Country Cancer Profile 2025

European Commission

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The Country Cancer Profile Series

The European Cancer Inequalities Registry is a flagship initiative of Europe's Beating Cancer Plan. It provides sound and reliable data on cancer prevention and care to identify trends, disparities and inequalities between Member States, regions and population groups. The Country Cancer Profiles identify strengths, challenges and specific areas of action for each of the 27 EU Member States, Iceland and Norway, to guide investment and interventions at the EU, national and regional levels under Europe's Beating Cancer Plan. The European Cancer Inequalities Registry also supports Flagship 1 of the Zero Pollution Action Plan. The Profiles are the work of the OECD in co-operation with the European Commission. The team is grateful for the valuable inputs received from national experts and comments provided by the OECD Health Committee and the EU Thematic Working Group on Cancer Inequality Registry.

Data and information sources

The data and information in the Country Cancer 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.

Additional data and information also come from the European Commission's Joint Research Centre (EC-JRC), the EU statistics on income and living conditions (EU-SILC) Survey, the World Health Organization (WHO), the International Agency for Research on Cancer (IARC), the International Atomic Energy Agency (IAEA), the European Society for Paediatric Oncology (SIOPE), the European Union Agency for Fundamental Rights (FRA LGBTIQ), the Health Behaviour in School-aged Children (HBSC) survey as well as from the 2023 Country Health and Cancer Profiles, and other national sources (independent of private or commercial interests). The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway. Mortality and incidence rates are age-standardised to the European standard population adopted by Eurostat in 2013.

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.

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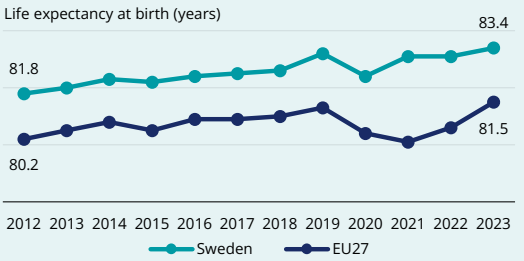
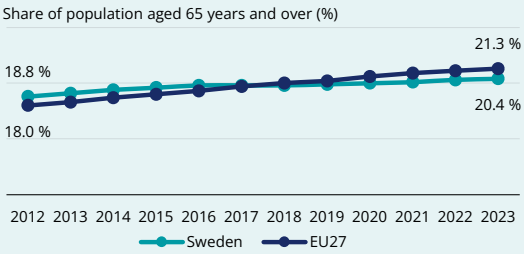
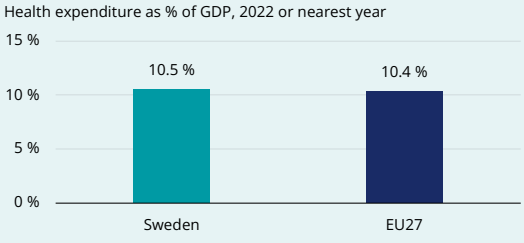
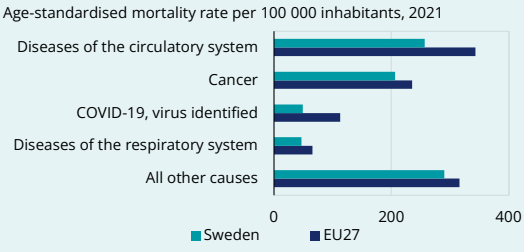


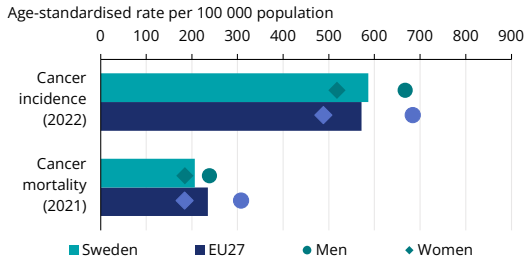






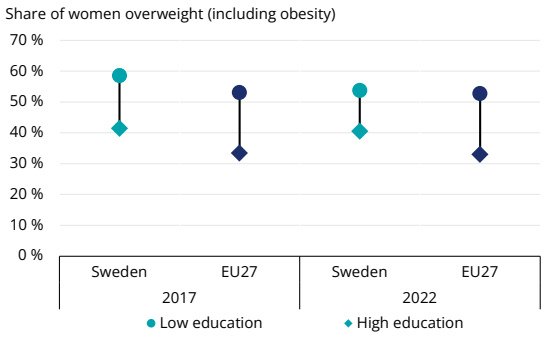
Source: Eurostat Database.

1. Highlights



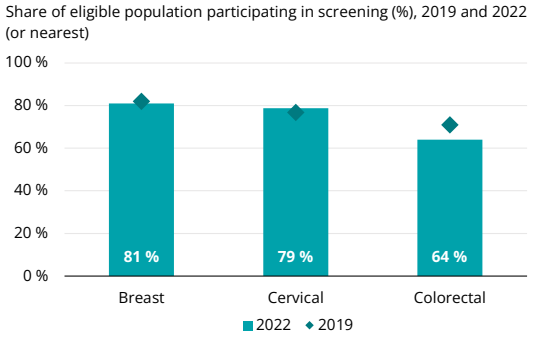
Cancer in Sweden

Cancer incidence in Sweden increased by over 30% between 2012 and 2022. Estimated cancer incidence in 2022 among Swedish men was 667 new cases per 100 000, which is lower than the EU average of 684 per 100 000. Among women, cancer incidence (518 new cases per 100 000) was higher than the EU average (488 per 100 000). Cancer mortality is among the lowest in the EU, at 207 per 100 000 compared to the EU average of 235 per 100 000.



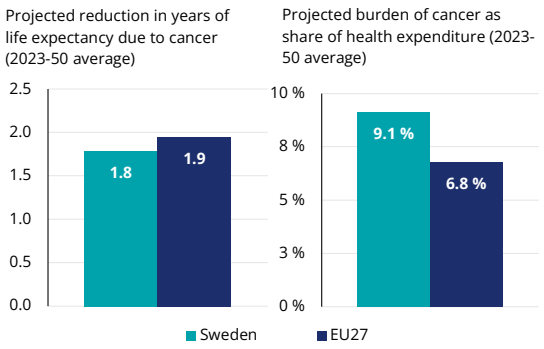
Risk factors and prevention policies

Prevalence of some major risk factors for cancer, such as daily smoking and alcohol consumption, is lower in Sweden than across the EU. However, relatively high prevalence of other risk factors – such as overweight or obesity, occupational exposure and low fruit consumption – is concerning. Inequalities between socio-economic groups among adults are high for overweight and obesity prevalence, but the gap between education levels is smaller than the EU average. Prevalence of risk factors for cancer is generally lower among adolescents in Sweden than the EU average, but with trends showing an increase in overweight and alcohol consumption.



Early detection

Sweden has three population-based screening programmes for cervical, breast and colorectal cancers, with high participation rates among the eligible population. Screening for cervical and breast cancers were the first programmes implemented, while rollout of the colorectal cancer screening programme began in all regions in 2022. Most regions in Sweden offer or plan to offer organised testing for prostate cancer, and pilot studies for screening for lung cancer are ongoing. Promoting participation in screening and reducing inequalities has been a focus of Sweden's National Cancer Strategy.



Cancer care performance

Sweden's National Cancer Strategy was established in 2009 with the overarching goals of reducing the risk of developing cancer; improving the quality of cancer patient management and improving survival and quality of life after a cancer diagnosis. Cancer survival in Sweden has increased considerably over recent decades. The estimated future impact of cancer on life expectancy is lower in Sweden than the EU average. Conversely, the projected burden of cancer on total health expenditure is larger in Sweden than the EU average. Large inequalities in access to cancer rehabilitation and palliative care services in Sweden exist. Efforts to improve these were part of the plan for national investment in cancer care in 2024 and 2025.

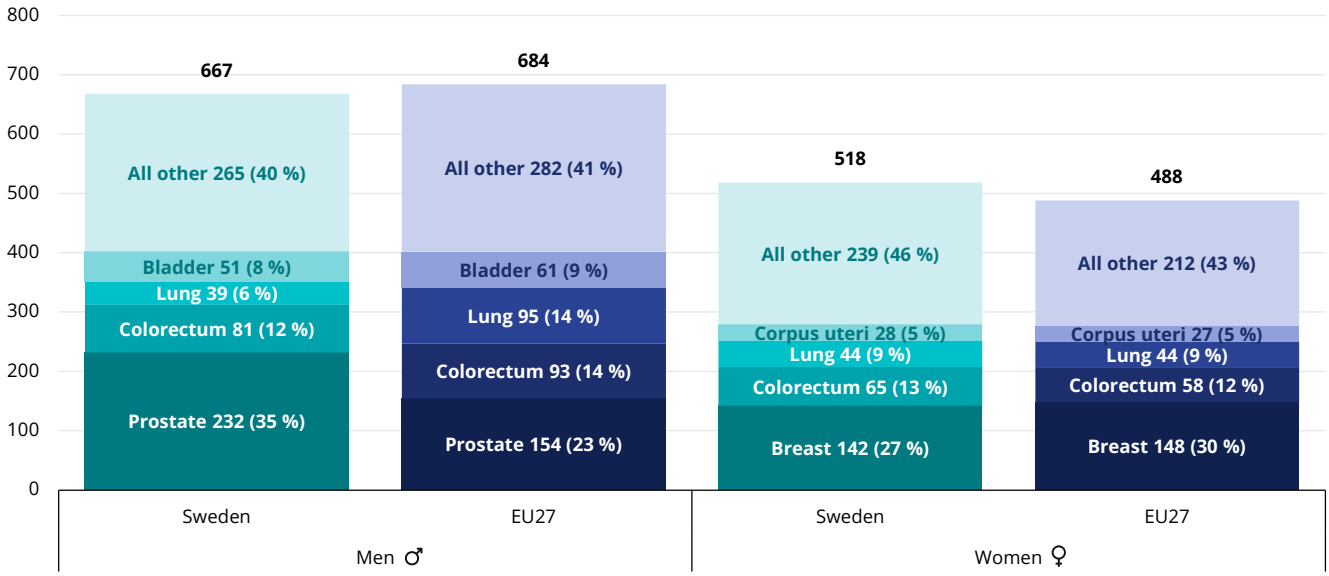
2. Cancer in Sweden

Cancer incidence has increased by 30% over the past decade

According to the European Cancer Information System (ECIS) of the Joint Research Centre, cancer incidence among Swedish men was estimated to be 667 new cases per 100 000 population in 2022, which is lower than the EU average of 684 per 100 000. Among women, cancer incidence (518 new cases per 100 000 population) was estimated to be higher than the EU average (488 per 100 000) (Figure 1). Data from the National Cancer Register show that the total number of new cancer cases in Sweden increased by over 30% between 2012 and 2022. Looking forward, ECIS estimates that cancer cases will increase by 19% between 2022 and 2040.

Figure 1. Incidence of prostate cancer among men is higher in Sweden than across the EU

Age-standardised incidence rate per 100 000 population, estimates, 2022



Notes: 2022 figures are estimates based on incidence trends from previous years, and may differ from observed rates in more recent years. Includes all cancer sites except non-melanoma skin cancer. Corpus uteri does not include cancer of the cervix.
Source: European Cancer Information System (ECIS). From https://ecis.jrc.ec.europa.eu, accessed on 10 March 2024. © European Union, 2024. The incidence percentage breakdown was re-computed based on age-standardised incidence rates and as such differs from the percentage breakdown of absolute numbers shown on the ECIS website.

Prostate cancer is responsible for the highest incidence among men, at 35% of incidence rates, compared to 23% across the EU. Among women, breast cancer is responsible for the highest incidence, at 27% of incidence rates, compared to 30% across the EU.

Compared to other EU countries, incidence of skin melanoma is high among both men (54 new cases per 100 000 population) and women (48 per 100 000) in Sweden (compared to 24 per 100 000 among men and 19 per 100 000 among women in the EU), however a decline in incidence has been observed for the younger population (up to 59 years) in recent years. Incidence of prostate cancer is also higher (232 new cases per 100 000 population) than the EU average (154 per 100 000). Conversely, incidence of lung cancer among men (39 new cases per 100 000 population) is considerably lower than the EU average (95 per 100 000).[1] Incidence of lung cancer among men has decreased over recent decades, dropping by 28% between 1970 and 2022 according to data from the National Cancer Registry (using age-standardised incidence according to the 1970 census). For Swedish women the trend is reversed, with an increase in lung cancer incidence per 100 000 age-standardised population of 249% between 1970 and 2022. During the same period, breast cancer incidence increased by 117% and prostate cancer by 128%. Part of the increase in breast cancer and

1 *Lung cancer also refers to trachea and bronchus cancers.*

prostate cancer is explained by the introduction of breast cancer screening and the use of PSA testing during this period. The largest rise in incidence was observed for malignant melanoma, with increases of 620% among men and 404% among women in new cases per 100 000 age-standardised population.

