



State of Health in the EU

# SWEDEN

Country Health Profile 2025

## The Country Health Profiles 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 knowledge transfer. The 2025 edition of the Country Health Profiles includes a special section dedicated to pharmaceutical policy.

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 Observatory's 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, the Survey of Health, Ageing and Retirement in

Europe (SHARE), the European Cancer Information System (ECIS) 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 2025, based on data that was accessible as of the first half of September 2025.

## Demographic and socioeconomic context in SWEDEN, 2024

Demographic factors	Sweden	EU
Population size	10 551 707	449 306 184
Share of population over age 65	21 %	22 %
Fertility rate 2023 <sup>1</sup>	1.5	1.4
Socioeconomic factors		
GDP per capita (EUR PPP) <sup>2</sup>	44 705	39 675
At risk of poverty or social exclusion rate <sup>3</sup>	17.5 %	20.9 %

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. At risk of poverty or social exclusion (AROPE) is the percentage of people who are either at risk of poverty, severely materially and socially deprived, or living in a household with very low work intensity.

Source: Eurostat Database.

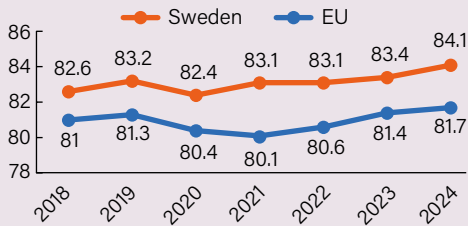
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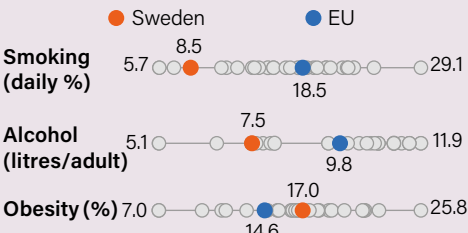
# 1 Highlights



Life expectancy at birth

## Health Status

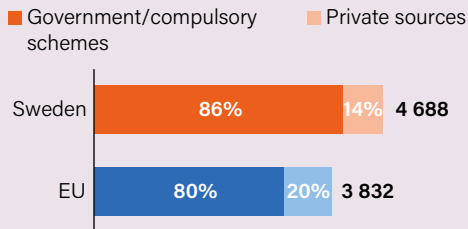
In 2024, life expectancy in Sweden reached a record 84.1 years, the highest in the EU alongside Italy. This level exceeds the EU average by nearly two and a half years and represents a near one-year increase since 2019. The gender gap in life expectancy remains among the narrowest in Europe at three years, compared with an EU average of over five years. Moreover, older Swedes enjoy the longest healthy life expectancy at age 65 in the EU, underscoring exceptional health outcomes in later life.



Adults, 2022 (or nearest year)

## Risk Factors

Sweden has one of the EU's lowest daily smoking rates at under 9 % in 2022, down from 14 % in 2010, though snus use remains high among men and e-cigarette use among youth is slightly above the EU average. Adult obesity affects 17 % of the population, above the EU average of 15 % despite high physical activity rates. Alcohol consumption is low and tightly regulated, with new rules allowing limited farm sales, while state-controlled retail distribution remains the primary channel.



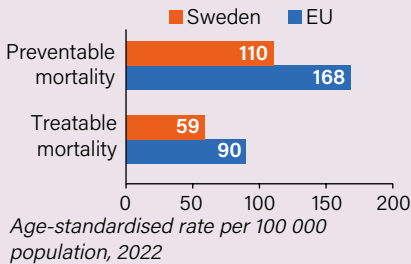
Health spending per capita (EUR PPP), 2023

## The Health System

Sweden's healthcare spending ranks fourth highest in the EU at EUR 4 688 per capita in 2023, approximately one fifth above the EU average. Public expenditure accounts for 86 % of total spending, above the EU average of 80 %, reflecting strong tax-based financing, while out-of-pocket payments represent 13 % of total spending compared to 16 % across the EU. This robust public commitment maintains universal coverage while keeping household costs comparatively low.

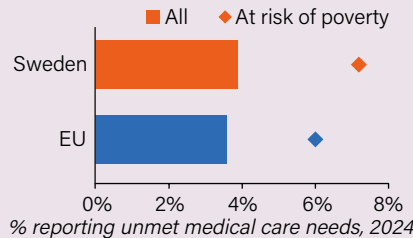
## Health System Performance

### Effectiveness



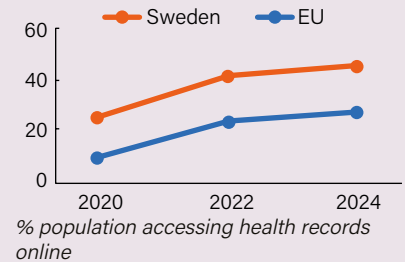
In 2022, Sweden achieved the EU's lowest avoidable mortality rate, with both treatable and preventable mortality over one-third below their respective EU averages. Sweden's performance in these areas demonstrates a well-functioning health system capable of effectively treating life-threatening conditions and reducing risk factors that cause premature death.

### Accessibility



In 2024, 3.9 % of Swedish residents with a healthcare need reported unmet needs, a share slightly above the EU average and mainly driven by long waiting times. Delays are most pronounced in specialist care, where three in ten patients wait longer than the 90-day guarantee. Access gaps are particularly marked in primary and mental healthcare, both exceeding EU averages, with rural areas disproportionately affected.

### Resilience



Swedes consistently use digital health services more than their EU peers, including higher rates of seeking health information online, booking appointments digitally and accessing personal e-health records. These high utilisation levels reflect both the maturity of Sweden's digital health infrastructure and the population's familiarity with technology in healthcare interactions.

## Spotlight: pharmaceuticals

Sweden spends EUR 454 per capita on retail pharmaceuticals, 11 % below the EU average despite higher overall health expenditure, reflecting strong cost-containment measures such as mandatory generic substitution and substantial manufacturer rebates. Generic medicines account for 36 % of prescriptions, delivering the lowest prices among 20 European countries. Access to new medicines is faster than in most other EU countries, while pharmaceutical R&D investment is twice the EU average, supporting high patent activity, although recent declines in clinical trial applications have prompted government action.

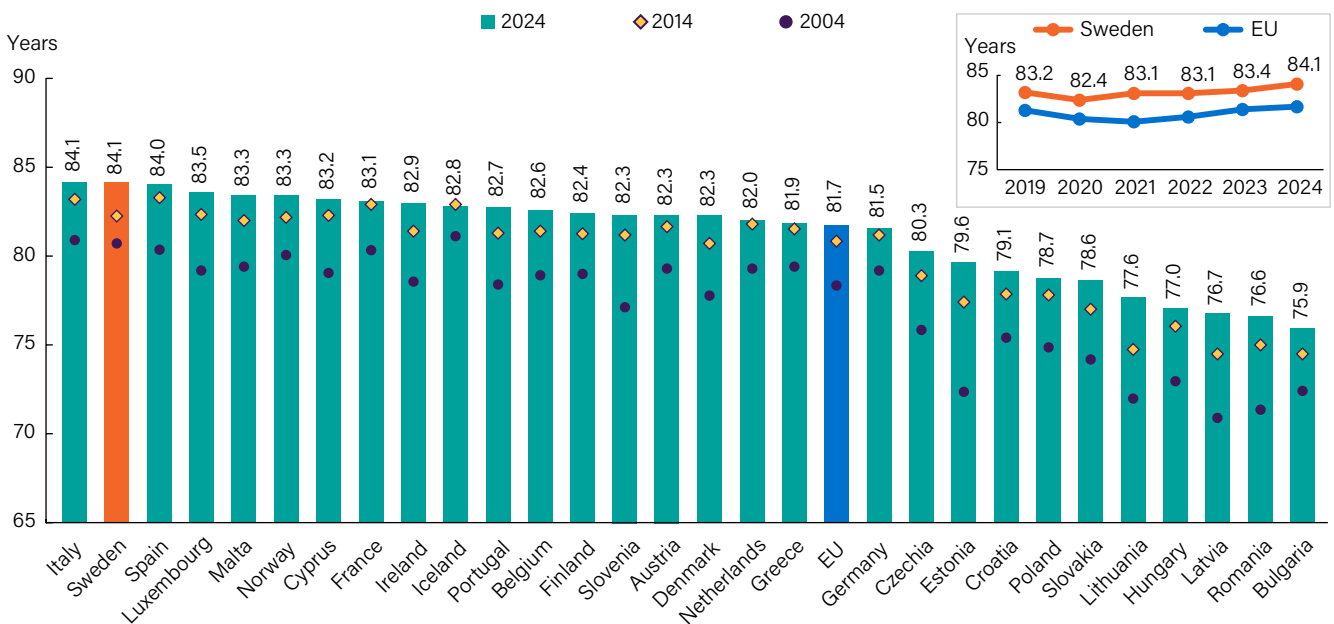
## 2 Health in Sweden

### Sweden boasts the highest life expectancy at birth in the EU

Sweden demonstrates exceptional population health outcomes, with life expectancy at birth reaching 84.1 years in 2024 - nearly two and a half years above the EU average. Following a nearly one-year decline in 2020 due to pandemic-related mortality, life expectancy rebounded in 2021 and by 2024 had surpassed its pre-pandemic level by almost one year (Figure 1). While Swedish men generally have shorter life

expectancies than women, consistent with patterns across European countries, Sweden stands out for its notably smaller gender gap compared to most EU member states. In 2024, Swedish women could expect to live three years longer than men, significantly below the EU average gap of 5.2 years. This narrower differential stems primarily from Swedish men achieving the highest life expectancy at birth in the EU, at almost three and a half years above the EU average for men.

Figure 1. Sweden's life expectancy at birth exceeded its pre-pandemic level by nearly a year in 2024



Note: The EU average is weighted.

Source: Eurostat (demo\_mlexpec).

### Sweden's life expectancy gains reflect major declines in cardiovascular and cancer mortality, though ageing is shifting the disease burden

Over the past two decades, Sweden has made notable progress in population health, evidenced by a 4.2-year increase in life expectancy at birth between 2004 and 2024. This achievement can be largely attributed to significant reductions in mortality from major non-communicable diseases: most prominently, the age-standardised death rate from circulatory system diseases fell by 50 %, driven by major advances against ischaemic heart disease. Mortality from cancer also declined by nearly one fourth, with progress on both fronts outpacing the EU average. Nevertheless, the disease burden remains concentrated among these leading causes: as of 2022 (most recent data available), cardiovascular diseases and cancer collectively accounted for 54 % of all deaths in Sweden, a share slightly lower than the EU average. Furthermore, reflecting population ageing trends, Alzheimer's disease and other dementias have

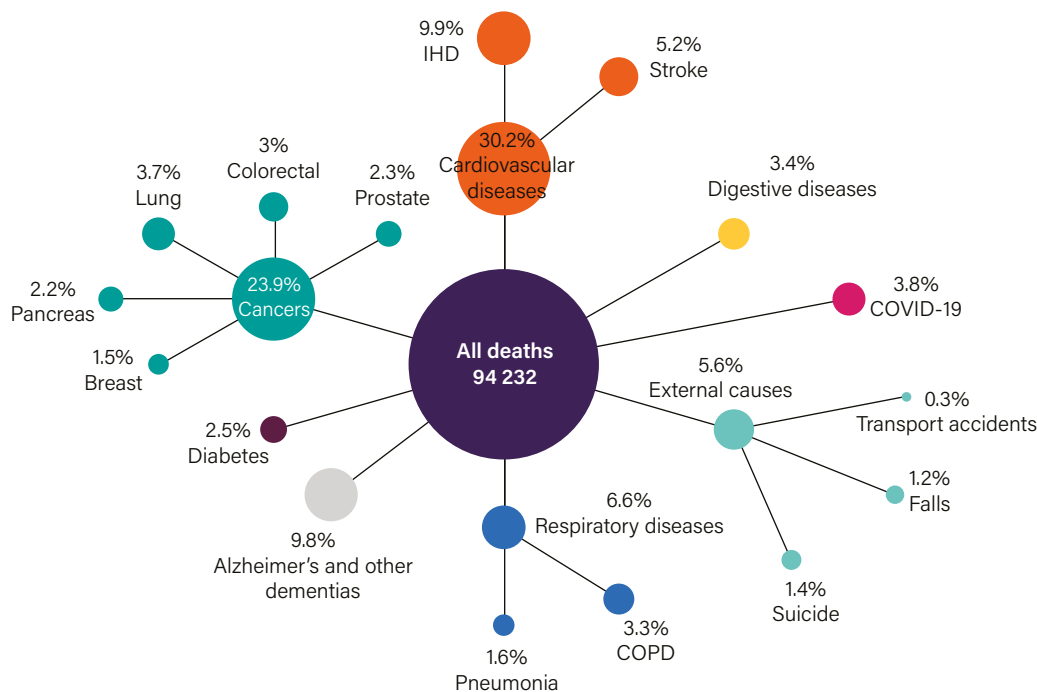
emerged as the third leading cause of mortality, responsible for approximately one in ten deaths (Figure 2).

### Sweden's older adults enjoy the longest healthy life expectancy in the EU

Sweden's demographic transition reflects the combined effects of rising longevity, persistently low fertility, and the ageing of the baby-boom generation. These factors have increased the share of people aged 65 and over from 17 % in 2000 to 21 % in 2024, with projections indicating a further rise to 23 % by 2050. Despite this trend, Sweden is expected to retain one of the youngest populations in the EU, where the share of people aged 65 and over is projected to reach 30 % by mid-century.

