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Comparative Analysis of Swedish Education and Health Policies in the Context of Social Justice[1]

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Abstract

Educational policies aimed at preventing educational inequalities that cause socioeconomic inequalities and ensuring equality of opportunity are within the scope of the idea of social justice. Policies aimed at ensuring equality of opportunity in education aim to minimise the impact of conditions that occur against the will of individuals on the results and achievements obtained in the education process. In addition, health policies to reduce health inequalities that cause socioeconomic inequalities are also considered within the concept of social justice. In this sense, in order to ensure social justice, it is necessary to develop policies to improve socioeconomic conditions and to ensure accessibility, equity and equality in the access and provision of health services. The Swedish education system aims to ensure equality of opportunity for all children regardless of their socio-economic background and to make education services accessible to all, in the same way, the Swedish health system aims to provide high quality health services to the entire population within the framework of the principle of equality in line with welfare policies. In this study, in order to understand whether Swedish social justice practices are effective on socioeconomic inequalities, the historical process and current situation of the problems that cause these inequalities and the education and health policies implemented to address these problems are given extensive information and a comparison is made based on OECD and World Bank data in order to reach concrete results.

Keywords: *Socioeconomic Inequality, Social Justice, Education Policies, Health Policies*

Jel Codes: *I10, I20, I31*

İsveç Eğitim ve Sağlık Politikalarının Sosyal Adalet Bağlamında Karşılaştırmalı Analizi

Öz

Sosyoekonomik eşitsizliklere sebep olan eğitim eşitsizliklerinin önlenmesine ve fırsat eşitliğinin sağlanmasına yönelik eğitim politikaları sosyal adalet düşüncesi kapsamında yer almaktadır. Eğitimde fırsat eşitliğini sağlamaya yönelik politikalar, bireylerin iradesi dışında gerçekleşen şartların eğitim sürecinde elde ettiği sonuçlar ve başarılar üzerindeki etkisini azaltmayı amaçlamaktadır. Bununla birlikte sosyoekonomik eşitsizliklere sebep olan sağlık eşitsizliklerinin azaltılmasına ilişkin sağlık politikaları da sosyal adalet anlayışı içerisinde değerlendirilmektedir. Bu anlamda sosyal adaletin sağlanması için sosyoekonomik koşulların iyileştirilmesine ve sağlık hizmetlerinin erişiminde ve sunulmasında erişilebilirliğin, hakkaniyetin ve eşitliğin sağlanmasına ilişkin politikaların geliştirilmesi gerekmektedir. İsveç eğitim sistemi, sosyoekonomik geçmişten bağımsız olarak tüm çocuklar için fırsat eşitliğini sağlamayı ve eğitim hizmetlerini erişilebilir olarak herkese sunmayı, aynı şekilde İsveç'e ait sağlık sistemi de, refah politikaları gereği sağlık hizmetlerini tüm nüfusa eşitlik ilkesi çerçevesinde yüksek kaliteli olarak sunmayı amaçlamaktadır. Çalışmada, İsveç sosyal adalet uygulamalarının sosyoekonomik eşitsizlikler üzerinde etkili olup olmadığının anlaşılabilmesi için bu eşitsizliklere sebep olan sorunların ve bu sorunlara yönelik uygulanan eğitim ve sağlık politikalarının tarihsel süreci ve güncel durumu hakkında geniş bilgi verilmekte ve somut sonuçlara ulaşabilmek amacıyla OECD ve Dünya Bankası verileri baz alınarak bir karşılaştırma yapılmaktadır.

Anahtar Kelimeler: *Sosyoekonomik Eşitsizlik, Sosyal Adalet, Eğitim Politikaları, Sağlık Politikaları*

Jel Kodu: *I10, I20, I31*

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INTRODUCTION

Education policies aimed at preventing educational inequalities that cause socio-economic inequalities and ensuring equal opportunities are within the scope of social justice policies. Education and training activities are among the most important duties of the state and education services should be provided to all citizens by educational institutions within the framework of certain procedures in a way to ensure equal opportunities. Policies aimed at ensuring equality of opportunity in education aim to minimise the impact of conditions that occur against the will of individuals on the results and achievements achieved in the education process. Ensuring equality of opportunity in education and increasing individual capacities through education policies for disadvantaged groups is important for ensuring social justice.

Health services policies related to the reduction of health inequalities that cause socioeconomic inequalities are also considered within social justice policies. Health inequalities, which are defined as all unjust and preventable differences in health status, do not only arise as a result of factors such as individual preferences, genetic characteristics or living conditions, but also various policies and legal regulations implemented by the state affect health status. On the other hand, policies of the state affecting social status such as living, working, housing and nutrition conditions, which are outside the field of health, have an impact on health status. It is stated that the most effective method for preventing inequality in health is practices aimed at ensuring social justice. In this sense, in order to ensure social justice, it is necessary to develop policies to improve socioeconomic conditions and to ensure accessibility, equity and equality in the access and provision of health services.

The Swedish education system aims to ensure equality of opportunity for all children regardless of socio-economic background and to make education services accessible to all. Free compulsory education services are accessible to both boys and girls in line with gender equality. Sweden aims to create an equitable and fair education system that is independent of socio-economic conditions such as income, social status, place of birth, etc. in order to make the stages of education accessible to all. In order to achieve successful results in this regard, socio-economic barriers to access to education services are eliminated and individuals are given the opportunity to make a choice in accordance with their capacities. According to the current education system legislation, parents and children can freely choose between public or private schools and children studying in private schools are not charged any fees and are financed by the state in order to make education services widespread and accessible. When analysed comparatively at the international level, it is stated that the Swedish education system has a very egalitarian structure. However, the Swedish education system has been undergoing a process of change since 1990. The first of these changes is that the education system has been left to the administration of local governments in a remarkable way, and the second is that education has entered into a process of marketisation with private schools.

The Swedish health care system aims to provide high quality health care services to the entire population within the framework of the principle of equality in line with welfare policies. In the 1982 Swedish Health and Medical Services Act, it is stated that health services should be distributed in an inclusive, high quality, equal and fair manner for the entire population and the level of unmet needs should be minimised. It is stated that Sweden ranks high among developed countries in policies to ensure fairness in access and delivery of health services. In order to minimise socio-economic barriers to

access to health services in Sweden, these services are free of charge except for co-payments and are financed primarily through general taxation. In general, all segments of society have the same rights to health care and pay equal co-payments for health services, except for children, adolescents, the elderly and beneficiaries of preventive services such as maternity care, vaccinations and cancer screenings. Sweden's health system is regulated by national legislation and administered by local authorities. The Ministry of Health and Social Affairs is responsible for determining Sweden's overall health policy, while regional governments (county councils) finance and administer health services. Services for the care of the elderly and the disabled are provided by municipalities.

The aim of the study is to evaluate historically and comparatively how the policies related to the idea of "social justice", which advocates the necessity of measures to bring socioeconomic inequalities that arise as a result of inequality in education and health to a fairer level, have performed in developed countries such as Sweden. In order to understand whether the social justice practices implemented in developed countries are effective on socioeconomic inequalities, the problems that cause these inequalities and the social justice policies to be implemented against these problems should be examined in detail. For this purpose, the study provides extensive information on the historical process and current situation of Sweden's education and health policies and makes a comparison based on OECD and World Bank data in order to reach concrete results. In this context, Sweden's social justice measures and their results are evaluated both historically and compared with the data of the UK and Germany, which are among the other welfare state models.

The study consists of four section. The first two chapters deal with Sweden's education and health policies in detail, while the last two chapters present a comparative evaluation of these policies in terms of social justice.

1. SWEDISH EDUCATION POLICY

Sweden has a long history of education for the common good. Inclusive and formal education for children started in 1842, initially in religious institutions. In the early 20th century, some educational reforms were made, the first national curriculum was established and control was transferred to the municipalities in 1930. During this period, the Swedish education system offered children an academic and vocational school system largely according to their social background and social class, resulting in educational stratification. This led to inequalities of opportunity and achievement among Swedish youth from different socio-economic backgrounds, with working class children being barred from university early in their school careers due to academic discrimination. In the post-World War II period, the Swedish education system underwent some reforms to reduce socio-economic inequalities in opportunities and achievements (Rolfe, 2021:18). In order to create an egalitarian society and promote tolerance and social integration, public schools were created that brought together students from different groups and state support for non-state schools was restricted (Burström, 2015:89). Thus, education became a public service run almost entirely by the state.

Subsequently, in 1962, a 9-year comprehensive stage of education was made compulsory, and in 1970 both academic and vocational education programmes were combined into a single secondary stage. Principles to ensure fair education that provides students with the opportunity to progress in life were enshrined in law and curricula in the 1980s. While the Swedish compulsory education system continued to be comprehensive, reforms in education were implemented in the 1990s in line with the new public management approach to improve academic performance through competition. As a result of

these reforms, decentralization and marketisation emerged through the establishment of private (independent) schools and offering parents a choice between public and private schools, and educational equity decreased with the reintroduction of differentiated provision. The vocational and academic segregation that emerged before the war was later transformed into social and cultural segregation and increasing differences in student achievement (Rolfe, 2021:19). It is thought that these differences may cause inequality of opportunity and thus socioeconomic inequalities.

Since the early 1990s, the Swedish education system has changed fundamentally as a result of developments such as the devolution of education services from central to local government control, the proliferation of privately run and state-funded free private schools, the introduction of parental choice in school enrolment and the increasing marketisation of education through subsidies. Since 1992, when parents were given the right to choose their child's school, the proportion of independent schools in Sweden has increased from around 5 per cent in 1997 to 17 per cent in 2020, and these independent schools enrolled 15 per cent of children of compulsory school age in 2020. Swedish students, especially those living in metropolitan areas, have a wide range of schools to choose from, and this choice offers many different opportunities, especially after compulsory education (Rolfe, 2021:23). The presence of private schools, especially in big cities, puts students in a more advantageous position in terms of choice alternatives and may lead to educational inequalities.

