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“Good and equitable health” – a critical analysis of equity discourses in Swedish regional action plans for mental health

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ABSTRACT

The goal of Swedish public health policy is to create conditions that enable good and equitable health and eliminate avoidable health inequities. Although previous research emphasizes the importance of considering inequities in mental health promotion and policy, and although researchers and policy makers emphasize the importance of a system-approach to mental health, there seems to be an ambiguity in how the concept of equity is understood. Therefore, the aim of this study was to critically examine equity and inequity discourses in Swedish regional action plans for mental health. A critical discourse analysis based on Foucault’s discourse theory was used to reveal discursive practices of inequity. Twenty-two regional action plans for mental health were analyzed. The analysis identified three discourse strands: the vague language of equity, the inequitable people, and education as a pathway to equity, all of which are entangled through the individualization of equity. Overall, the equity discourse was interpreted as representing a naturalistic and liberal view on equity. This could be understood as contributing to upholding the system of inequities rather than dismantling it. There is a need for clarification about the considered causes of mental health inequities as well as possible solutions.

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Health equity; policy analysis; mental health policy; critical discourse analysis


Introduction

The overall goal of Sweden’s public health policy is to create conditions in society to enable good and equitable health, and eliminating avoidable health inequities within one generation (The Public Health Agency of Sweden 2024). This goal stems from the United Nation’s Sustainable Development Goals and the work of the national Commission for Equity in Health appointed by the Swedish government in 2015. The assignment for the Commission was to review and suggest actions to reduce health inequities. However, in their reports the Commission states that one challenge was the lack of a common understanding of the concept of health inequities or how they are produced (Lundberg 2018).

A commonly used definition of health equity versus health equality is by Whitehead (1991) who defines inequity, as opposed to inequality, as differences in health that are unnecessary and avoidable as well as unfair and unjust. The concept of inequity has a moral and ethical aspect to it, that is, it does not merely define differences in health and health determinants (Whitehead, 1991). The Swedish language, however, does not differentiate between equity and equality in the way the English language does, instead the word “jämlighet” is generally used for both equity and equality. This paper applies the differentiation of equity and equality according to the Whitehead definition and when the Swedish term “jämlighet” is directly translated “equity/equality” will be used when no official English translation is provided.

The knowledge of inequities in health and health determinants is vast. Mental health is, similarly to health in general, inequitably distributed in Sweden, with queer people, people with disabilities, people

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depending on financial support, unemployed young people, people born outside of Sweden, and single mothers having a larger mental ill-health burden compared to the population at large (The Public Health Agency of Sweden 2019).

Health equity is a common theme in national and international health policy, even though it is often found to be ambiguous in meaning (Amri et al. 2021; Tweed et al. 2022). Previous studies with young people highlight the importance of considering inequities in youth mental health promotion (Gard et al. 2024; 2025). One way to focus on the underlying structural causes of mental ill-health, instead of individual factors, can be to include social determinants of mental disorders in policy recommendations for mental health promotion and disease prevention (Lund et al. 2018). Lund et al. (2018) also argue the importance of considering social, cultural, and environmental factors related to socioeconomic status, gender, ethnicity, age, and disabilities, when aiming to reduce mental ill-health on population level, for instance, by striving to reduce income inequalities.

The Swedish government's Ministry of Social Affairs and the Swedish Association of Local Authorities and Regions (SKR) have since 2012 had an agreement regarding actions for mental health promotion and suicide prevention. The agreement states that mental health in the population varies by age, gender, gender identity, birth country, education, income, sexual orientation, and disabilities. It also emphasizes the problem of inequities and raises the need to work with living conditions on individual and population level as part of mental health promotion and disease prevention efforts (Government Offices of Sweden 2023). As a part of the agreement, the local and regional authorities produce regional action plans on county level, containing goals and actions for local and regional mental health promotion and suicide prevention (The Swedish Association of Local Authorities and Regions 2024). The local authorities, that is, the municipalities, are responsible for, among other things, schools, social services, and child care, whilst the regional authorities are responsible for health care, public transport, and regional development in each of the 21 counties in Sweden (Government Offices of Sweden 2004).

The regional action plans for mental health have previously been criticized for focusing on actions on an individual level and ignoring the structural determinants of mental ill-health (Fjellfeldt 2023). Fjellfeldt (2023) further identifies that this differs from the national policies, which describe both individual and societal actions, such as reducing inequities in living conditions, whilst the regional action plans suggest support on an individual level, often for individuals at risk of or with existing mental health problems.

