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Covid (In)equalities: labor market protection, health, and residential care in Germany, Sweden, and the UK

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Abstract

How have differently institutionalized welfare regimes dealt with the Covid-19 crisis? In particular, how have they confronted the social and economic inequalities exposed by the virus? Taking three European countries—Germany, Sweden, and the UK, corresponding broadly to conservative-continental, social democratic, and liberal regime types—this paper tracks the virus response in the areas of income and employment protection and health and residential care. With attention paid to issues of “capacity” and the institutional arrangements in each case, we find that institutional histories in Germany and Sweden permitted a certain recidivistic reliance on established practices in the areas of employment and social protection. In sum, certain social and economic inequalities were mitigated as these countries set aside recent trends toward “liberalization” and mobilized longer-standing institutional capacities to protect some groups, although by no means all. Evidence of this trend is less clear in the health and residential care sectors, where Germany had existing capacity, allowing its older population to weather the crisis in better order than its counterparts in Sweden and the UK. In the UK, welfare liberalization has led to increased social and economic inequalities and funding reductions in health and residential care—all of which have reduced the country’s ability to deal with severe crisis. The Covid response in this case was agile, but also chaotic, with little being done to ameliorate the positions of the most vulnerable groups.

Keywords: Covid-19; equality; employment protection; health; social care

The Covid-19 pandemic has presented an unprecedented exogenous shock to nations’ economic, social, and welfare systems. Confronted by a fast-spreading virus, and variants thereof, for which no meaningful treatment was available, European countries effectively had to “lock down” their societies and economies in a manner, and to an extent, not seen in Europe outside wartime. In this situation, governments were faced with two fundamental challenges in their attempts to contain overall infection and mortality rates: the need to protect *lives* and *livelihoods*. Both challenges have important egalitarian implications involving, for example, the nature of funding and support for those most exposed to infection and increased mortality and measures to protect the livelihoods of people hit hardest by reduced economic output and consequent income loss. This article focuses on how three Western European countries—Germany, Sweden, and the UK—responded to the Covid “stress test.” We ask

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whether this exogenous “punctuation” (Baumgartner et al., 2009) has affected the policy sub-systems of employment and social protection and health and residential care, paying specific attention to the fact that Covid appears to have triggered instances of “institutional recidivism”—understood as a reversion to, and renewed reliance upon, previously established institutionalized practices. This tendency can be explained in part by an almost “natural” inclination to return to known and trusted institutional arrangements at a time of crisis. After all, risk has to be managed somehow and a global pandemic is arguably not the best moment to experiment with extensive institutional change. Certainly, from an ideational point of view, reliance upon “old” regime ideas can provide the comfort of the known, while also reducing transaction costs in policy making when *speed* matters. However, we would not expect such policy recidivism to be exhibited consistently across all policy areas—and, as we discuss below, the term is best applied to employment and social protection measures taken in Germany and Sweden. Recidivistic tendencies are less evident in the areas of health and residential care—and also less evident in the UK. Nevertheless, these tendencies are significant because they raise questions about institutional resilience and the strength and persistence of the trend toward welfare state (neo)liberalization in recent decades (see Streeck & Thelen, 2005). The paradox, of course, is that, although the Covid challenge may have led to a return to institutional norms in some instances, disrupting the “forward march of neoliberalism” in the process, this dynamic may resurrect “old” inequalities while simultaneously neglecting the position of emerging minorities and marginal groups.

Methods

Our chosen countries conform closely to the original regime types developed by Esping-Andersen (1990), conservative corporatist, social democratic, and liberal. We use his typology as a theoretical and methodological starting point partly because it takes account of the historical-institutional development of welfare systems and partly because, in so doing, it implicitly raises questions about the resilience of institutional arrangements during periods of significant challenge. In this way, Esping-Andersen’s classification of welfare regimes provides an institutional marker against which Covid policy responses can be examined. In choosing to use Esping-Andersen’s typology, however, we do not assume that his regime types are static entities unable to respond to changing social, political, and economic circumstances. Regimes *do* change, at least incrementally (Streeck & Thelen, 2005), but they do not entirely lose their institutional shape. That said, we need to proceed cautiously for two reasons. First, as mentioned, the *gestalt* of each nation’s welfare institutions has changed, in some cases considerably, since Esping-Andersen was writing a generation ago—and largely in a market-liberal direction (Ellison, 2006). In employment and income protection, this liberalizing trend is particularly relevant for our two nonliberal cases, Germany and Sweden (Fleckenstein & Lee, 2017; Pavolini, 2015; Theobald, 2015; Wollmann, 2016). Second, our chosen areas of analysis do not entirely conform to those utilized in the *Three Worlds of Welfare Capitalism*. Whilst employment and income protection enjoy great prominence in Esping-Andersen’s typology because of his central concern with decommodification, health and social care did not feature centrally in the *Three Worlds*. Still, historically, health and social care in Germany and Sweden, despite some evidence of liberalization, largely complies with the welfare ideologies identified by Esping-Andersen, while in the UK, which has followed an increasingly liberal path since the early 1980s, health care, although remaining free at the point of need, has experienced extensive marketization and privatization, and social care (both domiciliary and residential) has been almost entirely privatized. So, despite “creeping liberalism” in two cases and a significant shift toward the liberal welfare paradigm in the third, these regimes have either continued to display important elements of the institutionalized approaches to welfare and (in)equality that characterized their postwar welfare systems or, as with the UK, have reinforced tendencies that have progressively become part of the “post postwar” welfare landscape. With these considerations in mind, we move on to explore how these regimes have responded “institutionally” to an exogenous event of hitherto unseen scale.

