

Chapter 1

Introduction

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Population ageing, the shift in age distribution towards older ages, is of immense global concern. It is taking place to a varying degree all over the world, more in Europe and some Asian countries, less on the African continent. The worldwide share of people aged 65 years and above is predicted to increase from 7.5% in 2005 to 16.1% in 2050 (UN 2007, p.11). The corresponding figures for developed countries are 15.5 and 26.2% and for developing countries 5.5 and 14.6%. While population ageing has been going on for some time in the developed world, and will continue to do so, most of the change is yet to come for the developing world. The change in developing countries, however, is going to be much faster than it has been in the developed world. For example, while it took more than 100 years in France and more than 80 years in Sweden for the population group aged 65 and above to increase from 7 to 14% of the population, the same change in Japan took place over a 25-year period (UN 2007, p. 13). The scenario for the future is very similar for most developing countries, including highly populated countries like China, India and Brazil. While the start and the speed differ, the shift in age structure towards older ages is a worldwide phenomenon, stressing the significance of the concept *global ageing*.

What, then, are the consequences of global ageing? What can the developed world learn from its previous experience, and what can the developing world gain from the changes ahead? Assuming that the age of retirement stays stable, the number of elderly per worker will multiply. Hence, the transfers from workers to the elderly will increase regardless of whether funded by the elderly themselves through savings, through their families or through the public sector. In order to understand and learn from these anticipated changes and from previous experience of the consequences of population ageing, we must, however, also understand its causes.

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The first stage of population ageing is primarily driven by fertility decline (Chap. 2). This is the reason why it began earlier in Western Europe than in developing countries and this is also why population ageing is going to be much faster in developing countries than in Western Europe as the decline in fertility will be more rapid there. The fact that population ageing, in its first stage, primarily is driven by a decline in fertility may seem counterintuitive given the huge increase in life expectancy at birth shown in the developed world over the past 150 years, from ~40 to 80 years. However, one should bear in mind that most of this decline has led to a rejuvenation of the population since the years gained predominantly have been in ages below 65 years. It was not until life expectancy at birth reached above 70 years of age that the fertility decline started to contribute to population ageing in the developed world, which is quite recently (Lee 1994). It is therefore very important to distinguish between population ageing and individual ageing. Still, it is expected that population ageing in the developed world in the future to a greater extent will be driven by declining mortality in older ages. Thus, population ageing in Europe and elsewhere in the developed world has shifted from being determined by a decline in fertility to being driven by a mortality decline among the elderly, which has major implications for its consequences.

Population ageing in the developed part of the world was until recently more than compensated for by the decline in the youth population. As a result, the number of young and old in relation to the size of the working-age population decreased. Families benefited from this situation as it meant that they had fewer to support and society benefited as the size of the working-age population increased. This phenomenon is known as a 'demographic gift'. While the developed world already has granted this 'gift', the developing world is in the midst of unwrapping it. It is argued that in Asia between a third and a fourth of the economic growth in recent years is due to this phenomenon (Mason 2007). While future population ageing in the developing world to a certain extent will follow past ageing trends in the developed world, ageing in the developed world will in the future take on a new form. Consequently, the developed world, for example Western Europe, will have less to learn from its own experience than the developing part of the world will or can. Furthermore, the speed of ageing in the developing countries differs, and the fact that population ageing has gone seemingly smoothly in the past is no guarantee that it will do so in the future.

Consumption and production at various ages constitute the link between population age structure and the economy. Consumption and, more so, production vary with age. Thus, the change in the consumer-worker ratio is only a first approximation of what will happen in the future. Recent figures for Europe, as well as for the US, show that consumption increases sharply with age (Mason 2007). In addition, per capita consumption among the elderly has also increased over the past decades due to rising social care and healthcare costs. Hence, future population ageing in Europe and other parts of the developed world will be very costly and it will not be offset by declining costs for the youth population. In fact, even if age-specific consumption among the elderly as well as all other age-groups is kept constant, the net consumption deficit, that is total consumption minus total

labour earnings in a given year, will increase with 350% by 2050, taking Sweden as an example (Chap. 2).

Sweden is, for many reasons, of particular interest when it comes to population ageing and the consequences thereof. Until recently, Sweden had the highest proportion of elderly in the world. Average life expectancy in Sweden is also very high. Nevertheless, even if the fertility rate is somewhat higher than in most other developed countries, it is still too low to keep the labour force from shrinking, as is also the case elsewhere in the developed world. Furthermore, while Sweden has amongst the highest immigration levels in the developed world, immigration still cannot stop population ageing in this country (Chap. 2), or in other countries (UN 2007, pp. 18–20). Thus, while population ageing in Sweden is pronounced due to its early development, it is not extreme. The underlying factors are the same as in other parts of the developed world.

Sweden is also of particular interest since a large part of the transfers across generations takes place within the public sector. At first, the development of the welfare state was no more rapid in Sweden than in other West European countries. In 1960, public expenditure constituted 31% of GDP, which was somewhat lower than in France, Germany, Britain and Austria. Social entitlements in Sweden have since expanded in one area after the other: childcare, child allowances, education, education allowances, unemployment insurance, social welfare allowances, industrial injuries compensation, disability compensation, early retirement pensions, partial retirement pensions, supplementary pensions, housing allowances, and so forth, covering all stages of life. In other parts of the world a considerable amount of these transfers and services take place within the family, like in Southern Europe, or are supplied through the market, like in the US. As a consequence of the expansion of social and medical services, Sweden took the public expenditure lead in the 1970s and has kept it since even though many other countries are following suit, most notably those in Northwestern Europe. Today social transfers account for 21% of GDP alone (SOU 2004) and while transfer payments are not a cost in themselves, they need funding, as do other parts of the welfare state. Due to its far-reaching coverage in smoothing consumption over a person's lifespan and providing insurance against various risks, Sweden and the other Nordic countries stand out in comparison with most other countries. The term 'the Swedish model' (alternatively 'Scandinavian model' or 'Nordic model') is often used to label its features.

