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Sweden and the COVID-19 Crisis

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Working paper series 2021:9

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WORKING PAPER SERIES 2021:9

QoG THE QUALITY OF GOVERNMENT INSTITUTE

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Box 711, SE 405 30 GÖTEBORG

October 2021

ISSN 1653-8919

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QoG Working Paper Series 2021:9
October 2021
ISSN 1653-8919

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Introduction

When the new coronavirus SARS-CoV-2 began to spread across Europe in early 2020, Sweden adopted public-health policies that were markedly different from those of most other Western European states. Sweden's government, parliament, and public-health authorities refrained from the sorts of coercive policies that other countries put in place and did little to restrict the freedom of movement or the freedom of assembly. Preschools, elementary schools, and lower-secondary schools remained open throughout the spring, as did most restaurants and shops. Instead of resorting to coercion, Swedish authorities issued voluntary recommendations that were meant to limit the spread of the virus by persuading citizens to reduce their social interactions and protect themselves and others from the disease.¹

A few months later, in the autumn of 2020, Sweden, like most of Western Europe, was struck by a second wave of the COVID-19 epidemic, which proved to be even deadlier than the first. During this period, Sweden's government, parliament, and public-health authorities put in place policies that were more restrictive and that made the Swedish approach to the COVID-19 crisis more similar to that of other countries. By January 2021, the parliament had adopted new legislation that authorized the government to impose new restrictions on shopping centers and other businesses, and children in lower secondary schools were taught in their homes in many parts of the country.

This working paper examines Sweden's public-health policies in the twelve-month period between January 2020, when Swedish authorities took the first steps to prepare the country for the new epidemic, and December 2020, when Sweden found itself in the middle of the epidemic's second wave and new, more restrictive policies were being prepared and enacted.² We begin with a brief overview of the spread of the new coronavirus in Sweden, examining the number of known infected, the number of fatalities, and the pressures on the health-care system. In the section that follows, we describe the public-health policies Sweden put in place during the COVID-19 crisis in 2020. We then turn to an analysis of the social and political factors that explain Sweden's distinctive approach to public-health policy during the pandemic.

¹ This working paper is part of a comparative book project on COVID-19 responses, initiated by professor Dong-Young Kim and professor M. Jae Moon, and financially supported by KDI School of Public Policy and Management. We are grateful for the support from our colleagues and from the KDI School.

² The findings for the first six months of 2020 are reported and discussed in Dahlström and Lindvall (2021). This working paper covers all of 2020 and therefore both the first and the second wave of the pandemic.

The COVID-19 Epidemic in Sweden

On January 16, 2020, the Public Health Agency of Sweden published the first news about COVID-19 on its website.³ The agency informed the public about the discovery of a new coronavirus in Wuhan, China, but assessed the risk of the disease spreading to Sweden as “very low.”⁴ On January 31, however, the first COVID-19 case was detected in Sweden.⁵ In February, the agency informed the Swedish public of new COVID-19 outbreaks in South Korea, Iran and Italy. At the end of the month, on February 25, the Public Health Agency changed its assessment of the risk of more cases in Sweden to “high” but the risk of community transmission of the disease within Sweden was still seen as “low.”⁶ The next day, the second Swedish COVID-19 case was confirmed, and in the following days further cases were reported. In the beginning of March, the agency changed its risk assessment again. It now suggested that there was a “very high” risk of more cases and a “moderate” risk of community transmission within Sweden. On March 10, finally, the risk assessment for community transmission of the new coronavirus within Sweden was raised to the highest level, “very high.”⁷

Since the rate of testing has varied greatly over time -- with many more tests being performed in the autumn than in the spring -- it is difficult to compare the infection rates during different phases of the COVID-19 crisis in Sweden. One must keep this in mind when considering Figure 1, which shows how many new coronavirus infections were reported to the Public Health Agency of Sweden in that year, beginning with the first case and ending on December 31, 2020: the figure underestimates the number of infected in the spring, since so few tests were performed then compared with the autumn (see Figure 2, which plots the number of tests that were performed per week between late January and the end of December). Nevertheless, the figure shows clearly that there were two distinct waves of the epidemic, one beginning in late March

³ The Public Health Agency of Sweden, January 16, 2020: <https://www.folkhalsomyndigheten.se/nyheter-och-press/nyhetsarkiv/2020/januari/nytt-coronavirus-upptackt-i-kina/>. For the sake of simplicity, we use the names coronavirus, SARS-CoV-2 and COVID-19 throughout, although other terms were used before the virus and the disease got their current official names.

⁴ The Public Health Agency of Sweden makes risk assessments on a five-point scale with the risk levels *very low*, *low*, *moderate*, *high* and *very high*.

⁵ The Public Health Agency of Sweden, January 31, 2020, <https://www.folkhalsomyndigheten.se/nyheter-och-press/nyhetsarkiv/2020/januari/folkhalsomyndigheten-foreslar-att-nytt-coronavirus-tas-upp-i-smittskyddslagen/>.

⁶ The Public Health Agency of Sweden, February 24, 2020, <https://www.folkhalsomyndigheten.se/nyheter-och-press/nyhetsarkiv/2020/februari/information-till-resenarer-om-det-nya-coronaviruset/>.

⁷ The Public Health Agency of Sweden, March 10, 2020, <https://www.folkhalsomyndigheten.se/nyheter-och-press/nyhetsarkiv/2020/mars/flera-tecken-pa-samhallsspridning-av-covid-19-i-sverige/>.

and the other beginning in the middle of October. The two waves are even more clearly visible in Figure 3, which describes the number of new COVID-19 patients that were admitted to Swedish intensive-care units per day during 2020, and in Figure 4, which describes the number of individuals who died with COVID-19 each day.⁸ Taken together, these figures show that the virus spread quickly in the month of March 2020, resulting in high morbidity and high mortality at the end of March and in April; the infection rates and the death rates then fell slowly but surely during the spring, summer, and early autumn of 2020, until the rate of infection picked up again in the middle of October, resulting once more in high morbidity and high mortality in November and December. By the end of 2020, more than 10,000 individuals had died with COVID-19. Since Sweden has a population of just over 10 million, this meant that the total number of deaths exceeded 0.1 percent of Sweden's population.

The death rate in Sweden was significantly higher both in the spring and in the autumn of 2020 than in Sweden's closest neighbors, Denmark, Finland, and Norway. Starting in the spring and summer of 2020, these differences between the death rate in Sweden and the death rates in the neighboring countries were at the center of a major political debate within Sweden. This political debate was preceded by an intense debate among doctors and public-health experts, where some scholars at Swedish universities were very critical of the Public Health Agency of Sweden and of the methods it relied on. The critics wanted the government and the state authorities to put in place more coercive and stringent policies to halt the spread of the new coronavirus.⁹

As we will discuss in more detail in the next section, it is instructive to distinguish among four phases of the COVID-19 epidemic in 2020. We will now proceed to examine the policies Sweden's government, parliament, and public authorities put in place during these different phases of the pandemic.¹⁰

⁸ Note that the information in Figure 4 refers to people who were ill with COVID-19 when they died, which does not necessarily mean they died of COVID-19.

⁹ See, for example, Marcus Carlsson et al., "Folkhälsomyndigheten har misslyckats – nu måste politikerna gripa in", DN Debatt, 14 April 2020.

¹⁰ Throughout the pandemic, the official goals of the Swedish epidemic-control policy were to (1) limit the spread of infection in the country; (2) secure resources for health care; (3) limit the impact on socially important activities; (4) mitigate the consequences for citizens and businesses; (5) mitigate people's concerns, among other things through information, and (6) take the right actions at the right time. See <https://www.regeringen.se/regeringens-politik/regeringens-arbete-med-anledning-av-nya-coronaviruset/>.

Public-Health Policies in Sweden During the COVID-19 Pandemic

Sweden's epidemic-control policy during the COVID-19 crisis has been markedly different from that of other Western European countries. With a few important exceptions, Sweden's government, parliament, and administrative authorities have refrained from introducing coercive policy measures that interfere with the lives of individuals and the activities of private-sector companies and other organizations. The Public Health Agency of Sweden emphasized early on during the crisis that their policy for epidemic control was based on voluntarism and on the idea that a well-informed and motivated public can and will take responsible decisions. In the view of the agency, a policy based on voluntarism is generally more effective than coercive measures.¹¹ The Swedish epidemic-control policy is therefore based on recommendations and general advice from the relevant authorities.¹² It is also primarily such recommendations and general advice that have affected people's lives during the COVID-19 epidemic, not strict rules and regulations.¹³

As we have already mentioned, Swedish crisis management during the COVID-19 epidemic in 2020 can be divided into four different phases: (1) a phase with no (detected) community transmission, from January to mid-March; (2) a phase with high community transmission, from mid-March until early June; (3) a phase with low community transmission, from early June to late October; (4) and a phase with high community transmission, from late October through December.¹⁴

From January to mid-March, the goal of Swedish public-health policy was to identify all cases of COVID-19 in Sweden. COVID-19 cases were identified by testing individuals who showed symptoms after traveling

¹¹ The Public Health Agency of Sweden, February 5, 2020, <https://www.folkhalsomyndigheten.se/nyheter-och-press/nyhetsarkiv/2020/februari/information-om-karantan/>.

