Sweden's strategy report for social protection and social inclusion

2008 – 2010

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1 Common strategy for social protection and social inclusion

Under the open method of coordination, the EU Member States have been working together since 2000 on issues relating to combating poverty and social exclusion, working for sustainable and reasonable retirement pensions and sustainable and accessible health care and long-term care. The conclusions from the meeting of the European Council in Lisbon indicate that modernisation and improvement of social protection is an important step towards attaining the overall Lisbon objectives.

In 2003, the Commission presented a proposal aimed at streamlining cooperation in the social area. The proposal means that the three strands referred to above are merged, while the special specific aspects of each strand can be developed further. Under the new proposal, a joint strategy report is to be drawn up in the social area rather than individual reports, as was done previously. The present report provides an opportunity to take an overall view and look at the whole of social policy together. The new model for cooperation means that reporting is simplified and greater emphasis is given to exchanging experience, which is the actual basis for cooperation under the open method of coordination.

New common objectives have been adopted for this work. These build on the previous objectives adopted at Nice and Laeken and provide a basis for the preparation of national strategies for social protection and social inclusion. The overarching objectives of this work are to promote:

a) social cohesion, equality between men and women and equal opportunities for all through adequate, accessible, financially sustainable, adaptable and efficient social protection systems and social inclusion policies;

b) effective and mutual interaction between the Lisbon objectives of greater economic growth, more and better jobs and greater social inclusion, and with the EU's Sustainable Development Strategy;

c) good governance, transparency and the involvement of stakeholders in the design, implementation and monitoring of policy.

The national strategy report on social protection and social inclusion is the second of its kind and will cover a two-year period, The Ministry of Health and Social Affairs has been responsible for preparing the report. The report is laid out on the basis of guidelines drawn up by the Social Protection Committee. It was noted ahead of the work on the report that circumstances differ for the different strands, and this is reflected in the guidelines for the report.

Work on the strategy report began with an information and consultation meeting with representatives of non-governmental organisations and the social partners. The meeting proved to be of great value and prompted several good ideas that have been utilised in work on the report.

1.1 Evaluation of the social situation

Growth in the Swedish economy slowed in 2007, partly due to a weaker international trend. Growth in GDP in 2008 and 2009 is expected to be around 2% per year, which can be described as a mild economic slowdown. However, public finances remain strong.

Employment increased by 2.4 per cent in 2007. Growth in employment was particularly strong in groups whose position in the labour market is weak, the number of young people in employment rising by 8.8%, for example, and the number of people born outside Sweden who are in employment increasing by 6.2%. The sharp growth in employment was a consequence of the buoyant economy, but also indicates that government policy has been successful.

A lower rate of growth is expected after the sharp growth in the labour market in 2007. The reforms which the Government has implemented, including lowered income tax and reduced levels of unemployment benefit, are expected to make a positive contribution to the rise in employment throughout the period 2007–2011. The new-start job scheme is also making a positive contribution to growth in employment.[1] Employment is expected to increase by a total of 49 000 over the period 2008–2009.

Absence due to sickness has co-varied with growth in employment for many years. Despite the rate of employment having now increased for two years, sick leave levels have continued to decrease. The changes to sickness insurance implemented by the Government, combined with

TABLE 1. EU EMPLOYMENT TARGETS AND SWEDISH OUTCOME IN 2007, PER CENT

	Total	Men	Women	Older workers (55–64 age group)
Employment rate, 15-64 age group	74.2	76.5	70.2	70.0
EU target 2010	70.0		60.0	50.0

Source: Eurostat.

TABLE 2. NATIONAL EMPLOYMENT AND UNEMPLOYMENT IN 2007 (PER CENT)

	Total	Men	Women	Young people (15/16–24 age group)		
				Total	Men	Women
Regular employment rate[2], 20–64 age group	77.4					
Unemployment, 15–74 age group	6.1	5.9	6.5	19.2	18.7	19.8
Unemployment, 16–64 age group (previous definition)[3]	4.6	4.6	4.7	11.7	11.9	11.4

Source: Statistics Sweden.

[1] The new-start job scheme reduces the cost of labour through a credit to the employer's account. The new-start job scheme is aimed at people who have been receiving unemployment benefit, sickness benefit, sickness and activity compensation or financial assistance for more than one year.

[2] Regular employment covers the 20–64 age group. Regularly employed includes everyone employed in that age group according to the Labour Market Survey, not including those participating in the labour market programmes dependent on the state of the economy sabbatical leave, positions for unemployed graduates, bonus jobs, educational-leave replacement, general employment support, strengthened employment support, special employment support, step-in jobs, employment support for those on long-term sick leave and support for business start-ups, according to statistics from the Swedish National Labour Market Administration. With effect from April 2005 those employed abroad but registered in Sweden are included. The number of people in regular employment is divided by the population in the 20–64 age group.

[3] The previous definition of unemployment only included the *openly unemployed* and not *full-time students actively seeking work*. The age group is 16–64.

stricter Swedish Social Insurance Agency rules are judged to have reduced the rate of sick leave.

Reduce exclusion

It is crucial to reduce exclusion and get more people into work in order to achieve a high level of prosperity, and this is therefore the Government's overarching and most important objective. The preliminary outturn for 2007 shows that the number of people (measured as full-time equivalents) whose means of support comes from schemes related to ill-health, unemployment or social assistance fell by as many as 121 000. Despite the strong trend, the Government judges that continued measures are required to achieve a lasting increase in employment and to reduce social exclusion. The reform strategy for more people in work and reduced social exclusion rests on three pillars:

- Providing better incentives to work
- Making it simpler and less expensive to take on employees
- Making it simpler and more profitable to start and run businesses.

The Government takes a particularly serious view of the composition of social exclusion. Government policy is therefore intended to increase employment in particular among groups that are weakly placed in the labour market, such as young people, older people, those born abroad and women who work part time.

To fund future welfare, it is necessary for more people to be in work and for the number of hours worked to increase. A high employment rate is essential if a generous welfare policy is to be possible. Work and the ability to provide for themselves boosts people's security and freedom. The challenge for the future is to create conditions in which people both want to work and have an opportunity to do so. Activation is therefore an overarching principle in the Swedish Government's economic policy.

Far too many people are leaving the labour force early on the grounds of sickness. Various measures have been taken in recent years to reduce sick leave. In February 2008, the number of days of paid sick leave had fallen by 50 per cent in comparison with 2002; the number of people receiving sickness or activity compensation has fallen slightly but remains high. The Government has launched a broad reform programme in sickness insurance so that it provides greater impetus and opportunities for return to work.

More elderly people and more children

Every year, more and more Swedes live to see their hundredth birthday. In 2007 there were 1 458 people, 1 188 women and 225 men, over the age of 100. Average life expectancy in 2007 was 82.9 years for women and 78.9 years for men (Statistics Sweden). Average life expectancy will continue to increase, and the increase will be greater for men than for women. This means that in 2020 there will be a greater proportion of elderly people in the Swedish population, and the difference in average life expectancy between the genders will be smaller. The elderly in most cases remain in good health for an ever longer time. This is a very welcome trend, but there are still problems. Many elderly women and men have meagre financial resources, and care is still not sufficiently good for all elderly people. Many family members, particularly women, bear great responsibility for their relatives. In addition, in ten to fifteen years the number of elderly persons over the age of 80 and needs for long-term care will increase at an even faster rate. Needs will also look very different – everything from healthy elderly people who just need a little extra help around the home to elderly people with an extensive need for assistance.

The Government's view is that the quality of care of elderly women and men needs to be improved. Preven-

tive efforts, medical care and social provisions need to be improved. The Government's long-term elderly care policy is based on the elderly and their relatives having a sense of reassurance, the care provided to them meeting reasonable standards of quality and dignity and providing the individual with greater freedom of choice. Long-term improvement in quality should be supported by measures such as systematic use of open comparisons between health care providers and by the development and use of relevant indicators in this area.

The birth rate affects the population trend and is thus of key significance to future growth. The number of children born in Sweden fell in the 1990s. In 1999 the downturn was reversed, and the number of births has since risen every year. In 2007 the average birth rate was 1.88 children per woman. The forecast for the cumulative fertility rate in 2008 is 1.90 children per woman.

Poverty evolution

The concept of poverty is multifaceted and difficult to define. It may, for example, apply to access to material resources to meet the basic needs for survival. As a broadened term it may also include intangible assets such as education and social capital. Only economic poverty is considered here.[4]

"Risk of poverty" in EU contexts is defined as the proportion of the population who have a disposable income below 60 per cent of the median in the country.[5] Risk of poverty, otherwise known as relative poverty, is a measure of how unevenly incomes are distributed within the country and thus does not take account of the country's general level. On the other hand, it shows what incomes various groups have in relation to the normal population. Another way of measuring poverty is to take an absolute income limit as a basis. If a threshold value of this kind is used, the limit for poverty is set at a particular level of income which can be regarded as a minimum with which to meet the needs of a family for food, housing, clothing, medicines etc.

Relative poverty has developed differently than absolute poverty in Sweden[6]. Relative poverty has increased since 1994 because differences in income have increased, i.e. earned incomes have increased at a faster rate among those on middle and high incomes than among those on low incomes. Relative poverty in 2006 was almost 11 per cent. Unlike relative poverty, the proportion of people with incomes below the absolute poverty line has fallen since the mid-1990s to 4.5 per cent in 2006. The proportion of people receiving financial assistance has also decreased, by just over 44 per cent over the past ten years, and less financial assistance is now drawn than at the beginning of the 1990s. However, long-term receipt of financial assistance among young people is virtually unchanged.

Both relative and absolute poverty vary in different population groups. The proportion of people living in poverty in 2006 was around three times higher among those born abroad than among persons born in Sweden, and this ratio has been constant during the current decade. This applies to both relative and absolute poverty. However, as the labour market situation for those born outside Sweden

[4] Both income and wealth are of significance when an attempt is made to shed light on the financial situation of different population groups. This report, however, only contains measures of income, and we therefore obtain an incomplete picture of the financial situation. It is perfectly possible, for example, to have low income and high wealth, that is to say for a person to be classified as financially in need without actually being so.

[5] The term equivalised means that account is taken in calculations of the number of household members and the economies of scale large households can be assumed to have.

[6] The presentation is based on Statistics Sweden surveys of household finance. The Statistics Sweden equivalence scale has been used.

improves the proportion living in poverty is also decreasing. There are also groups facing financial hardship among people with disabilities. One of the reasons is that many people have never had an opportunity to enter the labour market and have to depend on social protection systems for life.

Sweden has an even distribution of income in comparison with other EU Member States. Transfers have a great redistributing effect in Sweden, in particular because families with children receive comparatively high benefits. In 2006, just over 6 per cent, or 130 000, of all children in Sweden were living in families whose disposable income was below the absolute poverty line, compared with 18 per cent in the mid-1990s. The proportion of children in households in receipt of financial assistance has fallen sharply. Only 6 per cent of all children are living in households receiving financial assistance, which is half the level in the early 1990s. Relative child poverty, on the other hand, shows a different trend. On 2006 around 15 per cent of all children were living in families that can be said to be relatively poor. This proportion has increased in recent decades.

Children's standard of living varies greatly depending on the type of family they belong to. Poverty is greatest among children both of whose parents were born outside Sweden. Among these households around 20 per cent are poor according to the absolute poverty line. However, poverty among children whose parents were born abroad has halved since the start of 2000. Children with a lone parent face substantially greater financial hardship than children whose parents live together. This applies irrespective of whether the parent was born in Sweden or abroad. The rate of relative poverty for lone parents increased from 11 per cent in the early 1990s to more than 29 per cent in 2006.

Studies have shown that countries, such as the Sweden and the other Nordic countries, with well-developed universal welfare tend to have lower levels of financial vulnerability. In these countries public services play an important role in the low proportion of economically vulnerable children. The female activity rate combined with public childcare is an important factor in explaining the relatively low proportion of economically vulnerable lone-parent families.

The degree of economic vulnerability among children and the living conditions of economically vulnerable children are affected by developments in a number of different policy areas such as integration, the labour market, social services, family and education. For the most vulnerable groups, single mothers and families with parents born outside Sweden, there is thus a combination of measures in several policy areas.

1.2 Strategic approach and overarching objectives

A universal welfare policy and an active labour-market policy are characteristic of the Swedish social model. The overarching objective for policy over the period 2008–2010 is to create more jobs and reduce exclusion. The number of people facing exclusion is expected to decrease by more than 190 000 by 2010.

1.2.1 Universal welfare is the foundation of social protection and social inclusion

> Objective: Promote social cohesion, equality between men and women and equal opportunities for all through adequate, accessible, financially sustainable, adaptable and efficient social protection systems and social inclusion policies

The Swedish welfare system comprises general health care and social care, social insurance that provides financial security in illness, disability and old age and for families

with young children and basic supplementary protection in the form of financial assistance.

The Swedish welfare system is universal and covers the whole population. It is financed through compulsory contributions and taxes. This means that everyone pays towards welfare and everyone benefits from it, not just the ones who have the greatest needs. A universal system has large redistributing elements that level out financial resources and living conditions. It redistributes between different groups in society and contributes to levelling out the incomes of individuals between the various stages of their lives. Universal welfare obviously also provides support for the most vulnerable groups in society. This type of supplementary support must continue to be strong.

Activation is an important principle in universal welfare policy. Work is the basis of welfare and also provides an opportunity for personal and social development as well as social participation in the community. Work or education and training are always preferable to benefits. A long period of unemployment leads to exclusion and inadequate participation in society. The Government's labour-market policy is based on measures to promote activation and skills enhancement and to bring about a more flexible labour market through greater employability for those who are out of work and to create security in adaptation to new circumstances. Both women and men having the same opportunities to participate in the labour market and participating on equal terms is a fundamental issue of justice. Under the Equal Opportunities Act, the employer has to make it easier for both female and male employees to combine gainful employment and parenthood.

A modern family policy

Universal welfare is intended to create equal opportunity for everyone and equality between men and women. Swedish family policy contributes towards enabling parents to combine family life and work. Parental insurance, together with childcare based on the different wishes and needs of families with young children enables both men and women to combine bringing up a family with work. This contributes to greater gender equality. Sweden has a high rate of female participation in the labour force, along with a relatively high birth rate. The rate of participation in the labour force of women with young children is also higher than in most other European countries.

Supportive family policy that includes a child's perspective and a well-developed policy on gender equality are fundamental factors that promote the security and well-being of families, socially and financially. This, together with high employment, creates favourable conditions for an increase in birth rate. As support for families with young children is designed on the basis of 'activation', most of the income of families with young children comes from their own work. Consequently, the prospects of being able to support a family ultimately depend on the trend in employment. Parental insurance covers parents' loss of income when they are at home with children. Parental insurance consequently contributes to reinforcing the norm that a fixed income improves the prospects for having children.

By international standards, Swedish family policy provides very extensive support to families with children and therefore has a positive impact on the material conditions applicable to having children, both through direct allowances and by making it easier for parents to combine work and family.

A modern family policy must be based on families being different, having different wishes and needs but being of equal value. The Government wants family policy to be aimed at strengthening the power parents have over their own life situation and at increasing families' freedom of choice. The Government wants to reduce national political control in favour of the family's own free choice. With the aim of increasing family choice, on 1 July 2008

the Government introduced an option for the municipalities to provide a child-raising allowance. The child-raising allowance makes possible a gentler transition between parenthood and work. Applications for child-raising allowance can be made for children between the ages of 12 months and 3 years who appear in the population register in the municipality concerned. The child-raising allowance may be paid to caregivers who live and are registered with the child.

The Government introduced another family policy reform at the same time. The gender equality bonus is intended to improve the prospects of gender equality in both parental leave and participation in the world of work. The gender equality bonus is intended as an incentive for parents to share parental leave as evenly as possible. The gender equality bonus will be calculated on the basis of how a child's parents share parental leave and the days of parental benefit they take. Parents who share parental leave equally by each taking an equal number of days of parental leave will receive the maximum bonus provided that they work while the other parent takes parental leave. Parents who have joint custody of a child are entitled to gender equality bonus.

Swedish welfare policy faces a number of challenges. It is primarily a matter of increasing the level of employment and reducing exclusion. To respond to this challenge, all the resources in the labour market must be utilised. There is a need to get more people into work and to get more people to work longer, create more flexible jobs and reduce sick leave levels. It is also important to encourage people to have children by further improving opportunities to combine family and work and by strengthening support for parents of young children. In the area of health care, there is a need to utilise resources more effectively, and both the effectiveness and productivity of care need to be improved.

1.2.2 Interaction between the Lisbon Strategy and the EU's Sustainable Development Strategy

Objective: To promote effective and mutual interaction between the Lisbon objectives of greater economic growth, more and better jobs and greater social cohesion, and the EU's Sustainable Development Strategy

One of the aims underlying the proposal to streamline cooperation in the social area was to strengthen the social dimension of the Lisbon Strategy. It is necessary for economic, social and employment policy to work together so that the Lisbon objectives can be attained. The interaction between the revised Lisbon strategy and application of the open method of coordination in the social area must be mutual. Measures for social protection must be designed in such a way that they contribute to economic growth and employment, while measures aimed at growth and employment in turn must support the social objectives. The Swedish pension system is an example of this dynamic interaction working smoothly. Incentives for employees to work longer contribute to economic growth. The Swedish pension system is based on lifetime earnings. This means that the longer someone works, the higher the pension received. At the same time, the pension system is linked to demographic and economic trends, as income pension firstly is linked to average life expectancy and secondly is index-linked to the general movement in wage levels.

The initiatives taken by the Government to strengthen the groups that find it most difficult to obtain employment are also of great significance in preventing social exclusion. More than 1.1 million people living in Sweden were born abroad. Sweden is rich in language skills and experience and knowledge of different cultures. This asset must be utilised. Work, education and training and non-discrimi-

nation form the basis of integration policy. Integration in the labour market at present is far from adequate, as the level of employment among those born outside Sweden is significantly lower than that of people born in the country. In 2005, 62 per cent of all persons of working age born outside Sweden were in employment, 59 per cent of women and 65 per cent of men. People born abroad are also over-represented among the long-term unemployed. The Government is implementing general measures to boost employment and combat long-term unemployment, which has created new opportunities for people born outside Sweden. In addition to these general measures, special efforts have been made to improve education and employment opportunities for women and men with a non-Swedish background.

Sustainable development is an overarching objective of government policy. All decisions are to be formulated so as to take account of economic, social and environmental consequences. Work on sustainable development is based on the realisation that growth and welfare can only be maintained if investments are made in the common resources that form the basis of the national economy. The basic principle underlying the general pension system is that it should be financially stable and sustainable.

Streamlining of EU cooperation in the social area has made it possible to take a look at the whole of welfare policy together. This makes the social dimension clearer. This is an essential requirement if the Lisbon objectives of economic growth, employment and social inclusion are to be achieved, as well as the objectives of sustainable development.

1.3 Overarching message

The policy of universal welfare provides the basis on which to create social cohesion and equal opportunities for everyone. A welfare policy that covers everyone is most likely, in the long term, to create adequate, accessible and financially sustainable security systems. It produces good distributional effects, while also having a high degree of legitimacy, as everyone who contributes to the system also benefits from it.

This is also the basis for all three strands of the national strategy report. The general pension system, like health care and long-term care, covers the whole population on equal terms. Universal welfare policy creates the basis on which to prevent poverty and social exclusion and is therefore the foundation on which the Swedish action plan for social inclusion is built. Universal welfare contributes to reducing the gaps between different groups in society, but it must be supplemented by support targeted at the most vulnerable groups in society so that social inclusion that covers everyone is attained.

The importance of a high level of participation in the labour force is a continuous thread running through the three different strands of the report. High employment is essential if a generous and financially sustainable welfare system is to be maintained. Activation is therefore an important aspect in universal welfare policy. Having a job is the best way of influencing one's own economic situation. Work and education are the basis of people's personal and social development and are important factors underlying participation in society.

2 National action plan for social inclusion 2008–2010

Under the cooperation between the EU Member States to prevent poverty and social exclusion, the Member States have drawn up national action plans, in 2001, 2003 and 2006, to contribute to fulfilling the objectives established by the European Council in Nice in 2000 for this area. The objectives are to:

- facilitate participation in employment and access for all to resources, goods, services and rights
- prevent the risk of exclusion
- act on behalf of the most vulnerable and
- mobilise all relevant actors

Section 2.1 examines development towards the objectives formulated in the Swedish action plan for the period 2006-2008. The four prioritised objectives the Government has established for social inclusion over the period 2008–2010 are presented in section 2.2. The measures the Government has decided on to attain these objectives are described in sections 2.3 to 2.6. An account is given of the processes in response to the jointly established goal of good governance in section 2.7. Trends in the indicators chosen to monitor the priority objectives are presented in Annex 2.

2.1 Follow-up of national action plan 2006–2008

In the previous action plan for social inclusion, the Government highlighted four priority objectives, promoting work and education and training for everyone, increasing integration, tackling homelessness and exclusion from the housing market and strengthening groups in particularly vulnerable situations. A picture of developments in these areas is presented below.

2.1.1 Employment is increasing and sick leave is decreasing

Follow-ups, taken together, show that Government policy for full employment has been successful. The proportion of people in work has risen from 72.1 per cent in 2004 to 74.2 per cent in 2007. Employment is increasing principally among people who have completed upper secondary and post-secondary education. Large parts of the country have benefited from this positive trend, and the increase covers half the counties in both southern and northern Sweden, as well as the three metropolitan municipalities. The proportion of people who are long-term unemployed has fallen from 1.2 per cent in 2004 to 0.8 per cent in 2007. Unemployment has also decreased among young people (aged 15–24), but remains higher than in the population as a whole, and stood at 19.1 per cent in 2007. Young people born outside Sweden are a group who find it particularly difficult to gain entry into the labour market. Twenty-eight per cent of this group were unemployed in 2007. People with disabilities also find it difficult to enter the labour market.

Sick leave rates are continuing to fall. The number of women and men in receipt of sickness benefit has fallen by around 50 per cent since it peaked at the end of 2002. The number of people receiving sickness and activity compensation is only declining slowly, however, and remained constant in 2006 and 2007.

