Sweden

Health system **summary** 2024

European Observatory on Health Systems and Policies
a partnership hosted by WHO

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Contents

This Health System Summary is based on the *Sweden: Health System Review* (HiT) published in 2023 but is significantly updated, including data, policy developments and relevant reforms as highlighted by the Health Systems and Policies Monitor (HSPM) (www.hspm.org). For this edition of the Health System Summary, key data have been updated to those available in September 2024 unless otherwise stated. Health System Summaries use a concise format to communicate central features of country health systems and analyse available evidence on the organization, financing and delivery of health care. They also provide insights into key reforms and the varied challenges testing the performance of the health system.

Main sources:

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How is the health system organized?

Health care is decentralized to regions and municipalities, with national oversight

Organization

Health care is part of social protection in Sweden, with predominantly tax-based financing and public provision. The goal is to provide good health and care on equal terms. It covers almost everyone who lives or works in Sweden, a population of around 10.6 million. The main responsibility for financing, organizing and providing health care is delegated to the 21 regions (see Box 1). The responsibilities of the 290 municipalities include financing, organizing and providing health care in ordinary and special housing for elderly people and people with functional impairments, as well as health care in schools, including preventive health care, basic medical services and health education for students.

Box 1 Capacity for policy development and implementation

The national government is responsible for the overall regulation of Sweden's health care system. Policy development typically occurs through government commissions that propose regulatory reforms. While regions and municipalities must adhere to national laws and regulations, they enjoy significant autonomy within these boundaries. This autonomy includes developing local health systems, clinical pathways, contracting services to private providers, payment systems, care programmes and priority setting. Shared responsibility between national and local governments strengthens the system but also poses challenges in coordination and adherence to national reforms. Additionally, divided responsibility among semi-autonomous government agencies can lead to coordination issues and misalignment from a local government perspective.

Planning

The Ministry of Health and Social Affairs, supported by national agencies, is responsible for overall health care policy and high-level oversight. Regions and municipalities set priorities based on population needs and system constraints, making political decisions accordingly. Regions allocate resources and responsibilities across health care providers, monitor provider activities, and hold them accountable for their performance. Boards of elected politicians manage priority setting and resource allocation to health care providers.

Providers

Each region in Sweden has a highly integrated health care system, with most hospitals owned and operated by the regions. However, the mix of public and private outpatient providers varies significantly across regions. Primary Care Centres (PCCs) employ a range of professionals, including general practitioners (GPs), registered nurses, physiotherapists and psychologists. Since the introduction of freedom of establishment in 2010, the number of privately owned PCCs operating with public financing has increased, though the balance of public and private PCCs still differs widely among regions.

How much is spent on health services?

Health expenditure in Sweden is relatively high and the health system provides universal coverage

Funding mechanisms

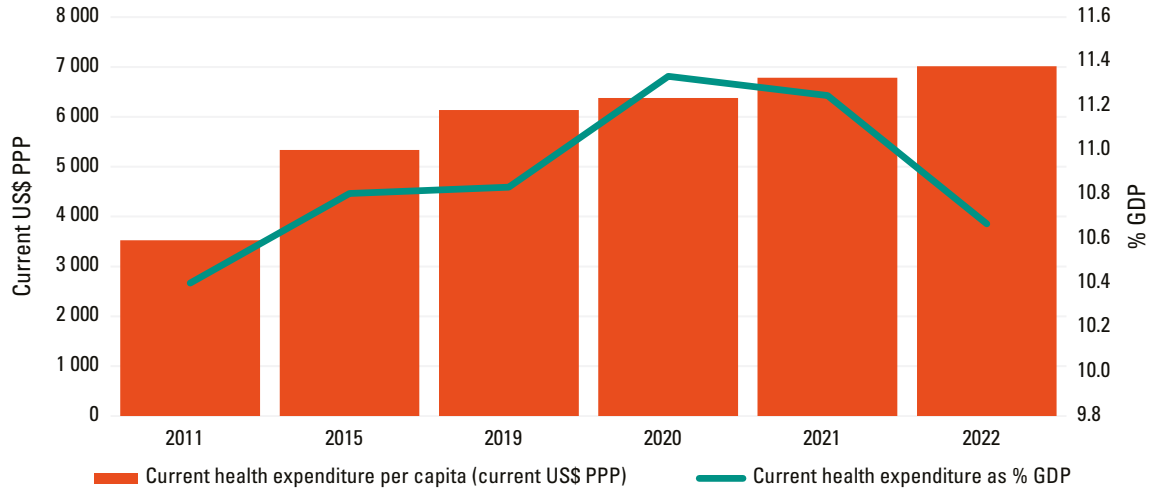
Health expenditure is funded by local taxes and supplemented by national government grants and user charges. National government spending in 2022 accounted for 23%, regional spending was 44%, and municipality spending was 19%. National government funding has increased significantly since 2015, especially during the pandemic year 2020. Private health financing represented 14% of current health expenditure in 2022, where the majority (92%) came from households' out-of-pocket (OOP) payments. Voluntary health insurance (VHI) has mainly a complementary role, representing 1% of total health expenditure in Sweden.

Health expenditure

Between 2011 and 2022, health expenditure per person in Sweden, when adjusted for differences in purchasing power, nearly doubled, from US$ 3526 to US$ 7017 (Fig. 1). Compared with other countries in the EU, current health expenditure per capita in Sweden is well above the EU average of US$ 4104 (Fig. 2). As a percentage of GDP, Sweden's health expenditure grew from 10.4% in 2011 to 10.7% in 2022 (Fig. 1) and remains above the EU average of 8.5%.

Public expenditure on health was 86% of total health expenditure in 2022, which is well above the EU average and third highest in the EU, behind Germany and Luxembourg.

