Available at http://www.framtidsstudier.se .

87 Szebehely, M., "Activities for older and disabled people under private management". In: Hartman, L. (ed), *Consequences of Competition. What is Happening with Swedish Welfare?* (in Swedish). Stockholm: SNS Förlag, pp. 215-257.

88 SOU 2008:51, "A life in dignity for people in elderly care" (in Swedish). Stockholm: Socialdepartementet, 2008.

89 Nyberg, L., "EU in local politics – A study of agendas from municipalities, county councils and regions" (in Swedish). Stockholm: SKL, 2010.

90 Government Offices of Sweden, "Swedish National Reform Programme 2011". Stockholm: Regeringskansliet, 2011. Available at http://sweden.gov.se.

91 Swedish Association of Local Communities and Regions, Municipal and county council database, http://www.kolada.se.

the development of long-term care in the different municipalities and the country as a whole, particularly the development concerning the care of the elderly. The board is collecting statistical information on the different forms of care, service, support and accommodation for elderly people in the different municipalities.[92]

As a response to the intensive public debate about bad conditions in private nursing homes, the open comparisons of health care have been expanded to include also the care and services for the elderly. In these comparisons, the quality of care is measured by indicators of care, treatment, safety, hygiene, participation, food and social activities. The results are published annually in a separate report from the Swedish Association for Local Communities and Regions together with the National Board of Health and Medical Care. These results have shown significant differences among the different municipalities and between different parts of the country in the quality as well as the availability and efficiency of long-term care.[93]

Beside this statistical information and the open comparisons, the National Board of Health and Welfare has also commissioned studies concerning health care for the elderly. There have been studies of different forms of home care, the use of drugs among elderly, treatment of different age related diseases like cataract, dementia, stroke, and palliative care at the end of life.[94] Based on these and other studies, the National Board has developed national quality indicators for monitoring the care of elderly persons in the different municipalities.[95] The Swedish Council on Technology Assessment in Health Care has also made some assessments in this field, for example methods for treatment of stroke and dementia.[96] In addition, there is also a lot of research focusing on care of the elderly. The most important institute for such research is the Ageing Research Centre in Stockholm.[97]

2.4.5 Critical assessment of reforms, discussions and research carried out

The system of long-term care is decentralised to the municipalities in Sweden. This means the same advantages and disadvantages as the decentralisation of the health care system. The municipalities can make their own priorities and organise their services according to local needs and conditions, but there are also significant differences between the municipalities both in the resources available and in the access, quality and efficiency of long-term care. The differences between the municipalities are greater than the differences between the county and regional councils, since there are 290 municipalities of different size and population, but only 20 different county and regional councils.

The **access** to long-term care is problematic. There is a lack of places in institutional care and special accommodation as a result of the restructuring of long-term care during the last fifteen years. This means that there are long waiting times for institutional places, particularly for care of the elderly. The government is dealing with this problem by supporting an increasing

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92 National Board of Health and Welfare, *The Elderly Guide* (in Swedish). Stockholm: Socialstyrelsen, 2011.
93 Swedish Association of Local Communities and Regions & National Board of Health and Welfare, *Open Comparisons 2011: Care and Services for the Elderly* (in Swedish). Stockholm: Sveriges Kommuner och Landsting och Socialstyrelsen, 2011.
94 National Board of Health and Welfare, *Annual Report on Health Care and Social Services 2011* (in Swedish). Stockholm: Socialstyrelsen, 2011.
95 National Board of Health and Welfare, *National Quality Indicators for Care of Elderly Persons* (in Swedish). Stockholm: Socialstyrelsen, 2010.
96 Swedish Council on Technology Assessment in Health Care, http://www.sbu.se.
97 Relevant publications can be found at http://www.ki-su-arc.se.

privatisation and introduction of free choice for the elderly.[98] However, at the same time, there is a growing suspicion of private providers of long-term care as a result of reports in the mass media about bad treatment of old people in private nursing homes.

There are significant differences in the **quality** of long-term care, particularly in the care of the elderly, between different municipalities and different parts of the country. The national government is hoping that the ongoing development of statistical information and the publication of open comparisons of care and services for the elderly will reduce these differences.[99] Maybe at the same time it will also help the municipalities to locate and get rid of problematic private providers. The question is, however, if these measures will be enough to solve the basic structural problem of a great number of independent municipalities with different resources available for long-term care. The question is also whether a reduction of differences between municipalities will lead to an improvement in the quality of long-term care, or just an adaption to an average quality level.

