



# State of Health in the EU

## Sweden

### Country Health Profile 2021

## The Country Health Profile series

The State of Health in the EU's Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policymakers and influencers with a means for mutual learning and voluntary exchange.

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

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## Data and information sources

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

(HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

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

This profile was completed in September 2021, based on data available at the end of August 2021.

## Demographic and socioeconomic context in Sweden, 2020

Demographic factors	Sweden	EU
Population size (mid-year estimates)	10 327 589	447 319 916
Share of population over age 65 (%)	20.0	20.6
Fertility rate <sup>1</sup> (2019)	1.7	1.5
Socioeconomic factors		
GDP per capita (EUR PPP <sup>2</sup> )	36 643	29 801
Relative poverty rate <sup>3</sup> (%; 2019)	17.1	16.5
Unemployment rate (%)	8.3	7.1

<sup>1</sup>. Number of children born per woman aged 15-49. <sup>2</sup>. 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. <sup>3</sup>. Percentage of persons living with less than 60 % of median equivalised disposable income. Source: Eurostat database.

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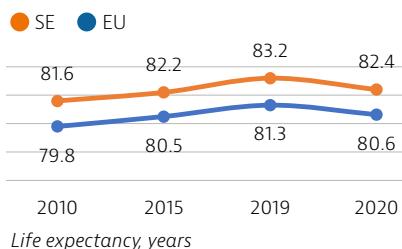
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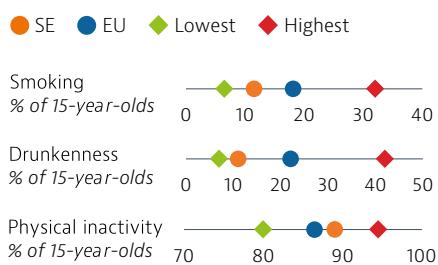
# 1 Highlights

Life expectancy in Sweden is among the highest in the EU, although it declined by nearly one year in 2020 as a result of the COVID-19 pandemic. The health care system generally performs well in providing good access to high-quality care. However, challenges persist in providing equal access to care for the population living in different regions, ensuring timely access to care, achieving greater care coordination for people with chronic diseases and improving the quality of long-term care.



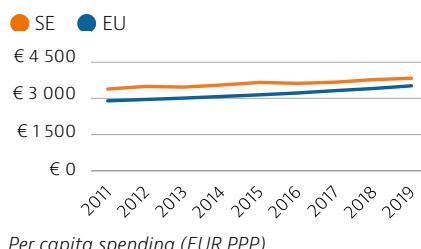
## Health status

Life expectancy at birth was 82.4 years in 2020 – almost two years above the EU average – but it fell by almost one year in 2020 because of the high number of deaths from COVID-19. More than two thirds of COVID-19 deaths were among people aged 80 and over.



## Risk factors

Smoking rates among adults in Sweden are among the lowest in EU countries, but use of other tobacco products such as snuff is common. Overall alcohol consumption per adult has decreased over the past decade and is much lower than the EU average. Adolescents in Sweden also report low rates of smoking and excessive alcohol intake, but high rates of physical inactivity.

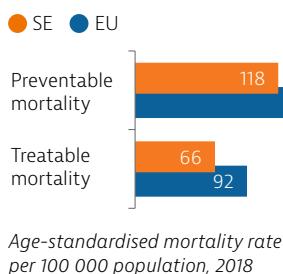


## Health system

Health spending per capita in Sweden was the fourth highest in the EU in 2019, and the third highest in terms of health spending as a share of GDP. Most health spending is publicly funded (85 %). The growth rate in health spending was relatively modest in the years prior to the pandemic, but the government increased spending on health in 2020 and 2021 in response to COVID-19.

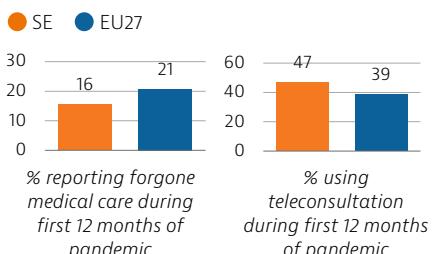
## Effectiveness

Sweden had low rates of mortality from preventable and treatable causes in 2018, pointing to a generally effective public health and health care system under normal circumstances.



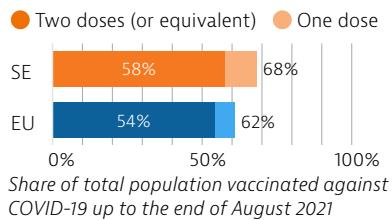
## Accessibility

During the first year following the pandemic, one in six people in Sweden reported some unmet needs for medical care, which is lower than the EU average. The use of teleconsultations increased quickly in Sweden during the pandemic to maintain access to care.



## Resilience

Sweden tried to balance protection of people's health and protection of economic and social activities in managing the COVID-19 crisis. While fewer restrictions were imposed, particularly during the first wave, the death toll was high compared with other Nordic countries. By end of August 2021, 58 % of the population had received two doses or the equivalent – slightly more than the EU average.



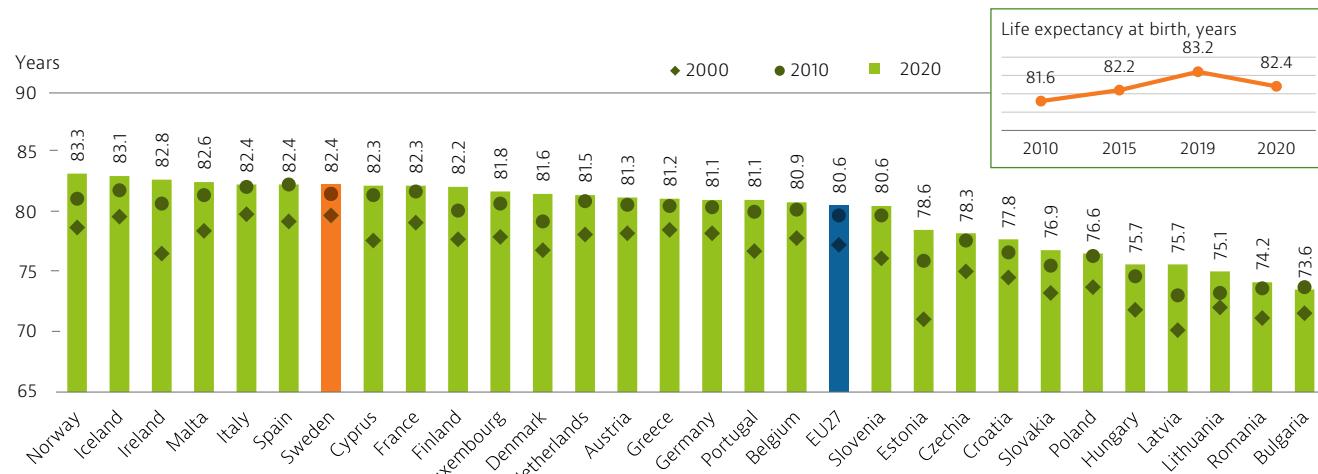
# 2 Health in Sweden

## Life expectancy in Sweden fell in 2020 due to COVID-19

Life expectancy at birth in Sweden was one of the highest in the EU in 2020, despite the sharp temporary reduction of 0.8 years due to the relatively high number of deaths from COVID-19 (Figure 1). This

reduction is slightly larger than the average in the EU overall (0.7 years). This was the biggest decline in life expectancy in Sweden since 1944 (Statistics Sweden, 2021).

**Figure 1. Life expectancy was among the highest in the EU in 2020 despite the drop due to COVID-19**



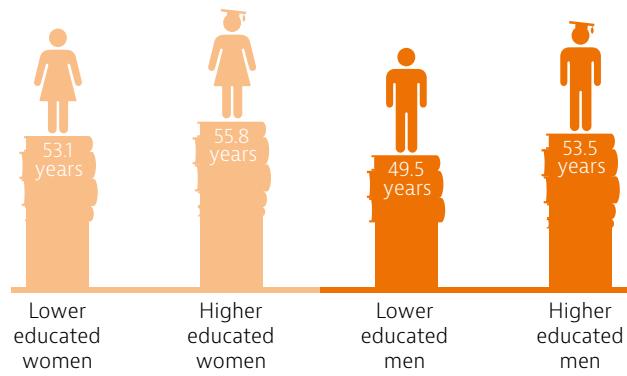
Note: The EU average is weighted. Data for Ireland refer to 2019.  
Source: Eurostat Database.

## Gender and social inequalities in life expectancy are less pronounced than in most EU countries

The gender gap in life expectancy in Sweden is much smaller than in other EU countries (3.5 years compared with 5.6 years for the EU average). Inequalities in life expectancy by education level are also less pronounced than in most other EU countries. Nonetheless, life expectancy at age 30 for men with the lowest level of education was four years lower than for the most educated in 2017, while the gap between the lowest and highest educated women was about three years (Figure 2).

In 2020, socioeconomic inequalities in life expectancy are expected to rise, since excess mortality due to COVID-19 was highest in areas with high numbers of migrants and people on lower incomes (Public Health Agency of Sweden, 2021a).

**Figure 2. The education gap in life expectancy was four years for men and about three years for women**



Education gap in life expectancy at age 30:

Sweden: 2.7 years

EU18: 3.4 years

Sweden: 4.0 years

EU18: 6.9 years

Note: Data refer to life expectancy at age 30. High education is defined as people who have completed tertiary education (ISCED 5-8) whereas low education is defined as people who have not completed secondary education (ISCED 0-2).

Source: Eurostat Database (data refer to 2017).

## Ischaemic heart disease, stroke and lung cancer were the main causes of death before the pandemic

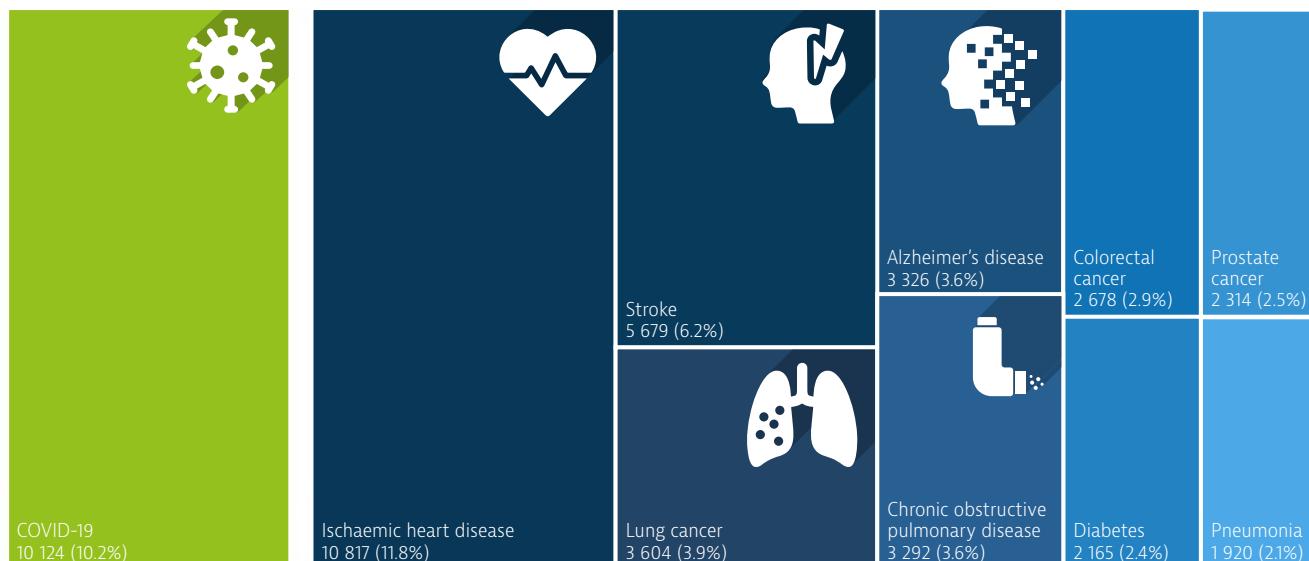
In 2018, circulatory diseases accounted for one third of all deaths in Sweden (33 %), followed by cancer (all sites), which accounted for one quarter (25 %).

