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Analytical support on
social protection reforms and
their socio-economic impact

Country Document 2013

Pensions, health and long-term care

Sweden

November 2013

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On behalf of the
European Commission
DG Employment, Social Affairs and Inclusion

Gesellschaft für Versicherungswissenschaft und -gestaltung e.V.
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1 Executive Summary

The Swedish pension system is robust, financially sustainable, and performs well in terms of income adequacy. The system has universal coverage - including the self-employed and the free professions - so all income-earners are subject to the same set of rules concerning their pension. Occupational pensions supplement public benefits for more than 90% of the workforce, and low-income earners are covered by other forms of income support in retirement (guarantee pension, old-age income support). However, older pensioners, especially single women, are much more likely to be risk of poverty than younger pensioners, male pensioners and couples.

There have been few recent reforms. The only recent changes to the pension system are the introduction of a life-cycle default fund in the premium pension system to replace the original default fund. The rationale for the legislation was to match investments more closely with the age profile of premium pension savers whose capital is placed in the default fund. The second recent change is the introduction of a slightly different method for calculating the balance ratio in the income pension system, which reduces the impact of short-term financial market fluctuations on the indexation of pensions.

Three issues dominate debates about the future direction of the pension system: the retirement age, the design of the premium pension, and the design of automatic balancing. The main recommendation of the government-appointed Retirement Age Commission is that retirement ages for all parts of the pension system, including occupational pensions, should be raised and linked to average life expectancy. Two aspects of the premium pension are controversial and have been debated at length in 2013. First, the premium pension system does not function well in terms of individual freedom of choice. The second aspect of the premium reserve that has sparked much debate concerns the potentially very different pension outcomes that the system is likely to produce. The automatic balancing mechanism has also been the topic of much debate. A major evaluation of the Swedish pension system carried out by an outside expert published in 2013 argues that the automatic balancing mechanism harms pensioners more than workers.

The Swedish healthcare system is decentralised. The state is responsible for overall health care policy while the 16 county councils and four regions have the overall responsibility for health care services. Since the organization of health care is open to the individual county council, there are regional differences in the governance and provision of health care, which constitute a major challenge for the health care system. During the last decade, there have been efforts towards strengthening national influence, for example through the development of national “action plans”. Furthermore, since 2010 all county councils are mandated to offer patient choice and private providers within primary care, and there is a national guarantee concerning waiting times in primary and specialist care. Since 2006, quality and performance indicators have been regularly presented for individual county councils and hospitals, with the aims to increase the quality of care, transparency and data quality. Both outcome and process measures are included.

Municipalities are responsible for long-term inpatient health care and care for older people. The county councils are responsible for patients until they are discharged from hospital, while responsibility for home nursing and rehabilitation lies with the municipalities. This places high demands on the coordination of care between municipalities and county councils. The freedom of choice has been a prominent focus also in long-term care. It has been pointed out that patients with dementia, stroke, mental disabilities or sensory impairments may not be able to use their right to choose. The Government has commissioned an investigation into the

effects of the system of choice, for users/patients, the development of quality, costs and efficiency, and the development of the elder care market.

Current reform debates primarily revolve around whether for-profit cooperations should be allowed to operate in health and long-term care. A further issue of heated debate is the effects of New Public Management (NPM) within health care, especially steering models that focus exclusively on certain productivity outcomes.

2 Pensions

2.1 System description

2.1.1 Major reforms that shaped the current system

The current pension system is the result of a major reform adopted in two steps, in 1994 and 1998. In June 1994, a five-party coalition in Parliament adopted the principles of the new pension system. The decision came after more than a decade of discussion and investigation. In 1998, the same coalition of parties adopted detailed legislation to implement the new system (Anderson and Immergut, 2007). The reformed pension system has the following characteristics:

- Earnings-related pensions are based on notional defined contributions (NDC) and lifetime earnings
- Pension contributions are shared by employers and employees
- Earnings-related pensions rely on both pay-as-you-go financing and partial funding
- Pension accrual and pension pay-outs are automatically adjusted to wage growth and life expectancy
- Retirement age is flexible starting at 61
- Part of the earnings-related pension contributions (13.5% of contributions) is ear-marked for funded, individual investment accounts (the premium pension)
- Pension rights are earned for parental leave, sick leave, and compulsory military service
- Individuals with insufficient pension rights receive a guarantee pension which provides basic income support.

The new system took effect in 1999 and was fully operational in 2003. Only persons born 1938 and later participate in the reformed system; those born before this are covered by the previous system.[1] Transitional rules apply for persons born between 1938 and 1953. Persons born 1954 and later are fully covered by the reformed system.

The five-party coalition behind the pension reform is a crucial driver of policy change since the original reform was adopted in 1994 and 1998. The five parties represent a very broad coalition, accounting for 88% of seats in Parliament in 1994 and 1998, and 81% today. The five parties have developed a committee structure (the "Pensions Group") in which they negotiate all aspects of the pension system related to the reform, and they have committed themselves to this bargaining structure. This means that all changes to the pension system must be accepted by the five parties that originally backed the reform.

[1] The previous system included both a flat-rate basic pension (*folkpension*) and an earnings-related pension, ATP. The basic pension was equal to one "base amount" (an accounting unit used in all social insurance schemes), and the ATP system paid a defined benefit based on the best 15 of 30 years of labour market participation. A full ATP pension was 60% of 6.5 base amounts, plus the basic pension. Pensioners without an ATP pension received a supplement (*pensiontillskott*) to their basic pension as well as a housing subsidy. The previous ATP system was transformed into a supplementary pension (*tilläggspension*) in the 1994/98 reform. Persons in the old system who received only the basic pension, the pension supplement and housing subsidy are now covered by the guaranteed pension.

There have been no major changes to the original reform in the past several years, but several issues are on the political agenda (the premium pension, the retirement age, the design of the automatic balancing mechanism) which are discussed later in this report.

2.1.2 System characteristics

The current pension system consists of three parts:

- The income pension (*inkomstpension*)
- The premium pension (*premiepension*)
- The guarantee pension (*garantipension*)

Both the income pension and the premium pension are defined contribution (DC) schemes. The total pension contribution is 18.5% of pensionable income: 16 percentage points for the income pension and 2.5 percentage points for the premium pension. Contributions are shared between wage-earners and employers: wage-earners pay 7% of their eligible earnings up to a ceiling of 8.07 "income base amounts"[2] which is roughly equal to average wages. In 2012 the annual ceiling was SEK 440,622. Employers pay 10.21% on income below the earnings ceiling, and half of this for earnings above the ceiling. The latter is called a "tax" rather than a pension contribution, and the revenues from it are transferred to the state budget rather than to the pension system. Because of the effects of the tax system (the individual pension contribution is not subject to tax), nominal contributions add up to 17.21%, rather than 18.5%. The net contribution, however, is 18.5%. The central government pays the pension contribution for those receiving social insurance or unemployment insurance benefits that qualify for pension accrual.

Income Pension
The income pension is a "notional defined contribution" (NDC) pension based on lifetime earnings. This means that the scheme emulates a funded defined contribution scheme by estimating an internal rate of return for accumulated pension contributions. All insured persons have an account with the Swedish Pensions Agency (*Pensionsmyndigheten*) where their contributions are recorded. The notional balance in the account is indexed annually to an "income index" (*inkomstindex*) based on real wage growth for wage-earners aged 16-64. At retirement, notional assets in the individual account are converted to an annuity using the "annuity divisor" (*delningstal),* which is the expected remaining unisex life expectancy for that person's cohort (all members of his/her birth year) plus an internal rate of return of 1.6%. This means that later retirement increases the pension benefit significantly because the divisor decreases and pension assets increase. The reverse is true for earlier retirement. The notional assets of those who die are credited to the surviving members of that birth year cohort; these are called "inheritance gains" (*arvsvinster*). Administrative costs are deducted annually. Benefit pay-outs are indexed to an "economic adjustment index" (*följsamhetsindex*) which is the income index minus 1.6.[3]

Premium Pension
The premium reserve is also an individual account at the Swedish Pensions Agency, but unlike the NDC accounts, premium pensions are funded. Participants may place their

[2] The income base amount is an accounting device used in social insurance schemes, and it is indexed to increases in average earnings.

[3] For example, if the income index is 2.0, the economic adjustment index is 2.0-1.6 = 0.4. 1.6% is deducted because the same percentage rate of return is applied to the notional annuity at retirement. Thus the annuity is front-loaded and this is compensated for afterwards by the construction of the economic adjustment index.

premium pension contribution in up to five investment funds from a catalogue. To minimize administrative costs, pension contributions and fund choices are centrally managed by a government agency, the Swedish Pensions Agency (from 2000-2011 the Premium Pension Agency, or *Premiepensionsmyndighet*, PPM, administered the system). Contributions are administered temporarily until individuals' tax liability is determined and the amount of their premium pension credit can be calculated. After the exact amount of the pension contribution is determined, the capital is used to purchase shares in the investment funds that the person has chosen. The capital of non-choosers is invested in a state-run default fund. The premium pension default fund was the Premium Savings Fund (*Premiesparfonden*) until May 2010, when it was replaced by AP Såfa (*Statens årskullsförvaltningsalternativ*), a life-cycle fund. AP Såfa invests completely in equities until a participant reaches age 56 and then gradually increases the share of bonds in the investment mix. The share of bonds is 35% at age 65, 50% at age 70, and 67% at age 75 (www.pensionsmyndigheten.se).

At the end of 2012 there were 793 funds administered by 104 different financial service companies (Swedish Pensions Agency, 2013). All fund balances are annuitized at the time of retirement and can be paid out either as a fixed annuity (*traditional försäkring*) or as a variable annuity (*fondförsäkring*). For both, the capital is divided by the annuity divisor to calculate the annual pension. The divisor is adjusted for changes in future life expectancy. If an individual chooses a fixed annuity, an individual's capital is sold to buy the annuity. If an individual chooses a variable annuity, the capital is not sold, but stays in the funds chosen by the individual, and the level of the premium pension is calculated every year depending on the value of the capital at the end of the year. In order to finance monthly pension payments, capital is sold each month.

Every person with pension rights in Sweden receives an annual pension statement from the Swedish Pensions Agency, the so-called "orange envelope," that contains estimates of future pension benefits (for both the income pension and premium pension) based on current individual employment and different economic growth scenarios.

Buffer Funds

Like the old system, the income pension system is partially funded: the system is mainly pay-as-you-go, but there are sizable buffer funds. In the reformed system, AP Funds 1-4, and AP 6 are the buffer funds. About 12% of pension liabilities in the public system are covered by these AP Funds. At the end of 2012 there was SEK 958 billion in the buffer funds (Swedish Pensions Agency, 2013, p. 10). The new buffer funds are smaller than in the old system and play a smaller role in collective capital formation. Over time, the assets in the premium reserve will exceed those in the AP Funds. At the end of 2012, assets in the premium pension system totalled SEK 514.7 billion, or about 54% of the value of the AP buffer funds (AP 7 Såfa, the default fund in the premium pension, is included in the figure for the premium pension).

