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1 Executive Summary

Most 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 when people leave the labour market has already increased in Sweden. The new pensions system is part of the explanation but improved health and changes in the educational level of the cohorts close to retirement are also important.

The new pension system is presented in the report and also the important supplementary occupational pensions. The occupational pension systems (there are four major ones) have all changed as a response to the changes 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.

The health care and long-term care is in international perspective 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 present economic crisis are discussed in the report. They have been much discussed during the past year. For the pensions, 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.

2 Current Status

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 a long time gradually increased. 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 (2008) 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 c. 0.3 in 2004 to more than 0.5 in 2030. The number of young people (below active age), will be unchanged at c. 0.5 per person of active age.

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 standard in the public sector services (health care and old age care but also other parts of the public sector as education) or lower replacement rates in the income transfer programs 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 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 programs were introduced or existing programs 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 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 2007. Included in the table are the Nordic countries and some countries that often 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 2007 among men and women aged 55-64

Country	Men		Women	
	1994	2007	1994	2007
Denmark	63.8	66.9	43.1	55.7
Finland	43.9	59.2	38.9	58.3
Iceland	95.9	90.4	80.5	80.7
Norway	71.5	74.7	55.4	64.6
Sweden	70.5	76.4	62.6	69.6
Austria	41.3	51.3	18.4	28.9
France	42.1	42.6	30.1	38.0
Germany	53.1	66.5	28.3	49.8
Netherlands	41.8	63.3	18.5	41.1
Switzerland	82.9	78.4	47.2	60.3
United Kingdom	64.0	68.9	40.7	50.1
USA	65.5	69.6	48.9	58.3
Canada	59.5	67.1	36.9	53.3
Japan	85.0	84.9	48.1	52.5

Source: OECD (2008).

If we study labour force participation among women aged 55-64 we find that it increased considerably between 1994 and 2007. 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 (%) 1990-2008 in Sweden among men aged 55-64 years

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

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 (%) 1990-2008 in Sweden among women aged 55-64 years

Age	1990	1995	2000	2004	2006	2007	2008
55-59	78.8	77.3	79.1	79.4	79.9	80.2	80.6
60	69.0	65.7	67.1	69.9	70.2	72.2	72.1
61	62.2	59.5	58.7	67.0	65.8	65.2	66.4
62	54.5	48.6	52.1	58.0	59.7	59.1	60.2
63	46.7	37.7	35.1	49.3	51.1	52.5	50.0
64	37.3	31.2	25.2	40.7	40.7	46.0	44.4
16-64	82.6	76.1	75.5	75.7	76.1	78.2	78.2

Source: Labour force surveys, SCB.

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

Table 4: Labour force participation (%) in Sweden 2006-2008 among those aged 60-70 years

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

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) 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: 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
Men			
55-59 years	438	146	26
60-64 years	536	534	703
65 years (taking up pension the month becoming 65)	667	637	845
Older than 65 years	153	497	675
All	1794	1814	2249
Women			
55-59 years	1	4	4
60-64 years	208	438	992
65 years (taking up pension the month becoming 65)	589	676	862
Older than 65 years	61	384	575
All	859	1502	2433

Source: SPV (2008).

Table 5 shows that the number who take up a pension later than 65 has increased much 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 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 agreement of a right to early old age pension.

2.1 Pensions

2.1.1 The current pension system

The Parliament decided in June 1994 on the principles of a new pension system. The new pension scheme was gradually introduced from 1999 on. All parts apply from January 2003. The new pension system consists of three parts: income pension, premium pension and guarantee pension. Income and premium pension are based on the whole life income. Every year, an amount corresponding to 18.5% of the insured person's pensionable income is assigned to an individual pension entitlement. The insured pays 7% of the earnings through a national pension contribution up to 8.07 income base amounts (the income base amount is SEK 50,900 in 2009). Employers pay 10.21% of the wage to the pension system regardless of the wage level. The 17.21% (7.00+10.21) corresponds to 18.5% of the pension basis. The explanation for the discrepancy is that the national pension contribution of 7% is deducted from income when the pension basis is calculated (0.93*8.07 income base amounts = 7.5 income base amounts). From the contributions, 16 percentage points goes to the income pension and 2.5 percentage points to the premium pension.

The contributions paid provide pension entitlement. In addition to wage from employment and income from self-employment, benefit from sickness, disability and unemployment insurance is counted as income. Studies (with study assistance), national service (conscription) and years with children up to four years of age also confer pension entitlement. The pension basis has a ceiling of 7.5 income base amounts before tax per year.

The 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 (pension rights for those who have died during the year); the pension balance is decreased by the costs of administering the pension being distributed among the insured; and the pension balance calculated in this way is adjusted by the general development of income with the aid of an income index. The income index is based on the average income for all who have had income during a year. To smooth out the effect of business cycles, the index is then calculated as the average income change during the last three years (where income from earlier years is adjusted by the consumer price index in June every year). Finally, the income index is adjusted by the consumer price index for the latest June to June period.

When the pension starts to be paid, it is calculated taking into consideration the predicted growth in the economy and the calculated length of life for the cohort to which the person belongs. The pension balance is divided by a denominator determined by these two factors. If life expectancy gradually increases, later cohorts will receive a lower income pension than earlier cohorts at a given income. Higher growth in the economy provides higher pensions through indexation.

The income pension is adjusted from the year it is drawn with the aid of the general income development with a deduction for the rate of growth assumed when calculating the denominator (this growth norm is 1.6%).

To insure that the pension system is financially stable, i.e. that the pension liability does not exceed the assets in the system, each year the Government determines a balance ratio. The balance ratio shows the balance between assets and liabilities in the pension system. 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. If the balance ratio is less than 1.00, the income index will be multiplied by the balance ratio when pensions are calculated in order to restore the balance between assets and liabilities.