¹² The Public Health Agency of Sweden differs between *general advice* and *recommendations*. A general advice is a specification of what the public and various organizations can do to comply with laws, executive orders and regulations. A general advice is not binding in itself but is linked to a binding rule. A recommendation is based on existing knowledge without being linked to binding regulations. For a discussion about this distinction from constitutional and administrative law perspectives, see Wenander (2020).

¹³ "Folkhälsomyndighetens föreskrifter och allmänna råd om allas ansvar att förhindra smitta av covid-19 m.m.", in *Gemensamma författningssamlingen avseende hälso- och sjukvård, socialtjänst, läkemedel, folkhälsa m.m.* HSLF-FS 2020:12. the National Board of Health and Welfare, April 16, 2020.

¹⁴ The official goals of the Swedish epidemic control policy have the entire period, according to the government, been to (1) limit the spread of infection in the country; (2) securing resources for health care; (3) limit the impact on socially important activities; (4) mitigate the consequences for citizens and businesses; (5) mitigate people's concerns, among other things through information, and (6) take the right action at the right time. See <https://www.regeringen.se/regeringens-politik/regeringens-arbete-med-anledning-av-nya-coronaviruset/>.

in areas with documented outbreaks of the disease and people who had been in contact with individuals with confirmed COVID-19. However, there was no quarantine of individuals who had been in areas with documented community transmission of COVID-19. People who returned from affected areas were instead asked to pay attention to symptoms themselves, contact the health-care advice platform 1177 Vårdguiden for further assessment and stay in their homes if they had symptoms.¹⁵ The strategy was based on the assumption that individuals without symptoms were not infectious and that there was no community transmission of COVID-19 in Sweden. Until mid-March, preparations were also made for the possibility that more drastic measures might be required. In early February, COVID-19 was added to the list of dangerous diseases in the Swedish Communicable Diseases Act (Smittskyddslagen, SFS 2004:168), which made it possible for the coercive measures that law allows to be used in COVID-19 cases.¹⁶ The Public Health Agency of Sweden turned to the government with this proposal on January 31, 2020, and the government took the decision at a special meeting of the cabinet on February 1. In the beginning of March, travel restrictions were also introduced for certain countries.¹⁷ On March 10, the Public Health Agency of Sweden announced that they saw signs of community transmission of the COVID-19 infection in the Stockholm and Västra Götaland regions and that there was now a “very high” risk of an outbreak with endemic community transmission of the disease within Sweden. Two days later, public gatherings were limited to a maximum of 500 people.

On 13 March, the day after restrictions on public gatherings were introduced, the Public Health Agency of Sweden announced that the epidemic-control policy had entered a new phase.¹⁸ From mid-March -- when infection rates in Sweden were already very high -- the government, the Public Health Agency of Sweden and the National Board of Health and Welfare (Socialstyrelsen) took a number of new decisions and issued

¹⁵ The Public Health Agency of Sweden February 5; the Public Health Agency of Sweden February 24; the Public Health Agency of Sweden, March 9, 2020, see <https://www.folkhalsomyndigheten.se/nyheter-och-press/nyhetsarkiv/2020/mars/folkhalsomyndigheten-rekommenderar-provtagning-av-sjuka-som-varit-i-tyrolen/>. *1177 Vårdguiden* is a platform for information and advice on health and care in Sweden. Individuals can, among other things, use digital services or call for health care advice. 1177 Vårdguiden is a collaboration between Sweden's 21 regions.

¹⁶ The ordinance (2020:20) says that the provisions of the Communicable Diseases Act (2004: 168) on generally dangerous and socially dangerous diseases shall be applied to 2019-nCoV infections.

¹⁷ The Public Health Agency of Sweden, March 6, 2020, <https://www.folkhalsomyndigheten.se/nyheter-och-press/nyhetsarkiv/2020/mars/folkhalsomyndigheten-har-rekommenderat-avradan-fran-resor-till-norra-italien/>; The Public Health Agency of Sweden, March 9, 2020, <https://www.folkhalsomyndigheten.se/nyheter-och-press/nyhetsarkiv/2020/mars/folkhalsomyndigheten-rekommenderar-provtagning-av-sjuka-som-varit-i-tyrolen/>.

¹⁸ The Public Health Agency of Sweden, March 13, 2020, <https://www.folkhalsomyndigheten.se/nyheter-och-press/nyhetsarkiv/2020/mars/ny-fas-kraver-nya-insatser-mot-covid-19/>. Unlike the authorities in Norway, the Public Health Agency of Sweden did not at this time report on the various strategies the agency may have considered, which has been criticized in the public discussion. Concerning Norway see Utbrudsgruppen ved Folkehelseinstituttet, COVID-19-epidemien: risikovurdering og respons i Norge, version 3, March 12, 2020. For example of criticism in the Swedish public debate see Olle Häggström, Olof Johansson Stenman, Joacim Rocklöv, Stefan Schubert och Markus Stoor, "Alternativ coronastrategi för Sverige kan rädda liv", DN Debatt, Dagens Nyheter, April 30, 2020.

recommendations and general advice that had a strong impact on people's lives as well as on the activities of private companies and other organizations. In the report “Folkhälsomyndighetens föreskrifter och allmänna råd om allas ansvar att förhindra smitta av covid-19 m.m.” from the Public Health Agency of Sweden, there were for example several pieces of general advice that severely limited the activities of agencies, companies, municipalities, regions, associations and religious organizations. The general advice included restrictions on the number of people on the premises to avoid crowds, the suspension of physical meetings, calls to to work from home and to refrain from social events and travel.¹⁹ Moreover, universities, university colleges and upper secondary schools (gymnasier) were advised to introduce online teaching, and there were more restrictions on public gatherings (a maximum of 50 people), and on restaurants, bars and cafés. It is from this point that one could reasonably speak of a “lockdown” of Swedish society, although most of the measures that were taken remained voluntary.²⁰

With a declining number of new patients and falling numbers of deaths with COVID-19 (Figures 3 and 4), some of the restrictions were eased during the summer and in the first half of the autumn of 2020. In this period, we saw the third phase of the Swedish policy response. The recommendation of online teaching for upper secondary schools, for example, was lifted in June, and though things didn't quite go back to normal, most students and university students started the autumn semester on site in their schools.²¹ The recommendation against non-necessary travel was also lifted in June. Moreover, the authorities withdrew the recommendation that people over the age of 70 should avoid social gatherings, as well as the ban on visits to all nursing homes in the country, in the autumn of 2020.²²

The Public Health Agency prepared for an autumn with locally concentrated outbursts of COVID-19, with testing, tracing, monitoring and communication as the main measures taken against such local transmission (individual responsibility, social distancing, and hand hygiene were, however, always the backbone of the Swedish strategy).²³ In line with this type of reasoning, the agency opened up for the possibility of making

¹⁹ “Folkhälsomyndighetens föreskrifter och allmänna råd om allas ansvar att förhindra smitta av covid-19 m.m.”

²⁰ For a good overview of Sweden's early response see Ludvigsson (2020).

²¹ See <https://www.folkhalsomyndigheten.se/nyheter-och-press/nyhetsarkiv/2020/maj/gymnasieskolorna-kan-oppna-till-hostterminen/>.

²² See <https://www.folkhalsomyndigheten.se/nyheter-och-press/nyhetsarkiv/2020/september/alla-har-ett-stort-ansvar-for-att-minimera-smittspridning-nar-besoksforbudet-upphor/> and <https://www.folkhalsomyndigheten.se/nyheter-och-press/nyhetsarkiv/2020/oktober/viktigt-att-alla-tar-ansvar-nar-allmanna-rad-andras-for-personer-som-ar-70-ar-och-aldre/>.

²³ See <https://www.folkhalsomyndigheten.se/nyheter-och-press/nyhetsarkiv/2020/september/insatser-mot-nya-utbrott-av-covid-19/>.

stricter recommendations locally during a limited time.²⁴ When the cases started increasing in October (see Figures 1, 3, and 4), the Public Health Agency of Sweden, in collaboration with regional-level authorities, started implementing this strategy, first in Uppsala on October 20, then in Skåne on October 27, followed by Stockholm, Västra Götaland, and Östergötland on October 29.²⁵ Within just over a week in late October 2020, the most populated areas in Sweden were again covered by strict recommendations, sometimes even stricter than during the spring.