Focusing on more specific diseases, ischaemic heart disease (nearly 12 % of all deaths) and stroke (over

6 %) were the leading causes of mortality in 2018. Lung cancer was the most frequent cause of death by cancer (Figure 3).

In 2020, COVID-19 accounted for over 10 000 deaths in Sweden (10 % of all deaths). An additional 4 500 deaths were registered in the first eight months of 2021. More than two thirds of deaths were among people aged 80 and over.

**Figure 3. COVID-19 accounted for a large share of deaths in 2020**



Note: The number and share of COVID-19 deaths refer to 2020, while the number and share of other causes refer to 2018. The size of the COVID-19 box is proportional to the size of the other main causes of death in 2018.

Sources: Eurostat (for causes of death in 2018); ECDC (for COVID-19 deaths in 2020, up to week 53).

The mortality rate from COVID-19 up to the end of August 2021 was 10 % lower in Sweden than the average across EU countries (about 1 420 per million population compared with an EU average of 1 590), although it was many times higher than in Norway and Finland.

When looking at excess mortality, the number of excess deaths from all causes in Sweden from March to December 2020 compared with previous years was lower than the number of COVID-19 deaths. This indicates that deaths from other causes were lower and that there was no undercounting of the number of COVID-19 deaths in Sweden, unlike in several other EU countries (Box 1).

## Most people report being in good health, but there are disparities by income group

In 2019, more than three quarters of people in Sweden (76 %) reported being in good health – a greater share than in the EU as a whole (69 %). However, as in other countries, people on lower incomes are less likely to report being in good health: only 66 % of Swedes in the lowest income quintile reported being in good health compared to 86 % of those in the highest.

## Nearly two in five adults in Sweden have a chronic condition

Nearly two in five Swedish adults (38 %) reported having at least one chronic condition in 2019 – a slightly higher proportion than in the EU as a whole (36 %), according to EU-SILC. This proportion increases with age: 55 % of people aged over 65 reported at least one chronic condition. Many of these conditions increase the risk of severe complications from COVID-19. As with self-reported health, there is a gap in prevalence of chronic conditions by income group: 46 % of Swedish adults in the lowest income

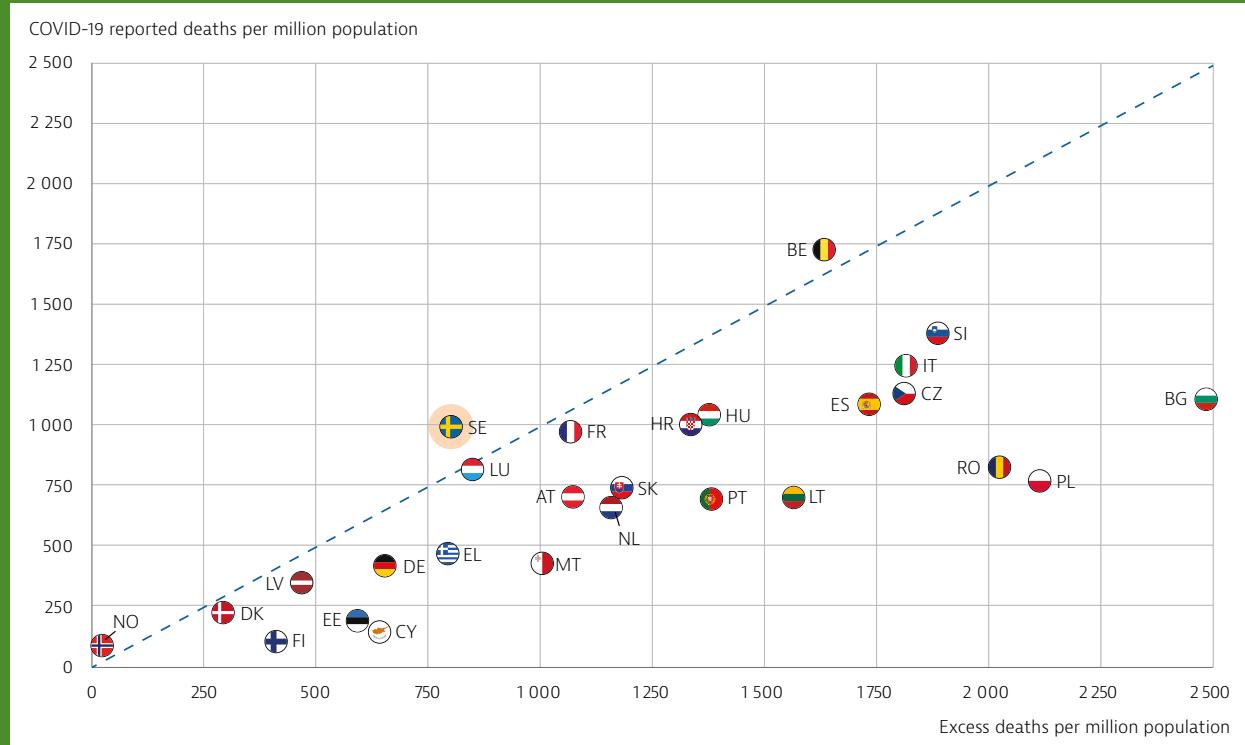
## Box 1. Excess mortality was lower than the number of COVID-19 deaths in 2020

The number of deaths from COVID-19 was reported with higher or lower accuracy by countries depending on testing activities and other issues related to the attribution of causes of death, resulting in comparability limitations.

The indicator of excess mortality (defined as the number of deaths from all causes over what would have been expected based on the experience from previous years) can provide a measure of deaths due to COVID-19 that is less affected by these issues. Between March and December 2020, the number

of excess deaths in Sweden was lower than the number of reported COVID-19 deaths, indicating that deaths from other causes (such as influenza) were lower than in previous years. Excess mortality in Sweden was also lower than in most other EU countries, suggesting that several countries seem to have undercounted the number of COVID-19 deaths (Figure 4). While Sweden ranked ninth highest among EU countries in deaths from COVID-19 in 2020, it ranked only nineteenth based on excess mortality. Nonetheless, excess mortality in Sweden in 2020 was much higher than in all other Nordic countries.

**Figure 4. Excess deaths in Sweden were lower than COVID-19 deaths between March and December 2020**



Note: Iceland is not included in this figure because excess mortality was negative between March and December 2020.  
Sources: ECDC (for COVID-19 deaths); OECD based on Eurostat data (for excess deaths).

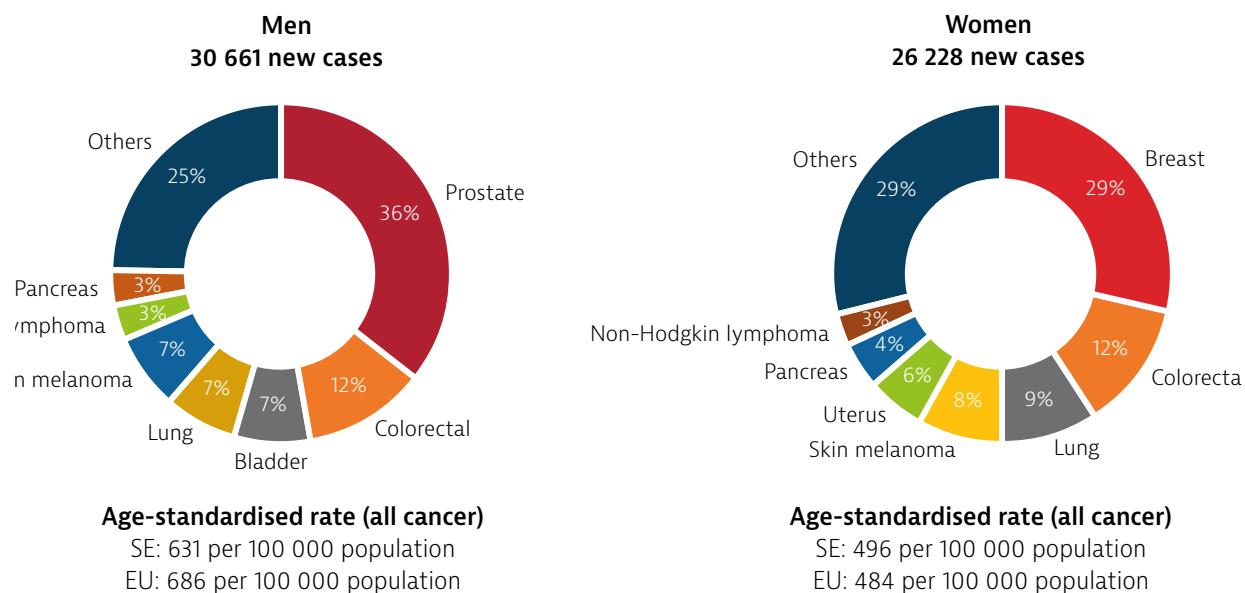
group report having at least one chronic condition, compared with 30 % of those in the highest.

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

About 23 500 people in Sweden died of cancer in 2018, and according to estimates from the Joint Research Centre based on incidence trends from previous years, around 57 000 new cases of cancer were expected in 2020. The cancer incidence rate was expected to be slightly lower than the EU average for men and slightly higher for women. Figure 5 shows that the

most frequent cancer sites among men are prostate, lung, and colorectal, while among women breast cancer is the leading cancer, followed by colorectal and lung cancer. Since 2010, Sweden has had national cancer strategies to reduce the risk of cancer, to improve the quality of cancer care, and to reduce differences between population groups in morbidity and survival (see Section 5.1).

**Figure 5. About 57 000 of new cancer cases were expected in Sweden in 2020**



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

## 3 Risk factors

### Behavioural risk factors account for more than one third of all deaths

Over one third (34 %) of all deaths in Sweden can be attributed to behavioural risk factors – including dietary risks, tobacco smoking, alcohol consumption

and low physical activity – which is below the EU average (39 %). Air pollution in the form of fine particulate matter ( $PM_{2.5}$ ) and ozone exposure alone accounted for about 1 % of all deaths in 2019 – a much lower share than the EU average (Figure 6).

**Figure 6. More than one in three deaths in Sweden can be attributed to behavioural risk factors**



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

Sources: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

## Smoking and alcohol consumption have decreased

Fewer than 10 % of adults in Sweden smoked daily in 2019, down from 14 % in 2010. The proportion of adults who smoke every day in Sweden is the lowest in the EU. These figures, however, do not include the use of other tobacco products. In 2019, 21 % of Swedish men and 5 % of women used snuff daily. As with other tobacco products, the use of snuff increases the risk of ischaemic heart disease and stroke, as well as pancreatic, mouth and oesophageal cancers.

Alcohol sales and consumption per person aged 15 years decreased slightly (by 4 %) between 2010 and 2019, and the rate is lower than in most EU countries. During 2020, seven out of ten people reported that they did not change their alcohol consumption due to the pandemic. More people reported reduced use of alcohol (19 %) than increased use (8 %), especially among young adults (Systembolaget, 2021).