The pension can be drawn at the earliest from the age of 61. A preliminary denominator is used to calculate the pension for those drawing a pension before the age of 65. This pension is adjusted when the person reaches the age of 65. There is no upper limit for when the pension must start to be drawn. In the previous system, the pension did not become higher if it started to be drawn after the age of 70 than if it was first drawn at the age of 70. The pension now becomes greater, the later it starts to be drawn. See Table 6 for the development of the age distribution for those who start to take up a pension.

Table 6: Age distribution of men and women who were granted a new old age pension in 2003 and 2007

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

[1]: This group also includes those who take out a pension the month after they become 65.
Source: Försäkringskassan, "Ålderspension. In- och utflöden i pensionssystemet", Statistik 2007:3.

The part of the pension basis set aside for the premium pension is invested according to the choice of the individual in at most five funds out of c. 800 registered by the premium pension authority, PPM. 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% 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 system if the reduction was not made.

If the income pension is low or non-existent, a guarantee pension supplements the pension. The maximum guarantee pension in 2009 is SEK 7,597 per month for an unmarried pensioner and SEK 6,777 for a married pensioner. 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 can only be paid to persons who live in Sweden or in EU/EEA countries or in other countries with which Sweden has an agreement. Guarantee pension is not tested in relation to wage, agreement-based pensions or private pensions but only in relation to income pension and premium pension (calculated as if they had been paid from the age of 65). The amount of the guarantee pension is not affected by any transferred premium pension rights.

Occupational pension are complementing the pensions from the social insurance system for most people in Sweden. More than 90% of employees are covered by occupation 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 last fifteen years. They have changed from being DB plans to entirely or mainly being DC 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 social insurance old age pension system, and over that ceiling a combination of DB and DC plans.

All supplementary pension schemes have a flexible pension age. 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 7 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 7: 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 8 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. The 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 8: Decision form, DB or DC pensions, and coverage of occupational pensions

Occupational pension scheme	Decision form	Contribution	DB/DC	Coverage
Government employees	Collective agreement	Fees	DC; partly DB for income parts over the ceiling	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 called 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 him/herself in which funds the fees should be placed and there is no guarantee of a minimum growth of the assets. When saving in IPS the fees are placed in an account and the individual decides if the money should be placed in shares, bonds or funds. IPS gives no guaranteed interest rate and it is not in any way insurance.

Sweden has had and still has different forms of part-time pensions. Part-time options exist in the old age pension and the disability pension schemes, but there has also been a special

social insurance part-time pension system and there are now occupational pension schemes for those working in the public sector. A part-time pension system[1] may have different effects on labour supply. A part-time pension may lead to that some who in other case would 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 with 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 (see Wadensjö and Sjögren, 2000, and Wadensjö, 2003, for the development of the rules over time). 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 increase or decrease of the labour supply. They found that the labour supply increased somewhat, especially among women.

From 2003 there is 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 government (municipalities and counties). In the state sector those aged between 61 and 65 years may get a part-time pension if the employer agree. The working hours may be reduced with at 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 with the same percentage. When the part-time pensioner become 65 years, 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.

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 Prospects and problems for 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 sustainable solution for the long-term stability of the pension system and in this way avoid political conflicts regarding the system later on. The pension system has, however, encountered some problems already before the present economic crisis; some of these problems have aggravated during the crisis and some new ones have appeared.

The level of the guarantee pensions. Those who had low wages during their professional life or who have not worked many years get a guarantee pension. The guarantee pension replaced the basic pension (folkpensionen) of 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

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

pensioners will be gradually poorer compared to pensioners who receive an income pension. Projections 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, at the same time, more uneven than in most other countries. This will most likely lead to strong political pressure later on to enhance the guarantee pensions and there will probably be political decisions on discrete increases of the pensions. Another way of solving 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 is that labour income and pensions are taxed in the same way. Going against that principle, with the intention to increase labour supply[2] the current Government has introduced a special deduction for people in paid work. This change of the tax system has met with 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 not have led to the same kind of protests, would have been to reduce the payroll taxes (taxes paid only by those with a labour income and not by those receiving a pension). More studies on how taxes influence labour supply and a more general discussion of the tax structure could be an outcome of the present debate.

The income ceiling in the pension system. There is a ceiling in the income pension system. Over that ceiling a special payroll tax is paid which amounts to one half of the total pension contribution on income parts below the ceiling. Income parts over the ceiling are not taken into account in 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 income reduction. The long-term trend is that the occupational pension schemes became increasingly important, which may lead to less support for the social pension scheme. An additional problem with the ceiling is that stable incomes lead to higher pensions than incomes that vary over the years, given the average income. This is particularly relevant for those with income close to the ceiling. Most problems could be solved with an increase of the ceiling to a factor of e.g. 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 in the meaning that no further political decisions should be necessary. The ups and downs in the economy should be handled by the funds, i.e. within the system. If, together with expected payments of pension contributions, they are too low to cover future payments of pensions, a balancing mechanism should take care of that problem and the pensions should be decreased to keep the balance.

The present crisis has led to a large decline in the value of the pension (AP) funds in the social security system. The income pension would decline, if no changes were made, by about 4% in nominal terms in 2010. 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, has asked the Social Insurance Board to undertake a study of possibilities to avoid the predicted reductions of the pensions in 2010. The Social Insurance Board presented a report in spring 2009 containing some different alternative solutions. The special pension group declared that they prefer a solution with gradual changes in the balancing of the system (three-year average change). The Government will probably put forward a proposal to the Parliament later in 2009. None of the alternatives will eliminate the variations over time in pensions. The value of smoothing out the variation (which also

[2] According to a recent study by Lina Andersson, Växjö University, 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).

means that the pensions are reduced gradually during several years instead of more markedly in just one year) has to be set against the value of having a more consistent system.