These regional actions took the Swedish policy response into its fourth phase. The government and the authorities responded to the high and increasing transmission of the virus that causes COVID-19 with more restrictions, also on the national level. In the beginning of December, the Public Health Agency again recommended online teaching for upper secondary schools (gymnasium), and in mid-December the agency made recommendations restricting traveling, social contacts outside the household, sports, shopping, and social contacts with elder people. In November and December, new and stricter recommendations and regulations for restaurants, bars and cafés were implemented. For example, the Public Health Agency of Sweden advised against seating more than four guests per table, and the government issued an ordinance banning alcohol after a certain hour (at first, alcohol was not allowed in restaurants, bars, and cafés between 10 pm and 11 am, later the rule was changed to 8 pm--11 am).²⁶ In the autumn of 2020, the government, its agencies and the regions also prepared for vaccinations against COVID-19 to start in January of 2021. This process started already in late August but intensified later in the autumn.²⁷

²⁴ See <https://www.folkhalsomyndigheten.se/nyheter-och-press/nyhetsarkiv/2020/oktober/lokala-allmanna-rad-vid-utbrott-av-covid-19/>.

²⁵ See <https://www.folkhalsomyndigheten.se/nyheter-och-press/nyhetsarkiv/2020/oktober/beslut-om-skarpta-allmanna-rad-i-upp-sala-lan/>. <https://www.folkhalsomyndigheten.se/nyheter-och-press/nyhetsarkiv/2020/oktober/beslut-om-skarpta-allmanna-rad-i-skane-lan/>. <https://www.folkhalsomyndigheten.se/nyheter-och-press/nyhetsarkiv/2020/oktober/beslut-om-skarpta-allmanna-rad-i-stockholms-lan-vastra-gotalands-lan-och-ostergotlands-lan/>.

²⁶ Förordning (2020:956) om tillfälligt förbud mot servering av alkohol,

<https://www.folkhalsomyndigheten.se/smittydd-beredskap/utbrott/aktuella-utbrott/covid-19/skydda-dig-och-andra/rekommendationer-for-att-minska-spridningen-av-covid-19/>,

<https://www.folkhalsomyndigheten.se/contentassets/ea9f45d2562d42d9957b8bf08e2bc3e6/hslf-fs-202091.pdf>, and

<https://www.regeringen.se/pressmeddelanden/2020/11/forbud-mot-alkoholforsaljning-fran-klockan-22/>.

²⁷ See <https://www.folkhalsomyndigheten.se/nyheter-och-press/nyhetsarkiv/2020/augusti/delredovisning-for-nationell-plan-for-vaccinationer-mot-covid-19/> and

<https://www.folkhalsomyndigheten.se/nyheter-och-press/nyhetsarkiv/2020/november/start-for-vaccinationer-mot-covid-19-tidigast-i-januari-2021/>.

Since the Swedish authorities emphasized voluntarism throughout all four phases of the COVID-19 crisis, it is important to know if the general public was aware of and followed the recommendations and advice of the authorities. The Swedish Civil Contingencies Agency conducted surveys from 21 March onward to assess behavioral changes among the general public. During the first half of 2020, virtually all respondents (99 percent) stated that they had changed their behavior in some way. For example, the vast majority stated that they followed the Public Health Agency's advice to wash their hands more thoroughly (86 per cent) and to keep a greater distance from others (85 per cent).²⁸ After 20 August 2020, the Swedish Civil Contingencies Agency also used a new survey item to assess whether the general public had enough information to comply with recommendations. The vast majority of the respondents answered that they were knowledgeable enough. In August and September about 80 percent answered that they were well-informed about how to behave in public and private gatherings. About 70 percent said the same thing concerning testing and vaccinations, and about 60 percent stated they knew enough to make informed choices in their working lives, in educational contexts, and when they used public transportation.²⁹ During the fourth phase of the crisis, when specific local and regional actions were taken, the Swedish Civil Contingencies Agency asked respondents if they had enough information about local restrictions and recommendations, and 86 percent answered that they were fairly or very well-informed.³⁰ Finally, the Swedish company Telia has made available aggregate cell-phone data on traveling patterns within Sweden, and the data show a decline of 20 percent of daily trips within Sweden.³¹ Taken together, these pieces of evidence suggest that the Swedish general public was aware of and followed recommendations and advice from the authorities, but it is difficult to determine what effects these behavioral changes had, and how much effect more stringent rules would have had in comparison.

It is also worth mentioning a few things that didn't happen in Sweden in 2020. Preschools and primary schools did not close, nor did lower secondary schools (although they were closed in January 2021 in many parts of the country). No general recommendations regarding face masks on public transports or in public places were issued. And although both the Ministry for Foreign Affairs and the Public Health Agency of Sweden issued travel advice recommending Swedes to limit travel, no bans on traveling within the country,

²⁸ Kantar Sifo, *Rapport om förtroende, oro och beteende under coronakrisen, 21 mars–31 maj, Rapport till MSB*, 2020-05-31. Concerning public trust during the COVID-19 epidemic, see also Esaiasson et al. (2020).

²⁹ Kantar Sifo, *Rapport om förtroende, oro och beteende under coronakrisen, 21 mars–24 augusti, Rapport till MSB*, 2020-08-24; Kantar Sifo, *Rapport om förtroende, oro och beteende under coronakrisen, 21 mars–28 september, Rapport till MSB*, 2020-09-28.

³⁰ Kantar Sifo, *Rapport om förtroende, oro och beteende under coronakrisen. December, Rapport till MSB*, 2021-01-10.

³¹ See <https://www.telia.se/privat/aktuellt/hemma-i-folknatet/covid-19-mobiliteetsanalys>.

or on leaving the country, were introduced. In addition, neither health checks nor quarantine were required when entering Sweden, and no policy of confinement was implemented.

Meanwhile, the Swedish parliament and the Swedish government have taken a number of steps to mitigate the economic damage that is caused by the COVID-19 epidemic.³² The single most costly measure was the new support program for “short-term work” that was introduced in the spring of 2020. Through a government decree and then a new law that applied retroactively from mid-March 2020 (SFS 2020: 375), it became possible for companies during the COVID crisis to apply for funding for short-term leave for their staff amounting to up to 60 percent of working hours, a percentage that was later increased to 80 percent during the months of May, June and July. Although firms have had this possibility to lay off their staff temporarily, with funding from the government, unemployment has increased. Both the average benefit level in the unemployment insurance system and the cap on high benefits have been raised, and it has become easier for individual employees to qualify for unemployment insurance. Meanwhile, the qualifying day in the health insurance system – a rule that says there is no sick pay for the first day away from work – has been removed. One reason for that rule change was that the government wanted to give employees incentives to stay at home if they had mild symptoms of illness. In addition, the government and the parliament have taken a number of steps to protect Swedish companies directly from the consequences of the economic downturn. The second most costly new measure in 2020, after the short-term work program, was a form of direct support to Swedish companies, which was based on the estimated reductions in their turnover. The third most costly measure was a temporary reduction in social security contributions (which are paid by employers in Sweden). The government has also temporarily taken over the responsibility for sick pay, which is normally paid by the employer in the beginning of a period of illness for an employee.

Explaining Sweden’s Response to the COVID-19 Crisis

In this section, we will discuss the social and political context in which Sweden’s distinctive public-health policies during the COVID-19 crisis were adopted and implemented. We concentrate on those characteristics of Swedish society and the Swedish political system that other scholars and political commentators in

³² This overview is based on Finanspolitiska rådet (2020).

Sweden and abroad have pointed to when they have sought to explain the choices Sweden's government, parliament, and public-health authorities made during the pandemic.

Experts and Politicians

One important difference between Sweden's approach to the COVID-19 pandemic and that of other, comparable countries in Western Europe is that at least in the beginning of the crisis, many of the operative decisions were made by experts and bureaucrats in public agencies, not by elected political leaders in the government and in parliament. The willingness of Sweden's political leadership to delegate public-health policymaking to administrative authorities -- particularly in the beginning of the crisis -- has been highlighted by Andersson and Aylott (2020), among others, and it was quite clear to anyone who followed Swedish politics in the spring of 2020: the Swedish government trusted the judgment of the public-health authorities and waited for advice from the bureaucracy before introducing new legislation or government decrees (Andersson and Aylott 2020).

