
Welfare services in Sweden – with New Zealand comments

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Abstract

Two countries on the opposite side of the globe – Sweden and New Zealand– similarities and differences!

This article is an introduction to the following articles about aspects of social services in Sweden. These articles, written from a Swedish perspectives and context, give some pictures of the welfare sector in the areas of elderly care, psychiatric care and disability care which hopefully will be of interest especially for New Zealand readers. To build the understanding of the Swedish model this introductory article starts with a theoretical approach to welfare systems. To understand the context in which services are delivered, it is necessary to both give some basic facts about the countries¹ and about services – regulation, conditions, organisations and implementation, including how services have developed historically and influenced the current situation – and to include comments and reflections from a New Zealand perspective. These external comments and reflections are also a way to broaden the interest and value for New Zealand readers as well as for international readers in general and, not least, Swedish readers.

Approaches to welfare

Theories facilitate understanding of life and what is going on around us. Theories on welfare help us classify welfare systems and policies. The idea with these articles from Sweden is not to carry out a complete comparison but to look at some areas with 'new eyes'. Comparing policy is however a part of everyday life. By assessing one situation, one service, one country against another, we gain a better perspective on the current situation as well as on the options and constraints we face. In short, we learn through comparing. As we are not really comparing countries but more contrasting countries there is a need to recognise initial cultural and institutional differences. This involves looking beyond the frontiers of one country to explore other ways in which social policies may be framed. Such studies are typically concerned with specific policies rather than with the policy system as a whole, just as here we are mainly dealing with elderly policies, disability policies and psychiatric policy, not social policy in general.

Theorists have generally identified three broad social systems which deal with the tasks that support day-to-day living in capitalist societies. These are the household system², the economic or market system and the public welfare system. There are many well-known

¹ An overview of facts for the two countries is presented in Appendix One.

researchers on welfare state issues. One of the more famous is Esping-Andersen (1990). He classified countries in a ranking list, the so called decommodification scores, due to a number of factors concerning income, sickness benefits etc and to what degree the population was included.

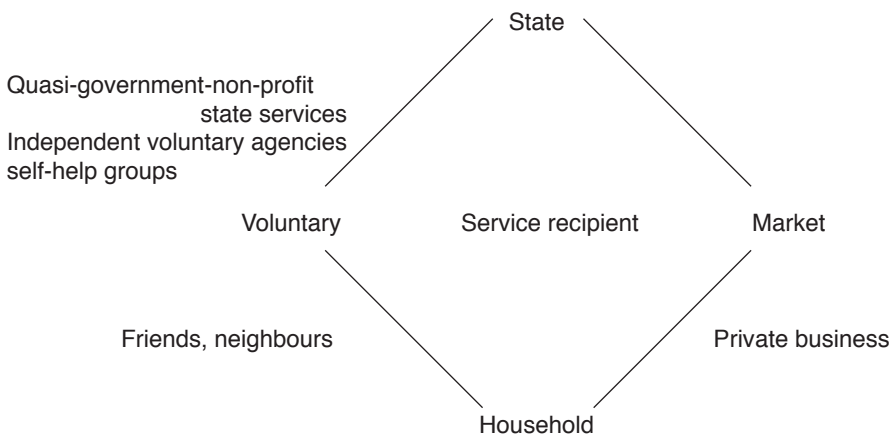
... the degree to which citizens can freely, and without potential loss of job, income or general welfare, opt out of work when they themselves consider it necessary (Esping-Andersen 1990, p. 23).

According to Esping-Andersen the welfare states can be clustered into three distinct regime-types:

1. *The liberal welfare state* - in which means-tested assistance, modest universal transfers or modest social insurance plans predominate. Low level of decommodification. Esping-Andersen puts New Zealand in this category.
2. *The corporatist welfare state* - where the historical corporatist-states' legacy was upgraded to the new 'post-industrial' class structure. Esping-Andersson puts France in this category.
3. *The social democratic welfare state* - countries in which the principles of universalism and de-commodification of social rights were extended also to the middle classes. Esping-Andersen puts Sweden in this category.

The complexity of European policies and practice (which can easily be exemplified for people with, for example, disabilities) can be grasped through the emergence of the idea of a welfare mix. The concept provides the basis for understanding that there are a number of social actors involved. These actors are the state, the market, private households and other independent groups. The idea of a welfare mix challenges the more rigid distinctions of the conservative/liberal/social democratic typology.