Beyond longer lives, the quality of Sweden's extended lifespans sets it apart from most EU countries. In 2022, a 65-year-old woman in Sweden could expect to live another 21.9 years, nearly ten months longer than the EU average, while a 65-year-old man could expect 19.6 additional years, nearly two years more than the EU average. Importantly,

Figure 2. Cardiovascular diseases and cancer account for over half of all deaths in Sweden

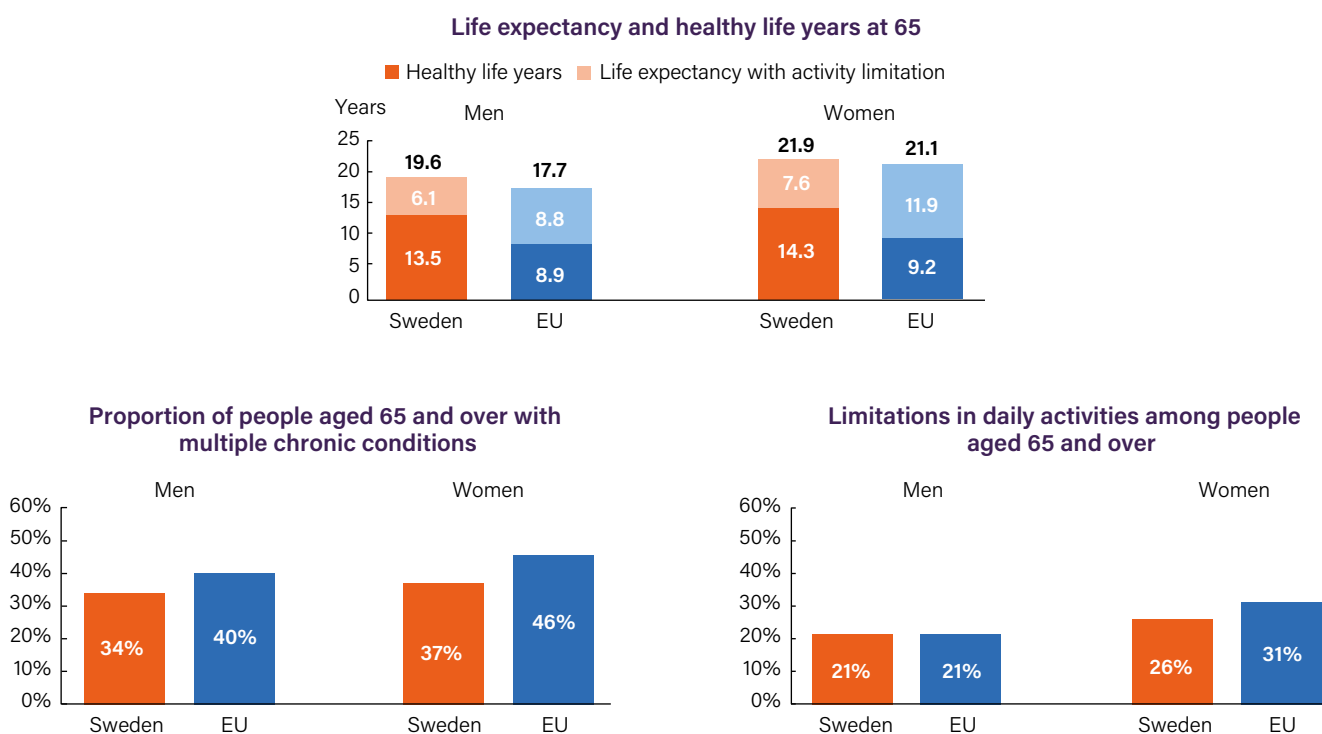


Note: IHD= Ischaemic heart diseases; COPD = chronic obstructive pulmonary disease.  
Source: Eurostat (hlth\_cd\_aro). Data refer to 2022.

Swedish men and women aged 65 enjoy the highest healthy life expectancies in the EU, spending more than two-thirds of their remaining years free from disability, compared with less than half among their EU peers. This advantage is particularly pronounced among women, who can expect to live over five more years in good health than the EU average (Figure 3). This favourable pattern of healthy ageing is mirrored in chronic disease prevalence: in 2022, only 34 % of Swedish

men and 37 % of women aged 65 and over reported living with more than one chronic condition compared with EU averages of 40 % and 46 % respectively. Similarly, while 21 % of Swedish men aged 65 reported limitations in daily activities, in line with the EU average, Swedish women showed a five-percentage-point lower prevalence than their EU counterparts, further underscoring their superior health status in later life.

Figure 3. Fewer older people in Sweden report having chronic conditions than the EU average



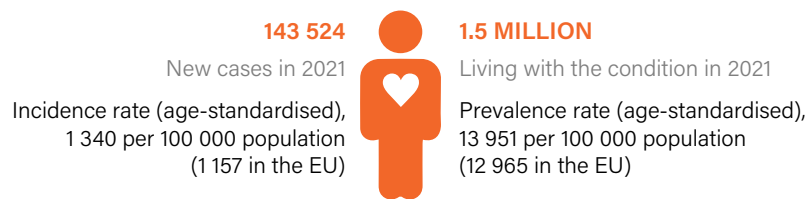
Source: Eurostat for healthy life years (tespm120, tespm130) and SHARE survey (for chronic diseases and limitations in daily activities). Data refer to 2022 and 2021-22, respectively.

## Sweden's above-average cardiovascular disease rates reflect superior detection and survival

Cardiovascular diseases (CVDs) remain the leading causes of death in Sweden and are also the main contributors to morbidity and disability, reflecting patterns observed across the EU. Estimates from the Institute for Health Metrics and Evaluation (IHME) indicate that around 144 000 new CVD cases occurred in Sweden in 2021, with 1.5 million people living with a cardiovascular condition; this corresponds to an age-standardised incidence rate of 1 340 per 100 000 population - about 16 % above the EU average; the prevalence rate of CVDs in Sweden likewise exceeded the EU average by about 7 % (Figure 4). Rather than indicating

worse population health, these elevated figures reflect the strengths of the Swedish healthcare system, with advanced diagnostics, screening and robust national registries ensuring effective case detection. Likewise, higher survival rates contribute to a higher prevalence, as more individuals survive and live longer with managed CVDs. Gender disparities in cardiovascular health are consistent with European trends, as men experience significantly higher disease rates. Within the broader group of cardiovascular conditions, ischaemic heart disease, resulting from the narrowing of coronary arteries, was the most common, generating an estimated 49 000 new cases annually and accounting for 34 % of all CVDs in Sweden.

**Figure 4. Sweden's incidence and prevalence rates of CVDs are slightly higher than the EU average**



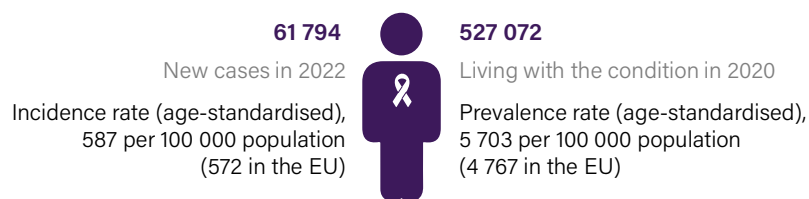
Source: IHME, Global Health Data Exchange (estimates refer to 2021).

## Reflecting higher survival, Sweden's cancer prevalence rate is above the EU average

According to estimates from the Joint Research Centre, about 62 000 new cancer cases occurred in Sweden<sup>1</sup> in 2022, while 527 000 people were estimated to be living with a cancer diagnosis in 2020, equivalent to about 5 % of the country's population (Figure 5). Sweden's estimated cancer burden slightly exceeds the EU average, with age-standardised incidence rates 3 % higher and prevalence rates 6 % above the EU average. This elevated prevalence,

despite only modestly higher incidence, reflects Sweden's high and improving survival rates relative to the EU average, a pattern consistent with broader Nordic epidemiological trends (OECD/European Commission, 2025). Gender disparities in cancer risk follow EU-wide patterns, with the crude cancer incidence rate among men being 18 % higher than among women. Among men, prostate, colorectal and skin cancers represent the most frequent diagnoses, while among women, breast, colorectal, and skin cancers are most common.

**Figure 5. Over 5 % of Sweden's population is estimated to have a cancer diagnosis**



Notes: These are estimates that may differ from data from Sweden's Cancer Registry. Cancer data includes all cancer sites except non-melanoma skin cancer. Source: European Cancer Information System (estimates refer to 2022 for incidence and 2020 for prevalence).

## 3 Risk factors

### Behavioural and environmental risk factors account for a fourth of all deaths in Sweden

Preventable risk factors account for a substantial share of Sweden's mortality burden, although their overall impact

remains below the EU average. Estimates from the IHME indicate that in 2021, around 22 200 deaths in Sweden were attributable to behavioural risk factors, including tobacco use, unhealthy diets, alcohol consumption and low physical activity.

<sup>1</sup> According to real data from Sweden's Cancer Register (<https://www.socialstyrelsen.se/statistik-och-data/register/cancerregistret/>), 72 108 people received a cancer diagnosis in 2022.

Dietary risks were the leading contributor, responsible for 47 % of these preventable deaths, followed by tobacco smoking, which accounted for 40 %. Environmental factors also contribute to premature mortality. In 2021, an estimated 1 000 deaths were linked to exposure to fine particulate matter (PM<sub>2.5</sub>) and ozone pollution. Taken together, behavioural and environmental risks were responsible for one quarter of all deaths in Sweden, compared with 29 % across the EU (IHME, 2023).

### Smoking rates are among the lowest in the EU, but vaping is popular among adolescents

Sweden has made notable progress in curbing traditional tobacco smoking: between 2014 and 2023, daily smoking rates fell from 12 % to under 9 %, the lowest share in the EU (Figure 6). This success is largely attributed to the substitution of cigarettes with smokeless tobacco (snus). In 2024, over 15 % of the population aged 16+ used tobacco-based snus daily, with another 5 % using tobacco-free versions. Recent policy reforms have formally embraced this product substitution as a public health strategy: in late 2024, the government adopted a new policy framework, shifting the goal from curbing total tobacco use to reducing its harm. This was implemented through risk-based taxation, which cut snus taxes by 20 % and raised cigarette taxes by 9 % (Regeringskansliet, 2024). At the same time, e-cigarette use among adolescents has emerged as a challenge, mirroring EU-wide trends: in 2022, 23 % of 15-year-olds reported using e-cigarettes in the previous month, slightly above the EU average of 21 %.

### Sweden maintains low alcohol consumption levels through a restrictive policy framework

Alcohol consumption in Sweden remains among the lowest in the EU. In 2023, adults consumed 7.4 litres of pure alcohol

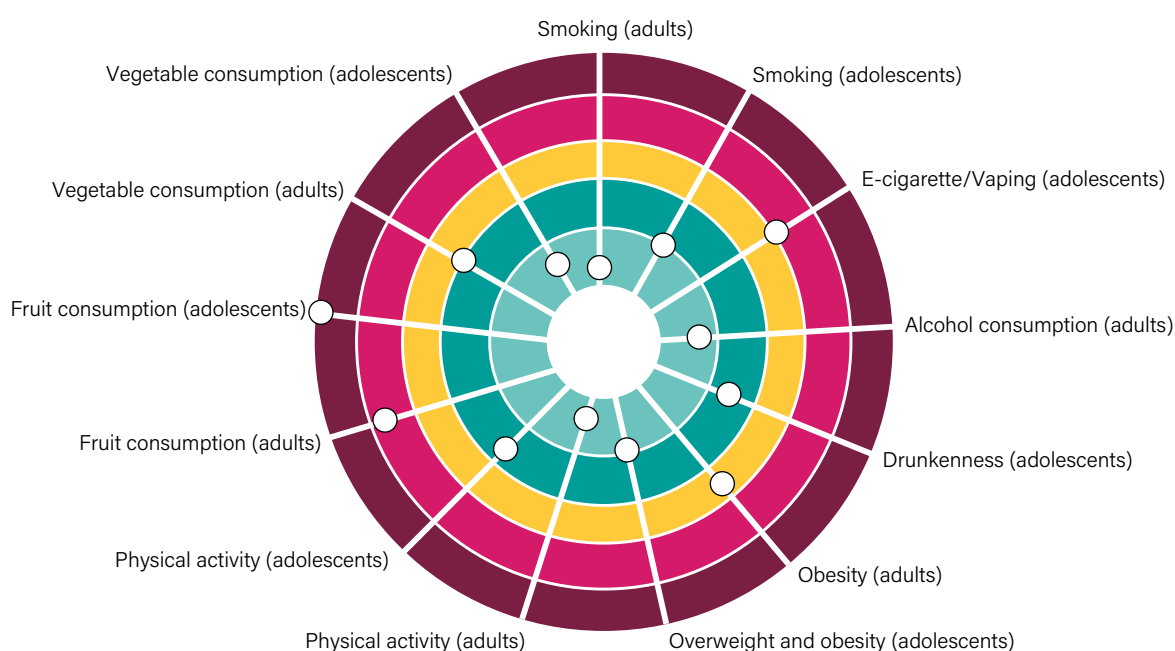
per person, about 25 % below the EU average. Among adolescents, 18 % of 15-year-olds reported having been drunk more than once, also lower than the EU average of 23 %. These comparatively low rates are the result of Sweden's longstanding restrictive alcohol policy, centred on *Systembolaget*, the state-owned retail monopoly enforcing strict controls, including no advertising, no promotional pricing, limited opening hours and a minimum purchase age of 20. This model recently underwent a cautious reform: in April 2025, the Parliament approved new legislation permitting limited farm sales of wine, beer, cider, and spirits by small producers. However, strict per-customer purchase limits mean the reform is unlikely to materially affect overall consumption patterns.

