Form-of-state, Parliamentary Monarchy

GDP per capita (current US$), 57,488, among the highest in the EU

Sweden joined the E.U. in 1995, and its population recently reached over 10.7 million people

Located in northern Europe, most of its population lives in southern, coastal, and urban areas, while the north is sparsely populated.

Highest income tax rate in the world. More than 57% is annually deducted from people's incomes.

Sweden placed 7th out of 156 countries in the World Happiness Report 2019, and its healthcare system is one of the best in the world.

Higher education is free, including medical schools, not only to Swedes, but also to those who reside in the rest of the EU, the European Economic Area, and Switzerland. Like healthcare, it is largely financed by tax revenue.

There are no tuition fees; a physician can expect an average monthly salary of 77,900 SEK ($8,500).

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Human Dignity, Solidarity, Cost-effectiveness. Three Basic Principles in Swedish Healthcare

Despite having the highest taxes in the world, the living conditions and healthcare in Sweden are among the best in the word. Sweden operates on the principle that those who need medical care most urgently are treated first, furthermore, universal coverage and caps on user charges contribute to equity in access and a low level of unmet needs, especially due to costs and travel distance.

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Reading time

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The Swedish healthcare system is mainly government-funded, universal, and enrollment is automatic to all legal residents. Its organization is decentralized, nationally regulated, and locally administered, although private healthcare also exists. The country is divided into 290 municipalities and 21 regional councils. Swedish policy states that every regional council must provide residents with good-quality health and

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medical care, and work to promote good health for the entire population. On this regard, the National Board of Health and Welfare (Socialstyrelsen), government agency under the Ministry of Health and Social Affairs, compiles information and develops standards to ensure good health, social welfare and high-quality health and social care for the whole population.

A distinctive feature of Swedish welfare policy is that it is largely universal, namely, public services and social transfers are designed as social rights that cover the entire population in different life situations, not just vulnerable groups. Consequently, Sweden has a large and comprehensive public sector, with total public expenditure accounting for about half of Sweden's GDP (measured in terms of consumption). The largest share (38%) comprises transfers to cover social protection (such as old age pensions but also expenses for care for elderly individuals, such as home services and special accommodation). Healthcare is the second largest part followed by education, general public services, and economic affairs. The share of public expenditure in GDP on social protection and healthcare has been quite stable since 2011, and varied between 27.9% and 25.9% (Eurostat, 2022a).

All three levels of government (national government, regions, and municipalities) engage in the healthcare system:

- At the national level, the *Ministry of Health and Social Affairs* is responsible for **overall healthcare policy and regulation and sets budgets for government agencies and grants to regions**, working in concert with eight national government agencies.
- At the regional level, 21 regional bodies/councils are responsible for **financing and delivering primary and hospital health services** to residents. Regional councils are political bodies whose representatives are elected by region every four years on the same day as national general elections.
- At the local level, 290 municipalities are responsible for **care of the elderly and disabled people, including long-term care, as well as healthcare in schools**. Although in most countries care for the elderly or those who need psychiatric help is conducted privately, in Sweden local, publicly funded authorities are in charge of it.

Swedish healthcare is thus generous and provides extensive coverage in terms of breath, scope, and depth, however, there is no predefined benefits package, and services vary to some extent throughout the country because the responsibility for organizing and financing healthcare rests with the regions and municipalities. Broadly, however, the publicly financed health system covers public health and preventive services, primary care, inpatient and outpatient specialized care, emergency care, outpatient medical devices, dental, mental health, rehabilitation, social services, long-term care, as well as prescription drugs.

Rather the Health and Medical Services Act states that responsible healthcare authorities are obliged to provide care on the basis of need for all residents. **The ethical platform and the general guidelines for priorities in health and medical care on which the parliament has decided, aim to clarify and strengthen the goal of care on equal terms, a principle that has been valued for a long time in Swedish health and medical legislation (Government Bill 1996/97:60)**. The ethical platform is deliberately designed not to provide detailed guidance on how healthcare should be delivered and managed, among other things due to regional self-governance. Based on the ethical platform, there are four priority groups to guide decisions about resource use at the political and administrative level as well as in clinical practice:

- Priority group 1: Life-threatening acute conditions, diseases that lead to permanent impairment or premature death without treatment, severe chronic diseases, palliative care and end-of-life care, care of people with reduced autonomy (patients who, for various reasons, find it difficult to assert their right to care and a dignified existence)
- Priority group 2: Prevention, habilitation and rehabilitation
- Priority group 3: Less severe acute and chronic conditions
- Priority group 4: Care for reasons other than illness or injury

Swedish healthcare is predominantly financed by taxation. Public funding comes primarily from regional and municipal taxes, supplemented by the national government grants and by user charges. **Overall, in terms of expenditure, over 86% of the service production is conducted by public providers. Inpatient and outpa-**