Considering the problem of mental health inequities, and the suggested system-approaches by researchers, such as Fjellfeldt (2023), Lund et al. (2018), and Tweed et al. (2022), as well as national policy to reduce inequities, there is a need to explore how the concept of equity is understood and practiced in the regional action plans for mental health. The aim of this study was to critically examine equity and inequity discourses in Swedish regional action plans for mental health.

Methods

This study is conducted as a critical discourse analysis (CDA) of Swedish regional action plans for mental health. CDA considers language as a social practice and is interested in the relationship between language and power, between discourse and practice. A CDA approach based on Foucault's discourse theory specifically concerns knowledge valid at a certain time and space (Wodak and Meyer 2001). The CDA in the present study was inspired by the approach described by Jäger (2001), both as it centers discourse as a social practice, with discourse determining individual and collective actions, and thus exercising power, and as Jäger (2001) provides practical analytical tools. The function of discourse in a "bourgeois-capitalist modern industrial society" is to legitimize and ensure government (Jäger, 2001, p. 34) and CDA can be useful to reveal discursive practices of inequity (Wodak and Meyer 2001). The action plans constitute power in practice in several ways, as they exercise power in themselves as documents of local and regional governments. Studying equity informed by critical theory involves considering inequities as created and upheld by institutions of power (see Wodak and Meyer 2001).

Table 1. Example of the analytic steps.

Text	Code	Discourse strand	Subtheme
"All children should have access to equal/equitable conditions for good health and early support." Gotland	Access to equity for health	The vague language of equity	Equity as buzz words
"Have clients been able to reduce their support from in-home support services?" Blekinge	Reduced support from society seen as positive	The inequitable people	The burden
"Provide knowledge to actively prevent all forms of discrimination and offer good and equitable care to everyone despite gender identity, gender expression, and/or sexual orientation." Halland	Increase knowledge about LGBTQI+	The education path to equity	Educate about the target group

Data collection and materials

In order to find the regional action plans for all of the 21 counties, the search terms "regional action plan" (regional handlingsplan), "mental health" (psykisk hälsa) and "suicide prevention" (suicidprevention) were used on the websites of the regions and the official website for the agreement (The Swedish Association of Local Authorities and Regions 2024), aiming to find the most recent plan published at the day of the search. A total of 22 regional action plans were included in the analysis. One of the 21 counties, Västmanland, had separate action plans for adults and for young people, making the total number of action plans 22. No action plans were excluded from the analysis. The documents were between eight and 49 pages long. Some of the action plans contained a background analysis and a description of the issues regarding mental health and ill-health, and some merely contained tables with goals, actions, and planned evaluations. All of the action plans were retrieved on January 9, 2024.

There were no human participants in the study and ethical approval was not needed for the study according to the Swedish Act (2003:460) concerning the ethical review of research involving humans.

Data analysis

A critical discourse analysis was performed, guided by the approach described by Jäger (2001). The fragments in the analysis (Jäger, 2001) consisted of the 22 action plans. These were read through several times in order to get acquainted with the material. Sections containing text about either a certain group of people, such as migrants, children, or people of low socioeconomic status, or containing concepts that the action plans seemed to relate to equity, such as health equity, equal terms, or sustainable development, were identified in the first round of coding. This coding procedure was used for the first 11 action plans, in the remaining action plans the codes developed with the first 11 actions plans were used. The coding was useful to identify and break down the discourse to smaller parts which was used to construct the discourse strands. It was conducted by the first author and was reviewed, discussed and adapted together with the co-authors. Codes were adjusted, merged, and split throughout the process and the process also included going back and reading the documents to ensure that our interpretation was well founded. The codes were examined to identify patterns in the data, representing the dominant discourses; see examples in Table 1. The critical examination of the discourse was conducted by aiming to reveal assumed truths, and by studying contradictions, what was being said, and what was not being said (Jäger, 2001). Through this process, three discourse strands, with subthemes and an entanglement of discourse strands, were identified.

Results

Three discourse strands with sub-themes were identified in the analysis. The discourse strands were entangled through the notion of equity being individualized. The analysis will be presented in the results section and discussed further in the discussion section.

