European Commission

State of Health in the EU

Sweden

Country Health Profile 2023

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European Observatory on Health Systems and Policies
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The *Country Health Profile* Series

The *State of Health in the EU*'s *Country Health Profiles* provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policy makers and influencers with a means for mutual learning and voluntary exchange. For the first time since the series began, the 2023 edition of the Country Health Profiles introduces a special section dedicated to mental health.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in co-operation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Systems Performance Assessment (HSPA).

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Data and information sources

The data and information in the *Country Health Profiles* are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was finalised in September 2023, based on data that were accessible as of the first half of September 2023.

Demographic and socioeconomic context in Sweden, 2022

Demographic factors	Sweden	EU
Population size	10 452 326	446 735 291
Share of population over age 65 (%)	20.3	21.1
Fertility rate[1] (2021)	1.7	1.5
Socioeconomic factors		
GDP per capita (EUR PPP[2])	42 264	35 219
Relative poverty rate[3] (%)	16.0	16.5
Unemployment rate (%)	7.5	6.2

1. Number of children born per woman aged 15-49. 2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries. 3. Percentage of persons living with less than 60 % of median equivalised disposable income. Source: Eurostat Database.

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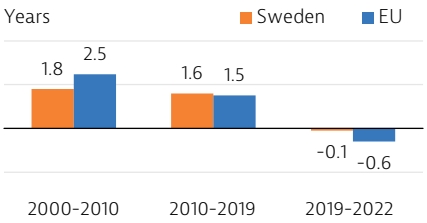
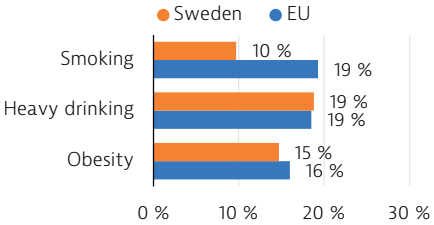
1 Highlights



Changes in life expectancy at birth

Health Status

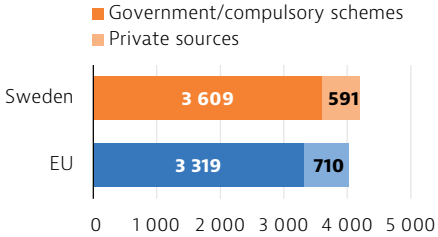
Life expectancy in Sweden was the second highest in the EU in 2022, reaching 83.1 years. Following a sharp fall in the first year of the pandemic, in 2021 and 2022 life expectancy rebounded to close to pre-pandemic levels. Inequalities in life expectancy by education level are large in Sweden and have increased over the past two decades.



% of adult population, 2019

Risk Factors

About one third of all deaths in Sweden in 2019 could be attributed to behavioural risk factors. While smoking rates among adults are the EU's lowest, use of snuff is common. About one in five adults (19 %) reported heavy alcohol drinking in 2019 – a proportion matching the EU average. The adult obesity rate is slightly below the EU average, but it reached 15 % in 2019, up from 11 % in 2010.



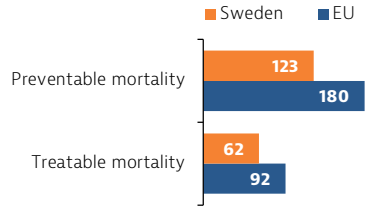
EUR PPP per capita, 2021

Health System

Sweden's health spending slightly surpasses the EU average: per capita spending was EUR 4 200 in 2021 compared to EUR 4 028 across the EU (adjusted for differences in purchasing power). Public funding covered 86 % of health expenses, exceeding the EU average of 81 %. As a share of GDP, health spending reached 11.2 % in 2021 due to pandemic-related costs.

Effectiveness

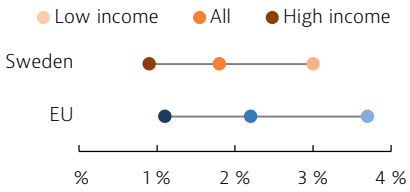
Sweden's low rates of preventable deaths from causes such as lung cancer, alcohol-related deaths and road traffic accidents is linked to strong public health policies. Low rates of mortality from treatable causes also point to an effective healthcare system in avoiding deaths from potentially fatal conditions.



Age-standardised mortality rate per 100 000 population, 2020

Accessibility

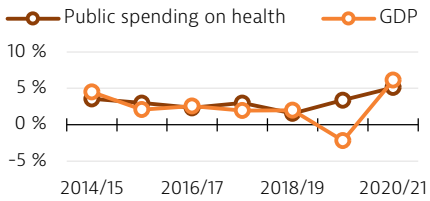
Access to healthcare is generally good and unmet medical care needs are generally low. However, issues concerning access to care in remote regions persist and waiting times for elective surgery have increased in the aftermath of the pandemic.



% reporting unmet medical care needs, 2022

Resilience

Public spending on health increased by over 3 % in 2020 and by over 5 % in 2021 in response to the pandemic. Sweden's Recovery and Resilience Plan has allocated EUR 452 million to address shortcomings in the long-term care sector that were brought to public attention during the pandemic.



Annual change in real terms

Mental Health

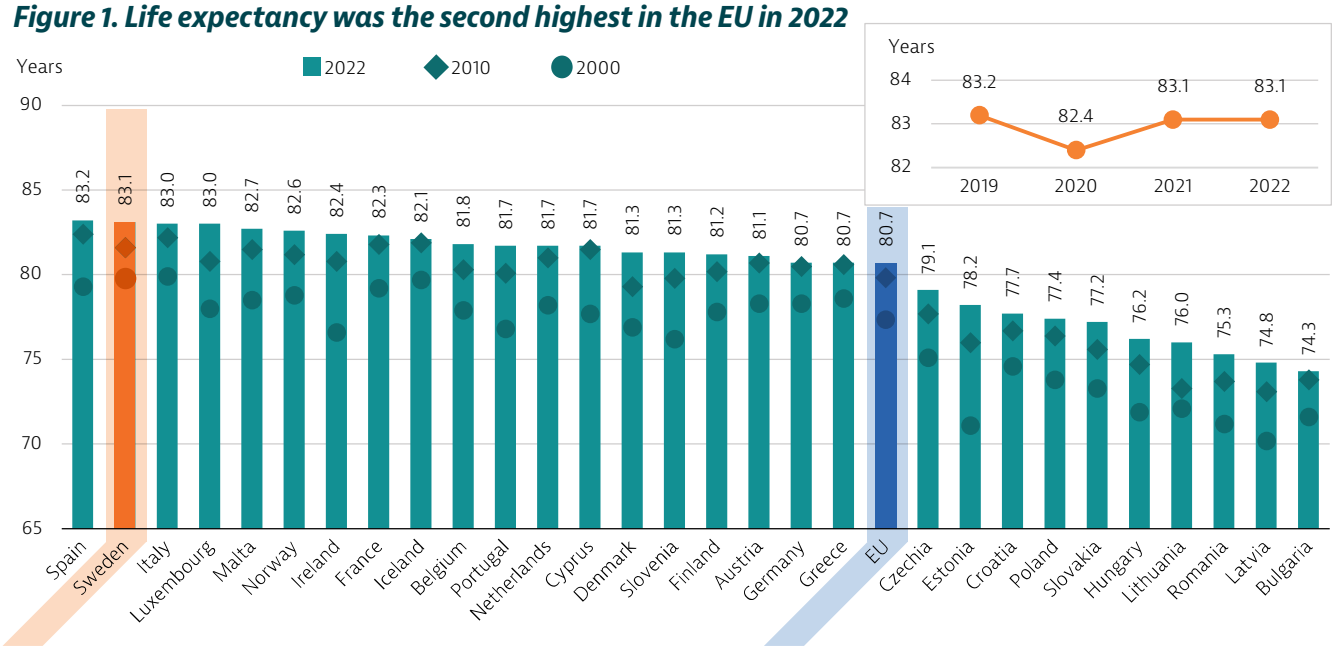
About 17 % of people had a mental health issue in Sweden in 2019, which is close to the EU average. Common disorders include anxiety and depression, with higher prevalence among women and those on lower incomes: 16 % of men and 18 % of women in the lowest income quintile reported depression in 2019, compared to 8 % of men and 9 % of women in the highest income quintile. A new mental health strategy is under development.

2 Health in Sweden

Sweden has one of the highest life expectancy levels in the EU

Life expectancy at birth in Sweden was the second highest in the EU in 2022, reaching 83.1 years. Following a sharp reduction of 0.8 years in 2020 due to the high number of deaths from COVID-19, life expectancy rebounded in 2021 to return almost to its pre-pandemic level, and remained unchanged in 2022 (Figure 1).

Figure 1. Life expectancy was the second highest in the EU in 2022



Notes: The EU average is weighted. The 2022 data are provisional estimates from Eurostat that may be different from national data and may be subject to revision. Data for Ireland refer to 2021.
Source: Eurostat Database.

The gender gap in life expectancy in Sweden is much smaller than in most EU countries. In 2022, Swedish women could expect to live 3.3 years longer than men, which is well below the EU average gap of 5.4 years.

Social inequalities in life expectancy are larger than those by gender in Sweden

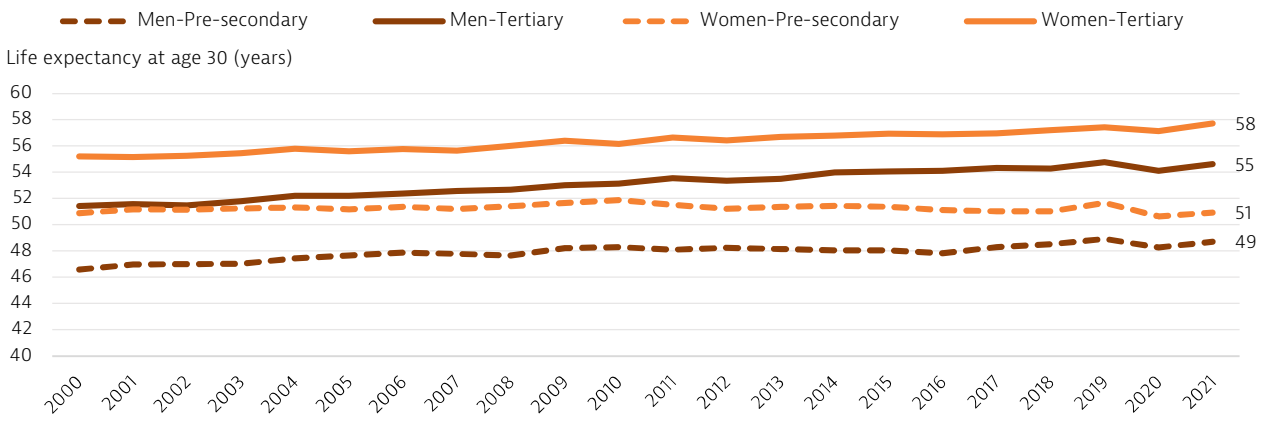
Inequalities in life expectancy by socioeconomic status are greater than those by gender. At age 30, Swedish women with the highest level of education could expect to live 6.8 years longer than those with the lowest level in 2021, while the gap was 5.9 years among Swedish men (Figure 2). The education gap among women increased by 2.5 years between 2000 and 2021, while the increase among men was more moderate – by 1.1 years.

This growing education gap in life expectancy is partly related to an uneven distribution in improvements in living and working conditions over the last two decades, resulting in growing income inequalities. While the share of people with the lowest level of education (defined as less than secondary education) has decreased over the past two decades with the rising trend in educational attainment, those with low levels of education are increasingly disadvantaged on the labour market and in society (Public Health Agency of Sweden, 2019). They are also more likely than those with higher education levels to be exposed to risk factors such as smoking, poor nutrition and low levels of physical activity. Such exposure significantly contributes to the likelihood of mortality at younger ages.