1.1. Financing and Organisation of Swedish Education Services

Until the early 1990s, Sweden's education system was characterised by strong state control and regulation, which sought to provide a comprehensive education programme as a countermeasure against inequalities according to gender, class and future prospects. In the 1980s there was a gradual transition to a semi-centralised system of financing education, with responsibility shared between the state and municipalities. This semi-centralised financing system was then abolished in the early 1990s, and from 1993 onwards the financing was fully devolved to the municipalities. The introduction of a nationwide voucher system to allow parents to choose schools freely led to schools competing for students, and a quasi-market gradually took shape across Sweden (Rolfe, 2021:24). Therefore, localisation and privatisation processes took place in the Swedish education system after 1980. The belief of neoliberal policies that the public sector should be downsized was also seen in the Swedish education system and the private sector was authorised to carry out education services.

The Swedish education system aims to provide educational services for all, ensuring equal opportunities for all children regardless of socio-economic background. Compulsory education is free of charge and school is accessible for both boys and girls. Parents and children are free to choose public or private schools. Children attending private schools independent of the municipality are not charged any fees and are financed by the state. The education system is centrally regulated by the state, but the municipalities decide on the number of students in each school. Municipalities, which have local authority over schools, try to adapt education services to local needs by organising schools in various ways (Westling Allodi, 2007:134). Although private schools are authorised to provide education services, the fact that the financing is entirely state-owned and that no fees are charged to citizens shows that education services are intended to be made widespread and the egalitarian idea is to be maintained. The localisation of the education system in order to make it more sensitive to local needs also serves the same purpose.

In Sweden, municipalities are responsible for primary and secondary schools (Burström, 2015:96) and education is financed by taxes. According to the Swedish Education Act, compulsory education for children in the Swedish education system starts at the age of 6 and continues for at least ten years. Compulsory education in Sweden consists of four stages: pre-school (kindergarten), primary school (3 years from age 6), secondary school (3 years from age 9) and high school (3 years from age 12). Children between the ages of six and thirteen are also provided with out-of-school care before and after school hours (Sweden, 2002).

Nursery or kindergarten is provided by Swedish municipalities for children aged 1-5 years, and around 85 per cent of Swedish children in this age range attend nursery or kindergarten. The amount of the municipal subsidy for pre-school education varies depending on the age of the child and whether the parents are employed or not. The Swedish pre-school system emphasises the importance of play in a child's development in accordance with a curriculum that aims to meet children's individual interests and needs. The Swedish pre-school education system endeavours to provide children with the same opportunities in life in accordance with gender equality (Sweden, 2002).

In the Swedish education system, after upper secondary school, students are offered an optional fifth stage of education equivalent to upper secondary school between the 10th and 12th years of school life (from the age of 15). This stage covers three years of study, during which students can choose from 18 national programmes, six of which are university preparatory and twelve vocational programmes. Entrance requirements differ between the programmes, but students are required to achieve passing grades in Swedish, English and mathematics from the last years of compulsory education. In 2021, around 86 per cent of Swedish ninth-graders are eligible for a vocational programme and 82-85 per cent for a national programme. There are also high schools for the mentally disabled or programmes targeting specific groups, such as athletes (Sweden, 2002). This three-year period of education after compulsory upper secondary school education is a preliminary preparation process for young people to realise their academic or vocational goals and represents an important stage in obtaining the necessary opportunities to achieve their goals in life.

The Swedish education system includes a growing number of government-funded private (independent) schools, which are free of charge for Swedish citizens. Following a legislative change in the 1990s, parents and their children were given a free choice between municipal or private schools. Although private schools have existed in Sweden since the introduction of compulsory education, they did not become a competitive alternative to municipal schools until government-funded schools was introduced by the 1992 law. In 2020-2021, around 17 percent of compulsory schools and 35 percent of high schools are private schools, with 16 percent of all compulsory school students and 29 percent of all high school students attending them. The same rules apply throughout the Swedish school system, and private schools have to follow the national curriculum just like regular municipal schools (Sweden, 2002). Therefore, there is no difference between public and private schools in terms of curriculum and school fees. However, public schools need to be able to compete with private schools in terms of physical conditions, teacher quality and regional distribution, otherwise inequalities may arise.

After the 1992 reform, the number of private schools increased steadily from 200 to 800 in primary schools and from 70 to 450 in secondary schools until 2013. Likewise, the number of students in private primary schools increased from 17,000 in the mid-1990s to 126,000 in 2013, and in secondary schools from 5,000 to 85,000. Private schools and child day care centres

are run by cooperatives, church organisations and private companies. It is stated that the recent increase in private schools has primarily been realised by for-profit private equity companies (Burström, 2015:96).

1.2. Distribution of Swedish Education Services

In contemporary western societies, the main goal of education policy is to provide equal educational opportunities for all children. This goal includes activities to access education, equalize opportunities, remove barriers and support disadvantaged individuals to benefit from education. In this sense, an individual should not be denied educational opportunities because of characteristics such as gender, socioeconomic background, ethnicity or health. Despite the radical market-oriented education reforms implemented in the 1990s, efforts to equalize educational opportunities have been and continue to be a long-standing priority in Swedish education policy (Brannlund & Edlund, 2020:69). Indeed, it is stated that the main purpose of supporting private schools is to further expand accessible and inclusive education services.

Sweden, a pioneer in introducing compulsory education, has long had a reputation as a social democratic welfare state. Education is an important component of this social model (Rolfe, 2021:23). In post-World War II Swedish education reforms, the concept of "equivalence" and the related concepts of equal educational opportunity and equal distribution of education were used to articulate the goals of social justice. In the current education law, the concept of equity relates to the individual's access to education, students' performance and outcomes measured by school inspections. Besides the concept of equality, the globally spreading concepts of "inclusive education" and "education for all" have been incorporated into Swedish education policy. In this context, it is emphasized that children with disabilities, previously excluded or disadvantaged groups in a society should have the right to access education (Erixon Arreman & Dovemark, 2018:573).

The Swedish education system has made great efforts to make not only compulsory education but also the subsequent stages of education accessible to all. One of the strategies for this is to create an egalitarian and fair school system based on general principles, independent of income, social status, place of birth, etc. In this way, economic barriers to participation in educational services are eliminated and individuals are given the opportunity to choose an education that suits their capacities. One of the principles that inspired the Swedish education system is the idea of making it possible to see education as a right, not as a duty or burden (Westling Allodi, 2007:135).

In Sweden, it is argued that the family policy model that encourages women's labor force participation reduces child poverty and income inequalities in single-income households, leading to better conditions for access to education and a more equal distribution of resources for families to invest in their children's education. On the other hand, it is also argued that this policy was implemented not to address educational inequalities, but to cover the high tax burden necessary to finance the benefits and services of the social democratic welfare state. It is therefore necessary to ensure the participation of a large part of the population, including women, in the labor market. Therefore, it is argued that Sweden, which employs more than 80 percent of the population who are mothers, indirectly contributes to reducing educational inequalities (Sachweh, 2016:302-303). In this sense, it is stated that social reforms aimed at improving the socioeconomic conditions of families in line with the welfare state approach since the second half of the 20th century have played an important role in achieving successful results in reducing educational inequalities among children. Therefore, not only reforms to expand compulsory education but also efforts to improve living conditions have positive results in ensuring social justice in education.

A comparative analysis at the international level reveals that the Swedish education system has a very egalitarian structure. In this sense, Sweden has made more efforts and achieved more positive results in terms of educational equality than many other countries. After the Second World War, the basic principle of the Swedish education system was to ensure that all students receive a similar quality education regardless of their background. However, there are still many important gaps, which give rise to debate about the realization of Sweden's ambitious goals for education at all levels, from pre-school to higher education. As in any society, Sweden is characterized by social stratification and inequalities. While almost every child in Sweden has access to basic education, students gradually acquire different levels of knowledge at later stages, leading to unequal access at upper secondary and tertiary level. Existing indicators such as tests and grade point averages make it clear that this differentiation exists and continues to increase with different levels of education (Daun & Hansson, 2006:245).

The Swedish education system has been undergoing educational paradigm shifts over the last few decades. First, the Swedish education system has gone from having one of the most centralized systems in the world to a remarkably decentralized structure, and from being among the top OECD countries in terms of equity in the education system, it has started to lose this position. The second is the transformation of education from a public service to a commodity to be purchased from the market by changing the understanding of education from a communitarian to an individualist view. In this sense, while the Swedish education system has long been known for its "school for all" and inclusive tendencies, recent marketization moves have contributed to increasing social segregation within the education system (Magnusson et al., 2019:67). In this sense, it is stated that the localization and privatization moves made within the framework of the new public administration approach in the Swedish education system under the influence of post-1980 neoliberal policies and the globalization process have increased inequalities in education.

The introduction of free school choice has been the cornerstone of the reform of the Swedish education system. The abandonment of the proximity principle, which obliged students to attend the nearest school, and the introduction of a voucher system to be used for school financing after students' choice of school are the key elements of the school choice system. In addition, Sweden has created favorable conditions for the opening of private schools operating as businesses independent of government control. Following the introduction of private schools school choice policies, the literature has identified increasing socioeconomic and ethnic segregation between schools. This differentiation between schools is also reflected in achievement differences between schools (Rolfe, 2021:25). Therefore, it is stated that the private school and school choice reform, which was supported with the aim of expanding accessible, equal and inclusive education services, has caused inequalities on the contrary.

