CHAPTER - 5
SOCIAL PROGRAMMES IN SWEDEN

SOCIAL WELFARE PROGRAMMES:

As social problems become more complex and services provided were extensive and diversified, Sweden is seen to be relying were on a professional approach. Similarly, as the family and church, the two basic social units, find tackling social problems unmanageable on their own, the State steps in and assumes greater responsibility. Notwithstanding state's role voluntary groups like the Parents Association still have a influencing role in policy decisions pertaining to various social programmes. For example, if the Parents’ Association decided that there was no need for sex education at the school level the school authorities have to comply with the request. There is also a provision for legal appeal at every level in line with the principle of participation and self-determination. As in most democratic countries, Sweden also experiences a difference of opinion on approaches between the personnel in the professional system and political system.
Organisation

Figure 3 and 4 show the structure of the Swedish Political System and the division of responsibilities between Kommunes and public authorities at the regional and the national level respectively. It is evident that the different levels of administrative structures are inter-related - the national level where the policies are made by government through the Parliament, Regional County Councils and the Kommune Councils. Each level has definite functions and powers of taxation. At the national level, national policy perspectives are evolved along with the well-knit administrative link up for supervision, allocation of resources and training. The government formulates Legislations with regard to social welfare services, housing and labour market. Further, at the national level, there are National Associations for County Councils and Kommunes.
Figure 3: The Structure of the Swedish political system.

Geographical information

<table>
<thead>
<tr>
<th>National level</th>
<th>Organisational dimension</th>
<th>Regional level</th>
<th>Local level</th>
</tr>
</thead>
<tbody>
<tr>
<td>STATE (STAT)</td>
<td></td>
<td>COUNTY (LAN)</td>
<td>MUNICIPALITY (KOMMUN)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parliament (riksdag) (elected)</td>
<td>Government</td>
<td>Ministries (Departments)</td>
<td>Central Agencies (Ambetsverk)</td>
</tr>
<tr>
<td>Government</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government's Secretariat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admin corporations &amp; state-run business</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>County Administration with a board (Lansstyrelse)</td>
<td>County Administration with boards (eg. lantbruksnämnden)</td>
<td>County council (landsting) (elected)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Bodies eg. tax authorities</td>
<td>Local Bodies eg. Labour exchange bodies &amp; bodies administering boards.</td>
<td>Local Bodies eg. Hospitals</td>
<td>Municipal Council (Kommunfullmäktige) (elected)</td>
</tr>
</tbody>
</table>

Note: The ASM organised at regional and national level unlike other bodies included in the scheme are voluntary associations.
Figure 4: The Division of Responsibilities between Municipalities and Public Authorities at Regional and National level.

### THE NATION

1. Passes laws concerning frames, allocations, supervision.
2. Directs state administration.

### THE REGION

1. State county administration (country administrative board, county executive boards).
2. County council administration.

### THE MUNICIPALITY

- Education (training for nursing and care occupations, agrl.
- Training, Forestry training, Telecommunications.
- Youth Sports, Vocational rehabilitation.
- Social security.

- Medical care
- General Hospitals
- Mental Hospitals
- Ind. health care, the national dental service
- Care of the mentally retarded
- Social welfare (family counselling, orphanages)
- Public Health (General hygiene)
- Communications
- Building planning
- Civil defence
- Ele. & water supply
- Municipal admin.
- Social welfare
- Temperance care
- Care of the aged
- Public assistance
- Housing
- Sanitation, Environment, protection
- Fire services
- Leisure Sports, young persons.
- Arts
- Public Health (General hygiene)
- Entertainment
- Commerce & Industry
- Regional Transport
- Streets and Parks.

Participation in regional planning together with the country admin. board.

---

Source: Gustafsson, 1980
At the regional level too, the Kommunes have regional branches. The main administrative board and councils of the counties function at this level. This facilitates regional planning not on a proportional allocation basis but as per the needs of the region, considering the regional imbalances. The Regional Councils and Boards are given the power of evolving policies and programmes in the areas of social welfare, health, education, training, vocational rehabilitation, etc.

The Kommune is the primary unit of all social welfare activities. The specific programmes under its control being, child care, temperance care, care of the aged, public assistance, schools, housing, sanitation, public health etc. It is clear that most activities revolve around the Kommunes. Every five years, the Kommune considers what is called a 'Rolling Plan'.

