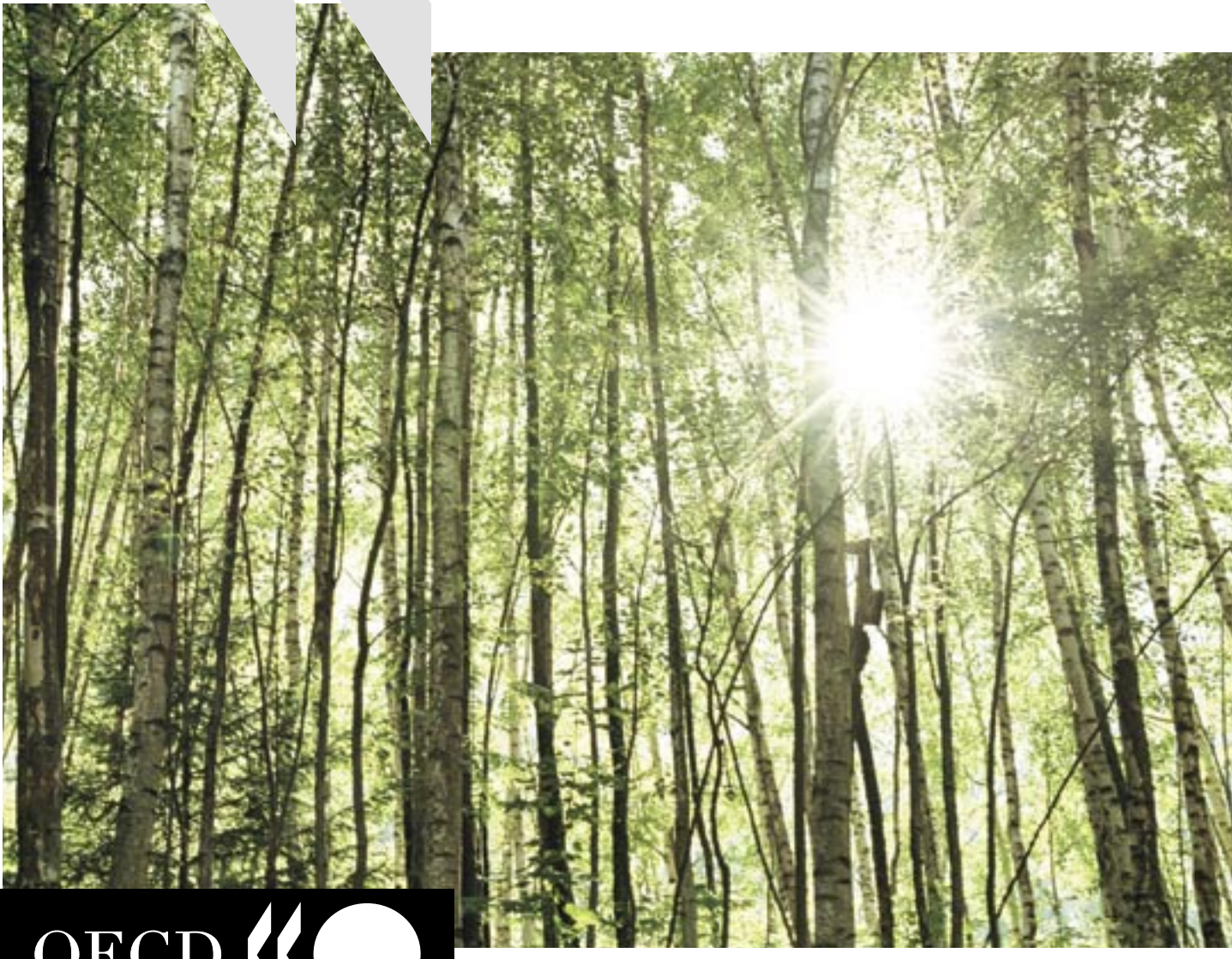
OECD Economic Surveys

Sweden



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ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

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BASIC STATISTICS OF SWEDEN

THE LAND

Land area (1 000 sq. km)	411
Lakes (1 000 sq. km)	39
Arable area (1 000 sq. km) (2003)	27
Woodland (1 000 sq. km) (1998-2002)	227

Inhabitants in major cities, including suburbs (31 December 2003) thousands

Stockholm	1 694
Göteborg	817
Malmö	536

THE PEOPLE

Population (31 December 2003), thousands	8 976
Number of inhabitants per sq. km	22
Net natural increase (average 1999-2003) thousands	–1.0
Net natural increase per 1 000 inhabitants (average 1999-2003)	–0.4
Net migration (average 1999-2003), thousands	24.5

THE PRODUCTION

Gross domestic product in 2004 (Kr billion)	2 542.9
GDP per head, US$	38 609

Gross fixed capital formation in 2004

Per cent of GDP	15.9
Per head, US$	6 155

Employment

Total civilian, thousands, 2004	4 214

Per cent of total, 2003

Agriculture, forestry, fishing	2.1
Industry	22.7
Other	75.2

THE GOVERNMENT

Per cent of GDP in 2004:

Public consumption	27.8
General government current revenue	58.2
Public gross fixed capital formation	2.8

Composition of Parliament

	Number of seats
Social democrats	144
Moderates	55
Liberals	48
Christian democrats	33
Left	30
Centre	22
Greens	17
Total	349

Last general election: September 2002

Next general election: September 2006

THE FOREIGN TRADE

Exports of goods and services, 2004 (per cent of GDP)	46.2

Main merchandise exports (per cent of total), 2003

Forestry products	13.3
Mineral products	9.4
Chemical products	12.0
Energy products	3.2
Engineering products	51.6
Other products	10.5

Imports of goods and services, 2004 (per cent of GDP)	38.2

Main merchandise imports (per cent of total), 2003

Forestry products	3.4
Mineral products	8.4
Chemical products	11.0
Energy products	9.4
Engineering products	43.9
Other products	23.9

THE CURRENCY

Monetary unit: Krona

Currency units per US$, average of daily figures:

Year 2004	7.35
April 2005	7.08

Executive summary

The Swedish economy has undergone impressive changes and has delivered a remarkable surge in productivity since the mid-1990s. Consequently, per capita incomes are slowly making up the ground lost in earlier decades. Labour market performance, however, has been less inspiring. Employment rates have yet to recover to their 1990 peaks and hours of work need to increase to support the welfare state.

The key challenge is to maintain the core of the social welfare system despite an ageing population. While Sweden's fiscal situation is better than most other OECD countries, it needs to be strengthened further to be sustainable in the long term. Because the long-term budget constraint is binding, the tradeoff between public services now and in the future needs to be recognised – the more that is consumed today, the less room there will be for social services in the future. Achieving sustainability requires:

Strengthening the fiscal position

Sweden has ambitious targets for public finances but the commitment to those goals needs to be re-invigorated, otherwise the budget surplus will remain well below the government's target of 2% of GDP. More emphasis should be given to the surplus target as a guide for policy, the margins under the expenditure ceilings should not be used for discretionary spending, and the level of the ceilings should be consistent with the surplus target. Raising taxes might be counter-productive in the long term as high tax wedges hold down labour supply. However, adjusting the tax base by returning to a uniform VAT and cutting marginal income tax rates could help improve work incentives.

Reducing sickness absences

Sickness and disability absences are much higher than in most OECD countries, mainly because sickness benefits are generous and easy to get. Sweden needs to move to the sort of "mutual obligations" approach that it already uses for unemployment insurance. Key reforms would be to check eligibility more carefully; make greater use of independent medical assessments; ensure that the majority of beneficiaries take part in rehabilitation; and introduce some form of experience rating for firms. If Sweden can move towards international best practice in these areas, the sickness problem may be largely solved without having to cut benefit levels.

Raising hours worked

Various leave schemes also contribute to Sweden's low average working hours, and the government should assess whether the labour supply costs are outweighing the social benefits. Parental leave *could be adjusted to improve the earnings prospects of women* (e.g. *by increasing the share that is not transferable between parents*). Study leave *needs to become more job-focussed.* Sabbatical leave *does not help labour supply and should be abolished.*

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Boosting employment

Young people *need to enter the workforce earlier. This means redesigning the entry rules to tertiary education (so that more people go directly from school) and encouraging students to finish their studies quicker (by shortening the time for which grants are available, for example).* For older workers, *the government could consider giving greater incentives to delay retirement.* Unemployed people *would get back to work faster if the unemployment insurance and Activity Guarantee programmes were overhauled. Finally, softening the last-in-first-out rule could reduce sickness absences and enable workers to switch jobs more easily.*

Getting better value for money from public spending

There is scope to do more with less in the public sector. Local governments especially need to be more willing to open up to competition and to make more use of outsourcing and benchmarking. The regulatory framework also needs strengthening to ensure that public and private suppliers are treated equally.

This report also includes an in-depth chapter that looks at how to get better quality and value for money from the healthcare system.

This Survey is published on the responsibility of the Economic and Development Review Committee of the OECD, which is charged with the examination of the economic situation of member countries.

The economic situation and policies of Sweden were reviewed by the Committee on 19 May 2005. The draft report was then revised in the light of the discussions and given final approval as the agreed report of the whole Committee on 3 June 2005.

The Secretariat's draft report was prepared for the Committee by David Rae and Martin Jørgensen under the supervision of Peter Jarrett.

The previous Survey of Sweden was issued in March 2004.

This Economic Survey may not include an examination of certain policies that are relevant to the country but fall within the competence of the European Community. While some of these policies may be examined in the Survey of the Euro Area, other policies may not be examined by the EDRC, as the European Commission currently maintains that the Economic Surveys should be limited in their coverage. No limits apply to the policies that can be covered in the Economic Surveys of other OECD countries.

The Commission and the member States of the European Union are working actively on ways of reviewing EC and EU wide policies within the context of the EDRC

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Assessment and recommendations

Sweden has been one of the OECD's better-performing economies

Sweden's economic performance over the past decade or so has been impressive in many respects. The business sector has shown its resilience by brushing off some fairly large shocks, including a global slowdown and the bursting of the telecoms bubble. The current account has swung from a deficit to a large and growing surplus. The fiscal accounts have moved into surplus, and the government has moved into a net asset position. Inflation has been maintained at a low level. And one of the more encouraging signs for the country's medium-term outlook is the remarkable surge in productivity. This productivity pick-up appears to be sustainable and can in part be attributed to the various structural and macroeconomic policy reforms put in place since the economic crisis of the early 1990s. The labour market performance has been less exemplary, however, even though it is better than in many other European economies. While labour force participation and employment rates are high, especially among women and the elderly, the overall employment rate has not yet recovered to its pre-crisis level and hours of work are low by OECD standards.

Maintaining the welfare system under the pressures of ageing and globalisation will require further reforms

Since the underlying economy is sound, the key challenge for Sweden is for the long term: to maintain the core of its welfare system in the face of a variety of internal and external pressures. Public finances are already feeling the effects of several forces, and others are in the pipeline. On the expenditure side, the greying of the population will lift demand for public services such as healthcare and elderly care. As well as these purely demographic spending pressures, there will no doubt be demands to raise public service standards over time, especially in healthcare, both because people will be getting wealthier and because new technologies will expand the range of services that can be offered. On the revenue side, tighter integration within the EU and globalisation more broadly are making it harder to maintain the high tax rates on mobile bases that are needed to finance the country's ambitious public expenditure programmes. The tax base is also coming under pressure from within as high tax wedges are putting downward pressure on labour supply and encouraging people to operate in the "informal economy" instead.

Boosting labour supply is the best option

Maintaining the welfare system – and the egalitarian Swedish model more broadly – is certainly possible, but it will require further policy reforms. Although the fiscal situation is

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much better than in most OECD countries, it is a little shy of the level needed to ensure that the welfare system will be financially sustainable in the long term. The most immediate priority is therefore to comply with the government's surplus target of 2% of GDP. Public finances need to be strengthened by at least one percentage point of GDP. Maintaining the surplus at the target level for 15 years or so afterwards would allow net assets to be accumulated that can later be drawn down to finance the age-related spending pressures. Spending cuts and tax increases are both difficult, so the most attractive option for achieving the surplus target is to increase labour supply. Key areas are reducing sickness and disability absences and raising participation by youths, the elderly and immigrants. In the absence of progress in these areas, the government would need to be more ambitious still in its savings plans or be forced to cut back on the welfare state in the future.

Achieving the 2% surplus target would go a long way towards what is needed to safeguard current service levels. However, it would leave no room for anything extra. For the reasons discussed below, tax financing alone will probably not be able to cover this extra demand. This suggests that some further adjustment of the Swedish model may be necessary over time. First, Swedes will need to decide what are the core parts of the system that should still be provided free of charge to everyone. Second, other financing sources may have to be used to a certain extent for some of the lower-priority services. Finally, the tradeoff between public spending now and in the future needs to be recognised. There is an understandable demand for generous parental, study and sabbatical leave, for instance, but the less that people work today, the fewer public services the country will be able to afford in the future.

The tradeoff between equality and efficiency needs to be carefully balanced

Equality remains a high priority in Swedish policymaking and among the general public. There is little, if any, acceptance of policies that would permanently widen the income distribution. This is a legitimate social choice. Of course, the best option is to look for reforms that would be good for growth and that would leave the long-run income distribution intact, and then try to find compensation mechanisms to offset any short-run impacts on dispersion. But where that is not possible, such strong distributional concerns can be costly. There is sometimes a tradeoff between equity and efficiency which needs to be recognised. Sweden may be foregoing growth-enhancing reforms which, if implemented, might make it significantly easier to achieve other social objectives.

The bolts on the fiscal framework should be tightened

By international and historical standards, the fiscal framework is working relatively well. Fiscal policy is constrained by a top-down budget process, multi-year expenditure ceilings and a medium-term target for the general government surplus. Combined with the political will to make them work, they have delivered an average budget surplus of 1.6% of GDP in recent years (so long as the exceptional year 2000 is included), despite several years of economic weakness. However, there are signs that the framework is starting to fray around the edges. While the ceilings have helped rein in expenditure, the government has avoided breaching them in the past few years only because some spending has been

channelled through tax expenditures instead. Moreover, the 2005 budget was strongly expansionary and inconsistent with the surplus target. Unless some of this is clawed back, the structural surplus is likely to remain well below the government's 2% surplus target.

Although the framework is still functioning adequately, the commitment to sound public finances needs to be re-invigorated. More emphasis will need to be given to the surplus target as a guide for policy. An important reform would be to ensure that the level of the expenditure ceilings is consistent with the surplus target. The framework could also be augmented with a medium-term debt target to reduce the chances of slippage from year to year. The expenditure ceilings should also be made more binding. The main problem is a tendency to spend up to the limit even in good years. Much of this additional spending ends up as transfers to local government, which means that central government is often adding to the pro-cyclical swings in county and municipal budgets that are caused by the balanced-budget rules. To avoid this, it would help to make sure there is an adequate margin for business cycle fluctuations. In addition, tax expenditures should not be used to get around the ceilings.

Raising income taxes might be counter-productive

Raising taxes may look like an easy way to strengthen the fiscal situation but it is likely to be costly and perhaps even counter-productive. In the short term, it would reduce the pressure to reprioritise spending or to find productivity improvements instead. Further out, it would reduce labour supply. High tax wedges have a negative impact on hours of work; raising them further is likely to worsen the situation, in which case it may not generate much in the way of receipts anyway. But there is scope to collect revenue in less costly ways. Making the VAT uniform again and continuing the shift towards green taxes would raise revenue that could then be used to reduce labour income taxes, thereby improving work incentives.

Labour supply needs to rise

Avoiding any discouragement to work is crucial in order to preserve national income and to shore up public finances. Sweden cannot afford to have one of the world's most generous welfare systems if labour supply is just average. The main avenue for achieving this is to reduce the disincentives that currently hold down average hours of work. Working hours are low partly as a result of sickness and disability absences, but other forms of time off work along with negotiated reductions in working hours also contribute to the problem. There are several pockets where employment could be enhanced as well.

Reducing sickness absences is the single biggest labour market challenge

On a normal day, nearly a fifth of the potential workforce is on sick leave or receiving a disability benefit. The sickness rate has soared since 1998, especially among long-term absences, and is close to an all-time high (it has edged back from its peak more recently, but much of the improvement is because people have moved onto disability benefits instead). The causes of the problem are not hard to find. Compared with other OECD

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countries, sickness insurance is both generous and easy to get. Swedes have a legitimate social goal of protecting sick people from undue hardship. However, the more generous the system, the more vigilant policymakers must be about ensuring that benefits are reserved only for those who need them. In this respect, Sweden falls well short of international best practice. However, an overly hard line is not necessary. Simply moving towards the middle of the pack would help a great deal. By doing so, the sickness problem may be largely solved without having to directly reduce benefit rates.

The government has set a target of halving the number of sick-listed people by 2008. It has taken some steps to try to tighten up administration, especially by bringing local offices under its wing. But tougher enforcement of a soft system is not enough. It needs to develop the sort of "mutual obligations" approach that is already used for the unemployed, which means placing greater responsibilities on the sick person, the employer and the social insurance office:

- *Eligibility criteria need to be tightened further*. Despite attempts since 2003 to tighten up, almost everyone who requests sick leave is granted it. There are several options for dealing with this, most of which are common practice in other countries. In the initial stages, doctors need to be more thorough in assessing a person's work capacity and should be given greater support by the social insurance office if they feel that a request should be denied. To ensure that short spells do not become long ones, extending a medical certificate should be less easy (for instance, not over the telephone), and benefits should have a maximum duration of one year. Independent medical assessments by a social insurance doctor should be introduced for long-term sickness and disability recipients. It would also help if the ultimate decision to grant long-term benefits were made in a regional or central office and by a panel of experts, rather than, uniquely, by local politicians. Once a benefit is granted, work capacity should be regularly re-assessed (the government is trying to do this, but it is not clear how rigorously the policy is being implemented in local offices). A full-scale review of the existing stock of long-term recipients may also be warranted, and occasional random checks could be re-introduced.
- *Receiving a benefit should entail certain obligations for the sick person*. In most cases, benefit receipt should depend on participation in vocational rehabilitation or other integration measures. In general, the earlier this starts the better. The new policy of having a meeting after a few weeks among the various parties is a good one, but it is important that this is done on time. Moreover, the social insurance office needs greater powers to act when a beneficiary refuses rehabilitation.
- *Increase incentives on employers*. From this year, employers are required to pay the first two weeks of sick pay plus 15% of sickness benefits for the rest of the spell unless the individual is working part time or undergoing rehabilitation. The aim is to get people into rehabilitation earlier, but it is unclear whether this is the best way of going about it. The government should monitor the response of companies to this new regime; if it is not having the intended effect, it could be replaced with a higher up-front cost for employers but with a limited duration (for example, covering sick pay for the first two to three months). Employers' incentives could also be sharpened by introducing industry or firm experience rating. As a first step, different sickness insurance premiums could be set for public and private employers. Introducing a clearer division between workplace injuries and the general sickness insurance scheme would also help, as it would separate

out the conditions over which companies have some influence. Steps may also be needed, however, to minimise any adverse selection problem if firms were to respond by not hiring high-risk groups (although this has not been a major problem in the Netherlands).

- *Extend the waiting period*. A one-day wait is short by European standards, and Sweden's past experience shows that extending it could have a big impact on short-term absences. It may also help change the culture surrounding sick listing.
- *Monitor partial or part-time sick leave*. The government is encouraging partial benefits as a way of keeping people attached to the workforce. However, they can be unhelpful if they invite a higher inflow and are used merely as an income top-up for workers who want to scale back their hours for lifestyle reasons. Sweden will need to rethink its approach if it finds that partial benefits are being used in this way.
- *Reduce the extent to which sickness and disability benefits are used for early retirement*. People retiring early are often better off taking the sickness insurance path so that they get a higher pension when they turn 65. One solution is to change the rules so that benefit income does not count as much as earned income towards the defined-contribution pension.

Taken together, these proposals would imply a radical shift in Sweden's approach to sickness and disability insurance, making it more similar to approaches elsewhere.

Overly generous leave schemes reduce labour supply

Several paid leave schemes have been introduced for various social reasons, but they have the side effect of reducing effective labour supply. In total, they contribute as much as sickness to lost work time:

- The *parental leave* scheme has valid family policy objectives but may have become too generous in the sense of harming women's labour market prospects. The social goals of the scheme need to be traded off against these costs. In general, measures that increase the duration of mothers' leave should be avoided so as not to aggravate gender segregation and human capital loss, which are detrimental to longer-term career prospects. But one way to improve the scheme would be to increase the share that is not transferable between parents.
- *Study leave* is aimed at making it easier for older workers to retrain, but many use it instead for personal enjoyment or as a break from work. This problem could be reduced if study grants were limited to only those courses that are clearly job-related.
- A paid *sabbatical leave* scheme was introduced this year whereby employees can take up to a year off and be replaced by an unemployed person. The aim is to provide workers with a chance for recreation or personal development (even though the study leave scheme gives ample scope for the latter) and to give the unemployed a foothold in the labour market. While small, there is likely to be pressure to expand the programme. It should be abolished instead. Workers who want extra holidays can always negotiate them, but they should not be paid for by the taxpayer. Furthermore, arguing that this scheme benefits the unemployed relies on the misperception that there is only a fixed amount of work to be shared around (the "lump-of-labour fallacy").

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Young people need to enter the workforce earlier

Younger adults are another under-used source of labour supply. They tend to enter the workforce later than in most countries, partly because of a late start to university. Admission is based mainly on grades, but there are plenty of ways to improve one's chances by studying for an extra year or two in a post-secondary programme. This creates a pointless "arms race", at the end of which mostly the same people gain entry, but it takes an extra couple of years to achieve. Some simple solutions include giving preference to people who qualify directly from school and not granting bonus points for irrelevant work experience. Once students have started studying, generous grants and an absence of tuition fees mean they are in no hurry to graduate. One way to encourage them to finish more rapidly and choose courses more relevant to the labour market would be to introduce modest tuition fees backed by income-contingent loans. But if that is not acceptable, other ways to improve efficiency should be found. For example, Sweden could consider Norway's new policy of converting some of the student's loans into grants if studies are finished within the prescribed period. In addition, income support rules that allow students to take a year of paid holiday during a course should be modified: grants should be given only for the minimum duration of a course, while those who want to take longer could finance that through the loan scheme.

There may be some scope to increase labour supply among older workers

There is also scope to increase participation among older workers, even though Sweden does better than most other OECD countries in this respect. The incentives to retire early that are embedded in the public pension system are lower than in many countries because, although the pension can be taken at any time from age 61, the payout rate is increased the longer somebody stays working. However, there are two reasons why the government may want to consider tilting incentives even further, going beyond neutrality. First, while the current adjustment is appropriate for an actuary, most people probably have a subjective rate of time preference that is higher than the standard discount rate. It therefore takes a bigger financial incentive to encourage them to postpone their retirement. Second, the tax they would pay if they stayed at work has positive spillovers for the rest of society, such as providing more room for better welfare services in the future. Society and public finances will be better off so long as the extra taxes exceed the financial cost of the incentive.

Measures for getting the unemployed back to work could be improved

Improvements to the unemployment insurance (UI) system could lower the rate of joblessness, thereby providing additional labour input. The administration of UI is patchy. Similar cases can be treated differently across the country, with some local offices being more likely than others to extend a benefit beyond the normal maximum. In addition, while the *Activity Guarantee* is an improvement on the previous system, it is not being used as well as it should be. It is designed to provide full-time, tailored labour market programmes for the long-term unemployed who need special help. Instead, it is

being used to give unlimited access to UI benefits. To deal with these problems, the institutions should be streamlined (by merging the national and local labour market boards, for example), local case offices need to apply the rules consistently, sanctions on those who are not actively looking for work should be strengthened, and the *Activity Guarantee* should be of limited duration and offered only to those who need intensive programmes. In general, Sweden would get better value for money from its active labour market programmes if they were shorter and started earlier in the unemployment spell. This would best be done in conjunction with the introduction of profiling in order to minimise the risks of spending money assisting people who would easily find a job by themselves.

A more flexible labour market would raise employment and reduce sickness absences

Job prospects for marginalised groups are likely to be raised if employment protection legislation (EPL) were eased. While there is no clear international evidence that EPL affects the *un*employment rate, there is evidence that strict EPL reduces *em*ployment and participation rates. In Sweden, the main restriction is the seniority or "last in first out" rule. This is designed to give extra protection to older workers and to reduce the amount of stigma associated with being made redundant. However, it may have several adverse side-effects. It risks locking people into less-suitable jobs (and Swedes do stay longer in the same job than employees in other countries). It reduces the probability that an employee might start a new venture for themselves if they lose their acquired tenure rights by doing so. It may make sick people more reluctant to change jobs, which in some cases might eliminate the cause of their illness in the first place. Finally, it may raise the sickness rate for another reason, as there are some signs that absenteeism is higher when there is strong job protection.

There is scope to do more with less in the public sector

Another way to strengthen public finances is to raise the efficiency of the public sector. Opening up to competition can be a powerful way of achieving this. Ultimately, all levels of government should think about whether the public sector needs to provide certain services at all. There is still a tendency in Sweden to think that, if the government has to step in, it must also produce the services itself. Public policy objectives can often be achieved through regulation and outsourcing instead. Although exposure to competition and the regulatory background have got better over the years, there is room for further reform. First, the market activities of municipalities and other public institutions should be subject to normal competition legislation, and the competition authorities should have the power to impose sanctions on local governments. Second, the public procurement process needs to be improved so that there is a level playing field between internal and external suppliers. Third, more use of benchmarking could help uncover best practice and show up the poorer-performing local governments. Finally, there is considerable scope for selling state assets, especially in competitive parts of the business sector.

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The healthcare system is in good shape

The *Survey* also includes an in-depth look at Sweden's healthcare system. By international standards, it is in good shape. Healthcare is of a high quality, the system is relatively well funded, and the various players have been innovative in the way they finance and deliver services. However, there are some problems around the edges. The main challenges are to improve access to primary care, lift quality in the lower-performing regions, increase value for money in the hospital sector and put financing on a more stable and sustainable basis.

Access could be improved, especially to primary care

Too many people go to a hospital for their primary care because there is a shortage of GPs and because doctors work short hours. The number of family doctors might be boosted if it was easier for specialists in other fields to retrain as specialists in family care. Doctors could be encouraged to work more, deal with patients more efficiently and have more convenient consultation hours by introducing mixed payment systems that include a fee-for-service element. In the hospital sector, the Waiting Time Guarantee should be adjusted to make it consistent with the principle that those most in need should be treated first (for example, by making duration in the queue just one of several factors that determines when a person is treated).

Too much decentralisation harms quality and efficiency

Decentralised responsibility for healthcare has its advantages. It has allowed counties to experiment with different ways of running their systems, which is one reason why Sweden's healthcare system is relatively innovative and flexible. However, *excessive* decentralisation in some areas affects quality and patient safety (for example, too many emergency units are below the minimum safe size, while insufficient co-ordination between counties and municipalities leads to problems in the grey area between hospital care and social care). It also affects efficiency because of duplication. The government should consider reducing the number of counties to perhaps half a dozen or fewer, which would also help the counties re-organise their hospitals so that fewer are below safe size. Co-ordination between municipalities and counties needs to improve, especially for people with psychiatric, drug or alcohol problems.

The hospital sector could be run more efficiently

In the hospital sector, there are considerable regional differences in efficiency, quality and medical practice. In most counties, there is a need to: enhance the role of purchasers; improve hospital funding mechanisms, including some form of per-case payment; improve management through better case costing systems, especially in psychiatry, outpatient and primary care; and make more use of multi-year budgets. The government could also encourage a greater diversity of providers by removing restrictions on for-profit hospitals

or allowing exemptions on a case by case basis – but only when an adequate regulatory framework is in place to minimise the risk of cream skimming.

Funding arrangements are unstable and unsustainable

The current funding arrangements have several problems. With balanced-budget rules, healthcare financing is too cyclical. Possible solutions include stabilisation funds, giving counties a less-cyclical tax base (such as property taxes), calculating the tax base as a moving average and moving to multi-year budgeting. Second, the income tax base may not grow fast enough with an ageing population. Counties may need a share of the national VAT, for example. Finally, the high-cost protection ceilings on user charges should be re-assessed because patient charges are not having the desired effect of channelling people to the right level of service. The government could raise the ceilings, which have fallen significantly in real terms, or make them a fixed percentage of household income instead of a flat amount.

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Chapter 1

Key challenges

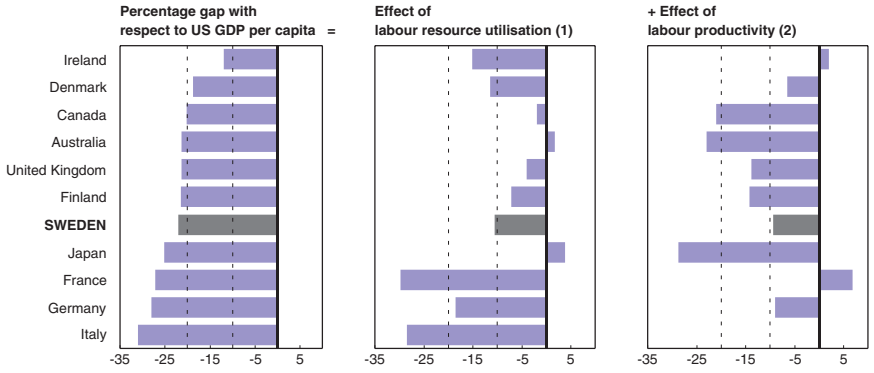
This chapter discusses the key challenges facing the Swedish economy. It reviews its performance since the crisis of the early 1990s, including the remarkable surge in productivity in the business sector. Next, it looks at the labour market and the reasons why employment has not recovered to its pre-crisis level. Sweden's key challenge is then discussed: how to maintain the core of its welfare system despite a greying population. Public finances will be squeezed from several quarters: a higher demand for social services as people get older; a reduction in the share of the population that is working; and ongoing tax pressures caused by globalisation and economic integration in Europe. The first solution is to increase labour supply by reducing sickness absences, raising average hours of work and increasing the employment rates of those groups where participation is still relatively low; the second solution is to improve value for money in public services. The chapter concludes by discussing the tradeoff between equality and other social objectives.

For several decades, Sweden has ranked highly in most indicators of the quality of life. Its public health, educational attainment, employment rate and poverty level are among the best in the world. Per capita incomes are relatively high (Figure 1.1), even if they have slipped in relative terms since the 1970s. Swedes also have a clear global conscience, devoting substantial resources to preserving the environment, helping poorer nations and providing a haven for refugees. The centre-point of its social and economic model is a large and wide-ranging welfare state. The welfare system is characterised by generous and comprehensive social insurance, extensive income redistribution, a preference for universal rather than means-tested benefits, large-scale public ownership and production, and a wage bargaining framework that delivers considerable wage compression. This paradigm obviously requires a large role for government, which is one reason why the business sector employs fewer people today than it did in 1970 and why the amount of consumption that households can choose for themselves (real private consumption) has grown much more slowly than elsewhere (Figure 1.2).

Sweden's most important economic challenge is a long-term one: to make sure that its social model can withstand the internal and external pressures that will be building up in coming years. The looming demographic burden caused by an ageing population is well understood by now, even if there is uncertainty about how big an impact it will have on public finances. Tax bases are becoming more mobile across countries, making it harder to raise the amount of revenue needed to fund such a large public sector. The taxation of capital and profits has been constrained by international competition for many years now, while the eastward expansion of the EU is making it more difficult to maintain radically

Figure 1.1. **The sources of differences in income**

2004, in PPP terms



Note: The gap in GDP per capita is only approximately equal to the sum of the two components shown as there is a small additional demographic effect (differences in the share of population that is of working age). For Sweden, this contributes 2.2 percentage points to the income gap.

1. Labour resource utilisation is measured as total number of hours worked divided by the working-age population.
2. Labour productivity is measured as GDP per hour worked.

Source: OECD, *National Accounts, Labour Force Statistics*.

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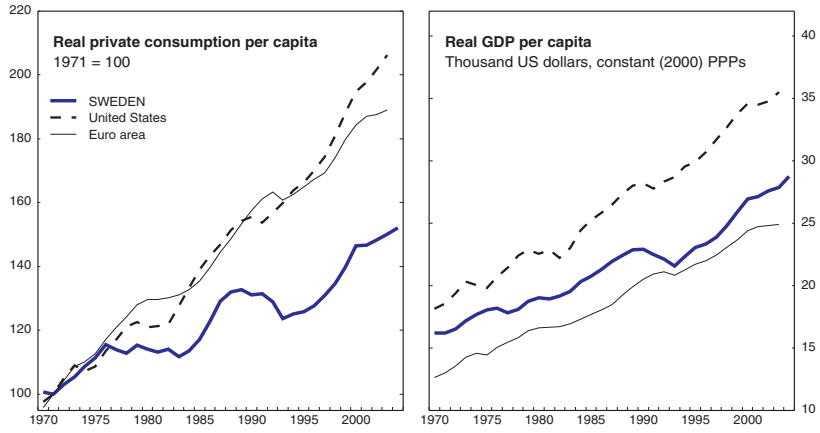
Figure 1.2. **GDP and private consumption per capita**



Source: OECD, *National Accounts*.

different sales tax rates (on alcohol, for example). Meanwhile, people are to some extent escaping high income taxes by reducing their hours of work or operating in the black economy. Finally, there is a risk of high taxes driving the most talented Swedes offshore. While a brain drain is not a major problem today, it is difficult to judge whether it will become more of an issue in the future.

Faced with these pressures, policy reforms will be needed to ensure that the core of the system will be financially sustainable. The key goal is to increase labour supply. The more that Swedes work today, the more welfare services they will be able to afford in the future. The most obvious way of doing this is to reduce sickness absences, although there are several other pockets of labour supply potential as well. Moreover, the public sector needs to provide better value for money by raising its efficiency and trying to deliver higher quality services. Finally, the government needs to look at how the welfare system is financed and to make sure that revenues are raised in less costly and distortionary ways.

The rest of this chapter reviews Sweden's economic performance and elaborates on the key challenges it faces. The chapters that follow develop specific recommendations for achieving them (while Annex 1.A1 reviews progress on the recommendations made in previous *Surveys*). The final chapter is an in-depth look at the healthcare system. Healthcare faces challenges in its own right, but it also provides a case study for many of the themes discussed in the report.

Economic performance over the past decade

The long-term relative decline in the Swedish economy has been much discussed. Sweden slipped from having the third highest per capita income in the OECD in 1970 to fourteenth place by the early 1990s (Figure 1.2, right panel). The causes are also fairly well understood: they include poor structural and macroeconomic policies, insufficient competition in the business sector, rigid labour markets and an overshooting in the size of government (with public expenditure peaking at nearly three-quarters of GDP in 1993). A combination of external shocks and policy mistakes culminated in a banking crisis and severe economic slump in the early 1990s.

The transformation since then has been impressive in many respects, but a little disappointing in others. The macroeconomic policy framework has clearly improved. Inflation expectations are now well anchored by the central bank's credible inflation-targeting regime, while the central government's budget decisions are made within the constraints of a medium-term fiscal framework. These strategies have delivered low inflation and a reduction in public debt. Various microeconomic reforms have also lifted the country's sustainable growth rate. The deregulation process has been fairly widespread (albeit with the odd glaring exception such as the housing market), competition has been strengthened and there is relatively little "red tape" holding back the business sector (Conway *et al.*, 2005). Exporters in particular have benefited from the favourable business environment, although entry to the EU in 1995 and the depreciation of the currency shortly before that helped as well. Consequently, after several decades of current account deficits, Sweden has been running sizeable surpluses (averaging 4.8% of GDP) ever since joining the EU.

Trend productivity growth has picked up

The most impressive aspect of Sweden's performance has been the pick-up in productivity growth. Indeed, labour productivity has been the sole driver of growth in per capita incomes since the mid-1990s (Table 1.1). For the reasons described earlier, productivity growth in the 1970s and 1980s had been weak by international standards (and this was a genuine poor performance, not a statistical illusion caused by mis-measurement of the government sector – see Box 1.1). Since 1995, however, growth in output per hour worked for the whole economy has averaged around 2.3%, which is one of the higher rates in the OECD. Some of this improvement can be attributed to one-off factors that are unlikely to be repeated over the medium term, including a cyclical bounce-back from the slump of the early 1990s. Nevertheless, it is clear that the trend or sustainable rate of productivity growth has improved as well (Figure 1.3, left panel).[1]

The ICT manufacturing sector can take some of the credit…

The improvement in labour productivity has been most pronounced in manufacturing, where growth in output per hour averaged 7.6% per annum in the decade to 2001 (Table 1.2). The largest contribution came from the ICT sector, much of which is due to a single telecommunications company, Ericsson. Government policy has contributed here, as Sweden was one of the first European countries to deregulate its telecommunications market. While ICT manufacturing has made a significant contribution to the recovery and has become a "flagship" for Sweden's corporate sector, its importance should be kept in perspective. In the late 1990s, the ICT sector was only slightly larger than in the EU as a whole and was much smaller than in Europe's "new economy stars", Finland and Ireland (Table 1.3).[2] Moreover, the productivity improvements that the sector has created do not automatically lead to higher national income. Prices of ICT goods have been falling sharply on export markets, so to the extent that Swedish companies are price takers, they will be better off only if they can raise productivity more quickly than their competitors.[3] In any case, productivity has improved in other manufacturing industries as well. The auto, pharmaceutical, machinery and pulp and paper industries have been particularly strong. Growth in labour productivity in the business sector *excluding* ICT has averaged a respectable 2.4% per annum since 1995 (Figure 1.3, right-hand panel).

Table 1.1. **Output and productivity growth**

Annual average percentage change

	Sweden	OECD[1] average	Euro Area average	Average of other Nordics	Australia	Canada	Denmark	Finland	France	Germany	Ireland	Italy	Japan	Netherlands	New Zealand	Norway	Spain	United Kingdom	United States
GDP per capita…																			
1970s	**1.6**	2.7	3.0	3.5	1.3	2.7	1.5	3.2	2.7	2.6	3.2	3.0	3.2	2.1	0.6	4.2	2.5	1.8	2.2
1980s	**1.9**	2.4	2.3	2.0	1.5	1.5	1.5	2.6	1.9	2.0	3.3	2.0	3.3	1.7	1.2	2.2	2.5	2.4	2.2
1990-1995	**0.1**	1.4	1.5	0.7	2.0	0.6	1.6	–1.4	0.7	..	4.0	1.3	1.2	1.4	1.8	3.2	1.2	1.4	1.2
1995-2004	**2.4**	2.2	2.3	2.5	2.2	2.3	1.7	3.3	1.7	1.1	5.9	1.3	1.2	1.7	1.8	2.1	2.1	2.3	2.2
***… equals* labour productivity (GDP per hour worked)…**																			
1970s	**2.3**	2.9	3.7	3.9	1.7	1.7	2.8	3.4	3.6	3.6	4.6	4.0	4.2	4.0	0.4	4.6	4.5	2.7	1.6
1980s	**1.2**	2.1	2.4	2.1	1.2	1.0	2.0	2.8	2.9	2.3	3.7	2.1	3.4	2.3	0.6	2.6	3.1	1.9	1.4
1990-1995	**2.1**	2.2	2.7	1.9	1.9	1.3	1.9	2.5	1.9	2.6	3.6	3.1	2.3	2.1	0.4	3.5	2.3	2.7	1.2
1995-2004	**2.5**	2.0	1.8	2.3	2.2	1.6	1.4	2.6	2.0	1.5	4.9	0.5	2.1	0.6	1.2	2.4	–0.2	2.2	2.4
***… plus* labour utilisation (hours worked per capita)**																			
1970s	**-0.7**	–0.7	–1.1	–0.5	–0.3	0.9	–1.3	–0.2	–0.9	–1.0	–1.5	–0.9	–0.9	–2.0	0.3	–0.4	–2.0	–0.9	0.6
1980s	**0.7**	0.1	–0.4	–0.1	0.2	0.5	–0.4	–0.2	–1.0	–0.3	–0.4	0.0	–0.1	–0.6	0.6	–0.4	–0.5	0.5	0.8
1990-1995	**–2.0**	–0.7	–1.2	–1.2	0.2	–0.8	–0.3	–3.9	–1.2	–0.6	0.5	–1.9	–1.1	–0.7	1.3	–0.2	–1.1	–1.3	–0.1
1995-2004	**–0.1**	0.3	0.5	0.2	0.1	0.8	0.3	0.7	–0.3	–0.4	1.2	0.8	–0.9	1.1	0.5	–0.2	2.4	0.3	–0.1
Contribution to growth from investment in capital[2]																			
1985-1990	**1.3**	1.1	1.1	..	0.9	1.5	1.2	0.9	0.9	..	0.5	1.1	1.3	1.0	..	..	1.9	1.0	0.9
1990-1995	**1.0**	1.0	0.9	..	0.7	1.1	0.9	0.4	0.9	1.2	0.5	0.8	1.3	0.9	..	..	1.6	1.0	0.7
1995-2002	**1.5**	1.1	1.1	..	0.7	1.2	*1.5*	*0.7*	0.8	0.8	*1.4*	*1.0*	1.1	*1.2*	..	..	*1.3*	*1.3*	1.1
***… of which:* ICT capital[2, 3]**																			
1985-1990	**0.5**	0.4	0.3	..	0.3	0.4	0.6	0.9	0.2	..	0.2	0.3	0.3	0.3	..	..	0.5	0.4	0.5
1990-1995	**0.4**	0.3	0.2	..	0.3	0.3	0.4	0.2	0.1	0.3	0.1	0.1	0.3	0.3	..	..	0.3	0.3	0.5
1995-2002	**0.9**	0.5	0.5	..	0.6	0.6	*0.8*	*0.5*	0.3	0.3	*0.6*	*0.4*	0.5	*0.6*	..	..	*0.4*	*0.7*	0.8
Multifactor productivity[4]																			
1985-1990	**0.2**	1.2	1.6	..	0.5	–0.5	0.0	2.1	1.8	..	3.2	1.2	3.0	0.7	..	..	0.7	0.7	0.9
1990-1995	**0.5**	1.1	1.3	..	1.8	0.4	1.0	1.3	0.8	..	3.3	2.0	0.8	0.7	..	..	0.6	1.3	0.8
1995-2002	***0.7***	1.2	1.3	..	2.1	1.0	*0.1*	*2.6*	1.4	0.8	*4.4*	*0.1*	0.6	*0.9*	..	..	*–0.8*	*1.0*	1.2

1. Average of 20 countries (excludes Austria, Czech Republic, Greece, Hungary, Luxembourg, Mexico, Poland, Slovak Republic, Turkey). The OECD, Euro and Nordic averages are unweighted (simple) averages.
2. Capital stock measured by flow of capital services.
3. ICT capital services are based on harmonised deflators.
4. Figures in italics are 1995 – 2001.

Source: OECD Productivity database (*www.oecd.org/statistics/productivity*).

Box 1.1. **Are international comparisons distorted by differences in the size of government?**

Productivity growth in the government sector is hard to measure and is arbitrarily set to zero in the national accounts of most countries. This implies that countries with bigger governments may find their reported growth in productivity and real GDP biased down compared with other countries, even if their "true" productivity growth is higher. But is this bias large in practice? The first point to make is that it is not just the output of government services that is hard to measure; many other services are difficult to measure as well – estimating the real output of a school or hospital is difficult regardless whether it is owned publicly or privately. Hence, what matters for international comparisons is not so much the weight of government in the economy, but the share of personal services in total output. The second point is that statistical agencies tend to treat services in a similar way, so if service sectors are similar in size then measurements in different countries will be biased approximately equally.