The variation of the value of the funds. Not only the value of the 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 has led to reductions in the values of the pension funds mainly containing stocks. It is not a problem for those who are young and who are not taking up a pension in the near future, but indeed 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.

2.2 Health care

2.2.1 System characteristics and reforms

In international comparisons the Swedish health 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 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 hospitals and medical care from the local municipalities. The national Government was responsible for the mental hospitals and for primary health care, but this responsibility was decentralised to the county councils in the 1960s. The aim was to create an integrated system of health care at the regional level. 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 level to the local level, in order to achieve 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.[3]

It is important to understand that the political as well as the financial power in the Swedish health system rests mainly on the regional level and, to some extent, also on the local level, but not so much on the national level. Both the county councils and the municipalities are quite independent from 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 services according to local needs. In 2007, the county councils were financing 71%, and the municipalities 8% of the total expenditures for health care, while the national Government contributed a mere 2% of the expenditures in the form of state grants earmarked for special purposes.[4]

[3] See e.g. Axelsson, R., “The organizational pendulum – Health care management in Sweden 1865-1998”. *Scandinavian Journal of Public Health*, 2000, 28(4): 47-53.

[4] National Board of Health and Welfare, “Annual Report on Health Care” (in Swedish), Stockholm: Socialstyrelsen, 2009. Available at http://www.socialstyrelsen.se/Publicerat/2009/10430/2009-126-72.htm.

The dominant and independent position of the county councils means that the characteristics and reforms of the Swedish health system have to be described and discussed mainly from a regional point of view. There are many different developments as well as different political majorities in the different county councils.

Health organisation

There are presently 18 county councils and two regions in Sweden. The county councils are of different geographical size and the populations are ranging between 126,897 (Jämtland) and 423,169 (Östergötland). Stockholm county council is an exception with a population of 1.98 million. The two regions, Skåne and Västra Götaland, have populations of 1.21 and 1.56 million respectively.[5] These regions 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 regions by merging 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 six to nine regions in order to have a more sustainable organisation on the regional level. This development will, however, take some time since the regions will be determined on the basis of negotiations between the county councils concerned.[6]

On the national level, the Government through the Ministry of Health and Social Affairs is responsible for the overall health policy of the country. The Parliament is responsible for the health legislation. The most important law is the Health and Medical Services Act from 1982, where the responsibility of the county councils and regions for the provision of health care is established. The law affirms the independent positions of the county councils and the regions regarding the organisation of the health services. In spite of their independence, however, the National Board of Health and Welfare supervises the quality and safety of health care provided by the county councils and regions.

Due to the different local conditions, the county councils and regions have chosen different organisational structures.[7] The organisation of the health services is usually divided into a number of district health authorities. Some of the county councils and regions have also different 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 79 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. Eight of them are highly specialised regional hospitals, being, at the same time, university hospitals.[8]

Health financing

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[5] Statistics Sweden, Population database 2009, http://www.ssd.scb.se/databaser/makro/start.asp.

[6] SOU 2007:10, "Final Report of the Responsibility Committee" (in Swedish). Stockholm: Ministry of Finance, 2007. Available at http://www.regeringen.se/sb/d/8728/a/77520.

[7] The organisation of the different county councils and regions is shown on their respective homepages. There are also links to all the county councils and regions on the homepage of the Swedish Association for Local Communities and Regions, http://www.skl.se/artikel.asp?A=290&C=444.

[8] Swedish Association for Local Communities and Regions, 2009, http://www.skl.se/artikel.asp?A=238&C=451.

Owing to the division of responsibilities between the different levels, the data on health care expenditures in Sweden are not so reliable. When the care of the elderly and disabled was decentralised from the county councils to the municipalities, it was temporarily classified as social service. However, the quality of the data has been improving during the 2000s. In 2008, about 90% of the total expenditures of the county councils and regions, and 29% of the total municipal expenditures, were related to health care.[9] As a percentage of GDP, the total health care expenditures in Sweden are now on an average level (9.2%) compared with other EU countries.[10] They used to be on a higher level in the beginning of the 1990s, but were being decreased and stabilised during the past two decades as a result of cost containment measures taken by the county councils and regions.[11]

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 in primary health care, who are contracted and financed by the county councils and regions. There are also hospitals that are run by private companies but financed for the most part by county councils or regions. In 2005, the contracting of private providers accounted for almost 10% of the total health care expenditures of the county councils and regions.[12] The number of private providers varies between the different county councils and regions. This seems to be down largely 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 councils and regions 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 with private practices. Many of them 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 includes patient fees to the county councils and regions.[13] In Sweden there is a co-payment system, i.e. that all patients are paying a nominal fee in connection with visits to the public hospitals and health centres. The fee varies between the different county councils and regions, and also between different treatments, always amounting, however, to 3% of their total revenues.[14]

[9] Swedish Association of Local Communities and Regions, 2008, http://sjvdata.skl.se/.
[10] OECD Health Data, 2008, http://stats.oecd.org/index.aspx.
[11] European Observatory on Health Systems and Policies, Health Systems in Transition: Sweden. Copenhagen: World Health Organization. Available at http://www.euro.who.int/Document/E88669.pdf.
[12] 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.
[13] WHO Statistical Information System (WHOSIS), Core health indicators, 2008, http://apps.who.int/whosis/database/core/core_select.cfm.
[14] Swedish Association for Local Communities and Regions, 2007, http://www.skl.se/artikel.asp?A=58868&C=370.