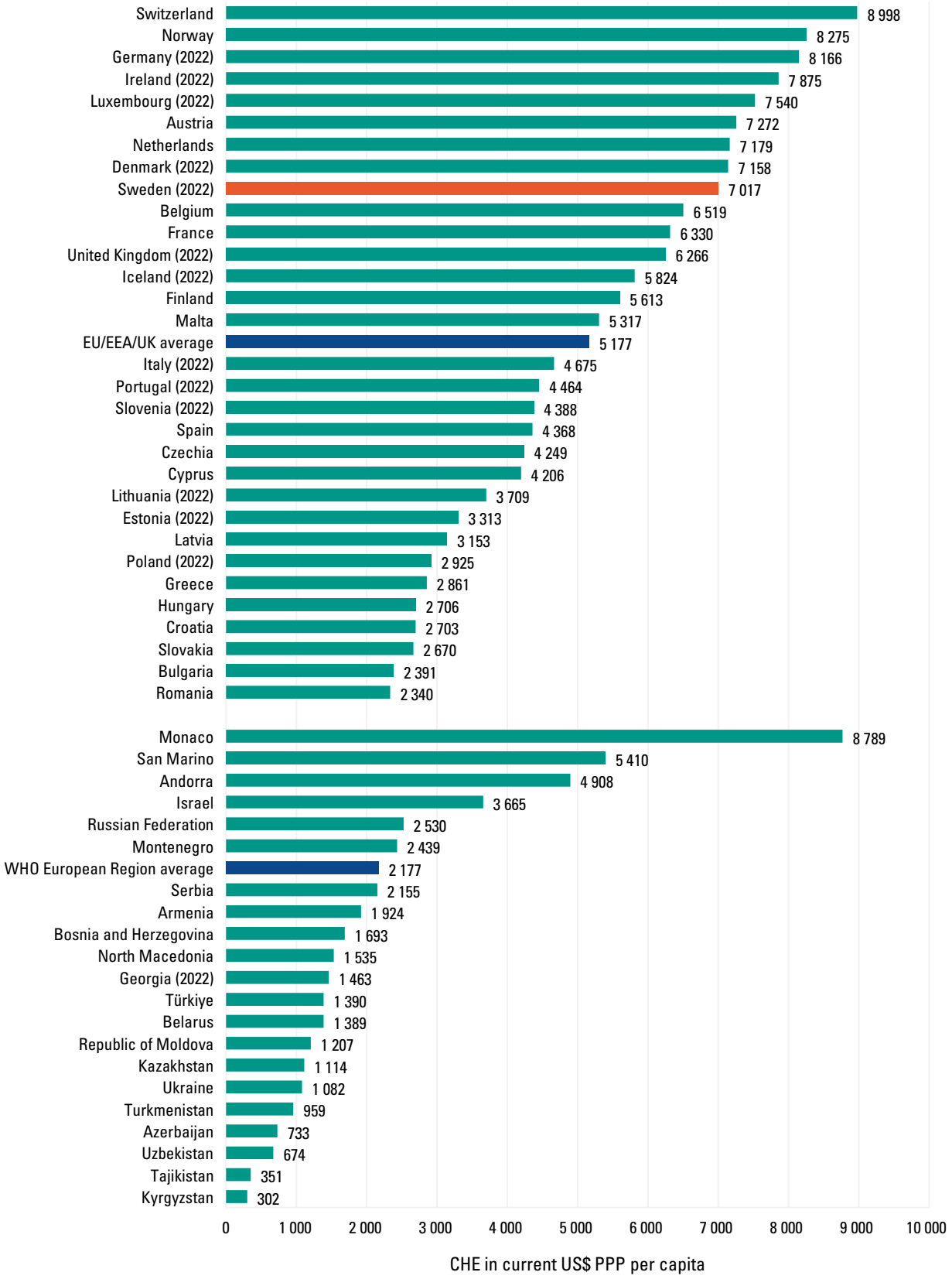
Fig. 1 Trends in health expenditure, 2011–2022 (selected years)



Notes: GDP: gross domestic product; PPP: purchasing power parity. This time series was selected because in 2011, the calculation of health care expenditure was altered, when part of the elderly care expenditure was reclassified as health care. This meant that health care expenditure increased by 2.1% as a share of GDP between 2010 and 2011.

Source: WHO, 2024.

Fig. 2 Current health expenditure (US$ PPP) per capita in WHO European Region countries, 2021 or latest year available

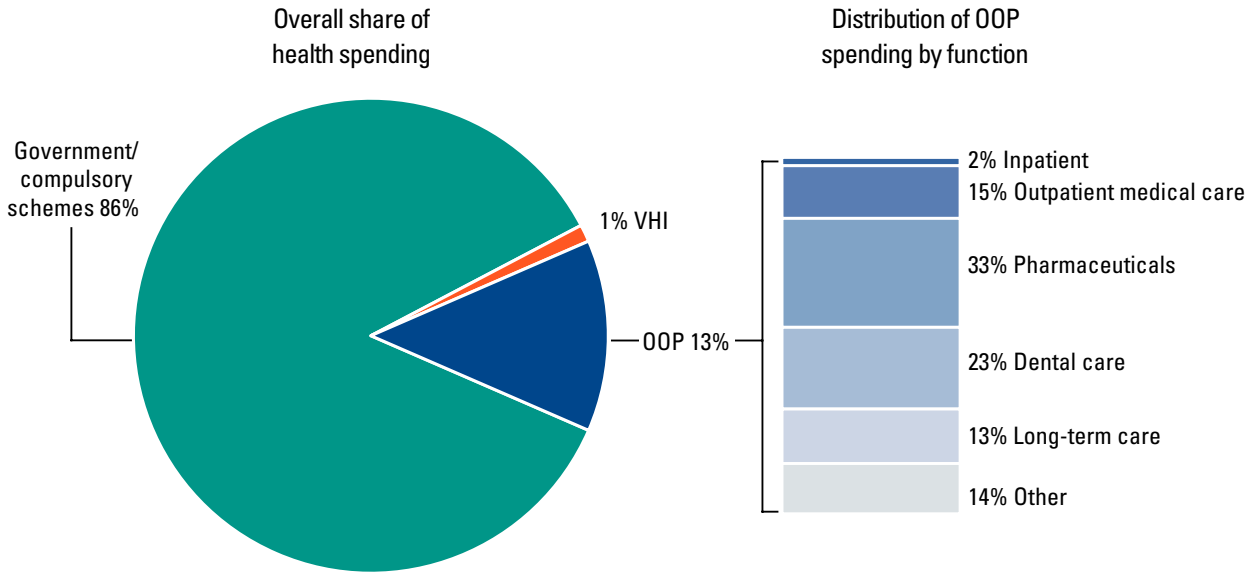


Notes: CHE: current health expenditure; EEA: European Economic Area; EU: European Union; PPP: purchasing power parity.
Source: WHO, 2024.

Out-of-pocket payments

About 13% of health spending in Sweden comes from out-of-pocket payments (OOP) (Fig. 3). The three largest areas of OOP health spending are pharmaceuticals (33%), dental care (23%) and outpatient care (15%). Patient fees are charged for almost all types of services and medical products, with exceptions such as child and maternity care, dental care up to 24 years of age, and many services for people aged 85 years and older. The regions determine the fees, so they vary across the country. There are annual caps on specific types of user fees, such as primary care, outpatient care, and pharmaceuticals.

Fig. 3 Composition of out-of-pocket payments, 2022



Notes: OOP: out-of-pocket; VHI: voluntary health insurance.
Source: OECD, 2024.

Coverage

The Swedish health care system is generous in both breadth and scope, as coverage is based on registered residence and all cost-effective treatments should be included; however, there is no predefined benefits package. Instead, the Health and Medical Services Act states that responsible health care authorities are obliged to provide care on the basis of need to all residents. Waiting times are the main barrier to access (see Box 2 and the section *Accessibility and financial protection*).