A rough answer to the question can be given by comparing growth in real value added per worker in the personal and community services (PCS) sector (which covers the majority of government output, including public administration). From 1995 to 2002, *measured* labour productivity growth in this sector averaged 0.5% per annum in Sweden, compared with 0.0% in the 17 other OECD countries for which data are available. Hence, pure measurement differences (*i.e.* 0.5% growth *versus* 0.0% growth) bias Sweden's aggregate productivity estimates *upwards* by no more than 0.1% per annum (it may be smaller: because of inter-industry trade, measurement biases can partially cancel out when aggregating). Next, the share of the PCS sector in total value added is 23% in Sweden, compared with 21% in the other countries. The fact that Sweden has a slightly bigger PCS sector biases down its measured productivity growth by around 0.06% per annum. The combined effects roughly cancel out in this case, so it can be concluded that these measurement issues are having a negligible impact on Sweden's position relative to other countries. A similar conclusion is reached by comparing productivity estimates and relative sector shares for all services rather than the narrower PCS sector.

The general conclusion is that while differences in government size matter in theory because service-sector output is poorly measured, the bias for most countries will be no more than a tenth of a percentage point or so. Hence, comparisons of total economy output will usually give the same story as comparisons of business-sector output.

... but ICT use does not seem to have lifted productivity in the service sector

The benefits of ICT are increasingly accruing to users rather than producers of the technology. Performance in this area appears mixed, however. Swedish firms are leaders in their use of the Internet and have been heavy investors in ICT equipment (Table 1.1). There are few clear signs, however, that this has led to a pick-up in labour productivity in the service sectors that are commonly thought to benefit most from new technologies.[4] The reasons for this are not obvious, but one possible explanation, discussed in the previous *Survey*, is that large parts of the service sector remain sheltered from effective competition, either because they are mainly provided by the government or because they are protected by sector-specific regulations.

Table 1.2. **Contribution to labour productivity growth in the manufacturing sector**

Percentage points per annum

	Contribution from productivity growth within each sub-industry ("within" effect)		Contribution from reallocating resources across sub-sectors ("structural adjustment" effect)		Total	
	1981-90	1991-2001	1981-90	1991-2001	1981-90	1991-2001
ICT	0.33	1.94	–0.16	2.96	0.17	4.90
Automotive	0.12	0.76	–0.09	0.13	0.03	0.89
Chemicals	0.09	0.28	–0.04	0.27	0.05	0.55
Machinery	0.33	0.39	0.01	0.01	0.34	0.40
Pulp and paper	0.12	0.43	0.04	–0.04	0.16	0.39
Electrical machinery	0.10	0.10	–0.22	0.24	–0.12	0.34
Fabricated metals	0.18	0.22	0.02	0.08	0.20	0.30
Basic metals	0.30	0.26	–0.30	–0.08	0.00	0.18
Other sub-sectors	0.89	1.15	0.04	–1.50	0.93	–0.35
Total	**2.46**	**5.53**	**-0.70**	**2.07**	**1.76**	**7.60**

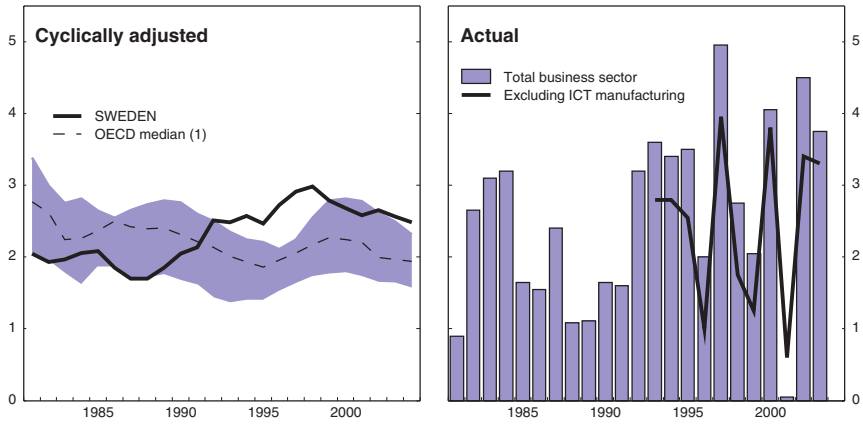
Source: Lind, Daniel (2003), "Swedish Manufacturing Productivity in an International Perspective During Four Decades – What can We Learn From the 1990s?", The Swedish Confederation of Professional Employees, Stockholm.

The productivity gains have partly been undone by a lacklustre labour market

The main disappointment when it comes to economic performance has been the labour market. Compared with most other countries, growth in labour supply has been on the low side. Although there has been a recovery from the trough in 1993, total hours worked in 2004 were still 6% below the peak recorded in 1990. The only broad industry that has a higher labour input than in 1990 is private-sector services, while hours worked in manufacturing remain 15% lower. Admittedly, this comparison is a little unfair because it measures the current cyclical softness with an all-time high, but even looking through these cyclical effects, labour market performance has still been lacklustre. The primary

Figure 1.3. **Labour productivity growth has picked up**

Output per hour in the business sector, annual percentage change



1. The shaded area shows the middle two quartiles (*i.e.* half the countries fall in this range).

Source: Statistics Sweden.

Table 1.3. **The ICT manufacturing sectors in several European economies**

	Size[1]		Composition[2]				R&D intensity[3]
	in 1980	1998-2000	Office machinery and computers (ISIC 30)	Electrical machinery and apparatus (ISIC 31)	Radio, television and communications equipment (ISIC 32)	Medical, precision and optical instruments (ISIC 33)	
Sweden	**2.2**	**2.8**	**4.1**	**26.2**	**45.6**	**24.1**	**9.1**
Finland	0.7	5.7	0.1	12.3	78.3	9.3	7.6
Ireland	2.9	6.8	30.6	13.3	34.3	21.8	1.4
EU	3.0	2.5	7.2	39.4	29.9	23.4	..

1. Size is measured by the share of gross value added in ICT manufacturing sectors (ISIC 30-33) relative to total manufacturing gross value added, in per cent.
2. This shows the composition of the sector in 2001 (2000 for Sweden), in per cent. The four components add to 100.
3. R&D intensity is business R&D expenditure as a percentage of total value added in the sector in 2001.

Source: ECB (2004), "Sectoral Specialisation in the EU: A Macroeconomic Perspective", Occasional Paper No. 19, European Central Bank.

weak spots in labour supply are described later in this chapter. The good news is that the combination of trends in productivity and labour supply adds up to growth in GDP per capita that has been marginally above the OECD average since the mid-1990s. Consequently, the long-running decline in relative living standards has clearly stopped and has probably gone into reverse. The process has not gone smoothly, however. The economy has been hit by some sizeable shocks to demand, productivity and prices over the past few years, and the job market has been unusually slow to bounce back (Box 1.2).

The ageing challenge: to preserve the core of the welfare system as the dependency ratio rises

The demographic transition to an older population will place a significant strain on Sweden's tax-financed welfare system. Dealing with this pressure is probably the most important challenge for the Swedish economy over the long term. Public finances today are a little short of the level required for long-term sustainability – that is, if today's tax and spending programmes were "put on autopilot" and run forward into the future, and if people continue to behave much as they do today (having the same employment rates and the same rate of sickness absenteeism, for example), then within ten years or so government finances would have swung into a permanent deficit, leading to ever-increasing public debt. Put another way, unless there are further policy changes the country will not be able to afford to maintain even its current level of transfers and public services into the future, let alone have room to meet the demand for improved services that is sure to come as people's incomes continue to rise.

The full force of these demographic changes will not be felt for another decade, so there is some breathing space. However, this does not imply that policymakers can wait before making the difficult decisions. In order to have maximum effect, some of the policy reforms will need to be put in place before the relevant cohort retires so they can have time to plan and adjust their behaviour. In addition, the relatively large proportion of people currently of working age provides a fiscal window of opportunity to pre-save for these future cost pressures by running healthy budget surpluses today.

The outlook for labour supply

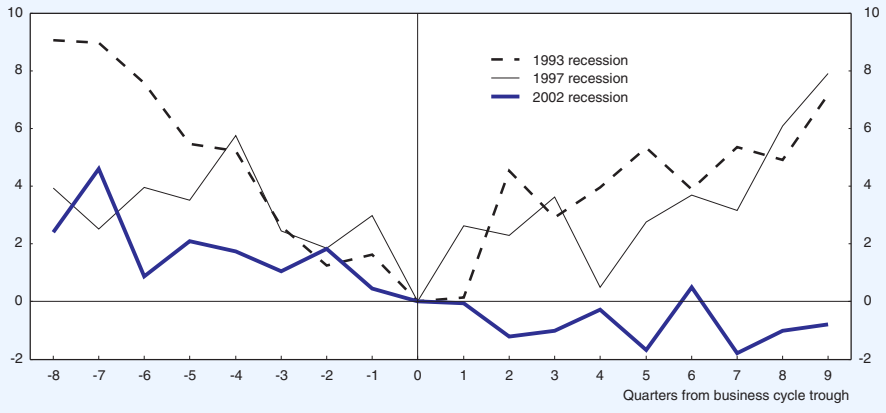
The retirement of the baby boom generation combined with a rise in average lifespans will lead to a large rise in the old-age dependency ratio. By 2030, the number of people aged 65 and over is projected to increase by half. In contrast, the number of people of working age will have increased by just 4%, and most of this will be among people aged 55-64, a

Box 1.2. **Recent trends**

Sweden has been enjoying a three-year-long economic expansion that has mainly been driven by demand for its exports. The telecoms sector has been a large influence on the country's business cycle, and it is now recovering from the crash early in the millennium. Motor vehicle exports have also done well over the past year or two. The recovery has broadened to include domestic demand, and a self-sustaining expansion in output is now well and truly under way. Business icnvestment picked up in response to low interest rates and high rates of capacity utilisation, while residential construction has steadily gained strength. The labour market, however, remains soft. Unemployment remains stuck around 6½ per cent (on an ILO definition), or nearly 8% if people on active labour market programmes are included. Compared with previous recoveries, it has taken an unusually long time for output growth to feed through to the labour market (Figure 1.4). This of course is the counterpart to the productivity revival. It also implies that the economy has some spare capacity, which has been holding down inflation. A stronger exchange rate, subdued international inflation and tougher domestic competition have also helped keep prices in check. Consequently, the core inflation rate fell below the bottom of the central bank's 1-3% target range early in 2005, although it is expected to bounce back up again as these one-off factors abate. Low inflation has enabled the central bank to hold interest rates at relatively low levels. Once these cyclical dynamics have played themselves out, growth in GDP per capita should settle down to a sustainable path around 2% per annum over the medium term (Table 1.4).

Figure 1.4. **The labour market has been slow to bounce back**

Total hours worked over recent business cycles[1]



1. The lines show hours worked as a percentage of their level at the trough of the business cycle. The trough is the point at which the output gap is largest (1993q4, 1997q1 and 2002q2).

Box 1.2. **Recent trends** *(cont.)*

Table 1.4. **Summary of medium-term projections**

	2003	2004	2005	2006	Average 2007-10
Real GDP growth (% per annum)	1.6	3.0	2.8	3.3	2.3
Real private consumption growth (% per annum)	1.5	1.8	2.4	2.7	2.5
Real business investment growth (% per annum)	–2.8	4.9	10.1	6.3	2.5
Output gap (% of potential output)	–1.6	–1.0	–0.5	0.3	0.2
Current account balance (% of GDP)	6.4	8.0	6.6	6.5	5.8
Employment rate (% of working-age population)	74.2	73.5	73.3	73.7	73.7
Core CPI inflation rate (Q4 on Q4, per cent)	2.2	0.8	0.6	1.6	2.0
General government surplus (% of GDP)	–0.1	1.2	0.7	0.8	0.7
General government structural surplus (% of GDP)	1.0	1.9	1.2	0.6	0.6

Source: OECD Economic Outlook 77 Database.

group that has relatively low labour supply. While the basic demographic forces are relatively easy to predict, the outlook for net migration is much less certain. The government's central scenario assumes that the annual net migration will stay around 0.2% of the population over the long term. In this scenario, immigration accounts for all of the projected increase in the working-age population over the next few decades. The number of working-age Swedes is expected to fall.

How these trends translate into labour supply depends on many offsetting factors (see Chapter 1 of last year's *Survey* for a more detailed discussion of possible scenarios). *First*, there has been a long-term trend towards earlier retirement. Although Swedes on average retire a little later than in other European countries, there is still a steep decline in participation as workers get older, and they retire about six years younger than they did in 1965. In addition, many older Swedes who are not retired are nevertheless on long-term sick leave and so are effectively out of the workforce anyway. *Second*, average hours for full-time workers have fallen over the past generation, although this has been offset by women moving from part-time to full-time employment. Over long periods, the main determinants of working time are income and taxes. People tend to prefer to take out some of their productivity and income gains in the form of more leisure, and this trend will no doubt continue. However, labour taxes also influence this decision. Higher income taxes would probably exacerbate the trend towards shorter working hours (see Chapter 2).

Third, by far the largest share of the immigrant inflow is expected to come from outside the EU. This is a group that has struggled for many years to get a foothold in the Swedish labour market. *Fourth*, the proportion of young people in tertiary education may continue to increase. This keeps them out of the labour market when they are young, but better-educated people tend to retire later, so the overall impact on the average length of working life is uncertain. *Finally*, sickness absenteeism and disability have increased significantly over the past decade. The extent to which the government can succeed in reversing this trend in a sustainable way will have a significant impact on the future labour supply. Accordingly, this *Survey* will devote substantial attention to this question.

Table 1.5. **Scenarios for total hours worked**

Per cent

	Changes from 2003		
	2010	2020	2050
Total demographic impact on total hours worked, basic scenario	0.1	0.6	4.9
of which:			
Size of native working age population, 20-64 years	–0.4	–2.1	0.4
Size of immigrant working age population, 20-64 years	3.1	5.6	9.2
Composition effects from employment rates (age, gender and origin)	–2.4	–2.7	–4.5
Composition effects from working hours (age, gender and origin)	–0.2	–0.1	–0.3
Additional change from prolonged trends			
Trend towards lower participation continues until 2020	–4.3	–9.4	–10.1
Trend towards lower working hours continues until 2020[1]	–1.6	–3.5	–3.5
Additional change from better integration of immigrants[2]	2.1	4.2	8.9

1. An annual decrease in average working hours per year of 0.2 per cent is assumed. That is only half of the average annual decrease between 1960 and 2002, reflecting that a further shift from part-time to full-time employment might take place in the future.
2. Half of the difference in employment rates to native Swedes is assumed to be eliminated by 2020.

Source: Statistics Sweden; Ministry of Finance; OECD calculations.

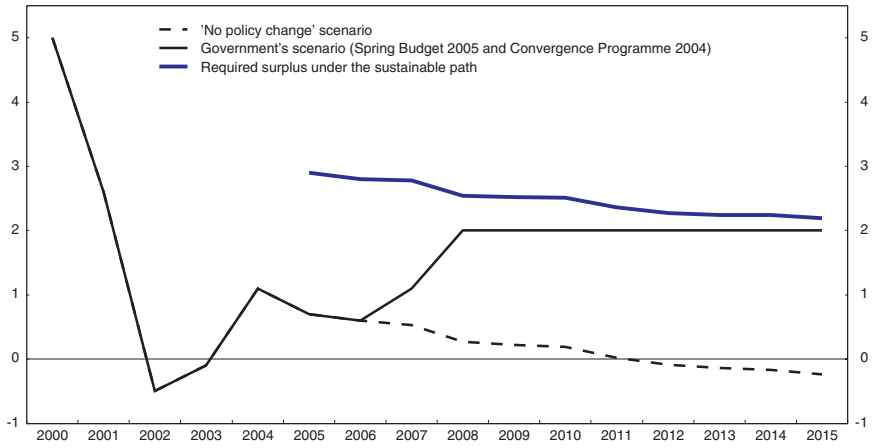
Putting the pieces together, demographic developments under a "no policy change" scenario should result in a potential labour supply that is only around 5% higher in 2050 than it is today (Table 1.5). If reforms are delayed and the trend towards lower participation and shorter working hours is not stopped until 2020, then labour supply could fall by nearly 10%. The main message from Table 1.5, however, is not the precise numbers, which are very uncertain, but that the assumptions about the labour market behaviour of the resident population swamp the purely demographic changes. These in turn depend heavily on tax and welfare policies. Hence, Sweden's economic destiny will be shaped not so much by forces out of its control but by the policy choices it makes in response to them.

The outlook for public finances

On a "no policy change" basis, the demographic and labour supply outlook described above is projected to raise public primary expenditure by 4½ percentage points of GDP between 2005 and 2050 (see Chapter 2 for details and for some alternative scenarios). Revenues will also rise to some extent, but not by enough to offset the increase in spending. The primary balance will therefore deteriorate by an estimated 3¼ percentage points of GDP over that period.

Given this outlook, the government would need to be running a surplus of 3% of GDP this year in order to ensure that fiscal policy was on a sustainable track (in the sense that it would be on the path that satisfies the government's inter-temporal budget constraint) – see Figure 1.5. This would obviously imply considerably tighter fiscal policy compared with the government's forecast of 0.6% of GDP for this year. A tightening of this magnitude is unrealistic and would probably be damaging in the short-term. However, achieving the government's medium-term surplus target of 2% of GDP over the next few years would go a long way – although not all the way – towards ensuring that fiscal policy was sustainable. Moreover, delaying fiscal consolidation would make the job harder. It would also worsen the inter-generational income distribution – the baby boom cohort is approaching retirement, so

Figure 1.5. **The general government fiscal surplus needs to rise**
General government net lending, per cent of GDP



Source: Ministry of Finance; OECD calculations.

there is a small of window of opportunity to have them contribute to reducing debt in preparation for the extra demands they will place on public spending later on.

Getting fiscal policy onto a sustainable path is clearly a tall order. However, Sweden's attempts to improve public finances have been much more energetic and successful than most other OECD countries. In the first place, there is a sound fiscal framework: a top-down budget process, multi-year expenditure ceilings and medium-term targets for the budget balance. These measures are designed to act as a straitjacket for fiscal policy. They have worked fairly well and have provided some genuine restraint on spending, but some tax expenditures have been used to get around the expenditure ceilings and the government has fallen short of its surplus target for several years (see Chapter 2). Second, Sweden is starting from a better position than many other countries: it is running a small surplus, gross debt has fallen to around 50% of GDP (on a Maastricht definition), and financial assets exceed financial liabilities. Third, the projected increase in public spending is less alarming than in the majority of OECD countries (Casey *et al.*, 2003), partly because the increase in the dependency ratio is less pronounced. On the other hand, many of the countries that appear to be in a worse position than Sweden also have more room to move. This *Survey* will argue that Sweden has very little room to increase income taxes, and may actually benefit from reducing them, and that its already fairly high employment rate implies it has fewer untapped reserves of labour supply.

Meeting demand for improved public services

The scenario in Figure 1.5 deals with the required surplus to maintain the current level of public services into the future. In some ways this is an unrealistic premise. Most welfare services are income elastic, meaning that people will demand more as productivity growth drives up average incomes. However, this effect is not taken into account in these calculations. The government's scenario implies that by 2050 private consumption per person will have increased by around 150% in volume terms, while public consumption will be essentially unchanged: it assumes people will demand more cars and foreign

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Table 1.6. **Increase in public service standards (enrichment)**

Growth in real public consumption per person over and above the amount due to demographic (age and gender) effects, per cent per annum

Since 1950	Since 1960	Since 1970	Since 1980	Since 1990	Since 2000
2.3	2.0	1.2	0.6	0.2	0.5
Required surplus today to be on a sustainable fiscal path[1]					
20.2	17.8	11.4	6.7	3.7	5.9

1. The sustainable path refers to the surplus at which the inter-temporal budget constraint would be satisfied.

Source: OECD calculations based on Swedish Long Term Survey.

holidays, for example, but not more welfare services. Based on historical patterns, it is more realistic to assume that public expenditure will grow more quickly than implied just by the demographic pressures (Table 1.6). Even the conservative assumption that spending grows 0.5% per annum faster than in the baseline scenario means that the surplus would need to be 6% of GDP this year (according to OECD estimates) to ensure that fiscal policy was on a sustainable path. This is clearly unrealistic and illustrates that alternative approaches will have to be found.

The public sector needs to become more efficient

Given its size, the extent to which the public sector can improve its efficiency will have a large influence on how much pruning of the welfare state may need to be done in the future. One of the more effective ways of increasing productivity is to expose the public sector to greater competition. Studies in Sweden and abroad have shown that the production and provision of public goods and services tends to become significantly more efficient when they are opened up to competition, while quality has been maintained or improved (Konkurrensverket, 2002). Although there has been some improvement over the past decade, Sweden is still a long way from using all the possibilities in this area. To a large extent, public financing still implies public production or delivery: while there has been a slight increase in the private provision of welfare services, public employees still make up nearly 90% of those employed in this sector (MOF, 2004). Some local governments are less willing than others to change the way they operate, and there have been cases of municipalities breaching public procurement rules and even ignoring court rulings afterwards. In areas where the private sector has tried to gain a foothold, the playing field has sometimes been tilted in favour of the public providers by regulatory barriers or anti-competitive practices (see the previous *Survey*). Finally, the state is the corporate sector's largest shareholder; its share of business-sector activity is the highest in the EU. The government retains major holdings in the sorts of industries that many other countries have successfully privatized, including post, telecommunications, electricity, airlines and retailing. By doing so, it is foregoing efficiency gains and tying up capital that could be used elsewhere (such as to provide better welfare services).

In future, it will also be important to find better ways to reallocate resources towards the high-priority areas. For example, the changing age structure of the population means that the number of schools and teachers should fall, with those resources being moved into healthcare and elderly care. However, historical experience in Sweden and elsewhere shows that this is hard to do (MOF, 2004). This may mean re-examining the division of responsibilities across levels of government and looking at the way central government grants are allocated.

Labour supply needs to rise if the welfare system is to be maintained

Average hours of work are low

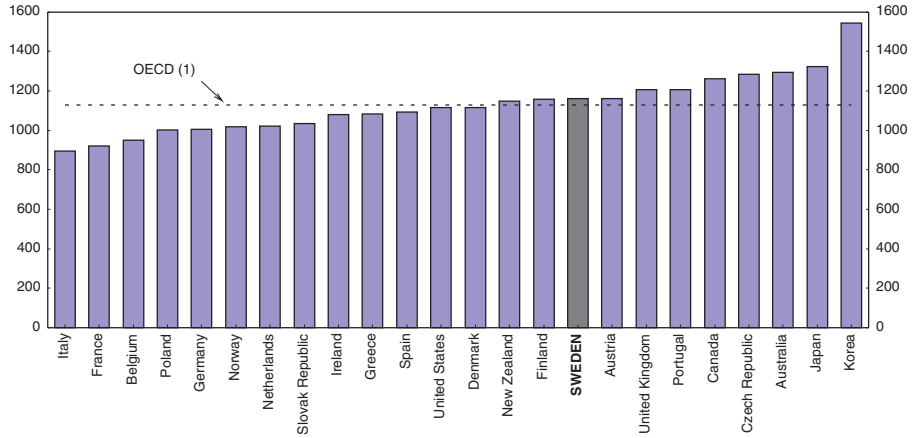
A distinguishing feature of the Swedish labour market is that it combines fairly high employment rates with low average hours of work. The result is that the total labour supply is only around average (Figure 1.6). Consequently, tax rates are higher than they otherwise would be in order to raise the funds needed to pay for public services. Part of the explanation for why working hours are low is that the "standard" working week is around one hour shorter than the European average. Most of the shortfall, however, is caused by people being absent from work, with holidays, sickness and parental leave being the most common reasons. Taking all these absences into account, the "average" Swede takes 17 weeks off work each year.

The impact of this level of absenteeism is that looking only at the employment side of the equation gives a misleading picture of how Sweden's labour market has performed over time. While employment rates have picked up since 1990, so too have absences – especially long-term sickness, but there has also been a trend towards longer maternity leave. The result is that the number of people at work has been fairly flat for more than a decade (Figure 1.7). Combine this with a shorter normal working week and the fact that the shift from part-time to full-time employment among women appears to have halted, and the total number of hours worked in Sweden is almost the same as it was 20 years ago. However, this labour supply has to finance government spending that has almost doubled in real terms.

The highest priority is to reduce sickness and disability absences

The incidence of sickness and disability has soared in recent years, particularly for long-term absences from work. Consequently, around a fifth of the potential workforce was either on sick leave or receiving a disability benefit last year. This is the highest rate of absenteeism due to illness in the OECD. Older people are more likely to be off work sick, and they account for a significant share of the increase since 1998. To some extent, therefore, a sickness benefit is the preferred route to early retirement; in other countries, some of these older workers would instead appear in the unemployment statistics or be drawing a public early retirement pension. Nevertheless, the problem of sickness absences goes beyond this and is apparent across all age groups. The sickness rate of a Swede in his or her twenties, for example, is higher than the overall absence rate in all but four European countries. Moreover, the outlook is disturbing: the shift in employment patterns that is likely to occur in the medium term – namely, a greater demand for public service workers, the vast majority of whom are women – will be concentrated on the groups that today have the highest rates of absenteeism. Women are about twice as likely as men to be receiving a sickness benefit, and the absence rate in the public sector is significantly higher than in the private sector.

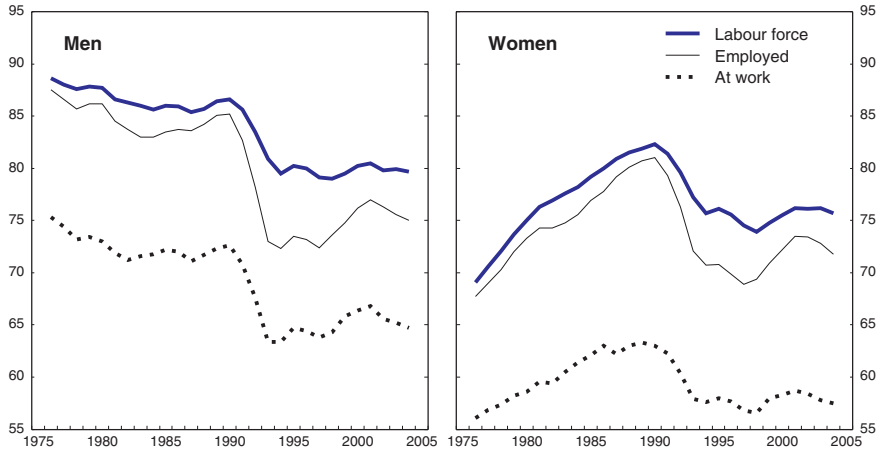
Figure 1.6. **Total labour supply is around average**
Hours worked per person of working age, 2003



1. Unweighted average of 24 countries.

Source: OECD Annual Hours and Productivity Databases.

Figure 1.7. **Effective employment is much lower than actual employment**
Per cent of population



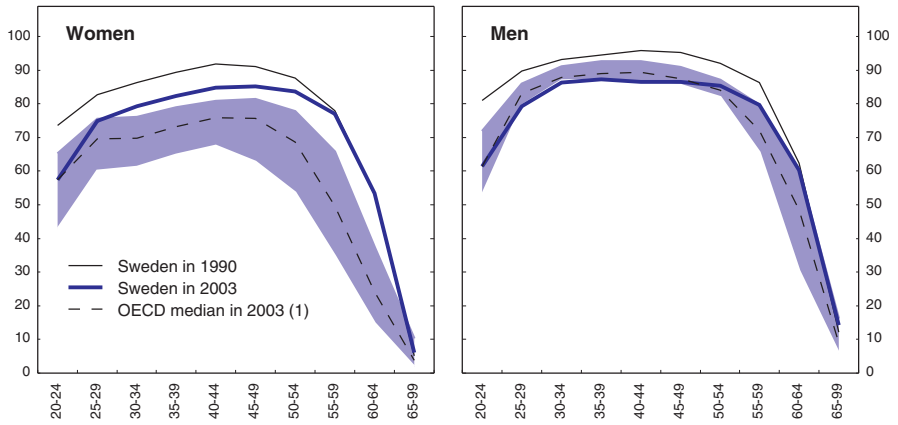
Source: Statistics Sweden, OECD.

There are several pockets where employment could be increased as well

While the aggregate employment rate is above average, this masks some large differences in labour market performance across different groups of the population. Although Sweden has less scope than other countries to raise overall employment, there are still several pockets where it could be increased to some extent.

- In almost all age groups, male employment rates have not recovered to their pre-slump levels (Figure 1.8). Indeed, the employment performance of prime-age men remains relatively poor: it is below the OECD average and several percentage points less than in

Figure 1.8. **Employment rates by age**
Per cent



1. The shaded area shows the middle two quartiles (*i.e.* half the countries fall in this range).
Source: OECD ELS database.

the other Nordic countries. The rise in non-participation among this group reflects an increase in the number of people who regard themselves as unable to work and have therefore retired early or are receiving a disability benefit, combined with an increase in the number of people studying (around 7% of the age group is studying, although not all of them full time).

- Comparing across education levels, it is the *most* educated people who account for this shortfall in employment compared with prime-age men in other countries – Sweden does fairly well when it comes to finding jobs for the less skilled. A similar pattern is apparent for women. In their case, however, employment rates are above average for all levels of education, but the *relative* performance is less impressive the more education a person has.
- Despite having recovered to some extent from its trough in the mid-1990s, the female employment rate also remains significantly below the levels achieved in 1990. The reasons are similar to those for men: higher disability rates and more prime-age women studying.
- The employment rate of young people is below average (after excluding those who work a few hours a week while studying). Labour supply among the young is reduced because they are spending a long time in the education system. There are two aspects to this. *First*, entry to the workforce and to university tends to be delayed in part because 40% of young people repeat some of the last part of their schooling in order to raise their grades. *Second*, they take a long time to finish their university studies. Taken together, these effects mean that the age at which young people establish themselves in the labour market has increased by around five years since 1987 (SOU, 2001). Moreover, the number of people aged 16-24 who are neither working nor studying has more than doubled since 1990.

- There is *some* room to increase employment among older people, although the scope may be limited unless public income support programmes change radically. The employment rate of 55-64 year-olds is already above the OECD average (although recall that many of these people will not actually be working because they are receiving a long-term sickness benefit), and the average effective retirement age in Sweden is a little higher than in most OECD countries. It is difficult to reverse the long-standing trend towards earlier retirement that has taken place almost everywhere over the past few decades, and the key step that needs to be taken – reforming the pension system – has largely been done in Sweden.

Moreover, some of the people who are employed may not be in the job that suits them best. Sweden has relatively strict employment protection rules, the most significant of which is the last-in-first-out or seniority rule that gives a great deal of job security to people who stay with the same employer. Not surprisingly, Swedes tend to stay in the same job much longer than in other OECD countries (see last year's *Survey*). While this may help them gain firm-specific skills, and possibly increases the willingness of employers to contribute to their continuing education as adults, the reduced job mobility does make it harder to reallocate the scarce labour supply to the areas where it is most needed. That may also be why there is relatively little entrepreneurship in Sweden (see last year's *Survey*); both owners and the initial employees may be giving up too much in terms of accumulated job security rights if they take a risk with a new start-up company. The country's dysfunctional housing market also makes it harder for people to move to a new job in another part of the country (see the 2002 *Survey*). The relatively rigid labour and housing markets mean that productivity is likely to be lower than it could be.

Achieving environmental objectives in the least-cost way

Achieving sustainable development requires that economic, environmental and social objectives be well balanced. Sweden has high environmental ambitions and has been fairly successful at achieving them, benefiting from solid institutional and regulatory frameworks and significant planning and legislative reform. Remarkable progress has been made in decoupling environmental pressures from economic growth. Extensive use of economic instruments is part of the explanation. For instance, the ongoing "green tax shift" (expected to amount to around 1% of GDP over 2001-10) involves higher rates of environmental taxes, fully offset by reductions in labour taxation.

Although impressive gains have been made, there are a number of areas where policies could be made more efficient. *First*, decentralisation of responsibility for implementing environmental policies has led to large variations in municipalities' supervisory efforts, thus creating an unequal playing field for businesses across the country. This suggests that the central government should improve its guidance of lower levels of government and that inspection and enforcement responsibilities at all levels of government be reviewed and sanctions on firms more widely used (OECD, 2004b). A *second* issue is the lengthy process of gaining a license for projects with environmental implications (1½ to 2 years for larger installations). This implies high transaction costs and may hinder investment that could benefit both economic development and protection of the environment. *Third*, there has been a lack of progress in reducing nitrate runoffs into the Baltic Sea. The high cost of reducing such emissions from Sweden alone indicates that an area-wide emissions trading mechanism could be more effective (OECD, 2004c). *Finally*, Sweden has set national targets for greenhouse gas emissions that

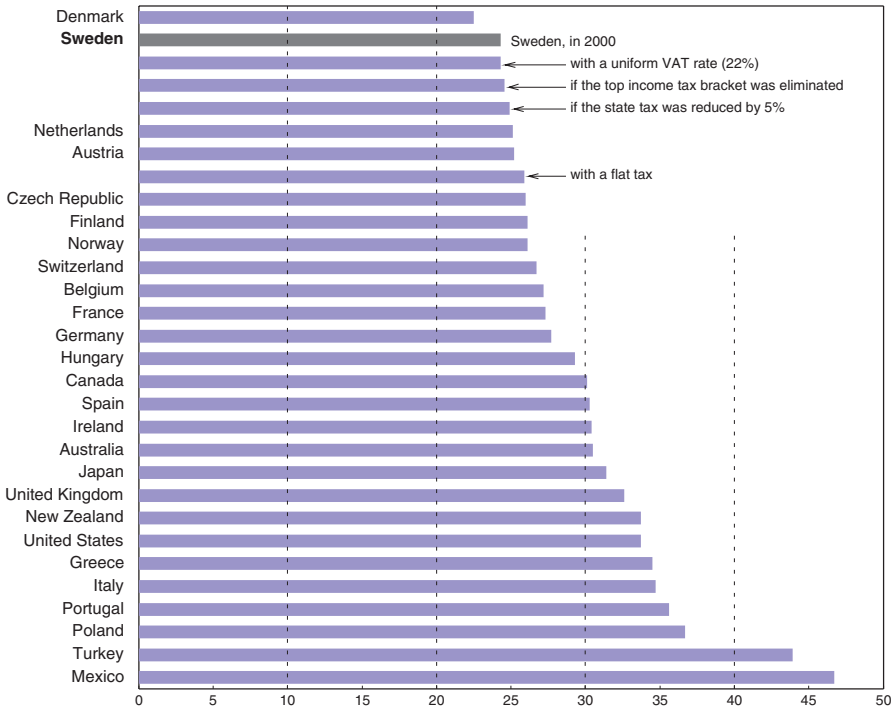
go well beyond its Kyoto commitment, even though it already has low per capita emissions. However, its GHG abatement costs are higher than necessary in some areas because economic analysis is not always used to identify the most cost effective abatement options. Its participation in the EU emissions trading programme, however, should reduce the cost of achieving its goals.

The equity-efficiency tradeoff

Many of the challenges discussed in the report have implications for equality. Sweden currently has the second-most equal income distribution in the OECD (Figure 1.9),[5] despite some widening over the past two decades. The distribution of lifetime incomes is more equal still because a large proportion of welfare services involve redistribution across time for the same individual. Maintaining a high degree of equality is a clear social objective. A challenge for policymakers, however, is to ensure that the benefits of income equality are appropriately traded off against the costs. In later chapters, this *Survey* will argue that Sweden's high marginal taxes on labour income are having a negative impact on labour supply and on the incentives to get employment-related higher education. In addition, the country's compressed wage distribution may be reducing productivity and increasing absenteeism (Alexopoulos and Cohen, 2004). Reforms that may improve Sweden's economic performance – and may help make the welfare system more robust – are often rejected if they would also widen the income

Figure 1.9. **The income distribution is relatively equal**

Gini coefficients in 2000[1]



1. A higher GINI coefficient implies greater income inequality. It can range from 0 (everyone having the same income) to 100 (one person having all the income).

Source: OECD calculations; Swedish Ministry of Finance; Förster, Michael and Marco Mira d'Ercole (2005), "Income distribution and poverty in OECD countries in the second half of the 1990s", OECD, *Social, Employment and Migration Working Papers* No. 22.

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distribution, even by a small amount. Of course, this is a legitimate social choice. However, part of the problem may be that Swedes look at the income distribution in an absolute sense, rather than by comparing with other countries, and therefore lack a metric to judge how large in a qualitative sense any policy impacts might be. To illustrate this point, Figure 1.9 shows the estimated static impact on the income distribution of some hypothetical tax reforms (some of which are discussed later in the report). The simplest example is to make the VAT a uniform flat rate again, as it was in 1990. The change in the Gini coefficient of income dispersion that this would cause is small enough that it is difficult to even see in Figure 1.9. Even the fairly radical step of moving to a flat income tax would, in a static sense, leave the country with one of the most equal distributions in the world.[6] The conclusion here is not so much what it says about the specific tax policies, but that Swedes may need to change their frame of reference when thinking about equity, otherwise they risk rejecting sensible reforms for the sake of avoiding what may actually be minor changes in the income distribution.

Conclusions

Sweden has undertaken important reforms that have improved its economic performance over the past decade and which go some way towards safeguarding its welfare society. But more needs to be done in the areas of improving public finances, boosting labour supply and enhancing efficiency in the public sector. Policy options for achieving these goals are described in the remaining chapters of the *Survey*. The next chapter analyses the fiscal challenge in more detail, reviews progress to date and discusses some of the steps that are needed to get better value for money from government. Chapter 3 deals with the country's single biggest structural economic problem – sickness and disability absences – and describes the sorts of measures that work in other countries. Chapter 4 looks at other aspects of the labour market. Finally, Chapter 5 contains an in-depth review of the healthcare system.

Notes

1. Separating trend from cycle is difficult for any country, but is especially uncertain for a country such as Sweden that has been recovering from such a deep recession. Nevertheless, the assessment that the trend productivity growth rate has increased is fairly robust. It is evident from a variety of methods of separating the structural and cyclical components, including filtering approaches (*e.g.* the HP and Kalman filters, in both univariate and multivariate frameworks), simple statistical analysis (moving averages) and graphical analysis (looking at peak-to-peak growth, for example). The improvement is also apparent whether one looks at the whole economy or just the business sector, and the conclusion is not altered in a qualitative sense when various measurement problems are taken into account (such as how to assess quality improvements in high-tech goods), although the estimated size of the pick-up will differ.
2. More up-to-date information on value added shares in ICT is not yet available for Sweden. Hence, it is hard to know to what extent it has bounced back from the telecoms slump in the early 2000s. However, both export and profitability estimates suggest there has been a substantial turnaround.
3. These price developments are evident in the terms of trade, which have shown a trend decline since the mid-1990s. All of this decline can be attributed to the telecommunications sector.
4. See OECD (2004a), Tables A5.1 and A5.2.
5. The comparison in Figure 1.9 is for the year 2000, which was the peak of the telecoms bubble. For that reason, Sweden's income distribution may have been unusually dispersed that year.
6. There is an important distinction to be made between the static and dynamic impacts on the income distribution. Figure 1.9 shows the static impacts – *i.e.* assuming no behavioural responses. Cutting the top tax rate would lead to a greater widening of the income distribution than shown in

Figure 1.9 if it encouraged people to work longer hours, for example. However, objecting on social grounds to any widening that comes from these dynamic responses is different to objecting to static (or mechanical) redistributional effects. It would be equivalent to arguing against increasing the "size of the pie", and therefore to the amount of resources that are available for redistribution, that may come from an expansion in work effort.

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ANNEX 1.A1

Taking stock of structural reforms

This table reviews action taken on recommendations from previous *Surveys*. Recommendations that are new in this *Survey* are listed in the relevant chapter.

Recommendations	**Action taken since the previous *Survey* (March 2004)**
LABOUR MARKETS	
Resist reductions in working time.	A sabbatical leave scheme was introduced from 2005, with the condition that the person on leave is replaced by someone who is currently unemployed. This encourages reductions in working hours by those currently employed, although it is not clear whether it will reduce total working hours. The latest round of collective agreements among the social partners included the option to reduce working time.
Lower UI replacement rates to allow the wage structure to adapt to differences in unemployment risk.	No action. The recommendation is rejected by the government as the income replacement principle is central to its approach to social insurance.
Reduce the generosity of part-time unemployment benefits.	No action.
Encourage quicker completion of tertiary education with less generous grants, limiting availability to the normal duration of study programmes, and encouraging higher wage premiums for increased educational attainment.	No action.
Ease employment protection legislation further.	No action. The government rejects this recommendation as it believes EPL currently strikes the right balance between flexibility and job security.
Find ways to limit the damage to third parties from industrial action, using the Öberg report as a starting point.	The National Mediation Office was introduced in 2000. Its main tasks are (*a*) to mediate in labour disputes (compulsory mediation and requests to postpone action are two tools at its disposal); (*b*) promote an efficient wage formation process (by providing guidance and information on negotiations and collective agreements to the social partners); and (*c*) be responsible for wage statistics.
Enforce the Activity Guarantee rigorously, including firm sanctions for non-compliance. Add a time limit to the Activity Guarantee.	Enforcement is being steadily improved, although is still not as strong as it should be.

Taking stock of structural reforms *(cont.)*

Recommendations	Action taken since the previous *Survey* (March 2004)
Significantly reduce the use of ALMPs outside the framework of the Activity Guarantee, and ensure a sizeable overall downscaling. Eliminate poorly performing programmes.	Active labour market programmes have been expanded substantially. However, in the 2005 Spring budget, resources were shifted towards labour market training and job search. Subsidised employment will be shortened from 24 to 18 months, which will allow the number of subsidised jobs to be expanded.
Examine ways of raising employment among low-skilled immigrants, including language, activation and job-search programmes and time-limited wage subsidies.	Ongoing.
SICKNESS INSURANCE	
Improve the incentive structure for sickness benefits by placing more responsibility on employers and employees.	The employers' period for paying sickness benefits has been reduced from three to two weeks, while a 15% employers' co-payment has been introduced for the remainder of the sickness spell. The co-payment ceases if the employee is in rehabilitation or returns to a part-time job. No action on the employee side.
Introduce upper limits to the duration of sickness and UI benefits.	No action.
In sickness insurance, increase the powers of the national agency over local insurance boards and place more emphasis on rehabilitation and returning beneficiaries to the work force.	Local insurance boards are now government agencies rather than independent.
Reduce the effective replacement rate on sickness and disability that arises *inter alia* from housing supplements and payment of pension contributions on top of benefits.	The replacement rate for sickness benefits has been raised from 77.6% to 80%.
TAXATION	
Reduce marginal tax rates as part of a broad package of measures covering the taxation of earned and capital income.	Half of the fourth step of the multi-year programme to provide deductibility for employee social security contributions has been implemented. Further "green" tax shifts have been introduced, involving higher basic allowances for low and middle income earners along with lower social insurance contributions for employers to compensate for higher environmental taxes.
Raise the threshold for the state (central government) income tax rate.	The threshold was increased by less than the normal indexing formula in 2005.
Broaden the tax base by restoring and eventually increasing the property tax level.	No action.
Remove wealth, gift and inheritance taxes or at least raise their thresholds	Gift and inheritance taxes have been eliminated from 2005. The threshold for paying wealth tax has been increased.
Alleviate the effects of double taxation of corporate profits and dividends. Examine ways to minimise potential distortions to the allocation of capital embodied in the tax system. Reduce the corporate tax rate while broadening the base.	A change of the 3:12 rules reduced taxes applying to closely-held companies in 2004, and further measures are envisaged for 2006, implying a (long-run) tax relief of SEK 1 billion.
Simplify the basic allowance by making it the same for all income ranges or replacing it with a tax credit or an initial zero tax bracket.	No action.
Raise the effective rate of VAT to make room for greater income tax cuts.	No action, although a public commission on VAT will present a report in 2005.
Reduce the adverse effects on marginal effective tax rates arising from the housing allowances for young people and families with young children.	No action.
FISCAL FRAMEWORK	
Strengthen the expenditure ceilings by operating the ceiling for operational and non-entitlement transfers as a hard budget constraint on a three-year ahead basis, and building in an explicit safety margin on a separate ceiling on entitlement spending.	No action.
Rebalance the budget envelopes, and bolster the incentives for prioritising expenditures within and between expenditure areas.	No action.
Reduce the pro-cyclical effects of the balanced-budget requirement for local governments by shifting part of their tax base to property or by making counter-cyclical adjustments to state grants.	No action.
Strengthen the accountability of the state agencies and ensure that they have clear and measurable performance targets to achieve.	No action.