Circulatory diseases and cancer were the main causes of death in 2020, but COVID-19 accounted for a large share of deaths

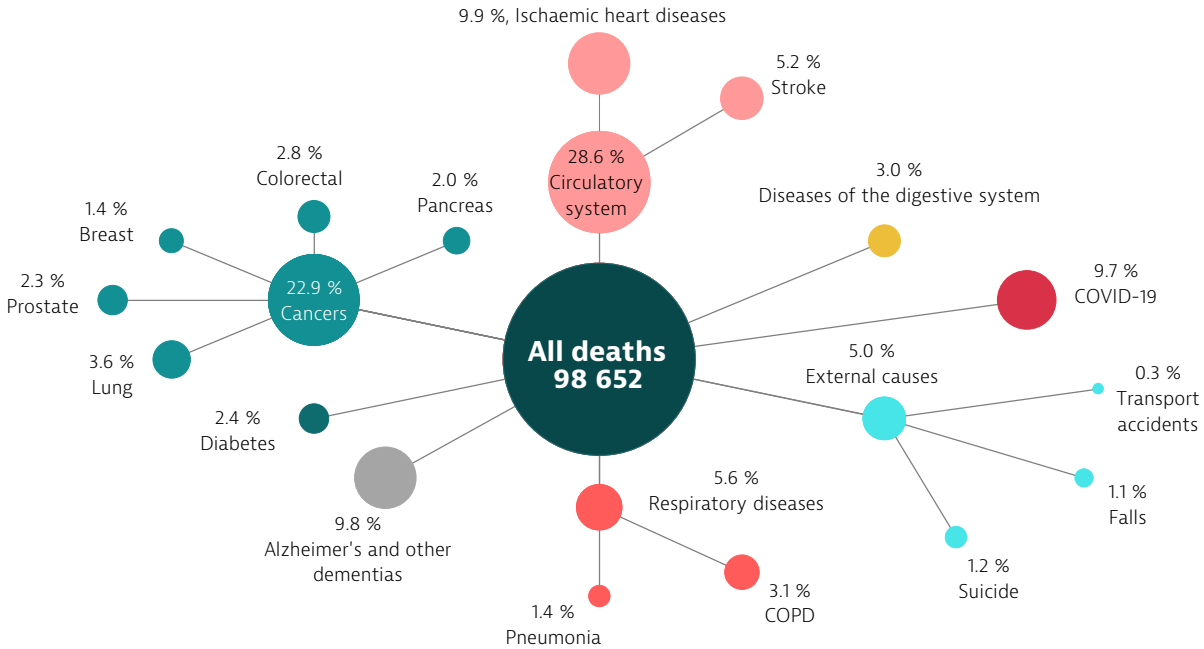
In 2020, the leading causes of death in Sweden were circulatory diseases – such as stroke and ischaemic heart disease – cancer, Alzheimer and other dementias, and COVID-19 (Figure 3). During the first year of the pandemic, COVID-19 accounted for nearly 9 500 deaths in Sweden (9.7 % of all deaths), making it the fourth leading cause. Over half of COVID-19 deaths in 2020 were among people aged 85 and over.

Figure 2. The education gap in life expectancy at age 30 is about 6-7 years in Sweden



Notes: Data refer to life expectancy at age 30. Low education is defined as people who have not completed secondary education (ISCED 0-2), whereas high education is defined as people who have completed tertiary education (ISCED 5-8).
Source: Statistics Sweden.

Figure 3. COVID-19 accounted for nearly 10 % of all deaths in 2020



Note: COPD refers to chronic obstructive pulmonary disease.
Source: Eurostat Database (data refer to 2020).

The broader indicator of (all-cause) excess mortality shows that excess deaths were about 8 % higher in Sweden in 2020 than in the previous five years. This proportion fell to 1 % only in 2021 and 4 % in 2022. The three-year average of excess mortality was the lowest among EU countries (Figure 4).

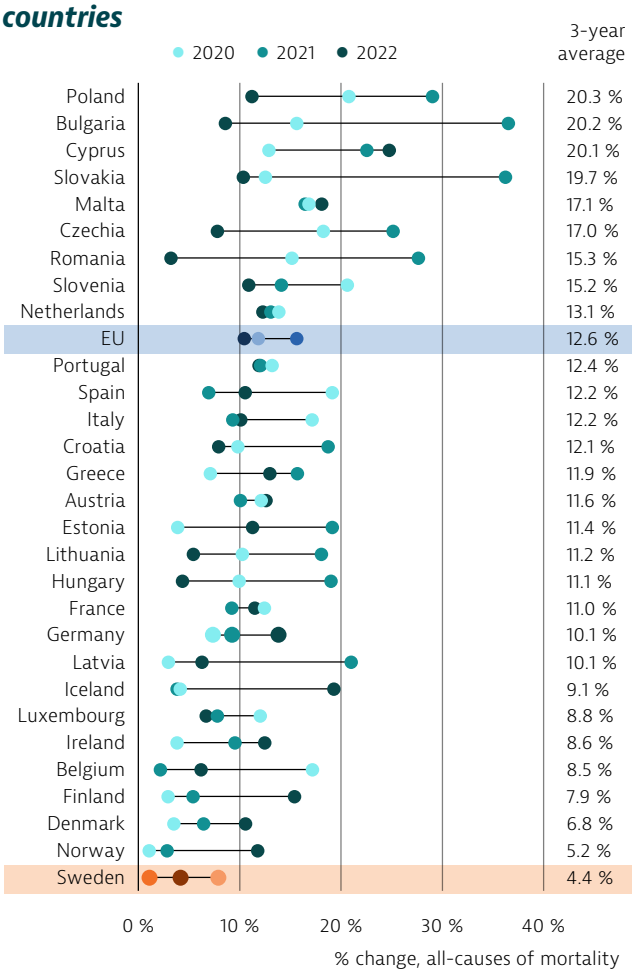
Women and men in Sweden live a greater portion of their lives after age 65 without disabilities

As a result of rising life expectancy, a fertility rate below replacement level and the ageing baby-boom generation, the share of people aged 65 and over in Sweden grew from 17 % in 2000 to 20 % in 2020. This share is projected to increase to 23 % by 2050.

In 2020, 65-year-old women could expect to live another 21.4 years – slightly more than the EU average – while 65-year-old men could expect to live 18.9 years – also above the EU average (Figure 5).

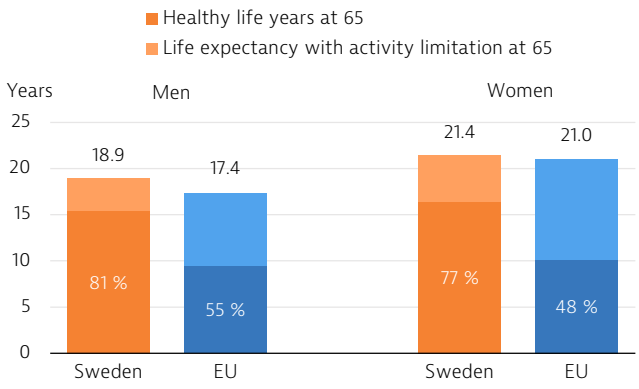
In comparison to other EU countries, in Sweden women and men at 65 enjoy a significantly higher proportion of their additional years of life without disabilities, so the gap in healthy life years between Sweden and the EU average is even wider. Nevertheless, similar to other countries, the gender gap in healthy life years at 65 between Swedish men and women is smaller than the gap in life expectancy. This is because women tend to spend a greater portion of their remaining life years living with disabilities and limitations in daily activities.

Figure 4. The three-year average of excess mortality in Sweden was the lowest among EU countries



Note: Excess mortality is defined as the number of deaths from all causes exceeding the average annual number of deaths in the five years preceding the pandemic (2015-19).
Source: OECD Health Statistics based on Eurostat data.

Figure 5. Older people in Sweden live longer and healthier than the EU average

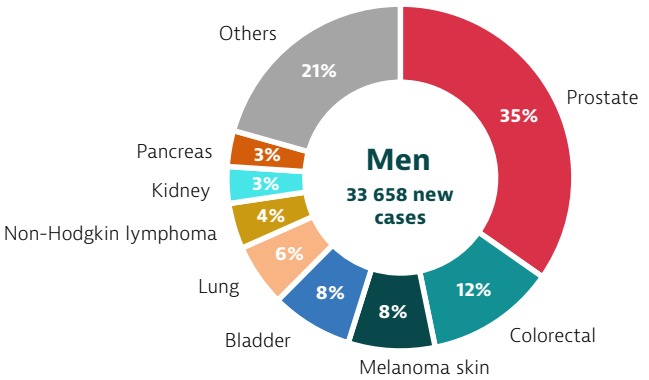


Source: Eurostat Database (data refer to 2020).

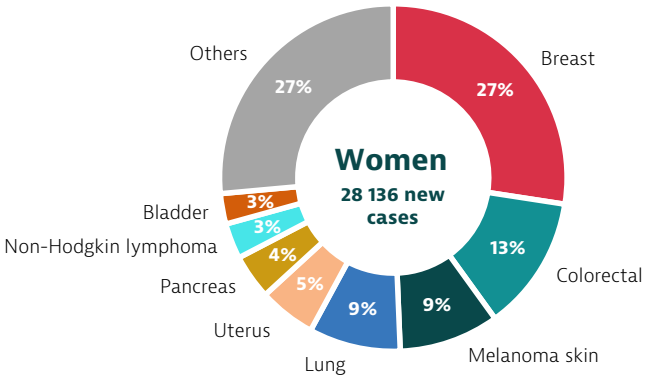
The burden of cancer in Sweden is close to the EU average

According to estimates from the Joint Research Centre, over 61 000 new cases of cancer were expected in 2022. The cancer incidence rate was expected to be slightly lower than the EU average for men and slightly higher for women. Figure 6 shows that the leading cancers among men are prostate and colorectal cancer, while among women the leading cancer is breast, followed by colorectal. Since 2009, Sweden has had national cancer strategies to reduce the risk of cancer, to improve the quality of cancer care, and to reduce differences between population groups in morbidity and survival (see Section 5.1).

Figure 6. Over 61 000 of cancer cases in Sweden were expected to be diagnosed in 2022



Age-standardised rate (all cancer): 667 per 100 000 population
EU average: 684 per 100 000 population



Age-standardised rate (all cancer): 518 per 100 000 population
EU average: 488 per 100 000 population

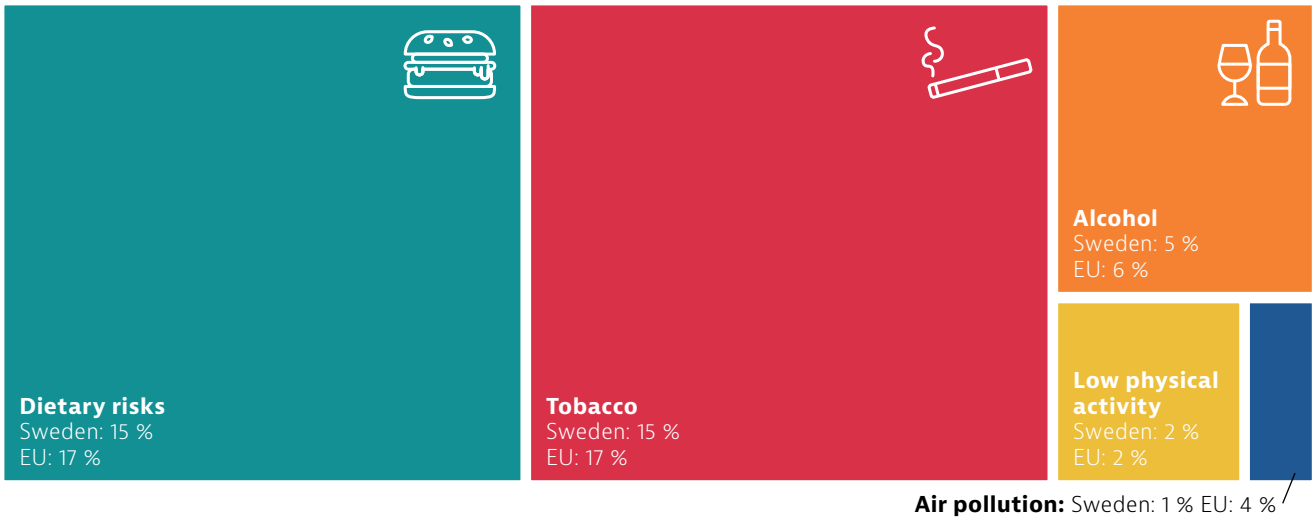
Notes: Non-melanoma skin cancer is excluded; uterus cancer does not include cancer of the cervix.
Source: ECIS – European Cancer Information System.