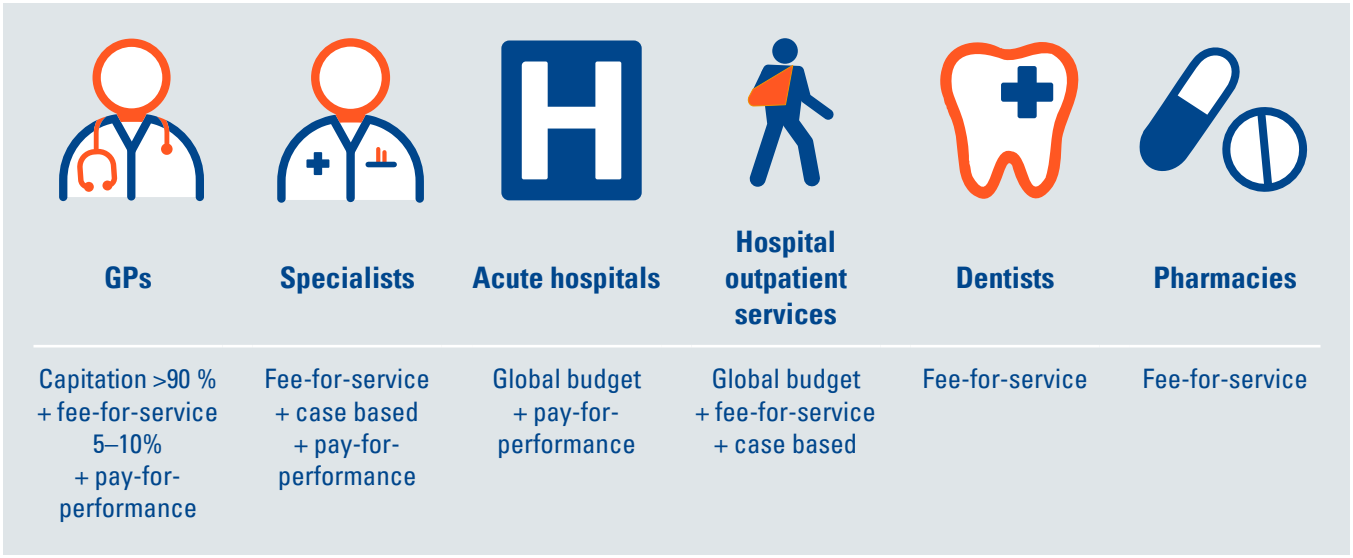
Box 2 What are the key gaps in coverage?

Although there is universal coverage, important rationing mechanisms include waiting times and OOP payments. The level of private cost-sharing is higher for medicines, dental care and technical devices, which are not covered by public funding to the same extent as hospital stays and outpatient care. Hence, there are relatively few people who forgo care and treatment due to various patient fees, but this is significantly more common with dental care. The proportion of the population who state that they forgo care for economic reasons is also low in Sweden compared with reports in other countries, as is the share of households that experience catastrophic spending. Various patient surveys report that long waiting times are a greater reason for forgoing care than OOPs (AHSCA, 2021; Eurostat, 2023).

Paying providers

The use of market mechanisms and contract-based governance have become the prevailing system within primary care following the 2010 choice reform. In primary care, the main form of payment is risk-adjusted capitation for listed patients (Fig. 4). The proportion of capitation varies between the regions. For specialized care, publicly owned hospitals and specialist clinics, global budgeting has historically been the basis for provider payment. Diagnosis-related group (DRG) compensation is only used exceptionally, and its role has decreased within hospital payment. In comparison with primary care, pay-for-performance (P4P)-related payment is less common in specialized care.

Fig. 4 Provider payment mechanisms in Sweden



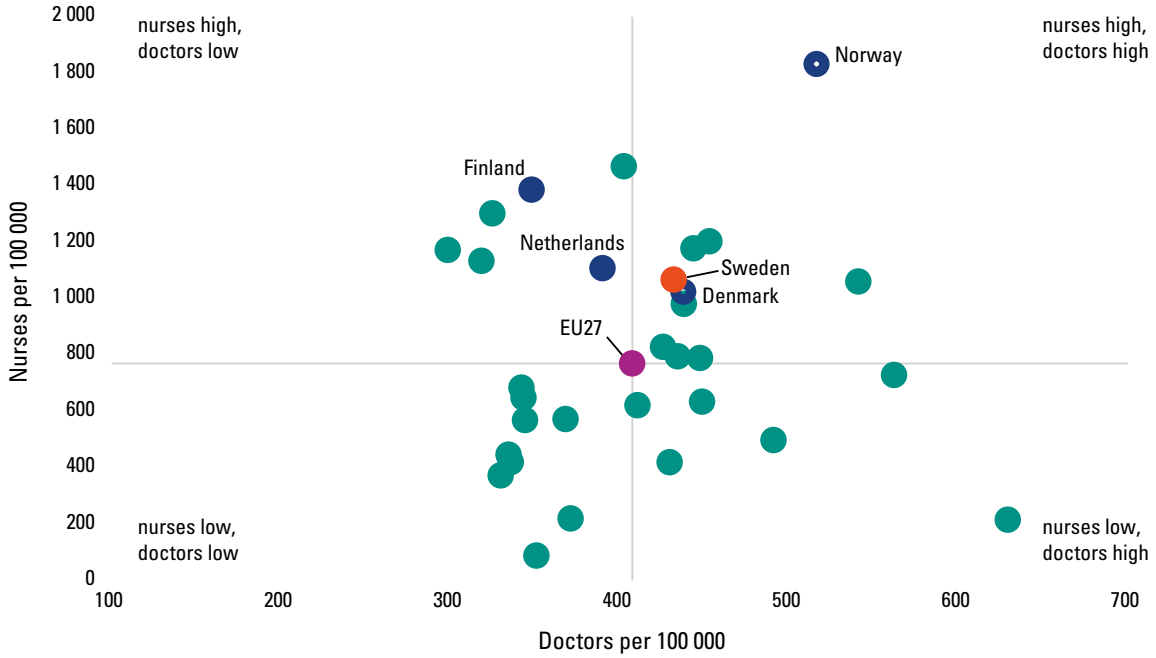
What resources are available for the health system?

Sweden has high numbers of doctors and nurses but is facing shortages of GPs and specialist nurses

Health professionals

Sweden has a comparatively high number of both doctors and nurses per capita for the EU, at 432 practicing physicians and 1067 practising nurses per 100 000 inhabitants in 2021 (Fig. 5). Despite an overall increase in the number of physicians since 2000, several regions report a shortage, particularly of GPs. Furthermore, the share of physicians specializing in general practice is lower in Sweden than in comparable countries. The number of registered nurses per capita has decreased since 2015 and regions report a shortage, particularly for nurses with specialist competence. There are large geographical differences in the number of health workers per inhabitant.

Fig. 5 Practising nurses and physicians per 100 000 population, 2021 or latest available year

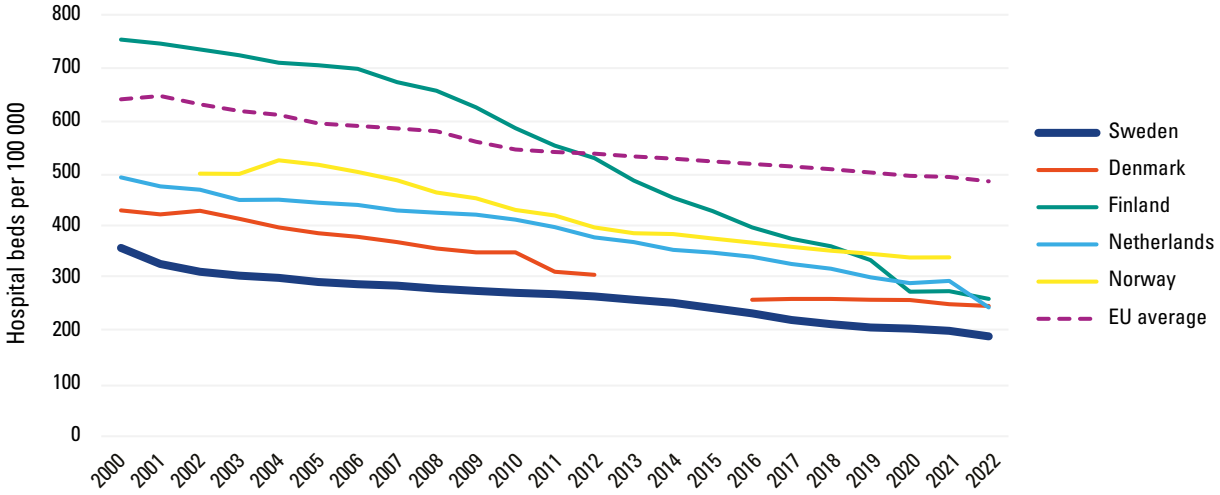


Note: Nurse numbers are for practicing nurses (with EU recognized qualification).
Source: Eurostat, 2024.