Initiatives to reduce exclusion

New start jobs were introduced in January 2007, and in April 2008 around 15 500 people had benefited from the initiative. This measure is targeted at the long-term employed, people on sick leave, people who had sheltered employment at Samhall, newly arrived immigrants and people who have been given prison sentences and are allowed out on parole or have been given conditional release. A third of people with new start jobs were born

outside Sweden. New start jobs have also proved a good initiative to help people with disabilities into the labour market. More than 14 per cent of all new start jobs have gone to people with disabilities.

The job guarantee for young people was introduced in December 2007 and is aimed at young people between the ages of 16 and 24 who have been registered as job-seekers at the Swedish Labour Market Administration for three months. The purpose of the job guarantee is for unemployed young people as quickly as possible to obtain work commensurate with their abilities or to start on or return to education in the ordinary education system. More than 17 000 people started on the programme during the period from December 2007 to June 2008. Around 5 000 have left the guarantee programme for employment. Relatively few people have left the programme for studies, but this will probably change during the autumn of 2008. Around 10 300 people were registered in the job guarantee scheme for young people at 30 June 2008. Of these, 46 per cent were women and 54 per cent men. Around 17 per cent of the participants were born outside Sweden and 9 per cent had a disability.

The Government has taken several measures to bring more people with disabilities into the labour market. During the term of government, the Government is investing SEK 1 000 million extra in Samhall and wage subsidies. The addition of funds for 2008 is SEK 558 million, which is equivalent to just over 2 000 wage subsidy places and around 1 000 places in Samhall.

The job and development guarantee, which is aimed at those who have been outside the labour market for a long period, has brought about a long-term improvement for the participants. Between the launch of the job and development guarantee in July 2007 and June 2008 more than 67 000 people started on the programme, while more than 24 000 left it. Around two-thirds of those who have left the guarantee scheme have gained some form of work or start on training other than labour market training. Almost half the participants are aged 50 or over. Over a quarter were born outside Sweden and a third had some form of disability.

The level of education is rising

The Swedish population has a very high level of participation in studies, which is due to several major educational initiatives in recent decades. The number of students in upper secondary school has increased steadily since 2000. The vast majority of students now go on to upper secondary school after compulsory primary and lower secondary school. This has led to a rise in the level of education in the country in recent years and to more than a fifth of the population aged 25–64 having at least three years of post-secondary education, while 15 per cent only have completed lower secondary education. The proportion of people aged 20–24 who have at least completed upper secondary education is 85 per cent among men and 89 per cent among women. A worrying development, however, is that the proportion of 18–24-year olds who have left school with at most lower secondary education increased among both women and men between 2000 and 2007.

Higher education was expanded in the 1990s, and the proportion of people who have started higher education studies up to the age of 25 increased from 37 to 44 per cent over the period 1998-2005. The proportion of women who have started on a higher education programme has increased more than the proportion of men who have done so.

Initiatives to reduce sick leave

During the period 2006–2008 central government introduced financial incentives for the county councils to give greater priority to sick leave issues in health care, known as the 'health care billion'. Under this initiative, the county councils are able to share the billion SEK in propor-

tion to the decrease in the rate of sick leave in the county concerned. This initiative is generally judged to have been a success. There is therefore interest in a continued initiative of this kind on the part of the county councils, medical profession and the Swedish Social Insurance Agency.

Clearer requirements to be met by insurance administration, influencing of attitudes through information campaigns and training of doctors are judged to be initiatives that have contributed to the reduced levels of sick leave. A measure considered to be of great value in improving the sick leave process is the introduction of decision-making support for doctors in the field of insurance medicine.

2.1.2 Increased employment has contributed to increased integration

Swedish integration policy is intended to contribute to attaining the overarching policy goal of promoting work and reducing exclusion. Follow-ups show that the increased employment has to a very great extent benefited the population group born outside Sweden who account for almost half the increase in employment during the first half of 2008. However, this group has a substantially lower level of employment than those born in Sweden.

Sweden is currently experiencing its highest level of immigration since records began in 1875. Nearly 100 000 people settled in Sweden in 2007. The majority of people moving to Sweden today are refugees and close family immigrants.

Since the change of government several reforms to increase the participation in the labour market of people born outside have been implemented. These are step-in and new start jobs, job deductions and the job guarantee for young people. In conjunction with the 2009 Budget Bill, the Government will present a cohesive strategy for integration policy up to 2010. This means continuing to work on general measures to tackle exclusion and strengthening the position of people born outside Sweden in the labour market. High priority continues to be given to tackling all forms of discrimination as an important element in the Government's efforts to respect human rights.

More people in work and more business start-ups

Several initiatives are in progress to ensure that new arrivals are offered work-oriented programmes early on, that these take place alongside participation in Swedish For Immigrants (SFI) and that new arrivals' knowledge and experience are put to better use. Pilot projects for certain new arrivals was in progress in three counties up to June 2008 with the Swedish Labour Market Administration as the coordinating authority, and according to a first interim report the prospects of finding work are improving. 'Step-in jobs' aimed at newly arrived immigrants and their families were introduced in July 2007. These step-in jobs strengthen the incentives for employers to take on staff, for municipalities to offer effective SFI early on and for individuals to enter the labour market alongside their SFI studies.

Government initiatives to foster enterprise among people born outside Sweden has contributed to a steady rise in the number of new business start-ups among people of foreign origin in recent years. Today around a fifth of all new businesses are run by people with foreign origin.

Development in urban districts with widespread exclusion

The lessons learnt in the Government's local development work in the metropolitan regions of Stockholm, Göteborg and Malmö. which were reported in the action plan for 2003-2005, have been passed on to more local authorities. An ordinance on urban development work (SFS 2008:348) has been adopted to create a common structure for development work in urban districts. It will be possible to

take initiatives in urban districts in the structural fund programmes for 2007-2013, including the national social fund programme, taking account of the local development agreements.

2.1.3 Importance of continuing to monitor the trend in homelessness

The latest survey of homelessness in Sweden was conducted during one week in 2005. Around 17 800 people were homeless at the time of the survey, which represented an increase since 1999. Three-quarters of these were men and a quarter were women. Between 1999 and 2005 the proportion of women and the proportion of people born outside Sweden rose. The 2005 survey showed that people born outside Sweden were over-represented in the group.

Statistics on the number of evictions shows that it fell by a third between 2001 and 2007. A total of 3 200 evictions were carried out in 2007 and 85 per cent of these were due to tenants not having paid their rent. These statistics include both residential and other premises. An extensive body of statistics is being developed in the area of homelessness which means that it will be possible to monitor the trend more satisfactorily from 2009 on than is the case at present. It is particularly crucial to be able to monitor the trend in the number of evictions in order to be able to see at local authority level how many households are evicted and how many children are affected. There were 383 children in evicted households in the first half of 2008. It is not yet possible to discern from the statistics whether this represents an increase or decrease, as the in-depth collection of statistics only began in 2008.

Initiatives to make it easier for individuals to become established in the housing market

The Government has introduced municipal rent guarantees to make it easier for individuals who for example have a record of non-payment of debt or have no steady employment/steady income to become established in the housing market. This guarantee means that a central government allowance is paid to municipalities that stand surety for the rent of individual households. Few municipalities have applied for rent guarantees, and it remains to be seen whether more municipalities will apply in 2008. The Government has also introduced a central government 'acquisition guarantee', which covers interest payments for first-time buyers' home purchases. The aim is to provide support for households that wish to buy a home but find it difficult to obtain mortgages despite having long-term ability to pay.

Discrimination in the housing market

The Ombudsman against Ethnic Discrimination (DO) has given priority to tackling discrimination in the housing market over the period 2006–2008. DO received 60 reports of discrimination in the housing market in 2006, and the number of such reports rose to over 90 in 2007.

2.1.4 Need for continued efforts to support groups in particularly vulnerable situations

Universal welfare policy forms the basis on which to create a community that accommodates everyone. With this universal welfare policy, the disparities between different groups in society can be reduced. If society's resources are also to reach those who are in a particularly vulnerable situation, universal welfare policy needs to be supplemented by targeted measures. The previous action plan gave particular emphasis to measures for children and young people, for women subjected to violence and their children and for girls and boys and young women and men who are subjected to honour-related violence. Measures to assist people with substance abuse or addiction problems and people with mental disabilities were also included.

Social care services for children and adolescents has been strengthened

Social care services for children and adolescents are an important resource that comprises preventive work, early action and various forms of non-institutional measures such as one-to-one counselling, social educational measures, school social measures and advanced networking targeted at children and families. On 1 November 2007 around 28 000 children and adolescents were the subject of one or more non-institutional care measures and around 14 000 children and adolescents were placed in 24-hour care.

A number of measures have been taken in recent years to improve the quality of social care for children and adolescents. The administrative and documentation system *Barns Behov I Centrum (Focus on the Needs of the Child – BBIC)* has been increasingly widely used, contributing to greater national uniformity and providing a basis for decision-making in which the situation and needs of children are given greater emphasis. Collaboration between social services and other organisations is necessary in order to draw attention to children and adolescents early on and provide them with the right support. The National Board of Health and Welfare, the National Agency for School Improvement and the National Police Board have devised a strategy for collaboration aimed at activities for children and adolescents. As well as a number of statutory changes to increase protection and support for children and adolescents which came into effect on 1 April 2008, the Government has set up an inquiry to further clarify the protection and support provided by society to children in socially vulnerable situations. The inquiry is due to present its final report in June 2009.

Need for continued efforts on behalf of women subjected to violence and their children

Long-term and sustainable work is required to combat violence by men on women, honour-related violence and oppression and violence in same-sex relationships. Crimes reported to the police have increased with regard both to physical abuse and to gross violation of a woman's integrity. Knowledge of the extent of and the trend in violence by men on women has increased in recent years. It emerged in a report from 2007 that 1.8 per cent of women aged 16-79 themselves report that they have been subjected to physical abuse at some time in the past year. More than 70 per cent of these are estimated to have been subjected to violence by a close relative or an acquaintance. The proportion of women who state that they have been subjected to violence or threats has increased since the start of the 1990s. In 2007 there were 26 857 reports of physical assault on women over the age of 15. Studies show that women with disabilities are particularly at risk of violence and abuse.

Alcohol and substance abuse affects individuals and society at large

Around 100 000 people in Sweden have a serious alcohol or substance abuse problem. Alcohol and substance abuse is a complex problem with consequences for both individuals and families and society at large. Alcohol abuse dominates, although there is a trend towards increased mixed abuse which may include abuse of alcohol, illicit drugs, doping agents and medicines. Men dominate with regard to both alcohol and drug abuse. The number of people in misuse care has been constant over the past five years. On the other hand, institutional care has decreased and has been replaced by care in the community.

People with mental illnesses and mental disabilities

It is estimated that around 30 per cent of the Swedish population today suffer from some form of mental ill-health, ranging from anxiety to more serious diseases such as psychoses. The number of people suffering from anxiety has increased since the beginning of the 1990s. The increase

applies generally in the population, but has been greatest among young women between the ages of 16 and 34. The proportion of older women suffering mild mental ill-health has been constantly high since 1980. The more serious diseases have not significantly increased over time.

The number of care episodes in non-institutional psychiatric health and medical care increased over the period 2001-2006. In the case of women, the number of care episodes per 100 000 population rose from just over 5 000 to around 8 500, while the equivalent rise for men was from around 4 500 to just over 6 500. The number of care episodes in institutional psychiatric care was constant at around 1 000 women and men per 100 000 population over the period.

2.1.5. More and more elderly

There has been an ever-increasing focus on demographic trends since the previous action plan. In the last 50 years there has been an almost four-fold increase in the number of people over the age of 65, from 770 000 to 1.5 million people, and the increase is expected to continue. The proportion of people over the age of 65 is also increasing, and it is estimated that in 2030 one in five Swedes will be an old-age pensioner, that is to say over the age of 65. Changes in the need for long-term care are not so strongly linked to the number of people over 65 years of age, but rather to changes in the number of people who are more than 80 years old. In ten to fifteen years, the number of elderly people over the age of 80 and thus the need for long-term care will increase sharply. Relative poverty among the elderly has been constant during the current decade, while there has been a gradual decrease in absolute poverty. In 2006 only two per cent of people over the age of 65 had an income below the absolute poverty line. With an ever greater proportion of elderly people, it follows that the health and well-being of elderly women and men is of key significance to the development of the whole of society and will be to an even greater extent.

2.1.6 Tougher legislation against discrimination

High priority continues to be given to tackling all forms of discrimination as an element in the Government's efforts to respect human rights. The anti-discrimination work of the Ombudsman has been made more effective and legislation outlawing discrimination has had a greater impact. During the spring of 2008 the Government presented the bill Stronger Protection against Discrimination (Government Bill 2007/08:95), containing proposals for a new law on discrimination and a new law on the Ombudsman against Ethnic Discrimination. The new legislation covers all grounds of discrimination and enters into force on 1 January 2009.

2.2 Prioritised objectives for the period 2008–2010

The Government considers that the most important objectives in 2008–2010 to combat poverty and social exclusion are to

- increasing the possibility of social inclusion for the elderly
- reduce exclusion among young people
- reduce absence from work due to ill-health
- continue to strengthen groups in particularly vulnerable situations.

The objectives for continued work are based on analyses of the trend in the areas prioritised in the previous action plan and follow-ups of the initiatives that have been implemented. A number of key challenges for Sweden, which are also important starting-points for continued

efforts, are stated in the joint report on social protection and inclusion in the EU, compiled by the Commission. These challenges are continuing to reduce the gap between those born in and outside Sweden and reversing the rise in youth unemployment, getting people on sickness and activity compensation back into work and reducing the influx of new recipients of these benefits.

This work is intended to attain the common aims on which the EU Member States have agreed.

- Ensuring access for all to the resources, rights and services needed for participation in society, preventing and addressing exclusion, and fighting all forms of discrimination leading to exclusion;
- Ensuring the active social inclusion of all, both by promoting participation in the labour market and by fighting poverty and exclusion.

2.3 Increasing the possibility of social inclusion for the elderly

As already mentioned, the Government attaches great importance to the fact that the number and proportion of elderly people in the population will increase. Vigorous measures are required in many different policy areas to face up to the changes that an ageing population will signify over the next few decades. Society is becoming more dependent on the contributions the older part of the population can make, in the world of work and elsewhere. It is important that general policy in various areas reflects the needs the population has, while it is also important to realise that municipal long-term care is and will continue to be a decisive guarantor of social protection and inclusion for the elderly population.

In view of the ever increasing number of elderly people in the population, it is very important that measures to increase social inclusion in society also encompass this group. It is a positive factor for many people to be able to continue to take part in the world of work as it provides an opportunity for both a work community and increased financial security. An accessible society is of great significance in improving elderly people's prospects of social inclusion. Long-term care and health care that work smoothly are obviously of great importance to the oldest elderly people. Issues such as dignity, freedom of choice and cooperation between actors to focus on the needs of the elderly are of key significance for a positive trend.

2.3.1 Government measures in general policy areas

In order to make it more attractive to employ elderly people, the special employer's contribution has been abolished for people over the age of 65. New-start jobs, which were introduced on 1 January 2007, are more beneficial to people between the ages of 55 and 65, as they are entitled to new-start jobs for twice the length of time they have been out of work, but for no more than ten years or until they reach the age of 65. People who have reached the age of 65 are additionally eligible for a higher job tax deduction than other employees. A law on discrimination containing protection against age discrimination at work, which is currently lacking in Swedish law, will come into effect on 1 January 2009.

The Government has tasked the National Institute of Public Health with presenting specific proposals for activity programmes adapted to the needs of the elderly, and to come up with proposals on how to create meeting places in the local area that promote physical activity and good dietary habits among the elderly and that reduce isolation and a sedentary lifestyle.

Having secure finances is important for everyone and particularly so for the elderly, as they generally have less opportunity to influence their financial situation than people

who are in gainful employment. This is described in more detail in the strategy report on pensions. The Government intends to take further steps in the autumn budget bill to improve economic conditions primarily for the least well-off pensioners.

Important work in ensuring a secure old age is making sure that the physical design of society creates the right conditions in which to meet changed needs. This applies to both the built environment and public transport and to services and information. Inadequate accessibility in society leads to people born with or acquiring a disability today not having the same opportunities as others to make their own choices. According to the National Institute of Public Health it is also one reason why ill-health among people with disabilities is substantially greater than among the rest of the population. A group of state secretaries has been appointed with a remit to jointly speed up development. Cooperation has also been established with the Swedish Association of Local Authorities and Regions. The Government intends to decide on a strategy for increased accessibility in collaboration with the Swedish Association of Local Authorities and Regions in 2008. The aim is to make a concerted effort on the strategic issues in work towards accessibility for people with disabilities in order to attain the set goals in the national action plan for disability policy up to 2010. The focus in the strategy is on issues concerned with accessible public transport, clearing easily remedied obstacles in the physical environment and work on accessible public administration.

2.3.2 Long-term care – key to the social inclusion of the elderly

Several initiatives are under way to improve long-term care and to give older people better prospects of a good life they can influence themselves. Proposals are currently being drawn up for free choice of provider in long-term care, a national set of values for long-term care and strengthened support for family members. In addition, the Government is contributing through incentive funds to strengthening preventive efforts and work on the social content of long-term care. Further details on these various initiatives are presented in the strategy report for health care and long-term care (sections 4.3.2 and 4.3.3 respectively).

2.3.3 Indicators and follow-up

- Proportion of the elderly in employment, broken down into men and women (Eurostat)
- Proportion of the elderly with mental ill-health, broken down into men and women (Statistics Sweden)
- Proportion the elderly with severe problems of prolonged illness, broken down into men and women (Statistics Sweden)
- Proportion of people living in relative and absolute poverty who are aged 65 or over (Eurostat)

The Government has commissioned the National Board of Health and Welfare, in cooperation with the Swedish Association of Local Authorities and Regions, to develop a national system for open comparisons of quality, costs and efficiency in municipal health and social care for the elderly and the county councils' home medical care. The remit includes developing national quality indicators to follow up and evaluate how health and social care are working. The aim is to make it possible to compare between different municipalities and county councils, to make information accessible to the general public, staff and decision-makers, to provide a national picture of health and social care for the elderly. The information will be usable in the organisations' own improvement efforts and serve as a basis for the national governance of health and social care for the elderly. It will also serve as a basis for service users' free choice of provider.

The National Board of Health and Welfare presented a

first interim report in June 2008, and a final report is due on 31 December 2009.

2.3.4 Responsibility for implementation of measures

The Swedish Labour Market Administration is the government agency responsible for creating a smooth-running labour market in order to attain the labour market policy goals. The Swedish Social Insurance Agency administers the social insurance which includes pensions.

Responsibility for accessibility issues is shared between different sectors according to what is known as the 'principle of responsibility and financing', which means that each sector in society has to formulate and run its activities so that they become accessible for all members of the public, including people with disabilities.

The municipalities are responsible for long-term care under the Social Services Act. This entails a duty to offer social care and special accommodation to elderly people in need of support. The National Board of Health and Welfare is the central expert and supervisory authority in the area of the social services, and the county administrative boards are responsible for operational supervision.

2.4 Reducing exclusion among young people

Young adults formerly completed their education and entered the labour market at a younger age than they do today. The time it takes for young people to become established in society has now become not just longer but also more unpredictable, and differs from the conditions applicable to other age groups. The establishment of young people in adult life is problematic in a number of key areas, for instance with regard to the labour market, means of support and health. Young people are therefore in many respects less well placed to influence their life and everyday existence. However, young people are not a homogeneous group and conditions that apply to them and their future opportunities differ according to a number of factors such as socioeconomic background, gender and national background. Although the trend has been in the right direction in several areas, for example with an increase in the participation of young people in elections, the proportion of young people who are subjected to violence has decreased and employment has increased, exclusion for large parts of the group of young people means long-term negative effects and it is crucial to improve conditions in general and to reduce the differences within the group.

Youth unemployment has fallen somewhat in recent years, but remains high and above the EU average. In 2007 the youth unemployment rate in Sweden was 19 per cent, compared with 15 per cent in the EU 27. The Government is investing in both the area of education and the area of the labour market to make it easier for young people to become established in the labour market.

2.4.1 Efforts to make it easier for young people to become established in the labour market

In line with the Government's general commitment in labour market policy to strengthening activation and increasing employment in the population, the Government has implemented a number of reforms to intensify the battle against the exclusion of young people from the labour market. The job guarantee primarily offers unemployed young people between the ages of 16 and 24 intensified support with an in-depth survey, study and vocational guidance and jobseeker activities including coaching. Following an initial period the matching-related efforts can be strengthened with measures such as work placement or training. This is combined with financial incentives in the form of scaled-down benefits. Reduced social security ex-

penses and new-start jobs signify lower payroll expenses for employers who take on young people. The Government intends to take a further step in the autumn of 2008 by proposing expanding the reform firstly to cover more age groups and secondly a greater reduction. Measures to ensure that the work capacity of young people is utilised as well as possible are presented in section 2.5.4.

Young people are also prioritised under the national structural fund programme for regional competitiveness and employment. The overarching aim of the programme is increased growth through good provision of skills and increased supply of labour. The European Social Fund is contributing around SEK 6.2 billion during the programme period 2007–2013, in addition to which there is co-financing in the same amount. The programme is aimed among things at making it easier for young people to become established in the labour market and preventing young people from ending up in exclusion.

The Government is also allocating funds to stimulate knowledge and method development with regard to how the re-entry of young parents into work and education and training can be encouraged and to analyse the living conditions of young people and their experience of their situation in a number of areas, with a special focus on work and education and training.

With the aim of increasing the impetus for young people in families receiving financial assistance to find work, the Riksdag (the Swedish Parliament) has decided that young people's income from holiday work will be exempted from testing of the right to financial assistance.

2.4.2 Radical educational initiatives are crucial

Education is of crucial significance to becoming established in the labour market, and increased education gives more people power over their own everyday existence and enables them to influence and shape their own lives. The Government intends to implement a radical upper secondary school reform starting in the autumn of 2011 with the aim firstly of meeting the needs of the business community for an educated workforce and secondly of making education fulfil the individual's interests and needs better. The upper secondary school will therefore be developed in the direction of more alternative forms of study and contain educational pathways both for students who want to go on to post-secondary education and for students who want to go straight into work. A trial of upper secondary school apprenticeship training with places for 5 000 students will be initiated in the autumn of 2008.