Health management

During the past 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 the development 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 councils and regions are free to organise the health services according to local needs, 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 councils and regions with purchaser-provider split have been rising and they have not been compensated by increased efficiency.[15] During the past few years, more and more county councils have therefore abandoned their market models so that now there are only two county councils and one region left with a purchaser-provider split. The others seem to have returned to a more traditional administrative organisation.[16]

Another development that has been inspired by New Public Management but also by political considerations is the increasing number of private health care providers, 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, which has been proposed by a parliamentary committee in 2008 and will be introduced in all county councils and regions in 2010. The county councils and the regions may develop 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 amendment to the Health and Medical Services Act.[17]

In some county councils and regions hospitals were privatised, i.e. they were taken over by private companies. These hospitals were in many cases hospitals with financial or other problems, so privatisation was regarded as an alternative to closing them down.[18] It is a difficult decision for politicians in a county 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 alternatives to closing down hospitals in the county councils and the regions. In recent years, there were a number of mergers of hospitals, or creation of hospital groups under a joint management. In spite of bad experiences, related to the size of the new organisations, these developments have continued and spread to more and more county councils and regions.[19]

Another alternative to closing down hospitals has been to integrate them into an organisation of local health care. 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.[20] There are also other developments of integration in the Swedish health system. In many hospitals there is a development towards integrated care pathways. Moreover, there is an increasing integration of services from the county councils,

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

[16] See the homepages of the different county councils and regions, which can also be reached on the homepage of the Swedish Association for Local Communities and Regions, http://www.skl.se/artikel.asp?A=290&C=444.

[17] SOU 2008:37, "Free patient choice of care" (in Swedish). Stockholm: Ministry of Health and Social Affairs, 2008. Available at http://www.regeringen.se/content/1/c6/10/29/06/103be5e1.pdf.

[18] See e.g. Kullén Engström A & Axelsson R, "The double spiral of change – Experiences of privatisation in a Swedish hospital". *International Journal of Health Planning and Management*, 2009 (in press).

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

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

regions and 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 sector and the social insurance system. During the past ten years, there have been a number of experiments with different models of intersectoral collaboration.[21]

Provisions of the system

The Swedish health 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 councils or by private providers and practitioners. However, in spite of official declarations that primary health care be the basis of the health system, the major part of the resources available for health services are 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. These hospitals are frequently involved in research, teaching and training, but they still belong to the county councils and regions.

In international comparisons, the performance and quality of the Swedish health system is usually placed very high. The health status of the Swedish population is also one of the best in the world.[22] 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 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. These initiatives have, so far, not been very successful. A more successful strategy has been to initiate open comparisons of the quality and efficiency of health care in different county councils, regions and hospitals, which are published by the Swedish Association for Local Communities and Regions together with the National Board of Health and Medical Care.[23]

The access problems in the Swedish health system are not limited to the hospitals. Because of the dominance of specialised health services, it is difficult to recruit general physicians to primary health care, particularly in the rural areas. The lack of general physicians has caused problems of access to health centres and many patients are instead going to the emergency departments of 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 intersectoral collaboration. There is also a new law for financial coordination of rehabilitation measures, which is an important part of the same strategy.

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

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

[23] National Board of Health and Welfare & Swedish Association of Local Communities and Regions, "Open comparisons of quality and efficiency of health care" (in Swedish). Stockholm: Socialstyrelsen och Sveriges Kommuner och Landsting, 2008. Available at http://brs.skl.se/brsbibl/kata_documents/doc39313_1.pdf.

2.2.2 Debates and political discourse

Health care has always been an important topic in public debate and the newspapers are usually filled with articles reporting and discussing all sorts of problems in the health system. Although the Swedish system has a good international reputation, the general public is not equally impressed judging from the reports and discussions in the mass media. The political debate 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 issues are not so controversial for the politicians. In fact, many of them are deeply involved in the governance of the health system on the regional and local level.

The recent public and political discussions on health care have focused on the reforms described in the previous sections. One of the issues discussed during the past year was the suggestion from the Responsibility Committee that the country should be divided into six to eight regions in order to have a more sustainable organisation for health care. Some of the county councils have already started negotiations to create new regions, while others have been more doubtful. Two of the county councils – Halland and Jämtland – have refused to enter into any negotiation with other county councils. Their refusal is based on regional rather than political arguments. Among the political parties, only the conservative party has expressed some doubts concerning the suggested regional structure.[24]

Another issue, which was being discussed for some time, is the privatisation of health services. Privatisation of public services has always been a controversial and ideological issue, separating the socialist parties from the liberal and conservative parties. The previous social democratic government introduced a law in 2004 to prevent profit-making private companies from running hospitals. When the present liberal-conservative coalition government came to power in 2006 this law was abolished. The discussion on privatisation in health care has continued and it is still one of the most controversial issues. Surprisingly, however, the political parties have largely agreed on the new system of free choice for patients in primary health care, although it will probably increase the number of private providers.[25]

During the past year, there has been much discussion about the open comparisons showing large regional differences in the quality and efficiency of health care. These comparisons were supported by politicians and they gave valuable inputs to improvements in the county councils and regions concerned. However, the comparisons were also being reported and discussed a lot in the mass media and many people were upset by the differences between county councils, regions and hospitals. Some have questioned the decentralised Swedish system and suggested that the state should take over the responsibility for health care from the county councils and regions. Others argued for a European health market where the Swedish patients can choose the best possible health care.[26]

2.2.3 Evaluations and impact assessments

The financial development in the Swedish health system is followed closely by the different county councils, regions and municipalities. The Swedish Association of Local Communities and Regions is compiling financial data from all county councils, regions and municipalities

