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# Annual National Report 2011

# Pensions, Health Care and Long-term Care

# Sweden

May 2011

Authors: Elisa Baroni (pensions) and Runo Axelsson (health care and long-term care)

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# 1 Executive Summary

Sweden has witnessed a good economic recovery after the financial crisis and its key economic indicators project that this recovery will continue up to 2014. The government's commitment is to consolidate this positive trend through a growth program, which aims to sustain high levels of employment, good welfare and social inclusion.

The pension reform of 1995 is still very much cherished as an overall successful attempt in creating a long-term sustainable pension system. While the financial crisis has highlighted some potential shortcomings (e.g. large cohort inequalities in rates of return from the funded part of the system, the premium pension, as well as inequalities in the effects of balancing indexation between pensioners and workers), the policy debate does not emphasise any need for big changes, except looking into the possibility of rising the legal pension age as a way to improve future pension adequacy. In the latest National Reform Programme pensions are not directly in focus and no specific national targets are formulated.

This does not mean, however, that the system is free from challenges. First of all, whether or not the pension age will be eventually raised, an analysis of its effects on e.g. people on sickness or disability benefits or on very low incomes needs to be carried out. More generally, such a policy (meant to make people work longer) might be not as successful as it was hoped if other labor supply disincentives exist in the system as a whole. It might be argued, for instance, that people who have large gaps in their work history and who currently must wait until 65 to get the minimum guarantee pension, are not going to benefit so much in terms of a higher final replacement rate by having to wait longer. In fact, in its current design, any increase in income pension rights coming from two additional years in work might be offset by a lower minimum guaranteed pension so that the additional years in work "might not pay off". At the same time, those on higher incomes are going to be insensitive to this policy change and possibly to any other parametric change in the old age pension, since their behavior is most likely driven by other incentives, mostly in the occupational pension sphere. Further analysis is needed on how to minimise interference from early retirement schemes as well as early exit through sickness and disability benefits, in order to make people work longer. Another question is how to favour job mobility in old age given the high costs of employers for hiring older workers (e.g. in terms of higher occupational pension costs).

The quality of health and long-term care is generally high, but there are significant differences between different regions and different 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 accessibility and quality of care, for example by introducing open comparisons of the availability, quality and efficiency of both health and long-term care between different county and regional councils, municipalities, hospitals and nursing homes. The government has also tried to increase freedom of choice in the health care system, which they believe will lead to better access and quality of care. This strategy, however, is based more on political ideology than on scientific evidence.

# 2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2010 until May 2011

## 2.1 Overarching developments

In the field of pensions, the main development in 2010 was the use of balancing indexation for the first time. The balancing indexation was switched on as a result of the 2008 crisis (since it is applied with a two years lag), which back then had produced a 20% fall in the value of the buffer funds. This, together with lower income growth, meant that in 2010 income pensions were for the first time reduced by an average of -3%. This reduction, which was mainly shouldered by pensioners, did on aggregate reduce pension liabilities sufficiently to bring the balance ratio back above 1 by the end of 2010 (hence balancing is expected to be at least temporarily off by 2012).

When the economic and financial crisis hit in 2008, the pension system had already been reformed so as to remain financially sustainable vis-a-vis changing demographic and economic conditions. Thus, the financial crisis represented a first-time test, in that it led to the need, in 2010, to activate automatic balancing. Despite strong pressures, e.g. from the media and new elections in 2010, politicians remained largely united in their view that the pension reform (the so-called pension agreement) should not be reviewed. The decrease in income pension which occurred in 2010 thus occurred without any other correcting changes, e.g. to the benefit or contribution rules (if one excludes minor indexation adjustments and tax reductions), and without any major debate questioning the long term adequacy of pensions in the event of a new crisis, or the need to strengthen safety nets for the poorest groups. It might be worth noticing, however, that in early 2011 the new elected leader of the major opposition party, Håkan Juholt, vowed to reopen the debate on pensions in the future.

Another important development concerned the opening of a new state option within the premium pension system, i.e. a default portfolio (where risk is spread between equity and bonds depending on age) within the state managed generational fund (AP Såfa). Since May 2010 this fund collects the premium pension contributions of those who do not want to make an active fund choice or want to have the state managing them, given the historically good performance of the state alternative and the highly competitive fee. Furthermore, in light of problems stemming from the emergence of expensive advisory services and the related mass fund changes, new regulations were approved in early 2011 to prevent related negative externalities such as large transaction costs, reduced fund supply and higher fund fees.

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 on the regional level of the society are 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 6-9 larger regional councils in order to provide a better financial base and a more sustainable organisation of health care. The regional councils were supposed to be established through mergers between neighbouring county councils. However, in 2011 regional councils were established in one of the smaller county councils (Halland) and on the island of Gotland, which is only a small municipality. More regional councils are being established, but not so much by mergers. Instead it seems that many 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 may also have consequences for the quality of care, which may be very different in the different regional councils. To counteract such a development, the national government has

introduced open comparisons of quality and efficiency between different county and regional councils. The government has also taken an initiative to increase the freedom of choice in the health care system, which they believe will lead to better access and quality of care.

There have not been so many reforms in the field of long-term care during the last few years. The situation has been problematic for a long time due to the demographic development with an increasing number of elderly people. 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 resources and political majority. Many municipalities have invited private firms to establish nursing homes in addition to the municipal institutions for long-term care. The results have been mixed and there has been an infected public debate about bad conditions in private nursing homes. As a result, the national government has expanded the open comparisons of health care 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 new pension scheme was introduced 1999 on and become fully established from January 2003. It covers gradually retirees born from 1938 onwards, with those born from 1953 covered entirely by the new system and those born earlier receiving a mix of new and old (ATP) pension. That is to say, people born in 1938 receive 80% of their pension from the old ATP rules (a defined benefit system based on the 15 best earnings years and 30 years of contributions for a maximum pension), and 20% from the new system; people born in 1939, 75% from the ATP and 25% from the new system etc. This also means that until 2018 no pensioner in Sweden will have a pension entirely calculated from the new rules. As of today, Sweden's 1.8 million pensioners are receiving a benefit calculated to a larger or smaller extent on a mix of both old and 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) and partly PAYG (the income pension). The latter can be classified as a Notional Defined Contribution (NDC) system, in the sense that it mimics a funded system with a defined contribution paid regularly into the insured' personal account; in reality most of the insured' contributions (i.e. those set aside against the income pension) are not accumulated but used to pay pensions to current retirees. Individual accounts are thus "notional" i.e. accounting devices in which life time contributions are "earmarked" to eventually calculate the pension amount due at retirement. Only a small part of the contribution (set aside for the premium pension) is actually invested to finance the insured own future retirement benefit.

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 51,100 in 2010).[1] Employers pay 10.21% of the wage to the pension system regardless of the wage

[1] EUR 1 = SEK 9.68 on 20 May 2010.

level. The 17.21% (7.00+10.21) of earnings corresponds to 18.5% of the pension basis[2]. 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 contributions nor income pension are paid.

The income pension can be drawn at the earliest from the age of 61. A preliminary denominator is used to calculate the pension for those drawing a pension before the age of 65. This pension is adjusted when the person reaches the age of 65. There is no upper limit for when the pension must start to be drawn. In the previous system, the pension did not become higher if it started to be drawn after the age of 70 than if it was first drawn at the age of 70. The pension now becomes greater, the later it starts to be drawn. See Table 1 below for the development of the retirement age since the system was introduced. We clearly see that a larger proportion of both men and women retired after age 65 in 2007 compared to 2003, when the new system came into effect.

Table 1: Age distribution of men and women who were granted a new old age pension in 2003 and 2007

| **Age** | **2003** | | **2007** | |
|---|---|---|---|---|
| | **Women** | **Men** | **Women** | **Men** |
| **61-64** | 9 | 17 | 20 | 25 |
| **65**[1] | 86 | 78 | 68 | 59 |
| **Older than 65** | 5 | 5 | 12 | 16 |

[1]*Also included in this group are those who take out a pension the month after they become 65. Source: Försäkringskassan, "Ålderspension. In- och utflöden i pensionssystemet", Statistik 2007: 3.*

Upon retirement, the income pension entitlements that a person can obtain through the contributions paid are calculated every year in three steps. An upward adjustment is made through distribution of inheritance gains (i.e. pension rights for those who have died during the year); the pension balance is decreased by the costs of administering the pension being distributed among the insured; and the pension balance calculated in this way is adjusted by the general development of income with the aid of an income index. The income index is based on the average income for all who have had income during a year. 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.

[2] 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.

When the income pension starts to be paid, an annuity is calculated 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 these two factors: (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 (ii) the income pension is adjusted from the year it is drawn in line with the general income index growth, 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.

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 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. No projections are used to calculate such amounts.

The PAYG system counts as Contribution Assets the flow of current contributions into it, plus the discounted value of the expected contributions given the existing population; this is based on how many years of "sustainable" contributions the state can count on, given current income and mortality patterns, what is known as the expected turnover duration. This is, simply put, the number of years which, multiplied by the current annual contribution flow, would generate enough resources to sustain the system's PAYG liability prevailing at the time of measurement. The expected duration is currently set at 31.7 years (but is regularly recalculated), based on the average age at which contributions are paid and pensions disbursed. Additionally, 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.

The system's Pension Liabilities are accounted as the flow of expected future discounted pension payments given the present demographic structure, i.e. the total pension liability to those who are alive today and who have not yet started to draw their pension (based on the current value of their notional account) plus the remaining liability towards those who are already drawing their pension, based on current life expectancy by age (no projections are used).

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 = $BalanceRatio * IncomeIndex$ if Balance Ratio < 1

The balance index is in other words 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 (i.e. changes to the expected turnover duration), 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 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 2010 automatic balancing was for the first time turned on in Sweden and all pensions and accounts have been indexed by the 2008 balance index (see Table 7 below). This at first implied a sudden total drop in the average income pension of 4.5%. A change to smooth this sudden drop through using a three year average index was approved in 2010, entailing an average benefit reduction for 2010 of -3% instead (being split between -1,4% from balance indexation and the rest from the norm which requires pensions to be always indexed by income growth minus 1.6% ). The amount in pension disbursements saved by the balancing in 2010 is estimated to be 10,3 billion SEK. In 2011, the reduction due to balancing is even larger than in 2010 (-2,7%), which together with the effect of the 1.6% norm will lead to a -4,3% total reduction in average income pensions this year.

Results as of December 31, 2010 show that after two negative years (2008 and 2009) the balancing ratio for 2010 (affecting indexation in 2012) is finally rising back above 1 (more

precisely 1,0024). This mainly can be explained by the strong performance of the buffer funds (10.3% growth in 2010), as well as positive increase in the contribution flow paid in (3.3%), and increase in total assets in the system (3,9%). At the same time the total pension liability somewhat decreased (1.9%) thanks to balancing and fall in income index growth. Overall the system went from a deficit in 2009 of 323 billion SEK to a surplus of 103 billion SEK by the end of 2010.