For foreign observers, the relationship between the government and the bureaucracy in Sweden may seem peculiar. It is, for example, different from the relationship between the government and the bureaucracy in Sweden's neighbors Denmark, Norway, and Germany. The Swedish Government Offices, which comprise all ministries, are small and have limited investigative resources compared with government ministries in these other neighboring countries. Swedish administrative authorities also enjoy more operational independence than public agencies in most other democracies, and their independence is protected by the constitution (Ahlbäck Öberg and Wockelberg 2016 and Pierre 2004). In 2020, the Government Offices consisted of the Prime Minister's Office, the Office for Administrative Affairs, and eleven ministries. The Prime Minister's Office is headed by the Prime Minister and each ministry is headed by a minister. Numerous agencies, such as the Public Health Agency, the National Board of Health and Welfare and the Swedish Civil Contingencies Agency (Myndigheten för samhällsskydd och beredskap), sort under each ministry. In January 2020, there were a total of 341 such agencies. Swedish agencies are quite different from each other, and they include everything from relatively small committees with narrow and specific remits to county administrative boards, large administrative agencies, and universities (Dahlström and Holmgren 2019). In 2020, there were approximately 229,000 annual full-time equivalents employed at these authorities, which can be compared with the approximately 4,600 people that are employed within the Government Offices (i.e. at the

ministries themselves). The majority of the resources of the administrative state are thus allocated to the public agencies.³³

According to Swedish administrative law and traditions, bureaucratic agencies make independent assessments that are based on the best available knowledge and the government listens to the experts at the agencies. In international comparison, what is perhaps the most striking is that Swedish ministers are prohibited by the constitution, the Instrument of Government, from giving instructions to agencies in individual cases (Chapter 12, Section 2). A commission of inquiry, *Styrtredningen*, summarized the Swedish administrative model as follows: “On the one hand, politicians decide and the administration executes, on the other hand, the administration must talk back with a clear voice” (SOU 2007:75, p. 13).

But bureaucratic agencies in Sweden can nevertheless be controlled indirectly, through legislation, executive orders, and written directives. The government's most important formal control instruments are the instructions that authorize each agency's operations, budgets, and yearly spending decisions. For each agency, the government writes a formal instruction that describes the agency's mission and organization. The government is free to change these instructions. The government can also change the budgets of individual agencies, even if it is the Swedish parliament that decides on the state budget. In the yearly spending instructions, written in connection with the budget, the government also gives detailed instructions to each agency on how the funds are to be used. In these spending instructions and in other government decisions, special assignments can be given to an agency (for example, to increase testing, or coordinate the purchase of protective equipment). Moreover, the government can steer agencies by appointing heads of agencies, although it is constrained by the Instrument of Government's provisions on meritocratic recruitment (Chapter 12, Section 5), and Swedish agency heads have employment contracts with strong employment security for a fixed term. In addition to these formal control instruments, there are informal contacts between the Government Offices and the agencies (Jacobsson 1984, Niemann 2013). These informal contacts are an important part of the governance structure. Ministers and officials at the Government Offices are not prohibited from having informal contacts with agencies under their own ministry for the purpose of obtaining information or achieving certain results -- as long as this does not affect decisions in individual cases, which would be a violation of constitutional law. Such informal contacts are made often, and they enhance the ability of the government to steer public authorities, even in a situation such as the COVID-19 crisis (Jacobsson and Sundström 2016, Pierre 2020).

³³ The Government Offices, *Regeringskansliets årsbok 2019*. Stockholm: Regeringskansliet 2019. The Swedish Agency for Public Management, *Statsförvaltningen i korthet*. Stockholm: Statskontoret 2020.

The constitutionally protected independence of administrative agencies means specifically that the parliament or the government may not “decide how an administrative agency should decide in a particular case concerning the exercise of authority vis-à-vis an individual or a municipality or concerning the application of law” (Chapter 12, Section 2). But as we’ve just discussed, this doesn’t mean that the government cannot control public agencies at all: it has several instruments that they can use to this end. It would therefore have been entirely possible for the government and the parliament to adopt policies that were more similar to those adopted in other democracies even if the public-health authorities favored a voluntarist approach. Most importantly, and as we will discuss in more detail below, it would have been constitutionally possible for the parliament to enact new laws, and it would have been legally possible for the government to introduce more far-reaching coercive policies within current legislation since the parliament authorized the government to do so via temporary enabling legislation.

But even if these things would have been formally possible, Sweden’s long tradition of administrative autonomy nevertheless helps to explain the Swedish response to COVID-19, especially in the early stages of the pandemic in the spring of 2020. Since the Swedish government usually lets administrative agencies act autonomously within the framework of existing legislation and regulations, the prevailing views within the public-health authorities, especially in the Public Health Agency, did much to shape policy in 2020.

Planning for a Pandemic

Since many of the operative decisions during the COVID-19 pandemic were made by experts and bureaucrats in public agencies, particularly the Public Health Agency of Sweden, it is important to consider the contingency plans that the Public Health Agency had drawn up for a possible global outbreak of a new infectious disease. In 2019 -- just before the outbreak of the COVID-19 epidemic -- the Public Health Agency published a report called “Pandemic Preparedness,” which described the agency’s views on appropriate policy during a pandemic (especially an influenza pandemic) and the demands such an event would place on Swedish society. According to that report, the main goals of Swedish policy during a pandemic should be both to “minimize mortality and morbidity in the population” and to “minimize other negative consequences for the individual and society.” The report emphasizes in particular the importance of “trying to reduce the spread of infection and delaying the course of the pandemic” so that “the curve is flattened” to reduce “the burden on the healthcare system and society” and to increase “preparation time” before a vaccine becomes available. Social distancing is listed as one possible measure that can be used to achieve

these goals. The idea of curbing the spread of a disease in order to “flatten the curve” was thus an integral part of Swedish policy.³⁴

But already before the crisis, one notes a certain skepticism on the part of the Public Health Agency concerning the appropriateness of far-reaching “non-medical” measures during a pandemic. On the one hand, the 2019 report emphasizes that in the early stages of a pandemic, there are few opportunities to limit the spread of infection and care for the sick medically, which means that the only “measures that exist to reduce a pandemic’s impact on society are so-called non-medical measures,” including “hand hygiene, coughing and sneezing etiquette, voluntary isolation in case of illness, avoiding public gatherings and public events, and closing schools.” On the other hand, the report emphasizes that the scholarly literature doesn’t show conclusively that such policies work. Among other things, the report cites a WHO study suggesting that the evidence for the effectiveness of non-medical measures is low. In addition, the report emphasizes that non-medical measures “may have a negative impact on the functionality of society,” so the political response to a pandemic must be “balanced.” The Public Health Agency’s assessment in 2019 was that the suitability of non-medical measures depended on “the severity, spread and societal context of a pandemic.”

When the Public Health Agency and the Swedish government explained the premises of Sweden’s COVID-19 strategy in the spring of 2020, they typically referred to this balancing act, taking into account both the expected effect of restrictive measures on the spread of infection and the broader social and economic costs associated with lockdowns. The decision to keep elementary, primary, and lower secondary schools open was justified in two ways, for example. On the one hand, the government emphasized that the spread of infection among children was low. On the other hand, the government noted that the social costs would be high if schools were closed, especially since the healthcare system would suffer if many employees were forced to stay home to take care of small children.³⁵ In June, Sweden’s state epidemiologist, Anders Tegnell, said on the radio that in the beginning of the COVID-19 epidemic, he had assumed that other countries would do much as Sweden did, since he believed that Sweden’s strategy was consistent with the prevailing

³⁴ “Pandemiberedskap. Hur vi förbereder oss – ett kunskapsunderlag.” Stockholm: Folkhälsomyndigheten 2019 (19074-1).

³⁵ See Sveriges Television, “Därför vill Folkhälsomyndigheten inte stänga grundskolor”, 18 March 2020 (<https://www.svt.se/nyheter/vetenskap/darfor-vill-folkhalsomyndigheten-inte-stanga-grundskolor>) and Skolvärlden, “Beskedet: Anna Ekström stänger inga skolor”, 12 March 2020 (<https://skolvärlden.se/artiklar/beskedet-anna-ekstrom-st%C3%A4nger-inga-skolor>).

ideas in the international public-health community.³⁶ These prevailing views within the public-health bureaucracy, combined with the deference that the government in Sweden typically extends to bureaucratic expertise, help to explain the Swedish policy response.