In addition to this the Government's educational initiatives aim to reduce exclusion from upper secondary school. It is the duty of the school to give all students the opportunity to fulfil their knowledge goals and for boys and girls to be able to operate on equal terms. In order to give all school students equal opportunities, the Government also has special measures to improve educational conditions in vulnerable areas. A special national strategy for the education of newly arrived children and young people has also been devised. In addition, extra funds are being invested to enable Swedish teaching to be developed for those born outside Sweden with the aim of speeding up the possibility of work and education and training. Initiatives in the form of supplementary courses for immigrant university graduates educated abroad have also been initiated with the aim of facilitating entry into the labour market.

The Government considers it to be of the greatest importance that all students are given what is needed to meet the school's targets. Early identification and early measures improve the prospects of preventing learning difficulties. The Government has therefore proposed several measures aimed at increasing target fulfilment. Schools are to be given access to skills that can provide individually adapted help for students who need special

support, and the Government has therefore decided that special teacher training will be designed in order to meet this need. A special government grant to boost the basic skills of reading, writing and arithmetic will also be introduced during the autumn of 2008.

The Government also considers it to be very important that the students' results are monitored and evaluated. As part of this work, targets in Swedish, Swedish as a second language and mathematics in grade 3 will be introduced from the autumn of 2008. National tests in grade 3 in these subjects will also be introduced from 2009. The National Agency for Education has also been tasked with proposing national tests in chemistry, physics and biology in grade 9.

The Government has also proposed a review of all syllabuses on the basis of the report Clear Goals and Knowledge Requirements in Compulsory School (SOU 2007:28). It is proposed that this review should begin in 2008. In addition, an inquiry chair has been given the remit of reviewing teacher training. The inquiry will present its proposals on 15 November 2008.

In addition, the Government emphasises the importance of everyone having a right to a safe school environment. The Government is therefore investing funds aimed at strengthening knowledge among school staff on how bullying arises and can be prevented.

In 2008–2010 the Government will be implementing a special investment of SEK 110 million in gender equality in schools. This initiative includes appointing a gender equality commission for schools. The commission will analyse gender differences in educational attainments, evaluate methods for breaking traditional gender roles and propose suitable action. Teachers and other school personnel will be offered in-service training on gender roles, honour traditions and sex and relationships education. The National Agency for School Improvement will support school student health to tackle mental ill-health. Few men are trained as teachers, and the National Agency for Higher Education will therefore analyse the reasons why this is so and propose measures.

2.4.3 Initiatives to improve the health of young people

Despite public health having improved for the population as a whole, mental ill-health among adolescents and young adults has increased. Mental health among teenage girls and young women is a cause for particular concern. The Government implemented major initiatives in the area of psychiatry in 2007. Half of the invested SEK 500 million went on improving child and adolescent psychiatry. The Government's initiative is primarily focused on improved accessibility, educational measures and quality improvements in health care. A development centre for the mental health of children has been established with the aim of increasing knowledge of effective methods with regard to preventive measures, early detection and early support. A more detailed description of measures to improve psychiatric care for children and adolescents is given in the National Strategy for Health Care and Long-Term Care.

2.4.4 Indicators and follow-up

- Proportion in employment and unemployed among young people (aged 15–24) broken down into men and women (Eurostat)
- Proportion who have completed at least upper secondary education (aged 20–24) and proportion with at most lower secondary education (aged 18–24) and not in further education or training, broken down into men and women (Eurostat)
- Proportion living in relative and absolute poverty among young people in the 20–29 age group, broken down into men and women (Statistics Sweden)

- Proportion of young people (aged 20–24) receiving financial assistance, broken down into men and women (National Board of Health and Welfare)
- Proportion of young people (aged 16-24) with mental ill-health, broken down into men and women (Statistics Sweden)

2.4.5 Responsibility for implementation of measures

The Swedish Labour Market Administration is the government agency responsible for creating a smooth-running labour market in order to attain the labour market policy goals. The National Agency for Education is the central administrative authority that governs and reviews the Swedish education system and thus has to ensure that the Governments training policy goals are fulfilled. The National Board for Youth Affairs is the government agency whose task it is to develop and pass on knowledge of the living conditions of young people, follow up the aims of the Riksdag and the Government for national youth policy and support the municipalities in their youth policy work.

2.5 Reducing absence from work due to ill-health

It is of the greatest importance that as many people as possible can provide for themselves through their own work. Shorter periods of sick leave and the number of sickness benefit cases lasting more than one year have both decreased in recent years, but the problem of too many people being put on sick leave for a long period of time and often ending up in permanent exclusion persists. It is therefore essential to bring about a more active sick-leave process with early measures to ensure that the individual's work capacity is utilised to a greater extent. Those who are already on long-term sick leave or are in receipt of activity compensation or sickness benefit must also, if possible, be supported to enable them to return to work.

As mentioned previously, the problem that those who are put on sick leave remain so for a long time and often end up in permanent exclusion persists. The same applies to people who are receiving sickness and activity compensation. The Government is therefore continuing with and reinforcing its efforts to reduce sick leave and increase return to work over the period 2008–2010. This requires new solutions and approaches. Active rehabilitation measures and improved support combined the individual's motivation and commitment are crucial to the success of return to work. The longer a person is on sick leave, the lower the likelihood that he or she will able to return to work. Early action is therefore important. In addition, close links to the labour market are required if measures that support a return to work are to be successful. Sickness insurance must also become more predictable and provide better impetus for a return to work. The measures implemented to create more pathways to work are expected to lead to a significant drop in the number of people who claim sickness insurance benefit over the next few years.

2.5.1. Reformed sick leave process

A rehabilitation chain with fixed times for the testing of work capacity was introduced in July 2008. The basis of assessment for right to sickness benefit has been linked to these times. The situation in which the sick leave process was often too slow and in which there was a risk of the rehabilitation potential initially found being lost is thus broken. It is important that cases in which the work demand is no longer compatible with a person's ability are identified early and that sick leave in these cases becomes the start of a re-adjustment process. The task of the Swedish Social Insurance Agency is to facilitate the conversion

to new work where necessary, and cooperation with the Swedish Labour Market Administration will therefore be strengthened. A statutory right to time off is order to try out other work is proposed. The fundamental aim behind the right to time off is to make it easier for people on sick leave to return to work.

2.5.2 Improved rehabilitation

The Government's intention is to introduce support measures for the insured that strengthen measures taken to reform the sick leave process. One such measure relates to enhancement of the company health service so that it can represent first-line medical care for employees. The company health care service can thus contribute support to rehabilitation measures as well as preventive activity. It is additionally proposed that a rehabilitation guarantee should be introduced for medical rehabilitation. The guarantee is intended initially, starting in 2008, to apply to the large diagnosis groups of diffuse pain in the back and neck and milder mental problems such as anxiety and depression. The more long-term formulation of the guarantee will be decided in 2009, with the support of proposals from a special inquiry. The Government has allocated a total of SEK 3.4 billion over the period 2008–2010 to health and medical care to be spent on enhanced activity in the company health service and for medical rehabilitation in the county councils.

2.5.3 Increased opportunity to try out work for people receiving sickness benefit

During the current year the Government will also present proposals to the Riksdag on changes to the rules on sickness benefit. The aim is to increase security for an insured person who receives sickness benefit but wishes to try to work. It will thus be both worthwhile and easy to utilise even limited work capacity for sickness benefit claimants. The new rules will particularly favour those who receive partial sickness benefit, which more often means women than men. More and more women being able to take further steps into the labour market in turn improves gender equality.

2.5.4 The work capacity of young people will be utilised

With the aim of reducing exclusion among young people, the Government has decided to appoint an inquiry chair to review activity compensation. The principal task of the inquiry chair is firstly to improve the regulations on activity compensation so that the work capacity of young people is utilised as well as possible and secondly to propose ways in which activity compensation could be adapted to planned changes to sickness benefit and sickness compensation.

2.5.5 Rehabilitation in social enterprises

The Government has decided to invest SEK 35 million in a trial activity with alternative actors in rehabilitation in which social enterprises can play an important role. The trial is aimed at people who have been on sick leave for more than two years, people receiving temporary sickness compensation and people receiving activity compensation.

2.5.6 Uniform work capacity concept

The Government has also appointed a person to chair an inquiry which is to describe and analyse the concept of work capacity and present a uniform concept apparatus and uniform assessment criteria and methods to assess functional status and work capacity in social insurance and labour market policy. The underlying principle is that

greater significance is to be attributed to the individual's functional status in the assessment of work capacity.

2.5.7 Indicators and follow-up

- Number of people receiving sickness benefit full and part time broken down into men and women (Swedish Social Insurance Agency)
- Number of people receiving sickness and activity compensation full and part time broken down into men and women (Swedish Social Insurance Agency)

2.5.8 Responsibility for implementation of measures

The Swedish Social Insurance Agency is the government agency responsible for social insurance. The principal tasks of the Swedish Social Insurance Agency are to administer individual cases in the social insurance and allowance systems. Its remit also includes promoting the work capacity of individuals so that the prospects of them providing for themselves through their own work are improved.

2.6 Continuing to strengthen groups in particularly vulnerable situations

The Government considers it essential to continue to strengthen groups who are in particularly vulnerable situations. There is a need to create long-term evidence-based measures based on the individual's needs and wishes. Violence against women is a major social problem which the Government has chosen to tackle broadly. Combating physical abuse means combating exclusion, as there is a clear link between severe physical abuse and social exclusion such as homelessness, unemployment and indebtedness, as well as somatic and mental illness. Physical abuse is a public health problem which does not just affect the abused person but to a great extent affects his or her family too. Children are particularly vulnerable. Efforts to improve quality and equivalence and to meet the needs of particularly vulnerable abusers therefore continue to be crucial.

Particular emphasis is given to homelessness in the previous action plan, and the Government presented a strategy aimed at tackling homelessness and exclusion from the housing market which extends to 2009. Tackling homelessness requires sustainable and coordinated efforts, and homelessness therefore also constitutes a priority area in this action plan. The factors underlying both physical abuse and homelessness are complex and can be sought at the levels of both the individual and society. It has become increasingly clear that people with mental illness are at increased risk of suffering both abuse and homelessness. The Government therefore intends to strengthen both psychiatric and other measures for people who have a mental illness. Psychiatric care is a priority issue for the Government, and SEK 500 million has been allocated annually in 2007 and 2008. Large parts of these initiatives have been targeted at raising skills levels for personnel in both psychiatric care and in the social services for people with mental disabilities, as well as improving access to psychiatric care for children and adolescents.

To combat exclusion, continued attention needs to be focused on those groups that have a special need for support from society. Social services of good quality are of great significance in preventing people in vulnerable situations from ending up in permanent exclusion. Central government measures to promote the development of quality are concerned with supporting knowledge and method development, making open comparisons possible between providers and between municipalities and strengthening the individual's freedom of choice. Central government is also allocating incentive funds for different purposes to assist the responsible authorities in their development activity.

2.6.1 Strengthened support for women who are subjected to violence and their children and honour-related violence

An amendment to Chapter 5 Section 11 of the Social Services Act which clarifies the responsibilities of the social welfare committees for battered women came into force on 1 July 2007. This amendment means that the social welfare committee in particular has to take account of the fact that women who are subjected to violence and children who have witnessed violence may need help and support.

In November 2007 the Government also presented an action plan to combat violence by men against women, honour-related violence and oppression and violence in same-sex relationships (Govt Comm. 2007/2008:39). The action plan draws up the principal features of efforts to combat such violence during the electoral period and comprises a large number of measures in different policy areas, which will be gradually developed and specified. The action plan also comprises a large number of specific measures in different policy areas and a number of remits have been given to different actors with the aim of building a comprehensive structure around women who have been subjected to violence and their children. The problems of honour-related violence and oppression, which principally afflict girls and young women but also boys and young men, are covered by these measures, but are also given separate attention. The measures in the action plan are concerned with protection and support, strengthened preventive work, strengthened quality and effectiveness in the justice system, measures targeted at perpetrators of violence and increased collaboration and increased knowledge. The Government is altogether allocating SEK 800 million to implementation of the action plan during the electoral period.

2.6.2 Initiatives aimed at strengthened care of people with misuse and addiction problems and their families

In 2008 the Government decided on a strategy for the development of misuse and dependency care which extends to 2010. Three areas have been identified for action. Improved Quality, Increased Equivalence and Increased Access to Measures for groups that find it difficult to have their own care needs met.

One of the most strategically important measures to improve quality is to promote the development of more evidence-based care in accordance with the National Board of Health and Welfare's recently published national guidelines on misuse and dependency care. The Government is giving the Swedish Association of Local Authorities and Regions (SALAR) the role of driving the implementation of the guidelines through an agreement between central government and SALAR.

To ensure equivalence and legal certainty, the National Board of Health and Welfare and the county administrative boards have been commissioned to conduct in-depth supervision of misuse care throughout the country during the period 2008–2010. The service user and patient perspective is being developed in this supervision, and forms of service user involvement are being developed.

There are groups that find it difficult to have their care needs met. Many women with misuse and dependency problems are in a situation in their lives that increases the risk of being subjected to violence, and they may find it more difficult to obtain help compared with other women who are subjected to violence. The Government has therefore taken the initiative to increase knowledge in misuse care on violence, so that women's specific needs can be better met. The Government stimulates measures targeted for instance at children with parents who have misuse problems through development funds and knowledge development.

To ensure that people with misuse receive the right action at the right time and from the right care provider, the Government has appointed an inquiry with a remit to clarify the responsibilities and tasks of the municipalities and county councils and to consider any needs for amendments to the legislation.

People with misuse and dependency problems, as well as people who are homeless, often suffer from mental ill-health. The measures which the Government is implementing under psychiatric health care and the activities of the social services for people with mental disabilities will also benefit these people. A total of SEK 1 billion has been allocated to improving care for people who are suffering from mental ill-health.

2.6.3 Continued efforts to counteract homelessness and exclusion from the housing market

In May the National Board of Health and Welfare and the Swedish Enforcement Authority published guidance on efforts to prevent evictions. In addition, a compilation of knowledge on effective methods with regard to different types of housing measures will be published in December 2008. Work is in progress at the Swedish Enforcement Authority to develop the statistics so that it is evident at local authority level how many households have been evicted. These statistics will constitute an important basis for continued efforts.

Another important part of the homelessness strategy is the funds the Government has allocated to support the municipalities in their development work. The development funds can be used for instance to reach the most vulnerable, for example through outreach activity with expertise from both social services and health care and the voluntary organisations. Personal advocates can serve as a link between the outreach field work and the authority contacts for instance in resolving the housing situation at the time of discharge from inpatient care.

It is extremely important to be able to monitor the trend in homelessness. The National Board of Housing, Building and Planning will therefore survey the secondary housing market every three years, beginning in 2008. In December of the same year the affected authorities will submit a joint proposal on how homelessness is to be measured continuously.

The Ombudsman against Ethnic Discrimination (DO), as mentioned in the section on follow-up, has been pursuing special work since 2006 focusing on the access of vulnerable groups to the housing market and the relationship between segregation and discrimination. The project has a gender perspective and examines whether ethnic discrimination in the housing market affects men and women differently. DO is also monitoring how discrimination affects young people with a non-Swedish ethnic background.

2.6.4 Indicators and follow-up

- Physical abuse of women and gross violation of women's integrity reported to the police (Swedish National Council for Crime Prevention)
- Number of people subject to measures in substance abuse care at 1 November, broken down into women and men (National Board of Health and Welfare)
- Number of reports received by the Ombudsman against Ethnic Discrimination (DO) of discrimination in the housing market (DO)
- Number of evictions broken down by type of household and number of children in the household (Swedish Enforcement Authority from 2009)
- Number of people who are in a situation of homelessness, broken down into women and men (National Board of Health and Welfare)

2.6.5 Responsibility for implementation of measures

Responsibility for women and men, girls and boys in socially vulnerable situations receiving the support and help they need rests on the municipality. The National Board of Institutional Care (SiS) is responsible for government-run care of young persons and people with misuse and dependency problems that takes place without the consent of the individual. The National Board of Health and Welfare is the central expert and supervisory authority in the area of the social services, together with the county administrative board.

2.7 Better governance

In this section an account is given of the processes that correspond to the jointly established objective of good governance:

- That social inclusion policies are well coordinated and involve all levels of government and relevant actors, including people experiencing poverty, that they are efficient and effective and mainstreamed into all relevant public policies, including economic, budgetary, education and training policies and structural fund (notably European Social Fund) programmes.

2.7.1 Dialogue on the strategy report

Work on preparing the Swedish strategy report for social protection and social inclusion 2008–2010 was initiated by a hearing with affected organisations and authorities. The aim was to gather views on the overarching priorities the Government intended to highlight in the strategy report. The organisations were also given an opportunity to send in views and comments in writing. Some organisations felt that this hearing did not provide an opportunity for a real dialogue. The Government considers it vital to learn of the organisations' views on the contents of and priorities in the strategy report, and the ways in which this is done may need to undergo further development. It is, however, even more important that there is a structure for a continuous dialogue with different stakeholders in ordinary discussion routines. Various forms of consultative procedure with affected stakeholders are therefore a natural part of the work of the Swedish Government Offices and the government agencies.

2.7.2 Consultation when policy is formulated and implemented

Consultation and formal consultation procedure in connection with inquiries

The inquiry system is a key element in the Government's work. It is very important to have broad collaboration with affected stakeholders already when an inquiry is held on an issue. The Government also states in inquiry terms of reference that consultation is to take place for example with representatives of various service user interests. Taking account of various interests when an inquiry is conducted into an issue provides a good basis for the proposals made by the inquiry to be well considered and endorsed by those who are affected.

When the inquiry has submitted its report, this is sent out to organisations, government agencies, legal bodies etc. to give them an opportunity to submit their views. The views of the formally consulted bodies are compiled and then provide an important basis for continued discussion of the proposals.

The work of the government agencies

The great majority of the policy initiatives presented in sections 2.3 to 2.6 are implemented by government agencies or by municipalities and county councils.

The Government controls the work of the government agencies through annual appropriation directives and through special remits. The tasks given to the governmental agencies in the appropriation directions are reported back to the Government in the annual report, with information for instance on expenses, revenues and profit or loss. The Government can monitor and evaluate the activities of the government agencies on the basis of the annual reports. Separate feedback is provided on remits given to the government agencies through special government decisions.

When the Government formulates a remit, it is often stated that consultation has to take place with those groups which in various ways are affected. An example of collaboration is the implementation of the Government's strategy to counteract homelessness and exclusion from the housing market. In the preparatory work the Government held a hearing with a broad collection of stakeholders from national agencies, county administrative boards, municipalities and housing market organisations, both property owners and tenants, and organisations representing the network against social exclusion. It was consequently possible for the strategy to be endorsed and formulated in accordance with views expressed. The National Board of Health and Welfare was tasked with implementing the strategy and for this purpose establishing a national steering group with affected agencies and the Swedish Association of Local Authorities and Regions. The steering group has appointed a reference group containing representatives of voluntary and service user organisations, among others, in order to be able to monitor and influence the work on the basis of the interests of their target groups.

Consultative body within the Swedish Government Offices

The Government tries to mobilise all actors in efforts to combat economic and social vulnerability by encouraging and supporting the creation of local processes aimed at social inclusion in partnership between municipalities, government agencies and organisations. The Government's own model for consultation is intended to provide legitimacy for forms of consultation at local and regional level and to represent good practice in how his work can proceed.

It was against the background of the 2003 national action plan that the Government decided that there should be a commission for service user influence on social development issues in the Ministry of Health and Social Affairs, chaired by the Minister of Public Health and Social Services. The commission has now been in existence for five years and consists of representatives appointed by the organisational network the Network Against Social Exclusion and one representative each from the Swedish Association of Local Authorities and Regions and the National Board of Health and Welfare. The work of the commission is focused on particularly vulnerable groups. The topics for the commission's meetings are decided jointly and the commission is thus a forum where issues that are of current interest to both the organisations and the Government are discussed and elucidated on the basis of the perspective of service users. As well as being a consultative body, the commission holds seminars on current topics such as social enterprise. The seminars, which from the outset were intended in particular to provide an opportunity for an exchange of experience between service user and other stakeholder organisations in the area of the social services, have also become a channel through which to put forward the service user perspective at a more overarching level to administrators and decision-makers in municipalities and national agencies and at the Swedish Government Offices.

The Service Users Commission is not the only consultative body that exists at the Swedish Government Offices. The Disability Commission and the Pensioners Commis-

sion are other examples in the social area that operate in a similar way.

New model for collaboration between central government and the municipalities and county councils

In the area of the social services, the Government is trying out a new model which entails central government and the Swedish Association of Local Authorities and Regions entering into an agreement on common priorities at national and local level to support the development of knowledge and bringing about more knowledge-based activity. Both the responsible authorities and central government need to make long-term and strategic efforts which are coordinated. For 2008, central government and the Swedish Association of Local Authorities and Regions (SALAR) have entered into an agreement on joint actions and priorities to develop the care of substance abusers and addicts.

Agreement between the Government and non-profit organisations in the social area

The Government considers that non-profit organisation involvement has not received the attention it has merited. Increased knowledge of the social economy in the 1990s and the Government's endeavour to increase diversity and freedom of choice in society have contributed to making this commitment visible. The Government, the Swedish Association of Local Authorities and Regions and non-profit organisations in the social area have therefore, in a broad dialogue, drawn up a proposal for an agreement that entails a mutual declaration of intent. The principal aim of the agreement is to strengthen the independent and independent role of the non-profit organisations as spokespersons and opinion formers, as well as to support the emergence of a substantially greater diversity of providers and suppliers in health care and social care. It is anticipated that the Government will take a decision on the agreement in the autumn of 2008. The organisations will then be invited each separately to accede to the agreement.

A number of overarching principles are proposed in the agreement. One such is the principle of dialogue. The measures proposed are concerned with utilising and examining the opportunities, if necessary, to expand the participation of the non-profit sector in commissions that already exist, inviting the Swedish Association of Local Authorities and Regions to attend the meetings between central government and the non-profit sector, indicating the terms of reference for inquiries the importance of gathering the views of the non-profit sector and paying attention in central government supervision of social services to how collaboration takes place with the non-profit sector. There is to be continuous follow-up of the agreement.