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

| | *2008 (used in 2010)* | *2009 (used in 2011)* | *2010 ( Used in 2012)* |
|---|---|---|---|
| (a) Buffer Fund | 707 | 827 | 895 |
| (b)Contribution Assets | 6477 | 6362 | 6575 |
| (c)Pension Liabilities (incl. Administration costs) | 7428 | 7512 | 7367 |
| Pension Deficit ((a+b)-c) | -244 | -323 | 103 |
| Balance Ratio | 0.9672<br>0.9826 (with 3 years averaging) | 0.9549 | 1,0024 |

*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 2010 is SEK 7,526 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)[3]. The maximum amount is received by those who have no contributions nor

[3] This is a slight decline since 2009 due to a decline in the price index.

entitlment 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 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 the onsetting 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). In 2010, 46% of all retirees had some guarantee pension. In 2010, they effectively lost only between 0.9 and 3% in their public pension due to the somewhat compensating effect of the guarantee pension against the reduction in income pension due to balancing. Those 199,000 retirees for instance with an income pension up to 1.26 basic amounts have fully recuperated their loss through 100% matching in the guarantee pension[4]. Overall, since the poverty risk is highly associated to having some guarantee pension as part of one' s retirement income, this effectively means that the poor will have been affected much less by the balancing, if at all. The overall increase in guarantee pension due to balancing is estimated to be 511 million SEK in 2010.

Another effect which is produced by changes in the indexing of the ATP/ income pension is the meas-tested housing add-on benefit for pensioners. In 2010, 255,000 individuals have gained in higher housing benefit due to a lower pension income base (i.e. those who did not get full compensation of the balancing by the guarantee pension). This has reduced their average final loss to only 0.7%. Those with a housing benefit but without guarantee pension have witnessed a slightly higher loss of 2.2%.

In Table 3 below we report the final distribution of pension income losses due to balancing (including compensation from guarantee pension and housing benefit add-on).

Table 3: Distribution of Percentage Losses in 2010 monthly pension due to balancing effect

| *%* Loss due to Balancing | ***N. Pensioners Affected*** | ***Percentage*** |
|---|---|---|
| 0 | 199 000 | 10,9 |
| <0-minus 1 | 149 000 | 8,2 |
| minus 1-minus 3 | 419 000 | 22,9 |
| minus 4,5 | 1 058 000 | 58,0 |
| Total | 1 825 000 | 100,0 |

*Source: PensionsMyndigheten Försäkringsanalys 2009b*

It is also important to remember that already in 2009 the government had lowered income tax for pensioners (in the form of a higher tax deduction). More tax reductions have been passed in 2010 as a way to partly compensate for the balancing effect (as well as for equity reasons with workers, see next section). Thus, despite balancing, in 2011 pensioners with a monthly

[4] The minimum reduction of 0.9% was due to lowering of the price index.

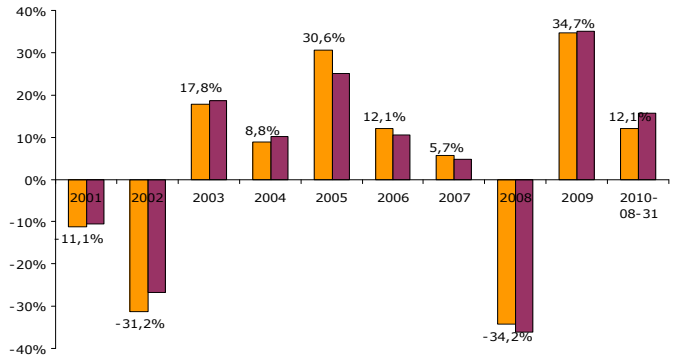
pension up to 16,000 SEK are expected to see an increase between 0.5 and 4% in their netto income (Försäkringsanalys 2009b).

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 by 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 2010, premium pension assets amounted to 414,593 million SEK; Around 26% of the total premium pension assets were invested in the state managed option. 2010 was again a good performance year for the premium pension system, as the increase in average premium pension fund value was 12.1%, with the state option slightly overperforming the average fund (purple column in the graph below). Since its inception, the system has been subject to two major financial crises which have made returns rather volatile.

Figure 1: Premium Pension Funds Performance since system started

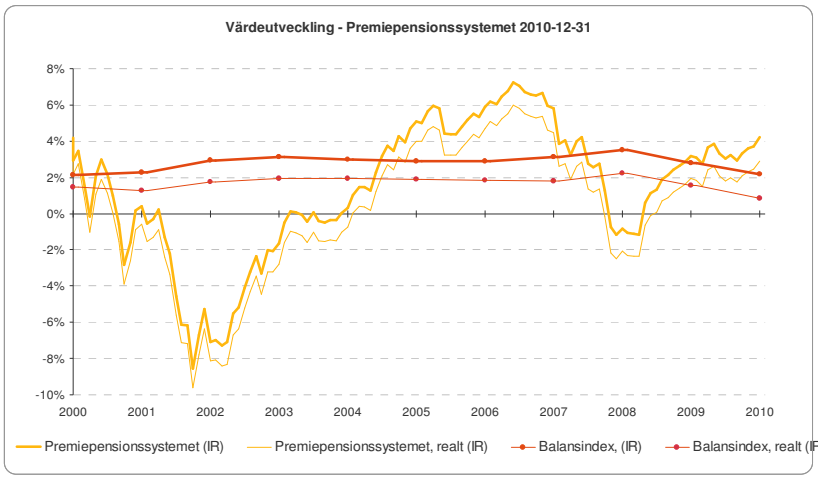



*Source: Swedish Pension Agency, http://www.pensionsmyndigheten.se/FondArsstatistik2010.html*

A major question when assessing the performance of the premium pension is whether it can overall fulfill its original purpose to provide a way to spread risks for individuals between developments in labor 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 on the next page 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/FondArsstatistik2010.html*

Despite two major crises, we see that by 2010 the premium pension had earned a yearly net nominal return of 4.2% compared to 2,2% earned by the income pension system. 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.

*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. 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 being DB (Defined Benefit) plans to entirely or mainly being 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 it becomes. Only the earlier system for white-collar workers in the private sector has an upper limit for which the pension must be taken out (70 years). 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.

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. Table 4 shows that the supplementary pensions' part of all pension incomes for men aged 65-69 increased from 20.3% in 1996 to 27.7% in 2007 and from 15.6 to 19.0% for women aged 65-69. The occupational pensions are becoming more and more important.

Table 4: Share of pension income according to forms of pension for those aged 65-69

| | ***The national pension system*** | | ***Occupational pensions*** | | ***Private pensions*** | |
|---|---|---|---|---|---|---|
| **Year** | Men | Women | Men | Women | Men | Women |
| **1996** | 74.4 | 80.6 | 20.3 | 15.6 | 5.3 | 3.8 |
| **2002** | 67.9 | 76.2 | 24.2 | 16.4 | 8.0 | 7.4 |
| **2006** | 64.0 | 72.1 | 27.7 | 19.0 | 8.1 | 8.9 |
| **2007** | 62.2 | 70.3 | 29.4 | 20.3 | 8.4 | 9.4 |

*Source: Calculations based on statistics (the HEK data base) from Statistics Sweden*

Table 5 summarises the main features of the different pension systems. As shown by the review, the agreement-based occupational pensions differ in various respects, but there are considerable similarities between the systems – similarities that have become greater with the changes undertaken in recent years. All four systems have changed in the same direction as the social insurance system, namely from a defined benefit to a defined contribution system. The schemes for blue-collar workers and white-collar workers in the private sector have gone furthest in this direction, being entirely defined contribution systems. In the central and local government systems, there are defined benefit parts for those above the ceiling in the social insurance scheme.

The DC-systems are actuarially fair and by that not redistributive. The DB parts in the government and municipal/county council sectors are financed by actuarially fair fees paid by the employer. If the fees are seen as a part of the wage by the employers and the employees and by that influence the wages set in negotiations, then the DB-parts are also non-redistributive.

The replacement rate is on 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.

Table 5: Decision form, DB or DC pensions, and coverage of occupational pensions

| *Occupational pension scheme* | *Decision form* | *Contribution* | *DB/DC* | *Coverage* |
|---|---|---|---|---|
| **Government employees** | Collective agreement | Fees | DC; partly DB for income parts over the ceiling for cohorts born before 1972 | All in the sector covered by collective agreements |
| **Employees in county councils and municipalities** | Collective agreement | Fees (DC) and public means (DB) | DC; partly DB for income parts over the ceiling | All in the sector covered by collective agreements |
| **White-collar workers in the private sector** | Collective agreement | Fees | DC | All in the sector covered by collective agreements |
| **Blue-collar workers in the private sector** | Collective agreement | Fees | DC | All in the sector covered by collective agreements |

*Source: own compilation*

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 thousands 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. Ather 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 Debates and political discourse

The present social security pension system was decided on by Parliament in 1994 and 1998 after an agreement with all four political parties forming the present coalition government and the present major opposition party, the Social Democratic Party. One aim of the reform was to gain the support of a large majority of the Parliament in order to achieve a prolonged and stable solution of the pension system also in the long run and in this way avoid political conflicts regarding the system later on. The pension system has however met some problems already before the present economic crisis and some of these problems have been aggravated during the crisis and some new ones have appeared. The main issues in 2010 / early 2011 are discussed below.

**Effects of balancing on income pension.** One intention behind the new income pension system is that it should be self-contained i.e. that no further political decisions should be necessary when it should become financially unsustainable. The ups and downs in the

economy should be handled authomatically by the funds in the system. If, together with expected payments of pension contributions, they are too low to cover expected payments of pensions, a balancing mechanism should take care of that problem and the pensions should be decreased to keep the balance (and the contribution rate fixed). The present crisis has led to a large decline in the value of the pension (AP) buffer funds in the social security system. The income pension should have declined, if no changes had been made, by about 4.5% in nominal terms in 2010. In 2009, a special pension group consisting of members from the five political parties, who supported the pension reform and who continually follow the development of the pension system, asked the Social Insurance Board to conduct a study of possibilities to soften the predicted reductions of the pensions in 2010. The Social Insurance Board presented a report in spring 2009 containing some different alternative solutions.[5] The special pension group declared that it prefered a solution with gradual changes in the balancing of the system (calculating the balance ratio over a three-year average). The Government put forward a proposal to the Parliament.[6] The value of smoothing out the variation (which also means that the pensions are reduced gradually during several years instead of more in just one year) has to be set against the value of having a more consistent system. The idea of gradual change was further developed by Pensionsmyndigheten (2010b). The new rules were included in SFS 2010:110 (Socialförsäkringsbalk) decided from March 4, 2010.

