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Sweden: Markets within Politics

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The Swedish welfare state is regularly praised (or maligned) as the prototype of publicly organized and provided welfare. No matter how you slice it, the public sector is among the largest in the OECD, with public sector spending totalling 54 percent of GDP in 2005; the tax levels required to finance these extensive public commitments are similarly high (Statistiska centralbyrån 2007: 31). As in most other advanced industrial countries, pensions and health care are the two largest categories in the public budget, and governments have faced strong economic and political pressures to reform both programs. The public pension and health care systems have undergone substantial change during the past two decades, but both programs remain firmly within the public sector. However, the role of 'markets within politics' has increased substantially.

Today's reformed pension system is more market-conforming in terms of its actuarial fairness than the old 'ATP' system it replaced. Indeed, the introduction of the individual pension accounts in the new system (the 'premium reserve') defies the public-private distinction because it represents a quasi-private scheme administered by a public sector agency. The health care sector has experienced a similar set of changes. Internal markets have been introduced, and private providers are now permitted to compete with public ones. Thus the central conclusion of this chapter is that public dominance prevails, but the role of markets and other mechanisms usually associated with private provision has increased markedly. Politicians have introduced market mechanisms into pensions and health care in order to improve efficiency, cut costs, and stave off calls for more radical privatization initiatives. These shifts in the structure and financing of pensions and health care have far-reaching implications for the *politics* associated with pensions and health care. The reformed pension system is designed to function without political interference, thus taking much of the politics out of public pension provision (Anderson

2005). And the further decentralization of health care means that local governments take the heat for slow service delivery and increasing out of pocket expenses. In sum, developments in both sectors are marked by the partial retreat of the state--the public pension operates autonomously and most health care decision making is in the hands of local government.

THE PUBLIC-PRIVATE MIX IN HEALTH CARE

The Swedish health care system is dominated by public provision. The central government provides substantial public funding (from tax revenues) and sets the regulatory framework, and the 20 county councils (*landsting*) administer the system. The county councils are obligated to provide equal access to quality health care for all of their residents, and despite central regulation, they have considerable autonomy in their role as health care providers. Health care outcomes are among the best in the world. Life expectancy for women was 82.8 in 2005 and 78 for men, and infant mortality is very low.[1]

Sweden spends about 9 percent of GDP on health care (Socialstyrelsen 2005: 17), which is close to the OECD average. Health care financing relies on a mix of local taxation, state grants, and user charges. About 70 percent is financed by local taxes, 16 percent by the state, 3 percent is covered by patient charges, while the remaining 10 percent comes from other sources.[2] About 90 percent of health care costs are publicly financed; the fifth highest level (behind Luxembourg, the Czech Republic, the Slovak Republic and the UK) in the OECD in 2004. As noted, county councils have much freedom, so it is not uncommon for public hospitals to purchase private health care services. According to OECD data, public health spending in Sweden has decreased as a share of GDP by 5 percent between 1990 and 2004.[3]

Patient fees are comparatively low, although they have risen in recent years. A doctor's visit typically costs SEK 100-150, and there is a small charge per day for hospital stays. A high cost limit (per year) means that no one pays more than SEK 900 per illness per year and SEK 1800 per year for prescription drugs. Unlike other national health care systems, patients usually do not need a referral to visit a specialist.

The Swedish health care system is strongly decentralized. Its current organization dates to 1862, when the regional political units called county councils (*landsting*) were created and given the responsibility of operating the hospitals, which had been state-owned since the Reformation in the 16th century. In 1955, national public health insurance was introduced, obligating the counties to provide care to all citizens at heavily subsidized cost. Over the following decades, the system was gradually transformed into an NHS-type system, financed primarily through local income taxes levied by the counties. In this process, most of the remaining private providers in the out-patient sector disappeared as their financial conditions deteriorated (Immergut 1992). Thus, until very recently, Swedish health care could be described as a system of virtually all publicly provided services, managed directly by elected county council politicians and their staff of civil servants. Services were available to all citizens, and private health insurance in Sweden was rare. Elections to the political assemblies of the 21 county councils (functioning like regional parliaments) are held every fourth year, on the same day as elections to the national parliament and municipal level. Since Sweden is a unitary state, the central government retains an overriding political responsibility for the health of the population and can adopt national laws governing aspects of the health care system, such as basic patient rights or regulations regarding contagious diseases. Through the National Board of

Health and Social Welfare (*Socialstyrelsen*), an expert agency, the government can also issue guidelines regarding medical practice and evaluate developments at county council level.

In recent decades both policy-makers and researchers have been more concerned with the governance of the system. This can be attributed both to harsher economic conditions and increasing interest in new public management. Reforms implemented during this period have generally been oriented towards decentralizing political power within the system and making the county councils more autonomous. In the 1970s and 1980s, the national legislation regulating the health care tasks of county councils was replaced by so-called discretionary laws, which stipulated overriding goals and values of the system, rather than detailed rules. During the 1970s, such decentralization reforms were primarily driven by the desire to strengthen the democratic character of the system by allowing for more localized decision-making and local community involvement. In the 1980s, the continued decentralization policies in the health care area became framed in the 'management by objectives' philosophy that had gained influence among Swedish policy-makers at the time (Montin 1997). At this point, it was stated that the role of the county council politicians should be to set goals for administrators and professionals within the system but leave its actual management to these groups. This meant a departure from the previous emphasis on detailed local planning, while provider units (hospitals, clinics, primary care health centers) became more self-governing.