Health infrastructure

The 21 regions in Sweden work together within six larger collaborative health care regions, each of which includes at least one university hospital. There are 66 emergency hospitals, and nearly all regions are engaged in significant efforts to renovate or replace existing facilities. Sweden had 190 hospital beds per 100 000 inhabitants in 2022, the lowest rate in the EU (Fig. 6). This low number may be attributed to the extensive provision of care in both regular and specialized housing. Medical equipment is financed by the regions, and in 2022, Sweden had 1.74 magnetic resonance imaging (MRI) units and 2.37 computed tomography (CT) scanners in hospitals per 100 000 population (Fig. 7).

Fig. 6 Hospital beds per 100 000 population in Sweden and selected countries, 2000–2022



Source: Eurostat, 2024.

Fig. 7 Magnetic resonance imaging (MRI) and computed tomography (CT) scanners in Sweden, per 100 000 population, 2022

	MRI scanners per 100 000 population	CT scanners per 100 000 population
Sweden	1.74	2.37
Lowest and Highest in EU (range)	0.56 (Hungary) - 3.73 (Greece)	1.07 (Hungary) - 4.88 (Greece)

Source: Eurostat, 2024.

Distribution of health resources

Most primary care centres (PCCs) are located in densely populated and metropolitan municipalities. For those in rural areas, the average distance to travel is longer because large parts of Sweden are sparsely populated. Even though there are hospitals in each region, there are significant differences in average travel times to a hospital across regions. For instance, in the three largest regions of Stockholm, Skåne and Västra Götaland, almost no inhabitants have a travel time to a hospital exceeding 45 minutes. In the more sparsely populated regions, between 15% and 36% of inhabitants have a travel time that exceeds 45 minutes (SAHCSA, 2018).

How are health services delivered?

Health services are delivered in an accessible and flexible way

Public health

The Public Health Agency oversees national public health responsibilities, focusing on surveillance and analysis of communicable diseases, as well as contingency planning for outbreaks. The 21 infectious control units in the regions handle operational infection control, providing support, advice, and conducting contact tracing. Around 70 notifiable diseases are registered under the Communicable Diseases Act, categorized by their level of risk. Regions organize screening programmes based on National Board of Health and Welfare (NBHW) recommendations, which vary regionally, with general screening for breast, cervical and colorectal cancers.

Responsibilities are divided: regions manage primary care, child and maternal health, and youth clinics, while municipalities oversee social and school

health services, emphasizing preventive care and mental health support for students. Municipalities also manage public health aspects such as food control and sanitation. The Regional Administrative Boards represent the government in the regions, ensuring national goals are met locally. Employers are mandated to provide occupational health care, covering physical and mental health services for employees. Non-governmental organizations, especially in sports, play a crucial role in public health, largely supported by voluntary efforts and some national funding.

Primary and ambulatory care

The regions and municipalities share responsibility for primary care in Sweden. Regions primarily focus on providing primary care for the general population, ensuring access to GPs. Meanwhile, municipalities offer basic nursing health care to patients receiving social services and home care. Sweden operates under a freedom of choice system, allowing for the establishment of health care providers within regional primary care. PCCs employ various health care professionals alongside GPs (Box 3).

Key differences lie in the scope of services covered by the choice system across regions and in how regional health care and municipal health and social care are organized. The gatekeeping role of primary care and access to outpatient specialized care can vary between regions. However, patients are always free to seek primary care and outpatient specialized care without any geographical restrictions.

Box 3 What are the key strengths and weaknesses of primary care?

Efforts to enhance primary care in Sweden have been ongoing since the early 1970s, focusing on multi-professional Primary Care Centres (PCCs) where GPs, nurses, specialist nurses, counsellors, and occupational therapists collaborate in providing patient care. The emphasis on PCCs as the organizational unit, rather than individual GPs, reflects this tradition.

In recent years, both national and regional levels have agreed on a reform agenda to shift health care delivery from hospitals to primary care/PCCs, specialist clinics, mobile teams, digital solutions, or patient homes. However, the anticipated financial redistribution from hospitals to primary care has not materialized, with ongoing challenges in access outside office hours and care coordination, especially for patients with chronic illnesses. In 2022, it was estimated that there were approximately 40% fewer (full-time equivalent) GPs than the number indicated as needed by PCCs (SAHCSA 2023).

Hospital care

Since the mid-1990s, there has been a growing emphasis on transitioning from hospital inpatient care to outpatient and day care, alongside concentrating highly specialized services, and distinguishing emergency care from elective care. Efforts also aim at integrating care horizontally and vertically within the health system (Box 4). The National Board of Health and Welfare estimates a shortage of 2230 care place in 2023, with a balanced situation possible by 2026 through adding 1220 places and reducing needs by 1010 (NBHW, 2024). There is no specific regulation governing emergency care, allowing regions to adapt their emergency care protocols. Patients with trauma or critical conditions are often referred to regional or university hospitals.

Box 4 Are efforts to improve integration of care working?

In 2015, clinical pathways (*Standardiserade vårdförlopp*) were introduced in cancer care to enhance coordination among care providers, aiming to reduce waiting times and regional disparities. Initial evaluations have shown positive effects on coordination, continuity of care and collaboration among different stakeholders, although the impact on waiting times remains inconclusive.

In 2019, person-centred and cohesive pathways (*personcentrerade och sammanhålla vårdförlopp*) were introduced across other diagnostic areas to streamline patient processes and minimize unnecessary waiting times for both diagnosis and treatment. Given the recent implementation of these pathways, evidence on their effectiveness is still limited.

Additionally, the Act on Coordinated Discharge was enacted in 2018 to improve integration between regional and municipal health care providers, as well as municipal social services, for patients discharged from inpatient care.

Pharmaceutical care

Pharmaceutical distribution is highly regulated, with the pharmacy market mostly adhering to a single-channel system (the direct-to-pharmacy model) despite re-regulation efforts. About 98% of pharmaceuticals are distributed through two main distributors. Generic substitution is compulsory for medically equivalent drugs. Regions maintain formulary committees to advise on pharmaceutical use in primary care and outpatient settings. The Council on New Therapies provides recommendations to regions regarding the use of new and costly pharmaceuticals, playing a significant role in pharmaceutical governance.