Expenditure on Social Welfare Programme:

During 1970-71, the social welfare expenditure was twenty eight per cent of the budget while seventeen per cent was spent on education and thirteen per cent on defence. In 1981 the share for social welfare in the budget was almost one third (32.8 per cent) out of which
The lean's share went to Health Insurance (thirty six per cent) and Employment Provident Fund (thirty three per cent). The other programmes like the care for the aged (4.4 per cent), care for the children (5.5 per cent) selective social assistance (1.6 per cent) getting to marginal share and rest for miscellaneous services. The tables 1 and 2 provide expenditures on social services and the sources of revenue. As can be seen, the emphasis on social welfare had changed from the approach of 'helping people to help themselves' to the gradual assumption of responsibility by the State to provide the total care. The welfare services are also seen dominating in their share of social service expenditure. However, it should be noted that the cost of the administration of services is kept at appreciably low levels.

The major resource of revenue for social welfare is through taxation. Sweden has substantially higher taxes compared to other countries. The rate of taxation is decided by local and regional bodies and varies between twenty five and thirty four per cent. Those who earn between six thousand and nine hundred and twenty seven thousand and six hundred kroners S.Kr (Swedish Kronner) per annum pay two per cent of their income as tax.
<table>
<thead>
<tr>
<th>Composition of Swedish Social Service Expenditure</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Sickness</td>
<td>35.5</td>
</tr>
<tr>
<td>2) Old Age, Invalidity etc.</td>
<td>42.7</td>
</tr>
<tr>
<td>3) Employment Injury</td>
<td>0.6</td>
</tr>
<tr>
<td>4) Unemployment and labour market policies</td>
<td>5.3</td>
</tr>
<tr>
<td>5) Families and children</td>
<td>13.4</td>
</tr>
<tr>
<td>6) Social Assistance</td>
<td>0.9</td>
</tr>
<tr>
<td>7) Miscellaneous</td>
<td>0.7</td>
</tr>
<tr>
<td>8) Central Administration</td>
<td>0.9</td>
</tr>
</tbody>
</table>

Source: Cost and financing of the Social Services in Sweden 1976
### TABLE - 2

<table>
<thead>
<tr>
<th>SOURCES OF REVENUE FOR SOCIAL SERVICES</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Central Government</td>
<td>27.9</td>
</tr>
<tr>
<td>2) Local Government</td>
<td>26.0</td>
</tr>
<tr>
<td>3) Contribution of employers</td>
<td>37.7</td>
</tr>
<tr>
<td>4) Contribution of employees</td>
<td>1.2</td>
</tr>
<tr>
<td>5) Income from funds</td>
<td>7.2</td>
</tr>
</tbody>
</table>

Source: Ibid
The taxes rise successively up to fifty eight per cent covering an income up to two two hundred and seven thousand kroner per annum. An average unskilled worker pays sixty per cent whereas a white collar high professional pays tax up to eighty per cent. However, this progressive tax structure allows deductions on debts.

Of the various social welfare programmes, here only three programmes are discussed in detail. These are Health care, Care of children and Employment care. However, these are not discussed as programmes per se but to understand the welfare strategies reflecting the programme objectives of social welfare in Sweden.

HEALTH CARE
The outstanding feature of the swedish health system is that all Swedes have an equal coverage and an equal access to all types of medical resources and care, irrespective of their salary level, social status or health condition. The basic reason for providing equal access to health care is due to welfare responsibility of the state in providing compulsory insurance coverage to every citizen in Sweden.
The factor promoting accessibility of vulnerable groups to health services is also facilitated by discouraging private medical practice. There are also indirect ways by which private practice is made less attractive. For example, the private physicians do not have staff privileges available at the government hospitals in Sweden. If a patient requires hospitalisation, he will be admitted to a government hospital where his private physician can no longer take care of him. Further, there are no surgeons in private practice. However, fourteen per cent of physicians still have private practice of which only four per cent are full-time. Thirty per cent of such physicians in the field of dental care are above the age of sixty five. However, as many as fifty per cent of the dentists are doing private practice. There are also a large number of Otolaryngologists and Clinical Cardiologists doing private medical practice. Thus, young doctors are dissuaded both by the counter attractions of modern hospital based medicine, and also because Swedish people feel "that it is not right to earn money from ill people".
The health care in Sweden is not totally free. A basic minimum nominal fee of seven kroners is charged per patient per visit. The patient is expected to cover the minimal charges and thus the ceiling exists for lower limits and beyond this minimal level, the State covers the rest through Insurance.