In the early 1990s, the economic situation of the counties deteriorated, both because of local unemployment (generating less tax revenue) and reductions in central government grants to the health care sector (which constitute about 15 percent of total health care expenditure). The need to contain costs reinforced within the counties the existing interest in market-oriented organizational reforms. Guided by the ideals of the 'new public management' (NPM) movement,

the counties began to experiment with organizational models that separated purchaser and provider functions and allowed for privatization and competition on the provider side (for example, Hood 1995). Apart from promoting economic efficiency and cost awareness, a stated objective behind these NPM reforms was to strengthen the role of the political representatives within the system. These reforms were made possible by changes in national legislation that removed some of the remaining barriers to fully independent health care provision at county council level by making it legal, for the first time, for the county councils to contract out the provision of services to private, including for-profit, actors. By the end of the 1990s, a majority of the county councils had introduced purchaser/provider splits and private contracting practices. The 1990s also saw a reinforced political emphasis on the rights of patients, both at the national political level and among the county councils themselves (Department of Social Affairs 1999).

During the 1980s and 1990s political and administrative power within this system were further decentralized. In recent years, waiting lines and poor coordination between different health providers have led to a critical debate about the functioning of the system and the performance of the county councils. Since the late 1990s, the government has made some attempts to strengthen its control over the system, but, so far, these efforts do not appear to have been very successful. In addition, some observers believe that the country councils are too small to provide efficiently all types of specialized care within their geographical areas.[4] As a result, Swedish health care today is characterized by ongoing discussions about the future of the country councils and their degree of independence from the central government.

The key political decision-making bodies within the Swedish health care system are the county councils, as they provide over 90 percent of all services. The small share of health care provided by non-public actors (about 9 percent) is typically regulated and, to an overwhelming

degree, financed by the county councils as well. The county councils are also the employers of most health care personnel in Sweden, including the vast majority of doctors. Although the central government formally retains political responsibility for ensuring that health services are available to all citizens, the actual task of providing the services (including dental care) has been delegated to the county councils.

The most important national legislation underpinning the system is the Health and Medical Services Act of 1982. This Act is framework legislation so it sets out general objectives and does not regulate the system in detail. Thus it gives the county councils much freedom in organizing the provision of services. The county councils enjoy considerable financial autonomy from the central government as well because they have the right to levy local taxes. Central government block grants make up about 20 percent of the system's total finances.

In 1991, the Local Government Act further extended the already substantive political autonomy of the county councils by removing existing regulations regarding their internal organization and giving them the right to contract out service provision to non-public actors, including profit-making enterprises (Montin 1992). This led to locally-initiated reforms in many county councils, the most common of which was the division of purchasing and provision and the expansion of patient choice. Local reforms during the second half of the 1990s often also included elements of decentralization, like making provider units more organizationally independent or delegating the purchasing of services to local boards (Anell 1996). During the same period, responsibility for long-term and home-based health care, and later out-patient psychiatric services, were transferred from the county councils to the 290 municipalities who are traditionally the providers of social services for the elderly and handicapped. This added a new

set of actors to the health care system, whose jurisdictions and responsibilities are not always clearly separated from those of the county councils.

The main role of the central government in the highly decentralized Swedish system is to formulate the overriding political goals and values guiding it. The government can also propose more detailed regulations regarding matters of national interest, for instance patient rights or contagious disease prevention. The government supervises the system through its expert agency, the National Board of Health and Welfare (*Socialstyrelsen*). Among the tasks of the Board is to collect data from the county councils to monitor their performance, evaluate policy outcomes and provide treatment guidelines and other kinds of medical information to health care providers.

It should be noted, furthermore, that in practice health policy in Sweden is often formulated through largely informal contacts between the main actors of the system, that is, the government (represented by the Ministry of Social Affairs), the Board of Health and Welfare and the organization representing the county councils at the central level, and the National Federation of County Councils (*Landstingsförbundet*). The predominantly cooperative and consensual nature of these relations may at least in part be attributed to the dominant position of the Social Democratic Party in post-war Swedish politics, which resulted in Social Democratic governance at the central, regional and local political levels during most of this period.

A prominent goal behind the far-reaching decentralization of political power to the county councils in the 1980s and 1990s was to strengthen the democratic character of the health care system. Reformers sought to bring the decision-making process within the system closer to the population and create new opportunities for active community involvement. Above all, it was hoped that their democratic accountability would be enhanced. Free choice of care provider in combination with a 'money follows the patient' system of reimbursement was another reform

measure employed to empower health consumers and democratize the system further (Blomqvist 2002).