Long term care

Sweden has a comprehensive, publicly financed long-term care system, with national policy promoting home care over institutional care. The responsibility for means testing, financing, and organizing long-term care services for elderly individuals and people with functional impairments lies with the municipalities. Generally, receiving long-term care requires a needs assessment, except for services such as security alarms and some home care. The Social Services Act is a framework law emphasizing the right of individuals to receive public services, such as special housing or help at home, according to their needs at all stages of life. Children and adults with extensive functional impairments are also entitled to support according to a specific act.

Dental care

Both public and private operators provide dental care in a competitive market. Approximately two thirds of adult dental care within the general allowance is conducted at around 3550 clinics operated by 2000 private care providers. The financing of dental care for individuals over 24 years of age differs from the rest of the health care system, as the majority is financed out-of-pocket by households. While providers are free to set their own prices, the Dental and Pharmaceutical Benefits Agency determines the reference prices for different treatments.

What reforms are being pursued?

Reforms endeavour to enhance primary care, standardize specialist care and improve infrastructure

Box 5 provides a snapshot of the key health reforms over the past 10 years. The 2015 Patient Act granted citizens free choice of primary and outpatient specialized care nationally, but led to unexpected consequences with the establishment of new private digital health care providers and increased expenditures. To strengthen primary care, the government initiated targeted funding in 2018 to develop a new system emphasizing prevention and person-centred services. The reform agenda aims to clarify primary care responsibilities, enhance regional and municipal collaboration, and establish PCCs as the first contact point. Specialist care reforms focus on evidence-based, standardized processes, and service concentration at national and regional levels. Key initiatives include six collaborative regional cancer centres and the National System for Knowledge-driven Management, which organizes care into 26 national programme areas. Legislation in 2018 limits national specialized medical care to five units meeting specific criteria. Future developments may involve debates on transferring responsibilities from regions to the national government.

More recent reforms include the use of performance-based payments from the government to regions to address the decreasing number of care places in hospitals per capita and enhance patient safety. In June 2023, the Swedish eHealth Agency was directed to create a roadmap for a unified national digital infrastructure for health care, automate information transfer to national quality registers, and study a uniform certificate handling system. Additionally, a national investigation is underway to improve municipal health care staffing and conditions. To tackle long waiting times, a new care intermediation system will connect patients with alternative providers, supported by a national catalogue of available services and waiting times. A May 2024 inquiry proposed a stronger waiting time guarantee for specialized care, allowing patients to receive care outside their region without extra cost. Additionally, a national plan for maternity care was initiated in early 2024 to ensure safe, accessible and equal maternity care.

Box 5 Key health system reforms over the past 10 years

Patient Act (2015): The Patient Act of 2015 is a cornerstone of Swedish health care policy, focusing on person-centred care and allowing patients free choice of outpatient care provider nationwide. This legislation aims to empower patients by giving them more control over their health care decisions and ensuring their preferences and needs are prioritized.

National System for Knowledge-driven Management (2018): Established in 2018, the National System for Knowledge-driven Management aims to ensure equitable access to evidence-based, high-quality health care across Sweden. This system enhances care coordination and standardizes practices, promoting consistency and quality in health care outcomes.

National Specialized Medical Care (2018): Implemented in 2018, this regulation limits national specialized medical services to a maximum of five health care units. It concentrates resources and expertise, ensuring efficient and effective delivery of complex medical interventions.

National Medication List (2021): Introduced in 2021, the National Medication List allows patients to maintain and share comprehensive medication information with health care providers, enhancing medication management and patient safety.

Box 5 (Continued)

Changes to the Health Care Act (2019 and 2022): Amendments in 2019 and 2022 emphasize preventive and primary care in Sweden's health care system. They regulate citizen registration with primary care practices, ensuring timely access to necessary health care services.

New care intermediation system (2023): These initiatives seek to identify areas of excess capacity, enabling quicker patient access to care, with the Swedish eHealth Agency developing the necessary infrastructure and a national catalogue detailing all health care providers and their services.

National plan for maternity care (2024): The aim is to establish a clear nationwide strategy for comprehensive maternity care, covering pregnancy, childbirth and postpartum, while promoting strategic improvements to enhance accessibility and reduce regional disparities.

How is the health system performing?

Sweden has high patient satisfaction and low unmet needs for health care

Health system performance monitoring and information systems

Health system performance is monitored through several systems. National health data registries, which are mandatory and population-based, contain individualized data on diagnosis and health care consumption (excluding primary care). National medical quality registries cover specialized care, containing individualized data on diagnosis, treatment, and outcomes. The National Board of Health and Welfare (NBHW) produces reports on health care developments, dental care, social services, and international comparisons.

Primary care quality includes over 150 indicators for acute and chronic conditions, mental illness, rehabilitation, continuity, multimorbidity and lifestyle habits. In January 2024, 97% of PCCs could track their results through automated data extraction (SALAR, 2024). Open comparisons refer to annual performance comparisons of different health care services published by NBHW, with the 2015 report including 350 measures. National health care monitoring by the Swedish Agency for Health and Care Services Analysis (SAHCSA) uses indicator-based assessments.