The main purpose of the free choice system, which has been in place in schools since the early 1990s, is to try to improve the quality of education through competition. However, there have been criticisms that there is little evidence to support this aim, that the best students choose the same schools and leave behind less performing students, and that the free choice system therefore increases disparities between schools. Likewise, there are those who argue that the impact of the selection system on overall education quality and equity is low, but that the market gains power in terms of school choice (Burström, 2015:98).

2. SWEDISH HEALTH POLICY

After the Second World War, Sweden developed a public welfare system to ensure that all welfare services, including health care, are comprehensive, of high quality and inclusive and accessible to all. The idea of providing quality care services to the entire population is recognized as part of the public welfare system in Sweden, providing high quality health care, education services, elderly care and other social services an inclusive welfare system, such as the Swedish health system, needs to gain the approval of the middle class in order to gain legitimacy and be sustainable. This means that services must be of high quality to satisfy all service users. If successful, the system can promote egalitarianism and social integration as intended. Health care, like other welfare services, is largely based on egalitarian principles. The 1982 Act on Health and Medical Services states that the main objective of Swedish health care is to ensure quality, equal and fair distribution of services to the entire population (Burström et al., 2017:2).

National health insurance was introduced in 1953, and following reforms requiring hospitals to provide outpatient services to patients at subsidized costs, health services were predominantly provided by the public sector. In 1969, a comprehensive reform made all hospital doctors full-time salaried employees and reduced the number of private providers from 25 percent in 1970 to 5 percent in the 1980s (Burström, 2015:89). More recently, although public providers provide the majority of health services, the proportion of private (for-profit) providers has increased in recent years, especially in areas such as outpatient care and primary health care (Burström et al., 2017:2).

2.1. Financing and Organisation of Swedish Health Services

Sweden's health system is regulated by national legislation and managed by local governments. The Swedish general health policy is determined by the Ministry of Health and Social Affairs, while health services are financed and provided by regional governments (county councils). Municipalities are responsible for the care of the elderly and disabled. Health services are financed primarily through taxes collected by the county councils and municipalities, while the central government also provides the necessary funding. The scope of health services includes inpatient, outpatient, dental, mental health and long-term care, as well as prescription drugs. Provincial councils set the fees for all types of health services and the co-payment rates for services such as primary hospital admissions and hospitalizations (Glenngard, 2020:181). Thus, as in education, decentralization dominates the provision and financing of health services.

The Swedish state has three levels of responsibility for running the health system. At the national level, the Ministry of Health and Social Affairs is responsible for formulating and regulating the overall healthcare policy and, working with eight national government agencies, sets budgets for state institutions and regions. At the regional level, 21 regional governments are responsible for the provision and financing of health services to citizens. At the local level, 290 municipal institutions are responsible for the care of the elderly and disabled, including long-term care (Glenngard, 2020:181). In this sense, it is understood that the organization and management of health service providers is left entirely to local and regional governments.

In Sweden, there are 7 university hospitals, all state owned, and about 70 state-owned community hospitals, which are under the responsibility of regional governments. There are also 6 private hospitals, 3 of which are not-for-profit. The seven university hospitals and two thirds of the 70 regional hospitals provide full emergency services. Each of the Swedish

provinces is divided into 6 health regions to facilitate cooperation between providers and provide a high level of advanced health care. High-end healthcare services, often using state-of-the-art technical equipment, are carried out by university hospitals to ensure high quality and efficiency and to conduct R&D studies (Glenngard, 2020:185-186). The fact that 77 out of 83 health care institutions are state-owned and the most advanced conditions are found in public university hospitals shows that the impact of the post-1980 political changes on the Swedish health system is weak.

As the responsibility for organizing and financing health services lies with regions and municipalities, services vary to some extent across the country. However, it is generally stated that the government-funded health system covers the following services (Glenngard, 2020:183):

1. Public health and preventive services
2. Basic care, including maternity care
3. Inpatient and outpatient specialized care
4. Emergency Care
5. Inpatient and outpatient prescription drugs
6. Mental Health services
7. Rehabilitation services including physical therapy
8. Disability support services, including durable medical equipment such as wheelchairs and hearing aids
9. Patient transportation support services
10. Home care and long-term care, including home care, nursing home care and hospice care
11. Dental care and optometry for children and young people
12. Limited subsidized adult dental care.

2.2. Distribution of Health Services in Sweden

According to the Health and Medical Services Act, Sweden's health care system covers all legally resident citizens and enrollment in health care is automatic. Asylum-seekers and children without identity documents and children who are permanent residents are entitled to health care. At the same time, adult asylum seekers and adults without identity documents are entitled to non-deferrable health services, such as maternity care (Glenngard, 2020:181). Health equity is a high priority in Sweden and the Swedish Public Health Policy states that the overall aim of health policy is to provide quality health conditions for all on equal terms. The aim of the Swedish Health Care Act is to ensure equity in access to needs-based health care. However, there are those who point out that some research shows that health service utilization is not always as closely related to health status and need as expected (Agerholm et al., 2013:318).

Glenngard (2020:181) states that three basic principles apply to all health services in Sweden. These are:

1. Human dignity: All human beings, regardless of their status in society, have equal and identical rights to dignity.

2. Need and solidarity: Those most in need are prioritized for treatment.
3. Cost-effectiveness: Improving health status and quality of life requires a reasonable balance between measured costs and benefits.

In order to minimize financial barriers to accessing health services in Sweden, these services are primarily financed through general taxation. However, for most types of healthcare services, a certain amount of co-payments are made by the citizen when visiting a general practitioner or specialist. On the other hand, there are also arguments that these payments are a financial barrier for some people seeking health care and thus undermine equity in access to health care (Agerholm et al., 2013:318).

In general, all social groups have the same rights to health care. Ceilings on what individuals spend from their own budgets apply to all, and the overall cap on user fees is not determined by income. Some targeted groups, such as children, adolescents and the elderly, are exempted from user fees. In addition, preventive services such as maternity care, vaccinations and cancer screenings are also exempt from co-payments (Glenngard, 2020:184). Everyone living in Sweden, whether they pay taxes or not, has access to healthcare services and healthcare expenditures above predetermined ceilings are covered by the government sector. In addition, the national occupational injury insurance covers all healthcare costs arising from occupational accidents (Thakur et al., 2003:8-9). The fact that everyone pays equal co-payment for the use of health services, that disadvantaged people and critically important health practices are exempted from this payment, and that there is no obligation to pay tax for the use of health services shows that both the principle of equality and the principle of need are observed. Providing quality and equally accessible health services to everyone, regardless of their income group, is important for ensuring social justice.

Sweden ranks in the top three of eleven high-income countries in measures to ensure equity in health care. The Health and Medical Services Act emphasizes equal access to need-based services, equal health rights for all and the need to minimize the level of unmet needs. Inequalities in healthcare access outcomes are measured by the National Health and Welfare Board and the Public Health Agency, primarily in relation to gender, income and education. Various supportive programs are in place to reduce inequalities in service uptake. In order to prevent patients with intensive health care needs from not receiving services from primary health care providers, the regional government allocates a fund that takes into account both general illness and the socioeconomic conditions of registered individuals (Glenngard, 2020:187). Thus, with such support practices, it is seen that the increasing effect of socioeconomic conditions on health inequality is tried to be minimized.

In recent years, however, there has been an increasing public-to-market orientation in the Swedish health system. In 2008, a national law was adopted giving citizens the freedom to choose between providers in different areas of health care, including health and social care. In 2010, the Health and Medical Services Act was amended to require regional and provincial councils to allow citizens to choose their primary care providers and to allow private sector providers to operate freely in this area if they meet certain defined criteria. The objectives of the primary health care choice reform are stated as increasing patients' freedom of choice, expanding private health care provision to increase access to health and care services, and increasing quality and innovation through competition among providers. This reform implies a shift from an egalitarian to a libertarian ideology in healthcare (Burström et al., 2017:2-3). Therefore, the private sector is being

encouraged in the provision and utilization of services in order to increase the quality and accessibility of services in the field of health, although not to the same extent as the level of change in education services.

In parallel, it is argued that in Sweden, low socio-economic groups largely avoid seeking medical care when they are in need of health and care services, and there are indications that such people have recently increased. This avoidance and inability to always get the care they need, and hence the aggravation of illnesses before seeking medical help, can exacerbate health inequalities. Studies show that mortality rates for some diseases are higher in lower socioeconomic groups because of delays in diagnosis and treatment (Agerholm et al., 2013:318-319). These studies show that despite all efforts for equality and accessibility, the negative impact of socioeconomic inequalities on health status has not been completely eliminated, and that this negative impact has even increased recently.

3. COMPARATIVE ANALYSIS OF SWEDISH EDUCATION POLICIES IN TERMS OF SOCIAL JUSTICE

Access to high quality education services is among the important factors that provide individuals with opportunities to use their talents and progress. Education services play an important role in an individual's social, political and economic participation. Therefore, the state should ensure equality of opportunity in education services for every child and prevent disadvantaged social and cultural backgrounds from negatively affecting educational performance. Ensuring equality of opportunity in education is a necessity in terms of ensuring social justice, and if it is not ensured, it will cause a social vicious circle. Because those who cannot benefit from adequate educational services will be left behind in terms of social participation and will be exposed to social inequality, and those who are socially unequal will not be able to access adequate education. Ensuring social justice is only possible by breaking this vicious circle. In addition, trying to improve the skills of individuals through education will have positive consequences for the individual and the national economy (Schraad-Tischler, 2011:15).