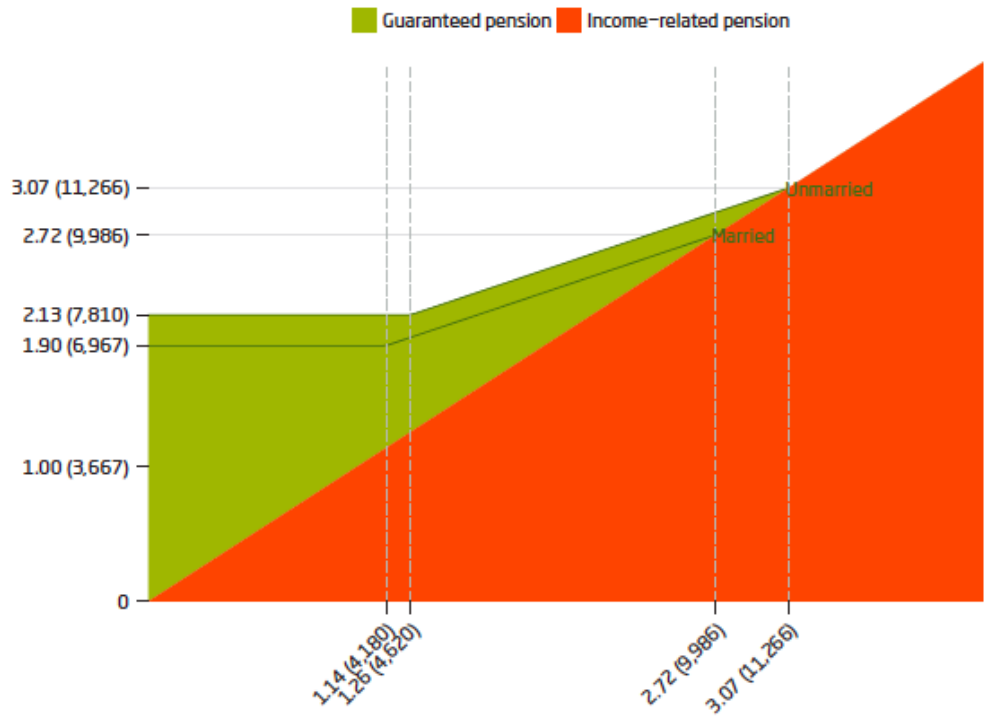
Guarantee Pension

For those with insufficient income pension rights, the guarantee pension scheme pays basic income support. The pension is payable starting at age 65, and 40 years of residence in Sweden between the ages of 25 and 45 are required for a full pension. The pension is reduced proportionally for missing years.

The guarantee pension is designed as a supplement to the income pension, up to a threshold. If a pensioner does not have any income pension rights at all, the guarantee pensions is 2.13 price base amounts for single pensioners and 1.90 price base amounts for married/partnered pensioners. For those with an income pension, the following applies: if the income pension is 1.26 price base amounts or less for a single person and 1.14 price base amounts for someone with a partner, the guarantee pension is reduced in proportion to the size of the income pension. For pensioners whose income pension is higher than these levels, different rules apply. A single pensioner receives a yearly guaranteed pension which is the difference between 0.87 price base amounts and 48% of the share of the income pension which exceeds 1.26 price base amounts. A partnered pensioner receives an annual guarantee pension equal to the difference between 0.76 price amounts and 48% of the parts of the income pension which exceeds 1.14 price base amounts.

The figure below shows how the guarantee pension is constructed. The numbers on the Y and X axis are price base amounts, and the numbers in parentheses are the monetary amount of the pension in SEK. To use one of the examples above: a single pensioner with no income pension receives 2.13 price base amounts, or SEK 7,810 per month. The guarantee pension does not supplement the income pension above the levels of 3.07 price base amounts for a single pensioner and 2.72 price base amounts for a pensioner with a partner.

Figure 1: Income pension and guarantee pension



Source: The Swedish Pensions Agency, 2013, p. 26.

Retirees with low income are also eligible for housing supplements. The housing supplement is a tax-free, income-tested supplement payable starting at age 65. The maximum level of the supplement is 93% of the housing costs per month that are below SEK 5,000 for a single and SEK 2,500 crowns for someone with a partner. Singles receive a supplement of SEK 340 and those with partners get a supplement of SEK 170 (2013 figures).

Old-Age Income Support

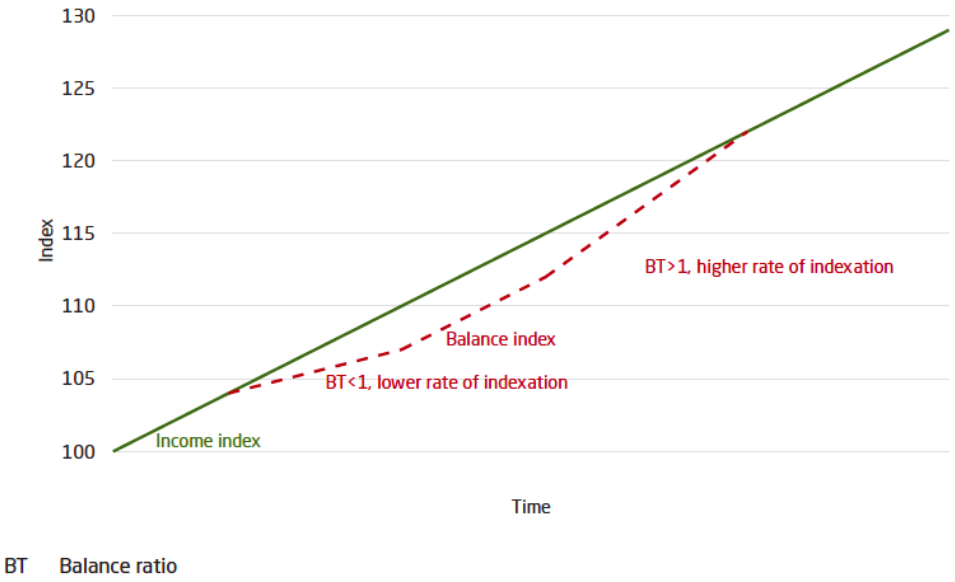
Finally, old-age income support (*äldreförsörjningsstöd*, ÄFS) is the last resort source of income support for those 65 and older. The benefit is income-tested and guarantees a basic minimum of SEK 5,353 per month and a housing benefit. Very few elderly people receive this benefit; in 2013 there are 15,700 recipients---less than 1% of all pensioners. The overwhelming majority of those receiving this benefit consist of people who have not lived in Sweden for 40 years and do not qualify for a full guarantee pension. In 2013, 88% of those receiving the benefit were born outside of Sweden (Ministry of Finance, 2013, p. 16).

Automatic Stabilizers

The reformed pension system also includes automatic stabilizers to ensure the financial sustainability of the system. The "automatic balancing" mechanism requires the Swedish Pensions Agency to calculate the notional assets and liabilities of the system annually. Notional assets are the sum of all future pension contributions (16% of qualifying income) and the financial assets in the AP Funds. Notional liabilities are the sum of pension promises to those still in employment and those already in retirement. Both assets and liabilities are based on a three-year moving average. If the ratio of assets to liabilities, the balance ratio (*balanstal),* falls below one, the balancing mechanism is activated. Both pension rights and benefit payments are indexed at a lower rate until balance is restored. After balance is restored, pension accrual and pay-outs are indexed at higher levels to make up for losses caused by automatic balancing---this is referred to as the "catch-up period". The balancing mechanism operates with a two year lag: for example, if the balance ratio falls below 1.0 in 2013, balancing takes place in 2015. The figure below shows the effect of balancing on pension accrual and pay-outs. The solid line shows the indexation of pensions under normal conditions (i.e. by using the income index). The dotted line shows the effect of balancing: pensions are indexed to the change in the "balance index" instead of the change in the "income index". The balance index is calculated by multiplying the balance ratio (which is less than 1.0 if balancing is activated) and the income index. For example, if the balance ratio is 0.990 and the income index is 104.00, the balance index is 102.96 (0.990 x 104.00). Pensions are then increased by 2.96% (Swedish Pensions Agency, 2013, p. 24). It is important to note that automatic balancing can either mean a lower rate of indexation (i.e. a slower increase), or it can mean a reduction in the value of pensions, depending on the values of the balance ratio and income index.

The automatic balancing mechanism was activated for 2010 and 2011. In 2012 and 2013 income pensions were increased by 3.5 and 4.1%. For the year 2014 income pensions will be reduced by 2.7%. Benefits which are linked to inflation will decrease by 0.2%.

Figure 2: Effect of balancing mechanism



Source: Swedish Pensions Agency, 2013

Occupational Pensions

Four negotiated agreements cover nearly 90% of Swedish wage-earners:

- **SAF-LO** (blue-collar private sector workers);
- **ITP-1** (white collar workers in the private sector);
- **PA03** (for state employees); and
- **KAP-KL** (for municipal employees).

The occupational pension sector has grown in importance during the last few decades. In 2010, negotiated pensions constituted 22% of all pension pay-outs (Pensionsmyndigheten 2012, p. 97). If we estimate the size of the different pension pillars according to the total value of contributions paid into the different schemes, the occupational pension sector is even larger. In 2010, 62% of contributions were paid to the state pension, 34% to occupational pensions, and 4% to private pension savings. Premium pension contributions are included in the figure for the state pension (Swedish Ministries of Finance and Social Affairs, 2013, p. 21). In 2011, occupational pension assets administered by life insurance companies were SEK 1,582 billion, about a 50% increase since 2006 (Swedish Ministries of Finance and Social Affairs, 2013, p. 41). In comparison, assets in the premium pension system totalled SEK 433.5 billion in 2011.

The occupational pension sector has changed substantially since the 1990s. The four large sectoral schemes remain, but they are no longer defined benefit. Today, private-sector occupational pensions are defined contribution, and participants choose the type of funded pension product they prefer. Public sector occupational pensions are hybrid schemes, combining elements of defined contribution and defined-benefit (Lindquist and Wadensjö 2011; Swedish Ministries of Finance and Social Affairs, 2013, p. 37; Pensionsmyndigheten 2012, p. 96). In general, employers in all four sectoral schemes pay a contribution of 4.5% of wages below statutory pension ceiling, and 30% of wages above it. This makes occupational

pension costs for high income earners much higher than they are for average wage earners. 36% of wage earners had income above the statutory pension ceiling in 2007 (Swedish Ministries of Finance and Social Affairs, 2013, p. 38).