To facilitate our analysis, we make use of primary data drawn from the OECD, the UK Office for National Statistics (ONS), Eurostat, the International Monetary Fund, Statistics Sweden, and other sources to highlight key contextual factors that underpin the discussion. Of particular interest are pre-Covid spending patterns and resourcing in the areas of employment protection and health and social care. These provide a baseline from which it is possible to gauge the extent of the extra resources marshaled to combat the crisis. We also draw on a range of secondary literature, including recently published analyses of Covid responses by key think tanks and governmental bodies in our three countries.

Table 1. Health care in Germany, Sweden, and the UK: spending, beds, and staffing.

	Spending per capita (USD, PPP), 2019 ^a	Hospital beds per 1,000 pop, 2019 ^a	Practicing doctors per 1,000 pop, 2019 ^a	Practicing nurses per 1,000 pop, 2019 ^a	Intensive care beds per 100,000, 2020 ^b
Germany	6,518	8.0	4.4	13.9	33.9
Sweden	5,552	2.1	4.3	10.9	5.8 ^c
UK	4,500	2.5	3.0	8.2	10.5 (England)
OECD	4,087	4.4	3.6	8.8	12.0

^aOECD (2021a).^bOECD (2020a).^cLofgren (2020).

With the virus far from over, it is too early to estimate Covid's final impact, or lack of it, on economic and social equality, so we do not offer an assessment of country responses in this regard. Rather, what follows is a broadly qualitative analysis that considers the extent to which responses were institutionally coherent and generously conceived—and, in so doing, how well they took account of egalitarian issues.

Covid-19 in Germany, Sweden, and the UK: an overview

Some basic metrics provide an indication of our countries' levels of preparedness in terms of fiscal stability and the resourcing of health and social care. Turning first to economic measurements, debt-to-GDP ratios give a general indication of national economic robustness. German and Swedish debt levels, for example, were considerably more favorable than those of the UK between 2015 and 2020 with both countries recording current account surpluses in 2019 (OECD, 2021b). Average wages in Germany and Sweden rose consistently following the downturn of 2007–2008 but not in the UK where wages fell markedly after the financial crisis before climbing to just over 2007 levels by 2019. A combination of benefit reductions and falling wages saw the median incomes of the poorest fifth of the population decline by 4.8% between 2011 and 2020, this general indication of income inequality masking further inequalities associated with gender, disability, ethnicity, and geography (Agrawal & Phillips, 2020; Blundell et al., 2020, p. 293; Tidball et al., 2020).

A general snapshot of the pre-Covid state of health systems in Germany, Sweden, and the UK indicates that Germany is a big spender, with numbers of hospital beds, doctors, nurses, and intensive care beds consistently outstripping UK figures (see Table 1). Of more significance for present purposes are indicators that show the ability to make staff and space available.

To deal with a surge in demand. Both Germany and Sweden have more doctors and nurses per 1,000 of the population than the UK, while Germany has almost four times the number of hospital beds than the other two countries. Occupancy rates also vary, with English rates standing at 88.2% in the first quarter of 2019–2020 (O'Dowd, 2021), while the German rate was closer to 80% (OECD, 2020a, p. 13). ICU capacity differs widely as Table 1 makes clear. Turning to residential care, funding models and levels of public resourcing differ across the three countries with both Germany and Sweden enjoying higher levels of public funding and slightly increasing bed capacity, while the UK experienced real terms funding reductions and declining bed capacity in the lead-up to 2020 (Eurostat, 2020).