3 Risk factors

Behavioural risk factors account for over one third of all deaths, a share below EU average

Over one third (34 %) of all deaths in Sweden in 2019 can be attributed to behavioural risk factors – including dietary risks, tobacco smoking, alcohol consumption and low physical activity. This share is below the EU average (39 %). Air pollution in the form of fine particulate matter ($PM_{2.5}$) and ozone exposure alone accounted for about 1 % of all deaths in 2019 – a much lower share than the EU average (Figure 7).

Figure 7. About one in three deaths in Sweden can be attributed to behavioural risk factors



Notes: The overall number of deaths related to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable intake, and high sugar-sweetened beverages consumption. Air pollution includes exposure to $PM_{2.5}$ and ozone.
Sources: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

Smoking among adults is the lowest in the EU, but heavy alcohol drinking persists

Fewer than 10 % of adults in Sweden smoked daily in 2021, down from 14 % in 2010. The proportion of adults who smoke every day in Sweden is the lowest in the EU (Figure 8). These figures, however, do not include the use of other tobacco products. In 2021, 20 % of men and 6 % of women in Sweden used snuff daily. As with other tobacco products, the use of snuff increases the risk of ischaemic heart disease and stroke, as well as pancreatic, mouth and oesophageal cancers.

While overall consumption of alcohol among adults has declined over the past two decades and is now lower than in most other EU countries, heavy drinking remains relatively high. Nearly one in five adults (19 %) reported heavy drinking in 2019, a higher proportion than in many EU countries.[1] Among adolescents, 17 % of 15-year-olds reported in 2022 that they had been drunk more than once in their life – a proportion close to the EU average of 18 %.

Physical activity rates are relatively high, but fruit and vegetable consumption is very low

A greater proportion of Swedish adults report doing at least moderate physical activity each week than in most other EU countries. This is also the case among adolescents, but still only 16 % of 15-year-olds in Sweden reported engaging in at least moderate physical activity each day in 2022 – only a slightly higher proportion than the EU average of 15 %.

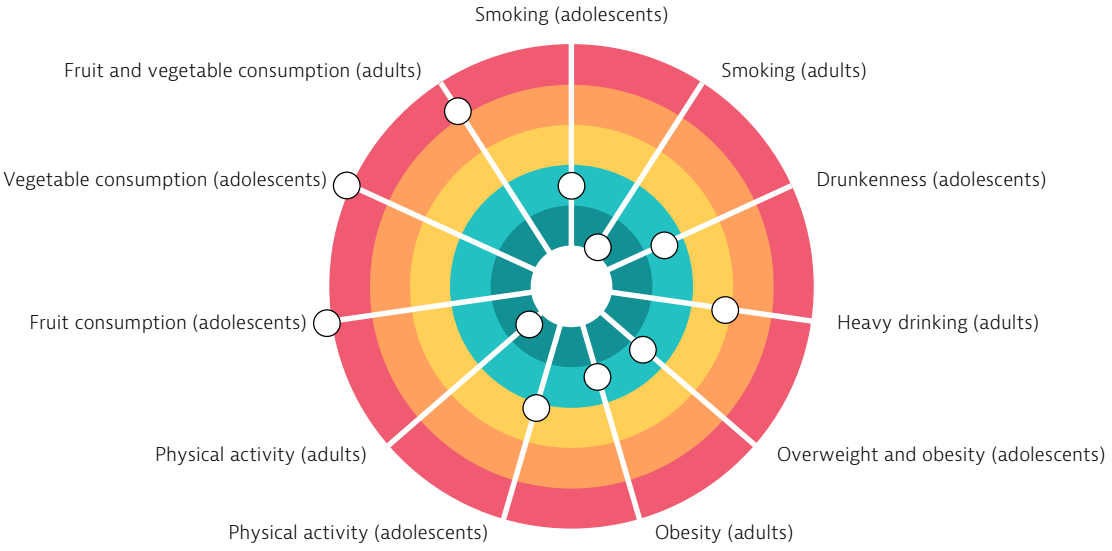
The proportion of adolescents who report eating at least one portion of vegetables or fruit per day is among the lowest among EU countries: only about 20 % of 15-year-olds reported in 2022 that they ate fruit or vegetable each day. Similarly, only 8 % of adults ate at least five portions of fruit and vegetables in 2019 – a lower proportion than in most other EU countries.

1 *Heavy drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults.*

More than one in seven adults in Sweden (15 %) were obese in 2019, a rate that has grown over time but remains lower than in most other EU countries.

The same is also true among adolescents, with almost one in five (19 %) being overweight or obese in 2022 – a rate lower than the EU average (21 %).

Figure 8. Sweden performs better than most EU countries on most risk factors, except fruit and vegetable consumption

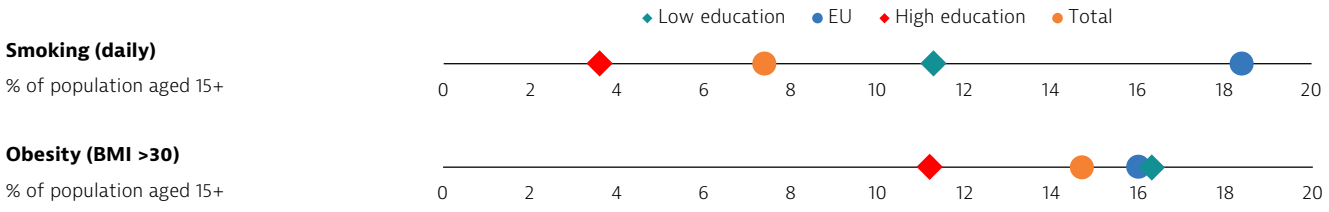


Notes: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white "target area" as there is room for progress in all countries in all areas.
Sources: OECD calculations based on HBSC survey 2022 for adolescents indicators; and EHIS 2019 for adults indicators.

People with lower education are more likely to smoke and be obese

Many behavioural risk factors in Sweden are more common among people with lower education or income levels. According to the 2019 European Health Interview Survey, 11 % of adults who had not completed secondary education smoked daily, compared to only 4 % among those with tertiary education (Figure 9). In the same vein, 16 % of adults without secondary education were obese, compared to only 11 % of those with higher education.

Figure 9. Smoking and obesity rates are higher among the least educated



Note: Low education is defined as people who have not completed secondary education (ISCED 0-2), whereas high education is defined as people who have completed tertiary education (ISCED 5-8).
Source: Eurostat Database (based on EHIS 2019).

4 Health system

The health system is decentralised with national oversight

All Swedish residents are covered for health services, regardless of nationality. The national government is responsible for regulation and supervision, and the 21 regions have responsibility for financing, purchasing and providing healthcare services. The regions oversee primary, specialist and psychiatric healthcare, while the 290 municipalities are responsible for care for people with disabilities, rehabilitation services, home care, elderly care and school healthcare.

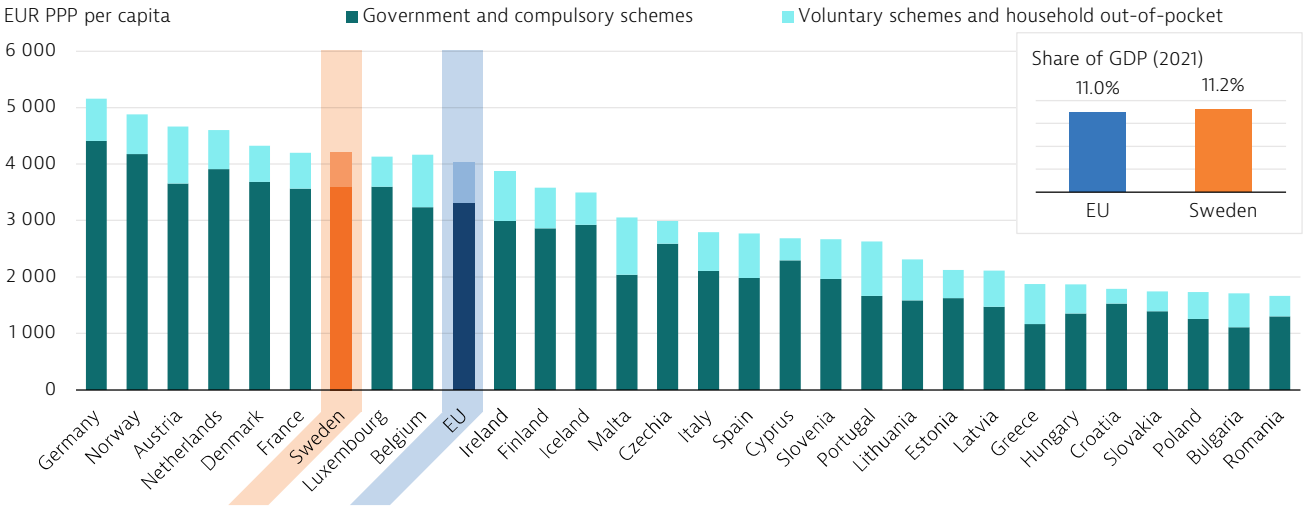
According to the political agreement (the Tidö Agreement) that underpins the government, a government inquiry will investigate how to centralise the healthcare system to improve efficiency and equity and to reduce waiting times. However, the lack of political consensus at the national and local levels is likely to favour more incremental changes. This ongoing inquiry is taking stock of the advantages and disadvantages of a centralised healthcare system and is expected to make politically feasible proposals.

Sweden's health expenditure is slightly above the EU average

In 2021, Sweden's health expenditure amounted to 11.2 % of GDP, a slightly higher share than the EU average of 11.0 %. On a per capita basis and adjusted for differences in purchasing power, health spending was also slightly higher in Sweden than the EU average in 2021 (EUR 4 200 compared to EUR 4 028) (Figure 10).

Public expenditure accounted for 86 % of total health spending – a higher share than the EU average of 81 %. Most of the remaining health spending (13 %) was paid directly out of pocket by households. Small patient fees are charged for almost all types of services, with notable exemptions applicable to vulnerable groups (see Section 5.2). Voluntary health insurance only accounted for about 1 % of health spending, but the take-up has expanded as it can offer quicker access to care.

Figure 10. Sweden spent over 11 % of GDP on health in 2021



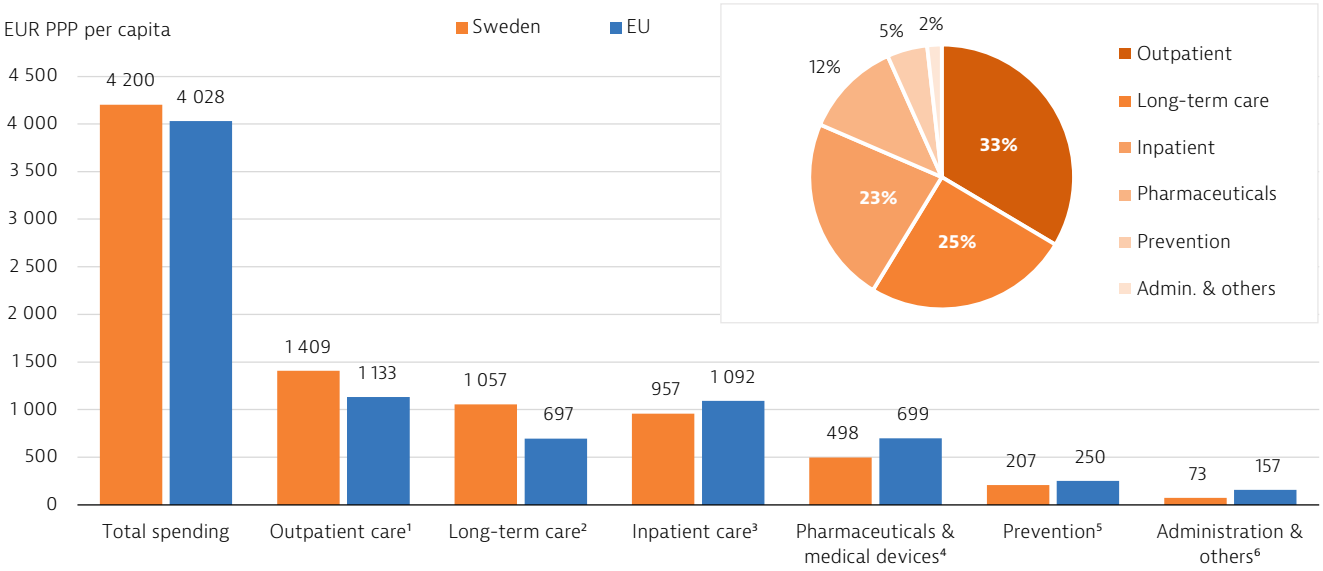
Note: The EU average is weighted.
Source: OECD Health Statistics 2023 (data refer to 2021, except Malta (2020)).