The majority of private-sector negotiated pension schemes operate much like the premium pension. Participants bear all risk for their investment choices, and they choose from a range of pension products offered through a fund platform. The public sector occupational pension schemes are somewhat different: there is no fund platform, but instead pension providers wishing to be included in the system must meet certain criteria in order to be part of the fund assortment.

2.1.3 Details on recent reforms

As noted above, there have been few recent reforms. The only recent changes to the pension system are:

- The introduction of a life-cycle default fund in the premium pension system (AP 7, Såfa, see discussion above) to replace the original default fund. The new default fund was introduced in April 2010. The rationale for the legislation was to match investments in the default fund more closely with the age profile of premium pension savers whose capital is placed in the default fund. The share of equities is larger for younger savers, and the proportion of bonds increases with age.
- The introduction of a slightly different method for calculating the balance ratio in the income pension system. In 1999, the five parties backing the original pension reform adopted legislation to introduce a three-year moving average (instead of using the annual average) for calculating the value of the buffer funds for the purpose of determining the balance ratio. This reduces the impact of short-term fluctuations on financial markets on the balance ratio. The buffer funds have sizeable investments in equities (50-60%), so the buffer funds lost 22% of their value in 2008 as a result of the stock market downturn (Pensionsmyndigheten, 2009, p. 28).

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

In 2011, there were about 2 million pensioners aged 55 or older. If we include pensioners aged 65 or older, there were 1.765 million (www.scb.se). Pensioners are a heterogeneous group, so there are large variations in terms in pension levels. Despite this heterogeneity, all pensioners are guaranteed a minimum level of income via the guarantee pension and income-tested old age support (ÄFS). These sources of basic income support ensure that a fairly small proportion of the elderly are at risk of poverty.

According to the recently presented Budget Bill for 2014, the share of pensioners with very low income - 60% of median disposable income - has increased somewhat between 2002 and 2011, from just fewer than 12% to just fewer than 14%. The share is projected to decrease in 2012 and 2013.

Table 1: Elderly poverty rates 2012-2013

Age & Household Situation		**Proportion with low income in 2013 (projection)**		**Increase or decrease since 2012**	
		Men	**Women**	**Men**	**Women**
66-79	Single	13	18	-4	-2
	Partner	4	4	0	0
80+	Single	20	22	-2	-4
	Partner	7	6	-1	0

Source: Ministry of Finance, 2013, p. 18.

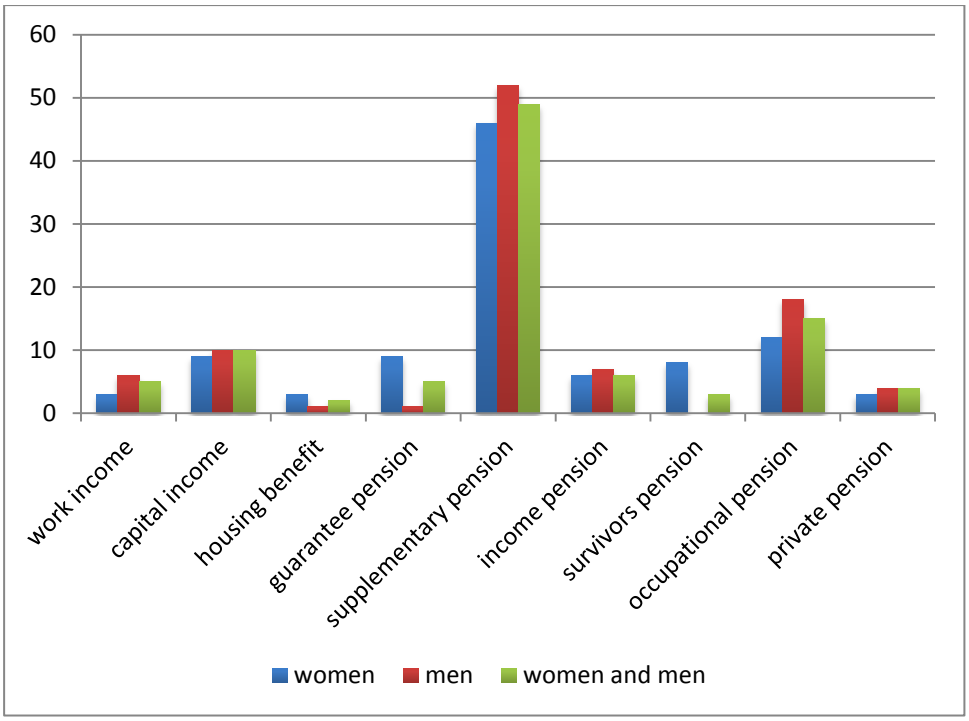
As the table above shows, pensioners living alone are more likely to have low income, and single women living alone are more likely to have low income than men living alone or pensioners living with a partner. The share of persons with low income increases for single men and women over age 80. Pension increases in 2013 probably explain much of the decrease in the share of older persons with low income between 2002 and 2013.

EUROSTAT statistics suggest a similar picture, although the figures differ from the ones used in policy documents in Sweden. In 2012, 17.5% of those aged 65 or older were at risk of poverty (defined as 60% of equivalised median income after social transfers), but the proportion is much higher for women than for men. According to EUROSTAT, 23.1% of women 65 and older were at risk of poverty, compared to 10.2% of men (www.eurostat.eu). Women's at-risk-of-poverty rates are likely to decrease in the next two decades as the number of female pensioners with full time or nearly full time lifetime earnings increases.

Pensioners receive income from several sources: employment, capital investments, housing supplement, the guarantee pension, the supplementary pension (the old ATP system), the income pension, the premium pension, occupational pensions, and private pensions. The graph below shows income sources for persons aged 66 or older in 2009. The data is shown in per cent. For example, 49% of the total income for women and men 66 and older came from the supplementary pension scheme. Because the reformed pension system is not yet fully phased in, only 6% of pensioners' income came from this source. Thus, 55% of pensioner income comes from the two earnings-related pension systems. As the chart shows, occupational pensions are an important source of income for pensioners, accounting for 15% of pension income. 5% of pensioner income comes from employment.

The chart also demonstrates that women pensioners as a group tend to receive a larger share of their income from housing benefits and the guarantee pension than men. The share of women's income that comes from occupational pensions and supplementary pensions is also lower than it is for men.

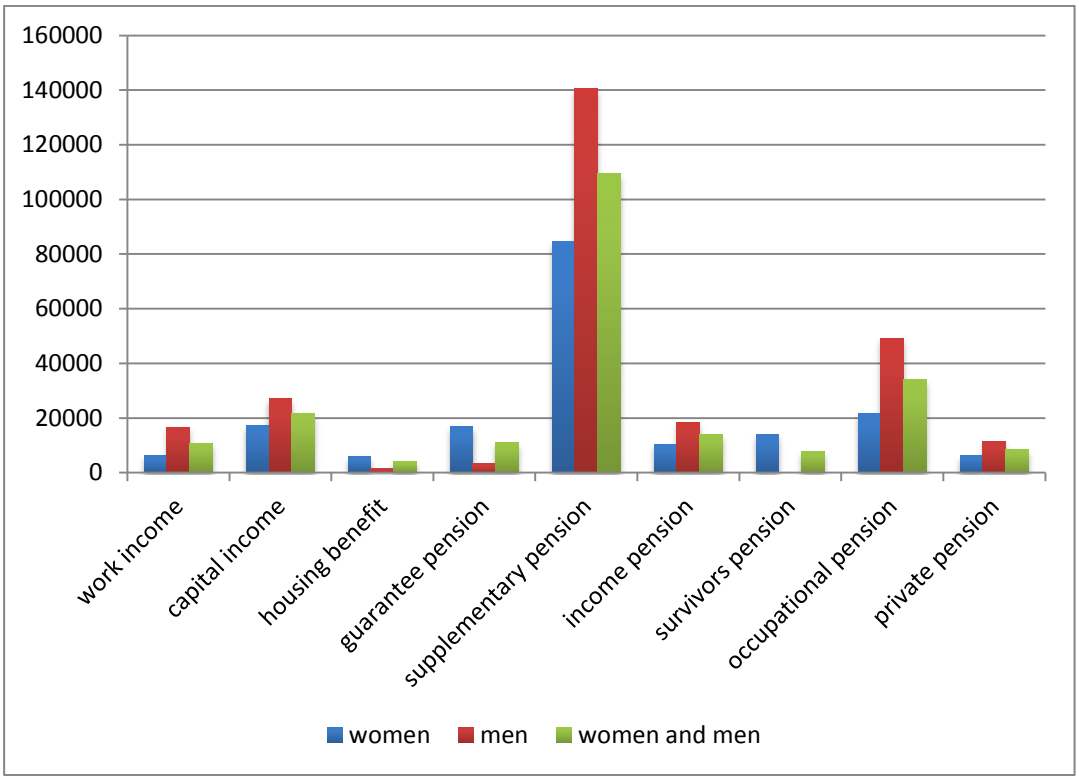
Figure 3: Income sources for persons 66 and older, in per cent (2009)



Source: Swedish Ministry of Social Affairs, 2011, p. 33.

The graph below shows a different aspect of the same data. The graph shows the average amount of annual income from different sources (in SEK) for men and women. Men receive a much higher average supplementary pension benefit than women (SEK 140,636 for men and SEK 84,695 for women), and men's average occupational pension is significantly higher than women's (SEK 49,298 for men versus SEK 21,818 for women).

