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# Ethical Problems and the Role of Expertise in Health Policy: A Case Study of Public Policy Making in Sweden During COVID-19

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## ABSTRACT

Although the literature widely discusses the role of academics as experts in public policy making, empirical case studies on ethical problems related to the production and implementation of health policy are scarce. During COVID-19, the Swedish policy document (PD) *National Principles for Prioritization in Intensive Care under Extraordinary Conditions* was produced in collaboration with 11 academic experts. Based on a case study, this article examines ethical problems related to the production and implementation of this PD by conducting an analysis of key PDs directed at caregivers during this time. Three ethical problems are identified and analyzed, which relate to starting points, the content of the PD, and the implementation. This study provides strong theoretical support for Jonathan Wolff's model of engaged political philosophy, as well as practical support on avoiding undesirable consequences of policy making and preparing academics for expert roles in public policy.

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## ABSTRACTA

Aunque la literatura analiza ampliamente el papel de los académicos como expertos en la formulación de políticas públicas, los estudios de casos empíricos sobre problemas éticos relacionados con la producción e implementación de políticas de salud son escasos. Durante la COVID-19, el documento de política sueco (PD) Principios nacionales para la priorización en cuidados intensivos en condiciones extraordinarias se elaboró en colaboración con once expertos académicos. Basado en un estudio de caso, este artículo examina los problemas éticos relacionados con la producción e implementación de este DP mediante la realización de un análisis de los DP clave dirigidos a los cuidadores durante este tiempo. Se identifican y analizan tres problemas éticos, que se relacionan con los puntos de partida, el contenido de los DP y su implementación. Este estudio proporciona un sólido respaldo teórico para el modelo de filosofía política comprometida de Jonathan Wolff, así como apoyo práctico para evitar consecuencias indeseables de la formulación de políticas y preparar a los académicos para roles de expertos en políticas públicas.

### 抽象的

尽管文献广泛讨论了学者作为公共政策制定专家的作用，但与卫生政策的制定和实施相关的伦理问题的实证案例研究却很少。在 COVID-19 期间，瑞典与 11 名学术专家合作制定了政策文件(PD)《特殊情况下重症监护优先国家原则》。本文基于案例研究，通过对这一时期针对护理人员的关键绩效数据进行分析，探讨了与该绩效数据的制定和实施相关的伦理问题。识别并分析了三个伦理问题，涉及PD的出发点、内容和实施。这项研究为乔纳森·沃尔夫的参与政治哲学模型提供了强有力的理论支持，也为避免政策制定的不良后果和为学术界在公共政策中扮演专家角色做好准备提供了实际支持。

## 1 | Introduction

Swedish authorities produce policy documents (PDs) such as regulations, guidelines, and expert briefs prepared by committees to aid and direct healthcare principals, staff, and managers in effectively responding to health crises and pandemics (see e.g., MSBFS 2015:4; FHM 2019). During COVID-19, new PDs were hastily produced and implemented by the Swedish authorities to further support and direct local healthcare crisis management. One of these, the *National Principles for Prioritization in Intensive Care under Extraordinary Conditions*, published in April 2020 by the National Board of Health and Welfare, is the subject of this single case study. This PD (henceforth referred to as the ‘COVID-Prio PD’ and labeled as ‘PD1’) concerns ethically sensitive questions about stricter priorities in healthcare, such as prioritizing treatment levels for patients based on biological age and expected remaining lifespan. The COVID-Prio PD was produced with the aid of an all-male expert group consisting of physicians and philosophers.

Academics are often recruited to participate in committee work in connection with public policy making, in line with established democratic ideals of decision making based on knowledge and enlightened understanding (Dahl 1989; Hermansson 2003). What, then, are the merits and challenges of involving academics in policy-making processes? The literature on this topic is fragmented, and the issue is often discussed in ‘separate silos’—for example, through concepts such as evidence-based policy making, epistemic communities, and ideas and politics (Christensen 2021). According to Christensen (2021), this disintegrated approach to the role of academics in policy making has hindered sustained empirical study. Nevertheless, questions have been raised about philosophers as public policy experts because of the prestige of ideal theory within this field and its generally limited interest in contextual issues and feasibility (Wolff 2011; Christensen, Holst, and Molander 2022; Holst 2024). The aim of the present case study is to contribute empirically to these important discussions on ethical problems that may emerge and confront academics engaged in public

policy making. Specifically, this article offers an in-depth investigation of a single case of philosopher-assisted public policy production and policy implementation during a severe public health crisis—namely, the PD laying out the Swedish healthcare system’s principles for prioritization in intensive care under extraordinary conditions. These ‘extraordinary conditions’ refer to the situation in the Swedish healthcare system during 2020–2022, when resources to treat catastrophically ill patients suffering from acute respiratory disease were severely strained.

Ethical problems may arise in connection with the rapid development and implementation of PDs prepared to guide healthcare professionals in confronting crises. Here, ethical problems denote a situation in which established ethical values in society are threatened and where, for example, one group of people may gain advantages at the expense of others. As will be shown, a series of ethical problems emerged in the production and implementation of the COVID-Prio PD, which could have been prevented, at least to some extent. This article explores what alternate approaches among the committee experts could have helped to prevent the emergence of these problems. The results provide strong support for Jonathan Wolff’s model of *engaged political philosophy* (Wolff 2018).

Jonathan Wolff’s (2018) model, we argue, offers a pragmatic approach to addressing real-world problems by emphasizing context and practical problem-solving over abstract theorizing. The approach involves extensive contextualization and problematizing of why a particular issue has come to public attention, identifying the positions in the debate, and exploring what drives stakeholders apart (Brister 2023). In the context of the case study presented in this article, Wolff’s model underscores the importance of understanding the systemic deficiencies and organizational challenges within the Swedish healthcare system. It highlights the need for a diverse expert group that includes not only philosophers and physicians but also frontline workers and social scientists who can provide a more comprehensive understanding of the practical implications of policy decisions. As this article will demonstrate, this integrative approach can

help prevent ethical problems and ensure that policies are both effective and just.