The first time striking of the automatic balancing in 2010 has led to rather few studies highlighting the possible effects that the so-called "brake" might actually have, at least theoretically, in the long term, what kind of labor supply effects it might generate as well as whether such a design hides potential equity problems between generations. A general reflection and call for re-evaluation of the system is given by Barr and Diamond (January 2011). In their paper the authors highlight how in the recovery part of the balancing there are actually potential gains to be made by workers (e.g. if they can increase their contributions by working more then) while pensioners cannot benefit in the same way by this feature.

**Taxes on wage incomes and pensions.** One of the main principles regarding income taxation in Sweden has been that labour income and pensions are taxed in the same way. The present Government (which came to power in 2006) has introduced a special deduction for those who are working with the intention to increase labour supply[7] and which goes against that principle. This change of the tax system has led to sharp criticism from the pensioners' organisations. Since 2009, pensioners have received a tax benefit in the form of a higher tax-free income ceiling. In the wake of the financial crisis and the on-setting of the automatic balancing, in May 2010 the Swedish Parliament decided to further lower taxes for pensioners too. This issue has also been much discussed in the September 2010 election debate. By the end of 2010, as a result of the tax change, most pensioners with some guarantee pension did not see any reduction in their net pension income (while both guarantee pension and income pension would have decreased). Those with only guarantee pension actually saw a net increase compared to 2009. On January 1, 2011 the re-elected Alliance government introduced an additional increase in the tax-free income allowance for communal tax. In 2011 people with only guarantee pension (for instance elderly women living alone) will receive a maximum tax reduction of 6-7% of their gross income per year. Better off pensioners will see

[5] Försäkringskassan (2009).

[6] See Regeringens proposition 2008/09:219, Utjämnat värde för buffertfonden vid beräkning av balanstalet.

[7] According to a recent study by Andersson (2009), the program does have the intended effect. The income effect of the deduction (leading to lower labour supply) is of about the same size as the substitution effect (leading to higher labour supply).

a reduction in their communal tax liability corresponding to 1,8 - 2,2% of their gross income. In the spring budget the new Alliance government pledged to increase the tax-free income limit even further for 2012 for pensioners to compensate them for continuing loss in income pension in 2011.

**Performance of premium pension system and introduction of new State Alternative.**The premium pension was introduced with the aim to spread risks between developments in the labor (affecting income pension growth) and capital markets. The financial crisis in 2008 led however to a large drop both in the income pension buffer funds (ca. -20%, with consequent innescation of the balancing index) as well as in the average funds available in the premium pension funds "market square" (ca. -34%). If beside this we consider any loss in the DC funds of the occupational insurance schemes and of the personal pension insurance, it is clear that those people who were close to retirement when the crisis hit will have likely incurred a loss on all fronts since they won't have time to recoup, nor be directly compensated for any losses (if not through tax relief).

Despite strong financial performance of the premium pension funds after the crisis (+34% in 2009 and +12.1% in 2010), and despite that by 2010 99% of pension savers had again a positive return on their premium pension account, the crisis has highlighted several problems with the current funded part of system: (i) as shown in Figure 2, the real internal rate of return of the system i.e. the real return on the average premium pension account since entering the system has been extremely volatite and by 2010 it had barely surpassed the rate of return on the risk free alternative (i.e. if income indexing had been applied to the same account). While a long time horizon is necessary to smooth out such volatility, it is clear that large differences will exist between people depending on when they enter and or exit it. Flexible withdrawal age can only partially offset these in-built differences (ii). Consequently it has emergered that the funded part of the public pension is subjet to large cohort inequalities, mostly deriving from timing / length of investment as well as individual portfolio choice. 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 2009, 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 6: Premium Pension Investor Activity, 2009

| N. Changes since entering PM | % Net Rate of Return | % of Savers |
|---|---|---|
| 0 (Default Option) | 3,8% | 42% |
| 0 (First choice only) | 3,3% | 43,2% |
| 1 | 3,5% | 21,1% |
| 2 to 10 | 3,7% | 22,7% |
| 11 to 20 | 4% | 6,3% |
| 21 to 50 | 5% | 5,9% |
| 50+ | 8% | 0,7% |

*Source: Premium Pension Pensionssparande och Pensionärerna 2009*

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 3.8%/, higher than the return obtained by those who have made a moderate number of changes. In 2010, the state option was fundamentally revisited, so that it now requires to be also actively chosen (at least upon entering the system). The default option is now a tailored made portfolio (where the individual can choose among three different risks levels) invested into a generational fund (AP Såfa), which essentially changes the portfolio composition according to age (from 55 it becomes a mix of equity and bonds, before it compounds only of bonds).

**Problem of Mass Fund Changes.** With nearly 800 funds available in Pensionsmyndigheten' s premium pension investment platform (so called "fondtorget" or funds market place), many have felt that the system is overly complex. A natural response to this complexity has been the rise of different types of "advisory services" which either sell financial advice or more likely act as managers of individuals premium pension accounts on behalf of an estimated 10% of pension savers (ca. 600,000 individuals). These "advisors" currently operate in a regulatory vacuum; they charge very high up-front fees (estimated between 500 and 1400 SEK a year, regardless of performance) for getting access to individual account details (i.e. pin codes) which they use to make random portfolio changes (i.e. not tailored to individual characteristics such as age or risk preference). Since 2007, the level of activity in the "fondtorget" has increased dramatically: from 2.5 to 4.6 million annual fund changes registered in 2010 by Pensionsmyndigheten (i.e. an increase of 160% ). Only in January 2011 the pension agency recorded 3,5 million orders for fund changes. It is estimated that at least 55% of these changes are done by "advisory" firms on behalf of their clients (through their pin codes); the way they usually operate is by planning "robot attacks" on the system, i.e. they use automatised programmes through which they change simultaneously funds for thousands of users. This is becoming known as the problem of "mass fund changes". These unforeseen attacks generate enormous strain on the administration of the system and rise transaction costs. Fund companies cannot 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 are being forced to increase their fees to meet increases in administration costs. In the short term it has been seen that the fund share prices are also negatively affected (see Dahlqvist et al. 2011). Thus the problem of mass fund changes becomes essentially one of large negative externalities which result in lower supply of funds, higher costs and possibly worse performance of the system, whereby all pension savers can potentially loose.

In December 2010 the government gave Pensionsmyndigheten the remit to investigate and propose solutions. In March 2011 Pensionsmyndigheten released a report which essentially proposed 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" as registered fund companies which trade in their own funds or in funds of funds). Based on this report in April 2011 the Government has opted for the hard option and outlaw these services. 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.

**The level of the guarantee pensions.** Those who have had low wages or who have not worked many years get a guarantee pension. The guarantee pension replaced the basic pension (*folkpensionen*) in the earlier pension system. The guarantee pension is tested against the income pension, being lower the higher the income pension becomes. The guarantee

pension is consumer price indexed and not, as the income pension, indexed to the growth of wages. This means that if there is a real wage growth in the long run, the guarantee pension will gradually become lower compared to the income pension. It is estimated that since 2000 the guarantee pension has lost 4.9% in cumulative growth compared to the income pension. The poorest pensioners will be gradually poorer compared to pensioners who get an income pension. Furthermore due to indexation rules alone even those pensioners who retire with an income pension around 60% of the median will fall to below 50% within 10-15 years into retirement (see Pensionsålder report page 32). Other reports (e.g. Klevmarken, 2010) confirm a likely increase in poverty rates by 2040 by ca. 14%. Predictions made for a number of countries show that given the present rules the income distribution among pensioners will gradually become more uneven in Sweden and more uneven in Sweden than in most other countries. It most likely means that there will be strong political pressure to enhance the guarantee pensions later on and that there will be political decisions on discrete increases of the pensions. Another way to solve this problem would be to change the indexing method for the guarantee pension, for example to use the same method as for the income pension.

**Pension Age.** 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). The proposal arises from the fact that longer life expectancy in Sweden will inevitably lead to a sizeable reduction in pension if not supplemented by an increase in the retirement age; someone born in 1990 will need to work until ca. 68 if they would want to retire with the same pension of someone born in 1930 (and retiring at 65). Older people (55-64) in Sweden have already one of the highest participation rates in Europe (70%), with one of the highest effective retirement ages (63.8). Yet despite that the pension age is flexible and upwards adjustments to the pension benefit exist for those postponing retiring after 65. Nearly 90% of those who are 65 today have already retired. The Pension Group will be looking into various options e.g. the possibility of 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). A report published by Pensionsmyndigheten (Pensionsåldern report, 2011) highlights some of the problems with raising e.g. 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 repercussion 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 krowns (see page 39 in the report). The report introduces possible solutions such as not giving extra pension rights to those who would receive sickness insurance past 65, or more simply to rather revise the lowest age for drawing the old age pension (currently 61). This could be rised to 62, 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.

**Incentives to Work Longer.** While the government has an ambition to promote "active ageing", it can be argued that the incentives to work past age 65 are not so strong in the public pension, particularly for the higher earners who are more likely to respond to incentives built in the second pillar provision.

More generally, despite upward adjustments in the benefit calculation for those retiring after 65, in the public system the income ceiling below which pension rights can be earned is fixed; effectively this means that the share of pensionable earnings decreases with age. As a larger share of earnings from an additional year in work at 65 will likely be above the pension ceiling, income pension rights gained then will compensate for a lower share of total income than they would have had at earlier ages. Occupational pensions would instead provide the stronger incentive to increase labour supply for older workers. In sum, despite actuarial adjustments, the new public system might not contain particularly strong incentives to work past 65, for both the better off (as they are unlikely to be able to substantially increase their public pension rights) and for the worse off (as any increase in income pension that they might earn could be offset by 100% or 48% withdrawal of the guarantee pension, as well as losses in the means tested housing benefit).

Incentives to work longer might come from the existence of part time pension arrangements. Sweden has had and still has different forms of part-time pensions. Part-time options exist in the old age pension and the disability pension schemes, but there has also been a special social insurance part-time pension system (which was stopped in 2000) and there are now occupational part-time pension schemes for those working in the public sector. A part-time pension system[8] may have different effects on labour supply. Lachowska, Sundén and Wadensjö (2008) have studied if the part-time pension system leads to an increase or decrease of the labour supply. They found that the labour supply increased somewhat, especially among women.

**Evaluation of Pensionsmyndigheten**. In January 2010 a new Pension Agency (Pensionsmyndigheten ) was introduced to handle all public pension benefits (incl. premium pension). The Swedish Insurance Inspection (ISF) should supervise the PPM system. An evaluation report of Pensionsmyndigheten first year was published by Inspektion för SocialFörsäkring in December 2010.

An important challenge for the Pension Agency will be to meet the information gap regarding pensions in their totality. As people are required to take more responsibility for their final pension outcome, an essential task for the new Agency will be to provide individuals with a clear and accessible view of what they have earned so far, at what costs, and how they can affect future amounts. At present the Agency is involved in a private-public initiative (www.minpension.se) which collects and brings under one roof all information of every individual on their total pension sources (including different occupational or private schemes). The project is expected to be nearly completed by the end of 2011.

