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Competition and Regulation in the Healthcare Sector – Note by Sweden

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1. Introduction

1. In 2022, the Swedish Competition Authority (SCA) published a report examining how digital healthcare services affect competitive conditions within primary care.[1] This contribution summarises some of the main conclusions of the 2022 report pertaining to the topic of the roundtable.

2. The contribution describes the system of choice in the Swedish primary healthcare system, and the emergence of digital healthcare providers over the last 10 years. It focuses particularly on the question of different parallel reimbursement models for healthcare centres and digital healthcare providers, and how this risks distorting competition. Proposals by the SCA to address the competition problems identified through the report are also presented, as well as some developments in the market since the publication of the report. The contribution also briefly describes enforcement work by the SCA related to digital healthcare providers.

2. Systems of choice in the Swedish healthcare system[2]

3. The responsibility for the healthcare system in Sweden is shared between the state, the 21 regions, and the 290 municipalities.[3] The role of the government is to establish principles and guidelines and to set the political agenda for healthcare. The regions organize public primary and specialised care (including hospital care). The municipalities are responsible for care of the elderly, for people with physical or mental disabilities, for services for people released from hospital care and for school healthcare.

4. There are both public and private providers of healthcare. Since 2010 it has been mandatory for the regions to provide a system of choice for users in primary care, whereas the provision of a system of choice for specialist care is voluntary for regions. There is a 'right of free establishment', which means that all providers who meet the requirements may establish a healthcare centre in the region, and are thereby entitled to reimbursement from the region for the services provided. The regions therefore have no power to refuse any provider permission to establish new healthcare centres or to determine where these should be located.

5. In a healthcare choice system, all providers receive the same remuneration in accordance with the respective region's rules, which means that providers do not compete on price, but by attracting residents to register with them by offering various aspects of quality, such as accessibility and patient care.

[1] Swedish Competition Authority, The impact of private digital healthcare services on competition in primary care, report 2022:3

[2] This section draws directly from Sweden's contribution to the 2018 WP2 roundtable on Designing Publicly Funded Healthcare Markets, DAF/COMP/WP2/WD(2018)37, which contains a fuller description of the healthcare market in Sweden.

[3] One municipality, Gotland, an island located in the Baltic Sea, has the same responsibilities for healthcare as the regions.

3. The emergence of digital healthcare providers

6. Private digital healthcare providers began operations in the 2010s through agreements with the regions of Jönköping and Sörmland. Public digital healthcare provision progressed more slowly, although virtually all regions have now introduced their own healthcare appointments or included them in their respective tendering of primary care.

7. Since private digital healthcare providers were established in the mid-2010s, the number of digital consultations has risen significantly. Nationwide, digital "out-of-region" consultations rose from around 20,000 in 2016 to just over 600,000 in 2018. Demand rose during the pandemic year of 2020. According to data from Region Sörmland, which handles the invoicing of reimbursement for most private digital healthcare companies, there were 2.7 million visits to digital providers connected to healthcare centres in the region in 2025.[4]

8. Digital consultations are not only used to see doctors; there are also several other professions that conduct such consultations, such as specialist nurses, physiotherapists, psychologists and counsellors.

4. Different reimbursement models for consultations

4.1. Capitation reimbursement model for physical healthcare centres

9. Healthcare centres are mainly reimbursed through a fixed payment per patient, known as a capitation payment, rather than visit-based renumeration. A rationale for this is that variable payments effectively become an incentive to increase the number of visits and thus drive costs up. The payment is weighted to reflect patients' expected care needs, which means that healthcare centres have an incentive to attract even those patients requiring extensive care.

4.2. Per-visit reimbursement model for many digital consultations

10. On the other hand, for many consultations with digital providers, a standardised reimbursement for visits applies. This is the case when the patient is registered in one region but the digital provider is established in another region, triggering the payment of an agreed 'out-of-region' per-visit reimbursement.

11. Reforms that extended the possibility to seek out-of-region care were initially predicted to have only a marginal effect, affecting patients travelling to another region to seek care, or for patients living near a regional border.[5]

12. However, the effect has been much greater owing to the advent of digital healthcare. The SCA noted that in 2021, the regions paid just over SEK 800 million in digital out-of-region reimbursement to private digital healthcare providers, meaning that private digital healthcare services accounted for 1–2 per cent of the regions' primary care budgets at that time.

[4] https://regionsormland.se/nyheter/nyhetslista/region-sormland-varnar-vardgivare/

[5] SOU 2013:2, *Patient Act – Interim Report of the Patient Empowerment Inquiry*.

5. Implications of digital healthcare providers for competition

5.1. Improved accessibility and acceptance of digital services

13. The SCA's report found that private digital healthcare services have contributed to increased access to primary care, as they are available virtually round the clock, all year round. By primarily utilising healthcare staff in ways that do not impact other healthcare services, this can contribute to an efficient use of resources from a societal perspective. Through digital platforms and triage, patients can be quickly and easily directed to the appropriate level of care. Patients and registered healthcare staff can also avoid unnecessary travel when more appointments take place digitally. Patients who use these services are also more likely to continue using them.