The philosophy of the Swedish health system emphasises on effective utilisation of existing health resources. The stress is on better organisation and quality of medical care rather than simply on greater quantity of health services. Similarly the Swedish health system achieves balance between preventive and curative approaches. For example, the SKF factory, the Swedish ball bearing factory Goteborg, where six thousand people work is given priority. The clinic that is run there has a staff of four doctors and nine nurses. Audiograms are compulsory for all workers on noisy machines; posters and seminars stress the use of ear plugs, etc. The workers who are exposed to lead and silica have to undergo periodic checks to detect possible toxicity before the symptoms occur. They are also advised to avoid contact with machine oil that might cause eczema.
The clinic staff treat several hundreds of workers each day without the workers having to leave the factory and the nurses making rounds at most production areas. This primary health care is given by the larger companies at their own expense. (Glazer 1970, Swedish Institute 1983)

The Swedes have accepted hospital as concept to meet the health needs of their citizen in contrast to primary community health centres and other outreach cells, the chief reason being an economic one as they have less number of doctors and it was considered more efficient to pool their services together.

Organisational Set Up: It is found in Sweden, the planning of health policy and services are nation-wide. The central government administration below the parliament and the cabinet is divided into two divisions: i) the Ministry of Health and Social Affairs (SOCIAL DEPARTEMENTET) which prepares cabinet business and draws up general guidelines in such fields as health care, social welfare services and health insurance and ii) The National Board of Health and Welfare (SOCIAL STYRELSEN) which is an independent
administrative agency handling planning and monitoring of health care, supply of pharmaceutical products and social welfare services. Further, there is Swedish Planning and Rationalisation Institute of Health and Social Services, which supports research and development work in health care administration, construction and equipment matters. The National Board of Health and Welfare in Stockholm sets national planning priorities in cooperation with the Ministry of Health. Sweden’s twenty four County Councils and three Kommunes which are directly responsible for financing and running the hospitals within each area. A systems approach is employed to provide adequate health care facilities to meet the changing needs. The statistics relating to area, population, illness rates, medical facilities, personnel and projective figures for future, are updated regularly and hospital planning is a continuous process.

The decision-making pertaining to health policy and services’ are decentralised. In Sweden, the goals of decentralisation are to provide optimal care to the patients at the right place and at the right time. That means to give the best care without undue demands
on scarce resources. However, this has resulted in fewer hospitals of greater size and patients have to travel longer distance to reach a hospital leading to considerable difficulty in the colder North.

Structure of the hospitals: There are three levels of hospitals in the region, each level serving a larger population base and having medical facilities as shown in Figure 5.

The district hospitals located peripherally serve a population of seventy five thousand people and have at least four special departments like internal medicine, general surgery, radiology, anaesthesia and occasionally they include paediatrics and obstetrics. The central hospitals located in the county cover a population of two lakhs and fifty thousand including facilities for thirteen to twenty medical, surgical and laboratories. The regional hospital takes in referral patients from the county central hospitals. It draws from a population of about a million and has facilities for all special treatment. There are seven such hospitals of
FIGURE - 5

THE HOSPITAL SYSTEMS

REGIONAL (County)

Population
1,000,000

DISTRICT

Population
250,000
300,000

KOMMUNE

Population
60,000 to
90,000

Population
15,000

Note: There is a level, central between District and Regional levels, in the Hospital System.
which five are running medical and nursing schools as well.

Services: The Swedish Health System is also known for its integration and rationalisation. Dental care, care for the disabled and the handicapped are also offered side by side. The bed ratio as per 1984 figures come to sixteen per thousand inhabitants of which five are general, five long term, three and a half psychiatric and two and a half for the mentally retarded. There are seven places per thousand inhabitants in municipal homes for the elderly. However, the number of outpatient visits to physicians is comparatively low, about two and a half medical treatments per person per year. Of this, fifty three per cent take place at the hospitals, thirty per cent are to district physicians and only seventeen per cent are to private doctors.