Students with a more advantageous socioeconomic background have a better performance in self-actualization than others. In addition, the socioeconomic opportunities of the school also have a positive impact on the future life conditions of individuals. In other words, if individuals with the same socioeconomic opportunities study in schools with different socioeconomic backgrounds, differences will emerge in the performance of individuals. In order for the socioeconomic backgrounds of students and schools to be less determinant on the performance of individuals, education policies should be geared towards improving students. Otherwise, the fact that the education system produces individuals with inadequate performance will have great costs in terms of failing to ensure social justice (Schraad-Tischler, 2011:22).

Government expenditures and investments in early childhood education are important for lifting children out of their disadvantaged socioeconomic conditions. According to the results of the PISA (OECD Program for International Student Assessment) study, students who receive preschool education tend to perform better in school than students who do not. When this education is longer and the class size is smaller, school performance improves even more. Again, according to the results of the PISA study, segregation of children in early childhood according to their abilities and performance has negative consequences in terms of providing fair educational opportunities and reducing the impact of socioeconomic background. The more integrative the school systems are in early childhood and the less segregated they are, the more productive the results will be in terms of learning success and educational justice (Schraad-Tischler, 2011:24-25).

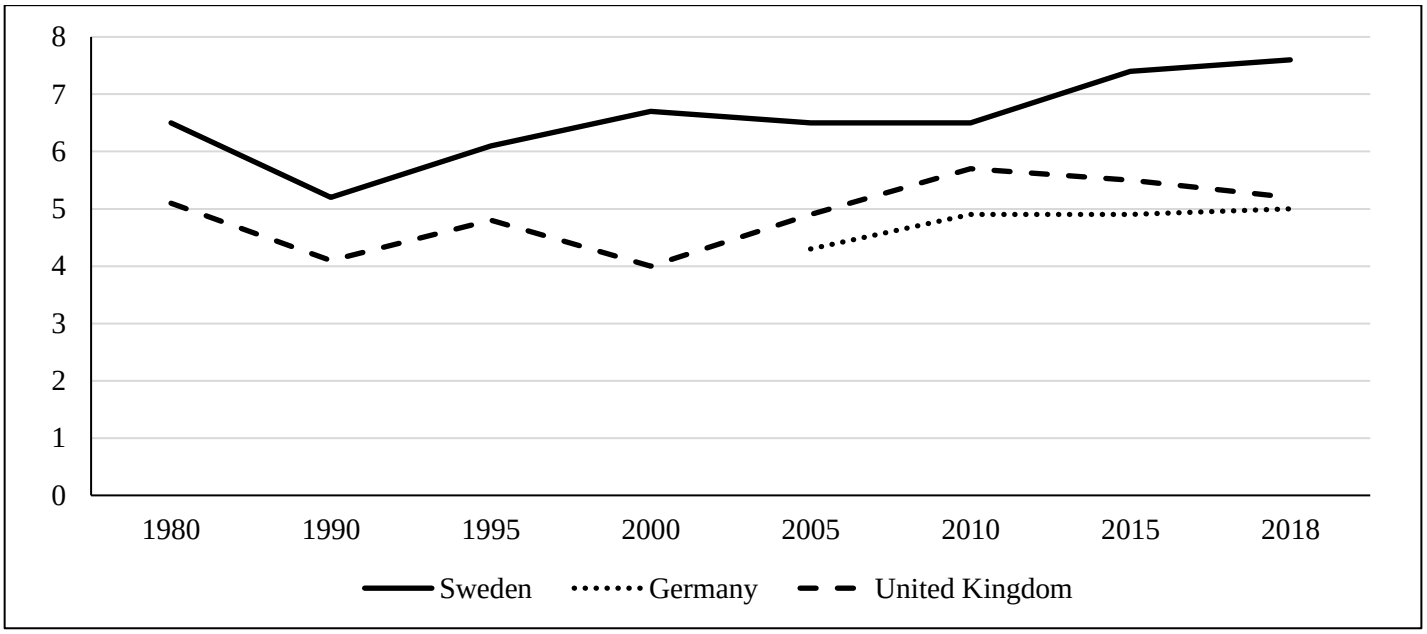

Figure 1: Public Spending on Education (% of GDP)

Source: World Bank, 2022.

Public spending on education includes direct expenditures on educational institutions as well as education-related government subsidies to households. In this sense, government expenditure on education includes expenditure on schools, universities and other public and private institutions that provide or support educational services. This indicator is shown as a percentage of GDP. The level of education expenditure shows the priority that governments give to education (OECD, 2022c). As shown in Figure 1, Sweden has a higher level of government expenditures on education compared to other countries and the expenditures have been on an upward trend since 1990 until today. The post-1990 education reforms transferred the supervision and financing of schools to local governments and facilitated the opening of state-funded private schools. After 1990, the number of private schools financed by the state and the number of students has increased day by day. Even though the number of private schools has increased, since these schools are financed by the state, there has been no decline in government expenditures on education; on the contrary, they have continued to increase. The aim here has been to give parents the right to choose between public and private schools and to ensure equality of opportunity by expanding education to the whole society.

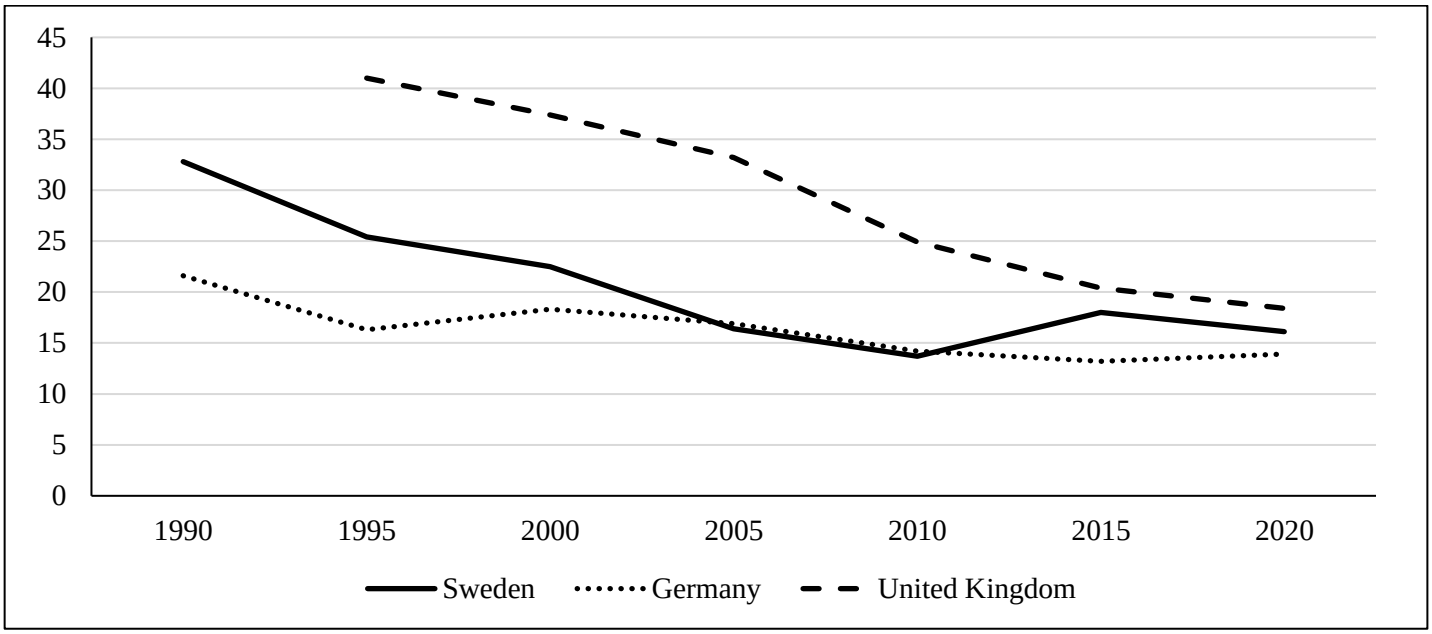

Figure 2: Adult Education Level-Below Upper Secondary (% of 25-64 Year-Olds)

Source: OECD, 2022a.

This indicator shows the proportion of the adult population aged 25-64 who have graduated from primary or secondary school and have not attended any school. The indicator is measured as a percentage of the population of the same age (OECD, 2022b). The rate of graduation below high school in Figure 2 is an important indicator of individuals' access to education and shows the numerical position of low-educated individuals in society over the years. Between 1990 and 2020, the rate in Sweden has been on a general decline, except for the period 2010-2015. The sharp increase in 2014 is thought to be due to the impact of the immigrant population. Sweden, which is in a more advantageous position compared to the UK in terms of the ratio, lags behind Germany in terms of the dissemination of education.