Did these reforms have the intended effects? Reform outcomes have generally been hard to measure, given the plurality and vagueness of the stated goals (which were also related to the value of economic efficiency), but evaluations point to that community involvement in health policy-making has reached state goals in at least some communities. Patient organizations appear to have become more actively involved in trying to influence processes of local health services purchasing. Other examples of community involvement include participation in health policy study groups and meetings with county council politicians (Bergman and Dahlbäck 2000). The introduction of health services purchasing has also led to more active attempts on part of policy makers to establish local medical needs and preferences, for instance through public surveys. In some county councils, like Östergötland, there have also been moderately successful attempts to involve the local community in priority-setting, for instance through polls and discussion groups (Garpenby 2002). Among providers, the introduction of patient choice and performance-related payments has stimulated a new interest in measuring and evaluating patient satisfaction.

Patient choice of provider is probably the one reform measure that has received the most public attention. Patients now enjoy the right to choose their provider freely, both at primary and secondary care levels and across county borders. So far, patient flows between county councils remain marginal, however, and there is some indication that bureaucratic obstacles prevail when people seek care outside the previous ‘catchment areas’ of, for instance, individual hospitals. Recent research indicates that another reason for persistent low patient mobility may be related to the attitudes of medical professionals, whose role in informing patients about their right to

provider choice for further treatment is crucial for implementing this part of the reform (Windblad-Spångberg 2003).

Whether political accountability within the system has increased as a result of the decentralization reforms is hard to determine as well. There are some indications that local politicians have become more directly involved in the planning and purchasing of health services, thus 'taking back' some power from the civil servants (Bergman and Dahlbäck 2000). Political accountability within the system may also have been enhanced by a different factor: increased media attention to health care issues in recent years. This has resulted in local politicians being exposed to a greater level of public scrutiny. At the same time, the organization of health care provision has become more complex since the introduction of contracting and more 'market-like' relations between actors within the system. The increasingly complex web of contracts between the county councils and a multitude of different providers tend to create diffuse lines of accountability and make the system less transparent. This problem is further complicated by the recent transferral of responsibility for long term care and out-patient psychiatric services from the county councils to the municipalities, a change that sometimes has left patients confused about who is responsible for providing various services.

At present, questions of central-local relations and responsibility for various health services are highly salient in Swedish politics. As stated above, the government has attempted recently to reassert its influence over developments within the system, both through legislation and negotiated agreements with the county councils. Evaluations of these efforts demonstrate, however, that governmental attempts to influence policy priorities often fail (National Board of Health and Welfare 2004). Partly in response to what has come to be regarded as an overly complex system, with overlapping lines of jurisdiction between different public bodies, the

government appointed in 2003 an investigative committee to review the overall structure of and division of responsibilities within the health care system (Ministry of Finance 2003).[5] Since then, several political interest groups, including the conservative (*Moderaterna*) and liberal (*Folkpartiet*) parties, the Swedish Medical Association, (*Sveriges läkarförbund)* and the main union federation, the LO *(Landsorganisationen)* have openly advocated the abolition of the county councils. These recent political developments illustrate the fact that power struggles within the nearly all-public Swedish health care system often have constituted themselves along the lines of central-local relations.

Whether the market-orienting reforms and the decentralization of powers to the county councils have actually strengthened the political governance of the Swedish health care system remains unclear. That the county councils have become more autonomous vis-à-vis the national government during this period is obvious, which can be said to have reinforced the local democratic character of the system. By the same token, regional variation within the system has increased significantly, making broad characterizations of developments within it increasingly difficult. The few post-reform evaluations of the democratic governance of the system show that efforts have indeed been made in many counties to involve local communities in decisions regarding purchasing priorities. However, it has been difficult to create the kinds of institutions that would promote the required level of citizen-politician interaction for this (Bergman and Dahlbäck 2000; Garpenby 2001; Petterson 1998). In many counties, the 'purchaser side' has often been too weak to bargain effectively with providers, and the politicians have tended to lose influence to civil servants and professionals in the often complicated and technical negotiations that purchasing of health services entail. A further complicating factor for democratic governance within the system is increased provider choice available to patients. This can be said

to strengthen the system's democratic character, but it also makes priority-setting and planning within the system more difficult.

It is clear that the increased autonomy of the county councils in recent years has resulted in attempts by national authorities to regain some control over the system. For example, the central government passed legislation to prohibit the sale of hospitals to for-profit firms in 2002, formulated national guidelines for prescribing drugs and choosing treatment methods, and adopted a new, national 'action plan' (*nationella handlingsplanen*) in 2001 to promote governmental (Social Democratic) health priorities. The emerging power struggle between regional and national levels of government has been reinforced by local party politics. Many county councils are governed by different parties than those in the national government (this phenomena is explained by voters 'splitting their ticket' between the national and county council elections, which has become more common).

At the same time, the continued need for cost containment and rationalization in the health care system has made local policy choices more controversial and exposed county council politicians to public discontent, in some cases even death threats. This is especially the case when hospital closings are announced. Dissatisfaction with the county council political leadership in many regions, not least among medical professionals, has fueled demands that the county councils be reorganized or even abolished. Other critics have argued that the county councils are too small to plan health care provision effectively; or that out-patient care should be localized even further and transferred to the municipal level. Hence, at this time, the future of the county councils is uncertain and structural reforms reformulating their tasks cannot be ruled out.