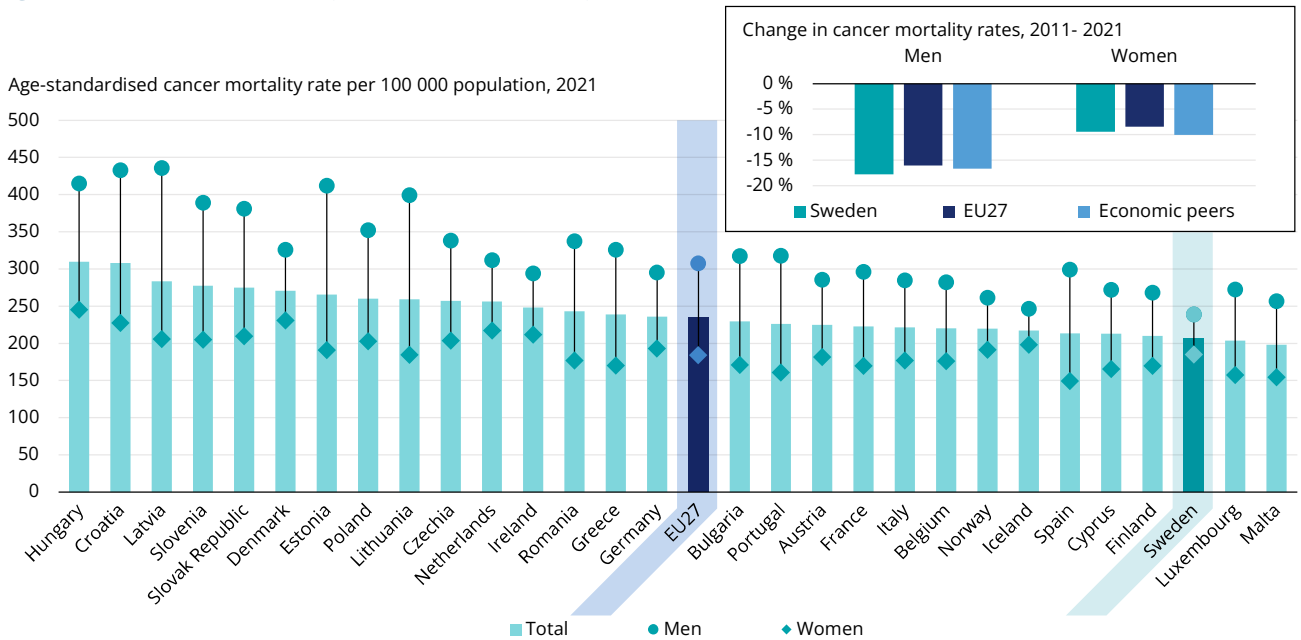
Age-standardised cancer mortality is the third lowest in the EU, with a relatively low gender gap

Cancer mortality in Sweden is the third lowest in the EU, at 207 deaths per 100 000 age-standardised population compared to the EU average of 235 deaths per 100 000 (Figure 2). As in all other EU+2 countries,[2] men had significantly higher mortality rates than women. However, the gender gap is the lowest among EU countries, with a difference between men and women of 54 deaths per 100 000 population compared to a difference of 124 per 100 000 across the EU. Mortality rates among men decreased significantly between 2011 and 2021 (-18%), a marginally larger change than that across Sweden's economic peers[3] (-17%); mortality rates among women also decreased (-9%), but at a slightly lower rate than that across Sweden's economic peers (-10%). Time trends presented by the regional cancer centres (RCCs) in Sweden show that the gender gap in both incidence and mortality has decreased markedly for lung cancer, pancreatic cancer and gastric cancer since the 1970s, which probably explains part of the overall decreased gender gap in cancer mortality.

Lung and colorectal cancers were the two leading causes of cancer deaths in Sweden in 2021. Lung cancer mortality accounted for 16% of all cancer deaths and colorectal cancer for 12%, followed by prostate and pancreatic cancers (9% each).

Even though the cancer mortality rate in Sweden is decreasing, cancer is the second largest cause of death after cardiovascular diseases. In 2021, cancer mortality even surpassed cardiovascular mortality for men in the region of Stockholm. As mortality from cardiovascular diseases is decreasing considerably faster than cancer mortality, cancer is likely to become the leading cause of death. Deaths from cardiovascular diseases per 100 000 age-standardised population decreased by 32% between 2011 and 2021, while the corresponding decrease for cancer deaths was 13%.

Figure 2. Gender inequality in cancer mortality in Sweden is the lowest in the EU



Notes: Economic peers are defined as tercile clusters based on 2022 GDP per capita in purchasing power standard terms. Economic peers for SE are AT, BE, DE, DK, IE, IS, LU and NO.
Source: Eurostat Database.

2 *EU+2 countries include 27 EU Member States (EU27), plus Iceland and Norway.*

3 *Economic peers are defined as tercile clusters based on 2022 GDP per capita in purchasing power standard terms. Economic peers for SE are AT, BE, DE, DK, IE, IS, LU and NO.*

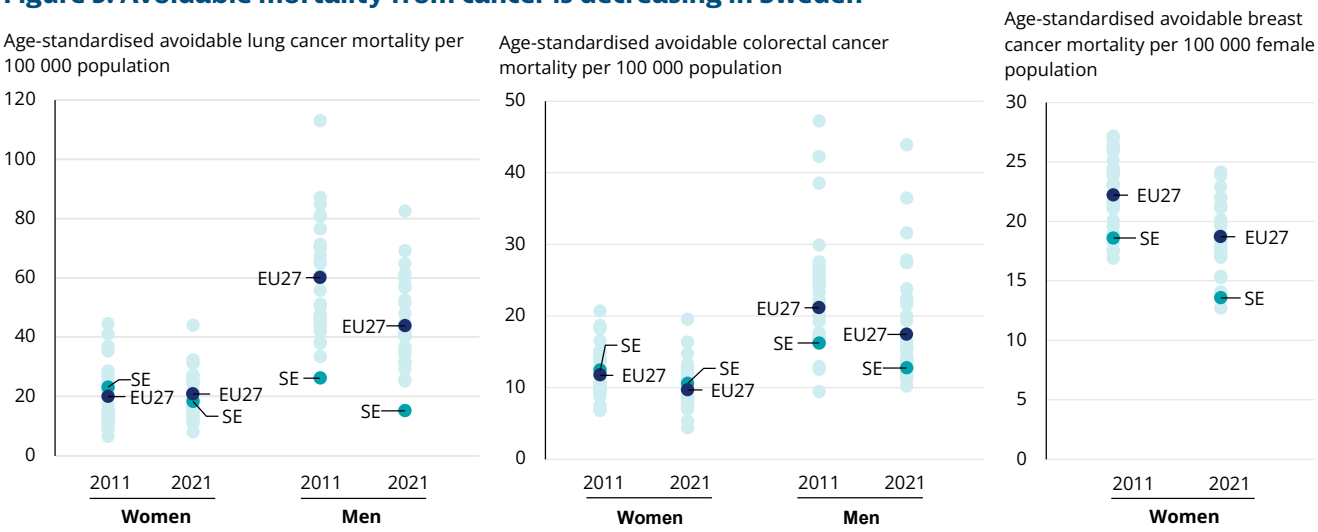
Avoidable mortality is decreasing in Sweden, particularly for breast cancer and lung cancer

Thanks to improved prevention strategies and advances in treatment options, today a significant proportion of cancer deaths in people under 75 years old are considered potentially avoidable[4] – either through public health interventions that minimise exposure to cancer risk factors (preventable cancer mortality) or through the provision of optimal oncological care (treatable cancer mortality).

Preventable mortality from lung cancer in Sweden in 2021 was 18 deaths per 100 000 among women (12% lower than the EU average) and 15 per 100 000 among men (65% lower than the EU average). Compared to 2011, the rate has decreased by 20% for women and 42% for men, while the EU average increased by 4% for women and decreased by 27% for men during the same period. The improvements in Sweden relate to a decreasing prevalence of smoking over the past years, reflecting the positive impact of tobacco control policies in recent decades.

In 2021, treatable mortality from breast cancer in Sweden was 14 deaths per 100 000 women, which is 28% lower than the EU average (Figure 3). The rate has decreased by 27% compared to 2011, while the EU average decreased 16% in the same period. The corresponding figures for colorectal cancer in Sweden were 11 deaths per 100 000 among women (10% higher than the EU average) and 13 per 100 000 among men (27% lower than the EU average). Compared to 2011, the rate has decreased by 15% for women and 21% for men, while the EU average decreased by 18% for both women and men during the same period. Efforts to improve early diagnosis (such as the rollout of the colorectal cancer screening programme in 2022) and cancer care quality (such as establishment of Comprehensive Cancer Centres and standardised care pathways) will help to achieve further reductions (see Sections 4 and 5.2).

Figure 3. Avoidable mortality from cancer is decreasing in Sweden



Note: Avoidable mortality figures relate to deaths of people aged under 75.
Source: Eurostat Database. Data refer to 2021.

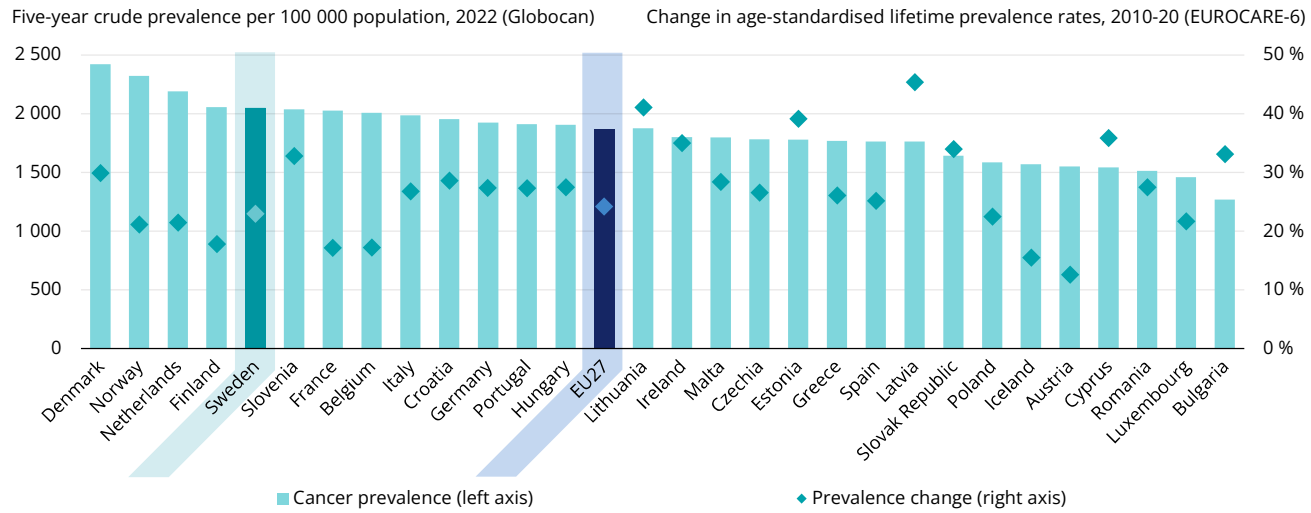
Sweden has the fifth highest cancer prevalence among EU+2 countries

Sweden has higher five-year cancer prevalence[5] than the EU average (Figure 4). According to data from Globocan, there were 2 051 cancer cases per 100 000 population in Sweden in 2022, which is 9% higher than the EU average of 1 876 cases per 100 000. In addition, data from Nordcan reported a 10-year prevalence in Sweden of 2 721 cases per 100 000 population in 2010 and 3 317 cases per 100 000 in 2022, which corresponds to an increase of 22% and is the highest ever recorded level since the start of data collection. According to estimates from EUROCARE-6 data, between 2010 and 2020, lifelong cancer prevalence increased by 23% in Sweden, compared to 24% across the EU. The relatively high cancer prevalence in Sweden can be related to the high cancer survival (see Section 5.2).