This can be illustrated by a diamond – a welfare diamond.



Source: Hill 1996:129

² Household is preferred to family system because it does not privilege a particular form of primary association based on kinship. Many households are not family based. The type of family can also vary greatly. Despite this variation welfare provisions are usually predicated on a traditional family unit.

These different welfare approaches for services to older people or people with disabilities are very clearly demonstrated in the way services are organised in Sweden. There are different ways of organising care and services for different groups of people in a society and the different approaches/welfare mix in different countries belonging to different welfare systems, as illustrated by 'the welfare diamond'.

Another way to analyse welfare services is to scrutinise what is at stake by using four dichotomies: residual versus institutional welfare; absolute versus relative poverty; selective versus universal provisions and horizontal versus vertical equity (Bryson, 1992, p. 55). For an analysis of the articles in this journal we focus on the residual versus institutional welfare dichotomy and selective and universal provisions.

A residual or marginal view of welfare holds that the state provisions should come into play only when there is a breakdown in the natural mechanism for the support of the individuals – the family, the market and voluntary charities. The state is the lender of last resort. An institutional view on the other hand sees welfare provisions as normal – first line functions of modern industrial society and implies no stigma, no emergency, no abnormality. Esping-Andersen and Korpi add that the institutional model does not recognise any boundaries for public welfare commitments. The institutional welfare state aims to ensure a decent standard of living for its citizens and guarantees 'full citizenship rights unconditionally' (Esping-Andersen & Korpi 1987, p.40). Countries that can be said to have institutional welfare state structures all share relatively high material wealth. This applies very clearly to the model welfare states of Nordic nations and to New Zealand.

Selective – universal provision

Selective services are targeted only to those who meet specified criteria of need. The mechanism most commonly associated with selective services is the means test, which is used to screen out people on the basis of income or assets or both. The implication underlying a means test is that self-support is primarily the duty of the individual. State involvement is the last resort. The pragmatic reason for means testing is that governments are unable or unprepared to fund universal provisions. Universal services on the other hand are available to everyone, regardless of their personal circumstances. Selective services take into account the particular circumstances of the individual. Universal services take account of individual circumstances only to ascertain that the person is a member of the broad universal category for whom the service is intended.

From cradle to grave: a brief overview of parts of the social sector in Sweden

Historical development

Before World War I, the Swedish social system was largely modeled on the example of Germany. The labour movement and other 'popular movements' (temperance, women etc.) gained major influence at an early stage. During the 1930s, Sweden began to build up what then Prime Minister Per Albin Hansson called 'the home of the people'. Its vision was to lift Sweden out of poverty once and for all, and to build a society where all citizens, regardless of gender, class and social origins, would be guaranteed basic economic security. This Swedish 'home of the people' would not be dependent on charity, but instead would be financed by a tax system in which the well-to-do would bear the main economic burden. The principle was 'from each according to ability, to each according to needs'. This ambi-

tious programme not only included economic reforms, but also encompassed, for example, a construction programme designed to guarantee all citizens high-quality housing, with appropriate central heating, ventilation, access to daylight, kitchen and hygiene facilities, etc. From the early 1930s, the Social Democrats ruled without interruption for more than 40 years, including their grand coalition government with the other non-communist parties during World War II. It was mainly during the 1950s and 1960s, a period of unparalleled economic growth in Sweden, that the world's most extensive tax-financed social welfare system was built up (Gynnerstedt, 1997a).

During the 20th century, at the price of the world's highest tax burden, Sweden built up what is often called the world's most generous general social welfare system, with such elements as virtually free (that is, tax-financed) schools, child care, health care, pensions, elder care, social services and various economic security systems. In recent decades, once the country's previous steady, high economic growth had come to an end, the Swedish welfare state has been under heavy pressure. Today the country's economic security systems are financially burdened and are struggling with serious structural problems. Without a doubt, Sweden has become 'harder around the edges'. Yet the main features of the Swedish welfare state, with its publicly guaranteed and publicly financed safety net for everyone in the country, remain intact (www.sweden.se Quick facts Sweden in Brief).