### 2.2.3 Impact of EU social policies on the national level

The publication of the EU Green Paper on pensions was met by a number of responses by all major stakeholders including government agencies[9], trade unions and the financial industry.

In general, Sweden has responded positively to the big challenges highlighted by the Green Paper – e.g. the need to promote active ageing by establishing better incentives to work longer. This is shown by the recent focus of the Pension Group to study possibilities to raise the pension age. While the public system provides some incentives to work longer, it is aknowledged that in order to achieve this objective a coherent policy environment must be

[8] For a recent survey of part-time pension systems in a number of countries, see Kantarci and van Soest, 2008.

[9] See Pensionsmyndigheten s answers to the Green Book on https://secure.pensionsmyndigheten.se/download/18.3e1fabfa12c58e757cc800019647/2010-10-15%3A+Remissvar+gr%C3%B6nbok+om+pensioner.pdf.

created through taxes, contributions and pension rules which together make working more (and employ older workers) pay off.

Sweden strongly supports the OMC in the social policy area. It does not seem that EU policy is leading to any major revisitation of its national pension policies or strategies since these are seen to generally conform already with the principles highlighted in the Pension Green Book as well as within the Europe 2020 strategy. In terms of sustainability, Swedish pension expenditures will remain stable over time (around 9.5% of GDP in 2007 and in 2060). Pension adequacy issues are more critical for Sweden and are being adressed through promotion of active ageing (i.e. working longer) as well as active participation and choice in pension saving.

In line with such goals, the Swedish NRP 2011 clearly sets work for all who can at the heart of its reform programme for sustainable growth, sustainable welfare and social inclusion. At the same time the areas of social protection, and pensions in particular, are not directly in focus; no specific national targets - e.g. to reduce recently increased poverty risks among the elderly by a certain percentage – have been yet formulated. Furthermore, the NRP is unbalanced with respect to addressing support measures for e.g. those who have already retired and who can no longer affect their life long earnings. Current pensioners are not considered in the national reform strategy, although we know that they represent one of the groups with higher risks of poverty (especially women).

### 2.2.4 Impact assessment

This section aims to review the performance of the current Swedish pension system in terms of pension level (i.e. average pension benefit relative to the average income for people in age 16-64) and of the replacement rate (i.e. the size of the pension relative to pre-retirement income) offered to its current retirees[10], as well as those projected for future generations. Pension levels and replacement rates are measures of pension adequacy which are commonly used internationally. The chapter also assesses the impact of the system on gender inequality and on poverty.

When the Swedish Pension Reform was first formulated in 1994, pension levels and replacement rates were addressed (Government Bill 1993/94:250 pages 50 and 62-63). The importance to preserve similar pension levels to the old system was stressed, as well as similar replacement rates. A replacement rate between 55 and 65% for someone"working to a normal extent", given 2% real growth and certain other conditions was thus anticipated (for the public component of the pension). Recent data from the Pension Agency, the EC ECP and SPC indicators as well as independent research show that both measurements might be falling short of these goals for future generations. We will review pension levels and replacement rates in turns.

*Pension levels*

It is important to premise that there can be many "right" way to calculate the pension level (as well as the replacement rate), depending on e.g. over which samples of individuals the calculations are made, which income definition or income profile are used. In its "Orange Report" for 2010, the Pension Agency clarifes that its reported pension levels for instance (i) are defined in relation to average gross incomes for the 16-64 years old in order to reduce sensitivity to assumptions on the shape of the income profile function (ii) exclude from averages all those with fewer than 30 years of income amounting to at least one income-

[10] Retirees in 2009 were individuals born in 1948 or earlier.

related base amount at age 65 (iii) include only income insured in the pension system, that is only up 8.07 income-related base amounts. Ca. 11% of all pension qualifying incomes in Sweden exceed this amount. If these were included, the calculated pension levels should be reduced by ca. 10%. Indeed, the pension level as measured by the ECP-SPC is much lower and the drop over time more drastic than what is given by the Pension Agency (from 49.3% in 2007 to 30.1% in 2060. Overall, it is important to keep these methodological questions in mind when interpreting and comparing data.

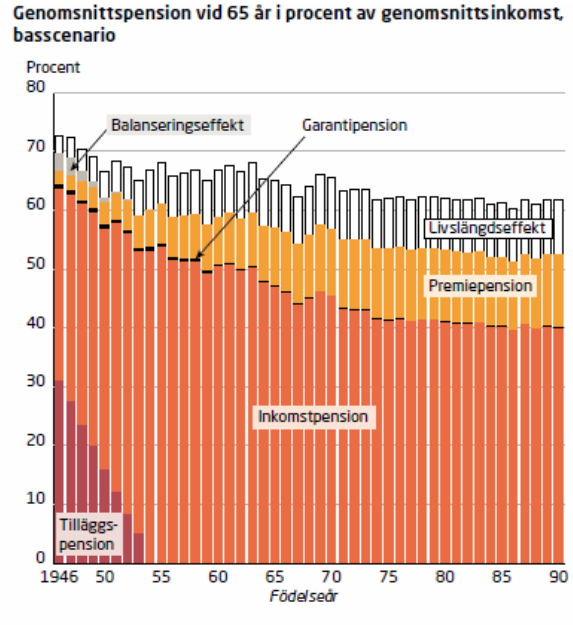
Generally, for the pension level to be constant over time it would be necessary that e.g. the number of workers and the number of retirees was constant, that time spent in active versus retired life was also constant, that the income and the pension bases grew at the same rate. Due to e.g. population aging, this is not possible. This means that there will be yearly variations in the position of the elderly relative to average living standards.

In the Orange Report 2010[11], a base scenario for current and projected pension levels was calculated, by birth cohort; this again represent the average pension received from someone retiring at age 65 in that cohort relative to the average income for someone age 16-64 in the same year. Key base assumptions incude an average return to the premium pension of 3.25%, and an average incomes growth rate of 1.8 percent. The most remarkable effect is the large drop between the pension level enjoyed by the older cohort (1946, which is 65 in 2011), namely 66%, and the projected pension levels for someone born in 1965 (57%) or for someone born in 1990 (52%), given the same years of work experience (40). A 2% decrease in the pension level every five years is attributed to expected changes in life expectancy between cohorts. The rest is due to losses from the old DB to the new DC system. Cohorts which retire entirely under the new system (post 1953) need to work longer to compensate for this drop; the retirement age of someone born in 1990 should be postponed to 68 years and 3 months just to compensate for the increases in life expectancy compared to someone born in 1930.

Furthermore, the generational drop in pension level will be affected by whether the balance is activated or not. The balancing activated in 2010 will affect the pension level at least for cohorts born between 1946-49, and the level of their pension will be roughly 3% lower than what it would have been relative to the average income (see Figure 3). This effect, however, in the base scenario will gradually disappear by 2020. From then on the balancing is expected to remain above one, due to demographic factors as well as buffer fund returns which are expected to be higher than the income index (defining fund outflows).

[11] Page 28-29

Figure 3: Average Pension Level by Birth Cohort, Base Scenario




*Source: Orange Report 2010, page 28.*

Alternative scenarios test the sensitivity of the pension level to different assumptions: optimistic assumptions (average yearly returns to the premium pension funds of 5.5% with 2% income growth) can compensate somewhat the effects of increasing life expectancy and deliver a higher pension level for younger cohorts 1970-1990 (up to 60%). Pessimistic assumptions (1% growth in in incomes as well as in returns to premium pensions) deliver a scenario instead where balancing would be on for the whole projection period, with a pension level of 68% for birth cohort 1944 but only 48% for birth cohort 1990. From these projections it emerges clearly that assumptions made about growth and returns to pension funds are crucial in actually determining the evolution of the pension levels and the size of inter-generational differences in this measure. Similarly, results will be affected by whether the brake is on or off and for how long. In the optimistic scenario the balance ratio remains well above 1 for the entire period while in the pessimistic scenario it oscillates constantly below or above one.

*Replacement rates*

Replacement rates generally measure to which extent someone´s first pension replaces their last earnings. Generally, the replacement rate is a function of the (assumed or observed) income trajectory (i.e. how incomes behave towards the end of one´s career), of the length of working life and of the retirement age, and of the pension benefit rules.

Sweden has today a replacement rate in line with the EU-27 average. The EPC-SPC Joint Country Report for Sweden reports a net theoretical replacement rate (TRR) for a male in 2008 of 65%, compared to an average of 66% across the EU. However Sweden is expected to witness one of the largest drops in these indicators by 2048 if the retirement age is kept constant. Extending working life beyond 65 should improve adequacy indicators, if only slightly. Although different projections show somewhat different numbers, all lie within the same region: by 2046 the ISG for instance reports an increase from a net TRR of 54.7% if retiring at 65 to one of 61% if retiring at 67[12]. The more recent 2010 EPC-SPC Country

[12] See ISG's Update of Current and Perspective Theoretical Replacement Rates for Sweden (2009), page 102.

Profile for Sweden[13] shows an increase from a lower TRR at 65 from 48.2% in 2008 to one of 53.8% at 67 by 2048. The latter source however also highlights that working longer will entail a larger drop in the net TRR relative to 2008 levels: from 76% in 2008 down to 53.8% in 2048 for someone working up to 67 (i.e. a drop of -22.2%), compared to a drop of "only" -16.8%, (from 65% in 2008 to 48.2% in 2048) if working up to age 65. In other words, in the future working past 65 might on average not pay off as much as it does today, when the pension benefit is still calculated as a mix of old and new rules.

More generally, as described for instance by Sherman (2006), a reduction in the replacement rate of the income pension for younger cohorts was to be fully anticipated in light of "transition" effects including primarily increases in life expectancy (reducing the annuity for younger cohorts), and fading out of the defined benefit ATP system. Some of this reduction should however be compensated by the "maturing" of the premium pension system: gradually retirees will have matured longer periods in the funded system (by 2050 retirees should have contributed to the funded system since the beginning of their career), hence getting a higher replacement rate from this source. Eventually, a full pension was conceived to be split in an ideal proportion of 87% from the income pension and 14% from the premium. In reality however, the extent of this compensation (and this compositional structure of the pension) is uncertain, and depends on many factors, in particular working years and real returns to pension savings. Testing the sensitivity of results to different assumptions about e.g. interest rates, career duration and earnings growth rates, is therefore crucial to get an idea of the intervals within which replacement rates might lie in the future. Another useful indicator is with this regard the distribution of the (net or gross) replacement rate given different income brackets (see Pensions At A Glance 2011, OECD, page 309).

Table 7 below reports data from the Pensionmyndigheten on the actual average replacement rates observed for cohorts 1939-1942 (from the public pension component only). These rates are calculated as the first public pension income relative to the five last income years before retirement. We already see that retirees born in 1942 enjoy a replacement rate which is nearly 6% lower than those born in 1939. These results are slightly higher than other estimates provided by independent research because of the assumptions made by Pensionmyndigheten.