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Taking stock of structural reforms *(cont.)*

Recommendations	Action taken since the previous *Survey* (March 2004)
PUBLIC-SECTOR EFFICIENCY	
Identify and pursue cost-effective ways of improving the performance of the education system, particularly in mathematics and science.	No action.
Look at ways of truncating the years spent in school by raising the number of hours spent in instruction each year towards international averages, and re-examining the balance between instruction time and after-school care.	No action.
Develop better indicators of school performance in order to increase transparency and to help identify the factors that influence outcomes.	No action.
Strengthen the voucher element, and institute a system of tuition fees in tertiary education, allowing institutions to offer whatever courses and places they wish, while encouraging students to complete their studies more quickly.	No action.
COMPETITION	
Strengthen the Competition Authority's capacity to combat hard-core cartels and other serious breaches of competition law.	No action.
Improve the leniency system by providing for substantial, non-criminal sanctions on individuals	In December 2004 a committee presented a proposal for criminalising infringements against competition law. The proposal has been circulated for comments.
Streamline the process and reduce the time for competition cases to be dealt with. Reconsider the need for two separate judicial reviews of the rulings of the Competition Authority.	A Commission is looking into this and is due to report by July 2005.
Strengthen the legal framework governing market activities of municipalities and other public institutions, bringing them within the scope of the Competition Act and providing greater opportunity for competitors to seek redress. Rationalise the present supervisory structure for public procurement into a single agency with scope to impose sanctions, and ensure that tenders from internal and external suppliers are treated equally. Increase outsourcing of public services. Specify clearly in government's mandates to the agencies what are their core activities and place limits on expansions in other directions.	No action.
Reduce state ownership, with emphasis on separating natural monopolies from competitive activities.	No action.
Continue efforts to dilute incumbent power in electricity. Make further investments in Nordic transmission infrastructure to reduce bottlenecks and prevent market power.	No action.
Expose all the activities of the state-owned passenger rail company to competition and require it to operate under a hard budget constraint with no prospects of further government capital injections to bail it out.	No action.
Allow owners to charge market rents for new housing, and progressively strengthen municipalities' incentives to supply suitable land sites for housing construction, for example through instituting a municipal property tax.	In September 2004 a committee recommended changes to rules determining residential rents with the purpose of encouraging new rental units. The report has been circulated for comments and the government intends to act on the proposal.
Resolve the outstanding obstacles to implementing the EU directive for building materials, and encourage municipalities to facilitate competition in construction.	In mid-2005, a Commission will present a report on planning and construction legislation.
Modify the planning process to require that the benefits of increased competition be explicitly taken into account when local authorities decide on application for supermarket sites.	No action.
Consider alternative regulatory mechanisms that would allow the introduction of competition in alcohol retailing without sacrificing control over access to liquor.	No action.
INNOVATION AND ENTREPRENEURSHIP	
Strengthen incentives to commercialise publicly-funded research by sharing intellectual property rights between the researcher and the institution. Develop the supporting organisational structure and expertise to effectively commercialise research.	A committee will present a report on this matter in the first half of 2005.

Taking stock of structural reforms *(cont.)*

Recommendations	Action taken since the previous *Survey* (March 2004)
Remove the quantitative restrictions on venture capital investments by institutional investors including private pension funds.	No action.
PROMOTING ENVIRONMENTALLY SUSTAINABLE GROWTH	
Ensure that rigorous cost-benefit analysis is systematically used to evaluate environmental policy options.	No action.
Reinforce the economic incentive to install NO_x abatement equipment on Baltic shipping by raising fairway dues on those ships operating without the equipment.	No action.
Restructure energy and carbon taxes so that marginal abatement costs are equalised across the economy while taking appropriate measures to address competitiveness concerns.	No action.
Consider using a domestic cap-and-trade approach to meeting Kyoto targets. Use the market mechanisms under the Kyoto Protocol to meet targets in the most cost-effective manner.	The EU-wide emissions trading system has been introduced from 2005.
Examine carefully the policies to promote renewable energy sources to ensure that they do not overstep the mark and become *de facto* industrial policy. Allow market signals to play a greater role in determining the appropriate mix of energy supply. Build sunset clauses into research and development projects.	No action.
Ensure that the competition drawbacks of encouraging a switch from individual to district heating are fully addressed.	No action.
Align energy taxes with energy content, and apply uniformly across all energy consumers.	As part of the continued green tax shift, the energy tax system is under review.
Examine the merits of either adopting a minerals accounting approach and taxing nitrogen losses (*i.e.* residual balances) to provide an economic incentive to reduce the damage from agriculture or shifting to an environmental-outcomes-incentive charge for farmers. Exploit the possibilities allowed in the reforms of the Common Agricultural Policy of shifting agricultural support to those measures that would reduce the environmental externalities.	No action.
Reconsider the emphasis placed on recycling, using cost-benefit analysis.	No action.
Consider moving to a weight-based waste collection system. The prohibitions on landfill should be reconsidered.	Gradually taking place at the municipal level.

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Chapter 2

Strengthening public finances

This chapter discusses the outlook for public finances given the pressures that will arise from the ageing of the population and the forces of globalisation. It looks at how public finances measure up against the government's 2% surplus target and discusses what is needed to ensure that the current welfare system will be financially sustainable in the future. The key conclusion is that reaching the 2% target over the next few years will go a long way towards making the welfare system sustainable. But getting there requires some fiscal consolidation, and for the welfare system to be fully sustainable, additional measures are required. It would be best to bring about the necessary improvement of public finances through spending restraint and measures that boost employment and/or deliver better value for money from public services. The chapter also discusses what may look like an easy option – raising tax rates – but which may be costly and perhaps even counter-productive in the long term, because of the adverse impact on labour supply.

Public finances in Sweden are in good shape when compared with most other OECD countries. The general government is running a surplus and financial assets exceed financial liabilities. The main challenge therefore lies ahead, when the ageing population will bring about a substantial rise in public expenditure. Sweden is already well prepared in comparison to many other OECD countries, because the 1999 reform of the pension system means that the bulk of future increases in old-age pension payments will be financed by a build-up in assets over the next couple of decades. The public expenditure issues related to ageing are therefore concentrated on the rising demand for health and elderly care. Public finances are also being squeezed from the revenue side. The income tax base is coming under pressure from within as high taxes on earnings are driving down labour supply and encouraging people to operate in the "informal economy" instead. Tighter integration within the EU and globalisation more broadly are adding to the difficulty of maintaining high tax rates.

Preparing for the demographic pressures by reducing debt was one of the main reasons for introducing the 2% surplus target for the general government in 1997. While the importance of meeting this target is recognised by the government, follow-through has not been quite adequate. Instead, fiscal policy in recent years has focussed more on short-term business-cycle management and reversing some of the tax increases and expenditure cuts that were implemented during the budget consolidation phase in the 1990s. As a result, on current projections the surplus is likely to remain well below the target. Now that the cyclical position is becoming more satisfactory, getting back on a sustainable course should be the main fiscal priority.

Strengthening of public finances is needed to make the welfare state sustainable

The ageing of the population will lead to a substantial deterioration of public finances in the longer term. This is a natural consequence of a social model in which a wide range of publicly provided income insurance schemes, education, and health and elderly care are largely financed by taxes with little by way of individual user payments. As fewer people will pay while more will receive, a financing gap will gradually emerge. Exactly how big this gap will eventually become is a matter of great uncertainty. Calculations reaching far into the future obviously depend significantly on the underlying assumptions. Demographic projections, for instance, are particularly sensitive to net immigration, which has fluctuated a great deal in Sweden. Changes in longevity can also have large effects, as the elderly are the main recipients of publicly-provided social services. The impact in this case will depend on whether increased longevity reflects more healthy years or medical advances that make it possible to keep people alive despite serious and costly health problems. Evolving labour market behaviour is another area of uncertainty. For example, is it sensible to assume that trend declines of participation rates and annual hours worked by those at work will continue? Another question is whether projections should include an

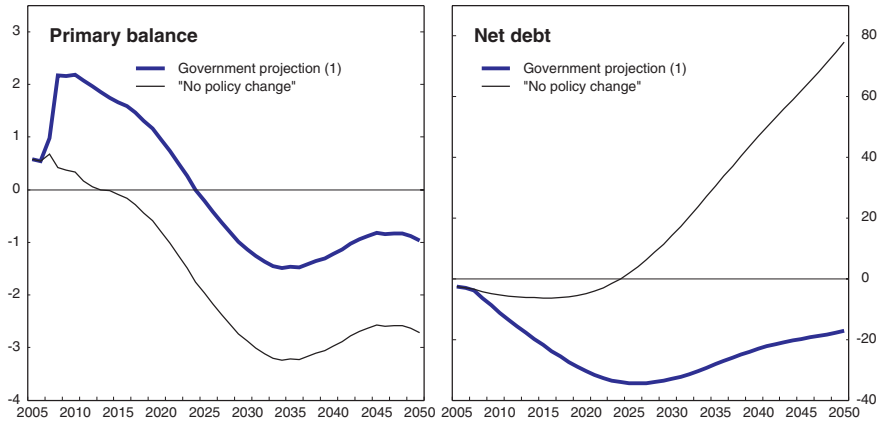
enhancement of service standards, which is likely to be demanded as productivity growth drives up real household incomes.

The basic benchmark is a "no policy change" scenario, in which current labour market behaviour and existing standards in the welfare system are extrapolated. In such a scenario, public primary expenditure is projected to increase by 4½ percentage points of GDP between 2005 and 2050. Higher spending on health and elderly care accounts for the bulk of this increase. The rise in spending is partly offset by higher tax revenues because tax bases will also increase in proportion to GDP as pensions are paid out and spent on consumption. Despite that, the general government primary surplus is projected to drop by 3¼ percentage points of GDP over the next four decades or so, leading to a substantial increase in net debt (Figure 2.1).

The government has an alternative scenario that makes a number of favourable assumptions about labour market behaviour and about tax revenues. This scenario is not a forecast as such, but is designed to show what would be needed to shore up public finances in the period before the big expenditure pressures set in. *First*, it assumes a substantial improvement of the primary balance from 2008, so that the 2% target is continuously met until 2015. *Second*, it assumes a gradual improvement in the integration of immigrants in the labour market.[1] *Third*, it includes a structural improvement in public finances of ¼ percentage point of GDP in 2007 because various spending programmes in the central government budget have only temporary financing, and it is assumed that they are not prolonged. Altogether, these three assumptions boost the general government primary balance by around 1¾ percentage points of GDP compared to the "no policy change" scenario described earlier (Figure 2.1). That allows a gradual strengthening of the current net asset position, so that net interest receipts can cover most of the primary deficits in the future. The result is that the general government remains in a comfortable net asset position right through mid-century.

Figure 2.1. **Population ageing will depress public finances**

General government, per cent of GDP



1. The government's projections were presented in the 2004 Convergence Programme submitted to the EU.

Source: Ministry of Finance; OECD calculations.

Table 2.1. **The fiscal gap is sizeable**[1]

	Per cent of GDP
"No policy change" scenario	–2.2
– effect of raising tax rates in 2008-2015	1.2
– effect of assuming automatic expenditure cuts in 2007	0.3
– effect of assuming improvement in labour market integration of immigrants	0.2
Government scenario	–0.5
"No policy change" scenario, without increasing longevity leading to more healthy years[2]	–2.9
"No policy change" scenario, with public consumption growing ½ percentage point more per year	–5.9

Note: These calculations are based on the long-term projections presented in Ministry of Finance (2004), *Update of Sweden's Convergence Programme*, November. Some marginal adjustments have been made to create a "no policy change" scenario. In addition, two alternatives to the "no policy change" scenario have been made to illustrate the sensitivity of the estimate of the fiscal gap with regard to assumptions on expenditure growth.

1. The fiscal gap indicates to what extent public finances deviate from fiscal sustainability. A negative number means that a permanent improvement of general government net lending of the indicated size is required relative to the projected value of ¾ per cent of GDP in 2005.
2. *I.e.* it is assumed that the increase in longevity does not just push the demand for elderly care to later ages.

Source: OECD calculations.

In the "no policy change" scenario, public finances are on an unsustainable trajectory in the sense that the debt ratio rises sharply over time. More precisely, it implies the government does not currently satisfy its inter-temporal budget constraint (which states that today's net debt cannot exceed the present value of future primary surpluses). The fiscal gap, *i.e.* the required improvement of public finances in order for the inter-temporal budget constraint to be met, is estimated to be 2¼ per cent of GDP (Table 2.1). The general government would therefore need to be running a surplus of around 3% of GDP this year in order to be on this sustainable path. This type of calculation is a fairly mechanical and simplistic way of assessing where fiscal settings need to be, but it points to three clear conclusions. *First*, a substantial improvement in public finances is necessary. The government needs at least to achieve its 2% surplus target rather than the ¾ per cent of GDP projected over the next year or two. *Second*, it needs to consider the costs of delaying fiscal consolidation: the longer the delay, the higher the bar is raised. The next ten years provide a window of opportunity before the baby boomers retire; it is likely to be easier to improve public finances while this cohort is still at work. There is also an issue of equity across generations, because any substantial delay in fiscal consolidation will push more of the adjustment burden onto future generations. Hence, this *Survey* reiterates the message from the previous two *Surveys*: the 2% surplus target should be achieved sooner rather than later. Finally, the likelihood that even 2% is not quite ambitious enough to ensure full sustainability in a technical sense implies the need to supplement it with measures to further lift labour supply and improve public sector efficiency. The more that is done in these areas, the lower the probability that there may need to be cutbacks in public service standards at the margin in the future.

Changing key assumptions alters the estimated fiscal gap but is unlikely to eliminate it

Although estimates of the fiscal gap can be sensitive to changes in the underlying assumptions, the overall finding – that public finances need to be strengthened for the welfare state to be sustainable – is fairly robust. For instance, one of the basic parameters when estimating the fiscal gap is the nominal interest rate (on government bonds) used to

calculate the present value of future primary balances. It is assumed to be 5¼ per cent[2] in the calculations presented in Table 2.1; lowering it by 1 percentage point raises the fiscal gap by 0.4 percentage point of GDP and *vice versa*.

A number of other assumptions pull in opposite directions. In the projections, half the increase in longevity is in additional healthy years, so that demand for elderly care is partly pushed to later ages. This obviously dampens public expenditure pressure. If instead the increase in longevity is assumed not to lead to more healthy years, the fiscal gap would be nearly 3% of GDP in the "no policy change" scenario (Table 2.1). On the other hand, annual hours worked per worker are set to fall by 0.2% per year throughout the projection period as households take out part of the welfare improvement arising from income growth in the form of extra leisure. That lowers tax revenues substantially in the long run and increases the fiscal gap compared to a scenario where working hours per employed are kept unchanged.[3]

The demand for public services could well expand more rapidly

Thus far, the projections have been based on an assumption of unchanged public service standards. This implies that the number of service hours per elderly person in the care sector and the take-up rate of each cohort remain the same. This is, however, an optimistic assumption compared to past trends (see Chapter 1) and is likely to lead to an underestimation of the real pressure on public finance in the future. In the projections, per capita private consumption grows by 2% per annum, while real public consumption is flat, given the assumption of zero productivity growth in production of welfare services. That is unlikely to satisfy an ever richer population. If the volume of tax-financed consumption of such services were to grow in line with that of privately-produced goods, public service expenditures would increase much faster. The potential impact on fiscal sustainability is huge: assuming just ½ percentage point higher growth in public consumption per annum in the "no policy change" scenario increases the fiscal gap to almost 6% of GDP.

Fiscal easing has pushed public finances off a sustainable course

Although Sweden still has a surplus in general government net lending, as one among a minority of OECD countries, the last five years have witnessed a sharp worsening of the fiscal position, which has brought the surplus well below the 2% target. Following an impressive (and admittedly one-off) surplus of 5% of GDP in 2000, the fiscal balance dipped slightly into deficit in 2002 and 2003, before rebounding into positive territory last year (Table 2.2). While cyclical swings and higher sickness costs explain a large part of this pattern, tax cuts, higher benefit levels and higher service standards in the welfare system lie behind much of the reduction in the surplus. Most of this easing has been by the central government, although its actions have partly been aimed at covering local government financing gaps. Over the six-year period to 2004, discretionary fiscal decisions by central government have contributed to reducing the general government fiscal balance by over 1% of GDP per annum on average. That is of a similar magnitude to the consolidation measures introduced in the period 1995-98. Spending increases at the local level also contributed to the reduction of general government net lending from 2000 to 2002, while subsequent tax hikes and spending cuts – as local governments struggled to meet their balanced-budget requirements – have helped strengthen general government finances in the last couple of years.

Table 2.2. **Discretionary fiscal policy has contributed to the deterioration of the fiscal balance**

Per cent of GDP

	1998	1999	2000	2001	2002	2003	2004	2005[1]	2006[1]
General government net lending	1.9	2.3	5.0	2.6	–0.5	-0.1	1.1	0.8	0.8
of which:									
Central government	0.5	4.2	2.6	7.4	–1.9	–1.7	–0.8	–	–
Local government sector	0.2	0.1	0.2	–0.2	–0.5	–0.3	0.1	–	–
Pension system	1.3	–2.0	2.2	–4.6	1.9	1.9	1.9	–	–
Discretionary central government fiscal policy[2]	0.2	–0.9	–1.1	–1.7	–1.8	–0.5	–0.4	–1.2	–0.3

Note: Large transfers to the central government made net lending in the pension system negative in 1999 and 2001.
1. OECD projections.
2. Contribution to change in net lending; Ministry of Finance estimates.

Source: Statistics Sweden; Ministry of Finance; *OECD Economic Outlook* 77 database.

The easing at the central government level has been motivated partly by policies to promote labour supply – by reducing marginal taxes – and by a wish to bring welfare provisions back to what they were before the cuts during the 1990s. Following the slowdown in 2001-02, it has also had a substantial short-term stabilisation component, even though the country's powerful automatic stabilisers (Girouard and André, 2005) would already have done most of the job. The "temporary employment subsidy" to local governments (tax revenue transferred from the central government since 2002) is one such example. It has allowed counties and municipalities to maintain and even expand employment at a time when falling tax revenues (as a share of GDP) would otherwise have induced spending restraint. The 2005 budget used similar measures for stabilisation purposes, including a prolongation of the "temporary employment subsidy" to 2005 and 2006 and expanding it by around ¼ per cent of GDP in both years. In general, discretionary counter-cyclical policies should be avoided, especially in a country where the automatic stabilisers are so strong. But if they are pursued, temporary stabilisation should not be engineered through permanent expenditure measures (such as funds that ensure higher employment or higher service standards by local governments).

The 2005 budget also introduced additional tax cuts of 0.3 percentage point of GDP (including further tax credits for pension contributions, abolition of inheritance and gift taxes, and a higher threshold for paying the wealth tax). While these tax cuts should remove some distortions from the economy and are in line with previous OECD recommendations, the timing was not ideal and the fiscal room for *unfunded* tax cuts was lacking: if the 2% surplus target is to be achieved, tax reductions need to be matched by cuts in lower-priority expenditures. Overall, the 2005 budget measures are estimated to have weakened projected central government finances by ¾ – 1 percentage point of GDP in the years 2005-07, leaving the expected budget surplus at around ¾ per cent of GDP. That suggests that there is still too much focus on short-term issues at a time when growth is picking up and is probably sufficient to bring about an improvement in the labour market.

The fiscal framework is under strain

The recent developments in public finances point to an increased strain on Sweden's fiscal framework. It was introduced in the wake of the budgetary crisis in the early 1990s and consists of three pillars: multi-year nominal expenditure ceilings for central

government (from 1997); a balanced-budget requirement for local governments (from 2000); and the 2% surplus target for the general government (from 1997). These rules have undoubtedly been instrumental in making Sweden one of the OECD countries with the most enviable public finance positions. But while compliance with the rules was facilitated by the favourable business cycle until 2000, the subsequent downturn pointed to some weaknesses. The main problem is that the framework was not able to induce adequate spending restraint in good times, a phenomenon observed in many other OECD countries in the latter part of the 1990s.

The central government expenditure ceilings have been quite successful at reining in expenditure. They have not yet been breached, at least in a technical sense, because there is still a strong political commitment to complying with them. However, the margins under the ceilings have consistently been eroded. In principle, these margins should provide adequate room for expenditure surprises and for automatic stabilisers to work. Instead, they have to a large extent been used for discretionary spending; initial margins of around ¼-1% of GDP three years ahead have usually vanished by the time that year came around (Table 2.3). Furthermore, observance of the targets has in several instances been achieved through tax expenditures of various kinds (see previous *Survey*). With the Budget Bill for 2005, there is once again practically no margin under the stated ceilings (for 2007, only an indicative ceiling was shown in the budget because the government is waiting for more robust estimates of potential GDP to serve as an anchor for the ceiling; a ceiling for 2007 should be set in the 2006 Budget Bill). There are no specific rules on how the expenditure ceilings should be set, but implicitly the government has been targeting a constant share of potential GDP since 2000. That is not quite ambitious enough to provide the required backup for the 2% surplus target.

The balanced-budget requirement for local governments has not been able to impose sufficient restraint on spending increases either. The requirement implies that deficits have to be countered by surpluses within the next two years (three years as from 2005). But there are no rules as to how to deal with expenditure savings or extraordinary revenue during a cyclical upturn. Consequently, local governments raised spending in the years around the millennium when the economy boomed. When the downturn hit, the choice was to cut back spending or raise taxes. Higher taxation has been the most common response, although substantial spending cuts have also been made by some local governments during the last couple of years. The pro-cyclical behaviour induced by the system has also been spurred by cyclical sensitivity of local governments' only tax base, household income. Spending restraint in good years may also be difficult if the central government is known to stand ready with support when there is a threat that local service standards could be reduced. Indeed, to avoid further tax increases or cuts in local service standards the government has substantially increased its grants to counties and municipalities for the next couple of years (Figure 2.2). This has improved the outlook for local government finances compared to the last *Survey*, although at the expense of a weaker central government budget position.

The 2% surplus target was the one objective that had to give when spending eagerness and cyclical downturn clashed. The main purpose of the target is to provide a substantial reduction in public debt in preparation for the future expenditure pressures arising from the ageing population and to make sure there is room both for automatic stabilisers to work and for a substantial margin for discretionary counter-cyclical fiscal policy. In order to allow for short-term deviations, the target applies "over the business cycle". While that should provide

Table 2.3. **Margins under the ceilings have been steadily eroded and tax expenditures increased**

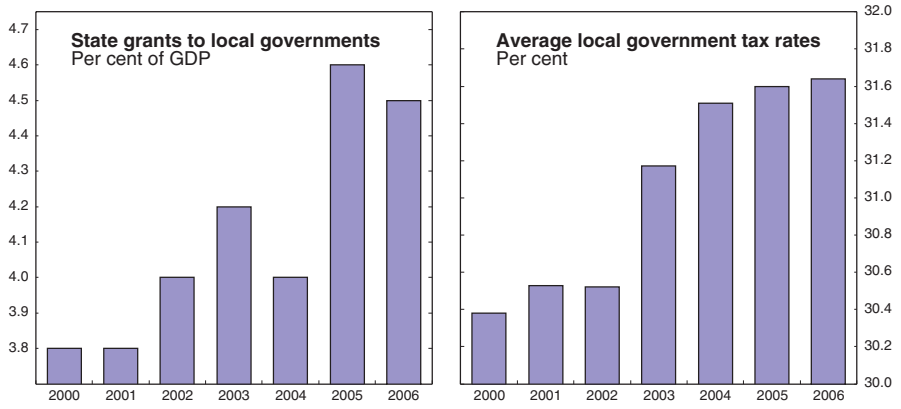
Per cent of GDP

	1997	1998	1999	2000	2001	2002	2003	2004	2005[1]	2006[1]	2007[1]
Expenditure ceiling[1]	36.2	34.3	33.8	32.8	32.9	32.9	32.9	32.9	32.7	32.4	32.2
Actual expenditures[1]	34.9	34.2	33.8	32.6	32.7	32.8	32.8	32.8	32.6	32.4	31.9
Ex post margin	1.3	0.1	0.1	0.2	0.2	0.0	0.1	0.1	0.0	0.1	0.4
Tax expenditures outside the ceilings[2]	–	–	–	–	0.1	0.2	0.3	0.4	0.5	0.4	0.1
Planned contingency margins in Budget Bill for:											
1999	1.3	0.1	0.2	0.3	0.9						
2000		0.1	0.0	0.1	0.2	1.0					
2001			0.1	0.0	0.1	0.4	0.7				
2002					0.1	0.1	0.1	0.3			
2003						0.0	0.0	0.0	–		
2004						0.0	0.0	0.0	0.5	1.0	
2005							0.1	0.0	0.0	0.1	0.3[3]

1. For reasons of comparability across years, the expenditure ceilings are harmonised to take into account technical adjustments. Numbers for actual expenditures and tax expenditures outside the ceilings are Ministry of Finance estimates.
2. These figures show tax expenditures that are close substitutes to ordinary expenditure (where financing is provided by crediting the tax accounts of those providing for the expenditure). Total tax expenditures amount to around 8% of GDP.
3. Indicative level not based on proposed ceiling (Budget Bill 2005).

Source: Fischer, Jonas (2005), "Swedish Budget Rules: Praise from Brussels, Pressure at Home", *ECFIN Country Focus*, Vol. 2, Issue 4; Ministry of Finance; OECD calculations.

Figure 2.2. **Higher state grants may hold back tax hikes by local governments this year and next**



Note: State grants exclude VAT and are corrected for adjustments related to changes in regulations made by the central government.

Source: Ministry of Finance; Statistics Sweden, *www.scb.se*; Landstingsförbundet and Svenska Kommunförbundet (2004), *Kommunernas och landstingens ekonomiska läge*, November 2004, Stockholm.

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Table 2.4. **General government finances are falling short of the surplus target**

Per cent of GDP

	2000	2001	2002	2003	2004	2005	2006	Average 2000-06	Average 2001-06
General government net lending									
OECD	5.0	2.6	–0.5	–0.1	1.1	0.8	0.8	1.4	0.8
Ministry of Finance	5.0	2.6	–0.5	–0.1	1.1	0.7	0.6	1.3	0.7
National Institute of Economic Research	5.0	2.6	–0.5	–0.1	1.1	0.3	0.4	1.3	0.6
Cyclically-adjusted general government net lending									
OECD	3.9	2.6	0.0	1.0	1.9	1.2	0.6	1.6	1.2
Ministry of Finance	3.9	2.9	0.2	0.8	1.8	0.9	0.7	1.6	1.2
National Institute of Economic Research	3.5	2.6	0.0	0.4	1.8	0.9	0.6	1.4	1.1

Source: Ministry of Finance; National Institute of Economic Research (2005), *The Swedish Economy – March 2005*, Stockholm; *OECD Economic Outlook 77* database.

enough flexibility to prevent pro-cyclical adjustments to public finances, it also leaves open to a range of interpretations what constitutes a business cycle and what size of discretionary measures are acceptable. Using the average surplus for the period 2000-06 as a yardstick, on either OECD, Ministry of Finance or National Institute of Economic Research projections for 2005-06, the government is falling short of the target by around 2/3 percentage point of GDP (Table 2.4). An alternative way of monitoring compliance is to look at the structural surplus. Such estimates are of course sensitive to the methods applied, including those used to calculate the output gap. It can, in particular, be difficult to capture large swings in capital and corporate tax revenues. Nevertheless, the divergence from the target is even larger if one looks at the estimated structural surpluses for this year and the next.

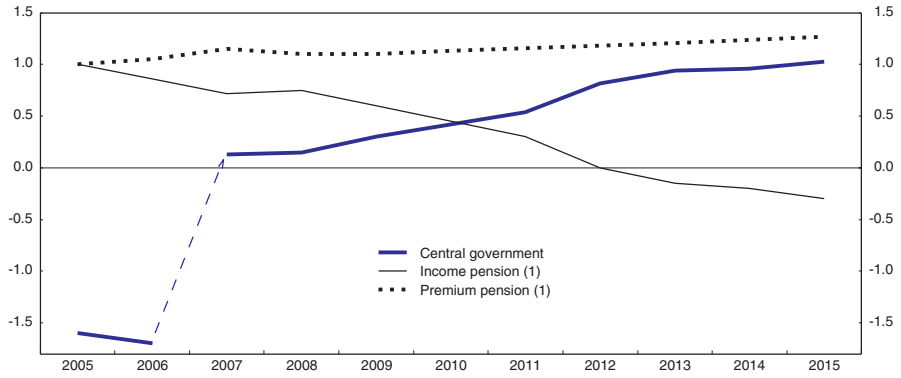
The surplus target is neither set for a specific period nor linked to a debt target at some future time. But, as noted above, in the government's long-term projections it is assumed to be in place until 2015. During that period, the surplus in the pension system is projected to fall gradually from 2% to 1% of GDP. Since the balanced-budget requirement should ensure that net lending by local governments remains close to zero, this implicitly translates into a requirement that central government finances improve by 2½ percentage points of GDP between now and 2015 (Figure 2.3).

While the framework is working reasonably well by international and historical standards, some modifications may make it a more useful tool for fiscal control. A number of possible improvements were discussed in detail in the in-depth chapter on public expenditure in the 2002 *Survey*. Options include, for instance:

- *Central government expenditure ceilings:* First of all, tax expenditures should not be used to circumvent the ceilings. Second, an explicit link between the ceilings and the surplus target should be made so that it is possible to monitor directly whether the former are ambitious enough to achieve the latter. Finally, a specific cyclical margin could be introduced, as is currently being considered by the government. To be effective it should be ring-fenced from everything except business-cycle-related spending changes. A more complicated alternative, which is designed to achieve a similar outcome, would be to set a separate ceiling for operating expenses and non-entitlement transfers, and another one for

Figure 2.3. **Reaching the 2% surplus target will require a substantial improvement of central government finances**

Net lending of government sectors, per cent of GDP



Note: Local governments are assumed to observe the balanced-budget requirement.

1. The public old-age pension consists of a funded part, the premium pension, and a pay-as-you-go part, the income pension.

Source: Ministry of Finance; OECD.

entitlement expenditures that includes an adequate margin – which cannot be transferred to non-entitlement expenditures – for dealing with business cycle fluctuations.

- *Local government finances:* Reforming the balanced-budget requirement so that local governments' tax bases are calculated as the average taxable income over a number of years (see Chapter 5). That would restrain expenditure-boosting in a year with extraordinary amounts of revenue. The risk of pro-cyclical effects could also be dampened by counter-cyclical adjustments of central government grants. Another option would be to give local governments access to more stable tax bases, such as property taxes.
- *Surplus target:* The surplus target could be augmented with a debt target to reduce the chances of slippage from year to year. Another possibility would be to set the target on the basis of cyclically-adjusted net lending, although such targets have their own problems (Joumard *et al.*, 2004), and for central government only as local governments already have to balance their budgets and the pension system is fully self-contained.

To what extent is pre-saving an appropriate strategy?

Adhering to the 2% surplus target would bring public finances a long way towards fiscal sustainability. Over and above that, the government should evaluate to what extent pre-saving is an appropriate strategy for dealing with pressures arising from ageing and further demand for higher public services standards. While it is prudent to maintain surpluses and reduce debt in the period before the ageing pressures begin to mount, the permanent nature of the demographic changes in Sweden suggests that measures should also be sought that reduce future expenditure pressures and provide a reasonable division of the fiscal burdens across generations. The reform of the pension system has already made public finances more robust to demographic changes and goes a long way to ensuring inter-generational equity (see previous *Survey*).

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As noted, the main public expenditure issues related to ageing are health and elderly care. Here, the government should focus on better linking the contributions made by generations and individuals over their lifetimes with the benefits they receive from the welfare system. If it focuses solely on pre-saving in the period before ageing pressures set in, so that net asset returns can cover future increases in health and elderly costs, current generations may end up saving more than might be fair from an inter-generational equity perspective. It may not be reasonable to have current generations finance expenditure increases that arise because future generations live longer or demand higher service levels than today. But they should of course help finance their own current and future demand for public services, including expected expansions of service standards. This applies in particular in health care, where it will be practically impossible to refuse people care or make them pay more than a symbolic user charge. Some alternative ways of financing health and elderly care in the future are discussed in Chapter 5.

What tools are available to improve public finances?

What then can be done in response to the public finance pressures? The short answer is that Swedes must either work more, pay more taxes, improve efficiency in publicly-funded services or narrow the scope of the welfare state – or some combination thereof. Given the strong attachment to the welfare system, it is unlikely that they will accept significant adjustments of public services and social insurance as one of the first directions to pursue. This is the option of last resort, reserved for crises such as the one in the early 1990s. Tax increases have been discussed recently, but the question is whether that is a sensible strategy for the future. Striving towards more efficient publicly-financed services is appealing, but not easy to achieve without rethinking what should be provided by the public sector itself and possibly moving towards larger units at the lower levels of government. Getting people to work more is clearly a priority, but it is difficult given the disincentives built into the tax and benefit systems.

Raising taxes could be costly and perhaps even ineffective in the long term

All taxes involve a cost to the extent that they distort the behaviour of households and firms. This gives rise to an efficiency loss. One of the most important distortions in practice is the impact on labour supply that comes from driving a wedge between the labour cost paid by employers and the after-tax income received by the worker. Both average and marginal tax rates influence labour supply. Simplifying a little, the average rate affects whether the person will participate at all in the labour market (or perhaps emigrate), while the marginal rate influences the average number of hours worked. The question is: how large are these distortions in practice? The concept of the marginal cost of public funds (MCPF), or excess burden, tries to capture the indirect costs of raising additional tax revenue in terms of the distortions in behaviour that it induces. In general, the distortionary costs are larger when the tax base is more sensitive (*i.e.* when it is easier for people to change their behaviour), and they increase with higher tax rates; in fact, the MCPF is approximately proportional to the square of the tax rate, so raising taxes from 50 to 55% of GDP is significantly more costly than going from 30 to 35% of GDP. For Sweden, one prominent study found that the MCPF was around 1.5 by the end of the 1980s, *i.e.* for each *krona* of extra revenue the indirect costs were 0.5 *krona*, but that the 1990 tax reform lowered that number to around 1.2 (Agell *et al.*, 1995). These estimates are lower than in some earlier studies,[4] reflecting both the effects of tax reforms and a lower assumed

elasticity of hours worked (an uncompensated wage elasticity of only 0.1).[5] However, tax rates have been raised since the early 1990s, and there are several other reasons to suspect that the MCPF today is larger than indicated by these estimates:

- The impact of income taxes on labour supply is particularly uncertain, especially the effect on average hours worked per employee. Most of the international academic evidence finds that the impact of income taxes on working hours is fairly low. However, the majority of studies look at individual countries over time and are therefore unlikely to be particularly powerful (Box 2.1). The impact of taxes on labour supply seems more obvious when comparing across countries.
- Most Swedish studies of the MCPF have used hours elasticities derived from estimates of the labour supply response of people already working. A more recent study (Kleven and Kreiner, 2003) attempts to capture labour supply effects on both participation and hours and finds that the MCPF is substantial when both effects are taken into account. For instance, a proportional increase of tax rates in Sweden would involve an efficiency loss of 1.30 *krona* for each *krona* raised in revenue, assuming participation and hours elasticities of 0.2 and 0.1, respectively (even though the hours elasticity here is smaller than suggested by the cross-country evidence). This places it near the top quartile of OECD countries (Table 2.5). Raising revenue through progressive taxes is about three times as costly as from proportional or flat taxes, so the additional cost from more progressivity in the tax system needs to be traded off against whatever social benefits it has in terms of a more equal income distribution (see Figure 1.9).
- Over time, globalisation is making tax bases more sensitive to tax rate changes. This is certainly the case for capital taxes and some indirect taxes, for instance on alcohol, but individuals may also become keener on moving abroad for better-paying jobs.
- Labour demand shifts may amplify the negative effect of taxes on labour. In a cross-country study, Davis and Henrekson (2004) find that such taxes shift demand away from sectors that use less skilled workers intensively; as market work by such workers is more responsive to labour demand shifts, the negative effect of taxes is increased.
- The negative effects on the intensity of work effort, education incentives and job mobility are not taken into account. Also, the elasticity of *taxable income* to a change in tax rates can be higher than the elasticity of *labour supply*, because people can alter the way they are compensated (*e.g.* more fringe benefits or tax-favoured pension contributions) and change their consumption/saving behaviour (Hansson, 2004).

Overall, there are likely to be significant costs associated with raising tax rates further. While calculations of the MCPF are highly sensitive to the applied elasticities, even fairly conservative assumptions generate non-trivial estimates. Sweden already has the highest taxation as a share of GDP across the OECD, and since 90% of the incidence of taxes eventually falls on labour (Lundgren *et al.*, 2005), raising tax rates is likely to lead to a substantial distortion of the labour/leisure decision. However, whether it is efficient to raise additional tax revenue is a matter of the benefits associated with the public expenditures that are to be financed. In economic terms, the marginal cost of raising the revenue, *i.e.* the MCPF, needs to be evaluated against the marginal utility derived from public spending. Chances are that the demographic pressure for more health and elderly care will push up marginal utility of these services, but the MCPF may increase as well.

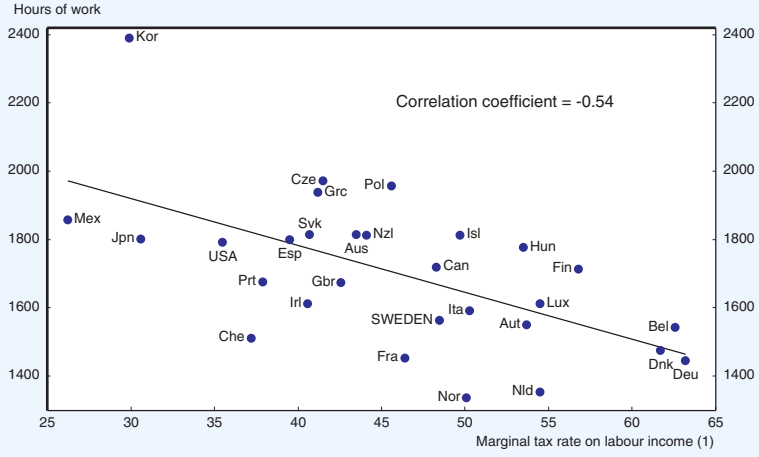
This suggests that tax increases should not be used to try to close the financing gap. Rather, there are good reasons to re-evaluate which services should be financed by the

Box 2.1. **Income taxes and working time**

In theory, high income taxes can be expected to reduce the participation rate and average hours of work by distorting the labour-leisure choice. The question is, how large are these effects in reality? This box discusses the second effect, the impact on average working hours. Swedish studies have tended to give results that are similar to research in other countries, finding elasticities around –0.1 to –0.2 for men, and –0.1 to –0.5 for women. However, there are several reasons for suspecting that estimates from single-country studies may be biased downwards. *First*, the econometric power of a single-country study on aggregate time series data is probably quite low. A time series analysis would involve regressing a highly-trended variable (hours per person) on several other highly trended variables. It is very hard to disentangle the effects of each of these long-term trends. In contrast, there is more variation between countries, so a cross-country or panel analysis should have greater power. *Second*, event studies using within-country panel data, which look at how individuals respond to an identifiable policy change such as a tax cut, may under-estimate the elasticity because the time span is usually not long enough for the full effects to be felt (it will take many years before people have fully adjusted their behaviour). *Third*, studies of behaviour in the past may not be a reliable guide to current conditions. Elasticities may well have been lower in a collective bargaining framework (because it would reflect the elasticity of the median union member, rather than the marginal member), and so they may have increased now that decentralised bargaining has become more common. In addition, various flexible pay schemes have been agreed on some parts of the Swedish labour market, allowing individual employees to choose freely between wage, pension contributions and time off (see Chapter 4).

The link between hours of work and taxes may be easier to see when looking across countries. Simple correlation analysis suggests that countries with higher taxes on labour tend to have lower average working hours (Figure 2.4) and fewer people working long hours (40 hours or more). Countries with higher income taxes have also had the steepest declines in working time over recent decades, although the simple correlation here is weaker (around –0.25 for the countries shown in Figure 2.4).

Figure 2.4. **High taxes reduce hours of work**



1. Marginal income tax rate plus employee contributions and indirect taxes, single person with no children earning the average wage.

Source: OECD, *Taxing Wages 2003/2004*; Estimates based on European Labour Force Survey. See *OECD Employment Outlook* (2004) for further details.

Box 2.1. **Income taxes and working time** *(cont.)*

The scatter-plot is interesting, but a more detailed analysis needs to control for other factors that also influence average hours. These include income (the demand for leisure should rise as incomes go up), the share of females in the labour force (many women work part-time) and age (older people tend to work less). The equation below is based on a pooled regression of average working hours in 16 countries from 1975 to 2002, building on the analysis in OECD (2005b):[1]

$$\log hrs = \underset{(6.1)}{-0.3293}\log prod \underset{(3.9)}{-0.5606}\, taxes \underset{(9.6)}{-0.3413}\, fm + \underset{(10.6)}{0.3745}\, gap \underset{(5.0)}{-0.1507}\, gap_{t-1} + const + trend$$

$(s.e. = 0.0137)$ *ADF (Swedish residuals)* $= -3.86 (prob = 0.01)$

Estimation: 2SLS, pooled data for 16 countries, 1975 – 2002 (number of observations=448)

where *hrs* is average hours worked per employed person per year, *prod* is hourly labour productivity, *taxes* is the implicit personal income tax rate (see Carey and Rabesona, 2002), *fm* is the proportion of females in the workforce (a proxy for part-time work) and *gap* is the output gap. Country-specific fixed effects and time trends are included. *ADF* refers to the Augmented Dickey Fuller test and indicates that the Swedish long-run equation is co-integrated.

This equation suggests that there is a significant negative link between income taxes and average hours of work after controlling for other influences on working time. Among these 16 countries, average hours worked per employee fell by an average 12% between 1975 and 2002. The estimated elasticity implies that around one-third of this can be attributed to higher income tax rates. In Sweden's case, it implies that average working hours could be increased by 9% if the tax rate was reduced to the average of the sample of countries.

There is always uncertainty over econometric estimates, and this analysis could no doubt be improved – especially by using a better measure of the tax burden (*i.e.* a true marginal tax rate rather than an implicit average rate). However, it does suggest that looking across countries can give additional useful information about the impact of taxes on labour supply.