4 *Avoidable mortality includes both preventable deaths that can be avoided through effective public health and prevention interventions, and treatable deaths that can be avoided through timely and effective healthcare interventions.*

5 *Cancer prevalence refers to the proportion of the population who have been diagnosed with cancer and are still alive, including those currently undergoing treatment for cancer and those who have completed treatment. Five-year cancer prevalence includes people who have been diagnosed within the previous five years, while lifetime prevalence considers those who have ever received a cancer diagnosis.*

Figure 4. Cancer prevalence is relatively high in Sweden

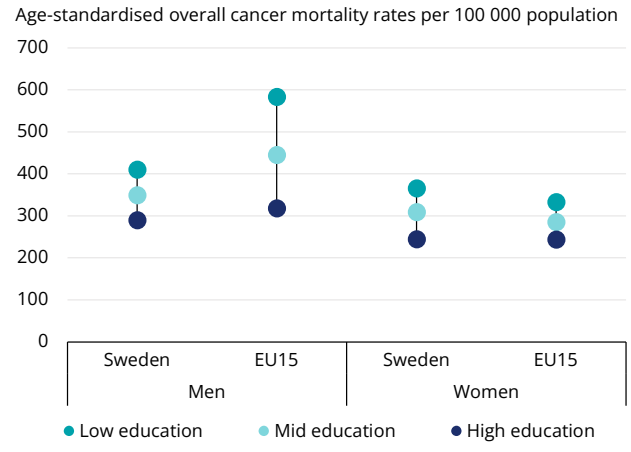


Sources: IARC Globocan Database 2024; EUROCARE-6 study (De Angelis et al., 2024).

Socio-economic inequalities in cancer mortality among men in Sweden are smaller than the EU averages

Overall cancer mortality in Sweden is higher among individuals with lower education levels than those with higher education levels (Figure 5). The gap in age-standardised overall cancer mortality rates by education level among Swedish men (42%) is smaller than the EU average gap (84%) while it is larger among Swedish women (50%) than the EU average (37%).

Figure 5. The education gap in cancer mortality among men in Sweden is smaller than in the EU, but it is larger among women



Note: Data come from the EU-CanIneq study and refer to 2015-19. EU15 refers to unweighted average of 14 EU countries and Norway.
Source: European Commission/IARC/Erasmus MC (2024), Mapping socio-economic inequalities in cancer mortality across European countries. ECIR Inequalities factsheet.

The update of the National Cancer Strategy is expected in 2025

The Swedish Government is working on an update of the National Cancer Strategy. The current Strategy was established in 2009, with the overarching goals of reducing the risk of developing cancer; improving the quality of cancer patient management; improving survival and quality of life after a cancer diagnosis; reducing regional differences in survival time; and reducing differences in morbidity and survival time between population groups (Box 1). Within the Strategy, six regional cancer centres (RCCs) were founded in 2010, along with formation of national and regional specialist collaborative groups and national guidelines. In addition, standardised care pathways were introduced in 2015 with the aims of reducing waiting times, standardising diagnostic strategies, increasing patient satisfaction and reducing regional inequalities in timely access to care. In 2023, 83% of all cancer patients were included in 1 of 31 standardised care pathways.

In 2023, the Swedish Agency for Health and Care Services Analysis was given a government task to produce a status report on the 2009 National Cancer Strategy (Agency for Health and Care Services Analysis, 2024). The report concluded that the National Cancer Strategy provided structure and direction but lacked in prioritisation, implementation and follow-up; that target fulfilment differed between target areas; and that the implementation of the standardised care pathways had created coherent flows in cancer care but needed to be developed further in order to reach lead time goals. It was highlighted that childhood cancer care had become part of the Strategy, but needed to be developed further;

and that new medical technology development, EU initiatives and a parallel national initiative of transitioning some parts of the healthcare from inpatient to primary care needed to be considered in an updated Strategy. A first proposal for an updated Strategy will be presented in early 2025.

Box 1. The Swedish cancer plan will be updated in 2025

The 2009 Sweden's National Cancer Strategy aligns with the priorities of Europe's Beating Cancer Plan, aiming to reduce cancer risk, improve patient quality of life, prolong survival and minimise disparities (Table 1). The Strategy includes policies to combat cancer risk factors; free population-based screening for breast, cervical and colorectal cancers; and multidisciplinary specialist teams, national clinical guidelines, clinical quality registries and basic and specialised palliative care. Quality of life of cancer patients is a focus area of the Strategy. Multiple national working groups have been established, among them a group that aims to improve paediatric cancer care. Sweden is also focused on cancer research and several institutions participate in EU-funded projects. Cancer inequalities is a primary focus of the 2009 National Cancer Strategy, to reduce disparities between population groups and by region in survival time after a cancer diagnosis. The planned update of the National Cancer Strategy in early 2025 is supposed to take a holistic perspective that includes prevention, early detection, diagnostics, treatment, rehabilitation, palliative care and follow-up care. There are supposed to be several priority topics, such as the adoption of precision health, to sync health promotion and prevention efforts with other disease areas, and efforts to ensure optimised care processes and increased accessibility. The strategy is also supposed to take into account Europe's Beating Cancer Plan.

Table 1. Sweden's National Cancer Strategy aligns with Europe's Beating Cancer Plan

Pillars of EBCP				Transversal themes of EBCP		
Prevention	Early Detection	Diagnosis and treatment	Quality of life	Cancer inequalities	Paediatric cancer	Research and innovation
●	●	●	●	●	●	●

Notes: EBCP = Europe's Beating Cancer Plan. Blue indicates that Sweden's National Cancer Strategy includes a specific section on the topic; orange indicates that the topic is covered in one of the Strategy's sections without being the only focus; and pink indicates that this topic is not covered in the Strategy.
Source: Adapted from "Study on mapping and evaluating the implementation of Europe's Beating Cancer Plan" (not yet published).

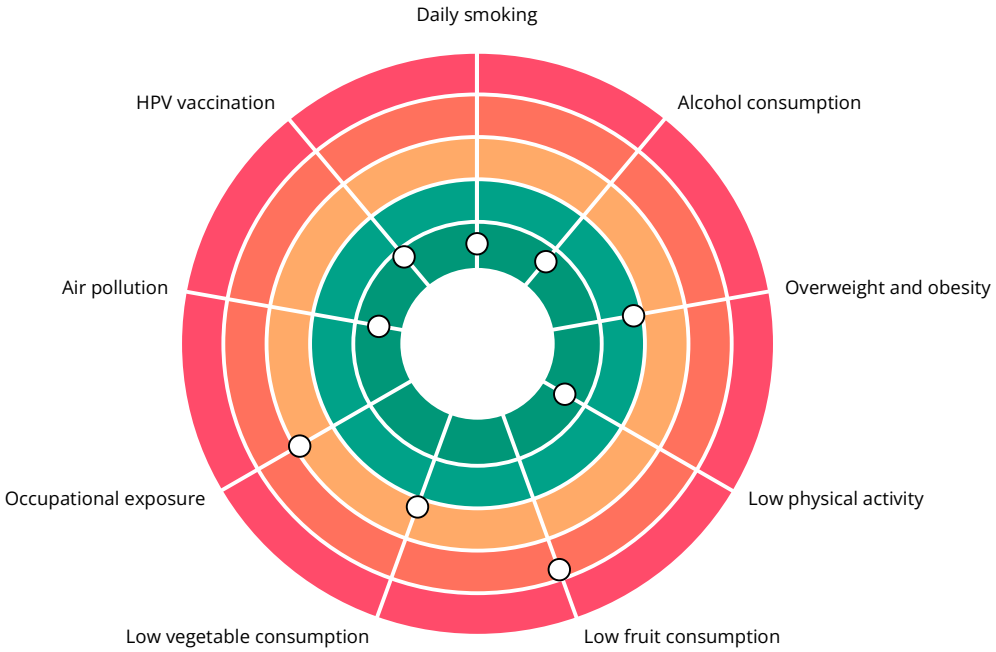
3. Risk factors and prevention policies

Sweden has relatively high prevalence of unhealthy diet and occupational exposure

Prevalence of some major risk factors for cancer such as daily smoking and alcohol consumption is lower in Sweden than across the EU (Figure 6). Sweden also ranks among the top three EU countries when it comes to physical activity, air quality and HPV vaccination. However, the relatively high prevalence of other risk factors – including overweight or obesity, occupational exposure and low fruit consumption – raises some concerns. In 2022, spending on prevention[6] represented 4% of current health expenditure in Sweden – lower than the EU average of 6%.

Air pollution in Swedish cities measured by particulate matter with a diameter less than 2.5 micrometres ($PM_{2.5}$) (a component of outdoor air pollution classified as carcinogenic to humans) is low (6 µg/m³) relative to the EU average (12 µg/m³). Sweden also has relatively high coverage of HPV vaccination. Girls are offered vaccination against HPV infection free of charge through the national childhood vaccination programme since 2012. Since 2020, boys have also been included in the programme. Vaccinations are carried out in schools. In 2023, the proportion of girls who received all recommended doses of the HPV vaccine by age 15 was 85% in Sweden, compared to 64% on average in the EU. For boys, this figure stood at 92% in 2023. There is little variation across Swedish regions. HPV vaccination is also offered free of charge to women born 1994-99 in an effort to eliminate cervical cancer by 2027. The National Public Health Agency plans to adopt a new recommendation of HPV vaccination for boys and men up to 26 years to further decrease HPV-related cancers.

Figure 6. Sweden has relatively high prevalence of low vegetable and fruit consumption, and occupational exposure



Notes: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white "target area" as there is room for progress in all countries in all areas.
Sources: OECD calculations based on 2022 EU-SILC Survey for overweight, obesity, physical activity, fruit and vegetable consumption (in adults); Eurofound Survey for occupational exposure; OECD Health Statistics for smoking, alcohol consumption (in adults) and air pollution; and WHO for HPV vaccination (15-year-old girls).

6 *Prevention expenditures as reported in health accounts should include activities outside of national programmes (e.g. opportunistic cancer screening or counselling for smoking cessation during a routine physician contact), however in practice countries may have difficulty in identifying prevention spending outside of such programmes.*

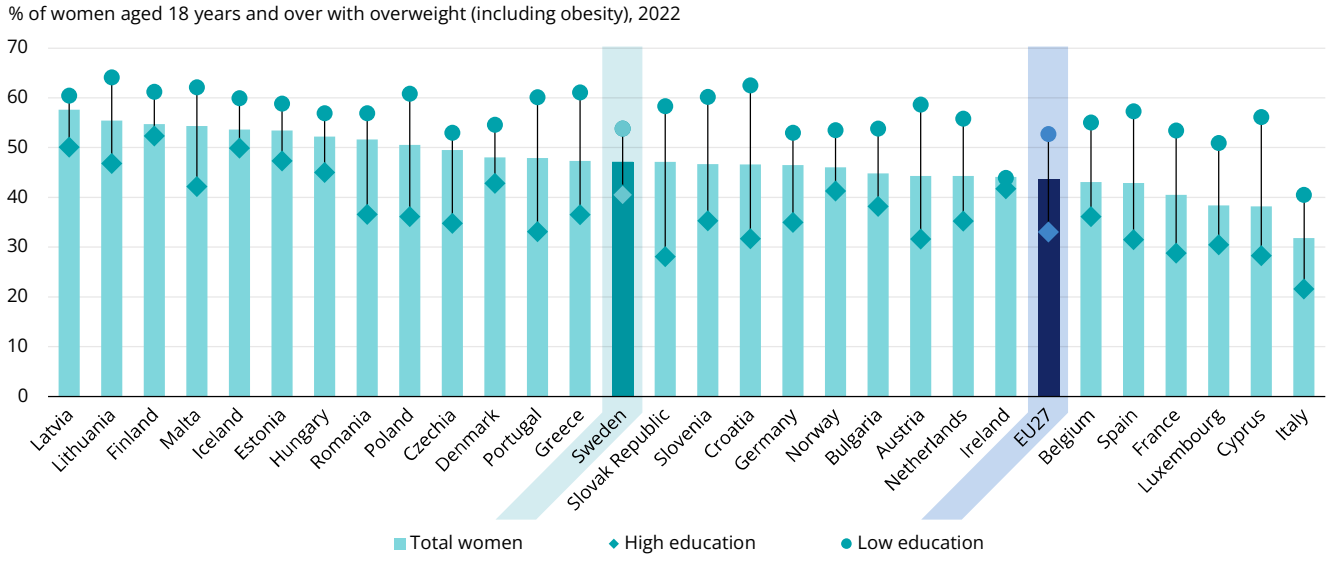
Previous estimates have shown that almost one-third of all cancer cases (28%) in Sweden could be attributed to preventable risk factors, with smoking contributing to the largest share (11%), followed by ultraviolet radiation (7%), obesity and overweight (2%), poor diet (2%), alcohol consumption (2%), cancer-related infections (2%) and low physical activity (1%) (Fridhammar, Hofmarcher & Persson, 2020). There are large differences in exposure to cancer risk factors between socio-economic groups – especially for smoking. The prevalence of daily smoking in Sweden in 2022 was 10 percentage points higher in the group with the lowest education levels (12%) than the highest (2%), even though trends in tobacco smoking are decreasing among all socio-economic groups (Public Health Agency, 2022). In addition, Sweden has the lowest smoking prevalence in the EU (at 9% in 2022)[7]. According to the Swedish Cancer Society, prevalence of exposure to ultraviolet radiation is more common among those with higher education levels, with increased risk for developing malignant melanoma.