One third of health spending is dedicated to outpatient care

Outpatient care accounted for one third of health spending in 2021 and was the largest category of expenditure in Sweden (Figure 11). One quarter (25 %) of all health spending was dedicated to long-term care – a much higher share than the EU average (16 %). Inpatient care accounted for 23 % of all health spending, which is a lower share than a decade ago, and much lower than the current EU average (28 %). The reduction over the past decade reflects a move towards outpatient services and away from hospital inpatient care. Spending on outpatient medicines is comparatively low because of low prices and high generic substitution.

Spending on public health and prevention increased greatly during the pandemic in Sweden as in other EU countries. It accounted for nearly 5 % of health spending, a greater share than the about 3 % that was usually allocated to prevention before the pandemic.

Figure 11. Outpatient and long-term care make up 60 % of health spending



Notes: 1. Includes home care and ancillary services (e.g. patient transportation); 2. Includes only the health component; 3. Includes curative-rehabilitative care in hospital and other settings; 4. Includes only the outpatient market; 5. Includes only spending for organised prevention programmes; 6. Includes health system governance and administration and other spending. The EU average is weighted.
Source: OECD Health Statistics 2023 (data refer to 2021).

Sweden has universal population coverage for health services, and user charges are low

Coverage is universal in Sweden, with health services either freely available or accessible with small copayments. User charges are set by the regions. For 2023, fees were SEK 150-300 (EUR 13-26) for a primary care visit, and up to SEK 400 (EUR 35) for a specialist visit. User fees for medical consultations are capped at SEK 1 300 (EUR 116) per individual per year, and for prescribed medicines at SEK 2 600 (EUR 233). Exemptions from user charges apply for people under 20, older people and pregnant women.

Most hospitals are publicly owned while several private primary care providers offer care

Both public and privately owned healthcare facilities are publicly funded in Sweden. Public hospitals at the regional level provide acute care, while university hospitals provide highly specialised care. Private hospitals also exist. Patients are covered by the same regulations and fees in both types of facilities. Following the act on compulsory patient choice in primary care in 2010, the number of patients seeking care with private primary care providers expanded, including for online consultations.

Private health insurance coverage is low, but raises concerns about equity

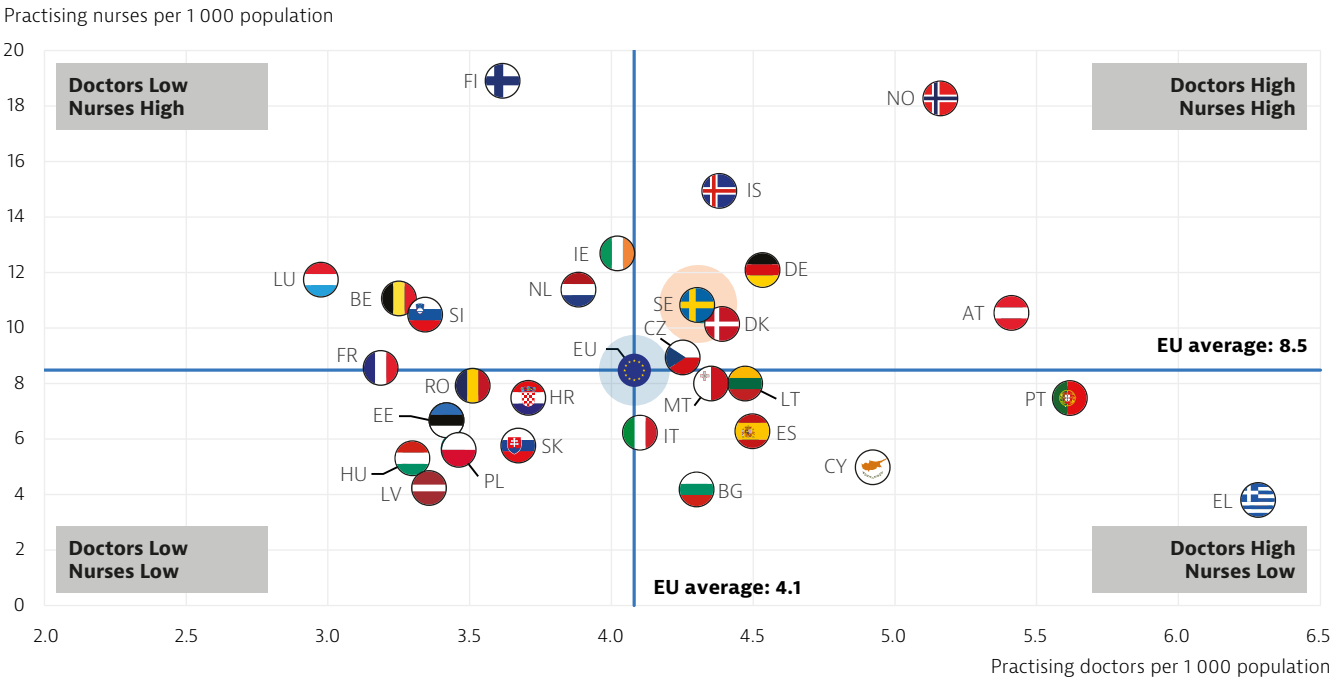
The number of people with private health insurance has increased in the last 15 years. In 2021, about 7 % of people had voluntary health insurance. This is mostly employment based and mainly provides people with faster access to outpatient visits and elective surgery, health check-ups and other occupational health services.

Although private health insurance coverage is low, it gives rise to concerns about equity in access. Healthcare covered by supplementary health insurance is provided by private care providers that often also offer publicly funded care. In the agreements between the care providers and the insurance companies, the waiting time for a specialist visit is often capped at 7 days and for surgery at 21 days. In contrast, agreements with regions for publicly funded care are often based on a maximum of 90 days (the national waiting-time guarantee). Care providers may prioritise patients with supplementary insurance to fulfil the agreements with the insurance companies, raising equity concerns that priority may not be based on needs.

The densities of doctors and nurses are higher than the EU averages

Sweden had higher numbers of doctors and nurses per 1 000 population than the EU averages in 2020, at 4.3 doctors (compared to the EU average of 4.1) and 10.7 nurses (compared to the EU average of 8.5) (Figure 12).

Figure 12. Sweden has a higher number of doctors and nurses per 1 000 population than the EU average



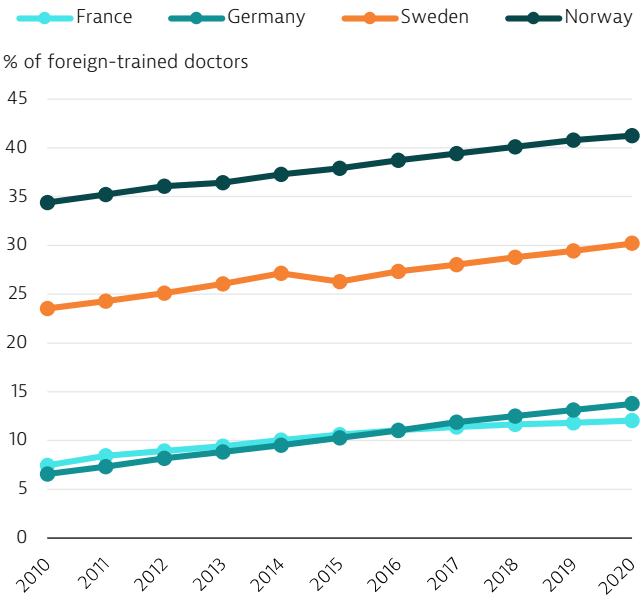
Notes: The EU average is unweighted. The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Greece, the number of nurses is underestimated as it only includes those working in hospitals.
Source: OECD Health Statistics 2023 (data for most countries refer to 2021 except Sweden (2020)).

The number of doctors has increased since 2000, driven in part by an increasing number of foreign-trained doctors. The share of foreign-trained doctors increased from 24 % of all doctors in 2010 to 30 % in Sweden in 2020 (Figure 13). However, over one fifth of these foreign-trained doctors are Swedish citizens who went abroad to obtain their first medical degree before returning to Sweden. The number of foreign-trained but native doctors has quadrupled since 2006 due mainly to limited capacity in domestic medical schools.

Despite the increasing density of doctors, several regions report shortages of general practitioners (GPs) (see Section 5.2). The share of GPs in Sweden is much lower than the EU average (14 % compared to 20 %).

The density of nurses has remained stable in the last decade, and several regions report some shortages – especially of specialist nurses.

Figure 13. The share of foreign-trained doctors in Sweden increased to 30 % in 2020



Note: In 2020, over one fifth of foreign-trained doctors in Sweden and over half of foreign-trained doctors in Norway were people born in these countries who went abroad to obtain their first medical degree before returning.
Source: OECD Health Statistics 2023.

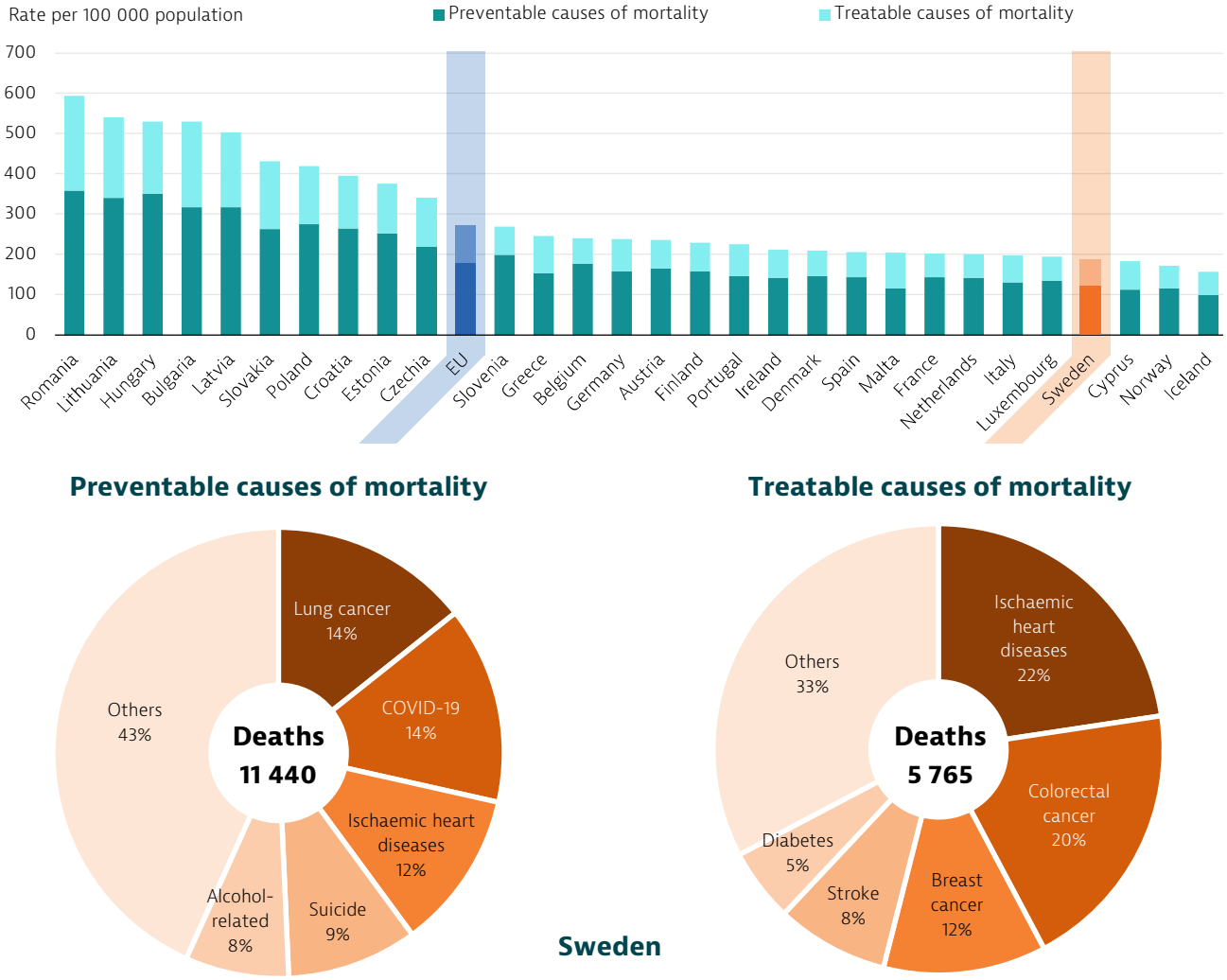
5 Performance of the health system

5.1 Effectiveness

Sweden has one of the lowest rates of avoidable causes of mortality in the EU

Sweden had very low rates of mortality from preventable and treatable causes in 2020, which point to an effective public health and healthcare system in avoiding deaths from conditions that are deemed to be preventable or treatable (Figure 14). The low preventable mortality rate is largely due to low rates of premature deaths from lung cancer and cardiovascular diseases.