The emphasis on further decentralization within the already decentralized Swedish health care system over the last two decades has reinforced the tradition of local democratic

governance. At the same time, however, this trend has exposed the system to far-reaching changes initiated by local reformers. Continuing budget constraints in many county councils also means that local policy-makers will have to continue to search for new ways to contain expenditure. This makes it likely that regional differences within the system will increase further, as political priorities come to reflect differing regional circumstances and value orientations.

Despite productivity gains, waiting lists continue to plague the system. In 2005 the Social Democratic government and the county councils introduced a 'care guarantee' setting the maximum wait at three months.[6] The ongoing process of European integration has added an international dimension to the issue of timely access to care. A recent decision by the European Court of Justice confirms patients' rights to seek treatment abroad, and this has potentially far-reaching implications for the Swedish health care system.

THE PUBLIC-PRIVATE MIX IN PENSIONS

Historical Background

Sweden was one of the first countries to legislate a universal public pension. Before the breakthrough of full parliamentary democracy in 1921, Liberal groups in the two-chamber Riksdag vied for control of the 'social question' with influential farmers and the nascent Social Democratic Party. Farmers' opposition to Bismarckian-style social insurance delayed the introduction of public pensions until 1913, when the government led by Liberal Prime Minister Karl Staaff introduced a universal old age and invalidity pension scheme in 1913. The design of the new scheme satisfied agricultural and labor interests, and passed easily.[7] The 1913 Law

provided for a contribution-based pension (*avgiftspension*). Invalids were eligible for a means-tested supplement (*pensionstillägg*). Total pensions were low, and in 1935 this 'premium reserve system' (*premiereservsystemet*) was replaced by the flat rate basic pension (*folkpension;* Elmér 1960: 50-51, 66ff). By the end of World War II, the Social Democrats had become of the dominant party in the Riksdag, and the party soon embarked on its so-called 'Harvest Period' during which the major programs of the postwar welfare state were introduced. A key component of this strategy was a substantial increase in the basic pension so that it covered basic living costs. By the early 1950s, the size of the pension equalled about 30 percent of average industrial wages (Ackerby 1992).

With the basic pension firmly in place, political actors turned their attention to earnings-related pensions in the 1950s, ushering in perhaps the greatest political conflict of the postwar period: the 'ATP Struggle' (*ATP-striden*). In the 1950s, public employees and white collar workers enjoyed generous occupational pensions while the majority of households only had access to the basic pension. Metalworkers, later supported by the Trade Union Confederation, LO, were the first blue collar group to demand earnings-related pensions on equal terms with white collar workers. With blue collar workers pushing hard for legislation on supplementary pensions, the Social Democratic-Farmers coalition government appointed several commissions to study the issue, but agreement with the non-socialist parties (backed by employers) was elusive. To break the deadlock, an advisory referendum was held in 1957. The Social Democratic proposal received a plurality, followed by the Liberal-Conservative proposal and the Agrarians' proposal. The Social Democrats went ahead with their proposal, prompting the break-up of their coalition with the Farmers' Party. The legislation passed by a razor-thin margin in 1959 and the Social Democratic government called early elections to consolidate their gains.[8]

The new national supplementary pension scheme (ATP, in force since 1960) provided earnings-related pensions to all wage-earners, including the self-employed. Collectively negotiated white collar pensions were retained, and in 1971 LO members got their own collective pensions (Ståhlberg 1993: 13). A key element of the ATP reform, and the Social Democrats' new 'wage-earner strategy,' was the inclusion of the white-collar workers in the ATP scheme on favorable terms. ATP's benefit formula was based on the best 15 of 30 years of labor market participation, and this was specifically designed to gain white collar workers' support (Svensson 1994).

The ATP was closely integrated with the existing basic pension. Together with the basic pension, a full ATP pension would provide 65 percent of previous income (the best 15 of 30 years) up to the ATP ceiling (equal to average earnings). According to the generous transition rules, the system would approach maturity by the early 1990s. The ATP system also included provisions for disability pensions (*förtidspensioner*) and family pensions (*familjpensioner*), which provided coverage to widows and orphans.

In the 1960s and 1970s, Social Democratic governments, now firmly in control of government, improved public pensions with the support of the opposition. In 1969, the pension supplement (*pensionstillskott*) was introduced for those who were not included in ATP or who had few ATP points. After a series of increases, the supplement equaled about half of the basic pension by the early 1990s. Between 1970 and 1972, eligibility rules for disability pensions were relaxed so that it could also be awarded for so-called labor market reasons.[9] In 1974, sickness and unemployment insurance were made taxable and eligible for pension points. In 1976, the pension age was reduced from 67 to 65, and the partial pension (*delpension*) was introduced. Workers aged 60-64 who switched to part-time employment became eligible for the

partial pension[10] until they reached retirement age. In 1982, the basis for ATP contributions was increased to include the entire wage sum even though only incomes up to a specified ceiling earned pension points. Since 1982, the care of small children has also been eligible for ATP pension points. Throughout the 1970s and 1980s, employer contributions to both the basic pension and ATP pension system were raised several times.