Table 7: Average Replacement Rates of State Pension, cohorts 1939-1942

| Birth Year | Average Replacement Rate |
|---|---|
| 1939 | 75.8% |
| 1940 | 72.7% |
| 1941 | 71.1% |
| 1942 | 69.3% |

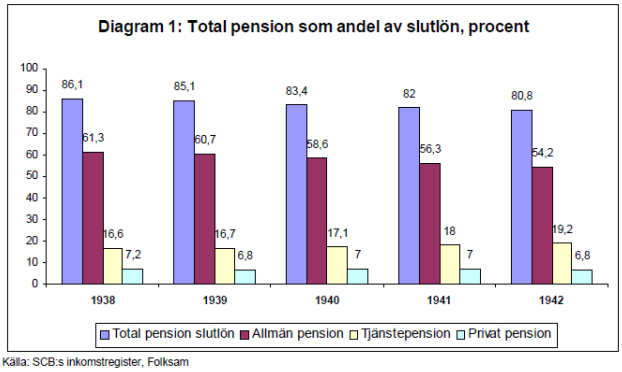
*Source: Pensionsmynidgheten (2010e)*

An independent analysis was published in 2010 for cohorts 1938-1942 by the insurance company Folksam (Svärdman, 2010), which looked at replacement rate relative to the last salary (rather than the last five years). Importantly, this analysis includes also incomes above the insurable amount when calculating the replacement rate, which is not included in the Pensionmyndighten calculations. As a result, the replacement rate from the public pension (61.3% for 1938) is roughly 10% less than what is calculated by the Pension Authority

[13] Ibid page 158.

(Figure 4). The total replacement rate is shown to drop as fast, by 7% for cohorts which are only 4 years apart, mainly due to sharp reductions in the public component of the pension, while the proportion coming from occupational pensions is slightly higher (from 16 to 19%).

Figure 4: Total Replacement Rates for cohort 1938-1942




*Source: Folksam Report 2010-12-09*

*Legend : Blue = Total Pension as % last salary ; Red = Public Pension as % of last salary ; Yellow = Occupational Pension as % last salary ; Green = Private pension as % last salary.*

To see how working generations will be affected when they retire, models needs to make several assumptions about their earnings and savings up to retirement. Flood (2003) as well as Flood, Klevmarken and Mitruut (2006) provide estimates of replacement rates based on a simulation model called SESIM. This gives a comprehensive account of the development of a range of factors for assessing the situation for pensioners with different earning histories and retirement ages. Flood (2003) considers the total replacement rate (including occupational and private pensions) for cohorts born between from 1940 to 1960 (retiring between 2005 and 2025), by income percentiles (i.e. lower than 25%, between 25% and 75% and above 75% in the income distribution). Results are shown in Table 8.

Table 8: Simulated Replacement Rates for Cohorts 1940-1960 (Flood, 2003)

| Cohort | Income class | Age of Retirement 65 | | Age of Retirement 67 | | Age of Retirement 63 | | High return 7% | | Low return 3% | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Age 65-69 (1) | Age 70-74 (2) | Age 67-71 (3) | Age 72-76 (4) | Age 63-67 (5) | Age 68-72 (6) | Age 65-69 (7) | Age 70-74 (8) | Age 65-69 (9) | Age 70-74 (10) |
| 1940 | < p25 | 102 | 104 | 111 | 112 | 97 | 100 | 109 | 107 | 104 | 100 |
| | p25-p75 | 83 | 76 | 88 | 81 | 83 | 73 | 85 | 76 | 82 | 73 |
| | > p75 | 78 | 68 | 83 | 72 | 76 | 63 | 82 | 71 | 77 | 64 |
| 1950 | < p25 | 86 | 82 | 88 | 86 | 77 | 74 | 93 | 88 | 81 | 76 |
| | p25-p75 | 77 | 65 | 81 | 69 | 69 | 61 | 83 | 73 | 74 | 65 |
| | > p75 | 71 | 58 | 79 | 66 | 69 | 56 | 77 | 63 | 70 | 55 |
| 1960 | < p25 | 77 | 70 | 85 | 77 | 69 | 66 | 86 | 79 | 70 | 63 |
| | p25-p75 | 74 | 63 | 76 | 66 | 67 | 56 | 84 | 73 | 65 | 55 |
| | > p75 | 69 | 55 | 76 | 62 | 65 | 52 | 78 | 64 | 66 | 54 |

**Note:** SESIM generated 1999 – 2041.
All individuals have worked at least five years before retirement and survived at least 10 years after.
Inflation ≈ 2%/year, real wage ≈ 2%/year and long interest rate 5%/year.

Flood's simulation shows that younger cohorts (born after 1953 and retiring entirely in the new system at age 65) will enjoy a lower total replacement rate on average (74% of earnings compared to 83% for those born after 1940), unless retirement age is delayed to 67, and returns on savings are very high (7%). In general, poorer individuals (those liying below the twentyfifth percentile) will always enjoy a higher replacement rate than those lying in the top percentiles of the income distribution, thanks to the higher coverage of guarantee pension and housing benefit. For low income earners the pension can often replace income above 100%.

Interestingly also, for all income groups the replacement rate drops further in older ages (above 70 years old) compared to the years immediately after retirement. Flood at al. (2006) indeed warn of the increased poverty risk for the very old associated to the new system.

In 2006, the Report by the Indicators Sub-Group (ISG) of the Social Protection Committee (SPC) provided an other alternative source of modelling the replacement rate for Sweden stemming from both public and occupational pension (ITP/ITPK) for individuals retiring at 65 in 2005 (born in 1940), 2010 (born in 1945), 2030 (born in 1965) and 2050 (born in 1985) after 40 years of work at the average wage, with reference to work income the year before retirement. The real rate of return on funds is assumed to be 3% and earnings growth at 1.8%.

Table 9: Simulated Replacement Rate for Cohort 1940-1985

| | *2005* | *2010* | *2030* | *2050* |
|---|---|---|---|---|
| Gross RR from public pension | 53 | 49.6 | 42.6 | 40.4 |
| Gross RR from occupational pension | 14.7 | 15.3 | 15.8 | 15.4 |
| Gross RR Total | 67.7 | 64.9 | 58.4 | 55.8 |
| Net RR Total (incl. housing benefit for pensioners) | 71.4 | 67.8 | 60.2 | 56.7 |

*Source: Current and Prospective Replacement Rates, Report by the Indicators Sub-Group (ISG) of the Social Protection Committee, page 120 (2006)*

Net replacement rates tend to confirm the other results. Younger workers (born after 1965) will receive ca. 10% lower replacement rate than older workers who retired at the same age. The same study shows the effects of rising working life by 2 years (retiring at 67 instead of 65): for someone born in 1940, this would increase the replacement rate from the public pension to from 53 to 64.8%, but for someone born in 1985 it will only rise it from 40.4 to 45.8%. In other words the youngest cohort will have to work up to 44 years to obtain a replacement rate close to what someone born in 1940 would get with working 40 years.

*Gender issues*

In Sweden, today we do observe a net gender difference in pension incomes and poverty rates. Retired women earn on average a pension which is 85% that of an equivalent male pensioner (SEB, 2007) but this ratio can be as low as 70% among low income groups (Normann, 2008). The poverty risk for elderly women is one of the highest in Europe, with 18% of over 65 women being poor against 9% of men (Zaidi, 2007). These inequalities are obviously matured in the course of the old pension system (pre-2003). Although female labour market participation is relatively high today (ca. 70%), we still observe differences between men and women indicating that certain inequalities coming from the working years might not yet disappear among future generations of retirees. Currently, around 35% of women still work part time, a much higher proportion than men. Also, the average time spent in the labour market is lower for women (ca. 37 years against 40 for men), the average wage is lower (84-92% that of a man with the same job) and the retirement age is earlier (61.6 for women against 62.3 for men). The same gender difference can be observed in the monthly average pension of existing cohorts of retirees (born 1937-1944), with women getting a median pension of ca. 8500 SEK against ca. 13,000 SEK for men (Försäkringsanalys, June 2009). Women in these cohorts get also a higher proportion of guarantee pension (60% ca. against 10% ca. of men).

The new Swedish public pension system is essentially insurance-based: while favoring labor supply, it might penalise relatively more those who have interrupted labor histories or low incomes (such as women). However, it also contains features which tend to favor women such as unisex annuitisation factors or a universal minimum guarantee pension. The funded component does not discriminate against women per se but gender differences might emerge in relation to possible differences in risk taking and investment behavior between the sexes.

Kruse, Ståhlberg and Sunden (2004), do a theoretical calculation of replacement rates by gender in the new system, looking at four main representative "types": (1) women who work full time over the whole life cycle; (2) women who work full time until the first child, part time afterwards; (3) women who work for a total of 10 years before getting married or having children; (4) women who work part time for their whole life. Table 10 below shows results as percentages of what a full time working man would get. Results are given in an interval for the low and highly educated respectively.

Table 10: Woman' s pension benefits as a percentage of a full time working man

| | *(1) Full Time* | *(2) Full Time / Part Time* | *(3) 10 years total* | *(4) Part Time* |
|---|---|---|---|---|
| Yearly State Pension | 80-100 | 80* | 35-40 | 60-70 |
| Replacement Rate | 100-120 | 100-120 | 120-145 | 100-125 |
| Return to Contributions Paid | 115-130 | 120* | 310-400 | 120-130 |

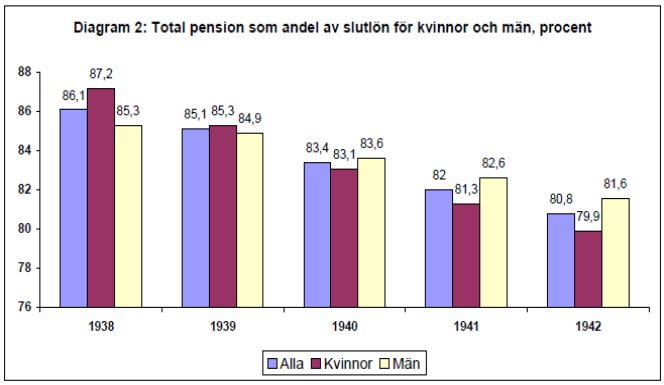
**No difference between low and highly educated*

*Source: Kruse, Ståhlberg and Sunden (2004), page 31*

On average, theoretically at least women get a lower pension than men; this difference is very large for those women who work less than full time and are low educated. However, their replacement rate and return to contributions can be higher than those for a full time working man (e.g. due to lower final earnings). Clearly women pay dearly career interruptions in terms of lost yearly pension relative to a full time working man, and family policies stimulating greater female labor supply e.g. in conjunction with child rearing might prove decisive for improving relative pension outcomes.

