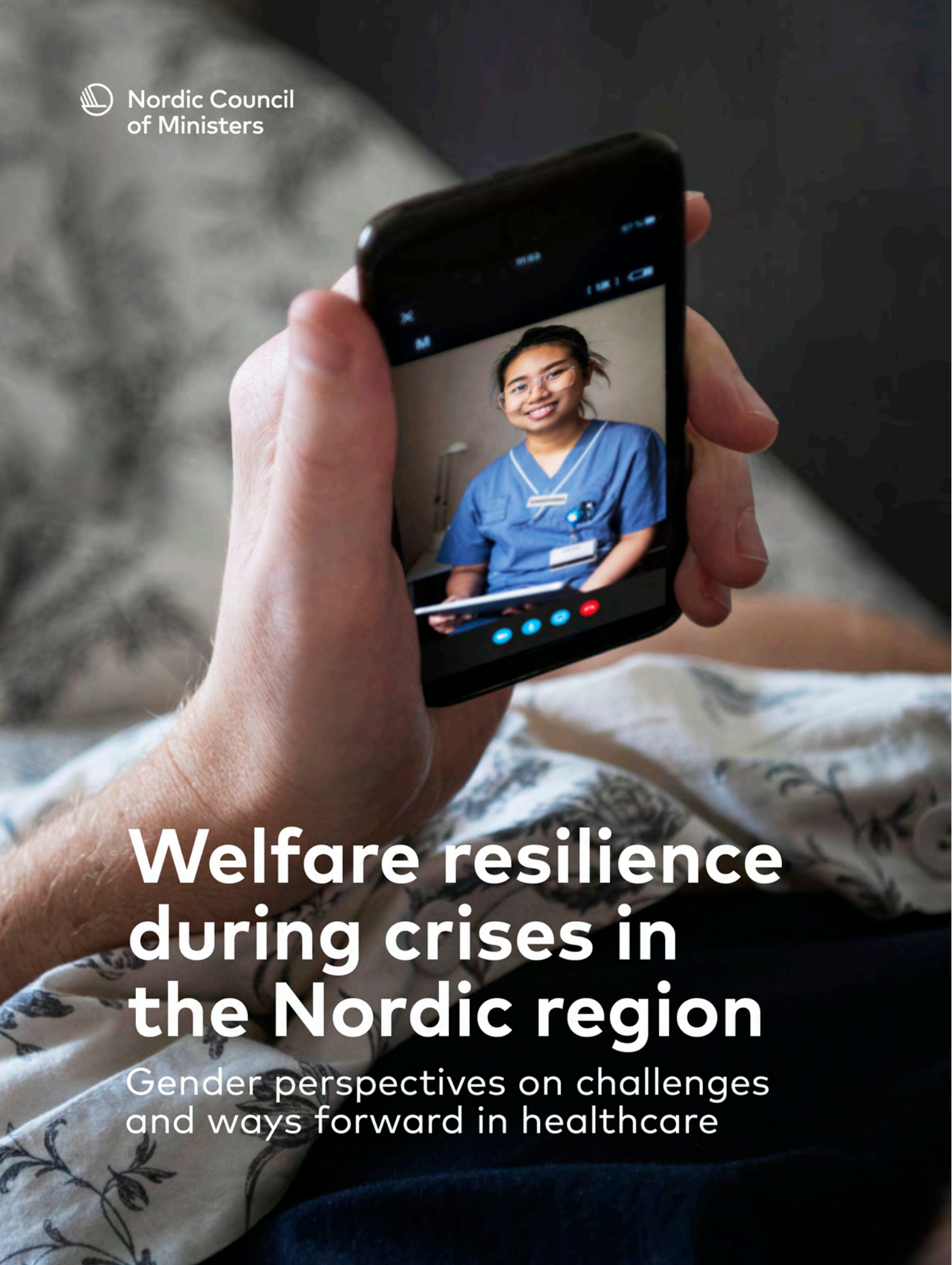
Nordic Council of Ministers



Welfare resilience during crises in the Nordic region

Gender perspectives on challenges and ways forward in healthcare

Content

This publication is also available online in a web-accessible version at:
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About the publication

How can we strengthen crisis preparedness and welfare resilience in the Nordic region with a focus on healthcare? How can we better understand and analyse challenges and opportunities to make better decisions? The financial crisis, pandemic, war and environmental and climate threats of recent years show that the global risk landscape is evolving rapidly and that the threats to our societies are becoming increasingly interconnected and complex.

Experiences from the COVID-19 pandemic show that crisis preparedness and resilience within welfare are crucial, both for good and equal health outcomes and for the functioning of society in general. At the same time, the challenges facing the welfare state are considerable. The need for welfare services, particularly in healthcare, is increasing at a rate that means there are not enough workers to meet demand. The demographic challenges of increasing life expectancy and an ageing population are evident throughout the Nordic region.

Availability of skilled labour is therefore one of the biggest challenges facing the welfare state. Increased recruitment is needed, but so are better conditions to ensure that those already working in healthcare remain in their jobs. Issues related to the organisation, management and coordination of the welfare state are key, as the supply of skilled labour involves many different actors across a number of levels (Vold Hansen, Bjørkquist & Jerndahl Fineide, 2023).

Both the problem statement and analysis need to include a gender perspective. Otherwise, we risk missing important pieces of the puzzle in building future welfare resilience. Many professions in the healthcare sector are female dominated and specialisations are gender divided. Salaries are generally low compared to male-dominated professions with similar educational and skill requirements. In addition, perceptions of both needs and skills within the sector are strongly gendered, further reinforcing the gender-segregated labour market. The healthcare provided is also unequal. There are significant regional variations in access to healthcare and differences in how women's and men's healthcare needs are met. In the long run, this risks exacerbating vulnerabilities in healthcare during future crises.

Lessons learned from the COVID-19 pandemic show that crisis management went hand in hand with the development of knowledge. At the same time, it became clear that applying past lessons to new crisis situations is challenging. The Nordic Council of Ministers has therefore taken the initiative to produce this publication, developed by NIKK, Nordic Information on Gender, based at the Swedish Secretariat for Gender Research, University of Gothenburg. In the publication,

researchers in global public health, economic history, demography, sociology and social work contribute reflections and problematisations in four essays. Based on their research findings, they open up new perspectives, questions and possible solutions for future crises. The other texts in the publication are written by Angelica Simonsson, a researcher in education and analyst at the Swedish Secretariat for Gender Research. The report was originally written in Swedish and subsequently translated into English.

Method

The starting point for this publication is to reflect on welfare resilience from the perspective of healthcare in future crises grounded in research-based knowledge from a gender perspective. Applying a gender perspective serves to complement an otherwise incomplete analysis, supplementing it with patterns, conditions and needs that would be missed in the absence of such a perspective. It offers a way to compensate for and counteract gaps and shortcomings that would otherwise result in inadequacies, inefficiencies and potentially weaker resilience.

At the same time, this is a vast field that encompasses an incalculable number of approaches, subjects of study and perspectives. This publication does not claim to cover the entire potential field. Instead, the aim is to bring perspectives on gender and resilience closer together and to include some concrete examples. Bringing together texts by several researchers is an attempt to frame the issue of welfare resilience in a new way and to stimulate discussion between fields and perspectives that would otherwise not meet. The aim is to encourage practice, policy and research to explore further questions at the intersection of gender and resilience with regard to welfare.

Application procedure and assignment

How did this publication come to be? Why was it written by these particular researchers and why did they write it in essay form?

In the spring of 2024, NIKK issued an open call for doctoral students and postdoctoral researchers, who were encouraged to write an essay based on their previous research. The purpose of the publication: to contribute to increased knowledge to better understand and analyse the challenges and thereby provide a better foundation from which to make decisions that strengthen crisis preparedness and increase welfare resilience in the Nordic region. The call for papers was widely promoted by NIKK. Targeted mailings were also sent to specific research environments and individual researchers identified as relevant to the subject. The purpose of this broad call was to encourage interest among researchers across different fields, partly to gather different, new and urgent perspectives and partly to bring these into dialogue with each other.

The application was limited to the overall theme of future crisis scenarios, and the assignment was for texts to be exploratory in nature but grounded in research-based knowledge (essay form). Three starting points provided a common framework:

1. resilience and preparedness for future crises
2. within the Nordic region
3. from a gender perspective

These three starting points were deliberately formulated in broad terms to accommodate a variety of approaches and interpretations. Furthermore, proposed texts were expected to contribute new and relevant perspectives within at least one of three themes:

1. the organisation and management of healthcare
2. the professions, occupations and supply of skills within healthcare
3. the working environment and working conditions within healthcare

The six researchers, represented by four texts in this publication, were selected through a competitive process. Their essay proposals were deemed to raise new and pressing questions grounded in research-based knowledge. Angelica Simonsson, Fredrik Bondestam and Ulrika Jansson, all from the Swedish Secretariat for Gender Research, served as editors for the contributions.

Disposition

The introduction to the publication outlines the concepts of resilience, gender and healthcare, as well as how they can be understood together. Particular focus is placed on how resilience and gender perspectives can be understood in the context of healthcare.

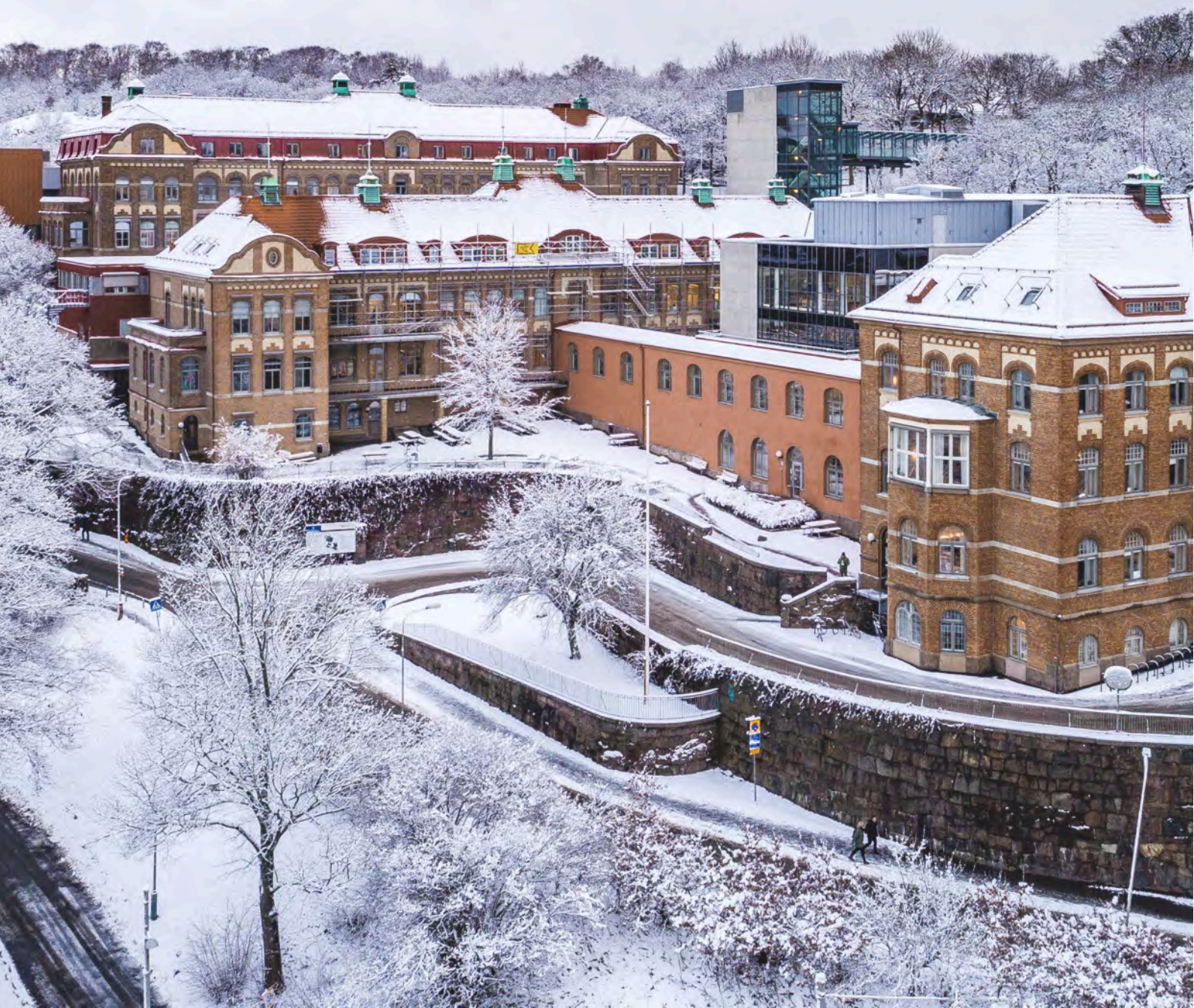
This is followed by a description of the essay as a text form and a brief summary of each of the four essays.

The publication's four main texts are then presented, written by six researchers in the fields of global public health, economic history, demography, sociology and social work.

The conclusion summarises the researchers' main points. Key messages and perspectives to be included in future discussions are highlighted to contribute to a deeper understanding of welfare resilience in future crises in the Nordic region.

Introduction by

Angelica Simonsson



Introduction: Resilience, gender and healthcare in the Nordic region

Angelica Simonsson

Why a gender perspective on resilience and healthcare?

The Nordic welfare states have long been seen as role models in combining equality, accessibility and high quality of life. However, the COVID-19 pandemic and other societal crises have exposed several vulnerabilities in terms of resilience in healthcare, particularly in relation to gender structures and gender equality. To ensure that the welfare system remains sustainable and inclusive even under pressure, a clearer understanding of the gendered dimensions of resilience is needed. But how are crisis, resilience and gender connected?

To start, we discuss how previous experiences and collective understandings shape our interpretations of what constitutes danger and crisis. Predicting the future and possible dangers and sources of recovery tends to be based on our experiences and images of what has come before. Contemporary interpretations of what constitutes danger or a crisis are largely based on previous experiences and shared understandings.

Our understanding of what constitutes a crisis seems to require a kind of dramaturgy. A crisis is something out of the ordinary, and as such we imagine it beginning somewhere, building to a crescendo and then ending. The crisis has a before and an after. Those who address the dangers of the crisis and counteract the misery it inflicts act within a specific time frame. These heroic practices are often identified as extraordinary and necessary. They are lifted out of the everyday, made visible as something fantastic, good and decisive. However, there are often other people involved whose achievements are taken for granted and overshadowed.

During the COVID-19 pandemic, heroes and their heroic deeds were seen in different attire than we had previously been accustomed to. The white, blue and green uniforms of nursing assistants and nurses suddenly took on a different meaning in the collective understanding of danger and rescue. This was attire that kept the coronavirus and dangerous disease at bay. Medical scrubs, plastic visors and face masks became symbols of resilience, and those who wore them daily were seen as tirelessly performing heroic deeds. In the UK, healthcare workers were

applauded daily as they left their homes to go out into what was presented as a battle. In the Nordic countries, the applause did not take hold in the same way, but for a period of time, food boxes were distributed to healthcare workers, and the overwhelming consensus among the public was that these healthcare workers were performing heroic deeds and fighting for us all. For a period, the collective understanding of the female-dominated healthcare and social care sector was transformed. Here was a battle, and here were heroes fighting it – for a time. Then the vaccine entered the scene, and the scientists who developed it gradually took over the status of heroes. The work on the healthcare floor continued but the food boxes became more infrequent. The crisis was considered over.

But it was not only applause that accompanied the working lives of nursing assistants, nurses and care assistants during the COVID-19 pandemic. Those working on the frontline also had to endure heavy criticism, not least from relatives of those affected by the disease and for circumstances that the nurses and care assistants themselves were often more than dissatisfied with but had no mandate to change. On the frontline, they found themselves caught between bureaucracy and budgets on the one hand and ethical conduct, stress and compassion on the other.

Based on this retrospective view of the COVID-19 crisis, we can see how reflections on resilience with respect to future crises are based on the intersection of our understandings of time, crisis, gender and work. This requires us to dig into, examine and challenge our ideas about what a crisis is, what the function and value of welfare is and how the future can ever be (pre)reflected. It also requires us to examine and challenge how images of femininity and masculinity shape our understanding of women and men as groups and how this impacts our expectations of the work they do and how we value it. In other words, we could say that a lack of imagination about the heroic deeds that will save us and keep society together and functioning in future crises risks rendering dangerously incomplete images of what future resilience is and should be.

Ideas about welfare and resilience

The perception of welfare resilience is closely linked to perceptions of what welfare is and can be. It is therefore relevant to ask whether there is an ambiguity in traditional but nevertheless prevailing perceptions of welfare and resilience. What characterises understandings of welfare and what characterises understandings of resilience? Who are the people who work in the welfare sector and what are the needs to which work within the welfare sector must respond?

As a work environment, healthcare within the welfare sector is strongly female dominated. The work itself, providing healthcare and social care, is often gender coded as feminine, or at least not masculine. A traditional view, and one that still prevails in contemporary society, is one that sees the need for care, i.e. needing help

and social support to cope, as a sign of weakness; it is therefore also often gender coded as feminine, or at least not masculine. This is despite the fact that both men and women need healthcare and social care during their lifetimes.

So, what is resilience? What do we perceive as resilience and resilient systems? The concept and its meaning are multifaceted and will be discussed in more detail later. For now, however, we can focus on its connotations of resistance and robustness. There is seemingly an implication that resistance requires power and strength. In our prevailing, traditional, understandings of femininity and masculinity, these characteristics are typically associated with masculinity.

How can a sector characterised by a strongly female-dominated workforce that identifies and meets feminine-coded needs be understood as strong, robust, durable and resilient? This may require some reflection, challenging our own understanding of gender and how different actions are often linked to perceptions of gender. Welfare resilience, in terms of healthcare, is not just about technology, resources or organisation but also, to a large extent, about relationships, justice and representation. Raising awareness of the relationship between gender and resilience is therefore not a side task but a key to sustainable resilience in healthcare in Nordic welfare states during future crises.

Welfare and healthcare systems in the Nordic countries

While the welfare models and healthcare systems of the Nordic countries are similar, they have certain differences. These short sections do not claim to summarise or cover the nuances of these systems or the systems in their entirety. They are intended to provide sufficient context for the essays in the publication and the overarching issues of gender and resilience.

Nordic welfare models

There is no single accepted definition of the 'Nordic welfare model' (Kvist et al., 2012). However, some common features and differences can be described. In general, it can be said that the Nordic concept of welfare is broad and encompasses both material and immaterial resources, with collective resources being seen as important in many phases of life (Kvist et al., 2012). Esping-Andersen (1990) categorises the Nordic models as social democratic, comparing them with more liberal or conservative models. The Nordic welfare states do not focus solely on remedying problems when they arise but rather trying to prevent them from arising in the first place. This can be done, for example, by striving to change structural income differences and reduce social inequalities in terms of people's opportunities to work and start a family (Kvist et al., 2012). While the Nordic welfare states are built on these fundamental principles, ideas and approaches associated with market liberalism are now prevalent in these societies. The

common features of the models include: universal benefits that guarantee basic welfare services to everyone regardless of income; high public expenditure financed through taxes; a strong public sector that provides healthcare, education and social care; and comprehensive social insurance with a focus on, for example, unemployment benefits, pensions, sickness and parental insurance. Differences between the Nordic models include the degree of decentralisation, the level of participation and organisation of private providers within welfare services, the approaches taken to participation and security in the labour market and the extent of gender equality policy measures.

Perspectives on Nordic welfare models

Universal access to welfare services has contributed to a high degree of equality in the Nordic countries (Kvist et al., 2012). When describing the Nordic character, however, it is important not to oversimplify it as what is sometimes referred to as 'Nordic exceptionalism' (Keskinen et al., 2021). This exceptionalism has slightly different meanings across different academic disciplines. In general, the concept describes a tendency to emphasise the Nordic character as particularly fair, equal or equitable, while descriptions of, for example, the colonial history of the Nordic countries or persisting inequalities are not mentioned, or at least conveniently sidelined (for further reading, see, for example, Keskinen et al., 2021; Angell & Larsen, 2022; Larsen et al., 2021b).

The cornerstones, aims, systems and organisation of the Nordic welfare states have been examined and criticised in terms of how they work in practice, what their effects are and have been, and how notions of the Nordic welfare state models have been oversimplified. This has been approached from various perspectives and with a focus on different elements of both the welfare state models and their healthcare systems. For example, gender equality indices often show that the Nordic countries are among the most gender equal in the world, but these indices are often simplistic and thus risk contributing to a skewed, or at least reductive, picture of gender equality in the Nordic region (Kirkebø et al., 2021). Von Saenger (2025), for example, argues that current social developments are challenging the Swedish welfare model.

Despite a strong welfare state, cracks are clearly visible in elder care, with inequalities between women and men and linked to socio-economic status (von Saenger et al., 2023). Von Saenger et al. (2023) show that working-class daughters care for their parents to a greater extent than others. This informal side of the welfare state, in which responsibility is unevenly distributed across the population, needs to be studied and problematised beyond simplistic indices. To understand the effects of welfare state models and systems, the complexity of people's living conditions needs to be taken into account. For example, health inequality does not appear to be any less prevalent in the Nordic countries than in other Western European countries, which is highlighted as paradoxical given these countries'

redistributive social policies (Dalh & van der Wel, 2015). To study and ultimately address this, it is important to tackle inequality itself, rather than primarily problematising health aspects (Douglas, 2015). Douglas (2015) argues that we must go beyond *health* and asks rhetorically why we do not address the root cause of health inequality, namely *inequality* in society.

