Annual National Report 2010

Pensions, Health and Long-term Care

Sweden

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On behalf of the
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1 Executive Summary

Most European countries, including Sweden, have an ageing population. The costs of the welfare state increase with the old-age share, leading to problems for public finances. If the number of hours worked increase, tax revenues increase and less income transfers are paid out. A higher retirement age is one way to increase the numbers of hours worked in the economy. The age at which people leave the labour market has risen in Sweden since the mid 1990s as in many other countries. The social insurance pension system decided upon in the 1990s is part of the explanation, but improved health as well as changes in the educational level of the cohorts close to retirement are also important.

The new pension system is presented in the report, including, due to their high relevance, supplementary occupational pensions. The occupational pension systems (there are four major ones) have all been changed as a response to the alterations in the social insurance pension system. There may be space for more changes in the pension system and the rules regulating employment and other income transfers for older workers.

Health care and long-term care, as considered with an international perspective, are of high quality in Sweden, but the ageing population leads to an increased demand for these services. Studies also show that there are large differences between different county councils, regions and municipalities regarding availability and quality of the services provided.

The implications of the economic crisis are discussed in the report. They have been much discussed during the past two years. As far as pensions are concerned, the main discussion is how to avoid a large dip in the pension levels in 2010, while in health care and long-term care the discussion reflects mainly on the fact that a deterioration of the finances of county councils and regions (health care) and municipalities (care of the elderly) may lead to reduced quality. In political discussions prior to the elections, this year the taxation of pensions compared to labour income has also been in focus.

2 Current Status, Reforms as well as the Political and Scientific Discourse during the previous Year

In most economically developed countries the share of the population being of active age is declining. The share being in active age declines both due to low fertility and due to that people are living longer. A larger part of a cohort reaches 65 years of age than before and those who reach that age have more remaining years than earlier cohorts. The average length of life has been gradually increasing for a long time. First it increased mainly due to a decline in child mortality, later mainly due to a decline in mortality among those of active age and now mainly by that people who reach retirement age have more remaining years. See SCB (2010) for a forecast of the future reductions of the mortality rates in Sweden. This development is expected to continue. The fertility rate is stable and the average length of life is expected to rise in Sweden as in other countries. Statistics Sweden's forecast shows that it is likely that the number of people over active age per person of active age will increase from ca. 0.3 in 2004 to more than 0.5 in 2030. The number of young people (below active age), will be unchanged at ca. 0.5 per person of active age. This year the number of people who is 80 years and older are 494 000, they will be close to 800 000 in 2030 and close to one million in 2060. The population aged 65 years or older will be of the same size as the population below 20 in 2030 and larger than that population thereafter.

An ageing population leads to increased demand for health care, old age care and pensions. The costs of the welfare state increase with the old age share. If increased tax rates and lower standards in the public sector services (health care and old age care but also other parts of the public sector such as education) or lower replacement rates in the income transfer programmes are excluded, the number of hours worked in the economy has to increase. An increased number of hours worked leads to higher taxable incomes and to that more taxes are paid to the public sector.

Several ways for increasing the number of hours worked in the economy have been put forward. The most important ones are: 1) an increase of the number of hours worked for those employed, for example by that some who work part-time (mainly women) start to work full-time instead, 2) a more rapid transition from education to the labour market; for many young people it takes several years after completed education before they are fully established in the labour market, 3) an increase in employment among groups with low employment rates such as people with disabilities and refugee immigrants, 4) an increased labour immigration and 5) a higher (real) retirement age.

For many years labour force participation and employment declined among older people in Sweden and in other countries. To some extent this could be explained by a decrease in the formal retirement age (the age at which a full pension is granted) and higher pensions, but labour force participation and employment declined also among those in the age group below the formal pension age. The employment decline in this age group (older active age) is to a high extent related to business cycle variations and to possibilities to get an income transfer below the age for an old age pension. More people lose their jobs in downturns of the economy and in many countries special programmes were introduced or existing programmes changed making it easier to get an income transfer. The intention was in many cases to facilitate for young people to establish themselves on the labour market. The policy failed: Young people did not get jobs to a higher extent, the older workers did not return to the labour market in the succeeding upswing period, and a social norm of early retirement was

established. In Sweden, this development towards early retirement did not go as far as in many other countries. Sweden belongs to a group of late exit countries together with Iceland, Japan, Norway, Switzerland and the USA.

The development towards a lower real (and in some cases also lower formal) retirement age ended in the 1990s. The change was partially a result of policy changes. In several countries the lowest possible age for taking up an old age pension was raised, early exit options were closed or made less attractive. The result has also been clear tendencies to a higher real retirement age in many countries. There have been political complications as changes in the pension schemes are politically sensitive. Proposals and decisions of changes in the pension system have many times been met with demonstrations and other forms of protest in several countries.

Table 1 shows the development of the share in the labour force among those aged 55-64 in a number of OECD-countries between 1994 and 2008. Included in the table are the Nordic countries and some countries that often have been mentioned in the Swedish political debate. We have chosen one year in the mid-1990s as the labour force participation was lowest then in most countries.

Table 1: Labour force participation 1994 and 2008 among men and women aged 55-64

Country	Men		Women	
	1994	2008	1994	2008
Denmark	63.8	65.8	43.1	52.8
Finland	43.9	60.5	38.9	59.0
Iceland	95.9	90.9	80.5	78.1
Norway	71.5	75.0	55.4	64.9
Sweden	70.5	76.7	62.6	69.3
Austria	41.3	52.8	18.4	31.6
France	42.1	42.6	30.1	37.7
Germany	53.1	67.2	28.3	50.6
Netherlands	41.8	62.7	18.5	42.5
Switzerland	82.9	78.9	47.2	61.6
United Kingdom	64.0	70.1	40.7	50.0
USA	65.5	70.4	48.9	59.1
Canada	59.5	67.2	36.9	54.6
Japan	85.0	85.1	48.1	53.1

Source: OECD (2009).

If we study labour force participation among women aged 55-64 we find that it increased considerably between 1994 and 2008. The increase in labour force participation among women started earlier among young women and they have continued to work as they have become older.

Labour force participation has also increased among men aged 55-64 in the same period. The exceptions are Iceland, Switzerland and Japan, countries with very high labour force participation among older men already 1994 and which still have high participation rates compared with other countries even if the labour force participation has declined somewhat in Iceland and Switzerland and remained on the same level in Japan.

We shall turn to the development in Sweden and do so by using the Labour force surveys from 1990 to 2008. For men the decline in labour force participation is very strong between 1990 and 1995 (a period of economic crisis) both for those aged 55-64 and for those younger than 55. See Table 2. From 1995 the share of all of active age being in the labour force is more or less constant. There is, however, a slight increase among those aged 55-59 and a large increase among those aged 60-64.

Table 2: Labour force participation (%) 1990-2009 in Sweden among men aged 55-64 years

Age	1990	1995	2000	2004	2006	2007	2008	2009
55-59	87.4	82.2	83.9	83.8	84.9	85.2	86.7	87.6
60	74.2	71.6	73.7	76.1	78.9	78.8	77.6	83.6
61	70.9	64.9	66.5	72.5	71.6	76.3	73.0	76.6
62	65.9	55.9	57.4	66.1	67.1	68.4	71.0	70.1
63	58.0	51.3	43.6	58.9	58.0	63.0	62.8	62.7
64	48.8	41.9	38.0	48.2	52.1	51.2	53.2	53.9
16-64	87.0	80.2	80.2	79.7	81.3	82.9	83.1	82.7

Source: Labour force surveys, SCB.

The development of labour force participation among women is more or less the same as that for men (see Table 3). The increase in labour force participation between 1995 and 2008 among those aged 60-64 is more or less the same for women as for men.

Table 3: Labour force participation (%) 1990-2009 in Sweden among women aged 55-64 years

Age	1990	1995	2000	2004	2006	2007	2008	2009
55-59	78.8	77.3	79.1	79.4	79.9	80.2	80.6	81.6
60	69.0	65.7	67.1	69.9	70.2	72.2	72.1	73.5
61	62.2	59.5	58.7	67.0	65.8	65.2	66.4	67.6
62	54.5	48.6	52.1	58.0	59.7	59.1	60.2	60.7

63	46.7	37.7	35.1	49.3	51.1	52.5	50.0	52.0
64	37.3	31.2	25.2	40.7	40.7	46.0	44.4	42.9
16-64	82.6	76.1	75.5	75.7	76.1	78.2	78.2	77.7

Source: Labour force surveys, SCB.