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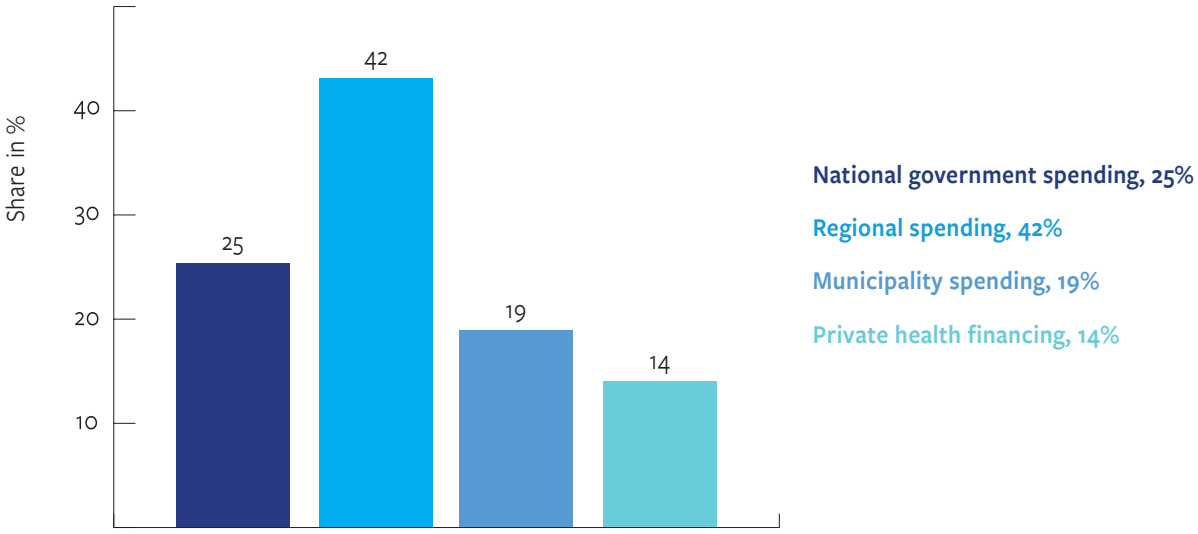
Healthcare Expenditure, Break-down by Government Bodies



tient specialized care absorbs around two thirds of the funding, where almost all hospitals are public owned and managed. Private care provision is limited to urban areas, mostly in the major cities. To service its over 10.7 million people, Sweden has 70 regionally owned public hospitals, seven university hospitals, and six private hospitals.

Although very low and with a price cap, patient fees are charged for almost all types of services and medical products, except for targeted groups, such as children, adolescents, and the elderly; in addition, preventive services, such as maternity care, immunizations, cancer screenings and dental care, up to the age of 19 (as of 1 January 2025. Until 2024 costs were covered up to the age of 23) are free and have no co-payments. For physical visits and treatments within outpatient care, patients pay flat-rate fees up to a maximum ceiling of 1,300 Swedish kronor (SEK) [118 euros (EUR)] per 12-month period. The level of private cost-sharing is higher for pharmaceuticals, dental care, and technical devices (dental and pharmaceutical benefits are determined nationally and are subsidized). However, for prescribed pharmaceuticals within the National Drug Benefit Scheme, the share of co-payment decreases up to a maximum cost of SEK 2,600 (EUR 234) over a 12-month period. There is also a co-payment scheme for dental care such that the state covers part of the cost according to the reference price list above SEK 3 000 (EUR 279). As a result, there are relatively few people who forgo care due to patient fees, but this is more common regarding dental care.

Costs for health and medical care as a percentage of Sweden's gross domestic product (GDP) is quite stable, and on par with most other European countries, representing a little over 11% of GDP, ranking fourth in the European Union, higher than the Nordic average (0.9 percentage points higher) and 2.2 percentage points above the EU average. **On average, around 14-16 % of all health expenditures are private; of these, 93% are out-of-pocket. Most out-of-pocket spending is for drugs and dental care.** Private supplemental coverage (VHI-Voluntary Health Insurance) accounts for less than 1 % of total health expenditures, and about 4% of private health expenditure, and is used primarily to guarantee quick access to an ambulatory care specialist and to avoid waiting lists for elective treatment. **In general, all social groups are entitled to the same benefits. Ceilings on out-of-pocket spending apply to everyone, and the overall cap on user charges is not adjusted for income.** To battle its large medical waiting lists, Sweden implemented a 0-30-90-90 rule. The wait-time guarantee, or the 0-30-90-90 rule, ensures that there will be zero delays, meaning patients will receive immediate access to healthcare advice and a seven-day waiting period to see a general practitioner. The rule also guarantees that a patient will not wait more than 90 days to see a specialist and will receive surgical treatment, like cataract removal or hip-replacement surgery, a maximum of 90 days after diagnosis. Sweden's government also committed 500 SEK million ($55 million) to significantly decrease wait time for all cancer treatments.