Summing up this brief assessment of “crisis-readiness,” it seems clear that Germany was in a strong position to deal with the initial impact of the virus partly because of its robust fiscal standing and partly because its health and social care sectors were comparatively well resourced. Although these initial advantages did not mean that the country escaped unscathed, Germany nevertheless had the capacity to deal with the worst effects of the crisis so far without its welfare, health, and care systems being overwhelmed. In the Swedish health sector, there was pre-Covid “capacity,” despite the numbers of ICU beds being low at the outset—a shortage that was quickly made good. However, as indicated, the residential care system proved a weak spot, and this issue will be returned to in the country section below. The four nations of the UK, with little existing institutional capacity, rapidly had to adopt measures to offset the relatively poor state of the UK's social protection system while simultaneously adopting emergency measures to shore up the resource-starved health sector—largely at the expense of residential care. These measures, developed at speed, successfully mitigated the immediate social

and economic impact of Covid but failed to address the position of disadvantaged groups that were particularly vulnerable to contracting the virus.

Welfare state capacity and the Covid-19 response in Germany

The German economy was hit hard by Covid-19. In the first quarter of 2020, the GDP dropped by 2.3%, and this was followed by a 9.7% fall in the second quarter (DESTATIS, 2021). The summer months allowed some economic recovery, but over the entire year, the economic output declined by 5.5% (OECD, 2020b), which would normally translate into a massive increase in unemployment and hardship. To cope with the economic and social impact of the pandemic, Germany—governed by a so-called Grand Coalition government of Christian and social democrats—heavily relied on established policy tools; and whilst important efforts were made to make policies more inclusive, we can observe the enduring effect of its Bismarckian legacy.

Traditionally, Germany has been considered the epitome of the status-preserving welfare state, with social insurance benefits firmly corresponding with previous earnings (Esping-Andersen, 1990; Olk & Riedmüller, 1994). In recent years, however, this Bismarckian system has undergone changes that have shifted it in a liberal direction. Although significant elements of the Bismarckian model, notably the dualized German labor market, continue to exist, the labor market changes introduced by the Hartz reforms of the early 2000s undoubtedly decreased the protective capacity of German welfare arrangements, with an increasing number of people relying on means-tested, flat-rate unemployment protection, in addition to reduced job security as a result of labor market deregulation (Fleckenstein, 2008; Hassel & Williamson, 2004). So, while a shrinking core of workers continues to enjoy privileged social and job protection, those at the margins of the labor market have, over time, become more vulnerable.

In its crisis response, Germany resorted to the long-established policy of short-time working (*Kurzarbeit*), which allows employers to reduce their employees' working time (including zero hours, so-called *Kurzarbeit Null*), and workers receive the equivalent of unemployment benefits (with a replacement rate of 67% for those with children and 60% for those with no dependant) for the hours they were not working (Schulten & Müller, 2020). Whilst short-time working, as an established instrument, indicates some considerable institutional readiness to protect livelihoods, it was thought insufficient to cope with the Covid-19 crisis. Hence, short-time working arrangements have been enhanced and replacement rates temporarily improved—70%–77% from the fourth month and 80%–87% from the seventh month, with the timespan of support extended from 1 to 2 years. Importantly, administrative changes made access to short-time working easier, particularly for service sector jobs. In the past, short-time working was typically confined to the export-oriented manufacturing sector (Eichhorst & Rinne, 2020). The scheme was also extended to temporary agency workers (Schulten & Müller, 2020, p. 5), which could be considered an important improvement of social protection for labor market outsiders. Short-time working peaked at 7.3 million workers in May 2020 (KPMG, 2020)—for comparison, 1.5 million workers were on short-time working at the height of the 2008 financial crisis (Eichhorst & Rinne, 2020, p. 5).

However, a number of apparent inequities mar this picture. First, many workers in low-wage sectors, of whom many are women, do not benefit from employer-provided enhancements to the short-time working scheme because they are unlikely to be covered by generous collective bargaining agreements (Schulten & Müller, 2020, p. 14). Second, married women in short-time work tend to receive lower levels of support owing to Germany's system of joint taxation. Married women typically pay more tax on "their" earnings, when their spouses earn higher incomes; and for these women, this translates into lower net salaries, which form the basis for calculating short-time working allowances (Hammerschmid et al., 2020). Third, women comprise over 60% of those in so-called marginal employment (*geringfügige Beschäftigung*), and this group of workers is not eligible for the short-time working scheme. Unsurprisingly, then, short-time working is less prevalent in low-income groups and, equally unsurprisingly, unemployment amongst the low-waged and marginally employed has been higher during the pandemic than for middle- and high-income employees (Blom & Möhring, 2021; Hammerschmid et al., 2020). To address this issue, proposals were made for a minimum short-time working allowance but were rejected by the Grand Coalition government (Sell, 2020)—the consequence being that social protection for women in particular has been weaker. The Covid-19 crisis has exacerbated existing gender inequalities.