It is also of interest to study labour force participation among those who are 65 or older. One way to do this is to look at labour force participation in one-year intervals from the age of 60 to 69. We do that for three years: 2006, 2007 and 2008.

Table 4: Labour force participation (%) in Sweden 2006-2009 among those aged 60-70 years

	2006	2007	2008	2009	2006	2007	2008	2009
Age	Men				Women			
60	78.9	78.8	77.6	83.6	70.2	72.2	72.1	73.5
61	71.6	76.3	73.0	76.6	65.8	65.2	66.4	67.6
62	67.1	68.4	71.0	70.1	59.7	59.1	60.2	60.7
63	58.0	63.0	62.8	62.7	51.1	52.5	50.0	52.0
64	52.1	51.2	53.2	53.9	40.7	46.0	44.4	42.9
65	22.5	28.9	29.1	28.7	18.6	17.3	19.1	20.5
66	17.2	21.0	29.0	24.7	11.9	13.9	14.5	17.7
67	16.1	15.5	19.1	21.0	10.3	10.1	11.3	10.2
68	18.6	15.7	18.7	15.7	5.5	7.4	10.9	9.2
69	8.0	15.6	12.5	18.6	4.6	6.7	6.4	7.9

Source: Labour force surveys, SCB.

We find that there is a large difference in labour force participation among those aged 64 and those aged 65. It shows the importance of the traditional pension age of 65. The drop in participation is hardly possible to explain by for example a sudden deterioration in health status when becoming 65. In spite of that the pension age is flexible in the income pension system (61 is the minimum pension age) and that people from 2003 on are covered by the law on job security (LAS)[1] until they reach the age of 67, many still see 65 as the age of retirement. However, labour force participation has increased among those aged 65 and 66, especially among men. The development from a retirement age of 65 to a retirement age of 67 is especially strong in the state sector (see Table 5).

Table 5 shows that the number who take up a pension later than 65 in the state sector has much increased since mandatory retirement was forbidden from 2003 for those below 67 years of age. The large increase in the number of women being granted an old age pension aged 60-64 is explained by that the social security administration became a part of the state sector in 2005. Most of those working in that administration are women and they had an

[1] See Lag (SFS 1982:80) om anställningsskydd.

agreement of a right to early old age pension. Of central government employees who were born in 1944 and who had a formal retirement age of 65, 80% were still working at the end of 2009.[2]

Table 5: The number of newly granted old age pensions for men and women employed in the state sector 2002, 2005 and 2007

Sex and age	2002	2005	2007	2009
Men				
55-59 years	438	146	26	8
60-64 years	536	529	699	593
65 years (taking up pension the month becoming 65)	667	631	839	798
Older than 65 years	153	494	671	974
All	1794	1800	2235	2373
Women				
55-59 years	1	4	4	0
60-64 years	208	433	988	651
65 years (taking up pension the month becoming 65)	589	672	858	904
Older than 65 years	61	378	572	797
All	859	1487	2422	2352

Source: SPV (2010).

2.1 Pensions

2.1.1 The Swedish Pension System

Public Pensions

The Parliament decided in June 1994 on the principles of a new public pension system. The new pension scheme was gradually introduced in 1999 and entered fully into force in January 2003. It covers retirees born from 1938 onwards, with those born after 1952 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 earning years and 30 years of contributions for a maximum pension), and 20% from the new system; people born in 1939 obtain 75% from the ATP and 25% from the new system etc. This also means that until 2015, 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 smaller or larger extent based on a mix of both old and new rules.

[2] See SPV (2009).

The table below summarises the distribution of Swedish retirees (by age of retirement and birth year):

Table 6: Percentages of Swedish Retirees by Age of Retirement and Birth Year

Birth year	**61**	**62**	**63**	**64**	**65**	**66**	**67**	**68**	**69**	**70**
1938	3,7	2,3	2,3	2,1	77,4	4,0	3,2	0,8	0,3	0,3
1939	4,0	1,9	2,1	2,3	75,8	6,3	2,3	0,8	0,3	
1940	3,1	2,2	2,5	3,2	76,1	4,9	2,5	0,7		
1941	3,0	2,3	3,1	3,7	73,3	6,1	2,7			
1942	3,6	3,0	3,5	3,9	70,9	5,9				
1943	4,2	3,2	3,6	5,3	66,7					
1944	4,8	3,3	4,5	5,7						
1945	5,2	4,1	5,1							
1946	6,0	4,7								
1947	6,3									

Source: Pensionsmyndigheten, Försäkringsanalys 2009a

The new public pension system consists of three components: income pension, premium pension, and guarantee pension. Income and premium pensions 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 (premium pensions) and partly PAYG (income pensions). 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 insuree's personal account; in reality, most of the insuree's contributions (i.e. those set aside for 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 contributions (set aside for the premium pension) is actually invested to finance the insurees' 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 of up to 8.07 income base amounts (the income base amount is SEK 51,100 in 2010).[3] Employers pay 10.21% of the wage to the pension system, regardless of the wage level. The 17.21% (7.00+10.21) of earnings correspond to 18.5% of the pension basis[4]. From the total contributions paid, 16 percentage points go to the income pension and 2.5 percentage points to the premium pension.

The pension basis is calculated from earned and other income multiplied with 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

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

[4] 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.

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 neither contributions nor income pensions are paid.

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 after the age of 70 than if it was first drawn at the age of 70. The pension now increases, the later it starts to be drawn. See Table 7 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 the age of 65 in 2007 compared to 2003, when the new system came into effect.

Table 7: Age distribution of men and women who were granted a new old-age pension in 2003 and 2007

	2003		2007	
Age	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 of those who have died during the year); the pension balance is decreased by administration costs which are distributed among the insured; and the pension balance calculated in this way is adjusted by the general development of income with the help of an income index. The income index is based on the average income for all those 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 (with income from earlier years being 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.

When the income pension payout starts, an annuity is calculated taking into consideration the projected 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 annuitisation 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's 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 "First-Fourth" and "Sixth National Pension Funds", as they are called.

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:

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

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 ageing 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 corresponds to what was calculated in December of two years earlier. 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 implies 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 8 below). This at first implied a sudden drop in the average income pension of 4.6%. A change to smooth this sudden drop through using a three year average index was approved in 2010, entailing a benefit reduction for 2010 of 3% instead, but resulting in larger losses the following years (see next section). The amount in pension disbursements saved by the balancing in 2010 is estimated to be SEK 10.3 billion.

Projections currently envisage that the balancing will continue until 2013. Results as of December 31, 2009 (which will affect 2011 pension indexation, where pensions will be reduced by 4.3%) show that the main reason for the persistence of the balancing mechanism is primarily the first-time falling of contribution assets by 1.8% (while buffer funds have actually been growing by 17% since 2008), as well as an increase of 1.1% in the pension liabilities mainly due to higher life expectancy and increasing payout periods.

Table 8: Assets, Liabilities and Balance Ratios (in Billions of Swedish Crowns)

	2008 (used in 2010)	*2009 (used in 2011)*	*2010 (projected, for use in 2012)*[5]	*2011 (projected, for use in 2013)*
(a) Buffer Fund	707	827	-	-
(b)Contribution Assets	6477	6362	-	-

[5] Data for 2010 are not available yet. The balance ratio for 2010 will be calculated in spring 2011, and so on.

(c)Pension Liabilities (incl. Administration costs)	7428	7512	-	-
Pension Deficit ((a+b)-c)	-244	-323	-	-
Balance Ratio	0.9672 0.9826 (with 3 years averaging)	0.9549	0.9655	0.9860

Source : Swedish Pension Authority, Orange Report (2009), and Annika Sunden, "The Swedish Pension System and the Economic Crisis", 2009.