Nordic healthcare systems

In a report, Schmidt et al. (2022) provide an overview of the Nordic medical care and nursing systems. Below, outlines are presented for each of the five Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, based mainly on this report.

The Nordic healthcare systems are all largely publicly funded. Overall, these countries' healthcare systems are regulated by a healthcare act, as well as other laws governing social care, social services and patient safety. Denmark, Finland, Norway and Sweden have three administrative levels, while Iceland has two. The systems are generally described as having a relatively high degree of decentralisation, with the exception of Norway, which is described as semi-centralised.

In Denmark, supervision is conducted at the national level, while specialist and psychiatric care is organised at the regional level and medical care and nursing care services at the municipal level. Challenges in the Danish system are described as including difficulties in coordinating primary care, social services and specialist care.

In Finland, legislation, regulation and licensing is a responsibility at the national as well as regional level, while care, health and medical services have been provided by 21 so-called welfare areas since 2023. Challenges in the Finnish system are described as relating to coordination and equality, which it is hoped will be addressed by the relatively recent structural reform.

In Norway, legislation and budget allocation are managed at the national level, while at the regional level there are specific authorities responsible for specialist care. At the municipal level, primary care is provided by general practitioners who operate their own practices. Challenges in the Norwegian system are described as including cooperation between the municipal and regional levels.

In Iceland, healthcare is organised and planned at the regional level, while healthcare services are provided at the local level. Challenges in the Icelandic system are described as including fragmentation and challenges in primary care.

In Sweden, legislation and the distribution of state subsidies is managed at the national level, while the regional level provides specialist care, psychiatric services and primary care. Social care and social services are a local responsibility.

Challenges in the Swedish system are described as including weak primary care and few permanent care contacts. In recent years, various initiatives and reforms initiated at the national level have attempted to strengthen local healthcare but with limited results so far.

The focus of the report (Schmidt et al., 2022) is on the Nordic countries' work towards more integrated healthcare and social care, which is why this perspective is particularly emphasised. However, it is striking that all five countries are described as having common challenges in terms of (1) coordination when responsibilities are transferred, i.e. when a patient moves between different administrative levels, (2) the scale and coordination of primary care and (3) demographic developments, with an ageing population and a declining younger population.

A quick overview such as this makes it clear that the healthcare systems of the Nordic countries function differently in terms of governance, organisation and responsibility. From a common starting point of the fundamental principle of universal welfare, different healthcare systems have been developed. They differ in terms of both levels and how responsibility and mandates are assigned within and between these levels. In other words, the systems have fairly similar goals, but how they are administered differs. This also results in different conditions in terms of how the systems act and respond in crises. Vold Hansen et al. (2023), for example, highlight the scope for flexibility and standardisation based on the different conditions that exist in Norway and Sweden as a key aspect with regard to the central control and coordination of their healthcare systems. According to Vold Hansen et al. (2023), this may have affected the impact of the COVID-19 pandemic in both countries. In other words, the framework for the Nordic welfare states and the healthcare systems it encompasses manifest both differences and similarities with regard to the conditions for dealing with future crises. This brings us to the topic of resilience in welfare, which is discussed in the next section.

What is resilience?

Resilience is a multifaceted concept that is used in many different contexts, but broadly speaking it can be described as the ability to withstand, adapt to and recover from stress or crises. One way of expressing it is in terms of the capacity to cope with pressure by adapting to something new, or the ability of a system to return to 'normal' after an unforeseen event (Wiig et al., 2020). Another way of understanding resilience is to say that it is a system's ability to both cope with change and continue to develop (Stockholm Resilience Centre, n.d.). Systems are understood here in a broad and unspecified sense, and can be anything from an individual to a forest or an economy. Fundamental to all these general descriptions of resilience is that systems exposed to disruption also have the basis for renewal.

The concept attempts to capture the ability to manage and harness change within a given system.

Resilience in different areas of society

Resilience is a concept that is used and discussed in several different areas of society and is therefore ambiguous: depending on the area being discussed, the concept has slightly different meanings.

Within the broad field of the environment, for example, one focus of discussions is the ability of different ecosystems to withstand and recover from events such as fires or storms. In social planning, it is on society's ability to withstand, adapt to and recover from events such as flooding in cities through specific urban planning. In the field of technology, it is how different IT systems can withstand cyberattacks. In economic terms, it is the ability of markets to withstand and recover from events such as a financial crisis. In psychology, it is individuals' ability to withstand and recover from various types of stress and trauma, such as divorce. The examples go on.

Even within the same field, the concept can have several meanings depending on the level of the system in question: are we referring to resilience at the global, national, regional, local or individual level? There is also a built-in time dimension that affects the type of resilience in question: are we referring to resilience before, during or after a change or shock (Ignatowicz, 2023)? Or are we referring to this time span as a whole? As mentioned, understandings of crises have a certain dramaturgy.

Valuation of time and workload

However, a common interpretation is that resilience is seen as a kind of multidimensional process that refers to the ability of a system to respond to limited periods of time characterised by greater challenges, shocks or stress than usual. This therefore requires an assessment of both time (what constitutes a limited period of time?) and load (what constitutes a 'normal' and 'abnormal' load?) in the system. As can be seen, there is room for different interpretations and perspectives of the concept.

In the case of a discussion on resilience in healthcare, the question of how and when consensus and understanding is considered to have been reached with regard to aspects of time and other valuations must also be raised. Determining what constitutes resilience within a given system can be seen as an exercise of power: a certain period of time and level of stress might be considered extraordinary, while another period of time and level of stress will be considered normal. Who has the prerogative of interpretation in these considerations and what are the consequences?

Resilience as a perspective on healthcare

Instead of talking about what resilience *is*, that resilience covers a certain area or represents a certain type of security system or adaptability within the framework of an ecosystem, a healthcare system or a city, we can look at resilience as a *perspective*. Like other perspectives, such as the gender perspective, it is based on a set of reference points that different actors include in an analysis. For example, a *gender perspective* on healthcare can shed light on how care is organised, provided and allocated between and within women and men as groups, and how this appears to happen in different ways and to a certain extent based on different premises. Similarly, a *resilience perspective* on healthcare systems can highlight the ability or inability of different parts of a system to withstand stress, flex, adapt, learn and develop. Asking the question 'What is resilience in healthcare?' can therefore be somewhat misleading. Depending on the perspective applied, different parts of healthcare systems will appear to be more or less salient to investigate and discuss. Are we thinking primarily from the perspective of the care recipient or the care provider? Do we mean local, regional, national, Nordic or international healthcare? Do we weave in factors such as age, functional variation, ethnicity, migration background and level of education?

Discussing resilience as a perspective on healthcare thus opens up new questions and allows us to shine a light on the systems in partly new ways. It also places demands on the analyses that are carried out: it is not a matter of identifying and defining specific conditions ('*this* is resilience in healthcare!') that can then be handed over to politics and practice to map out and manage. Instead, it is about problematising an empirical area with the help of analytical concepts to gain insight into things that may previously have been hidden or taken for granted or whose meaning may previously have been understood differently. Applying resilience as a perspective, it is thus possible to make practice and empirical data appear in slightly new ways. A resilience perspective therefore has the potential to offer a special lens through which to view healthcare, revealing certain practices, circumstances or functions in a different light.

Different levels and actors

The particular perspective on resilience that is taken informs the different levels, actors and strategies in focus. This could be at the system level, where the focus may be on flexibility and surplus capacity to quickly reallocate resources. It could be at the individual level, where the psychological and physical capacity of healthcare personnel has consequences for the overall capacity of the system, including working conditions, working environment, family relationships and more. It could involve secure technology and digital capabilities, the supply of resources such as

medicines and medical equipment, the organisation's capacity for learning, the ability to collaborate between different actors or the ability to achieve a more equal distribution in terms of the administration of care needs and provision. The list could go on and on.

Resilience in healthcare research

In healthcare research, resilience is often highlighted as an important component in ensuring that healthcare systems can meet challenges and continue to deliver high-quality healthcare (Wiig et al., 2020). Research also focuses on defining what resilience is and how it can be measured (Ignatowiczs, 2023). Here, resilience refers to the ability to develop the quality of systems such that they can be maintained and developed as they are affected by periods of high stress or unforeseen shocks. Al Asfoor et al. (2024) highlight, among other things, available resources, networks and the working environment of staff as key prerequisites for resilience in medical care and systems. However, it is not just a matter of preventing, withstanding or adapting during times of additional stress. When resilience is discussed in health-care research, a broad perspective is often taken that includes how the healthcare chain as a whole and its individual parts respond to variations, not solely from a preventive perspective. The discussion also focuses on learning and improving, based on what has been successful and what has gone wrong (Hedqvist et al., 2024).

Research shows that resilience in medical care systems needs to be based on patient needs (Behrens et al., 2022). Research on resilience often focuses on the quality of healthcare and how it is linked to patient safety. How healthcare needs are met thus becomes a factor for consideration with regard to maintaining and optimising quality in the system. However, it should be emphasised that there is considerable uncertainty even within research about what resilience in healthcare systems means (Ignatowicz, 2023). As a field, research on resilience in healthcare has been identified as fragmented and in need of greater clarity (Agostini et al., 2023).

Another example of discussions of resilience in healthcare is the OECD (2023) report on how we can prepare for the next crisis by investing in resilience in the healthcare system. According to the OECD (2023), the COVID-19 pandemic showed that healthcare systems are not resilient to shocks, with consequences for the global economy and cohesion. The report understands resilience as important for managing shocks. The meaning of resilience here is based on an understanding of crises as unforeseen, extensive and time limited. The report presents some areas within healthcare systems as particularly vulnerable, which has negative consequences for resilience. Among other things, it emphasises that inequalities left the systems unprepared and that the systems were understaffed and underfunded before the crisis.

Gender and resilience perspectives on healthcare

When a resilience perspective is crossed with a gender perspective on healthcare, an additional layer is added to the analysis. This, in turn, has consequences for practice, policy and research. More perspectives provide an opportunity to identify and highlight more strengths but also, above all, imbalances and weaknesses in the Nordic healthcare systems of. This highlights the consequences of the systems for citizens, both those in need of care and those who provide care. In the results of the OECD (2023) report, for example, it becomes clear that equality perspectives need to be considered to provide a more complete analysis of strengthened resilience in the future.

Social dimensions

A resilience perspective combined with a gender perspective has the potential to highlight and problematise the social dimensions of healthcare systems and their function in society. These dimensions broadly concern the different consequences of the systems for different citizens in need of care, different citizens who provide care and the society that hosts the systems. From these perspectives, a system that is fair, inclusive and gender equal can be seen as being more resilient in terms of consequences for care recipients, care providers and the society and population that relies on the system to deliver healthcare and nursing.

The OECD (2023) is not alone in highlighting social dimensions in analyses of the resilience of healthcare systems. Previous research has highlighted that a resilience perspective can reveal that conditions such as limited access to resources and a lack of employees can be self-perpetuating factors in the systems (Wiig et al., 2020). Vold Hansen et al. (2023) argue that 'organisational slack' is needed, with room for sufficient organisational flexibility at various levels, for coordination to be efficient during crises. Factors such as working conditions and working environments, and how they function and structure conditions, then become further factors to consider with the aim of understanding how the quality of systems can be maintained and optimised under additional pressure and stress and in the event of unforeseen events. Working conditions, working environments, the relationship between work, family and leisure time for those working in the sector and so on, thus become necessary parts of analyses that seek to identify something about resilience in healthcare systems. Who are the people working in healthcare systems? How do their working conditions structure possibilities for a sustainable healthcare system? How does work within the systems structure the possibilities for a liveable life for those who sustain them?

Intersectional perspectives on vulnerability in crises

Research highlights the importance of starting from patients' needs in understanding resilience in medical care (Behrens, 2022). Patients are a heterogeneous group, and previous research has clearly shown that crises such as pandemics and wars tend to affect groups of individuals to different degrees and in different ways. How severely and in what ways someone is affected can be linked to factors such as socioeconomic status or position, ethnicity, disability, gender and more (Chisty et al., 2021; Siller et al., 2022; Vedadhir et al., 2023). In other words, vulnerability and the need for care are not evenly distributed across the population but rather can be clearly linked to different power structures such as gender, ethnicity, disability and education level.

To obtain as complete a picture of the problem as possible, it is therefore necessary to take an intersectional perspective on resilience in healthcare. This provides a more comprehensive picture of what the needs will look like and, above all, an opportunity to address these needs ahead of time by confronting the fundamental problem of inequality. To understand health inequalities, Hill (2015) argues that an analysis needs to take into account social structures (such as the labour market and education system), social positions (such as gender, ethnicity and sexuality) and mediating factors (such as behaviour and environment). This reflects the shift in thinking that has been called for in research, and as mentioned in an earlier section: to focus more clearly on the fact that inequality in itself is a health factor (Douglas, 2015).

To take this reasoning further, from a resilience perspective on healthcare in the Nordic region, it is necessary to try to identify and address, for example, structural and social factors that construct and perpetuate inequality in society. If the resilience of welfare is to be strengthened, it seems that inequality in society also needs to be reduced.

In the second part of the publication, we see how Mulinari problematises gender, class and liveable lives through an analysis of the temporal aspects of working conditions in medical care. It becomes clear that an analysis of the sustainability of the medical care system needs to take into account the temporal aspects of work based on how they structure and shape the living and working conditions of workers. Lapidus' text provides a problematisation of class, gender and age in health insurance systems. The text emphasises the importance of examining the complexity of how unequal access to healthcare affects not only individuals but also trust in the welfare society as a whole. Liljas and Burström problematise age and gender in analyses of healthcare and social care systems for older adults and conclude that greater resources need to be made available for the care of older adults. In their text, Duvander and Lundgren highlight the importance of challenging and problematising outdated gender perceptions of family and working life in planning for a heightened state of alert.

Resilience and gender perspectives on time and the future

Another dimension of resilience and gender perspectives on healthcare is the time frame being discussed with regard to future resilience. In the simplest terms, and as Solli (2023, p. 185) writes in his reflections on the welfare state, 'When is the future?'? What happens to our understanding of resilience if we consider the current situation in parts of the healthcare system to already be one of crisis? What happens if we shift both our perception of crises and future time frames to include contemporary conditions so as to problematise the impact on unforeseen future crises from that perspective? If we are already in a crisis, does that shift our understanding of what is needed to strengthen resilience in the future? If we are already in a crisis, does that shift our understanding of the sustainability of the work being done in healthcare today?

Time is a necessary analytical dimension and direction for knowledge generation when reflecting on future resilience. A gender and resilience perspective can problematise our understanding of a crisis and its dramaturgy by challenging our understanding of the future/time in question. One way to discuss resilience in the future is to place concern and time at the centre of our thinking. By using contemporary concern as a method, we can make a contemporary risk assessment and thus try to better prepare for future crises.

Crises seem to imply a certain time span, which in turn can be seen as linked to notions of sex and gender in its various stages. The causes of crises and their immediate management tend to be masculine coded (Hobbins et al., 2020). *How* we understand crisis and risk, and *what* we understand as crisis and risk, is therefore not free from gender perceptions (Hobbins et al., 2020). This has consequences for our understanding of *when* (in time) a crisis is upon us. What type of risk or threat is understood or 'qualifies' as right or sufficient to be defined as a crisis, and by whom? Gender and resilience perspectives on healthcare can thus challenge our understanding of *when* a crisis is present, thereby helping us to develop sustainable systems, both now and in the future. Interpretations of what is considered a risk and what is considered a vulnerability in society is influenced by norms of masculinity and femininity (Ericson, 2020).

Vold Hansen et al. (2023), for example, argue that the COVID-19 pandemic affected more and more areas as the crisis was redefined. They describe how what was initially limited to a health crisis gradually expanded into a social crisis (Vold Hansen et al., 2023). Understanding the problem provides a certain definition, which in turn defines the needs present and response required. In this way, the understanding and definition we apply will delimit the governance (laws and regulations) and administrative organisation for control and management that is implemented or engaged. It also has consequences for society's picture of who is considered to be

affected. A health crisis may be limited primarily to those who are perceived as working in or in need of medical care, whereas a social crisis is much more widespread.

Another example is provided by Ericson et al. (2024), who argue that both crisis preparedness and crisis management are gendered. Applying a gender perspective to the management of forest fires, among other things, Ericson et al. (2024) show how different crisis-related situations receive or do not receive public recognition. Masculine-coded practices, such as being on the frontline of firefighting, receive recognition and attention, while feminine-coded work involving care and bureaucracy are overshadowed (Hobbins, 2020). The crisis management system tends to exhibit a kind of gender-segregated chain of professions, with masculine-charged first responders at one end of the spectrum and feminised care and support, which takes care of the wounded and traumatised, at the other (Ericson et al., 2024).

The time dimension, of course, also encompasses a focus on issues that are important for the future. But how do we become literate about the future? How can we develop our ability to understand and 'read' the future before it happens? Based on existing research, questions can be asked about future conditions and events. We can use dimensions of the past and present to create frameworks and patterns on to which to project our ideas about the future.

The essays in the publication raise questions that highlight the importance of challenging the time dimension in the perception of crises. What happens when the present is already characterised by uncertainty and when some people have already been able to secure peace of mind for the future? In Lapidus' text, we are presented with arguments that challenge the current system, in which certain social groups have access to private health insurance. In the text, Lapidus discusses how trust is eroded in welfare states that over time develop parallel systems, under which some can receive priority privately. In this way, fears about the future can manifest feelings of security and peace in the present – for some. And what about older adults, among whom anxiety is already widespread? Liljas and Burström write about healthcare and social care for older adults and experiences gained during past crises and pandemics, from which systems seem not to learn. What about all those who are already anxiously caring for others? Mulinari's text reflects on the working environment for nurses who work and wear themselves out under conditions beyond their control, resulting in many being unable to continue working in the profession. Duvander and Lundgren urge us to reflect on how past notions of gender, family and work will present problems if war postings are to be implemented in the future. They emphasise the importance of not clinging to old ideas about the roles people take in family and working life, as this creates false assumptions when we imagine how society should function in future crisis situations.

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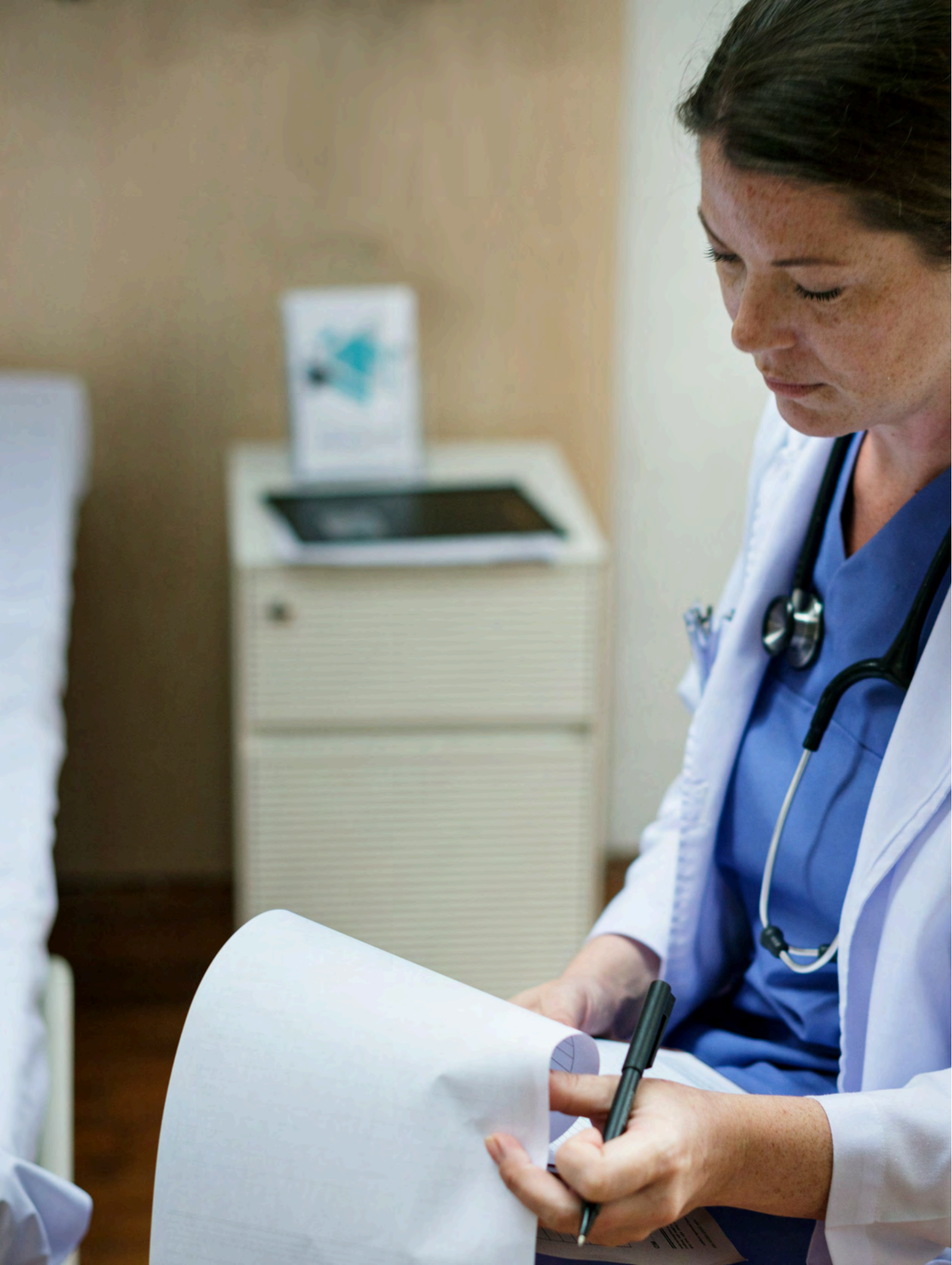


About the essays

The academic essay as a text form

It takes time and effort to develop reasoned arguments about the future based on research. Accordingly, a suitable form is needed, one that can accommodate reasoning, reflections and questions with a scientific basis. The academic essay was therefore chosen as the text form.