### High physical activity levels contrast with poor dietary habits and rising obesity rates

Sweden leads the EU in adult physical activity: in 2022, nearly 60 % of adults reported exercising at least three times per week, nearly double the EU average of 31 %. Among adolescents, activity levels were more modest: 16 % of 15-year-olds reported engaging in daily physical activity, a share in line with the EU average. Dietary habits reveal less favourable trends: in 2022, only 17 % of 15-year-olds reported eating fruit daily, the lowest rate in the EU. Adult fruit consumption also lagged, with less than half eating at least one portion daily compared with an EU average of 61 %.

Despite strong participation in physical activity, obesity rates have increased in recent years. In 2022, 17 % of Swedish adults were classified as obese, above the EU average of 16 % and reflecting an increase from 2017. Among adolescents, overweight and obesity affected 19 % of 15-year-olds in 2022, an increase from 15 % in 2018. Although this rate was still

**Figure 6. Sweden outperforms most EU countries on key risk factors except in fruit consumption and adolescent vaping**



Note: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country reaches the white target area, indicating that all countries have room for improvement in all areas.

Sources: OECD calculations based on HBSC survey 2022 for adolescents' indicators; Eurostat based on EU-SILC and OECD Data Explorer for adults indicators (2022 or nearest year).

below the EU average of 21 %, its increase may signal an intensification of the issue without preventive action to curb further growth.

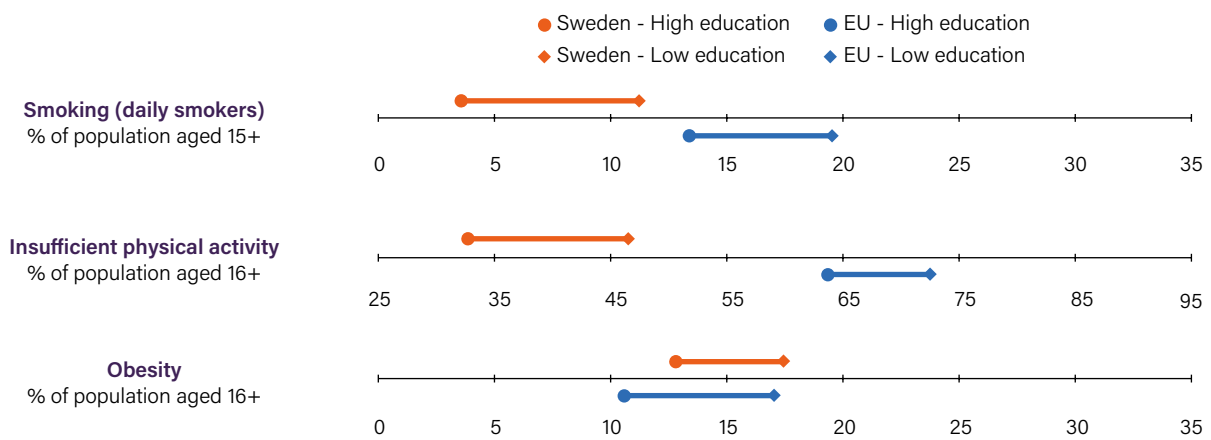
**Behavioural risk factors are more common in lower socioeconomic groups**

As in other EU countries, many behavioural risk factors in Sweden are more common among people with lower education levels. In 2019, daily smoking rates among adults with lower education levels reached 11 %, compared to just 4 % among those with higher education, a 7-percentage point gap that surpassed the corresponding EU average difference. A similar pattern appears for insufficient physical activity:

while Sweden's overall inactivity rates are vastly below the EU average, the educational gradient is more pronounced.

These socioeconomic disparities are also visible in obesity patterns, where 18 % of the least educated adults were obese in 2022 compared to 13 % among the most educated (Figure 7). These inequalities are deepened by rising economic vulnerabilities. Since 2019, long-term unemployment has increased significantly among lower socioeconomic groups, reinforcing health risks that often extend to the next generation. For example, 60 % of children whose parents have only compulsory education do not complete upper secondary school, perpetuating cycles of disadvantage.

**Figure 7. Despite lower overall rates, Sweden shows steeper social gradients in smoking and physical inactivity**



Note: Low education is defined as the population with no more than lower secondary education (ISCED levels 0-2), whereas high education is the population with tertiary education (ISCED levels 5-8). Low physical activity is defined as people doing physical activity 3 times or less per week. Source: Eurostat based on EHIS 2019 for smoking (hlth\_ehis\_sk1e) and EU-SILC 2022 for physical activity and obesity (ilc\_hch07b, ilc\_hch10).

# 4 The health system

**Sweden’s decentralised healthcare system combines public financing with growing private provision in primary care**

Sweden’s healthcare system is structured around a highly decentralised model of governance. While the national government sets the overarching policy and regulatory framework, the 21 regional authorities are responsible for financing and delivering the majority of health services. A third tier of governance, the 290 municipalities, is mandated to provide long-term care, home-based services for older people and individuals with disabilities. Sweden’s publicly-financed, universal system has been undergoing a significant transformation. Although public institutions continue to dominate hospital care, the private sector’s role in primary care has grown substantially over time, with private providers now operating approximately 44 % of primary care centres, albeit with considerable regional variation (Fredriksson & Isaksson, 2022). This expansion was accelerated by the

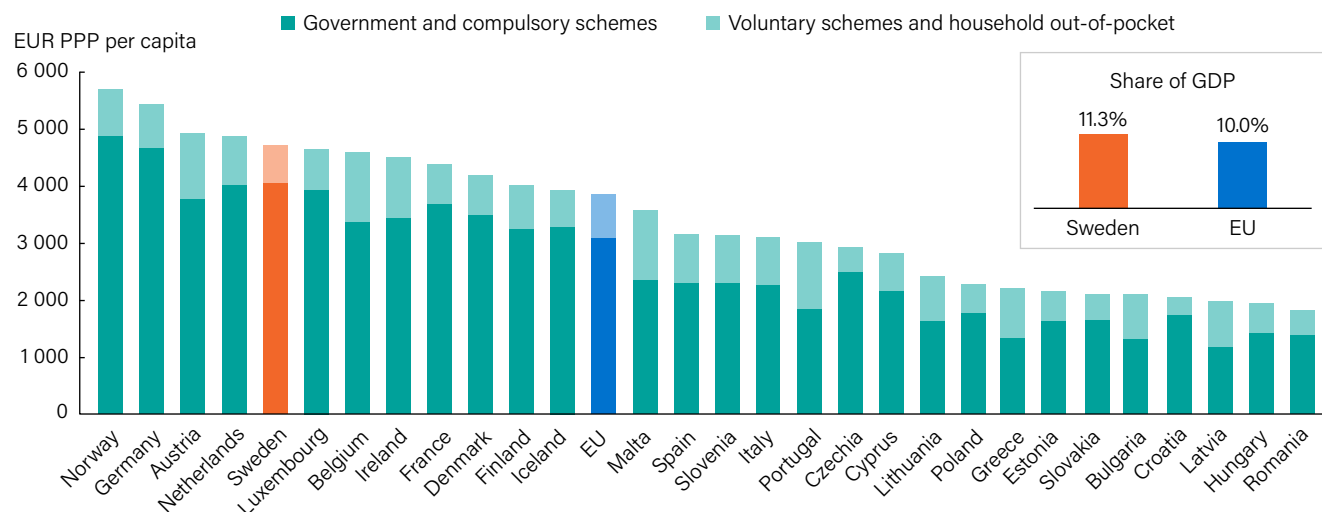
2010 *Act on Patient Choice*, which empowered individuals to select any accredited public or private provider.

Building on this framework, Sweden launched a major reform initiative in 2018, ‘Good quality, local healthcare’ (*God och nära vård*). Supported by significant state financing, representing over 20 % of the public healthcare budget in 2025, the policy aims to reorient the system from hospital-centric services towards more accessible, person-centred local care by strengthening collaboration between primary care, specialised outpatient services and municipal care.

**Sweden maintains high health spending, driven by sustained public funding**

Sweden’s health spending ranks fourth highest in the EU, both in per capita terms and as a share of GDP (Figure 8). In 2023, per capita expenditure reached EUR 4 688 (adjusted for purchasing power), about 22 % above the EU average of

**Figure 8. Sweden ranks fourth in the EU for health spending per capita and as a share of GDP**



Note: The EU average is weighted (calculated by OECD).  
Sources: OECD Data Explorer (DF\_SHA); Eurostat Database (demo\_gind). Data refer to 2023.

EUR 3 844; health spending accounted for 11.3 % of GDP in the same year. Recent trends reflect both long-term structural shifts and the short-term impact of the COVID-19 pandemic: between 2015 and 2023, real per capita health spending grew at an annual average of 0.9 %, driven by a 1.2 % rise in public expenditure that offset a 1.0 % decline in private spending. The pandemic caused sharp fluctuations, with real per capita spending rising by 41 % in 2021 to fund emergency measures, then falling by 3 % in 2022 before returning to modest growth in 2023, again led by public financing. Preliminary estimates for 2024 suggest that real per capita spending has stabilised at a level about 5 % higher than in 2019, with the entire net increase attributable to sustained public expenditure.

**High public financing combined with structured cost-sharing ensures high financial protection**

Sweden's healthcare financing is dominated by the public sector and supported by carefully designed cost-sharing arrangements. In 2023, public expenditure accounted for 86 % of total health spending, well above the EU average of 80 %. This strong tax-based commitment to universal coverage keeps the financial burden on households comparatively low: out-of-pocket (OOP) payments represented 13 % of total spending compared with 16 % across the EU. The system combines modest, uniform patient fees with annual expenditure caps that protect individuals from excessive costs. For example, primary care visits typically cost SEK 150-300 (about EUR 14-28) depending on the region, while annual limits apply separately to consultation and prescription fees. To reinforce long-term fiscal sustainability, the government introduced major revisions to the medicine cost-sharing scheme in July 2025, including a higher annual OOP payments ceiling that has prompted criticism from patient groups (see Section 5.2). Despite these planned cost increases, Sweden maintains targeted protections for vulnerable groups, with children, pregnant women and older people continuing to benefit from exemptions or reduced fees.

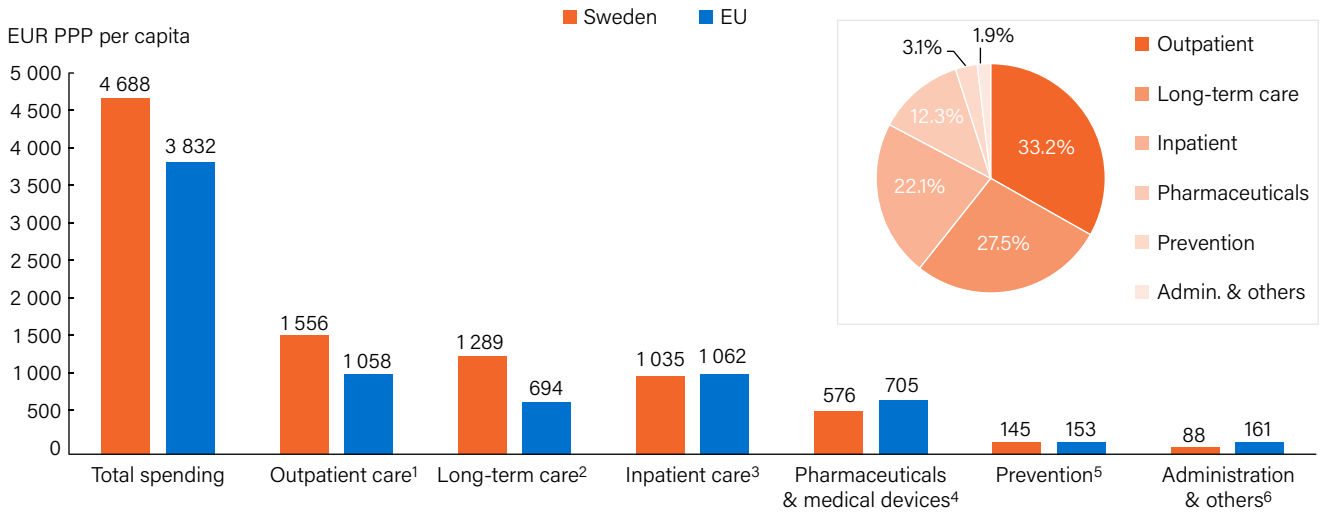
**Sweden's health spending profile reflects a shift toward outpatient care, supported by cost containment in pharmaceuticals**

Sweden's health spending pattern reflects distinct policy choices that set it apart from most EU countries. Most notably, the country has successfully shifted care away from traditional hospital settings: in 2023, outpatient services accounted for 33 % of total health spending - one of the highest shares among EU countries with above-average per capita expenditure (Figure 9). In contrast, inpatient care absorbed only 22 %, well below the EU average of 28 %. A defining feature of Sweden's spending mix is the high share devoted to long-term care (LTC), which represented 28 % of total health expenditure in 2023 compared with an EU average of 18 %. This reflects Sweden's longstanding integration of support for older people as a central component of its health system and broader welfare model. Conversely, spending on retail pharmaceuticals (12 %) remains relatively low due to effective price regulation and strong generic uptake, while preventive care accounts for a slightly smaller share of total spending (3 %) than the EU average.