There is a current interest in citizenship reflecting major social developments, which have taken place in Europe and the rest of the world during recent years. Ongoing changes in European welfare models and world-wide welfare systems call for a new and dynamic understanding of social citizenship. These changes may involve among other things new relationships between public and private responsibility for social risk protection especially in old age, between rights to receive and duties to participate (Hvinden & Johansson, 2007).

Government situation since 2006 election

After the 2006 election, 12 years of Social Democratic government ended when the four Alliance parties – the Moderates (formerly Conservatives), Liberals, Center (formerly Agrarians) and Christian Democrats – formed a government. The prime minister is the chairman of the Moderates. The Social Democrats, who ruled Sweden for most of the 20th century and enjoyed a uniquely dominant position of power over national policy compared to other Western European countries, turned in one of their worst election performances ever. In the new Parliament they are in opposition along with the Left Party (ex-communists) and the Green Party.

In the 2010 election, the centre-right alliance got nearly 49.28% of the votes and remained in power – albeit with no outright majority for the alliance. The Moderate Party garnered 30.06%, far ahead of previous results of around 20%. The Social Democrats declined to its lowest percentage of votes since World War 1. The party got 30.66%, far below previous results of around 40%. The left of centre coalition (Social Democrats, Green Party and Left Party) got 43.6% of the votes in this election. A new party, the Sweden Democrats got 5.7% of the votes and took its place in parliament for the first time. 'It's an entirely new political landscape', was the comment from political scientists and journalists after the election (<http://www.sweden.se/eng/Home/Quick-facts/Sweden-in-brief/Government-politics/>).

New Zealand

New Zealand's welfare framework is increasingly working with and developing approaches to programmes and services which reflect the bicultural base of New Zealand society reflected in the Treaty of Waitangi signed between Māori as the indigenous people and the British Crown in 1840. Historically Māori had social and economic systems built around collective identities in which whānau (extended families) were a central feature. Welfare was provided through whānau and iwi (tribal) systems. Pensions were first provided in the 1898 Old Age Pensions Act and compensation for industrial injuries was provided in the Industrial Conciliation and Arbitration Act 1894. Financial support was extended to some families in 1924 and the Social Security Act 1938 provided for benefits for sickness and unemployment, and a universal and means-tested pension and created a universal health system. Public housing (known as state housing) was established at the same time and full employment formed a fundamental part of the welfare state programmes.

Welfare programmes were minimally expanded after World War II with a universal family benefit in 1946, the introduction of no-fault accident compensation in 1974 and a statutory benefit for lone parents in the same year. National (conservative) governments ruled for much of the period after World War II and generally left the welfare state structures intact. They introduced a universal superannuation payment in 1977, linked to the average wage and paid to all, without a means test, on reaching the age of 60 (increased to 65 from 1998). New Zealand does not have a compulsory retirement age, but many people retire from work at the age of 65. However, an increasing number are continuing to work part-time beyond that age.

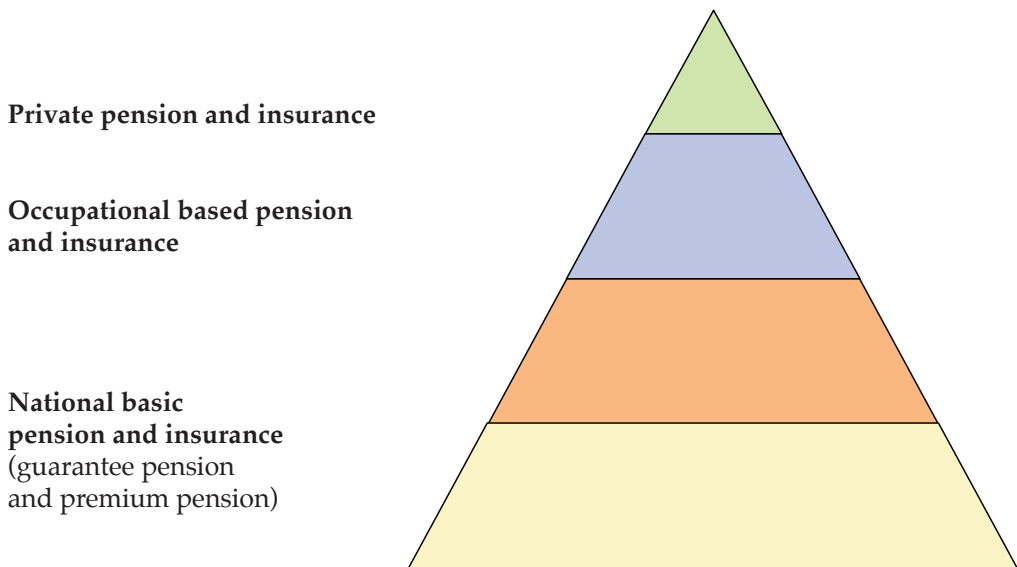
Major changes have occurred since the election of the Labour government in 1984 with the focus on full employment disappearing, increased charges for state services across a range of social services, increasing programmes of privatisation in the provision of services and the introduction of competitive mechanisms in many aspects of the welfare state. In addition, the National government cut welfare benefits significantly in 1991, a decision which has been a major influence on the growth of poverty in New Zealand in the last two decades. In addition, continuing unemployment (at times quite high) and a programme of tax cuts over the last 25 years has seen significant growth in income inequality, with faster growth than in any other OECD country (Organisation for Economic Cooperation and Development, 2008).