While prevalence of smoking has decreased in Sweden, prevalence of snuff (a type of smokeless tobacco) has increased, with 29% of reported users among men and 13% among women in 2023 based on information from the Swedish Council for Information on Alcohol and Other Drugs. According to the IARC, smokeless tobacco is associated with increased risk of cancers of the oral cavity, oesophagus and pancreas. New nicotine products such as e-cigarettes and nicotine pouches have also been introduced into the market. White snuff and nicotine pouches were used by 13% of Swedish 9th graders, and 24% of older adolescents in 2023 according to the Council for Information on Alcohol and Other Drugs. The risk of cancer from these products is not yet known, but due to the health risks from nicotine they will need close monitoring.

Socio-economic disparities in overweight and obesity among women are lower in Sweden than across the EU

In Sweden, the prevalence of overweight (including obesity) among adult women was 47%[8] in 2022, which was higher than the EU average (44%) (Figure 7). As in most countries, rates of overweight were significantly higher among women with lower education levels (54%) than those with higher education levels (41%), although the gap in Sweden (13 percentage points) is smaller than the EU average (20 percentage points). However, prevalence of overweight in Sweden decreased more between 2017 and 2022 among women with lower education levels (-8%) than among those with higher education levels (-2%). This decrease was also higher than the EU averages of -1% in both education groups.

Figure 7. In Sweden, prevalence of overweight among women at all education levels is higher than the EU average



Note: Overweight (including obesity) includes those with a body mass index (BMI) above 25.
Source: Eurostat Database.

7 *The Public Health Agency of Sweden reports a smoking prevalence of 6%.*

8 *The Public Health Agency of Sweden reports a prevalence of overweight (including obesity) of 45% among women in the age group 16-84 years.*

Poor nutrition contributes to overweight and obesity. In 2022, 52% of Swedish adults consumed fruits (compared to 39% in the EU) and 41% consumed vegetables (compared to 40% in the EU) less than once daily.

There has been a strong focus on prevention policies in Sweden in recent years

Responsibility for prevention of health risk factors is distributed among a broad range of actors at all levels of Swedish society, including at the national, regional and municipal levels. There has been a strong focus on prevention policies in Sweden in recent years. On behalf of the Confederation of Regional Cancer Centres, the National Working Group for Cancer Prevention in 2020 developed a plan for the preventive work within the RCCs (Confederation of RCCs, 2020), which was updated in 2023. The purpose of the plan was to describe activities to prevent cancer and promote healthy lifestyles at the national level within the framework of the RCCs' mission.

In 2018, the NBHW published national guidelines for prevention and treatment of unhealthy lifestyle factors (NBHW, 2018a). The recommendations included interventions for lifestyle factors such as tobacco use, alcohol consumption, unhealthy eating habits and insufficient physical activity, with the aim of improving health and preventing disease. The guidelines emphasised interventions aimed at specific risk groups, which include adults at particular risk (for example, due to illness or social vulnerability), adults about to undergo surgery, children and adolescents, and pregnant women, with updated guidelines planned for publication. In addition, national guidelines specifically for obesity care were published in 2023 (NBHW, 2023). These emphasise the importance of early detection and co-ordinated care in obesity, and note that the Swedish healthcare regions need to set aside more resources for the care of children and adults with obesity in the coming years.

Some regions in Sweden offers health check-ups in primary care to a selected part of the population (e.g. all 40-year-olds) with a focus on unhealthy lifestyle factors. The Physical Activity on Prescription model has been used in Sweden since the early 2000s and includes person-centred individualised counselling, written evidence-based physical activity recommendations, follow-up and community support. The initiative has shown positive effects on physical activity levels as well as health outcomes for longer periods in both clinical follow-up studies and randomised controlled trials. In 2022, 60% of people aged over 15 engaged in physical activity at least three times per week – double the EU average (31%).

The Leisure Card is a government initiative aimed at providing children and young people aged 8-16 with increased access to sports, culture, outdoor activities, and other community activities. It can be used as payment for leisure activities within, for example, sports organisations, outdoor organisations, and other organisations within civil society and the cultural sector. The reform will be launched to children and families in 2025, with the aim of increasing physical activity among children and adolescents.

While smoking, alcohol use and obesity levels among adolescents are lower than in the EU, trends in fruit and vegetable consumption are concerning

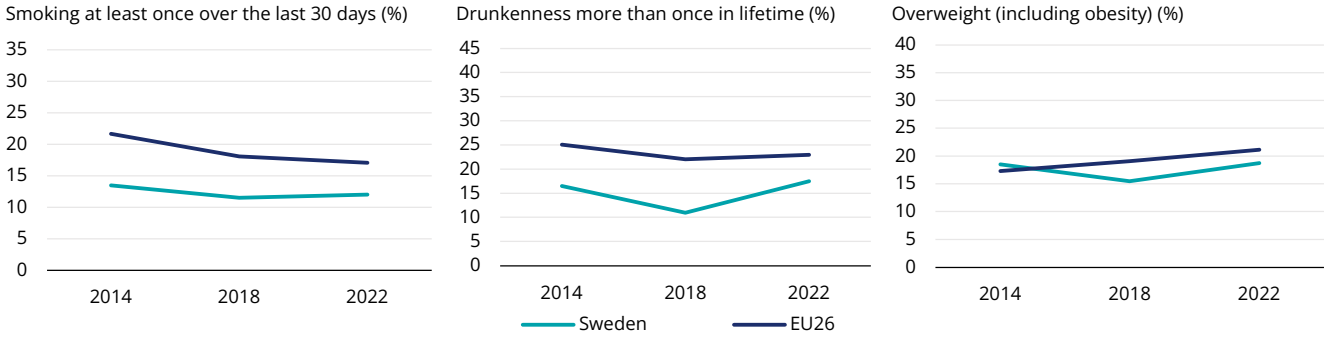
The prevalence of risk factors for cancer is generally lower among adolescents in Sweden than across the EU[9], but with some exceptions (Figure 8). In 2022, the prevalence of smoking (at least once in the last 30 days) among Swedish 15-year-olds was 12%, which was 5 percentage points lower than the EU average, and tobacco use had decreased by 1.5 percentage points during 2014-22. The prevalence of repeated drunkenness in the same age group was 17%, which was also more than 5 percentage points lower than the EU average, but had increased slightly by 1 percentage point during 2014-22. Overweight (including obesity) among 15-year-olds in Sweden follows the same pattern, with a lower prevalence of 19% compared to the EU average in 2022 (-2 percentage points) and a marginal increase during 2014-22 (0.2 percentage points). Overweight and obesity are more concentrated among children whose family background is disadvantaged. In Sweden, 11-to-15-year-olds who are in the bottom 20% of family affluence are 9 percentage points more likely to be overweight (23%) than those in the top 20% (14%), based on the Family Affluence Scale.

Sweden performs less well when it comes to daily fruit and vegetable consumption among 15-year-olds compared to other EU countries. In 2022, the prevalence of daily fruit consumption was 17%, which was 13 percentage points lower

9 *The data is taken from the Health Behaviour in School-aged Children Survey, and may differ from national source.*

than the EU average, and the prevalence for daily vegetable consumption of 23% was 11 percentage points lower. The trend also decreased during 2014-22, with daily consumption down by 5 percentage points for fruits and 16 percentage points for vegetables. However, the share of 15-year-olds engaging in 60 minutes of physical activity daily in Sweden is slightly higher than in the EU – at 16% compared to the 15% EU average.

Figure 8. Smoking, alcohol use and obesity levels among adolescents are lower in Sweden than across the EU



Notes: The EU average is unweighted. Data refer to 2022, and are based on children aged 15 years. EU26 for smoking and drunkenness; EU25 for overweight.
Source: Health Behaviour in School-aged Children Survey.

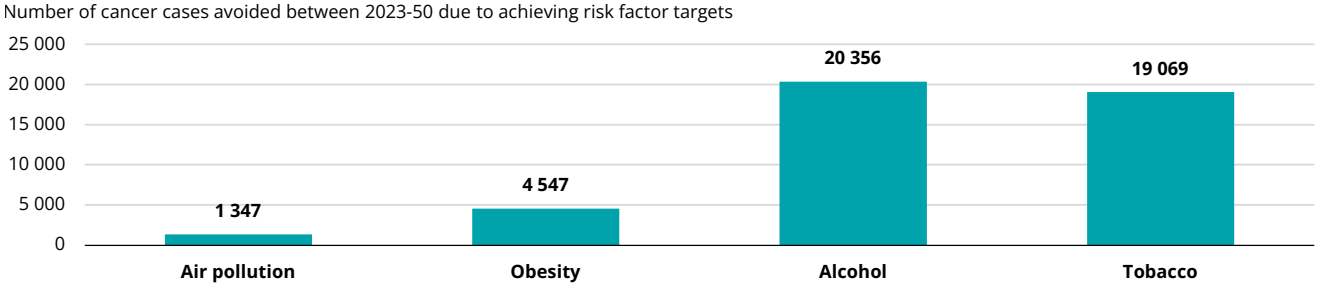
Use of e-cigarettes is increasing quickly among adolescents and young adults

Electronic cigarettes (e-cigarettes or vapes) are devices loaded with a liquid that often contains nicotine and various flavourings. According to statistics from the Council for Information on Alcohol and Other Drugs, around 1-2% of those aged 17-84 in Sweden stated that they had vaped in the last month in 2017, a value which increased to 5% in 2023. The corresponding level among young people, aged 17-29, increased from 6% in 2017 to 16% in 2023, with a stronger increase among young women. Among ninth graders (15-16 year-olds), the prevalence of vaping during the past month was relatively stable at around 5% for girls and 7% for boys in 2014-21, but increased sharply to 23% in girls and 18% in boys in 2022, before dropping back to 22% and 13%, respectively, in 2023.

By achieving alcohol reduction targets, Sweden could prevent over 20 000 new cancer cases

Like all countries in Europe, Sweden has a substantial opportunity to reduce new cancer cases in the country by focusing on primary prevention. According to OECD Strategic Public Health Planning (SPHeP) modelling work, the biggest potential – for a reduction of 20 356 cancer cases between 2023 and 2050 – is from meeting alcohol reduction targets (Figure 9). Meeting further targets would also reduce the cancer burden by 19 069 (tobacco), 4 547 (obesity) and 1 347 (air pollution) cases over the same period.

Figure 9. Sweden has an opportunity to reduce new cancer cases if alcohol, tobacco and obesity reduction targets are met



Note: The target for tobacco is a 30% reduction in tobacco use between 2010 and 2025, and less than 5% of the population using tobacco by 2040. For alcohol, the target is a reduction of at least 20% in overall alcohol consumption and a 20% reduction in heavy drinking (six or more alcoholic drinks on a single occasion for adults) between 2010 and 2030. For air pollution, it is an annual average $PM_{2.5}$ level capped at 10 µg/m³ by 2030 and at 5 µg/m³ by 2050. For obesity, the target is a reduction to the 2010 obesity level by 2025.
Source: OECD (2024), Tackling the Impact of Cancer on Health, the Economy and Society, https://doi.org/10.1787/85e7c3ba-en.

4. Early detection

As part of the 2009 National Cancer Strategy, continuous follow-up of participation and quality of existing and future screening programmes was recommended, as well as maintaining a high participation rate throughout the country. It was also recommended that future screening programmes should be introduced in a co-ordinated and structured manner to avoid regional differences, and that efforts should be made to reach population groups with lower participation rates.

Population-based screening programmes have evolved to follow evidence-based recommendations

Sweden has three nationwide population-based cancer screening programmes (screening actively offered to a specific at-risk target population), including screening for cervical, breast and colorectal cancers.

Screening for cervical cancer was the first national cancer screening programme recommended in Sweden, implemented during 1967-77. In 2015, the NBHW issued recommendations that cervical cancer screening should be changed from primary cytology (smear test) to primary HPV testing for women aged 30-64, and women aged 23-29 tested with primary cytology. The current screening programme recommendation is primary screening with an HPV test for women aged 23 and over, with an initial screening interval of five years and an interval of seven years among women aged 49 and over. The last screening should be offered to women aged 64-70.