## 1.1 | Contextual Setting of the Case

In terms of the context of the studied case, the following circumstances are particularly important. First, in Sweden, the responsibility for healthcare is divided between the state, 21 regional authorities with independent power of taxation, and 290 municipal governments (also with independent power of taxation). The regional authorities provide the public with primary, secondary, and tertiary care, while responsibility for the long-term care of the elderly is divided between the regional authorities and the municipalities. The national government has an overall responsibility to provide the regions and municipalities with political, regulatory, and financial frameworks. Furthermore, the regions and municipalities rely on a vast number of private contractors, especially in primary care and care for the elderly. The Swedish healthcare system is thus characterized by governance complexity and a fragmented organizational structure (Svallfors and Tyllström 2019).

According to the Swedish Constitution, the so-called *Instrument of Government*, public authority must be exercised with respect for the equal value of all people and with respect for the freedom and dignity of the individual (SFS 1974:152, Ch. 1, Sect. 2). Discrimination is prohibited. The same ethical and democratic value system is found in the Swedish healthcare act, which states that healthcare must be provided with respect for the equal value of all people and with respect for the dignity of the individual person (SFS 2017:30). Those who have the greatest need for care must be given priority, and determining who has the greatest need requires a medical assessment and reflects a principle of solidarity. Finally, there is a third principle concerning cost efficiency. These three principles (human dignity, care based on need, and cost efficiency) constitute the priority platform decided by Parliament (Regeringens Proposition 1996/1997:60); they are “interdependent and lexically ordered,” which means that “they are not three loosely coupled principles that can be replaced or changed arbitrarily without thereby risking the platform’s basic idea being lost” (Engström et al. 2020).

Second, the healthcare act emphasizes the need for sufficient staffing, adequate premises, and relevant equipment in the provision of good care (2017:30, Ch. 5, Sect. 2). Even under ‘normal’ conditions, these resources are limited, which is why priorities need to be established daily by healthcare professionals, with support from the priority platform decided by the Parliament. However, in some cases, such a medical priority setting has been proven difficult to implement in practice, for example, due to applied control models such as care contracts and demand-driven care (Falkenström 2012; Falkenström and Höglund 2018).

Third, as pointed out by the Swedish authorities before COVID-19: “The purpose of Swedish crisis preparedness is to protect the life and health of the population, the functionality of society, and the ability to maintain our fundamental values

such as democracy, the rule of law, and human freedoms and rights” ([www.regeringen.se/regeringens-politik/krisberedskap](http://www.regeringen.se/regeringens-politik/krisberedskap), Accessed 24 May 2024). The Public Health Agency of Sweden state that, in the event of a pandemic, society’s overall goal is to minimize mortality and morbidity in the population, as well as to minimize other negative consequences for the individual and society (FHM 2019). This purpose and these goals refer to and confirm the well-established ethical and democratic value system that should entrench all Swedish public agencies (SFS 1974:152).

Fourth, through legislation and regulations, society places certain demands on how different actors should prepare an adequate response to crises and pandemics (SFS 2006:544; 2006:637). Various kinds of support in the form of policy briefs and recommendations from authorities are offered. For instance, shortly before the COVID-19 pandemic developed, the Swedish Public Health Authority (FHM) published a policy brief on pandemic preparedness: *How We Prepare—a Knowledge Base* (FHM 2019):

To handle outbreaks of infectious diseases, good preparedness is needed at national, regional, and local levels in the form of action plans, access to emergency stocks, access to sufficient and competent staff, structures for cooperation and communication, etc. Resources for preparedness in the event of an outbreak need to be ensured, and a plan for flexible capacity increase must exist in healthcare and in laboratories.

(FHM 2019, 13)

Fifth, the FHM emphasizes the importance of integrating considerations of ethical dilemmas in pandemic crisis planning and of developing decision-making processes in the crisis-planning stage that enable healthcare staff and organizations to handle ethical dilemmas that may occur (FHM 2019). Previous research has shown, however, that ethics hold a weak position in the management and control of Swedish healthcare and that ethical considerations are rarely integrated into ordinary decision-making processes (Falkenström and Höglund 2019).

Sixth, for decades, Swedish healthcare has faced significant structural and organizational challenges. A primary issue is the shortage of hospital beds, compounded by geographical and social disparities that create unequal access to care. These factors contribute to worsening health issues among the aging population, difficulties in addressing rising care demands, and a decline in both workplace conditions and employee motivation (Anskär et al. 2019; Anell 2020). Employee burnout, stress, significant levels of sick leave, a high degree of voluntary part-time work, and high turnover rates are well-documented phenomena in Swedish healthcare (see e.g., Aronsson et al. 2017; Arbetsmiljöverket 2023). All these factors are known to create problems in the access to and provision of care, and analyses have concluded that the persistent lack of resources has led to serious injury and deaths (Siverskog and Henriksson 2022; IVO 2023).

Long-term care for the elderly has long been neglected and given low priority in terms of resource allocation in Sweden, mirroring a global situation in which long-term care systems are underfunded, fragmented, lack accountability systems, suffer from poor coordination between healthcare and long-term care, and have an undervalued workforce (Szebehely, Strandell, and Stranz 2020). Workers in the Swedish long-term care system are predominantly women, many with a migrant background; their earnings are low, and their work is increasingly intensified and surveilled (Szebehely 2018; Szebehely, Strandell, and Stranz 2020). Understaffing is common, and many employees are on short-term contracts and lack formal training. Residents in long-term care facilities often have complex care needs, which are difficult to properly manage due to the fragmented organization of care and accessibility problems in secondary and tertiary care provision (cf. Pennbrant et al. 2020). Authorities have long recognized shortcomings in the cooperation between different actors in the care of the elderly, which put patients at risk of ‘falling through the cracks’ and missing out on quality care and medical interventions (Socialstyrelsen 2013; IVO 2017). During the COVID-19 pandemic, several organizational shortcomings were also reported in connection with the care of older people: the Corona Commission found that long-known structural deficiencies had the greatest negative impact on elderly care during the COVID-19 pandemic, during which many residents in elder care facilities were insufficiently protected from the virus (SOU 2020:80). Thus, even under pre-pandemic conditions, the Swedish healthcare system was operating under severe pressures due to split responsibilities and a persistent lack of resources, including insufficient levels of staffing. The situation was therefore already far from satisfactory when COVID-19 emerged and the pandemic hit.