Social security system in Sweden

Sweden offers a framework of publicly funded social provisions ranging from pensions and health care to parental allowances and employment related insurances. The national basic pension and insurance system are often combined with occupational based insurance plans. Insurance in Sweden aims at providing financial security through a stable welfare society for all. The social security system has many parts, ranging from parental leave and child care to sickness and accident insurance, disability assistance and care for the elderly. It covers all Swedish residents.

Sweden's social security system is primarily funded by statutory contributions under the national basic pension and insurance plan. Many employers supplement these contributions with payments under occupational-based agreements with their employees. Individual em-

ployees can also top up their provision with private insurances. People contribute to their national pension, which is income-based, for every year they work. There is also a small portion of the national pension called the guaranteed pension. This is for people who have had very little income or no income at all in their life. The guaranteed pension provides them with a minimum amount each month. Pensioners with low income can receive a housing supplement. The survivor's pension, housing supplement for pensioners and subsistence allowance for pensioners are other pension benefits (Försäkringskassan 2010). Retirement age is normally at 65 but people can choose to start receiving their pension between the ages of 61 and 67. The pension and insurance pyramid shows the parts which constitute the total pension for the individual.



National and local organisation of services

The areas of responsibility of the Ministry of Health and Social Affairs relate to social welfare: financial security, social services, medical and health care, health promotion and the rights of children and disabled people (www.sweden.gov.se).

The National Board of Health and Welfare (socialstyrelsen or SOS) is a government agency under the Ministry of Health and Social Affairs, with a very wide range of activities and many different duties within the fields of social services, health and medical services, environmental health, communicable disease prevention and control and epidemiology. In the social services field the Board deals with elderly persons in need of care, persons with functional disabilities, children and young persons at risk, women exposed to violence, persons living on welfare and persons with abuse problems. The Board gives instructions and general guidelines for the social services and also follows up and evaluates on the national level the situation of persons who are dependent on the work of the social services. The task of the Board includes preparing official statistics related to the work of the social services and conducting information reviews.

The role of central government is to establish principles and guidelines for care and to set the political agenda for health and medical care. This is achieved by means of laws and ordinances or by reaching agreements with the Swedish Association of Local Authorities and Regions (Sveriges Kommuner och Landsting, SKL), which represents the county councils and municipalities.

Sweden is divided into 290 municipalities, 18 county councils and two regions. There is no hierarchical relationship between municipalities, county councils and regions since all have their self-governing local authorities with responsibility for different activities. Sweden's municipalities are responsible for care of the elderly in the home or in special accommodation. Their remit also includes care for people with physical disabilities or psychological disorders. Municipalities are also responsible for providing support and services for people released from hospital care as well as for school health care (www.Sweden.se).

Organisation in New Zealand

As indicated briefly above, New Zealand has a range of social security benefits, paid by a central government agency and funded through taxation. There are a range of categorical benefits (sickness, unemployment, invalids, widows, lone parents) supported by housing assistance (available to beneficiaries and those in work) and other forms of means tested assistance. There is no universal child benefit (that was removed in 1991) and a system of tax credits provides some support for families but children with parent/s not in paid work are discriminated against in that major elements of this assistance are only available if parents are in paid work.