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 certain 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)[6]. The maximum amount is received by those who have neither contributions nor entitlement to the income pension. For those with an income pension above zero, yet below the maximum pension income threshold (more precisely up to 1.26 basic amounts (1.14 for couples)) the income pension amount is deducted 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 2009, 42% 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[7]. Overall, since the poverty risk is highly associated to having some guarantee pension as part of one's retirement income, this means in effect that

6 This is a slight decline since 2009 due to a decline in the price index.

7 The minimum reduction of 0.9% was due to lowering of the price index

the poor will have been affected much less by the balancing, if at all. The overall increase in guarantee pensions due to balancing is estimated to be SEK 511 million in 2010.

Another effect which is produced by changes in the indexing of the ATP/ income pension is the means-tested housing add-on benefit for pensioners. In 2010, 255,000 individuals have gained higher housing benefits 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%.

Table 9 below shows the final distribution of pension income losses due to balancing (including compensation from guarantee pension and housing benefit add-on).

Table 9: 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 pension up to SEK 16,000 are expected to see an increase between 0.5 and 4% in their net income (Pensionsmyndigheten 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 the 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 Authority (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 to invest his or her money in. 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% as 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 2009, premium pension assets amounted to SEK 343,583 million; the increase in value during 2009 was 34.7%. Data for 2010 have not yet been published.

Occupational and Private Pensions

Occupational pension 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. 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 past 15 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.

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. The supplementary pension systems more or less eliminate the ceiling. In 2007, 36% of all employees had income parts over the ceiling. Table 10 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 10: 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 11 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 are 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 11: Form of decision form, DB or DC pensions, and coverage of occupational pensions

Occupational pension scheme	*Form of decision*	*Contribution*	*DB/DC*	*Coverage*
Government employees	Collective agreement	Fees	DC; partly DB for income parts over the ceiling	All in the sector covered by collective agreements
Employees in county councils and municipalities	Collective agreement	Fees (DC) Means are set aside in the books for the DB part	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

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.

Sweden 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 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. A part time pension may lead to that some people who would otherwise have left the labour market continue to work. Others who would have continued to work full time if the system had not existed reduce their working hours. The combined effect could be either an increase or a reduction of labour supply.

There was a special social insurance part time pension system between 1976 and 2000. Those who were 60-65 years and who reduced their working time by at least five hours a week and continued to work at least 17 hours per week could get a replacement of 65% of the income lost due to the reduced number of working hours.[9] As a part of the agreement on the new pension scheme in 1994 it was decided to abolish the special part time pension system. The last part time pensions were granted in 2000. 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.

Since 2003, there has been an agreement on a special part time pension for those employed in the state sector, and since 2007 also an agreement for those employed by local governments (municipalities and counties). In the state sector those aged between 61 and 65 years may get a part time pension if the employer agrees. The working hours may be reduced with at the most 20 hours a week. The part time pension replaces 60% of the income lost due to the reduction of working hours. If the wage increases, the part time pension increases at the same percentage. When the part time pensioner reaches 65 years of age, the part time pension is discontinued and the person has to take a full pension, a part time old-age pension or go back to full time work.[10]

The agreement for those employed by the municipalities and counties implies that the conditions for those getting a part time pension should be settled by further agreements on the local level. The central agreement for those employed by the municipalities and the counties declares that it is possible to have a part time pension until 67 years of age and not, as in the state sector, only until reaching 65 years of age.

2.1.2 Current debate about the pension system

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 emerged. The main issues are discussed below.

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

8 For a recent survey of part-time pension systems in a number of countries, see Kantarci and van Soest, 2008.
9 See Wadensjö and Sjögren, 2000, and Wadensjö, 2003, for the development of the rules over time.
10 See Lachowska, Sundén and Wadensjö (2008).

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. The poorest pensioners will be gradually poorer compared to pensioners who get an income pension. 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.

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[11] and which goes against that principle. This change of the tax system has led to sharp criticism from the pensioners' organisations. They are criticising the Government for treating the pensioners in an unfair way. An alternative way of reducing the taxes on labour, which would probably have not led to the same kind of protests, would have been to reduce the payroll taxes (taxes paid by only those with a labour income and not by those with only a pension). In the wake of the financial crisis and the introduction of the automatic balancing, in May 2010 the Swedish Parliament has in fact decided to lower taxes for pensioners, too. This issue has also been much discussed in the September 2010 election debate. Both the Government Alliance and the Opposition have pledged to reduce taxes further for pensioners to compensate them for the loss in income pension.

The income ceiling in the pension system. There is a ceiling in the income pension system (7.5 income base amounts). Over that ceiling a special payroll tax is paid which is half the size of the total pension fee on income components below the ceiling. Income components over the ceiling are not a basis for the calculation of credits in the income pension system. For those with an income over the ceiling the occupational pension schemes replace part of the labour income. The long term trend is that the occupational pension schemes are becoming increasingly important, which may lead to less support for the social pension scheme. An additional problem with the ceiling is that the time profile of incomes becomes important for those with income close to the ceiling. Stable incomes lead to higher pensions than incomes that vary wildly over the years. Most of the problems could be solved with an increase of the ceiling to for example 10 instead of 7.5 base amounts. Many have incomes in that interval.

The balancing mechanism in the income pension system. 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 should it become financially unsustainable. The ups and downs of the economy should be handled automatically 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

[11] According to a recent study by Andersson (2009), the programme 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).

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.[12] 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.[13] The value of smoothing out the variation (which also means that the pensions are reduced gradually over 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 on March 4, 2010.

Pensionsmyndigheten has in different reports dealt with various issues regarding the pension system. In one report (Pensionsmyndigheten 2010c) it is among other things proposed that the Swedish Insurance Inspection (ISF) should supervise the PPM system and not only the income pension system. Another report (Pensionsmyndigheten 2010a) discusses the costs related to that individual change, the placement between different funds, and how those changes should be handled.

The variation of the value of the funds. Not only the value of the buffer funds in the income pension system (the AP funds) but also most of the PPM funds (the premium part of the social security system), the funds of the occupational insurance schemes, and the funds of the personal pension insurance are sensitive to variations in the stock market. The present crisis had led to reductions in the values of the pension funds mainly containing shares. It is not a problem for those who are young and who are not taking up a pension in the near future but a serious problem for those close to retirement. One conclusion is that the default fund (for those not making an active choice) should contain more bonds for those close to retirement (generational funds) and that the pension authorities and companies (PPM, occupational pension funds, private pension insurance companies) should advise those close to retirement to make a choice of less risky alternatives.

What will happen with the pension system in the next few years? One important change has already been taken: the change in the balancing mechanism. In the next few years it is most likely that the tax treatment will be more like that of labour income than it is now. Both the Government and the opposition have proposed changes in that direction, albeit of different scales.

2.1.3 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 aged 16-64) and of the replacement rate (i.e. the size of the pension relative to pre-retirement income) offered to its current retirees[14], as well as those projected for future generations.

[12] Försäkringskassan (2009).
[13] See Regeringens proposition 2008/09:219, Utjämnat värde för buffertfonden vid beräkning av balanstalet.
[14] Retirees in 2009 were individuals born in 1948 or earlier.

Pension levels and replacement rates are measures of pension adequacy which are commonly used internationally.

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 of the Pension Authority as well as independent research show that both measurements might be falling short of these goals for future generations. Thus, pension levels and replacement rates will need to be reviewed in turns.

Pension Levels

It is important to premise that there can be many "right" ways to calculate the pension level (as well as the replacement rate), depending on e.g. over which samples of individuals the calculations are made or which income definition is used. In its "Orange Report" for 2009, the Pension Authority clarifies that its reported pension levels for instance (i) exclude from averages all those with fewer than 30 years of income amounting to at least one income-related base amount at age 65 (ii) 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%. Overall, it is important to keep these methodological questions in mind when interpreting and comparing data.