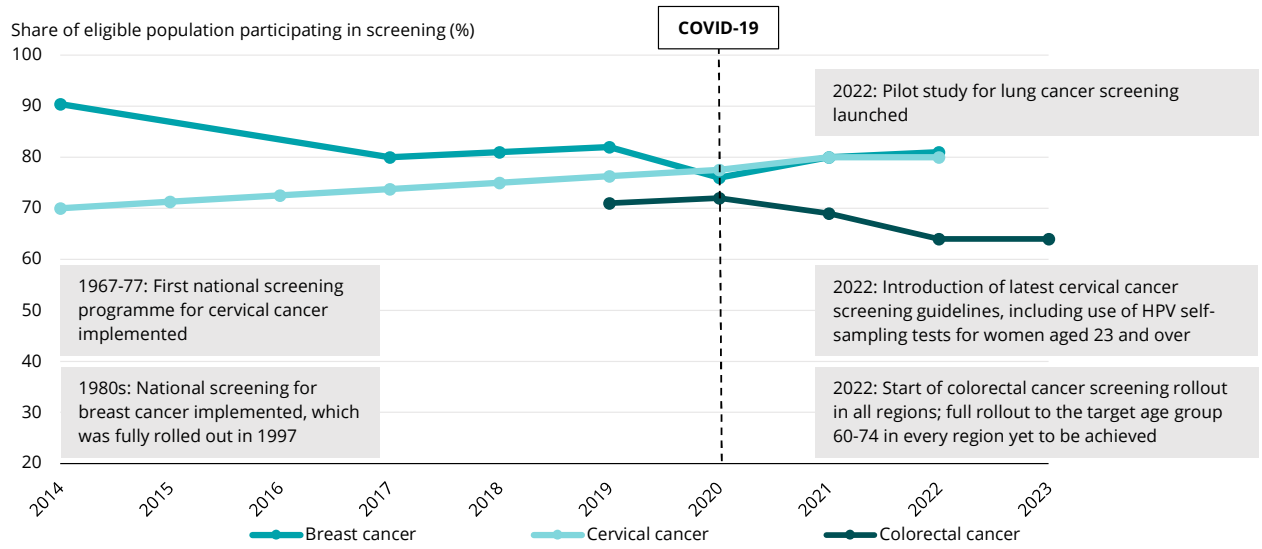
Screening for breast cancer with mammography started in the 1980s and was fully rolled out in 1997, with a recommended screening interval of 18-24 months. All women aged 40-74 are offered mammography screening, and around 60% of all breast cancer cases are detected through the screening programme (NBHW, 2022a).

In 2014, the NBHW recommended that colorectal cancer screening with a faecal occult blood test should be offered to the population aged 60-74 every two years. Owing to circumstances such as ongoing screening studies and shortages of some categories of healthcare professionals – notably gastroenterologists – the colorectal screening programme was implemented unevenly across geographical regions of Sweden. In 2022, however, it started to be rolled out in all regions, although full rollout to the entire age group in every region is yet to be achieved. The NBHW plans to investigate the evidence and the conditions for lowering the starting age for colorectal cancer screening to 50 years.

There are regional and socio-economic disparities in participation in screening programmes

The average participation rate in breast cancer screening in Sweden is just over 80% (Figure 10), with relatively small regional differences – apart from Region Stockholm, where the participation rate is around 70% according to the Swedish Cancer Society. However, there are possible explanations behind this figure related to the data reported – such as inaccuracies in the data, and mammography examinations taking place outside the screening programme at private clinics (Agency for Health and Care Services Analysis, 2020). The participation rate in cervical cancer screening in Sweden was 80% in 2022. For colorectal cancer screening, 64% of the invited population was screened in 2022 and 2023, and the participation rate was generally higher among women (69%) than men (62%) according to the Swedish Cancer Society. The regions of Stockholm and Gotland were the first to offer screening for colorectal cancer in 2009, and the participation rate in 2023 was 68% in Stockholm and 73% in Gotland.

Figure 10. Screening participation rates are high and relatively stable in Sweden



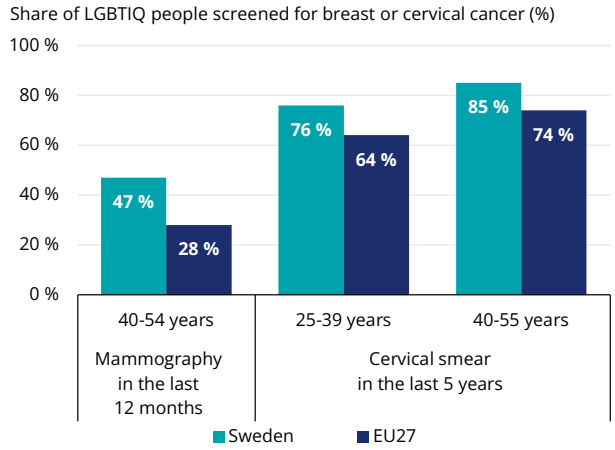
Notes: Data refer to mammography screening among women aged 40-74 years within the previous 18 to 24 months (based on programme data) except for 2014 where they refer to the age group 50-69 years within the past two years (based on survey data), cervical cancer screening within the screening interval (5.5 years for women aged 23-49 and 7.5 years for women aged 50-70) and colorectal cancer screening among the invited population aged 60-80 within two years (based on programme data).
Sources: OECD Health Statistics 2024 for breast cancer; National Quality Register for Prevention of Cervical Cancer for cervical cancer; National Quality Register for Screening for Colorectal Cancer for colorectal cancer.

There are socio-economic differences in participation rates in screening programmes in Sweden. For instance, the participation rate in breast cancer screening among women aged 40-54 was 64% for those with lower education levels and 82% for those with higher education levels in 2019-20 (NBHW, 2022a). Promoting participation in screening and reducing inequalities has been a focus of Sweden's National Cancer Strategy. In 2010, a process of quality development and increased participation in cervical and breast cancer screening was started. One effort to promote this was to make breast cancer screening free of charge throughout the country from July 2016, with the aim of reaching socio-economically vulnerable groups. In 2023, the RCCs, together with the regions, ran a national campaign about the importance of participation in national screening programmes. In addition, Sweden uses peer-to-peer helpers who educate those within their community networks about screening. Another example of promoting participation in cervical cancer screening is use of self-tests for HPV, which was recommended by the NBHW in the updated guidelines for cervical cancer screening in 2022 (NBHW, 2022b).

LGBTIQ people in Sweden participate more in breast and cervical cancer screening than their counterparts in the EU

According to the EU LGBTIQ Survey III, participation in cancer screening among LGBTIQ persons is higher in Sweden than in other EU countries (Figure 11). For breast cancer screening, 47% of LGBTIQ cisgender females, trans women and intersex people aged 40-54 years reported having had a mammogram in the previous 12 months, much higher than the EU average of 28%. For cervical cancer screening, 76% of the relevant LGBTIQ population aged 25-39 in Sweden reported having had a smear test in the previous 5 years (higher than the 64% in the EU), while 85% of those aged 40-55 in Sweden reported a smear test (higher than the 74% in the EU). This aligns with the relatively high screening rates seen in Sweden in the general population as compared with the EU.

Figure 11. Participation in cancer screening among LGBTIQ people is higher in Sweden than in other EU countries



Note: LGBTIQ survey results refer to age groups and/or screening intervals that do not align with the population screening approach in EU countries, and should not be compared.
Source: The European Union Agency for Fundamental Rights (EU LGBTIQ Survey III).

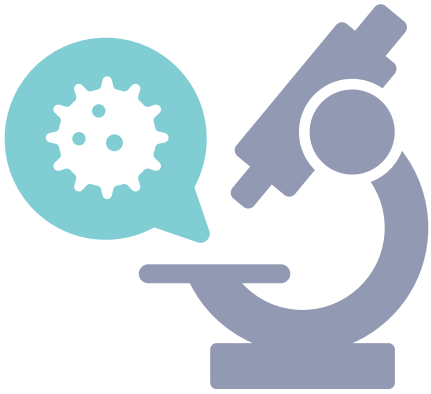
Organised testing for prostate cancer is offered in some regions

There are no national screening programmes for prostate cancer or lung cancer in Sweden. The NBHW recommended against screening for prostate cancer with only prostate-specific antigen testing in 2018, and concluded that screening with prostate-specific antigen and complementary tests needed to be investigated further before a positive recommendation could be given (NBHW, 2018b).

However, the RCCs were commissioned by the government to support the regions in organising prostate cancer testing of asymptomatic men. The work is co-ordinated by a national working group with representatives from each healthcare region. As of September 2024, a total of 13 out of 21 regions have started organised testing and by the end of 2024 almost all regions were expected to have started. Testing procedures and age groups covered differ between regions.

A pilot study for lung cancer screening was launched in 2022

Lung cancer leads to most cancer-related deaths in Sweden, largely because it is often diagnosed at a late stage. Previous studies have shown that screening for lung cancer would be cost-effective in a Swedish setting (Andersson et al., 2021). The NBHW has not yet recommended lung cancer screening; it is calling for a study to be implemented in Sweden in order to answer remaining questions about the structure of a possible screening programme. A pilot study for lung cancer screening by the RCC Stockholm Gotland among women based on current and previous smoking habits was rolled out in the region of Stockholm in 2022, with plans for extension to men in 2024. Pilot projects for lung cancer screening in collaboration with RCCs are also planned within the northern, western and southern healthcare regions.



5. Cancer care performance

5.1 Accessibility

Direct financial consequences for a Swedish cancer patient are limited because all residents are covered for health services, including cancer treatment, with only small out-of-pocket copayments. The proportion of the population reporting unmet needs for medical care in Sweden (2.1%) were similar to the EU average (2.4%) in 2023.

Healthcare expenditure as a share of GDP in Sweden was 11% of GDP in 2022, the sixth highest in the EU. In 2024, a visit to a primary care facility cost EUR 9-35 (SEK 100-400), and a visit to specialised care facility cost EUR 17-39 (SEK 200-450), depending on the region. Copayments for outpatient visits are capped at about EUR 122 (SEK 1 400) per 12-month period. Medical consultations are free of charge for patients aged up to 18 (up to 20 in some regions) and for citizens aged over 85. Copayments for overnight stays in hospitals amount to around EUR 11 (SEK 130) per day.

The patient cost for prescription medicines is capped at EUR 248 (SEK 2 850) per year, whereas hospital medicines are included in the copayments for inpatient care. Asylum seekers and people staying in the country without necessary permits, are entitled to subsidised healthcare and dental care that cannot wait, which includes emergency healthcare and urgent dental care. They are also entitled to maternity care, advice on contraception and abortion, and care provided under the Swedish Communicable Diseases Act (a law intended to prevent the spread of contagious diseases). Furthermore, children up to the age of 18, have the right to receive subsidised healthcare to the same extent as people resident in the same region, regardless of their migratory status. These rules apply to people who are not just visiting Sweden temporarily.

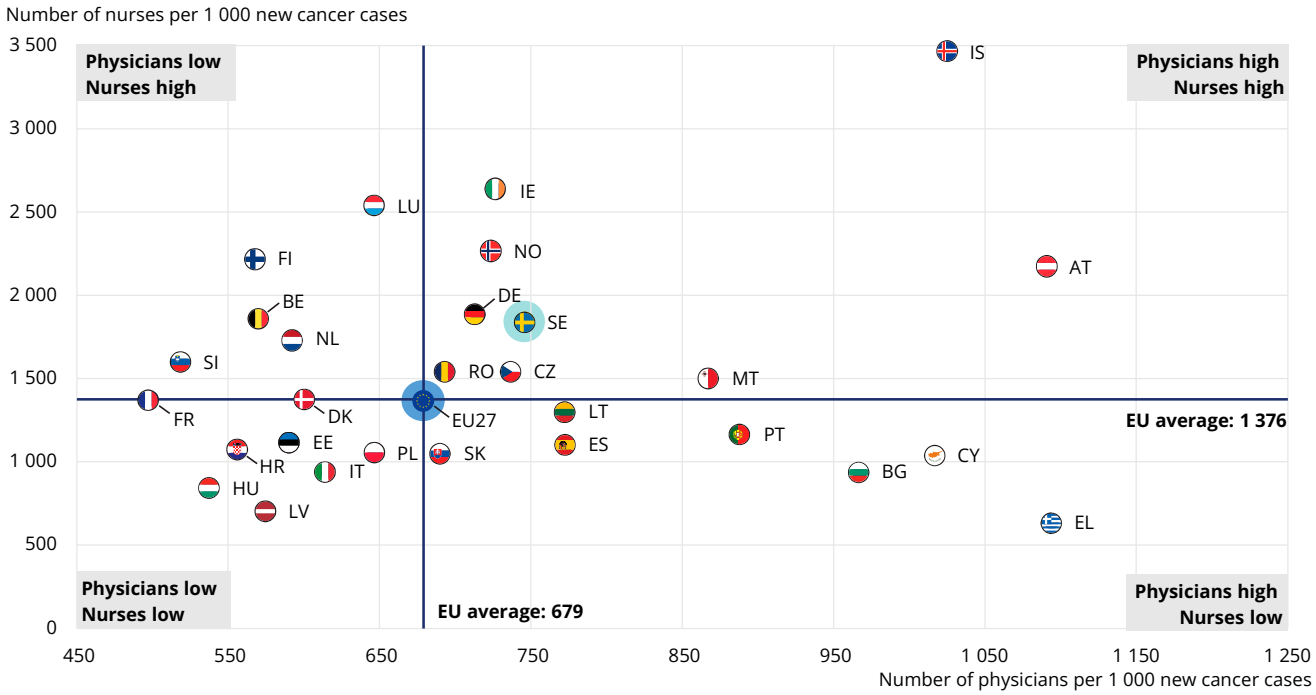
Sweden has a high density of nurses and physicians, but there are some regional imbalances

Sweden belongs to the group of countries with a high supply of physicians and nurses relative to new cancer cases. There are 746 physicians per 1 000 new cancer cases, which is higher than the EU average of 679 per 1 000 (Figure 12). The number of physicians per 100 000 population employed in the healthcare sector increased by 13% in the last decade – from 352 per 100 000 in 2011 to 399 per 100 000 in 2021 (NBHW, 2021).