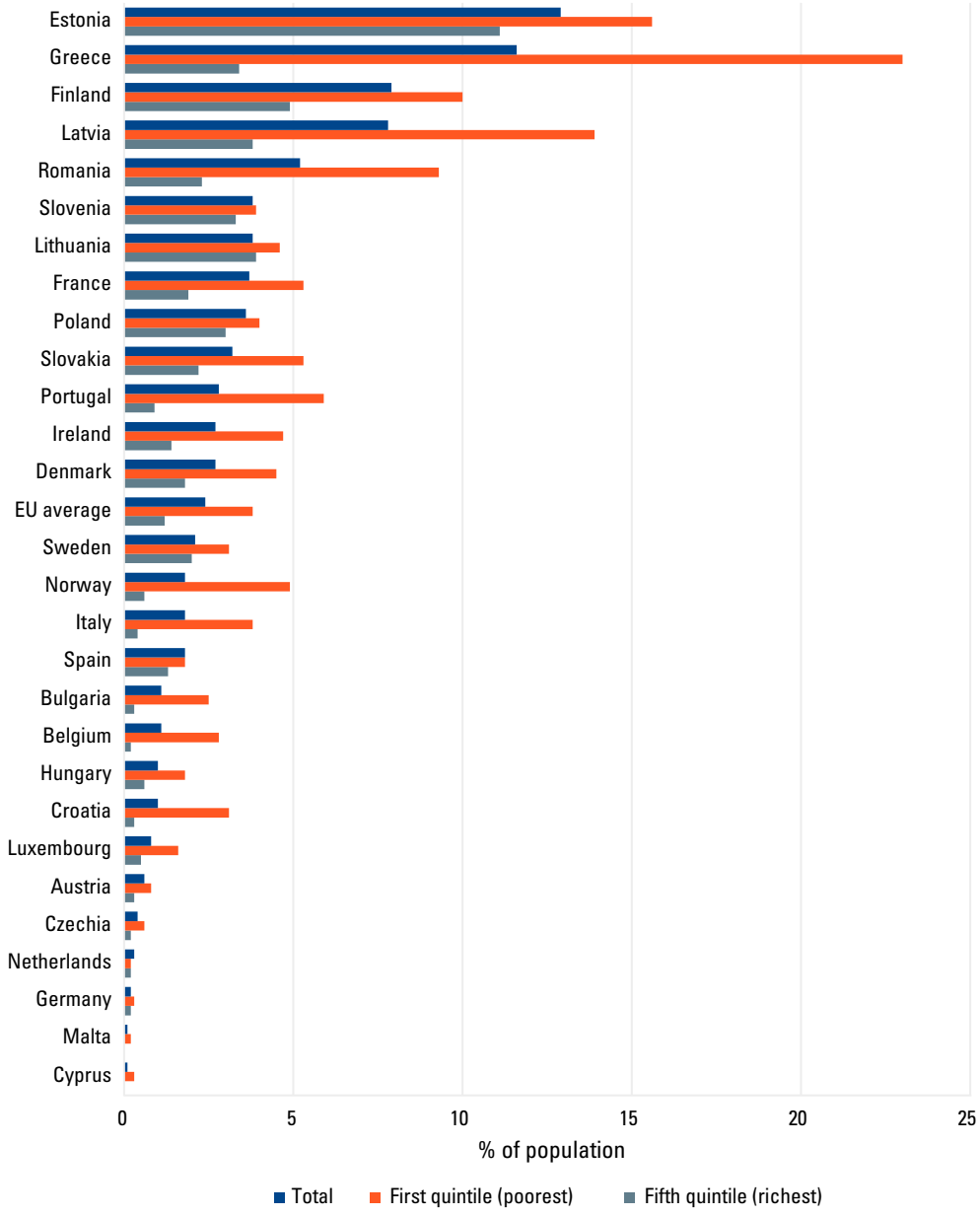
Accessibility and financial protection

Overall, unmet needs for medical care in Sweden are just below the EU average (Fig. 8). Unmet needs for health care due to costs or distance are very low in Sweden, but higher than the EU average with respect to waiting times. Although long waiting times are not a new challenge within the Swedish health system, the share of patients on waiting lists having a first appointment, surgery or other planned treatments

within the national care guarantee has been decreasing. In 2023, 30% of patients had been waiting for a first appointment in specialized care for longer than the waiting guarantee limit of 3 months; this was 40% for treatment or surgery. In May 2024, the government launched an inquiry aimed at creating a new waiting time guarantee for specialized care featuring shorter time limits, earlier care from outside the patient's region, and measures for supervisory authorities to enforce the guarantee without financial penalties.

The share of households that experienced catastrophic healthcare spending is also low in Sweden from an international perspective. However, it is somewhat more common to have refrained from accessing dental care than from other health care due to costs.

Fig. 8 Unmet needs for a medical examination (due to cost, waiting time, or travel distance), by income quintile, EU, 2023



Source: Eurostat, 2024.

Health care quality

The measures of health care quality are generally high in Sweden and show a positive trend. Since 2008, the number of patients being admitted to hospitals for diabetes, chronic obstructive pulmonary disease, asthma or congestive heart failure and hypertension has decreased by more than one third (NBHW, 2022a). This is lower than in comparable countries such as Denmark and Finland (see Fig. 9). Mortality in cancer and diagnoses such as acute myocardial infarction and stroke have also decreased. In particular, the in-hospital mortality rate for haemorrhagic stroke has decreased and is lower than in comparable countries (Fig. 10).

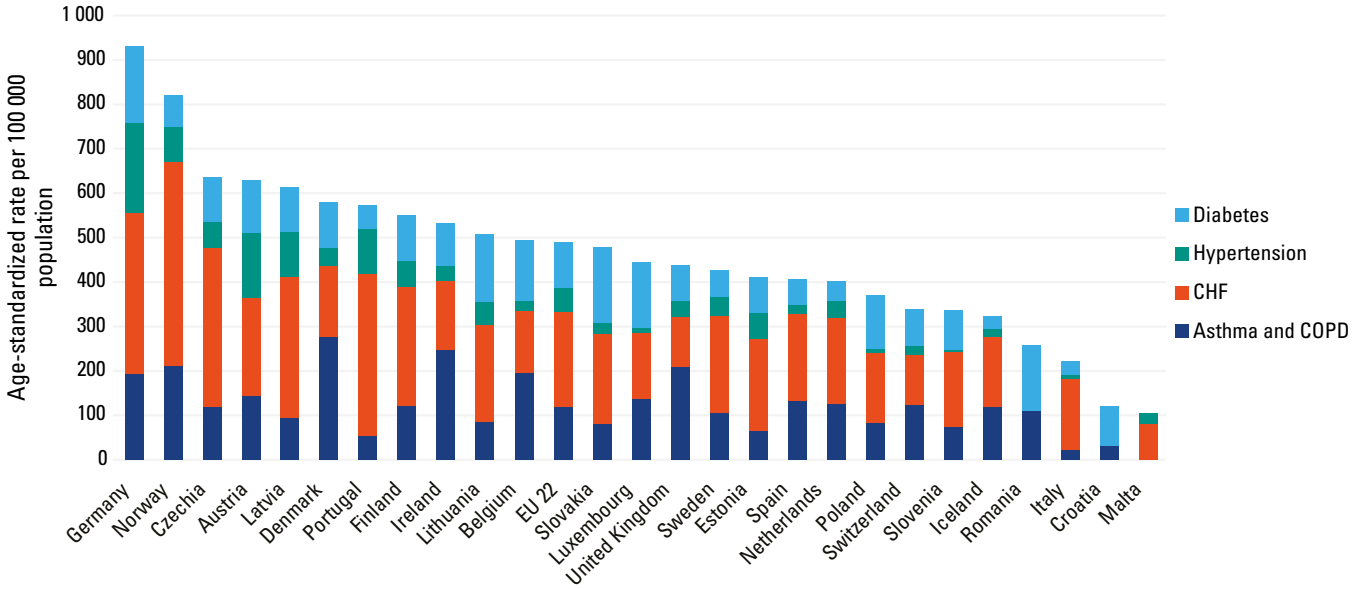
A majority of Swedish patients are satisfied with the quality of care that they receive (Box 6). However, a lower share of patients experience primary care as person-centred. Moreover, Swedish patients are comparatively less satisfied with the coordination of care than their European counterparts. There is also unwarranted variation in availability of care and health outcomes between socioeconomic groups and geographical regions.

Box 6 What do patients think of the care they receive?

A majority of Swedish patients have positive experiences with health care staff and coordination: 83% report positive encounters regarding participation, co-creation, treatment and communication, while 77% are satisfied with coordination between providers. Elderly individuals, those with lower education levels, and men are generally more positive, whereas patients in worse health report poorer experiences (SAHCSA, 2022).

Internationally, Sweden performs well in hospital care experiences, with 92% of patients feeling involved in care decisions and 94% stating that doctors often or always treated them in a professional manner in 2021. However, primary care and regular GP appointments show poorer results in patient participation in treatment and in care coordination (SAHCSA, 2021).

