Gendered Effects of Covid-19

Challenges Facing The Swedish Health Workforce

GADIP, December 2020

This report has been written by Malva Staaf on behalf of GADIP - Gender and Development in Practice

Revised by Ulla Björnberg and Birgitta Jordansson

GADIP 2020
www.gadip.se
info@gadip.se

Gothenburg, Sweden

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List of abbreviations

CES – The Centre for Epidemiology and Community Medicine
ICN – International Council of Nurses
IVO – The Health and Social Care Inspectorate
ICU – Intensive care units
JIT – Just-in-time
MHSA – Ministry of Health and Social Affairs
NBHW – The National Board of Health and Welfare
NPM – New Public Management
OECD – Organisation for Economic Co-operation and Development
PHA – The Public Health Agency
PPE – Personal protective equipment
SAHP – The Swedish Association of Health professionals
SALAR – The Swedish Association of Local Authorities and Regions
SMA – The Swedish Medical Association
SWEA – The Swedish Work Environment Authority
WHO – The World Health Organization

Introduction

Swedish measures to mitigate the spread of the Covid-19 virus have in several ways been less restrictive than those in other countries and due to the divergence from the common European approach, renouncing strict lockdowns, Sweden's comparatively "lenient" response to the pandemic has caused national as well as international debates. A recently published report[1] show that there have only been a few legislative measures implemented since the beginning of the virus outbreak, hence the Swedish strategy has primarily relied on compliance with recommendations from governmental agencies.

However, the aspirations have been similar to other countries considering the aims of reducing transmission and "flatten the curve". In the national pandemic preparedness plan outlined by the Swedish Public Health Agency (PHA)[2], the overarching aims are presented to be; to reduce the mortality and the morbidity in the population, to minimize various negative consequences for individuals and society at large, to protect people over the age of 70 and to avoid overwhelming the healthcare system.

Although it is too early to draw definitive conclusions on the effectiveness of specific strategies to mitigate the spread of Covid-19, the virus outbreak has shown that the implications and impacts have been unequally affecting different groups of the Swedish population. Statistics published in November 2020 reveal that out of a total of 5 941 deaths in Sweden, as many as 5 303 concern people over the age of 70.[3] A significant share of those diseased furthermore received care at special accommodations or in-home care[4], which gave rise to debates on issues related to the operation of the care organizations as well as inadequate collaborations between the Swedish regions and municipalities.[5] At an early stage during the Covid-19 outbreak, PHA also reported the incidence in Covid-19 higher among foreign-born groups of the population.[6] Initially, this was largely explained with reference to deficient information and language barriers, yet ultimately it shed light on deepening spatialized socio-economic inequalities and factors of vulnerability such as cramped housing accommodations, occupations that cannot be performed from home and overall precarious working conditions promoting greater risk of infection.[7]

Moreover have health workers, of which a vast majority are women, struggled to stay safe in a high-pressure work environment where there have been severe staffing shortages, shortages in personal protective equipment (PPE) and of access to rapid testing of the virus. Due to health workers prolonged contact with patients/care recipients infected with Covid-19, identified or not, they thus have greater exposure to the virus and run greater risk of transmitting it to others.[8]

Against the outlined background this report aims to highlight some of the gendered, as well as classed and racialized, effects of Covid-19 by examining how the women-dominated healthcare workforce responding to the pandemic have been affected by emerging challenges. More specifically the report centers the working conditions for nurses, assistant nurses and care assistants employed within different areas of care through examining national and regional Covid-19 measures, staff policy and structural frameworks prevailing the Swedish healthcare system. Due to the high death tolls among the elderly population receiving in-home care or care in special accommodations, the report furthermore puts particular emphasis on the working conditions for health workers employed within Swedish elderly care.

Method and structure

This report brings together a wide range of secondary sources collected between September 2020 and December 2020, predominantly from Swedish newspapers, Swedish labor unions and Swedish authorities. Additionally, the report compiles a selection of national and international surveys published over the last few years. Thus, through a broad mapping of secondary data, the report highlights various aspects of the Covid-19 pandemic's impacts on health workers as it emerged through the material reviewed. Yet since the Covid-19 pandemic is seemingly far from over, new insights are successively gained and further data is continuously being provided. Consequently, the examination presented in this report must be seen as a reflection of the information available and selected at the time of writing.

The main sections of the report are structured in four parts; the first part briefly gives background to the Swedish healthcare system and workforce, and to the national authorities instructed to limit the spread of infection. The second part examines challenges associated with the Covid-19 pandemic that is impacting health workers to varying extent, followed by a third part addressing the pandemic's impact on the physical and mental well-being of health workers during the current pandemic. The fourth and final part highlights a few notions regarding structural challenges in Swedish healthcare that have been recurrent in the material reviewed.

Quotations in the report have been translated from Swedish to English.