The **sustainability** of long-term care is depending mainly on the financial situation of the municipalities and the development of the expenditures related to long-term care. The expenditures for care and services for the elderly are expected to rise because of the ageing population. According to the national government, however, the society will be able to finance its commitment to health and social services for the elderly through "sound public finances and a high rate of employment".[100] This is a political statement, for what it is worth, but it seems that the government is not so worried that the consequences of the ageing population will threaten the sustainability of the system of long-term care in Sweden. There is more concern, among foreign observers, that future demographic changes may require Sweden to seek alternative methods to increase the financing of long-term care.[101]

2.5 The role of social protection in promoting active ageing

2.5.1 Employment

There is a flexible retirement age in Sweden. According to the Swedish pension system, income pension can be drawn at the earliest from the age of 61, but there is no upper limit for when the pension must start to be drawn. The system is designed to encourage people to continue working as long as possible. The later a person retires, the higher the pension will be. Calculations have shown that if a person retires at 61, the pension will be 72% of what it would have been if the person retired at 65. In the same way, if a person retires at 68, the pension will be 29% higher than if the person had retired at 65.[102]

As mentioned before, the health status of the Swedish population is one of the best in the world and life expectancy is longer than in most other countries. In 2009, life expectancy was 83 for women and 79 for men.[103] Swedish people also think that they will be able to work longer than

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98 European Commission, National strategy reports on social protection and social inclusion 2008-2010: Sweden, http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/nap/sweden_en.pdf.

99 European Commission, Joint reports on social protection and social inclusion 2009: Sweden, http://ec.europa.eu/employment_social/spsi/joint_reports_en.htm.

100 European Commission, National strategy reports on social protection and social inclusion 2008-2010: Sweden, http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/nap/sweden_en.pdf.

101 Colombo et al, *Help Wanted? Providing and Paying for Long-Term Care.* Paris: OECD, 2011.

102 Pensionsmyndigheten, "The Swedish pensions system", http://www.pensionssystemet.se.

103 WHO Statistical Information System (WHOSIS), World Health Statistics 2011, http://www.who.int (accessed in January 2012).

people in other countries. According to a recent European public opinion poll, there are more people in Sweden than in other EU countries that would like to work after they have reached the age when they are entitled to a pension.[104] If it is possible to do so is depending on the labour market. With an increasing unemployment among young people, there is a struggle for employment between generations. Moreover, older people are not always viewed positively by employers. Therefore, a parliamentary commission has recently suggested an extended protection against age discrimination.[105]

2.5.2 Participation in society

Swedish pensioners are not only in good health, they are also active participants in society. According to the European public opinion poll mentioned above, Swedish people would like to work longer than their counterparts in other countries. There are also flexible arrangements that permit a gradual reduction of working hours or part-time employment for older people. There are also possibilities for financial remuneration of different contributions, for example informal care of family members.[106] Old people in Sweden are also active in voluntary work, mainly in social, political or religious organisations and in interest groups for old people and pensioners. In the comparative studies of the EU project on healthy ageing 2004-2007, Sweden had the highest number of older people participating in political and welfare organisations among the 15 Member States at that time.[107] This picture has been confirmed in the recent public opinion poll, where Sweden is first among the 27 current Member States when it comes to active participation of older people in voluntary work.[108]

Participation in voluntary work and other forms of professional activity are often regarded as an antidote to social exclusion and loneliness of old people, since it can keep them active and provide a sense of meaning and purpose to their lives. Participation and social support is also regarded as one of the cornerstones of the Swedish strategy for healthy ageing.[109]

2.5.3 Healthy and autonomous living

As a result of the restructuring of long-term care that has taken place in Sweden during the last fifteen years, places in institutions and special accommodation have been reduced, so more and more old people are now receiving health care and social services in their homes. As mentioned before, the municipalities are responsible for the provision of these services in collaboration with the county and regional councils. There is also a growing private sector involvement, not only in nursing homes but also in apartment blocks for old people, which are run by private companies. However, with an increasing number of old people living in their homes, there is a risk for isolation and social exclusion.[110]