'Essay' means attempt. It is a way of exploring reasoning, reflecting and analysing ideas through writing, using a slightly more personal approach than, for example, a scientific article. Here, writing can be seen as a method of investigation, a way of exploring, engaging and associating, rather than simply transferring information. The essay form can be likened to 'a learned conversation' (Wallsten & Moberg, 2018, p. 65), in which science is presented hand in hand with critical discussion. It is an approach to reasoning in which the outcome does not have to be obvious from the outset, and which may lead to more questions than were present at the beginning of the process. In short, it is a form that is well suited to developing new questions and arguments about the future, based on science.

The researchers have used their previous and ongoing research as a platform for their writing. Based on this, they have developed arguments and questions concerning future Nordic resilience in welfare.

In other words, this publication is a collection of essays, through which researchers representing a wide range of focuses and perspectives share well-founded reflections and arguments and pose questions that encourage both reflection and action.

Four essays

The four texts in this publication have a certain inherent order. They constitute individual examples of arguments, questions and reflections that are relevant to healthcare within the welfare system, as viewed from a gender and resilience perspective. The researchers represent a wide range of disciplines, and the texts therefore also address different empirical contexts within healthcare, as well as different knowledge perspectives. The texts consider and reflect on challenges, both at the system level and at the point where staff meet users. Taken as a whole, the texts cover the entire spectrum between these extremes, as well as the conditions and circumstances that frame it. They move between macro-level structures and policy frameworks, meso-level organisational structures, leadership, communication and collaboration within healthcare, and micro-level individual actions and scope

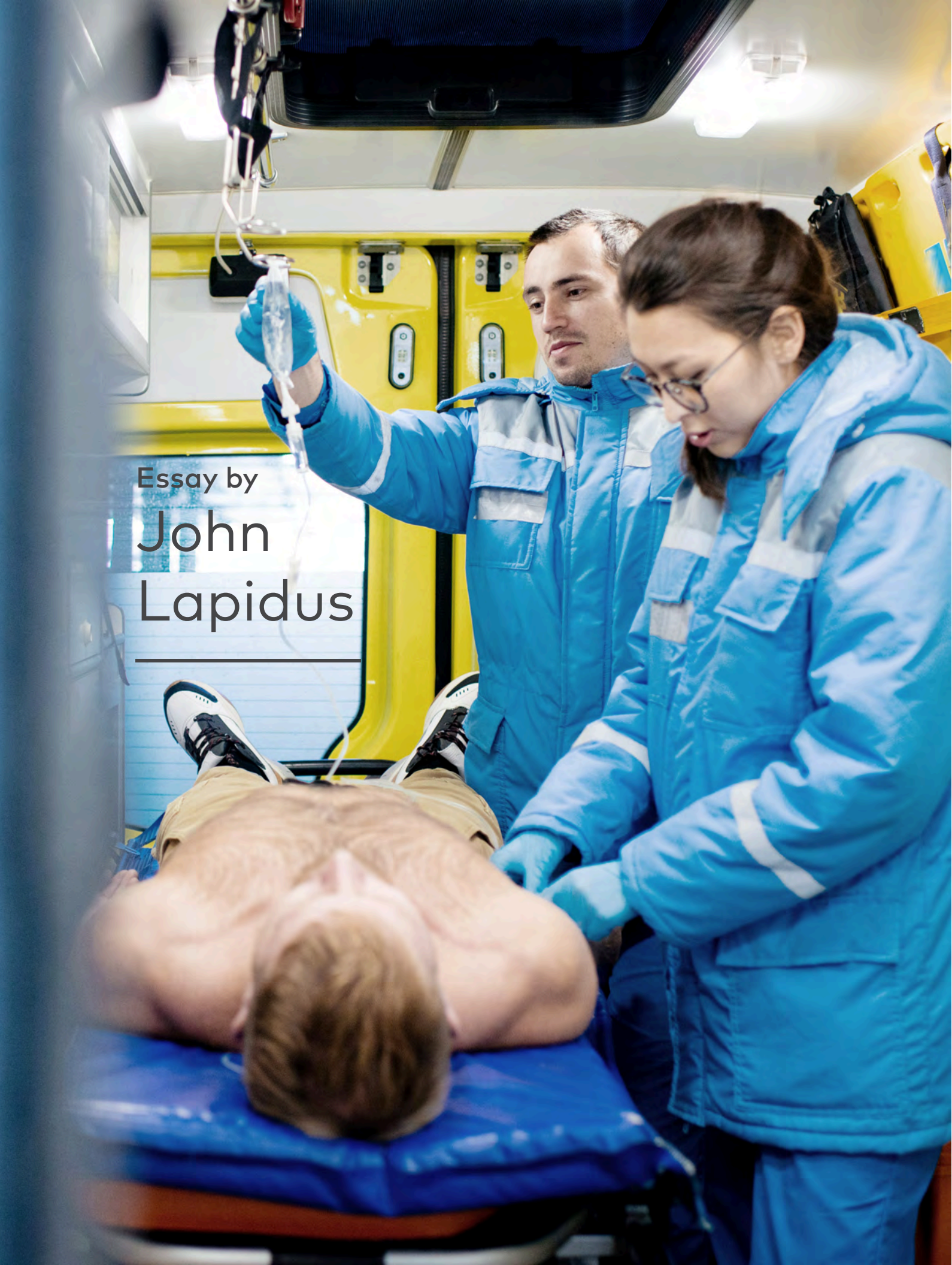
for action. All four texts use gender and resilience perspectives in their analyses of Nordic healthcare but approach the subject from different angles, at partially different levels and with different approaches. In-depth reasoning is presented alongside exploratory questioning. Sometimes priorities and approaches are clearly advocated, while other times we are left with more questions than answers. All the essays ask the reader to pause and reflect; tomorrow's trials are still shrouded in mystery, but there is knowledge and experience to draw on.

THE FIRST ESSAY is written by John Lapidus, a researcher in economic history at the University of Gothenburg. We are presented with a critical analysis of the rapid growth of private health insurance. The text addresses macro-level challenges and focuses on the development and consequences of the two-tier system that is being created. Lapidus offers an in-depth discussion of the complexity of the so-called hidden welfare state and its implications for the resilience of the welfare state as a whole. He discusses how this development challenges legislation on medical care in the Nordic countries, which is based on the principle of healthcare according to need and on equal terms, and how this leads to reduced resilience.

THE SECOND ESSAY is written by Ann Liljas and Bo Burström, researchers in global public health at Karolinska Institutet. They begin by discussing the shortcomings in the preparedness of Sweden's healthcare and social care systems for older adults, which became apparent during the COVID-19 pandemic. With a view to learning lessons for the future, Liljas and Burström draw attention to the need for both sustainable organisation and sustainable staffing in this area of healthcare and social care systems, taking demographic developments into account. Taking Sweden as a starting point, they discuss the link between working conditions and staff turnover and the ability to maintain high-quality healthcare. The text addresses both the macro and meso levels and highlights a number of examples from which lessons can be learned. Questions are raised about how collaboration, exchange of experience and learning can increase resilience, and the spotlight is turned on how financial and human resources need to be prioritised.

THE THIRD ESSAY is written by Paula Mulinari, a researcher in social work at Malmö University. We encounter reflections, fears and hopes from women working in healthcare. Mulinari's text is based on individual stories, in which experiences of the prevailing conditions in the sector form a platform for discussing temporal inequality and crisis at the societal level. From a resilience perspective, Mulinari argues that women employed in the healthcare and social care sector are already in a crisis situation, with constant work-related stress, high sick leave rates and greater responsibility for unpaid care work in the home. The text raises questions about whether the sector is in a state of permanent crisis that workers are paying the price for, how welfare is organised and how time and greater temporal justice can be crucial to strengthening resilience.

THE FOURTH ESSAY is written by Ann-Zofie Duvander, a researcher in sociology and demography, and Minna Lundgren, a researcher in sociology and risk and communication, both of whom work at Mid Sweden University. They focus on medical care and nursing in extreme situations, such as war. The text raises questions about the challenges of a future heightened state of alert, for both the sector and those who work in it. Duvander and Lundgren highlight aspects of contingency planning that relate to family and the labour market, and the risk of conflicts that may arise, for example, if those who are expected to serve also have a high degree of responsibility for caring for both the elderly and children at home. The text looks at both the meso and macro levels: it raises questions about crisis preparedness at the system level and how this affects both the organisational level and individuals. The authors describe a fragmented and largely privatised sector that faces major challenges, even in the absence of a crisis, and raise questions about how this affects planning for future resilience.



Essay by

John Lapidus

The hidden welfare state: How the rise of private health insurance is making the Nordic countries less resilient, equal and equitable

John Lapidus

Healthcare legislation in the Nordic countries is based on the principle that care should be provided according to individual need and on equal terms. The rapid growth of private health insurance is challenging these legislative provisions, with countries now moving away from their established healthcare models. The trend is towards divided systems that are no longer shared. One part – *the visible welfare state* – continues to be publicly funded directly through taxes. A growing part – *the hidden welfare state* – is based on private health insurance, which on closer inspection is not as private as this term suggests. The ongoing privatisation and fragmentation of Nordic healthcare is leading to reduced resilience. In other words, it is undermining the ability of healthcare systems to quickly 'bounce back' to a well-functioning state.

The permanent crisis in Nordic healthcare

The widespread development of society towards neoliberalism (Laruffa, 2024), a trend that has been proceeding for several decades, has had a significant influence on Nordic healthcare systems. Healthcare privatisation has been high on the agenda, and the healthcare systems of the Nordic countries have undergone major changes, both in terms of provision and financing. Large parts of the public healthcare systems have been sold off to private operators, while insurance companies and private health insurance providers have entered the new healthcare markets.

The rapid growth of private health insurance means that the Nordic countries are moving away from the social democratic (Esping-Andersen, 1990) healthcare models that were established in the 1970s and 1980s towards divided (Hacker,

2002) systems that are no longer common but characterised precisely as being separated in two. One part – *the visible welfare state* – continues to be publicly funded directly through taxes. But there is also a growing part – *the hidden welfare state* (Howard, 1999) – based on private health insurance, which on closer inspection is not as private as the term suggests but rather sponsored by the state in a variety of ways (Lapidus, 2019).

The ongoing division of Nordic healthcare marks a return to the privatisation and fragmentation that characterised the healthcare sector after the Second World War. That is, before healthcare became a public undertaking that was removed from market logic and control and before the enactment of laws such as the Swedish Health and Medical Services Act (SFS 2017:30), which stipulates that care should be provided to all citizens according to individual need and on equal terms.

Private health insurance challenges the egalitarian healthcare legislation in all Nordic countries, primarily by creating favourable rules and entry points for those who take out private insurance, conflicting with the wording of these laws. It is equally obvious that the insurance system increases class inequality. Insurance companies focus on risk, which in the case of healthcare means that certain groups are excluded from the possibility of taking out insurance, while those performing manual work, for example, have to pay higher premiums than white-collar workers – the latter being at lower risk of workplace illness and injury (Lapidus, 2025). A further sign of the presence of class-based mechanisms that increase inequality is that private health insurance is taken out by high-income earners to a much greater extent than by low-income earners.

At the same time, private health insurance increases gender inequality, partly because more men than women take out insurance policies (Palme, 2017). Another gender equality factor, of which there are many, is age discrimination built into insurance policies for the purposes of profit maximisation, which, like inadequate care for the elderly (Wennberg, 2017), disproportionately harms women, for the simple reason that women live longer than men.

If we look at the bigger picture, we can see healthcare privatisation as just one part of an overall trend of gender equality coming under threat from neoliberalism, which, together with neoconservatism, 'downplay[s] or ignore[s] structural gender inequalities in a mutually reinforcing way' (Lin & Wang, 2023). Perhaps it is true that 'markets do not always operate against the interests of women' (Elson, 1992), but at the overall societal level, neoliberal policies lead, among other things, to increased pay and wealth gaps. This, in turn, has consequences for gender equality, as low-paid jobs are often dominated by women, but also because increased class differences pave the way for far-right movements that threaten many of the rights for which women have fought (Donà, 2021).

An important piece of the puzzle in the healthcare context is that a growing public sector was previously, during the development phase of public healthcare systems, regarded as part of the process of democratisation (Premfors, 1991), but neoliberalism is reframing the public sector as a problem and burden that should be streamlined as much as possible. The fact that, for example, elderly care in the Nordic countries is characterised by this neoliberal policy of scarcity (Blyth, 2013) also has consequences for gender equality, among other things, because working women are forced to take on greater responsibility for their relatives when the state withdraws from this area (Meagher & Szebehely, 2013).

The privatisation and fragmentation of Nordic healthcare could lead to reduced resilience, i.e. an inability of healthcare systems to quickly 'bounce back' to a well-functioning state in crisis situations (Wiig et al., 2020). One such example was the COVID-19 pandemic, during which there was uncertainty over whether private healthcare personnel could be compulsorily called up (Persson, 2020). However, if we broaden the concept of resilience to include issues such as the above-mentioned violations of equality and gender equality in the healthcare legislation of the Nordic countries, there appears to be a permanent crisis that shows no signs of a resilient bounce back.

There are many reasons for the ongoing and deepening crisis in public and 'social democratic' healthcare systems, not least legislation that has promoted increased privatisation of healthcare provision and financing since the early 1990s. At the same time, there is a lack of understanding across all countries of what has been termed Baumol's cost disease (Baumol, 2012), i.e. that services such as healthcare become relatively more expensive than goods over time in all countries experiencing economic growth. This means that taxes must be kept at a certain level and that the state must continue to provide additional resources, but in a country like Sweden, the opposite is true: the tax ratio has fallen dramatically (SCB, 2024) and previously indexed government grants have been de-indexed. As a result, the government has a fixed budget available – the so-called 'space for reform' – which is only partially assigned for healthcare and other welfare services, for which it was previously earmarked (Lapidus, 2025).

The emergence of a parallel healthcare system

In recent years, private health insurance has become widespread in all Nordic countries. The most common type of insurance is that which guarantees rapid access to care, usually at clinics where publicly funded patients wait their turn in accordance with public healthcare guarantees of various and slower types. Private health insurance thus creates parallel systems alongside what was previously a common Nordic healthcare system. These parallel systems require their own infra-structure, for example in the form of booking systems, where private healthcare

providers and insurance companies can meet to book quick appointments for policyholders. At the same time, entirely new professional groups are needed, such as healthcare coordinators and claims adjusters, with the latter keeping track of policyholders' medical histories to avoid the adverse selection that every insurance company fears. Adverse selection occurs when individuals with an increased risk of illness slip into the smaller groups of healthy and able-bodied individuals designated by insurance companies. Admitting people with an increased risk of illness leads to higher costs and increased premiums for all policyholders, which in turn can cause that particular insurance company to lose out to competitors.

At first glance, insurance markets appear to be entirely private and parallel systems, but in reality they are intertwined with public systems in every conceivable way. The most obvious example of this is that most privately insured individuals are attended to by healthcare providers that receive most of their income from public financiers and publicly financed patients. These private healthcare providers therefore enter into one type of agreement with public financiers and a completely different type of agreement with the many insurance companies operating in the new healthcare markets. This creates two different points of access to thousands of clinics around the Nordic countries: a fast queue for those with private health insurance and a slow queue for those relying on publicly funded healthcare.

Not only are private health insurance companies dependent on public systems in various ways, they are also directly subsidised by the public sector. To varying degrees, the Nordic countries have promoted the growth of private health insurance through generous tax deductions, and private insurance companies are therefore not as private as the term would suggest. This type of government expenditure, in the form of lost tax revenue, falls within the scope of 'the hidden welfare state' (Howard, 1999), which also gets its name from the commercial secrecy that often characterises semi-private schools, healthcare and services of this kind. In the Nordic countries, trade associations for insurance companies keep much of the statistical data on private health insurance, information that they can choose whether or not to disclose, depending on who requests it.

The emergence of the hidden healthcare system has major consequences for public and visible healthcare, which, in a universal welfare state, is supposed to be available to all citizens. Firstly, there are a number of undermining factors rooted in the fact that, thanks to their insurance policies, policyholders no longer have a vested interest in seeing the shortcomings of public healthcare addressed and are less willing to contribute through their taxes to a public healthcare system on which they are less dependent. Secondly, when private health insurance becomes widespread common healthcare systems cease to exist altogether. Two parallel systems that operate according to two completely different logics can never be the same as a universal system that is common to all citizens. Instead, what occurs is that each of the Nordic countries ends up with two different welfare states – or, in this case, two different healthcare states – one based on a visible healthcare

system that relies on direct financing through taxes and the other based on a hidden healthcare system that relies on tax deductions and free-riding on public healthcare infrastructure.

Private health insurance in the Nordic countries

In all Nordic countries, rates of private health insurance have increased significantly since the beginning of the 2000s. Private insurance is most common in Denmark, where 2.9 million people, nearly half the population, have private health insurance (F&P, 2024). However, a distinction should be made between complementary and supplementary insurance: complementary insurance covers provisions that are not included in the public commitment (e.g. chiropractic and dental care), whereas supplementary insurance provides faster care for policyholders than for publicly funded patients. In Denmark, there is considerable overlap between supplementary and complementary insurance, meaning that many Danes are covered by both types of insurance. This paper focuses solely on supplementary insurance, which is also the most common type in the Nordic countries. Looking exclusively at supplementary insurance, 1.7 million Danes, just under 30 per cent of the population, are covered (Tikkanen et al., 2020).

In Norway, the same dramatic increase in private, supplementary health insurance can be seen as in the other Nordic countries, from 50,000 policyholders in 2003 to over 800,000 today, nearly 15 per cent of the population (Kellner Lysne et al., 2024). Likewise in Sweden, the figure has risen to over 800,000 policyholders (Grant Thornton, 2024), a similar number to Norway in absolute terms but fewer relative to the population. In Finland, 1.3 million people, or 23 per cent of the population, currently have private health insurance (Löytömäki, 2024). One exception to these rising figures is Iceland, where private health insurance does not yet exist on the same scale (Alexandersen et al., 2016).

As can be seen, there are significant similarities between most of the Nordic countries, but there are also distinctive features that are worth examining more closely. One of these is, as mentioned, the prevalence of supplementary insurance in Denmark, and another is the high proportion of children covered by private insurance in Finland. As many as 40 per cent of all Finnish children under the age of seven are covered by private health insurance (Lehtonen, 2017), and children under the age of three are the largest user group of private healthcare (Sointu et al., 2021). This means that almost half of all Finnish children can be seen by a specialist directly, while the other half must first see a nurse and then a general practitioner before potentially being able to access specialist care. For these privately insured children, it is therefore parents and not medical professionals who determine how, when and for which symptoms to seek a specialist consultation, which can drive up healthcare costs and be counterproductive in many other ways, known as low-value care.

One of the purposes of effective primary care is precisely to be a first line of healthcare, from where a determination is made over whether to refer the patient to specialist care. However, private health insurance creates some confusion when it comes to this so-called gatekeeping. This is particularly true of insurance policies that include so-called referral requirements, i.e. insurance that requires a referral from the publicly funded healthcare system to access specialised care provisions. In a large Norwegian study (Breivold et al., 2024), 42 per cent of all general practitioners surveyed said that they often or always feel pressured to refer patients with private health insurance to specialist care even if there are no medical grounds to do so. Furthermore, 18 per cent of doctors stated that they often or always encounter unpleasant reactions such as aggression, threats or reprisals if, for professional reasons, they refuse to comply with a referral requirement made by a patient with private insurance.

Of the 1,309 Norwegian doctors, 93 per cent stated that private health insurance increases the risk of wasting resources through over-treatment, while 90 per cent stated that such insurance contributes to inequality in healthcare (Breivold et al., 2024). Similar percentages were reported in a large Danish study (Andersen et al., 2017), and according to a survey I initiated myself there does not appear to be any significant difference in Sweden. Several of the doctors I interviewed said that it is difficult to resist demanding policyholders and that health centres seek to avoid financial loss resulting from the risk of patients leaving their register.