2.7.3. The perspectives that are always to permeate policy

A majority of the areas of policy that are of significance to social inclusion are sector-transcending, which means that the goals for these policy areas to be taken into account in the Government's work, as well as permeating all sectors of society. Examples are integration policy, gender equality policy, disability policy and the rights of the child under the UN Convention on the Rights of the Child. These sector-transcending policy areas, known as mainstreaming areas, can be regarded as an expression of the need for women and men, girls and boys, regardless of ethnic background or disability, to be included in the policy conducted at national, regional and local level. When these goals are taken into account in decision-making at all levels, the goals for social inclusion will also have a broad impact in Swedish policy.

3 National strategy for pensions

3.1 Swedish pensions

The greater part of the incomes of Swedish pensioners comes from the national pension system. Alongside these incomes, almost everyone receives an occupational pension. In addition to the national pension and occupational pension, the individual is free to supplement this insurance with private pension savings.

A guarantee pension is paid for those who have not themselves earned a reasonable earnings-related pension. For those who do not qualify for a sufficiently large guarantee pension there is maintenance support for the elderly. Those who need it can also be granted a means-tested housing supplement. This basic protection is intended to provide pensioners with a reasonable standard of living and constant purchasing power over time. As well as the benefits of the pensions system there are other public services and benefits intended to make it possible for the elderly to maintain a good standard of living.

3.1.1 The national pension

Pension entitlement is credited at 18.5 per cent of pension-qualifying income throughout life in accordance with the 'principle of lifetime earnings', under which each Swedish krona paid in contribution provides an equivalent pension entitlement. Certain transitional provisions apply to persons born before 1954. When a pension saver dies, the remaining funds in the saver's account are distributed to other savers in the form of inheritance gains.

The fixed contribution of 18.5 per cent of pension-qualifying income is paid partly by the insured and partly by the employer. The insured pays an employee's pension contribution of 7 per cent of gross income up to a ceiling of 8.07 income base amounts. The employer's payment of contribution to the pension system, the retirement pension contribution, is 10.21 per cent of the payroll expense and is paid on earnings up to 8.07 income base amounts. In addition, there is a tax on incomes above 8.07 income base amounts. Tax, which is paid at the same rate as the employer's pension contribution, goes to the government budget and is unrelated to the old-age pension system.

In addition to income from gainful employment, compensation for loss of income for instance in the case of sickness, unemployment and parental leave is also pension-qualifying. The equivalent of the contribution the employer would have paid is financed from the government budget. In addition, certain notional incomes provide pension entitlement as well as actual earnings. In a pensions system based on lifetime earnings there is a need for special compensation, from a pension point of view for absence from the labour market that should reasonably not result in reduced pension entitlement. A supplementary pension entitlement, known as a pension-qualifying amount, is therefore allocated to certain groups of society. These pension-qualifying amounts are granted to four groups: parents of small children, conscripts, students and persons receiving sickness and activity compensation. The contributions for these amounts are wholly financed from general tax revenue.

The earnings-related pension, the income and premium pension, can be drawn at the earliest at the age of 61. The annual pension increases the later the person chooses to retire. Pension entitlements can be earned for any period of time, and there is no particular retirement age. Under the Employment Protection Act, employees are entitled to remain in their jobs until they reach the age of 67. Pension may be drawn at 25, 50, 75 or 100 per cent. If the individual continues to work after pension has started to be drawn, new pension entitlement is earned, regardless of age.

Contributions are paid to two different parts of the pension system, which together make up the general earnings-based pension. The greater part, 16 percentage points of pension-qualifying income, goes to the pay-as-you-go system, that is to say a system where the contribu-

tions made by the working population pay for the pension benefits of the same year, and provide an equivalent pension entitlement. Earned pension entitlements in the pay-as-you-go system are increased annually in line with the change in average income in society. At the time of retirement, the annual amount of pension is calculated by dividing the individual's total pension capital by an annuity divisor. This is principally based on the statistically assumed remaining average life expectancy of people born in a particular year. The effect of calculating the annuity divisor with a future advance rate of growth is that the pension initially becomes higher than it otherwise would have been. Another effect of this is that the annual index-linking does not become as high as the average growth in incomes as this advance sum is already factored in.

The remaining 2.5 percentage points of the pension contribution are funded in the premium pension system, a premium reserve system, on an individual premium pension account, in those funds which the insured chooses. The size of the premium pension depends on contributions paid in, the return produced by the chosen funds and the age at which someone chooses to draw their pension.

Anyone who for various reasons does not receive a sufficiently large pension from the general old-age pension system receives basic protection, which is paid in the form of guarantee pension or maintenance support for the elderly, sometimes topped up by housing supplement. Unlike the old-age pension system, which is contributory and is outside the government budget, the basic protection is funded from tax revenue. Changes in level may thus become relevant in the future as a consequence of political priorities. A feature common to the various forms of basic protection is that they can be paid no earlier than at the age of 65.

The guarantee pension is offset against other pension from the Swedish old-age pension system and against comparable foreign general pension, but is not reduced by wage income, capital income, occupational pensions or private pension insurance.

Housing supplement for pensioners is a means-tested supplement to pension which is affected by housing costs, income and wealth. Housing supplement amounts to 93 per cent of the cost of housing up to SEK 5 000 per month for single persons. The cost of housing for a person who is married or cohabiting is calculated at half the couple's joint housing cost, that is to say up to SEK 2 500 per month. The maximum housing supplement that can be paid is thus SEK 4 650 per month. The housing supplement is reduced in accordance with special rules depending on the wealth of the individual and any spouse, pension income, capital income, any earned income etc. The amount is tax-free.

Only a reduced guarantee pension can be paid for those who have not been resident in Sweden for a sufficiently long time. To ensure that these persons do not become dependent, in the long term, on social assistance provided by the social services, there is further protection in the form of maintenance support for the elderly. Maintenance support for the elderly is a means-tested support which is intended to guarantee a reasonable standard of living for people who are aged 65 or over. The amount is tax-free.

3.1.2 Occupational pension and private pension saving

A very large proportion of wage earners, estimated at around 90 per cent, are covered by some form of occupational pension scheme. The four major collective agreement areas insure around 80 per cent of wage earners. Occupational pension agreements are generally concluded through collective agreements between labour market partners, and bind all parties covered by the agreement. The legislation does not lay down any particular requirements for the content of the pension agreements. Defined-

benefit solutions previously dominated the market, but a clear trend towards defined-contribution occupational pensions is now discernible.

The contractual insurance schemes normally signify a supplement to the basic old-age pension for wage earners who receive incomes up to the earnings ceiling in social insurance, while it represents the principal insurance protection for portions of income above the earnings ceiling in the national system.

In addition to income pension and occupational pension, it is possible to have private pension savings. Private pension saving, in an insurance scheme or in a pension savings account, differs from other private saving in that there is an entitlement to tax deductibility.

3.1.3 Other benefits

There are other systems and benefits that contribute to the welfare of the elderly and that are of great significance in assessing what a reasonable level for pensions is. Long-term care is heavily subsidised, and recipients of long-term care only pay a small proportion of the actual cost. The municipality offers a mobility service for those who, due to disabilities, are unable to travel on public transport. This service enables people with disabilities to travel by taxi or on specially adapted vehicles at prices that are at the same level as those for public transport.

With regard to health care, dental care and medication, there is special high-cost protection which means that the patient only pays charges or costs up to a certain sum.

3.2 Reasonable and sustainable pensions in a modernised system

The national pension system is designed to be financially sustainable. Pension can never become higher than the system can manage. This means that it is always the pensioners and pension savers (the pensioners of tomorrow) who bear the financial risk, just as happens in private pension saving.

3.2.1 Development in relation to set objectives 2005–2008

3.2.1.1 Promotion of a longer working life

The people of today are healthier and live longer than at any time in history. This is one of the greatest triumphs of modern society. However, ever rising average life expectancy has not been reflected in a longer working life. As real incomes rise, individuals have reduced their working hours in the past hundred years. This reduction in hours of work has been taken for instance in more holiday, shorter shifts, longer weekends and earlier retirement. An ever greater proportion of life on old-age pension, combined with ever decreasing numbers of people of working age, means that fewer and fewer people have to provide for more and more. This is what normally creates problems for the finances of national pension systems. The Swedish system, however, is self-regulating and financially sound. On the other hand, fewer people in work and a shorter working life leads to lower pensions and other socioeconomic problems.

Table 3 shows the Statistics Sweden's projection for expected remaining life expectancy at age 65, broken down by year of birth. Necessary retirement age is the retirement age required for all age cohorts to receive the same monthly pension. The table also shows the expected time spent as a pensioner, and this is compared with those born in 1930. It can be seen that even if people work longer to compensate for the effect of an ever longer life, everyone will still be old-age pensioners for an ever longer time.

The principle of lifetime earnings is fundamental to the national pension system. In a system based on lifetime

TABLE 3. AVERAGE LIFE EXPECTANCY AND RETIREMENT AGE

Age cohort born in	... reaching age 65	Life expectancy at 65	Necessary retirement age	Time as pensioner	Time as pensioner compared with 1930
1930	1995	82 yr 5mth	65 yr	17 yr 5 mth	0
1938	2003	83 yr 4 mth	65 yr 8 mth	17 yr 8 mth	+3 mth
1940	2005	83 yr 7mth	65 yr 9 mth	17 yr 10 mth	+5mth
1945	2010	84 yr 3 mth	66 yr 3 mth	18 yr	+7 mth
1950	2015	84 yr 10 mth	66 yr 7 mth	18 yr 3 mth	+10 mth
1955	2020	85 yr 3 mth	66 yr 11 mth	18 yr 4 mth	+11 mth
1960	2025	85 yr 7 mth	67 yr 2 mth	18 yr 5 mth	+1 yr
1965	2030	85 yr 11 mth	67 yr 5 mth	18 yr 6 mth	+1 yr 1 mth
1970	2035	86 yr 3 mth	67 yr 7 mth	18 yr 8 mth	+1 yr 3 mth
1975	2040	86 yr 7 mth	67 yr 10 mth	18 yr 9 mth	+1 yr 4 mth
1980	2045	86 yr 10 mth	68 yr	18 yr 10 mth	+1 yr 5 mth
1985	2050	87 yr	68 yr 2 mth	18 yr 10 mth	+1 yr 5 mth
1990	2055	87 yr 1 mth	68 yr 2 mth	18 yr 11 mth	+1 yr 6 mth

Source: Swedish Social Insurance Agency 2008

earnings, income earned throughout life affects the level of pension, that is to say the longer someone works and contributes the higher the pension becomes. The individual earns entitlement to income pension and premium pension regardless of age, provided the income exceeds the earnings floor set for the limit for the duty to submit an income tax return. If pensioners who have taken their pension remain in gainful employment, their pension will be updated two years after the year of earnings in relation to the newly earned pension entitlement. It is thus possible to influence one's pension with continued work even after starting to draw pension. A pension system based on the principle of lifetime earnings provides good incentives to work.

Length of working life

A Swedish krona paid into the system early in life remains for a long time and earns interest for more years than a krona paid in later in life. That individuals start to work earlier is advantageous for both the individual's own pension, the national economy and the pension system. An individual who starts his or her working life earlier can also be expected to be able to retire earlier than others from the same generation who start their working careers later. It is often easier for an average 25-year-old to expand the work he or she can offer than it is for an average 67-year-old.

The principle of life-time earnings provides a direct and clear link to the length and extent of working life. A longer working life for the individual can be attained by starting to work earlier, retiring later or by increasing the number of hours worked. Many people who are retiring today entered the labour market at an earlier age than many of the young people do today. It is also difficult to predict when the young people of today will retire and what their career patterns will look like.

Detailed discussion on the length of working life is presented in the Swedish Social Insurance Agency report Analyserar 2007:6.

Age of entry into the labour market

There are a number of different of ways of measuring at what age young adults are fully established in the labour market. A common measure is the age of establishment, which is assumed to occur when 75 per cent of an age cohort are employed in the labour market. This is stated as being just over 27. The age of establishment in 1990, by way of comparison, was just over 20. Another measure is age of entry. This measure is calculated in the same way as the age of establishment, but the limit in this case is 50 per cent employed. The age of entry is around 20.

The level of education in the population is far higher today than it was 100 years ago. Increased knowledge, general and professional, has been a crucial factor in the rise in prosperity that has taken place. Overall, education has contributed to a growth in productivity which often makes up for the loss of lifetime working hours the ever longer periods of education and training have entailed. There is probably an upper limit where the increase in productivity due to education and training from the point of view of the national economy, does not outweigh the reduced supply of working hours.

Another related problem is that the ever later time of establishment in the labour market can also lead to many people having to work to a relatively old age or having to save a relatively large amount of money to be able to achieve a reasonable level of pension. One way of looking at this is that there is a risk that many people over-consume education, beyond what is optimal from the point of view of lifetime earnings, *de facto* only transferring spare time from old age to youth, which they then have to compensate for. It is therefore evident that there is a risk of some of the young adults of today putting themselves into situations that condemn them to future poverty traps which, in addition, they are perhaps not always aware of. This may, in the long run, become a social problem.

A basic university degree can in principle be gained at the age of 22–23. The fact that in reality it takes longer is not entirely negative, and there may be advantages to alternating studies with practical experience of the world of work. However, theoretical studies are not the only way. Many of the professions in which there are currently a shortage of labour and for which there can also be expected to be demand in the future, such as the skilled trades and certain professions in health and social care, can in principle be started directly after leaving upper secondary school.

Age of exit and transition to old-age pension

The flexible age of retirement from 61 and the possibility of partial drawing of pension makes it easier to gradually scale down the number of hours worked. This also means that there is a difference between age of retirement and age of exit, that is to say the age at which someone leaves the labour market. Under the legislation there is normally an entitlement to retain employment up to the age of 67 – a rule which could previously be negotiated away in collective agreements. Such negotiations lead to all employees in the Swedish labour market in principle being obliged to leave at the age of 65.

Participation in the labour force of older people in Sweden has increased in recent years. This is reflected in the average age of exit from the labour force having increased. The average age of exit in 2006 was 63, calculated for people who were in the labour force at the age of 50. The average age of drawing national pension was around 65. The rise in age of exit is probably due in part to people in their sixties now being more highly educated than previous generations and having a different professional structure. A large part of the rise in age of exit in recent years is due

to old-age and occupational pensions before the age of 65 having decreased. These are principally people who retire under special severance agreements or through contractual retirement and thus without premature drawing of old-age pension from the national system. A direct effect of many in each year cohort receiving sickness compensation (previously invalid pension) is that the age of exit is lower than the age of drawing. These people change over to old-age pension at the age of 65.

3.2.1.2 Spreading of information and general knowledge affect how long people work and how much they save

Everyone insured under the national pension system has, since 1999, received information on their own pension from the national system (the 'Orange Envelope'). Since 2004 there has also been the Internet portal minpension.se, which is a cooperative venture between the central government and the private pension companies.[7] At minpension.se it is possible to view the national pension and the collectively agreed occupational pension, and it is also possible to add one's private pension saving. The aim is to provide a combined picture of the total pension.

It is during the period of earning that an insured person can influence his or hers pension, and it is thus also essential that more people gain greater knowledge of how the pension system works and an understanding that there is a clear correlation between contributions made and the size of the future pension. Increased knowledge makes it possible to plan for how long one should work and wishes to work and also makes it possible to decide whether to voluntarily build up additional pension protection. Ignorance of one's pension and of the pension system, poses an obvious risk of saving too much or too little. The risk of surplus saving may lead to a future negative incentive for work and consumption additionally becoming too low during the years of professional activity.

One way of increasing knowledge of the link between contributions and benefits is through individual pension statements. The Orange Envenlope only contains information about the national pension. The individual normally receives pension from several sources. If the projections are to represent a good basis for decisions, however, they need to be coordinated. The Swedish Social Insurance Agency and the Premium Pension Authority (PPM) therefore have ongoing cooperation on the projections. One of the aims is to include other players in the pension market and in that way bring about improvements for the insured.

The Swedish Social Insurance Agency conducts regular surveys of public knowledge of the national pension system. The latest survey was done in December 2007 and is presented in the Swedish Social Insurance Agency's annual report for 2007. The survey shows that the level of knowledge has increased slightly among both men and women, but that the increase is clearest among men. Of all people surveyed, 40 per cent say that they know the national pension quite well, which is a rise on previous years. 87 per cent of those questioned are aware that it is the principle of lifetime earnings, that is to say the income earned throughout life, that affects pension, which is up on the figure for 2006. The fact that pensions are affected by economic conditions in Sweden is familiar to 85 per cent. Results differ between the two genders, however, with the proportion of men who are aware of this having risen to 87 per cent while the proportion of women has fallen to 85 per cent. Knowledge that the performance of premium pension funds affects the national pension has increased to 84 per cent. Although there has been an improvement in the figure, 20 per cent are still unaware that age of retirement is flexible,

[7] www.minpension.se

believing instead that it cannot be drawn until the age of 65. A third say that their confidence in the pension system is quite high.

Despite the efforts that have been made to inform people about the Swedish pension system, knowledge of the system among the insured thus remains inadequate, and is increasing only very slowly. One of the remits of the Swedish Social Insurance Agency and the PPM under their current obligation, is therefore to continue to endeavour to spread knowledge on the pension system, with the objective of more people becoming aware of what influences their future pension.

3.3 Reasonable pensions

The reformed national pension system is aimed at creating fairness both within and between generations and being flexible in response to economic and demographic trends. The legitimacy of a national pension system is strengthened if everyone, regardless of income, receives a significant portion of their pension from it and are able to maintain a dignified standard of living after retirement. An overarching aim of the Government's policy on the elderly (the tax-funded part of the pension system) is to offer index-linked basic protection to those with a low or no income-related pension. The costs of basic protection should, at the same time, be kept within reasonable limits from the point of view of the national economy. Another concern is that the level of basic protection should not have a negative impact on the incentive to work. However, it is only by valuing the national pensions together with supplementary pension systems, housing supplements and benefits in long-term care and the welfare system that a complete picture can be gained of pensioners' standard of living.

The greater part of the Swedish national pension system is designed as a pay-as-you-go system. The system redistributes scope for consumption from the gainfully employed population to pensioners. Underlying this redistribution is a pledge between several generations. An important feature of a pension system is that it is designed in such a way that distribution conflicts between generations are avoided. The Swedish pension reform signifies a clearer contract between the generations than the previous pension system. Everyone now pays just as much in contribution as they draw in pension, and the pensions will therefore in the future be based to a far greater degree than previously, on the extent to which those who receive pension have contributed to financing the system, in the form of contributions paid in. Adjustment indexation means that changes both for better and for worse are shared between the gainfully employed population and the pensioners and that flexibility is attained in relation to economic development. This means that future generations will not have too great a burden imposed on them based on a social contract decided on by previous generations.

The national pension system also helps to dose the income gap between different groups in society and therefore also contributes to solidarity within generations. The employers' pension contributions above the ceiling go directly to the government budget, while the government budget in turn finances the basic protection, social insurance benefits and pension-qualifying amounts for parents with young children etc.

The annuity divisors in both the distribution and premium pension systems are calculated on the basis of joint mortality tablets for men and women. As women on average live longer than men, they can be expected, as a cumulative figure over life, to draw more pension in proportion to their paid contributions than men.

3.3.1 Basic protection and the risk of poverty

Basic protection

In looking at the basic protection in the Swedish pension system, it is important to bear in mind that it is designed on the basis of the criterion that there is a housing supplement for pensioners (BTP). BTP in the proper sense is a kind of means-tested pension benefit, and in Sweden forms a major part of the basic security for pensioners.

There is often discussion in the Swedish debate of the pensioners with the lowest disposable income. However, there is no obvious answer to which these pensioners are, and there is no definite definition. A common international definition of financial vulnerability is 'risk of poverty' or relative poverty, which according to the EU standard is measured as the proportion of people who have less than 60 per cent of the median income. As is evident from section 1.1, however, this measure is not complete, as it among other things, does not take account of wealth.

If the pensioners with the lowest income are to be find, the measure of financial vulnerability is inadequate, and there are two sources of error that are clearly manifested in the calculation of BTP. As BTP is part of the basic security and is often defined as a means-tested pension benefit it is included in the measure of financial vulnerability, but wealth or housing cost are not.

BTP is tested against net wealth (as net wealth is regarded as realisable and can be converted to income). The measure of financial vulnerability is consequently misleading. A person who only has guarantee pension, but at the same time has greater net wealth, will therefore not receive any BTP. This person will consequently be regarded as financially vulnerable. This means that it is possible to have high net wealth and yet be regarded as financially vulnerable. If such a person gives away his or her net wealth, he or she will receive full BTP and no longer be defined as financially vulnerable.

BTP is directly dependent on the housing cost. As the housing cost is not included in the measure of financial vulnerability, the measure will also be misleading for this reason. This has the result that the income side is measured but not the expenditure side. One consequence of this is that a person who only has guarantee pension and a low housing cost of SEK 3 000 will have a low BTP and thus such a low income that he or she is defined as financially vulnerable. If this person moves to housing that costs SEK 5 000, BTP increases and she or he is thus no longer defined as financially vulnerable. In reality, however, BTP has to be used to pay the rent, and when it has been paid the person with a higher rent is obviously financially less well off. The consequence is that the person who is financially worse off after cost of housing is not defined as financially vulnerable.

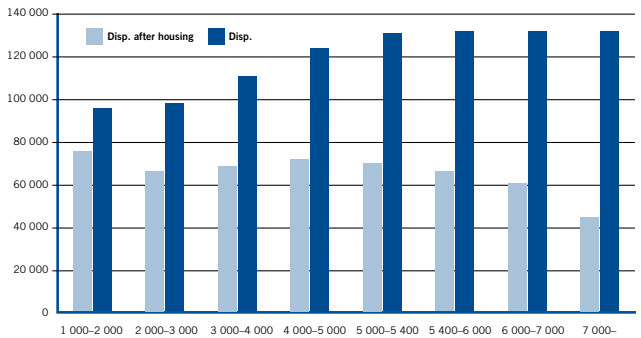
The problem that arises is thus that the measure of financial vulnerability shows that people with a low housing cost and high net wealth are worse off than those who have a high housing cost and no net wealth, which in practice is not the case.