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[104] European Commission, Special Eurobarometer 378, "Active ageing" http://ec.europa.eu/public_opinion/index.
[105] SOU 2010:60, "An extended protecxtion against age discrimination" (in Swedish). Stockholm: Integrations- och jämställdhetsdepartementet, 2010.
[106] Ds 2008:18, "Support to relatives who take care of family members" (in Swedish). Stockholm: Socialdepartementet, 2008.
[107] Berensson et al, "Healthy ageing – A challenge for Europe" (in Swedish). *Socialmedicinsk tidskrift,* vol 87(3), 2010; Swedish National Institute of Public Health, *Healthy Ageing in Europe – Lessons Learnt and Ways Forward.* Östersund: Statens Folkhälsoinstitut, 2009.
[108] European Commission, Special Eurobarometer 378, "Active ageing" http://ec.europa.eu/public_opinion/index.
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The National Institute for Public Health has suggested a strategy for healthy ageing, which is based on four cornerstones. The first is participation in society and social support from family and friends. This includes social networks and meeting places for old people. The second cornerstone consists of activities for old people that are rewarding, worthwhile and meaningful. It is important for old people to feel included and needed in society. The third and fourth cornerstones are good eating habits and physical exercise.[111] This strategy requires collaboration between many different organisations and sectors of the society. Beside the National Institute for Public Health, the municipalities as well as the county and regional councils are important actors. There are also private companies and voluntary organisations involved in healthy ageing. In order to implement the strategy for healthy ageing it is important to make all of these actors collaborate across the boundaries of the different organisations and sectors. This is a challenge for the future.[112]

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Abstracts of Relevant Publications on Social Protection

[R] Pensions

- **[R1] General trends: demographic and financial forecasts**
- **[R2] General organisation: pillars, financing, calculation methods or pension formula**
- **[R3] Retirement age: legal age, early retirement, etc.**
- **[R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.**
- **[R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.**

[H] Health

- **[H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.**
- **[H2] Public health policies, anti-addiction measures, prevention, etc.**
- **[H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.**
- **[H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.**
- **[H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)**
- **[H6] Regulation of the pharmaceutical market**
- **[H7] Handicap**

[L] Long-term care

[R] Pensions

[R3] PENSIONSMYNDIGHETEN, «PensionsÅlder», 2011
http://www.pensionsmyndigheten.se/3436.html

"Pension Age"

This report has been written to look at what might be expected to happen to the pension system as life expectancy increases and economic conditions change. Furthermore it reviews few possible alternatives for tackling further life expectancy increases such as rising different types of "pension ages".

[R2] PENSIONSMYNDIGHETEN, «Orange Rapport. Årsredovisning 2010», 2011 (Orange Report). http://www.pensionsmyndigheten.se/3573.html

The second yearly Orange report from the Swedish Pension Agency. Very similar in structure to the report for year 2009, but with updated information for 2010, including forecast scenarios of the system's balance, pension levels and replacement rates.

[R4] PPM, «Pensionsspararna och pensionärerna 2010», Rapport 1:2011. Stockholm: PPM, 2011.
https://secure.pensionsmyndigheten.se/3086.html

"The people who are saving for their pensions and the pensioners in 2010"

A report on the results for the individuals of their savings in the premium reserve part of the new pension system. One result is that the development differs greatly depending on the choice of funds. The report contains detailed statistics on the development of the values of the funds for different groups (according to age, gender, income, education) since the start of the system in 2000.

[R1] SCB, «Sveriges framtida befolkning 2010-2060», Stockholm: SCB, 2010.
http://www.scb.se/Statistik/BE/BE0401/2010I60/BE0401_2010I60_SM_BE18SM1001.pdf

"Sweden's future population 2010-2060"

This is a forecast made by Statistics Sweden on the development of the Swedish population from 2010 up to 2060. It underlines the significance of the ageing of the Swedish population. The number and share of the population being 65 years and older is increasing and the increase is even larger for those who are 80 years and older.

[R5] SOCIALDEPARTEMENTET, «Efter 65 – Inte bara Pension», Stockholm: Ds, 2011:42.

"After 65 – Not just Pensions"

This is a report made by the Social Affairs Department on the economic situation of the Swedish elderly population. It underlines that the number of those working past 65 is increasing, and reviews more in general the income sources of the elderly and how their incomes have developed in the past years.