Careful consideration of such circumstances will likely promote stronger analyses and policy recommendations (Wolff 2018, 2019). In the realm of public policy, context is not merely a backdrop but a critical component that shapes the effectiveness and ethical soundness of policy decisions. Jonathan Wolff’s model of engaged political philosophy, which will be introduced in the next section, underscores the importance of grounding policy development in a thorough understanding of the specific social, historical, and organizational contexts in which policies are implemented.

## 2 | Theoretical Framework

PDs are instruments of control produced by authorities and public decision-makers to guide decisions and activities in a certain direction within a specific subject area. They are normative and constitute one of several tools for governance. In practice, actions and interactions are governed by more-or-less coordinated sets of rules and procedures. These so-called ‘institutions’ provide actors with a framework that reduces uncertainty and gives structure to collective actions (March and Olsen 1989; Powell and Di Maggio 1991; Lascoumes and Le Gales 2007). Yet, how a certain PD is received and understood in local healthcare settings depends on the approaches, routines, and culture that are gradually developed and established through various forms of control, management, and educational programs.

Organizational ethics in healthcare deals with the ethical aspects of the structure, organization, and control models of the healthcare system. PDs and guidelines are examined to identify how conflicting goals, values, and interests are and should be handled (Gibson et al. 2014; Emanuel 2000). A basic assumption is that the structural design of the system has—at least to some extent—been intentionally planned to achieve certain effects. The design produces certain functions, positions, and power relations. Financial and human resources are distributed to maintain these functions. The design thus regulates relationships and interactions between different actors and activities in the healthcare system (Emanuel 2000). Decisions concerning policy, control models, and budgets may enable or limit the interests and actions of various stakeholders; these circumstances strongly affect local caregivers’ opportunities to perform based on professional knowledge and codes of conduct. On what basis and how policy and guidelines—such as principles for medical priorities—are developed and implemented are thus of great importance for medical practice and patients (Falkenström 2021).

Nearly all major policy issues are highly complex or have specific technical attributes (Ingold and Gschwend 2014, 993), so decision-makers “routinely access knowledge and advice from various experts” to inform their decisions. While the provision of expert advice is well embedded in all policy-making systems, Easton et al. (2022, 309) argue that “these processes require scrutiny in times of crisis”—not least because they have wide-ranging social and health implications and because advice from unelected experts during crises is “delivered under emergency powers that may be seen as bypassing the transparency norms of democratic debate and accountability” (Easton et al. 2022, 311). Another problem revolves around the concentration of specific knowledge in smaller groups of experts, which can lead to “epistemic monopolies” (Koppl et al. 2012). Holst (2024) points out that, while experts may have different competencies and educational backgrounds, philosophers seem to be increasingly in demand.

To create purposive data and to analyze the empirical material, the perspective of organizational ethics in healthcare is used in combination with Jonathan Wolff’s (2018) model of engaged political philosophy. The role of philosophers in policy making has been the subject of scholarly debate for decades (cf. Brock 1987; Kymlicka 1993; Buchanan 2009). Philosophers, Buchanan (2009, 276) argues, “tend to take a positive view of the role they see Philosophy playing in contemporary public policy.” Wolff (2019, 2) has summarized this view as the assumption that moral and political philosophy “is made for the analysis of public policy, exploring foundational values, and consolidating them into theories and prototype policies that could, with reasonable adjustment, fit practical needs to improve the moral quality of our public lives.” Wolff claims that philosophers do have an advantage in contributing to policy making, particularly owing to their training in analyzing values and how to approach dilemmas. However, while they tend to enjoy a privileged role as experts in policy-making processes, philosophers can only see a part of the reality that they are analyzing and speaking about (2019, 5)—and their training may hamper the policy process. He develops this notion through a theory—or, rather, a methodology—wherein ‘applied philosophy’ is contrasted with ‘engaged political philosophy.’

*Applied philosophy* is about addressing “real-world problems by working out how to solve them by ‘applying’ a moral or political theory, thereby providing ‘philosophical foundations’ for social and public policy” (Wolff 2018, 3). This approach, Wolff argues, runs the risk of dogmatism, under-determining policy outcomes (since theories are often compatible with several contradictory policy moves), implausible recommendations, and partial implementation. *Engaged political philosophy* avoids these problems by starting not from theory but from the problem at hand: why has this issue come to public attention right now? What are the positions in the debate, and what drives people apart? In this approach, the philosopher holds no distinctive, privileged role as “the formulator of the theory that provides a moral foundation for public policy” (Wolff 2018, 17); rather, the philosopher “identifies relevant values, in the context of a problem, current facts, past history, and contemporary alternatives” (Wolff 2018, 17). This, Wolff argues, includes “sifting and balancing to articulate the moral dilemmas. Unlike applied philosophy, then, engaged political philosophy emphasizes context and careful analysis of the problems in need of attention” (Wolff 2018, 17).

Wolff’s model of engaged political philosophy represents a significant shift in the way political philosophy is approached and applied. The model emphasizes the importance of philosophers engaging directly with real-world issues and public policy, thereby bridging the gap between theoretical discourse and practical application. It is, we argue, a transformative approach that seeks to make philosophical inquiry more relevant and impactful in addressing contemporary social issues. It emphasizes the need for methodological pluralism, encouraging the use of various methods and tools, including normative analysis, empirical research, and interdisciplinary collaboration, allowing for a more comprehensive understanding of complex social issues and the development of actionable solutions. The imperative of interdisciplinarity aims to provide insights that are both theoretically sound and practically applicable.

Central to the model, then, is the idea that political philosophy should not remain confined to abstract theorizing but should actively engage with real-world problems and public policy. This approach emphasizes the practical application of philosophical principles to improve societal well-being and address the needs of marginalized and vulnerable populations. We draw on these scholarly debates on the role of philosophers in policy making, and particularly on Wolff’s engaged political philosophy approach, to analyze critical aspects of the production and implementation of the COVID-Prio PD.