1. The countries are Australia, Belgium, Canada, Denmark, Finland, France, Germany, Italy, Japan, the Netherlands, Norway, Spain, Sweden, Switzerland, the United Kingdom and the United States. The key change compared with OECD (2005b) is to estimate the equation using instrumental variables rather than least squares. The justification is that, for reasons of data availability, the proxy for the tax rate is the implicit tax ratio (tax receipts relative to household income). This variable is highly endogenous with respect to the hours of work variable on the left hand side of the equation. Hence, it is instrumented out using the government spending ratio as an instrument. Doing so substantially increases the estimated coefficient, as is expected from theory (Li and Sarte, 2003, show that the same endogeneity issue substantially biases down estimates of the impact of income taxes on growth rates across countries). A less important change relative to OECD (2005b) is to include the output gap to soak up some of the dynamics in the long-run equation and because the tax variable and its instrument are cyclical. An age effect (the share of the workforce aged 55 and over) was tested but found to be insignificant. Finally, the estimates were robust to the inclusion of variables that capture product market and labour market regulations.

public sector and which services may be more appropriately purchased by households themselves. Only 17% of public transfers and subsidies actually imply redistribution between individuals in the Swedish welfare state when looking over lifetimes. The rest is financed by individuals themselves during some point of time in their lives (Pettersson and Pettersson, 2003). Reducing the intra-individual redistribution and the associated tax

Table 2.5. **The marginal cost of public funds is likely to be significant**

Indirect cost of raising one additional unit of tax revenue[1]

	Proportional tax increase (unchanged progressivity in the tax system)		Progressive tax increase (tax system becomes more progressive)
	Uncompensated hours elasticity = 0.0 Participation elasticity = 0.2	Uncompensated hours elasticity = 0.1 Participation elasticity = 0.2	Uncompensated hours elasticity = 0.0 Participation elasticity = 0.2
Australia	0.28	0.47	0.72
Austria	0.87	1.70	3.91
Canada	0.30	0.52	0.83
Denmark	0.68	1.24	2.36
Finland	0.98	2.19	7.19
France	0.57	1.04	1.92
Germany	1.12	2.81	17.75
Greece	0.26	0.46	0.72
Iceland	0.37	0.57	0.85
Ireland	0.55	1.16	2.57
Italy	0.38	0.76	1.42
Japan	0.19	0.27	0.36
Netherlands	0.90	1.87	4.85
New Zealand	0.20	0.28	0.36
Norway	0.46	0.75	1.18
Spain	0.34	0.56	0.88
Sweden	**0.74**	**1.30**	**2.41**
Switzerland	0.35	0.50	0.69
United Kingdom	0.37	0.57	0.83
United States	0.15	0.24	0.34

Note: The table shows the indirect or spill-over cost of raising an additional unit of tax revenue. For example, in Sweden's case, an extra *krona* of revenue via a progressive tax increase would have welfare costs of an additional 2.41 *krona*. By construction, the MCPF tends to infinity as the economy approaches the maximum of the Laffer curve and becomes negative thereafter.

1. The effects from both average taxes and benefit systems are included. Because replacement rates may be overestimated, the study also presents estimates of the MCPF without the effect from benefit systems. In these estimates, the efficiency loss is approximately halved.

Source: Kleven, Henrik J. and Claus T. Kreiner (2003), "The Marginal Cost of Public Funds in OECD Countries – Hours of Work Versus Labour Force Participation", CESinfo Working Paper No. 935, April.

collection costs could improve economic efficiency. Distortions could also be reduced if, for a given tax share, the tax base was shifted away from income taxes and towards *e.g.* property taxes or other less mobile tax bases.

Improving efficiency of publicly-funded services holds some potential

Productivity gains in the provision of publicly funded services are important to curb the pressure on public expenditure. Although the nature of publicly financed services, and most other services for that matter, makes it difficult to realise such gains, productivity *can* be raised; just looking at the substantial differences in costs (even after correcting for various structural factors) between local governments suggests that a significant potential exists for more efficient production if the performance of the weakest localities can be brought up to that of the strongest. Better use of technological innovations, improvements of administrative procedures and more competition in the provision of services financed by the public sector would be important elements of such a strategy.

There are gains to be made from more competition in the public sector

Introducing more competition in the provision of publicly funded services is likely to hold the greatest potential for improving efficiency (the main issues were discussed in an in-depth chapter on competition in last year's *Survey*). OECD countries have tried a number of ways to improve the efficiency of public outlays, including greater emphasis on transparency and benchmarking, competition exposure (internally and externally, through activity-contingent payment systems, outsourcing and privatisation), user charges and consumer choice.[6] In Sweden, significant changes along these lines have been made in, for example, education, health and care services through the introduction of voucher systems, purchaser-provider split and user charges (see OECD, 2002). Deregulation, privatisation and increased procurement of publicly-provided services have also taken place. Despite these efforts, there are still large areas where competition is weak or non-existent. Attempts to open up for competition have been very diverse among local governments, for instance.

Over the longer term the Swedish authorities should in general consider whether the private sector is better placed to deliver some of the goods and services that the public sector currently provides. Today, there are signs that central and local level governments operate to an unjustified extent in areas where private companies already exist (Konkurrensverket, 2004). When they do, it often distorts competition in the market. Unclear legislation is partly to blame. Central government authorities and agencies are subject to certain restrictions, as are lower levels of government through the Local Government Act, but there are large grey areas and the legality of local government companies cannot be tested in court. This suggests that the legal framework for government activities in competitive markets needs to be strengthened. In general, legislation and instructions to government agencies should clearly state that government institutions may get involved in activities only where there is a clear public role (for example, when market failures have been identified). Adequate enforcement mechanisms should also be introduced. When they do operate alongside private providers, legislation and enforcement should make sure that there is a level playing field. This would, for instance, require that public-sector units operating on competitive markets were separated in government accounts in order to avoid cross-subsidisation. Government-owned companies currently operating in areas where there are no market failures should be privatised.

Outsourcing *via* public procurement could also bring about efficiency gains. Although openly advertised public procurement is above EU-average shares, there are still large unused possibilities in this area (Konkurrensverket, 2002). However, procurement may be held back by weaknesses in the legislative and institutional framework, as well as reluctance by some municipalities and central government institutions to put activities out to tender. This is unfortunate, as experience with public procurement in general has been positive. For instance, tendering processes have required a precise specification of level and quality of the services in question, which has allowed redundant functions to be identified and eliminated. To help to expand competitive tendering, the previous *Survey* recommended that more resources be devoted to education, information and supervision in the area of public procurement. By increasing outsourcing, opportunities would also be expanded for nascent entrepreneurs to emerge in currently under-developed parts of the personal and social services sector. Because of identified practices that impede effective procurement, for instance unlawful direct procurement, it was also recommended that the

supervisory structure be rationalised and given the right to levy fines, and that legislation be modified to ensure a level playing field between internal and external producers.

Transparency and benchmarking tools can also be useful to improve efficiency, as they focus the attention of taxpayers and providers on how the performance of one unit compares with that of others. In Sweden, comprehensive data sets are already available on the Internet that provide indicators on the coverage and costs of public services for each county council and municipality. This has helped to uncover best practice and has put pressure on local administrations to raise quality and cost effectiveness by "naming and shaming" the poor performers. Nevertheless, further work on refining unit costs for all activities would help shed light on where efficiency gains could be realised. A more systematic use of comparisons, for instance for peer pressure, could improve dissemination of best practices. This would in particular be helpful in the various insurance systems (sickness and unemployment), where there are large differences in performance among local offices.

Fiscal federalism reforms have been made in other countries to improve efficiency

Efficient use of public funds is also a matter of a well designed government structure and an appropriate division of responsibilities. Along with its Nordic neighbours, Sweden is among the OECD countries where the number and complexity of tasks delegated to local governments is largest. This highly decentralised structure is rooted in the emphasis put on local democracy and the ability to match service provisions to local preferences. It is, however, uncertain whether the current structure will be the right one for the future. For example, the boundary between health care and social care for the elderly is becoming progressively more blurred, and health care itself is becoming more technical and specialised. As is discussed in more detail in Chapter 5, both these forces may mean that some reorganisation of local responsibilities is needed, possibly involving amalgamations of sub-national governments. A government commission is currently looking into this matter; its final report will be published in early 2007. The biggest impact of amalgamations may lie in an increased potential for quality improvements. However, larger government units may also make it easier to reallocate resources from lower-priority to core activities (such as health and elderly care), to open up the public sector to competition and to utilise e-government more intensively, as they would have greater possibilities of managing the associated processes. In the end, the choice may increasingly be between decentralised local democracy and ensuring the best services for the population.

Raising labour supply is key to maintaining the welfare state

Efficiency improvements will make it easier to meet increases in demand for public services, but they will not help reduce the expected expenditure pressure from ageing. That requires measures to boost the labour force so that the dependency ratio does not rise as sharply. But getting Swedes to work more is likely to require some adjustment to the welfare system. These issues are examined in the next two chapters.

Box 2.2. **Summary of recommendations**

Tighten fiscal policy so that the 2% surplus target is achieved. Tax increases should be avoided because they are likely to be costly in terms of their impact on labour supply. Improve the efficiency of publicly-funded services by: limiting the scope for government activities to areas where there are clearly identified market failures; privatising government owned companies currently operating in competitive markets; further exposing publicly financed services to competition while ensuring that there is a level playing field between private and public providers by making the latter subject to effective enforcement mechanisms (fines); and improving dispersion of best practices by further developing comparative datasets at all levels of government.

Central government expenditure ceilings: Tax expenditures should not be used to circumvent the ceilings. The ceilings should be set at a level that is consistent with the surplus target. Introduce a specific cyclical margin that is ring-fenced from anything but business-cycle-related spending changes.

Local government finances: Restrain expenditure boosting in years with booming revenues by basing the balanced-budget requirement on average taxable income over a number of years. Revenues could also become more stable by giving local governments access to property taxes. Alternatively, central government grants could be adjusted counter-cyclically.

Surplus target: Augment the surplus target with a medium-term debt target to reduce the chances of slippage from year to year.

Notes

1. Specifically, the difference between employment rates of native Swedes and immigrants is reduced by one-third in the period until 2020.
2. It is assumed that the nominal interest rate starts out at 5.5% and declines to 5% by 2030. Thereafter it increases to 5.2% in 2050. The average over the full period is around 5¼ per cent. This profile is in line with those depicted for a number of the larger OECD countries, notably the United States, in the scenarios in OECD (2005a).
3. It can be argued that the latter would have been more consistent with the general rule of unchanged labour market behaviour, but the assumption of decreasing working hours is maintained because interactions with the pension system make the calculation very complex. It should be noted that, contrary to old-age and occupational pensions, deferred tax payments on voluntary private pension savings (taxed on an ETT basis) are only partially taken into account in the projections; they should give some additional boost to government revenues in the future, although no exact estimate is available.
4. The most comprehensive study of the MCPF in Sweden (referenced in Statskontoret, 2003) is more than two decades old, but its theoretical insights are still valuable. For instance, the efficiency loss is considerably higher from an increase in municipal income taxes than it is for higher VAT. It is also higher if revenue is spent on pure transfers or services that are otherwise perfect substitutes for private consumption than if on collective public consumption or infrastructure, as in the latter case the income effect will lead to higher labour supply. The MCPF is less if the tax finances a service that is complementary to other taxed goods or services or to work. It is higher if the service is complementary to leisure.
5. These estimates by Agell *et al.* (1995) were based on the tax wedge of an average production worker and an uncompensated wage elasticity of 0.1, which is representative of the estimates of wage elasticities for married men found in microeconometric studies on Swedish data. Much higher

estimates of the MCPF were obtained when applying the tax wedge of an average white-collar worker and wage elasticities typically found in Swedish studies on female labour supply.

6. The appropriateness of each measure depends on the service in question. Where well functioning private markets exist or can be expected to emerge quickly, competitive tendering may be preferred. Alternatively, free choice of supplier (for instance, through voucher systems) can be offered to users, thereby creating competition over quality between producers. Benchmarking of public-sector units can give insight into the cost structure in production when private involvement is practically impossible (for example, when the exercise of authority is involved), and competition can be created by awarding funding on the basis of performance.

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Chapter 3

Best practice for reducing sickness and disability absences

Sweden's single biggest economic problem is the high number of people absent from work due to sickness or disability. This chapter describes the problem and looks at what other countries have done to reduce absenteeism. It emphasises a mutual obligations approach to sickness insurance. This means placing greater responsibilities on the sick person, the employer and the social insurance office to get that person back to work as soon as possible.

On an average day, around 14% of the working-age population is either on sick leave or on a disability benefit. This amounts to a significant drain on labour supply, incomes and economic activity. Recognising this, the government has set a target to halve the number of sick-listed people between 2002 and 2008. Achieving this goal would not only make Swedes wealthier now, it would go a long way towards ensuring that the welfare system can be sustained in the long term. The causes of such a high rate of absenteeism are not hard to find. Compared with other OECD countries, sickness insurance in Sweden is both generous and easy to get. Maintaining both of these features will not be possible. This chapter reviews the types of reforms that have worked in other countries and draws lessons about the steps that could be taken. The most important step would be to change the culture of sickness and disability insurance from one of providing passive income replacement towards the "mutual obligations" approach that Sweden already uses for unemployed people. In practice, this means placing greater responsibilities on the sick person, the employer and the social insurance office to get that person back to work as soon as possible. The government has taken some steps in this direction, but it needs to go further. If administration and gatekeeping can be brought closer to international best practice, then the problem of absenteeism might be solved without having to cut benefit levels.

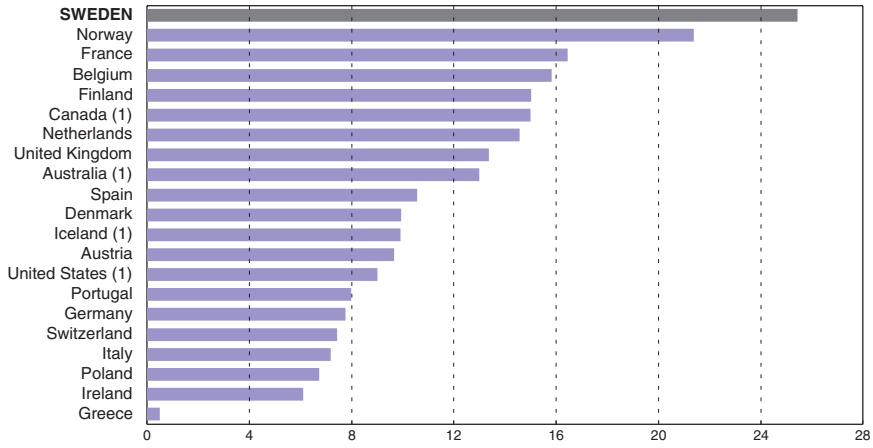
Who are the sick and disabled?

The problem of sickness and disability absences can be split into two components: people who have a job but are not at work because of illness (sickness absentees); and people who are out of the labour force for medical reasons (the inactive). Sweden compares badly on both dimensions. *First*, the average number of working days lost per year due to sickness is the highest in the OECD (Figure 3.1).[1] This reflects both a high absence *rate* (*i.e.* the share of people who take time off in a given period) and a *long average length* of each spell (partly because sickness benefits can last several years). *Second*, the share of the potential workforce that has dropped out of the labour market for reasons of illness or disability appears to be large by international standards, especially for older people (see Figure 3.2, although note that it can be hard to distinguish between early retirement and inactivity caused by illness).

There are several "natural" reasons why Sweden's sickness rate might be higher than in other countries. The most obvious is that the workforce is relatively old, and absence rates rise with age. But this cannot be the sole explanation because sickness absences are high across all age groups (Table 3.1). A second factor is that the female participation rate is high, and in most countries women are more likely than men to be off work sick. On the other hand, Swedes are healthier than most and have a long life expectancy (see Chapter 5), which should mean they are less likely to fall sick. Based on econometric evidence, it seems that the total effect of the various demographic and labour market characteristics is roughly zero, with the different factors cancelling each other out (Table 3.2).

Figure 3.1. **The number of working days lost due to sickness is the highest in the OECD**

Working days lost per full-time equivalent employee per year, 2004

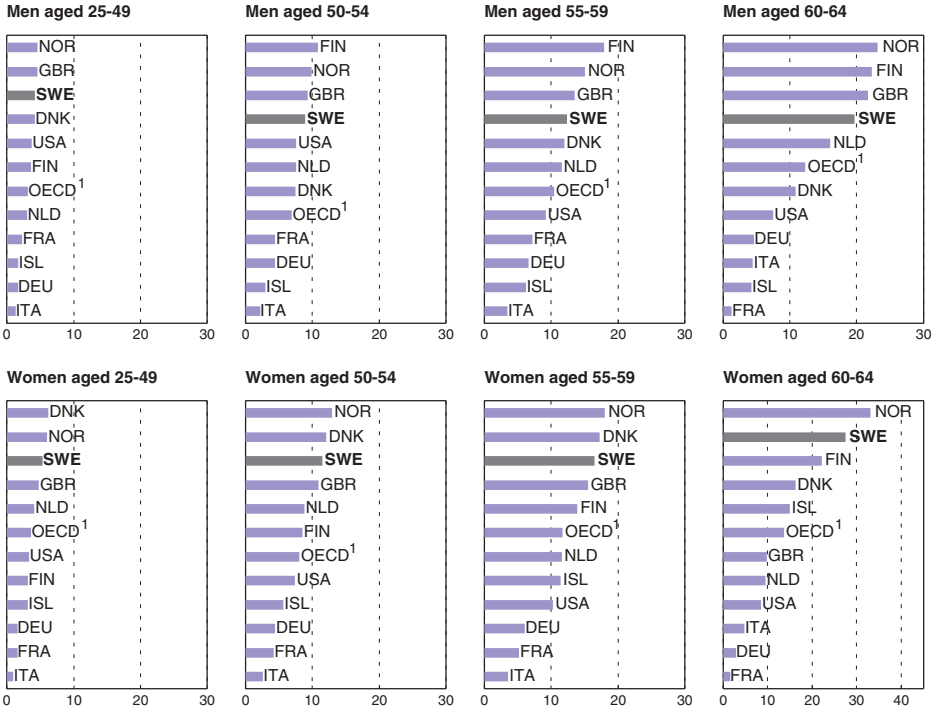


1. 2002.

Source: OECD estimates based on the European Labour Force Survey spring results.

Figure 3.2. **Inactivity because of illness or disability**

Percentage of the population in each age group, 2003



1. Average of 23 OECD countries for which data are available. Data for USA are 2001.

Source: European Labour Force Survey.

Table 3.1. **Sickness absence rate**

Percentage of people absent from work for the whole week in which the survey was taken, 1983-2001

	Age					
	Twenties	Thirties	Forties	Fifties	60-64	**Total**
Sweden	**2.5**	**3.1**	**3.9**	**4.4**	**9.1**	**4.2**
Netherlands	3.2	3.9	4.5	5.9	4.9	**4.1**
Norway	2.4	2.7	3.1	4.3	7.2	**3.2**
France	1.8	2.1	2.5	3.9	4.0	**2.4**
Finland	1.3	1.8	2.5	4.4	5.3	**2.3**
United Kingdom	1.8	2.1	2.5	3.9	4.0	**2.0**
Denmark	1.5	1.6	1.7	2.3	2.7	**1.7**
Germany	0.9	1.1	1.4	2.7	3.2	**1.4**
Weighted average	**1.5**	**1.8**	**2.2**	**3.3**	**4.1**	**2.1**

1. Data are the averages for 1983-2001, except Sweden (1987-2001) and Norway (1989-2001).

Source: Bergendorff, Sisko (2003), "Sickness absence in Europe – A Comparative Study", Swedish National Social Insurance Board.

Looking more closely at Sweden itself, there are significant differences in sickness absence rates across various groups (Figure 3.3):

- *by gender:* Sickness rates for women are, on average, twice as high as for men. The discrepancy has widened over time. Not surprisingly, rates are higher for women with young children.
- *by age:* Absence rates rise steadily with age. A man in his late-50s has an absence rate about as high as a women in her early-30s.
- *by education level:* The rate for people with only primary education is especially high at younger ages. Overall, it is around three times as high as for those with tertiary education.
- *by sector:* Employees in the public sector are about a third more likely to be off work than their counterparts in the private sector. A similar pattern is found in other countries that have high sickness absence rates, but it contrasts with France, Germany and Denmark where absence rates are almost the same in the government and business sectors.

Table 3.2. **The absence rate is not explained by demographic and labour market factors**

Sickness absence rate (share of people absent due to sickness for at least one hour during the reference week of the survey, average 1995-2003, per cent).

	Per cent
Swedish sickness absence rate	5.20
EU (unweighted) average sickness absence rate	2.75
Difference between Sweden and EU	**2.45**
The impact from having…	
… a higher labour force participation rate	0.56
… a lower share of part-time employment	0.32
… lower average hours of work	-0.09
… longer life expectancy	-0.73
Total difference explained by demographic and labour market factors	**0.06**

Note: In the model on which these calculations are based, there is no statistically significant impact coming from the age structure of the population once the other labour market variables have been included. The authors conclude that the age effect is captured within those variables.

Source: OECD calculations based on the econometric results from Bonato and Lusinyan's (2004) panel data study of work absences in Europe (IMF Working Paper 04/193).

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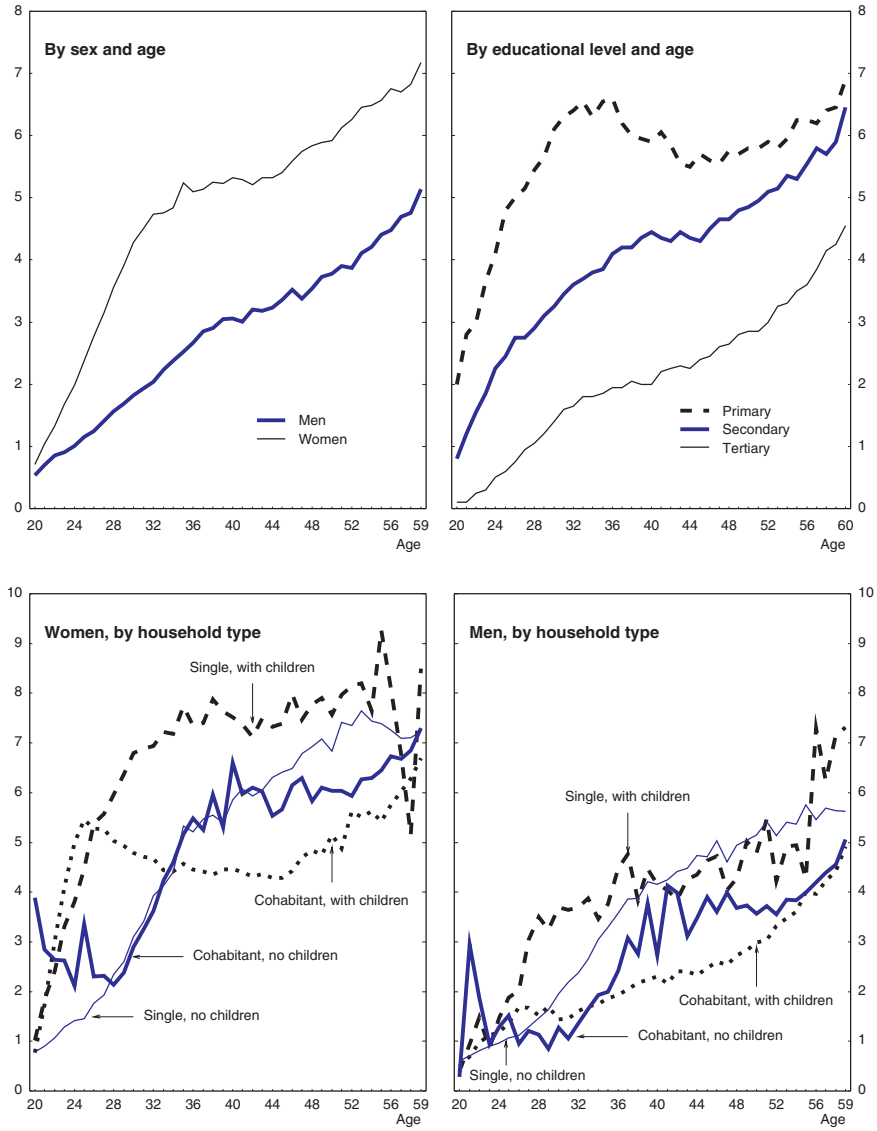
Figure 3.3. **Sickness rates**
Per cent

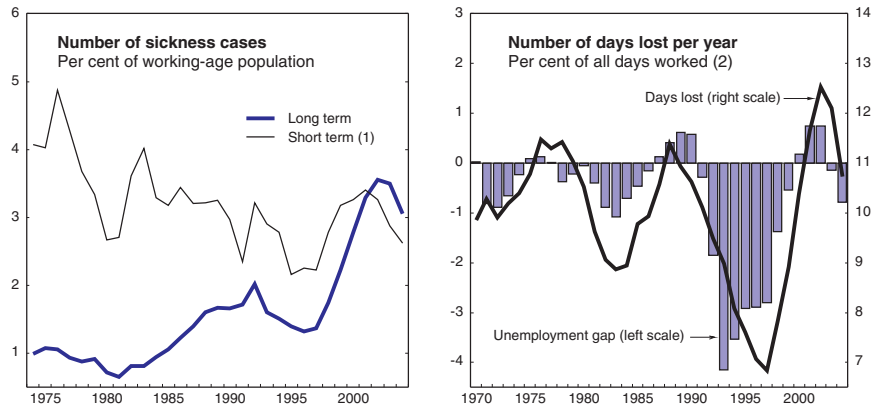


Source: Statistics Sweden.

Similar patterns are seen for people who are on disability benefits. The main difference is that on average they are older, with half aged over 55.

Looking at developments over time, the number of short-term sickness cases has shown a slight downtrend over the past few decades, but it is highly cyclical, rising when the labour market is tight[2] and falling significantly when unemployment is high (Figure 3.4). Sickness spells have been getting longer, however. The number of long-term spells has increased significantly, surging by more than 150% since 1998. The ageing of the population can explain only a small fraction of this increase; instead, it reflects the cyclical pick-up, more generous benefit levels and substitution between disability and long-term sickness benefits (access to disability benefits was tightened in the late 1990s). The result is that the total number of days

Figure 3.4. **Sickness cases and days lost**

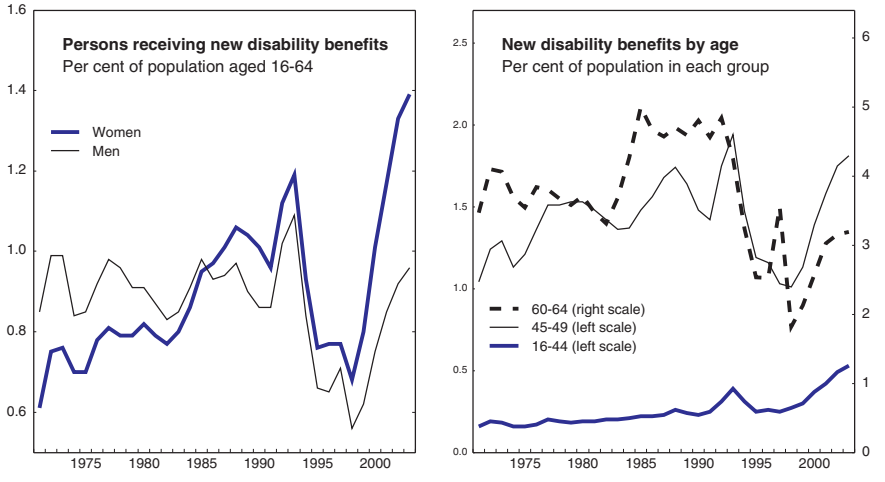


1. The series has been adjusted (upwards) after 1992 so that it includes the waiting day and the number of days paid by employers (so it is comparable with the pre-1992 figures). The adjustment is based on Henrekson (2004) and NIER (2004).
2. These data are from a different administrative source than the data for Table 3.3, so they are not exactly comparable.

Source: National Institute of Economic Research, Statistics Sweden; OECD.

off work remains close to an all-time high (Figure 3.4, right-hand panel). The good news is that the number of sick days has fallen significantly over the past two years, although much of this reduction is because people have shifted onto disability benefits instead. Hence, the total number of working days lost due to ill health (sickness and disability combined) fell by only 1.5% from 2003 to 2004 (NIER, 2005). Looking back a little further, the inflow to disability pensions has leapt since the late 1990s, especially among women (Figure 3.5). It has also been getting younger (Figure 3.5, right-hand panel), and is now at or around its highest level for all age groups except those 60 to 64 years-old. As in most countries, the fastest rate of increase has been among people with stress and depression.

Figure 3.5. **The inflow to disability pensions has surged**



Source: Swedish National Insurance Agency and OECD.

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It is worth noting that these trends are not related to measures of health status. When compared with other countries, the high *rate* of benefit receipt is hard to square with the fact that Swedes are relatively healthy (see Chapter 5). Nor has the *increase* in work absences been caused by any decline in population health: if anything, health indicators have continued to improve over the past 20 years. Moreover, the share of older people reporting that they are in good health has increased fairly steadily over time (OECD, 2003a).

Overview of the system

Sickness insurance (SI) is a compulsory publicly administered programme aimed at providing compensation for lost income during temporary sickness spells. Compensation can be full (100%) or partial (¾, ½ or ¼), depending on the extent of loss of earnings capacity. The focus is now more clearly on a person's capacity to work in general, not necessarily whether they can go back to their old job. The benefit level has changed frequently over the past 20 years, with fairly sizeable cuts through the recession of the 1990s but some reversal since then (Table 3.3). It is now 80% of previous earnings (up to a ceiling of 115% of the average wage, although collective agreements often cover earnings above the ceiling). It is common for collective agreements to top-up the replacement rate to as much as 100% over the first three months. SI is funded primarily through a payroll tax levied on employers (around 12% of wages). A sickness benefit can be granted for an unlimited time, but recent policy changes have been aimed at trying to reduce the number of benefits granted for longer than one year.

Table 3.3. **Replacement rate history**

Sick leave compensation as a percentage of own income (and the share paid by employers)[1]

	Dec. 1987 to Feb. 1991	Mar. to Dec. 1991	Jan. 1992 to Mar. 1993	Apr. to June 1993	July 1993 to Dec. 1995
First day	90	**65**	**75** ***(75)***	**0** ***(0)****	0 *(0)**
Days 2-3	90	**65**	**75** ***(75)***	75 (75)	75 *(75)*
Days 4-14	90	**80**	80 ***(80)***	80 (80)	80 *(80)*
Third week	90	**80**	80	80	80
Fourth week	90	**80**	80	80	80
Until 90 days	90	**80**	80	80	80
Until 1 year	90	90	90	80	80
Over 1 year	90	90	90	80	**70**

	1996	1997	Jan. to Mar. 1998	Apr. 1998 to June 2003	July 2003 to Dec. 2004	Jan. 2005
First day	0 *(0)**	0 *(0)**	0 *(0)**	0 *(0)**	0 *(0)**	0 *(0)**
Days 2-3	75 *(75)*	75 *(75)*	**80** ***(80)***	80 *(80)*	**77.6** ***(77.6)***	**80** ***(80)***
Days 4-14	**75** ***(75)***	75 *(75)*	**80** ***(80)***	80 *(80)*	**77.6** ***(77.6)***	**80** ***(80)***
Third week	**75**	75 ***(75)***	**80** ***(80)***	80 ***(0)***	**77.6** ***(77.6)***	**80** ***(12)***
Fourth week	**75**	75 ***(75)***	**80** ***(80)***	80 ***(0)***	**77.6**	**80** ***(12)***
Until 90 days	**75**	75	**80**	80	**77.6**	**80** ***(12)***
Until 1 year	**75**	75	**80**	80	**77.6**	**80** ***(12)***
Over 1 year	**75**	75	**80**	80	**77.6**	**80** ***(12)***

* The waiting day can be partly avoided after 1993 by reporting sick part way through the day.

1. The figures in brackets show the share that employers are required by law to pay. It does not include any top-ups (for most of this period, there has been an average 10% employer top-up, although this does vary across industry and has varied over time). Throughout the period shown in the table, coverage of the public system has been capped (but fewer than 10% of wage earners have consistently been above this cap, and collective agreements usually cover income above the cap). The **figures in bold** highlight changes relative to the previous scheme. From 2005, employers pay 15% of sick pay for full-time sick, but not if the sick person works part-time or is in employer-funded rehabilitation.

Source: National Social Insurance Board; OECD (2003), *Ageing and Employment Policies: Sweden*, Paris.

A *disability benefit* is available to those aged 30 and over whose work capacity has been reduced permanently. Since 2003, the disability pension has been renamed "sickness compensation" and has been integrated with the sickness insurance system (previously it was part of the pension system). However, this chapter will continue to refer to it as a disability benefit because it is less confusing for non-Swedish readers. It is available also for partial disability, and a temporary disability benefit can be given when work capacity is expected to be reduced for 1-3 years. The replacement rate, around 64%, is lower than for the sickness benefit. Younger people (aged 19-29) receive "activity compensation", which is essentially the same as the disability pension except that it is granted only for a limited time (up to three years) and social insurance offices must try to find measures that will help improve their health or physical or mental capacity for work.

In effect, *work injuries* are bundled together with the sickness and disability system. On paper they are different schemes, but they are administered by the same agency and, like other social security benefits, are financed from employers' contributions. The difference is that somebody injured at work receives full (*i.e.* 100%) compensation in the form of an annuity that tops up their sickness or disability benefit (so long as they have suffered a lasting reduction in work capacity).

The system is administered by the Swedish Social Insurance Agency. This new body was created in January this year by merging the 21 regional social insurance offices. The merger was made in an attempt to improve implementation and to reduce regional variations in practice. Local branches are now government offices, so now they can be controlled more directly by the national authorities. Administrative procedures have been tightened up to some extent, especially after a package of reforms that took effect in July 2003 (see Box 4.2 of 2004's *Survey* for details), but they are still looser than in most other countries (see Box 3.1 and the rest of this chapter).

Box 3.1. **Normal procedures over a sickness spell**

The first day of a sickness spell is a "waiting day", and in principle the sick person receives no pay or sickness benefits that day. Employers pay sick pay from the second to the fourteenth day (and 15% of sickness benefits thereafter; see below). After one week, a medical certificate must be produced. These are usually provided by the individual's own GP. After two weeks the social insurance office becomes involved. It decides about entitlement to further sickness benefits and the degree of reduced working capacity, based on the original medical assessment. A sickness benefit can be paid for an unlimited period, so long as the person is unable to work because of sickness and has not been transferred to a rehabilitation benefit or a disability pension. The employer must produce a rehabilitation plan after 1-2 months (this can be done in conjunction with the insurance office). Around this time there should be a meeting between the person on sick leave, the employer and the insurance office; the government wants these meetings to take place more often. The person may then undergo rehabilitation (medical, social or vocational). If it seems likely that the reduced work capacity will last longer than a year, he or she will be granted a temporary or permanent disability benefit. In principle there should be a re-evaluation after one year of sick leave allowance, but in the past these have often not been performed on time and in any case the doctors at the social insurance office do not perform an independent medical assessment. For those awarded a disability benefit, there should be a re-assessment at least every three years. Implementation is patchy, however, although the government is trying to improve the process for long-term absentees.

What works in other countries?

The rest of this chapter reviews policy experiences in other countries and looks at how Sweden's approach compares with international best practice. The key features of the different benefit systems are compared in Table 3.4. It should be noted that in the discussion that follows, there is often no clear distinction drawn between short-term and long-term sickness, disability and work injury schemes because different countries use different labels and the issues are so intertwined.

Table 3.4. **Summary of main characteristics of sickness benefit systems**

		Benefit level (% of previous earnings)[1]					
	Number of waiting days	After around 1 week	After around 1 month	After six months	Maximum duration (years)	Employer period (weeks)	Index of compensation generosity[2] (OECD = 100)
Countries with high absence rates[3]							
Sweden	**1**	**80**	**80**	**80**	**Unlimited**	**2**[4]	**130**
Norway	0	100	100	100	1	2	130
Netherlands	0	70	70	70	2	104	111
Belgium	1	100	60	60	1	4	99
Middle countries							
Finland[5]	0	70	70	70	1	0	..
France	3	50	50	51	3	0	95
Canada	..	55	55	0	0.3	..	50
Austria	3	50	50	60	1	12	95
United Kingdom	3	flat (24)	flat (26)	0	1	28	80
Australia	..	flat (22)	flat (22)	flat (22)	..	..	122
Denmark	0	50	50	50	1	0	103
Iceland	14[6]	flat (23)	flat (23)	flat (23)	1	0	..
Switzerland	3	80	80	80	2	3	126
Spain	3	51	64	64	1.5	2	115
Portugal	3	65	65	65	3	0	118
United States	7	100	60	60	1	..	80
Countries with low absence rates							
Germany	0	90	90	70	1.5	6	115
Poland	..	80	100	0	0.5	..	115
Italy	3	50	67	0	0.5	12	84
Ireland	3	flat (53)	flat (53)	flat (53)	Unlimited	0	..
Greece	3	flat[7] (29)	flat (54)	flat (54)	1	0	..

1. Benefit rules are complex. These columns show approximate replacement rates of the public insurance scheme for "typical" full-time workers. Replacement rates in some countries, including Sweden, are often topped up to 100% by employers for a certain period. For flat rate benefits, the figures are for a single-earner family with two children earning the average wage. See the Sources for exact details of the various schemes.
2. This is a summary index of benefit generosity based on ten dimensions, including coverage, ease of access, benefit level and duration and the strictness of medical assessment. See Annex 2 of OECD (2003), *Transforming Disability into Ability*, for more details.
3. Countries are ranked in descending order of average sickness absence rate in 2002.
4. From 2005, employers pay a 15% co-payment for the full duration of a (full-time) sickness spell.
5. The figures for Finland take account of the employer top up, in which the employer pays 100% for 3 days and effectively eliminates the waiting days. This is done through central agreements that cover all wage earners.
6. The waiting period starts after a physician has certified the illness.
7. Strictly speaking, the benefit level is not a flat rate but is capped at a low level and therefore most people will be receiving the maximum – namely, 29% of the economy-wide average production worker wage for the first 15 days and 54% thereafter.

Source: EU MISSOC database (*http://europa.eu.int/comm/employment_social/missoc/missoc2004_en.pdf*); OECD (2003), *Transforming Disability into Ability*, Paris.

Better administration and gatekeeping

Receiving a benefit should entail certain obligations for the sick person

Developing a culture of mutual obligations means that benefit receipt should depend on participation in employment, vocational rehabilitation and other integration measures. Active investment should be the counterpart to benefit receipt to ensure that the sickness benefit is not just a soft alternative to the unemployment insurance system. The earlier this starts the better. The OECD's review of policies for sick and disabled people concluded that "the most effective measure against long-term benefit dependency appears to be a strong focus on early intervention. As soon as a person becomes [sick or] disabled… a process of tailored intervention should be initiated" (OECD, 2003b, p. 162). The most appropriate measures and timing will obviously depend on individual circumstances. Taking this approach implies that recipients who do not co-operate in reintegration efforts should face some sort of sanction; in Norway, for example, sickness benefit payments can be withheld if a claimant rejects rehabilitation measures. While Sweden is a leader among OECD countries when it comes to *offering* early rehabilitation, it is less good at ensuring that people actually take it up.[3] Increasing the focus on active measures should also apply to older people, especially as they are more likely to be long-term benefit recipients. However, no OECD country performs well in this respect. Benefit administration for people over the age of 45 is usually very passive and tends to focus on income support rather than trying to get the beneficiary back into the workforce.

Improving the initial assessment process

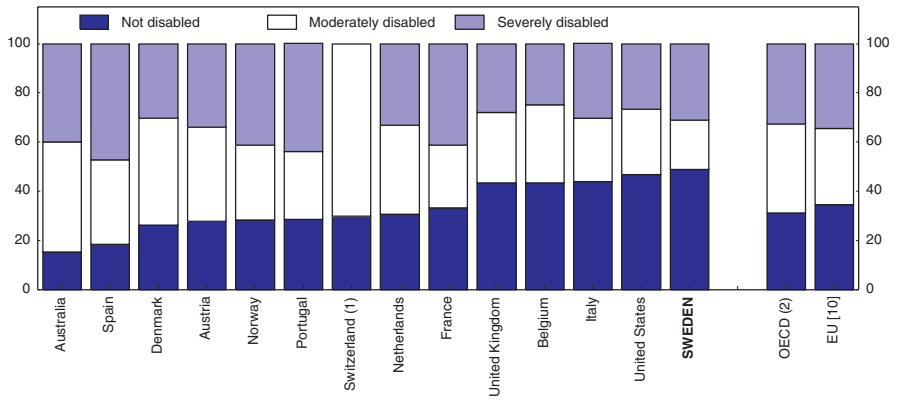
A major challenge is to find the right balance between minimising both the exclusion error (refusing the benefit for people who need it) and the inclusion error (granting benefits to those who do not need them). Some sort of gatekeeping is required. However, getting a sickness benefit appears to be much easier in Sweden than in most countries. Half of all Swedes who are receiving some form of sickness or disability payment do not actually regard themselves as disabled (Figure 3.6). Moreover, sickness absence rates are more pro-cyclical than in most countries, another sign that access is relatively easy and in some cases is in a certain sense voluntary (Table 3.5).

The first step in the assessment process is the requirement to provide a medical certificate. In Sweden, this occurs after the seventh day. In Finland and Iceland, by contrast, a certificate is needed from the first day, and in Germany it is required after the third day. More important, however, is how the medical assessments are actually done. In most countries, assessment – at least for long-term benefit recipients – is done by specialised insurance doctors rather than by the applicant's own doctor. That is not really the case in Sweden. Social insurance physicians base their opinion on the assessment of the applicant's own GP (OECD, 2003) and do not re-examine the patient. Individuals themselves therefore have a great deal of influence over sick-listing decisions. One study found that in nearly 90% of the cases in Sweden, the physician offered sick listing only after the patient had specifically requested it, while another study found that patients were seldom denied a medical certificate if they asked for one.[4] GPs in most countries are not in a good position to make unbiased decisions because they have every incentive to please a patient who may have been with them for many years.

Sweden has tried to improve the assessment process since 2003, but with limited success so far. An important step has been to abolish the "Ghent model", effective from the

Figure 3.6. **Half of Swedish sickness and disability recipients do not classify themselves as disabled**

Disability status of disability benefit recipients, late 1990s, per cent



1. "Severe" and "moderate".
2. Switzerland excluded from the average.

Source: OECD (2003), *Transforming Disability into Ability*, Paris.

start of 2005, in which the system was administered by autonomous legal entities, and instead local offices have become government agencies staffed by civil servants. Bringing them under the government's wing should, in time, lead to more control and better – and more uniform – implementation of policy. Indeed, local offices have got tougher over the past two years, but they have much further to go. The sickness benefit refusal rate remains very low, at around 1%.[5] Even this small improvement has been difficult. Earlier this year, for example, the civil court in Uppsala found that the local insurance office had been wrong to refuse sick pay to a person who declared himself incapable of working after his boss had "exposed him to insults, bullying and harassment." It appears that cultural attitudes have not moved fully towards assessing a person's ability to work in general, rather than in his or her previous job.

While it is necessary to tighten up decisions on initial sick listing, it is far more important to make sure that short spells do not become long ones. In Sweden, extending a medical certificate is easy and in some cases is done over the telephone (although technically this is against the rules). In contrast to most countries, GPs retain a major role for long-term sickness and disability benefits as well. However, they are often not the best

Table 3.5. **Sickness absences are strongly pro-cyclical in Sweden**

Correlation between sickness absence rates and the unemployment gap

Belgium	–0.82*	Ireland	0.04
Sweden	**–0.51***	Finland	0.06
Netherlands	–0.47*	Denmark	0.08
Greece	–0.36	Norway	0.17
Iceland	–0.24	Luxembourg	0.28
Germany	–0.23	Austria	0.28
Switzerland	–0.09	Spain	0.30
United Kingdom	–0.03	Italy	0.30
France	0.03	Portugal	0.43

* Significant at the 5% level.