1. Background

The Swedish healthcare workforce

The Swedish healthcare workforce is largely women-dominated, which is in line with global figures showing that women make up around 70 percent of all workers in health and social care.[9] In 2018, the most common occupation in Sweden was assistant nurses employed within in-home care and elderly care, and out of 135 300 employees, 91 percent were women.[10] Among care assistants, an occupational group consisting of 72 265 employees, 76 percent were women and among nurses, an occupational group consisting of 47 450 employees, 89 percent were women.[11] Moreover, foreign-born health workers have great significance for the Swedish healthcare sector. Among care assistants, 40 percent are foreign-born, among nurses 12 percent are foreign-born and among assistant nurses 26 percent are foreign-born.[12] Overall, these statistics stress that women, not least foreign-born women, have played a crucial role in responding to the ongoing Covid-19 pandemic and the risks that predominantly women health workers incur.

The Swedish healthcare system

Healthcare in Sweden is provided by a national decentralized healthcare system divided into three administrative levels – state, regions and municipalities. The role of national government is to establish principles and guidelines, and set the political agenda for health and medical care that is being carried out through laws and ordinances, or agreements with the Swedish Association of Local Authorities and Regions (SALAR).[13] Sweden's 21 self-governed regions are responsible to provide residents with adequate healthcare and to implement internal controls of all healthcare operations, currently performed by the Health and Social Care Inspectorate (IVO). Furthermore, Sweden's 290 self-governed municipalities are instructed to provide adequate care for the elderly, in the home or in special accommodations. Their duties also include care for people with physical disabilities or psychological disorders and providing support and services for people released from hospital care as well as for school healthcare.

The basic health and medical care is commonly referred to as primary care comprised of general medical practitioners offering medical examinations, care and treatment

of most common conditions and illnesses. Specialized care is the term for care that requires more specialized medical measures than what is available through primary care, and highly specialized care refers to care offered at certain hospitals. Elderly care is referring to both care provided in special accommodations (elderly homes) and in-home elder care. These services, like all other healthcare services in Sweden, can be both public and private.[14]

The National Board of Health and Welfare (NBHW) states that Swedish healthcare continues to demonstrate good results in international measurements[15], and the Swedish government furthermore asserts that many of the challenges confronting Swedish healthcare can also be seen in other countries such as issues of access, quality, efficiency and funding.[16] Yet, important to note is that the Swedish healthcare system has seen vast changes since the 1990's financial crisis, and the new ways of governing healthcare – also known as New Public Management (NPM) – has both affected the way healthcare organizations are run as well as the staffing of the organizations.[17] Research also show that the trends in change implied with NPM have led to higher workloads, lower degrees of job security, lower job satisfaction, and increased fatigue as well as more psychosomatic symptoms among healthcare staff.[18]

Swedish authorities providing Covid-19 guidelines

The responsible authorities instructed to limit the spread of infection in Sweden are mainly PHA, coordinating communicable disease control at national level, and NBHW, supporting and coordinating the health and medical care preparedness of the various regions.[19] As an expert authority in issues on infection control, PHA is thus providing guidelines regarding protective measures against Covid-19 for workers within health and social care, which comprises recommendations to follow basic hygiene routines as well as existing routines outlined to prevent droplet and contact-spread infections. In some cases, protective clothing and other PPE is also recommended.[20] NBHW, working under the Ministry of Health and Social Affairs (MHSA) with a wide range of activities within the field of social services, health and medical services, patient safety and epidemiology have furthermore been publishing a large number of knowledge-based reports and web-based guidance's for the health workforce during the Covid-19 pandemic.[21] These reports serve to support decision makers on different levels of the healthcare system and include information about basic healthcare hygiene, introductions to new health workers, information on sick leave due to Covid-19 etc. Additionally, the Swedish Work Environment Authority (SWEA) has an important role in protecting health workers since they hold national responsibility to make sure that the Work Environment Act is being enforced. SWEA has also developed specific material and guidelines as a response to the outbreak of the Covid-19 virus.[22]

2. Emerging challenges related to Covid-19

Changing PPE guidelines

PHA has recurrently underlined the importance of all health workers feeling safe and secure at their workplace during the Covid-19 pandemic, which requires sufficient PPE and training in its use.[23] To mitigate transmission, a local risk assessment has been advised prior to every work activity in order to evaluate proper choice of protective clothing, PPE and other safety equipment.[24] However, the national guidelines regarding PPE have changed during the pandemic, and in April 2020 the Swedish regions reported that the standard PPE would onwards be comprised of visors, aprons and gloves.[25] The new guidelines did thus not advise of facemasks or full-coverage protective clothing, which was initially recommended, other than in particular cases.

> *Protective equipment in male professions is generally considered highly important, yet when it comes to ill health, sickness and even death in a women-dominated profession, it is suddenly no longer the case*

Many health workers considered the new guidelines a lowering of the safety standards, which led to widespread protests and the creation of a Facebook-group as well as a petition under the slogan "Refuse to lower hygiene requirements – Covid-19" [authors translation]. The Facebook-group gathered over 30 000 members, and the petition raised around 5 500 signatures.[26] In a recently published article, it was furthermore revealed that SWEA had put forward a gendered aspect of the PPE guidance change, stating that protective equipment in male professions is generally considered highly important, "yet when it comes to ill health, sickness and even death in a women-dominated profession, it is suddenly no longer the case".[27] The Swedish Association of Health Professionals (SAHP) also questioned the new guidelines, mainly due to divergences from the recommendations outlined by WHO.[28] However, the Swedish chief epidemiologist Anders Tegnell asserted that the new guidelines were not intended to lower the safety requirements and that the PPE recommendations were in fact in line with knowledge and experience "particularly pointed out by WHO".[29]

In June 2020, PHA once again updated the PPE guidelines stating that visors *and* facemasks should be used in all work activities that involve risk of contact with body

fluids when there is a confirmed or suspected Covid-19 infection.[30] Although, since the Swedish regions finally determine the local guidelines, there have been varying interpretations between different healthcare facilities throughout the pandemic.