Among adolescents, 11 % of 15-year-olds reported in 2018 that they had been drunk more than once in their life – a lower proportion than in most EU countries (the EU average was 22 %).

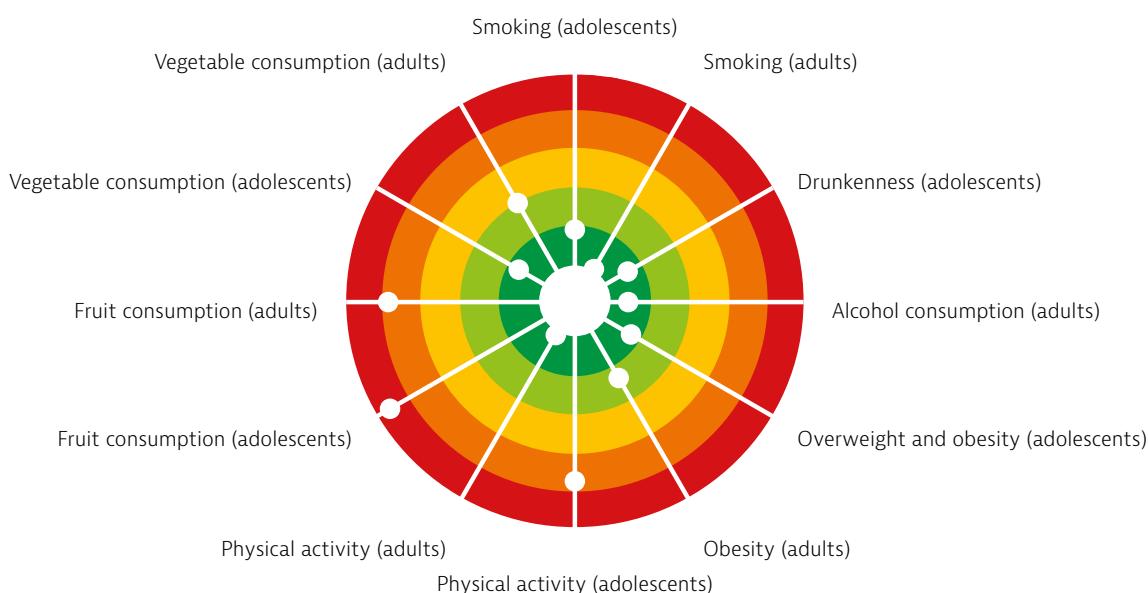
## Physical activity rates are relatively high among adults, but low among adolescents

A greater proportion of Swedish adults report doing at least moderate physical activity each week than in most other EU countries, but the opposite is true among adolescents. Only 11 % of 15-year-olds in Sweden reported engaging in at least moderate physical activity each day in 2018 – a lower proportion than the EU average of 14 %.

While the proportion of adolescents who report eating at least one portion of vegetables per day is relatively high compared with other EU countries, it is relatively low for eating at least one portion of fruit: about three quarters of 15-year-olds reported in 2018 that they did not eat fruit each day. The same is also true for adults: fewer than half reported that they ate at least one portion of fruit each day in 2019.

More than one in seven adults in Sweden (15 %) were obese in 2019, a rate that has grown over time but remains lower than in most other EU countries (Figure 7). The same is also true among adolescents, with about one in six (16 %) being overweight or obese in 2018 – a rate lower than the EU average (19 %).

**Figure 7. Physical inactivity and nutrition of adolescents are public health issues in Sweden**



*Note: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white “target area” as there is room for progress in all countries in all areas.*

Sources: OECD calculations based on HBSC survey 2017-18 for adolescents indicators; and OECD Health Statistics, and EHIS 2014 and 2019 for adults indicators.

## Social inequality contributes to health risks

Many behavioural risk factors in Sweden are more common among people with lower education or income. In 2020, 13 % of adults who had not completed secondary education smoked daily, compared to only 4 % among those with tertiary

education. In the same vein, 67 % of adults without secondary education were overweight or obese, compared to only 45 % of those with higher education. This higher prevalence of risk factors among socially disadvantaged groups has a significant impact on health inequalities.

# 4 The health system

## The health system is very decentralised

All Swedish residents are covered for health services, regardless of nationality. The national government is responsible for regulation and supervision, and the 21 Swedish counties have responsibility for financing, purchasing and providing health services. The counties oversee primary, specialist and

psychiatric health care, while the 290 municipalities are responsible for care for people with disabilities, rehabilitation services, home care, social care for children and adults, elderly care and school health care. The governance structures established to manage the COVID-19 pandemic included a variety of authorities across levels of government (Box 2).

### Box 2. Governance of the COVID-19 pandemic involved multiple authorities and a new pandemic law

The COVID-19 response is managed by the central government (through the Ministry of Foreign Affairs and Ministry of Social Affairs), along with other authorities including the Public Health Agency, which coordinates surveillance, communications and testing, and the National Board of Health and Welfare, which coordinates hospital beds and other resources. The Swedish Civil Contingencies Agency provides pandemic information to the public and supports other agencies, while the regions are tasked with scaling up health care capacity.

*Source: COVID-19 Health Systems Response Monitor.*

During the COVID-19 pandemic, the Swedish Parliament approved a legislative amendment that temporarily gave the government increased powers to be able to quickly take measures to limit the spread of infection. This was followed by a temporary pandemic law passed in March 2021, which went beyond the Communicable Diseases Act and the Code of Conduct to extend the scope of measures at the government's disposal, including power to impose restrictions on businesses.

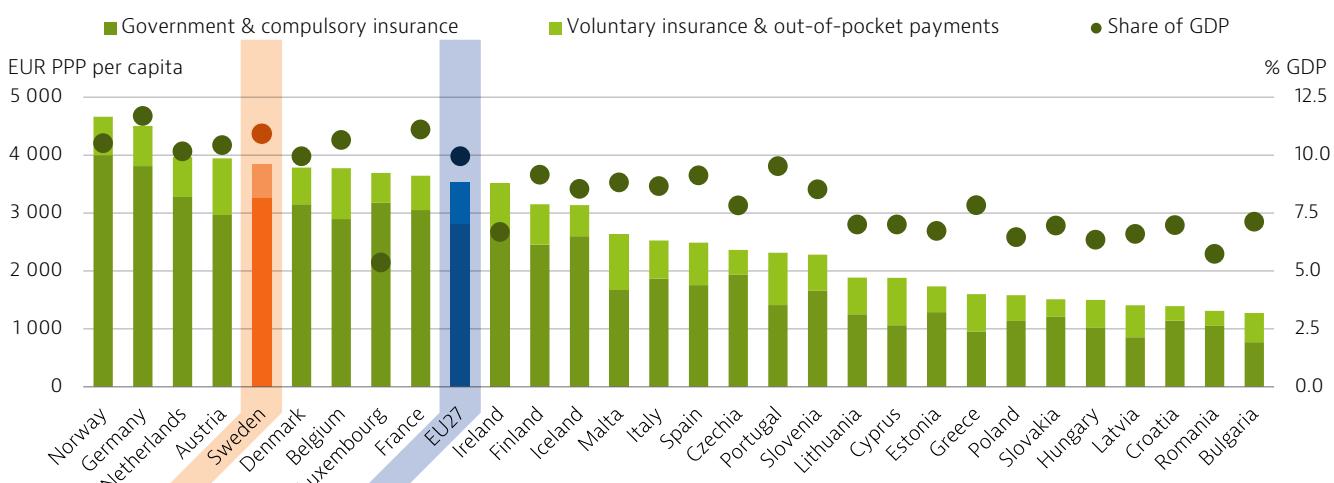
## Most health spending is funded from public sources

Health expenditure in Sweden is mostly financed by revenues from local taxes, along with direct transfers from the national government, subsidies to the regions for outpatient medicines and specific national programmes. In 2019, Sweden's health expenditure amounted to 10.9 % of GDP – the third highest share among EU countries and well above the EU average of 9.9 % (Figure 8). At EUR 3 837 in 2019 (adjusted for differences in purchasing power), Sweden's spending

on health per person was the fourth highest among EU countries.

Public expenditure accounted for 85 % of total health spending – also considerably above the EU average (80 %). Most of the remaining health spending (14 %) is paid directly out of pocket by households, while voluntary health insurance only accounted for about 1 % of health spending. However, the number of people with private voluntary health insurance coverage has increased over the past 20 years, as this facilitates quicker access to private specialist care.

**Figure 8. Sweden spends more on health than most other EU countries**



*Note: The EU average is weighted.*

*Source: OECD Health Statistics 2021 (data refer to 2019, except Malta 2018).*

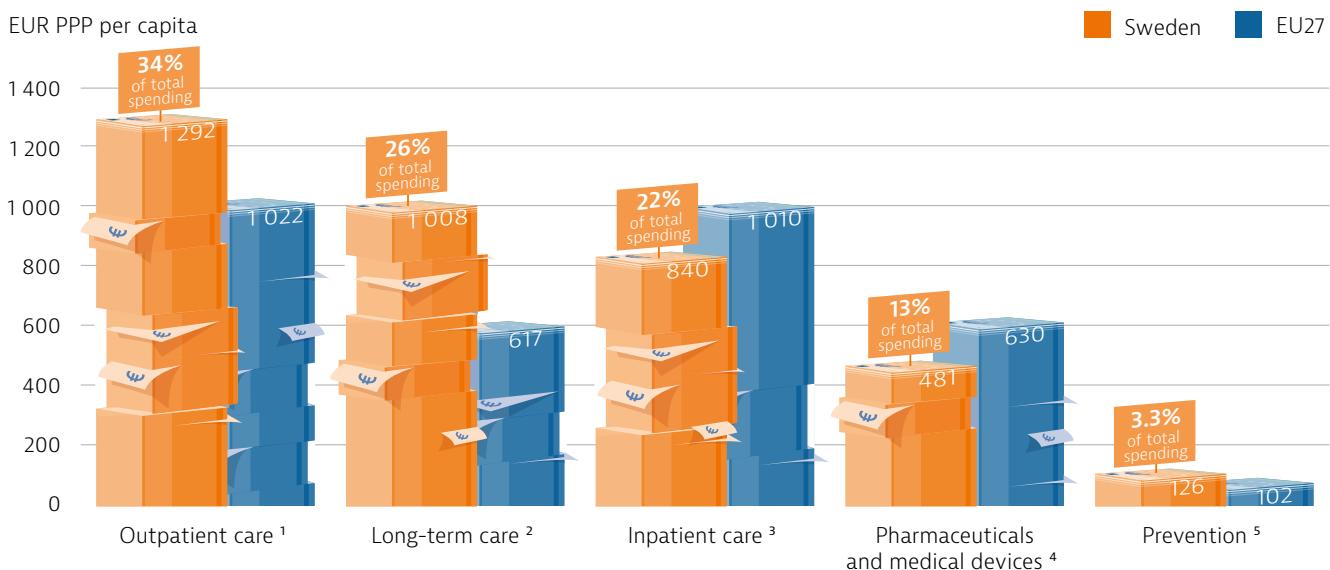
## One third of health spending is dedicated to outpatient care

Outpatient care (including home care) is the largest category of health spending in Sweden, and accounted for just over one third (34 %) of all health spending in 2019 (Figure 9). This reflects efforts over the past two decades to contain spending on hospital care by strengthening outpatient services. Spending on long-term care accounted for more than one quarter (26 %) of all health spending. Per person, such spending was nearly double the EU average. Inpatient care (typically provided in hospitals) accounted for

22 % of all health spending – a lower share than a decade ago and much lower than the EU average (29 %).