Partly offsetting these inegalitarian tendencies have been a number of government initiatives aimed at bolstering the position of the worst off. For instance, unemployment benefits were extended by up to 3 months, and the so-called “wealth test” of unemployment assistance (so-called Hartz 4) was suspended to improve access to basic income support (especially, by self-employed who are typically not covered by unemployment insurance) (Eichhorst & Rinne, 2020, p. 5f). Furthermore, stabilizing the labor market, a comprehensive stimulus package was launched in June 2020 totaling 30% of the value of GDP, which included temporary VAT reductions, a one-off lump sum payment of €300 per child and a range of support measures for businesses and the self-employed (KPMG, 2020). The mobilization of these substantial resources in the Covid-19 crisis response has, in principle, been similar to policies during the 2008 financial crisis, presenting a Keynesian policy response that was feasible because of Germany’s sound fiscal position; indeed, the country has started to produce fiscal surpluses rather than building up more debt (Cantillon et al., 2021). Nevertheless, despite greater inclusiveness, the policy response in social protection has been heavily shaped by the country’s Bismarckian legacy, and this relative “insider” focus leaves those in the low-wage sector more vulnerable.

Not only did the fiscal environment before Covid-19 allow comprehensive crisis policies protecting livelihoods, but it was also conducive to high institutional capacity in the health and residential care sector. Unlike the experiences of Sweden and the UK, Germany has generally fared better in terms of overall rates of infection and fatalities. For example, taking “baseline” mortality in 2020 based on 2015–2019 data, Karlinsky and Kobak (2021, p. 5) found excess mortality in Germany (understood as the difference between actual all-cause mortality from the beginning of the pandemic in March 2020 and the baseline) to be 4%, with Sweden and the UK standing at 10% and 18%, respectively.

Whilst the number of Covid-related deaths in residential homes is thought to be largely a reflection of infection rates in the general population, considerable cross-national differences can still be observed. Using data from the first Covid-19 wave, Frisina Doetter et al. (2021) calculate the mortality in care homes one would expect based on the assumption that infection rates in the general population drive Covid-19 deaths in care homes. The predicted value is then compared to actual mortality in care homes for a selected number of countries, including Germany and Sweden. In Germany, actual mortality is half of predicted mortality, whereas in Sweden actual and predicted mortality are basically identical. It appears that Germany managed to protect its elderly population in care homes better than Sweden; and Frisina Doetter et al. suggest that fast crisis response in the long-term care sector, adherence to guidelines from the European Centre for Disease Control and Prevention, and strong support from care homes when implementing these guidelines explain the difference between Germany and Sweden. Whilst the management of Covid-19 in care homes is certainly critical to protect residents, the institutional capacity of the health care sector to serve Covid-19 patients needs to be considered, in addition to income protection preventing the spread of the virus. As the earlier presented health care indicators show, not only does Germany’s spending per capita significantly exceed the OECD average (by about 62%), it also spends more than Sweden (plus about 15%) and UK (plus about 30%). This is reflected in better staffing (namely, the number of practicing doctors and nurses) and greater hospital capacity, including intensive and acute care beds. Thus, by comparative standards, Germany’s social-insurance-based health care sector can be thought to have presented a high degree of institutional readiness, with a clear egalitarian “knock-on” effect when the pandemic hit in March 2020.

To protect both employees and residents in the care sector from contracting and spreading the virus (in other words, keep infection rates low), income protection mechanisms need to be in place that allow employees to self-isolate when displaying Covid-19 symptoms or when in contact with Covid-19-infected people without causing hardship and/or significant income loss, which is likely to reduce compliance. In Germany, existing public health legislation stipulates that employers’ duties to continue the payment of the regular salary of quarantining employees for up to 6 weeks, and the costs are reimbursed from the authorities. Also, self-employed workers can claim the reimbursement of lost income when self-isolating (KPMG, 2020). In terms of institutional capacity, the existing income protection system was well placed to contribute to fighting the spread of the virus, which is reflected in an infection rate that is, for instance, 35% lower than infection levels in the UK, where, as discussed below, only minimal income protection was made available to those unable to work because of self-isolation.

Welfare state capacity and the Covid-19 response in Sweden

As noted above, Sweden was relatively hard hit by the Covid-19 pandemic. Excess mortality was about 8% higher during 2020 than in the previous years, which places Sweden below the European average but still significantly higher than the other Nordic countries (Statistics Sweden, 2021). The Swedish strategy to contain the spread of the virus has relied foremost on voluntary measures regarding hygiene, social distancing, and travelling and less on mandatory measures and lock downs. This relatively moderate approach has been questioned both domestically and abroad but defended by the Swedish Public Health Agency as taking a broader public health and societal perspective and being easier to sustain over the long term (Public Health Agency of Sweden (Folkhälsoinstitutet), 2021). Like most other countries, Sweden experienced a sharp economic decline as a result of the pandemic. GDP was reduced by 3.2% in 2020 and unemployment rose from about 7% in January 2020 to 8.3% in the fall of 2021 (Nier, National Institute of Economic Research, Sweden (Konjunkturinstitutet), 2021).