### 3 | Data and Method

Our data stem from two research projects: one on the commissioning, production, and use of expert reports in Swedish healthcare governance and one on organizational learning after health crises. Both projects involve analyses of PDs regarding Swedish pandemic preparedness, and these analyses have raised new questions and led us to the present case study.

The COVID-Prio PD (PD1) sparked a public debate in Sweden during the pandemic. As one intensive care physician noted, the issues raised in the PD were considered a “red-hot potato”

(Selberg 2022, 59) because they dealt with limiting access for some segments of the population to medical interventions that, under pre-pandemic conditions, would be considered necessary and justified—essentially upending the ethical foundation of the Swedish healthcare act. The PD, then, dealt with complex ethical issues that would normally be settled within the context of polity.

As stated in its preface, eleven named experts, all either moral philosophers or medical doctors, were involved in the production of the COVID-Prio PD. These circumstances—that is, the weight and complexity of the issues confronted in the PD and the composition of the expert group—justify the choice to place this specific PD at the center of our analysis. To obtain richer empirical data material and a more contextual understanding of the case, a selection of a few other PDs has also been included and analyzed. These PDs were also published by Swedish authorities at that time and were intended for caregivers. There is no reason to assume that all relevant PDs have been included, but we are confident that necessary and sufficient PDs are included to answer our research questions. For three reasons, we have chosen not to conduct interviews, which could have been justified in a case study like this. First, we do not intend to examine the thoughts or experiences of the experts or public officials. Second, it would have been difficult to protect their identity and thus live up to standards of sound research ethics. Finally, the data have proven to be sufficiently exhaustive for the purpose of the article.

A strategic selection was made of a total of six PDs produced by Swedish authorities and directed to healthcare providers during COVID-19. A PD produced by Region Stockholm was also included and analyzed to obtain an example of relevant regional PDs produced and implemented at this time and thus to contribute further facts and contextual understanding of the case. The choice of region was made on the basis that Stockholm was one of the most affected regions in the country at this time.

All the included PDs took as their starting point the current and uncertain situation related to COVID-19. They are concise and instruction-oriented. Two PDs, one produced by the Public Health Authority and the other by the National Board of Health and Welfare, focused on measures to reduce the spread of infection. In these documents, practical suggestions were given for working methods for municipal healthcare. The National Board of Health and Welfare also produced a checklist aimed at managers, with a focus on patient safety. The same authority produced two PDs on national principles for prioritization, which included advice regarding the assessment of care needs. One was intended for routine healthcare and the other for intensive care. Region Stockholm’s PD concerned municipal healthcare and consisted of regulations for care flows. References to the National Board of Health and Welfare’s PDs on national principles for prioritization were frequent in the analyzed PDs. It is relatively clear from the titles of the included PDs what they were about (Table 1).

A single case study design was chosen to obtain in-depth knowledge and understanding of both the current phenomena and a particular case bound by time and activity (Priya 2021; Yin 2014). This case study draws attention to the production

**TABLE 1** | PDs included and analyzed in the case study.

| Assigned number | Name   | Designation                           | Sending authority                        |
|-----------------|--|---------------------------------------|--|
| PD1             | National Principles for Prioritization in Intensive Care under Extraordinary Conditions [COVID-Prio]   | 2020-04-29 version 2                  | The National Board of Health and Welfare |
| PD2             | National Principles for Prioritizing Routine Healthcare during the COVID-19 Pandemic: Knowledge support for Developing Regional and Local Guidelines     | 2020-04-22 version 2                  | The National Board of Health and Welfare |
| PD3             | Recommendations for the Administration of and Decisions on Protective Measures Against COVID-19 in Healthcare  | 2020, item number 20197               | The Public Health Authority              |
| PD4             | Checklist for Increased Patient Safety during the Ongoing COVID-19 Pandemic: To support you as a manager and leader                                      | 2020, item number Dnr. 4.3-16706/2020 | The National Board of Health and Welfare |
| PD5             | Working Methods in Municipal Healthcare in case of COVID-19: Practical Proposals for Municipal Healthcare in Collaboration with Social Services          | 2020, item number Dnr. 4.3-16706/2020 | The National Board of Health and Welfare |
| PD6             | Governing Regulations for Patient Flows between Care Providers in the Stockholm Regional and Municipal Care System during the Ongoing Spread of COVID-19 | 2020-05-20 version 3                  | Region Stockholm                         |

Note: The Swedish titles have been translated by the authors.

and implementation of the COVID-Prio PD and thus places a single PD at the center of the investigation. The other PDs were included by purposive sampling to provide further information about the context, meaning, and importance of the single case, as well as contextual information on its implementation (Punsch 2005).

The analysis was targeted and guided by the purpose of the case study and the research questions. A structured and themed question guide inspired by the theoretical framework was used to draw attention to relevant issues in the PDs (Table 2). In accordance with Bowen (2009), the document analysis was organized in three steps: skimming, thorough investigation, and interpretation. More specifically, the PDs were initially read through to obtain an overview of the content. The PDs were then reread while keeping the research questions in mind. We also remained open to any other findings of value to the purpose of the case study. The thematization gave structure to the empirical data and made it easier to make comparisons between findings in the PDs and to discover patterns of importance for the results. The responses were compiled in a separate document. Subsequently, the data material was coded and categorized based on its content and discussed in light of the chosen theory (Rennstam and Wästerfors 2015).

## 4 | Results

Three bodies of ethical problems emerged from the analysis and are presented and discussed below. These problems are related

to different phases in the process of the production and implementation of the current policy: the *starting point*, the *content*, and the *implementation*.

### 4.1 | The Starting Point: Problem, Purpose, State of Affairs, and Expertise

Inspired by Wolff's (2018) model of engaged political philosophy, we start with the following questions: What was the problem in need of attention? And why did this problem come to the authorities' attention at that time? What was the current state of affairs? All quotes are translated from Swedish to English by the authors.