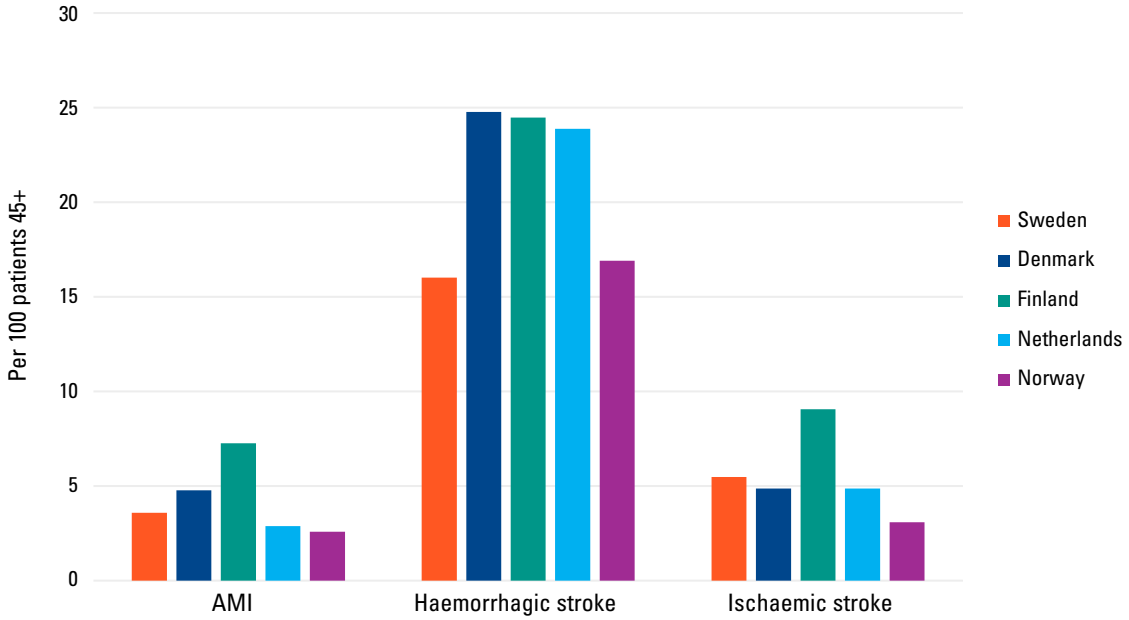
Fig. 9 Avoidable hospital admission rates for asthma and chronic obstructive pulmonary disease, congestive heart failure, hypertension and diabetes, 2021



Notes: CHF: congestive heart failure; COPD: chronic obstructive pulmonary disease. Croatia and Romania: no data for CHF or hypertension; Malta: no data for asthma & COPD or diabetes.

Source: OECD, 2024.

Fig. 10 In-hospital mortality rates (deaths within 30 days of admission) for admissions following acute myocardial infarction, haemorrhagic stroke and ischaemic stroke, Sweden and selected countries, 2021 (or latest year available)



Note: AMI: acute myocardial infarction.

Source: OECD, 2024. (Data refer to 2021 or nearest year).

Health system outcomes

In comparison with other EU countries, Sweden records among the lowest levels for mortality due to preventable and treatable causes (Fig. 11). Sweden performs better in terms of preventable mortality than, for instance, Finland, Denmark, Norway, the United Kingdom and the Netherlands (see also Box 7). For mortality from treatable causes, among the Nordic countries only Norway performs better. The low rate of treatable mortality indicates that the Swedish health care system has been effective at an overall system level at focusing on selected conditions related to mortality.

Treatable mortality is higher for men than for women, but the difference has decreased over the past 18 years: from almost 30 deaths per 100 000 inhabitants in 2000 to about 10 per 100 000 inhabitants in 2018 (NBHW, 2020). Treatable mortality is also higher in those with lower educational attainment. There are also geographical differences; the difference between regions with the lowest and highest treatable mortality is about 20 deaths per 100 000 population. Differences between groups in the population with different levels of education and across regions have decreased since 2013 (SAHCSA, 2022).

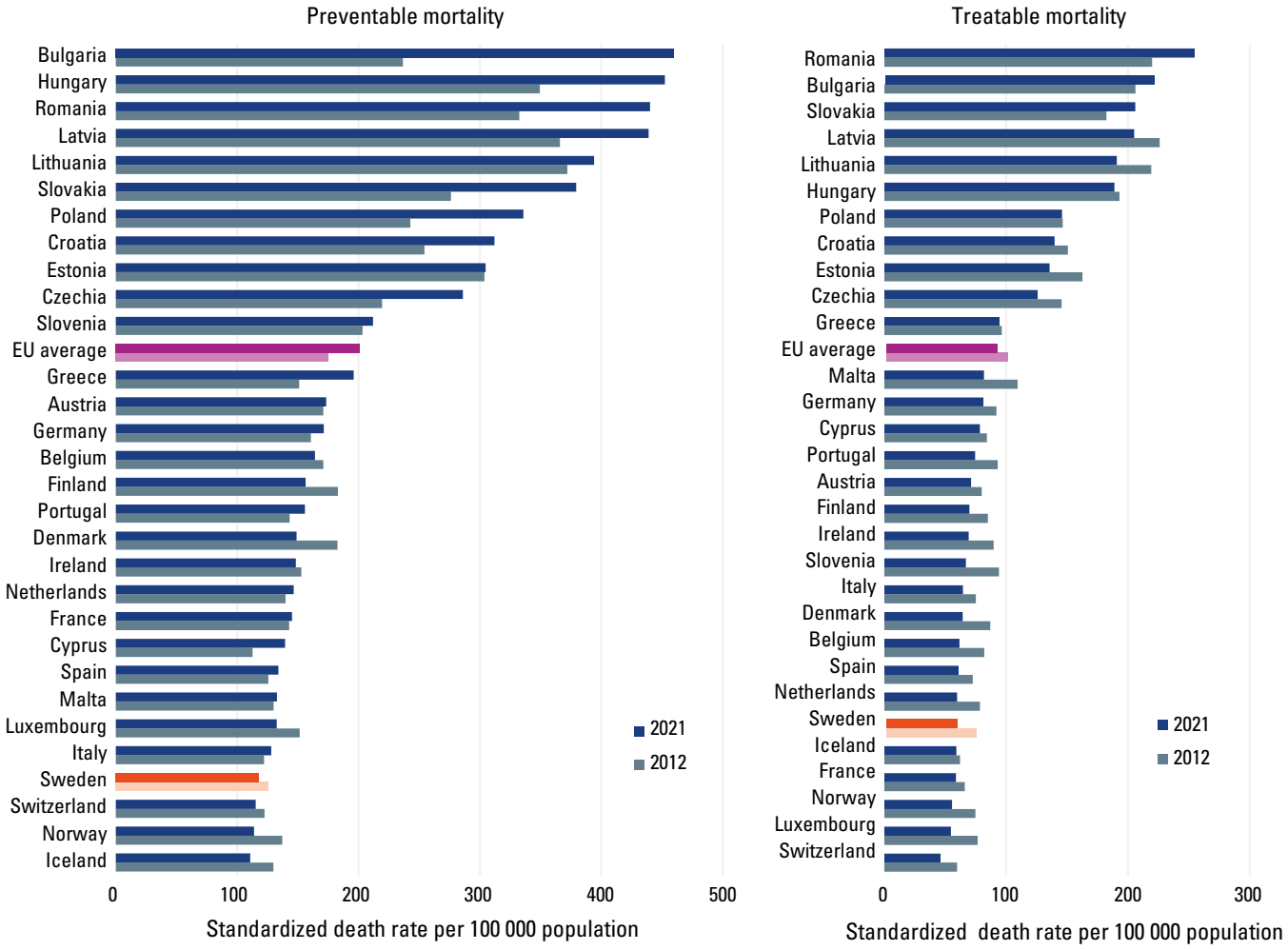
Box 7 Are public health interventions making a difference?