Lack of PPE and challenges in distribution

The global shortage of PPE caused by "rising demand, panic buying, hoarding and misuse"[31], and the shortage of PPE within the Swedish healthcare sector have been debated issues since the beginning of the Covid-19 outbreak. There have also been numerous debates regarding deficiencies in the distribution of PPE among the Swedish regions and municipalities, and deficiencies in pandemic preparedness regarding protective clothing, PPE and other safety equipment.

In a national status report from April 2020[32], NBHW stated that the Swedish regions needed assistance in ensuring adequate protective equipment for health workers over time, and several regions also reported about a lack of adequate PPE. An examination outlined by the Swedish news program *Ekot*[33] released in April 2020 moreover shows that the three urban regions that was (at the time) hardest hit by the Covid-19 virus, Region Stockholm, Region Västra Götaland and Region Skåne, lacked requirements to keep stocks of protective clothing, PPE and other safety equipment in their epidemic contingency plans. Hence the three regions placed their orders on protective equipment when the outbreak of Covid-19 was already a fact, competing with each other as well as large states on the international market, which resulted in various outcomes in terms of deliveries.

The emergency response manager at NBHW, Johanna Sandwall, considers the lack of PPE and other safety equipment within the Swedish regions largely dependent on economic models (just-in-time, JIT) that make it cheaper to keep things on the road — "a strategy that has proven malfunctioning when a disturbance occurs".[34] The Swedish Left Party furthermore states that the JIT concept is not suitable for the healthcare sector and argues that every region should keep stocks of protective equipment for emergencies.[35]

But the opinions on appropriate strategies differ. In October 2020, Region Västra Götaland reported that the stocks of adequate protective equipment during the first weeks of the pandemic outbreak was running out. However, the chairman of Västra Götaland's regional board, ultimately responsible for the region's activities, is critical towards keeping emergency stockpiles and states that the ability to make rapid adjustments and place quick deliveries on certain products is the right way to go.[36]

Despite the contradictory opinions regarding emergency stockpiles and pandemic preparedness, the established lack of PPE and other safety equipment has affected health workers to varying extent throughout the Covid-19 pandemic. An interview

study with 924 members of SAHP, "Nurse in times of Corona 2020" [37] [authors translation] published in May shows that only four out of ten nurses have had access to adequate protective equipment since the beginning of the virus outbreak. Almost 50 percent consider the patient safety decreased since the beginning of the virus outbreak and six out of ten who have managed patients/care recipients with a confirmed infection with Covid-19 consider the patient safety decreased due to Covid-19.

> *The Swedish healthcare sector was not equipped for the pandemic to hit*

Johan Styrud, chairperson of the Swedish Medical Association (SMA), contends that the Swedish healthcare sector was not equipped for the pandemic to hit and declares that for those working at the "front-line" of the virus outbreak in primary care and in advanced in-home care, there has at times been very little protection at hand.[38] Styrud also declares that the lack of protective equipment has been significant in Swedish hospitals, which led the regions to the global market for PPE, yet stresses that the Swedish municipalities have had an even harder job competing at the international market for PPE.

Differences in access to PPE

Although the PPE shortages have affected a large proportion of all health workers, Sineva Ribeiro who is the chairperson of SAHP argues that the safety of staff working in hospitals has not been the greatest issue but the safety of staff working within municipal care due to severe lacks of PPE and inadequate safety routines.[39] The Swedish Municipal Workers' Union Kommunal also reveals that they have received particularly alarming messages on lacks of PPE from staff employed within the elderly care, and Kommunal furthermore highlights additional difficulties in obtaining a safe work environment and social distancing in in-home elder care since the staff is performing both health and social care interventions in an unregulated care environment.[40]

Furthermore, a prioritization of PPE for nurses, possibly at the expense of assistant nurses and care assistants employed within the elderly care, has been indicated in the debates surrounding protective equipment. One example of this regards a safety representative stop at an elderly home in northern Sweden that was revoked, despite severe lacks of approved respiratory protection. At the time of the safety representative stop, the municipality concerned in fact held stocks of respiratory protection, yet the employer considered these intended for the nurses, which left the assistant nurses with self-made (non-approved) protection.[41] Municipal employees around the country have also testified to being provided with inferior protective equipment compared to other occupational groups, or in worst case none at all, in a "distribution staircase" where

in-home care and hourly employees ended up at the bottom. [42]

In a recently published report by SALAR, "Facts about the elderly care in light of the Corona pandemic"[43] [authors translation], numerous employees within the elderly care confirm that they have not had access to adequate PPE and other protective equipment since the beginning of the virus outbreak. The report moreover declares widespread uncertainties among the staff regarding PPE usage, as well as worries about the PPE shortage. A survey published in March 2020[44] conducted with 182 medically responsible nurses employed within the elderly care in different Swedish regions similarly shows that 55 percent of the participants' regarded the access to PPE low or critically low, and in June 2020, data collected by the analysis and research company Novus[45] revealed that every other worker within Swedish elderly care was *still* worried about the access to adequate safety equipment.