The COVID-Prio PD was developed by the National Board of Health and Welfare as a direct result of the COVID-19 pandemic. In the preface, the responsible Deputy Director-General writes that the principles in the document are intended to be applied if the development of the spread of infection leads to a situation wherein the need for intensive care within the population exceeds the available resources (PD1, 3). The Deputy also states that these principles "will need to be adapted and concretized by local healthcare representatives as they are to be applied in concrete situations. The COVID-Prio PD further states that these principles can be used as a starting point for prioritizing 'other forms of care where seriously ill patients are treated and where the availability of resources is affected by the pandemic'" (PD1, 3). Thus, the problem that was considered in need of attention was a feared imbalance between intensive care needs and

**TABLE 2** | Structured and themed question guide.

| Themes                                     | Questions to the PD   |
|--|---|
| 1. Problems and purpose                    | <p>What was the starting point of the PD? What problems does the PD address? How are the problems described and contextualized? Why was the PD introduced at this time? What consideration is given to how the problem has developed over the years?</p> <p>What was the purpose of the PD?</p> <p>Who were the recipients of the PD?</p> |
| 2. Expertise                               | <p>What kind of experts were engaged in the production of the PD? How was the choice of experts motivated?</p>  |
| 3. Content                                 | <p>What characterizes the content of the PD?</p>  |
| 4. Conflicts and risks                     | <p>Are there any conflicts of interest addressed? If so, which ones? Are risks and potential consequences identified and analyzed? If so, which ones?</p> <p>Who would gain from the implementation of the policies in the PD? Who would lose?</p>  |
| 5. Implementation                          | <p>What does the PD say about the implementation of national principles for prioritization in intensive care under extraordinary conditions? What does the PD say about PD1? Does the PDs refer to each other? If so, in what ways?</p>   |
| 6. Ethical problems (analytical questions) | <p>Do any ethical problems emerge related to the production and implementation of the PD? If so, which ones?</p>  |

available resources. The following purpose of the PD was explicitly formulated: “The purpose of the document is to support healthcare [professionals] in making decisions about priorities according to the current ethical platform for open priorities in healthcare, which is also expressed in the healthcare act” (PD1, 3). The authority thus emphasizes that the stricter national principles presented in the PD are compatible with current legislation in the area. This suggests that the patients who would benefit from the principles laid out in the PD were those with the greatest need for treatment.

Yet another purpose is apparent from the document: “In connection with the difficult decisions that may be required based on these principles, healthcare professionals may experience ethical stress. Ethically well-grounded principles can reduce ethical stress, because healthcare staff can feel supported in making difficult decisions on good grounds and not arbitrarily” (PD1, 8–9).

The expert group mentioned and thanked in the preface of the document is all male (PD1, 3). No women are mentioned as having contributed to the work in producing the PD, nor any nurses or representatives from municipal healthcare where elderly people are cared for. No social scientists—such as psychologists, political scientists, or sociologists—were part of the expert group. The choice of expert provision is not motivated in the document, which was finalized in a few days (according to a member of the expert group)<sup>1</sup> and introduced in the spring of 2020.

The PD does not address or even mention central aspects affecting Swedish healthcare capacity—namely, the well-known systemic deficiencies, such as high levels of staff turnover and problems with retention due to employee dissatisfaction; the lack of hospital beds; social and geographical inequalities in access to healthcare; and problems with quality care provision in the care of the elderly. Rather, the COVID-Prio PD starts from the assumption that difficult prioritizations will follow from increasing care needs resulting from the pandemic. The problem is presented, then, as the consequences of a biological event (i.e., the spread and severity of infection) and not as the consequences of structural conditions. From the perspective of engaged political philosophy, this reveals a limited contextual attention and narrow analysis of the problem that the policy was supposed to solve.

## 4.2 | The Content

In the COVID-Prio PD, the National Board of Health and Welfare states that the principles laid out in the document are based on, and congruent with, the national ethical platform for Swedish healthcare. Our analysis, however, suggests that the PD's stricter principles for prioritizations under extraordinary circumstances deviate from the national platform, which ranks human dignity above the principle of care provision based on need. The PD stresses that the principle of human dignity does not allow for prioritization based on a patient's chronological age, social situation, or functional impairment, nor on the basis of whether or not the patient has contributed to her own condition. However, it states that the “indication for intensive care” needs to be “stricter” during extraordinary circumstances and reserved for “patients for whom intensive care has great probability of contributing to continued life”; this means that, while chronological age is not in and of itself allowed to dictate the level of care provided, biological age is allowed to do so (PD1, 6). *Biological age* refers to physical resilience and is assessed based on the number of failing vital functions/organs, degree of comorbidity, and chronological age (PD1, 6). “Under normal circumstances,” the PD states, intensive care is provided “even to patients with a low probability of survival”; “in connection with an extraordinary situation,” however, intensive care resources must be “reserved for those who are most likely to survive” (PD1, 6). Where the limit is drawn, the PD states, “depends both on indication and the current access to resources” (PD1, 6).

To some extent, the reasoning in the PD appears to go against the principle of human dignity. Well-established ethical goals and values tend to be relativized within the PD and reduced in relation to a feared shortage of resources during the pandemic. This deviation is justified in a footnote: “Normally, the benefit of

the intervention is assessed based on the parameters of life span and quality of life. In this situation, it is impossible to assess the patient's future quality of life, and, because of this, the principles focus entirely on life span" (PD1, 8).

The analysis of the other PDs shows that they possess similar discrepancies. One example of this is that, even though one of the purposes of these other PDs is to aid in the provision of high-quality care and care based on individual need, the emphasis within them is on older people's ability to cope with a certain treatment (intensive care), rather than on assessing an individual's need for care (PD5; PD6). In this regard, the PDs lay out values and principles that deviate not only from professional codes of conduct and the established ethical values and goals in Swedish society but also from the ethical underpinnings emphasized by the Public Health Authority (FHM 2019) before COVID-19.

The PDs' focus on elderly patients and their ability or inability to cope with a certain treatment (intensive care) appears particularly problematic since the policy recommendations were aimed at municipal healthcare. In the municipal care system, that is, in long-term care facilities and home aid for the elderly, employees are not expected to have the same knowledge, understanding, and experience in applying the national prioritization platform as physicians and registered nurses within regional, tertiary healthcare facilities.