	Sweden Average	EU Average	Eu Ranking
Health expenditure per capita (US$ PPP)	6,347	4,224	7th (lower than Norway (7,168) and Germany (7,037), similar to Denmark but higher than Finland (4,897)
Health expenditure as % of GDP	11%	9.2	4th after Germany (12.8), France (12.2) and Austria (11.5)
Public expenditure on health as % of total expenditure on health	86%	75.1	3rd After Czechia (87.4) and Luxembourg (87.3)

Note: US$ PPP: US dollars adjusted for differences in purchasing power.
Sources: Statistics Sweden, 2022h; WHO, 2022.

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There are both public and private providers of healthcare, and the same regulations apply to both. When regional councils buy services from private healthcare providers, it is based on a model where the healthcare is financed by the council but carried out by the private provider.

The measures of medical healthcare quality are generally high in Sweden and show a positive trend, with most Swedish patients being satisfied with the quality of care that they receive. Life expectancy in the country is among the highest in the EU and the general health among the population is good. Reports from the WHO and the OECD, among others, confirm that healthcare in Sweden provides good access to high-quality care. Sweden's life expectancy is 82.4 years old. This surpasses the life expectancies in Germany, the UK, and the United States. Maternal healthcare in Sweden is particularly strong because both parents are entitled to a 480-day leave at 80% salary and their job is guaranteed when they come back. Sweden also has one of the lowest maternal and child mortality rates in the world. Four in 100,000 women die during childbirth and there are 2.6 deaths per 1,000 live births. There are 5.4 physicians per 1,000 people, which is twice as great as in the U.S and the U.K, and 100% of births are assisted by medical personnel.

Challenges in Swedish healthcare relate to long waiting times for elective, specialized services and a lack of continuity of care, particularly in rural areas. Although having a comparatively high equality in health compared with many other EU countries, health gaps and differences in health status exist across different socioeconomic groups.

Oral Health – Differs from Rest of Healthcare System

There is freedom of choice for patients in the dental care market in Sweden. Dental care is provided by both public and private operators in a competitive market. The National Board of Health and Welfare (*Socialstyrelsen*) standardizes dental care across the country through regulations and general guidelines.

All dental care for people under the age of 19 is free, and all children visit a dentist regularly. After the age of 19, they no longer qualify for free dental healthcare and must pay out-of-pocket. However, the government pays them annual subsidies, or an allowance, of 600 SEK ($65) to pay for dental expenses. In Sweden, the cost of a tooth extraction is 950 SEK ($103) and the cleaning and root filling for a single root canal costs 3,150 SEK ($342). If dental care costs total anywhere between 3,000 -15,000 SEK ($326-$1,632), the patient is reimbursed 50% of the cost. If it exceeds 15,000 SEK, 85% of the cost is reimbursed.

Preventive dental care for children and young people is the most important task of the Public Dental Service and the regions are responsible for summoning all children and young people (from around 3 years of age) for regular check-ups, advice and, if needed, treatment. Two thirds of adult dental care within the general allowance is conducted at approximately 3,550 clinics run by the 2,000 private care providers. Financing of dental care for those above 19 years of age differs from the rest of the healthcare system, as the majority is financed out-of-pocket by households and pricing is free, although the Dental and Pharmaceutical Benefits Agency (*Tandvårdsoch Läkemedelsförmånsverket*) determines the reference prices for different treatments.

The presence of private providers varies in the country, with the largest share in cities. The largest single private provider, with about 21% of the market, is *Praktikertjänst*, a producer cooperative owned by dentists who are also operationally responsible for clinics. However, the majority of care providers are small and have an annual turnover of less than SEK 5 million (EUR 0.47 million). The Public Dental Service performs approximately one third of adult dental care within the framework of the government dental care support, with about 800 clinics distributed across all regions.

Dental health in the population is developing positively and in 2018, 75% of the population aged 16–84 years experienced good or very good dental health. Swedish dental care generally has a preventive approach, and dentists generally call upon their registered patients for regular check-ups or treatment each or every second year. In 2019, about 77% of the population aged 24 years and over had visited a dentist for a regular check-up during the past 3 years.

The proportion was somewhat higher for those under the age of 24. About 7% of the adult population had only visited a dentist for acute treatment. People with lower education and who are born outside Sweden are more likely to have avoided visiting a dentist for financial reasons compared with those born in Sweden. People with lower education, lower income and who are born outside the EU have fewer remaining and intact teeth, lower self-perceived dental health and are less likely to make regular dentist visits.