The policy measures taken by the Swedish social democratic-green government to protect the economy and sustain livelihoods during the pandemic followed two main tracks: direct aid to firms in the form of loans and tax credits and subsidies of wage costs through a state-funded short-time work scheme. The scheme, which is based on pre-existing legislation, was enacted in the Spring of 2020 and made it possible for employees to reduce their work time by up to 80% while receiving up to 95% of their wages (capped by an income ceiling). By June 2021, nearly 600,000 employees had been covered by the allowance, corresponding to 18% of all private sector workers (OECD, 2021b; Swedish National Mediation Office (Medlingsinstitutet), 2020). The Swedish short-term work scheme has been described as relatively generous by international comparison, not least in that it covers virtually the whole private sector, including part-term workers and those employed in temporary agencies while requiring only a 3-month employment period (Johansson & Selberg, 2020). Because the loss of jobs during the pandemic occurred mainly in the service and retail industries, those employed in these sectors have been affected disproportionately, particularly younger people, the low-skilled and migrants (Campa et al., 2021; OECD, 2021b). No difference in employment effects has been found between men and women in Sweden, which can be explained by factors such as women's higher employment in the public sector, and schools and preschools remaining open (Campa et al., 2021).

In addition to measures aimed at protecting the economy, Swedish policy responses to the Covid-19 pandemic also included a series of measures to temporarily reinforce existing social insurance provisions. Sick pay insurance, normally compensating income loss by 80% up to a ceiling, was extended in several ways. Administrative conditions such as medical certificates and a first qualifying day were removed and access extended to new groups such as suspected carriers of the Covid-19 virus and medical risk groups (Greve et al., 2021). Unemployment insurance, based on the Ghent system and providing up 80% income replacement, was temporarily reinforced as well. The main adjustments included the relaxation of qualifying conditions (time worked and time of union membership), extension to part-time employees, and slight raise of several benefit levels (Greve et al., 2021). Taken together, these government initiatives extended the existing social insurance system to meet the challenges of the pandemic by increasing both its accessibility and generosity. In this sense, the measures represent a reinforcement of Sweden's legacy as a social democratic welfare state, relying on relatively generous universal protection systems rather than means-testing and targeting.

If the Swedish social insurance system showed a relatively high capacity to respond to the pandemic, things were a bit shakier in the social services area. Both the health and residential care sectors in Sweden were strongly affected by the pandemic due to the country's relatively high infection rate in the first and second waves. A system akin to the UK's National Health Service, Swedish health care is tax-funded and universal, offering access to care services at low cost to all citizens on equal terms. The system is heavily decentralized, managed by 21 autonomous regional governments. In 2019, Sweden spent 11% of its GDP on health care, which is slightly above the EU average. Even so, the pandemic placed a high level of stress on the system, exposing some weaknesses. Most notably, the low number of ICU beds led to initial concerns that the system would become overburdened. Other challenges were staff shortages, particularly within the ICUs, and shortages in medical technology and personnel protection equipment early in the pandemic (Nylén, 2021). The low supply of ICU and acute care hospital beds in the system is the result of rationalizations in the hospital sector since the 1990s to achieve higher cost effectiveness (Blomqvist & Winblad, 2013). The shortages of medical equipment early in the pandemic

can at least in part be attributed to the adoption of cost-cutting “just-in-time” delivery systems adopted in many regions (Pierre, 2020).

The pandemic also demonstrated that the decentralized nature of the Swedish health care system can be a disadvantage in a crisis context. National oversight and coordination had to be strengthened, which delayed some initial crisis responses. In addition, it became difficult for some regional governments to secure deliveries of Personal Protective Equipment (PPE) and other equipment on the international market. The government therefore authorized the National Board of Health and Welfare to assist the regions in purchasing supplies and reallocating these among them, thereby strengthening central control. On the positive side, the Swedish health care system demonstrated a high capacity for flexibility during the pandemic, as additional resources were made available through the government and quickly re-allocated to the treatment of Covid-19 patients. Most notably, the supply of ICU beds increased in just a few months from 500 to 1,100 (SALAR, 2021). Evaluations also indicate that mortality among hospitalized Covid-19 patients was lower than in some other European countries and that there was a decline over time, indicating a rapid “learning effect” within the system (Strålin et al., 2021).