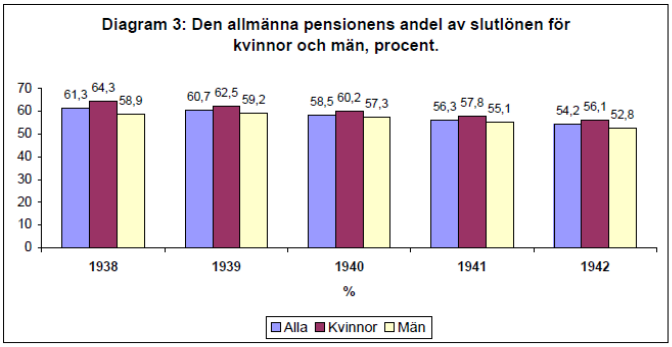
When looking at actual data on gender differences in replacement rates among current retirees (born between 1938 and 1942), the Folksam report (2010) shows how the old ATP compensated women better than men (thanks to the 15 best years rule) compared to the new system; the average replacement rate for a woman born in 1938 is higher than for a man, but this result is quickly reverted for a woman born in 1944 (see Figure 5a). In particular, the replacement rate offered by the public pension decreases by nearly 8% for a woman compared to 6% for a man over this period.

Figure 5 (a): Total Pension as percentage of final salary for men and women, cohort 1938-1942




Källa: SCB:s inkomstregister, Folksam

Figure 5 (b): Public Pension as percentage of final salary for men and women, cohort 1938-1942




Källa: SCB:s inkomstregister, Folksam

*Source: Folksam (2008). Legend: Blue = All; Red = Women; Yellow = Men.*

Gender differences in monthly pensions are expected to rise for younger cohorts (Folksam, 2008), particularly for white collar workers: women born in the 1970s are expected to get a (total) replacement rate which is 62% of their last salary compared to men in the same category (66%). This difference is again attributed to shorter careers and worse wage progression even in the same job. In general, occupational pensions for private sector employees offer conditions which reward women less than public sector contracts (e.g. due to higher life expectancy for women).

When it comes to gender differences in premium pension, current pensioners share is almost non-existent (since the funded part was introduced only in 1995). Premium pension will start to play a bigger role after the 1953 cohort start to retire (and even then it will amount to only a few percentages of the total pension). A full premium pension will only mature for cohorts born from 1985 onwards. Gender differences in this source of pension can already be observed in the way contributions are made by the sexes. In 2009, men had on average 12,100 SEK more in the premium pension account (the average value being 66,900 SEK for men and 54,800 SEK for women). The average total account growth in 2009 was also higher for men (31.8) then for women (30.3%), although the average yearly growth since 1995 has been rather equal at around 3.6-3.7% (Premiepensionmyndigheten, 2009). Overall, women tend to have lower risk portfolios then men.

*Poverty impact*

Sweden's relative poverty rates for the elderly (over 65) had decreased between 2000 and 2005 but have actually increased again since 2005. Yet, despite the crisis by 2009 they still had remained below the EU-15 level according to Eurostat data (18% against 19.5%). The relative poverty risk of elderly males has increased from 6.6% in 2005 to 9% in 2008 and 10.4% in 2009. The relative poverty risk of elderly females has increased from 14.9% in 2005 to 20.4% in 2008 and 24% by 2009, well above the European average. This development is partly a consequence of the developments of the net median income over time of the over 65 relative to that of 16-64 years old, as the ratio went slightly down from 78.3% in 2005 to 74.4% in 2009 (Eurostat data). This means that more elderly have fallen behind the poverty line since 2005 as their net median incomes have grown more slowly than those of working age people. This also implies that the pension system has not compensated the median pensioner enough to keep up with developments in the income of the median worker.

Looking at pension income sources, it is mainly receipt of the guarantee pension (indexed to prices) which determines whether a pensioner's income will fall behind the rest (and possibly behind the poverty line)[14]. Differential growth rates of pension indexation between income pensions (indexed to incomes) and guarantee pensions (indexed to prices) can also explain growing inequality among pensioners, in so far as those with pension guarantee will loose out from general growth in living standards, especially in periods when real income growth will be higher; the larger the share of guarantee pension in one´ s total, the greater the falling behind. As of 2010, fewer pensioners had some guarantee pension (41%) compared to 2005 (51%), i.e. the proportion has decreased in relative terms (somewhat less in absolute terms). The share of individuals with only guarantee pension has also decreased (14.4% of the total in 2010 compared to 19% in 2005).

While it is expected that the share of people on the guarantee pension will continue to decrease over time (as e.g future retirees will supposedly gain higher pension rights through e.g. higher education and coverage levels), other forces coming from possible negative developments on the income pension side (e.g. more frequent strikes of the automatic balancing mechanism due to lower than expected growth or poor performance in the capital markets) might also imply higher reliance on this source[15].

When looking at indicators of severe material deprivation the proportion of elderly (over 65) in this case is lower than for the population at large, and rather stable since 2004 (0.7%), down to 0.5% in 2009. Women report a slightly higher yearly level than men, but it still remain low.

[14] The maximum guarantee amount for both couples and singles (average ca 700 Euros per month) lies in fact below the poverty line (ca 1000 Euros per month in 2010, according to author´ s calculations), and those who have no or little other sources on top of the guarantee pension (e.g. income pension or housing benefit) will be thus considered poor. Housing benefit is means tested and the maximum amount (ca 250 Euros a month for a single pensioner) would not be sufficient to raise a pensioner with the maximum guarantee pension out of poverty.

[15] In 2010, for instance, those 199000 people who had both guarantee and income pension with 100% withdrawal (25% of total) got fully compensated for the automatic reduction in income pension through a 100% increase in guarantee pension, amounting to ca 61 million Euros (excluding adjustments to the housing benefit).

Table 11: Context Indicators for Sweden

| **Tackling poverty in old age: context indicators** | | |
|---|---|---|
| **Policy (sub-)area** | **Indicator** | |
| Adequate income support in old age | Aggregate replacement ratio *(excluding other social benefits)* | 0.61 (2007) |
| | Median relative income of elderly people (65+) | 0.78 (2007) |
| | Change in Theoretical replacement rates | -13% |
| | Impact of social transfers (including pensions) in reducing poverty[16] | -13.9% (2009)[17] |
| Sustainable pensions | Current and Projected change in pensions expenditure (public and total) 2006-2050 | 0,6% of GDP |

### 2.2.5 Critical assessment of reforms, discussions and research carried out

The Swedish experience of pension reform, albeit still short-lived, offers already several interesting points for reflection. The ambition of the reform is to create a pension system which can achieve greater financial stability thanks to e.g. the automatic balancing feature and its linkages to life expectancy changes (hence has chances to survive long term to demographic aging), while delivering income adequacy (thanks to a universal minimum guarantee which compensates the poorest for any negative adjustment), and also some degree of intergenerational fairness (at least in normal circumstances, by anchoring the growth of pensions to that of work incomes). The reform also was meant to give individuals more control of their own pension outcome by making the funded part compulsory, thus leaving people some freedom to decide how to invest a small part of their pension contributions. Initial data however highlight how the system is not completely shielded against negative surprises, particularly highlighted by the recent financial crisis.

Choosing an automatic balancing mechanism implies that pensioners will get the hit (in terms of benefit reduction) in adverse times; workers will also be affected in the growth of their saving accounts but will most likely have the chance to make up for the temporary loss e.g. by working more (if they are not too close to retirement). The automatic feature of the system is meant to reduce political tensions around who should pay when the hard moments come. The challenge however is to stick to the rules in these moments. The Swedish experience in 2010 has shown that this is easier said than done, as for instance strong political pressures to partly deviate from the initial indexation rule have ultimately won, potentially undermining confidence in the system, despite the existence of measures to minimise the impact of the automatic balancing, particularly on the poorest pensioners. This is not to criticise the decision to change a parameter but rather to say that the system is not as "automatic" as it is

[16] The indicator for the poverty risk before social transfers (excluding pensions) must be interpreted with caution for a number of reasons. First, no account is taken of other measures that can have the effect of raising the disposable income of households and individuals, namely transfers in kind, tax credits and tax allowances. Second, the pre-transfer poverty risk is compared to the post-transfer risk with all other things being equal, namely assuming unchanged household and labour market structures, disregarding any possible behavioural changes that the absence of social transfers might entail.

[17] This is the poverty reduction impact calculated as the difference between poverty risk excluding all social transfers (40.5%) and excluding social transfers but including pensions. (see http://epp.eurostat.ec.europa.eu/portal/page/portal/income_social_inclusion_living_conditions/data/database).

supposed to be. Given that political pressures to reduce taxes for pensioners have been also implemented in 2010 and again in 2011, a policy of benefit reduction in times of financial distress – which would be in the spirit of the new pension system - has therefore ultimately not been successfully implemented in Sweden.

More generally, the system has been designed to deliver a pension level and replacement rates with assumptions which might not hold in reality: working at least 40 years for instance is not "normal", but a political ambition (Sherman 2006). Once the transitional generations will have disappeared, demographic and economic pressures might surface again to threaten public finances (e.g. reductions in the contribution base) and balancing might thus become the norm rather than the exception. In this (rather underplayed) scenario, guaranteeing an "adequate" pension to future pensioners might prove challenging, unless an older minimum retirement age or increases in the fixed contribution rate were to be introduced. Incentivising people to work (even) longer remains an important question for Sweden, as well as promoting more research on the effects that the new system actually has on labor supply (e.g. what are the labor supply effects of balancing?). At the other end of the spectrum, considering the increasing age of graduation from tertiary education in Sweden, and the government´s commitment to increase the number of people with higher education by 2020, opens the question whether a stronger life-cycle perspective should be shaping policy, i.e. an approach where every stage of the life cycle, from education upwards, is made to be coherent with the objectives of a better and more secure retirement.

Furthermore, the recent financial crisis has highlighted that the system, or at least its funded part, might be overly complicated and not sufficiently regulated. With nearly 800 funds to choose from within the premium pension, the rapid increase in expensive "advisory" services, creating negative externalities for the whole insured collective, has highlighted the importance to set more resources on better financial information and better regulation. It has also highlighted the possibility of growing inequality in the system, and the problems linked to let individual's freedom, as they might not always make the best financial choices. In this respect the role of the state fund option and of a "soft" paternalism is regaining ground and might be one of the next issues for debate.

## 2.3 Health Care

### 2.3.1 The system's characteristics and reforms

In international comparisons the Swedish health care system is often described as a Beveridge system, although it was developed long before the Beveridge report in 1942 proposed a National Health Service in the UK. In fact, the Swedish health care system was developed already in the middle of the 1800s. Moreover, the Swedish system has never been a national health system. From 1862 the county councils on the regional level of the society have been responsible for the financing as well as the provision of most health services in the country, while the national government has had mainly a supervisory role.