With regard to organizational and administrative issues during a pandemic, the Public Health Agency distinguished in its planning before the COVID-19 crisis among the roles played by international organizations, the government, state authorities, the regions, and the municipalities. Judging from the 2019 report, the assumption was that the government would have a limited role, namely to “ensure access to vaccines and antivirals,” to decide whether a disease should be “classified as dangerous” for the purposes of the provisions of the Communicable Diseases Act, and to decide on an “antiviral storage strategy.” The Public Health Agency itself was assumed to have many different tasks, including the coordination of pandemic preparedness at the national level. The National Board of Health and Welfare was expected to oversee and coordinate emergency health-care measures regionally and locally and issue regulations on the use of pharmaceuticals. The Swedish Civil Contingencies Agency was expected to coordinate various actors at the national level and to monitor the impact of a pandemic on society as a whole. Municipalities, regions, and regional infection-control physicians were expected to have a number of more operational tasks.

The Swedish approach to COVID-19 was thus in most respects consistent with the ideas that informed prior planning for a pandemic outbreak of a new communicable disease. In other words, what needs to be explained concerning Sweden’s distinctive approach is not a change in policy, but the fact that Swedish public authorities -- as well as the government and parliament -- did not change policies, even if other countries did.

Toward the end of 2020, in what we have referred to as the fourth phase of the Swedish policy response to COVID-19, both the government, parliament, the national public-health authorities, and regional decision-makers put in place more restrictions than in the spring, affecting, for instance, lower secondary school students, restaurants and bars, and shops (which were instructed to limit the number of customers they admitted and to take other precautions). It is difficult to assess whether the change in policy came at the initiative of the government or if the views of the government, the national public-health authorities, and local decision-makers co-evolved, but it seems clear that the consequence of this reorientation was to bring Swedish COVID-19 policies closer to the Western European mainstream.

³⁶ See <https://sverigesradio.se/avsnitt/1518764>.

Laws and Lawmaking

One proximate cause of Sweden's choice to refrain from introducing new coercive measures in 2020, in addition to the prevailing views within the public-health bureaucracy and the deference that is usually afforded to administrative agencies in the Swedish political system, is that existing public-health legislation was based on a voluntarist approach. Moreover, there was little legal basis, at least in the early stages of the pandemic, for a nationwide lockdown, for restrictions of the freedom of movement, or for other sorts of new restrictions on private individuals and organizations.

Swedish policies concerning the spread of infectious diseases are primarily governed by the Swedish Communicable Diseases Act. The 2004 Communicable Diseases Act, like previous public-health legislation, affords regional infection-control physicians with far-reaching powers when it comes to local coercive measures, such as quarantine, isolation, and restrictions on travel.³⁷ But the Communicable Diseases Act is also based on the idea that individual citizens bear a great deal of personal responsibility for what happens during an epidemic. The second chapter of the Act begins, for example, by stating that “Everyone shall, by paying attention and taking reasonable precautions, contribute to preventing the spread of communicable diseases.” The emphasis on voluntariness in Sweden's COVID-19 policies in the spring of 2020 was thus nothing new -- Swedish legislation in the public-health domain has long been based on similar principles.³⁸ It is interesting to note that the provisions of the Communicable Diseases Act on extraordinary disease-control measures at the local and regional levels were not in fact applied during the COVID-19 crisis in 2020: since the government declared early on that COVID-19 is a socially dangerous disease, these more coercive provisions of the Communicable Diseases Act could in principle have been applied, but they were not.³⁹

Most of the coercive policies that were adopted and implemented during the COVID-19 epidemic were based on other pieces of legislation, primarily the Public Order Act, which regulates order and safety at public gatherings and public events (SFS 1993:1617). Most importantly, a ban on public gatherings and public events with more than fifty participants was announced in the spring of 2020 (SFS 2020:114). The fact that the Public Order Act is only applicable at public gatherings and public events is an important part of the explanation for the often-noted discrepancy between how different domains of Swedish society were affected by the restrictions that were introduced during the COVID-19 epidemic. For example, more than

³⁷ See especially 8–12 § in Chapter 3 in the Communicable Diseases Act.

³⁸ See Olof Petersson, “Sverige valde coronastrategi med 2004 års smittskyddslag”, *DN Debatt* 9 June 2020.

³⁹ See SFS 2020:20, later approved by parliament.

fifty people could gather in a shop, but not at a theater or at a sports event.⁴⁰ There were also a few that were introduced during the COVID-19 epidemic that were based on laws other than the Public Order Act. For example, in late March, a national ban on visits to elderly-care homes was announced, which was in turn based on a provision of the Social Services Act (SFS 2001:453).⁴¹ Entirely new legislation was also adopted in the spring of 2020, including a new law on temporary infection-control measures at restaurants. But most of the new laws that were adopted during this period dealt with the economic and social fallout of the COVID-19 epidemic, not with preventing the spread of the infection. For example, amendments were introduced in the Swedish Companies Act and in other laws on organizations and associations that made it possible to conduct meetings in a safe manner. Some of the economic policy measures that were introduced during the crisis also resulted in new legislation.⁴²

It would be wrong to explain Sweden's distinctive policies during the COVID-19 pandemic with the absence of legislation that authorized the government and the public-health authorities to introduce more coercive and stringent measures. It would have been entirely possible for the government to introduce new legislation that provided a legal basis for such a strategy. Indeed, the rapid adoption of legislation that allowed private companies and other organizations to adapt to the pandemic demonstrates that the capacity for immediate political action existed. Perhaps even more importantly, in April 2020, the parliament passed a new law that temporarily gave the cabinet the authority to adopt more drastic policies by government decree in connection with the COVID-19 epidemic. To be more specific, a temporary addition was made to Chapter 9 of the Communicable Diseases Act, which applied until July 2020 (SFS 2020:241) and which enabled the Government to "issue special regulations on the relationship between individuals and the government that place demands for individuals or otherwise relate to interventions in their personal or financial circumstances, if it is necessary to prevent the spread of the virus that causes COVID-19 and it is not possible to wait for the Riksdag's approval." The measures that the government was authorized to implement included "temporary closures of shopping centers," "temporary closures of social and cultural meeting places, such as bars, night-clubs, restaurants, cafeterias, gyms and sports facilities, libraries, museums and public meeting places" and "temporary closures or other restrictions of ... ports, airports, or bus stations or railway stations." But even

⁴⁰ "Förordning om förbud mot att hålla allmänna sammankomster och offentliga tillställningar" (2020:114). For a discussion, see Wenander (2020).

⁴¹ Förordning (2020:163) om tillfälligt förbud mot besök i särskilda boendeformer för äldre för att förhindra spridningen av sjukdomen covid-19.

⁴² Lag (2020:526) om tillfälliga smittskyddsåtgärder på serveringsställen. Lag (2020:198) om tillfälliga undantag för att underlätta genomförandet av bolags- och föreningsstämmor. Sveriges kommuner och regioner, "Sammanträden med fullmäktige, nämnder och styrelser m.m.i kommun, region och kommunalförbund under spridningen av det virus som orsakar sjukdomen covid-19", memo, Version 6, 4 May 2020. Lag (2020:548) om omställningsstöd.

if this temporary law existed, the government did not take the opportunity that it afforded to put in place more restrictive disease-control measures in 2020 (Jonsson Cornell 2020). In the beginning of 2021, however, during the fourth phase of the pandemic, the Swedish parliament adopted a similar law, which again authorized the government to regulate private companies and other organizations, and this time the government did put in place more stringent rules.

The work of parliament continued uninterrupted during 2020. On March 16, 2020, the group leaders of Sweden's eight parliamentary parties entered into an agreement on reducing the number of parliamentarians who participated in the votes in parliament, the Riksdag, to 55, in order to "ensure that the Riksdag can fulfill its tasks even in the event of a large number of members of the Riksdag being prevented from participating in the work of the Riksdag." It is worth noting that this institutional change had the form of a voluntary, reciprocal agreement among the group leaders of the parliamentary parties; it was thus not a question of a formal change in the parliament's rules or in other laws. This is not unusual, however, for there are other important rules about parliamentary procedure in Sweden that have the form of agreements among the parties (notably the rules for adjusting the number of voting members when some members are absent). With the new informal rules in place, the parliament remained operational and was highly active throughout 2020, as is evident from our review of the legislative measures that were taken to reduce the spread of infection and the economic policy measures that were taken to mitigate the economic effects of the crisis.⁴³

In the beginning of the COVID-19 epidemic, political decision-making was fairly consensual, as we discussed earlier, but the level of conflict increased gradually in the spring of 2020 as it became clear that the death toll in Sweden was much higher than in neighboring countries. The parties on the right have criticized the center-left government for pursuing an overly cautious policy, and they have called for an expansion of more systematic testing and, in the case of the populist-far-right Sweden Democrats, school closings. In the televised party leader debate on 7 June 2020, the differences among the parties were already considerable. The Christian Democrat leader Ebba Busch said, for example, that the Social Democratic-led government had "deliberately allowed the infection to spread." The leader of the Sweden Democrats, Jimmie Åkesson, referred back to the consensual political style in Swedish politics earlier in the spring and declared that the opposition parties must now confront the government on its public-health policies.⁴⁴

⁴³ "Överenskommelse om kammarens och utskottens arbete med anledning av spridningen av covid-19." Sveriges Riksdag, Stockholm, 16 March 2020.