Source: Bonato, Leo and Lusine Lusinyan (2004), "Work Absence in Europe", IMF Working Paper 04/193.

judge of whether someone can re-enter the workforce. The majority of long-term problems reflect back, knee or mental disorders which are difficult to diagnose and usually require specialists to gauge the degree of work that a person is capable of doing. That is why most countries have strengthened the role of independent medical assessors for longer-term problems. There is a trend towards increased use of interdisciplinary teams of experts – including vocational specialists – that make the final benefit decision. Rejection rates can be high, ranging from 17 to 25% in Norway and Denmark to around 50% in Austria and Portugal. The only other countries where GPs play as important a role as they do in Sweden are Norway and the United States. Both cases are revealing. Norway has the second-worst sickness absence problem in the OECD, and absenteeism in the United States is higher than might be expected, considering that benefit levels there are on the low side. Australia and Switzerland have circumvented the gatekeeping problem by making increasing use of the possibility to ask for an additional, independent medical assessment. This is now done in about two-thirds of all cases, demonstrating how important a second opinion can be. While there are no regulations that prohibit independent second opinions in Sweden, they are almost never undertaken.

Decisions to grant long-term disability benefits should be made in a regional or central office, and by experts rather than politicians

An additional problem is that local insurance offices can find it hard to make an unbiased assessment, especially in small communities where the applicant is likely to know the case officer. Some countries try to solve this problem by having decisions on permanent disability *prepared* locally but *made* more centrally by a social insurance doctor who is not part of that community. This is done in Finland, Spain, Norway and the United States, for example. In Sweden, the formal decision to grant long-term benefits is made by a local social insurance board comprising local politicians. The panel does not include the insurance officer or a physician, although its decision is based on the investigation made by the social insurance office. Sweden is the only OECD country with this type of system. Some other countries also use independent panels to make the final decision (*e.g.* Italy, Switzerland and Portugal), but in every case it includes doctors or experts in vocational rehabilitation.

Regular monitoring and re-testing is necessary

Once a benefit is granted, assessment should be repeated at regular intervals to determine whether a person's condition or work capacity has changed. Put another way, sickness benefits normally should be granted for a fixed duration only. There clearly needs to be flexibility here, as re-testing is unnecessary if a disability really is permanent. In some countries, and especially in Scandinavia, benefits are more or less permanent because re-testing is rare, even if it is theoretically possible at any time. As noted in Table 3.1, a re-evaluation should take place after one year of sick leave allowance, although in the past these have often not been performed on time. Disability benefits should be re-evaluated at least every three years, but again implementation of this policy has been patchy. Moreover, none of these re-evaluations includes an independent medical re-assessment. Reconsidering a person's eligibility is done more regularly and systematically in some other countries. Reviews take place every two to three years in Austria, Germany and Italy, for example, and within five years in Australia and the Netherlands. In most countries, however, there is a big difference between the policy "on paper" and how strictly it is

implemented in practice. Nevertheless, the Dutch experience shows that follow-up assessments can be helpful. In the mid-1990s they reviewed all recipients below age 45 (including those who had previously been granted a permanent benefit), leading to reclassifications or loss of benefit in a third of all cases (OECD, 2003b). The government is clearly trying to improve the re-assessment process, and international experience shows that it would be helpful to step up efforts in this area.

Occasional random checkups on SI recipients can be an effective way to find out whether a person's health has improved and to combat fraud. This may sound tough, but it is common in other European countries (*e.g.* Austria, Belgium, France and Italy), and in some countries checks are possible at the request of the employer. Checkups were part of the Swedish approach until the 1980s, but since then there has been virtually no monitoring of benefit recipients. Each country has to make its own decision as to how hard a line to take, but having no checking at all is surely too soft – and is strikingly at odds with the strict mutual obligations approach that Swedes are comfortable with for the unemployed.

The use of partial sick leave must be carefully monitored

The government is putting increased emphasis on partial or part-time benefits. In theory, decisions to grant partial benefits should depend on how much work the sick person is capable of doing. In practice, it is based on how much work he or she actually does (virtually everyone receiving a partial benefit works part time). It is hard to know whether partial benefits are a good idea or not. There is a risk that they invite a higher inflow, especially among older workers who may want to scale back their hours of work for lifestyle reasons. A partial benefit then becomes an income top-up while they go through a gradual early retirement. If there were no option to grant a partial benefit, then some of these people would stay at work full time, but others would completely withdraw from the workforce and receive a full benefit instead. There is no clear evidence of which of these two effects would dominate. However, the international experience is that countries which place more emphasis on partial benefits tend to have particularly high benefit recipiency rates (although causation could run in the other direction: countries with high inflow rates may try to deal with them by encouraging partial benefits). This partly explains why Denmark has moved in the opposite direction to Sweden, replacing partial benefits with wage subsidies ("flexjobs"). Sweden therefore needs to carefully monitor how partial benefits are being used, especially considering that the inflow to partial benefits has surged since 1999, but with little apparent reduction in the inflow rate to full benefits.

Flexible rules can help overcome benefit traps

It is important that benefit rules are flexible so that people can "try out" going back to work without having to worry about going through the whole administrative process again if their attempt fails and they need to go back on a benefit. Sweden is a leader in this respect. A disability benefit can be put on hold for up to two years, and it continues to be paid for the first three months back at work. The problem is that few people make use of this option. In the first two years after the scheme was introduced (in 2000), less than 0.5% of recipients tried to go back to work. This lack of interest might suggest that income replacement rates are high enough that most people on disability benefits have little interest in returning permanently to the workforce. Of course, it might also be the case that they are in fact too sick to work.

The Dutch experience with tighter administration

Faced with similar problems to Sweden, the Netherlands has radically restructured its sickness and disability systems. Better gatekeeping and administration have been key parts of the reforms, along with experience rating of firms. Both employers and employees face greater obligations earlier in the sickness spell, especially concerning rehabilitation. When someone subsequently applies to move off sickness insurance and onto a disability benefit, the social insurance office can refuse the request if it thinks that rehabilitation efforts have not been sufficiently serious. Social insurance doctors also have less discretion in granting access to partial disability benefits, with gatekeeping having become more rules based. The sickness insurance scheme has been privatised, with employers now responsible for the first two years of sick pay, and there will be some privatisation of the partial disability scheme from next year (giving employers a choice between public, private or no insurance). These measures have all contributed to a significant reduction in sick leave, driving it below Swedish levels for the first time for many years (OECD, 2004). Firms are able to re-insure the risks they face under the sickness insurance scheme, but it is interesting that this does not seem to have diluted the incentives they face: after controlling for factors such as firm size, the rate of absenteeism has been virtually the same whether a firm re-insured or not (de Jong and Lindeboom, 2004). This suggests that adverse selection – where only the "bad" firms choose to re-insure – has not been a significant problem in the private insurance market.[6]

Increasing incentives on employers

For how long should employers be responsible?

In recent years, most countries have increased obligations on employers to encourage them to invest in prevention and retention measures. Employers in Sweden have had to pay the first two or three weeks of sickness insurance since 1992 (except for a brief period in 1997 when they covered the first month). Practices vary widely, but this is on the low end of the scale (Table 3.4) which may be why it does not seem to have had much impact so far.[7] Employers in the Germanic countries, for example, pay the first one to three months, while obligations can be as long as six months (in the United Kingdom) or two years (in the Netherlands).

Employers' responsibility for sick pay underwent a significant change this year. On top of paying for the first two weeks (a reduction from the three weeks for which they were previously responsible), employers must now pay 15% of the cost of sickness benefits for the remainder of the sickness spell. In return, the payroll tax was lowered so that labour costs for employers as a group should be roughly unchanged. The charge will not apply if the sick person is in rehabilitation or working part-time, and their liability ends if the employee is granted a permanent disability benefit. The aim is to give firms a greater incentive to avoid workplace injuries and to get people into rehabilitation earlier. However, it is unclear whether this is the most sensible way of going about it. The key issue is the optimal time profile of their financial obligations, including the question of whether responsibility should go to zero at some point. It is hard to say whether it would be more effective for firms to cover the full benefit for a longer but limited period (say, three months) or to pay 15% indefinitely. The first option might be a better way to meet the government's main objective, namely to have the sick person's problems dealt with sooner in the spell, because they could reduce their costs significantly by encouraging the employee to enter a vocational rehabilitation programme early on. Under the alternative

setup, there is less urgency because the firms' net savings may be quite low (it avoids the 15% co-payment but must pay for the rehabilitation programme).[8] The second question – whether the firms' responsibility should go to zero – depends to a large extent on how many of the long-term sick go back to work. If long-term sickness is mainly a stepping stone to a permanent disability benefit or to early retirement, then employer obligations merely raise average labour costs rather than improve incentives at the margin. For these reasons, it might have been better if the government had extended beyond 21 days the period for which employers have full responsibility, but to have kept a definite cut-off period after which the public SI system would take over. A government commission in 2000 recommended changes along those lines (extending the employer's period to 60 days and lowering the payroll tax), but the proposal was rejected by the social partners.

Involving employers in vocational rehabilitation

Active involvement by employers can be an effective way to deliver successful re-integration. Different approaches exist, ranging from moral suasion and work-based occupational health programmes to compulsory employment quotas. Swedish employers are obliged to prepare a rehabilitation plan, and in this respect Sweden is an example of good practice that is not found in many other countries. However, many employers ignore their obligations. To make the requirement more effective requires empowering employers to prepare sensible plans (*e.g.* giving them better assistance), monitoring the plans and their impact and introducing sanctions for non-compliance. At the same time, the social insurance office will need greater powers to act when a person refuses rehabilitation. Moreover, simply putting more emphasis on monitoring and managing employees can be surprisingly effective. In Svenska Statoil, for example, every employee on long-term sick leave and those who had had more than five absences in a year were called in for a discussion with a manager and the Human Resources division. By doing so, it halved its absenteeism rate between 2001 and 2004 (PersonnelToday, 2004).

Introducing industry or employer risk rating

Most countries have some form of risk rating across industries, at least for work injuries, although some have different SI rates as well. Sweden is one of the few that still levies the same premium in all sectors despite there being relatively large variations in absence rates across industries (Table 3.6). This reduces the incentive to try to curb work-

Table 3.6. **Sickness absence rates vary markedly between sectors**

Average number of sick days per worker aged 30-64 in establishments with at least 30 employees in 1991

Electricity and gas	13
Construction	15
Trade	18
Mining	18
Government administration	20
Manufacturing	22
Banking and Finance	27
Health and childcare	28
Transport	30
Total	**25**

Source: Arai, Mahmood and Peter Skogman Thoursie (2004), "Sickness Absence: Worker and Establishment Effects", *Swedish Economic Policy Review* 11, 9-28.

place injuries and implicitly subsidises employment in high-risk sectors. Industry risk rating could usefully be introduced in Sweden, although in the first instance it could be limited to injuries and illnesses that are clearly work-related.

Basing insurance premiums on the individual firm's history is less common, although it is used in around half a dozen OECD countries. Individual experience rating creates strong incentives for firms to try to reduce work-place injuries and get their employees back to work. Dutch companies face different premiums depending on how successful they are at reducing absenteeism, and premiums there have become more differentiated over time (OECD, 2004). In New Zealand's work injury scheme, companies with a good safety record, and who can show that they have taken significant steps to minimise the risks to their workers or who were actively involved in rehabilitating employees, are able to negotiate substantial reductions in their premiums. In response, many firms have tried actively to improve their working environments.

Sweden could consider a similar approach. The 15% co-payment does create some differentiation across firms as those with poor sickness records will pay more, but this is equivalent to a deductible or excess in insurance terms, rather than an experience-rated premium. As a first step, Sweden could consider setting different SI contribution rates for public and private employers. Sickness absence is a third more prevalent in the public sector. It appears that only some of this can be explained by the fact that the public sector is more likely to employ older female workers[9] (although it is fair to say that the evidence on how much variation exists across industries, after taking account of individual characteristics such as sex and age, remains inconclusive; further research would help policymakers assess whether industry-related premiums would be helpful or not).

The main potential drawback of experience-rated premiums is that they give employers an incentive to avoid hiring people who might be sick listed in the future (adverse selection). But this incentive has already been created through the introduction of the 15% co-payment, and in any case it can be mitigated or avoided. One way is to exclude the highest risk groups, such as former disability recipients and people with a history of repeated sickness spells (as in the Netherlands). Indeed, Sweden already does this, as employers can avoid paying sick pay if a worker has been given an exemption in advance through a special high-risk protection. An additional option is to ban detailed investigation of a job applicant's medical history, as has been done in the Netherlands and to some extent in the United Kingdom.

Having a separate workplace injury scheme

The appropriate financial obligations on employers differ between work injury and general sickness/disability programmes. That is why the two risks are separated in most countries. They require a different funding structure (costs of work injuries should be fully borne by the employer) and justify a different minimum level of disability (even minor reductions in work capacity from a work injury should be fully compensated). Sweden's approach of largely combining the two systems is unusual and means that, at the margin, employers probably pay too little for work injuries and too much for sickness spells that are out of their control. The fact that employers did not take out private re-insurance to cover the costs they faced under the previous rules reinforces this conclusion. It would be better to separate the systems, basing the work injury programme on the ILO's internationally agreed list of occupational diseases. Although the work injury scheme should be run under different rules and have different financing, there are advantages to keeping some co-ordination with

sickness insurance because a sick person will need the same type of support and rehabilitation no matter whether the injury was caused at work or not.

Shouldering employers with extra costs may backfire unless other parts of the system are reformed as well

An important proviso applies to any measure that imposes costs on employers. For the policy to be effective, the company has to be able to do something to reduce sickness absence. If not, financial responsibility just drives up labour costs and may have a negative impact on employment. Incentives will be sharpest where the employer faces an increased marginal benefit from reducing absenteeism and has some levers with which to do something. This means that an increased responsibility for employers needs to go hand in hand with other reforms that tighten benefit administration and reduce the incentives for employees to misuse the system. The approach of imposing rehabilitation responsibilities and a 15% co-payment on firms is likely to be more effective if the government also takes bigger steps towards the sorts of gatekeeping and administration improvements discussed in this chapter.

Moreover, reforms would be more effective if employment protection rules were eased at the same time. International evidence shows that strict employment protection leads to more absences.[10] Swedish evidence points in the same direction: workers on temporary contacts are only half as likely as permanent employees to be off sick (Meyer and Wallette, 2005). In addition, sick listing is to some extent used as a way of getting around seniority rules that make it harder to lay off older workers. Placing more responsibility on employers for sickness absences will increase the effective cost of these employment protection rules and may make firms less willing to hire in the first place. It was for similar reasons that Austria and Germany recently relaxed their special dismissal protection rules for disabled workers, realising that they were causing more harm than good for older workers.

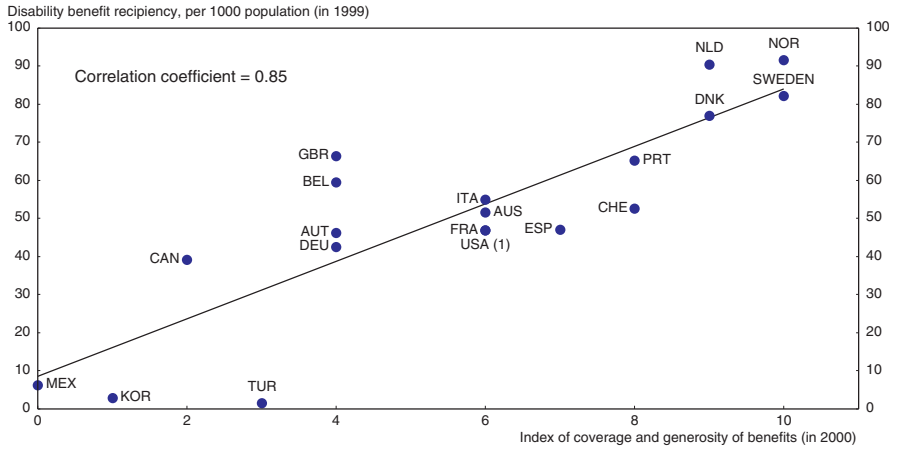
Restructuring benefit systems to minimise the disincentives to work

Beware of making the sickness and disability system too generous

There is no doubt that high benefit levels reduce the incentive to work. Comparing across countries, OECD (2003b) found that benefit levels and coverage are the two most powerful predictors of sickness and disability rates (Figure 3.7). In a more rigorous econometric study of work absences in European countries, Bonato and Lusinyan (2004) show that the level of benefits has a large impact on the absence rate and that the elasticity is particularly big in Sweden. Their estimates suggest that cutting the benefit replacement rate by 10 percentage points would reduce absences in Sweden by around 11%. The link between benefit levels and the absence rate in Sweden is clear even from a casual glance at Swedish data. In the late 1980s and early 1990s, benefit replacement rates were around 100%. Benefit levels were reduced through the first half of the 1990s, and a one-day waiting period was introduced in 1993. The number of sick cases was substantially reduced, especially after 1993. In 1998, benefit replacement rates increased again, particularly for longer absences where the rate went from 75% to 90%. Around the same time, the incidence of long-term sickness began to increase dramatically. This is not to say that the compensation level has been the only factor behind these developments. Nevertheless, various studies that control for other factors also confirm that changes in benefit generosity have had strong effects on sick leave behaviour in the past. Henrekson and Persson (2004), for example, concluded that "when the insurance system is made more generous, the aggregate number of sick days increases, and when the system is made more austere, the number falls".[11]

Figure 3.7. **Coverage and generosity determine benefit recipiency levels**

Benefit coverage and benefit generosity *vs* benefit recipiency outcome



1. The scatter plot is the same value for the United States and France.

Source: OECD (2003), *Transforming Disability into Ability*, Paris.

The more generous the system, the greater the risk of moral hazard. There are many Swedish studies which demonstrate that moral hazard and misuse of SI are significant problems (for example, absence rates for men are higher on their birthday or when major sporting events are on – see Skogman Thoursie, 2002 and 2005). That is one reason why countries with more generous sickness and disability schemes need to be more vigilant about ensuring that benefits are given only to those people who genuinely need them. Finland and Germany, for example, both have relatively generous benefit levels but have better gatekeeping and earlier intervention than Sweden. Their absence rates are noticeably lower as a consequence.

Extending the waiting period beyond one day

In order to reduce moral hazard, optimal insurance policies usually include an "excess" or "deductible" that the insured party has to pay. In the case of sickness insurance, this corresponds to the waiting period before benefits are paid. In Sweden, the waiting period is one day. This is short by European standards; three days is the norm (Table 3.4), and it can be as long as 9 or 14 days (in Finland and Iceland respectively). Sweden's experience shows that the waiting day has a sizeable impact on the absence rate. When the waiting day was abolished between 1987 and 1991, so most people could report sick with no loss of earnings, the number of one-day and two-day absences surged.[12] In 1992 the waiting day was restored; this move, along with a cut in the replacement rate, led to a sharp fall in short-term leave.

Making sure sickness and disability benefits are co-ordinated with other parts of the social security system

Sickness and disability benefits are often used as a more attractive route to early retirement. Sweden has taken some care to design a flexible pension system in which the payout rate is actuarially reduced the earlier it is taken. While nice in theory, the problem is that few people are influenced by the incentive because it is easy to leave the workforce on a sickness or disability pension instead. A relatively small fraction of people take their

public pension before the age of 65. It is more common for older workers to take unemployment or sickness insurance for a year or two and then either retire on a pension (if they are 65) or move on to a disability benefit: a third of 65 year-olds have previously been awarded a disability benefit. For most workers, there is a large financial incentive to take the sickness insurance pathway to early retirement. For typical 55 year-olds on an average income, for example, the net present value of their future income stream if they retire *via* the labour market insurance path is more than twice as big as that resulting from taking the public and occupational pension route (Palme and Svensson, 2003).[13] One reason is that benefits are not actuarially reduced before age 65, whereas the pension is. But perhaps more importantly, sickness and disability benefits count as pensionable income. A person is therefore better off retiring on a benefit and continuing to build up a bigger pension, which they then take at age 65.

Some countries have started to deal with similar problems in their own disability and retirement systems. For example, benefits are actuarially reduced for older recipients in Austria and Germany to try to keep the different income support systems co-ordinated. And in Portugal, Poland and Spain, earned income counts more than benefit income towards the defined-contribution pension.[14] Based on experience abroad, it is probably unrealistic to expect labour supply to increase significantly – even if the disability route to early retirement were closed off to some extent – as most older people want to retire and will choose the best pathway available. The difference, however, is that if they choose to retire early under the pension scheme, then they rather than the taxpayer will pay for it.

Finally, it is worth noting that many people are better off claiming sickness insurance rather than unemployment insurance because SI has a higher ceiling (115% of the average wage, compared with around 90% for UI). It would be better to align the systems, as recommended by the Lindbeck Commission more than a decade ago.[15]

Box 3.2. **Summary of recommendations**

The scale of the problem in Sweden means that comprehensive reforms in many areas are needed. Few of the recommendations on their own would make much of a dent in the problem of absenteeism. Together, however, they might. The key is to develop a culture of "mutual obligations" in which the sick person, the employer and the social insurance office each have clear responsibilities.

Responsibilities for the social insurance office

Improve the assessment process: Require a medical certificate earlier. Re-assess eligibility more frequently, and re-introduce occasional random checks. Social insurance doctors should undertake an independent medical assessment, possibly after a few weeks but certainly before granting permanent disability benefits. The decision to grant a disability benefit should be made by a panel comprising social insurance and rehabilitation experts, not by local politicians.

Carefully monitor how partial benefits are being used to ensure they are not just an income top-up for people who want to scale back their working hours. Make it easier for people on partial benefits to change employer.

Box 3.2. **Summary of recommendations** *(cont.)*

Responsibilities for the employer

Increase financial responsibilities on employers, but only if other parts of the system are tightened up as well. Monitor their response to the 15% co-payment. If it does not have the intended effect, replace it with a higher up-front cost but with a limited duration (*e.g.* full responsibility for the first 2-3 months only). Involve employers in vocational rehabilitation, and ensure this starts earlier. Introduce employer or industry risk-weighting. As a first step, the premium could be differentiated between the public and private sectors.

Separate out the workplace injury scheme, and have it fully funded by employers. Consider allowing this scheme to be run by the private sector. In negotiating labour market agreements, ensure that these agreements do not overrule policy objectives (*e.g.* through top-ups to benefit levels).

Reforms would be more effective and have fewer side effects if employment protection rules were eased as well.

Responsibilities for the sick person

Increase the focus on active measures – in most cases, receipt of a benefit should depend on participation in employment, vocational rehabilitation and other integration measures.

Extend the waiting period beyond one day. Sickness and disability benefits should not count towards pensionable income (at least beyond a certain age) so as to reduce the incentives for using these benefits as a pathway to early retirement. Align the SI and UI ceilings.

If all other reforms fail to deliver a significant reduction in absenteeism, then as a last resort the generous benefit levels may have to be cut.

Notes

1. The estimates in Table 3.3 are from the Spring European Labour Force Survey. Absences in Sweden continued to fall for the rest of 2004, so the figure for the whole year is likely to be lower than shown here.
2. There are two common explanations of why such absences may be pro-cyclical. First, high unemployment acts as a worker disciplining device, reducing the likelihood that they will take sick leave for minor health problems. Second, a tight labour market may pull in marginal workers who are more likely to have higher rates of absenteeism. There is no clear evidence whether health itself may vary over the business cycle, for example due to work pressure during boom times.
3. In 2003, less than one in five long-term (more than 60 days) sickness benefit recipients were in a rehabilitation programme. Of those who were, their programmes lasted an average of 100 days.
4. See Englund and Svärdsudd (2000) and Granvik (1998).
5. From March to September 2003, 2 741 applications for a new benefit or for extension of an existing benefit were refused. At an annual rate, this corresponds to around 2% of the stock of sickness benefit recipients and thus is 1% of the inflow given that the average duration is around ½ year. See Dagens Nyheter (2005).
6. The private insurance market has evolved over time, with the variation in premium rates across firms having become much larger in the last couple of years. When sickness pay was first privatised in 1996, around half of all companies took out private insurance. The insurance companies competed fiercely for customers in the first years, so premiums were well below their break-even level. It was hard to see what impact privatisation had in the early years because its effects were masked by a cyclical upswing, as absenteeism tends to rise when the labour market is

tight (see Table 3.5). Insurers began adjusting premiums in 2000 and 2001 after making heavy losses, with premium rates becoming noticeably differentiated across firms.

7. See Statens Folkhälsoinstitut (2003) and Hytti (2003).

8. It could be argued that rehabilitation should not start too early because of the high deadweight costs of paying for a programme that many people would not need because they would go back to work soon enough anyway. That may be true, but it calls into question the basic objective of trying to encourage early intervention; it is not relevant to the question of whether a high up-front cost would be better than a flat 15% when it comes to achieving the goal.

9. Some of the difference can be explained by differences in gender and age: the public sector employs more women and older people, for example, both of which will tend to raise sickness rates (Olsson, 2003). This will be offset to some extent by different average education levels. Arai and Skogman Thoursie (2004) find that substantial variation across establishments and across sectors remains even after individual characteristics have been taken into account.

10. In one Italian study, for example, absenteeism more than doubles as soon as a worker is protected from firing (Ichino and Riphahn, 2003). For other evidence, see the studies referred to in Ichino and Riphahn (2004).

11. In another study, Johansson and Palme (2004) found that the benefit reform in 1991 had the largest impact on short-term absences, but the poor design of the reform made it *less* likely that people would return to work if they had been on the benefit for more than 90 days. The reason is that the benefit rate was lowered only for the first three months of each sickness spell, so people who went back to work risked having to rejoin the sickness benefit later at a lower rate.

12. See Andrén (2004) and Henrekson and Persson (2004). The latter study estimated that the abolition of the waiting day in 1987 boosted the average number of sick days by 10%. The effect was of moderate size but statistically insignificant for men, but was highly significant for women.

13. In Palme and Svensson (2003), the net present value for that 55 year-old is almost exactly twice as large in the labour market insurance path relative to the pension path. Their modelling, however, is based on the old pension system. The new notional defined-contribution system makes the sickness and disability option even more attractive.

14. In Portugal, only earned income counts towards a disability benefit. In Poland, benefit income accrues at half the rate of earned income. In Italy, a full disability benefit accrues towards a pension, but a partial disability benefit earns no pension rights.

15. The systems were partially aligned in July 2003; from that date, people moving from UI to SI would face the lower UI ceilings on their benefits.

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Chapter 4

Raising hours worked

This chapter discusses other ways to increase labour supply, aside from reducing sickness absences (which is discussed in Chapter 3). High labour taxes and the benefit system are contributing to reduce hours worked, and it is recommended that marginal tax rates be lowered by moving to other tax bases. Generous leave schemes also reduce working hours. Although labour force participation is high in general, there are still pockets where it can be raised, notably by getting young people through the educational system faster, improving the integration of immigrants and reducing incentives to early retirement. Labour supply would also benefit from stricter application of unemployment rules and from the elimination of ineffective active labour market programmes.

Boosting hours worked is one of the best options for coping with the effects of an ageing population. Demographic changes imply that a larger share of the population will be in age groups where participation in the labour market and hours worked are typically lowest, thus significantly changing the balance between contributors to and beneficiaries of the welfare state. The more that labour supply can be raised, the less likely it will be that cutbacks may need to be made to the welfare state in the future.

High employment rates combine with low average working hours in Sweden

In terms of total labour supply, Sweden is around average among OECD countries (see Figure 1.6, where Sweden nevertheless is placed among the top 10 of 24 countries). This reflects high employment rates, in particular for women, but low annual working hours for those in employment. High absence rates are the main reason for the shortfall in hours at work. While employment rates for men and women are 75 and 72%, respectively, the share actually at work is 10 percentage points lower for men and 15 percentage points lower for women (see Figure 1.7). This is not because Swedes have more holidays, but because they are more than twice as likely to be absent for various other reasons than the average of countries; only Norway matches Sweden in that respect (Table 4.1). Half of this is due to sickness absences, suggesting that the single most important challenge is to reduce the high number of people absent for this reason. This issue is dealt with in Chapter 3. The other half is due to various leave schemes, including parental, study and sabbatical leave. On top of high absence rates, the normal workweek is a little shorter than the European average, although Swedes are more likely to work overtime.

High taxes on labour income depress labour supply

Lowering working hours is a natural way for households to seek gains in welfare when income rises. But the choice between earned income and leisure is significantly distorted by taxes on labour income. International evidence suggests that countries with high taxes are also those with the lowest working hours (see, for instance, Davis and Henrekson, 2004; Prescott, 2004; and the analysis in Box 2.1).

In Sweden, the expansion of publicly provided paid leave schemes and reductions of annual working hours in collective agreements should be seen in context with a high tax burden on labour. Today, various schemes for lower working hours have been agreed in most parts of the labour market, including some where the individual employee can freely choose between wages, pension contributions and time off.[1] These schemes are likely to be the main reason why Sweden has seen a relatively large reduction in working hours of full-time employees since 1995 (Table 4.2). The effect on total working hours has, however, been mitigated by a drop in the share of part-time workers.

The acknowledgement of a link between the distortionary effects of labour taxes and labour supply was one of the main motivations behind the 1990 tax reform, which aimed at reducing marginal taxes for all income groups. The ambitions were for the highest

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Table 4.1. **Anatomy of a typical work year**

Decomposition of average annual hours worked by full-year equivalent workers (dependent employees working full or part-time weekly hours, 2002)

	Annual hours of work	Average weekly hours on all jobs	Usual weekly hours of work on the main job	Extra hours on main job (overtime, flexitime, etc)	Hours on additional jobs	Annual weeks worked	Holidays	Absences for other reasons
	(a) = (b) * (f)	(b) = (c)+(d)+(e)	(c)	(d)	(e)	(f) = 52–[(g)+(h)]	(g)	(h)
	Hours	Hours worked per week				Weeks worked/not worked		
Poland	1 817	41.8	40.2	0.3	1.3	43.4	6.2	2.4
Greece	1 816	40.7	40.2	0.1	0.4	44.6	6.7	0.6
Hungary	1 798	40.9	40.3	0.4	0.2	43.9	6.3	1.8
Slovak Republic	1 761	41.8	41.4	0.3	0.1	42.2	6.9	2.9
Iceland	1 714	43.2	39.9	1.7	1.7	39.6	6.1	6.3
Czech Republic	1 692	41.3	40.4	0.7	0.3	41.0	6.2	4.8
Portugal	1 688	40.4	39.3	0.3	0.8	41.8	7.3	2.9
Spain	1 639	38.8	38.6	0.1	0.2	42.2	7.0	2.9
Switzerland	1 586	37.5	34.3	2.7	0.5	42.3	6.0	3.7
Ireland	1 585	36.3	35.8	0.2	0.3	43.7	5.7	2.6
Luxembourg	1 582	37.9	37.3	0.5	0.1	41.7	7.5	2.8
United Kingdom	1 546	38.2	37.2	0.7	0.4	40.5	6.5	5.0
Italy	1 533	37.4	37.2	0.1	0.1	41.0	7.9	3.1
Austria	1 497	38.4	36.6	1.4	0.4	39.0	7.2	5.9
Finland	1 491	38.8	36.9	1.4	0.4	38.5	7.0	6.5
Germany	1 480	36.5	35.2	1.1	0.2	40.6	7.8	3.6
France	1 467	36.2	35.2	0.8	0.3	40.5	7.0	4.6
Belgium	1 451	36.3	35.7	0.3	0.3	40.0	7.1	5.0
Denmark	1 410	36.3	34.8	0.8	0.7	38.9	7.4	5.7
Sweden	**1 349**	**38.1**	**36.0**	**1.4**	**0.7**	**35.4**	**6.8**	**9.8**
Norway	1 339	37.3	34.8	1.8	0.7	36.0	6.5	9.5
Netherlands	1 223	31.8	30.1	1.3	0.4	38.4	7.5	6.1
Unweighted average	1 567	38.5	37.2	0.8	0.5	40.7	6.8	4.5

Note: For all countries, absences due to sickness and maternity are counted twice to adjust for an estimated 50% under-reporting of absences in labour force surveys. See Annex 1.A1 of the *OECD Employment Outlook 2004* for a detailed discussion of this and other assumptions underlying the estimates in this table.

Source: OECD estimates based on European Labour Force Survey and EIRO (2002), "Working Time Developments – 2002", *www.eiro.eurofound.ie/2003/03/update/tn0303103u.html*. See *OECD Employment Outlook 2004* for further details.

Table 4.2. **Full-timers have reduced their working hours**

Average actual hours worked per year per employee

	Overall change 1990-2002 (%)	Percentage change attributable to:		
		Change in hours of full-timers	Change in hours of part-timers	Change in share of part-timers
Austria[1]	–1.6	1.8	–0.3	–3.0
Belgium	–7.8	–3.4	0.0	–4.0
Denmark	2.1	0.3	–0.1	1.8
Finland[1]	–2.6	–0.1	–0.9	–0.9
France	–6.1	–4.2	0.4	–2.3
Germany	–6.0	–1.3	–1.1	–3.8
Greece	3.0	3.2	0.1	–0.3
Hungary[1]	1.2	1.1	0.1	–0.2
Ireland	–7.6	–2.1	0.1	–5.5
Italy	–3.0	–1.3	0.2	–2.0
Luxembourg	–4.8	–1.7	–0.6	–2.3
Netherlands	–8.9	0.3	–0.1	–8.9
Norway[1]	1.0	–2.1	0.2	2.9
Portugal	–4.6	–4.0	0.2	–0.8
Slovak Republic[1]	4.5	4.4	–0.2	0.3
Spain	–2.7	–0.5	0.1	–2.2
Sweden[1]	**–0.6**	**–3.2**	**–0.3**	**2.8**
Switzerland[1]	–3.2	0.2	0.4	–3.9
United Kingdom	–1.5	–0.1	0.7	–1.8
Unweighted average of above countries	–2.1	–0.5	–0.1	–1.5

1. Data for these countries cover the period 1995 to 2002.

Source: OECD estimates based on the European Labour Force Survey. See *OECD Employment Outlook 2004* for further details.

marginal tax rate to be no more than 50% and for the share of people paying central government taxes to be below 15%. But during the period of consolidation of public finances in the mid-1990s, an extra central government tax of 5% was introduced for the highest-income earners, and thresholds for paying central government taxes have not kept pace with wage increases. Although the government has lowered income taxes several times since 2000, mostly by a special tax credit for taxpayers' contributions to the pension system, this has to a large extent been offset by higher local government taxes. As a result, the highest marginal tax rate is still around 56%. Taking into account social contributions as well, the marginal tax wedge on labour for a single, childless employee earning twice or more of the average production worker wage (APW) is about 67% (Figure 4.1).

The incentives to work more hours are further reduced by means-tested benefits, although these are much less common in Sweden than elsewhere (overall, around 7% of public income transfers are means-tested; 29% are paid at the same flat rate for everyone; while the remainder are of an insurance type and thus tied to previous income). According to one study, the average marginal effective tax rate (METR) was 46% in 2003 (Eklind *et al.*, 2004).[2] Those with the highest METRs (over 60%) typically have low income, such as part-time workers, while METRs of this magnitude are seldom among full-time employed; yet 35% of them have METRs in the interval 50-59%. Tax and benefit systems also distort incentives for individuals when deciding whether to work at all. In particular, those with an earnings potential below the ceilings in the unemployment and sickness

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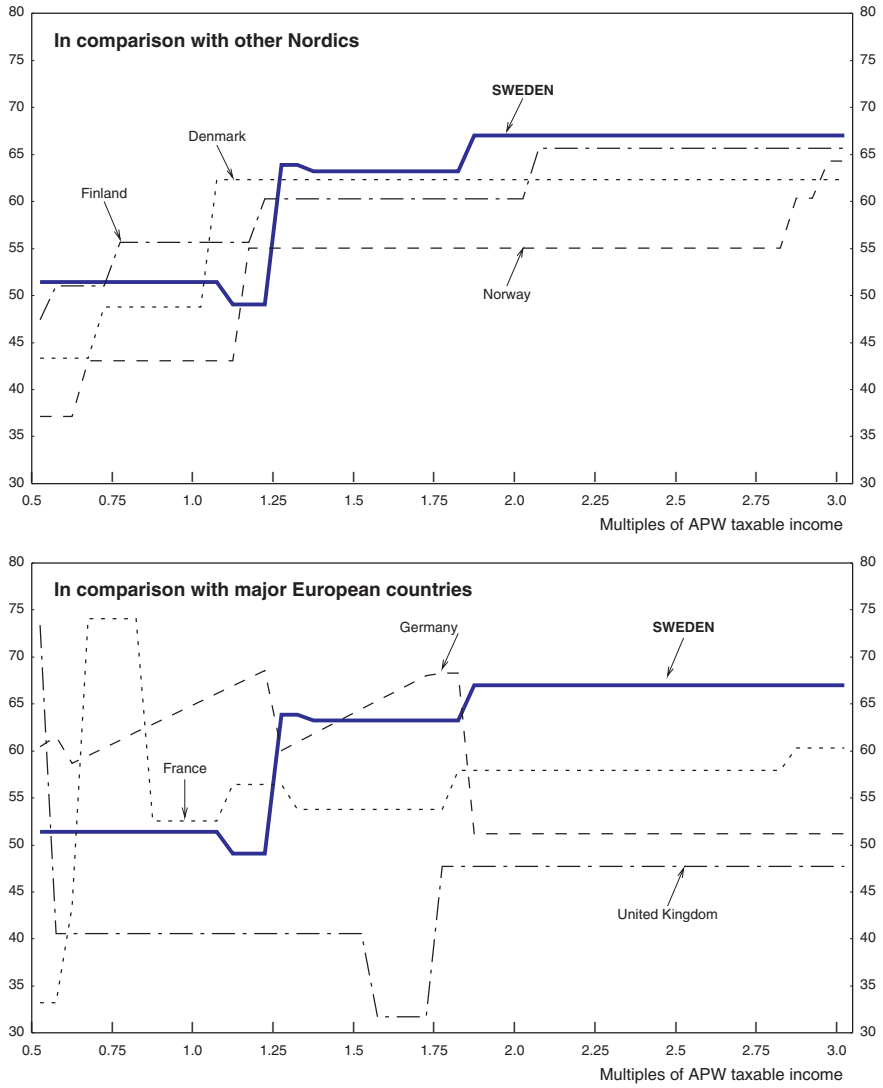
Figure 4.1. **The marginal tax wedge is high**[1]
For a single person with no children in 2003, per cent



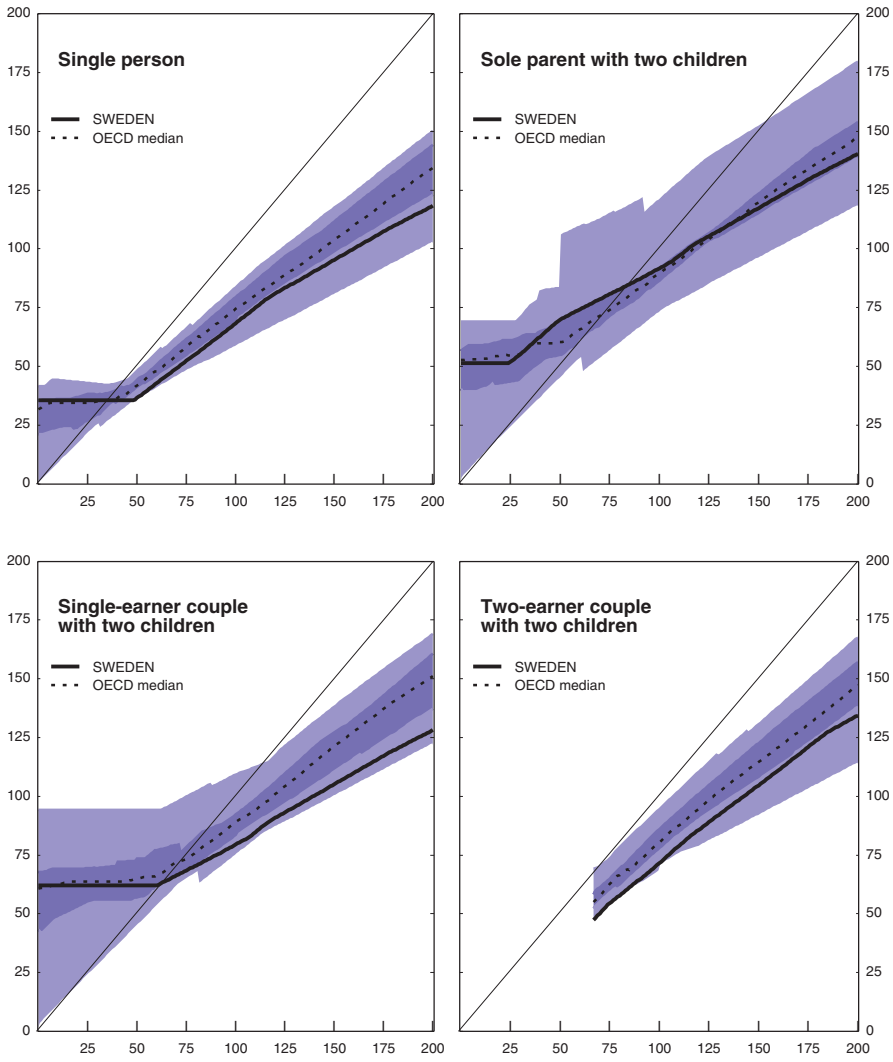
1. Tax wedges – between labour costs to the employer and the corresponding take-home pay of the employee – are calculated by expressing the sum of personal income tax, employee and employer social security contributions together with any payroll tax, as a percentage of labour costs.

Source: OECD Taxing Wages database.

insurance systems (around 115% of APW) face very high replacement rates. Looking across OECD countries, the interaction between tax and benefit systems in Sweden has a fairly large impact on work incentives for most family types; in each case take-home pay relative to gross income is among the lowest quartile of OECD countries over most of the income scale except for sole parents (Figure 4.2). Furthermore, the increase in take-home pay from extra work is relatively small in single-breadwinner families.

Since Sweden already has fairly high employment rates overall, the top priority for tax reforms should be to lower the high marginal tax rates, since they impact on the working-

Figure 4.2. **Take-home pay relative to pre-tax earnings is low**
Per cent of average economy-wide pre-tax earnings



Note: The horizontal axis shows pre-tax income as a percentage of economy-wide average earnings. The vertical axis shows take-home pay after taxes and social assistance entitlements have been taken into account (assuming the family is not entitled to unemployment insurance). The dark shaded area shows the OECD inter-quartile range (half the countries lie in this range); the light area shows the full range of the 22 OECD countries in addition to Sweden for which data are available.

Source: Caron *et al.* (2004), "Indicators of Unemployment and Low-Wage Traps"; OECD, Social, Employment and Migration Working Paper No. 8.

hours decision. Going back towards the principles of the 1990 reform would be an obvious benchmark. That would involve reducing central government tax rates and raising their thresholds. The associated revenue losses would be fairly small (*e.g.* 0.2% of GDP from reducing the top central government tax rate from 25 to 20%), and may even be negligible if the tax cuts provoked an increase in labour supply. Going further than the 1990 reform and reducing the lower central government tax rate of 20% (currently raising revenue of just 1.1% of GDP) would improve work incentives for a larger part of the prime-age working

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population – around one-third of full-time workers aged 25-59 pay this tax. It would also provide a stronger financial reward for human capital investments. The effect on the income distribution from reducing central government income taxes is likely to be small (see Figure 1.9), especially when seen over a full lifetime.

The high METRs and replacement rates in the bottom part of the income distribution suggest that it would also be important to focus attention here. While the most effective option would be to reduce benefit replacement rates, this would be hard given Swedes' attachment to a high level of publicly-provided income protection. A second-best option would be some sort of in-work benefit, for instance an earned income tax credit (EITC). However, to have any significant impact a general EITC would need to be of a magnitude that would involve large costs in terms of lost revenue. The fiscal costs would be reduced if the credit was phased out over a short income interval, but that would introduce higher marginal effects in that interval, and the degree of wage compression in Sweden means that even an income-tested tax credit would still straddle a sizeable portion of the income distribution.