Policyholders' demands risk driving up costs and increasingly turning healthcare into a consumer product, with many believing they deserve the best and most expensive care even for the most minor ailments. At the same time, healthcare is becoming a kind of prestige product, with policyholders striving to keep up with those around them: my neighbour has bought gold insurance, and I only have silver! Nordic insurance companies know how to exploit this kind of anxiety and competition. That is why they are constantly developing new products, while stratifying their insurance policies into bronze, silver and gold levels, depending on customer status and ability to pay (Euro Accident, 2025).

Driving forces behind private health insurance

It is not only insurance companies that have driven the rapid growth of private health insurance: it has also been encouraged by the governments of the Nordic countries through generous tax deductions. In both Denmark and Norway, the trend gained momentum thanks to deductions introduced by liberal-conservative governments in 2002 and 2003 (Tynkkynen et al., 2018). Likewise in Sweden, tax deductions have been an important factor behind the growth of private insurance. In Finland, private health insurance policies taken out through employers are tax-free benefits for employees (Vero.fi, 2024), contributing to the trend towards a divided healthcare system.

In Sweden, however, a Social Democratic government took the initiative to introduce a law on the taxation of private health insurance benefits, which came into force in 2019. The purpose of the law was to end public sponsorship of insurance policies, but after private meetings with the Swedish Tax Agency, the industry organisation Insurance Sweden (Svensk Försäkring) and the insurance company Skandia succeeded in getting the benefit taxation reduced to only 60 per cent (Lapidus, 2025). This tells us something about the influence that the private healthcare industry has gained over the healthcare systems of the Nordic countries, influence that also came into play when a Swedish government inquiry deviated from a government directive to propose a ban on private health insurance (Lapidus, 2025).

At a deeper level, the emergence of private health insurance in the Nordic countries would not have been possible without the preceding privatisation of provision. Only when there is a nationwide network of private healthcare providers do insurance companies have somewhere to send their customers, as publicly run healthcare providers do not give priority based on private health insurance coverage. Policyholders cannot go to Karolinska University Hospital in Stockholm or Oslo University Hospital and demand priority treatment but must instead contact a private healthcare provider.

In this way, privatisation of provision was a prerequisite for the insurance market. At the same time, private health insurance is a trigger for further privatisation of provision in various ways (Lapidus, 2025). While there is sometimes careless talk about privatisation in general terms, it is important to study different types of privatisation and their mutual interaction in the Nordic countries.

Private health insurance is not for everyone

So who takes out private health insurance? Unsurprisingly, there are clear class and gender differences, with high-income earners greatly outnumbering low-income earners and men greatly outnumbering women. In terms of gender, Sweden is a typical example, with two-thirds of policyholders being male and one-third female (Palme, 2017). In terms of class, Finland is a good example, where 30 per cent of high-income households have private health insurance, compared to only 8 per cent of low-income households (SOU 2021:80). The large class differences in the purchase of private health insurance are not surprising, given that insurance companies prefer to attract individuals who are as young, healthy, able-bodied and high-earning as possible. Those with increased risk of illness have to pay higher premiums or, in many cases, are refused insurance. One example of this is that insurance companies often want to know the ratio between manual and white-collar workers when a company purchases insurance for its employees, as manual workers are at higher risk of both workplace illness and injury. A high proportion of manual workers means more expensive premiums for the contracting company. It is

therefore on not only ideological but also purely material grounds that the trade unions within the Swedish Trade Union Confederation (LO) criticise these insurance policies, which disadvantage the working class, while white-collar unions are increasingly offering such policies to their members.

Insurance companies' business model is based on contrasting the excellence of their own products with public healthcare to create doubt and concern among those who choose not to take out insurance. Typical examples include the Danish company Gjensidige's slogan 'Your shortcut to fast treatment' (Gjensidige, 2025), Norwegian Storebrand's comparisons between its own waiting times and those of public healthcare (Storebrand, 2025) and Danish DSS's focus on the security that insurance provides policyholders (DSS, 2025). Emphasising the peace of mind that private health insurance provides is common practice. The other side of the coin is that public healthcare is unable to provide this peace of mind to citizens, and the consequence of persistent advertising and propaganda may be a gradual decline in trust in public healthcare.

Insurance companies justify private health insurance by saying that it creates healthy and peaceful policyholders, at the same time denying the inequality and injustice on which the entire insurance system is based. One example is the Swedish trade association Insurance Sweden, which tries to promote the notion that all social classes have the same access to insurance (Erlandsson, 2019) and persistently denies that private healthcare providers discriminate between those who have insurance and those who do not – despite the fact that the main purpose of insurance is precisely to offer priority over publicly funded patients (Svensk Försäkring, 2024).

Simultaneously justifying and denying the function of private health insurance is an effective way of establishing dominance (Van Dijk, 1993), legitimacy and general confusion over what insurance actually means. Legitimacy is central to the private healthcare industry's ability to push through its agenda. The creation of legitimacy is partly aimed at the large majority of the population who uphold the principles of equal treatment established in healthcare legislation and therefore view the emergence of parallel healthcare systems with some scepticism. But even more importantly, it is about fostering legitimacy among individuals, companies and organisations that take out insurance policies, because even among these groups there is often a sense of unease about receiving unlawful, priority access to care over other citizens. This applies not least to white-collar unions that offer private health insurance to their members, while at the same time claiming to support universal healthcare systems. It is particularly important to address these and like-minded actors with legitimising, neoliberal arguments that they are not undermining the common good at all but rather doing public and universal healthcare a great service by leaving it to its own devices.

Private health insurance, crisis and resilience

A fragmented and privatised healthcare system risks reducing society's resilience in times of crisis, while at the same time encouraging some citizens to act in accordance with the new doctrine of individualism and selfishness. One example is the COVID-19 pandemic, during which some managers were publicly criticised for improperly arranging vaccines for themselves and their relatives. However, it should also be noted that these managers had already disregarded the principles of the Health and Medical Services Act. For years, they had been encouraged to purchase private health insurance for themselves and their families, so why should the same approach not apply to vaccines?

A good illustration of these conflicting signals is the editorial page of the Swedish newspaper *Expressen*. On the one hand, the editorial page usually welcomes the growing number of Swedes who jump the healthcare queue with private health insurance (Expressen, 2020). On the other hand, the same editorial page (Marteus, 2021) claimed that business leaders who obtained vaccines on their own initiative were guilty of criminal acts.

Insurance companies also found themselves in a difficult position during the pandemic. On the one hand, completely new opportunities arose to capitalise on people's concerns, on the other, allowing some people to jump the queue for healthcare could be perceived as more cynical than usual. Insurance companies therefore had to find more subtle ways to advertise their products, precisely at a time when they could sell more insurance policies than ever before. One such method was a so-called survey in which the Swedish insurance company Länsförsäkringar asked the opinion poll company Novus to ask a single question to private individuals aged 18–79 and those employing 1–10 people: 'Do you think that public healthcare will be there for you when you need it?' (Länsförsäkringar, 2020).

This so-called survey was one of several discreet ways of marketing private health insurance at a sensitive time. However, some customers were anything but discreet, demanding special treatment even when it came to COVID-19. Insurance companies were therefore forced to explain that their policies did not cover COVID-19. For other types of care, however, private insurance continued to apply as usual. Länsförsäkringar was careful to point out that the pandemic would not affect policyholders' rights, stating on its website: 'For other illnesses and ailments, health insurance applies as usual' (Länsförsäkringar, 2021).

Policyholders thus continued to have priority access to specialist care, while at the same time a so-called healthcare debt was created as a result of several regions cancelling planned operations due to the COVID-19 crisis. This meant that policyholders continued to use healthcare resources, perhaps more than ever

before, as even more care coordinators (often nurses) and claims adjusters (often nurses) were needed to address policyholders' concerns and claims during the COVID-19 pandemic.

At the same time, there was uncertainty about whether private healthcare personnel could be called up during a national crisis such as the COVID-19 pandemic, which meant that neither politicians nor civil servants could provide clear answers on how the regulations should be interpreted (Persson, 2020). At the same time, increased foreign ownership of Swedish healthcare began to attract attention, prompting the Social Democratic government to commission the Swedish Defence Research Agency to conduct a study on democratic and other risks (Budryk et al., 2023). The research institute concluded that there was limited awareness of the risks and further stated that 'The risk does not necessarily increase with foreign ownership but rather with private ownership, as this limits public transparency and control.'

Consequences of divided Nordic healthcare states

In all Nordic countries, new actors are being drawn, willingly or unwillingly, into the new healthcare and insurance markets. Among the actors with a direct financial interest in continued privatisation are insurance companies and private healthcare providers. However, there are also a number of intermediaries who benefit financially from this development, such as insurance brokers, who act as a link between insurance companies and the companies and organisations that purchase private health insurance. Among the more reluctant actors are, for example, white-collar unions, which face a difficult dilemma in that, on the one hand, they claim to defend the Nordic universal healthcare model and, on the other hand, they offer private health insurance to their members.

The emergence of parallel healthcare systems in the Nordic countries poses a significant threat to the public, and previously common, healthcare systems. Firstly, there are a number of undermining factors, such as the public sector being drained of human resources and a decline in willingness to pay tax and in public opinion and trust in public healthcare. Secondly, the common systems are, by definition, being broken down by the rapid growth of private health insurance. This is because two different healthcare systems based on two fundamentally different logics are simply not the same thing as a common, universal system in which all citizens, regardless of class and gender, collectively contribute and participate.

That there is a trend towards a divided healthcare system in the Nordic countries is a matter of fact, but perceptions and opinions about this trend are, of course, subject to personal leanings. It is perfectly possible to argue in favour of unequal and wallet-driven healthcare, because why should healthcare not be bought and

sold like almost all other products in a market economy? There is a wealth of neoliberal moral philosophy to draw on here (see, for example, Friedman, 1962; Rand et al., 1986), but one problem is that representatives of the private healthcare industry rarely rely on the straightforward and intellectually honest arguments that exist for the continued privatisation of healthcare provision and financing.

In most cases, the private healthcare industry has not needed to make any arguments at all, as the development towards a divided healthcare system has been characterised by the type of gradual and almost insidious changes that have been typical of much of the neoliberal advance (Streeck & Thelen, 2005). However, once such changes have become a matter of public debate, representatives of the private healthcare industry have invented a kind of neoliberal newspeak (Lapidus, 2025), in which every step towards a divided welfare system is argued to be in the interests of public and universal healthcare, despite each such step taking us further away from universal healthcare on equal terms. It should also be added here that there are healthcare laws that stipulate the requirement for care according to individual need and on equal terms, which is why those who argue for the current wave of privatisation should at the same time argue for these laws to be repealed and rewritten.

Furthermore, representatives of the private healthcare industry often claim that the emergence of parallel healthcare systems in the Nordic countries are the result of shortcomings in public healthcare. But on closer inspection, there is no public healthcare system in the world that can compete with a parallel system that targets the healthiest and most affluent groups in society. This is especially true if that system freerides on public infrastructure and is promoted by the government through generous tax breaks and new laws and regulations that favour the private sector at the expense of the public sector.

In the Nordic countries, governments have promoted parallel healthcare systems, and these countries have thus seen rapid growth in private health insurance rates. The more private insurance systems grow, the more difficult it becomes for politicians to reverse the trend, especially as influential voter groups benefit from the new privileges. By promoting private insurance systems, politicians have given these voter groups the option to opt out of the public system. These groups therefore no longer have a vested interest in resolving the shortcomings of public healthcare. In fact, they do not even experience the shortcomings, as insurance companies' care coordinators ensure that they receive preferential treatment over other citizens. Politicians are grateful to avoid criticism from these influential groups, who can continue to weaken the healthcare budget, which, in contrast, must be increased if quality of healthcare is to be maintained and keep pace with developments in the rest of society.

That there are hardly any actors fighting for public healthcare has not helped to check the influence of the private healthcare industry. This is evident, for example, when public healthcare inquiries are sent out for consultation, with an increasing number of consultation bodies tending to be private healthcare groups and insurance companies, all of which have a financial interest in the continued privatisation of healthcare. However, there are no corresponding campaign organisations for public funding among the bodies consulted.

Conclusions – and possible paths towards increased healthcare resilience

What we are seeing today is a gradual return to the fragmented and privatised healthcare system that characterised the Nordic countries before the public systems were established. At the same time, people's values regarding issues such as care based on individual need and on equal terms are changing, a trend fuelled by insurance companies' and private healthcare providers' constant criticisms of public healthcare, used as a selling point for their own products.

It is not only the Nordic countries that have experienced a wave of healthcare privatisation in recent decades. Similar patterns can be seen in France (Cordilha, 2023), Canada (Bodner et al., 2022), Brazil (Costa, 2017), India (Hooda, 2020) and many other countries around the world. Even healthcare systems that are very similar to those in the Nordics with regard to the principle of universality, such as those in Spain and the United Kingdom, are now characterised by ongoing privatisation of provision and financing. Thus, every year, Britain and Spain set new records for the number of private health insurance policies taken out (Corbatón, 2024; Stearn, 2024).

The trend towards increased privatisation and fragmentation risks reducing the resilience of healthcare systems during crises such as the COVID-19 pandemic. In countries that once had universal, market-free (so-called decommodified) healthcare systems of a 'social democratic' nature (Esping-Andersen, 1990), including the Nordic countries, this development also represents a crisis in relation to the principles of universality and equal care for all citizens that are still enshrined in healthcare legislation. This is therefore a constantly deepening crisis for public healthcare systems, one that has major consequences in terms of class and gender equality. It is a crisis from which there seems no easy way of bouncing back, as is required for healthcare systems to be considered resilient (Wiig et al., 2020).

To restore resilience, in terms of ensuring equal healthcare for all citizens, increasingly drastic measures will be required as the Nordic healthcare systems become more and more divided. One example could be legislation to slow down the rapid growth of private health insurance, i.e. laws that prohibit private healthcare

providers from entering into agreements with both public and private financiers. The next step could be measures to prevent privatisation of provision – sometimes referred to as profits in welfare – which enables and triggers the rapid growth of private health insurance. On a more general level, it will likely be necessary for income and wealth gaps to be reduced: under current class divides, it is difficult to generate sufficient interest to rebuild this type of resilience in healthcare systems.

- The rapid growth of private health insurance needs to be understood and managed from a crisis and resilience perspective, so that the resilience and equality of the systems can be strengthened.
- The division of the Nordic healthcare systems requires political reforms and practical measures to counteract unequal access and ensure that healthcare remains a shared welfare resource.
- Ways back to a common and market-free (decommodified) healthcare system should be developed and tested as an alternative to restore legitimacy, solidarity and equality in healthcare.

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Essay by

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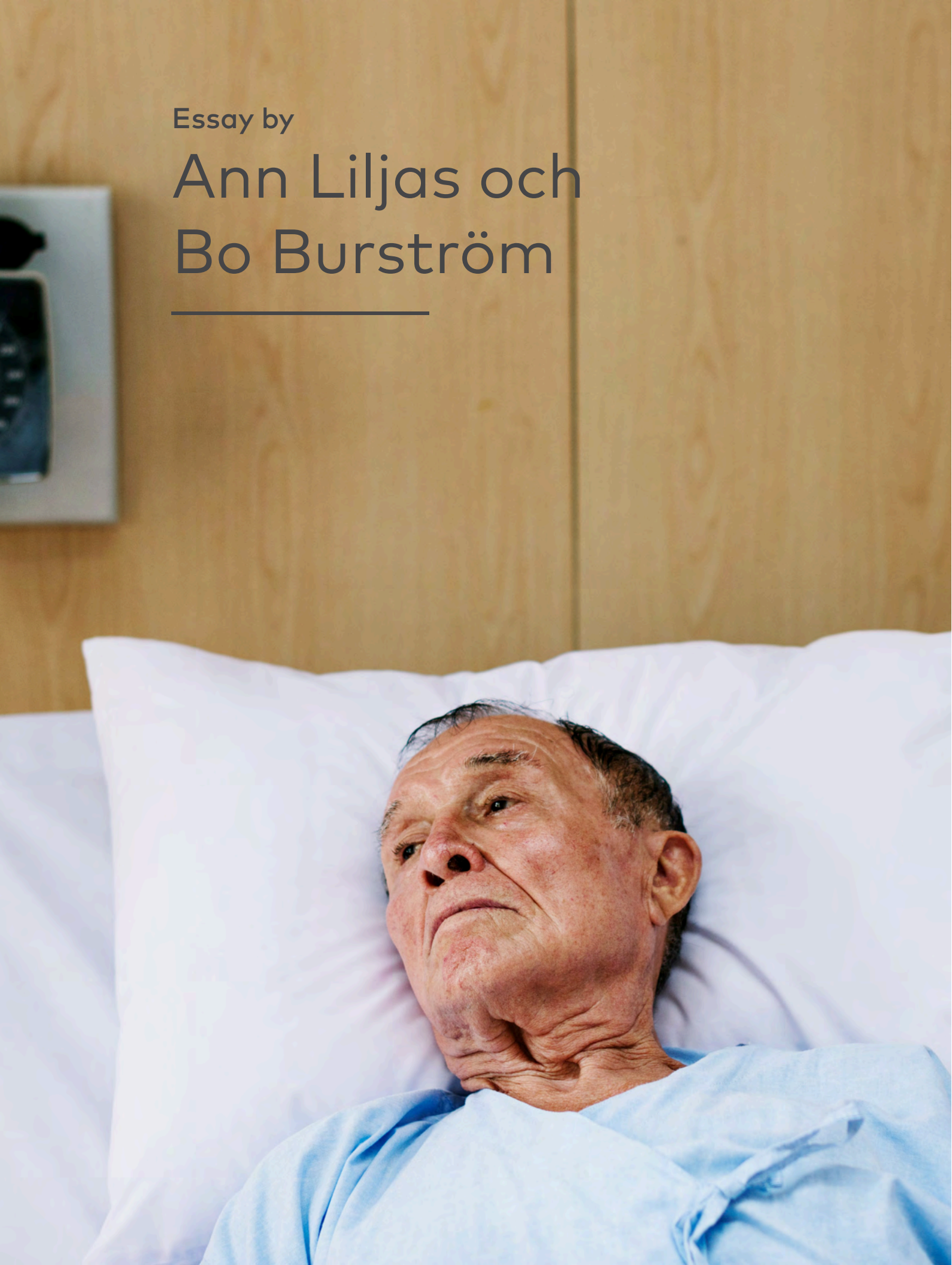

Healthcare and social care for older adults to enhance crisis preparedness

Ann Liljas and Bo Burström

In the Nordic region, the proportion of older adults in the population is growing rapidly. The COVID-19 pandemic exposed long-known shortcomings in healthcare and social care systems for older adults in need of complex care, not least in Sweden. The social care sector for older adults was unprepared and ill-equipped when the pandemic struck. The shortcomings in socialcare for older adults were due to, among other things, a lack of resources, fragmented organisation and insufficient staffing. Mortality affected mainly older adults and frail individuals, especially in Sweden but also in other Nordic countries. The majority of healthcare and social care staff are women, but fewer and fewer are choosing to work in this sector. How can healthcare and social care be designed sustainably, both now and in the future, to also make the system more resilient to future crises?

Why focus on healthcare and social care for older adults?

The proportion of older adults in the population is increasing rapidly in the Nordic region and the rest of the world. In Sweden, Statistics Sweden has predicted that the proportion of people aged 80 years and older will increase by 60 per cent between 2018 and 2030 (Statistiska Centralbyrån, 2025). The increase is also expected to continue in the future. Although life expectancy is increasing over time (Enroth et al., 2022), social disparities are also increasing, not least in terms of income (Nordregio, 2024). The proportion of people aged 80 years and older in the population is sometimes seen as an indicator of the need for healthcare and medical care, as the incidence of illness increases with age. More people will have multiple illnesses simultaneously (multimorbidity) and thus need good, local care, delivered in collaboration between healthcare and social care services. This pattern is evident throughout the Nordic region. The text in this essay is based on research on Sweden, but given the many similarities between the Nordic countries, it can hopefully contribute to learning for the entire region.

The COVID-19 pandemic exposed long-standing shortcomings in the healthcare and social care systems for older adults in need of complex care. According to the Swedish Coronavirus Commission (SOU 2020:80), the social care sector for older adults was unprepared and ill-equipped when the pandemic hit, despite the presence of structural shortcomings being known in advance, and the then government, as well as previous governments, should have taken action to address this. The shortcomings in the preparedness of social care for older adults were due to, among other things, fragmented organisation, a lack of staff, low competence, and unreasonable working conditions, an inadequate regulatory framework, obstacles for municipalities to employ doctors and gain access to medical equipment, and late and sometimes poor decision-making and ineffective measures. The Coronavirus Commission also sharply criticised the late and inadequate measures taken to prevent the spread of infection early in the pandemic, which increased the general spread of infection and thus also the risk of infection among older adults. Furthermore, the government should have been clearer in its leadership in terms of managing the crisis (SOU 2022:10).