When the county councils were established they took over the responsibility for the somatic hospitals from the local municipalities. The national government was responsible for the mental hospitals and for primary health care, but these responsibilities were decentralised to the county councils in the 1960s. The aim was to create an integrated health care system at the regional level of the society. In 1967 the county councils were responsible for all the different branches of health care. This system was changed in 1992, when the responsibility for care of the elderly was further decentralised from the regional to the local level, in order to achieve a better integration with the municipal social services. For the same reason, in 1996 the

responsibility for care of the disabled and long-term psychiatric care was also decentralised from the county councils to the municipalities.[18]

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 can 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 expenditures for health care. The national government contributed only 2% of the total expenditures in the form of state grants that were earmarked for special purposes.[19]

The dominant and independent position of the county councils means that the characteristics and reforms of the Swedish health care 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. There are also 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.[20] 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 the 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 better financial base and a more sustainable organisation on the regional level. The regional councils were supposed to be established through mergers between neighbouring county councils.[21] 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.[22] More regional councils are being established, but not so many by mergers. Instead it seems that many county councils are just changing their names to regional councils.

[18] Axelsson, R., "The organizational pendulum – Health care management in Sweden 1865-1998". *Scandinavian Journal of Public Health*, 2000, vol. 28(4), pp. 47-53.
[19] National Board of Health and Welfare, *Annual Report on Health Care and Social Services 2011* (in Swedish), Stockholm: Socialstyrelsen, 2011. Available at http://www.socialstyrelsen.se/publikationer2011/2011-2-1.
[20] Statistics Sweden, Population database 2010, http://www.scb.se/Pages/TableAndChart_308469.aspx.
[21] SOU 2007:10, "Sustainable organisation of society with development power. Final report of the Responsibility Committee" (in Swedish). Stockholm: Finansdepartementet, 2007. Available at http://www.regeringen.se.
[22] Statistics Sweden, Population database 2010, http://www.scb.se/Pages/TableAndChart_308469.aspx.

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 responsibility of the county and regional councils for the provision of health care is established.[23] The law also confirms the independent position of the county and regional councils regarding the organisation of the health services. In spite of their independence, however, the National Board of Health and Welfare is supervising the quality and safety of health care provided by the county and regional councils.

Due to different local conditions, the county and regional councils have chosen different organisational structures.[24] 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 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 83 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. [25]

*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 2009 about 90% of the total expenditures of the county and regional councils, and 29% of the total municipal expenditures, were related to health care.[26] As a percentage of the GDP, the total health care expenditures in Sweden are now on an average level (9.4%) compared with other EU countries.[27] They used to be on a higher level in the beginning of the 1990s, but have been decreased and stabilised during the past two decades, mainly as a result of cost containment measures taken by the county councils and regions.[28]

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 hospitals that are run by private companies but financed to a great deal 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.[29] In 2008 came a Law on System of Choice with the aim to facilitate the

[23] SFS 1982:763, "Health and Medical Services Act" (in Swedish). Stockholm: Socialdepartementet, 1982.
[24] 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/web/Landsting.aspx.
[25] Swedish Association of Local Communities and Regions, Health care database 2011, http://sjvdata.skl.se/.
[26] Swedish Association of Local Communities and Regions, "Costs and revenues 2009" (in Swedish), http://www.skl.se/web/kostnader_och_intakter.aspx.
[27] OECD Health Data 2010, http://stats.oecd.org/index.aspx?DatasetCode=HEALTH (accessed in April 2011).
[28] European Observatory on Health Systems and Policies, *Health Systems in Transition: Sweden*. Copenhagen: World Health Organisation, 2005. Available at http://www.euro.who.int/Document/E88669.pdf.
[29] Government Offices of Sweden, "Health and medical care in Sweden", 2007. Available at http://www.sweden.gov.se.

contracting of private providers and to encourage competition in the public sector.[30] The number of private providers varies however between different county and regional councils. This seems to be 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. 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 surgeries, but there are also group practices. In 2005, the private expenditures on health care amounted to 18.3% of the total health care expenditures, but that figure also included patient fees to the county and regional councils.[31] 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.[32]

*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.[33] 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 market models or returned to a more traditional administrative organisation.[34]

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. The county and regional councils may have their own models for accreditation of private providers and for reimbursement of public as well as private

[30] SFS 2008:962, "Law on System of Choice" (in Swedish). Stockholm: Socialdepartementet, 2008.
[31] WHO Statistical Information System (WHOSIS), Core health indicators 2008, http://apps.who.int/whosis/database/core/core_select.cfm (accessed in April 2011).
[32] Swedish Association for Local Communities and Regions, Costs and revenues 2009 (in Swedish), http://www.skl.se/web/kostnader_och_intakter.aspx.
[33] Hallin, B. & Siverbo, S., *Control and Organising in Health Care* (in Swedish). Lund: Studentlitteratur, 2003.
[34] 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/web/Landsting.aspx.

providers, but the rights of the patients to choose their providers of primary health care will be laid down in an addition to the Health and Medical Services Act.[35]

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 hospitals with financial or other problems, so privatisation has been regarded as an alternative to closing them down.[36] 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.[37]

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.[38] 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.[39]

*Provisions of the system*

The Swedish health care system is providing a wide range of health services. 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 the 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 highly specialised regional hospitals, which are also university hospitals. In these hospitals there is also a lot of research, teaching and training, but they still belong 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 also one of the best

[35] SOU 2008:37, "Free patient choice of health care in Sweden. Report from the Committee on Patient Rights" (in Swedish). Stockholm: Socialdepartementet, 2008. Available at http://www.regeringen.se.
[36] 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.
[37] 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.
[38] Edgren, L. & Stenberg, G., *The Faces of Local Health Care* (in Swedish). Lund: Studentlitteratur, 2006.
[39] 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, March 2011. http://www.ijic.org

in the world.[40] 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 government has taken several initiatives to deal with these problems, for example by issuing a national guarantee for care within a certain period of time and by offering patients a free choice of hospitals and other health care providers.[41] These initiatives have, however, 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 results are published by the Swedish Association for Local Communities and Regions together with the National Board of Health and Medical Care. From 2011 a new agency for health care analysis has also been established for this purpose. The comparisons have shown significant differences between different county and regional councils, but also between different hospitals.[42]

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 less 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.[43] These experiments have resulted in a Law on Financial Co-ordination of Rehabilitation Measures, which is an important part of the same strategy.[44]

### 2.3.2 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 the mass media. However, the political debate on health care is not as intensive as the public debate. This may be due to the Swedish political tradition of

[40] WHO Statistical Information System (WHOSIS), Core health indicators 2008, http://apps.who.int/whosis/database/core/core_select.cfm (accessed in April 2011).

[41] SOU 2008:127, "The patient's right. Some proposals to strengthen the position of the patient" (in Swedish). Stockholm: Socialdepartementet. Available at http://www.sweden.gov.se.

[42] Swedish Association of Local Communities and Regions & National Board of Health and Welfare, *Open Comparisons of the Quality and Efficiency of Health Care in Sweden*. Stockholm: Socialstyrelsen, 2010. Available at http://www.socialstyrelsen.se/publikationer2010/2010-11-9.

[43] Andersson, J., Axelsson, R., Axelsson, S. B., Eriksson, A. & Ahgren, B., "Collaboration in vocational rehabilitation. A systematic review of knowledge and experiences in the field" (in Swedish). Stockholm: Nationella Rådet för Finansiell Samordning, 2010.

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

compromise and consensus, but it may also be due to the fact that the health care issues are not 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".[45] Studies have shown, however, that many sick-listed people have been forced out on the labor 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.[46]

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 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.[47]

Another issue, which has 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 to stop profit making private companies from running hospitals, the so-called stop law.[48] When the present liberal-conservative coalition government came to power in 2006 this regulation was immediately abolished.[49] The discussion on privatisation in health care has continued and it is still one of the most controversial issues. Surprisingly, however, all the political parties have largely agreed on the new system of free choice of providers for patients in primary health care, although this system is expected to increase the number of private providers.[50]

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[45] Government Offices of Sweden, "Swedish National Reform Programme 2011". Stockholm: Regeringskansliet, 2011.

[46] Ministry of Health and Social Affairs, "Proposals to improve the sickness insurance" (in Swedish). Memorandum, April 2011. Available at http://www.sweden.gov.se/sb/d/14510.

47 SOU 2007:10, "Sustainable organisation of society with development power. Final report of the Responsibility Committee" (in Swedish). Stockholm: Finansdepartementet, 2007. Available at http://www.regeringen.se.

[48] Prop. 2004/05:145, "Forms of management of publicly financed hospitals". Stockholm: Socialdepartementet, 2005. Available at http://www.sweden.gov.se.

[49] Prop. 2006/07:52, "Forms of management of hospitals" (in Swedish). Stockholm: Socialdepartementet, 2007. Available at http://www.sweden.gov.se.

[50] SOU 2008:37, "Free patient choice. Report from the Committee on Patient Rights" (in Swedish). Stockholm: Socialdepartementet, 2008. Available at http://www.regeringen.se.

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. However, 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 state should take over the responsibility for health care from the county and regional councils in the same way as it has happened in Norway.[51] Others have argued for a European health market where the Swedish patients can choose the best possible health care.[52]

### 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 indifferent 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.[53]

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 for the county and regional councils, the Swedish national reform programme (NRP) has been focusing mainly on other fields of development like employment, education, poverty reduction and pensions.

As mentioned before, there have been some discussions about the open comparisons of quality and efficiency in the Swedish health care system, but not any discussion about the OMC on the European level. There seems to be no impact of the Europe 2020 strategy on the Swedish debates on health care reforms, and there is very little written about health policy in the Swedish NRP. This may be due to the fact that the national government is not very much involved in health policy. Concerning the access and quality problems in health and long-term care, the NRP is referring to "major initiatives" to increase accessibility, freedom of choice and quality of care.[54] It is obvious that the government believes that increasing the freedom of choice through competition and privatisation will lead to better access and quality of care. This belief is however based on political ideology rather than scientific evidence.

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[51] European Observatory on Health Systems and Policies, *Health Systems in Transition: Norway*. Copenhagen: World Health Organization, 2006. Available at http://www.euro.who.int/Document/E88821.pdf.

[52] *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.skl.se/web/Vardbarometern_2_1.aspx.

[53] Swedish Association of Local Authorities and Regions, "EU in local politics – A study of agendas from municipalities, county councils and regions". Stockholm: SKL, 2010. Available at http://www.skl.se.

[54] Government Offices of Sweden, "Swedish National Reform Programme 2011". Stockholm: Regeringskansliet, 2011.

### 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 in the labour market after the financial crisis. At the same time, the health care expenditures are 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.[55]

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.[56] The open comparisons of the quality and efficiency of health care in 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.[57] 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 in Sweden.

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.[58] There are also 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 etc.[59] 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. Evaluation and assessment is an important part of this research. Different parts of the health system have been evaluated, for example local health care and intersectoral collaboration in vocational rehabilitation.[60]

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[55] 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.

[56] Swedish Association of Local Communities and Regions, Health care database, http://sjvdata.skl.se.