[H] Health

[H1-H3] SOCIALSTYRELSEN, «Lägesrapport 2011 – Hälso- och sjukvård och socialtjänst». Stockholm: Socialstyrelsen, 2011.
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"Annual Report on Health Care and Social Services 2011."

Annual report by the National Board of Health and Welfare on the quality, availability and efficiency of health care and social services in Sweden. The report is based on extensive studies of different aspects of the Swedish health care system.

[H2-H3] STATENS FOLKHÄLSOINSTITUT, «Folkhälsopolitisk rapport 2010». Östersund: Statens Folkhälsoinstitut, 2010. http://www.fhi.se

"Report on Public Health Policy 2010".

Report on how health has developed in recent years and the future challenges of public health. The report describes different measures taken to tackle these challenges and how different actors can contribute to the public health of the future.

[H3-H5] SVERIGES KOMMUNER OCH LANDSTING, «Vårdbarometern». Stockholm: SKL, 2010. http://www.vardbarometern.nu.

"The Barometer of Care."

Recurrent report of public opinions on different aspects of health care by the Swedish Association of Local Communities and Regions.

[H1-H5] SVERIGES KOMMUNER OCH LANDSTING & SOCIALSTYRELSEN, «Öppna jämförelser av hälso- och sjukvårdens kvalitet och effektivitet – Jämförelser mellan landsting 2011». Stockholm: Sveriges KOmmuner och Landsting och Socialstyrelsen, 2011.
http://www.socialstyrelsen.se.

"Open comparisons of the quality and efficiency of health care – Comparisons between County Councils 2011"

Annual report containing a large number of comparisons of different aspects of health care, including its availability, quality and efficiency, in the different county and regional councils and also different hospitals in Sweden.

[L] Long-term care

[L] SOCIALSTYRELSEN, «Lägesrapport 2011 – Hälso- och sjukvård och socialtjänst». Stockholm: Socialstyrelsen, 2011. http://www.socialstyrelsen.se.

"Annual Report on Health Care and Social Services 2011."

Annual report by the National Board of Health and Welfare on the quality, availability and efficiency of health care and social services in Sweden. The report is based on extensive studies of different aspects of the Swedish system for health and long-term care.

[L] SVERIGES KOMMUNER OCH LANDSTING & SOCIALSTYRELSEN, «Öppna jämförelser 2011: Vård och omsorg om äldre», Stockholm: Sveriges Kommuner och Landsting och Socialstyrelsen, 2011. http://www.socialstyrelsen.se.

"Open comparisons 2011: Care and services for the elderly."

Annual report containing a large number of comparisons of different aspects of the care of the elderly, including its availability, quality and efficiency, in the different municipalities in Sweden.

[L] SOCIALSTYRELSEN, «Äldreguiden». Stockholm: Socialstyrelsen, 2010. http://socialstyrelsen.se/aldreguiden

"The elderly guide"

General information about home care, nursing homes and daily activities for elderly people in Sweden. The information can give guidance in connection with choice of elderly care and services.

List of Important Institutions

Ageing Research Center (ARC) at the Karolinska Institute and Stockholm University
Webpage: www.ki-su-arc.se
The primary goals of the ARC are to (a) carry out and support high-quality ageing research from a medical, psychological and social perspective; (b) advance multidisciplinary efforts in research on ageing; (c) offer graduate students a high-quality education in a stimulating environment; (d) foster collaboration with researchers who specialise in ageing in Sweden and abroad; (e) develop cross-links between available data sets; and (f) direct the acquired knowledge into interventions.

Akademikerförbundet SSR
Webpage: www.akademssr.se
Akademikerförbundet SSR is a union of university graduates whose members have a degree in economics, social science, social work or personnel management. The members can be found in all sectors of society. Twenty-five per cent of the professionals hold executive or managerial positions. The union consists of more than 300 local chapters and regional councils with one national office. The General Meeting is the supreme decision making body of the union and takes place every second year. The Executive Committee is supplemented in the professional domain by special Professional Councils.

AMF Pension
Webpage: www.amf.se
AMF Pension was established in 1973 to handle STP, a supplementary pension scheme for non-salaried employees in the private sector, later replaced by SAF-LO contractual pension plan. AMF is located in Stockholm. AMF is a limited liability life insurance company that is owned equally by the Confederation of Swedish Enterprise and the Swedish Trade Union Confederation (LO). The company is run according to mutual principles, entailing that AMF's profits accrue in their entirety to the policyholders. AMF's focus is on occupational pensions in both the retail and corporate markets, either as traditional life insurance or as unit-linked insurance. AMF has approximately 240 employees.