This pandemic, which hit older adults particularly hard, is perhaps the clearest example of the need for resilience in healthcare and social care systems. In Sweden, as in the other Nordic countries, the majority of those who died between 2020 and 2022 were aged 70 years or older (Socialstyrelsen, 2024a). Most of them (72 per cent) lived in care homes for older adults (long-term accommodation, living in their own flat, staffed around the clock). The proportion of the population that died from COVID-19 was significantly higher in Sweden than in the other Nordic countries. However, our study on excess mortality paints a more complex picture. To calculate excess mortality, the number of deaths for a specific period is compared with a previous period. In Sweden, excess mortality was elevated in 2020. However, the results showed that excess mortality during 2020-2022 was comparable to Denmark and Norway, while Finland had twice the excess mortality of Sweden (Burström et al., 2024).

The fragmented organisation of social care for older adults cited by the Coronavirus Commission refers to the division of responsibilities. In Sweden, social care for older adults is a municipal responsibility, while medical and nursing care is a regional responsibility. Municipalities are also responsible for home help and can employ nurses for this purpose. Medical involvement requires an agreement with the region. The fact that older adults receiving home help and living in care homes were at highest risk of dying reflects the vulnerability of these individuals but also suggests that there is potential for the system to be improved at the strategic level (e.g. improved facilities), tactical level (staff) and operational level (e.g. cohort care and personal protective equipment). In turn, there may be significant potential for cross-organisational learning, both nationally and through the exchange of knowledge and information with other Nordic countries, which have similarly designed healthcare and social care systems albeit with slight variations

(Szebehely, 2020). The Swedish COVID-19 Committee's interim report clearly described the shortcomings of the Swedish healthcare and social care system for older adults and the measures that would be needed. More extensive and effective collaboration, as well as greater involvement of doctors in municipal healthcare and medical care, is needed, but no comprehensive measures have yet been taken. According to the final report from the inquiry *God och nära vård* (High-quality and local healthcare; SOU 2019:29), a greater proportion of care should be provided locally as primary care (general medical care through health centres), which is expected to cover the majority of care needs (Myndigheten för vård- och omsorgsanalys, 2025). Similar trends can be seen across the Nordic countries, which are all experiencing challenges in recruiting staff (Larsen et al., 2020). Healthcare and social care is a female-dominated sector, both among professional staff and those who provide care within the family. Particularly in social care, not least home help (care provided in the home), many women are underpaid compared to male-dominated sectors such as construction (Nordic Council of Ministers, 2019). There are also gender aspects with regard to care recipients within healthcare and social care for older adults: a large proportion of vulnerable older adults who receive healthcare and social care are women. Additionally, there are also socio-economic differences in health and in the need for healthcare and social care (Jämställdhetsmyndigheten, 2022).

With a rapidly ageing population and the experience of a widespread crisis that primarily affected older adults, there is reason to study the concept of resilience in relation to healthcare and social care for older adults. When discussing the concept of resilience in this text, we are referring to the need for the healthcare and social care system, rather than older individuals, to develop the resilience to cope with crises such as a pandemic. Furthermore, we see resilience as an ongoing process rather than a one-off phenomenon. Through *restoring*, *maintaining* and *improving*, the system can be developed to function in the long term and thus be sustainable (Helmen Borge, 2005). In terms of *restoring*, we are referring to a short-term process by which the system returns to normal after a crisis. In the meantime, its function must be *maintained* to allow for *improvements* to be made, for example, after a crisis. By asking questions and exploring them, we can gain insight into how resilience can be expressed and develop guidance on how healthcare and social care systems could be designed (Helmen Borge, 2005).

What is the current situation regarding healthcare and social care for older adults?

The Nordic countries have similar systems in terms of healthcare and social care for older adults, but there are some variations in the design and delivery of services (Vabø & Szebehely, 2012). Common to all is the demographic challenge of an increasing proportion of older adults and difficulties recruiting staff. The coverage

rate, i.e. the proportion of older adults covered by comprehensive social care for older adults (those receiving home help or in care homes), is highest in Denmark, while Norway has the highest proportion of older adults in care homes and Sweden has the highest proportion of older adults receiving home help. Finland has the lowest overall coverage rate but also has a higher proportion of older adults receiving formal (paid) social care from family members or other close friends or relatives. Informal care is common in all Nordic countries (Myndigheten för vård- och omsorgsanalys, 2021).

The Nordic countries invest a large proportion of their GDP into social care for older adults. In 2018, the proportion was 2.4 per cent in Sweden, 2.3 per cent in Norway, 2.0 per cent in Denmark and 1.7 per cent in Finland (Myndigheten för vård- och omsorgsanalys, 2021). Previous reports have shown that Iceland has a lower expenditure than the other Nordic countries (0.5 per cent in 2012 compared to 2.3 per cent in Sweden in the same year; Nordic Social Statistical Committee, 2013). In all five countries, social care is provided by a mix of public and private providers. In Sweden, the proportion of profit-making providers is highest, while other countries have a larger proportion of non-profit providers. In Denmark and Norway, municipalities may be exempt from competition with for-profit operators and award contracts directly to non-profit organisations. There are shortcomings in the coordination of medical and nursing services in all Nordic countries, despite the slight organisational variances between the countries (Larsen et al., 2020). In Iceland, the state and municipalities collaborate on the provision of social care for older adults. In Finland and Norway, municipalities are responsible for both social care for older adults and primary care, which can facilitate collaboration. In Sweden, services are divided between municipalities and regions, which can complicate delivery of medical care and social care for older adults (Myndigheten för vård- och omsorgsanalys, 2021).

Despite the ongoing increase in the proportion and number of older adults among the Swedish population, the number of people in care homes decreased from 82,626 in 2017 to 77,173 in 2021 (Socialstyrelsen, 2023). However, the cost per person per year increased by approximately SEK 100,000 during the same period, to SEK 1,020,427. The total costs for municipalities for care homes, home help and home nursing care increased by 3.9 per cent between 2017 and 2021, mainly driven by increased costs for home help (9 per cent). However, care homes account for the largest share (57 per cent) of costs. In 2021, a total of 227,400 people aged 65 years and older received municipally funded home nursing care. Approximately half of these also received home help services. More than half of those who received home nursing care were aged 80 years and older, and 60 per cent also received home help services.

It has long been known that there are problems with understaffing and recruitment within primary care, not only in Sweden but in several Nordic countries (Nordic Council of Ministers, 2014). Similarly, in social care, there is a growing need and

uncertainty with regard to future recruitment opportunities, which will be necessary to meet the growing needs of an ageing population. In Sweden, an additional 59,000 people will need to be employed in social care for older adults by 2031 to meet increased need. Factoring in retirement, the total recruitment need will be 110,000 people. Of the 191,000 people employed in social care for older adults in 2022, 45 per cent were nursing assistants and 24 per cent were care assistants. Among care assistants, 60 per cent had fixed-term contracts, while among nursing assistants the figure was 16 per cent. Almost half of both occupational categories worked part-time (Socialstyrelsen, 2023). It is therefore worrying that the number of nurses in social care for older adults is declining slightly, as is the proportion of specialist doctors in geriatrics. During the pandemic (2020), inspections were carried out at 98 care home facilities in Sweden, which found that one-fifth of residents had not received an individual medical assessment. A follow-up survey in 2022 showed that, compared to 2021, 60 per cent of municipalities reported that access to doctors was unchanged, while 16 per cent reported that access had declined; only 10 per cent reported that access to doctors had increased. Among municipalities that employed specialist nurses, 81 per cent reported shortages in the availability of such staff. The shortages were said to be due to competition from other employers and a lack of specialist nurses.

In Sweden, municipalities have different user fees for social care. Most municipalities charge the maximum fee for round-the-clock care (SEK 2,139/month), but there are large variations in costs of food and home help hours (SEK 70-488/hour). Most municipalities charge SEK 200-400 per hour. High costs in a municipality affect access to home help for low-income earners (Socialstyrelsen, 2023). National insurance contributions in the Nordic countries vary between 5 and 8 per cent across Sweden, Norway and Denmark, while contributions are about 17 per cent in Finland (Myndigheten för vård- och omsorgsanalys, 2021). In summary, it can be said that healthcare and social care for older adults are facing major challenges in all five countries, both due to the increasing proportion of older adults and difficulties recruiting staff.

Women sustain healthcare and social care for older adults

Women outnumber men in the health and social care employment sector. The most common occupation among women in Sweden in 2023 was nursing assistant, a profession in which 112,100 women and 15,900 men were employed (Kindblom & Westholm, 2025). Female-dominated professions are characterised, on average, by lower pay and poorer working conditions compared to male-dominated professions. The shortage of staff in social care for older adults is partly due to poorer employment conditions, working environment and pay.

Gender pay gaps reflect levels of disposable income among women, which are approximately 20 per cent lower than for men (Jämställdhetsmyndigheten, 2025). Many people working in social care for older adults are foreign born, which can mean they face language barriers and have limited insight into their rights. Women also often work part-time or in hourly positions, allowing employers to cover staffing needs when necessary. However, this creates uncertainty and insecurity for employees over their incomes and livelihoods, as well as that of any family members. For many, accepting shifts at short notice is therefore necessary to support themselves and continue to be seen as an attractive employee.

During the COVID-19 pandemic, hourly staff were brought in to a much greater extent than usual to cover sick leave among regular staff. However, high staff turnover also increased the risk of infection. In addition, some temporary workers did not turn down shifts despite exhibiting symptoms of infection due to fear of lost income and being looked over for work in the future. This exposed a social problem that needs to be addressed before the next pandemic or other crisis hits: workers must be guaranteed income security during times of crisis and that they will still be seen as an attractive employee on the labour market beyond the crisis.

The Swedish trade union Kommunal represents a large proportion of workers in social care for older adults. In their 2022 survey, only 46 per cent of members within the field stated that they wanted to continue working in social care for older adults over the next three years. When the same survey was conducted ten years earlier, that figure was 76 per cent. The main reasons for not wanting to continue were related to the poor working environment, not being able to work until retirement, pensions being too low and salaries being too low (Bucht, 2023). The working environment in healthcare is too often characterised by high workloads combined with insufficient staffing, a lack of care places and long waiting times. These factors are also examples of causes of moral distress among healthcare staff (Brune et al., 2024). Moral distress occurs when a person feels inadequate in doing what is considered ethically correct, which not only negatively affects staff but can also jeopardise patient safety (Canadian Medical Association, 2020). Such situations occur frequently among healthcare and social care staff and are largely a result of resource shortages.

The shortcomings and challenges highlighted above have been known for a long time but need to be addressed as soon as possible. It also shows that resilience within the healthcare and social care system with regard to staff must first be *restored* in order to be *maintained* and further *improved* in the future. This is critical for the healthcare and social care system but also central from a gender perspective as the majority of staff are women.

Reforms and investigations concerning healthcare and social care for older adults in Sweden

How is the issue of healthcare and social care for older adults handled politically? What reforms and changes have been proposed to improve the situation? What effect have these had? Below are some current examples from Sweden.

The Act of Systems of Choice

A large proportion of medical and nursing care for older adults with complex care and social care needs is expected to be provided through primary care, while social care is expected to be provided by municipal services. The Act on Systems of Choice (LOV) (SFS 2008:962) came into force on 1 January 2009 and applies to municipalities and regions when they establish freedom of choice systems for healthcare and social services. While it is voluntary for municipalities to introduce freedom of choice systems, it is mandatory within regional primary care. The reform thus ensures freedom of establishment for activities that meet basic requirements, with public funding from the municipality and region respectively.

Just over half of Sweden's municipalities have introduced LOV (SFS 2008:962) in social care for older adults, more so in large cities in the south and less so in the north and in sparsely populated municipalities. Around 20 per cent of all care homes for older adults are privately run and 24 per cent of home help hours are provided by private operators (Vårdföretagarna, 2022).

Primary Health Care Choice Reform

The Primary Health Care Choice Reform was implemented nationally in 2010 and resulted in an increase of approximately 20 per cent in new health centres, the majority of which are profit-driven limited companies. Most new establishments were located in large cities, with fewer in rural areas and on the outskirts of cities. The proportion of private healthcare providers is highest in the Region Stockholm (69 per cent of all healthcare centres) and lowest in the Västerbotten Region (13 per cent). Individuals/patients can register at the healthcare centre of their choice, and the cost of their care is paid by the region.

The Primary Health Care Choice Reform has been criticised for depriving regions of their ability to manage establishments according to need and for the increase in primary care visits largely among people with minor needs (Burström et al., 2017; Riksrevisionen, 2014).

In addition, a government inquiry (SOU 2016:2) found that the Primary Health Care Choice Reform has made it more difficult to care for older adults with complex care needs, as the reform has led to a lack of coordination and collaboration. In view of

this, the report proposed that those in this group be exempt from the Primary Health Care Choice Reform and given a special track within primary care. However, this has never been discussed further or tested.

High-quality and local healthcare

Another report, *God och nära vård* (High-quality and local healthcare; SOU 2019:29), proposes that primary care should be strengthened and form the basis of the medical and nursing care system and a hub for the care of older adults with complex needs, alongside municipal social care. The National Board of Health and Welfare's follow-up of *God och nära vård* (High-quality and local healthcare; 2023) reported a slight increase in collaboration between responsible authorities but a decline in opportunities to see a doctor at care homes for older adults when needed and no increase in the proportion of patients with a regular doctor, healthcare contact or social care contact. In the spring of 2025, the Swedish Agency for Health and Care Services Analysis presented a final report on the transition to high-quality and local healthcare, in which they drew similar conclusions. They further noted that none of the goals of the transition had been achieved, probably because operations have not received improved resources (Myndigheten för vård- och omsorgsanalys, 2025). This is remarkable, as the report by the National Board of Health and Welfare already stated that financial challenges across regions and municipalities could affect the transition work (Socialstyrelsen, 2024b).

Investigation into an act on social care for older adults

During the pandemic, possible changes to the Social Services Act were discussed, including, for example, on care homes for older adults and a so-called social care for older adults act with possible changes to expand medical expertise in care homes. Work on updating the Social Services Act is currently underway. A report on the introduction of an act on social care for older adults was presented in the summer of 2022, focusing on increased quality and equality in healthcare and social care for older adults (SOU 2022:41). The report contained proposals on how medical and nursing care legislation could be strengthened to improve the quality and availability of healthcare and social care for older adults. The proposal covered both municipalities that provide social care and regions that provide healthcare. It also included measures on health promotion and disease prevention, as well as person-centred approaches. However, the government chose not to proceed with the introduction of an act on social care for older adults, which brought the undertaking to a halt.

Investigation into strengthening medical expertise in municipal medical and nursing care

A commission also presented a report on strengthening medical expertise in municipal medical and nursing care (SOU 2024:72). The report points out that municipal medical and nursing care will become increasingly important in the transition to high-quality and local care. The report proposes, among other things, that municipalities should be able to employ doctors, that municipalities should have a medical management function and that regions should have a function that acts as a counterpart to municipal healthcare and medical care, which can be important, not least in the event of extraordinary events or increased preparedness. It also proposes that the state should allocate funds for the further training of nurses in municipal medical and nursing care. However, the proposal for municipally employed doctors has been criticised by both the Swedish Medical Association and the Swedish Medical Society (Torkelsson, 2025).

In summary: A review of reforms and investigations shows that not much has changed that could improve healthcare and social care for older adults. Older adults with complex needs did not benefit from the Primary Health Care Choice Reform – if anything, it increased the fragmentation of healthcare and social care. A proposal to exempt this group and create a special track in primary care did not go ahead. In care for older adults, the number of private providers has increased, but a large proportion of those in need of care lack the resources and cognitive ability to make choices. Freedom of choice is also geographically limited to large cities. The proposal for an act on social care for older adults did not go ahead, nor did the proposal that municipalities should be able to employ doctors to provide healthcare and social care for older adults. The report on a transition to high-quality and local healthcare is therefore one of the few conceivable ways forward and contains many proposed improvements, but the lack of financial resources and recruitment difficulties across regions and municipalities make implementation difficult.

What can be done to improve healthcare and social care for older people?

Beyond additional resources for healthcare and social care, there is a need to further develop existing working methods and establish new ones. In Sweden, the COVID-19 pandemic highlighted the importance of nurse practitioners, who collaborate with, for example, care homes for older adults. Municipal nurse practitioners were responsible for ensuring that healthcare was administered safely and correctly, which in practice could mean training staff in how to use personal protective equipment correctly and reduce the spread of infection through proper

hygiene. Research has shown that nurse practitioners also played a central role in clarifying and communicating the constantly changing guidelines from the health and medical authorities to, among others, care homes for older adults. In municipalities where nurse practitioners took on such a role, the burden on staff at care homes for older adults was eased in terms of managing and communicating new guidelines and recommendations to staff (Liljas et al., 2024). In preparing for future crises and pandemics, the experiences of decisive and significant efforts by nurse practitioners during COVID-19 should therefore be taken into account. The role and importance of nurse practitioners in daily operations should also be prioritised to establish routines that will form a basis for future crises.

Another important lesson from the COVID-19 pandemic is that communication from authorities must be clear and consistent. During the pandemic, too many different guidelines were issued, which healthcare and social care staff found confusing and contradictory, causing further uncertainty among staff (Agerholm et al., 2023; Liljas et al., 2024). This is unfortunate in several ways, as international research from the 2009 influenza epidemic showed that information should be communicated from a single credible source, such as a government agency (Staes et al., 2011). The same study also showed that, given the vast amounts of information available, information that is potentially new to people should be clearly indicated. This guidance was available prior to the COVID-19 pandemic, but was not taken into account. This shows that the dissemination of research must become more effective.

The World Health Organisation (WHO) advocates for patient-centred integrated healthcare and social care, arguing that such an approach offers significant opportunities to meet the needs of an ageing population. However, a survey within primary care in the Nordic countries showed that integrated healthcare is very limited: no Nordic country has introduced nationally integrated healthcare. The initiatives that do exist consist of local projects in a few municipalities or regions (Larsen et al., 2020). It is clear that closer cooperation is needed between regional medical and nursing care and municipal medical and nursing care and social care. Care for older adults must become a more attractive field of work, and staff need to be the focus of initiatives aimed at improving training, employment conditions, working environments and pay.

Although the challenges described above appear to be substantial, there are examples of promising local initiatives throughout the Nordic region. It is important to follow up and learn from a variety of approaches. One Swedish example is the municipality of Norrtälje, which has an older population than the rest of the Region Stockholm. The need for healthcare and social care in this area is therefore greater than for other population groups in the county. In the early 2000s, the emergency hospital in Norrtälje was threatened with closure but was eventually converted into a local hospital through in-depth collaboration between the then county council and

the municipality, which resulted in a joint organisation (Tiohundra) sustained through co-financing. This integrated healthcare and social care system has been widely praised by both patients and staff, who feel that communication between units and actors is facilitated by having a joint organisation, which in turn has resulted in both a seamless healthcare and social care chain and a good working environment. A study of COVID-19 mortality among people aged 70 years and older in the Region Stockholm showed a lower mortality rate in Norrtälje than in other municipalities (Doheny et al., 2024), which may be partly due to the closer cooperation and communication (Nordic Welfare Centre, n.d.). The Region Stockholm budget for 2025 explicitly states that an investigation will be conducted into how the Norrtälje model can be spread to other operations within the region.

In Sweden, other local models with increased cooperation between social care, primary care, home nursing care and hospitals have also been studied, including in Borgholm in Region Kalmar County, Region Västmanland and Storuman in Region Västerbotten (Ström, 2018, 2023; Castilla, 2025). These models all ensure close communication between all actors involved in care for older adults and that the majority of care is provided in the home.

Another example can be found in Norway, where a model for integrated care aimed at frail older adults has been praised for focusing resources on older adults who would otherwise be at risk of multiple hospital admissions. The model is based on applying a holistic approach to patient needs. A geriatrician, family doctor and nurses from both the hospital and municipality meet with the patient and develop a care plan focused on what is important for the patient to be able to cope with in everyday life. Goals are followed up every six months to enable older adults to continue living at home. The model was launched in the early 2020s and has already spread to several municipalities in southern Norway. The model is an example of how older adults can be empowered to live independently in a way that strengthens society (Hamre, 2023).

Final reflections

In its report, the Swedish Agency for Health and Care Services Analysis states that the failure to achieve the goal of high-quality and local care is due to, among other things, a lack of financial and human resources. Strengthening primary care is crucial, yet not currently being given sufficient priority. The report also recommends greater government control over the transition to local healthcare (Myndigheten för vård- och omsorgsanalys, 2025). Given the existing difficulties in healthcare and social care for older adults, and based on the current demographic challenge of the rapidly increasing proportion and number of older adults in the population, extensive resources and measures are required. A clear vision and plan are needed, both from the state and in regions and municipalities in Sweden. Increased

exchange of experience and learning between the Nordic countries could enable new solutions, as many of these challenges are shared.

Greater collaboration is needed between social care and healthcare and medical care. A number of different approaches are likely to be needed, adapted to local conditions. To successfully care for older adults, the status, working conditions and working environment of those who work in healthcare and social care, mainly women, need to be improved. Furthermore, the proposals for reform that have been developed should be tested, followed up and evaluated scientifically. The experiences gained during the pandemic should be used to strengthen systems in preparation for future crises. By learning from the differences and initiatives in the Nordic countries, in terms of both structure and approach, the care of older adults can be improved.