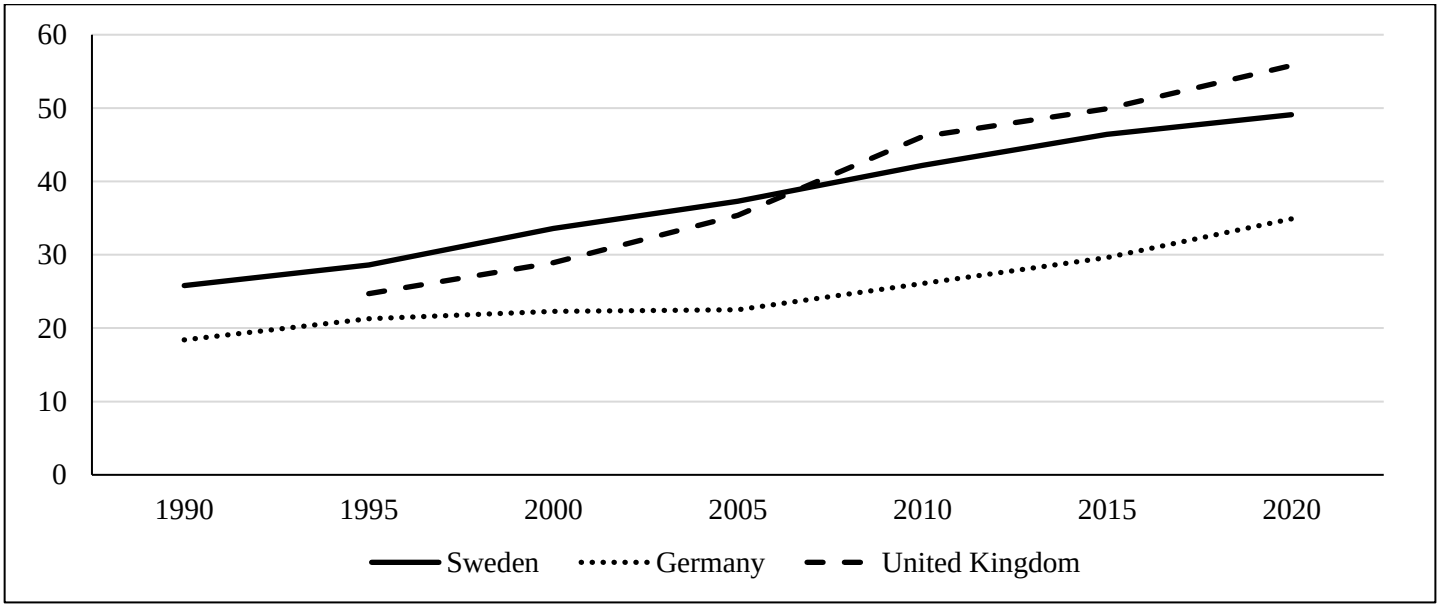

Figure 3: Population with Tertiary Education - 25-34 Year-Olds (% in Same Age Group)

Source: OECD, 2022a.

Higher education graduation rate for the population aged 25-34 is an important indicator of individuals' access to higher education and the numerical position of educated young people in society. An increase in this rate over the years means that equal opportunities and continuity in education are ensured. Figure 3 shows that between 1990 and 2020, Sweden's university graduation rate among the population aged 25-34 has nearly doubled and is ahead of Germany. This shows that Sweden attaches importance to higher education and expands opportunities to ensure equal opportunities in education.

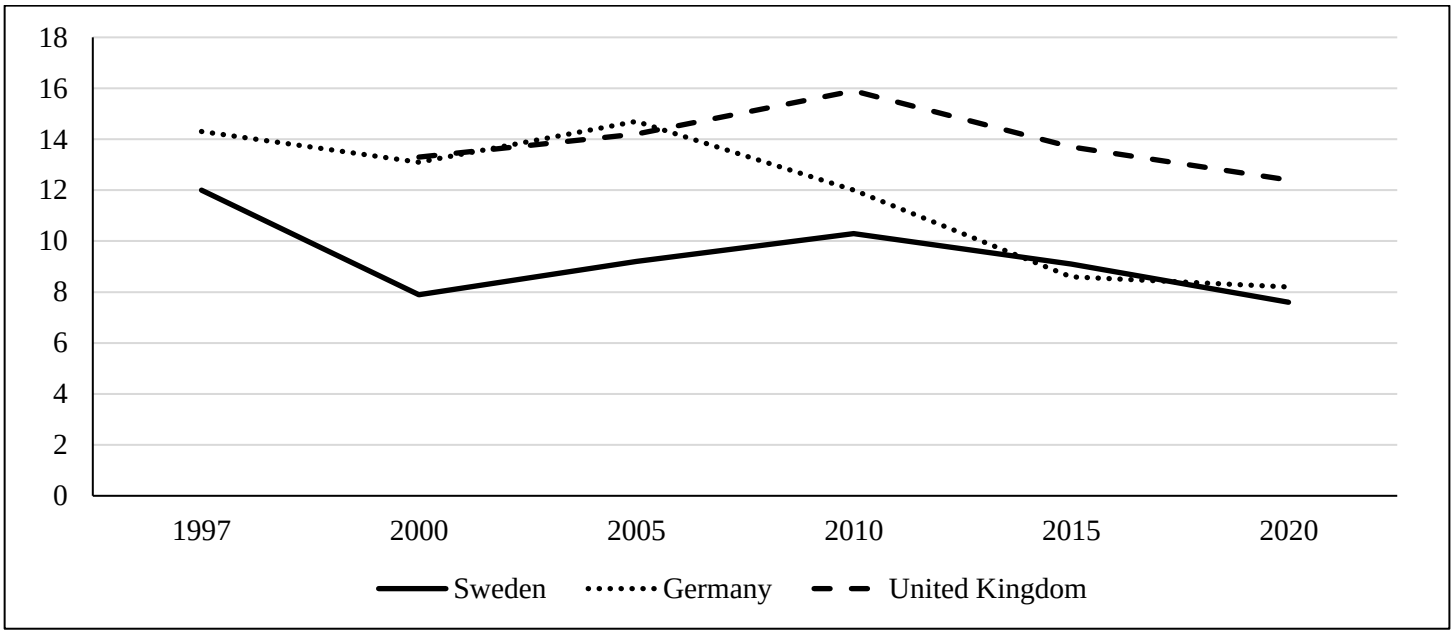

Figure 4: Youth Not in Employment, Education or Training-NEET (15-29 Year-Olds, % in Same Age Group)

Source: OECD, 2022a.

"The Youth not in Education, Employment or Training" (NEET) indicator shows the share of young people who are not in school and not in the labor market in their age group (OECD, 2022i). Figure 4 shows the NEET rates of the countries between 1997 and 2020, and the graph shows that Sweden has the lowest rate, even though it has experienced a period of ups and downs in the relevant period. The fact that the number of young people who are both not in school and not working in the labor market has a decreasing trend over the years is considered an indicator that young people's access to education has increased and that they have reached the opportunity for self-realization. Therefore, the existence of positive developments in ensuring equal opportunities and social justice is confirmed.

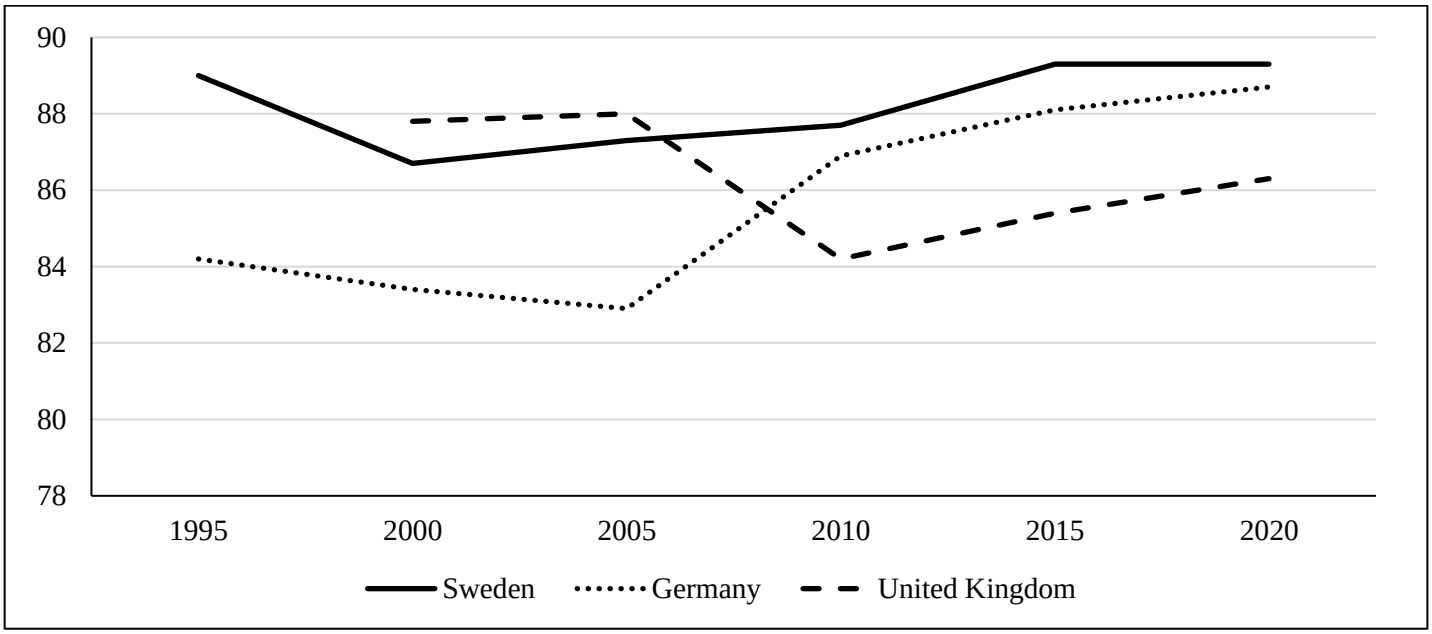

Figure 5: Employment by Education Level-Tertiary Education (% of 25-64 Year-Olds)

Source: OECD, 2022a.

Figure 5 shows the employment rate of university graduates among 25-64 year olds. Between 1995 and 2020, the employment rate of university graduates in Sweden ranges between 86-89%, which is quite advantageous compared to other countries. Being able to take part in the labor market after university education is an important indicator both for educated individuals to realize their own goals and for reducing socioeconomic inequalities. Otherwise, it would be to keep young people in the education process for a certain period of time and then let them down without providing them with job opportunities, which is accepted as an expression of social unrest and the failure to ensure social justice. In this sense, Sweden has increased the employment rate of university graduates after 2000, resulting in individual and social benefits from access to education. The less an individual's educational success depends on the socioeconomic status of his/her family and the more his/her vocational goal is influenced by his/her education, the greater the equality of opportunity. Sweden appears to be successful in this regard.