[24] SOU 2007:10, *op.cit.*
[25] SOU 2008:37, *op.cit.*
[26] "The Barometer of Care" is an annual study of public opinion by the Swedish Association of Local Communities and Regions. The report from 2008, http://www.vardbarometern.nu/downloads/Vardbarometern-2008.pdf.

in annual statistical reports. In addition, the association is forecasting the tax revenues as well as the total expenditures of the county councils, regions and municipalities. According to the latest prognosis, the tax revenues are expected to increase in spite of the current financial crisis. However, expenditures are also expected to rise, in particular health care expenditures, as a result of the ageing population, so it may still be difficult to balance the budgets of the county councils, regions and municipalities.[27]

Health data are collected mainly by the county councils and the regions. These data include statistical information on morbidity and mortality, visits to health care providers, diagnoses, treatments, operations etc. They are compiled by the Swedish Association of Local Communities and reported to the National Board of Health and Welfare. The open comparisons of the quality and efficiency of health care in different county councils, regions and hospitals are based on the same health data, but they are also published separately in order to have more impact on the development of health care.[29] As mentioned before, these comparisons have shown significant differences in the quality as well as the efficiency of health care between county councils, regions and hospitals in Sweden.

Besides these statistical sources, there are also studies by the National Board of Health and Welfare on different aspects of health care, for example the access to health care in terms of waiting times and waiting lists, patient safety, quality of care, social inequities in health, and efficiency of health services.[30] There are also regular assessments of medical methods carried out by the Swedish Council on Technology Assessment in Health Care. The council is assessing the evidence base of different medical methods and technologies. In 2008, there were a number of assessments of methods for treatment of asthma, glaucoma, inflammatory bowel disease, etc.[31] In addition, there is a lot of research on the Swedish health system going on, not only in medical schools and schools of public health but also in faculties of social science and even in business schools. Evaluation and assessment is an important part of this research. Different parts of the health system were evaluated, for example local health care and intersectoral collaboration in vocational rehabilitation.[32]

Unfortunately, there have been a very limited number of evaluations of the purchaser-provider model in the Swedish county councils and regions. Since about half of the county councils introduced a purchaser-provider split in the 1990s, while the other county councils kept their traditional administrative organisation, there was a very good situation for comparative research, almost like a natural experiment. Now, most of the county councils have abandoned the model and reversed to the traditional organisation, so the experimental situation no longer exists.

[27] Swedish Association of Local Communities and Regions, Prognoses of tax bases 2008-2012, http://www.skl.se/artikel.asp?A=1562&C=1050.

[29] National Board of Health and Welfare & Swedish Association of Local Communities and Regions, *op.cit.*, http://brs.skl.se/brsbibl/kata_documents/doc39313_1.pdf.

[30] National Board of Health and Welfare, 2009, *op.cit.*

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

[32] See e.g. Ahgren, B., & Axelsson, R., "Evaluating integrated health care: A model for measurement". *International Journal of Integrated Care*, 2005, http://www.ijic.org/ Ahgren B, Axelsson SB & Axelsson R, "Evaluating intersectoral collaboration: A model for assessment by service users". *International Journal of Integrated Care*, 2009, http://www.ijic.org/.

2.2.4 Critical assessment of reforms and discussions

The Swedish health 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, regions and municipalities are responsible for the financing and provision of health services, while the national Government has 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 regard to the decentralised nature of the Swedish health system. The advantages are that the county councils, regions and municipalities can make their own priorities and organise their health services according to local needs. The disadvantages are that there are regional differences in both the quality and the efficiency of health services. Moreover, there are regional differences in the access to health care.

The **access** to health services is a problem in the Swedish health 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 disadvantages of the rural areas.

The **quality** of the health services in the Swedish system is generally high, but there are significant differences between different county councils and regions, and also between different hospitals. The creation of larger regions may help to reduce these differences, at least within the regions, and so may also the open comparisons of the quality and efficiency of health services that are published by the Swedish Association of Local Communities and Regions together with the National Board of Health and Welfare. The Government is supporting these open comparisons as a strategy to reduce the regional differences.[33] The question is whether this will be enough to mitigate public dissatisfaction with these differences.

The **sustainability** of the health 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 were being decreased and stabilised during the past two decades as a result of cost containment measures taken by the county councils and regions. Expectations are such that they may rise in the future because of the ageing population, but not so much as to threaten the sustainability of the system.[34] The larger regions are also expected to result in a more sustainable organisation of health care. There are indications, however, that the mergers of county councils into regions may be a long and difficult process.

[33] 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.

[34] 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.

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 be better integrated with the municipal social services. In 1996, the responsibility for the 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 were reduced and more people now receive care and services in their homes.

There are presently 290 municipalities in Sweden. They provide a number of services for their inhabitants, from child care and school education to technical services, social services and care of the elderly. Since the municipalities are financing most of their services through municipal taxes, they are quite independent of the national Government. This means that they can make their own priorities and organise the services according to the needs of the local population. The municipalities are also very diverse, with different geographical size and populations ranging between 2,516 (Bjurholm) and 810,000 (Stockholm).[35]

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. This law gives a right to individuals to receive municipal services, but, at the same time, it also affirms 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.

In 2008, about 29% of the total municipal expenditures in Sweden were related to long-term care: 19% were related to care of the elderly and 10% to care of the physically and mentally disabled.[36] The municipalities are responsible for the provision of health care and social services to the elderly and the disabled, while the county councils and regions are responsible for providing medical care to these groups of patients. A parliamentary committee has pointed out that this division of responsibilities is not very clear. Therefore, the Committee recommended enhanced collaboration between the municipal health care and the primary health care and hospital care of the county councils and regions in order to develop a more integrated long-term care.[37] An obligation for the municipalities, the county councils and regions to work together in the provision of long-term care was 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. 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 provided by private companies.[38] This means that the privatisation of services has gone further in long-term care than in health care. In addition,

[35] Statistics Sweden, Population database 2009, http://www.scb.se/Pages/TableAndChart____262456.aspx.