One way of dealing with these problems is to also take account of housing cost and net wealth in the definition of the financial vulnerable pensioners. It is also this method that is used in the legislation for special housing supplement and maintenance support for the elderly. The difference in disposable income before and after cost of housing is paid, is illustrated in Diagram 1 (see next page).

There is a ceiling level of SEK 5 000 in BTP. It is shown in Diagram 1 that this leads to disposable income after payment of cost of housing[8] decreasing rapidly as soon as

[8] To illustrate the situation for the individual, it is the actual housing cost that has been used on the calculations. It is the actual housing cost that is used in calculation of housing supplement and maintenance support for the elderly.

DIAGRAM 1. DISPOSABLE INCOME PER CONSUMPTION UNIT BEFORE AND AFTER PAYMENT OF HOUSING COST, MEAN VALUES PROJECTION 2009



the cost of housing passes SEK 5 000 per month. This is due to the pensioner having to pay the whole of the portion of the cost of housing that exceeds the ceiling.

Improvements have been implemented for pensioners in recent years. Further analysis of the financial situation of pensioners is in progress, and the Government intends to take further steps to improve financial conditions primarily for the pensioners with the lowest income.

Occupational pension

With regard to the discussion on social security safety nets it is important to take into account the role of occupational pensions in the Swedish pension system. It is estimated that around 90 per cent of wage earners are covered by some form of occupational pension scheme. The Swedish pension system is also designed on the basis that the system of occupational pensions exists. There is a ceiling on pension-qualifying income in the national pension system, and employer's contributions for income above this ceiling do not provide pension entitlements but go to the government budget. However, there is no such ceiling in the occupational pension system, and the insured can be credited with pension entitlements for the whole of their income. It can thus be said that the occupational pension compensates where the national pension does not do so. If the system of occupational pensions had not existed, it is likely that the basic system would not have had a ceiling for earning or at least would have had a substantially higher ceiling. Similar considerations apply to the level of contribution to the national system, which is adapted to provide a reasonable pension together with the occupational pension.

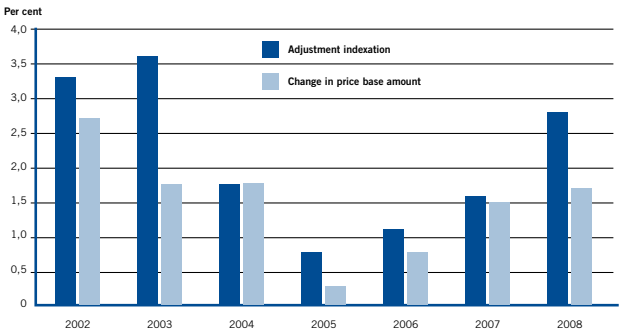
It is therefore important not to forget BTP and occupational pensions in discussions on and calculations for Swedish basic protection.

Indexation of pension

Income pension follows the general trend in income through what is known as adjustment indexation. The portion of basic protection that is index-linked is the guarantee pension, which follows price movements. Price indexation means that the value of the guarantee pension is safeguarded and does not deteriorate in absolute terms. However, the value weakens in relation to other pension benefits when there is real wage growth.

Diagram 2 shows the movement in adjustment indexa-

DIAGRAM 2. ADJUSTMENT AND PRICE INDEXATION 2002–2008, PER CENT.



tion and price indexation. The cumulative change in adjustment indexation is 16.0 per cent, while it is 11.1 per cent for the price base amount. The relative weakening of the guarantee pension is thus 4.9 percentage points. The level of the payments of earnings-related pension in 2008 are around SEK 6 billion higher as a consequence of adjustment indexation.

The level of guarantee pension is fixed but price-indexed, and this forms part of the pension agreement. An amendment to the agreement is required if this is to be changed. There are, however, instruments other than making changes to the pension system that can be used to make changes for guarantee pensioners.

3.3.2 Basic protection and incentive for work

The basic protection in the national pension system consists of the guarantee pension and the housing supplement for pensioners. The basic protection exists to guarantee a minimum level accepted by society for those whose other pension is not sufficiently high.

There is an endeavour for the basic protection to be sufficient to provide a reasonable standard of living for the elderly. There will always be groups that lack, or have inadequate, earnings-related pension. The basic protection is a deliberate departure from the principle of lifetime earnings and activation.

For a person with low earned pension entitlement, the present level of basic protection means that further contribution payments do not necessarily mean that the final pension will be other than marginally higher. It is anticipated, however, that the number of recipients of guarantee pension will fall in the longer term as incomes are expected to increase faster than the price-indexed limit for guarantee pension. Price indexation of the guarantee pension results in basic protection that guarantees a certain level of purchasing power, but also provides some incentive for work related to the faster development of income in earnings-related pensions.

The earnings-related pension decreases as life expectancy increases, unless working life is duly prolonged. Part of this life expectancy effect is captured by the guarantee pension. The guarantee pension compensates for part of the decrease in earnings-based pension from the increase in life expectancy. Given a particular level of earnings-related pension balance, increased life expectancy results in a lower monthly amount, which can then lead to more guarantee pension. However, this effect can be counteracted by the expectation of more rapid growth in real wages and salaries than the change in the annuity divisor. In some cases this means, however, that the guarantee pension cannot be fully flexible in response to the earnings-related pensions, and the age limits must instead be changed if the guarantee pension is not to expand at the expense of the earnings-related pensions.

3.4 Financial sustainability

The old-age pension system is directly linked to the economy and the development of average life expectancy. Together with the strong link between contributions paid and benefits paid out, the system is financially highly sustainable and from an international point of view very stable. The system is autonomous and is not affected by fluctuations in the government budget. The income and expenditure of the old-age pension system can only be used for old-age pension purposes.

Regarding the sustainability of public finances, Sweden has set as its goal a surplus in public sector financial savings of on average 1 per cent of GDP over an economic cycle. A surplus of this kind creates a stable basis on which to face up to the challenges, in addition to pensions, posed by the sharp increase in the proportion of elderly people in the population in the future.

In the event of unfavourable demographic or economic development there may nevertheless be an imbalance in the system, making it impossible to compound the income pension account and the income pension with the growth in average income and at the same time finance payments of the income pension with a fixed contribution. In order to maintain the contribution rate in the pay-as-you-go system at the level of 16 per cent, income indexation must be suspended in such a situation. This is done by activation of so-called balancing.

Whether balancing comes into play or not depends on how the balance ratio develops. The balance ratio shows the relationship between the system's calculated assets and liabilities. The assets largely comprise the flow of contributions and to a lesser extent the assets in the buffer fund. The flow of contributions is calculated according to how large a pension liability the flow of contributions could finance, given the demographic and economic conditions in the period of measurement. The liability consists of everything which at some time is to be paid out in pension to the present-day pension savers and pensioners. If the balance ratio is above 1, the assets are greater than the liabilities. If the balance ratio is below 1, the liabilities are greater and balancing is activated and will be active until the balance ratio exceeds 1.

The result of the income pension system in 2007 was SEK –82 billion, which meant that the system's surplus carried forward was SEK 18 billion. This is equivalent to 0.26 per cent of the system's pension liability of SEK 6 996 billion and the balance ratio is thus 1.0026. The changes in the balance ratio can be tracked in Table 4 below.

From the time when the first balance ratio was established, the trend was downward for several years. However, the balance ratio developed positively during 2005 and 2006, although it decreased again in 2007. Many factors influence the outcome and balance ratio of the pension system. The principal explanation for the negative trend in 2007 is that average income, which determines the compounding of the pension liability, increased more than contribution revenue, which together with turnover period determines the change in the contribution asset. The increase in average income for 2007 has had a more rapid impact than increase in total income.

3.4.1 The general pension expenditure and how it is financed

Payments of the public earnings-related pensions are primarily financed by regular pension contributions on pension-qualifying income from the active generation. Pension-qualifying income is largely made up of the incomes of wage earners and the self-employed. Taxable social insurance and unemployment benefits and pension-qualifying amounts are also included. Central government annually pays to

TABLE 4. CHANGES IN THE BALANCE RATIO

Position at 31/12	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
Balance ratio, year	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Assets	5 611	5 789	6 042	6 253	6 490	6 803	7 014
Pension liability	5 432	5 729	5 984	6 244	6 461	6 703	6 996
	179	60	58	9	28	100	18
Balance ratio	1,03	1,0105	1,0097	1,0014	1,0044	1,0149	1,0026

the subsystems concerned the charges that accrue on such income. Payments of old-age pension in 2007 totalled SEK 215 861[9] million, which is around 7 per cent of GDP[10].

The pension from the pay-as-you-go system is also financed from the buffer funds and their interest income. The buffer fund consists of five national pension funds (AP funds) comprising the First to Fourth National Swedish Pension Fund and the Sixth National Swedish Pension Fund. At 31 December 2007 the assets of the national pension funds totalled SEK 898 billion, which accounts for around 13 per cent of the assets side of the pay-as-you-go system, which largely consists of the value of future contributions to income pension. The income pension from the pay-as-you-go system is index-linked to the average growth in income and therefore does not have any link to what happens with the return on the financial assets. On the other hand, the return on the national pension fund has some effect on the financial development of the system, but will principally affect unpaid pensions if the pay-as-you-go system is under-consolidated, as the automatic balancing mechanism can be activated, for example as a result of a poor return on the national pension funds.

The pension system is autonomous and bears its own costs entirely. This means that the system's administrative costs are also financed from contributions and fund capital. In a similar way to private systems, the administrative costs consequently affect the size of pensions. Administrative costs for the whole earnings-related pension totalled just over SEK 2 billion in 2007, which is equivalent to around 1 per cent of annual payments. In addition to this are costs of capital management in the national pension funds and the premium pension, The costs increased at the time of the pension reform, but the trend now is for them to decrease, Constant efforts are made to reduce administrative expenses.

The basic protection guaranteed by central government is financed by tax revenue, and the administration of this basic protection is also financed through the government budget.

3.4.2 The occupational pensions and how they are financed

Occupational pension agreements are generally entered into through collective agreements between the social partners. There are no particular statutory requirements for the contents of pension agreements, but employers have to ensure that they meet their pension obligation in a satisfactory manner. This can be done through account allocation combined with a financial guarantee, such as credit insurance, or through the allocation of funds to a pension plan. Employers can also insure the obligation to make pension payments by paying premiums to an occupational pension insurance scheme, which is provided by a life assurance company or a superannuation fund. This scheme should be run in such a way that the individual beneficiary has all the knowledge necessary to take informed decisions. The occupational pension insurance schemes are equated to life assurance and are therefore covered by the rules applicable to life assurance activity.

Most occupational pension agreements today are defined-contribution for incomes covered by the national pension system. The trend for incomes that surpass the earnings ceiling is also for more retirement benefit agreement systems to be defined-contribution, although some are still defined-benefit.

[9] Payments for retirement pensioners, earnings-related pension SEK 188 227, guarantee pension 20 371 and housing supplement 7 263 million, Source: Swedish Social Insurance Agency

[10] GDP at current prices in 2007: SEK 3 073 832 million. Source: Statistics Sweden

3.5 Current development

3.5.1 Pensions and working life

As the population becomes steadily older and average life expectancy rises, a prolonged working life is important both for the individual and for society. Average life expectancy has risen by around one year in the past ten years, but this is not reflected in a longer working life. Working life can be prolonged by lowering the age of entry or raising the age of exit. The Government has implemented several reforms aimed at both lowering the age of entry and raising the age of exit and in so doing bringing more younger and older people into employment.

The job tax deduction is designed to give pensioners who work extra tax relief on their work income. The aim is to provide a stronger incentive for older people to stay in or return to the labour market. In order to also increase the incentive to retain and take on older staff, employers who employ people over the age of 65 have been exempted from the special payroll tax which they would otherwise pay on incomes that exceed the ceiling for pension-qualifying income.

The Government previously lowered social security contributions for people who at the start of the year are between the ages of 18 and 24 in order to make it easier for young people to enter the labour market and to create employment among the young. To further reinforce this initiative, the Government has proposed that the reduction with effect from 1 January 2009 should cover everyone under the age of 26, while making the decrease even greater. The social security contributions for young people are to consist of the retirement pension contribution and a quarter of other contributions. This measure has the effect of making the cost to companies of employing a young person around 13 per cent lower than would normally be the case.

3.5.2 Transparency in the system

The Orange Envelope is sent every year to those who are insured under the national pension system. They receive information on the pension entitlements they have earned during the year and the total amount in their pension accounts. Most people also receive a projection of future pension. The aim in sending out the information is to increase understanding of the national pension among those who are insured and for more people to learn that it is possible for them to influence their future pension during the period of earning and through the age at which they take it. Another aim is to inform people how large their future pension is likely to be. Continuous work is also under way to improve and adapt the information in the envelope so that those who are insured can absorb it.

An important element in this supply of information is the annual report of the pension system (Orange Report) prepared annually by the Swedish Social Insurance Agency. As the size of pensions is partly dependent on the financial position and development of the pension system, a regular annual report on the system's assets and liabilities is essential. This is also a condition in determining whether the system's automatic balancing mechanism should be activated. The annual report is also intended to make it possible to follow and understand the financial development of the pension system and to shed light on each of the factors that determine the size of both the income pension and the premium pension. The report is thus intended to inform people insured under the system of how trends can affect their pensions. This means that the report is to shed light on the demographic, economic and behavioural risks and opportunities that determine the system's financial position and directly affect, or may in future affect, the value of pensions.

3.5.3 Political stability

As a pension system is a long-term commitment, it is important that it is not just financially but also politically sustainable. The design of the pension system can influence many life choices for the insured during their working lives. People insured under the system therefore have to have an adequate idea, long before they retire, of what pension they can anticipate under various circumstances, that is to say what affects the earning of pension entitlements. The rules of the pension system must therefore be stable and based on a broad agreement so that the ground rules stay the same when there is a change of government.

A characteristic feature of the Swedish pension reform was an endeavour to attain the broadest possible political consensus on the design of the pension system. Five of the seven parties represented in the Riksdag are behind the political agreement that underlies the reform: the Social Democrats, the Moderates, the Centre Party, the Liberal Party and the Christian Democrats, who together account for nearly 90 per cent of members of parliament. These parties cooperate on changes to the system. Political consultations and statements on issues relating to the reform were previously dealt with by the Implementation Group. This group completed its work at the time of the parliamentary elections in 2006.

At the last meeting of the Implementation Group it was decided that a special monitoring group would be set up with the task of attending to the agreement and otherwise consulting on current pensions issues concerning the pension agreement. This monitoring group, which has been named the Pension Group, was set up following a government decision on 29 November 2007. The written terms of reference governing what issues are to be included n the pension agreement were adopted in April 2008. Retirement age can be mentioned among the issues to be dealt with. Changes have occurred in average life expectancy and the number of years of gainful employment since the pension reform was introduced. The group is to draw up alternatives for how this should be dealt with in the pension system.

3.5.4 Information on and knowledge of the pension system

New pension authority

Old-age pensions are a key central government commitment. The stability of the system is of great importance to Sweden's ageing population, and the needs of the insured for information and knowledge are greater than in previous pension systems. As it is during the period of earning that insured persons can influence their pension, there need to be greater focus on the time prior to retirement.

The client-centred administration of pension benefits today is shared between the Swedish Social Insurance Agency and PPM. This has led to problems from the point of view of the insured, for instance with regard to access to information and service. Problems have also arisen from the administrative point of view in relation to control, management and accountability. A separate authority for old-age pensions is better placed to meet the needs of the insured for information on and knowledge of pension issues.

The Government has therefore appointed an inquiry which is to prepare and implement the formation of a pension authority with responsibility for the administration of the national old-age pension and certain related pension benefits, that is to say the pension administration which at present is undertaken by the Swedish Social Insurance Agency and PPM. The new authority is due to the established on 1 January 2010.

The Pension Council

By forming the Pension Council, the Swedish Pension Insurance Agency and PPM have taken the initiative to de-

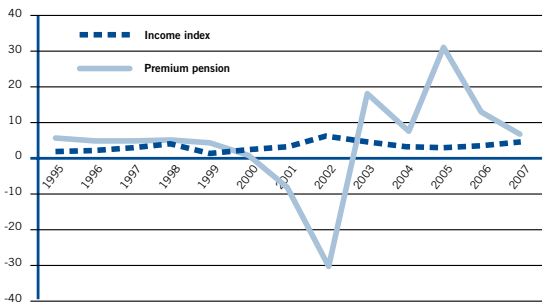
velop cooperation between the players in the area of pensions. Representatives of employee, employer and pension organisations, among others, sit on the Pension Council. The idea behind the Council is that it should be a forum for discussion, information and exchange of experience on pensions. The Council is to work on industry-wide terminology, clearer common information to clients on the various parts of the pension, coordination of information efforts via the Internet and of calculation assumptions in pension projections, as well as a better factual basis for the whole pension and follow-up of the actual financial outcome of the various parts of the pension. The objective of the joint actions is for the insured, with less expenditure of effort, to attain greater knowledge of their own total pension savings and the pension these can be assumed to lead to.

3.5.5 Number of funds, active choices, administrative charges

An important motive for the premium pension element was to increase the influence of individuals over their pensions. There was also a wish to encourage higher individual saving and contribute to the supply of venture capital to the business community and to levelling out risk. With the element of premium pension in the national earnings-based pension, indexation became dependent both on the growth of income in society and on return on capital.

Diagram 3 shows the growth of the income index and the annual return on premium pension since 1995, measured as internal rate of return. The average rate of return has been 2.7 percentage points higher in the premium pension system than the indexed rise in the income pension system[11]. As can be seen in the diagram the volatility in the premium pension system is, however, considerably greater.

DIAGRAM 3. ANNUAL PREMIUM PENSION RATE OF RETURN AND INCOME INDEX 1995–2007, PER CENT.



Source: PPM.

At the end of 2007 there were nearly 5.4 million pension savers and more than 450 000 pensioners in the premium pension system. Fund capital under management totalled just over SEK 308 billion. 59 per cent of pension savers who have not drawn their pension have invested their funds in portfolios they have chosen for themselves, while 41 per cent have not made any active choice of fund and have had their savings invested in the Premium Savings Fund. This can be compared with equivalent figures from the start-up year of 2000, when 67 per cent chose their own portfolio and the remaining 33 per cent did not make any active choice. At the end of last year a total of around 2.4 million pension savers had their premium pension assets in the Premium Savings Fund. The Premium Savings Fund is managed by the Seventh Swedish National Pension Fund, and is a fund with a medium-level risk and low charges, 85 per cent of the capital being invested in equities.

[11] Individual return may, however, vary substantially. This contributes to increased spread in pensions, which is not dependent on the principle of lifetime earnings.

TABLE 5. NUMBER OF FUNDS, ANNUAL CHANGE

Year	Number of funds
2007	785
2006	779
2005	725
2004	697
2003	664
2002	644
2001	597
2000	465

Source: PPM.

The number of funds has increased since the start of the premium pension system, from 465 in 2000 to 785 in 2007 , while the number of active choices has decreased. The issues of number of funds and options are under review.

In 2007 each pension saver on average paid 0.46 per cent of the pension balance in charges, comprising 0.33 per cent in fund manager's charge and 0.13 per cent in administration charge. PPM has introduced a ceiling of SEK 100 on the levying of charges for administration. Just over 2 million savers paid the maximum charge in 2007. The rate of charge has decreased in percentage terms in comparison with previous years, and the proportion a particular pension saver pays has consequently fallen. As the balance in the premium pension system increases, the total charge in Swedish kronor has however increased.

4 National strategy for health care and long-term care

4.1 Introduction

International comparisons show that Swedish *health care* is well placed in relation to other countries and that Sweden achieves better results than other countries for instance with regard to average life expectancy, infant mortality and cancer survival. Swedish health care continues to attain ever improving results for several of the most common diseases such as heart attacks, stroke, diabetes and cataracts. The ability of primary health care to offer effective counselling in mental ill-health has improved in the past two years. Disease prevention efforts appear to have increased, and more and more county councils are reporting that this is a priority area for them. There is, however, scope for improvement with regard to accessibility and patients' freedom of choice of care provider.

An important tool in improving accessibility and creating safer and more effective health care is enhanced use of Information and communication technologies (ICT) in the sector. Sweden is already one of the leading nations in the world in this area through a long history of advanced use of ICT support in the health and social care sector. A number of measures are now being implemented under the National Strategy for eHealth to ensure that necessary information on a patient can be available when needed to guarantee good and safe care. The Government has initiated close cooperation between the key players in the sector to implement necessary reforms and investments. The next step in this work is to establish an EU project involving 12 Member States, in which Sweden will coordinate efforts to bring about a European patient overview service and the possibility of sending ePrescriptions between countries. The aim is to create the necessary basis for reliable and safe patient mobility within the EU.

Inquiries and follow-ups show that *long-term care* largely fulfils its remit. There are nevertheless some deficiencies, for instance in the individual adaptation of decisions on action to be taken. Service users state that long-term care is bureaucratic and that they do not have an adequate opportunity to influence their everyday lives. The Government takes these deficiencies seriously and has therefore appointed an inquiry which submitted its final report on 31 May 2008. The inquiry proposes a national set of values for long-term care and makes clear how social care should be focused so that elderly people can life a life of dignity with a sense of well-being. The proposed set of values entails a change of perspective in the way in which the elderly are viewed and a higher level of aspiration, so that greater quality is attained in Swedish long-term care. The Inquiry's proposals are currently under discussion in the Swedish Government Offices.

It is also important to create the necessary conditions for an old age of dignity from a European perspective, as many European countries are facing a demographic trend towards an ever increasing proportion of the population being elderly. Together with France and the Czech Republic, the two countries preceding as holders of the EU presidency before it takes over in the autumn of 2009, Sweden has agreed on a joint priority for the period of presidency of the three countries, "Healthy, Active and Dignified Ageing".

4.2 Health care

4.2.1 Development in relation to the 2006 strategy report

Following the change of government in the autumn of 2006, the Swedish strategy report was updated in the autumn of the same year to reflect more accurately the new government's intentions in the social area. As Sweden's final report to the Commission did not arrive until after the designated closing date, the official Swedish report was not reproduced in the joint report on social protection and social inclusion adopted by the Council on 22 February 2007.