Central government in New Zealand has traditionally been a major funder and provider of health and social services, with local and regional governments having a very minor role. The economic and social changes over the last 25 years have seen the growth in the social service sector of voluntary, not-for-profit organisations, increasing provision of services by iwi and by ethnic communities and the state decreasing its direct provision but retaining a regulatory and funding role. Funding has often been through contracting, often partially funded, with gaps met through part charges and by fund raising activities by not-for-profit organisations.

Health and medical care in Sweden

In the Swedish health care system, responsibility for health and medical care is shared by the central government, county councils and municipalities. The Health and Medical Service Act (HSL) regulates the responsibilities of the county councils and the municipalities. The Swedish health care system is government-funded and heavily decentralised. Responsibility for providing health care is decentralised to the county councils and in some cases to the municipalities. County councils are political bodies whose representatives are elected by their residents every four years on the same day as the national general elections. The county councils and municipalities have the primary responsibility for planning, funding and running health care.

Sweden's entire population has equal access to health care services. The prevalence of psychiatric illness or psychiatric disorders in Sweden is equal to that of many European countries. Between two and four percent of the total population seek psychiatric care in one

year. A higher percentage of those seeking treatment come from urban areas. Individuals with long-term psychiatric illness receive care from psychiatric care organisations as well as from public social service agencies (socialstyrelsen art no 2006-114-22).

Organisation

Primary care has traditionally played a less important role in Sweden than in many other European countries. Today most health care is provided in health centres where a variety of health professionals – doctors, nurses, midwives, physiotherapists and others – work. Around 25 percent of health centres are privately run by enterprises commissioned by county councils.

About 70 hospitals provide specialist care with emergency room services 24 hours a day. Eight are regional hospitals where highly specialised care is offered and where most teaching and research is located. Since many county councils have small service areas, six health care regions have been set up for more advanced care. The county councils own all emergency hospitals, but health care services can be outsourced to contractors. For pre-planned care there are several private clinics from which county councils can purchase certain services to complement care offered within their own units. This is an important element of the effort to increase accessibility.

Costs and fees for care

Costs for health and medical care amount to approximately nine percent of Sweden's gross domestic product (GDP). The bulk of health and medical costs in Sweden are paid for by the county council and municipal taxes. The rest is financed by contributions from the state, and patient fees only account for a few percent (www.sweden.se). It is now more common for county councils to buy services from private health care providers. Ten percent of health care is financed by the county councils but carried out by private care providers. An agreement guarantees that patients are covered by the same regulations and fees that apply to the municipal care facilities.

The fee for staying in a hospital is SEK 80 per day (2010)⁴. Fees for outpatient care are decided by each county council. Fees to consult a primary care physician range from SEK 100 to 200 depending on the county council. For specialist visits there is an additional fee of a maximum SEK 300. To limit costs for the individual there is a high-cost ceiling, which means that no patient ever needs to pay more than SEK 900 over a 12-month period. A similar ceiling exists for prescribed medication, so no one pays more than SEK 1,800 per 12-month period (www.sweden.se *Fact sheets in health care* April 2010).

New Zealand

Health services are organised and provided on a regional basis, through 19 District Health Boards. Some specialist services are provided on a regional or national basis. Health Boards provide hospital care and surgery and some limited services outside the hospital setting. Health care is free to New Zealand citizens and residents. Governance is undertaken by a Board which is partly elected and partly appointed and funding is provided through central government which also maintains a regulatory role. Increasingly, not-for-profit organisations are taking on a greater role in areas such as mental health services (they have always

⁴ Five Swedish Crown (kronor) are approximately equivalent to \$1NZ.

been very involved in services for older people and for those with a disability). The private sector is also a significant provider of residential services for older people.

General practice is largely organised on a subsidised fee-for-service basis, with charges varying between different practices. Services for children are subsidised at a greater rate than for adults although there are often major issues of cost for medical care for children out of normal practice hours. There is a part-charge for prescriptions, with the rate varying for different medications. There is a limit on the total costs for a person during the course of the year, linked to income and health status. Medical specialists also operate in private practice and charge for their services as do private hospitals. Approximately half of the New Zealand population has private medical insurance which meets some of the charges by medical practitioners and private hospitals; private (fee charging) surgical hospitals are a significant part of the hospital sector. All of this results in large inequalities in access to health care depending on location and financial circumstances.