[57] Swedish Association of Local Communities and Regions & National Board of Health and Welfare, *Quality and Efficiency in Swedish Health Care*. Stockholm: Socialstyrelsen, 2010. Available at http://www.socialstyrelsen.se/publikationer2010/2010-11-9.

[58] National Board of Health and Welfare, *Annual Report on Health Care and Social Services 2011* (in Swedish). Stockholm: Socialstyrelsen, 2011. Available at http://www.socialstyrelsen.se/publikationer 2011/2011-2-1.

[59] Swedish Council on Technology Assessment in Health Care, http://www.sbu.se/sv/Publicerat.

[60] Ahgren, B. & Axelsson, R., "Evaluating integrated health care: A model for measurement". *International Journal of Integrated Care*, 2005, vol 5, http://www.ijic.org ;Ahgren, B., Axelsson, S. B. & Axelsson, R., "Evaluating intersectoral collaboration: A model for assessment by service users". *International Journal of Integrated Care*, 2009, vol. 9, http://www.ijic.org.

Unfortunately, there have been very few evaluations of the internal markets in the Swedish county and regional councils.[61] 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. 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 as a whole can be described as a system with high performance and quality. The health status of the Swedish population is also 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 and 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 a national guarantee for care within a certain period of time. The new system of free choice for patients in primary health care is also expected to improve the access to health services by increasing the number of private providers. However, there is a risk that these providers will establish their practices mainly in the big cities, which may increase 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.[62] The question is if it will be enough to calm down the public dissatisfaction with the differences in health care. The question is also whether a reduction of regional differences will lead to an improvement in the quality of health care, or just an adaption to an average quality level.

[61] 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.

[62] 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 **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 decreased 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.[63] The larger regional councils are expected to provide a better financial base and a more sustainable organisation of health care. There are indications, however, that the mergers of county councils into regional councils may be a long and difficult process.

## 2.4 Long-term Care

### 2.4.1 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 and other developments related to the financial situation of the municipalities, there has been a restructuring of long-term care during the past 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 of the elderly. Since the municipalities are financing most of their services through municipal taxes, they are quite independent of the national government. This means that they can 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).[64] This means that there are financial as well as social and demographic differences, but also different political majorities. This means that the municipalities may set 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.[65] 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.

As mentioned before, Sweden has an ageing population. 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

[63] European Commission, Joint reports on social protection and social inclusion 2009: Sweden (in Swedish), http://ec.europa.eu/employment_social/spsi/joint_reports_en.htm.
[64] Statistics Sweden, Population database 2010, http://www.scb.se/Pages/TableAndChart____308469.aspx.
[65] SFS 2001:453, "Social Service Act" (in Swedish). Stockholm: Socialdepartementet, 2001.

increasing.[66] 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.[67] 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.[68]

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 an increased 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.[69] 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 and financed by the municipalities. Moreover, nearly 11% of the home services granted to elderly people in 2007 were provided by private companies.[70] 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.[71] 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.

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.[72] 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, however, 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.[73]

### 2.4.2 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

[66] Colombo et al, Help Wanted? Providing and Paying for Long-Term Care. Paris: OECD, 2011.
[67] Swedish Association of Local Communities and Regions, "Costs and revenues 2009" (in Swedish), http://www.skl.se/web/kostnader_och_intakter.aspx.
[68] Colombo et al, Help Wanted? Providing and Paying for Long-Term Care. Paris: OECD, 2011.
[69] SOU 2004:68, "Integrated home care" (in Swedish). Stockholm: Socialdepartementet, 2004. Available at http://www.sweden.gov.se/sb/d/189/a/26584.
[70] 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
[71] SFS 2008:962, "Law on System of Choice" (in Swedish). Stockholm: Socialdepartementet, 2008.
[72] Ds 2008:18, "Support to relatives who take care of family members" (in Swedish). Stockholm: Socialdepartementet, 2008. Available at http://www.regeringen.se/content/1/c6/10/24/99/a1f0e833.pdf.
[73] SFS 2009:549, "Law on Amendment in the Social Service Act". Stockholm: Socialdepartementet, 2009.

physical or mental disabilities. Moreover, with the present demographic development, there will be an increasing number of elderly people in Sweden with a longer and longer life expectancy. This means an ageing population where more and 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 and 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 accomodation.[74]

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.[75] There have been many reports in the mass media of old people who have been treated badly 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. These reports 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.[76] Thus, the care of the elderly remains one of the most important topics in the political debate.

### 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, but there is also some influence from the exchange of ideas and best practice that is taking place within the EU.[77]

As mentioned above, there have been some discussions in the municipalities as well as on the national level on the quality of long-term care in different institutions, but there have not been any discussions on the OMC on the EU level. There seems to be no impact of the Europe 2020 strategy on the Swedish debate and there is very little written about long-term care in the Swedish NRP. In the same way as concerning health care, the NRP is referring to initiatives to increase freedom of choice in elderly care, for example through incentive funds for

[74] 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.

[75] 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.

[76] SOU 2008:51, "A life in dignity for people in elderly care" (in Swedish). Stockholm: Socialdepartementet, 2008. Available at http://www.regeringen.se/sb/d/10057/a/106288.

[77] Swedish Association of Local Authorities and Regions, "EU in local politics – A study of agendas from municipalities, county councils and regions". Stockholm: SKL, 2010. Available at http://www.skl.se.

municipalities that want to introduce free choice systems.[78] The government is convinced that increasing the freedom of choice will lead to better quality of care. It remains to be seen.

### 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.[79] The National Board of Health and Welfare is following 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.[80]

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 care of 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 by 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 elderly care.[81]

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.[82] 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.[83] 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.[84] 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.[85]

### 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

[78] European Commission, "Swedish National Reform Programme", 2011.
[79] Swedish Association of Local Communities and Regions, 2010, http://www.kommundatabas.se/.
[80] National Board of Health and Welfare, *"The Elderly Guide"* (in Swedish), 2011. http://www.aldreguiden.socialstyrelsen.se/
[81] Swedish Association of Local Communities and Regions & National Board of Health and Welfare, *Open Comparisons 2010: Elderly Care*. Stockholm: SKL, 2010. Available at http://brs.skl.se/brsbibl/kata_documents/doc39863_1.pdf.
[82] National Board of Health and Welfare, 2009, *Annual Report on Health Care 2009* (in Swedish), Stockholm: Socialstyrelsen, 2009. Available at http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/8496/2009-126-72_rev2.pdf.
[83] National Board of Health and Welfare, *National Quality Indicators for Care of Elderly Persons* (in Swedish). Stockholm: Socialstyrelsen, 2010. Available at http://socialstyrelsen.se/publikationer2009/2009-126-111
[84] Swedish Council on Technology Assessment in Health Care, http://www.sbu.se/sv/Publicerat/
[85] Relevant publications can be found at http://www.ki-su-arc.se/.

needs and conditions, but there are also significant differences between the municipalities both in the resources available and in the 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 privatisation and introduction of free choice for the elderly.[86] However, at the same time, there is a growing suspicion of private providers of care for the elderly as a result of reports in 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 government is hoping that the ongoing development of statistical information and the publication of open comparisons will reduce these differences.[87] Maybe at the same time it will also help the municipalities to locate and get rid of bad 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 for elderly care. The question is also whether a reduction of regional differences 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 of the elderly are expected to rise because of the ageing population. According to the national government, however, the society will hopefully be able to finance its commitment to health and social services for the elderly through "sound public finances and a high rate of employment".[88] 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.[89]

[86] 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.
[87] European Commission, Joint reports on social protection and social inclusion 2009: Sweden (in Swedish), http://ec.europa.eu/employment_social/spsi/joint_reports_en.htm.
[88] 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.
[89] Colombo et al, Help Wanted? Providing and Paying for Long-*Term Care.* Paris: OECD, 2011.

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# 3 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 Pensionsmyndigheten. 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.

**[R2]** PPM, «Årsredovisning för Premiepensionsmyndigheten avseende år 2009», Stockholm: PPM, 2010.

https://secure.pensionsmyndigheten.se/download/18.6f80d11e1268eba4ef480006697/%C3%85rsredovisning+PPM+2009.pdf

*"Yearly report regarding the PPM pension authority for 2009"*

This is the final annual report from the PPM agency covering 2009. The PPM agency became part of the new Pensionsmyndigheten from January 2010. The report stresses that a large part of the losses in the pension funds in 2008 due to the stock market development has been recovered in 2009.

**[R4]** PPM, «Pensionsspararna och pensionärerna 2009», Rapport 1:2010. Stockholm: PPM, 2010.

https://secure.pensionsmyndigheten.se/3086.html

*"The people who are saving for their pensions and the pensioners in 2009"*

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.

**[R3]** SPV, «Statens Pensionsverks Årsredovisning år 2009», Sundsvall: SPV, 2010.

http://www.spv.se/NR/rdonlyres/8BE2B4C1-9C10-41E9-916C-91F4E2A09B0E/0/SPVarsredovisning2009.pdf

*"Yearly report from SPV regarding 2009"*

This is the annual report from the National Government Employee Pensions Board, the organisation that is responsible for the pensions of those employed by the national government. It contains information on the collective agreements regarding pensions.

**[R3]** SPV, «Pensionsavgångar inom statsförvaltningen 2009», Sundsvall: SPV, 2010.

"*Leaving employment with a pension among those employed by the central government in 2009"*

This is a study of the number and composition of newly granted pensions for those employed by the national government. It shows that a larger part of those becoming 65 years of age gradually continue to work. The number of state employees who retire later than the month they became 65 is larger than the number who retire the month they became 65 (the standard retirement age) for the first time ever in 2009.

**[H] Health**

**[H1-H3]** SOCIALSTYRELSEN, «Lägesrapport 2011 – Hälso- och sjukvård och socialtjänst». Stockholm: Socialstyrelsen, 2011.

http://www.socialstyrelsen.se/publikationer 2011/2011-2-1.

*"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,H4]** SVERIGES KOMMUNER OCH LANDSTING**,** "EU in local politics – a study of agendas from municipalities, county councils and regions". Stockholm: SKL, 2010. http://www.skl.se.

A report written for the Swedish Association of Local Communities and Regions by a political scientist from Lund University. The report examines the influence of the European Union on Swedish municipalities, county councils and regions.

**[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 2010». Stockholm: SKL, 2010.

http://www.socialstyrelsen.se/publikationer2010/2010-11-09.

*"Open comparisons of the quality and efficiency of health care"*

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, «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.

**[L]** SVERIGES KOMMUNER OCH LANDSTING, «Öppna jämförelser 2010: Vård och omsorg om äldre», Stockholm: SKL, 2010.

http://brs.skl.se/brsbibl/kata_documents/doc39863_1.pdf.

*"Open comparisons of the care of the elderl."*

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.

# 4 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.*

**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.*

**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 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*

**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 or religious group.*

This publication is financed by the European Community Programme for Employment and Social Solidarity (2007-2013). This programme was established to support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Lisbon Strategy goals in these fields. The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries. The Programme has six general objectives. These are:

(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