Figure 14. Avoidable mortality was among the lowest in the EU in 2020



Notes: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable (or amenable) mortality is defined as death that can be mainly avoided through healthcare interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The lists attribute half of all deaths from some diseases (e.g. ischaemic heart disease, stroke, diabetes and hypertension) to the preventable mortality list and the other half to treatable causes, so there is no double-counting of the same death.
Source: Eurostat Database (data refer to 2020).

Sweden has a long tradition of public health policies to reduce risk factors

Sweden's low levels of preventable deaths from causes such as lung cancer, alcohol-related deaths and road traffic accidents can be explained in part by strong public health policies. Public awareness campaigns and high taxes on tobacco and alcohol have contributed to restricting consumption. The alcohol control policy is characterised by a state retail monopoly, which limits access to dedicated stores with restricted opening hours. It also imposes a minimum age of 20 to buy alcohol in Systembolaget, the government-owned chain of alcohol stores.

In 2021, Sweden adopted a Comprehensive Strategy against Alcohol, Narcotics, Doping, Tobacco and Gambling for 2021-25. Building on the previous strategies since 2011, its overarching goal is a society free from illicit drugs, with reduced alcohol-related harm and reduced tobacco use.

Low mortality from traffic accidents is the result of a longstanding road safety strategy, called Vision Zero, which has as an ultimate goal that nobody should be killed or seriously injured in traffic accidents. This strategy has been successful: fewer than 200 people died in road accidents in Sweden according to preliminary figures for 2021 – down from over 500 in 2003 (European Road Safety Observatory, 2022).

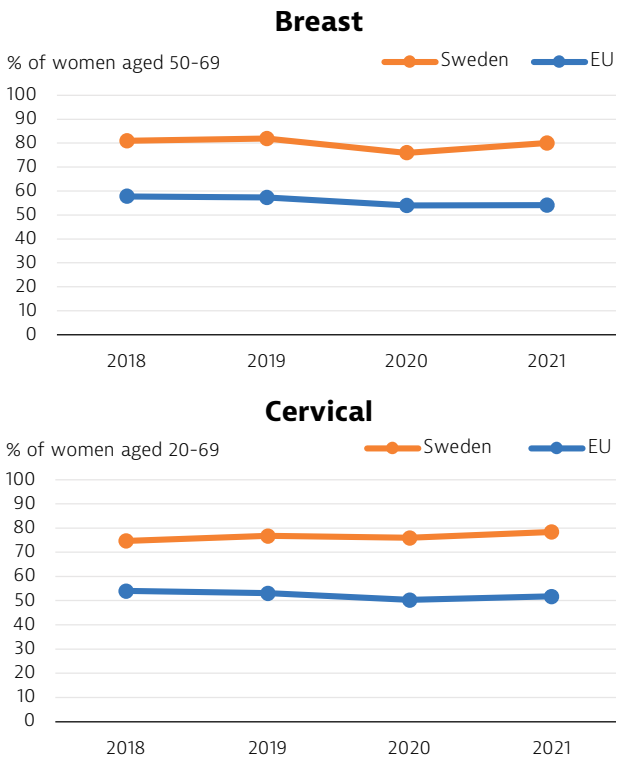
Sweden has high screening rates for breast and cervical cancer, and is fully rolling out colorectal cancer screening

Sweden has three nationwide population-based cancer screening programmes that are free of charge for participants, related to breast, cervical and colorectal cancers (OECD, 2023a).

All Swedish regions offer mammography screening for women aged 40-74, and cervical cancer screening is also rolled out nationally for women aged 23-64. Participation rates in these two screening programmes have been well above EU averages both before and during the pandemic. While screening rates fell slightly during the first year of the pandemic in 2020, it went back up in 2021, although breast cancer screening rates still remained slightly below their pre-pandemic levels in 2021 (Figure 15).

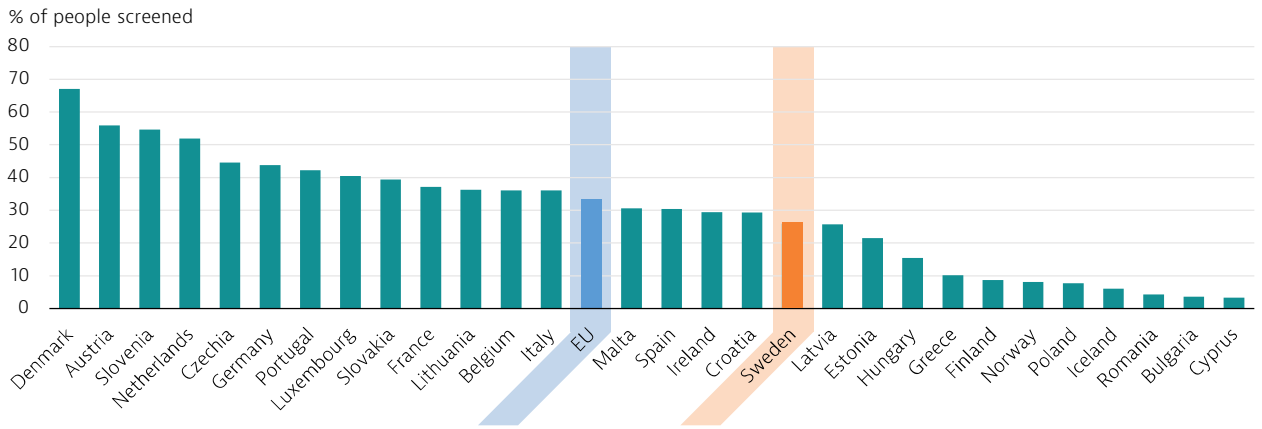
On the other hand, screening for colorectal cancer was not widely offered to men and women across the country until 2021, and only 2 of the 21 regions provided screening for their residents aged 50-59 prior to that. This explains why only 26 % of people aged 50-74 in Sweden reported having been screened in the last two years in 2019, which was a lower share than the EU average of 33 % (Figure 16). In 2022, however, all regions sent invitations to participate in colorectal cancer screening, completing the programme rollout, which is expected to result in higher screening rates.

Figure 15. Breast and cervical cancer screening rates are well above EU averages



Note: The EU average is unweighted. Rates refer to the share of individuals within the target groups who have undergone screening periodically.
Source: OECD Health Statistics 2023 (based on national programme data).

Figure 16. Relatively low colorectal cancer screening rates in 2019 reflected incomplete programme rollout



Notes: The EU average is weighted. Survey data from 2019, referring to people aged 50-74 screened over the past two years.
Source: Eurostat Database (based on EHIS 2019).

5.2 Accessibility

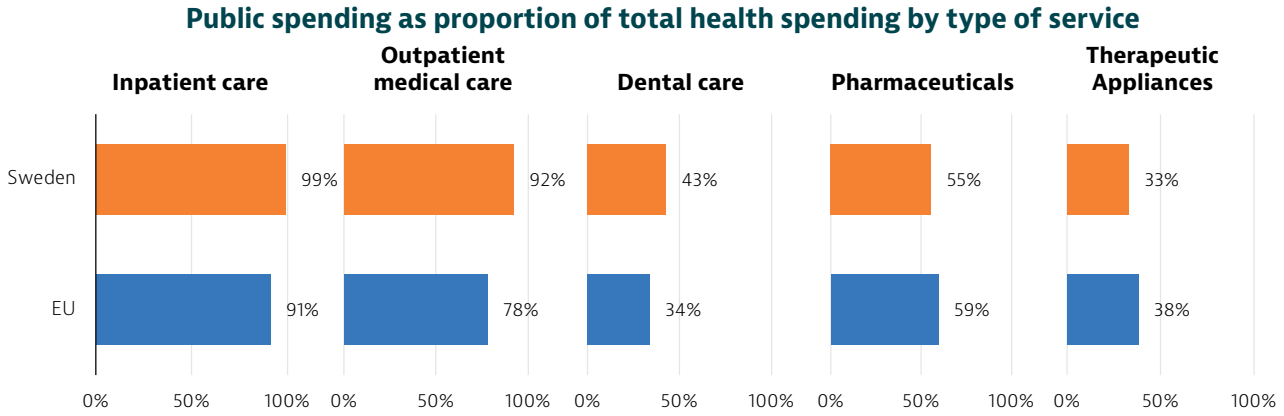
The benefits package is broad, but some disparities exist across regions

All residents in Sweden are entitled to publicly funded health services, and the regulation of health service provision to recently arrived immigrants has also improved in recent years. Even though Sweden has a broad benefits package and a healthcare law with a strong focus on equity and needs-based provision, the regional structure – with 21 autonomous regions – leads to some disparities in service coverage rules in different parts of the country. To mitigate this structural problem, the National Board for Health and Welfare and the Swedish Association of Local Authorities and Regions work together to agree on common guidelines and strategies.

Copayment caps mitigate the negative impact of user fees, but cost barriers exist

Some 13 % of health spending in Sweden is funded out of pocket – a slightly lower share than the EU average (14.5 %). Copayments are applied to almost all types of services and goods, with the exceptions of maternal and child health services provided in primary care settings and some services for people aged over 85. The regions set the copayments independently, and the copayment structure provides an incentive to consult primary care providers over hospital visits. The caps on copayments for outpatient consultations and for prescribed medicines are set nationally, while the specific fees for outpatient consultations are decided regionally. Public coverage is lower for dental care, pharmaceuticals, and therapeutic appliances than for inpatient and outpatient care (Figure 17). Dental care is generally subject to higher copayments, except for those aged under 24.

Figure 17. Coverage is greater for inpatient and outpatient care than for dental care and pharmaceuticals



Notes: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines and medical non-durables. Therapeutic appliances refer to vision products, hearing aids, wheelchairs and other medical devices. The EU average is unweighted.
Source: OECD Health Statistics 2023 (data refer to 2021 or nearest available year).

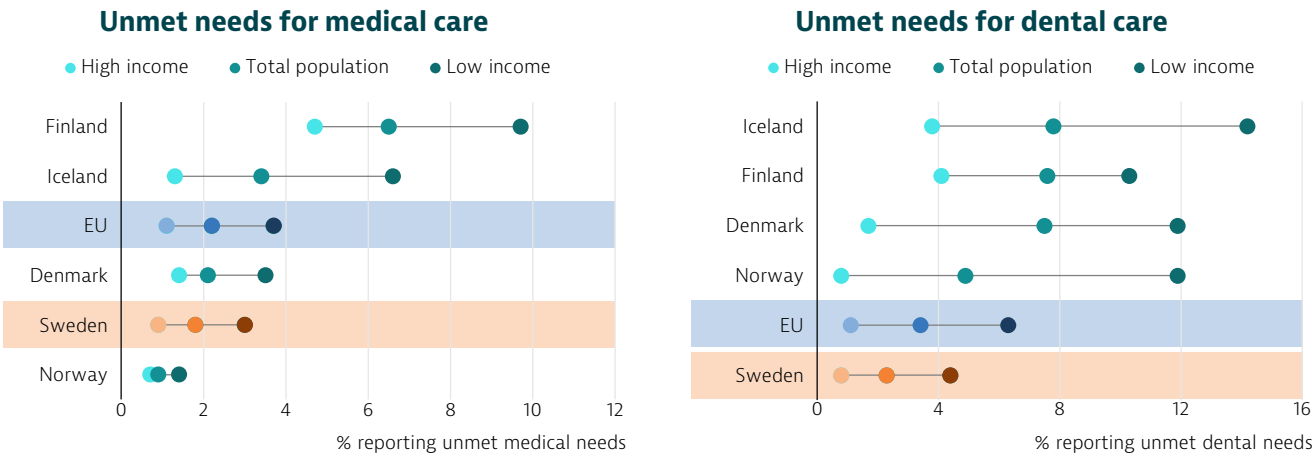
Unmet medical and dental care needs are low

According to EU-SILC data, unmet needs for medical care were low: less than 2 % of all respondents and 3 % of respondents on low incomes reported episodes of unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times in 2022. The percentage of people reporting unmet needs for dental care in Sweden was also low: only 2.3 % of all respondents reported such unmet dental care needs in 2022, but it was almost twice the overall average among people in the lowest income group (Figure 18).