- Resources for healthcare and social care systems for older adults must be strengthened. Since multiple illnesses often require both healthcare and social care, it is clear that closer collaboration is needed between regional medical and nursing services on the one hand, and municipal medical and nursing and social care services on the other.
- Clear visions and plans are needed at multiple levels for the implementation of proposed reforms. The implementation of proposed reforms should be monitored and evaluated scientifically.
- Social care for older adults must become a more attractive field of work, and staff need to be the focus of initiatives aimed at improving training, employment conditions, working environments and salaries.
- Greater exchange of experience and learning between the Nordic countries could enable new solutions, as the problems and challenges faced are in many respects common in these countries. Experiences from the pandemic should be utilised to avoid extra work and prepare and strengthen systems for future crises.

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Essay by

Paula Mulinari

The crisis is already here – the question is who has time to take care of it?

Paula Mulinari

For many healthcare workers, crisis is already an everyday reality – and it is getting worse. Not only because they encounter people during periods of crisis in their lives but also because their own working conditions are characterised by what could be called *a permanent care crisis* – a crisis that is highly gendered. It is mainly women who perform care work, both paid and unpaid, and it is their time that is being exhausted. What, according to the employees themselves, is needed to create temporal justice in healthcare? How can we organise a welfare system based on social resilience rather than gendered temporal inequality?

We cannot have any more cuts to healthcare. People are getting older and older, and that requires greater care; that's how we have to think about it. Instead of cuts, we need to expand. Workloads must be reasonable. They talk about production, but when you work in healthcare, you can't talk in terms of production – we don't produce anything. That's the first mistake people make when they talk about this.

(nurse)

An essay on not having the time and opportunities for greater temporal justice

Do you have a second? In the workplace, especially in the healthcare sector, the answer to that question is all too often no (Socialstyrelsen, 2023; Sveriges Radio, 2023; Ventovaara et al., 2024). Do you even have time to read this text because it (hopefully) seems interesting and not because you must? Some may find this question a little trivial as an introduction to a text about preparedness and resilience. Do we even have time to think about time when other major emergencies

such as war, environmental disasters, economic crises and genocide are ever present? At the same time, time, or more specifically the lack of time, is an everyday challenge for many employees, not least women in the public sector.

Stories about 'not having time for what is really important at work' (Vision, 2023), as well as experiences of patients and users being exposed to risks (Inspektionen för vård och omsorg, 2023), are recurring themes in studies of the public sector. Individual and collective descriptions of insufficient time to take breaks or recover outside of work are also common (Aronsson, Astervik & Gustvasson, 2013; Selberg, Sandberg & Mulinari, 2021; Grip, 2025). These temporal inequalities pose significant challenges for welfare societies. In addition, these inequalities are gendered. Firstly, inequality between women and men is increasing both within and outside paid work. Secondly, long periods of sick leave, especially among women in the public sector (AFA Insurance, 2023), pose a challenge for individuals, their families and society at large. Thirdly, temporal inequalities make it more difficult to recruit workers in key areas of society such as healthcare. Finally, gendered temporal inequality makes it more difficult to seriously create a resilient healthcare and social care sector. This is because the employees at its core are already too few and overworked, both physically and emotionally, even before a crisis has struck.

In this essay, I will discuss how issues relating to the organisation of working hours are central to increasing resilience in healthcare. The essay is based on interviews conducted as part of a research project together with sociologist Rebecca Selberg and health scientist Magnus Sandberg, which aimed to study why nurses and social workers leave their jobs and what could make them stay.

Staff in healthcare and social care have proven to be incredibly resilient, but they pay a heavy price. The Swedish Social Insurance Agency's report *Analys av skillnader i nyttjande av sjukförsäkringen* (Analysis of differences in the use of health insurance; 2025) shows that there are significant differences between women and men when it comes to sick leave. Women are more than twice as likely as men to take extended sick leave due to stress-related mental ill health. The report also shows that women still take greater responsibility for unpaid work in the home. Women's higher risk of sick leave is explained by a combination of a lack of gender equality in their private lives and shortcomings in their organisational and social working environment. Women are also at greater risk of being on sick leave due to mental ill health. This is partly because women are more likely to work in so-called contact services within the welfare sector. It is in these professions that we see a marked increase in sick leave due to mental ill health. It is also the case that, regardless of profession, women are more than twice as likely as men to take sick leave due to stress-related mental ill health (Försäkringskassan, 2024).

In other words, women pay a high price for today's working life – with their health, their time and their lives. In this sense, the crisis is already here. It is a welfare crisis

but also a gender equality crisis. One could say that what is actually most 'resilient', in terms of resistance to pressure, is gender inequality in and outside working life (Acker, 2006).

This essay is based on the premise that it is employees themselves who, through their experience, know what needs to be done – both to enable people to work and to make them want to work in a key area of society. What are their visions for building a care sector that takes into account the needs of both patients and staff? How can we create a welfare sector that is sustainable? At a time when we are constantly fed dystopias – both current and future – I want to highlight the importance of thinking about alternative approaches to organising time. I believe the concept of *temporal justice* can help us to do just that.

Temporal inequality, temporal justice and crises

According to Robert E. Goodin (2010), we often understand equality as something that can be measured in monetary terms, for example inequality is often measured in terms of differences in income. However, control over one's time and the freedom to use it as one wishes are crucial aspects of democracy, he argues (2010). Unequal distribution of time shapes people's everyday lives and futures, affects their bodies, health and finances, and, not least, fundamentally affects the possibilities for creating a more equal society. Achieving temporal justice not only means a more equal distribution of time but also changing how people's time is valued, so that some people's time (and thus work) is not seen as more important than that of others. In her book *The Problem with Work: Feminism, Marxism, Antiwork Politics, and Postwork Imaginaries* (2011), Kathy Weeks emphasises that time is a central dimension of power, especially in relation to work, reproduction and the possibility of living a meaningful life. For Weeks, time is not just something we have or lack – it is something that is shaped, valued and controlled politically. Weeks argues that one problem in today's society is that working hours function as a normative framework: being 'busy' with work is seen as virtuous, while leisure time is often viewed with suspicion – especially if it is not filled with something considered 'meaningful'. Weeks emphasises that, from a gender equality perspective, the demand for better working conditions needs to be complemented by demands for less paid work, not more. Today, however, research shows that the opposite development is occurring: paid work is spilling over into people's time outside work, meaning that more and more of people's time is tied up in paid work (Grip, 2025). Meanwhile, more and more wage earners are finding it difficult to balance their lives, especially single mothers, known as the 'working poor' (Carlén & de los Reyes, 2024). Weeks believes that being able to imagine other ways of relating to time is essential. Thinking about time from a utopian perspective should therefore not be seen as dreaming, she argues, but rather as something that captures the problems that exist in today's working life and imagining how things could be different.

With regard to work in healthcare, several researchers have highlighted that care is a practice that is difficult to define in terms of the clock time that usually governs work (Hämäläinen et al., 2024; Håkansson, 2024; Palmqvist, 2020). Karen Davies (1994), for example, developed the concept of 'process time' to highlight those aspects of care work that cannot be captured by linear, standardised clock time. Process time is instead non-linear, context-bound and difficult to schedule: comprising simultaneous events, fluid boundaries and waiting. It differs from 'task-oriented time' in that it emphasises how work is embedded in social relationships. Lack of time and the invisibility of care fundamentally reflect what philosopher Nancy Fraser refers to as the 'crises of care' (2016). Fraser argues that capitalist societies create a 'crisis of care' through their dependence on socially reproductive work, while at the same time undermining the conditions that make this work possible. This results in a crisis in the reproductive sphere, i.e. the sphere, institutions and relationships required to care for people (e.g. caring for children, older adults and the sick, housework, emotional support and education). This crisis can take many forms, from those working in care professions being forced to do more in less time and with fewer staff, to cuts in public services and more and more reproductive work being placed on individuals rather than collective institutions.

In the Nordic countries, austerity policies are not a temporary measure but a permanent state of affairs. While temporary austerity measures aim to deal with short-term crises, permanent austerity is a response to a 'chronic' crisis – one that is politically manufactured (Seymour, 2014). Permanent austerity means that concepts such as cost-effectiveness, production and outcomes permeate the healthcare process and influence values and understanding of what healthcare is. In *Against Austerity*, Seymour argues that austerity is not a necessary response to economic crises but rather an ideological strategy aimed at restructuring the economy to benefit capital at the expense of the working class. He argues that the economic crisis was used as a pretext to implement reforms and privatisations (see Lapidus in this publication), which in various ways undermine the Welfare state. Perhaps the key is not to think in terms of one crisis but rather several interconnected ones. The concept of a 'polycrisis' reflects the fact that not only are we living in a time of multiple crises but that they are intertwined and mutually reinforcing. Economic crises, social crises and geopolitical crises cannot be understood in isolation but rather must be understood as interwoven. A major challenge is that welfare institutions, the workplaces where many women work, are often expected to respond to multiple social problems simultaneously. It is also the case that women are often the hardest hit by crises (Khosla et al., 2024). The question is therefore whether the healthcare sector is in a permanent crisis, with employees constantly forced to compensate for this through their work.

A public sector in transition – a permanent crisis for employees

Researchers, inspired in part by Nancy Fraser (2016), are increasingly discussing whether we are in a social care crisis, even in the Nordic welfare states (Hansen et al., 2022; Selberg & Mulinari, 2022; Wrede, 2008). These countries have previously been described as women-friendly welfare states, but according to several studies, the trend towards neoliberal governance and business-inspired management models has worsened conditions for workers in social care (Sundsbø et al., 2023). In the book *A Care Crisis in the Nordic Welfare States? Care Work, Gender Equality and Welfare State Sustainability*, authors Hansen, Dahl and Horn (2022) argue that there is a specific care crisis in the Nordic context. The care crisis, they argue, is evident in what have been identified as the most gender-equal welfare models. The authors highlight extensive underfunding of the care sector, which makes it increasingly difficult to recruit and retain care staff. Changes in the governance of social care, with more detailed control and new forms of management, have resulted in increased workloads and stress among staff. This, in turn, affects care quality and makes recruitment more difficult. The authors of the book note that the care crisis is characterised by a lack of resources, deteriorating quality, poor working conditions and insufficient time for care workers to take care of themselves and others. The crisis is also clearly gendered, as women make up the majority of both formal and informal carers. The resistance of care to being subsumed into the logic of economics, especially its physical and relational dimensions, makes it a field where economics and politics are in constant conflict (Tronto, 2014).

The dismantling of the welfare state has meant that reproductive work has intensified (Ulmanen, 2015), while demands for profitability and capacity to work have increased and stress in working life has grown. A painful example of how this equation affects people is that while the life expectancy of the population as a whole is increasing (at least for those whose life expectancy can be calculated), the life expectancy of working-class women is decreasing (Klepke, 2018). Temporal inequalities are also clearly shaped by a labour market in which racialised workers are more likely to have precarious employment (Mulinari, 2024). The working class in Sweden today is increasingly made up of racialised workers (Neergaard, 2021). Racialisation is a process in which people are attributed particular characteristics or treated in a certain way, often based on their skin colour and perceptions of race. Within medical care and nursing, many of these people are women, although now they increasingly include men. The temporal inequality within the medical- and nursing sector is therefore not only gendred but also racialised.

An important change that has affected working conditions in the public sector is the implementation of New Public Management (NPM). A significant body of research has identified the introduction of NPM as a key reason for increased workloads and growing dissatisfaction among welfare workers (Mustosmäki et al., 2020). Within medical care and nursing, NPM has shifted focus from patients to administration and budget constraints and from employees to managers. It has also placed greater emphasis on organisational professionalism at the expense of occupational professionalism (Selberg & Mulinari, 2022).

The concept of resilience, discussed in the introduction, has many different meanings. In healthcare, for example, it can mean the capacity to manage crises, adapt to change and recover from stress. Resilience is thus seen as a key factor for sustainability and patient safety in times of increasing demands, staff shortages and societal crises – not least during the COVID-19 pandemic. One problem that became apparent during the COVID-19 pandemic is that resilience often depends on staff flexibility, loyalty and willingness to push personal boundaries (Montgomery et al., 2024). This can lead to resilience being romanticised, obscuring the actual costs for those working on the frontline – especially women, who make up the majority of care staff globally. As much research showed during the pandemic, many workers in healthcare were expected to compensate for systemic failures – by working overtime, being available during crises and coping with increased demands, despite insufficient resources (Abay, 2024; Wall & Bergman, 2021). In the short term, this may contribute to maintaining a 'functioning system', but in the long term, it risks undermining staff wellbeing, contributing to burnout and exacerbating staff turnover.

The Swedish Association of Local Authorities and Regions (SALAR) estimates that the need for staff in care for older adults in Sweden will increase by 66,000 people by 2033 as a consequence of the ageing population (Sveriges Kommuner och Regioner, 2023). SALAR argues that an increase in full-time employment is one way to meet this need, as many people in the sector currently work part time. At the same time, research (see, for example, Grip, 2025) shows that full-time work often means increased time pressure, difficulties in balancing paid and unpaid work and increased demands on employees' flexibility. Many people work part time in order to balance their lives. Research also shows that even those who formally work part time often work more than part time in practice, as a result of work having intensified, with much of it being unpaid to 'keep up' with what is expected (Selberg, Sandberg & Mulinari, 2021). These temporal inequalities in turn lead to reduced resilience in healthcare. It becomes more difficult to manage crises and recover from them when the central resource – employees – is exhausted even before a crisis has struck. During the pandemic, it became common in many countries to applaud healthcare workers. The OECD report *Beyond Applause? Improving Working Conditions in Long-Term Care* (2023) emphasises the need to go beyond applause and nice words and seriously address conditions for employees.

It highlights that even before the pandemic, staff were working under very poor conditions. The need for labour, for example in care for older adults, is a global challenge: people want to work in a sector in which wages are low and working conditions poor. Applause is all well and good, but what is needed, according to the OECD, is respect[1]: recognition, greater control over work, more resources, better pay, new technology, improved working conditions and training initiatives. One could add that what is also needed are other ways of organising working time. Suggestions for how this can be done are discussed below.

Collectivise the view of time

Time has long been at the centre of feminist theory and politics. The unequal distribution of time between paid and unpaid work is a fundamental aspect of gender inequality and affects all areas of life. The eight-hour working day is an institution that is over a hundred years old. During these hundred years, Swedish workers have not succeeded in shortening the working day, despite public debate and a number of attempts. Instead, women (especially working-class women) often work part time to allow them to combine paid work with unpaid care work for older adults and children. A report by the Swedish Association of Health Professionals from 2025 shows that 34% of its members work part time, of whom 57% state that they do so because they need rest to recover (Vårdförbundet, 2025). Among municipal workers, nearly six out of ten employees work part time (Kommunal, 2022).

One of the nurses we interviewed in our research project describes the difficulties of working full time:

I won't be able to stay on as a nurse until I retire, I already know that. I work part time because of the enormous workload in the department. It's impossible to work full time, you can't cope, you're constantly tired. Even so, I never have enough time at work. I don't have time for my patients. I feel like I'm rushing in and out of patients' rooms, and even though I want to sit down and talk to them about their situation or just ask if they want a cup of coffee, there's no time for that.

1. RESPECT for the caring profession:
   - Recognise care workers, both economically and socially
   - Enforce effective regulations governing the LTC sector
   - Sustainably fund the LTC sector
   - Pay better salaries
   - Equip workers with new technologies
   - Collective bargaining for better work conditions
   - Train to retain LTC workers

One way to deal with this time conflict is to work part time, and many of the nurses we interviewed did just that, allowing them to act in line with what they themselves perceived as professional and ethical care. Another nurse describes the same scenario, saying that she does not see herself being able to work as a midwife until she retires:

Maybe I can manage a few more years, but in the long run – I won't be working as a midwife or nurse when I retire. I'm absolutely certain of that. And it's sad, because I'm really committed and love my job. I enjoy it, and I know I'm making a contribution, but under the current circumstances, staying on is not an option.

INTERVIEWER: *What could make you stay?*

Half the workload and better pay [laughs]. Then I would definitely stay.

Nurses are left alone to deal with 'lean organisations' by working part time, planning for early retirement and limiting their free time. A central tension in care work thus arises from the different time logics that characterise care organisations: on the one hand, the logic of care that puts the patient at the centre and, on the other hand, a logic characterised by efficiency and 'lean management' (Keisu, Öhman & Enberg, 2016). Providing care involves a web of different actors but also a web of time, which one might call a 'web of care time'. The interviews show that organisations operate on the assumption that employees will give of their time, a process of organisational time appropriation:

We were often called on: they wanted us to come in early if we had an evening shift, stay late if we had worked during the day [or] take an extra shift at the weekend because someone was ill. So even if I thought I had a day off, I was still contacted by work, and just the thought of putting colleagues in a position I wouldn't want to be in myself, even if you say no, it's still stressful.

The permanent understaffing is left to individual workers to resolve. It also obscures the fact that working time is collective time. Nurses' working time is intertwined with the time of others: colleagues, patients, relatives. The temporal contradiction that arises in the workplace is thus also based on the organisational perception of time as something individual and separate, when in fact it is a relational and collective phenomenon. The problem is that neither workers' nor patients' time is at the centre of organisational logic. Highlighting the discrepancy between the time work actually takes and the time it is considered to take can therefore be seen as a way of increasing resilience in medical care and nursing, enabling patients, users, employees and their relatives to perform and receive the care they need. The struggle for time is in fact a struggle for a true utopia, where care work is allowed to take time and where time is recognised as a collective concern. For the public sector to change, it is necessary to recognise that care must be allowed to take time. Public sector employees (and indeed all workers) should

have the opportunity, and organisations should have the resources, to devote time to care. Not only to perform basic care, but also, for example, to drink coffee with a patient or relative, listen to a patient's story, reassure a new nurse, build relationships with other staff, talk to colleagues, reflect on the situation at work, rest, adapt and recover.

Among the workers interviewed, there were two suggestions on how this could be done: to give those working in the public sector more influence over operations and to allow care to take both time and money. Let those who provide care also have a say in how it is organised:

If I could suggest something... If it was up to me, I would get rid of all the managers and replace them with people who have worked on the floor themselves and know what the reality is like.

One of the nurses posed the key question: "What if we, the workers, took over?" What if? What would increased democratic control over public healthcare look like, beyond simply replacing managers or leadership styles? Many felt that it was nurses' knowledge of the workplace that should shape organisational decisions and structures around social care work. The nurses interviewed felt strongly that their workplaces were a far cry from this ideal. Instead, they described a gap between their crucial role in providing care and their marginalised role in its organisation. Many expressed frustration that social care work – i.e. tasks that focus on improving or maintaining patients' physical and/or emotional well-being – is neither recognised nor valued:

Everything revolves around money. But healthcare is — I mean, healthcare shouldn't be about saving money. Healthcare should be about providing good care within reasonable limits. It's political too, on so many levels, even on a personal level (among managers), but also higher up. There needs to be change [everywhere]. We've had enough.

While some of the nurses expressed that managerial positions should be eliminated entirely, others believed that managers and politicians should be replaced by people who genuinely care. It could be said that some formulated a utopian vision of a workplace governed by the workers themselves, while others imagined a real utopia in which managers still existed but with different priorities. Our material shows that many nurses feel that the problem is not that managers and politicians *do not know* what it is like on the floor, but that they *do not want to know* – and that they do not care.

INTERVIEWER: *If there is something you want to complain about, do you dare to do so?*

Yes, I think so, absolutely, but then you always get these shitty answers, politicians' answers, like: "We'll look into it," or "Yes, we know we have to do something about this," and then nothing happens. ... We have a noticeboard on which you can write a note with a suggestion, and then they collect them and read them, but nothing ever happens with our suggestions. It feels like a way for them to avoid us complaining directly to them; instead, we have to write it down on a note, and then we're supposed to be satisfied.

The problem, according to many nurses, was that no one listened to them. A central theme is the gap between nurses and managers, in terms of both means and goals. Nurses often emphasised that managers lack the knowledge required to organise daily work in an organisation for which the primary task is to provide care. According to many interviewees, this poses a direct threat to both patients and staff. Our material shows that healthcare staff rarely participate in the key decisions made by managers. Instead, they are forced to participate in meaningless activities that diminish their competence.

Allow social care to be visible and take time

In the opening quote, one of the interviewed nurses makes it clear that they do not produce anything, and that the first mistake made when talking about healthcare is to view it as a production unit rather than a place where people are provided care and treatment. When managers prioritise finances over care, nurses feel that they lack the time resources needed to provide care. One of the nurses highlighted how these priorities shape everyday working life:

The biggest problem is resources. For example, in our department, we are only allowed to spend ten per cent of our time meeting with patients who have been discharged, which means that we cannot do proper follow-ups... we cannot do what is actually important for patients. We are expected to live up to something that does not exist. There are no resources to allow us to live up to the goals that management sets for us. I think people think differently the higher up you go. Maybe they think about money: money is what's important, it's what controls everything. It's about the budget. We get new managers and new demands, new demands for cutbacks, new budgets, and they refer to them all the time. They say: "we really appreciate what you've done, but we don't have the resources for it". It's all about money. And I'm so tired of it, everything being about money. Healthcare is about healthcare, not about saving money. Healthcare should be about providing care, but instead they are cutting back on healthcare and on healthcare workers' salaries. The whole idea is wrong.