The Government's goals for Swedish health-care policy are: *The population shall be offered needs-oriented, accessible and efficient care of high quality*, which also correlate with the common objectives within the EU (accessibility, quality and sustainability). With regard to the above stated national and European objectives, Swedish health care policy has come to focus on initiatives that improve accessibility, quality, freedom of choice and diversity of care providers.

A feature common to the initiatives taken with the aim of improving care and creating the necessary conditions for financially sustainable development is that they are, in general, targeted at the whole population and not individual groups.

A number of inquiries have been appointed with the aim, for instance, of reviewing the care guarantee, the patient's options and the diversity of care providers and patient safety.

As part of its endeavour to guarantee patient safety, accessibility and quality of care and to improve the efficiency of care administration, the Government is continuing to work towards creating effective and appropriate supply of information in health care. A Patient Data Act came into force in July this year. This Act is intended to facilitate the exchange of information in health care and to strengthen patient influence over the information that is gathered and recorded on the patient.

Regarding quality initiatives, mention can be made of the strategy of good care that has existed since 2007. This strategy is a manifestation of more active and systematic control of knowledge in health care, for instance through follow-ups based on national quality indicators.

A more detailed description of the Government's initiatives in the health-care sector follows below.

4.2.2 Accessibility

All citizens are to feel secure in the knowledge that care will be available when it is needed. A number of measures have been implemented in the present decade aimed at improving accessibility and strengthening the position of the patient, for example the national accessibility initiative, the national action plan for the development of health care and the national care guarantee.

Care guarantee

Since 2005 there has been a 'care guarantee' in Sweden, under which the county councils are obliged to offer care with limited waiting times. As follow-ups have shown that the care guarantee is not working entirely as intended and that there are still long waits for some types of treatment, there is a need for the prospects of patients receiving care in time and being able to choose care provider and time of care for themselves to be further improved. An important aspect of such efforts is to continue to develop the national care guarantee and freedom of choice in care and to put them on a statutory basis. Statutory regulation will make the obligation of the health service towards the patient clearer for both the patient and the care provider. The Government therefore, in 2007, appointed an inquiry with the remit to submit proposals regarding how the national care guarantee and free choice of care can be regulated by law.

Diversity

To enable patients to make use of the right to free and individual choice in health care, it is necessary for the care to be notable for openness and diversity with respect to content, form and care provider. A diversity of care providers in publicly funded health care can stimulate the development of innovative, cost-effective solutions, improved accessibility and freedom of choice.

To promote greater diversity in health care, in 2007 the

Government appointed an inquiry (The Patient's Rights in Care, S 2007:07), with the remit to investigate and present proposals on how freedom of establishment can be introduced in primary health care. The underlying principle is that competition is to take place on equal terms for all publicly financed primary care.

The inquiry presented its interim report Choice of Care in Sweden (SOU 2008:37) in April 2008. In its report, the inquiry presents a model containing a mandatory freedom-of-choice system. Under the proposal, a basic remit will be established nationally for primary care by the Government or the agency designated by the Government. The county councils can complement the basic remit on the basis of local circumstances and in so doing form their choice-of-care system. All care providers who meet specified requirements are entitled to establish themselves. The system of remuneration is to be based on the money following the patient's choice and on private and public care providers being treated equally. It is up to each county council to decide on the more detailed formulation of the remuneration.

The proposal focuses on the position of the patient. The patients' options are clarified and strengthened by the right to choose health care provider, where the remuneration follows the patients' choices. The power to choose provider is transferred from the county council to the patient. A choice-of-care system with freedom of establishment additionally increases the likelihood of more care providers becoming established. As a result of the care provider being financed through the patient's choice, it is crucially significant to the care providers how the patients choose, which can enhance the quality of care. The nationally adopted basic remit can additionally contribute to making the public obligation clearer and making more uniform follow-up of primary care possible. It is proposed that the legislative proposals and the system of freedom of establishment in primary care will come into effect in 2009.

Supply of information and ICT development

An important element in efforts to improve accessibility in care is to make safe and effective exchange of information possible, both between care units and between patients and the care system. The aim is to bring about better interaction between health-care providers and support stronger patient orientation in the organisation with the aid of new ICT support. New legislation, in the form of the Patient Data Act which came into force in July this year, will balance improved patient safety with strong protection of privacy.

The Act aims to strengthen patient safety by facilitating exchange of information in health care and strengthening the patient's influence over who has access to their own medical records.

The Patient Data Act covers all care providers regardless of who the responsible authority is, and among other things regulates the possibility of care providers exchanging data electronically across organisational boundaries. The previous prohibition of electronic direct access between care providers is abolished, and a possibility of care providers creating a combined picture of the patient's previous care history with the patient's consent is created. At the same time, the possibility of patients checking how the information contained in their own records is used is strengthened by the introduction of a new system for obtaining consent. As a confidence-building measure, requirements are also introduced for patients to be able to view a log, showing which health-care personnel have read their records.

The Government has also been cooperating for many years with the Swedish Association of Local Authorities and Regions to establish nationally coordinated and quality-assured medical advice on the Internet and over the phone, through the services *Sjukvårdsrådgivningen.se* and *Sjukvårdsrådgivningen 1177*. The aim in introducing these services to is improve the reassurance of patients by offer-

ing practical guidance ahead of a health-care visit and to offer advice on health and self-medication. This service will be expanded in 2009 to cover personal information about patients' own health, electronic access to extracts from patient records and the possibility of booking appointments with doctors and renewing prescriptions for medicines. In the longer term the objective is to be able to present comparative information adapted to particular target groups on the quality and outcome of care from different care providers. The service will therefore become an important tool for all members of the public, both ahead of a health-care visit and in choosing care provider, and will provide greater opportunities for participation and self-determination for the individual.

Psychiatry

Psychiatric health care is a priority issue for the Government. Last year and during the current year a sum of SEK 500 million has been allocated annually to improving psychiatric care, and parts of this investment have been targeted at improving the accessibility of psychiatry, principally child and adolescent psychiatry.

One way of improving access to child and adolescent psychiatry is to strengthen the care guarantee in this area. The Swedish Association of Local Authorities and Regions (SALAR), under an agreement with central government, has examined the prospects of introducing a strengthened care guarantee, which would mean that waiting times for visits and treatment are not to exceed 30 days (rather than 90 days, as stated in the general care guarantee). SALAR's assessment is that the responsible authorities has to be able to attain the shorter waiting times no later than 2011. The Government intends to support the authorities responsible for health care in their efforts to attain a strengthened care guarantee.

4.2.3 Quality

Knowledge-driven care

Knowledge-based and appropriate health care means that care has to be based on knowledge and proven experience and be designed to meet the needs of the individual patient as well as possible. The National Board of Health and Welfare has been tasked since 1996 with drawing up national guidelines for care and treatment. These guidelines are usually based on material from the Swedish Council on Technology Assessment in Health Care. The guidelines are intended to provide national knowledge-based support to the work of the authorities responsible for medical care with the programmes and priorities.

Too much development work is done in isolation, with the result that patients do not obtain the care they ought to receive according to science and proven experience. To ensure that research in organisation, control and leadership etc. has a greater practical impact, the Government has therefore taken decisions to strengthen the funding of the research programme *Vinnvård*. The programme has a number of aims, for instance workplaces in the health and social care system are to become better at effectively converting quality-assured knowledge into practical action in everyday life and developing forms of work and management systems to improve the ability to assimilate new knowledge.

Since 2007 there has been a national strategy for what is known as good care. The work on Good Care is based on the Medical Services Act and the Dental Services Act. Indicators that reflect several dimensions of quality are required to be able to assess whether the population receives good care when it needs it. What is characteristic of good care is that it is knowledge-based and appropriate, safe, patient-focused, effective, fair and provided within a reasonable time.

The strategy manifests more active and systematic

knowledge driving of health care. Evidence-based knowledge is needed to identify what types of improvements are desirable and what potential the improvements may have. Systematic improvement efforts are then needed to convert knowledge into practical action. Effective and appropriate supply of information is essential for members of the public, care personnel and decision-makers to have access to necessary information. National organisational follow-up based on national quality indicators with open comparisons are needed to identify problems, show whether changes lead to improvements and stimulate learning. The Government's strategy for good care also includes enhanced systems of remuneration and greater diversity to create favourable conditions for good care centred on the patient.

A common information structure and uniform terms and concepts are essential if the exchange of information in care is to work safely and effectively and if it is to be possible for data to be comparable and capable of correct interpretation between caregivers across time and space. The Government has therefore tasked the National Board of Health and Welfare to run two projects, firstly to establish a national information structure that defines what information needs to follow the patient between different care providers, and secondly to establish a national technical language for health and social care based on the global nomenclature system Snomed CT.

Patient safety and supervision

Patient safety is a priority issue for the Swedish Government. A government inquiry was appointed in the spring of 2007 with a remit to review the legislation from the point of view of patient safety. The inquiry is due to present its proposals to the Government by 31 December 2008.

The National Board of Health and Welfare, which is the supervisory authority for health care and the competent authority in the area of patient safety, has initiated a survey of harm in health care similar to the studies previously conducted in Denmark and the United Kingdom. It will then become possible to at least make broad comparisons between Sweden and other countries with regard to the incidence of harm in health care. The study was presented in June 2008, and shows that 8.6% of patients suffer some form of harm in connection with health care, and that there are a total of around 100 000 cases of harm in health care and 630 000 extra patient days. One element in the Government's endeavour to minimise the risk of harm in health care is to ensure that necessary information about a patient can be available to treating health care personnel, if patients themselves give their consent. The Government's efforts together with authorities responsible for care and authorities under the National Strategy for eHealth forms the basis of this endeavour, as they establish a common agenda for how the key players in the sector are to proceed in order to clear away legal, semantic and technical obstacles to reliable and effective supply of information in all health and social care activity.

The county authorities, which are responsible for health care activity, are working intensively on patient safety issues. The Swedish Association of Local Authorities and Regions (SALAR), which is a stakeholder organisation, in 2007 launched a National Patient Safety Initiative, the aim of which is to halve the incidence of health care-related infections by the end of 2009 in comparison with 2006.

The National Board of Health and Welfare, SALAR and several other organisations have also arranged three national patient safety conferences since 2003, and a fourth one is due to be held in September 2008.

The National Board of health and Welfare also has supervisory responsibility for health care and for health-care personnel. The primary purpose of this supervision is to strengthen patient safety and improve quality of care by preventing harm and eliminating risks in care. In addition,

there is an obligation on care providers to notify the National Board of Health and Welfare if a patient is affected, or is at risk of being affected, by serious harm or disease in connection with care. The National Board of Health and Welfare compiles and feeds back information on serious incidents in care and publishes binding regulations for health care on issues concerned with patient safety and quality.

Psychiatry

The Government regards improving quality in psychiatry as a crucial issue. One aspect of efforts to bring about improvements is being able to carry out reliable measurements of quality and results in psychiatry. A commitment was therefore made to quality registers in psychiatry in spring this year. This commitment means gathering the quality registers together in a web portal and ensuring that they attain good quality by the end of 2010.

Another important factor in establishing good quality in psychiatry is to ensure a high level of expertise among staff who encounter people with a mental illness or a disability. Efforts have therefore been made in 2007 and 2008 to raise expertise firstly in psychiatric health care and secondly in social services for people with mental disabilities.

4.2.4 Financially sustainable development

Development of productivity and efficiency

The future demographic trend, combined with the widening gap between what health care can achieve on the one hand and what society is capable of funding on the other, is making increased demands on efficient utilisation of care resources. This highlights the need to further improve both the productivity and efficiency of care.

The work of the National Board of Health and Welfare and the Swedish Association of Local Authorities and Regions on what are known as open comparisons (see also under Quality) is intended to contribute to the control of health care, as both favourable results and deficiencies are highlighted in a more structured way than previously. The aspiration is, in turn, for the comparisons to prompt county councils to make improvements and contribute to mutual learning. A related part of the work also consists in in-depth analyses of the detailed quality and efficiency indicators in the open comparisons, in which explanations are sought for differences in health-care outcomes. There is an aspiration to analyse the general determining factors and specific factors of success which are of importance to an health-care system which is efficient and works smoothly. By analysing variations in outcomes between responsible authorities and care providers, systematic improvement work is stimulated as an element in the attainment of improvements in productivity and quality.

Evidence-based care

A condition to be met in order to be able to ensure sustainable funding, is that all care is provided with the most appropriate treatment for each situation, while procedures which are not medically justified are eliminated. The compilations of studies made by the Swedish Council on Technology Assessment in Health Care lead both to effective methods having a major impact in health care and to ineffective treatment being dropped.

Effective supply of information

In much the same way that methods of treatment have to be evidence-based and qualitative, health-care administration must be quality-assured. As well as new and more appropriate ICT support contributing to improved quality of care and greater patient safety, ICT represents a tool for improving the efficiency of health-care administration. Here too, the National Strategy for eHealth is essential in affording health-care personnel access to ICT support that

works smoothly and improves the efficiency of administrative processes. Today, inefficient and outdated routines create an administrative burden for staff, thereby extending waiting times for care and increasing costs to society. With appropriate ICT support, the patient's care process can be speeded up, which will not only benefit the health situation and confidence in health care of the individual but also the cost-effectiveness of care and rehabilitation.

Efficiency improvement through both greater concentration and collaboration

Sweden has a too small patient population for all care providers to be able to develop and run the most highly specialised medical care. Since 1 January 2007 it has been possible for such care to be provided as national specialised medical care, following a decision by the National Board of Health and Welfare. National specialised medical care refers to health care operated by a county council and coordinated with the whole country as the catchment area. Such care which it may be appropriate to provide as national specialised medical care is estimated to account for less than one per cent of all in-patient care episodes. The National Board of Health and Welfare has so far decided that heart surgery on children and adolescents and ocular oncology should be organised as national specialised medical care. A concentration of the most highly specialised care can be expected to lead to more effective utilisation of health-care resources.

Alongside the concentration of highly specialised care, further structural changes are taking place with the aim of improving the efficiency of care through both more rational distribution of work and increased collaboration between different organisations. With the aim of striking the right balance between acute and planned care so that greater efficiency, medical safety and quality can be achieved, work is in progress for example on combining and profiling the planned surgery in several county councils. Another trend is for community care concepts, in which long-term care, primary care and specialised care in particular are linked together, to be implemented in a number of different county councils. The aspiration is to improve the efficiency of health-care measures through an integrated approach between organisations to meet the most common care needs of the population, particularly for patients with special care needs who often require recurring contact with different parts of the health-care system and for whom the contacts continue over long periods. The commitment to 'care pilots', who are to be available to support patients and ensure that they find their way through the care system, also forms part of the community care trend.

Governance and distribution of responsibilities

The parliamentary inquiry known as the Committee on Public Sector Responsibilities has studied the prospects of the present-day system of public administration meeting its public welfare commitments. In most areas of policy, responsibility is currently split among several levels, which makes it difficult for members of public to obtain an overview of the social organisation and know where, and how, to demand accountability. The Committee has proposed changes to the current structure and distribution of tasks between central government/agencies, municipalities and county councils, with the aim of creating an efficient and financially sustainable structure for health care. The Committee presented its final report in February 2007.

Public health and financially sustainable development

A healthy population creates a better basis for prosperity and improved growth through reduced sick leave, higher employment, higher productivity and a reduced need for health and social care. There are several areas that point to the correlation between health and economic growth.

The Government is implementing measures for instance to reduce alcohol and drug abuse and the consumption of tobacco.

Long-term demand for welfare services

The Ministry of Health and Social Affairs is working on a project to shed light on the long-term demand for, and costs of, welfare services. The project is a more in-depth version of the 2003/2004 Long-Term Survey with a focus on health and medical care as well as health and social care for the elderly (the Long-Term Survey is a permanent investigative function which conducts long-term analyses of economic development over a 15-20-year period). Various aspects will be looked at in this work. Examples of these are demographics, trends in health, income, technologies, changes in expectations and values and the relationship between the efforts of the public institutions and those of family members.

4.3 Long-term care

4.3.1 Development in relation to the 2006 strategy report

Many of the initiatives in long-term care policy described in the updated strategy report which the new government presented to the Commission in April 2007 have not yet been completed. It is therefore too early to draw general conclusions on the outcome. Outcomes for those initiatives which have been completed are presented below.

The training initiative made for personnel in long-term care, the 'Competence Ladder', has now been completed. The committee's final report shows that 120 000 employees in 287 of the county's municipalities have taken part in the Competence Ladder, which is equivalent to just over 60 per cent of the total number of employees in health and social care of the elderly. Among the areas of knowledge which the municipalities have chosen to focus on, the most common are respect, ethics and values, dementias, rehabilitation, terminal care and meal and nutrition issues. Although the committee has completed its work, the exciting development work in those municipalities which have received support from the Competence Ladder continues.

The obligation on municipalities and county councils to work together so that individuals receive the care and treatment their condition demands has been enshrined in law since 1 January 2007 in the Medical Services Act. Since 1 January 2007 the county councils have been obliged to allocate the medical resources needed for individuals to be offered good health care in special accommodation, in day centres and in ordinary accommodation in these municipalities which have such health care responsibility. The county council has to enter into agreements with the municipalities on the scope and forms of medical assistance. If the county council fails to meet its obligations under the agreement, the municipality is entitled to engage doctors on its own initiative and to receive reimbursement of its related expenses from the county council. There are examples of improvements with regard to medical assistance in municipal health care, but there are also many examples of deficiencies. The deficiencies are due both to the shortage of doctors and to a lack of agreements on the assistance of doctors.

Special support was introduced in 2007 to increase diversity in long-term care, among other areas, by outsourcing activities.

A more detailed description of the Government's ongoing initiatives in long-term care follows later in this section.

4.3.2 Accessibility of long-term care

To be able to assess whether present-day access to health and social care is satisfactory, three is a need for needs to

be related to the health and functional capacity etc. of elderly people. The previous positive picture of the trend in the health of the elderly is no longer so clear. The ability of elderly people to cope with activities of daily living has improved. At the same time, increasing numbers of elderly people are reporting health problems and complaints of various kinds. Good accessibility of long-term care depends in part on elderly people having various alternatives to choose from.

The National Board of Health and Welfare's social services statistics for 2007 show that the proportion of people over the age of 65 who receive home help or have special accommodation, as in previous years of the current decade, has been fairly constant, at around 15 per cent. On the other hand, long-term care has been restructured so that more people receive home help and fewer people live in special accommodation. The need for action increases with rising age, and four out of every five people who need action to be taken are over the age of 80. Seventy per cent of those who are recipients of home help service or live in special accommodation are women. The proportion of people in the population over the age of 80 receiving home help service or living in special accommodation has decreased somewhat every year of the current decade. In 2007, however, the proportion increased by nearly two percentage points, and 39 per cent of those over the age of 80 now receive home help service or live in special accommodation, a higher proportion than at the start of the decade. The number of people who receive both home help service and local-authorityl home medical care is rising. This suggests that more elderly people with multiple needs are being cared for at home.

Municipal health and social care also comprises a number of other measures, principally those that are intended to improve the prospects of the elderly continuing to live at home. There is now access to more data on long-term care as a result of the introduction of individually based statistics in 2007. In 2007 around 145 000 people in ordinary housing had personal safety alarms. Around 10 600 people had been granted day care facility assistance. Just over 11 000 people had been granted short-term places for example for respite or rehabilitation. Just over 5 400 people over the age of 65 were granted financial family member compensation for the help they provided to a family member.

The long-term care costs of the municipalities decreased between 2002 and 2006, while county council costs for elderly health and medical care increased somewhat.

The number of places in special accommodation decreased by 23 300 between 2000 and 2007, principally as a result of accommodation with a lower standard of housing having been phased out. The proportion of elderly people in special accommodation who share rooms with someone other than a husband, wife, partner or family member has steadily fallen and in 2007 was one per cent. Numbers of beds in hospital care are decreasing, and altogether around nine per cent of beds disappeared over the period 2001-2006. Lengths of stay in hospital have also decreased appreciably in the past decade thanks to developments in medical equipment. The consequences of the reduced number of hospital beds and places in special accommodation are becoming increasingly visible. Shorter lengths of stay, increased throughput of elderly patients in hospitals and an increased number of people who are ready for discharge from acute medical care are examples of this. With an increased proportion of health and social care provided in people's own homes and more people living in special accommodation, there is a tendency for this to lead to increased consumption of hospital care in the longer term.

The decease in the number of places in special accommodation has been under way for a long time. New provisions were therefore introduced into the Social Services Act in July 2006 to tackle problems associated with unreasonable waiting times. Under these provisions, mu-

nicipalities that do not implement a decision on special accommodation etc. within a reasonable time have to pay a charge to central government. The Government has allocated SEK 500 million annually from 2007 to encourage the municipalities to build and convert special forms of accommodation.

The proportion of elderly people who receive health and medical care from private care providers has increased in the current decade. Nearly 11 per cent of people over the age of 65 who were granted home help service in 2007 had this provided privately. Nearly 14 per cent of elderly people who were living in special accommodation in 2007 were living in privately run housing.

In the past ten years various client-choice models have been introduced as alternatives or complements to procuring operation under contract. The client-choice system gives the elderly the option of choosing provider themselves, either private or local authority. In December 2006, 24 municipalities around the country had introduced client choice or a similar arrangement, and an equal number were planning to do so.

To increase the options available to the elderly, the Government appointed an inquiry, Free Choice in Elderly Care, with a remit to propose measures to encourage elderly people being given more alternatives in long-term care. The inquiry has submitted its report Being Able to Choose – an Act on Free Choice Systems. The inquiry proposes a new law which is intended to serve as a voluntary tool for those municipalities and county councils that wish to test the competitiveness of activities which they run themselves so that choice of provider can be left to the service user. The report is currently being circulated for formal consultation.

Since 2007 elderly people have been able to receive or purchase services and nursing under two systems subsidised by society. This trend means that the elderly, to a greater extent than previously, have an opportunity to take responsibility for obtaining the service and assistance they need. It is too early to say to what extent the possibility of purchasing household services will be utilised and what consequences this will in turn have for public long-term care.