**Sweden sustains high health workforce levels, but regional and specialty shortages persist**

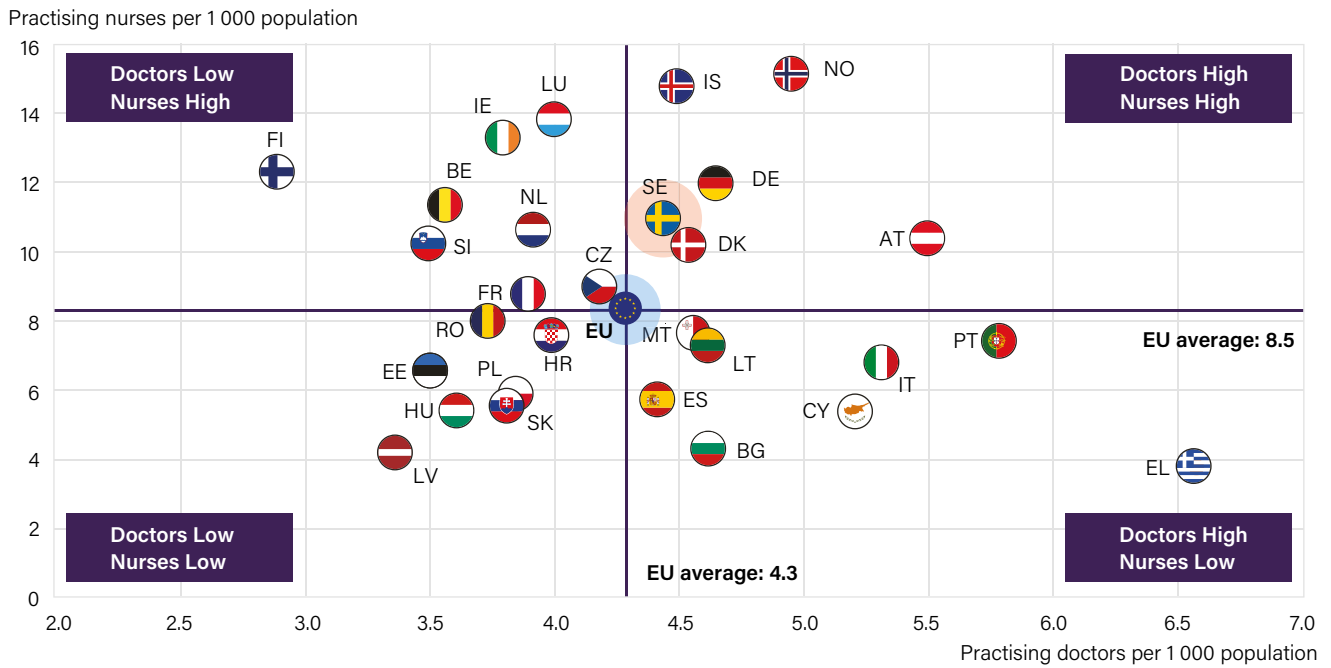
Sweden has a comparatively robust health professional workforce, with 4.5 doctors per 1 000 population in 2022 - about 5 % above the EU average, and 11.0 nurses per 1 000 population - nearly 30 % higher than the EU average of 8.4 (Figure 10). The number of doctors grew by 12 % over the past decade, supported by foreign-trained physicians who now account for around 30 % of the total. The nursing workforce has remained stable over the same period but continues to stand well above EU levels. These aggregate figures, however, mask substantial regional disparities that compromise equitable access to care (see Section 5.2). All 21 regions report shortages of both general practitioners and specialist doctors, with the most severe gaps in rural and northern areas. More fundamentally, general practitioners

Figure 9. Outpatient medical care accounts for one-third of Sweden's healthcare 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 (calculated by the OECD).  
Sources: OECD Data Explorer (DF\_SHA). Data refer to 2023.

Figure 10. Sweden has a comparatively high number of doctors and nurses



Note: 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 practice, resulting in a large overestimation of the number of practising doctors. In Greece, the number of nurses is underestimated as it only includes those working in hospital.  
Source: OECD Data Explorer (DF\_PHYS, DF\_NURSE). Data refer to 2023 or nearest year.

(GPs) account for only 14 % of the physician workforce compared with an EU average of 20 %, reflecting difficulties in strengthening primary care capacity.

**Hospital bed shortages reflect a decades-long strategy now under strain**

Sweden's healthcare system is characterised by the lowest hospital bed density in the EU, a direct result of a long-standing policy to shift care towards outpatient, community and digital settings. While this lean model has

successfully contained costs and fostered integrated care, it is now strained by rising demand, leading to significant capacity constraints.

The government is tackling this issue on two fronts. The 2025 budget allocated SEK 3.7 billion to strengthen primary and local specialised care under the *God och nära vård* initiative, SEK 1 billion to reduce surgical waiting lists and another SEK 1 billion distributed to the 21 regions based on several performance indicators. In parallel, a more structural challenge stems from reimbursement mechanisms that do

not adequately incentivise home-based and digital services that could ease hospital demand. To address this structural gap, an EU-funded project led by Karolinska University

Hospital is developing a new payment model to support Sweden's transition toward a more distributed and sustainable care system.

# 5 Performance of the health system

## 5.1 Effectiveness

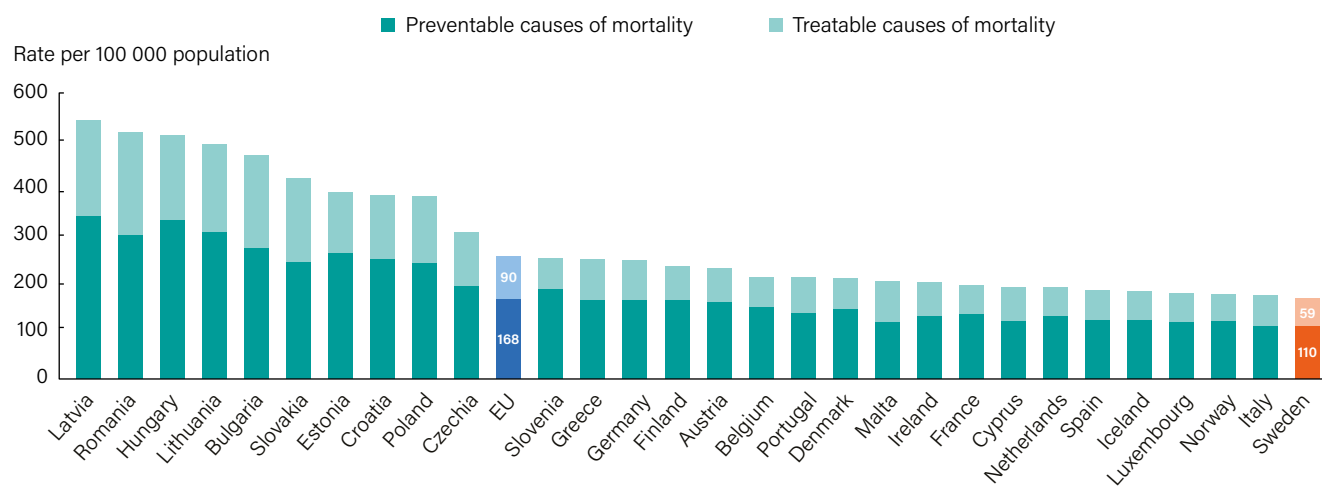
### Sweden leads the EU in avoidable mortality, reflecting strong public health and clinical performance

In 2022, Sweden reported the lowest rate of avoidable mortality in the EU, reflecting the combined effects of strong

public health policies and a high-performing healthcare system (Figure 11). This result underscores Sweden's capacity to prevent deaths from both treatable and preventable causes through effective care and comprehensive population-level interventions.

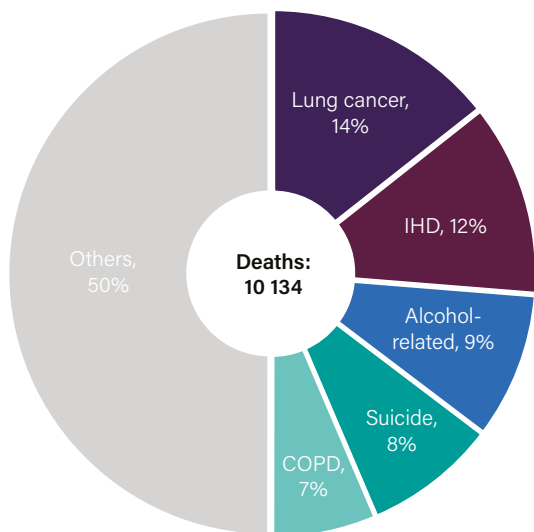
Clinical effectiveness is particularly evident for treatable causes of death: mortality was 34 % below the EU average

Figure 11. Sweden has the lowest avoidable mortality rate in the EU

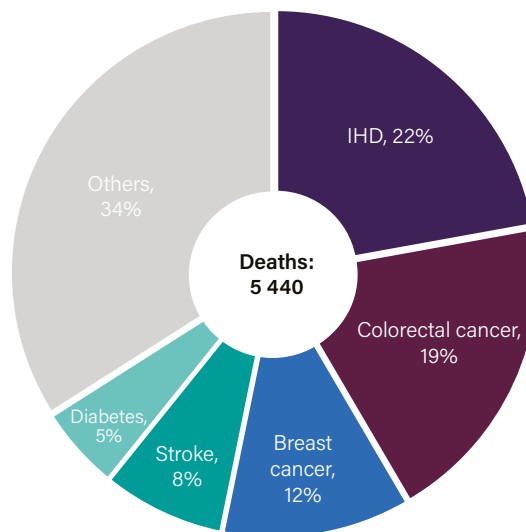


### Sweden

#### Preventable causes of mortality



#### Treatable causes of mortality



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 for some diseases (e.g. ischaemic heart diseases, 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. COPD refers to chronic obstructive pulmonary disease.

Source: Eurostat (hlth\_cd\_apr). Data refer to 2022.

in 2022, demonstrating the system's ability to deliver prompt, high-quality treatment for life-threatening conditions. Outcomes for ischaemic heart disease, colorectal cancer, and breast cancer are especially strong, supported by well-established care pathways and early detection.

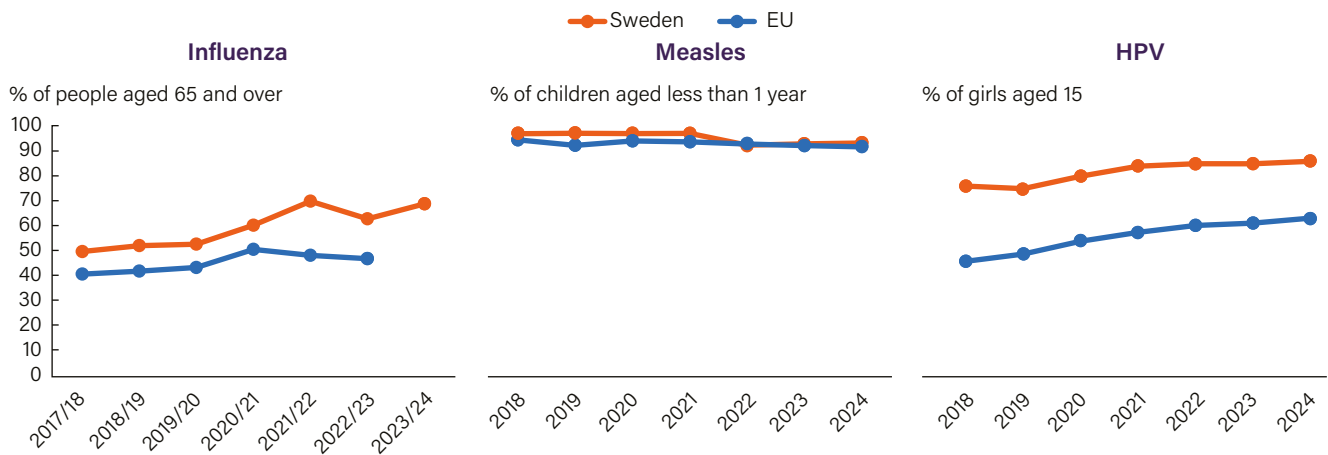
Mortality from preventable causes was nearly 35 % below the EU average, also the lowest in the EU, highlighting the effectiveness of Sweden's prevention strategies. Current mortality patterns still reflect legacy effects of past risk exposures: despite today's tobacco use being among the lowest in Europe, lung cancer remains the leading cause of preventable death, largely due to smoking habits prevalent in earlier decades.