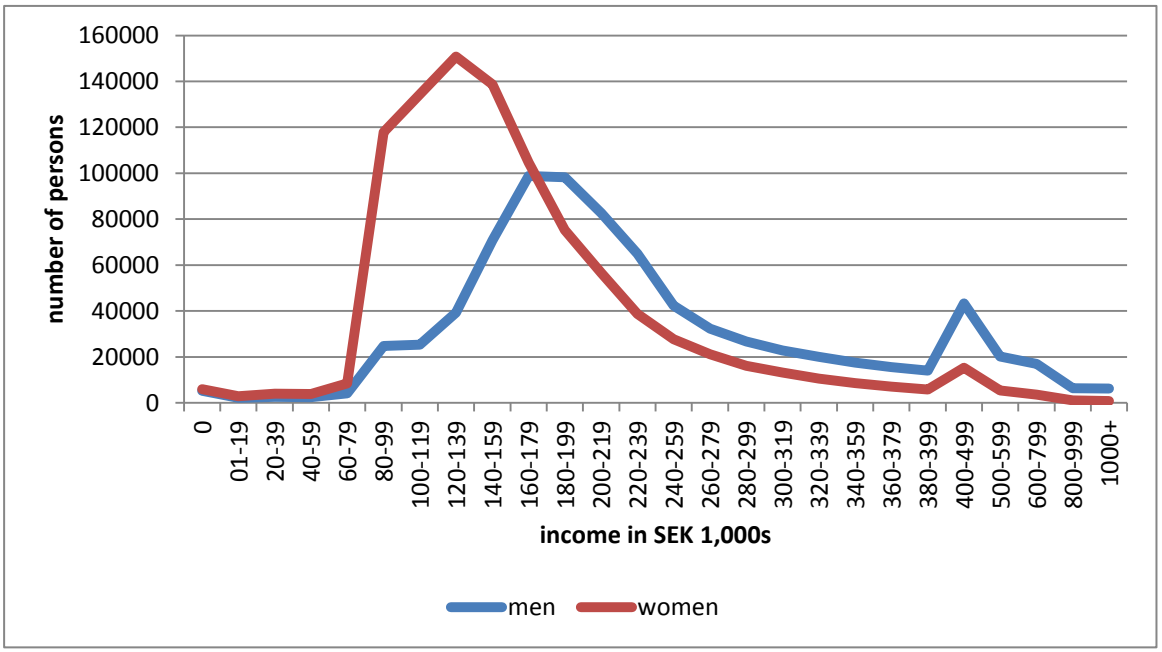
Figure 4: Income sources for persons 66 and older; average amount per category in SEK (2009)



Source: Swedish Ministry of Social Affairs, 2011, p.33.

Another way to observe the relationship between men's and women's incomes in retirement is to compare the number of male and female pensioners at different income levels (does not include capital income). The chart below does this, showing that higher numbers of women have low incomes (for example, between SEK 60,000 and SEK 179,000) than men.

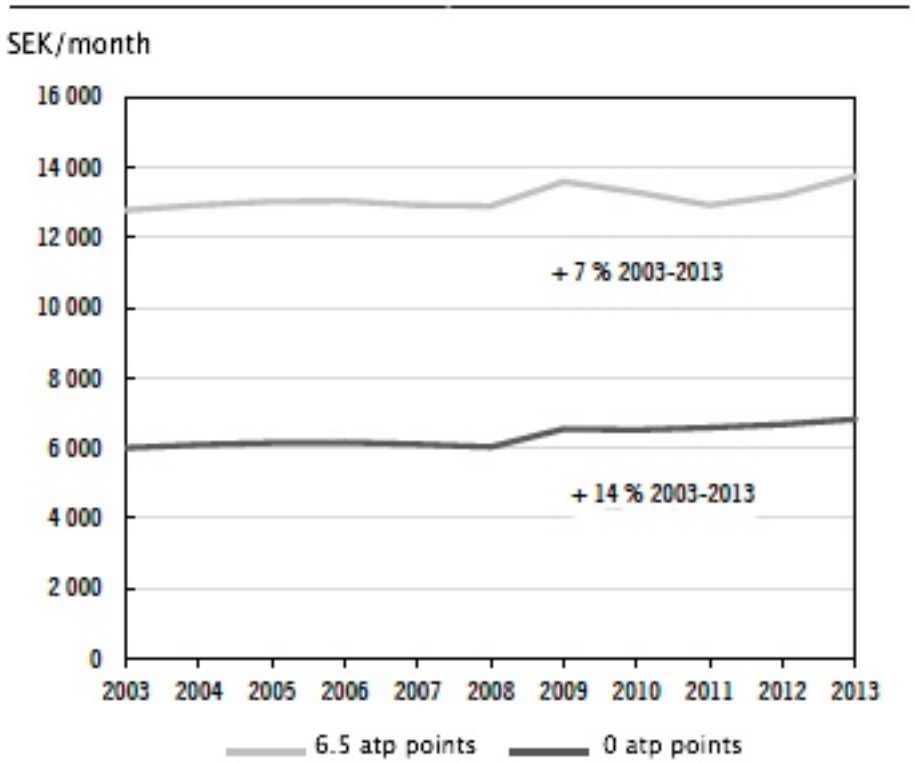
Figure 5: Income for those 65 or older, by gender, 2011



Source: www.scb.se

In terms of public pension income, pensioners have fared differently during the last decade. In particular, those with the lowest pensions have seen their incomes increase the most since 2003, relative to more affluent pensioners. Low income pensioners' incomes rose by 14%. The main reason for this is the tax cuts for pensioners in the years 2009, 2010, 2011 and 2013. An unmarried pensioner with only basic support in the form of a guarantee pension--- about SEK 6,000 per month--- experienced a 14% increase between 2003 and 2013. In contrast, a pensioner with 6.5 ATP pension points (equal to about average wages; based on the old system)--- between SEK 12,000 and 14,000 per month--- had an increase of 7% in the same period (see chart below). Housing subsidies are not included in these figures, even though they are very important for those with a low pension.

Figure 6: Income pension increases between 2003 and 2013



Source: Ministry of Finance, 2013, p. 13

To summarize, the Swedish pension system performs well in terms of income adequacy, although women are more likely to be at risk of poverty than men, especially at higher ages. Pensioners living alone are also more likely to be at risk of poverty than pensioners living with partners. Finally, the income adequacy function of the system has weakened somewhat because of the design of the automatic balancing mechanism, which tends to hurt pensioners more than it does workers, largely because workers have more time to benefit from the "catch up" phase of the balancing mechanism than pensioners do. This issue is discussed below in section 2.3.

2.2.2 Sustainability

One of the core features of the Swedish pension system is financial sustainability. As discussed in previous sections, the income pension system is an autonomous system that is designed to be self-financing. Pension accrual and pay-outs are automatically adjusted to changes in life expectancy, the value of the buffer funds, and developments in real wage growth. This means that the pension system is constructed so that economic and demographic developments, rather than political decisions, determine the rate of return to notional pension assets and pension pay-outs. One of the strengths of the Swedish system is that it has performed more or less the way it was designed to work in terms of financial sustainability. To be sure, pensioners were hit hard in 2012 and 2013 by automatic balancing, but the government stepped in to provide tax cuts to pensioners to offset some of the cuts. The

general budget finances the tax breaks, so they do not affect the financial status of the pension system.

The stock market downturns of the early 2000s and 2008 have led several political actors to question some of the basic elements of pension system. The activation of the automatic balancing mechanism in 2010 and 2011 led to outcry among pensioners and labour organizations. Because of widespread dissatisfaction among pensioners about pension cuts, the non-socialist government adopted tax cuts for pensioners that offset much of the negative effect of balancing. In 2014, income pensions will be reduced again, by 2.7%. Another round of tax breaks for pensioners will offset some, but not all, of the reduction in pension pay-outs. Pensioners' organizations have responded to these developments by calling for the abolition of the premium pension system and the transfer of that portion of the pension contribution (2.5 percentage points) to the income pension system. This issue is discussed at more length below in section 2.3.

One of the goals of the pension system is to create strong work incentives, i.e. to encourage people to work more and to work longer. However, the de facto retirement age has not increased as much as policymakers had hoped. In fact, the average retirement age has remained stable since 1998, at approximately age 65 (Pensionsmyndigheten, 2013). A major report issued by an investigatory commission (the "Retirement Age Commission"; see http://www.pensionsaldersutredningen.blogspot.se) in April 2013 observes that 80% of workers retire when they reach age 65. Moreover, the number retiring between 61 and 65 has been higher than expected (Statens Offentliga Utredningar: 25). Nevertheless, an increasing number of retirees combine employment with pension receipt. Between 1997 and 2009, the percentage of retirees aged 66 with income from employment increased from 19% to 36%. For this group, employment income was 19% of their total income in 2009. For those aged 65 and over, employment income was 5% of total income (Statens Offentliga Utredningar 2012: 28, p. 32). On the basis of the findings of the Retirement Age Commission, the government is considering legislation to rise the minimum retirement further. This issue is discussed below in section 1.3.

2.2.3 Private pensions

As discussed above, private occupational pensions negotiated in collective agreements are important sources of income in retirement. Occupational pensions have changed significantly in the last two decades. Until recently, the four large occupational pension schemes were defined benefit. Today, most occupational pensions for those born after 1972 are defined contribution. The typical pension contribution is 4.5% of wages below the statutory ceiling (SEK 424,500 annually in 2013) and 30% of income above the ceiling. Thus occupational pensions are an important supplement to public pension income. Moreover, given that 36% of workers had income above the ceiling in 2007, occupational pensions are a very important source of pension income for those with high incomes. Indeed, the assets in occupational pension schemes exceed assets in the premium pension system (Swedish Ministries of Finance and Social Affairs, 2013).

The wide coverage and size (in terms of contributions and pension pay-outs) mean that occupational pensions are a core element of the overall pension system in Sweden. However, the defined contribution design of these funded pensions means that individuals are fairly exposed to capital markets. According to the calculations of the Swedish Pensions Authority, about 40% of pensions will be based on investments on capital markets in the future (premium pension and occupational pensions). Whether this is a strength or a weakness depends mainly on the long-term performance of capital markets and the timing of retirement in relation to financial market fluctuations.

2.2.4 Summary

The Swedish pension system is robust, financially sustainable, and performs well in terms of income adequacy. The system has universal coverage - including the self-employed and the free professions - so all income-earners are subject to the same set of rules concerning their pension. Occupational pensions supplement public benefits for more than 90% of the workforce, and low-income earners are covered by other forms of income support in retirement (guarantee pension, old-age income support). However, older pensioners, especially single women, are much more likely to be risk of poverty than younger pensioners, male pensioners and couples.

Because of the pension system's reliance on DC principles, work incentives are strong. However, financial market fluctuations can mean variations in the level of the premium pension even for those with the same contribution history. Even the income pension is not immune to financial market swings: the assets in the large buffer funds are heavily invested in equities, so a stock market downturn can lead to slower or negative indexation of income pensions because of the automatic balancing mechanism.

2.3 Reform debates

Three issues dominate debates about the future direction of the pension system: the retirement age, the design of the premium pension, and the design of automatic balancing.

Raising the effective retirement age
As noted above, the reformed pension system is designed to provide incentives for people to work more and longer. Although the effective retirement age has increased to 65, policymakers argue that it needs to increase even more because of life expectancy gains and the increasing old age dependency ratio. The five parties behind the pension reform agreed in early 2011 that the government should establish an official commission of inquiry to investigate issues related to raising the effective retirement age and to propose legislative alternatives. The commission, the Retirement Age Commission (*Pensionsåldersutredningen*), issued its final report in April 2013 (Statens Offentliga Utredningar 2013:25). The commission's main recommendation is that retirement ages for all parts of the pension system, including occupational pensions, should be raised and linked to average life expectancy.