Under the Act (1993:387) concerning Support and Service for Persons with Certain Functional Impairments (LSS), persons with extensive and lasting functional impairments are guaranteed good living conditions, the help they need in daily living and the right to influence what support and service they receive. The aim is to enable the individual to live like other people. Personal assistance, together with assistance benefit under the Assistance Benefit Act (1993:389) (LASS), has made it possible for people with extensive disabilities to live a self-sufficient and independent life. Since 2001 it has been possible to retain personal assistance after reaching the age of 65.

Health, social network and the ability to cope with the activities of daily living are factors which have been found to have a significant bearing on how much health and social care the elderly population needs. Studies have shown that most elderly people rate their health as good while reporting that they have many diseases and are taking many medicines. The same applies to social networks, where most elderly people are satisfied with their social contacts even though they occur more rarely.

The municipalities are responsible for health care in special forms of accommodation and in day centres up to and including the level of nurse. Just over half the municipalities in the country also have this responsibility for home medical care in ordinary accommodation. The county council always has responsibility for the the actions of doctors. Municipal health care costs account for 14–17 per cent of the municipalities' total expenditure on care of the elderly and disabled.

In its Budget Bill for 2008, the Government has allocated further funds in comparison with 2007, for measures in

elderly policy. A total sum of SEK 2.4 billion is allocated, and SEK 1.34 billion of this sum is allocated in incentive grants to municipalities and county councils to raise the quality of health and social care for elderly people. There are seven priority areas: increased access to doctors, drug reviews, dementia care, rehabilitation, diet and nutrition, preventive activity and social content.

4.3.3 Quality in long-term care

The Government's strategic focus for the continued development of policy on the elderly described in the 2007 Budget Bill continues to apply. Elderly women and men are to be able to rely on being offered dignified and high-quality care. There is a special focus on the mast fragile individuals, the ones who have difficulty having their voice heard. The Government has adopted a number of measures which, over the next few years, will strengthen the development of quality in health and social care of the elderly.

Incentive grants to strengthen health and social care for the elderly

All the county councils and all but one of the municipalities have applied for and received part of the incentive grant of SEK 1.34 billion to develop health and social care for the elderly. Substantial development work is in progress around the country at present in the areas of access to doctors, drug reviews, dementia care, rehabilitation and diet and nutrition. Preventive efforts and the social content of measures are two more priority areas that are important in strengthening the social inclusion of the elderly. Preventive home visits are an important method of reaching out to groups which it is otherwise difficult to reach with information on health and life style. Greater attention needs to be paid to people who are recipients of care measures for the elderly. Attending day centres, meeting places and other open activities are an important way for elderly women and men to maintain and improve their functional capacity and can provide stimulation and content in everyday life. Voluntary organisations can make a great contribution here.

Accommodation for the elderly

Work is continuing in the special commission which is due to present proposals on ways in which the development of homes and accommodation for the elderly can be promoted. The Government takes a positive view of the development of retirement housing that offers more and more elderly people the possibility of finding accommodation suited to their needs in their old age on their own initiative.

Support for family members

The contributions of family members are often an essential factor in enabling an elderly person to carry on living in their ordinary home. Many family members are in need of better support, for example through respite so that they have time for rest and recreation. Support for family members who look after and support elderly people has been developed over a period of nine years with the aid of government incentive grants. In 2008, the Government has allocated a total of SEK 100 million to the municipalities, family member and pensioner organisations and a national centre of expertise for family member issues. The support of family members is a priority issue for the Government. A proposal for a clarification in the Social Services Act to the effect the municipalities are to be obliged to offer assistance to family members is currently being circulated for formal consultation.

A life of dignity in long-term care

There is a need for a common and clear set of values in long-term care. Human dignity, values and an ethical ap-

proach need to be made clear in daily activity so that the quality of content can be developed and trust in long-term care can improve. The set of values needs to be shared both by service users and the public and by politicians and employees. The Government appointed a chair of inquiry whose remit included proposed measures to create dignified long-term care. The inquiry chair's report was presented on 31 May 2008. The inquiry proposes that a national set of values for long-term care should be introduced into the Social Services Act and should clarify how social care should be oriented so that the elderly person is able to live a life of dignity and have a sense of well-being. The proposed set of values entails a change of perspective in the way in which the elderly are viewed, and higher quality is to be attained in long-term care. The inquiry's proposals are currently under discussion in the Swedish Government Offices.

Follow-up, development and research

The Government's initiatives have the effect of driving the development of better national statistics and quality indicates which provide the necessary basis for open comparisons of quality in health and social care of the elderly. Today there is substantially more data, new and better data, than previously with regard to describing and analysing health and social care of the elderly. At the same time it is difficult to provide an exhaustive description of quality in long-term care. There are wide local differences between municipalities, but there may also be wide differences in quality, costs and outcomes within a municipality. The overall impression, however, is that the prospects of developing health and medical care for the elderly are improving rapidly and moving in a favourable direction.

Knowledge of dementia issues and family-member issues needs to be gathered nationally and disseminated to personnel in health and social care, decision-makers, elderly people and family members. Two national centres of expertise have been launched, one for dementia issues and one for issues relating to family members.

Part of the Government's commitment to the elderly consists of funds specifically targeted at research in the area of the elderly. In 2007, 25 centres benefited from the Government's commitment to support for local and regional centres for research and development. Activities at the R&D centres are close to the practical situation, such as developing the social content in the daily life of the elderly, assisting towards nutritionally correct and appropriate meals becoming high points of everyday life and preventive work. An initiative for the development of more and easily accessible aids and other technology for the elderly is being implemented.

Staff

It is crucial for elderly people to be treated with respect by staff with the right skills if they are to experience dignity and reassurance in their existence. The 'Competence Ladder' is continuing in 2008, with the support of funds paid out previously. Work in health and social care of the elderly has become increasingly advanced and complex, making increased demands for staff to have both broad and specialised skills. The Government has appointed an inquiry to present proposals for a national strategy for the provision of skills in municipally financed health and social care of elderly women and men.

4.3.4 Financially sustainable development in long-term care

Creating long-term sustainability in a system as important to welfare as health care and social services for the elderly is a key task for society. A condition that needs to be met if long-term sustainability is to be achieved is that society is able to fund its commitment to health and social

services through sound public finances and a high rate of participation in the workforce.

Roughly SEK 2.4 billion has been allocated to elderly policy in the 2008 Budget Bill and will allow municipalities and county councils new funds with which to implement improvements in quality and efficiency. Commitments to improved skills, investment support for special accommodation, research, open comparisons, statistics and follow-up and technological development can be mentioned as examples. Good quality and good efficiency are essential if long-term legitimacy is to be gained for this activity among the public.

The Ministry of Health and Social Affairs is working with the Ministry of Finance on a project which is intended to shed light on the long-term demand for and costs of welfare services, including health and social services for the elderly. The challenges faced by present-day funding systems will be illustrated in various scenarios. This work can be viewed as an in-depth study of the material in the Long-term Survey 2003/2004, which focused on medical care and social services for the elderly. Various aspects will be looked at in this work. Examples of these are demographics, trends in health, income, technologies, changes in expectations and values and the relationship between the efforts of the public institutions and those of family members.

ANNEXES

Annex 1. Health care – complementary background

The organisation of the Swedish health care system and long-term care

The operation of care, including health care and social services for the elderly, is decentralised to Sweden's 21 county councils and 290 municipalities. The autonomy of the county councils and the municipalities follows from the Swedish Constitution and the Local Government Act. In each county council and municipality there is a democratically elected decision-making assembly. The county councils and, to some extent, the municipalities are responsible, through taxation, for the principal funding of health care and the municipalities for long-term care. The duty of the county councils and municipalities to provide health care is governed by the Health and Medical Services Act. The municipalities are responsible for health care in special accommodation and the authorities of the county councils are responsible for providing all other health care.

The duty to provide long-term care is governed by the Social Services Act. Under the Act, the municipalities are obliged to offer social care and special accommodation to elderly people in need of support.

National strategy for eHealth

ICT use forms a natural part of health-care activity today. Almost all patient records are now electronic in Swedish health care, and both prescriptions and lab results etc. are sent electronically. However, there is great potential to make the use of ICT more efficient and to improve it. This is primarily due to the fact Sweden, as an early user of various forms of ICT support has a number of older systems that are unable to communicate with one another.

As a result, the Swedish Government and the Swedish Association of Local Authorities and Regions agreed to develop a close cooperation on ICT development in the health-care and social services sector. The *National High-Level Group for eHealth* was appointed in March 2005. The group contains representatives of the Ministry of Social Affairs, the Swedish Association of Local Authorities and Regions, the National Board of Health and Welfare and the Association of Private Care Providers. The work is undertaken under the Dagmar Agreement, a government-financed agreement between central government and the Swedish Association of Local Authorities and Regions for special development projects to develop health care.

The High-Level group's work has resulted in a national strategy for eHealth which is to serve as support for local and regional development work. A number of measures have been initiated to attain ICT use which, in the best way possible, promotes work in the care sector. The measures must be taken at various levels, at county and municipal level and also at national level. County councils and municipalities have responsibility for operational activity and thus have the principal responsibility for the

development of ICT use, while central government and several other actors have the task of providing the necessary basis for development through laws and regulations and through uniform terminology and a uniform information structure.

The work which needs to be performed has been divided into six strands:

1. Harmonise laws and regulations with increased ICT use.
2. Create a common information structure.
3. Create a common technical infrastructure.
4. Create the necessary conditions for collaborating and activity-supporting ICT systems.
5. Make possible access to information across organisational boundaries.
6. Make information and services readily accessible for the public.

The results of this work are presented in annual status reports. The most recent status report, presented in May 2008, shows that work is progressing more quickly than expected, as many of the measures proposed in the strategy have now been fully developed or are being introduced. The county councils have also strengthened their coordination so that they can supply the new national services, through the establishment of a common purchaser function in the Swedish Association of Local Authorities and Regions.

The care guarantee

Since 1997 there has been a visit guarantee, meaning that the primary care sector has to offer assistance, either over the phone or through a visit, on the same day as contact is made. If contact with a doctor is required, the waiting time must be no more than 7 days and a person with a confirmed referral to specialist care must be offered this within 90 days.

Central government and the Swedish Association of Local Authorities and Regions in 2005 signed an agreement to extend the visit guarantee to a care guarantee that also encompasses waiting time for treatment. The care guarantee entails an obligation for the county councils to offer treatment within 90 days from the time when a decision on treatment has been taken. The guarantee applies throughout the country and covers all treatment in the county councils' planned care. The care guarantee also means that the county council has to help patients to obtain care in some other county council if the waiting time for a visit or treatment exceeds 90 days in their own county council.

Annex 2. Indicators relating to social inclusion, health care and long-term care

Increasing the possibility of social inclusion for the elderly

PROPORTION OF ELDERLY PEOPLE IN EMPLOYMENT. PER CENT.

Year	Proportion in employment 65–69 age group	
	Men	Women
2000	17.5	112
2001	17.7	9.3
2002	19.0	8.7
2003	16.6	9.8
2004	15.9	9.0
2005	17.2	8.9
2006	16.1	9.4
2007	18.9	10.4

Source: Eurostat.

PROPORTION OF THE ELDERLY WITH MENTAL ILL-HEALTH*. PER CENT.

Year	Men			Women		
	65–74 age group	75–84 age group	85+ age group	65–74 age group	75–84 age group	85+ age group
2002/03	13.1	19.0	26.8	25.6	33.7	36.0
2004/05	10.2	13.0	10.9	24.1	25.4	28.8
2006**	14.5	9.6	14.4	29.9	24.6	29.8

Source: Statistics Sweden. Survey of Living Conditions (ULF).

* Replies to the question: "Do you possibly have any of the following? Apprehension, nervousness or anxiety? 1) Yes, severe. 2) Yes, mild. 3) No."

** Two different collection methods were used in the 2006 survey, which means that comparability with previous years is affected.

PROPORTION WITH SEVERE COMPLAINTS OF LONG-TERM ILLNESS* AMONG THE ELDERLY. PER CENT.

Year	Men			Women		
	65–74 age group	75–84 age group	85+ age group	65–74 age group	75–84 age group	85+ age group
2002/03	19.9	26.8	37.9	25.2	37.2	45.4
2004/05	15.8	24.9	34.9	25.8	35.8	40.4
2006**	16.7	22.8	33.4	27.4	32.7	36.0

Source: Statistics Sweden. Survey of Living Conditions (ULF).

* Replies to the question: Has any "prolonged illness, affliction or accident or other weakness" or "regularly takes medication for something" and the illness/affliction is "severe or very severe".

** Two different collection methods were used in the 2006 survey, which means that comparability with previous years is affected.

PROPORTION OF PEOPLE LIVING IN RELATIVE AND ABSOLUTE POVERTY WHO ARE AGED 65 OR OVER. PER CENT.

Year	Relative poverty* (below 60% of median income)	Absolute poverty**
2000	9.4	7.3
2001	11.2	6.4
2002	10.8	4.8
2003	7.1	3.5
2004	6.7	3.6
2005	7.0	2.9
2006	8.0	2.0

Source: Statistics Sweden/National Board of Health and Welfare.

* The official EU term is "risk of poverty".

** The limit of *absolute* poverty (the poverty line) is defined as the threshold value for the level of income (disposable income) which can be regarded as a minimum with which to meet a family's needs for food, housing, clothing, medicines etc. The definition of the absolute poverty line is based on guidance standards for decisions on financial assistance, Standardised other consumption is based on the expenditure that applied to the 1985 guidance income support standard. It is added together so that the total is equivalent to purchasing power over time, that is to say account is taken of inflation. The poverty line also largely coincides with the level of financial assistance, which is intended to ensure a reasonable standard of living. The amounts vary across the country as the cost situation differs from one municipality to another.

The threshold values have been built up on the basis of four components. 1) Standardised housing expenses (which vary with region). 2) Template for local travel (persons who have reached the age of 18). 3) Template for trade-union fees (for persons who during the year have worked at least half time). 4) Standard amount for other consumption.

Reducing exclusion among young people

PROPORTION IN EMPLOYMENT AND UNEMPLOYMENT AMONG YOUNG PEOPLE. PER CENT.

Year	Proportion in employment 15–24 age group		Proportion in unemployment 15–24 age group	
	Men	Women	Men	Women
2000	36.6	37.1	10.8	8.1
2001	45.6	47.0	12.7	10.6
2002	43.7	44.3	13.4	12.4
2003	42.7	44.1	15.5	13.1
2004	39.2	39.9	19.8	17.2
2005	38.2	39.7	22.0	21.8
2006	40.2	40.4	21.0	22.0
2007	42.0	42.3	18.8	19.8

Source: Eurostat.

PROPORTION WHO HAVE COMPLETED AT LEAST UPPER SECONDARY EDUCATION (AGED 20–24) AND PROPORTION WITH AT MOST LOWER SECONDARY EDUCATION (AGED 18–24) AND NOT IN FURTHER EDUCATION OR TRAINING. PER CENT.

Year	At least upper secondary education among 20–24-year-olds		At most lower secondary education among 18–24-year-olds	
	Men	Women	Men	Women
2000	82.8	87.6	9.2	6.2
2001	84.2	86.8	11.3	9.7
2002	85.2	88.3	11.4	9.3
2003	84.3	87.2	9.8	8.2
2004	84.8	87.2	9.3	7.9
2005	86.4	88.7	12.4	10.9
2006	84.5	88.6	13.3	10.7
2007	85.4	89.0	–	–

Source: Eurostat.

PROPORTION LIVING IN RELATIVE AND ABSOLUTE POVERTY AMONG YOUNG PEOPLE AGED 20–29. PER CENT.

Year	Relative poverty* (below 60% of median income)	Absolute poverty**
2000	12.8	12.0
2001	13.7	11.0
2002	17.1	13.4
2003	15.2	11.1
2004	17.8	13.3
2005	19.5	14.3
2006	20.7	12.3

Source: Statistics Sweden/National Board of Health and Welfare.

* The official EU term is "risk of poverty".

** The limit of *absolute* poverty (the poverty line) is defined as the threshold value for the level of income (disposable income) which can be regarded as a minimum with which to meet a family's needs for food, housing, clothing, medicines etc. The definition of the absolute poverty line is based on guidance standards for decisions on financial assistance, Standardised other consumption is based on the expenditure that applied to the 1985 guidance income support standard. It is added together so that the total is equivalent to purchasing power over time, that is to say account is taken of inflation. The poverty line also largely coincides with the level of financial assistance, which is intended to ensure a reasonable standard of living. The amounts vary across the country as the cost situation differs from one municipality to another.

The threshold values have been built up on the basis of four components. 1) Standardised housing expenses (which vary with region). 2) Template for local travel (persons who have reached the age of 18). 3) Template for trade-union fees (for persons who during the year have worked at least half time). 4) Standard amount for other consumption.

PROPORTION OF YOUNG PEOPLE (AGED 20–24) RECEIVING FINANCIAL ASSISTANCE. PER CENT.

Year	Financial assistance at some time during the year		Long-term financial assistance (10 months or longer)	
	Men	Women	Men	Women
2000	9.1	10.1	1.7	2.5
2001	8.0	8.7	1.6	2.3
2002	7.6	7.9	1.7	2.2
2003	7.5	7.7	1.9	2.3
2004	7.8	8.1	2.1	2.9
2005	7.9	8.2	2.1	2.5
2006	7.5	7.5	1.9	2.3
2007	6.4	6.6	1.9	2.2

Source: National Board of Health and Welfare.

PROPORTION OF YOUNG PEOPLE AGED 16–24 WITH MENTAL ILL-HEALTH*. PER CENT.

Year	Men	Women
2002/03	13.0	28.3
2004/05	13.6	30.3
2006**	13.7	26.7

Source: Statistics Sweden. Survey of Living Conditions (ULF).

* Replies to the question: "Do you possibly have any of the following? Apprehension, nervousness or anxiety? 1) Yes, severe. 2) Yes, mild. 3) No."

** Two different collection methods were used in the 2006 survey, which means that comparability with previous years is affected.

Reducing absence from working life due to ill-health

NUMBER OF PEOPLE RECEIVING SICKNESS BENEFIT BROKEN DOWN INTO FULL TIME AND PART TIME.

Year	Sickness benefit/full time		Sickness benefit/part time	
	Men	Women	Men	Women
2000	71 949	113 837	54 099	49 703
2001	80 999	127 201	49 401	57 617
2002	79 292	123 108	44 703	64 812
2003	69 918	109 076	40 005	67 680
2004	58 680	91 610	35 307	63 775
2005	50 149	77 523	30 609	56 811
2006	45 468	69 642	25 911	53 300
2007	39 614	59 190	21 213	44 012

Source: Swedish Social Insurance Office.

NUMBER OF PEOPLE RECEIVING SICKNESS BENEFIT BROKEN DOWN INTO FULL TIME AND PART TIME.

Year	Sickness benefit/full time		Sickness benefit/part time	
	Men	Women	Men	Women
2003	168 188	213 947	42 978	82 176
2004	173 715	225 591	47 273	93 063
2005	175 190	230 599	50 119	100 881
2006	173 034	228 081	50 447	103 335
2007	170 881	224 923	50 543	105 399

Source: Swedish Social Insurance Office.

Continuing to strengthen groups in particularly vulnerable situations

PHYSICAL ABUSE OF WOMEN AND GROSS VIOLATION OF WOMEN'S INTEGRITY REPORTED TO THE POLICE.

Year	Physical abuse	Gross violation of a woman's integrity
1990	14 463	..
1991	14 285	..
1992	15 827	..
1993	17 928	..
1994	18 567	..
1995	18 933	..
1996	18 560	..
1997	19 095	..
1998	20 172	198
1999	20 912	923
2000	20 519	1 147
2001	20 490	1 513
2002	21 510	1 572
2003	22 481	1 860
2004	22 753	2 068
2005	24 097	2 152
2006	25 491	2 384
2007	26 857	2 514

Source: National Council for Crime Prevention.

NUMBER OF REPORTS RECEIVED BY THE OMBUDSMAN AGAINST ETHNIC DISCRIMINATION (DO) ON DISCRIMINATION IN THE HOUSING MARKET.

Year	Men	Women
2003	34	18
2004	32	24
2005	36	17
2006	33	26
2007	66	25

Source: Ombudsman Against Ethnic Discrimination.

NUMBER OF PEOPLE IN A SITUATION OF HOMELESSNESS IN 2005.

	2005
Men	4 538
Women	13 142
Gender unknown	154
Total number homeless	17 834

Source: National Board of Health and Welfare.

THE NUMBER OF WOMEN AND MEN IN SUBSTANCE ABUSE CARE AT 1 NOVEMBER.

	2002	2007	Change (per cent) 2002–2007
Individual needs-tested outpatient care	10 980	11 580	+5
of which women	3 320	3 570	+8
of which men	7 660	8 010	+5
24 hour care	3 400	2 870	-16
of which women	930	750	-10
of which men	2 570	2 110	-18
– of which compulsory institutional care	289	279	-3
of which women	94	84	-11
of which men	195	195	0
Total number of people treated	14 480	14 440	0
of which women	4 250	4 320	+1
of which men	10 230	10 120	-1

Source: National Board of Health and Welfare.

Indicators relating to health care and long-term care

SELF-REPORTED UNMET NEEDS FOR MEDICAL TREATMENT. PROPORTION OF PEOPLE WHO HAVE REPORTED UNMET NEEDS FOR MEDICAL TREATMENT ON THE BASIS OF PROBLEMS WITH ACCESSIBILITY RELATING TO ABILITY TO PAY, WAITING TIMES AND DISTANCE. PER CENT.

	Age	2004	2005 (EU 15)	2006 (EU25)
EU	18–44	–	4.4	3.2
Sweden		3.1	2.8	3.5
EU	45–54	–	5.2	4.2
Sweden		1.6	2.8	3.2
EU	55–64	–	4.8	3.7
Sweden		2.3	2.5	2.4
EU	65–74	–	4.8	3.5
Sweden		1.7	2.8	2.1
EU	75 +	–	3.9	3.3
Sweden		2.1	1.4	0.9

Source: Eurostat, EU-SILC 2005.