> *Several of the complaints made by health workers employed within the elderly care show that staff who tried to point out the shortcomings in safety routines to the management were silenced*

By reason of the risk indications from Swedish elderly care, a national supervision is currently carried out by IVO[46], and the initial control of 1 045 care activities confirms the image given in society in general; in-home elder care, elderly homes and other special accommodations have seen great challenges in preventing transmission. At present, in-depth supervision is relevant in approximately one in ten of the 1 045 inspected elderly care activities and IVO attests that they have observed examples of staff ordered to work despite having a confirmed infection with Covid-19, and examples of staff managing both healthy and ill care recipients without adequate PPE. Moreover, IVO has outlined several challenges in limiting the spread of infection within Swedish elderly care. In particular, the large amounts of information from different governmental agencies distributed in various channels has made it difficult for care managements to ensure that the staff have access to the latest information. Also, managers point at deficiencies in safety routines as well as difficulties in creating a sustainable staffing situation.

In September 2020, *Ekot* published a review[47] of complaints received by IVO during the spring. Several of the complaints made by health workers employed within the elderly care show that staff who tried to point out shortcomings in safety routines to the management were silenced, and some employees even state that the management actively tried to cover up how serious the situation really was.

Sick leaves, “sickness attendance” and lack of staff

Due to an increase in sick leaves and extensive staffing shortages, the Covid-19 crisis has entailed great demands on flexibility and endurance for health workers. During the spring 2020, it was reported about the increased workloads at Swedish intensive care units (ICU), and in April it was announced that the Swedish so-called “crisis situation agreement” had been activated for ICU’s in Region Stockholm.[48] An article published in May 2020[49] moreover states that the situation at ICU’s in all of Sweden have been highly pressured since the outlined preventive Covid-19 recommendations (stay at home at slightest symptom of illness) severely increased the overtime among healthcare staff that had to cover up for their absent colleagues. As evidence of this, an ICU at Södra Älvsborg hospital reported that the amount of overtime hours had increased 900 percent during April 2020 compared to April 2019.[50]

Although, the demands on health workers have not only exaggerated within the intensive care; IVO’s inspection[51] of the elderly care particularly highlights an increasing amount of understaffed elderly homes worsened by the Covid-19 pandemic. In June 2020, the number of sick leaves at Swedish elderly homes was reported equivalent to over 6 200 full-time employees, yet an investigator at Kommunal believe the unrecorded numbers to be even higher. Kommunal as well as the reports from IVO also emphasize a problem that is well known in Swedish elderly care, that is the “sickness attendance” among employees who should report sick, yet attend work because the staffing is already heavily strained.[52]

> *”There are multiple reasons behind employees reporting for work despite feeling ill; low-paid health workers can neither afford to stay at home, nor do they want to cause an additional burden for their already overburdened colleagues*

As an illustration of the aforementioned difficulties with sickness attendances within the elderly care, 23 out of 57 employees at an elderly home in Gothenburg stated in a survey from April 2020[53] that they experienced one or more of the symptoms associated with Covid-19, however they were still at work ready to start their shifts. According to Kommunal’s local chairperson, Ann Skarsjö, there are multiple reasons behind employees reporting for work despite feeling ill; low-paid health workers can neither afford to stay at home, nor do they want to cause an additional burden for their already overburdened colleagues. Furthermore, Skarsjö explains, managers have in fact urged employees to return to work, and on top of that, temporary workers are not covered by the currently abolished qualifying deduction[54] implemented by the Swedish government in response to the Covid-19 pandemic. This means that temporary workers do not get compensated for the qualifying period.

Relocations of health workers

Health workers have also suffered from extensive relocations due to the increased workloads and lack of staff implied with the Covid-19 pandemic. Ann Johansson, vice chairperson of SAHP, explains that the relocations has meant an entirely new situation for the Swedish healthcare system due to the fact that transfers between employers usually do not occur.[55] Johansson also underline that transfers of staff primarily should be based on voluntariness, however, "if the region employ you, your contract is applicable to all units within the region given the adequate competence".[56]

Despite many health workers seemingly have wanted to help, there are also several examples of relocations that were met with stark criticism from those concerned. One example is a notable case where a district nurse chose to resign after being relocated to the emergency care without her approval, and due to health reasons could not manage the increased workload and prolonged work hours.[57] Other examples are a planned relocation of school nurses that Eskilstuna Municipality wanted to place within the in-home elder care, assigned with tasks they had not performed in many years[58], and a relocation of school nurses in Burlöv Municipality that were placed to work within the elderly care.[59] The latter raised loud protests among the nurses who considered the children's as well as their own well-being compromised. Overall, the previously cited study "Nurse in times of Corona 2020"[60] confirms that as many as 41 percent of the participants have had to change their tasks or change ward due to Covid-19, and 58 percent also state that they are dissatisfied with their work situation.