The COVID-19 pandemic and related containment measures limited access to health services. Surveys carried out in spring 2021 and spring 2022 found that 15 % and 19 % of the population reported having current unmet healthcare needs at the time of the survey (Figure 19). These proportions were close to the EU averages.[2]

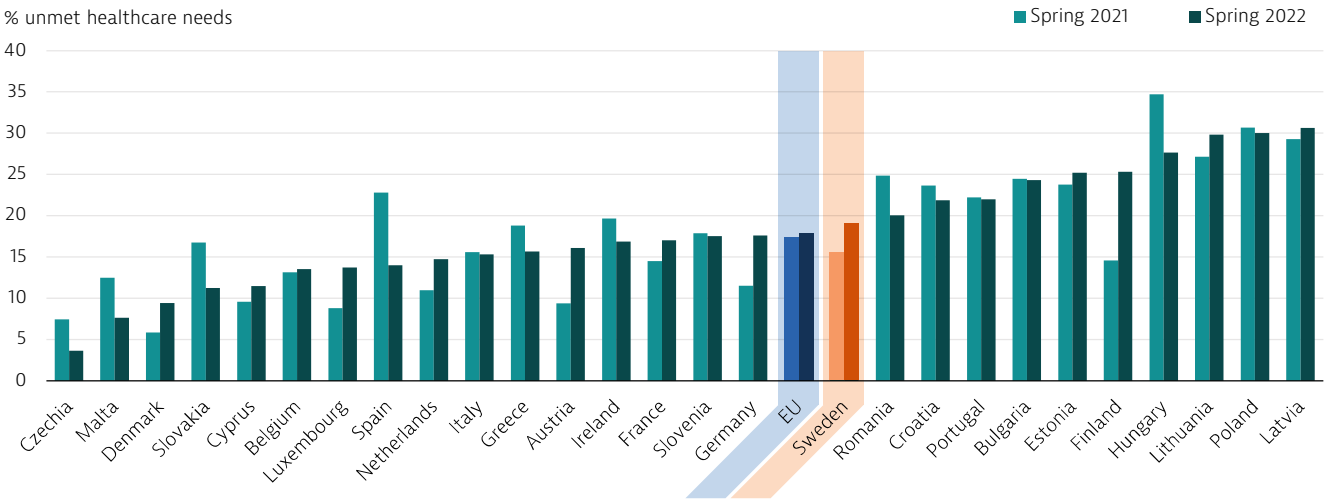
2 *The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.*

Figure 18. Unmet medical care needs are low, but unmet dental care needs are higher for people on low incomes



Note: Data refer to unmet needs for a medical or dental examination or treatment due to costs, distance to travel or waiting times.
Source: Eurostat Database, based on EU-SILC (data refer to 2022, except Norway (2020) and Iceland (2018)).

Figure 19. Unmet healthcare needs in spring 2021 and spring 2022 in Sweden were close to EU averages



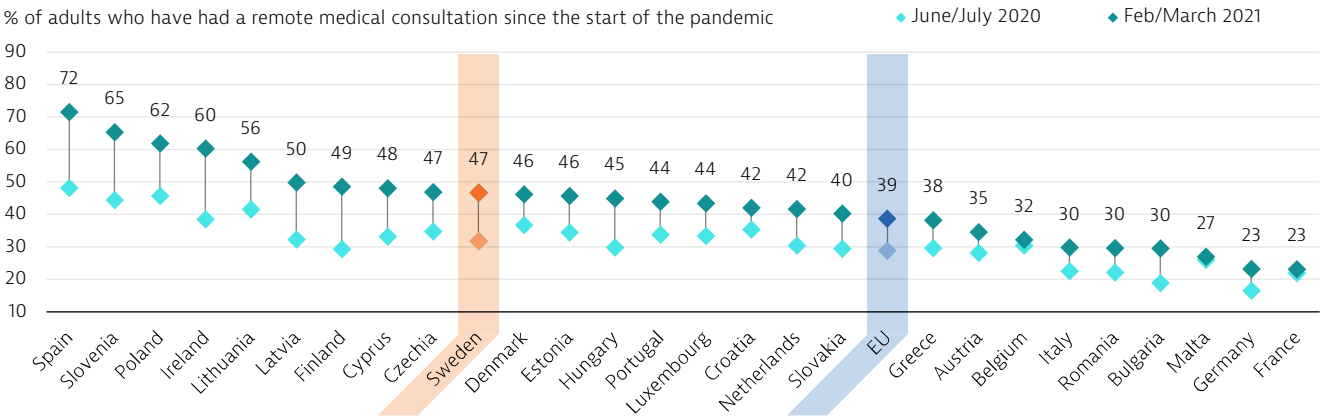
Note: The EU average is weighted.
Source: Eurofound (2022), Living, working and COVID-19 e-survey.

Sweden regulated teleconsultations to integrate them better into local healthcare systems

Telehealth services were one complementary solution to maintain or improve access to care during the pandemic. Nearly half (47 %) of Swedish adults reported in early 2021 having had at least one teleconsultation since the start of the pandemic, up from 30 % in summer 2020 (Figure 20). The number of teleconsultations increased sharply during the pandemic, but they still account for a small share of the total number of doctor consultations – about 18 % of GP primary care consultations in 2020.[3] Teleconsultations not only replace in-person consultations but also induce new care consumption, creating a risk that they might increase demand for lower-value care. Teleconsultations have led to increased costs for the regions, despite lower average costs per consultation, because of this newly induced demand. Unlike in-person consultations, the use of teleconsultations is higher among those with high education and income levels (Swedish Agency for Health and Social Care Analysis, 2022).

3 *In Sweden, only mobile phone applications and video consultations are covered as in-person consultations (not telephone calls).*

Figure 20. Almost half of Swedish adults had at least one teleconsultation during the first year of the pandemic



Notes: The EU average is weighted. Low reliability for 2021 data from Cyprus, Latvia and Malta, and for 2021 and 2020 data from Luxembourg because of low sample sizes.
Source: Eurofound (2022), Living, working and COVID-19 e-survey.

Teleconsultation use has risen since digital healthcare providers located in all 21 regions were allowed to offer the service throughout the country in 2015. As regions have financial responsibility for covering care that their residents receive in other regions, a recommended teleconsultation price and a minimum patient fee were agreed across the country in 2017. Following the rise in teleconsultation use during the pandemic, new legislation was passed in 2022 to integrate teleconsultations better into local healthcare systems; this requires Swedes to register in only one primary care centre, and caps changes of primary care centre at two per year.

Furthermore, Sweden is set to invest EUR 3.8 million to develop e-health services and applications as part of the rollout of the EU Cohesion Policy 2021-27 programming. About 40 % of this amount will be co-financed by the EU.

Waiting times continue to attract public attention

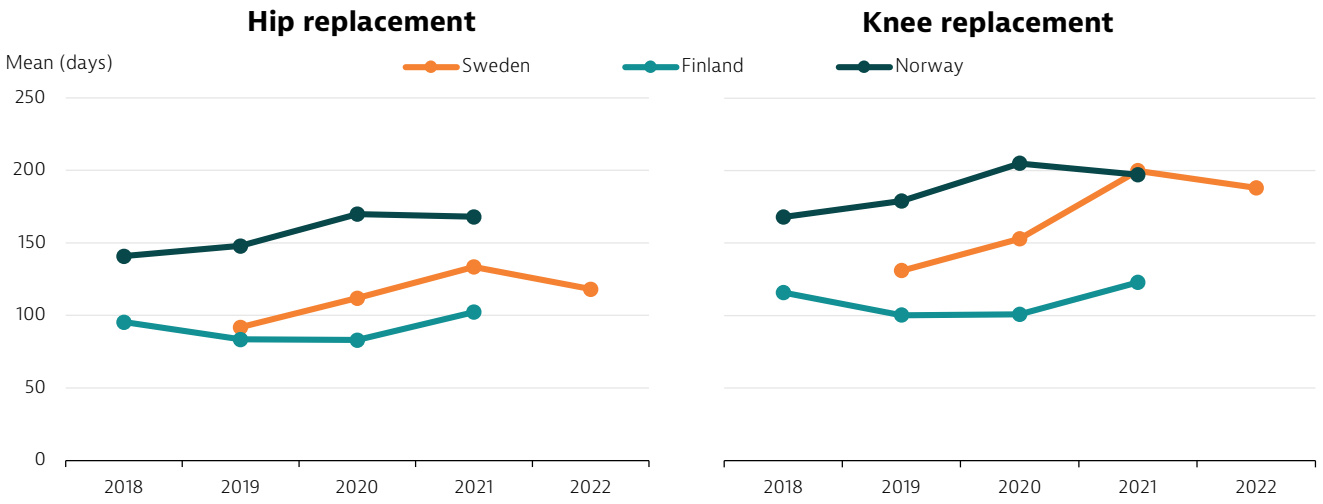
Long waiting times have been a longstanding feature of the Swedish health system, and the problem has been subject to numerous debates and policy initiatives since well before the pandemic. The most important policy initiative was the Health Guarantee Act of 2010, which stipulated maximum waiting times for different types of services. Other initiatives included national programmes to incentivise regions to reduce queues (these were abolished in 2015) and increase transparency through regular publication of data on waiting times. This monitoring was initially developed at the regional and national levels, and from 2019 onwards, extended to the individual provider level in primary care, and subsequently, as of 2021, at the hospital level.

The Swedish Association of Local Authorities and Regions uses four core indicators to measure the care guarantee in accordance with the law: contact with primary care on the same day, a medical assessment within three days, a first visit to specialist care within 90 days, and an intervention within 90 days.

The disruption of hospital and other health services during the pandemic resulted in substantial increases in waiting times in 2020 and 2021, particularly for specialist care. In March 2020, 80 % of patients had a first consultation with a specialist within 90 days and 71 % had an intervention within 90 days. These shares dropped to 67 % for a specialist consultation and 44 % for an intervention by June/July 2020.

Focusing on specific interventions, the mean waiting time for patients to get a hip replacement increased from 92 days in 2019 to 112 days in 2020, and continued to increase further in 2021, before it started to fall in 2022. The pattern was similar for knee replacement although the waiting time was generally higher both before and during the pandemic: it increased from 131 days on average in 2019 to 153 days in 2020 and 200 days in 2021, before starting to fall slightly in 2022 (Figure 21). The mean waiting time for these two interventions was higher in Sweden than in Finland in 2021, but lower than in Norway for hip replacement, although the data is not strictly comparable because the measurement of waiting times start earlier in the patient care pathways in Norway.

Figure 21. Waiting times for hip and knee replacements increased greatly following the pandemic



Note: Waiting times in Norway are overestimated due to an earlier starting point in the measurement process.
Source: OECD Health Statistics 2023.

The number of advanced practice nurses in primary care remains very limited

Sweden has increased the scope of practice for nurses by developing positions for specialist nurses in primary care to improve access to care in a context of a low supply of GPs. Such advanced practice nurses receive additional training at the master's degree level. However, as of 2022, there were only about 35 advanced practice nurses in Sweden. The main barriers to the deployment of such advanced practice nurses include the lack of positions with clearly defined tasks and low wage supplements compared to regular nurses. The National Health Competence Council recommended in 2023 to introduce this professional role as a regulated profession to support its deployment in primary care. The Council recognised that a thorough review is necessary regarding the educational pathways and the specific roles and functions of advanced practice nurses to reach an agreement between stakeholders and the creation of new posts (Nationella vårdkompetensrådet, 2023).