**Sweden maintains high vaccination coverage, with recent efforts focusing on reversing minor declines and improving outreach**

Sweden's vaccination programmes perform consistently well, reflecting a robust public health infrastructure and high

public confidence in immunisation. As in most EU countries, seasonal influenza vaccination targets people aged 65 and over. Coverage has remained above the EU average, peaking at 70 % in 2021/2022 as uptake rose among high-risk groups during the pandemic. After a slight dip in 2022/2023, coverage rebounded in 2023/2024, nearing its pandemic-era high (Figure 12). Childhood vaccination coverage is also strong, particularly for measles and HPV. In 2024, 94 % of children under age 1 received the first measles dose, slightly above the EU average of 92 %. To address a modest post-pandemic decline, authorities are investing in digitised immunisation information systems to identify and reach under-vaccinated groups. HPV vaccination is a particular success: coverage among 15-year-old girls rose from 76 % in 2018 to 86 % in 2024, placing Sweden second in the EU and about 35 % above the EU average. Since 2020, the national childhood programme has also included HPV vaccination for boys, complementing the programme for girls introduced in 2012.

**Figure 12. Vaccination coverage rates for influenza, measles and HPV are above the EU average**



Notes: The EU average is weighted for influenza (calculated by Eurostat) and unweighted for measles and HPV. Sources: OECD Data Explorer (DF\_KEY\_INDIC), Eurostat (hlth\_ps\_immu) and WHO/UNICEF.

**High screening uptake supports Sweden's early cancer detection strategy**

Sweden operates three nationwide cancer screening programmes guided by national evidence and priorities, which sometimes diverge from EU guidance. For example, the breast cancer programme offers mammography to women aged 40-74 - wider than the EU's recommended 50-69 years - based on Swedish research indicating that tumours in younger women can demonstrate more aggressive growth patterns. The programme uses age-stratified intervals: every 18 months for women aged 40-49 and every 24 months for those aged 50-69. This approach prioritises maximum mortality reduction, accepting the trade-offs of higher resource use and false-positive rates.

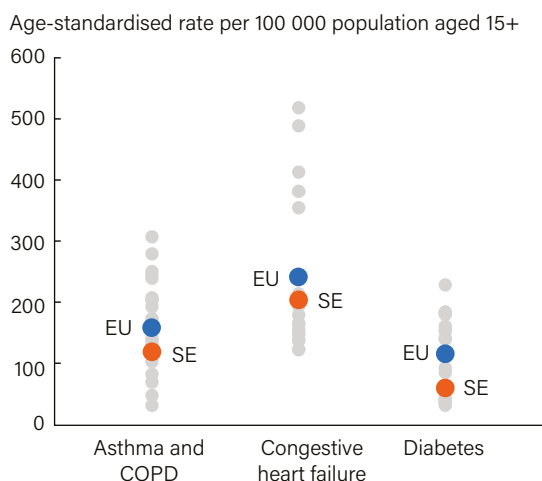
Strong public trust and well-organised screening infrastructure yield participation rates substantially above EU averages. In 2023, breast cancer screening achieved 83 % participation, compared to the EU average of 57.5 %. Similarly, cervical cancer screening, offered to women aged 23-64, reached 78 % participation, more than one-third higher than

the EU average. The colorectal cancer screening programme, targeting adults aged 60-74, progressed more gradually, with full national implementation achieved only in 2022. However, once in place, participation rose quickly, reaching nearly 65 % in 2023 compared with an EU average of 48 %.

**Low hospital admission rates for chronic conditions point to highly effective outpatient care**

Sweden's robust primary care system is highly effective at managing chronic disease, resulting in hospital admission rates that are among the lowest in Europe. In 2023, the combined hospitalisation rate for diabetes, congestive heart failure (CHF), asthma, and chronic obstructive pulmonary disease (COPD) was 25 % below the EU average, reflecting robust primary care capacity and effective chronic disease management. Unlike most EU countries, which saw a sharp drop in admissions for chronic conditions in 2020 followed by a rebound, Sweden maintained its established downward trajectory throughout the crisis. In 2023, admissions for CHF were 15 % below the EU average, those for asthma and COPD 24 % lower, and admissions for diabetes were nearly

**Figure 13. Avoidable admissions for chronic conditions in Sweden are lower than the EU average**



Note: Admission rates are not adjusted for differences in disease prevalence across countries. The data pertain to 2023. Source: OECD Data Explorer (DF\_HCQO).

50 % below the EU average (Figure 13). A key driver of this sustained improvement has been the expanded role of nurses in Swedish primary care, particularly in managing diabetes and asthma.

## 5.2 Accessibility

### Sweden's public coverage rates for healthcare services are above the EU average

Sweden provides universal health coverage to all residents, a commitment reflected in public financing rates that exceed EU averages for most core services. Nearly all costs for inpatient care (99 %) and outpatient care (93 %) are publicly covered, and even dental care coverage (42 %) is significantly higher than the EU average. The main exception is pharmaceuticals, where public coverage at 54 % falls slightly below the EU average, a result of Sweden's graduated co-payment model (Figure 14). While financial coverage is extensive, the definition of what is covered is notably decentralised. Sweden operates without an explicit national benefits package, instead relying on the principle of providing all necessary and cost-effective treatments based on medical need. To manage the risk of service variations

across the 21 autonomous regions, Sweden's National Board of Health and Welfare (NBHW) and the Association of Local Authorities and Regions (SKR) collaborate to develop common guidelines, ensuring equitable standards are maintained nationwide.

### Co-payment caps and exemptions mitigate the regressive impact of user fees

Sweden maintains one of the EU's lowest levels of private healthcare financing, with only 14 % of health expenditure privately funded in 2023. This spending consists almost entirely of OOP payments, concentrated in retail pharmaceuticals (34 %), dental care (24 %) and outpatient care (13 %) (Figure 15). Although co-payments apply broadly across services, strategic exemptions exist for maternal and child health in primary care and for selected services for older people. While regions retain some discretion over co-payment levels, the national policy framework incentivises the use of primary care over hospital-based care.

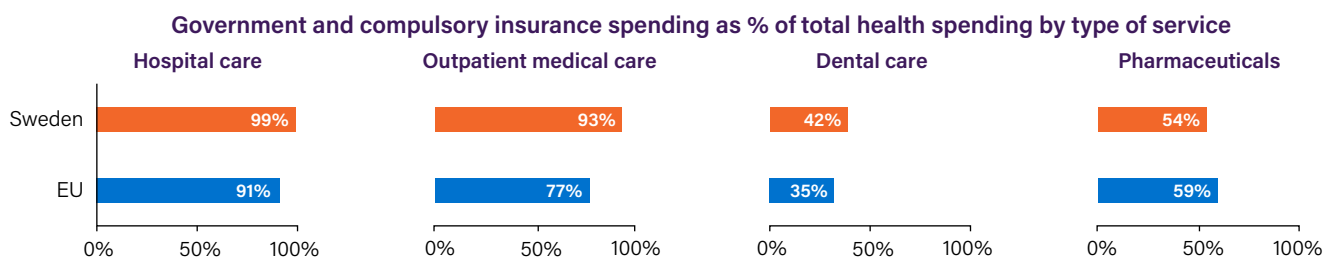
To strengthen long-term fiscal sustainability and address rising pharmaceutical costs, in July 2025 the government introduced a major reform of the medicine cost-sharing system. The annual OOP ceiling increased from SEK 2 900 (~EUR 260) to SEK 3 800 (~EUR 345) and the reimbursement structure was redesigned so that patients initially bear a higher share of medicine costs before receiving gradually increasing subsidies. Once cumulative annual medicine costs reach SEK 7 117 (~EUR 645), a 'free card' covers all further expenses (Swedish eHealth Agency, 2025).

As in many other EU countries, public funding for dental care remains relatively limited, resulting in higher co-payments. However, recent and upcoming reforms aim to improve affordability and access: in January 2025, the age threshold for free dental care was lowered from 23 to 19 years in most regions, and a new public dental care scheme for people aged 67 and over will take effect in January 2026 (Regeringskansliet, 2025).

### Excessive waiting times drive Sweden's unmet needs for medical care

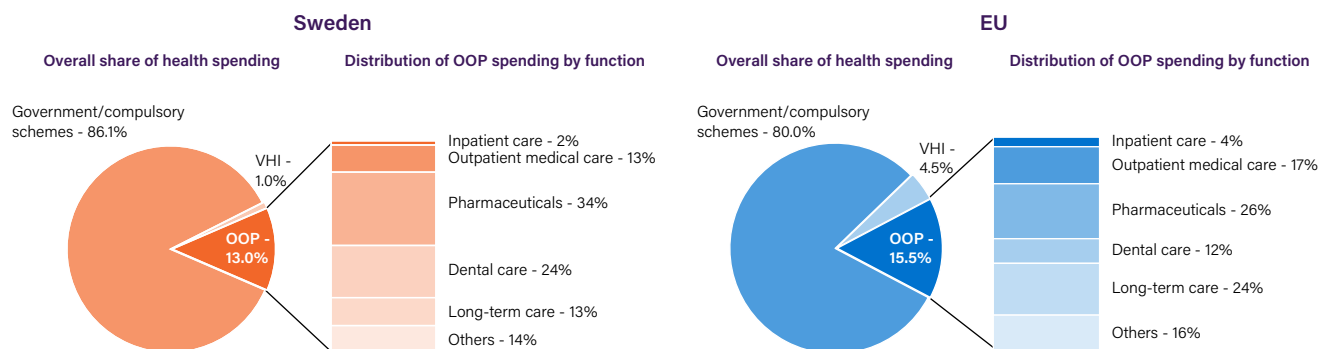
In 2024, 3.9 % of people who reported medical needs in Sweden were unable to meet at least some of them, a share slightly above the EU average of 3.6 %. Cost-related barriers remain minimal thanks to strong public financing and protection mechanisms; instead, most reported unmet

**Figure 14. Public coverage rates are higher than the EU average except for 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 as well as medical non-durables. The EU average is unweighted. Source: OECD Data Explorer (DF\_SHA). The data pertain to 2023.

Figure 15. Sweden has a lower share of out-of-pocket spending than the EU average



Note: VHI also includes other voluntary prepayment schemes. The EU average is weighted. Source: OECD Data Explorer (DF\_SHA). Data pertain to 2023.

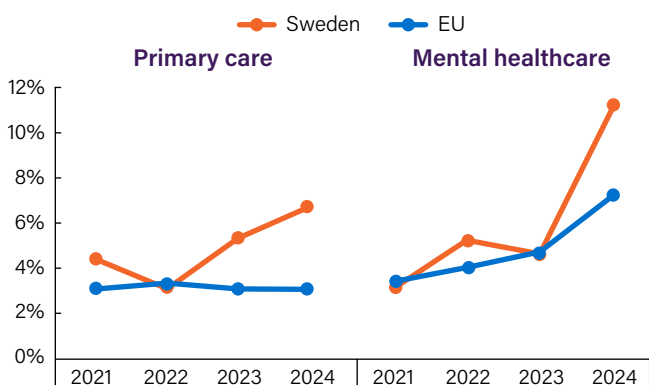
needs stem from long waiting times. Excessive waiting times remain a systemic challenge, particularly in specialist care: since 2021, around 30 % of patients have consistently waited longer than the mandated 90-day limit for a first consultation (Regeringskansliet, 2024).

These delays disproportionately affect lower-income groups: in 2024, 7.2 % of people at risk of poverty who reported medical needs were unable to meet at least some of them, compared with an EU average of 6.0 % for this group. Access gaps are particularly noticeable in primary and mental healthcare, where 7.0 % and 11.0 % of the population, respectively, reported some level of unmet need, both above EU averages and continuing an upward trend (Figure 16). While some progress has been made toward the three-day primary care access target in certain regions, improvements remain uneven and insufficient to reverse the overall negative trend.

**Despite Sweden's large health workforce, regional shortages undermine equitable access to care**

Despite having one of the EU's highest health workforce densities (see Section 4), Sweden faces marked regional disparities in the distribution of doctors, particularly in primary care. While large urban regions such as Stockholm and Västra Götaland report high coverage of general practitioners, several others, including Blekinge, Västerbotten

Figure 16. Self-reported unmet needs for primary and mental healthcare are rising



Note: Primary care includes access to a GP/family doctor or a health centre. Source: Eurofound's "Living and working in the EU" e-survey (2025).

and Gävleborg, record much lower rates. High turnover and persistent recruitment difficulties continue to undermine continuity of care, especially in rural and remote areas, prompting many regions to expand mobile care teams and extend opening hours to improve access. Reliance on temporary locum doctors (*hyrläkare*) has declined, with the number of regions using them to maintain basic service continuity in primary care falling from eight to four between 2023 and 2025, as most regions now restrict such contracts for permanent positions (Socialstyrelsen, 2025). Workforce shortages remain most acute in primary care and key specialties such as psychiatry and geriatrics, where sustained recruitment remains challenging.

The specialist nursing workforce shows similar regional disparities, aggravated by high retirement rates, constrained training capacity and competition from private providers (Figure 17). In response to these mounting pressures, Sweden has recently launched its most comprehensive workforce consolidation strategy to date, combining performance-based funding and enhanced accountability mechanisms to strengthen staffing and address long-standing inequities across regions (Box 1).

