COVID-19 Impact Exposes the Collapse of the Swedish Model

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Dec. 1—Alarming reports from Sweden of deaths of the elderly in nursing homes and in-home care, and of the same soaring infection rates as in most other parts of Europe, have raised questions over the Swedish policy to combat the COVID-19 pandemic all along. The lack of a resolute response to the virus in Sweden has been seen as a better model to handle COVID-19 by those in Europe and the United States who oppose lockdowns, and even doubt the danger of the virus. In reality, the so-called Swedish Model for handling COVID-19 came out of bungling practices of a much wider process of collapse of the Swedish welfare state and its Swedish Model ruling system, including its lack of morality towards the elderly.

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Soaring infection and death rates among the elderly receiving in-home care and in nursing homes have raised questions about Sweden's measures to combat COVID-19.

The preconditions in Sweden to stop the virus were extremely favorable in comparison with most nations in the world. Sweden's relatively high living standard, modern health services, and low national debt should have made it possible to cope with the crisis as well as its neighboring Nordic nations of Finland and Norway have done. But the death rates in these two nations are a tenth of that in Sweden. Moreover, Sweden has a low number of persons per household and access to extra housing in the countryside for distancing.

As of November 27, there have been 6,681 COVID-19 deaths in Sweden, a country of about 10.4 million, which is 643 deaths per million. This stands in sharp contrast to 59 deaths per million in Norway, 70 in Finland, 138 in Denmark, and 183 in Germany. Sweden ranks with the other nations of high death rates: Spain with 942 deaths per million, Italy with 861, and France with 768. Belgium is very high, with 1,407 per million; the United States is 800 per million.

In Sweden, nursing homes and the elderly in general figure prominently in infection and death rates. Nine out of ten of the COVID-19 deaths are in the age group 70 years and older. A major part of all deaths—2,892—occurred in the nursing homes for the elderly. On November 24, the Health and Social Care Inspectorate (IVO) reported on critical deficiencies of medical care in nursing homes, after officials inspected the medical records of 847 of patients with COVID-19. The results show that in all Swedish regions there were cases in which the elderly had not received individual evaluations from a doctor, or even a nurse. Patients and their relatives had also not been informed about treatment or lack of it, or had not been able to influence decisions.

There was an uproar about this in the spring from health personnel, patients' families, and professors. They reported that old people in nursing homes were not given hospital treatment nor even oxygen, when COVID-19 was suspected. Instead, they were declared dying and given only palliative care, regularly including morphine, which in the case of a lung disease like COVID-19, kills the patient.

The National Board of Health and Welfare issued an official directive to doctors recommending they not meet their patients physically, citing concern that such in-person contact could spread the virus to the elderly. This decision, however, reflects the policy of long-term neglect of the elderly in the Swedish health care system,

and in Swedish culture. In this context, the no-doctor-visit concept became, in effect, a policy of triage, as the main purpose it served was to keep down the pressure on the health care system. This is part of the strategy whose intent is to "keep down the curve," that is, to keep down pressure for COVID-19 hospitalizations, to stay below the capacity limits in hospitals. This strategy prevails in Sweden to this day.

There is now a second wave of the virus going through the nursing homes, killing the aged, and hitting hospitals. Anonymous reports from hospital staff focus on such infractions as COVID-19 patients sharing rooms with non-infected, severely ill patients. In late November, came an inquiry into the death of two patients who were infected at the University Hospital in Malmö.

British Government

Sir Patrick Vallance, the UK's Chief Scientific Adviser, recommended letting people get infected to develop a herd immunity.

'Herd Immunity' Not Eradication

From the beginning, leading authorities rejected the policy of trying to eradicate the virus, or even to contain it. Despite early and continuous protests from other Swedish epidemiologists and physicians, the policy has been to learn to live with the virus, until there is herd immunity either through enough people having acquired immunity, or through a vaccine.

This is so, despite denials by the public authorities in charge, led by State Epidemiologist Anders Tegnell. Documentation has been provided on this by Johan Anderberg, a journalist and author, who has a forthcoming book, *The Herd* (Ahlander Agency, spring, 2021) on the Swedish approach to COVID-19. Anderberg provides some early email correspondence of Tegnell, in an article in *Svenska Dagbladet* November 11 , showing that, as the article states, "herd immunity, i.e., to accept that a part of the population will get infected, was a part of the early policy."