Sweden spent a smaller proportion of health expenditure on outpatient pharmaceuticals and medical devices (13 %) compared to the EU average (18 %). The relatively low spending on pharmaceuticals dispensed outside of hospitals can be attributed in part to lower prices for medicines and relatively high use of generics. Spending on prevention accounted for 3.3 % of all health spending – a share higher than the 2.9 % EU average.

**Figure 9. Sweden spends almost twice as much as the EU average on long-term care**



*Notes: The costs of health system administration are not included. 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. The EU average is weighted.*

Sources: OECD Health Statistics 2021, Eurostat Database (data refer to 2019).

## Sweden has universal population coverage for health services, and user charges vary across regions

Coverage is universal in Sweden, with health services either freely available or with small co-payments. User charges are set by the regions. For 2021, fees were SEK 100-300 (EUR 10-30) for a primary care visit, up to SEK 400 (EUR 40) for a specialist visit – which is lower with a referral – and SEK 100 (EUR 10) per day of hospitalisation for an adult. User fees for medical consultations are capped at SEK 1 150 (EUR 115) per individual per year, and for prescribed medicines at SEK 2 350 (EUR 235). Exemptions from user charges apply for people under 20, older people and pregnant women.

## Private health insurance is rapidly gaining popularity in Sweden

The number of people with private health insurance has increased rapidly in the last 15 years, and at the end of 2019 some 681 000 people had supplementary health insurance, although the type of coverage and premiums vary substantially. This insurance is mostly employment based, and mainly provides people with faster access to outpatient (ambulatory) visits and elective surgery, but often also includes health check-ups and other occupational health services. Although private health insurance coverage is still relatively marginal, it does raise concerns about equity in access to services.

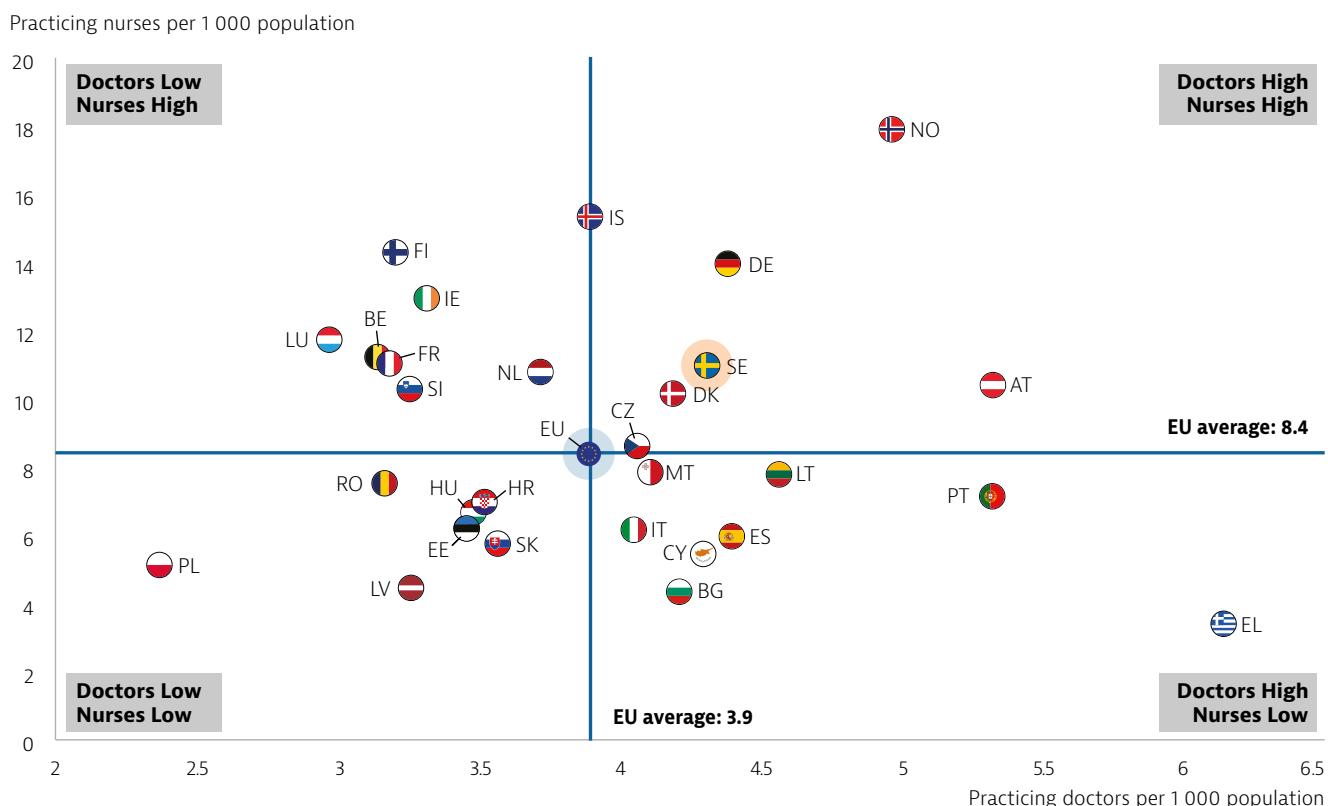
## There are many private primary care providers, but most hospitals are publicly owned

Both public and privately owned health care facilities are publicly funded in Sweden. Patients are covered by the same regulations and fees in both types of facilities. Public hospitals at the regional level provide most of the acute care, while university hospitals provide highly specialised care. Private hospitals also exist. After they were given the right to receive public funding just over a decade ago, the numbers of private primary care providers expanded rapidly. Public and private physicians (including hospital specialists) and other health workers are predominantly salaried employees.

## Despite high physician numbers, there are relatively few general practitioners in Sweden

Sweden has a higher number of both physicians and nurses per population than the EU averages, at 4.3 doctors per 1 000 population in 2018 (the EU average is 3.9) and 10.9 nurses per 1 000 population (the EU average is 8.4) (Figure 10). However, general practitioners (GPs) account for only one in seven physicians, so the density of GPs in Sweden (0.6 per 1 000 population) is one third lower than the EU average (almost 1 per 1 000 population). Nurses have taken on an expanded role in primary care, with the ability to prescribe medicines and coordinate care.

**Figure 10. Sweden has a higher number of doctors and nurses per population than most EU countries**



Note: The EU average is unweighted. In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Greece, the number of nurses is underestimated as it only includes those working in hospitals.  
Source: Eurostat Database (data refer to 2019 or the nearest year).

## Before the COVID-19 pandemic, Sweden had the lowest number of hospital beds in the EU

In 2019, Sweden had the lowest number of hospital beds per capita in the EU, at 2.1 beds per 1 000 population (compared to the EU average of 5.4). This is partly because most hospital activities in Sweden focus on curative (acute) care, whereas most rehabilitation services and all long-term care are provided outside of hospitals. The average length of stay in hospital has come down over the past decade, and was about 25 % lower than the EU average in 2018 (5.7 versus 7.5 days).

During the second wave of the COVID-19 pandemic in December 2020, intensive care unit (ICU) beds in Sweden were nearing 80 % capacity due to the increasing number of COVID-19 patients, particularly in Stockholm. While hospitals could have increased the number of ICU beds further, an insufficient number of the necessary ICU specialist staff would have been available to support them (see Section 5.3).

## Health reforms have focused on increasing accessibility and improving quality of care

Swedish people are free to choose their primary care providers and to contact specialists directly in most regions. Recent efforts have aimed to increase access to health services and shorten waiting times. The waiting times guarantee allows patients to contact a primary care centre on the day they have a health

issue; to receive a medical assessment in primary care within three days; and to see a specialist or receive any necessary treatment or surgery within 90 days in the case of a new health problem or a severely deteriorating health condition (see Section 5.2). If these thresholds for waiting times are not met, patients are offered care elsewhere, paid for by their region.

# 5 Performance of the health system

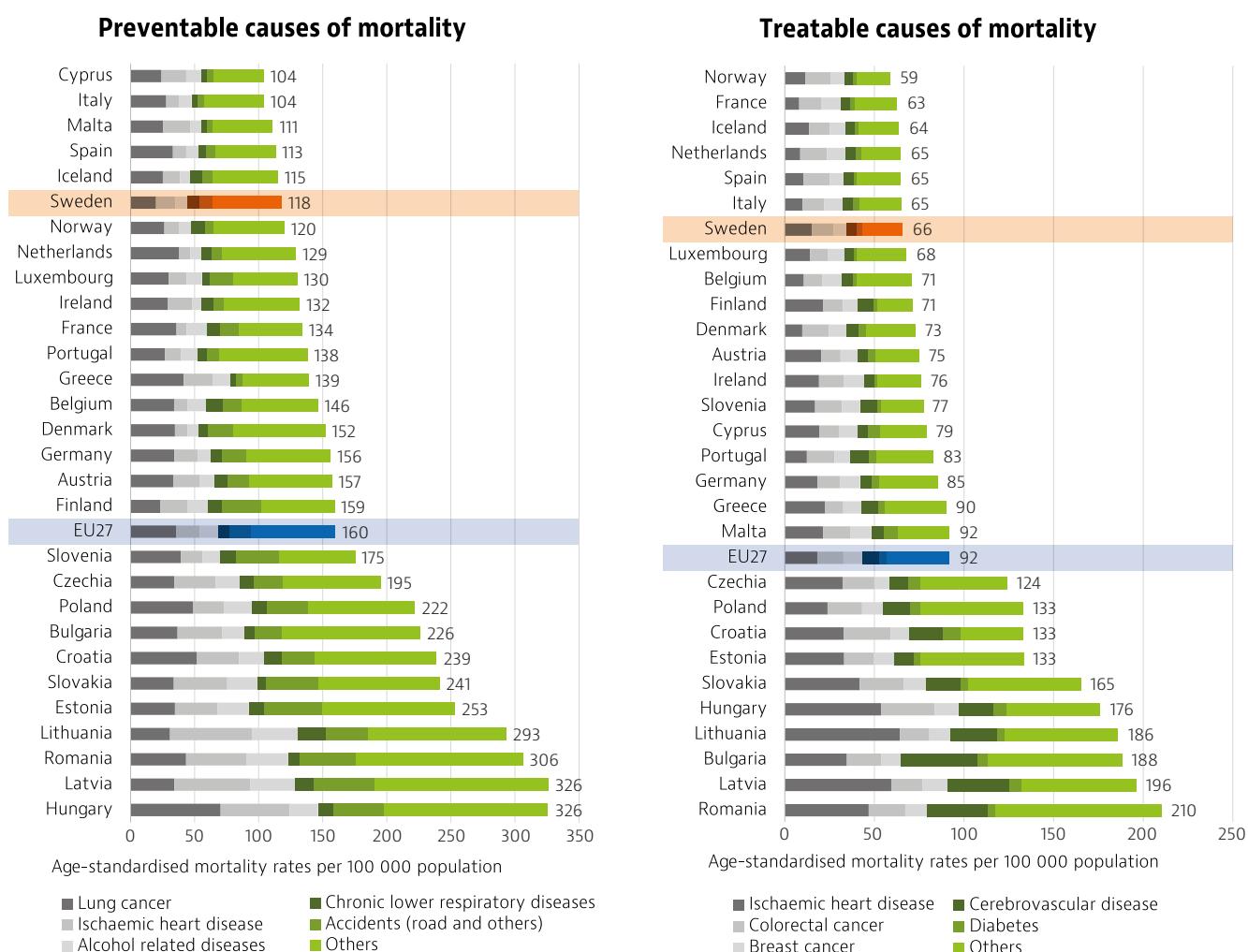
## 5.1. Effectiveness

### Before COVID-19, Sweden had low mortality from preventable and treatable causes

Sweden had low rates of mortality from preventable and treatable causes in 2018, which point to an

effective public health and health care system in avoiding deaths from conditions that are deemed to be preventable or treatable (Figure 11). The low preventable mortality rate is largely due to low rates of premature deaths from cardiovascular diseases, alcohol-related causes and lung cancer.