Social services in Sweden

The objective of social services policy in general is to strengthen the capability and opportunities for social and cultural participation of people who are in economically and socially vulnerable situations and to strengthen protection of children at risk (www.sweden.gov.se).

Child care

Of the 9.3 million people who live in Sweden, almost two million are under 18. Swedish law makes sure children are well protected and defends their rights, with various organisations devoted to their well-being. The Swedish social welfare system goes to great lengths to make sure that children are well protected and cared for, but also that parents are able to handle both family and a career simultaneously.

Family policy covers a number of different benefits. Child allowance is the benefit that reaches the largest number of people and which also accounts for the greater costs. All children who live in Sweden are entitled to child allowance.

Parental insurance enables women and men to combine family life and work. Parental benefit provides financial compensation to parents who stop work to look after their children for longer or shorter periods. There is also a temporary child benefit which provides financial compensation when a parent needs to stay at home from work to take care of a sick child. Housing allowance provides support for families with children with a low income. Parents of children with disabilities can receive child care allowance to enable them to take care of the child at home.

Everyone has to attend school for at least nine years in Sweden. There are no school fees. Children start school at the age of seven (six-year-olds attend preschool classes) and finish at 15. Then they have a choice of staying on for senior high. The school year is divided into two terms, spring and fall. At present, children are graded in years 8 and 9. This might be the case for younger children in the future too.

To protect the rights of children and look after their interests, the Swedish government

has appointed an ombudsman. The ombudsman is obliged to follow the 1989 United Nations Convention on the Rights of the Child and enforce it in Swedish society. The convention is a set of rules agreed upon by many countries to protect children. Sweden was one of the first countries to sign up.

Thirty years ago, Sweden became the first nation in the world to prohibit all corporal punishment of children. This radical step pioneered the way for many more countries to follow suit. Spanking, slapping, smacking, pinching, hair-pulling, whipping, paddling – corporal punishment by any name or means is prohibited, at home and in school, and severely frowned upon. This has not always been the case. Until the 1960s, nine out of 10 preschool children were spanked at home. Slowly, though, more and more parents voluntarily refrained from its use and corporal punishment was prohibited throughout the education system in 1958. During the 1970s, the debate on child abuse intensified. When Parliament voted on the issue in 1979, two-thirds of parents were already in favour of a legal injunction. On March 15, 1979, the members of the Swedish parliament were the first in the world to vote for the prohibition. The law was implemented on July 1, 1979 and cemented popular attitudes. In the 1980s only a third of children were spanked, and in the 1990s that number had shrunk to about a fifth. Sweden's neighbours Finland and Norway enacted similar laws in 1983 and 1987. Austria followed in 1989. Then the pace picked up, and as of today, 24 countries have taken the same step, and another 23 have stated that they will implement legislation (www.sweden.se).

Elderly policy

Health and social care for the elderly constitutes an important part of Swedish welfare policy. Of Sweden's 9.3 million inhabitants, 18 percent have passed the retirement age of 65 and are pensioners. This number is projected to rise to 23 percent by 2030, at which time about one in five Swedes is expected to be of retirement age.

We also have a high longevity in Sweden. Today we talk about four ages - childhood and adulthood as the first two; the third starts at the end of the fifties and covers mainly the early retirement period, while the fourth normally is described from the beginning of the eighties and the rest of life. The consequences for welfare services and their implementation are comprehensive. Earlier we talked about retired people as a homogenous group but the need of services is normally not the same when you are 65 as when you are 85. The third age covers many transition activities from working life to leisure time, from private housing to supported services, from health condition to frail life (Thelin, 2011; Gynnerstedt, 2011).

The elderly represent a growing share of the Swedish population. Many are in good health and lead active lives, and most live in their own homes. The objective of elderly policy is for older people to have active lives and influence on society and their own everyday lives to be able to grow old in security and retain their independence, and for them to be treated with respect and have access to good health and social care services. The aims of care of the elderly in Sweden have for decades been to guarantee a secure financial situation, good housing, and service and care according to needs. Public help is intended to give care recipients freedom of choice and influence and to maintain high standards. All the elderly should have equal access to these welfare 'products' regardless of age, sex, ethnicity, place of residence and purchasing power.