Anderberg points out that the United Kingdom, in the early stage of the pandemic, had the same policy of "herd immunity" as the Swedish Model. On March 12, Sir Patrick Vallance, the UK government's chief scientific adviser, presented the government's policy. Vallance said that it is important to understand that this is not about preventing everybody from being infected, which is neither possible nor desirable, as you want some immunity in the population. He asserted that a level of immunity was needed to protect the UK from this in the future.

Just a few days later, the UK abandoned that strategy and implemented a lockdown.

A predecessor to Tegnell, now-retired medical doctor and expert on communicable diseases Peet Tüll, listed three alternative strategies in an email found by Anderberg. The first alternative was a total lockdown of the society for four weeks. The second was to find as many infected people as possible, trace all close contacts, and put them in a two-week quarantine. The third alternative was, "Let the contagion happen, slowly or fast, to reach a hypothetical 'herd immunity." Tüll recommended the second alternative and warned that the third would lead to thousands of deaths. Later the same day, Tegnell answered, "Yes. we have walked through all this and in spite of everything landed on Number 3."

WHO

Peet Tüll, former head of the communicable diseases unit at Sweden's National Board of Health and Welfare, recommended large-scale testing, contact tracing, and quarantining.

The same source reports on other leading Swedish experts also getting the same answer from Tegnell, who

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Anders Tegnell, Sweden's State Epidemiologist, is in charge of the country's response to COVID-19. Like Vallance, he promoted the policy of allowing the virus to spread.

explained that the contagion was also already domestic—in the community transmission stage, and contact tracing was futile.

Swedish Constitutional Law

The policy of allowing the virus to spread explains the lax Swedish countermeasures. However, it must also be understood that Tegnell and the bureaucrats in charge had to consider the extreme juridical and even constitutional limits to any effective measures. A policy of lockdown is just not possible under the Swedish basic law which rules that all Swedes have freedom of movement. The Communicable Diseases Act (2004:168) emphasizes and places a responsibility on the individual not to spread disease, and only allows for isolation of infected persons. No preemptive general measures for non-infected persons are allowed, unlike in Finland, where the whole county around Helsinki could be sealed off.

Actually, the only other two laws possible to use are the Swedish Public Order Act (1993:1617) about public order and meetings, and the law regulating alcohol use in restaurants. That is why, besides regulations within institutions—allowing the banning of visits to nursing homes—the only general restrictions against COVID-19 were limited to a maximum limit for public meetings—to at first 500, then 50 persons, which closed most theaters and cultural events but not shopping. Beyond that, restaurants could be regulated using the alcohol law.

Thus, Swedish public authorities are not allowed to implement anything like China did, and they refused to implement any model like South Korea, which has used mass testing, contact tracing and isolation. So, they were left with learning to live with the virus. The result is similar to what happened in other nations overwhelmed by numbers of infected persons, without advance preparations. Sweden started massive efforts to try to organize the health system to take care of the storm of incoming patients. Besides implementing its few available laws, Sweden's main thrust was to issue recommendations for social distancing, handwashing, avoiding unnecessary travel, etc., which has been the mantra replacing any real policy to counter the pandemic.

Beside the heroic efforts by hospitals, what did happen was that people began taking precautions even before the authorities issued recommendations, by distancing themselves socially, and by emptying the streets, shops, restaurants, and workplaces. When on March 16, authorities declared that persons aged 70 and over were a specific risk group, this age cohort loyally stayed home, and has remained there ever since. A month of such voluntary actions, together with the very limited restrictions ordered by the authorities, broke the trend of rising numbers of deaths and hospitalizations. This lasted until the fall surge.

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Even before the authorities issued recommendations, the Swedish people began practicing social distancing, emptying the streets, shops, restaurants, workplaces, and entertainment venues. Here, the Fontänen movie theater.

Actually, the Government in Sweden is a very weak minority coalition and had limited power to take any initiative to override the restrictive laws, and get something done about the highly complicated pandemic,

unlike what happened in many other countries. The Government implemented the limited lawful measures demanded by Tegnell and the authorities in charge, not the other way around. Moreover, the bureaucrats quarreled among themselves about the "scientific validation" of the use of masks, which to this day has blocked any recommendation for them.