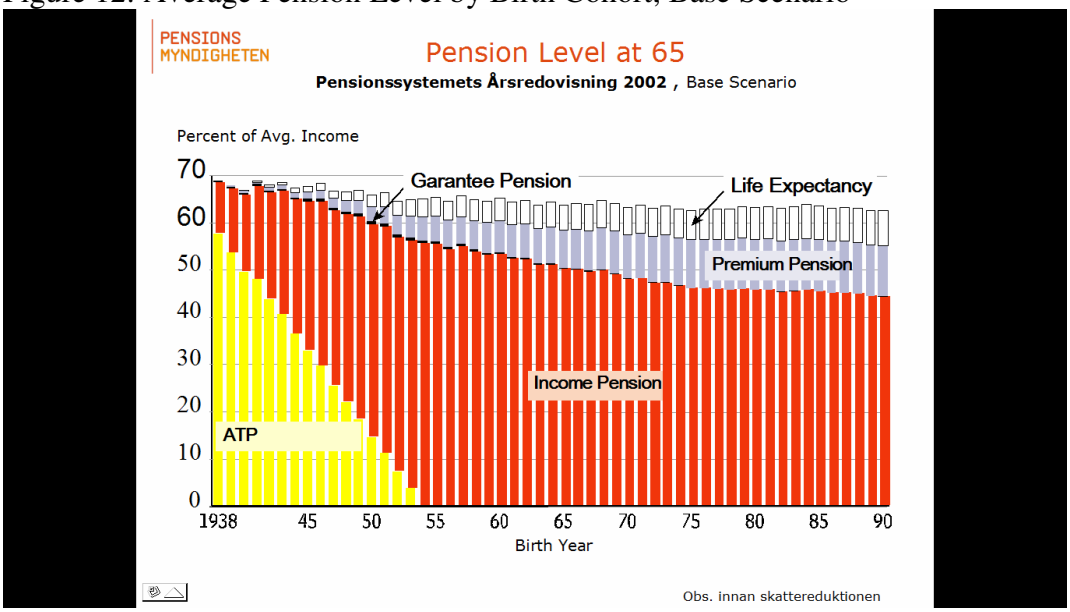
Generally, for the pension level to be constant over time it would be necessary that the number of workers and the number of retirees be constant, and that the income and the pension bases grew at the same rate. Due to e.g. population ageing, this is not possible. This means that there will be yearly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

In the Orange Report 2009[15], a base scenario for current and projected pension levels is 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 include an average return to the premium pension of 3.25%, and an average income growth rate of 1.8%. The most remarkable effect is the large drop between the pension level enjoyed by the older cohort (1944, which was 65 in 2009), namely 66%, and the projected pension levels for someone born in 1965 (57%) or for someone born in 1990 (53%), 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.

[15] Page 27-29

Furthermore, the generational drop in pension levels will be affected by whether the balance is activated or not. The balancing activated in 2010 will affect the pension level for cohorts born between 1945-1955, and the level of their pension will be roughly 3% lower than what it would have been relative to the average income (see Figure 12). This effect, however, in the base scenario will gradually disappear; it is in fact calculated that from 2013 ca. up until 2035 the balance ratio will fluctuate around 1 and above 1 thereafter (primarily since the returns to the buffer funds are assumed higher than incomes growth).

Figure 12: Average Pension Level by Birth Cohort, Base Scenario



Source: Orange Report 2009, 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 70%). Pessimistic assumptions (1% growth 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.

Replacement Rates

According to Sherman (2006), a reduction in the replacement rate of the income pension for younger cohorts was thus fully anticipated in the 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.

Table 13 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 based on the assumptions made by Pensionmyndigheten.

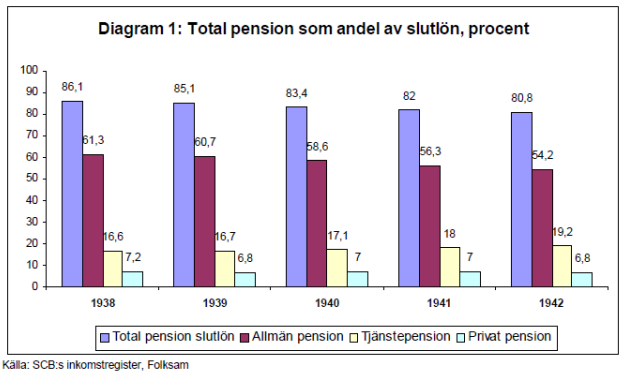
Table 13: Average Replacement Rates of State Pension, cohorts 1939-1942.

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 the 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 (Table 14). 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% ca.).

Table 14: 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 need to be used which 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 15.

Table 15: 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 lying 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 et al. (2006) indeed warn of the increased poverty risk associated to the new system for the very old.

In 2006, the Report by the Indicators Sub-Group (ISG) of the Social Protection Committee (SPC) provided another 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 16: 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

Net replacement rates tend to confirm the other results. Younger workers (born after 1965) will receive a 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 two years (retiring at 67 instead of 65): for someone born in 1940, this would increase the replacement rate for the public pension from 53 to 64.8%, but for someone born in 1985 the increase will be from 40.4 to 45.8% only. 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 women aged over 65 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 in 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. SEK 8,500 against ca. SEK 13,000 for men (Pensionsmyndigheten 2009a). 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 favouring labour supply, it might penalise relatively more strongly those who have interrupted labour histories or low incomes (such as women). However, it also contain features which tend to favour 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 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 17 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 17: Women'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

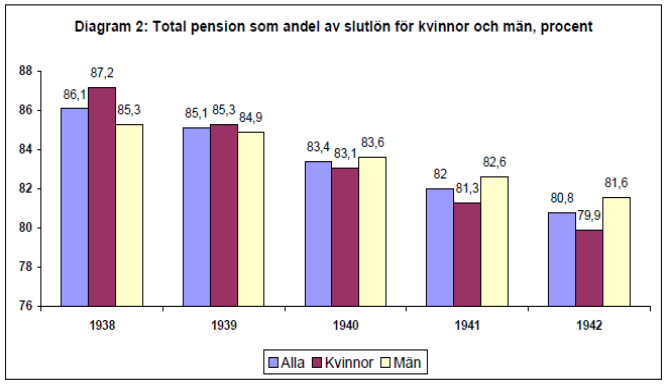
Replacement Rate	100-120	100-120	120-145	100-125
Return to Contributions Paid	115-130	120*	310-400	120-130

**No difference between low and highly educated*
Source: Kruse, Ståhlberg and Sunden (2004), page 31

On average, at least in theory, women get a lower pension then 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 labour supply e.g. in conjunction with child rearing might prove decisive for improving relative pension outcomes.

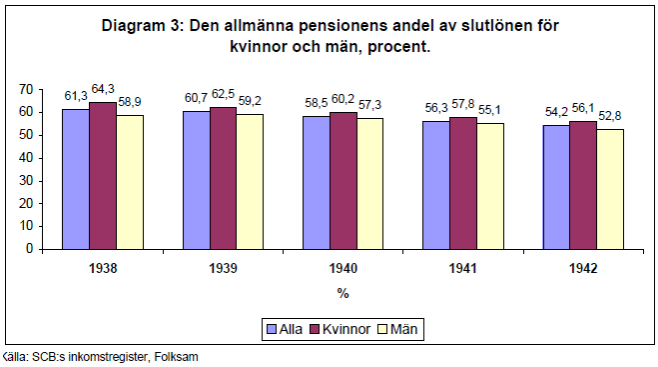
When looking at actual data on gender differences in replacement rates among current retirees (born between 1938 and 1942), the Svärdman report (2010) shows how the old ATP compensated women better than men (thanks to the 15 best years rule) compared to the new system; the average replacement rate for a woman born in 1938 is higher than for a man, but this result is quickly reverted for a woman born in 1944 (see Table 18). 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.

Table 18 (a): Total Pension as percentage of final salary for men and women, cohort 1938-1942



Källa: SCB:s inkomstregister, Folksam

Table 18 (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 of women).

When it comes to gender differences in premium pension, the 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 will start to retire (and even then it will amount to only a low percentage 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 SEK 12,100 more in the premium pension account (the average value being SEK 66,900 for men and SEK 54,800 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.

2.1.4 Critical assessment of reforms, debates and research

The Swedish experience of pension reforms, 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 in the long term to demographic ageing), 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 under normal circumstances, by anchoring the growth of pensions to that of work incomes). Initial data, however, highlight how the system is not completely shielded against negative surprises, particularly for transitional generations which now find themselves to bear the expected costs of the change (compared to the more generous benefit they would have received under the old rules) as well as the unexpected, namely those linked to 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 strong political pressures to deviate from the rule have 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. Given that political pressures to reduce taxes for pensioners have been also implemented in 2010, 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 (increases in life expectancy, reductions in the contribution base and uncertain returns) and balancing might thus become the norm rather than the exception. In this 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.