The number of daily smokers in Sweden has decreased by 60% since 2006, reaching 6% in 2021, due to no-smoking campaigns, tax increases and smoking bans, with a significant decline among younger age groups. However, daily snuff use among 16-29-year-olds has risen, prompting new nicotine regulations in 2022.

Alcohol consumption indicating increased risk dropped to 15% in 2021, a 10% decrease since 2006, primarily due to reduced drinking among 16-29-year-olds, while trends in other age groups vary. Public health measures include alcohol taxation, a government retail monopoly (*Systembolaget*) on alcoholic drinks containing over 3.5% alcohol by volume, and restricted marketing.

Obesity prevalence has increased by 30% since 2006, contributing significantly to chronic disease and premature death. National efforts to combat this include public awareness campaigns, grants to sports organizations, health promotion in schools and physical activity on prescription recommendations in clinical practice.

Fig. 11 Mortality from preventable and treatable causes, 2012 and 2021



Note: After 2020, deaths due to COVID-19 are counted as preventable deaths, resulting in an increase in mortality from preventable causes for most countries.

Source: Eurostat, 2024.

Health system efficiency

As an entry point for discussion, Figure 12 shows that Sweden has low treatable mortality rates but high health care expenditure compared with countries with similar mortality levels. It performs well in some common technical efficiency metrics, including average length of stay in hospital, day-case surgery rates and in generic substitution (see Box 8). However, it performs less well in input measures such as staff turnover, sickness absence and deployment of staff.

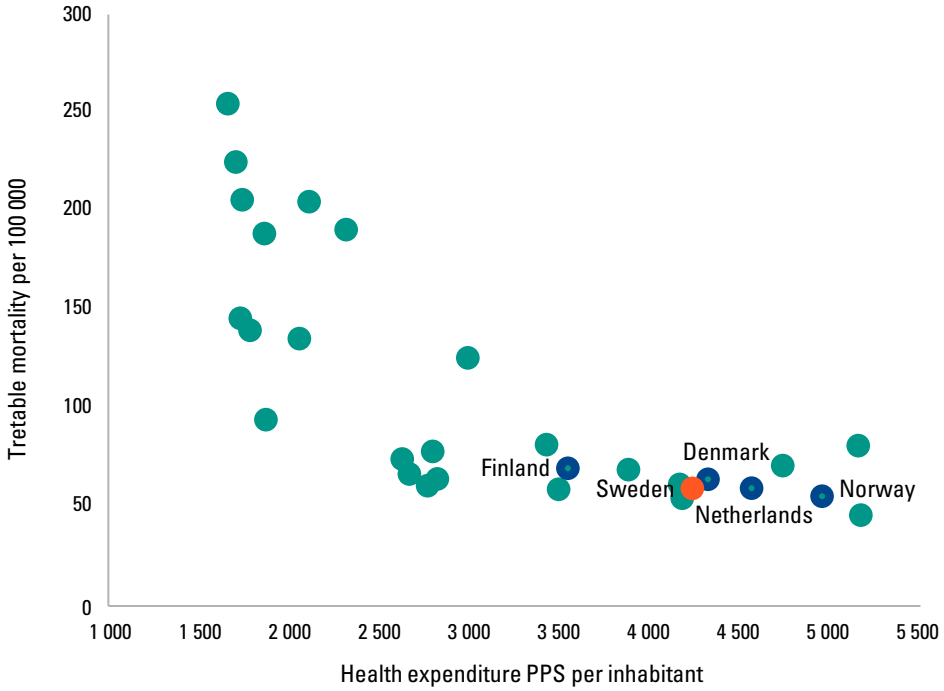
Hospital technical efficiency in Sweden is weaker than in other countries, partly due to difficulties in recruiting and retaining nurse specialists, which is influenced by perceptions of a poor working environment. Sweden has the lowest number of hospital beds per capita in the EU and one of the shortest hospital stays. While bed occupancy rates are high, indicating efficient use, this also leads to bottlenecks and workplace challenges. Productivity in Swedish hospitals is slightly lower compared with Denmark, Norway and Finland (Rehnberg, 2019).

Box 8 Is there waste in pharmaceutical spending?

Pharmaceuticals that are 5–15 years old have comparatively high prices in Sweden and are at the same time used the most. In part, the relatively high price level for new, effective pharmaceuticals in comparison with older, less effective pharmaceuticals in the medium period in Sweden is a result of value-based pricing. This pricing strategy aims to enable equal and early access to new and innovative medicines, while maintaining good cost control and cost-effective use over time.

In 2015, all of Sweden's regions adopted a collaborative model with authorities and companies to ensure the cost-effective and efficient use of certain new drugs. This model, known as nationally ordered implementation, involves negotiating prices and jointly managing the introduction and monitoring of drugs based on recommendations from the Council on New Therapies. In 2021, these agreements led to estimated savings of about SEK 2.7 billion (€254 million) on prescription pharmaceuticals (TLV, 2022).

Fig. 12 Treatable mortality per 100 000 population versus health expenditure per inhabitant, Sweden and selected countries, 2021



Note: PPS: purchasing power standard.

Source: Eurostat, 2024.

Summing up

Sweden's health care system is focused on accessibility, efficiency, and modernization

The Swedish health care system is characterized by high public funding, universal coverage, the adoption of modern technologies and proactive efforts to prevent unhealthy lifestyles. These factors contribute to low levels of unmet needs, favourable health outcomes and a generally good health status compared with other countries.

Improving availability of services has been a key policy goal, with efforts including the introduction of privatization and increased choice in primary care and certain areas of specialist care. Recent reforms have primarily focused on enabling quicker patient access to care, reducing waiting times, enhancing continuity and coordination of care and improving overall health system efficiency. Several initiatives have been aimed at strengthening the primary care sector. Reforms in specialist care have concentrated on implementing evidence-based, standardized care processes and further centralizing services at national and regional levels. Additionally, regions have shifted financial incentives for providers from activity-based and P4P models to fixed and/or capitated payments. Other innovations include supporting role substitution among staff categories, advancing digitalization and establishing a national maternity care strategy.

Population health context

Key mortality and health indicators

Life expectancy (years)	2023
Life expectancy at birth, total	83.4
Life expectancy at birth, male	81.7
Life expectancy at birth, female	85
Mortality	**2021**
All causes (SDR per 100 000 population)	849.74
Circulatory diseases (SDR per 100 000 population)	257.05
Malignant neoplasms (SDR per 100 000 population)	206.62
Communicable diseases (SDR per 100 000 population)	22.18
External causes (SDR per 100 000 population)	47.85
Infant mortality rate (per 1 000 live births)	1.9
Maternal mortality per 100 000 live births (modelled estimates)*	4.5

Notes: * Maternal mortality data is for 2020

Sources: Eurostat, 2024; WHO Regional Office for Europe, 2024

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