While the Swedish health care system ultimately appears to have managed the pandemic crisis quite well (Pierre, 2020; SALAR, 2021), the same cannot be said about the residential care sector. Part of the universal public welfare system, services to the elderly are provided by the 290 municipalities in Sweden. Delivery is predominantly public, while private contractors provide about 20% of all services (Winblad et al., 2017). In the autumn of 2020, a government-appointed commission concluded that quality problems in the residential care sector, such as high staff turnover, low staff education, and poor hygiene routines, had contributed to the failure to prevent the virus from spreading in this sector where a high percentage of all Covid-related deaths occurred (Swedish Corona Commission, 2020). A further shortcoming exposed by the pandemic is the complicated division of responsibilities between the regional health care authorities and municipal social care organizations. In particular, medical attendance by doctors in residential care homes, which is provided by the regions or private firms, was found to be inadequate in many instances. It can thus be concluded that there was insufficient capacity in this sector to respond appropriately to the crisis. However, to offset criticisms of the lack of skilled personnel in the sector, the government together with the main social partners in the sector, the Swedish Association of Local Authorities and Regions, and the Municipal Workers Union launched a program in 2020 to provide on-the-job training and better employment conditions in elder care. The program is expected to cover 10,000 workers (Swedish Ministry of Finance (Finansdepartementet), 2020) and arguably provides an example of reliance on social democratic welfare state-type arrangements—relationships with the social partners and worker training—that has characterized elements of the Swedish response to the virus.

This observation notwithstanding, the pandemic has exposed social inequalities within Swedish society and is likely to exacerbate them. For example, the risk of Covid infection and related death has been shown to be substantially higher among immigrants from low- and middle-income countries (OECD, 2020a, p. 60). In 2020, 20% of the Swedish population was born overseas—a share that has increased markedly in recent decades due to the arrival of large groups of refugees from the Middle East and Africa (Valeriani et al., 2020). In common with the UK, where mortality rates among minority ethnic groups have also been high, increased mortality among migrant groups has been attributed to factors such as poorer initial health status, more crowded living arrangements (including intergenerational living), and higher employment in sectors where home working has not been possible (Diderichsen, 2021; Valeriani et al., 2020).

In sum, Swedish policy responses to protect economy and society from the effects of the Covid-19 pandemic appear largely consistent with its tradition as a social democratic welfare state, favoring strong public involvement and universal policies. In some instances, it appears that this legacy has been relied upon and indeed reinforced during the pandemic, for example, in the form of state planning and coordination and higher level of public subsidies. Even so, the effects of the pandemic on social equality can be seen mainly in the labor market, where unemployment has risen predominantly in sectors with low-skilled and migrant workers, and in mortality rates, where migrant groups are clearly overrepresented. In this regard, the Covid-19 pandemic has highlighted the fact that the integration of migrants has become a major challenge for the Swedish welfare state.

Welfare state capacity and the Covid-19 response in the UK

As indicated, in the wake of a decade of first of Coalition and then majority Conservative governments' austerity measures (Hills, 2015; Hills & Stewart, 2016), the UK was not well placed to deal with the Covid-19 crisis. Pensioner protection apart, the pre-Covid benefit system in the UK's four nations experienced continuous reductions in working age benefits and benefits for children between 2010 and 2020, meaning that social security spending is anticipated to be about £34 billion lower by 2023–2024 than it would have been had the 2010 system remained in place (Gardiner, 2019). Spending on public services, meanwhile, particularly those supplied through English local authorities, declined considerably, especially after 2013–2014, falling by 49% in real terms (National Audit Office, 2018, p. 12), equating to a 28.6% “real terms reduction in ‘spending power’” (Hastings et al., 2015; see also Bambra et al., 2021). Local authority spending cuts had a particularly deleterious effect on adult social care, the Health Foundation (2018) estimating that social care funding across the UK in 2019–2020 will be less than it was in 2010–2011—and this bearing in mind that numbers of older people are increasing and that there is rising demand for specialist care services. Successive reviews of the care sector (no less than 12 white papers, green papers, and consultations in the past 20 years according to the National Audit Office, 2018, p. 16) have only recently culminated in a “partial” health and social care strategy outlined by the Conservative Government in September 2021, with the care sector due to receive £5 billion of extra funding over 3 years, starting in October 2023 (Foster, 2021).