4. COMPARATIVE ANALYSIS OF SWEDISH HEALTH POLICIES IN TERMS OF SOCIAL JUSTICE

Another element of social justice is the equitable provision of health services. Inequalities in health services arise when the living conditions shaped by political, social and economic forces are disadvantageous. The social and economic policies implemented have an impact on how the living conditions of individuals will change positively or negatively from birth to death and whether they will be able to fully use their potential for self-realization throughout their lives. In this sense, affordable, inclusive and quality health services are important in terms of ensuring social justice. Therefore, in order to prevent health inequalities, public health policies should aim to provide high quality health services at the lowest possible costs, covering the largest possible population. In order to identify inequalities in health, some data in the OECD database are utilized (Schraad-Tischler, 2011:15-16).

If individuals' self-assessments of their personal health differ according to the income groups they are in, concerns arise about the equality of opportunity offered to ensure social justice. In other words, if individuals in the lowest income bracket

evaluate their health more negatively than those in higher income groups or if they feel less healthy than those in other income groups as a result of being in the low income group, it is thought that there is a negative impact on the equal distribution of health services. In this sense, in order to ensure social justice, individuals' good or bad evaluations of their personal health should be independent of the effect of their income group (Schraad-Tischler, 2011:36-37).

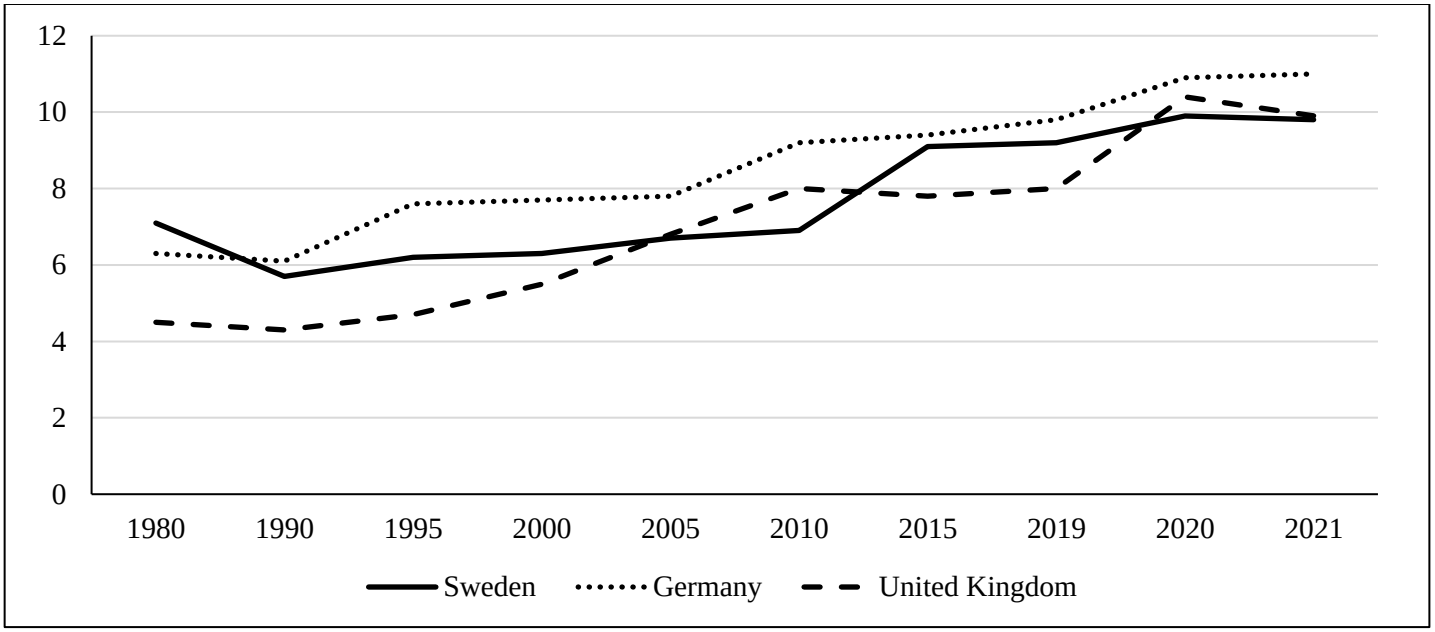

Figure 6: Total Government Health Spending (% of GDP)

Source: OECD, 2022a; OECD, 2003.

Total government health expenditure includes current government spending on health products and services, including aggregate services such as personal health care services (curative care services, rehabilitative care services, long-term care services, ancillary services and medical products), preventive and public health services. However, this expenditure item excludes expenditure on investments. This indicator is measured as a percentage of GDP (OECD, 2022e). Figure 6 shows the public health expenditures of countries between 1980-2021. According to the graph, it is seen that the Swedish health expenditure ratio is on an upward trend at a level similar to other countries. Although Sweden's health services are largely carried out by government health institutions, it is stated that there has been an increase in the number of private health institutions, especially after 2010. Especially after 2010, the sharp increase in the Swedish public health expenditure ratio draws attention.

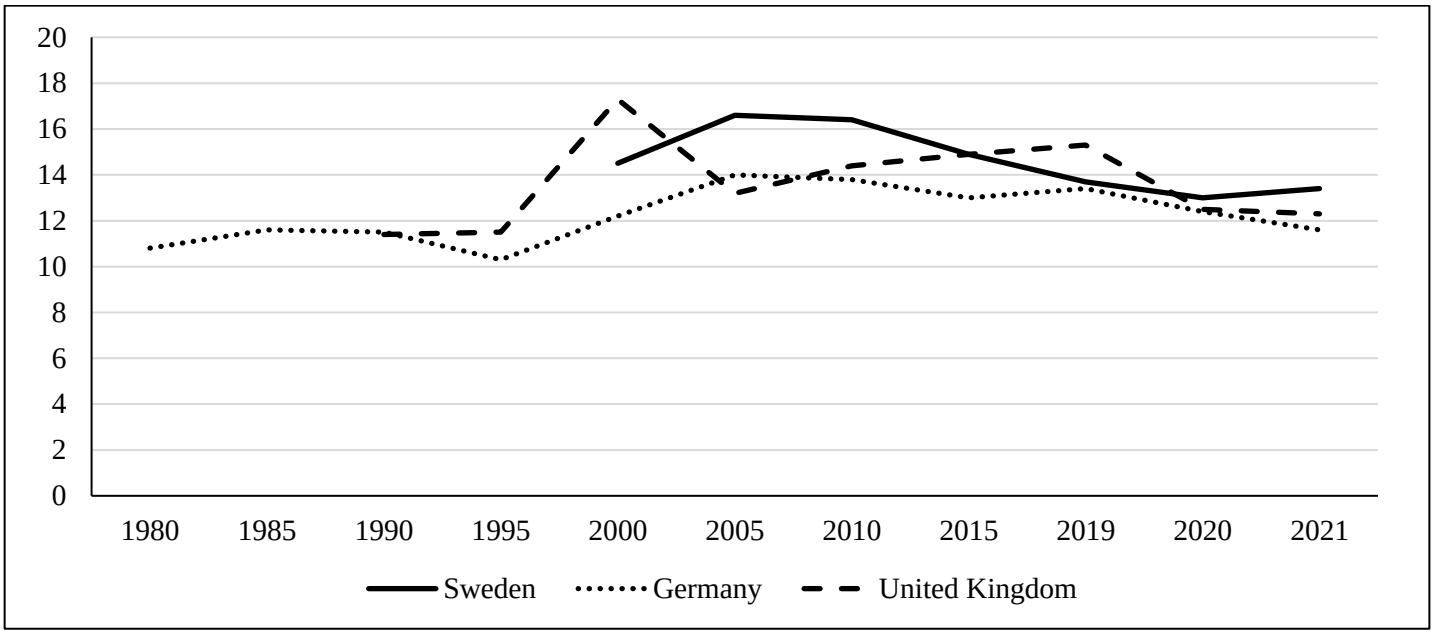

Figure 7: Out-of-Pocket Health Expenditures (% of Total Health Spending)

Source: OECD, 2022a.

In terms of financing of health services, it is stated that out-of-pocket health expenditures have a determining role in the use of health services and if these expenditures are high, the demand for health services will decrease. High out-of-pocket health expenditures may cause individuals with low income levels to become poorer and more importantly, individuals may postpone the use of health services even though they need them (Kılıç & Çalışkan, 2013:195-196). Out-of-pocket health expenditures include voluntary health insurance and out-of-pocket health payments made by households. The share of out-of-pocket health expenditures in total health expenditures is a data showing whether health services are inclusive and accessible. According to Figure 7, Sweden's out-of-pocket health expenditures increased in the 2005-2010 period and followed a decreasing trend between 2010-2020. During the pandemic period, it is observed that these expenditures increased and Sweden has a higher expenditure rate compared to other countries. When the decrease in out-of-pocket health expenditures in the last decade is evaluated together with the increase in total public health expenditures in the same period, it is thought that the inclusiveness and accessibility of health services have increased.