2.2 Health care

2.2.1 System 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. 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 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 system of health care 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.[16]

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.[17]

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.

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16 Axelsson, R., "The organisaional pendulum – Health care management in Sweden 1865-1998". *Scandinavian Journal of Public Health*, 2000, vol. 28(4), pp. 47-53.

17 National Board of Health and Welfare, *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.

Health care organisation

There are presently 18 county councils and two regional councils in Sweden. The county councils are of different geographical size and the populations range between 126,666 (Jämtland) and 427,106 (Östergötland). Stockholm county council is an exception with a population of 2,019 million. The two regional councils, Skåne and Västra Götaland, have populations of 1.231 and 1.569 million respectively.[18] These councils were created in 1997 and 1999 through mergers of previous county councils. One of the main reasons behind the 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. There is currently a development to create more regional councils by merging more 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 have a better financial base and a more sustainable organisation on the regional level. This development will take some time, however, since the regional councils will be established through negotiations between the county councils concerned.[19]

On the national level, the Government is responsible for the overall health policy of the country through the Ministry of Health and Social Affairs. 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. [20] 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.[21] The organisation of the 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 81 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 at the same time are also university hospitals. [22]

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

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18 Statistics Sweden, Population database 2010, http://www.scb.se/Pages/TableAndChart_287608.aspx.

19 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/sb/d/8728/a/77520.

20 SFS 1982:763, "ealth and Medical Services Act" (in Swedish). Stockholm: Socialdepartementet, 1982.

21 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.

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

period classified as social service. However, the quality of the data has improved during the 2000s. In 2008 about 90 % of the total expenditures of the county and regional councils, and 29% of the total municipal expenditures, were related to health care.[23] As a percentage of the GDP, the total health care expenditures in Sweden are now on an average level (9.2%) compared with other EU countries.[24] They used to be on a higher level in the beginning of the 1990s, but have been reduced and stabilised during the past two decades, mainly as a result of cost containment measures taken by the county councils and regions.[25]

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 extent by 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.[26] The number of private providers varies between the different county and regional councils. This seems to depend 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 provide specialised somatic or psychiatric care, but there are also physiotherapists and other health related therapists with private practices. 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.[27] In Sweden there is a co-payment system, which means that all patients pay 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.[28]

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

[23] Swedish Association of Local Communities and Regions, Costs and revenues 2009 (in Swedish), http://www.skl.se/web/kostnader_och_intakter.aspx.

[24] OECD Health Data 2009, http://stats.oecd.org/index.aspx?DatasetCode=HEALTH (accessed in April 2010).

[25] 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.

[26] Government Offices of Sweden, "Health and medical care in Sweden", 2007. Available at http://www.regeringen.se/content/1/c6/08/60/43/d913c54a.pdf.

[27] WHO Statistical Information System (WHOSIS), Core health indicators 2008, http://apps.who.int/whosis/database/core/core_select.cfm (accessed in April 2010).

[28] Swedish Association for Local Communities and Regions, Costs and revenues 2009 (in Swedish), http://www.skl.se/web/kostnader_och_intakter.aspx.

been compensated by an increased efficiency.[29] During the last few years, more and more county councils have therefore abandoned their market models and now there is only one county council and one regional council left with a purchaser-provider split. The others have gone back to a more traditional administrative organisation.[30]

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 is expected to be introduced in all the 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 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.[31]

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.[32] 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.[33]

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.[34] 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.[35]

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

30 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.

31 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/content/1/c6/10/29/06/103be5e1.pdf.

32 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), in press.

33 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.

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

35 Axelsson, R. & Axelsson, S. B., "Integration and collaboration in public health". *International Journal of Health Planning and Management*, 2006, vol. 21(1), pp. 75-88.

Provisions of the system

The Swedish health care system provides 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 in the world.[36] 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 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.[37] 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 and the different hospitals, which are published annually by the Swedish Association for Local Communities and Regions together with the National Board of Health and Medical Care.[38]

The access problems in the Swedish health care system are not limited to the hospitals. Because of the dominance of specialised health services, it has been difficult to recruit general physicians to primary health care, particularly in the rural areas of the country. The lack of general physicians has caused problems of access to the health centres and many patients are instead going to the emergency departments of the hospitals. Another consequence of the dominance of specialised health services is that there are fewer resources available for health promotion and rehabilitation. In recent years, however, there has been an increasing interest in vocational rehabilitation as a strategy to reduce sick leave. There have been a number of experiments with different models of collaboration between the health sector and other sectors involved in vocational rehabilitation, for example the social and employment services and the social insurance system. There is also a new law for financial coordination of rehabilitation measures, which is an important part of the same strategy.[39]

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36 WHO Statistical Information System (WHOSIS), Core health indicators 2008, http://apps.who.int/whosis/database/core/core_select.cfm (accessed in April 2010).

37 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/sb/d/10057/a/117565.

38 Swedish Association of Local Communities and Regions & National Board of Health and Welfare, *Open Comparisons of Quality and Efficiency of Health Care* (in Swedish). Stockholm: SKL, 2009. Available at http://www.skl.se/web/Oppna_jamforelser_av_halso-_och_sjukvardens_kvalitet_och_effektivitet_2009.aspx.

39 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.

2.2.2 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 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. One of the main issues discussed during the last two years has been the suggestion from the Responsibility Committee that the country should be divided into 6-8 regional councils in order to have a more sustainable organisation for health care and regional development. Some of the county councils have already started negotiations to create new regional councils, while others have been more doubtful. Two of the smaller county councils – Halland and Jämtland – have refused to enter into any negotiation with other county councils. Among the political parties, only the conservative party has expressed some doubts concerning the suggested regional structure.[40]

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, 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.[41] When the present liberal-conservative coalition government came to power in 2006 this regulation was immediately abolished.[42] 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.[43]

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

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40 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/sb/d/8728/a/77520.

41 rop. 2004/05:145, "Forms of management of publicly financed hospitals". Stockholm: Socialdepartementet, 2005. Available at http://www.sweden.gov.se/sb/d/4417/a/43318.

42 rop. 2006/07:52, "Forms of management of hospitals". Stockholm: Socialdepartementet, 2007. Available at http://www.sweden.gov.se/sb/d/1938/a/77286.

43 SOU 2008:37, "Free patient choice. Report from the Committee on Patient Rights" (in Swedish). Stockholm: Socialdepartementet, 2008. Available at http://www.regeringen.se/content/1/c6/10/29/06/103be5e1.pdf.

over the responsibility for health care from the county and regional councils in the same way as has happened in Norway.[44] Others have argued for a European health market where the Swedish patients can choose the best possible health care.[45]

2.2.3 Evaluations and impact assessments

The financial developments in the Swedish health care system are closely followed by the different county and regional councils and also by the different municipalities. The Swedish Association of Local Communities and Regions also collects and compiles financial data from all of the county and regional councils and all of the municipalities. In addition, the association forecasts 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 expected to increase modestly due to the current 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 without contributions from the state budget. [46]

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.[47] 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.[48] As mentioned before, these comparisons have shown significant differences in the availability, quality and 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.[49] There are also regular assessments of medical methods carried out by the Swedish Council on Technology Assessment in Health Care. This council assesses the evidence base of different medical methods and technologies. In 2009 and 2010 assessments were made of methods for treatment of diabetes, migraine, chronic wounds, abdominal aortic aneurysm, inflammatory bowel disease etc.[50] 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

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

45 *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 2008 is available at http://www.skl.se/web/Vardbarometern_2_1.aspx.

46 Swedish Association of Local Communities and Regions, 2010, http://www.skl.se/web/Ytterligare_nedskrivning_av_skatteprognosen.aspx.

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

48 Swedish Association of Local Communities and Regions & National Board of Health and Welfare, *op.cit.*, http://www.skl.se/web/Oppna_jamforelser_av_halso-_och_sjukvardens_kvalitet_och_effektivitet_2009.aspx.