14. Private digital healthcare services have also contributed to increased acceptance and uptake of digital services within primary care. Digitalisation can, in various ways, bring significant benefits in the form of greater efficiency, improved service and accessibility within at least some parts of primary care.

15. Accessibility can also create demand, as many patients now expect both short waiting times to see healthcare staff and round-the-clock availability.

5.2. The 'out-of-region' reimbursement model drives costs

16. The 'out-of-region' reimbursement model for digital visits operates as a flat-rate payment as is therefore volume-related. There is no cap on the number of visits a private digital provider can bill the region for, nor is the reimbursement differentiated to reflect the doctor's workload. This therefore creates an incentive for more visits and consequently higher costs.

17. Healthcare centres furthermore find it difficult to compete by offering similar digital services because their reimbursement system provides little or no variable reimbursement for digital visits.

5.3. Healthcare centres bear the costs of private digital healthcare visits

18. The SCA found that the out-of-region reimbursement model affects the structure of the regions' reimbursement models within their healthcare choice systems, since regions end up paying for services they have not commissioned and which they find difficult to monitor.

19. When patients use private digital healthcare services, healthcare centres within the healthcare choice systems are affected in several ways. Above all, the healthcare centres' finances are affected because the costs of out-of-region reimbursement are borne by primary care in the patients' home region, and either result in direct deductions from the health centres' remuneration or indirectly affect them through the cost being absorbed centrally within the primary care budget.

5.4. Different reimbursement models distort competition

20. Physical healthcare centres and private digital healthcare services financed through out-of-region reimbursement are subject to two diametrically opposed reimbursement systems with different purposes and regulatory effects. However, both operate in the same market, as both target the same patients and are financed within the framework of the regions' healthcare choice systems.

21. This has implications for competition. Concern was expressed in the course of the SCA's study that patients with greater healthcare needs, such as elderly people with multiple conditions and those with chronic illnesses, will remain at healthcare centres, leading some primary healthcare managers surveyed in the report to argue that private digital healthcare services do not actually relieve the burden on the rest of primary care. According to those representatives, this does not create competition on a level playing field, but rather allows digital providers to "cherry-pick" the best cases.

22. There was also criticism expressed from regions that private digital healthcare services are exploiting the reimbursement scheme in a way that drives large volumes of patient visits for minor ailments, which places a financial burden on the rest of the publicly funded primary care system.

5.5. A lack of direct agreements between regions and healthcare providers limits documentation and monitoring

23. The system for out-of-region reimbursement means that regions and digital healthcare providers do not have a direct contractual relationship. This means that systematic monitoring by the region in question is not possible. It also means that private digital healthcare providers are not covered by the region's medical records system and other IT solutions, which is otherwise a requirement for all healthcare providers within a choice system. Private digital providers therefore only have access to incomplete medical histories. Similarly, limited information is provided by the digital healthcare providers to the home region.

24. The SCA has therefore proposed that all healthcare record systems should be able to communicate with one another.

5.6. The out-of-region reimbursement model hinders innovations and business models

25. The SCA concluded that the current reimbursement system had been a pre-requisite for the development of private digital healthcare services. Out-of-region reimbursement has provided stability and a clear national regulatory framework to work within.

26. However, at least one company indicated in the course of the SCA's study that there are significant opportunities to develop digital services other than video calls with healthcare staff, such as by providing patients with support for self-care. This would, however, require different reimbursement models.

6. Measures to address competition problems arising from different remuneration models

6.1. Encourage contractual relationships between regions and digital healthcare companies

27. The SCA noted in the report that the competition problems arising from different remuneration models would largely disappear if the regions had a direct contractual relationship with the private digital healthcare companies. Such a contractual relationship would result in the digital healthcare services being integrated into the regions' healthcare choice systems, rather than being considered as 'out-of-region' providers.

28. During 2021, when the report was prepared, private digital healthcare companies started to establish themselves in the physical healthcare sector, partly by acquiring

healthcare centres, particularly in Region Stockholm and Region Skåne. This was expected to lead to the providers being reimbursed under the regions' standard reimbursement systems and being subjected to the same requirements and conditions as other healthcare centres, since they would no longer be able to invoice via other regions under the out-of-region reimbursement scheme. Subsequent developments in reimbursement since the publication of the report are described further below.

Competitive tendering

29. The SCA recommended in its report that services provided by private companies with public funding should be procured through competitive tendering. Such competitive tendering means that any economies of scale and coordination benefits will, at least in part, accrue to the public sector. Another benefit of such a structure is that the public sector enters into a contract whereby the companies undertake to provide the services in accordance with the agreed terms. If there is competition from other companies, this also encourages companies to improve the value for their customers, for example through higher quality or lower prices, whilst striving to minimise their costs, for example through efficiency improvements or new production methods.

30. An alternative to competitive tendering through public procurement is to establish a freedom of choice system or to introduce a requirement to provide digital healthcare services within an existing healthcare choice system. In this model, requirements and conditions can then be adapted on an ongoing basis each year through dialogue between the authority and the providers.