Centre for Health Equity Studies (CHESS)
Webpage: chess.su.se
At CHESS, junior and senior researchers from sociology, psychology and public health sciences work together on issues of health and inequality. CHESS is the result of long term collaboration between Stockholm University and Karolinska Institutet.

The Swedish Social Insurance Inspectorate (Inspektionen för socialförsäkringen (ISF)
Webpage: www.inspsf.se
The Swedish Social Insurance Inspectorate (Inspektionen för socialförsäkringen, ISF) is a new Swedish government agency, established on July 1, 2009. The ISF has been set up to provide an independent supervisory function for the Swedish social insurance administration. The objectives of the agency are to strengthen compliance with legislation and other statutes and to improve the efficiency of social insurance administration through system supervision and efficiency control.

The ISF is an authority under the Ministry of Health and Social Affairs and reports to the Minister for Social Security

KPA Pension
Webpage: www.kpa.se
KPA Pension has been handling pensions for municipal and county council staff since 1922. SPV is located in Stockholm. KPA now handles pension and insurance plans for more than one thousand employers and over one million employees.

Min Pension i Sverige AB
Webpate: www.minpension.se
Min pension is a public private partnership administered by the Swedish Insurance Association (Sveriges Försäkringsförbund) which aims to give at no cost for the individual a total view of their pension earned so far (including public, occupational and private) and the possibility to do individual pension forecasts.

Ministry of Employment
Webpage: www.sweden.gov.se/sb/d/8281/a/74023
The Ministry of Employment is concerned with matters concerning employment offices, implementation of labour market policies, adaptation of work and rehabilitation focusing on working life, as well as other labour market issues relating, among other things, to people with disabilities and unemployment benefit. Plus it is responsible for the EU employment strategy and the European Social Fund's programme in Sweden. Moreover the Ministry deals with tasks in the field of working life like issues relating to working hours, work environment, the organisation of work and labour legislation.

Ministry of Health and Social Affairs
Webpage: www.regeringen.se/sb/d/1474
The areas of responsibility of the Ministry of Health and Social Affairs concern basic welfare issues: financial security in the event of illness, in old age and for families with children, social services, health care and medical care, public health and children's rights, individual support for people with disabilities, and the coordination of the national disability policy. There are three ministers in the Ministry of Health and Social Affairs: the Minister for Health and Social Affairs, the Minister for Care of the Elderly and for Public Health and the Minister for Social Security.

National Board of Health and Welfare
Webpage: www.socialstyrelsen.se
The National Board of Health and Welfare is a government agency under the Ministry of Health and Social Affairs, with a very wide range of activities and many different duties within the fields of social services, health and medical services, environmental health, communicable disease prevention and control and epidemiology. The Government determines the policy guidelines. The majority of activities focus on staff, managers and decision makers in the above mentioned areas. The authority gives support, exerts influence and supervises in many different ways.

National Government Employee Pensions Board (SPV)
Webpage: www.spv.se/hem
SPV was established in 1963 and today is one of Sweden's largest providers of pension administration. SPV is located in Sundsvall, Sweden. SPV pays about 240 000 pensions each month at an annual value of SEK 15 billion. SPV has about 350 employees. Pension administration involves applying the rules of pension agreements and computing and paying the different components of the pension.

Nordic School of Public Health (NHV)
Webpage: www.nhv.se
The Nordic School is an institution for postgraduate education and research in public health. It belongs to the Nordic Council of Ministers and is based in Gothenburg. The Nordic School is a multidisciplinary institution with competency in medicine, psychology, social sciences and other related subject areas. Research is conducted in different fields related to public health, for example health promotion, health management and epidemiology. There is also research on global health, migration and health, mental health and universal design. NHV has a special role in following the developments in the Nordic health systems.

Pension Age Enquiry
Webpage: www.pensionsalderutredning.se
This is a website – blogg driven by the Pension Age Group, containing many resources on the question of extending working life for the elderly.Their own report will be uploaded here as soon as published in March 2012.