Prelude to Reform

In the mid-1970s, welfare state reform reached the political agenda in Sweden as it did in many other West European countries. The oil shocks and the emergence of stagflation rattled the foundations of the Swedish welfare state because generous social policy and high tax rates presupposed steady economic growth and full employment. The non-socialist parties governed Sweden from 1976-82 but made little progress on welfare state reform. The Social Democrats returned to power in 1982 and promptly started a debate about how to modernize the welfare state. Pension reform was slated to be part of this debate, so the government appointed an official commission of inquiry to pinpoint areas in need of reform (SOU 1990: 76).[11] Despite the participation of major stakeholders (unions, employers, political parties and other experts), and nearly ten years of work, the commission could not agree on significant reform proposals. The commission's work, however, did set in motion a period of serious debate about the direction of reform. Before the Social Democrats could take any concrete steps, the non-socialist parties won the September 1991 election, so the initiative was now in their hands. The new government wasted little time. The Minister of Social Affairs (Liberal Party) recruited the opposition parties to negotiate on pension reform. After several years of deliberations in a closed parliamentary working group, the non-socialist coalition government adopted framework legislation in the

spring of 1994 with the support of the opposition Social Democrats. [12] The Social Democrats returned to office in September 1994, so they presided over the passage of detailed legislation in 1998.[13] The reform has been implemented in steps between 1995 and 2001, and the new system was fully operational starting in 2003.

Briefly, the reformed pension system breaks with the old system in several important ways. First, benefits are based on lifetime earnings rather than the best 15 of 30 years of labor market participation. Second, the earnings-related pension includes mandatory individual accounts (the 'premium reserve'). Third, a pension-tested 'guarantee pensions' replaces the old basic pension. Finally, wage earners pay individual contributions into the system, and the state (or relevant social insurance agency) pays contributions for pension credits earned for child-rearing, military service and spells of sickness, unemployment and disability.

The new public pension system consists of three parts: the guaranteed pension (*garantipension*), the income pension (*inkomstpension*), and the premium pension (*premiepension*). This system replaced the basic pension (introduced in 1913) and the ATP pension (adopted in 1959).[14]

The guarantee pension covers residents with insufficient earnings-related benefits. For those born before 1938, the old basic pension (*folkpension*) continued to pay a flat-rate benefit until 2003 when it was converted into the 'transitional guarantee pension.' Those with income from employment (including the self-employed) are covered by the new income pension and the premium pension. There is no separate scheme for civil servants or the self-employed.

The National Insurance Board (*Försäkringskassan*) administers the guarantee pension and the income pension.[15] The Premium Pension Authority (*Premiepensionmyndigheten*, PPM), a state agency, administers the premium pension. The PPM was set up in 1998 to administer

contributions to the individual accounts (the premium reserve) and to manage contracts with the fund managers whose products are part of the premium pension catalogue. In 2004 wage earners could choose between 600 investment funds, including a public default fund, the Premium Savings Fund (*Premiesparfonden*) for those who do not make an active fund choice.[16]

General revenues finance the guarantee pension, a clear break from previous policy in which employers paid an earmarked contribution (6.75 percent of payroll) that covered about 52 percent of basic pension costs in 1993. This contribution was eliminated in 1998. Earmarked pension contributions finance both the income pension and the premium pension. Of the 18.5 percent total pension contribution, 16 percentage points are allocated to the income pension and 2.5 percentage points to the premium pension. Another novelty in the reformed system is that wage-earners pay 7 percent of their eligible earnings up to a ceiling of 8.07 'income base amounts.'[17] In the old system, employers paid the entire contribution. In 2004 the contribution ceiling was SEK 42,300, and it is indexed to increases in average earnings. Employers pay 10.21 percent contribution to the earnings ceiling, and half of this for earnings above the ceiling. The latter is called a 'tax' rather than a pension contribution.

The reformed system breaks with past policy by eliminating unfunded liabilities. This does not necessarily mean that all pension promises are backed up by money in the bank. It does mean that all pension rights are backed up by contributions, whether these are paid by wage-earners, employers, or the state. General revenues finance the entire contribution for 'child years'[18] and those in military service. For claimants of unemployment insurance or sickness benefit, the state pays the employer share of the contribution (10.21 percent), and the individual pays her contribution as if she were working. In 2002 state payments for those receiving social

insurance benefits or those not working were 12 percent of all revenues in the income pension scheme (Riksförsäkringsverket 2004:32).

Like the old system, the new pension system operates largely on a pay-as-you-go basis, with 'buffer' funds to compensate for economic and demographic shifts. The scope and function of the buffer funds in the new system are much different from that of the old system.[19] Under the old pension system, the AP[20] Funds functioned both as buffer funds and as a source of capital for infrastructure such as public housing. At their peak in the 1980s, assets in the AP Funds equalled about 40 percent of GDP, enough to cover pension payments for more than seven years without contributions. In the reformed pension system, the buffer funds are smaller and play little role in terms of an active investment strategy. Over time, the assets in the premium reserve will exceed those in the AP Funds.