Moreover, the analyzed PDs demonstrate internal contradictions. On the one hand, the frail, multimorbid elderly were identified as the patient group hardest hit by COVID-19; on the other hand, they were presented in the PDs as a group of patients that should be kept away from hospitals—where the most advanced medical care is provided—as far as possible: "As far as possible, medical complications and deteriorating conditions must be taken care of on site" (PD 6, 2). "For frail elderly people with extensive care needs, care in an emergency hospital is recommended only if urgent interventions are required that cannot be handled at the ordinary level of care, such as emergency surgery" (PD 6, 2).

Although the elderly share the characteristic of being older, these are people with individual care needs and conditions. The serious ethical problem demonstrated here is that elderly and frail people, according to the content in the PDs, are at risk of being treated as a group and discriminated against. According to Wolff's (2018) model, adopting a broader perspective and conducting a more thorough analysis of contextual conditions and risks—such as identifying which healthcare providers are likely to implement stricter principles—could have mitigated the risk of discrimination.

### 4.3 | The Implementation

Regarding implementation, the COVID-Prio PD states that the principles laid out within it need to be adapted and concretized by specific care providers as they are applied (PD1, 3), and that they "must be adapted to the local resource situation when they are to be implemented" (PD1, 7). However, the PD does spell out that care providers need to be more restrictive in terms of "starting or continuing intensive care" and that they should be careful

not to "burden intensive care units with patients who will have a low priority." Other parts of the healthcare system, the PD states, "are forced to become more restrictive in referring patients or consulting intensive care units on behalf of low-priority patients"; this means showing "great restrictiveness in performing procedures that may require follow-up care in intensive care units" (PD1, 7).

Here, the purpose of the PD appears in a slightly different light compared with the purpose outlined on page 3 in the same PD: namely, "to support healthcare [professionals] to make decisions about priorities according to the current [national] ethical platform." Instead, the PD emphasizes that resources must be reserved for patients with a high probability of survival and clearly signals that intensive care must not be unnecessarily burdened. The assumption is that actors in other parts of the healthcare system are competent enough to make adequate assessments based on these principles. This appears to be an ethically risky strategy considering the consequences it may have for patients in need of care.

It is well-known that intensive care is inherently risky, may not benefit all patients, and can cause severe harm (cf. Lee, Kang, and Jeong 2020). In line with this, the National Board of Health and Welfare emphasizes in the COVID-Prio PD that so-called biological age and its impact on patient benefit in terms of continued survival will be central to the implementation. Assessment of biological age, the PD states, requires the identification and balancing of various factors, to which "established estimation scales" can contribute (PD1, 6). Regarding such established estimation scales, the Region Stockholm PD *Governing Regulations for Patient Flows between Care Providers in the Stockholm Regional and Municipal Care System during the Ongoing Spread of COVID-19* states that "individual medical assessments must precede decisions at higher care levels." On the other hand, it also recommends the use of the Clinical Frailty Scale (CFS) for guidance in medical decisions (PD 6). The CFS is a recognized and often-used "judgment-based tool to screen for frailty and to broadly stratify degrees of fitness and frailty" and to "summarize information from a clinical encounter with an older person, in a context in which it is useful to screen for and roughly quantify an individual's overall health status" (Dalhousie University 2024). According to a group of Swedish physicians, use of this scale could contribute to avoiding "casually assigning people of high chronological age a low priority" in receiving treatment (Ekerstad et al. 2022). The CFS is very likely to be among the unnamed "established estimation scales" referred to in the COVID-Prio PD. Despite encouraging the use of estimation scales designed to summarize information from a clinical encounter to assess individual health status, a consistent message in the analyzed PDs is—as shown above—that care for elderly patients, regardless of the results of scale-based judgments, should be provided onsite; that is, outside of hospitals and their more advanced treatment options (PD6).

In another PD published by the National Board of Health and Welfare, titled *Working Methods in Municipal Healthcare during COVID-19* (PD5), both the CFS and the PDs of national principles for priority setting (PD1; PD2) are referenced. This PD sets out to guide consulting physicians and registered

nurses working in long-term care *in assessing patients' ability to cope with treatment* (PD5). It is important to discern that this is not the same as assessing a patient's individual medical needs. Here, long-term care providers are encouraged to use the CFS to assess a patient's ability to cope with treatment and to discuss the treatment process in the event of a possible COVID-19 infection, "based on the prognosis [of the patient] and the national principles for prioritizing routine healthcare during the COVID-19 pandemic and the national principles for prioritizations in intensive care under extraordinary conditions" (PD5, 2).

Yet another issue of ethical concern related to the implementation was that, even though individual medical assessments were advocated in several of the analyzed PDs aimed at aiding and directing the crisis response within long-term care facilities, it was repeatedly emphasized that these assessments should preferably take place remotely (see e.g., PD5, 4). None of these PDs highlighted any possible risks connected with stricter principles for priority setting, the use of the CFS in this context, or the recommendation that assessments take place remotely—that is, by physicians not actually on location.

Finally, it is worth noting that, through inspections of long-term care facilities, the Health and Care Inspectorate concluded that staff members in these facilities often lack training to assess patients and that "many vital assessments of patients are made by those with the lowest level of education" (IVO 2023, 7). During the early stages of the pandemic, the Inspectorate noted that it had encountered the use of local guidelines for generalized assessments of care needs (as opposed to individual assessments by physicians); generalized recommendations for levels of treatment; and generalized treatment restrictions for residents in end-of-life care facilities for the elderly (the so-called specialized care homes or 'SÄBO') (IVO 2020), clearly demonstrating that deviations from the national ethics platform took place during the pandemic within the long-term care system.