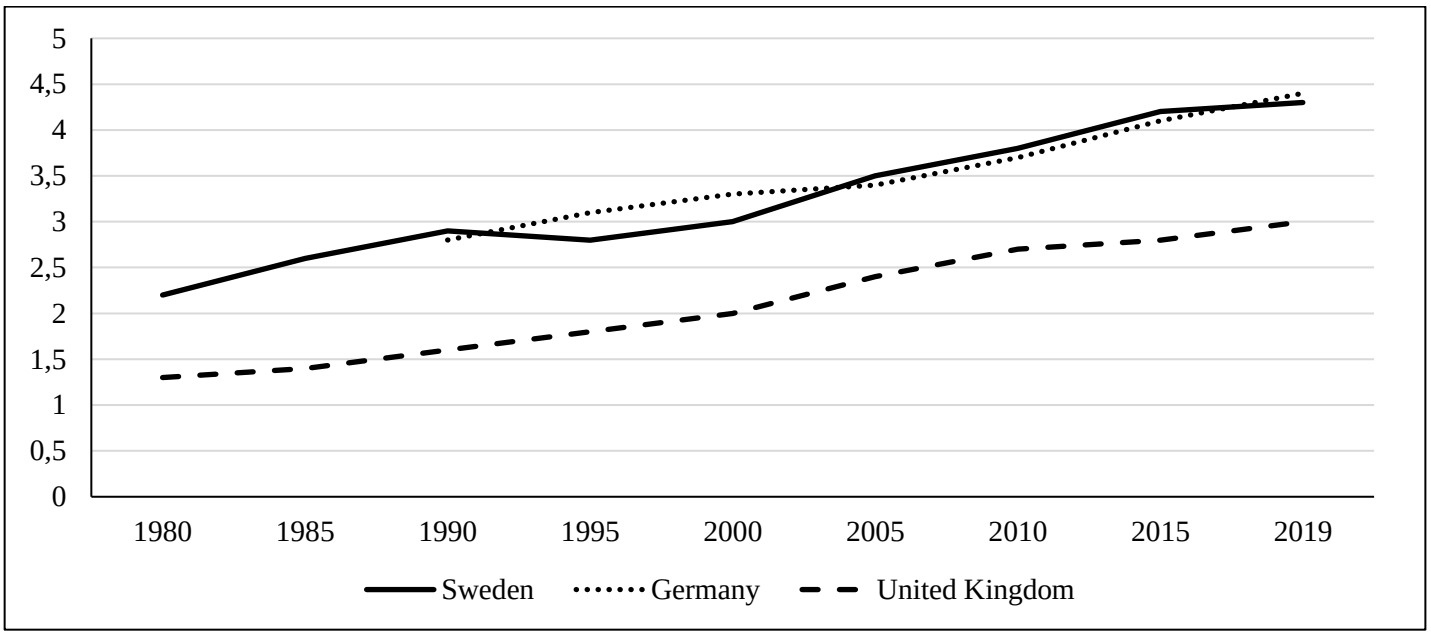

Figure 8: Doctors (Per 1000 Inhabitants)

Source: OECD, 2022a; World Bank, 2022; OECD, 2003.

Doctors are defined as specialised personnel who are responsible for providing direct and continuous health services to patients. This indicator is measured by the number of doctors per 1000 people (OECD, 2022d). The number of doctors, who have the highest responsibility among health professionals, determines the accessibility and inclusiveness of health services. Figure 8 shows the number of doctors per thousand people in countries between 1980-2019. According to the graph, although there has been an increase in the number of doctors in all three countries in the last forty years, it is understood that Sweden and Germany, which have similar values, have a much higher ratio of doctors than the UK. Therefore, considering the increase in the number of doctors, it is considered that the distribution, accessibility and inclusiveness of Swedish health services have made positive progress in terms of ensuring social justice.

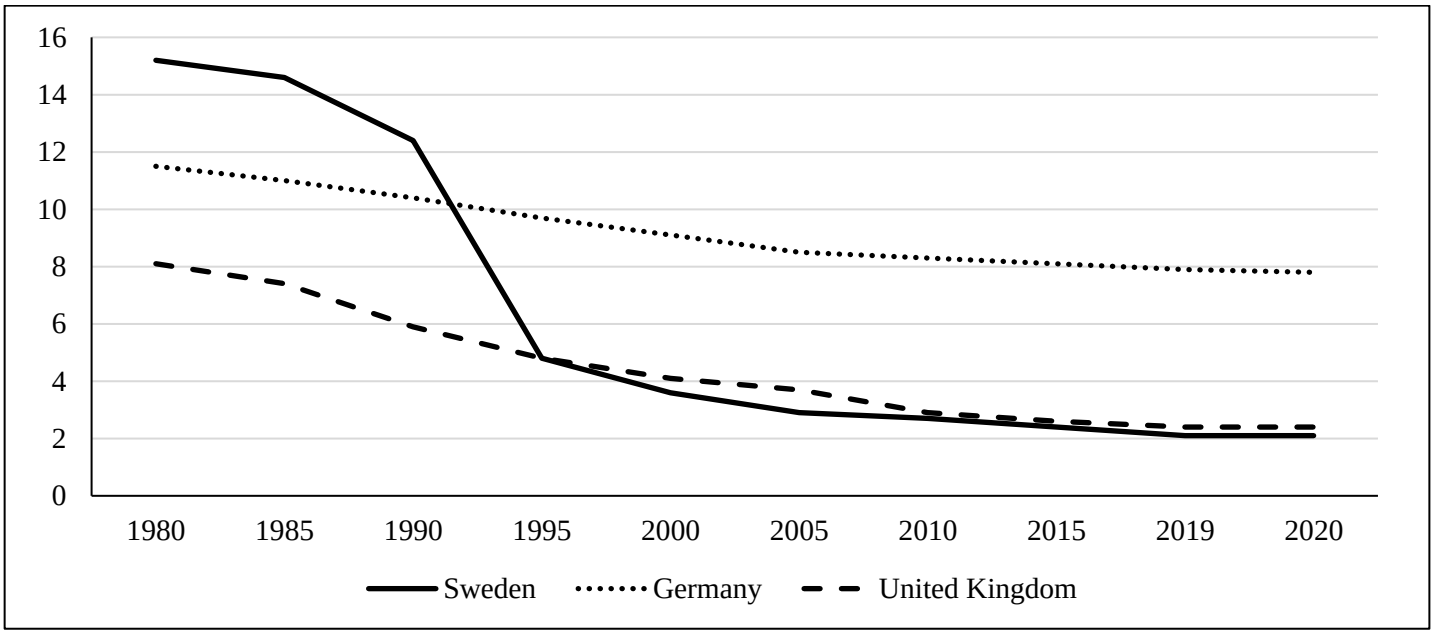

Figure 9: Hospital Beds (Per 1000 Inhabitants)

Source: OECD, 2022a.

The number of hospital beds refers to the number of beds in hospitals that are maintained and available for immediate use to serve inpatients. In this sense, hospital beds include therapeutic (or acute) care beds, rehabilitation care beds, long-term care beds and other beds in hospitals. This indicator is measured by the number of beds per thousand inhabitants (OECD, 2022f). While most health systems are inclusive, the quality of health services and ease of access to these services vary across countries. Self-financed private health institutions generally cater to the middle and upper classes, which are minorities in societies. Here, the distribution of the number of hospital beds between public and private institutions has an important place (Schraad-Tischler, 2011:34-35). It is important that the number of hospitals is adequate for the country's population in order to ensure that health services are inclusive, accessible and of high quality. Figure 9 shows the number of hospital beds per thousand inhabitants between 1980 and 2020. According to the graph, it is seen that Sweden lost its superior position between 1980-1990 in terms of the number of beds compared to other countries, and after 1990, the number of beds decreased rapidly and became the country with the lowest number of beds. In this sense, the fact that Sweden has such a statistic raises doubts about the adequacy of health services to ensure social justice in terms of bed capacity.

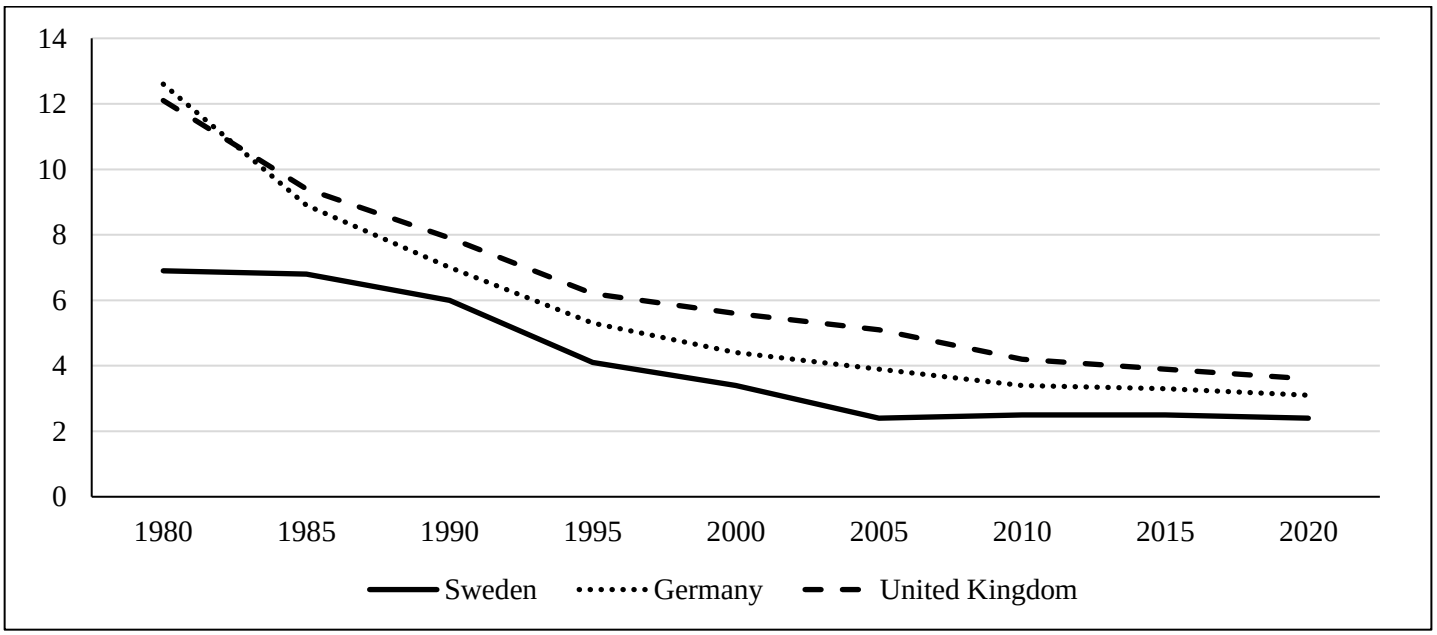

Figure 10: Infant Mortality Rates (Deaths/1 000 Live Births)

Source: OECD, 2022a.