49 National Board of Health and Welfare, 2009, *Annual Report on Health Care2009* (in Swedish), Stockholm: Socialstyrelsen, 2009. Available at http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/8496/2009-126-72_rev2.pdf. .

50 Swedish Council on Health Technology Assessment, http://www.sbu.se/sv/Publicerat/.

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.[51]

Unfortunately, there have been very few evaluations of the internal markets in the Swedish county and regional councils.[52] 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 evaluations 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.

2.2.4 Critical assessment of reforms and discussions

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

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[51] Ahgren, B. & Axelsson, R., "valuating integrated health care: A model for measurement", *nternational 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/.

[52] Hallin, B. & Siverbo, S., *op.cit.* and Berlin, J. *Purchaser Control of Health Services* (in Swedish), öteborg: Förvaltningshögskolan, 2006.

and the National Board of Health and Welfare. The Government is supporting these open comparisons as a strategy to reduce the regional differences.[53] 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 level of quality.

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.[54] 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.

2.3 Long-term care

2.3.1 System 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 decentralised from the county councils to the municipalities for the same reason. During the past fifteen years, there has been a restructuring of long-term care. 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 finance most of their services through municipal taxes, they are quite independent of the national government. This means that they can set their own priorities and organise the services according to the needs of the local population. The municipalities are also very different, with different geographical size and populations ranging between 2.500 (Bjurholm) and 829.417 (Stockholm).[55]

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. [56] 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 supervises the quality of the long-term care provided by the municipalities.

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53 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.

54 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.

55 Statistics Sweden, Population database 2010, http://www.scb.se/Pages/TableAndChart____287608.aspx.

56 SFS 2001:453, "Social Service Act" (in Swedish). Stockholm: Socialdepartementet, 2001.

In 2008, about 30 % of the total municipal expenditures in Sweden were related to long-term care: 19 % were related to care of the elderly and 11 % to care of the physically and mentally disabled.[57] 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 unclear. 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.[58] An obligation for the municipalities to work together with the county and regional councils and regions 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 them were contracted and financed by the municipalities. Nearly 11 % of the home services granted to elderly people in 2007 were also provided by private companies.[59] This means that the privatisation of services has gone further in long-term care than in health care. In addition, many elderly rent flats in buildings specially designed for old people and run by private companies, which also offer different services to their tenants. Another form of private involvement in long-term care is the increasing number of informal care givers who are supported by the municipalities to take care of elderly or disabled family members.[60]

2.3.2 Debates and political discourse

The care of the elderly has been an increasingly important topic in the political as well as the public debates and discussions in Sweden for a long time, 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 gets old but only a smaller part of the population has physical or mental disabilities. Moreover, with an ageing population there will be more and more people 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 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 dissatisfied with 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

[57] Swedish Association of Local Communities and Regions, 2010, http://www.skl.se/web/kostnader_och_intakter.aspx.

[58] SOU 2004:68, "Integrated home care" (in Swedish). Stockholm: Socialdepartementet, 2004. Available at http://www.sweden.gov.se/sb/d/189/a/26584.

[59] 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.

[60] 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.

services and nursing homes, which in their view would give the elderly people and their relatives a wider choice of services and accomodation.[61]

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. 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.[62] Thus, the care of the elderly remains one of the most important topics in the political debate.

2.3.3 Evaluations and assessments of impacts

The financial developments regarding long-term care are closely followed 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.[63] The National Board of Health and Welfare follows the development of long-term care in the different municipalities and the country as a whole, particularly the care of the elderly. The board collects statistical information on the different forms of care, service, support and accommodation for elderly people in the different municipalities.[64] There are also open comparisons of the availability, quality and efficiency of care for the elderly, which are published by the Swedish Association of Local Communities and Regions annually. These comparisons have shown significant differences among the different municipalities and different parts of the country in the availability as well as the quality and efficiency of elderly care.[65]

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 cataracts, dementia, stroke, and palliative care at the end of life.[66] 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.[67] The Swedish Council on Technology Assessment in Health Care has also done some assessments in this field, for example on methods for treatment of stroke and dementia.[68] In addition, there

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61 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.

62 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.

63 Swedish Association of Local Communities and Regions, 2010, http://www.kommundatabas.se/.

64 National Board of Health and Welfare, *"The Elderly Guide"* (in Swedish), http://www.aldreguiden.socialstyrelsen.se/.

65 Swedish Association of Local Communities and Regions, *Open comparisons of the care of the elderly* (in Swedish). Stockholm: SKL, 2009. Available at http://www.skl.se/web/Oppnajamforelser_Aldreomsorg.aspx.

66 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.

67 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.

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

is also a lot of research that focuses on care of the elderly. The most important institute for such research is the Aging Research Centre in Stockholm.[69]

2.3.4 Critical assessment of reforms, discussions and research

The system of long-term care is decentralised to the municipalities in Sweden. This entails the same advantages and disadvantages as the decentralisation of the health care system. The municipalities can set their own priorities and organise their services according to local needs and conditions, but there are also significant differences between the municipalities both in the resources available and in the 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 18 different county councils and two regional councils.

The **access** to long-term care is problematic. There is a lack of vacancies 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 placement, 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.[70] However, at the same time, there is a growing suspicion of private providers of care for the elderly as a result of reports in the mass media about poor 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.[71] Maybe at the same time it will also help the municipalities to locate and eliminate 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 level of quality.

The **sustainability** of long-term care is dependant 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, 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".[72] 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.

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69 Relevant publications can be found at http://www.ki-su-arc.se/.

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 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.

72 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.

3 The Financial Crisis[73]

The financial crisis in 2008 led to effects not only for the financial markets but also for other markets including the labour market. The Swedish Economy is strongly export-oriented and has strength in producing investment goods. It meant that export demand declined and by that employment in especially manufacturing but also in the building industry. As most employed in those industries are men the employment situation for men was more influenced than the employment situation for women. For those below 55 years of age employment declined in Sweden. For those aged 55-64, on the other hand, the employment did not decline but the unemployment increased. This means that the labour force participation increased for this group – people did not react to the crisis by retiring earlier.

For the pension system the crisis led as earlier mentioned to lower values of their funds as a result of the development in the stock market and to lower amounts paid in fees as labour income increased as a result of the decline in the number employed.

Lower labour incomes also led to lowered tax bases and thereby less in tax revenues for municipalities and counties. This meant in turn problems for the financing of old age care and health care.

Sweden is one of the three EU countries that fulfil both the requirement of a budget deficit not larger than 3 % of the GDP and the requirement of that public debt should not be greater than 60% of GDP. The political authorities, the Government and the Parliament, therefore have an option of diminishing the burden for municipalities and counties.

[73] For an analysis see Finanspolitiska rådet (2010).

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PENSIONSMYNDIGHETEN (2009b), FörsäkringsAnalys: Bostadstillägg till Pensionärer 09-06-12, www.pensionsmyndigheten.se

PENSIONSMYNDIGHETEN (2010a), 2K – kompletterande kanaler, Dnr/ref LED 2010-9

PENSIONSMYNDIGHETEN (2010b), Beräkningsuppdrag – alternativa sätt att beräkna inkomstpensionssystemets pensionsskuld och avgiftstillgång, Dnr/ref PAD 2010-75

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4 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

[R2] FÖRSÄKRINGSKASSAN, «Orange Report. Annual Report of the Swedish Pension System 2008». Stockholm: Försäkringskassan, 2009.
http://www.forsakringskassan.se/irj/go/km/docs/fk_publishing/Dokument/Publikationer/arsredovisningar/orange_rapport_2008_engelsk.pdf

This is the yearly report for 2008 from the Swedish Social Insurance Agency on the social insurance pension system. It is the last yearly report from this agency on the pension system. From 2010 on Pensionsmyndigheten is responsible for the social insurance pension scheme and also for reporting on the development of the pension system. Pensionsmyndigheten is also responsible for the Orange report of 2009, the year before its start. The appellation 'Orange report' relates to the colour of the envelopes in which information on pensions are distributed.