Three bodies of ethical problems have been identified and described above. These problems correspond to previously observed shortcomings in the use of expertise in public policy processes, such as a limited interest in contextual issues and an overly narrow set of expertise, leading to a limited or incorrect understanding of conditions on the ground. This may have led to an exaggerated belief in the usefulness of the COVID-Prio PD, for example, in terms of its ability to guide implementation of fair priorities and reduce ethical stress among healthcare staff. These results provide additional support for Wolff's (2018) model of engaged political theory, which warns of the gaps between theory and practice in applied political philosophy and the risks of connecting philosophical reasoning with public policy without properly accounting for context. In the following section, particularly important results will be discussed further.

## 5 | Discussion

Our analysis raises several questions connected with ethics: Was the policy problem well-founded? Why did this issue come to

public attention at that time? What purposes and interests did the current policy serve? Who wins and who loses? Could a different composition of expertise have reduced the risks of negative consequences?

### 5.1 | A Well-Founded Concern?

Considering the context of long-term organizational deficiencies in Swedish healthcare, such as a lack of hospital beds and a persistent lack of other key resources, the new and stricter principles for priority setting that were quickly introduced in the early stages of the pandemic can be understood as a response to a well-founded concern that the actual resources in the healthcare system would be insufficient to meet the mounting medical needs related to COVID-19. Hence, the stricter principles (PD1) seem to be motivated by an approaching situation of debilitating shortages. However, the fact that the long-term structural problems in the Swedish healthcare system had not been rectified before the emergence of the pandemic implies that the risks and vulnerabilities were not sufficiently assessed and/or confronted by regions and municipalities, despite previous policy setting and directives on crisis preparedness since the last pandemic in 2009 (the swine flu). Moreover, if the already established platform for medical priority setting did not work satisfactorily despite being widely applied, what suggested that these new principles would better serve the purpose? Thus, instead of taking necessary and sufficient measures in time at higher organizational levels, the authorities—assisted by the eleven male academic experts—put increased pressure on already overloaded healthcare staff when the severity of COVID-19 became evident. The long-standing, unsolved problems merged with the new and urgent problems that materialized in connection with the pandemic. This is the social, organizational, political, and—to some extent—historical context in which the new and stricter principles for medical priority setting in intensive care were produced and implemented.

### 5.2 | Possible Risks and Consequences

The potential risks and consequences of implementing the national principles were not adequately addressed in the policy documents (PDs). For example, the prevailing work conditions could have significantly influenced individual medical assessments under the new, stricter guidelines. Remote medical assessments, particularly in chaotic situations where physicians must rely on potentially overburdened nurses and care workers in long-term care facilities, pose significant risks. In the National Board of Health and Welfare's PD "*Working Methods in Municipal Healthcare in Case of COVID-19*" (PD5), references were made to the Clinical Frailty Scale (CFS) and the PDs with stricter prioritization principles. This likely signaled to municipalities and long-term care facilities to avoid hospitalizing the elderly and to limit their access to advanced treatment options. Although PD5 referenced the statutory prioritization platform, it failed to define its ethical principles or clarify which values should take precedence in prioritizing care and directing care flows during the pandemic. These ambiguities in policy recommendations could lead to unethical actions in local care provision, an outcome surely unintended by the physicians and philosophers involved in

the policy-making. Presumably, this problem could have been avoided by a different approach with a different composition of the expert group, by including, for example, nurses with experience of long-term care and social scientists with an empirically grounded understanding of the organizational challenges in the Swedish healthcare system.

This lack of an empirically grounded understanding and appreciation of the specific challenges in long-term care is not unique to the Swedish case. One of the leading experts on care for the elderly, Professor Marta Szebehely (2020, 7), wrote an expert brief in which she noted that, early on in the pandemic, the European Centre for Disease Prevention and Control—which tracked recommendations and restrictions implemented throughout Europe—identified no measures issued for long-term care residents. In fact, Szebehely noted, most governments seemed surprised by how negatively affected long-term care facility residents were by the pandemic, but this should not have come as a surprise, she argued, given how underfunded elderly care is. She quoted the Organization for Economic Co-operation and Development (OECD): “The pandemic is highlighting [long-term care systems’] structural problems in terms of insufficient staffing, poor job quality, and insufficient skills, all of which have a toll on quality of care and safety.” (OECD 2020, quoted in Szebehely, Strandell, and Stranz 2020, 9). None of these insufficiencies were addressed in the PDs, nor were their potential effects on the implementation of new and stricter medical priorities dealt with.

Regarding the stated importance of PD1 to healthcare professionals, it is reasonable to presume that frontline workers may have experienced relief when they received the authority’s support to implement stricter and simplified priorities. On the other hand, it is also reasonable to think that healthcare professionals may have experienced increased ethical stress because so many people were affected by the virus and dependent on medical assistance. Many healthcare professionals in Sweden were emotionally and physically exhausted and felt let down by the principals even before the pandemic (Selberg, Sandberg, and Mulinari 2022). That the PDs required them to apply stricter principles not readily compatible with the core of the statutory priority platform could have increased their dissatisfaction. This risk is also neglected in the PD, as is the risk of further undermining the professions’ trust in the authorities.

### 5.3 | What Purpose Did the Policy Serve? Who Won and Who Risked Losing?

Sweden’s regional authorities are legally responsible for meeting their citizens’ need for care; because of this, they have independent taxation powers (Blomqvist and Winblad 2021). It is thus in the regions’ interest that the care system is adequately resourced so they can justify their decisions regarding resource allocation. It is technically possible that the COVID-19 Prio PD containing the stricter principles could have been used by the regions to argue that resources were adequate during the pandemic, rather than having confronted in advance an imbalance between care needs and available resources. Simply put, if fewer people are deemed a priority in need of high-level medical interventions,

existing hospital beds may be regarded as sufficient even within the context of a pandemic. That would mean that the interests of a regional authority outweighed those of its citizens or a certain group of patients. However, the purpose of the Swedish platform for medical priority setting is not to compensate for inadequately resourced healthcare systems; it is to distribute resources based on need and to provide care in accordance with ethical standards. What our analysis indicates, though, is that there is a risk that the COVID-19 Prio policy that was implemented with the support of other PDs—such as the instructions to municipal healthcare on care flows and recommendations on medical assessments of the elderly’s need for care—primarily served the interest of making the available resources appear to be sufficient by effectively reducing the number of patients in need of intensive care. There is nothing in the PDs that would prevent care providers from using them to preclude a shortage of hospital beds, which is not necessarily the same as having enough intensive care beds in relation to the actual need for intensive care. After all, the current policy development may have contributed to the group identified as the most vulnerable and hardest hit by COVID-19 in Sweden being discriminated against in the pandemic response.