Sweden has 1 844 nurses per 1 000 new cancer cases, which is higher than the EU average of 1 376 per 1 000. Sweden also scores highly on the European Oncology Nursing Society (EONS) Cancer Nursing Index 2022. Overall, Sweden performs well compared to other EU countries on recognition of nurses, but advanced cancer nursing roles are not yet implemented and recognised at the system level.

In 2024, the NBHW published a status report on the demand and supply of healthcare professionals in Sweden, indicating shortages in some professions and regional differences (NBHW, 2024). The number of nurses per 100 000 population employed in the healthcare sector decreased from 883 per 100 000 in 2011 to 857 per 100 000 in 2021 – a drop of 3%. Sweden has specialised nurses within different healthcare areas, including oncology. The number of specialist nurses per 100 000 population employed in the healthcare sector decreased by 3% and the number of radiology nurses by 1% between 2017 and 2021. Forecasts indicate that the lack of licensed healthcare personnel will remain or increase until 2035.

Figure 12. Sweden has higher supply of nurses and physicians per new cancer case than the EU average



Notes: The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). Data refer to practising nurses except in Portugal and the Slovak Republic, where they refer to professionally active nurses. In Greece, the number of nurses is underestimated as it only includes those working in hospitals. In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors. The EU average is unweighted.
Source: OECD Health Statistics 2024. Data refer to 2022 or latest available year.

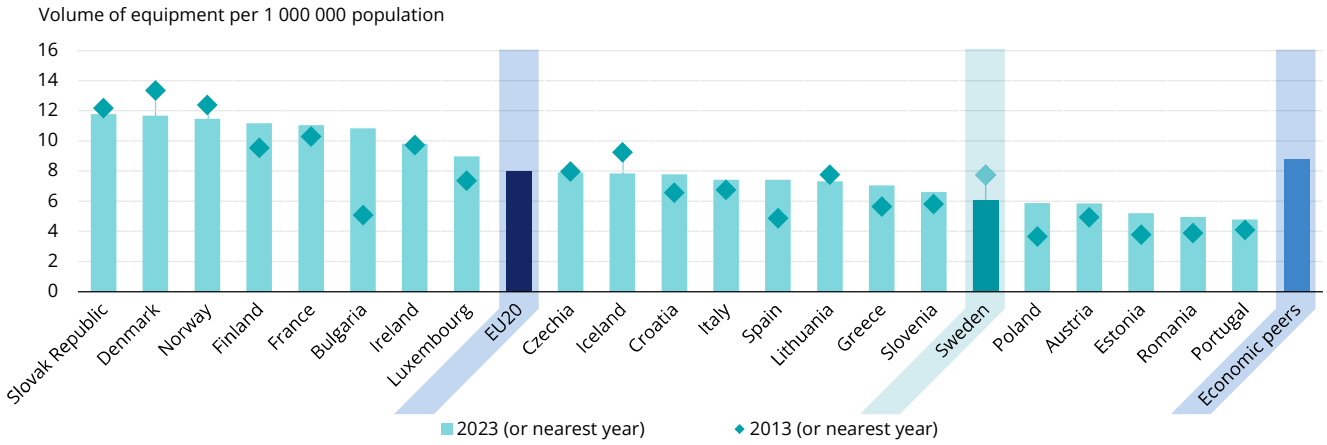
The volume of radiation therapy equipment has decreased over the past decade

In Sweden, access to radiation therapy equipment is relatively low (Figure 13). The volume of radiation therapy equipment was 6 per 1 000 000 population in 2023, which is 24% lower than the EU average (8 per 1 000 000) and 31% lower than the average among Sweden's economic peers (9 per 1 000 000). The volume has decreased by 22% since 2012.

Radiation therapy contributes to 30% of all cures for cancer. A report on radiation therapy in the Nordic countries[10] (Confederation of RCCs, 2022) showed that availability in Sweden is closely connected to the low supply of specialised healthcare personnel. It noted that Sweden is losing ground in many areas of radiation, and highlighted that the consequences of recruitment problems, together with reduced research activities, are becoming increasingly apparent. The lack of both specialised physicians and nurses affects the degree of utilisation of available equipment. The lack of skills also contributes to slower development and spread of new technology and treatment methods in Sweden compared to, for example, Denmark and Norway. The lack of physicians involved in research further limits opportunities to conduct research and development on the same level as comparable countries. Special efforts by the confederation of RCCs together with the National Working Group for Radiation Therapy have been made to strengthen the field of radiotherapy. This includes efforts to increase accessibility, ensure the equitable introduction of new methods, expand clinical research, enhance educational initiatives, and optimise resource utilisation within Swedish radiotherapy.

10 *Nordic countries refer to Denmark, Finland, Iceland, Norway and/or Sweden.*

Figure 13. Access to radiation therapy equipment in Sweden is relatively low



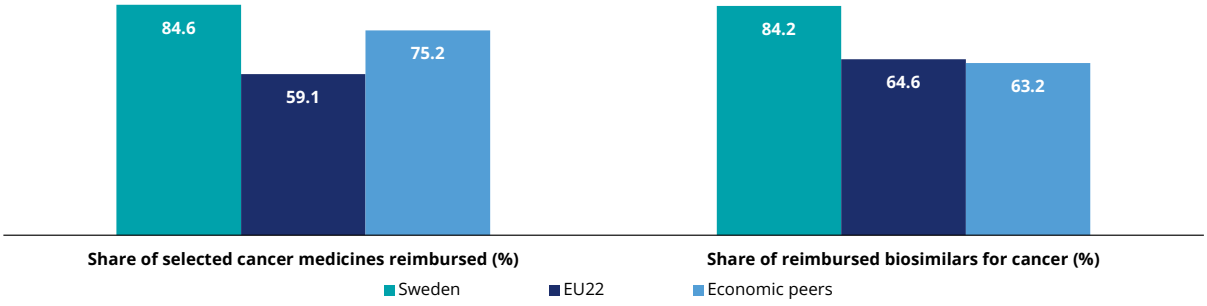
Notes: The vast majority of radiotherapy equipment in EU countries is found in hospitals. Data for Portugal and France includes equipment in hospitals only while data for other countries refer to all equipment. Economic peers are defined as tercile clusters based on 2022 GDP per capita in purchasing power standard terms. Economic peers for SE are AT, DK, IE, IS, LU and NO. The EU average is unweighted.
Source: OECD Health Statistics 2024.

The share of oncology drugs reimbursed in Sweden is well above the EU average

The proportion of indications of a sample of cancer medicines (for breast and lung cancer) with a high clinical benefit publicly reimbursed or covered in Sweden is 85%, which is higher than the EU average (59%) and the average among its economic peers (75%) (Figure 14). The share of biosimilars for cancer medicines with public reimbursement or coverage is 84%, which is also higher than both the EU average (64%) and the average among Sweden's economic peers (63%).

Effective authorisation and availability of new cancer drugs in Sweden are managed through a collaborative process involving healthcare regions and government agencies. This joint effort is guided by health economic evaluations conducted by the Dental and Pharmaceutical Benefits Agency. The New Therapies Council acts as an expert group to recommend adoption of new medicines and drug therapies (Country Fact Sheets, 2024).

Figure 14. Access to new oncology medicines and biosimilars is higher in Sweden than across the EU



Notes: The analysis includes a sample of 13 indications of 10 new cancer medicines for breast and lung cancer with a high clinical benefit and 19 biosimilars of three cancer medicines (bevacizumab, rituximab, trastuzumab), with active marketing authorisation by the European Medicines Agency as of 26 March 2023. The data represent the share of the indications or biosimilars that were on the public reimbursement list on 1 April 2023. Economic peers are defined as tercile clusters based on 2022 GDP per capita in purchasing power standard terms. Economic peers for SE are AT, BE, DE, DK, IE, IS, NL and NO. The EU average is unweighted.
Source: Hofmarcher, Berchet and Dedet (2024), "Access to oncology medicines in EU and OECD countries", https://doi.org/10.1787/c263c014-en.

There are plans to review and improve cancer rehabilitation care in Sweden

There are inequalities in access to cancer rehabilitation care in Sweden – both related to differences across geographical regions and depending on diagnosis. Access to diagnosis-specific rehabilitation is often better for the most common cancer types, and patient advocate associations can sometimes also provide education and psychosocial support. In 2023, the NBHW was commissioned by the government to review cancer rehabilitation on a regional level. It will support the regions in implementation of procedure codes in registry data to enable data-driven follow-up of cancer rehabilitation.

There is scope to improve palliative care in some regions and for some diagnoses

Specialised palliative care is organised into palliative inpatient care and hospices, advanced home care and multidisciplinary palliative care consultant teams assisting hospitals, primary care and municipality healthcare. The Swedish Cancer Society reviewed access to palliative care in a 2024 report, which highlights three areas in need of improvement: unequal access to care, a lack of political governance and structure, and a lack of development of skills and education (Swedish Cancer Society, 2024). There are inequalities in access to palliative care between both regions and diagnoses. The Swedish guidelines for palliative care (first issued in 2014) are under revision.

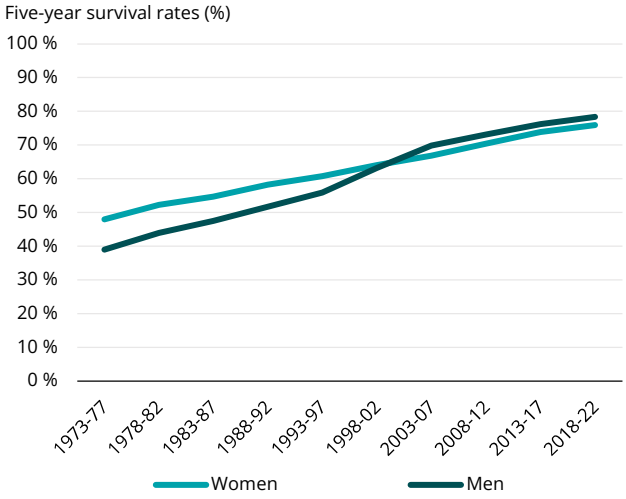
In Sweden, a national quality registry for palliative care covers all deaths. Information includes questions regarding the patient's last week of life, which is answered by healthcare staff and relatives. The aim is to improve end-of-life care for the patient and their relatives.

5.2 Quality

Cancer survival rates are increasing steadily in Sweden

Cancer survival is monitored by the NBHW through the Swedish Cancer Registry. Data are regularly published in the Nordcan database, together with comparable data from all Nordic countries. Cancer survival in Sweden has increased considerably over recent decades and is the highest among the Nordic countries for both men and women. According to data from Nordcan, the five-year relative cancer survival rate in Sweden in 2018-22 was 78% for men and 76% for women. In 1973-77 the corresponding figures were 39% for men and 48% for women (Figure 15). Among the most common cancer types, very high five-year survival rates were recorded for breast cancer (93%), prostate cancer (95%), and melanoma (94% in men and 96% in women) in the diagnosis period 2018-22. Colorectal cancer had survival rates of 72% in women and 70% in men. Lung cancer had low survival rates (35% in women and 27% in men) in 2018-22, but saw a strong increase in the last decade (21% in women and 16% in men in 2008-12), which might have been driven by the introduction of new cancer medicines, foremost immunotherapies and partly also targeted therapies. Compared to the other Nordic countries, Sweden has the second highest survival in lung cancer after Norway among women and the third highest survival among men after Norway and Iceland.

Figure 15. Five-year cancer survival in Sweden has increased progressively among both men and women in recent decades



Source: Swedish Cancer Registry (Link: https://nordcan.iarc.fr/en).