⁴⁴ When it comes to economic policy, as opposed to public-health policies, the political parties have had different views concerning some of the measures taken during the crisis, especially with regard to the timing. For obvious reasons, the government, led by

Constitutional Considerations

On the basis of the arguments we made in the previous section, we conclude that the government could have adopted more stringent measures if it had wanted to do so: since a temporary law authorizing the government to take more drastic measures was adopted in April 2020, it seems highly likely that the government would have been able to win the Riksdag's support for a different approach. Some observers, such as the economist Lars Jonung (2020), have argued, however, that Sweden's policies during the COVID-19 epidemic are best explained by provisions of the Swedish constitution -- the 1974 Instrument of Government -- that make it difficult for both the government and parliament to enact laws that suspend individual rights. Jonung refers, among other things, to the protection of civil liberties and rights in Chapter 2 of the Instrument of Government, the principle of municipal self-government, and the independence of Sweden's administrative agencies, which we have already discussed.

Our view is that this interpretation of the Swedish constitution goes too far. When it comes to the protection of civil liberties in Chapter 2 of the Instrument of Government, we begin by noting that the freedom of assembly, which is otherwise highly protected, may be restricted if the purpose is to “counteract an epidemic” (Chapter 2, Section 8). Jonung states that this exception only applies to the freedom of assembly and not, for example, the right to move freely within Sweden. However, the protection of the right of free movement is not absolute either. Like many other freedoms, the freedom of movement may be restricted (Chapter 2, Section 20) if the purpose is “acceptable in a democratic society” and as long as the restrictions do not go “beyond what is necessary with regard to the purpose that has caused them” (Chapter 2, Section 21). It is true that a qualified majority is required to adopt laws that restrict people's freedoms right away -- and not with a twelve-month delay -- but it seems likely that a big majority in parliament would have been supportive of new, restrictive laws, for in April, as we have noted, the parliament did support a far-reaching, albeit temporary, law authorizing the government to take measures designed to limit the spread of COVID-19. When it comes to municipal self-government, the Instrument of Government allows the parliament to adopt laws that assign new tasks to municipalities, or regulate their services, as long as the restrictions of self-government do not go “beyond what is necessary” (Chapter 14, Section 3).

the Social Democrats, has been particularly keen to protect wage earners, for example through changes in unemployment insurance, while the center-right opposition has been more keen to protect business. On the whole, however, economic policymaking during the COVID-19 crisis were consensual. Particularly in the beginning of the epidemic, it was clear that Sweden was moving from a phase of political polarization (which was noticeable during the protracted government formation process of 2018–2019) to a phase where the willingness to compromise was higher. On the 2018–2019 government formation process and the political situation in Sweden after the 2018 election, see Teorell et al. (2020).

The Operational Capacity of Public Authorities and Local Governments

The political capacity of the government and parliament, which we have discussed in the two previous sections, is one thing. Another, related factor that was much discussed in Sweden in 2020 is the operational capacity of the public-health authorities and, especially, of regional and local governments. Regional and local governments have played a very important part in the implementation of the national response to COVID-19, since Sweden's regions are responsible for the healthcare system and since the local governments, the municipalities, are responsible for the elder-care sector, which was hit hard by COVID-19. The need to coordinate the response to a pandemic was anticipated in the 2019 report on pandemic preparedness that we cited earlier: it emphasizes that a pandemic requires "collaboration among all actors at all levels" (p. 9). One such structure is the National Pandemic Group, the main task of which is "to promote the coordination of measures planned and implemented to deal with a pandemic"; it includes representatives of the Public Health Agency, the Swedish Civil Contingencies Agency, the Medical Products Agency, the National Board of Health and Welfare, and an organization that represents Sweden's municipalities and regions.

The COVID-19 outbreak was a major challenge for healthcare in Sweden, as in many other countries. The efforts to limit the negative consequences of the pandemic for Swedish health care have been focused on reducing the spread of infection, so that the available health care capacity is not exceeded, and on increasing capacity in certain areas.⁴⁵ The government, the regions, the municipalities, and other authorities have, among other things, worked to increase the test capacity, the number hospital- and intensive care units available for COVID-19 patients, and the availability of protective equipment. The Public Health Agency of Sweden and the National Board of Health and Welfare have been responsible for monitoring and coordinating various parts of Sweden's health care system, while the 21 regions and the 290 municipalities have been responsible for implementing new policies within the health-care and social-care systems during the pandemic.

In mid-March, the Director-General of the World Health Organization, Dr. Tedros Adhanom Ghebreyesus, called on the countries of the world to "test, test, test."⁴⁶ Sweden has been able to perform so-called Polymerase Chain Reaction tests (PCR) since January 17, and all university hospitals had the capacity to perform PCR tests from February 28, 2020 (Ludvigsson 2020, 11). PCR testing is an established method for identifying an ongoing COVID-19 infection. PCR tests detect the presence of genetic materials from the virus that causes the infection. But the number of PCR tests performed in Sweden was relatively small, due to

⁴⁵ "Securing resources for health care" is one of the government's goals with their COVID-19 response.

⁴⁶ Dagens Nyheter, March 16.

lack of access to test equipment and because of ambiguities about who was responsible for performing and financing the tests (Ludvigsson 2020, 12). In February 2020, fewer than 1,000 individuals were tested. By mid-March, the number had risen to about 10,000 per week. On March 30, the Public Health Agency of Sweden was commissioned by the government to urgently increase the number of tests.⁴⁷

The test capacity has since expanded gradually. The Public Health Agency took measures to increase the analytical capacity of the country's laboratories, with the goal of having a capacity for approximately 150,000 tests per week, a goal that was reached in mid-July. In mid-April, the government and the Public Health Agency announced that 50,000–100,000 tests a week would be carried out.⁴⁸ The goal of 50,000 tests during one week was reached in June (week 24). During the autumn of 2020, the capacity continued to increase and toward the end of the year almost 300,000 tests were done each week. Figure 4 shows the number of individuals who have taken PCR tests in Sweden per week (data from the Public Health Agency). The number of individuals who took PCR tests has varied between 11 (week 4) and just under 300,000 (week 51).

The Public Health Agency has argued that the goals of PCR testing are different during the different phases of a pandemic.⁴⁹ In the first phase, which Sweden was in until mid-March, the focus was on testing everyone with symptoms and then conducting a thorough infection tracing. After the first phase, priorities were made. The Public Health Agency of Sweden suggested that the most prioritized group are people who have an ongoing illness; the second group is health care staff; the third group are staff in other socially important activities and the fourth group are everyone else. The Public Health Agency argued further that when the phase of acute community transmission was over, everyone that needed a test could be tested. It should however be noted that representatives of the Public Health Agency have later said that the low number of tests during the spring of 2020 was not a result of strategic planning but of low capacity.⁵⁰

⁴⁷ "Uppdrag om att skyndsamt utöka antalet tester för covid-19", S2020 / 02681 / FS. On May 8, the government also announced that they had commissioned Harriet Wallberg as test coordinator. She was placed at the Public Health Agency of Sweden. (<https://www.regeringen.se/pressmeddelanden/2020/05/harriet-wallberg-ny-testkoordinator-for-coronatester/>).

However, Harriet Wallberg announced that she wanted to end the assignment already after about three weeks

(Dagens Nyheter, June 2). In the media it was stated that the reason was that she had not a large enough mandate (Dagens Nyheter, June 3).

⁴⁸ <https://www.svtplay.se/klipp/26448670/antalet-coronatester-ska-utokas-kraftigt>

⁴⁹ The Public Health Agency of Sweden, "Nationell strategi för utökad provtagning och laboratorieanalys av covid-19", version 4, 2020-06-10.

⁵⁰ Public hearing on the corona crisis, Swedish Television, January 10 2021.