Although dental health in general has improved in the population, the share of preschool children with caries has increased and

Three Basic Principles Apply to all Healthcare in Sweden:
Human dignity: All human beings have an equal entitlement to dignity and have the same rights regardless of their status in the community.
Need and solidarity: Those in greatest need take precedence in being treated.
Cost-effectiveness: When a choice has to be made, there should be a reasonable balance between costs and benefits, with costs measured in relation to improvement in health and quality of life.

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birth and socioeconomic factors have a clear connection with the risk of caries at 6 years of age. Prevention and health promotion are important parts in identifying children at risk of developing illness and such initiatives, in collaboration with several care providers, are under development in many parts of the country, especially in vulnerable areas. The initiative *Increased accessibility in child health care* (2018–2020) aimed at promoting equal health through support for children with an increased risk of poorer health and dental health. Many regions used subsidies within the agreement to develop collaboration between child healthcare and dental care, which contributed to a form of systematic work with children's oral and dental health that had not existed before.

Dentists are trained at four universities. As for medical school, admission to a university dental school requires graduation from secondary school with subjects that include natural science. The study program lasts for 5 years and includes both theoretical and practical training.

Prevalence of Oral Diseases, 2019

Prevalence of untreated caries of deciduous teeth in children 1-9 years	Prevalence of untreated caries of permanent teeth in people 5+ years	Prevalence of severe periodontal disease in people 15+ years	Prevalence of edentulism in people 20+ years
38.6%	**36.1%**	**20.5%**	**11.3%**

Data source: Global Burden of Disease Collaborative Network. GBD 2019. Seattle: IHME; 2020.). Taken from: Oral Health Country Profile, WHO

Economic Impact

Total expenditure on dental healthcare in million (US$)	3,376
Per capita expenditure on dental healthcare (US$)	327
Total productivity losses due to 5 oral diseases in million (US$)	2,253

Data source: WHO; 2019. Taken from: Oral Health Country Profile, WHO

Oral Health Workforce

	Total No.	**Per 10 000 pop.**
Dental Assistants and therapists	4,966	4.9
Dentists	8,077	8.2

Data source: The National Health Workforce Accounts (NHWA) data platform, WHO; 2020.
Taken from: Oral health Country Profile, WHO

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Availability of Procedures for Detecting, Managing and Treating Oral Diseases in the Primary Care Facilities in the Public Health Sector (2021)

Oral health screening for early detection of oral diseases	available
Urgent treatment for providing emergency oral care & pain relief	available
Basic restorative dental procedures to treat existing dental decay	available

Data source: WHO NCD Country Capacity Survey, NCD CCS; 2021. Taken from: Oral Health Country Profile, WHO

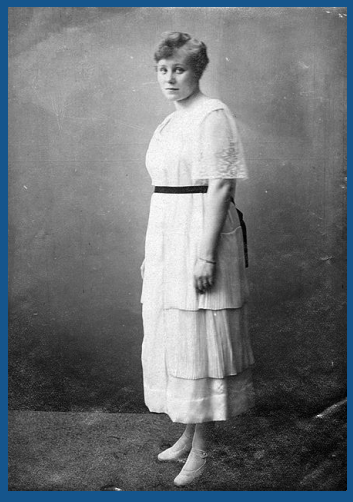
Oral Health Interventions as Part of Health Benefit Packages (2021)

Coverage of the largest government health financing scheme (% of the population)	Yes
Routine and preventive oral health care	Yes
Essential curative oral health care	Yes
Advanced curative oral health care	Yes
Rehabilitation oral health care	Yes

Data source: WHO Health Technology Assessment and Health Benefit Package Survey; 2021. Taken from: Oral Health Country Profile, WHO

>> CURIOSITY BOX <<

Nanna Charlotta Svartz, (b. 1890, d. 1986) Swedish physician, first female professor at a public university in Sweden. Her research focused on gastrointestinal diseases and rheumatology. On 17 December 1937, she was appointed professor for internal medicine at the Karolinska Institute by government decision and was the first female professor for medicine and at a public university. Before her, only Sofia Kovalevskaya had become a professor in Sweden in 1889, which was only possible because of the university being a private institution. Although she had allies, among others Israel Holmgren, who supported her throughout her career, there were many critics who doubted a woman could be able to be a professor. As she was always one of few women in the positions she worked in, she followed a strict separation of work and private life and adopted certain signs of male professionalism to obtain authority among colleagues and students. She always wore a suit and tie and even hid her pregnancy, only notifying her colleagues after the child was born.
In 1948, she was appointed the first head of the new King Gustaf V research institute (Konung Gustaf V:s forskningsinstitut) at Karolinska hospital, which the King inaugurated himself in the same year. The medicine Salazopyrine was invented by her to treat rheumatism and gastrontestinal diseases in the 1930s. It was Pharmacia's first medical product and sold since the 1940s. It is still in use. She died in 1986 at the age of 96 in Stockholm.



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