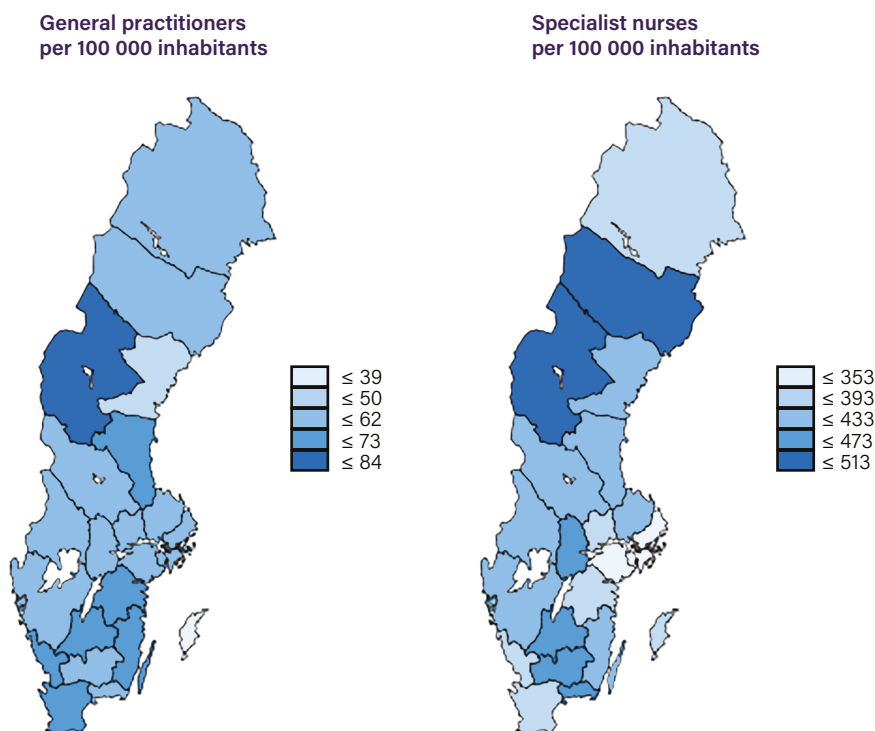
**5.3 Resilience**

Health system resilience - the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks and structural changes - has become central to policy agendas. Key priorities include easing pressures on service delivery, strengthening health infrastructure and workforce capacity, adapting crisis preparedness strategies, supporting digital innovation and safeguarding long-term sustainability.

**Hospital capacity shortages persist despite major investments, as staffing constraints hinder Sweden's expansion plans**

Sweden has undergone a long-term decline in hospital bed numbers, reflecting a deliberate policy to shift care from costly inpatient settings to more efficient outpatient services. While this model successfully contained costs and maintained quality for decades, it has increasingly become a vulnerability. In 2023, hospital bed capacity was the lowest in the EU, at 1.9 beds per 1 000 population, well below the EU average of 5.1, and hospital

Figure 17. The distribution of GPs and specialist nurses across Sweden is uneven across regions



Source: Socialstyrelsens statistikdatabas, all specialist nurses and all GPs employed in healthcare, both public and private, by December 2022.

### Box 1. Sweden’s comprehensive workforce consolidation strategy

In 2024–2025, Sweden introduced a workforce strategy that shifts from passive recruitment incentives to performance-based measures with strict accountability. The centrepiece, the Rural and Remote Staffing Grant, allocates SEK 800 million annually to support permanent placements in underserved areas through salary supplements of up to 20 %, relocation bonuses, and free housing. To receive funding, regions must convert at least 70 % of temporary staffing expenditure into permanent contracts within two years. Complementary measures include a SEK 1.3 billion nurse-staffing fund to create more than 2 000 permanent posts and reopen closed beds, and scholarships providing a full salary during training for doctors in shortage specialties who commit to five years in underserved regions.

Regulatory changes in 2025 expanded advanced practice nurses’ scope to include prescribing most chronic-disease medications, while reforms to *Bastjänstgöring* (basic service) require all newly qualified doctors to complete at least 16 weeks in rural or county hospitals. Pathways for foreign-trained professionals were accelerated via fast-track licensing for EU/EEA nurses and a pilot offering 2 000 extended work visas for non-EU staff willing to work in shortage areas.

The accountability framework links 70 % of regional subsidies directly to increases in permanent staffing rather than agency hours. Regions must publish semi-annual dashboards on permanent positions, locum use, and turnover, while the NBHW may reallocate up to 10 % of funds mid-year away from underperforming regions, creating a strong incentive for measurable results.

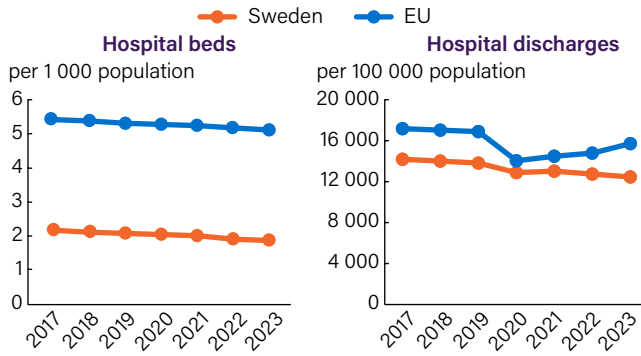
Sources: Socialstyrelsen (2024) and Regeringskansliet (2024).

discharge rates were about 20 % lower (Figure 18). In 2024, the NBHW confirmed a shortfall of 2 230 hospital beds, highlighting that the system’s infrastructure had become too small to meet demand. This capacity gap is geographically concentrated, with the three largest urban regions accounting for 60 % of the total shortfall.

In response, the government launched a multi-year expansion plan, allocating over SEK 2 billion (~EUR 180 million) annually to staff 1 220 new beds while addressing the remaining shortfall through efficiency gains. Implementation, however, has proved challenging: despite substantial funding, NBHW data showed a further decline of 40 staffed beds between

2023 and 2024 (Socialstyrelsen, 2025), with data revealing that the root cause of the shortfall stems less from a lack of physical capacity or financing than from a critical shortage of nursing staff. As a result, the strategy has been fundamentally redesigned: the government now requires workforce reforms, specifically targeting recruitment and retention, as a precondition for regions to access new capacity funding (SKR, 2025). The persistence of this challenge has led to a revision of targets: the original goal of closing the capacity gap by 2026 has been postponed to 2027, and the NBHW now warns that, without more decisive action, equilibrium may not be reached before 2033 (Socialstyrelsen, 2025).

**Figure 18. Sweden has one of the lowest hospital bed capacities in the EU**



Note: The EU average is weighted for hospital beds and unweighted for hospital discharges (calculated by the OECD).  
Sources: Eurostat (hlth\_rs\_bds1) and OECD Data Explorer (DF\_KEY\_INDIC).

**Persistent surgical backlogs have prompted reforms to strengthen Sweden's statutory care guarantee**

Sweden's waiting times for elective surgery reflect both the lingering effects of pandemic-related disruption and structural challenges in ensuring timely access. In 2021, average waiting times for hip and knee replacements rose to nearly 50 % above pre-pandemic levels. Although they declined substantially in 2022 and 2023, they remain above 2019 levels and continue to exceed those in regional peers such as Denmark. This recovery trajectory contrasts with Finland, where waiting times have continued to increase (Figure 19). Cataract surgery proved more resilient to pandemic pressures, yet access remains uneven: between August 2023 and August 2024, 41 % of patients nationally waited longer than the 90-day benchmark, ranging from just 7 % in Stockholm to 70 % in Västerbotten (Regeringskansliet, 2024). Across all elective surgical procedures, the statutory 90-day guarantee has not been met, with around 45 % of patients waiting beyond the target between 2021 and 2024 (Regeringskansliet, 2024).

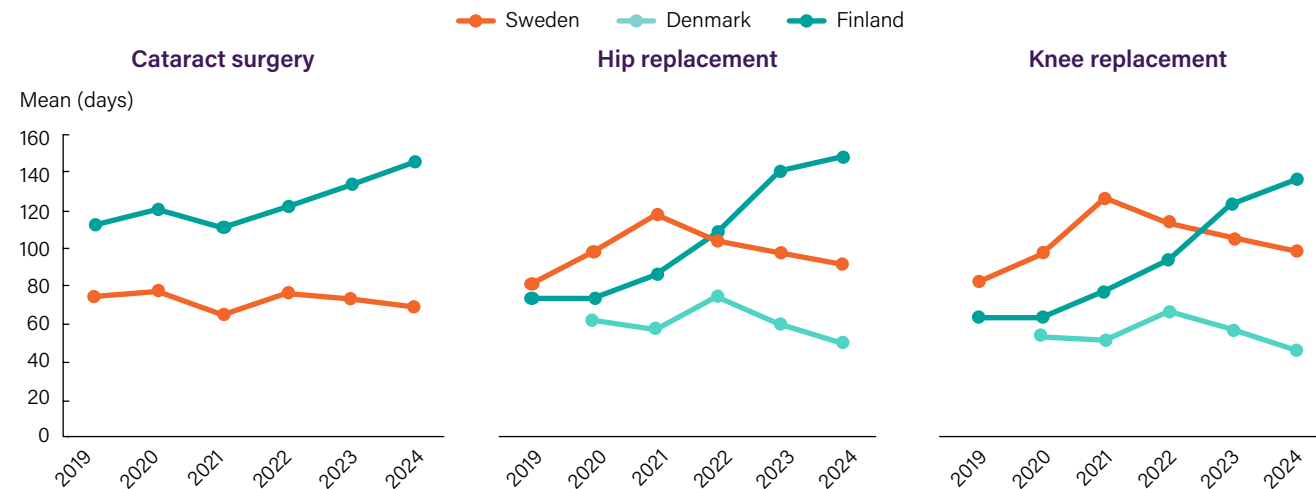
To address these persistent backlogs, the government launched an inquiry in 2024 to reinforce the statutory care guarantee. The inquiry proposed one-off, performance-based state contributions, shorter time limits and earlier cross-county referrals when local targets are not met. Based on its recommendations, the NBHW was tasked with allocating SEK 497 million to regions in 2025, with payments linked to additional procedures in hip replacement, pelvic organ prolapse repair, and cataract surgery (Socialstyrelsen, 2025).

**Sweden reformed medical and nursing education to better align training with workforce needs**

Sweden's annual medical graduate output has stabilised at approximately 14 graduates per 100 000 population in 2023, aligning with the EU average after gradual expansion that added about 440 training places between 2017 and 2023 (Figure 20). To accelerate the transition of new doctors into practice, Sweden undertook a major reform of medical education in 2021, replacing the previous internship requirement with a six-year programme leading directly to licensure. Graduates then complete an integrated first year of basic training (*Bastjänstgöring*) before entering residency programmes lasting at least five years. A key challenge has been alleviating training bottlenecks that delay progression to full qualification. Previously, new graduates waited an average of 11 months for an internship, and a priority of the reform is to prevent similar delays in the new basic training phase - particularly in general practice, where funded training posts remain insufficient. To address these shortages, the NBHW allocated SEK 847 million to regions between 2022 and 2024 to expand training capacity, with an additional SEK 226 million planned for 2025. Complementing these efforts, the National Care Competence Council submitted a 2025 plan to better align medical graduate output with funded residency placements (Regeringskansliet, 2025).

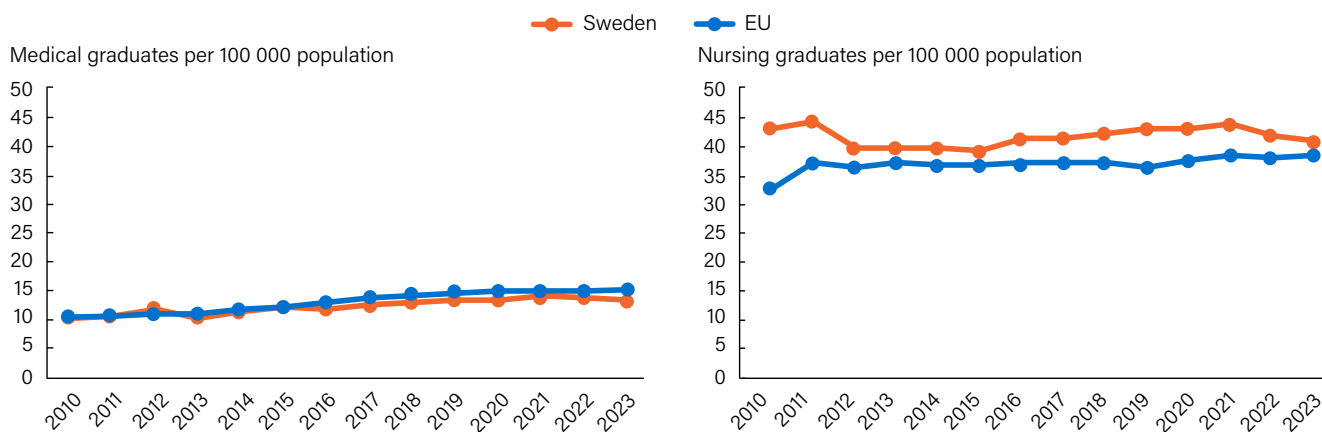
By contrast, nursing education in Sweden has historically been well aligned with workforce needs, although recent reforms are introducing new pressures. Graduate output remains stable and robust at 41 per 100 000 population

**Figure 19. Mean waiting times for hip and knee surgery in Sweden are lower than in Finland, but significantly above Denmark's**



Source: OECD Data Explorer (DF\_WAITING).

Figure 20. The medical and nursing graduates' output in Sweden is in line with EU averages



Note: The EU average is weighted (calculated by the OECD). Data include graduates from all nursing programmes, not limited to those meeting the EU Directive for general nurses.  
Source: OECD Data Explorer (DF\_GRAD).

in 2023, about 7 % above the EU average. However, the 2023 reform to comply with EU Professional Qualifications Directive requirements mandating at least 2 300 hours of supervised clinical practice has strained placement capacity and the availability of qualified supervisors. Nursing schools have sought implementation flexibility amid concerns that rapid expansion could compromise either admission levels or training quality (University of Gothenburg, 2023). Post-licensure pathways remain well established, with one-year postgraduate programmes in fields such as intensive care and midwifery. These advanced practice roles are becoming increasingly important as Sweden addresses workforce distribution and service delivery challenges through skill-mix adjustments.