[36] Swedish Association of Local Communities and Regions, 2008, http://www.kommundatabas.se/.

[37] SOU 2004:68, "Integrated home care" (in Swedish). Stockholm: Ministry of Health and Social Affairs, 2004. Available at http://www.sweden.gov.se/sb/d/189/a/26584.

[38] European Commission, National strategy reports on social protection and social inclusion 2008-2010, *op.cit.*

many elderly rent flats in houses specifically designed for old people and run by private companies, who also offer different services to their tenants. Another form of private involvement in long-term care is the increasing number of informal carers who are supported by the municipalities to take care of elderly or disabled family members.[39]

2.3.2 Debates and political discourse

The care of the elderly has for a long time been an increasingly important topic in the political as well as the public debates and discussions in Sweden, while the care of people with physical or mental disabilities has not received equal attention. This focus on the care of the elderly is natural since everyone is getting old but only a smaller part of the population has 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 focused on the development and the reforms described in the previous section. One issue that has been discussed for some time is the restructuring that was taking place in most municipalities with a reduction of places in institutional care and special accommodation. This reduction has become more and more controversial as the number of frail elderly with multiple chronic diseases has been steadily increasing. Many elderly people and their relatives have been complaining about unreasonable waiting times for institutional care. The political parties have the same view of the problems but their solutions differ. The social democratic opposition wants to give more money to the municipalities for home care and special accommodation, while the liberal-conservative government wants to increase the private services and nursing homes, and give the elderly people and their relatives a free choice of providers.[40]

In spite of the Government support to privatisation, the increasing number of private nursing homes and private service providers has become another controversial issue in the Swedish municipalities. It is controversial not only for the political parties, but also for the general public. There were many reports in the mass media of old people who were treated badly due to cost containment measures to improve profits in the private companies or insufficiently trained personnel employed by the private providers. These reports upset many people and the political opposition also took advantage of this situation. Thus, the care of the elderly remains one of the most important topics in the political debate.

2.3.3 Evaluations and impact assessments

The financial development regarding long-term care is followed closely by the municipalities and compiled by the Swedish Association for Local Communities and Regions. The expenditures have been rising as a result of the ageing population, and this development is expected to continue.[41] The National Board of Health and Welfare is following the development of the long-term care, particularly the care of the elderly. The national board annually collects statistical information about the different forms of care, services, support and accommodation for elderly people in the different municipalities.[42] There are also open

[39] Ds 2008:18, "Support to care of family members" (in Swedish). Stockholm: Socialdepartementet, 2008. Available at http://www.regeringen.se/content/1/c6/10/24/99/a1f0e833.pdf.

[40] 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.

[41] See Swedish Association of Local Communities and Regions, 2008, http://www.kommundatabas.se/.

[42] National Board of Health and Welfare, "Care of the elderly" (in Swedish). Stockholm: Socialstyrelsen, 2008. Available at http://www.socialstyrelsen.se/Publicerat/2009/10297/2009-125-2.htm.

comparisons of the quality of care, which are published annually by the national board. These comparisons revealed significant differences among the different municipalities and different parts of the country in the quality of care for elderly people.[43]

Beside this statistical information and the open comparisons, the National Board of Health and Welfare also carried out studies concerning health care for the elderly. There were studies on different forms of home care, the use of drugs among elderly, treatment of different age-related diseases like cataract, dementia, stroke, and palliative care at the end of life.[44] The Swedish Council on Technology Assessment in Health Care also issued some assessments in this field, for example methods for treatment of stroke and dementia.[45] In addition, there is a lot of research focusing on care for the elderly. The most important institute for such research is the Aging Research Centre in Stockholm.[46]

2.3.4 Critical assessment of reforms, discussions and research

Long-term care is decentralised to the municipalities in Sweden. This means the same advantages and disadvantages as the decentralisation of health care. The municipalities can make their own priorities and organise their services according to local needs, but there are also differences between the municipalities in the quality and access to long-term care. The differences between the municipalities are larger than the differences between the county councils and regions, since there are 290 municipalities of different size and population, but only 18 different county councils and regions.

The **access** to long-term care is problematic. There is a lack of places in institutional care and special accommodation as a result of the restructuring of long-term care during the past 15 years. This means that there are long waiting times for institutional places, particularly with regard to care for the elderly. The Government is dealing with this problem by supporting an increasing privatisation and an introduction of free choice for the elderly.[47] However, at the same time, there is a growing suspicion of private providers as a result of reports in the media on bad treatment of old people in private nursing homes.

There are large differences in the **quality** of long-term care, particularly as regards the care for the elderly, between different municipalities and different parts of the country. The Government hopes that the ongoing development of statistical information and the publication of open comparisons will reduce these differences.[48] Maybe, this will help at the same time to help the municipalities to identify and get rid of bad private providers. The question is 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 **sustainability** of the long-term care is depending 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 in the future because of the ageing population. According to the Government, however, the society will hopefully be able to

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[43] National Board of Health and Welfare, "Open comparisons of the care of the elderly" (in Swedish). Stockholm: Socialstyrelsen, 2008. Available at http://www.socialstyrelsen.se/Publicerat/2008/10135/2008-126-13.htm.