**Figure 11. Mortality from preventable and treatable causes was low before the pandemic**



*Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Half of all deaths for some diseases (e.g. ischaemic heart disease and cerebrovascular disease) are attributed to preventable mortality; the other half are attributed to treatable causes. Both indicators refer to premature mortality (under age 75). The data are based on the revised OECD/Eurostat lists.*

*Source: Eurostat Database (data refer to 2018, except for France 2016).*

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

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

In 2021, Sweden adopted a Comprehensive Strategy for Alcohol, Narcotics, Doping, Tobacco and Gambling for 2021-25. Building on the previous strategies since 2011, its overarching goal is a society free from illicit drugs, with reduced alcohol-related harm and reduced tobacco use. The most recent strategy has a stronger focus on narcotics, with an aim of zero deaths due to drugs and narcotics, as well as protection of children and young people (Public Health Agency of Sweden, 2021b).

Low mortality from traffic accidents is the result of a longstanding road safety strategy, called Vision Zero, which has as an ultimate goal that nobody should be killed or seriously injured in traffic accidents. This strategy has been successful: fewer than 200 people died in road accidents in Sweden according to the preliminary figures for 2020 – down from over 500 in 2003.

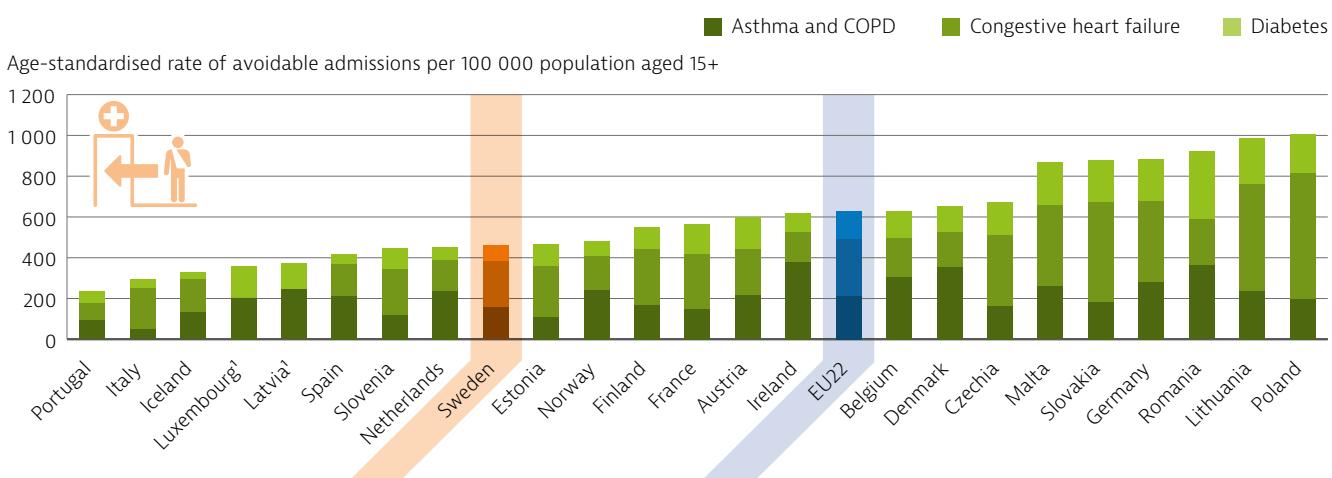
## Vaccination rates among older people could be improved

Only 52 % of Swedish people aged 65 and over were vaccinated against influenza in 2019-20, which is slightly higher than the EU average but still below the WHO recommended target of 75 % (Public Health Agency of Sweden, 2021c). Take-up has been stable at around 50 % in recent years. Increasing coverage has been challenging, partly due to complacency and a lack of confidence in influenza vaccines, limited public communication on influenza vaccination, and not actively offering the vaccination to all those entitled to it (Public Health Agency of Sweden, 2016).

## Low rates of avoidable hospital admissions reflect relatively strong outpatient care

For several communicable diseases and chronic conditions such as asthma and chronic obstructive pulmonary disease (COPD), diabetes and congestive heart failure, hospital admissions can be avoided through well-organised disease management in outpatient care. Although some countries have even lower rates, Sweden's rate of hospital admissions for these conditions are below the EU average (Figure 12). This is partly explained by the lower prevalence of these conditions in Sweden compared to most other EU countries, but it also reflects Sweden's strong outpatient care sector, which manages to keep the number of hospitalisations low by treating these patients effectively in outpatient settings.

**Figure 12. Avoidable hospital admissions for chronic diseases in Sweden are below the EU average**



Note: 1. Data for congestive heart failure are not available in Latvia and Luxembourg.  
Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).

## Cancer care has improved, but screening is still not fully rolled out

Survival following diagnosis for different types of cancer (breast, cervical, colorectal and lung cancer and childhood leukaemia) has increased in Sweden over the past decade, and is among the highest in the EU, reflecting earlier diagnosis and effective treatments (Figure 13).

Since implementation of the national cancer strategy in 2010, Sweden has put much effort in improving cancer care, and the government also identified cancer care as a priority for new investment in 2019-21. The 2021-23 budget includes an additional EUR 60 million per year to improve patient experiences by creating standardised pathways and involving all stakeholders in the care process; this aims to minimise delays and uncertainty for patients. While the strategy has a strong focus on quality and equity in treatment, it also targets prevention and early detection. This is aligned with the European

Commission's Europe's Beating Cancer Plan, presented in February 2021 (European Commission, 2021).

All Swedish regions offer mammography screening for women aged 40-74, with a high level of coverage. Among women aged 50-69, 95 % reported that they had had a breast examination in the past two years in 2019 – the highest rate among EU countries. Cervical cancer screening is also rolled out nationally for women aged 23-64. The primary screening test is cytology for women aged 23-29 and human papillomavirus testing for women over 30. The screening uptake has been high and reached over 80 %, but declined to 76 % in 2018.

On the other hand, screening for colorectal cancer is not yet widely offered to men and women across the country, and only 2 of the 21 county councils provide screening for their residents aged 50-59. This explains why only 37 % of people aged 50-74 in Sweden reported ever having been screened in 2019, compared to the EU average of 51 %.

**Figure 13. Cancer survival rates in Sweden are above the EU average**



### Prostate cancer

Sweden: 91 %  
EU23: 87 %



### Childhood leukaemia

Sweden: 89 %  
EU23: 85 %



### Breast cancer

Sweden: 89 %  
EU23: 82 %



### Cervical cancer

Sweden: 68 %  
EU23: 63 %



### Colon cancer

Sweden: 65 %  
EU23: 60 %



### Lung cancer

Sweden: 20 %  
EU23: 15 %

*Note: Data refer to people diagnosed between 2010 and 2014. Childhood leukaemia refers to acute lymphoblastic cancer.  
Source: CONCORD Programme. London School of Hygiene and Tropical Medicine.*

Preliminary statistics show that the quantity of cancer care remained unchanged in 2020, but the pandemic disrupted the rollout of cancer screening programmes (Public Health Agency of Sweden, 2021a).

## 5.2. Accessibility

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

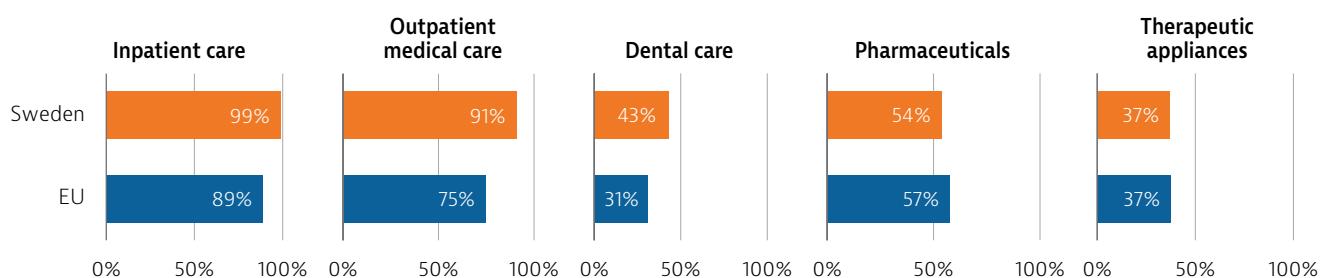
All residents in Sweden are entitled to publicly funded health services, and the regulation of health service provision to recently arrived immigrants has also been improved in recent years. Even though Sweden has a broad benefits package and a health care law with a strong focus on equity and needs-based provision, the regional structure – with 21 autonomous county councils – leads to some disparities in service coverage rules in different parts of the country. To mitigate this structural problem, the National Board for Health and Welfare and the

Swedish Association of Local Authorities and Regions work together to agree on common guidelines and strategies.

### Co-payment ceilings limit the adverse effects of user fees, but cost barriers exist

Some 14 % of health spending in Sweden is funded out of pocket – slightly lower than the EU average (15 %). Co-payments are applied to almost all types of services and goods, with the exceptions of maternal and child health services provided in primary care settings and some services for people aged over 85. The regions set the co-payments independently, and the co-payment structure provides an incentive to consult primary care providers over hospital visits. Only the co-payments for prescribed medicines and dental services are set at the national level. Most out-of-pocket spending goes on pharmaceuticals and dental care, as these services are generally less covered than hospital inpatient and outpatient care (Figure 14).