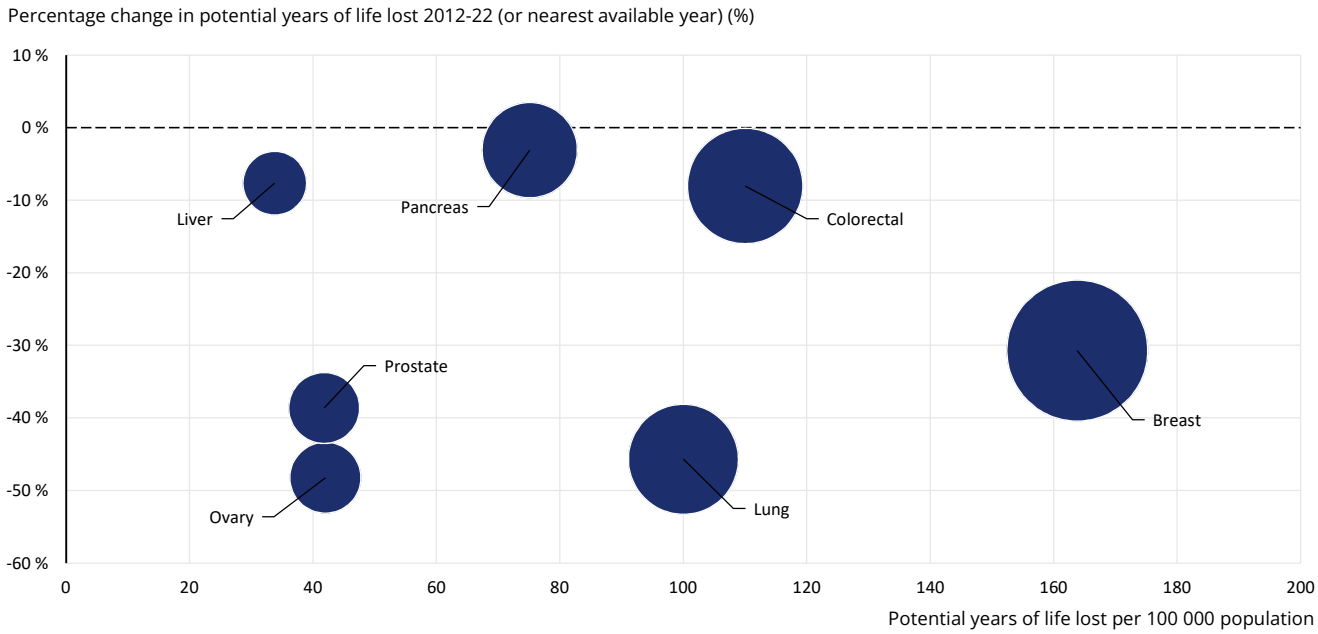
The survival rate has historically been higher among women than men, but the trend switched at the beginning of the 21st century. This relates to reverse trends in incidence of lung cancer, with an increasing trend for women (which drags down the average survival) and decreasing trend for men (which increases the average survival), as well as an increase in incidence of prostate cancer.

Potential years of life lost due to cancer is almost 40% below that in the EU

Potential years of life lost (PYLL) is an interesting complementary measure of the impact of different cancers on society, because it puts a higher weight on cancer deaths among younger individuals. Examining the change in PYLL over time across various cancer sites can point to improvements in cancer care systems via reductions in premature mortality. The overall potential years of life lost due to cancer across all sites in Sweden in 2022 was 840 per 100 000 population. This is 38% lower than the EU average (1 355 per 100 000). The number of potential years of life lost has decreased by 25% since 2012, compared to a 19% decrease across the EU on average.

The cancer responsible for most potential years of life lost in Sweden was colorectal cancer, at 110 years lost per 100 000 population in 2022 (Figure 16), although this rate had decreased by 8% since 2012. Breast cancer was responsible for 164 years lost per 100 000 women in 2022, but the rate had decreased by 31% since 2012. No cancer site registered an increase in the number of potential years of life lost between 2012 and 2022.

Figure 16. All main cancer sites registered a decrease in the number of potential years of life lost in Sweden over the last decade



Notes: The rate of PYLL from breast, cervical and ovarian cancer is calculated in women only, while the rate of PYLL from prostate cancer refers to men. Pink bubbles signal an increase in the percentage change in PYLL during 2012-22 (or latest available year); blue bubbles signal a decrease. The size of the bubbles is proportional to the PYLL rates in 2022.
Source: OECD Health Statistics 2024.

Organisation of cancer care is decentralised in Sweden

The Swedish healthcare system is characterised by a decentralised governance structure. The national government is responsible for regulation, and the 21 regions are responsible for financing and providing healthcare for their residents, whether it is produced by the region, or purchased from a private healthcare provider or another region. Some healthcare services, such as retirement homes and school healthcare services, are the responsibility of the 290 municipalities. Furthermore, Sweden is organised into six larger healthcare regions, which co-operate on providing specialised healthcare such as cancer care. Every healthcare region has at least one university hospital.

While several areas of the healthcare system are decentralised, other features of specialised care are centralised. The six RCCs that were established in line with the 2009 National Cancer Strategy support the work of national and regional multidisciplinary guideline groups, which establish clinical guidelines and quality registries. These enable follow-up of, for example, national guidelines and quality registries to ensure adherence and set quality assurance goals.

There are currently four accredited Comprehensive Cancer Centres (CCCs) in Sweden, including in the three metropolitan regions. Karolinska CCC was the first, established in 2020, followed by Skåne University Hospital and Sahlgrenska University Hospital in 2022 and Linköping University Hospital in 2024. The status of CCC, as defined by the Organisation of European Cancer Institutes (OECI) is a confirmation that the centre meets the high demands placed on quality, care, education and research in the field of cancer.

According to the 2023 OECD Policy Survey on Cancer Care Performance, Sweden has sought efficient ways of providing high-quality care in recent years. The country has developed concentrated cancer care delivery, and established cancer care networks to provide high-quality care and provide cancer care in multidisciplinary teams. Promoting multidisciplinary care was part of the 2009 National Cancer Strategy, and it is supported by the national cancer care programmes. For instance, 99% of all breast cancer cases (with regional variation ranging from 97% to 100%) were assessed by multidisciplinary teams before treatment start in 2023, according to information from the National Quality Registry for Breast Cancer.

Many cancer quality registries include patient-reported experience and outcome measures

Sweden has a large number of health data registries run by the NBHW, including the Swedish Cancer Registry founded in 1958. This high-quality registry covers health data for the

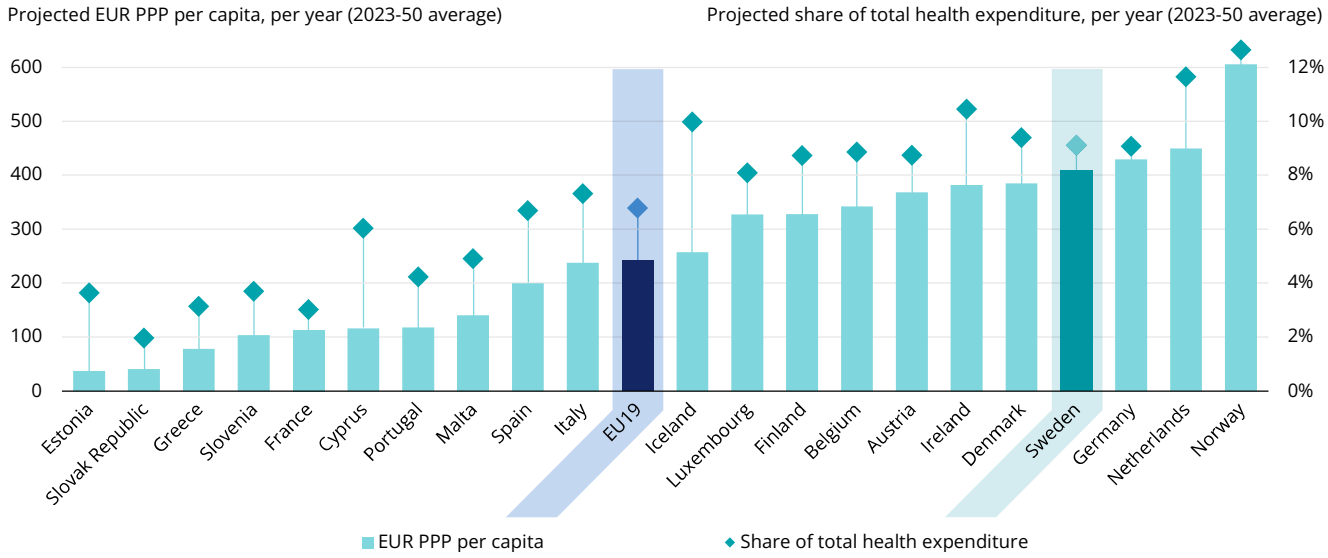
entire population and stores personal identification numbers, which enables linkage to other registries. Sweden also has over 30 clinical quality registries with national coverage of cancer, covering the vast majority of cases. Many cancer quality registries in Sweden include information on patient-reported outcome and experience measures (PROMs and PREMs). PREMs are also registered as part of standardised care pathways, which provide information on patients' experience of being included in a cancer pathway at both regional and national levels. This information includes topics such as participation and involvement, emotional support, and availability (Confederation of RCCs, 2024a). In addition, a national collection of forms for PROMs are recommended and free to use by the healthcare sector to create a more standardised approach to follow-up and improve care quality. The forms were developed by the Swedish Association of Local Authorities and Regions together with Inera (a digitisation company that works on behalf of the Swedish municipalities and regions), and will eventually also include information on PREMs.

5.3 Costs and value for money

The burden of cancer on health expenditure is anticipated to remain higher than the EU average in the coming 25 years

According to OECD SPHeP modelling work, between 2023 and 2050, total health expenditure is estimated to be 9% higher in Sweden due to the burden of cancer (Figure 17). This equates to an average of EUR PPP 409 per person per year. This figure is much higher than the EU19 average (EUR 242). Overall, the per capita health expenditure on cancer care is expected to grow by 34% in Sweden between 2023 and 2050, compared to 59% in the EU27.

Figure 17. The projected burden of cancer on health expenditure in Sweden is estimated to be higher than the EU average



Note: The EU average is unweighted.
Source: OECD (2024), Tackling the Impact of Cancer on Health, the Economy and Society, https://doi.org/10.1787/85e7c3ba-en.

Sweden will lose the equivalent of 159 full-time workers per 100 000 population due to reduced employment related to cancer

About one-third of all new cancer cases among women and a quarter of all cases among men affect people aged under 65, according to statistics from the Swedish Cancer Registry. For many people, cancer therefore means, in addition to the impact on health and quality of life, new circumstances for their work life. The Swedish Social Insurance Agency provides cancer patients with a degree of flexibility to be on sick leave, either fully (100%) or as part (75%, 50% or 25%) of their ordinary work time. A large Swedish study showed that patients with colorectal cancer recorded high rates of short-term sick leave – especially during the first two years after diagnosis – but gave no clear indications of high rates of long-term sickness absence (Beermann et al., 2022). Another Swedish study indicated that breast cancer survivors had higher rates of sickness absence than the general population.

According to OECD SPHeP modelling work, through its impact on employment (combining unemployment and part-time work), cancer reduces workforce participation and productivity. Sweden is expected to lose the equivalent of 159 full-time workers per 100 000 population due

to the need to reduce employment, on average over 2023-50. In addition, cancer is expected to lead to a loss of the equivalent of 43 full-time workers per 100 000 people due to absenteeism and 49 per 100 000 due to presenteeism.[11]

The Dental and Pharmaceutical Benefits Agency is responsible for evaluating oncology drugs

Two important challenges for future expenditure on cancer care are the increasing age of the general population – which will translate into a higher number of cancer patients and fewer people of working age paying taxes to finance healthcare services – and increasing expenditure on cancer medicines. Between 2008 and 2018, cancer medicine sales per capita increased by 104% from EUR 28 to EUR 57 in Sweden, and by 144% from EUR 25 to EUR 61 across the EU. Nevertheless, this reflects the fact that new and better, but more expensive, treatment options have been made available for people with cancer.

Sweden uses a value-based approach to assess and price new medicines used in outpatient settings (prescription medicines). The Dental and Pharmaceutical Benefits Agency (TLV) is the government agency whose remit is to determine whether a pharmaceutical product, medical device or dental care procedure should be subsidised by the state. Cost – effectiveness is one of three criteria TLV uses to appraise a new prescription medicine. TLV submitted a report to the government in 2024 on the possibility of using registry data to improve monitoring of drug use and clinical effectiveness (TLV, 2024). The ability to follow up on drug use is an important part of TLV's work in ensuring that the cost of the treatment is reasonable in relation to the benefit. New hospital medicines are appraised directly by the healthcare regions, yet they may receive recommendations from the New Therapies Council on whether to reimburse the medicine, and may also ask TLV to conduct a cost – effectiveness analysis to provide further guidance on the value for money of that medicine.