History: In 1860’s county councils were established mainly to operate hospitals for somatic illness. Till 1955, the health insurance was voluntary which was made compulsory tax-financed in 1955. In 1963, the health insurance was combined with various other pensions and called the National Social Insurance Act. Since the
Seven Kroner Reform of 1970, no physician is permitted to see private patients in the clinics. In mid-1960’s, even the outpatient services and the psychiatric care were taken over from the central government. The 1983 Health and Medical Services Act has further widened the responsibilities of the county councils.

Budget: The county councils spend seventy five to eighty per cent of their resources on health care alone. The health costs have increased from three in 1960 to ten per cent of the Gross Domestic Product. The cost is met mostly by county councils through taxation, fifteen per cent central subsidies, eleven per cent state grants for medical education, research and psychiatry, nine per cent as compensation from the National Health Insurance System, and the patient’s fee covering four per cent.

An Overview: It is well reflected in the case of Swedish health system that the value system of the society and its political and administrative structures had been conducive to the development of health care. Unlike many other countries, the inhabitant is not
treated as a consumer availing the health services according to his financial ability and competitively in the open market. To discourage corruption and adulteration, the State manufactures medicines. Needless to say, the Swedish health care system has been adjudged as one of the best in the world.

However, as pointed out by evaluation studies some of its negative points are impersonal services and shortage of staff and beds which create long waits for admission. This ranges from three weeks for a 'semi-emergency' to six months for a 'non-emergency'. Further, there is lack of continuity of care, absence of choice by patients for doctors and hospitals and high taxes. Despite the above shortcomings for which attempts are made to overcome, the infant survival rate is the highest in the world and infant mortality was only seven per thousand in 1983. Time and motion studies are used to improve design of patient and staff areas such as placing nurses' stations, utility rooms and treatment rooms close together. The nurse in Sweden can alter the treatments suggested by the doctor on her own initiative in an emergency. The Swedes see doctors less, use hospitals more. The reason for the
success story is also due to the fact that Sweden has a small population, homogenous culture, common values, traditions and a single language.

CARE FOR THE CHILDREN

Approaches: The child care programme in Sweden is mostly public. This includes pre-school and after-school recreational activities for children in the early years of compulsory schooling. These public services of the state aim to provide the children with a good and secure growth environment. The compulsory nature of schooling, after-school care and the like, reflect the shift of the responsibility of parents to the State.

On closer examination of the Swedish child care system, it is found that the State is only too anxious to integrate children into the community. Towards this, they have orientation for parents, home language training and the care of the sick child. It is remarkable that the Swedes believe that unless a child is strong in the basic culture of the family (like language), it may be difficult to integrate the child with the macro society. Further, the child care
programme and the social Legislations associated with it aim at to protecting the children from broken homes and the like which hamper their growth. It is also surveyed that every third child in Sweden will see different parents before reaching teenage. And over sixty per cent of parents of children are changed before they are fifteen years of age.

In a vacuum of family life teenagers are being swept away by commercialism leading to drug addiction. Every ninth child in Sweden is said to be psychologically disturbed. Under these circumstances among others, the custody of a child may be transferred from one parent to another even if the parents object. If the drug abuse or other indulgence of the parents poses a permanent danger to the child’s health or development, then the State undertakes the care for the child. The Law in 1970 has rendered both sexes to have equal rights with children born in or out of wedlock. Even if they divorce, they can still continue to be guardians as per Legislation in 1977. In 1979, a Legislation provided economic support to children of spouses present and former. It also forbids punishment of children by parents.
History of the programme: The expansion of child care services was considered as an important family policy issue of 1970’s with high priority. The pre-school programme dates back to late 1960’s when women started working. Between 1917 and 1948, families with children were eligible for reduction in their tax assessments. From 1946 all primary and elementary school children have been given free lunch, books, and writing materials. In 1956, the health insurance programme took over from the local Public Assistance Committee. In 1960, the act was amended and the Child Welfare Board took over the responsibility. In 1962, social assistance was provided to children. In 1969, the Cabinet appointed a Family Law Reform Commission and continued to operate with reports in 1974, 1979 and 1983 respectively.

The Organisation for Child Care: The policies and programmes governing child care services are regulated by the Central Government through the Social Services Act of January 1982. The National Board of Health and Social Welfare is responsible for stimulating
pedagogical and social development work in the child care field. The programmes are supervised by the latter and the county administrations. However, child care programmes are predominantly a responsibility of the Kommune.