[44] National Board of Health and Welfare, 2009, *op.cit.*

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

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

[47] European Commission, National Strategy Reports on Social Protection and Social Inclusion 2008-2010, *op.cit.*

[48] European Commission, Joint reports on social protection and social inclusion 2009, *op.cit.*

finance its commitment to health and social services for the elderly through sound public finances and a high rate of employment.[49] 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.

3 Impact of the Financial and Economic Crisis on Social Protection

The present financial crisis only started half a year ago, which means that is difficult to say something about the consequences, particularly as we do not the length of the crisis. It is therefore only possible to speculate about the possible consequences of the crisis for pensions, health care and long-term care in Sweden.

There are some issues of worry regarding the pension system in the present crisis as mentioned in section 2.1.2:

1) The PPM pension is decided by the value of the funds that the individual has selected. If a person has selected funds consisting mainly of shares and the share prices are low (as at present) a person may get a much lower pension than expected.

2) The balancing mechanism in the income pension system means that the pensions and the growth of the pensions become lower than expected in periods of crisis.

3) The funds of the occupational pensions are to a large extent placed in shares, and so are also many of the funds for the private pensions. This also means that these pensions are sensitive to the variations in the development of the stock market.

The most important problem, however, is not the present economic crisis but the long-term problems with an ageing population. It is important that the labour supply increases, not least among those of older active age and over the traditional retirement age of 65. Below are listed a number of remarks and proposals. Most of them are options for the political authorities, while others are options for the social partners.

- Increase the minimum age for mandatory retirement from 67 to 70, as in for example of Iceland and France (from 1 January 2009), or forbid mandatory retirement as in the US and Canada.
- Make 67 years and not 65 the normal retirement age in the different income transfer systems. The present design of the sickness and unemployment benefit system forces those aged between 65 and 67 who become unemployed or long-term sick to leave the labour market and take up an old age pension.
- Increase the lowest age for taking an old age pension from 61 to 62 (as in for example the US).
- In a financial crisis such as the present one, avoid introducing special programs for early exit with an income transfer.

[49] European Commission, National strategy reports on social protection and social inclusion 2008-2010, *op.cit.*

- Many studies show that self-employed people work to a higher age than employees. Support to self-employed and especially older self-employed may contribute to higher employment among older people.
- Diminish the incentives to leave early in the various income transfer systems.
- Increase the ceiling in the old age pension system. This will eliminate a part of the effects of the DB part in the supplementary pension schemes. An alternative is to change the supplementary pension schemes to DC plans and shorten the transition period from DB to DC.
- When restructuring the public sector avoid offering pensions up to retirement for older employees.
- Abolish the rules existing in some supplementary pension schemes which forbid those who have received a pension to take a new job.
- Abolish the rule in the part-time pension system for state employees, which makes it impossible to continue to have a part-time pension between 65 and 67. This rule in practice means that those who take a part-time pension take a full-time old age pension at 65. This change could be financed for example by raising the minimum pension age in the part-time pension system from 61 to 62.

The present crisis also means less tax revenues to the county councils and regions that are in charge of health care and the municipalities who are in charge of long-term care. The effects will be strongest for those municipalities, county councils and regions that have a large share of older people. A number of small municipalities in sparsely populated areas have old populations. The result is small revenues at the same time as the ageing population leads to an increase of the demand for health care and long-term care. There are various lags in the systems, so the real test of what will happen in the two sectors will first take place in 2010.

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.

[R1-R5] FÖRSÄKRINGSKASSAN «Analys av balanstalets konstruktion och funktion», Svar på regeringsuppdrag Dnr 186662-2009.
"A study of the construction and the function of balancing mechanism in the old age pension scheme"

The financial crisis will lead to a decline in the nominal social insurance old age pensions in 2010. The Government asked the Social Insurance Administration to make a study of methods to make the decline of the pensions smaller but keep the structure of the system. This report is the response to the Government.

[R1-R5] KRUSE, A., «Socialförsäkringar och globalisering», Report 32 to Globaliseringrådet, The Swedish Government, 2009.
"Social insurance and globalisation"

This study discusses the effects of globalisation on the Swedish labour market and the social insurance system. Special emphasises is put on the effects related to the fact that Sweden is a member of the European Union.

[R1-R5] RIKSREVISIONEN, «Delpension för statligt anställda», RiR 2008:27
"Part-time pension for state employees – implementation and effects"

This study is on the special part-time pension system introduced in 2003. In the period 1976-2003 there was a special social insurance pension scheme giving a high compensation to those who were 60 and older and who reduced their working hours. This scheme was abolished as a part of the agreement on the new old age pension system. However, in similar system was introduced by collective agreements for state employees in 2003 and for those employed by the municipalities and counties in 2007. This report is a study of the inflow in the part-time scheme for state employees and a discussion on the consequences for labour supply.

[R1-R5] SJÖGREN LINDQUIST, G., & WADENSJÖ, E., «Ett svårlagt pussel – kompletterande ersättningar vid inkomstbortfall», Report to ESS 2007:1, Stockholm Report to the Ministry of Finance, 2007.
"A complicated puzzle – compensation complementing the social insurances"

This study is a detailed report of the supplementary compensations in Sweden. They are mainly determined by collective agreements but also by private insurance. The study covers both the history and the actual design of the schemes. This study (204 pages) complements two earlier studies also of book-length published in 2005 and 2006. Results from those studies mentioned have also been published in number of reports, books and articles. The publications contain numerous references to research in Sweden in the fields covered.

[R1-R5] SJÖGREN LINDQUIST, G., & Wadensjö, E., «Arbetsmarknaden för de äldre», Report to the Ministry of Finance, Finanspolitiska Rådet, Stockholm, 2009.
"The labour market for older people"

A comprehensive report that covers different aspects of pensions, organisation, retirement age, older workers' activities and income and social conditions. Results from this study are under publication as articles in different scientific journals.