**Figure 14. Coverage is greater for inpatient and outpatient care than dental care and pharmaceuticals**



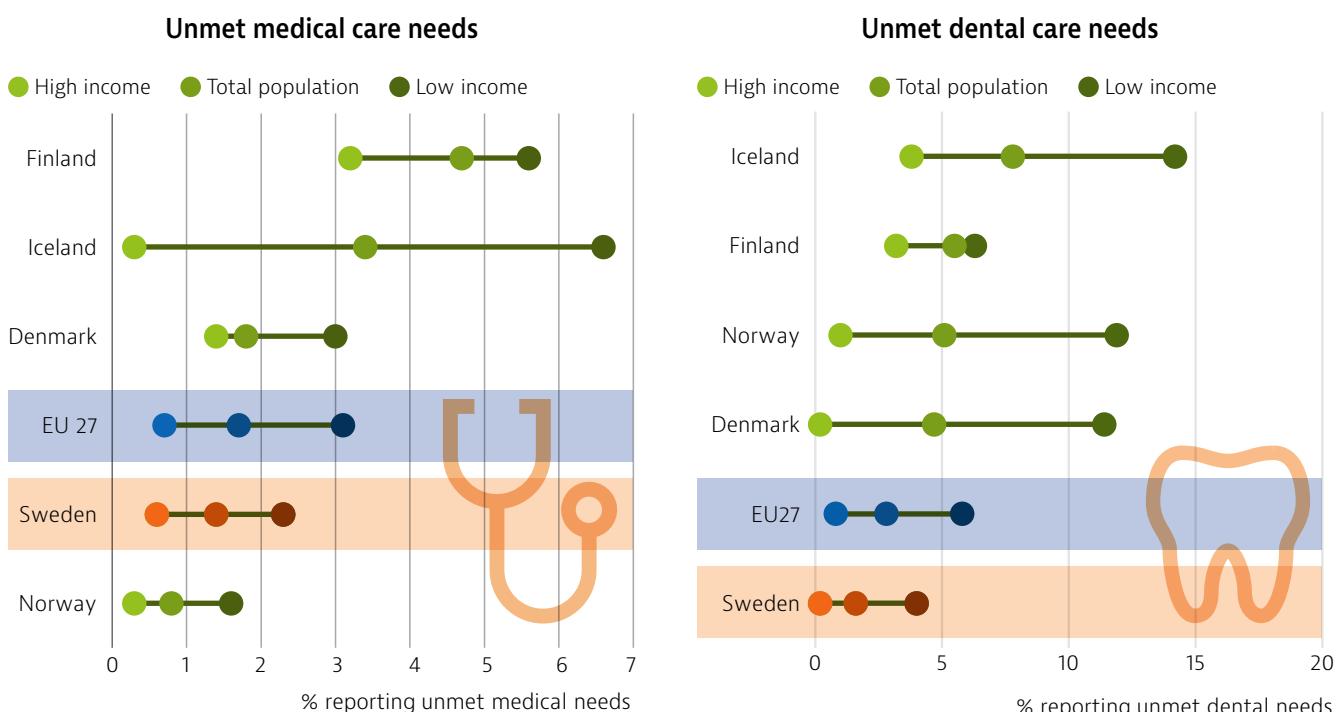
Note: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines as well as medical non-durables. Therapeutic appliances refer to vision products, hearing aids, wheelchairs and other medical devices.

Source: OECD Health Statistics 2021 (data refer to 2019).

Before the COVID-19 pandemic, unmet needs for medical care were low: 1.4 % of all respondents and 2.4 % of respondents on low incomes reported episodes of unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times in 2019. The percentage of people reporting unmet needs for dental care in Sweden was below 2 % in 2019, but it was more than double the overall average among people in the lowest income group (Figure 15).

Dental care is not included in the basic benefits package, and it is subject to higher co-payments for adults above the age of 24. A recent government report recommended major reform to the dental care system in 2026 to tackle inequalities in access (Ministry of Social Affairs, 2021).

**Figure 15. Unmet medical care needs are low, but unmet dental care needs are higher for people on low incomes**



Note: Data refer to unmet needs for a medical or dental examination or treatment due to costs, distance to travel or waiting times.  
Source: Eurostat Database, based on EU-SILC data (data refer to 2019, except for Iceland 2018).

According to another Europe-wide survey carried out in February/March 2021, unmet medical care needs during the first year of COVID-19 were reported by

16 % of Swedes – a share lower than the EU average of 21 % (Eurofound, 2021).<sup>1</sup>

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

## Waiting times for specialist consultations and non-urgent surgery increased during the pandemic

Excessive waiting times have been a longstanding feature of the Swedish health system, and the problem has been subject to numerous debates and policy initiatives. The most important initiative was the Health Guarantee Act of 2010, which stipulated maximum waiting times for different types of services. Other initiatives included national programmes to incentivise regions to reduce queues (these were abolished in 2015) and increase transparency through regular publication of data on waiting times. This was done at both the individual provider level, to help patients make informed choices, and the national level – comparing regions to put pressure on regional administrations.

The Swedish Association of Local Authorities and Regions (2021) uses four core indicators to measure the care guarantee: contact with primary care on the same day, a medical assessment within three days, a first visit to specialist care within 90 days, and an intervention within 90 days. During 2020, the share of people getting same-day contact with primary care declined from 93 % to 87 %. A medical assessment was received by 81 % of people, with only minor variation from one month to another during the pandemic.<sup>2</sup> However, increased digitalisation due to the pandemic made it more complicated for certain population groups to contact health care services (Public Health Agency of Sweden, 2021a).

The pandemic had a substantial effect on specialist care. In March 2020, 80 % of patients had a first visit to a specialist within 90 days and 71 % had an intervention within 90 days. These shares dropped to 67 % for the first visit in June 2020 and 44 % for the first intervention in July 2020. Even though the health system recovered later, the shares in December 2020 remained below the pre-pandemic level (77 % for the first visit and 60 % for the first intervention). There was also clear regional variation in access to specialists and interventions, in favour of urban areas (Swedish Association of Local Authorities and Regions, 2021).

The government has committed to increasing efforts to reduce waiting times – for example, by signing agreements with the Swedish Association of Local Authorities and Regions.

## Advanced practice nurses improve access to care, but more health workers are needed to meet demand

Sweden has successfully increased the scope of practice of nurses in primary care – for example, by setting up nurse consultations in lieu of GP consultations. This helps to address the low supply of GPs and allows registered nurses with additional training and sufficient experience to prescribe some medicines. However, the number of such advanced practice nurses and specialist nurses remains limited, and the number of new graduates with an advanced nursing degree and specialty training has fallen since 2005.

In its 2021 annual report, the National Board of Health and Welfare (2021) reported that the COVID-19 crisis had substantially affected health care personnel in Sweden, as they had been under a heavy burden during the pandemic. Additional health care personnel will be needed for rehabilitation for those people with long-term symptoms. The shortage of health care personnel is greater in rural areas. There is also an increased demand for more experienced personnel nationwide.

## 5.3. Resilience

This section on resilience focuses mainly on the impacts of and policy responses to the COVID-19 pandemic.<sup>3</sup> As noted in Section 2, the COVID-19 pandemic had a major impact on population health and mortality in Sweden in 2020 and the first half of 2021. While the mortality rate from COVID-19 up to the end of August 2021 was lower than the EU average, it was much greater than in other Nordic countries. The pandemic also had an impact on the economy. Swedish GDP fell by about 3 % in 2020, which was less than the EU average (6 %), but about the same reduction as in other Nordic countries. The unemployment rate in Sweden increased in 2020, particularly among young people, going up from 20 % in 2019 to 24 % in 2020 for those aged 15 to 24.

### Sweden chose a different strategy against COVID-19

Sweden had a greater number of COVID-19 cases than the EU average during the first wave of the pandemic in spring 2020 and the second wave that started in autumn 2020 (Figure 16). Unlike most countries, which adopted strict lockdowns during the first wave of the pandemic to curb the spread of the

2. However, some of these figures on waiting times in primary care are uncertain as a result of transition to a more comprehensive data collection method based on administrative registers. The worsening of waiting times during the pandemic may be underestimated.

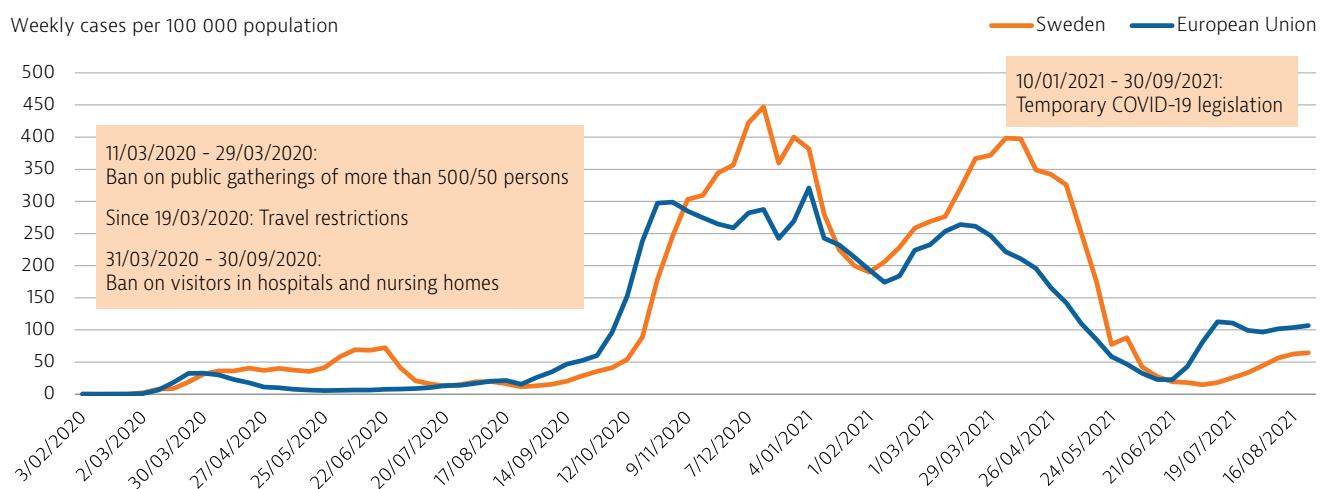
3. In this context, health system resilience has been defined as the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks (EU Expert Group on Health Systems Performance Assessment, 2020).

virus, the Swedish government took a less restrictive approach to managing the pandemic. Responsibility for developing policy responses and recommendations to tackle COVID-19 was delegated to the Public Health Agency, as the authority responsible for public health in both normal times and crisis situations. Initially, Sweden only pursued social distancing measures such as bans on large gatherings and travel restrictions.

The number of new COVID-19 cases remained high during late spring 2020 (May/June), when most European countries were seeing a large reduction following the first lockdowns. While the second wave

in autumn 2020 started a few weeks later in Sweden than in many other countries, infection rates began to rise quickly by mid-November and reached a high peak in December 2020 and January 2021. After a temporary reduction, the number of cases started to go up again in February 2021, and the number of new cases only started to come down in May 2021. There were hopes initially that the greater number of cases during the first wave would reduce the size of any second wave because of greater immunity, but the second wave ended up being substantially larger than the first.

**Figure 16. The number of reported cases of COVID-19 reached higher peaks in Sweden than the EU average**



*Note: The EU average is unweighted (the number of countries included in the average varies depending on the week). The number of COVID-19 cases in Sweden and other EU countries was underestimated during the first wave in spring 2020 due to more limited testing.*

Source: ECDC for COVID-19 data and authors for containment measures.

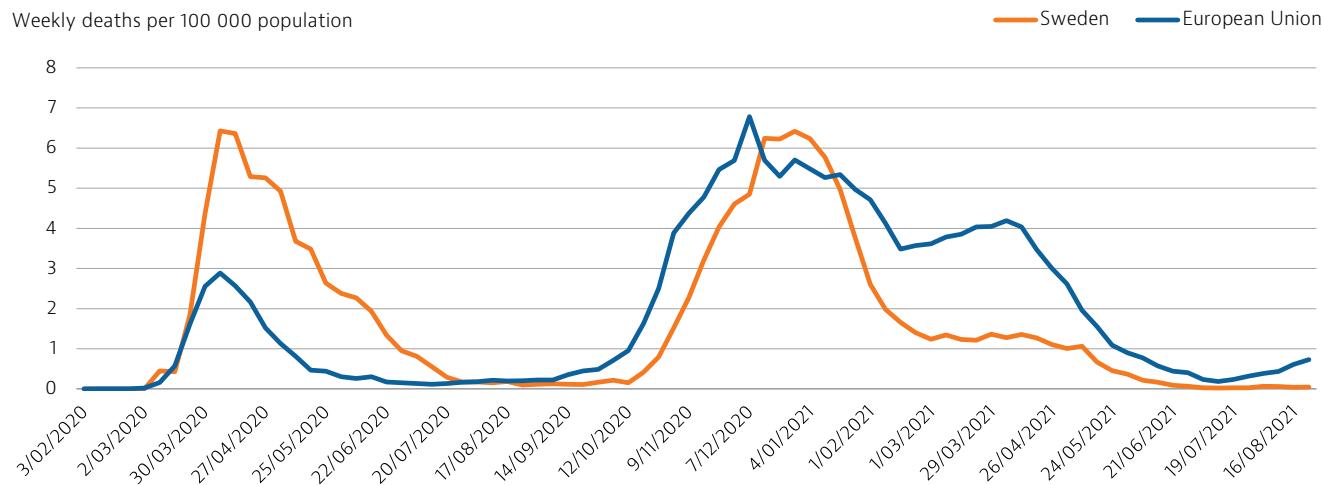
The mortality rate from COVID-19 was also higher in Sweden than the EU average up to the end of March 2021, mainly because of the higher death rate that occurred during the first wave of the pandemic in spring 2020.<sup>4</sup> The high mortality rate during the first wave was driven by the high number of cases and deaths among older people living in nursing homes. By end of June 2020, nearly half (47 %) of all COVID-19 deaths were among residents of nursing homes. The mortality was also substantially higher among migrants, especially those born in Africa and the Middle East compared to the Swedish-born population, in both the first wave and second wave (Public Health Agency of Sweden, 2021d).