The commission proposed a target retirement age of 66 starting in 2019. This would mean that the minimum age for receipt of the guarantee pension and housing subsidies would have to be adjusted to this retirement age, i.e. increased from 65 to 66. In addition, the minimum pension age for the income pension would have to increase from 61 to 62 starting in 2015, with another increase to 63 around 2019. In order to encourage a longer working life, statutory employment protection would apply to age 69 starting in 2016 (the current limit is age 67).

The commission also proposed raising the minimum retirement age for occupational pensions to at least 62. Some occupational schemes currently allow retirement at age 55. Occupational pensions are negotiated by employers and unions, so the government has no authority to implement changes in these schemes. The commission suggested tripartite talks between the government, unions and employers to negotiate a higher retirement age. Unions have already signalled their displeasure at the suggestion of government interference in collective bargaining. The Social Insurance Minister has already declared that the government can use the tax code to push employers and unions towards raising the retirement age in collective schemes. Currently, contributions to occupational pensions are tax deductible as long as the earliest pension age is not lower than 55, and the Minister has stated his willingness to push

for changes in the tax code (i.e. limiting tax deductibility to schemes where the earliest retirement age is 62) to get the unions and employers to comply.

The premium pension

Two aspects of the premium pension are controversial and have been debated at length in 2013. First, the premium pension system does not function well in terms of individual freedom of choice. The system is designed to give individuals a wide range of investment options for the portion of their public pension contribution (2.5 percentage points of qualifying wages) that is allocated to the premium pension. The current fund catalogue offers about 800 mutual funds, but very few pension savers actually exercise their freedom to choose an investment fund. The overwhelming majority of new pension savers (>98%) do not actively choose a fund from the catalogue, so their capital is placed in the default fund, the Generational Savings Fund.

The latest evaluation (Swedish Ministries of Finance and Social Affairs, 2013) of the premium pension points to the high number of fund choices and unnecessarily high management fees are two of the most pressing problems facing the system. After thirteen years in operation, the number of participants making active choices has fallen dramatically. Even more dramatic is the radical decrease in active choice among new entrants: since 2006, less than two per cent of new entrants have made an active choice. The pattern of active or passive choice is more nuanced if we look at whether premium pension savers remain passive over time. Data concerning premium pension choices indicates that premium pension savers become more active as their income increases. That is, the longer a person participates in the premium pension system, the more likely he/she is to make an active investment choice. Even so, the level of active choice is not high. For example, 1.6% of new participants made an active choice in 2007, and the percentage had increased to 18% four years later. The author of the 2013 evaluation argues that most pension savers simply cannot deal with the information costs associated with the very large number of choices in the premium pension system. There are 800 funds in the catalogue, compared to 4 to 40 investment choices in most Swedish occupational pension schemes. These information costs mean that savers with insufficient information or knowledge end up choosing the default fund or they remain in their initial fund choice.

The evaluation made two proposals to address the problem of complexity. The first alternative is to create several (for example, about 10) large, state-run investment funds with different risk profiles that pension savers can choose between. This would also mean abolishing the fund catalogue with 800 private mutual fund products. The second proposal is to make small adjustments to the current system, for example, requiring pension savers to regularly confirm their choices.

The second aspect of the premium reserve that has sparked much debate concerns the potentially very different pension outcomes that the system is likely to produce. Depending on individual investment choices, financial market fluctuations and the timing of retirement, the pension income generated by the premium pension can vary dramatically, even among persons in the same birth cohort and among persons who have had the same lifetime income and thus the same level of contributions. When the system is fully phased in, the premium pension will comprise about 20% of the overall statutory pension, or SEK 3,500 per month, for an average earner with a medium risk portfolio after 40 years of contributions. Other pensioners with the same lifetime earnings from employment may receive between SEK 1,700 and SEK 6,000 per month depending on the rate of return to their fund portfolio (*Premiepensionsmyndigheten*, 2009, p. 6).

In 2013, the Social Democratic Party, the Trade Union Federation (LO), and all of the major pensioner's organizations called for the abolition of the premium pension and the transfer of premium pension assets and pension rights to the income pension system. It is unlikely that this will happen, given that the Social Democratic Party has committed itself to the pension reform, and the five party pension group makes decisions consensually. Most of the other parties in the pension group have declared that they will not accept the abolition of the premium pension, so it is highly unlikely that it will happen. However, it is possible that the Pensions Group will negotiate a reduction in the size of the premium pension contribution (i.e. from 2.5% to 2.0%). Besides the Social Democratic Party, two other parties in the Pensions Group have signalled their willingness to discuss this.

Automatic balancing

As briefly discussed above, the automatic balancing mechanism has also been the topic of much debate. A major evaluation of the Swedish pension system carried out by an outside expert published in 2013 argues that the automatic balancing mechanism harms pensioners more than workers. The balancing mechanism is a harsh instrument that can lead to sharp cuts in pension accrual and pay-outs. Pensioners are harmed more by the mechanism because they have much less time than workers do to reap the gains of the "catch-up" period in which pensions are indexed at a higher rate of return than normal (if the balance ratio permits this) after the initial phase of balancing in which pensions are indexed more slowly - or even reduced - in order to restore balance. The Pensions Group negotiated a change in the calculation of the buffer funds in 2009 in order to dampen the effects of the balancing mechanism. Given that pension cuts required by the balancing mechanism were implemented in 2010 and 2011 and are scheduled for 2014, it is not inconceivable and the Pensions Group will negotiate additional adjustments to the balancing mechanism.

National reforms and EU 2020

The Europe 2020 strategy has not had much influence on Swedish policy debates and decision-making concerning pensions. Despite this, Swedish policy priorities are largely in line with the Europe 2020 strategy because the current pension system rests on a political compromise that emphasizes both fiscal sustainability and benefit adequacy. As discussed above, raising the retirement age is an important item on the political agenda, and much preparatory analysis has already been carried out. It is likely that some form of pension age increase will be adopted in the immediate future. In addition, the government has adopted policy changes and tax breaks for pensioners that aim to shield them from the negative effects of the financial and economic crisis. In addition to tax cuts for pensioners, the government has increased the housing benefit for low-income pensioners. These measures are discussed in Sweden's National Reform Programme, but they are rooted in policy debates that have been conducted for more than a decade.

3 Health care

3.1 System description

3.1.1 Major reforms that shaped the current system

In 1862, the regional division into municipalities and county councils was established. In the beginning, the county councils were responsible only for health care for the poor. From 1919, country councils became responsible for epidemic diseases, and gradually, more and more tasks were allocated to county councils. From the 1920s onwards, health care became an ever increasing part of the total budget, and from 1938, also dental care became part of the county councils remit. The major expansion of both in-patient and primary care took place between 1950 and the 1980s, with specialist care concentrated to a few large-scale hospitals. During the 1970s, county councils were used as a means of creating new employment opportunities in regions hit by de-industrialization, which contributed to the expansion. (Nilsson & Forsell, 2013)

From the mid 1980s, many county councils struggled with deficits and low productivity. The 1990s recession accelerated ongoing changes in the health care system, and there was a sharp decrease of both the number of beds and staff, especially assistant nurses. In regions where county council employment had been used to buffer against shrinking labour demand, the number of staff in 2010 was about half of that in 1990. Emergency care has been further concentrated to a few hospitals (ibid). Privatization started on a small scale in 1984 as doctors were permitted to open private practices while still being employed by county councils. As part of an increasing focus on cost control, a number of New Public Management (NPM) reforms were implemented in the early 1990s, including a purchaser-provider split. However, many county councils have returned to a traditional mode of planning and control (The Health Systems and Policy Monitor). Regionalisation, in which county councils assume responsibility for regional development, which is normally managed by governmental county administrative boards, has recently been established through mergers in Skåne and Västra Götaland, and through a reorganisation of the county councils of Halland and Gotland.

3.1.2 System characteristics

The Swedish healthcare system is decentralised. The state is responsible for overall health care policy while the 16 county councils and four regions have the overall responsibility for health care services, as stated in the Swedish Health and Medical Services Act of 1982. About 70 % of the county council's total costs are financed through taxes, 16 % by state grants and 4 % are financed through patient fees (SALAR, 2013a). Each county council takes its own decisions on the tax rate and how to allocate tax revenues. Primary care forms the foundation of the health care system and there are over 1100 primary care units throughout the country. There are about 70 hospitals at the county level, while specialized care is concentrated to the seven regional/university hospitals. (Health Systems and Policy Monitor).

Since the organization of health care is open to the individual county council, there are regional differences in the governance and provision of health care. For example, the proportion of private primary care units varies substantially between the county councils. In some counties, for example in Stockholm, about half of all units are privately owned, whereas only a few private primary care units exist in some county councils. From 2007, accredited private providers may freely establish themselves and compete with public and private health care centres. Private providers are publicly funded in the same way as publicly run primary care. Private hospitals are rare; there are a total of six in the country, three of which are for profit. (Health Systems and Policy Monitor)

The national level primarily governs through establishing laws and ordinances or by reaching agreements with the Swedish Association of Local Authorities and Regions (SALAR), a collaborative national organization which represents all county councils/regions and municipalities. There are a total of eight government agencies in the area of health, medical care and public health. The newly established (June 2013) Inspectorate for Health Care and Social Services (Vårdanalys) follow up on and evaluate health care services to determine whether they correspond to the goals laid down by the central government. The National Board of Health and Welfare (Socialstyrelsen) develops norms and standards, provides support, and disseminates information. Moreover the Board maintains health data registers and official statistics.

3.1.3 Details on recent reforms

In 2009, the Swedish pharmacy market was re-regulated by allowing private owners to operate pharmacies. At the same time, non-prescription drugs were made permitted for sale outside of pharmacies. A recent evaluation of the reform has shown that the number of pharmacies has increased by about 40 %, to 1300 in 2013 (Statskontoret, 2013). The total cost for drugs with generic alternatives has decreased by 10 %. New brands have been established for non-prescription drugs, which cost 15-75 % less than previous brands. Patients however report that the quality of advice given has decreased, and 60 % of staff says that there are fewer opportunities for training. The supervision of retail for non-prescription drugs, which is the responsibility of the municipalities, is also found to be lacking.

During the last decade, there have been efforts towards strengthening national influence. One way to strengthen national governance is the development of national "action plans". These are implemented by county councils but supported by additional government grants. The PRIO-strategy concerns improving access to psychiatric care for children and young people, development of preventive measures, increased access to somatic care for psychiatric patients, more patient-focused psychiatric care and increasing employment among those with a mental disability (Socialdepartementet, 2012a). In 2012 a new strategy for equal care was launched, covering 2012-2016 (Socialdepartementet, 2012b). Among the initiatives are open comparisons of county councils and individual clinics (see 3.2.2), surveying patients' experiences of access to and quality of primary care and specialist care, and training personnel in health care to ensure equal treatment and prevent discrimination. Several target groups are mentioned, among them national minorities, children of lone parents, people with dementia or psychiatric illness, and people with disabilities. Another long-term strategy concerns the cost-effective, safe and efficient use of pharmaceuticals, including antibiotics (Socialdepartementet, 2012c).