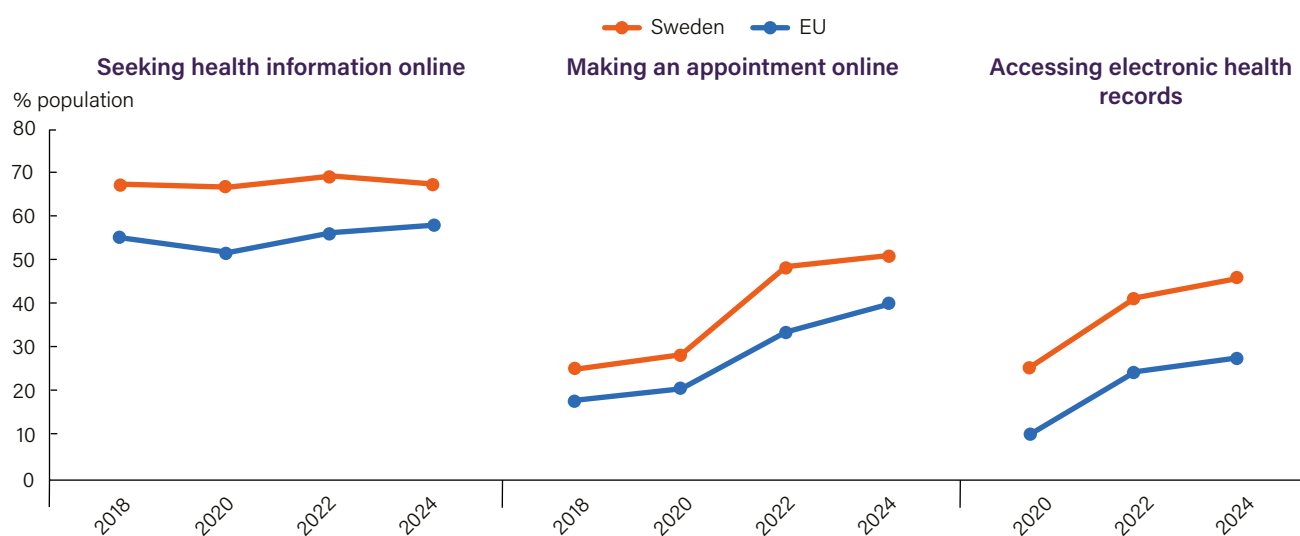
**High digital investment and strong public uptake make Sweden a European leader in technology-enabled healthcare**

Sweden's sustained strategic commitment to technology-enabled healthcare delivery positions the country among

Europe's most digitally advanced health systems. This commitment is evident in high levels of investment in health information and communication technology (ICT); in 2023, capital expenditure on health ICT reached EUR 5.9 million per 100 000 population, the third-highest level after Austria and Denmark and more than two and a half times the EU average.

The returns on this technological investment are clearly visible in population-level digital health engagement: Swedish residents demonstrate consistently higher utilisation of digital health services compared to other EU countries across multiple dimensions, including seeking health information online, scheduling appointments digitally and accessing personal e-health records (Figure 21). These high adoption rates reflect both the maturity of Sweden's digital health infrastructure as well as the population's comfort with technology-mediated medical interactions. Beyond citizen-facing services, Sweden continues strengthening its capacity to deliver healthcare services through other digital technologies such as artificial intelligence (AI) (Box 2).

Figure 21. Sweden exceeds the EU average in the use of digital health tools across all major areas



Source: Eurostat database (isoc\_ci\_ac\_i).

## Box 2. Leveraging AI to improve the quality and efficiency of Sweden's healthcare system

Sweden has established a coordinated national approach to integrating artificial intelligence into its publicly funded healthcare system. The government's Vision *eHealth 2025* and national AI strategy prioritise healthcare transformation, backed by significant investment in digital infrastructure. The flagship Information-Driven Healthcare programme (2019-2024) united all 21 regional health authorities with academia and industry to scale successful pilots nationwide. Real-world deployments already demonstrate tangible benefits:

- *Medical imaging and diagnostics:* AI-assisted mammography screening detected 4 % more cancers than traditional double-reading while halving radiologists' workload. Similar algorithms in pathology help specialists make more consistent diagnoses by quantifying immune cell patterns in cancer biopsies.
- *Predictive analytics and early intervention:* AI models predict patient no-shows to optimise appointment scheduling and reduce waiting lists. In neonatal intensive care, AI monitoring detects infections up to 24 hours before symptoms appear, enabling life-saving early treatment.
- *Workflow optimisation:* Pilots in primary care use AI-based triage tools to collect structured patient histories and prioritise cases, reducing administrative burden and improving patient flow.

The national centre *AI Sweden* coordinates many of these projects, including a 2024 partnership with Unity Health Toronto that combines leadership training, shared data platforms, and collaborative tool development across three major university hospitals. This systematic approach positions Sweden to scale proven AI applications nationwide, enhancing care quality and system efficiency while building healthcare workforce capacity for the digital future.

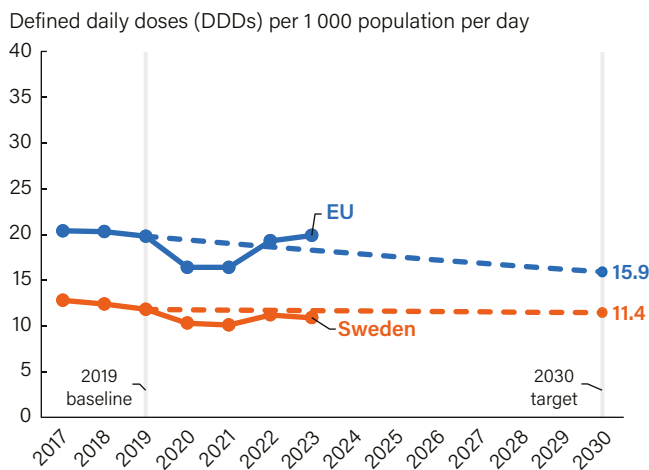
Source: AI Sweden (2025).

### Sweden is a European frontrunner in combating antimicrobial resistance

Sweden's approach to antimicrobial resistance (AMR) delivers exceptional outcomes, rooted in a long-standing culture of prudent use. Antibiotic consumption is the second-lowest in the EU and, after only a marginal pandemic-era decline from an already low baseline, rebounded modestly to an estimated 10.9 defined daily doses per 1 000 population in 2023, 45 % below the EU average and well within Sweden's national 2030 reduction target set under the EU Council Recommendation in 2023 (Figure 22). This positive result is reinforced by high-quality prescribing, with nearly 70 % of antibiotics falling within the WHO's low-resistance 'Access' group. As a direct result, the ECDC's composite AMR index ranks Sweden second-best in the EU.

Building on this foundation, Sweden is pioneering a transformative procurement model to ensure the availability of critical antibiotics without encouraging overuse. Piloted in 2020, the system de-links payment from sales volume by providing manufacturers with fixed annual payments. This removes the financial incentive for overuse while guaranteeing supply - an innovation that has attracted significant international attention. This approach is a cornerstone of Sweden's broader 2024-2025 national strategy to combat antibiotic resistance (Ministry of Health and Social Affairs, 2023).

Figure 22. Sweden has already reached its 2030 antibiotic consumption reduction target



Note: The EU average is weighted. The chart shows antibiotic consumption in hospital and the community. The dashed line illustrates the policy target pathway to meet the 2030 reduction targets defined by the EU Council Recommendation on stepping up EU actions to combat antimicrobial resistance in a One Health approach - 2023/C 220/01. Source: ECDC ESAC-Net; 2023 data for Sweden from Public Health Agency of Sweden and Swedish Veterinary Agency, Swedres-Svarm 2024.

# 6

## Spotlight on pharmaceuticals

### Strong cost-containment and broad access policies keep Sweden's pharmaceutical spending below the EU average

Despite Sweden's total health spending per capita being 22 % higher than the EU average, expenditure on retail pharmaceuticals was only EUR 454 per capita in 2023 - 11 % below the EU average of EUR 510, reflecting an effective combination of cost-containment and broad access policies (Figure 23). Within the Nordic region, Sweden ranks second in per capita retail pharmaceutical spending after Iceland, largely due to structural differences in medicine distribution. A comparatively large share of pharmaceutical consumption is channelled through community pharmacies rather than hospitals: reimbursed prescription drugs dispensed in retail settings account for over two-thirds of total pharmaceutical spending, compared with 59 % across the EU. Hospital-procured medicines represent about 20 %, while non-reimbursed prescribed drugs and over-the-counter (OTC) products make up the remainder. OTC medicines and medical non-durables constitute over one-third of retail spending, a relatively high share reflecting Sweden's permissive distribution model, which allows sales in both pharmacy and non-pharmacy outlets.

Sweden's cost-containment framework remains central as pharmaceutical consumption and spending patterns evolve (Box 3). Mandatory generic substitution sustains competitive pricing, with compliance so high that additional co-payments by patients opting for branded drugs account for only 0.3 % of total benefits-scheme costs. Confidential manufacturer rebates further reduce net public spending below list prices, while rigorous health technology assessments (HTA) and

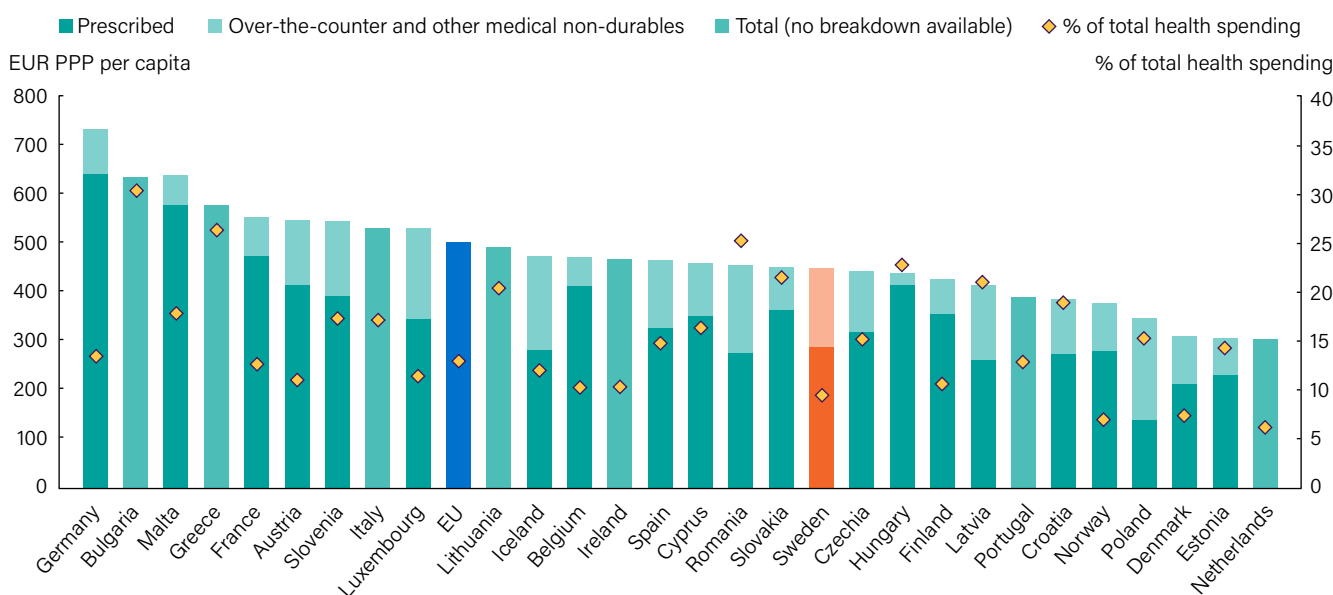
indication-specific reimbursement limits direct prescribing toward the most cost-effective options.

### Sweden manages pharmaceutical pricing and reimbursement through an ethics-based, prevalence-adjusted framework

Sweden's pharmaceutical pricing and reimbursement operate under a coordinated governance model that balances cost-effectiveness with patient access. The Dental and Pharmaceutical Benefits Agency (TLV) determines inclusion in the national benefits scheme and sets list prices, applying an ethical platform that prioritises human dignity, need and solidarity, and cost-effectiveness. Sweden does not use a single explicit cost-effectiveness threshold; willingness to pay varies by disease severity and, increasingly, population size. Since 2024, TLV has implemented a more nuanced framework, under which treatments for very rare conditions may be accepted at higher cost-effectiveness ratios, offset by expectations of lower prices for medicines used in larger populations.

To promote consistent adoption of new hospital therapies, the regions' Council for New Therapies (*NT-rådet*) issues national recommendations informed by TLV analyses, supported by a legal requirement for local medicines committees. Cost containment is reinforced by the expanding use of confidential rebates, with paybacks estimated at SEK 3.3 billion in 2023 and projected to reach SEK 4.7 billion in 2026 (TLV, 2025). Crucially, since 2024 TLV has assessed comparators using net prices (after confidential rebates), addressing the 'list-price illusion', whereby value can be overstated if benchmarked against a discounted incumbent (TLV, 2025).