As in many other EU countries, the number of deaths in Sweden during the second wave from mid-November 2020 to the end of February 2021 was greater than during the first wave from early March to late June 2020 because the second wave lasted longer (Figure 17).

In its interim report from October 2021, the Corona Commission concluded that Sweden's handling of the pandemic had been too slow and pandemic preparedness had been inadequate (Box 3).

4. As noted in section 2 above, the excess mortality in Sweden was lower than in most other EU countries in 2020, as many countries undercounted the number of COVID-19 deaths due to limited testing and other issues related to the attribution of causes of death.

## Figure 17. The number of deaths from COVID-19 was high in Sweden in the first two waves



Note: The EU average is unweighted (the number of countries included in the average varies depending on the week). The number of COVID-19 deaths in many EU countries was underestimated during the two waves due to more limited testing and issues related to the attribution of causes of death. Excess mortality (from all causes of death) was lower in Sweden than the EU average during the first 12 months of the pandemic.

Source: ECDC

### Box 3. The Corona Commission submitted a report in late October 2021 providing a preliminary assessment of Sweden's handling of the pandemic

The government established in July 2020 a Corona Commission to investigate the management of the COVID-19 pandemic by the Government, Government agencies, regions and municipalities and compare the Swedish strategy to that of other countries. The Commission submitted its second interim report in late October 2021, with a final report due in February 2022. The Commission's most important conclusions in its October 2021 report included that:

"Sweden's handling of the pandemic has been marked by a slowness of response. The initial disease prevention and control measures were insufficient to stop or even substantially limit the spread of the virus in the country."

Sweden's pandemic preparedness was inadequate.

Source: Corona Commission, Sub-report 2 – Sweden during the pandemic, October 2021

Existing communicable diseases legislation was and is inadequate to respond to a serious epidemic or pandemic outbreak.

Sweden's system of communicable disease prevention and control was and is decentralised and fragmented in a way that makes it unclear who has overall responsibility when the country is hit by a serious infectious disease.

The health care system has been able, at short notice, to adapt and to scale up care for people with COVID-19. This is largely thanks to its employees. Adaptation has been achieved at the price of extreme pressure on staff and of cancelled and postponed care. [The country] will therefore live with the consequences of the pandemic for a long time to come."

### The initial containment strategy was based on a combination of recommendations and regulations

The initial strategy to contain the COVID-19 was based on the 2004 Communicable Diseases Act, which emphasises individual responsibility in preventing the spread of diseases. The most important recommendations were for people to stay at home when they had the slightest symptoms of an infection, to maintain distance from others both outdoors and indoors, and to wash their hands. Specific risk groups, including those aged 70 and over, were encouraged to avoid close contact with others

and to avoid places with large gatherings. Legally binding rules included bans on public gatherings – initially of more than 500 people, but brought down to 50 people – visits to nursing homes and crowding in restaurants, cafés and bars.

To facilitate compliance with the recommendations and rules, the government and parliament decided to abolish the qualifying day of sickness, so that workers could stay at home with the slightest symptoms without major financial consequences.

The requirement for a medical certificate for sick leave longer than seven days was also removed to relieve the burden on primary care.

Primary and secondary schools were kept open to promote equal opportunities and the well-being of young people, since at the beginning of the pandemic it was thought that children and young people were not playing a significant role in spreading the infection.

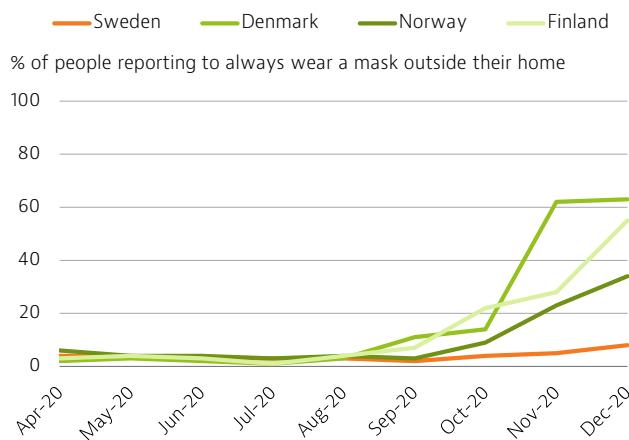
The rules and recommendations were less strict than, for example, in the neighbouring countries of Norway and Finland. In spring 2020, temporary legislation was adopted to give the government emergency powers to respond to the COVID-19 pandemic. These provisions automatically expired on 1 July 2020, without having been used. Further temporary COVID-19 legislation was introduced on 10 January 2021, allowing the authorities to introduce restrictions on activities in different places. The law provided the opportunity to limit the size of crowds and to close restaurants, and it applied until 30 September 2021.

The government and relevant competent authorities imposed the following measures to contain the spread of the virus:

- All gatherings with over 500 participants, including cultural and sport events, were banned on 11 March 2020. The ban was changed to cover all public gatherings over 50 people from 29 March 2020. From 1 November 2020, the ban was eased to allow public events with a maximum of 300 seated participants, but another ban on organising public gatherings and public events with more than 8 participants was introduced on 24 November 2020.
- Restaurants and bars were generally not closed, but from 24 March 2020, only consumption of food and drink while seated was allowed. From 20 November 2020, serving alcohol was banned after 22:00. This ban was tightened to 20:00 from 24 December 2020 to 15 January 2021.
- Visitor restrictions in hospitals were introduced by county councils, and in elderly care by certain municipalities. A national ban on visiting elderly people was introduced by the government on 31 March 2020; it expired on 1 October 2020.
- Distance education was recommended for colleges, polytechnics and universities on 18 March 2020. Colleges and universities reopened on 15 June 2020. On 7 December 2020, secondary schools and colleges and universities were switched to distance learning for students aged 16 and over. A week later, the government asked Stockholm's schools to adopt distance learning for pupils aged 13-15 as well.

In mid-December 2020, Swedish public health authorities recommended wearing face masks on public transport for the first time. However, the rate of regular mask-wearing in public spaces was very low in Sweden, even compared to the other Nordic countries, because the scientific evidence in support of their utility was seen as inconclusive (Figure 18).

**Figure 18. The mask-wearing rate was very low in Sweden**



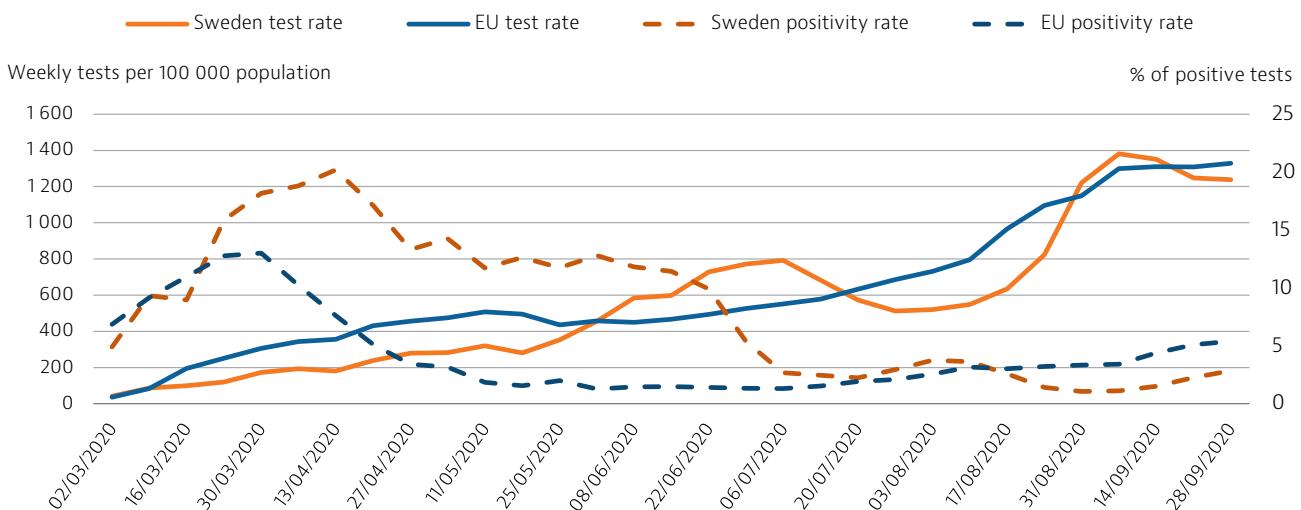
Source: YouGov data (<http://www.coviddatahub.com/>).

### Testing capacity was limited at the beginning of the pandemic, but gradually expanded

One of the problems in Sweden at the beginning of the pandemic was the limited testing capacity. Testing activities were below the EU average until the end of May 2020. Testing was limited mainly to people with COVID-19 symptoms, explaining the high positivity rates from March to May 2020 (Figure 19). Only a small number of tests were carried out in the community, limiting the capacity to detect early new cases and to take proper measures to contain the spread of the virus.

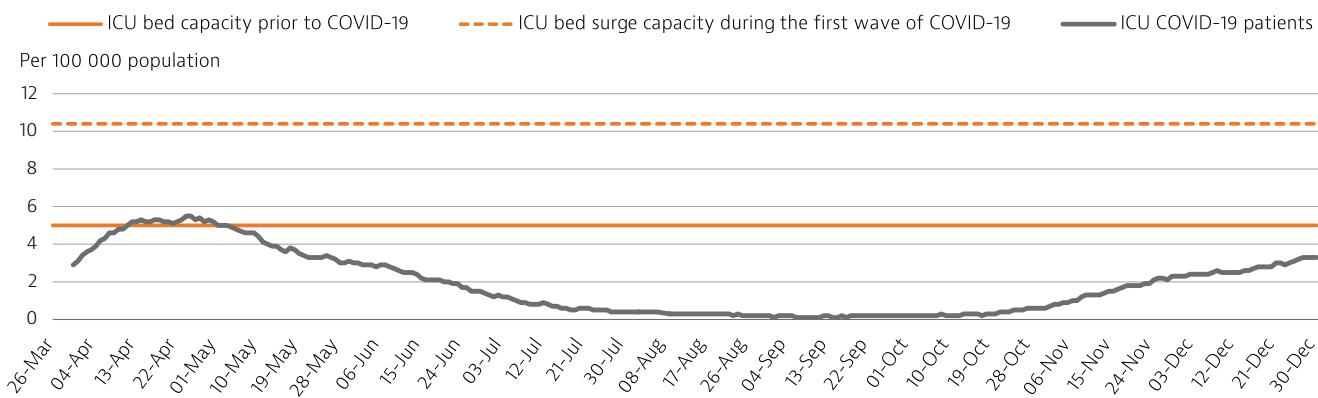
### The availability of intensive care beds was stretched

Before the COVID-19 pandemic, ICU capacity in Sweden was among the lowest among EU countries, with around 5 ICU beds per 100 000 population in 2019. This was less than half the average in the 14 EU countries with available data (OECD/EU, 2020). Sweden doubled its ICU capacity during the first wave of the pandemic to respond to the surge in demand for ICU care (Figure 20). The Stockholm International Fairs exhibition facility was converted into a field hospital with the help of the Swedish Defence Force, and several other ICU beds were set up temporarily.