The introduction of automatic stabilizers is another important and innovative feature of the new pension system. The 'automatic balancing' mechanism requires the National Insurance Office to calculate the notional assets and liabilities of the system every year. Notional assets are 90 percent of total assets and are the sum of all future pension contributions (16 percent of qualifying income).[21] AP Fund assets make up the remaining 10 percent of financial assets. Notional liabilities are the sum of pension promises to current workers and retirees. 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 the system returns to balance (Riksförsäkringsverket 2000).[22]

All social insurance benefits in Sweden are based on a bookkeeping device called the base amount (*basbeloppet*), which was introduced with the ATP reform in 1959. In the old pension system, there was a single base amount indexed to inflation. The full ATP pension was

equal to 6.5 base amounts, which combined with the flat rate basic pension of 1 base amount, added up to a pension of 7.5 base amounts. This level was approximately equal to average wages, at least in the first two decades of the ATP's existence. The reformed pension system breaks with this principle by introducing three kinds of base amount: the 'price base amount' (*prisbasbelopp*), the 'increased price base amount' (*förhöjda prisbasbeloppet*), and the 'income base amount' (*inkomstbasbeloppet*). The new 'price base amount' replaces the old base amount, and it is the basis for calculating the guarantee pension and several other social insurance benefits. The 'increased price base amount' is also indexed to inflation, but when it was introduced in 1998 its initial value was set higher than the price base amount. The 'increased price base amount' is used to calculate supplementary pension rights for those born between 1938 and 1953 who are covered by the old ATP system and the new pension system. Finally, the 'income base amount' is indexed to increases in pension-carrying income, and is the basis for calculating the income ceiling for income pensions (7.5 'income base amounts') as well as the notional pension assets (*avgiftsunderlag*) in the new pension system. In 2006 the price base amount is SEK 39,700, the increased price base amount is SEK 40,500, and the income base amount is SEK 44,500.

Residents with insufficient income from the income pension system have the right to the guarantee pension starting at 65.[23] The guarantee pension replaces the basic pension, pension supplement and the special tax deduction for pensioners. A novel aspect of the guarantee pension is that it is taxable (the old basic pension was not). The size of the guarantee depends on the level of pension rights in the income pension system, so the amount varies. In 2006 the guaranteed minimum is 2.13 price base amounts, or SEK 86,149 annually. Married pensioners receive 1.9 price base amounts (SEK 76,820) each. The premium pension, private pension

income and occupational pension income do not affect the level of the guarantee pension. To qualify for the maximum benefit, 40 years of residence from age 25 are required. For those who do not meet this requirement (usually immigrants), there is a special maintenance allowance. Low-income pensioners are also eligible for the pensioners housing supplement (BTP). The guarantee pension is payable to those born 1938 or later.[24]

One of the most distinctive features of the reformed pension system is that earnings-related benefits are based on 'notional defined contributions' (NDC). This does not mean that pensions are pre-funded and backed up by 100 percent capital coverage as in a true defined contribution scheme. Instead, the income pension scheme emulates a pre-funded defined contribution scheme by estimating an internal rate of return for accumulated pension contributions. The new system counts lifetime contributions, and the monthly benefit is calculated based on (gender-neutral) life expectancy at the time of retirement. The National Insurance Office administers individual NDC accounts. The notional balance in individuals' accounts is indexed annually to an 'income index' (*inkomstindex*) based on changes in average pension-carrying income for wage-earners aged 16-64. At retirement, an individual's notional assets are converted to an annuity using the 'annuitization divisor' (*delningstal)* which is the expected remaining life expectancy for an individual's cohort plus an internal rate of return of 1.6 percent. The reformed pension system permits flexible retirement, starting at age 61. Thus later retirement increases the pension benefit because the divisor decreases and pension assets increase. The reverse is true for earlier retirement. The notional assets of those who die before retirement are credited to her birth year cohort. Administrative costs are deducted annually. Benefit payouts are indexed to the adjustment index (*följsamhetsindex*) which is the income index minus 1.6.[25]

Another innovative component of Sweden's reformed pension scheme is the 'premium reserve:' 2.5 percentage points of the 18.5 percent income pension contribution are placed in a defined contribution, individual investment account. Individuals currently choose from about 600 investment funds. The PPM, a state agency, administers premium pension accounts and manages contracts with investment funds. All fund balances are annuitized at the time of retirement and can be paid out either as a fixed annuity with a minimum rate of return of three percent or as a variable annuity. Premium pensions cannot be inherited; and the individual bears all investment risk. The premium pension is payable from age 65.[26]

The reformed pension system is being gradually phased in. Those born between 1938 and 1953 receive pensions according to the old and new systems.[27] Every person with pension rights in Sweden receives an annual pension statement from the National Insurance Office, 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.

Several factors account for the adoption of one of the most radical pension reforms in the OECD. First, Sweden experienced a deep economic crisis in the early 1990s that prompted across-the-board cuts in government spending. Between 1990 and 1993, Sweden went from budget surplus to recording a deficit of 12.3 percent of gross domestic product (GDP). During the same period, open unemployment rose from 1.7 percent to 8.2 percent (Huber and Stephens 1998; Pontusson 1992). Second, the historic defeat of the Social Democrats in the 1991 election meant that the non-socialist government coalition managed the crucial initial stages of the pension reform negotiations. The Social Democrats had already come out in favor of major pension reform in their 1990 budget, and the party's opposition role in the Riksdag certainly

made it easier to overcome some of the opposition within the party and among blue collar union members. Finally, crucial aspects of the existing policy structure facilitated a strategy of 'rationalizing redistribution.' (Anderson and Meyer 2003). Specifically, the capital in the AP Funds (about 30 percent of GDP in the early 1990s) could be used to finance the transition to the new system. Moreover, reform advocates could credibly claim that the introduction of the lifetime earnings benefit formula was more fair than the old 15/30 rule that benefited mainly white collar workers.