It is important to note that not everyone who became severely ill from COVID-19 should have received intensive care; as is the case in non-pandemic situations, some patients are justifiably not considered viable for this type of taxing care. Studies have confirmed a poor prognosis of intensive care for critically ill COVID-19 patients in the age group > 80 years (Dres et al. 2021). However, it is our contention that all elderly patients—in congruence with the Swedish healthcare act—should have received an individual medical assessment and care based on need, something that the content and implementation of the current PD appears to make more difficult.

### 5.4 | Philosopher-Assisted Policy Development in Complex Healthcare Settings

Philosophers have come to play an important role as experts in contemporary policy making. According to Holst (2024, 48), they are especially relied upon to assist in policy development as ‘ethics experts’ within biomedicine and the life sciences. There are a number of concerns with expert advice in policy production, particularly related to issues regarding selection processes, legitimacy, institutional capture, and bias. Experts, Holst (2024, 53) argues, tend to “identify with their profession and are prone to frame problems so that they fall within their disciplinary matrices or epistemic cultures”; furthermore, experts “may lack ‘political literacy,’ that is, an understanding of political processes and good political judgment” (Holst 2024, 53). This may result in recommendations that lack feasibility. On the other hand, Holst (2024, 53) notes it may also lead experts to “exaggerate how a state of affairs may constrain the space for political action,” in what Habermas (2015) and others have called ‘technocracy.’

The single case study presented in this article suggests a broader concern with relying on philosophers to complement physicians in ethically sensitive policy production involving medical decisions and healthcare organization: the risk of

misunderstanding, understanding only partially, or discounting altogether the context-specific challenges of implementing new criteria for healthcare provision during a massive crisis. If an expert group consists of two professions—one of which is at the top of the medical hierarchy, normally operating with a greater distance to patients and everyday gatekeeping and priority setting than, for example, nurses (cf. Halvorsen, Førde, and Nortvedt 2008; Tønnessen et al. 2020), and the other is typically distanced from empirical studies on and familiarity with the organizational conditions of providing care in, for example, underfunded long-term care facilities—then it is quite likely that this expert group will frame and conceptualize ethical problems and implementation issues too narrowly. If not lacking in ‘political literacy,’ they may lack ‘organizational literacy,’ which risks blinding them at least partially to the potential risks and consequences of their contributions. As Holst (2024, 57) put it, “philosophers’ inclination to focus on concepts and argumentative relations before empirical detail, along with their sometimes limited historical and contextual knowledge of policy issues, may compromise forecasting and approximations of long-term developments.” Furthermore, having an all-male expert group consisting solely of physicians and philosophers could risk reproducing gendered hierarchies, as the everyday deliberations and practical problems on the female-dominated ‘shop floor’ are disregarded and made to disappear in sterilized decision-making processes that focus on concepts and experiences based in and relevant for those in the higher echelons of the healthcare system.

## 6 | Conclusion

The purpose of this article was to contribute empirically to discussions on ethical problems that may emerge and confront academics engaged in public policy making, especially in the context of policy development assisted by academic experts, philosophers in particular. The questions asked were whether any ethical problems emerged in the production and implementation of the COVID-Prio PD and how such problems may be prevented in the future. There are several implications of the findings of this study. Theoretically, the results provide strong support for Wolff’s (2018) model of engaged political philosophy. Our case study suggests there are compelling reasons to adopt this approach to prevent context-related ethical issues in the future. Additionally, our study indicates that the model has significant potential to inform empirical research on the policy process.

There are practical implications too. First, experts contributing to public policy should not always accept the premises of the task at hand or even the ‘tools’ selected to finish it. A greater awareness of epistemic limitations should encourage experts to engage in reflexive conversations regarding the composition of the group tasked with analyzing a problem and producing policy, asking what the epistemic limitations in the group are and how these can be remedied. To give just one example based on this case study, was it reasonable that no nurses were recruited to the expert group tasked with aiding a government body to produce new principles for care provision during the height of a pandemic? What epistemic limitations may have resulted from excluding the category of frontline workers who spend more time bedside than all other professions—and who engage, according

to research, in daily priority-setting processes as gatekeepers within the healthcare system (Suhonen et al. 2018; Tønnessen et al. 2020)? There is a need for a more reflexive and critical approach to expert provision and epistemic culture from both authorities and the experts themselves throughout the process.

Second, academic experts and policy makers must ensure that they have a better understanding of the social and organizational context in which the recipients of their PDs operate. Given that the variety of knowledge and professional experience in the COVID-Prio PD expert group was quite limited, again taking this case study as an example, the expert group itself should perhaps have understood that its members’ comprehension of the problem and of potential issues with implementation was only partial (Wolff 2018). If such an understanding is limited or lacking altogether, there is a risk that PDs may be misunderstood, have unintended or counterproductive effects, or simply be impossible to comply with. There is also a risk of undermining trust in society and its institutions and authorities. As noted by Wolff (2018, 2019), an increased interest in the historical and empirical circumstances that produced the problems at hand will likely promote stronger analyses and policy recommendations. It may also lead authorities and experts to understand when it is better *not* to come up with a new policy.

Finally, those responsible for healthcare—namely, politicians and civil servants at all levels—should prioritize minimizing well-documented structural risks and vulnerabilities and work to ensure that established ethical principles are well-known and legitimate at all decision-making levels. This is, arguably, a more fruitful and dignified way to go than to hastily produce—in the middle of a pandemic that authorities had expected but failed to properly prepare for (Ekengren, Engström, and Rhinard 2021)—new and somewhat unclear principles for providing or denying patients potentially life-saving treatment.

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### Conflicts of Interest

The authors declare no conflicts of interest.

### Endnotes

<sup>1</sup> Personal communication between the first author and one of the members of the expert group.

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