**Figure 19. Testing capacity at the beginning of the pandemic was lower in Sweden than in many EU countries**

Note: The EU average is weighted (the number of countries included in the average varies depending on the week).

Source: ECDC.

**Figure 20. Mobilisation of additional ICU beds helped hospitals to manage peaks in demand**

Sources: COVID-19 Health System Response Monitor for ICU bed capacity; Swedish Intensive Care Registry for ICU COVID-19 patients.

A shortage of personal protective equipment (PPE) for health care staff was another issue, and hospitals in the capital region were forced to reuse disposable PPE after sanitization. The National Board of Health and Welfare confirmed that Sweden had no strategic stock reserves of PPE to distribute to health care workers.

The health system in the Stockholm region also faced shortages of qualified health personnel, and appealed to anyone with experience in health care to volunteer. Within a few weeks, more than 5 000 people – including students, retired health professionals and others working in other fields – had registered as volunteers. The Swedish Defence Force was also called in to assist with staffing, equipment and logistics.

### The first wave of the COVID-19 pandemic hit especially long-term care residents

The first wave of the pandemic in Sweden hit people living in long-term care (LTC) institutions particularly hard. Between March and the end of June 2020, nearly half (47 %) of all COVID-19 deaths were among LTC residents, and another quarter were among people receiving LTC at home. The virus spread in nursing

homes in various ways, including through residents returning from hospital, family visits (before the ban) and infected but asymptomatic LTC staff. As noted above, from 31 March to 1 October 2020, visits to LTC residents were banned. Insufficient testing of staff and residents in nursing homes in the first few months of the pandemic also slowed early detection and isolation of confirmed cases. The lack of PPE and the physical infrastructure of nursing homes also limited opportunities to contain the spread of the virus.

Staff shortages due in part to some staff being on sick leave or self-isolating led to greater use of temporary staff with less or no formal training. A national online training programme focusing on hygiene measures was developed and taken by more than 140 000 LTC workers.

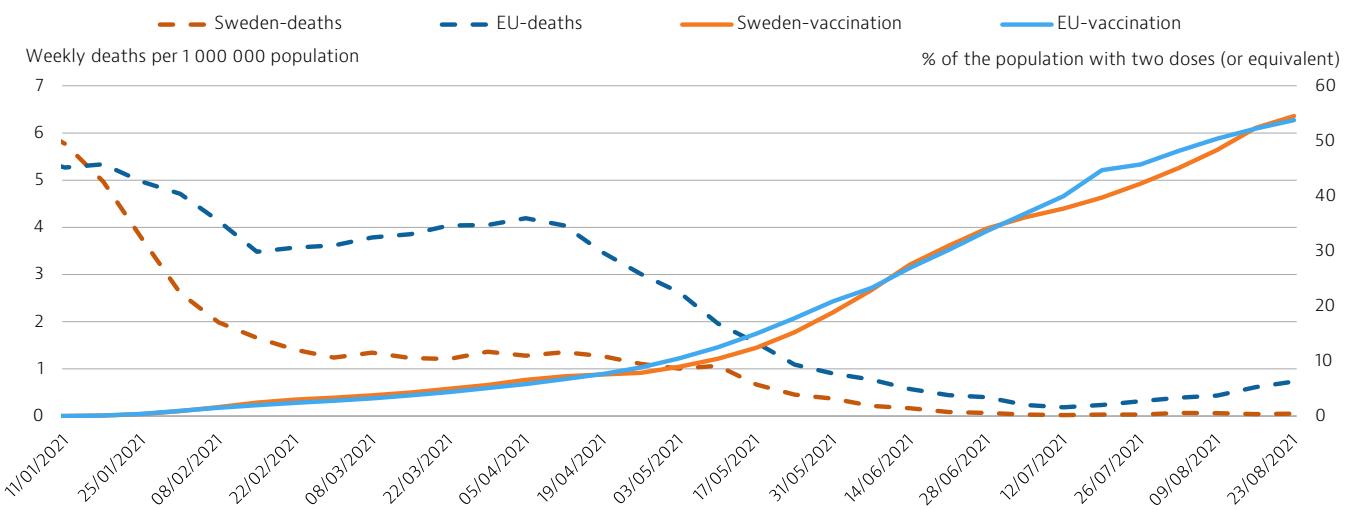
The Corona Commission concluded in its first report from December 2020 that the strategy of protecting elderly people had failed because of structural shortcomings that had been well-known for a long time. These shortcomings led to residential care being unprepared and ill-equipped to handle a pandemic (Corona Commission, 2020).

## The economic and social consequences of the COVID-19 pandemic were significant

Some groups were more affected by the economic and social consequences of the pandemic than others (Public Health Agency of Sweden, 2021a). Job losses mainly affected people who already had weak positions in the labour market, such as young people, people born abroad and employees in the trade, hotel, restaurant and transport sectors.

Swedes' lifestyles were also affected in different ways. People became less physically active and consumed more snacks and sweets. However, there was no increase in smoking and harmful alcohol use. Mild forms of emotional distress were more commonly reported. Older people were more often concerned about COVID-19, but there were signs of growing symptoms of anxiety, worry and depression among vulnerable population groups, such as migrants and children in families where there are mental health problems, addiction or violence (Public Health Agency of Sweden, 2021a).

**Figure 21. The share of the population vaccinated against COVID-19 at the end of August 2021 was slightly above the EU average**



Sources: ECDC for COVID-19 deaths and Our World In Data for vaccination rates.

## The government increased public spending on health in response to the crisis in 2020 and 2021

The Swedish government greatly increased public spending on health in 2020 in response to the crisis, and this was also expected to increase by more than 10 % in 2021, including increased transfers for health care to municipalities and regions, SEK 16 billion (EUR 1.6 billion) for testing and tracing and SEK 10 billion (EUR 1.0 billion) for vaccinations.

Sweden's Recovery and Resilience Plan was adopted in May 2021. Several measures address the availability of health workers – in particular, nurses in both health

## The acceptance of COVID-19 vaccines is high

Regions are responsible for arranging vaccinations in Sweden. According to recommendations by the Public Health Agency of Sweden (2021e), people with the greatest need for protection against COVID-19 would be offered the vaccine first – before those at lower risk of serious illness and death. There were four vaccination priority groups based on age, morbidity and disability. Family members and staff caring for these groups were also vaccinated in the same order. Acceptance of the vaccination was very high: 88 % of Swedish adults and 97 % of people aged 70 and over reported that they were likely to or certainly would get vaccinated (Public Health Agency of Sweden, 2021f).

By the end of August 2021, over 55 % of the Swedish population overall had received two doses or the equivalent – a slightly higher proportion than the EU average. The increase in vaccination has been accompanied by a reduction in the number of COVID-19 deaths (Figure 21).

care settings and nursing homes. Under the "Meeting demographic challenges" component of the Plan, the Care for Older People Initiative has been allocated EUR 458 million to upskill existing care personnel in order to cope with both short-term and long-term skill requirements. A core element of the Initiative is to improve access to training by covering staff salaries during the training period. Another element proposes the introduction of a protected professional title for assistant nurses in both health care and elderly care settings, as a way to improve the attractiveness and recognition of the profession and to standardise the qualification.

# 6 Key findings

- While life expectancy in Sweden remains higher than in most EU countries, the high number of deaths from COVID-19 led to a reduction of 0.8 years in life expectancy in 2020. This reduction was close to the EU average fall, but much greater than in other Nordic countries.
- Beyond COVID-19, the burden of cancer and other non-communicable diseases should not be underestimated. About 23 500 people in Sweden died from cancer in 2018, which is more than twice the number of COVID-19 deaths in 2020 (about 10 000). Since the implementation of the national cancer strategy in 2010, Sweden has put much effort in improving cancer care. The government also identified cancer care as a priority for new investment in 2019-21. While the strategy has a strong focus on quality and equity in treatment, it also targets prevention and early detection. Preliminary data for 2020 indicate that cancer care was not affected during the pandemic, although cancer screening programmes were disrupted.
- Waiting times for health services are a longstanding issue, and a greater proportion of the population had to wait longer than three months to get access to specialists or to interventions during the pandemic in 2020. The government has committed to increasing efforts to reduce waiting times.
- Sweden allocates a large amount of money to health, with spending per capita and as a share of GDP among the highest in the EU. The government also increased public spending on health in 2020 in response to the pandemic, with a further increase of over 10 % planned for 2021. This includes additional health care transfers to municipalities and regions, the equivalent of EUR 1.6 billion for testing and tracing, and EUR 1.0 billion for COVID-19 vaccinations.
- The initial approach to managing the COVID-19 pandemic in Sweden was unique. Unlike other Nordic and western European countries, which adopted strict lockdowns during the first wave to curb the spread of the virus, the Swedish government took a less restrictive approach, trying to strike a balance between protection of people's health and protection of economic and social activities. Social distancing measures were imposed, such as bans on large gatherings and travel restrictions, but these were less stringent than in other countries. There were hopes that the greater number of cases during the first wave would help mitigate any second wave because of greater immunity, but the second wave ended up being slightly larger than the first in terms of numbers of cases and deaths.
- The first wave of the pandemic hit people living in long-term care institutions particularly hard. Nearly half of all COVID-19 deaths in Sweden during the first wave were among long-term care residents, and another quarter were among people receiving long-term care at home. Insufficient testing of staff and residents in nursing homes during the first few months of the pandemic slowed early detection and isolation of confirmed cases. The lack of personal protective equipment and the physical infrastructure of nursing homes also limited opportunities to contain virus transmission.
- People with the greatest need for protection against COVID-19 were offered the vaccine first, including older people, people with chronic diseases, family members and staff caring for these people. By the end of August 2021, over 55 % of the total population in Sweden had received two doses of a COVID-19 vaccine or the equivalent – a slightly higher proportion than the EU average. The increase in vaccination has been accompanied by a reduction in the number of COVID-19 deaths.

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## Country abbreviations

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

# State of Health in the EU

## Country Health Profile 2021

The Country Health Profiles are an important step in the European Commission's ongoing *State of Health in the EU* cycle of knowledge brokering, produced with the financial assistance of the European Union. The profiles are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, in cooperation with the European Commission.

The concise, policy-relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU/EEA country. The aim is to create a means for mutual learning and voluntary exchange that can be used by policymakers and policy influencers alike.

Each country profile provides a short synthesis of:

- health status in the country
- the determinants of health, focussing on behavioural risk factors
- the organisation of the health system
- the effectiveness, accessibility and resilience of the health system

The Commission is complementing the key findings of these country profiles with a Companion Report.

For more information see: [ec.europa.eu/health/state](http://ec.europa.eu/health/state)

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