The programme: Chart 3 provides a total picture of the child care in Sweden. The striking point about the programme is that risks are well anticipated and services provided so that no child remains uncared for. The parents pay about five thousand kroner per child per year. Beyond this lower limit, the State takes care of the rest. The programmes thus are financed through local tax revenues (thirty eight per cent), parent's fee (twelve per cent) and the State subsidies (fifty per cent) financed through employers' payroll fee.
THE SWEDISH PROGRAMME OF CHILD CARE

Age
1 Year --> Family Planning Programme
   "every child has the right to be wanted"

9 months

Birth --> Parental Insurance System
   Parental Education
   Full Parental Care of mother
   Pediatric health care - barnyard central

"Parent" --> School Health Services
Care district/country/health services until mental & dental care
6 months at-home child minders

+6 months: child eligible for day care
Waiting List

<table>
<thead>
<tr>
<th>Full-time</th>
<th>Part-time</th>
<th>&quot;Family&quot; day nursery</th>
<th>Private day nursery</th>
</tr>
</thead>
<tbody>
<tr>
<td>day care</td>
<td>pre-school</td>
<td>4-7 years</td>
<td>6 mon.-7 yrs</td>
</tr>
<tr>
<td>nursery</td>
<td>3-5 hrs/</td>
<td>5+ hrs/day</td>
<td>(daghammet)</td>
</tr>
<tr>
<td></td>
<td>6 mon.-7</td>
<td></td>
<td>day</td>
</tr>
<tr>
<td></td>
<td>yrs.</td>
<td></td>
<td>5+ hrs/day</td>
</tr>
<tr>
<td>1980</td>
<td>17%</td>
<td>3%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Grundskolan 100%
After School

Hangout Parent at Relative/ Private "Family" "Fri
by your- home friend child day nursery mmet leis
self 48% 7% 8% 99% 7%
17%

Includes part-
timers who work only when child in school
An overview: The evaluation reports concerning child care in Sweden report more job satisfaction among the staff. In places like Stockholm where ethnic minorities are more, language is a barrier in providing care. It is reported that there is growing alienation of children from their parents. Such children are called "amiara children". The factors which more or less prevent children from having deep relation with the parents are (i) their spending more time in day care or school and after-school recreation centres; (ii) the children feel that their economic ties are more with the State than with the parents as the latter are paid by the State through child allowances.

On the other hand, there is increasing feeling among parents to have less number of children. Housing shortage is one reason for the small family norm. Further, since full retirement and old age pension is provided, they tend to feel that there is no need to have children to take care of them when they are old. The changing role of women as equals makes them career conscious and reports reveal that fifteen per cent decide not to have children, sixty per cent one-child and thirty three per cent wish to have two children. In
1984, eighty five per cent of families had only one or two children. Thus, the programme of education for all, equal rights and opportunity for women do seem to be having adverse effects on the child care programmes.

UNEMPLOYED CARE:
The unemployment is considered as a contemporary problem in Europe. A few decades earlier, it was not considered as a structural problem. Whereas in Sweden, though having relatively lower rate of unemployment, started answering to the needs of the unemployed as early as 1930’s.

Formulation of Policy:
The local government initiated the policy towards the unemployed care. The voluntary action an the trade unions formed pressure groups, influencing the formulation of social legislation in the Parliament by the political parties. The consistent view taken by the bureaucrats to support the emergence of policy towards unemployed care and programme despite the change in the political power is a point note worthy. In 1894, the administrative governor of Stockholm established the
survey of the first investigation of unemployed. In 1900, the first political motion for unemployment insurance was supported by liberal party, conservative party, but was defeated. The conservative party in power in 1910, established the first national count on unemployment. In 1916, the first national work relief programme was offered. In 1934, when the social democrats were in power, the bill on unemployment insurance was passed in the Parliament. It was administered through insurances run by the trade unions. In 1965, national labour market board was constituted. In 1974, a scheme to offer insurance to non-unionised unemployed was also offered. Thus the policy for unemployment care is a culmination of the efforts of bureaucrats, political parties, trade union, philosophers and voluntary action.

Implementation of Programmes:
There is equal emphasis given through the programme activities, both on creation of jobs and prevention of closure of factories on one side, and on the other side providing reasonable allowance to unemployed and also training to equip them. Sweden respects international conventions like that of ILO in maintaining employment
exchanges through the government. It has equal coverage even to the immigrants. The unemployed care programme is uniformly organised at local level three hundred and sixty employment exchanges. There is ample scope for local and regional councils to upgrade the programme activities while maintaining the universal coverage of services.