Like many other countries, Sweden experienced a shortage of protective equipment in the early spring of 2020, and during both waves of the epidemic, the capacity of intensive care in Swedish hospitals was put to the test. On March 16, the government commissioned the National Board of Health and Welfare to ensure access to protective equipment and other protective materials, and on March 19, the National Board of Health and Welfare was commissioned to set up a coordination function for intensive care units.⁵¹ Figure 3 shows the number of new intensive care patients per day in Sweden over the year (data from the Public Health Agency, January 26, 2021). There was a sharp increase in the number of patients in intensive care during March and April, and then again from mid-October to the end of the year. Based on information from the National Board of Health and Welfare, between 65 and 70 percent of the full capacity of Sweden's intensive-care units was utilized during the spring. As a national average, capacity utilization never exceeded 75 percent during the first six months of the year. However, some individual regions were under more pressure.⁵²

The National Board of Health and Welfare cooperates with the Swedish Civil Contingencies Agency and the County Administrative Boards to monitor hospital and intensive-care capacity in the regions, as well as the need for medical and protective equipment in the regions and municipalities. The National Board of Health and Welfare has a five-point measure of stress on these systems that ranges from no impact to critical impact.⁵³ Severe or critical impacts have been reported from a large number of regions for consumables; in other areas, only a few regions have been seriously or critically impacted. Some of Sweden's 290 municipalities also reported that they experienced a serious or critical impact regarding consumables, personnel, home care services, management functions, or the supply of medicines. The strain on the Swedish health-care and elderly-care systems was thus great in some parts of the country. The situation was particularly serious in April. The National Board of Health and Welfare wrote in its status report to the Swedish Civil Contingencies Agency on April 16 that the impact within the remit of the National Board of Health and Welfare varied from moderate to critical and that it was expected to increase in the coming weeks. The National Board of Health and Welfare stated that "consequences in two weeks' time include the risk of serious or critical

⁵¹ Regeringsbeslut S2020/011558/FS, S2020/011594/FS samt S2020/01849/FS. Se även S2020/02443/FS.

⁵² Data from the National Board of Health and Welfare (email September 25, 2020).

⁵³ The five scale steps are: "None", "Moderate", "Significant", "Serious" and "Critical" impact. Information from the National Board of Health and Welfare, e-mail 2020-10-22.

impact in several regions regarding IVA [intensive care] units, protective equipment and medical equipment.” The National Board of Health and Welfare also emphasized that there was a risk of “increased impact on municipal health and medical care and social services.”⁵⁴

The Case of Elder Care

The Swedish elder-care system was hit hard by COVID-19. It can be divided into two different types of care: home care and special housing (including residential nursing homes). In Sweden, elder care is the responsibility of the 290 municipalities (which in passing means that it falls under the social services and thus does not primarily belong to health care), but in both home care and special housing there are both public and private providers (Szebehely 2011). In January 2020, 191,910 people over the age of 70 had home care and 79,410 people over the age of 70 lived in special housing. These groups have been very vulnerable. By April 28, 90 percent of those who had died with COVID-19 were over 70 years old. Half of those individuals lived in special housing while just over a quarter had home care.⁵⁵

The vulnerable situation of older Swedes has been common knowledge, and measures have been taken to protect those groups, but many observers within Sweden have claimed that not enough was done in this regard. One measure that has already been mentioned was the government's decision on March 30 on a national ban on visits to nursing homes.⁵⁶ Other issues that seem to have been important were staff turnover at the nursing homes, protective measures for the staff, and the medical care that was available to residents of the nursing homes. The media has reported major problems when it comes to recruiting personnel and securing protective equipment for both home care and nursing homes.⁵⁷ There have also been media reports claiming that qualified care for fragile elder individuals was not prioritized in certain regions.⁵⁸ However, these reports have been disputed by the responsible officials.⁵⁹

In mid-April, the Government commissioned the Swedish Health and Social Care Inspectorate to investigate how the work against COVID-19 in the elder care was conducted in the municipalities. The Swedish

⁵⁴ The National Board of Health and Welfare 2020-04-16, dnr. 10.2.5075/2020, p. 1.

⁵⁵ The National Board of Health and Welfare, "Statistik om smittade och avlidna med covid-19 bland äldre efter boendeform", dnr. 6.7-15552/2020, 2020-05-06.

⁵⁶ "Förordning om tillfälligt förbud mot besök i särskilda boendeformer för äldre för att förhindra spridningen av sjukdomen covid-19", SFS 2020:163.

⁵⁷ Dagens Nyheter 2020-04-08, Dagens Nyheter 2020-05-21.

⁵⁸ Dagens Nyheter 2020-10-13, Eskilstuna Kuriren 2020-05-12.

⁵⁹ See the discussion in Dagens Nyheter 2020-10-19.

Health and Social Care Inspectorate's reports from late autumn 2020 revealed that there were examples in all regions of infected individuals in nursing homes who did not get individual medical assessments and who were not prioritized for hospital care.⁶⁰

A large evaluation has already been conducted of the measures that were taken to protect individuals within the elder care system from the infection. By the end of the spring of 2020, a majority of the political parties in parliament demanded a government commission of inquiry into how Sweden handled the COVID-19 epidemic. The government initially wanted to delay forming such a commission, but on June 30, it decided to appoint a committee that was tasked with "evaluating the measures taken by the government, the relevant administrative agencies, the regions, and the municipalities to limit the spread of the virus that causes COVID-19." The assignment included the elder care system. The committee consists mainly of scholars of social science, although a former director of the organization representing Sweden's municipalities and regions and a member of the clergy are also included as members.⁶¹

The Corona Commission published its first report in December 2020, and made several very critical observations concerning the Swedish elder care system in general and the protective measures that were taken by the authorities in particular. The overall conclusion was that the Swedish strategy for protecting old and fragile, individuals within the elder care system had failed. The report identified structural weaknesses in Swedish elder care as one of the main explanations of the failure to protect older Swedes. These weaknesses included the organization of the care (too many actors and not enough coordination), the fact that there was too much staff turnover, and shortcomings with respect to the training, the medical skills, and the working environment of the staff within the elder care system. Moreover, when evaluating the specific responses within the elder care during the pandemic, the Commission's conclusion (2020) was that they were often late and insufficient. An international comparison showed that the Swedish response was slower than in the neighbouring Nordic countries. According to this report, these delays may have contributed to the high Swedish death toll in Swedish nursing homes (Szebehely 2020).

⁶⁰ <https://www.ivo.se/tillsyn/tillsyn-aldreomsorgen-covid-pandemin/>

⁶¹ Kommittédirektiv, dir. 2020:74, "Utvärdering av åtgärderna för att hantera utbrottet av det virus som

orsakar sjukdomen covid-19", 2020. See also: <https://www.regeringen.se/pressmeddelanden/2020/07/coronakommissionens-ledamoter-utsedda/>.

Conclusions

The Swedish approach to COVID-19 differed from that of most other comparable democracies in Western Europe. Rather than putting in place coercive policies that would have restricted the freedom of movement or the freedom of assembly, closing schools, or requiring mask-wearing, the Swedish government and Swedish public authorities chose to issue voluntary recommendations that were meant to limit the spread of the virus by persuading citizens to reduce their social interactions and to protect themselves and others from the new disease.

This was not nothing. The general public did change its behavior during the COVID-19 epidemic. Nevertheless, there is now broad agreement within Sweden that the high death rates, especially among older Swedes, represent a failure of the Swedish political system. But there is less agreement on what explains this failure. According to one view -- which is held, for instance, by the prime minister, Stefan Löfven -- the main failure isn't that there was anything wrong with the overall strategy; the main failure is that the strategy would have required more effective testing in the first stage of the pandemic and more effective protections for the vulnerable old-age population, especially those living in care homes.⁶² According to a different view, the overall strategy itself, not failures of implementation, was the problem. In this view, Sweden should have put in place stronger restrictions from the start -- restrictions similar to those that were adopted in neighboring countries such as Denmark and Norway. Public-health experts and medical experts remain divided. So do the political parties: the more conservative parties in the Swedish parliament have favored more restrictive policies; the governing center-left parties and the centrist opposition parties have been less critical of the approach that Sweden took in 2020.