Any tax reform package should be fully financed in order not to worsen fiscal sustainability, either by scaling back low-priority expenditure programmes or by moving to tax bases that are less distortionary. Increasing the relatively low property taxes would be one option, although it would have to be timed right and phased in carefully. Eliminating the lower rates of VAT (*e.g.* on food and books) would be another. It would have practically no distributional effects and yield around SEK 20 billion (0.8% of GDP) (Lundgren *et al.*, 2005). Other options would be to let, for instance, an EITC partly replace the current basic allowance in the income tax system or use revenue generated from further increases in environmental taxes for reductions in taxes on earned income only (instead of increasing the basic allowance as has been done with the SEK 13½ billion worth of "green tax shifts" that have been implemented so far). While this would shift more of the tax burden onto people not working, the distributional effects over individuals' lifetimes would be smaller, as most people are active on the labour market at some stage in their working age.

Generous leave schemes contribute to the shortfall in working hours

Taking a break from work for reasons of child caring, education, or plain joy of it is a valid personal choice between income and leisure. In Sweden, the attractiveness of temporary withdrawal from the workforce is expanded by a variety of tax-financed leave schemes. While popular, it needs to be recognised that these schemes come at a cost in terms of lower labour supply and thus less contribution to financing the welfare system. The more these schemes are used today, the fewer public services will be affordable in the future.

Maternity and parental leave have a significant negative impact on average working hours. The parental leave scheme is very generous by OECD standards, providing 16 months in total per child.[3] The benefit rate is also generous, especially in the cases where employers top up benefits to 90 or even 100% of salary for most of the leave period. The scheme is very flexible: days can be taken until the child is eight years old and in fractions of a day.

The key question is whether the system has become so generous that the costs outweigh the benefits. The evidence for Sweden is inconclusive. However, across OECD countries, there is reasonably clear evidence that women are more likely to enter and stay in the labour force if they have rights to short-duration maternity leave. But there is no

consistent pattern among long-duration schemes – in some cases they appear to lower employment rates or to harm a mother's long-term earnings potential (OECD, 2001). In Sweden, the long leave entitlements certainly contribute to mothers' absences from work for more than a year, and such long interruptions are unlikely to advance career prospects. Rather, they may lead to lower earnings potential and to maintaining and reinforcing gender segregation in the labour market, which is substantial in Sweden (EC, 2004).

While Sweden's parental leave scheme serves valid family policy objectives, better labour-market outcomes for women might be achieved by changing the leave provisions. A government committee is currently scrutinising the parental leave and is to deliver recommendations by September 2005. A key principle behind any reforms should be to avoid measures that increase the duration of mothers' leave further in order not to aggravate gender segregation and human capital loss. One way to improve the system might be to increase the share that is not transferable between parents. Also, it is questionable whether there should be an automatic right for parents to shift to part-time work until the child is eight years old, irrespective of the wishes of the employer. Changes along these lines are unlikely to have significant effects on the child's development and welfare. The government intends instead to raise both the ceiling on parental benefits for the first four-fifths of leave days and the flat rate paid for the remainder of days in order to make parental leave more attractive to men who are more likely to have earnings above the ceilings. However, measures that increase generosity should be avoided, as they might instead lead to longer leave periods of mothers.

Sweden also has a generous scheme for study leave, which is a main element in the strategy of lifelong learning. All employees are entitled to this leave and can receive study allowance (grants and loans) up to the age of 50. The duration can be from one week up to several years, and courses are free of charge in the public education system. The government intends to expand the scheme to enable a greater number of older students to fund their education this way. It is questionable whether that money would be well spent. Only half of those starting in tertiary education take an exam because many are older students who do not have a certified qualification as the goal for their studies (SOU, 2004). To screen out those without any real intention of getting a diploma or who are studying just for the pure personal fun of it, study allowances could be limited to only those courses that are clearly job-related.

Yet another general leave scheme was introduced in 2005. Following a number of pilot projects, sabbatical leave is now available for 10 000 persons in 2005 and 14 000 persons in 2006. Employees can, with the agreement of their employer, take 3-12 months off and be replaced by an unemployed person registered at the public employment service (PES), during which they will receive 85% of the UI benefit. The main purpose of this scheme is to give employees the opportunities for recreation, skill improvement or some other personal development, while enabling the unemployed to strengthen their position in the labour market *via* temporary employment. Although the number of places is small, there will be pressure to expand it as around 40 000 applications (almost 1% of the labour force) were received this year. A sabbatical leave scheme was also in place in Denmark in the 1990s, but it was abolished on the grounds that this kind of work-sharing arrangement is detrimental to the objective of raising employment. Sweden should abolish its scheme as well. While it is intended to help long-term unemployed, replacements are mostly found among people who have recently lost their job.

There are still pockets where labour market participation can be raised

Although Sweden has fairly high participation rates in international comparison, especially for women, there are certain pockets where employment could be raised further. These are found in both ends of the age spectrum and among immigrants.

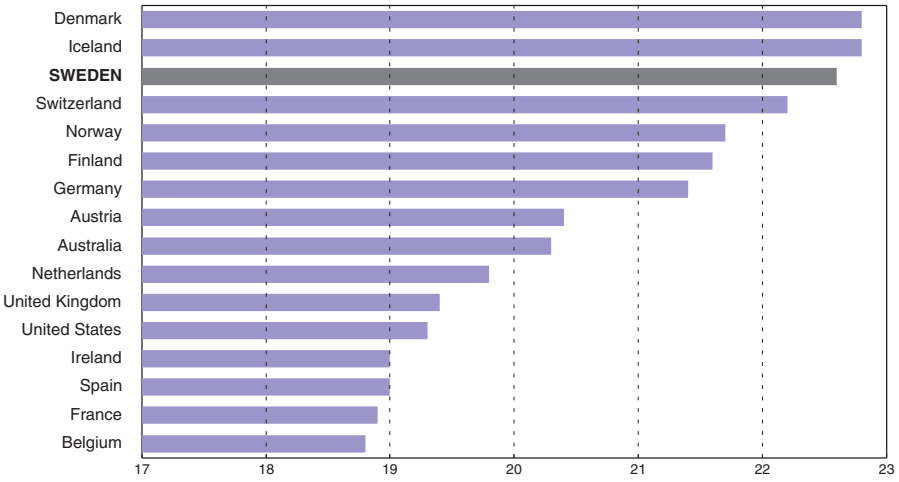
Students should finish studies more quickly

Labour force participation rates of youths have dropped significantly in the last 15 years, partly as a result of the employment "shake-out" during the economic crisis in the early 1990s and partly because of the strong policy emphasis on improving educational attainment. This has delayed labour market entry of young people. But their human capital has been boosted, which is an important element of growth-oriented policy. Nevertheless, there are clear signs of inefficiencies in the system; Swedes start tertiary education later than in most other OECD countries (Figure 4.3), and they take a long time completing their studies.

Late entry is mainly explained by the design of admission rules to tertiary education. Qualification based on upper-secondary school grades is the principal route into tertiary studies (the national university aptitude test is another important way of getting access), and the system offers a variety of possibilities for maximising one's grades via choice of special courses and programmes and by re-taking already passed courses in municipal adult education so as to improve one's grades. Around 40% of new students aged 20-22 had studied in municipal adult education before starting tertiary education in 2002 (SOU, 2004). This has led to a situation where some upper-secondary students are forced to improve grades because those who are two years older have done that and therefore raised the thresholds for gaining access to tertiary education. Ultimately, it is likely to be the same people getting a study place, but after essentially wasting one or two years. An expert committee delivered a catalogue of recommendations to reduce these problems last year, and the government is now working on proposals to change admission rules. These

Figure 4.3. **Students start their tertiary education late**

Median age of starting tertiary education

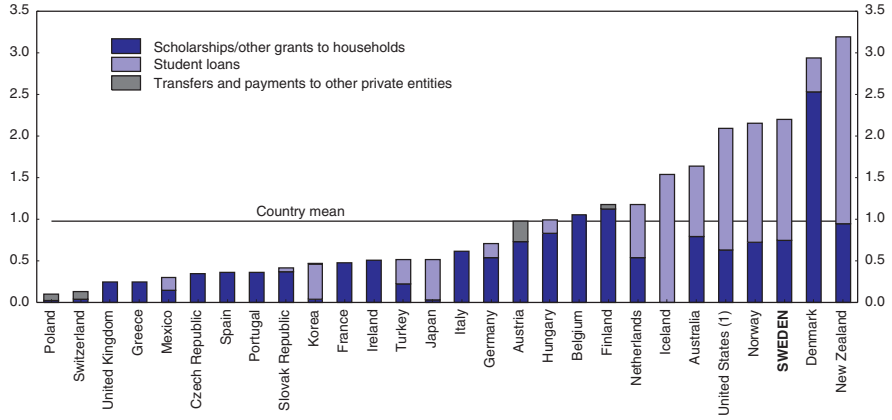


Source: OECD Education at a Glance 2003.

proposals include giving more weight to grades for "tougher" courses (such as mathematics and foreign language other than English), reducing the weight given to work experience and tightening the conditions for entry for those with grades from municipal adult education. That would implicitly give more weight to the initial set of grades obtained. If these steps are found to be ineffective, the government may have to consider a tougher approach. That could include abolishing the option of improving passed grades in municipal adult education altogether (while maintaining a second chance for those who failed a course to get a pass grade by re-taking the course) as well as the option of taking locally designed courses in upper-secondary education (for instance, a course in mushroom picking) that can be substituted for normal courses (like mathematics) when calculating overall grade-points. Extra points for work experience could also be awarded only for such experience that is relevant to the study in question.

The long time spent in tertiary education is to some extent explained by interrupted studies. Taking a break for a semester or more is fairly common, and many people change their specialisation during studies. While getting a bachelor degree is supposed to take 6 semesters, the average length of effective studying was 8-9 semesters for students graduating in the period 1998-2002; adding study breaks brings the total to 9-11 semesters (SOU, 2004). Generous study allowances and the absence of tuition fees are also likely to be part of the reason for drawn-out studies (Figure 4.4). One option for encouraging students to finish more rapidly and choose courses more relevant to the labour market would be to introduce modest tuition fees backed up by income-contingent loans. After all, loans are already extensively used as backup for living expenses. If that is not acceptable, an alternative could be to convert some of the student's loans into grants if studies are finished within the prescribed period, a model recently implemented in Norway. Tightening the requirement for demonstrated study activity in order to be eligible for study allowances would be another way of increasing throughput. To qualify for study allowance, students have to achieve at least 30 out of 40 (the norm) study points per year, *i.e.* they have the option of taking what effectively amounts to one year of subsidised leave during a study

Figure 4.4. **Study support is generous but comprises mostly loans**
Public subsidies for education to households and other private entities as a percentage of GDP, by type of subsidy



1. Including post-secondary non-tertiary education.

Source: OECD Education at a Glance 2004.

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Table 4.3. **The impact of policy changes on the private rate of return to university education**

	Change in percentage points
Introducing tuition fees of 10% of the average wage (€ 230 per month)	–1.19
All student support is given in the form of loans	–0.23
Finishing studies six months earlier	1.00
A higher wage premium for tertiary graduates (55% rather than 50%)	0.93
Cutting the average tax rate on high-income earners by 3 percentage points	1.32

Note: The level of the private internal rate of return has been estimated to be around 11% per annum in Blöndal *et al.* (2002) and around 8% in *OECD Education at a Glance 2004*.

Source: OECD calculations.

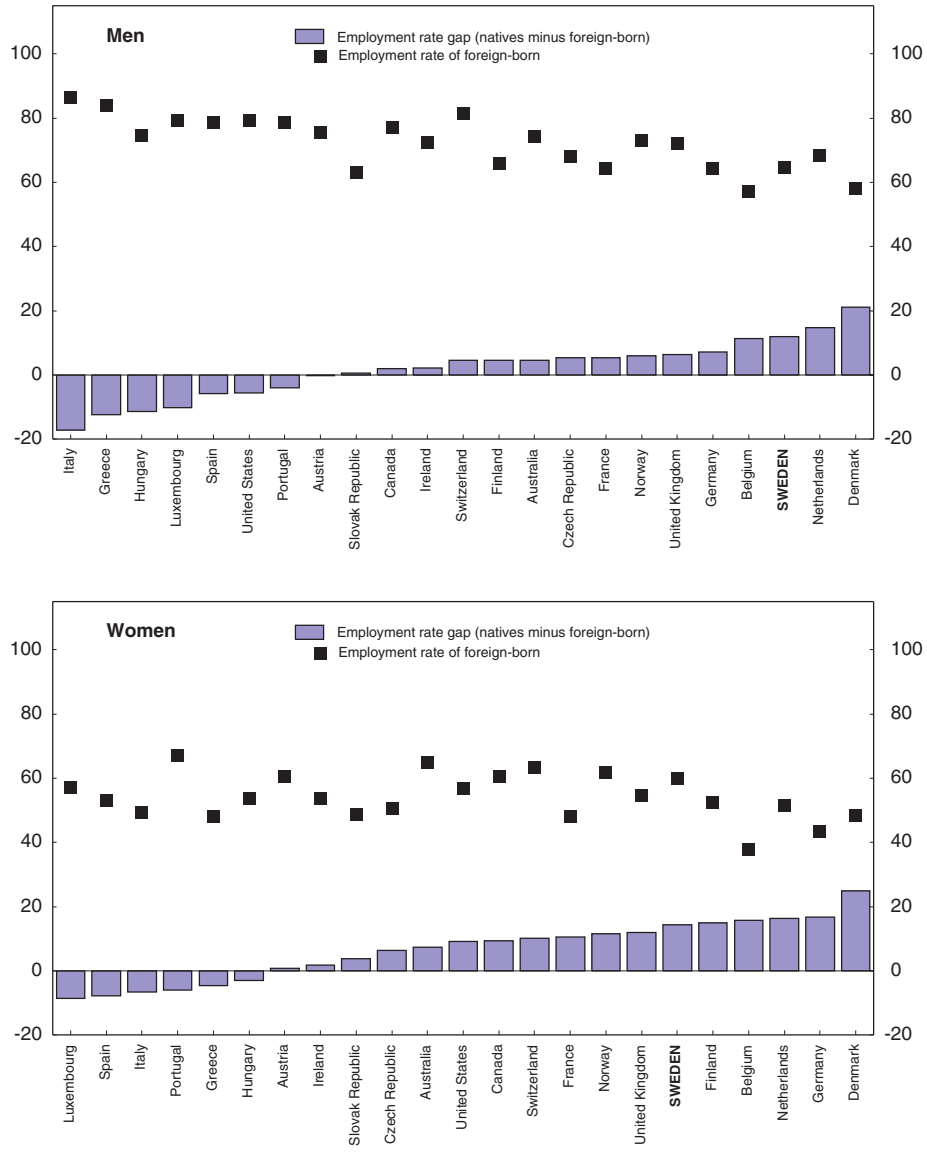
programme that is supposed to last for three years. Providing grants only for the minimum length of a study programme, while offering loans with income-contingent repayments instead, is yet another alternative. However, the room to move may not be substantial. The generous study subsidies counter the negative impact on incentives to undertake tertiary education that arises from a compressed wage distribution and high taxes on earned income. The private return to higher education is overall around the average of countries for which data are available (Blöndal *et al.*, 2002), but it is very low, maybe even negative, for some professions that will be increasingly demanded (for instance, nurses). Nevertheless, to the extent that a tightening of study allowances is successful in getting students to enter the labour force faster, their lifetime earned income will be higher. On balance, the effect on the rate of return to tertiary education may therefore be rather small (Table 4.3). The rate of return would also be boosted if marginal tax rates were cut.

Better integration of immigrants on the labour market would help

On current population projections, immigrant inflow to Sweden will keep the working-age population from falling in the next 50 years. This may suggest that immigration can help alleviate the demographic burden from the ageing of the population. But that will not be the case unless integration of immigrants on the labour market is improved. The employment rate of the foreign-born is fairly low compared to that of native Swedes (Figure 4.5). On current patterns of labour market performance, the average immigrant will therefore be a net burden to public finances (see previous *Survey*). By international standards, the employment rate of male immigrants is particularly low – both in absolute terms and relative to the employment rate of the native population. This may in part be explained by the fact that immigration to Sweden to a relatively large extent is made up by refugees (Figure 4.6), who are harder to integrate into the labour market. However, even in comparison with other EU countries with immigration dominated by refugees, integration of male immigrants into the Swedish labour market is relatively weak (Århammar, 2004). This is doubly unfortunate, as studies show that if first-generation immigrants have troubles getting a foothold in the labour market, then their children are also more likely to have difficulties integrating as well.

The lengthy process involved in assessing applications for asylum is likely to be an important impediment to integration. Around two-thirds are refused in the end, but it can

Figure 4.5. **Immigrant employment gaps are big**
Employment rates of working-age individuals by gender
2003



Source: OECD, *Trends in International Migration*, SOPEMI 2004.

take up to four years before a final decision is made because of time-consuming appeal procedures. During most of that time, refugees in principle have no possibilities to work and the language training they are offered falls short of that available to immigrants with a residence permit.[4] Furthermore, weaknesses in work practices among the various responsible authorities and inefficient integration measures seem to have reduced immigrants' possibilities of quickly entering the labour market. The main problems are

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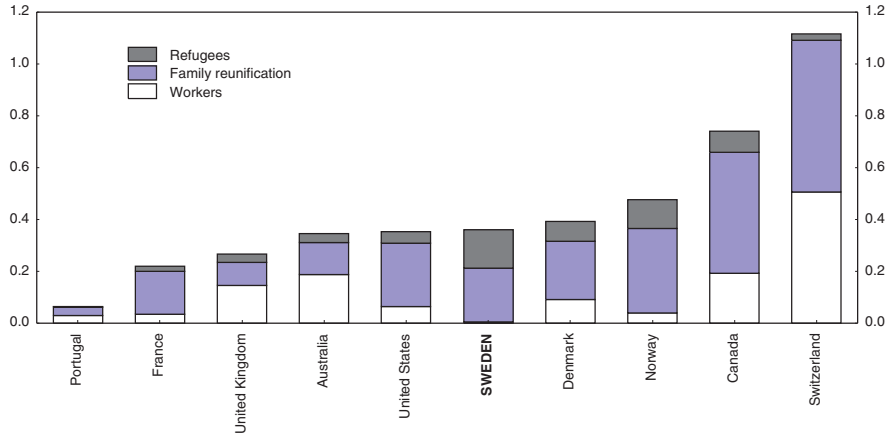
Figure 4.6. **Refugees constitute a relatively large part of immigration**
Permanent or long-term immigration by main categories, per cent of population, 2002



Note: See source for details on definitions for individual countries.
Source: OECD, *Trends in International Migration*, SOPEMI 2004.

lack of coordination; programmes and education that are not based on the competences of the individual; and too little emphasis on providing direct contact with the labour market (Århammar, 2004).

Low-skilled immigrants are particularly disadvantaged in Sweden because relatively few jobs are available that do not require any formal education. High minimum wages and a compressed wage distribution mean they cannot price themselves into the market. Heavy taxes on earned income further depress households' demand for home and other personal services – jobs that in other countries provide easy access to the labour market for immigrants, and others, with low skills. The tax and benefit systems also reduce the economic incentives for people at the low end of the wage scale to participate actively on the labour market. For skilled immigrants employers are often uncertain about the value of their foreign education, and many do not know that foreign credentials can be evaluated by the National Agency for Higher Education. Finally, discrimination, both among employers but also by authorities, is often mentioned as a problem.

The government is working to improve integration by strengthening co-operation between the responsible authorities, by focussing more on individualised measures that emphasise language and labour market training, and by battling discrimination. Another priority is to quicken the processing of asylum applications so that the full range of integration measures can start earlier.[5] Further efforts to improve knowledge among case officers of how to help immigrants integrate seem also to be called for. Introductory wages – conditioned on an assessment of skill levels that gives a high weight to linguistic knowledge – could be considered as a supplement to temporary wage subsidies, providing another way for employers to check an immigrant's skills before offering a regular contract. In general, the possibility of hiring labour for shorter periods and on more flexible terms can affect employers' willingness to recruit immigrant workers, especially if they are uncertain about their competences and productivity. That uncertainty could also be reduced if the process of validation of foreign qualifications were improved. Lower top marginal tax rates could help develop

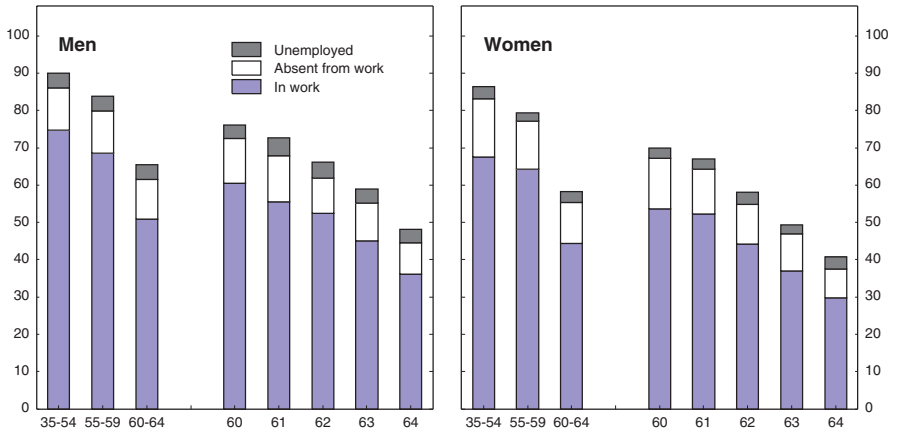
demand for personal and household services, generating jobs that are suitable for low-skilled immigrants.

Incentives to postpone retirement could be increased

Sweden has relatively high labour market participation of older workers. Since the pension reform in 1999 an impressive increase of participation rates among 60-64 year-olds has taken place, with rates rising nearly 12 percentage points for women and 10 percentage points for men. Nevertheless, participation of older males used to be much higher: the rate of men aged 60-64 has declined from 85% in the early 1960s to 65% in 2004. For both men and women, participation drops significantly at ages above 60 when occupational and public old-age pensions can be taken (Figure 4.7). Furthermore, the formal routes into early retirement are often complemented by informal exit routes *via* social security programmes, for instance sickness, disability and unemployment benefits.

In principle, the old-age pension system does not distort retirement incentives. With the 1999 reform, notional defined-contribution pension accounts were introduced (while mostly financed on a pay-as-you-go basis; see last *Survey*), and an actuarially neutral adjustment of pension wealth is made if retiring early (the "normal" pension age is 65, but pensions can be claimed from the age of 61). However, there are a number of reasons why public old-age pensions may still promote early retirement. While an actuarially neutral pension system in principle would not introduce distortions in the individual's retirement decision, there are two aspects of the retirement decision that such a system fails to take into account. *First*, from the point of view of an individual who may have a limited number of remaining healthy years, the subjective discount rate on pension wealth may be higher than the discount rate in the system, implying that the actuarial adjustment in the pension system does not provide an adequate compensation for postponement of retirement. *Second*, from the point of view of the society, the higher tax revenues resulting from continued work create financial gains outside the pension system. This also applies to the

Figure 4.7. **Participation rates drop significantly for 60-64 year-olds**
Per cent of working age population, 2004



Source: Statistics Sweden, *www.scb.se*.

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Table 4.4. **Main income source after labour force exit for people born between 1927 and 1932**

Per cent

	Men						Women					
	Total	Blue-collar workers	White-collar workers	Civil servants	Local govern. employees	Self-employed	Total	Blue-collar workers	White-collar workers	Civil servants	Local govern. employees	Self-employed
Pension pathways	*48.0*	*34.7*	*53.9*	*51.3*	*51.6*	*50.5*	*57.4*	*43.7*	*64.5*	*67.6*	*67.3*	*61.0*
Public old-age pension	27.0	24.3	31.0	25.9	25.4	41.6	33.7	25.7	36.2	28.3	41.1	48.9
Occupational pension	14.2	4.2	12.6	16.4	20.5	5.8	13.7	5.1	19.5	32.0	16.9	4.4
Partial retirement benefit	6.8	6.2	10.3	9.0	5.7	3.1	10.0	12.9	8.8	7.3	9.3	7.7
Insurance pathways	*39.9*	*54.9*	*32.7*	*38.6*	*36.5*	*28.9*	*35.5*	*51.3*	*24.7*	*27.7*	*25.2*	*32.5*
Sickness insurance	26.9	34.8	18.8	22.4	28.3	16.8	20.5	31.1	12.6	14.0	17.0	17.8
Unemployment insurance	6.4	14.1	8.6	5.4	1.8	6.9	8.4	13.1	7.7	4.8	2.5	5.7
Disability pension	6.6	6.0	5.3	10.8	6.4	5.2	6.6	7.1	4.4	8.9	5.7	9.0
Other income sources	*12.1*	*10.6*	*13.5*	*10.1*	*11.8*	*20.6*	*7.2*	*5.1*	*11.0*	*4.5*	*7.5*	*6.5*

Source: Palme, Mårten and Ingemar Svensson (2004), "Pensionssystem och pensionering", *Ekonomisk Debatt*, No. 4.

reduction in (means-tested) housing allowances when postponed retirement leads to higher annual pension payments. These effects are typically not taken into account by the individual when deciding whether to retire. Furthermore, the pension system generates a problem of moral hazard because old-age pension rights, contrary to occupational pension rights, are accumulated while receiving social security benefits (see Chapter 3). Even before the introduction of the new pension system, sickness and unemployment insurance were used as exit routes by nearly one-third of the population (Table 4.4).

It is still too early to assess the possible effects of the new system on retirement behaviour, as the first payments from the reformed system started only in 2001 and cohorts born between 1938 and 1953 will receive pensions partly from the old and partly from the new system. However, for the reasons listed above, it can be argued that society as a whole would gain from tweaking the tax system so as to provide an incentive for later retirement.[6] A more direct option for increasing the average retirement age would be to link the earliest age of pension eligibility to longevity, although for this to be effective access to alternative exit routes would need to be restricted.

Implementation of unemployment policies should be tightened

A well-working unemployment system is important if policies to increase participation are to be effective. In Sweden, unemployment policies are based on a combination of relatively generous unemployment insurance (UI) benefits, rigorous requirements to seek employment and be prepared to take suitable jobs or participate in appropriate labour market programmes and sanctions for non-compliance with the rules. This strategy can successfully reconcile a dynamic labour market with a high degree of income security (OECD, 2004). Yet, there are possibilities for improving the workings of the system.

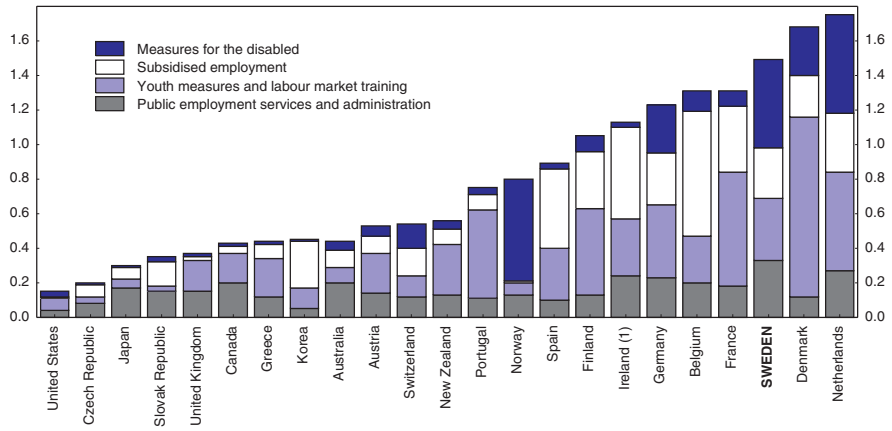
Strengthen enforcement of UI benefit rules

The UI system seems to be characterised by low search activity among unemployed, significant deficiencies in the public employment service's (PES) supervision of unemployment insurance and substantial regional disparities in the application of

regulations. There are, for instance, large variations among local PES offices in how frequently they question applicants' rights to compensation and how commonly unemployment benefits are extended beyond the normal 60-week limit (there has been a massive increase in the number of such extensions in recent years[7]). Part of the problem may be the dual role of the PES as service provider and monitoring authority. Especia lly in smaller communities, there is a tendency for case officers to apply the rules less strictly, possibly because personal acquaintance between a case officer and an unemployed person is more likely. Individual action plans are also of varying quality, and the National Labour Market Board seems to do a lacklustre job in controlling, following-up and assessing how these plans are used (Statskontoret, 2004a). The government has consequently instructed the National Labour Market Board to improve its efforts, but the Board's follow-through seems to have been inadequate.[8] The financing of UI benefits may also reduce labour market efficiency. Membership fees in UI funds account for only around one-fifth of total payments, and there is no connection between unemployment for members of a UI fund and fees in that fund – the marginal costs are covered by the central government. At the same time, most wage bargaining is decentralised to the branch level. The incentives for labour market actors to link wage demands with the costs of unemployment are therefore weak.

Overall, there seem to be significant potential gains from improving the performance of the institutions governing the UI system, especially considering that Sweden is the OECD country that spends the most on public employment services and administration (Figure 4.8). *First*, sanctions for not actively seeking a job or refusing appropriate job offers or offers of places in active labour market programmes should be strengthened.[9] Transferring the role of enforcer from the individual case officer to a board in each PES would probably make it easier to apply sanctions. *Second*, amalgamating the National Labour Market Board and the county labour boards in a single nationwide agency should make it easier to ensure a more consistent application of administrative procedures, and it would eliminate the grey areas of responsibility between the two levels of authority

Figure 4.8. **Expenditure on active labour market policy is high**
Per cent of GDP, average 1999-2002



1. 2001.

Source: OECD Employment Outlook 2004.

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(Statskontoret, 2004b). *Third*, guidelines for local PES offices need to be clearer, including when and how referrals of a job or a place in a labour market programme to an unemployed person should be made and when extensions of the UI benefit period can be granted. The emphasis should be on more active job matching and control of availability earlier in the unemployment spell.

Use ALMPs to test labour market availability, but terminate low-efficiency programmes

Compulsory participation in active labour market programmes can work as a test of willingness to work and thus eligibility for UI benefits. In Sweden, the general rules are that the PES can refer an unemployed person to an active labour market programme only if it is "considered appropriate for both the individual and from a general labour market policy perspective" (Runeson, 2004), and the programme should be no longer than six months. More systematic use of labour market programmes is made for the long-term unemployed and those who are about to lose UI benefit eligibility. These people can be channelled into the Activity Guarantee (introduced in 2000), which is a framework within which the participant can take part in all regular labour market programmes or engage in various job-search activities, while receiving the equivalent of UI benefits. While the Guarantee is an improvement on the previous system, it provides in effect an open-ended access to income support at the level of UI benefits, as there is no time limit to participation within it.[10]

In general, experience with most active labour market programmes has been discouraging.[11] The government should therefore be cautious in allocating more funds to such schemes. There was some reduction in places and expenditures in 2003 (Table 4.5), but more resources were allocated with the 2005 budget, and the Swedish Labour Market Administration got a further increase in funds in the 2005 Spring budget to finance employment subsidies and training programmes, despite prospects of a reduction in unemployment. The Spring budget also redirected funds from theoretical education to labour market training, which has been found to be more effective. The government should continue to re-evaluate the usefulness of current programmes and reallocate resources to those that demonstrate clear positive effects on employment probabilities. Programmes with poor outcomes should be abolished altogether. To improve search activity and check willingness to work, the PES should refer unemployed people to programmes of short duration earlier in the unemployment spell. It is important, though, to strike a balance so that the possible positive effects on job-search activity arising from the *motivation effect* are not offset by a *lock-in effect* from spending time in programmes and thus being unable to search for a job in the meantime. A system of profiling (where statistical criteria are used to find the most appropriate approach for getting the individual back into work) could be

Table 4.5. **The number of places in ALMPs has been reduced**

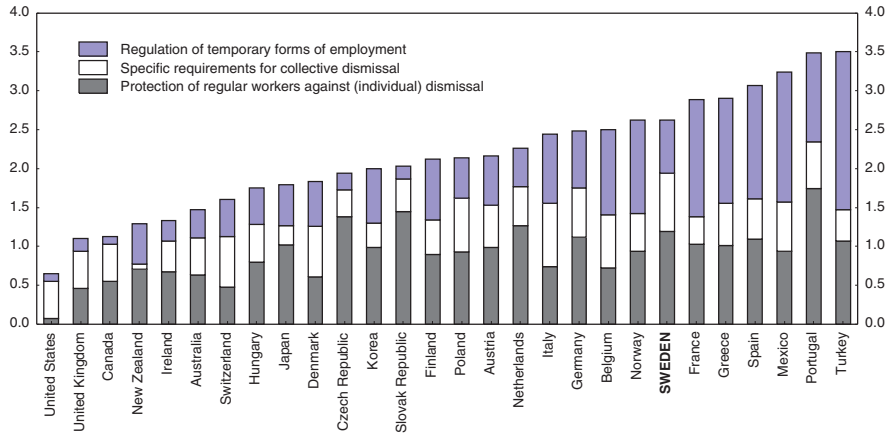
1 000 persons

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Labour force	4 319	4 310	4 264	4 255	4 309	4 362	4 414	4 421	4 451	4 459
Registered unemployed	333	347	342	276	241	203	175	176	217	246
People in ALMPs	198	202	191	173	142	113	112	117	92	106
Activation rate[1]	37.3	36.8	35.8	38.5	37.1	35.7	39.0	39.9	29.8	30.1
– as a per cent of labour force	4.6	4.7	4.5	4.1	3.3	2.6	2.5	2.6	2.1	2.4

1. Number of people in ALMPs as a per cent of the sum of registered unemployed and people in ALMPs.

Source: Statistics Sweden, *www.scb.se*.

Figure 4.9. **Employment protection is relatively strict in Sweden**
Overall strictness of EPL in 2003



Note: Indicators can range from 0 to 6 with higher values representing stricter regulation.
Source: OECD Employment Outlook 2004.

introduced to minimise the risk of wasting money and efforts on people who could easily find a job themselves. The Activity Guarantee should be reserved for those with a genuine need for intensified help to get back to work. This could relieve resources at the PES offices for more focussed efforts in counselling and monitoring of the long-term unemployed. Limiting the time spent in the Guarantee, for instance to one or two years as recommended in the 2001 *Survey*, would prevent it from being used for receiving UI benefits indefinitely.

Easing of EPL could help labour market entry of certain groups

The key challenge of raising labour supply also suggests that the emphasis on employment protection legislation (EPL) in Sweden should be reassessed. Sweden has for long been among the OECD countries with the strictest EPL (Figure 4.9). But raising employment rates of groups with less attachment to the labour market may be made more difficult by EPL. While there is no clear international evidence that EPL affects the unemployment rate, there is evidence that strict EPL reduces mobility and employment and participation rates. In Sweden, the last-in-first-out rule in the Employment Protection Act is the main restriction. It is designed to give extra protection to older workers and to reduce the amount of stigma associated with being made redundant. This favouring of those staying for a long time in a job is likely to be a main reason why tenure is long compared with other countries (see previous *Survey*). While this may lead to more firm-specific human capital, it may also reduce economy-wide human capital by reducing the "cross fertilisation" of ideas and it comes at a cost of reduced mobility and entrepreneurship. It may also impede shifting to a less demanding job late in one's working life and risks inducing more absence from the workplace as older workers try to ease their work burden; effective time at work may be low and less efficiently spent as a result.

Although downsizing of labour input is not difficult in Sweden, the question of who exactly is to be laid off is a matter of negotiation between the employer and the labour unions. This may make the employer more risk-averse when hiring – at the expense of groups at the margin, for instance immigrants, who are more often hired on temporary

contracts. The result could be a more segregated and less equal labour market, which is at odds with Sweden's desires for equality. Less strict EPL may avoid such tendencies. As the key challenge going forward is to raise labour supply, policies need to focus on increasing employment rates of those on the margin of the labour market, rather than protecting insiders.

Box 4.1. **Summary of recommendations**

Reform the tax system so as to improve work incentives: Reduce marginal income taxes; options include raising the thresholds for paying these taxes or cutting the rates for both tax brackets. Alternative financing could be sought in higher property taxes and by removing preferential VAT rates. Further "green tax shifts" could involve reductions in earned income taxes rather than all taxes.

Reform the parental leave scheme: Improve female labour market outcomes by increasing the share that is not transferable between parents. Avoid measures that increase the duration of mothers' leave further in order not to aggravate gender segregation and human capital loss. Abstain from making the leave benefits more generous.

Make study leave less attractive and abolish sabbatical leave: Limit study leave allowances to only those courses that are clearly job-related. Terminate the sabbatical leave scheme.

Earlier start in tertiary education and faster throughput: If the government's new proposed measures to promote an earlier study start prove inadequate, it could go further by removing the option for improving upper-secondary grades in municipal adult education. The option of substituting locally designed courses for normal courses when calculating upper-secondary grade points could be removed too, and extra points could be awarded for relevant work experience only. To speed up throughput, the study-activity requirement for study allowance eligibility should be tightened. Grants should be provided only for the minimum length of a study programme and loans with income-contingent repayments should be offered instead. Tuition fees combined with income-contingent loans could also be introduced, but if that is not acceptable, an alternative could be to convert some of the student's loans into grants if studies are finished within the prescribed period.

Better integration of immigrants: Shorten the time of reaching a final decision on asylum applications so that full economic integration can start earlier. Continue working towards more individualised integration programmes that focus on language and job training, using time-limited wage subsidies or introductory wages and continue to improve the process of validation of foreign qualifications.

Improving unemployment policies: Raise efficiency and equality in administration of labour market policies by amalgamating the National Labour Market Board and the county labour market boards. Strengthen sanctions for inadequate job search activity and for refusing job offers or offers of a place in active labour market programmes. Make a board in each PES – instead of the individual case officer – responsible for enforcement. Terminate inefficient labour market programmes. Refer unemployed to short-duration programmes earlier in order to raise search efforts and test availability, but introduce profiling to minimise the deadweight costs. Limit the length of the Activity Guarantee, and reserve it for those that really need intensified programmes.

Employment protection legislation: Job prospects for marginalised groups are likely to be raised if EPL were eased.

Notes

1. These schemes were first introduced in the manufacturing industry in 1995, and, when the current collective agreement for a daytime worker ends in 2007, the number of working days will be nine days less than in 1995 (Medlingsinstitutet, 2005). Lowering working hours has also been on the government's agenda for some time; its committee on new work time and vacation rules recommended in 2002 that a system of flexible working time be introduced allowing for time off amounting to five days per year, but no change in legislation has been presented yet.
2. In this study, METRs (or "marginal effects") are calculated as the change in household disposable incomes from an increase in gross wage income of SEK 12 000 (€ 1 333) per year. It shows the combined effect of marginal taxes, lower benefits and higher income-contingent contributions and fees. It does not include employers' contributions or consumption taxes.
3. Parental benefits are paid for a period of 480 days (16 months). 390 days are paid at 80% of annual income up to a ceiling of around 115% of the APW. Parents with low or no income at all receive a minimum guaranteed benefit of SEK 180 per day (EUR 20). The last 90 days are paid at a universal flat rate of SEK 60 per day (EUR 6.7).
4. While refugees are allowed to work if the Swedish Migration Board's initial assessment of their asylum application is expected to take more than four months, the work permit is withdrawn if residence is denied by the Board, and the refugee is not allowed to work during a subsequent appeal process. Furthermore, the PES is only available to refugees once they are granted a residence permit. The language training available to asylum seekers does not qualify for entering the regular Swedish education system, contrary to the "Swedish for Immigrants" course that is offered immigrants with a residence permit.
5. More resources have been allocated to expand capacity for processing asylum applications. Also, the government has instructed the Swedish Migration Board to analyse how the process can be shortened. According to the Board, the time used for making an initial assessment of asylum applications has been shortened lately and the target of a maximum 6 months (initial) processing period is within reach.
6. The pension system is autonomous and separate from the central government budget. It is based on actuarial principles, and any extra compensation for working an additional year would therefore be given at the expense of other pension beneficiaries if this compensation were provided within the pension system. Extra encouragement for older workers to stay in the labour force would therefore have to be provided from outside the pension system.
7. Extension of the compensation period is supposed to be granted only when a further period of receiving UI benefits affords better chances of ending people's unemployment spells than their participation in activities covered by the Activity Guarantee. Part of the explanation for the increase in granted extensions is that the number of places in programmes under the Guarantee has been inadequate. In order to prevent people waiting for such programmes from falling out of the UI system, the duration of UI benefits has typically been prolonged.
8. In its instructions to the National Labour Market Board for 2004, the government requested the Board to ensure that: *i*) the regional and local differences in the application of rules within the UI system be reduced significantly; *ii*) the referral instrument and questioning of UI benefit eligibility be used more efficiently and frequently; *iii*) all referrals to jobs or labour market programmes be followed-up by the PES; and *iv*) systematic benchmarking be used. The main instruments should be clearer guidelines on when to use the referral instrument, when to question UI benefit eligibility and when to extend UI benefits beyond the normal 60 week limit. Also, the quality of individual action plans should be improved. However, the Swedish Unemployment Insurance Board has assessed that the National Labour Market Board's efforts in these dimensions have been unsatisfactory (IAF, 2004).
9. Grubb (2001) showed that sanctions are used less in Sweden than in other countries. This is unfortunate, because even warnings about sanctions can have as strong an effect as a sanction itself according to one study on Swiss data (referenced in Fredriksson and Holmlund, 2004).
10. The Activity Guarantee is supposed to kick in after around 12 months and no later than 27 months of unemployment, and its main aim is to prevent long-term registration with the PES. Within the Guarantee, special mediation and guidance activities along with ordinary labour market programmes are offered on – in principle – a full-time basis, and one programme follows another on a continuous basis until the unemployed person gets a job, enters the ordinary education system or starts up a company. The indefinite duration is what distinguishes the Guarantee from other ALMPs, along with the increased job-search assistance (counselling) and stronger monitoring (because of the full-time nature of activities).

11. See, for instance, Calmfors *et al.* (2002), Fredriksson and Johansson (2003), Boone and van Ours (2004), and Forslund *et al.* (2004).

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Chapter 5

Improving quality and value for money in healthcare

This chapter reviews the strengths and weaknesses of the Swedish healthcare system and the challenges that it will face in the future. It discusses ways to improve access to primary care, including different methods for paying GPs, whether access is less equitable than in other countries and the role of patient fees. The maximum waiting time guarantee for elective surgery is reviewed, along with ways of reducing regional variations in quality. The extent of decentralisation is questioned, as that may be affecting the quality of care and value for money in some areas, including elderly and psychiatric care. Mechanisms for improving the hospital sector are also examined including fee-for-service (DRG) payment mechanisms and whether for-profit hospitals would help. Finally, it considers ways to make financing more stable and sustainable.

Sweden's healthcare system has had some bad press in the past few years. The same is true in many other OECD countries, but from an international point of view Swedes can be pleased with the system they have. Their healthcare is of high quality, the system is relatively well funded, and the various players have been innovative when it comes to delivering and paying for services. But the demands placed on healthcare systems are changing. More procedures can be performed non-invasively, as day surgery or outside of a hospital altogether. The greying of the population will increase the number of elderly people requiring care, while developments such as gentler anaesthetics have expanded enormously the range of treatments that can be offered to them. For older people in particular, there is a need for a more seamless model in which primary care, social care and in-hospital treatments are connected in a more coherent way. At the same time, there is a trend towards greater specialisation in which a smaller number of medical "centres of excellence" will provide highly technical procedures. A key question is whether the current decentralised structure is the right one for dealing with these challenges. The system faces several other challenges as well – to continue to shift away from hospital care, which means access to primary care has to improve; to reduce the variations in medical quality and practice across the country; to improve the boundary between medical and social care; to continue to boost value for money, especially in the hospital sector; and to put financing on a more stable, certain and sustainable base.