[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

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

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

[H1-H3] SOCIALSTYRELSEN, "Hälso- och sjukvårdsrapport". Stockholm: Socialstyrelsen, 2009. http://socialstyrelse.se/Publicerat/2009/10430/2009-126-72.htm
"Annual Report on Health Care"

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 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
"Final Report of the Responsibility Committee"

The Responsibility Committee presents an analysis of the division of responsibilities between the different levels of the Swedish society. Focusing on health care and regional development, the committee suggests a new regional geography, which means a merger of county councils into 6-9 regions.

[H1-H5] SOU 2008:37, "Vårdval i Sverige. Delbetänkande från utredningen om patrienträttigheter". Stockholm: Socialdepartementet, 2008.
http://www.regeringen.se/content/1/c6/10/29/06/103be5e1.pdf
"Free choice of patient care"

Report by the Committee on Patients' Rights in Health Care suggesting a compulsory system of free choice for patients in primary health care to be introduced in all the county councils and regions 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 is left to do?"

The report by a governmental committee deals 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.

[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 cooperation between social insurance and health care."

This is a report from a governmental investigation. Its starting point is that since 1 July 2008 there are more stringent rules in the sickness benefit system and that is therefore is needed with a closer cooperation between the social insurance organisation and health care. The report also put forward different proposals so that people may get quicker access to rehabilitation.

[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 regarding cancer prevention and treatment for the future"

The number of people with cancer is increasing, mainly due to the ageing of the population. According to a forecast, the number will double until 2030. The report from a governmental committee stresses that policy changes are needed. More resources to prevention are needed but also the health care for cancer patients has to be improved. A special topic discussed is than the incidence rate differs between different groups of the population.

[H1-H5] SOCIALSTYRELSEN OCH SVERIGES KOMMUNER OCH LANDSTING, "Öppna jämförelser av hälso- och sjukvårdens kvalitet och effektivitet. Jämförelser mellan landsting 2008". Stockholm: Socialstyrelsen och Sveriges Kommuner och Landsting, 2008. http://brs.skl.se/brsbibl/kata_documents/doc39313_1.pdf
"Comparisons of the quality and efficiency of health care in different county councils and regions in Sweden in 2008"

The report contains a large number of comparisons of different aspects of health care, including the availability, quality and efficiency of care, in the different county councils and regions in Sweden.

[L] Long-term Care

[L] SOCIALSTYRELSEN, «Äldre – vård och omsorg den 30 juni 2008. Kommunala insatser enligt socialtjänstlagen samt hälso- och sjukvårdslagen», Stockholm: Socialstyrelsen.
"Care of the elderly - 30 June 2008, Municipal activities according to the legal framework".

This report contains statistics on different form of care, service, support and accommodation for elderly people in different municipalities.

[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 care of family members”

Report from a governmental committee on the increasing the financial support to relatives who take care of elderly or disabled family members.

[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 old age care”

This report from a governmental committee proposes a higher standard in old age care. The report stresses that the old people should have a say in the design and development of old-age care. The report also contains many other proposals including a proposal on better evaluation of old-age 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 people of all ages”

This report from a special delegation reports results from an investigation on the housing situation for older people. The starting point is that the share of the population being 85 years and older is gradually increasing and that the number of special housing places for those who cannot continue to live at their own dwelling are too few. The delegation is proposing a special economic support for the establishment of new special dwelling for older people.

[L] SOCIALSTYRELSEN, “Öppna jämförelser 2008. Vård och omsorg om äldre”, Stockholm: Socialstyrelsen, 2008.
http://www.socialstyrelsen.se/Publicerat/2008/10135/2008-126-13.htm
“Open comparisons of the care of the elderly in 2008”

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

5 List of Important Institutions

Aging Research Center (ARC) Karolinska Institutet and Stockholm University

Webpage: www.ki-su-arc.se

The primary goals of the ARC are to (a) carry out and support high-quality aging research from a medical, psychological and social perspective; (b) advance multidisciplinary efforts in research on aging; (c) offer graduate students a high-quality education in a stimulating environment; (d) foster collaboration with aging researchers 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 % 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

Webpage: http://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.*

Arbetsmarknadsdepartementet – Ministry of Employment

Address: Rosenbad 4, SE-103 33 Stockholm
Phone: 0046 (0) 8 405 10 00
Webpage: http://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 the field of Working life like issues relating to working hours, work environment, the organisation of work and labour legislation. Continuing professional development.

Centre for Health Equity Studies (CHESS)

Webpage: www.chess.su.se

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

KPA Pension

Webpage: http://www.kpa.se

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

The Ministry of Health and Social Affairs

Webpage: http://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.

The National Government Employee Pensions Board (SPV)

Webpage: http://www.spv.se/hem

SPV was established in 1963 and is today 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 15 billion SEK. 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 competences 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 to follow the developments in the Nordic health systems.

PPM

Webpage: http://www.ppm.nu/

PPM manages the Premium Pension System, which is a part of the Swedish National Pension System. The authority administers pension savers′ premium pension accounts, makes decisions regarding the payment of premium pensions and underwrites and manages assets that are invested in the Premium Pension System's annuity product. It also provides information about the system.

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. Our 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 to bridge 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 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, sick and parental leave and pensions.

Swedish Social Insurance Agency

Webpage: http://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.

Socialstyrelsen - National Board of Health and Welfare

Webpage: www.socialstyrelsen.se

The Socialstyrelsen 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, exert influence and supervise in many different ways.

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 level, 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.

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. We also organise managers, teachers and researchers within our professions, as well as students training to qualify for any of our 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/employment_social/progress/index_en.html