Turning to the onset of Covid, it is by no means inaccurate to tell a story of dither and delay when assessing the UK central government's response to the initial onslaught of the virus, particularly where the decision to lock down was concerned (Calvert & Artbuthnot, 2021). Nevertheless, this is by no means the whole picture and, in some areas, measures were taken swiftly—and to some effect. Confronted by Bank of England forecasts of a 14% drop in output, the worst for 300 years, and a potentially catastrophic rise in unemployment, two headline programs were established to protect businesses, workers, and the economy in general. The Coronavirus Job Retention Scheme (JRS) was first announced on 20 March 2020, 3 days before the official lockdown declaration, and the details of the Self-Employment Income Support Scheme (SEISS) were revealed on 26 March. Backdated to 1 March, the JRS allowed employers to claim 80% of usual monthly wage costs up to a maximum of £2,500 per month (exclusive of Employer National Insurance Contributions and minimum automatic enrolment pension contributions) for Pay-As-You-Earn (PAYE) employees on full-time, part-time or zero hours contracts, thus allowing their employees to be “furloughed” but remain in employment. SEISS aimed to support self-employed people by providing a cash grant of 80% of their profits, up to £2,500 per month, initially for a period of 3 months. Both schemes, which covered all four nations of the UK, were extended as the pandemic progressed but effectively came to an end in October 2021. Taken together, these schemes have cost just under £100 billion at the time of writing.

Where benefits are concerned, those receiving Universal Credit (UC) were supported by the relaxation of certain criteria, such as work search, availability requirements, and the removal of the minimum income floor for the self-employed. Furthermore, a £20-per-week increase in UC payments was paid until October 2021, when it was controversially terminated, while those in low-income employment and receiving Working Tax Credit also received a £20 uplift until March 2021 when this weekly payment was replaced by a one-off payment of £500. Finally, in an effort to compensate those who lost income either because of a positive Covid test or because they had to self-isolate, a separate one-off payment of £500 was made available, paid through local authorities (Entitledto, 2021).

On the face of it, these central state interventions in the UK's liberal market economy are similar in tone and intent to the emergency initiatives taken in Germany and Sweden. They appear to mark a significant “Keynesian” departure from the UK's liberal path. Closer analysis of the “winners” and “losers” in the UK government's Covid strategy, however, suggests that the policies adopted were “deracinated” and essentially heuristic and did little to offset the challenges faced by those most exposed to the virus and its consequences. Where the JRS is concerned, for example, although furloughed jobs tended to be concentrated in specific sectors and age groups hardest hit by the economic downturn (18–25 year olds (HMRC, 2021), minority ethnic, and specifically Asian groups (Brack et al., 2021), and women (HMRC, 2021), the proportion of the workforce on furlough never exceeded 30%, indicating that many people have either had to work throughout the pandemic or, through redundancy, been forced onto the benefits system. Unlike the German case, where certain groups on lower incomes have been protected through short-term working arrangements, the UK furlough scheme did not prevent

Table 2. Age-standardized death rates by ethnicity in England and Wales, involving C-19 among males and females aged over 9 years between 2 March and 28 July 2020 (rates per 100,000 pop).

	Male	Female
White	106.8	65.7
Mixed	167.1	93.8
Indian	175.3	99.8
Pakistani	200.3	115.7
Bangladeshi	270.5	111.0
Chinese	133.3	75.5
Black African	287.7	114.8
Black Caribbean	270.3	128.8
Other	191.9	99.5

ONS (2020).

employers terminating contracts or prioritizing permanent employees over casual staff for furlough, nor did it make supplementation of the 80% wage subsidy mandatory (39% of those working in hospitality were affected by this “wage cut”; TUC, 2021). Where SEISS is concerned, roughly 1.25 million self-employed people have been refused payments owing to the government’s strict eligibility criteria (Cribb et al., 2021). Other issues associated with difficulties in claiming UC (Summers et al., 2021), or in claiming one-off payments for self-isolation (Booth, 2021) point to government reluctance to be too generous to those at the sharp end of the pandemic. Poorer and minority ethnic groups and those who suffer from pre-existing health problems and poorer housing conditions have been particularly at risk. Taking ethnicity, for example, ONS figures demonstrate significant differences in first-wave mortality rates between the majority ethnic group and other groups in England and Wales (see Table 2; Bambra et al., 2021; Platt & Warwick, 2020). These differences were also evident during the second wave. Age-standardized mortality rates per 100,000 population in England for the year ending 30 June 2021 were 158.9, 277.4, and 350.2 for White/White British, Black/Black British, and Asian/Asian British, respectively (Health Security Agency, 2021).

With respect to health and social care, given the starting-gate strictures mentioned above (see Table 1), it is not surprising that insufficient staffing capacity meant that existing NHS staff had to be reassigned to Covid-related duties, thus jeopardizing “normal” NHS business. Cancer treatment and routine operations, for example, were all but suspended during Covid’s first and second waves. It is also not surprising that the need to protect NHS staff from infection by incoming Covid patients meant that the service had the first call on scarce PPE—at the expense of the residential sector (British Academy, 2021; Calvert & Artbutnot, 2021). Furthermore, the lack of NHS bed capacity had a particular impact on this sector, especially in the early stages of the pandemic. Estimates indicate that, following NHS guidance in March 2020, 25,000 untested patients were rapidly discharged into care homes in England and Wales between mid-March and mid-April (BBC, 2020), laying the foundations for a residential sector crisis that saw 27,000 “excess deaths” (compared with a 5-year average) (ONS, 2021) and the two countries second only to Belgium in deaths per million people aged 60–65 and over (OECD, 2020a). In Scotland, too, care homes were at the center of the first-wave crisis. In the first week of April 2020, for example, “care home deaths were more than 160% higher than the historic average of weekly deaths in care homes” (Bell et al., 2020).