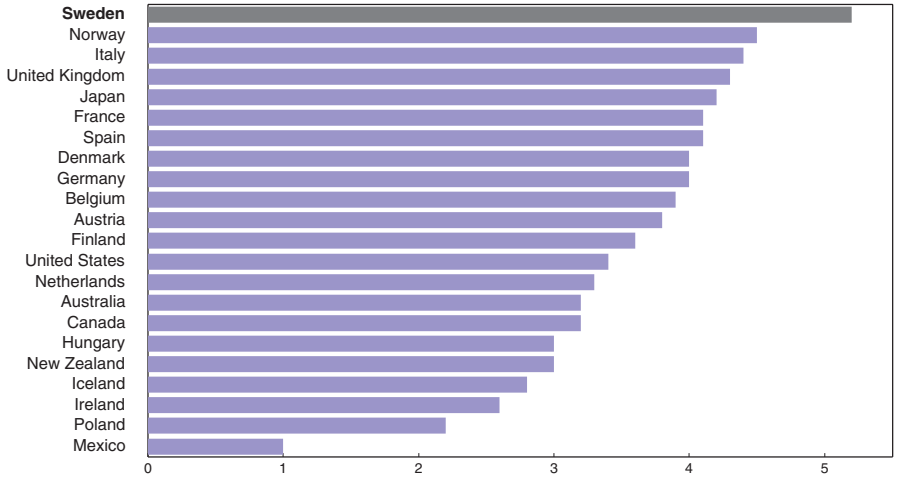
Context and overview of the system

The social and health background – an old but healthy population

Sweden has a relatively old population, with the largest proportion of very old people (aged 80 and over) in the OECD (Figure 5.1). As a result, the strains caused by population ageing are weighing on its healthcare system earlier than elsewhere. On the other hand, the population is relatively healthy. Most indicators of health status have been well above average for several decades (Annex 5.A1). Life expectancies are long, while medically avoidable deaths are relatively low for almost all disease groups. Equally impressive, it has in some cases managed to keep improving the health status at least as quickly as in other countries. Infant mortality, for instance, has halved since 1990 even though Sweden had the OECD's second-best rate to begin with. Healthy lifestyles contribute to this good overall performance. Relatively few Swedes are overweight, their daily calorie intake is moderate, and they take plenty of exercise, drink less alcohol than elsewhere and are not heavy smokers (see Annex 5.A2).

The main problems are related to circulatory diseases, as is the case in the whole of northern Europe. These cause half of all deaths in Sweden. There are large variations between the north and the south of the country, as well as between the big cities and smaller municipalities. Heart problems and diabetes are much more common in the rural north, while cancers are more frequent in the south and in the cities. As in many countries, young women stand out as a group whose health has failed to improve over recent years. This is mainly due to psycho-social problems rather than physical illnesses.

Figure 5.1. **The population is relatively old**
Per cent of total population aged 80 years and older, 2002



Source: OECD Health Data 2004.

The healthcare system is highly decentralised

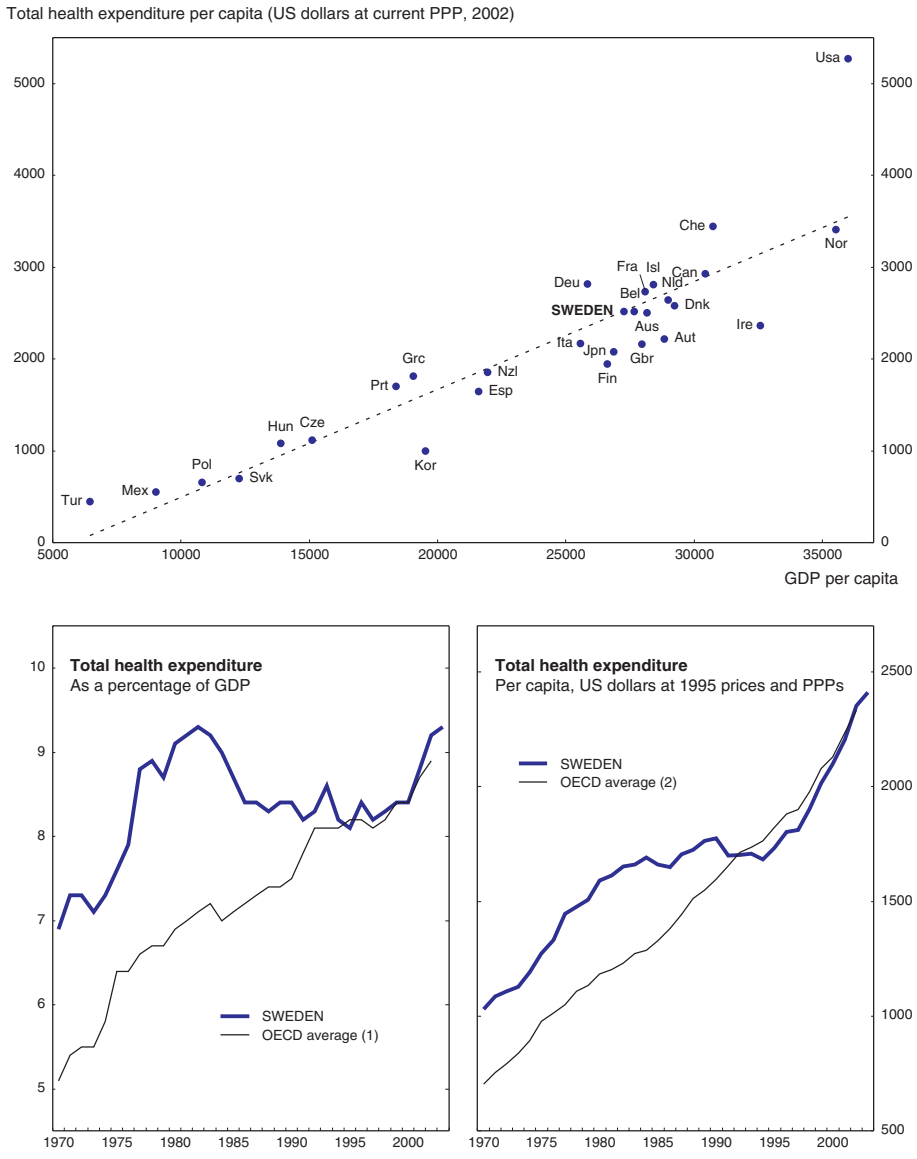
Sweden has an integrated public healthcare system in which the majority of financing and almost all the delivery is provided by the public sector. The main responsibility lies with the 20 *county councils* and one local authority (for convenience, they will be referred to as the 21 county councils in the rest of this chapter). These county councils own and run most hospitals and are responsible for the delivery of primary and hospital care, including public health and preventative care. They are relatively small, with a median population of 275 000 people. Only three have more than 500 000 residents. Counties usually divide themselves into several healthcare *districts*, each of which is run by an elected board. The counties are grouped loosely into six *medical care regions* that are designed to improve co-operation in highly specialised care, research and training. Each region has a population of 1-2 million and includes at least one university hospital. The counties also regulate privately run but publicly financed healthcare providers. They control the establishment of new private practices and the rules about the number of patients that private practitioners can see each year and set the fee schedule that must be adhered to if a private provider wants to be reimbursed by the social insurance system. Most *primary care* is publicly provided. Only a quarter of outpatient consultations are conducted in private facilities, and most of those are in the larger cities and have contracts with the county council. Purely private primary care is rare. Long-term psychiatric care and care of the elderly and the disabled are the responsibility of the 289 *local authorities* (municipalities). The *central government* (through its *National Board of Health and Welfare*) plays a role by setting national goals and guidelines, although these are not always implemented consistently across the country.

It is financed mainly through income taxes

Health expenditure is financed mostly through income taxes, with the private funding share (around 15%) below the OECD average but in line with the other Nordic countries. Out-of-pocket spending is well below the OECD average.[1] Private health insurance is almost non-existent, covering less than 1% of healthcare costs. Overall, the financing of the system is close to proportional, *i.e.* neither pro-rich nor pro-poor.[2]

After having been much higher than in almost any other country throughout the 1970s and 1980s, total health spending is now in line with the level that would be expected considering the country's GDP per capita (Figure 5.2). Expenditure was very restrained from the mid-1980s to the mid-1990s, reflecting a general need to rein in the health sector and the fallout from the fiscal crisis in the early 1990s that led to severe cutbacks right through the public sector. In healthcare, a large contribution to cost control came from a structural reform in 1992 in which the responsibility for elderly care and some other functions was shifted from counties to municipalities. As part of this process, a large number of elderly

Figure 5.2. **Total health expenditure is in line with national income**



1. Unweighted average of 23 countries.
2. Unweighted average of 22 countries.

Source: OECD Health Data 2004.

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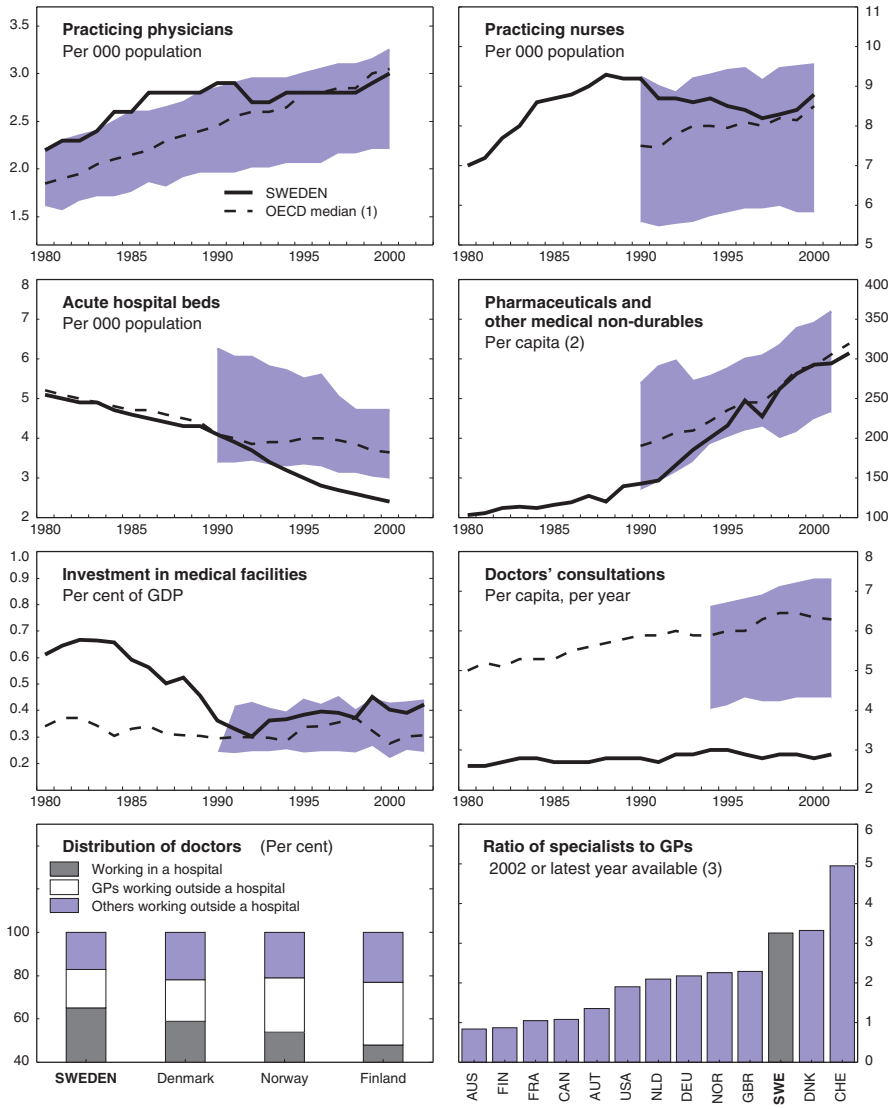
Figure 5.3. **Health resource utilisation**



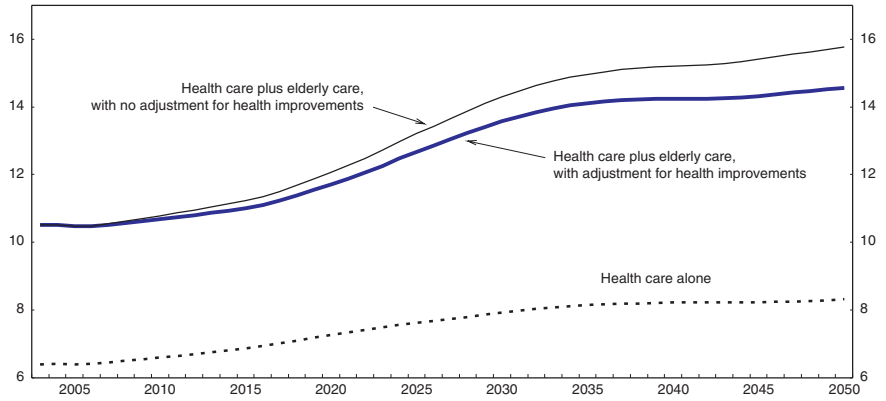
1. The shaded area shows the middle two quartiles (*i.e.* half the countries fall in this range). The number of countries used to calculate the median is different in each panel, but ranges from 12 to 24. The inter-quartile range is calculated only if at least 18 countries are available.
2. US dollars at 1995 prices and PPPs.
3. For Sweden, the number of specialists excludes specialists in family medicine.

Source: OECD Health Data 2004.

"bed blockers" were moved from acute care beds into either home care or public nursing homes. Despite this shift, there is a general impression that the Swedish system is still skewed towards hospital care rather than primary care, although it is difficult to back up that impression with hard evidence (Figure 5.3).[3]

The period of expenditure restraint now seems to have come to an end. Spending surged by 23% between 2000 and 2003, which is especially remarkable considering that increases in pharmaceutical costs have been subdued. The recent jump has far outstripped the increase in the volume of services, implying that much of this extra cash has gone into

Figure 5.4. **Long-term spending pressures**
Per cent of GDP



Note: This chart shows public expenditure on health and elderly care expenditure, rather than total expenditure.
Source: Ministry of Finance.

higher wages and prices, or lower productivity, rather than generating an increase in output (although there is some uncertainty about growth in the volume of services).

Future spending pressures will be significant, especially for elderly care

Sweden's relatively old population means its healthcare expenditure is about 10% higher than it would be if the population was as young as in Ireland or the United States, for example (SALA, 2004). Despite having this "head start", spending is still expected to rise by more than the OECD average over coming decades (Bains and Oxley, 2005). The key reason is its expensive elderly care system, where the increase in expenditure is projected to be larger than for healthcare itself (Figure 5.4).[4]

The ageing pressures will also be felt in the labour market, with some regions likely to face critical staff shortages. If the ratio of staff to patients is to remain unchanged, the elderly care sector will need to employ nearly 9% of the labour force by 2050, while the health sector overall would employ more than one in six workers. For this reason, Sweden's fiscal forecasts assume that, by 2020, public-sector wages will have to rise by around 10% more than in the private sector to help attract staff.

Strengths

Quality appears to be high

As noted above, the population is healthy by international standards. But it is hard to know how much of this can be attributed to the health system and how much is due to lifestyle and genetic factors. Clinical outcomes, such as treatment survival rates, provide a better measure than health status when it comes to assessing the performance of healthcare systems. Unfortunately, international comparisons of outcomes are scarce and difficult to interpret. However, Sweden does well in the handful of international comparisons that have been made. One recent analysis, which modified the World Health Organisation's well-known ranking of health systems, looked at standardised death rates from causes that health systems can do something about; in that study, Sweden ranked first out of 19 OECD

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countries.[5] It also performed well in the OECD's three disease-based comparisons of health-sector outcomes (which looked at survival rates for stroke victims, for example).[6]

The system is innovative and flexible

By international standards, the Swedish healthcare system appears to be one of the more flexible and innovative. The high degree of decentralisation is a contributing factor. County councils can choose their own operational structure, and many give considerable autonomy to each clinic. Some counties have run with this freedom and have been at the leading edge of international trends in healthcare. The so-called "Stockholm model" is the most well known, but it is not the only innovative district. Successful experiments in one county tend to be adopted in various forms by others. Compared with many countries, primary care has shifted more quickly towards well equipped multidisciplinary centres rather than solitary GPs; district nurses have broad responsibilities that include managing their own caseloads and doing home visits; there has been some shift towards "continuous care" by improving the transition between inpatient and outpatient care (although this is not yet working as well as it could); hospitals have become more specialised and (with some exceptions) tend to be funded and run in a more professional manner than in the past; and there is greater transparency and willingness to do something about long waiting times.

Evidence-based medicine is used to raise quality and set priorities

Sweden is a leader in the use of medical databases to benchmark and improve the quality of treatment throughout the country. Its flagship product is the set of around 50 National Quality Registers. These contain individual-based data on diagnoses, treatment and outcomes for specific diseases or conditions. The first registers were started up by the medical profession in the 1970s. Their purpose is to support research and learning about best practice. Participation is voluntary,[7] but peer pressure has ensured that most databases have very high coverage rates. They are primarily hospital based, so coverage of outpatient services is poor. A quality register in psychiatry is only now starting to be developed.

The registers have been a powerful way of waking up hospitals that are under-performing in particular procedures. They have also led to faster dissemination of information about treatment methods and problem areas and have given early warnings about shortcomings in new methods of treatment and new technologies (Box 5.1). Health professionals are slowly opening up the registers to the public, and this has led to intensive media scrutiny of those at the bottom of the league tables.

Some of the players in the healthcare system have begun to use clinical evidence to drive a formal priority-setting exercise. The aim is to be more rigorous and open about the prioritisation decisions that have always been hidden within the system. Östergötland County has been leading this approach, ranking treatments on a priority scale based on assessments of medical and cost effectiveness, and publishing the results on the Internet. It also released a list of low-priority procedures that would no longer be publicly funded, but a media maelstrom forced it to back down. It has also set up, in conjunction with Linköping University, a *Center for Medical Technology Assessment* that undertakes condition-based comparisons of technologies in order to help set priorities. For example, before finalising a contract with private chiropractors the County Council asked the *Center* to look at whether chiropractic care was more cost-effective than physiotherapy. *The National Board of Health and Welfare* also has several projects on priority setting, while the *Swedish Council on Technology*

Box 5.1. **Examples of National Quality Registers**

The National Heart Surgery Registry was established in 1992 and records information on virtually every heart operation. It covers basic patient data such as age and sex, risk factors such as height and weight, previous diseases and drugs used, methods of diagnosis, details of treatment, complications and the date of death. The main outcome measure is the mortality rate. A report on 30-day mortality rates in each participating department is published each year, and these have triggered intense discussions about the differences among heart units. This has contributed to a fall in 30-day mortality for coronary surgery to rates that compare well with other countries.

The *National Hip Replacement Registry* was established in 1979 and, like the Heart Surgery Registry, has 100% coverage. It covers the patient's age and sex, preoperative diagnosis, the type of prosthesis and fixation techniques and the number of re-operations. The main outcome measure is the number of re-operations. Research based on the Registry showed better success and fewer complications from using cemented rather than un-cemented prostheses. This led to improved cementing techniques and a significant reduction in re-operation rates. Today, un-cemented total hip replacement is used in just 4% of cases, compared to 14% in Norway and 50% in the United States.

The *National Stroke Registry* began in 1995. It records details of treatment immediately following an acute stroke and the types of aftercare provided in the three months after the attack. Analysis of the registry confirmed results from randomized studies that patients treated in a specialised stroke unit had lower mortality and fewer disabilities and were more likely to return to their own home. It also revealed large differences across the country in the proportion of stroke patients that were treated in a stroke unit and in the use of drugs such as anti-coagulants (which ranged from less than 10% of patients in one unit to more than half in another). Identifying these variations has helped to reduce them.

Assessment in Healthcare (SBU) reviews and summarises the international medical literature in order to disseminate best practice through the profession.

There is considerable patient choice

County councils have progressively increased patients' freedom as to where and by whom they will be treated. Patients can choose their primary care clinic, their GP and their preferred hospital. They can also choose whether to be treated at a health centre or to go directly to a hospital outpatient department. In some counties, a referral from a GP is needed if a person wishes to see a specialist. A referral may also be needed to receive care outside his or her county. While patients have much freedom, counties try to influence their decisions by, for example, charging less for a GP visit than a hospital visit and more if a patient seeks treatment in another county.

Key challenges

Despite these strengths, the system faces some ongoing challenges. These include improving access and productivity in primary care to take some of the pressure off the hospital sector; improving co-ordination and reducing fragmentation among the different

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parts of the system; taking the productivity-enhancing reforms that have been carried out in some county hospitals and introducing them throughout the country; and trying to ensure that financing becomes more stable and sustainable in the long term.

Improving access to primary care

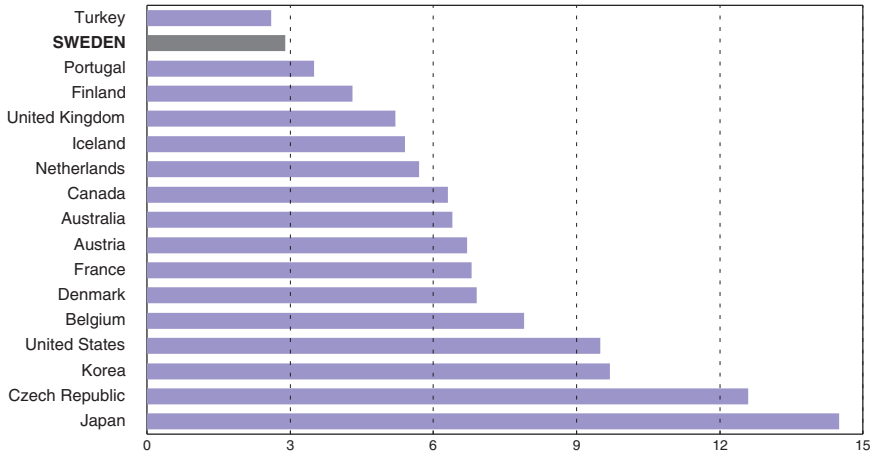
Access to primary care can be difficult. Opening hours are inconvenient, and getting an appointment is not easy.[8] Consequently, half of all patients go straight to a hospital for their primary care. This contributes to the relatively low number of doctors' consultations in primary care (Figure 5.5). [9] This is both inconvenient and costly, and means that physicians are less likely to provide the "seamless" or "continuous" care that many patients need.

There is a shortage of family doctors, and they work short hours

While the number of practicing doctors per capita is in line with OECD standards, the structure of specialisation is not. In particular, there are too many specialists relative to GPs. That makes the system less efficient, but more importantly it puts quality at risk as surgeons have to perform a minimum number of procedures each year in order to "stay in practice". The low number of primary-care physicians is compounded by their having the shortest working week of any doctors in Europe (Eurostat, 2001).[10] Physicians' productivity could be boosted by changing the way they are paid. Most doctors receive a fixed salary and therefore have few incentives to see more patients or deal with them more efficiently. Moving to some form of activity-based payment would help, as the international evidence on fee-for-service payment methods shows that they boost the supply of medical services. However, they can reduce rates of referral and the volume of prescriptions, and a pure fee-for-service system creates incentives for over-servicing (OECD, 2004). Several countries are therefore moving towards a mixture of capitation and fee-for-service. Sweden experimented briefly with such a system in 1994. The Family Doctor's Act, which had the goal of encouraging primary care physicians to "go private", introduced a mixed payment system and allowed patients to

Figure 5.5. **Swedes do not see a doctor very often**

Consultations with an ambulatory care physician per person, per year
Average 1998 to 2002 (or latest available year)



Source: OECD Health Data 2004.

change their family doctor every 12 months. Nevertheless, the Act was repealed a year later by the incoming government despite most physicians believing the reform was a success (Quaye, 2001). Stockholm County has experimented more recently with a mixed payment system. The results were positive, so from 2005 it has moved to a 50-50 mixture of capitation and fee-for-service for all its primary care providers. However, any move towards activity-based funding would need to be carefully designed so that it would not lower productivity by encouraging physicians to carry out the basic services that they currently leave to nurses.

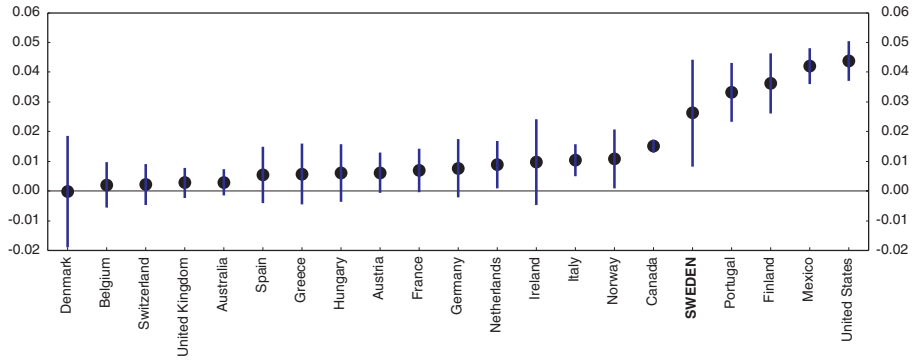
People on high incomes have better access to primary care

Sweden is one of a group of countries (including the United States, Portugal, Mexico and Finland) that has inequitable access to primary care in the sense that people on higher incomes are more likely to visit a GP (Figure 5.6).[11] This disparity in access seems to have worsened over time (Whitehead *et al.*, 1997). In contrast, access to inpatient care does not depend on an individual's income. Although people on higher incomes also have better access to dental care, this is true of all OECD countries, and Sweden is the least pro-rich among them. In any case, it is a matter of judgement as to whether the inequities in access to primary care are "large": after adjusting for differences in need, the average number of GP visits for people in the bottom income quintile is 0.81 per quarter, compared with 0.98 for the top fifth of income earners.

It is not obvious why access to primary-care physicians is less equitable than in other countries. The fees for seeing a doctor may be one explanation, but this is not at all clear. Patients pay a small charge for most medical services. Each county sets its own fee, although they are fairly similar across the country. A GP visit, for example, costs around SEK 100 (€ 11), although it is free for people under 20 years old. In addition, the central government imposes a ceiling on out-of-pocket payments so that nobody pays more than about € 100 a year for outpatient care. Swedish evidence on access to primary care suggests that differences across income groups exist only for infrequent users; heavy use

Figure 5.6. **Access to physicians is relatively inequitable**

Horizontal inequity (HI) indices for probability of a doctor visit, 2000



Note: The plotted points are horizontal inequity (HI) indices which summarize the inequality in the probability of at least one doctor visit (per annum) across income quintiles after need differences (variations in self reported health) have been taken into account. Positive values of HI indicate inequity favouring the rich; negative values indicate inequity favouring the poor. The vertical lines show the 95% confidence interval.

Source: Van Doorslaer, Eddy and Cristina Masseria (2004), "Income Related Inequality in the Use of Medical Care in 21 OECD countries", OECD Health Working Paper No. 14.

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of the healthcare system is unrelated to income (Gerdtham and Trivedi, 2000). This pattern is exactly what would be expected in a system like Sweden's where there are user fees with an annual cap. Yet survey evidence suggests that fees are not shutting people out of medical treatment to any significant extent: in 1999, just 2.3% of the adult population (and 1½ per cent of those over 60 years old) said they had avoided treatment for reasons of cost.[12] A second explanation for the inequitable access is that it might reflect supply rather than demand, as private GPs are much more common in the richer neighbourhoods of the big cities. Most private doctors have contracts with the county council and are reimbursed with public funds, the main difference being that they tend to be reimbursed on a per-case basis rather than getting the fixed salary that publicly employed doctors receive. Hence, they have incentives to work longer hours and to see more patients. If so, the "inequity" possibly tells us more about the advantages of fee-for-service payment mechanisms than about the drawbacks of user charges.

Cutting waiting times for elective surgery

Excessive waiting times for elective surgery have been a political issue for many years and have prompted measures such as the maximum waiting time guarantee (see Box 5.2). There is little information, however, to assess whether Sweden's problem is worse than in other countries with free public systems (but the fact that there is little demand for private insurance suggests that it may not be).[13] A new *National Treatment Guarantee* was agreed in 2003, although implementation has been delayed by disagreement with the counties over whether they need extra funding to honour it (it will be implemented on 1 November this year). The guarantee is based on the "0-7-90-90" rule – meaning instant contact (0 delay) with the healthcare system; seeing a GP within 7 days; consulting a specialist within 90 days; and waiting no more than 90 days after being diagnosed to get treatment.

A problem with such a guarantee is that it does not necessarily reduce the median waiting time for the system as a whole. Unless output rises, either through an increase in resources or productivity, it may just cut long waits by increasing short waits. That is not necessarily a bad thing, since total welfare may rise as the gain in welfare for a patient who had been waiting a very long time probably exceeds the loss in welfare of someone whose short wait is extended a little. But it may contradict the government's principle that the people with the greatest need should be treated first. Instead, Sweden should look at a more sophisticated alternative such as New Zealand's scoring system for prioritising patients. By doing so, duration in the queue would be one of several factors – rather than the only one – for determining priority once a person has been placed on the queue.

Further structural reforms are likely to be more successful than the Treatment Guarantee at cutting waiting times. Siciliani and Hurst (2003) show that waiting times are likely to be shorter in systems with greater capacity (more beds or physicians, for example) and with activity-based payment for doctors and hospitals. Direct financial incentives to providers may also help. In Spain, for example, inpatient waiting times were cut sharply after the introduction of bonuses for staff and hospitals who managed to reduce their waiting times.

Could the private sector be used to shorten queues?

Private insurance may be one way to take some of the pressure off the public system, although it must be carefully regulated to ensure that the private market does not have adverse spillovers onto the public system. Currently, only 1½ per cent of the population has

Box 5.2. **The maximum waiting time guarantee**

Waiting times for some procedures had reached unacceptable levels by the end of the 1980s: it was normal to wait more than a year for a hip replacement, a coronary bypass or a cataract operation, for instance. In 1991, the county councils and the government agreed to introduce a maximum waiting time for 12 procedures. The agreement was that a patient who could not get treatment within three months at their local hospital should be offered treatment at another public or private hospital, paid for by the county. Around SEK 500 million of extra funding was provided (equivalent to a 0.4% rise in the health budget).

The policy led to a dramatic cut in waiting times, at least initially. For example, the average wait for coronary artery surgery fell from more than a year to just 6 weeks by the end of 1992. The proportion of cataract patients receiving treatment within three months rose from 25% in 1991 to 70% in 1992 and 60% in 1993.

The initial success seems to have been due to increased supply and better management of waiting lists. Extra work, reorganization and a transition to new technologies – especially day surgery – were the most common strategies adopted by hospitals (Or, 2002). In general, the introduction of the guarantee appears to have led to improved resource use within hospitals. Interestingly, patients were seldom sent to other departments with shorter waiting lists. Moreover, the implementation of the guarantee did not have any significant side effects such as crowding out other procedures that were not subject to the maximum waiting time (Hanning, 1996).

The success, however, was temporary. Average waiting times began to creep up again after the first couple of years and in some cases were close to their original levels by the end of 1996 when a revised guarantee was introduced. That new policy focused on access, setting maximum waiting times for first contact with GPs and outpatient visits to specialists in secondary care. There was no maximum wait for treatment. This policy was never formally evaluated and was superseded in 2003 (see the main text).

private insurance cover. They are usually executives, and premiums are paid by their employers. Policies normally cover only supplementary elective procedures, and treatment takes place in a private hospital. The market has not developed as much in Sweden as in some other countries partly because there is no tax break for private health insurance, although it may also be a signal that the system works reasonably well for people with serious disorders.

The main advantages of having a parallel privately-funded and privately-run sector are that it brings extra funding into the health system without calling on the public purse, and improves patient welfare by shortening waiting times. If some patients choose to go private, they not only make themselves better off but they also shorten the waiting time for others in the public queue. Private hospitals expand capacity, and this can have an additional benefit for the public system. For example, Sophiahemmet, Sweden's largest private hospital, sells spare capacity to the local county council, which helps cut waiting times at public hospitals. The government's main concern is that private insurance may lead to queue jumping if private patients are treated in public hospitals. In principle, that should not be possible in Sweden, but in practice the public and private caregivers co-operate closely, with doctors circulating between both types of hospital (Lofgren, 2002a). Consequently, the government would need to strengthen the regulatory framework if the

private insurance market expanded significantly. Moreover, there is a short-term transition issue in that the supply of physicians cannot be increased overnight, so if there is little spare capacity then an overly speedy expansion of the private sector may crowd out supply in the public system.

The system may be too fragmented

It is unclear whether the current degree of decentralisation is appropriate for a 21st century medical system in which "seamless" care, greater use of expensive technologies and enhanced European integration will play increasing roles. Problems related to the small size of some parts of the system are already becoming apparent. There are two distinct aspects to this – the size of the political units (counties) and the size of individual hospitals or clinics. The most serious problems are the ones that affect quality and medical safety. It is difficult to say what the optimal size of a hospital or medical region should be (and that obviously depends on the treatment), but the Health and Welfare Board considers that an emergency hospital needs a catchment area of at least 80 000 to 90 000 inhabitants. While a few smaller units have been closed or merged, one in three emergency hospitals is still under this minimum safe size. Excessive fragmentation can also affect quality by reducing coherence among providers, with patient records being held in dozens of incompatible computer systems, for example. Dealing with these problems would be easier with fewer counties because larger political units would probably be more able to rationalise resources by, for instance, increasing the amount of specialisation among their hospitals (and, in some cases, closing them). While county councils are loosely grouped into six medical care regions to improve co-operation in highly specialised care (so that not every county has a thoracic surgery unit, for example), there is much less co-operation when it comes to "ordinary" treatments and day-to-day administrative matters.[14] Other problems caused by decentralisation and fragmentation include: waste through duplication (such as having 21 pharmaceutical boards); greater difficulty in reallocating resources (progress at shifting resources away from inpatient care in hospitals and towards outpatient and primary care is slower than the government wants); instability in funding (revenues of small counties are more volatile); and more difficulty reducing regional variations in quality and medical practice (see below).

These problems have prompted a debate about the rationale for decentralisation in the first place. The standard fiscal federalism argument for decentralisation is based on local democracy: small local units are better placed to take account of regional differences in preferences. However, healthcare is an area where this argument is weak or even irrelevant: when it comes to healthcare, people are unwilling to accept differences in quality or in what is offered across the country. In any case, county council tax rates – which provide the bulk of healthcare funding – are virtually the same everywhere: 18 out of 20 county tax rates are within ±0.5 percentage points of the mean. A committee is currently reviewing the structure of government and the division of responsibility for all public services, with a special focus on healthcare, and is due to report in 2007. There is a strong case for reducing the number of county councils to perhaps half a dozen or fewer. Some commentators would go further, eliminating that layer of government entirely and shifting responsibility for the hospital sector to the central government (as Norway has recently done). That would have certain advantages, but it risks losing one of Sweden's strengths, namely the ability for the more innovative counties to try out new ways of providing and paying for healthcare.

The transition from hospital care to social care is not as smooth as it should be

Long-term care is a much more important part of Sweden's health and social welfare systems than in most other countries. Sweden spends more than any other OECD member on long-term care for the elderly and disabled (when measured as a percentage of GDP – see Table 5.1). This is partly by choice and partly by necessity, as the high employment rate among women creates a need for a formal system of care for the elderly. Services are almost entirely publicly financed (user charges amount to around 5% of costs) and mostly publicly provided (eight out of ten local authorities provide 90% or more of these services – the Stockholm area being the main exception).

The elderly-care system underwent major organisational changes following the Ädel reforms in 1992 when responsibility for long-term medical care of the elderly and disabled was transferred from county councils to municipalities. Care provided by doctors, however, remained with the counties. The aim was to change the culture from medical to social care. Municipalities became financially responsible at the same time and now have strong financial incentives to find care outside a hospital because they have to reimburse county councils for patients who are medically ready to be discharged but who stay in hospital. In one swoop that moved around 40 000 "bed blockers" out of expensive acute care beds and into other forms of care – either at home or in a municipal nursing home.

Home care has also undergone major changes. The proportion of elderly people receiving home help has more than halved since 1995. Tight constraints on municipal finances have led to stricter rationing of home care and a shift towards personal care and home nursing rather than help with domestic chores such as cleaning, laundry and shopping. There are large variations across municipalities as to what they now offer by way

Table 5.1. **Expenditure on long-term care**

Per cent of GDP

	Home care	Institutional care	Total	*of which*: Public	*of which*: Private	Share of population aged 65 and over receiving long-term care in an institution	Share of population aged 65 and over receiving home-care benefits
Sweden	**0.8**	**2.1**	**2.9**	**2.7**	**0.1**	**7.9**	**9.1**
Denmark	..	..	..	2.5	..	..	..
Norway	0.7	1.5	2.2	1.9	0.3	6.0	18.0
Austria	..	..	..		1.3	3.6	14.8
Germany	0.5	0.9	1.4	1.0	0.4	3.9	7.1
Ireland	0.2	0.4	0.6	0.5	0.1	4.6	5.0
Netherlands	0.6	0.8	1.4	1.3	0.1	2.4	12.3
Spain	0.2	0.4	0.6	0.2	0.5	..	..
Switzerland	0.2	1.3	1.5	..	..	7.0	5.4
United Kingdom	0.4	1.0	1.4	0.9	0.5	5.1	20.3
Australia	0.4	0.8	1.2	0.9	0.3	5.3	14.7
Canada	0.2	1.1	1.2	1.0	0.2	3.7	..
Japan	0.3	0.6	0.8	0.8	0.1	3.2	5.5
New Zealand	0.1	0.6	0.7	0.5	0.2	..	5.2
United States	0.3	1.0	1.3	0.7	0.6	4.3	2.8

Source: OECD (2005a), "Long-term Care Policies for Older People", forthcoming.

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of home care assistance, although it can be quite intensive: a fifth of those who get home help receive at least 50 hours a month.

There are considerable problems in the "grey area" where responsibility moves from county councils to municipalities. The municipalities claim that patients are now sent home "quicker and sicker" because counties have a financial incentive to discharge them as early as possible.[15] Municipalities are sometimes unable to provide the medical care they feel is needed, partly because they are not permitted to employ their own doctors. The counties counter that municipalities are not providing enough elderly or long-stay beds, so around one in ten hospital beds is still occupied by someone who is medically ready to be discharged and who should be treated in primary care or at home. The co-ordination problem is most noticeable for people undergoing rehabilitation but is also apparent for those with psychiatric, drug or alcohol problems. Rehabilitation efforts are inadequate, with too little home care provision and poorly functioning collaboration between social welfare provision and healthcare. Last year, a committee delivered recommendations on how to improve the boundary between the two parts of the system. It proposed putting a greater responsibility on municipalities to provide integrated social and health care while giving them the ability to hire their own doctors if they feel that the counties are not allocating enough physician time to municipal home care (SOU, 2004).

What is clear is that some municipalities are not living up to their obligations. In 2000, around 5 000 elderly people were either waiting to receive assistance to which they were entitled or had their application for support rejected unfairly (Parliamentary Auditors, 2000). The government believes this problem still exists today and is caused by the financial difficulties of some local governments.

There are similar issues of inadequate funding and quality in psychiatric care and care for people with alcohol or drug addictions. The government has recently appointed a national co-ordinator who will work with the providers of psychiatric care. One of his tasks is to estimate if patients with severe psychiatric disorders are receiving the medical care they need. Another is to improve collaboration between healthcare and social services for people with chronic psychiatric disorders.

The care sector also faces a severe recruitment problem. Wage levels are relatively unattractive, and so staff turnover is high. There has also been a surge in the number of care workers absent on sick leave or retiring early. In addition to trying to retain the current workforce, municipalities need to expand employment in line with the increase in the number of elderly under their care. The National Board of Health and Welfare foresees a need to recruit 200 000 people over the coming decade (to put this in perspective, around 280 000 people are employed in the sector today). If nothing else, this suggests that wages for care workers will need to increase faster than in other sectors, adding to the financial pressures that municipalities will face in the future.

Co-ordination failures, under-provision and recruitment problems all point to a basic problem of funding not matching the aspirations for the system. The choice is between spending more (even though Sweden already spends a very large amount on social care), accepting a lower level of public provision or introducing more private financing.

At the same time, Sweden may get better quality and value for money through greater customer choice and private provision. These are currently quite limited: private providers account for only 15% of the market, and only ten municipalities allow residents to choose

who will provide long-term and home care. In each of these cases, the local government decides which services a person should receive and gives them a voucher to spend where they wish. Some other countries, such as Germany, the Netherlands and Austria, have gone a step further by giving consumers a portion of their support in cash and allowing them to decide for themselves what to spend it on. There have been no evaluations of free choice or private provision in Sweden, and so it is hard to know what their impact on quality has been. But overseas experiences have been positive (OECD, 2005a). In the Netherlands, for example, people receiving care *via* a personal budget felt less dependent because they had more control over when care is provided and by whom – the latter being particularly important since long-term care often involves the most intimate aspects of a person's life: dressing, bathing and toileting (Miltenburg and Ramakers, 1999).

Regional variations in quality and medical practice could be reduced

Indicators discussed earlier in the chapter suggest that the average quality of medical care is high by international standards. Moreover, quality seems to be improving. Analysis based on data in the quality registers shows a steady improvement in results following many procedures, and no area has had a deterioration in quality (NBHW, 2003). However, there are considerable regional differences in the use of scientifically accepted treatment methods and in the type of medication prescribed.[16] These differences do not seem to be related to the health needs of local populations; instead, they may reflect differences in the ability of some of the smaller health units to pay for expensive pharmaceutical courses, and perhaps also differences in practices among medical providers.

Resources could be freed up by creating a more efficient hospital sector

Progress towards running the hospital sector on a more professional and business-like way has been mixed. Some counties have been more proactive and innovative than others, moving away from the "command and control" model by making clinic managers responsible for outcomes but giving them more management autonomy in the process. Others have tended to run the system much as it has been in the past, with central control and inflexible line-by-line budgets. As a consequence, there are large variations in efficiency levels between the county councils: after adjusting for age, distance, mortality and morbidity, expenditure levels vary by more than 30% (Saltman and Berleen, 2000). Several options for lifting the efficiency of the system while keeping it predominantly publicly financed are discussed below.

Improve payment methods so they reward productivity

Most counties who have separated the purchaser and provider roles use some form of per-case payments, often complemented with volume ceilings and quality requirements. NordDRG is the most common system. Some studies of the experiments in Stockholm County in the 1990s found that the shift towards per-case payments permanently lifted productivity by 10–15% relative to clinics that continued to use global budgets.[17] DRG payment systems have become more widespread in recent years, being used to some extent in two-thirds of counties. In six counties, they are fully integrated into the internal budgets of hospitals (meaning they are also used to allocate funding *within* hospitals).

There are potential risks associated with activity-based payment systems, but they are unlikely to be large enough to outweigh the likely productivity gains. Stockholm's experience in particular shows no evidence of "DRG creep", cream skimming or over-

treatment of patients,[18] while the impact on quality is unknown. The main problem that arose – as in other countries – was that the rise in output induced by the new system led to budget over-runs. Whether this is a good or bad depends on one's point of view. The positive interpretation is that activity-based funding unleashed hidden productivity in the sector, helping to reduce the waiting list problem.[19] The downside is that the county has less control over its budget, but if it is unhappy with that then it is implicitly saying it is unwilling to pay for the level of output that its healthcare system is capable of producing once its incentives are sharpened. Indeed, Stockholm County responded by imposing budget caps and cutting DRG prices, thereby sharing the productivity gains between the county and the clinic. Most other counties have also capped spending, meaning that many systems have more or less reverted to the global budgeting that existed in the 1980s. At best this means they are not getting the full potential of per-case payment systems; at worst, it can create perverse incentives as certain treatments stop once a hospital has hit its annual funding ceiling.