As we have already described, austerity measures in the Nordic countries are not a temporary phenomenon. Permanent austerity means that much of the work that is part of nurses' everyday lives becomes invisible – because it cannot be measured. What nurses themselves identify as important thus becomes unimportant to the organisation, forcing them to either do the work anyway (increasing their exploitation) or refrain from doing it (increasing feelings of ethical stress and reducing pride in their work).

When does a crisis become a crisis?

For many workers in medical care and nursing, the crisis is already an everyday reality. Not only because they encounter people in moments of crisis in their lives, but also because their own working conditions are characterised by what Nancy Fraser has called 'a permanent crisis of care' – a crisis that is highly gendered (2016). It is mainly women who perform social care work, both paid and unpaid, and it is their time that is being exhausted. The crisis is therefore already here – and it is deepening. To build a resilient healthcare system, gender equality work needs to be strengthened. This means, among other things, seriously rethinking how working hours are organised. Today, a lack of time is wearing down staff, both physically and emotionally. That is why the issue of crisis and resilience is also a gender equality issue. A society where women's work continues to be undervalued, underpaid and, at the same time, time-consuming will find it more difficult to cope with crises. At the same time, the responsibility for managing the crisis is placed on these very women – who often cannot manage their own lives. Temporal justice can offer a path towards more sustainable welfare. It is about taking the ongoing crisis seriously – as the workers themselves express it. They are not just calling for resources, but pointing to something deeper: the need for time to do their work, time to recover and the resources to provide care with the compassion and professionalism required. Fundamentally, their testimonies raise a bigger question: Who should decide the content of work and the time it requires? What rationales should govern?

There is a tendency to view a crisis as something that will happen in the future – a state of emergency for which we can prepare. But in healthcare, crisis is already part of everyday life. It is not always visible in the headlines, but it is noticeable in the fact that staff do not have time to do their work as they would like, that patients do not receive the care they need and that relatives are having to take on increasing responsibility. We must start thinking of crises not just as sudden events but as protracted conditions. This applies, of course, to the climate crisis, but also to the care crisis. Workers are already carrying the resilience of the healthcare system on their shoulders – at the expense of their bodies, relationships and dreams for the future. If we are serious about building a sustainable healthcare

system, we must listen to them. Applause does not create resilience. What is needed is time, resources and influence – giving greater control over one's own life. This is crucial not only for gender equality, but also for maintaining a healthcare system that is not based on women's unpaid overtime but on collective social responsibility.

In Michael Ende's novel *Momo* (1980), the grey time thieves hunt people's time. The grey gentlemen justify their constant theft of time with promises of increased efficiency and wealth. People are expected to gain more time by saving it – but 'time is life,' writes Ende, and the more you save, the less you have left and the poorer you become. Ende's book about the girl Momo and her companion, the high-tech but slow turtle Cassiopeia, was published in 1973 and can be read as an early critique of the dehumanising nature of capitalism. It shows how increased demands for efficiency and productivity crowd out everything that is not considered paid labour, relegating other activities to meaninglessness – because they 'only' take time. *Momo* ends happily, when the four friends finally defeat the grey gentlemen, Ende writes:

"And the doctors had time to devote themselves to each patient in peace and quiet. The workers could work at a calm pace with love [...] Everyone could take exactly as much time for everything as they needed or wanted, because now there was once again plenty of it to go around."

(Ende 2003: 308)

The question is: What would we see if working hours in healthcare were actually changed?
What synergies would then become possible? In many ways, inequality is such a normalised crisis that it is rarely referred to as such. But for healthcare workers – and for all of us who at some point require care – the care crisis is a reality that is paid for with time and lives. At a time when resources are diminishing and needs are growing, the workload for staff and responsibility for relatives are increasing. It is an everyday crisis that must be taken more seriously. Otherwise, we risk continuing to place the responsibility for resilience on individuals – instead of building systems that actually support people in crisis and make it possible to meet them together.

- Improving conditions for temporal justice is one of the major gender equality issues of our time.
- If we seriously want a resilient welfare sector, we must also take the issue of gender equality more seriously. Temporal inequalities in the welfare sector are clearly gendered, and racialised and it is primarily women who are currently forced to juggle the care crisis with their own time, health and bodies.
- We need new understandings of time in working life, understandings that recognise and allow time for care and recognise time as something collective and relational within the welfare sector. Developing and exploring new understandings and distributions of time would not only strengthen the resilience of welfare but also give people greater opportunities to live sustainable lives – both at work and outside of work.

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Essay by

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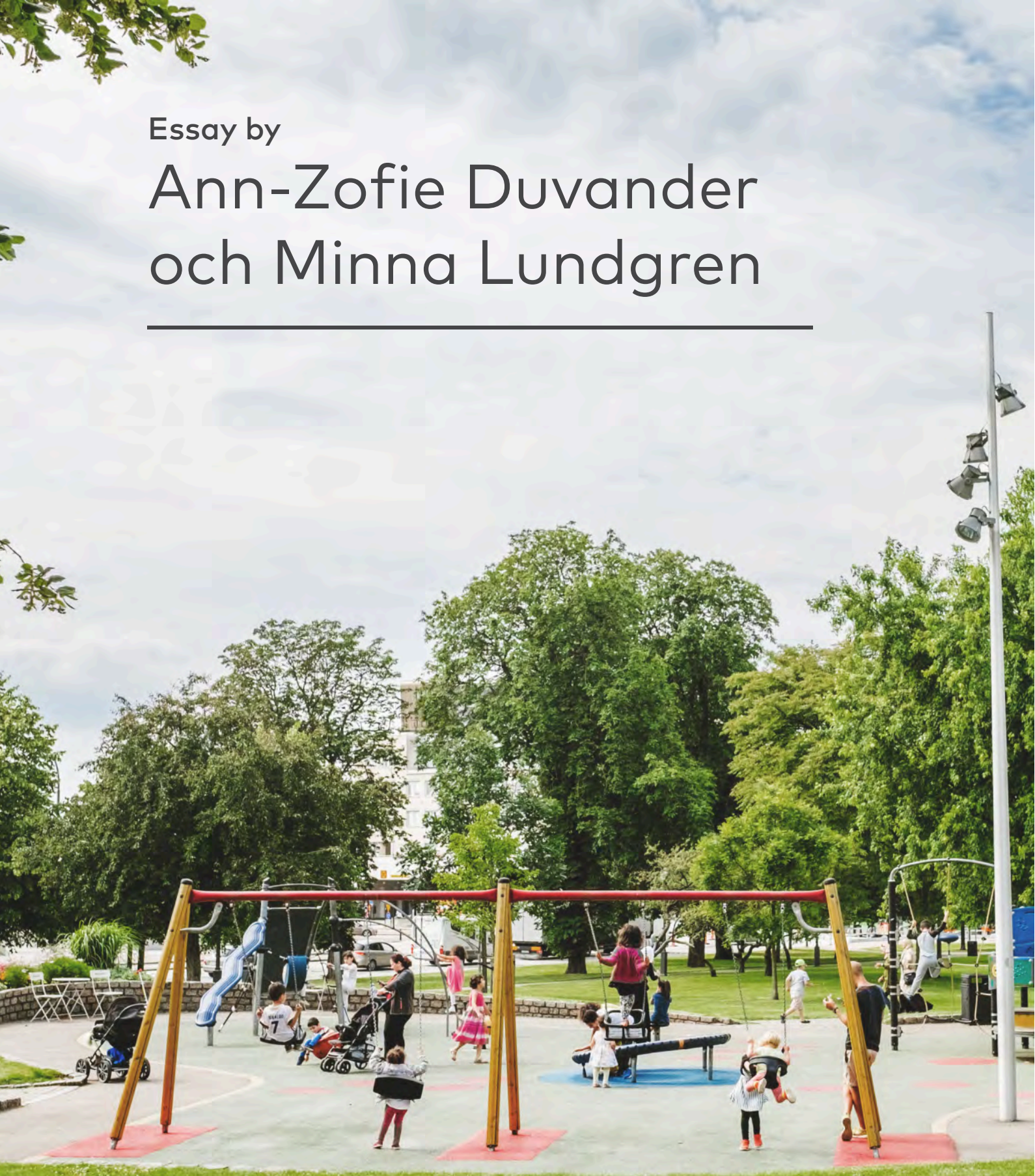

Provision of care during a crisis – will it work?

Ann-Zofie Duvander and Minna Lundgren

In times of a heightened state of alert or war, the Nordic countries face major challenges in terms of planning for medical care and nursing services as well as social services. Such a situation affects people in need of healthcare and social services, organisations that provide healthcare and social services, and the women and men who work in healthcare and social services. The need for healthcare is likely to increase, but how responsibility for this will be shared is unclear. A fragmented and largely privatised sector faces major challenges, even without a crisis. The need for care for children and elderly relatives is also likely to increase. How those working in the sector balance these different needs, largely women who are already under pressure, will be critical.

The Nordic Council of Ministers has agreed on a cooperation programme with the aim of making welfare accessible to everyone in sustainable and inclusive societies (Nordiska Ministerrådet, 2024). Medical and nursing care for the elderly and people with certain disabilities are central to Nordic welfare, and it will be particularly important for these services to function well in the case of a heightened state of alert or war. As a result of Russia's war in Ukraine, which began in 2014 and continued with a full-scale invasion in 2022, the security situation has changed and the Swedish government has decided to resume total defence planning. This means, among other things, that authorities that perform socially important tasks need to plan for their operations to function in the event of heightened alert or war, i.e. that operations must be maintained and able to withstand stress. In Sweden, the National Board of Health and Welfare is the authority responsible for health, healthcare and other care, and in recent years has been given several expanded assignments related to crisis preparedness in medical and nursing care (Government Decisions No. S2024/01060 and S2024/01055). Preparedness includes planning to ensure availability of personnel through total defence duty and wartime postings, a system that was introduced after the Second World War. At that time, the main focus was on wartime postings for men to perform duties in the Armed Forces in the event of war, while they had other jobs in peacetime. With the resumption of total defence planning, many authorities besides the Armed

Forces have now begun to plan for how their operations will function in the event of a heightened state of alert or war, including through the wartime postings for personnel. However, major and radical changes have taken place in Nordic societies since the advent of total defence planning in the 1950s, not least that both women and men are now almost equal contributors to the workforce. In this text, we will discuss issues related to the need for and planning of medical care and nursing in the case of a heightened state of alert or war in today's Nordic societies. We will start from the Swedish context, which we know best, but the issues we will discuss are also highly relevant in the other Nordic countries.

A recent report on staffing in civil defence (SOU 2025:6) addresses changes in the labour market, highlighting privatisation and the emergence of subcontractors in medical and nursing care, healthcare and other care as new challenges for total defence planning. However, the implications of total defence planning for a modern society, with a workforce consisting of both women and men, and thus mothers and fathers, are hardly problematised or discussed. In general we have in the literature hardly found any mentioning of the consequences of the fact that women and men today are both engaged in paid work and parenting. For society to be resilient and resistant in a crisis, we believe that aspects of gender, in intersection with other categories such as family situation, age, citizenship and rural and urban residence, must be taken into account. How effectively medical and nursing care for citizens will function in a society in a state of crisis or heightened state of alert needs to be viewed from at least three perspectives:

1. Those in need of healthcare and other care
2. Employers who are responsible for ensuring the provision of healthcare and other care
3. Care providers, i.e. staff of various kinds and from different professional groups

For all three perspectives, gender, in intersection with other categories, is central, and we will discuss the conditions for carrying out these activities in the event of a heightened state of alert or war. One example is that Early Childhood Education and Care (ECEC) provision for those who perform socially important activities should be prioritised (SOU 2025:6, Regulation 1991:1195). However, if extended working hours and limited holiday leave become relevant, there will be a need to define the workers affected and, among other things, what this means for the increased need for childcare (perhaps primarily with regard to ECEC). None of the above perspectives can neglect the individuals involved and what can reasonably be expected of them. Our discussion is by no means exhaustive but can be seen as an argument that realistic planning of how work is to be carried out during a heightened state of alert or war must take into account who is expected to perform various tasks, and here gender is a highly relevant factor.

During the Second World War, women replaced conscripted men in the labour market to some extent, but during the first half of the 1950s, strong economic growth meant that many families could live on one salary (Nermo, 2000). There was also resistance, especially to married women to be engaged in paid work, and access to childcare was very limited. To the extent that married women did paid work, their income was primarily seen as a supplement to that of their husband, with men's higher wages justified by their role as breadwinners. Under these circumstances, the system of wartime postings required women to take primary responsibility for the home and children when men were called up for training exercises and in the case of war. This stands in sharp contrast to today's society, where expectations of labour force participation are gender-neutral and social institutions such as ECEC and schools make this possible. The labour market participation for women aged 15-74 in Sweden in April 2025 was 67.1 per cent and for men 70.9 per cent[2]. Among women engaged in the labour market, 15.8 per cent were temporary employed. Among men, the same figure was 13.2 per cent (SCB, 2025). Female employees are the dominant group in municipal and regional medical and nursing care for elderly, and many of them also bear primary responsibility for the home and family when the working day is over. Authorities' current planning for the continued functioning of operations in the event of social crises and extraordinary circumstances such as war, will have a significant impact on many women employed in the public sector. Some of them may be assigned to wartime postings within the framework of their employment, while the vast majority are expected to serve at their regular workplace in accordance with their general national service. It is therefore very much a gender and equality issue how these employees will be able to fulfil their general duty of service and whether this duty conflicts with expectations of care in the private sphere.

First, we need to briefly go through some concepts that are important for this essay, the first of which is *total defence duty*. All Swedish citizens and permanent residents of Sweden between the ages of 16 and 70 are subject to total defence duty, which includes:

1. military defence service within the Swedish Armed Forces,
2. civil defence service in rescue services and similar activities, and
3. general national service.

Military defence service means that you have completed basic training in the Swedish Armed Forces and, in most cases, have a wartime posting (see below) for service during heightened state of alert or war. Civil defence service is the civilian equivalent of military defence service (Myndigheten för samhällsskydd och

2. Nordic Statistics reports the following figures for labour force participation in the Nordic countries for people aged 20-64 in 2024: Denmark 83.4 (men) and 76.9 (women); Finland 77.3 (men) and 76.6 (women); Iceland 90.2 (men) and 83.4 (women); Norway 82.5 (men) and 77.4 (women); and Sweden 83.9 (men) and 79.9 (women). All figures are given as percentages (table WORK02). Also, Eurostat (2025).

beredskap, 2025). These duties affect certain sections of the population, while general national service can include almost everyone of working age. During heightened states of alert, the government can prescribe general national service to ensure that socially important activities continue to function. General national service can therefore apply to all or parts of the country and to certain activities. Those employed in the public sector are generally expected to continue their regular work but may also be required to serve elsewhere. This is decided by the employer (for government employees) or by the Swedish Public Employment Service (for others). During heightened state of alert, general national service means, among other things, that employees do not have the right to terminate their employment.

Wartime postings are an important tool for systematically planning who will serve where in the case of total defence. Wartime posting means that a decision is made on where an individual will serve during a heightened state of alert or war. There are two types of wartime postings, the first of which is service under the act on total defence duty (1994:1809) and includes military and civil defence services. The second type of wartime posting involves employer planning. Employers who are responsible for carrying out socially important activities apply to the Swedish Defence Conscription and Assessment Agency to have their staff assigned to wartime postings in the event of a heightened state of alert. This means that the employer will call on certain employees in the event of a heightened state of alert or war. This is to maintain operations and ensure that employees are not called upon for other socially important activities. An employee can therefore be assigned to the Swedish Armed Forces within the framework of military defence service, to the emergency services within the framework of civil defence service or to their regular employer. Recently, the number of wartime postings in the country has increased. Between 2017 and 2020, the number of municipalities that checked whether people were available for wartime postings, or applied for wartime postings for employees via the Swedish Defence Conscription and Assessment Agency, increased from 19 to 120. In 2022, 15 regions and 105 municipalities had placed employees in wartime postings, and these figures increased to 19 and 163 respectively between 2022 and 2024 (Plikt- och prövningsverket, 2021; 2025). The number of municipalities and regions assigning personnel to wartime postings is thus increasing, but they are doing so in different ways. For example, Region Skåne has assigned all permanent staff to wartime postings, while Region Stockholm has assigned only those in key positions (Granestrand, 2023).

Medical care provided by regional authorities and healthcare and nursing care provided by municipalities are socially important activities that are required to meet society's basic needs (Myndigheten för samhällsskydd och beredskap, MSB, 2023). Planning to ensure that these activities continue to function does not currently take into account circumstances or opportunities related to gender, family status, individual care commitments or other circumstances. But how do care needs

change in a crisis situation? And what means are available to those responsible to ensure that these needs are met? And how will it be possible to fulfil the general national service for all of us, who are, of course, more than just 'general individuals'?

We will begin by describing how needs for medical care and nursing care can change in a crisis situation.

Changed needs for medical care and nursing care during a heightened state of alert

War radically changes the way society functions. It has major consequences for both public and private activities and, of course, for all individuals. A key factor in a crisis or war situation is that the need for healthcare and other care is likely to increase (see, for example, SOU 2025:6). The crisis situation itself can lead to people being injured and needing both emergency and long-term care. Elderly care as well as other care is currently provided either at home in the form of home help services or in special housing. However, a large proportion of care is also provided by family members, who in a crisis situation may be forced to relocate or work longer hours. Relatives have taken on an increasingly important role in caring for elderly family members (Ulmanen & Szebehely, 2015), and there is a strong expectation by the public providers that that relatives carry out at least some of the care and contact needed. If relatives will not assist with some care, there is a risk that the elderly and others in need of care will suffer, or that home help service providers will become overburdened. This is already a trend in the Nordic countries where for instance the differences in access to public care between urban and rural areas are increasing (Rostgaard et al., 2022; Sjögren & Parding, 2024). In many municipalities in rural and sparsely populated areas, the older part of the population is overrepresented, and long distances can become even more problematic in situations where society is exposed to external stresses. This is likely true in all Nordic countries.

Furthermore, experiences from for instance Ukraine show that crises often lead to internal displacement within a country. Internally displaced individuals place a strain on local communities, and existing social services must continue to function even in situations of war and crisis. Vulnerable groups become even more vulnerable, such as children (Armitage, 2022), the elderly and individuals with disabilities (see, for example, Patarwy et al., 2023; Regev & Vasylchenko, 2025; Rosenthal et al., 2022) as well as those who are economically marginalised.

Membership of NATO may also have consequences for all Nordic countries, even if war does not take place in their territory. For example, NATO countries may need to assist with patient evacuation or a rapid influx of patients in the event of mass casualty incidents (see for example Socialstyrelsen, 2025).

These aspects affect the burden of and need for both healthcare and nursing care, but one area that is rarely mentioned in relation to crises is ECEC and other childcare. A well-developed, high-quality ECEC system is something that is now seen as an integral part of the welfare state, but it has a short history (Duvander & Nyberg, 2023). When childcare provision began to be expanded in the 1970s and 1980s, the goal was to create a universal childcare system that was equally available and beneficial to children across economic and social backgrounds. Intellectual stimulation was an important aspect in the provided childcare, but also at least one warm meal each day. In a crisis situation, it should be kept in mind that many children may need support of various kinds, including medical care. Experiences from COVID-19 also show how easily children's participation is overlooked in periods of crisis, contravening a number of regulations to protect children's rights (Kjellander & Sjöblom, 2023). At the same time we may all agree that it is crucial to care for the next generation during a heightened state of alert.

In sum, we can assume that the need for healthcare as well as other care will increase during a crisis, both because a larger part of the population will find themselves in vulnerable situations and because those who currently provide the unpaid care in the private sphere will likely have less capacity to do so. But what means, interests and responsibilities do those in charge, such as local authorities, regions and private care providers, have to safeguard these in many ways increased needs during a crisis?

Responsibilities during crisis in a new labour market

The privatisation of areas of the welfare state that previously were public has increased over time. For example, in 2007, 26 per cent of all Swedish healthcare centres were private, a figure that rose to 47 per cent in 2023 (Sveriges kommuner och regioner, 2024). In central Stockholm, there are now only a few healthcare centres that are publicly run. This raises a number of questions regarding how responsibility is distributed and the possibilities to take on this responsibility.

The legal situation for private providers of healthcare and other care is unclear when it comes to operating during heightened states of alert or war, as the relevant legislation was introduced at a time when almost all healthcare and other care services were run by the public sector. There are also major differences between Sweden's municipalities, where core municipal services have been privatised to varying degrees. In some municipalities, it may be as much as half of all activities, while in others the proportion of privately run activities is very small (Arbetet, 2024). Similar trends can also be seen in Norway (Ågotnäs et al., 2019) and Finland (Mathew Puthenparambil, 2018). What legal responsibility does a private healthcare provider actually have to continue operations during a crisis? Globalisation means that many of the private providers are international companies

or foreign owned, and it is possible that these providers also have financial requirements and responsibilities to balance in other countries.

However, it is clear that ultimate responsibility for municipal and regional care recipients lies with the public sector, that is the municipality and the region. For example, were a privately owned nursing home to go bankrupt in a situation during which the government had introduced a heightened state of alert, the municipality would be responsible for ensuring the availability of functioning elderly care. This may lead to major challenges, not least as the municipality may not have the staff reserves available to do so.