In May 2020 it was reported that one of the Swedish regions that had been impacted the most by relocations was Region Västerbotten.[61] Initially, the relocations mainly affected school nurses that were transferred to municipal healthcare institutions. Yet later on, staff from primary care, various care clinics and departments were also relocated to newly installed Covid-19-wards at different hospitals. Jenny Olsson, department chairman of SAHP Västerbotten, describes that healthcare staff that was relocated to infection and medical departments experienced feelings of merely "waiting for the crisis to hit", whilst at the same time neglecting their ordinary tasks. Olsson also states that this caused a lot of stress, worry and feelings of guilt among the staff, as well as increased the so-called "care-debt" (i.e. postponed surgeries, specialist care etc.) at several healthcare facilities.

> *" Even though the employees got their weekly rest on paper, in fact they only got one weekend off per six weeks, which gave them very little time for recovery*

Statistics published in May 2020[62] moreover reveal a duplication of sick leaves at hospitals in Region Sörmland, Region Stockholm and Region Östergötland compared

to statistics from 2019. In Region Östergötland, a crew pool was established to solve the urgent need of staffing, but it was only partially based on voluntariness and many nurses were transferred against their approval. In Region Sörmland, the solution was deemed schedule changes, however this was met with discontent from healthcare staff who expressed feelings of being "shoved around". Lena Lindh, president of SAHP Sörmland, also emphasizes that even though the employees got their weekly rest on paper, in fact they only got one weekend off per six weeks, which gave them very little time for recovery.

Lack of Covid-19 testing of health workers

In a report published in June 2020[63] in-depth interviews with around thirty health workers have been conducted, aiming at giving voice to what staff within Swedish healthcare think that the general public should know about their work situation during the initial phase of the Covid-19 outbreak. The respondents expressed great concern over not knowing weather a colleague's symptoms were signs of a harmless flue or an infection with Covid-19, and the staff thus wished for all employees within the healthcare sector to be tested continuously. The report furthermore stresses that a low extent of testing of health workers has given rise to mistrust from healthcare managers who, according to the participants, seems to suspect a refusal to work when staff report sick due to Covid-19 symptoms.

At an early stage of the virus outbreak in Sweden, PHA recommended prioritized testing of health and social care staff, but to perform wide testing there is a need for sufficient material and staff with adequate competence. Region Stockholm states in an enforcement decision published in March 2020 that "there are currently not enough resources to take samples of healthcare staff"[64], and in April 2020 it was reported about an acute lack of test material in several regions[65] and an overall shortage of biomedical analysts.[66]

> *" The region's desire to improve the statistics over tested health workers led to healthcare staff being blamed for not raising the volumes of tested staff to the desired extent*

An article published in June 2020[67] reveals that Region Stockholm did not provide broad testing of health care staff until May 2020 and as a solution to the lack of testing, and to the difficulties associated with home test kits, the staff was referred to a digital care app ("Always Open"). However, the app was also open to the general public, which placed healthcare staff in the same care queue as the rest of the population. Furthermore, the region's desire to improve the statistics over tested health workers led to healthcare staff being blamed for not raising the volumes of tested staff to the

desired extent.

SALAR also verifies that it has taken a lot of time to bring about an appropriate broad testing of health workers employed within the elderly care, and several municipalities have recurrently emphasized difficulties in performing wide testing of staff.[68] Moreover, as 18 000 health workers in Region Stockholm were tested for a Covid-19 study in the beginning of April 2020, elderly care staff was not included among the participants despite the worsened situation at elderly homes and within in-home elder care.[69] As a response to a noted incident in Botkyrka Municipality where an employee within the elderly care was declined Covid-19 testing, twice, the employee's daughter initiated a petition demanding elderly care staff to be offered testing for the virus and urged health workers to sign.[70] However, Botkyrka Municipality took a different approach than the one decided upon in the City of Stockholm and instead offered health workers antibody tests.[71]

During the fall 2020, debates regarding testing of elderly care staff once again took off and medical organizations argued that, to reduce the risk of Covid-19 transmission, a more comprehensive testing of both staff and care recipients ought to be performed[72]. Since then, the effectiveness of performing antibody tests, Covid-19 tests, infection tracing and wide "screenings" has been evaluated.

3. Physical and mental health impacts of Covid-19

Covid-19 infection among health workers

There is currently no comprehensive data on confirmed infections with Covid-19 among the Swedish healthcare workforce. Neither are there any international uniform figures of illness among health workers according to the International Council of Nurses (ICN).[73] Though statistics compiled by PHA[74] released in May 2020 show that over 10 300 health care and social workers had tested positive for the Covid-19 virus, a number that corresponds to almost half of all confirmed cases (20 754) during the first three months of the pandemic outbreak.