There are variations of activity-based payment mechanisms that are based on more than just output. The day surgery department at Huddinge University Hospital, for example, has experimented with a team-based incentive model. A bonus wage system was introduced, based on a balanced scorecard comprising output, cost and patient satisfaction. It led to greater productivity, improved financial performance and increased patient satisfaction. It was well liked by the staff and helped to ease recruitment problems (Arvidsson *et al.*, 2004). Modified fee-for-service payments have also been introduced in Gävleborg (where money follows only those patients who choose a hospital outside their own district) and in Jönköping. Stockholm County is moving to a mixed funding system in which hospitals will be reimbursed in three parts: fee-for-service, a fixed capitation-based component and a 2% slice that is related to quality and performance.

A more diverse range of providers

Most Swedes want to retain a primarily tax-financed system. But public financing does not necessarily mean that the providers have to be publicly owned. However, in Sweden the private sector plays a tiny role in the hospital sector, accounting for just 3% of employment. The government claims to be in favour of more diversity among providers through county councils entering into contracts with co-operative and voluntary care providers. But policy is currently unclear regarding how the public and private systems should interact (whether there should be complete separation, for example) and on the role of for-profit providers. After one of Stockholm's emergency hospitals (St. Göran's) was sold to a private company, the government temporarily banned any deals that would transfer the operation of a public hospital to a private company. This decision was made despite St. Göran's being the most cost-efficient acute-care hospital in Stockholm and one of the clinics most respected by patients and staff (see Box 5.3). The ban has now expired, but the government is considering a rule that every county must run at least one public hospital. As it stands today, a public hospital that accepted privately-financed patients would be in breach of local government legislation if it made a profit by doing so.[20] But there is no way to enforce this law, nor is it clear whether the government wants to strictly enforce it. This might create increasing problems over time as employers are obliged to pay for rehabilitation measures under the sickness insurance scheme (see Chapter 3), and it would be natural for them to buy such services from public hospitals where they have spare capacity. It is uncertain, however, whether they are able to do so. This situation needs to be clarified. For

Box 5.3. **Privatising St. Göran's Hospital**

St. Göran's Hospital has been at the centre of an ideological tug of war for the past decade. It is an acute-care hospital in Stockholm and employs around 1 100 staff – making it mid-size by European standards. It was the first acute-care hospital in Sweden to be restructured as a company, and the only one to be privatised.

In 1994, the conservative Stockholm county government gave St. Göran's a company structure with the intention of selling it. Later that year the incoming Social Democratic government promised to return the hospital to a more traditional structure, but backed down due to strong opposition from hospital staff and their union (Lofgren, 2002b). It was operated as a council-owned business enterprise until 1999, when it was sold to Capio, a company that owns hospitals throughout Europe.

The exercise appears to have been a success. St. Göran's has always been one of the more efficient hospitals, and it continues to operate at a cost level at least 10% below its most efficient public counterpart in Stockholm (Hjertqvist, 2001). It has a reputation for being one of the more innovative hospitals, is rated highly by the public and is regarded by the staff as being a more rewarding place to work than it used to be. There have been no complaints about a deterioration in quality or that the profit motive has distorted behaviour in medically inappropriate ways. Some people have questioned whether the contract with Stockholm County favours St Göran's relative to public providers, although this is not clear.

the future, the government is reluctant to see any expansion in for-profit providers, believing they would be more likely to cream skim or over-treat patients and be less likely to spend on preventative care. While the government's fears are understandable, they are probably exaggerated. The combination of public financing and private delivery works well in several countries, and the government is more likely to achieve its goal of having a greater diversity of providers if it allows for-profit companies into the market. The regulatory environment is more important than ownership or the profit motive. Rather than a blanket restriction on for-profit activities in all public hospitals, it could instead limit the ban to university research hospitals. That would coincide with international practice and would be in line with the recommendations of the government's 2002 commission on for-profit providers in healthcare. Alternatively, it could allow for-profit providers only in metropolitan regions where the public has plenty of alternatives. But it would need a robust regulatory framework to ensure that public and private providers follow the same rules in order to minimise any risk of adverse selection. It would probably require greater centralisation as well.

Managing demand through user charges

It is difficult – and usually unnecessary – to try to influence demand in the hospital sector. The main exception is when patients go to an emergency room for treatment they should be getting from their local GP, which is common in Sweden. User fees are designed to steer patients towards the right type of treatment, which is why specialists cost more than a GP and a self-referral to an emergency room costs about three times as much – around € 30 to € 35 – as a trip to the family doctor. However, the relatively low ceiling on patient fees means that these incentives do not bite for many people – around ten million "fee free" outpatient visits are made each year. One option is to raise this ceiling. The current annual maxima were set in 1992, and average wages have increased by around 70% since then,

implying a significant fall in the real burden on households. A second possibility is to have the ceiling depend on household income, so that nobody pays more than, say, 1% of their annual income in out-of-pocket charges. This might have been a hard system to administer ten years ago, but should be relatively easy with modern smart-card technology. Doing so would re-instate the price signals of the system and raise the amount of co-payments by those on higher incomes, without jeopardising access.[21]

Better management and cost accounting

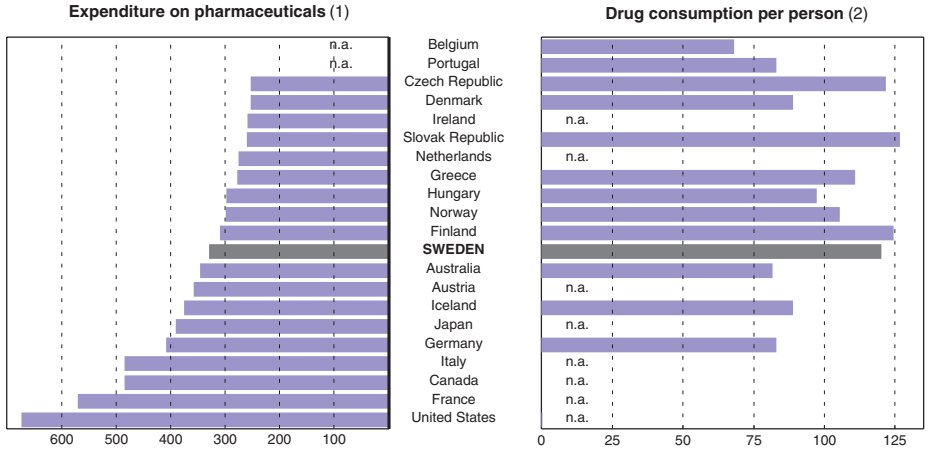
Most clinics have a high degree of management autonomy, but the information on which they can make resource allocation decisions is sometimes lacking. Only one out of five hospitals has a case costing system for inpatient care, although some information is collated and distributed as a national database. Case costing systems for psychiatry, outpatient care and primary care are rare. Annual rather than multi-year budgeting also makes planning more difficult. Incorporating cost information into the National Quality Registers would be one way to provide efficiency benchmarks and to help set priorities.

Improving control over pharmaceutical spending

Real per-capita spending on pharmaceuticals rose by 115% between 1990 and 2002, one of the fastest rates of increase in the OECD. This is partly due to a simple "catch up" of the level of expenditure from below average to near the middle of the pack (Figure 5.7). But economic incentives have also played a part. Until recently, drugs were effectively free at the margin for county councils because costs were reimbursed directly by the central government. Patients pay some of the costs out of pocket, but with a cap so that nobody pays more than SEK 1 800 (€ 200) per year. Around one million people have hit this threshold at any point in time and are therefore entitled to free medicine.

A new system of pharmaceutical subsidies took effect in 2002. The aim of the reform was primarily to stem the rise in expenditure. A National Pharmaceutical Benefits Board now decides which medicines are to be subsidised and what their price will be (based

Figure 5.7. **Spending on pharmaceuticals is around average**



1. Per person, US dollars at PPP, 2002 or closest available year. Includes expenditure on other medical non durables.
2. Index of consumption measured in Defined Daily Doses (DDDs) across seven major drug classes. Average of available countries = 100.

Source: OECD Health Data 2004.

partly on a proposal from the manufacturer), taking account of cost-effectiveness, both in absolute terms and compared with alternative ways of treating the same condition. All prescriptions must now be replaced at the pharmacy with the cheapest equivalent product unless the patient's doctor rules otherwise on medical grounds. However, the patient can choose a more expensive product and pay the difference.

These reforms have had a dramatic effect on the growth in drug spending: real expenditure per person was virtually unchanged in 2003 and 2004 (and is projected to be unchanged this year as well). This is partly thanks to increased price competition between generics and their brand-name equivalents, although it has helped that a couple of big-ticket drugs went off patent in 2003 and that fewer new drugs have been coming on stream.

The responsibility for financing pharmaceuticals is also being shifted. Since 1998, the central government has been in the process of handing over responsibility to the counties so that the drug budget becomes integrated with the rest of the healthcare system. In the latest of a series of "transition agreements", the block grant to counties has been increased for 2005-07 to cover pharmaceutical costs. The allocation of funds is largely based on demographic factors rather than pharmaceutical usage. While it makes sense to move to an integrated health budget, the counties have received what is to some extent a poisoned chalice. National bodies decide which drugs will be subsidised, what their price will be, and how much patients will have to pay (the SEK 1 800 ceiling is set by parliament). Counties, therefore, have almost no levers to help control spending except by trying to influence doctors' prescribing habits. But even there they have little influence because they have no access to information on prescription and purchasing habits, and they believe there is significant over-prescribing and that as many as one in ten inpatient visits is due to the effects of mixing drugs. For these reasons, the counties want greater access to the drug information register and a permanent financing arrangement in which the central government continues to carry some of the risk of future expenditure pressures.

The monopoly over retail distribution of drugs is unnecessary

The retail distribution of pharmaceuticals is in the hands of a state monopoly, Apoteket. Its objective is to ensure nationwide access at equal prices. Eliminating competition, however, runs the risk of raising prices and lowering service quality and convenience. Many other OECD countries impose restrictions on prices and entry to pharmaceutical retailing, usually because effective price competition is difficult when consumers are fully reimbursed for the cost of medicines and therefore have no incentive to shop around for the best price. But Sweden is the only country that restricts distribution to a single state-run monopoly. This is despite the conditions for price competition being *stronger* than in many other countries, as most consumers pay at least some of the cost of prescriptions out of their own pocket.

Aside from any efficiency considerations, on 31 May 2005 the European Court of Justice ruled that the distribution monopoly was illegal as there are no mechanisms in place to ensure that Apoteket cannot discriminate against other suppliers from other EU countries. Whether illegal or not, the monopoly is unnecessary. The government's objectives could still be met even if the distribution chain was opened up to some competitive pressure (as discussed in the previous *Survey*). For example, the government could tender out the right to run a pharmacy in certain locations or to run a nationwide chain. This approach of "competing for the market" would ensure that the most efficient provider would be selected. It would also reveal information about costs, and therefore about the appropriate retail margin. The government could also change the drug pricing

policy so that it sets the *maximum* price rather than the actual price, which would bring it into line with its neighbours. This would allow competition to drive down prices in urban areas; by doing so, many consumers would be made better off but none would be made worse off. Sweden could learn from the favourable deregulation experiences in Norway, Denmark and Iceland. In each case, customers enjoyed improved accessibility thanks to more pharmacies, longer opening hours and reduced waiting times. Consumers in Norway and Iceland also benefited from considerable price discounts (IHE, 2001; Anell, 2004).

The case for liberalising the sale of non-prescription drugs is more clear-cut. Most over-the-counter medicines are not subsidised, even when prescribed by a doctor. Allowing them to be sold in other retail outlets such as supermarkets could help reduce prices and increase convenience for consumers. Apoteket's monopoly over these products should be abolished.

Making financing more stable and sustainable

Most of the discussion so far has centred on ways to boost productivity and quality. While these are important, they will do little to solve the biggest long-term problem – how to pay for the surge in costs that is sure to come over the next few decades. Tax revenues cannot be expected to finance the expansion of elderly care and healthcare in the future (Finansdepartementet, 2004; OECD, 2004). Even if the bulk of the system remains publicly funded, other sources of revenue will need to be found at the margins. And with resources unable to keep pace with demand, some difficult choices will have to be made about which sectors must reduce expenditure and which services might be discontinued altogether (NBHW, 2003). This will require stronger co-ordination and priority setting than exists among the various parts of the welfare system today.

Currently, the counties are responsible for around 85% of public spending on healthcare. The bulk of their revenue comes from a flat-rate income tax. Central government grants, some of which are earmarked for specific uses, account for almost all of the remainder. The relative split between local taxes and central grants has been virtually unchanged since 1980 (Table 5.2). Municipalities also raise their revenue using proportional income taxes.

This funding arrangement creates several problems. First, because the counties are responsible for very little apart from healthcare,[22] it is almost like having 21 earmarked health taxes. And because the tax rates are so similar, the system is not much different to having a single national health tax. This means it is hard to trade off health spending against other demands on the public purse – a problem that will become more and more apparent as ageing populations demand a greater share of public resources. For example, the declining number of children creates an opportunity to switch resources from education and towards healthcare, but this is hampered because education and healthcare are run by two different levels of government. The central government can bring about this sort of reallocation by adjusting its grants to local government, but it then becomes a political decision with

Table 5.2. **Financing county council medical care**

Per cent

	1980	1989	2001
County taxes	70.6	72.8	70.4
Central government grants, etc.	26.0	25.4	26.8
Patient charges	3.4	1.8	2.8

Source: Federation of County Councils and Ministry of Finance.

winners and losers and would almost certainly be more difficult to achieve than reallocating funds within a single political entity. Moreover, the separation of responsibilities between county councils and municipalities makes it harder to re-allocate between the health and elderly care sector, such as shifting resources out of the hospital sector and into institutional or home care for the elderly. The different financing sources for sickness insurance and healthcare create similar problems. Nobody has an incentive to try to minimise the *total* costs of ill health; waiting lists, for example, are a useful way to control expenditure in hospitals but they reduce labour supply and make the sickness insurance scheme more expensive if people stay away from work and draw a sickness benefit while waiting to be treated.

A second problem is that the fastest-growing spending area is tied to a fairly slow-growing tax base.[23] For the counties, the effects on healthcare costs of ageing alone could be financed with a modest increase in tax rates, though the required increase for municipalities to balance their budget is much greater (Table 5.3). But demand is sure to grow more quickly than incomes, and under current arrangements this pressure will have to be financed by income taxes at a time when the number of people at work will be falling. Granting counties a broader tax base, such as a property tax or share of the national sales tax, would help make the system more financially sustainable.[24]

Third, public health expenditure is sensitive to the business cycle because county councils have just one tax base and face balanced budget rules (Figure 5.8). This business cycle risk should be shifted off the healthcare budget. One way to achieve this is to give

Table 5.3. **Consumption and taxes in the long term**

	2003	2020	2035	2050	Change, 2003-2050
			Public consumption Per cent of GDP		
Elderly care	4.1	4.4	6.0	6.3	+2.2
School education	4.5	4.3	4.7	4.6	+0.1
Other purposes	4.8	5.1	5.1	5.1	+0.3
Total, municipalities	**13.4**	**13.8**	**15.8**	**16.0**	**+2.6**
Healthcare	6.4	7.3	8.1	8.3	+1.9
Other purposes	0.4	0.3	0.4	0.3	–0.1
Total, county councils	**6.8**	**7.6**	**8.5**	**8.6**	**+1.8**
University education	1.5	1.4	1.5	1.5	+0.0
Other purposes	6.5	6.2	6.3	6.1	–0.4
Total, central government	**8.1**	**7.6**	**7.8**	**7.6**	**–0.5**
Total, general government	**28.3**	**29.0**	**32.1**	**32.2**	**+3.9**
			Income tax rates required to balance the budget[2] Per cent		
Municipal rate	20.8[1]	21.0	23.4	23.5	+2.7
County council rate	10.5[1]	11.0	11.6	11.6	+1.1
			Alternative scenario: elderly care without the health adjustment[3]		
Municipal consumption	13.4	14.3	16.7	17.3	+3.9
Municipal tax rate	20.8[1]	21.2	24.3	24.8	+4.0

1. 2004.
2. Central government transfers are assumed to be a constant proportion of revenues, including income tax revenues from private pensions.
3. This scenario does not make any adjustment for healthier lives as people live longer.

Source: Ministry of Finance and OECD calculations.

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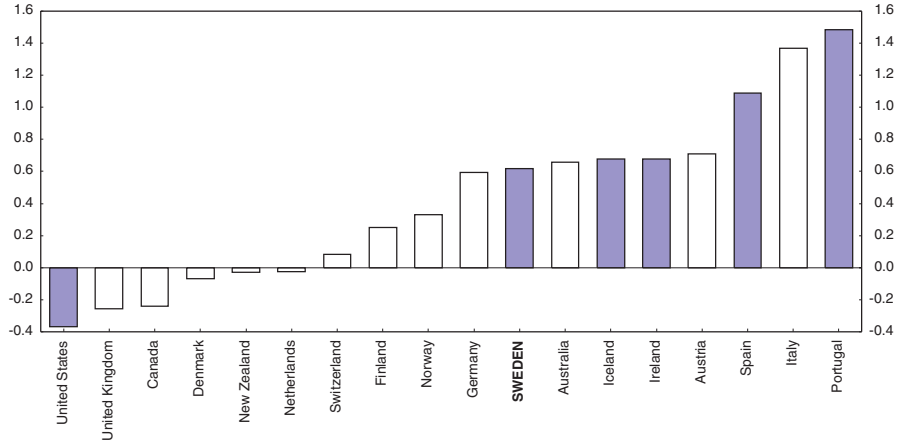
Figure 5.8. **Health spending is significantly pro-cyclical**

Slope coefficient from a regression of growth in per-capita health spending *vs* growth in per-capita GDP, 1980-2002



Note: Statistically significant relationships are shaded

Source: OECD calculations based on OECD Health Data 2004.

counties access to a non-cyclical tax base, such as property or land tax. A second option is for the central government to run a stabilisation fund, adjusting its block grants counter-cyclically, as was recommended by the STEMU Committee in 2002. Having fewer but larger counties should also stabilise revenues since bigger counties would be less susceptible to idiosyncratic revenue shocks. Finally, counties could shift to a medium-term fiscal framework along the lines of those used by many central governments: they would lay out spending plans several years in advance, be given more short-term flexibility to run cyclical deficits but face a tougher medium-term constraint in the form of a strict debt target and sanctions for non-compliance.

The fourth problem is that the budget constraint is too soft. Supplementary "one off" funding is given to county councils and municipalities twice a year in the main budget bill and the Spring Update. The amounts have averaged nearly 1% of local government revenues each year over the past decade (Table 5.4). While in principle the grants are given for specific purposes, in practice they largely compensate for the fact that the standard block grant mechanism does not make any allowance for wage and price increases. Cost control would improve if there was more certainty over financing. Currently, the counties know that the central government will probably bail them out with additional "temporary" grants if they are facing a deficit.

There are no easy answers to these funding issues. The right mix of funding mechanisms depends in part on how the delivery of services is organised:

- As a general rule, the institutions responsible for providing services should also be responsible for funding them. Otherwise, if they do not face the full (marginal) cost of production, they may use resources wastefully and have less incentive to improve productivity; it is precisely this problem that led to a lack of control over pharmaceutical spending, for example. This can be taken as a warning against a model where county councils continue to be responsible for delivery but are funded solely by block grants from the centre.

Table 5.4. **Supplementary appropriations to local government are common**
Per cent of local government revenues (excluding supplementary appropriations)

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Decisions made in:										
1996	1.0	1.8	1.7	1.7	1.6	1.6	1.5	1.4	1.4	1.3
1997		0.9	1.7	2.6	2.4	2.3	2.2	2.2	2.0	2.0
1998			0.3	0.3	0.8	1.0	1.3	1.4	1.4	1.3
1999					0.5					
2000					0.1	0.5	0.7	0.9	0.8	0.8
2001						1.2				
2002							0.9	0.8		
2003								0.1	1.4	1.8
2004								0.3	1.4	1.4
Total	**1.0**	**2.6**	**3.7**	**4.5**	**5.5**	**6.6**	**6.7**	**7.0**	**8.3**	**8.6**
Annual increase	1.0	1.7	1.1	0.8	0.9	1.1	0.1	0.3	1.3	0.2

Note: The figures cover supplementary appropriations for all activities, not just healthcare, and include tax expenditures.

Source: National Institute of Economic Research.

- If delivery and financing are to be aligned, then why not abolish county councils and have healthcare run from the centre? Indeed, this chapter has noted some of the problems – in terms of efficiency and patient safety – caused by excessive fragmentation, and that current arrangements have evolved to be very much like having a single national health tax anyway. On purely economic grounds, there seems little rationale for retaining this extra layer of government. But as noted earlier, one of the strengths of the Swedish approach is its willingness to experiment and innovate, and that may be lost if the system were run by a central bureaucracy. There is clearly a tradeoff here.
- Compulsory social insurance is similar to tax financing except that it is easier to partly pre-fund ageing-related expenditures (because the money can be ring-fenced, much like in the pension system). This would improve equity since medical care is currently financed as a distributional system, while the significance of age argues in favour of redistribution across time (which can be done through either the government redistributing across time or through individual health accounts).
- Private insurance can bring extra funding into medical care, and will be almost inevitable if counties continue their trend towards limiting the services they provide for free. But as noted above, it can cause problems unless the public and private systems are well separated and regulated. It also has equity implications.
- Greater private financing through user charges will also improve the long-term sustainability of the system. Clearly, up-front fees cannot be too high or they will shut some people out of treatment that they need. But Sweden has more scope than most countries to use patient charges because its income distribution is so equal – there are relatively few people who are genuinely too poor to be able to pay at least something towards their medical treatment.

The issues of long-term financial sustainability are similar but more severe for long-term care. Municipal finances are already under strain. The past decade has seen a reduction in the proportions of people aged 80 and over receiving home help and institutional care, and municipalities are planning further cutbacks in institutional care in

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the years to come (NBHW, 2003). Long-term projections imply that municipalities will need to raise tax rates by between 2½ and 4 percentage points in order to maintain the current level of services (Table 5.3). There is a stronger case here, however, for individuals to pay a greater share of long-term care costs. Incomes of older generations have risen relative to those at the start of their careers, and many retired people are relatively asset-rich. One option is to look again at the level of user charges. Since 2002, the central government has set limits on municipal fees; these have the effect that a third of the elderly who receive home help or residential care get it for free, and nobody pays more than SEK 1 572 ([euro] 170) a month.

A second option for elderly care is to increase private financing through a social insurance scheme and to set the contribution rate so that it is at least partly pre-funded. Mandatory insurance has at least two advantages. *First*, it is an efficient way to pool risks so that individuals or families do not face catastrophic costs of nursing home care. *Second*, it allows more pre-funding than in a pay-as-you-go system and is therefore more equitable since today's workers would contribute more to their post-retirement expenses. Japan, Germany, Austria and Luxembourg have all introduced mandatory insurance for long-term care, a step that has been well received by the public (OECD, 2005a). Indeed, a mixture of higher fees, compulsory insurance and tax financing has recently been suggested by the local government association. A greater private contribution to care costs would be more feasible if the government were able to encourage the development of actuarially fair annuity and reverse mortgage markets[25] to help people convert some of their wealth into income. In the longer term, one could also imagine a system whereby older people, who usually have significant assets, accumulate user fees (up to a limit) and have the charges taken from their estates when they die (although this can create its own problems[26]).

Summary and recommendations for reform

The most immediate challenge is for municipalities to improve the funding and quality of psychiatric and social care. In the medium term, the challenges are to improve access to primary care, lift quality in the lower-performing regions and increase value for money in the hospital sector. The longer-term challenges revolve around financing. Funding needs to become more stable, and additional sources of finance need to be found, especially in elderly care. At the same time, this needs to remain consistent with Swedish social *mores*. These themes are not new. They are similar to the issues discussed a decade ago in a review of Nordic healthcare systems (Alban and Christiansen, 1995), and the commission that is currently looking at the financing of healthcare is covering similar ground to a commission that reported in 1992. That does not mean that nothing has happened since then – far from it. Rather, it emphasises that most of the reforms do not imply a radical change to the system but represent a continuous evolution in line with the changing demands placed on the healthcare system.

Box 5.4. **Recommendations for reform**

Access

Improve access to primary care by making it easier to become a family doctor (*e.g.* allow people to practice as a GP as soon as they become a doctor, make it easier for specialists in other fields to retrain as family doctors or completely remove the requirement to be a family care specialist). Encourage GPs to work longer hours and deal with patients more efficiently by introducing mixed payment systems that include a fee-for-service element.

Adjust the *Waiting Time Guarantee* to make it consistent with the principle that those most in need should be treated first (by making duration in the queue just one of several factors that determines who gets treated when).

Quality

Reduce fragmentation. Reduce the number of counties from 20 to perhaps half a dozen or fewer. Merge emergency units to minimise the number that are under the smallest safe size.

Improve the "grey area" between social and healthcare by clarifying responsibilities and improving co-ordination between municipalities and county councils. Step up rehabilitation efforts, especially for people with psychiatric, drug or alcohol problems. Ensure municipalities live up to their legal obligations, perhaps through financial sanctions.

Work towards *reducing regional variations* in quality and medical practice, *e.g.* through greater benchmarking.

Structure and management

Hospital sector: enhance the role of purchasers; improve hospital funding mechanisms, including some form of per-case payment; encourage a greater diversity of providers by removing the ban on for-profit hospitals or allowing exemptions on a case-by-case basis – but only when a robust regulatory framework is in place to minimise the risk of cream skimming; improve management through better case costing systems, especially in psychiatric, outpatient and primary care; make more use of multi-year budgets. These reforms are primarily the responsibility of the county councils.

Expand *customer choice* and private provision in elderly care.

Abolish *Apoteket's* monopoly – certainly for non-prescription drugs and probably for other drugs as well.

Financing

More stable and sustainable financing: reduce the cyclical influence on county council budgets by giving them a less-cyclical tax base, using a medium-term fiscal framework or running a central stabilisation fund. Increase the sustainability of their tax base by broadening it to include property tax or a share of the national sales tax. In elderly care, look again at the level of user charges, which are unsustainably low, and consider mandatory insurance as a way of funding part of the system over the long term.

User charges: either raise the high-cost protection ceilings on patient charges, which have fallen significantly in real terms over time, or make the ceiling a set percentage of household income (instead of a flat amount).

Notes

1. Out-of-pocket spending is around 10% of the total (based on the household expenditure survey, which found that 2% of households' disposable income was spent on healthcare in 1999).
2. De Graeve and van Ourti (2003), for example, show that health financing is fairly neutral (although *slightly* regressive on balance), because the tax system is relatively flat and there are small (but regressive) out-of-pocket payments. See also Gerdtham and Sundberg (1996).
3. There is a commonly expressed view that the Swedish system is more hospital-based than in other countries, but there is very little hard data to prove it. However, the bottom-left panel of Table 5.3 does confirm that the share of physicians based in a hospital is higher than in other Nordic countries, while the bottom-right panel shows a low ratio of GPs to specialists (even after adjusting the Swedish data to account for the fact that all GPs are also counted as specialists).
4. These projections are obviously highly uncertain. For example, there is some evidence that healthcare costs for most individuals are concentrated in the last few years of life; if so, forecasts that are based only on the age profile of spending will overstate the upcoming increase in public spending. The government's baseline scenario for long-term care shown in Table 5.4 builds in a steady improvement in health at a given age, but it does not make such an adjustment for healthcare itself. For every year that life expectancy rises, half of that increase is assumed to be healthy years (so a 77.5 year-old in 2050 is assumed to use the same level of elderly care services as a 75 year-old today). Without this assumption, elderly care spending would rise by an extra 1.3 percentage points of GDP by 2050. But if the same assumption were applied to healthcare, spending would be around 0.5% of GDP lower.
5. See Nolte and McKee (2003) and WHO (2000). The World Health Organisation study ranked health systems according to the level and distribution of health attainment, system responsiveness and the fairness of financing, taking into account a country's economic and educational attainment. The Nolte and McKee study, by comparison, looked only at amenable mortality – *i.e.* conditions that are amenable to treatment by the healthcare system. Sweden ranked fourth rather than first if ischaemic heart disease is also taken into account, although the authors argue that it is unclear whether that condition should count as "amenable".
6. These studies show that fatality rates are relatively low for ischaemic stroke patients; the five-year survival rate for breast cancer victims has risen substantially since 1980 and is now above the European average (although differences between countries are not particularly large); and survival and readmission rates for people admitted to hospital with acute myocardial infarction (heart attack) are around average. See Moon (2003), Hughes (2003) and Moïse (2003) for summaries of these projects. While these studies provide some useful information, it is hard to draw strong conclusions because there are too many factors other than the health system that influence survival rates – especially differences in the severity of cases in different countries.
7. There are also four compulsory registers. They collect data on outcomes but have only limited information on treatments and case mix. They cover cancer, hospital discharges, medical birth and cause of death.
8. Half of respondents to a survey in 2003 said it was hard to get through to a primary clinic on the telephone. Of those who did eventually get through, half could see a doctor the same day, and 80% within a week (NBHW, 2003). But many people do not bother, and go to a hospital instead.
9. The number of doctors' consultations may also be low because of Sweden's emphasis on team-based working methods, such as nurse practitioners performing tasks that are done by GPs in other countries. Not all of these consultations will be recorded in the statistics.
10. The short working week means that the average GP sees 15-20 patients a day, well below rates in the Netherlands, Switzerland, the United Kingdom and Spain (around 26-30 a day). See Quaye (2001) for data on Sweden, and The Royal College of General Practitioners (1992) for other European countries.
11. The estimates for equity of access in Table 5.6 are corrected for differences in need (based on self-reported health). There is an important difference in the data between Sweden and the other countries in the study in that the Swedish data records how many doctor visits were made in the previous three months; most other countries record visits over the previous year. This means that the probability of a visit cannot be compared with the others, but it should not bias the estimate of equity of access across income groups. The German result, for example, is also based on a three-month reporting period but shows no signs of income inequity, while pro-rich inequities based on 12-month data are confirmed for Sweden by van Doorslaer *et al.* (2002).
12. These survey results are cited in Hjertqvist (2002).

13. Siciliani and Hurst (2003) report that the mean waiting time for cataract surgery in 2000 was long by international standards, while Lofgren (2002a) shows that waiting times were similar in Stockholm and Vancouver for a range of surgery. The information vacuum is compounded by inadequate data on surgery rates, as day surgery is counted as a routine GP visit rather than as a surgical procedure.

14. Even six regions may be too many for some treatments, and the government intends to concentrate certain activities in to two or three centres of excellence. It will be up to the Health and Welfare Board to decide how many and which hospitals will perform particular procedures.

15. The decision to discharge a patient is entirely up to the hospital doctor.

16. For example, there are large differences in the use of reperfusion treatment of heart attack patients, access to care at stroke units following a stroke and eye operations to treat cataracts (NBHW, 2003).

17. In their first year of use in Stockholm County, for example, inpatient care rose by 8%, day surgery by 50% and outpatient visits by 15%. See Hakansson (2000) for a review of the relevant studies.

18. See Hakansson (2000) for a review of the evidence available up to that time. Quaye (2001) interviewed various Swedish health professionals and, when asking whether they thought DRG a good system for allocating healthcare resources, found that "overwhelmingly politicians, physicians and health economists reported that it is the best system available so far".

19. In principle, increased output is not necessarily helpful if it is due to so-called supplier-induced demand. But as noted above, there is no evidence that this was the case in Stockholm.

20. An exception to this rule is that local governments can export services "abroad", which in this context means they can make a profit by treating foreigners in Sweden.

21. Income-related user charges already exist in a certain form in elderly care. Charges are capped, and there is a low-income floor to ensure that individuals have a minimum amount of disposable income left after paying their user charges. This means that the lowest-income elderly people pay nothing, while those on slightly higher incomes pay reduced charges until the constraint of the income floor no longer binds.

22. Counties are also responsible for public transport, certain educational activities at high schools and upper-secondary schools, and cultural activities, but healthcare represents around 90% of their outlays.

23. The personal income tax base will fall as a share of GDP due to the decline in the number of people at work, but this will be partly offset by income tax paid as people draw down their pension savings.

24. Although these tax bases would be more sustainable, they may be less stable over the business cycle. Various smoothing mechanisms should therefore be considered, such as basing the transfer of VAT revenues from central to local governments on a rolling multi-year average of the tax base.

25. See OECD (2005b) for a discussion of why these markets are relatively thin at present.

26. There is a potential problem that if the asset testing is too stringent, then it may alter the level of savings before retirement. It may also distort savings decisions if people try to shift savings into "sheltered" areas, such as housing, other physical assets or family trusts, and may increase the incentive to hide assets offshore.

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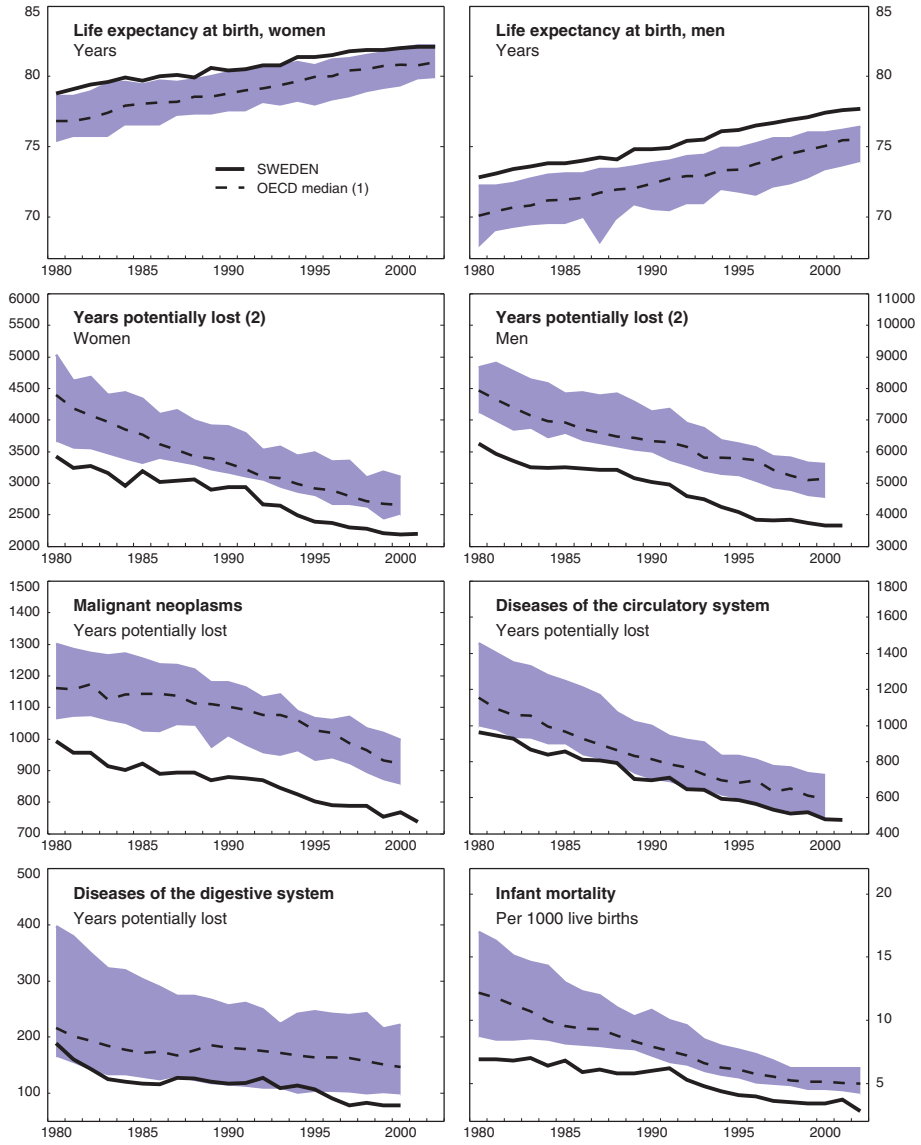
ANNEX 5.A1

Indicators of health status

Figure 5.A1.1. **Indicators of health status**



1. The shaded area shows the middle two quartiles (*i.e.* half the countries fall in this range).
2. The Potential Years of Life Lost is a summary measure of avoidable or premature mortality, providing an explicit way of weighting deaths occurring at younger ages (before 70 years), that are in principle preventable. It is measured as years lost per 100 000 people.

Source: OECD Health Data 2004.

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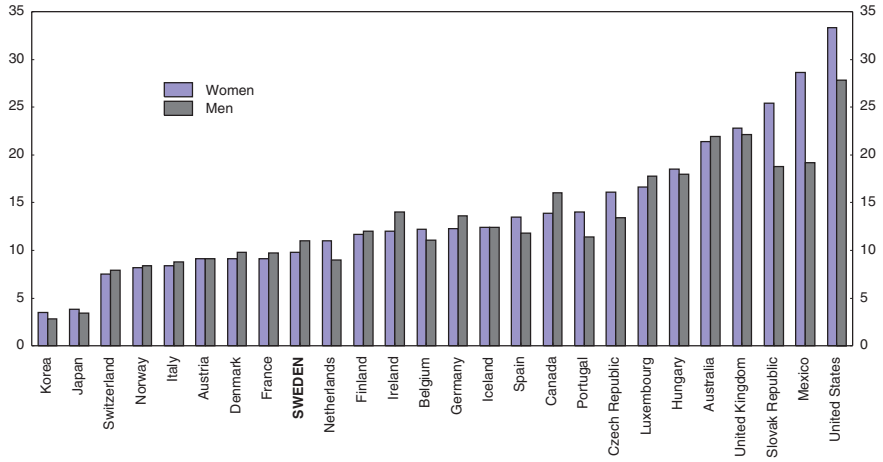
ANNEX 5.A2

Lifestyle factors that influence health

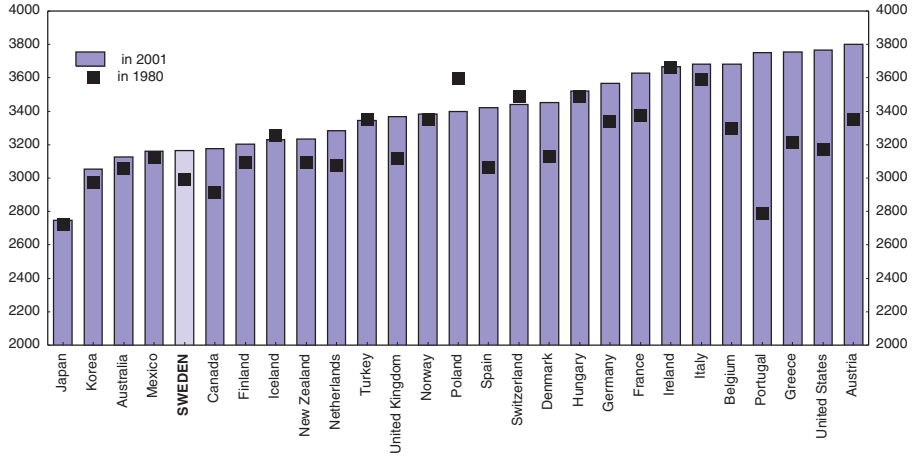
Figure 5.A2.1. **Swedes are relatively slim**
Percentage of people with a body mass index of 30 kg/m^2 or more, 2002



Source: OECD Health Data 2004.

Figure 5.A2.2. **Calorie intake is low**

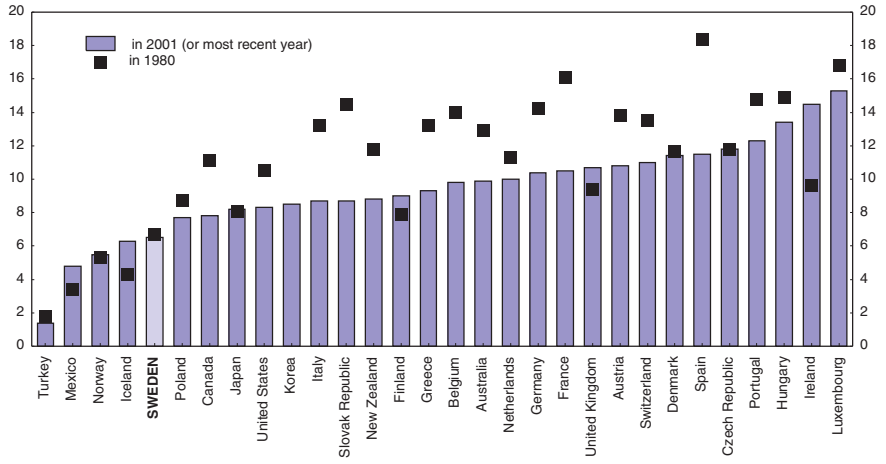
Total calories per capita per day



Source: OECD Health Data 2004.

Figure 5.A2.3. **Alcohol consumption is low**

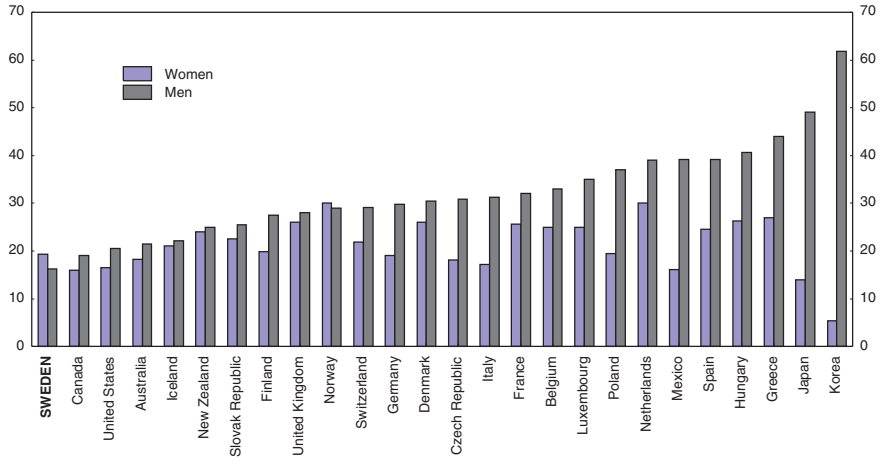
Annual consumption of pure alcohol, litres per person aged 15 and over



Source: OECD Health Data 2004.

Figure 5.A2.4. **Smoking rates are low**

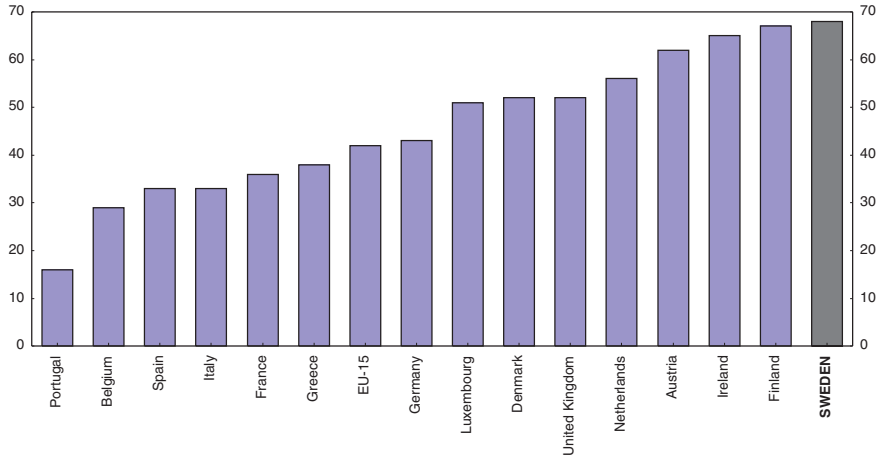
Percentage of the population that smokes daily, 2002 or most recent year



Source: OECD Health Data 2004.

Figure 5.A2.5. **Swedes exercise a lot**

Percentage of adults engaging in sport at least 3 hours per week, per cent, 1997



Source: Institute of European Food Studies.

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