The Swedish reform is all the more remarkable when we consider that politicians faced a popular, universal, and nearly mature pension system. The 'lock-in' effects of pension policy development dictated that reform would have to take place within the structure of the existing system. The non-socialist parties recognized this, but the large capital reserves in the AP Funds provided an opening for fundamental change. The role of the AP Funds in facilitating the transition to the new pension system can hardly be exaggerated. By 2004, the AP Funds had transferred SEK 350 billion (about € 38 billion) to the government budget to compensate the state for increased costs resulting from the reform. This made it possible to devote a larger share of contributions (16 percent of qualifying income) to income pensions, (compared to 12 percent of qualifying income in the old system) and to devote 2.5 percentage points to the new funded accounts. Thus the reform means that more resources flow to earnings-related pensions while the state assumes the non-insurance functions of the old pension system (basic security, survivor's pensions, disability pensions). The financial cushion provided by the AP Funds gave reformers a degree of maneuvering room that simply does not exist in other public pension systems (Anderson and Immergut 2007; Anderson and Meyer 2003).

The role of the AP Funds is important for another reason as well. As assets accumulate in the new premium reserve, it will eventually replace the AP Funds as a source of investment capital. Although this aspect of the reform would not affect the level of benefits, it was a major victory for the non-socialist parties because they succeeded in the partial privatization of very large publicly controlled pension funds. Finally, the reform was an opportunity to 'rationalize redistribution' (Anderson and Meyer 2003; Myles and Pierson 2001) because the existing benefit formula (the 15/30 rule) was considered unjust. This feature of the old system was repeatedly criticized by reformers, and given the very high levels of female labor force participation, the rationale behind the old rules was hard to justify.

In sum, retirement provision remains overwhelmingly public, despite the sweeping reforms of the 1990s. Most Swedes' retirement packages rely heavily on public pensions, topped up by occupational pensions bargained as part of collective wage agreements.[28] Individual private pension savings accounts have become more popular in the last decade, but remain fairly insignificant in comparison to public and occupational coverage. Thirty-eight percent of those aged 20-64 have individual accounts, with an average value of about SEK 6000 in savings (about $800; www.scb.se). Despite the growing importance of contractual and private provision, the public system provides the bulk of retirement income. Income inequality in retirement is likely to increase, however, because future pension income will more closely mirror employment income as well as variable investment returns for the premium pension. [29]

Comparing the Public-Private Dichotomy in Pensions and Health Care

The pace of reform in both health care and public pensions since the early 1990s has been dramatic. Both systems remain firmly within the public sector, but the role of the state has

changed substantially. Internal markets now permeate the health care system, and most decision-making has been decentralized. Despite enduring public dominance, the state has retreated in favor of local government (health care) and autonomous public agencies administering more or less self-sustaining programs (pensions). These changes mean that the state is less implicated in the *politics* surrounding both programs. The reformed pension system operates on 'auto-pilot' so decisions about raising or cutting benefits emerge from the built-in automatic stabilizers. In short, the state makes no promise about the level of future (earnings-related) pension benefits. So far, the potentially negative effects of the new system remain untested; benefits have been indexed at least as much as they would have been in the old system, and those who 'lose' under the new pension system have adequate time to adjust their labor force and savings behavior in order to compensate for their losses. The retreat of the state is similar in health care. The decentralization reforms of the 1990s mean that the county councils face any hard decisions about the allocation of resources. To be sure, the state remains the central financier and regulatory player, but county councils have considerable leeway in organizing health care delivery.

The wave of reforms during the last two decades has redrawn the lines of conflict characteristic of both sectors and has led to the emergence of new actors as the state has retreated. The central line of potential conflict in health care is between local government and the central state. In pensions, the potential for conflict is much diminished because of the automatic features of the new pension system. Notional defined contributions and automatic stabilizers mean that if pensions decrease, it is because of economic and demographic trends and not because of a specific political decision.

Private providers are the main new actors in health care, whereas investment funds have entered the world of public pensions because of the introduction of the premium pension. Assets in the premium reserve at the end of 2006 totaled about SEK 230 billion ($30 billion). In 2007 wage earners could chose from more than 600 investment funds. Since the premium pension was introduced in 2003, assets have increased in value by 29.2 percent (PPM 2007). Since all wage earners participate in the scheme, all now have a stake in financial markets, even if one chooses the state-run default fund for those who do not make an active choice.

Swedish membership in the European Union (since 1995) has potentially important implications for both health care and pensions policy because of the rules governing the internal market. Recent European Court of Justice rulings establish the right of patients to seek (and be reimbursed for) health care outside of their home country. It is too early to tell what the full ramifications of these rulings will be, but the NHS-style health care systems in the EU, including Sweden, now face the previously unthinkable prospect of residents seeking care in other EU member states in order to avoid waiting lists or to seek treatment not offered at home. This development obviously threatens the sovereignty of national health care systems like Sweden's at the same time that it increases the pressure to expand care options and improve access to care.