The Government puts a lot of emphasis on the freedom to choose the primary health provider, as well as the free establishment of privately owned primary care, as a means to improve access of care. Since 2010, all county councils are mandated to provide patient choice and private providers in primary care, but each county council determines the specific demands on providers as well as the system of remuneration (SFS 2008:962). In 2013, 68 billion SEK (about € 7.8 million) has been allocated to 13 county councils who are developing systems of choice of care within specialist care (http://www.government.se/sb/d/15472/a/184692). The total sum allocated to increase patient choice during 2012-2014 is 360 billion SEK. The arguments put forward in favour of increasing patient choice are to empower patients, and to make it easier for private providers to establish a primary care practice (Fredriksson et al 2013). While studies have shown that both the number of new providers, and the number of visits in primary care have increased (Vårdanalys, 2013a), it has been debated whether equality of access has been affected. The Swedish Agency for Health and Care Services

Analysis are currently evaluating the reform by investigating equality of care between socioeconomic groups.

There is currently an ongoing reorganization of Government agencies within health care and public health. Since June 2013, there is a new agency (the Inspectorate for Health Care and Social Services/*Inspektionen för vård och omsorg*) with the responsibility for supervision of providers, health care professionals and handling complaints from the public. The overall purpose is to strengthen the supervisory function but also to separate it from normative functions, which used to be part of the National Board of Health and Welfare. The Government will also establish the Agency for Health and Care Infrastructure to coordinate the development of information technology solutions for the health and social care sector, and the Swedish Institute for Communicable Disease Control and the National Institute for Public Health will be merged to create the new National Institute for Public Health. The latter agency will also take over functions relating to environmental health and public health monitoring from the National Board of Health and Welfare. (Health Systems and Policy Monitor)

3.2 Assessment of strengths and weaknesses

The strong tradition of local self-government has led to unfavourable regional differences, as highlighted by for example The National Board of Health and Welfare (Socialstyrelsen, 2011a). The report underlined the existence of large regional differences in quality and access to care, including pharmaceutical treatment, and large social inequalities in avoidable care and mortality. This is in sharp contrast to the main objective of health care according to the Health and Medical Services Act (1982:763): Care on equal terms, according to need. Areas especially emphasized in the report were for example the various systems of patient fees. Fees are set by the individual county councils and can differ substantially. Although the systems for health care, pharmaceuticals and aids have ceilings, the combined fees may add up to high amounts during a short time interval.

There is a lack of doctors within certain specialties, and the regional differences are large in this respect. The use of new (more costly) pharmaceuticals also differs between county councils, and some county councils have divergent guidelines from the national guidelines set by the National Board of Health and Welfare. Avoidable in-patient care is twice as common among people with low education compared to high education. Research has also shown higher mortality and higher disease stage at diagnosis of malignant melanoma for people with a low level of education (Eriksson et al 2013), and social inequalities in treatment of lung cancer and prostate cancer (Berglund et al 2010, Berglund et al 2012). The report on unequal care has led to the strategy for equal care which was mentioned above, and these unjustified differences constitute a major challenge for the health care system.

3.2.1 Coverage and access to services

All Swedish residents are granted access to care, regardless of nationality. Emergency coverage is provided to all patients from the EU and European Economic Area countries, and nine other countries with which Sweden has bilateral agreements (Source: the Health Systems and Policy Monitor). Regarding access for non-residents, from June 2013 people who stay in Sweden without a legal permit will have the same subsidized health and dental care as an asylum seeker (Act 2013:407). For children, this applies to all health care and dental care, including preventive care. For adults, all care that cannot be delayed, including dental care, is covered.

Health care services are highly subsidized and some services, like maternity care and primary care for children, are provided free of charge. Patient fees in primary care vary between 150 and 200 SEK depending on the county council, and fees for specialist care vary between 50

SEK after referral to at most 350 SEK. Patient fees in in-patient care also vary widely between county councils (and sometimes according to age, income, or duration), from 40 SEK/night to 100 SEK/night. (SALAR, 2013b) There is a national ceiling for health care costs set at SEK 1100 (€122). When the ceiling has been reached, the patient pays no further charges for the remainder of the 12-month period. There is a separate ceiling for co-payments of prescribed drugs. Up to SEK 1100, the patient has to pay the full amount, and the maximum amount over 12 months is SEK 2200 (Health Systems and Policy Monitor). In the National Survey of Public Health, only 2 % of the population state that they have refrained from care due to financial reasons (www.fhi.se). This is however more common among the unemployed (9 %), the 20 % with the lowest incomes, and young people (16-29 year-olds).

In the Public Performance Reports (see 3.2.2), availability indicators are presented (SALAR/ National Board of Health and Welfare, 2013). According to the National Healthcare Survey, 80 % of people agreed wholly or in part with the statement, "I have access to the health care I need" while 8 %t reported that they lacked access to care. The counties varied between 3 and 11 %. Among those with poor health, access to care was lower than for other groups. Since 2005, there is a national care guarantee concerning acceptable waiting times. A patient should be able to contact primary care the same day (0), and should see a primary care doctor within seven days (7). An appointment with a specialist is to be offered within 90 days (90), and an intervention should be offered within 90 days after being ordered (90). If these waiting times are not met, the patient should be given information about seeking care with another provider.

Table 2 Four indicators of availability of care

Indicator	**Average (%)**	**Range (%)**
Phone calls answered	89	71-99
Primary care within 7 days	93	83-98
Specialist appointment within 90 days	92	81-99
Surgical procedure within 90 days	88	72-98

Source: National Healthcare Survey 2012

To support the national guarantee, a performance based grant, the 'waiting list billion', has since 2009 been rewarded to those county councils that meet the national guarantee. A follow-up of the 'waiting list billion' has shown overall positive effects with increasing access to both primary and specialist care (Socialstyrelsen, 2012a). Patients are however still not satisfied regarding access to specialist care. As the report states, there is a risk that returning patients are sacrificed for new patients, which are covered by the guarantee. This would indicate that those with the greatest need are not prioritised.

3.2.2 Quality and performance indicators

Equity in health care and social care is supported by the Public Performance Reports (SALAR/ National Board of Health and Welfare, 2013). These have been published since 2006 in, among other areas, health care and elderly care (Ministry of Health and Social Affairs/Socialdepertementet, 2010). Indicators on medical quality are taken from the Swedish National Board of Health and Welfare registers and the national quality registries (www.kvalitetsregister.se). There are at present 73 registers and 169 indicators within different areas, from respiratory failure to rectal cancer. Both outcome and process measures are included. A number of the indicators are patient-reported outcome measures (PROMs)

and patient-reported experience measures (PREMs), taken from the National Healthcare Survey and National Patient Survey. Other indicators include per capita costs and availability of care within a certain time. The aims of the open comparisons are to increase the quality of care, transparency and data quality. Indicators are reported in ranked county-by-county comparisons, hospital data is reported by county and time trends are presented at the national level.

A recent evaluation of the method of Public Performance Reports state that transparency has increased and the comparisons have strengthened the means to improve the quality of health care, although comparisons are assessed as insufficient as a means of improving the work done at individual clinics (Vårdanalys, 2012). The effect on improving data quality has been weak, but the Public Performance Reports has pointed out areas where improvements are needed. For cancer care (breast, prostate, colon and rectum cancer) target levels have recently been set by the National Board of Health and Welfare with the purpose to increase quality and efficiency of care. Lung cancer care has had set targets since 2011 (Socialstyrelsen, 2013a). Indicators may concern survival and relapse, coverage in quality registers, proportion of patients in RCTs, multidisciplinary conference prior to treatment and after operation, complete pathology analysis, re-operation, radiation and specific medication. In May 2013, the Board was commissioned to develop indicators also regarding stroke, diabetes and cardiac care.

3.2.3 Sustainability

The Government assesses the finances of the county councils and municipalities to be stable during the coming years, despite the weak economy. A large majority of all county councils and municipalities reported positive results in 2012 and income from taxes are expected to increase, both due to employment growth and tax increases. Although budgets have been tightened, both health care expenditure and expenditure for long-term care has continued to increase. As a response to the economic crisis, the Government contributed with extra state funding in 2011, and county councils and municipalities generally raised taxes both in 2012 and 2013.[4] With a continuously increasing proportion of elderly, it is imperative that total employment also increases for the long-term sustainability of care and a continuing high quality of care.

3.2.4 Summary

The Swedish healthcare system is decentralised. The state is responsible for overall health care policy while the 16 county councils and four regions have the overall responsibility for health care services. Since the organization of health care is open to the individual county council, there are regional differences in the governance and provision of health care. For example, patient fees vary widely between county councils, availability of specialist care, and certain pharmaceuticals may differ. There is also evidence of social inequalities in cancer care and avoidable in-patient care and mortality. These unjustified differences constitute a major challenge for the health care system.

During the last decade, there have been efforts towards strengthening national influence, for example through the development of national "action plans". Action plans have been introduced in e.g. psychiatric care, equal care, and pharmaceutical use. Furthermore, since 2010 all county councils are mandated to offer patient choice and private providers within

[4] See Government Bill Prop. 2012/13:100, spring budget of 2013.

primary care, and there is a national guarantee concerning waiting times in primary and specialist care.

Since 2006, quality and performance indicators have been regularly presented for individual county councils and hospitals, with the aims to increase the quality of care, transparency and data quality. There are at present 73 registers and 169 indicators within different areas, from respiratory failure to rectal cancer. Both outcome and process measures are included. For cancer care (lung, breast, prostate, colon and rectum cancer) national target levels have been set. Indicators will also be developed regarding stroke, diabetes and cardiac care.

3.3 Reform debates

During 2012, Sweden's largest newspaper *Dagens Nyheter* ran a series of articles which severely criticised the New Public Management (NPM) within health care, especially steering models that focus exclusively on certain productivity outcomes, like number of visits, whereas the quality of care and the end-results in terms of morbidity and mortality are overlooked (Zaremba, 2013). According to the arguments brought forward, the detailed level of cost control may lead to a prioritization of only those tasks that are remunerated (answering phones within 1 minute, but not giving patients their test results within a reasonable time). These articles, written by an award-winning journalist, led to a heated debate, and was supported by many employees in health care. In June of this year, a petition, called *Läkaruppropet* (The doctor's proclamation), was posted online by a network of medical doctors (http://upprop.nu/vvgv). In the petition, the link between quantity and quality is challenged, and the administrative burden put on doctors due to the steering system is condemned as being equivalent to de-professionalisation and leading to less time being spent on patients. The focus on cost control is even seen as jeopardizing medical ethics as the most ill, and therefore costly patients, are avoided rather than prioritized. So far, over 9000 people, mostly MD's, have signed the petition. Meetings have been arranged jointly with The Swedish Society of Medicine during autumn 2013 to discuss alternative ways to organize health care. The response from the political side has been less than favourable, and the benefits of documenting care (in quality registers) and the overall high quality of care in Sweden is instead brought forward (Molin, 2013). However, recently an investigation was launched into better ways to use health care employees' resources and decrease the administrative burden (http://www.regeringen.se/sb/d/16781/a/226126).