These initial problems were tackled fairly swiftly following the publication of the *Coronavirus (COVID-19): adult social care action plan* on 15 April, leaving care homes better prepared to deal with the protracted second wave of the pandemic that started in late October 2020 and tailed off toward the end of February 2021. Although the care home death toll remained high, the availability of PPE, an enhanced testing regime and the onset of a successful vaccination strategy resulted in a lower number of deaths, as a proportion of total deaths. In summary, although impressive progress was made in protecting care home residents from infection after April 2020, as researchers at the King’s Fund have pointed out (Charles & Ewbank, 2021), taken in the round, the Covid “stress test” dramatically exposed the existing inequalities in the UK’s residential care “system”—specifically resource inequalities between the health and residential sectors, resource differences among private care home providers, and the low wages

and poor working conditions of care home staff in all four UK nations (see also [House of Commons, 2020](#)).

Discussion

These case studies display certain broad similarities in their responses to Covid. For example, despite no significant evidence of “policy learning”, various forms of demand-side protection were swiftly deployed to offset the risk to livelihoods of mass unemployment and economic collapse. Again, as could be anticipated, each country took measures to support its health care system and, less speedily in some instances, also took steps to mitigate Covid’s impact on its residential care sector. Closer inspection of governmental responses, however, reveals differences that speak to the institutional disparities among the three welfare regimes and the different approaches taken toward the social and economic inequalities that were exposed during the crisis. Here, although both countries clearly experienced difficulties and differed in their attitudes to lockdown, Germany and Sweden, with generally greater institutional system-capacity, proved to be more “resilient” than the UK, in some instances displaying “institutionally recidivist” tendencies in a renewed reliance on regime-specific arrangements to provide material assistance and protection to certain vulnerable populations. Challenging the trend toward “liberal” labor market and social protection policies, short-term working in Germany, also swiftly introduced in Sweden, appears to have been particularly important as a buffer in both cases, protecting many people in the lower paid sectors of the labor market. Even so, where equality issues are concerned, “institutional recidivism” only takes us so far. For one thing, reliance on established institutional practices can result in the perpetuation, or resurrection, of traditional inequalities as we have seen in the German case. For another, it may draw attention away from the need to develop specific measures to protect emerging minority groups—something that arguably characterizes aspects of the Swedish response.

In contrast to the “social democratic” character of the Swedish approach to unemployment protection and income replacement, health and residential care appears to have fared less well because the recent legacy of retrenchment and marketization has stripped the system of much of its excess capacity. That said, while hospitals experienced difficulties at the margin, aided by central government, they broadly coped with the challenge of the virus. The high number of deaths in the Swedish residential care sector, however, speaks to a wider failure to protect the lives of older people in this increasingly marketized area of welfare ([Winblad et al., 2017](#)). Of course, whereas income support measures can be adjusted relatively quickly, quality deficiencies in the service sector are more difficult to reverse at short notice—although it is important to note that Swedish efforts to strengthen working conditions in residential care via additional funding and agreements with the social partners compare favorably with the UK’s failure to do so. Germany, conversely, had existing institutional capacity in both its health and social care sectors that have so far proved sufficient to deal comparatively successfully with the challenges the country faced during the pandemic. A very different institutional dynamic has been evident in the UK where the liberal legacy of labor market flexibility and welfare retrenchment, perhaps particularly in England, was exposed by Covid, necessitating significant short-term, demand-side deviations from the liberal path with regard both to employment and social protection, and health and residential care.

Looking across the three countries, a final observation is that, irrespective of regime type, the Covid crisis has not prompted governments to *extend* equality measures to new populations and minority groups, despite, in many cases, their heightened vulnerability to the virus. Although discouraging, our analysis clarifies the reasons for this apparent failure. On the one hand, the recidivistic tendencies and persistence of institutional legacies identified in Germany and Sweden, by encouraging “a return to type”, militate against such an outcome. On the other hand, in the UK, the chaotic, ad hoc nature of the Covid response—a consequence of the country’s liberal legacy—prevented the development of a coherent strategy, thereby increasing the likelihood that the measures taken would fail to take full account of the needs and interests of the most vulnerable, and exposed, sections of society.

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