Infant mortality rate is defined as the number of deaths of children under one year of age per 1000 live births (OECD, 2022g). Infant mortality rate is an important indicator for ensuring social justice in health activities. Among OECD countries, Sweden has one of the lowest infant mortality rates (Schraad-Tischler, 2011:36). As seen in Figure 10, infant mortality rates in Sweden have been realised both in a decreasing trend and at a lower level compared to other countries in the last forty years.

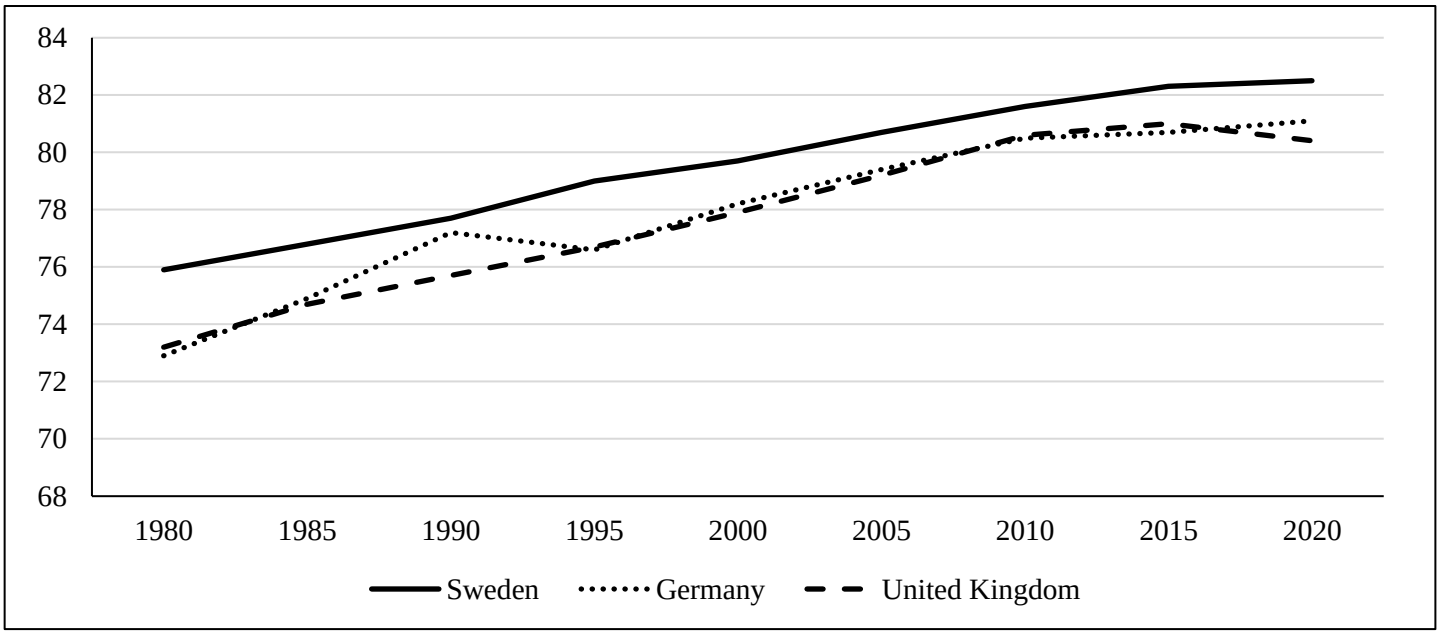

Figure 11: Life Expectancy at Birth (Years)

Source: OECD, 2022a.

Life expectancy at birth is an expectation of how many years a newborn baby will live on average if current mortality rates do not change. Life expectancy at birth is one of the most frequently used health status indicators, and in order to achieve

gains in this area, many factors such as higher living standards, better education, and greater access to quality health services need to be realised. This indicator is calculated in years (OECD, 2022h). Figure 11 shows that Sweden's life expectancy at birth between 1980 and 2020 is higher than that of other countries. This can be interpreted as higher living standards and more favourable access to education and health services in Sweden.

CONCLUSION

It is stated that the Swedish education system is based on the goal of equal opportunity in education in line with the welfare state approach. In the early 20th century, the Swedish education system was initially characterised by socioeconomic inequalities to the detriment of the children of workers. After the Second World War, with the development of the welfare state, both socioeconomic inequalities were eliminated and a compulsory education reform was carried out for the nationalisation and expansion of education in accordance with the aim of accessibility and equal distribution of education services. As a result of these reforms, it is stated that inequalities in education decreased until the 1990s. However, the globalisation process and neoliberal policies had an impact on Sweden as in the rest of the world, and the education system was decentralised in the 1980s and privatised in the 1990s. In order to ensure better quality and accessibility of education, the activities of private schools have been supported with state funds since the 1990s. As a result, the number of private schools and the number of enrolled students have increased continuously until today. While some argue that these moves have led to inequalities in education, others state that the Swedish education system still acts in accordance with the principle of equality. However, it is also stated that after the introduction of the private school and school choice reform, there has been socio-economic and ethnic segregation among schools and the Swedish education system has regressed in the ranking of OECD countries in terms of equality in the education system.

It is seen that the historical development process of Sweden's education policies is generally in line with the results of the comparative evaluation based on OECD and World Bank data. To evaluate Sweden's education policy in general in terms of ensuring social justice; the Swedish education system underwent a transformation after 1990 and the share of private schools in education services gradually increased in terms of the number of schools and students. Parents were given the right to choose private schools, which are fully financed by the state, in addition to public schools. The financing and supervision of both public and private schools have been transferred to local governments and government expenditures on education have tended to increase in the long run. In the long run, it is observed that the number of people with low education has decreased while the number of university graduates has increased, and on the other hand, the majority of higher education graduates are employed in the labour market. In this sense, it is considered that the efforts and results achieved in Sweden to ensure equality of opportunity in the field of education for individuals to realise themselves are more positive than in the UK and Germany. However, despite these efforts, it is also stated that second generation immigrant children are in a disadvantaged position compared to Swedish children in terms of access to higher education in Sweden.

When the Swedish health system is evaluated in terms of ensuring social justice, it is understood that it is the most stable service area in Sweden. It is stated that the equal, high quality and accessible characteristics of health services, which were nationalised with health reforms after the Second World War, have increased until today. Although there has been a low level of privatisation in the recent period, it is seen that the state plays a very active role in this regard. The fact that 77 out

of 83 health care institutions are state-owned and that the most advanced conditions are found in state university hospitals shows that the impact of post-1980 political changes on the Swedish health system is weak. In addition, the fact that everyone pays equal contributions for the use of health services, disadvantaged people and critically important health applications are exempted from this payment, and there is no obligation to pay tax in the use of health services shows that both the principle of equality and the principle of need are observed in health services. Providing quality and equally accessible health services to everyone, regardless of their income group, is important in terms of ensuring social justice. In this context, the fact that the organisation and management of health service providers in Sweden is left entirely to local and regional administrations and that local administrations are authorised in the financing and execution of health services shows that policies are formulated and executed by taking local needs into account. On the other hand, some studies claim that there are indications that there is an increase in the number of low socio-economic groups in Sweden who avoid seeking medical care even though they need health and care services. This avoidance of treatment may lead to aggravation of diseases and increase in health inequalities. It is also argued that individual co-payments for health care are a financial barrier for some people, thus undermining equity in access to health care.

It is seen that the historical development process of Sweden's health policies is generally in line with the results of the comparative evaluation based on OECD and World Bank data. If Sweden's health policy is evaluated in terms of ensuring social justice; Swedish health services are largely carried out and financed by public service organisations. Health services and employees were nationalised after the reform in 1969. The law enacted in 1982 aims to make health services fair, inclusive, high quality and accessible for all. When the post-1980 period is analysed, positive developments are observed in public health expenditures, out-of-pocket health expenditures, number of doctors, infant mortality rates, life expectancy at birth, in contrast to the negative situation in the number of hospital beds in Sweden. It is understood that Sweden has followed a more favourable course than the UK and Germany in terms of achieving the goals of being fair, inclusive, quality and accessible for health services and ensuring social justice. Of course, it should not be forgotten that the population situation, which plays an important role here, is in Sweden's advantageous position.

ETİK BEYAN VE AÇIKLAMALAR

Etik Kurul Onay Bilgileri Beyanı

Çalışma, etik kurul izni gerektirmeyen bir çalışmadır.

Yazar Katkı Oranı Beyanı

Yazarın katkısı %100’dür.

Çıkar Çatışması Beyanı

Çalışmada potansiyel bir çıkar çatışması bulunmamaktadır.

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