The vague language of equity

The Swedish public health goal of “good and equitable health” has found its way into the action plans in overall goal formulations or rationales for suggested actions. The phrase seems to be used in a way that portrays equitable as being synonymous with good; neither “good” nor “equitable” is further explained or conceptualized, but are present as general, positive terms.

Groups of people are represented in the equity discourse in both negative and positive terms. When groups of people are represented more positively it is mainly through the concepts of participation or involvement. Even though the action plans do not provide a clear definition of either equity or participation, the definitions can be understood through the discourse. This is exemplified through the two subthemes described below.

Equity as buzzwords

The representation of equity in the discourse is vague, and when the concept of equity is considered in the action plans it takes on different meanings, including equity or equality, but also what could be understood as buzzwords such as social sustainability, gender equality, closing the gap in a generation, norm criticism, social determinants of health, inclusion, and participation. This is exemplified below, where it is stated that different perspectives were taken into account.

“When prioritizing initiatives, a gender, gender equality and equality/equity perspective were considered.”

Kronoberg

Without a description of how these perspectives were considered in the planning of actions, it is as though it should be self-evident to the reader what an “equity perspective” would entail in practice. Moreover, statements that can be seen as self-evident further contribute towards the equity discourse being read as superficial. This includes stating that everyone should have equal access to health care, without clarifying that this being the basic legal requirement in the healthcare system, and without stating actions to be taken towards equal access in practice. However, an understanding of equity that is a bit more clear, seems to be geographical equity, for instance, stating that all young people in the county should be able to access a youth clinic or using the term “reducing inequity” as referring to differences between urban and rural areas of the county.

Participation or involvement

Participation can be understood as an important action for mental health equity, although the understandings, including related concepts such as influence or involvement, are kept vague. Patients or service users in addiction and psychiatric care, referred to as “users”, as well as people with disabilities, are stated as important to involve in the planning and evaluation of actions, in order to make use of their knowledge and experiences on an organizational level. The participation of users is mostly discussed in relation to difficulties in reaching and engaging said users. Even if user participation is generally described as positive, this quote suggests some hesitation to “let users in” to participate at a higher decision-making level.

“However, there is a lack of a systematic approach to the whole process, and user involvement should be conducted in an equal/equitable manner throughout the entire county. Therefore, it becomes difficult to let user representatives in at higher levels, as a small group cannot speak for everyone.”

Uppsala

It is unclear how the policy understands representation of users, if a small group cannot speak for others. Further, the policy also seems to assume that those working at the higher levels of the organizations could not have experiences of being ‘users’ of the organization’s services themselves.

Children are also to be included, using the Convention on the Rights of the Child as an argument. More often than where the participation of adults is concerned, the importance of child participation mostly refers to children being included in their own care. The practical work of involving children to participate with their knowledge and experiences on a more organizational level, is kept vague.

“An important prerequisite for success is to involve children and young people - both in individual meetings and in the development of activities that offer promotional, preventive, and treatment interventions. Participation is also a crucial part of the development of ‘close care’ and contributes to better outcomes of the interventions offered. Therefore, there is a need for a special focus on strengthening the participation and influence of children and young people.”

Stockholm

Participation can be read, also in this example, as a way to work towards the vague idea of equity. However, groups in the population other than children and users, referring to users of psychiatric and social services, are not mentioned in relation to participation, even though many different groups are named and their mental health problematized. This ties into the discourse strand “the inequitable people”.

The inequitable people

Equity and inequities in relation to different groups of people in the population are mainly presented on an individual basis, rather than through identifying inequitable systems. Certain groups of people are the bearers of mental health inequities and described as exposed, vulnerable or, as in the case with children, in need of protection, or sometimes, as a burden. The discourse of inequities and vulnerabilities can be interpreted as referring to something that lies within an individual, rather than something an individual is subjected to. This is exemplified through the three subthemes presented below.

The exposed

Inequities in mental health are mainly expressed by listing at-risk groups, either by providing statistics or by emphasizing particular vulnerabilities for different groups. Groups described as especially vulnerable to mental ill-health are: individuals with a short education, individuals dependent on social benefits, LGBTQ individuals, children, young people, old people, single mothers, indigenous Sami individuals, individuals living in rural areas, individuals born in a country outside of Sweden, individuals with disabilities, children within the social service system, unaccompanied minors, individuals who are unemployed, individuals with addiction, children who do not perform well in school, girls, boys, women, and men. It is not always clear if the intent is to identify groups exposed to mental ill-health, or more exposed in general, without specifying exposed to, or from, what. Despite acknowledging inequities between different groups, the exposure is often attributed to individual factors rather than societal, that exposure is a state certain groups are in, rather than those groups are being exposed by external factors.