Ann Johansson, vice president of SAHP, denotes that it is difficult to get a clear picture of how vulnerable healthcare staff has been due to the current lack of data, yet a plausible reason for the spread of infection is that health workers were tested very late on in the virus outbreak; "wide testing paired with trimmed hygiene and safety routines as well as adequate protective equipment could have been crucial factors in protecting the employees".[75]

A report published in April 2020[76] states that given sufficient protective equipment, the occupational exposure to Covid-19 should be minimal, which has been proven in other well-resourced settings. However, at high patient load, protective equipment has been limited in a large number of countries, including Sweden.

> *Reports make visible that Covid-19 has become the most prevalent work-related illness in Sweden – mainly among women employed within health and social care*

In April 2020, Covid-19 was classified as a work-related illness, and up until 18 October 2020, 6 281 Covid-19 related reports have been received by SWEA.[77] Out of the total amount of reports, 2 671 were received from assistant nurses and care assistants, 1 724 were received from nurses with special competence and 1 029 were received from personal assistants and in-home care assistants.[78] Thus, the reports make visible that Covid-19 has become the most prevalent work-related illness in Sweden – mainly among women employed within health and social care.

Structural inequalities increasing the risk of infection

The ongoing virus crisis has made socio-economic differences, residential segregation and already existing health challenges even more explicit, not least since the incidence in Covid-19 has been reported heightened among foreign-born population groups during various stages of the pandemic outbreak.[79] In April 2020, Stockholm suburbs Rinkeby – Kista, Spånga – Tensta suffered from greater spread of infection compared to the rest of the region, and PHA is currently investigating conceivable causes such as few possibilities to maintain social distancing due to overcrowded housing accommodations, occupations that cannot be performed from home (e.g. care, service and transport) and long commuting distances with public transports.[80]

However, the transmission of the virus in certain geographical areas has also been linked to ill-founded assumptions about "cultural patterns"[81], and the spread of infection in Swedish elderly care has occasionally been explained with reference to "refugees" and "asylum seekers" among the staff who "may not always be understanding the information".[82] The Swedish nationalist and right-wing populist political party, the Sweden Democrats, was furthermore quick to declare themselves skeptical of Swedish elderly care "being used as an integration measure".[83]

> *The structural and material hinders obstructing compliance with the outlined preventive Covid-19 recommendations – promoting greater risk of infection among already vulnerable groups of people – need to be further assessed*

Although there might have been inadequacies regarding the equal spread of Covid-19 related information to all citizens as well as to employees within the healthcare sector, the racist and xenophobic discourse permeating the public and political debate, and the guilt particularly laid upon foreign-born health workers require serious interrogation. Thus, the structural and material hinders obstructing compliance with the outlined preventive Covid-19 recommendations – promoting greater risk of infection among already vulnerable groups of people – need to be further assessed.

A recent geographical study[84] map out how potential risk factors for infectious diseases are localized in the city of Stockholm, Gothenburg and Malmö, in order to examine a potential interconnection between segregation and material hinders as a source for the seemingly heightened risk of infection with Covid-19 among foreign-born population groups. No certain causations were established, yet the study clearly sheds light on the inequalities that prevail in Sweden's largest city regions; cramped housing accommodations is overlapping with low education, a high share of households with both younger and older members, few car owners and a high share of residents working as assistant nurses and care assistants.

In a study published in the Swedish medical journal *Läkartidningen*[85] researchers also address a "vicious circle" of health workers potentially getting infected at the workplace due to lacks of adequate protective equipment/inadequate hygiene routines, and continue the spread of infection to family and community members, which in turn increases the risk of infecting even more health workers. Consequently, population surveys in geographically delimited areas have been advocated as well as targeted Covid-19 efforts and measures considering inequalities and exclusion.

Mental health impacts of Covid-19 among health workers

In addition to risk of contracting the infection, health workers responding to the Covid-19 pandemic are also suffering from physical and mental exhaustion, elevated stress levels and emotional pain from loss of life as well as from having to make painful ethical decisions on patient care in an environment of constant shortages. Moreover, an important aspect that has been emphasized among health workers during the pandemic is bad conscience over not being able to comply with PHA's Covid-19 guidelines[86], and staff employed within the elderly care have also articulated feelings of being misunderstood when reading how Swedish media presents their sector in a poor light.[87]

> *Staff employed within the elderly care have also articulated feelings of being misunderstood when reading how Swedish media presents their sector in a poor light*

A report by the Centre for Epidemiology and Community Medicine (CES)[88] declares that health workers managing patients infected with Covid-19 are particularly vulnerable to mental health issues during and after the Covid-19 pandemic due to the increased risk of infection, and risk of infecting others, paired with rapidly changing directives around safety measurements and procedures causing stress and anxiety. Furthermore, healthcare staff who have been working under increased pressure throughout the Covid-19 pandemic has shown high rates of sickness absence due to psychiatric diagnoses already prior to the virus outbreak[89] which indicates prevalent problems among healthcare professions and the sick leaves are likely to increase within already pressured occupational groups.[90]

Several Swedish hospital managements also consider the increased workloads connected to Covid-19, and the difficulties in managing infected patients, a severe health hazard for the healthcare staff.[91] Worry and anxiety regarding ethical concerns,

stress due to an increased number of patients, not receiving enough support and not getting enough rest are emphasized as the most frequent risk factors for mental illness. The study "Nurse in times of Corona 2020"[92] furthermore show that one out of three Swedish nurses have experienced worry and concerns over being infected with Covid-19 and four out of ten have experienced worry and concerns over infecting others. One out of three nurses' also experience that they, due to Covid-19, cannot give the care they wish to give and almost one out of four nurses have experienced some kind of ethical stress regarding the triage of sick patients/care recipients.