The main goal of this working paper has been to discuss some of the potential explanations for Sweden's distinctive policy choices in the COVID-19 pandemic that have been suggested in the scholarly literature and in political commentary in Sweden and abroad. We have found little support for some of the explanations that have been suggested, especially the idea that the Swedish government and the Swedish public-health authorities were prevented from responding more aggressively to the COVID-19 crisis because they were bound by prior legislation or by the Swedish constitution. Our view is that the government and the parliament could have put new policies in place if they had wanted to: Sweden's approach was a political choice, not a legal or constitutional necessity. But there are other political explanations that we have not

⁶² In a recent interview, Prime Minister Löfven identified those as the two main failures of the Swedish policy response to COVID-19; see <https://www.dn.se/sverige/stefan-lofven-testningen-borde-ha-kommit-igang-tidigare/>.

been able to dismiss. We would especially like to mention three interrelated factors that we believe played an important role. The first is that Swedish contingency planning for a new global infectious disease, such as COVID-19, placed little emphasis on lockdowns, school closures, or other coercive “non-medical” measures, since the responsible authorities believed that the social costs of such an approach were likely to exceed the health benefits. The second factor is that Swedish governments typically defer to the expertise of public administrative agencies, as long as those agencies act within their remit, as defined by legislation and the government’s general instructions to the bureaucracy. The third factor concerns implementation failures at the regional level (testing) and the municipal level (elder care), which, if they had been anticipated beforehand, might have caused the public-health authorities and the government to reconsider their voluntarist approach, since that approach depended on the availability of information that would have allowed citizens to make informed decisions (testing) and on special protections for particularly vulnerable groups (elder care). Sweden has often been well-served by its centuries-old administrative structures, which afford public agencies a great deal of autonomy, but when it comes to the COVID-19 crisis, one wonders if elected officials, with their broader political experience, would perhaps have been better able than public-health experts to predict the difficulty of implementing the regional- and local level public-health policies that were necessary to make Sweden’s ambitious national strategy work.

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Appendix: Figures

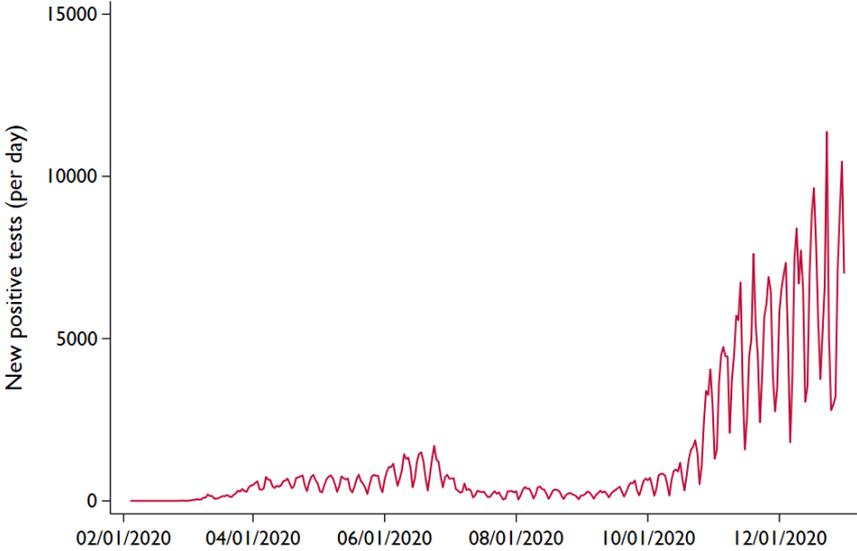


Figure 1. New COVID-19 cases reported to the authorities (per day). Note that the figure does not accurately describe the actual number of infected since the rate of testing has changed greatly over the period examined. Source: Folkhälsomyndigheten (accessed 26 January 2021)

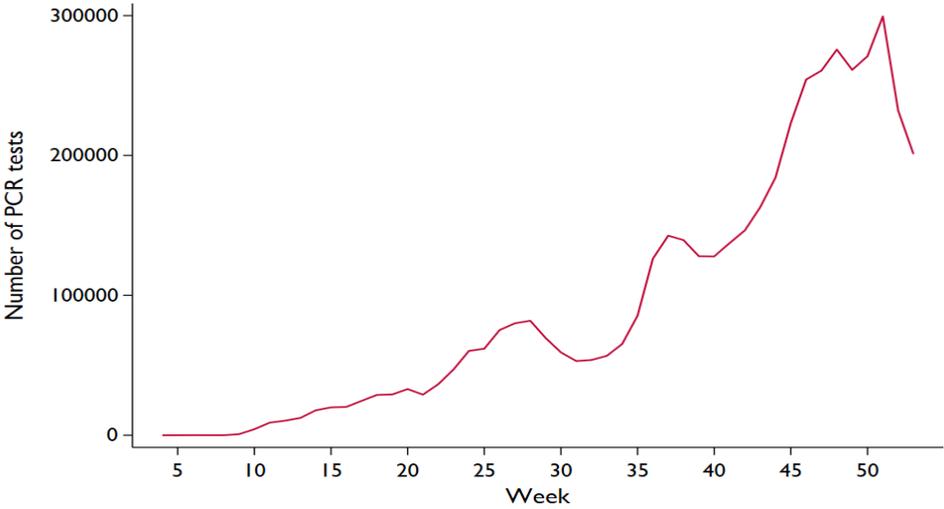


Figure 2. COVID-19 tests per week, January to December 2020. The data are incomplete since not all laboratories report figures to the Public Health Agency of Sweden, Folkhälsomyndigheten. Source: Folkhälsomyndigheten (e-mail message 11 January 2021)

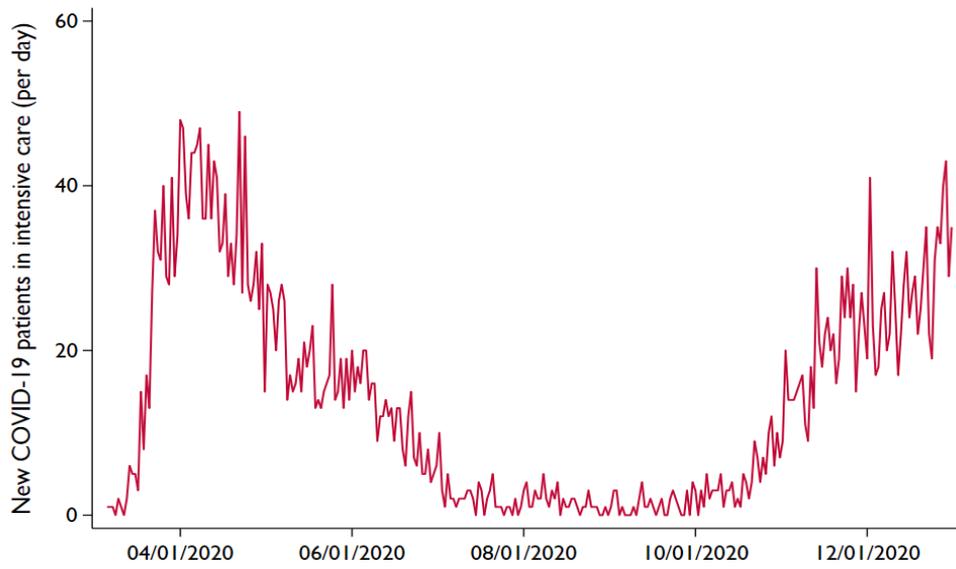


Figure 3. New patients with COVID-19 in intensive care (per day). Source: Folkhälsomyndigheten (accessed 26 January 2021)

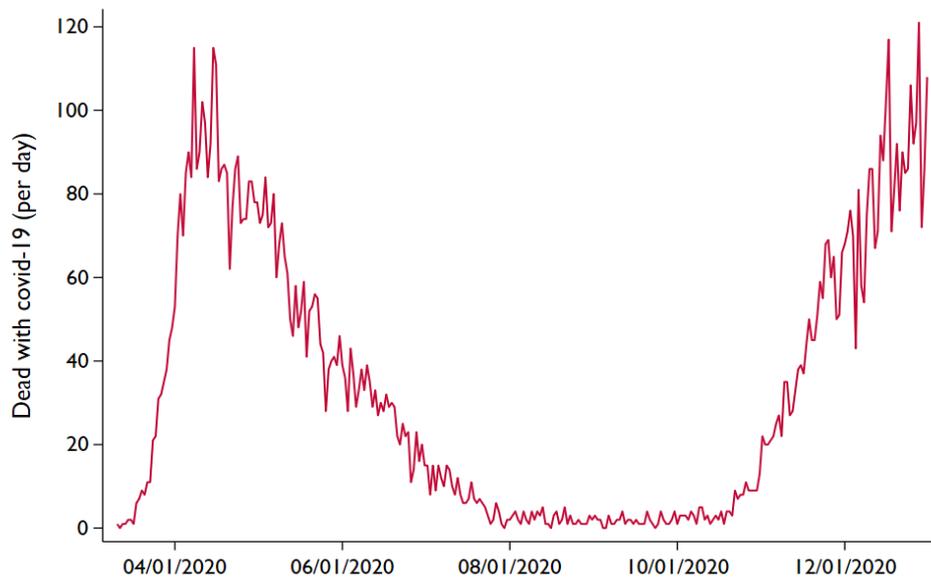


Figure 4. Dead with COVID-19 (per day). Source: Folkhälsomyndigheten (accessed 26 January 2021)