A Constitutional Crisis

The response to the SARS-CoV-2 reveals another feature of the collapsing Swedish Model. In the Swedish administrative system, it is the public authorities who have executive powers, not the Government, and these authorities are very disunified. The leadership of the Swedish official efforts to contain COVID-19 is entrusted to the Public Health Agency (PHA) of Sweden, which is the public authority for communicable disease control, whose department head is the above-mentioned State Epidemiologist Anders Tegnell.[1] Tegnell and the Director of the Public Health Agency, Johan Carlsson, are in charge of the Swedish response to the COVID-19 pandemic with input from other responsible agencies at national level, and from international entities such as the European Union and the World Health Organization.

The most important among the other authorities is the National Board of Health and Welfare, which is in charge of medical health care, and coordination with the 21 regions of Sweden, whose county councils oversee hospitals and doctors, and 290 municipalities, which provide care through nursing homes and home care services. These 21 regions are run mostly by the political opposition like many of the municipalities; and they are independent institutions, just as the other municipal national public authorities, which make their own decisions, without any direct control from the Government. In sum, this fragmented, dysfunctional system is run by bureaucrats, each one of whom lacks the oversight of the national efforts, and, in many cases, makes sub-optimizing decisions, putting the priority on their own budget and activity.

This bureaucratic, fragmented rule has been praised as a Swedish policy to rule by science and competence, not by populist politicians. In reality, it is not only a nasty permanent bureaucracy, but an obsolete heritage of the pseudo-democratic corporatist Swedish Model from its heyday of the one party, forty-year rule under the Social Democrats. During that time period, the party was ruling the so-called "independent" public authorities through corrupt corporatist political backdoor dealings, with a myriad of party affiliated peoples' movements representing "the will of the people."

Now these corporatist party institutions negotiating with their counterparts from other powerful corporatist influence groups have mostly disintegrated. The structure of "independence" (from influence from the democratically elected Parliament and Government) is still there, guarded by the corrupt interests of the non-parliamentary influence groups. It leaves the public authorities all by themselves, under the influence of the remaining power groups, but more and more responsive to the whims of the media. The COVID-19 crisis is therefore also a constitutional crisis in Sweden.

The response to COVID-19 by the "responsible" public authorities, led by Tegnell, was concentrated on the hospital care system, in keeping below the curve of cases. This failed miserably as these leading authorities "forgot" about not only the nursing homes, but also the homecare for the elderly, overseen by the municipalities. The upper class of public bureaucrats actually had very little knowledge of this part of the society, all the while providing for protective personal equipment (PPE) and other measures for the hospitals.

Meanwhile, the whole population—especially the less educated and marginalized, could see for themselves, and feel in their hearts, that the Swedish arrogant bureaucrats in charge were lost. One Swedish TV program showed how shocked a Swedish doctor was, when dressed in full PPE, she had found an immigrant assistant nurse, without any PPE, giving home care services, treating an old woman up close. The doctor happened to be present only for some occasional medical treatment, but the assistant nurse did daily rounds, seeing to the elderly in their homes. So, the most prevalent public care of elderly, run by the municipalities, was not even included in the "prioritized" national strategy to protect the elderly.

The inevitable epidemiological pattern showed dramatically that at the same time infection rates started to increase among the elderly, it also started increasing in immigrant districts and among typical immigrant professions. The fact of segregation in Sweden was clear for all to see. Moreover, this summer a public investigation reported that the old Swedish Model of low-income differentials has been replaced by its opposite.

1. A discussion of the Public Health Agency of Sweden's COVID-19 work is available here.

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The hospital system has been undermined by privatizations and financial austerity, leading to downsizing and the lowest rate of hospital beds per capita in Western Europe. Shown, the Emergency and Infectious Diseases Unit at Skåne University Hospital in Malmö.

Sweden now has one of the fastest rates of increasing income disparity in the world.

Hospital Privatization, Increased Contagion

The hospital system of the Swedish welfare model has been much undermined by financial austerity, especially since the Swedish banking crisis 1987-93, and again after the 2008 international banking crisis, which has led to downsizing, and the lowest rate of hospital beds per capita in Western Europe.

On top of that, the most extreme liberal experiment in Europe of privatization of hospitals, and especially, of elderly care, has been implemented. As each privatized health provider puts priority on its own bottom line, this process has further fragmented the Swedish health care system.

The significance of that in the current situation is that pressure for profits has led to downward pressures on the labor conditions for the health workers. Salaries, professional education, and costly medical personnel are kept at minimum levels. The elderly care sector, also the competing publicly owned care, has been reduced to a gig economy, where home care patients/clients are visited, on average, by 16 different workers per two-week period, many of them short term workers, whom the patient/client has never seen before.