[R5] FÖRSÄKRINGSKASSAN, «Sjukersättning – de bakomliggande skälen till ställningstagande, svar på regeringsuppdrag 2009-12-18». Stockholm: Försäkringskassan, 2009.
http://www.forsakringskassan.se/irj/go/km/docs/fk_publishing/Dokument/Nyheter/091222_rapporter/57501_09_Rapport.pdf
"Disability pension – the reasons behind the decisions taken, answer on requested information from the Government 2009-12-18"

Sjukersättning (disability pension) has been in focus of the political debate the last year. This report contains responses to the ministry on how decisions on granting or not granting a disability pension are motivated. The reasons for not granting an application for a disability pension are in focus for this report. Also dealt with is if the change in the rules from July 1, 2008 had any effects for the share of applications granted.

[R3] FÖRSÄKRINGSKASSAN, «Inkomstutvecklingen för individer med sjukersättning och aktivitetsersättning. Ekonomisk standard 1991-2006.» Socialförsäkringsrapport 2009:12, Stockholm: Försäkringskassan, 2009.
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"The income development for people with disability pensions between 1991 and 2006)"

> *The report contains information on the income development and the command of economic resources for those who have had a disability pension in the period 1991-2006. There has been a gradually decline in relative incomes for this group mainly due to that more young people get a disability pension. Those who are granted a disability pension when they are young will later, when they retire, get a very low old age pension.*

[R3] FÖRSÄKRINGSKASSAN, «Medelpensioneringsålder». Socialförsäkringsrapport 2009:9, Stockholm: Försäkringskassan, 2009.
http://www.forsakringskassan.se/irj/go/km/docs/fk_publishing/Dokument/Rapporter/Socialf%c3%b6rs%c3%a4kringsrapporter/Socialf%c3%b6rs%c3%a4kringsrapport%202009%209.pdf
"Average age when getting a pension and when leaving the labour market"

> *The report contains information on the average retirement age measured in several different ways. It shows that there has been a clear tendency to later retirement in Sweden in the last decade. The age when starting taking up a pension was lowest in 2002 and has since then been gradually increasing. The average age when leaving the labour market started to increased already in the 1990s. One important factor behind the changes is the decline in the number taking up a disability pension, another is the changes in the old age pension system.*

[R3] Lachowska, M., Sundén, A. and Wadensjö, E. 2008, «The impact of a phased retirement programme: A case study », IZA DP 4284

> *According to an agreement between the unions and the central government employer organisation, Arbetsgivarverket, a special part-time pension system was introduced in 2003. This paper is a study on how this scheme was implemented by one large governmental employer. The main result is that both individual characteristics and the economic situation of the local workplace are important.*

[R2] PENSIONSMYNDIGHETEN, «Orange Rapport. Årsredovisning 2009», Stockholm: Pensionsmyndigheten, 2010. (Yearly report regarding the Swedish pension system for 2009)
http://www.pensionsmyndigheten.se/download/18.6280544c1278b6211fd8000555/Orange+Rapport+2009.pdf

> *The first yearly Orange report from Pensionsmyndigheten, the new authority in charge of the social security pensions (both the income pension and the PPM pension). The report covers the year 2009, i.e. the year before Pensionsmyndigheten was founded. The report contains detailed information on the design of the pension schemes and its development.*

[R5] PENSIONSMYNDIGHETEN, «Försäkringsanalys: Bostadstillägg till Pensionärer, 09-06-12» (Insurance Analysis: Housing Benefit to Pensioners). http://www.pensionsmyndigheten.se/download/18.3e1fabfa12c58e757cc800027084/F%C3%B6rs%C3%A4kringsanalys+BTP+090612.pdf

This paper shows how pensioners have been affected in their total pension income by the striking of the automatic balance when including changes to the guarantee and housing benefit.

[R5] PENSIONSMYNDIGHETEN, «Försäkringsanalys: Ålderspension, 09-06-30» (Insurance Analysis: Old Age Pension). http://www.pensionsmyndigheten.se/download/18.3e1fabfa12c58e757cc800027087/F%C3%B6rs%C3%A4kringsanalys+%C3%85lderspension+090630.pdf

This is a presentation of latest data on receipt of the main public pensions (income, guarantee and premium pension) by different cohorts of existing pensioners.

[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 2008», Rapport 1:2009. Stockholm: PPM, 2009.
https://secure.pensionsmyndigheten.se/download/18.55d850a012569f73994800020173/Rapport+1%3A2009.pdf
"The people who are saving for their pensions and the pensioners in 2008"

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.

[R2] PPM, «Analytiskt testamente. 11½ år med premiepensionssystemet och PPM, Stockholm: PPM, 2009.
https://secure.pensionsmyndigheten.se/download/18.6280544c1278b6211fd80001438/ANALYTISKT_TESTAMENTE_TRYCK.pdf
"Analytical testimony. 11½ years with the premium reserve system and the PPM authority"

The PPM agency existed for 11½ years before becoming a part of a new Pensionsmyndigheten. This report is a summing up of the activities of the agency during that period. One of the topics dealt with in the report is the effects on future pensions of the large decline in the value of the funds due to the stock market development.

[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.

[R4] Sjögren Lindquist, G. and Wadensjö, E. 2009, «Retirement, Pensions and Work in Sweden», Geneva Papers on Risk and Insurance, Vol. 34, No. 4, 578-590

This article is a study of the development of the situation of older people in Sweden, especially those of older active age. It presents the institutional framework and actual development of pensions and labour force participation.

[R2] Sjögren Lindquist, G. and Wadensjö, E. 2009, «A viable public-private pension system», forthcoming in B. Ebbinghaus (ed.), Varieties of Pension Governance: Pension Privatisation in Europe, Oxford University Press, Oxford

This study shows the structure of the Swedish pension system with emphasis on the occupational pension schemes and the personal pensions. Those schemes have gradually become more important during the 90s and the 00s.

[R4] Sjögren Lindquist, G. and Wadensjö, E. 2009, «The Labour Market for Older Workers in Sweden: Changes and Prospects", European Papers on the New Welfare – the counter-ageing society, No. 13, 104-116

The labour force participation among those aged 55 and older has gradually increased in Sweden since the mid-1990s. This paper presents that development and tries to explain it. The future prospects for older workers on the Swedish labour market are also discussed.

[R4] Sjögren Lindquist, G. and Wadensjö, E. 2009, «Ett längre arbetsliv – arbetsliv och arbetsmarknad för äldre», in Inkluderande arbetsliv, En skrift från Arbetsmiljöpolitiska kunskapsrådet, SOU 2009:93
"A longer working life – working life and the labour market for older people"

This is a study that was done for a governmental commission and which presents the labour market situation of older workers in Sweden and discusses various measures to increase labour force participation among older workers.

[R2] SOCIALDEPARTEMENTET. 2009. «Detta är pensionsöverenskommelsen»
"This is the pension agreement"

A detailed presentation of the income pension agreement decided on in 1994 and 1998 and its history. This report is a very introduction to the pension reform for those who are able to read Swedish.

[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.

[R3] Sundén, A. 2009, «The Swedish Pension System and the Economic Crisis», Center for Retirement Research, Issue in Brief, Number 9-25, Center for Retirement Research at Boston College

This paper presents the reaction in the Swedish Pension System to the economic crisis. In focus is the balancing mechanism in the income pension system and proposals to change it so that variations in pensions are dampened.

[R5] Svärdman, H. (2010), Vad blev den för Pension 2010 ?, Folksam Rapport 4:2010. http://feed.ne.cision.com/wpyfs/00/00/00/00/00/11/10/ED/wkr0013.pdf

This paper shows how replacement rates for Swedish cohorts born between 1938 and 1942 fall rapidly and more than what was anticipated by Pensionsmyndighetens official projections. The study shows the difference which using different income income definitions can make to the final statistics, for instance by including incomes above the insurance threshold replacement rates fall by ca. 10% compared to what is officially presented.

[R4] Wadensjö, E. 2009, « Sweden », in P. de Beer and T. Schils (eds.), The Labour Market Triangle, Employment Protection, Unemployment Compensation and Activation in Europe, Edward Elgar, Cheltenham

This chapter presents the different parts of the Swedish labour market regulation and labour market policy – the employment protection, the unemployment compensation schemes and the active labour market programmes – and how the different parts are related to each other.