According to the Social Services Act (1982) the elderly have the right to receive public service and help at all stages of life. All who need help to support themselves in their day-to-day existence have the right to claim assistance 'if their needs cannot be met in any other way'.

The challenges for the welfare sector have created new situations with the general trend of individualisation in society as well as in the social service sector. Freedom of choice, market competition and individual freedom are some of the new keywords which have resulted in outsourcing and privatisation of some of the services. Differences in services and in organisational structures with alternative forms of provisions have consequences for the way municipalities deliver, implement and carry out service for people in need. The motives for these changes have been different, but one has been to increase the alternatives for the service user. Other motives have been to make the public service more efficient by market competition (Gynnerstedt 2002).

Organisation and costs

Developments in the 1990s were characterised by the Ädel reform when responsibility for care of the elderly was shifted over to the municipalities. Since that reform came into force, a steady increase in the workload, both in institutional and home-based care, has been identified. This means that the elderly moving to institutional care today are more frail and dependent both in terms of functional and cognitive capacity. At the same time, and accentuated during recent years, the number of beds in institutional care in the municipalities has dropped substantially. This in turn has further increased the pressure on municipal caring services for the elderly and on outpatient services.

The 1990s also implied a 'marketisation' in the care of the elderly, which was opened up for new providers (producers) of services and care. Another trend is that there is an ongoing shift of responsibility, from the public to families, regarding welfare of the elderly. There is a debate on the role of family and state in the care of elderly persons. This debate provides empirical evidence of the shifting balance of family, state and market in the total panorama of elderly care. Total spending on aged adults has stagnated, and institutional care is shrinking in absolute and relative terms, but public home help for elders in the community is decreasing even more. Family members increasingly shoulder the bulk of care, but privately purchased care also seems to be expanding. Informal care is estimated to have provided 60 percent of all care to elders in the community in 1994 and 70 percent in 2000 (Sundström, Johansson & Hassing, 2002).

This should be viewed against the background of the 'Swedish model' of publicly financed and provided services and care for all, according to need. Furthermore, there is an increasing awareness that most families and next of kin provide care and supportive services. This is described in the article by Albin, Siwertsson and Svensson (see p. 66). The bulk of all elderly care is provided by the municipalities. Some have contracted out their elderly care services. Everybody is allowed to choose whether they want their home help or special housing to be managed by public or private operators.

Most elderly care is funded by municipal taxes and government grants. In 2008, the total cost of elderly care in Sweden was SEK 91.8 billion. Only four percent of the financing came from patient charges. Health care costs to be paid by the elderly themselves are subsidised

and based on certain rate schedules. Care of the elderly is almost totally financed by taxes. The user only pays a fraction of the cost (5-6 percent). The largest share of the cost (about 82-85 percent) is covered by local taxes (www.sweden.se).

Disability Policy

The objectives of disability policy are: a social community based on diversity; a society designed to allow people with disabilities of all ages full participation in the life of the community; equal opportunities in life for girls and boys, women and men with disabilities. Ensuring that people with disabilities have power and influence over their everyday lives has long been the prime goal of Swedish disability policy. The focus is now on democracy and human rights. The disability perspective should be mainstreamed into Swedish society as a whole and not be confined to the health care and social services sectors.

Work on disability policy is to focus particularly on: identifying and removing obstacles to full participation in society for people with disabilities; preventing and combating discrimination against people with disabilities; enabling children, young people and adults with disabilities to achieve independence and self-determination. The policy area covers measures to remove obstacles to full participation in society, and action to combat discrimination and individual support. The measures are cross-sectoral and are included in most policy areas.

In conjunction with the International Year of Disabled Persons in 1981, the Swedish government drew up a national action programme on disability issues, supported by all the parties in the Parliament. The environmentally related concept of handicap, introduced by the active and strong movement of people with functional impairment, plays a central role in the Swedish disability policy. This means that a handicap is not viewed as a characteristic of a person but as something that arises when a person with a functional impairment is confronted by an inaccessible environment. This approach lays responsibility on all organisers, both public and private, to ensure that the activities they run are accessible to all and that they do nothing to turn an injury or illness into a handicap.

A national action plan on disability policy, 'From Patient to Citizen', adopted in 2000, has shifted the emphasis in Swedish policies targeting disabled people (Proposition 1999/2000:79). Before, government action in this area largely centred on social issues and welfare matters. The emphasis today is on democracy and human rights. Swedish disability policy has been given a clear-cut citizen's perspective.