Similarly, the national supervision of Swedish elderly care carried out by IVO[93] states that one of the greatest challenges for health workers in elderly homes and within in-home elder care during the Covid-19 pandemic has been a widespread anxiety concerning the risk of infection, and risk of infecting others. IVO also report that many employees are battling feelings of guilt over not attending work despite being ill, and over the well being of care recipients that are being compromised due to the prevailing circumstances.

4. Challenges prior to Covid-19

General conditions in Swedish healthcare

The hard labor conducted by health workers have generated the general public as well as politicians' praise during the Covid-19 pandemic, yet some argue that this follows a historical pattern with health workers entering the spotlight whenever there is a major crisis, only to recede into the margins of public and political consciousness during times of equilibrium.[94] Health workers have also expressed their discomfort of being labelled "heroes", a term that has been used plentiful in Swedish media, proclaiming that the heroism narrative sits uneasily with their own idea of the work they perform on a day-by-day basis.[95] Furthermore, the masculinized rethoric of war ("front-line workers", "soldiers" etc.) used to describe, and seemingly to enhance, the work of healthcare staff sheds light on the relationship between gender and status in the healthcare sector. Researchers also argue that invoking the language of heroism risks stifle much needed conversations about the obligations health workers have to work and the importance of reciprocity and limits to the levels of risk that we can expect health workers to shoulder.[96]

> *While the Covid-19 pandemic indeed has implied additional challenges for the healthcare workforce, employees within Swedish healthcare have called out inadequacies in work environment, organization and patient safety for a long time*

While the Covid-19 pandemic indeed has implied additional challenges for the healthcare workforce, employees within Swedish healthcare have called out inadequacies in work environment, organization and patient safety for a long time. Heavy workloads and demanding patient relations leaves occupational groups within health and social care particularly vulnerable to illness, and data show that health workers have the highest sickness absence rates in Sweden[97] prior to Covid-19. Recent statistics also confirm that women employed within Swedish healthcare, regardless of position, are lower paid than their male coworkers[98] and foreign-born health workers have testified to ethnic and racial discrimination from colleagues, patients/care recipients and managements.[99]

A report from 2018[100] outlined on behalf of Kommunal and SAHP reveals that up to four out of ten employees have regretted their choice of occupation due to the working conditions – the most common reasons being the wage situation and understaffing –

and more than 50 percent have considered changing workplace over the past year due to the overall working situation. 55 percent do not consider the employer to provide adequate conditions for them to do a good job and merely 33 percent of the employees consider the staffing adequate in order for them to do a good job. Moreover, 45 percent of the employees have trouble sleeping at least once a month due to the work situation, and only one fourth of the employees consider their work situation healthy. Lastly, six out of ten employees experience that their job has become more difficult over the past five years. Overall, the data presented is thus rather alarming, but consistent with messages received from health workers regarding their experiences during the first few months of the outbreak of Covid-19 in Sweden; poor working conditions, a long-term dismantling of the healthcare system with deteriorated economic resources and a lack of preparedness are particularly emphasized as causes of frustration.[101]

Precarious employments

The Covid-19 crisis has shed light on the employment conditions for staff working within Swedish healthcare. Particularly since precarious employments, meaning all forms of fixed-term employments, have been emphasized as a plausible reason for the spread of infection in elderly homes and within in-home elder care as it leads to reduced continuity, reduced competence and reduced influence for the staff.[102] Fixed-term employees furthermore do not have the right to sickness compensation, which clearly hampers the possibility to decline work hours despite being ill.[103] Referring to the precarious employment conditions among workers in health and social care, the national representative at Kommunal describes a growing "silent workforce"[104] with decreased opportunities to make demands on their work environment. The president of Kommunal similarly raises the issue of staff that has been afraid to speak up regarding deficiencies in the use of and access to PPE during the ongoing pandemic due to factors such as precarious employments, (low) levels of education and experience.[105]

> *Fixed-term employees do not have the right to sickness compensation, which clearly hampers the possibility to decline work hours despite being ill*

Statistics from SALAR[106] show that the amount of fixed-term employments is somewhat higher within municipal healthcare than the average in the Swedish labor market, and that the share of full-time employments among nurses, assistant nurses and care assistants are considerably lower compared to other occupational groups within the municipalities. Among assistant nurses and care assistants employed within all areas of Swedish healthcare, around 29 percent are fixed-term employees, and

part-time work is also common among the same occupational groups.[107] According to Kommunal, there is moreover a higher share of fixed-term employments within privately funded healthcare than within publically funded healthcare; 18 percent of all workers within public healthcare are fixed-term employees compared to 24 percent within private healthcare. Additionally, 50 percent of the fixed-term employees within the Swedish healthcare sector are employed under the most precarious conditions, being called in if necessary or work by hour.[108]