These European developments notwithstanding, national politics will continue to dominate pensions and health care. Both systems--their creation, consolidation, and recent reform--have been heavily influenced by the political dominance of the Social Democratic Party. The victory of the non-socialist parties[30] in the September 2006 election marks the end of more than a decade of Social Democratic rule. It is important to note that the Conservatives remade themselves as the ‘party of workers’, signaling their acceptance of public dominance in welfare. But the non-socialists want a different kind of public dominance than the Social Democrats. The

toughest reforms have already been adopted, so the current and future issue concerns which political block (the non-socialists or the socialists) will dominate the process of further consolidation. Fiscal austerity, at least in the short term, is not a pressing issue because the budget is in surplus, and the pension system is now largely self-financing. However, ageing will continue to create challenges for both the health care system and the elder care system. Thus, the pension challenge may be 'solved' but the care-related implications of ageing have yet to be effectively dealt with.

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ENDNOTES

[1] Sweden has the fourth lowest infant mortality in the world in 2003 behind Iceland, Japan and Finland (Socialstyrelsen 2005: 33).

[2] Most Swedes only pay local income tax, which averages about 30 percent of taxable income. High income earners pay an additional 20 percent in state income tax. The municipalities and country councils share the local revenue.

[3] www.oecd.com.

[4] The size of the county council areas varies between 60,000 and 1.8 million people.

[5] The committee will present its final report in 2007.

[6] After three months the patient has the right to be treated elsewhere at the cost of his/her home county council.

[7] See Heclo (1974) and Baldwin (1990).

[8]For discussions of the ATP reform, see Heclo (1974: 246).

[9]This change was intended to help wage-earners between the ages of 60 and 64 in poor health or with physically taxing jobs.

[10]The partial pension paid 65 percent of lost income without reducing the amount of pension points earned until retirement age.

[11] Sweden is known for its forward-looking investigative commissions that are often or usually appointed to study reform needs and propose policy change.

[12] Initially, the Left Party and the New Democracy Party participated in the negotiations but both quickly left the group, complaining that the committee's work was undemocratic.

[13] See Anderson and Immergut (2007) and Lundberg (2003) for the politics of the reform process.

[14] All citizens were entitled to the basic pension while ATP provided benefits based on previous income from work. In addition, the partial pension (*delpension*) and disability pension (*förtidspension*) provided benefits for early retirees. The relevant reports from official commissions of inquiry are Ds 1992: 89; DS 1995: 41; SOU 1994: 20; and SOU 1997: 131.

[15] The National Insurance Office (Försäkringskassan) took over this function from the National Social Insurance Board (*Riksförsäkringsverket*) in 2005.

[16] On the premium pension see Weaver (2003/04).

[17] The pension contribution is not pension-carrying, so 93 percent of 8.07 income base amounts is 7.5 income base amounts (100 percent - 7 percent fee = 93 percent).

[18] The amount of the pension credit is calculated according to the most favorable of three methods and goes to the mother unless the parents apply for the father to receive the credit. One of the calculation methods is to award the pension credit for income equivalent to one 'base amount,' or euro 4,500. Sixty percent of women are eligible for a higher credit (See *RFV redovisar* 1999: 12. Den nya allmänna pensionen).

[19] In the new system, AP Funds 1-4, and 7 are the buffer funds. In the old system, AP Funds 1-4, 6, and 7 were the buffers.

[20] AP stands for 'Allmänna pensionsfonderna' or national pension funds that are part of the public pension system. There are currently seven AP Funds.

[21] Proposition 2005/06: 01. *Ålderspensionssystemet vid sidan av statsbudgeten*.

[22] In 2004, the balance ratio was 1.0014. Notional assets were SEK 5,607 billion, and financial assets in the AP Funds were SEK 646 billion, for a total of SEK 6263 billion in assets. Liabilities were SEK 6244 billion.

[23] The ceiling is 3.16 price base amounts for singles and 2.8275 price base amounts for spouses.

[24] Those born earlier fall under the old system, so they received the old basic pension (and possibly supplements) until 2003, when a transitional guarantee pension was introduced for this particular group. The transitional guarantee pensions pays the same net amount as the old basic pension and pension supplements that the retired person was entitled to before 2003.

[25] For example, if the income index is 2.0, the economic adjustment index is 2.0-1.6 = 0.4. 1.6 percent 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.

[26] On the premium pension, see R. Kent Weaver (2002/2003) and SOU (1997: 131).

[27] The calculation is proportional. For example, someone born in 1940 receives 13/16 of his/her pension from the old system and 3/16 from the new.

[28] Four sectoral pension schemes top up public benefits, covering about 90 percent of wage earners. For most wage earners, these schemes add about 10 percent to public benefits. The amount is higher for higher income earners.

[29] In 1997, income inequality in Sweden was among the lowest in Western Europe (Jansson 2000: 8) despite a slight increase in the 1990s.

[30] Conservatives, Center Party, Christian Democrats, and Liberals.