The policymakers have also shown a determination to introduce broad-based solutions in the quest for a society that is accessible from as many aspects as possible and to as many citizens as possible. This is seen as a way of avoiding the need for special solutions for certain groups, an approach that tends to be costly.

Swedish disability policy, therefore, is now concentrating on:

- Identifying and removing obstacles to full participation and full equality in society.
- Preventing and fighting discrimination.
- Promoting equality between disabled girls and boys, women and men.

The disability perspective is to become a natural part of all policymaking and all public activities. Government agencies have begun to make their premises, activities and information generally accessible. Public officials are to be trained in disability issues so that persons with disability are not prevented from exercising their rights as citizens as a result of ignorance or degrading treatment or both.

The Social Services Act from 1982 regulates the services to all citizens, but in addition special programmes have addressed the needs of persons with disabilities. The local authorities' social services have ultimate responsibility for ensuring that all those who live in the area obtain the support and help they need. This does not mean that the assistance must be provided by local authorities but they are obliged to make sure that it is provided for the individual in a suitable manner. Local authorities must work to enable persons with physical and mental functional impairments to live in a way that corresponds to their needs and to play an active part in the community by traveling and gaining access to public premises and so forth. The Social Services Act also obliges the municipal social services to conduct activities among people with psychiatric disorders. Social services are obliged to plan their assistance programmes for such individuals in consultation with psychiatric care organisations and other public bodies and organisations (socialstyrelsen Art no 2006-114-22).

A law in force from 1994, the Act concerning support and services for persons with certain functional impairments, known as LSS, aims to provide support and services to persons with functional impairments including those with impairments due to psychiatric disorders. This is a rights law supplementing other legislation. Its aim is to give persons with extensive disabilities greater opportunities for leading an independent life and to assure them of equal living conditions and full participation in community life. This law and its implementation are described in the article on personal assistance in public administration by Gynnerstedt and Bengtsson.

One factor of importance for the development of disability policy is the disabled peoples movement. At a national level there are more than 70 organisations representing specific disability groups, with some 2,000 local associations nationwide. The national organisations have formed the Swedish Cooperative Body of Organisations of Disabled Persons, an umbrella organisation comprising about 33 member organisations which are run and dominated by persons with functional impairments. The organisations normally receive financial backing from the state, county councils and local authorities for their activities as political interest groups, that is, their work involving publicity, opinion formation and research on politically important disability issues. Through their experiences and their active work, these organisations have come to be regarded as valuable advisers on disability issues. Their representatives are involved in working and reference groups at central, regional and local level, which address issues of importance to persons with function impairments. In 1993, the UN introduced the document *The Standard Rules on the Equalization of Opportunities for Persons with Disabilities*. Ever since, these have been a cornerstone of Swedish disability policy. In 1994, a Disability Ombudsman was appointed to supervise compliance with the rules.

From a New Zealand perspective

New Zealand's social services for children, older people and disabled people are quite complex and difficult to describe briefly. Government plays a significant regulatory role in a

system which is increasingly characterised by diversity of providers and contracts between government departments and service providers. Increasingly, government has limited its role to what are described as 'core services', with the definition of what constitutes 'the core' being tightened. Government still provides some limited services in relation to care and protection of children, with the not-for-profit sector and iwi playing an increasingly significant part, often under contract to the major government department.

The not-for-profit sector is even more significant in provision of services for older people and for people with disabilities, with a range of organisations at a local and national level engaged in service deliveries. Disabled people have always been significant in disability services, an emphasis which has grown markedly in recent years as disabled people have emphasised their rights. This culminated recently in their key role in the establishment of the United Nations Convention on the Rights of Disabled Persons.

Services for older people are much less developed, with the not-for-profit sector and private providers being the major participants. Here too, government has played a regulatory and funding role, particularly in relation to accommodation. A small number of local authorities provide a limited range of housing to those who meet the means tested requirements. Some major local authorities have sold their accommodation for older people, arguing that this is not one of their core functions. The increasing numbers of retired people over the next two decades will place significant pressure on services and facilities for older people. It is estimated that by 2035 there will be more people over the age of 65 than under the age of 15 in New Zealand, for the first time in the country's history.

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