5.3 Resilience

The COVID-19 pandemic has proved to be the most significant disruption to health systems in recent decades. It has shed light on the vulnerabilities and challenges in countries' emergency preparedness strategies and on their ability to provide healthcare services to their populations. In response to the enduring effects of the pandemic – as well as other recent crises, such as cost-of-living pressures and the impact of conflicts like the war against Ukraine – countries are implementing policies to mitigate the ongoing impacts on service delivery, invest in health system recovery and resilience,[4] improve critical areas of the health sector and fortify their preparedness for future shocks.

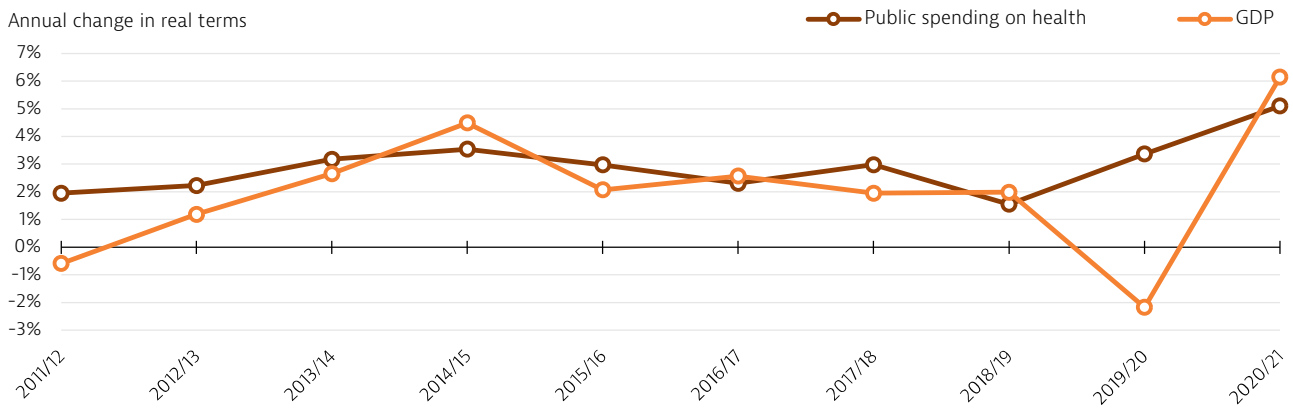
Sweden's COVID-19 response led to a significant increase in public spending on health in 2020 and 2021

In the years before the pandemic, public spending on health in Sweden was growing at a rate of 2-3 % per year in real terms, and was generally growing in line with GDP. In the first year of the pandemic, public spending on health started to increase more rapidly, by 3.4 % in 2020, and the growth rate accelerated to over 5 % in 2021 (Figure 22). The strong growth rate in 2021 was driven by the cost directly related to managing the COVID-19 pandemic and the vaccination campaigns, as well as a "catch-up" effect of healthcare activities that were postponed during the first year of the pandemic.

The substantial increase of government health spending in response to the pandemic confirmed a trend in the funding mix of health expenditure over time, by giving more weight to spending by the national government. National government spending in 2020 (including direct spending on certain national programmes, investment and indirect spending in the form of a general equalisation grant and a targeted prescribed medicines grant) accounted for 25 % of overall health spending, up from 20 % in 2019.

4 *In this context, health system resilience has been defined as the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks (EU Expert Group on Health Systems Performance Assessment, 2020).*

Figure 22. The pandemic led to a strong increase in public spending on health

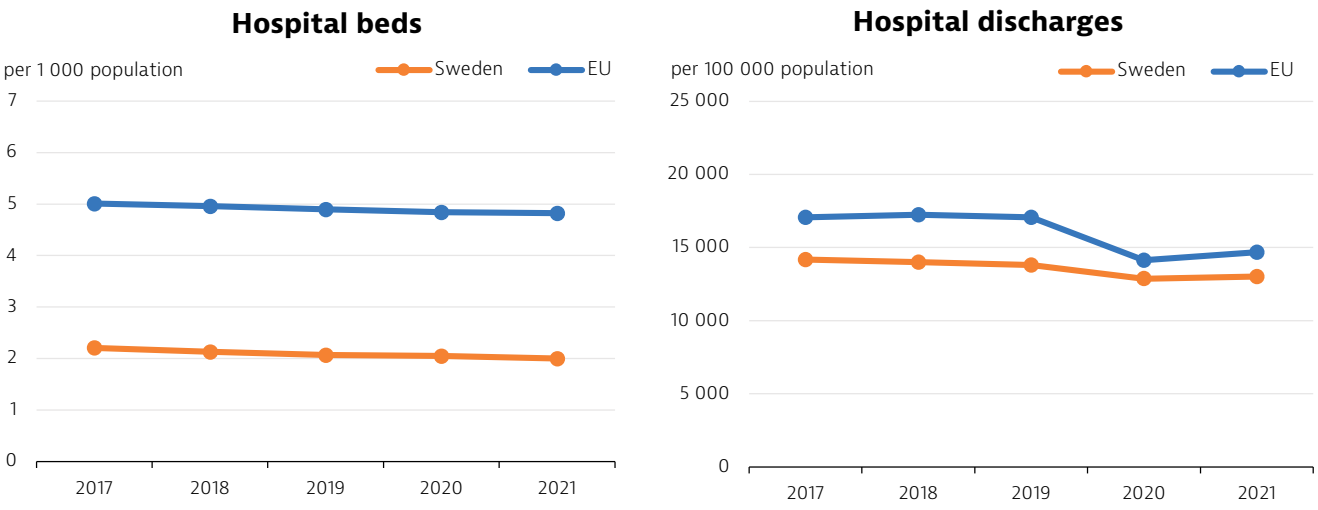


Source: OECD Health Statistics 2023.

The number of hospital beds in Sweden is very low, and hospital stays are also lower than the EU average

In the years before the pandemic, Sweden had fewer hospital beds per population than any other EU country (2.1 hospital beds per 1 000 population in 2019 compared to EU average of 4.9 per 1 000), and this situation did not change during the pandemic. This is partly because most rehabilitation and long-term care beds are not located in hospitals. To address the sudden increase in demand for intensive care during the first year of the pandemic, Sweden increased its intensive care unit capacity mainly by redeploying existing beds and by postponing non-urgent hospital care to create a buffer of excess resources (beds, staff and equipment) while at the same time reducing the risk of hospital outbreaks (OECD, 2023b). As a result of these disruptions, hospital stays fell by 7 % in 2020, although this reduction was much less pronounced than the EU average (Figure 23).

Figure 23. Hospital beds per capita in Sweden were the lowest in the EU before and during the pandemic



Note: The EU average is unweighted.
Source: OECD Health Statistics 2023.

Following recent national evaluations that concluded that the number of hospital beds in Sweden is insufficient, the government tasked the National Board of Health and Welfare to allocate SEK 2 billion (EUR 175 million) in performance-based payments to regions to increase the number of beds in 2023. In addition, the Board is developing a national plan to reduce current bed shortages.

The pandemic drew attention to the long-term care sector, leading to a proposed new Elderly Care Act

The pandemic brought increased attention to the shortcomings of the long-term care sector in Sweden. Structural issues – such as the persistent lack of staff as a result of unattractive working conditions – affect the quantity, quality and safety of long-term care services. These challenges hindered the response to the pandemic (Statens Offentliga Utredningar, 2022).

To address these issues, a budget of EUR 452 million from Sweden's Recovery and Resilience Plan has been allocated to improve long-term care by upskilling and training new staff.[5] In addition, a national inquiry published in 2022 proposed the adoption of a special Elderly Care Act to complement the existing Social Services Act (Statens Offentliga Utredningar, 2022). The proposal aims to clarify the mission and content of elderly care and to improve quality standards and monitoring. It contains new objectives in terms of prevention and health promotion, and access to services.

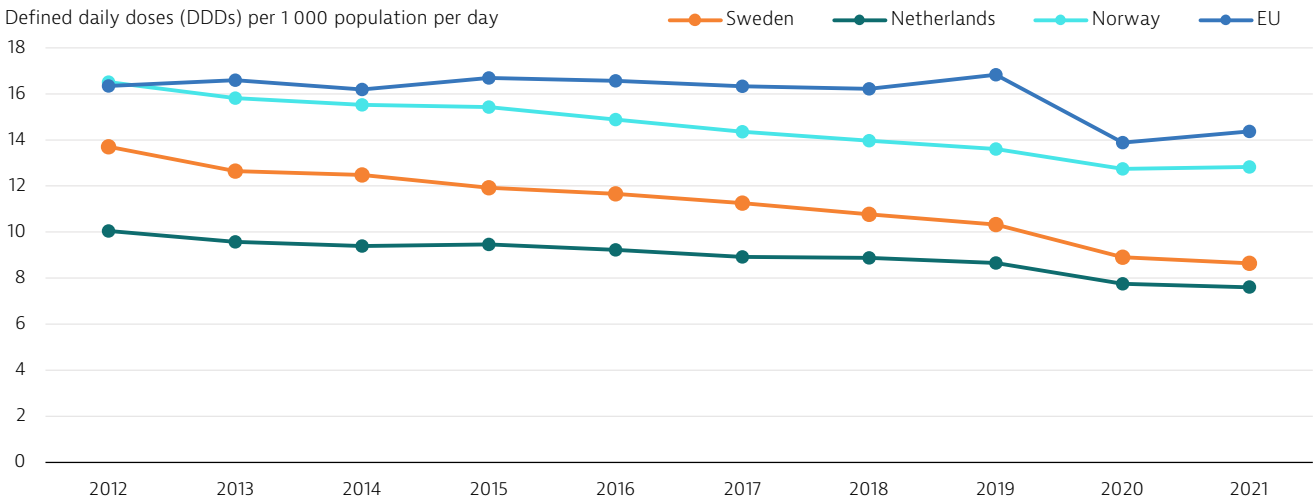
Sweden has one of the lowest community antibiotic consumption rates among EU countries

Antimicrobial resistance (AMR) is a major public health concern in the EU, with estimates of about 35 000 deaths due to antibiotic-resistant infections (ECDC, 2022), and healthcare-associated costs of around EUR 1.1 billion per year (OECD/ECDC, 2019). Antibiotic overprescription and overuse in humans are major contributors to AMR.

Sweden had one of the lowest rates of antibiotic consumption in the community (excluding hospitals) across EU countries in 2021, and the consumption has gradually decreased over the past decade and during the pandemic (Figure 24).

Sweden takes a comprehensive approach to address AMR. The strategy for 2020-23 has the overarching goal of preserving the possibility of effective treatment of bacterial infections in humans and animals (Government Offices of Sweden, 2023). It comprises seven objectives, including enhancing monitoring and surveillance systems to track antibiotic consumption and resistance patterns; establishing robust infection prevention and control measures in healthcare settings; promoting a responsible use of antibiotics; and increased public awareness of antibiotic resistance.

Figure 24. Antibiotic consumption in Sweden has decreased over the past decade



Notes: The EU average is unweighted. Data cover only consumption in the community (excluding hospitals).
Source: ECDC ESAC-Net.