The policy for the unemployed care are evolved by cabinet and parliament. The major task of carrying out the programme of unemployment care is handled by the national labour market board (NLMB). The NLMB is an organisation represented by the trade unions, employers association and national board of education. The NLMB is similarly organised at three levels, national, regional and kommune level. While at the national level, cabinet, ministry of labour, national board of education and NLMB decide the policy; at the regional and kommune level there are committees organised for various functional activity of NLMB like employment exchanges and training.

The national labour market board decides administering
the employment exchanges and offering services like unemployment allowances also leads the planning measures to rectify unemployment. In order to prevent unemployment, it leads to activities for giving government aid for strengthening local capacity to employ and alongside provide protection of employment. Thus there are variety of programme activities there are measures influencing labour supply, primarily to encourage occupational and geographical mobility. Certain activities are intended to influence the demand for labour, either by means of subsidies to retain or increase employment at companies by means of individual oriented measures such as relief poor, employment for older people and occupationally handicapped. There are also regional development aids and payment of cash benefits to the unemployed which in some cases in ninety per cent of the earlier wage.

The budget allocation for national labour market board increased since 1950's. The budget, in 1984 has thus increased five times. The expenditure pattern thus reveals the political will of the government to compare unemployment.
Evaluation

Study of the past records of the NLMB with reference to their goals set and the programmes planned, the impact and feedback, provide the following emerging trend. The analysis is based on the Secondary data collected from NLMB, and the publications of Swedish Institute (Swedish Labour Market Policy, June 1983).

Phase I: The period between late 1950 and end of 1960, the policy goals were framed on the model evolved by Gosta Rehn, an economist of the Swedish Trade Union Movement. The tenets of the policy goals were to attain full employment using an expansive non-selective financial policy which entailed inflatory risks. This further changed to a restrictive financial policy with an ambitious, selective labour market policy. During the 1960’s there was rapid expansion and structural changes in the Swedish business sector. In tune with it, the policy goals aimed towards facilitating occupational mobility. The key phrase in an officially formulated policy was "full, productive and freely chosen employment". But the rapid economic growth and structural changes had resulted in further aggravation
of the situation of regional imbalance. Towards alleviating this, Social Welfare and Income distribution policies were framed especially the emphasis was on occupationally handicapped.

Phase II: The full employment policy goal was replaced by 'work for everyone' in early 1970's. This implied facilitating the entry of people who are outside the existing work force. The related programme goals included efforts to break down traditional sex attitudes to occupational choices and to encourage equality between men and women.

Phase III: The late 1970's and early 1980's witnessed growth of individuals who are in danger of being pushed out of jobs due to economic downturns. The policy goals combating this were efforts within the companies by means of various subsidies to employers to keep people in jobs until general economic conditions improved. The 1981/82 period saw a growth in the cash benefits of the unemployed. Figure 6 provides the trend of policy goals.
Figure 6

Policy Goals on Unemployment Insurance - Trends

<table>
<thead>
<tr>
<th>TIME &amp; SETTING</th>
<th>POLICY GOALS</th>
<th>IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Late 1950 - end of 1960 REHN MODEL</td>
<td>Full employment (non-selective financial policy to combat inflation)</td>
<td>Job placement services</td>
</tr>
<tr>
<td></td>
<td>Restrictive financial policy and selective labour market policy</td>
<td></td>
</tr>
<tr>
<td>1960's - structural reformation of the Swedish business sector</td>
<td>Geographical and occupational mobility (full productive and freely chosen employment)</td>
<td>led to social welfare problems</td>
</tr>
<tr>
<td></td>
<td>Social welfare and income distribution policy Regional development goals included also the needs of handicapped, child and old</td>
<td></td>
</tr>
<tr>
<td>1970's</td>
<td>Full employment goals replaced by &quot;work for everyone&quot; (esp. for occupational handicaps)</td>
<td></td>
</tr>
<tr>
<td>Late 1970's</td>
<td>Protecting jobs, subsidies to industries</td>
<td></td>
</tr>
</tbody>
</table>
While in the case of health care and child care the programme activities have been maximised, but in the case of unemployed care it is still in the process of leading to maximisation and stabilisation of service delivery. Since unemployment is also contemporary issue it is taken up for in-depth study.