People’s health is affected by many different factors. Individual factors can be, for example, gender, age, heredity, and possible disabilities.

Stockholm

By identifying gender, age, heredity, disabilities as individual traits, the responsibility of society, which the public organizations are acting within, is reduced to equal treatment of these individuals, as opposed to, for instance, examining sexism, ageism, or ableism in their organizations.

Even though the listed groups in fact seem to include everyone in society, some of these groups are further problematized by being described as “hard to reach” and it is stated that more work is needed to reach the “hard to reach” groups. The groups are in some instances not identified further, as it should be obvious to the reader who is “hard to reach”. However, there are some attempts to shift the responsibility from the groups to the organization, both in acknowledging that some groups do not have equal

access to health care and social services, and also implying that the organization needs to find ways to reach certain groups.

Build competences around the Sami people's mental health and ways to reach the Sami population.

Jämtland

At the same time, the Sami population is here singled out as not being part of the public organizations, as being a group that needs to be reached somewhere else, outside the usual reach of the organization. The mental health of the Sami people is in the example also individualized, in that there is a need to build competences around Sami health, not around determinants of Sami health.

The protected

Children are a group of people that is clearly present in the actions plans. In general, children are also understood as exposed but, as opposed to other identified exposed groups, they are also in need of protection, this is especially true for children with "difficulties" or "at risk". One way of protecting children is by better coordination between public organizations.

An important point of departure for collaboration is to together define which children today risk not being identified or getting support and help in time, and to define missions and responsibilities in relation to these children. This can concern young children with autism who do not receive adequate support in their everyday life, or children with self-harming behavior. It can also concern children who grow up in vulnerable areas, children in families who have fled to Sweden and children growing up with addiction, mental ill-health, and violence in the family.

Stockholm

When presenting the children at-risk in this example, many different risks are grouped together. For instance, children growing up in "vulnerable neighborhoods" or children who have refugee parents are grouped with children exposed to abusive parents. This highlights the vulnerability of the child, not the actions or processes of the adult world that are harmful to the child.

The burden

The discourse of different groups as a burden is especially clear when the action plans focus on older people. A common analysis provided is the change in age demographics with fewer people of working age having to provide for more older people.

This burden that old people constitute is discussed in relation both to health care and to society in general. Another example of a group being presented as a burden are people with disabilities, in that the action plans describe goals aiming at reducing the need that people with disabilities have of social support, rather than goals related to the mental health of people with disabilities. The burden is in some instances quantified, by exemplifying costs associated with sick leave due to mental illness. Thus, people with disabilities, recipients of support from social services, and those "far away from the job market" are generally presented as a burden, the analysis suggests.

"Being out of work contributes to inequalities/inequities in health and long-term unemployment is a risk factor for mental ill-health."

Örebro

In stating that not having a job contributes to inequities in health, the responsibility of health inequities is placed on the individual, in this case an unemployed person who is already marginalized in society. However, there are some exceptions to the responsibility being placed on individuals, when the organization's own responsibility to be an "inclusive" employer is highlighted. However, it is still unclear how "inclusive" is to be understood or who is included in the inclusion, but the example nevertheless stands out in the discourse by placing responsibility on the organization. The example above suggests that education is a path to inclusion, which ties into the discourse strand "the education path to equity".

The education path to equity

The analysis suggests that the discourse around actions for mental health equity mainly relies on increasing knowledge. When describing an action targeting those at risk of mental ill-health, the action plans often refer to those people as “target groups”. It is suggested that increased knowledge can be gained by either educating the target groups themselves or by educating health and social service practitioners about the target groups. This is exemplified through the two subthemes presented below.

Educate the target group

Target groups in need of education about mental health are mainly young people and people with foreign backgrounds. The discourse entails an understanding that increased knowledge about health on an individual level will lead to better health for the individual.

“Exposed groups: What should be accomplished? Foreign-born, residents at high risk of future illness and children and young people with mental ill-health have the tools and the knowledge to improve their health.”