Stress Research Institute
Webpage: www.stressforskning.su.se
The Stress Research Institute is a national knowledge centre in the area of stress and health. The Institute is part of the Faculty of Social Sciences at Stockholm University and conducts basic and applied research on multidisciplinary and interdisciplinary methodological approaches. Their mission is to study how individuals and groups are affected by different social environments, with particular focus on stress reactions and health factors. The long-term objective of the research is to contribute to improved public health. The Institute was integrated on 1 October 2007 into Stockholm University.

Swedish Association of Local Authorities and Regions (SKL)
Webpage: www.skl.se
The SKL represents the governmental, professional and employer-related interests of Sweden's 290 municipalities, 18 county councils and two regions (Västra Götaland and Skåne). The association strives to promote and strengthen local self-government and the development of regional and local democracy. The operations of the Association are financed by the fees paid annually by members according to their tax base. SKL is an employer's organisation for municipalities, county councils and regions.

Swedish Council on Technology Assessment in Health Care (SBU)
Webpage: www.sbu.se
SBU conducts systematic reviews of research and research results to assess the evidence base of different methods and technologies of medical and health care. Scientific assessment in health

care aims to identify interventions that offer the greatest benefits for patients while utilising resources in the most efficient way.

Swedish Institute for Health Economics (IHE)
Webpage: http://www.ihe.se/start-2.aspx
The IHE is located in Lund, Sweden. IHE is a well-established non-profit research institute, specialised in health economic analysis, which contributes to sound decision-making in health-care and in bridging the gap between health economic research and various actors in the health care sector. IHE was the first centre for health economics research established in Sweden.

Swedish Institute for Social Research (SOFI)
Webpage: www.sofi.su.se
Research at SOFI is focused on four major areas where social institutions shape individual living conditions and life chances – institutions related to labour markets, welfare states, families, and gender. Their work is characterised by theoretically informed empirical analyses of questions having scientific as well as practical importance. Both economists and sociologists strive for international recognitions and competitiveness in their own disciplines. They submit their research to major journals and participate in leading international research networks within their disciplines.

Swedish Medical Association
Webpage: www.slf.se
The Swedish Medical Association is the union and professional organisation for medical practitioners. Important issues dealt with include doctors' work environment, salaries, working hours, training and research. The SMA also has a key role to play in influencing the development of health care in Sweden. Over 90% of Sweden's doctors belong to the SMA. The SMA enters into collective agreements on behalf of its members in areas such as general employment conditions, which includes salaries, working hours, holidays, sickness and parental leave and pensions.

Swedish National Institute of Public Health (SNIPH)
Webpage: www.fhi.se
The SNIPH is a state agency under the Ministry of Health and Social Affairs. The Institute works to promote health and prevent ill health and injury, especially for population groups most vulnerable to health risks. The three main functions of the Institute are: To monitor and coordinate the implementation of the national public health policy. To be a national centre of knowledge for the development and dissemination of methods and strategies in the field of public health, based on scientific evidence. To exercise supervision in the areas of alcohol, tobacco and illicit drugs. Since most public health activities in Sweden take place at the local and regional levels, the majority of the Institute's work is directed toward staff, managers and decision makers within municipalities, counties, regions and other organisations. The Institute lends support, exerts influence and supervises in the areas of health promotion and disease prevention.

Swedish Social Insurance Agency (Försakringskassan)

Webpage: www.forsakringskassan.se

The Social Insurance Agency provides financial security in the event of illness, disability and old age as well as for families with children. Social insurance is an important part of the Swedish social security system. The Swedish social insurance covers everyone who lives or works in Sweden. It provides financial protection for families and children, for persons with a disability and in connection with illness, work injury and old age.

The Swedish Pensions Agency (Pensionsmyndigheten)

Webpage: http://www.pensionsmyndigheten.se/

On 1 January 2010, Pensionsmyndigheten (the Swedish Pensions Agency) took over the responsibility for all national pensions. The purpose of this is to simplify administration and make things easier for pension savers and pensioners. All the administration concerning the national pension will be dealt with in one and the same place. In the new authority, it will be easier to find out about other parts of the national pension.

Vårdförbundet - Swedish Association of Health Professionals

Webpage: www.vardforbundet.se

Vårdförbundet is a trade union and professional organisation for registered nurses, midwives, biomedical scientists and radiographers. They also organise managers, teachers and researchers within their professions, as well as students training to qualify for any of the four professions. Vårdförbundet is not affiliated to a political party or to any governmental organisation

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(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en