There is no demographic solution to funding the welfare state in general, or to funding transfers to the elderly, at least not within a 25–30 year period which is the time it takes for a birth bulge to enter the labour force. Migration will make a very modest contribution at best (Chap. 2). Since the welfare system in Sweden is primarily funded through income taxes, it is dependent on the size of wage sums and tax levels. In order to maintain present levels of benefits either the tax burden on those working has to increase, or the tax base has to expand. Sweden, however, already has one of the highest income tax levels in the world leaving little or no room for expanding revenues this way (Chap. 3). Could tax revenues be expanded by increasing other taxes, such as value added tax and income tax? Again, in this

context, Sweden is already at a high level and, if anything, one would expect these taxes to decline (Chap. 3). It is true that the hours worked could be increased by entering the workforce at an earlier age, retiring later, working longer hours per week, more weeks each year, and so on. Even though labour force participation already is high in Sweden in comparison with other European countries, there still is room for improvement. It is, however, debatable whether this will fully solve the problem (Chap. 3). The question is then whether present levels of social and medical care can be maintained by increasing efficiency or if we could expect cuts in the welfare systems.

Sweden is, once again, interesting since some of the Swedish welfare systems already have undergone substantial reforms recently. This is the case for the pension system which dates back to 1913 when it became the first general pension system in the world (Chap. 4). While it started as a contributions-benefit system funded by contributions from the labour force and paid back as benefits when they retired, it was then turned into a so-called pay-as-you-go system, where current benefits are paid by contributions from the current workforce. The pay-as-you-go system was put under pressure, partly because of population ageing but also due to a long period of slow economic growth. As it became financially unstable, a new system more similar to the original one was developed. Other countries, such as France, Italy, and Spain, have been in similar situations, restructuring their pension systems in various ways, though the reforms have been less radical than in Sweden. Almost 10 years have passed since the Swedish pensions reform was implemented, which is why it is appropriate to assess whether it has fulfilled its purpose and discuss whether it will be able to manage the changes in population age structure that lie ahead. The conclusion is that while the system will survive, benefits will be reduced under the pressure of increasing longevity that, however, could be counterbalanced by postponed retirement (Chap. 4).

The systems for elderly care in Sweden also underwent significant transformation in the 1990s, although less profound than in the case of the pension system (Chap. 5). Elderly care has always been a local responsibility in Sweden, albeit regulated by the state. The autonomy experienced by the local communities when organising care for the elderly has, nevertheless, changed. During certain periods, old people's homes were the obvious choice with regard to elderly care. During the 1950s, as housing standards improved and additional labour in terms of housewives became available, home-based services became the dominant form of elderly care. Around 1990, however, the local communities were given increased autonomy in organising elderly care. Since then, several competing systems have emerged and it remains an open question whether they will survive the pressure of an ageing population or whether the state will take financial responsibility for elderly care and, for example, introduce a system of elderly care insurance.

Financing healthcare for the elderly and in general is another emerging issue in Sweden. Today, health expenditure accounts for 9.1% of GDP in Sweden, slightly above the OECD average (Chap. 6). The healthcare system in Sweden can be characterized as a public health service model, with some 85% of the costs publicly financed, again somewhat over the OECD average of 73%. While

the healthcare system mainly is public it is, however, not nationally organised but instead decentralised with regard to both its organisation and its funding. In fact, in Europe only Finland has a more decentralised system. County-council income taxes are the most common way of financing healthcare in Sweden. Like elsewhere, costs for healthcare (of which inpatient care costs dominate) are considered very high and various ways of increasing the efficiency or simply cutting costs are being tested. While the standard of Swedish healthcare is as high as in other parts of the industrialised world, the waiting time for diagnosis and treatment is long. Thus, the system is under pressure even before taking population ageing into account.

What, then, are the consequences of population ageing for future spending on healthcare and what measures can be taken to ensure high quality and fast access in the future? By using a micro-simulation model, Lindgren and Lyttkens (Chap. 6) have estimated that the demand for healthcare will increase by 30% by 2040. Technological change is a non-solution, since it has only served to increase costs in the past, as is institutional change. A fundamental reform, like the pensions reform in the 1990s, seems unlikely, as does explicit priority setting. Instead, one could expect healthcare to be a highly prioritised public activity also in the future, possibly crowding out other activities, such as public subsidies for housing.

To summarise, the Swedish welfare system has undergone profound changes over the past decade, in several respects deeper and more extensively than other West European countries. This is particularly the case for the pension system, but the social care systems for the elderly have also changed a great deal. The healthcare system is presently undergoing transformation to some extent in order to promote efficiency and keep costs from exploding. Population ageing over the next few decades will put even greater pressure on the welfare state, possibly lowering the compensation degree or crowding out some of its main activities. Thus, the question is whether the Swedish welfare model will take on a different form – if this has not already taken place – or whether it will remain similar to what it is today, rendering it relevant to use the concept also in the future. To phrase it differently, and alluding to the topic of the concluding chapter of this volume (Berg, Chap. 7), are we moving towards a new Swedish model? The questions regarding the survival of the welfare system, and whether it will take on a different form under the pressure of population ageing is, however, not a genuine Swedish issue but of importance to all welfare societies.

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