Jönköping

In this example, the goal is for the groups in question to be able to improve their own health, suggesting that these groups cannot handle their own health today. Young people are especially highlighted as a group where mental health promoting resources are spent. This seems to mainly take the form of “empowerment,” by educating young people about mental health or “life skills” through school programs or information to young people about where they can turn if “feeling bad.” Another “target group” for education and information are foreign-born people who are portrayed as being in need of an increased understanding of mental health and the healthcare system.

Educate about the target group

The purpose of educating practitioners about the target group often seems to be to improve treatment of the patients or clients of a specific target group. The education about target groups is not just focusing on those at-risk of mental ill-health within a certain group, but also education generally about different social, cultural, or ethnical communities, such as LGBTQ-people or the Sami population. Even though it is practitioners being educated, the problem is still put on the individual by highlighting their vulnerability and in need of special treatment.

This target group [people with neuropsychiatric disability, addiction, or severe social problems] are, more than others, dependent on an approach characterized by respectful treatment, continuity and flexibility in order to, through collaboration, be able to give these individuals good preconditions to an equal/equitable health and quality of life.

Gotland

It is not clear why this group of people would need more respectful treatment than others. Part of the discourse around education concerns educating practitioners is to improve their “cultural competence”, specifically regarding the Sami culture but also regarding the culture of foreign-born individuals. It does not seem to be considered that the practitioners themselves could also belong to the “target group”. Moreover, besides placing the problem on the individual patient or client, the solution of the problem is placed on individual care workers.

Individualizing equity

The discourse strands described above are entangled through an individualization of the problem of inequities. Those who are at risk of mental ill-health have, with the help of support or education from the public sector, an individual responsibility to act and be different, for instance, by getting employment if they are unemployed. Individuals are also said to need knowledge, both minority individuals at

risk of mental ill-health, and individual practitioners working in caring professions within the public sector. When highlighting the importance of participation and inclusion, this is mainly seen as benefitting the individual by making the individual feel included, rather than the organization benefitting from the knowledge of marginalized groups. Even the concept of equity itself is mainly understood in individual terms.

“...offer a good and equal/equitable care to everyone regardless of gender identity, gender expression, and/or sexual orientation.”

Halland

Good and equal/equitable care is in this example presented as an offer to everybody. Equity in health is then seen as something that is given to an individual patient, rather than health equity being a desired state in health care or in society. Throughout the discourse, equity is vaguely understood as being done through participation, while inequities are portrayed as stemming from individual vulnerabilities within those exposed and the responsibility of tackling mental health inequities is placed on individuals through increasing their knowledge.

Discussion

Result discussion

The aim of the study was to critically examine equity discourses in regional action plans for mental health. There is a vagueness and a lack of concrete definitions around the concept of equity. The discourse contains notions of an individualized equity, without much discussion of system-factors of inequities. Rather, inequities seem to be understood as lying within minority individuals, as different groups of people are understood as vulnerable and illiterate in relation to mental health.

In the action plans the discourse of equity-related terminology is largely represented by the use of, what can be described as, buzzwords, such as social sustainability. There is a lack of explanations or discussions of the concept of equity, which is perhaps to be interpreted as a limited understanding, but also as an assumed consensus around the use of the concept. Other scholars have also found how equity is often used as a self-evident concept in research and often without developing the further theoretical underpinnings (Papastephanou 2018, p. 209). The discourse of inequities is less vague, however, and instead there is an understanding in the discourse that inequities lie within the individual, and thus the responsibility for health equity also lies within the individual, specifically individuals of marginalized groups. This aligns with the analysis of similar action plans by Fjellfeldt (2023), who saw that despite knowledge of structural determinants of mental ill-health, the responsibility for mental health was placed on the individual.

The individuals, as part of different “target groups” for various actions, are constructed through a process of othering and even though the listed groups of people at risk of mental ill-health could be seen as covering virtually everyone, some groups, such as migrants, LGBTQ people, and Sami people, are furthered othered in the discourse. The process of othering is conducted by the creation of the Other in relation to the neutral Self (see Spivak 2015). The othering was especially clear when “hard to reach” groups are identified, as it is not taken into account that individuals of these “hard to reach” groups are also working in health care, social services, or other parts of the organizations. This othering and categorization of identities can be argued to reproduce the system of inequities, rather than contribute towards dismantling it (Papastephanou 2018).