Those critical of the 2010 patient choice reform, and the design of the reimbursement system, argue that the new model introduces care based on demand rather than on need, and that it creates incentives for providers to be established where it is profitable (Fredriksson et al 2013). The critique has been especially harsh regarding the system of patient choice in some county councils, like Stockholm. According to unions and professional associations, the system, with equal remuneration regardless of a patient's state of health, gives incentives to maximize the number of patients in a given time to the detriment of those with the most complex needs. The remuneration has also been criticized as being too low and the whole system as being underfinanced. Since the specific design of the patient choice system is different in different county councils, they are also likely to have different effects. A comparison between three county councils shows that in Stockholm and Skåne, care consumption has increased the most for those with the least need, whereas in Östergötland the groups in most need of care has benefitted the most (Vårdanalys 2013a). According to the agency, this is above all related to the system of remuneration. In the county of Östergötland, the remuneration is dependent on both the age and income distribution in the local area. Furthermore, the remuneration has a larger fixed part (capitation) and is less dependent on the number of visits.

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

When the regional system of county councils and municipalities was established in 1862, it contained 2,500 municipalities. These have gradually been collapsed into the 290 and their tasks include schools and child care, social welfare services, roads, water, sewerage and energy infrastructure. Long-term care was previously the responsibility of county councils, but since 1992 the municipalities are responsible for long-term inpatient health care and care for older people. In the mid 1990's, the municipalities also took over the responsibility of care for the physically disabled and for those suffering from long-term mental illness. Prior to this, home help for the elderly was the responsibility of the municipalities, and medical care was the county councils responsibility. The coordination between municipalities and county councils was difficult and one purpose of the reform was to better integrate medical and social care. However, changing the dividing line seems to have shifted the problem further up the chain of care. Another purpose was to move care into people's homes and out of institutions. This is an ongoing development (Nilsson&Forsell, 2013).

4.1.2 System characteristics

In 2012, the total number of institutions in the 290 municipalities providing (LTC) for the elderly was 2700, and there were 2300 different units providing home-based care. The total number of recipients of home help in 2012 was 220 000 people, while 90 500 individuals were residing in care homes. 27 % of home-help units and 15 % of care homes were privately run. (Socialstyrelsen, 2013b) Today, the average age when admitted to a care home is about 84 years, and after only a year, half of those admitted will have deceased (Bergman, 2012). The total cost of health care and LTC was 14.1 % of GDP in 2011, a slight increase by 0.4 percentage points since 2002. 23 % of all costs for care are allocated to care for the elderly (Socialstyrelsen, 2013c). This represents 95 million SEK in 2011, a decrease by 4.5 percentage points of all municipal social services since 2002. 67 % of the municipalities total costs are financed through local taxes, state grants represent 18 % and user fees 6 % (Source: SALAR). Fees for LTC include care, rent, and meals. The maximum amount charged for care, whether home-based or in a care home, is 1760 SEK per month. All people receiving care are ensured a minimum of 5,000 SEK disposable income after tax and other expenses have been paid. For older people with high costs for housing and low pensions, there is a special means-tested housing benefit with a maximum of 5 000 SEK per month for a single person. Around 250 000 people receive this benefit yearly (The Swedish Pensions Agency).

4.1.3 Details on recent reforms in the past 2-3 years

The freedom of choice has been a prominent focus also in long-term care (see 3.1.3 and 3.3). It has been pointed out that certain patient groups, such as those with dementia, stroke, mental disabilities or sensory impairments, may not be able to use their right to choose (Meinow et al 2011). Those best placed to reap the benefits of increased choice are those with the ability to be 'active consumers' of care. The Government has commissioned an investigation into the effects of the system of choice, and an evaluation will be presented in 2014.[5] This evaluation will focus on the effects for users/patients, the development of quality, costs and efficiency,

[5] Committee Directive Dir 2012: 91 issued by the Ministry of Health and Social Affairs.

and the development of the elder care market. The investigation will also give recommendations concerning a similar law on patient choice as the one introduced for primary care in 2010.

An educational effort within long-term care is taking place between 2011 and 2014; the Boost for Carers, a SEK 1 billion training initiative. Municipalities and other providers that arrange courses in e.g. geriatric care and gerontology for nursing assistants can apply to take part of the special grant. In 2013, 293.5 million SEK was available for courses that may be held at higher secondary or tertiary level. Since 2013, the initiative covers also employees who work with people with functional limitations. The National Board of Health and Welfare has also been given the task of providing leadership training for managers in elder care. The training is on tertiary level and is equivalent to 30 ECTS. The cost for the course is paid by the government while travel expenses, temporary replacements etc. are paid by the municipalities. (Socialstyrelsen.se). The county councils are responsible for patients until they are discharged from hospital, while responsibility for home nursing and rehabilitation lies with the municipalities. This places high demands on the coordination of care between municipalities and county councils. Since 2011 an ongoing agreement between SALAR and the Government focuses on improving care for the most frail elderly, with the overall aim to enhance care coordination between county councils and municipalities. 4.3 billion SEK has been allocated to support mutual, long-term and systematic efforts within the overall aim. The five areas covered are better coordination of health and social care, increased quality of pharmacological treatment, palliative care, preventative care and dementia care. Since 2013 also mental health is included. As part of this agreement, quality registers in elderly care and evidence-based care have been introduced, and performance based bonuses have been developed (Socialstyrelsen, 2012b).

Another ongoing project is the development of local 'dignity guarantees' within elder care, with support from the Government. Since 2011 national ethical guidelines are part of the Social Services Act. These state that care for the elderly should preserve dignity and wellbeing, respect individual integrity and self-determination, provide for social activities and ensure a safe environment. Municipalities may apply for grants to develop local dignity guarantees, with the purpose of increasing the quality of care and to clarify what the individual can expect from LTC. A follow-up in February 2013 shows that in 2012 117 municipalities were given this grant (Socialstyrelsen, 2013d). So far, 106 municipalities have developed at least three local guarantees, but only a few have started to implement them.

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

5% of those in the age group 65 years or older reside in care homes, and another 8% receive home help. Among the estimated 305,000 65 years and above with major functional limitations, only 30% live in care homes. The proportion has decreased by 4 percentage points since 2007 (Socialstyrelsen 2013c). There has been a shift in focus within home care, so that the typical number of hours per recipient has increased, and recipients with few hours (1-10 per week) have become increasingly uncommon. Given that old people with less extensive needs are less likely to receive home help, it is not surprising that the number of hours spent on care by relatives has increased. One third of those providing help are estimated to spend 30 hours or more per week.

During 2007-2011, the total number of employees in long-term care decreased by 6%, while the total number of hours worked was stable (ibid). Based on full-time equivalence, 74% work as nurses' aides/nursing assistants, and only 4.5% as nurses. This is equivalent to 4.2

nurses, and 69.5 nursing assistants per 1.000 in the population 65 years and above. The Board of Health and Welfare assess that 1/5 of audited care homes have a shortage of nurses. In 2012, a survey was conducted among elderly people who already receive some sort of care (Socialstyrelsen, 2012c). In the survey, 40% state that it is difficult to get in contact with a medical doctor. Access to nurses is better for those residing in care homes (75% have good access) than for those receiving care in the home (less than 70%). Only 1.6% of all nurses working in elder care have specialist training in gerontology.

4.2.2 Quality and performance indicators

Prior assessments (2010-2011) show that although an overwhelming majority are satisfied with the care provided 80% of units assessed do not fully comply with national rules and regulations. An overall shortage of staff leads to poorly individualised care, few opportunities for going outdoors, and sometimes a lack of physical activity and rehabilitation measures. There was a shortage of night-time staff, and safety alarms were not responded to within a reasonable amount of time. Many elderly feel that they are not included in planning their own care, and that information is not adapted to the individual. ¼ of assessed municipalities had unsatisfactory routines in their handling of benefit applications. In many cases, documentation regarding whether interventions decided on were actually carried out was lacking. (Socialstyrelsen, 2011b, 2012d)

In the area of elderly care (Vårdanalys, 2013b), public performance reports are deemed to have become an important tool to increase the quality of care, although many municipalities find it difficult to use the results as they are being presented presently. It is an ongoing challenge to get an impact in those areas of care that bridge the responsibilities of county councils and municipalities. In contrast to health care, collecting data and developing indicators is a new effort and the area is continuously evolving, which makes it difficult to compare performance over time. Important quality registers within the area include the palliative register, Senior Alert (risk assessment regarding falls, malnutrition, oral health, and pressure wounds), SweDem (early diagnosis of dementia) and BPSD (Behavioural and Psychiatric Symptoms in Dementia). The latter register is used to rate symptoms in later stage dementia among patients in elderly care, and is followed by individually tailored interventions, that follow the national guidelines for dementia care which have been in place since 2010. Originally a local initiative in Skåne, it is now used by almost 600 units in 90 % of all municipalities (http://www.bpsd.se/).

4.2.3 Sustainability

In the short run there is no immediate crisis in LTC financing, although the economic recession has meant decreasing tax revenues for many municipalities. However, with the growing proportion of elderly, costs for long-term care are expected to rise by 70% until 2050, and the costs for health care by 30% (Socialstyrelsen, 2013c). The future demand for labour within long-term care is expected to increase by 50%. Also GDP is projected to increase, and as a percentage of GDP, the total costs of both long-term care and health care are projected to increase from 13% to 16%. According to a SALAR-report (2010), given that the previous cost development during 1980-2005 has been on average 1 percentage point above that projected by demography, an alternative scenario would be an increase (as a percentage of GDP) of 75 % just in elder care.

4.2.4 Summary

Since 1992 the 290 municipalities are responsible for long-term inpatient health care and care for older people. 5 % of those in the age group 65 years or older reside in care homes, and

another 8 % receive home help. The county councils are responsible for patients until they are discharged from hospital, while responsibility for home nursing and rehabilitation lies with the municipalities. This places high demands on the coordination of care between municipalities and county councils. Recent policy initiatives include an educational effort within long-term care; the Boost for Carers. In 2013, SEK 293.5 million was available for courses that may be held at higher secondary or tertiary level. At present, only 1.6 % of all nurses working in elder care have specialist training within gerontology. Measures are also taken to ensure better coordination between county councils and municipalities in the care of the frailest elderly. The freedom of choice has been a prominent focus also in long-term care. In 2012, 27 % of home-help units and 15 % of care homes were privately run. It has been pointed out that patients with dementia, stroke, mental disabilities or sensory impairments may not be able to use their right to choose. The Government has commissioned an investigation into the effects of the system of choice, for users/patients, the development of quality, costs and efficiency, and the development of the elder care market.