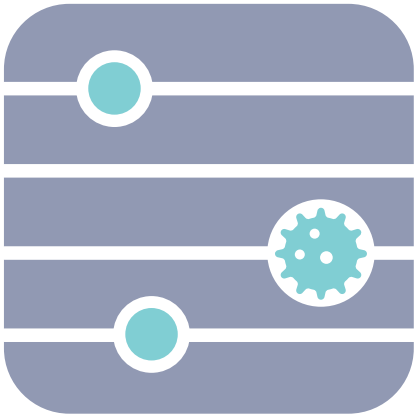
Use of cancer medicines in clinical practice is guided by national treatment guidelines. Despite this, actual usage may still differ between healthcare regions, even though a report by the Confederation of RCCs showed that the regions were mostly compliant with national recommendations by the New Therapies Council in 2023. Further improvements in national coverage of the Cancer Drugs Registry are needed to facilitate better monitoring of actual use of medicines compared to recommendations.

5.4 Well-being and quality of life

The impact of cancer on life expectancy is expected to be lower in Sweden than in the EU

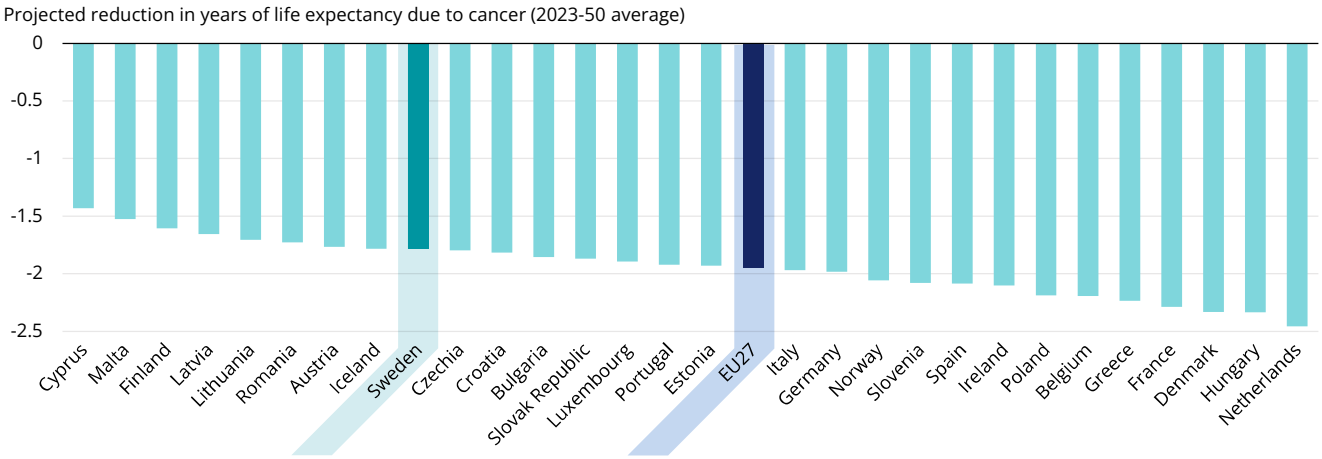
Cancer is one of the main causes of death and disability in EU countries, with an impact on well-being and quality of life. According to OECD SPHeP modelling work, in Sweden between 2023 and 2050, cancer will reduce average population life expectancy by 1.8 years compared to a scenario without cancer (Figure 18). This number is lower than the EU average (1.9 years). For context, it took Sweden from around 2008 to 2019 to increase its life expectancy by 2 years.

In addition, cancer takes a substantial toll on the mental health of the population through its associated symptoms and treatment side effects, and impact on daily life, social roles and work. According to the OECD's SPHeP model, Sweden is anticipated to have higher depression rates because of cancer, at an additional age-standardised rate of 10 cases per 100 000 population per year.



11 *Presenteeism refers to lost productivity that occurs when employees are not fully functioning in the workplace because of an illness, injury or other condition.*

Figure 18. Sweden is projected to experience a reduction in life expectancy of 1.8 years between 2023 to 2050 due to cancer



Note: The EU average is unweighted.
Source: OECD (2024), Tackling the Impact of Cancer on Health, the Economy and Society, https://doi.org/10.1787/85e7c3ba-en.

Quality of life among people with cancer is not systematically monitored in Sweden

Increased incidence of cancer and survival means that more people are living with cancer than in previous decades. Even for advanced disease, many effective treatments are now available that can slow progression and extend life. As cancer survival increases and the disease becomes chronic in some cases, quality of life, rehabilitation and palliative care are playing a more central role in the care of cancer patients and survivors. The primary outcome in cancer treatment has usually been survival, and survival rates have increased for many forms of cancer. Less focus has been directed at quality of life among people with cancer: how they feel during and after treatment, and what opportunities there are to regain the health they had prior to the cancer diagnosis. However, over the past years, the commission tasked with updating the national cancer strategy has been instructed to incorporate this in the new plan.

In Sweden, there is no opportunity to follow up outcomes on the quality of life of patients with cancer generally at a national level (Agency for Health and Care Services Analysis, 2024). Available data can primarily be obtained from individual studies in Sweden or internationally. National quality registries report clinical outcomes and organisational measures such as waiting times. However, about 15 quality registries in the field of cancer provide information on follow-up of PROMs such as quality of life. This includes the registries for colon and rectal cancer, and head and neck cancer. The breast cancer registry began collecting PROMs with modules from five different instruments in 2020 (Confederation of RCCs, 2024b).

Informal carers are supported by paid leave

Cancer affects not only the person who becomes ill but also their relatives. An informal carer can be a partner, child, parent or close friend. In Sweden, a carer can receive 100 days of paid leave for terminal care according to the rules of the Swedish Social Insurance Agency. Paid leave is set at the national level, and corresponds to almost 80% of the person's salary, although a cap applies. Paid leave can be used by relatives of working age up to age 67, and terminal illness must be proved – for example, with a doctor's certificate.

Sweden has increased investment in rehabilitation

A national programme for cancer rehabilitation was established in Sweden in 2014, developed within the RCCs. Interventions included in the national programme are based on the domains of physical, psychological, social and existential needs with relevance for the quality of life of people with cancer. They also include support for carers.

There are also efforts in cancer rehabilitation within Swedish civil society, and collaborations between the civil society and healthcare regions. One example is "Kraftens hus", which is a non-profit organisation that provides a meeting-point for people with cancer and survivors of cancer.

As part of national investment in cancer care in 2024, the RCCs in Sweden were allocated SEK 220 million (EUR 19 million) to distribute to various initiatives in cancer care. These include efforts to improve cancer rehabilitation and palliative care.

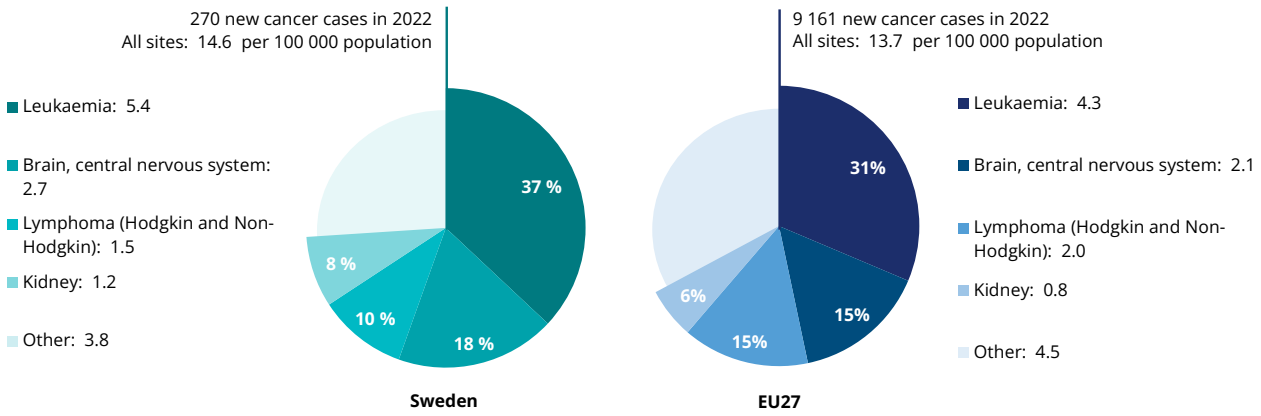
6. Spotlight on paediatric cancer

According to ECIS, it is estimated that in Sweden 270 children and adolescents up to age 15 were diagnosed with cancer in 2022. This is equivalent to 14.6 per 100 000 children diagnosed with cancer in 2022 – with slightly higher rates for boys than girls, and higher compared to 13.7 per 100 000 across the EU (Figure 19). Data from the Swedish Cancer Registry show that incidence trends have been decreasing slightly since the 1980s. Leukaemia is the most commonly diagnosed cancer type, with 5.4 cases per 100 000 (37%), followed by brain and central nervous system cancers and lymphoma.

According to Eurostat, cancer mortality rates in Sweden are lower, with a 3-year average mortality rate of 1.9 per 100 000 children as compared to 2.1 in the EU. The NBHW reports socio-economic disparities in paediatric cancer, where parental education levels impact children's chances of surviving cancer. Between 2009 and 2013, the three-year survival rate was 86% for children of parents with lower education and 92% for those with higher-educated parents.

Figure 19. Cancer incidence rates for children aged 0-14 are slightly higher than the EU average

Age-standardised incidence rate per 100 000 population (aged 0-14), estimates, 2022



Notes: 2022 estimates are based on incidence trends from previous years, and may differ from observed rates in more recent years. "All sites" includes all cancer sites except non-melanoma skin cancer.
Source: European Cancer Information System (ECIS) for cancer incidence. From https://ecis.jrc.ec.europa.eu, accessed on 10 March 2024. © European Union, 2024.

As part of the Genomic Medicine Sweden (GMS) initiative founded in 2018 for translating innovation in genomics into precision medicine, all newly diagnosed children with cancer have been offered whole-genome sequencing since 2021. The initiative has been allocated government funds since 2018. In 2024, the Ministry of Social Affairs allocated additional funds to continued development of precision health and diagnostics through GMS. This includes continued national implementation of use of precision diagnostics in clinical trials in cancer, and national and international data sharing for development of precision medicine. Another project, called BrainChild, will integrate data with artificial intelligence technology to facilitate access to health data related to childhood cancer with the overarching objective of increasing survival and improving quality of life.

The SIOPE's OCEAN project on paediatric cancer care identified that the country has six institutions treating children with cancer, with relatively good geographical distribution (SIOPE, 2024). Furthermore, all 13 infrastructural and treatment modalities such as stem cell transplants, brachytherapy, photon and proton radiation therapy, survivorship care clinic are available to care for paediatric cancer patients in Sweden. However, out of the 436 clinical trials involving paediatric and adolescent cancer patients in Europe between 2010 and 2022, only 54 were running in Sweden (12%). This is the second highest among the Nordic countries, behind Denmark at 17% (SIOPE, 2024). In addition, in 2018, 72% of the 68 medicines identified as essential for treating cancer in patients aged 0 to 18 were available in Sweden, compared to 76% in the EU on average (Vassal et al., 2021).

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovak Republic	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
Czech Republic	CZ	Greece	EL	Lithuania	LT	Portugal	PT		

European Cancer Inequalities Registry

Country Cancer Profile 2025

The European Cancer Inequalities Registry is a flagship initiative of the Europe's Beating Cancer Plan. It provides sound and reliable data on cancer prevention and care to identify trends, disparities and inequalities between Member States and regions. The Registry contains a website and data tool developed by the Joint Research Centre of the European Commission (https://cancer-inequalities.jrc.ec.europa.eu/), as well as an alternating series of biennial Country Cancer Profiles and an overarching Report on Cancer Inequalities in Europe.

The Country Cancer Profiles identify strengths, challenges and specific areas of action for each of the 27 EU Member States, Iceland and Norway, to guide investment and interventions at the EU, national and regional levels under the Europe's Beating Cancer Plan. The European Cancer Inequalities Registry also supports Flagship 1 of the Zero Pollution Action Plan.

The Profiles are the work of the OECD in co-operation with the European Commission. The team is grateful for the valuable comments and suggestions provided by national experts, the OECD Health Committee and the EU Thematic Working Group on Cancer Inequality Registry.

Each Country Cancer Profile provides a short synthesis of:

- the national cancer burden
- risk factors for cancer, focusing on behavioural and environment risk factors
- early detection programmes
- cancer care performance, focusing on accessibility, care quality, costs and quality of life.

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