**Figure 23. Sweden spends over 10 % less on retail pharmaceuticals compared to the EU average**



Note: This figure represents pharmaceutical expenditures dispensed through retail pharmacies for outpatient use only. It excludes medications administered in hospitals, clinics or physician offices.

Source: OECD Data Explorer (DF\_SHA). Data pertain to 2023, except for Norway and Malta (2022).

**Box 3. Sweden's pharmaceutical spending is projected to rise significantly in the next two years**

In 2024, Sweden's retail pharmaceutical spending was concentrated in a few therapeutic areas, reflecting uptake of innovative medicines alongside savings from patent expiries. Nervous-system medicines formed the largest category at SEK 6 billion, driven by new therapies for Attention Deficit Hyperactivity Disorder (ADHD) and migraines. Cardiovascular and oncology medicines were similarly large (each ~SEK 4.95 billion): cardiovascular outlays rose with newer agents, partly offset by generic entry, while oncology pressure eased due to recent patent expiries. Spending on biologics for inflammatory diseases grew by 12 %, tempered by price competition. The fastest growth was in diabetes treatments (SEK 3.69 billion; +14 %), reflecting wider use of newer agents.

Medicine costs are projected to continue rising, though policy changes could materially alter this path. The NBHW projects benefit-scheme retail medicine costs to increase by 20 % between 2024 and 2028, while hospital medicine costs are projected to grow by 15 %. These projections exclude the government's reform of high-cost protection thresholds (see Section 5.2), which is expected to reduce public spending on retail medicines by about SEK 2 billion annually from 2026.

Source: Socialstyrelsen (2025).

**Despite rigorous assessment, Sweden ensures comparatively fast and broad access to new medicines**

Despite TLV's rigorous assessment framework, Sweden delivers comparatively rapid access to new medicines. According to the EFPIA Patients W.A.I.T. indicator, between 2020 and 2023, 50 % of EU-approved products reached Swedish patients, above the EU average of 46 %, placing Sweden mid-pack within the Nordics on a par with Finland at 50 %, behind Denmark at 60 % and well ahead of Norway at 37 % and Iceland at 34 % (Newton et al, 2025). Speed is a particular strength: the median time from EU marketing authorisation to public availability is about 361 days, considerably faster than the EU average of 578 days and second only to Denmark (339 days) among Nordic peers. Notably, this performance is achieved without relying on formal early-access pathways that can inflate headline availability metrics elsewhere.

These comparisons, however, should be interpreted with care: the W.A.I.T. indicator measures time to public listing and the share of products listed, but it does not capture clinical uptake, prescribing restrictions or manufacturers' launch-sequencing decisions across markets. Lower 'availability' can reflect selective, value-based reimbursement rather than poorer access per se, and overall timelines depend not only on HTA appraisal but also on subsequent pricing negotiations, budget processes and the timing of company submissions. As Sweden integrates the EU HTA Regulation framework from January 2025, harmonised assessments and shared evaluation resources are expected to strengthen scientific rigour while potentially accelerating access to cost-effective innovations without compromising cost-containment principles.

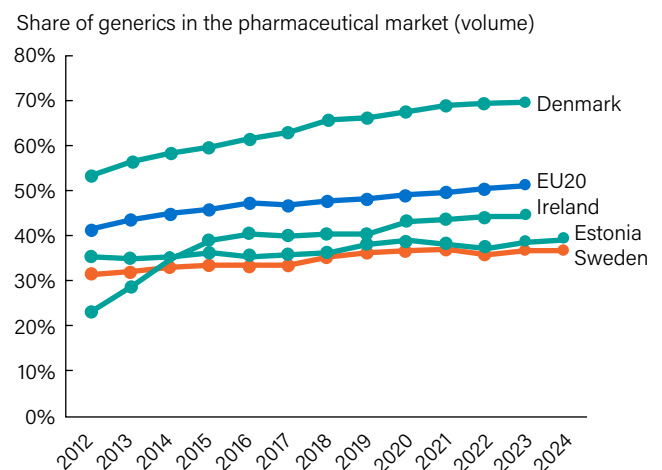
**A strict substitution system and price-control measures keep Sweden's off-patent medicine prices among the lowest in Europe**

Sweden employs a robust pharmaceutical cost-containment strategy, with generic substitution playing a central role in keeping prices low by international standards. Since 2002, a 'product-of-the-month' system has required pharmacies

to dispense the least-expensive reimbursed, substitutable product within designated substitution groups and package sizes. The Swedish Medical Products Agency defines substitutability criteria, while TLV designates the monthly 'winners' and backups; originator products can compete directly with generics and are sometimes selected as the most cost-effective option.

This framework has sustained high generic uptake and low off-patent prices. In 2023, generics accounted for roughly two-thirds of retail prescription volumes, while their value share remained substantially lower, reflecting strong price competition. TLV's 2023 international comparison found Sweden to have the lowest prices among 20 European countries for medicines facing generic competition (TLV, 2023). Measurement issues can, however, obscure this performance in cross-country comparisons. Using defined daily doses (DDDs) across the entire pharmaceutical market, the generic share in 2023 was under 40 %, below the EU average of 51 % (Figure 24). This apparent gap reflects a

**Figure 24. Sweden's total generic market penetration by volume is lower than the EU average**



Note: The EU average is weighted.  
Source: OECD Data Explorer (DF\_GEN\_MRKT).

broader denominator and a smaller retail base in Sweden, as a growing share of outpatient prescribing concerns still-patented specialist medicines (e.g. GLP-1 receptor agonists) outside the substitution regime. Moreover, when originators underbid competitors and win monthly tenders, savings are realised without increasing the 'generic' numerator (E-hälsomyndigheten, 2024).

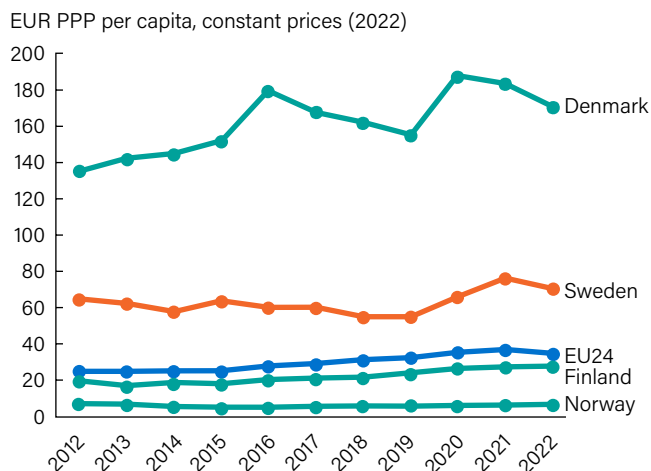
Beyond substitution-driven savings, Sweden applies a "15-year rule" that automatically reduces list prices by 7.5 % for older products with limited generic competition once the substance-form group reaches 15 years from initial marketing authorisation, maintaining tight price control where market forces alone may be insufficient.

### Sweden's pharmaceutical R&D ecosystem combines substantial business investment with expanding public support

Sweden hosts a strong pharmaceutical research and development (R&D) base, anchored by both large-firm laboratories and a dense network of small and medium-sized biotech companies. This strength is evident in the country's per capita business R&D investment by pharmaceutical manufacturers, which reached EUR 71 per capita in 2022. This figure is more than double the EU average of EUR 35 and represents a 7 % increase from 2019, following years of gradual decline. While this investment intensity is below leaders such as Denmark, it notably surpasses both Finland and Norway (Figure 25). In absolute terms, pharmaceutical R&D rose to about SEK 18.1 billion in 2023, accounting for nearly 5 % of total EU pharmaceutical business R&D. Industrially, Sweden is also a meaningful producer, ranking eighth in the EU and representing roughly 4 % of EU pharmaceutical output in 2023 (EFPIA, 2025).

Policy support is significant: payroll-based tax relief reduces employer social charges by 20 % on eligible R&D salaries, with the monthly cap raised to SEK 3 million per corporate group from January 2024. The 2024 Research and Innovation Bill sets a four-year funding trajectory, adding SEK 1.5 billion in 2025 and scaling to SEK 6.5 billion by 2028, with approximately SEK 600 million earmarked for precision medicine, mental health, women's health, and dementia research (Regeringskansliet, 2024). The R&D environment is further strengthened by open-access translational platforms such as SciLifeLab's Drug Discovery and Development platform, the Testa Centre bioprocess testbed in Uppsala and the National ATMP Innovation Cluster coordinated by Vinnova. The Bill also targets research capacity: of the 2028 increment, roughly SEK 1.6 billion is directed to higher-education research appropriations and SEK 4.9 billion to research councils and institutes.

**Figure 25. Sweden's business pharmaceutical R&D investment is twice the EU average**



Note: The EU average is weighted (calculated by the OECD).  
Source: OECD Data Explorer (DF\_ANBERDi4).

### Sweden remains a strong pharmaceutical innovator, though declining clinical trial activity has prompted new policy measures

Sweden's innovation metrics show sustained strength alongside emerging pressures that have prompted policy action. International patent activity indicates sustained momentum: after falling from over 12 per million population in 2010 to 6.3 in 2014, applications have exceeded 10.0 annually since 2018, peaking at 13.6 in 2021. This level is two to three times the EU average, with Sweden-based applicants accounting for roughly 7 % of all pharmaceutical patent applications originating from EU countries, a notable share given Sweden's comparatively small population.

Clinical trial activity has also been a key strength, historically operating at nearly double the EU average at about 35 new trials per million population. However, a 21 % drop in trial applications per capita in 2023 has triggered a proactive policy response to maintain the country's competitive edge. The government has launched an inquiry to boost trial numbers, while the Medical Products Agency is piloting innovative decentralised trials involving home visits and remote monitoring (Swedish Medical Products Agency, 2024). This comes as Sweden's research landscape remains distinctive, with a relatively high proportion of publicly-funded clinical trials (60 %) and a strong focus on early-phase development.

## 7 Key findings

- Sweden demonstrates excellent population health outcomes, with life expectancy at birth reaching 84.1 years in 2024, nearly two and a half years above the EU average and the highest in the EU. Cardiovascular diseases and cancer remain the main causes of mortality, collectively accounting for 54 % of all deaths. While incidence and prevalence rates for these conditions are above the EU average, this reflects the strength of the health system, with advanced case detection leading to more people living longer with managed disease. Sweden leads the EU in healthy ageing, with 65-year-olds enjoying the highest healthy life expectancy in the EU.
- Behavioural and environmental risk factors caused one-quarter of deaths in Sweden in 2021, below the EU average. Poor diet is the leading contributor, followed by tobacco use. While Sweden has the EU's lowest adult smoking rates, adolescent e-cigarette use is rising. Despite high adult physical activity levels, poor diet and low adolescent fruit consumption contribute to adult obesity rates above the EU average.
- Sweden's highly decentralised healthcare system provides universal coverage financed predominantly by public sources, resulting in low out-of-pocket payments. Resources are heavily oriented towards outpatient services and long-term care, while inpatient care accounts for a below-average share of 22 %. While doctor and nurse densities remain well above the EU average, sizeable regional disparities in their availability persist despite recent efforts to expand permanent staffing and reduce reliance on temporary locum doctors.
- Sweden leads the EU in avoidable mortality with treatable mortality 34 % below the EU average and preventable mortality 35 % lower, the best performance in the EU. High vaccination coverage supports this success, including influenza uptake exceeding the EU average and HPV vaccination at 85 %. Cancer screening participation is exceptional, with breast, cervical and colorectal screening rates substantially exceeding EU averages. Strong outpatient care effectiveness is demonstrated by hospital admissions for chronic conditions 25 % below the EU average.
- Sweden has high public coverage for inpatient and outpatient care, keeping financial barriers to access low. However, unmet medical needs rates slightly exceed the EU average, driven primarily by long waiting times, with about 30 % of patients waiting beyond the mandated 90-day specialist consultation limit. Sweden is increasing the annual out-of-pocket ceiling for medicines to address rising costs. At the same time, it is expanding public dental coverage for younger and older age groups.
- Sweden faces significant hospital capacity challenges; with the EU's lowest hospital bed density, nursing staff shortages undermine expansion efforts causing surgical backlogs, as 45 % of patients wait beyond the 90-day guarantee for elective procedures. Medical and nursing education reforms are underway, though clinical placement bottlenecks persist. Conversely, Sweden leads in technology-enabled healthcare with the third-highest health ICT investment and strong digital tool adoption. The country is a European frontrunner in antimicrobial resistance, maintaining the second-lowest antibiotic consumption in the EU.
- Despite high overall health spending, Sweden's retail pharmaceutical expenditure per capita is 11 % below the EU average, reflecting a robust cost-containment framework driven by mandatory generic substitution, expanding use of confidential rebates and rigorous health technology assessments. Despite this rigorous framework, Sweden provides faster access to new medicines than most EU countries, with a median time to availability of 361 days. The country's pharmaceutical R&D ecosystem is a key strength, with business R&D investment per capita more than double the EU average.

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### Country abbreviations

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



# State of Health in the EU

## Country Health Profiles 2025

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 2025 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;
- an account of the pharmaceutical sector and policies within the country.

Complementing the key findings of the Country Health Profiles is the *Synthesis Report*.

For more information, please refer to:  
[https://health.ec.europa.eu/state-health-eu\\_en](https://health.ec.europa.eu/state-health-eu_en)

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