Through our analysis, it is difficult to interpret the equity discourse as something more than a rather empty idea without a deeper, substantive content, as a washing of the concept of equity. The focus on individuals and marginalized groups rather than system in relation to mental health inequities in the discourse, contributes towards a naturalist understanding of inequities. These naturalistic understandings of inequities and exposure aligns with a liberal world view (see Brown 2015; Papastephanou 2018). If inequities are seen as natural and unavoidable, then society can merely hope to alleviate some of the consequences of inequities by vague attempts at education and “equitable treatment”. A naturalistic and liberal

view of equity and inequities seem to correspond to an overall equity discourse within public health. Amri et al. (2021) conducted a discourse analysis on leading documents from the World Health Organization and found a similar liberal equity discourse. The equity discourse also aligns with the commonly used Rawls' theory of justice, which allows for an unequal distribution of resources to improve the situation for the most vulnerable (Rawls 1971). The actions targeted at certain groups in the action plans could be argued to be a form of compensatory measures in order to reduce inequities, rather than approaches to change the system causing inequities. Public health policy and research need to address public health needs on a system-level, not just an individual level (Rutter et al. 2017), especially when addressing health inequities (Rod et al. 2023). Patterns of vulnerabilities and inequities need to be identified, while at the same time considering the risk of stigmatization and othering. One possible approach could be connecting vulnerability to the system rather than to the social group or individual (Rod et al. 2023).

Methodological considerations

There are several limitations in writing up a discourse analysis in a different language than the language analyzed (Kučera and Mehl 2022). A specific challenge for this study relates to the terminology and to the Swedish language not differentiating between equity and equality. In some sections it was clear that the term referred to equal distribution, such as the geographical distribution of health care, or to justice, such as the treatment of LGBTQ individuals. But often it was unclear, as the concept of "jämlighet" was not defined further.

Another challenge was identifying and collecting the data. Some of the websites of the regions were difficult to navigate and search, and there is a risk that more recent action plans have been published that were not found through the searches. Also, even though the action plans were written within the same agreement and by similar organizations they differed in structure and length. Some contained background information and a regional analysis of mental health, whilst others merely listed goals, actions, and planned follow-up. Jäger (2001) emphasizes the importance of processing every discourse fragment in the same way, which was sometimes challenging when the texts to a large degree differed from each other. However, through the analysis, even though the content of the texts differed, it became clear that the discourse on equity was similar between the action plans.

The analysis was mainly conducted by the first author. However, all of the co-authors read the action plans and continuously discussed the interpretation and the analysis, this contributed towards reaching completeness. A CDA can be considered complete when no new content is revealed. The analysis in this study is based on the interpretations of the authors and we are also part of the discourse being analyzed (see Jäger, 2001). We have attempted to share our analytical process with transparency, by describing the theoretical underpinnings of the concept of equity, showing examples of the steps in the analysis (see Table 1) and including quotes from the action plans to illustrate and provide examples of the discourse strands and sub-themes.

Conclusion

Our analysis suggests that the equity discourse in the Swedish regional action plans for mental health is vague and built up using different buzz words. The use of buzz word without further explanation or conceptualization creates a rather empty equity discourse. A washing of the concept of equity. The issue of mental health inequities is individualized, individuals of minority and marginalized groups being presented as responsible for their own mental ill-health. The solution for reaching mental health equity is also individualized, by educating individuals of identified target groups or by educating practitioners about these targeted groups. The focus on target groups, rather than root causes or processes of marginalization, risks consolidating a categorization of people, rather than challenging the system of inequities. Vague equity discourses, equity washing, cannot result in concrete actions towards mental health equity. Clarification is necessary both in relation to causes and suggested solutions for mental health equity. In order for practitioners in the organizations to make use of the action plans and make actual changes towards mental health equity there is a need to be clear in how equity is understood and how this understanding is politically underpinned.

Authors' contribution

Gard: Conceptualization, data curation, formal analysis, methodology, writing original draft.

Isma: Conceptualization, methodology, supervision, writing reviewing & editing

Mangrio: Conceptualization, methodology, supervision, writing reviewing & editing

Enskär: Conceptualization, methodology, supervision, writing reviewing & editing

Ingvarsdotter: Conceptualization, methodology, supervision, writing reviewing & editing

Ethical approval

There were no human participants in the study and ethical approval was not needed for the study according to the Swedish Ethical Review Authority and the Swedish Act (2003:460) concerning the ethical review of research involving humans.

Disclosure statement

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Data availability statement

The analyzed documents are freely available online and can also be accessed by contacting the correspondent author.

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