6.2. Review reimbursement models

31. As the out-of-region reimbursement scheme means that different operators in the same market are subject to diametrically opposed incentives, competition risks being distorted. The SCA has therefore proposed that the out-of-region reimbursement scheme should be reviewed.

32. The regions' capitation-based reimbursement models applicable to healthcare centres could serve as a starting point for private digital healthcare providers as well. Reimbursement should instead create incentives where remuneration for good treatment outcomes over time is rewarded. This should also be feasible, as an increasing number of diagnoses can be investigated and treated digitally.

33. In its 2022 report, the SCA also proposed that there may be reason to review and clarify what is reimbursable under the concept of 'qualified healthcare'. Describing the implications in greater detail and thereby regulating when reimbursement is to be paid between the regions should, to some extent, help curb a trend where conditions that could instead be referred to the national health information portal[6] place a burden on the healthcare system.

34. The SCA also noted that the upfront fee that a patient pays for a physical visit to a healthcare centre may in some cases be higher than for a visit to a private digital healthcare provider. This may create an incentive for patients to seek care from private digital healthcare services rather than visit the healthcare centre where the patient is registered. In this context, however, it should be noted that the rules on high-cost protection also apply to digital visits, which is why patients whose healthcare needs exceed the high-cost threshold will not have to pay a further patient fee.

[6] The system known as '1177', where health information is provided online or over the phone.

35. The SCA therefore proposed in its report that the regions should review patient fees so that patients are encouraged to turn first to the healthcare centre where they are registered.

7. Developments subsequent to the SCA's report

36. Since the publication of the SCA's report in 2022, there have been several developments related to the question of provision and reimbursement of digital providers' healthcare.

37. Some private digital healthcare companies are reported to have continued to invoice via the out-of-region reimbursement scheme for listed patients in Stockholm, despite having a contract with the region. In February 2026 a deal was made between Region Stockholm and one of digital healthcare providers that the provider should pay back SEK 18 million and successively stop the out-of-region reimbursement scheme for listed patients.[7]

38. Meanwhile, it has also been reported that a digital provider of psychological care that had previously had a contract with Region Stockholm decided to terminate that agreement as a result of the region lowering reimbursement levels for digital care in the region. One consequence of this was that out-of-region reimbursement would be triggered for patients in Stockholm using that service, thus raising costs for the region.[8]

39. In 2023, an inquiry presented several proposals related to making digital care more integrated into the care chain. Among other things, the inquiry proposed that regions should not be required to pay for their patients' digital visits in other regions unless a needs and suitability assessment had first been carried out by that region.[9]

40. The Swedish government has stated that the current system of remuneration and fees needs to be developed and coordinated. In 2025, it gave an inquiry the task of analysing and proposing how governance can be strengthened through a system of national principles for reimbursements and fees in the healthcare sector. The inquiry has also been tasked with analysing the need for regulated levels of reimbursements at the national level. The inquiry will report on its findings and proposals by June 2026 at the latest.[10]

41. At the level of the regions, the appropriateness of reimbursement models has continued to be discussed. Among other things, Region Sörmland reported in February 2026 that it had audited certain digital healthcare providers and issued warnings related to irregularities in the invoicing of contacts that they did not deem to meet the requisite definition of care that qualifies for remuneration.[11] Also in February 2026, the Swedish Association of Local Authorities and Regions agreed on recommendations to lower the

[7] https://www.regionstockholm.se/nyheter/2026/01/overenskommelse-om-fakturering-av-digital-vard/

[8] https://www.svt.se/nyheter/lokalt/stockholm/skattesmall-nar-digital-psykologtjanst-lamnade-region-stockholm

[9] Effektiv och behovsbaserad digital vård, Ds 2023:27

[10] Tilläggsdirektiv till utredningen Behovsstyrd vård (S2024:05)

[11] https://regionsormland.se/nyheter/nyhetslista/region-sormland-varnar-vardgivare/

level of remuneration per out-of-region digital consultation,[12] and in April 2026, it announced new recommendations clarifying which types of contacts with digital healthcare providers should be deemed to count as qualified healthcare.[13]

8. Enforcement work related to digital healthcare providers

42. Separately from its advocacy work described above, conduct by digital healthcare providers has additionally been the subject of enforcement work by the SCA. In decisions issued in April 2025, the SCA found that four digital healthcare companies had entered into bilateral agreements to refrain from advertising their services against each other's brand names in Google Search in a manner that prevented them from fully competing for all potential customers (known as non-brand bidding agreements).[14]

43. The SCA decided that these amounted to object infringements of the Swedish and EU prohibitions of anticompetitive agreements. Three of the companies were ordered to pay administrative fines amounting to a total of approximately SEK 26 million. The fourth company received full immunity from fines for notifying the infringements to the authority. The matter has been appealed by two of the parties to the Patent and Market Court.

12 https://skr.se/pressrum/aktuellt/nyhetsarkiv/revideradeersattningarfordigitalutomlansvard.9910.html

13 https://skr.se/pressrum/aktuellt/nyhetsarkiv/enbartkvalificeradvardgerersattningfordigitalvard.10652.html

14 Case number 288/2022.