Data on employment conditions within the Swedish healthcare sector also show considerable differences between foreign-born and Swedish-born health workers. According to statistics from 2018[109], 27 percent of all foreign-born health workers have a precarious employment, compared to 17 percent of all Swedish-born health workers. Precarious employments within Swedish elderly care are also more common among foreign-born workers; around 29 percent of Kommunal's foreign-born members have a precarious employment compared to 19 percent of the members born in Sweden. Noticeably, among those with a healthcare education, it is twice as common with precarious employments for foreign-born health workers compared to health workers born in Sweden.[110]

Elderly care's "lower status"

The Covid-19 pandemic has markedly affected elderly home residents internationally with 19-72 percent of Covid-19 deaths occurring in special accommodations according to a report published in May 2020.[111] Simultaneously, research has pointed at national as well as international tendencies of neglect and undervalue of elderly care in terms of resources. Globally, elderly care staff is concentrated into lower status and worse terms of employment than the healthcare workforce in general; the wages are low and many employees work involuntary part-time or by hour.[112] Studies have also been put forward showing that elderly care staff traditionally receives less support than staff employed within other healthcare organizations in times of crisis[113], and Swedish health workers employed in municipal care have confirmed this tendency by expressing dissatisfaction with the predominant focus on emergency care and the reducing of elderly care to "the last step in the care chain".[114]

> *Most countries pandemic control, including Sweden's, placed an initial focus on the intensive care, which was prioritized regarding protective equipment and testing of the virus*

Researchers from the Department of Social Work at Stockholm University argue that due to the combination of Swedish governmental agencies' focus on emergency care (with higher status) and Swedish elderly care's scarce resources (and considerably

lower status), it is no wonder that the Covid-19 pandemic has hit elderly homes to such a great extent.[115] The delay in responses on how to mitigate transmission within Swedish elderly care can be illustrated by the Swedish media coverage, which shows that up until 8 March, 75 000 articles had been published about Covid-19 – yet less than 1 percent focused on the elderly care.[116] In a report published as part of the Corona Commission's examination of Swedish elderly care[117], the author furthermore concludes that most countries pandemic control, including Sweden's, placed an initial focus on the intensive care, which was prioritized regarding protective equipment and testing of the virus. The report also emphasizes that international organizations such as WHO and OECD, as well as various international researchers, have noted that the Covid-19 pandemic has set focus on resource and organizational deficiencies within elderly care, which is often underfinanced.

Conclusion

Through an examination of the working conditions for nurses, assistant nurses and care assistants, this report elucidates the disproportionate role women play in responding to the Covid-19 pandemic and the challenges as well as risks they incur. Although it is difficult to get a clear and nuanced overview of the situation since the crisis is seemingly far from over and since various data is still lacking, what may be ascertained is that the Covid-19 pandemic has reshaped the healthcare landscape and placed additional burden on healthcare staff facing heavier workloads, PPE shortages and increased physical and mental strain.

An important aspect to draw from this report is the necessity of acknowledging the difficult and tremendously valuable work performed by health workers during the current pandemic, but the individualized narratives that on the one hand labels health workers "heroes", yet on the other hand imposes guilt upon them (especially upon foreign-born health workers) calls for interrogation. What needs to be emphasized is rather the connection between the duty of health workers and society's reciprocal obligations, and the increased challenges to the occupational health and well-being of women in caring professions has to be included in policies as well as decision-making. Furthermore, the intersectional burdens exacerbated by Covid-19 highlighted in this report stresses the political awareness needed to deal adequately with inequalities in the current pandemic crisis as well as in future crisis scenarios.

The Swedish Covid-19 strategy has, since the beginning of the virus outbreak, received critique over being aimed at a homogenous majority society; the authorities' language use and communication methods have been denounced for lacking clarity and the overall strategy has been critiqued for not considering the fact that the ability to maintain social distancing is far from the same for everyone.[118] Moreover, in a report from the national Corona Comission[119] presented in December 2020, the failure to protect the elderly population is primarily related to structural issues within the elderly care that has existed long before the outbreak of Covid-19, and according to the authors of the report a national overview of the municipalities' preparedness when the spread of infection took off was lacking. Several measures that need to be taken within the elderly care are pointed out in the report such as decreased numbers of hourly employees, increased medical competence, increased access to nurses at elderly homes and increased medical equipment on site. The Corona Comission also emphasizes the urgency of increased education and higher wages for health workers employed within the elderly care, especially for those at the bottom of the scale.

During the fall 2020, the infection rates have once again risen[120] and a new wave of Covid-19 has hit Sweden as well as the world in general. Many lessons have hopefully contributed to improvements in managing health workers' situation, but the structural problems confronting the Swedish healthcare sector demand reforms that require being built up over time. This report also demonstrates that the role of gender, class and ethnicity pose urgent challenges for policy makers to attend to.

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info@gadip.se

Gothenburg, Sweden