SELF-REPORTED HEALTH PER AGE AND GENDER PROPORTION OF PEOPLE REPORTING THAT THEIR HEALTH IS POOR OR VERY POOR. PER CENT.

		Women		Men	
	Age	2004	2005	2004	2005
EU (15)	15–24	–	1.6	–	1.4
Sweden		2.7	1.8	2.8	1.2
EU (15)	25–34	–	2.5	–	2.8
Sweden		3.6	4.0	4.0	1.6
EU (15)	35–44	–	5.1	–	4.9
Sweden		6.2	5.8	4.6	2.9
EU (15)	45–54	–	10.7	–	9.9
Sweden		9.2	7.9	8.6	6.2
EU (15)	55–64	–	15.9	–	14.6
Sweden		11.7	5.6	7.9	7.9
EU (15)	65–74	–	24.0	–	19.0
Sweden		8.2	12.4	6.1	7.2
EU (15)	75–84	–	34.6	–	28.8
Sweden		18.6	14.1	13.1	13.7

Source: Eurostat, EU-SILC 2005.

COST OF HEALTH CARE PER CAPITA, TAKING ACCOUNT OF PURCHASING POWER (ADJUSTED FOR PURCHASING POWER PARITY), US DOLLARS.

	2001	2002	2003	2004	2005	Increase in cost 2001–2005
Austria	2 898	3 018	3 236	3 418	3 519	21%
Belgium	2 452	2 631	3 080 (b)	3 290 (e)	3 389 (e)	38%
Czech Republic	1 055	1 199	1 353 (b)	1 413	1 479	40%
Denmark	2 561	2 656	2 793 (b)	2 972 (e)	3 108 (e)	21%
Finland	1 861	2 012	2 045	2 202	2 331	25%
France	2 649	2 795	3 011 (b)	3 191	3 374	27%
Germany	2 754	2 886	3 129	3 169	3 287	19%
Greece	2 178	2 364	2 616	2 669	2 981	37%
Hungary	977	1 115	1 291 (e)	1 337 (e)	–	–
Ireland	2 151	2 368	2 536	2 742	2 926	36%
Italy	2 188	2 278	2 281	2 437	2 532	16%
Luxembourg	3 270	3 729	4 727 (b)	5 352 (e)	–	–
Netherlands	2 525	2 775	2 910 (e)	3 094 (e)	–	–
Poland	647	734 (b)	754	814	867 (e)	34%
Portugal	1 685	1 783	1 832 (e)	1 896 (e)	2 033 (e)	21%
Slovakia	642	716	798	1 061 (b)	1 137	77%
Spain	1 617	1 723	1 954 (b)	2 099 (e)	2 255 (e)	39%
Sweden	2 409	2 593	2 760	2 827	2 918	21%
United Kingdom	2 034	2 228	2 328 (b)	2 560 (d)	2 724 (d)	34%

Source: OECD Health Data 2007.

b = time series interrupted, d = different methodology, e = OECD estimate.

COST OF HEALTH CARE IN RELATION TO GDP. PER CENT.

	2001	2002	2003	2004	2005
Austria	10,0	10,1	10,2	10,3	10,2
Belgium	8,7	9,0	10,1 (b)	10,2 (e)	10,3 (e
Czech Republic	6,7	7,1	7,4 (b)	7,3	7,2
Denmark	8,6	8,8	0,1 (b)	9,2 (e)	9,1 (e)
Finland	6,7	7,0	7,3	7,4	7,5
France	9,7	10,0	10,9 (b)	11,0	11,1
Germany	10,4	10,6	10,8	10,6	10,7
Greece	9,8	9,7	10,0	9,6	10,1
Hungary	7,2	7,6	8,3 (e)	8,1 (e)	–
Ireland	7,0	7,2	7,3	7,5	7,5
Italy	8,2	8,3	8,3	8,7	8,9
Luxembourg	6,4	6,8	7,8 (b)	8,3 (e)	–
Netherlands	8,3	8,9	9,1 (e)	9,2 (e)	–
Poland	5,9	6,3 (b)	6,2	6,2	6,2 (e)
Portugal	8,8	9,0	9,7 (e)	9,8 (e)	10,2 (e)
Slovakia	5,5	5,6	5,9	7,2 (b)	
Spain	7,2	7,3	7,9 (b)	8,1 (e)	8,2 (e)
Sweden	8,7	9,1	9,3	9,1	9,1
United Kingdom	7,5	7,7	7,8 (b)	8,1 (d)	8,3 (d)

Source: OECD Health Data 2007.

b = time series interrupted, d = different methodology, e = OECD estimate.

TOTAL COSTS OF PHARMACEUTICALS AND OTHER MEDICAL NON-DURABLE GOODS/CONSUMABLES IN RELATION TO TOTAL HEALTH CARE COSTS. PER CENT.

	1980	1985	1990	1995	2000	2001	2002	2003	2004	2005
Austria	–	–	–	9,1	11,8	11,6	12,2	12,6	12,2	11,6
Belgium	17,4	15,7	15,5	16,7	–	–	–	–	–	–
Czech Republic	–	–	21,0	25,1	23,4 (b)	24,0	23,9	24,2	24,8	25,1
Denmark	6,0	6,6	7,5	9,1	8,8	9,2	9,8	9,3 (b)	9,0 (e)	8,9 (e)
Finland	10,7	9,7	9,4	14,1	15,5	15,8	16,0	16,0	16,3	16,3
France	16,0	16,2	16,9	16,0 (b)	18,2	18,8	18,7	16,5	16,6	16,4
Germany	13,4	13,8	14,3	12,9	13,6	14,2	14,4	14,5	14,0	15,2
Greece	18,8	–	14,3	15,7	–	–	–	–	–	–
Hungary	–	–	–	25,0	–	28,5	27,6	27,8 (e)	29,2 (e)	–
Ireland	10,9	9,9	12,2	10,5	10,6	10,6	11,1	11,6	11,8	10,9
Italy	–	–	20,3	20,7	22,0	22,5	22,5	21,8	21,2	20,1
Luxembourg	14,5	14,7	14,9	12,0	11,0	11,5	10,3	9,4 (b)	8,9 (e)	–
Netherlands	8,0	9,3	9,6	11,0	11,7	11,7	11,5	–	–	–
Poland	–	–	–	–	–	–	28,4	30,3	29,6	28,0 (e)
Portugal	19,9	25,4	24,9	23,6	22,4 (b)	23,0	23,3	21,4 (e)	22,3 (e)	21,9 (e)
Slovakia	–	–	–	–	34,0	34,0	37,3	38,5	31,4 (b)	31,9
Spain	21,0	20,3	17,8	19,2	21,3	21,1	21,8	22,9 (b)	22,8 (e)	22,9 (e)
Sweden	6,5	7,0	8,0	12,3	13,8	13,2	13,0	12,6	12,5	12,0
United Kingdom	12,8	14,1	13,5	15,3	–	–	–	–	–	–

Source: OECD Health Data 2007.

b = time series interrupted, d = different methodology, e = OECD estimate.

EXPECTED REMAINING YEARS OF LIFE AND HEALTHY YEARS OF LIFE AT BIRTH AND AT AGE OF 65 IN 2005.

	WOMEN						MEN					
	At birth			At age 65			At birth			At age 65		
	Life expectancy	Expected number of healthy years	Expected number of healthy years in relation to total life expectancy %	Life expectancy	Expected number of healthy years	Expected number of healthy years in relation to total life expectancy %	Life expectancy	Expected number of healthy years	Expected number of healthy years in relation to total life expectancy %	Life expectancy	Expected number of healthy years	Expected number of healthy years in relation to total life expectancy %
Austria	82.3	59.6	72.4	20.4	6.6	32.6	76.7	57.8	75.4	17.0	6.7	39.5
Belgium	81.9	61.9	75.7	20.2	9.5	46.8	76.2	61.7	80.9	16.6	9.1	55.2
Cyprus	81.1	57.9	71.4	19.1	4.8	25.1	76.8	59.5	77.5	16.8	6.7	39.8
Czech Republic	79.3	59.9	75.5	17.7	6.9	38.8	72.9	57.9	79.4	14.4	6.5	44.8
Denmark	80.5	68.2	84.7	19.1	14.1	73.8	76.0	68.4	90.1	16.1	13.1	81.3
Estonia	78.2	52.2	66.7	18.1	3.4	19.1	67.3	48.0	71.3	13.1	3.4	26.1
Finland	82.5	52.4	63.5	21.0	6.5	31.2	75.6	51.7	68.3	16.8	6.2	37.1
France	–	64.3	–	–	9.4	–	–	62.0	–	–	8.2	–
Germany	82.0	55.1	67.1	20.1	5.9	29.4	76.7	55.0	71.7	16.9	6.5	38.2
Greece	81.6	67.2	82.3	19.2	9.9	51.7	76.8	65.7	85.5	17.1	9.5	55.5
Hungary	77.2	53.9	69.9	17.2	5.0	29.0	68.7	52.0	75.8	13.3	5.0	37.5
Ireland	81.7	64.1	78.4	20.0	9.9	49.5	77.3	62.9	81.4	16.8	9.1	54.1
Italy	–	67.0	–	–	9.7	–	–	65.8	–	–	9.4	–
Latvia	76.5	53.1	69.4	17.2	5.4	31.6	65.4	50.6	77.4	12.5	5.0	4.03
Lithuania	77.3	54.3	70.2	17.6	4.3	24.4	63.5	51.2	78.3	13.0	5.1	39.0
Luxembourg	82.2	62.1	75.5	20.4	9.2	45.0	76.6	62.2	81.2	16.7	9.3	55.9
Malta	81.4	70.1	86.2	19.4	11.1	57.2	77.3	68.5	88.6	16.2	10.5	64.8
Netherlands	81.7	63.1	77.2	20.1	10.9	54.1	77.3	65.0	84.1	16.4	10.4	63.1
Poland	79.3	66.6	84.0	18.5	10.1	54.7	70.8	61.0	86.2	14.3	8.3	58.3
Portugal	81.3	56.7	69.8	19.4	5.1	26.3	74.9	58.4	77.9	16.1	6.2	38.7
Slovakia	78.1	56.4	72.2	17.1	5.3	31.3	70.2	54.9	78.3	13.3	4.8	36.2
Slovenia	80.9	59.9	74.0	19.3	8.5	44.4	73.9	56.3	76.1	15.2	7.4	49.0
Spain	83.7	63.1	75.5	21.3	9.1	42.6	77.0	63.2	82.1	17.3	9.6	55.7
Sweden	82.9	63.1	76.1	20.7	10.9	52.5	78.5	64.2	81.8	17.4	10.5	59.9
United Kingdom	81.1	65.0	80.1	19.5	11.1	56.7	77.1	63.2	82.0	17.0	10.3	60.7

Source: Eurostat.

LIFE EXPECTANCY IN SWEDEN AT BIRTH, AT AGE 50 AND AT AGE 65 BROKEN DOWN INTO MEN AND WOMEN. 1951–2007.

	Remaining average life expectancy in years					
	Men			Women		
Year	At birth	At age 50	At age 65	At birth	At age 50	At age 65
1951–1960	70.89	25.54	13.85	74.10	27.47	15.00
1961–1970	71.73	25.70	13.93	76.13	28.87	16.05
1971–1980	72.26	25.82	14.10	78.10	30.41	17.47
1981–1985	73.55	26.46	14.60	79.53	31.45	18.39
1986–1990	74.37	27.17	15.09	80.22	32.06	18.91
1991–1995	75.60	28.03	15.70	80.98	32.59	19.42
1996–2000	76.89	28.95	16.35	81.83	33.19	19.93
2001–2005	77.99	29.89	17.11	82.41	33.64	20.30
1983	73.62	26.51	14.65	79.61	31.59	18.49
1984	73.84	26.73	14.81	79.89	31.72	18.65
1985	73.79	26.60	14.66	79.68	31.59	18.50
1986	73.97	26.83	14.80	79.99	31.84	18.69
1987	74.16	26.99	14.99	80.15	31.99	18.90
1988	74.15	26.99	14.95	79.96	31.85	18.70
1989	74.79	27.56	15.40	80.57	32.37	19.17
1990	74.81	27.50	15.30	80.41	32.20	19.04
1991	74.94	27.60	15.42	80.54	32.34	19.21
1992	75.35	27.82	15.55	80.79	32.42	19.27
1992	75.49	27.91	15.56	80.79	32.40	19.19
1994	76.08	28.43	16.03	81.38	32.92	19.75
1995	76.17	28.42	15.97	81.45	32.90	19.70
1996	76.51	28.61	16.10	81.53	32.95	19.73
1997	76.70	28.77	16.25	81.82	33.20	19.92
1998	76.87	28.94	16.34	81.94	33.30	20.03
1999	77.06	29.11	16.45	81.91	33.23	19.92
2000	77.38	29.41	16.69	82.03	33.30	20.08
2001	77.55	29.60	16.88	82.07	33.36	20.06
2002	77.73	29.64	16.90	82.11	33.37	20.01
2003	77.91	29.83	17.01	82.43	33.67	20.32
2004	78.35	30.19	17.39	82.68	33.92	20.56
2005	78.42	30.21	17.36	82.78	33.93	20.61
2006	78.70	30.45	17.60	82.94	34.13	20.75
2007	78.94	30.70	17.84	82.99	34.14	20.67

Source: Statistics Sweden.

INFANT MORTALITY PER 1 000 LIVE BIRTHS.

	1980	1985	1990	1995	2000	2005
Austria	14.3	11.2	7.8	5.4	4.8	4.2
Belgium	12.1	9.8	6.5	5.9	4.8	3.7
Czech Republic	15.9	12.5	10.8	7.7	4.1	3.4
Denmark	8.4	8.0	7.5	5.1	5.3	4.4
Finland	7.6	6.3	5.6	3.9	3.8	3.0
France	10.0	8.3	7.3	4.9	4.4	3.6
Germany	12.4	9.1	7.0	5.3	4.4	3.9
Greece	17.9	14.1	9.7	8.1	5.4	3.8
Hungary	23.2	20.4	14.8	10.7	9.2	6.2
Ireland	11.1	8.8	8.2	6.4	6.2	4.0
Italy	14.6	10.5	8.2	6.2	4.5	4.7
Luxembourg	11.4	9.0	7.3	5.6	5.1	2.6
Netherlands	8.6	8.0	7.1	5.5	5.1	4.9
Poland	25.5	22.0	19.3	13.6	8.1	6.4
Portugal	24.2	17.8	11.0	7.5	5.5	3.5
Slovakia	20.9	16.3	12.0	11.0	8.6	7.2
Spain	12.3	8.9	7.6	5.5	4.4	4.1
Sweden	6.9	6.8	6.0	4.1	3.4	2.4
United Kingdom	12.1	9.4	7.9	6.2	5.6	5.1

Source: OECD Health Data 2007.

AGE-STANDARDISED RELATIVE SURVIVAL FROM BREAST CANCER. 1 AND 5 YEARS AFTER DIAGNOSIS. RELATES TO CASES DIAGNOSED BETWEEN 1990 AND 1994. PER CENT.

	1 year	5 years
Austria	93.6	75.4
Czech Republic	88.6	64.0
Denmark	93.9	74.9
Estonia	87.7	61.9
Finland	95.8	81.4
France	96.4	81.3
Germany	93.4	75.4
Italy	95.6	80.6
Malta	93.1	74.8
Netherlands	95.8	78.2
Poland	87.2	63.1
Portugal	94.2	71.9
Slovakia	87.5	59.5
Slovenia	90.8	67.4
Spain	94.4	78.0
Sweden	96.5	82.6

Source: European Community Healt Indicators (ECHI).

AGE-STANDARDISED RELATIVE SURVIVAL FROM CERVICAL CANCER, 1 AND 5 YEARS AFTER DIAGNOSIS. RELATES TO CASES DIAGNOSED BETWEEN 1990 AND 1994. PER CENT.

	1 year	5 years
Austria	86.0	63.6
Czech Republic	86.2	65.2
Denmark	86.7	66.7
Estonia	79.0	53.2
Finland	84.6	66.0
France	88.4	67.8
Germany	83.2	63.5
Italy	88.1	66.6
Malta	83.7	64.4
Netherlands	87.7	69.4
Poland	76.3	48.2
Portugal	85.6	55.6
Slovaka	80.4	57.1
Slovenia	83.7	59.9
Spain	86.3	68.7
Sweden	89.2	69.6

Source: European Community Healt Indicators (ECHI).

NUMBER AND PROPORTION OF THE POPULATION OVER THE AGE OF 65 WHO ON 1 OCTOBER 2000–2006 WERE RECEIVING HOME HELP SERVICES OR INSTITUTIONAL CARE (SPECIAL ACCOMMODATION) AND COSTS AND PROPORTION OF COSTS IN RELATION TO GDP FOR LONG-TERM CARE SERVICES (HC 3).

	Home help service		Institutional care		Total		Costs	
	Number	Percentage (%)	Number	Percentage (%)	Number	Percentage (%)	SEK m	Proportion of GDP
2001	121 700	7.9	118 600	7.7	240 300	15.6	15 504	0.67%
2002	125 200	8.2	115 500	7.5	240 700	15.7	16 729	0.69%
2003	128 000	8.3	110 900	7.2	238 900	15.5	17 353	0.69%
2004	132 300	8.5	104 800	6.7	237 100	15.2	17 898	0.68%
2005	135 000	8.6	100 400	6.4	235 300	15.0	18 374	0.67%
2006	140 300	8.9	98 600	6.2	238 900	15.1	20 074	0.69%

Source: National Board of Health and Welfare and the National Accounts (Statistics Sweden).

Annex 3. Contribution from the Network Against Social Exclusion

The Network Against Social Exclusion consists of people who are active in around forty organisations that combat social exclusion.

1. Collaboration with affected parties

Collaboration with all affected parties is a key aspect in developing and implementing the plan of action. This collaboration must be improved. Among other things the dialogue with the Ministry of Health and Social Affairs must be initiated much earlier than has happened to date. It is not just a matter of the Government having to listen to us but also of us having a real opportunity to influence the priorities and contents of the Swedish action plan. It is important at the same time that the Government coordinates different policy areas so that all affected authorities are committed to reducing exclusion.

We want the dialogue also to be improved in terms of implementation. In order to make better use of the thorough knowledge that exists in the Service Users Commission, this needs to be activated and its role clarified. The Government must additionally create incentives and methods so that the municipalities commit themselves to implementation together with volunteer, service user and provider organisations.

The strategy report should lead to an in-depth discussion of the social situation in Sweden. The organisations in the network will also take responsibility for this debate.

2. The Lisbon Strategy and social cohesion

The action plan should make it clear that social cohesion has to be given as much emphasis to economic growth in the future Lisbon strategy. This should also be clearly apparent in the national report on the Lisbon Strategy which Sweden is due to submit this year.

3. Disparities are increasing in Sweden

The favourable economic trend in Sweden has not benefited everyone. According to several studies, disparities have actually increased. We wish to draw attention to the following circumstances, which should be reflected in the analysis of the strategy report and the priorities identified in it.

Compared with the early 1990s, household incomes today are more unevenly distributed, and long-term receipt of income support (over ten months) has increased. Conditions for people who are dependent on social insurance systems have steadily worsened. There are consequently large groups living at or below the poverty line, especially people born outside Sweden, lone parents and young adults (nearly 30 per cent in the 20–27 age group are poor).

People with a foreign background suffer greater exclusion than others and find it more difficult to gain access to work, housing, education and training, social services and health care. There is both structural and individual discrimination. A third of poor adults have a foreign background and 30–50 000 people are waiting for decisions on applications for asylum. Around 20 000 people who are

non-registered are estimated to be in Sweden. Most are refugees in hiding, while a smaller group are victims of human trafficking.

No decrease is taking place in child poverty. Children of single parents and people born outside Sweden are at greater risk of living in poverty, as are children who live in families on long-term income support and children with parents who have mental illnesses. One in four children live in overcrowded housing. Children are evicted just as much as in the past.

Hundreds of thousands of people are far removed from the ordinary labour market. Unemployment is particularly high among people with disabilities, young people and people of foreign origin.

Disability reduces quality of life. A large proportion of aggregate ill-health in society is among people with disabilities. Poor health is more than ten times more common among people with disabilities.

Access to care and treatment for people with addiction problems has not improved. The number of deaths among these people increased in the past year to 350.

Access to housing for people with a poor social foothold and financial problems has deteriorated. Housing costs are rising. The proportion of young adults in the 20–27 age group with their own homes has fallen over the past ten years (from 62 to 53 per cent). Extreme overcrowding is increasing rapidly, especially among newly arrived refugees.

Eighteen thousand people are homeless in Sweden, and the number has risen since the latest survey. The proportion of women and people born abroad is increasing in particular.

Exclusion is increasing through the increased use of IT-based communication, especially in authorities. Lack of familiarity with computers, a low educational background, language difficulties, certain disabilities and weak financial resources lead to reduced inclusion. In the long term this poses a danger to democracy.

4. Principles

- Exclusion is a complex problem and cannot be reduced to employability in the labour market. The way in which work is viewed must change to create a "broadened labour market" which makes it possible for everyone who wants to work to do so on the basis of their own circumstances.

- The most vulnerable people must be guaranteed their basic rights too. They must have the right to a life of dignity, equal treatment, access to welfare services such as health care, social care, education and housing according to need and on equal terms. International conventions and Swedish legislation must be followed.

- A strong and universal welfare policy is a fundamental requirement if a fair society based on solidarity that prevents marginalisation and exclusion is to be attained.

- Priorities and proposals in previous action plans must be followed up and openly presented to political decision-makers and affected parties.

5. Measures to be prioritised

- A large combined programme for the integration of people with a foreign background.

- Zero vision for child poverty. Children must no longer be evicted from their homes.

- Access to the labour market through
  - flexible solutions that suit the individual with the support of voluntary and service users' organisations.
  - implementation of a social enterprise programme.

- Housing policy based on the right of everyone to good-quality housing, equal treatment of different forms of housing, offering tenancy to everyone who demands it and special support for groups with special needs.

- People who have to rely on society's ultimate safety net must be guaranteed a 'reasonable standard of living' – an essential requirement for full democratic participation in society – through access to resources above the poverty line through the adaptation of minimum standards in the social insurance system.

- Active efforts to mainstream everyone into the IT society.

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