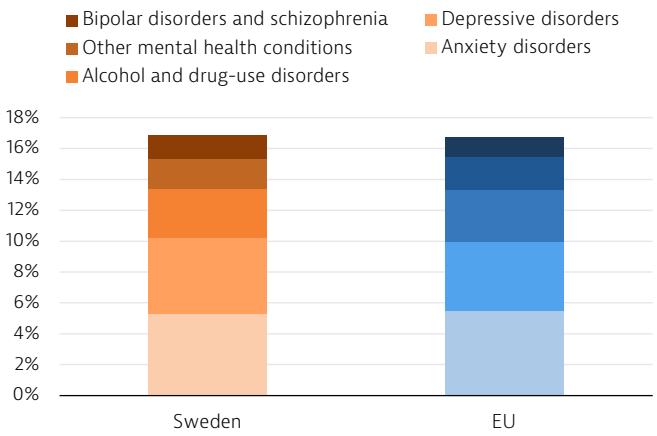
5 *These figures on Sweden's Recovery and Resilience Plan refer to the original Annex to the Council Implementing Decision regarding the approval of the Recovery and Resilience Plan for Sweden. These may be amended by the end of 2023.*

6 Spotlight on mental health

The estimated rate of mental health issues is close to the EU average

Although there are significant gaps in information about the prevalence of mental health issues in Sweden, as in all EU countries, the available evidence suggests that mental health issues affect a large number of people every year. According to IHME estimates, about 17 % of people had a mental health disorder in Sweden in 2019 – a proportion similar to the EU average (Figure 25). The most common mental disorders in Sweden are anxiety disorders and depressive disorders (each affecting 5 % of the population). An estimated 3 % of the population have alcohol and drug-use disorders. Severe mental illnesses such as bipolar disorders and schizophrenia affect about 1 % of the population.

Figure 25. An estimated one in six people had a mental health issue in 2019

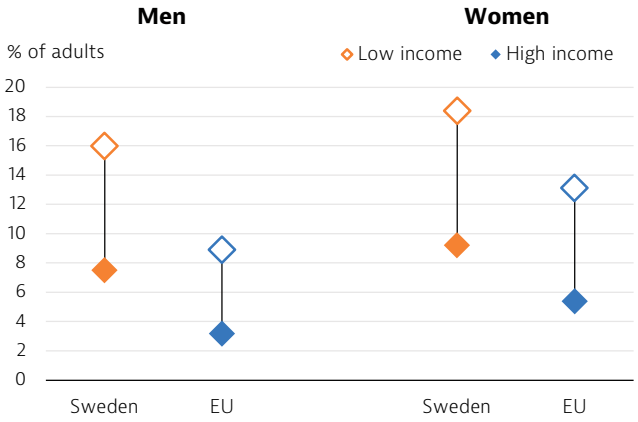


Note: The EU average is unweighted.
Source: IHME (data refer to 2019).

Several mental health conditions are more common among women than men, including anxiety disorders, depressive disorders and bipolar disorders. Some of these gender gaps may be due to a greater propensity of women to report these problems. However, one exception is alcohol and drug-use disorders that are reported more frequently by men.

There is a substantial socioeconomic gap in self-reported depression. In Sweden, as in all other EU countries, people on lower incomes are more likely to report depression: about 16 % of men and 18 % of women in the lowest income quintile reported depression compared to only 8 % of men and 9 % of women in the highest income quintile in 2019 (Figure 26). People who are employed typically report lower levels of depression than those who are unemployed, as employment tends to enhance self-esteem and societal sense of worth. Conversely, job loss generally exacerbates mental health issues.

Figure 26. People on lower incomes are twice as likely to report depression as those on high incomes in Sweden as in other EU countries



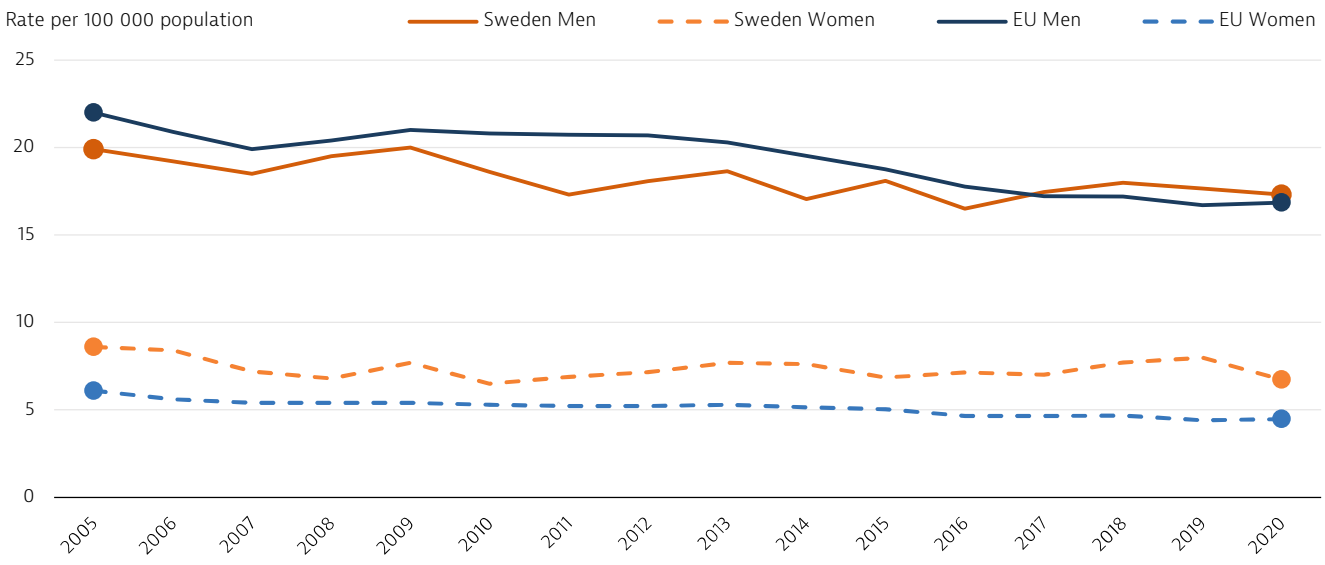
Note: High income refers to people in the top income quintile (20 % of the population with the highest income), whereas low income refers to people in the bottom income quintile (20 % of the population with the lowest income).
Source: Eurostat Database (based on EHIS, 2019).

The number of suicides among men and women in Sweden declined on average between 2005 and 2020, and was close to the EU average for men but above it for women. As in other EU countries, most of the 1 200 suicides in 2020 in Sweden were among men (Figure 27). However, the gender gap in suicide attempts is reversed in Sweden, because women often do not use a method that brings on death. Among the 7 580 people hospitalised for suicide attempts in 2021, 62 % were women (Karolinska Institutet, 2022). Various factors, such as significant life events (e.g. loss of a loved one, divorce, job loss), social isolation and socioeconomic or cultural factors, can contribute to suicidal thoughts and attempts.

The mental healthcare system fosters a community-based approach

In Sweden, the national government has overall responsibility for mental healthcare, and sets policies, regulations and guidelines. Regional authorities have responsibility to plan, organise and deliver mental healthcare, while municipalities

Figure 27. Suicide rates have decreased in Sweden since 2005, but remain above the EU average for women



Source: Eurostat Database.

provide social services and are responsible for substance abuse and addiction treatment. In addition, the Public Health Agency of Sweden is responsible for the coordination of the national work on mental health and suicide prevention.

Sweden places strong emphasis on community-based services. Primary care centres and the GPs and psychologists employed there are usually the first points of contact for people seeking mental healthcare. They assess, diagnose, treat (mostly for mild-to-moderate symptoms) and refer to specialised mental health services. Psychiatrists provide consultations in primary care centres for patients with severe symptoms, and appointments are available without referral. Specialised mental healthcare is also provided in psychiatric clinics and hospitals, but provision of services in these specialised settings has reduced as community-based care has developed.

The number of beds in specialised psychiatric care decreased from about 4 390 in 2012 to 4 160 in 2022 – a reduction of 5 % during that decade.

The mental health strategy aims to strengthen coordination and collaboration between stakeholders

Over the last decade, the national government has developed mental health strategies to strengthen coordination and collaboration across the authorities responsible for mental healthcare. The last strategy (2016-20) was structured around five priorities: promotion of mental health and prevention of mental health issues; early detection and access to services; targeted interventions for vulnerable groups; people-centred care; and better organisation and leadership. The strategy focused on collaboration with the Swedish Association of Local Authorities and Regions to enhance promotion and prevention activities by financially incentivising and rewarding local and regional actors. Most regions translated the national strategies into regional strategies and plans. In total, the national government supported about 3 300 initiatives in 2021 (National Board of Health and Welfare, 2022). Such plans emphasised improvements to mental healthcare for children and young people. For example, many municipalities built youth teams to intensify early identification of psychiatric conditions and perform outreach activities, such as regular school visits to deliver psychological counselling and information.

In 2021, the government put forward a proposal to the parliament that responsibility for substance abuse treatments should be transferred to regions to improve access and care continuity. While regions are responsible for mental healthcare, the municipalities are responsible for services for people with substance abuse issues. In practice, this shared responsibility can result in patients being referred from psychiatric emergency departments to municipal addiction clinics, and vice versa. The parliament did not reject or approve the proposal. The government elected in 2022 is currently reviewing this proposal. A new mental health strategy to address mental illness and suicide prevention is under review by the government.

7 Key findings

- Life expectancy in Sweden is among the highest in the EU, reaching 83.1 years in2022. Following a reduction of 0.8 years in 2020 due to deaths from COVID-19, it rebounded in 2021, and remained close to its pre-pandemic level in 2022. The gap in life expectancy by socioeconomic status is greater than the gap by gender. At age 30, women with higher levels of education could expect to live 6.8 years longer than those with lower levels in 2021, while the gap was 5.9 years among Swedish men.
- Sweden performs better than most other EU countries on many behavioural risk factors, except certain aspects of nutrition. As in other countries, overweight and obesity rates have increased among adolescents and adults, but they remain lower than the EU average.
- The COVID-19 pandemic resulted in disruption of hospital and other health services in Sweden, as in other EU countries. Large amounts of non-urgent hospital procedures were postponed during the first year of the pandemic, resulting in fewer hospital stays and surgical procedures in 2020. Hospital activity went up slightly in 2021, but still remained below pre-pandemic levels. The reductions in activity resulted in increased waiting times for interventions such as hip and knee replacements in 2020 and 2021. While waiting times for these surgical interventions started to decrease in 2022, they remained higher than before the pandemic.
- Use of teleconsultations increased sharply during the pandemic as a way to maintain access to care while reducing the risk of infections, and nearly half of Swedish adults reported having had at least one during the first year of the pandemic. Legislation passed in 2022 aims to integrate teleconsultations better into local health systems. However, there are concerns that some teleconsultations may offer low-value care and that they might increase inequality in access, as they are mainly used by people with higher education and income levels.
- In 2021, Sweden's health expenditure as a share of GDP reached 11.2 %, which is slightly higher than the EU average (11.0 %) and also higher than before the pandemic (10.8 % in 2019). This rise was mainly driven by increases in public spending on health during the pandemic. The public share of health spending in Sweden (86 %) was significantly higher than the EU average (81 %) in 2021.
- The number of hospital beds per 1 000 population in Sweden is the lowest in the EU, partly because most rehabilitation and long-term care beds are not located in hospitals. Recent evaluations indicate that the overall number of hospital beds is not sufficient. In response, the government asked the National Board of Health and Welfare to allocate SEK 2 billion (EUR 175 million) to the regions to increase the number of public beds in 2023. The Board is also working on a national plan to address hospital bed shortages.
- Shortcomings in the long-term care sector in Sweden garnered increased public and political attention during the pandemic. To address workforce shortages in long-term care, Sweden's Recovery and Resilience Plan has allocated a budget of EUR 452 million to upskill and train new staff.
- About one in six people (17 %) had a mental health issue in Sweden in 2019, which is close to the EU average. The most common mental health issues are anxiety and depressive disorders. The mental healthcare system fosters a community-based approach. A new mental health strategy to address mental illness and promote suicide prevention is under development.

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovakia	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT		

European Commission

State of Health in the EU
Country Health Profile 2023

The *Country Health Profiles* are a key element of the European Commission's *State of Health in the EU* cycle, a knowledge brokering project developed with financial support from the European Union.

These Profiles are the result of a collaborative partnership between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, working in tandem with the European Commission. Based on a consistent methodology using both quantitative and qualitative data, the analysis covers the latest health policy challenges and developments in each EU/EEA country.

The 2023 edition of the Country Health Profiles provides a synthesis of various critical aspects, including:

- the current state of health within the country;
- health determinants, with a specific focus on behavioural risk factors;
- the structure and organisation of the health system;
- the effectiveness, accessibility and resilience of the health system;
- For the first time in the series, an account of the state of mental health and related services within the country.

Complementing the key findings of the Country Health Profiles is the Synthesis Report by the European Commission.

For more information, please refer to: ec.europa.eu/health/state

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