In addition to the increased privatisation of welfare services, the employment types have become increasingly heterogenous. Perhaps the best example is the so-called gig economy, which involves companies and private individuals purchasing services from individual contractors via a range of platforms. A study from 2016 shows that 10 per cent of the Swedish population between the ages of 16 and 64 have at some point worked in this economy (Huws et al., 2016). Håkansson (2024) shows that the gig economy has also left its mark on the welfare sector, where many workers do not have permanent employment and must instead wait for requests from a range of employers. They need to respond quickly to short-term and immediate requests to get sufficient work opportunities. This set-up of services risks seriously affecting healthcare and other care in the event of a heightened state of alert. The reason is that the staff who are usually contracted for short 'gigs' often have several potential employers, having sometimes too few and sometimes too many job requests. They may also have been assigned other work through the Swedish Public Employment Service within the framework of general national service as well as to wartime postings by, for example, the Armed Forces. In addition, fixed-term contracts will affect the available staffing and such contracts account for about 15 per cent of all employment in Sweden (ekonomifakta.se), but likely a larger proportion in the sectors with which this paper is concerned. Employers can choose to assign fixed-term employees to wartime postings, but this will be much more difficult if they only have a short lead time for planned working hours.

Many of those engaged in home help services work for several providers. Loyalty to a temporary employer is not a given and, in the frequent cases of multiple employers, it is not possible to be loyal to several employers during a heightened state of alert. Those who are only employed on an hourly or on-call basis are also not covered by general national service, as they are only considered employees during the shifts they have agreed to work (SOU 2025:6). In other words, employers who are heavily dependent on hourly staff will face staffing challenges in the case of a heightened state of alert.

Perhaps one of the most difficult problems is gaining an overview of healthcare and other care needs and to make an estimate of the personnel required. Who will have

knowledge of existing needs and those that arise? This is not easy, as needs are constantly changing, both regarding the elderly, medical and other care. Local authorities and regions have the responsibility, but as provision is largely private today, it will be difficult to get a comprehensive picture.

In sum, we can expect different employers to take on responsibilities in different ways, have different opportunities and perhaps different levels of willingness to organise the provisions that will be needed in the event of a heightened state of alert. Gaining an overview of the required and available workforce will be a challenge. Recruitment to the welfare sector is already a major problem throughout the Nordic region (Penje & Berlina, 2021). So, who are the people who work in healthcare and other care, and what possibilities and limitations do they have to carry out their work in a crisis situation?

Individuals working in healthcare are not just anyone

Today's labour market is in a state of constant change. There is currently a high level of unemployment due to the economic downturn, but the labour force participation is also high, not least because women in the Nordic region participate in the labour market to a high degree. The labour market is largely gender segregated and women often work in typical welfare sectors such as education, healthcare and other care, where provision must also function in the event of a crisis or war. An overwhelming majority, 87 per cent, of registered nurses in Sweden are women (Socialstyrelsen, 2024). Another example is that there is a predominance of women in the dental profession and an almost equal distribution of women and men who are registered doctors (Socialstyrelsen, 2024). The most common profession in Sweden is nursing assistant, and 89 per cent of the country's nearly 130,000 nursing assistants are women (Statistics Sweden, 2023).

While female labour force participation is high in the Nordic countries, there is a significant discrepancy between foreign-born and native-born women, with a large proportion of foreign-born women, especially newly arrived, not in employment. In Sweden immigrant women seem to face greater obstacles to establishing themselves in the labour market than immigrant men (Landell, 2021). In theory, those who are outside the labour market can be called upon for general national service during a heightened state of alert, and thus be assigned to work in areas such as healthcare and ECEC, where needs can be expected to increase. A parallel can be drawn to the fact that during the Second World War many women served in a 'reserve labour force'. However, the problems of applying general national service to people without relevant education, experience or service should not be underestimated.

The high employment rate amongst women in Sweden and the Nordic countries could lead to a larger pool of workers available for wartime postings and also to more workers who can serve in a location other than their regular place of work within the framework of general national service. However, employed women are also the ones who often have main responsibility for homes and children, responsibilities that are unlikely to diminish, but rather increase, during a crisis. As a result, they will often not be able to be deployed or serve in another location, as wartime postings or the conditions of war in general sometimes require. As there is still a skewed gender distribution of responsibility for children, it is likely that women will take on greater responsibility during a heightened state of alert, while also working in critical welfare sectors that are necessary for society to function. It is therefore remarkable that the many investigations and reports engaged with the question on how Sweden will manage staffing needs in a time of crisis do not shed more light on how the issue of private care should be resolved.

During the COVID-19 pandemic, some ECEC were forced to close for periods due to staff shortages. In these cases, children of parents working in essential services were given priority for places at other ECEC that remained open. How will this affect those who are not in permanent employment but regularly take on temporary work with different employers? If those parents are not provided ECEC for their chidlren, it will present a setback for medical care, nursing as well as other sectors that recruit according to the 'gig principle', as these parents will need to look after their children instead of taking temporary gigs. Even before the COVID-19 pandemic, a clear division was visible in the labour market, with the conditions for vulnerable groups and those in stable situations with permanent employment becoming increasingly distant (Eriksson et al., 2017). This situation should be understood from a gender perspective, as it is mostly women who have the insecure jobs and who will also likely take on childcare responsibilities if ECEC is limited.

Although gender equality in the private sphere has increased, many women continue to bear primary responsibility for childcare and other household tasks. Jobs in medical care and nursing are not particularly flexible in terms of working hours and opportunities to work from home. Flexibility in employment has proven to be a salient issue for gender equality in relationships in which couples are raising children together. In more restricted professional fields, part-time work among women remains a common way of managing the tension between work and family life (Öun & Grönlund, 2022). Among the members of the Swedish Association of Health Professionals, 34 per cent work part time (Vårdförbundet, 2025). The main reason for this is the intensive workload in healthcare, followed by the need to have more time for family. It can be assumed that the workload in healthcare will increase even more in the event of war and, at the same time thatprivate responsibilities will not decrease. A higher proportion of men are assigned wartime postings in the Swedish Armed Forces, which may entail service in another location.

The consequences may be that private childcare responsibilities will be even more gender unequal.

Looking back at the Second World War, the resistance to married women working resulted in long shifts for the usually unmarried nurses serving in war zones around the world. Today, the situation has changed radically, and many women working in health care and other care have children at home, which likely will affect their ability to work long shifts. The demand for ECEC and schooling during inconvenient hours may have to be considered.

Another aspect of public services is public transport. Access to efficient public transport affects people's ability to get to work. About 60 per cent of the country's population over the age of six use public transport regularly and women more so than men (Svensk Kollektivtrafik, n.d.). If public transport services are reduced, it will affect the possibilities to get to work, particularly for women and those in sparsely populated areas.

In sum, how to meet the growing need for both workers and care for children and others in the private sphere risks becoming a battle over resources, a battle in which the reserves are limited. To pay attention to this competition over resources will help us to ensure that the most vulnerable are protected. Women are at risk of finding themselves in difficult situations, facing demands from employers and, more or less explicitly, demands to provide care in the home. Below, we discuss additional factors in the private sphere that may affect workers' abilities to fulfil their general national service.

Individuals are often part of a family

Like most other countries, Sweden has seen major changes in family dynamics. Perhaps the most important one to have consequences for resilience in the workforce for medical care and nursing, is that parental separations are relatively common. According to Statistics Sweden (SCB statistikportal), in 2024, 73 per cent of all children aged 0-21 lived with both their original parents, while the rest lived with one parent and sometimes another adult in the household. Approximately half of children who are registered with one parent live alternately with their parents, and the absolute majority of those living with one parent live with their mother. However, the statistics are uncertain and reflect a fluid situation in which living arrangements change with children's age and other events in the lives of children and parents. Reconstituted families are relatively common, and at least one in ten children live in such a family. From an adult's perspective, it is not unusual to have children with different partners. Today, there is also greater variation in the way families take shape, including same-sex parents and parents who have chosen to have children on their own.

What significance do family dynamics have in terms of wartime postings and general national service? If one parent is deployed to another location for general national service, it will increase the burden on the parent who remains at home. Moving with a partner may be impossible, as it is not possible to resign if the government has prescribed general national service. This can entail many logistical difficulties and hardly considers the child's perspective, as their access to both parents is limited. The situation can also be complicated by differing age groups of children within the same family or household and everyday planning that involves parents living apart. For many, it is simply the case that the care puzzle is complicated and each person in the household (and in a broader sense, the parental constellation) is more vital and needed, and thus more difficult to cover for. In a typical case, we can compare an old-school nuclear family with a mother who works part time or as a homemaker and a father who is deployed in a wartime posting, with today's fulltime working parents who have their children alternately and live with new partners and additional children in new constellations. It is clearly more difficult to do without the care of such a mother and/or father compared to a father from a 1950s single-income family, who was certainly needed but who's care responsibilities could be covered to a greater extent by the mother, whose primary responsibility was care. Equal parenting is an important aspect of public policy in the Nordic countries and is often seen as a success, perhaps especially as fathers have taken on a greater role in caring for their children. In a crisis or war situation, shared parenting needs to be considered. Will fathers today agree to leave their children if they are deployed to a wartime posting in another location? How will the children experience being separated from a parent for a long period of time?

Another important factor to consider is the prevalence of occupational homogamy, i.e. the trend for women and men to form couples with someone in the same profession or industry as them. This is particularly relevant when both adults in a household work. It is common, for example, for military personnel to live together and have children with other members of the armed forces or in similar professions. Other examples include the fact that a quarter of all doctors are married to another doctor (and a tenth live with a nurse) and 15 per cent of all police officers are married to another police officer (Widegren, 2016). These are examples of professions that are particularly important for society's resilience during a crisis.

What happens if a parent and worker deployed to a wartime posting needs to serve in another location, for example at a temporary field hospital, and their partner is also involved in socially important work? How does this affect the other parent's ability to perform their duties? Whose work is most important? The register of wartime postings exists to ensure that one person is not assigned a posting by several organisations at the same time. However, we know very little, if anything, about multiple wartime postings within the same household, or wartime postings for parents who do not live in the same household. What happens to the children if both parents are expected to serve in locations other than their place of

residence? As mentioned, it is likely that this is common given the high proportion of homogamous parents. In addition to affecting individual families, this also affects the functionality and resilience of society, as public services may face challenges of unknown scope in terms of utilising as planned personnel deployed to wartime postings.

Will medical care and nursing services function during a crisis?

For society to be resilient, and for crisis and war planning to be realistic, consideration must be given to who lives in Sweden and with whom they live and have formed families. Traditionally, wartime postings affected almost exclusively men. Now that women are part of the workforce, it is impossible to ignore the care needs that must be met in the private sphere: the care that those outside the workforce (typically housewives) previously provided. In addition, we are working longer into our older years, and care assistance from grandparents is often not possible as their participation in the labour market is also needed.

A large proportion of the population is gainfully employed, and we are accustomed to viewing this as something positive; it is actually the fulfilment of an important political goal. There is no doubt that women's participation in the labour market has led to increased gender equality, economically independent women and more financially secure children. Equally, labour force participation has undoubtedly led to meaning, dignity and independence from family and state. High labour force participation has also been a positive for economic development. Now that the female labour reserve has largely been utilised, crisis planning must take this into account. There is no one to take care of children and the elderly in need if everyone is expected to work even more than they do in peacetime. Unless everyone works more, it may be difficult to meet increased needs, especially in healthcare and other care. It is the same women who are expected to perform these intensified tasks. This raises questions about the sustainability of current planning.

The Swedish total defence system has never been tested in a real-life situation, and the challenges we describe here are therefore hypothetical. Today, we see that it is still unclear to many in the population what laws apply in the event of a heightened state of alert or war. Those who have been assigned to wartime postings should have been informed of what this entails, but it is not always certain that this is the case. Many individuals are also unaware of the general national service. In addition, mobility in today's labour market is so large that even if an employee is fully aware of their situation, it can be difficult for employers to keep track of their employees' circumstances and any commitments they may have to other organisations, as information about individual wartime postings is not public. Furthermore, neither employers nor the Swedish Defence Conscription and Assessment Agency have

information about those in relationships in which both partners are assigned wartime postings, possibly entailing deployment to another location. This makes realistic planning difficult. One possible consequence is that the responsibility falls on the employees themselves, who must balance their duties with other needs, such as caring for children and other relatives with needs.

The work of dealing with crises in general, but in particular in medical care, nursing and other care, is not yet systematised, coordinated or planned in detail. When this work is undertaken, we would put forward the same risk that applies to the sector even in the absence of an acute crisis: when there are insufficient resources, the most vulnerable may suffer most. This is critical in medical care, nursing and other care, as these activities mainly deal with people in need of assistance. It is also more difficult to get an overview of needs today. Those who work in healthcare and other care also have commitments outside work, and if they are not given the possibility to take care of these, they may be unable to fulfil their duties or wartime postings. This will result in the workforce either becoming exhausted, or choosing the most urgent needs of care, most likely private care, or to conditions that lead to children in need of care having less access to their parents in situations characterised by crisis and unrest, i.e. situations in which children have greater need for security. These are issues concerning gender equality in work and care, issues regarding the child's perspective, regional differences, older and younger parts of the population, individuals with different family situations and with different economic situations. Is there anyone who exists outside of these characteristics who will be able to guarantee the provision of healthcare and other care in a situation of crisis or war?

- Without taking into account how the labour market and family responsibilities have changed, there is a risk of underestimating the challenges of a heightened state of alert within planning for medical care and nursing.
- Who is responsible for ensuring that healthcare and other care needs are met? Who is even able to get an overview of these needs?
- Who is expected to work during a heightened state of alert and how are they able to balance family responsibilities with increased demands on service?
- How can realistic planning take into account the fact that most people working in healthcare and other care are women, who also have significant responsibilities in their private lives?

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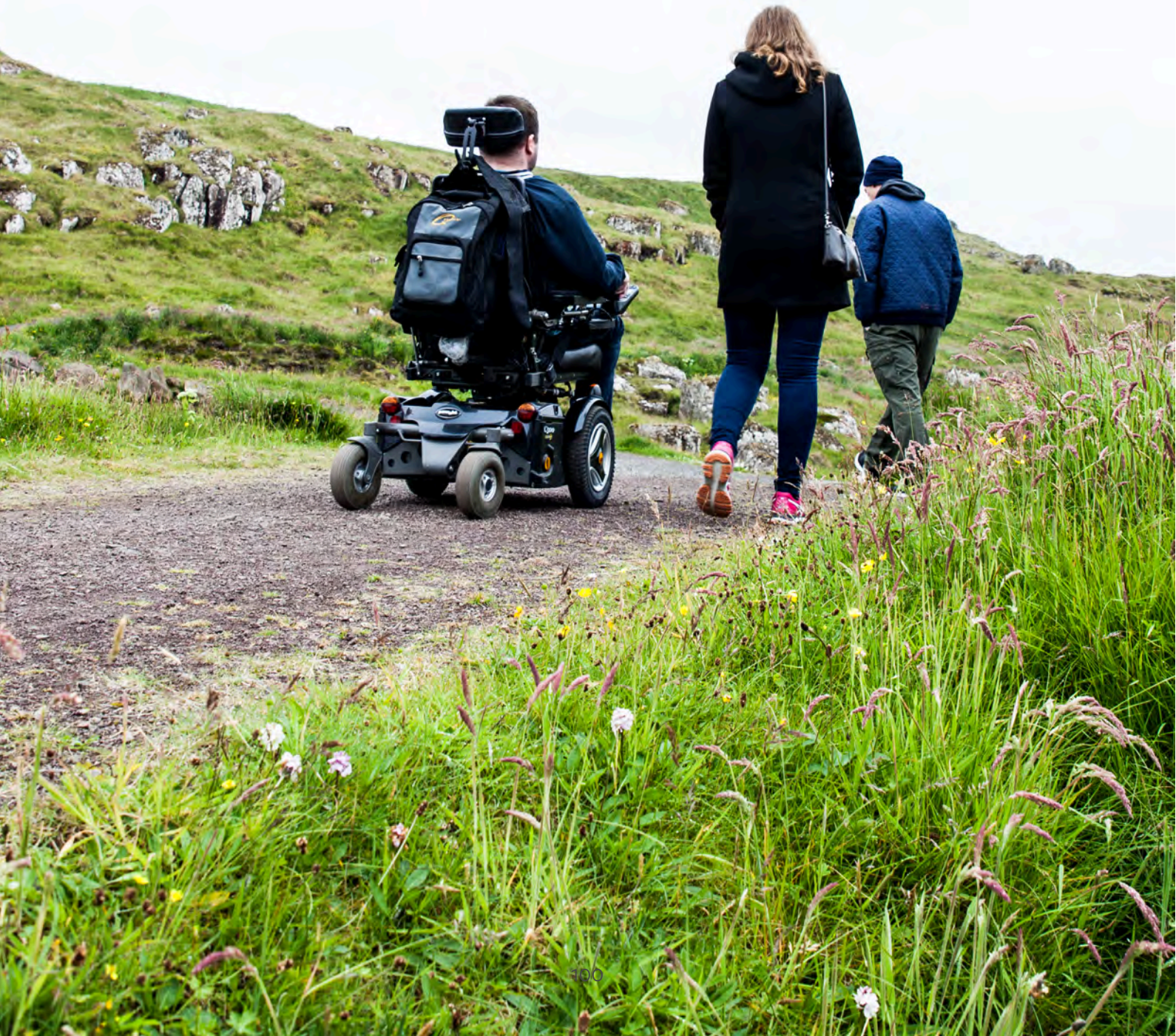
Conclusion



Conclusion and key messages

Closing remarks

This publication takes a broad approach to resilience and gender in terms of healthcare in Nordic welfare systems. Resilience in healthcare refers to the ability to withstand, adapt to, learn from and recover from crises. The starting point is that experiences from the COVID-19 pandemic and other global threats show that the resilience of the welfare state is crucial for both society and individual health. At the same time, it faces significant challenges, including demographic changes, skills shortages, a gender-segregated labour market and inequalities in healthcare. A focus on future resilience requires us to problematise how we understand crises, time and risk. Intersectional gender perspectives are necessary to understand how vulnerability during crises is affected by factors such as gender, class, ethnicity and disability. Structural inequalities need to be addressed to ensure resilience.

The texts in this publication emphasise that applying a gender perspective to these challenges is key. By combining resilience and gender perspectives, the texts highlight in various ways how structural inequalities affect caregivers, care recipients and society as a whole. The need for intersectional analyses, to understand vulnerability and build a more sustainable welfare system, has been highlighted. Above all, the texts have in various ways clarified the importance of viewing resilience not only as a capacity but as a process that involves social justice, representation and liveable conditions. In conclusion, here are some key points that have been highlighted in the various texts in the publication.

Key messages from the essays

Lapidus:

- The rapid growth of private health insurance needs to be understood and managed from a crisis and resilience perspective, so that the resilience and equality of the systems can be strengthened.
- The division of the Nordic healthcare systems requires political reforms and practical measures to counteract unequal access and ensure that healthcare remains a shared welfare resource.
- Ways back to a common and market-free (decommodified) healthcare system should be developed and tested as an alternative to restore legitimacy, solidarity and equality in healthcare.

Liljas and Burström:

- Resources for healthcare and social care systems for older adults must be strengthened. Since multiple illnesses often require both healthcare and social care, it is clear that closer collaboration is needed between regional medical and nursing services on the one hand, and municipal medical and nursing and social care services on the other.
- Clear visions and plans are needed at multiple levels for the implementation of proposed reforms. The implementation of proposed reforms should be monitored and evaluated scientifically.
- Social care for older adults must become a more attractive field of work, and staff need to be the focus of initiatives aimed at improving training, employment conditions, working environments and salaries.
- Greater exchange of experience and learning between the Nordic countries could enable new solutions, as the problems and challenges faced are in many respects common in these countries. Experiences from the pandemic should be utilised to avoid extra work and prepare and strengthen systems for future crises.

Mulinari:

- Improving conditions for temporal justice is one of the major gender equality issues of our time.
- If we seriously want a resilient welfare sector, we must also take the issue of gender equality more seriously. Temporal inequalities in the welfare sector are clearly gendered, and racialised and it is primarily women who are currently forced to juggle the care crisis with their own time, health and bodies.
- We need new understandings of time in working life, understandings that recognise and allow time for care and recognise time as something collective and relational within the welfare sector. Developing and exploring new understandings and distributions of time would not only strengthen the resilience of welfare but also give people greater opportunities to live sustainable lives – both at work and outside of work.

Duvander and Lundgren:

- Without taking into account how the labour market and family responsibilities have changed, there is a risk of underestimating the challenges of a heightened state of alert within planning for medical care and nursing.
- Who is responsible for ensuring that healthcare and other care needs are met? Who is even able to get an overview of these needs?
- Who is expected to work during a heightened state of alert and how are they able to balance family responsibilities with increased demands on service?
- How can realistic planning take into account the fact that most people working in healthcare and other care are women, who also have significant responsibilities in their private lives?

About this publication

Welfare resilience during crises in the Nordic region

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