Over time, the proportion living in care homes has decreased, and those with less extensive needs are less likely to receive home help. As a proportion of all municipal social services, costs decreased by 4.5 percentage points between 2002 and 2011. Thus today higher efforts are expected from informal carers. However, demanding more from relatives will decrease labour supply and thus may jeopardise the overall goal to increase labour market participation rates. Given the growing proportion of elderly, costs for long-term care are expecting to increase, and it will be a challenge to maintain and develop the access and quality of care.

4.3 Reform debates

Whether private for-profit providers should be permitted to operate within health care and long-term care has been debated lively, fuelled by several highly publicised scandals within nursing homes. The criticism is especially targeted at large private health care corporations owned by venture capitalists, who manage to generate high profit margins exceeding those in other service sectors, while avoiding taxes through elaborate, although legal, tax planning. (The Health Systems and Policy Monitor) A majority of voters reject for-profit providers in welfare services, according to public surveys, but the only party that has said that they want to regulate profit-taking is the left party, whereas the Social Democrats are clearly divided on the matter. The National Board of Health and Welfare has made an evaluation of possible quality differences between private and public providers in elder care (Socialstyrelsen, 2012e). Their conclusion was that there were no systematic differences in quality between publicly and privately operated elderly care services. However, they also assess that the available information is rather scant and further studies are needed. The report also pointed at other factors that might be of greater importance, like the size of individual units (where smaller units perform better), and the educational level of the staff. From the industry, it has been emphasised that the municipalities have a possibility to enhance quality through their formulation of quality targets in their tenders (Svenskt Näringsliv/Almega, 2013). For example, demands on previous quality levels or staffing could be included, as well as performance-based remuneration.

A more general debate on the overall quality and the future costs for elder care has been initiated recently, stimulated by a documentary TV-series (http://www.svt.se/sveriges-basta-aldreboende/). In the documentary, specialist within gerontology and caring pointed at common problems like poor and unpalatable diet, multi-medication, lack of rehabilitation measures and few social activities. Some of these shortcomings may be amended through new binding regulations regarding dementia care (SOSFS 2012:12) and from 2015 for all residential care homes. The regulations concern for example a guarantee concerning 24 hour

staffing, that employees have adequate training, and that services granted are always followed up. SALAR has opposed these new regulations, partly due to anticipated cost increases. The Government has so far not made any statements regarding higher state grants to cover increased expenses.

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6 Annex – Key publications

[Pensions]

SWEDISH PENSIONS AGENCY (2013), The Orange Report 2013. April.

This annual publication presents statistics and information about the structure and development of the Swedish pension system. The report explains in detail how each of the components of the pension functions and their financial structure. There is also data concerning the sources of pensioners' income and an analysis of possible future scenarios for the development of the pension system.

BARR, NICHOLAS (2013) The pension system in Sweden. Report to the Expert Group on Public Economics. Report 2013:7.

This report was written at the invitation of the Expert Group on Public Economics under the auspices of the Ministry of Finance. The report offers a detailed analysis of the strengths and weaknesses of the pension system from an economist's point of view. The report praises several aspects of the Swedish system: benefit adequacy, flexible retirement choices, and fiscal and political sustainability. The report also identifies the following weaknesses: declining capacity of the pension system to prevent poverty; the automatic balancing system; choice overload in the premium pension; and the way that occupational pension systems sometimes hinder mobility and longer working lives.

[R3; R4] STATENS OFFENTLIGA UTREDNINGAR (2013) Åtgärder för ett längre arbetsliv. Slutbetänkande av Pensionsåldersutredningen, SOU 2013: 25.

This report is the final publication of the Retirement Age Commission. The report presents a detailed analysis of factors influencing pension take-up and exit from the labour market. The report proposes raising the retirement age in the statutory pension schemes as well as in the occupational schemes negotiated by unions and employers.

[R2; R5] SWEDISH MINISTRY OF SOCIAL AFFAIRS and MINISTRY OF FINANCE (2013) Vägval för premiepensionen. Ds 2013: 35.

This evaluation of the premium pension system finds that the system is both complicated and expensive. The report argues that the very high number of investment fund choices means that the system is too complicated for most pension savers. The report recommends either drastically reducing the number of investment options or keeping the current structure with minor adjustments, particularly requiring pension savers to confirm their choices regularly. In terms of cost, the report recommends an upper limit on fees charged by investment funds.

[R3; R4] PENSIONSMYNDIGHETEN (2013) Medelpensioneringsålder och utträdesålder 2012.

This publication presents detailed statistics and analysis concerned the average age at which people leave the labour market and/or start receiving an old-age pension. The report also includes data concerning the development of average pension age over time, as well as the average age that people begin working.

[Health care]

THE HEALTH SYSTEMS AND POLICY MONITOR, SWEDEN. retrieved on Oct 10 2013.

http://www.hspm.org/countries/sweden25022013/countrypage.aspx,

The health systems and policy monitor is a platform providing a detailed description of health systems and information on reforms and changes that are particularly policy relevant. The information provided is both comprehensive and up-to date. Its country pages include information on organization and governance, financing, physical and human resources, service provision, health reforms and assessment of the health system.

GOVERNMENT OFFICES OF SWEDEN (2013), Objectives and priorities for health and medical care, retrieved on Oct 10 2013

http://www.government.se/sb/d/15472/a/184692

This document outlines the 2013 objectives and priorities of the Government with regard to access to care, eHealth, personal health care accounts, patient safety and patient involvement, mental health, coordination of elderly care, pharmaceuticals and national quality registers.

SALAR/NATIONAL BOARD OF HEALTH AND WELFARE (2013), Quality and Efficiency in Swedish Healthcare - Regional Comparisons 2012, Stockholm.

This is the seventh report in in the series where health care quality and efficiency in the 21 Swedish health care regions is compared, by using a set of national performance indicators. Virtually all of the indicators that reflect survival and mortality reflect a favourable trend. The results are a bit more equivocal when it comes to drugs and medicinal products. The results for some indicators are broken down by the educational level of the patients. Those with the least education have poorer survival rates, higher mortality rates and a greater incidence of avoidable hospitalisation. Another general observation is that gaps in the quality of healthcare services are trending in different directions depending on whether women or men are considered. Both major and minor differences have emerged.

SOCIALSTYRELSEN (2013c) Tillståndet och utvecklingen inom hälso- och sjukvård och socialtjänst. Lägesrapport 2013, Stockholm.

”Annual Report on Health Care and Social Services 2013“

This is an annual report from the Board of Health and Welfare on the current situation and recent developments within health care, social services, disability and elder care. The general conclusion of the report is that although mortality for most causes continuous to decrease, there are social inequalities both in health and health care. Almost 90 % of patients in primary care are happy with the care provided, but more people in psychiatric care are dissatisified. Costs for primary care have increased by almost 10 % since 2007, while costs for long-term home care has increased by 18 %. Despite of this, the relative costs for elder care compared to all municipal social services has decreased during the same period.

SOCIALSTYRELSEN (2011a), Ojämna villkor för hälsa och vård – Jämlikhetsperspektiv på hälso- och sjukvården, Stockholm.

“*Unequal conditions for health and care – an equality perspective on health care*“

This report highlights regional and social disparities in health care, as well as ongoing initiatives and suggestions on how to remedy the situation. Areas covered in the report are

cancer care, the system of patient fees, lack of specialists in psychiatry and gerontology, and regional differences in guidelines for prescription of pharmaceuticals. Social inequalities are shown to be large in avoidable in-patient care, and avoidable mortality is higher among men and among foreign-born. There are also social inequalities in access to specialist care and pharmaceuticals, cancer care, and dental health. Regional differences are large regarding cancer care and care for alcoholism and drug dependency. Especially vulnerable groups regarding access to somatic care are psychiatric patients and people with disabilities.

[Long term care]

THE HEALTH SYSTEMS AND POLICY MONITOR, SWEDEN. retrieved on Oct 10 2013.

http://www.hspm.org/countries/sweden25022013/countrypage.aspx,

The health systems and policy monitor is a platform providing a detailed description of health systems and information on reforms and changes that are particularly policy relevant. The information provided is both comprehensive and up-to date. Its country pages include information on organization and governance, financing, physical and human resources, service provision, health reforms and assessment of the health system.

GOVERNMENT OFFICES OF SWEDEN (2013), Objectives and priorities for elderly care retrieved on Oct 10 2013
http://www.government.se/sb/d/15472/a/184513

This document outlines the Government priorities for 2012 with regard to ethical values and standards in elderly care through e.g. local dignity guarantees, coordination of care for the most frail elderly people, intitatives and protection for people with dementia, education and training intiatives, housing and freedom of choice within long-term care.

SOCIALSTYRELSEN (2013c) Tillståndet och utvecklingen inom hälso- och sjukvård och socialtjänst. Lägesrapport 2013, Stockholm.

"Annual Report on Health Care and Social Services 2013"

This is an annual report from the Board of Health and Welfare on the current situation and recent developments within health care, social services, disability and elder care. The general conclusion of the report is that although mortality for most causes continuous to decrease, there are social inequalities both in health and health care. Almost 90 % of patients in primary care are happy with the care provided, but more people in psychiatric care are dissatisified. Costs for primary care have increased by almost 10 % since 2007, while costs for long-term home care has increased by 18 %. Despite of this, the relative costs for elder care compared to all municipal social services has decreased during the same period.

Vårdanalys (2013b), Öppnar jämförelser för ökad kvalitet i vård och omsorg om äldre? Rapport 2013:2, Stockholm

"Does public reporting increase the quality of elder care?"

In this report, the Inspectorate for Health Care and Social Services evaluates the use of public reporting and quality registries within elder care. This area is quite recent and under constant development which makes it difficult to draw distinct conslusions. The purpose of public reporting are to increase quality of care, system transparency and the quality of data and indicators. The tentative conclusion is that public reporting has increased the opportunities to increase the quality of care, that the data presented to the public is not adequately user

friendly, that it is difficult to get an impact in the care bridging the county councils and municipalities and that the quality of indicators need to be further developed.

This publication is commissioned by the European Union Programme for Employment and Social Solidarity – PROGRESS (2007-2013)

This programme is implemented by the European Commission. It was established to financially support the implementation of the objectives of the European Union in the employment, social affairs and equal opportunities area, and thereby contribute to the achievement of the Europe2020 Strategy goals in these fields.

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