This has not been helpful to contain the pandemic. Furthermore, the private hospitals were excluded from any obligation to handle COVID-19 cases. Some of them even continued with their unnecessary, cosmetic medical services. It was the public hospitals, starved to the bone of hospital beds and staff, which represented the capacity level, which "the curve" was not allowed to surpass.

The pressure for cost cutting did not even allow infected patients to be separated from the noninfected, even down to sharing the same room. In the spring, the lack of PPE, and the continuing turnover of health care workers created a toxic mix where the hospitals and elderly care were spreading the virus.

In reaction to the scandalous death wave in nursing homes and home care services, the health care industry has started to listen and partially implement the longstanding demands from the trade unions for long-term employment contracts, and job training. But the privatizations and financial sector behind the extreme fragmentation so far have not been touched.

Delayed Testing

Implementing mass or targeted testing had no place in the "Number 3" herd immunity strategy chosen by Tegnell and the authorities in charge. Instead, limited testing was concentrated on patients with symptoms. Mass testing was delayed, in spite of the generous and portentous cooperation between Swedish and Chinese laboratories, which from April 1, saw planeloads of the most advanced automatic test analysis equipment and test kits arrive in Sweden from China. A private donation from the Wallenberg Foundation financed the exclusive equipment and transport. Sweden had the knowledge of how to handle the equipment because of earlier scientific cooperation between the two countries.

But the bureaucrats hesitated to expand testing, bringing up such excuses as that it had to be done in ways so that the results could be scientifically verifiable as a survey. After much delay, the Government stepped in, and on April 1 mandated the Public Health Agency to expand testing capacity from 50,000 a week to 150,000. On May 8, the Government appointed Harriet Wallberg as a special testing coordinator between the

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Harriet Wallberg served as Sweden's national COVID-19 test coordinator in May 2020. She is a professor of physiology at the Karolinska Institutet.

Public Health Authority and the 21 hospital regions and with central supplies of testing buses and test kits. The regions also did contact tracing.

By June, Sweden began to implement mass testing as part of its strategy. The approach is in the direction of the South Korea model, which had earlier been dismissed. As of the end of November, testing in Sweden is running at the rate of nearly 270,000 per week, which is the highest per capita rate in Europe.

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Prime Minister Stefan Löfven has now taken control over Swedish policy against COVID-19, announcing strict social distancing measures and supporting the putting aside of some rights in the Basic Law for the same purpose.

Summer Slow, Then Fall Infections Surge

The rate of infections increased at first because of the expanded testing. But the death rates were very low when the vacation period started in July, and this continued. On September 30, the ban was lifted on visits to nursing homes. But as of the middle of October, an autumn surge in infections had started.

Among the factors in the pick-up in COVID-19 case infections are the private parties of students and other young people. They just disregarded the recommendations from the authorities. In September PHA warned about outbreaks of infections found in sports clubs and teams. There was a sharp difference in protective behavior expressed by the 70+ folk and the younger generations in following recommendations. Shopping and visits to restaurants increased.

Some Swedes, especially the younger ones, misunderstood "herd immunity" to mean that they should even promote infections among themselves so the nation would arrive at herd immunity sooner, in order to protect the elderly and get out of the pandemic faster.

When the second wave began, the recommendations and lax measures were not enough to stop a surge in infections. The predictions by Tegnell about a slow autumn surge proved wrong. On November 20, the Government stepped in and Prime Minister Stefan Löfven announced a ban on public meetings exceeding eight persons, and strict recommendations to avoid all meeting of others beyond one's own close family. On November 22 he spoke to the nation, delivering a strong message to everybody to change their behavior in order to save Christmas.

What was made clear was that Tegnell and the public authorities are no longer determining the Swedish policy on COVID-19; it is now the Government that is doing so. This change is mostly supported by the established media and the population, and has sparked a full debate about much overdue constitutional changes. Some media point to and support the Prime Minister's "putting aside rights and freedoms in the Basic Law." If pursued it could become the beginning of a possible democratic revolution in Sweden against the dictatorship of bureaucrats.

This is an urgent question in the upcoming world financial crisis, and the necessity of defeating the push for the fatal Great Reset. The financial "public authorities" in Sweden and globally are even more tightly controlled by corporatist and other non-elected influence groups, centered in the City of London and Wall Street, than are the health services sectors. Defeating this financial menace is as much a matter of life and death, as defeating the pandemic.