[H] Health

[H1-H3] SOCIALSTYRELSEN, «Hälso- och sjukvårdsrapport 2009. Stockholm: Socialstyrelsen, 2009. http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/8496/2009-126-72_rev2.pdf.
"Annual Report on Health Care 2009."

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

[H1,H4,H5] SOU 2007:10, «Hållbar samhällsorganisation med utvecklingskraft. Slutbetänkande från Ansvarskommittén». Stockholm: Finansdepartementet, 2007. http://www.regeringen.se/sb/d/8728/a/77520.
"Sustainable organisation of society with development power. Final Report of the Responsibility Committee."

Final report from the Responsibility Committee presenting an analysis of the division of responsibilities between the different levels of the Swedish society. Focusing on health care and regional development, the committee proposes a new regional geography, which means a merger of county councils into 6-9 regional councils.

[H1-H5] SOU 2008:37, «Vårdval i Sverige. Delbetänkande från Utredningen om Patienträttigheter. Stockholm: Socialdepartementet, 2008. http://www.regeringen.se/content/1/c6/10/29/06/103be5e1.pdf.
"Free patient choice of health care in Sweden. Report from the Committee on Patient Rights."

Report from the Committee on Patient Rights proposing a system of free choice for patients in primary health care to be introduced during 2010 in all of the county and regional councils in Sweden.

[H2,H3] SOU 2008:117, «Patientsäkerhet. Vad har gjorts? Vad behöver göras? » Stockholm: Socialdepartementet, 2008. http://www.regeringen.se/sb/d/11201/a/117784.
"Patient security. What has been done? What needs to be done?"

Report from the Patient Safety Committee dealing with patient security and how maltreatment in health care is dealt with and should be dealt with in the future. A new system of reporting and other legal changes are proposed.

[H1-H5] SOU 2008:127, «Patientens rätt. Några förslag för att stärka patientens ställning». Stockholm: Socialdepartementet, 2008. http://www.sweden.gov.se/sb/d/10057/a/117565.
"The patient's right. Some proposals to strengthen the position of the patient."

Report from the Committee on Patient Rights proposing several changes in the health care legislation, for example a legal regulation of the national care guarantee and the free choice of health care providers.

[H2,H3] SOU 2009:11, «En nationell cancerstrategi för framtiden». Stockholm: Socialdepartementet, 2009. http://www.regeringen.se/sb/d/108/a/120976.
"A national strategy for cancer prevention and treatment in the future."

Report from the Committee for a National Cancer Strategy containing an analysis of the increasing number of people with cancer. More resources for prevention are proposed but also improved care for cancer patients.

[H4,H5] SOU 2009:84, «Regler för etablering av vårdgivare. Förslag för att öka mångfald och integration i specialiserad öppenvård». Stockholm: Socialdepartementet, 2009. http://www.regeringen.se/sb/d/108/a/134565.
”Rules for establishment of care providers. Proposal to increase variety and integration in specialised non-institutional health care.”

Report from the Committee on Patient Rights proposing a new system for establishing care providers who are publicly financed in specialised non-institutional health care.

[H1,H4,H5] SOU 2009:89, «Gränslandet mellan sjukdom och arbete». Arbetsförmåga/Medicinska förutsättningar/Försörjningsförmåga. Stockholm: Socialdepartementet, 2009. http://www.sweden.gov.se/sb/d/11223/a/134930.
“The borderland between illness and work. Work capacity/Medical conditions/Supportive ability.”

Final report from the Commission on Work Capacity containing proposals on how the concept of illness should be interpreted, how work capacity should be understood and judged in different situations, and how an employment programme should be able to strengthen individuals in their way back to support themselves.

[H4,H5] SOU 2009:49, «Bättre samverkan. Några frågor kring samspelet mellan sjukvård och socialförsäkring». Stockholm: Socialdepartementet, 2008.
http://www.regeringen.se/sb/d/11223/a/127156.
“Closer Collaboration. Some issues regarding the collaboration between social insurance and health care.”

Report from the Committee on Patient Rights proposing closer cooperation between the social insurance system and the health care system, particularly in the coordination of rehabilitation.

[H3-H5] SVERIGES KOMMUNER OCH LANDSTING, «Vårdbarometern». Stockholm: SKL, 2008. http://www.vardbarometern.nu/downloads/Vardbarometern-2008.pdf.
“The Barometer of Care.”

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

[H1-H5] SVERIGES KOMMUNER OCH LANDSTING & SOCIALSTYRELSEN, «Öppna jämförelser av hälso- och sjukvårdens kvalitet och effektivitet». Stockholm: SKL, 2009.
http://brs.skl.se/brsbibl/kata_documents/doc39313_1.pdf.
“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] Ds 2008:18, «Stöd till anhöriga som stödjer och vårdar närstående». Stockholm: Socialdepartementet, 2008. http://www.regeringen.se/content/1/c6/10/24/99/a1f0e833.pdf.
"Support to relatives who take care of family members."

Report from a government committee on financial support to relatives who take care of elderly or disabled family members. The committee suggests changes in the social legislation to encourage and support such care.

[L] SOCIALSTYRELSEN, «Äldre – vård och omsorg andra halvåret 2008. Kommunala insatser enligt socialtjänstlagen samt hälso- och sjukvårdslagen». Stockholm: Socialstyrelsen, 2009. http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/17780/2009-10-112.pdf
"Care of the elderly the second part of 2008. Municipal activities according to the laws on social services and health care."

Report from the National Board of Health and Welfare containing statistics on different forms of care, service, support and accommodation for elderly people in different municipalities.

[L] SOCIALSTYRELSEN, «Nationella kvalitetsindikatorer. Vården och omsorgen om äldre personer». Stockholm: Socialstyrelsen 2009. http://www.socialstyrelsen.se/publikationer2009/2009-126-111
"National quality indicators for care of elderly persons".

Report from the National Board of Health and Welfare on the development of a national system for open comparisons within the care of elderly persons. The report contains indicators concerning undernourishment, falls, wounds, terminal care and drugs from pharmacies.

[L] SOU 2004:68, «Sammanhållen hemvård». Stockholm: Socialdepartementet, 2004. http://www.regeringen.se/sb/d/189/a/26584.
"Integrated home care."

Report from the Committee on Care of the Elderly containing an analysis of the unclear division of responsibilities between county councils and municipalities, which is causing conflicts and territorial struggle between the organisations involved. The committee proposes that the municipalities shall have the responsibility for all home care, except medical home care.

[L] SOU 2008:51, «Värdigt liv i äldreomsorgen». Stockholm: Socialdepartementet, 2008. http://www.regeringen.se/sb/d/10057/a/106288.
"A life in dignity for people in elderly care."

Report from the Dignity Committee proposing a higher standard in the care of the elderly. The report stresses that old people should have a say in the design and development of care. It also contains a proposal on better evaluation of elderly care.

[L] SOU 2008:113, «Bo bra hela livet». Stockholm: Socialdepartementet, 2008. http://www.sweden.gov.se/sb/d/10057/a/117943.
"Good housing conditions for the whole life."

Report from the Delegation on Housing for Older People on the results of an investigation of the housing situation for the elderly, proposing a special economic support for the establishment of new special accommodation for older people.

[L] SVERIGES KOMMUNER OCH LANDSTING, «Öppna jämförelser av vård och omsorg om äldre», Stockholm: SKL, 2009.
http://www.socialstyrelsen.se/Publicerat/2008/10135/2008-126-13.htm.
"Open comparisons of the care of the elderly."

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

5 List of Important Institutions

Ageing Research Center (ARC) at the Karolinska Institute and Stockholm University

Webpage: www.ki-su-arc.se

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

Akademikerförbundet SSR

Webpage: www.akademssr.se

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

AMF Pension

Webpage: www.amf.se

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

Centre for Health Equity Studies (CHESS)

Webpage: chess.su.se

At CHESS, junior and senior researchers from sociology, psychology and public health sciences work together on issues of health and inequality. CHESS is the result of long term collaboration between Stockholm University and Karolinska Institutet.

The Swedish Social Insurance Inspectorate (Inspektionen för socialförsäkringen (ISF)

Webpage: www.inspsf.se

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

KPA Pension

Webpage: www.kpa.se

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

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 Agency

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.

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

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